February 26, 2007

Citizens of Wake County:

Wake County is an evolving community. The diversity of the population, the continued growth toward a more urban environment and the amazing growth in the number of individuals who live here make Wake County an exciting, vibrant place to live, work and learn. These same factors challenge our system of services that attempts to meet the needs of this community's burgeoning populace. This Wake County Community Assessment process provides accurate, up-to-date information that allows the citizens, leaders and service providers to plan together to meet those needs.

The development of this document was a collaborative effort that involved direction from a Community Steering Committee, facilitation by Wake County Human Services and input from a broad group of citizens of Wake County. Work groups reviewed data and results from community surveys and focus groups. The final report offers an overview of Wake County including demographics, geography and history. The majority of the document is divided into six key areas: behavioral and social health, economic health, environmental health, lifelong learning, physical health and safety. Each area addresses multiple issues related to the topic including contributing factors, disparities and unmet needs.

This Executive Summary presents the specific findings from each of the key areas. These findings are being used by leaders and community members from Wake County to develop an Action Plan for the community. A prioritization process will allow our community to identify the most urgent and encompassing issues for the next four years.

This Action Plan will ask us to come together around a common vision of a healthier, safer, supportive community for all Wake County residents and move us forward while focusing our resources over the next four years.

A recent Blue Ribbon Committee focused on the infrastructure needs of Wake County. However, the Committee began its report by stating that "a true community is much more than bricks and mortar. It is defined not simply by how it looks, but also by how it governs, by the richness of its social fabric, and by the spirit of its people." To assure that our community is the best it can be, we must first have the knowledge of what needs to be done and, secondly, the will for positive change. This document is the knowledge of what we need to do; the citizens of Wake County are the will. Please join us as we move forward in this process of change.

Tony Gurley
Chair, Wake County
Board of Commissioners

Hilda Pinnix-Ragland
Vice President, Northern Region
Progress Energy Carolinas

Co-Chairs, Wake County Community Assessment Steering Committee

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Acknowledgements

Wake County community leaders came together in 2006 to assess the overall health and well being of our community. The Wake County Community Assessment Steering Committee worked with County staff from Human Services and other departments to collect and assess data, to implement and review community surveys and focus group data, and to prioritize issues needing attention in Wake County.

A special appreciation goes to this group for their hard work and dedication to this complex process and extensive project.

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Introduction

The Community Assessment process is the first step in the development of a community action plan that will address documented and prioritized needs in Wake County. Over the past year, a Steering Committee comprising more than 60 community, faith, business, hospital, nonprofit and government representatives directed the activities of the assessment process and provide input on issues of interest. This committee was chaired by Hilda Pinnix-Ragland, Vice President of Progress Energy Carolinas and Commissioner Tony Gurley, Chairman of the Wake County Board of Commissioners.

A Core Staff Team was formed to ensure consistent data collection and engagement of community partners. Work groups composed of community topic experts and County staff reviewed data and produced the chapters of the Community Assessment report covering six areas:

1] Behavioral and Social Health

2] Economic Health

3] Environmental Health

4] Lifelong Learning

5] Physical Health

6] Safety

The Assessment presented by the six work groups builds the foundation for:

- •] Creation of the Wake County Community Assessment Action Plan, initiated by several hundred community partners at a Planning Forum on February 26, 2007, held at WakeMed Health & Hospitals' main Raleigh campus.
- •] Ongoing discussion for planning and development of strategies to be implemented by and for community stakeholders – individually or collaboratively – including business, government, hospital, nonprofit, education and faith-based organizations.
- •] Prioritizing the most critical issues affecting the quality of life of all residents of Wake County and addressing them "head-on."
- •] Providing benchmark information for measuring the community's success and progress in seizing opportunities and meeting challenges.

Data Collection Methodology

Information for the Community Assessment came from data, community surveys and community focus groups. From July to September 2006, the Community Assessment Team conducted 28 focus groups with 251 participants. In addition, 3,232 surveys were completed in English and 117 surveys were completed in Spanish.

The 2006 survey was reviewed and edited by the Primary Survey Data group. Variables were added to reflect more diverse topics that could be of concern to citizens. Surveys were piloted with the Community Assessment Steering Committee. The final survey contained 132 questions, including the demographics section. Surveys were translated in Spanish by bilingual staff. Surveys were made available on-line (in English only) from June 12 through July 31, 2006. Citizens were directed to the on-line survey in a variety of ways, including with general media publicity and communication channels through local government, North Carolina State University and many businesses and agencies.

Efforts were made to reach populations less likely to use or have access to the Internet. Approximately 4,000 hard copies of surveys were available in English and Spanish and were distributed to organizations that serve Spanish speaking clients, Senior Centers, Child Care Programs, health or human services organizations that serve low-income or underserved populations, Juvenile Justice, area churches, YMCA, public libraries and regional health centers.

Survey Responses by Age Denominator

119. City/Town in which you LIVE	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Raleigh	48.3%	**60.4%**	**55.8%**	**58.1%**
Cary	10.9%	1.2%	12.1%	15.3%
Garner	3.9%	5.8%	4.9%	3.8%
Fuquay-Varina	3.8%	3.5%	4.7%	4.2%
Apex	3.4%	7.0%	4.2%	3.3%
Wake Forest	2.9%	4.7%	3.3%	3.1%
Knightdale	2.4%	2.3%	3.1%	2.1%
Holly Springs	2.1%	1.2%	2.9%	1.6%
Wendell	1.7%	4.7%	1.9%	2.0%
Zebulon	1.2%	2.3%	1.5%	1.2%
Morrisville	1.2%	3.5%	1.5%	0.9%
Rolesville	0.6%	0.0%	0.7%	0.8%
Other	<0.5%	0.0%	0.0%	0.0%
No Answer Given	17.3%	3.5%	3.4%	3.5%

120. How long have you lived in Wake County?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
more than 10 years	**48.9%**	**26.6%**	**48.4%**	**78.4%**
1 to 5 years	16.2%	32.5%	23.7%	7.7%
6 to 10 years	14.1%	22.1%	20.1%	8.2%
Less than 1 year	2.9%	12.7%	3.8%	1.6%
I do not live in Wake County	2.3%	2.3%	2.5%	3.0%
No Answer Given	15.3%	3.5%	1.2%	0.9%

121. City/Town in which you Work	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Raleigh	55.3%	47.6%	66.1%	63.7%
Cary	7.7%	3.5%	9.3%	8.7%
Morrisville	2.9%	2.3%	4.4%	1.5%
Garner	1.1%	4.7%	1.5%	0.7%
Fuquay-Varina	1.8%	5.8%	1.9%	2.0%
Apex	1.3%	3.5%	1.5%	1.6%
Wake Forest	1.0%	2.3%	0.9%	1.0%
Holly Springs	0.8%	0.0%	1.1%	0.8%
Zebulon	0.8%	1.2%	1.0%	0.7%
Knightdale	0.5%	1.2%	0.7%	0.3%
Wendell	0.5%	3.5%	0.3%	0.7%
Rolesville	<0.5%	0.0%	0.1%	0.1%
Other	0.2%	1.2%	0.4%	0.1%
No Answer Given	26.1%	23.3%	10.7%	17.6%

122. Do you work for Wake County	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Yes	16.2%	4.6%	19.8%	18.8%

123. Your Gender	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Female	61.1%	65.1%	73.9%	67.4%
Male	22.5%	31.3%	24.5%	29.9%
No Answer given	16.1%	3.5%	1.5%	2.4%

124. Your Age	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
40 - 49 years	24.1%		43.4%	
30 - 39 years	19.8%		35.8%	
50 - 59 years	17.7%			66.8%
20 - 29 years	11.4%		20.5%	
60 - 69 years	6.2%			23.1%
15 - 19 years	2.2%	81.3%		
70 - 79 years	2.0%			7.7%
80 years and over	0.6%			2.2%
10 - 14 years	0.5%	18.5%		
No Answer Given	15.2%			

125. Racial/Ethnic identification	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
White or Caucasian	50.7%	16.2%	59.5%	65.1%
Black or African American	22.1%	51.1%	25.1%	26.1%
Hispanic/Latino	4.6%	12.7%	7.0%	1.6%
Multi-racial	3.4%	11.5%	4.1%	3.1%
Asian or Pacific Islander	1.0%	2.3%	1.3%	0.7%
Native American	0.6%	2.3%	0.5%	1.0%
Other	0.8%	2.3%	0.9%	0.9%
No Answer Given	16.4%	1.2%	1.5%	1.3%

126. Education	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
College graduate	32.8%	2.3%	42.9%	33.3%
Post graduate degree	22.9%	0.0%	25.4%	33.1%
Some college (no degree)	12.5%	5.8%	14.9%	15.4%
High School Graduate/GED	7.5%	37.1%	7.8%	7.9%
12th Grade or Less, no diploma or equilivant	4.2%	48.7%	3.6%	3.4%
Vocational/Technical	3.6%	0.0%	3.6%	6.1%
No Answer Given	16.1%	5.8%	1.4%	0.6%

127. Are you a Member of a Faith Organization	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Yes	51.9%	25.5%	58.5%	70.2%
No	30.6%	69.7%	38.7%	27.4%
No Answer Given	17.2%	4.7%	2.6%	2.2%

128. Employment Status	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Employed full-time	57.9%	10.4%	74.7%	60.7%
Employed part-time	9.3%	15.1%	11.2%	10.3%
Retired	6.6%	1.2%	0.8%	23.1%
Unemployed	6.1%	20.8%	8.2%	3.6%
Student full-time	2.5%	41.8%	2.3%	0.5%
Student part-time	0.4%	4.7%	0.4%	0.0%
No Answer Given	16.9%	5.8%	2.1%	1.7%

129. How much money do you have to support your household each year?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
$25,000 to $49,999	21.4%	5.8%	27.6%	22.5%
$50,000 to $74,999	16.2%	2.3%	18.6%	22.1%
$100,000 or higher	14.7%	5.8%	16.8%	19.8%
$75,000 to $99,999	11.6%	0.0%	14.1%	14.5%
$15,000 to $24,999	5.8%	3.5%	6.7%	7.2%
Less than $5,000	4.6%	54.7%	4.9%	1.6%
$5,000 to $14,999	4.5%	11.5%	5.1%	5.0%
No Answer Given	20.7%	16.2%	6.0%	6.9%

130. Number of people dependent on the money you have to support your household:	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Two (2)	24.6%	15.1%	23.3%	42.4%
One (1)	21.9%	38.3%	24.7%	27.1%
Three (3)	14.3%	12.7%	17.5%	16.1%
Four (4)	13.1%	11.5%	18.9%	8.7%
Five (5)	4.7%	7.0%	7.6%	0.9%
Six (6)	2.1%	2.3%	3.2%	1.0%
Seven (7) or more	0.7%	1.2%	0.8%	0.7%
No Answer Given	18.1%	11.5%	3.6%	2.7%

131. Do you have health insurance?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Yes	73.5%	58.1%	85.6%	91.5%
No	8.7%	15.1%	11.8%	6.4%
Don't know or not sure	1.1%	22.1%	0.8%	0.5%
No Answer Given	16.4%	4.7%	1.6%	1.4%

132. If you have health insurance, what kind(s) do you have?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Managed Care (HMO, PPO, Etc.)	38.1%	7.0%	30.3%	38.8%
Private - traditional	26.8%	41.8%	50.4%	36.2%
Government Other than VA	6.2%	2.3%	5.4%	12.5%
Medicare	5.1%	10.4%	1.4%	16.8%
Medicaid/Health Choice	3.4%	16.2%	4.9%	3.4%
Veteran's Administration (VA)	1.2%	2.3%	1.0%	2.7%

Secondary data for the Community Assessment was collected from dozens of sources, including the Behavioral Risk Factor Surveillance Survey, the State Center for Health Statistics, Wake County Human Services data bases, the Centers for Disease Control and Prevention (CDC), and the U.S. Census.

Twenty-eight focus groups, representing nine target audiences, were conducted throughout Wake County during the months of July and August 2006 to gather community perceptions of physical health, behavioral and social health, economic health, environmental health, safety and lifelong learning issues affecting the community. Focus groups are informal sessions in which representatives of target populations are asked to discuss their thoughts on a specific topic – in this case, the needs and strengths of Wake County. The groups were usually small (8-12 persons per group), with particular emphasis placed on recruiting people who were representative of the community or target groups of interest. Because the process required a trained facilitator and recorder, 15 facilitators and/or recorders were recruited and trained.

Audiences reached through the focus groups included:

- African-Americans (2 groups)
- Latino/Hispanic (6)
- Faith community (2)
- Service providers (7)
- Youth (4)
- People with disabilities (2)
- Seniors (3)
- Young adults/college students (1)
- People living with HIV (1)

Demographics

Twenty-eight focus groups were conducted, reaching 251 total participants.

Gender and racial breakdown of participants

	Female	Male	Unknown	Total
African-American	74	31	3	108
Asian	1	4	0	5
Caucasian	56	19	0	75
Hispanic/Latino	44	15	0	59
Multi-Racial	3	0	0	3
Other/Unknown	0	1	0	1
Total	178	70	3	251

Age/race distribution

	0-18	19-24	25-61	62+	Unknown	Total
African-American	30	2	62	11	3	108
Asian	0	0	4	1	0	5
Caucasian	4	0	49	22	0	75
Hispanic/Latino	17	5	35	2	0	59
Multi-racial	2	0	1	0	0	3
Other/Unknown	0	0	1	0	0	
Total	53	7	152	36	3	251

Geographic distribution

	Total # Focus Groups per location	Total # Participants residing in town
Apex	1	5
Cary	2	16
Fuquay-Varina	3	29
Garner	1	11
Holly Springs	0	8
Knightdale	0	4
Morrisville	0	0
Raleigh	17	111
Rolesville	2	38
Wake Forest	1	10
Wendell	1	19
Zebulon	0	0

WAKE COUNTY BY THE NUMBERS: 2000 - 2005 - 2010

During the 1990s Wake County grew at an average rate of 4.8% annually. Since 2000:

- •] Wake County's landscape continues to evolve into a more urban form.
- •] Wake County's population continues to diversify with new residents migrating from other counties, states and countries.
- •] Wake County has added, on average, 66 residents every day (persons who are born here or move here).
- •] Wake County's marketplace continues to change to meet the demands and service needs of a growing, diversifying population.

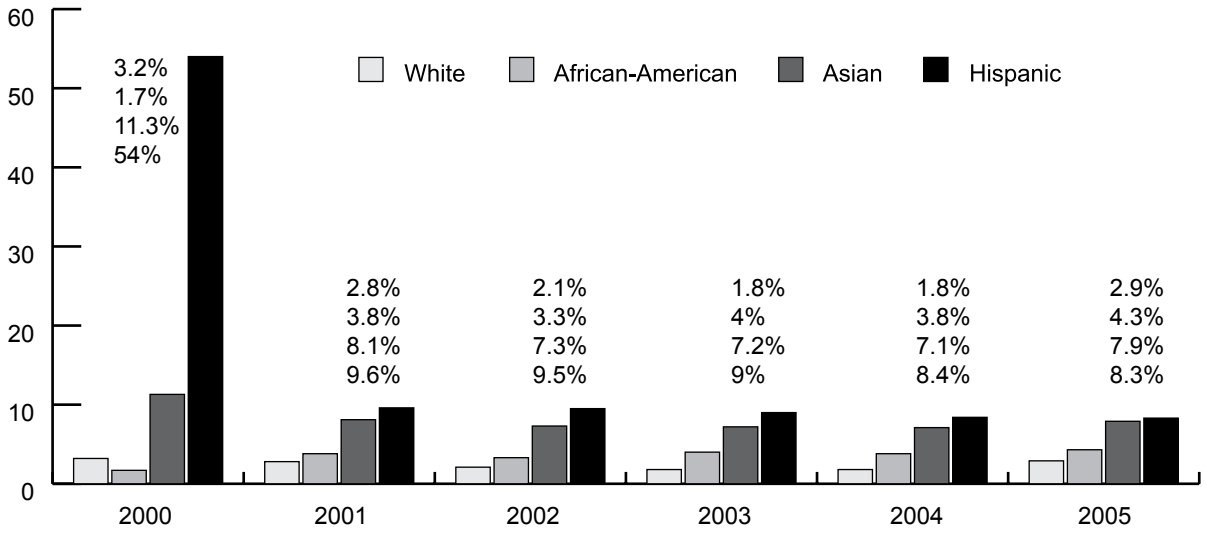
The July 1, 2005 North Carolina State Demographer's Wake County population estimate represents:

- •] An increase of 121,182 residents since July 1, 2000;
- •] An average annual growth rate approaching 4.0 percent since July 1, 2000.

Urbanization Trends: Population Growth & Density

During the 1990s, Wake County grew at an average rate of 4.8% annually. During the first five years of the new millennium, Wake County's growth has slowed slightly to about 4.0% annually, yet we have an increasing number of births, unprecedented public school student population growth, a rapid pace of new housing permits, and a more diverse community. Although white, non-Hispanics residents make up the largest racial group in Wake County; they declined as a percentage of the total population between 2000 and 2005. The Asian population grew rapidly, at 51%. Growth among Wake County's Hispanic/Latino population was the most substantial: between 2000 and 2005 the number of Hispanics/Latinos living in Wake County increased by 63%. Growth rates of non-Hispanics and Blacks/African-Americans were more modest at 13% and 23%, respectively.

Wake County Population Growth Rates by Selected Race/Ethnicity 2000-2005



Wake County's landscape continues to evolve into a more urban form.

2005 Certified County Population Estimates:
Top 3 Most Populous Counties in North Carolina

Rank	County	July 1 Population	2006 Projection
1	MECKLENBURG	796,232	820,487
2	WAKE	755,034	782,283
3	GUILFORD	441,428	448,694
	STATE of N.C.	8,682,066	8,828,041

2005 Certified County Population Estimates:
Top 3 Counties in North Carolina
With the Largest Population Increase since April 2000

Rank	County	July 1 Population	2000 - 2005 Population Increase
1	WAKE	755,034	127,168
2	MECKLENBURG	796,232	100,862
3	UNION	161,332	37,560
	STATE of N.C.	8,682,066	635,253

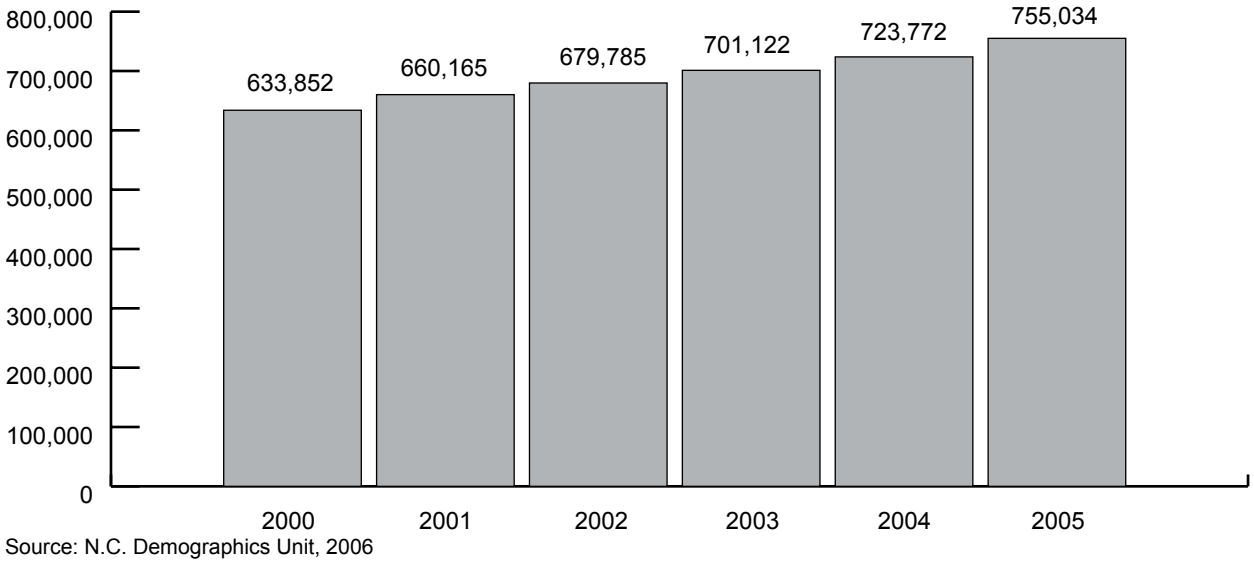
2005 Certified County Population Estimates:
Top 3 Most Densely Populated Counties in North Carolina
(Density: Population per Square Mile – Land Area)

Rank	County	July 1 Population	Land Area	Density
1	MECKLENBURG	796,232	526.28	1,512.98
2	WAKE	755,034	831.92	907.58
3	New Hanover	180,358	198.93	906.64
	STATE of N.C.	8,682,066	48,710.88	178.24

Source for each table above N.C. State Demographics Unit, 2006.

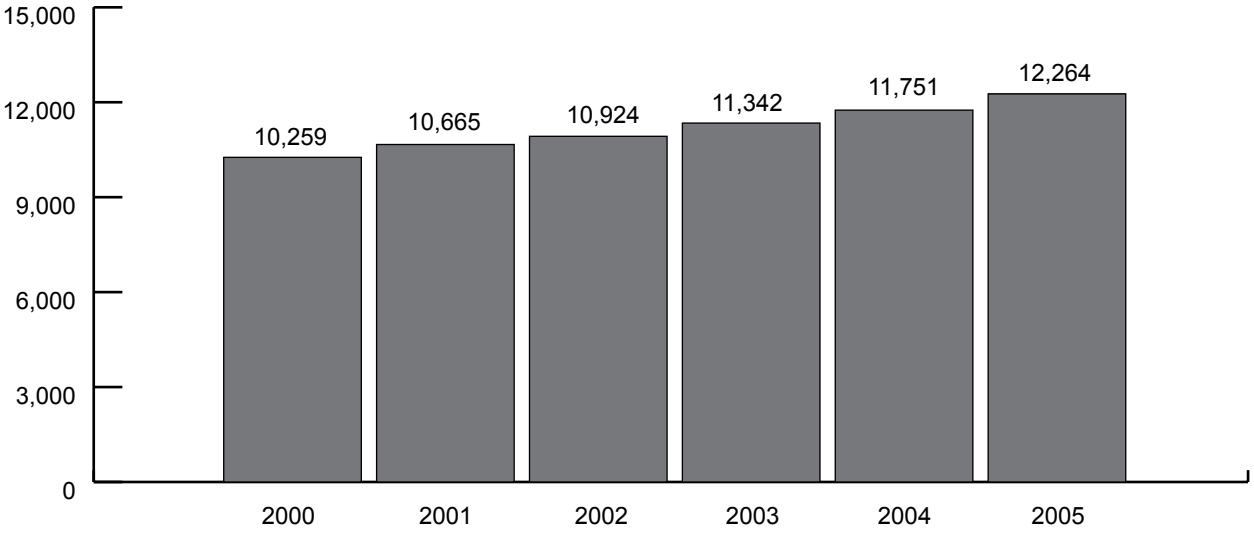
Wake County has seen its population per square mile increase from 754.72 in 2000 to 907.60 in 2005, overtaking New Hanover County as the second densest county within the state.

Wake County Population 2000-2005



Source: N.C. Demographics Unit, 2006

Wake County Births 2000-2005



All ethnic/racial groups have seen an increase in births; however, the largest increase has been in Hispanic births. In 2000, 1,146 births were of Hispanic origin, while in 2005, the number was 2,216. (Source: N.C. Department of Health and Human Services, 2005 Birth Data)

Growth In Unincorporated Wake County

The most recent State Demographer's report documents that 755,034 people lived in Wake County on July 1, 2005. The number of residents outside of Wake's twelve (12) city and town jurisdictions totaled 173,591, compared to 172,016 residents in July 2004. As more land is annexed by Wake County's incorporated jurisdictions, the population growth in the balance of Wake County would be expected to decrease or stabilize. Despite annexations, the number of people residing in the unincorporated areas of Wake County ranks highest among the state's 100 counties.

2005 Certified County Population Estimates: Top County in North Carolina with the Most People Residing Outside of Incorporated Cities and Towns

Rank	County	July 1 Population	Non-municipal Population	% Municipal Population
1	WAKE	755,034	173,591	77%
	STATE of N.C.	8,682,066	4,075,836	53%

2005 – 2010 Wake County Planning Population Projections

County-level projections, including the 2005 and 2006 forecasts, are documented in the Wake County Planning Department/Informed Decisions Inc. Report, published in 2001. These original projections were based on Census 2000 data and assumed annual county-level population growth rates of 3.3 for 2004-2006. However, the most current data (July 2005) from the U.S. Census Bureau and N.C. State Demographer's Office estimate that Wake County's population grew 4.2% between July 2004 and July 2005. After reviewing recent estimates and growth rates for 2005, Wake County Planning has updated its 2006 population projection to reflect a 4.1% increase over the NC State Demographer's 2005 estimate of 755,034.

Year	NC State Demographer	Wake County Planning
2006	782,283	785,990

The chart below illustrates growth at a 4.0% rate based on the N.C. State Demographer's 2005 estimate of 755,034.

Year	Wake County Population Projection	Projected Annual Growth Rate
2006	785,990	4.1%
2007	817,429	4.0%
2008	850,126	4.0%
2009	884,131	4.0%
2010	919,496	4.0%

Service and Program Implications

In 2000, Wake County had approximately 157,000 young people ages 0-17. By 2005, this number had climbed to approximately 196,700. This influx of children has had a substantial impact on the public school system, health services and other services designed to meet the needs of youth in Wake County. The senior population has seen similar growth. In 2000, Wake County had slightly more than 90,000 residents aged 55 and over. By 2005, this population had grown to nearly 119,000 people aged 55 and over. As with children, this increasing number of seniors has service implications.

Between April 2000 and July 2005, 20% of all new population growth in the State of North Carolina occurred in Wake County. This demographic component and others noted previously in this report – urban growth and population density – influence program delivery and design decisions for Wake County service providers. They affect communities' strategies for planning employment, residential, educational, and recreational activity centers that are functional, safe, healthy and desirable.

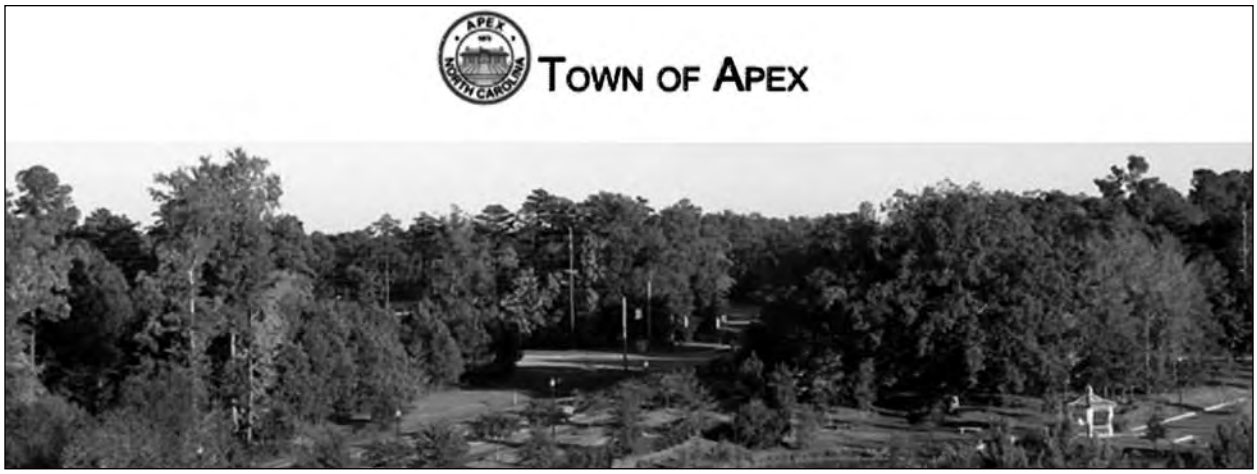


Image: Town of Apex Website, November 2006

Community Characteristics:

... Apex retains its small-town character in a region that is experiencing rapid growth. In short, we place a high value on our historic heritage while planning for our future residents in the many neighborhoods now under construction. Apex reflects an ideal urban community with excellent schools, quiet, friendly neighborhoods, and a growing number of businesses providing jobs and convenient shopping opportunities ... *[Excerpt from "Message from Mayor Keith H. Weatherly," 2006]*

Community Contact Information:

Primary Address: Apex Town Hall
73 Hunter Street
Apex, NC 27502

Telephone Number: (919) 249-3400

Website: www.apexnc.org

TOWN OF APEX DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	20,212	27,203[3]	36,615[4]
% White Alone	85.1	79.5	77.4
% Black Alone	7.5	11.4	11.8
% American Indian Alone	0.3	.04	.04
% Asian Alone	4.3	4.7	5.7
% Pacific Islander Alone	0.1	0.0	0.0
% Some Other Race Alone	1.1	2.1	2.5
% Two or More Races	1.7	1.9	2.1
% Hispanic Origin **(Any Race)**	3.2	4.6	5.3
% College Graduates	58.8	No estimate	No Projection
# Of Households	7,397	9,911	12,065
% Family Households	75.5	80.2	80.5
% Owner-Occupied Households	76.6	75.8	74.3
Average Household Size	2.73	2.70	2.69
Median Age	31.2 years	33.6	35.1
% Age under 5 years	10.4	9.5	9.5
% Age 65 and over	4.0	4.1	4.3
Median Household Income	$71,052	$82,506	$100,092
Median Housing Value[5]	$125,002	$174,353	No Projection
# Of New Residential Permits Issued[5]	834	445	No Projection
# Of New Non-Residential Permits Issued[5]	30	30	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.22/.78	.19/.81	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Cary Website, November 2006

Community Characteristics:

The January 2004 Issue of Money Magazine named Cary the hottest town in the East and one of the six Hottest Towns in America. In August 2006, Cary was again recognized by Money Magazine as one of the Best Small Cities in America, ranking fifth on the magazine's list of Best Places to Live. ... On the whole, Caryites are a blessed, hard-working group with one of the highest median household incomes in the state. And being no further than 20 minutes from major universities such as Duke, North Carolina State, and the University of North Carolina, it's no wonder that education is an important part of Cary life. More than two-thirds of adults hold a college degree. Nearly nine in 10 citizens have access to the Internet in Cary (called the "Technology Town of North Carolina") ... Yet we've remained the *Town* of Cary while growing to more than 100,000 people. *[Excerpt from Town of Cary's website, 2006]*

Community Contact Information:

Primary Address:	Cary Town Hall 316 North Academy Street Cary, NC 27513
Telephone Number:	(919) 469-4007
Website:	www.townofcary.org

TOWN OF CARY DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	94,536	115,916[3]	142,113[4]
% White Alone	82.2	79.9	77.4
% Black Alone	6.1	6.4	6.5
% American Indian Alone	0.3	.03	.03
% Asian Alone	8.1	9.4	11.4
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	1.5	1.8	2.0
% Two or More Races	1.8	2.0	2.3
% Hispanic Origin **(Any Race)**	4.3	5.1	5.7
% College Graduates	60.7	No Estimate	No Projection
# Of Households	34,906	41,673	48,550
% Family Households	72.0	69.2	67.7
% Owner-Occupied Households	72.8	71.6	71.8
Average Household Size	2.69	2.70	2.71
Median Age	33.7 years	34.8	35.4
% Age under 5 years	8.1	7.6	7.6
% Age 65 and over	5.4	5.9	6.4
Median Household Income	$75,122	$82,808	$97,144
Median Housing Value[5]	$128,154	$187,053	No Projection
# Of New Residential Permits Issued[5]	839	1,481	No Projection
# Of New Non-Residential Permits Issued[5]	119	31	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.29/.71	.25/.75	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3] North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation 2010 Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Fuquay-Varina Website, December 2006

Community Characteristics:

Fuquay-Varina is the result of a merger in 1963 of two historic and distinctive communities, Fuquay Springs and Varina. As a result, the town has two historic downtown areas that are major focuses of community identity. According to the Chamber of Commerce website, Fuquay-Varina is a "small town with wide open spaces in a rural setting." The town's Comprehensive Growth Management Plan emphasizes Fuquay-Varina's "village character", which is comprised of features such as "close knit" land uses; pedestrian-friendly streets and neighborhoods; parks, open space, and greenery; and a friendly, cooperative spirit. *[Excerpt from Wake County Growth Management Strategy Report December 2002]*

Community Contact Information:

Primary Address: Fuquay-Varina Town Hall
401 Honeycutt Road
Fuquay-Varina, NC 27526

Telephone Number: (919) 567-3907

Website: www.fuquay-varina.org

TOWN OF FUQUAY-VARINA DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	7,898	12,207[3]	18,872[4]
% White Alone	70.6	72.5	71.0
% Black Alone	24.4	21.8	22.4
% American Indian Alone	0.4	0.6	0.6
% Asian Alone	0.5	0.7	0.9
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	2.9	3.0	3.5
% Two or More Races	1.2	1.4	1.6
% Hispanic Origin **(Any Race)**	7.4	7.7	9.1
% College Graduates	27.1	No Estimate	No Projection
# Of Households	3,122	3,775	4,414
% Family Households	68.1	70.5	68.8
% Owner-Occupied Households	61.6	68.8	70.7
Average Household Size	2.48	2.48	2.48
Median Age	32.6 years	33.8	34.7
% Age under 5 years	8.8	8.9	8.9
% Age 65 and over	13.0	10.2	9.3
Median Household Income	$42,903	$54,191	$63,610
Median Housing Value[5]	$74,111	$118,715	No Projection
# Of New Residential Permits Issued[5]	245	580	No Projection
# Of New Non-Residential Permits Issued[5]	20	20	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.49/.51	.34/.66	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Garner Website, December 2006

Community Characteristics:

Garner is a unique and inviting combination of the best of the old and the most innovative of the new. Nowhere else in the state does the solid bedrock of family-oriented tradition and the progressive catalyst of new ideas and new technology meet and mingle. A truly fascinating harmony is found in our community of over 18,000 people. That harmony has drawn thousands of new residents to Garner during the last 20 years as workers and leaders in business, industry, government and research look for an affordable, traditional home for their families...Because Garner has a small-town heritage, it's the kind of place where neighbors meet at their mailboxes and talk over local issues - where everyone turns out for the Friday night high school football games or the annual Independence Day Festival..Since development has been steady, but not explosive over the last decade, Garner has had time to plan for essential facilities and services to accommodate the growth that's now coming its way. Today, Garner is the place to find all the opportunities that go along with economic growth and all the benefits of city living in a less taxing, more gracious living and business environment. *[Excerpt from Town of Garner website, Newcomer's Guide to Garner, December 2006]*

Community Contact Information:

Primary Address:	Garner Town Hall 900 7th Avenue Garner, NC 27529
Telephone Number:	(919) 772-4688
Website:	www.ci.garner.nc.us

TOWN OF GARNER DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	17,757	22,406[3]	28,232[4]
% White Alone	67.0	63.3	61.3
% Black Alone	27.1	29.6	30.7
% American Indian Alone	0.4	0.4	0.5
% Asian Alone	1.1	1.3	1.5
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	2.8	3.7	4.1
% Two or More Races	1.5	1.7	1.9
% Hispanic Origin **(Any Race)**	4.7	6.1	6.8
% College Graduates	28.2	No Estimate	No Projection
# Of Households	6,950	8,160	9,432
% Family Households	69.5	66.8	65.0
% Owner-Occupied Households	69.1	69.8	70.1
Average Household Size	2.51	2.49	2.48
Median Age	35.8 years	37.6	39.2
% Age under 5 years	6.7	6.4	6.4
% Age 65 and over	10.9	12.0	12.4
Median Household Income	$47,380	$52,517	$61,471
Median Housing Value[5]	$76,786	$116,650	No Projection
# Of New Residential Permits Issued[5]	193	449	No Projection
# Of New Non-Residential Permits Issued[5]	32	17	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.39/.61	.39/.61	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3] North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Holly Springs Website, December 2006

Community Characteristics:

A name like Holly Springs conjures images of cool waters steadily trickling from resilient, deep aquifers, springs that run past vibrant, age-old holly trees that have withstood storms and droughts, wars and depressions, and times of peace and prosperity. Indeed, this southern Wake Town originated at such a place, where 40-foot holly trees towered over freshwater springs. Some of the local centuries-old springs feed creeks and ponds to this day. ... Located in southwestern Wake County, Holly Springs is growing rapidly while preserving its small town atmosphere. While the Town welcomes growth, leaders also are determined to control the quality and placement of new developments while preserving open space and creating public areas ... Part of ensuring a successful downtown was building Town Hall in the heart of Holly Springs. On Main Street, Town Hall is a center of constant activity. Opened in 2003, the 35,000 square-foot, two-story brick building was designed in an architectural style reminiscent of the 19th century when Holly Springs was founded. A combination Town cultural center and Wake County library opened downtown in late 2006, offering additional opportunities for youth and adults alike. *[Excerpt from Town of Holly Springs website, Holly Springs Town History, December 2006]*

Community Contact Information:

Primary Address:	Holly Springs Town Hall 128 S. Main Street Holly Springs, NC 27540
Telephone Number:	(919) 557-3900
Website:	www.hollyspringsnc.us

TOWN OF HOLLY SPRINGS DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	9,192	15,190[3]	25,109[4]
% White Alone	77.1	75.3	73.6
% Black Alone	18.6	19.5	20.3
% American Indian Alone	0.4	0.4	0.5
% Asian Alone	1.2	1.4	1.7
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	1.1	1.7	2.0
% Two or More Races	1.4	1.6	1.8
% Hispanic Origin **(Any Race)**	3.0	3.8	4.5
% College Graduates	50.7	No Estimate	No Projection
# Of Households	3,316	4,303	5,172
% Family Households	78.7	76.5	75.0
% Owner-Occupied Households	85.7	84.7	85.0
Average Household Size	2.77	2.73	2.72
Median Age	30.7 years	33.2	34.4
% Age under 5 years	11.5	10.0	9.9
% Age 65 and over	2.8	4.1	4.6
Median Household Income	$69,550	$76,263	$89,907
Median Housing Value[5]	$112,315	$153,077	No Projection
# Of New Residential Permits Issued[5]	485	846	No Projection
# Of New Non-Residential Permits Issued[5]	7	14	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.10/.90	.10/.90	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

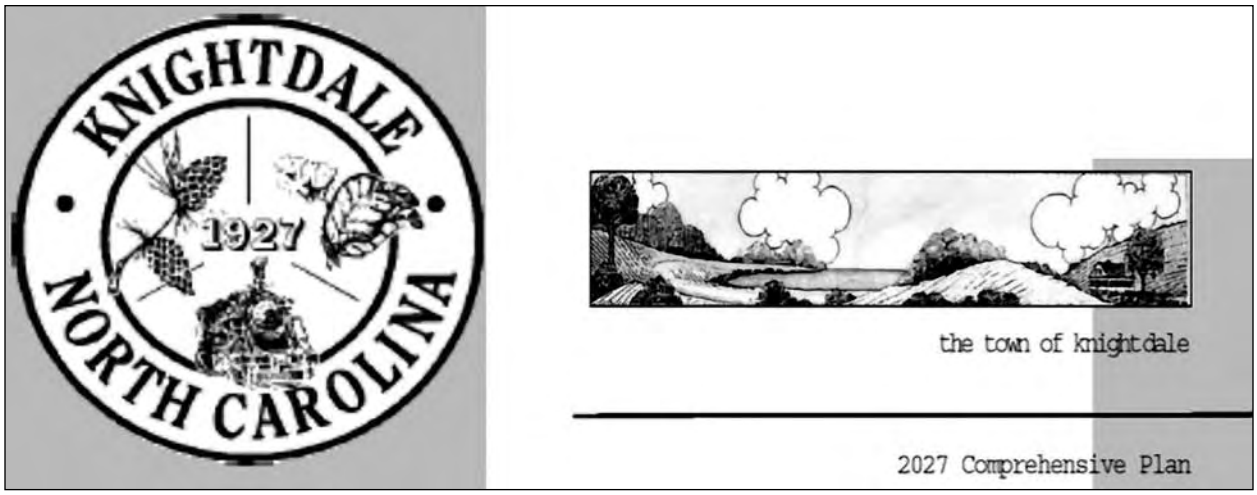


Image: Town of Knightdale Website, December 2006

Community Characteristics:

Knightdale is situated about six miles east of the City of Raleigh across the Neuse River. Knightdale is predominately an agrarian town with more than 44% of the overall planning area used for agricultural production. The official seal of the Town of Knightdale embodies a train, cotton, a tobacco leaf and a pine tree. These symbols of Knightdale's historic beginnings and economic origins say much about her citizens' desires for Knightdale's future... The natural environment is attractive and includes a countryside that remains dotted with family farms, pastures, and forests. For now, much of Knightdale's natural system remains intact. These qualities remain within Knightdale's ability to enhance, manage and sustain...Everyone agreed that our greatest potential in the future would lay in the enhancement and preservation of a unique character for Knightdale and that we should avoid losing our qualities even as we continued to be integrated into the larger regional engine...The people's vision for Knightdale in 2027 can be summarized by the term "town and country." *[Excerpt from Town of Knightdale website, Town of Knightdale 2027 Comprehensive Plan, adopted July 2003]*

Community Contact Information:

Primary Address:	Knightdale Town Hall 950 Steeple Square Court Knightdale, NC 27545
Telephone Number:	(919) 217-2220
Website:	www.ci.knightdale.nc.us

TOWN OF KNIGHTDALE DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	5,958	6,938[3]	8,076[4]
% White Alone	67.9	67.0	64.8
% Black Alone	26.8	23.4	24.1
% American Indian Alone	0.4	0.4	0.4
% Asian Alone	1.5	1.4	1.7
% Pacific Islander Alone	0.0	0.1	0.1
% Some Other Race Alone	2.0	5.7	6.7
% Two or More Races	1.4	2.0	2.2
% Hispanic Origin **(Any Race)**	3.7	9.7	11.3
% College Graduates	33.7	No Estimate	No Projection
# Of Households	2,172	2,633	3,089
% Family Households	74.9	72.6	70.9
% Owner-Occupied Households	74.3	75.9	76.4
Average Household Size	2.70	2.69	2.69
Median Age	31.0 years	33.4	34.2
% Age under 5 years	9.4	8.4	8.4
% Age 65 and over	5.1	7.1	7.4
Median Household Income	$56,021	$60,740	$70,382
Median Housing Value[5]	$ 93,379	$ 124,602	No Projection
# Of New Residential Permits Issued[5]	108	193	No Projection
# Of New Non-Residential Permits Issued[5]	9	27	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.23/.77	.25/.75	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Morrisville Website, December 2006

Community Characteristics:

In 1852, Jeremiah Morris donated three acres of land to the North Carolina Railroad for a train depot, and Morrisville was born... A century and a half later, Morrisville is once again at a crossroads. But now it is a crossroads of the region, with great access to employment centers like Research Triangle Park and major transportation hubs like Interstate 40 and Raleigh-Durham Airport... As a result of this outstanding location and the rapid growth of the region, our community has nearly tripled in population in the last seven years…growing to a community of more than 14,000. Yet, Morrisville remains a small town in the heart of the Triangle. At present, the town is adding about 4.5 new residents every day. In the midst of this growth spurt Morrisville's small town character is beginning to disappear. As a result, there is widespread interest in reestablishing a center of community where our paths might frequently cross and where others will know when they have arrived in Morrisville. *[Excerpt from Town of Morrisville website, Town Center Plan, Revised Public Review Draft 11/7/06]*

Community Contact Information:

Primary Address:	Morrisville Town Hall 100 Town Hall Drive Morrisville, NC 27560
Telephone Number:	(919) 463-6200
Website:	www.ci.morrisville.nc.us

TOWN OF MORRISVILLE DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	5,208	12,829[3]	16,649[4]
% White Alone	76.5	80.0	77.2
% Black Alone	11.0	6.7	6.9
% American Indian Alone	0.4	0.4	0.4
% Asian Alone	9.1	9.9	12.0
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	1.2	1.1	1.3
% Two or More Races	1.9	1.9	2.1
% Hispanic Origin **(Any Race)**	3.3	3.5	4.1
% College Graduates	55.5	No Estimate	No Projection
# Of Households	2,476	3,274	3,959
% Family Households	52.4	63.7	61.7
% Owner-Occupied Households	30.3	56.1	54.9
Average Household Size	2.10	2.09	2.09
Median Age	30.3 years	33.3	32.7
% Age under 5 years	7.3	8.1	8.3
% Age 65 and over	4.0	4.6	5.3
Median Household Income	$56,548	$83,350	$95,771
Median Housing Value[5]	$106,149	$154,616	No Projection
# Of New Residential Permits Issued[5]	418	212	No Projection
# Of New Non-Residential Permits Issued[5]	30	23	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.57/.43	.42/.58	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4] Capital Area Metropolitan Planning Organization. 2030 Long Range Transportation Plan.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Raleigh Website, December 2006

Community Characteristics:

Centrally located within Wake County, the City of Raleigh is North Carolina's state capital and the county's largest municipality. Known as the "City of Oaks," Raleigh's parks, lakes and greenery are valued by citizens and rated highly in community appearance surveys. Raleigh's diverse neighborhoods maintain their unique characters, and the city is a regional center of education, culture and historic resources, offering a variety of activity centers such as downtown, City Market and Cameron Village. *[Excerpt from Wake County Growth Management Strategy Report, Community Profiles, December 2002]*

Beginning in early 2007, the City of Raleigh is embarking on an 18- to 24-month process to thoroughly update its Comprehensive Plan. In the nearly two decades since the last update, the city has seen tremendous growth and change, on the outskirts of its planning jurisdiction as well as in established neighborhoods and commercial centers, where redevelopment and infill are occurring more frequently. A new plan is needed to ensure that Raleigh's quality of life continues to be protected as the City grows, emphasizing neighborhood preservation, a strong economy, ample parks and recreation, improved mobility for all modes of transportation, and the protection of the City and region's natural resources and environmental quality. *[Excerpt from City of Raleigh Planning Department website, December 2006]*

Community Contact Information:

Primary Address:	City of Raleigh 222 West Hargett Street Raleigh, NC 27601
Telephone Number:	(919) 890-3040
Website:	www.raleighnc.gov

CITY OF RALEIGH DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	276,903	337,766[3]	413,088[4]
% White Alone	63.3	62.1	60.5
% Black Alone	27.8	27.3	27.4
% American Indian Alone	0.4	0.4	0.4
% Asian Alone	3.4	3.9	4.7
% Pacific Islander Alone	0.0	0.0	0.1
% Some Other Race Alone	3.2	4.1	4.7
% Two or More Races	1.9	2.1	2.3
% Hispanic Origin **(Any Race)**	7.0	8.3	9.4
% College Graduates	44.9	No Estimate	No Projection
# Of Households	112,608	129,928	149,067
% Family Households	54.5	53.2	51.4
% Owner-Occupied Households	51.6	53.1	53.5
Average Household Size	2.3	2.28	2.28
Median Age	30.9 years	33.0	33.9
% Age under 5 years	6.3	6.2	6.3
% Age 65 and over	8.3	8.9	9.2
Median Household Income	$46,612	$54,081	$62,886
Median Housing Value[5]	$80,820	$140,167	No Projection
# Of New Residential Permits Issued[5]	3,184	4,459	No Projection
# Of New Non-Residential Permits Issued[5]	545	180	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.34/.66	.31/.69	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Rolesville Website, December 2006

Community Characteristics:

Rolesville is a rapidly growing small town in northern Wake County where residents value and enjoy the benefits of small town living while having immediate access to the benefits of a major metropolitan area. Rolesville is located just 10 miles north of downtown Raleigh. Traditional and progressive, Rolesville embraces the old and the new, and while continuing to grow, the Town balances growth with quality and looks toward the future. Rolesville is characterized by a tremendous amount of civic involvement and volunteerism that brings people together around a broad spectrum of interests and issues. Annual community events include the Fall Festival in October, Recreation Day in April, Fourth of July Celebration and the Christmas Parade and Tree Lighting in December. When asked about the town, life-long residents and newcomers alike proclaim that the people are the heart and soul of the town. The people of Rolesville are embracing the future while holding steadfast to their desire to maintain the high quality of life that is Rolesville. *[Excerpts from Town of Rolesville website, Mayor Nancy Kelley's Corner, December 2006]*

Community Contact Information:

Primary Address:	Rolesville Town Hall 200 East Young Street Rolesville, NC 27571
Telephone Number:	(919) 556-3506
Website:	www.ci.rolesville.nc.us

TOWN OF ROLESVILLE DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	907	1,742[3]	3,346[4]
% White Alone	84.0	77.0	75.3
% Black Alone	8.5	18.7	19.6
% American Indian Alone	0.2	0.4	0.4
% Asian Alone	0.4	0.6	0.8
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	5.7	2.4	2.9
% Two or More Races	1.1	0.8	0.9
% Hispanic Origin **(Any Race)**	6.9	3.9	4.6
% College Graduates	21.0	No Estimate	No Projection
# Of Households	353	441	522
% Family Households	75.1	77.1	71.4
% Owner-Occupied Households	70.5	83.0	78.6
Average Household Size	2.57	2.56	2.56
Median Age	36.3 years	35.3	35.3
% Age under 5 years	6.2	7.7	7.8
% Age 65 and over	11.4	7.4	7.7
Median Household Income	$46,838	$62,013	$70,497
Median Housing Value[5]	$88,180	$131,116	No Projection
# Of New Residential Permits Issued[5]	19	200	No Projection
# Of New Non-Residential Permits Issued[5]	1	1	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.26/.74	.18/.82	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

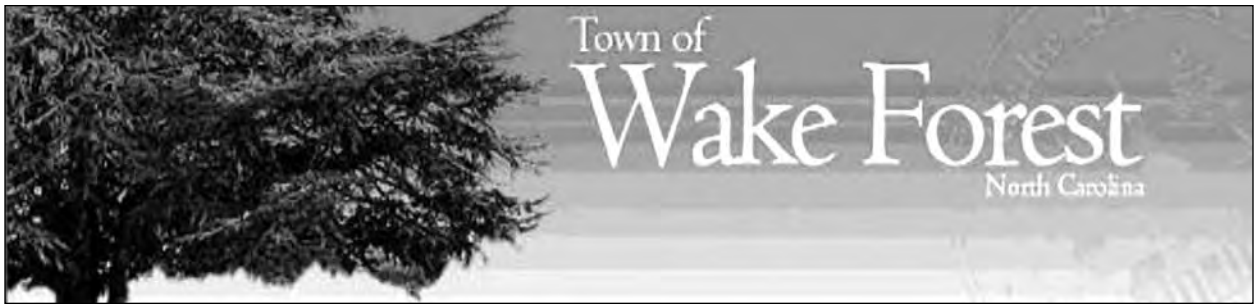


Image: Town of Wake Forest Website, December 2006

Community Characteristics:

... Located in northern Wake County, Wake Forest is a progressive community with a vibrant downtown that boasts more than 100 businesses, including several outstanding restaurants and specialty shops. Mindful of its rich heritage, the downtown is also an officially registered historic district. Representative of its academic history, the town is the home of Southeastern Baptist Theological Seminary and the Southeastern College at Wake Forest.

Incorporated in 1909, the town continues its emergence as a major player in the phenomenal growth and activity witnessed throughout the Triangle. Wake Forest maintains its small town character, however, by captivating newcomers and long-time residents alike with its incomparable warmth and charm. *[Town of Wake Forest website, December 2006]*

Community Contact Information:

Primary Address:	Wake Forest Town Hall 401 Elm Avenue Wake Forest, NC 27587
Telephone Number:	(919) 554-6100
Website:	www.wakeforestnc.gov

TOWN OF WAKE FOREST DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	12,588	19,598[3]	30,514[4]
% White Alone	79.6	80.7	79.4
% Black Alone	15.8	14.0	14.4
% American Indian Alone	0.2	0.2	0.3
% Asian Alone	2.0	2.1	2.6
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	.8	1.3	1.5
% Two or More Races	1.6	1.7	1.9
% Hispanic Origin **(Any Race)**	2.1	3.0	3.6
% College Graduates	43.0	No estimate	No Projection
# Of Households	4,617	6,112	7,358
% Family Households	73.8	72.6	71.0
% Owner-Occupied Households	63.1	67.9	68.3
Average Household Size	2.66	2.66	2.66
Median Age	31.6 years	33.2	33.9
% Age under 5 years	9.8	9.1	9.0
% Age 65 and over	7.9	7.0	7.1
Median Household Income	$52,307	$63,386	$74,546
Median Housing Value[5]	$65,966	$144,206	No Projection
# Of New Residential Permits Issued[5]	371	1,001	No Projection
# Of New Non-Residential Permits Issued[5]	54	31	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.24/.76	.22/.78	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Image: Town of Wendell Website, December 2006

Community Characteristics:

Just 10 miles from Raleigh, Wendell is located on US 64 in eastern Wake County. With the opening of US 264, we are just minutes from I-440 in Raleigh. Wendell is a growing town of 5,000 that truly embraces the motto "Small Town Charm – Capital City Connection."

The Town of Wendell is striving to maintain the small town charm and unique character of the town as we grow. The historic downtown area is a focal point and is home to restaurants and stores offering clothing, gifts, antiques, musical instruments, books, jewelry and much more. The Town also boasts many beautiful homes that pay tribute to our past. We value our history as we plan for the future with the development of many new neighborhoods. We are always striving to make our Town better and are working to embrace growth while preserving our small town atmosphere. *[Excerpt from Town of Wendell website, Mayor Timothy Hinnant Message, December 2006]*

Community Contact Information:

Primary Address:	Wendell Town Hall 15 East Fourth Street Wendell, NC 27591
Telephone Number:	(919) 365-4444
Website:	www.townofwendell.com

TOWN OF WENDELL DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	4,247	5,042[3]	5,985[4]
% White Alone	70.4	71.0	69.1
% Black Alone	24.1	22.4	23.2
% American Indian Alone	0.4	0.3	0.4
% Asian Alone	0.4	0.7	0.8
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	3.3	4.1	4.9
% Two or More Races	1.3	1.5	1.6
% Hispanic Origin **(Any Race)**	5.9	7.4	8.7
% College Graduates	19.3	No estimate	No Projection
# Of Households	1,675	1,900	2,163
% Family Households	66.8	65.7	63.8
% Owner-Occupied Households	69.7	72.8	73.1
Average Household Size	2.50	2.47	2.46
Median Age	33.7 years	36.3	37.5
% Age under 5 years	8.0	7.5	7.4
% Age 65 and over	12.5	11.9	11.8
Median Household Income	$39,750	$63,386	$55,966
Median Housing Value[5]	$65,978	$92,488	No Projection
# Of New Residential Permits Issued[5]	61	83	No Projection
# Of New Non-Residential Permits Issued[5]	3	0	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.21/.79	.25/.75	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports Residential Property Values, Building Permits Issues, and Tax Base Components.

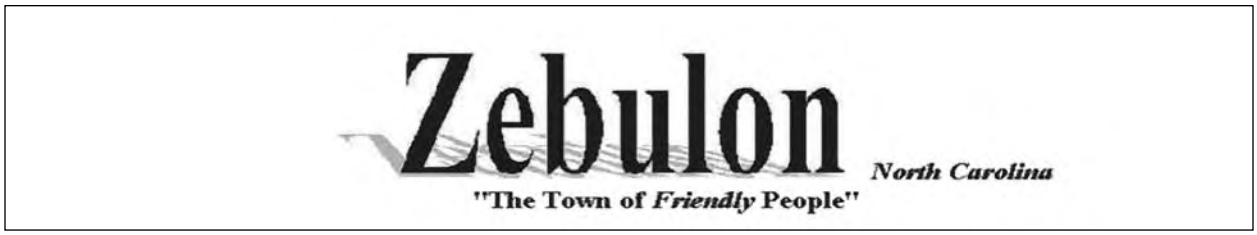


Image: Town of Zebulon Website, December 2006

Community Characteristics:

Zebulon is the easternmost municipality in Wake County and is located further from the county's center in Raleigh than any other community... Zebulon's small town, friendly atmosphere is at the core of its community identity. An historic downtown area, affordable neighborhoods and social diversity are key community characteristics. Zebulon is also known as the site of Five Counties Stadium, a regional attraction that is the home of the Carolina Mudcats Double A baseball team. *[Excerpt from Wake County Growth Management Strategy Report, December 2002]*

Community Contact Information:

Primary Address:	Zebulon Town Hall 100 N. Arendell Avenue Zebulon, NC 27597
Telephone Number:	(919) 269-7455
Website:	www.ci.zebulon.nc.us

TOWN OF ZEBULON DEMOGRAPHIC PROFILE: 2000 – 2005 ESTIMATES & 2010 PROJECTIONS

Demographic Characteristic	2000[1]	2005[2]	2010[2]
Population	4,046	4,606[3]	5,242[4]
% White Alone	53.7	57.5	55.9
% Black Alone	39.7	35.8	36.5
% American Indian Alone	0.6	0.5	0.5
% Asian Alone	1.0	1.0	1.2
% Pacific Islander Alone	0.0	0.0	0.0
% Some Other Race Alone	4.0	4.1	4.8
% Two or More Races	1.0	1.0	1.2
% Hispanic Origin **(Any Race)**	8.6	8.5	9.7
% College Graduates	15.7	No estimate	No Projection
# Of Households	1,551	1,787	2,047
% Family Households	68.3	69.4	67.7
% Owner-Occupied Households	61.0	69.5	70.0
Average Household Size	2.57	2.54	2.53
Median Age	32.8 years	35.0	36.0
% Age under 5 years	8.5	7.9	7.8
% Age 65 and over	12.4	10.5	10.6
Median Household Income	$36,250	$45,455	$52,850
Median Housing Value[5]	$104,709	$92,208	No Projection
# Of New Residential Permits Issued[5]	21	27	No Projection
# Of New Non-Residential Permits Issued[5]	1	4	No Projection
Tax Base Components Ratio (Commercial/Residential)[5]	.63/.37	.67/.33	No Projection

Sources: [1]U.S. Census Bureau, Census 2000. Profiles of Demographic Characteristics: General, Social, Economic and Housing.
[2]Wake County Economic Development Commission. 2005/2010 Municipal Profiles: Demographic and Income and Housing.
[3]North Carolina State Demographics Unit. July 2005 Municipal Population Estimates by County.
[4]Wake County Planning Department. 2000-2005 Growth Rate Straight-line Extrapolation Computation.
[5]Wake County Revenue Department. 2005 Statistical Reports: Residential Property Values, Building Permits Issues, and Tax Base Components.

Chapter 2: Opportunities and Challenges

Introduction

Wake County has developed a national and international reputation as one of the best places to raise a family, obtain an education and run a business. Over the past decade, the rankings have remained consistently high for the Raleigh-Durham area for overall quality of life, with recognitions including:

2006

- #1 Highest Growth County in N.C. (Wake County), US Census Bureau, March 2006
- #2 Best Place for Business and Careers (Raleigh), Forbes Magazine, May 2006
- #2 Best Value Public College (North Carolina State University), Princeton Review, March 2006
- Top 10 Projected Home Appreciation Market (Raleigh), MSN.com, April 2006

2005

- Top 15 Counties in America, American City Business Journals
- #2 Best Place for Business and Careers (Raleigh-Durham), Forbes, May 2006
- Top 20 Places to Live, Work & Play (Raleigh-Durham-Chapel Hill), Homebuilder.com, November 2005
- #2 Best Public Education System, Expansion Management, April 2005
- # 3 Best Large Metro Areas for New Businesses and Entrepreneurs, National Policy Research Council, October 2005
- #2 Schools That Rock (Raleigh-Durham-Chapel Hill), Rolling Stone, July 2005
- #5 Knowledgeable Workforce (Raleigh-Cary), Expansion Management, July 2005
- #17 Healthiest City (Raleigh-Durham-Chapel Hill), Sperlings Best Places, June 2005
- Five Star Quality of Life Metro (Raleigh-Cary), Expansion Management, April 2005
- #2 Most Educated City (Raleigh), American Community Survey, US Census Bureau, released April 2005

(From the Report of the Blue Ribbon Committee on the Future of Wake County, July 2006, and Wake County Government's website www.WakeGOV.com)

These accolades are attributed to the many advantages and opportunities afforded by Wake County. Home to the internationally acclaimed Research Triangle Park (along with Durham County), the area provides a world-class combination of economic vitality, educational opportunity, environmental quality and a strong sense of community. A well-rounded combination of business and industry, higher education, historic preservation, arts and culture, trees, greenways and lakes offers Wake County residents a quality lifestyle with excellent job and educational opportunities, whether they prefer rural or urban settings. When asked, "What is the best thing about living in Wake County?" Community Assessment focus group respondents overwhelmingly stated that strong job and educational opportunities, along with a diverse population, attracted them to and kept them in Wake County.

Wake County includes 12 municipalities:

- Apex - www.apexnc.org
- Cary - www.townofcary.org
- Fuquay-Varina - www.fuquay-varina.org
- Garner - www.ci.garner.nc.us
- Holly Springs - www.townofhollyspringsnc.net
- Knightdale - www.ci.knightdale.nc.us

- Morrisville - www.ci.morrisville.nc.us
- Raleigh - www.raleigh-nc.org
- Rolesville - www.ci.rolesville.nc.us
- Wake Forest - www.wakeforestnc.gov
- Wendell - www.townofwendell.com
- Zebulon - www.ci.zebulon.nc.us

Raleigh is the state capital and county seat. A seven-member Board of Commissioners elected for four-year terms governs Wake County. Under the Board's direction, the county manager oversees the daily provision of services to citizens ranging from health programs and other human and social services to parks and recreational opportunities, land use planning and zoning responsibilities, law enforcement and public safety, solid waste disposal and recycling, and libraries.

Wake County's largest employers include the State of North Carolina, Wake County Public School System, N.C. State University, WakeMed Health & Hospitals, SAS Institute, Rex Healthcare, Progress Energy, City of Raleigh, Cisco Systems and Wake County government. Providing business and private air service to nearly nine million travelers each a year, the Raleigh-Durham International Airport is an integral economic hub. A wealth of small businesses adds to the employment opportunities in the county.

Recreation and leisure services range from lakes and parks, to the North Carolina Symphony, North Carolina Museum of Art and Exploris Museum. Sports fans of all ages and tastes will find something to love, whether it's watching the National Hockey League's Carolina Hurricanes win the Stanley Cup, as they did in 2006, or taking in a Carolina Mudcats professional baseball game. Local fans are especially renowned for their enthusiastic support of Atlantic Coast Conference basketball and football thanks to the three "home" teams: the N.C. State Wolfpack in Raleigh, Duke Blue Devils in Durham, and University of North Carolina Tar Heels in Chapel Hill.

Wake County continues to grow in numbers and in diversity. Although whites remain the largest racial group in Wake County, the percent of nonwhites increased between 2000 and 2005. During this period the number of Hispanics/Latinos living in Wake County increased by 63%. The Asian population also grew rapidly at 51%. In addition, the county is experiencing smaller increases within other minority groups, such as Indian, African and Middle Eastern peoples. These changes in Wake County's demographics have brought a cultural richness to the area, broadening the experiences of children and of the entire community. The county's immigrant populations also have provided a broad workforce to meet the needs of expanding service industries and, in many cases, brought talent and expertise to the technology and research industries in the area.

Disparities

Although Wake County continues to grow and prosper, disparities and disparate outcomes continue to exist. Eliminating disparities is one of the most important tasks facing the community. Many of these disparities can be reduced or avoided by using existing knowledge and having the will to partner to close these gaps.

The terms that will be used to describe disparities are taken directly from Wake County data. In some cases the term "minority" is used to indicate populations other than Caucasian American. The terms whites (presumably for Caucasian Americans), African- American, black and Hispanic also are used. White, black, and African-American describe categories of race, while Hispanic describes a category of culture. These terms are used only to help identify disparities in particular categories of the population.

Disparities between whites and blacks in Wake County are both stark and pervasive. Compared to white children, African-American children in Wake County are:

- two times more likely to die in the first year of life,
- four times more likely to be suspended from school,
- six times more likely to score below grade level on an end-of-grade test,
- eight times more likely to be in foster care, and
- six times more likely to live in poverty.

Some of the health-related issues among adults are:

- African-American adults are 12 times more likely to be diagnosed with HIV.
- African-American women have a 32% higher death rate from breast cancer than white women.
- African-American men are twice as likely to be diagnosed with prostate cancer in late stages than are white men.
- African-Americans have a death rate of 295.5 (out of 100,000) due to heart disease and 96.5 due to stroke, compared to 240.0 and 68.3, respectively, for whites.
- The prevalence of diagnosed diabetes is 1.5 times greater for African-Americans than whites; the average death rate from diabetes is 2.5 times greater among African-Americans.
- From 2000 to 2004, the death rate for minority males due to homicide was 15.4 for Wake County (69 deaths) compared to white males with a rate of 2.7 (37 deaths), and an overall county rate of 3.7 (135 deaths). Minority male deaths were approximately half the total deaths from homicide in the county during that time period.

Economic disparities exist as well, including:

- According to Census 2000, black families fall in 15% of the poverty level compared to Hispanics at 23% and whites at 5%.
- Black families with children ages 5 and above who are below the poverty level is 23% compared to Hispanic at 27% and whites at 3%.
- The African-American median household income is 44% below whites. In 2003, the African-American median income was $33,163 compared to whites' median income of $59,449.
- The same finding is true for per person income. In 2003, the per person income for blacks was $17,626 compared to whites at $32,125.
- Neighborhoods for people of color are more likely to be poor than predominately white neighborhoods.
- While only 3% of white children in Wake County live in poverty, 20% of African-American children live in poverty.

Minority youth do not fare well with the juvenile justice system, illustrated by the following disparities:

- African-American youth comprise 17% of the youth population, but represent 27% of all drug violation arrests.
- For weapon offenses, whites and African-Americans were reported for similar rates of carrying guns (5.5% whites and 6.5% African-American), yet African-Americans represent 32% of all weapons arrests at a rate twice that of whites.
- African-American adults in Wake County are 14 times more likely to be imprisoned.
- In 2005 African-Americans comprise 71% of the Wake County prison population compared to whites at 20.4%.
- In recent years the rate of African-American and Hispanic/Latino youth in North Carolina in the criminal justice system has skyrocketed. African-American and Hispanic/Latino males comprise roughly 18% of the state's population; however they represent 75% or more of those in the criminal justice system.

In addition, education disparities are apparent in the school system:

- The gap in reading and math scores for black and Hispanic students is 17 points lower than for white and Asian students.
- Students who are receiving free and reduced lunch, an indicator of poverty, are disproportionately represented in the numbers of students who are below grade level in reading and math.
- Black males represent 28.5% of those suspended, four times the percentage of white males who are suspended. Black females represent 14.6% of those suspended, more than six times the percentage of white females.
- Black and Hispanic students represent 49% of those retained in ninth grade. Ninth grade retention also correlates with high school dropout. Asian (92%) and whites (88%) were more likely to graduate than blacks (68%) and Hispanic/Latino students (72%). (WCPSS Outcomes Summary for 2004-2005)

Disparities in other populations:

- There are disparities for white males. In 2004, the crude rate for unintentional injury deaths for white males between the ages of 20-24 was 88.54 (204 white males) compared to a rate for black males of 55.45 (41 black males). The rate for both white and black males was much greater than for females of both races in the same age category (26.93 white females and 24.31 for black females).
- From 2000 – 2004, the suicide rate for white males was 15.4, or 177 deaths, compared to a rate in minority males of 5.9, or 24 deaths. White females also had higher rates than minority females for suicide, 4.4 or 58 deaths for white females compared to 1.8 or 7 deaths for minority females.
- Between 2000 – 2004, the unintentional motor vehicle death rates for white males in Wake County was 17.0 or 212 deaths, compared to a rate of 5.8 or 72 deaths for white females.

These disparities present the county with ongoing challenges to assure that all citizens have the opportunity to benefit from the many resources that are available here.

Geography

Wake County has a land mass of approximately 549,000 acres, or 860 square miles. From east to west, Wake County measures 46 miles. From north to south, the county measures 39 miles. The four major roadways passing through Wake County are U.S. Highways 1, 64 and 401 and Interstate Highway 40. Wake County is considered to be in a transitional zone between the Piedmont uplands and the Coastal Plain and, therefore, within the fall zone. Wake County has an average annual temperature of 59.8 F and an annual precipitation of 41.43 inches. The elevation of the county ranges from 160 feet to 540 feet above sea level. The Neuse River and its tributaries drain about 80% of the county, and the southwestern part is drained by tributaries of the Cape Fear River. The stream network generally flows in a southeasterly direction. (www.WakeGov.com)

History

In 1771, the North Carolina General Assembly created Wake County from Johnston, Cumberland, and Orange counties. The leaders of the state decided to locate the capital of North Carolina in Raleigh in 1792. Raleigh, though the seat of the state and county government, remained a small southern town until the 1920s, and the surrounding countryside remained primarily rural until after World War II.

From early settlement in the 1730s to around the time of the Civil War, Wake County shared a way of life with most of North Carolina, with its scattered modest-sized farms and sparsely populated communities. Rural localities, each usually containing a church, school, store, gristmill, and (by the early twentieth century) cotton gin, were the hubs of human activity. Farming families raised and produced most, if not all of their food and apparel, and few ventured far from home to market their surpluses. Following the era of initial settlement, population growth in the county was slow, particularly in the 1820s and 1830s when many residents moved out of the county to developing areas of the state and nation where fresh land was plentiful and cheap, and opportunities were better for commercial farming. Beginning in the 1840s, railroad construction stemmed out-migration somewhat by providing some commercial farmers with links to important regional and northern markets. However, although market-oriented agriculture was gaining a foothold, subsistence farming still dominated Wake County rural life.

The six decades between the Civil War and World War I were years of tremendous change in Wake County and throughout North Carolina. Economic pressures, population growth, and increased contact with people outside the state began transforming traditional ways of living. The Civil War and Reconstruction altered both white and black labor systems and generated changes in the South's social and economic structures. An economic system based on tenant labor and the commercial production of cotton and tobacco evolved, which brought prosperity to some farmers but led many into poverty. Wake County's rural landscape became decidedly different during these years, as larger farms were divided and subdivided into smaller farms. The cultivation of tobacco required specialized curing and storage barns, the numbers of which grew exponentially as many farmers turned from cotton to tobacco in the early twentieth century. Commercial and industrial expansion spread throughout the county as more and more railroads were constructed to connect Wake to important market centers, and towns were established to serve local commercial needs.

During the years immediately after the Civil War, there were very few large-scale construction projects in rural Wake County, as the county's citizens struggled to recover from the conflict and its resulting economic problems. By the mid-1880s, however, a period of relative prosperity dawned. Subsistence and diversified farming gave way on many farms to monocrop commercial agriculture. Population and the number of farms increased dramatically and railroads created new towns. At the same time, the size of farms decreased and the number of families who worked as tenants on the farms of others rose steadily. Tremendous numbers of buildings in the county's rural areas and small towns were built from the 1880s to the 1910s, reflecting the architectural transformation that was a part of these enormous changes. The landscape is densely populated with small farmsteads dating from these years, most with simple, conservative houses and farm buildings. The small towns that grew up during the late nineteenth and early twentieth centuries are, for the most part, artifacts of the development that railroads fostered and that cotton and tobacco markets nurtured.

An agricultural depression during the early 1920s ended the brief period of rural prosperity after World War I. And as Wake County farmers and townspeople encountered The Great Depression of the 1930s, traditional ways of life began to change more rapidly. Automobiles and better roads encouraged mobility. Federal government limits on cotton and tobacco production levels, as well as the mechanization of farming and the increased use of pesticides, reduced the amount of acreage under cultivation and the number of laborers in the fields. By the time of World War II, a county that was once predominantly rural and agricultural was becoming increasingly urban and oriented toward commercial and industrial interests.

Though increasingly urbanized, the Wake County of today still bears some resemblance to its past appearance. Many areas near the edges of the county remain rural, and family and neighborhood networks are still vital to the social fabric of rural communities. A surprisingly large number of traditional farmhouses and farm buildings and small community churches, schools, and stores still dot the landscape, although they are rapidly being replaced or surrounded by subdivisions and shopping centers. Despite all of the growth in recent years, interest in Wake County's rural and small-town heritage thrives, fostered by local historical societies and other public and private groups who promote community pride among old and new residents alike. (from *The Historic Architecture of Wake County, North Carolina, by Kelly A. Lally, 1994)*

Faith and Spirituality

The faith community in Wake County has become a powerful force, addressing health and social issues in the community. Faith-based organizations in Wake play a critical role in areas such as health promotion and disease prevention programs (i.e. cardiovascular health, diabetes, substance abuse, HIV/AIDS, STDs, health screenings, health fairs, and environmental and policy changes regarding nutrition and physical activity), counseling/mental health, housing, unemployment and many other social issues.

Although religion cannot guarantee good health, it does seem to provide good habits, social support and interaction, and it helps reduce stress. Churches and faith groups are forging many successful initiatives to encourage lifestyles changes. The faith community provides continuous support to families in need and plays a critical role in health promotion, care and social issues.

From African Methodist Episcopal to Zen Buddhism, Wake County offers a wide range of worship and meditative opportunities. According to information compiled by the Inter-Faith Alliance of Wake County, approximately 800 faith-based churches or faith groups exist in the county.

Responses to the Wake County Community Assessment surveys and focus groups indicate that a significant number of Wake County residents rely on their place of worship for important information. Participants in focus groups were asked where they receive information concerning physical, mental, economic, substance abuse and environmental health issues, and indicated their place of worship was an especially important source of information for physical health and substance abuse issues. Participants also were asked: "To whom do you turn when you need help with physical/mental/environmental/economic issues?" They consistently named their place of worship as a source of help, more frequently than professionals or agencies.

The faith community in Wake County provides a great deal of assistance and services to the community, such as: food banks, soup kitchens, clothing and linen closets, financial assistance, counseling, mentoring, camps and after school programs to children and youth, exercise classes and walking groups. Faith organizations also provide health care, housing/shelter for the homeless and seniors, substance abuse prevention counseling and resources related to faith and meditation.

Chapter 3: Behavioral and Social Health

Six populations were analyzed to identify current resources available to them within Wake County, as well as service gaps and emerging issues. The groups examined were:

- Senior adults in need of protective services
- Adults in need of substance abuse services
- Mental health services for adults
- Children served by Wake Counties Child Welfare Division
- Individuals with developmental disabilities
- Children requiring mental health and/or substance abuse services

The current and anticipated growth of the county's population will require increased care for all behavioral and social health services regardless of insurance coverage. Future service availability will have to be addressed as more children, adults and seniors continue to relocate to this area with multifaceted and complex needs. Investment in prevention and treatment services will be both necessary and prudent, in order to reduce the number of people with mental health and substance abuse issues who end up in county jails and state prisons.

Adult Mental Health

Current State of Affairs

Mental health problems refer to signs and symptoms that impair function or cause distress to individuals. A report of the Surgeon General defines mental disorder or mental illness as diagnosable conditions that impair thinking, feeling and behavior and interfere with a person's capacity to be productive. The general target population for adult mental health services in Wake County is 18 years or older. Severe and persistent mental illness causes people to have problems functioning in daily life, and with relationships, employment, and maintenance of physical health or other activities.

Based on Wake County's 2002 population, about 14% of residents are in need of mental health services each year. About half of those are diagnosed with severe mental illness or considered to be severely and persistently mentally ill. As the County continues to grow, an increase in the need for adult mental health services can be anticipated. Unfortunately, research illustrates that two-thirds of those with mental illness do not seek treatment. Additionally, many who lack health insurance but need services do not receive them. Of those adult mental health clients who received services in 2002, 55% were uninsured, while 45% had Medicaid or other insurance.

Because of the rapid growth, limited staff resources and difficulty accessing private providers, increasing numbers of those seeking treatment are turning to the public health sector at the same time that Wake County Human Services (WCHS) is moving toward divestiture as part of mental health reform. This means that WCHS is providing fewer direct consumer services but is instead assuming the role of directing care, or ensuring that care is available through other providers.

Trends

Rapid growth in Wake County continues to have a significant impact on the state of adult mental health. The impact is being seen more in the county jail and local prisons instead of acute psychiatric hospitals. The closing of Dorothea Dix Hospital is expected to result in an increase in homelessness as well as admissions to jail and prisons. In North Carolina, the issue of the incarceration of individuals with MI or MR/DD (mental illness or mental retardation/developmental disabilities) is particularly urgent, given the dramatic transformation of the mental health, developmental disabilities, and substance abuse service system as the result of State Law 2001-437. A recent consultant's report identified significant problems with continuity of care for services in the North Carolina system, resulting in service coordination gaps (Thompson and Broskowski, 2006). Law enforcement staff have indicated that the numbers of individuals with MI or MR/DD unable to access adequate and consistent treatment is increasing, resulting in higher numbers of these individuals in local jails. A point-in-time census conducted by the U.S. Bureau of Justice (James and Glaze, 2006) found that on June 30, 2005, North Carolina jails contained 17,171 inmates. If, as national statistics cited above indicate, 64% of these inmates have mental health problems and 5% a developmental disability, then on any given day, nearly 11,000 individuals with mental health problems and more than 850 individuals with a developmental disability are in jail, and less than one in five of them will receive treatment while there. In September 2006, a chart review was conducted on all Wake County adult admissions (ages 18-64) admitted to Dorothea Dix; 30% of these adults classified themselves as being homeless.

Substance use disorders cause cognitive, behavioral and physical symptoms in individuals, families and communities. In 2004, approximately 9-10% of the U.S. population met the criteria for a substance use disorder within a given year, according to the National Epidemiologic Survey on Alcohol and Related Conditions. In 2004, 152 Wake County residents were admitted to Dorothea Dix for being dangerous to themselves or others. Of these admissions, 73% of the males and 57% of the females were discharged with a diagnosis of substance abuse or dependence. Wake County Crisis and Assessment Services reported that 2,246 individuals seeking mental health treatment between March 2003 and April 2004 were diagnosed with a primary substance use.

Growth also has increased service gaps in the adult mental health care for the Hispanic/Latino population, as that population continues to grow.

Community Perceptions

In the 2006 Wake County Community Assessment survey, respondents listed the most important mental health issues as mental health care, depression, and alcohol and drug abuse. In addition, jail and prison overcrowding, poverty, lack of health insurance and the absence of affordable medications were listed as serious concerns. These additional concerns can negatively impact adult mental populations in Wake County.

Resources and Strengths

Wake County provides a variety of behavioral and social health service options to residents. Mental health reform legislation has created opportunities for more community-based services for those meeting eligibility criteria. This has resulted in more nongovernmental providers delivering prevention and treatment services. Mental health and substance abuse services for both adults and children continue to expand, offering residents more choices and locations in which to seek care. These strengths will serve the County and its partner providers well as we move forward to address changing needs.

Emerging issues

Community mental health leaders and citizens have identified numerous concerns regarding the current state and future challenges for adult mental health services in Wake County. These challenges can be separated into three general categories:

- Front Door Services – This category refers to services designed to provide early crisis intervention to prevent acute inpatient admissions or, even worse, disabling outcomes or death in cases of acute suicide or homicide risks. It also includes issues related to "access" of early intervention services. In Wake County, local hospitals have reported an increase in mental health patients seeking assistance in their emergency departments. In addition, the County has seen substantial increases in non-emergency visits to emergency services departments. Immediate attention must be given to the development of new "front door services" as well as improvement of existing crisis intervention services. These are needed to reverse the current trends of overcrowded emergency departments, extended wait times, increased admissions to state hospitals and non-reimbursed burdens on local law enforcement agencies for extended custody and transportation needs.

  Examples of "front door" services that are needed include:

  1] Community supports and case management crisis intervention capabilities.

  2] "First Responder" crisis intervention capabilities and responsibilities already included in state reform requirements.

  3] "Individual Client Crisis Plans" by providers already included in state reform requirements.

  4] Mobile Crisis Management Teams across Wake County, a Medicaid approved "enhanced service" capable of 24/7 dispatch to clients in crisis.

  5] Crisis Intervention Center to manage present and anticipated increased volume of urgent and emergent mental health events, as well as alternative and central diversion sites for potential hospital emergency department admissions.

- Acute-Care, Local Inpatient Capacity – With the anticipated closing of Dorothea Dix Hospital by 2008, Wake County will be faced with finding alternatives for acute, inpatient care. Wake County is reviewing proposals for local inpatient care, but it is unlikely that the additional service will be available by 2008. Plans for interim alternatives for additional capacity were being considered as of February 2007. There is a significant shortage of acute geriatric psychiatric beds, partly due to increased medical complications of older patients. Two years ago, Dix officials reported 19 geriatric patients; currently, the geriatric unit has 30 patients. The State has acknowledged the lack of safe and appropriate placement options for geriatric patients with mental illness, dementia or substance abuse disorders and has gone on record to take the lead in creating specific facilities to ensure the necessary housing resources are available in local communities.

- Back Door Services – This category refers to provision of adequate services known as "step-down services," for patients who do not need inpatient care or are discharged from it. When a person is admitted to an acute, inpatient unit, discharge planning begins on the day of admission, not the day of discharge. Shortages of step-down services and other community resources make care coordination difficult, according to professional health care providers. Factors affecting back door services include:

  1] Poverty – Approximately 25% of all patients are readmissions. Many people in living in poverty do not take their medications and have to return to Dorothea Dix for medication stabilization, prescription refills and appointments at mental health centers.

  2] Homelessness – Patients at Dix are sometimes discharged to homeless shelters due to lack of community housing for the indigent. This number is expected to increase significantly. Many of the homeless seek inpatient admission due to bad weather, lack of money, or the need for medical or psychiatric care.

3] Shortage of outpatient/community adult mental health providers – According to Dix officials, there are not enough outpatient providers and resources to meet needs. Dix once discharged female patients to the YWCA, but this facility has closed. Additionally, there continues to be a shortage of access to outpatient psychiatrists. A limiting factor regarding discharge planning from Dix for making referrals is the wait times for psychiatric appointments. The referral capacity in the community, while growing, has not yet reached a mature capacity to meet the present needs of provider referrals.

4] Crime rate and increases in prisons and jails – Trends indicate that more mental health patients are being incarcerated rather than receiving adequate treatment. Increasingly, law enforcement officers are being called on to take clients to distant hospitals.

5] Long-term placement resources – Wake County lacks adequate residential resources for patients who do not require continued acute-care level of care, but need higher levels of supervision. The Raleigh *News & Observer*, in an article entitled "Mixing Mentally Ill, Aged Recognized as Risky" (Oct 22, 2005), disclosed that more than 80 percent of residents in a rest home in Durham were mentally ill, and a third of them were younger than 50 years old. Separately, the newspaper has covered ongoing problems of a former long-term Dix resident diagnosed as a fire starter who is continually moved from home to home within Raleigh because the facilities are unable to care for him.

Behavioral Health Issues Facing Senior Adults

Adult Care Homes

Decades ago, adult care homes began increasing care to individuals with mental health problems. This was in response to expert opinion that this group would be better served in smaller, community-based centers than large state hospitals. State officials and care providers have been debating this issue ever since.

