



Road to Community Health

Our Health. Our Stories. Our Future.



2025 Mecklenburg County
Community Health Assessment



MECKLENBURG COUNTY
North Carolina

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STEERING COMMITTEE AND PUBLIC HEALTH LETTERS

Dear Community Members,

We are proud to share with you the 2025 Mecklenburg County Community Health Assessment (CHA), *Road to Community Health*, a reflection of the voices, stories, and data that shape the health of our communities.

As members of the Live Well Meck Steering Committee, we come from diverse backgrounds, nonprofits, healthcare, government, education, and beyond, but we are united by one goal: to create a healthier Mecklenburg County.

This assessment is more than just numbers on a page. It's a community-wide effort that centers the lived experiences of our residents. We listened to what people had to say through surveys, focus groups, and youth-led Photo Voice projects, and we paired those insights with local data to understand both the challenges and the bright spots across our county.

We want to thank every resident who contributed their time, thoughts, and creativity to this process. Your voice is helping shape the future of health in our neighborhoods.

We also want to be clear: this report is not the end, it's the beginning. The CHA will help guide the next steps in building a Community Health Improvement Plan (CHIP) that reflects what matters most to our residents. Together, we can work toward a future where everyone has the opportunity to live well.

Thank you for being part of this journey.

In partnership,

The Live Well Meck Steering Committee

Dear Mecklenburg County Community,

It is my honor to share the 2025 Mecklenburg County Community Health Assessment (CHA) on behalf of Mecklenburg County Public Health, *Road to Community Health*.

The title is intentional. Improving health is not a single initiative or short-term effort, but a long road that requires shared direction, steady leadership, trusted partners, and the voice of our community guiding the way.

Every three years, the CHA provides a comprehensive view of our community's health, including where we are making progress, where gaps exist, and where we must focus our collective energy moving forward. As the quarterback agency for the Mecklenburg County Community Health Assessment, Mecklenburg County Public Health convenes the Live Well partner network, aligns strategy, stewards data, and ensures that the community voice remains at the center of decision-making. This report reflects both rigorous data analysis and the lived experience of residents across our county.

We are proud to support this work, but lasting progress is only possible through the strength of our partners. I extend my deepest gratitude to every nonprofit organization, healthcare organization, educational institution, grassroots leader, and resident advocate who stands beside us. Together, we are building systems that improve health and quality of life within our community.

This report is not the end of the road; it is a mile marker, a point to reflect on our progress, recommit to the work ahead, and move forward together with shared purpose. Thank you for your continued partnership in building a healthier Mecklenburg County.

With Gratitude,

Dr. Kimberly Scott

Dr. Kimberly Scott
Interim Public Health Director



Executive Summary

PURPOSE

Every three years, Mecklenburg County Public Health (MCPH) works with community members and partners to understand the health and well-being of our community. This report is called the Community Health Assessment.

This year's CHA was shaped by people like you, from youth to community leaders. We combined data with real stories and lived experience to provide a more complete picture of health in our community.

We also paid close attention to factors that impact health, such as housing, jobs, education, safety, and food access.

GOAL

The goal of the CHA is simple: Listen. Learn. Act. We listen to what people are experiencing in their neighborhoods, look at health data, and work together to find ways to ensure that everyone in our county has an opportunity to be healthy.

Live Well Meck Community Health Assessment Advisory Committee

The Live Well Meck Advisory Committee informed all phases of the CHA process, including assessment design, recruitment, community engagement activities, and data analysis. The team included representatives from public health, healthcare systems, colleges/universities, and the nonprofit sector. Committee members provided insight into community priorities, helped identify data gaps, and ensured the process remained inclusive and transparent. Members included:

Organization	Representative	Title
YMCA of Greater Charlotte	Adrienne Hobbs	Sr. VP Northern Operations & Youth Development
Cabarrus Rowan Community Health Center (CRCHC)	Brittany Payne	Chief Administrative Officer
Camino Research Institute	Lenin Caro	Lead Community Researcher
Northeastern University	Allyson Hudson	Program Mgr., MPH Program
Northeastern University	Jada Jackson	Community Engagement Mgr.
Alliance Health	Cindy Murphy	Sr. Dir., Community and Member Engagement
University of North Carolina at Charlotte	Tyisha Terry	Lecturer, Dept. Of Epidemiology & Community Health
University of North Carolina at Charlotte	Dr. Allissa Desloge	Asst. Professor, College of Health & Sciences
Advocate Health	Sheila Wright	MSN, RN, Community Health Ministry Mgr.
Advocate Health	Kristen Soni	Director Community Health Needs Assessments
Advocate Health	Destiny James	Community Health Sr. Project Mgr.
Novant Health	Kimberly Dull	Sr. Dir, Community Health & SDoH
Novant Health	Melissa Melendez	Mgr., Community Health Services
Mecklenburg Co Public Health	Mia Turner	Health Program Mgr.
Mecklenburg Co Public Health	Paige Bennett	Deputy Director
Mecklenburg Co Public Health	Donna Smith	Epidemiologist
Mecklenburg Co Public Health	Susan Long-Marin	Health Mgr., Epidemiology
Mecklenburg Co Public Health	Karina Gonzalez	Latino/Hispanic Engagement Mgr.
Mecklenburg Co Public Health	Keon Lewis	Community Health Assessment Coordinator
Mecklenburg Co Public Health	Dr. Kimberly Scott	Interim Health Director

Other core partners included the **Community Advisory Network**, a Mecklenburg County-led convening of local grassroots organizations, and resident leaders who served as trusted community-based organization leaders, community health workers, and messengers within their communities.

ORGANIZING & PLANNING

The CHA planning process began with the establishment of a dedicated internal MCPH assessment team to secure resources and coordinate collaboration. MCPH worked closely with Live Well Meck partners to develop a timeline and outline key milestones.

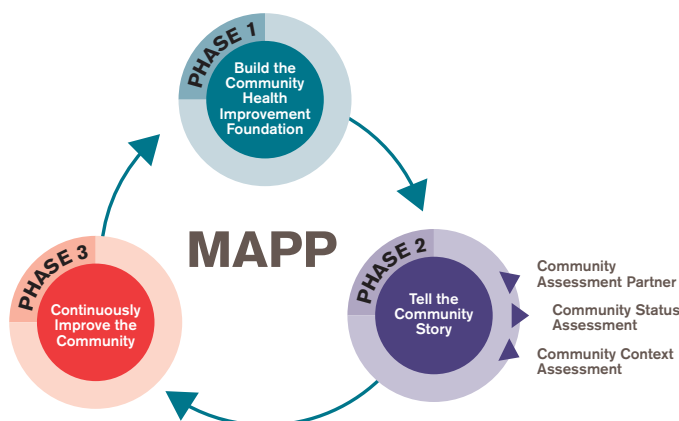
The Live Well Meck Steering Committee met bimonthly to review progress, align priorities, and integrate feedback. The North Carolina Institute for Public Health (NCIPH) was engaged as a consultant to provide technical support for the design of the community prioritization survey, its administration, and data synthesis and analysis.

This collaborative planning ensured that both scientific rigor and community voice remained central throughout the CHA.

FRAMEWORK

The Mecklenburg CHA uses a modified version of the MAPP 2.0 model, a framework developed by the National Association of County and City Health Officials (NACCHO) paired with the County Health Rankings Population Health Framework.

The paired frameworks promote a balanced approach integrating quantitative data, community engagement, and strategic action planning to identify and improve population health outcomes.



COMMUNITY ENGAGEMENT AND INPUT

Community engagement served as both a relationship-building and data collection strategy for the CHA. MCPH and partners hosted a variety of events and outreach activities designed to build trust, share data, and gather diverse lived experiences.

Events such as **Meck Design: Road to Community Health** created interactive spaces where residents could engage in the CHA process, provide feedback on data collection methods, share lived experiences, and identify assets and challenges in their communities.

DATA COLLECTION & ANALYSIS

The CHA used multiple data sources to create a comprehensive picture of health in Mecklenburg County.

Quantitative data included local Behavioral Risk Factor Surveillance System (BRFSS) data, hospitalization and mortality records, and community-level social and environmental indicators.

To ensure diverse community voices were represented in the report, qualitative data collection was expanded through focus groups, interviews, and youth Photo Voice, allowing residents to express their perspectives in their own words and images.

Together, these data provided a comprehensive understanding of community assets, needs, and opportunities for improvement.

KEY FINDINGS

- **Overall health status:** According to the Robert Wood Johnson County Health Rankings, Mecklenburg County fares better than the average county in North Carolina for population health and well-being, and better than the average county in the nation.
- **Rapid population growth:** Mecklenburg County is growing rapidly, reaching an estimated 1,206,285 residents, with the most significant growth occurring within the Hispanic/Latino population, reshaping community needs and service demand. This growth represents a 31% increase in the population since 2010.
- **Insurance coverage gains:** The uninsured rate in Mecklenburg County declined following North Carolina’s Medicaid expansion, resulting in estimates of up to 88,000 residents gaining health coverage as of November 2025 through the expansion.
- **Leading causes of death:** Chronic diseases such as cancer, heart disease, and stroke remain the leading causes of death in Mecklenburg County, underscoring the need for sustained prevention and management efforts across the life course.
- **Cost of living pressures:** Food insecurity and housing affordability have emerged as growing concerns, with an increasing proportion of household income devoted to housing costs, particularly among renters and low-income households
- **Maternal and child health inequities:** While infant mortality rates have improved overall, significant and persistent gaps remain between Black and White infants.
- **Opioid and overdose trends:** Data from the Overdose Data to Action (OD2A) initiative show promising early declines in overdose deaths, highlighting the impact of naloxone distribution, treatment access, and data-driven prevention strategies.

ISSUE PRIORITIZATION

Following data collection, MCPH and partners facilitated a community-driven process to identify and prioritize key health issues. A survey was disseminated to collect community input. Results were compiled, analyzed, and shared at two Community prioritization meetings titled *Destination Wellness*.

Two *Destination Wellness* meetings brought residents, partners, and decision-makers together to review findings and weigh priorities using data and lived experience.

- At this event, a prioritization matrix and guided exercise were facilitated to come to a consensus on community health challenges. Participants ranked key health and social issues based on magnitude, seriousness, and community readiness to act.
- The following priorities were identified as areas of focus for 2026–2028.
 - Access to Care
 - Chronic Disease
 - Maternal & Child Health
 - Mental Health
 - Violence Prevention
- Cross-cutting priority emphasis: While the core priorities remain consistent, there is a strengthened focus on addressing social determinants of health that cross all priorities. Housing stability and educational access were identified as critical upstream drivers influencing health outcomes across priorities to be considered in all priority-related strategies.
- Within chronic disease prevention, food security was elevated as a central strategy.

Date:	Location:	# of participants:
9/26/2025	Valerie C. Woodard Conference Center	71
10/29/25	Virtual Meeting	40

Summary:

Participants reviewed CHA data, discussed prioritization survey results, and identified the most pressing health priorities.

About

The Mecklenburg County Community Health Assessment (CHA) is a comprehensive review of data and community insight used to understand the conditions that influence health and well-being across the county. The CHA brings together multiple information sources to examine current health outcomes, identify emerging trends, and better understand the factors shaping health in Mecklenburg County.

The assessment incorporates both secondary data from established local, state, and national data systems and primary data collected through a mixed-methods approach, including quantitative analysis and qualitative input from residents and community partners. These data are used to examine patterns over time and to compare Mecklenburg County's health status with North Carolina and selected peer counties nationwide.

The 2026 CHA is grounded in the Live Well Meck framework, which centers community voice, shared accountability, and the conditions that allow people and places to thrive. Using this framework, the CHA examines how social, economic, environmental, and structural factors intersect to influence health outcomes across the community.

A core component of the CHA is understanding Mecklenburg County's dynamic, diverse population and identifying communities that face disproportionate health risks. The CHA synthesizes key findings to support decision-making, guide strategic investment, and align efforts across residents, community-based organizations, health systems, and public and private partners. By placing accessible, actionable data in the hands of the community, the CHA supports collective impact to build on existing assets, address barriers, and expand opportunities for health so that Mecklenburg County can be the healthiest place to live, work, and play for all.

What's New in the 2025 CHA?

Since the 2022 CHA, Mecklenburg County has experienced significant demographic shifts, emerging public health challenges, and evolving community priorities. The 2025 CHA reflects these changes by:

- Aligning fully with Live Well Meck to emphasize upstream conditions, shared responsibility, and community-driven solutions
- Incorporating expanded and more timely data sources to better capture trends and emerging community health needs and improvements
- Strengthening the use of mixed methods to elevate lived experience and community voices alongside quantitative data
- Prioritizing data accessibility to ensure findings are usable by residents and partners, not only institutions



Chapter 1: **Our Community**

Mecklenburg County is a place of rapid growth and home to North Carolina's largest city, Charlotte. Its geography, economy, culture, and population shape how health is experienced across neighborhoods and generations. Understanding these conditions helps provide context for the health outcomes and priorities explored throughout this assessment.

Geography and Place

Mecklenburg County is located in the south-central Piedmont region of North Carolina and covers approximately 524 square miles, according to the US Census Bureau.¹ The county blends urban, suburban, and rural communities. At the heart of the county is the city of Charlotte, the county's largest municipality and economic hub. Surrounding Charlotte are six towns: Cornelius, Davidson, Huntersville, Matthews, Mint Hill, and Pineville, each with its own unique character, assets, and community needs contributing to the broader county landscape.

Mecklenburg County is one of the fastest-growing counties in the state and nation, with new residents arriving daily.² This growth brings opportunities, including economic development, but also creates challenges, including housing affordability, transportation, infrastructure, and environmental stress. Access to safe places to exercise and play, healthcare facilities, affordable and healthy food, and other essential resources that shape health and well-being varies by neighborhood.

Where people live matters.

Zip code remains a powerful predictor of health. By looking closely at our communities and the resources available within them, we can better understand how to advance health across the entire county.



Historic and Cultural Context

Mecklenburg County's health landscape is shaped by its history. The region evolved from agriculture and industry to its recent emergence as a Fortune 500/1000³ and national banking hub. While economic growth has brought prosperity to many, the benefits have not been shared equally across the community.

At the same time, Mecklenburg County is defined by resilience, innovation, and cultural richness. From historic African American neighborhoods like Brooklyn, Biddleville, and West End,⁴ to thriving immigrant communities across east Charlotte⁵ and beyond, our county's cultural landscape is vibrant and growing. Charlotte-Mecklenburg Schools reported 201 native languages spoken by enrolled students representing 158 countries in the district, making Mecklenburg County one of the most diverse communities in North Carolina.⁶ Diversity is one of the county's greatest strengths and an essential part of how health and well-being are defined and understood.



Population and Demographic Change

Home to 1.2 million people, Mecklenburg is one of the most diverse counties in North Carolina and the second most populous county in NC. According to the U.S. Census, Charlotte ranks 6th among US cities and towns with the largest numeric population gains between 2023 and 2024, with an increase of more than 23,400 residents.¹² Population growth projections estimate nearly 1.7 million residents by 2050, 40.9% increase from 2024 figures.

TOTAL POPULATION

1,206,285

MEDIAN AGE

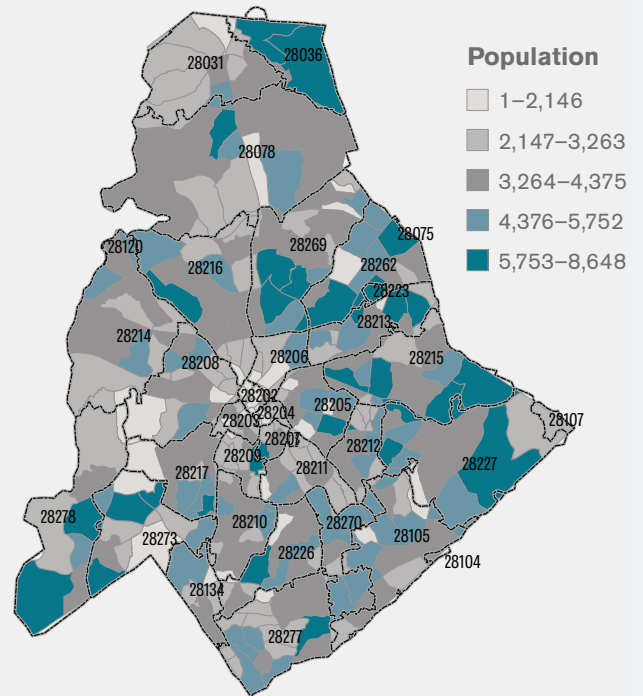
35.5

MEDIAN INCOME

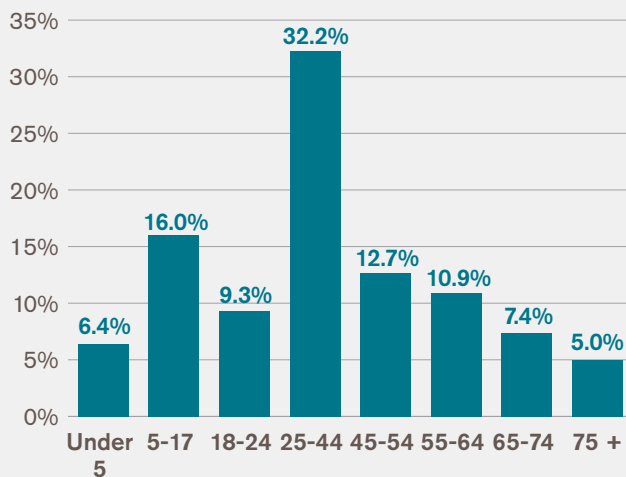
\$90,494

Map 1. Total Population

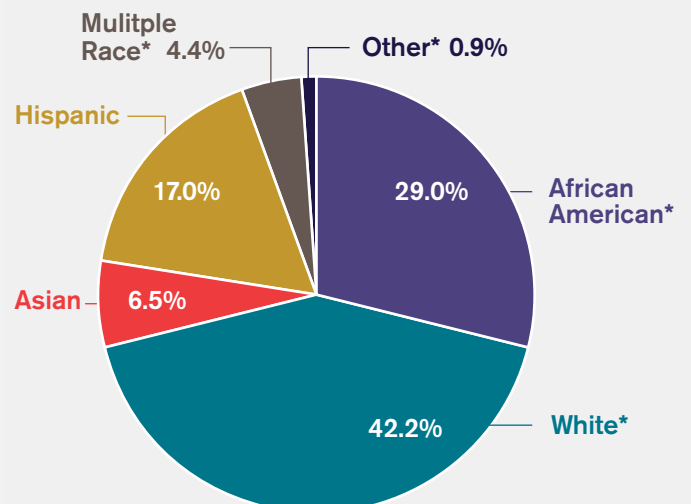
Source: Mecklenburg County Public Health and GIS



AGE DISTRIBUTION



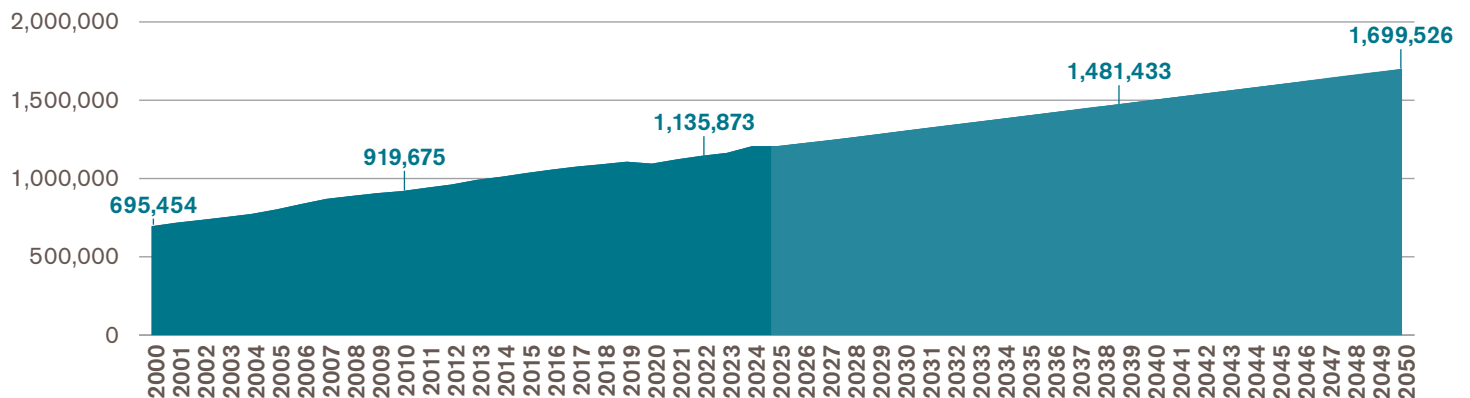
RACIAL/ETHNIC COMPOSITION



*Non-Hispanic

Figure 5.

Total Population Estimate and Projection



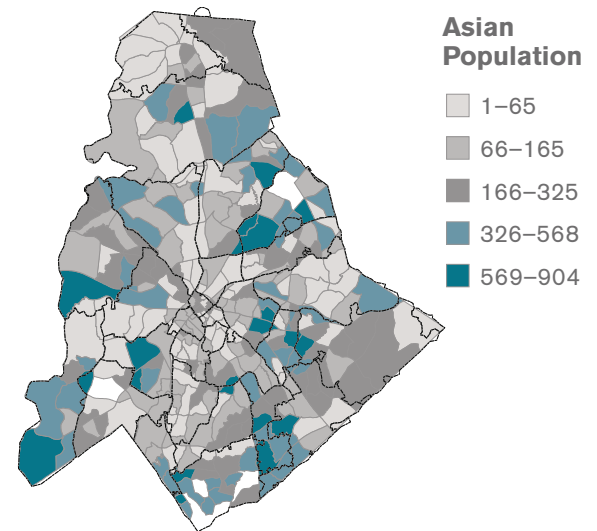
Sources: US Census, ACS 1-Year Estimate, NC OSBM, State Demographer

Population growth over the past two decades has been largely driven by Latino and Hispanic residents, who represent one of the county’s fastest-growing demographics. Asian communities have also grown significantly, contributing to the county’s cultural vitality. A majority-minority community, this diversity is one of the county’s greatest strengths and an essential part of how health and well-being are defined.

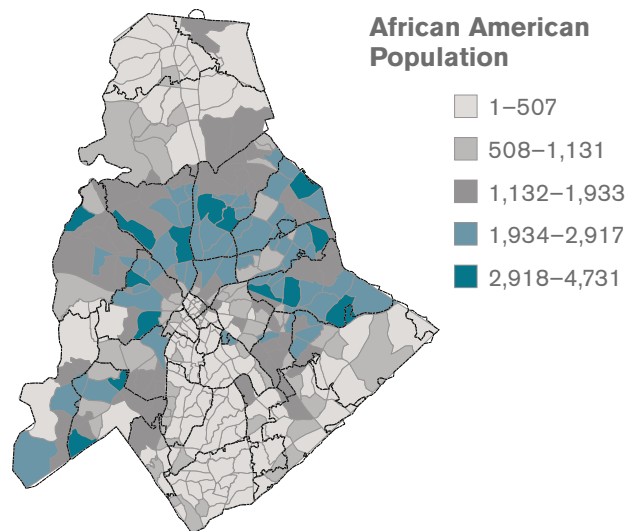
- Since the last CHA, Mecklenburg County has experienced 7.5% population growth
- Hispanic residents increased from 146,710 residents in 2020 to almost 205,000 residents in 2024, now representing 17% of the county’s population
- Asian residents have increased by 20% between 2020 and 2024, growing to over 79,000 residents.

Overall, the Charlotte-Mecklenburg area remains a desirable place for many. In 2025, Mecklenburg County fared better than the average county in North Carolina for community health well-being and better than the average county in the nation based on the County Health Rankings & Roadmaps Program.¹³

Map 2. Asian Population



Map 3. African American Population



Map Sources: Mecklenburg County Public Health and GIS

Births, Birth Outcomes, and Early Life

Birth outcomes provide insight into both population trends and the health of families and communities.

In 2024, Mecklenburg County accounted for 13% of all births in the state of North Carolina.¹⁴

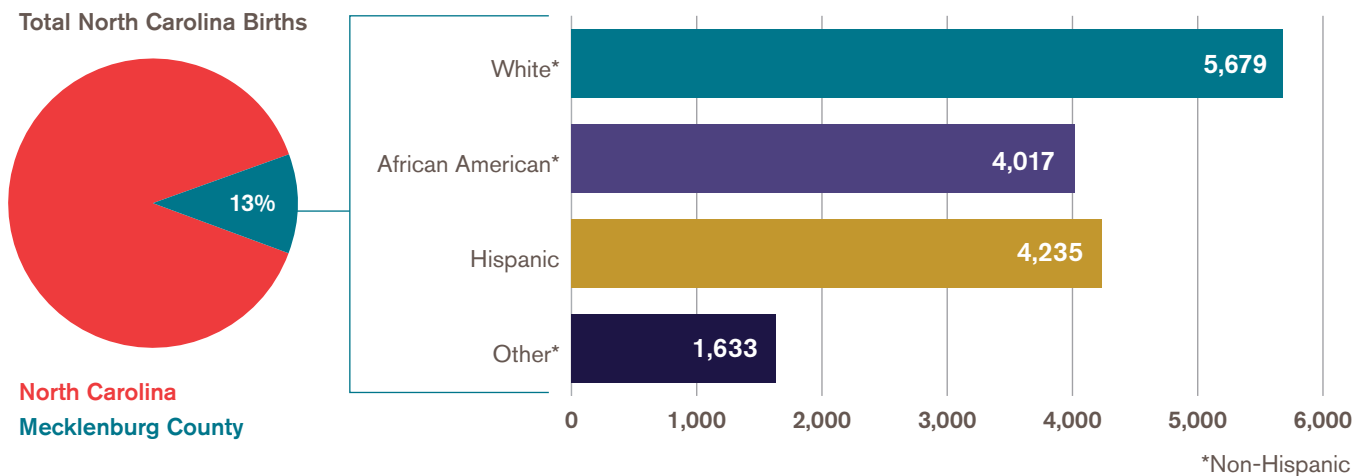
Several indicators suggest progress, including improvements in infant mortality rates and preterm birth outcomes compared to state averages.

However, persistent disparities remain. Black infants in Mecklenburg County die before their first birthday at higher rates than White infants, reflecting broader inequities in access to care, maternal health, and social conditions.

Births

In 2024, 15,564 births occurred in Mecklenburg County.

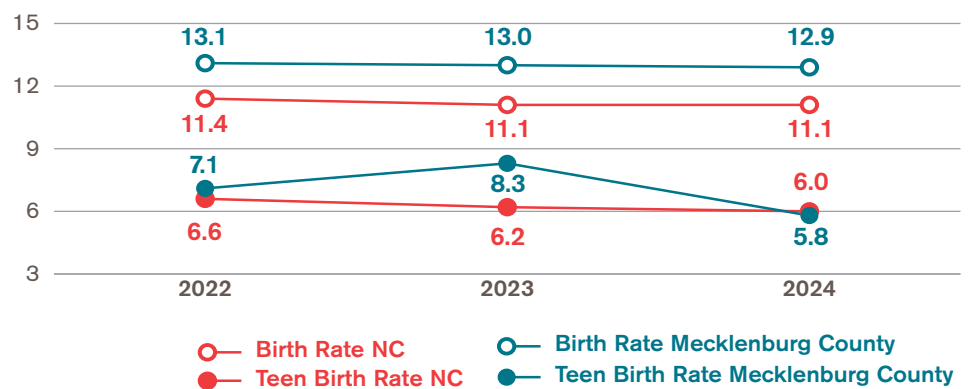
Figure 6. **Live Births by Race/Ethnicity, Mecklenburg 2024**



Source: NC 2024 Babybook, SCHS

Although the number of births in Mecklenburg continues to rise, the overall birth rate, factoring in the county's population growth, has declined over time. The rate has decreased from 15 births per 1,000 in 2010 to 12.9 per 1,000 in 2024.

Figure 7. **North Carolina and Mecklenburg Birth Rates per 1,000, 2022–2024**

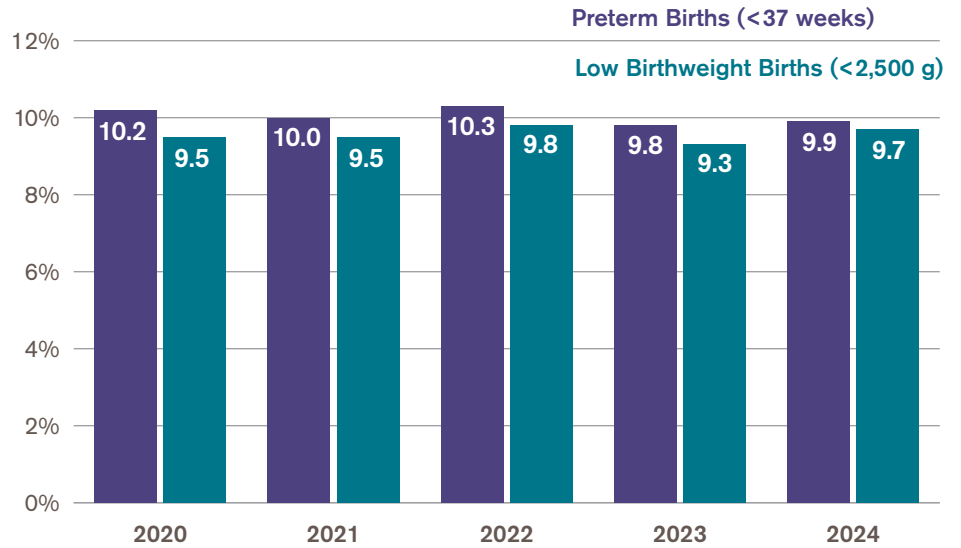


Birth Outcomes

Babies born too early (less than 37 weeks gestational age) and those with low birth weight (less than 2,500 g) are at risk for adverse health complications such as impaired development, infections, and death.

- Mecklenburg County's preterm birth rate (9.9%) is below the 2024 preterm birth rate in North Carolina of 10.7%, but above the Healthy People 2030 objective of 9.4%.
- Mecklenburg County's 2024 low birthweight rate (9.7%) is higher than NC (9.3%) and higher than the Healthy People 2030 goal of 9.4%.

Figure 8. **Percent Preterm and Low Birthweight (<2,500g) Births, Mecklenburg 2020–2024**

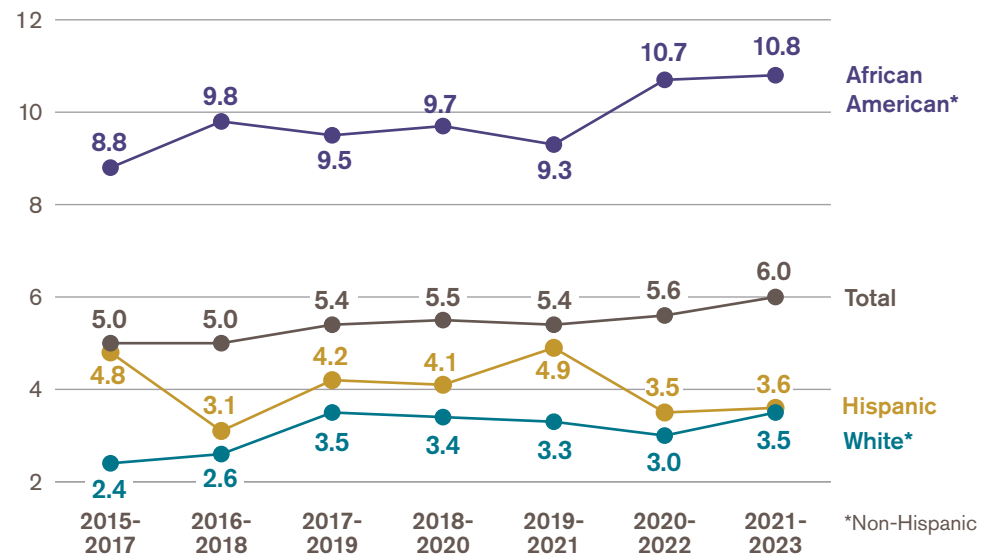


Source: NCDHHS, SCHS

Since 2020, the Mecklenburg County infant mortality rate has been lower than that of the nation and approaching the Healthy People 2030 goal to reduce infant mortality rates to 5.0.

- Black Infants die before their first birthday at rates nearly 3.5 times that of White infants in Mecklenburg County.

Figure 9. **Infant Death Rates per 1,000 Live Births by Race/Ethnicity, Mecklenburg 2015–2023**



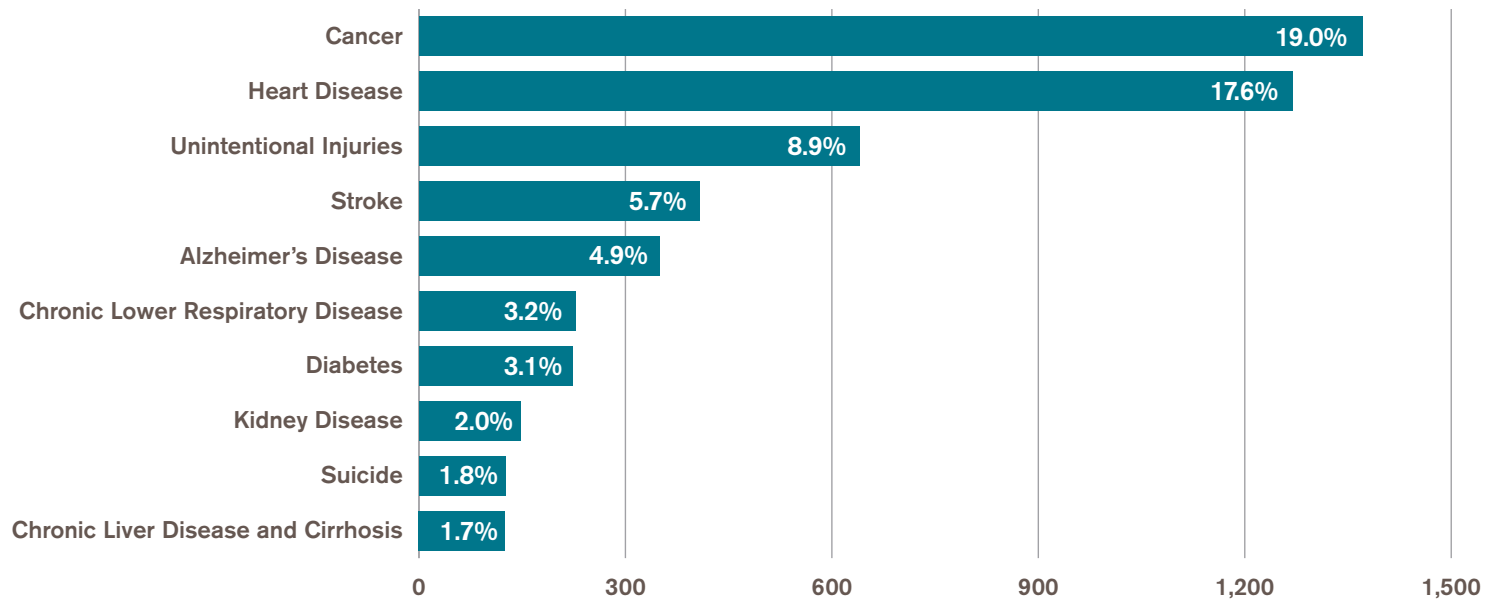
Source: NCDHHS, SCHS

Mortality and Leading Causes of Death

Chronic diseases such as cancer, heart disease, and stroke remain the leading causes of death in Mecklenburg County. Unintentional injuries, including motor vehicle crashes, overdoses, and falls, are a leading cause of death among children, adolescents, and working-age adults. The COVID-19 pandemic temporarily reshaped mortality patterns, but longer-term trends point to the continued impact of chronic disease.

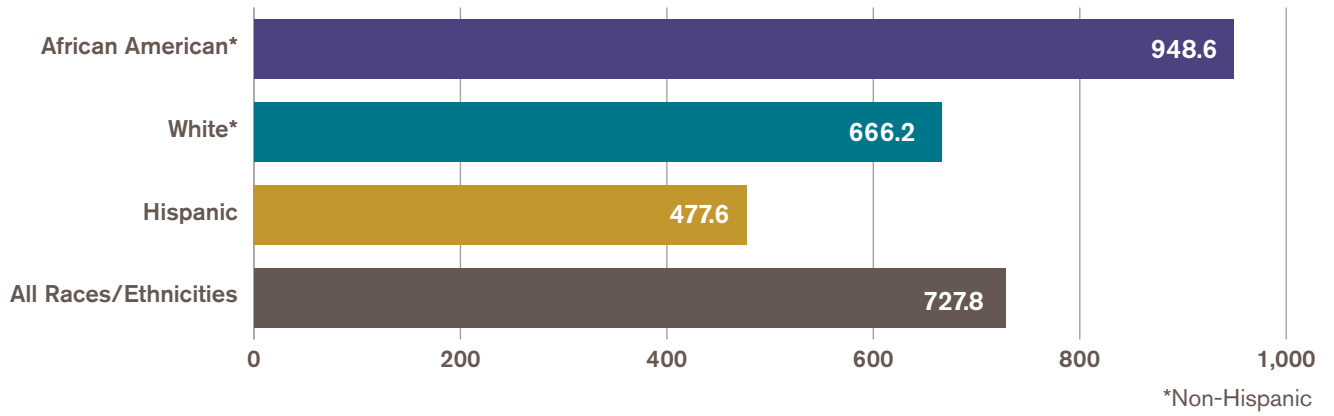
- In 2023, there were 7,205 deaths in Mecklenburg County. 8 out of the top 10 leading causes of death during that time were chronic conditions such as cancer, heart disease, and stroke.
- Cancer and heart disease were consistently the leading causes of death in Mecklenburg County.
- Unintentional Injuries frequently rank as the third leading cause of death, except for years 2020 and 2021, when COVID-19 took that position. They are the leading cause of death for persons aged 1–44 years.

