

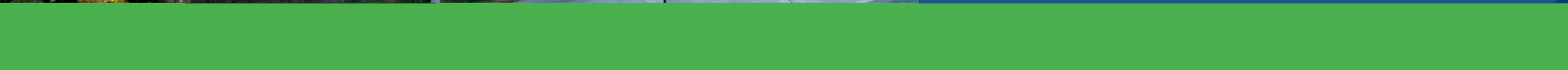


**UNION  
COUNTY**  
HUMAN SERVICES

# 2025 Community Health Assessment



**Union County  
Human Services Agency**



# Letter from the Public Health Director

**Dear Community Members, Partners and Stakeholders,**

On behalf of Union County Public Health, I am pleased to present the 2025 Community Health Assessment (CHA) report. This comprehensive assessment reflects our ongoing commitment to understanding and improving the health and well-being of every resident in our County.

The CHA is a vital tool for identifying the most pressing health challenges facing our community. Through data analysis, community surveys, focus groups, and collaboration with local organizations, we have gained valuable insights into the social, economic and environmental factors that influence health outcomes in Union County.

Key findings from this year's assessment highlight both progress and persistent disparities. While we have seen improvements in areas such as childhood immunization rates and access to primary care, challenges remain in addressing chronic diseases, mental health, substance use, and the social determinants of health, such as housing, education and food security.

This report is not just a reflection of where we are; it is a call to action. It provides a roadmap for strategic planning, resource allocation and collaborative initiatives that will guide our efforts over the next three years. We are committed to working alongside our community partners, healthcare providers and residents to implement evidence-based strategies that promote health equity and improve quality of life for all.

I want to extend my deepest gratitude to everyone who contributed to this assessment. Your voices, experiences and expertise are the foundation of this work. Together, we can build a healthier, more resilient Union County.

Sincerely,

**Traci Colley**

Director | Union County Public Health

# Table of Contents

<b>Executive Summary .....</b>	<b>4</b>
Vision Statement .....	4
CHA Leadership.....	4
CHA Partnerships & Collaborations.....	4
Regional Collaboration.....	5
Theoretical Framework/Model.....	5
Collaborative Process.....	5
Key Findings.....	6
The Main Story: Root Causes & Who Is Most Affected.....	7
Health Priorities.....	7
Next Steps.....	7
<b>Introduction &amp; Background .....</b>	<b>8</b>
Purpose of the Community Health Assessment.....	8
Community Definition .....	9
CHA Requirements & Cycle.....	9
Regional Collaboration.....	9
Overview of the CHA Process .....	10
Population Health Framework.....	10
Organization of the Report.....	11
<b>Union Community Profile.....</b>	<b>12</b>
Demographics .....	12
Gender & Age Distribution.....	12
Race/Ethnicity .....	12
<b>Social &amp; Economic Factors .....</b>	<b>15</b>
Education.....	15
Income.....	17
Housing.....	21
Limited English Proficiency.....	31



Labor Workforce and Employment .....	32
Unemployment .....	35
Poverty Rates .....	37
<b>Secondary Data Overview .....</b>	<b>41</b>
Indicator Summary Table .....	41
Healthy North Carolina 2030 .....	45
<b>Health Outcomes .....</b>	<b>47</b>
Life Expectancy .....	47
Leading Causes of Death and Mortality Rates .....	48
Mortality Trending .....	49
Death Disparities .....	52
Chronic Disease.....	55
Communicable Diseases.....	58
Maternal and Infant Health .....	63
Mental Health .....	72
Safety and Injury.....	76
<b>Health Behaviors.....</b>	<b>84</b>
Substance Use Disorder.....	84
<b>Clinical Care.....</b>	<b>94</b>
Access to Care .....	94
Insurance Coverage.....	100
<b>Physical Environment .....</b>	<b>103</b>
Environmental Health .....	103
Land-Use and Greenspace.....	108
Access to Exercise.....	109
Access to Transportation.....	110
<b>Primary Data .....</b>	<b>111</b>
Surveys .....	111
Focus Groups .....	128



Key Informant Interviews.....	131
<b>Inventory of Community Resources.....</b>	<b>133</b>
Health and Resource Guide.....	133
UC CARES.....	133
<b>Priority Setting and Priority Selection.....</b>	<b>134</b>
<b>Next Steps: Community Health Improvement Plan.....</b>	<b>136</b>
<b>References.....</b>	<b>137</b>



## Executive Summary

The State of North Carolina requires all local public health departments receiving state funding to conduct a Community Health Assessment (CHA) as part of the public health accreditation process. The CHA identifies factors affecting county residents' health, assesses the availability of local resources, and engages community members to identify strengths, concerns, emerging issues, and needed services. The assessment also serves as the foundation for the Community Health Improvement Plan (CHIP).

## Vision Statement

Union County envisions a healthy community and a hopeful future in which all residents have equitable opportunities to achieve their highest level of health and well-being.

## CHA Leadership

Union County used a multi-sectoral leadership approach, collaborating with Atrium Health and Novant Health. The county has aligned its assessment cycle with hospital partners and completed recent CHAs in 2016, 2019, 2022, and 2025.

## CHA Leadership Team

Name	Title	Organization
Stephanie Starr	Community Support and Outreach Director	Union County Human Services
Traci Colley	Public Health Director	Union County Human Services
Ana Diaz	Epidemiologist	Union County Human Services
Janet Payne	Human Services Administrator	Union County Human Services
Ashley Burts	Public Health Nursing Director	Union County Human Services
Erica High	Community Engagement and Health Educator	Union County Human Services
Hilda Siera	Community Engagement and Health Educator	Union County Human Services
Kristine Gross	Human Services Manager	Union County Human Services
Nicole Hricik	Senior Communications Specialist	Union County Public Communications
Maria Shannon	Strategist   Community Engagement Community & Social Impact Division	Atrium Health

The leadership team launched the 2025 CHA on December 3, 2024, and met monthly for six months to guide the process and oversee data collection.

## CHA Partnerships & Collaborations

Union County uses the Healthy Union Advisory Coalition (HUAC) as its CHA advisory committee. The coalition includes representatives from healthcare, government, business, human services, education, community organizations, faith communities, and residents. HUAC members review progress on the CHIP and help identify and prioritize community health issues.



**Types of Partnerships Represented on the Advisory Committee and Number of Participants**

<b>Partnership Type</b>	<b>Number of Participants</b>
Human Services Agency (Consolidated)	10
Hospital/Health Care System(s)	5
Healthcare Provider(s)	2
Behavioral Healthcare Provider(s)	6
Community Organization(s)- charity, NGO	4
Educational Institution(s)- colleges, universities	2
Schools – Pubic, Private, Charter	3
Public Members	1
Government Departments and Municipalities	3

**Regional Collaboration**

Union County participated in the Central Carolina Community Collaborative (CCCC), a regional partnership launched in 2024 with support from The Duke Endowment to strengthen community voice and coordination in the Community Health Assessment process. The collaborative brings together public health departments, health systems, United Way agencies, academic partners, and community organizations across Central North Carolina to identify shared health needs and opportunities. Through this effort, participating counties used common goals, timelines, data sources, and a standardized community survey, while also conducting local focus groups, interviews, and outreach to reflect county-specific experiences. This coordinated approach improved efficiency, strengthened community engagement, and enabled Union County to align its assessment with regional partners while maintaining local priority-setting and decision-making.

**Theoretical Framework/Model**

The 2025 CHA uses a population health framework based on the County Health Rankings model. This approach recognizes that multiple factors shape health outcomes and examines both the length and quality of life. Data was organized into four key areas: health behaviors, clinical care, physical environment, and social and economic factors.

**Collaborative Process**

In January 2025, CHA leadership presented the process and timeline to HUAC. Additional updates were provided in March and May. In July, staff presented a comprehensive overview of the CHA and CHIP development process. Secondary data were reviewed during the September and October meetings, and the findings from the primary data were presented in October. The coalition completed priority settings during the October 2025 meeting.



## Key Findings

Across all population health domains, primary and secondary data show that significant social, economic, and geographic disparities shape health outcomes in Union County. While overall health indicators often compare favorably with state averages, many residents—particularly lower-income households, communities of color, rural populations, and older adults—face greater barriers to housing, transportation, healthcare, and access to healthy living conditions. Chronic disease, mental health challenges, housing affordability, and access to care emerged as consistent concerns across data sources, indicating the need for coordinated, equity-focused strategies (Centers for Disease Control and Prevention [CDC], 2023; U.S. Census Bureau, 2023; County Health Rankings & Roadmaps, 2024).

### Access to Care

- Many residents report delays in receiving needed care due to cost, insurance limitations, provider shortages, transportation barriers, and difficulty navigating services, with these challenges more pronounced among lower-income, Latino, and rural populations (U.S. Census Bureau, 2023; North Carolina Department of Health and Human Services [NCDHHS], 2024).

### Affordable Housing

- Housing costs continue to outpace wages, particularly for renters and lower-income households, contributing to cost burden, eviction risk, and homelessness, with disparities by race and geography (National Low Income Housing Coalition, 2025; U.S. Census Bureau, 2023; U.S. Department of Housing and Urban Development [HUD], n.d.).

### Substance Use Disorder

- Substance use, particularly involving opioids, tobacco, and marijuana, continues to affect residents across age groups, with higher risk and limited treatment access in lower-income and rural communities (NCDHHS, 2024; CDC, 2023).

### Chronic Disease

- Cancer, heart disease, diabetes, obesity, and high blood pressure remain leading health concerns, with a higher burden among lower-income residents and certain racial and geographic populations (CDC, 2023; North Carolina State Center for Health Statistics, 2024).

### Mental Health

- Mental health challenges, including depression, suicide, and unmet treatment needs, were consistently identified across surveys, focus groups, and key informant interviews, with cost, stigma, and provider shortages creating barriers to care (NCDHHS, 2024; CDC, 2023).

### Environmental Health

- Residents reported concerns about water quality, housing conditions, transportation, and access to safe spaces for physical activity, with environmental risks and infrastructure limitations varying across municipalities and disproportionately affecting lower-income and rural areas (County Health Rankings & Roadmaps, 2024; U.S. Environmental Protection Agency, 2023).



## The Main Story: Root Causes & Who Is Most Affected

Across data sources and community input, a consistent story emerges about health in Union County. While overall health outcomes are often better than state averages, these results mask significant disparities driven by social and economic conditions. Many residents—particularly lower-income households, communities of color, rural residents, and older adults—experience barriers to stable housing, reliable transportation, affordable healthcare, and healthy living conditions. These underlying factors shape patterns of chronic disease, mental health challenges, and substance use across the county.

Housing affordability, access to care, and substance use disorder are closely interconnected. Rising housing costs and limited affordable options contribute to financial stress, instability, and displacement, which are associated with poorer mental and physical health outcomes. Residents facing housing instability or cost burden are more likely to delay medical care, experience mental health challenges, and face increased risk of substance use. At the same time, gaps in healthcare access—driven by provider shortages, transportation barriers, and insurance limitations—make it harder for residents to obtain preventive care, behavioral health services, and substance use treatment. These challenges are particularly pronounced among working-age adults, Latino residents, rural households, and lower-income populations.

Substance use disorder both reflects and reinforces these underlying social and economic pressures. Limited access to treatment, stigma, and fragmented systems of care contribute to ongoing overdose risks and unmet behavioral health needs. Working-age adults, particularly men and those in lower-income or justice-involved populations, experience the highest overdose and substance-related harms.

Together, these patterns demonstrate that the county's top priorities—Access to Care, Affordable Housing, and Substance Use Disorder—share common root causes: economic stability, service availability, and structural barriers. Addressing these priorities through coordinated, equity-focused strategies will improve health outcomes and reduce disparities across the community. These findings directly informed the community-driven prioritization process described in the Priority Setting and Selection Section below.

## Health Priorities

Based on the data review and community-driven prioritization process, the following three priority areas were selected:

**Access to  
Care**

**Affordable  
Housing**

**Substance  
Use Disorder**

## Next Steps

In spring and summer 2026, HUAC will develop CHIPs for each priority area using the Results-Based Accountability (RBA) framework.



## Introduction & Background

### Purpose of the Community Health Assessment

The Community Health Assessment (CHA) is a systematic, community-engaged process for identifying and evaluating the health needs of the population (NCDHHS, 2024). The assessment provides a comprehensive picture of residents' current health status, highlights disparities, and examines the social, economic, and environmental factors that influence health outcomes. The findings are used to guide planning, inform policy decisions, and support the development of the Community Health Improvement Plan (CHIP) (NCDHHS, 2024).

In North Carolina, local health departments that receive state funding are required to complete a CHA as part of the public health accreditation process (NCDHHS, 2024). Nonprofit hospitals are also required to conduct a Community Health Needs Assessment under federal regulations. As a result, many communities, including Union County, conduct the CHA through a collaborative process that aligns local health department and hospital assessment cycles.

The CHA serves several key purposes:

- **Inform public health planning:** Provide data-driven insights to identify priority health issues and allocate resources effectively.
- **Engage the community:** Incorporate input from residents, community partners, and stakeholders through surveys, focus groups, and interviews.
- **Meet regulatory requirements:** Fulfill state accreditation standards and federal hospital assessment requirements.
- **Support collaboration:** Bring together healthcare providers, community organizations, local government, and residents to address complex health challenges.

The CHA also serves as a baseline for monitoring changes in health over time and as a resource for organizations seeking to improve health and quality of life in Union County (NCDHHS, 2024).



## Community Definition

For this assessment, the community is defined as all residents of Union County, North Carolina. The CHA process is designed to reflect the needs and experiences of the county's full population, including groups that may face health disparities or barriers to care.

## CHA Requirements & Cycle

In North Carolina, local health departments that receive state funding are required to conduct a CHA as part of the public health accreditation process. The CHA is conducted on either a three- or four-year cycle (NCDHHS, 2024).

Union County conducts the CHA on a three-year cycle in collaboration with its hospital partners. Recent assessments were completed in 2016, 2019, 2022, and 2025.

The CHA process culminates in the development of a Community Health Improvement Plan (CHIP), which outlines strategies, partners, and performance measures for each identified priority area. The CHIP is monitored annually through the State of the County Health report (NCDHHS, 2024).

## Regional Collaboration

Union County participated in the Central Carolina Community Collaborative (CCCC), a regional partnership launched in 2024 with funding from The Duke Endowment to strengthen community voice and coordination in the Community Health Assessment process. The collaborative brings together public health departments, health systems, United Way agencies, academic institutions, and community-

based organizations across Central North Carolina to improve health outcomes and advance health equity.

The CCCC was designed to support a more consistent, efficient, and community-centered approach to the CHA process across participating counties. Through this partnership, member organizations worked together to develop shared goals, timelines, data tools, and engagement strategies. The collaborative approach enabled participating counties to use common survey instruments, share data platforms, and coordinate analysis methods, while still incorporating local input and addressing community-specific needs.

As part of this regional process, Union County used a standardized community health survey developed by a multi-county subcommittee. The survey was distributed in multiple languages and administered both electronically and in paper format to increase accessibility. In addition to the shared regional survey, Union County conducted its own focus groups, key informant interviews, and local outreach activities to ensure that the assessment reflected the unique experiences and priorities of county residents.

Regional collaboration also supported the use of common secondary data sources, consistent indicator definitions, and shared analytic tools. This approach improved comparability across counties, reduced duplication of effort, and enabled local partners to allocate more resources to community engagement and priority-setting activities.



Although data collection and some analyses were conducted collaboratively, each county retained responsibility for interpreting its results, identifying local health priorities, and developing its own Community Health Improvement Plan. This structure ensured that the assessment process benefited from regional coordination while preserving local decision-making and community ownership.

Overall, the regional collaboration strengthened the CHA process by expanding community engagement, improving data quality and consistency, and fostering partnerships across sectors and county lines. This coordinated approach supports more effective, aligned strategies to address shared health challenges throughout the region.

### **Overview of the CHA Process**

The CHA follows a structured, community-driven process designed to identify key health issues and inform action. The North Carolina CHA Guidebook outlines a twelve-step process that includes preparation, data collection, community engagement, identification of health problems, prioritization, reporting, and evaluation (NCDHHS, 2024).

Throughout the process, community members, partners, and stakeholders are actively engaged to ensure that the assessment reflects the experiences and needs of the full population. Community input is incorporated through surveys, focus groups, interviews, advisory committee meetings, and other engagement activities (NCDHHS, 2024).

This collaborative approach ensures that the CHA is conducted with the community rather than on the community, strengthening trust, improving data interpretation, and supporting shared ownership of the resulting priorities and strategies.

### **Population Health Framework**

This CHA is organized using a population health framework based on the County Health Rankings model. This framework recognizes that health outcomes are influenced by a broad range of factors beyond medical care, including health behaviors, clinical care, social and economic conditions, and the physical environment (County Health Rankings & Roadmaps, 2024).

By applying this model, the CHA examines both the length of life (mortality) and the quality of life (morbidity) and analyzes the conditions that shape health across the community. This approach helps identify upstream factors contributing to health disparities and supports the development of strategies to address the root causes of poor health.



## Organization of the Report

This report is organized according to the population health framework.

Following this introduction, the CHA includes:

- Community Profile
- Social and Economic Factors
- Health Outcomes
- Health Behaviors
- Clinical Care
- Physical Environment
- Primary Data
- Inventory of Community Resources
- Priority Setting and Health Priorities

The report concludes with the priority health issues that will guide the development of the Community Health Improvement Plan.



## Union Community Profile

### Demographics

Union County, North Carolina, was established in 1842 and is located southeast of Charlotte within the Charlotte Metropolitan Statistical Area. The County covers approximately 643 square miles and includes 14 municipalities, with Monroe serving as the county seat. Union County operates under a Board of Commissioners–Manager form of government, with a five-member board elected countywide and an appointed county manager (Union County, n.d.).

Union County is the eighth-largest county in North Carolina, with an estimated population of 263,386 residents (North Carolina Office of State Budget and Management [NC OSBM], 2024). The county remains one of the fastest-growing areas in the state, with an 8.2% increase in population between April 1, 2020, and July 1, 2023 (U.S. Census Bureau, 2023). Long-term projections indicate continued growth, with the population expected to increase by approximately 28.5% between 2020 and 2030, 19.9% between 2030 and 2040, and 16.7% between 2040 and 2050. Overall, the county's population is projected to grow by approximately 51% between 2022 and 2042 (NC OSBM, 2024).

Population projections indicate continued growth in the coming decades. Between 2020 and 2030, the population is projected to increase by 28.5%, followed by 19.9% between 2030 and 2040 and 16.7% between 2040 and 2050. Overall, between 2022 and 2042, the population is expected to increase by approximately 51% (OSBM, 2024). During the same period, the population age 65 and older is projected to increase by approximately 120%, reflecting a rapidly aging population (OSBM, 2024).

The median age in Union County is 39.9 years, similar to the statewide median age of 39.4 years (U.S. Census Bureau, 2023). Approximately 6.6% of the county's population is veterans, slightly lower than the statewide rate of 7.2% (U.S. Census Bureau, 2023)

### Gender & Age Distribution

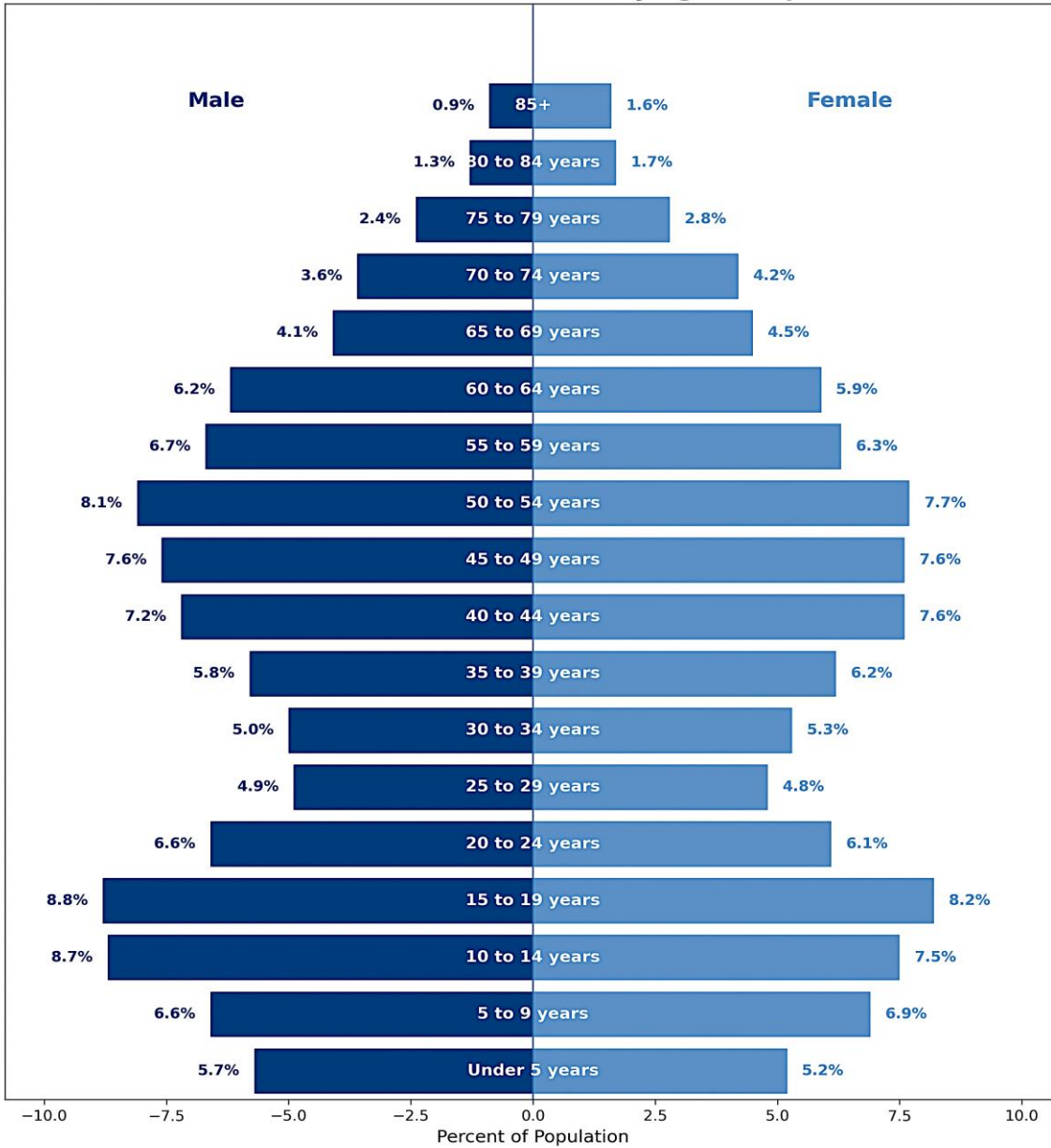
The gender distribution in Union County is nearly balanced, with females representing 50.3% of the population and males 49.7%. This is like statewide patterns, in which females account for 51.1% of the population and males for 48.9% (U.S. Census Bureau, 2024).

### Race/Ethnicity

According to the American Community Survey, approximately 67.1% of residents identify as White, 13.5% as Hispanic or Latino, 10.9% as Black or African American, and 4.5% as Asian, with smaller percentages identifying as multiracial or as members of other racial groups (U.S. Census Bureau, 2024). In comparison, North Carolina's population is 60.3% White, 20.1% Black or African American, 11.4% Hispanic or Latino, and 3.3% Asian (U.S. Census Bureau, 2024). These differences reflect Union County's demographic composition within the state and highlight the importance of culturally responsive services and outreach.