Statistics show that more than 40% of residents living in adult care homes in North Carolina and Wake County are younger individuals with mental health problems. Unfortunately, rules governing the operation of adult care homes address the needs of the elderly. Facilities are often ill equipped to handle behavioral issues that arise from caring for this growing younger population. Consequently, both younger and older residents may be put at risk, sometimes with tragic results. In 2004, North Carolina lawmakers called for a study of this issue. In December 2005, recommendations were made that included better training for staff and increased staffing levels but these recommendations have not yet been implemented. In September 2006, the N.C. Department of Health and Human Services announced plans to develop a new type of facility that would serve aggressively mentally ill individuals now housed in adult care homes. In addition, the state pledged to convene a long-range study to map out a full array of housing options for persons with mental health problems.

Child Mental Health and Substance Abuse

Current State of Affairs

For a child or adolescent, mental illness or mental health problems can interfere with functional daily life, including schoolwork, relationships and physical health. Mental health problems affect the way young people think, feel and act, and can lead to school failure, family conflicts, alcohol and other drug abuse, violence or suicide. These problems can be very costly to families, communities and the health care system. When children or adolescents are unable to function at home, school or in the community for an extended period of time, or if the severity is high or life threatening, they are said to have a "serious emotional disturbance." *(Report of the Surgeon General, 2000)*

Substance use or abuse can complicate the emotional or behavioral problems of young people. Although a small percentage of young people actually become "addicted," the majority go through a period of experimentation or regular use. Whatever the pattern of use, it becomes a problem when it interferes with how an adolescent functions at home, school or in the community. Clearly, the problem turns serious when a youth begins engaging in negative and/or self-destructive behavior because of substance use. The impact of severe substance use on the individual is much the same as that for mental illness, but is exacerbated by physical health problems.

Mental disorders, mental health problems and substance abuse appear in families of all social classes and of all backgrounds. Many factors create a greater risk for some children. They include:

- Family history of mental or substance abuse problems
- Abuse or neglect
- Exposure to violence
- Significant drug activity within the child's environment/community
- School or learning related problems
- Poverty
- Caregiver separation or loss of important people or relationships
- Physical health problems

It is estimated that 10% of children nationally have emotional/behavioral problems severe enough to cause impairment in their functioning at home, school or community. Five percent of all children have at least a serious emotional or behavioral disturbance. *(Report of the Surgeon General, 2000)*. Based on 2005 data from national school surveys *(Monitoring the Future, University of Michigan)*, 50% of youth have used an illicit drug by the time they near graduation (12th grade).

Trends, Disparities, Gaps, Unmet Needs

The Wake County Public School System's 2006-07 enrollment is 128,070 students, making it the second largest school system in North Carolina, after Mecklenburg. This compares with 120,504 the previous year, a jump of more than 7,500. In 2002, enrollment stood at 108,000 students. The total number of children ages 0-17 living in Wake County is as follows: *(2006 N.C State Demographics; County/State Population Projections From 2004)*

0-4 years	58,157
5-9 years	55,002
10 to 14 years	53,083
15 to 17 years	33,233
Total 0-17 years	**199,475**

This total of 199,475 is an increase from 159,888 in 2000. *(N.C State Demographics; Certified County/State Population Estimates.)*

Along with population growth comes an increase in children who need mental health and/or substance abuse services. Other issues, such as school suspensions and juvenile crime, also rise. Statewide, juvenile crime complaints have risen from 39,416 in 2002 to 40,633 in 2005.

The following charts show recent trends in Wake County on these issues:

Wake County Public School System suspensions

Fiscal Year	FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06
Short Term Suspensions	16,499	18,758	20,471	20,855	20,430
Long Term Suspensions & Expulsions	560	668	777	1034	1054

Wake County juvenile complaints submitted to Juvenile Court

Year	2000	2001	2002	2003	FY 04-05	FY 05-06
Total # of Complaints	2416	1114	2241	2641	2962	3109

Wake County children served in the public mental health system for some type of mental illness, mental disorder, or substance abuse problem

Year	2001	FY 03-04	FY 04-05	FY 05-06
Total Served	2500	4174	4346	4526

In 2005, 232 Wake County children were admitted for inpatient psychiatric treatment in a state hospital and approximately 500 were admitted to community hospitals. Approximately 800 of the 4,526 children served in the public mental health system were diagnosed as severely emotionally disturbed and at risk of out-of-home placement or already placed out of their home in a residential treatment facility. *(Statistics maintained by Wake County Human Services)*

Gaps and Unmet Needs

Many children and adolescents with serious mental illness require very intensive interventions to address their mental health and substance abuse treatment needs. They often are unable to function at home, school or in the community. Many require treatment in a residential facility in order to improve their level of functioning and return home. Specialized residential treatment facilities tend to be located in other parts of the state, making treatment and reunification with families more difficult.

Children who have severe needs that require intensive specialized services, including residential treatment, are often at risk for commitment to institutions such as psychiatric hospitals or juvenile justice facilities. The need for services will increase as hospitals downsize and more children with serious emotional/behavioral and substance abuse problems are identified over the next five years. The new mental health/substance abuse community-based service system does have intensive services intended to prevent the need for out-of-home placements. Because these services are new to North Carolina, there will be a learning curve.

To meet the growing needs of children, the following services are needed.

- Ongoing training in the new community-based crisis diversion services such as intensive in-home therapy and other evidence-based services.
- Highly structured residential treatment facilities that can manage severely disturbed adolescents located in Wake County.
- Moderate and high management specialty residential treatment facilities in Wake County or nearby in order to help continued work with families.
- Crisis diversion beds that can manage children with psychiatric emergencies outside of a hospital setting.

Community Perceptions

Of the 3,232 citizens responding to the 2006 Wake County Community Assessment surveys, 73.6% consider school overcrowding to be a serious or moderate problem. School overcrowding increases the likelihood that those with emotional and behavioral problems will be under additional stress, and possibly act out more at school. Of the respondents who were 19 years old and younger, 29.1% reported alcohol and drug use as the most important mental health issue.

Of those surveyed, 70.5% consider gang activity a serious or moderate problem. Although gang involvement is not a mental health disorder, 86% of youth treatment programs report serving suspected gang-involved youth. *(Source: "Plan to Prevent Gang Activity & Violence in Wake County;" Wake County Gang Prevention Partnership assessment results, February 2006)*

Resources and Strengths

Since the last Wake County Community Assessment in 2002, North Carolina has implemented many changes in mental health and substance abuse prevention and treatment services. The Federal Centers for Medicare and Medicaid approved a range of new services for individuals with mental health and substance abuse problems. The North Carolina reform plan includes these new services along with the requirement that counties privatize behavioral health services. Although Wake County already had many private contract agencies providing services for children and adolescents, the new service system has changed how and where services are accessed as well as the types of services provided.

Medicaid benefit packages are now categorized as either "basic" or "enhanced" benefits. Basic includes outpatient therapy and medication management. Enhanced includes new intensive services. Most of the new services are community based and can be provided at the resident's preferred location, such as home, school, or other settings.

Basic treatment services for children and families are generally adequate to meet the needs of most families. A multitude of outpatient therapists in Wake County serve Medicaid recipients under the age of 21. Also, many agencies enrolled with Medicaid provide the new enhanced services. A list of all providers of these behavioral health services can be found on the Wake County website at www.wakegov.com/humanservices/lme/default.htm.

The following are examples of some of the new enhanced services for children and adolescents:

- Community support services – Aimed at building skills and development necessary to adapt to home, school, work and other places, interventions are psychoeducational and supportive. Community support services are designed to follow the young person throughout treatment in order to improve service planning.
- Intensive in-home – This is a time-limited intensive family intervention intended to stabilize the living arrangement and prevent the need for out-of-home placements. The services are delivered primarily in the home with a family focus to diffuse the current crisis and to reduce the likelihood of a recurrence.
- Multisystemic Therapy (MST) – This is an intensive family and community-based service designed for families with youth who have anti-social, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquent behaviors, and who have serious emotional disturbances and/or are abusing substances. This treatment service is based on empirical data and evidence-based interventions.

A complete description of the Enhanced Benefit Services for Mental Health and Substance Abuse can be found on the N.C. Division of Mental Health/Developmental Disabilities/ Substance Abuse Services website at www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm

Emerging Issues

A wide range of issues needs to be considered in the area of child mental health:

- The continuing growth in Wake County's population will result in an increase in the number of children and adolescents with mental health and substance abuse problems.
- Plans by the State of North Carolina to downsize state hospitals means there will be fewer beds for children with mental illness who are experiencing severe or life threatening psychiatric emergencies. Effective, intensive community services will be needed to ensure the safety of these children. Currently, adolescents are hospitalized at Dix, Holly Hill Hospital in Raleigh or the University of North Carolina at Chapel Hill. The County has contracted with Holly Hill to close gaps that will be encountered with the closure of Dix in 2008.
- Emerging gang activity is threatening vulnerable teens in Wake County. Many prevention and treatment providers are not equipped to address gang issues that these teens bring to their programs. Therefore, training in effective prevention and intervention services and strategies is needed.
- The implementation of the new Medicaid services has caused much confusion, partly due to inconsistent interpretations. Training, technical assistance and monitoring by local officials is imperative to assure that consumers are receiving the best and most appropriate care possible.
- The numbers of families who do not speak English is increasing. More service providers who speak other languages, primarily Spanish at this time, are needed.
- Some families with health insurance cannot find providers who provide the appropriate services under their health plan, or their mental health insurance is not adequate to meet the needs of their children. Most health plans do not provide coverage for services needed by severely mentally ill children. These families are currently seeking services through the public health care system.

Adult Substance Abuse

Current State of Affairs

Substance use disorders cause cognitive, behavioral, psychological and physical symptoms that affect individuals, as well as families and communities. The essential feature of a substance use disorder is the continued use of a substance despite significant substance-related problems. There is no consistent pattern of abuse or dependence.

Approximately 9-10% of the U.S. population meets the criteria for a substance use disorder within a given year *(National Epidemiologic Survey on Alcohol and Related Conditions, 2004).* This number includes individuals abusing alcohol, sedatives, tranquilizers, opioids (such as heroin and methadone), amphetamines, hallucinogens, cannabis, cocaine, and/or inhalants. Significant resources are expended in the treatment of substance use disorders. In April 2004, 152 Wake County residents were admitted to Dorothea Dix Hospital because they were considered dangerous to themselves or to others. Of these patients, 73% of the males and 57% of the females were released with diagnoses of substance abuse or dependence. Wake County Crisis and Assessment Services reports that between May 2003 and April 2004, 2,246 individuals seeking mental health treatment were diagnosed with a primary substance use disorder. Data provided in 2004 by WakeMed revealed that the average length of stay for patients treated for addiction-related disorders was six days, and the average cost of treatment per individual was $19,474. Addiction disorders can lead to a range of medical problems including withdrawal seizures, liver disease, inflammation of the pancreas and brain damage. Ultimately, substance abuse can lead to death.

It is not only the treatment of substance use disorders that is costly to the community. According to Wake County Child Protective Services, approximately 85% of parents being investigated for child abuse or neglect meet the criteria for substance abuse or dependence. In 2005, there were 549 deaths in alcohol-related motor vehicle accidents in North Carolina; this represents 36% of all motor vehicle fatalities in the state that year *(Mothers Against Drunk Driving, 2006).* According to 2006 data from The National Clearinghouse for Alcohol and Drug Information, U.S. companies lose $100 billion a year due to substance abuse by employees; the losses are caused by absenteeism, legal expenses, decreased productivity and on-the-job accidents. The impact of substance use disorders is clearly evident in the criminal justice system. The Office of National Drug Control Policy reported 44,594 drug arrests in North Carolina in 2003, with another 46,337 arrests for substance-related larceny/theft and 17,716 arrests for substance-related assault. Approximately 80% of incarcerated individuals in the U.S. have a substance abuse or dependence diagnosis. *(Drug and Alcohol Council, 2000)*

Trends, Disparities, Gaps, Unmet Needs

Treatment Facilities: As the general population increases, the number of individuals with addiction disorders who require treatment increases, as well. Wake County is fortunate to have both an Adult Medically Supervised Detoxification and Inpatient Substance Abuse Treatment facility. There is also a Non-Medical Social Detoxification service available within the local community. With the closure of Dix Hospital, Wake County understands the need to create a Locked Medical Detoxification facility, and is engaged in community discussions about this.

Dual Diagnosis: Mental illness and substance abuse/dependence have historically been considered separate problems requiring separate and distinct treatments. However, many persons who are diagnosed with mental illness also have an addiction disorder, and vice versa. Therefore, current trends are to treat both mental illness and substance abuse/dependence simultaneously and in the same setting, based on a high percentage of persons who are diagnosed with more than one disorder. For instance, according to a 2005 national survey of over 43,000 people, approximately 60% of individuals with an addiction disorder who sought treatment also had an independent mood disorder. Such individuals are said to be dually-diagnosed. More clinicians who are trained in dual diagnosis treatment are needed to meet demand.

Latino Services: Another need is for more resources directed at preventing and treating addiction disorders in the Latino population. Wake County has one of the nation's fastest-growing Latino populations. While approximately 5% of the county's population is of Latino origin, Latinos account for approximately 12% of car accidents in North Carolina involving alcohol. *(NC Latino Health, 2003)*

Nicotine Dependence: Historically, substance abuse treatment programs have not addressed nicotine dependence. People who abuse drugs are also likely to be cigarette smokers. More than two-thirds of drug abusers are regular tobacco smokers, a rate more than double that of the rest of the population. NIDA researchers have found that craving for nicotine appears to increase craving for illicit drugs among drug abusers who also smoke tobacco, and this relationship suggests that smokers in drug treatment programs may be less successful than nonsmokers in staying off drugs. *(Nicotine Craving and Heavy Smoking May Contribute to Increased Use of Cocaine and Heroin, Patrick Zickler, NIDA NOTES, October 2000)*

Community Perceptions

Of the 3,232 Wake County citizens responding to the 2006 Community Assessment surveys, 71.5% consider illegal drug activity to be a serious or moderate problem. Out of 106 ranked problems, illegal drug activity had the 4th highest ranking. Approximately 70% of the responders consider alcohol and drug use/abuse to be a significant problem, ranked 7th, and 70% consider drinking and driving to be a significant problem, ranked 10th. In 39% of the groups, substance abuse was noted to be a major health problem in the community. In summary, it appears that the citizens of Wake County consider substance abuse and its consequences to be significant community problems.

Resources and Strengths

Since the last Wake County Community Assessment was published in 2002, both Wake County and the State of North Carolina have experienced many changes under the umbrella of mental health reform. After several years of creation and review, the Centers for Medicare and Medicaid approved a range of new services for individuals with mental health and substance abuse problems. That, in addition to the requirement that counties privatize most of the behavioral health services they provide, has changed how and where people access services, as well as the type of services they obtain.

The Enhanced Benefit Services for Mental Health and Substance Abuse became effective on March 20, 2006. Several new types of services for individuals in need of treatment for addiction can be provided in various settings. For example, some services remain clinic-based, while others can be provided wherever the consumer desires. The Enhanced Benefit Services for Mental Health and Substance Abuse offer an array of services from comprehensive assessment to community support to intensive treatment. They describe five different types of treatment specifically for substance abusing or dependent individuals, as well as four different types of detoxification services.

Some of the new definitions are:

- Substance Abuse Comprehensive Outpatient Treatment – This is a new service designed for individuals in need of intensive treatment, for whom traditional individual and/or group therapies have been unsuccessful. This program provides services five days per week, four hours per day, for at least 30 days. It can be likened to Partial Hospitalization programs that are typically offered for individuals with chronic mental illness needing a service to help them remain in the community.
- Substance Abuse Intensive Outpatient Program – This service is similar to the one above. It is provided three days per week, three hours per day, for approximately 12 weeks. Again, it is designed for individuals who have been unsuccessful with less intensive services, but have a safe and stable place to live. Some Intensive Outpatient Programs are offered during the evening hours for people who are employed.
- Community Support – This is a new service designed for individuals with both substance abuse and mental health needs, and replaces services formerly known as "case management." Community Support services are designed to follow the person regardless of other treatment he/she is currently receiving. For example, if a person is participating in an intensive outpatient program but relapses and needs inpatient treatment, the Community Support professional would help that person obtain that level of care, as well as assist with reentry into the community upon discharge. Community Support services also are designed to assist people in acquiring any and all of the services they may need in order to become productive citizens, including housing, vocational, educational, medical and more. According to the Enhanced Benefit Services for Mental Health and Substance Abuse, the Community Support provider "assumes the role of advocate, broker, coordinator and monitor of the service delivery system on behalf of the recipient."

A complete description of the Enhanced Benefit Services for Mental Health and Substance Abuse can be found on the Division of Mental Health/Developmental Disabilities/Substance Abuse Services website at www.dhhs.state.nc.us/mhddsas/servicedefinitions/index.htm

Wake County is fortunate to have many substance abuse services that include the following: prevention/early intervention, assessment, detoxification services, crisis services, community support, basic outpatient services (individual, group and family therapies), intensive services (Substance Abuse Intensive Outpatient Programs and Substance Abuse Comprehensive Outpatient Treatment), inpatient, and residential services including supervised living, halfway houses and Oxford Houses. The challenges are to secure these services in adequate numbers, as demand often exceeds supply, as well as to identify and secure adequate funding. While the Legislative Oversight Committee was recently successful in securing additional money for behavioral health treatment, the State of North Carolina is still well below average in total per capita spending for these services *("The Second Report Card," North Carolina Psychiatric Association, March 16, 2006).* The majority of those individuals needing enhanced substance abuse services do not have private pay insurance or Medicaid and must meet eligibility requirements for state funding. *(January 18, 2007 document prepared by the Legislative Oversight Committee Staff listing Funds for Substance Abuse Programs as a "Potential Item for Consideration" out of 16 others.)*

Several years ago, Wake County primarily contracted with one large agency for the provision of adult substance abuse treatment services. Now the Wake County Local Managing Entity contracts with several private non-profit agencies. Because this list changes frequently, providers of behavioral health services are not listed in this report but may be found on the Wake County website at www.wakegov.com.

Wake County also has been successful in implementing an Integrated Dual Disorders Treatment (IDDT) program with a community-based agency. This is an evidence-based practice service that targets individuals with both substance dependence and mental health diagnoses, for whom traditional treatment approaches have been unsuccessful. This intensive, time-unlimited service is geared toward individuals who have frequented hospital or inpatient services and crisis services or who may have been incarcerated on several occasions. Often, these persons are unemployed and homeless. However, despite frequent use of services, these residents have never fully engaged with a treatment provider or stayed involved with treatment services long enough for a successful recovery. IDDT services are designed to spend as much time as necessary to persuade residents of the benefits of consistent participation in treatment. IDDT links or helps the residents first meet their basic needs for housing, food and clothing and then continues to work with them on their goals.

The Wake County Local Managing Entity also recently obtained funding to begin an early intervention service to provide HIV testing for those receiving substance abuse treatment. This grant will allow for certified staff to administer HIV tests at sites where consumers are receiving substance abuse treatment services. The results of the Ora-Quick Rapid HIV Antibody Test are provided within 20 minutes. Wake County works with an agency that has been providing HIV services for a number of years. Staff will regularly be on-site at several substance abuse treatment provider agencies to administer the tests and provide follow-up and case management.

Emerging Issues

- With the closing of Dorothea Dix Hospital scheduled for early 2008, Wake County will lose the only locked detoxification unit. With approximately 500 admissions annually to this unit, there clearly will be a need for an inpatient mental health facility, including a locked detoxification unit. As yet, there is no plan to construct such a facility.
- Wake County's Latino population continues to increase dramatically. Many of these individuals either fear substance abuse treatment or unable to afford it. For those that do seek treatment, their choice of community-based providers is minimal. There is a need for more bilingual and Spanish-speaking therapists and psychiatrists with the capability and capacity to work with Latinos who are addicted and essentially indigent.
- Greater resources will be needed to provide adequate mental health and substance abuse services to inmates in Wake County jails.
- Wake County's public transportation system will need to expand in order to accommodate the county's growing population. There will also be a need for increased availability of affordable housing and assisted living.
- With the implementation of mental health reform in North Carolina, services once provided by county government agencies are being divested and moved into the community. This is likely to pose challenges for private providers as they attempt to balance the appropriate level of service with ability to pay and allowable reimbursements.

Developmental Disabilities

Current State of Affairs

A developmental disability, as defined by N. C. statute, is a mental or physical condition that occurs before the age of 22, results in substantial functional limitations and is likely to continue indefinitely. The most common types of developmental disability are mental retardation, autism, Cerebral Palsy and traumatic brain injury. Most people with a developmental disability are able to fully participate in their communities with support and/or publicly funded services. Based upon the most recent U.S. Census figures for Wake County, approximately 14,978 children and adults with developmental disabilities live in the community. This number continues to grow along with the general population.

Publicly funded services available to support children and adults with developmental disabilities in Wake County include: Case Management, Skill Development, Vocational/Day Activity and Residential Supports. The intensity of support varies depending on individual needs and preferences. The intent of providing publicly funded supports is to help people with disabilities live independently and inclusively in their communities. Services are funded by state allocation, Medicaid and Community Alternative Program for people with Mental Retardation and Developmental Disabilities (CAP-MR/DD). State allocated funds, including CAP-MR/DD, have not kept pace with population growth. Most children with disabilities live in families that do not meet Medicaid income eligibility, and for those who do, Medicaid pays for case management only. Waiting lists for all services continue to grow. Even as people are enrolled in services from waiting lists, nearly 30 eligible individuals are added to waiting lists each month.

Yearly Trends

	2003	2004	2005	2006
Clients Served	1,862	2,414		Tim
Waiting for Services	970	1,046	1,074	1,172

The discontinuation of Developmental Therapies resulted in the State Division of MH/DD/SAS terminating these services. The Legislative Oversight Committee however restored this funding in 2006. The LME has been successful in divesting of internal DD Case Management and shifting these services to Private Providers.

Child Welfare

Current State of Affairs

Child Welfare is a program within Wake County that is state regulated and county administered. It is designed to assure the safety, permanence and well being of the children living in Wake County. The Child Welfare Department empowers the county to identify concerns of abuse, neglect and/or dependency of children. The County also must ensure that the children and their families will be provided with appropriate services and resources. In Wake County, Child Welfare is divided into three sections: Child Protective Services (CPS) Intake and Assessments, CPS Treatment/Case Planning and Child Placement (Foster Care and Adoptions).

In February 2005, Wake County Child Welfare changed its service delivery model to the Multiple Response System. This change was sanctioned by the State of North Carolina in order to provide more family-centered services to child welfare clients, and involves multiple approaches to investigations and assessments of all reports of abuse, as well as reports stating concerns. These reports can include abandonment, child fatalities, families who refuse the family assessment process, children taken into custody by law enforcement and physicians, reports of children in social services' custody or concerns about day care or other institutions.

Family assessments are conducted on the majority of the reports received by Wake County Child Welfare. These reports concern allegations of neglect and dependency. When an investigation is substantiated or a family is found in need of services, the case is often transferred to the CPS Treatment/Case Planning Unit. During this stage, the social workers have personal contact with the family at intervals determined by the risk level. Child and Family Team meetings are scheduled, and designed to bring all family members, support systems, services providers and CPS social workers together to create the In Home Family Services Agreement. This agreement incorporates the goals that the family will work toward in order to reduce and/or eliminate the risk to the children so that CPS services are no longer needed.

In families where the risk level to the children is high, Wake County Human Services (WCHS) will assume legal custody of the children through court intervention, and place children in licensed foster care or group homes, as required. Based on regulations established at the state level, foster care is considered a temporary service. Strong efforts are made to work with the birth parents/caretakers in order to reunite the families. Also, according to state policy, parents/caretakers are given 12 months to eliminate the issues that required the children to be placed in the legal custody of WCHS. If parents are not able to meet this requirement, WCHS may pursue permanent care for the child such as guardianship/custody with a relative and/or adoption.

To better serve families, child welfare teams have been established at the County's regional centers in the southern and eastern areas of the County, while traditional teams are established at the main county location. This helps social workers better understand the needs and resources of the area and to provide clients with easier access to services. However, specialized units within the CPS Treatment/Case Planning section assist families with concerns of sexual abuse and parents with cognitive delays regardless of their county location.

Contributing Factors

Substance abuse continues to be one of the leading causes of children and families coming to the attention of the Child Welfare department. In the majority of cases in which children were found to need ongoing protective services, substance abuse was found to be a contributing factor.

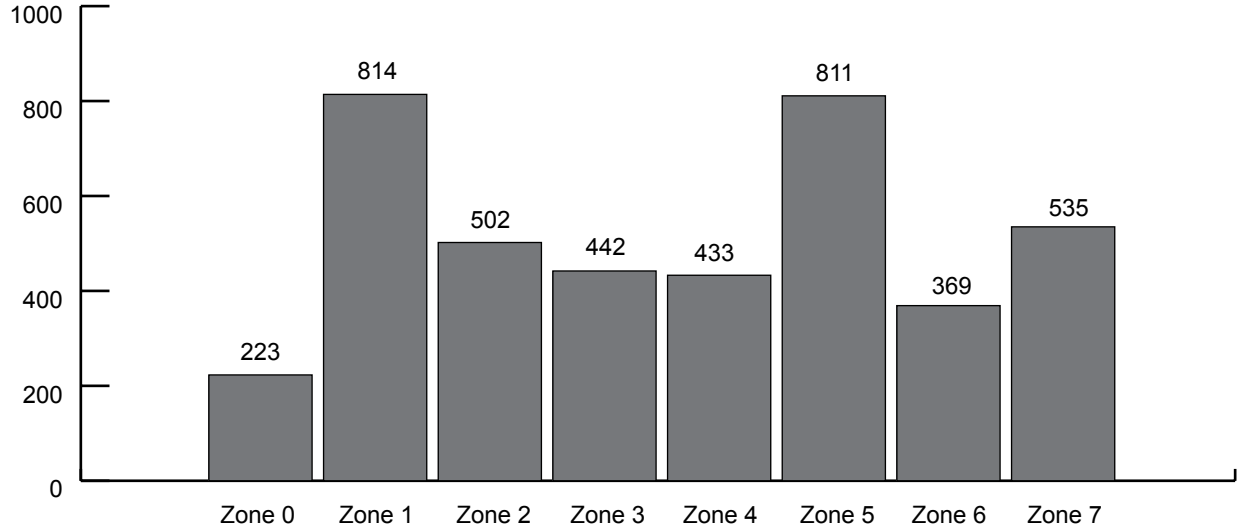
This has been a long-term concern of the department. WCHS has established a protocol designed to ensure the safety of newborns that test positive for any type of illegal drug or if the mother tested positive for an illegal drug at the time of the child's birth. The Child Welfare department also has two substance abuse counselors designated to work specifically with families involved with CPS. These counselors are able to provide evaluations, referrals and some educational services to assist the families with eliminating this challenge. Also, WCHS provides the CPS social workers with tools, training and support to expand their knowledge of substance abuse and all other risk factors.

The Child Welfare department also is continuing its efforts to foster the growth of community partners and faith collaboratives. These programs provide support for the families in the community in which they live and may be able to offer additional resources.

Trends

The number of reports received by CPS continues to rise annually. The number of new reports accepted for investigation/assessment has risen by approximately 57% since 2002. During fiscal 2005-2006, 4,129 reports were accepted by CPS. Of these, 75.1% were alleging neglect, 12.1% physical abuse, 4.1% sexual abuse and 1.5% were for concerns of dependency. Other reports were for a combination of concerns, reciprocal investigations for other counties or assisting other counties. After completion of these investigations/assessments, 12.5% of the cases were found to be in need of services and 9.9% were substantiated.

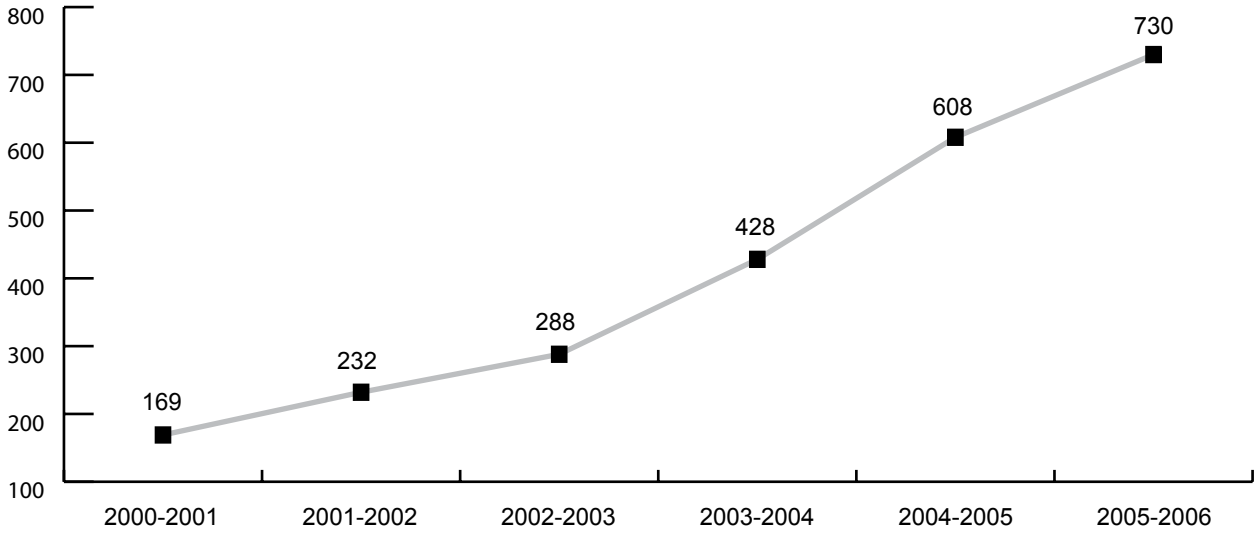
Accepted CPS Assessments FY 06 by Geographic Area of Wake County



Zone 0	No fixed or Known Address and Assists
Zone 1	Downtown (Inside the Beltline, Southeast Raleigh)
Zone 2	South Central (Southeast Raleigh, Garner)
Zone 3	Eastern Wake (Wendell/Knightdale/Zebulon)
Zone 4	Northern Wake (Wake Forest, Northeast and Northwest Raleigh)
Zone 5	West (Apex, Cary, Morrisville)
Zone 6	Southern Wake (Fuquay-Varina, Holly Springs, Willow Spring)
Zone 7	North Central (North Raleigh)

The number of cases referred for CPS Treatment/Case Planning services also has increased. In fiscal 2001-2002, 232 new families were identified for CPS Treatment/Case Planning services; that number increased by 200% by fiscal 2005-2006, to 730. Broken down geographically, the highest number of cases are coming from the downtown Raleigh zone, 26.1%, and the West (Cary, Apex, Morrisville) zone, 16.7%.

New Wake County CPS In-Home Services Treatment Cases Increase in Service Demand Over 6 Year Period



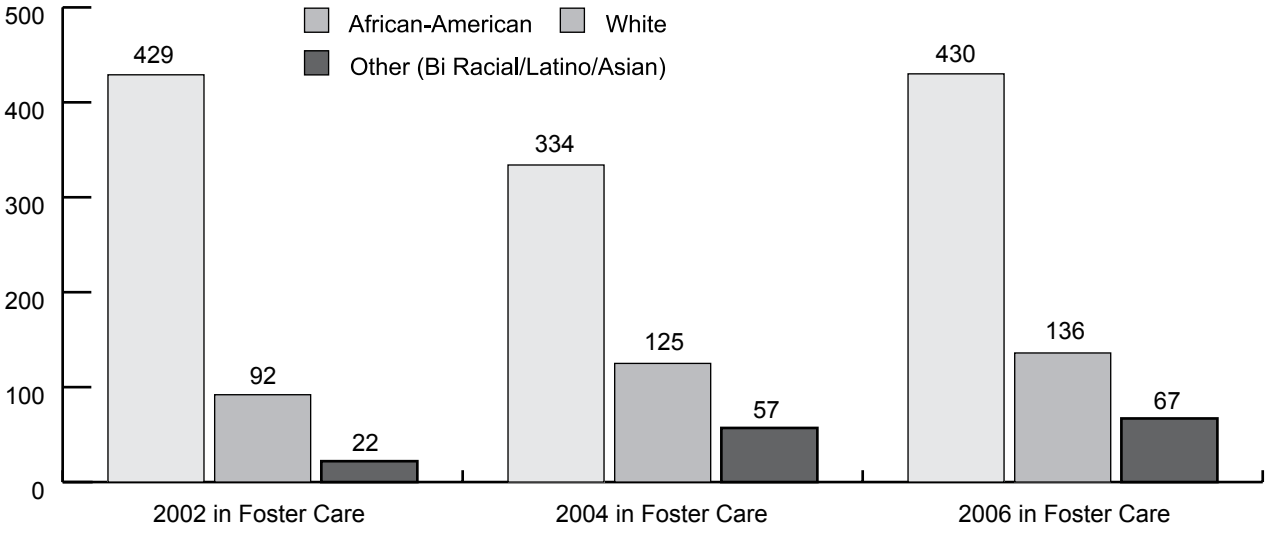
The rate of placement of children into foster care also has increased since the last Wake County Community Assessment. However, this increase is not as drastic as that of CPS Treatment/Case Planning services. In 2002, 543 new children were placed into the legal custody of WCHS. In 2004, that number dropped slightly to 519 new children. In 2006 it rose again to 633 new children placed into foster care in Wake County. The largest portion of these children came into foster care from the downtown Raleigh zone, 31.7%; the Southern Wake zone which consists of Fuquay-Varina, Holly Springs, and Willow Springs, 15.0%; and the West zone which consists of Apex, Cary and Morrisville, 11.7%.

Wake County Child Welfare makes significant efforts to keep children in the same area from which they were removed. Unfortunately, there are not always appropriate placements in that area. However, the County has achieved a standard of placing children less than 10 miles from their homes 48.4% of the time. Additionally, the County has decreased the number of out-of-county placements to less than 5% of children who enter care. These goals were achieved by increased efforts to recruit and maintain appropriate foster care homes and additional services implemented to place children with relatives.

Disparities

Similar to other urban areas, Wake County has a growing number of African-American families involved with CPS services and African-American children in custody of Wake County. In 2006, 68% of the children brought into foster care in Wake County were African-American. Wake County Child Welfare is continuing to address this concern with an ongoing study group, participation in a National Breakthrough Series Collaborative on Racial Disproportionality and Disparate Outcomes, and training for staff and community partners. Child Welfare is constantly addressing these disparities and attempting to analyze the causes and effects.

Children in Wake County Foster Care by Race (June 30)



Wake County Foster Care Caseload by Race	2002	%	2004	%	2006	%
African American (Black)	429	79	337	65	430	68
Caucasian (White)	92	17	125	24	136	21
Other Races	22	4	57	11	67	11
TOTAL	543		519		633	

Community Perceptions

Of the 2,975 English-speaking residents surveyed during the 2006 Wake County Community Assessment, approximately 56.6% viewed child abuse and neglect as a moderate or serious problem. A total of 117 Spanish-speaking community residents completed this portion of the survey. About 82.9% found child abuse and neglect to be a moderate or serious problem in the community. Similarly, 41.7% of the English-speaking residents found foster care and adoptions to be a moderate to serious concerns. Also, 61.5% of the Spanish-speaking residents found foster care and adoption to be a moderate to serious problem in the community.

Resources and Strengths

Child Welfare in Wake County is addressed with the following resources:

- Wake County Human Services
    1. Extensive programming and follow up for adolescents in foster care including, but not limited to, cluster groups for foster parents of teens, awards night, "Real Life" activities, group graduations, Links program and more.
    2. Group treatment programs with focuses such as parenting and anger management for children and parents.
    3. Psychological evaluation services for children and parents.
    4. CPS Treatment/Case Planning that has CPS specialists in sexual abuse and developmental disabilities.
    5. Specialized clinical/CPS program for sexually abused children.
    6. Specialized services for parents involved in CPS Treatment/Case Planning or Child Placement Services that are diagnosed with developmental disabilities (DD). The program includes, but is not limited to, DD assessments and on-site DD parenting classes.
- Another Choice for Black Children, Methodist Home for Children, Children's Home Society and Lutheran Family Services
    1. Private providers working in the area of foster care and adoption services.
- Guardian ad Litem
    1. Volunteers appointed by the court to represent the best interest of children who come into WCHS custody on petitions of abuse and/or neglect. The Guardians complete an independent investigation and present their findings and recommendations in court.
- The Faith Partnership (church ministries/collaborations established in most geographical areas), Kiwanis, St. Augustine's College, Family Resources Center, Choices for Children Program and more.
    1. Faith and community-based organizations that provide a support network for Wake County CPS/ Child Placement.
    2. Support is provided by faith and community groups for foster children and families as well as for birth families.

Gaps/Unmet Needs

Recruitment efforts are ongoing for safe and appropriate foster care homes in the areas where children are removed. Foster families also are needed to take children of all ages, especially older children and teens. It is a goal of the County to increase the number of foster homes in the different geographical zones to serve all the children of Wake County.

Emerging Issues

It is expected that the number of reports of child abuse, neglect and dependency will continue to increase due to the growing population of the county, along with increased public education and awareness of the services. This will place a greater demand on workers and available resources. Also, the growing Latino population will affect the need for bilingual workers and appropriate services to address their needs.

Health in the Aging Population in Wake County

Current State of Affairs

North Carolina is reaching a milestone this decade as the state's 2.3 million baby boomers begin reaching retirement age. Baby boomers are those born between 1946 and 1964. This year, the oldest baby boomers become eligible to receive services under the Older Americans Act, which defines senior adults as ages 60 and over. The impact of the aging baby boomers is evident in the projected growth of older adults between the years 2000 – 2030.

Chronic Conditions

Even when practicing a healthy lifestyle, senior adults face the likelihood that their health will decline over time. Age is a risk factor for numerous chronic conditions. Some of the following conditions are especially applicable to seniors' mental health as they age:

- **Alzheimer's disease:** A chronic condition of concern is Alzheimer's disease, which damages judgment and memory. The N.C. Division of Aging and Adult Services estimated there were 2,774 people living in Wake County in 2000 with mild, moderate or severe cases of Alzheimer's disease. That number is predicted to increase by 50% to 4,129 by 2010. Those with Alzheimer's disease cannot predict outcomes of their actions or evaluate risks, and can become lost, ill from exposure, easily dehydrated or malnourished, or become easy prey for exploitation. They can succumb to self-neglect or die from neglect by others.
- **Depression:** Depression in senior adults also is a serious chronic condition that often goes undiagnosed and treated. Nationally, depression affects about 67 million senior adults ages 65 and over, but only about 10% of these individuals receive treatment. Clinical depression can be triggered by long-term illnesses such as cancer, diabetes, stroke and heart disease. Older adults who are depressed are more likely to commit suicide than their younger counterparts. In addition, older adults with depression can expect to have approximately 50% higher health care costs than non-depressed senior adults. Risk factors for depression include gender (female), being unmarried, stressful life events and lack of a supportive social network. Depression can also increase an individual's likelihood of developing certain illnesses, primarily those affecting the immune system. (www.healthyplace.com/Communities/depression/elderly.asp)
- **Substance Abuse:** Substance abuse affects more than three million men and women over the age of 60. The Center for Substance Abuse Treatment has estimated that almost 17% of the elderly population in the United States abuses alcohol and drugs. Drug use among institutionalized senior adults is even more prevalent. Although substance abuse is statistically at epidemic proportions, it typically goes unreported and undiagnosed. Substance abuse by senior adults is easy to hide, because seniors are often less active in mainstream society and there is simply no one around to notice. Senior adults are not likely to get in trouble with the law and have little contact with the criminal justice system. Because many seniors are retired, they are also not likely to lose a job or career because of problems with alcohol. Historically, many seniors who abuse substances are also experiencing social isolation and physical health problems. Many are coping with grief due to the loss of a loved one, while others are facing housing, financial, marital and mental health problems. *(Your Guide to Alcoholism/Substance Abuse, About.com, July 23, 2006)*

Senior Friendly Communities

The concept of senior friendly communities has emerged as a focal point of the North Carolina Aging Services Plan. A senior friendly community is comprised of individuals, neighborhoods, agencies and organizations that work together to improve the quality of life of older adults wherever they live. A senior friendly community is one that promotes positive intergenerational interaction, considers the needs and interests of seniors in community planning, supports seniors' efforts to live independently, values seniors' contributions to the community, and acknowledges the importance that family and friends play in the lives of senior adults.

Triangle J Area Agency on Aging, which serves Wake County, is one of 17 Area Agencies on Aging working with the Division of Aging and Adult Services to develop a blueprint for senior friendly North Carolina communities. Priority issues now being addressed include the following:

- Development of a senior center model of the future that addresses the needs and interests of Baby Boomers.
- Promotion of volunteer opportunities that allow senior adults to use their skills and knowledge.
- Increased access to care through development of a computerized information and assistance system. *(The 2003-2007 North Carolina Aging Services Plan)*

Chapter 4: Economic Health

The Economic Health chapter focuses on employment, job readiness, access to child care, ability to attain basic needs, housing, homelessness and transportation. For some residents of Wake County, as across the nation, wages are not keeping pace with the increasing costs of food, clothing, and shelter. The challenge for Wake County is to address the areas in economic health that make individuals vulnerable to a lower standard of living. Communities will need to develop solutions to close the gap between those that make a livable wage and have a decent standard of living and those who do not.

Employment

Current State of Affairs

While many factors play a role in determining the overall economic health of any community, the unemployment rate remains one of the most comprehensive measures. In Wake County the unemployment rate has dropped over the last few years, from 5.6% in 2002 to 4% in 2005. Across North Carolina, the unemployment rate has decreased from 5.5% in 2004 to 5.2% in 2005. Although Wake County is fortunate to maintain a lower unemployment rate than other parts of the state, its most vulnerable citizens continue to bear the brunt of economic difficulties. The long-term impact of these patterns will affect many other community health factors such as the crime rate, homelessness, access to education and child care, as well as tax revenues.

The unemployment rate parallels the business cycle, with recessions and recoveries. Youth and minorities continue to experience higher rates of unemployment. With continued changes in the economy, the potential for joblessness is increasing for all income brackets. Unemployment will need to be vigilantly monitored for long-term impact on the ability of workers to retire, the crime rate and homelessness.

Wake County has approximately 18,000 dislocated workers *(2000 Census)*. This is primarily due to employment reductions in the high-tech industry. Laid off workers are finding it difficult to locate jobs in their field and many are forced to take other jobs, often at lower wages. The Wake County JobLink Career Center has seen a significant increase in the number of workers who have been laid off. In general, these workers are well educated and/or highly skilled. The length of time needed to obtain employment is taking longer, six to eight months, compared with two to four months a year ago.

While no single event explains the current employment situation, a number of determining factors have had significant impact over the past few years. In addition to continued employment reductions, more than 1,300 individuals in the county were either displaced or laid off by business closings and/or downsizing efforts in fiscal 2004-2005. The following factors have contributed to the current employment environment:

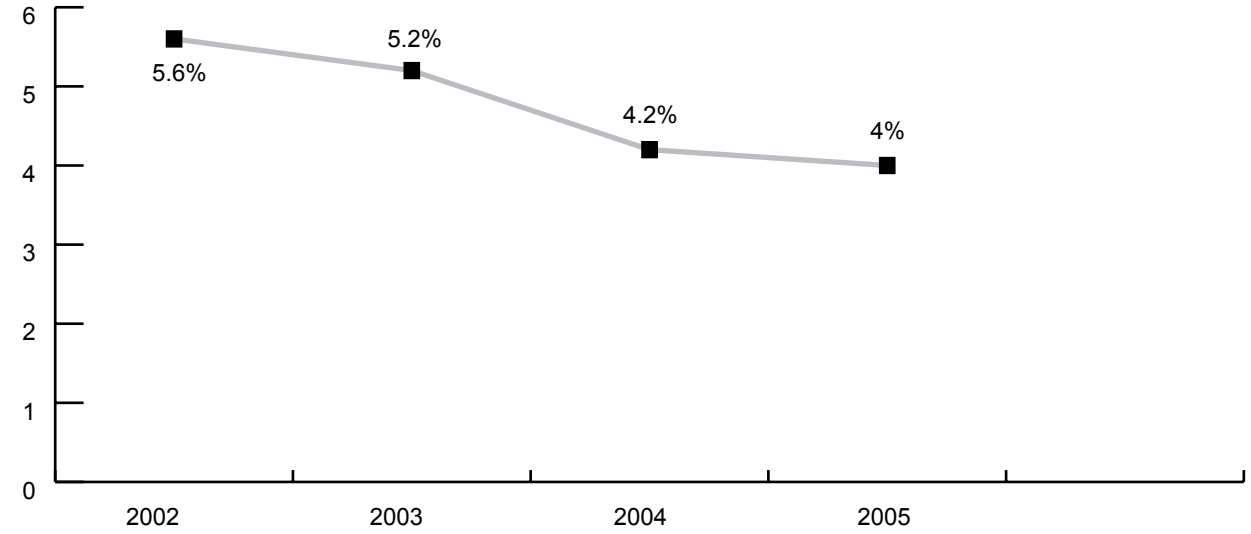
Lack of Education and Training: Family income and education are closely linked, for the most part. Those individuals without a sufficient level of education or training often find it difficult to earn livable wages based on the types of jobs for which they qualify.

Substance Abuse and Mental Illness: The most recent Work First planning document estimates that more than 9% of the population in the county and in the state is addicted to alcohol or drugs. Work First is North Carolina's temporary assistance for needy families program. Citizens and human services professionals have consistently identified substance abuse as one of the contributing factors to unemployment as well as a variety of other community concerns. The changes coming from ongoing mental health reform promise to make this an area worth watching closely in coming years.

Trends

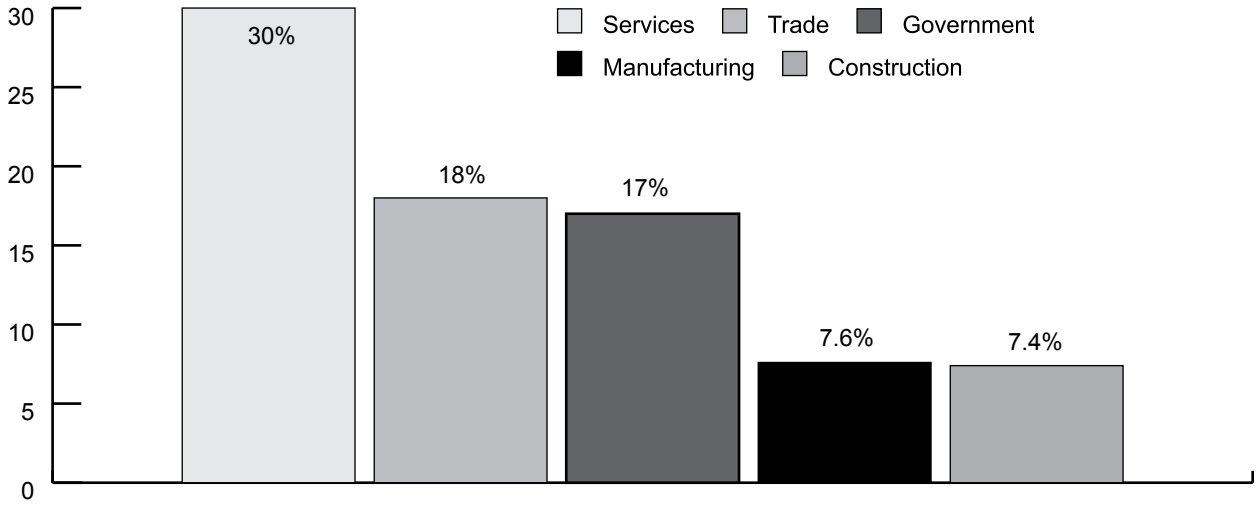
The average unemployment rate in Wake County for 2005 was 4.0%. This is a significant decrease from the unemployment rate in 2002, which was 5.6%. The graph below shows the unemployment rates for 2002 through 2005. Through October 2006, unemployment rates in Wake County averaged 3.36%.

Unemployment Trends - Wake County



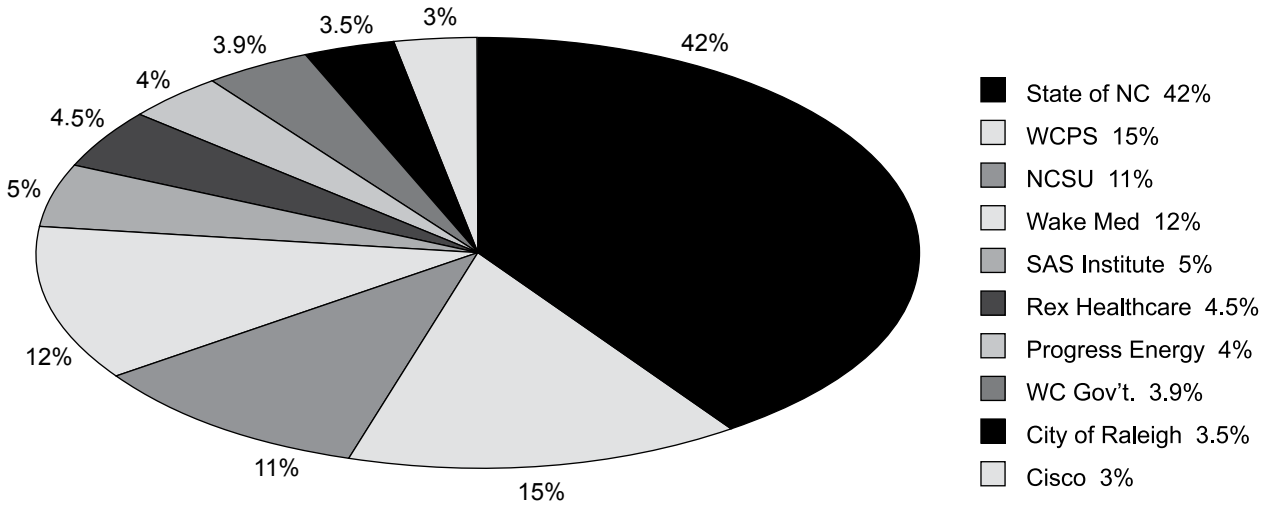
In October 2006, Wake County's civilian labor force included 433,123 workers. As outlined in the most recent Work First planning document, Wake County continues to feature a diverse employment base with the largest sectors being service, 30.2%; trade, 18.2%; government, 17.6%; manufacturing, 7.6%, and construction, 7.4%. It is projected that the service and retail trade industries will continue to experience the greatest growth over the next 10 to 15 years.

Wake County Employment Sectors 2005



While the unemployment rate has fluctuated somewhat over the last several years, the top 10 employers in the county have remained fairly consistent. Wake County's 10 largest employers in 2005 were the State of North Carolina, Wake County Public School System, North Carolina State University, WakeMed Health & Hospitals, SAS Institute, Rex Healthcare, Progress Energy, Wake County Government, City of Raleigh and Cisco Systems. The table below lists the largest employers and the percentage of employees:

Wake County's Largest Employers 2005



According to 2004 U.S. Census Bureau statistics, Wake County 's population was about 67% Caucasian citizens, 21% African-American citizens and 7% Hispanic citizens. However, the numbers of those at or below the poverty level, as measured by their eligibility for Work First and other supports, continues to skew more toward minority populations. The typical Work First family consists of a single, African-American mother who is 24-years-old or younger with one child age 6 or under. Latinos are more widely represented among Work First families than the general population would indicate. Additionally, the average Work First participant has a 10th grade education and fewer marketable job skills than the population as a whole. While there are no easy answers, Wake County must continue its efforts to move all areas of its population toward greater self-sufficiency.

Community Perceptions

Nearly 47% of participants in the 2006 Wake County Community Assessment survey indicated that a lack of job opportunities in Wake County was a problem. However, participants in the focus groups believed employment opportunities were among the best features of living in the county.

Resources and Strengths

The Capital Area Workforce Development Board, in partnership with national, state and local government, is the local policy board responsible for planning, oversight and coordination of workforce initiatives in the county. It currently administers the following programs:

- JobLink Career Center – Offers universal and convenient access to an array of services for job seekers.
- Federal Workforce Investment Act – Develops a local workforce investment plan.
- Rapid Response Assistance for Closings/Reductions in Force – Advises employers and assists in the transition of individual employees affected.
- Youth Development – Provides support for youth activities that promote improved educational achievement, employment, and development of youth leadership.

Additionally, Wake County Human Services and a variety of faith and community-based partnerships and agencies help residents obtain and maintain employment and work toward self-sufficiency for themselves and their families.

Emerging Issues

One issue facing the County is changes in what have been highly skilled and paid job markets. Employment opportunities in trade sectors, telecommunications and high-technology computer-related fields have decreased significantly. Mirroring national trends after the tragedy of Sept. 11, 2001, airline industries and manufacturing were hit hard with layoffs totaling over 18,000 for Wake County and the Research Triangle Park. Service industry and government jobs have increased, specifically in the areas of health care and education. However, these occupations, both in the private and public sector, are affected by funding availability within local, state and federal governments.

The education requirements needed to attain jobs have also risen. The report entitled "Quality Education for All, North Carolina 20/20" projects that by 2010, 85% of all jobs will require competencies equivalent to 14 or more years of education.

In addition to more aggressively filling these gaps, the County must continue to move its most vulnerable citizens toward greater self-sufficiency. Dislocated workers in the manufacturing and technology fields continue to experience difficulty in finding comparable employment. The increase in the educational level necessary to attain a living wage that was mentioned in the 2002 Community Assessment continues to exist. All of these issues, combined with the challenges represented by upcoming mental health reform, promise to make the next few years challenging.

Job Readiness

Introduction

Job readiness is one area of critical importance as Wake County strives to develop a workforce prepared to meet the demands of a global economy. The County works with local universities and businesses to fuel an innovative economy. Although the area has had some downsizing and layoffs, the county still attracts new businesses and industries due, in part, to its highly skilled and trained labor force. In October 2006, the Employment Security Commission of North Carolina reported a county civilian workforce of 433,123. The number of workers employed at that time was 419,147.

Current State of Affairs

A variety of factors point to a successful job readiness climate in the county. The Wake County Public School System (WCPSS) leads school districts across the state and nation in end-of-course and proficiency tests, SAT scores, and other performance measuring criteria. Wake County had a SAT participation rate of 76.2% in 2005. The state average was 65% and the national average was 45%. The majority of students who take the SAT attend college. Wake County also has a youth development agenda that emphasizes strengthening expectations for youth professionals in the labor market. Many of these students will be the workers needed for the projected high-growth industries that require more training and education, such as health care, education, and business/financial services.

SAT participation is an indicator of the number of students who stay in high school. Education minimizes the number of "at-risk" youths, reducing social costs such as welfare and others related to the juvenile justice system of the county. Education also increases the impact they can make as productive, contributing adults.

Another useful indicator reflective of the available labor supply throughout Wake County comes from the Employment Security Commission (ESC). In the county, 17,183 individuals registered with the ESC for work. Of those, 11.9% had zero to 6 months of experience, 18.08% had seven to 24 months of experience, and 57.8% had over 24 months of experience. This is higher than the state percentage of 55.7%.

The increase in demand for jobs in health services, education services, construction, and financial activities is tremendous, and these are also some of the area's highest projected growth occupations. A vast number of declining occupations require less training than post secondary vocational training. Many declining occupations are production-related, or manufacturing and natural resources occupations.

Community Perceptions

Participants in the 2006 Wake County Community Assessment focus groups identified access to higher education and learning opportunities as some of the best assets in the county.

Resources and Strengths

A strong focus of Wake County's Joblink Centers is to provide information regarding jobs and available services and resources to adults and youth. More than 6,600 high school graduates registered with the ESC for jobs statewide in 2005. Of the teens taking advantage of specialized youth services, most seek employment in growth fields. Young females gravitate toward nursing, especially certified nursing assistants, while young males tend to choose construction work.

Businesses are striving to make appropriate hiring choices through personality and aptitude testing to reduce the loss of time and money that results from employee turnover. In addition, they are paying more attention to intangible qualities such as good work habits, flexibility, dedication, willingness to learn and the ability to work in a team-oriented environment.

Job preparedness and development activities are offered for both youth and adult job seekers within the county. As a training option for eligible adult and dislocated workers, the Capital Area Workforce Investment Act (WIA) implemented On Job Training (OJT) as a business service through contracted service providers. These individuals will benefit from work-based training rather than, or in conjunction with, classroom training.

The labor force of Wake County should continue to meet the employment demands of its businesses because of the numerous programs and services offered to employers, workers, and job seekers. There are 14 colleges and universities adding to the labor pool each year for the increasing number of jobs requiring secondary and post secondary education. Performance measuring continues to be a primary focus for the WCPSS. Workers in transition have access to services geared to help find, train and/or re-train for available positions to ensure the economy of the area continues to thrive. The N.C. Community College System is the primary source of job training programs in the county. The programs are intended to be available to assist the public at large in choosing training programs to suit their needs. All are listed on the Department of Education and Training Web site. The list is extensive, includes several private organizations, and lists training programs in everything from computer training and certifications to dental assisting. *(Source: NC STARS)*

Emerging Issues

Increasingly, businesses are looking for skill portability in their employees, allowing them to adapt more readily to rapidly and constantly changing business environments.

Workers need opportunities to increase their skills as well as learn new ones. Most often this training needs to be concurrent with their employers either through on-the-job training opportunities or after hours at local training institutions.

Job seekers and workers need wages and fringe benefits that allow them to enjoy and participate in the quality of life offered in Wake County. Policies that consider children, elderly relatives, and opportunities for advancement are also highly desired.

Access to Childcare

Current State of Affairs

Childcare subsidies help parents with limited incomes pay for childcare so they can work or attend school. These subsidies benefit all industries in the state by enabling parents to work productively outside the home and attend higher education programs to update their skills. They lay the groundwork for North Carolina's economic future by preparing upcoming generations for school and workplace success and attracting businesses to the state's skilled workforce. A survey completed by families in homeless shelters reported that the biggest obstacle to obtaining employment is childcare.

Childcare subsidies benefit families by:

- Helping parents work and attend school.
- Providing a safe setting for children.
- Better preparing children for school.
- Providing quality early childhood education to promote children's success in language, math and social skills.

Childcare subsidies help the community by:

- Enabling working families to invest in the local economy and tax system through their earnings and purchase of child care.
- Offsetting the cost of child care subsidy services through working families' abilities to pay taxes.
- Stabilizing childcare arrangements and allowing parents to be more focused on their jobs and, subsequently, better employees.

There are 602 licensed childcare facilities in Wake County, including 281 centers and 321 family childcare homes with a total capacity of 30,967 slots. Of these, 542 accept tuition subsidies. While there are some childcare centers with empty classrooms, 3,500 children are on the waiting list to receive childcare subsidies. This is the highest number of children on the waiting list in the County's history. Of the 281 licensed childcare centers in the county, 135 (48%) have a four- or five-star quality rating (with five stars being the maximum awarded). Only 108 of these centers accept children receiving tuition subsidies. Of the 321 licensed family childcare homes, 80 (25%) have a four- or five star rating.

Trends

In 1990, there were 30,174 children under the age of five in Wake County. By 2006 that number had nearly doubled, to 58,157, and by 2010, that number is projected to move past 70,000.

Community Perceptions

Nearly 55% of those responding to the 2006 Wake County Community Assessment survey felt that childcare affordability is a problem in the County. Participants in the focus groups stated that childcare subsidies are needed for children who were not born in the United States.

Resources and Strengths

Wake For Kids is a local fundraising effort to assist with scholarships for families on the childcare tuition subsidy waiting list. Smart Start and Action Group C of the 10-Year Plan to End Homelessness are partnering with businesses and non-profit groups to spearhead this effort. The goal of this fund-raising effort is to raise $50,000 for childcare subsidies. To date, several hundred dollars have been raised. The program, called Kids First, went online in the middle of November 2006. Increased funding for childcare subsidy can be through a collaboration that involves private businesses, non-profits, government, and individual participation.

More at Four, Head Start, Title I Pre-School, and Child Care Subsidy have a combined screening sheet to assist in placing children. A common application process is in development. This will enable parents to apply for all four programs at one time. With the same application, Wake County could get a better picture of the need for services. The combined screening will allow the County to eliminate duplication. It also will provide more comprehensive evaluations of children's needs and placements that will better fit their needs, particularly for those with developmental delays, and special needs.

The Wake County Public School System, Child Care Services Association, 4-H, Raleigh Parks and Recreation, Child Care Providers, Division of Child Development and Subsidy Program have partnered to expand before/after school programs for track-out care of children in year- round schools. This collaboration builds community capacity to provide quality care for children outside of the traditional school year and gives parents more affordable, safe choices for their children's care while they work.

Emerging Issues

There is a serious need for additional affordable, accessible, quality childcare in Wake County. The need/demand will continue to increase due to:

- •] Increasing numbers of low wage jobs.
- •] Migration to Wake County because of the availability of jobs.
- •] Increased demand for services not met by current resources.
- •] Expense of childcare.
- •] Benefits to employees: 1) After receiving child care subsidies, 54% of families reported they missed less time from work. 2) Seventy-three percent of families that worked more than two years reported that receiving child care subsidies assisted them in keeping their jobs.
- •] Benefit to employers: Childcare subsidy is framed as a benefit.
- •] Benefit to children: Quality childcare is important in early childhood education and development.

Ability to Attain Basic Needs

Current State of Affairs

The ability to attain basic needs is measured by a person's ability to pay for food, clothing, utilities and other bills. Thousands of Wake County families are living below the poverty level. Families have responded by trying to create more two-earner households. Women entering the workforce comprise the majority of additional workers, which has added new pressures on the family. These include the need for more affordable day care, more work-related stress within families and a decline in the time that can be allocated to children and the home. The welfare of children and their families is clearly improved when such basic needs as food, health care and safe housing are met on a consistent basis.

Trends

For the first nine months of fiscal 2005-06, Wake County's Work First caseload remained stable with little fluctuation from month to month. Other factors included the diminishing value of the minimum wage dollar and the education level of the consumer. When Congress passed the Personal Responsibility and Work Opportunity Act of 1996, it made sweeping changes to federal public assistance programs. The change from Aid to Families with Dependent Children (AFDC) to Temporary Assistance for Needy Families (TANF) signified a transformation in the goals. This was a shift from a human investment model to a Work First system. As a result, Wake County had 1,506 Work First cases as of June 1, 2006. In May 2006, Work First served 2,713 families with 5,901 recipients. This represents a decrease of nearly 73% since the implementation of the new policies in 1996. These rates almost matched the State's Work First decrease of 74.6%. At the same time, the need for food assistance increased. A total of 18,519 families received food assistance as of May 31, 2006. This represents a 53.5% increase in families receiving food assistance since May 31, 2000.

The most striking indicator of Wake County's affluence is its high median family income, which is $71,600. This compares with $67,149 in 2000 and $44,302 in 1990. Wake County's median family income ranked significantly higher than the state average of $46,335. However, an increase in affluence is shadowed by an increase in the number of county residents living in poverty. Between 1990 and 2000 the number of people in the county below the poverty line increased from about 34,200 to more than 47,600. In 2005, an estimated 75,430 Wake County residents were living below the poverty line.

The average annual wage per worker in Wake County in 2000 was $35,336. This is a 57.2% increase in wages from 1990 when the average wage was $22,493. In 2005, the average annual wage in the county was $40,560. A family of four living in poverty earns only $17,652 annually and clearly cannot afford basic needs such as food, clothing and shelter. These families are the most distressed; however, even families earning 80% of Wake County's median family income find it difficult to live in Wake County and make ends meet.

As of June 1, 2006, the Wake County Work First Program served 2,713 households comprising 5,901 individuals. Of these, 1,058 are child-only households and 1,655 are Work First Family Assistance (WFFA) households, those in which the adults have an employment obligation. Less than 1% of the county's population receives Work First cash assistance. Half of the county's Work First families receive assistance for less than one year. The average Work First cash assistance payment is $212.26 per month.

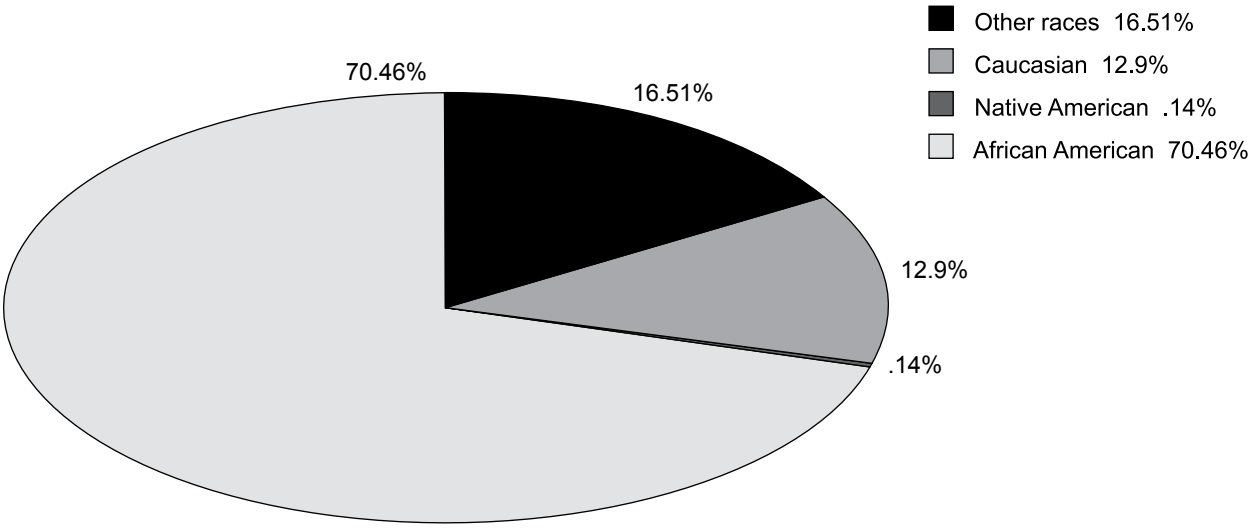
Two additional indicators of a family's capacity to pay for basic needs are Food Stamps and Medicaid caseload trends. Both have increased over the last year.

Food assistance, also known as Food Stamps, enables low-income families to purchase food with an Electronic Benefit Card (EBT). The total amount of food assistance received by Wake County recipients during the past fiscal year totaled $47,684,820. As of May 31, 2006 there were 42,336 active Food Stamp recipients.

During the past fiscal year, Wake County's Family Medicaid program experienced a 17.6% increase. The N.C. Health Choice program reported a 24.5% increase despite a freeze on enrollment. There has been an increase of 12.45% in the average monthly number of Medicaid recipients in Wake County.

As of June 1, 2006, there were 1,506 families receiving Work First. The racial composition of Wake County's Work First Program is disproportionately composed of African-Americans and those of Hispanic origin.

Families Receiving Work First Assistance Distributed by Race 2006



Nationally, the elderly, black and Hispanic poverty rates are more than two and one-half times those of whites. The poverty rate for females is double that of males. Those over age 75 have substantially higher poverty rates than those 65-74 years. *(The Social Health of the Nation, 1999)*

Community Perceptions

Nearly 63% of the respondents to the 2006 Wake County Community Assessment survey indicated that poverty was a problem in Wake County. Only 38% of respondents indicated that having access to food assistance was a problem. Community Assessment focus group participants stated that Medicaid services and Special Supplemental Nutrition Program for Women, Infants, Children Programs (WIC) are needed for children who were not born in the United States. Participants also stated that they need help paying rent and electric bills.

Resources and Strengths

The nonprofit community in Wake County provides emergency rent payments and utility payments to families in need. However, their resources are limited. The largest provider of services relating to basic needs is Wake County government. Wake County Human Services (WCHS) provides emergency rent payments and energy payments, Work First caseload and Food Stamp assistance.

Emerging Issues

On a broader scale, local advocates for low-income citizens have noted, "the working poor are laboring harder and longer than ever before just to get by." The following items are considered to be emerging issues for the ability to attain and maintain basic needs:

- Increasing demand for services.
- Escalating costs of prescription drugs with more job layoffs.
- More rapid exhaustion of emergency funds (used to finance medications).
- A significant increase in the number of workers who have been laid off, many of whom are well educated and /or highly skilled.
- A disproportionate percentage of income needed for housing and utility costs.
- Changes in mental health redesign which will affect families' ability to care for members with mental illness, developmental disabilities and substance abuse problems.

Housing

Introduction

Housing continues to be an important issue in Wake County. Assuring that citizens can afford safe, decent and affordable housing is a growing concern. As prices for homeownership and rental units increase, it becomes harder for lower income families to access affordable housing. Meeting the demand for housing that serves people with special needs is also an important issue facing the county.

Current State of Affairs

As the population of Wake County continues to increase, the need for affordable housing increases. Many people are finding it almost impossible to purchase a home on one income, still pay for basic living expenses and save money for the future. Problems related to housing are worsening or failing to improve. These include the decline in home ownership among the young, the cost and availability of affordable rental units, and homelessness.

Trends

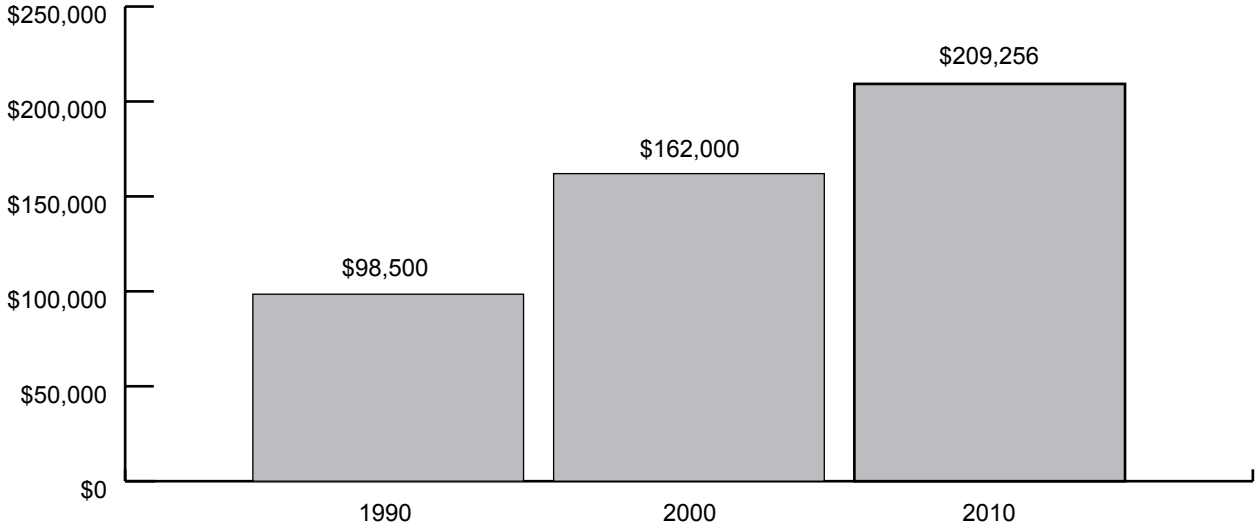
Approximately 34% of all households in Wake County are classified as renters. A typical two-bedroom market rate apartment averaged $461 in 1990, $725 in 1998, and $850 in 2006, an 18% increase between 1998 and 2006. In order to afford a market rate apartment in Wake County, a household must earn $34,000 annually, or $16.35 per hour for a 40-hour work week *(Out of Reach 2006, National Low Income Housing Coalition (NLIHC)*. Options are limited for those who earn less than $16.35 per hour. The 2003 Housing Affordability Task Force Report shows there is a need for over 25,000 units of affordable rental housing for low- and moderate-income families, or those earning less than $30,000 per year. This need is expected to increase to almost 30,000 units in 2007.

The Raleigh Housing Authority reports a waiting list of 5,300 families for Section 8 vouchers to help pay for rent and 2,000 families waiting for public housing units. In addition, the Housing Authority of Wake County reports a list of 171 low-income families waiting for Section 8 vouchers and 921 families waiting for public housing units.

Home ownership is problematic for low- and moderate-income families. The price of home ownership has increased significantly. In 2000, the median home sales price in Wake County was $162,000. In 2002, it was $168,000, an increase of 4%. In 2007, the median sales price is expected to rise to $194,629. A moderate-income family of four earning $57,300 can afford to purchase a home costing approximately $130,000. This means that persons earning less than 80% of median family income may have a difficult time becoming homeowners. In 1990, home sales in Wake County totaled 8,607; of those, 5,551, or 65%, were considered affordable at prices below $120,000. In 2000, of the 18,280 total sales, 4,066, or 23%, were priced below $120,000. In 2002, out of 18,702 total sales, 3,492, or 19%, were considered affordable. The trend continues to keep low-wage and service workers from being homeowners here.

Employment and population growth drives demand for rental and owner occupied housing. In 2005, the Census Bureau estimated that the population of Wake County was 748,815. This is an increase of 19% since 2000, when the population was 633,229. The number of employed has increased from 249,436 in 1990 to an estimated 389,050 in 2005, a 56% increase. About 65% of Wake County's households are owner occupied; 35% are renter occupied.

Increase in Median Home Price



Contributing factors for housing are affordability and availability. These are due to the private market not developing low rent housing, a lack in the number of affordable housing developers, and mental health reform adding to the demand of affordable rental housing. Affordable rental housing and home ownership opportunities remain more difficult today for young families and low-income households. Low-income households have a higher rate of being cost burdened by housing, which means spending 50% or more of their income on housing costs, or living in severely sub-standard housing.

Community Perceptions

Sixty percent of the people responding to the 2006 Wake County Community Assessment survey indicated that access to affordable housing is a problem in Wake County. Participants in the Community Assessment focus group stated that the lack of affordable housing is a major health problem in Wake County.

Resources and Strengths

The following two tables list the housing resources available in Wake County:

Agencies Providing Home Ownership Assistance

Agency	Program	Target population	# of Families Served per Year
DHIC (Downtown Housing Improvement Corporation)	Developer, 2nd mortgages	Families with incomes of $30,000/yr	80
Passage Home	Developer, home buyer classes, credit counseling, post home ownership counseling for 1 year	Families at or below 80% of Median Family Income (MFI) concentrating on families below 60% of MFI	50
Habitat for Humanity	Credit counseling, 1st mort financing, pre and post purchase counseling	Families between 30% and 50% of MFI with need	50
City of Raleigh	Second mortgage funds & housing rehabilitation funds	Families with incomes of $30,000 per year	
Resources for Seniors	Housing rehabilitation & emergency repair	Older adults	
Wake County	Housing rehabilitation & emergency repair	Families earning less than 80% of the area MFI	40
USDA Rural Development	Guaranteed loans 1st mort & housing rehabilitation loans	Families earning less than 80% of the area MFI	100
Triangle Family Services	Credit Counseling	Anyone is eligible but most clients have a household income of under $35K/yr	3000
NACA (Neighborhood Association of America)	Homeownership counseling, down payment assistance	Anyone who is a homebuyer and does not currently own a home is eligible	75
Wake County Housing Authority	Down payment assistance program; Section 8 homeownership program	Families earning less than 80% area MFI; housing authority residents	3
North Carolina Housing Finance Agency	Down payment assistance, second mortgages and first mortgages	Families and individuals earning at or below 120% of MFI	3,300

Agencies Providing Rental Opportunities

Agency	Program	Target population	# of Families Served per Year
DHIC (Downtown Housing Improvement Corporation)	Develops and owns affordable rental units throughout Wake County (1,173 units)	Families and elderly households with incomes less than 60% of the MFI	1,173
Passage Home	Owns 80 rental units in Raleigh, provides support services	Families at or below 80% of MFI concentrating on families below 60% of MFI	80
Episcopal Housing Ministry, Inc.	Develops and owns affordable rental units throughout Wake County (204 units)	Families earning between 31% and 50% of the area MFI	204
City of Raleigh	Owns approximately 250 units and makes loans to developers of affordable rental units	Families with incomes at or below 50% of MFI	250
CASA (Community Alternatives for Supportive Abodes)	Owns 146 units throughout Wake County	Special needs individuals and families	75
The Carying Place	Rents 3 units in Cary	Families earning at or below 30% area MFI	6
Wake County (Department of Human Services)	Loans to developers of affordable rental; support services and Client Assistance funds.	Families earning less than 40% of the area MFI; families participating in the Work First program	100
USDA Rural Development	Direct & Guaranteed loans (Section 515)	Families earning between 31% and 50% of the area MFI	100
Raleigh Housing Authority	Approximately 2,000 public housing units (all in Raleigh) and 3,500 Section 8 Certificates and vouchers (anywhere in Wake County)	Families earning up to 50% of the area MFI	4,000
The Women's Center of Wake County	Owns 2 units of permanent rental housing	Families earning below 40% of area MFI	2
Wake County Housing Authority	343 public housing units and 190 Section 8 certificates	Families earning up to 50% of the area MFI	50

Without the county investing in more affordable housing, more people who work in Wake County will be forced to live elsewhere. County investment in apartments and single-family homes will leverage additional federal, state and private funds, as well as add to the tax base of the county and individual municipalities in which the apartments and homes are located. Between 2000-2005, the county's investment of $6 million in local funds and $3.5 million in HOME funds for affordable housing assisted 421 families and leveraged approximately $70.5 million in other public and private funds. The county's investment of $5.5 million in Community Development Block Grant (CDBG) funds has helped to preserve affordable housing for 347 low-income families through the homeowner and investor rehabilitation programs and the emergency grant program.

Wake County Housing Investment FY 2000-2005

Source	Dollars Invested	Units Produced/Preserved
County Capital Improvement Plan	$6,000,000	252
CDBG	$5,500,000	347
HOME	$3,500,000	169
Total	$14,000,000	768

The county works cooperatively with both the private sector and other public agencies to develop affordable units. In rental developments, the county works with both for profit and nonprofit developers to build affordable apartments. In these developments, several units are reserved for very low-income families, the same clients that are served by other human services programs such as food stamps, health clinics and emergency services.

Currently Wake County Housing and Community Revitalization (HCR) has an annual budget of approximately $3.9 million from CDBG, HOME and local sources as well as program income received from loans made. The current focus of HCR's programs is to serve families earning $30,000 and below. HCR has four main programs:

- Addition of affordable housing units
- Preservation of affordable housing for homeowners
- Use of public entities to improve the infrastructure in low-income neighborhoods to support affordable housing
- Provision of rental vouchers available for homeless, working families and individuals.

The programs are at work all over the county outside Raleigh, Cary and Holly Springs.

Emerging Issues

Implications for lack of affordable housing units are:

- More persons living in substandard conditions.
- More persons forced to live outside of Wake County although they work in the county, increasing traffic and air pollution.
- More people needing basic services from the county because of their housing cost burden and subsequent insufficient funds for other necessities.
- More homeless individuals creating a potential burden on jails and hospitals.

A current emerging issue is housing for residents being released from Dorothea Dix Hospital. With the imminent closing of the hospital, there is a great need for housing that is both affordable and provides the tenant access to needed services. An estimated 2,000 people in Wake County with a diagnosed mental illness are served by Wake County Human Services. Most of them require affordable, supportive housing. Supportive housing is defined as housing with services. Persons with severe and persistent mental illness can often function outside an institutional setting in housing that includes services such as medication management, life skills training, employment assistance and case management. According to the Wake County 2005 Continuum of Care Application, there are currently 231 units of supportive housing for persons with a mental illness in the county, with 10 under development; 1,759 units are needed.

A major on-going issue is closing the gap between the availability and demand for affordable housing for families earning less than $30,000 per year. For homeownership, the gap in available units compared to the number of units needed is projected to be near 4,700 by 2007. For rental housing, it is forecast to be 29,556 in 2007.

Homelessness

Introduction

Homelessness is a sad reality for some citizens. Men, women, families, and youth experience homelessness for a variety of reasons, such as lack of affordable housing, low paying jobs, substance and alcohol abuse, mental illness and family conflict. Criminal records, bad credit, poor employment histories and deficient independent living skills are additional causes. Wake County's high cost of living, especially housing expenses, makes a homeless person's transition to full economic self-sufficiency an often long and frustrating process. Although numerous supportive services and programs exist for people experiencing homelessness in this community, funding for these services has not kept pace with demand. This has resulted in more people experiencing homelessness on either a temporary or chronic basis.

A concentrated effort is underway to solve the problem of homelessness. After many years of discussion and growing frustration with a "manage the problem" approach, in February 2005 the Raleigh/Wake County 10-Year Action Plan to End and Prevent Homelessness was published. Sponsored by a partnership of the Wake Continuum of Care, City of Raleigh, Triangle United Way and Wake County, with input from consumers, citizens, business leaders, and service professionals, this comprehensive plan is now being implemented across the community. The plan and the first annual progress report can be viewed on the City of Raleigh's website at www.raleighnc.gov/endinghomelessness.

Current State of Affairs

Over the course of a year, approximately 3,300 persons are homeless in Wake County.

In Raleigh, the South Wilmington Street Center (SWSC), the largest of the city's eight homeless shelters, served 2,044 men, with a total of 77,242 overnight stays and 141,567 meals between July 1, 2005, and June 30, 2006.

The U.S. Department of Housing and Urban Development (HUD) defines homeless persons as those who lack a fixed, regular, and adequate nighttime residence, including persons whose primary nighttime residence is:

- A supervised public or private shelter designed to provide temporary living accommodations;
- Time-limited/nonpermanent transitional housing arrangements for individuals engaged in mental health and/or substance abuse treatment;
- An institution that provides a temporary residence for individuals not intended to be institutionalized, or a public or private facility not designed for, or ordinarily used as, a regular sleeping accommodation.

In addition, myriad problems that contribute to homelessness include:

- Poor health and disabilities,
- Lack of educational and marketable skills,
- Lack of stable employment options which pay a living wage and provide benefits,
- Lack of accessible and affordable transportation,
- Institutional histories, and
- Lack of helpful support networks of family and non-homeless friends.

The Wake Continuum of Care (WCoC) conducts annual comprehensive, countywide Point-in-Time counts. The WCoC asks town police and fire departments to identify camps and gathering places of homeless persons. Working without publicity, outreach workers from several agencies and faith communities go to these places and count the number of people who are on the streets, in camps or under railroad bridges in the latter part of the evening. On the same night, emergency shelters and transitional housing programs complete a tally of those staying in their facilities.

Triangle Region Point-in-Time Homeless Count 2003-2006

	Durham	Orange	Wake	Triangle Total
Total 2006	502*	237	981*	1,720
Total 2005	535	230	1,106	1,871
Total 2004	578	179**	1,235	1,992
Total 2003	529	179	1,472	2,180

*Outstanding data from the State of North Carolina and local providers regarding sheltered count in Wake County and Durham County. ** Count completed in late 2003, so data for Orange County was used both years.

On January 26, 2006, 981 people were counted in the one-day survey of homelessness, providing a single "snapshot" of who was homeless on that particular night. Of those, 213 were children. In addition to those counted in shelters, 106 people were found outdoors living on the streets. Another 15,000 people were estimated to be living doubled up with family or friends, and at risk of homelessness. Family homelessness in Wake County is rising by an estimated 11% yearly.