Figure 10. **Leading Causes of Death (LCD), 2023**



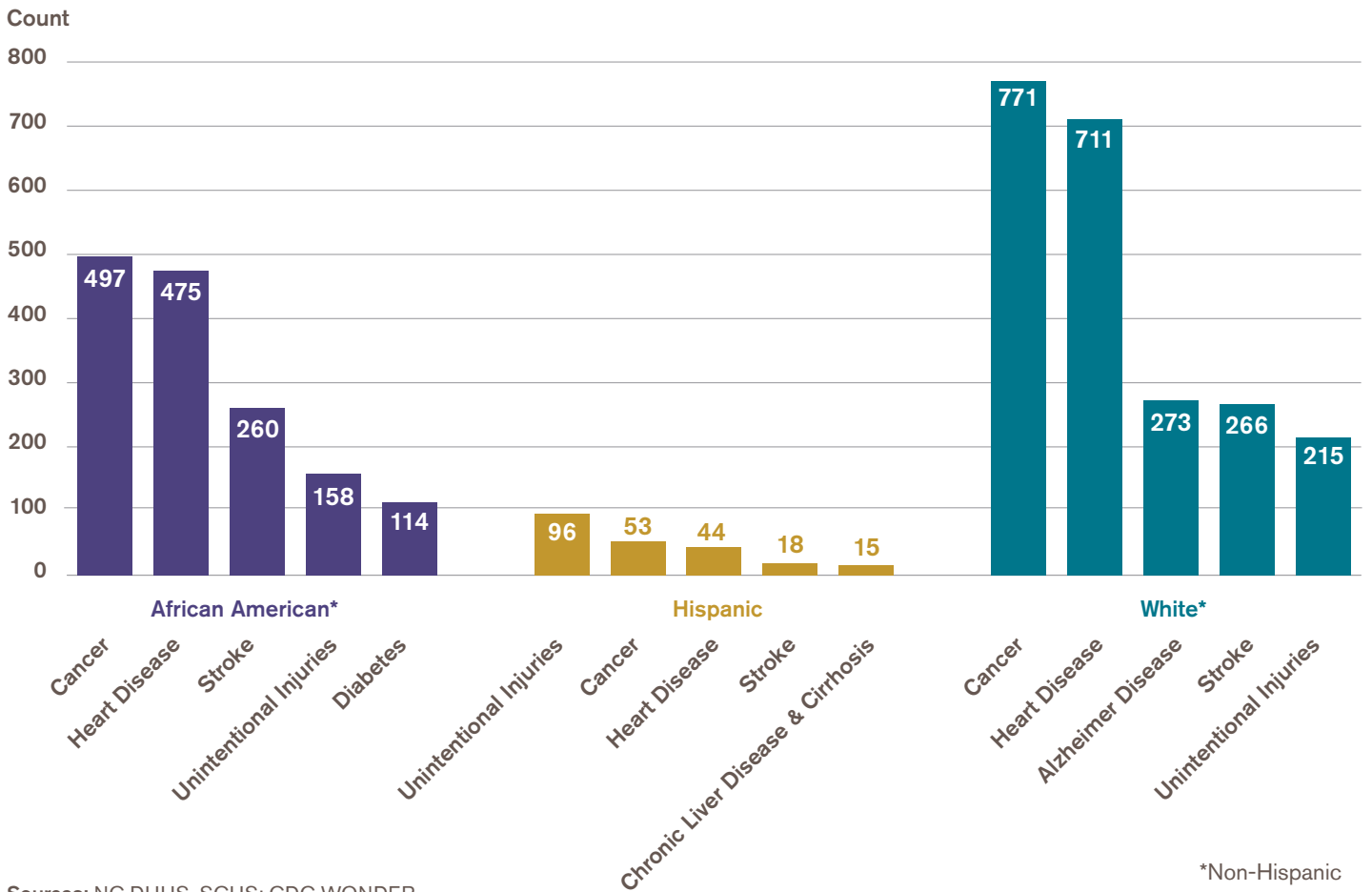
Sources: NC DHHS, SCHS; CDC WONDER

Figure 11. **Death Rates by Race/Ethnicity, 2019–2023**
5 Year Age-Adjusted Rates per 100,000



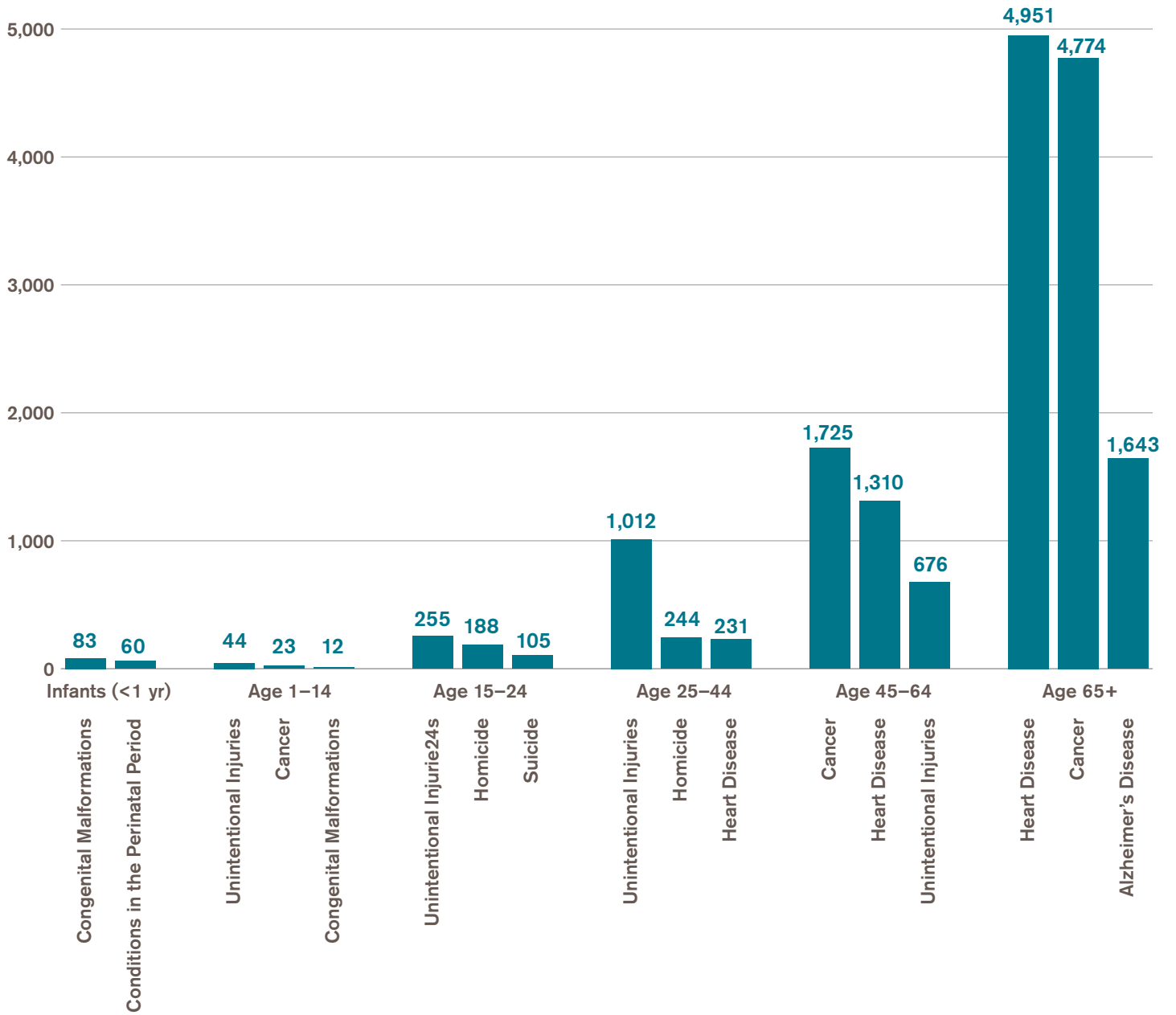
Source: NC DHHS, SCHS

Figure 12. **Leading Causes of Death By Race/Ethnicity, 2023**



Sources: NC DHHS, SCHS; CDC WONDER

Figure 13. **Leading Causes of Death By Age Group, 2019–2023**

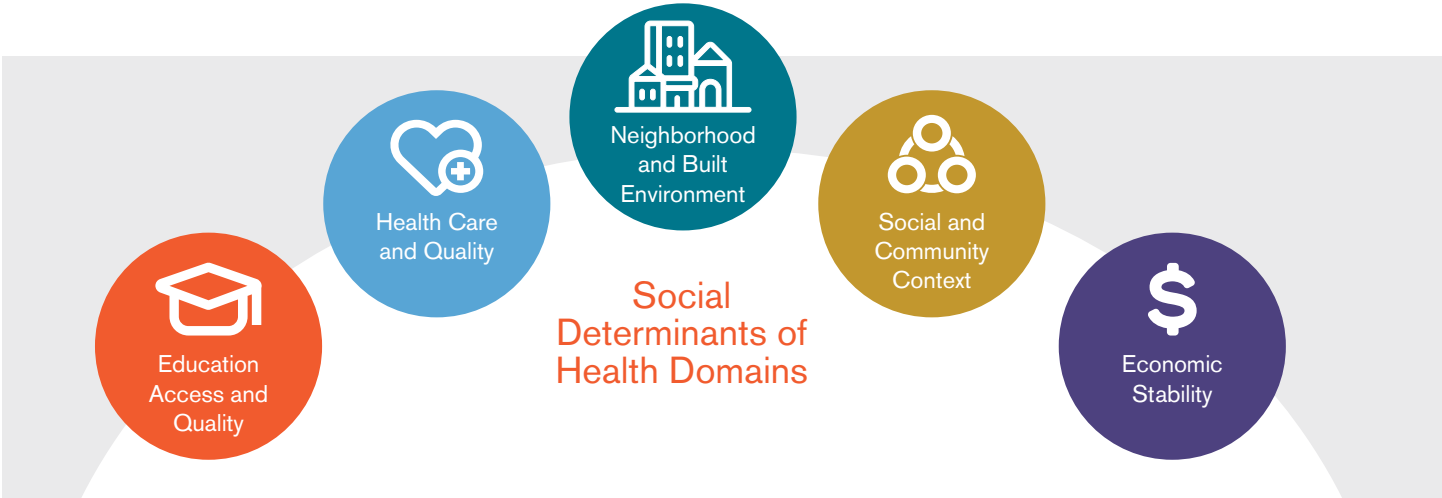


Sources: NC DHHS, SCHS; CDC WONDER



Social Determinants of Health & Vulnerable Populations

Social Determinants of Health (SDOH) are the circumstances in which people are born, grow up, live, work, and the systems put in place to deal with illness. These circumstances are shaped by a wider set of forces: economics, social policies, and politics.



Across Mecklenburg County, some residents carry a greater health burden not because of personal choices, but because of conditions and systems they must navigate every day. In this assessment, vulnerability reflects the conditions and barriers people experience that shape their access to health and opportunity, not who they are.

Populations experiencing these circumstances include individuals with low incomes, people who are underinsured or uninsured, older adults, people with disabilities, individuals experiencing housing instability or homelessness, and residents with limited English proficiency.

Table 1. **Social and Economic Development Measures**

	2010	2017	2024
Population Living Below Poverty	15.3%	11.1%	10.5%
Children (under 18 yrs) Living Below Poverty	21.2%	16.5%	14.2%
Uninsured Population	17.1%	11.5%	10.9%
Adults 25 years and older with No High School Diploma	12.1%	9.1%	8.9%
Severe Housing Cost Burden Among Renters ($\geq 50\%$ Income)	---	21.4%	24.1%
Household without Internet Subscription	---	11.3%	4.0%

Source: US Census, ACS 1-Year Estimate

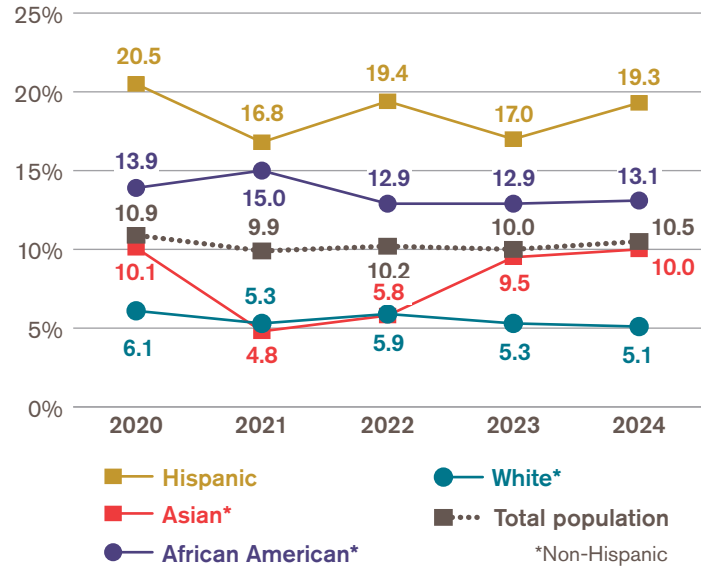
Data on households without internet subscriptions is not available for 2010. The ACS began collecting this information in 2013. Prior to that, internet access data was captured through the Current Population Survey, so comparable estimates are not included for 2010.

Data on severe housing cost burden is not available for 2010. Prior to 2014-15, ACS tables only reported thresholds of $\geq 30\%$ and $\geq 35\%$, limiting the ability to calculate $\geq 50\%$ measure consistently for earlier years.

Poverty and ALICE Households

Traditional poverty measures alone do not fully capture the extent of economic hardship in Mecklenburg County. Inflation serves as a key indicator of economic well-being. When prices rise faster than wages and other sources of income, purchasing power declines, making it difficult for households to manage their expenses. This is an important issue for poverty-level households and for households that are asset-limited, income-constrained, and employed (ALICE), earning above the Federal Poverty Level (FPL) but still below the costs of essential needs. The ALICE Essential Index, a collaborative national research endeavor led by the United Way of Northern New Jersey, provides a set of metrics to measure changes over time in the costs of the household basics that matter most to ALICE and poverty-level households: housing, childcare, food, transportation, health care, and basic technology.¹⁵

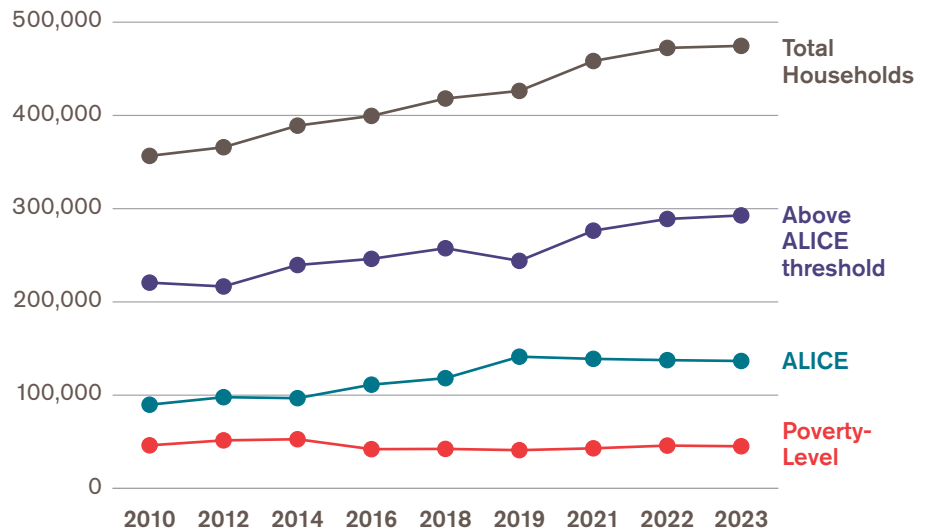
Figure 14. **Poverty in the Past 12 Months by Race, 2020–2024**
% of Population Living Below Poverty



Source: US Census, ACS

- In 2023, an estimated 10% or over 45,000 households in Mecklenburg were poverty-level. However, an additional 136,000 households were ALICE, nearly 18,000 more households in comparison to year 2018.

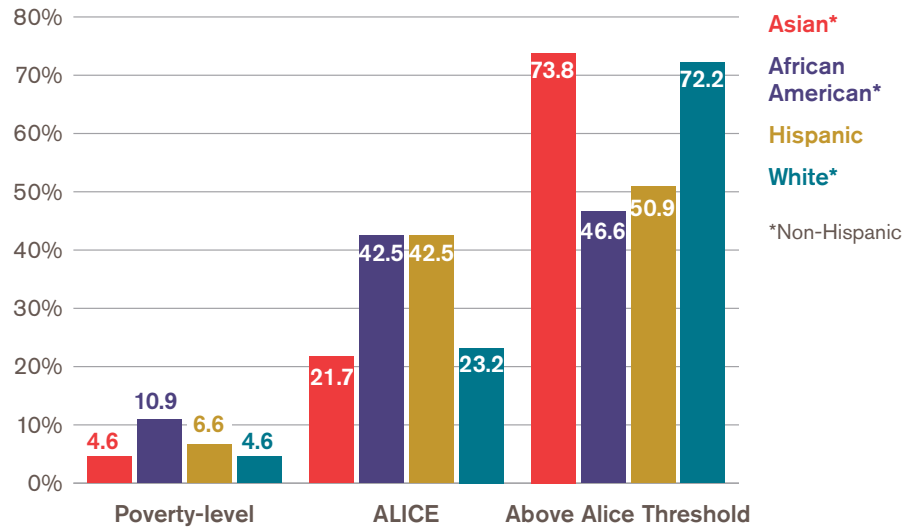
Figure 15. **Number of Households in Poverty and ALICE Status, 2010–2023**



Source: UnitedforAlice 2025 NC Report

- Financial hardship is not equally distributed, with some racial and ethnic populations experiencing ALICE more than others.

Figure 16. **Households Experiencing Financial Hardship by Race/Ethnicity, Mecklenburg 2023**



Source: UnitedforALICE 2025 NC Report

Many households in Mecklenburg County face rising costs for essentials such as housing, food, and childcare. The Living Wage calculator identifies the annual wages needed for different household types in Mecklenburg County to meet basic needs. While the median household income in the county is \$90,494, an estimated 42% of households make less than \$75,000 annually. (Source: US Census, ACS 2024 1-yr estimate)

Table 2. **Living wage calculation for Mecklenburg County, North Carolina**

	Number of Children			
	0	1	2	3
1 Adult	\$55,307	\$92,088	\$112,486	\$135,262
Two Adults (1 Working)	\$73,572	\$85,128	\$92,984	\$106,419
2 Adults (Both Working)	\$73,572	\$102,541	\$122,086	\$141,731

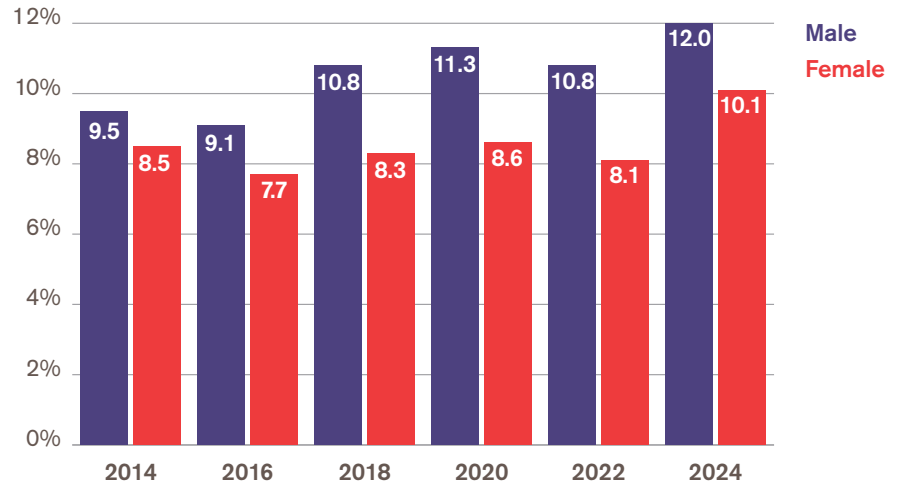
Source: MIT Living Wage Calculator. (2025)¹⁸

Educational Attainment

People with high educational attainment tend to experience better health outcomes and longer lives than those with fewer years of education.¹⁷ Education paves the way for jobs with higher pay, better health insurance, and the means to live a healthier life.

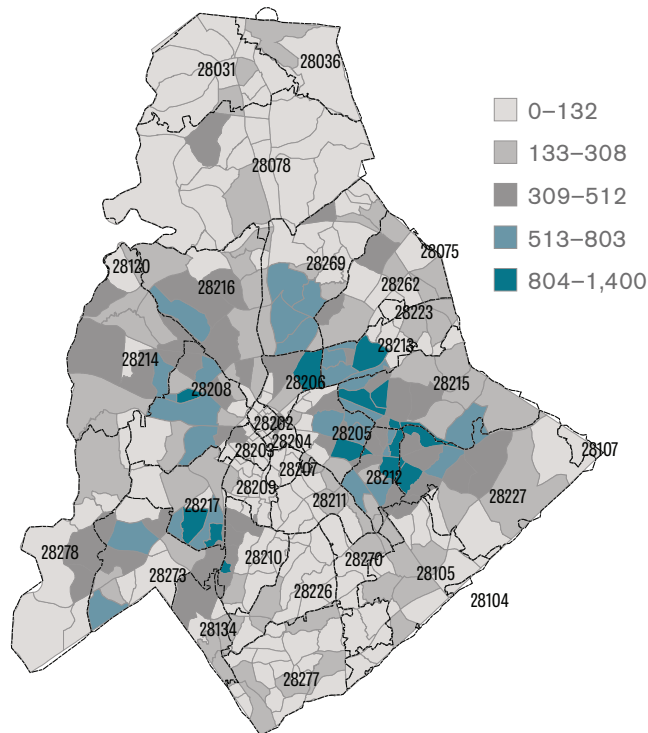
While education is integral to health, not all residents have access to the same quality of education. Policies, limited community resources, and exposure to adverse life experiences can undermine students' success, setting the stage for poor health outcomes in our most vulnerable populations.

Figure 17. **Percent of Population 25 and Over with No High School Diploma, Mecklenburg 2014–2024**



Source: US Census, ACS

Map 4. **Percent of Population 25 and Over with No High School Diploma**



Source: Mecklenburg County Public Health and GIS

Chronic Disease

Across the county, residents with low educational attainment and low income have higher rates of diseases, such as diabetes and cardiovascular disease as well as risk factors that predict these conditions.

Figure 18. Chronic Disease Indicators in Adults by Education and Income, Mecklenburg 2024



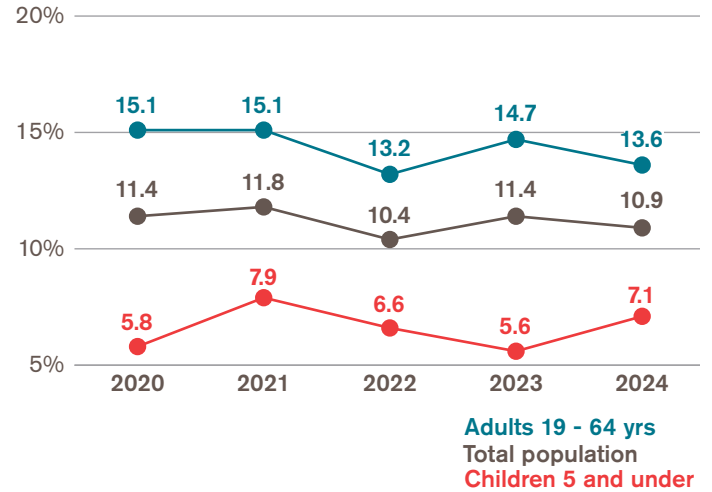
Source: Mecklenburg Local BRFSS

Uninsured Populations

Health insurance plays a critical role in access to preventive health care, timely treatment, and overall health outcomes. While Mecklenburg County has made progress in reducing the percentage of residents without health insurance, the number of uninsured residents continues to represent a substantial share of the community and reflects ongoing barriers to affordability, employment, and eligibility.

- The percentage of uninsured Mecklenburg residents has decreased from 11.4% in 2020 to 10.9% in 2024. The latest estimate of Mecklenburg County's uninsured population, released in 2024, is approximately 130,000 individuals.

Figure 19. **Uninsured Populations by Age Group, Mecklenburg 2020–2024**

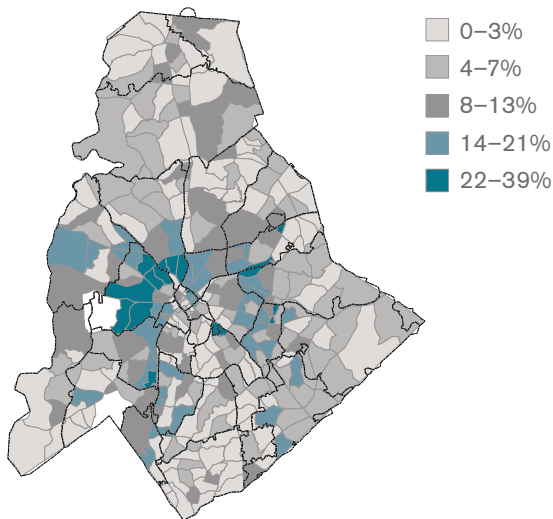


Source: US Census, ACS

Households Without Internet

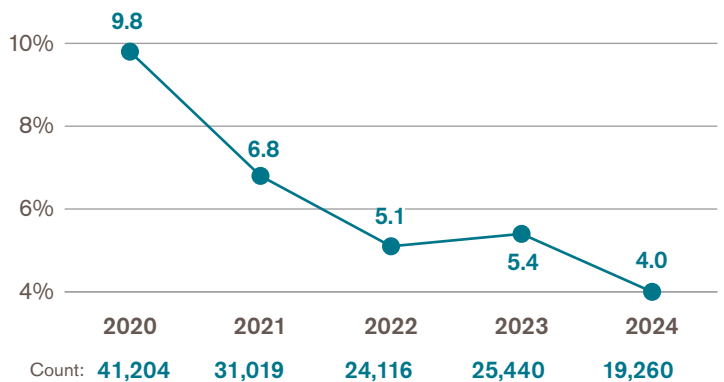
Households without internet access face significant barriers to health, education, employment, and essential services in an increasingly digital world, making digital access an important marker of vulnerability.

Map 5. **Percent of Households without Internet**



Source: Mecklenburg County Public Health and GIS

Figure 20. **Percent of Households without Internet Subscriptions, Mecklenburg 2020–2024**

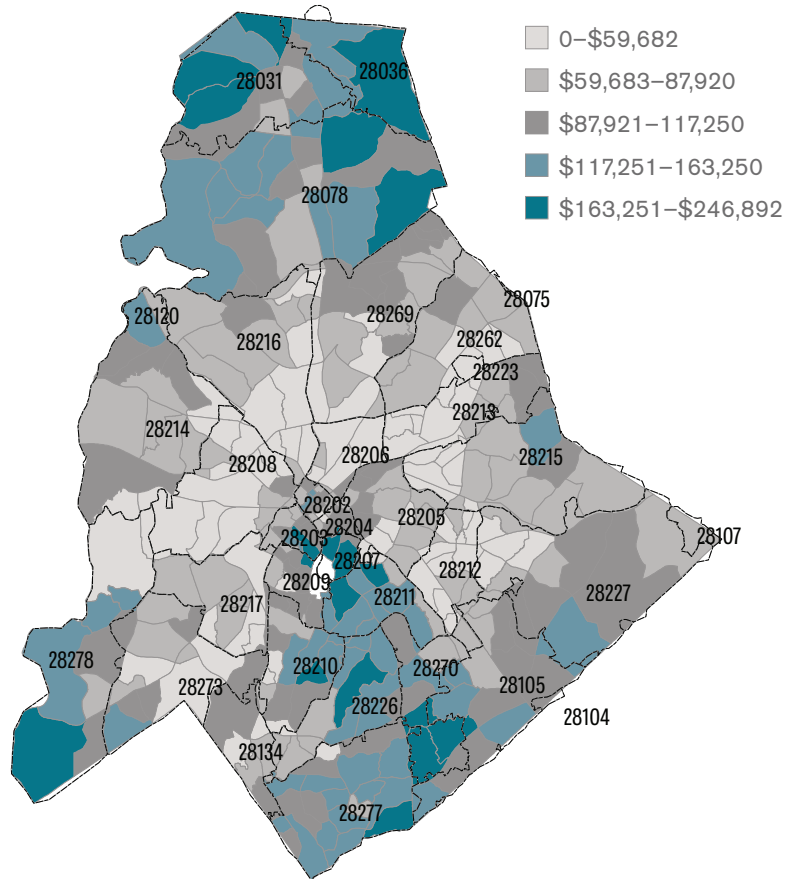


Source: US Census, ACS

Low-Income Families

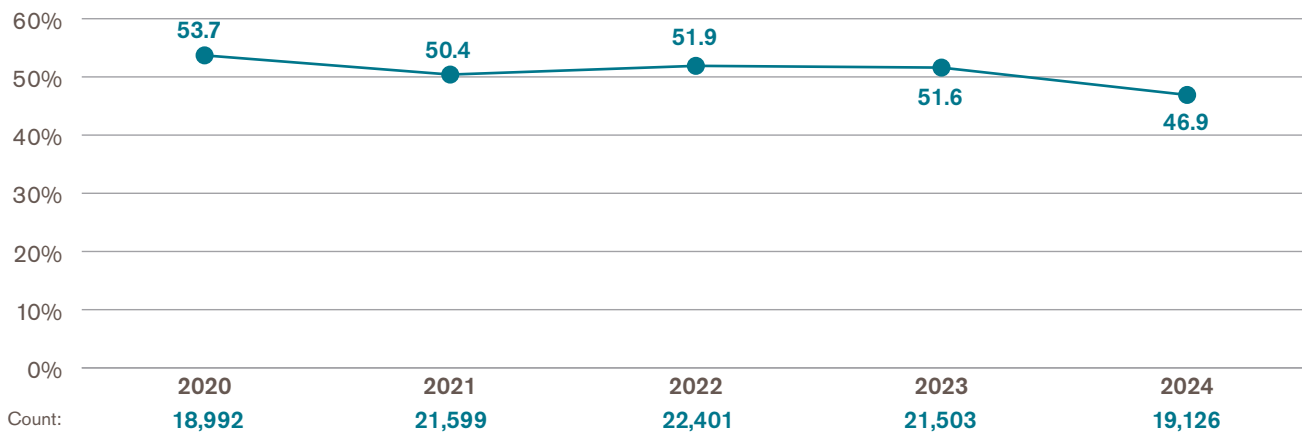
Low-income families often face compounding barriers that impact health and well-being. Since income shapes nearly all aspects of daily living, it is one of the most influential determinants of health and a key indicator for identifying communities at increased risk of poor health outcomes.

Map 6. **Median Household Income**



Source: Mecklenburg County Public Health and GIS

Figure 21. **Percent of Households receiving Food Stamps/SNAP with Children Under 18 years, Mecklenburg 2020–2024**

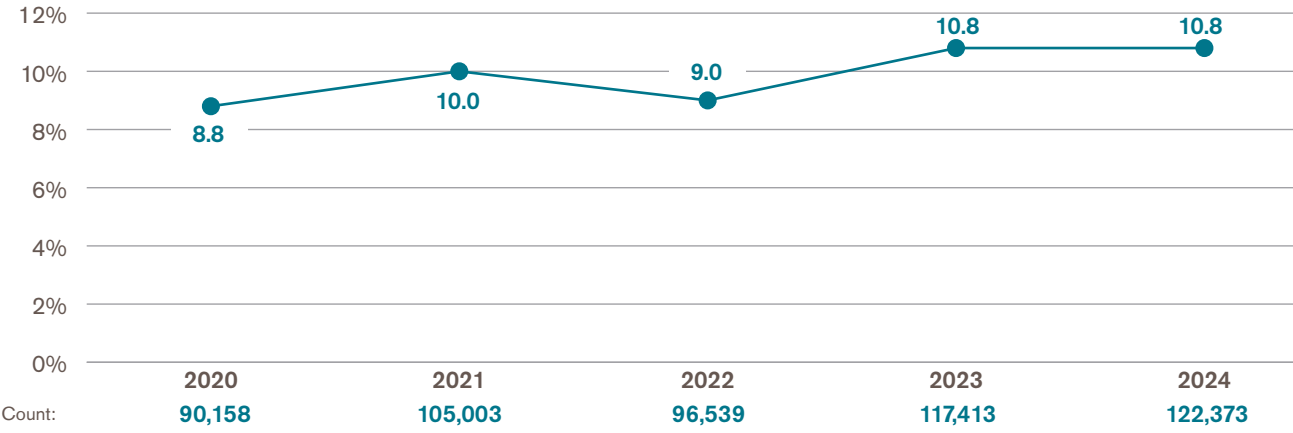


Source: US Census, ACS

Persons with Limited English Proficiency

Fluency in English is a key factor in an individual's ability to navigate the healthcare system. Residents with limited English proficiency may face significant challenges in attaining employment and receiving quality care.

Figure 22. **Percent of Persons Who Speak English Less than Very Well, Mecklenburg 2020–2024**



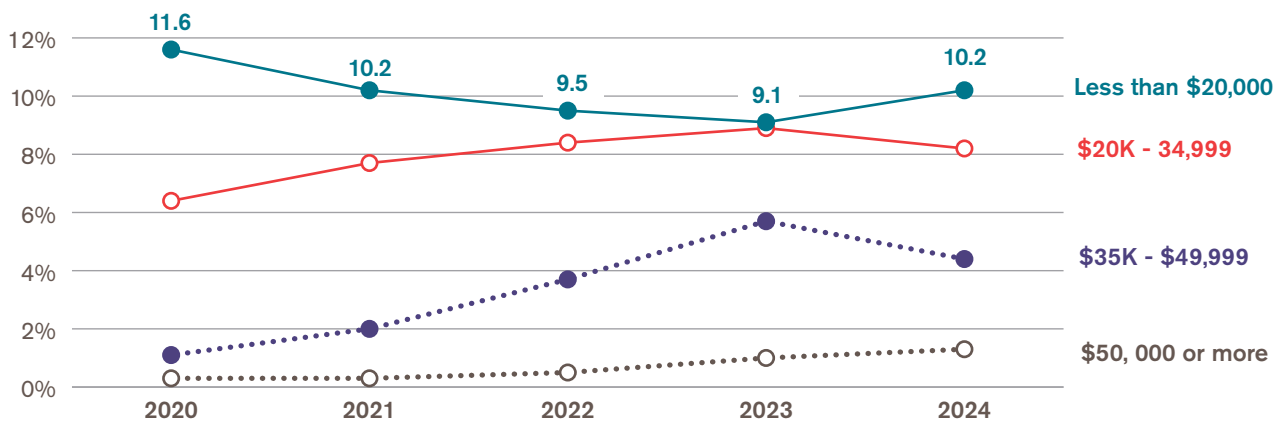
Source: US Census, ACS

Housing Instability or Homelessness

Housing affordability is a key factor shaping health and stability. When households are required to spend a large share of their income on housing, fewer resources remain for basic needs like food, health care, transportation, childcare, and more. In Mecklenburg County, trends in severe housing cost burden highlight growing financial pressure among renters and signal increased vulnerability to housing instability and related health risks.

- Nearly 1 in 4 renters in Mecklenburg County experience severe housing cost burden (SHCB), paying more than 50% of household income for housing costs. The rate of SHCB in the county has increased significantly over time.

Figure 23. **Percent of Households (Renters) with Severe Housing Cost Burden by Income, Mecklenburg 2020–2024**



Source: US Census, ACS

Mecklenburg County has experienced a significant loss of affordable rental housing over the past decade. Since 2015, more than three-quarters of the county’s low-cost rental units have disappeared, driven by redevelopment, increased construction costs, rising rents, and a market shift toward higher-end housing. As a result, there is now a shortage of more than 32,000 rental units affordable for households earning at or below 30% of the area median income.

Housing instability continues to affect thousands of residents each year. While the total number of people experiencing homelessness declined by 14% compared to the previous year, more than 2,400 individuals were experiencing homelessness as of mid-2025. At the same time, the number of people entering homelessness for the first time increased by 11%, and overall shelter utilization rose modestly from 2024 to 2025.

These trends disproportionately affect communities of color and households with very low incomes. Black residents make up 29% of Mecklenburg County’s total population but account for 74% of individuals experiencing homelessness. Most renters who struggle to afford housing are Black and/or Latino, underscoring how limited affordable housing and rising rental costs continue to widen existing racial and economic disparities across the county.¹⁸

Together, these geographic, historical, environmental, and demographic factors shape the context in which health outcomes occur in Mecklenburg County. They explain why disparities persist, why progress varies across groups, and why community voice is essential to understanding health beyond the numbers.

The next chapter, Our Process, describes how this assessment brought together data and lived experience to better understand these patterns and identify action priorities.

Environmental Conditions

The environments where Mecklenburg County residents live, work, and play directly impact health and quality of life. Environmental conditions include air quality, water safety, food sources, and built environments.

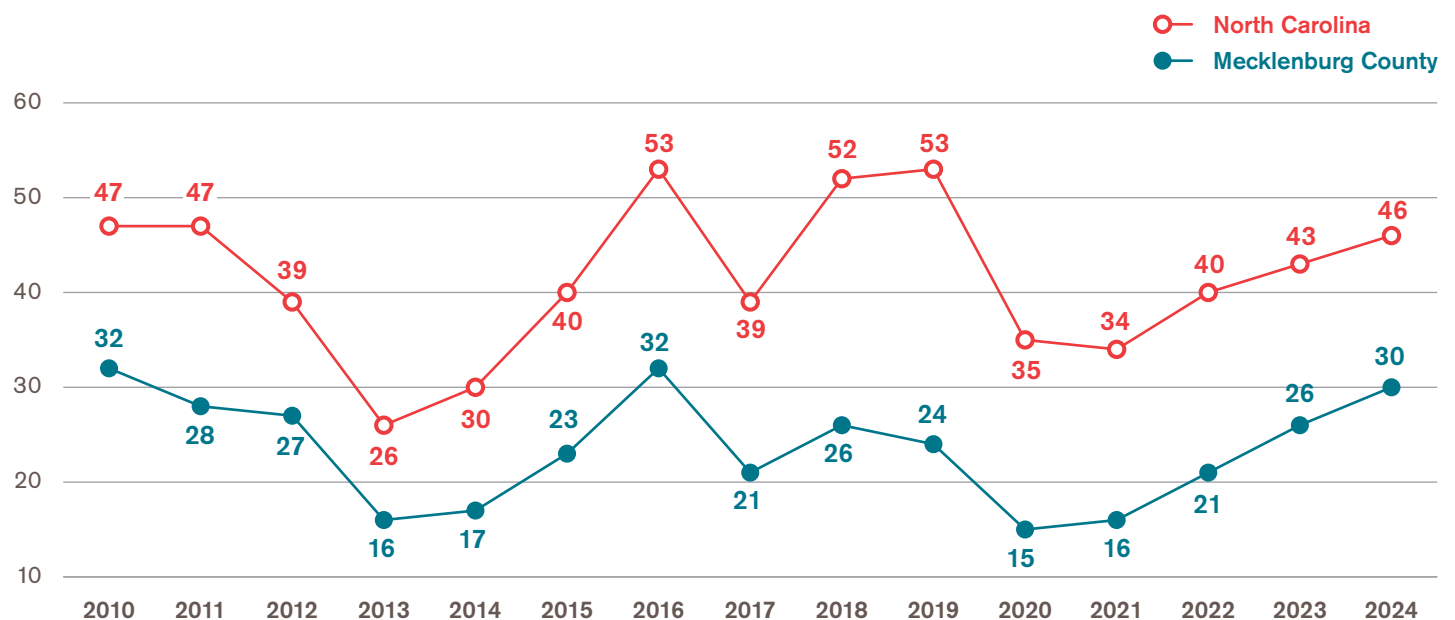
Exposure to harmful pollutants can increase a person’s risk of respiratory diseases, heart disease, and certain cancers.^{7,8,9} Individuals with lower incomes often reside in polluted areas with unsafe water, while children and pregnant women face increased health risks from pollution. Additionally, communities continue to experience the adverse health and quality-of-life impacts of climate change.

Heat-Related Illness

Climate-related risks, such as extreme heat, are increasing, disproportionately affecting communities with limited resources.¹⁰ Heat-related illnesses (HRI) remain a public health concern due to the rise in frequency, duration, and intensity of heat events. This is particularly challenging for older adults, outdoor workers, and individuals without access to reliable cooling.