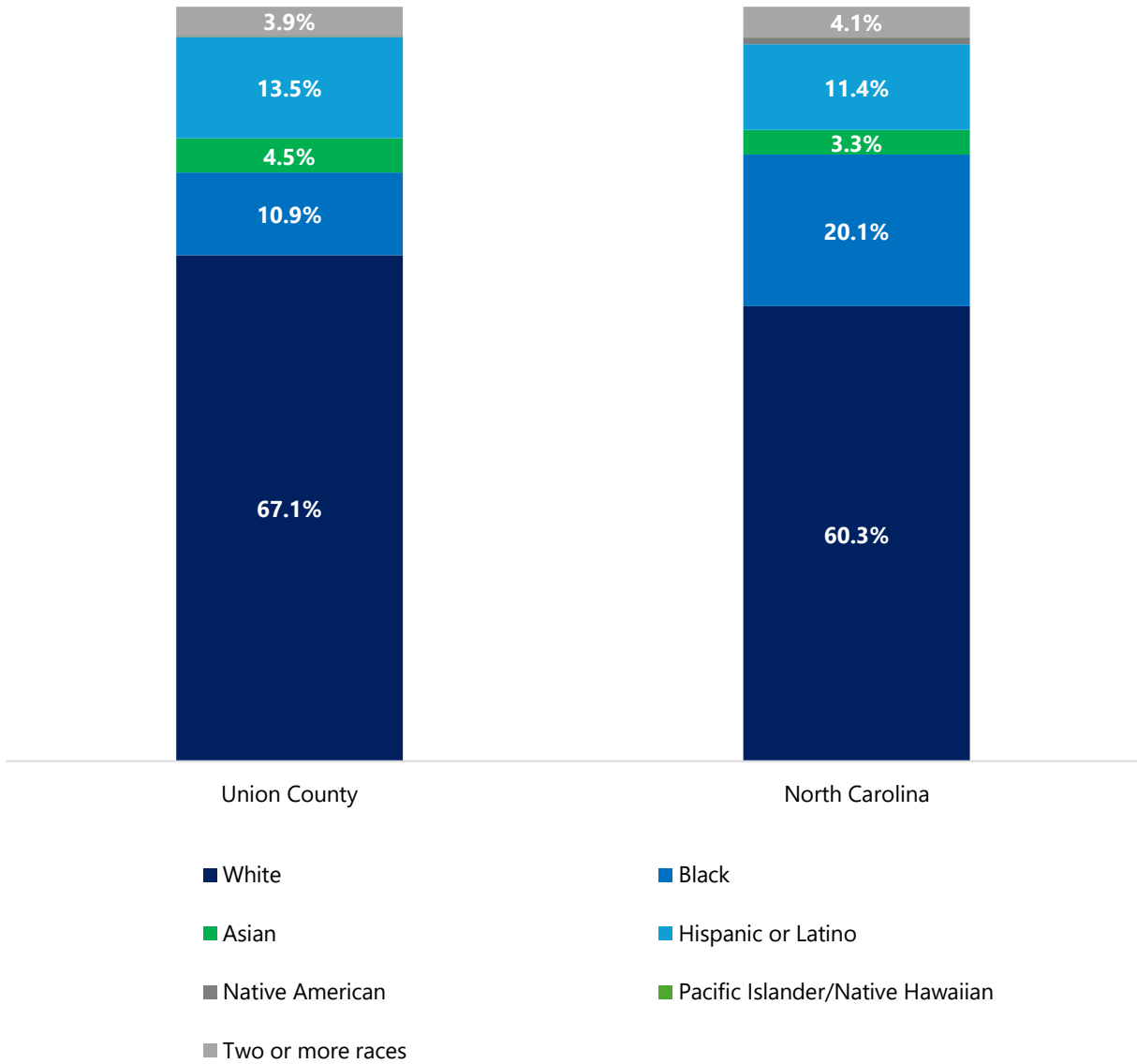
### Union County Population Pyramid Percent Male and Female by Age Group



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2020-2024



## Percent of Union County and North Carolina Population by Race/Ethnicity, 2020-2024



Data Source: U.S. Census Bureau, ACS 5-Year Estimates, 2020-2024



## Social & Economic Factors

### Education

Union County Public Schools (UCPS) is the sixth-largest school district in North Carolina, serving nearly 41,000 students across 53 schools and employing more than 5,000 staff members (UCPS, 2024). The district's 2023–2024 graduation rate was 93.3%, exceeding the state average, and UCPS outperformed the state and other large districts across several accountability measures during the 2024–2025 school year (UCPS, 2024). The student population is diverse, with 51.5% White, 22.2% Hispanic, 12.4% Black, and 13.9% identifying as other racial or ethnic groups; approximately 37.8% of students are eligible for free or reduced-price lunch (UCPS, 2024).

In addition to the public school system, Union County has five charter schools serving approximately 4,800 students. It is home to two higher education institutions: Wingate University and South Piedmont Community College (North Carolina Department of Public Instruction [NCDPI], 2024).

Overall, Union County's high school graduation rate is 90.9%, slightly higher than the North Carolina rate of 89.6% (U.S. Census Bureau, 2023). However, substantial disparities exist across racial and ethnic groups. Non-Hispanic White students have the highest graduation rate (94.97%), followed by non-Hispanic Black students (87.72%) and Asian students (87.76%). In contrast, Hispanic or Latino students have a significantly lower graduation rate (67.77%), and American Indian students have the lowest rate at 56.43% (U.S. Census Bureau, 2023). These differences reflect ongoing inequities in educational attainment and opportunity.

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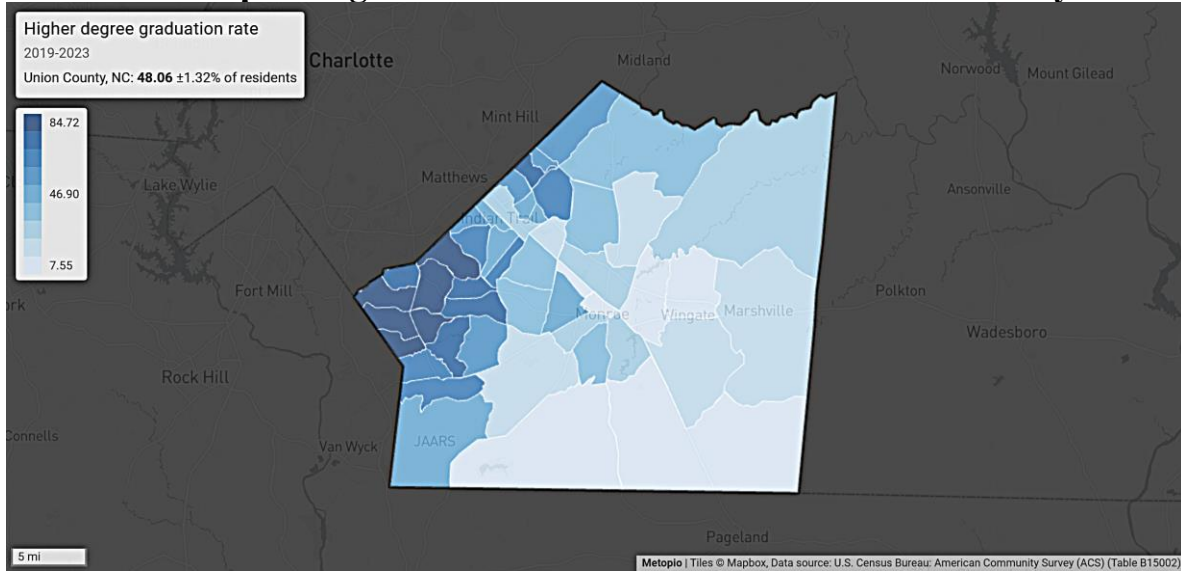
Among residents age 25 and older, 39% hold a bachelor's degree or higher, compared to 34.7% statewide. (U.S. Census Bureau, 2023).

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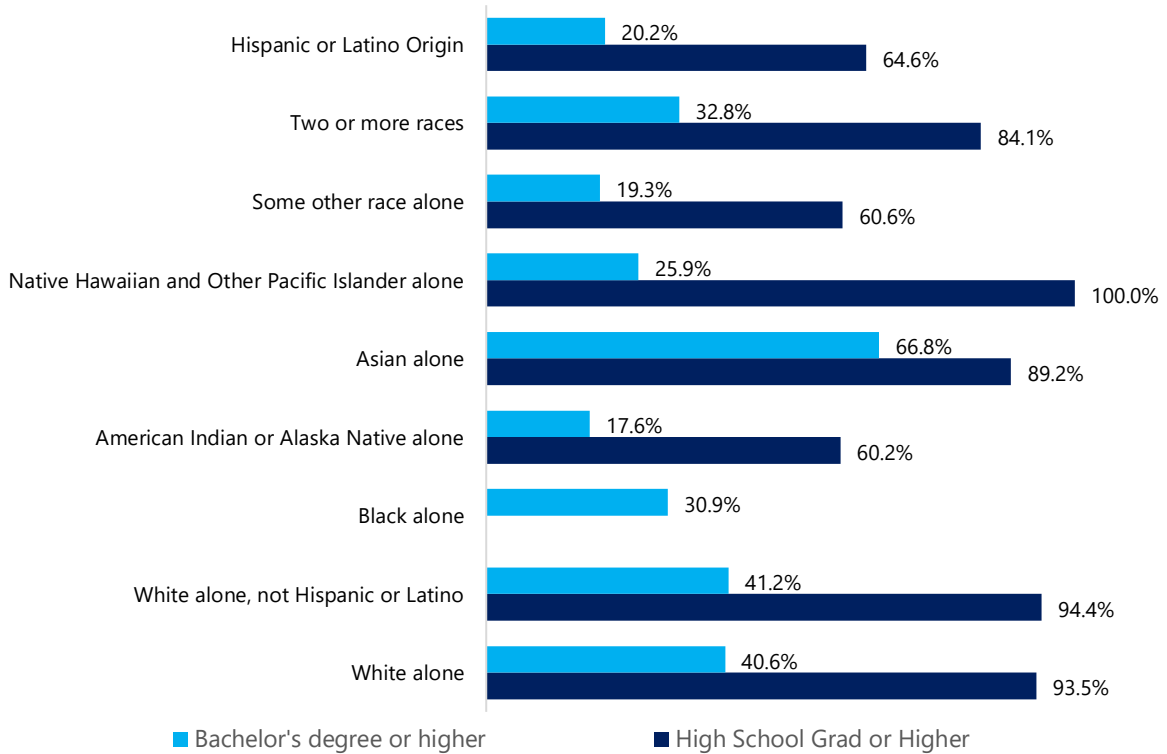
Educational attainment also varies geographically, with some municipalities reporting lower graduation rates, while others, such as Weddington and Waxhaw, report rates above 95% (U.S. Census Bureau, 2023). Disparities also persist by race and ethnicity: Hispanic or Latino and American Indian/Alaska Native residents have the lowest levels of high school and bachelor's degree attainment, while Asian residents have the highest proportion of bachelor's degrees (U.S. Census Bureau, 2023).



## Map of High School Graduation Rates in Union County



## Educational Attainment of Union County Residents, by Race/Ethnicity



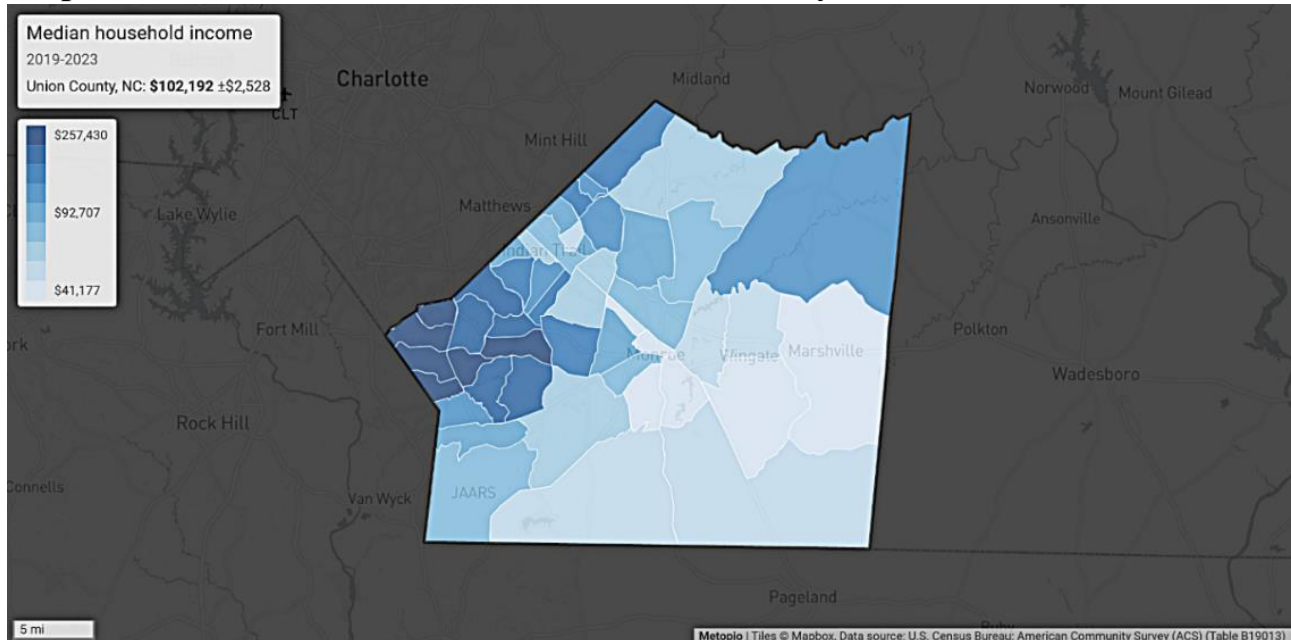
Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



## Income

Union County's economic indicators are generally strong. The county's median household income is \$99,243, significantly higher than the North Carolina median of \$69,904 (U.S. Census Bureau, 2023). However, income varies widely across municipalities, reflecting substantial geographic disparities. Median household incomes exceed \$196,000 in Weddington and \$250,000 in Marvin, while communities such as Marshville, Monroe, and Wingate report median incomes between approximately \$60,000 and \$67,000 (U.S. Census Bureau, 2023).

### Map of Median Household Income in Union County

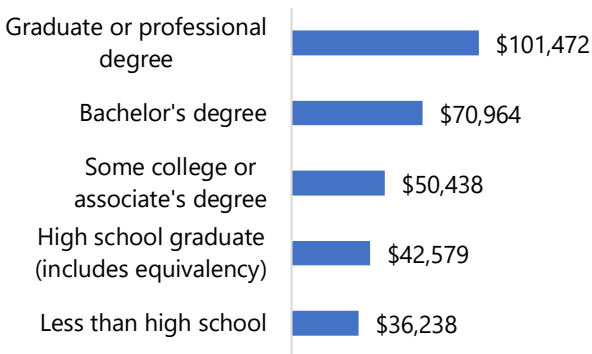


Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

Significant disparities also exist across racial and ethnic groups. Asian households report the highest median income at \$220,789, while Black households have the lowest at \$74,560. Hispanic or Latino households report a median income of \$79,764, and households identifying as two or more races report \$80,792 (U.S. Census Bureau, 2023). These differences highlight persistent economic inequities across racial and ethnic groups.

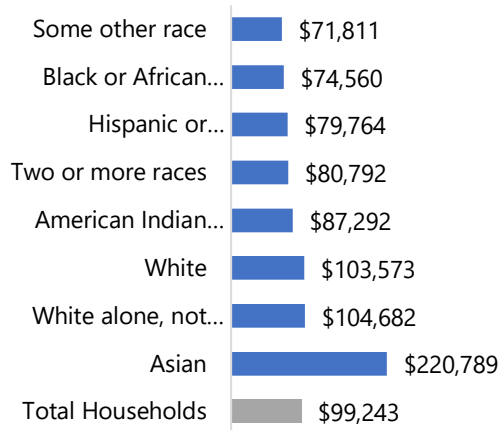


### Median Earnings in the past 12 months (2023 inflation adjusted dollars), by educational level for population 25 and over, 2019-2023



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

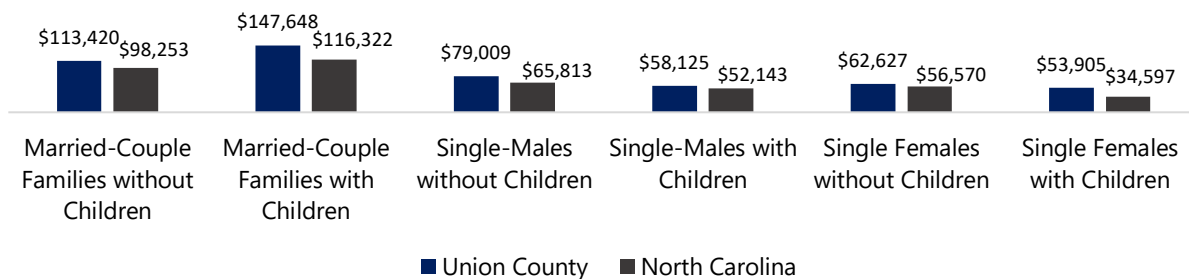
### Median Household Income by Race/Ethnicity, Union County, 2019-2023



Data Source: US Census Bureau, American Community Survey, ACS, 2024

Household structure also influences income levels. Married-couple families, particularly those with children, report the highest incomes, averaging approximately \$145,000 in Union County compared to \$120,000 statewide (U.S. Census Bureau, 2023). Single-parent households, especially single mothers, experience the lowest median incomes, reflecting continued gender and family-structure income disparities. Overall, while the county's higher median income reflects economic growth and proximity to the Charlotte labor market, economic inequities persist across race, geography, and household type.

### Income in the Past 12 months (in 2023 Inflation-Adjusted Dollars) in Union County, by Family Composition, 2019-2023



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023.

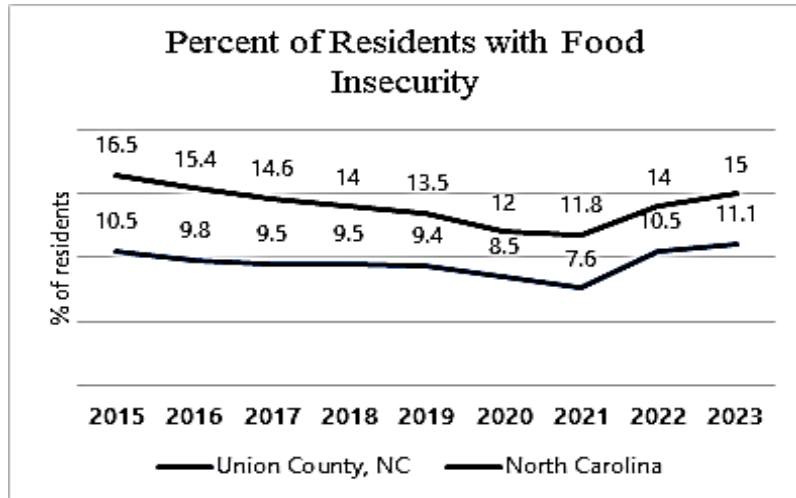


## Food Insecurity

Food insecurity remains a concern in Union County despite rates being lower than the North Carolina average. Between 2015 and 2021, food insecurity declined locally, followed by a notable increase between 2021 and 2023, mirroring statewide and regional trends. In 2023, approximately 11.1% of Union County residents experienced food insecurity, compared to 15.0% statewide (Feeding America, 2023). These increases reflect rising food costs, inflation, and the expiration of pandemic-era nutrition support.

Food insecurity is defined as limited or uncertain access to adequate, nutritious food and is associated with higher rates of chronic disease, mental health stress, and increased healthcare costs (Feeding America, 2023). Although programs such as the Supplemental Nutrition Assistance

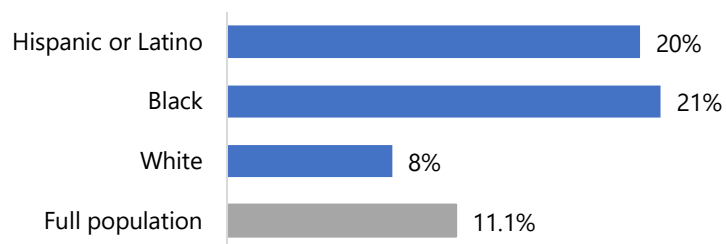
Programs (SNAP), Women, Infants, and Children (WIC), and the Emergency Food Assistance Program (TEFAP) provide critical support, but gaps in access to nutritious food remain.



Data Source: Feeding America Map the Meal Gap, 2024

Significant disparities persist by race, ethnicity, and age. In 2023, food insecurity affected 21.0% of Black residents and 20.0% of Hispanic or Latino residents in Union County, compared to 8.0% of White residents (Feeding America, 2023). Children are also disproportionately affected, with 10.4% of residents ages 0–17 experiencing food insecurity, placing them at greater risk for poor health, developmental challenges, and educational difficulties (Feeding America, 2023).

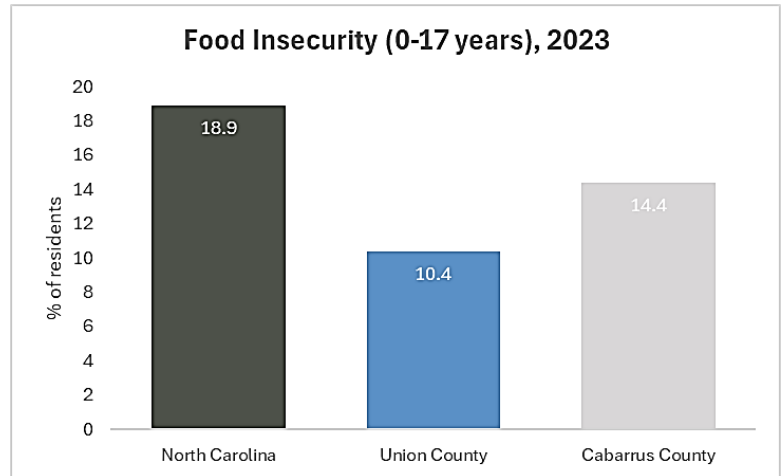
## Percent of Food insecurity by Race/Ethnicity, 2023



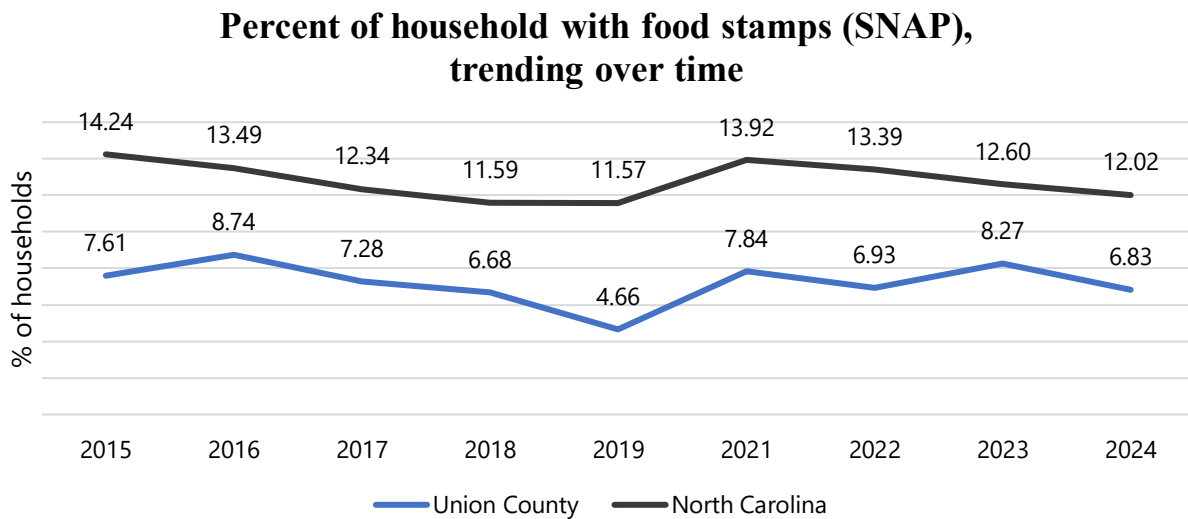
Data Source: Feeding America Map the Meal Gap, 2024



Participation in SNAP has fluctuated over time, declining before the COVID-19 pandemic, increasing during and after 2020, and remaining elevated in 2023. Approximately 8.3% of Union County households received SNAP benefits in 2023 (U.S. Census Bureau, 2024). Racial and ethnic disparities in SNAP participation persist, with higher participation among Black, Hispanic or Latino, Native American, and Pacific Islander households, reflecting higher levels of economic need and the continued importance of nutrition assistance programs (U.S. Census Bureau, 2024).



Data Source: Feeding America Map the Meal Gap, 2024



Data Source: US Census Bureau, American Community Survey, ACS, 2020-2024



## Housing

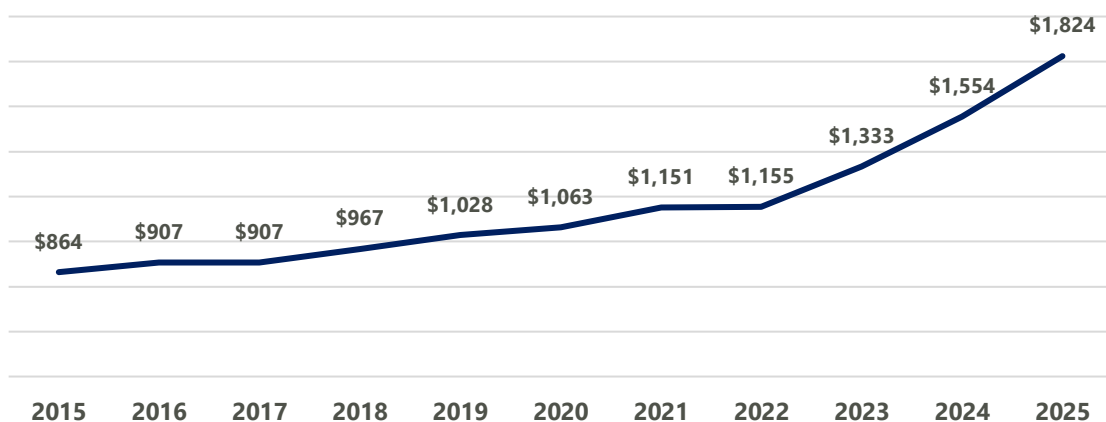
Housing affordability, cost burden, eviction, and homelessness are key social and economic factors that influence health by shaping financial stability, access to basic needs, and overall quality of life. When households spend a large share of their income on housing, they have fewer resources for food, transportation, childcare, and healthcare, which increases stress and the risk of poor health outcomes (HUD, n.d.; Urban Institute, 2023).

### Housing Affordability

Union County faces growing challenges related to housing affordability, reflecting broader state and national trends. Housing is typically considered affordable when it costs no more than 30% of a household's gross income (HUD, n.d.). When housing costs exceed this threshold, households are more likely to experience financial strain that can negatively affect health, employment stability, and access to basic needs (HUD, n.d.; Urban Institute, 2023). In Union County, rising home values and rents, limited housing supply, and wage growth that has not kept pace with housing costs have contributed to reduced affordability for many residents (U.S. Census Bureau, 2023).