The chart below provides more detail from the 2006 Point-in-Time count:

Homeless Population	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Number of Families with Children (Family Households):	45	58	0	103
Number of Persons in Families with Children:	146	186	0	332
Number of Single Individuals and Persons in Households without Children:	387	156	106	649
Total Persons:	533	342	106	981

This method, however, has serious limitations in accurately counting the number of persons experiencing homelessness. The count is done only one night per year and during the winter when people are more creative in finding temporary shelter from the weather. The count is limited primarily to the downtown Raleigh area and targets areas where homeless people will most likely be found. The shelter survey does not include all shelters, hospitals, jails, or other treatment facilities. The SWSC alone served over 2,000 unduplicated men during the year in which this count occurred. Looking at several data sources, it becomes obvious that the number of people experiencing homelessness fluctuates over a period of several years. It is reasonable to suggest, based on data from shelters, that the actual number of homeless persons in the county is higher than reported through the Point-in-Time count. Regardless of the actual number of homeless persons in the community, the knowledge that many citizens lack a safe, permanent residence is cause for more attention and resources to help eradicate homelessness in the county.

Many homeless persons find themselves in that situation because they are priced out of the housing market. A majority of people who are homeless work, most often in low-paying service jobs that provide no benefits.

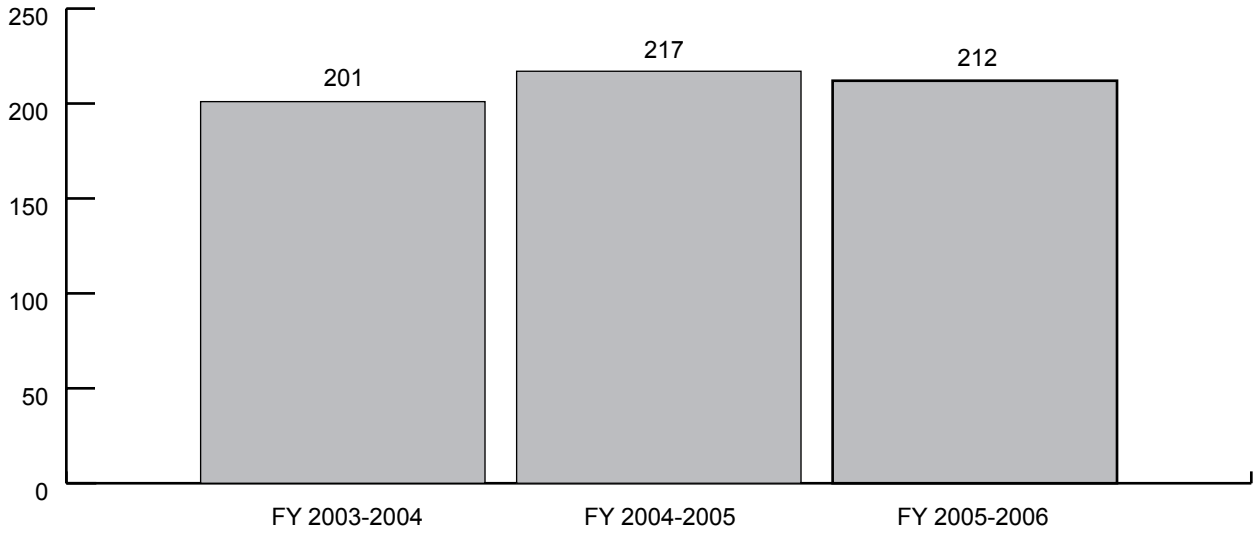
The North Carolina Housing Coalition reports that 740,000 households in the state live in substandard housing or are paying too much for housing. This "housing affordability gap" is especially acute in high-cost housing areas like Raleigh, where the fair market rent for a two-bedroom apartment is $799. With the minimum wage at $5.15 per hour, even people earning twice that can't find affordable housing. In fact, over 25,000 additional housing units are needed for people earning less than 40% of median income. The current area median income for a family of four is $71,600 per year.

Trends

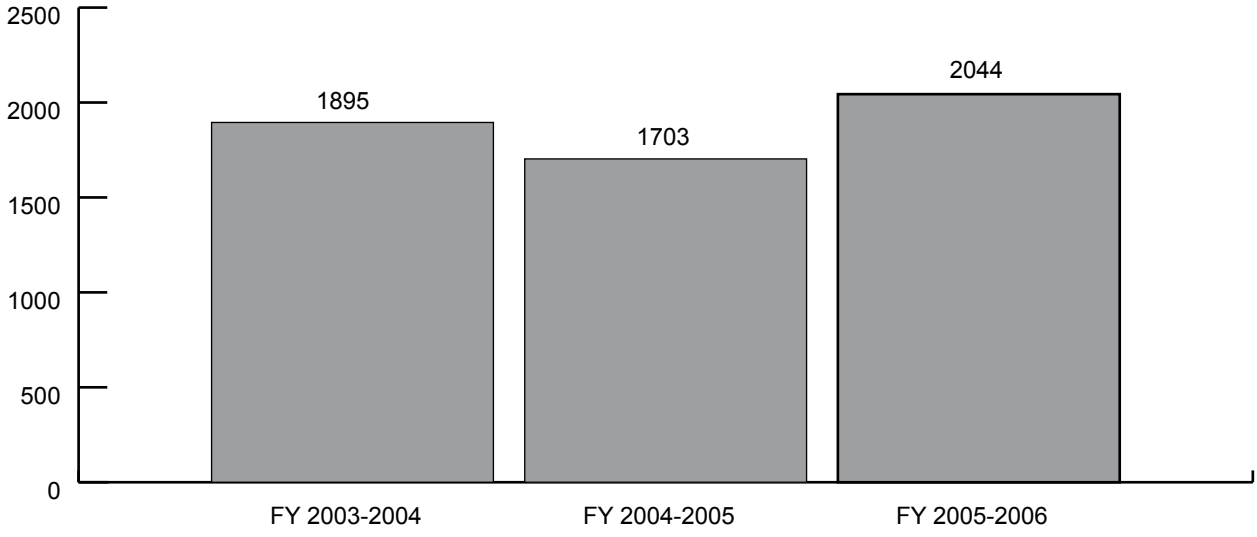
An estimated 842,000 adults and children in the United States are homeless in a given week, with 3.5 million adults and children experiencing homelessness over the course of a year. Homelessness is a challenging problem with no single or simple solution. Generally, people are homeless because of a complex interplay of individual risk factors and structural barriers that must be addressed in any comprehensive system to prevent and end homelessness. The homeless population is heterogeneous and includes single adults, homeless families with children, and unaccompanied youth. Nationally, the majority of homeless people, 66%, are unaccompanied adults, but the number of homeless families is growing. Nearly one-fourth of homeless people are children under age 18 with a parent; 42% of the children are under the age of 5.

In Wake County, the SWSC provides emergency shelter and basic needs to men experiencing homelessness. It also offers supportive services and help to develop plans that lead to self-sufficiency. It serves roughly two-thirds of the estimated 3,300 persons who experienced homelessness in the county last year. Data taken from the last three annual reports at SWSC document the most recent trends among men experiencing homelessness in Wake County:

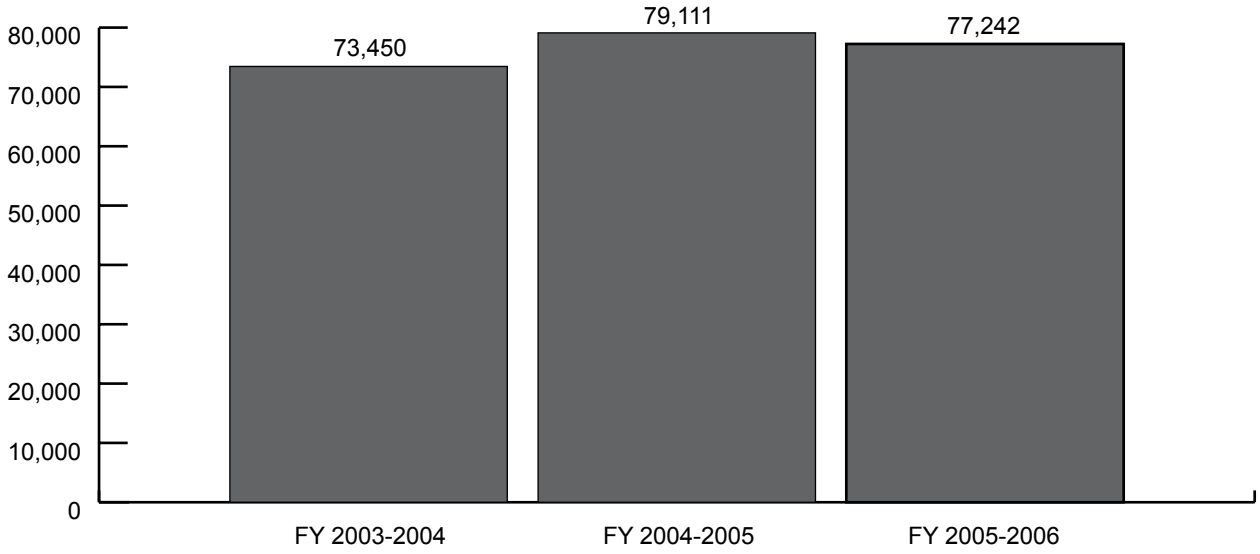
Average Daily Occupancy of Men



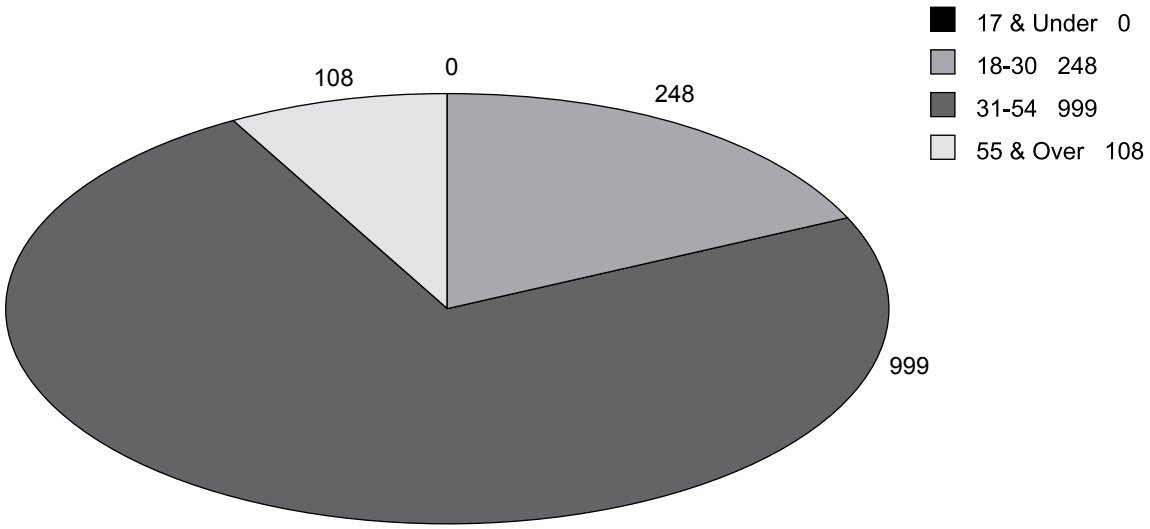
Unduplicated Number of Men Served



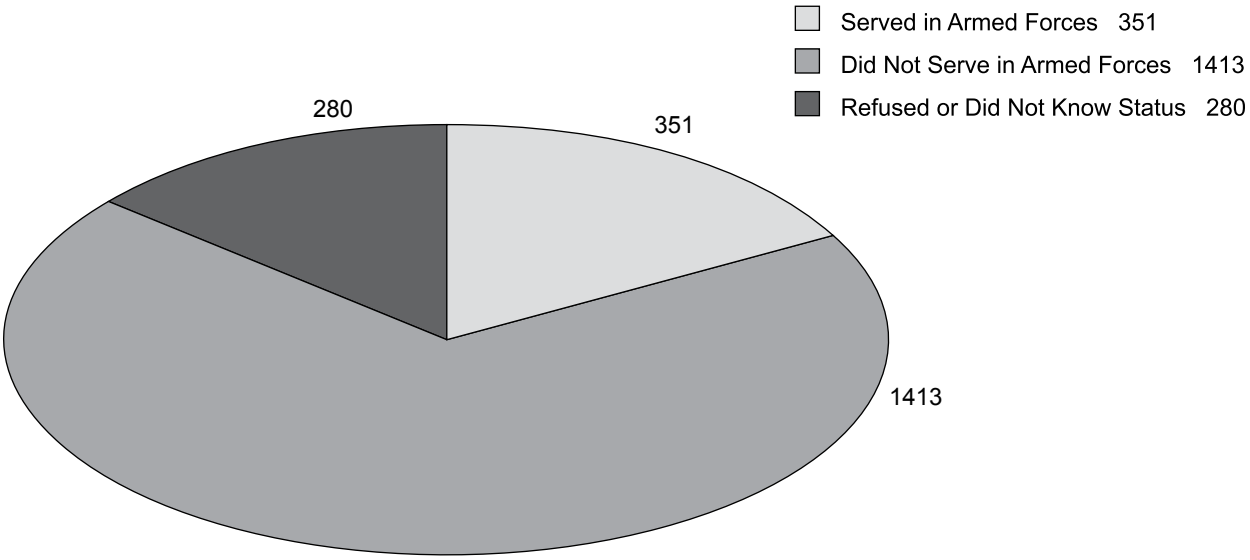
Number of Beds Utillized



Shelter Access by Age New Guests



Veteran Status



A number of risk factors may lead to or prolong homelessness. For example, African Americans and Hispanics/Latinos, who are more likely to be in lower income brackets and lack access to health care, are over represented in the homeless population. Nationally, 40% are Arican-American, 11% are Hispanic, and 8% are Native American. At the SWSC in Wake County, 60% are African-American, compared to 21% in the general countywide population.

A significant percentage of homeless people have mental illnesses and/or substance use disorders and chronic physical conditions. Nationally, almost half, or 46%, of homeless adults who use services report chronic physical disorders. Sixty-six percent report substance use and/or mental health problems. Serious health and behavioral health disorders make it difficult for individuals to find and retain housing, maintain employment, and navigate the health, housing, and social service systems. Thirty-five percent of homeless people in Wake County have serious mental illnesses and 66% have chronic substance use disorders; many have both disorders. *(2006 Point-in-Time Count)*

Some of these individuals are among the group now referred to as "chronically homeless." According to research, the chronically homeless population accounts for 10% of shelter users, but consumes half of the total shelter days. Another 10% of people who are homeless are considered episodically homeless (people who shuttle frequently in and out of the shelter system), and the remaining 80% are transitionally homeless (people who typically exit the shelter system after a short stay). At 13%, Wake County's population of people who are chronically homeless is over the national average.

Trauma/domestic violence is another individual risk factor that may lead to or prolong homelessness. The rate of trauma among women who are homeless is staggering. Researchers found that 92% of women who are homeless report severe physical and sexual assault over their lifespan, often beginning in childhood *(Bassuk et al., 1996)*. Such trauma may precipitate or exacerbate mental illnesses and substance use disorders, and mental and addictive disorders make women more vulnerable to abuse. In Wake County, 83% of female-headed homeless households have recent domestic violence as one contributing factor to their homelessness.

People who become homeless generally have small social support networks and the members of their networks often are unable to offer material help. Any attempt to end homelessness in a city, a state, or the nation must take into account all of the vulnerabilities of homeless people.

People who are homeless require a broad range of housing, health and mental health care, substance abuse treatment, and social services, all of which typically are provided by separate agencies with their own funding streams, eligibility criteria, and treatment philosophies.

The Raleigh/Wake County 10-Year Action Plan to End and Prevent Homelessness has identified several key gaps in services and the corresponding strategies to address these unmet needs:

Prevention: Prevent individuals and families from becoming homeless through comprehensive discharge planning, targeted resources, research and advocacy. Preventing homelessness is more cost-effective and humane than allowing people to become homeless in the first place. Any community effort to end homelessness must include substantial prevention resources.

Key strategies:

- Create and execute comprehensive, client-centered discharge plans coordinated with community agencies for individuals who are at risk of homelessness and are leaving foster care, mental health or medical facilities, and jails and prisons.
- Design and implement a prevention effort for individuals and families at risk of homelessness, combining emergency assistance funds with short-term intensive support from professional caseworkers, and follow-up by local faith-based or other nonprofit organizations.
- Target prevention activities within the public school system to all school-aged children to provide education on homelessness and provide "reach in" services to identify those who are at greater risk of becoming homeless.

Engagement: Expand and coordinate outreach efforts and create interim housing to help people who are homeless. Once believed to be a nontraditional service, outreach to disengaged homeless people, often street and woods dwellers, is now considered the first and most important step in helping these people get needed services. *[Substance Abuse and Mental Health Services Administration (SAMHSA) 2003].*

Key strategies:

- Develop Safe Havens, low demand supportive housing, as engagement housing for people who are chronically homeless and who have serious mental illnesses and/or substance use disorders.
- Develop a 24/7 service for the community that provides immediate information, referral and crisis management for persons currently experiencing housing emergencies.
- Gradually phase down shelters and transitional housing with targeted short-term housing models that will provide a brief and supportive transition to permanent housing.
- Strengthen outreach and engagement efforts by eliminating duplication of effort, addressing gaps in services, and providing key services at a central location.

Housing: Expand the availability and choices of permanent housing that are affordable to individuals and families with extremely low incomes. In Wake County, there remains a gap of at least 25,000 units of affordable housing. More than 15,000 people are precariously doubled up with relatives or friends *(2000 Census).* Many individuals and families, especially those with mental illnesses and/or substance use disorders, need supportive services to help them remain in housing.

Key strategies:

- Increase the supply of permanent housing affordable to individuals and families at 0-40% of area median income to meet the deficit.
- Develop resources to fund and provide access to supportive services to those in housing at levels appropriate to those individuals and families who have been chronically, acutely or intermittently homeless as well as those who are at risk of being homeless.
- Promote a variety of affordable housing choices throughout Raleigh and Wake County for individuals and families.
- Establish a Housing First model of permanent supportive housing consistent with individuals' needs, preferences, and priorities to serve people who are homeless. The Housing First model provides permanent housing immediately to persons who are homeless and offers the residents voluntary supportive services as long as they need them.

Employment/Education: Create education, job training, and employment opportunities specific to the needs of individuals and families who are homeless, recently homeless, or at risk of homelessness, including those with mental illnesses and/or substance use disorders and youth ages 16-21. Most people who are homeless want and need to work. A survey of homeless assistance providers revealed that their clients cited "help finding a job" as their number one need, followed by help finding affordable housing, and help paying for housing *(Burt et al., 1999)*.

Key strategies:

- Establish strategic alliances with the business and educational communities to design and provide education, job readiness, and training opportunities for individuals and family members who are homeless, recently homeless, or at-risk of homelessness.
- Establish employment opportunities that enable residents of supportive housing who express a desire to work to do so.
- Fund services and supports that enable individuals and family members who are homeless, recently homeless, or at risk of homelessness to participate fully in employment opportunities.
- Develop specialized job training and employment services for people who are homeless and have mental illnesses and/or substance use disorders.

Services and Supports: Improve and expand services and support resources for people who are homeless, at-risk of homelessness, or recently homeless to help them achieve maximum independence and self-sufficiency. Housing is necessary but not sufficient to help people who are homeless – particularly those with multiple physical health, mental health, and social service needs – achieve residential stability, psychiatric stability, and sobriety. Many individuals and families require some level of supportive services, which will vary in type and intensity depending on individual and family needs.

Key strategies:

- Expand the ability of publicly funded and private, nonprofit community providers to better serve people with mental illnesses and/or substance use disorders who are homeless or at risk of homelessness.
- Expand current multi-service centers (Cornerstone, Bason Street Center, Women's Center) to serve as "one-stop shops" for individuals and families who are homeless or at risk of homelessness who need health, mental health, substance abuse, and social services, as well as housing, or help obtaining public benefits, employment assistance, transportation and childcare.
- Implement targeted efforts for individuals and families who are chronically, acutely or intermittently homeless as well as those who are at risk of being homeless, with a special emphasis on survivors of trauma (domestic violence, sexual assault, or child abuse), youth aging out of foster care, immigrants and refugees, veterans, ex-offenders, underserved minorities, and gay, lesbian, bisexual, and/or transgendered youth.
- Work closely with mainstream providers to promote an integrated, comprehensive system of care that would allow individuals and families who are homeless or at risk of homelessness to walk in any service door, be assessed, and be provided with or referred to services (the "no wrong door" approach to service provision).

Additionally, each year the WCoC works to obtain substantial funds to provide housing and support services to persons who are experiencing homelessness. The following table was included in the most recent request for funding and outlines some of the continuum's goals:

Objectives to End Chronic Homelessness and Move Families and Individuals to Permanent Housing	Local Action Steps (How are you going to do it? List action steps to be completed within the next 12 months.)	Measurable Achievement		
		In 12 months	In 5 years	In 10 years
1. Create new permanent housing beds for chronically homeless persons.	Develop 10 new units in the coming year by applying for funding from HUD, the City of Raleigh, Wake County, and the NC Housing Finance Agency.	10 units	50 units	100 units
2. Increase percentage of homeless persons staying in permanent housing over 6 months to 71%.	Increase support services available to persons living in permanent housing by partnering with the faith community's "Circles of Support" and WCHS Supportive Housing Team.	5 new house-holds	30 new house-holds	60 new house-holds
3. Increase percentage of homeless persons moving from transitional housing to permanent housing to 61%.	Provide rental subsidies or vouchers to assist persons with rent to maintain housing stability through Wake County's Voucher Assistance Program and through the 2006 HUD application.	25 vouchers	50 vouchers	100 vouchers
4. Increase percentage of homeless persons becoming employed by 11%.	Create new jobs through cooperation with the Greater Raleigh Chamber of Commerce	10 jobs	40 jobs	60 jobs
5. Ensure that the CoC has a functional Homeless Management Information System.	Develop annual funds to support the Homeless Management Information System and staff; add new user agencies annually	$20K; 2 users	$100K; 5 users	$100K; 10 users

Community Perceptions

Fifty-one percent of respondents to the 2006 Wake County Community Assessment Survey felt that homelessness was a problem in Wake County.

Resources and Strengths

Wake County continues to have a homeless services system, made up of many nonprofit and governmental agencies, that provides a wide array of emergency shelter, transitional housing, permanent housing, and supportive services. Most of these agencies belong to the Wake County Continuum of Care (WCoC) that has recently received its nonprofit status from the Internal Revenue Service as a 501(c)3 organization. The WCoC meets monthly to improve the service delivery system while working toward the goal of ending and preventing homelessness.

Several recent initiatives are strengthening the efforts aimed at homelessness in Wake County. These include:

1] Raleigh/Wake County 10-Year Action Plan to End and Prevent Homelessness
In February 2005, after a year of planning involving the entire community, the Raleigh/Wake County 10-Year Action Plan to End and Prevent Homelessness was presented and work on its implementation began. Volunteers now work in 12 strategy groups in the areas of prevention, outreach/engagement, housing/support services, and education/employment.

2] Supportive Housing Team
Wake County Human Services created a team of six staff who provide supportive housing services to the residents of the county. The central goal of this team is to increase the residential stability of citizens while improving their well being and quality of life. In addition to the intensive services that the Supportive Housing Team offers under site-based and community-based supported housing, the team also provides less-intensive services to the general public. These include ready-to-rent tenant educational classes, housing vacancy listings, and housing information and referrals. These services are available to all citizens and, in most cases, participants do not have to meet any specific eligibility criteria. However, specifically targeted populations include those with long histories of homelessness, families that episodically and periodically undergo crises, and youth transitioning into adulthood. Many of these individuals also may be coping with mild mental illness, chemical abuse, and/or other disabilities. It is believed that these participants frequently use costly crisis and other institutional services.

3] Circles of Support
As part of the Raleigh/Wake County 10-Year Action Plan to End and Prevent Homelessness, Catholic Charities is coordinating Support Circles for families and individuals who are homeless. Local participating congregations form a "circle" of volunteers to help a family or individual who is experiencing homelessness locate affordable, permanent housing and offer support as the family/individual becomes established in the community. Rental subsidies are available to the family/individual.

4] Housing First Program
The Housing First model provides permanent housing immediately to people who are homeless and offers the residents voluntary supportive services as long as they need them. As opposed to models where the individual has to be "ready for housing" by going through a system of services while living in a shelter, in the Housing First model, the individual moves into permanent housing first and simultaneously receives supportive services and training. A new Housing First program in the community will have an ultimate capacity for 18 households.

5] Transitional Voucher Program
Wake County Human Services' Housing and Community Revitalization Division instituted a short-term rental assistance program of up to 24 months for individuals/families who are homeless but employed. This program is administered by two local non-profits agencies, Community Alternatives for Supportive Abodes (CASA) and Passage Home. A minimum of 30 households benefit from this program at any given time.

6] Incentive Housing Dormitory
SWSC Incentive Housing Dormitory (IHD) is the final phase of shelter services for men participating in the program at South Wilmington Street Center. The IHD is located approximately two miles from the main facility and has 19 units of efficiency housing.

This housing is targeted to assist men in re-entering a self-directed and self-sufficient lifestyle by providing them with a realistic apartment-like setting with many life-like opportunities and challenges. Men have opportunities to practice lessons they have learned while participating in the case management program. Those who qualify to move to the IHD have earned the privilege of privacy and are held accountable to demonstrate their ability to live independently. The case management team continues to provide non-obtrusive services to help the men be successful in their goals. While residing in the IHD, case management services also focus on acquisition of safe, decent, affordable housing and development of community supports.

7] **HUD Funding**
Since the mid-1990s, the Wake Continuum of Care (WCoC) has successfully submitted an application to the U.S. Department of Housing and Urban Development for its Homeless Assistance Program funds annually, resulting in a significant increase in the number of housing units and supportive services in the community. In 2005, the WCoC was awarded $2,309,650 for six projects, including a new 10-unit apartment complex for person who are chronically homeless and have a disability. The WCoC submitted its 2006 application requesting $2,368,794 for 12 projects.

8] **Tax Credit Developments**
Beginning in 2003, through a joint venture between the N.C. Housing Finance Agency and the N.C. Department of Health and Human Services, developers who are awarded tax credits allocate a percentage of their units to households who are homeless or who are headed by a person with a disability. Each developer must work with a local lead agency that is responsible for providing supportive services to tenants in the targeted units as they need and want them. Currently, 69 targeted units are operational or under development in Wake County.

9] **Relationship with North Carolina's 10-Year Plan to End Homelessness**
At the same time the community is implementing its 10-year plan to end homelessness, the state, through the North Carolina Interagency Council on Coordinating Homeless Programs (ICCHP), is developing a similar statewide plan. Two members of the ICCHP are members of the Raleigh/Wake County 10-year plan's Leadership Council.

Emerging Issues

The following issues must be considered in regard to homelessness in the community:

Mental Health Transformation
The state of North Carolina has undertaken a process of transforming the statewide mental health system. As a result, Wake County Human Services (WCHS) is becoming an assuror of services instead of a direct provider of services to persons with mental illness, developmental disabilities, and/or substance abuse disorders. It is anticipated that this change will be complete in 2007. WCHS is the local managing entity charged with assuring services are delivered adequately by contracted service providers. While it is hoped that any change in service provision is seamless for the consumer, an initial concern has been that there is not sufficient funding from the state to finance the community-based service system.

Closing of Dorothea Dix Hospital
As part of the mental health transformation, Dorothea Dix Hospital (DDH) is scheduled to close in 2008 upon the construction of a new state psychiatric hospital in Butner, N.C. The new hospital will replace both DDH and John Umstead Hospital, another state psychiatric hospital already in Butner. This 432-bed hospital will have fewer beds than Dix and Umstead combined. Once DDH closes, there will be no public inpatient psychiatric treatment available in Wake County. Plans are underway to create such a facility.

In addition to a local inpatient unit, efforts must be made to increase the amount of housing and accompanying supportive services for persons who will no longer be hospitalized for long periods of time. Some initial funding from the state allowed for the development of a supported housing complex. However, if these efforts do not continue, the number of persons in the community who are homeless and disabled will grow. Experience has shown that too many people are now discharged to emergency shelters directly from DDH. Some of those discharged are not well served in large settings like shelters and end up on the streets.

In 2006, the N.C. General Assembly increased funding for supported housing. Wake County has identified the type of and number of housing units needed. An emerging issue is seeing that sufficient housing is available for those who are disabled due to mental illness, developmental disabilities, and substance abuse disorders and who are living in the community instead of a state hospital.

Health Care
There is an increasing prevalence of serious illness, chronic illness, and physical disabilities among persons who are homeless. Like psychiatric hospitals, general hospitals are more often discharging persons to emergency shelters or other precarious housing situations. Homelessness is not conducive to recuperation and rehabilitation. Horizon Health Center is designed specifically to provide primary health care for people who are homeless, but there's been a decrease in Horizon's capacity this year. There is a coordinated medical respite program at the SWSC for men and the Raleigh Rescue Mission for women that provides limited medical beds needed for medical issues and recuperation from surgery or other procedures. However, because there are limited beds, many others who are in need of respite care are discharged to shelters without coordinated care. The emerging issue is that the illnesses are becoming increasingly more serious. While efforts are being made to address this problem, additional resources are needed to care for the health of persons who are homeless.

Sustainability of the Raleigh/Wake County 10-Year Action Plan to End and Prevent Homelessness

Volunteers have formed strategy groups to implement several strategies that, in combination, will end and prevent homelessness in Wake County. Homelessness is a complex problem, but one that can be solved with perseverance. More than a small number of people must sustain the effort and maintain the momentum to reach the county's goal. The challenge as a community is to keep the focus and continue the resolute action toward ending and preventing homelessness over the next nine years.

Transportation

Introduction

There is a need for available, affordable, flexible and responsive transportation services in Wake County. Most residents can drive to reach new employment, commercial, retail and residential opportunities in the county. However, for those who cannot drive or lack vehicles, the transportation alternatives remain limited.

Current State of Affairs

Wake County is fortunate in comparison to other counties in that we have many transportation service options available. Two urban services provide traditional fixed route services in Raleigh and in Cary. The county also has a regional service provider, Triangle Transit Authority (TTA), which provides regional commuter trips by fixed route and by vanpool and carpool coordination. A rail service is planned by the TTA to provide trips into the Research Triangle Park. The county also has localized demand responsive services that meet the needs of sponsoring human services agencies as well as rural public services that are available for the 170,000 residents of rural Wake County who have had no other transportation service.

Human Services Transportation
The Wake Coordinated Transportation Service (WCTS) provides a fully consolidated and brokered transportation service to meet the needs of the county residents. The WCTS puts customers on fixed route buses when feasible, and provides demand response transportation services to Wake County Human Services programs and other agencies and programs that agree to sponsor their customers. WCTS contracts services with one primary national vendor and several small local vendors creating a brokered service design. Coordination of trips among member agencies and programs provides a cost effective way to share overhead costs and allow agencies and programs to afford more trips than they could on their own. Brokering services allows the WCTS to build community capacity, offer more resources and help to meet the growing demand for these transportation services.

Rural Public Transportation
Transportation and Rural ACcesS (TRACS) is the newest transportation service offered by WCTS. TRACS operates primarily as a local service within four zones and is designed to meet transportation needs for the 170,000 people living in unincorporated Wake County. Longer trips are possible across these zones, but only after local trip needs have been fulfilled. The TRACS service is demand responsive, and is set up on a first-come, first-served basis. County residents can call the Transportation Services Center, a centralized call center, to make trip requests for both human services and rural public trip needs. Rural public trip needs are met on the TRACS service. The customer pays $2 for each leg of a trip within the localized service zone. Trip cost is $4 for out-of-zone service, and is based upon availability.

Raleigh Capital Area Transit (CAT) Bus Services
The City of Raleigh provides people within its city limits with a traditional fixed route bus service. Bus service is operated along major corridors with set time points, standardizing the service and creating consistency for the riders. This creates a "spoke and hub" service pattern allowing riders to come downtown and transfer to other bus lines to reach other parts of the city. This traditional service design has many advantages, including efficiency and productivity. People living reasonably close to the bus lines are able to access other parts of the city for a reasonable fare. The "spoke and hub" service design works well for everyone when the average trip would begin on an existing bus line and end downtown, or on another bus line. However, because of the county's growth, this service design does not adapt well to the new development.

Cary C-TRAN Services
The Town of Cary created the C-TRAN services several years ago to help elderly and disabled residents access the community. Services were soon made available to others living in Cary on a seat available basis. The service began, and continues on a limited basis, as a demand response design, similar to TRACS. As the demand grew, the town decided to add fixed route services.

Triangle Transit Authority (TTA)
The TTA was created to provide regional commuter trips from Durham, Orange and Wake counties into Research Triangle Park (RTP). The TTA provides fixed route express bus services designed for RTP commuters. The TTA also provides vanpool and carpool services. Other programs include ride match, park-and-ride and an Internet-based trip planner.

Trends

Demands for transportation services continue to grow as more resources and services are made available to the citizens of Wake County. Unmet transportation needs have consistently been identified as one of the top priorities by community-based plans and studies that cut across various programs, agencies and county departments.

Following are some ridership trends of the WCTS and TRACS program:

WCTS FY	WCTS Expense	Percent Trips	TRACS Increase	TRACS Expense	Percent Trips	Increase
04	$2.93M	119,000	-----	$80,750	2,583	-----
05	$3.4M	139,000	16.8%	$133,209	5,500	119%
06	$4.4M	187,000	34.5%	$192,692	13,262	141%

Community Perceptions

Nearly 60% of those responding to the 2006 Wake County Community Assessment survey indicated that access to transportation was a problem in the county. Participants in the Community Assessment focus groups stated that the lack of adequate public transportation prevents citizens from staying healthy. Participants also stated that transportation is not working to address the six areas of health for citizens.

Resources and Strengths

Wake County has many strengths and opportunities on which to build transportation services. The Capital Area Metropolitan Planning Organization (CAMPO) offers an excellent opportunity to more seamlessly coordinate all transportation needs and to advocate for more funding. CAMPO has staff and elected officials from local governments in Wake County, and some neighboring governments. Strengthening the support for transportation services at the staff and elected-officials levels of CAMPO is important. However, CAMPO is often overwhelmed with issues related to building and maintaining roadways, and should not be relied upon as the sole method for improving transportation services in the county.

The Growing Older Living with Dignity (GOLD) Coalition recently completed an update to the County Aging Plan. It identified the need for better transportation services as its top priority. The senior population is expected to grow tremendously in coming years, and they will expect to maintain their ability to access their communities. From a cost perspective, research has shown that every person who is able to maintain independence for an additional year of his or her life will result in a savings to the taxpayer of over $45,000. In its report, the GOLD coalition recognized that transportation services should not be dedicated only for seniors, but should be a "universal access design" so that all people who need transportation services can benefit. Working with the GOLD Coalition will be important in order to assure this important population will have its needs met, and that quality of life can be maintained for as long as possible.

The recently reauthorized federal transportation bill has identified increasing funding levels for transportation services like the WCTS for the next several years. Increasing funding for administration, capital, technology and operating assistance creates an opportunity to plan and expand services and meet more of these transportation needs. The new federal legislation also recognizes the importance of providing a quality and effective employment related transportation service that will help low-income persons achieve and maintain their independence. Wake County has received a sizeable Job Access and Reverse Commute (JARC) grant already. It will be important to advocate for the continuation of these employment transportation services and the grant funds that have been leveraged to provide these services.

New funding to support the continued implementation of advanced technology for the WCTS also presents a key opportunity. WCTS already uses an Internet-based routing and scheduling software that aids in providing quality service and efficiently managed resources. Enhancements to this software are needed to improve the ability to coordinate among the private providers, and to improve the ability to schedule and track services provided in "real-time," while immediately capturing important operating data and statistics. These technology enhancements require additional funds that may be leveraged through the new federal transportation bill.

Emerging Issues

In recent years the WCTS has reorganized how it operates to better prepare for and meet the emerging needs for transportation services in Wake County. The resulting changes and enhancements to the transportation services provided through the WCTS resulted in tremendous growth in services. As more people learn about the opportunity to access these services, the existing resources will become stretched. So far, available funding has not kept up with the growth in services provided. The quality of the services provided sometimes lessens and trip denials occur as the WCTS is forced to make service decisions based on controlling costs. In addition to the existing needs there are clearly emerging needs for services to the growing senior population. Residents in the urban areas have good services but it remains difficult for people living in rural areas of the county to consistently receive transportation services. It is in these rural areas that much of the growth and affordable housing is now occurring, so it will be critical for Wake County to plan for and provide an available, affordable, flexible and responsive transportation service that will create access and mobility for people in these parts of the county. It also must allow people to maintain their quality of life and independence for as long as possible.

Chapter 5: Environmental Health

The Environmental Health chapter examines how Wake County residents affect their environment and how it, in turn, affects their lives. Air quality, solid waste management, water quality and, especially, land use are all important elements of the county's environmental health. The design of communities in Wake County can promote active living, and taking to heart our environmental stewardship responsibilities promotes healthier living for us today as well as for generations following us tomorrow.

Air Quality

Introduction

This section covers ambient, or outdoor air quality, as well as the indoor air quality concerns of radon. Radon in groundwater is covered in the section on water quality in this chapter. Asthma is included in Physical Health (chapter 7).

Current State of Affairs – Outdoor Air Quality

The Environmental Protection Agency (EPA) designated the Triangle area as a non-attainment area for ozone in 2004, reflecting historically high concentrations, particularly in 1998, 1999 and 2002.

Ozone is a gas composed of three oxygen atoms. "Good" ozone occurs naturally in the stratosphere approximately 10 to 30 miles above the earth's surface and forms a layer that protects life on earth from the sun's harmful rays. "Bad" ozone, or ground level ozone, is a key component of smog. It is formed by a chemical reaction between Volatile Organic Compounds (VOCs) and Nitrogen Oxides (NOx) in the presence of heat and light in the lower earth's atmosphere. Volatile Organic Compounds are created in many ways, including from trees and other plants. Exhaust from motor vehicles is the largest source of Nitrogen Oxides. Ozone concentrations tend to be higher in hot, dry weather with light winds than in cooler, wetter, windier weather. High ozone concentrations typically occur between from the first of May to the first of October.

Ozone irritates the lungs, which causes repeated cough, chest pain, and shortness of breath as well as other symptoms. Ozone impairs the normal function of lungs and reduces the lung's defenses against respiratory infection and disease. Prolonged ozone exposure has been shown to result in lower rates of lung growth among children and permanent changes in lung structure, which may result in a reduced quality of life in later years.

Trends

The EPA and the N.C. Department of Environment and Natural Resources (DENR), Division of Air Quality, use a five-level color-coded system to identify ozone concentrations. Red means an unhealthy concentration of ozone while orange means the ozone concentration is unhealthy for sensitive groups.

Code red and orange days have declined substantially across North Carolina and in the Triangle area over the past few years. In the summer of 2004, when the weather was wetter than normal, the Triangle area had only two code orange days and no code red days. In the summer of 2005 when the weather was hot and dry, the Triangle area had 10 code orange days and no code red days. As of July 26, 2006, the Triangle had three code orange days and no code red days.

DENR's Division of Air Quality attributes recent air quality improvements to reductions in Nitrogen Oxide emissions from motor vehicles and the Clean Smokestacks Bill, which reduced emissions from coal-fired power plants and other industries.

Ambient air pollution is not concentrated in any particular area of Wake County, so there are no apparent disparities in its effects on the population. High levels of ozone affect children, elderly people and people with respiratory disease more than healthy adults, due to reduced capacities of their respiratory systems. Also, people who are active outdoors get exposed to higher levels of ozone than those who remain indoors.

Community Perceptions

In the 2006 Wake County Community Assessment, air pollution was considered a moderate to serious problem by 59.9% of survey respondents. Poor air quality was cited by 36% of focus groups as a major health concern.

Resources and Strengths

The N.C. DENR Division of Air Quality is responsible for monitoring air quality and preparing the State Implementation Plan, which outlines measures the state will take to ensure it complies with National Ambient Air Quality Standards.

Because a large measure of air quality is directly related to motor vehicle emissions, the Capital Area Metropolitan Planning Organization (CAMPO), the transportation planning agency that covers Wake County, is responsible for preparing transportation plans that comply with the state's plan and the national standards. CAMPO uses Federal Congestion Mitigation and Air Quality funds to assist in complying with National Ambient Air Quality Standards. It has allocated a large portion of those funds to computerize the traffic signalization systems of Raleigh and Cary in order to reduce emissions caused by idling.

Wake County government and the Wake County Public School System have implemented a number of recommendations from the County's Air Quality Task Force that are designed to improve air quality. Major actions include encouraging County employees to use alternatives to the single-occupant auto to get to work, changes to the county vehicle fleet to include hybrids and use of biodiesel fuel, changes to school bus policies and emissions, and raising public awareness of air quality by displaying ozone code posters in County buildings and parks.

Emerging Issues

The Triangle area is experiencing reductions in ozone levels, and the NC DENR Division of Air Quality staff projects that the Triangle area will come into compliance with National Ambient Air Quality Standards in 2007. However, staff caution that as vehicle miles traveled continue to increase, overall increases in motor vehicle exhaust are expected to outweigh the reductions in Nitrogen Oxides from individual vehicles, and if adequate air quality control measures are not taken, the Triangle area could again violate air quality standards in the next decade.

Radon

Introduction

Radon is a colorless, odorless gas that comes from the natural breakdown of uranium in soil, rock and water and gets into the air. Over a person's lifetime, radon particles can enter the lungs, attach themselves, and eventually lead to lung cancer. Radon's decay products can be trapped in the lungs where they produce a radiation dose. With as many as 15,000 to 22,000 deaths each year, radon exposure is second only to smoking in causing lung cancer deaths in the United States, according to the EPA and the Centers for Disease Control and Prevention (CDC).

Radon enters a home through cracks in walls, basement floors, foundations and other openings. It may contaminate the water supply, especially in private wells – affecting people while showering or running water in general.

Radon can be a problem in all types of homes, whether old, new, drafty, insulated, with or without basements. It is more harmful when trapped in higher concentrations indoors than it is outdoors. Local geology, construction materials and how the home was built are among the factors that can affect radon levels in homes.

One in 15 homes across the United States has elevated radon levels. As indicated by the U.S. EPA Radon Zone Map, Wake County is considered a Zone 2 county having moderate radon potential (from 2 to 4 picocuries (pCi/L)). Because the geology of Wake County is favorable for radon, the only way to know whether radon exists in elevated levels in a home is to test. Testing is simple and inexpensive, and, if discovered, radon problems can be resolved.

Current State of Affairs

Wake County Department of Environmental Services has completed two phases of a three-phased evaluation of radon levels in indoor air and private drinking water wells in homes across the county. The study is evaluating the levels of radon found across the county and its relationship to the geological environment of the county. It is hoped that this approach will allow meaningful statistical analysis of the data upon conclusion of the study, and demonstrate whether bedrock geology may be considered the primary determinant of indoor air radon in this region.

Trends

The primary trend is that more housing is being built in areas that have a high potential for radon generation, primarily in the Rolesville granite geologic unit and adjacent geological units.

Community Perceptions

Wake County has conducted the radon study on a voluntary basis at no charge to homeowners. A total of 1,380 homes have been involved, with 628 of the homes having private drinking water wells that were sampled. Two workshops for study participants were conducted to discuss radon and what the results meant. Trainings also were held for the building sector on radon resistant construction techniques and radon mitigation. Participant response has been very positive.

Resources and Strengths

Wake County Environmental Services, in partnership with N.C. State University's Department of Marine, Earth and Atmospheric Sciences and the N.C. DENR Radiation Protection Section, is leading this countywide study to evaluate radon levels in indoor air and groundwater in homes across the county. For further information on the radon study, visit the Wake County Environmental Services' website at www.wakegov.com/environment/radon/default.htm.

Reliable tests are available from certified radon testers and companies and can also be purchased from hardware stores and retail outlets, and by phone or mail order. Affordable solutions exist to reduce radon problems in homes and thousands of homeowners have already lowered radon levels. The typical cost is between $500 and $2,500.

Information about radon, other indoor air quality topics or the Wake County Radon Study is available from Wake County's Indoor Air Quality Program at 919-856-7400.

Emerging Issues

Radon has been identified as a concern, and the areas where the greatest likelihood of radon contamination have been identified and solutions are available.

Open Space

Introduction

Open space, in its various forms, offers respite and enjoyment to citizens seeking refuge from the noise and hectic pace of city life, while also protecting critical plant and animal habitat.

Working forests provide open space and wildlife habitat in addition to wood products, like paper and lumber. The U.S. Department of Agriculture reports that one acre of forest absorbs six tons of carbon dioxide and produces four tons of oxygen, thus meeting the oxygen needs of 18 people annually. Planting trees reduces runoff and erosion and improves water quality. Riparian buffers – the wooded areas located along streams – help prevent sediment and other pollutants from entering streams, provide cover necessary for animals, and prevent stream water temperatures from rising after rainfalls. Timberland and urban forests are effective sources of pollution abatement and control.

According to the National Arbor Day Foundation, over a 50-year period a single tree will generate $31,250 worth of oxygen, will provide $62,000 worth of air pollution control, and will recycle $37,500 worth of storm water. Planting one tree can be worth $2,615/year or $130,750 over its 50-year life.

Farmland provides the vast majority of Wake County's remaining forestland, wildlife habitat, and open space. The Watershed Management Plan indicates that the county's best water quality is found in agricultural areas. Protected open space in the form of parks provides public access for active and passive recreation. Other types of protected open space provide plant and animal habitat and help protect water quality.

Current State of Affairs

More than 41% of Wake County's land area has been developed. Approximately 10% of Wake County's land area is protected open space. The majority of these lands are protected by federal and state agencies.

Trends

Each day, about 27 acres of land in Wake County are converted from a natural state to a developed state. The Triangle Land Conservancy estimates that as much as 78% of the land area in Wake County will be developed by 2020.

As the population continues to grow, competition for undeveloped land increases the market value of that land, making it more costly to develop or to protect it as open space. Existing natural areas are threatened by population growth and urban development. The primary source of remaining undeveloped land in Wake County for potential urban development or open space protection is currently in agriculture or forestry.

Wake County's agricultural land has decreased by 7,190 acres, or 22% in the last four years. Agricultural land comprised 6.7% of the total land area of Wake County in 2002 and 5.4% in 2006. Similarly, land used for forestry in Wake County has decreased by 21,245 acres, or 22% in the same four-year period. Timberland comprised 20.9% of the total land area of Wake County in 2002 and 17.0% in 2006.

Agricultural and Forestry Land Use in Wake County

Land Use	2002	2006	Loss 02-06	% Wake County in 2002	% Wake County in 2006
Agriculture	36,652	29,462	7,190	6.7%	5.4%
Forestry	114,786	93,541	21,245	20.9%	17.0%

Source: Wake County Geographic Information Services

Community Perceptions

In the 2006 Wake County Community Assessment, 61% of focus group participants indicated that geography, including green space, trees and scenery, was the best thing about living in Wake County.

Resources and Strengths

Wake County is using a number of strategies to promote land protection, including tax relief, land trust funds and open space acquisition.

The Wake County Board of Commissioners has adopted an ordinance creating a non-binding Voluntary Agricultural District Program through the Wake Soil and Water Conservation District. As of July 24, 2006, 3,508 acres of farmland had been enrolled in 20 voluntary agriculture districts throughout Wake County. A process is underway to establish the Enhanced Voluntary Agricultural District. Wake County also provides use-value tax relief to qualifying farm owners to reduce the property tax burden on the local farming community. This reduced tax rate for farm operations has made it possible for agriculture to continue in many areas in the county despite rapidly escalating land values.

Open space includes forests, greenways, parks, meadows, fields, wetlands, floodplains, bodies of water, natural heritage sites, farms, and other significant lands. Wake County's Open Space program defines open space as protected land that is owned and managed in the public interest for several purposes, including to preserve natural resources, manage production of resources like forest and farmland, and to preserve historic and cultural property. The highest priority is placed on protection of water quality.

Wake County voters have approved two bond issues to purchase open space: one for $15 million in 2000 and another for $26 million in 2004. The County either buys open space directly, or uses the bond proceeds for its Partnership Grant Program. Through that program, Wake County partners with municipal and state governments, nonprofit organizations and individual property owners to protect open space.

As of June 5, 2006, Wake County had protected approximately 2,675 acres of land as open space. This land was purchased at a total cost of about $41.6 million. Wake County funded about $19.9 million of that cost and has leveraged grant funding and matching contributions to provide the remaining $21.7 million.

Other programs associated with open space preservation efforts include the Clean Water Management Trust Fund, N.C. Ecosystem Enhancement Program, and the Parks and Recreation Trust Fund. In the last few years these programs have provided more than $5 million in matching funds to help acquire significant properties. The Open Space program has worked with other county, state, and federal agencies to efficiently and effectively find interests in common with all those involved.

Emerging Issues

The goal of the Consolidated Open Space Plan is to protect one third of the 550,000 acres of land area in Wake County, or about 165,000 acres, as open space (shown in the chart). County staff, in conjunction with the Open Space and Parks Advisory Committee and the Board of Commissioners is currently reviewing the open space acquisition program to ensure that it is effective in securing needed open space.

Goal in Acres, Percent of Total Open Space

Categories of open space	Acreage	Percent of Total Open Space
Existing Protected Open Space	53,000	9.5%
Conserved Floodplain Lands (future)	60,000	11%
Protected through development	22,000	4%
Open space acquisitions/easements	30,000	5.5%
Total protected open space	165,000	30%

Solid Waste Management

Introduction

This section addresses the management of solid waste, which includes municipal solid waste; construction and demolition debris; land clearing debris like trees, stumps and stones; and special wastes, like household hazardous waste, large appliances, tires, batteries and electronics. This section also addresses measures to reduce, reuse and recycle solid waste.

Current State of Affairs

In fiscal 2003-2004, approximately 1,150,518 tons of municipal solid waste, including construction and demolition debris, were generated in Wake County. Of this amount, approximately 944,139 tons were landfilled and 22 tons were incinerated. Another 113,590 tons of materials were recovered through community recycling programs, including 45,614 tons of recyclables, 1,684 tons of white goods and 66,292 tons of yard waste. Additionally, 92,407 tons of construction and demolition debris waste were recovered and recycled. The government-recycling rate is approximately 18%.

Municipal solid waste in FY 2003-04

	Tons	Tons
Landfilled	944,139	
Incinerated	22	
Recovered through community recycling programs	113,950	
(Recyclables)		45,614
(White Goods)		1,684
(Yard Waste)		66,292
Construction and demolition debris recycled	92,407	
Total	1,150,518	

(Note: These recycling figures do not include business and institutional recycling programs that have no governmental involvement. The total recycling rate, including business and institutional programs is unknown, but it clearly would change the generation and recovery rates substantially.)

Trends

Of the 12 Wake County municipalities, eight reported increases in the per capita pounds of municipal solid waste between 2002 and 2005. Based on data from convenience centers and multi-material recycling centers, Wake County also showed an increase in the per capita weight of solid waste. These centers are open to the public and are not limited to Wake County residents in unincorporated areas.

Community Perceptions

Of the 2006 Wake County Community Assessment survey respondents, 38.5% and 33.8% indicated that recycling and garbage collection, respectively, were moderate to serious problems.

Resources and Strengths

Wake County and all municipalities are working hard to promote responsible waste disposal by residents and businesses. A number of initiatives are ongoing, including:

- Landfill: Wake County and all municipalities except Holly Springs have signed an interlocal agreement to dispose of municipal solid waste in the county's new South Wake Landfill. This agreement will ensure that participating Wake County governments will have adequate solid waste disposal capacity for 25 years.
- Recycling: Local governments in Wake County are actively trying to reduce the per-capita rate of solid waste that is disposed in landfills. All municipalities provide curbside collection of recyclables as part of their solid waste collection. Wake County provides 11 convenience centers throughout the county for residents (not businesses) and two multi-material recycling facilities for residents and businesses.
- Six municipalities encourage the public to compost by a combination of promotion, education and demonstration. Four municipalities sell compost bins. Other source reduction programs include grass recycling and junk mail reduction, and xeriscaping. Wake County offers a "Trash Takers" database to the public, which lists many options for various types of wastes. www.wakegov.com/county/recycling/trashtakers
- Two privately owned material recovery facilities accept residential recyclables generated in Wake County. These material recovery facilities are Paper Stock Dealers and Waste Management/Recycle America. Both are located in Raleigh.
- Wake County offers free waste reduction assessments to commercial and industrial establishments. www.wakegov.com/recycling/business/recyclingassistance.htm
- Wake County also provides grants to businesses for waste reduction and recycling programs. www.wakegov.com/recycling/business/grants.htm
- Food waste comprised over 12% of the Wake County's waste stream in 1999. Wake County provides information about food waste reduction to business generators through its website. www.wakegov.com/recycling/business/foodwaste.htm
- Wake County also encourages the public to reduce, reuse and recycle through public information and education. Wake County has implemented the "Feed the Bin" recycling program in the Wake County Public School System. Wake County publishes the "Wake County Recycling Guide" in the spring of each year, and posts it on the Wake County website, www.wakegov.com. The "Wake County Recycling Guide" includes information on special programs such as household hazardous waste, electronics, and litter reduction.
- All Wake County municipalities rely on the county's two multi-material sites for receipt of household hazardous waste. Household hazardous waste is accepted at the North Wake multi-material site on the first Saturday of each month and at the South Wake multi-material site on the third Saturday of each month from www.wakegov.com/recycling/households/houshazwaste.htm
- Other special wastes, such as white goods, tires, corrugated cardboard, used motor oil and lead acid batteries are accepted for recycling at the Wake County multi-material recycling facilities. Electronics may be recycled at the North Wake multi-material recycling facility. www.wakegov.com/recycling/facilities.htm

Emerging Issues

The interlocal agreement to use the new South Wake Landfill is projected to ensure participating municipalities municipal solid waste capacity for 25 years. The usable life of that landfill will depend on the success of local governments and businesses to reduce, reuse and recycle solid waste. Education of schoolchildren to reduce, reuse and recycle will have a great impact on our ability to be successful in reducing, reusing and recycling solid waste.

Zoonotic Diseases

Introduction

This chapter addresses two diseases that are transmitted to humans by animals, West Nile virus and rabies.

Mosquitoes and West Nile virus

Current State of Affairs

West Nile virus (WNV) is a potentially serious illness that is spread by the bite of an infected mosquito. Mosquitoes become infected when they feed on infected birds. The infected mosquitoes can then spread WNV by biting humans and other animals, such as horses.

Most people who are infected with West Nile, about 80%, will not become ill. Up to 20% of the people who become infected will display mild symptoms such as fever, headache, and nausea, typically lasting a few days. About one in 150 people infected with WNV will develop severe illness with symptoms such as high fever, headache, disorientation, convulsions or coma. These symptoms may last several weeks and hospitalization is often required in these cases.

There were no human cases of WNV and no WNV positive wild birds were reported in 2004.

Trends

First appearing in the U.S. in 1999, WNV has now spread through most of the country. North Carolina found its first case in a bird in 2000 and its first human case in 2002.

WNV flares up during mosquito season - summer and early fall. People typically develop symptoms between 3 and 14 days after being bitten by an infected mosquito, if they develop symptoms at all.

West Nile virus is fatal to several species of birds, including blue jays, crows, cardinals and raptors like hawks and owls. Since 1999, North Carolina and other states have tested dead birds and sentinel flocks of chickens to track WNV activity. By the end of 2002 WNV had been found in virtually every county in North Carolina. Extensive bird testing is no longer necessary, as it is clear that WNV is here to stay. However, the state still tracks reports of dead blue jays, crows, cardinals, hawks and owls to monitor virus activity.

In Wake County, one human tested positive for WNV in 2003 and in 2002. The person in 2002 was a resident from New York who was hospitalized in Wake County.

Community Perceptions

In the 2006 Wake County Community Assessment focus groups, 36% responded that environmental health problems, including zoonotic diseases, were major health concerns in the county.

The best way to avoid West Nile virus is to prevent mosquito bites. There is no specific treatment for WNV infection. Information and resources are available to residents in the following ways:

- For directions and a reporting form, see Public Health Pest Management's reporting web page. Residents also may contact Wake County Environmental Services at 919-856-7400.
- Mosquito-related complaints can be reported to Wake County Environmental Services at 919-856-7400.
- Questions concerning human cases and symptoms of mosquito-borne diseases should be directed to Wake County Human Services Communicable Disease staff, 919-250-4462. For more information about West Nile virus call the N.C. Communicable Disease Section at 919-733-3419.

Emerging Issues

Due to recent West Nile virus activity in Wake County, officials are urging residents to take steps now to protect against this and other mosquito-borne diseases.

Rabies

Current State of Affairs

Rabies is a disease caused by a virus that can infect all mammals, including humans. It is transmitted through contact with the saliva or nervous tissue of an infectious animal, usually through a bite. If an exposed person or animal is not treated quickly, the virus may infect the person or animal and result in death. The last North Carolinian to die from rabies was in 1953.

Rabies can infect any mammal. In North Carolina it is most common in raccoons, skunks, and foxes, and has also been found in dogs, cats, horses, cattle, bats, and other animals. (See related chart)

Because it can be fatal, rabies should be considered extremely dangerous. Therefore, it is important to prevent exposure to the rabies virus whenever possible. The best way to avoid rabies is to stay away from animals that appear sick or act oddly, and avoid contact with strange animals and wildlife. Since people's pets may be exposed to rabies when they come in contact with other animals, owners should have their pets vaccinated by a veterinarian against the disease. North Carolina law requires vaccination of dogs and cats.

Trends

Rabies has moved from western North Carolina to the east, including Wake County. Since 1996 there have been 181 positive cases of rabies in animals in Wake County. The raccoon population is the leading vector with 126 positives, bats next with 34, foxes with nine, cats with 11, and dogs with one positive.

Cases of Rabies in Wake County, by animals 1996-2005

Year	Bats	Cats	Dogs	Fox	Raccoon	Total Cases
1996	3	3	0	0	42	48
1997	0	0	1	1	15	17
1998	3	2	0	1	11	17
1999	2	0	0	0	3	5
2000	5	0	0	0	11	16
2001	4	1	0	2	16	23
2002	8	3	0	2	12	25
2003	2	1	0	2	5	10
2004	4	0	0	0	5	9
2005	3	1	0	1	6	11
Total	34	11	1	9	126	181

Source: North Carolina Department of Health and Human Services

Rabies is now a naturally occurring disease in wildlife throughout the Eastern states and much of the Midwest. It spreads from animal to animal over time to infect the animals of other areas. Occasionally, people moving wildlife from an infected area to a non-infected area spread it inadvertently. Because the virus may not cause disease in an infected raccoon for up to six months after a bite, animals without signs of disease are sometimes moved and later spread disease into uninfected populations of animals.

In the FY 05-06 local veterinarians gave rabies vaccine to 83,661 animals. Wake County personnel in annual rabies clinics and the animal shelter gave rabies vaccines to 2,387 animals, for a total of 86,048 animals vaccinated during FY 2005-06.

Community Perceptions

In the Wake County 2006 Community Assessment focus groups, 36% responded that environmental health problems, including zoonotic diseases, were major health concerns in the county.

Resources and Strengths

Pre-exposure rabies vaccine is recommended for veterinarians and people who work in animal control. This vaccine is available at Wake County Human Services. Treatment for humans following suspected exposure to rabies is available in all hospital emergency rooms in Wake County.

Rabies vaccine for animals is available from Wake County Animal Care, Control and Adoption at the annual rabies clinics held in the spring, usually the second or third week in April. Residents can call 919-250-1475 or visit www.wakegov.com/pets/rabies/default.htm for special vaccination clinics in their area. Also, local veterinarians offer vaccinations at any time.

Residents who see an animal acting strangely and suspect rabies should call Animal Care, Control and Adoption at 919-250-1475. The Wake County Animal Control office is located at 820 Beacon Lake Drive in Raleigh. The program enforces the Wake County Animal Control Ordinance, the North Carolina Rabies Law and other laws related to animal welfare. Its jurisdiction covers all of Wake County.

Emerging Issues

The small number of cats and dogs tested positive for rabies is an indication of the success of the rabies inoculation program.

Impact of Community Design on Active Living

Introduction

This section explores the impact of community design upon health, focusing on land use and transportation barriers to active living, as well as the impact of parks, trails and greenways upon active living. This section draws heavily upon information from Active Living by Design, a national program of The Robert Wood Johnson Foundation and is a part of the UNC School of Public Health in Chapel Hill. This program establishes innovative approaches to increase physical activity through community design, public policies and communications strategies.

Current State of Affairs

Physical inactivity strongly influences obesity and overweight, which play a significant role in the most common chronic diseases in the United States, including coronary heart disease, stroke and diabetes, resulting in at least 200,000 deaths annually. Diabetes increasingly affects individuals and their families. Type 2 diabetes is influenced by physical inactivity. Pediatricians and health scientists are increasingly concerned about Type 2 diabetes in children, due largely to physical inactivity. The estimated annual cost of obesity and overweight in the United States is approximately $117 billion. The potential savings, if all inactive American adults became physically active, could be $76.6 billion per year.

Americans are likely to be either inactive or participate in physical activities on an irregular basis. While the decision to be active is a personal choice, barriers to active living, such as a transportation system that is unfriendly to pedestrians and bicyclists, can make it difficult to be active. Removing barriers and creating more opportunities for active living through land use, design, transportation systems, and trails and greenways will increase physical activity and improve health.

Land use

Automobile–oriented land use policies reduce transportation choice, adversely affect air quality and safety, and discourage physical activity. A more compact and mixed land use pattern that offers short distances to interesting destinations combined with pedestrian and bike-friendly design features would encourage walking and biking; remove barriers to activity for everyone; and make healthy levels of physical activity attainable for more people during their daily routine.

Between 1982 and 1997, urban land density in the United States dropped by more than 20%, requiring greater reliance on cars for travel. From 1960 to 1990, the percentage of workers with jobs outside their county of residence tripled. Also, vehicle miles traveled rose dramatically and walking declined.

Acreage standards for schools range from 10-60 acres. Older schools typically occupy only 2-8 acres. These and other standards require that new schools be built in outlying areas, away from established neighborhoods, which tend to have sidewalks. Now, only one in eight children walk to school and only about one in 100 of school trips are made by bike.

Mixed land uses increase the number and percentage of walking and biking trips. For trips less than one mile, mixed-use communities generate up to four times as many walking trips. Walking trips tend to substitute for automobile trips in dense urban neighborhoods.

Transportation

Current transportation policies that promote automobile dependency adversely affect air quality and safety and discourage physical activity. Current transportation trends indicate that walking, biking and transit are becoming less practical, less convenient, less safe and less pleasant. For example, between 1997 and 1995, trips made by walking declined by 40% while driving trips increased by almost 90%.

A more balanced transportation system that offers more choices and encourages walking and biking would remove barriers to activity for everyone. People who report having access to sidewalks are 28% more likely to be physically active. Walking trips increase with good connectivity of the street network, a greater number of intersections and blocks, and streets with low speeds that are narrow and visually interesting.

Parks, trails and greenways and physical activity

Researchers have found positive relationships between settings for physical activity and physical activity patterns in adults. Other studies suggest that the presence of a trail can increase physical activity among adults.

In a University of Nebraska-Lincoln study, 20% of respondents reported that the presence of trails caused an increase in their physical activity. Another 56% of respondents stated they would use a trail if they had access to one in their community. In a Missouri survey, 55.2% percent of people using trails reported an increase in walking since they began using the trails. In a survey of U.S. adults, people with access to neighborhood parks were nearly twice as likely to be physically active as those without access to parks.

Resources and Strengths

Traditional zoning regulations typically separate land uses in order to separate incompatible uses. However, many communities are now realizing that different land uses, such as residential and commercial, can be mixed in compatible ways, and those mixed-use communities can be designed to promote active living.

All local governments in Wake County participated in the Growth Management Task Force, which identified issues of countywide importance and came to a consensus on strategies to address those issues. Two of those strategies are for local governments to create mixed-use development regulations and incentives, and to adopt standards and incentives to reinforce pedestrian-friendly development.

Transportation planning within Wake County is coordinated through the Capital Area Metropolitan Planning Organization. It has adopted a Bicycle and Pedestrian Plan to guide the development of bicycle and pedestrian transportation facilities, which include trails and greenways along with sidewalks, wide outside lanes for bikes, bike paths and bike lanes.

A majority of Wake County local governments require that developers construct sidewalks in new developments. About half of Wake County local governments have adopted a pedestrian plan for their jurisdiction, but a minority of local governments has adopted bike/greenways plans.

Emerging Issues

The success of mixed-use developments and the popularity of bicycle and pedestrian facilities have created a demand among residents that local governments are increasingly addressing in their development regulations and capital improvements.

One area of concern is the ability of schoolchildren to get to school by walking. The Wake County Public School System is often required by local governments to construct sidewalks on its properties. However, school sites are often located in areas where no sidewalks exist on adjacent properties. Also, the school system does not provide bus service to children within 1½ miles of the school, so if there is no sidewalk system, their ability to walk to school is restricted. Many instead are driven to school, resulting in traffic congestion around the school and limiting parents' ability to use alternative means of transportation.

Water Quality

Introduction

This section addresses water quality in:

- Surface water, including all watersheds, focusing on watersheds that drain to water supplies and recreational waters, including PCB contamination
- Groundwater, including pollutants such as radon
- On-site wastewater systems

In areas with natural ground cover, typically 40% of rainfall will return to the atmosphere by evapo-transpiration by plants. About 25% of the rainfall will infiltrate into the soil to shallow depths and will seep into streams, another 25% will infiltrate deeply to recharge groundwater, and about 10% will run off the land.

The runoff has the most potential to affect water quality because it picks up pollutants, such as motor oil from cars or fertilizer from lawns. If the runoff is not filtered through natural vegetation or other means, it enters streams with its pollutant load intact. Second, the runoff does not provide a source of water for vegetation, groundwater recharge or base flow for streams. This can cause stream bank erosion or sediment build-up, and can adversely affect aquatic animals, insects and wildlife that depend upon the stream.

A watershed is the land area that drains to a body of water. A watershed can be very small or encompass a major river basin. In Wake County, the Watershed Management Plan divided the county into 81 watersheds that range in size from .9 to 53.3 square miles in area for analysis. A water-supply watershed is one that drains to a lake that serves as a reservoir for water supply. In Wake County, 22 of the 81 watersheds are within water-supply watersheds.

Surface Water

Current State of Affairs

Wake County is 856 square miles in size and lies within two major river basins. Approximately 85% of the county lies within the Neuse River basin and the remaining 15% lies within the Cape Fear River Basin. There are approximately 1,500 miles of streams within Wake County.

In January 2003, Wake County's Watershed Management Task Force completed a Watershed Management Plan for all local governments in Wake County, classifying watersheds as healthy, impacted or degraded on the basis of an analysis of biological data, chemical pollutants, geomorphology and habitat degradation. Thirty watersheds were classified as healthy, 38 were classified as impacted and 13 were classified as degraded. Most of the degraded and impacted watersheds are located in the more heavily developed portions of Wake County. The healthy watersheds are principally in the outer perimeter of the county and are used primarily for agriculture and forestry.

Trends

An impaired stream is one that does not meet the standards for its designated uses, such as aquatic life protection, swimming, water supply and the like. According to the 2004 N.C. DENR Division of Water Quality listing, approximately 119.8 miles of Wake County streams are designated as "impaired." The draft listing of impaired streams for 2006 identifies approximately 118.4 miles of impaired streams.

The primary reasons for listing streams as impaired and potential sources include:

- Impaired biological integrity, likely from urban runoff/storm sewers
- Low dissolved oxygen, likely from land development
- Turbidity, likely from urban runoff/storm sewers

Community Perceptions

In the 2006 Wake County Community Assessment, 61% of survey respondents listed water pollution as a moderate to serious problem, with 48.8% citing safe drinking water as a moderate to serious problem. 36% of Community Assessment focus groups voiced concerns regarding environmental health, including water quality.

Resources and Strengths

Wake County has taken action to implement recommendations from the Watershed Management Plan. These include:

- Increasing riparian buffers in water-supply watersheds from 50 to 100 feet in width
- Prohibiting development throughout the floodplains
- Revising stormwater runoff controls to use U.S. Department of Agriculture numbers to manage stormwater
- Adopting open space subdivisions as an option to maintain open space in new developments
- Acquiring open space, especially in riparian areas (see section on open space for details)
- Evaluating septic systems to determine if they are contributing to water quality degradation
- Increasing its public education program
- Continuing to restore streams

Wake County is working with all municipalities in the county in the Stormwater Management Task Force to determine ways in which local governments in the county can work together to manage stormwater.

The county also is working with other local municipalities and counties throughout North Carolina to determine the best ways to comply with National Pollutant Discharge Elimination System (NPDES) Phase II requirements for managing non-point sources of water pollution. These requirements address many of the same actions recommended in the Watershed Management Plan, including identifying and removing illicit discharges of pollutants into streams.

Wake County improved its stormwater regulations by adopting standards that are more tailored for existing soils types and the location of properties in or outside of water-supply watersheds. These regulations encourage good site planning and low-impact development principles.

Emerging Issues

Actions local governments have taken to increase riparian buffers, restrict or prohibit development in flood plains, encourage appropriate site planning and educate the public are expected to improve water quality. Collaborative stormwater management throughout Wake County will bolster local governments' ability to maintain and improve water quality.

Water-supply watershed

Current State of Affairs

Water-supply sources include Falls Lake, Jordan Lake, Wake Forest Reservoir, Little River, Lake Benson (which served as the primary source of raw water prior to the opening of Falls Lake and which will be used again in the future) and the future Little River reservoir in eastern Wake County. The primary sources of water are Jordan Lake in western Wake County, with Apex and Cary drawing water at their joint water treatment plant, and Falls Lake in Northern Wake County, where Raleigh draws and treats water. Wake Forest also has a reservoir and treatment plant, as does Zebulon.

All local governments that have jurisdiction over land in water supply watersheds must comply with state regulations concerning riparian area buffers, impervious surfaces or density, land uses allowed and other requirements.

Trends

Demands for drinking water will continue to increase as population and non-residential development continues to increase. Water quality in Falls Lake and Jordan Lake is a concern.

Resources and Strengths

The water/sewer plan for Wake County outlined a number of steps to consolidate services. These included increasing the water supply and water treatment capacity to meet demand (including using water from Lake Benson and completion of the Little River Reservoir), increasing the allocation of water from Jordan Lake and establishing a water supply connection from Harnett County.

Emerging Issues

Wake County is moving forward with plans to build the Little River Reservoir. Local governments are pursuing conservation measures, such as reuse of treated wastewater for non-potable applications. This includes water used in irrigation and flushing of toilets. Low-impact development practices also have been implemented, such as collecting stormwater in cisterns for later use in irrigation and other non-potable uses. An example is the Legislative Building in downtown Raleigh, which is collecting stormwater in cisterns and using it for irrigation on the grounds.

Recreational Waters

Introduction

Wake County Environmental Services staff tests lakes where human contact with the water is permitted. These include four beaches at Falls Lake, including Sandlin, Beaver Dam, Holly Point north and south, plus New Life Camp, Lake Wheeler, Silver Lake, and Camp Kanata. Water quality checks are made for bacteria, including E coli and Enterococcus, plus sediment.

Current State of Affairs

Occasionally, Wake County has to close some of these locations because of high concentrations of bacteria. Enterococcus, which results from runoff, has been the largest problem in 2006.

Trends

Bacteria levels have been elevated as stormwater runoff has increased from additional development near these recreational waters.

Resources and Strengths

Wake County will continue to monitor recreational waters and work with owners and managers of these areas to maintain good quality water.

Emerging Issues

Increased runoff from additional development could cause more beach closures.

Polychlorinated Biphenyls (PCBs)

Introduction

Polychlorinated biphenyls are mixtures of up to 209 individual compounds known as congeners. PCBs have been used in transformers, capacitors and other electrical equipment because they don't burn easily and are good insulators. The manufacturing of PCBs was stopped in the U.S. in 1977 because of evidence they build up in the environment and can cause harmful health effects. Products made before 1977 that may contain PCBs include old fluorescent lighting fixtures and electrical devices containing PCB capacitors, and old microscope and hydraulic oils.

PCBs can still be released into the environment from hazardous waste sites, illegal or improper disposal of industrial wastes and consumer products, leaks from old electrical transformers containing PCBs and burning of some wastes in incinerators. PCBs do not readily break down in the environment and may remain there for very long periods of time. In water, a small amount of PCBs may remain dissolved, but most stick to organic particles and bottom sediments. PCBs also bind strongly to soil. Small organisms and fish in water take up PCBs. Other animals that eat these aquatic animals as food also take them up. PCBs accumulate in fish and marine mammals, reaching levels that may be many thousands of times higher than in water.

Consumption of fish contaminated with PCBs beyond what is recommended may increase a person's risk of developing cancer, infection, skin problems such as cracked fingernails and may cause learning deficits in infants from maternal exposure.

Current State of Affairs

Discovery of PCB fish contamination in Wake County is connected to an investigation of the Ward Transformer facility located on Mount Herman Road near the Raleigh-Durham International Airport. The process that the company used from 1964 to 1979 allowed PCBs to escape into the environment. Because of that past contamination, the site is on the National Priority List for investigation by the U.S. EPA.

Site-specific advisories have been issued for Little Brier Creek, Brier Creek, Lake Crabtree and Crabtree Creek, all downstream of the Ward Transformer facility. The public has been advised to not eat any fish from Little Brier Creek or Brier Creek, to not eat carp or catfish from Crabtree Creek and to limit consumption of carp and catfish caught in Crabtree Creek below Lake Crabtree to no more than one meal per month. Swimming, boating, and other recreational activities present no known significant health risks from PCBs and are not affected by this advisory. PCB-related risks, if any, from these activities have been shown to be negligible.

Trends

There should be no additional PCB sites, since PCB manufacturing stopped in 1977.

Resources and Strengths

Individuals with questions regarding fish advisories can contact the North Carolina Department of Health and Human Services at 919-715-6429. Individuals with questions regarding the environmental investigation can contact the North Carolina Superfund Section at 919-733-2801.

Emerging Issues

The primary source of money to clean up pollution such as this is the Superfund. Superfund has been slow in responding to this issue. Since PCB manufacturing stopped in 1977, there should be no more PCB contaminated sites in Wake County.

Groundwater

Introduction

The quantity and quality of groundwater not only affect people who rely on wells for drinking water, but groundwater also typically accounts for between 34% and 55% of total streamflow in Wake County. Groundwater base flow may account for nearly all of the streamflow during periods of drought. Without groundwater base flow, streams can run dry in periods of drought.

Groundwater quantity is affected by precipitation, evapotranspiration, withdrawals, impervious surfaces (which prevent recharge) and septic systems. Groundwater quality is affected by naturally occurring pollutants, such as radon and arsenic, leaking underground storage tanks, soil fumigants and nutrients.

Current State of Affairs

Approximately 141,000 Wake County residents rely on groundwater for drinking and other everyday uses, with 93,000 obtaining water from domestic wells. The remaining 48,000 are served by one of 275 community water systems. For the four fiscal years 2003 through 2006, Wake County received permit applications for an average of 575 wells per year and 42 replacement wells per year.

Generally, supply of groundwater does not appear to be a problem, since withdrawals range from 1% to 6% of average annual rainfall. However, in certain localized areas of the county high volume wells (such as community or irrigation wells) may impact neighboring private wells.

In most areas of Wake County that are served by community water systems, groundwater is void of contaminants that would prevent or restrict its use as drinking water. Disinfection, pH adjustment, and sequestration to remove iron and manganese are the only treatment methods used in the majority of systems. Several community water systems in Wake County treat groundwater to reduce the level of nitrates, radionuclides, and/or organic compounds to below drinking water standards.

Arsenic was detected above drinking water standards in 1% of samples from community water systems and domestic wells. Occurrences of arsenic in Wake County groundwater may result from natural sources, including minerals dissolved from rocks or from man-made sources including fumigants formerly used in tobacco farming and treating lumber. Ethylene dibromide (EDB) and 1,2 dichloropropane, formerly used as soil fumigants in tobacco farming, continue to be detected in a small percentage of samples, generally limited to the eastern parts of Wake County.

Trends

The Comprehensive Groundwater Investigation is the first such study of groundwater in Wake County. A general trend is that as more developments draw on groundwater and as more impervious surfaces prevent groundwater recharge, there are more shallow wells that have failed, requiring deeper drilling.

Resources and Strengths

In June of 2006, Wake County formed a stakeholders committee with a goal of reaching a consensus of a definition of groundwater sustainability in Wake County and to decide what, if any, strategies are necessary to reach sustainability, with a primary focus on private wells. This process should produce recommendations in 2007.

Wake County Environmental Services has an inspection and testing program for wells. www.wakegov.com/environment/sewer_wells/wells/default.htm

Wake County Environmental Services, in partnership with N.C. State University's Department of Marine, Earth and Atmospheric Sciences and the N.C. DENR Radiation Protection Section, is leading a three-phase countywide study to evaluate radon levels in indoor air and groundwater in homes across the county. More information on the radon study is available at www.wakegov.com/environment/radon/default.htm and in the radon section of this chapter of the Community Assessment.

Emerging Issues

The Comprehensive Groundwater Investigation recommended that Wake County develop an Environmental Monitoring Program for all water resources, including groundwater. The program should include a Long-Term Monitoring Well Network, including the installation of monitoring wells and stream gaging stations throughout the county.

The future trend in the development of groundwater resources in Wake County remains unclear. Municipal water supply plans suggest that fewer residents will rely on groundwater for their water supply in 2020. Yet, over the last several years the number of people connected to a community well system as well as the number of people served by a new domestic well has increased by approximately 4,000 per year.

Recharge rates in the Upper Falls Lake, Lower Falls Lake, Little River, and Swift Creek water supply watersheds are sufficient to sustain additional water supply withdrawals as development continues at current allowed densities. However, increased groundwater consumption in these areas may result in a decrease in stream baseflow in periods of average precipitation and cause some streams to go dry during extended periods of low precipitation.

On-site Wastewater Treatment and Disposal Systems

Introduction

On-site wastewater treatment and disposal systems, or septic tank systems, are accepted as a safe and effective means of treating and disposing of wastewater. Properly functioning and well-maintained septic tank systems provide an effective means of mitigating residential wastes, but when septic tank systems fail they pose public health concern, potentially contaminating surface and groundwater with pathogens and nutrients.

Factors significantly related to failure include landscape position, soil type, maintenance (especially for low-pressure pipe systems), system age, site maintenance, construction of structures over the drainfield, lack of vegetation or trees, the number of adults occupying the home, and lack of understanding about system operations and limitations.

Current State of Affairs

Approximately 58,000 septic tank systems are in use by nearly one-quarter of Wake County's residents. According to a study completed in 2005 by Wake County Environmental Services in cooperation with N.C. State University, approximately 9.7% of septic systems installed between 1982 and 2001 had failed. Older systems located in poorer soils with drainage fields that are not shaped to divert stormwater away from the drainage fields tend to fail more than other systems that do not share these characteristics.

Trends

An average of 1,540 new septic tank systems were permitted each year from 2003 to 2006. Fiscal year 2005 saw a peak of new construction applications, with 1,867, but in fiscal 2006, only 1,442 applications were submitted. Septic tank repair permit applications average around 420 per year.

Resources and Strengths

Wake County Environmental Services has reorganized its on-site wastewater functions to devote staff directly to repairs and maintenance of on-site wastewater systems. This change will allow some Water Quality staff to concentrate on new systems and others to concentrate on repairs and maintenance.

Because proper management of individual systems is critical for proper functioning, Wake County Environmental Services attempts to educate property owners on the proper use and maintenance of on-site systems. To that end, Environmental Services provides the Raleigh Regional Association of Realtors with educational materials, including videotapes and DVDs on proper on-site system operation and maintenance practices, which the Realtors give to purchasers of homes served by septic systems. Environmental Services also works with property owners to address failed systems.

Emerging Issues

Better prevention of failures could be accomplished through more public education efforts and post-installation inspections to ensure that septic tank owners do not take actions to reduce the viability of their systems.

As municipalities continue to expand and extend municipal sewer service to existing developments that are served by on-site systems, existing on-site systems in those areas will be phased out. Areas in the Falls Lake, Swift Creek and Wake Forest Reservoir watersheds will, by policy, not have municipal sewer service extended to them.

As the price for land continues to escalate and the attractiveness of conservation subdivisions continues to increase, it will be increasingly more difficult to locate septic systems, including repair areas, on smaller lots.

Chapter 6: Lifelong Learning

The values, beliefs and aspirations of a community often are reflected in the lifelong learning opportunities offered to its citizens. Formal and informal educational experiences are helping to shape Wake County's future. Formal education spans elementary schools to major universities, while museums, parks and libraries add to the informal learning adventures across the county.

Families and communities benefit tremendously from education. In 2005, U.S. families headed by a person with a high school diploma had median earnings of $25,829, while families headed by a college graduate had median earnings of $43,954 per year, a difference of 70%. Average annual earnings for people over the age of 18 with a bachelor's degree increased 24% between 1975 and 2001, while average earnings for people with a high school diploma increased only 3% for the same period. Persons without a high school degree had an actual decline in annual earnings from 1975 to 2001.

In 2000, 5.5% of Wake County's population was enrolled in colleges or universities. By 2004 that number had declined to 4.5%. During the same period, North Carolina's proportion of population enrolled in higher education increased from 4.5% to 5%. Wake County lagged state higher education enrollment over this four-year period.

However, the percentage of Wake residents with less than a high school diploma declined from 10.7% to 8.6% between 2000 and 2005. Residents with a bachelor's degree or higher increased from 43.9% to 48.2%; Wake County has twice the proportion of citizens with a bachelor's degree or higher than North Carolina as a whole.

According to U.S. family income data, historically only families headed by persons with a four-year college degree or higher kept up with inflation or improved their buying power. In Wake County the poverty level in 2000 was estimated at 7.8% of the population, compared to 12.3% across North Carolina. By 2005, the Wake County poverty rate had increased to 10.3%, and the North Carolina poverty rate increased to 15.1%.

Wake County has an abundance of learning resources. The Wake County Public School System (WCPSS) is the second largest school system in North Carolina, and is consistently ranked among the top public school systems in the country. WCPSS is one of the fastest growing school systems in the nation, adding nearly 7,500 students a year. Enrollment for 2006-07 exceeds 128,000 students. The county also has 56 private schools with more than 13,500 students. In 2005 almost 16,000 children, birth to age five, were enrolled in regulated childcare; about 31% of these children were supported by childcare subsidies.

Fifteen colleges or universities are based in Wake County or offer programs here, ranging from degree programs for traditional undergraduate and graduate students to many credit and non-credit classes for adults interested in lifelong learning.

In the broader sense of education, the community is fortunate to have state and local cultural resources such as the North Carolina Museum of Art, the North Carolina Symphony, an extensive state park system, the N.C. Museum of Natural Sciences and the N.C. Museum of History.