HRI emergency department visits declined between 2016 and 2020 in the county, dropping from 32 ED visits per 100,000 to 15 per 100,000 in 2020. Following the COVID-19 pandemic, HRI emergency department visit rates in the county increased to 30 per 100,000 in 2024.

Figure 24. Rate of Heat-Related Illness ED Visits per 100,000, 2010–2024



Source: NC DETECT

Lead Exposure/Poisoning

Exposure to environmental toxins such as lead remains an important health risk. Lead exposure can occur through ingestion of lead-based paint chips, contaminated food or water, or breathing lead dust. There is no safe level of lead in the blood, and children are at greatest risk. Lead exposure in children can result in developmental delays, behavioral challenges, and difficulty learning.¹¹

The Centers for Disease Control, CDC, uses a blood lead reference value (BLRV) of 3.5 micrograms per deciliter (µg/dL) to identify children with blood lead levels above most children’s levels. Elevated blood lead levels are defined as a blood lead concentration of 5 micrograms per deciliter or greater. CDC estimates that nearly 500,000 children in the U.S. have levels of lead in their blood higher than the blood lead reference value.¹¹

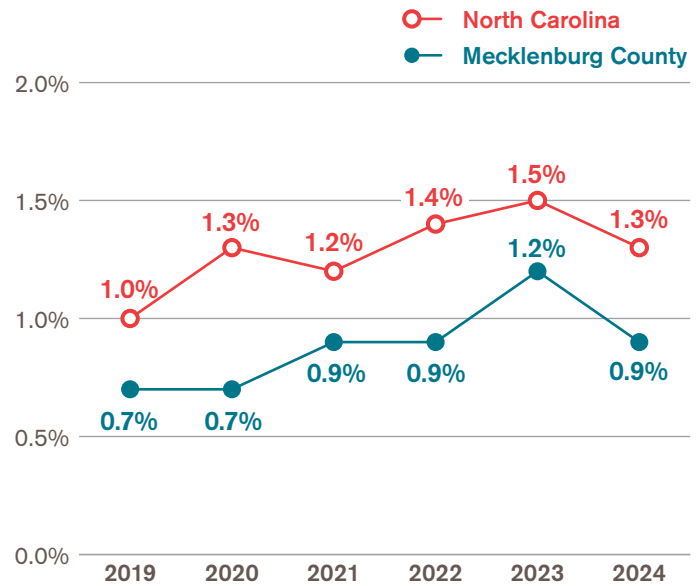
- In 2024 nearly 44% of Mecklenburg County children aged 12–36 months were tested for lead exposure with less than 1% or 112 children identified with elevated blood lead levels (BLL) ≥ 5 µg/dL. This marks a decline from 2023, when 150 children were identified with elevated blood lead levels.

Radon

The Environmental Protection Agency (EPA) identifies radon as the leading cause of lung cancer among nonsmokers and the second overall cause of lung cancer. This radioactive gas is odorless and colorless and occurs naturally in the environment.

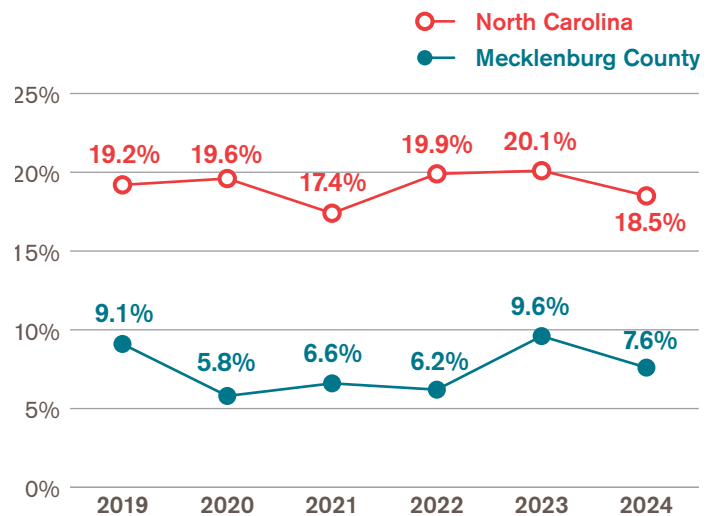
- To determine if mitigation should be performed, measured indoor air concentrations of radon are compared to the EPA action level of 4 pCi/L.

Figure 25. Percent of Children 12–36 Months Testing Positive for Elevated Blood Lead Levels, 2019–2024



Source: [NC Environmental Health Data Dashboard \(NC EHDD\)](#)

Figure 26. Percent of Buildings Tested with Elevated Radon Levels, 2019–2024



Source: [NC Environmental Health Data Dashboard \(NC EHDD\)](#)

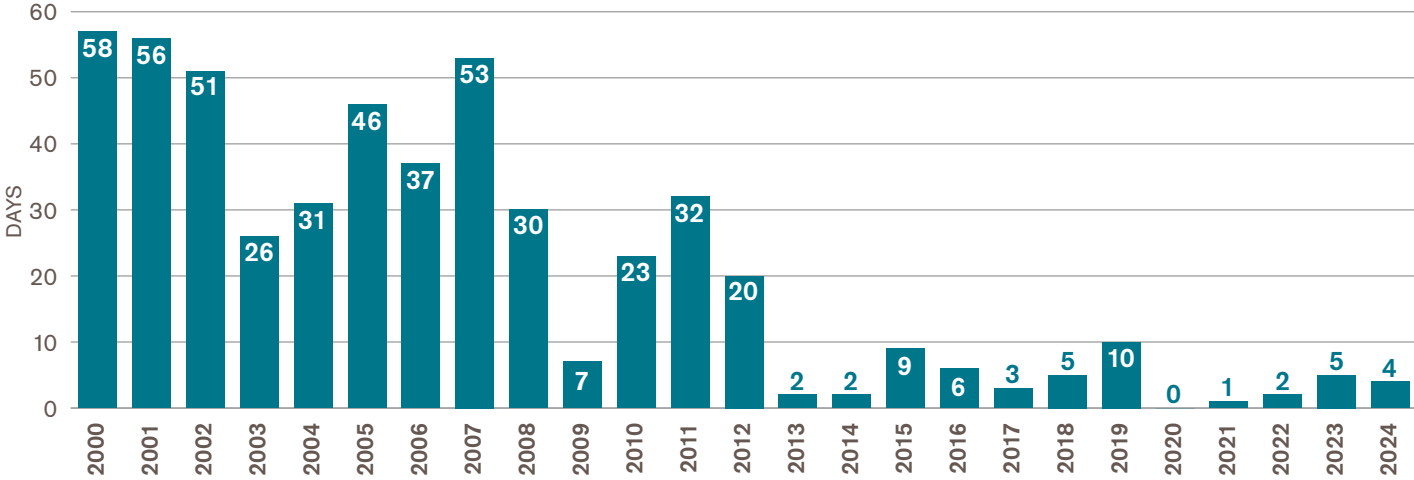


Air Quality: Ozone Days

Over the past decade, air quality in Mecklenburg County has improved due to regulatory standards and reductions in emissions.

- Ground-level ozone, a primary pollutant of concern for the area, has decreased dramatically. The number of days in the county exceeding national ozone standards declined from 71 days in 1999 to 4 days in 2024.

Figure 27. Annual Number of Days with Average Ozone Levels over National Standard, Mecklenburg 2000–2024



Source: [NC Environmental Health Data Dashboard \(NC EHDD\)](#)



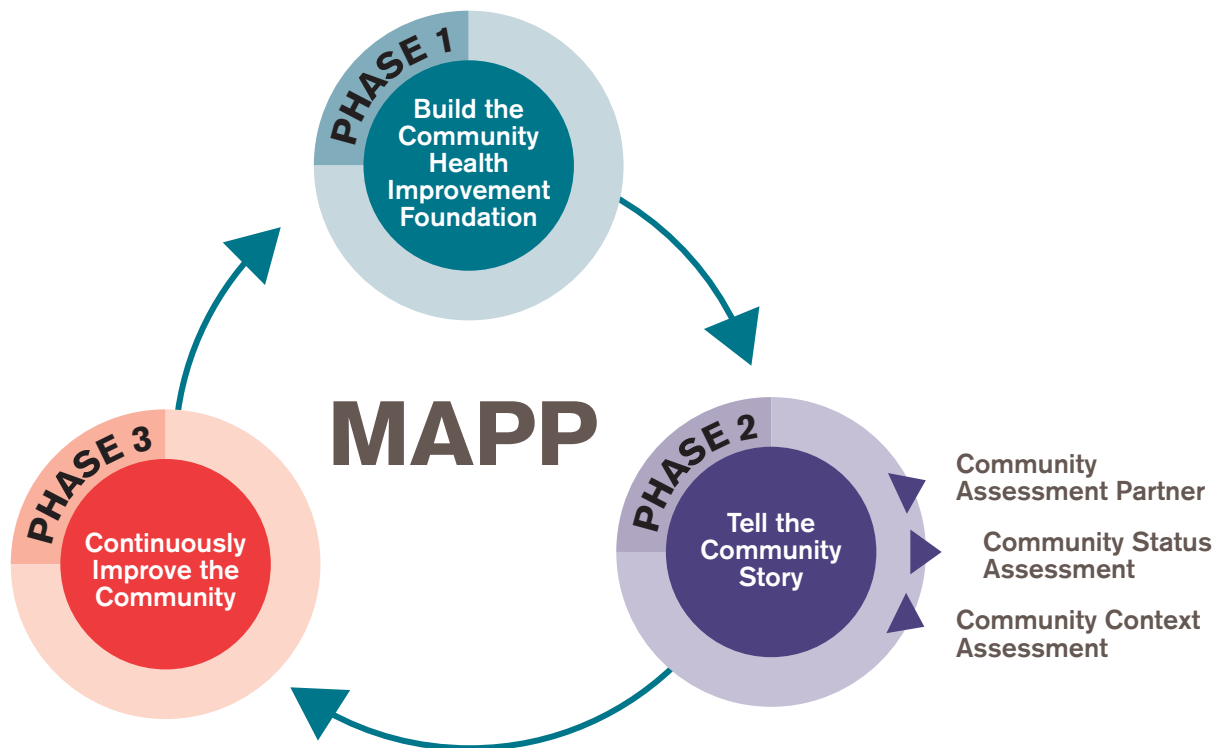
Chapter 2: **Our Process**

Our process describes how data, community voice, and partnership were brought together to develop a shared understanding of health and identify priorities for action. This chapter outlines the guiding frameworks, timeline, and methods for assessing community health and identifying action priorities.

Guiding Framework

The Mecklenburg Community Health Assessment (CHA) uses a modified version of Mobilizing for Action through Planning and Partnerships (MAPP) 2.0, developed by the National Association of County and City Health Officials.¹⁹ MAPP 2.0 provides a streamlined, three-phase approach to community health improvement:

1. Build a Community Health Improvement Foundation
2. Tell the Community Story
3. Continuously Improve the Community



Mecklenburg County adapted this framework to reflect the full scope of local assessment, engagement, and planning activities.

Phase 1: Build a Community Health Improvement Foundation

In Mecklenburg, this phase extended beyond partnership formation and includes establishing shared ownership of the assessment process. Activities included strengthening cross-sector partnerships through Live Well, aligning with existing strategic plans, identifying priority populations, and preparing the data infrastructure necessary to support transparent decision-making. This foundational work ensured that the assessment process was collaborative and positioned for action from the start.

Phase 2: Tell the Community Story

This phase reflected the core assessment work of the CHA. Mecklenburg's approach included a comprehensive *review of data*, quantitative and qualitative data, analysis of disparities, community engagement through focus groups, surveys, and events like Destination Wellness, which led to the *prioritization of findings* and broad communication of results. Data was contextualized by considering upstream drivers of health, such as economic stability, education, and housing, in relation to local outcomes. This phase ensured that the community's story was data-informed and grounded in lived experience centering a comprehensive strategy to *communicate findings widely*.

Phase 3: Continuously Improve the Community

In Mecklenburg, this phase bridges directly into Community Health Improvement Plan (CHIP) development and implementation. Findings from the CHA inform strategic action planning, measurable performance indicators, and shared accountability across partners. Continuous improvement is supported through the Results-Based Accountability (RBA) framework and transparent progress tracking through MECKtrics and public Clear Impact scorecards, ensuring that strategies are responsive and adaptive over time.

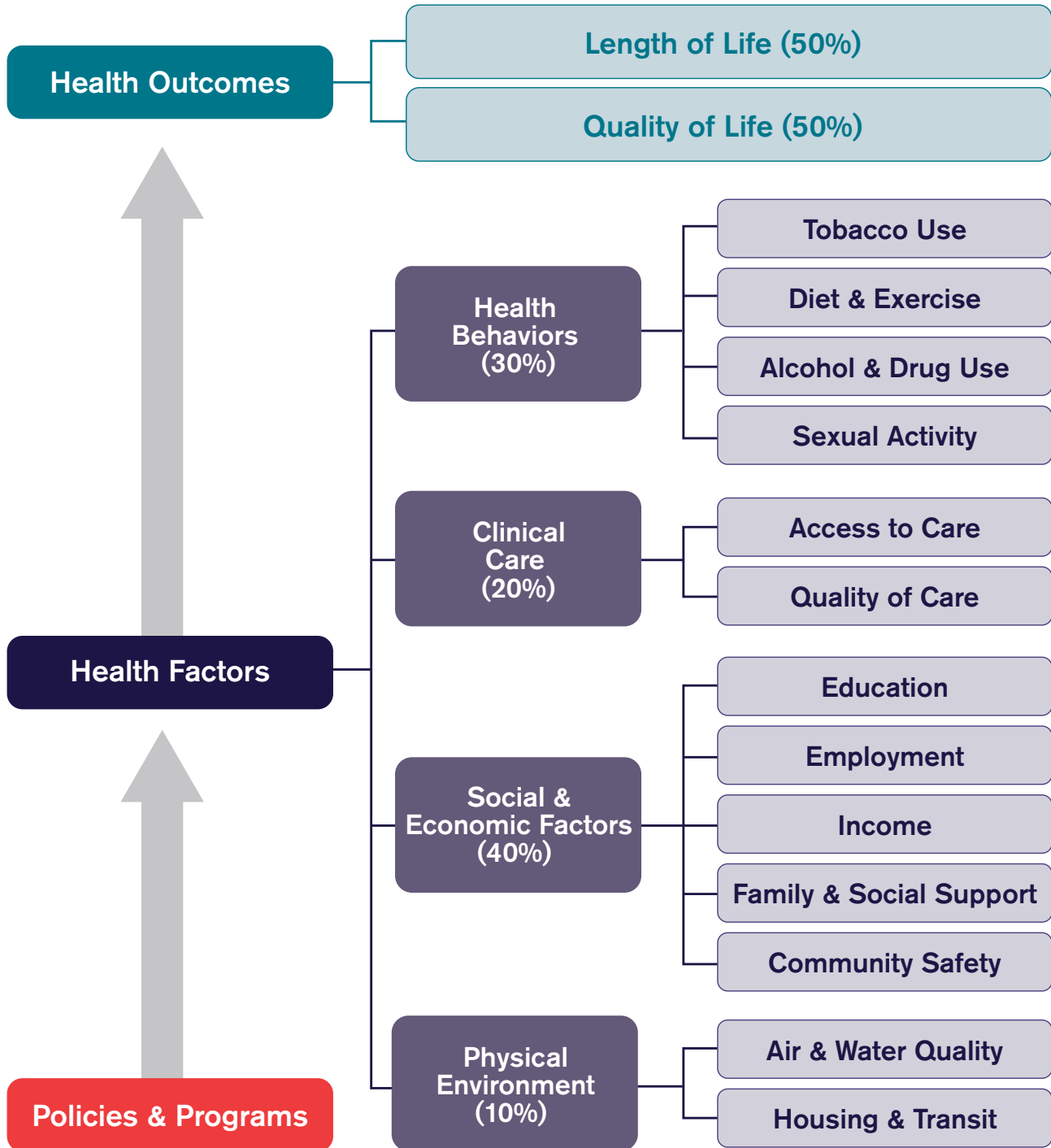
To further strengthen the assessment, Mecklenburg paired MAPP 2.0 with the original Health Model advanced by the Robert Wood Johnson Foundation²⁰ and the University of Wisconsin Population Health Institute County Health Rankings Model of Health. This connection will ensure that upstream social, economic, and environmental influences on health are clearly articulated and considered in future improvement strategies.

MAPP 2.0 Phase	Activity	Description
Phase II& III	Review Data	Gather and analyze primary and secondary data related to local health.
Phase II& III	Prioritize Findings	Conduct prioritization survey and host community event to finalize priority health issues
Phase II & III	Communicate Findings	Share findings from the CHA with local organizations and residents to support education, awareness, advocacy, funding, and program development including Conduct events like the Live Well Meck Tour, Meetings/ trainings; and disseminate the report through library catalogs, MCPH online scorecards and supporting tools, social media postings, and listserv mailings
Phases II & III	Action Planning	Host Meck Design annual CHIP planning and progress check event

**Phase III improvement is continuous and centered in all CHA activities.*

The 2025 CHA was conducted in alignment with North Carolina public health accreditation requirements and considers state and national improvement efforts, including [Healthy NC 2030](#),²¹ and [Healthy People 2030](#),²² led by the U.S. Department of Health and Human Services.

County Health Rankings Model



County Health Rankings Model ©2014 UWPHI

Timeline

Table 2. **Key Steps in the Mecklenburg County CHA Process**

Milestone	Summary	Date
Mecklenburg County BRFSS	Annual surveys to collect data on health-related risk behaviors, chronic conditions, and preventive services	February–April 2024
Live Well Meck Steering Committee Kickoff	Committee launched; 2025 CHA project charter and timeline established	August 15, 2024
Youth Photo Voice	Photo project with youth to gain insights into health challenges, assets, and opportunities	May–June 2025
Focus Groups	Groups with priority audiences to gain insights into health challenges, assets, and opportunities	May–August 2025
Meck Design 2025	Community CHA updates, CHIP progress check	June 2025
Prioritization Survey	Community survey to inform current health priorities	July–August 2025
Destination Wellness	Community meetings to finalize health priorities	September–October 2025
2024 SOTCH	Release of 2024 State of the County Health Report; BOCC meeting	October 2025
Live Well Community Tour	Tour to preview and disseminate CHA results	February–April 2026
CHA Public Release	Report release via digital and print formats	April 2026

Methods

The 2025 CHA used a mixed-methods approach to develop a comprehensive understanding of health and quality of life in Mecklenburg County. Combining quantitative and qualitative strategies allowed the assessment to identify population-level trends while capturing the lived experiences behind the data.

The CHA quantitative data review and compilation was led by the MCPH Epidemiology Program. The CHA data draws from primary and secondary data sources.

Quantitative

Primary data include information from the Annual Mecklenburg Health Survey, modeled on the CDC Behavioral Risk Factor Surveillance System (BRFSS).

Secondary data sources include but are not limited to North Carolina (NC) Vital Records, the NC State Center for Health Statistics, the National Center for Health Statistics, the Centers for Disease Control and Prevention (CDC), the Robert Wood Johnson County Health Rankings, and the US Census. Specific information on sources may be found in the report’s appendix.

The data presented in this report cover county demographics, birth outcomes, leading causes of death, and community health indicators for Mecklenburg County, peer counties and cities, municipalities within the county, and selected data points for priority health areas. The data review resulted in the identification of ten priority health areas of concern.

Mecklenburg County Behavioral Risk Factor Survey (Local BRFSS)

In addition to national and state surveillance data, Mecklenburg County Public Health conducts an annual local health survey to better understand health behaviors, conditions, and quality of life among county residents.

This survey complements the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) by:

- Providing county-specific estimates not available through state-level data
- Allowing for more timely trend analysis
- Including questions tailored to local priorities and emerging issues
- Supporting neighborhood- and population-level insight where sample size allows

The survey is conducted annually using standardized BRFSS methodology, with adaptations to reflect Mecklenburg County's population and information needs. Results are weighted to improve representativeness and are used throughout the CHA to complement other secondary data sources.

Qualitative

Qualitative methods were used to elevate community voices and provide context for quantitative findings. These strategies were intentionally designed to reflect best practices in community-based and participatory assessment.

Focus Groups

Focus groups were held with residents representing diverse ages, languages, identities, and lived experiences. Participants included youth and young adults, older adults, Spanish- and French-speaking residents, LGBTQIA+ individuals, and people experiencing housing instability or substance use challenges.

Discussions followed a semi-structured guide to explore access to care, preventive practices, and social conditions shaping health. The analysis focused on identifying cross-cutting themes shared across groups and population-specific nuances. This approach allowed the CHA to surface shared structural barriers while honoring distinct experiences.

Photovoice

To intentionally include youth perspectives, MCPH partnered with local organizations, Stratford Richardson YMCA and Teen Health Connections, to implement a Photo Voice project grounded in best practices for youth engagement.

Photo Voice is a qualitative method that empowers participants to document and reflect on their environments through photography and guided discussion. In this project:

- Youth were introduced to the purpose of the CHA, ethical considerations, and basic photography principles
- Participants captured images representing factors that influence health and well-being in their daily lives
- Facilitated group sessions provided space for youth to share stories, reflect on common themes, and connect images to broader community conditions
- Youth worked collectively to identify key themes and priorities reflected in their photographs

This approach prioritized youth voices, encouraged thoughtful reflection, and ensured that findings were shaped by youth rather than adults.

Data Integration and Synthesis

Quantitative and qualitative findings were analyzed independently and then integrated to develop a more complete understanding of community health. This process allowed lived experience to inform trend interpretation and ensured that data were grounded in a real-world context.

Findings were reviewed with internal and external partners to support accuracy, relevance, and shared understanding.

Community Meetings/Engagement

Destination Wellness

Following Meck Design, two smaller convenings titled *Destination Wellness* served as a follow-up session to maintain momentum and provide stakeholders with a snapshot of the Community Health Assessment (CHA) cycle. These sessions were designed to share updates that fostered engagement and strategic dialogue among stakeholders to support the development of the Community Health Improvement Plan (CHIP). A total of 111 participants registered across both sessions. Seventy-one registrants attended the in-person session at the Valerie C. Woodard Center on September 26, 2025, and forty participated in the virtual lunch-and-learn on October 29, 2025.

Meck Design 2025

On June 11, 2025, the second Meck Design was hosted at the Harris Conference Center on the campus of Central Piedmont Community College. The large-scale community convening hosted more than 275 community members, organizations, and health professionals. The event featured a data walk and priority-centered breakout sessions that highlighted insights and trends, and strategic progress. The event's interactive format enabled participants to engage in meaningful discussions that led to innovative strategies to address the community's health disparities.



Limitations and Gaps

While this CHA brings together a robust mix of quantitative data and lived experience, it does not capture *every* perspective or condition shaping health in Mecklenburg County. Some populations remain underrepresented in available data, and certain issues require more timely or localized information than existing systems can provide.

Several limitations should be considered when interpreting the findings in this assessment. Participation in qualitative methods varied by group, and not all populations or experiences are fully represented. Qualitative findings are not intended to be statistically generalizable but provide important context and depth.

Secondary data sources may be subject to reporting delays or gaps, and survey-based data may be affected by response bias. To mitigate these limitations, multiple data sources were used, and findings were triangulated where possible.

Additional data gaps include limited neighborhood-level data, inconsistent representation of smaller population groups, and individuals who are more disconnected from systems. Addressing these gaps is an ongoing priority for MCPH and Live Well partners. The CHA is not a one-time snapshot, but part of a continuous learning process.

The next chapter, Our Findings, presents the results of this work and highlights key trends, themes, and opportunities to improve health and well-being across Mecklenburg County.



Chapter 3: Our Findings

Mecklenburg County is more than its challenges. It is a community rich in relationships, cultural diversity, civic engagement, and institutional capacity. From neighborhood networks to greenways and expanding access to care, these bright spots reflect strengths already present in the community to help shape a healthier future.

Community Asset & Bright Spots

| Relational Capital and Narrative Power

The strength of relationships, lived experience, and community voice

Mecklenburg County's greatest asset lives in its people and their relationships. Across CHA engagement, residents spoke candidly about barriers, fear, discrimination, and frustration, but also demonstrated trust in one another, cultural pride, and a willingness to name solutions and be a part of their implementation. The willingness to speak, organize, and propose solutions reflects strong relational capital.

In Mecklenburg County:

- **Multigenerational households** provide informal caregiving and economic support
- **Faith communities** serve as trusted hubs for food distribution, health messaging, and other related resources
- **Cultural networks** create an informal safety net

Relational capital reduces isolation, supports resiliency, and increases readiness for collective action to tackle complex community health issues.



| Social Infrastructure

Institutions, civic spaces, and coordinated systems that create access to opportunity and well-being

Public libraries offer more than books. Mecklenburg County's 23 libraries provide access to technology, safe gathering spaces, and trusted locations for information sharing. Libraries also provided public Wi-Fi, educational programming, and community meeting space, making them critical to the community's social infrastructure.²³

| Built Environment & Infrastructure

Physical spaces that shape opportunities for health

Built environment is a strong determinant of health. The presence of accessible green space and recreation infrastructure supports mental health, physical activity, and community cohesion. Mecklenburg County is home to 290 parks and facilities on more than 22,500 acres of parkland serving residents from youth to seniors.²⁴

Mecklenburg County greenways are multi-use trails that connect neighborhoods, parks, schools, and more, creating accessible spaces for walking, biking, and outdoor recreation while also supporting environmental stewardship. The current greenway system includes but is not limited to:

- 82.5 miles of green trails
- 25.5 miles of greenway access trails
- 30.4 miles of urban trails
- 78.2 miles of nature preserve trails
- 225.5 miles of park trails²⁵





| Access to Care Innovation

Bright spots in expanding care beyond traditional clinical walls

Mecklenburg County is building momentum in expanding access to care beyond traditional clinical settings. A key bright spot is the growing investment in Community Health Workers (CHW) and related workforce development strategies that bridge community, clinical systems, and social support.

The Queen City Community Connect Coalition (QC4) was established to unify, equip, and empower CHWs across organizations in Mecklenburg County. The coalition provides a collaborative forum where CHWs share best practices, build professional networks, and elevate their experiences to strengthen community impact.

Investments in Mobile health and dental units have been made across local nonprofit organizations, health systems, federally qualified health centers, and the public health department to bring care directly to neighborhoods.

Mobile units allow the delivery of health screenings, immunizations, and health education to meet residents where they are. These units are increasingly being used to reduce transportation barriers, minimize missed appointments, and extend services beyond traditional brick-and-mortar facilities.



Youth Photo Voice

| Purpose

Mecklenburg County youth have not historically engaged in past CHA processes. To address this, the Live Well Steering Committee partnered with local organizations, including the Stratford Richardson YMCA, Teen Health Connection, and UNC Charlotte to engage youth in a Photo Voice Project.

This innovative approach allowed participants to creatively share their lived experiences and identify the public health priorities that matter most to them. Through these partnerships, we gained valuable insights directly from youth, helping guide more inclusive and responsive public health planning.

| Methodology

Youth selected to participate in the Photovoice Project were enrolled in the Stratford Richardson YMCA Teen Leaders and Teen Health Connection Programs. Participants were introduced to the project by a guest facilitator who highlighted photography tools, photo voice best practices, and the project's purpose.

Over four weeks, leading organizations hosted one-hour sessions to provide technical support, review collected photos, identify common themes, and share lived experiences amongst participants.

Project coordinators used Google Photos to share participant photos. Participating youth presented photo galleries at the conclusion of the project to share their experiences and common public health issues impacting their families, friends, and communities. Youth discussed collective galleries to identify youth-centered health priorities and themes to include in the CHA.

Key Themes Identified

1. Safety in Schools and Community:

- Youth emphasized the importance of seeking safety in schools and the need for effective communication with parents about potential threats.
- Safety concerns extended to various locations and common areas within their communities, underscoring the need for secure environments.

2. Self-Care and Mental Health:

- The significance of self-care practices was a prominent theme, with youth recognizing the need to prioritize their mental and physical well-being.
- Expanding awareness around mental health, disability rights, and accommodations was highlighted as crucial for fostering a supportive environment.



The photo above captures what a youth photo-voice participant described as a “moment of freedom.”



This photo captured by a project participant showcases what they described as a reminder of how history serves as a source of inspiration.



The above photo captures what a participant described as a place that brings peace and calm.



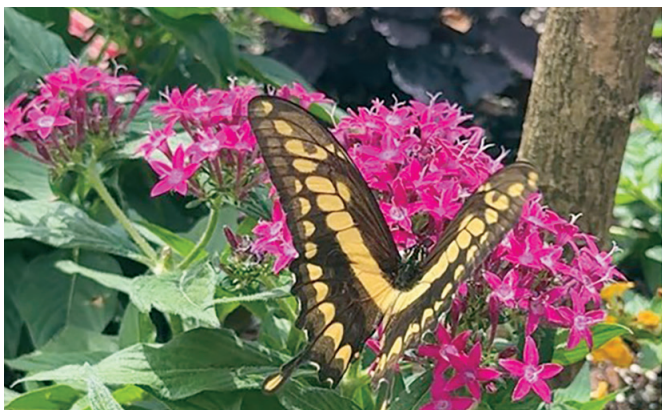
The photo captures what a participant described as community support and collaboration among YMCA youth leaders.

3. Community Support and Collaboration:

- Youth stressed the value of community support and the power of working together to address common challenges, i.e., belonging, achieving school success, and mental health.
- Inclusivity and establishing a sense of belonging at schools were identified as essential for creating a cohesive community.

4. Environmental Connection:

- The environment and the importance of connecting with nature, parks, and green spaces were recurrent themes.
- Youth advocated for environmental cleanup efforts and the preservation of natural spaces.



A participant captured an image of a butterfly to represent nature's peacefulness.

5. Cultural Growth and Artistic Expression:

- A culture shift and growth were noted, with students expressing the need for art and creativity as vital outlets for expression.
- Festivals and cultural events were seen as opportunities to celebrate diversity and foster community spirit.



The photo shows graffiti covering a utility box, described by a participant as a form of artistic expression.

6. Health and Nutrition:

- The importance of food, particularly fresh fruits and vegetables, was highlighted in relation to chronic disease prevention and the benefits of home-cooked meals.
- Teen health issues, including smoking and pregnancy, were highlighted emphasizing the need for education and support.



The photo above captures what a participant described as inspiration for advocacy and activism during a visit to the National Center for Civil and Human Rights.

7. Physical Fitness and Accessibility:

- Exercise and physical fitness were recognized as important for overall health.
- Accessibility to food, healthcare, services, education, recreation, and entertainment was a recurring concern.

8. Advocacy and Affirmation:

- Advocacy and affirmation were central themes, with students calling for greater support and recognition of their voices and experiences.
- Addressing homelessness and ensuring that all individuals have access to basic needs were also highlighted.



Youth hosted community activities at the Stratford Richardson YMCA and Teen Health Connection to present findings to peers, community leaders, parents, and others, describing perceptions of health through their lenses.

A full youth photo voice gallery is available on the Mecklenburg County Public Health Live Well website.

Focus Groups

To complement quantitative data and better understand how residents experience health in their daily lives, Mecklenburg County partnered with Common Good Data to conduct 8 focus groups with priority populations from May to September 2025. **A total of 53 Mecklenburg residents participated in focus groups, representing approximately 6–7 individuals per group.**

Priority populations were identified by the Live Well Steering Committee and Community Advisory Network in partnership with Mecklenburg County Public Health. Adult participants were recruited in partnership with trusted community organizations to ensure diverse representation of priority group areas.

Focus Group Priority Populations and Locations

Audience	Location
Young Adults	Virtual
Older Adults	Senior Center, Virtual
Spanish Speakers 1	County Library
Spanish Speakers 2	Virtual
French Speakers	Recreation Center
Meck County-General	Virtual
LGBTQIA	Virtual
Substance Use / Homelessness	Community Partner Agency

Focus group discussions followed a structured guide designed to explore residents' experiences of health and well-being. The discussion guide was intentionally open-ended to prompt sharing. Follow-up questions were used to probe for examples and clarify points. Two focus groups were conducted in Spanish, and a third was conducted in a mix of French and English.

Following the focus groups, written transcripts were prepared for analysis. Transcripts were reviewed to determine themes and shared experiences. While each group reflected distinct lived experiences, the discussions revealed consistent, cross-cutting themes that shape access to health and well-being across the county.

Results are organized by core themes that reflect shared experiences across age, language, identity, and socioeconomic status. Additionally, experiences by population groups are provided. Together, these voices provide context and meaning to the data presented throughout the report.

Cross-cutting Themes

1. Access to Affordable, Timely, and Respectful Health Care

Across all focus groups, residents described difficulty accessing affordable, available, and dignified care. High out-of-pocket costs, insurance gaps, long wait times, and experiences of being dismissed or rushed by providers were common. These barriers often led residents to delay care or rely on emergency departments, worsening health outcomes and eroding trust in the health system.

Participants frequently described being caught in eligibility gaps, earning too much to qualify for assistance but not enough to afford insurance or care.

“I feel like a lot of people are struggling that are in this weird economic bracket where they set the bar so low to where you can’t qualify to get help. But at the same time, you can’t really afford the insurance as well. So that’s another issue. Not being able to get insurance because you ‘make too much’, but you’re still struggling.”

– Young Adult Participant

Also, limits on household income were repeatedly shared as a barrier to accessing care. In the Spanish language group, when asked about health, one participant responded:

“Yo pienso lo económico, eso es lo primordial, la falta de ingreso.

I think the economic part is the main thing. It’s the lack of income.”

– Spanish-language Participant

Limited clinic availability, difficulty accessing specialists, and restrictive office hours further constrained care, particularly for working families, Medicaid recipients, and residents without reliable transportation.

2. Language, Communication, and Technology Barriers

Communication challenges emerged as a major barrier to care, extending beyond language alone. Participants described difficulty understanding medical terminology, navigating online portals, and accessing reliable information by phone. These issues were especially pronounced for older adults, individuals with disabilities, and residents with limited English proficiency.

“People assume that everybody has the internet and email and have moved away from paper. So there needs to be a continuation of printed resources.”

– Older Adult Participant

“Todo es un website, todo es a través de la tecnología. Y tú tienes muchos Latinos que ya están sobre los 65 años. Pero para entrar al portal tienes que crear un usuario, tienes que crear una clave. Tienes que... Aquello lo hace. Realmente... Es difícil.

Everything is a website, everything is done through technology. And you have many Latinos who are over 65 years old. But to access the portal, you have to create a username, you have to create a password. You have to... That does it, really... It’s difficult.”

– Spanish Speaking Participant

Phone systems were described as impersonal and ineffective, contributing to frustration and feelings of abandonment:

“I have spent like basically the whole day on, on hold. And somebody finally told me that they have one person that works there. You know... I have a mobility problem and I can’t go stand in line. And I’m, I’m trying to do it, you know, from the phone. And they also have an option where, you know, you can hit a number and they’ll call you back. They don’t call me back, I mean, so... and I’ve been trying to do this for weeks. I just feel like... nobody cares really is the bottom line, is how it feels.

– General Participant

For Spanish and French-speaking residents, lack of interpreters, and lack of dialect-appropriate interpretation, created mistrust and confusion:

“A lot gets lost in translation. The translators don’t know our health conditions.”

– French-speaking Participant

Participants emphasized that effective communication is not only about language, but also about how, where, and through whom information is shared.

3. Unmet Mental Health, Dental, and Other Care Needs

Mental health was consistently identified as a critical and unmet need across all groups. Participants described stigma, limited provider availability, lack of culturally responsive services, and high costs as barriers to seeking care.

“In Africa we think of mental health as ‘crazy.’ But really, we have trauma.”

– French-speaking Participant

“Nosotros como hispanos venimos pensando que solamente podemos tener ayuda si estamos ‘locos’.

We as Hispanics have come to believe that we can only get help if we are ‘crazy’”

– Spanish-language participant.

Several participants shared stories of delayed or fragmented mental health care with serious consequences, underscoring gaps between crisis response and long-term treatment.

Dental care was also widely described as inaccessible due to cost, despite its clear connection to overall health. One participant described being quoted a \$15,000 cost for a procedure to treat an aching tooth. Another focus group participants shared that many medical problems stem from poor dental care, acknowledging that a lack of dental care often leads to other health complications.

Participants called for expanded access to affordable, community-based services in both mental and dental health care delivered in ways that reflect their cultural values and lived experiences.

Other unmet needs included reproductive and sexual health services, vision care, maternal health support, and gender-affirming care, particularly for LGBTQIA+ residents and undocumented women.

4. Discrimination, Exclusion, and Mistrust

Experiences of bias based on age, race, accent, sexual orientation, gender identity, or immigration status were shared across multiple focus groups. These interactions contributed to avoidance of care and long-term mistrust of institutions.

“It doesn’t feel good when you’re not taken seriously.”

– Youth Participant

LGBTQIA+ participants described subtle but harmful forms of stigma during routine care including shame for requiring specific tests or procedures.

Immigrant participants described fear tied to the broader political climate, noting that concerns about surveillance or enforcement can deter families from seeking even basic services.

5. Difficulty Navigating the Health System

Many residents described the health system as complex, fragmented, and difficult to navigate without assistance. Insurance rules, appointment scheduling, and paperwork were frequently cited as overwhelming, particularly during illness or crisis.

“You just want somebody to talk to so that you’ll get to the right person first.”

– Older Adult Participant

Across groups, participants emphasized the need for trusted navigators: community health workers, case managers, or social workers, who can help residents understand options and stay connected to care.

“I think everybody should have their own caseworker. At least come out there and check on me. Everybody needs their own caseworker. They need someone out there to come and say, hey, I’m thinking about you today.”

– Substance Use and Homelessness Participant

They also highlighted that mobile clinics or other examples where health care providers came to visit communities who are unhoused or using substances would be very beneficial for their community to help navigate systems of care.

6. Need for Culturally Responsive, Community-Based Care

Participants consistently expressed a desire for care that reflects their cultural norms, identities, and lived experiences. Community-based models such as promotoras, peer navigators, mobile clinics, and services delivered through schools, churches, and senior centers were viewed as more accessible and trustworthy.

For LGBTQIA+ residents, access to gender-affirming and affirming preventive care was identified as a priority. Immigrant communities emphasized bilingual providers and culturally specific outreach as essential to improving engagement and outcomes.

7. Gaps in Education and Preventive Care

Across focus groups, residents described gaps in awareness about preventive services, eligibility, and where to obtain care. Participants cited limited outreach around vaccinations, screenings, chronic disease prevention, and sexual health, particularly when information was not culturally tailored.

Youth participants called for clearer, age-appropriate health education, while immigrant communities emphasized prevention strategies that can be practiced at home and in community settings.

8. Social Determinants of Health as the Context for Care

Health was consistently discussed alongside housing stability, transportation, food access, and neighborhood conditions. Participants emphasized that without addressing these underlying factors, improvements in health care access alone will be insufficient.

Housing emerged as the most urgent concern for people experiencing homelessness or substance use, while transportation barriers were especially impactful for older adults and people without cars.