Housing affordability affects a broad range of residents, not only households with very low incomes. Historical and ongoing discriminatory housing policies and practices, including redlining and exclusionary lending, have contributed to persistent disparities in homeownership, housing stability, and wealth (HUD, n.d.). Many essential workers (e.g., educators, childcare providers, service workers, and healthcare staff), seniors on fixed incomes, people with disabilities, and caregivers face heightened risk of housing instability (U.S. Census Bureau, 2023). Evidence indicates that investments in affordable housing are

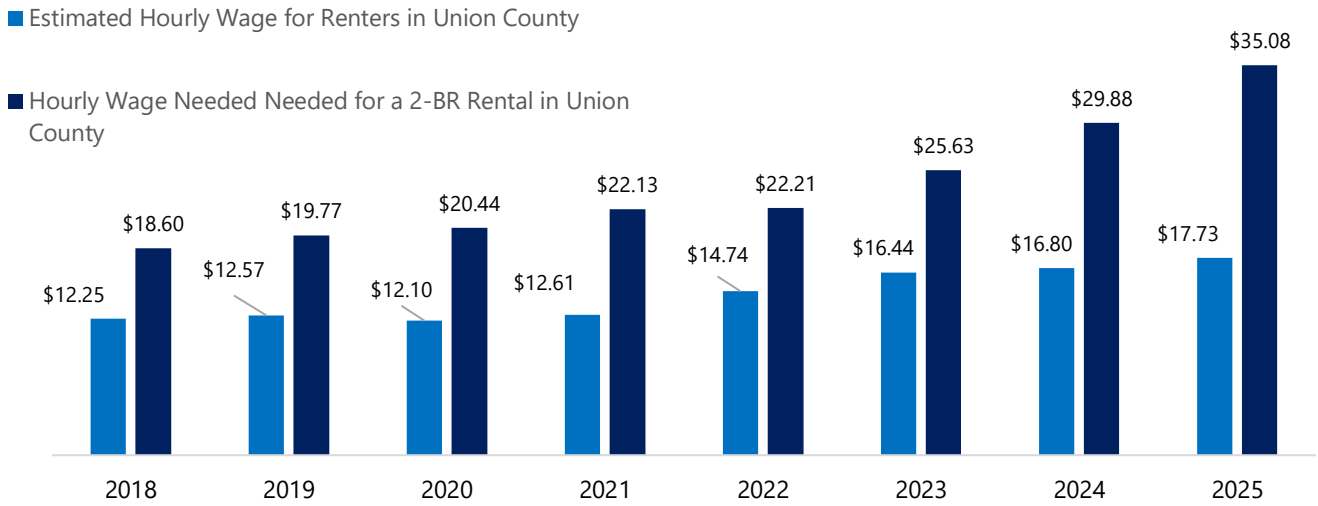
**Fair Market Rent for a 2 Bedroom Rental  
in Union County, NC**



Data Source: Fair Market Rents (40th PERCENTILE RENTS) | HUD USER. (n.d.)



## Estimated Hourly Wage for Renters vs. Wage needed to pay for a 2-bedroom apartment in Union County



*Data Source: Out of reach. (n.d.). National Low Income Housing Coalition*

associated with improved stability and downstream health benefits (Urban Institute, 2023).

Recent data indicate that, even when units are available, many are priced beyond the reach of low- and moderate-income households. HUD Fair Market Rent (FMR) estimates indicate that a two-bedroom unit in Union County requires an annual income of approximately \$72,960 to remain affordable (HUD, n.d.).

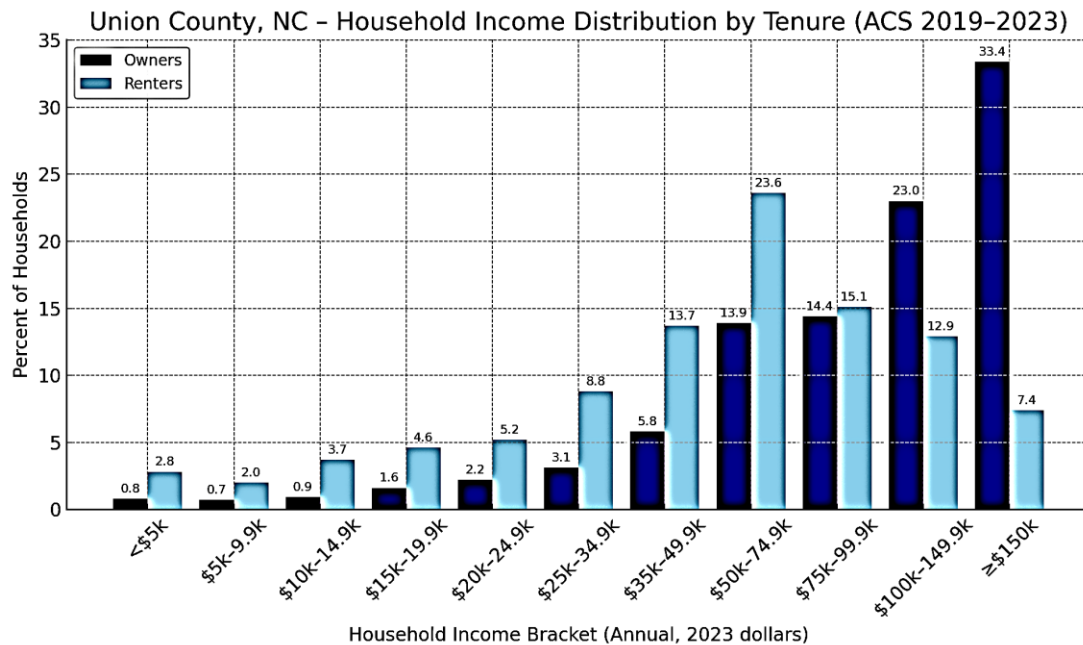
Comparisons of estimated renter wages and the wage required to afford a two-bedroom unit demonstrate a persistent gap between earnings and housing costs, particularly for

service-sector and essential workers (National Low Income Housing Coalition [NLIHC], 2025). In Union County, the hourly wage needed to afford a modest two-bedroom rental unit at fair market rent increased from \$18.60/hour in 2018 to \$35.08/hour in 2025 (NLIHC, 2025). Over the same period, the estimated average renter wage increased from \$12.25/hour to \$17.73/hour (NLIHC, 2025). This widening gap indicates that, by 2025, renters would need to earn roughly twice their estimated average wage to afford a two-bedroom unit without exceeding the 30% affordability threshold (NLIHC, 2025; HUD, n.d.).



## Income Differences Between Renters and Homeowners

Household income distribution in Union County differs substantially between renters and homeowners, highlighting structural differences in housing stability and affordability. From 2019–2023, renter households were disproportionately concentrated in lower- and moderate-income brackets, while homeowners were more heavily represented in higher-income categories (U.S. Census Bureau, 2023). Nearly half of renter households earned less than \$50,000 annually, while over one-third of homeowner households earned \$150,000 or more (U.S. Census Bureau, 2023). These disparities reinforce renters' economic vulnerability and increase the risk of cost burden, eviction, and housing instability (U.S. Census Bureau, 2023; Urban Institute, 2023).

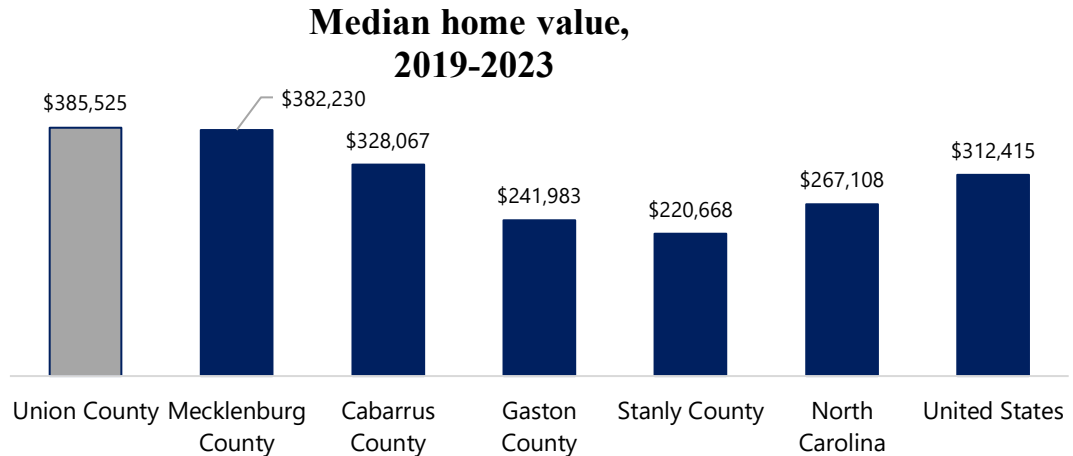


Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

## Home Values

Union County, NC, has the highest median home value at \$385,525, followed closely by Mecklenburg County, NC, at \$382,230. Cabarrus County, NC, has a median home value of \$328,067, while the median home value for the entire United States is \$312,415. North Carolina's median home value is \$267,108, significantly lower than the national median of \$267,108. Gaston County, NC, and Stanly County, NC, have the lowest median home values at \$241,983 and \$220,668, respectively. (U.S. Census Bureau, 2023). Higher home values can create wealth-building opportunities for homeowners but can also intensify barriers to homeownership and contribute to rising rents and displacement risk for lower-income households (Urban Institute, 2023).





*Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023*

### Housing Cost Burden

Housing cost burden is a significant issue in Union County, particularly among renters. Cost-burdened households are defined as those spending more than 30% of income on housing, while severely cost-burdened households spend more than 50% (HUD, n.d.). From 2019–2023, a substantial proportion of Union County renter households were cost-burdened, with the highest burden concentrated among lower-income households (U.S. Census Bureau, 2023). Although homeowners also experience housing cost burdens,

renters face a disproportionately higher risk of housing instability due to lower incomes and fewer financial buffers (U.S. Census Bureau, 2023).

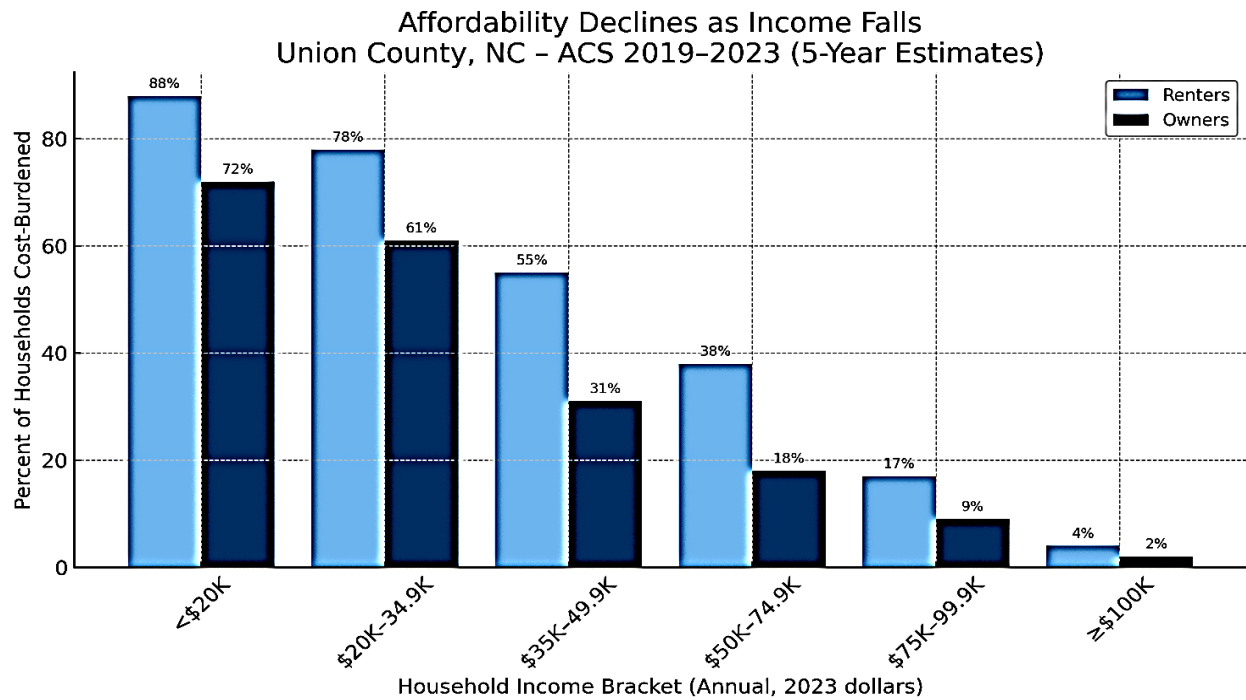
- 23% of Union County Households are Cost-Burdened (18,401 Households)
- 44% of Renters are Cost Burdened (5,881)
- 19% of Homeowners are Cost Burdened (12,520)
- 9.11% of Union County Households are Severely Cost- Burdened

*Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023.*



### Housing Burden by Income

Housing cost burden in Union County is strongly associated with household income and disproportionately affects lower-income renters. From 2019–2023, an estimated 88% of renter households earning less than \$20,000 annually were cost-burdened, compared to 72% of homeowners in the same income group (U.S. Census Bureau, 2023). Cost burden remains high among renters earning \$20,000–\$34,999 (78%) and \$35,000–\$49,999 (55%), while homeowners in these income brackets experience lower—but still substantial—cost burdens (U.S. Census Bureau, 2023). As income increases, cost burden declines for both renters and owners; however, renters consistently experience a higher burden at every income level (U.S. Census Bureau, 2023). A high-cost burden reduces a household’s ability to afford basic needs and increases the risk of eviction and adverse health outcomes (Urban Institute, 2023).



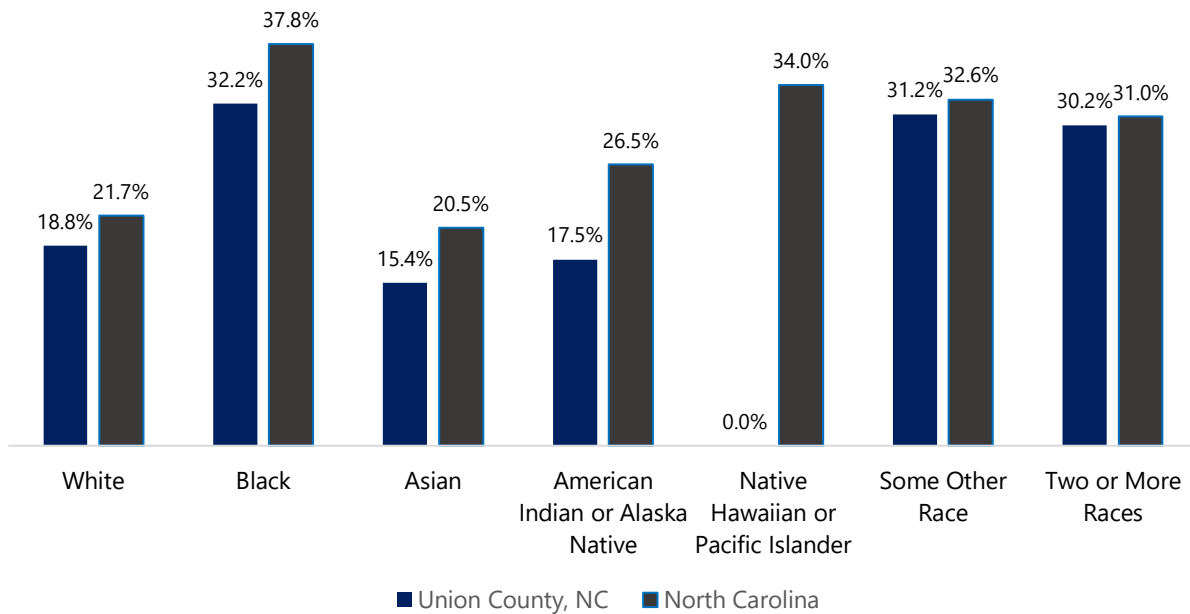
Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



### Housing Cost Burden by Race

Housing cost burden varies by race and ethnicity, reflecting longstanding inequities in income, housing access, and wealth. From 2019–2023, a higher percentage of Black households (32.2%) and households identifying as Some Other Race (32.6%) were cost-burdened compared to White households (18.8%) (U.S. Census Bureau, 2023). These disparities mirror broader structural patterns linked to discriminatory housing policies and unequal access to homeownership and affordable housing (HUD, n.d.; Urban Institute, 2023).

**Percent of Cost-Burdened Housholds in Union County,  
by Race Alone, 2019-2023**



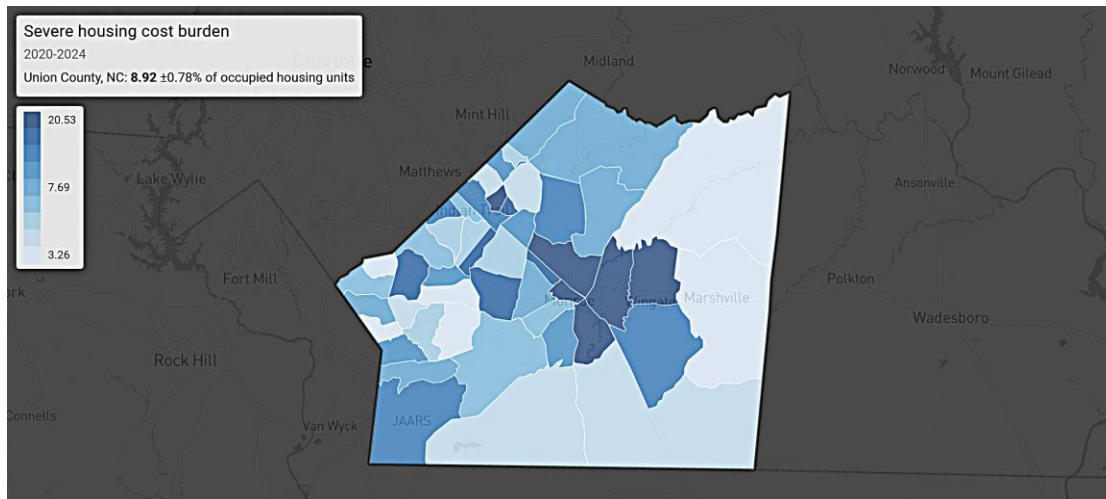
Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

### Severe Housing Cost Burden

Severe housing cost burden, spending more than 50% of income on housing, varies widely across Union County municipalities. Wingate has the highest percentage at 29.53%. Other towns, such as Lake Park, Mint Hill, and Monroe, also have relatively high percentages, ranging from 12.67% to 19.88%. In contrast, towns like Hemby Bridge, Indian Trail, and Waxhaw have moderate affordability rates ranging from 5.87% to 8.68%, indicating varying local affordability conditions and vulnerability to financial crises (U.S. Census Bureau, 2024). Severe cost burden is an upstream factor associated with housing instability, displacement, and homelessness (Urban Institute, 2023).



## Map of Severe House Burdened Residents in Union County

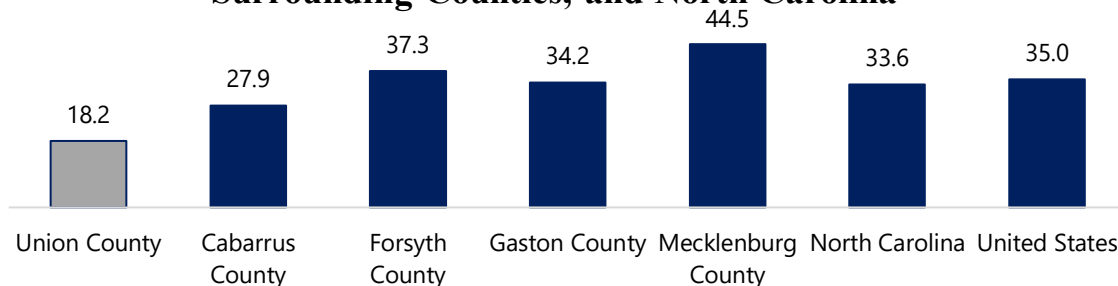


Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2020-2024

### Housing Availability

From 2019–2023, Union County had a lower percentage of renter-occupied housing units (18.2%) compared to North Carolina overall (33.6%) and the United States (35.0%) (U.S. Census Bureau, 2023). A lower share of rental housing can indicate a more limited rental supply, intensifying competition for available units and contributing to rising rents and housing cost burden—particularly for low- and moderate-income households, young adults, seniors, and essential workers (U.S. Census Bureau, 2023; Urban Institute, 2023).

### Percent of Renter Occupied Households in Union County, Surrounding Counties, and North Carolina

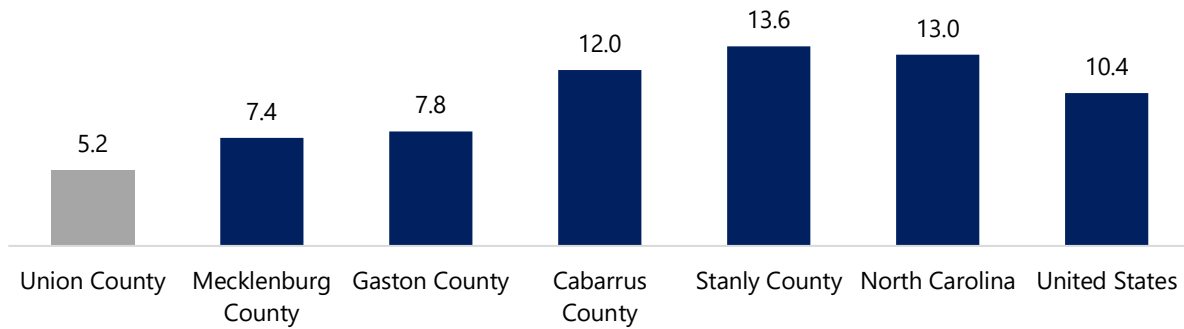


Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

Union County also had a lower housing vacancy rate (5.2%) than North Carolina overall (13.1%) and the United States (10.4%) from 2019–2023 (U.S. Census Bureau, 2023). Low vacancy rates suggest strong demand relative to supply, reducing housing choice and increasing upward pressure on rents and home prices, worsening affordability challenges for renters and first-time homebuyers (U.S. Census Bureau, 2023).



## Percent of Vacant Housing Units in Union County, Surrounding Counties, and North Carolina

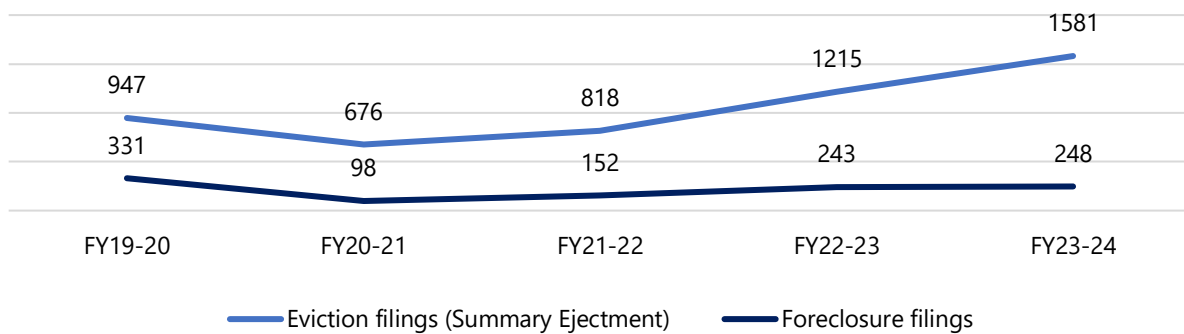


Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

### Evictions and Housing Instability

Eviction filings are a key indicator of housing instability and financial hardship. In the most recent year, Union County recorded more than 1,500 renter eviction filings and nearly 250 foreclosures (Eviction Lab, 2024; North Carolina Administrative Office of the Courts, n.d.). During the COVID-19 pandemic, eviction and foreclosure filings declined due to temporary moratoriums and forbearance policies; however, filings increased after 2021 as those protections expired (CDC, 2021; HUD, n.d.; Eviction Lab, 2024). Eviction risk is particularly elevated among cost-burdened renters and is associated with increased stress, poorer mental and physical health outcomes, and greater reliance on emergency services (Urban Institute, 2023; U.S. Interagency Council on Homelessness [USICH], 2023).

## Number of Eviction and Foreclosure Filings in Union County, trending over time



Data Source: North Carolina Administrative Office of the Courts, VCAP Issue Filings/Order Results FY2019–2020 through FY2023–2024



Evictions also impose economic costs on households and communities. Legal fees, court costs, and lost rent can contribute to financial instability for renters and increase pressure on landlords to raise rents, potentially accelerating the loss of affordable housing over time (Urban Institute, 2023). Evidence indicates that eviction prevention strategies—such as rental assistance, mediation, and targeted case management—can be more cost-effective than responding after displacement occurs (Urban Institute, 2023; USICH, 2023).

Average Cost of an Eviction: \$4,398 per case

- Lost rent: \$3,332
- Legal fees: \$500
- Financial damages: \$260
- Court costs: \$156
- Property damages: \$150

### Homelessness

Homelessness is closely linked to housing affordability, cost burden, and eviction risk. HUD defines homelessness to include individuals who lack a fixed, regular, and adequate night-time residence, including those who are literally homeless, at imminent risk of homelessness, or fleeing domestic violence (HUD, n.d.).

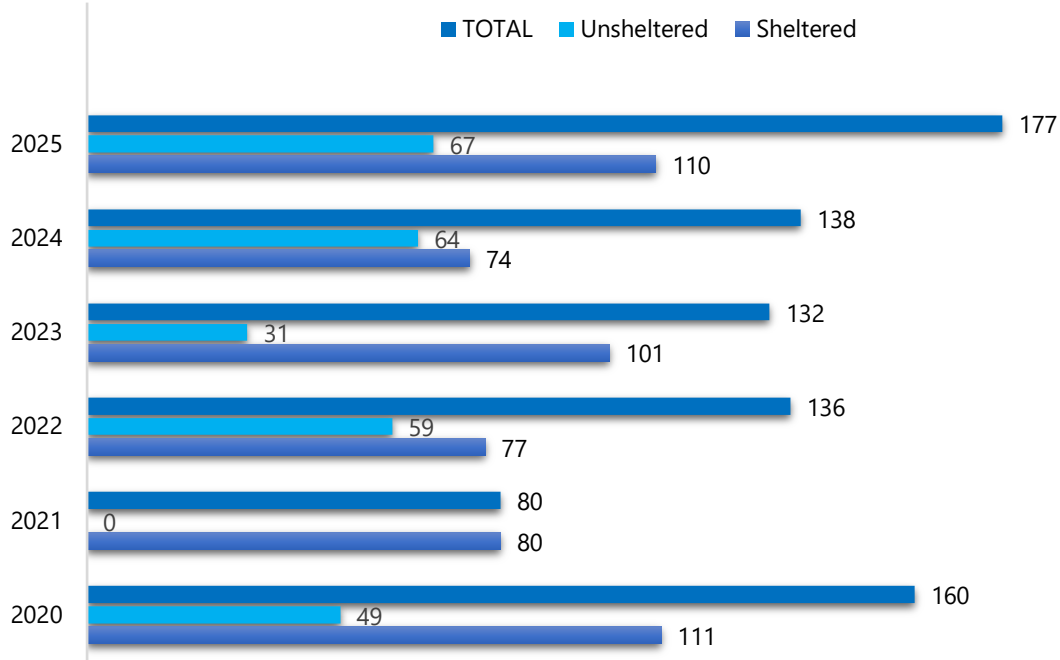
Union County Point-in-Time (PIT) counts show fluctuating but persistent homelessness. From 2020–2025, the number of individuals experiencing homelessness ranged from approximately 132 to 177 on a single night. In 2025, 177 individuals were identified, including 110 sheltered and 67 unsheltered (Union County, 2025). After declines during the early pandemic period, counts increased after 2022, with notable growth in unsheltered homelessness (Union County, 2025). Unsheltered homelessness increases risks for injury, exposure-related illness, infectious disease, and premature mortality, underscoring the need for coordinated housing, shelter, and supportive service strategies (USICH, 2023).