The second largest library system in the state, the Wake County Public Library System serves more than 370,000 registered borrowers annually. The library system spends a higher proportion of its budget on its collection than any of the other five large urban county libraries in the state. The library system also provides book study and discussion groups, computer access and numerous educational programs for all ages.

Trends

Several trends are important to the lifelong learning opportunities in Wake County:

- **Continuing and rapid growth.** Wake County has experienced rapid growth in recent years, adding about 25,000 people a year. From 1980 to 2005, the county's population has doubled to the current level of 780,000, and in the next 25 years, it is projected to double again, to 1.5 million. Between 1990 and 2005, WCPSS enrollment increased by more than 66,000 students. In November 2006, Wake County voters approved a $970-million school construction bond proposal, the largest in the county's history. The rapid growth in school enrollment is expected to continue and more schools will be needed across the county.
- **Aging population.** The number of older residents is increasing in Wake County. Between 1990 and 2000, the county grew by more than 13,000 elderly. In 2005, Wake County had an estimated 50,278 elderly. Although the number of Wake County residents 65 years of age and over has increased since 2000, the percent of the total population in this age group has been about the same during the last five years (7.3%). The growth in the number of older residents in the county will challenge the support and services of the lifelong learning opportunities.
- **Increasing number of both non-English-speaking people and low-income students.** More low-income students and those of limited English-speaking ability are entering the schools. More non-English-speaking adults also are entering the work force. The need to provide language skills is being addressed across the county. Additional pressure is being put on public service agencies with limited budgets to meet the needs of these residents. Low-income students often are at a disadvantage when enrolling in and completing higher education. Helping these students achieve their educational goals will be crucial to maintaining the count's educated economic base.

Sources

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Early Childhood Education

Current State of Affairs

In 2005, an estimated 67,748 children, birth to age 5, lived in Wake County. This is an increase of 3.3% over 2004. Approximately 13,550 children enter kindergarten each year.

Research shows that quality pre-kindergarten and childcare programs improve the lives of children from disadvantaged families. A review of 36 studies of early childhood programs, including preschool, found sizeable long-term effects on school achievement, grade retention, placement in special education and social adjustment.

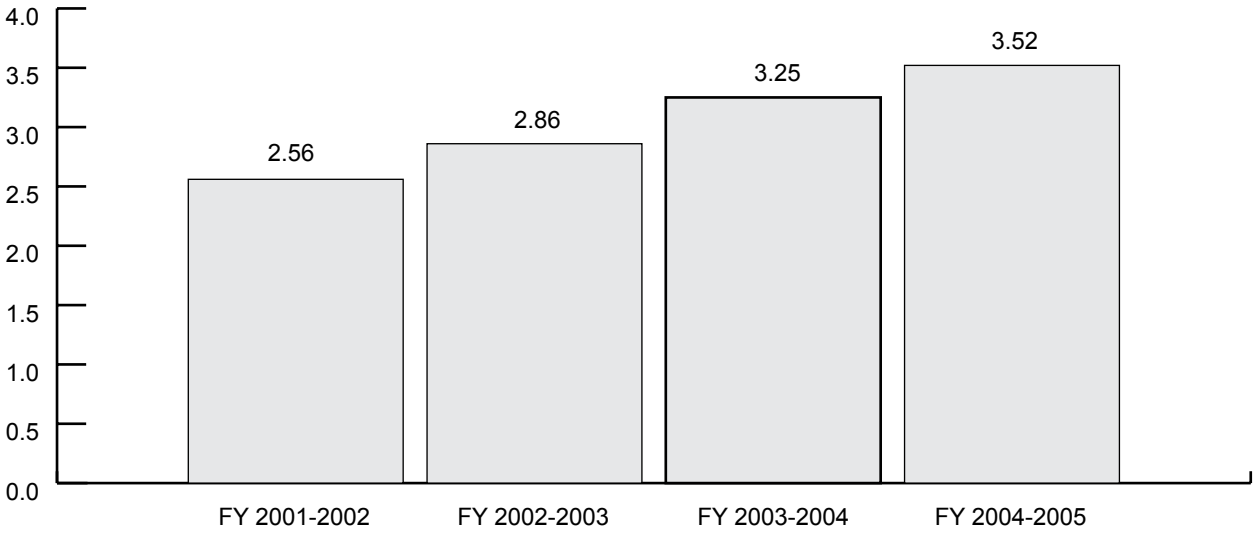
Approximately 15,900 children, birth to age 5, were in regulated childcare in Wake County during fiscal 2004-2005. This represents 23.4% of that population. This is a slight decrease from 24.2% of children, birth to age 5, in regulated care in 2003. Of the children in regulated care, 4,885 received childcare subsidy. Approximately 3,890 eligible children were on the wait list for services. In 2006-07, more than $35,700,000 will be spent on childcare subsidy services through funding from the Division of Child Development and Wake County SmartStart. There were approximately 600 regulated childcare facilities in Wake County in 2005.

Several programs are specifically designed to serve at-risk preschool children in Wake County. With the start of the 2006-07 school year, 764 children are enrolled in the More at Four Program, which targets disadvantaged children for a year of preschool before the start of kindergarten. Another 128 children are receiving federally funded Title I preschool services through WCPSS. Children also benefit from Head Start, a federally funded early childhood program operated in the county through a contract with Telamon Corporation. In 2006-07, 411 at-risk 3- and 4-year-old children are being served at sites across the county, while an additional 674 children are eligible and waiting to be enrolled. Despite this growing and identified need, federal funding has not increased for the past two years and is not expected to increase in 2007-08.

Trends

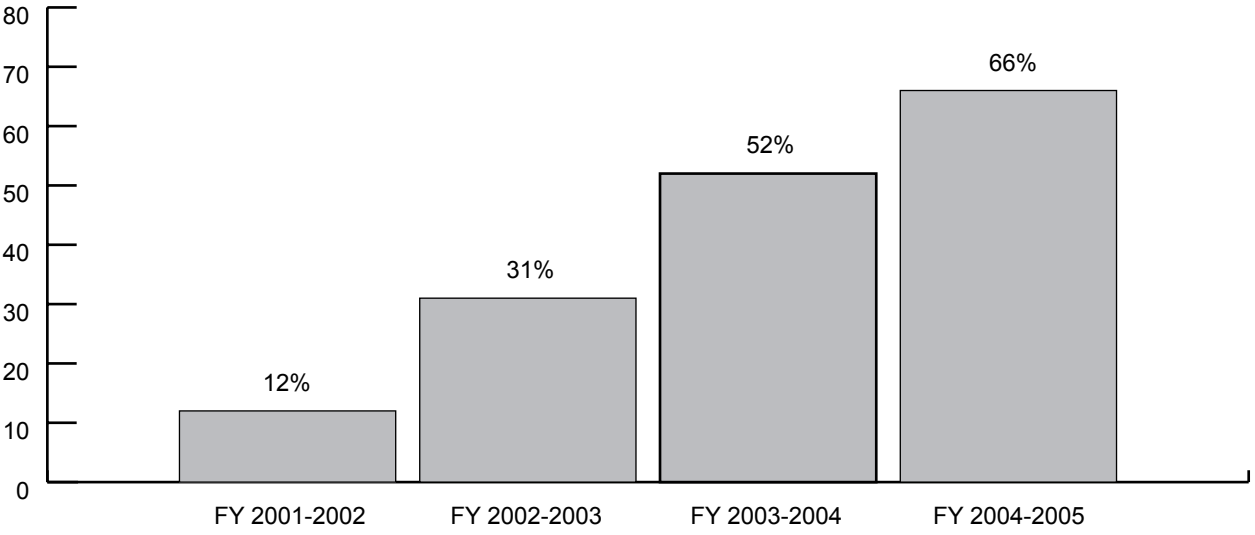
In recent years the quality of childcare in Wake County has improved substantially. Based on a quality rating system of one star or low quality to five stars or high quality, the average star rating for all children in child care increased by 38% from fiscal 2000-2001 to fiscal 2004-2005. Approximately 62% of children in care are in a four- or five-star program.

Average Star Rating of Quality for All Children in Care



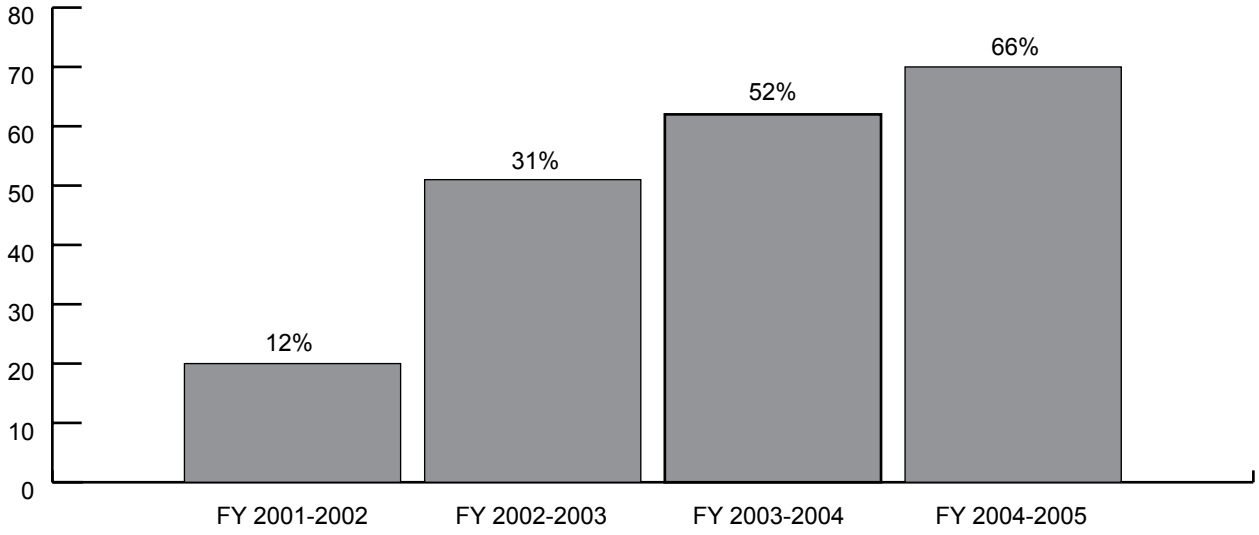
The differences for children who are receiving subsidy are even more significant. The percentage of children on child care subsidy and attending four- and five-star facilities was four times greater in fiscal 2004-2005 than in fiscal 2000-2001.

Percentage of Children Receiving Subsidy in 4 & 5 Star Facilities



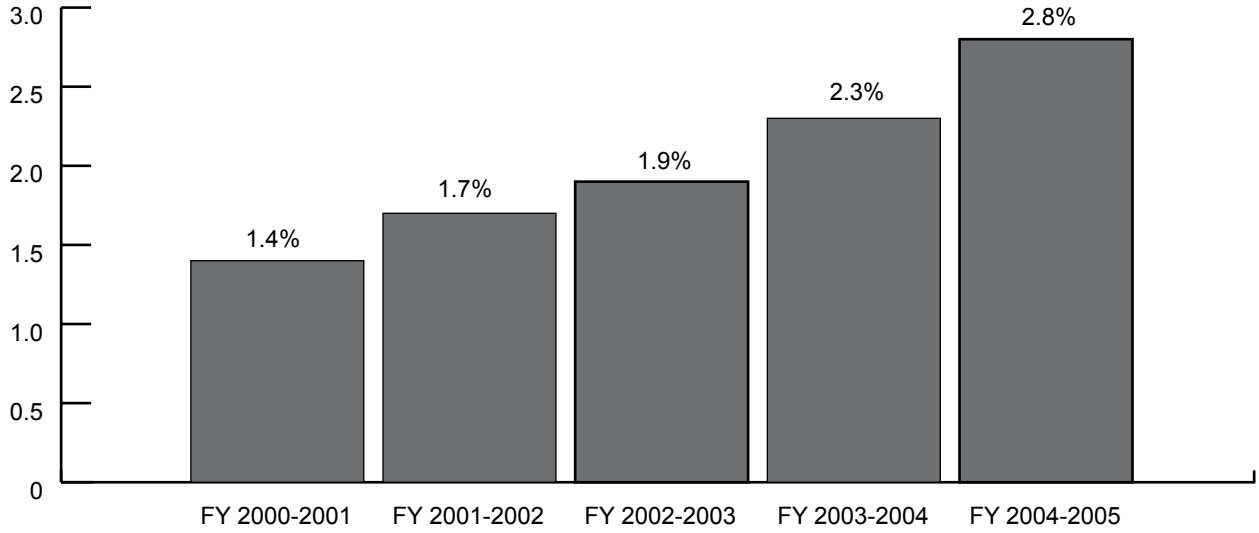
The percentage of children with special needs receiving subsidy attending four- and five-star facilities was more than three times greater in fiscal 2004-2005 than in fiscal 2000-2001.

Percentage of Children with Special Needs Receiving Subsidy in 4 & 5 Star Facilities

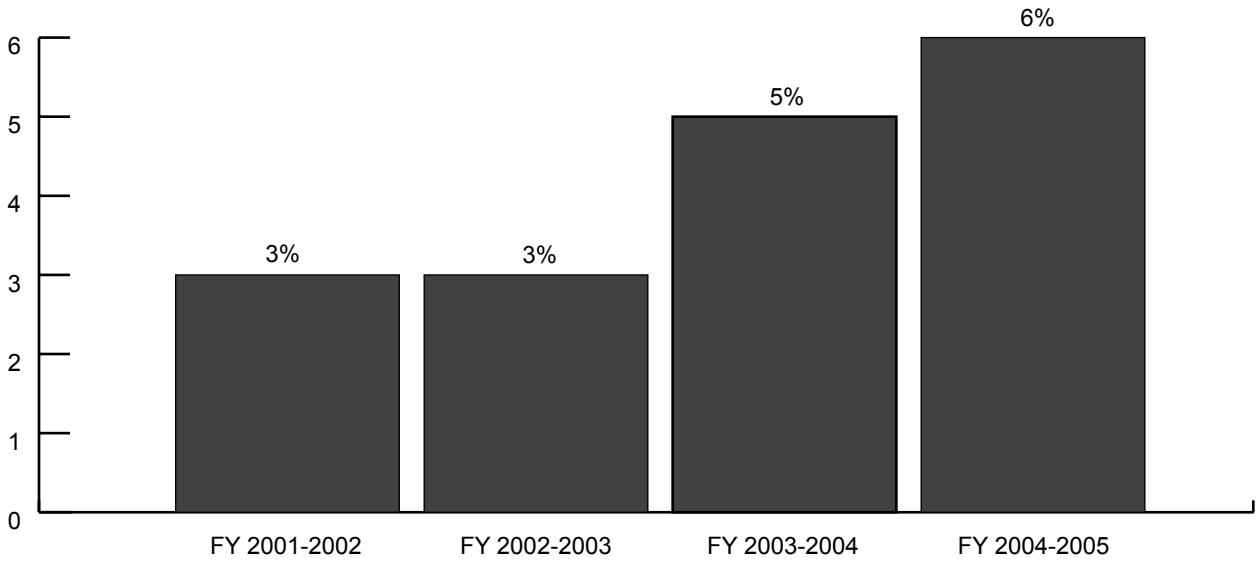


Improvements in the quality of regulated childcare have a positive effect on children in that care. Many of the most at-risk children are identified through the Early Intervention program administered through the N.C. Department of Health and Human Services. This program targets children with special needs and/or developmental delays. The following chart shows the increasing numbers of children identified and served in Wake County. The percentage of children birth through age 2, and also ages 3 to 5, receiving Early Intervention services was twice as great in fiscal 2004-2005 as in fiscal 2000-2001.

Children Birth to 2 Receiving Early Intervention



Percentage Children 3 - 5 Receiving Early Intervention



When coupled with the pre-school child population growth of approximately 27% between 2000 and 2006, the numbers are significant and affect a child's readiness for school.

Community Perceptions

Low-income families with young children struggle with the high cost of child care. As of March 2006, the average monthly cost of care in a five-star center in Wake County for an infant was $1,049 and for an older child, $800. These costs put high-quality care out of reach for many families. Childcare also is expensive in one-star centers. The cost for an infant is $877 each month and $668 for an older child.

Affordable and safe child care ranked 38th as a need in the 2006 Wake County Community Assessment. Some families report experiencing frustration and fear when applying for benefits, particularly if they are immigrants.

Emerging Issues

Low-income families with children are faced with a wide variety of issues that should be addressed by the community:

- Increasing costs of quality care for providers and parents.
- Increasing need and demand for high quality Pre-K programs like More at Four.
- Increasing demand for child care subsidy services.

Sources

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Public Education

Trends

Three trends will affect the WCPSS in the future:

1] The number of students in the school system will continue to increase, requiring additional schools, teachers and administrative support, and supplies and materials. This growth also will pose challenges from additional students with more risk factors.

2] Advances in curriculum, technology and educational services must be implemented while maintaining the focus on teaching and learning.

3] With more than 140 schools and five central office locations, ensuring financial accountability and adequate communications systems will be a growing challenge.

The school system has been growing steadily in recent years. In the 2006-07 school year, more than 128,000 students are being served. Of these students, 55.4% are white, 26.9% are African-American, 9.2% are Hispanic/Latino, 4.7% are Asian, 3.5% are multi-racial and .3% are American Indian. About 14.4% of students receive special education services, 27.1% of students qualify for free/reduced price lunches, and 4.8% are identified as Limited English Proficient (LEP). For the rest of this section, the statistics are from the 2004-05 school year. Data from the 2005-2006 school year are used for student suspensions.

Demographic and Enrollment Changes

As Table 1A shows, the growth rate between 2000-01 and 2004-05 has been about 19%, with annual increases of 3% to 5%. The school system had 96,057 students in 2001 and 113, 969 students in 2005. At the beginning of the 2005-06 school year, enrollment exceeded 120,000.

Table 1A: Membership by Grade Span, 2000-2005

	K-2	3-5	6-8	9-12	Total	Percent Change
2001	24,281	24,023	23,095	24,658	96,057	**
2002	25,390	24,766	24,412	26,344	100,912	5.10%
2003	25980	25,195	25,444	27,845	104,464	3.50%
2004	27,179	25,834	26,206	29,648	108,867	4.20%
2005	28,975	26,881	26,928	31,185	113,969	4.70%
2006	30366	27883	27,759	34,496	120,504	5.70%

Population trends suggest that, compared to 2001, the students being served by WCPSS today are more likely to come from poor families and to come from families with limited English proficiency.

Table 1B presents information about the growth of various groups. As the table shows, there have been large increases in the percentage of students qualifying for free or reduced price meals. In 1998 less than one in five students qualified for free or reduced price meals. In 2004, that number had increased to more than one in four. Students receiving English as a Second Language services more than doubled, from 2% to almost 5%. More than 16,800 students now qualify for special education services.

Table 1B: Change in Percent of Selected Categories

Year	F/RL	SpED	ESL
1998	19.7%	12.8%	2.0%
1999	20.1%	13.2%	2.7%
2000	20.3%	13.6%	3.1%
2001	21.3%	14.0%	4.0%
2002	21.1%	14.0%	4.6%
2003	24.3%	14.1%	4.8%
2004	26.5%	14.1%	4.9%

F/RL: Free and reduced lunch
SpED: Special education
ESL: English as a Second Language

Among entering kindergarten students, a range of readiness for school can be seen. Almost one-third, 32%, of kindergarteners knew more than 21 letter sounds, while 35% knew no letter sounds. At the same time, almost 70% of entering kindergarten children could identify more than 21 letters of the alphabet, while 18% knew fewer than 10. More than 50% of assessed kindergarteners could rote count higher than 20, and almost 15% could not count to 10. This range of variation among students will continue to present a challenge for WCPSS teachers and schools.

Academic Achievement: Elementary and Middle Grades

Qualitatively, WCPSS students perform at high academic levels. Every year, the State of North Carolina requires that all students, with the exception of some Special Education and LEP students, take End of Grade (EOG) testing. This program assesses reading and mathematics skills of students in grades three through eight. Tables 2, 3, and 4 give information about the performance of WCPSS students on these tests.

Table 2 shows the percentage of students whose scores were in Achievement Levels III or IV, considered to be at or above grade level. While small differences in percentages each year within a grade may be seen, the range of all the percentages shown fall between 87.1% to 93.5%. This indicates that in all the tested grades, more than eight out of 10 students were reading on grade level. Improvement trends appear to be strongly grade-related. A larger percentage of fifth grade students read at grade level than is true for fourth grade students. A similar pattern may be seen in middle grades. Most students in these grades are reading at or above grade level.

Table 2: Percent Reaching Lev III/IV on EOG Reading

Yr/Grade	3	4	5	6	7	8
2002-03	89.1%	90.0%	93.5%	87.7%	90.3%	92.2%
2003-04	88.1%	89.5%	93.5%	87.1%	90.2%	91.6%
2004-05	88.5%	88.6%	94.3%	87.9%	90.4%	92.0%

EOG: End of Grade

Table 3 shows information on mathematics achievement. In mathematics, an even higher percentage of students are performing at or above grade level than in reading. The range of percentages is from 87.9% to 96.4%.

Table 3: Percent Reaching Lev III/IV on EOG Mathematics

Yr/Grade	3	4	5	6	7	8
2002-03	93.5%	96.3%	95.6%	91.7%	87.9%	88.6%
2003-04	92.1%	96.4%	95.7%	92.3%	88.5%	88.0%
2004-05	89.9%	94.5%	94.1%	92.9%	88.9%	88.1%

EOG: End of Grade

Table 4 combines the results for reading and mathematics. This is calculated by identifying percentages of students with Level III or IV scores in reading and/or mathematics. This table shows a large and growing percentage of students performing at Level IV or above grade level. While the composite percentage has increased nine percentage points between 1998 and 2005, the percentage of students in Level IV has increased by almost 12 percentage points. It also is clear that the percent of students scoring in Levels I or II, below grade level, is decreasing.

Table 4: Percent Reaching Lev III/IV: Composite

Yr/ Grade	1998	1999	2000	2001	2003	2004	2005
Level III	34.5%	34.9%	33.3%	33.4%	30.9%	30.7%	31.6%
Level IV	47.4%	49.0%	51.6%	54.1%	60.4%	60.4%	59.3%
Total III/IV	81.9%	83.9%	84.9%	87.5%	91.3%	91.1%	90.9%

In 1998, the achievement gap between Asian and white students and African-American students on EOG reading tests was 33%. In 2005, the gap had shrunk to about 17%. While a gap in achievement continues to exist, the positive change is encouraging. Similar trends in the achievement gap in mathematics may be seen. Hispanic/Latino students experienced a slight decline in the percentage of students at/above grade level.

Students at risk of academic difficulty appear to be performing at about the same level as students not at risk. The same percentage of students with only one of three risk factors (free/reduced lunch, a proxy for poverty; students with disabilities; and students with limited English proficiency) are reading at the same grade level as the general student population. However, when the risk factors are accumulated, the percent of students reading at or above grade level declines dramatically.

Academic Achievement: High Schools

The State of North Carolina requires high school students enrolled in selected courses be tested. Table 5 gives results for the performance of WCPSS high school students on seven of these tests. It also provides a composite figure, in which performance on all tests is combined. Over the last three years, the composite percentage has changed very little. Of the courses listed in Table 5, all students are required to take algebra 1, English 1, and biology. The science courses shown, except for biology, are electives. Almost nine out of 10 students enrolled in algebra 1 and English 1 are able to achieve grade level or better on the associated End of Course (EOC) test.

Table 5: Percent of Students At/Above Grade Level in Selected EOC Tests & Composite

Yr/Crs	Composite	Alg 1	Engl 1	Chem	Biology	Geometry	Phy Sci	Physics
2003	83.1%	88.3%	88.8%	85.5%	74.2%	82.1%	61.5%	89.2%
2004	83.2%	89.4%	87.5%	88.7%	74.1%	78.1%	65.8%	92.5%
2005	83.2%	89.0%	87.4%	87.4%	74.2%	78.1%	67.2%	92.0%

EOC: End of Course

Other indicators of high school achievement include enrollment in and success in Advanced Placement (AP) courses and results of the SAT testing. AP courses are offered in all Wake County high schools, and enrollment in these courses has increased in recent years. Between 1997 and 2005, the number of AP examinations taken by WCPSS students has increased from 2,785 to 6,365. At the same time, the average score for these tests remains virtually unchanged. In 1997, the average AP score was 3.42 on a 5-point scale. In 2005, the average was 3.40.

The average SAT scores for WCPSS seniors have improved. Since 1991, the average SAT score for Wake County has exceeded the average state and national scores. Over the same period, the average WCPSS score has risen from 1007 to 1075, a 68-point increase. About 75% of WCPSS seniors take the SAT.

In the 2005-2006 school year, state officials also started looking at high school graduation rates. Preliminary estimates for WCPSS show that about 82% of students who began ninth grade in 2002 had graduated four years later. In June 2006, *Education Week* showed WCPSS with the second-best graduation rate among the 50 largest school districts in the nation, exceeded only by Fairfax County (Virginia) Schools.

The students who do not graduate are more likely to be African-American or Hispanic than white. Table 6 shows the percent of each ethnic group that dropped out of school from 1999 to 2005. Except for Hispanic students, the trends for all ethnic/racial groups show some modest positive changes.

Table 6: Drop Out Rates Disaggregated and Total

	Hispanic	Afr Amer	Multi	White	Asian	Total Wake	Total State
99-00	8.7%	7.0%	5.5%	3.0%	2.3%	4.1%	6.8%
00-01	7.2%	6.1%	4.8%	2.7%	1.3%	3.7%	6.4%
01-02	7.7%	6.3%	4.1%	2.2%	0.9%	3.5%	5.7%
02-03	6.5%	3.9%	4.8%	2.0%	2.4%	2.8%	5.3%
03-04	9.0%	5.4%	3.4%	2.2%	1.6%	3.4%	4.8%
04-05	8.8%	6.0%	4.7%	2.1%	1.9%	3.7%	4.9%

Table 7 compares the drop out numbers for Wake County and for four other large school districts in the state. These are Durham, Forsyth, Mecklenburg, and Guilford. Drop out rates in each of these districts and the state have decreased in recent years.

Table 7: Drop Out Rates in Urban Counties in North Carolina, 1998-2005

	98-99	99-00	00-01	01-02	02-03	03-04	04-05
Durham	8.2	6.1	4.6	6.2	5.8	5.9	5.7
Forsyth	7.2	6.4	5.5	5.8	5.3	5.2	5.0
Wake	4.7	4.1	3.7	3.5	2.8	3.4	3.7
Mecklenburg	7.7	6.8	5.8	4.8	4.0	4.5	3.1
Guilford	6.4	6	3.9	3.8	3.0	3.1	3.0
North Carolina	6.8	6.4	5.7	5.3	4.8	4.9	4.7

Suspensions and student discipline and the causes influence ability to learn. As Table 8 shows, there were more short-term suspensions than long-term suspensions. Short-term suspensions were for violations of policy relating to interpersonal conflict and misbehavior. Long-term suspensions involved more serious issues of health and safety.

Table 8: Number of Suspensions by Policy

Description/Policy	Violations
Short term suspensions	
Non-Compliance	5329
Fighting/Phys Aggression	5004
Class/Activity Disturbance	2032
Verbal Abuse/Disrespect	1436
Instigation of Fight/Physical Aggression	995
Long term suspensions	
Possess Drugs/Alcohol/Para	237
Assault on Student	129
Gang/Gang-Related Activity	107
Weapons/Dangerous Instrument	85

Table 8 focuses on the number of suspensions, not the number of students. In 2005-06, almost 5,000 girls in WCPSS schools were given at least one short-term suspension. More than 12,500 boys received at least one short-term suspension. Eight percent of girls and 20.5% of boys were suspended at least once.

Table 9 shows the percent of students in each racial/ethnic group who were suspended at least once during the school year. Overall, 14.4% of all WCPSS students were suspended in 2005-2006. African-American students were suspended at greater rates than any other racial/ethnic group.

Table 9: Students Suspended by Ethnic

American Indian	42	12.80%
Asian	195	3.50%
African-American	11086	34.20%
Hispanic	1419	12.80%
Multi racial	601	14.20%
White	4015	6%
Total	17358	14.40%

Summary of Academic Achievement

For the past three years, the percentage of WCPSS students scoring at or above grade level on the final course tests has stayed about the same. However, at the same time, more students in at- risk categories have enrolled in the school system. With test scores constant, the school system seems to be able to help these at-risk students achieve the same high level of success that has become the norm across the county.

Community Perceptions

In December 2005 and January 2006 the WCPSS surveyed students, parents, and teachers about their satisfaction with the schools. Surveys were provided in both English and Spanish. More than 42,000 surveys were returned, representing a response rate of 35%. In the survey, parents were asked to give a letter grade to their child's school; a resounding majority (88%) gave their schools a grade of A or B. The survey also asked questions about specific aspects of the schools, with parents in agreement on:

- Their child's school is safe, 96%;
- Their child's school provides a quality education program, 94%;
- Their child's school's buildings are clean and safe, 93%;
- Discipline has been handled fairly at the school, 94%.

In the Wake County 2006 Community Assessment, when asked "What do you think is the best thing about living in Wake County?" education was mentioned 56 times in 75% of the focus groups. A "good public school system" was specifically mentioned.

Resources and Strengths

In addition to high end-of-grade test scores, high SAT participation rates and strong graduation rates, one of the greatest strengths of WCPSS is the district's employees at all levels and in all job classifications. One of the superintendent's four main goals is the retention and recruitment of high quality staff. WCPSS leads the nation in the number of teachers, 1,137, who have earned certification from the National Board for Professional Teaching Standards.

Parental participation, through volunteering at the schools or serving on task forces and committees, are another strength of the district.

Emerging Issues

The single most important issue facing WCPSS will continue to be the rapid increase in the number of students. The need to house these students in safe buildings while providing the best opportunities for teaching and learning will be a major issue confronting this community for many years.

Another concern is the increase in the number of students with risk factors such as poverty, disability and lack of English-language proficiency. Table 11 shows the number of students over the last three years with these risk factors. The table includes an unduplicated count of elementary students with one, two, or three risk factors.

Table 11: Number of Students with Various Risk Factors/Multiple Risk Factors, 03-06

LEP	FRL	SWD	LEP/ FRL	LEP/ SWD	FRL/ SWD	ALL	Total K-5	
863	10321	4210	2703	73	2868	320	52988	03-04
857	11348	4162	2999	79	3109	321	55813	04-05
1126	12629	4263	3756	75	3219	380	59722	05-06

LEP: Limited English Proficiency
FRL: Free and reduced lunch
SWD: Students with disabilities

The table shows that the number of students with multiple risk factors has increased. While the district has been able to meet the needs of these students, the challenge is increased as the percent of students with these risk factors increases. Finding new and better ways to educate all children in Wake County will continue to be a challenge for the district and the community.

Non-Public Education

Current State of Affairs

Wake County has 56 non-public schools, which are conventional schools that may be defined as religious, independent, or independent with a religious component. Traditionally, non-public schools pride themselves on providing a personalized approach to education. These schools vary widely in size and type of campus.

Non-public institutions in North Carolina are required to report only the institution's name, address, and names of its chief administrator and owner(s) to the Division of Non-Public Education (DNPE). Therefore, significant information based on demographics and achievement is hard to obtain and determine. As the table below indicates, there has been an increase in enrollment over the past five years, with the exception of 2003-04.

Non-Public Schools Membership by Grade Span 2000-2005

	K-2	3-5	6-8	9-12	Total	Percent Change
2000-2001	3,587	2,906	2,471	3,042	12,006	
2001-2002	3,652	3,050	2,726	3,187	12,615	5.0%
2002-2003	3,795	3,202	2,998	3,272	13,267	5.1%
2003-2004	3,523	3,100	2,936	3,392	12,951	-2.4%
2004-2005	3,529	3,153	3,060	3,633	13,375	3.3%
2005-2006	3,470	3,133	3,107	3,815	13,525	1.1%

Some non-public school officials responded to a survey on their schools during the last five years. All of the schools that responded had a high school. Some of the results are as follows:

- 75% of the schools have fewer than 750 students.
- 88% have average class sizes smaller than 19 students per teacher.
- 87% have tuition under $15,000.
- 87% offer financial aid to their students.
- 100% of the schools have experienced an increase in enrollment and an increase in tuition/fees over the past five years.
- 88% have had a slight increase in diversity.
- 75% have implemented new programs such as more AP courses, honors courses, technology programs and additional sports teams as a result of an increase in enrollment.
- 100% boast a 100% graduation rate.
- 75% are planning for growth in the near future.
- 75% participate in collaborative programs within Wake County such as Habitat for Humanity, Adopt a Highway, Council for Learning Disabilities, Food Bank, Building Together, YMCA, Special Olympics, and the Teacher Together Technology Program.

Emerging issues

A task force is needed to research each segment of non public education within Wake County to better determine academic achievement and school demographics.

Sources

The North Carolina Association of Independent Schools website www.ncais.org/
State of North Carolina Department of Administration Division of Non-Public Education website www.ncdnpe.org/

Higher Education

Current State of Affairs

Fifteen colleges or universities have campuses or offer programs in Wake County. These institutions were surveyed, and seven responded. The information was gathered from these surveys for the academic year 2006-2007. This information is not a comparison of individual colleges and universities, but shows the range of higher education opportunities available within Wake County.

Summary Information from Higher Education Institutions in Wake County

	Low range	High range
Degree seeking student enrollment	651	20,546
Average age	20	32
Cost/credit hour	$39.50 in-state 219.50 out-state	$555
Percentage of students receiving financial aid	25.5%	96%
Percentage of students from Wake County	32%	83%

Three of the institutions had almost 10,000 students enrolled part-time in a continuing education course for the fall semester of 2006-2007. The surveys indicated approximately 7,000 students enrolled in graduate programs. Three of the colleges that responded offer graduate programs.

Trends, Disparities, Gaps and Unmet Needs

The Raleigh-Wake County area has numerous colleges and universities that offer educational opportunities to students graduating from high school as well as adult learners. These opportunities include credit programs that lead to certification, licensure or a degree, as well as non-credit programs that lead to personal growth, enrichment and/or development.

Institutions in the Raleigh/Wake County area are made up of public, private, not-for-profit and private for-profit institutions. The chart below lists the colleges and universities with programs in the county.

Overview of Higher Education Institutions that Operate in Wake County

Institutions	Main Campus Location	Membership	Type	Degrees Offered
Campbell University	Buies Creek, NC	NCICU/SACS	Private, Not-for-Profit/ Coed	BS, BA, Master's
East Carolina University	Greenville, NC	UNC/SACS	Public/Coed	Doctorate
ECPI	Raleigh, NC		For-Profit/ Coed	AA, AS, Certificate
Meredith College	Raleigh, NC	CRC/NCICU/ SACS	Private, Not-for-Profit/ Women's	BS, BA, Master's
Miller-Motte Technical College	Raleigh, NC		For-Profit/ Coed	Certificate
Mount Olive College	Mount Olive, NC	NCICU/SACS	Private, Not-for-Profit/ Coed	BA, BS, Master's
North Carolina State University	Raleigh, NC	CRC/UNC/SACS	Public/Coed	BS, BA, Master's 1st Prof Doctorate
North Carolina Wesleyan College	Rocky Mount, NC	NCICU/SACS	Private, Not-for-Profit/ Coed	BS, BA,
Peace College	Raleigh, NC	CRC/SACS	Private, Not-for-Profit/ Women's	BA
Pfeiffer University	Misenheimer, NC	NCICU/SACS	Private, Not-for-Profit/ Coed	BS, BA, Master's
Saint Augustine's College	Raleigh, NC	CRC/NCICU/ SACS	Private, Not-for-Profit/ HBCU/Coed	BS, BA, Licensure
Shaw University	Raleigh, NC	CRC/NCICU/ SACS	Private, Not-for-Profit/ HBCU/Coed	BS, BA, Master's1st Prof
Strayer University	Fairfax, VA	ACAIC/MSCIE	Private/ For-Profit/ Coed	BS, BA, Master's
University of Phoenix	Phoenix, AZ	HLC/NCACS	Private/ For-Profit/ Coed	BS, BA. Master's
Wake Technical Community College	Raleigh, NC	NCCCS/SACS	Public/Coed	AA, AS, Certificate /License

NCICU: North Carolina Independent Colleges and Universities
SACS: Southern Association of Colleges and Schools
UNC: University of North Carolina
CRC: Cooperating Raleigh Colleges

Meredith College, Peace College, North Carolina State University (NCSU), Saint Augustine's College and Shaw University are members of the Cooperating Raleigh Colleges (CRC). These institutions meet regularly to discuss current and emerging trends and issues. Members of this group broadcast information on events, classroom instruction and programs through the CRC Channel. The members of the CRC serve both traditional undergraduate students and adult learners. All CRC institutions offer traditional classroom instruction as well as online programs.

Several traditional colleges whose main campuses are not located in the Raleigh-Wake County area have opened satellite campuses here. These campuses offer traditional classroom instruction as well as distance learning opportunities. East Carolina University offers working adults the opportunity to earn a doctorate degree.

In addition to these traditional colleges and universities, the Raleigh-Wake County area has ECPI and Miller-Motte Technical Institute. Both are for-profit and offer course work that leads to diplomas, certificates, certification and/or licensure.

Scope of Analysis

For the purpose of this study, traditional institutions of higher education will be referenced. The institutions include Meredith College, NCSU, Peace College, Saint Augustine's College and Shaw University. These institutions are all part of Cooperating Raleigh Colleges (CRC) and all are accredited by the Commission on Colleges Southern Association of Colleges and Schools (SACS). All of these institutions are eligible to receive Federal Student Aid funds from the U.S. Department of Education and are required to report standard data to the department. This reporting makes it possible for statistical comparisons to be made.

Affordability

One of the issues facing students and their families is the cost of a college education and the family's ability to pay for that education. The Affordability Index is an indicator that tracks families' median income and changes in enrollment trends as the result of increases or decreases in the cost of college. From fall 2003 to fall 2005, there has been a slight decrease of 16% in the average enrollment. Average tuition for CRC institutions has increased by 6%, with the average tuition being $12,059 per academic year. Tuition averages range from a three-year low of $4,107 to a high of $19,022.

A study of CRC institutions for the four-year period from fall 2000 to fall 2004 is detailed below:

Affordability Factors for CRC Institutions in Wake County

Indicator*	Range	4-year Average
First-time full-time undergraduate Total	161 to 3,917	1,057
Any Aid Percentage Receiving	54% - 100%	88%
Federal Grants		
Federal Grants Percent Receiving	13% - 80%	42%
Federal Grants % Receiving Average Amt	$1,906 - $4,456	2,991
State/Local Grants		
State/Local Grants Percent Receiving	16% - 88%	60%
State/Local Grant % Receiving Average Amt	$1,202 - $4,754	2,641
Institutional Grants		
Institutional Grants Percent Receiving	3% - 94%	47%
Institutional Grants % Receiving Average Amt	$1,594 – $7,609	4,044
Loans		
Loans Percent Receiving	36% - 93%	65%
Loans % Receiving Average Amt	$1,369 – $6,484	3,346

**Does not include College Work Study, Plus Loans, Private Aid, etc.*
Source: US Department of Education, National Center for Education Statistics, Integrated Postsecondary Education Data System (IPEDS): Fall 2000 – Fall 2005

Based on the averages, 88% of incoming first-time full-time undergraduate freshmen receive some type of aid to finance their education. Of the 88%, 31% is received from institutional aid; 23% is from federal grants; 20% is from state/local grants; and 26% is from loans other than Plus Loans or private aid.

Changes in governmental policies that affect the amount of federal, state and local funding also have an impact on each individual student's ability to fund higher education.

In the past decade there has been a 3.9% increase in the number of Wake County residents who have attended a North Carolina public or private higher education institute inside the state. This contrasts with a 4.1% rate for Cumberland County residents and a 2.3% rate for Mecklenburg County residents.

Enrollment between 1994 and 2004 increased 3.7% for all public institutions in North Carolina. There was a 3.4% increase at public North Carolina four-year institutions and 4.8% at North Carolina community colleges. NCSU had an increase of 0.3% compared to an increase of 3.9% for Wake Technical Community College. The enrollment increase at private institutions was 1.3%, with variability between institutions. In Wake County, St. Augustine's headcount change for the years was -14.7%, Peace -0.6%, Meredith +0.8% and Shaw +3.6%.

Undergraduate yearly tuition and fees for in-state students between 1999 and 2005 increased $1,388, from $1,951 to $3,339. In Wake County, NCSU's tuition and fees increased $1,868, from $2,414 to $4,282. Community college tuition and fees across the state, which is standardized by the community college system, increased $757 to $1,244.

For private senior institutions, the overall increase from 1999 to 2005 was $4,050, from $11,784 to $15,834. In Wake County, Meredith's tuition increased from $9,290 to $19,000, Peace College from $8,885 to $16,881, St. Augustine's from $7,182 to $10,388 and Shaw from $6,854 to $9,438.

Other factors also impacted enrollment in local colleges and universities:

- **Shifts in population demographics** – An aging population that is living longer has produced a need for more health and mobility services that help the elderly. Higher education's response has been to develop new programs that address these issues while eliminating those academic programs that are no longer producing graduates or fulfilling a need.
- **Increases/decreases in federal funding** – Recent changes in the award criteria and income limits in the administration of the Federal PELL grant have excluded previous recipients and reduced award amounts for some, creating a need to find funding elsewhere.
- **Increases/decreases in state funding** – North Carolina Legislative Tuition Grant funding has increased by $100 for an academic year, increasing semester awards to $950 from $900.
- **Changes in industry changes/technology usage** – Business and industry's integration of technology with business and manufacturing processes has resulted in a need for training. In some instances job tasks have been redesigned and/or eliminated.
- **Changes in retention/graduation rates** – Students are taking longer to graduate from four-year degree programs. Of the CRC institutions, 48.56% of undergraduate students graduated in four years.
- **Increases in adult learning opportunities** – All institutions in the Raleigh/Wake County area offer adult learning opportunities either for credit or non-credit as well as offering online instructional delivery enhancements.
- **Increases in interest from non-Raleigh/Wake County area institutions** – Several institutions have opened within the past three years that target the working adult-learner population such as Strayer University and University of Phoenix.
- **Increases in the use of technology as a delivery method of instruction** – All institutions in the Raleigh/Wake County area use some type of course management instructional methodology via the Internet such as Blackboard, WebCT, CAMS and others.
- **Changes in data collections/technology** – Technology is increasingly used to collect and analyze data. This practice not only increases the speed of collection and analysis, but it has resulted in increased accountability, access to data resources and more accurate trend analysis.
- **Changes in immigration laws** – Initial changes resulted in a decrease in the number of non-resident foreign students enrolling in institutions in the United States and the Raleigh/Wake County area. This also has affected study abroad and faculty exchange programs in the past.
- **Changes in diversity** – Institutions of higher education have had to develop and implement programs that address the proliferation of the Spanish-speaking population in order to be able to provide adequate information or service. The North Carolina Community College System has in place English as a Second Language programs to help alleviate this gap. All CRC institutions in the Raleigh/Wake County area have programs designed to increase the diversity of their student body.

Resources and Strengths

This survey of higher education institutions in Wake County indicates numerous resources and strengths. Many of these institutions report increases in diversity enrollment and in developing programs to serve the growing Hispanic population and meet the community's workforce needs. Innovative partnerships with WCPSS also are notable.

- **Meeting the need for nurses and teachers**
  The teacher education program at Peace College is a partnership with WCPSS. Students can earn a dual licensure in elementary and special education. The dual nature of the program is designed to increase the number of graduates trained to teach, but also to increase retention of teachers. The program, with nine students in its first year, was designed with assistance from WCPSS.

  Many health sector initiatives are underway around the state and in Wake County. Wake Technical Community College is approved by the N.C. Board of Nursing to enroll 300 students in its Associate Degree nursing program, which prepares students to become registered nurses. While this is the largest community college nursing program in the state, there are still more than 500 students waiting to enroll. A lack of qualified teachers, lab and classroom space, clinical spots, and money for supplies limit the expansion of the program.

- **Effective Community Partnerships**
  Partnerships are in place with several local businesses such as Credit Suisse, Fidelity, and Novo Nordisk. Higher education institutions are working to make their curricula more innovative and relevant. Both Meredith and Peace recently have revised their general education requirements to reflect greater emphasis on cultural knowledge, experiential learning, and skills for a global society. Service learning in the curriculum and volunteer community service programs also are active components in the colleges and universities, such as St. Augustine's male mentoring program Omega C.H.A.M.P.S., which targets fourth through eighth grade boys raised in single-family homes, and its National Summer Youth Program, which targets approximately 150 economically disadvantaged youths.

- **Dual Enrollment**
  The trend toward dual enrollment in high school and college shows the ability of local colleges and universities to work with the community to meet the needs of students and employers.

  The number of dual enrolled students, high school students taking college courses at the community college, has increased. It now includes students from the public high schools, private schools and home schools.

  With support of the Governor's Learn & Earn initiative and the Bill and Melinda Gates Foundation, Wake County is one of many counties in the state that has created an Early College High School. This is part of the effort to redesign traditional high schools with the goal of graduating a greater percentage of students and helping ensure they are job or college ready. The Wake Early College of Health & Sciences opened on the Health Sciences campus of Wake Technical Community College in the fall of 2006 with 97 9th graders. The school will enroll no more than 400 students. These students will complete requirements for their high school diploma and two years of college credit in five years. The health and sciences theme is another effort to address the health care workforce needs of the future.

Emerging Issues

A wide variety of issues are being addressed by the various colleges and universities in Wake County:

- **Diversity**
  taken efforts to create a more diverse community by reaching out to the Latino and African-American communities. Meredith also has revised its general education program to emphasize cultural connections, understanding of diversity and a global perspective. Meredith Sociology and Education faculty tutor ESL students at partner schools. An engineering program with North Carolina State University enables Meredith to increase the number of women entering science and engineering fields.

  Peace College developed a Liberal Education program that teaches students the knowledge and skills necessary to be successful in today's global marketplace. Also, students in the dual elementary education/ special education program are required to become conversant in Spanish.

- **Lifelong Learning Opportunities**
  More than 10,000 students per semester are enrolled in noncredit courses across Wake County. Meredith offers enrichment classes, audit opportunities, workshops and children's programs. It also offers courses necessary for teacher licensure for women who already hold a college degree. In addition, Meredith offers professional development workshops and seminars for Local Education Agencies (LEAs), including those in Durham. NCSU also offers professional development workshops for teachers. Saint Augustine's College offers the Gateway Program for older students, and its classes are scheduled during the evenings and on the weekends. Saint Augustine's also offers the Second Chance Program, which is an alternative licensure program for those with a baccalaureate degree who are seeking certification as teachers. The local campus of the University of Phoenix intends to offer continuing education coursework to teachers and eventually offer bachelor's and master's programs in education.

- **Articulation**
  The College Transfer Articulation Agreement between the N.C. Community Colleges and the North Carolina University System was implemented in 1998. It does not address the transfer from Associate in Applied Science degree programs to related university programs. This is an obstacle to an easy transition for students, especially in areas of great workforce demand such as health care.

- **Graduation Within Six Years**
  According to www.northcarolina.edu, the graduation rate for first-time, full-time freshmen at all UNC institutions has increased from 57.2% in 1995 to 59.1% in 1999. Peace College has a six-year graduation rate that increased from 20.7% for the 1995-1996 entering class to 48% for the 1999-2000 entering class. According to the Meredith College Web site, 66.9% of students in the 1994-1997 classes graduated in six or fewer years. According to the America College Test (ACT), 50.9% of all college students graduated in five years.

Sources: Peace College, Meredith College website, www.northcarolina.edu, ACT

Community Enrichment and Education

Current State of Affairs

The Wake County Public Library System promotes the love of reading and fosters the pursuit of knowledge among county residents. Priorities include services for children, leisure or recreational readers and lifelong learners. The local library system also serves as a community gathering center and a place with technological services.

The library system consists of five regional libraries and 11 community branch libraries. The system also operates a genealogy and local history library, an electronic information center library, and two bookmobiles. Use of the library is varied and the clientele is diverse. When compared to similar public libraries in the state, the local library system excels (see chart at the end of this Chapter —State Library of North Carolina Statistics for Public Libraries, April 2006.)

Trends

Although historically a middle-class institution, public libraries in Wake County are serving a broad socio-economic spectrum. In addition to promoting reading, the library also serves the general learner with its collections and programs. There are increasing numbers of families from the African-American, Asian-American, and Latino-Hispanic population using both traditional and electronic library services. Access to the Internet continues to shape how information is provided to customers.

Increasingly, the library serves as a center for the community, often through partnerships with community agencies and civic organizations. It is a gathering spot for residents of all ages. Young children and parents, latchkey children and growing families and curious individuals of all ages visit the library on a routine basis to connect with the community.

Libraries, nationally, tend to thrive in difficult economic times. In Wake County, the public libraries are thriving as the population growth in the county creates ongoing demand for library resources. In 2003, Wake County voters approved a $35 million bond referendum to build more libraries. Meeting the demands for basic library service in a rapidly growing county will continue to be a challenge for the library system.

North Carolina Cooperative Extension - Wake County Center

Current State of Affairs

North Carolina Cooperative Extension (NCCE) - Wake County Center's role in lifelong learning is to extend informal educational resources of North Carolina State University and North Carolina A&T State University to Wake County citizens. NCCE delivers research-based information that involves urban and rural citizens in solving complex and challenging problems in their communities. The center comprises county educators/agents, professors, scientists and volunteers working together. NCCE assists town and city governments, industries, for-profit and non-profit agencies, as well as individuals, families, and communities of interest.

Specific examples of the informal, lifelong education includes, but are not limited to:

- *ServSafe:* In collaboration with Wake County Environmental Services, NCCE Family and Consumer Scientists assist with the training of food service providers to decrease food-borne illnesses and improve restaurant sanitation and food handling procedures.
- *First Time Home Buyers:* In collaboration with Wake County Human Services, NCCE professionals address low resource audiences regarding the home buying process, household budgeting and credit issues. Mortgage lenders are on hand to walk potential buyers through the financing process.
- *4-H Youth Development:* Eight after-school sites are offered around the county targeting middle-school youth for academic success and life skill development. In addition, NCCE coordinates over 60 4-H clubs and nearly 200 volunteer adults in communities. Urban 4-H touches young people through violence prevention, substance abuse prevention, pregnancy prevention, mentoring and peer education.
- *Environmental and Agricultural Education:* Extension experts provide water quality education, environmental law and regulation compliance and green industry education. More than 150 Master Gardener volunteers provide daily horticultural and pesticide application assistance to homeowners.

Emerging Issues

The main challenge for community enrichment and education is to continue to have the capacity to serve a rapidly growing diverse population.

Source

NC State Library Annual Statistics, July 1, 2004--June 30, 2005 (publication date – April 2006)

Appendix D NC State Library Annual Statistics July 1 - June 2004-2005 (published April, 2006)

FUNDING / OPERATING EXPENDITURES	Population Served	Total FTE	FTE / 25,000 population	Local Funds	Total Operating Income (state aid, federal, other)	Per Capita Income	Operating Expenditures Personnel Collections Other	Total Operating Cost per Capita			
Charlotte/ Mecklenburg	768,789	485.62	15.79	25,980,099	29,963,005	38.97	20,096,643 (69%)	2,910,916 (10%)	5,980,896 (21%)	37.71	
Wake	723,708	170.50	5.89	10,745,642	11,950,878	16.51	8,069,167 (66%)	2,693,631 (22%)	1,520,159 (12%)	16.97	
Guilford	345,694	106.88	7.73	9,240,466	9,919,286	28.69	5,466,042 (71%)	746,448 (10%)	1,449,312 (19%)	22.16	
Forsyth	320,756	103.75	8.09	7,046,293	7,626,130	23.78	4,730,059 (62%)	1,039,945 (14%)	1,803,388 (24%)	23.61	
Cumberland	310,850	162.58	13.03	6,391,655	7,538,862	24.25	5,033,438 (69%)	968,641 (13%)	1,263,470 (17%)	23.37	
Durham	236,789	102.58	10.07	5,600,768	6,132,362	25.90	4,027,327 (72%)	839,728 (15%)	743,002 (13%)	23.69	
COLLECTION PROFILES	# Adult Books	# Juvenile Books	# Audio	# Video	Total Print Collection	Total Nonprint Collection	Books per Capita	Adult Fiction	Adult Nonfiction	Juv Fiction	Juv Nonfiction
Charlotte/ Mecklenburg	847,347	574,189	65,313	49,602	1,421,536	114,915	1.85	43%	21%	29%	7%
Wake	828,828	672,790	24,212	0	1,501,618	24,212	2.07	26%	20%	44%	10%
Guilford	319,720	161,928	9,554	14,853	481,648	24,407	1.39	29%	19%	40%	12%
Forsyth	380,443	220,612	34,642	23,570	601,055	58,212	1.87	42%	20%	30%	8%
Cumberland	375,547	223,411	21,908	23,161	598,958	45,069	1.93	32%	25%	34%	9%
Durham	299,912	197,014	17,314	8,885	496,926	26,199	2.10	33%	24%	34%	9%
CIRCULATION	Adult	Childrens	Nonprint	Total Circulation	Circulation per Capita	Cost per circulation					
Charlotte/ Mecklenburg	3,648,927	1,997,830	1,078,699	6,725,456	7.35	$4.31					
Wake	3,364,907	3,903,455	140,707	7,409,069	10.04	$1.66					
Guilford	593,591	634,996	173,389	1,401,976	3.55	$5.47					
Forsyth	804,378	494,605	388,240	1,687,223	4.05	$4.41					
Cumberland	776,071	589,325	424,662	1,790,058	4.39	$4.00					
Durham	629,082	482,190	246,232	1,357,504	4.69	$4.13					
SERVICES	Registered Borrowers	# of library visits per capita	# Ref Questions	# Adult Programs	Attendance Adults	# of Children's programs	Attendance Children	Database Subscriptions (non NCLive)	Public Internet Stations	Virtual Visits	
Charlotte/ Mecklenburg	557,317	5.80	3,593,028	2,681	177,521*	32,418	541,740**	23	787	6,006,466	
Wake	372,659	5.50	873,964	1,278	25,613	3,330	152,780	11	450	480,600	
Guilford	186,626	7.91	249,548	2,289	36,191	3,555	102,063	12	227	463,353	
Forsyth	166,806	3.79	553,906	957	21,792	2,212	64,739	19	123	0	
Cumberland	154,562	4.11	322,141	374	13,062	4,861	135,847	12	272	416,171	
Durham	124,563	4.35	189,234	459	5,662	1,710	62,367	11	65	998,079	

* includes Nuvello, Citywide book festival ** includes Imag-on, Children's Museum

Chapter 7: Physical Health

A full and true characterization of Wake County is incomplete without an understanding of the community's physical health. This chapter highlights new trends and ongoing physical health issues across all age groups. There are large disparities involving age, gender, race and ethnicity. The first step in solving these dilemmas is to wholly identify and describe the problems in detail. The chapter is divided into four sections: Maternal and Infant Health, Children's Health, Adult Health and Communicable Diseases.

Maternal and Infant Health

Introduction

Babies need the best possible care before being born into today's world. Babies born prematurely (prior to 37 weeks' gestation) or with low birth weight (less than 5.5 pounds, or at very low birth weight, which is less than 3.3 pounds) are automatically at a disadvantage and face many challenges. Without the advantage of being born healthy, babies are more susceptible to infant mortality (defined as an infant who dies within the first year of life), birth defects and other physical and mental difficulties throughout their lives.

Current State of Affairs

Low birth weight is associated with a higher incidence of mental retardation, learning disabilities and other developmental problems. These problems for some babies will result in impaired cognitive skills and poor elementary school performance. There also may be lifelong physical effects for those children, such as heart disease, high blood pressure or kidney problems. Not only do the child and family bear the emotional burden of long-term health problems, there is an economic burden, as well. In the first year of life, the inpatient medical costs for a baby born at 35 weeks gestational age is approximately $2,500. At 27 to 29 weeks, medical costs exceed $42,000 and at 24 to 26 weeks, this soars to more than $75,000.

Births:

- Wake County Human Services (WCHS) is the primary provider of low-income prenatal care for women in Wake County, enrolling approximately 3,500 yearly.
- The ethnic breakdown of prenatal patients served by WCHS in fiscal 2005-06 was 12% white, 30% African-American, 56% Latina and 2% other.
- In 2005, there were 12,264 live births in Wake County, an increase of 4% from 2004.
- Of the 12,264 live births in Wake County in 2005, 73% were to white (including Hispanic women) and 27% were to African-American and all other women. The State Center for Health Statistics (SCHS) uses two broad categories to define infant ethnicity: "white" which includes Hispanic women and "minority" which includes African-American, American Indian and all other ethnicities.

Trends

Maternal Health: More than three out of five pregnancies of low-income women are unintended or unplanned. Women with unintended pregnancies are at a higher risk for preterm delivery and other complications.

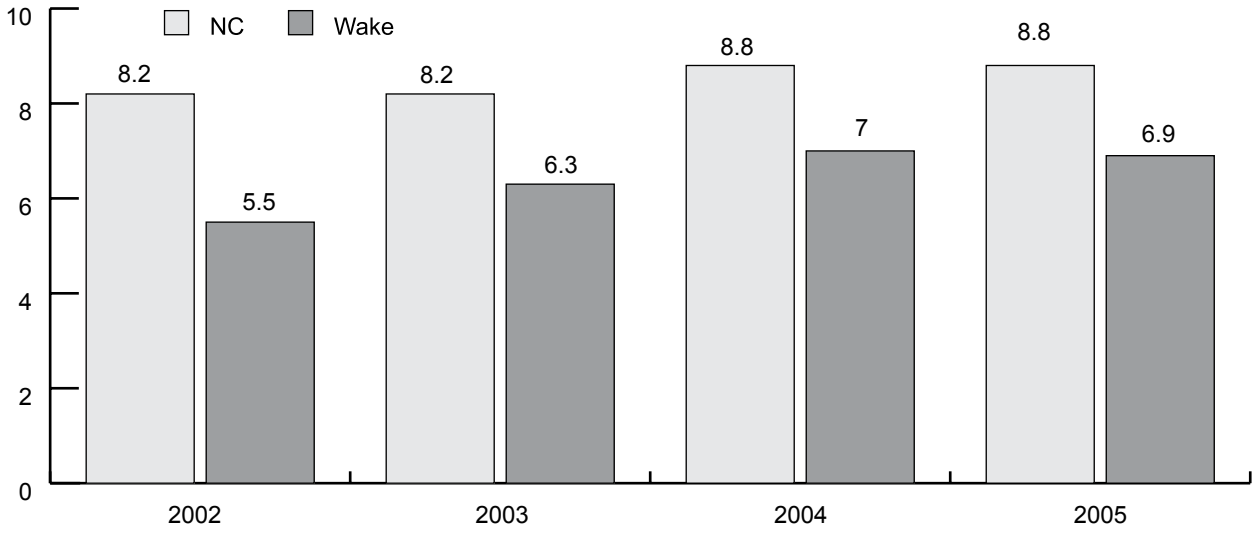
In North Carolina, 14% of women reported having smoked during their pregnancies. The WCHS Prenatal Clinic reports that up to 35% of its clients smoke. The Step by Step Program, which treats pregnant women and parents who abuse substances, reports that up to 84% of its clients smoke. A review of Wake County birth certificates revealed that one significant risk factor for low birth weight/fetal and infant death is smoking during pregnancy.

The health of women prior, during and after pregnancy has a huge impact on pregnancy outcomes. Quality prenatal care, essential to positive birth outcomes, cannot compensate for unhealthy behaviors such as smoking, substance abuse, poor nutrition and physical fitness.

Low Birth Weight: Historically, Wake County has consistently ranked below other counties for numbers of low birth weight births. Low birth weight births have decreased nationwide over the last several years due to new medical technology. This technology has helped save the lives of babies who would previously have died at birth. However, many of these babies may face numerous developmental and lifelong challenges. In Wake County for 2005, 6.6% of infants were born at low birth weight (LBW) with 1.5% at very low birth weight (VLBW). This is a slight increase from 2002 in which the rates were 6% and 1.6%, respectively.

Infant Mortality: Although infant death rates for Wake County are consistently below the state rates, infant deaths continue to be a concern in the county

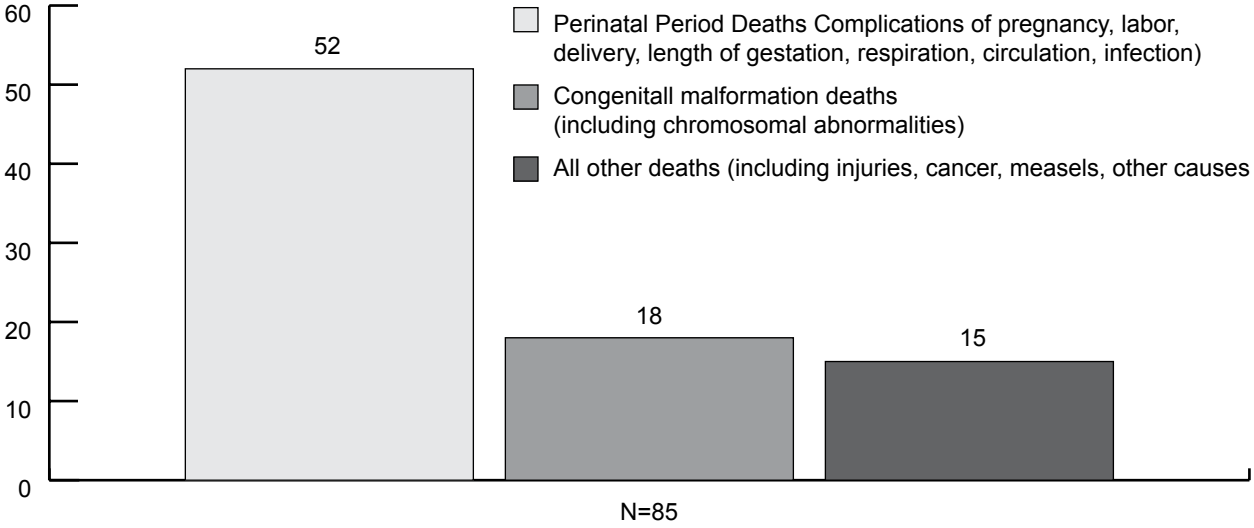
Infant Mortality Rates Per 100,000 Live Births 2002-2005 SCHS



SCHS: State Center for Health Statistics

In 2005, 85 infant deaths occurred in Wake County. Of these, 18 (21%) were the result of congenital malformations, deformations and chromosomal abnormalities. Fifty-two (61%) deaths occurred as a result of conditions originating in the perinatal period. These included complications of pregnancy, labor and delivery, length of gestation and fetal growth, respiratory and cardiovascular disorders, infections, fetal and newborn haemorrhagic and haematological disorders, digestive system and enterocolitis disorders. The remaining 15 (18%) deaths resulted from injuries, cerebrovascular disease, measles, cancers and unknown causes of death. Of the remaining 15 deaths, seven were from Sudden Infant Death Syndrome (SIDS.)

Infant Mortality Causes Wake County 2005 SCHS

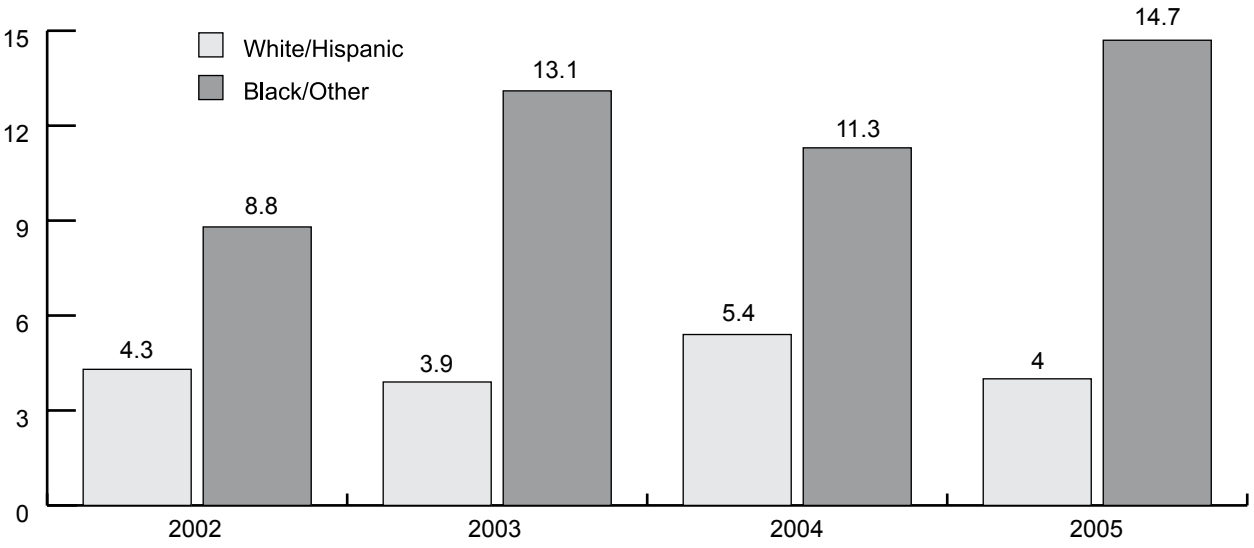


SCHS: State Center for Health Statistics

Disparities

A continuing area of major concern for Wake County's maternal and infant health is the persistent disparity between white/Hispanic and black/other infant mortality rates. As seen below, the disparity in 2005 was slightly over three times the white/Hispanic rate. The SCHS uses two broad categories to define infant ethnicity. These are "white" which includes Hispanic women and "minority" which includes African-American, American Indian and all other ethnicities.

Infant Mortality Rates Per 1,000 Births Wake County 2002-2005 SCHS



The greatest opportunity for preventing these deaths is to prevent premature births and promote healthy behaviors among women prior to and between pregnancies.

Teen Pregnancy Rate: The 2004 Wake County teen pregnancy rate for 15- to 19-year-olds (per 1,000) was 43.7, which is down slightly from 44.4 in 2002. A 26% decline in teen pregnancies from 1995-2004 has been realized for Wake County. Also, the county rate of 43.7 is less than the 2004 North Carolina rate of 62.5.

Gaps/Unmet Needs

Despite Wake County's broad array of services, accessibility is limited for numerous reasons. First, there continues to be a lack of broad public knowledge of available services. Service providers are not fully aware of the availability of other services and are often not referring women. Private providers are much less likely to screen applicants for issues such as substance abuse and domestic violence and therefore, do not identify women in need. The Step by Step program, for instance, receives few referrals from private providers yet statistics show that substance abuse knows no economic boundaries.

Some women choose not to use public health services because of perceived stigma. They perceive WCHS as being for "other" types of people when, in reality, the agency offers the most comprehensive services available. Some women may be aware of services, but lack the support or motivation to access them. These women need to be identified, and further, need support to encourage them to use the care. Social support seems to be one of the greatest identified needs among women of childbearing age.

Transportation is another barrier to service accessibility. The City of Raleigh's public transportation system can be difficult to use. Coordinated transportation is available in several rural areas for a nominal fee, but due to demand, services are limited. Medicaid-eligible women have access to free transportation, but some women and providers may be unaware of the availability and/or the timeliness of arranging it.

Language is another barrier. While Latina women have actively sought services, there are limitations due to language barriers or residency status.

Finally, there are limited support services available to fathers. Community-based organizations such as churches and fraternities have strong linkages with men, but are not necessarily addressing their health and social support needs related to pregnancy and parenting. Services focused on pregnant and parenting families are open to working with the male partners of the women but their primary focus is women and children. Unfortunately, many of the organizations that work with men are centered on negative issues such as domestic violence, criminal activities and child support enforcement, and do not offer positive parenting, self-help or prevention programs. There is a major gap in services that promote healthy behaviors in a preventive manner.

Community Perceptions

Approximately 62% of the 2006 Wake County Community Assessment survey respondents indicated that transportation was a concern in Wake County. In addition, 68% responded that affordable heath care also was a concern. This correlates with unmet needs information in maternal and infant health. Also, depression was a concern of approximately 58% of respondents. Additional resources for maternal and postpartum depression are emerging issues for Wake County.

Resources and Strengths

The Wake County community has incredible strengths that can be built upon to promote healthy births. In addition, Wake County's maternal and infant health indicators are better than many other North Carolina counties.

Wake County has multiple agency resources available for families. In addition to major area hospitals, WCHS provides programs for women while pregnant and postpartum and has a comprehensive Public Health Center. Additionally, a strong network of community-based organizations provides informal delivery of services. Numerous churches and community groups serve as resources to assist needy families. Also, private prenatal care providers have become increasingly available for Medicaid eligible prenatal women. Finally, there are multiple educational and support programs available to women who choose to use them. These support services include case management, parenting skills training, child development support, outreach and treatment for substance abusing pregnant women.

Emerging Issues

Several emerging issues in Wake County, along with one long-standing issue, need to be addressed.

The dramatic increase in the Latina population and the related births are significant emerging issues. While Latina women in Wake County, the majority of whom are first generation, are currently experiencing healthy birth outcomes, data from throughout the United States has revealed that second and third generation Latinas usually experience much poorer birth outcomes. There is an opportunity in Wake County to promote the maintenance of healthy birth outcomes among the Latina population in a preventive manner.

The promotion of women's health outside of pregnancy as a means to promote healthy births and reducing infant mortality outcomes is an opportunity for Wake County. Often promoting healthy behaviors during pregnancy is too late to affect the health of the fetus, particularly since many women are unaware of their pregnancy until late in the first trimester.

Maternal and postpartum depression is a concern that affects both mother and infant. Additional identification and treatment resources are needed in the county. (See Women's Health section in this chapter.)

Also, research indicates a link between periodontal disease and preterm deliveries. Findings indicate that women with periodontal disease are more likely to deliver a preterm, low birth weight infant. This information and its continued study is an opportunity for dental and prenatal care professionals to work together for better outcomes.

Finally, the persistent disparity between white/Latina and black/other mortality rates is a significant concern. Wake County must continue to address these disparities and risk factors.

Sources

NC State Center for Health Statistics
Prevent Child Abuse
ADA News March 2006
N.C. Department of Health and Human Services (DHHS) Public Information Office August 2006

Children's Health

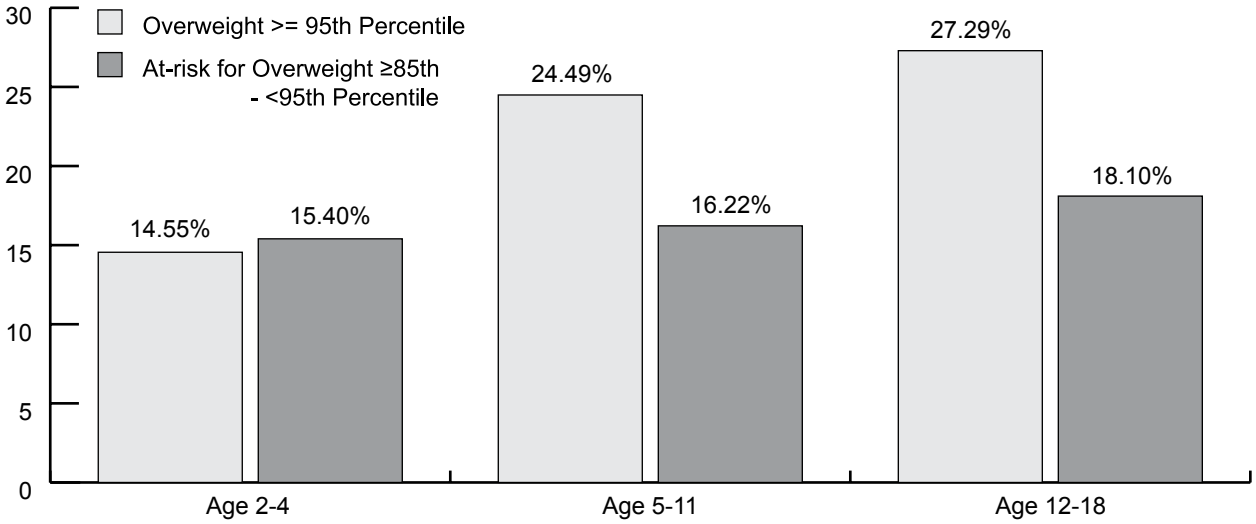
Overweight/At Risk of Overweight

Current State of Affairs

Today the terminology used to describe excessive weight in children and youth has been modified by the Centers for Disease Control and Prevention (CDC). The term "obesity" is no longer used. Instead, the CDC urges use of the terms "overweight" and "at risk of overweight." Both of these terms describe children and adolescents with serious conditions – "excess body weight that could pose medical risks."

The CDC defines "overweight" as those whose weight is equal to or above the 95th percentile for age/gender. "At risk of overweight" refers to those whose weight is greater than or equal to the 85th percentile but less than the 95th percentile for age/gender. According to Dr. Richard Gessner, these children suffer higher rates of medical complications including diabetes, hypertension, abnormal lipid (cholesterol) levels, asthma, gallbladder problems, sleep apnea and orthopedic stressors than do children of healthy weights. *(Source: Richard Gessner, MD, Raleigh Children's and Adolescent Medicine, 2003)* Overweight in childhood is also associated with psychosocial problems. *(Dietz W.H., Health consequences of obesity in youth: childhood predictors of adult disease. Pediatrics 1998).*

BMI-for-Age Percentiles by Age Group NC-NPASS* 2005

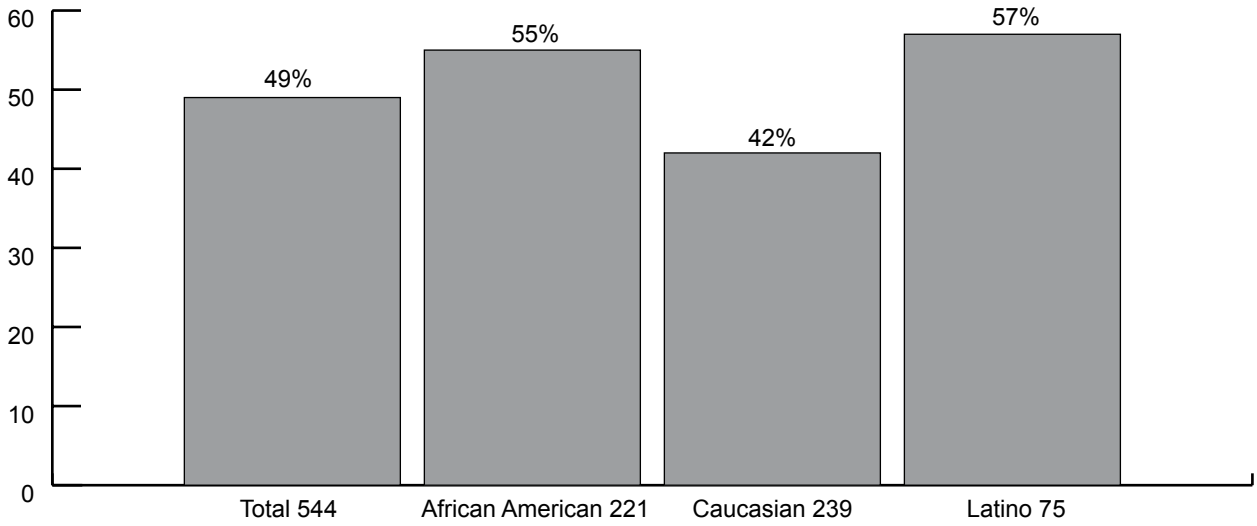


*North Carolina-Nutrition and Physical Activity Surveillance System (NC-NPASS) includes data on children seen in North Carolina Public Health Sponsored WIC and Child Health Clinics and some School Based Health Centers. Percentiles were based on the CDC/NCHS Year 2000 Body Mass Index (BMI) Reference.

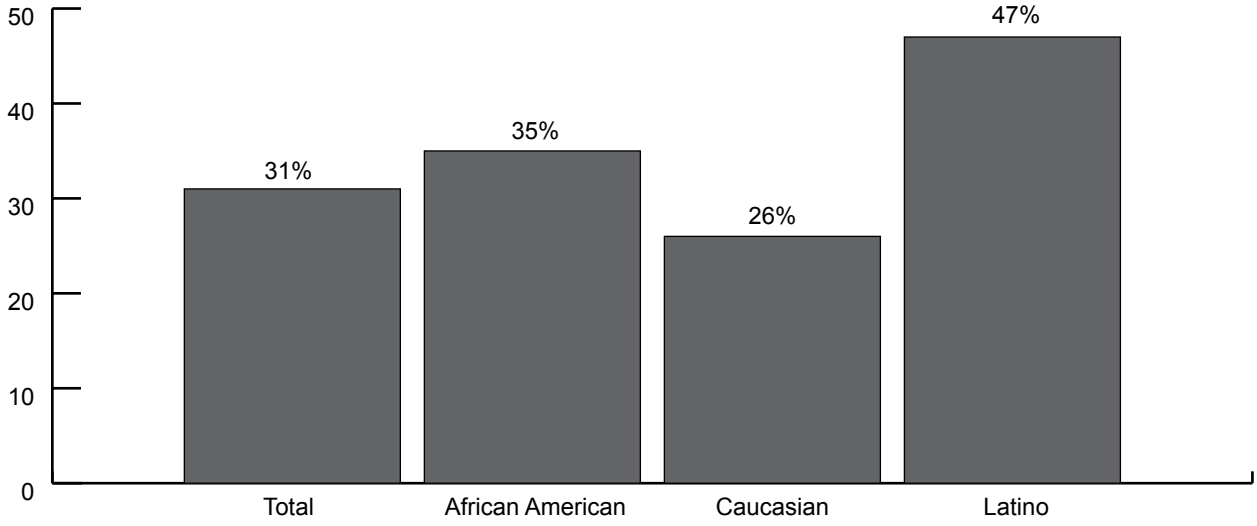
As noted in the chart above, of children seen in North Carolina Women, Infant and Children programs (WIC) and Child Health Clinics in 2005, 29.9% of 2- to 4-year-olds, 40.71% of 5- to 11- year-olds and 45.39% of 12- to 18-year-olds displayed Body Mass Index (BMI) greater than or equal to the 85th percentile. In other words, they were either at risk of overweight or overweight when both categories were combined. Also of note is the significant increase in unhealthy BMI levels with age. *(Source: N.C. Nutrition and Physical Activity Surveillance System, 2005)*

Disturbing rates, as noted in the next two charts, also were seen in exclusive Wake County studies. A 2003 pilot study of 544 Wake County Public School System (WCPSS) third graders revealed that 49% exhibited BMIs greater than or equal to the 85th percentile. A 2004 randomized study of all WCPSS kindergarteners showed that 31% exhibited this unhealthy weight level as well. *(Source: Wake County Human Services – Health Promotion and Chronic Disease Prevention Program)*

Third Grade
BMI Pilot Study BMIs ≥ 85th Percentile By Ethnicity WCHS 2003



Kindergarten
BMI Study BMIs ≥ 85th Percentile By Ethnicity WCHS 2004

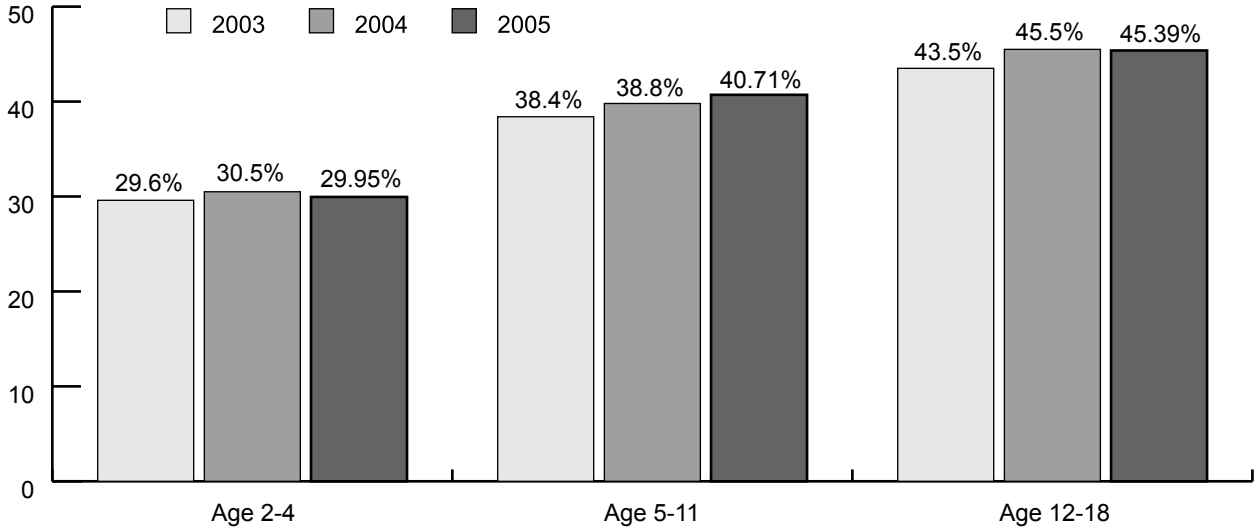


This randomized survey represents 8,702 WCPSS kindergarteners

Trends

As noted in the chart below, percent changes from 2003 to 2005 in BMI levels of children and youth seen in Wake County WIC and public health clinics are mixed. The percentage of children ages 2 to 4 years who displayed excessive BMI levels declined slightly from 30.5% to 29.95%. In 5- to 11-year-olds, this proportion increased from 39.8% to 40.71% and adolescents 12 to 18 years showed almost no change at 45.5% to 45.39%. All levels remain unacceptable.