“I don’t drive because of my condition, so now I have to find a way to get to the places.”

– Older Adults participant

“Housing is the biggest issue... if you can fix the housing crisis, a lot of things fall under that whether that be depression, just people having a place to even shower.”

– LGBTQIA+ Participant

| Themes by Population

Youth and Young Adults

Youth and young adults consistently described feeling dismissed or not taken seriously by health providers. Participants noted that health systems often focus on children or older adults, leaving young people in a gap with limited age-appropriate services and outreach.

Transportation and the county's car-centric design were cited as barriers to physical activity and preventive care, particularly for those without access to a vehicle. Rising food costs and limited access to affordable, healthy options also shaped daily health decisions.

“When I think about health in my community, I think about how there is lack of sidewalks for individuals to actually walk. You know, some people do have transportation as far as vehicles, but not everybody has a vehicle to actually have access to get to walking trails or get to tracks or rec centers or things of that nature, or even get to the park.”

– Youth participant

Key takeaway:

Youth want inclusive, respectful care environments, improved access to preventive education, and community design that supports physical activity and healthy living.

Older Adults

Older adults emphasized transportation, communication, and technology as primary barriers to accessing care. Many reported difficulties navigating online portals, phone systems, and appointment scheduling processes, particularly during times of illness or distress.

Social isolation emerged as an underlying concern, with senior centers and trusted community spaces playing a vital role in connecting older adults to information, services, and social support.

Key takeaway: Older adults benefit from person-centered communication, transportation support, and in-person navigation assistance embedded in familiar community settings.

Spanish-Speaking Residents

Spanish-speaking participants highlighted insurance gaps, legal status, and language access as central barriers to care. Undocumented status and income thresholds often excluded residents from Medicaid and other assistance programs, creating fear and uncertainty around seeking care.

Interpreter availability and dialect differences further complicated care experiences, particularly for Indigenous-language speakers. Participants expressed a strong preference for promotoras and bilingual community health workers who understand the cultural context and can guide families through the system.

Key takeaway: Trust, language access, and culturally rooted navigation are essential to improving health outcomes for Spanish-speaking communities.

French-Speaking Residents

French-speaking participants described challenges related to documentation status, interpretation quality, and unfamiliarity with the U.S. health system. Dialect mismatches in interpretation and reliance on impersonal systems contributed to mistrust and miscommunication.

Participants also expressed fear of unpredictable medical costs, which discouraged use of emergency services even when care was urgently needed.

Key takeaway: Linguistically accurate interpretation and trusted navigators are critical to ensuring safe, timely care for French-speaking residents.

LGBTQIA+ Residents

LGBTQIA+ participants emphasized challenges accessing gender-affirming, reproductive, and preventive care in environments that feel safe and respectful. Experiences of subtle stigma and lack of provider knowledge led some residents to avoid care altogether.

Participants also highlighted gaps in preventive education, including awareness of PrEP, HPV, Mpox vaccines, and appropriate screenings for transgender individuals.

Key takeaway: Inclusive provider training, affirming care environments, and targeted preventive education are essential to reducing disparities for LGBTQIA+ residents.

Residents Experiencing Substance Use and/or Homelessness

For participants experiencing substance use or homelessness, housing instability emerged as the most urgent health issue. Long waitlists, application fees, and eligibility requirements kept many residents in unsafe conditions that directly worsened physical and mental health.

Participants emphasized the importance of caseworkers, mobile clinics, and street-based outreach to help navigate care, manage chronic conditions, and reduce reliance on emergency departments.

Key takeaway: Stable housing, mobile care models, and intensive navigation support are foundational to improving health outcomes for this population.

General County Residents

Participants from the general county focus group echoed many cross-cutting concerns, including rising health care costs, difficulty accessing specialists, and frustration with impersonal systems. Several noted disparities in the availability of health-promoting resources across neighborhoods.

Key takeaway: Perceived inequities in neighborhood resources and service distribution influence residents' trust and engagement with the health system.

Community Health Status and Trends

| Access to Care

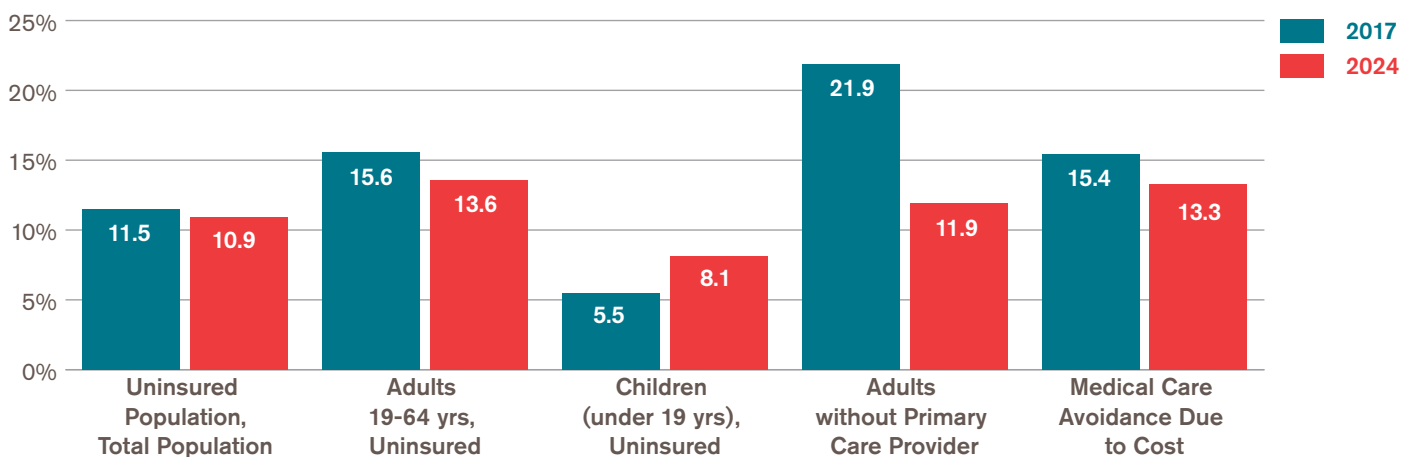
Healthy People 2030 emphasizes the importance of primary care as a foundation for health, noting that “Primary care providers offer a usual source of care, early detection and treatment of disease, chronic disease management, and preventive care.” People who have a usual source of care are more likely to receive recommended preventive health services, including vaccinations, blood pressure, and cancer screenings.

Access to care refers to whether people can get the health services they need when they need them. Mecklenburg County's Access to Care efforts define access through three key areas:

- 1. Financial Access-** whether individuals have insurance or financial resources needed to afford care
- 2. Geographic Access-** whether healthcare providers and services are available within a reasonable distance of where people live
- 3. Functional Access-** whether systems are easy to use, including factors like appointment availability, transportation, language access, and the ability to navigate the health system

Together, the following indicators provide a snapshot of how well residents are connected to care and where barriers remain.

Figure 28. **Access to Care Summary Health Indicators**

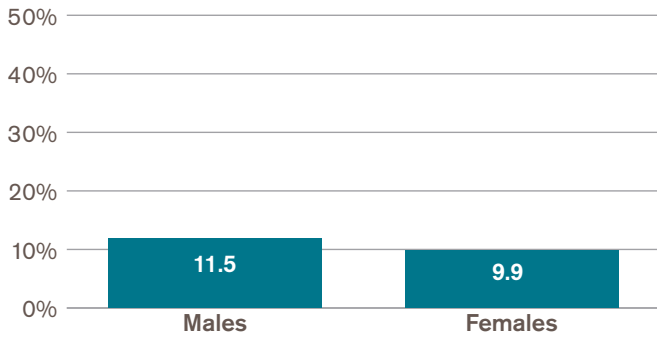


Source: US Census, ACS 1-Year Estimate, Mecklenburg BRFSS, [Children's Health Care Report Card](#)

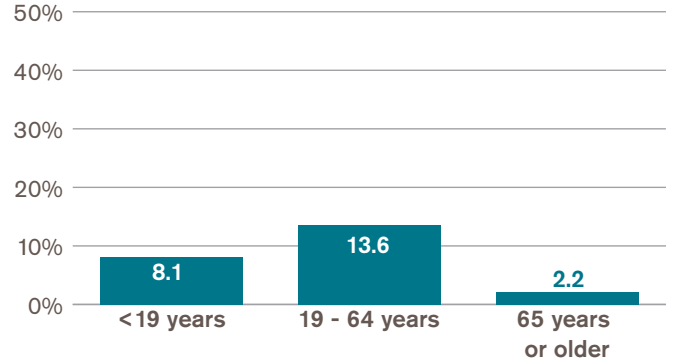
Note: The recent increase in uninsured children is largely attributed to the end of pandemic Medicaid protections and the return of eligibility reviews, with some children losing coverage due to paperwork and administrative barriers.

Figure 29. **Uninsured Percentage by Population Groups, Mecklenburg 2024**

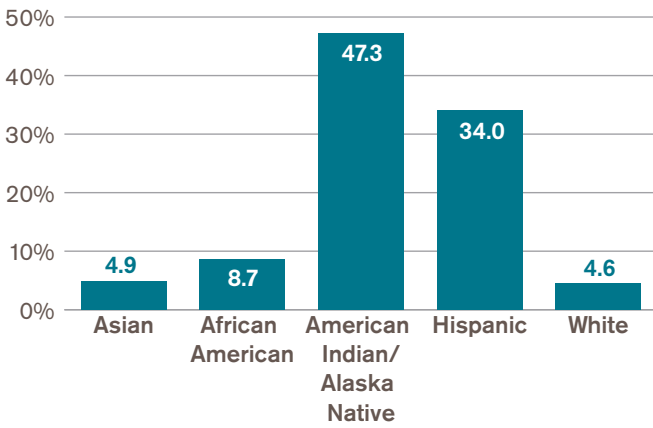
GENDER



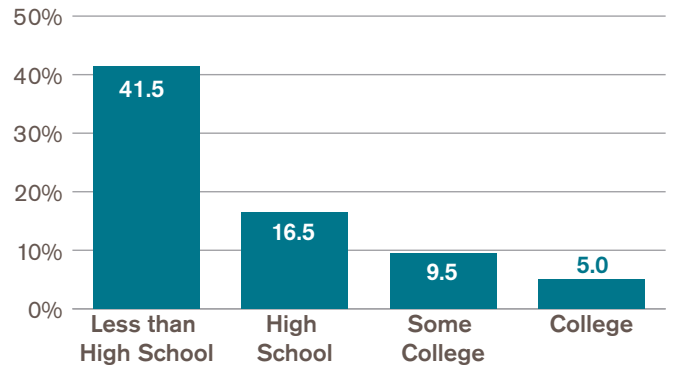
AGE



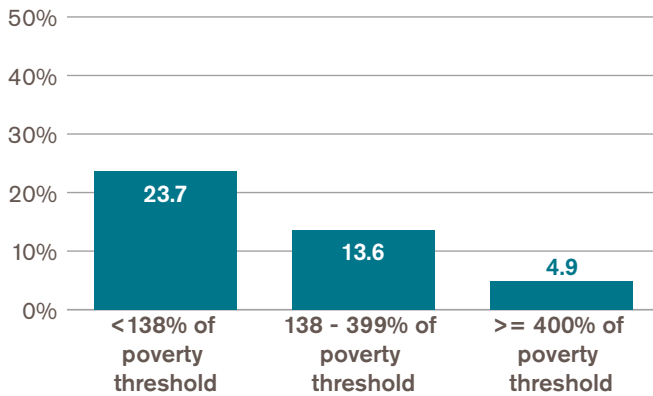
RACE/ETHNICITY



EDUCATION

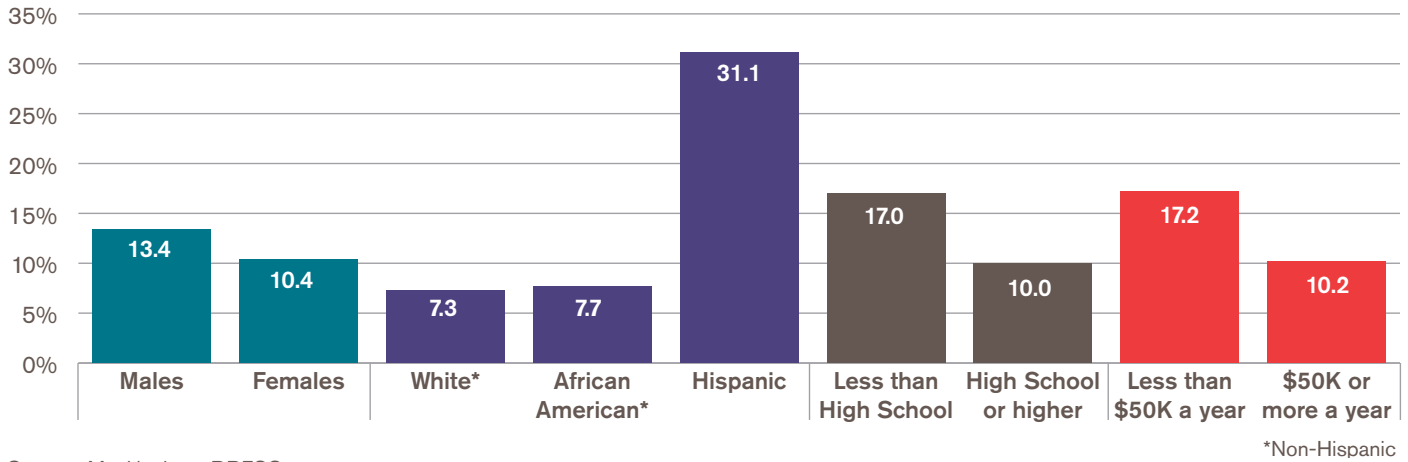


INCOME



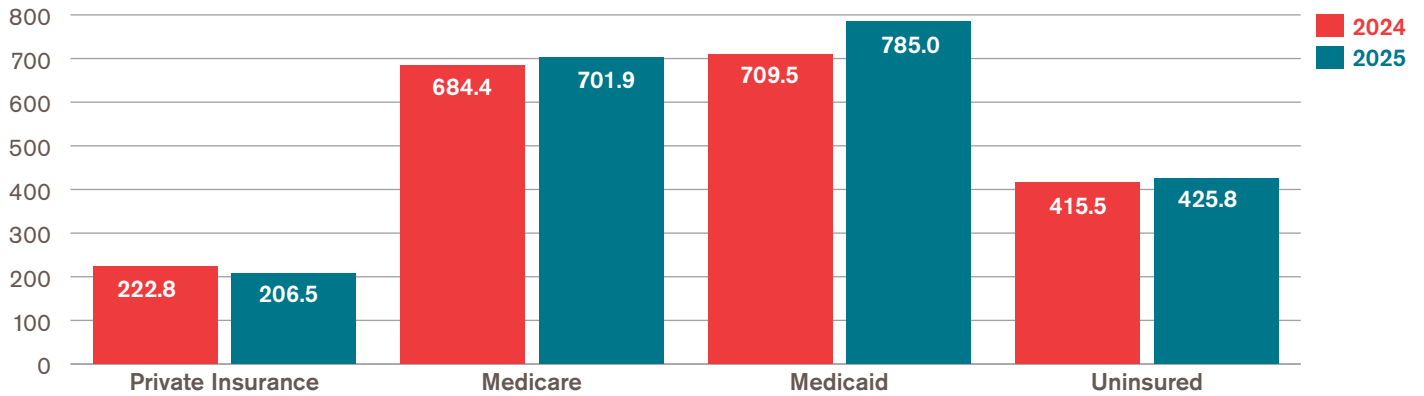
Source: US Census, ACS 1-Year Estimate

Figure 30. **Percent Adults Without Primary Care Provider by Demographics, Mecklenburg 2024**



Source: Mecklenburg BRFS

Figure 31. **Rate of ED Visits per 1,000 by Expected Source of Pay, Mecklenburg 2024 and 2025**



Source: NC DETECT

Chronic Disease

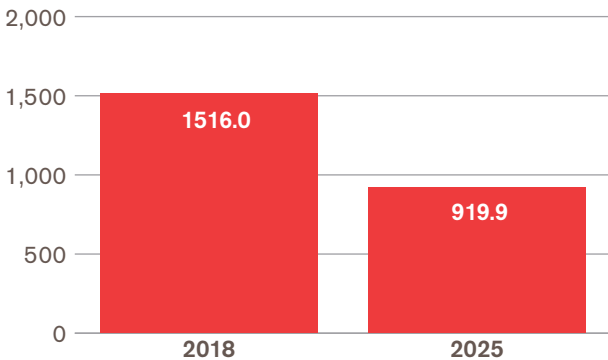
Chronic diseases are long-lasting health conditions that often develop over time and can significantly impact quality of life and life expectancy.

Many of the most common chronic diseases are influenced by factors such as tobacco use, diet, physical activity, and environmental conditions. Because chronic disease conditions account for a large share of illness and death in the community, prevention efforts that promote healthy behaviors and supportive community environments are critical.

The following indicators highlight disease patterns in our community and provide important context for understanding health risks, prevention opportunities, and areas where focused interventions may improve long-term health outcomes.

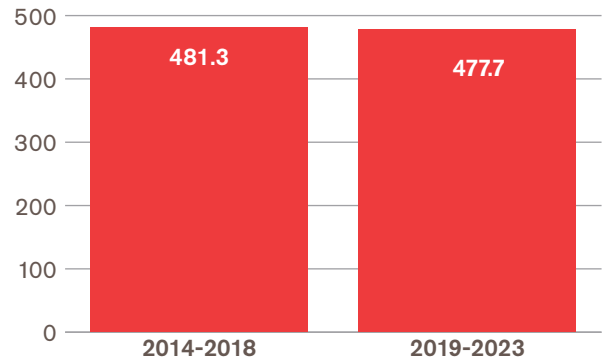
Chronic Disease Summary Health Measures

Figure 32. **Rate of Asthma-Related ED Visits in Children (less than 18 yrs) per 100,000, Mecklenburg**



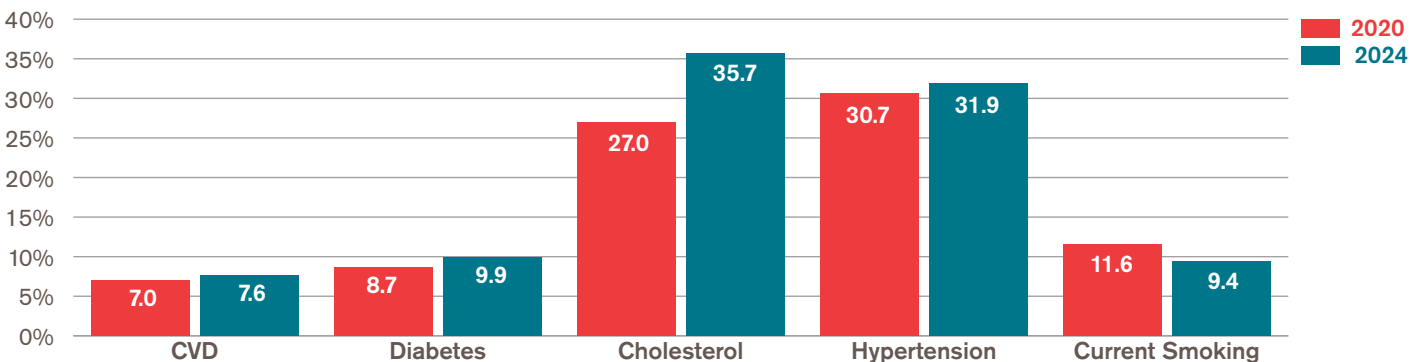
Source: NC DETECT; US Census, ACS 1-year Estimate

Figure 33. **Age-adjusted Cancer Incidence per 100,000, Mecklenburg 2014–2023**



Source: NC DHHS, SCHS

Figure 34. **Percent Prevalence of Chronic Conditions and Risk Factors in Adults, Mecklenburg 2020–2024**



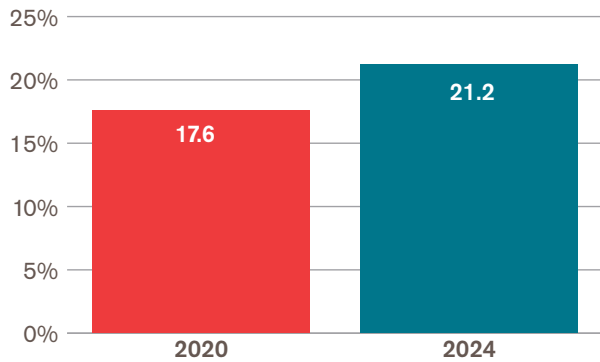
Source: Mecklenburg BRFSS

Mental Health

Mental health is a critical component of overall health and well-being. Conditions such as depression, anxiety, and other mental health challenges affect how people think, feel, and interact with others. Mental health is shaped by many factors, including life experiences, social connections, economic stability, and community environments. The following data summarizes local mental health trends.

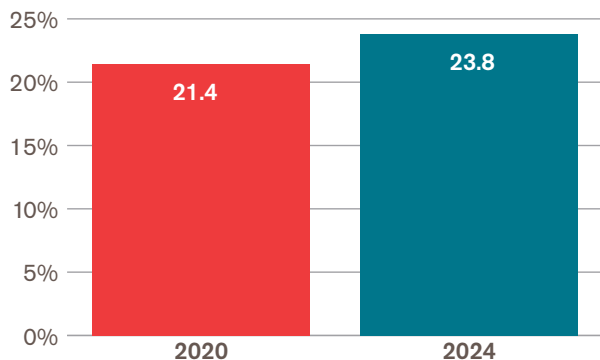
Mental Health Summary Measures

Figure 35. **Percent of Mental Health Days “Not Good” for 8 or more days in Adults (18 years or older), Mecklenburg**



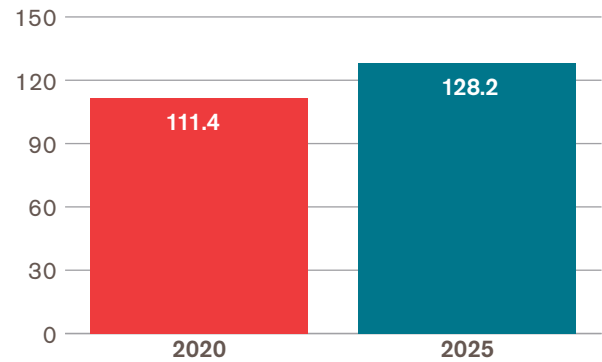
Source: Mecklenburg BRFSS

Figure 36. **Percent Prevalence of Depression in Adults (18 years or older), Mecklenburg**



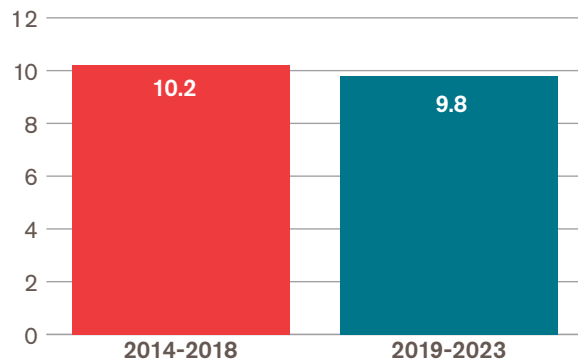
Source: Mecklenburg BRFSS

Figure 37. **Rate of ED Visits per 100,000 for Suicide Attempts in Children (<18 years) per 100,000, Mecklenburg**



Source: NC DETECT; US Census, ACS 1-year Estimate

Figure 38. **Age-adjusted Suicide Rates per 100,000 (5-year average), Mecklenburg**



Source: NC DHHS, SCHS

Violence Prevention

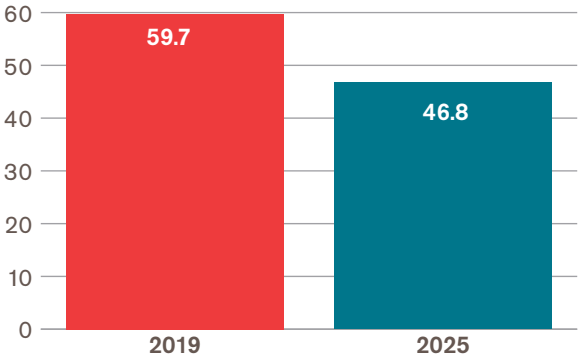
Violence is a significant public health issue that affects the safety, health, and well-being of individuals and communities. Exposure to violence can have lasting impacts on physical health, mental health, and community stability.

Many factors influence the risk of violence, including social and economic conditions, community environments, and access to supportive resources and opportunities.

The following data helps identify community patterns, populations most affected, and opportunities for prevention strategies that support safer and healthier communities.

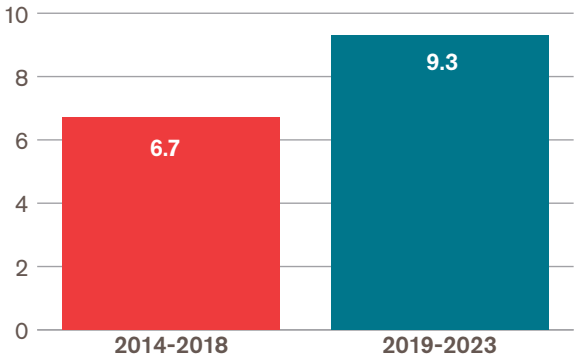
Violence Prevention Summary Measures

Figure 39. **Rate of Emergency Department Visits for Firearms and Gun Shot Wounds per 100,000 population, Mecklenburg**



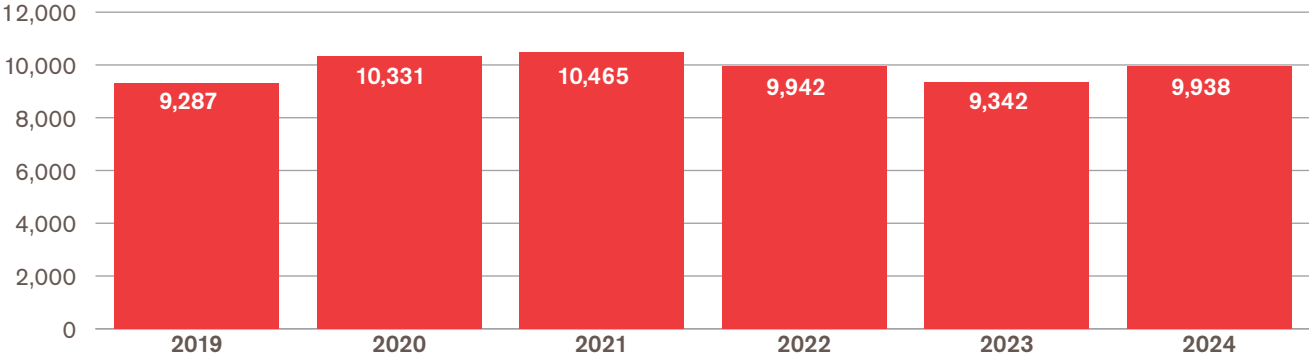
Source: NC DETECT

Figure 40. **Age-adjusted Homicide Rate per 100,000 population, Mecklenburg**



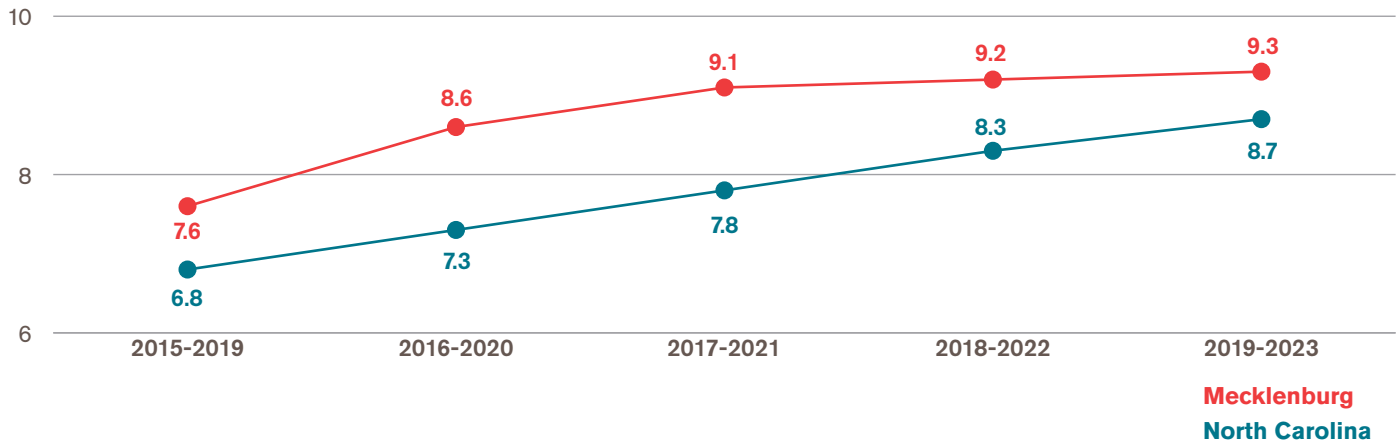
Source: NC DHHS, SCHS

Figure 41. **Number of Violent Crime Offenses in Charlotte, 2019–2024**



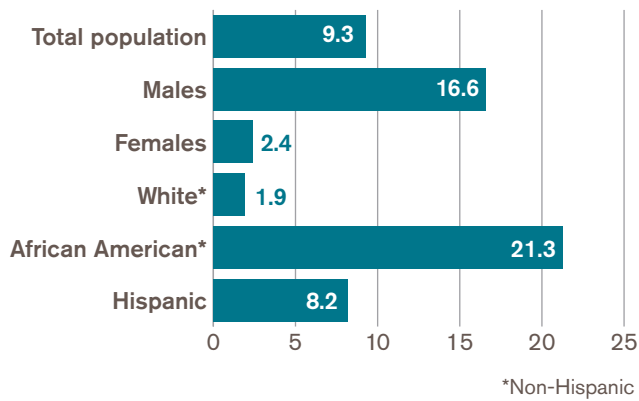
Source: CMPD Crime Statistics

Figure 42. **Age Adjusted Homicide Rates per 100,000, 2015–2023**



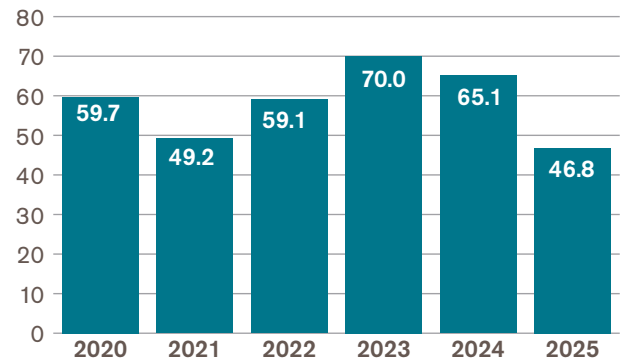
Source: NC DHHS, SCHS

Figure 43. **Age Adjusted Homicide Rates by Demographics, Mecklenburg 2019–2023**
5 Year Average Death Rates per 100,000



Source: NC DHHS, SCHS

Figure 44. **Emergency Department Visits for Firearms and Gun Shot Wounds, Mecklenburg 2020–2025**
Rates per 100,000



Source: NC DETECT

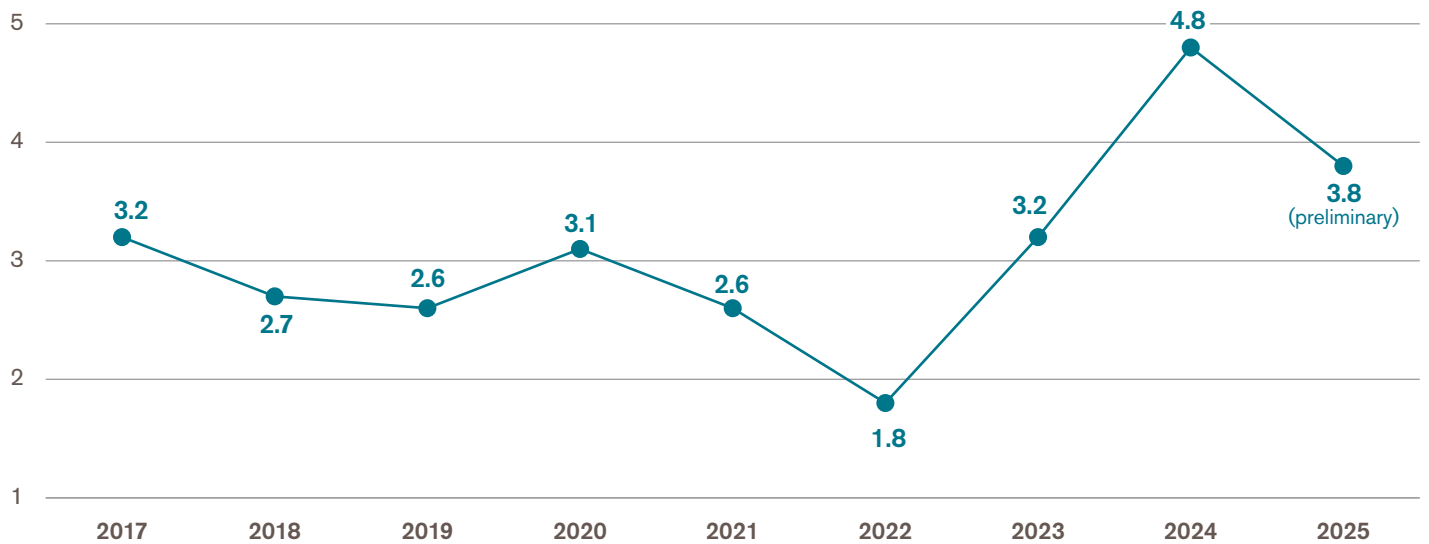
Infectious Diseases

Infectious diseases are illnesses that usually spread from person to person, through contaminated food, soil, or water, and through animal contact and insect bites. Infectious diseases, such as HIV/AIDS, Tuberculosis (TB), and Syphilis are a leading cause of illness and death around the world.

Tuberculosis

- Tuberculosis, also called TB, is a serious illness that mainly affects the lungs. The bacteria that cause tuberculosis are airborne and can spread when a person with the illness coughs, sneezes, or sings. TB cases were once on the decline across the world. However, disruptions in TB control programs during the COVID pandemic are thought to be a prevailing reason for the recent resurgence in the disease.
- Tuberculosis (TB) cases increased during 2020, before declining in 2021 and 2022, likely due to factors associated with the pandemic. TB cases have since rebounded, illustrating the need for continued prevention and control efforts.

Figure 45. **Tuberculosis Case Rates per 100,000, Mecklenburg 2017–2024**

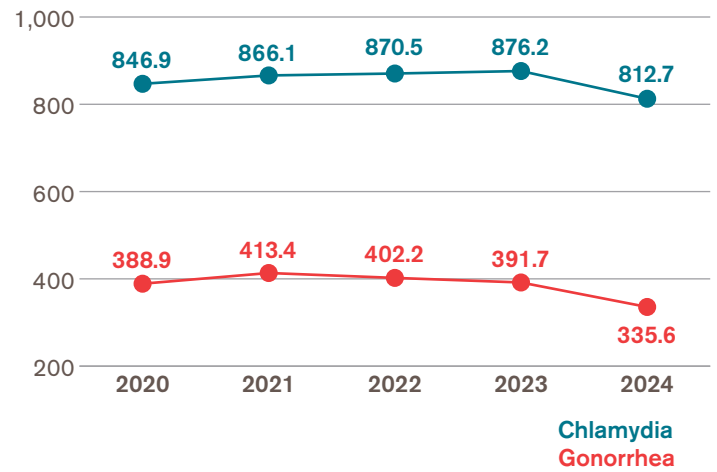


Source: NC EDSS

Chlamydia and Gonorrhea

- Chlamydia and Gonorrhea are two of the most frequently reported sexually transmitted infections (STIs).
- Following national trends, Mecklenburg witnessed increases in STIs beginning in 2016. However, rates appear to be stabilizing based on recent trends. Gonorrhea cases show early signs of decline based on data from the past three years.

Figure 46. **Chlamydia and Gonorrhea Case Rates per 100,000, Mecklenburg 2020–2024**

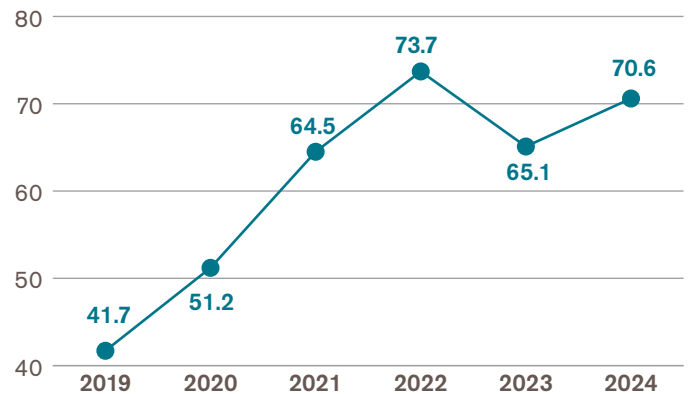


Source: NC EDSS

Syphilis

- Nationally and locally, syphilis cases have increased substantially over time. From 2019 to 2023, reported cases in the county increased by 65%.
- Along with the continued increase of syphilis in women, congenital syphilis is increasing. In Mecklenburg, there were 23 congenital syphilis cases in 2024, including 2 stillbirths or neonatal deaths attributable to congenital syphilis.

Figure 47. **Syphilis Case Rates per 100,000, Mecklenburg 2019–2024**

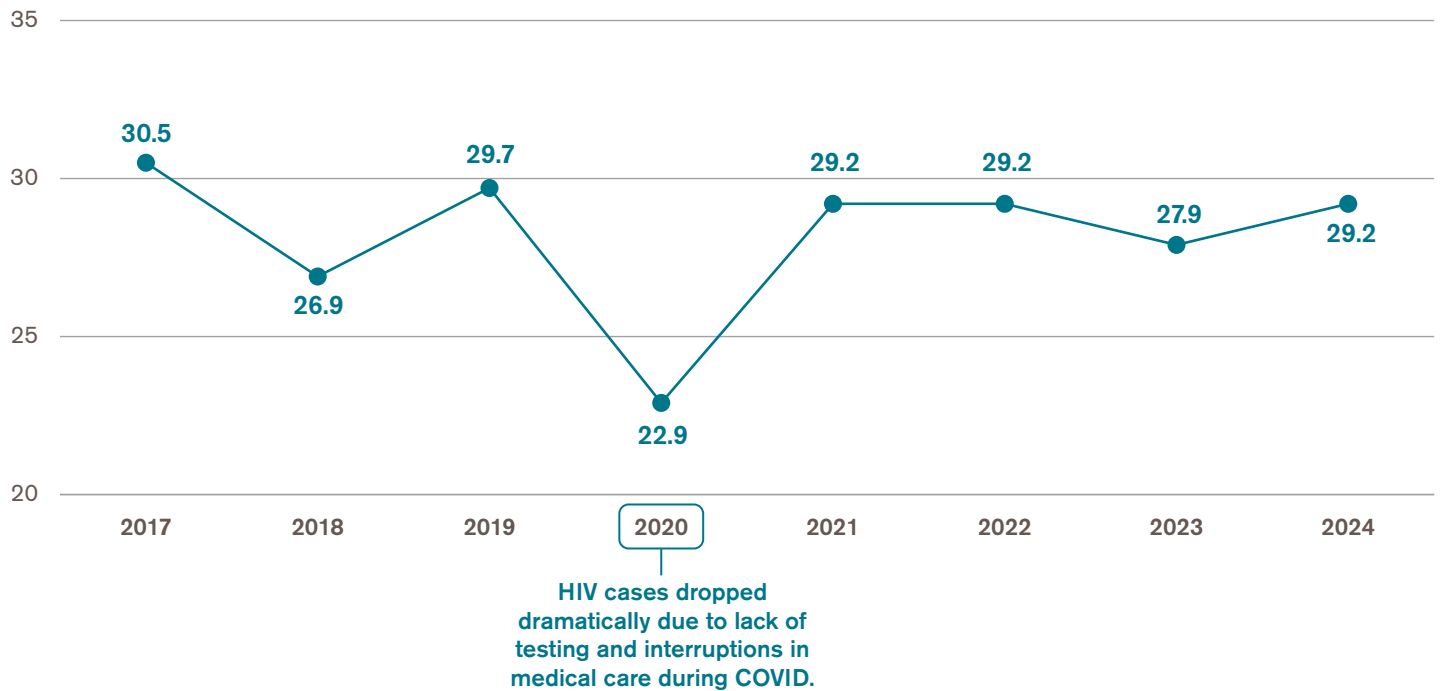


Source: NC EDSS

HIV Disease

- 7,724 people are currently living with HIV in Mecklenburg County, with 284 new cases reported in 2024. Over time, the HIV cases and case rates have stabilized in the county.
- The goal of HIV treatment is to achieve viral suppression, reducing HIV in the body to low or undetectable levels. Viral suppression rates in the Charlotte-Mecklenburg region are nearly 70%.