Statewide data reflect similar trends. North Carolina’s 2024 PIT count identified 11,626 individuals experiencing homelessness, including a substantial unsheltered population (North Carolina Coalition to End Homelessness, 2024). Homelessness is also closely associated with behavioral health needs, including substance use challenges, reinforcing the intersection between housing instability and mental health and substance use service capacity (USICH, 2023; North Carolina Coalition to End Homelessness, 2024).

These local trends mirror broader statewide patterns. According to the 2024 North Carolina Point-in-Time count, 11,626 individuals were experiencing homelessness statewide, including 2,085 individuals experiencing chronic homelessness, 688 veterans, and 4,523 unsheltered individuals. Approximately one-third of people experiencing homelessness in North Carolina report substance use challenges, highlighting the intersection of housing instability and behavioral health needs (North Carolina PIT Count; U.S. Department of Housing and Urban Development).



## Union County Point In Time Counts, trending over time



No unsheltered count in 2021 due to pandemic; 65 individuals identified

Data Source: North Carolina Balance of State Continuum of Care, Point-in-Time count results, 2020-2025

### Progress on CHIP – Housing and Homelessness

Housing and homelessness were identified as a priority area in the 2022 Community Health Assessment. The 2022–2025 Union County Community Health Improvement Plan (CHIP) outlines the community’s strategies to address this need. Key initiatives include the Housing Symposium, which brings partners together to coordinate solutions and share resources; Rapid Rehousing efforts that help individuals and families quickly move from homelessness into stable housing; and support for Emergency Shelter services to meet immediate needs. Progress notes from 2023, 2024, and 2025 document the implementation and outcomes of these strategies across the CHIP period. Click the links below to review the progress notes for each strategy and program:

- 🔗 [Housing Symposium](#)
- 🔗 [Rapid Rehousing](#)
- 🔗 [Emergency Shelter](#)



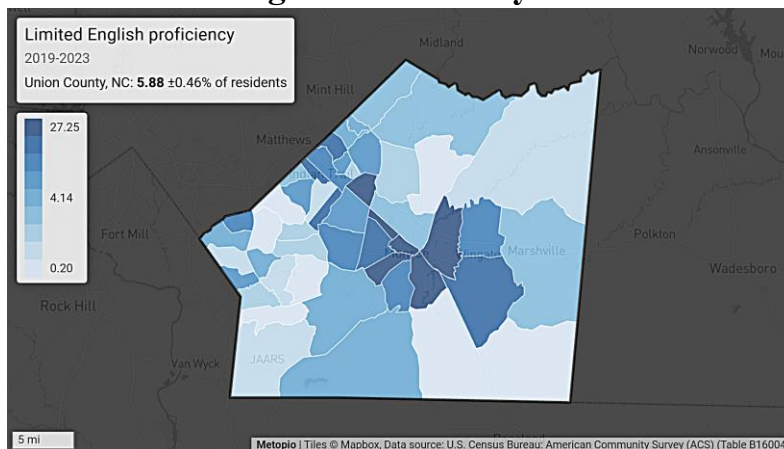
## Limited English Proficiency

Limited English proficiency (LEP) refers to the percentage of residents age 5 and older who speak a language other than English at home and speak English less than “very well” (U.S. Census Bureau, 2023). In Union County, 5.88% of residents meet the LEP definition, compared to 4.9% statewide (U.S. Census Bureau, 2023). LEP varies substantially by municipality, ranging from 0.63% in Mineral Springs to 14.98% in Monroe, 10.22% in Hemby Bridge, and 7.27% in Indian Trail (U.S. Census Bureau, 2023).

LEP also differs by age group. In Union County, LEP is highest among adults ages 18–64 (6.78%), slightly higher than the state rate (5.87%) (U.S. Census Bureau, 2023). Among residents ages 65 and older, Union County’s LEP rate (5.39%) is higher than the statewide rate (2.67%), indicating that a notable subset of older adults may face language-related barriers to accessing healthcare, navigating services, and obtaining social support (U.S. Census Bureau, 2023). LEP differs significantly by race and ethnicity: it is highest among Hispanic (32.12%) and Asian (18.33%) residents (U.S. Census Bureau, 2023). Among residents with LEP, Spanish is the most spoken language (72.8%), followed by other Indo-European languages (15.8%) and Asian or Pacific Island languages (9.9%) (U.S. Census Bureau, 2023).

These patterns suggest that language access strategies—including interpretation, translation, and culturally responsive outreach—remain essential to improving access to services and reducing inequities (U.S. Census Bureau, 2023).

## Map of the percent of Union County Residents with Limited English Proficiency



Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



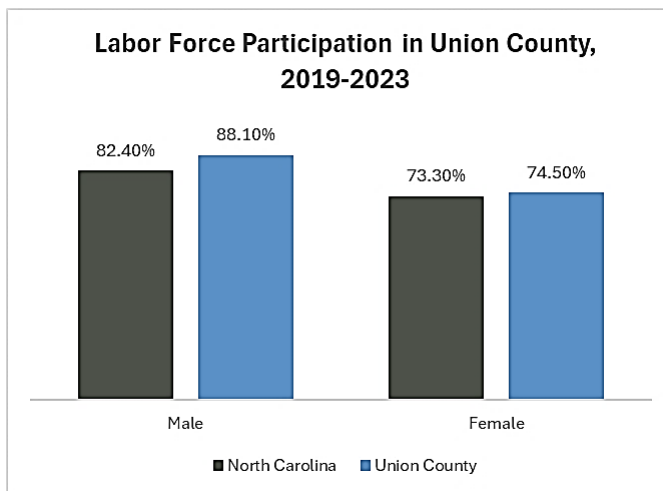
## Labor Workforce and Employment

Union County has approximately 123,262 employed residents. From 2022 to 2023, employment increased by 1.92%, reflecting continued labor market growth (U.S. Census Bureau, 2023). Major employment sectors include education services, healthcare, and social assistance, followed by professional, scientific, and management services and administrative and waste management services (U.S. Census Bureau, 2023).



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year, 2019-2023

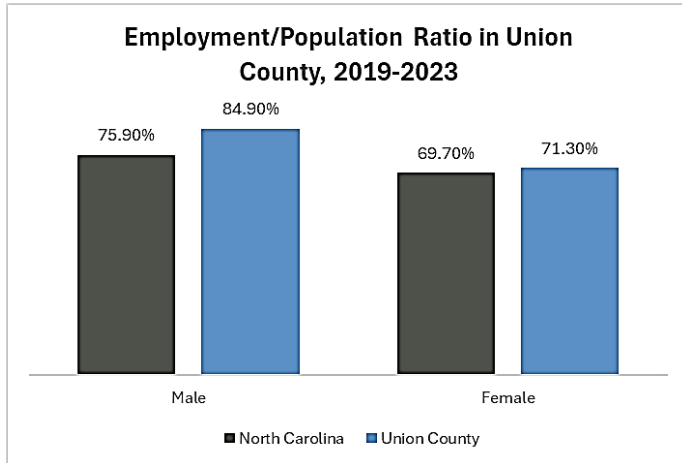
Labor force participation and employment rates in Union County are generally higher than the state overall, although disparities persist by gender, race/ethnicity, and educational attainment



(U.S. Census Bureau, 2023). Among males, 88.1% participate in the labor force in Union County compared to 82.4% statewide, and 84.9% are employed compared to 75.9% statewide. Among females, 74.5% participate in the labor force compared to 73.3% statewide, and 71.3% are employed compared to 69.7% statewide (U.S. Census Bureau, 2023).

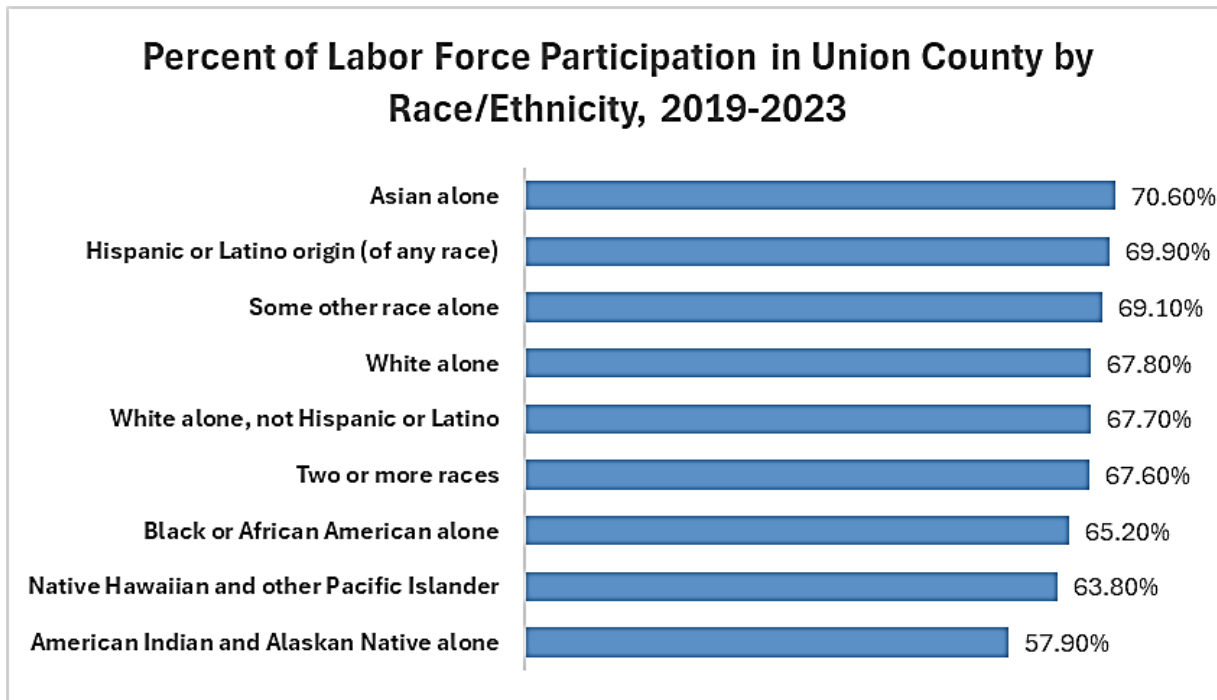
Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023





Participation rates also vary by race/ethnicity. Asian residents have the highest labor force participation rate (70.6%), followed by Hispanic or Latino residents (69.6%), while Black residents participate at a slightly lower rate (65.2%). American Indian/Alaska Native residents have the lowest participation rate (57.9%), suggesting potential structural barriers to employment access and workforce engagement (U.S. Census Bureau, 2023).

U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023.



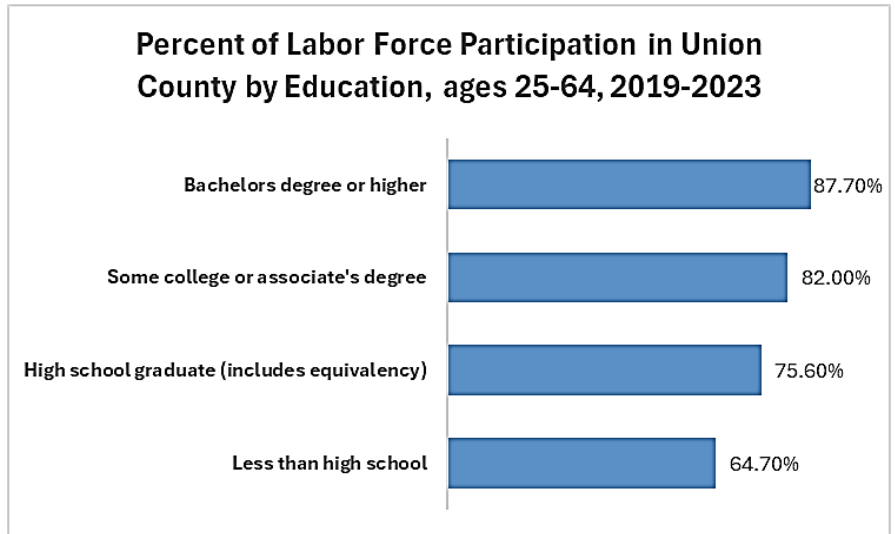
Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

Educational attainment is strongly associated with labor force participation. Residents with a bachelor’s degree or higher have the highest participation rate (87.7%), followed by those with some college or an associate degree (82.0%). Participation is lower among high school graduates (75.6%) and lowest among residents with less than a high school diploma (64.7%) (U.S. Census Bureau, 2023). This pattern highlights the importance of educational access and workforce training in strengthening economic stability and reducing disparities in employment opportunities (U.S. Census Bureau, 2023).

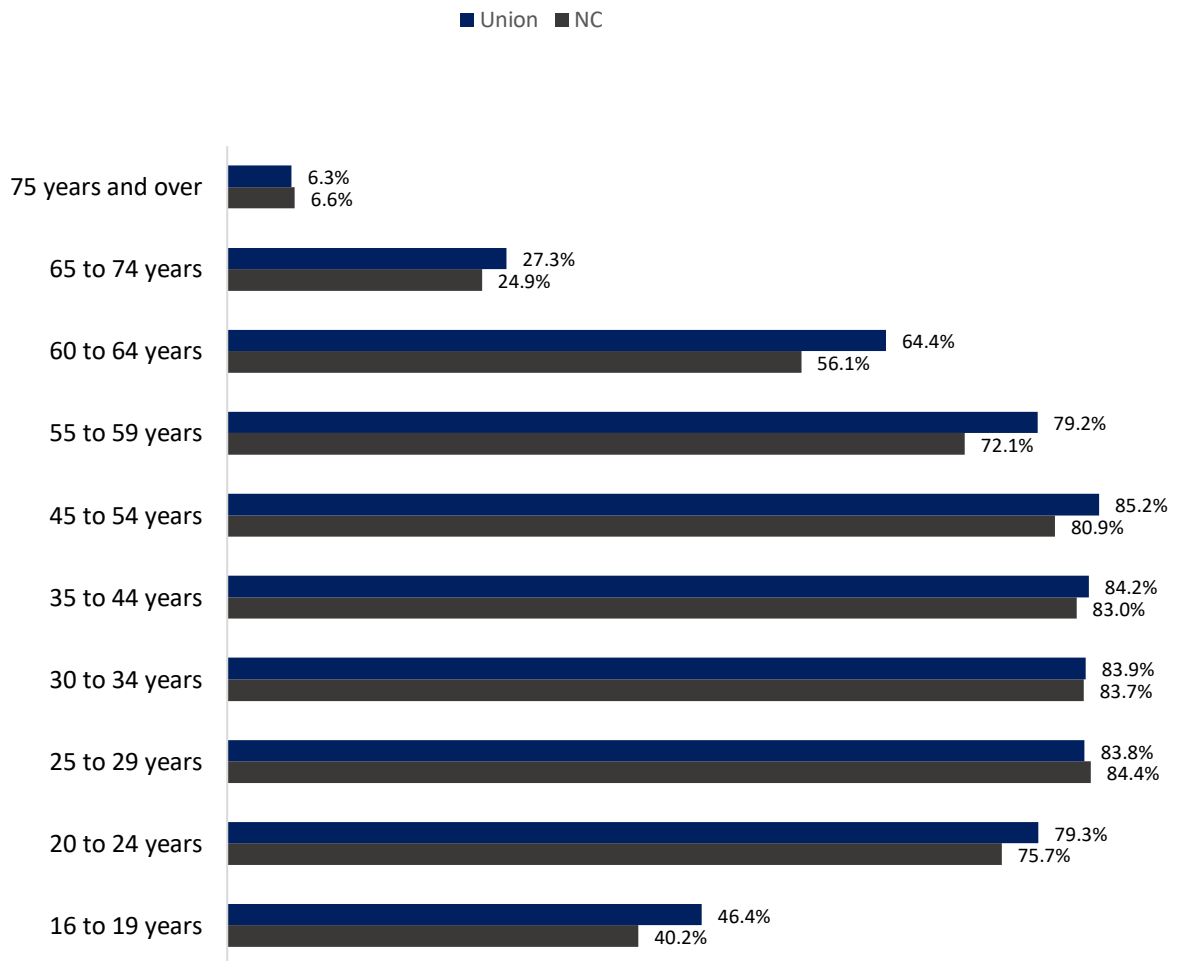


By age, participation is highest among prime working-age adults (25–54), then declines after age 55 and drops sharply among residents age 65 and older, reflecting retirement patterns and changing workforce capacity as the population ages (U.S. Census Bureau, 2023).

Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023.



### Percent of Labor Force Participation in Union County and North Carolina, by Age Group



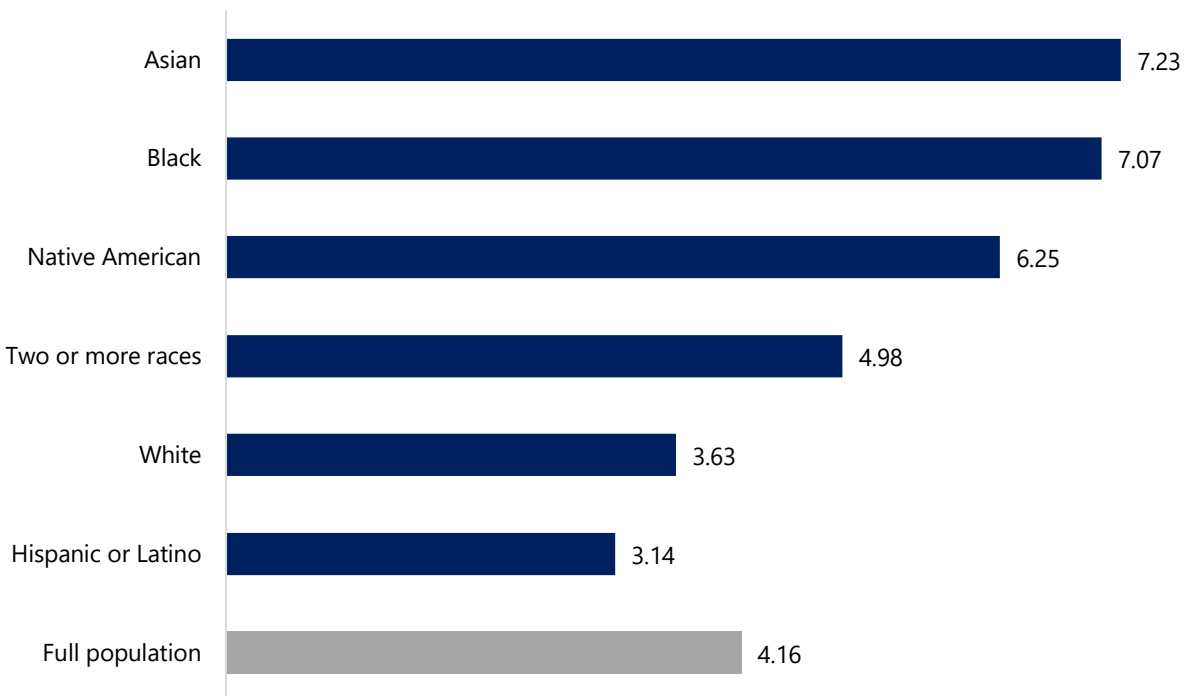
Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



## Unemployment

Union County's unemployment rate is lower than the statewide average, suggesting a relatively strong local labor market. From 2019–2023, Union County's overall unemployment rate was 4.16% compared to 4.83% statewide (U.S. Census Bureau, 2023). However, unemployment varies by race and ethnicity. In Union County, Asian and Black residents experience the highest unemployment rates (7.23% and 7.07%, respectively), while Hispanic or Latino residents have the lowest rate (3.14%) (U.S. Census Bureau, 2023).

### Unemployment Rate in Union County by Race/Ethnicity

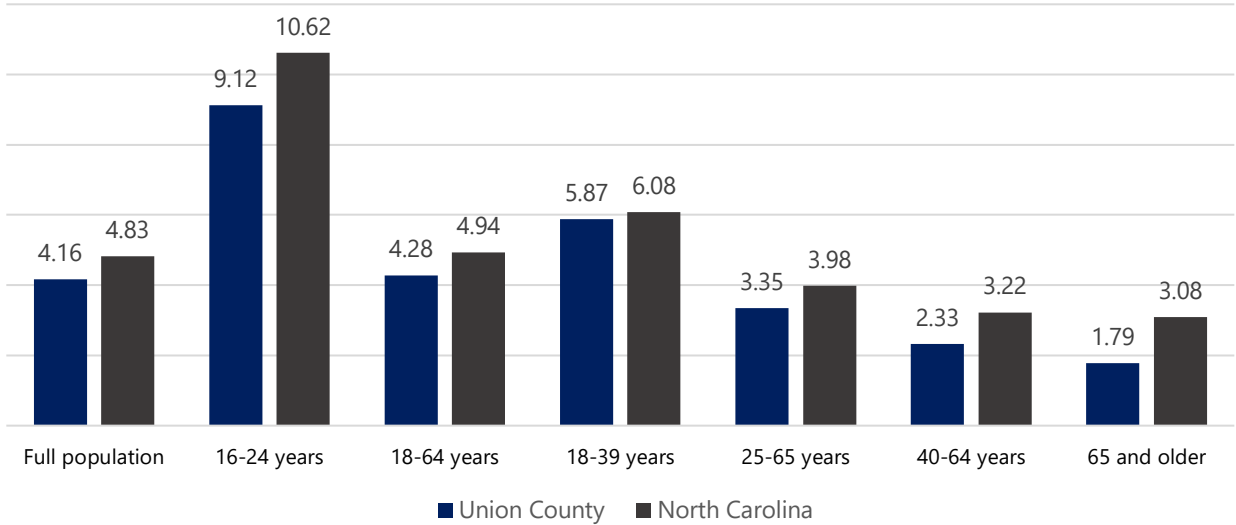


*Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023*

Unemployment also differs by age, with the highest rates among younger adults. Union County's unemployment rate for ages 16–24 (9.12%) is lower than the statewide rate (10.62%) but remains elevated relative to older age groups (U.S. Census Bureau, 2023). At the municipal level, unemployment varies widely, reflecting unequal access to employment opportunities, transportation, and job networks across communities (U.S. Census Bureau, 2023). These disparities underscore the need for targeted workforce strategies that improve equitable access to job training, education pathways, and employment opportunities across populations and geographies (U.S. Census Bureau, 2023).