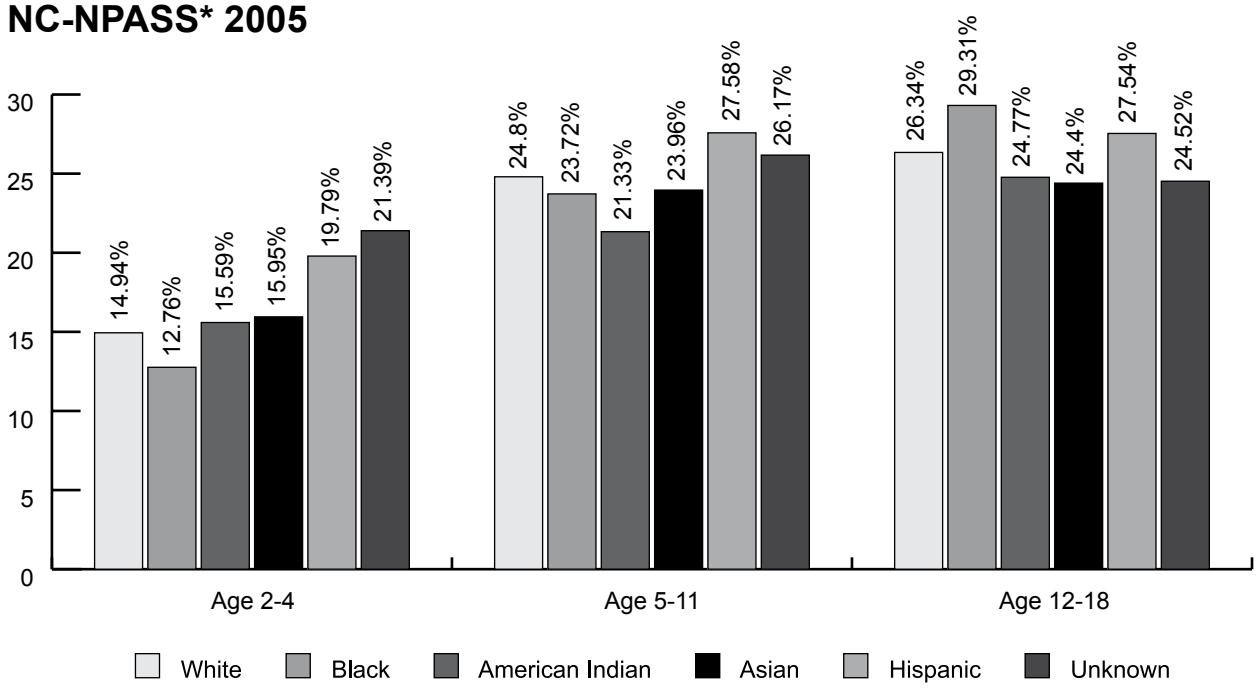
Proportion of Children ≥85th Percentile by Age Group NC-NPASS* 2003 to 2005



*North Carolina-Nutrition and Physical Activity Surveillance System (NC-NPASS) includes data on children seen in North Carolina Public Health Sponsored WIC and Child Health Clinics and some School Based Health Centers. Percentiles were based on the CDC/NCHS Year 2000 Body Mass Index (BMI) Reference.

Overweight children are more likely to be obese as adults. *(Serdula M.K., et.al. Do obese children become obese adults? A review of the literature. Prev Med. 1993)* According to the 2003 N.C. Healthy Weight Initiative, 60% of overweight children, 5 to 10 years, have at least one cardiovascular risk factor such as high cholesterol, elevated blood pressure or increased insulin levels, a symptom of type 2 diabetes. Also alarming is the number of children who are developing type 2 diabetes, historically seen in adults. According to the Academy of Pediatrics, in 1990 fewer than 4% of U.S. children exhibited this condition but by 2000, the percentage of children with type 2 diabetes had risen to an average of 20%. In those ages 10 to 19, depending on ethnicity, this varied up to 45%. The CDC estimates that one-third of U.S. children who were born in 2000 will develop diabetes, many as a result of excessive BMI levels. And "because of overweight, our current teen generation may be the first in the nation's history to have a shorter life expectancy than its parents." *(CBS News, Dr.Robert Suskind, Finch University, Chicago Medical School, 2002)*

Proportion of Overweight by Age, Race and Hispanicity NC-NPASS* 2005



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Disparities, Gaps, Unmet Needs

According to a 2006 report from N.C. Public Health State Center for Health Statistics, children in North Carolina who received well child care and other services from public health department clinics were substantially more likely to be overweight than children in a representative national sample. Since public health departments play an important role in health care delivery to high-risk populations, these departments can be an important health care resource for addressing childhood overweight. (SCHS, Study 151, August 2006)

The same report suggests that overweight adolescents are not getting adequate guidance at health visits. It recommends that efforts be made to assure that public health departments provide screening and counseling to low-income adolescents who are overweight. Among African-American adolescents, consideration should also be given to transportation problems that contribute to the lack of use of health care services, lack of culturally appropriate health services and shortages of those who accept Medicaid. (SCHS, Study 151, August 2006)

Wake County Human Services currently has one full-time equivalent nutritionist position dedicated to serving adolescents and women. However, there is no such service to address overweight in children above 5 years of age.

Community Perceptions

In the 2006 Wake County Community Assessment survey, 71% of respondents listed overweight in children as a moderate to serious problem. In rankings of 106 health, social, economic, environmental and safety problems faced by Wake County residents, childhood overweight was ranked fifth. Among efforts to successfully address health care in the county, 46% of focus groups identified health promotion programs and 32% identified physical activity in the schools.

Resources and Strengths

A number of interventions addressing the overweight problem in children and youth have been implemented in the county and state.

- WCPSS, in response to a federal mandate required for participation in the National School Breakfast and Lunch Program, recently created a local wellness policy. The policy promotes the use of high nutritional value foods for student rewards and functions. In addition, the WCPSS - Child Nutrition Services Program (CNS) promotes fruits, vegetables, whole grains and low fat milk for students.
- In 2006, North Carolina enacted nutrition standards for elementary school meals, cafeteria a la carte items, beverages, and after-school program snacks. These standards limit the offering of foods high in fat, saturated fat, trans fat and sugar. In another 2006 effort, the N.C. Department of Public Instruction and the N.C. Beverage Association mutually agreed to recommend healthier beverages in all schools.
- To promote increased physical activity for children, the N.C. State Board of Education passed the Healthy Active Children Policy in 2003 with revisions in 2005. This directs local school districts to require kindergarten through middle school students participate in regular physical activity a minimum of 150 minutes per week for elementary students and 225 minutes for middle schoolers averaging 30 minutes daily. WCPSS has successfully implemented this policy and others. "Drive to Fitness" is a program that engages students in increasing physical activity at home, reducing TV and computer time and improving nutritional habits. Middle and high schools in Wake County continue their transition from a sports-based program to a fitness-directed approach. High school students are required to take one credit of Healthful Living to graduate. High school electives provide opportunities for students to continue their health and fitness endeavors as a lifestyle choice. Fee-based health education programs are available at local hospitals and the Alice Aycock Poe Health Education Center.
- In both 2004 and 2005, Wake County Human Services held summits for community leaders to talk about ways to combat the overweight epidemic.
- WCHS's Child Care Health Consultants, who are also registered nurses, provide ongoing technical consultations to child care centers on all issues of health, including improvements needed in nutrition and physical activity practices. In 2005-06, these nurses provided services to 434 Wake County childcare facilities, reaching 17,000 children. In a related program called NAP-SACC (Nutrition and Physical Activity Self-Assessment for Child Care), this team worked with eight childcare facilities, reaching approximately 700 children. Through this program, these childcare facilities identified needs and made improvements in nutrition practices and physical activity for the children served.
- The Health Promotion and Chronic Disease Prevention Program of WCHS, in partnership with N.C. State University Recreation Resources, developed and distributed 500 informational CD-ROMs called "Healthy Activities for Wake County Youth" to area pediatricians. These CDs contain searchable databases that include over 1,100 non-competitive, physical activities offered by county and municipal parks and recreation departments.
- As of March 2006, the WCHS Special Supplemental Nutrition Program for WIC had a caseload of 15,205 participants (women, infants and children less than five years old). The estimated at-risk population in 2003 was 14,977. In addition to healthy food packages, WIC provides education to address nutrition and healthy weight issues for all participants (prenatal and postpartum women, infants and children up to the age of five years), including encouragement of breastfeeding. By July of 2007, the WIC Program plans to launch "Ready to Change," an initiative to provide more intensive prevention and intervention efforts to address overweight and obesity in all ages of clients served.

- Wake County's Cooperative Extension Program provides a variety of programs and materials for children and youth. These include: 1) *SyberShop,* a CD-ROM for children ages 13-19 which focuses on physical activity and healthy eating; 2) *Color Me Healthy*, a program for limited resource children ages four and five which provides interactive learning opportunities on physical activity and healthy eating; and 3) The *Expanded Food and Nutrition Education Program (EFNEP)*, a program designed to assist limited resource audiences in acquiring the knowledge, skills and behaviors necessary to secure nutritional well-being. The *4-H EFNEP* youth component, in partnership with Boys and Girls Clubs, WCPSS and Parks and Recreation Departments across the county, encourages positive dietary and physical activity changes for those ages 5 - 19 through hands-on, interactive experiences.
- Wake County continues to promote its many parks, greenways and open space. Pedestrian frienldy communities are being encouraged in new housing developments. For more information on these resources, refer to the Environmental Health chapter.

Emerging Issues

Obesity-related hospital costs for 6- to 17-year-old adolescents increased more than threefold from $35 million in 1979 to $127 million by 1999 as valued in 2001 dollars. As overweight children become overweight adults, diseases associated with obesity and health care costs are likely to increase even more. *(Wang G. and Deitz WH, Economic Burden of Obesity in Youths Aged 6 to 17 Years 1979 - 1999)*

The Adolescent Pregnancy Prevention Coalition of North Carolina recommends defining an excessive weight condition as a disease and ensuring third party coverage for prevention and treatment services for children and adolescents who are overweight or at risk of being overweight.

In the prevention of overweight in children, greater national emphasis is being placed on the WIC program. This is due to the large percentage of the nation's infants, approximately 50%, and children, approximately 33%, it serves. For the Wake County WIC program, over the past five years, there has been a 46% increase in Hispanic participation. As a result of cultural changes, significant modifications in the WIC food packages are expected to incorporate more ethnic preferences.

Diabetes is becoming more prevalent among overweight children, particularly African-American, Hispanic and Native Americans – populations traditionally lacking in healthcare coverage and/or access to health care. In response, WakeMed has established a pediatric diabetes program, which provides medical diabetes management for children ages 3 - 18 who have been diagnosed with either type 1 or type 2 diabetes. A 12-week program called *"Energize!"* teaches young people (6 – 18 years) how to build lifelong, healthy attitudes about food and fitness. To bridge the language barrier, a Spanish interpreter is available. In order to participate, each child/youth must be referred by his/her medical provider. WakeMed has found that children who are eligible for the program often fail to participate because they are not able to get medical referrals. To combat this problem, WakeMed is exploring ways to collaborate with community partners to provide these children with potentially life-saving assessments, referrals and interventions. (Source: WakeMed Pediatric Diabetes Program, 2006)

Although numerous efforts to promote good nutrition and physical activity are being made by local agencies, schools and child care providers, parents are ultimately responsible for their own health behaviors and examples they set for their children. Parental decisions in the grocery store, kitchen and dinner table (home or otherwise) strongly influence behaviors of their children. By example, parents set the standard for their children's food/beverage preferences, portion sizes and sedentary or active lifestyle behaviors.

Asthma

Current State of Affairs

Asthma is a leading chronic disease that affects children and is the most common long-term disease of children. It is a disease where airways of the lungs become inflamed and constricted causing repeated episodes of wheezing, breathlessness, chest tightness, and nighttime or early morning coughing. Why asthma develops and how to cure it is not known, although family history is thought to contribute to susceptibility.

Asthma may be controlled by knowing the warning signs of an attack, avoiding things that trigger an attack, and following current medical advice. When asthma is controlled there are fewer attacks and fewer subsequent symptoms that impact the child's sleep, school attendance, physical activity and hospital visits. Those with asthma and their caretakers must learn their particular "asthma triggers" and avoid them when possible. Asthma triggers and factors affecting the disease include: environmental tobacco smoke (also known as secondhand smoke), dust mites, and outdoor air pollution from industrial emissions and automobile exhaust.

In 2004, the Triangle area joined the U.S. EPA's list as a non-attainment area for ozone, a form of air pollution. Other triggers include cockroach allergen, pets, mold, strenuous physical exercise and adverse weather conditions including freezing temperature, high humidity and thunderstorms. Some foods, food additives and drugs also may be triggers. Strong emotional states also can lead to hyperventilation and an asthma episode. Source: www.cdc.gov/asthma/faqs.htm#attack

In Wake County, the Asthma Coalition studied this illness in relation to demographics and identified factors that may trigger asthma attacks. One factor was housing, including older homes with more likelihood of harboring insects, mold, dust mites and rodent allergens. Other factors included impacts from the environment, such as excavation and construction of new housing and businesses, traffic pollution and tobacco smoke.

Nationally in 2003, asthma accounted for an estimated 12.8 million lost school days in children. It is the leading cause of school absenteeism attributed to chronic conditions. *(National Center for Health Statistics. raw data from the National Health Interview Survey, U.S., 2003.)*

According to the North Carolina American Lung Association, more than 170,000 N.C. children have been diagnosed with asthma. Other related information includes:

- N.C. children with asthma miss 3.7 more days of school per year than non-asthmatics.
- Asthma affects an estimated 6.2 million children under 18 years; 4 million suffered from an asthma attack or episode in 2003.
- Asthma can be a life-threatening disease if not properly managed. In 2002, over 4,000 deaths were attributed to asthma.
- Fortunately, deaths due to asthma are rare among children and rates increase with age. In 2002, 170 children under 15 died from asthma compared to 675 adults over 85.
- Asthma is the third leading cause of hospitalization among children under the age of 15. In 2002, 641,242 emergency room visits were due to asthma in those under 15.
- Within the last few years, mortality and hospitalizations due to asthma have decreased and asthma prevalence has stabilized, possibly indicating a higher level of disease management.
- Asthma is 26% more prevalent in African-American children than in white children.

Source: N.C. American Lung Association- http://www.lungnc.org/medical-info/asthma.php

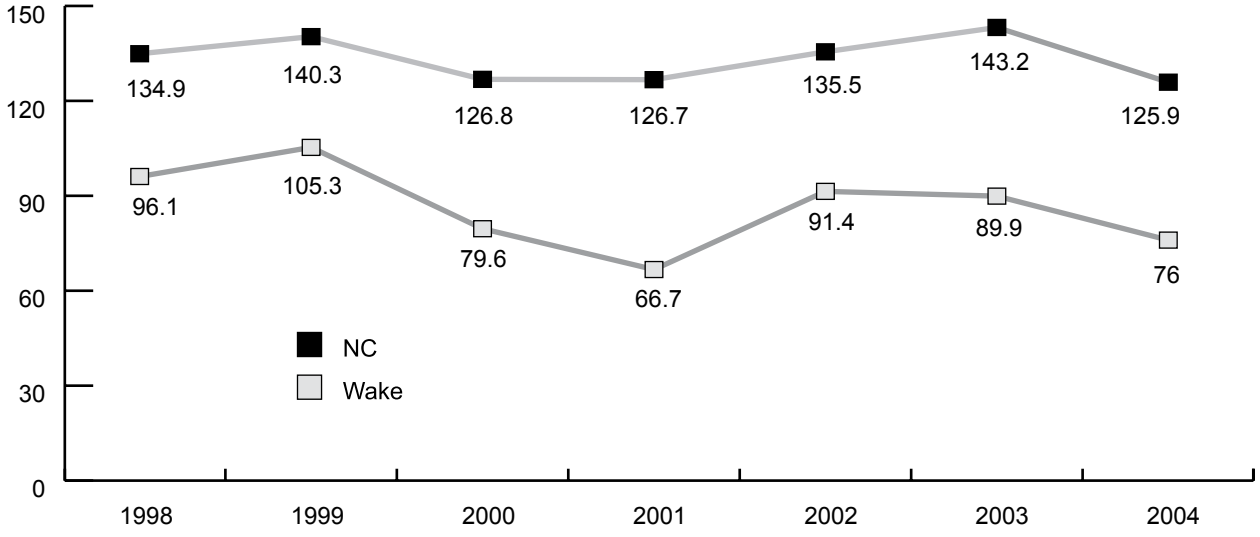
The Hospital Emergency Department rate of asthma cases continues to be high in Wake County compared to other areas in the state. The asthma case count is determined by the number of cases identified through Hospital Emergency Department Information Systems (HEDIS). These measures are strict and potentially undercount those served. As of September 2005, Johnston County was included with Wake County in the database of 50,000. However, Wake County cases contributed 80% of the data. There is seasonal variation, but after comparison with the same quarter in subsequent years, the count is trending downward. Yet the numbers still reflect the highest in the state. In 2002, estimated numbers of pediatric asthma cases of children under 18 in Wake County was 14,442. As of December 2005, the asthma case count was approximately 12,000.

Trends, Gaps, Unmet Needs

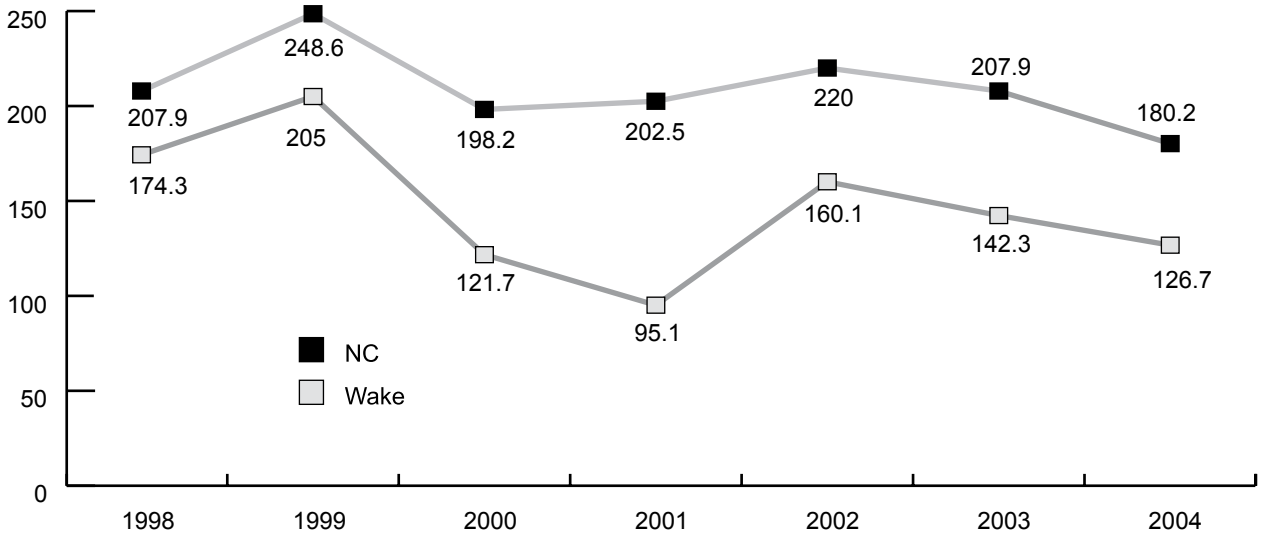
Traditionally the Southeast Raleigh 27610 Zip Code area has had the highest numbers of pediatric hospital discharges (ages 1-17) for asthma in all of Wake County with 188 and 156 discharges, respectively. These have included hospitalizations with either a primary or secondary diagnosis of asthma. Suspected as contributing to the asthma problem for this area were the location (a light, industrial area of the inner city), the relatively poor socioeconomic level, the housing conditions (older units built 40 - 50 years age), and the predominantly African-American composition of the population.

2004 State Center for Health Statistics (SCHS) data for Wake County indicates that 550 individuals were hospitalized with asthma. Of that, 36% (200) were 0 to 14 years of age. In 2005, asthma was the number one pediatric diagnosis at WakeMed. As seen in the tables below, for Wake County and North Carolina, the incidence of being hospitalized for asthma has remained consistent. Reaching the Hispanic population with asthma education is also of concern. The language barrier is accentuated given the lack of available Spanish interpreters and translated materials.

Asthma Hospitalization Rates Per 100,000 All Ages SCHS



Asthma Hospitalization Rates Per 100,000 Ages 0-14 SCHS



There are increasing demands to meet student health care needs in schools. A legislative bill was passed in the 2005-2006 General Session *(See Chapter 115C, Article 26A of the General Statutes)* which allowed students to self-administer emergency asthma and anaphylaxis medication. There are increasing numbers of students with inhalers in the public school system. Data from the WCHS school-based public health nurses regarding chronic disease has severe limitations and represents numerous scenarios. These include students with severe asthma, students that have health care resources with inhalers and nebulizers (devices used to administer medication in mist form to open airways), students that visit the nurse on the day she is at that school and parents or teachers who refer students because of health concerns. Students with well-controlled mild, moderate or even severe asthma may not have contact with the school nurse and may not be included in these numbers. Nurses serving two to three schools have limited time and resources for case finding and underreport the case count. There is a need for comprehensive data collection methods to track the number of children with asthma in the county.

Though there was an 18% increase in the use of inhalers in the schools from 2004-05 to 2005-06 (which is greater than the percent increase in population), additional factors could have influenced this number. Students being allowed to self medicate with inhalers in the public school setting and the new asthma legislation may have increased staff awareness to identify and refer students or students may have self reported more often.

The 2002-2003 school year saw a significant increase, 13%, in the use of nebulizer treatments in the schools. Since then the increase in nebulizers for treatment of asthma in schools is not significantly different than the school population growth. There was more of an increase in the use of nebulizers in the 2002-2004 school year. In the last several years the use of nebulizers for treatment of asthma has increased in proportion to the rate of new students.

Data from WCHS school-based nursing program reveal:

- More males have asthma than females.
- More African-Americans have asthma than Caucasian, Hispanic and other races.
- More families with asthmatic children have commercial insurance vs. Medicaid or self-pay status.
- At the completion of one year, participants showed a significant decrease in missed school days, acute doctor visits, oral steroid use, emergency visits and hospital admissions due to asthma.

These findings underscore the need for health-care providers, schools, families, and public health practitioners to be prepared to respond to asthma-related emergencies and to help students manage their asthma.

Community Perceptions

In 2006 Wake County Community Assessment surveys, 42.9% of respondents listed childhood asthma as a moderate to serious problem. The asthma triggers of cigarette smoking and air pollution were listed as moderate to serious problems by 60.9% and 59.9% of survey respondents, respectively. In regard to major health problems faced by Wake residents, 36% of focus groups listed environmental health, including poor air quality, an asthma trigger. When asked the causes of environmental health problems, 43% of focus groups reported lifestyles, including smoking, an asthma trigger.

Resources and Strengths

Asthma has a substantial impact on North Carolinians' health, quality of life and the economy. In June of 2000, WakeMed's Pediatric Asthma Program was organized, based on the management and treatment recommendations as published by the National Institute of Health. The enrollment of children 5-11 years of age into a 6-month education program started. Since that time, the program has expanded to include children ages 3-17. Using a case management approach, these families are followed for one year. During that year, the family attends a family group education session, and the asthmatic child has pulmonary function testing preformed once each season. The benefit of allergy skin testing is assessed and discussed with the families. Since the beginning of this program, the average annual enrollment has been 245 children per year, with a total enrollment of 867 children. Since the inception of WCHS Wee Wheezer program (children ages 3 and 4) in 2004, 75 children have enrolled. Referrals to the pediatric asthma program come from school nurses, parents and primary care providers.

School-based public health nurses from WCHS work with students, families and the primary health providers to develop asthma care plans and train school staff in care for asthmatic children. These nurses coordinate programs with Rex Hospital and WakeMed to provide programming for improvement of asthma outcomes. Some of the resources available include:

- The Rex Asthma Program has an asthma educational presentation for elementary school age children and is expanding to serve the middle school age group.
- The Asthma Coalition has gathered Wake County data and identified a high need area, that of providing education and training to health care providers in the county.
- Community Care Resource Management provides chronic disease management for asthma.
- The American Lung Association has resources including: "Open Airways" for asthma education and "not" for smoking prevention.
- CDC Asthma Control Programs and activities are available.
- Availability and access to durable medical equipment has improved. Nebulizers have become more compact and portable. Each public school has a nebulizer available as part of a grant through Rex Hospital Asthma Program. These provide students easy access and save families from having to purchase an additional one for school. Nebulizers are also available at emergency shelters.
- Recognition of asthma as a chronic health condition in children, by multiple public and private agencies, area hospitals, schools and the Asthma Coalition, has promoted partnering work toward health improvement for children.
- Hospitals and pediatricians are providing resources, including Peak Flow Meters, to support and educate families in regard to on-going asthma management.
- School campuses are smoke free.
- Project ASSIST is promoting smoke free restaurants.

Emerging Issues

Pediatric asthma continues to be an issue in Wake County. A primary prevention strategy for asthma does not exist, but asthma can be controlled. Schools can help improve asthma management among students whose asthma is not well controlled by providing health services, education and control of environmental triggers. Centers for Disease Control and Prevention (CDC), other federal agencies, the National Asthma Education and Prevention Program, and national nongovernmental organizations have developed resources to support asthma management activities at schools. The CDC's *Strategies for Addressing Asthma Within a Coordinated School Health Program* recommends research-based activities for schools to help students manage their asthma. These include obtaining a written asthma action plan for all students with asthma; ensuring that those with asthma receive education on asthma basics, asthma management, and emergency response and prohibiting tobacco use at all times among students, staff, and visitors to schools. Students, families, schools and health-care and public health practitioners working together can improve asthma management among students.

There continues to exist a variety of treatment options and opinions regarding asthma care and concerning diagnosis, acute treatment and long-term management/control. Indoor and outdoor air quality is an ongoing concern. Poor indoor air quality is frequently encountered in the home, in school and university buildings, as well as in the work place.

Asthma research continues in its relationship to allergies, genetic factors with possible links to a specific gene, immunology development and environmental factors.

Dental Health

Current State of Affairs

Dental decay is the most common chronic condition of childhood. Each year in Wake County, screenings are conducted in elementary schools and preschools. In the 2005-06 school year, more than 11,000 kindergarten, second grade and special class students in Title I schools were screened. Of these, 14%, or 1,515, had pain/infection and/or obvious untreated dental decay. An additional 8% of the students had questionable areas that were most likely decay. These numbers are very conservative since only decay that has progressed enough to create an obvious hole in the tooth can be detected during a screening with a tongue blade and flashlight.

Screenings in More at Four classrooms in Wake County Public Schools indicated that 14% of the students had pain/infection and/or obvious untreated dental disease. An additional 11% had questionable areas. One Head Start center screening identified 17% with obvious untreated disease and 18% with questionable areas. For children ages 0 to 35 months who were screened as part of Wake County Human Services Preventive Dental Visits, 14% had obvious untreated disease and another 11% had questionable areas of decay.

The 2003-2004 Statewide Dental Survey of North Carolina School Children found that approximately 31% of elementary schoolchildren have untreated decay in primary teeth and 13% in permanent teeth. The disease is concentrated in a small group of these children. Twenty percent have 90% of the untreated decay in primary teeth and 10% have 90% of the untreated decay in permanent teeth. As stated in the North Carolina medical journal, *Access to Dental Care,* November/December 2005, "Less than one in every five children enrolled in Medicaid uses preventive services in a given year." According to *Oral Health in America: A Report of the Surgeon General*, by age 17 years, 78% of children have experienced tooth decay.

Dental care is costly and for the majority of citizens, it is an out-of-pocket expense that those of low income cannot afford. Dental disease is not self-limiting and cannot be cured with a short course of antibiotics. If left untreated, it becomes more serious, painful, and even life threatening. Children affected with dental disease cannot perform as well in school as their healthy counterparts. They have difficulty eating and may have low self-esteem from the appearance of their decayed teeth.

Trends, Gaps, Unmet Needs

There are five times more untreated dental caries (the disease process leading to tooth decay) in children from low-income families than those from higher income. According to Healthy Carolinians, the determinants/risks for dental disease are low socio-economic status, lack of access to dental care, lack of education on the importance of oral health and a diet high in sugar.

According to the 2003-2004 Statewide Dental Survey of N.C. School Children, there were disparities in oral health by race and ethnicity. Latino children had the highest rates of tooth decay compared to whites and African-Americans, with white children experiencing the lowest rate of decay. The state survey found that decay rates for children whose parents have less than a high school education increased between 1987 and 2004.

In the last five years Wake County has seen tremendous growth in its Latino population. In the WCHS Dental Clinic, the number of Latino patients served has increased from 39% of the patient population in 2000/2001 to 68% in 2005/2006. There are tremendous dental needs seen in this population accessing care in the dental clinic and services are more complicated to provide because of the need for interpreter support. The immigrant population is also less likely to be eligible for Medicaid and Health Choice, which limit options for accessing services in the community if they do not have the resources to pay out of pocket. The WCHS clinic patients are 35% Medicaid, 8% Health Choice and 57% uninsured.

Community Perceptions

The 2003-2004 Statewide Dental Survey of N.C. School Children reported, "Depending on race and ethnicity, 21-36% of parents wanted dental care for their children but were unable to get it." Many of the parents indicated that their children needed treatment.

In the Wake County 2006 Community Assessment, 42.1% of survey respondents identified dental problems as serious to moderate with 36.4% reporting dental care as a serious to moderate problem.

Resources and Strengths

Wake County has well over 450 dentists with 24 practices agreeing to accept some Medicaid referrals. Of those practices accepting Medicaid patients, over half of them are not able to accommodate Spanish-speaking patients and many do not treat very young children. There is the need in Wake County as across the state to identify a dental home for children by age one for those determined to be at risk for dental caries, as recommended by the American Academy of Pediatrics. With North Carolina ranking 47th of the 50 states for dentist-to-population ratio there is limited access for those without personal resources for care.

There are several Safety Net Clinics in Wake County, which include Wake County Human Services Dental Clinic, New Bern Ridge Dental Center (NBRDC) that is affiliated with a Community Health Center, and Wake Smiles, a free clinic staffed by volunteer dentists. WCHS and NBRDC accept Medicaid and Health Choice, and bill uninsured patients on a sliding fee scale based on their ability to pay.

Water fluoridation continues to be the most significant dental therapy available. It has a 60-year history of safety in the United States and is responsible for approximately 30% reduction in caries in both primary and permanent dentitions. In 2006, approximately 79% of Wake County's population was receiving optimally fluoridated water. It is estimated that 21% of the population whose water source is a well or private community supply are not receiving optimal fluoridation. This is a 1% change from that reported in 2000, but represents a greater number of individuals without optimum fluoridation due to the population growth in Wake County.

Study results reported in the American Dental Association (ADA) News in May 2005 support children accessing care with a dentist by age one and the use of fluoride varnish to prevent dental caries in these very young children. In North Carolina Medicaid initiated reimbursement to physicians to address the preventive needs of these young children at risk for dental disease. The physician or their designated staff provides a screening, parent education and a fluoride varnish treatment at regular intervals for children up to age three with the expectation that by that age they will be established with a dental home.

Emerging Issues

Fluoride treatments, sealants, and good oral hygiene practices are proven therapies for the prevention of dental disease and reduce the need for fillings and tooth removal. It is critical to maintain programs that emphasize prevention of dental disease in improving the health of Wake County's children. It is also critical to address the disparities in access to care and level of dental disease for minority children.

Access to Health Care

Current State of Affairs

According to U.S. Census Data, more than 14% of Raleigh children live in poverty. In rural areas of Wake County, poverty is also pervasive and is complicated by lack of transportation to medical care. Racial disparities between whites and African-Americans are striking. In Wake County, 3% of white children live in poverty, in contrast to 20% of African-American children. Access to health insurance is linked to poverty. Many residents in the county are employed or live with persons who are employed, but cannot afford health insurance and do not qualify for Medicaid.

In 2004, 9.1% of Wake County children were uninsured in comparison to 11.2% across the state. Having health insurance coverage greatly increases opportunities for healthy outcomes. Children with insurance are better able to access preventive care, resulting in fewer illness-related days of absence from school and fewer and shorter hospital stays.

In Wake County, 35,318 children currently are eligible for Carolina Access (CA) Medicaid. Of these children, 93% (32, 892) are enrolled in Carolina Access and have been assigned a Primary Medical Care Home. Of the children who are enrolled in Carolina Access, 94% (~31,000) are a part of the Community Care of Wake/Johnston counties network. Community Care is an enhanced program for patients with CA Medicaid that focuses on access to care, care management and quality improvement. *(Source: NC Division of Medical Assistance)*

Even though a high percentage of Medicaid eligible children are enrolled and assigned to a medical home, there is evidence of an access to care problems in Wake County. One reason for this is the lack of Spanish-speaking capacity in the community. Wake County has one of the most rapidly growing Latino populations in the nation.

According to the N.C. State Division of Medical Assistance/Managed Care, every Medicaid health care provider is required to have Spanish-speaking capability. This could mean anything from bilingual staff to a shared interpreter among providers or use of a Spanish interpreter phone line. The vast majority of Spanish-speaking families with children covered by Medicaid seek services at Wake County Human Services (WCHS) and to a lesser extent, WakeMed. According to preliminary partial results of a survey of Wake County providers of pediatric care, approximately 80% of the pediatric patients receiving care at the clinics at WCHS are Spanish-speaking, but only an average of 8% of the patients receiving care in the five private practices that have responded to the survey, so far, are Spanish-speaking. In an initial survey of 17 practices in Wake and Johnston counties to assess their receptivity to and capacity for caring for Spanish-speaking patients, 11 practices had at least one functionally fluent staff member. Sixteen of the 17 practices expressed willingness to increase capacity to serve Spanish-speaking clients, but 13 reported they would need more resources and support to do so.

The WCHS Division of Economic Self-Sufficiency reports that its staff has taken an active role in educating Spanish-speaking families about Spanish-speaking pediatric care options in the community, in addition to WCHS and WMC, at the time that the families apply and are deemed eligible for Medicaid.

Trends, Gaps, Unmet Needs

The relatively high Wake County rate of hospital emergency department visits compared to the state average indicates limited access to a primary medical care home. In 2005 the average emergency department rate for Wake County children covered by Carolina Access (CA) Medicaid was 54/1,000 member months, compared to the statewide average of 49/1,000 member months. Member months refers to the product of the number of members in an insurance program multiplied by their months of available insurance coverage. A standard of 1,000 member months is used as the denominator in calculating (and thus comparing) medical use rates.

According to Action for Children North Carolina, in 2004, 9.1% of Wake County children were uninsured, which was a decrease from 10.1% in 1999. The percent of uninsured children across North Carolina decreased from 13.9% to 11.2% during that time.

Health Indicator		Current Year	Benchmark Year	% Change
		2004	2000	
Health Choice Enrollment (December; Ages 0-18)	Wake State	7,558 121,836	3,435 70,636	120.0% 72.5%
		2004	2000	
Medicaid Enrollment (December; Ages 0-18)	Wake State	36,907 674,963	28,689 559,025	28.6% 20.7%
		2004	1999	
Children Without Health Insurance (Percentage; Ages 0-17)	Wake State	9.1% 11.1%	10.1% 13.9%	-9.9% -20.1%

From: "Trends in Wake County Children's Health" prepared by John Rex Endowment and NC Child Advocacy Institute

In January 2006, all children birth to age 5 who were eligible for North Carolina Health Choice were transferred to Medicaid coverage. This new rule has continued to improve access to care by freeing capacity in Health Choice for older children.

Community Perceptions

In response to the 2006 Wake County Community Assessment focus group question, "What prevents you from being healthy?" 61% of focus group participants reported lack of services or limited access to services. In response to the question, "What are the causes of (your) major health problems?" 57% reported lack of access or lack of services and 39% reported lack of knowledge/information.

The Wake County 2006 Community Assessment surveys revealed that 68.1% of respondents considered affordable health care to be a moderate to serious problem. Also considered as moderate to serious, 47.4 % listed health care, 43.4% listed transportation to health care and 39.3% listed providers who accept Medicaid.

Resources and Strengths

Providers of preventive and acute care to uninsured Wake County children include Wake County Human Services Clinics, Wake Health Services and WakeMed. According to Wake County Human Services Division of Economic Self-Sufficiency, 168 practices serve Wake County Medicaid recipients. However, approximately 60 practices have restrictions on accepting new patients. This limits options for families with multiple children.

Most Wake County resources for health care to uninsured children are overextended. Project Access is a program of the Wake County Medical Society that is committed to improving the health of uninsured children in Wake County. The program coordinates access to subspecialty care, diagnostic testing, hospitalization and medication assistance to children who qualify based on household income. Over the past two years, 170 children have received specialty care and/or medication assistance through the Project Access program. These children are typically non-citizen children, with 90% representing the Latino community.

There are four acute care hospitals in Wake County including WakeMed Raleigh Campus, WakeMed Cary, Rex Hospital and Duke Health Raleigh Hospital. WakeMed has been the primary provider of indigent care for many years. In 1997 the county-owned public hospital was converted to private nonprofit. The North Carolina Fair Share Wake County Chapter and its allies successfully advocated to ensure that the hospital maintain the $43 million dollars allocated annually to indigent care.

Assistance with transportation to medical appointments is available for children who have Medicaid; there is limited access for non-Medicaid children. Wake Coordinated Transportation Services (WCTS) is a transportation resource that offers transportation for clients of WCHS. Eligibility is based on sponsorship by participating programs such as Medicaid, Maternal Child Health programs, Mental Health, Work First and other WCHS programs. Through the WCTS TRACS Program, general public transportation is available five days per week to residents of the county residing in the rural areas of Wake County at a nominal charge per person, per trip.

The WCHS Child Service Coordination Program (CSCP) is a home visiting program for children, birth to five, designed to identify as early as possible children who have physical, mental and/or social conditions that place them at high risk for developmental delays. A nurse or social worker provides assistance to families by linking them to resources in the community and helping families identify and overcome barriers to accessing those resources. The program then provides interventions to maximize their developmental improvements. One goal is to improve access to services by linking families to resources in the community and by helping families identify and overcome barriers to accessing those resources. In fiscal 2006, the program served 2,350 children. Over the past three years the number of children on the waiting list for CSCP services has varied from 175 to 250.

Emerging Issues

The hospital emergency department is the most expensive place to seek care for non-emergency reasons. Based on Medicaid paid claims, the average cost to Medicaid for a child with non-emergency visits to emergency departments in Wake County is approximately $500 per visit, whereas the average cost to Medicaid for a clinic visit to the child health clinic at WCHS is approximately $110. In 2004, the annual total cost to Medicaid for non-emergency visits by Wake County Carolina Access Medicaid children was $2.4 million and the annual total cost for all ED visits was approximately $5,639,502. The county pays 5% of these costs. For 2004, the average rate of asthma-related emergency department visits for Wake County CA recipients who are a part of Community Care was 28.8 visits per 1,000 member months. For 2005 the rate was 21.5 visits per 1,000 member months. These rates are about double the statewide rate of asthma-related ED visits for CA recipients who were part of Community Care. While the Wake County asthma-related ED rates have been decreasing (down 25% from 2004 to 2005, due to the efforts of Community Care, it is hoped) they are still significantly above the statewide rate. Again, this probably reflects, among other things, the lack of timely access to primary care.

In an effort to reduce improper use of emergency rooms, the Wake County Health Check staff initiates follow-up with families who have used them for non-emergency conditions. The Health Check coordinator educates the family about other options for non-emergency care. These include calling the advice line or requesting that Health Check assign them to another provider's practice for the current need, if they are unable to get an appointment within a short period of time.

The issue of limited access to care by Latino, Spanish-speaking families is a pressing problem. Community Care of Wake/Johnston Counties is leading a coalition that is in the process of applying for grant assistance to increase the linguistic and cultural competency of community providers in order to expand access to care for children in Wake County.

Access to subspecialist care remains a critical issue in health care access. Currently, Project Access helps coordinate access to subspecialists in Wake County, but there is much more demand than there are volunteer physicians to fill it. Patients can be sent to Wake Faculty Physicians or the University of North Carolina for some subspecialist care. Both programs will work with the patient to provide discounted fees based on income and need.

Adult Health

Chronic Disease / Health Promotion

Current State of Affairs

According to the CDC, the burden placed on society by obesity and related chronic diseases is enormous. In 2003, the N.C. State Health Director reported that overweight people in the state accounted for $4.9 billion in medical costs and lost productivity. *Obesity Research,* in January 2004, revealed that 1998-2000 N.C. medical expenditures related to obesity totaled $2.138 billion. Of this cost, $662 million was state funded by Medicaid. Recent estimates suggest that obesity accounts for 300,000 U.S. preventable deaths annually, second only to tobacco deaths. Since obesity is a major contributor to diabetes and heart disease, the number of these deaths could be cut by reducing the rate of obesity. 2005 mortality statistics for Wake County show 937 chronic disease-related and potentially preventable deaths: diabetes mellitus -125 deaths, cardiovascular disease – 513 deaths and cerebrovascular disease – 299 deaths. *(Source: SCHS 2005)*

Health screenings of 1,006 Wake County residents in 2005-06 found that 73% had blood pressure levels above recommendations. Of 572 screened for cholesterol, 26% displayed levels equal to or greater than the recommended 200 mg/dl. Of 949 screened for body mass, 61% were found to be either obese (30%) or overweight (31%). *(Source: WCHS – Health Promotion and Chronic Disease Program, 2006)* For adults, Body Mass Index (BMI) is based on individual height and weight. The metric formula is weight (kg) / [height (m)]. For most people, BMI correlates with the amount of fat on their bodies. However, BMI does not directly measure body fat. For athletes with large muscle mass, BMI may identify them as overweight even though they do not have excess body fat. In these situations, body fat analyses are needed.

BMI	Condition Termed
Below18.5	Underweight
18.5 – 24.9	Healthy weight
25.0 – 29.9	Overweight
30.0 – 39.9	Obese

The 2005 Behavioral Risk Factor Surveillance System (BRFSS) determined that 62.7% of Wake residents reported being either overweight (42.3%) or obese (20.4%). Worse, only 42% of adults reported meeting physical activity recommendations and only 21.5% reported ingesting five or more fruits and vegetables daily. *(Source: BRFSS 2005)* Recommended physical activity includes at least 30 minutes of moderate activity at least five days per week or 20 minutes of vigorous physical activity at least three days per week.

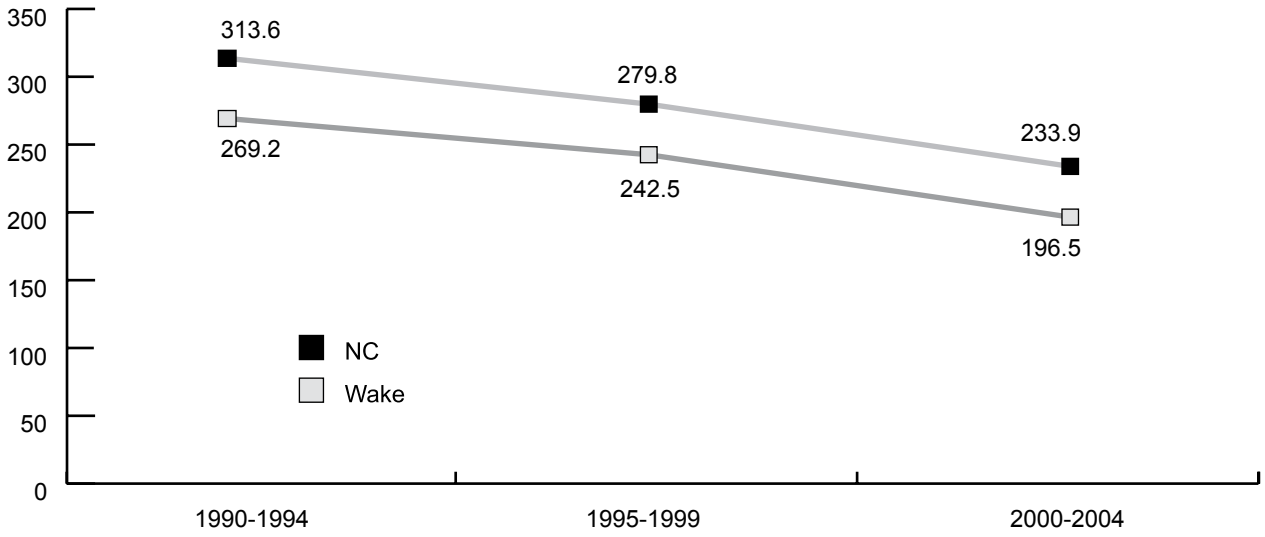
The 2005 BRFSS also found that, of Wake residents who had been screened for cholesterol, 31.9% reported elevated levels. For blood pressure, 21% reported a diagnosis of "high blood pressure."

Trends

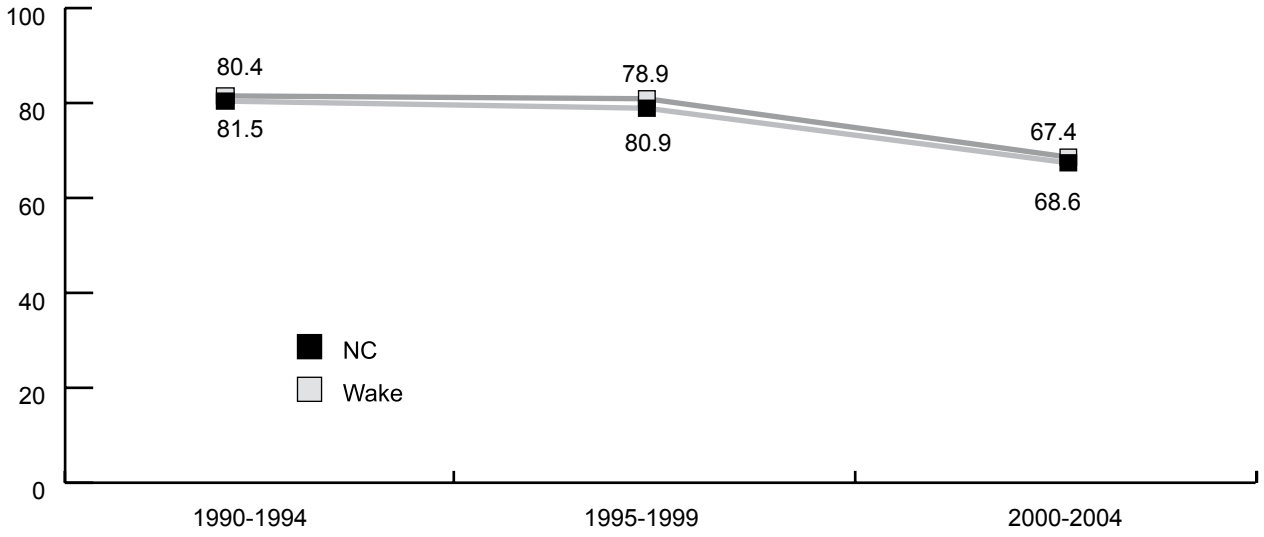
BRFSS data from 2002 to 2005 show that the percent of Wake residents who reported being overweight or obese rose by 8.1%. For the same period, declines were noted in both physical activity and fruit and vegetable intake: 1.2% fewer survey respondents reported achieving the recommended amount of physical activity and 3.7% fewer reported intake of five or more servings of fruits and vegetables daily. The number of those reporting high blood pressure, elevated cholesterol and diagnosis of diabetes, rose by 4%, 5.6% and 0.7% respectively. *(BRFSS 2002 - 2005)*

As noted in the graphs below, since 1995 -1999 age-adjusted death rates for heart disease and stroke in Wake County have steadily declined. Heart disease has declined by 46 deaths (from 242.5 to 196.5) per 100,000 population. Stroke has declined by 12.3 deaths (from 80.9 to 68.6) per 100,000 population. For diabetes, the death rate decline of 1.1 deaths per 100,000 was less pronounced (from 26.0 to 24.9) per 100,000 population. *(Source: SCHS – N.C. County Trends Reports)*

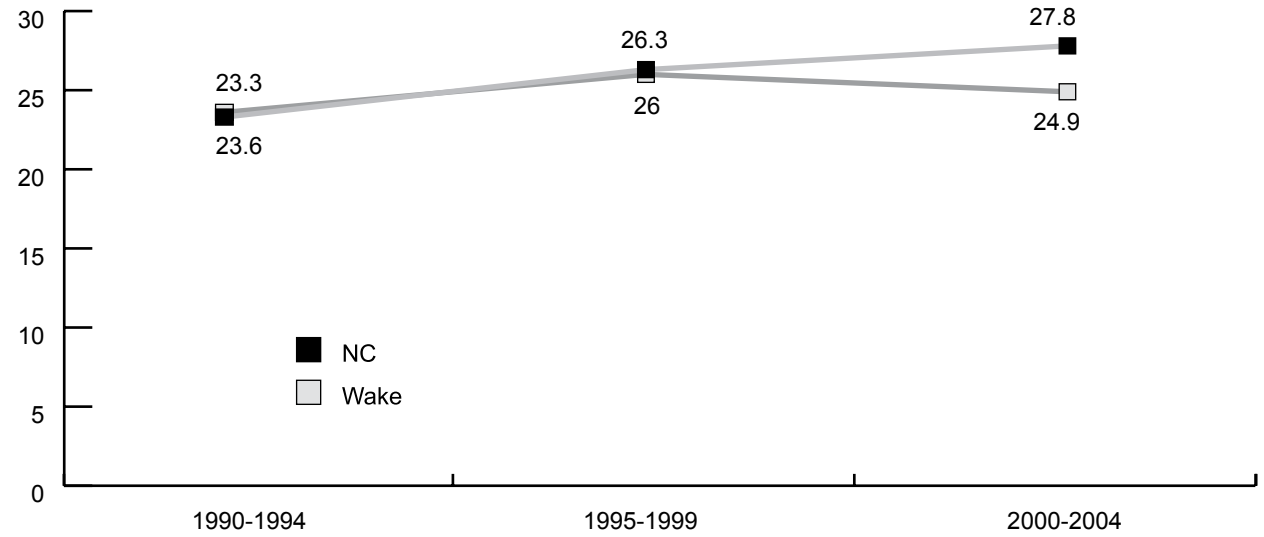
Age-Adjusted Heart Disease Death Rates
Deaths Per 100,000 Population



Age-Adjusted Sroke Death Rates
Deaths Per 100,000 Population



Age-Adjusted Diabetes Death Rates
Deaths Per 100,000 Population



To address these health issues, WCHS sponsored a 2004 community forum to address the needs of families, both adults and children, regarding solutions to the growing overweight and chronic disease issues. One result of the forum was a global information system (GIS) greenway mapping project to promote physical activity. WCHS – Health Promotion and Chronic Disease Program partnered with N.C. State University's Recreation Resources to map 114 miles of greenways and walking trails throughout the county. The result will be maps published to inform residents of trail locations and to encourage increased physical activity.

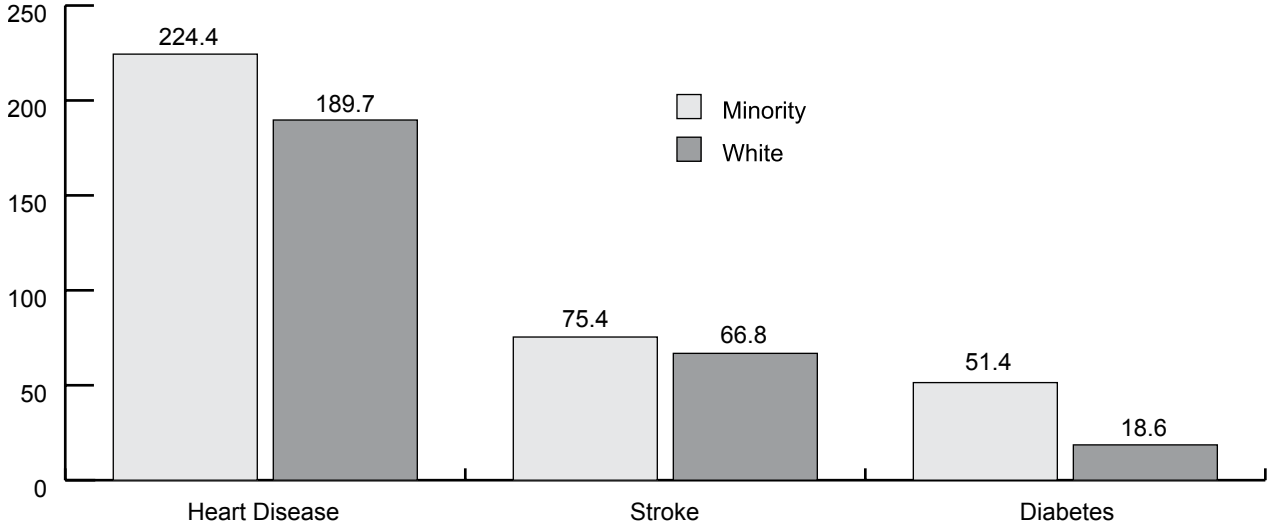
WCHS Health Promotion and Chronic Disease Program has made additional strides toward increasing the health of residents. From 2003 to 2006, efforts have included providing technical assistance and educational programs to 82 faith and community groups, potentially affecting 17,800 individuals. These organizations have, in turn, incorporated physical activity and nutrition policies and/or environmental improvements for members. Examples of improvements include: building of walking trails, establishment of walking groups, plus regular offerings of fruits, vegetables and water at meals and breaks. An additional 6,072 Wake citizens have participated in trainings regarding wellness, physical activity, nutrition and chronic disease prevention. Wake County government's website, along with local television and print media, have also been used to disseminate health information to the larger Wake County audience.

Citizens, predominantly from high health risk populations, have been screened, counseled and referred regarding chronic diseases. From 2003 to 2006, 2,901 citizens received these services; of these, 154 displayed blood pressures at the dangerous level of stage II hypertension and were referred for further care. Of 38 who responded to follow-up calls or letters, all reported that they had received care for hypertension. Since hypertension is the primary risk factor for stroke, this screening and follow up had the potential for saving approximately $3,800,000 in health costs for these individuals. This cost estimate is based on the work of T.N. Taylor and states, "The average lifetime cost of a stroke is estimated at $103,576 per stroke event." *(Source: Taylor TN, et.al., Lifetime cost of stroke in the US. Stroke. 1996; 27:1459-1466).*

Disparities, Gaps, Unmet Needs

Due to constraints caused by both lower economic and educational levels plus limited health care resources, minority populations die at higher rates from preventable diseases than do whites. In the chart below, this is demonstrated in heart disease, stroke and diabetes mortality rates per 100,000. For heart disease, the minority death rate of 224.4 is higher that that of whites, at 189.7. For stroke the rate is 75.4 in minorities versus 66.8 in whites. For diabetes, minorities die at more than twice the rate of whites - 51.4 versus 18.6 per 100,000 population. *(Source: SCHS 2005)*

Wake County Death Rates Per 100,000 SCHS 2005



Poor physical activity and nutrition behaviors also contribute to this problem in minorities more than in whites. The BRFSS indicated that only 35.6% of minority survey respondents achieved the recommended amount of daily physical activity, while 44.1% of whites achieved this. Findings are similar with fruit and vegetable intake. Only 16.4% of minorities reported eating the recommended five fruits and vegetables each day, compared to 23.5% for whites. Not surprising is the fact that, of the minority population reporting, 68.1% considered themselves to be either overweight or obese. This is higher than that of the white population, 60.2% of whom reported themselves to be overweight or obese.

With these disparities, it is clear that minority populations need health promotion and chronic disease prevention services on a practical and accessible basis. Educating citizens and enabling them to practice healthy behaviors is a foundation for a healthier population.

Community Perceptions

As part of the 2006 Community Assessment, Wake County residents shared their views through surveys and focus groups. Of survey respondents, 75.2% listed overweight in adults as a moderate to serious problem. In rankings of 106 health, social, economic, environmental and safety problems faced by Wake County residents, adult overweight was ranked second. Contributing to adult overweight, 67% of survey responders indicated that eating habits/nutrition were a problem, while 56.4% indicated regular exercise as a problem.

When asked what actions they took to stay healthy, 89% of focus groups included walking, dancing, sports and yard work, while 86% of focus groups listed eating a healthy diet. In response to the query of what prevents citizens from being healthy, 64% of focus groups included the factors of food cost and availability plus food preparation time. When asked what could be done to improve the problem, 71% of focus groups indicated that educating the community regarding health issues would be beneficial while 68% of focus groups listed offering more and improved services including those for low-income seniors and those of varying ethnicities. In response to the question of what is working in Wake County to address health issues, 46% of focus groups indicated that health promotion programs were of benefit.

Resources and Strengths

Free and fee-based programs are offered by local hospitals, Wake County Cooperative Extension, YMCA/YWCA, and 13 municipal and county parks and recreation departments. Depending on the organization, topics include diabetes control, heart disease prevention, weight loss/management, physical activity, stress reduction and more.

Social marketing campaigns were begun in 2005 and 2006 to address the issues of cardiovascular disease, hypertension and stroke. Efforts included: Proclamations by Wake County Commissioners recognizing February as Women's Heart Health Month and heart health promotions in *The News and Observer,* Screenvisions, Univision, four local radio stations, and local shopping malls. Six automated external defibrillators (AEDs), with accompanying training, were also provided to community partners along with sponsorship of new, blood pressure (JNC-7 guideline) trainings for medical providers.

Addressing the issue of diabetes in high health risk communities, the following activities have been implemented by Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together): A diabetes academy for health care providers and interested community members; Ready, Set, Walk Programs (13 programs in 2005) for African-American churches; and 51 diabetes awareness/nutrition education programs and workshops to faith and community based organizations.

Project S.E.L.F. (Smoking, Education, Lifestyle, Fitness), an initiative of Strengthening the Black Family, Inc., provides services in low-income areas of Wake County to reduce chronic disease rates. These include provision of walking groups, nutrition promotions and health education sessions. Specific subpopulations - men and seniors - are also targeted for services.

Emerging Issues

The economic burden of obesity and related conditions is staggering. Costs for hospital and outpatient care are 36% higher for an obese individual than one of healthy weight. Medication expenses are 77% higher for an obese individual. *(Source: R. Strum, Health Affairs 2002 Mar-Apr 21(2): 245-53)*. The rapid increase in obesity and associated costly chronic diseases make it imperative to address root causes. Obesity has roughly the same association with chronic health conditions as does 20 years of aging and the costs of obesity are estimated to exceed the health care costs of smoking and problem drinking.

As noted previously, the prevalence of obesity in adults is increasing and currently, at 30% in Wake County, is well above the *Healthy People 2010* target of 15%. To reduce obesity in the U.S., an effective public health response will require a combination of policies, programs, and supportive environments created through the combined activities of health-care agencies, government, media, business, industry, communities, schools, families, and individuals. *(CDC – MMWR 9/15/06)*

Tobacco Use

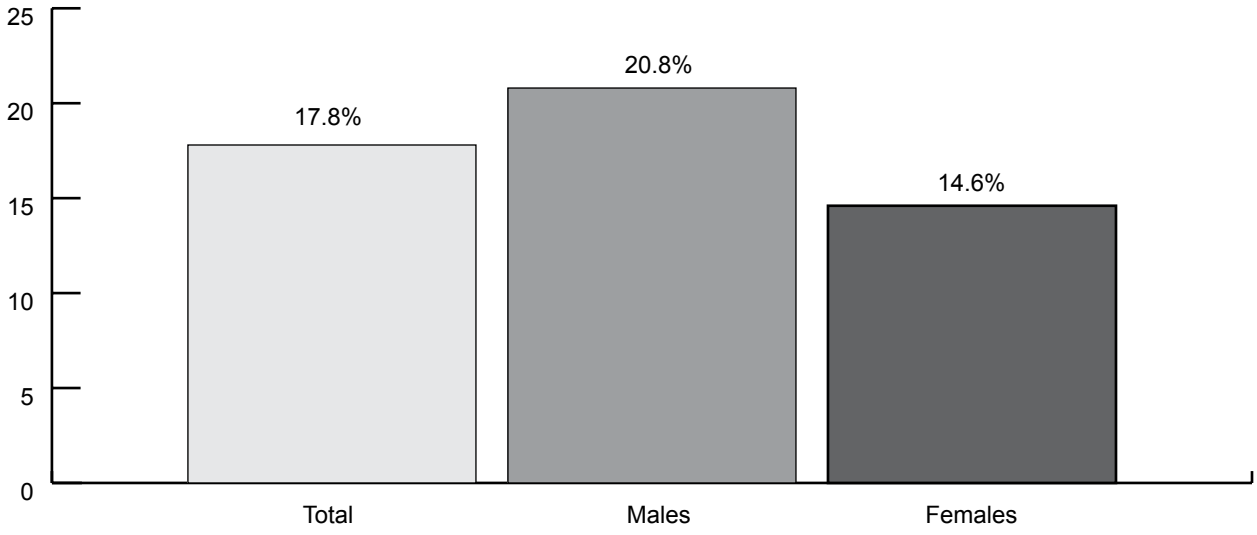
Current State of Affairs

Use of tobacco is the single, most preventable, leading cause of death in North Carolina. Tobacco use kills more people than alcohol, AIDS, car crashes, illegal drugs, murders and suicides combined. Thousands more die from other tobacco-related causes such as fires caused by smoking, more than 1,000 deaths per year nationwide, and smokeless tobacco use. *(Campaign for tobacco-free kids, 2006)*

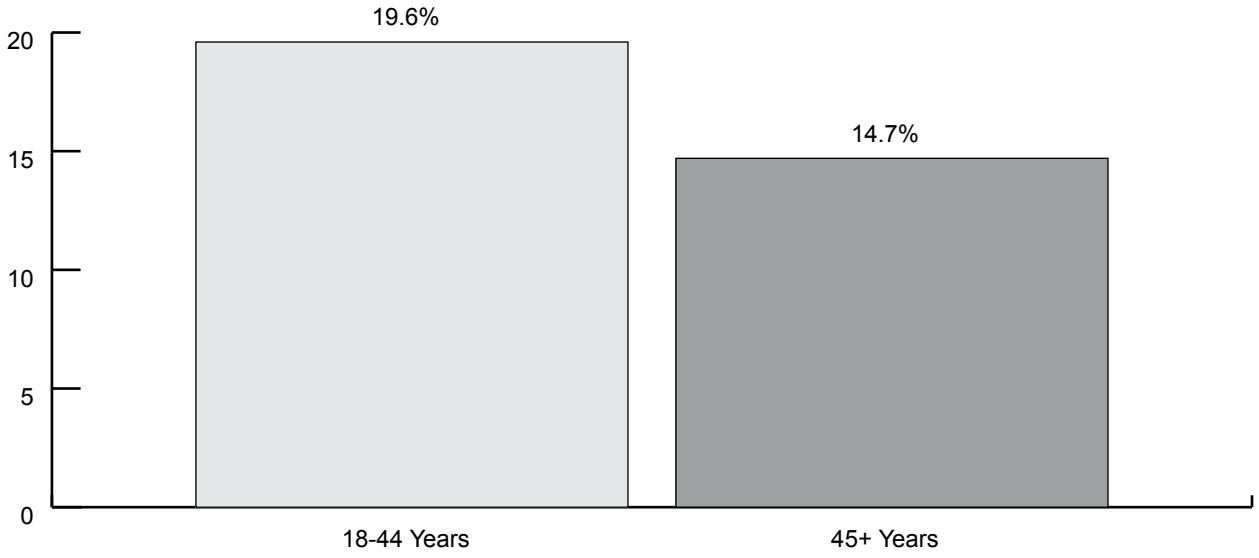
Each year, more than 430,000 Americans die prematurely from smoking-related diseases. Today, nearly a quarter of U.S. adults and about a third of U.S. youth continue to smoke.

From the tables below, it is evident that almost 18% of the Wake County adult population continues to smoke with minimum variance for gender or age. However, more adults of lower income and lower educational levels reported smoking than did others.

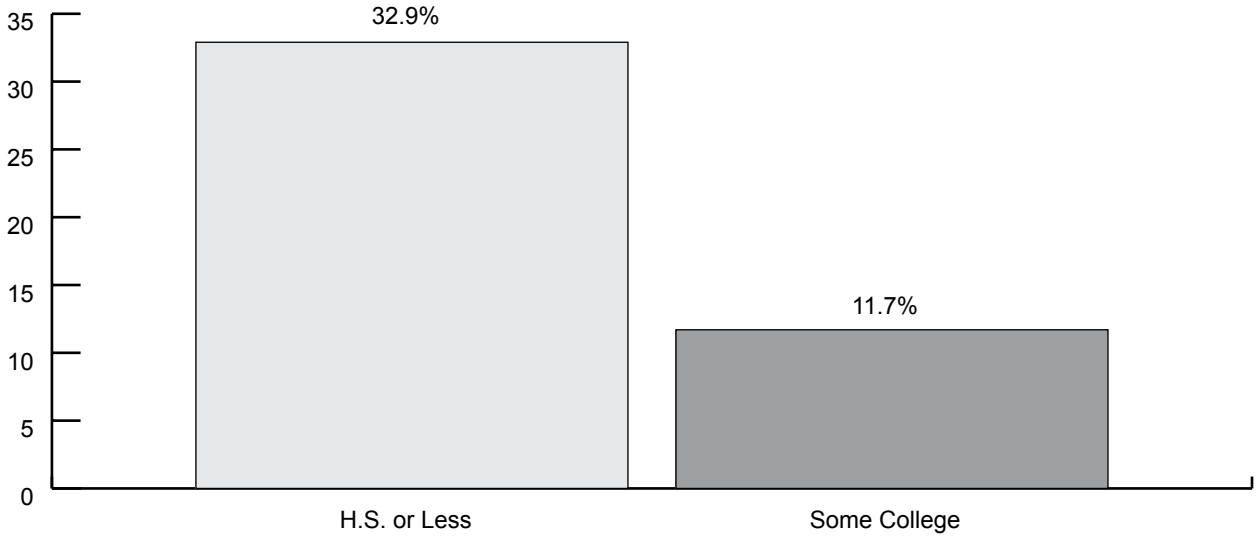
Percentage of Current Adult Smokers in Wake County, by Gender NC BRFSS 2005



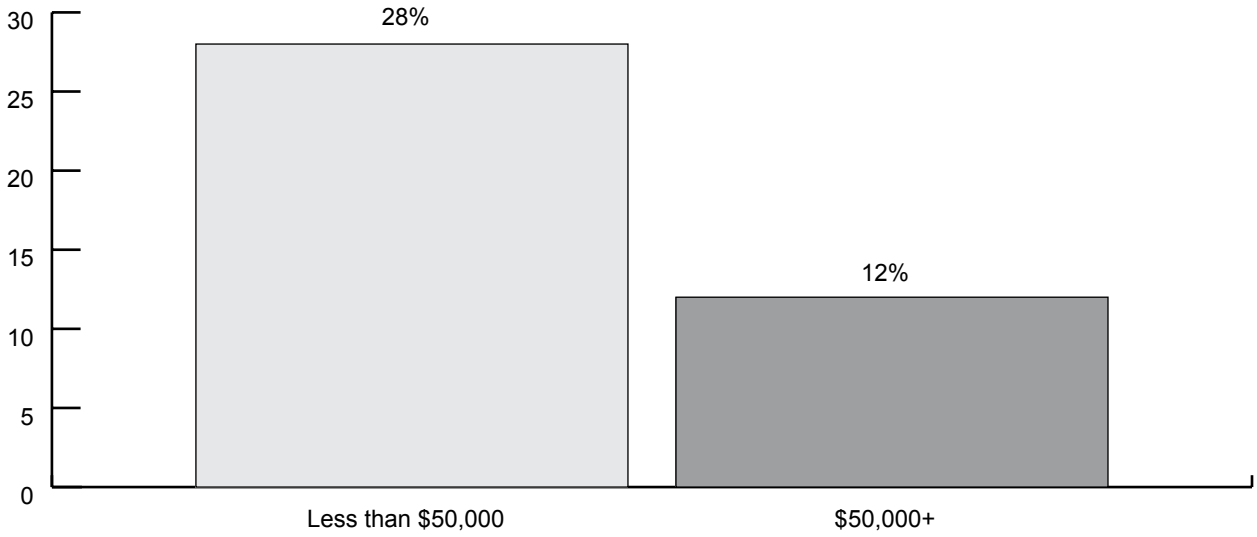
Percentage of Current Adult Smokers in Wake County, by Age
NC BRFSS 2005



Percentage of Current Adult Smokers in Wake County, by Educational Level
NC BRFSS 2005



Percentage of Current Adult Smokers in Wake County, by Income NC BRFSS 2005



According to N.C. Youth Survey 2005, 28.5% middle and high school students reported to be current tobacco users. Despite recent improvements, over one-third of today's young people are active smokers by the time they leave high school. In fact, more than one in every six is an active smoker as early as eighth grade. *(Surveillance and Evaluation Team, Tobacco Prevention Control Branch 2006)*

Healthcare costs in North Carolina, directly related to smoking, are $2.26 billion per year. Of this, $708 million is paid by the state for the Medicaid program. The incidence of tobacco usage is lower in Wake County than in North Carolina, but usage is still a concern to the public, due to dangers of secondhand smoke. Secondhand smoke exposure can cause disease and premature death in children and adults who do not smoke. Nonsmokers who are exposed to secondhand smoke at home or at work increase their risk of developing heart disease and lung cancer by 25-30%. *(US Surgeon General's Report, 2006)*

There is no safe level of exposure to secondhand smoke, which is known to cause and worsen heart and lung diseases in nonsmokers, children and adults alike. *(US Surgeon General's report on Involuntary Smoking, 2006)* This new information regarding secondhand smoke exposure is alarming in light of the fact that 20.8% of Wake County citizens who were surveyed reported asking a stranger to stop smoking around them in order to prevent tobacco smoke exposure. *(NC BRFSS, 2005)* Much information related to secondhand smoke exposure has been reported since the early 1990s, and more education and legislation are needed. *(Surgeon General's Report, 2006)*

In July 2004, legislation was passed by the N.C. General Assembly to allow state and local health departments and social services to adopt tobacco-free policies for their buildings. These policies also included provision of 50-foot smoke-free building perimeters to ensure smoke freedom at all doorways and ventilation areas. With this law on record, 14 Wake County Human Services buildings are now tobacco-free. This ensures freedom from smoke for more than 5,000 WCHS patrons and 1,000 employees.

In September 2004, Project ASSIST (American Stop Smoking Intervention STudy) launched an updated, smoke free dining website. It is housed on the WCHS Environmental Health web page, and is linked with restaurant sanitation grades. Since September 2005, the site has received nearly 5,900 hits, indicating increased citizen awareness of and interest in these smoke free facilities. Project ASSIST is constantly working with the community to increase the number of restaurants listed on this site. Currently, 175 restaurants are identified as smoke free.

During 2004, the N.C. General Assembly enacted legislation requiring state prisons to revise their smoking policies. Currently, prisons within the county are attempting to provide resources to assist inmates in quitting smoking. In 2005, ASSIST implemented a Freedom From Smoking program within the State Women's Prison.

Trends

In North Carolina, 78 out of 115 school districts have 100% tobacco-free school policies established. These policies prohibit the use of tobacco products any time and by anyone including students, staff, and visitors on school grounds, indoors and outdoors, or at school events. These tobacco-free zones also include school vehicles and school events whether or not the event is on school property. Today, more than half a million North Carolina youth are benefiting from tobacco-free campuses. All North Carolina school districts are encouraged to adopt these policies. *(NC Tobacco Free School, 2006)*. In 2004, WCPSS enacted a policy to prohibit tobacco use on all campuses and buildings, except for two administrative buildings. For this reason, WCPSS is one of 37 state school systems that do not meet the criteria as defined by the N.C. Tobacco Free School team of the Tobacco Prevention Control Branch.

Smoking rates among young adults between the ages of 18 and 24 have increased in recent years. The increases may be attributed to the aging of high school students whose smoking rates were high during the 1990s or they may be an indication of increased initiation of smoking among young adults. Disparities in smoking also exist among people of different educational levels, racial and ethnic groups. Smoking prevalence is highest among persons with lower educational attainment (9-11 years) and among American Indians/Alaskan Natives. If current patterns persist, nearly 25 million U.S. citizens will die prematurely from a smoking-related disease. Among adults, smoking trends in the past nine years have stagnated, demonstrating the need for policy changes that encourage quitting and improved access to proven cessation interventions.

In 2004, an estimated 44.5 million U.S. adults (20.9%) smoked. In N.C. for the same year, over 1.4 million (22.5%) of adults smoked. According to the American Lung Association, the annual prevalence of smoking declined 40% between 1965 and 1990 but has been virtually unchanged since. *(American Lung Association, 2006)* The 2003 BRFSS reported that, of those surveyed in Wake County, 16% were current smokers. This percentage increased in 2005 to 17.8% but continues to be below the state percentage of 24.8%. With interventions and availability of resources, the numbers of those who smoke are slowly decreasing. However, tobacco use is still a major health concern. Over half of the people who report to be smokers have stated that they would like to quit. *(Centers for Disease Control and Prevention)*

Community Perceptions

In the 2006 Wake County Community Assessment surveys, 60.9% of respondents listed cigarette smoking as a serious to moderate problem, with 48.7% listing lung cancer in the same severity category.

Resources

Research has shown that smoking cessation has major and immediate benefits for smokers of all ages. After one year of quitting cigarettes, the additional risk of heart disease caused by smoking is reduced by about one-half. After 10 years, the risk of lung disease for former smokers is less than one-half that of a continuing smoker. In five to 15 years, the risk of stroke for former smokers returns to the level of those who never smoked. *(Centers for Disease Control and Prevention)*

Several methods are available to help smokers quit the habit. Less intensive interventions, such as physician consultations with patients, can produce cessation rates of 5% to 10% per year. More intensive interventions that combine both behavioral counseling and pharmacological treatment can produce 20% to 25% quit rates in one year. *(Source: Who's still smoking-News Brief BRFSS, 2005)*

Project ASSIST is a community coalition that works to educate community members on the harmful effects of secondhand smoke exposure and to encourage local businesses/organizations to adopt a tobacco free policy. To increase resources, this group partners with the American Lung Association to increase the number of Freedom From Smoking facilitators. In 2006, the coalition plans to increase the number of public classes that are offered at low or no cost. Volunteers are welcome to join the coalition and be trained to communicate tobacco free messages to Wake citizens.

Working to improve air quality, project ASSIST partners with the American Lung Association, American Cancer Society and American Heart Association, Governor's Institute, Dimensions in Occupational Health and Safety and community volunteers to encourage tobacco prevention policy change laws.

Emerging Issues

Eliminating smoking in indoor spaces protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposure of secondhand from nonsmokers. The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), the preeminent U. S. body on ventilation issues, has concluded that ventilation technology is not reliable as a control for health risks from secondhand smoke exposure. (Surgeon General Report, 2006)

In 2004, 54.4% of North Carolinians surveyed supported tobacco free dining. *(Restaurant Survey, 2005 Tobacco Prevention and Control Branch)* Currently, 175 of Wake County's 1,600 restaurants are identified as smoke free. Project ASSIST continues to educate and provide assistance to restaurants that are interested in becoming smoke free.

In October 2005, the N.C. Division of Public Health and the N.C. Health and Wellness Trust Fund launched a tobacco use telephone *quitline*. This service is available toll-free to all North Carolinians and is staffed by trained tobacco cessation specialists. It is available from 8 a.m. until midnight 7 days per week at 1-800-QUITNOW. The *quitline* features a proactive service, meaning that once the tobacco user makes the first call, the cessation specialist can arrange to call the tobacco user back to check on progress and answer questions.

Plans are in place to have all major hospitals in Wake County implement tobacco free policies by July 4, 2007. These hospitals also plan to increase the number of smoking cessation classes to the community.

Women's Health (Breast and Cervical Cancer)

Current State of Affairs

Women's health has become a critical new focus in the health care system. Recent research has shown that men and women have different health problems and react differently to medications and treatments. Therefore, it is vital to consider these gender differences and study women's health issues holistically throughout a woman's lifecycle.

In North Carolina, the Center for Women's Health Research issues an annual report card on the health status of women in the state. The indicators include reproductive health, chronic disease, substance use/mental health, violence/injury, and barriers to health care, preventive health practices. Most of the indicators indicate that much work remains to be done.

Reproductive care and childbirth are the most common reasons for women of childbearing age to access the healthcare system. As previously stated, women's health needs vary throughout the women's life cycle. Preadolescent and adolescent girls are in need of information regarding their menstrual cycles, injury prevention and immunizations. Younger women in the teen years are mainly accessing the healthcare system to receive contraceptive and reproductive services. Women of childbearing age are in need of reproductive choice information and prenatal care. Middle-aged women seek services related to menopause, breast and cervical cancer screening and prevention. Older women are often in need of services in urogynecology and chronic disease care.

Trends, Gaps, Unmet Needs

Many women face barriers, including lack of health insurance, that make the acquisition of basic health care services difficult. In 2003, 15.6 percent of Americans were uninsured. The uninsured report more problems getting care and get less therapeutic care. They are diagnosed at later disease stages, sicker when hospitalized, and more likely to die early.

- Since 1999, the percent of women under age 65 with health insurance has been stable. However, current rates are below the Healthy People 2010 goal of 100%.
- In all years, black women had lower rates than white women, and Hispanic women had lower rates than non-Hispanic white women.
- Between 1999 and 2001, rates of health insurance have been stable among all racial and ethnic groups.
- No racial group achieved the Healthy People 2010 goal.
- In all years, women with less than a high school education and high school graduates had lower rates than women with at least some college education.
- Between 1999 and 2001, the rate of health insurance improved among near poor women and was stable for women in other income groups.
- No income group achieved the Healthy People 2010 goal.

According to the National Healthcare Quality Report (NHQR), the overall quality of health care for women in the United States is improving slowly. From the 2003 NHQR to the 2004 NHQR:

- Of measures with trend data for women, 59% showed improvement, with a median change of 1.4%, comparable to change observed in the general population.
- For services unique to women, 60% of measures improved. Although these improvements are modest, they also show that improvement is possible.

Females in the United States number 140 million, comprising over half of the total population. In addition:

- Nearly 30% of females are racial/ethnic minorities.
- Black women have higher death rates than whites due to heart disease, cancer, and stroke. Hispanic, Asian, Pacific Islander (API), American Indian and Alaska Native (AI/AN) women have lower death rates due to these conditions.
- Black and Hispanic women are more likely to report that they are in fair or poor overall health or that they have diabetes.
- Poverty disproportionately affects women. Nearly 13 million women live in households with incomes below the federal poverty level.
- Women are more likely than men to report having arthritis, asthma, autoimmune diseases, and depression.
- Women of lower socioeconomic level are more likely than high income women to report fair or poor overall health and limitations of activity. They are also more likely to report having anxiety or depression, arthritis, asthma, diabetes, hypertension, obesity, and osteoporosis.

Across measures in the 2004 NHQR by gender, significant gaps were found between the care received by men and women in the United States.

- Women received better care than men for 18% of measures, worse care for 22%, and comparable care for 59%.
- Women tended to receive better preventive care for cancer and cardiovascular disease than men. Men were found to receive better treatment for end stage renal disease and heart disease.

The 2004 NHQR also revealed that:

- Black women received poorer quality care than whites for 53% of measures and had worse access to care for 29%.

- Hispanic women received poorer quality care than non-Hispanic whites for 60% of measures and had poorer access for 87%.
- For services unique to women, blacks and Hispanics both received poorer quality care for 75% of measures than whites.

In 2005, an estimated 662,870 women were diagnosed with cancer in the U.S. Of these, cancer was projected to lead to death for 275,000. For specific types, an estimated 211,240 women were diagnosed with breast cancer and 10,370 with cervical cancer. Of these women, 40,410 were projected to die of breast cancer and 3,710 of cervical cancer. Mammograms and Pap tests are an effective means of reducing the incidence of late stage breast and cervical cancers, respectively, and mortality caused by these cancers.

- In 2000, the overall rate of Pap tests was below the Healthy People 2010 (HP2010) goal of 90%. The overall mammography rate reached the goal of 70%.
- Compared with whites, blacks had higher rates of Pap tests and lower rates of mammography, Asians had lower rates of both services, and AI/ANs had lower rates of mammography.
- Hispanics had lower rates of both services than non-Hispanic whites.
- For Pap tests, no racial or ethnic group achieved the HP2010 goal.
- Only white women achieved the HP2010 goal for mammography.
- Poor, near poor, and middle income women had lower rates of both Pap tests and mammography than high income women.
- Women with less than high school education and high school graduates had lower rates of both services than women with at least some college education.
- No socioeconomic group achieved the HP2010 goal for Pap tests.
- Only high income women and women with at least some college education achieved the HP2010 goal for mammography.

2003 Age Adjusted Cancer Incidence Rates Per 100,000 Population
NC Central Cancer Registry, July 2006

Cervical Cancer	White Female		AA Female		Hispanic Female	
	Cases	Rates	Cases	Rates	Cases	Rates
Wake	11	3.8	5	10.2	*	5.5
NC	207	6.2	81	9.1	17	3.1
US (1993-2003)		8.6		13.0		15.0

Breast Cancer	White Female		AA Female		Hispanic Female	
	Cases	Rates	Cases	Rates	Cases	Rates
Wake	400	165.9	100	179.2	9	23.2
NC	5,093	141.1	1,172	133.0	40	12.3
US (1993-2003)		130.8		111.5		91.4

Community Perceptions

In the 2006 Wake County Community Assessment, 68% of focus groups listed physical health as a major problem or concern, with reproductive health as one factor. As to causes of the above problem, 43% of focus groups listed both depression and unprotected sex as a lifestyle factor. Fifty-seven percent listed access to/lack of services as another cause. When asked what was working to address health issues, 46% of focus groups reported prevention programs, including pregnancy and domestic violence prevention programs. However, 61% of focus groups listed transportation as not working in efforts to address the population's health.

Survey respondents rated as moderate to serious problems for Wake County:

- Affordable health care listed by 68%.
- Unsafe sex listed by 60.8%.
- Depression listed by 58.5%.
- Domestic violence listed by 56.1%.
- Breast cancer listed by 51.4%.
- Providers accepting Medicaid/Medicare listed by 39.3%.

Resources and Strengths

Primarily for minority women, although not exclusively, in fiscal 2005-2006 the Breast and Cervical Cancer Control and Prevention, Educate Our Women and Healthy Women Healthy Wake Programs of WCHS provided 342 mammograms, 79 clinical breast exams and 73 cervical cancer screenings. Of these, five cases of breast cancer were detected with one being invasive. In medical cost, this is a potential savings of $60,000 - $70,000 per case (or $300,000 – $350,000 in total). From July – November of 2006, five cases of breast cancer were detected.

Lack of adequate health insurance is an enormous barrier for women seeking health care. The N.C. Division of Medical Assistance implemented the Medicaid Family Planning Waiver on October 1, 2005. It is a five-year demonstration waiver project for family planning services for the citizens of North Carolina. Called "BE SMART", this program is designed to reduce unintended pregnancies and improve the well being of children and families in North Carolina by extending eligibility for family planning services to eligible women between the ages of 19 through 55 and men ages 19 through 60 who meet the eligibility requirements for participation. A campaign to educate women about and encourage them to apply for the Medicaid Family Planning waiver was initiated in 2005.

In Wake County, there are more than 100 private OB/GYN providers and other physicians with varied subspecialties that relate to women's health care. However, for women who are uninsured, the list is limited to the services offered by a few. These include: Planned Parenthood, Wake Teen Medical, Wake Health Services, The Open Door Clinic, Alliance Medical Ministry and Wake County Human Services.

For uninsured women in need of primary care, the choices are very limited. Wake Health Services, Inc. offers care at its three locations. A fourth location on North Tarboro Road serves homeless men, women and children. Alliance Medical Ministries is a faith-based medical clinic offering affordable primary care to working adults. The Open Door Clinic offers free medical and pharmacy services to low-income patients who have no insurance and do not qualify for Medicaid.

Project Access is a physician-led community effort that has been providing health care for low-income, working but uninsured Wake County residents since September 2000. The Wake County Medical Society, in partnership with WakeMed, Rex and Duke Health Raleigh hospitals, manages it. Project Access is funded through grants and donations to the Wake County Medical Society's 501(c) 3 Community Health Foundation. The goal of Project Access is to work collaboratively with community agencies to fulfill the unmet healthcare needs of low-income, uninsured residents. Project Access provides a way for medical care providers to meet the needs of indigent patients. Designed by physicians, Wake County Medical Society's Project Access allows physicians to focus on the profession's fundamental values in a coordinated, fair, and efficient way.