Figure 48. **HIV Case Rates per 100,000, Mecklenburg 2017–2024**



Source: NC EDSS

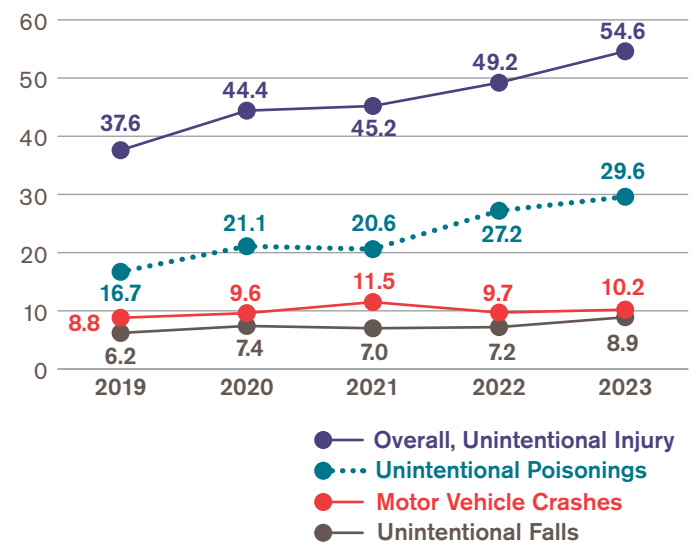
Unintentional Injury

Unintentional injuries refer to injuries that are not deliberately caused and are often preventable. The most common types are motor vehicle crashes, falls, fires, drownings and poisonings. In the nation, unintentional injuries are the leading cause of death for persons aged 1–44 years. Deaths, however, are just the tip of the iceberg. Millions of people who are injured survive and face life-long mental, physical, and financial problems.

Primary Causes of Unintentional Injury Deaths

- The three leading causes of unintentional injury deaths are motor vehicle crashes, poisonings (e.g. drug overdoses), and falls. Data on drug overdoses can be found in the Emerging Health Issues section.
- Unintentional injury death rates increased by 17% between 2018 and 2022, primarily due to rising drug overdose deaths.

Figure 49. **Deaths due to Unintentional Injuries and Primary Causes of Unintentional Injuries per 100,000, Mecklenburg 2020–2024**

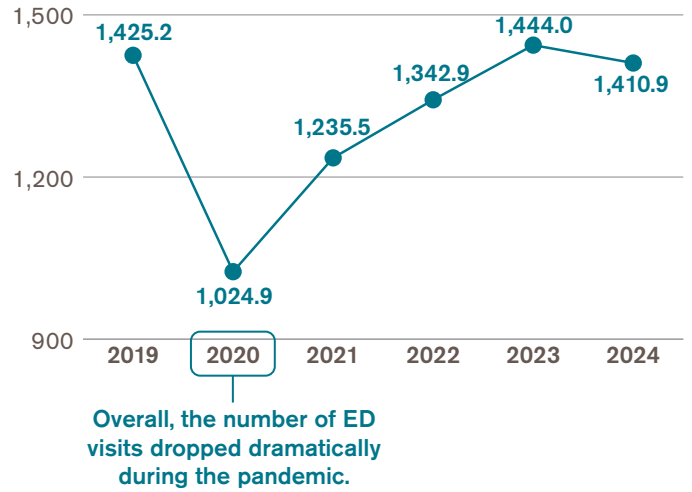


Source: CDC WONDER

Motor Vehicle Crashes

- Motor vehicle crash or collision (MVC) injuries include injuries among pedestrians, bicyclists, motorcyclists, and motor vehicle occupants. In 2023, there were 119 MVC deaths in the county, making it the second leading cause of unintentional injury deaths. However, deaths are only part of the story; even more residents experience non-fatal injuries resulting in emergency department visits and hospitalizations.
- MVC ED visit rate decreased from a 3-yr average (2017–19) of 1471.5 visits per 100,000 population to 1130.2 per 100,000 during the first two years of the pandemic (2020–21). By year 2024, the rate of MVC ED visits had increased to near pre-COVID levels.

Figure 50. **Rate of Motor Vehicle Crash Emergency Department Visits per 100,000, Mecklenburg 2019–2024**

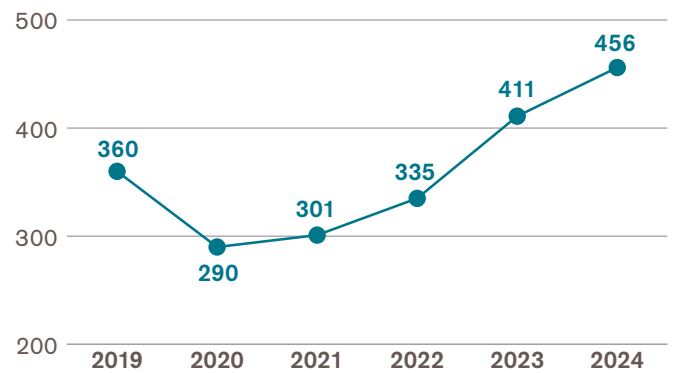


Source: NC DETECT

Traffic-related Pedestrian Injuries

- Traffic-related pedestrian injuries are preventable but are increasing. In 2021, there were 301 ED visits due to pedestrians suffering a traffic-related injury. By 2024, the number of ED visits increased to 456 visits. The majority of these visits were among Young Adults aged 25–49 years.

Figure 51. **Number of Traffic-related Pedestrian Emergency Department Visits (Total Number), Mecklenburg 2019–2024**

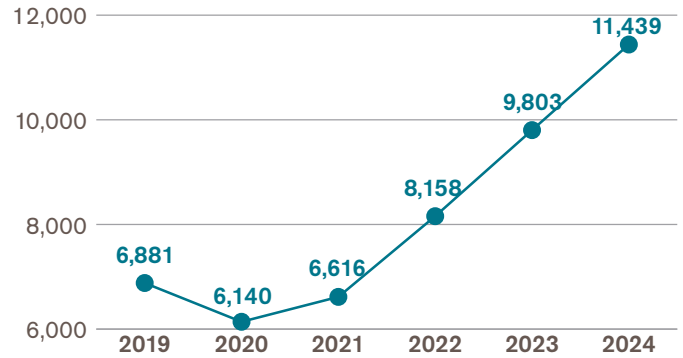


Source: CDC WONDER

Falls Among Seniors

- Falls are the third leading cause of unintentional injury deaths. Fall-related injuries and deaths are most common among older adults aged 65+. Risk factors for falls include poor eyesight, walking/balance challenges, age-related muscle mass loss, medication side effects, and safety hazards. While common, falls are preventable and are not an unavoidable consequence of aging.
- ED visits due to falls in Seniors have increased over time. Between 2019 and 2024, Fall-related ED visits in seniors increased from approximately 6,900 visits in 2019 to over 11,000 during 2024.

Figure 52. **Number of Emergency Department visits due to Falls among Persons 65 and older (Total Number), Mecklenburg 2019–2024**



Source: NC DETECT

Summary of Community Indicators

Summary of Community Health Indicators (SCHIs) are a subset of leading health indicators chosen to help organizations, communities, and public health leaders understand important drivers of health and well-being in Mecklenburg County. Most SCHIs address important factors that affect the major causes of death and disease in the county over the life span of residents. Summary indicators are grouped into seven major themes: Length of Life, Quality of Life, Leading Causes of Death, Health Factors, Clinical Care, Social and Economic Determinants, and Community Safety Measures.

LENGTH OF LIFE

- Premature Death
- Life Expectancy
- Infant Mortality
- Child Mortality

QUALITY OF LIFE

- Physical Health Days
- Mental Health Days
- Depression
- Diabetes Prevalence
- HIV Prevalence

LEADING CAUSE OF DEATH

- All Cause Death
- Heart Disease
- Cancer-Related
- Diabetes
- COVID-19

HEALTH FACTORS

- Current Smokers
- Obesity
- Physical Inactivity
- Excessive Drinking
- Sexually Transmitted Infections
- Teen Births

CLINICAL CARE

- Uninsured Population
- Primary Care Physicians
- Dentists
- Mental Health Providers
- Mammogram Screening
- Colorectal Screenings
- Flu Vaccinations

SOCIAL AND ECONOMIC DETERMINANTS

- Poverty
- Social Vulnerability Index
- Severe Housing Cost
- Cohort Graduation Rate
- Unemployment

- Speaks English less than “very well”
- Internet Availability
- Lack of Transportation
- Food Environment Index

COMMUNITY SAFETY MEASURES

- Homicides
- Suicides
- Firearm Fatalities
- Motor Vehicle Crashes
- Drug Overdose

Mecklenburg County Summary Community Indicators

Table 3. Indicators for Mecklenburg and North Carolina

	Mecklenburg, NC	North Carolina	Years of Data Used	
	Total Population, 2024	1,206,285	11,046,024	2024
Length of Life*	Life Expectancy (in years)	79.2 years	76.0 years	2021–2023
	Premature Deaths before 75, per 100,000 population	320	440	2017–2023
	Infant Mortality (per 1,000 Live Births)	5	7	2017–2023
	Child Mortality Rate (per 100,000 population)	60	60	2020–2023
Quality of Life*	Poor Physical Health Days	3.3	4.1	2022
	Poor Mental Health Days	4.9	4.9	2022
	Frequent Mental Distress	16%	16%	2022
	Diabetes Prevalence	11%	11%	2022
	HIV Prevalence (per 100,000)	693	385	2022
Leading Causes of Death (crude rates)^	All Cause Death (per 100,000)	619.4	994.4	2023
	Heart Disease (per 100,000)	109	195.6	2023
	Cancer-Related (per 100,000)	117.8	193.1	2023
	Stroke (per 100,000)	35.1	57.1	2023
	Diabetes (per 100,000)	19.2	31.8	2023
Health Factors*	Adult Current Smokers	13%	15%	2022
	Adult Obesity	34%	34%	2022
	Adult Physical Inactivity	19%	23%	2022
	Sexually Transmitted Infections	867.7	603.1	2022
	Teen Births (per 1,000 females ages 15–19)	17	17	2017–2023
Clinical Care*,#	Uninsured Adults	13%	14%	2022
	Children < 19 without health insurance	6%	5%	2022
	Primary Care Physicians (ratio)	1,080:1	1,410:1	2022
	Dentists (ratio)	1,390:1	1,610:1	2023
	Flu Vaccinations	54%	51%	2022
Social and Economic Determinants*^	Children in Poverty	14%	18%	2023
	Severe Housing Cost Burden	14%	13%	2019–2023
	Unemployment	3.8%	3.5%	2024
	High School Completion	91%	90%	2019–2023
	Speaks English less than “very well”	10.8%	5.4%	2024
	% Households without Internet	4.0%	6.8%	2024
	% Households with no Vehicles	6.4%	5.6%	2024
	Food Environment Index: Scale from 0 (worst) to 10 (best)	8.3	6.8	2022
Community Safety Measures (age-adjusted rates)*	Homicides (per 100,000)	9	8	2019–2023
	Suicides (per 100,000)	10	14	2019–2023
	Firearm Fatalities (per 100,000)	14	16	2019–2023
	Motor Vehicle Crashes (per 100,000)	10	16	2019–2023
	Drug Overdose Fatalities (per 100,000)	26	37	2019–2023

Sources: County Health Rankings and Roadmap (*); CDC WONDER (^); and U.S. Census, American Community Survey (#)

Peer County Comparisons

Peer counties are those experiencing similar trends and challenges in community health. They share key demographic, social, and economic indicators.

Wake, NC, is included as a neighboring county and peer despite its population composition being vastly different from Mecklenburg. Wake also shows higher rates for social and economic indicators that are positively associated with better health outcomes.

Peers with better or similar outcomes

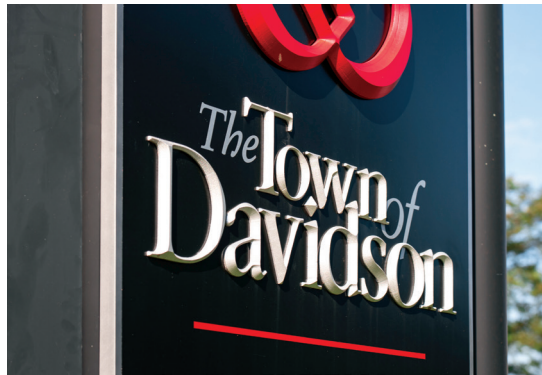
Peers with poorer outcomes

Table 4. Comparisons with Peer Counties

		Mecklenburg County, NC (Charlotte)	Wake County, NC (Raleigh)	Allegheny County, PA (Pittsburgh)	Davidson County, TN (Nashville)	Franklin County, OH (Columbus)	Years of Data Used
Length of Life*	Life Expectancy (in years)	79.2 years	81.2 years	77.4 years	75.5 years	76.0 years	2021–2023
	Premature Deaths, per 100,000	320	250	390	470	440	2021–2023
	Infant Mortality, per 1,000 live births	5	5	6	7	8	2017–2023
	Child Mortality Rate under 20 yrs., per 100,000	60	40	50	80	70	2020–2023
Quality of Life*	Average Poor Physical Health Days	3.3	3.2	3.9	4.2	4.3	2022
	Average Poor Mental Health Days	4.9	4.7	5.4	6.1	5.8	2022
	Diabetes Prevalence (adults 20 yrs. +)	11%	9%	9%	12%	12%	2022
	HIV Prevalence (per 100,000)	693	367	293	652	486	2022
Leading Causes of Death (crude rates)*	All Cause Death (per 100,000)	619.4	575.5	1113.9	841.7	805.4	2023
	Heart Disease (per 100,000)	109	104.6	265.7	169.3	154.3	2023
	Stroke (per 100,000)	35.1	53	49.9	42.1	43.2	2023
	Cancer-Related (per 100,000)	117.8	119.6	220.8	149.5	150.3	2023
	Diabetes (per 100,000)	19.2	15.6	26.5	25.5	19.5	2023
Health Factors*	Adult Current Smokers	13%	10%	15%	18%	15%	2022
	Adult Obesity	34%	26%	32%	32%	36%	2022
	Adult Physical Inactivity	19%	16%	21%	27%	23%	2022
	Adult Excessive Drinking	21%	21%	23%	19%	20%	2022
Clinical Care*	Sexually Transmitted Infections	867.7	516.6	453.6	871.7	718.2	2022
	Teen Births (per 1,000 females ages 15–19)	17	9	9	24	17	2017–2023
	% Population under 65 without health insurance	13%	10%	5%	15%	10%	2022
	Primary Care Physicians (ratio)	1,080:1	1,150:1	890:1	1080:1	970:1	2022
	Dentists (ratio)	1,390:1	1,320:1	1,000:1	1,180:1	1,010:1	2023
	Flu Vaccinations	54%	59%	54%	53%	56%	2022
Social and Economic Determinants*,#	Children in Poverty	14.2%	10.9%	14.6%	16.2%	17.6%	2024
	Severe Housing Cost Burden	14%	12%	12%	16%	14%	2019–2023
	Unemployment	3.8%	3.7%	4.3%	3.1%	4.1%	2024
	Speaks English less than "very well"	10.8%	6.8%	2.80%	11.00%	7.4%	2024
	% Households without Internet	4.0%	3.1%	6.8%	4.6%	4.8%	2024
	% Households with no Vehicles	6.4%	5.3%	10.8%	7.1%	7.4%	2024
	Food Environment Index	8.3	8.5	8.4	7.8	7.9	2019 & 2022
Community Safety Measures*	Homicide (per 100,000)	9	3	8	14	12	2017–2023
	Suicides (per 100,000)	10	9	13	13	12	2019–2023
	Firearm Fatalities (per 100,000)	14	9	15	20	17	2019–2023
	Motor Vehicle Crashes (per 100,000)	10	8	6	14	10	2017–2023
	Drug Overdose Fatalities (per 100,000)	26	19	52	75	59	2021–2023

Sources: County Health Rankings and Roadmap (*); CDC WONDER (^); and U.S. Census, American Community Survey (#)

City/Town Profiles



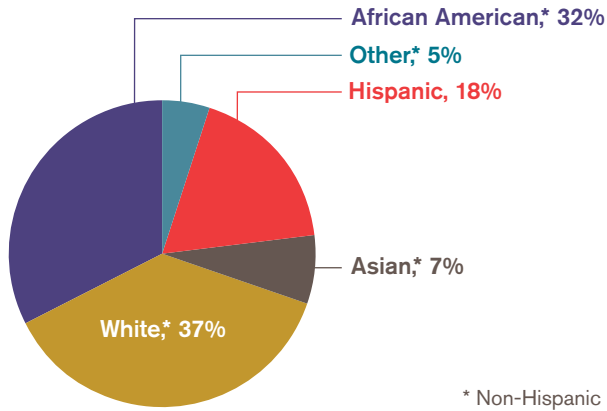
Charlotte, NC



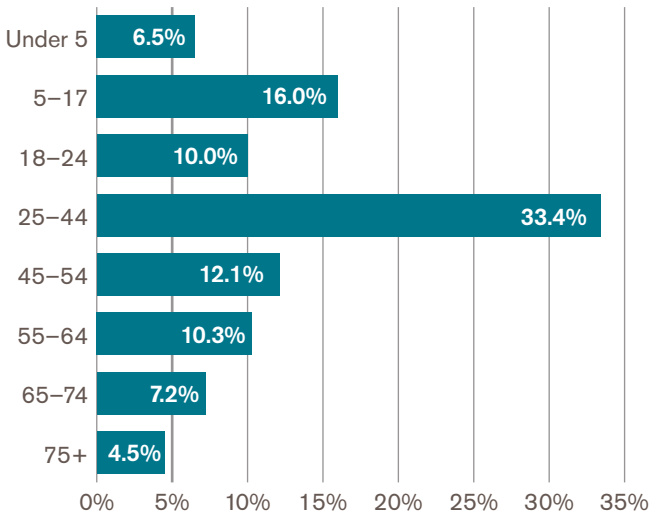
POPULATION, 2024

943,474

RACE/ETHNICITY



AGE DISTRIBUTION



Median Household Income
2019-2023

Educational Attainment
% of population 25 and older
HS Diploma or less, 2019-2023

Median Gross Rent
2019-2023

Charlotte, NC

\$86,416

27.3%

\$1,720

Mecklenburg

\$90,494

25.8%

\$1,730

Source: US Census, American Community Survey (ACS)

Summary Community Health Indicators

Table 5. Indicators for Mecklenburg and Charlotte

		Mecklenburg, NC 95% CI*	Charlotte, NC 95% CI*	Years of Data Used
Length of Life[^]	Premature Death Rate before 75 years, per 100,000 population	317.0	345.2	2019–2023
	All Cause Death Rate (per 100,000)	643.4	662.5	2019–2023
Quality of Life^{*,@}	% Poor Physical Health for ≥ 14 days (> 18 years)	10.7% (9.2–12.4)	11.1% (9.8–12.5)	2023
	% Depressive Disorder, self-reported (> 18 years)	22.4% (19.2–25.5)	22.3% (19.1–25.5)	2023
	% Diabetes Prevalence (> 18 years)	10.1% (8.6–11.6)	10.7% (9.2–12.2)	2023
	HIV Prevalence (per 100,000)	29.2	33.8	2024
Health Factors^{*,@}	% Adult Smoking	10.7% (8.5–13.1)	11.4% (9.8–13.0)	2023
	% Adult Obesity	29.5% (24.4–34.4)	30.1% (25.0–35.1)	2023
	% Adult Physical Inactivity	21.1% (17.3–24.9)	22.3% (19.0–25.7)	2023
	% Adult Binge Drinking	15.1% (12.5–17.6)	14.8% (12.2–17.5)	2023
	Sexually Transmitted Infections (per 100,000)	812.7	1067.8	2024
Clinical Care^{*,@}	% Adults 19–64 without health insurance	13.6%	15.2%	2019–2023
	% Children < 19 without health insurance	8.1%	8.6%	2019–2023
	Mammogram Screenings (% women age 50–74)	80.3% (72.9–86.4)	79.7% (72.8–85.3)	2022
	Colorectal Screenings (% adults age 50–75)	60.4 (54.9–65.7)	61.6% (56.7–66.1)	2022
Social and Economic Determinants[#]	% in Poverty	10.5%	11.9%	2019–2023
	% Severe Housing Cost (renters spending 50% or more of household income on rent)	21.4%	21.8%	2019–2024
	% Unemployment	3.4%	3.5%	2019–2023
	% Households without Internet	6.8%	7.2%	2019–2023
	% Households with no Vehicles	6.1%	6.7%	2019–2023
Community Safety Measures[^]	Homicides (per 100,000)	9.5	11.2	2019–2023
	Suicides (per 100,000)	9.8	10.3	2019–2023
	Firearm Fatalities (per 100,000)	14.2	16.2	2019–2023
	Motor Vehicle Crashes (per 100,000)	9.7	10.8	2019–2023
	Drug Overdose Fatalities (per 100,000)	23.3	25.7	2019–2023

Sources: CDC PLACES age-adjusted rates (*), NCDHHS, SCHS, Vital Records crude rates (^), NCEDSS crude rates (@) and U.S. Census, American Community Survey (#)

* 95% Confidence Interval.

— Rates are not available for health indicators with 5 or less deaths.

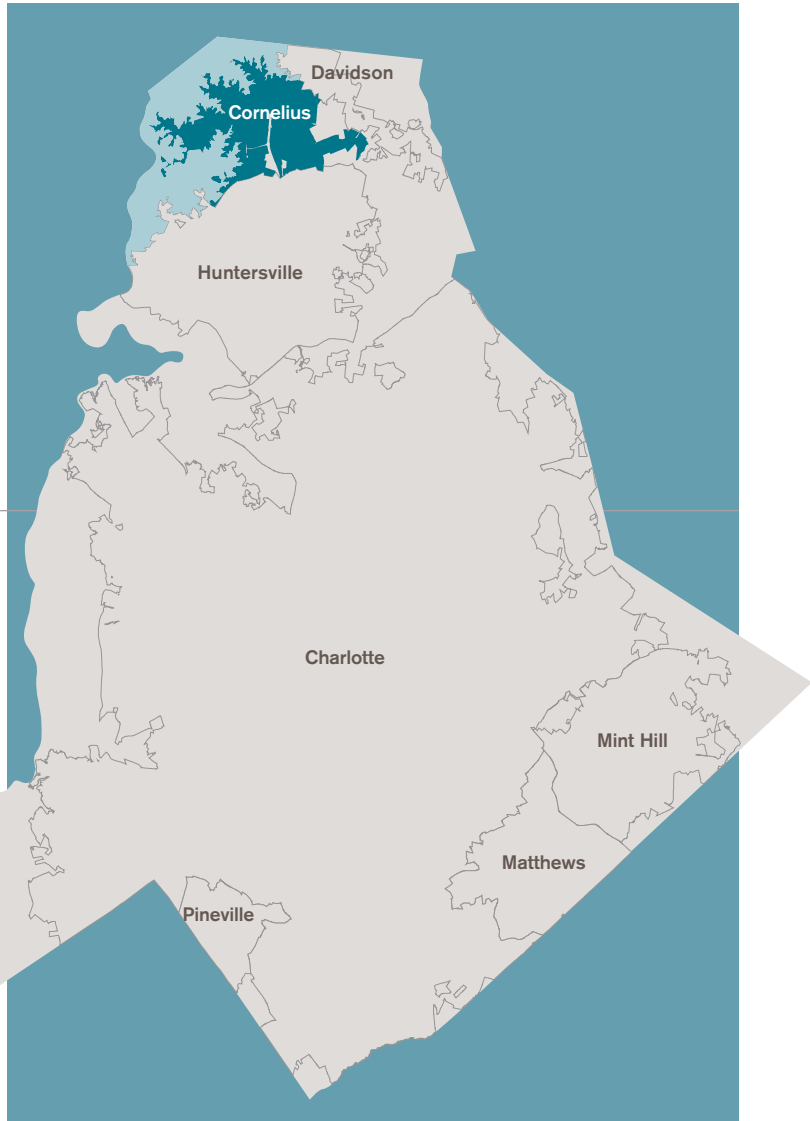
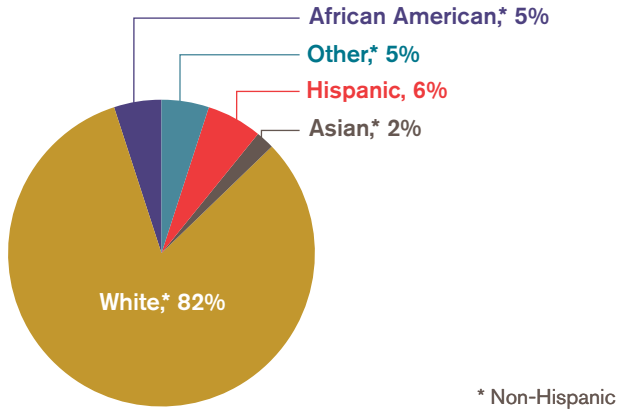
Cornelius, NC

POPULATION, 2024

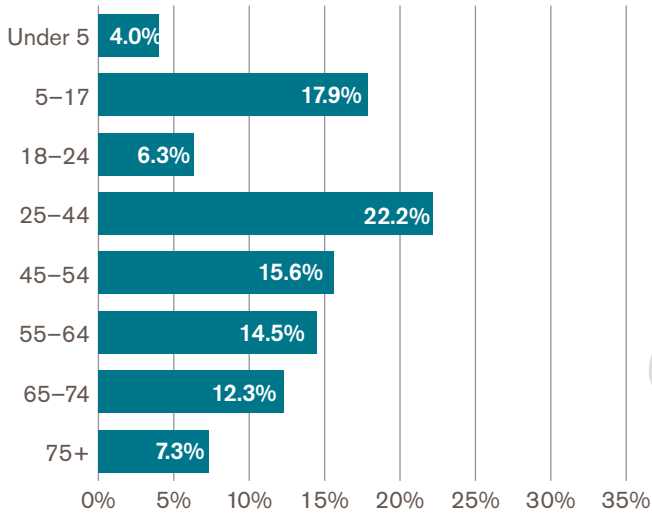
32,009



RACE/ETHNICITY



AGE DISTRIBUTION



Median Household Income
2019–2023

Educational Attainment
% of population 25 and older
HS Diploma or less, 2019–2023

Median Gross Rent
2019–2023

Cornelius, NC

\$114,688

14.5%

\$1,541

Mecklenburg

\$90,494

25.8%

\$1,730

Source: US Census, American Community Survey (ACS)

Summary Community Health Indicators

Table 6. Indicators for Mecklenburg and Cornelius

		Mecklenburg, NC 95% CI*	Cornelius, NC 95% CI*	Years of Data Used
Length of Life[^]	Premature Death Rate before 75 years, per 100,000 population	317.0	232.7	2019–2023
	All Cause Death Rate (per 100,000)	643.4	573.1	2019–2023
Quality of Life^{*,@}	% Poor Physical Health for ≥ 14 days (>18 years)	10.7% (9.2–12.4)	9.1% (8.0–10.3)	2023
	% Depressive Disorder, self-reported (>18 years)	22.4% (19.2–25.5)	24.6% (21.1–28.0)	2023
	% Diabetes Prevalence (>18 years)	10.1% (8.6–11.6)	7.1% (6.0–8.1)	2023
	HIV Prevalence (per 100,000)	29.2	3.6	2024
Health Factors^{*,@}	% Adult Smoking	10.7% (8.5–13.1)	8.6% (7.3–10.0)	2023
	% Adult Obesity	29.5% (24.4–34.4)	25.1% (20.6–29.8)	2023
	% Adult Physical Inactivity	21.1% (17.3–24.9)	15.3% (12.7–18.0)	2023
	% Adult Binge Drinking	15.1% (12.5–17.6)	18.0% (15.0–21.2)	2023
	Sexually Transmitted Infections (per 100,000)	812.7	244.7	2024
Clinical Care^{*,@}	% Adults 19–64 without health insurance	13.6%	6.7%	2019–2023
	% Children <19 without health insurance	8.1%	3.6%	2019–2023
	Mammogram Screenings (% women age 50–74)	80.3% (72.9–86.4)	80.1% (73.2–85.6)	2022
	Colorectal Screenings (% adults age 50–75)	60.4 (54.9–65.7)	65.3% (60.5–69.7)	2022
Social and Economic Determinants[#]	% in Poverty	10.5%	4.4%	2019–2023
	% Severe Housing Cost (renters spending 50% or more of household income on rent)	21.4%	16.9%	2019–2024
	% Unemployment	3.4%	3.6%	2019–2023
	% Households without Internet	6.8%	3.6%	2019–2023
	% Households with no Vehicles	6.1%	2.8%	2019–2023
Community Safety Measures[^]	Homicides (per 100,000)	9.5	--	2019–2023
	Suicides (per 100,000)	9.8	10.0	2019–2023
	Firearm Fatalities (per 100,000)	14.2	6.9	2019–2023
	Motor Vehicle Crashes (per 100,000)	9.7	6.9	2019–2023
	Drug Overdose Fatalities (per 100,000)	23.3	21.3	2019–2023

Sources: CDC PLACES age-adjusted rates (*), NCDHHS, SCHS, Vital Records crude rates (^), NCEDSS crude rates (@) and U.S. Census, American Community Survey (#)

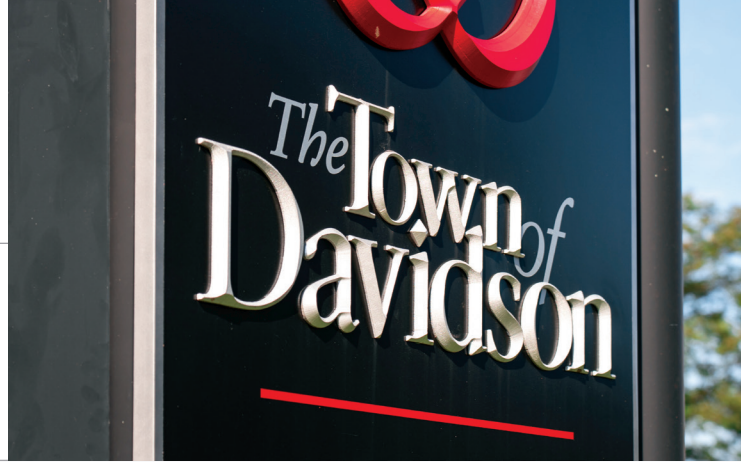
* 95% Confidence Interval.

— Rates are not available for health indicators with 5 or less deaths.

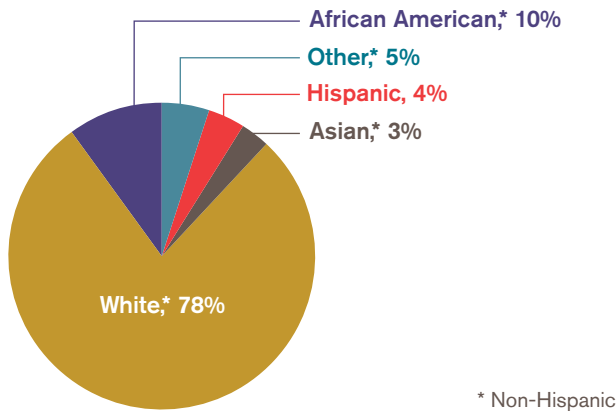
Davidson, NC

POPULATION, 2024

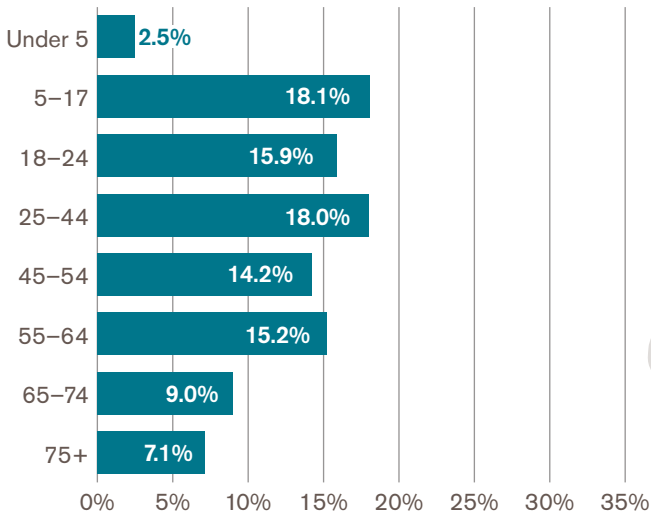
14,852



RACE/ETHNICITY



AGE DISTRIBUTION



Median Household Income
2019-2023

Educational Attainment
% of population 25 and older
HS Diploma or less, 2019-2023

Median Gross Rent
2019-2023

Davidson, NC **\$152,969**

11.8%

\$1,636

Mecklenburg **\$90,494**

25.8%

\$1,730

Source: US Census, American Community Survey (ACS)

Summary Community Health Indicators

Table 7. Indicators for Mecklenburg and Davidson

		Mecklenburg, NC 95% CI*	Davidson, NC 95% CI*	Years of Data Used
Length of Life[^]	Premature Death Rate before 75 years, per 100,000 population	317.0	219.9	2019–2023
	All Cause Death Rate (per 100,000)	643.4	804.0	2019–2023
Quality of Life^{*.@}	% Poor Physical Health for ≥ 14 days (> 18 years)	10.7% (9.2–12.4)	8.9% (7.8–10.1)	2023
	% Depressive Disorder, self-reported (> 18 years)	22.4% (19.2–25.5)	24.6% (21.3–28.1)	2023
	% Diabetes Prevalence (> 18 years)	10.1% (8.6–11.6)	6.9% (5.9–8.0)	2023
	HIV Prevalence (per 100,000)	29.2	22.8	2024
Health Factors^{*.@}	% Adult Smoking	10.7% (8.5–13.1)	8.0% (6.6–9.6)	2023
	% Adult Obesity	29.5% (24.4–34.4)	24.7% (20.2–29.2)	2023
	% Adult Physical Inactivity	21.1% (17.3–24.9)	14.6% (12.2–17.4)	2023
	% Adult Binge Drinking	15.1% (12.5–17.6)	18.0% (15.0–21.1)	2023
	Sexually Transmitted Infections (per 100,000)	812.7	303.5	2024
Clinical Care^{*.@}	% Adults 19–64 without health insurance	13.6%	4.0 %	2019–2023
	% Children < 19 without health insurance	8.1%	3.3 %	2019–2023
	Mammogram Screenings (% women age 50–74)	80.3% (72.9–86.4)	80.7% (74.2–85.7)	2022
	Colorectal Screenings (% adults age 50–75)	60.4% (54.9–65.7)	65.7% (61.1–69.8)	2022
Social and Economic Determinants[#]	% in Poverty	10.5%	7.0 %	2019–2023
	% Severe Housing Cost (renters spending 50% or more of household income on rent)	21.4%	23.2%	2019–2024
	% Unemployment	3.4%	3.9%	2019–2023
	% Households without Internet	6.8%	4%	2019–2023
	% Households with no Vehicles	6.1%	5.4%	2019–2023
Community Safety Measures[^]	Homicides (per 100,000)	9.5	---	2019–2023
	Suicides (per 100,000)	9.8	9.6	2019–2023
	Firearm Fatalities (per 100,000)	14.2	---	2019–2023
	Motor Vehicle Crashes (per 100,000)	9.7	---	2019–2023
	Drug Overdose Fatalities (per 100,000)	23.3	15.1	2019–2023

Sources: CDC PLACES age-adjusted rates (*), NCDHHS, SCHS, Vital Records crude rates (^), NCEDSS crude rates (@) and U.S. Census, American Community Survey (#)

* 95% Confidence Interval.

— Rates are not available for health indicators with 5 or less deaths.