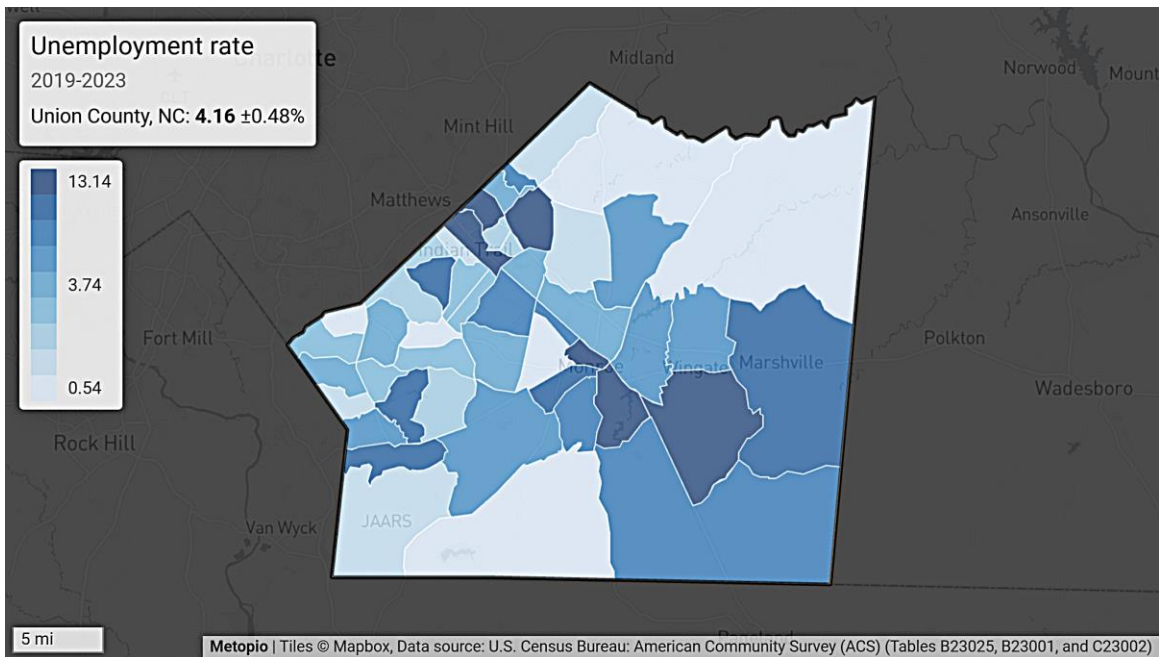


## Unemployment Rate in Union County and North Carolina, by Age



Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

## Map of Unemployment Rate in Union County



Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



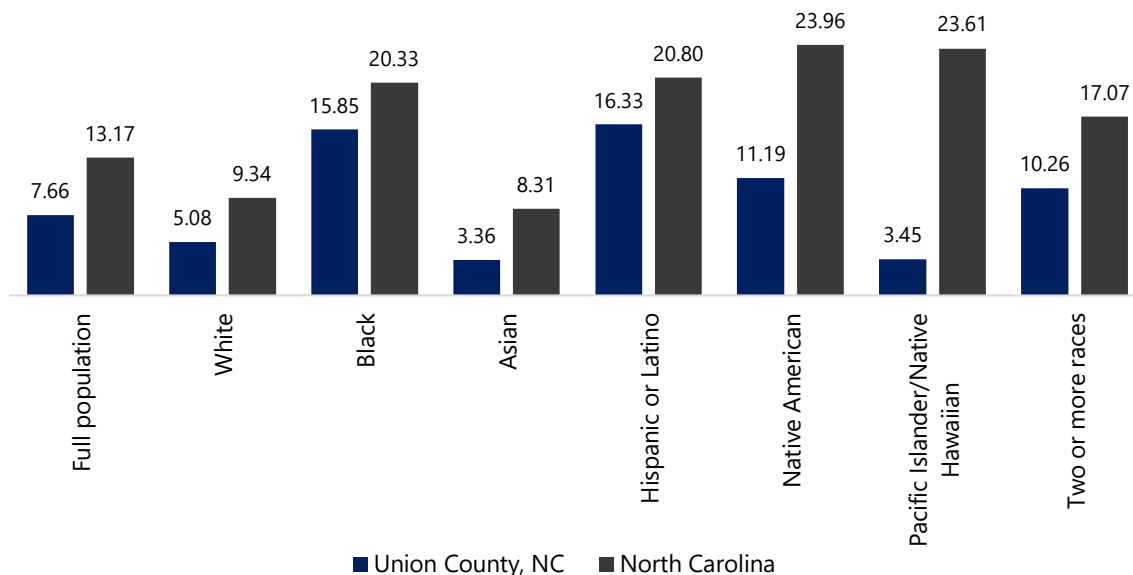
## Poverty Rates

Union County's overall poverty rate is lower than the statewide average, but substantial disparities persist by race/ethnicity, age, household type, education, and place. From 2019–2023, the poverty rate in Union County was 7.66%, compared to 13.17% statewide (U.S. Census Bureau, 2023).

Poverty differs significantly across racial and ethnic groups. In Union County, Hispanic or Latino residents experience the highest poverty rate (16.33%), while Asian residents have the lowest poverty rate (3.36%) (U.S. Census Bureau, 2023). Poverty rates also vary by sex, with females (8.33%) experiencing higher poverty than males (6.98%) in Union County, though both are lower than state averages (U.S. Census Bureau, 2023).

Household structure shows some of the most pronounced disparities. Female-headed households without a spouse are far more likely to experience poverty than married-couple households across racial and ethnic groups. The highest poverty rates occur among female householders identifying as "Some Other Race" (58.5%) and Hispanic or Latino (44.5%), reflecting compounded vulnerabilities related to income, caregiving responsibilities, and structural inequities (U.S. Census Bureau, 2023).

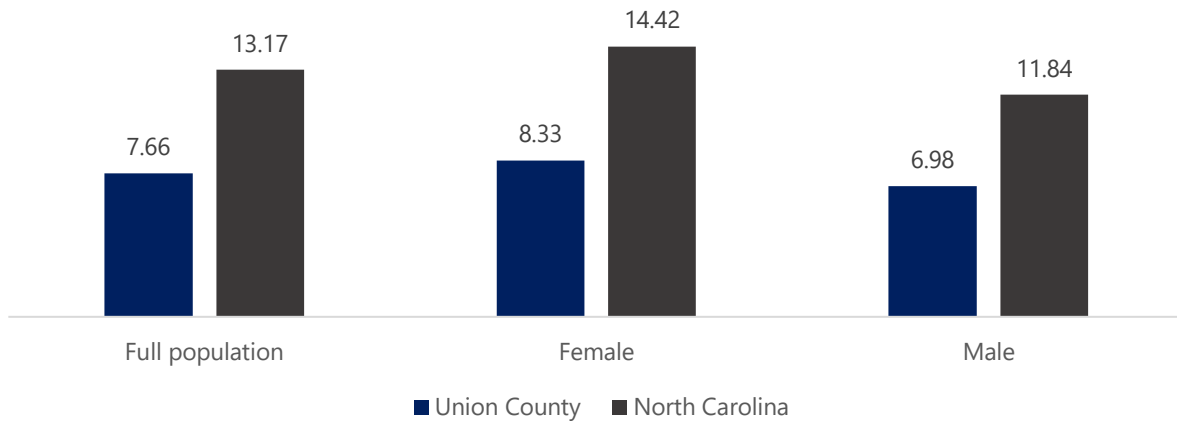
### Percent of Union County Residents Compared to North Carolina Residents in Poverty, by Race/Ethnicity



Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

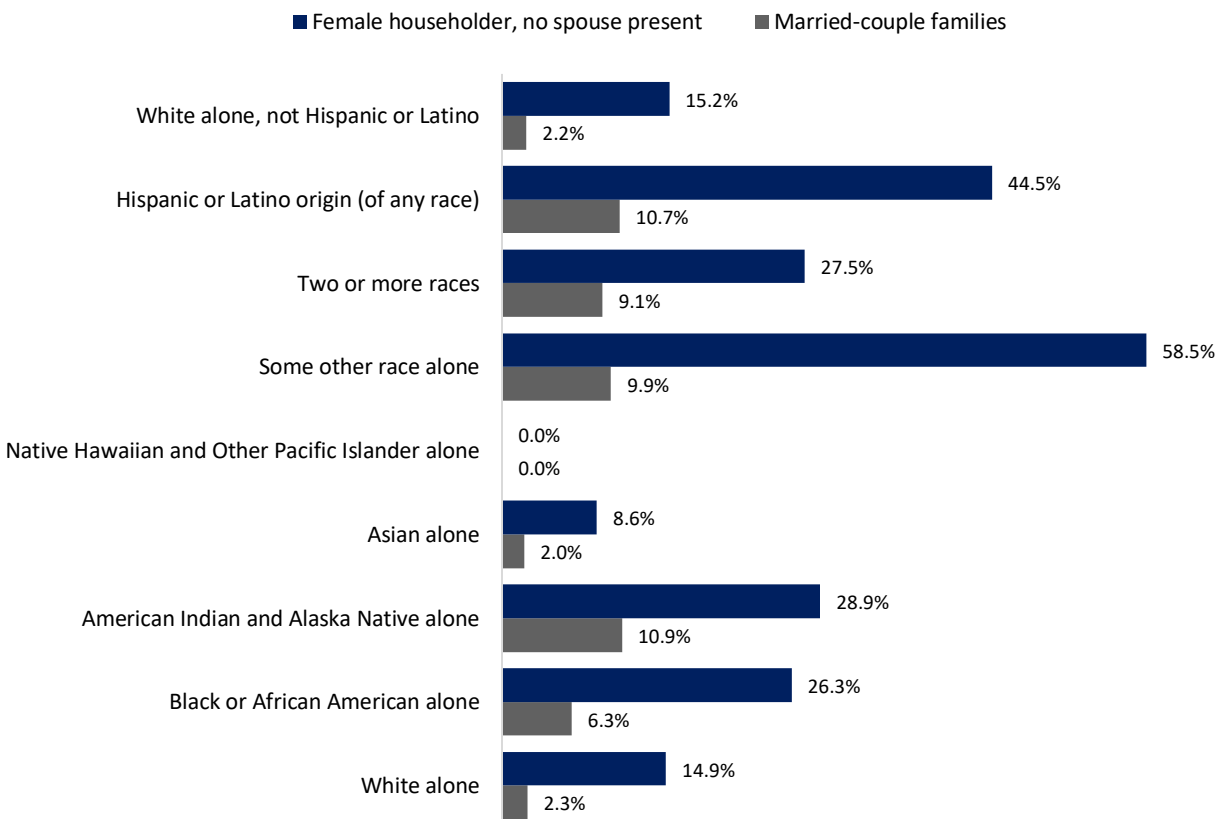


## Percent of Union County and North Carolina Residents in Poverty, by Sex



Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023.

## Percent of Residents in Union County and North Carolina Below the Poverty Level by Race/Ethnicity and Marital Status

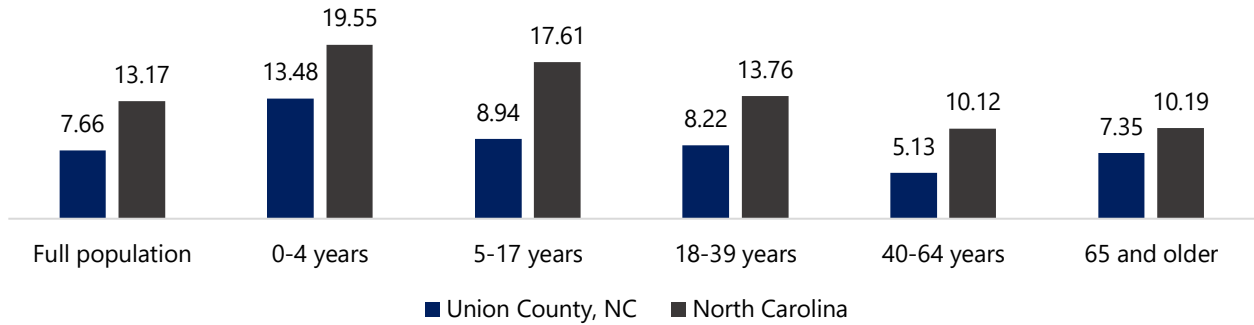


Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



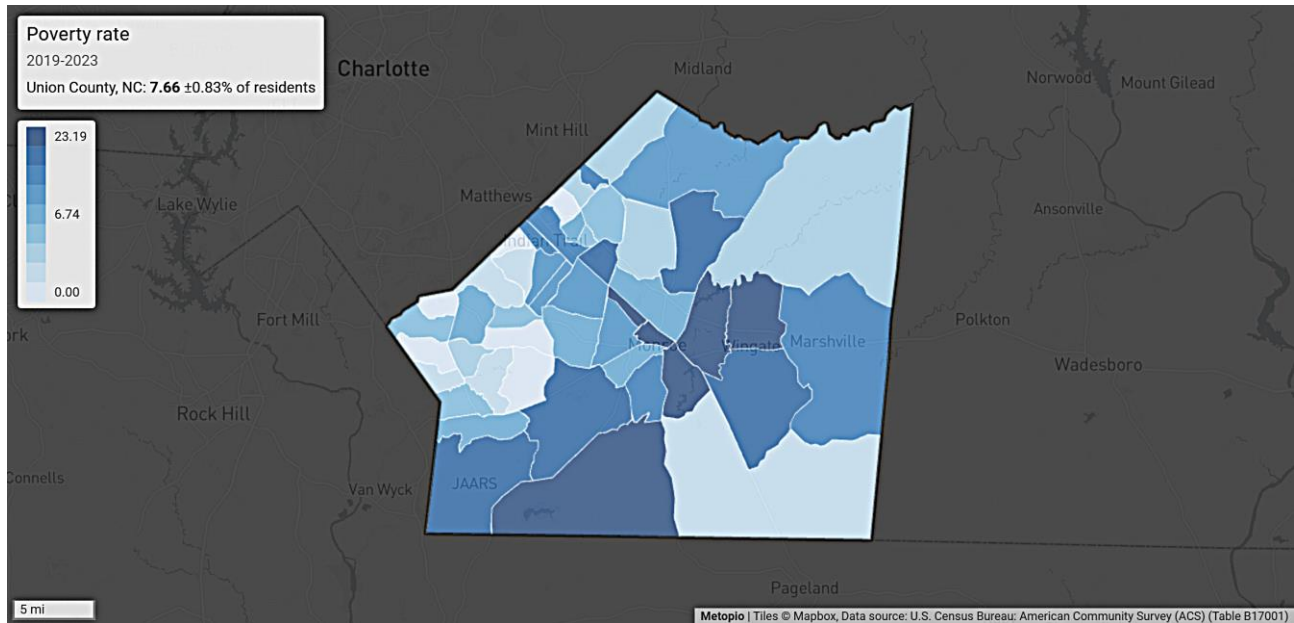
Poverty also varies by age. In Union County, the highest poverty rate occurs among young children ages 0–4 (13.48%), while poverty among adults age 65 and older is 7.35% (U.S. Census Bureau, 2023). Municipality-level poverty ranges widely (e.g., from 2.76% in Fairview to 25.39% in JAARS), indicating substantial geographic inequities in economic stability and access to opportunity (U.S. Census Bureau, 2023).

### Percent of Residents in Union County and North Carolina in poverty, by Age



Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

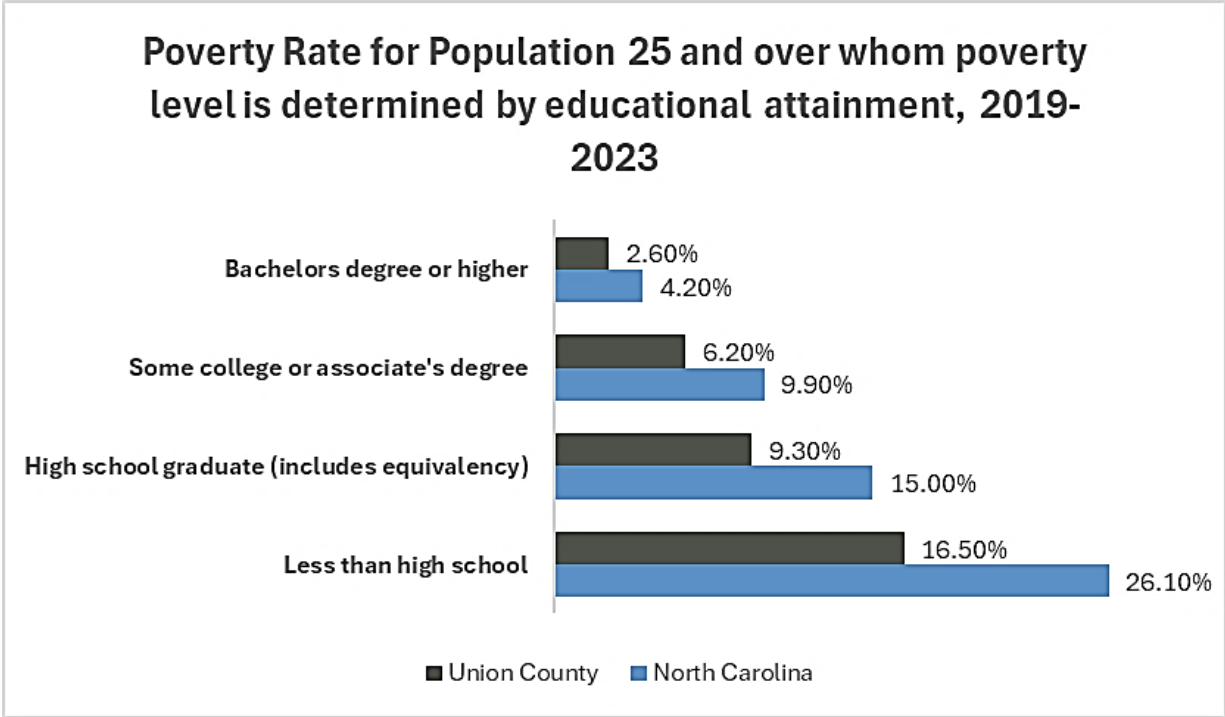
### Map of Poverty Rates in Union County



Data Source: US Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



In Union County, poverty rates decline sharply as educational levels rise, mirroring statewide trends but with consistently lower rates than North Carolina as a whole. Individuals without a high school diploma experience the highest poverty rate—16.5% in Union County compared to 26.1% statewide—while those with a bachelor’s degree or higher have the lowest poverty levels (2.6% vs. 4.2%). The data clearly show that higher education significantly reduces the likelihood of living in poverty, underscoring the importance of access to education and workforce training in promoting economic stability.



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



## Secondary Data Overview

### Indicator Summary Table

The following summary table provides a high-level overview of key health indicators in Union County compared with state benchmarks and peer counties. These indicators informed the data analysis and priority-setting process.

Health Indicator: Maternal, Child, & Infant Health	Data Year	Union County	Union Trending	North Carolina
Infant Mortality (<1yr) (rate/1000 live births)	2019-23	4.2	Decrease	6.9
Fetal Deaths (per 1,000 deliveries)	2019-23	5.9	Decrease	6.0
Neonatal Deaths (<28 days) (rate/1000 live births)	2019-23	2.9	Decrease	4.5
Post Neo-Natal Deaths (28 days-1 year)	2019-23	1.3	Decrease	2.3
Live Births (rate per 1,000 population)	2019-23	10	Same	11.3
Low Birth Weight (<=2500 g) (% of all live births)	2019-23	7.9	Same	9.4
Teen Pregnancy Rate (15-19 years) (per 1,000 females)	2023	11.1	Decrease	20.8
% Interval of <6 Months (between delivery & conception)	2023	12	Same	14
Unmarried Mothers (% of all live births)	2019-23	30.1	Increase	41.1

Data Source: NC SCHS, 2024

Health Indicator: Chronic Conditions (Mortality), age-adjusted, rate per 100,000 population	Data Year	Union County	Union Trending	North Carolina
Heart Disease	2019-23	136.7	Increase	165.2
Cancers – All Sites	2019-23	138	Decrease	152.9
Trachea, Bronchus & Lung	2019-23	31.8	Increase	36.7
Breast	2019-23	17.0	Decrease	19.8
Colon, Rectum, Anus	2019-23	10.6	Decrease	13.1
Prostate	2019-23	16.5	Decrease	20.0
Cerebrovascular Disease (Stroke)	2019-23	40.4	Increase	46.4
Chronic Lower Respiratory Disease	2019-23	26.8	Decrease	39.4
Alzheimer’s Disease	2019-23	56.8	Increase	36.5
Pneumonia & Influenza	2019-23	12.3	Decrease	13.1
Diabetes Mellitus	2019-23	27.5	Increase	17.9
Septicemia	2019-23	8.3	Decrease	12.0
Nephritis, Nephrotic Syndrome & Nephrosis	2019-23	18.1	Increase	16.8
Chronic Liver Disease & Cirrhosis	2019-23	8.2	Increase	13.3

Data Source: NC SCHS, 2024



Health Indicator: Injury Morality (rate per 100,000 population)	Data Year	Union County	Union Trending	North Carolina
Motor Vehicle Injuries	2019-23	11.5	Increase	16.4
All Other Unintentional Injuries	2019-23	37.2	Increase	57.4
Suicide	2019-23	9.7	Decrease	13.7
Homicide	2019-23	5.2	Increase	8.7

Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina Violent Death Reporting System (NC-VDRS) 2023

Health Indicator: Communicable Diseases (rate per 100,000 population)	Data Year	Union County	Union Trending	North Carolina
COVID-19 (age-adjusted mortality rate)	2017-21	35.4		34.6
Chlamydia	2023	401.5	Increase	616
Gonorrhea	2023	116	Decrease	246.6
AIDS (age-adjusted mortality rate)	2020-22	*	Same	1.6
Newly Diagnosed AIDS Average Rates	2022-24	3.5	Increase	7.1
Newly Diagnosed HIV Average Rates	2022-24	7.4	Increase	15.2
Newly Diagnosed Early Syphilis Average Rate (Primary, Secondary, Early Latent)	2022-24	16.2	Increase	36.0
Tuberculosis	2023	2.3	Increase	2

Data collected by NC EDSS Surveillance

Health Indicator: Healthcare Providers (rate per 100,000 population)	Data Year	Union County	Union Trending	North Carolina
Primary Care Physicians	2024	57.02	Increase	110.67
Dentists (per capita)	2024	76.0	Increase	105.9

Data Source: Centers for Medicare & Medicaid Services (CMS), 2025

Health Indicator: Life Expectancy	Data Year	Union County	Cabarrus County	Johnston County	North Carolina
Life Expectancy at Birth	2020-22	78.5	77.3	76.5	75.9
White Life Expectancy at Birth	2020-22	78.7	77.2	76.5	76.4
African American Life Expectancy at Birth	2020-22	73.3	74.5	74.1	72.1
Male Life Expectancy at Birth	2020-22	76	75.1	73.7	73
Female Life Expectancy at Birth	2020-22	81.2	79.4	79.2	78.8

Data Source: NC SCHS, 2024



<b>Health Indicator: Maternal, Child, &amp; Infant Health</b>	<b>Data Year</b>	<b>Union County</b>	<b>Cabarrus County</b>	<b>Johnston County</b>	<b>North Carolina</b>
Infant Mortality (<1 yr.)	2019-23	4.2	5.3	5.5	6.8
White Rate	2019-23	3.1	4.8	4.1	4.7
African American Rate	2019-23	13.0	9.2	10.4	12.9
Live Births (rate per 1,000 population)	2019-23	10.0	11.4	11.9	11.3
White Rate	2019-23	8.8	9.3	10.5	9.5
African American Rate	2019-23	10.6	11.9	12.0	11.8
Hispanic Rate	2019-23	15.3	18.1	17.1	18.4
Teen Pregnancy Rate (15-19 yrs.)	2023	11.1	20.3	15.3	20.8
White Rate	2023	5.5	9.0	9.5	11.8
African American Rate	2023	18.1	25.4	20.3	28.4
Hispanic Rate	2023	28.0	37.3	21.2	37.8

Data Source: NC SCHS, 2024

<b>Health Indicator: Demographic Characteristics</b>	<b>Data Year</b>	<b>Union County</b>	<b>Cabarrus County</b>	<b>Johnston County</b>	<b>North Carolina</b>
% High School Degree or Higher, 25 years	2019-23	92.0%	88.7%	92.0%	86.9%
% Bachelor's Degree or Higher, 25 years	2019-23	39.0%	37.7%	27.6%	34.7%
% Persons Without Insurance Coverage	2019-23	9.10%	8.82%	11.48%	11.09%
Unemployment Rate	2019-23	4.16%	4.52%	3.93%	4.83%
Median Household Income	2019-23	\$113,755	\$102,832	\$98,993	\$86,947
% Persons Living in Poverty	2019-23	20.81%	22.91%	28.45%	31.03%
% Language other than English	2019-23	5.88%	4.58%	5.70%	4.90%

Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023



<b>Health Indicator: Chronic Disease and Injury Mortality (age-adjusted rate per 100,000 population)</b>	<b>Data Year</b>	<b>Union County</b>	<b>Cabarrus County</b>	<b>Johnston County</b>	<b>North Carolina</b>
Heart Disease Mortality	2019-23	136.7	158.7	177.4	165.2
Cancers – All Sites	2019-23	138	139.5	160.1	152.9
Cerebrovascular Disease	2019-23	40.4	45.9	53.2	46.6
Chronic Lower Respiratory Disease	2019-23	26.8	35.8	38.3	39.4
Alzheimer’s Disease	2019-23	56.8	61.6	46.3	36.5
Suicide	2019-23	9.7	10.3	12.6	13.7
All Other Unintentional Injury	2019-23	37.2	52.3	55.6	57.4
Diabetes Mellitus	2019-23	17.9	17.9	25.5	27.5

Data Source: NC SCHS, 2024

<b>Health Indicator: Sexually Transmitted Diseases (rate per 100,000 population)</b>	<b>Data Year</b>	<b>Union County</b>	<b>Cabarrus County</b>	<b>Johnston County</b>	<b>North Carolina</b>
Newly Diagnosed HIV Average Rates	2022-24	7.4	11.4	13.2	15.2
Newly Diagnosed AIDS Average Rates	2022-24	3.5	7.8	4.9	7.1
Newly Diagnosed Early Syphilis Average Rates	2022-24	16.2	29.6	18.4	36.0
Newly Diagnosed Chlamydia Rates	2024	363.8	470.4	435.2	572.3
Newly Diagnosed Gonorrhea Rates	2024	88.5	141.2	150.0	205.4

Data Source: NC EDSS Surveillance

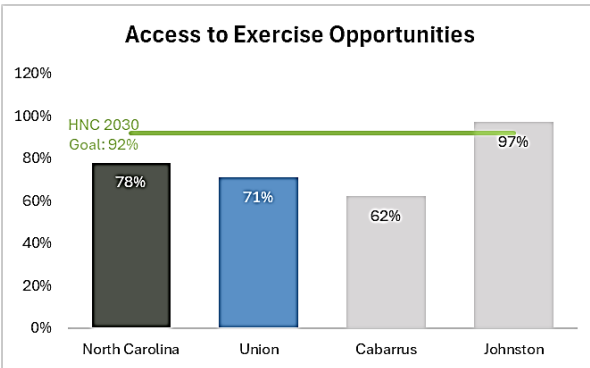
<b>Health Indicator: Healthcare Workforce (rate per 100,000 population)</b>	<b>Data Year</b>	<b>Union County</b>	<b>Cabarrus County</b>	<b>Johnston County</b>	<b>North Carolina</b>
Primary Care Physicians	2024	57.02	124.89	44.91	110.67
Nurse Practitioners	2023	47.01	139.5		118.55
Dentists	2024	33.58	58.90	39.81	61.17
Physician Assistants	2023	40.29	75.73		86.13

Data Source: Centers for Medicare and Medicaid Services, 2024

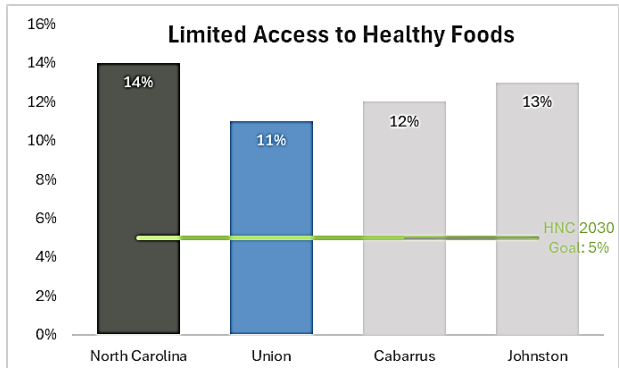


## Healthy North Carolina 2030

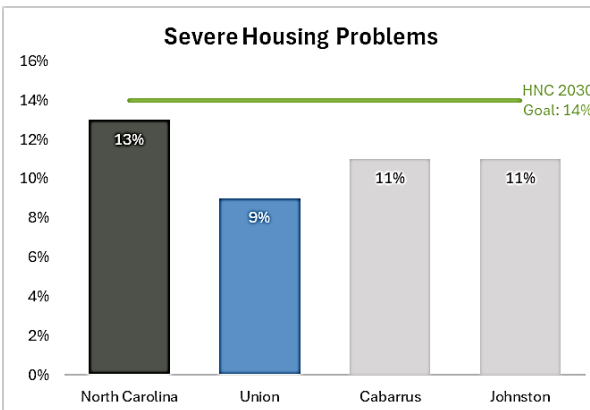
Healthy North Carolina (HNC) is a set of 21 health indicators with 10-year targets designed to improve the health status of North Carolinians. These indicators include both health factors and outcomes and are grouped into the following 5 categories: Social & Economic Factors, Physical Environment, Health Behaviors, Clinical Care, and Health Outcomes. For more information on each indicator and its data sources, see the full HNC 2030 Report.