The Wake County area has a variety of resources for the treatment of women healthcare issues. These include, but are not limited to:

Breast Cancer Program (Duke University Health System)
www.dukehealth.org/Services/Cancer/Programs/Breast/index
919-684-7641

Cancer Center (Duke University Health System)
www.dukehealthraleigh.org/healthservices/cancer/index
919-862-5400

Duke University Radiation Oncology (Duke University Health System)
www.radonc.duke.edu
919-660-2100

Hematology/Oncology Clinical Programs (UNC at Chapel Hill)
www.med.unc.edu/medicine/hemonc/clinical.htm
919-966-6748

L**ineberger Comprehensive Cancer Center** (UNC at Chapel Hill)
http://cancer.med.unc.edu
866-828-0270

Lineberger UNC Breast Center (UNC at Chapel Hill)
http://cancer.med.unc.edu/patient/programs/breast-center.asp
919-966-0381

Rex Cancer Center (Rex Healthcare)
www.rexhealth.com/centers/cancer/index_cancer_center.htm
919-784-3100

Wake Radiology Oncology Services
www.wakeoncology.com
800-675-2232

Wake County Human Services

Breast and Cervical Cancer Control Program
919-212-9301

Educate Our Women
(funded by Komen Foundation)
919-250-3876

Healthy Women, Healthy Wake
(funded by N.C. Health and Wellness Trust Fund - Health Disparities Initiative)
919-250-3876 or 919-250-4553

Emerging Issues

Cardiovascular Disease: Each year, about half a million women die of cardiovascular-related disease. It is the leading cause of death for both women and men. Although major risk factors for heart disease can often be prevented or controlled through lifestyle changes, physicians are less likely to counsel women than men about diet, exercise, and weight reduction.

After a first heart attack, women are less likely than men to receive diagnostic and therapeutic procedures and cardiac rehabilitation and more likely to die or have a second heart attack. Receipt of beta-blockers and aspirin upon arrival at the hospital for a heart attack is an effective means of minimizing the negative impact of the heart attack.

- In 2002, Medicare beneficiaries who were hospitalized for a heart attack, received beta-blockers upon hospital arrival only 76% of the time and aspirin on arrival only 85% of the time.
- Women were less likely than men to receive both medications.
- Blacks, compared with non-Hispanic whites, were less likely to receive aspirin. Hispanics were less likely to receive both medications.

Domestic Violence: Domestic violence is the single largest cause of injury to women between the ages of 15 and 44 in the United States, more than muggings, car accidents, and rapes combined. Each year an estimated four million women are battered and 2,000 of these battered women die of their injuries. Abuse occurs among all ages, genders, races, educational backgrounds and socioeconomic groups. For more specific infomation on domestic violence, please refer to the Safety chapter.

Nearly 18% of women surveyed, or 17.7 million American women, have been raped or been a victim of attempted rape during their lifetime, according to a collaborative study on violence jointly funded by the Department of Health and Human Services and the Department of Justice.

Research shows that approximately 900,000 parents are beaten or abused by their children each year. The National Elder Abuse Incidence study found that approximately 551,011 elder persons were abused or neglected in a 1-year period (1996).

Maternal and Postpartum Depression: Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for an extended time. Whether mild, moderate, or severe, the degree of depression determines one's medical treatment. This is common during pregnancy or within year after delivery and is called perinatal depression. The exact number of women with depression during this time is unknown. Often, it is not recognized or treated, because some normal changes of pregnancy cause similar symptoms.

Pregnancy Options: In 2005, there were 15,406 pregnancies with 3,043 (20%) ending in induced abortion. Abortion statistics for Wake County, 2000 to 2004, are reported below. *(Source: SCHS)*

COUNTY	LIVE BIRTHS	ABORTIONS	ABORTION %	COUNTY ABORTION RANKING
WAKE	54,941	15,703	22.2	11
NC TOTAL	593,731	135,968	18.6	-

There are many and varied pregnancy options in Wake County that include both abortion and adoption services. Planned Parenthood, A Women's Choice and Pregnancy Life Care Center are among the providers of these services.

Preconceptional Health Care: Preconceptional health refers to the well being of a woman who is planning to become pregnant. Good health before pregnancy is vital to having a healthy pregnancy and baby. Since more than 50% of all pregnancies in the United States are unplanned, most women are not aware they are pregnant in the crucial first eight weeks of pregnancy, when a baby's entire organ system forms.

Providing women and their partners with information to make timely informed decisions about their reproductive futures helps prevent unintended pregnancies and identifies risk factors that could affect reproductive outcomes. Risk factors include: diabetes, hypertension, phenylketonuria (PKU), HIV/AIDS, sexually transmitted diseases, repeated spontaneous abortions and previous low-birth weight infants. Others are underweight, overweight, vitamin deficiencies, smoking, alcohol and illegal drug use.

Careful review of a woman's medical, reproductive, nutritional and family history is needed so that potential problems can be discovered, education provided and interventions offered. Health care providers such as physicians, nurse-midwives or advanced practice nurses may provide such services. More funding and better insurance coverage of this type of medical evaluation is needed.

Vaccination for Protection from the Human Papilloma Virus (HPV): Human papilloma viruses (HPV) are recognized as the major cause of cervical cancer. In 2006, an estimated 10,000 women in the United States will be diagnosed with this type of cancer and nearly 4,000 will die from it. Studies also suggest that HPVs may play a role in cancers of the anus, vulva, vagina, and some cancers of the oropharynx.

The surest way to eliminate risk for genital HPV infection is to refrain from any genital contact with another individual. For those who choose to be sexually active, a long-term, mutually monogamous relationship with an uninfected partner is the strategy most likely to prevent genital HPV infection. However, it is difficult to determine whether a partner who has been sexually active in the past is currently infected.

HPV infection can occur in both male and female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Although the effect of condoms in preventing HPV infection is unknown, condom use has been associated with a lower rate of cervical cancer.

It is estimated that complete vaccination has the potential to reduce cervical cancer deaths around the world by as much as two-thirds. The vaccines are proven to be effective only if given before an individual is infected with HPV. It is important for both vaccinated and unvaccinated women to continue to undergo cervical cancer screening.

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Prostate Cancer

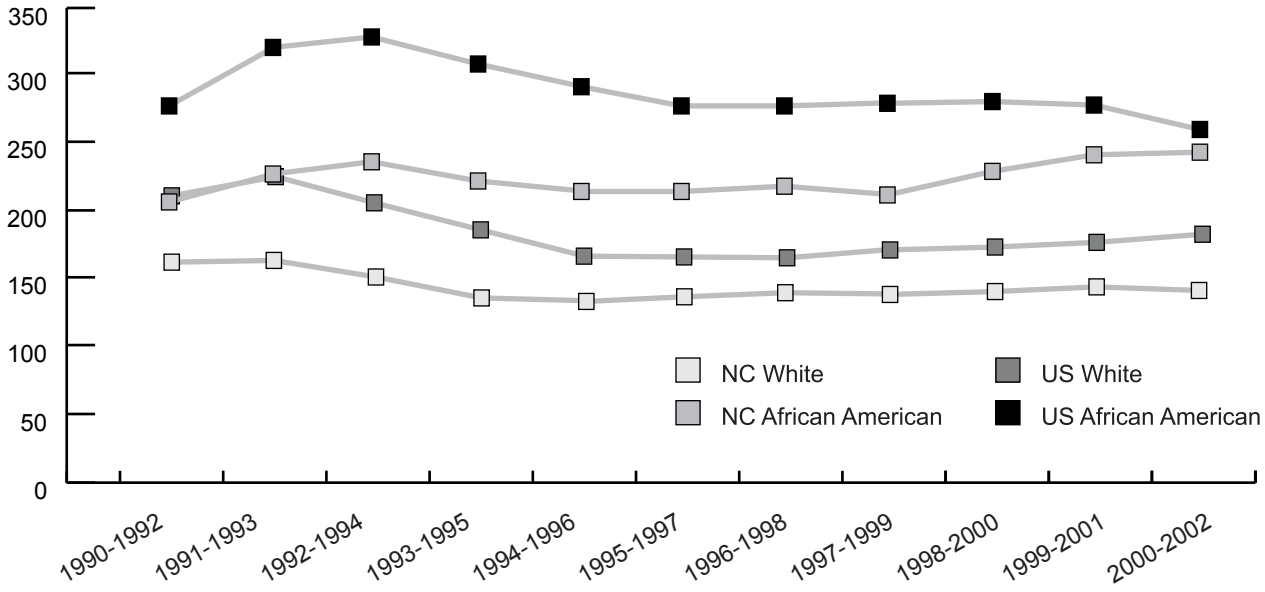
Current State of Affairs

Prostate cancer is the second most frequently diagnosed cancer in men both in N.C. and the U.S., second only to skin cancer. In leading causes of death in men, it is second only to lung cancer. Based on 2001-2003 rates, one in six men born today will be diagnosed with prostate cancer some time during their lifetime. *(Source: www.SEER.cancer.gov)* From 2000 to 2003, the median age at diagnosis of prostate cancer was 68, with 86.5% of men being diagnosed between the ages of 55 and 84. *(Source: N.C. Cancer Facts and Figures 2004).* National data from 2000-2003 indicates that African-American men experience a 63% higher incidence of prostate cancer (at 258.3/100,000) than do white men (at 163.4/100,000). *(Source: www. SEER.cancer.gov)*

In 2005, it was estimated that 6,310 new prostate cancer cases would be diagnosed in N.C. *(Source: N.C. Central Cancer Registry, 2005)*. Of that estimated number, 11.5 % or 787 died, including 50 in Wake County. *(Source: SCHS 2005)*. In 2006, the American Cancer Society (ACS) estimates that 234,460 men in the U.S. will be diagnosed with prostate cancer. Of that number, 11.6% or 27,350 men will die. *(Source: www. SEER.cancer.gov)*

The survival rate for all stages of prostate cancer has steadily improved in the past 20 years, from 67% to 98%. *(Source: N.C. Cancer Facts and Figures 2004)* For men age 50 or older with a life expectancy of at least 10 years, the American Cancer Society recommends that the prostate specific antigen (PSA) blood test and digital rectal exam (DRE) be part of the annual physical and that patients should be informed of the benefits and limitations of testing for early prostate cancer detection. If either the PSA or DRE result is abnormal, further evaluation is needed. It is also recommended that African-American men and men with a first-degree relative (father, brother, son) who has been diagnosed with prostate cancer at an early age should begin testing at age 45. Men with multiple first degree relatives who have experienced prostate cancer are at even higher risk and should begin testing at age 40. Prostate health education, regarding the benefits and limitations of early detection and treatment, is important in order to allow men to make informed decisions regarding further testing. The 2005 BRFSS Survey indicated that 35% of men older than 40 years throughout N.C. had never received PSA testing. In Wake County, 40% of men reported never having been tested. Also detected was poor or fair understanding of the advantages and disadvantages of PSA testing by 21% of men in North Carolina and 23% of men in Wake County. *(Source: SCHS 2005)*

Figure 1: Age-Adjusted Incidence Rate Per 100,000



Trends

Figure 1 above shows trends in prostate cancer incidence. For approximately the last 10 years, the number of new cases of prostate cancer in N.C. and U.S. Caucasians has been stable and lower than that of African-Americans. Incidence rates for African-Americans have fluctuated and, in 2000-2002, remained approximately 58% higher (at 239/100,000) than for whites (at 139 per 100,000). *(Source: Running the Numbers, NC Med J, March/April, 2006)*

Figure 2: Age-Adjusted Death Rate Per 100,000

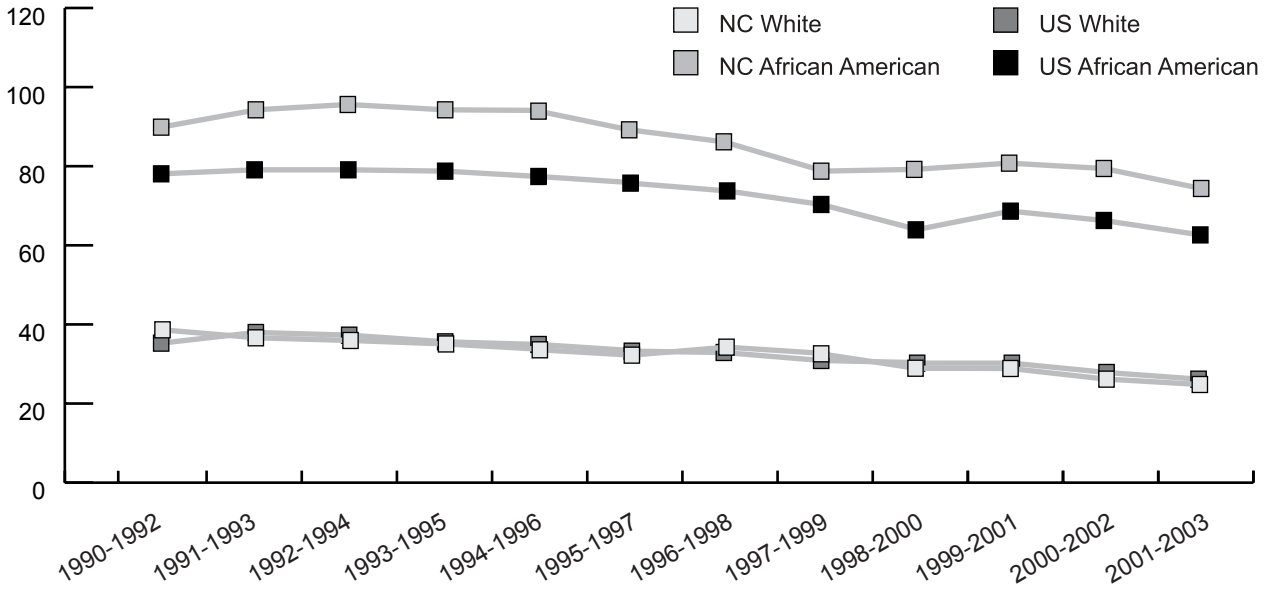


Figure 2 above shows trends in prostate cancer mortality. In the past 10 years, these rates have declined. Although whites in North Carolina have the same mortality rate as whites in the United States, African-Americans in the state have a higher mortality rate than African-Americans in the country. The overall rate for North Carolina is higher than the national rate. In the state, the 2000-2002 mortality rate for African-Americans (74/100,000) was almost three times as high as that for whites (25/100,000). *(Source: Running the Numbers, NC Med J, March/April, 2006)*

Disparities, Gaps and Unmet Needs

With the aging of the population, increasing numbers of older men will potentially develop prostate cancer. Access to health care, health insurance including coverage for screening, lower educational level and language barriers will continue to challenge efforts to overcome disparities. For those over the age of 65 the Medicare program will provide coverage. However, younger men and those either uninsured or underinsured will be more likely to forgo needed health care, including cancer screening. *(Source: Cancer Prevention and early Detection Facts and Figures 2005 - ACS)*

To have the greatest impact, a variety of cancer screening interventions are needed. The American Cancer Society (ACS) suggests establishing 1) computer-based reminder systems to assist clinicians in counseling age/risk-eligible patients regarding screening options, 2) adequate referral and follow up, 3) support systems, and 4) strategies to increase awareness of the roles of patients as well as physicians.

Community Perceptions

As part of the 2006 Wake County Community Assessment, county residents shared their views through surveys and focus groups. Prostate cancer was listed by 45.3% of survey respondents as a serious to moderate problem. Sixty-one percent of focus groups listed lack of services, including those to men, as a factor, which prevents this group from staying healthy.

Resources and Strengths

Several resources are available to help with the diagnosis and treatment of prostate cancer, including:

Prostate Cancer Support Groups in NC (Prostate Cancer Coalition of NC)
www.pccnc.org
919-321-0365

Prostate Cancer Program (Duke University Health System)
www.dukehealth.org
1-888- 275- 3853

Lineberger Comprehensive Cancer Center (UNC at Chapel Hill)
http://cancer.med.unc.edu
1-866-828-0270

Rex Cancer Center
www.rexhealth.com
919-784-105; 919-784 -7200

The Prostate Cancer Coalition of NC (PCCNC) is involved in cancer control programs across the state. One example is the Prostate Cancer Shepherds Program. This effort operates in Wake, Durham and Orange counties and is a community-based research initiative designed to reduce prostate cancer in African-American communities. It provides a diagnosed individual with a one-to-one trained prostate cancer survivor.

Also targeting minority communities is the N.C. Minority Prostate Cancer Awareness Action Team. This group of volunteer professionals, some of whom are prostate cancer survivors, works to increase awareness of prostate cancer issues. More information on cancer support groups is available at www.pccnc.org.

The Comprehensive Cancer Center of Duke University and Lineberger Comprehensive Cancer Center of the University of North Carolina participate in grant-funded studies to research racial differences in prostate cancer treatment outcomes, health care access and to improve the health of prostate cancer survivors. For more information, contact:

American Cancer Society 1-800-ACS- 2345 or www.cancer.org
Cancer Information Service 1-800-4CANCER
N.C. Advisory Committee for Cancer Coordination and Control 919-715-0121

Emerging Issues

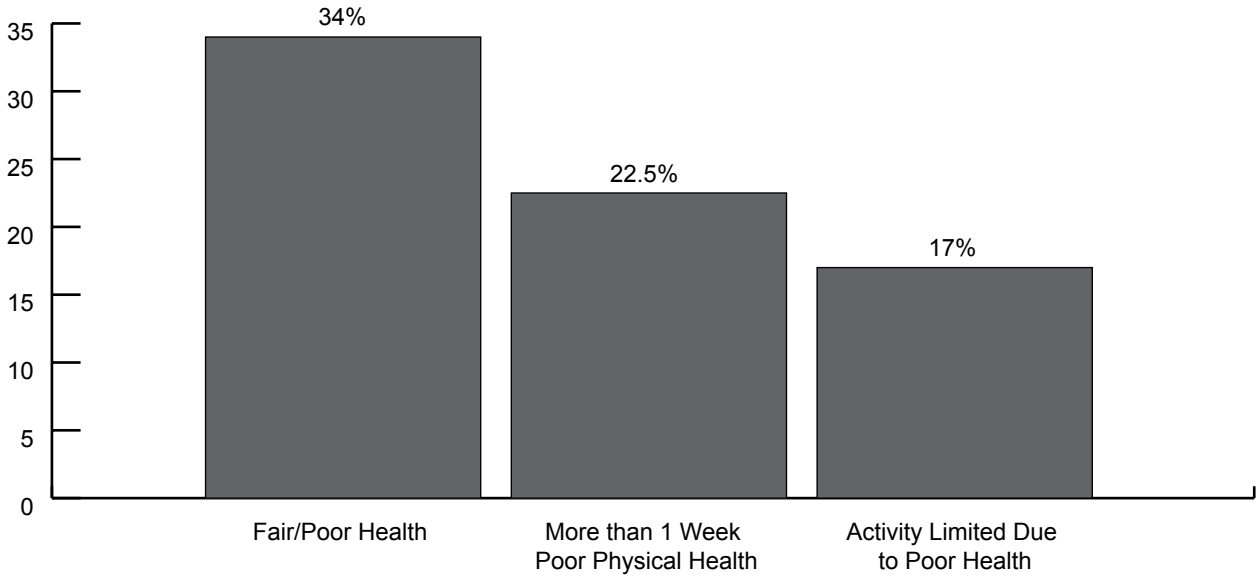
The declining trend in prostate cancer mortality in the state is encouraging. However, whether due to access to healthcare, stage at diagnosis or type of tumor, the disparity in mortality between whites and African-Americans must continue to be addressed. Medical research, screening and education of the population are avenues to be pursued. At the present time there is debate regarding the value of prostate cancer screening. However, both the American Cancer Society and the American Urological Association recommend that the patient and his physician discuss appropriate testing and follow up.

Senior Adult Population

Current State of Affairs

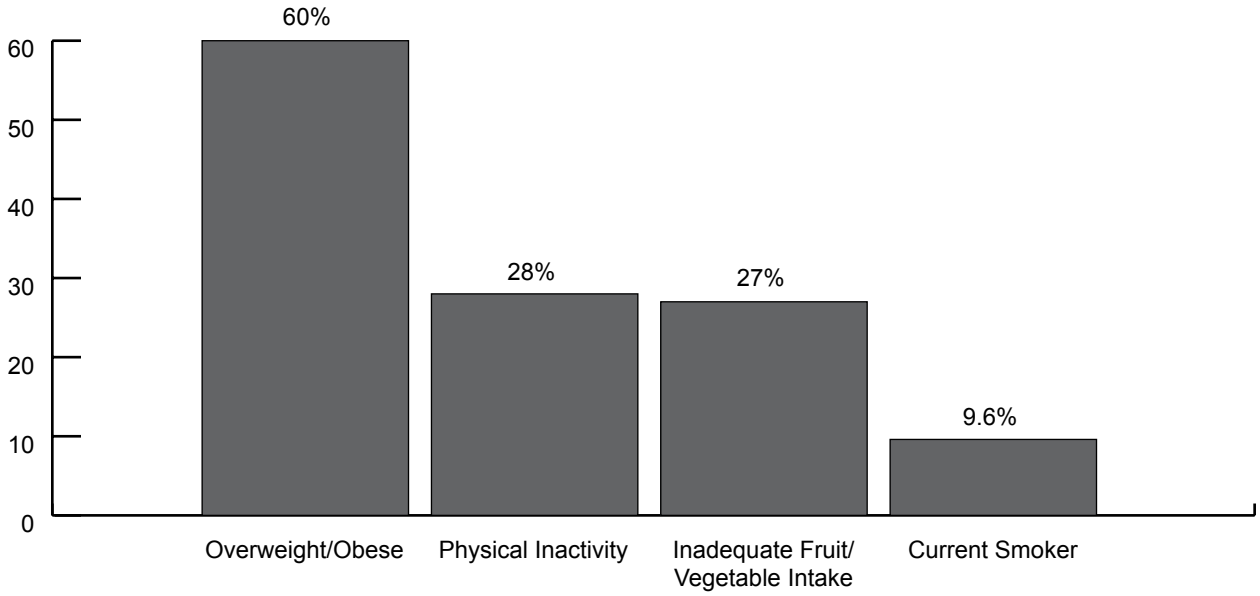
For 2005, it is estimated that 54,553 Wake County residents are age 65 and older. According to the 2005 Behavioral Risk Factor Surveillance System (BRFSS), 34% of N.C. survey respondents of this age considered their health to be fair/poor, with 22.5% reporting more than one week of poor physical health each month. Also reported was that 17 % of this group had activity limitations due to poor health.

General Health Status of North Carolinians Age 65+ 2005 BRFSS



Among factors reported as contributing to poor health were: overweight (60%), physical inactivity (28%), inadequate diet (fruit/vegetable intake) (27%), and smoking (9.6%) These habits/conditions also promote development and/or worsening of various chronic diseases.

Health Behaviors/Risk Factors of North Carolinians Age 65+ 2005 BRFSS

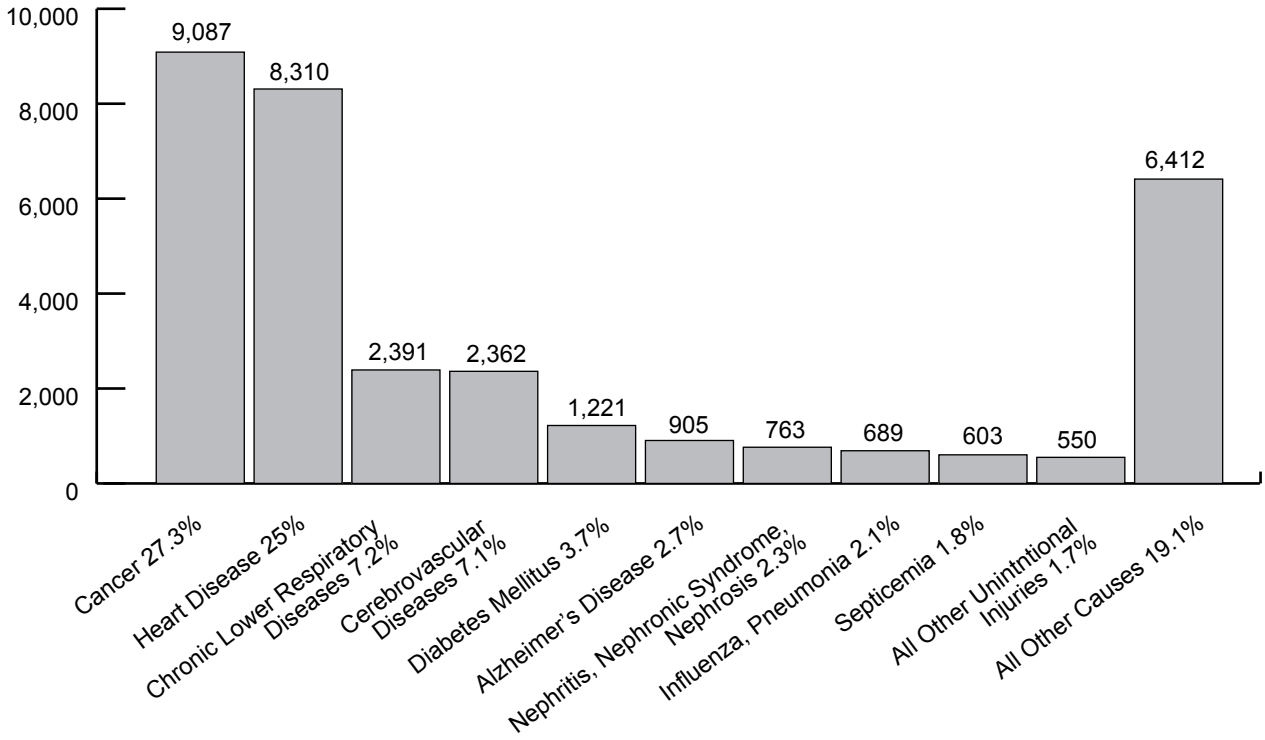


Practicing a healthy lifestyle with regular physical activity, healthy eating and avoiding tobacco can prevent much of the illness associated with age and chronic illness. Physical inactivity can increase a person's risk of heart disease, colon cancer, diabetes and hypertension. In contrast, regular exercise contributes to healthy bones, muscles and joints, relieves arthritis pain and reduces symptoms of depression. In regard to nutrition, many older adults have difficulty preparing meals as they experience increasing physical limitations. They also suffer from physical conditions that require dietary changes and altering of eating habits acquired over a lifetime. These changes can be hard to accomplish and equally hard to accept. However, the maintenance of good nutritional health is essential in order to prevent or delay chronic disease and disease-related complications.

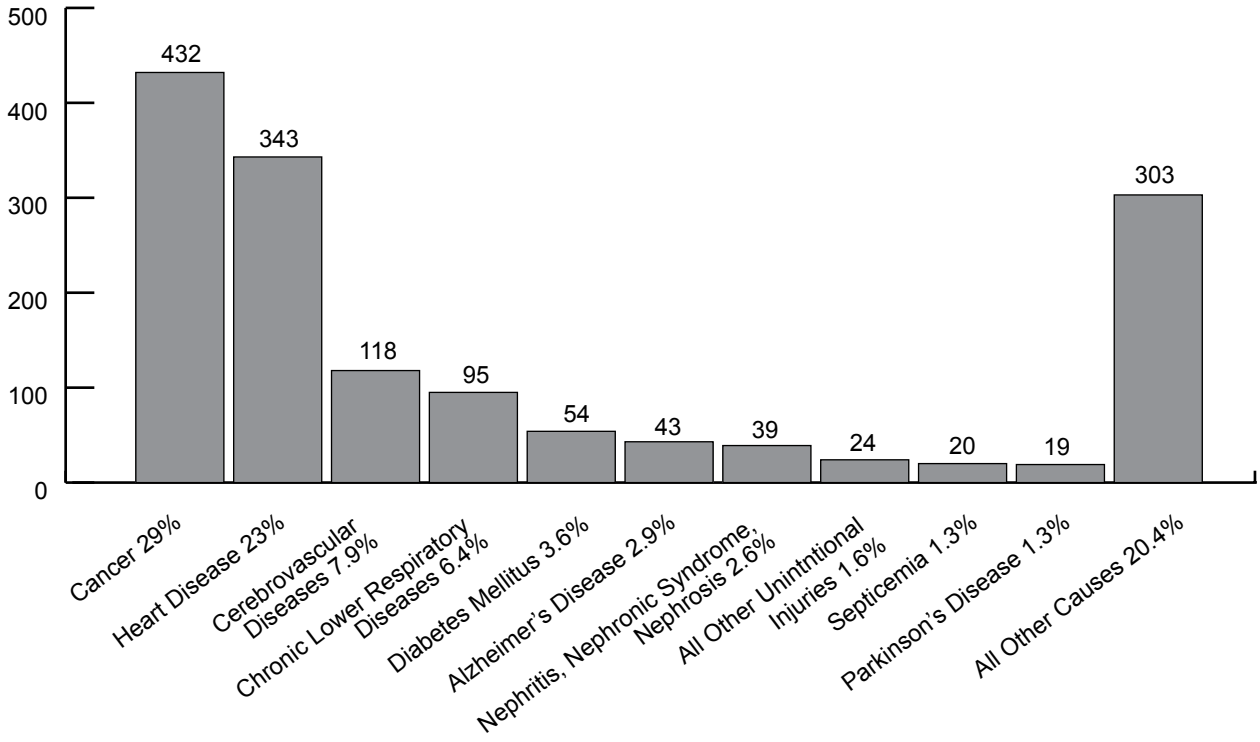
Chronic Diseases / Conditions

Even with healthy lifestyles, senior adults face the likelihood that their health will decline over time. Chronic conditions are the major cause of illness, disability and death in the United States. *(Source: NGA Center for Best Practice – 2004. Measuring the Years: State Aging Trends and Indicators)* Cancer and heart disease are the leading causes of death among North Carolinians and Wake County residents ages 65 to 84. These are followed by chronic lower respiratory diseases, cerebrovascular disease (stroke), diabetes and others as listed in Graphs 1 and 2.

Graph 1: Leading Causes of Death in North Carolina for Adults Age 65-84 2004 SCHS

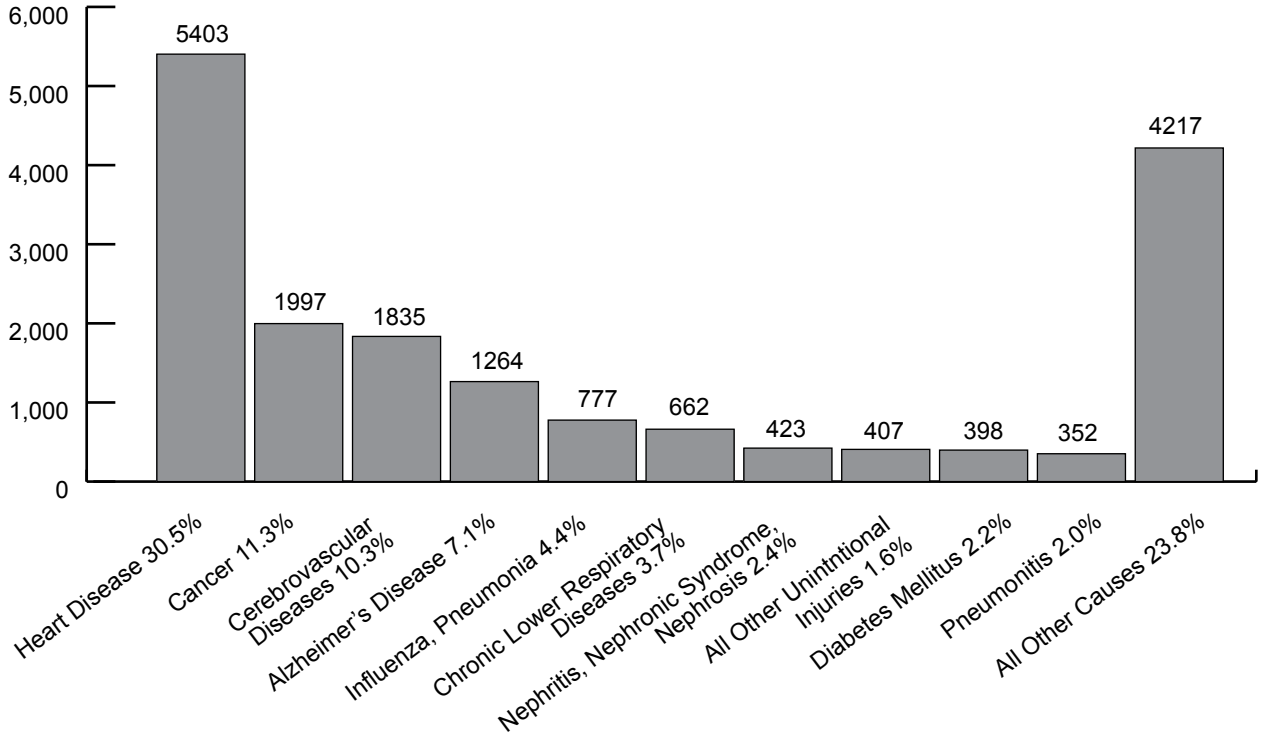


Graph 2: Leading Causes of Death in Wake County for Adults Age 65-84 2004 SCHS

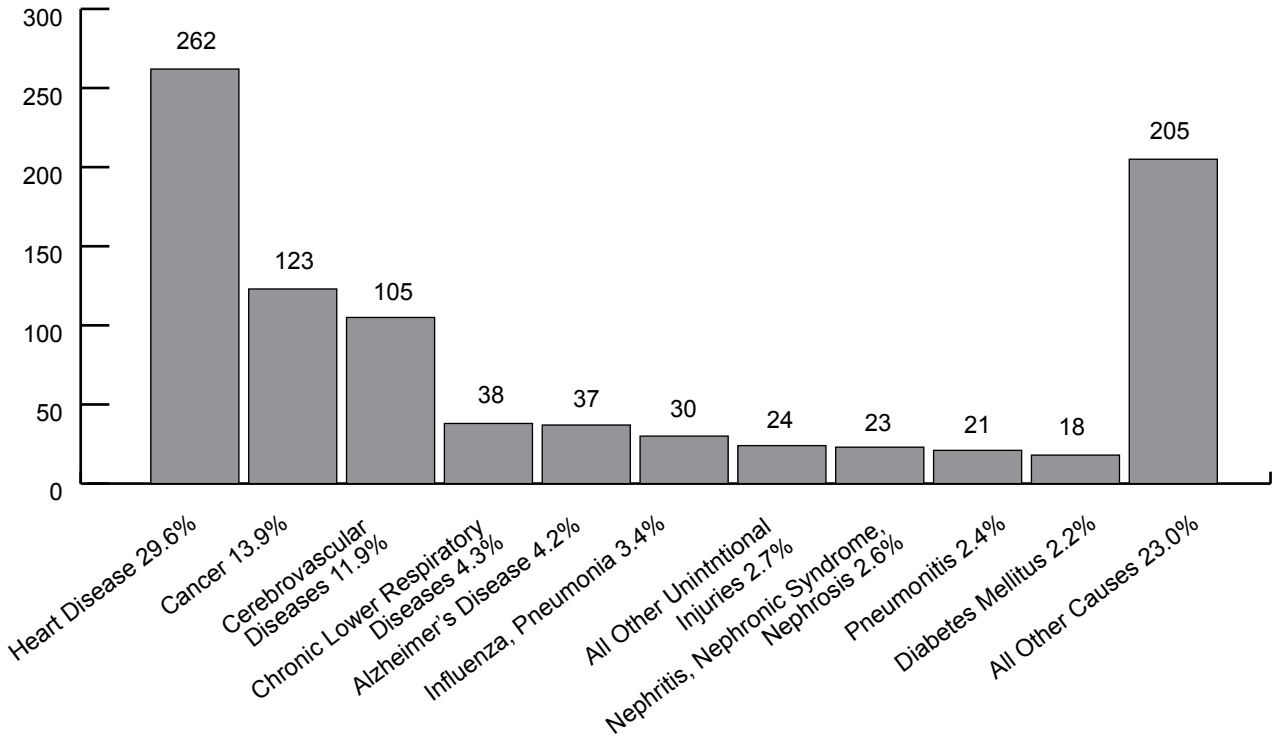


For North Carolinians and Wake County residents ages 85 and older, heart disease, cancer, and cerebrovascular disease are the leading causes of death. These are followed by Alzheimer's disease, influenza, pneumonia, chronic lower respiratory diseases and others as listed in graphs 3 and 4.

Graph 3: Leading Causes of Death in North Carolina for Adults Age 85 and Older, 2004 SCHS



Graph 4: Leading Causes of Death in Wake County for Adults Age 85 and Older, 2004 SCHS



In regard to certain diseases and conditions:

- Influenza is major health risk for senior adults and adults with weakened immune systems. It is estimated that approximately 50% of deaths due to pneumonia could be prevented through the use of a pneumonia vaccine. Flu shots are recommended annually, because the predominant strains of the virus change from year to year. *(Source: Wake County Aging Plan 2005 – 2009, Growing Older Living with Dignity)*
- In 2000, it was estimated that there were about 2,774 individuals in Wake County living with Alzheimer's disease. By 2010, that number is expected to increase by over 100% to 4,129. *(Source: North Carolina Division of Aging and Adult Services)*
- Depression in senior adults is a serious, chronic condition that often goes undiagnosed and untreated. Nationally, depression affects about 67 million senior adults age 65+, but only about 10% of these individuals receive treatment. Clinical depression can be triggered by long-term illnesses such as cancer, diabetes, stroke and heart disease, and older adults who are depressed are more likely to commit suicide than their younger counterparts. In addition, older adults with depression can expect to have approximately 50% higher health care costs than non-depressed senior adults. Depression can also increase an individual's likelihood of developing certain illnesses, primarily those affecting the immune system. (Source: www.healthyplace.com/Communities/depression/elderly.asp)

- The Center for Substance Abuse Treatment has estimated that almost 17% of the elderly population in the U.S. abuses alcohol and drugs. Drug use among institutionalized senior adults is even more prevalent. Although substance abuse is statistically at epidemic proportions, it typically goes unreported and undiagnosed. Substance abuse by senior adults is easy to hide, because seniors are often less active in mainstream society and there is simply no one around to notice. Senior adults are not likely to get in trouble with the law and have little contact with the criminal justice system. Because many seniors are retired, they are also not likely to lose a job or career because of problems with alcohol. Historically, many seniors who abuse substances are also experiencing social isolation and physical health problems. Many are coping with grief due to the loss of a loved one, while others are facing housing, financial, marital and mental health problems. *(Source: Your Guide to Alcoholism/Substance Abuse, About.com, July 23, 2006)*

Trends, Disparities, Gaps, Unmet Needs

In the senior adult population, as in others, barriers to health care include: lower educational level, limited English proficiency, disabilities, and limited income. In Wake County, 28% of citizens age 65 and above have less than a high school education with 1.4% having limited use of English. Also, 39.7% have one or more physical, mental or emotional disabilities. *(Source: NC Dept. of Aging 2003)*

With the earliest baby boomers born in 1946 beginning to reach their senior years and with the increase in life expectancy, North Carolina and Wake County must move quickly to meet the needs of a rapidly growing segment of the population. The 1979 –1981 average life span was 72.9 years. However by 1996-2000, it had increased (by 2.7 years) to 75.6 years. In 2001, 28% of N.C. citizens were age 50 and above. By 2030, this age group is projected to increase to 35% of the state's population. *(Source: A Healthy Profile of Older North Carolinians, April 2003)*

- Access to Care – An important component of independence is the ability to access affordable health care. Wake County has high quality health care resources for those senior adults who can access them. Unfortunately, many physicians are refusing or limiting the number of Medicare and Medicaid patients they accept because of low reimbursement rates. Because Medicare and Medicaid are the primary insurers for the majority of the county's senior adults who have insurance, many individuals are left struggling to find a doctor. *(Source: Wake County Aging Plan 2005 – 2009, Growing Older Living with Dignity)* In addition, those seniors who are looking for physicians whose declared primary specialty is geriatrics are faced with very limited choices.
- Prescription Drugs – Another issue of concern to Wake County seniors is the cost of prescription drugs. While Medicare Part D prescription drug coverage became available in January 2006, many plans cover only about 50% of prescription drug costs and have coverage gaps. Medicare helps pay for drugs up to a limit of $2,250. It then pays 0% until out-of-pocket expenses reach a total of $3,600, and then pays 95% of the costs for the rest of the year. Those senior adults experiencing the coverage gaps know how expensive medications are becoming. The average manufacturer price increase for brand name drugs continues to outpace the annual 3.8% rate of general inflation. Nearly 200 of the most commonly used brand name medications for older adults rose on average 6.3% in the 12 months ending with June 2006. These rising costs are forcing seniors to seek alternatives that offer price relief. Many of them are looking to the political arena and urging public officials to support legislation that would make nontraditional methods of obtaining prescription drugs both safe and legal. *(Source: AARP Studies Find Rising Prescription Drug Prices and Rising Voter Concern About Affordability, September 19, 2006)*

Community Perceptions

As part of the 2006 Wake County Community Assessment, residents shared their views through surveys and focus groups. When asked what was best about living in Wake County, 79% of focus groups indicated that resources, including services to seniors, ranked highly. When asked what improvements were needed, 68% of focus groups mentioned services, including those for low-income seniors. In regard to major health problems, diabetes was mentioned by 43% of focus groups and obesity by 39%.

Resources and Strengths

There are a variety of resources for seniors in Wake County. These include, but are not limited to:

Resources for Seniors, Inc., 1110 Navaho Drive, Raleigh. Provides a variety of home and community-based services that allow senior and disabled adults to maximize their independence while remaining in their homes. MAPS Program assists eligible participants to access free or low-cost medications through patient assistance programs.
www.resourcesforseniors.com
919-872-7933

FIGS (Filling in the Gaps), Wake County Human Services, 220 Swinburne St, Raleigh. Provides short-term financial assistance with prescription drugs for individuals without insurance.
www.wakegov.com
919-212-7000

Meals on Wheels, 1001 Blair Drive, Raleigh. Provides both congregate and home-delivered meals to senior adults who suffer from mental and/or physical impairment.
www.wakemow.org
919-833-1749

Seniors' Health Insurance Information Program (SHIIP), 111 Seaboard Ave, Raleigh. Provides information about Medicare, supplemental insurance, Medicare Part D and long-term care insurance.
www.ncshiip.com
919-733-0111

Alzheimer's Association Easter NC Chapter, 400 Oberlin Rd, Suite 220, Raleigh. Provides information and consultation, support groups, family resources center, advocacy.
www.alznc.org
919-832-3732

Adult Medicaid, Wake County Human Services, Multiple Sites:

220 Swinburne St, Raleigh	Telephone: 919-212-7000
1002 Dogwood Drive, Zebulon	Telephone: 919-404-3900
130 N Judd NE Parkway, Fuquay-Varina	Telephone: 919-557-2501

www.wakegov.com

Crisis and Assessment Services, Wake County Human Services Local Management Entity, 3000 Falstaff Rd, Raleigh. Provides treatment and referral services for individuals suffering from depression and other mental health problems.
www.wakegov.com
919-250-3133

Emerging Issues

The goal of health for seniors is no longer just the absence of disease and disability but rather wellness. Healthy aging, as defined in 2002 by the CDC and adopted by North Carolina's Division on Aging, requires development and maintenance of optimal physical, mental, and social well-being in older adults. Long-term support from government and society for health promoting policies and environments is necessary. Improving the capacity of health care and human service professionals to serve clients appropriately and effectively in cross-cultural settings is key to serving an increasingly diverse population.

North Carolina is reaching a milestone this decade as the state's 2.3 million baby boomers, those born between 1946 and 1964, begin to enter retirement age. This year, the oldest baby boomers become eligible to receive services under the Older Americans Act, which defines senior adults as age 60+. The impact of the aging baby boomers is evident in the projected growth of older adults between the years 2000-2030.

Projected Growth of North Carolina Adults Age 65+ (2000 – 2030)

	2000	2020	2030
Population Age 65+	969,112	1,640,811	2,208,168
% Increase from 2000		60%	130%

Projected Growth of Wake County Adults Age 65+ (2000 – 2030)

	2000	2020	2030
Population Age 65+	46, 766	116, 674	163,700
% Increase from 2000		130%	>250%

Increasing life expectancy is another factor contributing to the growth projected for the state's and county's older adults. Babies born in North Carolina today are expected to live, on average, to the age of 75.6 years. North Carolinians who are already 60, are expected to live, on average, to the age of 80. *(NC Study Commissions on Aging Report to the Governor and the 2006 Regular Session of the 2005 General Assembly)* While these statistics are promising, they must be evaluated in terms of the country as a whole. North Carolina is at a mild disadvantage compared to the United States. Those adults who are over age 65 in North Carolina have a lower life expectancy, higher rate of poverty and lower average education and income than their national counterparts. *(Source: The 2003-2007 NC Aging Services Plan)*

North Carolina's Profile in Comparison to the United States

	North Carolina	United States
Life Expectancy at Birth	75.6	76.9
Life Expectancy at 60 (additional years)	20.8	21.6

The tremendous growth in the senior population projected for Wake County will be accompanied by an increased demand for services and supports. Planning is crucial to assure that critical needs can be met. In view of this challenge, the WCHS Board established an Aging Services Committee, and charged it with the task of developing a countywide aging plan. The committee researched the current status of services for seniors in Wake County, identified issue areas of greatest concern and developed recommendations for each area. Recommendations were designed to guide efforts made by Wake County government bodies, non-profit agencies, private sector businesses and the community as a whole. The first phase of the plan was completed and presented to the Wake County Board of Commissioners in December 2005. Good health was identified as one of the areas of primary concern.

North Carolina and Wake County must prepare health policies and programs to meet the needs of this increasing segment. There will continue to be seniors in need of hospitalizations and treatments. But with promotion of healthy aging (health education, health screening and other prevention programs), hospitalizations, costly treatments and disabilities in later life can be reduced.

Some of the primary emerging issues are as follows:

- The continued growth in the number of older people has caused – and will probably continue to cause – an increase in the number of people who are most vulnerable to, and most affected by, chronic conditions.
- If past trends are any indication, some chronic conditions may be more common in the future. If disease rates rise while the number of older people grows, an increase in the number of people with chronic conditions can be expected.
- As a result of new diseases and health threats, different services may be needed in the future. Plans for future health care systems must be sufficiently flexible so that they can be responsive to diseases or health threats that are not yet known as well as to unpredictable threats such as those posed by environmental hazards or terrorism.
- The increase in obesity rates and the number of people who are overweight is of particular concern. The current high proportions of younger as well as older adults who are at risk for health problems related to being overweight suggest that the proportion of overweight elderly will be even higher in the future.
- Estimates based primarily on current disability rates and applied to the number of older Americans anticipated in the future suggest that more Americans will need long-term care in the future. People needing long-term care also will need a range of different services depending on the type and severity of the disabilities.
- Projections from the Federal Bureau of Labor Statistics indicate substantial growth in employment for health care providers. In the case of long-term care workers, the demand may continue to exceed the supply of available workers. The U.S. Department of Health and Human Services projects, for example, that there will be substantial shortages of paraprofessionals, such as home health aides and nursing aides.
- A shift to more community-based care is anticipated. The shift from institutional to community-based care in Medicaid is occurring more rapidly in some states than in others but the trend is expected to continue in all states. Home and community-based care can be provided in a variety of settings, including people's own homes as well as in assisted living facilities, which furnish care in a congregate residential setting.
- Traditional caregivers may not be available. Women of all ages are more likely to be in the labor force today than they were 40 years ago. As a consequence, fewer women are available to take on the traditional role of caregiver for family members. Families will continue to play an important role in ensuring that people who need care receive it, but in the future, more assistance will probably be required. The pool of potential caregivers may become more varied in the future. Older adults may be providing care for each other. Longer life expectancies make it more likely that there will be grandchildren who can assist family members. With increased instances of divorce, there may be more ex-spouses involved with the care of former family members as well. *(Source: NGA Center for Best Practices (2004), Measuring the Years: State Aging Trends and Indicators)*

Access to Health Care

Current state of affairs

The number of uninsured residents of Wake County continues to rise at alarming rates. In 2005, N.C. ranked 10th nationally of states with the largest percentage of uninsured people. Nearly 17% of N.C. residents were without health insurance. Of the nearly 1.4 million people in N.C. who are uninsured, it is estimated that nearly 100,000 reside in Wake County. According to 2005 BRFSS data, 19.1% of N.C. residents and 14.5% of Wake County residents were without health insurance.

Two-thirds of the uninsured are low-income individuals or families, earning less than 200% of the federal poverty level, or $38,700 for a family of four in 2005. (*Source: Cecil G. Sheps Center for Health Services Research, UNC at Chapel Hill, 2005)* The majority of uninsured adults (59%) have gone without coverage for a period of at least two years. Adults are more likely to be uninsured than children, making up 80% of the uninsured population. *(Source: The Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, January 2006.)*

Uninsured adults are less likely to receive preventive services than adults with insurance coverage. Also, 50.8% of uninsured vs. 22% of insured adults do not receive appropriate mammogram testing. Forty percent of uninsured do not have a regular place of medical care to go when they are sick or need medical advice compared to just 9% of those with insurance. *(Source: Institute of Medicine. Care without Coverage: Too Little, Too Late, 2002; Kaiser Commission on Medicaid and the Uninsured: Brief on Consequences of Being Uninsured by Jack Hadley)*

In 2005 in Wake County, there were 821 active primary care medical providers (internal medicine, family medicine, pediatrics, and OB-Gyn) and 362 mid-level providers (physicians assistants and nurse practitioners). *(Source: NC Medical Board data for 2005)* These numbers compare to 656 active physicians and 363 mid-level providers in 2004. *(Source: 2006 UNC Sheps Center for Health Services Research)* Most people have health insurance through their employers. In N.C. in 2004, 61% of non-elderly residents had employer-sponsored insurance. In 2000, 67.6% of residents had coverage through their employers. Decline in employment-based coverage has led to sharp growth in the numbers of uninsured. *(Source: Holmes M. Analysis of the US Census; Cecil G. Sheps Center for Health Services Research, UNC Chapel Hill, 2005)*

Trends, Gaps, Unmet Needs

The number of primary care physicians per 10,000 people in Wake County has remained stable. The number has remained at 9.3 primary care physicians per 10,000 in 1999, 2003, and 2005. *(Source: N.C. Medical Society)* Statewide, the percentage of uninsured North Carolinians increased by almost 15% from 2000 to 2004. *(Source: SCHS North Carolina State Center for Health Statistics)*

Access to healthcare varies depending on age, race, and income. Although the number of uninsured is rising in all groups, the largest percentage increases are in Latino and African-American populations.

Percent of Adults ages 18-64 with no health insurance
(Source: Report Card, 2006. Racial and Ethnic Health Disparities, NC OMHHD/SCHS)

	1997-2001	2002-2004
All	15.6	16.5
White	13.8	14,6
African American	19.5	22.3
Latino	26.8	61.1

Percent of adults who could not see a doctor in the previous 12 months due to cost

	1997-2001	2002-2004
All	12.0	15.1
White	10.8	13.2
African American	15.8	20.8
Latino	15.3	25.2

Fourteen percent of all hospital emergency department visits by Wake County patients were primary care related. *(Source: Solucient FY2003 database)* A rise in the number of those uninsured results in increases of local emergency department services for primary care needs. From 2003-2004, use of WakeMed's emergency room rose nearly 9% and projections are that this level of growth will continue.

Community Perceptions

Of 2006 Wake County Community Assessment focus groups, 68% reported that lack of transportation prevented them from staying healthy because of difficulty getting to needed services. Also, 61% mentioned lack of access to services/lack of services as reasons that prevented individuals from staying healthy. To improve these problems, 68% of focus groups listed the need to have more or improved services. Also, 39% reported that providing affordable transportation/improved transportation would improve this aspect of maintaining health. Positive actions listed by 21% of focus groups as working in Wake County to address health were services for Latinos (including: Open Door Clinic, Alliance Medical Ministries, Centra Para Familia and general use of bilingual staff) Also, 68.1 % of individual respondents in the 2006 Community Assessment survey considered affordable health care as a moderate to serious problem. In this category, 43.4% listed transportation to health care and 39.3% listed providers who accept Medicaid/Medicare as moderate to serious problems.

Resources and Strengths

There are four acute care hospitals in Wake County including WakeMed, Rex Hospital, Duke Health Raleigh Hospital, and WakeMed Cary. The bulk of Wake County's uninsured care is delivered at WakeMed. In 2005, WakeMed provided $119 million in unreimbursed care for the poor. That number is expected to increase by more than 30% in FY 2006. *(Source: WakeMed Health & Hospitals)*

Community resources for primary care:

Wake County Human Services
Clinical outpatient care provided five days a week at multiple locations. Services include: Preventive health and acute medical care for children ages 0-18, prenatal care, contraceptive health care for women, STD/HIV treatment, dental care for children and adults and treatment and preventive care of communicable diseases.

Wake Health Services
Federally qualified community health center providing primary medical care and dental care to children and adults at multiple locations in Wake County.

Alliance Medical Ministry
Acute and chronic primary medical care, preventive medicine services and health education provided to working, uninsured adult residents of Wake County. The clinic operates Monday – Friday from 8 a.m. to 5 p.m. and Saturdays 9 a.m. to noon. 50% of patients are Latino and 30% African-American; 100% are working uninsured and 98% have annual household incomes of less than $30,000.

Open Door Clinic
A program of Urban Ministries of Raleigh that provides chronic and urgent care to Wake County residents primarily in the weekday evenings.

CareLina Internal Medicine
WakeMed AHEC program for adult primary care needs located at WakeMed hospital.

Project Access
Program of Wake County Medical Society that provides subspecialty care via volunteer physicians to persons who qualify based on household income.

Emerging Issues

There is a compelling need to care for uninsured patients in a way that minimizes their use of emergency room services while improving the quality, continuity and availability of their medical care. The cost/patient visit in local emergency rooms averages about $1,000/visit. The average cost/patient visit in a local community clinic (such as Alliance Medical Ministry) is about $80/visit.

Most of the above resources for uninsured care are operating at or near capacity. CareLina Internal Medicine is no longer accepting new patients, and Wake Health Services and Open Door Clinic frequently have extended waiting periods for new patients. Increasing access to care for the medically underserved will mean increasing capacity of the county's safety net providers.

Access to care for Spanish-speaking patients is of concern. Wake County has one of the most rapidly growing Latino populations in the nation with a limited number of bilingual primary care practices. Transportation, availability of medications and subspecialist medical services are also limiting factors.

Project Access helps secure subspecialist services in Wake County, but there is much more demand than there are volunteer physicians to fill the needs. Patients can be referred to Wake Faculty Physicians or UNC in Chapel Hill for some subspecialist care. Both programs will work with patients to provide discounted fees based on income and need. Travel to the UNC medical clinics is complicated by the transportation need.

CapitalCare Net is a membership of safety net providers working collaboratively to develop initiatives to improve the health of the region's medically underserved. CapitalCare Net members include the majority of Wake County's safety net healthcare providers: WakeMed Health and Hospitals, Wake County Medical Society, Rex Healthcare, Wake County Human Services, Wake Health Services, Inc., Alliance Medical Ministry, Urban Ministries of Raleigh and Duke Health Raleigh Hospital.

CapitalCare Net uses centralized, web-based tools to assist local health care safety net providers in more efficiently providing services, thus having a positive impact on providers' capacity to serve the uninsured with high quality medical care. Goals of CapitalCare Net are to increase access to medical care, reduce duplication of services, improve quality of care, positively affect financing solutions for care of the region's uninsured and assess community health needs.

Communicable Diseases

Current State of Affairs

Communicable disease control is one of the most important core functions of public health. Excellent advances in infectious disease control have been made over the past 200 years, dropping mortality and morbidity from these diseases to the lowest levels in history – so low, in fact, that most people in the Western world are now living long enough to die from other chronic diseases, which have rightly become more of the overall public health focus. However, many parts of world still lack proper sanitation and other keys to controlling disease in which infection remains a high cause of death. Even in the United States, communicable disease has not been eradicated; with certain infections – HIV, for example – slowly rising after years of control.

North Carolina law requires 70 communicable diseases to be reported to local health departments as soon as they are diagnosed or strongly suspected. Wake County Human Services investigates all reported cases, following up not only with any possible contacts to further identify cases of disease, but also ensuring that all control measures are followed that would prevent the spread of disease to other people. For certain reportable diseases, prevention and treatment services are available through Wake County Human Services. On a yearly basis, sexually transmitted diseases (including HIV/AIDS, gonorrhea, chlamydia, and syphilis), tuberculosis, salmonella, Rocky Mountain spotted fever, and pertussis (whooping cough) are among the most frequently diagnosed reportable communicable diseases in Wake County.

Tuberculosis is a difficult disease to treat for many reasons. It requires starting a lengthy regimen of medications, each with the potential for many side effects. Individuals with TB must remain isolated until the treatment makes them unable to spread the disease to others. In the first seven months of 2006, 41 tuberculosis (TB) cases were investigated in Wake County with 26 true cases identified and reported to state officials. Eighteen (69%) of the TB cases were foreign born, one was homeless, and nine were African or African-American. Wake County staff have improved the procedure for homeless shelter investigations, and have seen a reduction in the number of TB cases in homeless residents from the eight cases in 2002 to two cases in 2005.

After the development of modern sanitation practices, immunizations became the most important weapon in the fight against communicable disease. Wake County has one of the highest immunization coverage rates of any county in North Carolina. The overall percentages of children receiving age-appropriate immunizations in Wake County were 91% in 2003, 91% in 2004, and 93% in 2005. WCHS also ensures that all children who receive vaccines from a Human Services provider are up-to-date by their third birthday, achieving the current year coverage rate of 96%. Several new immunizations are now available to help prevent the spread of communicable diseases.

Reported Communicable Diseases (Total Cases) Wake County 2001-2005*
Wake County Human Services Communicable Disease Program and HIV/STD Program

Disease Population	2005 749,989**	2004 721,437	2003 699,503	2002 679,510	2001 658,490	Disease Population	2005 749,989*	2004 721,437	2003 699,503	2002 679,510	2001 658,490
AIDS	142	138	129	105	86	Hepatitis C-Acute			1	2	
Campylobacter	51	53	53	57	36	HIV Disease***	208	185	225	166	149
Chlamydia	1915	2143	1738	1591	1576	Legionellosis	4	3			
Cryptosporidiosis	8	3	2	1	4	Listeriosis	3	4		1	
Dengue	3	2				Lyme Disease	16	27	35	15	11
E. coli Shiga Toxin Producing Infection	13	26	4	2	3	Malaria	7	1		6	4
Ehrlichiosis, Granulocytic		2			1	Meningitis, Pneumococcal	6	2		2	1
Ehrlichiosis, Monocytic	6	4		3		Meningococcal Disease	4			6	5
Ehrlichiosis, Unspecified	2					Pertussis (Whooping Cough)	9	11	9	6	9
Encephalitis, Arboviral (CAL, EEE, WNV, Other)	1	1	1			Rocky Mountain Spotted Fever	101	96	44	10	1
Enterococci, VRE	No longer reportable	46	60	54	52	Salmonellosis	157	157	137	132	104
Foodborne Illness				22		Shigellosis	16	13	47	58	36
Other or unknown	1	1				Streptococcal Infection, Group A invasive disease	16	6			7
Gonorrhea	725	1131	1291	1041	1270	Syphilis (primary, secondary, and early latent)	65	44	37	43	51
Hemolytic-Uremic Syndrome	1	8				Toxic Shock, streptococcal	1	2			
Hemophilus influenzae-invasive	7	9	6	5	5	Toxic Shock Syndrome	1	1	1		
Hepatitis A	5	8	14	45	16	Tuberculosis	34	53	46	57	40
Hepatitis B-Acute	11	6	13	31	21	Typhoid, Acute	1	1			
Hepatitis B-Carrier	72	78	128	175	98	Vibrio Infection other than Cholera	1	1	1		1
Hepatitis B-Perinatal		1		16		Vibrio Vulnificus	2				

Revised 8-18-06
Sources: Wake County Human Services Communicable Disease Program; NC 2005 HIV/STD Surveillance Report
*NC law requires reporting of specific diseases. Only those reported in Wake County since 2001 are included in this chart.
**Wake County 2005 Forecasted Population http://www.wakegov.com/planning/demographic/dd_Population.htm
***HIV Disease and AIDS cases should not be added together to get a total count. Some newly diagnosed individuals are counted in both categories in the reporting year.

FluMist Intranasal Vaccine is now available as an alternative to traditional flu injections. Pediarix vaccine, a combination of five shots, was licensed in 2003, reducing the number of shots young infants receive. Both medical professionals and citizens alike look to Wake County Human Services to provide updated and accurate information on vaccinations that protect them and their children. Vaccines are essential in protecting Wake County citizens against serious diseases that are still present around the world, such as polio and measles, as well as against disease still commonly found in the United States, including pertussis (whooping cough), influenza, and chicken pox.

June of 2006 marked the 25th year of HIV/AIDS in the United States. Since 1981, this disease has become one of the greatest public health challenges in the U.S. and around the world. In 2005, 208 new individuals were reported with HIV disease in Wake County. The demographics of local cases resemble the trends in the rest of the nation. Despite the successes of prevention programs in the county, racial and ethnic disparities still exist, especially among black men and women. The rate of HIV infection among African-Americans (81.4 per 100,000) is six times greater than whites (14.6 per 100,000) and three times greater than Hispanics (29.5 per 100,000). In addition, HIV prevalence remains high among men who have sex with other men (MSM). At least 45% of the cases in 2005 indicated that men having unprotected sex with other men was the likely the mode of transmission. Wake County has the second highest number of HIV cases of any county in North Carolina. The growing number of living persons with HIV means that not only are more persons potentially capable of transmitting the virus to others, but existing resources may not be adequate to ensure that these persons have access to appropriate care, treatment and prevention services. This continues to present a challenge to the entire community in Wake County.

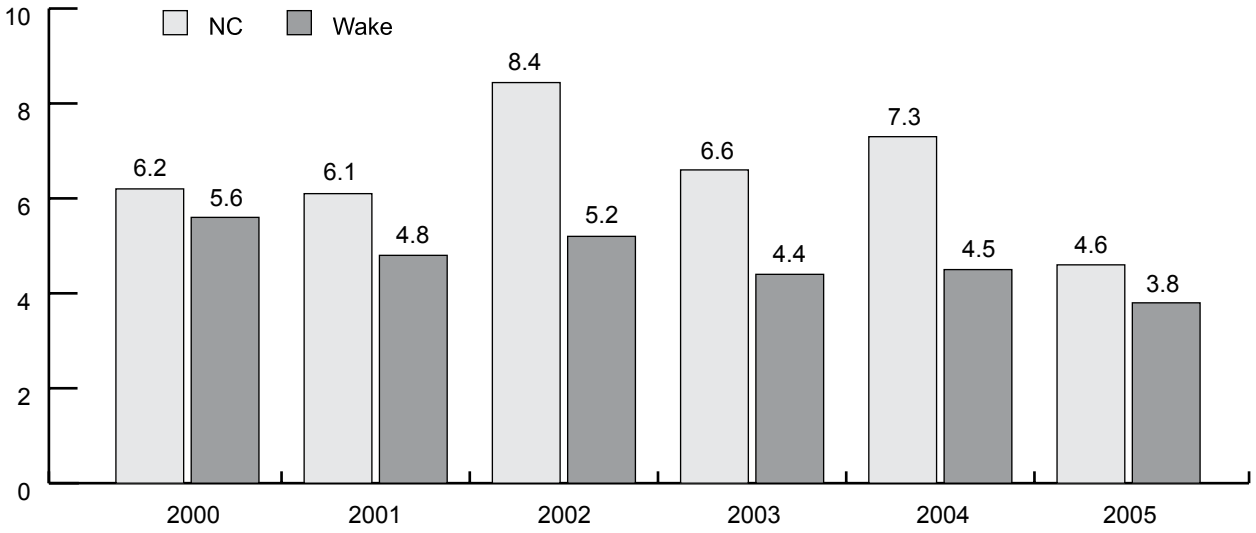
Trends, Disparities, Gaps, Unmet Needs

In 2004, 54% of the TB cases in the U.S. were foreign born, and approximately 50% of all Wake County TB cases are foreign-born. The overall TB case rate for the U.S. in 2004 was 4.9/100,000 people. However, when separated out, the U.S.-born rate was 2.6/100,000 and the foreign born was 22.8/100,000, meaning that the foreign born were 10 times more likely to have TB as those born in the U.S. In 2004, a 22-year-old foreign-born Hispanic male TB case exposed many children under the age 5, nine of whom were diagnosed and treated for active TB disease. Another area of concern is the continued disparity with the number of African or African-American cases. In Wake County during the past five years, the rate has ranged from 34% to 53% of the cases. In North Carolina during 2005, 159 of 329 total cases were of the African/African-American race. In the first seven months of 2006, nine of the reported cases in Wake County were black/African-American. State law mandates treatment of active TB, and legal action is sometimes necessary to ensure compliance with the medication regimen.

Tuberculosis Case Information: 2001-July, 2006

	Total Suspect Cases	Total Cases	Foreign Born Cases	HIV + Cases	Homeless Cases	African & African-American	Extra-Pulmonary Cases
2001	75	40	20 (50%)	3 (7%)	5 (12%)	19 (49%)	12 (31%)
2002	83	57	30 (52%)	11 (19%)	8 (14%)	25 (44%)	13 (23%)
2003	70	46	19 (41%)	9 (20%)	8 (17%)	24 (53%)	14(30%)
2004	73	53	30 (57%)	5 (9%)	4 (7.5%)	18 (34%)	16 (30%)
2005	72	34	17 (50%)	4 (12%)	2 (6%)	18 (53%)	10 (29%)
2006 through July	41	26	18 (69%)	0 (0%)	1 (.04%)	9 (35%)	11 (42%)

TB Incidence Rates Wake County and NC 2000-2005

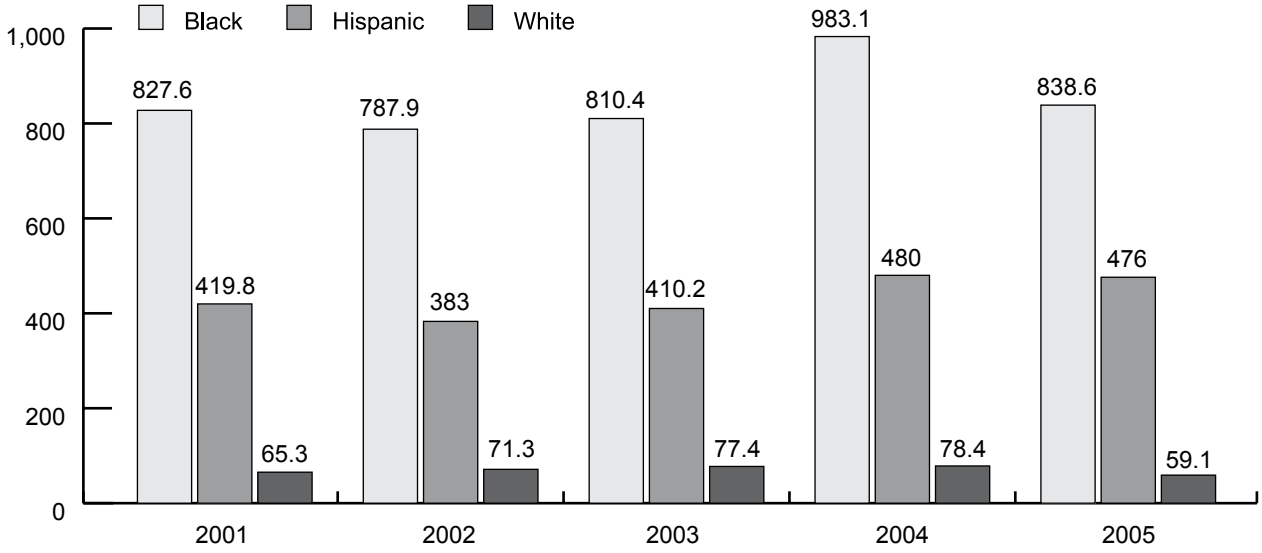


Summary of Legal Actions Taken Against Noncompliant Wake County Patients 1999-2005

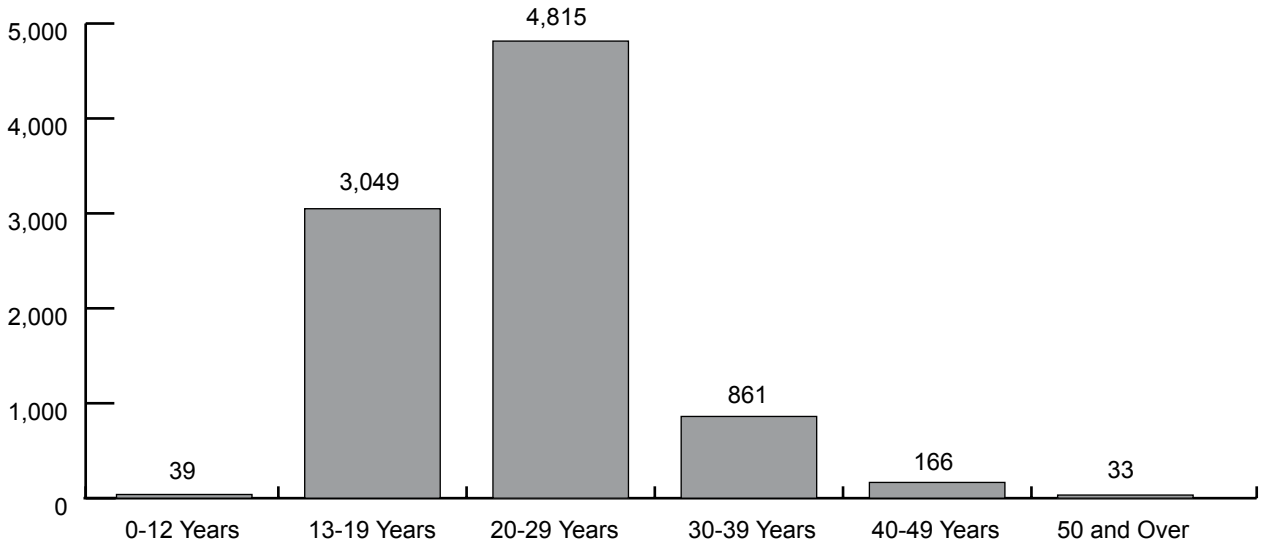
Legal Actions	Number
Warrants Issued	14
Trials continued and patients completed treatment awaiting trial	3
Convicted and completed treatment while incarcerated	4
Pled guilty and completed treatment while on probation	4
Arrested; released because incompetent to stand trial; re-arrested and finished treatment in group home facility	1
Never located	2

Sexually transmitted diseases (STD) are represented differently among gender, age, race, and ethnic groups. In Wake County, the black population represents 20.5% of the total population, but 58% of the total HIV cases. From 2001-2005, the Wake County rates of chlamydia were highest among females aged 13-29. In 2005, 70% of all chlamydia cases were among females. Blacks are 14 times more likely to get chlamydia than whites, and Hispanics are eight times more likely to get chlamydia than whites. Gonorrhea is the second most commonly reported STD behind chlamydia. Gonorrhea reports in Wake County have been stable over the last three years. However, rates among blacks are 23 times higher than whites, while Hispanic rates are three times that of whites. In 1998, CDC data reported that over 50% of all cases of syphilis in the U.S. were reported from 28 counties. Five of those counties were in North Carolina: Forsyth, Guilford, Mecklenburg, Roberson and Wake. In 1999, CDC provided funding to Wake County for the Syphilis Elimination Project. It successfully reduced the numbers of cases, from 105 in 1999 to 37 in 2003. There has been a recent rise in syphilis cases since 2003, however, and Wake County has seen an increase in male cases, from 27 cases in 2003 to 56 cases in 2005. On a very positive note, there have been no cases of congenital syphilis reported in the last five years.

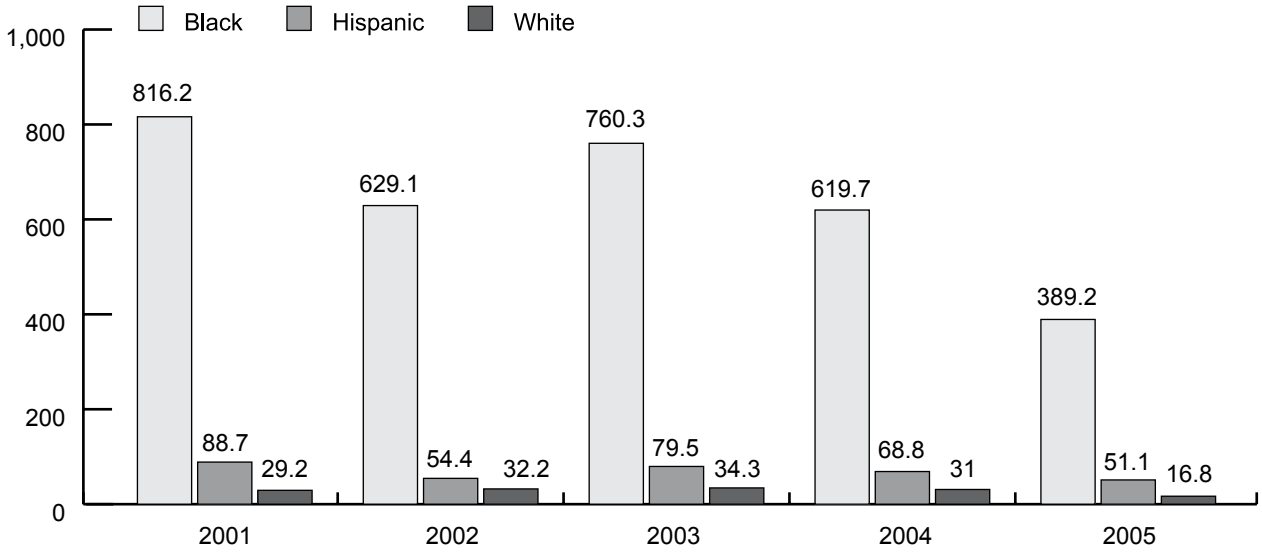
Chlamydia by Race, Rates Per 100,000 in Wake County 2001-2005



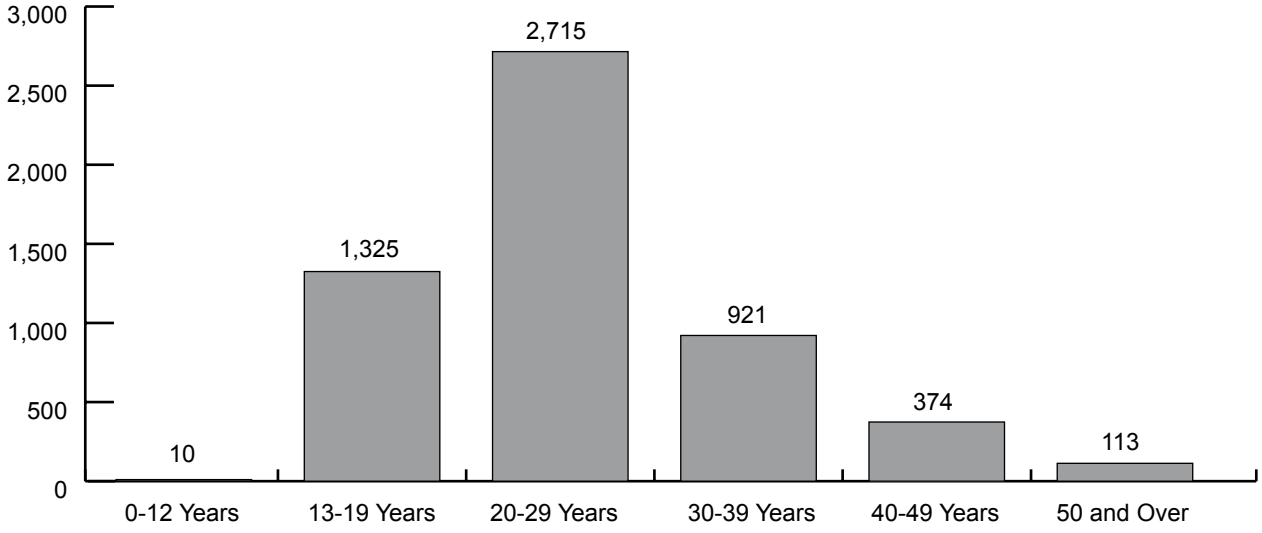
Chlamydia by Age in Wake County 2001-2005



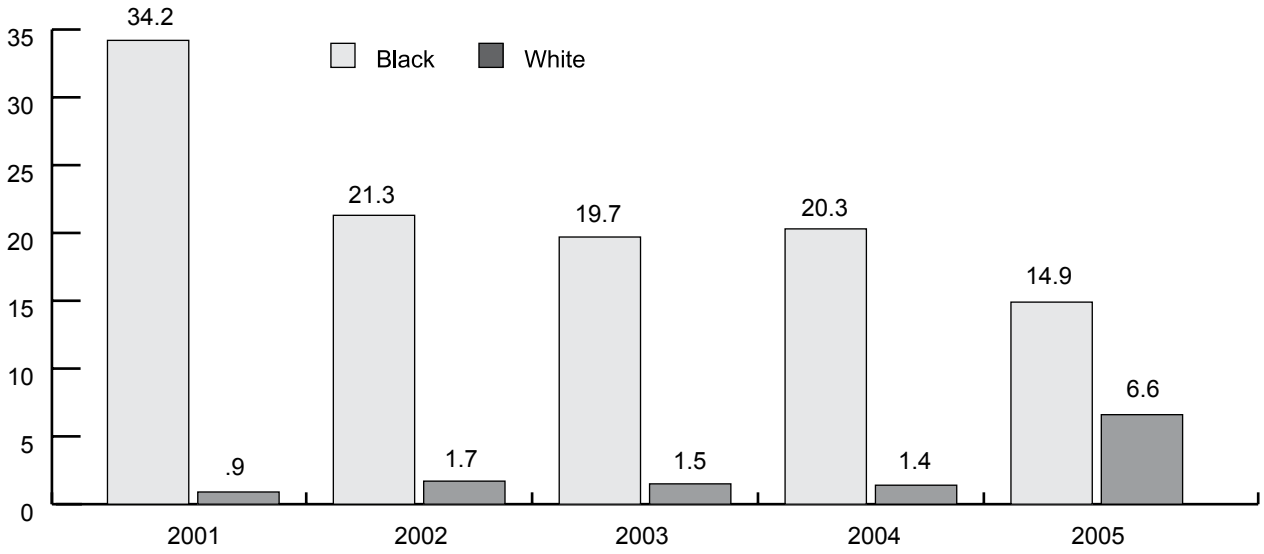
Gonorrhea by Race, Rates Per 100,000 in Wake County 2001-2005



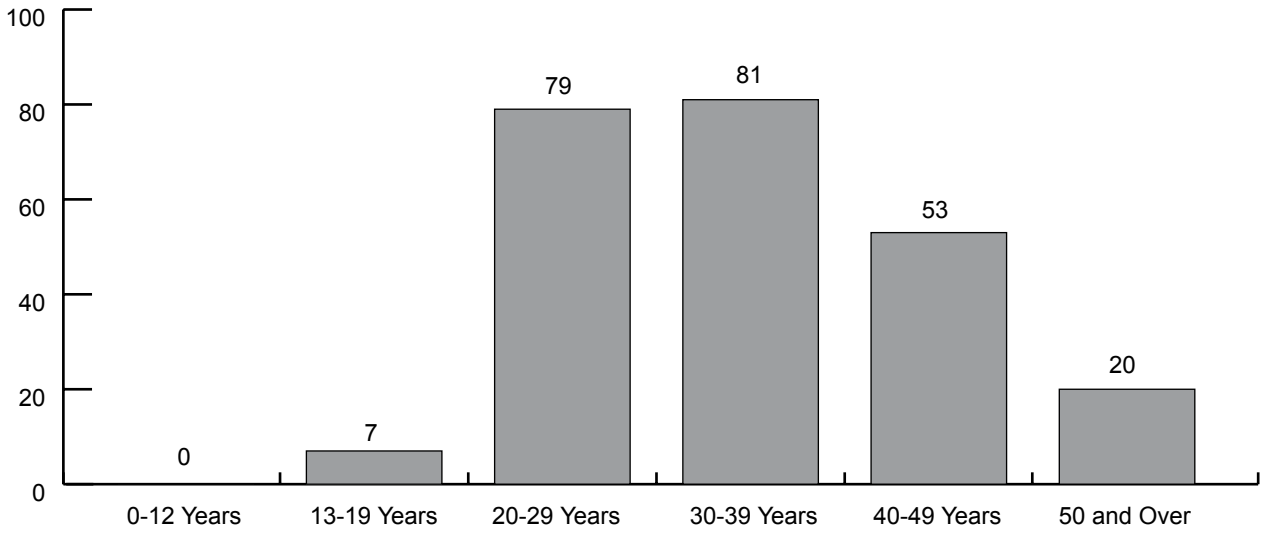
Gonorrhea by Age in Wake County 2001-2005



Syphilis by Race, Rates Per 100,000 in Wake County 2001-2005



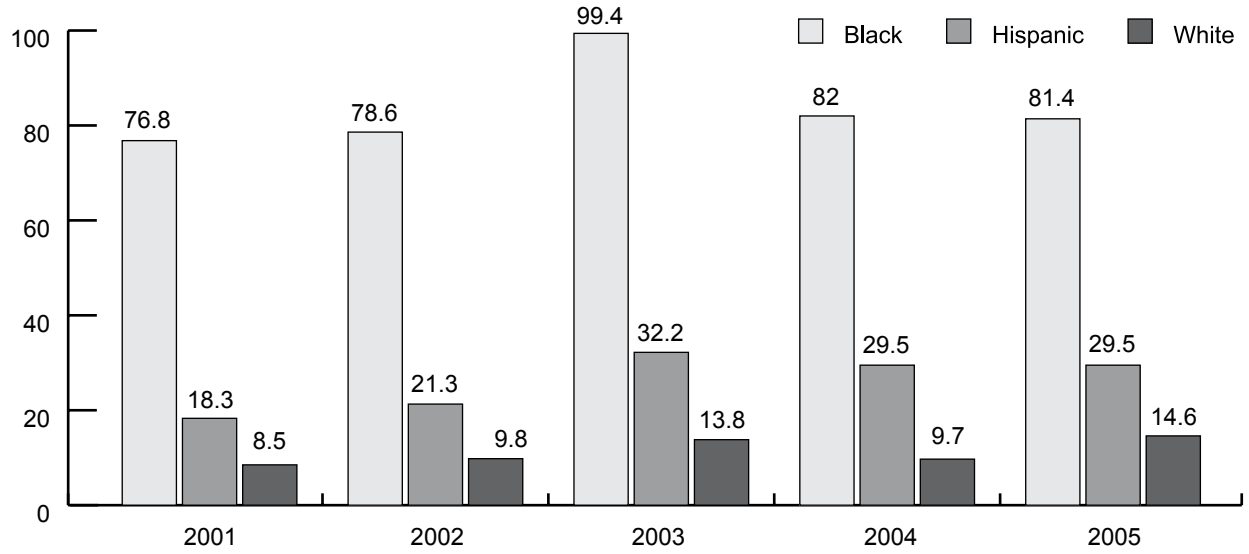
Syphilis by Age in Wake County 2001-2005



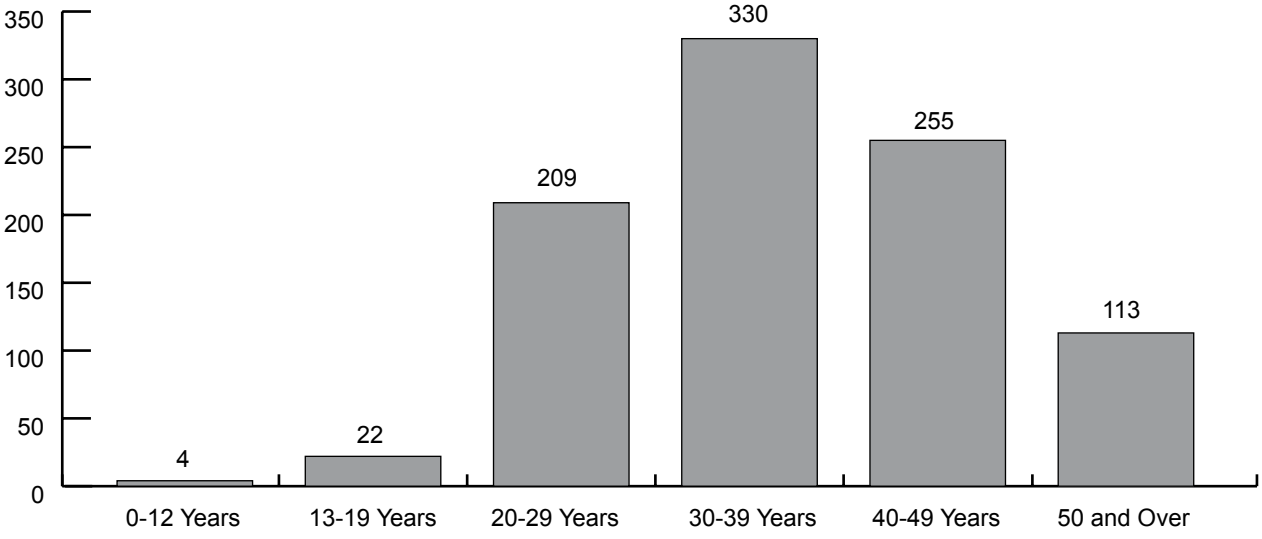
Increasingly in Wake County, minorities, the uninsured, the underinsured, women, and rural residents are not being served by the existing health care structure. Minority communities, especially African-Americans, are disproportionately affected by HIV disease and comprise the largest population served by the WCHS HIV Clinic. Blacks and Hispanics represent 27.6% of Wake County's general population, but are 74.3% of reported HIV-positive individuals. Changes in beliefs regarding the severity of HIV infection, prevention "fatigue," increase in drug usage (especially methamphetamine abuse), social problems and inequalities can limit the effective delivery of prevention programs and medical services. In the WCHS HIV Clinic, 47% of all new clients have end-stage or advanced AIDS upon entrance, which was the pattern common in the beginning of the AIDS epidemic 25 years ago. With today's advancement in treatment modalities, it is not socially justifiable to have so many persons beginning care in the advance stages of the disease.