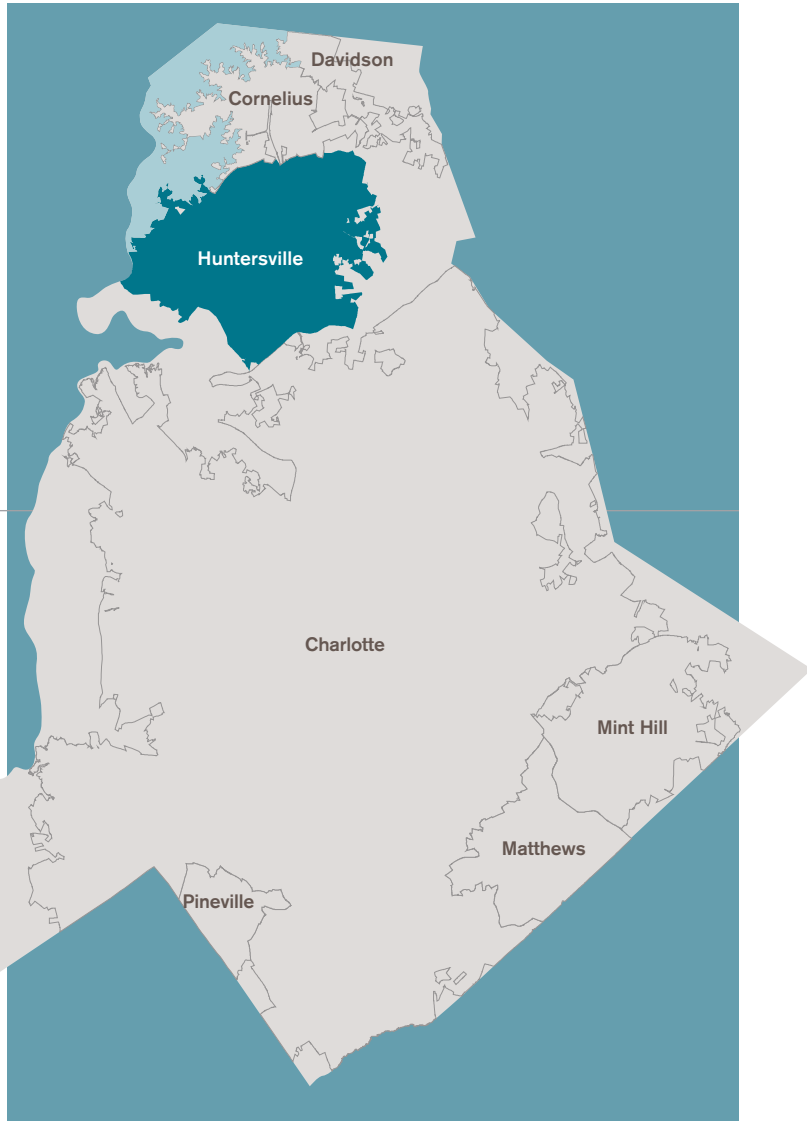
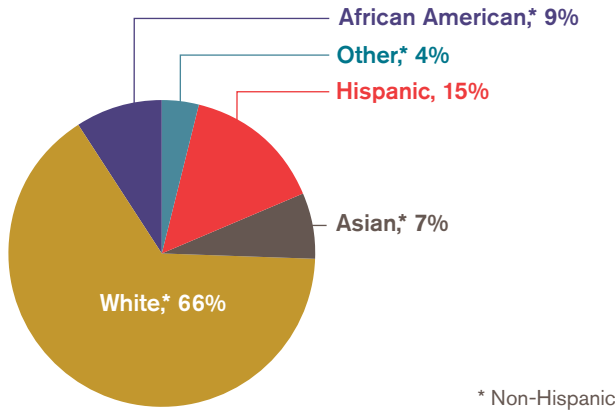
Huntersville, NC



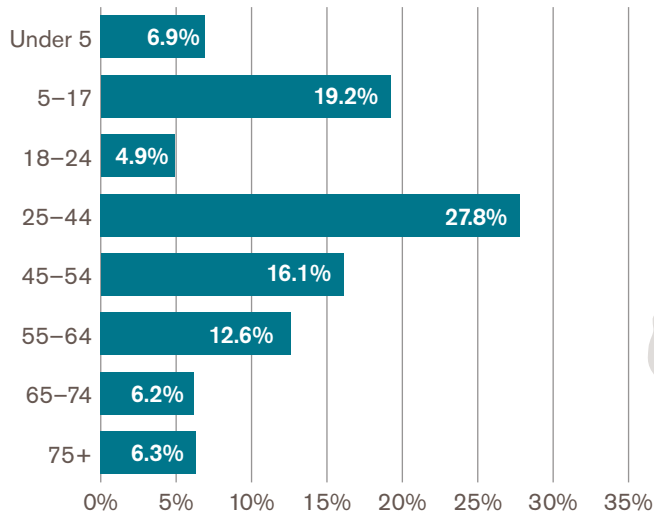
POPULATION, 2024

67,072

RACE/ETHNICITY



AGE DISTRIBUTION



Median Household Income
2019-2023

Educational Attainment
% of population 25 and older
HS Diploma or less, 2019-2023

Median Gross Rent
2019-2023

Huntersville, NC **\$116,438**

17.0%

\$1,840

Mecklenburg **\$90,494**

25.8%

\$1,730

Source: US Census, American Community Survey (ACS)

Summary Community Health Indicators

Table 8. Indicators for Mecklenburg and Huntersville

		Mecklenburg, NC 95% CI*	Huntersville, NC 95% CI*	Years of Data Used
Length of Life[^]	Premature Death Rate before 75 years, per 100,000 population	317.0	257.5	2019–2023
	All Cause Death Rate (per 100,000)	643.4	569.9	2019–2023
Quality of Life^{*,@}	% Poor Physical Health for ≥ 14 days (> 18 years)	10.7% (9.2–12.4)	9.2% (8.1–10.4)	2023
	% Depressive Disorder, self-reported (> 18 years)	22.4% (19.2–25.5)	23.8% (20.5–27.2)	2023
	% Diabetes Prevalence (> 18 years)	10.1% (8.6–11.6)	7.6% (6.5–8.7)	2023
	HIV Prevalence (per 100,000)	29.2	8.9	2024
Health Factors^{*,@}	% Adult Smoking	10.7% (8.5–13.1)	8.6% (7.4–10.0)	2023
	% Adult Obesity	29.5% (24.4–34.4)	25.6% (21.1–30.2)	2023
	% Adult Physical Inactivity	21.1% (17.3–24.9)	16.0% (13.5–18.7)	2023
	% Adult Binge Drinking	15.1% (12.5–17.6)	17.5% (14.6–20.6)	2023
	Sexually Transmitted Infections (per 100,000)	812.7	299.8	2024
Clinical Care^{*,@}	% Adults 19–64 without health insurance	13.6%	5.6%	2019–2023
	% Children < 19 without health insurance	8.1%	3.9%	2019–2023
	Mammogram Screenings (% women age 50–74)	80.3% (72.9–86.4)	80.7% (74.1–86.0)	2022
	Colorectal Screenings (% adults age 50–75)	60.4 (54.9–65.7)	64.7% (59.9–69.1)	2022
Social and Economic Determinants[#]	% in Poverty	10.5%	3.4%	2019–2023
	% Severe Housing Cost (renters spending 50% or more of household income on rent)	21.4%	19.1%	2019–2024
	% Unemployment	3.4%	3.6%	2019–2023
	% Households without Internet	6.8%	4.2%	2019–2023
	% Households with no Vehicles	6.1%	3.1%	2019–2023
Community Safety Measures[^]	Homicides (per 100,000)	9.5	3.9	2019–2023
	Suicides (per 100,000)	9.8	10.6	2019–2023
	Firearm Fatalities (per 100,000)	14.2	10.6	2019–2023
	Motor Vehicle Crashes (per 100,000)	9.7	6.1	2019–2023
	Drug Overdose Fatalities (per 100,000)	23.3	16.1	2019–2023

Sources: CDC PLACES age-adjusted rates (*), NCDHHS, SCHS, Vital Records crude rates (^), NCEDSS crude rates (@) and U.S. Census, American Community Survey (#)

* 95% Confidence Interval.

— Rates are not available for health indicators with 5 or less deaths.

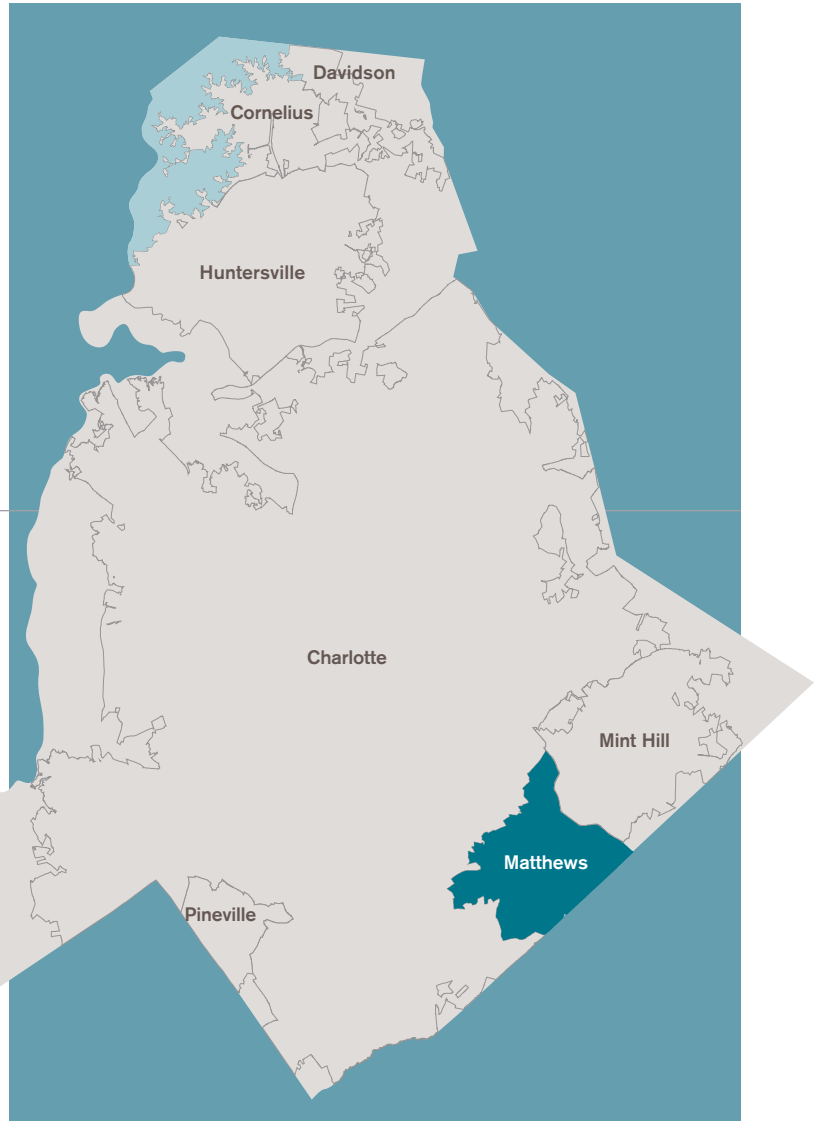
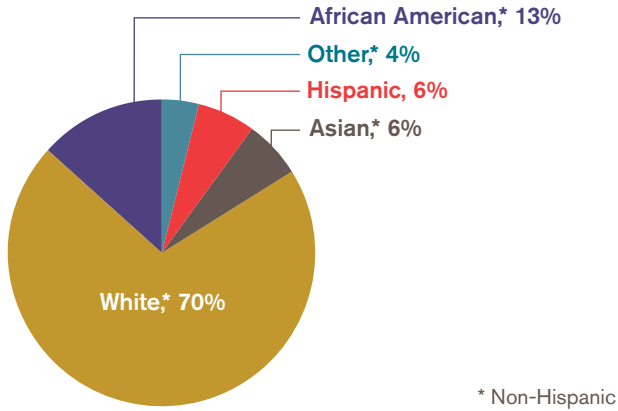
Matthews, NC



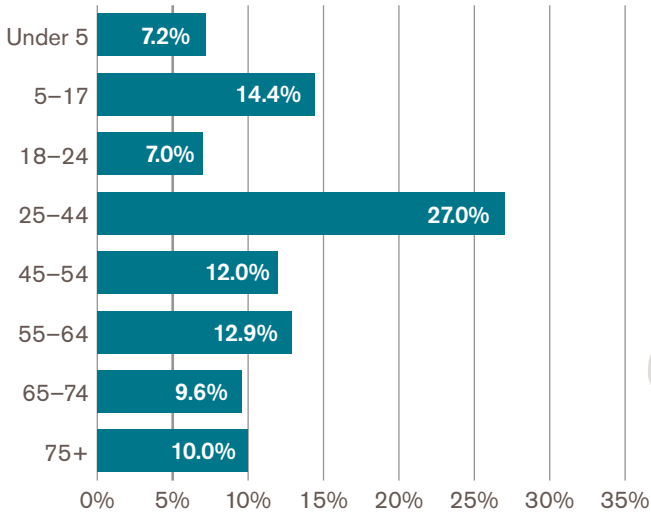
POPULATION, 2024

29,959

RACE/ETHNICITY



AGE DISTRIBUTION



Median Household Income
2019-2023

Educational Attainment
% of population 25 and older
HS Diploma or less, 2019-2023

Median Gross Rent
2019-2023

Matthews, NC

\$105,579

21.7%

\$1,670

Mecklenburg

\$90,494

25.8%

\$1,730

Source: US Census, American Community Survey (ACS)

Summary Community Health Indicators

Table 9. Indicators for Mecklenburg and Matthews

		Mecklenburg, NC 95% CI*	Matthews, NC 95% CI*	Years of Data Used
Length of Life [^]	Premature Death Rate before 75 years, per 100,000 population	317.0	404.7	2019–2023
	All Cause Death Rate (per 100,000)	643.4	1327.5	2019–2023
Quality of Life ^{*,@}	% Poor Physical Health for ≥ 14 days (> 18 years)	10.7% (9.2–12.4)	9.5% (8.3–10.7)	2023
	% Depressive Disorder, self-reported (> 18 years)	22.4% (19.2–25.5)	23.8% (20.5–27.2)	2023
	% Diabetes Prevalence (> 18 years)	10.1% (8.6–11.6)	7.6% (6.6–8.8)	2023
	HIV Prevalence (per 100,000)	29.2	15.6	2024
Health Factors ^{*,@}	% Adult Smoking	10.7% (8.5–13.1)	9.2% (7.8–10.7)	2023
	% Adult Obesity	29.5% (24.4–34.4)	25.7% (21.1–30.5)	2023
	% Adult Physical Inactivity	21.1% (17.3–24.9)	16.7% (14.0–19.7)	2023
	% Adult Binge Drinking	15.1% (12.5–17.6)	17.3% (14.4–20.3)	2023
	Sexually Transmitted Infections (per 100,000)	812.7	655.9	2024
Clinical Care ^{*,@}	% Adults 19–64 without health insurance	13.6%	8.8%	2019–2023
	% Children < 19 without health insurance	8.1%	4.8%	2019–2023
	Mammogram Screenings (% women age 50–74)	80.3% (72.9–86.4)	80.1% (73.4–85.6)	2022
	Colorectal Screenings (% adults age 50–75)	60.4 (54.9–65.7)	63.5% (58.7–67.8)	2022
Social and Economic Determinants [#]	% in Poverty	10.5%	4.0%	2019–2023
	% Severe Housing Cost (renters spending 50% or more of household income on rent)	21.4%	15.8%	2019–2024
	% Unemployment	3.4%	2.2%	2019–2023
	% Households without Internet	6.8%	8.2%	2019–2023
	% Households with no Vehicles	6.1%	3.9%	2019–2023
Community Safety Measures [^]	Homicides (per 100,000)	9.5	6.5	2019–2023
	Suicides (per 100,000)	9.8	14.9	2019–2023
	Firearm Fatalities (per 100,000)	14.2	11.7	2019–2023
	Motor Vehicle Crashes (per 100,000)	9.7	12.3	2019–2023
	Drug Overdose Fatalities (per 100,000)	23.3	20.8	2019–2023

Sources: CDC PLACES age-adjusted rates (*), NCDHHS, SCHS, Vital Records crude rates (^), NCEDSS crude rates (@) and U.S. Census, American Community Survey (#)

* 95% Confidence Interval.

— Rates are not available for health indicators with 5 or less deaths.

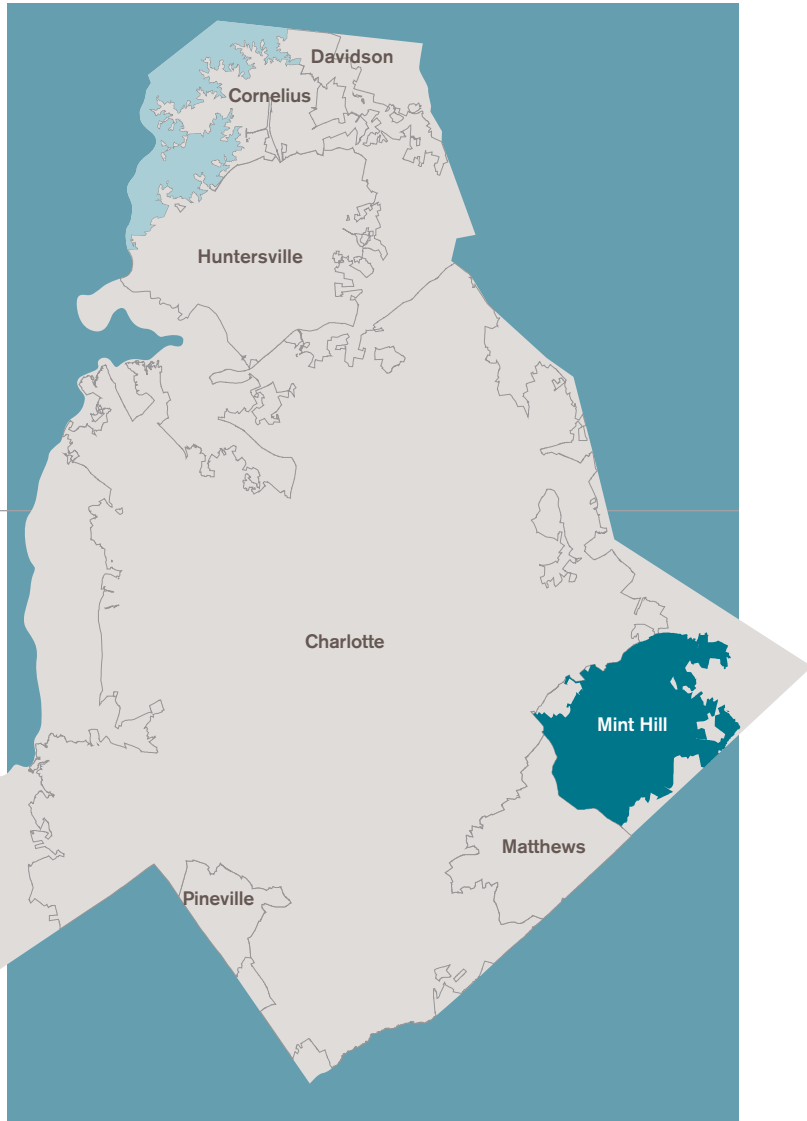
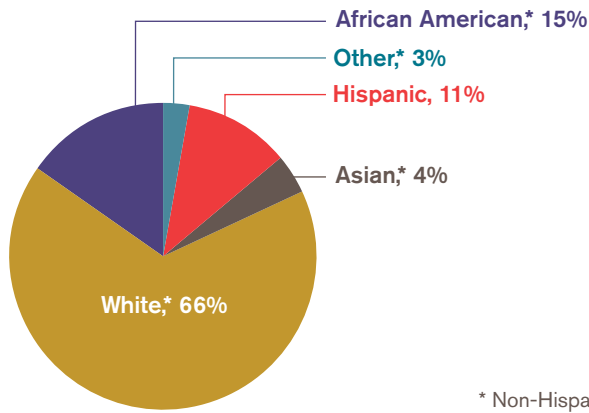
Mint Hill, NC



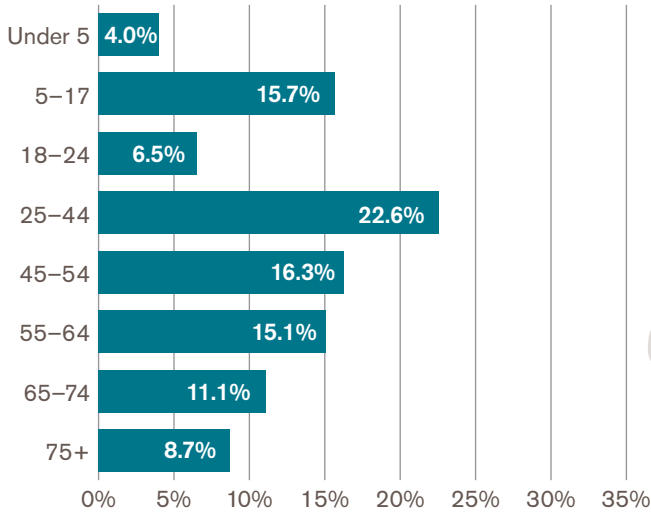
POPULATION, 2024

26,954

RACE/ETHNICITY



AGE DISTRIBUTION



Median Household Income
2019-2023

Educational Attainment
% of population 25 and older
HS Diploma or less, 2019-2023

Median Gross Rent
2019-2023

Mint Hill, NC

\$99,272

28.6%

\$1,498

Mecklenburg

\$90,494

25.8%

\$1,730

Source: US Census, American Community Survey (ACS)

Summary Community Health Indicators : Mint Hill

Table 10. Indicators for Mecklenburg and Mint Hill

		Mecklenburg, NC 95% CI*	Mint Hill, NC 95% CI*	Years of Data Used
Length of Life[^]	Premature Death Rate before 75 years, per 100,000 population	317.0	260.7	2019–2023
	All Cause Death Rate (per 100,000)	643.4	720.7	2019–2023
Quality of Life^{*,@}	% Poor Physical Health for ≥ 14 days (> 18 years)	10.7% (9.2–12.4)	11.1% (9.8–12.4)	2023
	% Depressive Disorder, self-reported (> 18 years)	22.4% (19.2–25.5)	24.4% (21.0–27.7)	2023
	% Diabetes Prevalence (> 18 years)	10.1% (8.6–11.6)	9.0% (7.8–10.3)	2023
	HIV Prevalence (per 100,000)	29.2	4.2	2024
Health Factors^{*,@}	% Adult Smoking	10.7% (8.5–13.1)	11.7% (10.0–13.4)	2023
	% Adult Obesity	29.5% (24.4–34.4)	28.3% (23.4–33.2)	2023
	% Adult Physical Inactivity	21.1% (17.3–24.9)	20.4% (17.3–23.7)	2023
	% Adult Binge Drinking	15.1% (12.5–17.6)	16.5% (13.7–19.4)	2023
	Sexually Transmitted Infections (per 100,000)	812.7	353.9	2024
Clinical Care^{*,@}	% Adults 19–64 without health insurance	13.6%	13.6%	2019–2023
	% Children < 19 without health insurance	8.1%	9.6%	2019–2023
	Mammogram Screenings (% women age 50–74)	80.3% (72.9–86.4)	78.4% (71.4–84.3)	2022
	Colorectal Screenings (% adults age 50–75)	60.4 (54.9–65.7)	60.8% (55.9–65.4)	2022
Social and Economic Determinants[#]	% in Poverty	10.5%	8.7%	2019–2023
	% Severe Housing Cost (renters spending 50% or more of household income on rent)	21.4%	18.0%	2019–2024
	% Unemployment	3.4%	4.8%	2019–2023
	% Households without Internet	6.8%	4.6%	2019–2023
	% Households with no Vehicles	6.1%	2.3%	2019–2023
Community Safety Measures[^]	Homicides (per 100,000)	9.5	4.4	2019–2023
	Suicides (per 100,000)	9.8	7.3	2019–2023
	Firearm Fatalities (per 100,000)	14.2	7.3	2019–2023
	Motor Vehicle Crashes (per 100,000)	9.7	4.4	2019–2023
	Drug Overdose Fatalities (per 100,000)	23.3	17.6	2019–2023

Sources: CDC PLACES age-adjusted rates (*), NCDHHS, SCHS, Vital Records crude rates (^), NCEDSS crude rates (@) and U.S. Census, American Community Survey (#)

* 95% Confidence Interval.

— Rates are not available for health indicators with 5 or less deaths.

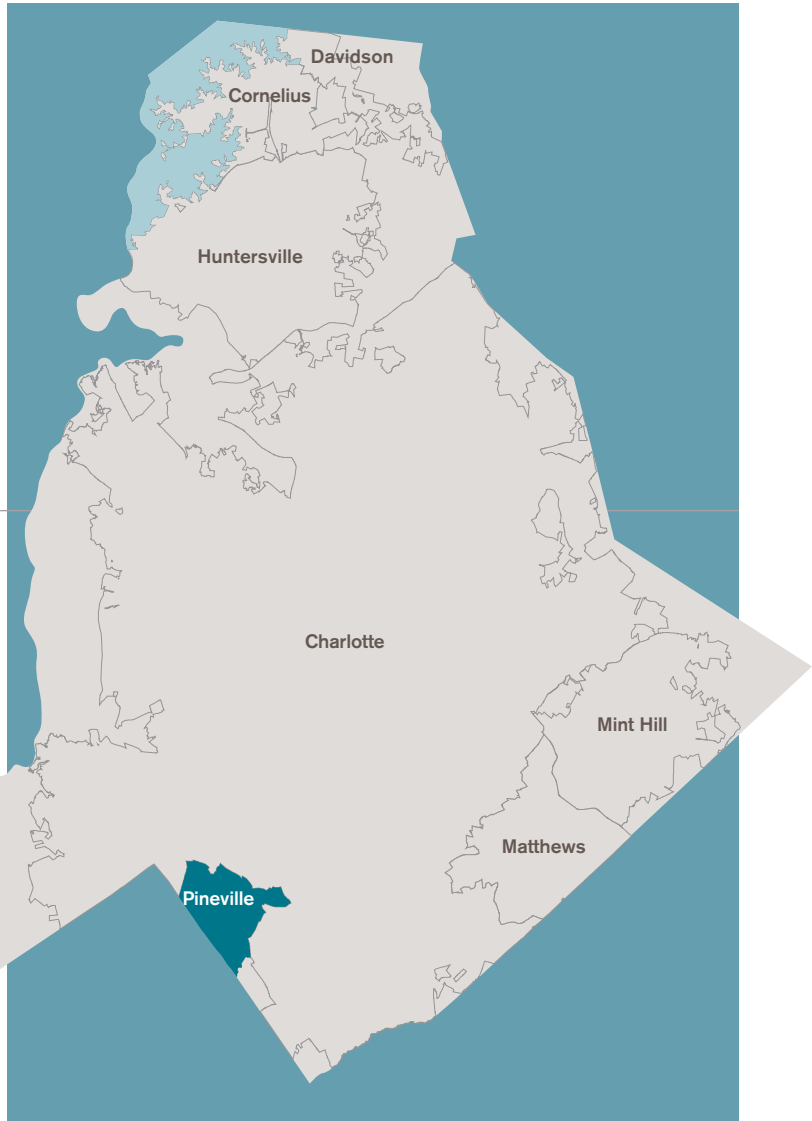
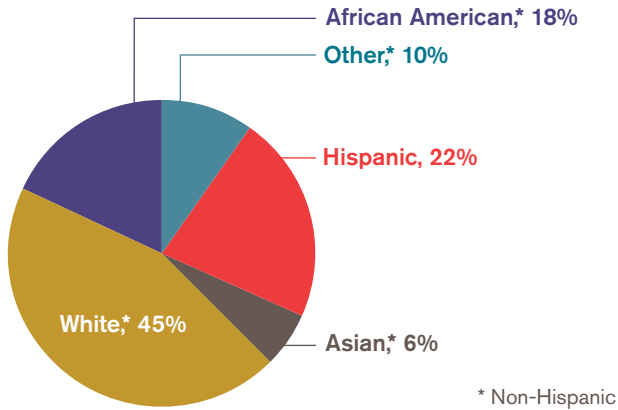
Pineville, NC



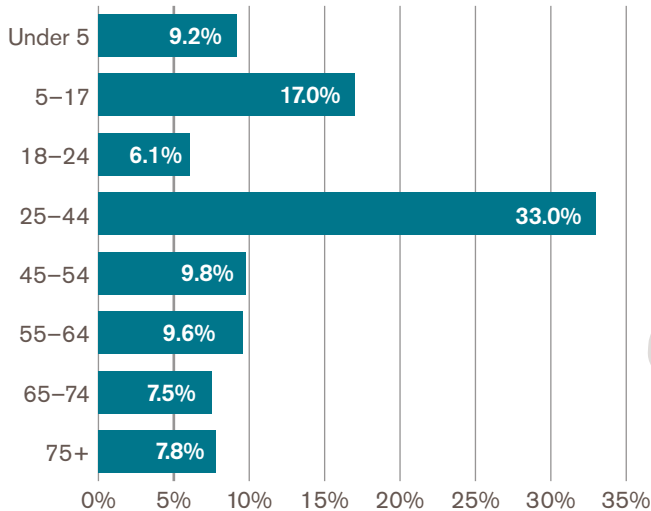
POPULATION, 2024

10,780

RACE/ETHNICITY



AGE DISTRIBUTION



Median Household Income
2019–2023

Educational Attainment
% of population 25 and older
HS Diploma or less, 2019–2023

Median Gross Rent
2019–2023

Pineville, NC

\$64,257

21.9%

\$1,467

Mecklenburg

\$90,494

25.8%

\$1,730

Source: US Census, American Community Survey (ACS)

Summary Community Health Indicators

Table 11. Indicators for Mecklenburg and Pineville

		Mecklenburg, NC 95% CI*	Pineville, NC 95% CI*	Years of Data Used
Length of Life[^]	Premature Death Rate before 75 years, per 100,000 population	317.0	379.5	2019–2023
	All Cause Death Rate (per 100,000)	643.4	1024.7	2019–2023
Quality of Life^{*,@}	% Poor Physical Health for ≥ 14 days (> 18 years)	10.7% (9.2–12.4)	12.0% (10.6–13.5)	2023
	% Depressive Disorder, self-reported (> 18 years)	22.4% (19.2–25.5)	23.8% (20.5–27.2)	2023
	% Diabetes Prevalence (> 18 years)	10.1% (8.6–11.6)	10.9% (9.4–12.4)	2023
	HIV Prevalence (per 100,000)	29.2	11.6	2024
Health Factors^{*,@}	% Adult Smoking	10.7% (8.5–13.1)	12.3% (10.5–14.3)	2023
	% Adult Obesity	29.5% (24.4–34.4)	31.0% (25.8–36.1)	2023
	% Adult Physical Inactivity	21.1% (17.3–24.9)	23.4% (19.9–27.0)	2023
	% Adult Binge Drinking	15.1% (12.5–17.6)	14.6% (12.0–17.2)	2023
	Sexually Transmitted Infections (per 100,000)	812.7	840.3	2024
Clinical Care^{*,@}	% Adults 19–64 without health insurance	13.6%	9.3%	2019–2023
	% Children < 19 without health insurance	8.1%	3.1%	2019–2023
	Mammogram Screenings (% women age 50–74)	80.3% (72.9–86.4)	75.3% (67.7–81.6)	2022
	Colorectal Screenings (% adults age 50–75)	60.4 (54.9–65.7)	58.2% (53.0–62.8)	2022
Social and Economic Determinants[#]	% in Poverty	10.5%	14.0%	2019–2023
	% Severe Housing Cost (renters spending 50% or more of household income on rent)	21.4%	27.8%	2019–2024
	% Unemployment	3.4%	4.2%	2019–2023
	% Households without Internet	6.8%	13.7%	2019–2023
	% Households with no Vehicles	6.1%	11.1%	2019–2023
Community Safety Measures[^]	Homicides (per 100,000)	9.5	---	2019–2023
	Suicides (per 100,000)	9.8	13.3	2019–2023
	Firearm Fatalities (per 100,000)	14.2	11.4	2019–2023
	Motor Vehicle Crashes (per 100,000)	9.7	---	2019–2023
	Drug Overdose Fatalities (per 100,000)	23.3	22.8	2019–2023

Sources: CDC PLACES age-adjusted rates (*), NCDHHS, SCHS, Vital Records crude rates (^), NCEDSS crude rates (@) and U.S. Census, American Community Survey (#)

* 95% Confidence Interval.

— Rates are not available for health indicators with 5 or less deaths.

Emerging Health Issues

While long-standing health challenges remain a priority, new and evolving issues are also shaping our community’s health. This section highlights emerging trends that may not yet appear in traditional health rankings but are increasingly impacting the county’s well-being. By paying attention to early trends, we can stay ahead of the curve and respond proactively with policies, programs, and partnerships.

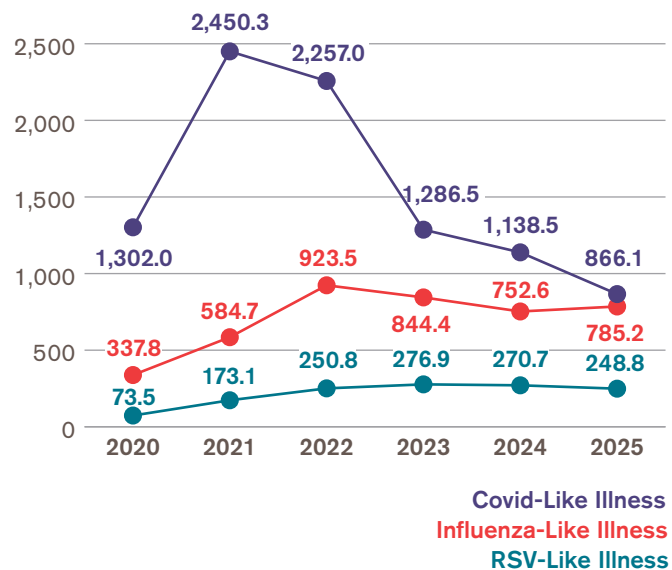
Vaccine-Preventable Diseases

- Vaccines are a safe and effective way to prevent diseases. Despite this fact, overall vaccination coverage has declined across the nation, and outbreaks of vaccine-preventable diseases, such as measles and mumps, have increased.
- The MMR vaccine requires high levels of vaccination coverage ($\geq 95\%$) to protect the public. In 2024, the Mecklenburg Kindergarten through 5 (K–5) MMR vaccination coverage was near 92%. (source: NC DHHS)
- In addition to measles, outbreaks of Pertussis (also called whooping cough) have occurred. Locally, Pertussis case reporting has increased from 4 cases reported in all of 2023 to 67 cases reported in 2025.
- The combination of declining vaccine uptake and increased global travel underscores the need for enhanced surveillance, heightened clinical awareness, and rapid response strategies to prevent outbreaks.

Respiratory Illness

- Respiratory viruses have a remarkable ability to evolve over time. These dramatic shifts can result in new strains that our immune systems have not encountered before, potentially causing widespread illness. Covid-19 and H1N1 are examples of these changes. This adaptability poses challenges for public health officials who must continuously monitor and respond to these emerging threats.
- Each year, respiratory viruses are responsible for hundreds of illnesses, hospitalizations, and deaths in Mecklenburg. In addition to the virus that causes COVID-19, there are many other types of respiratory viruses, including influenza (flu) and respiratory syncytial virus (RSV).
- Emergency department (ED) visits for people presenting with symptoms of COVID-19 without an actual diagnosis are called Covid-Like Illness (CLI). The rate of CLI ED visits peaked between 2020 and 2021, then declined in 2023.
- Rates of ED visits due to Influenza-like illness have increased over time. While ILI ED visits declined in 2023, overall rates remain higher than 5 years prior. ED visits for respiratory syncytial virus (RSV) have doubled within the past 5 years.

Figure 53. **Rate of ED Visits due to Acute Respiratory Infections per 100,000, Mecklenburg 2020–2025**

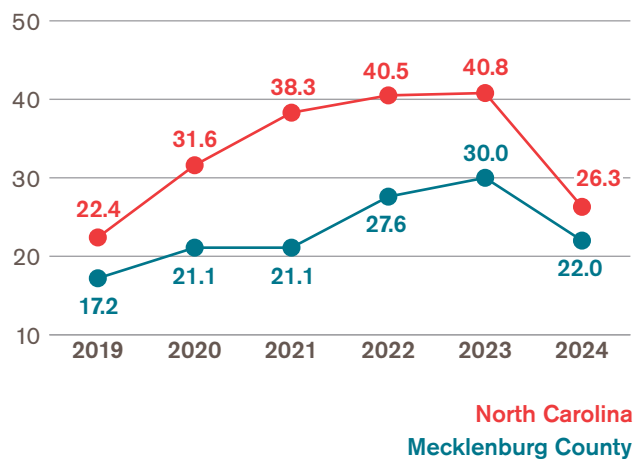


Source: NC DETECT

Drug Overdose

Recent state data shows that from 2019 to 2023, more than 41,500 North Carolinians lost their lives to a fatal overdose. In 2023 alone, there were 12 deaths per day. In the same time period, the state experienced an 83% increase in overdose death rates while Mecklenburg County saw a 76% increase.

Figure 54. **Drug Overdose Deaths per 100,000, Mecklenburg 2019–2024**



Source: CDC WONDER

Wastewater data from 2024–2025 indicate that several high-risk substances, such as cocaine and fentanyl, remain higher than regional and national averages in a key area of Mecklenburg County.

Among Mecklenburg County residents, overdose deaths were disproportionately higher among black and Hispanic populations, males aged 25–64, compared to white populations from 2019 to 2023. The number of deaths in Black and Hispanic populations has increased by over 200% compared to white populations (14%). The same can be seen in ED visits (55%) and MEDIC calls. The most vulnerable populations, or those who may have a higher risk of experiencing an overdose include:

- People experiencing homelessness
- Those involved with the justice system
- Those who have a history of mental health/behavioral health diagnoses

However, for the first time in years, near real-time surveillance data indicates a projected 27% decrease in fatal overdoses in 2024 compared to the prior year.

Suspected fatal overdose counts from January 2025 compared to suspected fatal overdoses in January 2024 indicate a 50% decrease in the same month. Non-fatal overdoses follow a similar trend.

Many similar key drivers seen across the nation can be attributed to the decline in overdose deaths seen in Mecklenburg County. This includes:

County-wide overdose prevention initiatives

- Overdose Data to Action program— a CDC-funded program that supports jurisdictions in implementing prevention activities and in collecting accurate, comprehensive, and timely data on nonfatal and fatal overdoses and in using those data to enhance programmatic and surveillance efforts.
- Opioid Settlement— funds awarded to Mecklenburg County to support addiction treatment, prevention, and recovery efforts

Naloxone distribution

- Increased by roughly 320% from 2021 to 2024
- Increased by roughly 1% in 2025, surpassing historic numbers in 2024

Opioid prescriptions

- A decrease in the number of opioids prescribed from 2019 to 2024 (stimulant prescriptions have increased in the same time period)

Reported harm reduction encounters in Mecklenburg County*

- 446% increase from 2024 to 2025

This downward trend in overdose death rates is not guaranteed to continue. The unpredictability of changes in the illicit drug supply highlights the need for continuous surveillance and data collection across many sectors, continued implementation of evidence-based programs and policies, and wider access to naloxone and life-saving medications.

*Harm reduction encounters as defined by the Centers for Disease Control and Prevention is any interaction with service providers where a need expressed by a participant is addressed and where services are provided including distributing naloxone through OEND programs, providing drug checking services, distributing fentanyl test strips, wound care kits, offering Hepatitis C and HIV services, and other services provided by harm reduction service providers.

Food Security

Food security is defined as having consistent physical and economic access to sufficient, safe, and nutritious food that supports an active and healthy life. While food access has long influenced health outcomes, recent local data indicate that food insecurity remains persistent in Mecklenburg County and is emerging as a more urgent concern amid rising costs and uneven access to healthy food environments.

Approximately 20% of Mecklenburg County households live in USDA-designated Low Income Low Access areas, where more than one-third of households are located more than one mile from a grocery store. This data, paired with availability, affordability, and accessibility of food information, makes up the Food Security Assessment and Dashboard, which is a spatial assessment of the food landscape and updates the existing knowledge of food access and disparities of healthy food outlets.



Local BRFSS data from 2024–2025 show only modest improvement in food insecurity compared to 2022, with 16% of adults reporting worry that food would run out before they had money to buy more, 11% reporting cutting or skipping meals, and 9% reporting hunger without eating due to lack of money. These experiences are not evenly distributed: Hispanic/Latino adults were significantly more likely than White adults to report food-related worry and meal reduction, and one in five Black adults reported concern about food running out.