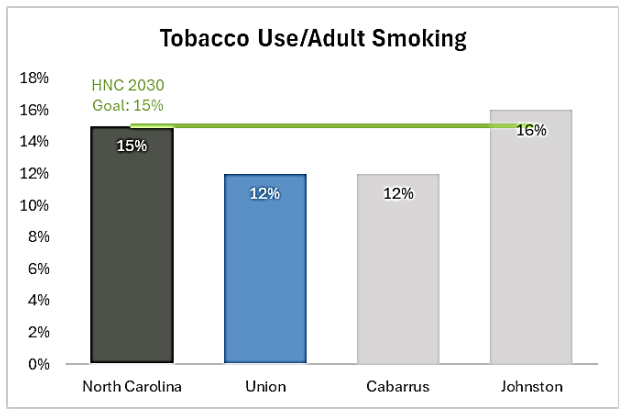
Data Source: County Health Rankings and Roadmaps, 2025



Data Source: County Health Rankings and Roadmaps, 2025

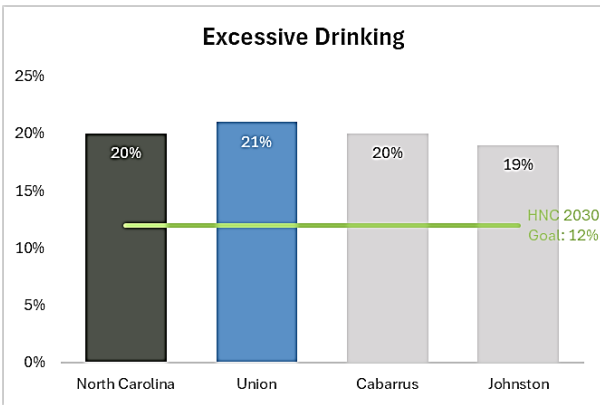


Data Source: County Health Rankings and Roadmaps, 2025

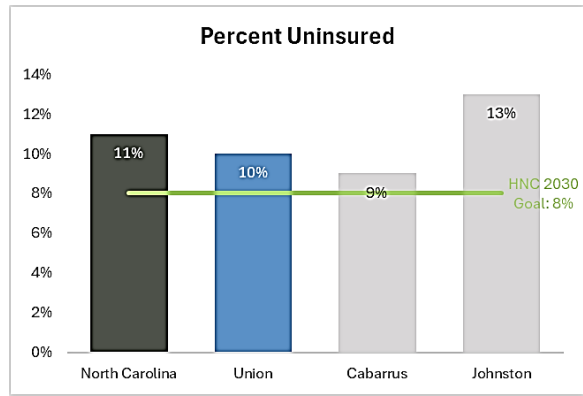


Data Source: NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), 2025

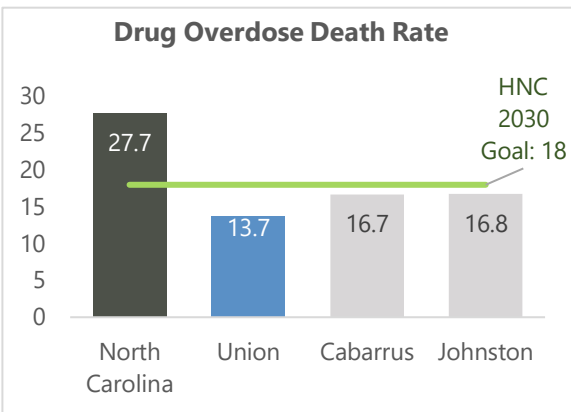




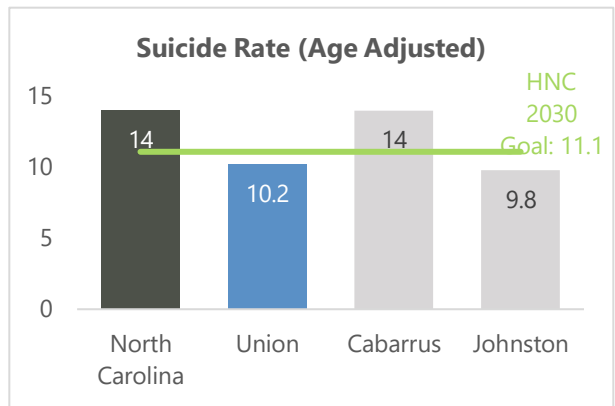
Data Source: NC State Center for Health Statistics, Behavioral Risk Factor Surveillance System (BRFSS), 2025



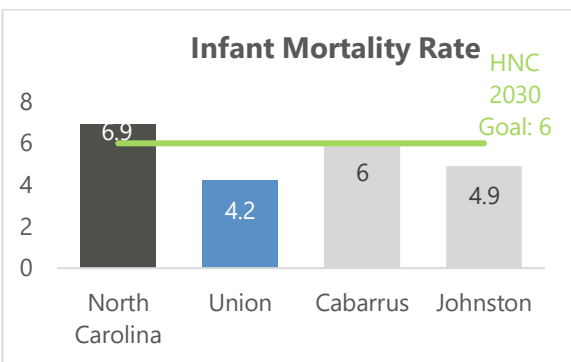
Data Source: Small Area Health Insurance Estimates



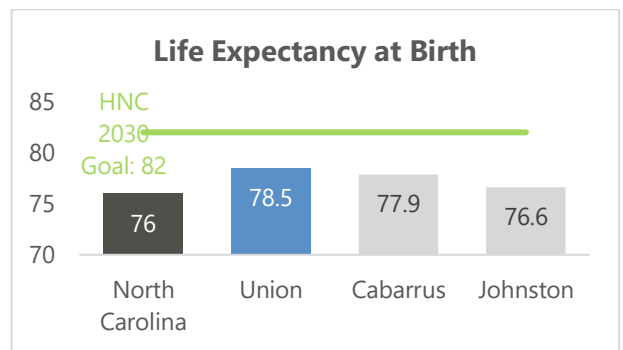
Data Source: North Carolina Overdose Epidemic Data | Division of Public Health, n.d.



Data Source: NC State Center for Vital Statistics, Vital Statistics, 2024



Data obtained from NC DHSS. The North Carolina State Center provides analysis of Vital Statistics records for Health Statistics. Title V Office Analysis of 2023 Birth Certificate data, 2024



Data Source: NC SCHS, 2024



## Health Outcomes

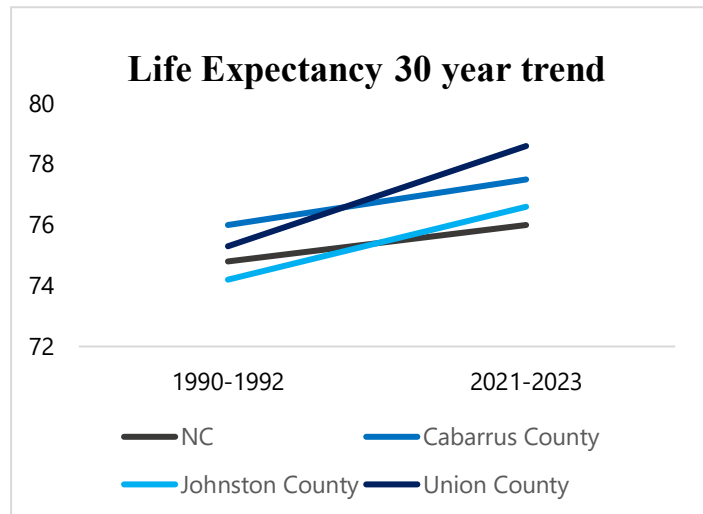
### Life Expectancy

Over the past three decades, life expectancy at birth has increased in Union, Cabarrus, and Johnston Counties, as well as across North Carolina. Union County experienced the largest improvement, rising from 75.3 years during 1990–1992 to 78.6 years during 2021–2023, a gain of 3.3 years (North Carolina State Center for Health Statistics [NC SCHS], 2024).

Across all geographies, life expectancy declined sharply during the COVID-19 pandemic and has only modestly recovered. Union County consistently maintained the highest life expectancy compared with the state and neighboring counties, though it experienced a notable decline between 2020 and 2022. From 2017–2019, Union County's life expectancy was 80.1 years, exceeding the state average (78.1) and the life expectancies of peer counties such as Cabarrus (78.6) and Johnston (78.1). By 2020–2022, Union County's life expectancy declined to 78.5 years, reflecting pandemic-related mortality impacts, but remained 1.3 to 2.6 years higher than in comparison areas. In the most recent period (2021–2023), Union County showed a slight rebound to 78.6 years, while North Carolina (76.0), Cabarrus (77.5), and Johnston (76.6) remained below pre-pandemic levels (NC SCHS, 2024; CDC, 2023).

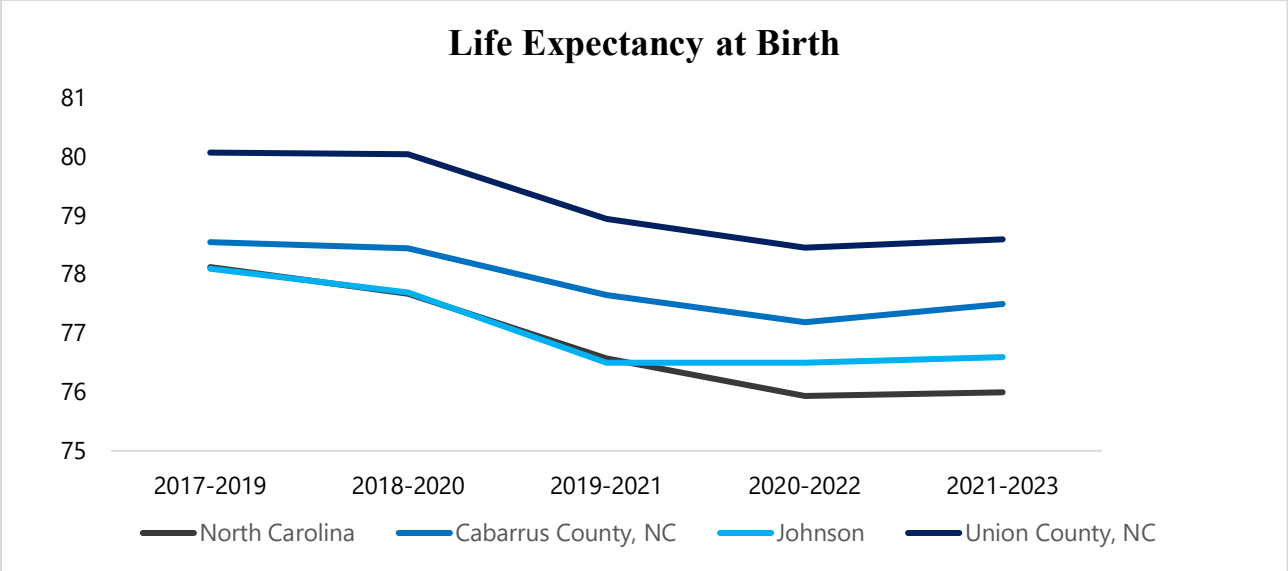
Significant disparities exist by sex and race. Across all geographies, females live substantially longer than males. In Union County, life expectancy is 76.3 years for males (95% CI: 75.7–76.8) and 81.1 years for females (95% CI: 80.6–81.5), representing a 4.8-year gender gap, like patterns observed statewide and nationally (CDC, 2023).

Racial disparities are also evident. White, non-Hispanic residents have higher life expectancy than Black, non-Hispanic residents in every geography. In Union County, life expectancy is 78.5 years (95% CI: 78.1–78.9) for White, non-Hispanic residents and 74.4 years (95% CI: 73.3–75.5) for Black, non-Hispanic residents. This reflects a 4.1-year racial life expectancy gap, comparable to—but slightly smaller than—the statewide disparity (NC SCHS, 2024; CDC, 2023).



Data Source: NC SCHS, 2024





Data Source: NC SCHS, 2024

### Leading Causes of Death and Mortality Rates

In Union County, cancer and heart disease remain the leading causes of death, with rates of 142.8 and 129.8 deaths per 100,000 residents, respectively. Both rates are substantially lower than the North Carolina averages and below those observed in Cabarrus and Johnston Counties (NC SCHS, 2024).

Across nearly all major causes of death, Union County demonstrates lower mortality rates than peer counties and the state overall, particularly for unintentional injuries, chronic lower respiratory disease, diabetes, and COVID-19 (NC SCHS, 2024).

These patterns suggest comparatively favorable outcomes related to prevention, chronic disease management, and access to care (County Health Rankings & Roadmaps, 2024; NC SCHS, 2024).

One notable exception is Alzheimer’s disease. Union County’s death rate of 46.9 per 100,000 exceeds the state average and is higher than Johnston County’s rate, reflecting a growing burden associated with an aging population (NC SCHS, 2024; Alzheimer’s Association, 2023).

Overall, these patterns indicate that while Union County performs relatively well across many major causes of death, continued emphasis on chronic disease prevention and expanded planning for aging-related conditions, including dementia and caregiver support, will be increasingly important.



**Ten Leading Causes of Death and Death Rate, per 100,000 residents, 2019-2023  
(Not adjusted by Age)**

Cause of Death	Union	Cabarrus	Johnston	NC
Cancer (all)	143	145.2	165.3	191.4
Heart disease	130	154.2	164.9	197
Alzheimer's disease	46.9	53.6	35.4	41.1
COVID-19	44.2	49.2	43.8	55.7
Cerebrovascular disease	36.9	42.4	46.9	54.6
Other Unintentional Injuries	33.6	51	52.4	59.1
Chronic lower respiratory disease	26	35.4	37.8	48.8
Diabetes mellitus	18.5	18.8	26.4	33.8
Nephritis, nephrotic syndrome, and nephrosis	17.4	20.1	18.1	20.2
Nutritional deficiencies	11.4	17	n/a	n/a

Data Source: NC SCHS, 2024

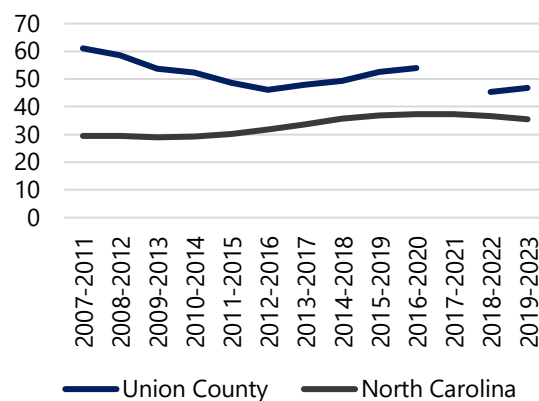
**Mortality Trending**

Long-term mortality trends in Union County show improvements across several major causes of death, though disparities remain.

**Alzheimer's disease:**

Alzheimer's disease mortality in Union County, NC, has shown a general decline over the years, with rates dropping from 61.1 in 2007–2011 to 46.7 in 2019–2023. In contrast, North Carolina's overall rates have increased, rising from 29.5 in 2007–2011 to 37.3 in 2016–2020. The data indicates a notable divergence in trends between Union County and the state. This suggests that Union County may have experienced unique local conditions or population characteristics that contributed to the decline in Alzheimer's mortality, while statewide rates have continued to rise (NC SCHS, 2024).

**Alzheimer's Disease mortality rate per 100,000 residents, trending over time**



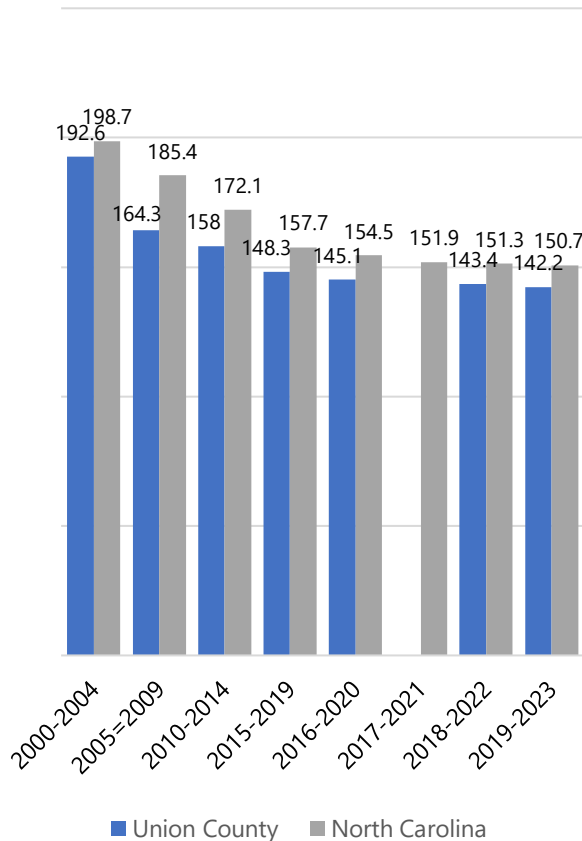
Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023



### Cancer:

Cancer mortality rates in Union County have declined over the past two decades. The rate in Union County decreased from 192.6 in 2000-2004 to 142.2 in 2019-2023, reflecting a significant decline. In contrast, North Carolina's cancer mortality rate also decreased but remained higher than Union County's, dropping from 198.7 per 100,000 in 2000-2004 to 150.7 per 100,000 in 2019-2023 (NC SCHS, 2024).

**Cancer mortality rate per 100,000 residents, trending over time**

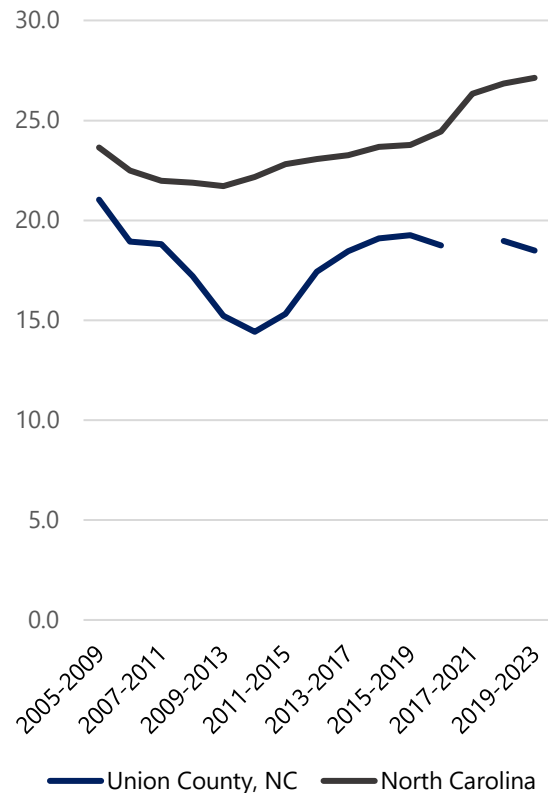


Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023

### Diabetes:

Diabetes mortality in Union County, NC, has shown a general decline over the period from 2005 to 2023, starting at 21.0 in 2005-2009 and decreasing to 18.5 in 2019-2023. In contrast, North Carolina's diabetes mortality rate has increased significantly, rising from 23.6 in 2005-2009 to 27.1 in 2019-2023. The data indicate a notable divergence in trends between Union County and the state, with Union County experiencing a more favorable decline in diabetes mortality rates (NC SCHS, 2024).

**Diabetes mortality rate per 100,000 residents, trending over time**



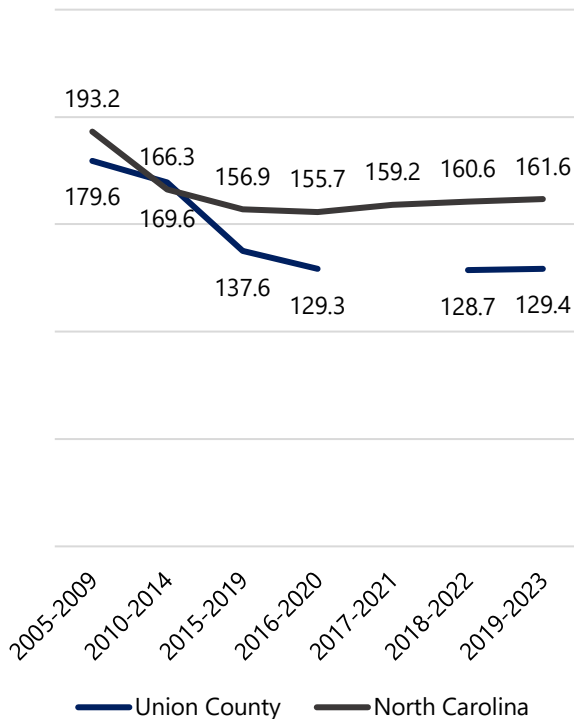
Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023



**Heart disease:**

Heart disease mortality rates in Union County, NC, have shown a consistent decline over the past two decades, dropping from 179.6 per 100,000 in 2005-2009 to 129.4 per 100,000 in 2019-2023. This trend is mirrored across North Carolina, although the state's rates have generally been higher than those in Union County. The most recent data indicates a slight increase in the state's heart disease mortality rate to 161.6 per 100,000 in 2019-2023. Notably, Union County's rate has remained lower than the state average across all periods (NC SCHS, 2024).

**Heart Disease mortality rate per 100,000 residents, trending over time**

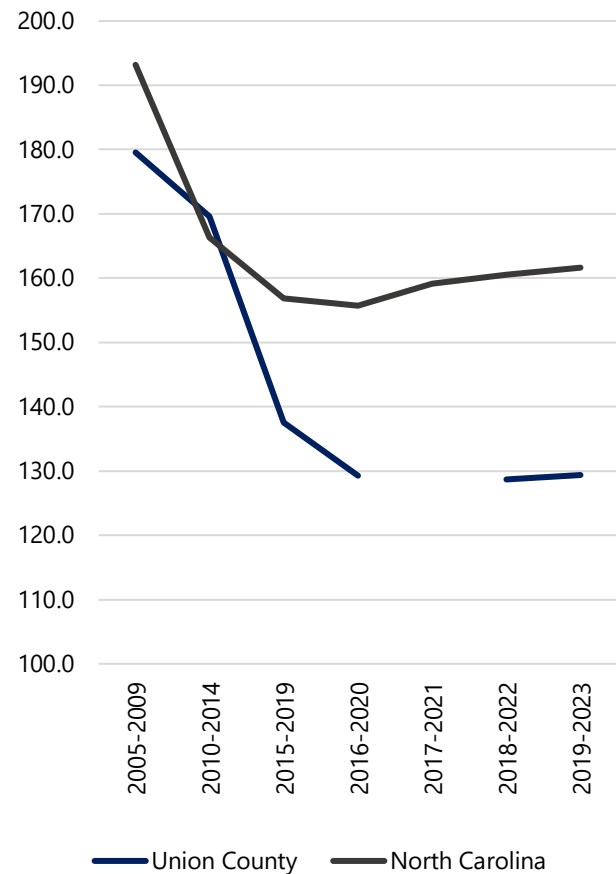


Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023

**Kidney disease:**

Kidney disease mortality in Union County, NC, has shown a general decline over the period from 2005 to 2023, with rates dropping from 19.6 to 17.3 per 100,000 population. The state of North Carolina has also seen a decline, with rates decreasing from 19.1 in 2006-2010 to 16.5 in 2019-2023. Union County's rates have consistently been higher than the state average, indicating a notable health disparity (NC SCHS, 2024).

**Kidney Disease mortality rate per 100,000 residents, trending over time**



Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023

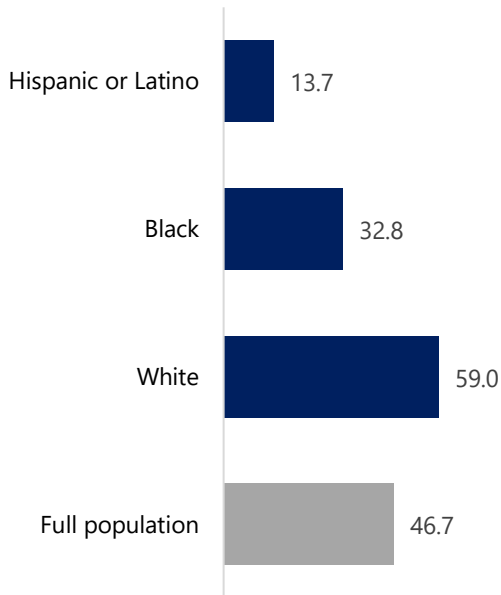


## Death Disparities

Significant disparities in mortality exist across racial and ethnic groups in Union County.