Individuals of Hispanic/Latino ethnicity represent 7% of people living with HIV disease in Wake County. While representing 11.8% of the population, Latinos represent 17% of all AIDS cases diagnosed within the United States. According to the American Social Health Associations Fact sheet "2005, Hispanics and Sexually Transmitted Disease," U.S. Latinos are disproportionately affected by sexually transmitted diseases (STDs). Complex issues regarding sexuality, gender, faith and immigration are all factors contributing to increased rates of STD infection. Language barriers, legal status, limited clinic hours, cultural differences, lack of health insurance and insufficient transportation all affect access to needed diagnosis and treatment.

HIV by Race, Rates Per 100,000 in Wake County 2001-2005



HIV by Age in Wake County 2001-2005



Easier access to immunizations for those in financial need has been accomplished over the last several years, with the expansion of the National Vaccines for Children program coverage. Due to rising rates of Hepatitis A in men who have sex with men, Twinrix (a combination of both Hepatitis A and B) vaccine has been made available at no cost to this population. Because of the success of the program, coverage has recently been expanded to other groups at increased risk. To date, almost 1,000 doses of the free Twinrix have been administered. Persons who are traveling internationally are often referred by their private physicians who cannot offer vaccines such as yellow fever and typhoid. In 2004, protocols were also developed to offer malaria prescriptions in the Travel Clinic.

The combination tetanus, diphtheria, and pertussis vaccine also was made available free of charge for all persons ages 11-64 needing a booster, as the childhood shots for whooping cough (pertussis) often do not provide lasting lifelong coverage. New parents and health care workers are encouraged to receive this vaccine as they can serve as potential reservoirs of pertussis and thus infect young, susceptible infants. Satellite immunization and influenza clinics were held at Southern Regional Center in Fuquay-Varina, and Eastern Regional Center in Zebulon during the 2004-05 and 2005-06 flu seasons.

Community Perceptions

In the 2006 Wake County Community Assessment survey, 49% of the English-speaking participants considered HIV/AIDS a serious or moderate problem. Also, 49.5% feel that other STDs were a serious/moderate problem and 60.8% felt unsafe sex was a serious/moderate problem. Only 25.3% of respondents felt that "new" communicable diseases were a serious or moderate problem. Of the Spanish-speaking participants who responded, 77.8% considered HIV/AIDS a serious/moderate problem, 76% felt that other STDs were a serious/moderate problem and 79.5% felt that unsafe sex was a serious/moderate problem.

Resources and Strengths

- The WCHS Communicable Disease Surveillance Team, which investigates all reportable diseases in Wake County citizens other than TB and the sexually transmitted diseases, works full-time on the prevention of outbreaks from communicable diseases such as salmonella, whooping cough, Hepatitis A and B, as well as mosquito and tick-borne infections like West Nile virus and Rocky Mountain spotted fever. The team responds to reports of disease from physician offices, hospitals, and often directly from citizens, while providing antibiotics, immune globulin, and vaccines to appropriate contacts of cases of various communicable diseases, such as meningococcal meningitis. Another large portion of the team's time is spent on animal bites and exposures. Because all animal bites are also reportable to the local health department, the surveillance team must determine whether or not an exposure to a dog, cat, bat, fox or other animal poses a risk of exposure to rabies. Although rabies has no cure, there is a series of shots, which will prevent the onset of the disease. There have been no human cases of rabies in North Carolina since the 1953, and the surveillance team helps to ensure that this trend will continue.

- The county TB program also provides preventive and treatment services at no charge to those diagnosed with latent or active TB infection. Clients seen in the tuberculosis program are from all socioeconomic levels and the number of visits rises yearly. The program is a resource for the local medical community, providing annual in-service updates. Literature from this program has been shared upon request from the N.C. State TB Control program, other counties and other states. The public sees this program as a resource for TB screening that is required for school or work. The TB Control Program of Wake County partners with community-based organizations: American Lung Association, Homeless Shelters, Alcohol and Drug Treatment Centers, local hospitals, medical groups, faith community, public schools, colleges, universities and businesses. Currently, the WCHS TB Control Program is participating in five approved research studies.

- WCHS's HIV/STD Community Program and the Sexually Transmitted Disease Clinic provide STD screening and HIV testing, prevention education, AIDS case management, surveillance and investigation, and treatment for HIV disease and STDs. In 2004, HIV testing was provided to 1,286 persons at 17 community-based testing sites; in 2005, that number increased to 1,908 persons receiving testing in the community, with 90% of the clients also screened for syphilis. Another 8,404 were tested in Wake County Human Services Clinics. The STD Clinic provides services to clients in Wake County, including high-risk populations and other individuals with HIV and other sexually transmitted diseases. In 2004, 3,504 STD cases and HIV were reported to the state. Of those, 11,724 clients were tested for HIV by Human Services in 2004. Through June of 2006, there were a total number of 655 HIV positive clients receiving primary health care and case management though the Wake County Human Services HIV clinic.

- Other AIDS Services Organizations (ASOs) provide services to HIV/AIDS clients. The Alliance of AIDS Services – Carolina provides emergency funds for housing, transportation and medical services, in addition to having a food pantry and faith ministries program. BERT-C (Basic Education Resource Treatment) and the Touching Life Center provide AIDS Case Management Services to Medicaid clients only. Glory to Glory House, Inc., provides housing for women with HIV/AIDS and mental health disease, as well as AIDS Case management to Medicaid clients only. HIV/AIDS case managers provide care coordination at Under One Roof, located across the street from the county STD clinic. With the extreme expense of HIV medications and the closure of the state's AIDS Drug Assistance Program, more patients are seeking case managers' help in accessing pharmaceutical assistance programs. A social worker position (bridge counselor) serves as a "bridge" between newly diagnosed individuals as they enter the HIV care system and require short-term care and coordination services.

- WCHS clinics see people from all socioeconomic levels, and often provide a safety net for those children unable to receive their required vaccines elsewhere. The N.C. Immunization Registry (NCIR), a web-based statewide immunization registry, began in Wake County on September 27, 2005. All local health departments in North Carolina now use the registry, and all private providers throughout the state are being added gradually. This enables practitioners to see all immunizations given to a particular client, regardless of where in North Carolina they were administered. This will be an aid in avoiding duplication of immunizations. Partnerships with faith-based organization and community-based organizations enable WCHS to successfully have clinics such as "Big Shot Saturday," a partnership providing back-to-school immunizations with the Junior League of Raleigh. In order to serve populations in southern and western Wake County, an immunization and TB skin testing clinic was established in January 2006 at the Southern Regional Center in Fuquay-Varina.

- The major hospitals in Wake County all contribute to the diagnosis, treatment, and investigations of communicable diseases. The hospitals and WCHS have strong partnerships in place should any disease outbreak or bioterrorism event take place in or around Wake County.

Emerging Issues

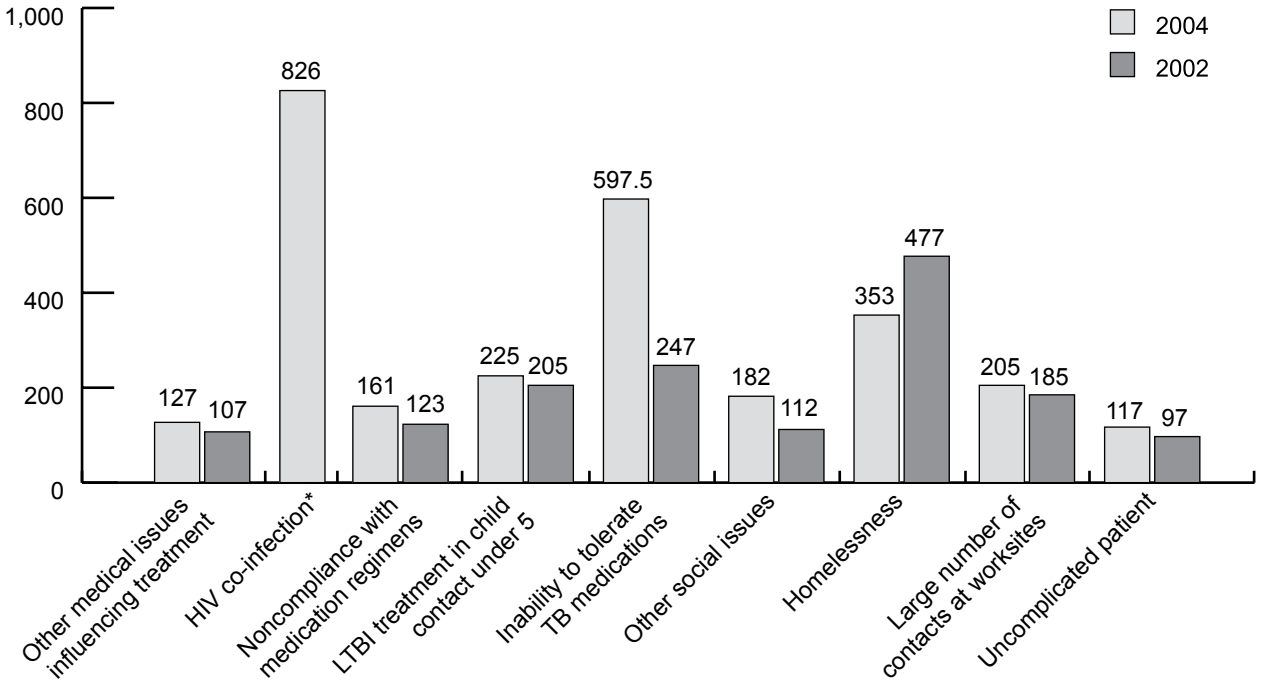
Wake County needs to continue its role in reducing communicable disease disparities. Immigrants are attracted to Wake County due mostly to job opportunities, but also for higher education, arts and culture, and recreational and leisure pursuits. Culturally appropriate education and outreach are significant keys to success in dealing with communicable disease. Wake County will continue to work to reduce TB and other communicable diseases by working with local partners, including hospitals, medical offices, and with the State of North Carolina. The TB staff provides labor-intensive investigation, follow-up, and directly observed therapy for cases and other high-risk clients. The number of visits outside of the facility has increased from 3,401 in 2002 to 4,770 in 2005. During the past five years, contact investigations have been done in universities, company settings (including state offices), community colleges, nursing homes, churches, high schools, pool halls, boarding houses, known drug houses, homeless shelters, the Wake County Alcohol Treatment Center, dialysis centers, and mobile home parks. In order to keep up with the increasing demand, TB skin testing for employment and school entry is offered at Wake County Human Services at three locations: Public Health Center, 10 Sunnybrook Road, Raleigh; the Southern Regional Center, Fuquay-Varina; and the Eastern Regional Center, Zebulon.

Several new vaccines are becoming available to help protect the health of Wake County citizens. Gardisil, the human papilloma virus vaccine, helps prevent the leading cause of cervical cancer in women, and was licensed in 2006 for females ages 9-26. Zostavax, a vaccine for shingles prevention in the senior population, also was licensed for use in persons 60 and older for the 2006 year. Both RotaTeq, a vaccine against the common gastrointestinal virus that is a leading cause of death worldwide in infants, and a combination vaccine against measles, mumps, rubella, and chickenpox were made available in 2006.

WCHS also must provide ongoing and up-to-date information on topics for the public, such as Avian Influenza ("bird flu") and bioterrorism. This will enable citizens of Wake County to stay abreast of current trends and recommendations, which will help them protect themselves.

One tool that will provide better information to citizens is electronic reporting of diseases. Wake County began using a new statewide database (NCEDSS, North Carolina Electronic Disease Surveillance System) in September 2006. This database replaces the current TB reporting system used by the state, and will soon enable electronic reporting of all 70 communicable diseases to the state. This tool will allow for more efficient disease tracking, investigation, and prevention in Wake County.

Comparison of Time (in hours) Spent on Factors Complicating the Care of TB Patients in 2002 and 2004



Chapter 8: Safety

All citizens have the right to live safely. Communities must work together to prevent crimes against one another and to prepare for natural disasters and man-made events. This chapter focuses on child safety, adult and juvenile crime, gangs, disaster response/preparedness and emergency management. Wake County continues to be one of the fastest growing areas in the country. This growth can be attributed to the county's world-class cultural, educational, recreational and economical opportunities. However, despite this success, the majority of citizens who participated in the 2006 Wake County Community Assessment survey listed safety as their second highest area of concern, second only to physical health. In the survey, 45.5% listed safety as their top concern.

Child Safety

Introduction

This section addresses intentional and unintentional injuries in children in Wake County. It also focuses on trends and issues for child safety.

Current State of Affairs

In 2005 the University of North Carolina Injury Prevention Research Program presented its findings from the document, *Injuries to North Carolina Children and the Role of Safe Kids*, to the North Carolina Safe Kids Coalition. This report stated: "Injury is the leading cause of death for children in North Carolina. Each year more than 200 children under the age of 15 die, approximately 3,200 are admitted to hospitals, and over 45,000 receive other medical care as a result of injuries. This means that in a typical year one out of every 34 children in North Carolina experiences an injury that results in death or medical care. Safe Kids and other organizations committed to injury prevention recognize that these injuries are not 'accidents' resulting from chance or unpredictable occurrences. Injuries are preventable when addressed through public policy, environmental changes and educational approaches, especially when adequate funding supports these strategies."

In Wake County, the total number of unintentional injury deaths to children ages 0-14 from 2002 to 2006 was 31, or 5.56 per 100,000. The total number of unintentional injury hospitalizations to children ages 0-14 from 2002 to 2006 was 708, or 126.9 per 100,000.

Causes of hospitalizations, deaths for Wake County children, 2002-2006

Leading Causes	Number of Hospitalizations	Number of Deaths
Motor Vehicle Occupant	95	13
Pedestrian	18	2
Bicycle	46	0
Drowning & Near Drowning	16	4
Fire Injury	9	1
Falls	183	2
Poisoning	65	0
Choking/Suffocation	12	4
Unintentional Firearm	2	0
Burn Injury	23	0
Natural Environment	48	2
Other Transportation	38	2
Struck by Person/Object	69	0
Cut or Pierce	23	0
Other	61	1

In examining injury data, the highest number of hospitalizations was from falls, followed by motor vehicle incidents, being struck by a person or object and poisoning. Though fewer children suffered motor vehicle injuries than falls, the highest number of deaths came from motor vehicle incidents, followed by drowning and choking/suffocation. This is vital information for agencies, organizations and community groups that provide information to parents about protecting their children. According to the State Center for Health Statistics (SCHS), from 2000 to 2004, the third leading cause of death was motor vehicle injuries, followed by other unintentional injuries. Suicide was listed sixth and homicide was ranked eighth.

The Behavioral and Social Health chapter in this report lists specific information on child protective services and assuring the safety of children. The number of new reports accepted for investigation and assessment continues to increase each year, and has increased 57% since 2002. From July 1, 2005 to June 30, 2006, 4,129 reports were accepted; of these, 75.1% were alleging neglect, 12.1% physical abuse, 4.1`% sexual abuse and 1.5% were for concerns of dependency. Ultimately, 12.5% of these cases were found to be in need of services and 9.9% were substantiated. Between fiscal years 2001-2002 and 2005-2006 there was an increase of 200% in new families identified for treatment or planning services. The number of families rose from 232 in 2001-2002 to 730 in 2005-2006.

Trends

The primary trend relating to child safety in motor vehicles appears to be the rapid population growth, which directly affects the number of children traveling. Many families move to Wake County from areas where laws to protect children while riding in motor vehicles are not as strict.

Population growth also has affected child welfare services. The number of families needing services is challenging the county's capacity to provide those services. In addition, Wake County has a growing number of African-American families involved in the child welfare system. In 2006, 68% of the children brought into foster care were African-American. The Child Welfare Division continues to reach out to African-American faith groups, community groups and other partners to build support for these families.

Community Perceptions

Data from the Wake County Community Assessment Survey in 2006 shows that of the 3,232 surveys completed in English, driving or riding in a car without seatbelts ranked as the 71st highest concern out of 106. The same survey was given in Spanish by paper copy to 117 people. Of these respondents, driving or riding in a car without seatbelts was the 16th highest concern (compared to 71st in English version surveys). For this population, more work may need to be done so that adults "buckle up" and also make sure their children are using child safety seats and buckled up as well. The Wake County Child Passenger Safety Program offers monthly child safety seat checks throughout the county. In 2005, the program provided services to over 3,000 citizens. Many did not know that child safety seats provide so much protection to children during motor vehicle accidents. However, they also think the instructions for installing safety seats are confusing.

Resources and Strengths

Socioeconomic status directly affects an individual's ability to purchase the proper child passenger safety seat equipment. Safe Kids Wake County is one of the strongest resources in the community. WakeMed is the lead agency for this coalition. In 2000, the Wake County Human Services Child Passenger Safety Program became a member of this organization. Safe Kids Wake County is composed of local law enforcement, health care agencies, fire and first responder agencies, civic organizations, school system personnel and community non-profit organizations, as well as county citizens. Much information about childhood injury and injury prevention is available from the North Carolina Injury Prevention Resource Center, www.iprc.unc.edu/pages/ncsafekids/resources.htm.

The Wake County Child Welfare Division addresses child safety and family re-unification in the county. Faith groups also are partnering with the division to provide support for foster parents, birth parents and kinship caregivers. More of these partnerships are encouraged as the county continues to address the growing number of families needing assistance.

Wake County also has many before and after-school programs that provide safe environments for children. Hundreds of nonprofit organizations focus on the well being of youth throughout the county.

Emerging Issues

Several issues need to be addressed in the area of child safety. These include:

- Child Passenger Safety – There is a need for more trained and certified staff and volunteers, especially bilingual, to meet the demands of the growing population in child safety seat education.
- All Terrain Vehicles (ATVs) - As ATVs become more powerful and complex, the rate of injury to children has become more serious. ATVs are not toys, and it is now illegal in North Carolina for children to operate ATVs outside the provisions set by law. In December 2005 a new law went into effect requiring children to be at least 8 years old to legally operate an ATV. They must also ride an ATV that is appropriately sized for their age. Children under 18 must be supervised to ride an ATV. The rate of hospitalizations and injury due to ATV use will need to be monitored to evaluate whether this policy initiative is making a difference.

City of Raleigh Crime

Introduction

Raleigh's overall crime statistics have historically compared well among similar cities, as it annually experiences an enviably low rate of crime. The Raleigh Police Department is committed to making the city an even better place to live, work, visit, and conduct business. The following information was compiled by the members of the Raleigh Police Department Compstat Unit, Downtown District Sergeant D. Linthicum, and crime analyst M. Sweden.

Current State of Affairs

The following chart details the crime statistics for the City of Raleigh from 2002 to 2006. It lists the total number of crimes for each category and the percentage change.

City of Raleigh Crime Statistics 2002-2006*

CRIME	2002	2003	2003	2004	2004	2005	2005	2006
MURDER	20	14	-30.00%	16	14.29%	21	31.25%	19
RAPE	118	112	-5.08%	115	2.68%	96	-16.52%	121
ROBBERY	778	782	0.51%	700	-10.49%	802	14.57%	773
AGG ASSAULT	1175	1181	0.51%	1135	-3.90%	1204	6.08%	1240
BURGLARY	3930	3399	-13.51%	2655	-21.89%	3117	17.40%	2768
LARCENY (ANNUAL INCREASE)	10813	10339	-4.38%	8694	-15.91%	8609	-0.98%	8000
MV THEFT (ANNUAL INCREASE)	1457	1400	-3.91%	1186	-15.29%	1147	-3.29%	1054
ARSON	92	78	-15.22%	79	1.28%	81	2.53%	69
ASSAULT – SIMPLE (ANNUAL DECREASE)	2905	3163	8.88%	3457	9.29%	4194	21.32%	3900
NOISE ORDINANCE	19	10	-47.37%	3	-70.00%	9	200.00%	8
FORGERY	557	560	0.54%	365	-34.82%	444	21.64%	261
FRAUD	1653	1449	-12.34%	1344	-7.25%	1479	10.04%	1373
EMBEZZLEMENT	294	259	-11.90%	260	0.39%	278	6.92%	265
STOLEN PROPERTY	418	419	0.24%	388	-7.40%	358	-7.73%	325
VANDALISM	3371	3067	-9.02%	3101	1.11%	3603	16.19%	3696
WEAPONS VIOLATION	555	547	-1.44%	657	20.11%	720	9.59%	713
PROSTITUTION**	108	167	54.63%	126	-24.55%	261	107.14%	124
SEX OFFENSES	414	371	-10.39%	406	9.43%	385	-5.17%	380
DRUG VIOLATIONS (ANNUAL INCREASE)	2654	2754	3.77%	3035	10.20%	3926	29.36%	3588

CRIMES AGAINST FAMILY***	158	129	-18.35%	139	7.75%	290	108.63%	276
LIQUOR LAW VIOLATIONS	20	21	5.00%	24	14.29%	22	-8.33%	20
DISORDERLY CONDUCT	300	349	16.33%	333	-4.58%	402	20.72%	411
VAGRANCY / BEGGING	3	4	33.33%	2	-50.00%	4	100.00%	6
ALL OTHER OFFENSES	1774	1753	-1.18%	1747	-0.34%	2027	16.03%	1921
RUNAWAYS	195	308	57.95%	276	-10.39%	240	-13.04%	229
TRUANCY	16	18	12.50%	13	-27.78%	14	7.69%	39
MISCELLANEOUS	7427	7143	-3.82%	8005	12.07%	9430	17.80%	9083
HUMANE	364	306	-15.93%	353	15.36%	401	13.60%	435
TOTAL	41588	40102	-3.57%	38614	-3.71%	43564	12.82%	41097

* This is a table of crime by offense and year, with the percentage change for each. The current year is up-to-date through November 2006.
** It should be noted that Prostitution increased 107.14% from 2004 (126 incidents) to 2005 (261 incidents).
*** It should be noted that "Crimes Against Family" increased 108.63% from 2004 (139 incidents) to 2005 (290 incidents).

Trends

In order to help prevent and reduce firearm violence in Raleigh, gun-related crimes must be studied. Raleigh Police Department's multi-year analysis showed:

- Between 1997 and 2005, two-thirds of all homicide victims were killed with a firearm.
- Almost 90% of all shootings occurring between 2002 and 2005 were nonfatal.
- Firearms were used to commit approximately 670 violent crimes during 2005, which included homicides, robberies, aggravated assaults, rapes, and sexual assaults. This represents a 3.5% increase in firearm violence from 2004. In addition, there were 281 reported incidents of shots fired.
- In most cases, fatal and nonfatal shootings occurred during a heated argument between people of the same race or ethnicity who knew each other and had easily accessible firearms; many of these arguments were drug-related. Most victims and suspects were residents of Raleigh.
- Most shootings, fatal and nonfatal, involved multiple suspects.
- Suspects in shootings were often victims of previous firearm violence, signifying a cycle of violence.
- Over half of the shooting victims and more than one-third of the shooting suspects had prior weapons violations and/or felony drug, assault, or robbery charges.
- Almost half of murder suspects and victims were convicted felons who, by law, could not legally possess or be in close proximity to firearm used in the murder.
- Many known shooting suspects had outstanding warrants for their arrest.
- Many armed criminals and shooting suspects remained at-large and dangerous in the city because those with information were unwilling, unmotivated, or too afraid to speak with the police.
- African-American males had the highest risk of being murdered with a firearm and being a victim of a nonfatal shooting compared to other races or ethnicities. Latino/Hispanic males had the second highest risk of being murdered by a firearm and being a victim of a nonfatal shooting.

- Approximately one in10 murders involving a firearm were the result of family or intimate partner violence. However, almost half of all family or intimate partner murders involved a firearm.
- Although fatal and nonfatal shootings occur throughout the city, the majority of shootings occurred in close proximity to street-level drug markets.
- Murders and robberies involving firearms have increased over the past year, along with reported shots fired. Assaults with firearms, however, decreased in 2005.
- The connection between firearm violence and drugs remains clear, and drugs are often known or logically suspected as being the cause for many acts of firearm violence.

The multi-year analysis also showed a disturbing trend in youth violence:

- Most dramatically, the number of youth 20 years of age or younger arrested for robbery increased 56% from 2004 to 2005.
- Between 2002 and 2005, most firearm-related murder victims were between the ages of 21 and 30, most frequently between 26 and 30 years. Most murder suspects, however, were younger than their victims. The greatest number of murder suspects was between the ages of 16 and 20 years.
- Shooting data showed connections between guns, gangs, and drugs. Many of the victims and suspects in shootings had ties to youth gangs, which continue to be an escalating and dangerous threat in Raleigh and throughout Wake County.
- In 2005, 236 (31%) illegal firearms were recovered from persons aged 15 to 24 years. The majority of these firearms were small-caliber handguns legally purchased by someone else in North Carolina. These firearms then changed hands several times in the year or years prior to the commission of a crime.

As Wake County grows, the Community Assessment Team will continue to document these types of statistics for the other Wake County municipalities and non-incorporated areas.

Strengths and Resources

The City of Raleigh has implemented several safety programs focusing on public awareness, education and prevention. Two were initiated in the downtown area. With the re-opening of Fayetteville Street, the emergence of residential and mixed-use housing, the growth of an entertainment district and the continuing cultural opportunities, the City of Raleigh is committed to maintaining downtown safety. These include:

- The Downtown Safety Ambassadors program – a public/private endeavor designed to strengthen the safety and security of the downtown area, this involves a partnership between the Police Department and the Downtown Raleigh Alliance. The ambassadors are licensed, unarmed security guards who patrol city parking decks and lots and provide escorts to and from locations within the business district. The program provides an higher level of service to the downtown area without requiring more police officers.
- The Lock Take and Hide program – introduced by the Police Department, this program is aimed at reducing the number of vehicle break-ins by increasing public awareness and changing the habits of motorists. It uses signs to remind people to lock their vehicles, take their keys, and hide belongings and valuables out of sight.
- The Raleigh Police Department initiated a 10-point plan addressing firearm violence in January 2006. The purpose of Raleigh's plan is to reduce firearm violence in the city by getting guns out of the hands of those who use them to commit crimes, by tracking down and arresting armed criminals, and by working closely and cooperatively with the community to prevent firearm violence.

Wake County Crime for Unincorporated Areas

Current State of Affairs/Trends

The following table represents Wake County's adult crime statistics for unincorporated areas for the past four years. Statistics were provided by Wake County's Public Safety office on adult offenses.

Wake County adult crime statistics, 2002-2006

State UCR Offense Categories	2002	2003	2004	2005	2006
Murder/Non-negligent Manslaughter	3	4	7	3	4
Rape, Forcible	39	32	19	44	25
Robbery	58	61	58	37	37
Assault, Aggravated	293	181	197	179	149
Burglary	1272	1105	1099	1124	1134
Larceny	3289	2129	1768	1849	1881
Motor Vehicle Theft	284	279	325	254	288
Assault, Simple	685	748	771	796	611
Arson	93	66	63	55	64
Forgery	79	136	123	110	95
Fraud	230	511	543	612	478
Embezzlement	14	24	16	21	13
Stolen Property	768	812	852	877	997
Vandalism	15	37	40	57	42
Weapon Law Violation	95	105	148	174	110
Prostitution Offenses	2	2	1	2	2
Sex Offenses	111	114	117	131	138
Drug/Narcotic Offense	1084	1114	1406	1184	1200
Sports Tampering		2			1
Family, Nov-violent against	263	185	210	223	150
Driving While Impaired	301	401	451	502	356
Disorderly Conduct	37	114	107	115	104
Obscene Material/Pornography		2	4	6	6
Other, All	734	882	905	920	877
Total	9749	9046	9230	9275	8762

It should be noted that stolen property and sex offenses are the only two offenses that increased every year, while overall crime decreased from last year.

Community Perceptions

Of the 3,232 Wake County citizens who completed the 2006 Wake County Community Assessment survey, 23.3% stated gang activity was their leading area of concern, followed by drinking and driving (18.2%), and crime and violence (16.7%).

Strengths and Resources

Even though overall crime decreased in the unincorporated areas of Wake County, efforts to fight crime will remain high. Gangs, illegal immigrants and drug trafficking are the root causes of most of the crimes that occur in the county. In order to curb these crimes and be proactive in serving and protecting the citizens of the county, the Wake County Sheriff's Department has:

- Formed an Intel Unit to monitor gang activity;
- Used the 5th floor of the jail to identify gang members and collect information about them;
- Tracked the number of illegal immigrants charged with crimes and reported them to the Immigration and Customs Enforcement Bureau;
- Created an IMPACT and a STOP team for drug interdiction and to patrol in high crime areas; and
- Implemented a Special Response Team that identifies drug dealers and gets them off the streets.

Domestic Violence

Introduction

Domestic violence is a disturbing and costly problem in Wake County, the state and nation. Locally, one in four women will experience domestic violence during her lifetime. Violence toward a partner or the threat of violence causing fear in that partner is considered a crime. Domestic violence also contributes to the increasing number of families who are homeless.

Current State of Affairs

In the next 10 years, Wake County's population is expected to surpass one million. The county works with area agencies to provide a safe haven for the mostly women and children who flee violence and to help end the cycle of domestic abuse. However, Wake County has the lowest number of shelter beds per capita of the 10 most populous counties in North Carolina and other similar metropolitan areas in the Southeast. The following chart compares the 10 most populous counties in North Carolina and the number of beds dedicated to victims of domestic violence per capita:

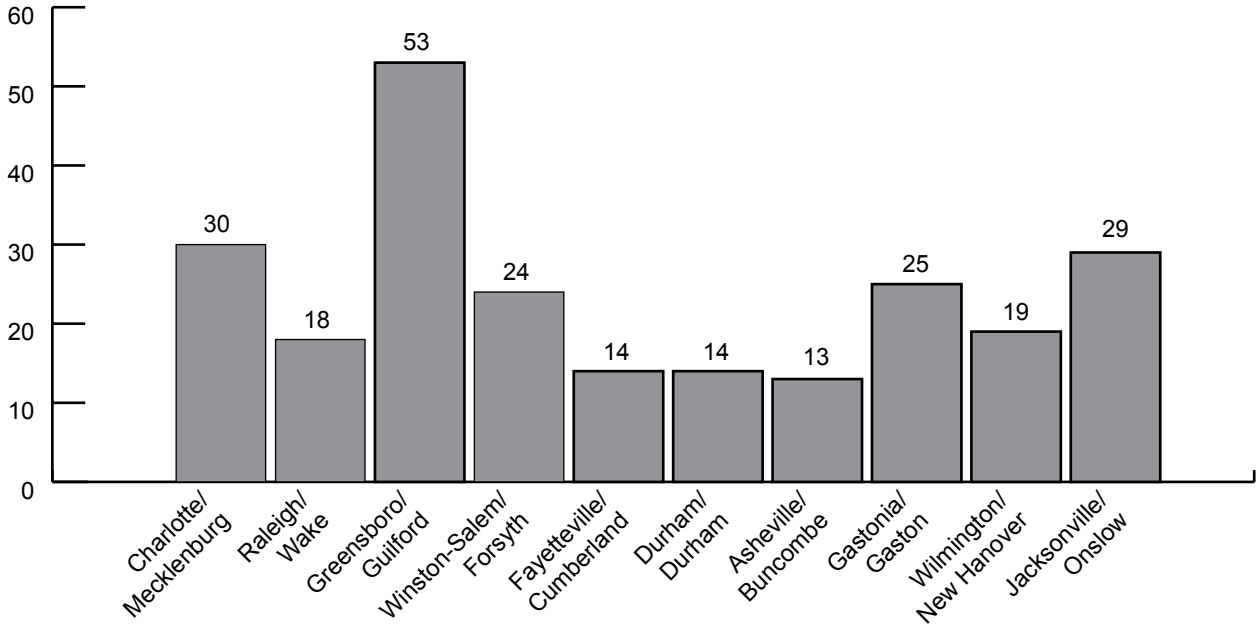
Largest N.C. counties with beds for domestic violence victims

City/County Served	Number of Beds	Beds per Capita (per Number of People)
Charlotte/Mecklenburg	30	1 per 25,720
Raleigh/Wake	18	1 per 39,973
Greensboro/Guilford	53	1 per 8,279
Winston-Salem/Forsyth	24	1 per 13,371
Fayetteville/Cumberland	14	1 per 22,304
Durham/Durham	14	1 per 17,123
Asheville/Buncombe	13	1 per 16,590
Gastonia/Gaston	25	1 per 7,778
Wilmington/New Hanover	19	1 per 9,134
Jacksonville/Onslow	29	1 per 5,320

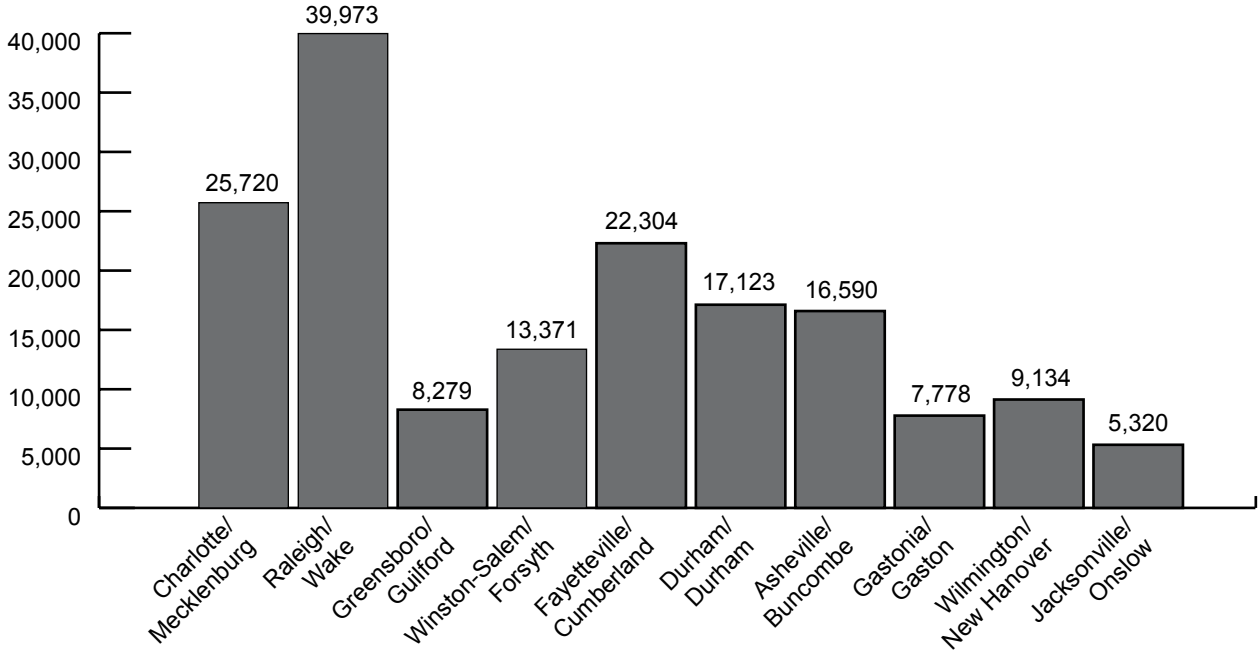
Source: Wake County Interact, Inc., 2006 Needs Assessment Report

In the table below, it would appear that Wake has a comparable number of beds with Forsyth, Cumberland, Durham, Buncombe and New Hanover counties. But in a comparison based on the number of people in the county, Wake County has only one bed per 39,973 people, compared to one bed per fewer people for all the other counties. For example, Mecklenburg County has one bed per 25,720, over 14,000 fewer people per available bed.

Number of Beds Dedicated to Domestic Violence
10 Most Populous NC Areas



Number of Beds Dedicated to Domestic Violence
10 Most Populous NC Areas



Trends

Domestic violence affects an estimated four million women each year, though the number could range as high as six million, given that many cases go unreported and that definitions of domestic violence vary among cultures and law enforcement agencies. Wake County provided services to more than 2,200 victims of domestic violence from 2004 to 2005, according to the N.C. Council for Women/Domestic Violence Commission. This was the second highest number of any county in North Carolina. According to the N.C. Council for Women, Wake County reported 4,331 calls from 2,241 domestic violence victims from 2004 to 2005. Approximately 42% (943) were white, 40% (897) were black, and 7% (168) were Hispanic/Latino. Ninety-four percent (2,113) were female and 6% (128) were male. By age, most clients, 39% or 867, were between 45 and 54 years old.

Interact is the nonprofit agency providing services to women, men and children who are victims of domestic violence. Interact provided in-office services to more than 3,000 people in the 2005-2006 year, representing a 17% increase over the previous year. The agency has seen a 15% to 18% increase each of the last several years in the number of people calling its emergency crisis lines. Trends include an increase in the number of women with children being served and increase in Hispanic/Latino and other immigrant populations.

Community Perceptions

The establishment of domestic violence programs has had significant impact on the lives of many women, men and children who are involved in violent relationships. According to a 2005 assessment conducted by Interact, the greatest need in Wake County is to expand safe housing options for families fleeing from abuse. The Interact study determined that the county needs 40 to 50 beds, instead of the current 18 beds, in order to meet current demand. This need is confirmed by data from the N.C. Council for Women. According to the N.C. Council for Women, in 2004-2005 Wake County had 29 referrals to other shelters due to lack of space. The county's shelter space was full for 304 days.

Resources and Strengths

The major resource for Wake County is Interact. Interact promotes violence-free relationships and communities through collaboration, public information, education and advocacy. It also provides a 24-hour crisis line, individual and group counseling, court advocacy, hospital response, residential counseling, community education and training, youth education services and community resource development. Interact collaborates with state and local governments, law enforcement, faith communities and other agencies throughout the county. Information is available at www.interactofwake.org. Several other community nonprofits focus on homelessness and substance abuse and deal with issues of violence in the populations they serve. These include the Women's Center, Urban Ministries and The Healing Place for Women. The N.C. Council for Women, Domestic Violence Commission funds various initiatives at the county level. Information on the council can be found at http://www.doa.state.nc.us/cfw/cfw.htm.

Emerging Issues

In the area of domestic violence in Wake County, the main issue is the lack of shelter options for victims and often children. For every person sheltered with Interact, the only domestic violence shelter program in the county during 2005, there was another who needed a safe place that was not available. Interact is regularly forced to place clients in hotels or with programs in other counties. The situation is expected to worsen as the population grows, unless additional resources are focused on serving this population.

Juvenile Crime

Current State of Affairs

Juvenile crime throughout the state of North Carolina has remained consistent over the last four years. In North Carolina, the top three juvenile crimes from 2002 to 2005 were simple assaults, larceny and simple affray (fighting). Juvenile crime is listed as "delinquent complaints" and is divided into several categories: violent class felonies, serious class felonies, misdemeanors and infractions.

North Carolina Juvenile Complaint Totals (Delinquent)	
2002	44,270
2003	45,083
2004	46,041
2005	45,389

http://www.juvjus.state.nc.us

Juvenile Complaints (Delinquent)

The following table compares Wake County's juvenile complaint statistics to Durham and Mecklenburg counties.

2002	County Complaint Totals
Wake	2,241
Durham	836
Mecklenburg	3,799

2003	County Complaint Totals
Wake	2,641
Durham	765
Mecklenburg	4,875

2004	County Complaint Totals
Wake	2,400
Durham	805
Mecklenburg	3,558

2005	County Complaint Totals
Wake	2,775
Durham	741
Mecklenburg	4,121

http://www.ncdjjdp.org/

In 2002-2003, the N.C. Department of Juvenile Justice and Delinquency Prevention completed a risk assessment of youth in the system. For Wake County, out of 545 youth, 16% had committed felonies prior to adjudication, 19% had committed misdemeanors, 5% were labeled undisciplined and 60% had no prior offense. Of those 545 youth, 467 were 12 years of age or older and 78 were under 12 years of age at the time of first complaint. In 2004 six youth sent to Youth Detention Centers, and seven were sent in 2005.

School Crime and Violence

During the last school year, WCPSS reported 1,159 acts of crime and violence among its 121,000 students (student enrollment in the current year, 2006-07, stands at 128,000). This is according to the 2005-06 Report on School Crime and Violence. This total correlates to 9.608 acts per 1,000 students, a decrease from 2004-05, when that number was 11.60 acts per 1,000 students. The state average for 1,000 students in 2005-2006 is 7.90.

The following table compares WCPSS statistics to Durham and Mecklenburg school systems.

Wake, Durham and Mecklenburg school system violence totals

2002-2003	Total # of Acts Committed	Total # per 1,000 students
Wake	767	7.358
Durham	216	7.029
Mecklenburg	506	4.664

2003-2004	Total # of Acts Committed	Total # per 1,000 students
Wake	1,081	9.955
Durham	244	8.112
Mecklenburg	537	4.747

2004-2005	Total # of Acts Committed	Total # per 1,000 students
Wake	1,316	11.6
Durham	293	9.56
Mecklenburg	651	5.549

2005-2006	Total # of Acts Committed	Total # per 1,000 students
Wake	1,159	9.608
Durham	286	9.187
Mecklenburg	820	6.702

Mecklenburg County seems to have fewer numbers and lower rates of violent acts than Wake over this three-year period. Wake County partners may want to explore what strategies or factors are keeping the rates lower in a county of similar size.

Community Perceptions

In the 2006 Wake County Community Assessment survey, 248 Wake County citizens stated that youth access to weapons and weapons in school were their most important safety concern.

Gangs

Current State of Affairs

The North Carolina Gang Investigators Association defines a youth/street gang as: "a group or association of three or more persons who may have a common identifying sign, symbol, or name, and who individually or collectively engage in, or have engaged in criminal activity that creates an atmosphere of fear and intimidation." *(from the Plan to Prevent Gang Activity and Violence in Wake County, Wake County Gang Prevention Partnership, February 2006.)* Wake County faces an escalating gang problem at a time when such gangs are well established throughout the country. Law enforcement has identified 12 primary gangs in the county, with the vast majority between the ages of 13 and 24, predominately male. Gangs are responsible for an increase in violent crimes and the sale and distribution of illegal drugs. It is imperative to educate today's youth about the dangers of becoming affiliated with gang activity.

Although gangs are nothing new to Wake County, recently there has been a significant increase in gangs and gang activities. Increased tagging and graffiti are signs indicating a growing number of gang sets forming in the county. Hispanic gangs are numerous and growing daily. Currently, the majority of gangs here are localized and lack structure and organization. However, influence from outside gangs may change this dramatically. Information provided by the Durham District Attorney's office indicates that Durham gangs are being sought after for national affiliation by California sets. It is likely that this will be true for Wake County gangs as well. What is commonly understood as "The Mafia" offers an analogy. These distinct groups of criminals can cause trouble in a community; once these groups are organized under a "family" or common organizational structure, their threat is far worse. Newer organized crime groups or gangs model themselves after "the Mafia," calling themselves gangsters in reference to this group.

The opportunity for prevention and early intervention still exists in Wake County. In a few years, this opportunity may no longer be available. In the WCPSS, gangs target a growing number of middle and elementary school youth for recruitment. A factor that contributes to the increase of gangs throughout the county and the state is the lack of stricter legislation in dealing with gang-involved criminal offenders.

Trends

The Wake County Gang Prevention Partnership has provided the following key data on gangs:

- In 2005, the Partnership identified 12 primary gangs in Wake County.
- Approximately half of all known gang members have grown up locally.
- African-American and Hispanic/Latino youth represent a disproportionate number of gang members.

Community Perceptions

According to the 2006 Wake County Community Assessment survey, citizens in the central, northern, southern and eastern regions listed gangs and gang activity as their area of greatest concern. Of the 3,232 responses, 753 (23.3%) stated that gang activity was their most important safety concern. The western region listed drinking and driving as the top area of concern, with gang activity second. African-Americans and whites listed gang activity as their top concern. Hispanics listed drinking and driving as the top concern, followed by gang activity.

The Wake County Gang Prevention Partnership conducted community and youth surveys. The results were published in February 2006. Key findings from 118 community surveys included:

- Every community surveyed expressed concern that there is some level of gang activity in their community.
- Over one-third of the respondents expressed concern about problems caused by gangs such as an increase in fear for safety, property damage and school disruption.
- Over half the respondents believed youth become involved in gangs because of the lack of positive youth activities and to gain a sense of belonging.
- Forty-two percent of those surveyed reported that they were not satisfied with the current response to gang activity in their community.
- Over half of the respondents believed that gang activity could be reduced or prevented by increased family involvement and early prevention programs.

The partnership also had 291 surveys completed by high school-aged youth, with 45 identifying themselves as currently or previously being involved in a gang. Key findings from the youth responses included:

- A lower awareness among youth of positive alternative activities in their communities.
- A lower perception of safety in schools.
- Youth gang members don't always respect the gang's code of conduct, initiations into gangs are not consistently required, members play limited roles with gangs, and firearms are easy to obtain.
- A high percentage of gang-involved respondents have adults in their lives associated with illegal activity.
- The size of gangs reported by the youth surveyed was larger than law enforcement data indicated.
- Responses suggest the importance of prevention components and support the claim that gang activity is an escalating threat in Wake County.

According to data from multiple focus groups conducted in various communities throughout the county and individual surveys, many see the increase of gangs as an issue in their community. They are concerned for the safety of their children and their neighborhoods. They would like increased law enforcement or programs to engage the youth.

Emerging Issues

According to the "Plan to Prevent Youth Gang Activity and Violence in Wake County,"some of the issues focusing on youth, families, partnerships and training are as follows:

- Youth at risk of and already involved in gang activity need access to economic opportunities.
- Youth at risk of and already involved in gang activity need an array of services that will link them to community resources for social, educational, vocational, health, housing and income needs.
- Wake County needs to work on partnerships between the criminal justice system agencies and communities to minimize the presence and illegal activities of youth gangs.
- Existing organizations providing services to at-risk youth do not feel equipped to deal with gang involved youth. More training must be provided to existing service providers.

Strengths and Resources

A variety of resources are available to address gang concerns across the county, including:

- Wake County has assembled a Gang Prevention Coalition consisting of 30 members representing areas of law enforcement, WCPSS, community-based organizations, drug enforcement agency, immigration, Raleigh Parks and Recreation, Boys and Girls Club of Raleigh, Haven House, Healthy Mothers Healthy Babies, Triangle United Way and other organizations. The vision of the partnership is to "create a community where youth and their families reject gangs and where gangs no longer exist." The group realizes that this issue is paramount and urgent. Information from the Coalition may be found at www.wakegov.com/humanservices/partherships/gangprevention.

- The Wake County Juvenile Crime Prevention Council's mission provides alternatives to incarceration and limited prevention services for youth at risk of being involved with the juvenile justice system. This council funds various programs for youth and their families. Information can be found at www.wakecojcpc.org.
- The Lost Generation Task Force was developed to address the high number of African-American and Latino youth involved in the juvenile and criminal justice system. Information on the task force can be found at www.ncneighbors.com/main.wsi?group_id=3198.

Disaster Response/Preparedness

Current State of Affairs

With more than 780,000 citizens and growing, Wake County must be prepared to respond to disasters on a massive scale. The September 11, 2001, terror attacks and the subsequent global unrest lends a sense of urgency to society's readiness to respond. Wake County and its partners are working together to provide a rapid, efficient and seamless response to disasters that affect local citizens. This requires strong relationships among public health, emergency management, EMS, fire and rescue, hospitals, Wake County Public School System, medical community, and law enforcement.

Disasters and emergencies strike at all hours of the day, mostly unexpectedly but sometimes with a warning, as in the case of hurricanes. Whether imminent damage is expected or not, the urgency to have emergency response plans in place has never been greater. Wake County has seen devastation from hurricanes, and the need for emergency response to the Apex chemical fire in 2006. Wake County encourages all citizens to have an emergency kit available for any/all disasters that will strike. All citizens who are able to take care of themselves should be prepared to stay at home for extended periods of time.

The top three hazards that Wake County faces in descending order are nuclear attack, water supply failure/ contamination, and severe winter storms.

1] **Nuclear attack:** A nuclear attack is defined as an attack upon the United States using nuclear weapons. Because Wake County is a highly populated industrial and business center, direct weapons effects could be expected from a nuclear attack. In a worst-case scenario, the detonation of a nuclear device within the City of Raleigh, severe casualties and property damage would be expected, with greater than 10% of the population and 10% of total property vulnerable to casualties and damage.

2] **Water supply failure/contamination:** A water supply failure is defined as the absence of an adequate water supply sufficient to maintain public health needs, essential business functions and/or services. Due to the integrity and reliability of Wake County's water supply system, the most likely cause of a disaster type water supply failure in the county would be contamination of the raw water supply, rendering it unusable. Contamination could possibly be precipitated by an accidental release of contaminants into the supply system or by an act of sabotage. Terrorism, in particular, is an increasing concern because of heightened activity in recent years. If a true water supply failure or contamination disaster were to occur in the county, more than 10% of the population and more than 10% of the property (economic value) would be vulnerable to negative effects.

3] **Severe winter storms:** These include cold, ice, snow, and wind in all forms and combinations; in the worst cases, storms paralyze cities, trap travelers, destroy property and take lives. Severe winter storms generally affect a minor percentage of the population such as the elderly, young and those who cannot care for themselves. The storms are rarely of sufficient duration to create a lengthy shutdown of business operations. The major vulnerability in terms of casualties would be from those citizens who lack sufficient shelter or are not in the best of health; this would be less than 1% of the total population. Similarly, the amount of property vulnerable to damage from a severe winter storm would be less than 1%.

Wake County must be ready to handle weather-related emergencies, technological disasters, chemical threats and nuclear events, large and small. A terrorist/bioterrorist attack may require a major response in order to minimize the impact on county citizens. The potential risk and response will vary according to the source of the threat. For example, a chemical spill in an isolated area may require treatment of a few individuals and decontamination of one specific site. In contrast, the Centers for Disease Control estimates that responding to a bioterrorism event involving ebola, plague or smallpox would require as many as 5,000 emergency responders working around the clock for five days at 22 medication dispensing sites across Wake County.

To meet these challenges, the county provides ongoing training and exercise opportunities to prepare staff to take on these new and challenging roles. This ability to respond entails a substantial commitment of resources from Wake County and its partners. It is critical that the county stay focused and continue to invest in preparedness so it is ready to handle a large-scale disaster if needed.

The following table illustrates potential hazards that threaten Wake County. Hazard levels are determined as high, medium or low based on the number of Wake County citizens that would be affected by the disasters.

Potential Hazards	Estimated Hazard Level		
Hazard	**High**	**Medium**	**Low**
Dam Failure			X
Drought		X	
Fixed Nuclear Facility			X
Flood		X	
Fuel Shortage			X
Hurricane		X	
Major Fire			X
Nuclear Attack	X		
Power Failure			X
Severe Winter Storm	X		
Tornado		X	
Transportation Accident		X	
Water Supply Contamination	X		
Terrorism Event		X	

The County's history of hurricanes and ice storms has provided opportunities for first responders to test the systems and plans in place. We have learned that these responses require that all partners bring their resources to the table. City and county governmental officials are the key decision makers during local disasters/emergencies. Wake County Emergency Management leads the efforts by guiding partners in plan development, facilitating the development of partnerships, developing opportunities to test plans and providing leadership during emergencies.

Emergency Medical Services (EMS) and area hospitals work daily to address individual medical emergencies in Wake County. During large-scale emergencies and disasters, their workload increases dramatically and tests their surge capacity. Law enforcement and fire services experience the same drain on existing services during these events. Public health often plays a major role in disasters as well, providing ongoing surveillance to allow early recognition of health related issues and providing guidance to the medical community to assure that appropriate care, such as immunizations, is provided. Throughout any type of disaster or emergency, consistent and accurate public information and education is crucial.

Quite often there is a need for some level of sheltering during disasters. The following is a list of Mass Care Centers that the American Red Cross, Wake County Government and a host of community partners are prepared to staff and manage:

- General Population Evacuation Centers
- Special Needs Evacuation Centers
- Family Centers
- Medical Triage and Basic Care Centers
- Domiciliary Care Contingency Shelters (Contingency Shelter)
- Mass Medication Dispensing Centers

Without data to confirm, the portion of the general public in Wake County that is most likely to need emergency shelter during a storm and depend solely on local government after a localized disaster are low-income families and citizens. This part of the community is most likely to have substandard housing, friends and family with substandard housing and inadequate income to pay for a hotel when needed or purchase disaster supplies. It is important for the County to educate citizens to prepare themselves and their family for a disaster, which can reduce the actual affect the event has on them.

Community Perceptions

According to the 2006 Wake County Community Assessment survey, county citizens in all regions listed disaster response/preparedness as the most important safety issue. Overwhelmingly, African-Americans, Hispanics and whites listed disaster preparedness as their most important emergency issue. Sheltering during an emergency was listed high among lower income residents while it was a minimal or non-issue among higher income residents.

Resources and Strengths

Members of the Wake County Disaster Preparedness Task Force have worked together since 2003 to develop plans, share resources, participate in exercises and support each other in disaster/emergency situations. The Task Force is facilitated by Wake County Emergency Management, and has seven subcommittees: Fire Services, Law Enforcement Services, Emergency Medical Services, Hospital Services, City/County/State Services, Private Industry Services and Public Health Services. This partnership works to ensure that resources coming into the County are used to address the most urgent needs, improving our response capabilities.

The County and municipalities work together in an incident command structure that meets federal requirements and allows all emergency responders to share a common language and framework, which improves their response capabilities during disasters. The process also provides a safety officer in compliance with the National Incident Management System.

Emerging Issues

A comment made at a recent briefing for congressional staff on a pandemic influenza outbreak succinctly captures the potential magnitude of this uncertain but urgent threat: "Once a pandemic happens, we will divide forever the progress of our nation as pre-pandemic and post-pandemic." When a pandemic occurs, the impact of the disease will join the lexicon of nation-changing incidents on the scale of September 11th and the 2005 Hurricane Season. In every locality, officials will be at the forefront of protecting public health, maintaining critical services and infrastructure, and leading the public from crisis to recovery.

An episode of pandemic influenza is the viral equivalent of a perfect storm. Three essential conditions must be met for an outbreak to begin:

- A new flu virus must emerge from the animal reservoirs that have produced and harbored such viruses – one that has never infected human beings and therefore, is one for which no person has developed antibodies.
- The virus has to make humans sick (most do not).
- It must be able to spread efficiently, through coughing, sneezing, or a handshake.

The avian flu virus H5N1 already has met the first two conditions: transfer to humans has been documented and the effects are deadly, with 30 to 70 percent lethality, but the transmission rates to humans and between humans are still relatively low. Recent reports suggest the virus is mutating and could change in ways that allow it to fulfill the third criterion. When the human-to-human transfer begins, unless it is controlled rapidly in the locality of the outbreak, current levels of international travel could help foster a pandemic in a matter of weeks.

Current projections anticipate that a pandemic would last from 12 to 24 months, infecting as much as 30% of the population in each of two waves. Many individuals may be sick and incapacitated, affecting a wide range of key services, such as food, energy, and health care that is delivered by the private sector. Economic activity will be disrupted severely, but basic services must still be maintained. Development of continuity of operations plans will be critical for both government and business.

A pandemic will force many key decisions to be made in a dynamic environment of shifting events, and partnerships must be built now and tested to ensure appropriate and rapid action. The impact of the disease, areas affected, capabilities available and stages of recovery must be considered constantly when determining response. The ability to make good decisions "on the fly" will be as important as good planning made in advance of a pandemic. Today, policy makers – and the general public – are becoming well informed about the issues and concerns surrounding a pandemic. But that does not mean we are fully prepared to respond. Proper planning and training for a pandemic flu will produce benefits even if a pandemic proves very mild or does not occur, because the preparation involved is transferable to virtually any type of public health emergency. Done well, pandemic flu planning will help our community become better prepared for all types of hazards.

Intentional and Unintentional Injuries in Adults, Emergency Management (EM) Statistics

Current State of Affairs

Injuries, whether intentional or not, require emergency medical response and present a cost to our society in both tangible and non-tangible ways. The top causes of intentional injury are assaults, stabbings and shootings, while car or motorcycle accidents, falls and poisonings make up the most unintentional injuries.

In 2004, there were 4,513 cases of injuries and poisonings, as reported in the N.C. County Health Data Book – 2006, State Center for Health Statistics. Total charges for these hospital admissions were $115,364,144. The average charge per day was $4,557, and the average charge per case was $25,563. From 2000 to 2004, motor vehicle injuries ranked as the seventh highest cause of death for Wake County residents of all ages, and other unintentional injuries was sixth.

When those numbers are viewed by age and or race, the following becomes clear:

- For newborns to 19-year-olds, motor vehicle injuries are the third leading cause of death, followed by "other unintentional injuries." Suicide is sixth and homicide is eighth.
- In the next highest age category, 20 – 39-year-olds, motor vehicle injuries rise in rank to number one, other unintentional injuries to number two, suicide to number 4 and homicide to number five.
- Unintentional injuries remain one of the top ten causes of death for every age group through 85+.

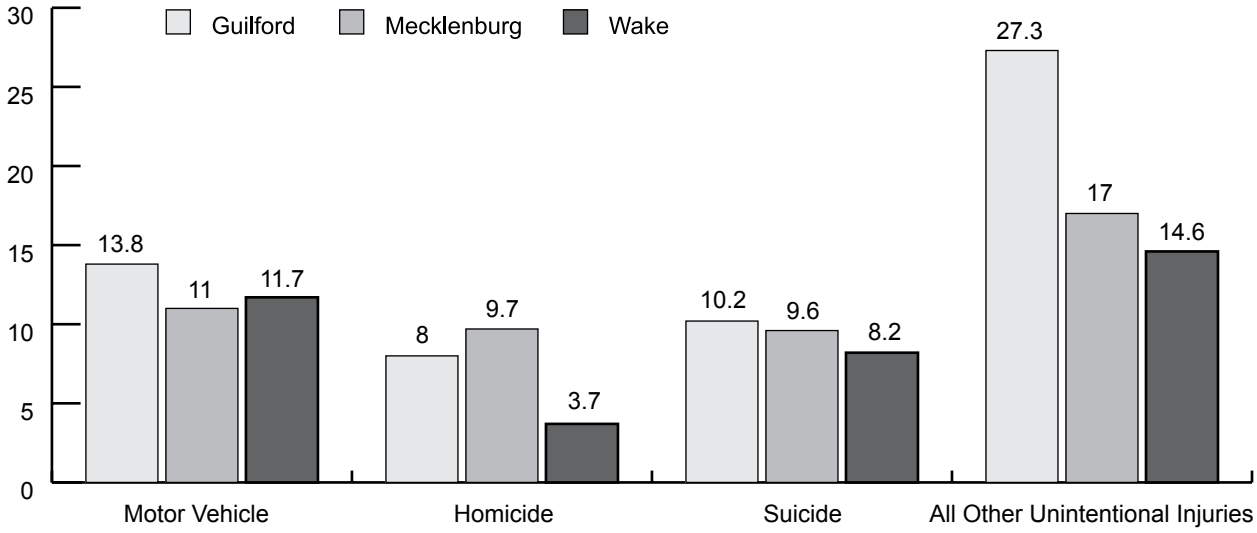
WakeMed is the central trauma center for Wake County. In 2006, it reported the following trauma figures: The top three causes of intentional primary injury were assault at 126, stab wounds at 109 and gun shot wounds at 94. The top causes of unintentional injury for the county were motor vehicle/motor cycle crashes at 1,072 and falls at 740. These figures are from the WakeMed Trauma Registry and represent patients who were treated as trauma patients only. These do not include minor injuries that were treated in the emergency department, but are life or limb-threatening injuries.

The following information represents age, sex and race specific data in 2004 for North Carolina for unintentional injuries, including motor vehicle injuries. Although the data is not available for Wake County, it can be assumed that some of these patterns still apply:

- For black males, the crude rate for unintentional injuries is 37 for 15 to 19 year olds, compared to the higher rate of 75 for white males of the same age range. The rates for black males steadily increase to a rate of 93 for 50 to 54 year olds, then decline slightly. After the 60 to 64 age category, the numbers were not high enough to calculate the crude rate.
- For white males ages 20 to 24, the crude death rate from unintentional injuries was 88 per 100,000. For white males ages 75 to 79, that rate rises to 148.8; for ages 80 to 84, to 238; and for 85+ to a rate of 512 per 100,000.
- For black females 35 to 39 years old, the crude rate of unintentional injuries was 36. Those numbers jump to a crude rate of 80 for 80 to 84 year olds and 165 for 85+ (though still less than white females in those age groups).
- For white females the crude death rate fluctuates between 22 and 32 until the age group of 70 to 74, where the rate rises to 104. For the 80 to 84 age group, the rate increases to 161, and again to 371 per 100,000 for those 85+.
- There were no numbers reported for Hispanic/Latino. Asian/Pacific Islander numbers were too small to report by age, race and sex.

The following chart represents the death rate for unintentional injuries in Wake County, compared to Guilford and Mecklenburg counties.

Death Rates Per 100,000 in 3 North Carolina Counties, 2001-2005



Taking one's own life is a public health problem that devastates friends, families and communities. Suicide is often misinterpreted as a response to a single stressful event. However, it is usually far more complex, with existing looming issues. Suicide brings difficult and uncomfortable reactions in most people. Too often, victims are blamed for their actions and surviving friends and family members are labeled. The number of suicides in the county in 2005 was 58, a death rate of 7.7%. The number of suicides from 2001 to 2004 was 229, a death rate of 8.2%.

As Wake County's population continues to grow, so does the number of automobile accidents, crashes, pedestrian injuries, and alcohol-related incidents. Statistics show that on average, in Wake County there is a crash every 0.3 hours, fatal injury every 114.3 hours and injury every 0.9 hours. The crash cost per hour is estimated at $72,705.

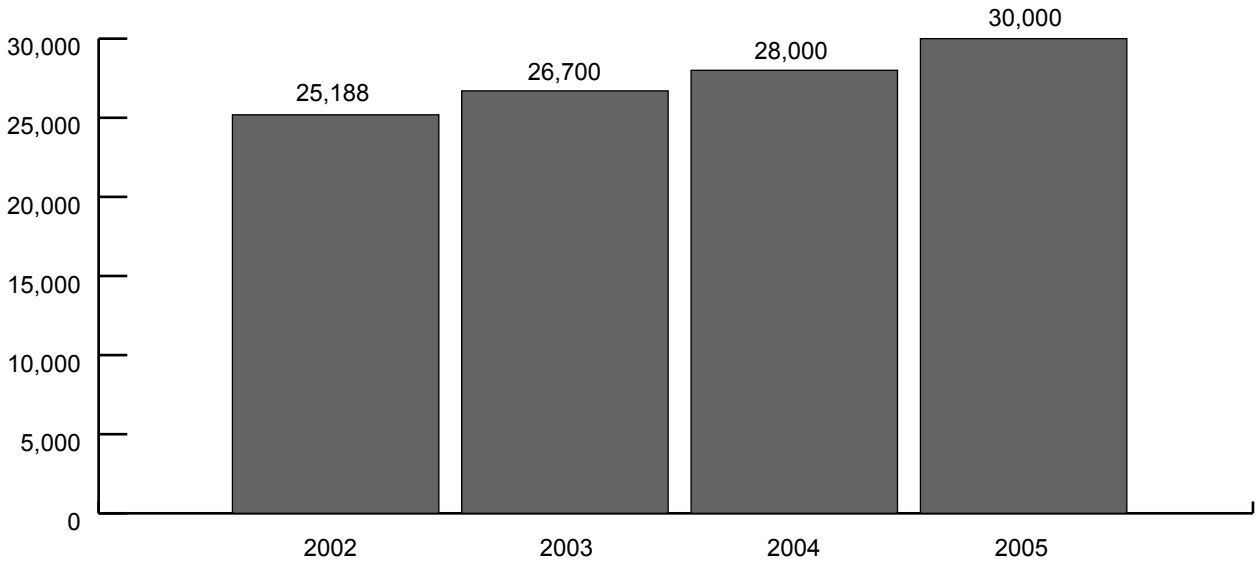
Wake County Traffic Crash Statistics for 2000-2004

	2000		2001		2002		2003		2004		5 Year Avg.	
Reportable	Crashes	Injuries	Crashes	Injuries	Crashes	Injuries	Crashes	Injuries	Crashes	Injuries	Crashes	Injuries
Fatal	55	63	49	54	69	77	63	75	65	72	60	68
Non Fatal Injury	6,451	9,992	6,264	9,712	6,147	9,494	6,343	9,931	6,513	10,126	6,344	9,851
PDO	14,014		14,310		14,633		15,443		15,550		14,790	
Total	20,520	10,055	20,623	9,766	20,849	9,571	21,849	10,006	22,128	10,198	21,194	9,919
Alcohol Related Crashes												
Fatal	19	23	10	10	13	13	14	20	21	22	15	18
Non Fatal Injury	462	776	509	790	420	645	391	625	404	640	437	695
PDO	509		599		468		379		444		480	
Total	990	799	1,118	800	901	658	784	645	869	662	932	713
Percent Alcohol Related												
Fatal	34.5%	36.5%	20.4%	18.5%	18.8%	16.9%	22.2%	26.7%	32.3%	30.6%	25.6%	25.8%
Non Fatal Injury	7.2%	7.8%	8.1%	8.1%	6.8%	6.8%	6.2%	6.3%	6.2%	6.3%	6.9%	7.1%
Total	4.8%	7.9%	5.4%	8.2%	4.3%	6.9%	3.6%	6.4%	3.9%	6.5%	4.4%	7.2%
Pedestrian Crashes												
Fatal	5	5	9	9	11	11	8	13	10	10	9	10
Non Fatal Injury	162	173	155	180	136	153	148	181	165	197	153	177
PDO	9		2		3		5		6		5	
Total	176	178	166	189	150	164	161	194	181	207	167	186
Bicycle Crashes												
Fatal	3	3	2	2	0	0	0	0	0	0	1	1
Non Fatal Injury	56	57	73	73	56	57	56	57	64	64	61	62
PDO	2		1		1		1		3		2	
Total	61	60	76	75	57	57	57	57	67	64	64	63
Motorcycle Crashes												
Fatal	2	2	5	5	9	10	4	4	6	7	5	6
Non Fatal Injury	129	138	135	162	132	155	127	150	135	167	132	154
PDO	32		32		31		23		28		29	
Total	163	140	172	167	172	165	154	154	169	174	166	160

http://www.ncdot.org/dmv/other_services/recordsstatistics/1_2004Fact.pdf

Emergency Medical Service (EMS) is taking more residents to the local hospitals, a reflection of the area's population growth. More citizens simply equal more transports. Transports increase around 6% a year. These numbers are seen in the chart below:

Number of Transports by Year



What Happens Next?

What happens next depends on you and all of our community partners. The Wake County Community Assessment will be an ongoing process, including implementation of the Community Action Plan, and further analysis and dissemination of data to the community to encourage dialogue on solutions.

Each of us is the key to a vibrant community. This Community Assessment and priority-setting process represent only the first doors we have unlocked as we move toward creating a community that will make everyone's life better. Now we must work together on solutions to address the concerns and issues we have prioritized. We must continue to shepherd the many strengths and resources we have in Wake County, and agree to focus our efforts on the identified priorities.

Here is how you can help:

1] Pick an area or issue in the Community Assessment of interest to you and let us know how you can help. You may want to volunteer your time and expertise, link us to other relevant communities and organizations, or help us find resources to address the issue.

2] Tell your family, neighbors, coworkers, faith groups, community organizations and business associates about the Community Assessment. Encourage them to read the information and get involved.

3] Stay engaged in this process. We need your help in keeping the dialogue alive as we move forward. To volunteer, make suggestions or request more information, please contact us at 919-250-4516.

The Community Health Division of Wake County Human Services has assembled a staff team to continue to present this data to the community and to government stakeholders who will use it for planning purposes. This team will also provide support and evaluation for the community efforts to address prioritized issues.

This can be an effective effort only if our community lives it, supports it and participates in it. Please find the areas that resonate with you, and be a part of the solution as we build on successes for the benefit of all of Wake County.

Quick-Reference Glossary

The following are some of the abbreviations used in this report.

ADA . . . . . American Dental Association

AFDC. . . . . Aid to Families with Dependent Children (changed to Temporary Assistance for Needy Families, or TANF)

ASSIST. . . . . Project ASSIST (American Stop Smoking Intervention STudy)

BMI . . . . . Body Mass Index

BRFSS . . . . . Behavioral Risk Factor Surveillance System

CA . . . . . Carolina Access

CAP-MR/DD. . . . . Community Alternative Program for people with Mental Retardation and Developmental Disabilities

CAMPO . . . . . Capital Area Metropolitan Planning Organization (sometimes called MPO)

CASA . . . . . Community Alternatives for Supportive Abodes

CAT . . . . . Capital Area Transit (bus services)

CDBG . . . . . Community Development Block Grant

CDC . . . . . Centers for Disease Control and Prevention

CFT . . . . . Child and Family Team

CNS . . . . . Child Nutrition Services program

CPS . . . . . Child Protective Services

CRC . . . . . Cooperating Raleigh Colleges

CSCP . . . . . Child Service Coordination Program

DD . . . . . Developmental Disabilities

DDH . . . . . Dorothea Dix Hospital

DENR . . . . . North Carolina Department of Environment and Natural Resources

DIRECT . . . . . Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together)

DRE . . . . . digital rectal exam

EBT . . . . . Electronic Benefit Card

EMS . . . . . Emergency Medical Service

EOG. . . . . End of Grade (testing)

ELS. . . . . English as a Second Language

GAL . . . . . Guardian ad Litem
GOLD . . . . . Growing Older Living with Dignity Coalition

HCR. . . . . Wake County Housing and Community Revitalization
HEDIS . . . . . Hospital Emergency Department Information Systems
HIV/AIDS . . . . . Human immunodeficiency virus/acquired immunodeficiency syndrome
HPV. . . . . Human papilloma virus
HP2010 . . . . . Healthy People 2010
HUD . . . . . U.S. Department of Housing and Urban Development

IDDT. . . . . Integrated Dual Disorders Treatment program

JARC . . . . . Job Access and Reverse Commute

LEP . . . . . Limited English Proficient (students)

MFI . . . . . Median Family Income

NBRDC. . . . . New Bern Ridge Dental Center
NC DENR. . . . . North Carolina Department of Environment and Natural Resources
NCEDSS . . . . . North Carolina Electronic Disease Surveillance System
NCIR . . . . . North Carolina Immunization Registry
NCSU . . . . . North Carolina State University
NHQR. . . . . National Healthcare Quality Report
NLIHC . . . . . National Low Income Housing Coalition

PSA . . . . . Prostate specific antigen blood test

RTP . . . . . Research Triangle Park

SACS . . . . . Southern Association of Colleges and Schools
SCHS . . . . . State Center for Health Statistics
SELF . . . . . Project S.E.L.F. (Smoking, Education, Lifestyle, Fitness)
SIDS. . . . . Sudden Infant Death Syndrome
SIP . . . . . State Implementation Plan
STD . . . . . Sexually transmitted disease
SWSC. . . . . South Wilmington Street Shelter

TANF . . . . . Temporary Assistance for Needy Families
TB . . . . . Tuberculosis
TRACS. . . . . Transportation and Rural ACcesS
TTA . . . . . Triangle Transit Authority

UNC . . . . . University of North Carolina

WCHS . . . . . Wake County Human Services
WCoC . . . . . Wake Continuum of Care
WCPSS . . . . . Wake County Public School System
WCTS . . . . . Wake Coordinated Transportation Service
WIA . . . . . Workforce Investment Act
WIC . . . . . Women, Infants and Children programs
WNV . . . . . West Nile Virus

Appendix I

Survey Forms

Focus Group Questions

Wake County Community Assessment Survey

INSTRUCTIONS: Please take about 15 minutes to fill out this survey.
Your answers are important to us! Please do not put your name on the survey.

The Community Assessment Planning Committee would like to know what you think about the health of your community. The results of this survey will help us develop programs that meet the needs of the community.

PLEASE FILL IN THE BOXES LIKE THIS ■.
Please do NOT put check marks or X's in the boxes.

Section I

Thinking about your community, fill in the box that shows how you feel about each of these issues:

1. Air Pollution
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

2. Safe Drinking Water
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

3. Water Pollution
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

4. Food Safety
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

5. Garbage Collection and Disposal
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

6. Recycling
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

7. Litter
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

8. Lead Poisoning
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

9. Animal Control
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

10. Safe Child Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

11. Available Child Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

12. Affordable Child Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

13. Child Abuse and Neglect
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

14. Foster Care and Adoption
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

15. Safe Day Care for Adults/Elders
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

16. Available Day Care for Adults/Elders
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

17. Affordable Day Care for Adults/Elders
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

18. Domestic Violence (wife or husband abuse)
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

19. Abuse of Elders/Adults with Special Needs
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

20. Alcohol/Drug Use
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

21. Illegal Drug Activity
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

22. Gang Activity
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

23. Crime
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

24. Violence
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

25. Youth Access to Weapons
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

26. Prostitution

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

27. Sexual Assault/Rape

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

28. Jail and Prison Overcrowding

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

29. Weapons in School

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

30. Children Prepared for Kindergarten

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

31. K-12th Grade Students Prepared for the Next Level of Education or Employment

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

32. School Overcrowding

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

33. Education Available for People with Learning and Developmental Disabilities

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

34. Available Afterschool/Summer/Track Out Programs

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

35. Affordable Afterschool/Summer/Track Out Programs

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

36. Access to Vocational Training for Adults

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

37. Affordable Higher Education for Adults (College)

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

38. Available Continuing Education and Learning Opportunities for Adults

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

39. Job Opportunities
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

40. Job-Related Accidents
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

41. Rapid Population Growth
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

42. Safe Roads and Bridges
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

43. Driving or Riding in a Car Without Seatbelts or Child Safety Seats
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

44. Unsafe Drivers
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

45. Drinking and Driving
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

46. Car Accidents
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

47. Available Public Transportation
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

48. Convenient Public Transportation
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

49. Safe Housing
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

50. Available Housing
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

51. Affordable Housing
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

52. Homelessness
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

53. Poverty

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

54. Parks and Greenways

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

55. Recreational Facilities

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

56. Access to Recreational Activities for Adults

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

57. Access to Recreational Activities for Teens

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

58. Access to Recreational Activities for Children

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

59. Information During a Disaster

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

60. Disaster Preparedness (hurricanes, ice storms, shelters)

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

61. Terrorism (biological, chemical, etc.)

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

Section II

How much of a problem is it for people in your community to find or use the following services?

62. Health Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

63. Affordable Health Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

64. Transportation to Health Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

65. Hospital Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

66. Emergency Room Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

67. Dental Care
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

68. Mental Health Care/Counseling
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

69. Drug and Alcohol Treatment
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

70. Relief for Caregivers (Respite Care)
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

71. Private Health Insurance Coverage
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

72. Medicaid/Medicare Enrollment Services
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

73. Providers Who Accept Medicaid/Medicare
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

74. Affordable Medicine
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

75. Food Assistance (money or food)
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

76. Housing Assistance (public housing or aid)

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

77. Utility Assistance (to pay electricity or fuel bills)

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

78. Shelters During an Emergency

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

79. 911 Emergency Services (fire, police, EMS)

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

80. Health Information

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

Section III

How much of a problem do you think your community has with any of the following health issues?

81. Regular Exercise

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

82. Cigarette Smoking

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

83. Unsafe Sex

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

84. Eating Habits/Nutrition

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

85. Breast Cancer

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

86. Lung Cancer

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

87. Prostate Cancer
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

88. Other Cancers
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

89. Diabetes
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

90. Heart Disease
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

91. High Blood Pressure
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

92. Stroke
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

93. Arthritis
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

94. Dental Problems
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

95. HIV/AIDS
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

96. Other Sexually Transmitted Diseases (herpes, chlamydia, syphilis etc.)
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

97. Diseases Passed From Person to Person (flu, chicken pox, tuberculosis, etc.)
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

98. Diseases People Get From Animals (rabies, Rocky Mountain Spotted Fever, etc.)
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

99. New Diseases (bird flu, SARS, etc.)
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

100. Mental Health Problems
- □ a. Not a problem
- □ b. Minor problem
- □ c. Moderate problem
- □ d. Serious problem
- □ e. Don't know or not sure

101. Depression

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

102. Suicide

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

103. Eating Disorders/Problems (Bulimia/Anorexia)

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

104. Childhood Asthma

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

105. Overweight Children

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

106. Overweight Adults

□ a. Not a problem
□ b. Minor problem
□ c. Moderate problem
□ d. Serious problem
□ e. Don't know or not sure

107. Please list other issues you feel are important to your community:

_____

_____

Section IV

Physical Health

108. ***Of the topics listed below, please fill in the most important health care issue for your community to address. Please fill in only one box:***

□ Health Care Services
□ Transportation to Health Care
□ Hospital Care
□ Emergency Room Care
□ Private Health Insurance Coverage
□ Medicaid/Medicare
□ Affordable Medicine
□ Dental Care

109. Of the topics listed below, please fill in the most important disease for your community to address. Please fill in only one box:

□ Childhood Asthma
□ Cancer
□ Diabetes
□ Heart Disease/Stroke
□ High Blood Pressure
□ Dental Problems
□ HIV/AIDS
□ Other Sexually Transmitted Diseases
□ Contagious Diseases (flu, tuberculosis, SARS etc)

110. Of the topics listed below, please fill in the most important lifestyle issue for your community to address. Please fill in only one box:

□ Driving or Riding in a Car without Seatbelts or Child Safety Seat
□ Unsafe Drivers
□ Cigarette Smoking
□ Regular Exercise
□ Unsafe Sex
□ Eating Habits/Nutrition
□ Overweight People
□ Health Information
□ Recreational Activities

Special Populations

111. Of the topics listed below, please fill in the most important family issue for your community to address. Please fill in only one box:

- □ Child Care
- □ Day Care for Special Needs Adults/Elders
- □ Domestic Violence (wife or husband abuse)
- □ Abuse of Special Needs Adults/Elders
- □ Child Abuse and Neglect
- □ Foster Care and Adoption
- □ Relief for Caregivers (Respite Care)
- □ Learning and Developmental Disabilities

112. Of the topics listed below, please fill in the most important mental health issue for your community to address. Please fill in only one box:

- □ Mental Health Care/Counseling
- □ Mental Health Problems
- □ Depression
- □ Eating Disorders/Problems (bulimia/anorexia)
- □ Suicide
- □ Alcohol/Drug Use
- □ Drug and Alcohol Treatment

Environmental Health

113. Of the topics listed below, please fill in the most important environmental health issue for your community to address. Please fill in only one box:

- □ Parks and Recreation
- □ Food Safety
- □ Air pollution
- □ Water Pollution
- □ Garbage
- □ Lead Poisoning
- □ Animal Control
- □ Safe Roads and Bridges
- □ Rapid Population Growth

Safety

114. Of the topics listed below, please fill in the most important safety issue for your community to address. Please fill in only one box:

- □ Drinking and Driving
- □ Illegal Drug Activity
- □ Gang Activity
- □ Crime/Violence
- □ Youth Access to Weapons
- □ Weapons in School
- □ Prostitution
- □ Sexual Assault/Rape
- □ Jail and Prison Overcrowding

115. Of the topics listed below, please fill in the most important emergency issue for your community to address. Please fill in only one box:

- □ Job-related Accidents
- □ Information During a Disaster
- □ Disaster Preparedness (hurricanes, ice storms)
- □ Shelters During an Emergency
- □ 911 Emergency Services (fire, police, EMS)
- □ Terrorism

Economic Health

116. Of the topics listed below, please fill in the most important economic issue for your community to address. Please fill in only one box:

- □ Job Opportunities
- □ Public Transportation
- □ Housing
- □ Homelessness
- □ Poverty
- □ Food Assistance (money or food)
- □ Housing Assistance (public housing or aid)
- □ Utility Assistance (to pay electricity or fuel bills)

Lifelong Learning

117. Of the topics listed below, please fill in the most important education issue for your community to address. Please fill in only one box:

- □ Children Prepared for Kindergarten
- □ Students Prepared for Higher Education or Employment
- □ School Overcrowding
- □ Afterschool/Summer/Track Out Programs
- □ Vocational Training for Adults
- □ Affordable Higher Education for Adults
- □ Available Continuing Education and Learning Opportunities for Adults

Overall Concerns

118. Please fill in the three (3) areas that concern you the most about your community. You may refer back to the previous lists to see what is included in each of these areas. Please fill in only three boxes.