Nationally aligned trends reinforce these findings. Data from Feeding America’s Mind the Meal Gap report show that food insecurity in Mecklenburg County increased from 10.8% in 2019 to 13.2% in 2023, reflecting a growing strain despite economic recovery in other areas. The data suggest that food insecurity is not only persistent but is increasingly shaped by affordability, access, and rising living costs, making it a critical emerging issue with direct implications for chronic disease and overall community well-being.

Building on recent investments in improved data tools, Mecklenburg County Public Health continues to strengthen how food security data are collected and used to better understand community needs and guide action.

Additional information about Food Security may be found on the [Mecklenburg County Food Security Dashboard](#).



MECKtrics

MECKtrics are Mecklenburg County’s core population health indicators, a shared set of data measures that help us track where we are, and where we need to go. The name reflects both our county and our commitment to using meaningful metrics to guide action.

Developed to track long-term progress and drive decision-making, MECKtrics are a curated set of indicators that reflect the most critical drivers of health and well-being for our community. MECKtrics are reviewed annually to monitor progress, identify emerging concerns, and assess whether we are advancing identified health priorities.

MECKtrics provide a transparent, shared framework to measure whether our collective efforts are moving the county toward better health outcomes. MECKtrics are an accountability tool that helps community partners, policymakers, and residents understand trends, determine impact, and align strategies to improve health and quality of life for all who call Mecklenburg County home.

MECKtrics status is categorized as improving, no change, or worsening based on trends from the baseline data year (2018-2019) to present.

We also review the most recent three-year period to better understand emerging shifts and alignment with current CHA priorities.

Recent data show a mixed pattern across MECKtrics. Youth suicide attempts and opioid overdose deaths reflect overall worsening when compared with the 2018 baseline. However, the most recent three-year trends suggest early signs of improvement in both areas.

In contrast, mental health-related emergency department visits have improved relative to baseline, but have shown a concerning uptick over the past three years indicating recent challenges despite longer-term progress.

Together these patterns reinforce the importance of considering long-term trends and recent movement to understand where progress is taking hold and where additional focus is needed.

Table 12. MECKtrics Population Health Indicators

	Indicators	Goal	Baseline	2019	2020	2021	2022	2023	2024	Status
Access to Care	Uninsured Adults <i>% Uninsured, Adults (19-64yrs)</i>	8%	16.2% (2018)	15.8%	15.1%	15.1%	13.2%	14.7%	13.6%	Improving
	Primary Care Access <i>% Adults (18+) without a PCP</i>	16%	28.0% (2019)	24.5%	21.9%	23.1%	25.6%	22.3%	12%*	Improving
	Primary Care Cost <i>% Adults (18+) unable to see doctor due to cost</i>	14%	18.9% (2019)	14.6%	15.4%	11.8%	16.4%	15.1%	13.3%	Improving

	Indicators	Goal	Baseline	2019	2020	2021	2022	2023	2024	Status
Chronic Disease Prevention	Adult Smoking <i>% Adults (18+) current smokers</i>	6%	13.9% (2018)	14.3%	11.6%	11.9%	10.4%	8.9%	9.4%	Improving
	Adult Physical Activity <i>% Adults (18+) with no physical activity within past 30 days</i>	16%	22.1% (2019)	18.6%	21.8%	20.3%	17.8%	18.2%	22.8%	No Change
	Food Security <i>% Adults hungry and did not eat because there wasn't enough money for food</i>	6%	18.9% (2019)	n/a	n/a	n/a	n/a	11.0%	11.0%	No Change
Violence Prevention	Homicides <i>Homicide Rate per 100,000</i>	6.0	7.0 (2018)	9.5	11.2	10.2	9.6	7.9	9.4	Worsening
	Firearm Injuries <i>Rate of ED visits due to Firearms per 100,000</i>	60	48.1 (2018)	48.6	59.7	49.2	59.1	70.0	65.1	Worsening

Mental Health	Suicides <i>Suicide Rate per 100,000</i>	8.6	9.6 (2018)	8.6	9.7	11.7	9.6	11.0	11.4	Worsening
	Youth Suicide Attempts <i>Rate of Youth ED visits due to suicide attempts per 100,000</i>	185	102.4 (2018)	115.4	111.4	139.6	213.5	205.6	199.1	Worsening
	Opioid Overdose (Deaths) <i>Opioid Overdose Deaths per 100,000</i>	13.1	15.5 (2018)	13.6	15.6	17.4	24.1	25.8	22.3^	Worsening
	Mental Health ED Visits (Depression) <i>Rate of ED visits due to Depression per 100,000</i>	751.2	1451.7 (2018)	1194.3	885.6	784	853.9	834.7	894.1	Worsening
	Mental Health Days Not Good <i>% Adults reporting mental health not good for 8 or more days per month</i>	14%	15.7% (2018)	14.8%	17.6%	15.8%	19.4%	20.1%	21.2%	No Change

	Indicators	Goal	Baseline	2013–2015		2016–2018		2019–2021	2022–2024	Status
Child & Maternal Health	Maternal Mortality <i>Maternal Deaths occurring up to one year after delivery per 100,000 live births</i>	15.7	13.5 (2016–18)	16.2		13.5		43.1	n/a	Worsening
				2019	2020	2021	2022	2023	2024	
	Breastfeeding Initiation <i>% births with infants breastfed at discharge</i>	90.0%	89% (2018)	89%	90%	89%	89%	89%	90.9%	No Change
	Infant Mortality <i>Infant deaths per 1,000 Live births</i>	4.0	5.1 (2018)	6.3	5.1	5.0	4.9	5.2	n/a	No Change

Note: Recent maternal mortality data are not yet available because NC requires detailed review of each case through the Maternal Mortality Review Committee before rates are finalized (NCDHHS State Center for Health Statistics).

* The Primary Care Access question was modified in 2024; therefore, the data gathered for that year is not comparable to reports from previous years.

^Source: NC Overdose Interactive Data



Chapter 4: **Our Priorities**

In 2022, four health priorities were identified during the CHA process: Access to Care, Chronic Disease Prevention, Mental Health, and Violence Prevention. During the inaugural Meck Design Community CHIP planning event, residents and community partners identified a fifth priority, Maternal and Child Health, confirming the overall focus areas for Live Well Meck and its community health improvement planning efforts.

Issue Prioritization: How Community Voices Shaped Our Focus

Identifying 2025 CHA priorities to support the future Community Health Improvement Plan was a community-driven process. Mecklenburg County Public Health worked alongside community partners to gather broad input on which health and quality-of-life issues matter most to residents across the county. This process intentionally combined multiple methods to ensure priorities reflected both widespread input and lived experience.

| Community Prioritization Survey

As part of the 2025 Community Health Assessment, the Live Well Steering Committee partnered with the North Carolina Institute for Public Health (NCIPH) to conduct a Community Prioritization Survey. The purpose of the survey was to hear directly from residents about which health issues they believe are most important to address to improve health and well-being in their communities.

Representative sampling strategies were deployed to recruit community members ages 18 and older. Approximately 5,000 postcards were mailed, encouraging community members to participate in the survey. Responses were collected from July 11, 2025, to August 24, 2025.

Developed by NCIPH with guidance from MCPH, the prioritization survey consisted of 9 questions that captured feedback on what health focus areas participants believed were most important to address to achieve better health outcomes, as well as demographics. The Prioritization survey questions included:

- (1) Two prioritization questions, asking participants what health issues and focus areas they believed were most important to address to achieve better health outcomes and quality of life in their community
- (2) Five demographic questions to collect data on participants' age, gender identity, race, ethnicity, and residence (municipality) within the county
- (3) Two eligibility questions to determine whether respondents were eligible to participate in the survey

The survey was available in both English and Spanish to improve accessibility and better reflect county demographics. Participants were asked to rank health and quality-of-life topics, along with a small number of demographic questions to help interpret results responsibly and understand who was represented.

| Reaching Residents Across the County

To encourage additional, broader participation, the survey used multiple outreach strategies. A random sample of residential addresses across Mecklenburg's municipalities received mailed invitations, helping ensure geographic representation. At the same time, community partners, county teams, and trusted messengers promoted the survey through newsletters, community events, clinics, and local organizations.

Outreach included engagement at large community events such as National Night Out, CLT Pride, and the African American Men's Wellness Walk, as well as outreach through community health workers, health department clinics, nonprofit and faith-based partners, and local sports organizations.

Throughout the survey period, responses were reviewed weekly. This allowed the team to identify underrepresented communities and adjust outreach strategies in real time to encourage broader participation.

Survey Participant Overview

Table 13. **Race and Ethnicity**

Responses	Sample (N = 622)*	ACS 2023 5yr est.
Race		
White	63.7% (321)	49.6%
Black or African American	19.9% (176)	30.5%
Asian	3.6% (20)	6.0%
American Indian or Alaskan Native	0.4% (6)	0.4%
Native Hawaiian or Other Pacific Islander	0.1% (1)	~0.0%
Other race not listed here	2.3% (16)	6.5%
Two or more races	3.5% (29)	7.0%
Prefer not to answer	6.5% (48)	-
Ethnicity		
Hispanic/Latino	11.6% (92)	13.1%

Table 13. **Age Groups**

Responses	Sample (N = 622)*	ACS 2023 5yr est.
18–24 years	2.9% (29)	12.0%
25–44 years	34.6% (251)	41.3%
45–64 years	39.5% (230)	31.4%
65–84 years	22.9% (87)	13.6%
85+ years	<0.1% (1)	1.6%

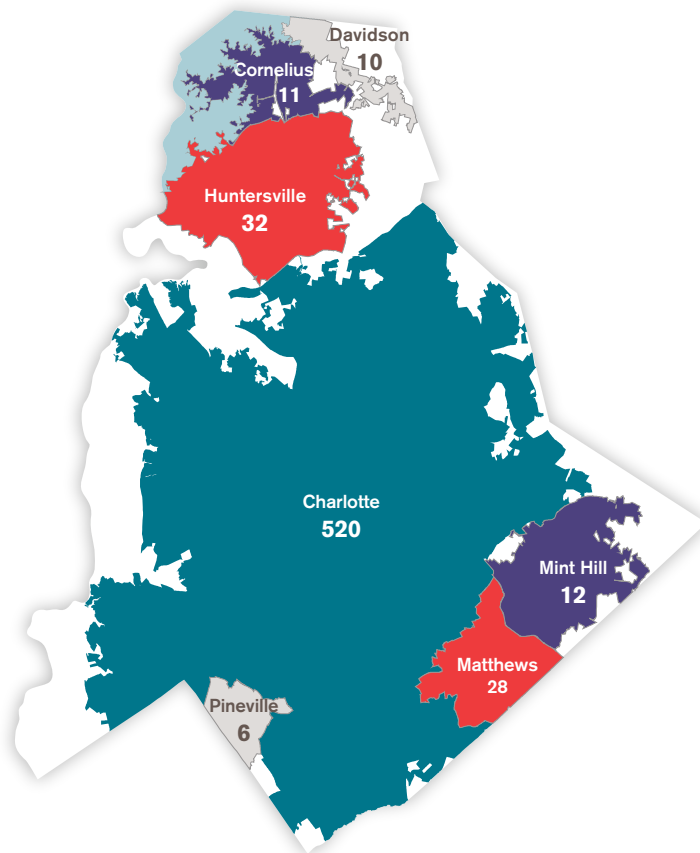
Table 13. **Gender**

Responses	Sample (N = 622)*	ACS 2023 5yr est.
Man	33.1% (157)	47.5%
Woman	64.7% (449)	52.5%
Prefer to self-describe	1.4% (6)	-
Prefer not to answer	0.8% (9)	-

*Prioritization results are displayed as weighted percentages (unweighted counts)

Note: Missing values were omitted from this table

Map 14. 2025 Mecklenburg CHA —
Prioritization Votes by Municipality



What the Survey Could and Could Not Tell Us

While the prioritization survey provided valuable insight into community perspectives, it represents one source of input. Participation required internet access, which may have limited who was able to respond. Some demographic groups were represented more heavily than others, and certain populations may not have found an online survey accessible or appropriate for sharing their experiences.

- The survey reached people ages 25–64, **fewer in age groups 18–24 and 85+.**
- The city of Charlotte was most represented in the survey, while **Pineville, Mint Hill, Davidson, and Cornelius** were less represented.
- **Women were overrepresented** in the survey.
- **Black or African American, Asian communities** were underrepresented.

Recognizing these limitations reinforced the importance of pairing survey results with additional community-engagement strategies to ensure that feedback and input are representative of community demographics.

Making Sense of the Survey Results

After the survey closed, responses were reviewed to remove incomplete, duplicate, or invalid entries. Results were then analyzed to identify which issues were most frequently selected as priorities across the county.

To ensure findings reflected Mecklenburg County as a whole, responses were weighted by municipality and aligned with population estimates. This helped balance participation across different parts of the county and ensured that no single outreach method or geographic area disproportionately influenced results.

Survey findings were summarized using descriptive statistics and visual displays to clearly communicate key priorities.

From Data to Community Decision-Making

Survey findings were not intended to stand alone. Results were shared with residents, partners, and stakeholders during two *Destination Wellness: Road to a Healthier Mecklenburg* community prioritization meetings. These sessions created space for reflection and discussion among community members, including groups underrepresented in the survey, and others who may not have participated. Attendees gained valuable insights into the community’s health status and finalized health priorities as a foundation for strategic planning to address those priorities through the community health improvement planning process.

Using survey results as a starting point, participants engaged in guided discussions to consider the magnitude of issues, their impact on quality of life, and the community’s readiness to act. Through discussion and consensus-building, participants identified the priority areas that will guide the 2026 to 2028 Community Health Improvement Plan.

This layered approach, combining survey data, community dialogue, and qualitative insights, ensured that final priorities were both data-informed and grounded in the lived experiences of Mecklenburg County residents.

Combining data compiled through residents’ lived experience, local data reviews, and periodization survey results led to the following priority areas of focus, which will inform the 2026 Community Health Improvement Planning process. Although the priorities have not shifted much, an underlying emphasis on the social determinants of health, particularly housing and education, has been specified.

The following results represent the highest-ranked health priorities identified by survey respondents, reflecting the issues considered most important for improving community health and quality of life.

Figure 55. Overall Prioritization Votes for Health Issues

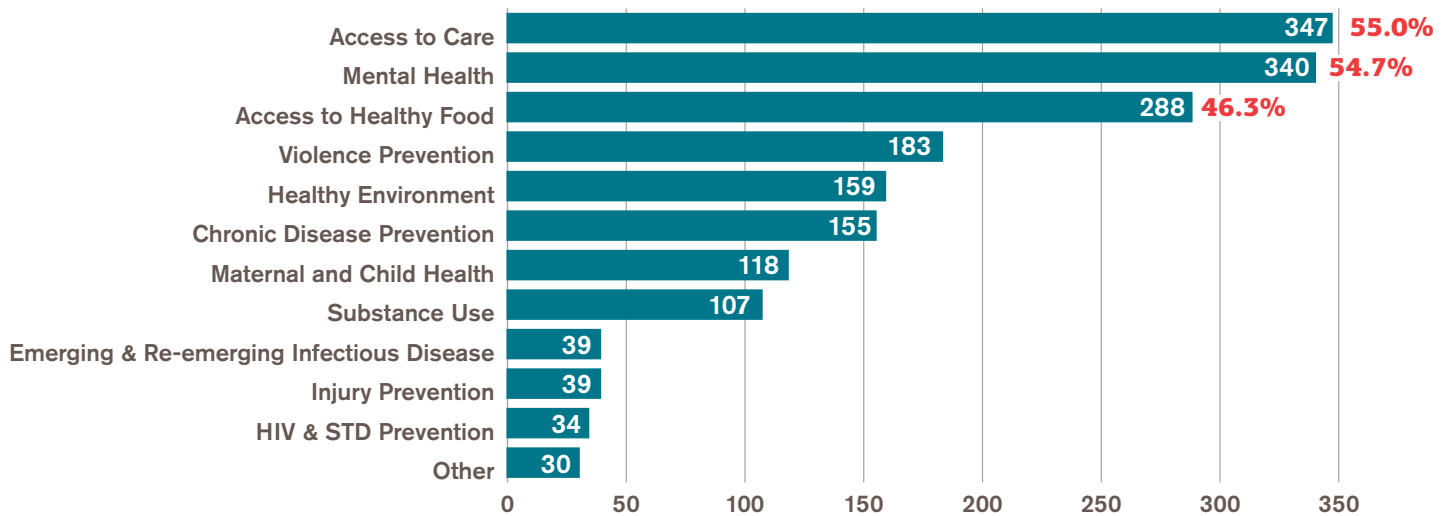
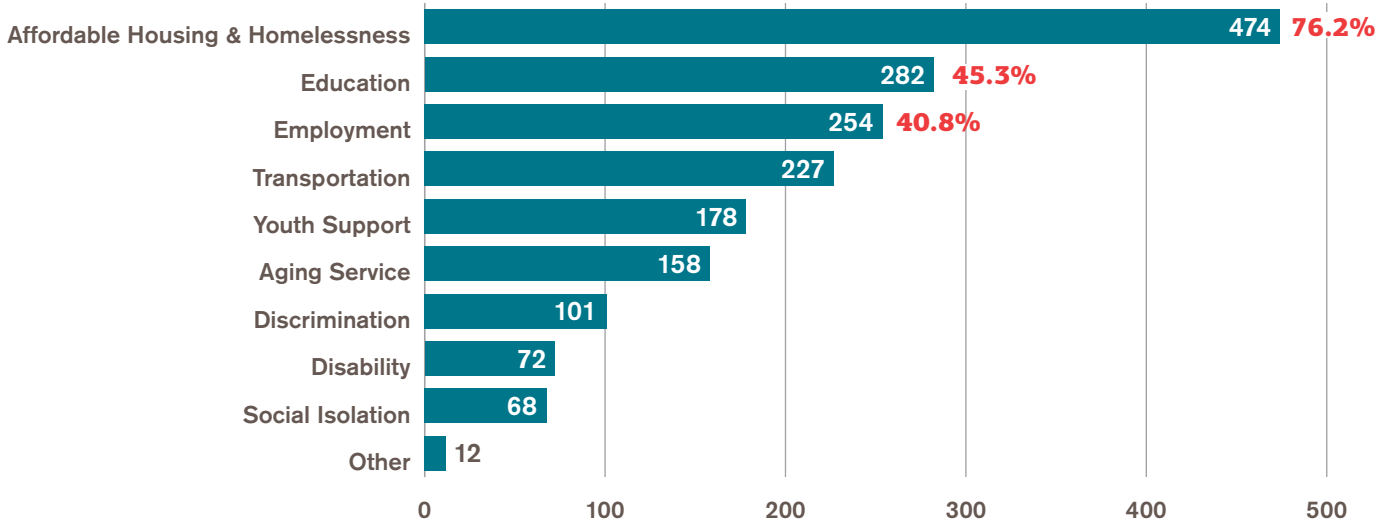
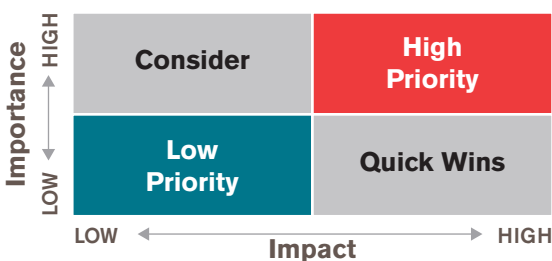


Figure 56. **Overall Prioritization Votes for Quality-of-Life Focus Areas**



During the *Destination Wellness* community meetings hosted both in person and virtually, 111 community members engaged in a structured, interactive process to translate survey findings into shared priorities for action. Participants worked in small groups to review the health and quality-of-life issues identified through the community survey. Using a visual prioritization matrix tool developed by UNC-NCIPH, each group discussed the issues and placed stickers into quadrants based on perceived importance and readiness for change. Topics that clustered in the “High Priority” areas were circled to visually signal alignment and urgency. Groups then participated in a one-minute “lightning round,” where they briefly presented their identified high priorities or quick wins and explained the rationale behind their selections, grounding their decisions in both data and lived experience. Following these discussions, participants cast collective votes to determine the top three health and top three quality-of-life issues affecting all communities that should be addressed to improve overall well-being. This participatory mapping process ensured that final priorities reflected both community voice and consensus-driven decision making.

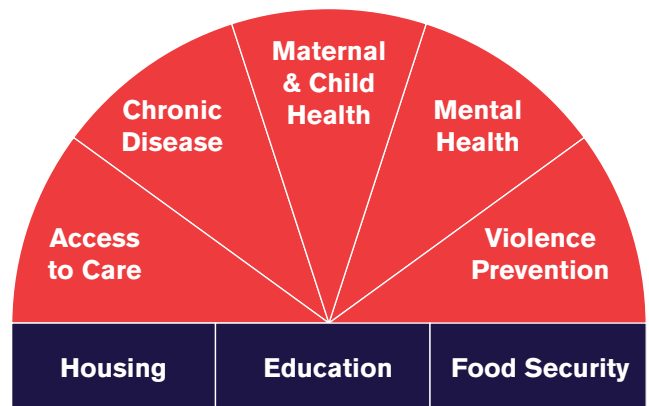
Figure 57. **Prioritization Matrix**



There was strong consensus among participants, steering committee members, and other community representatives to continue with the 2022 priority areas, given their clear alignment and overlap with the issues raised in the current mapping exercise and survey results. At the same time, key refinements emerged: food security should be more centrally positioned within the overall chronic disease prevention strategy, and greater emphasis should be placed on housing and education as foundational drivers of health.

Therefore, the 2025 priorities include Access to Care, Chronic Disease, Maternal and Child Health, Mental Health, and Violence Prevention, recognizing that food security, housing, and education remain essential cross-cutting themes influencing each of these focus areas.

Figure 58. **2025 Priorities**





Chapter 5: **Our Future**

Conclusions

The CHA sparks collaborative community action to address core community health issues. CHA findings are used by many organizations and community members as a reference for education, awareness, advocacy, funding, program development, and strategic planning to improve health and quality of life in Mecklenburg County.

The next step in the process is to develop a CHIP to address the top-priority issues identified through the CHA. Live Well will quarterback a coordinated CHIP process that acknowledges and aligns existing strategies, initiatives, and community plans to strengthen shared accountability and advance collective impact.

Using the Results-Based Accountability (RBA) framework, partners will define clear population-level results, identify measurable indicators, and develop evidence-informed strategies that answer the core questions: How much are we doing? How well are we doing it? Is anyone better off? An updated Clear Impact public scorecard will be developed within MECKtrics to transparently track progress, monitor performance measures, and ensure continuous improvement through the RBA framework.

The CHIP will build on existing plans, investments, and community-led efforts to reduce duplication and maximize coordination. The following internal Mecklenburg County plans and reports will provide foundational frameworks for joint health improvement planning along with other area initiatives.

- **The Way Forward, Community Violence Prevention Plan**
- **Mecklenburg County Access to Care Report**
- **Mecklenburg County Chronic Disease Prevention Plan**
- **Mecklenburg County Infant Mortality Report**
- **Mecklenburg County Behavioral Health Plan**

The Live Well Tour and Meck Design will anchor the next phase of community engagement as Live Well Meck transitions from assessment to action. The tour will share CHA findings across communities and create space for dialogue and local insight, while Meck Design will convene partners and residents to codesign strategies and align efforts in support of the Community Health Improvement Plan. Meck Design will include several enhancements, including a robust community asset-mapping process and dedicated tracks for key partners such as community health workers and faith leaders. Both events will create an interactive and engaging space to learn, share, plan, and strengthen partnerships to enhance local synergy around community health improvement goals.

As we look to the future, strengthening the Live Well infrastructure is essential to advancing community health. The 2026 CHIP process will launch the implementation of a tiered partnership approach within the Live Well Framework, strengthening local partnerships. Partners will organize across three tiers to support meaningful collaboration and shared accountability for improving community health.

- **Tier 1** partners include the existing Live Well Meck Steering Committee. This group includes systems partners serving in a steering/advisory role.
- **Tier 2** partners actively support implementation by aligning programs, sharing data, and participating in coordinated efforts that advance health priorities
- **Tier 3** partners include a broad network of community-based organizations, faith groups, institutions, and residents who contribute lived experience, local expertise, and on-the-ground action.

Together, these tiers create a flexible and inclusive partnership model that strengthens coordination, elevates community leadership, and drives collective impact across Mecklenburg County. Additionally, this framework centralizes community voice and provides residents with opportunities to inform implementation and guide course corrections over time.

Shared Accountability and Measurement for Action

Improving community health in Mecklenburg County is a shared responsibility. No single organization or sector can address these challenges alone. Progress depends on collaboration across healthcare systems, community-based organizations, local government, universities/academic institutions, employers, faith-based organizations, and residents themselves. All of us have a role to play in shaping the conditions that influence health through policy, programs, resource allocation, service delivery, and community leadership. The following table outlines how key partners contribute to collective impact for improved health.

Roles and Responsibilities

Table 14. Roles and Responsibilities by Sector

Sector	Role and Responsibility
Healthcare Systems	Deliver high-quality, accessible, and culturally responsive care, share data insights to identify trends and gaps, partner with public health and community organizations to improve prevention, care coordination, and follow-up; use community feedback to inform service design and outreach strategies
Community-Based Organizations	Serve as trusted connectors between residents and systems; elevate lived experience and community priorities; provide culturally grounded services and navigation support; create continuous feedback loops by sharing what's working, what is not, and emerging needs with partners
Residents and Community Members	Shared lived experiences, priorities, and concerns; participate in surveys, listening sessions, and community forums; help shape solutions that reflect real needs; hold systems accountable by providing ongoing feedback on access, quality, and responsiveness
Policymakers	Use CHA findings and community input to guide policy, funding, and planning decisions; remove structural barriers through legislation and resource allocation
University/Academic Partners	Use CHA findings to guide community-based participatory research, applied learning, and workforce training; integrate public health priorities into curricula; support evaluation and continuous improvement in partnership with community organizations
Mecklenburg County Public Health	Convene partners, steward data and community input; maintain Clear Impact dashboard, lead CHIP and SOTCH processes; facilitate coordination across sectors; identify and implement innovative and evidence-based priority-focused strategies; maintain feedback loops between residents, organization, and decision makers to inform ongoing improvement

Investments for a Healthier Future

Since the last CHA, Mecklenburg County Public Health has contributed to implementing CHIP strategies to address previously identified health priorities. Through collaborative efforts, demonstrate a commitment to achieving a healthier Mecklenburg County by reaching more than 120,000 individuals, through over 250 trainings, and 1,300+ engagement/outreach activities.

During these convenings, 900 collaborative partnerships with community-based organizations, faith-based organizations, and more resulted in more than \$500,000 in grants and funding to support organizations and initiatives addressing top health priorities identified in the CHA.

Recent investments informed by the prior assessment have focused on expanding access to care for uninsured and underinsured residents, supporting chronic disease prevention policy and programs, strengthening maternal and child health supports, and advancing violence prevention and behavioral health strategies.

Access to Care & Maternal and Child Health

The following efforts were funded to support expanded access to care and maternal child health programs

- **Care Ring** implements A Guided Journey, a Community Health Worker Program developed by Mecklenburg County Public Health to address maternal-child health disparities
- **Access to Care Fund** supports eight organizations, including federally qualified community health centers and charitable clinics, were funded to expand access to care for uninsured and underinsured Mecklenburg County residents
- **The Promotores de Salud Program** partners with the Fe y Salud Coalicion Latina to expand access to Promotoras, certified community health workers, to educate community members on potential health risks, resources, and referral opportunities for primary care and other health services
- **Mamava Lactation Pods** were installed at BOplex, providing a private space for breastfeeding and pumping for Bojangles Coliseum and Ovens Auditorium patrons in partnership with the Charlotte Regional Visitors Authority



Chronic Disease Prevention

The **Live Well Community Grants Program** was reimagined to ensure alignment with 2023–2025 CHIP chronic disease prevention strategies. The program provides community mini-grant funds to support chronic disease prevention and management initiatives for high-risk populations. Eligibility is limited to nonprofit community-based organizations and faith-based entities participating in the Village HeartBEAT program.

The following agencies were awarded funds to support 2025 CHIP implementation through innovative community-based chronic disease prevention efforts.

Table 15. **Grantees and Programs Funded**

Grantee	Program
Embrace All Latino Voices	Addressed chronic disease in the Latino community through monthly seminars on heart disease, diabetes, obesity, and lifestyle changes, reaching 1,547 community members.
Home4ME	Launched three 30-day Intergenerational Health Challenges, featuring workshops on meal planning, cooking, and physical activity, engaged 1,256 youth and adults.
Learning Help Centers	Delivered health education, diabetes prevention, mental health training, and assessments to 746 African American and Latino residents.
Trips for Kids Charlotte	Hosted seasonal youth cycling and community ride programs, plus free bike repair clinics serving 37 youth riders in priority neighborhoods
Wheatfield Ministry Inc.	Provided Zumba, Double-Dutch aerobics, walking groups, and healthy cooking workshops benefiting 2,261 participants
Faith CME	Distributed food boxes to 10,791 residents in the Hidden Valley community

Grantee	Program
First Baptist Church West	Offered line dancing, blood drives, and a Grab & Go Lunch program for senior adults serving 878 residents
Greater Bethel AME Church	Delivered hybrid cooking classes, physical activities, and smoking cessation sessions reaching 1,129 youth and adults.
Greater Salem Church	Trained community health workers and caregivers, hosted diabetes support programs, and provided testing and vaccination supporting 539 residents
The Heights Ministries	Addressed food scarcity through a community garden, food pantry, and workshops on healthy meal preparation, serving 397 residents
St. Luke Missionary Baptist Church	Distributed hot meals in Druid Hills supporting 2,728 residents
The Park Church	Offered mobile services for unhoused neighbors, including screenings and chronic disease prevention education, reaching 723 residents
The Elizabeth House Foundation	Provided mobile mammograms and education for 61 uninsured and underinsured women.
Fatith and Health Latino Coalition	Delivered diabetes and chronic disease prevention workshops serving Latino families across Mecklenburg County
Wayfinders	Kept youth physically active yearround through camps, outdoor adventures, and soccer programs engaging 8–18 year olds in 10–20 activities annually
Friendship Missionary Baptist Church	Offered CPR/AED certification and recertification training to 106 residents

Additionally, a nonprofit bootcamp program was launched to support area organizations. The six-month capacity-strengthening efforts was hosted in collaboration with Social Architects, LLC. This program offered in-person sessions, virtual workshops, and personalized coaching. Participants received actionable guidance on creating practical action plans, building effective boards, program evaluation, and mastering fiscal skills, empowering 18 nonprofit organizations to achieve lasting success.

| Mental Health & Violence Prevention

Our Community. Our Safety. Our Mission.

The countywide communications campaign was launched in partnership with 110 North, The Creative Agency. This campaign is designed to shift social norms around community violence, featuring local advocates promoting the message of peace and community safety during gun violence prevention month.

The campaign concluded with 9.9 million ad impressions, driving traffic to local community violence prevention initiatives, events, and safety resources.



Youth Violence Prevention:

The 100 Youth Advisory Council is a network of Mecklenburg County youth advocates dedicated to engaging with local organizations to ensure a youth-directed partnership that informs violence prevention strategies. The Council delivered 52 workshops to 148 youth across 31 sites, resulting in numerous recommendations to enhance violence prevention and mental programming and investments.

Peacekeepers Academy:

Supported 24 community-based organizations through two Peacekeepers Academy cohorts, centering capacity building, training, violence prevention, and technical assistance to enhance or scale local programming in alignment with CHIP strategies.

Table 16. **Peacekeeper Member Organizations and Programs**

Organization	Program
A Giving Heart Project	Delivered parent and youth workshops on homelessness and violence prevention while launching a mobile outreach trailer to support unhoused youth in priority zip codes.
The Compassionate Companion (Carla A. Carlisle, LLC)	Developed a youth-focused mental health and grief workbook and facilitated school-based sessions in partnership with local education and community organizations.
Ausie & Martin Rivens Scholarship Foundation	Engaged elementary students in positive music creation and conflict resolution workshops that promoted self-expression and peaceful problem-solving.
Concrete Roses Life Center	Expanded a school-based youth development program integrating social-emotional learning, academic support, and family engagement across multiple schools.
Gryphon Group Advisory	Provided high-fidelity aftercare and leadership development for youth impacted by poverty, violence, and displacement using a train-the-trainer model.
The Queen's Collective Birthing	Facilitated culturally responsive community conversations and grief healing circles to promote collective healing and wellness.

Organization	Program
Youth Education & Arts, Inc.	Hosted expressive arts workshops focused on conflict resolution and violence prevention for African American youth.
Help Adolescents Speak Out	Created a safe space for youth and parents to engage in dialogue around community challenges and violence prevention solutions.
Unique Blessings (Compass Project)	Delivered workforce development training, mentorship, and emergency assistance to support economic stability for youth and families impacted by housing instability and domestic violence.
Families Planet Improv	Provided trauma-informed, school-based programming in Title I schools to strengthen communication skills, social-emotional learning, and peer engagement.
Hard Grindz Kings Growing Kings Mentoring	Led a summer mentoring program combining outdoor experiential learning and team-building activities to strengthen leadership, discipline, and positive peer relationships.
Achieving Success on Purpose (ASOP)	Implemented the B.R.I.C.K. program offering evidence-based mental health counseling, life skills training, and family support for youth facing substance use, conflict, and behavioral challenges.
Exposure Project	Launched a youth entrepreneurship food truck initiative providing hands-on business development experience and real-world skill building.
Step Up To Leadership (SUTL)	Implemented a community-based violence prevention program engaging young men and families through workshops focused on economic stability and family strengthening.
Unity Charlotte International	Facilitated youth-centered programs promoting mental health awareness and positive engagement between youth and law enforcement.
Money Fiend\$	Hosted “Beats and Sneaks,” an educational series introducing youth to music production, fashion entrepreneurship, and creative industry pathways.
Money Magnets Club	Delivered financial literacy programming for youth and families, distributing educational resources and fostering near-peer mentorship opportunities.
Just Do It Movement	Expanded an identification access and financial literacy initiative, helping young adults secure essential documents and build foundational financial skills.
Sojourner Truth Place	Supported young adults in obtaining essential identification documents and financial literacy skills to improve stability and access to employment and housing opportunities.

Together, these efforts position Mecklenburg County to move forward with a shared vision, stronger partnerships, and a coordinated approach to ensuring everyone has the opportunity to be healthy, thrive, and live well.

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Appendices

Technical Notes

| Mecklenburg Peer City/County Comparisons

- **Peer County Comparisons:** Mecklenburg peers are from the Robert Wood Johnson County Health Rankings peer county comparison feature. Peer Counties are similar to Mecklenburg based on key demographic, social, and economic indicators.
- **County Health Rankings:** Apart from a few metrics, 2025 County Health Rankings data were used for peer county comparisons. County Health Rankings methods of data collection, analysis, and subsequent data sources vary from those used throughout this report. Therefore, information from this table may not be directly comparable with other data in this report.

| City and Municipality Population Health Data

- **Mortality Data:** For most municipalities, cause-specific deaths and premature deaths are relatively rare events. Areas with smaller populations can see significant changes in their rates from year to year. Additionally, small death counts can result in relatively unstable rates, making it more difficult to detect changes in small areas. To account for these challenges, rates were calculated using multiple years of data and population estimates from US Census (American Community Survey).
- **Age Distribution and Crude Death Rates:** Due to small population sizes, crude death rates were analyzed for each municipality. Caution should be used in comparing data across municipalities as death rates are greatly influenced by the age distribution of populations. In example, municipalities with more Seniors tend to have higher overall death rates as well as more deaths due to chronic conditions. Conversely, municipalities that are younger in age may have higher death counts due to injuries or motor vehicle crashes.

| Commonly Used Data Sources

BRFSS	Behavioral Risk Factor Surveillance System Survey
CDC WONDER	Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research
CMPD	Charlotte Mecklenburg Police Department
NC DHHS	North Carolina Department of Health and Human Services
NC DETECT	North Carolina Disease Event Tracking and Epidemiologic Collection Tool, a collaboration between North Carolina Division of Public Health and the University of North Carolina School of Medicine
NC DPH	North Carolina Division of Public Health
NC EDSS	North Carolina Department of Health and Human Services, Division of Public Health, Electronic Disease Surveillance System
NC SCHS	North Carolina Department of Health and Human Services, Division of Public Health, State Center for Health Statistics
US Census, ACS	United States Census Bureau, American Community Survey

Summary Community Health Indicator Definitions

Health Indicator	Definition
Premature Death	Number of deaths among residents under the age of 75 per 100,000.
Life Expectancy	Average number of years from birth a person can expect to live, according to the current mortality experience (age-specific death rates) of the population.
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births
Child Mortality	Number of deaths among children (under age 18) per 100,000 population
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days
Poor Physical Health Days, >=14 days	Percent of physically unhealthy days for 14 or more days in past 30 days
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days
Depressive Disorder	Percentage of Adults reporting being told by a doctor they have depression
Diabetes Prevalence	Percentage of adults 18 and above with diagnosed diabetes
HIV Prevalence	Number of people aged 13 years and older living with a diagnosis of HIV infection per 100,000
All Cause Death rate	Number of deaths among residents per 100,000.
Heart Disease	Number of deaths among residents due to heart disease per 100,000.
Cancer-Related	Number of deaths among residents due to Cancer per 100,000.
Diabetes	Number of deaths among residents due to Diabetes per 100,000.
COVID-19	Number of deaths among residents due to Covid-19 per 100,000.
Adult Smoking	Percentage of adults 18+ who are current smokers
Adult Obesity	Percentage of adults 18+ that reports a BMI greater than or equal to 30 kg/m ² .
Adult Physical Inactivity	Percentage of adults 18+ reporting no leisure time physical activity
Binge Drinking	Percentage of adults 18+ reporting binge drinking
Sexually Transmitted Infections	Number of newly diagnosed chlamydia cases per 100,000 population.
Teen Births	Number of births per 1,000 female population ages 15–19
Adults 19– 64 without health insurance	Percentage of residents 19–64 uninsured
Children <19 without health insurance	Percentage of residents <19 uninsured
Primary Care Provider	Ratio of population to primary care physicians
Dentist	Ratio of population to dentists.
Mental Health Provider	Ratio of population to mental health providers

Referenced Community Resources

Mecklenburg County benefits from a broad network of public agencies, health systems, federally qualified health centers, charitable clinics, and community-based organizations working to improve health and well-being. This list is not exhaustive. It reflects frequently referenced resources identified through data review, focus groups, and community engagement throughout this assessment process.

Meck Design 2026 will include a detailed system mapping process to better understand the local resource ecosystem, how organizations interact with one another, and where gaps and opportunities for improved coordination and impact exist.