Alzheimer's disease mortality in Union County varies significantly across racial and ethnic groups. The mortality rate among White residents is higher at 59.0 per 100,000, compared to the overall population rate of 46.7. In contrast, Black residents have a lower rate of 32.8, and Hispanic or Latino residents have the lowest rate at 13.7 (NC SCHS, 2024).

**Alzheimer's Disease mortality rate per 100,000 residents by Race and Ethnicity, 2019-2023**

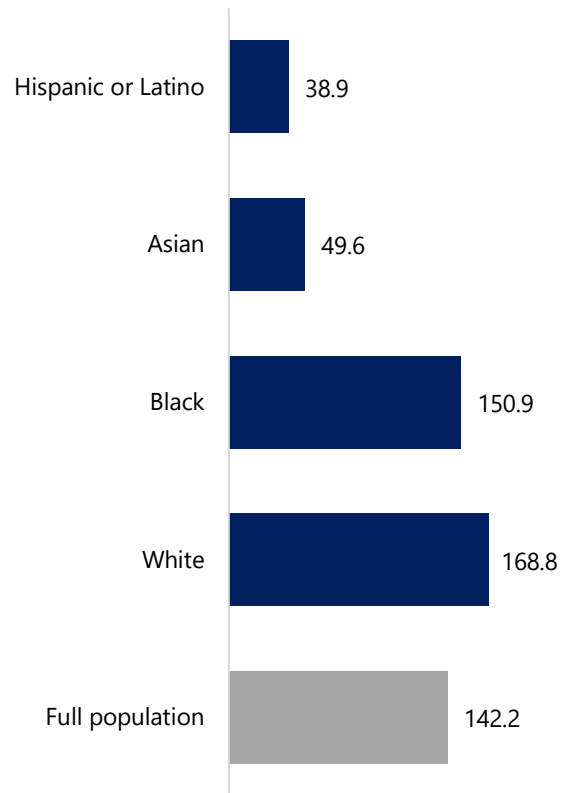


Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023

## Cancer:

Cancer mortality in Union County also varies across racial and ethnic groups. The overall cancer mortality rate is 142.2 per 100,000. Asian residents have the lowest rate at 49.6, while Hispanic or Latino residents have a rate of 38.9. In contrast, White residents have a higher rate of 168.8, and Black residents experience a rate of 150.9 (NC SCHS, 2024).

**Cancer mortality rate per 100,000 residents by Race and Ethnicity, 2019-2023**



Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023



## COVID

COVID-19 mortality in Union County shows disparities by race and ethnicity. The mortality rate among Black residents is higher at 57.4 per 100,000, compared to 48.0 among White residents. The overall mortality rate is 44.0, while the Hispanic or Latino population has the lowest rate at 29.8 (NC SCHS, 2024).

### COVID-19 mortality per 100,000 residents by Race and Ethnicity, 2019-2023

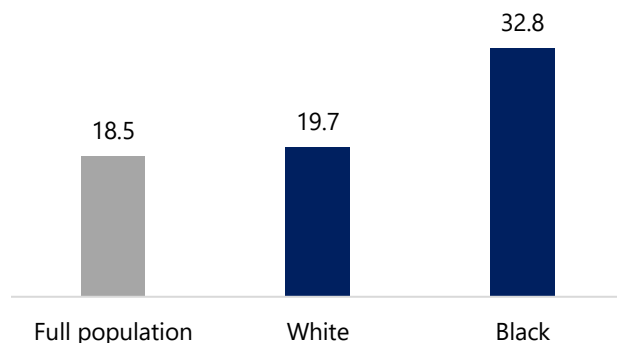


Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023

## Diabetes

Diabetes mortality rates also show disparities. The diabetes mortality rate for Black residents is significantly higher at 32.8 per 100,000, compared to 19.7 for White residents. The overall population rate is 18.5 (NC SCHS, 2024).

### Diabetes mortality per 100,000 residents by Race and Ethnicity, 2019-2023

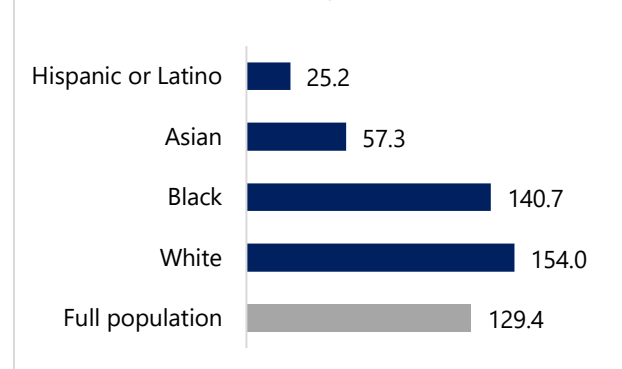


Data Source: Centers for Disease Control and Prevention (CDC), National Vital Statistics System Mortality (NVSS-M), 2023

## Heart Disease

Heart disease mortality varies across racial and ethnic groups. The overall rate is 129.4 per 100,000. White residents have the highest rate at 154.0, followed by Black residents at 140.7. Asian residents have a lower rate of 57.3, and Hispanic or Latino residents have the lowest rate at 25.2 (NC SCHS, 2024).

### Heart Disease mortality per 100,000 residents by Race and Ethnicity, 2019-2023

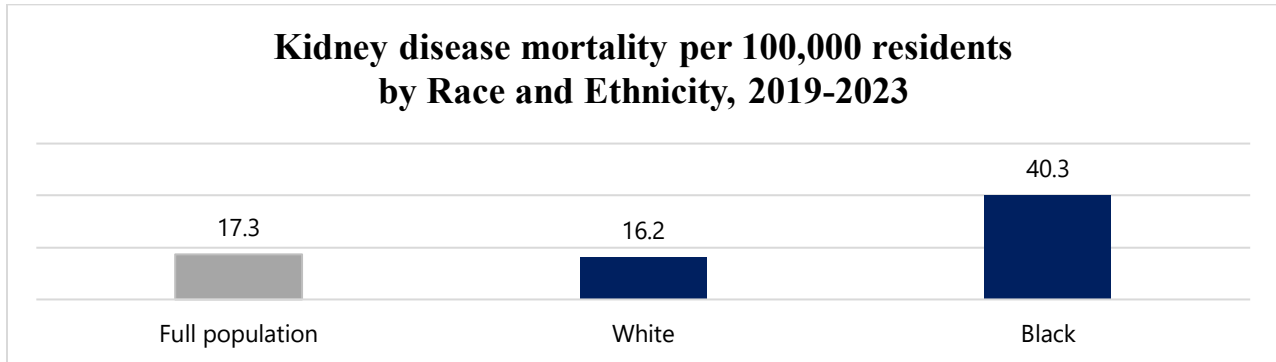


Data Source: NC SCHS, 2024



## Kidney Disease

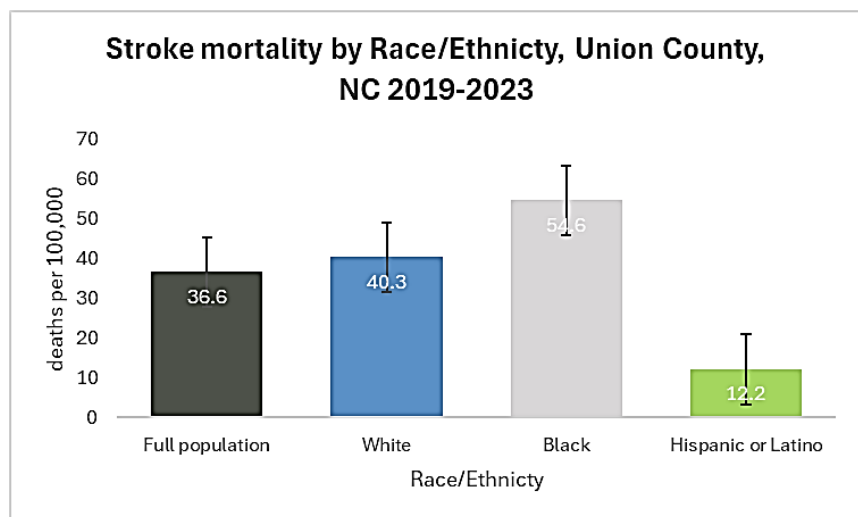
Kidney disease mortality rates also differ significantly by race. Black residents experience the highest mortality rate at 40.3 per 100,000, compared to the overall population rate of 17.3. White residents have a lower rate of 16.2 (NC SCHS, 2024).



Data Source: NC SCHS, 2024

## Stroke

Stroke mortality disparities are also present. Black residents experience the highest stroke mortality rate at 54.6 per 100,000, compared to the overall population rate of 36.6. White residents also have a higher rate at 40.3, while Hispanic or Latino residents have the lowest rate at 12.2 (NC SCHS, 2024).



Data Source: NC SCHS, 2024

These disparities reflect longstanding differences in income, access to care, environmental exposures, and structural inequities. National evidence shows that social determinants such as housing, education, employment, and access to healthcare significantly influence mortality outcomes across populations (CDC, 2023; County Health Rankings & Roadmaps, 2024).

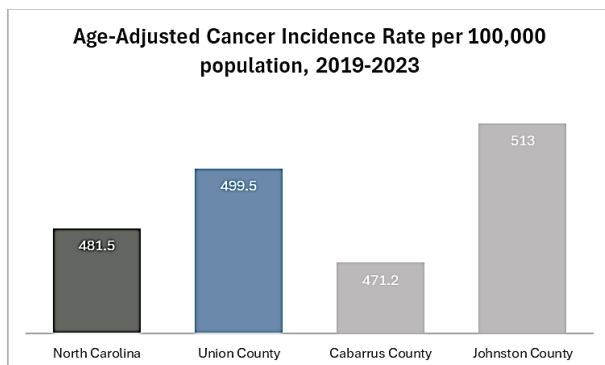


## Chronic Disease

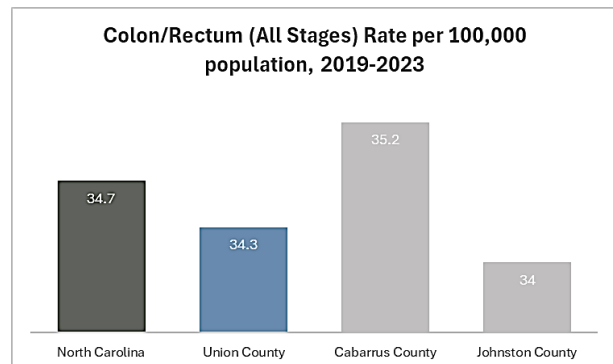
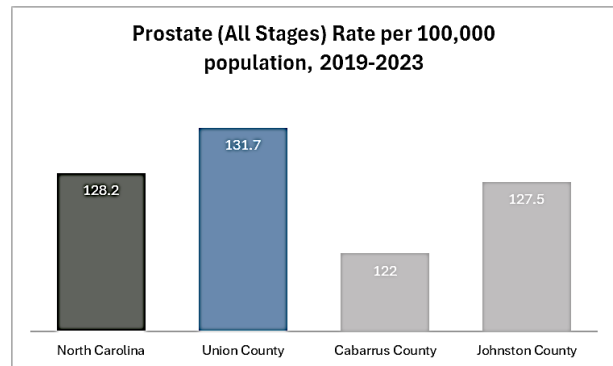
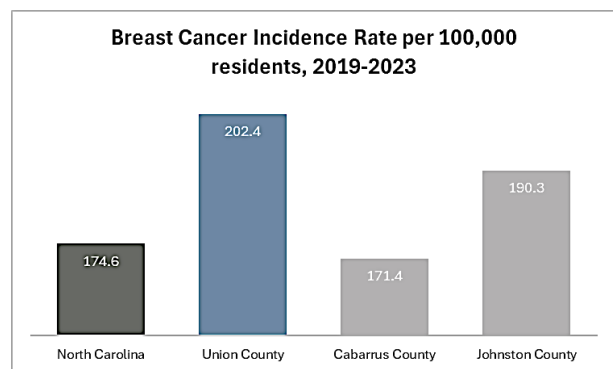
### Cancer

Cancer is the leading cause of death in Union County and North Carolina. Many cancers are influenced by preventable risk factors (e.g., tobacco use, diet, physical inactivity, UV exposure) as well as non-modifiable factors such as age, sex, and family history, underscoring the importance of prevention, screening, and early detection strategies across the lifespan (CDC, 2024).

From 2019–2023, Union County’s age-adjusted cancer incidence rate was 499.5 cases per 100,000, higher than Cabarrus County (471.2) and North Carolina overall (481.5), and lower than Johnston County (513.0) (North Carolina Central Cancer Registry [NCCCR], 2025). This pattern—higher incidence but comparatively favorable mortality—may reflect differences in screening uptake, stage at diagnosis, treatment access, and survivorship. Reducing the cancer burden in Union County will require equitable prevention and screening efforts, with targeted outreach to populations and places at higher risk and with lower access to timely care (CDC, 2024).

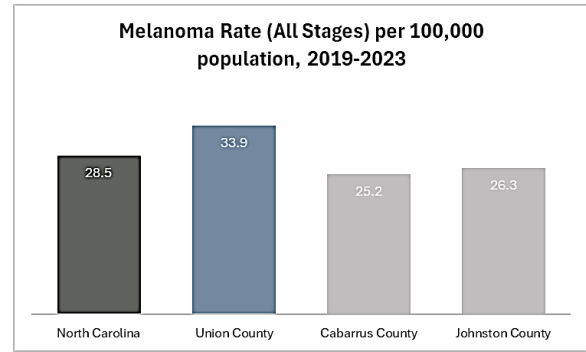
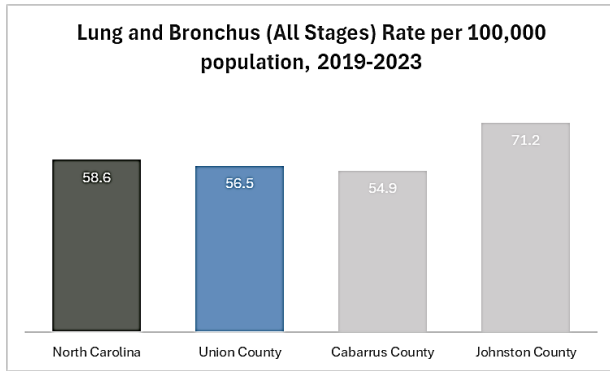


Across major cancer types (2019–2023), Union County showed elevated incidence for breast, prostate, and melanoma relative to peer counties and, in many cases, the state average (NCCCR, 2025). These findings reinforce the need for evidence-based screening (breast and colorectal), risk reduction (tobacco cessation; healthy weight), and prevention messaging tailored to the community context (e.g., sun safety and melanoma skin checks).



Source: NC Central Cancer Registry, 01/2025





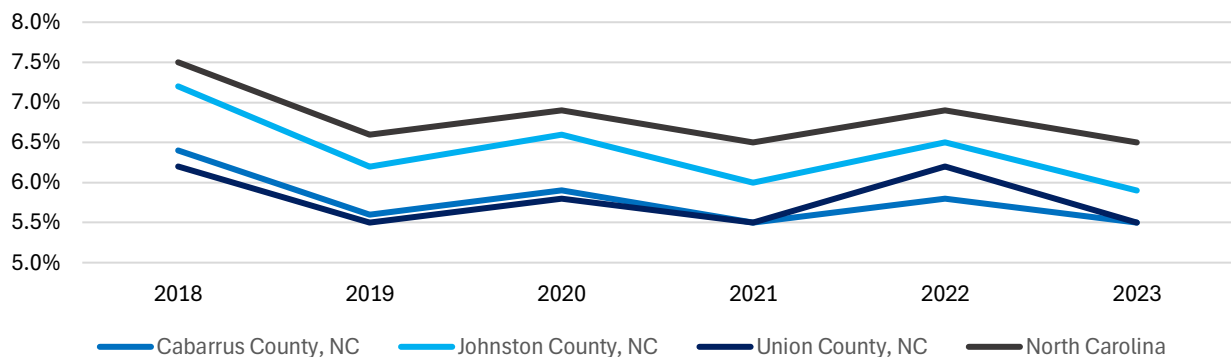
Data Source: NC Central Cancer Registry, 01/2025

### Coronary Heart Disease

Coronary heart disease (CHD) is a major contributor to disability and premature mortality and is shaped by modifiable risk behaviors and social determinants of health, including access to preventive care, healthy food, safe places to be active, stable housing, and economic opportunity (CDC, 2024)

From 2018 to 2023, Union County’s percentage of adults reporting coronary heart disease remained consistently below the North Carolina average and closely aligned with Cabarrus County, indicating relatively favorable trends over time. Union County declined from 6.2% in 2018 to 5.5% in 2019, then experienced modest fluctuations through 2022, returning to 5.5% in 2023, reflecting overall stability despite statewide and pandemic-era disruptions. In comparison, Johnston County and North Carolina consistently reported higher percentages across all years, with the state average remaining the highest throughout the period. Although all jurisdictions showed some year-to-year variation, particularly increases in 2020 and 2022, Union County’s rates remained lower than both Johnston County and the statewide benchmark, suggesting comparatively better outcomes and resilience over the six years (CDC, 2023).

### Crude Percentage of Adults with Coronary Heart Disease, 2019-2023



Data Source: Centers for Disease Control and Prevention, *Behavioral Risk Factor Surveillance System*. Accessed via the [PLACES Data Portal](#). 2023

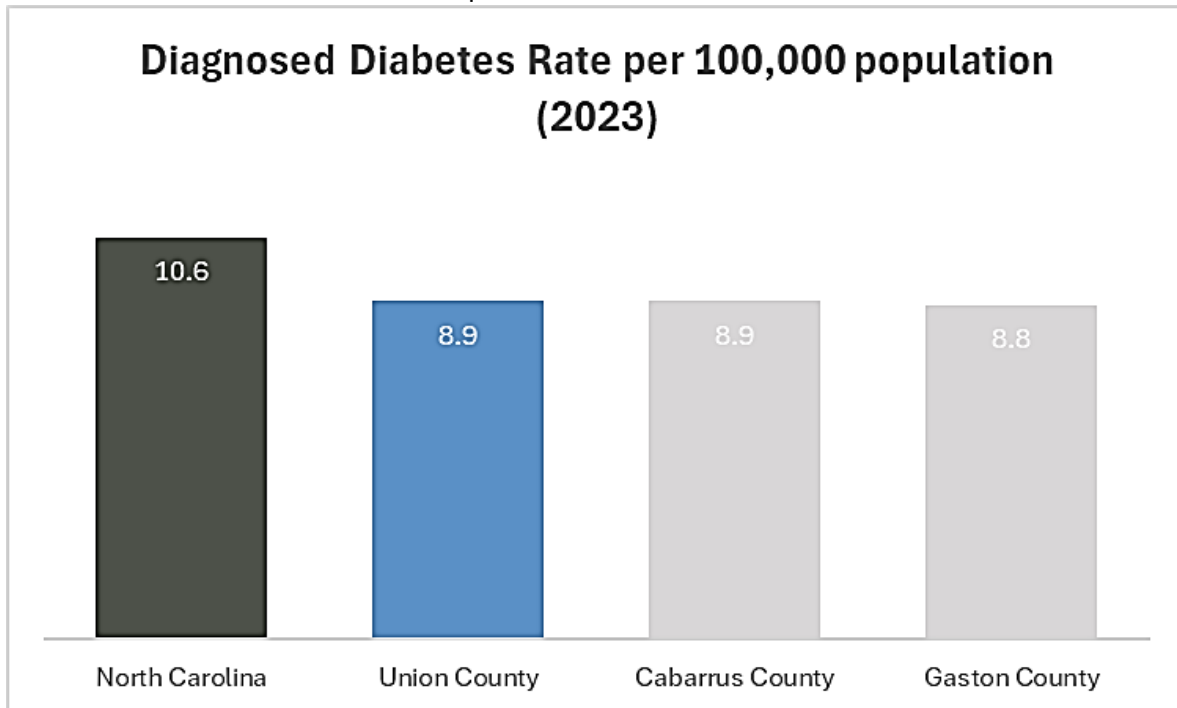


## Diabetes

Diabetes is a leading chronic disease in the United States and is associated with significant complications and preventable mortality. Nationally, approximately 38 million people have diabetes—about 1 in 10—and many are undiagnosed, highlighting the importance of prevention and early identification (CDC, 2024).

In North Carolina, diabetes burden is not evenly experienced: prevalence is higher among historically marginalized populations and among residents facing structural barriers such as lower educational attainment, lower income, food insecurity, and limited access to preventive care (CDC, 2024).

From 2018–2023, Union County’s diabetes prevalence increased but remained below the statewide average, while disparities across communities and contexts remain critical for planning. Diabetes prevention and management efforts should be paired with strategies that address upstream drivers—such as access to healthy food, safe activity spaces, stable housing, and affordable care—to reduce inequities in risk and outcomes (CDC, 2024).



Data Source: CDC, 2024

## Risk Factors

Chronic diseases are strongly influenced by a short list of modifiable risk behaviors—tobacco use, poor nutrition, physical inactivity, and excessive alcohol use—and by non-medical drivers such as social and economic conditions, neighborhood environments, and access to health care (CDC, 2024). These risk factors and social determinants of health contribute to unequal exposure and unequal opportunity to live a healthy life across communities (CDC, 2024).



## Communicable Diseases

### Avian Influenza

Avian Influenza, often referred to as Highly Pathogenic Avian Influenza (HPAI) or Low Pathogenic Avian Influenza (LPAI), is a major disease affecting multiple sectors of the agricultural industry nationwide (U.S. Department of Agriculture [USDA], 2024; CDC, 2024). Historically, it has been a seasonal disease of poultry that follows the migration patterns of wild waterfowl, with higher disease levels in cooler months and some respite in warmer months. These patterns appear to be shifting, and the disease has become more persistent year-round in some regions (USDA, 2024).

HPAI is a high risk to the turkey production industry in Union County, which ranks third in North Carolina for turkey production. It is also a major concern for the broiler industry, with Union County ranking fourth in the state for broiler production (North Carolina Department of Agriculture and Consumer Services [NCDA&CS], 2024). LPAI also poses risks to the poultry industry by reducing production and increasing the risk of conversion to HPAI (USDA, 2024).

Considering the scope of the poultry industry in Union County and its economic and community impacts, continued vigilance and preparedness for potential outbreaks are essential. In recent years, avian influenza viruses have also been detected in other species, including dairy cattle, feral cats, and small ruminants, and sporadic human infections have occurred, underscoring the need for ongoing monitoring and biosecurity (CDC, 2024; USDA, 2024).

Union County Public Health staff conduct surveillance and passive symptom monitoring of people with direct exposures to infected birds. Public health officials at all levels of government continue to monitor the situation closely, emphasizing early detection, containment strategies, and biosecurity measures to prevent transmission and protect both animal and human health (CDC, 2024; NCDHHS, 2024).

### HIV and AIDS

In 2024, 1,391 people in North Carolina were newly diagnosed with HIV, representing a rate of 15 per 100,000 adults and adolescents ages 13 and older (North Carolina Department of Health and Human Services [NCDHHS], 2024). When comparing new HIV diagnosis rates across Cabarrus, Johnston, and Union counties from 2019 to 2024, Union County had the most stable, consistently lower rates, ranging from approximately 4.5 to 7.5 per 100,000, with a slight upward trend after 2021 (NCDHHS, 2024). Cabarrus County showed substantial fluctuations, beginning around 10 cases per 100,000 in 2019, dropping to 7 in 2020, then rising sharply to about 18 in 2023, then falling to 9 in 2024. Johnston County followed a similar pattern of variability, starting near 11 in 2019, decreasing to 7 in 2020, then climbing to a peak of 14 in 2022 before dropping back to 11 in 2024 (NCDHHS, 2024). Overall, Cabarrus and Johnston experienced notable spikes and declines in HIV diagnoses, while Union exhibited relatively stable, lower incidence rates over time (NCDHHS, 2024).

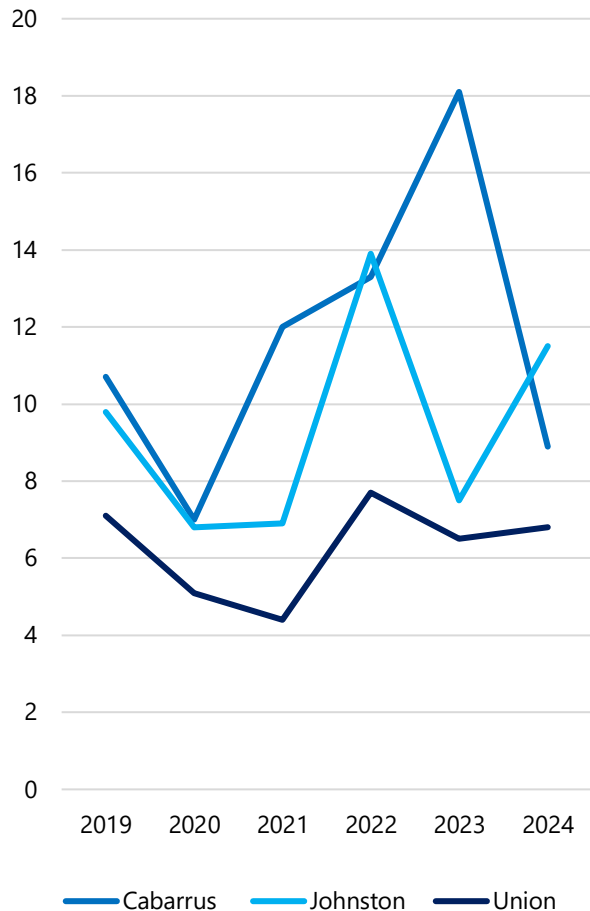


The 2024 Union County data show clear disparities by age and race. The highest HIV incidence occurred among young adults ages 18–24 (23.6 per 100,000), followed by adults ages 25–49 (9.8). Rates were low among residents ages 50–64 (1.9), and there were no reported cases among those ages 13–17 or 65 and older (NCDHHS, 2024). Racial and ethnic disparities were also pronounced: Hispanic residents had the highest rate at 18.6 per 100,000, followed by Black or African American residents at 11.6, while White residents had the lowest rate at 2.0 per 100,000 (NCDHHS, 2024). Overall, HIV incidence in Union County remained relatively stable over time but disproportionately affected young adults and Hispanic and Black residents (NCDHHS, 2024).