- □ Physical Health
- □ Special Populations
- □ Environmental Health
- □ Safety
- □ Economics
- □ Lifelong Learning

Section V

We would like to know a little about you. These questions are personal, but your name will not be connected with them in any way.

119. City/Town in which you LIVE:

- □ a. Apex
- □ b. Cary
- □ c. Fuquay-Varina
- □ d. Garner
- □ e. Holly Springs
- □ f. Knightdale
- □ g. Morrisville
- □ h. Raleigh
- □ i. Rolesville
- □ j. Wake Forest
- □ k. Wendell
- □ l. Zebulon
- □ m. Other _____

120. How long have you lived in Wake County?

- □ a. I do not live in Wake County
- □ b. Less than 1 year
- □ c. 1 to 5 years
- □ d. 6 to 10 years
- □ e. more than 10 years

121. City/Town in which you WORK:

- □ a. Apex
- □ b. Cary
- □ c. Fuquay-Varina
- □ d. Garner
- □ e. Holly Springs
- □ f. Knightdale
- □ g. Morrisville
- □ h. Raleigh
- □ i. Rolesville
- □ j. Wake Forest
- □ k. Wendell
- □ l. Zebulon
- □ m. Other _____

122. Do you work for Wake County Government?

- □ a. Yes, Department?_____
- □ b. No

123. Your Gender:

- □ a. Female
- □ b. Male

124. Your Age:

- □ a. 10-14 years
- □ b. 15-19 years
- □ c. 20-29 years
- □ d. 30-39 years
- □ e. 40-49 years
- □ f. 50-59 years
- □ g. 60-69 years
- □ h. 70-79 years
- □ i. 80 years and over

125. Racial/ethnic identification: (fill in all that apply):

- □ a. Asian or Pacific Islander
- □ b. Black or African American
- □ c. Hispanic/Latino
- □ d. Multi-racial
- □ e. Native American
- □ f. White or Caucasian
- □ g. Other_____

126. Education:

- □ a. 12th grade or less, no diploma or equivalent
- □ b. High School Graduate/GED
- □ c. Some college (no degree)
- □ d. Vocational/Technical
- □ e. College graduate
- □ f. Post graduate degree

127. Are you a member of a Faith Organization:

- □ a. Yes, Denomination:_____
- □ b. No

128. Employment Status (check all that apply):

- □ a. Employed full-time
- □ b. Employed part-time
- □ c. Unemployed
- □ d. Student full-time
- □ e. Student part-time
- □ f. Retired

129. How much money do you have to support your household each year?

- □ a. Less than $5,000
- □ b. $5,000 - $14,999
- □ c. $15,000 - $24,999
- □ d. $25,000 - $49,999
- □ e. $50,000 - $74,999
- □ f. $75,000 - $99,999
- □ g. $100,000 or higher

130. Number of people dependent on the money you have to support your household:

- □ a. one (1)
- □ b. two (2)
- □ c. three (3)
- □ d. four (4)
- □ e. five (5)
- □ f. six (6)
- □ g. seven or more (7+)

131. Do you have health insurance?

- □ a. Yes
- □ b. No
- □ c. Don't know or not sure

132. If you have health Insurance, what kind(s) do you have (check all that apply)?

- □ a. Private - traditional
- □ b. Managed Care (HMO, PPO, etc)
- □ c. Medicaid/Health Choice
- □ d. Medicare
- □ e. Veteran's Administration (VA)
- □ f. Government Other than VA

Thank you for taking the time to complete this survey.

Please return this survey BY JULY 15, 2006 to:
Dr. David Damsker
Wake County Human Services
PO Box 14049
Raleigh, NC 27620-4049

If you have any questions or concerns about this survey, please contact Dr. David Damsker (919) 250-4549 or Regina Petteway (919) 250-1199

Wake County Community Assessment Survey
Encuesta del Condado de Wake: Diagnóstico Comunitario

INSTRUCCIONES: Favor de tomar unos 15 minutos para llenar esta encuesta.
Sus respuestas son importantes para nosotros!
Por favor, no ponga su nombre en la encuesta. Esta encuesta es anónima.

El Comité del Diagnóstico Comunitario quisiera saber lo que usted piensa sobre la salud de su comunidad. Los resultados de esta encuesta nos ayudarán a desarrollar programas que atiendan las necesidades que su comunidad considera importantes.

Favor de rellenar la cajita en la siguiente forma
Por favor, no use X ni tachas.

Sección I

Pensando en su comunidad, que opina usted sobre los siguientes puntos?

1. Contaminación del Aire
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

2. Calidad del Agua Potable (de la llave)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

3. Contaminación del Agua
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

4. Seguridad de los Alimentos
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

5. Recolección y Eliminación de Basura
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

6. Reciclar
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

7. Basura Tirada
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

8. Envenenamiento con Plomo
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

9. Control de Animales
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

10. Guarderías Seguras
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

11. Guarderías Disponibles
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

12. Guarderías <u>a Costo Accesible</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

13. Abuso y Negligencia de Niños
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

14. Padres de Crianza y Adopción
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

15. Centros de Cuidado para Ancianos o Adultos que Sean <u>Seguros</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

16. Centros de Cuidado para Ancianos o Adultos que Sean <u>Disponibles</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

17. Centros de Cuidado para Ancianos o Adultos que Sean <u>a Costo Accesible</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

18. Violencia Domestica (abuso entre parejas)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

19. Abuso de Ancianos o Adultos Discapacitados
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

20. Uso de Drogas ilegales / Alcohol
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

21. Actividad ilegal de Drogas (venta, etc).
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

22. Actividad de Pandillas / Gangas
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

23. Crimen
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

24. Violencia
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

25. Jóvenes con Acceso a Armas de Fuego
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

26. Prostitución
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

27. Abuso Sexual / Violación
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

28. Cárceles y Prisiones Abarrotadas (muy llenas)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

29. Presencia de Armas de Fuego en las Escuelas
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

30. Niños Preparados para Entrar al Kinder (Jardín de Niños)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

31. Estudiantes de Grados K-12^{avo} Salen Preparados para el Próximo Nivel de Educación o para Trabajar
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

32. Escuelas Abarrotadas (muy llenas)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

33. Educación Disponible para Personas con Problemas de Aprendizaje o Discapacidad de Desarrollo
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

34. <u>Disponibilidad</u> de Programas Después de la Escuela o Verano/Track Out
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

35. Programas <u>a Costo Accesible</u> después de la Escuela o Verano/Track Out
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

36. Acceso a Entrenamiento Vocacional para Adultos
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

37. Educación Avanzada <u>a Costo Accesible</u> para Adultos (Universidad)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

38. Programas de Educación Continua para Adultos
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

39. Oportunidades de Trabajo
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

40. Accidentes en el Trabajo
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

41. Crecimiento Rápido de Población
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

42. Carreteras y Puentes Seguros
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

43. Manejar o Subir a un Auto sin el Uso de Cinturones de Seguridad o Asientos de Seguridad para los Niños
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

44. Conductores Negligentes / Irresponsables
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

45. Manejar Embriagado
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- e. No sé / No estoy seguro

46. Accidentes de Autos
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

47. Transporte Público <u>Disponible</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

48. Transporte Público <u>Accesible</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

49. Vivienda <u>Segura</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

50. Vivienda <u>Disponible</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

51. Vivienda <u>a Costo Accesible</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

52. Personas sin Hogar
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

53. Pobreza
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

54. Parques y Veredas para Pasear
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

55. Lugares para Hacer Deporte
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

56. Acceso a Programas de Recreación para <u>Adultos</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

57. Acceso a Programas de Recreación para <u>Jóvenes</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

58. Acceso a Programas de Recreación para <u>Niños</u>
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

59. Información Durante un Desastre
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

60. La Falta de Preparación en Caso de un Desastre (huracanes, tormentas de hielo, albergue durante el desastre)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

61. Terrorismo (biológico, químico, etc.)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

Sección II

¿Qué tan difícil se le hace a personas de su comunidad encontrar o usar los siguientes servicios?

62. Servicios de Salud (clínicas y doctores)
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

63. Servicios de Salud <u>a Costo Accesible</u>
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

64. Transporte a Servicios de Salud
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

65. Servicios de Hospital
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

66. Servicios Médicos de Emergencia
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

67. Cuidado Dental
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

68. Salud Mental / Consejería
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

69. Tratamiento para Abuso de Drogas o Alcohol
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

70. Ayuda a Familiares que Cuidan Diariamente de Enfermos o Ancianos en su Familia
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

71. Seguros Médicos Privados
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

72. Servicios para Inscribirse en Programas de Medicaid / Medicare
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

73. Proveedores que Aceptan Medicaid / Medicare
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

74. Medicinas <u>a Costo Accesible</u>
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

75. Comida / Alimentos para Emergencias (dinero o alimentos)
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

76. Asistencia para la Vivienda (sea mediante vivienda pública o ayuda económica)
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

77. Ayuda para Pagar la Luz o Gas
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

78. Albergue Durante una Emergencia
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

79. Servicios de Emergencias 911 (bomberos, policía, ambulancia)
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

80. Información acerca de la Salud
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

Sección III

¿Qué dificultad tiene su comunidad en las siguientes áreas de salud?

81. Ejercicio Regular (frecuente)
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

82. Fumar Cigarrillos
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ **e. No sé / No estoy seguro**

83. Sexo sin Protección
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

84. Hábitos de Comer / Nutrición
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

85. Cáncer de los Senos
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

86. Cáncer de los Pulmones
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

87. Cáncer de la Próstata
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

88. Otros Canceres
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

89. Diabetes
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

90. Problemas del Corazón
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

91. Presión Alta
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

92. Derrame Cerebral
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

93. Artritis
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

94. Problemas Dentales
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

95. VIH / SIDA
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

96. Otras Enfermedades de Transmisión Sexual (clamidia, herpes, sífilis etc.)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

97. Enfermedades que se Transmiten de Persona a Persona (influenza, varicela, tuberculosis, etc.)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

98. Enfermedades que se Transmiten de Animal a Persona (rabia, enfermedades que transmiten las garrapatas etc.)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

99. Enfermedades Nuevas (gripe aviar, SARS, etc.)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

100. Problemas de Salud Mental (nervios, etc.)
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

101. Depresión
- □ a. No es un problema
- □ b. Es un problema mínimo
- □ c. Es un problema moderado
- □ d. Es un problema serio
- □ e. No sé / No estoy seguro

102. Suicidios
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

103. Trastornos Alimenticios (Bulimia/Anorexia)
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

104. Asma en los Niños
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

105. Niños Sobrepeso
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

106. Adultos Sobrepeso
□ a. No es un problema
□ b. Es un problema mínimo
□ c. Es un problema moderado
□ d. Es un problema serio
□ e. No sé / No estoy seguro

107. Favor de escribir otros temas que usted considere sean importantes para su comunidad:

_____

_____

_____

Sección IV

Salud Física

108. ***De los temas mencionados abajo, favor de marcar el problema de salud más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Servicios de Salud (clínicas y doctores)
□ Transporte a Servicios de Salud
□ Servicios de Hospital
□ Servicios Médicos de Emergencia
□ Seguros Médicos Privados
□ Medicaid / Medicare
□ Medicinas a Costo Accesible
□ Cuidado Dental

109. ***De los temas mencionados abajo, favor de marcar la enfermedad más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Asma en los Niños
□ Cáncer
□ Diabetes
□ Enfermedad del Corazón / Derrame Cerebral
□ Presión Alta
□ Problemas Dentales
□ VIH / SIDA
□ Otras Enfermedades de Transmisión Sexual
□ Enfermedades Contagiosas (influenza, tuberculosis, SARS etc.)

110. ***De los temas mencionados abajo, favor de marcar el problema de estilo de vida más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Manejar o Subir a un Auto sin el Uso de Cinturones de Seguridad o Asientos de Seguridad para los Niños
□ Conductores Negligentes / Irresponsables
□ Fumar Cigarrillos
□ Ejercicio Regular (frecuente)
□ Sexo sin Protección
□ Hábitos de Comer / Nutrición
□ Personas Sobrepeso
□ Información acerca de la Salud
□ Actividades de Recreación

Poblaciones con un Enfoque Especial

111. ***De los temas mencionados abajo, favor de marcar el problema más importante de la familia el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Guarderías
□ Centros de Cuidado para Ancianos o Adultos
□ Violencia Domestica (abuso entre parejas)
□ Abuso de Ancianos o Adultos Discapacitados
□ Abuso o Negligencia de Niños
□ Padres de Crianza y Adopción
□ Ayuda a Familiares que Cuidan Diariamente de Enfermos en su Familia
□ Educación Disponible para Personas con Problemas de Aprendizaje o Discapacidad de Desarrollo

112. ***De los temas mencionados abajo, favor de marcar el problema de salud mental más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Salud Mental / Consejeria
□ Problemas de Salud Mental (nervios, etc.)
□ Depresión
□ Trastornos Alimenticios (bulimia/anorexia)
□ Suicidios
□ Uso de Drogas ilegales o Alcohol
□ Tratamiento para Abuso de Drogas o Alcohol

Salud del Medio Ambiente

113. De los temas mencionados abajo, favor de marcar el problema de salud del medio ambiente más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:

□ Parques y Recreación
□ Seguridad de los Alimentos
□ Contaminación del Aire
□ Contaminación del Agua
□ Basura
□ Envenenamiento con Plomo
□ Control de Animales
□ Carreteras y Puentes Seguros
□ Crecimiento Rápido de Población

Seguridad

114. ***De los temas mencionados abajo, favor de marcar el problema de seguridad más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Manejar Embriagado
□ Actividad ilegal de Drogas (venta, etc.)
□ Actividad de Pandillas / Gangas
□ Crimen / Violencia
□ Jóvenes con Acceso a Armas de Fuego
□ Presencia de Armas de Fuego en las Escuelas
□ Prostitución
□ Abuso Sexual / Violación
□ Cárceles y Prisiones Abarrotadas (muy llenas)

115. ***De los temas mencionados abajo, favor de marcar el problema de emergencia más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Accidentes en el Trabajo
□ Información Durante un Desastre
□ La Falta de Preparación en Caso de un Desastre (huracanes, tormentas de hielo, etc.)
□ Albergue Durante una Emergencia
□ Servicios de Emergencia 911 (bomberos, policía, ambulancia)
□ Terrorismo

Salud Financiera

116. ***De los temas mencionados abajo, favor de marcar el problema financiera más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Oportunidades de Trabajo
□ Transporte Público
□ Vivienda
□ Personas sin Hogar
□ Pobreza
□ Comida / Alimentos para Emergencias (dinero o alimentos)
□ Asistencia para la Vivienda (sea mediante vivienda pública o ayuda económica)
□ Ayuda para Pagar la Luz o Gas

Programas de Aprendizaje durante Diferentes Etapas de la Vida

117. ***De los temas mencionados abajo, favor de marcar el problema de educación más importante el cual su comunidad quiere que sea atendido. Favor de marcar sólo uno:***

□ Niños Preparados para Entrar al Kinder (Jardín de Niños)
□ Estudiantes de Grados K-12 Salen Preparados para el Próximo Nivel de Educación o para Trabajar
□ Escuelas Abarrotadas (muy llenas)
□ Programas Después de la Escuela o Verano/Track Out
□ Acceso a Entrenamiento Vocacional para Adultos
□ Educación Avanzada a Costo Accesible para Adultos (Universidad)
□ Programas de Educación Continua para Adultos

Áreas de Preocupación

118. ***Favor de marcar las tres (3) áreas que le preocupan más en su comunidad. Usted puede mirar las listas mencionadas arriba para recordar lo que está incluido en cada una de estas áreas. Favor de marcar sólo tres.***

□ Salud Física
□ Poblaciones con un Enfoque Especial
□ Salud del Medio Ambiente
□ Seguridad
□ Salud Financiera
□ Programas de Aprendizaje durante Diferentes Etapas de la Vida

Sección V

Nos gustaría saber un poco más acerca de usted. Estas preguntas son personales, pero su nombre no aparecerá en este documento.

119. Ciudad/Pueblo donde vive:
□ a. Apex
□ b. Cary
□ c. Fuquay-Varina
□ d. Garner
□ e. Holly Springs
□ f. Knightdale
□ g. Morrisville
□ h. Raleigh
□ i. Rolesville
□ j. Wake Forest
□ k. Wendell
□ l. Zebulon
□ m. Otro _____

120. ¿Cuánto tiempo lleva viviendo en el Condado de Wake?
□ a. No vivo en el Condado de Wake
□ b. menos de 1 año
□ c. 1 a 5 años
□ d. 6 a 10 años
□ e. más de 10 años

121. Ciudad/Pueblo donde trabaja:
□ a. Apex
□ b. Cary
□ c. Fuquay-Varina
□ d. Garner
□ e. Holly Springs
□ f. Knightdale
□ g. Morrisville
□ h. Raleigh
□ i. Rolesville
□ j. Wake Forest
□ k. Wendell
□ l. Zebulon
□ m. Otro _____

122. ¿Usted trabaja para el gobierno del Condado de Wake?
□ a. Sí, Departamento?_____
□ b. No

123. Su Sexo:
□ a. Mujer
□ b. Hombre

124. Su Edad:
- □ a. 10 a 14 años
- □ b. 15 a 19 años
- □ c. 20 a 29 años
- □ d. 30 a 39 años
- □ e. 40 a 49 años
- □ f. 50 a 59 años
- □ g. 60 a 69 años
- □ h. 70 a 79 años
- □ i. 80 años o más

125. Raza o grupo étnico: (marque todas las que le pertenezcan):
- □ a. Asiático o del Pacifico
- □ b. Negro / Afro-Americano
- □ c. Hispano / Latino
- □ d. Multi-racial
- □ e. Nativo Americano
- □ f. Blanco / Caucásico
- □ g. Otro_____

126. Educación:
- □ a. Menos de 12 años de escuela, sin diploma o equivalente
- □ b. Graduado de Escuela Preparatoria / GED
- □ c. Algo de Universidad (sin diploma)
- □ d. Vocacional / Técnico
- □ e. Graduado de Universidad
- □ f. Un Posgraduado de Universidad

127. ¿Pertenece a alguna iglesia o grupo religioso?
- □ a. Sí, Denominación:_____
- □ b. No

128. Empleo (marque todas las que le pertenezcan):
- □ a. Empleado de tiempo completo
- □ b. Empleado de medio tiempo
- □ c. Sin empleo
- □ d. Estudiante de tiempo completo
- □ e. Estudiante de medio tiempo
- □ f. Retirado

129. ¿Aproximadamente cual es el presupuesto anual de su familia?
- □ a. Menos de $5,000
- □ b. $5,000 - $14,999
- □ c. $15,000 - $24,999
- □ d. $25,000 - $49,999
- □ e. $50,000 - $74,999
- □ f. $75,000 - $99,999
- □ g. $100,000 o más

130. Número de dependientes en su familia:
- □ a. Uno (1)
- □ b. Dos (2)
- □ c. Tres (3)
- □ d. Cuatro (4)
- □ e. Cinco (5)
- □ f. Seis (6)
- □ g. Siete o más (7+)

131. ¿Tiene seguro médico?
- □ a. Sí
- □ b. No
- □ c. No sé o no estoy seguro

132. Si tiene seguro medico, ¿qué clase de seguro(s) tiene (marque todas las que le pertenezcan)?
- □ a. Privado - tradicional
- □ b. Managed Care (HMO, PPO, etc.)
- □ c. Medicaid/Health Choice
- □ d. Medicare
- □ e. De la Administración de Veteranos
- □ f. Seguro del Gobierno que no sea Veteranos

¡Gracias por tomar el tiempo de completar esta encuesta!

Favor de devolver esta encuesta antes del 15 de julio, 2006 a:
Dr. David Damsker
Wake County Human Services
PO Box 14049
Raleigh, NC 27620-4049

Si tiene cualquier pregunta o sugerencia por favor comuníquese con Carla Piedrahita (919) 250-3891

2006 Wake County Community Assessment

Focus Group Questions

15 Minutes Introduction Question

1] Let's go around the room and have each one of you introduce yourself and tell us what you think is the *best thing about living in Wake County.*

30 Minutes Behavioral Questions (10 minutes each): Participants should describe behaviors or things that their *target group* does or can do.

2] What does (specific target group) do to stay healthy in Wake County?

3] What prevents (specific target group) from (refer to the list of behaviors in Q 2?

4] What can be done to change these things? (Refer to the list of behaviors in Q 3) *See Recorder form)

65 Minutes Knowledge/Belief Questions: Participants should describe what they know about their *specific target group* from experience or second hand information (the news, a relative or etc.).

5] 25 Minutes: Three parts question:

a] In your opinion, what are the major health problems/concerns for (specific target group)?

b] What are the causes of these problems?

c] How have they improved or worsened over the last four years since the last Community Assessment was complete? (Refer to the 6 areas of health)

6] 10 Minutes: What things are working in Wake County to address the 6 areas of health for (specific target group)?

7] 10 Minutes: What things are not working in Wake County to address the 6 areas of health for (specific target group)?

8] 5 Minutes: Closing Statement (Script):

Thank you for your participation and contributions in shaping the future of Wake County. Please complete the demographic card if you have not done so.

APPENDIX II

2006 Wake County Community Assessment

Focus Group Results

Methodology

Twenty-eight focus groups, representing nine (9) target audiences, were conducted throughout Wake County during the months of July and August 2006 to gather community perceptions of physical health, mental health, economic health, environmental health, safety and lifelong learning issues affecting the community.

Focus groups are informal sessions in which representatives of target populations are asked to discuss their thoughts on a specific topic, in this case the needs and strengths of Wake County. The groups were usually small (8-12 persons per group), with particular emphasis placed on recruiting people who were representative of the community or target groups of interest. Because the process required a trained facilitator and recorder, 15 facilitators and/or recorders were recruited and trained. Focus groups are designed to be conversational, therefore open-ended, broad, yet focused questions were asked.

Audiences reached through the focus groups included:

- African Americans (2 groups)
- Latino/Hispanic (6)
- Faith Community (2)
- Service Providers (7)
- Youth (4)
- People with Disabilities (2)
- Seniors (3)
- Young Adults/College students (1)
- People living with HIV (1)

Demographics

Twenty-eight focus groups were conducted, reaching 251 total participants.

The Gender and Racial Breakdown of Participants Is as Follows:

	Female	Male	Unknown	Total
African American	74	31	3	108
Asian	1	4	0	5
Caucasian	56	19	0	75
Hispanic/Latino	44	15	0	59
Multi-Racial	3	0	0	3
Other/Unknown	0	1	0	1
Total	178	70	3	251

Age/race distribution is as follows:

	0-18	19-24	25-61	62+	Un-known	Total
African American	30	2	62	11	3	108
Asian	0	0	4	1	0	5
Caucasian	4	0	49	22	0	75
Hispanic/Latino	17	5	35	2	0	59
Multi-racial	2	0	1	0	0	3
Other/Unknown	0	0	1	0	0	1
Total	53	7	152	36	3	251

Geographic Distribution Is as Follows:

	Total # Focus Groups per Location	Total # Participants Residing in Town
Apex	1	5
Cary	2	16
Fuquay-Varina	3	29
Garner	1	11
Holly Springs	0	8
Knightdale	0	4
Morrisville	0	0
Raleigh	17	111
Rolesville	2	38
Wake Forest	1	10
Wendell	1	19
Zebulon	0	0

Themes by Question

Each focus group was analyzed by question and major themes generated. The themes were generated based upon the number of times something was mentioned and the number of groups mentioning it. The themes will note the number of times the response was given and the percentage of focus groups where it was mentioned. A complete listing of responses is attached.

Question 1: What do you think is the best thing about living in Wake County?

- •] Available Services/Resources (mentioned 66 times in 79% of focus groups). Examples of services included:
  - Services for seniors
  - Services provided by non-profit organizations
  - Hospitals
  - Services for children/youth
  - Services for disabled
- •] Geography of the County/Location (mentioned 60 times in 61% of focus groups)
  - Centrally located in State, close to mountains, beach
  - Small towns and large cities (both rural and urban)
  - Trees, scenery and green space
  - Located in the Capital City – provides voice at State level

- Education (mentioned 56 times in 75% of focus groups)
  - Good public school system
  - Access to higher education and learning opportunities
- Opportunities (mentioned 43 times in 64% of focus groups)
  - Employment
  - Professional development
  - For non-English speaking populations
- Friendly people/family (mentioned 38 times in 61% of focus groups)
- Diversity/Culture (mentioned 30 times in 54% of focus groups)

Question 2:What do (specific target group) do to stay healthy?

- Engage in physical activity (mentioned 93 times in 89% of focus groups). Types of physical activity included:
  - Walking
  - Dancing
  - Sports
  - Gardening/yard work
- Eat healthy (mentioned 36 times in 86% of focus groups)
- Access healthcare/available services (mentioned 42 times in 50% of focus groups). Ways and types of services accessed include:
  - Vaccinations/immunizations
  - Get/maintain health insurance
  - Comply with providers
- Develop/maintain social networks (mentioned 22 times in 50% of focus groups). This is done by:
  - Socializing with friends/family
  - Going to senior centers
- Stay active/involved in community (mentioned 19 times in 43% of focus groups)

Question 3:What prevents (specific target group) from staying healthy?

- Lack of money/economics (mentioned 73 times in 75% of focus groups.
- Lack of transportation (mentioned 58 times in 68% of focus groups)
- Access to services/lack of services (mentioned 57 times in 61% of focus groups)
  - Lack of services for men
  - Cost of services
  - Services far from home
- Unhealthy diet (mentioned 41 times in 64% of focus groups)
  - Cost of eating healthy
  - Healthy foods unavailable
  - Time needed to prepare healthy foods
- Lack of knowledge/information about services and programs (mentioned 40 times in 57% of focus groups).

- Lack of motivation (mentioned 37 times in 50% of focus groups)
- Fear/Lack of trust (mentioned 29 times in 46% of focus groups)
  - Of systems (healthcare, school)
- Violence/safety issues (mentioned 24 times in 32% of focus groups)
  - Gangs
  - Domestic violence/child abuse
  - Workplace safety
- Racism (mentioned 25 times in 18% of focus groups)
  - General
  - Schools
  - Church

Question 4: What can be done to change these things?

- Educate the community about health issues (mentioned 81 times in 71% of focus groups)
  - Nutrition and physical activity
  - Spanish speaking individuals about American laws
- Provide education in Spanish
  - Available resources/services
- Have more/improve services (mentioned 67 times in 68% of focus groups)
  - Affordable programs for youth
  - Affordable services for low income seniors
  - Culturally appropriate programs/services
- Provide affordable transportation/improve transportation (mentioned 25 times in 39% focus groups)
- Build partnerships/relationships (mentioned 20 times in 25% focus groups)
  - With police
  - Between parents and schools
  - Between universities and community

Question 5A: What are the major health problems/concerns for (specific target audience)?

- Physical health problems (mentioned 73 times in 68% of focus groups).
  - Diabetes (mentioned in 43% of focus groups)
  - Obesity (mentioned in 39% of focus groups)
  - STDs/AIDS (mentioned in 29% of focus groups)
  - Dental disease
  - High blood pressure
  - Cancer
  - Reproductive health
  - Teen pregnancy

•] Crime/Violence (mentioned 29 times in 64% of focus groups).
    - Gangs/youth violence (mentioned 14 times in 46% of focus groups)
    - Child abuse and neglect
    - Murder/homicide
    - Rape
    - Terrorism
•] Environmental health problems (mentioned 17 times in 36% of focus groups)
    - Apathy about the environment
    - Water quality
    - Animal waste
    - Restaurant sanitation
    - Poor air quality
    - Lead/mercury/mold
    - Zoonotic diseases
•] Substance use/abuse (mentioned 16 times in 39% of focus groups)
•] Poverty/economics (mentioned 14 times in 36% of focus groups}
    - Included lack of employment opportunities
•] Housing (mentioned 13 times in 36% of focus groups)
    - Included unsafe housing
•] Lack of mental health services (mentioned 10 times in 36% of focus groups).

Question 5-B: What are the causes of these problems?

•] Access to/lack of services (mentioned 68 times in 57% of focus groups)
•] Lack of money/economics (mentioned 48 times in 64% of focus groups)
•] Lifestyles (mentioned 38 times in 43% of focus groups)
    - Food and lack of exercise
    - Unprotected sex
    - Smoking
•] Stress/depression/mental illness (mentioned 26 times in 43% of focus groups)
•] Peer pressure (mentioned 26 times in 39% of focus groups)
•] Lack of knowledge/lack of information (mentioned 24 times in 39% of focus groups)
•] Lack of parental involvement (mentioned 23 times in 43% of focus groups)
•] Substance use/abuse (mentioned 23 times in 32% of focus groups)
•] Immigration issues (mentioned 23 times in 32% of focus groups)
•] Racism/race relations (mentioned 21 times in 25% of focus groups)
•] Lack of motivation/attitudes (mentioned 16 times in 39% of focus groups)
•] Heredity/culture (mentioned 16 times in 36% of focus groups)

Question 5-C: How have they improved or worsened over the last four years?

- Everything has worsened (mentioned 40 times in 46% of focus groups)
- Increase in crime/violence (mentioned 16 times in 32% of focus groups)
- More STDs/Teen pregnancy (mentioned 9 times in 29% of focus groups)
- Service availability has worsened (mentioned 9 times in 18% of focus groups)

Question 6: What things are working in Wake County to address the six areas of health for (specific target group)?

- Prevention programs (mentioned 22 times in 46% of focus groups)
  - Gang prevention partnership
  - Pregnancy prevention programs
  - Domestic violence prevention
  - HIV/STD prevention
  - Health promotion programs
- Public school system (mentioned 21 times in 32% of focus groups)
  - School safety
  - Physical activity in schools
  - School clubs and extracurricular activities
- Information dissemination (mentioned 17 times in 39% of focus groups)
- Promoting/protecting safety (mentioned 16 times in 39% of focus groups)
  - Visibility of police
  - Helmet usage
  - Car seat education and enforcement
  - Gun safety education
- Services for Latinos (mentioned 15 times in 21% of focus groups)
  - Open Door Clinic
  - Alliance Medical Ministries
  - Centra Para Familia
  - Libraries
  - Use of bilingual staff
- Partnerships/community engagement (mentioned 14 times in 32% of focus groups)

Question 7: What things are not working to address the six areas of health for (specific target group)?

- Transportation (mentioned 23 times in 61% of focus groups)
- Housing (mentioned 16 times in 32% of focus groups)

Other Comments

- When conducting next focus group make group more diverse to include people using transportation.
- Seniors do not like to drive far.
- Build a community theater close to Wendell.
- Be open-minded and acquire information.
- "We [African Americans] tend not to go to the doctor. Someone may say I ate some pork - that's the reason I have a headache."
- Tackling mental issues, although not as stigmatized, is not as easy as tackling others such as obesity because of the way those helping or suffering from these issues feel about this incapacity. "Superwoman" complex when dealing with mental illness (the person won't admit there is a problem to not cause disappointment).
- "Mental Health is also invisible so its easy to guard those behind closed doors without tackling and still managing to fool most when saying `I'm okay'"
- Although Cary is an expensive place to live, seniors feel its better than some of the other areas in Wake County.
- What will be done with Dorothea Dix? Use site for park similar to Central Park in NYC.
- Seniors want a tax break. They feel that their taxes are going to help people who irresponsibly have a lot of children that they cannot care for. In turn, they require social services that cause higher taxes.
- More money should be appropriated for better schools and teacher education.
- Need more jobs for people my age.
- "Old people watch you at home and think you're going to do something."
- "Until now, no surveys were done on the services that this center (NRC) needed.
- Wake County is not a healthy county.
- "Some kids just hang out with gangs and gang members and don't consider themselves part of a gang. They get money and free tattoos for doing favors."
- "Newspapers and media need to be more positive instead of focusing on negatives. It makes people distrust."
- Need help getting legal status in the US.
- Subsidized childcare is available only if child is born in the US. Child can only get WIC if not born in US - not Medicaid or other services.
- Need assistance paying rent and electric bills - these bills are always higher for Latinos.
- "We [Latinos] should help out by taking food and clothing to people who need it."
- "Parents don't necessarily have to go to parks to be involved with their children. There's plenty to do at home."

APPENDIX III

SURVEY DATA ANALYSIS

Demographics

Female	61.2%
Male	22.6%
No Answer	16.2%

White or Caucasian	50.8%
Black or African American	22.2%
Hispanic	4.6%
Other Races	5.8%
Multi-racial	3.4%
Asian or Pac Isl	1.0%
Native American	0.6%
Other	0.8%
No Answer Given	16.5%

<20 years old	2.7%
20 – 49 years old	55.4%
50 and over	26.6%
No Answer Given	15.3%

Income < $15,000	9.1%
$15,000 - $24,999	5.8%
$25,000 - $49,999	21.5%
$50,000 - $74,999	16.3%
$75,000 and higher	26.4%
No Answer Given	20.9%

117 (3.6%) answered the survey in Spanish

Receiving High School diploma/GED or less	11.7%
Attended/graduated college/vocation training	49.1%
Post-graduate degree	23.0%
No Answer Given	16.2%

Demographics

Central Region		**48.3%**
Raleigh	48.3%	
Northern Region		**3.4%**
Wake Forest	2.9%	
Rolesville	0.6%	
Southern Region		**13.2%**
Garner	3.9%	
Fuquay-Varina	3.8%	
Apex	3.4%	
Holly Springs	2.1%	
Eastern Region		**5.3%**
Knightdale	2.4%	
Wendell	1.7%	
Zebulon	1.2%	
Western Region		**12.2%**
Cary	11.0%	
Morrisville	1.2%	
No Answer Given/Other		**17.4%**

Areas of Most Concern

(participants could select up to three)

1. Physical Health 51.8%
2. Safety 45.5%
3. Environmental Health 44.8%
4. Economics 39.7%
5. Special Populations 20.4%
6. Lifelong Learning 19.5%

Physical Health 51.8%

Physical Health ranked among the top three areas of ***most concern*** within every group.

Physical Health was the ***most selected*** area of concern by…

- 4 of the 5 regions (Central, Northern, Southern, Eastern)
- 4 of the 5 income groups ($15,000 – $24,999, $25,000 - $49,999, $50,000 - $74,999, $75,000 and higher)
- 2 of the 3 age groups (20 – 49, 50 and over)
- 2 of the 4 Racial/ethnic groups (African Americans, Other Races)
- Both men and women

Safety 45.5%

Safety ranked among the top three areas of ***most concern*** within every group except:

Males.

Safety was the ***most selected*** area of concern by…

- Hispanic or Latinos
- People under 20 years of age
- People with incomes less than $15,000

Environmental Health 44.8%

Environmental Health ranked among the top three areas of ***most concern*** within every group except:

Eastern Region.

African Americans & Other Races

People with education equal or less than a high school diploma/GED

People with incomes between $15,000 and $24,999

Environmental Health was the ***most selected*** area of concern by…

- Western Region
- White or Caucasian
- People with post-graduate degrees

Economics 39.7%

Economics ranked among the top three areas of ***most concern*** among:

Eastern Region.

African Americans & Other Races

Men

People with education equal to or less than a high school diploma/GED as well as among those with post-graduate degrees

Economics was the ***most selected*** area of concern by…

- People with education equal to or less than a high school diploma/GED

Special Populations	**20.4%**
Lifelong Learning	**19.5%**

Neither of these two areas were selected by any group as among the three areas of most concern.

The strongest response for Special Populations was among people with incomes between $50,000 and $74,999 (27.5%) and among the Western Region (27.2%)

The strongest response for Lifelong Learning was among Hispanics or Latinos (36%) and among the Eastern Region (30.2%)

Areas of Most Concern

Physical Health (51.8%)

Question	Rank (of 106)	% Moderate/Serious Problem
Overweight Adults	2	75.2%
Overweight Children	5	71.1%
Affordable Health Care	9	68.1%
Affordable Medicine	11	67.4%
Unsafe Drivers	12	67.0%
Eating Habits/Nutrition	12	67.0%

Of the 40 questions regarding Physical Health, 16 were considered either a Moderate or Serious Problem by more than 50% of the respondents. 22 of the 40 ranked in the top half of concerns. Six areas (Recreational Facilities, Adult and Child Access to Recreational facilities, Animal to Person Diseases, New Diseases and Health Information) ranked among the bottom 10 concerns. Each were considered either a Moderate or Serious problem by less than 30% of respondents.

Areas of Most Concern

Safety (45.5%)

Question	Rank (of 106)	% Moderate/Serious Problem
Illegal Drug Activity	4	71.5%
Crime	5	71.0%
Gang Activity	8	70.1%
Drinking and Driving	10	67.9%
Violence	14	64.6%

Of the 16 questions regarding Safety, 8 were considered either a Moderate or Serious Problem by more than 50% of the respondents. 9 of the 16 ranked in the top half of concerns. Three areas (Shelters during an Emergency, 911 Emergency Services, Job Related Accidents) ranked among the bottom 10 concerns. Each were considered either a Moderate or Serious problem by less than 30% of respondents. 911 Emergency Services and Job Related Accidents were 105th and 106th (of 106) with less than 20% considering them a Moderate or Serious problem.

Areas of Most Concern

Environmental Health (44.8%)

Question	Rank (of 106)	% Moderate/Serious Problem
Rapid Population Growth	1	75.8%
Litter	18	62.3%
Water Pollution	23	61.0%
Air Pollution	27	59.9%
Safe Roads and Bridges	36	55.1%

Of the 12 questions regarding Environmental Health, 5 were considered either a Moderate or Serious Problem by more than 50% of the respondents. 6 of the 12 ranked in the top half of concerns. Three areas (Animal Control, Parks & Greenways, Lead Poisoning) ranked among the bottom 10 concerns. Each were considered either a Moderate or Serious problem by less than 30% of respondents.

Areas of Most Concern

Economics (39.7%)

Question	Rank (of 106)	% Moderate/Serious Problem
Poverty	17	62.7%
Convenient Public Transportation	20	61.8%
Affordable Housing	26	60.3%
Available Public Transportation	29	58.6%
Homelessness	31	57.1%

Of the 11 questions regarding Economics, 5 were considered either a Moderate or Serious Problem by more than 50% of the respondents. 6 of the 11 ranked in the top half of concerns. Available Housing and Utility Assistance were the two lowest areas of Economic concern. They tied for 82nd with 36.1% considering them Moderate or Serious Concerns.

Areas of Most Concern

Special Populations (20.4%)

Question	Rank (of 106)	% Moderate/Serious Problem
Alcohol/Drug Use	7	70.5%
Depression	30	58.5%
Domestic Violence (wife or husband)	34	56.1%
Child Abuse/Neglect	35	55.4%
Affordable Child Care	38	54.7%

Of the 18 questions regarding Special Populations, 6 were considered either a Moderate or Serious Problem by more than 50% of the respondents. 7 of the 18 ranked in the top half of concerns. Eating Disorders/Problems was the lowest area of Special Population concern. It ranked 89th with 34.8% considering it a Moderate or Serious problem.

Areas of Most Concern

Lifelong Learning (19.5%)

Question	Rank (of 106)	% Moderate/Serious Problem
School Overcrowding	3	73.6%
K12 Grade Students Prepared for Next Level	33	56.3%
Affordable Afterschool/Summer/Track Out Programs	53	48.8%
Affordable Higher Education for Adults	55	45.1%
Education Available for People with Learning and Developmental Disabilities	65	42.1%

Of the 9 questions regarding Lifelong Learning, 2 were considered either a Moderate or Serious Problem by more than 50% of the respondents. 3 of the 9 ranked in the top half of concerns. Available Continning Education for Adults was the lowest ranked Lifelong Learning Concern. It ranked 93rd with 30.8% considering it a Moderate or Serious problem.

Areas of Most Concern

1.	Rapid Population Growth	75.8%
2.	Overweight Adults	75.2%
3.	School Overcrowding	73.6%
4.	Illegal Drug Activity	71.5%
T5.	Overweight Children	71.0%
T5.	Crime	71.0%
7.	Alcohol/Drug Use	70.5%
8.	Gang Activity	70.1%
9.	Affordable Health Care	68.1%
10.	Drinking and Driving	67.9%

Areas of Least Concern

97.	Access to Recreational Activities (Children)	28.5%
98.	Recreational Facilities	26.8%
99.	Access to Recreational Activities (Adults)	26.7%
100.	Animal to Person Diseases	25.8%
101.	New Diseases	25.3%
102.	Health Information	24.9%
103.	Parks and Greenways	24.5%
104.	Lead Poisoning	23.1%
105.	911 Emergency Services	19.0%
106.	Job-Related Accidents	18.3%

Percents shown are the percents of respondents who consider the item either a Serious or Moderate Problem

APPENDIX IV

Survey Responses by Age and Race

Responses by Age Denominator				
119. City/Town in which you LIVE	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Raleigh	**48.4%**	**60.5%**	**55.8%**	58.1%
Cary	11.0%	1.2%	12.1%	15.4%
Garner	3.9%	5.8%	4.9%	3.8%
Fuquay-Varina	3.8%	3.5%	4.7%	4.2%
Apex	3.4%	7.0%	4.2%	3.3%
Wake Forest	2.9%	4.7%	3.3%	3.1%
Knightdale	2.4%	2.3%	3.1%	2.1%
Holly Springs	2.1%	1.2%	2.9%	1.6%
Wendell	1.7%	4.7%	1.9%	2.0%
Zebulon	1.2%	2.3%	1.5%	1.2%
Morrisville	1.2%	3.5%	1.5%	0.9%
Rolesville	0.6%	0.0%	0.7%	0.8%
Other	<0.5%	0.0%	0.0%	0.0%
No Answer Given	17.4%	3.5%	3.4%	3.5%

120. How long have you lived in Wake County?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
more than 10 years	**49.0%**	**26.7%**	**48.5%**	**78.5%**
1 to 5 years	16.3%	32.6%	23.8%	7.7%
6 to 10 years	14.1%	22.1%	20.2%	8.3%
Less than 1 year	2.9%	12.8%	3.8%	1.6%
I do not live in Wake County	2.3%	2.3%	2.5%	3.0%
No Answer Given	15.4%	3.5%	1.2%	0.9%

121. City/Town in which you Work	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Raleigh	**55.3%**	**47.7%**	**66.1%**	**63.8%**
Cary	7.7%	3.5%	9.4%	8.8%
Morrisville	2.9%	2.3%	4.4%	1.5%
Garner	1.1%	4.7%	1.5%	0.7%
Fuquay-Varina	1.8%	5.8%	1.9%	2.0%
Apex	1.3%	3.5%	1.5%	1.6%
Wake Forest	1.0%	2.3%	0.9%	1.0%
Holly Springs	0.8%	0.0%	1.1%	0.8%
Zebulon	0.8%	1.2%	1.0%	0.7%
Knightdale	0.5%	1.2%	0.7%	0.3%
Wendell	0.5%	3.5%	0.3%	0.7%
Rolesville	<0.5%	0.0%	0.1%	0.1%
Other	0.2%	1.2%	0.4%	0.1%
No Answer Given	26.1%	23.3%	10.8%	17.7%

122. Do you work for Wake County	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Yes	**16.3%**	**4.6%**	**19.8%**	18.9%

123. Your Gender	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Female	**61.2%**	**65.1%**	**74.0%**	**67.5%**
Male	22.6%	31.4%	24.6%	30.0%
No Answer given	16.2%	3.5%	1.5%	2.4%

124. Your Age	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
40 - 49 years	**24.1%**		**43.5%**	
30 - 39 years	19.9%		35.9%	

50 - 59 years	17.8%			**66.9%**
20 - 29 years	11.4%		20.6%	
60 - 69 years	6.2%			23.2%
15 - 19 years	2.2%	**81.4%**		
70 - 79 years	2.0%			7.7%
80 years and over	0.6%			2.2%
10 - 14 years	0.5%	18.6%		
No Answer Given	15.3%			

125. Racial/Ethnic identification	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
White or Caucasian	50.8%	16.3%	**59.6%**	**65.2%**
Black or African American	22.2%	**51.2%**	25.1%	26.1%
Hispanic/Latino	4.6%	12.8%	7.0%	1.6%
Multi-racial	3.4%	11.6%	4.1%	3.1%
Asian or Pacific Islander	1.0%	2.3%	1.3%	0.7%
Native American	0.6%	2.3%	0.5%	1.0%
Other	0.8%	2.3%	0.9%	0.9%
No Answer Given	16.5%	1.2%	1.5%	1.3%

126. Education	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
College graduate	32.9%	**2.3%**	**43.0%**	**33.4%**
Post graduate degree	23.0%	0.0%	25.5%	**33.1%**
Some college (no degree)	12.6%	5.8%	15.0%	15.5%
High School Graduate/GED	7.5%	37.2%	7.8%	8.0%
12th Grade or Less, no diploma or equil ivant	4.2%	48.8%	3.6%	3.4%
Vocational/Technical	3.6%	0.0%	3.6%	6.1%
No Answer Given	16.2%	5.8%	1.4%	0.6%

127. Are you a Member of a Faith Organization	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Yes	**52.0%**	25.6%	**58.6%**	**70.3%**
No	30.7%	**69.8%**	38.8%	27.5%
No Answer Given	17.3%	4.7%	2.6%	2.2%

128. Employment Status	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Employed full-time	**58.0%**	10.5%	**74.8%**	60.8%
Employed part-time	9.4%	15.1%	11.3%	10.4%
Retired	6.6%	1.2%	0.8%	23.1%
Unemployed	6.1%	20.9%	8.3%	3.6%
Student full-time	2.5%	**41.9%**	2.3%	0.5%
Student part-time	0.4%	4.7%	0.4%	0.0%
No Answer Given	17.0%	5.8%	2.1%	1.7%

129. How much money do you have to support your household each year?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
$25,000 to $49,999	**21.5%**	5.8%	**27.7%**	**22.6%**
$50,000 to $74,999	16.3%	2.3%	18.7%	22.1%
$100,000 or higher	14.8%	5.8%	16.8%	19.9%
$75,000 to $99,999	11.7%	0.0%	14.1%	14.6%
$15,000 to $24,999	5.8%	3.5%	6.7%	7.3%
Less than $5,000	4.6%	**54.7%**	4.9%	1.6%
$5,000 to $14,999	4.5%	11.6%	5.1%	5.0%
No Answer Given	20.8%	16.3%	6.0%	6.9%

130. Number of people dependent on the money you have to support your household:	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Two (2)	**24.7%**	15.1%	23.4%	**42.5%**
One (1)	22.0%	**38.4%**	**24.8%**	27.1%
Three (3)	14.4%	12.8%	17.6%	16.2%
Four (4)	13.2%	11.6%	19.0%	8.8%
Five (5)	4.7%	7.0%	7.6%	0.9%
Six (6)	2.1%	2.3%	3.2%	1.0%
Seven (7) or more	0.7%	1.2%	0.8%	0.7%
No Answer Given	18.2%	11.6%	3.6%	2.7%

131. Do you have health insurance?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Yes	**73.6%**	**58.1%**	**85.7%**	**91.6%**
No	8.8%	15.1%	11.9%	6.5%
Don't know or not sure	1.1%	22.1%	0.8%	0.5%
No Answer Given	16.5%	4.7%	1.6%	1.4%

132. If you have health insurance, what kind(s) do you have?	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 years old (n = 1793)	% of 50 years old and over (n = 859)
Managed Care (HMO, PPO, Etc.)	**38.2%**	7.0%	30.4%	38.9%
Private - traditional	26.8%	**41.9%**	**50.5%**	36.3%
Government Other than VA	6.2%	2.3%	5.4%	12.5%
Medicare	5.1%	10.5%	1.4%	16.9%
Medicaid/Health Choice	3.4%	16.3%	4.9%	3.4%
Veteran's Administration (VA)	1.2%	2.3%	1.0%	2.7%

Responses by Age Denominator

108. Most Important Health Care Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Affordable Medicine	**30.6%**	18.6%	**34.0%**	**39.8%**

Private Health Insurance Coverage	20.6%	**22.1%**	23.8%	23.9%
Health Care Services	15.0%	10.5%	18.7%	13.7%
Emergency Room Care	6.0%	11.6%	7.0%	5.5%
Medicaid/Medicare	4.8%	16.3%	5.6%	4.7%
Transportation to Health Care	4.2%	3.5%	4.5%	5.4%
Dental Care	2.6%	4.7%	2.8%	3.3%
Hospital Care	2.1%	7.0%	2.5%	1.9%
No Answer Given	14.0%	5.8%	1.2%	2.0%

109. Most Important Disease Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Heart Disease/Stroke	**15.5%**	8.1%	16.5%	**21.8%**
Cancer	15.4%	16.3%	**17.7%**	17.6%
Diabetes	14.6%	20.9%	15.8%	18.7%
HIV/AIDS	11.4%	**29.1%**	13.7%	10.1%
Contagious Diseases	9.8%	2.3%	12.1%	10.2%
High Blood Pressure	7.8%	5.8%	7.9%	11.2%
Childhood Asthma	4.8%	1.2%	6.9%	3.3%
Other STI	4.2%	5.8%	5.4%	3.0%
Dental Problems	2.0%	4.7%	2.3%	1.7%
No Answer Given	14.4%	5.8%	1.6%	2.3%

110. Most Important Lifestyle Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Overweight People	**18.3%**	9.3%	**20.9%**	22.0%
Unsafe Drivers	17.1%	11.6%	17.4%	**24.4%**
Eating Habits/Nutrition	10.4%	8.1%	11.8%	12.7%
Regualr Exercise	9.1%	11.6%	10.8%	9.4%
Cigarette Smoking	8.5%	14.0%	9.8%	9.3%
Unsafe Sex	8.5%	**20.9%**	11.2%	5.8%
Health Information	5.3%	5.8%	5.8%	6.5%

Recreational Activities	5.0%	3.5%	6.6%	4.7%
Driving or Riding in a Car without Seatbelts or Child Safety Seat	2.0%	10.5%	4.2%	3.5%
No Answer given	14.0%	4.7%	1.4%	1.6%

111. Most Important Family Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Child Care	23.0%	16.3%	**30.9%**	18.3%
Child Abuse and Neglect	19.0%	**19.8%**	21.9%	**22.5%**
Domestic Violence	13.2%	15.1%	15.1%	15.0%
Learning and Developmental Disabilities	7.9%	10.5%	9.3%	8.5%
Day Care for Special Needs Adults/Elders	7.5%	7.0%	6.1%	14.1%
Foster Care and Adoption	5.6%	16.3%	6.6%	4.9%
Relief for Caregivers	5.4%	2.3%	5.1%	9.0%
Abuse of Special Needs Adults/Elders	3.5%	9.3%	3.3%	5.1%
No Answer Given	15.0%	3.5%	1.8%	2.7%

112. Most Important Mental Health issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Alcohol/Drug Use	**21.6%**	**29.1%**	**23.6%**	26.7%
Mental Health Care/Counseling	19.7%	10.5%	**23.6%**	22.6%
Depression	18.5%	20.9%	21.8%	20.5%
Drug and Alcohol Treatment	10.1%	1.2%	11.4%	12.6%
Mental Health Problems	9.9%	9.3%	11.3%	11.9%
Eating Disorders/Problems	3.2%	11.6%	4.0%	2.1%
Suicide	2.1%	14.0%	2.3%	1.7%
No Answer given	14.9%	3.5%	2.0%	2.0%

113. Most Important Environmental Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)

Rapid Population Growth	37.6%	7.0%	**43.0%**	**49.4%**
Water Pollution	10.6%	11.6%	12.2%	12.5%
Air Pollution	10.1%	**23.3%**	11.7%	10.1%
Safe Roads and Bridges	8.0%	10.5%	9.7%	7.9%
Parks and Recreation	6.0%	9.3%	7.6%	5.2%
Garbage	5.2%	19.8%	6.4%	3.7%
Food Safety	4.2%	7.0%	4.6%	5.1%
Animal Control	2.3%	4.7%	2.1%	3.1%
Lead Poisoning	1.4%	3.5%	1.6%	1.5%
No Answer Given	14.4%	3.5%	1.2%	1.4%

114. Most important Safety Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Gang Activity	**23.3%**	**19.8%**	**28.1%**	25.3%
Drinking and Driving	18.2%	12.8%	20.3%	23.4%
Crime/Violence	16.7%	12.8%	19.7%	19.3%
Illegal Drug Activity	10.0%	4.7%	10.2%	15.1%
Jail and Prison Overcrowding	4.8%	4.7%	5.8%	5.1%
Youth Access to Weapons	4.1%	7.0%	4.8%	4.7%
Weapons in School	3.6%	14.0%	4.3%	3.0%
Sexual Assault/Rape	3.4%	7.0%	4.5%	2.6%
Prostitution	0.6%	9.3%	0.5%	0.1%
No Answer Given	15.0%	8.1%	1.8%	1.4%

115. Most Important Emergency Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Diaster Preparedness (hurricanes, ice storms)	**38.3%**	19.8%	47.4%	**41.1%**
911 Emergency Services (fire, police, EMS)	14.9%	18.6%	17.5%	16.6%
Information During a Disaster	11.8%	10.5%	13.5%	14.4%
Terrorism	7.8%	10.5%	7.9%	11.1%

Shelters During an Emergency	7.7%	**22.1%**	7.4%	10.1%
Job-Related Accidents	4.2%	12.8%	4.8%	4.2%
No Answer Given	15.3%	5.8%	1.5%	2.4%

116. Most Important Economic Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Job Opportunities	**27.4%**	**22.1%**	**33.3%**	29.2%
Public Transportation	17.3%	3.5%	20.3%	21.8%
Poverty	15.9%	31.4%	17.3%	19.4%
Homelessness	8.6%	10.5%	10.2%	9.5%
Housing	7.0%	14.0%	8.1%	7.1%
Housing Assistance	3.9%	4.7%	4.5%	4.9%
Food Assistance	2.7%	7.0%	3.1%	2.9%
Utility Assistance	1.9%	2.3%	1.7%	3.3%
No Answer Given	15.3%	4.7%	1.5%	1.9%

117. Most Important Education Issue	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
School Overcrowding	**30.1%**	19.8%	**37.4%**	31.4%
Students Prepared for Higer Education or Employment	24.4%	**20.9%**	26.7%	32.8%
Students Prepared for Kindergarten	7.6%	14.0%	8.4%	9.4%
Affordable Higher Education for Adults	7.4%	7.0%	9.8%	6.3%
Afterschool/Summer/Track Out Programs	7.2%	12.8%	8.9%	6.9%
Available Continuing Education and Learning Opportunities for Adults	3.9%	9.3%	3.7%	5.6%
Vocational Training for Adults	3.7%	9.3%	3.7%	5.4%
No Answer Given	15.6%	7.0%	1.5%	2.2%

118. Percent Ranking each as among the Three (3) areas of most concern	% of All 3232 Responses	% of 19 years old and under (n = 86)	% of 20 - 49 year olds (n = 1793)	% of 50 years old and over (n = 859)
Physcial Health	**51.8%**	43.0%	**60.7%**	61.1%

Safety	45.5%	**52.3%**	54.2%	50.2%
Environmental Health	44.8%	30.2%	52.0%	54.1%
Economics	39.7%	23.3%	47.0%	46.3%
Special Populations	20.4%	9.3%	23.4%	25.8%
Lifelong Learning	19.5%	20.9%	24.1%	20.0%

Responses by Racial/Ethnic Denominator

119. City/Town in which you LIVE	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Raleigh	**48.4%**	**51.6%**	**69.5%**	**57.3%**	**51.9%**
Cary	11.0%	17.3%	2.8%	7.3%	16.4%
Garner	3.9%	4.0%	5.7%	4.7%	5.3%
Fuquay-Varina	3.8%	5.7%	2.6%	2.0%	4.2%
Apex	3.4%	4.9%	1.1%	8.0%	3.7%
Wake Forest	2.9%	3.9%	2.1%	2.0%	4.2%
Knightdale	2.4%	1.8%	4.5%	4.7%	2.6%
Holly Springs	2.1%	3.0%	1.0%	3.3%	2.1%
Wendell	1.7%	1.4%	3.5%	1.3%	2.6%
Zebulon	1.2%	0.9%	2.4%	2.0%	1.6%
Morrisville	1.2%	1.5%	0.7%	1.3%	2.6%
Rolesville	0.6%	0.7%	0.8%	0.0%	0.5%
Other	<0.5%	0.0%	0.0%	0.0%	0.0%
No Answer Given	17.4%	3.3%	3.3%	6.0%	2.1%

120. How long have you lived in Wake County?	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
more than 10 years	**49.0%**	**60.9%**	**60.3%**	15.3%	**48.1%**
1 to 5 years	16.3%	15.8%	20.6%	**42.7%**	21.2%

6 to 10 years	14.1%	16.9%	12.8%	22.7%	22.8%
Less than 1 year	2.9%	2.9%	3.1%	11.3%	3.7%
I do not live in Wake County	2.3%	2.9%	1.5%	3.3%	3.2%
No Answer Given	15.4%	0.7%	1.7%	4.7%	1.1%

121. City/Town in which you Work	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Raleigh	55.3%	**65.1%**	**67.8%**	**52.0%**	**60.8%**
Cary	7.7%	11.6%	4.0%	3.3%	11.1%
Morrisville	2.9%	3.2%	2.8%	4.7%	6.3%
Garner	1.1%	0.9%	2.4%	0.7%	2.1%
Fuquay-Varina	1.8%	2.5%	1.5%	2.0%	0.5%
Apex	1.3%	1.8%	1.1%	1.3%	2.1%
Wake Forest	1.0%	0.9%	1.1%	2.7%	1.1%
Holly Springs	0.8%	0.4%	0.3%	2.0%	0.5%
Zebulon	0.8%	0.7%	0.8%	2.7%	2.1%
Knightdale	0.5%	0.4%	0.8%	1.3%	1.1%
Wendell	0.5%	40.0%	1.0%	0.0%	0.5%
Rolesville	<0.5%	0.0%	0.1%	0.7%	0.0%
Other	0.2%	0.2%	0.1%	4.7%	0.0%
No Answer Given	26.1%	11.3%	16.0%	22.0%	11.6%

122. Do you work for Wake County	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Yes	16.3%	20.3%	17.3%	13.3%	20.6%

123. Your Gender	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Female	**61.2%**	**70.3%**	**77.9%**	**75.3%**	**58.2%**
Male	22.6%	28.7%	19.4%	20.7%	39.2%
No Answer given	16.2%	1.0%	2.8%	4.0%	2.6%

124. Your Age	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
40 - 49 years	**24.1%**	**31.2%**	**23.8%**	20.7%	**30.7%**
30 - 39 years	19.9%	23.7%	21.3%	30.0%	21.7%
50 - 59 years	17.8%	24.1%	19.4%	7.3%	14.8%
20 - 29 years	11.4%	10.1%	17.5%	**32.7%**	12.7%
60 - 69 years	6.2%	7.5%	7.4%	0.7%	7.9%
15 - 19 years	2.2%	0.5%	5.4%	4.7%	7.4%
70 - 79 years	2.0%	2.0%	3.5%	1.3%	2.6%
80 years and over	0.6%	0.4%	1.0%	0.0%	1.1%
10 - 14 years	0.5%	0.3%	0.7%	2.7%	1.1%
No Answer Given	15.3%	0.1%	0.0%	0.0%	0.0%

125. Racial/Ethnic identification	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
White or Caucasian	**50.8%**	**100.0%**			
Black or African American	22.2%		**100.0%**		
Hispanic/Latino	4.6%			**100.0%**	
Multi-racial	3.4%				**58.7%**
Asian or Pacific Islander	1.0%				16.4%
Native American	0.6%				10.6%
Other	0.8%				14.3%
No Answer Given	16.5%				

126. Education	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
College graduate	**32.9%**	**44.2%**	**31.3%**	20.0%	**33.9%**
Post graduate degree	23.0%	34.1%	16.3%	6.0%	24.3%
Some college (no degree)	12.6%	12.5%	19.6%	16.0%	16.4%
High School Graduate/GED	7.5%	3.9%	18.0%	18.7%	8.5%

12th Grade or Less, no diploma or equilivant	4.2%	1.0%	7.5%	**32.0%**	9.0%
Vocational/Technical	3.6%	4.0%	5.6%	1.3%	4.8%
No Answer Given	16.2%	0.2%	1.7%	6.0%	3.2%

127. Are you a Member of a Faith Organization	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Yes	**52.0%**	**60.0%**	**68.1%**	**52.7%**	**55.0%**
No	30.7%	39.0%	28.0%	42.7%	40.7%
No Answer Given	17.3%	1.0%	3.9%	4.7%	4.2%

128. Employment Status	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Employed full-time	58.0%	**73.4%**	**61.1%**	**51.3%**	**68.8%**
Employed part-time	9.4%	11.4%	11.3%	12.7%	6.9%
Retired	6.6%	6.6%	10.9%	1.3%	9.0%
Unemployed	6.1%	5.9%	7.0%	25.3%	6.3%
Student full-time	2.5%	1.3%	6.4%	1.3%	5.8%
Student part-time	0.4%	0.2%	0.7%	1.3%	0.0%
No Answer Given	17.0%	1.2%	2.6%	6.7%	3.2%

129. How much money do you have to support your household each year?	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
$25,000 to $49,999	**21.5%**	**24.8%**	**26.7%**	**24.0%**	27.0%
$50,000 to $74,999	16.3%	21.7%	16.9%	8.7%	18.0%
$100,000 or higher	14.8%	24.0%	7.1%	2.0%	14.8%
$75,000 to $99,999	11.7%	17.1%	8.6%	4.7%	12.2%
$15,000 to $24,999	5.8%	3.8%	11.7%	18.7%	5.3%
Less than $5,000	4.6%	1.1%	14.3%	10.7%	8.7%

$5,000 to $14,999	4.5%	2.1%	10.4%	15.3%	5.3%
No Answer Given	20.8%	5.4%	4.2%	16.0%	10.6%

130. Number of people dependent on the money you have to support your household:	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Two (2)	**24.7%**	**31.4%**	25.2%	**20.0%**	29.6%
One (1)	22.0%	23.2%	**33.8%**	18.7%	27.5%
Three (3)	14.4%	17.5%	17.1%	18.0%	13.8%
Four (4)	13.2%	16.7%	13.8%	17.3%	13.2%
Five (5)	4.7%	5.6%	4.3%	10.7%	6.3%
Six (6)	2.1%	2.0%	1.9%	9.3%	3.7%
Seven (7) or more	0.7%	0.7%	0.8%	0.7%	1.1%
No Answer Given	18.2%	2.9%	2.9%	5.3%	4.8%

131. Do you have health insurance?	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Yes	**73.6%**	**94.3%**	**80.8%**	38.7%	**82.0%**
No	8.8%	4.5%	13.8%	**56.7%**	12.7%
Don't know or not sure	1.1%	0.2%	3.2%	1.3%	4.2%
No Answer Given	16.5%	0.9%	2.2%	3.3%	1.1%

132. If you have health insurance, what kind(s) do you have?	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Managed Care (HMO, PPO, Etc.)	**38.2%**	**35.8%**	**36.1%**	13.3%	**43.9%**
Private - traditional	26.8%	35.2%	25.9%	**16.7%**	32.8%
Government Other than VA	6.2%	8.5%	6.1%	3.3%	4.8%
Medicare	5.1%	5.2%	8.2%	2.0%	6.3%
Medicaid/Health Choice	3.4%	1.8%	8.9%	3.3%	4.2%
Veteran's Administration (VA)	1.2%	1.0%	2.1%	2.0%	1.6%

Responses by Racial/Ethnic Denominator					
108. Most Important Health Care Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Affordable Medicine	30.6%	**39.6%**	**30.4%**	16.0%	**33.9%**
Private Health Insurance Coverage	20.6%	25.7%	22.0%	16.0%	20.1%
Health Care Services	15.0%	15.3%	18.0%	**27.3%**	18.0%
Emergency Room Care	6.0%	5.7%	8.5%	7.3%	6.3%
Medicaid/Medicare	4.8%	4.6%	7.8%	8.7%	5.3%
Transportation to Health Care	4.2%	4.4%	49.0%	6.7%	5.8%
Dental Care	2.6%	2.1%	3.9%	8.7%	2.6%
Hospital Care	2.1%	1.8%	2.4%	4.0%	6.3%
No Answer Given	14.0%	0.9%	2.2%	5.3%	1.6%

109. Most Important Disease Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Heart Disease/Stroke	**15.5%**	**21.7%**	12.1%	6.0%	**16.4%**
Cancer	15.4%	20.6%	11.7%	17.3%	15.9%
Diabetes	14.6%	17.2%	16.7%	14.7%	**16.4%**
HIV/AIDS	11.4%	6.2%	**28.7%**	**19.3%**	9.0%
Contagious Diseases	9.8%	15.0%	3.1%	5.3%	14.3%
High Blood Pressure	7.8%	5.8%	16.3%	6.0%	9.0%
Childhood Asthma	4.8%	6.5%	2.8%	7.3%	7.4%
Other STI	4.2%	4.8%	3.8%	5.3%	5.8%
Dental Problems	2.0%	1.4%	2.5%	10.0%	2.1%
No Answer Given	14.4%	0.9%	2.4%	8.7%	3.7%

110. Most Important Lifestyle Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Overweight People	**18.3%**	**23.3%**	17.7%	12.0%	**20.6%**
Unsafe Drivers	17.1%	23.2%	10.3%	**25.3%**	16.4%
Eating Habits/Nutrition	10.4%	13.1%	11.1%	4.7%	11.6%

Regualr Exercise	9.1%	11.9%	9.3%	4.0%	7.9%
Cigarette Smoking	8.5%	10.0%	9.9%	6.0%	11.1%
Unsafe Sex	8.5%	4.8%	**20.5%**	11.3%	11.1%
Health Information	5.3%	4.4%	7.8%	14.0%	4.2%
Recreational Activities	5.0%	4.9%	7.7%	4.0%	9.5%
Driving or Riding in a Car without Seatbelts or Child Safety Seat	2.0%	3.7%	3.6%	12.0%	4.2%
No Answer given	14.0%	0.6%	2.1%	6.7%	3.2%

111. Most Important Family Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Child Care	**23.0%**	**26.9%**	**26.5%**	25.3%	**24.3%**
Child Abuse and Neglect	19.0%	25.0%	16.9%	16.7%	20.6%
Domestic Violence	13.2%	13.6%	15.5%	**30.7%**	14.3%
Learning and Developmental Disabilities	7.9%	8.9%	9.2%	10.0%	7.9%
Day Care for Special Needs Adults/Elders	7.5%	9.4%	8.1%	4.7%	7.4%
Foster Care and Adoption	5.6%	4.8%	10.0%	2.7%	9.0%
Relief for Caregivers	5.4%	7.1%	4.6%	4.7%	6.9%
Abuse of Special Needs Adults/ Elders	3.5%	3.2%	6.0%	1.3%	5.3%
No Answer Given	15.0%	1.1%	3.3%	4.0%	4.2%

112. Most Important Mental Health issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Alcohol/Drug Use	**21.6%**	23.1%	**28.7%**	24.7%	**24.3%**
Mental Health Care/Counseling	19.7%	**28.2%**	13.8%	14.0%	20.6%
Depression	18.5%	20.5%	20.5%	**32.0%**	21.7%
Drug and Alcohol Treatment	10.1%	10.8%	13.0%	12.7%	10.1%
Mental Health Problems	9.9%	12.2%	10.7%	7.3%	10.1%
Eating Disorders/Problems	3.2%	2.3%	6.3%	2.0%	6.9%
Suicide	2.1%	1.6%	4.7%	3.3%	1.6%
No Answer given	14.9%	1.2%	2.4%	4.0%	4.8%

113. Most Important Environmental Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Rapid Population Growth	**37.6%**	**52.0%**	**33.1%**	14.7%	**36.5%**
Water Pollution	10.6%	11.6%	12.1%	13.3%	16.4%
Air Pollution	10.1%	12.9%	8.5%	**15.3%**	10.1%
Safe Roads and Bridges	8.0%	9.1%	9.6%	8.0%	9.0%
Parks and Recreation	6.0%	5.1%	9.7%	10.7%	9.5%
Garbage	5.2%	4.2%	7.9%	**15.3%**	6.3%
Food Safety	4.2%	2.4%	9.6%	8.7%	4.8%
Animal Control	2.3%	2.1%	3.6%	1.3%	2.6%
Lead Poisoning	1.4%	0.3%	3.1%	9.3%	1.6%
No Answer Given	14.4%	0.6%	2.6%	3.3%	3.2%

114. Most important Safety Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Gang Activity	**23.3%**	**27.2%**	**29.5%**	**21.3%**	20.1%
Drinking and Driving	18.2%	24.4%	10.9%	28.0%	22.8%
Crime/Violence	16.7%	20.9%	17.3%	11.3%	19.6%
Illegal Drug Activity	10.0%	10.9%	13.6%	8.7%	12.2%
Jail and Prison Overcrowding	4.8%	5.4%	5.7%	6.7%	6.9%
Youth Access to Weapons	4.1%	3.9%	6.8%	6.7%	4.2%
Weapons in School	3.6%	2.3%	8.2%	6.0%	4.8%
Sexual Assault/Rape	3.4%	4.3%	3.3%	2.0%	4.8%
Prostitution	0.6%	0.1%	1.9%	0.0%	1.1%
No Answer Given	15.0%	0.7%	2.6%	9.3%	3.7%

115. Most Important Emergency Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Diaster Preparedness (hurricanes, ice storms)	38.3%	**47.9%**	**40.4%**	**30.7%**	**42.3%**
911 Emergency Services (fire, police, EMS)	14.9%	19.1%	15.2%	10.7%	14.8%
Information During a Disaster	11.8%	14.5%	12.8%	6.7%	15.9%

Terrorism	7.8%	8.9%	9.2%	7.3%	10.1%
Shelters During an Emergency	7.7%	5.7%	14.9%	14.0%	8.5%
Job-Related Accidents	4.2%	3.7%	3.9%	22.7%	5.3%
No Answer Given	15.3%	0.3%	3.6%	8.0%	3.2%

116. Most Important Economic Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Job Opportunities	**27.4%**	**29.5%**	**35.1%**	**40.7%**	**30.7%**
Public Transportation	17.3%	25.6%	8.5%	13.3%	26.5%
Poverty	15.9%	19.5%	18.4%	9.3%	13.8%
Homelessness	8.6%	8.5%	14.1%	5.3%	12.2%
Housing	7.0%	7.9%	7.9%	10.7%	6.3%
Housing Assistance	3.9%	4.0%	6.4%	5.3%	2.6%
Food Assistance	2.7%	2.6%	3.3%	7.3%	3.7%
Utility Assistance	1.9%	1.7%	3.5%	3.3%	1.1%
No Answer Given	15.3%	0.8%	2.8%	4.7%	3.2%

117. Most Important Education Issue	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
School Overcrowding	30.1%	**42.1%**	23.4%	**19.3%**	**32.8%**
Students Prepared for Higer Education or Employment	24.4%	29.5%	27.3%	18.7%	28.6%
Students Prepared for Kindergarten	7.6%	7.3%	11.1%	18.7%	6.3%
Affordable Higher Education for Adults	7.4%	7.7%	8.6%	15.3%	11.6%
Afterschool/Summer/Track Out Programs	7.2%	5.4%	14.8%	12.7%	6.3%
Available Continuing Education and Learning Opportunities for Adults	3.9%	3.2%	5.7%	8.0%	7.9%
Vocational Training for Adults	3.7%	4.1%	5.8%	2.0%	2.6%
No Answer Given	15.6%	0.7%	3.2%	5.3%	3.7%
118. Percent Ranking each as among the Three (3) areas of most concern	% of All 3232 Responses	% of White or Caucasian (n = 1643)	% of Black or African American (n = 718)	% of Hispanic or Latino (n = 150)	% of Other Race (n = 189)
Physcial Health	51.8%	64.0%	**57.2%**	43.3%	**57.7%**

Safety	45.5%	54.6%	50.7%	**49.3%**	50.8%
Environmental Health	44.8%	**65.2%**	27.9%	32.0%	48.7%
Economics	39.7%	48.6%	41.8%	28.7%	54.0%
Special Populations	20.4%	26.8%	17.4%	18.7%	24.3%
Lifelong Learning	19.5%	20.2%	24.7%	36.0%	26.5%

APPENDIX V

Spanish Survey Responses – Problems Ranked in Order

Question	Rank among Spanish Language Responses as either a "Moderate problem" or a "Serious problem"	Percent of Spanish Language Respones listing question as a "Moderate problem" or a "Serious problem" (n = 117)
023 Crime	1	86.3%
020 Alcohol Drug Use	2	85.5%
022 Gang Activity	3	85.5%
024 Violence	4	84.6%
021 Illegal Drug Activity	5	83.8%
018 Domestic Violence wife or husband abuse	6	82.9%
025 Youth Access to Weapons	7	82.9%
044 Unsafe Drivers	8	82.1%
043 Driving or Riding in a Car without Seatbelts	9	81.2%
094 Dental Problems	10	81.2%
013 Child Abuse and Neglect	11	80.3%
106 Overweight Adults	12	80.3%
027 Sexual Assualt Rape	13	80.3%
083 Unsafe Sex	14	79.5%
089 Diabetes	15	78.6%
046 Car Accidents	16	78.6%
101 Depression	17	78.6%
053 Poverty	18	77.8%
095 HIV/AIDS	19	77.8%
045 Drinking and Driving	20	77.8%
082 Cigarette Smoking	21	77.8%
105 Overweight Children	22	76.9%
104 Childhood Asthma	23	76.9%

096 Other STD	24	76.9%
090 Heart Disease	25	76.9%
091 High Blood Pressure	26	75.2%
100 Mental Health Problems	27	74.4%
097 Person to Person Diseases	28	72.6%
040 Job-Related Accidents	29	72.6%
029 Weapons in School	30	72.6%
026 Prositution	31	72.6%
028 Jail and Prison Overcrowding	32	71.8%
085 Breast Cancer	33	70.9%
032 School Overcrowding	34	69.2%
087 Prostate Cancer	35	69.2%
060 Disaster Preparedness	36	69.2%
052 Homelessness	37	67.5%
092 Stroke	38	66.7%
063 Affordable Health Care	39	66.7%
086 Lung Cancer	40	66.7%
061 Terrorism	41	66.7%
093 Arthritis	42	66.7%
019 Abuse of Elders Adults with Special Needs	43	65.8%
084 Eating Habits/Nutrition	44	65.8%
102 Suicide	45	65.0%
067 Dental Care	46	64.1%
008 Lead Poisoning	47	64.1%
088 Other Cancers	48	64.1%
074 Affordable Medicine	49	63.2%
001 Air pollution	50	63.2%
007 Litter	51	63.2%

039 Job Opportunities	52	61.5%
098 Animal to Person Diseases	53	60.7%
099 New Diseases	54	60.7%
003 Water Pollution	55	59.8%
069 Drug and Alcohol Treatment	56	59.8%
041 Rapid Population Growth	57	59.8%
059 Information During a Disaster	58	59.0%
047 Available Public Transportation	59	58.1%
064 Transportation to Health Care	60	57.3%
062 Health Care	61	57.3%
103 Eating Disorders/Problems (Bulimia/Anorexia)	62	56.4%
072 Medicaid/Medicare Enrollment Services	63	56.4%
012 Affordable Child Care	64	55.6%
005 Garbage Collection	65	54.7%
051 Affordable Housing	66	53.8%
004 Food Safety	67	53.0%
049 Safe Housing	68	53.0%
033 Education Available for People with DD	69	53.0%
066 Emergency Room Care	70	53.0%
048 Covenient Public Transportation	71	52.1%
037 Affordable Higher Education for Adults College	72	52.1%
002 Safe Drinking Water	73	51.3%
081 Regular Exercise	74	50.4%
076 Housing Assistance (public housing or aid)	75	50.4%
068 Mental Health Care/Counseling	76	50.4%
065 Hospital Care	77	49.6%
078 Shelters During an Emergency	78	49.6%
075 Food Assistance (money or food)	79	48.7%

035 Affordable Afterschool Summer Track Out Programs	80	48.7%
077 Utility Assistance (to pay electricity or fuel bills)	81	48.7%
038 Available Continuing Education for Adults	82	48.7%
071 Private Health Insurance Coverage	83	47.9%
057 Access to Recreational Activities Teens	84	47.9%
058 Access to Recreational Activities Children	85	47.9%
050 Available Housing	86	47.9%
080 Health Information	87	47.0%
014 Foster Care and Adoption	88	47.0%
030 Children Prepared for Kindergarten	89	47.0%
015 Safe Day Care for Adults Elders	90	46.2%
034 Available Afterschool Summer Track Out Programs	91	46.2%
006 Recycling	92	45.3%
054 Parks and Greenways	93	44.4%
070 Relief for Caregivers (Respite Care)	94	43.6%
031 K12 Grade Students Prepared for the Next Level	95	43.6%
010 Safe Child Care	96	43.6%
016 Available Day Care for Adults Elders	97	43.6%
073 Providers Who Accept Medicaid/Medicare	98	43.6%
017 Affordable Day Care for Adults Elders	99	42.7%
011 Availble Child Care	100	42.7%
056 Access to Recreational Activities Adults	101	41.0%
009 Animal Control	102	40.2%
036 Access to Vocational Training for Adults	103	39.3%
079 911 Emergency Services (fire, police, EMS)	104	37.6%
055 Recreational Facilities	105	36.8%
042 Safe Roads and Bridges	106	35.0%

Problem Rank	Question	% Considering this a "Moderate problem" or "Serious problem" (n = 3232)
1	041 Rapid Population Growth	75.8%
2	106 Overweight Adults	75.2%
3	032 School Overcrowding	73.6%
4	021 Illegal Drug Activity	71.5%
5	105 Overweight Children	71.0%
6	023 Crime	71.0%
7	020 Alcohol Drug Use	70.5%
8	022 Gang Activity	70.1%
9	063 Affordable Health Care	68.1%
10	045 Drinking and Driving	67.9%
11	074 Affordable Medicine	67.4%
12	044 Unsafe Drivers	67.0%
13	084 Eating Habits/Nutrition	67.0%
14	024 Violence	64.6%
15	091 High Blood Pressure	64.4%
16	046 Car Accidents	63.2%
17	053 Poverty	62.7%
18	007 Litter	62.3%
19	090 Heart Disease	62.1%
20	048 Covenient Public Transportation	61.8%
21	025 Youth Access to Weapons	61.4%
22	089 Diabetes	61.2%
23	003 Water Pollution	61.0%
24	082 Cigarette Smoking	60.9%
25	083 Unsafe Sex	60.8%
26	051 Affordable Housing	60.3%

27	001 Air pollution	59.9%
28	028 Jail and Prison Overcrowding	58.8%
29	047 Available Public Transportation	58.6%
30	101 Depression	58.5%
31	052 Homelessness	57.1%
32	081 Regular Exercise	56.4%
33	031 K12 Grade Students Prepared for the Next Level	56.3%
34	018 Domestic Violence wife or husband abuse	56.1%
35	013 Child Abuse and Neglect	55.4%
36	042 Safe Roads and Bridges	55.1%
37	071 Private Health Insurance Coverage	55.0%
38	012 Affordable Child Care	54.7%
39	092 Stroke	52.7%
40	085 Breast Cancer	51.4%
41	027 Sexual Assualt Rape	51.1%
42	100 Mental Health Problems	50.9%
43	093 Arthritis	49.6%
44	096 Other STD	49.5%
45	095 HIV/AIDS	49.0%
46	002 Safe Drinking Water	48.8%
47	086 Lung Cancer	48.7%
48	029 Weapons in School	48.6%
49	062 Health Care	47.4%
50	088 Other Cancers	47.2%
51	017 Affordable Day Care for Adults Elders	47.0%
52	039 Job Opportunities	46.8%
53	035 Affordable Afterschool Summer Track Out Programs	46.8%
54	087 Prostate Cancer	45.3%

55	037 Affordable Higher Education for Adults College	45.1%
56	060 Disaster Preparedness	45.1%
57	068 Mental Health Care/Counseling	45.0%
58	016 Available Day Care for Adults Elders	44.5%
59	015 Safe Day Care for Adults Elders	44.0%
60	019 Abuse of Elders Adults with Special Needs	43.6%
61	064 Transportation to Health Care	43.4%
62	104 Childhood Asthma	42.9%
63	069 Drug and Alcohol Treatment	42.5%
64	094 Dental Problems	42.1%
65	033 Education Available for People with DD	42.1%
66	066 Emergency Room Care	40.7%
67	034 Available Afterschool Summer Track Out Programs	40.7%
68	014 Foster Care and Adoption	40.6%
69	061 Terrorism	39.9%
70	097 Person to Person Diseases	39.9%
71	043 Driving or Riding in a Car without Seatbelts	39.9%
72	011 Availble Child Care	39.7%
73	073 Providers Who Accept Medicaid/Medicare	39.3%
74	030 Children Prepared for Kindergarten	38.5%
75	006 Recycling	38.3%
76	049 Safe Housing	38.3%
77	076 Housing Assistance (public housing or aid)	38.3%
78	010 Safe Child Care	38.0%
79	075 Food Assistance (money or food)	37.6%
80	070 Relief for Caregivers (Respite Care)	37.0%
81	067 Dental Care	36.4%
82	050 Available Housing	36.1%

83	077 Utility Assistance (to pay electricity or fuel bills)	36.1%
84	057 Access to Recreational Activities Teens	35.8%
85	004 Food Safety	35.6%
86	072 Medicaid/Medicare Enrollment Services	35.5%
87	059 Information During a Disaster	35.4%
88	102 Suicide	35.1%
89	103 Eating Disorders/Problems (Bulimia/Anorexia)	34.8%
90	065 Hospital Care	34.3%
91	005 Garbage Collection	33.8%
92	036 Access to Vocational Training for Adults	32.8%
93	038 Available Continuing Education for Adults	30.8%
94	026 Prositution	29.9%
95	009 Animal Control	29.7%
96	078 Shelters During an Emergency	29.3%
97	058 Access to Recreational Activities Children	28.5%
98	055 Recreational Facilities	26.8%
99	056 Access to Recreational Activities Adults	26.7%
100	098 Animal to Person Diseases	25.8%
101	099 New Diseases	25.3%
102	080 Health Information	24.9%
103	054 Parks and Greenways	24.5%
104	008 Lead Poisoning	23.1%
105	079 911 Emergency Services (fire, police, EMS)	19.0%
106	040 Job-Related Accidents	18.3%