- **Charlotte-Mecklenburg 311 Service Center connects residents to local government services, information, and service requests.**

Access to Care: Federally Qualified Health Centers and Safety-Net Clinics

- [C.W. Williams Community Health Center](#)
- [Charlotte Community Health Clinic](#)
- [Cabarrus Rowan Community Health Centers](#)
- [Camino Salud](#)
- [Care Ring](#)
- [Cook Community Clinic](#)
- [Hope Community Clinic of East Charlotte](#)
- [Shelter Health Services](#)
- [NC MedAssist](#)
Provides free prescription medication and health support to uninsured and low income residents

Public Health and Health Systems

- [Mecklenburg County Public Health](#)
County agency dedicated to protecting and improving community health through disease prevention, education, and safety regulation.
- [Atrium Health](#)
Hospital system; primary and specialty care
- [Novant Health](#)
Hospital system; primary and specialty care

Maternal, Child, and Adolescent Health

- [Women's Empowerment and Birth Equity Institute](#)
Provides culturally rooted education, physician-led consultations, and advocacy to combat disparities infant and maternal disparities
- [Smart Start Mecklenburg County](#)
Mobilizes resources, forges partnerships, and supports families to improve early childhood health, education and development
- [Teen Health Connection](#)
Adolescent-focused medical and behavioral health care
- [Time Out Youth](#)
LGBTQ+ youth support and affirming services
- [Care Ring](#)
Prenatal and postpartum services for uninsured residents

Mental and Behavioral Health

- [Alliance Health](#)
Behavioral Health Crisis: 24 hours a day, 7 days a week at 877-223-4617
- [Promise Resource Network](#)
Peer-led recovery and mental health support
- [Atrium Health Behavioral Health Charlotte](#)
Inpatient and outpatient services
- [Novant Health Mental Health Treatment and Services](#)
Inpatient and outpatient services: 24 hours a day, 7 days a week at 800-718-3550
- [Smith Family Behavioral Health](#)
Urgent care alternative for Emergency Room and Inpatient Psychiatric Hospitalization for individuals who have a mental illness and/or substance use disorder; 24 hours a day, 7 days a week
- [988 Suicide and Crisis Lifeline](#)
24 hours a day, 7 days a week. Provides free and confidential support to people in suicidal crisis or emotional distress

Housing Stability and Homelessness Prevention

- [Mecklenburg County Community Support Services](#)
Connects people experiencing homelessness and housing instability to available resources and services.
- [Roof Above](#)
Emergency shelter; permanent supportive housing
- [Crisis Assistance Ministry](#)
Emergency rent/utility assistance, clothing, and household goods for families facing financial crises
Emergency rent/utility assistance, clothing, and household goods for families facing financial crises
- [Inlivian](#)
Provides safe, decent, and affordable housing while fostering economic and social independence for residents

Food Security and Basic Needs

- [Second Harvest Food Bank of Metrolina](#)
Regional food distribution network
- [Nourish Up](#)
Food pantry and Meals on Wheels program
- [Mecklenburg County Department of Community Resources](#)
SNAP enrollment; childcare subsidy; energy assistance

Community Information, Referral, and Care Coordination

- [CharMeck311](#)
Support line for City of Charlotte and Mecklenburg County services
- [NC 211](#)
24-hour statewide information and referral line
- [NCCARE360](#)
Electronic referral network linking providers and community organizations
- [Find Help](#) (formerly Aunt Bertha)
Online platform that connects individuals to local resources for food, housing, healthcare, transportation, and other social services
- [Mecklenburg County Community Resource Centers](#)
In-person benefits and service navigation
- [City of Charlotte](#)
Online community resource directory

Violence Prevention and Community Safety

- [Safe Alliance](#)
24 hours a day, 7 days a week
Hopeline 980-771-4673 for info on parenting, domestic violence and sexual assault
Provides emergency shelter, court advocacy, trauma-informed counseling, and other resources for victims of domestic violence and sexual assault
- [Pat's Place Child Advocacy Center](#)
Child advocacy and forensic services

Alternatives to Violence Programs

Violence interruption conducted via street outreach, conflict mediation, and retaliation prevention, and community education.

- [Youth Advocate Program](#)
- [Urban League](#)

Mecklenburg County Healthcare Facilities by Type

To provide context on local health infrastructure, this appendix lists healthcare facilities by type licensed by the North Carolina Division of Health Service Regulation. While the presence of facilities does not guarantee access, this inventory supports transparency, highlights system capacity, and informs future planning. The following tables present licensed facilities by category.

Ambulatory Surgical Centers

Facility	Municipality
Presbyterian SameDay Surgery Center At Ballantyne, LLC	Charlotte
A Division of Carolina Digestive Health Associates P. A	Charlotte
Endoscopy Center-Huntersville, LLC	Huntersville
Charlotte Gastroenterology & Hepatology, PLLC	Charlotte
SouthPark Surgery Center, LLC	Charlotte
Endoscopy Center-Pineville, LLC	Charlotte
Endoscopy Center-University, LLC	Charlotte
Carolinas Physicians Network, Inc.	Charlotte
Endoscopy Center of Lake Norman, LLC	Huntersville

Adult Day Care Homes

Facility	Municipality
Northlake House	Charlotte
MerryWood on Park	Charlotte
Spring Arbor of Steele Creek	Charlotte
The Terrace at Brightmore of South Charlotte	Charlotte
Ranson Ridge Assisted Living & Memory Care	Huntersville
Charter Senior Living of Charlotte	Charlotte
Arbor Ridge at Huntersville	Huntersville
Preston House	Charlotte
The Pines On Carmel Senior Living	Charlotte
Oakbridge Terrace @ Matthews Glen	Matthews
Sunrise on Providence	Charlotte
The Laurels in the Village at Carolina Place	Pineville
The Haven in the Village at Carolina Place	Pineville
The Haven in Highland Creek	Charlotte

Facility	Municipality
The Laurels in Highland Creek	Charlotte
Cadence Huntersville	Huntersville
Cadence Senior Living at Mint Hill	Matthews
The Charlotte Assisted Living	Charlotte
TerraBella Little Avenue	Charlotte
Legacy Heights Senior Living Community	Charlotte
East Towne	Charlotte
Waltonwood Cotswold	Charlotte
Waltonwood at Providence	Charlotte
Mint Hill Senior Living	Charlotte
The Parc at Sharon Amity	Charlotte
Summit Place of Southpark	Charlotte
Willow Ridge Memory Care	Charlotte
The Little Flower Assisted Living	Charlotte
Brookdale South Charlotte	Charlotte
Brookdale South Park	Charlotte
Brookdale Charlotte East	Charlotte
Cuthbertson Village at Aldersgate	Charlotte
Parker Terrace	Charlotte
Brookdale Carriage Club Providence II	Charlotte
Brookdale Weddington Park	Matthews
Brighton Gardens of Charlotte	Charlotte
Brookdale Carriage Club Providence I	Charlotte
Hunter Village	Huntersville
Caramel Hills	Charlotte

Cardiac Rehabilitation Centers

Facility	Municipality
Atrium Health Cardiac & Pulmonary Rehabilitation	Charlotte
Novant Health Presbyterian Hosp Cardio-Pulmonary Rehab	Charlotte
Atrium Health Pineville Cardiac & Pulmonary Rehab.	Charlotte
Novant Health Wellness Center at Matthews	Matthews
Novant Health Wellness Center at Huntersville	Huntersville

Family Care Homes

Facility	Municipality
Truett's Family Care Home	Huntersville
Glen Haven-Huntersville	Matthews
Designer Solutions Care Homes	Charlotte
House of Peace Family Care Home	Charlotte
The Brownstone at Park Crossing	Charlotte
Sanctuary at Stonehaven 6	Charlotte
The Post at Providence 2	Charlotte
Farmwood Senior Living 2	Charlotte
The Brownstone	Charlotte
Rosewood Providence	Charlotte
Sanctuary at Stonehaven 5	Charlotte
Amata Estates	Charlotte
Caring Hands Senior Home	Charlotte
The Post at Mint Hill 1	Charlotte
The Post at Mint Hill 2	Charlotte
Blissful Living Senior Care	Mint Hill
Farmwood Senior Living	Charlotte
Sanctuary at Stonehaven 4	Mint Hill
De Good Shephard Senior Living	Cornelius
Peninsula Family Care Home	Charlotte
The Post at Providence	Mint Hill
Revived Senior Living	Huntersville
Joyful Senior Living	Charlotte
Sanctuary at Stonehaven 3	Charlotte
S & T Senior Care Lakeside	Charlotte
The Sanctuary at Stonehaven 2	Charlotte
Hamilton Family Care Home	Charlotte
The Sanctuary at Stonehaven	Charlotte
McClain's Family Care Home #1	Charlotte
Etta Love Family Care Home	Charlotte

| Hospice

Facility	Municipality
VIA Health Partners	Charlotte
VIA Health Partners Levine & Dickson Hospice House at Huntersville	Charlotte
VIA Health Partners Levine & Dickson Hospice House at Aldersgate	Charlotte
VIA Health Partners Levine & Dickson Hospice House at Southminster	Charlotte

| Hospitals

Facility	Municipality
Carolinas ContinueCare Hospital at Pineville	Charlotte
Carolinas Medical Center/Center for Mental Health	Charlotte
Carolinas Rehabilitation	Charlotte
Novant Health Ballantyne Medical Center	Charlotte
Novant Health Huntersville Medical Center	Charlotte
Novant Health Matthews Medical Center	Charlotte
Novant Health Mint Hill Medical Center	Huntersville
Novant Health Presbyterian Medical Center	Matthews
Carolinas ContinueCare Hospital at Pineville	Charlotte
Carolinas Medical Center/Center for Mental Health	Charlotte

| Mental Health

Facility	Municipality
Atrium Health Behavioral Health-Partial Hospitalization	Charlotte
Nevins, Inc.	Charlotte
Oak Street Group Home-St. Mark	Charlotte
Alexander Youth Network - PRTF	Charlotte
VOCA-Denbur Drive Group Home	Charlotte
Miller Family Home	Charlotte
Diamond's House #1	Charlotte
VOCA-Norwich Road Group Home	Charlotte
The Renfrew Center of North Carolina	Charlotte
Hinds' Feet Farm	Huntersville
Echelon 3	Charlotte
Miracle Houses-Swearingan	Charlotte
Inreach/ Highbury	Charlotte
One Step Forward Outreach	Charlotte
Echelon 4	Charlotte
Echelon 5	Charlotte

Facility	Municipality
VOCA-Mallard Drive	Charlotte
The Norland House	Charlotte
My Way Day Supports	Charlotte
Kerr Homes	Charlotte
VOCA-Woodbridge Road Group Home	Charlotte
Alexander Youth Network - Elm Unit	Charlotte
ARJ, LLC	Charlotte
Kerr Homes, Inc.	Charlotte
S.T.E.P's Developmental Day Academy	Charlotte
Day By Day Substance Abuse Services	Charlotte
Family First Community Services, LLC	Charlotte
Yorke Cottage	Matthews
Alphin Cottage	Matthews
Empowerment Quality Care Services	Charlotte
Carolina Family Alliance-Rise Program	Charlotte
Dalmoor Drive Group Home	Charlotte
Epiphany Family Services	Charlotte
McAlway Road	Charlotte
Briar Creek Road	Charlotte
Carmel Forest Drive	Charlotte
Bon Rea Drive Group Home	Charlotte
InReach-Clanton Road Day Supports	Charlotte
McLeod Centers for Wellbeing	Charlotte
The Workshop	Charlotte
VOCA-Simpson Group Home	Charlotte
Peace Cottage	Matthews
Merancas Cottage	Matthews
S.T.E.P's to Self-Determination	Charlotte
Collaborative Hope SAIOP	Charlotte
Family Preservation Services of NC-Carolina House	Charlotte
Starnes Group Home	Charlotte
The Insight Program	Charlotte
Hinds' Feet Farm-Puddin's Place	Huntersville
VOCA-Freedom Group Home	Charlotte
Jasper's House Day Treatment	Charlotte
Enoch Drive	Charlotte
Transcend E.D.	Matthews
Vinetta Green Home	Charlotte
VOCA-Harrisburg Road Group Home	Charlotte
Absolute Advocacy-Mecklenburg	Charlotte
Lilley Home	Charlotte

Facility	Municipality
VOCA-St. John's Church Road Group Home	Charlotte
Anuvia Prevention and Recovery Center	Charlotte
ROPES, Inc.	Charlotte
Hinds' Feet Farm, Inc.-Hart Cottage	Huntersville
Jeffery Evans Home	Charlotte
Atrium Health Behavioral Health-Partial Hospitalization	Charlotte
Choices for Recovery	Charlotte
Transitions Charlotte Day Program	Charlotte
Transitions Charlotte Developmental Day Program	Charlotte
HopeWay	Charlotte
Nelson Home	Charlotte
VOCA-Oak Drive Group Home	Charlotte
Bonnie's Home for Youth	Charlotte
VOCA-Purser Group Home	Charlotte
The Blanchard Institute, LLC	Charlotte
Lazy Creek Home	Charlotte
No Bounds, Inc.	Charlotte
Gaye Home	Charlotte
Bennett Home	Mint Hill
SECU Youth Crisis Center, a Monarch Program	Charlotte
Zenith Hope Center, LLC	Charlotte
Queen City Treatment Center	Charlotte
HomeCare Day Activity	Charlotte
Carolina Center for Recovery	Charlotte
New Beginnings Home	Charlotte
Harris Home	Charlotte
Summers Home	Charlotte
A Safe Haven	Charlotte
The Newbill Home	Huntersville
Harmony Recovery Center	Charlotte
Asbury Family Home	Mint Hill
NeuroRestorative-Sardis	Charlotte
Nevin #3	Charlotte
Royal Child	Charlotte
Smith Cottage	Matthews
The Emily Program-Charlotte	Charlotte
Spruce Cottage	Charlotte
Smythe Home	Charlotte
Rice Home	Charlotte
Pasadena Villa Outpatient Center-Charlotte	Charlotte

Facility	Municipality
Atrium Health Addiction Services Charlotte	Charlotte
Ruby Wilson Home	Mint Hill
Martin Home	Charlotte
Simmons Home	Charlotte
The Alexander Home	Charlotte
The Thompson Home	Charlotte
The Dunlap Home	Charlotte
Kandakai Home	Charlotte
The McCorbin-Harrington Home	Charlotte
The Hall Home	Charlotte
Miracle Houses-Kerrybrook Circle	Charlotte
Fraser Home	Huntersville
Roxie's Home of Love	Charlotte
Minor Home	Charlotte
Adult Homeless Substance Abuse Treatment-offsite(Men's)	Charlotte
Stephen Greaves	Charlotte
The Garner Home	Charlotte
VOCA-Wilson Avenue Group Home	Charlotte
Joseph House of Charlotte	Charlotte
The Murphy-Guy Home	Charlotte
The Clyburn Home	Charlotte
The Blanchard Institute, LLC	Corenlius
Inreach/Swans Run Road	Charlotte
Solomon Palace	Charlotte
Shep El Home	Huntersville
Ropes, Inc.	Charlotte
Tuckaseegee Group Home	Charlotte
Dawkins Home	Charlotte
Recovery Works	Charlotte
Amara Wellness	Charlotte
Farm Pond Group Home	Charlotte
The Moon Home	Charlotte
Graham Home	Charlotte
Christ Church Cottage Thompson Child & Family Focus	Matthews
J. Davis Home	Charlotte
PHAZES, Inc	Charlotte
Williamson Cottage-Thompson Child and Family Focus	Matthews
Residential Adolescent Community Services, Inc	Charlotte
Covenant's Dream Center III	Matthews
Choosing Change Residential Services, LLC	Charlotte
Life-Way Homes, LLC	Charlotte

Facility	Municipality
Grier Home 2	Charlotte
Rockmoor Ridge Care Center	Charlotte
Collaborative Hope - Skyview	Charlotte
Flowe Drive Group Home	Charlotte
The Williams Home	Charlotte
Cooley's House	Charlotte
Nina Moore Home	Mint Hill
Karita Freeman Home	Charlotte
Bright Touch House	Charlotte
Shropshire Home	Charlotte
Hansel Court	Charlotte
Right Choices	Charlotte
Kenan Cottage Thompson Child & Family Focus	Matthews
Inreach/ Shamrock Road	Charlotte
Bynum6 Care Home	Charlotte
The Bridget Smith Home	Charlotte
Judy Hilliard Home	Mint Hill
Mary McCullough Home	Charlotte
Advance IB Academy	Charlotte
Janice Ingram Home	Charlotte
The Village House	Charlotte
Digsby Home	Charlotte
The Thrive Initiative	Mint Hill
Extended Family Residences	Charlotte
Children Best Care Facility	Charlotte
Dilworth Center for Chemical Dependency, Inc.	Charlotte
Jeffers Home	Charlotte
Wings Group Home, LLC	Charlotte
#3831 Staunton	Matthews
Brenda Gibson Home	Matthews
Wilson Home Care	Charlotte
Sharon Allen Home	Mint Hill
The Trula Freeman Home	Charlotte
Echelon Day Support	Charlotte
Desiree Dickerson Home	Charlotte
1332 Crandon	Charlotte
Inreach/Williams Road	Charlotte
AWS@Hope Haven	Charlotte
Next Level Family Solutions, LLC	Charlotte
Praising Hands Day Support	Charlotte
Johnny B's, LLC	Charlotte

Facility	Municipality
A Step in the Right Direction LLC	Charlotte
Newport Academy-Lodge	Mint Hill
The Blessed Hands	Charlotte
Inreach/Nevins Road	Charlotte
Keisha Anderson Home	Charlotte
IOP Services	Charlotte
Patience and Passion Home Care	Charlotte
Davenport Home	Charlotte
Kipp Elementary Day Treatment	Charlotte
Angel Home	Charlotte
Barnabas Home	Cornelius
Inreach/Greywood Drive	Charlotte
Christ Church Home	Charlotte
Hall Home	Charlotte
Holt Home	Charlotte
Myer's Park Home	Charlotte
Miracle Houses Eagle Peak	Charlotte
Dreams and Vision, LLC DBC New Visions Home II	Charlotte
Reach Back for the Community	Charlotte
Charlotte Arts	Charlotte
Inreach/Lisa Circle	Charlotte
Ascend Recovery Center NC, LLC	Charlotte
Newport Academy-Mint Hill	Mint Hill
Pasadena Villa Outpatient-North Charlotte	Charlotte
The Blanchard Institute LLC	Charlotte
MHVII	Charlotte
Newport Academy-Charlotte	Pineville
Joyce Robinson Home	Charlotte
Alamance Academy, LLC	Charlotte
Inreach/Forsythia Circle	Charlotte
Affinity Clinical Services, PLLC	Charlotte
The Village House II	Charlotte
Katrina Renee's Safe Place LLC	Charlotte
HopeWay 250	Charlotte
HopeWay 260	Charlotte
HopeWay 270	Charlotte
Malikah Muhammad Home-Abe's Guided Footsteps	Charlotte
Alexander Transition House	Charlotte
Helping Hands Sanctuary LLC	Charlotte
Inreach/Stillwell Oaks	Charlotte
Concrete Roses Life Center	Charlotte

Facility	Municipality
Transformative Care, LLC	Charlotte
Life's Good Stay Here (Harmony Haven)	Charlotte
CarePath-Drury Drive	Charlotte
ProCure Therapeutic Agency-Mecklenburg	Charlotte
Excel Peer Support Services	Charlotte
Elevated Coaching & Healing	Charlotte
Renewed Beginnings Home Inc	Charlotte
Gifted Angels, Earthenware	Charlotte
Inreach/Crosby Road	Charlotte
Provisions Care LLC (Facility 1)	Charlotte
A Peace of Mind	Charlotte
The Carr Home	Charlotte
Pivotal Health, PC-Mecklenburg	Charlotte
Helping Hands Home	Charlotte
Ratliff's Home, LLC	Charlotte
Glenburn Lane Home	Charlotte
Nova Transformations LLC	Matthews
A Place of Second Chances	Charlotte
Carolina Outpatient Detox LLC	Charlotte
Inreach/The Plaza	Charlotte
Harrison Home	Matthews
Marshall House	Charlotte
Tansy Drive AFL	Charlotte
Shine Adult Home	Charlotte
Ed Smith Home	Charlotte
Giving Hope for All	Charlotte
HomeCare for the Carolinas, LLC	Charlotte
Nurturing Nest Residential Home	Charlotte
Behavioral Health Intervention Center LLC	Charlotte
The Village House III	Charlotte
Sure Foundation Behavioral Health Services	Charlotte
Sana Counseling LLC	Matthews
Connecting More Dots	Charlotte
Ascend Family Care Services	Charlotte
Guidelight SouthPark	Charlotte
Bray Drive Residence	Charlotte
Taylor's Helping Hands	Charlotte
Aseda Home	Charlotte
Sanctuary	Charlotte
Charles Henry Center	Charlotte
Innerchange Homes LLC	Charlotte

Facility	Municipality
Austin Children's Home	Charlotte
A Step in the Right Direction II	Charlotte
Able to Serve Home Services, Inc.	Charlotte
CT 18 Group LLC-Charlotte	Charlotte
The Wideman's House of Care	Charlotte
Royal Youth Home	Charlotte
Caring Hands Care	Charlotte
Charlotte Detox Center LLC	Charlotte
Syrenity House Empowered	Charlotte
Helping Hands Home	Charlotte
Specialized Health Care Services LLC	Charlotte
Liasions Community Care LLC #3	Charlotte
New Beginning Home Care	Charlotte
Jasper's House Day Treatment	Charlotte
Be Well Therapy Group	Charlotte
Abiding Path, LLC	Charlotte
TSG Behavioral Health & Community Services	Charlotte
Arising Sun of North Carolina/Kyhlie's House	Charlotte
Enduring Hands Community Care Inc.	Charlotte
Pinebrook Drive Group Home	Charlotte
Innovative Youth Solutions	Charlotte
A Mello Journey LLC	Charlotte
Brothers Care Group Homes	Charlotte
The Beckett Home	Charlotte
T&T Sanctuary House	Charlotte
The Wright Phase, LLC	Charlotte
Miracle Houses, Inc. Day Treatment Program	Charlotte
Mantle Court Group Home	Charlotte
Nevin #4	Charlotte
Nevin #1	Charlotte
Nevin #2	Charlotte
VOCA-Sandburg Group Home	Charlotte
VOCA-Oakhaven Drive Group Home	Charlotte
VOCA-Toddville Road Group Home	Charlotte
Inreach/Gaynelle Drive	Charlotte
Monroe Road	Charlotte
Heathcroft	Charlotte
Burtonwood Circle Home	Charlotte
Ravendale Drive Group Home	Charlotte
Leaves	Charlotte
Lakeview	Charlotte

Facility	Municipality
Inreach/Old Bell Road	Charlotte
Inreach/Larkhaven Road	Charlotte
Browne Group Home	Charlotte
Kelly Street Home	Charlotte
Villages of Hope Haven	Charlotte
Shelburne Place	Charlotte
Commonwealth Group Home	Charlotte
Ashcraft Home	Charlotte
Community Choices-CASCADE Services	Charlotte
The Taylor Home	Charlotte
Gail B. Hanks Group Home	Charlotte
Highland Mist Home	Charlotte
Atrium Health Addiction Services Ballantyne	Charlotte
Idlewild Home	Charlotte
The Kid's Workshop	Charlotte
Lifespan Graham	Charlotte
Turn Around	Mint Hill
Adult Homeless Substance Abuse Trtmt Offsite(women' s)	Charlotte
Community Treatment Alternatives II	Charlotte
Brite Horizon	Charlotte
Miracle House 1	Charlotte
Water Mill Home	Charlotte
New Vision Home	Charlotte
Community Treatment Alternatives I	Charlotte
Charlotte Treatment Center, Inc.	Charlotte
Mr. Bill's Place	Charlotte
Jireh's Place	Charlotte
Piney Grove Group Home	Charlotte
Inreach/Chelmsford Road	Charlotte
Miracle Houses-Monteith	Charlotte
Echelon 1	Charlotte
Alexander Youth Network - Charlotte Day Treatment	Charlotte
Alexander Youth Network - Oak Unit	Charlotte
Alexander Youth Network - Nisbet Unit	Charlotte
Alexander Youth Network - Dickson Unit	Charlotte
Beatties Ford Road Family Counseling Center	Charlotte
CASCADE Services	Charlotte
Unique Caring Adult Day Support Program	Charlotte

Nursing Homes

Facility	Municipality
White Oak Manor-Charlotte	Charlotte
Myers Park Nursing Center	Charlotte
Sherwood Health & Rehab	Charlotte
Plaza Health & Rehab	Charlotte
The Sharon at SouthPark	Charlotte
University Place Nursing and Rehabilitation Center	Charlotte
Matthews Health & Rehab Center	Matthews
Royal Park Rehabilitation & Health Center	Matthews
Sardis Oaks	Charlotte
Pine Crest Health & Rehabilitation	Charlotte
WillowBrooke Court SC Ctr at Matthews Glen	Matthews
Crown Haven Health and Rehabilitation	Charlotte
Charlotte Health & Rehabilitation Center	Charlotte
Pineville Rehabilitation and Living Center	Pineville
The Pines at Davidson	Davidson
Southminster	Charlotte
Peak Resources-Charlotte	Charlotte
Huntersville Oaks	Huntersville
Redwood Health & Rehab	Charlotte
Huntersville Health & Rehabilitation Center	Huntersville
Autumn Care of Cornelius	Cornelius
Pavilion Health Center at Brightmore	Charlotte
Briar Creek at The Barclay	Charlotte
Windsor Run, LLC	Matthews
Clear Creek Nursing & Rehabilitation Center	Mint Hill
Lakeside Health & Rehab Center	Huntersville
The Stewart Health Center	Charlotte
Mecklenburg Health & Rehabilitation	Charlotte
Wilora Lake Healthcare	Charlotte
Asbury Health and Rehabilitation Center	Charlotte
Brookdale Carriage Club Providence	Charlotte
Rockwell Park Rehabilitation and Healthcare Center	Charlotte

Meck Design Flyer



MECK DESIGN

Road to Community Health

Join us for a day of learning and collaboration! We'll review progress on the Community Health Improvement Plan, explore 2025 Community Health Assessment data, and gather input on future health priorities.

Wednesday, June 11, 2025
9:00 AM-3:00 PM
CPCC: Harris Conference Center

Join Us for Meck Design Day 2025: Road to Community Health!

Live Well Meck and Mecklenburg County Public Health invite you to a day of learning, collaboration, and innovation! This event will bring together community members, organizations, and health professionals to review progress on the Community Health Improvement Plan, explore the latest 2025 Community Health Assessment data, and engage in discussions to shape future health priorities.

Date: Wednesday, June 11, 2025
Time: 9:00 AM – 3:00 PM
Location: Central Piedmont Community College, Harris Conference Center

- ✓ Making sense of local health data to align on community needs
- ✓ Strengthening partnerships through connection and collaboration
- ✓ Sparking fresh ideas to tackle Mecklenburg County's biggest health challenges

Registration opens on April 1st and closes on May 23rd! Secure your spot today by clicking the button below.

Let's drive the future of community health together!

[Click here to register.](#)



Destination Wellness Community Prioritization Meeting Flyer

**You Spoke. We Listened.
Now Let's Build a Healthier
Mecklenburg County — Together.**

We are excited to invite you to *Destination Wellness: Road to a Healthier Mecklenburg*. As we continue on our road to community health, this gathering will share updates from the Community Health Assessment (CHA) process since Meck Design Summer 2025, including the results of the community priority survey highlighting health issues identified by the community.

- Date:** Friday, September 26, 2025
- Location:** Valerie C. Woodard Community Resource Center (Auditorium) 3205 Freedom Drive, Charlotte, NC
- Time:** 10am - noon
- Registration/Check-in:** 9 - 10am

Lunch will be provided.

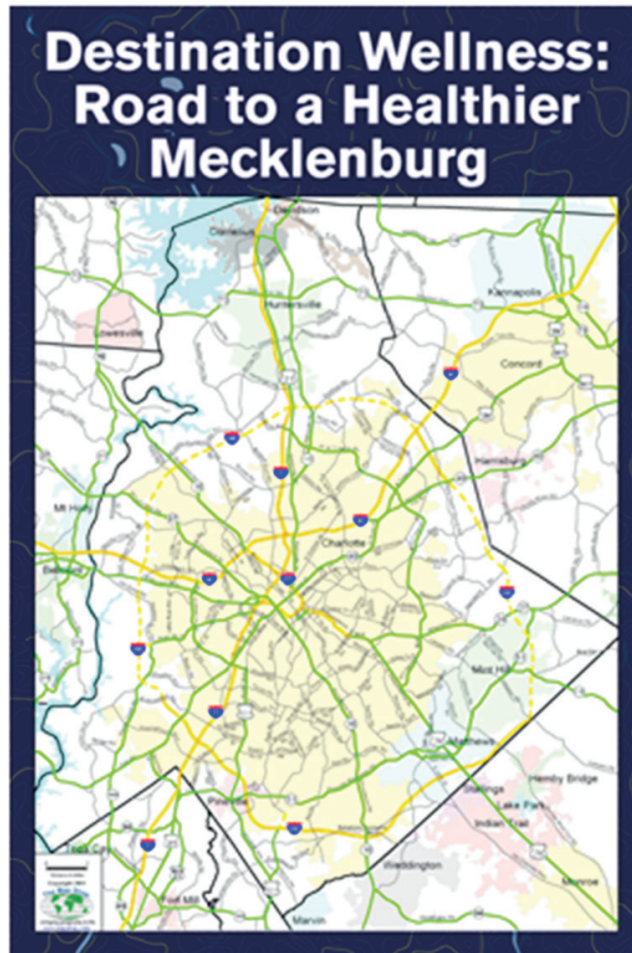
The purpose of this gathering is to

- review the latest CHA cycle data,
- learn about our current community health status and its trends, and
- identify top community health priorities together.

Destination Wellness is hosted by Mecklenburg County Public Health and the Live Well Meck Steering Committee.

Space is limited. **Registration is required** and must be completed by **Monday, September 22**.

With gratitude,
Live Well Meck
livewell@mecknc.gov



[Register to attend Destination Wellness.](#)



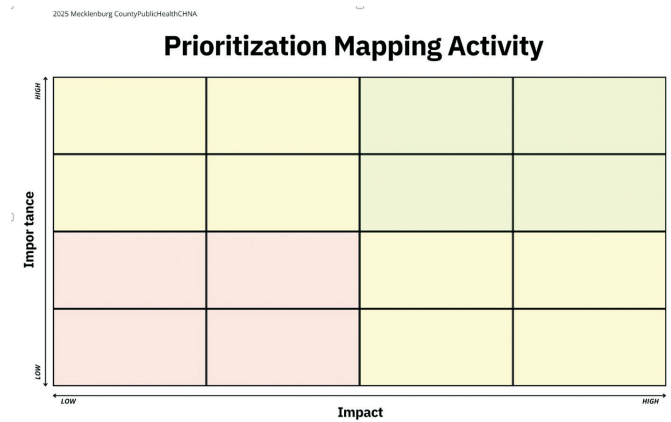
Prioritization Survey Email Listserv Mailer

Have thoughts about your community's health?

Share your insight by completing the assessment survey!

Visit tinyurl.com/mecksurvey or Scan the QR code to impact your community's health today

Prioritization Matrix Tool (Destination Wellness)



Prioritization Postcard Mailer

MECKLENBURG COUNTY
North Carolina
Public Health

Mecklenburg County Public Health
249 Billingsley Rd.
Charlotte, NC 28211

2025 Mecklenburg County Community Health Needs Assessment Survey

Encuesta sobre necesidades comunitarias de salud en 2025 en el Condado Mecklenburg

Congratulations!
Your household has been chosen to share your opinions and help decide what Mecklenburg County's top health priorities will be for 2025–2028.

Take this 15–20 minute survey by July 25 to play a vital role in our community's future!

Live Well Meck will work with the community to address the top priorities identified from this survey over the next three years to make Mecklenburg County a healthier place to live, work, and play.

¡Felicitaciones!
Su hogar ha sido seleccionado para compartir sus opiniones y ayudarnos a decidir cuáles serán las prioridades de salud en el Condado de Mecklenburg en 2025–2028.

¡Dedique 15–20 minutos para responder esta encuesta antes del 25 de julio y sea parte del futuro de nuestra comunidad!

Durante las proximas tres años, Live Well Meck trabajará con la comunidad para abordar las prioridades que resultan de esta encuesta para hacer del Condado de Mecklenburg un lugar más saludable para vivir, trabajar y jugar.

tinyurl.com/mecksurvey

For more information/ Para más información
health.mecknc.gov

Live Well MECK
Our Community. Our Well-Being.

Photo Voice Program Outline & Facilitator Guide

| Session Outline

I. Session 1: Introduction to PhotoVoice & Photography Basics

Objective: Introduce the project, discuss PhotoVoice methodology, and provide photography tips.

- **Welcome & Icebreaker (15 min)** – Have youth introduce themselves and share a photo on their phone that represents “health” to them.
- **Overview of PhotoVoice (5 min)** – Explain how photography can tell stories and influence public health
- **Guest Photographer: (30 min)** – Tips on composition, lighting, storytelling with images, and using both phone and digital cameras.
- **Photo Challenge/Ethics and Consent (10 min)** – Assign a mini task: “Capture one image this week that represents community health (good or bad).” Discuss responsible photography, privacy, and getting consent when taking photos of people.

Facilitator Instructions:

- Encourage open discussion and personal interpretations of health.
- Provide handouts on photography basics and ethical guidelines.
- Ensure youth understand the purpose of PhotoVoice.
- Encourage open discussion about what health means to them.
- Provide handouts on photography basics.

II. Session 2: Sharing & Analyzing Initial Photos

Objective: Discuss the photos taken, themes, and storytelling.

- **Photo Showcase (30 min)** – Each youth shares their image and describes why they chose it.
- **Theme Identification (10 min)** – As a group, identify common themes emerging from the images.
- **Deeper Analysis (10 min)** – Ask guiding questions: What story does this photo tell? How does it relate to community health? What emotions does it evoke?
- **Next Assignment (10 min)** – “Capture a series of up to 10 images that highlight a health challenge or strength in your community.”

Discussion Prompts:

- If someone unfamiliar with your community saw your photo, what would they learn?
- What is missing from the picture? (Context, people, emotions?)
- What are the biggest barriers to good health in your community?
- What do you love about your community’s approach to health?

Facilitator Instructions:

- Keep discussions focused on health topics.
- Help youth recognize patterns in their images.
- Encourage respectful feedback and dialogue.

Prompts for New Assignment:

- What does health look like in your community?
- Where do you see health challenges in your everyday life?
- How do spaces (parks, stores, streets) impact health?
- How does your family or culture define being “healthy”?

III. Session 3: Refining Stories & Preparing for Presentation

Objective: Help youth refine their narratives and prepare for the final showcase.

- Small Group Discussions (30 min) – Youth discuss their selected photos and refine their stories.
- Captions & Statements (15 min) – Have them write short descriptions for each image.
- Group Reflection (15 min) – Discuss challenges in capturing images and any changes in perspective.

Prompts & Questions:

- If your image had a title, what would it be?
- What do you want people to feel when they see your photos?
- How do your photos reflect personal or community experiences?
- What would you change or add if you could take the photo again?

Facilitator Instructions:

- Provide feedback on photo selections and captions.
- Ensure that all youth feel confident in presenting their work.

IV. Session 4: Showcase & Reflection

Objective: Present the Photovoice project to partners and peers to discuss findings.

- **Photo Exhibit (30 min)** – Display images for viewing.
- **Youth Presentations (10 min)** – Each youth shares their images and insights.
- **Community Dialogue (10 min)** – Open discussion with public health & Live Well representatives, organization staff, and community members.
- **Final Reflection (10 min)** – What did we learn? What actions can be taken based on these insights?

Prompts & Questions:

- What surprised you most about this project?
- What patterns or themes stood out across all the photos?
- What changes would improve community health based on what we’ve captured?
- How can public health officials and community leaders use these images to make a difference?

Facilitator Instructions:

- Ensure all youth have a chance to present.
- Facilitate a meaningful discussion between youth and community members.

Focus Group Cross-Cutting Themes Table

Key Themes	Access to Affordable, Timely, and Respectful Health Care	Language and Communication Barriers	Unmet Mental/Dental/ Other Health Needs	Discrimination and Exclusion	Difficulties Navigating the Health System	Culturally Responsive, Community-Based Care	Access to Education and Preventative Care	Social Determinants of Health
Meck County – General	Lack of insurance, out-of-pocket costs, and provider shortages	Minimal; most are fluent in English but still struggle with medical jargon	Stigma and cost prevent seeking mental-health care; dental services viewed as prohibitively expensive.	Youth feel dismissed by providers; experience ageism and bias in scheduling.	Unfamiliarity with insurance enrollment, appointment scheduling, and portal use. Complex paperwork and limited support lead to missed appointments.	Desire for community outreach that bridges gaps between county services and residents.	Vaccines, preventative care, health education and literacy, knowledge and access to information.	County's infrastructure, income inequality, and service distribution affect all groups.
Youth and Young Adults	High cost of insurance and lack of coverage							Food prices, transportation to clinics, and limited housing options shape daily health decisions.
Older Adults	Transportation barriers-hard to reach clinics; long wait times for appointments.							Older adults face technology-related communication barriers (e.g., portal log-ins).
Spanish Speakers	Insurance gaps, undocumented status leave many unable to afford care.	Interpreter services scarce; many providers cannot read or speak Spanish fluently.	Immigration related fears, cultural stigma, and insurance gaps deter help-seeking; dental care perceived as out-of-reach.	Immigration status, language, and cultural differences trigger prejudice in clinical settings.	Lack of knowledge of US-based health care system. Few resources or individual health navigators that are culturally and linguistically appropriate.	Strong preference for promotoras or bilingual workers who understand cultural norms. Seek interpreters fluent in language and local dialects; value culturally specific counseling.	Chronic disease, diabetes awareness, and health care management strategies. Access to health education and health literacy programming.	Housing instability and food insecurity intersect with immigration status and language barriers. Housing instability and food insecurity intersect with immigration status and language barriers.
French Speakers	Insurance gaps, documentation status, interpretation adds extra cost.	Lack of French-speaking interpreters and unfamiliarity with local dialects.						
LGBTQIA+	Gender and reproductive health services are expensive and often perceived as unwelcoming.	Concerns about culturally insensitive communication.	Concerns around culturally appropriate and gender-affirming care.	Stigma and/or lack of knowledge related to sexual orientation or gender identity		Need for gender-affirming, LGBTQIA+-friendly providers and peer navigators.	Need for preventative care, access to HPV and Mpox vaccines, access to PrEP	Housing and transportation challenges significant for this group.
Substance Use & Homelessness	Long waitlists for subsidized housing and costly emergency care drive people to rely on ERs instead of primary care.	Substance-use groups rely on community outreach and communication strategies	Challenge of untreated mental health and substance use issues, lack of access to affordable care.	Participants primarily focused on exclusion from housing as a primary health and wellness challenge.	Need for caseworkers and other individuals to help patients navigate.	Need mobile clinics and caseworkers who can walk with them to appointments and help with paperwork.	Substance use care and overdose prevention	Homelessness, unsafe neighborhoods, and lack of stable shelter directly impact physical and mental health outcomes.

Acknowledgements

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Improving community health is a shared responsibility, and this work reflects the strength of collaboration across our county.

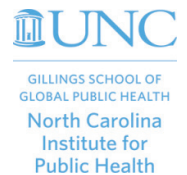
| Live Well Steering Committee



MECKLENBURG COUNTY
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Public Health



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- Charter is Creative
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- Harmony Health Therapeutic Services
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- Live Learn Play, Inc.
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