The number of people newly categorized as having Stage 3 HIV (AIDS) increased post-pandemic. There was a 37% increase in people newly diagnosed with Stage 3 HIV (AIDS) in 2024 (N=699) compared to 2020 (N=510), which may reflect diagnoses delayed during the pandemic shutdown (NCDHHS, 2024). When comparing AIDS diagnosis rates across Cabarrus, Johnston, and Union counties between 2020 and 2024, Union County had the lowest and most stable rates throughout the period, starting at 2.6 per 100,000 in 2020, decreasing to 1.0 in 2021, peaking at 4.7 in 2022, and then dropping to 2.3 in 2024 (NCDHHS, 2024). Cabarrus County showed the most dramatic rise over time: after a low of 1.0 per 100,000 in 2021, rates increased sharply to 7.2 in 2022. They continued climbing to 9.1 by 2024, making Cabarrus the county with the highest AIDS incidence

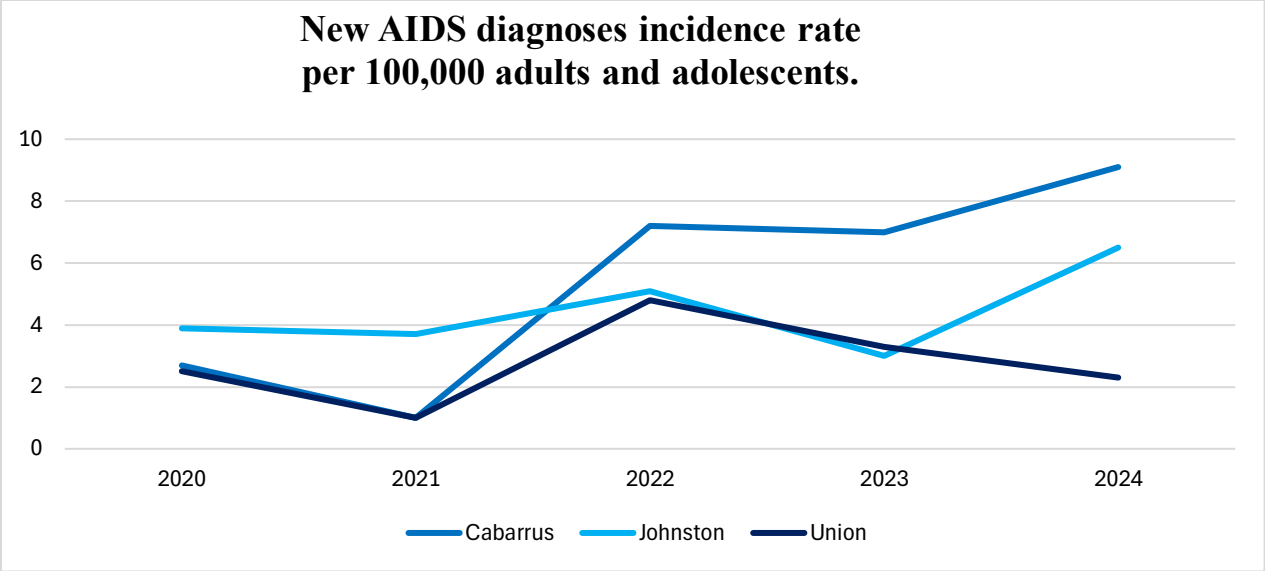
in the most recent year. Johnston County began with moderately higher rates in 2020 (3.9 per 100,000), dipped slightly in 2021, then rose to 5.1 in 2022 before falling again in 2023 and increasing to 6.5 in 2024 (NCDHHS, 2024). Overall, Cabarrus showed a consistent upward trend; Johnston fluctuated but ended higher than it began; and Union remained comparatively low, with minimal long-term change (NCDHHS, 2024).

### New HIV diagnosis per 100,000 adults and adolescents



Data Source: NCDHHS, HIV/STD surveillance—Quarterly report





Data Source: NCDHHS, HIV/STD surveillance—Quarterly report

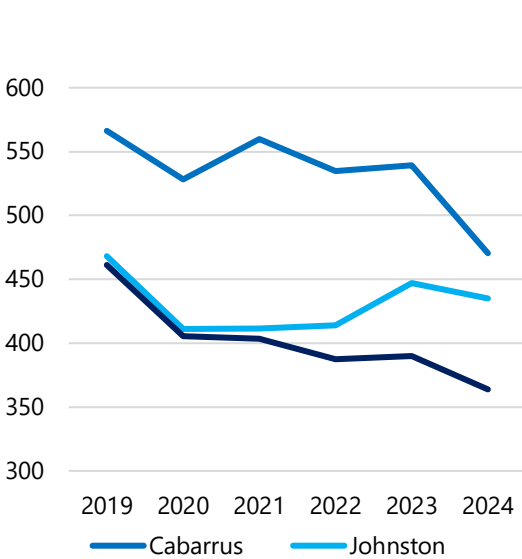
**Chlamydia and Gonorrhea**

Newly diagnosed chlamydia and gonorrhea infection rates in Union County have declined over the past six years, with overall rates remaining lower than in peer counties (NCDHHS, 2024). However, substantial disparities persist. In 2024, Black or African American residents experienced significantly higher incidence rates of both chlamydia and gonorrhea compared to all other racial and ethnic groups. Black or African American residents had the highest chlamydia rate at 974.4 cases per 100,000—more than double the rate among Hispanic residents, who had the second-highest incidence at 596.3 per 100,000. Similarly, Black or African American residents had the highest gonorrhea rate by a significant margin, at nearly 380 cases per 100,000, far exceeding all other groups. In comparison, Hispanic residents had the next highest rate at approximately 60 cases per 100,000 (NCDHHS, 2024).

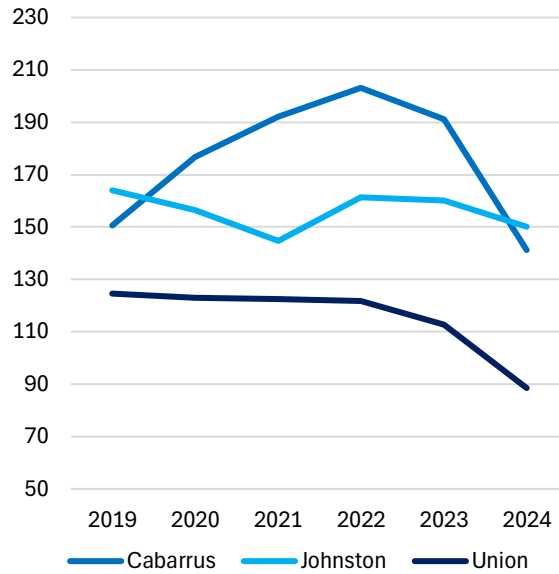
Both chlamydia and gonorrhea disproportionately affect younger populations. Young adults ages 18–24 experienced the highest rates of both infections, with 2,177.4 cases per 100,000 for chlamydia and 412.7 cases per 100,000 for gonorrhea. The next highest rates for both diseases occurred among adults ages 25–49, at 354.5 cases per 100,000 for chlamydia and 125.9 per 100,000 for gonorrhea. Adolescents ages 13–17 also experienced a high chlamydia rate of 347.8 per 100,000 (NCDHHS, 2024).



### Newly diagnosed Chlamydia cases per 100,000 residents



### Newly diagnosed Gonorrhea cases per 100,000 residents



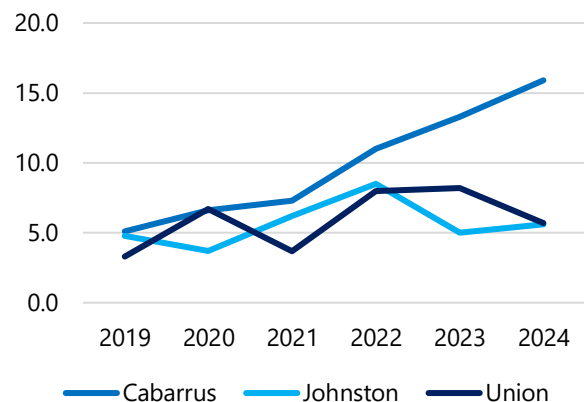
Data Source: NCDHHS, 2024

### Syphilis

Between 2019 and 2024, the incidence rates of early, non-primary, non-secondary syphilis in Union County and peer counties differed notably (NCDHHS, 2024). Cabarrus County showed a steady and pronounced upward trend, rising from roughly 5 cases per 100,000 residents in 2019 to about 16 per 100,000 in 2024, the highest rate among the three counties by the end of the period. Johnston County showed greater variability, with rates dipping in 2020, peaking at nearly 8.5 per 100,000 in 2022, and then declining to approximately 5 per 100,000 in 2024. Union County remained comparatively stable, consistently lower than Cabarrus, increasing from about 4 per 100,000 in 2019 to a peak of around 8 per 100,000 in 2022, then decreasing to 6 per 100,000 in 2024. Overall, Cabarrus showed a clear upward trajectory, Johnston fluctuated over time,

and Union maintained moderate but relatively steady rates over the six years (NCDHHS, 2024).

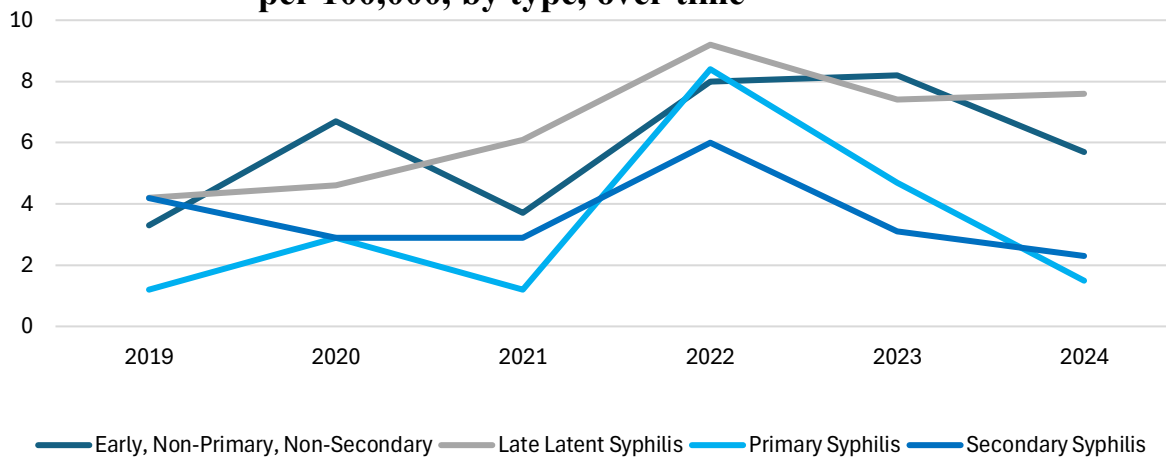
### Early, Non-Primary, Non-Secondary Syphilis rates per 100,000 residents



Data Source: North Carolina Department of Health and Human Services (NCDHHS), 2024



### Union County incidence rates of Syphilis Cases per 100,000, by type, over time



Data Source: North Carolina Department of Health and Human Services (NCDHHS), 2024

When examining four types of syphilis in Union County between 2019 and 2024, late latent syphilis consistently had the highest incidence, increasing steadily from about 4.3 cases per 100,000 in 2019 to a peak of 9.2 in 2022 before leveling off around 7.5 in 2024. Early, non-primary, non-secondary syphilis fluctuated more, rising from 3.3 in 2019 to 8.2 in 2023, then falling to approximately 5.8 in 2024. Primary syphilis remained low through most years but spiked sharply to 8.3 in 2022 before dropping to 1.5 by 2024. Secondary syphilis showed a similar pattern, increasing to 6.0 in 2022 before declining to 2.3 in 2024. Overall, nearly all syphilis types peaked in 2022, followed by declines in 2023–2024, suggesting a surge in transmission during 2022 with partial improvement in subsequent years. However, late latent syphilis continues to remain comparatively elevated (NCDHHS, 2024).

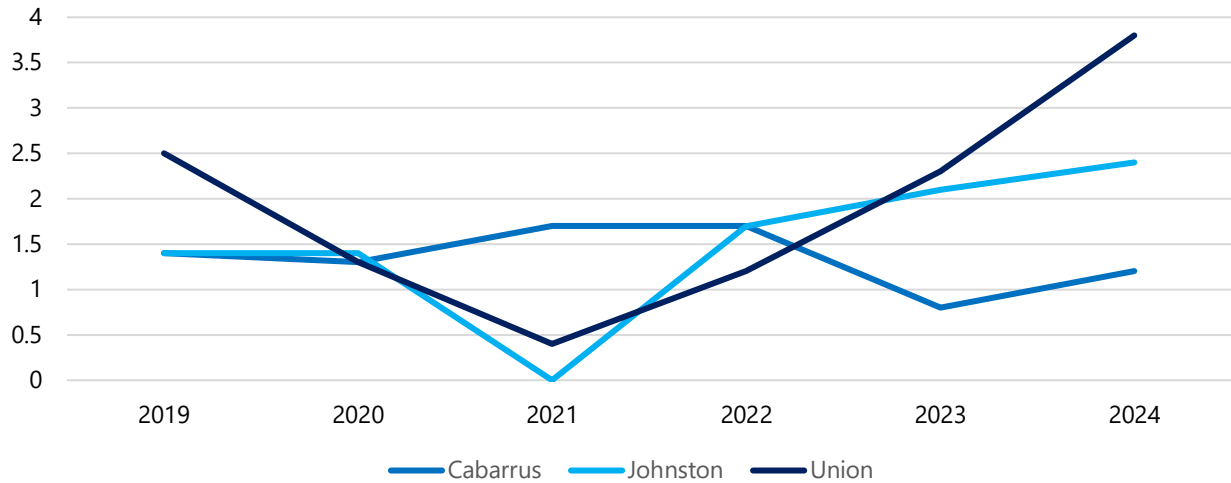
Disparities are also evident across race and ethnicity. Multiracial residents have the highest incidence rate at 15.8 cases per 100,000, followed by Hispanic residents at 13.3 and Black or African American residents at 11.6; white residents have the lowest rate at 4.4 cases per 100,000 (NCDHHS, 2024).

### Tuberculosis

Tuberculosis (TB) incidence increased in Union County in recent years compared to peer counties. Union County begins with the highest rate in 2019 at 2.5 per 100,000, but drops sharply to 0.4 in 2021, then increases steadily to 3.8 by 2024, making it the highest among the three counties at the end of the period. Cabarrus County remains relatively stable, ranging from 0.8 to 1.7 per 100,000, with a slight increase to 1.2 in 2024. Johnston County shows the most fluctuation, falling to zero in 2021, then climbing to 1.7 in 2022 and reaching 2.4 in 2024. Overall, the data indicates that Union experienced the most pronounced increase in TB incidence in recent years. At the same time, Cabarrus maintained consistently low rates and Johnston showed variable but gradually rising rates (NCDHHS, 2024).



### TB incidence rates per 100,000 residents



Data Source: North Carolina Department of Health and Human Services (NCDHHS), 2024

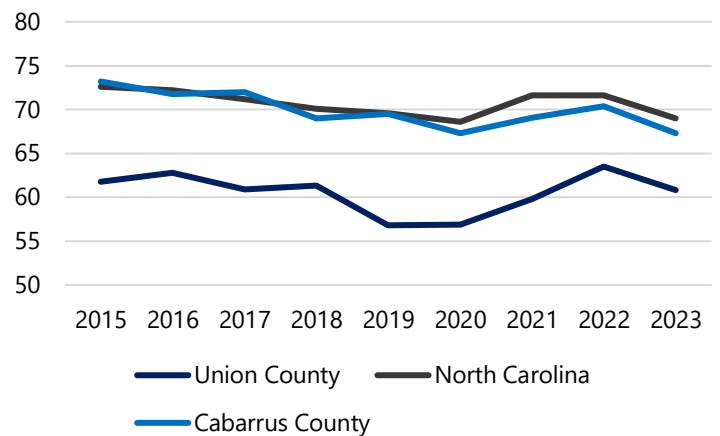
TB incidence increased in Union County in recent years relative to peer counties. In 2024, Union County reported 6 active TB cases and conducted extensive contact investigations and screening. Among those evaluated, Union County assessed 156 individuals for latent TB infection (LTBI); 63 began treatment, 21 completed treatments, and others declined, were lost to follow-up, or had incomplete treatment—highlighting both the scope of prevention work and the importance of adherence support and sustained follow-up (Union County Public Health TB Program, 2024).

### Maternal and Infant Health

#### Pregnancy and Fertility

The pregnancy rate in Union County has fluctuated in recent years, decreasing from 63.5 pregnancies per 1,000 women ages 15–44 in 2022 to 60.8 in 2023 (NC SCHS, 2024). This contrasts with the state’s overall rate, which has generally been higher, peaking at 72.6 per 1,000 women in 2015 (NC SCHS, 2024). Cabarrus County has also experienced a decline, with its pregnancy rate dropping from 72.0 in 2017 to 67.3 in 2023 (NC SCHS, 2024).

### Pregnancy rate per 1,000 women, trending over time

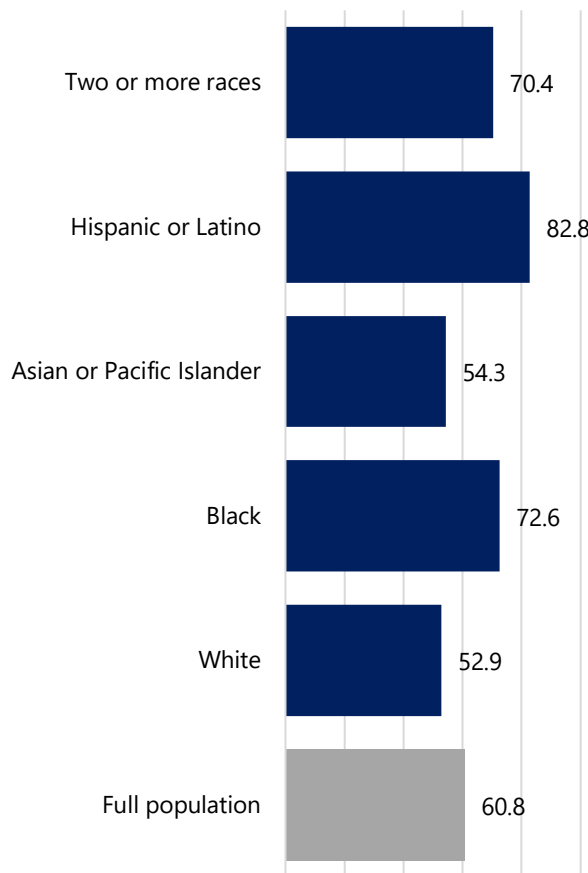


Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina State Center for Health Statistics (NC SCHS), 2023



The pregnancy rate among Hispanic or Latino individuals is notably higher than the full population average. Black individuals and individuals of two or more races also have higher pregnancy rates compared to the average. In contrast, Asian or Pacific Islander and White individuals have lower pregnancy rates. There is considerable variation in pregnancy rates across different racial and ethnic groups (NC SCHS, 2024).

**Pregnancy rate by per 1,000 women by Race and Ethnicity, 2023**

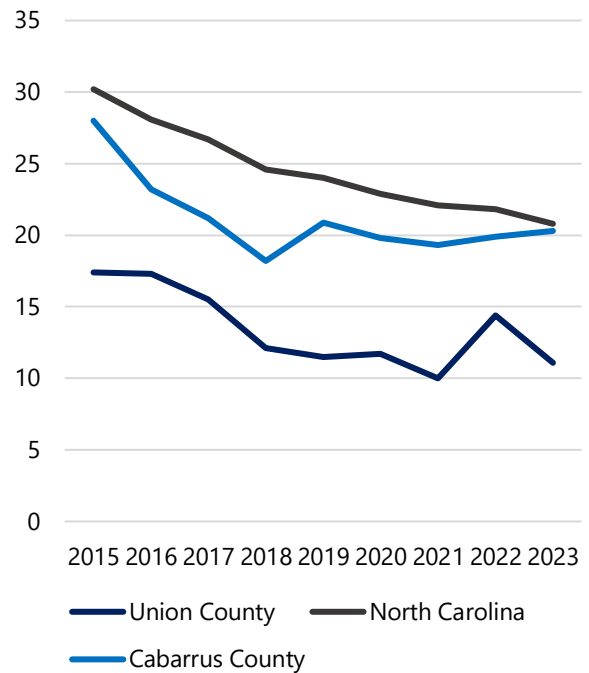


Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina State Center for Health Statistics (NC SCHS), 2023

**Teen Pregnancy**

Teen pregnancy rates in North Carolina have shown a general decline from 2015 to 2023. Union County has consistently maintained a lower rate than the state average, decreasing from 17.4 pregnancies per 1,000 females ages 15–19 in 2015 to 11.1 in 2023 (NC SCHS, 2024). Cabarrus County also experienced a decline during this period, though its rates remained higher than those in Union County. Statewide, the teen pregnancy rate dropped substantially from 30.2 in 2015 to 20.8 in 2023 (NC SCHS, 2024).

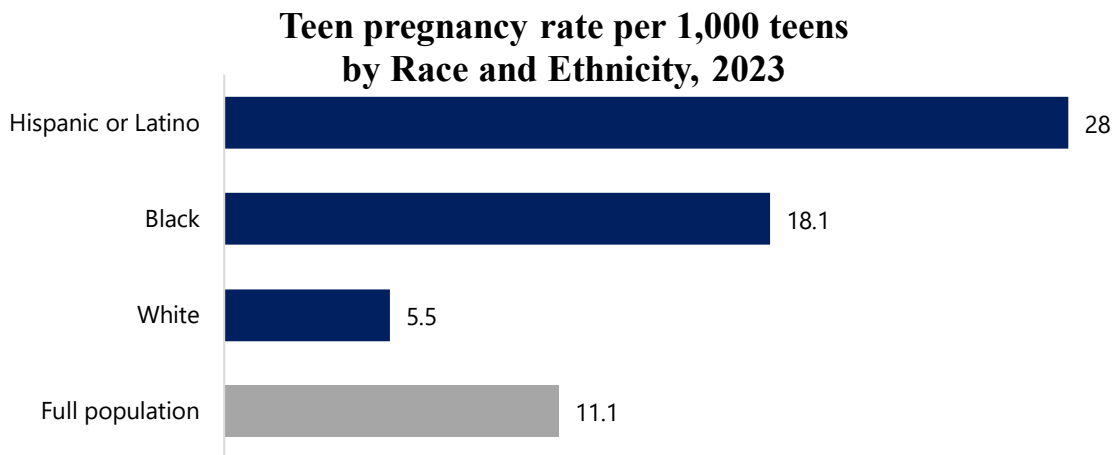
**Teen pregnancy rate per 1,000 teens, trending over time**



Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina State Center for Health Statistics (NC SCHS), 2023



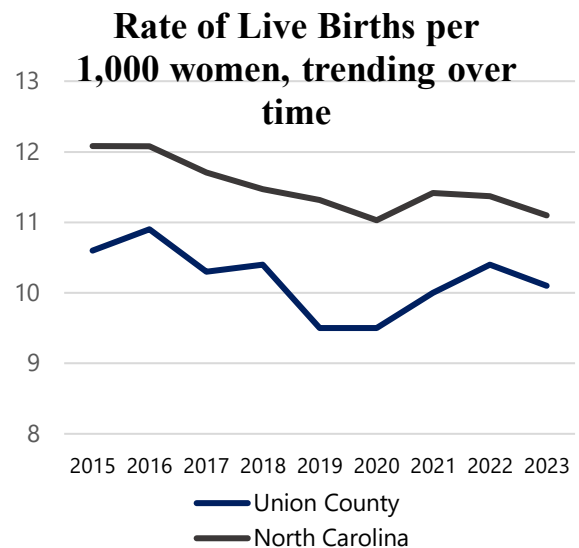
The data reveals the teen pregnancy rate in North Carolina across different racial and ethnic groups. Hispanic or Latino teens have the highest pregnancy rate at 28.0, followed by Black teens at 18.1. The overall teen pregnancy rate for the full population is 11.1. White teens have the lowest rate at 5.5. These disparities highlight the need for targeted interventions and support for specific communities.



*Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina State Center for Health Statistics (NC SCHS), 2023*

### Live Births

A live birth is defined as the complete delivery or removal of a fetus from its mother, regardless of the pregnancy's duration, in which the fetus shows any sign of life after separation (NC SCHS, 2024). The live birth rate per 1,000 population in Union County fluctuated between 9.5 and 10.4 from 2015 to 2023 (NC SCHS, 2024). North Carolina's overall live birth rate was consistently higher during this period, ranging from 11.03 to 12.08 per 1,000 population. Cabarrus County reported the highest rates among the three counties, peaking at 12.5 per 1,000 in 2017 (NC SCHS, 2024).



*Data Source: North Carolina State Center for Health Statistics (NC SCHS), North Carolina Vital Statistics Volume 1: Population, Births, Deaths, Marriages, Divorces, 2023*

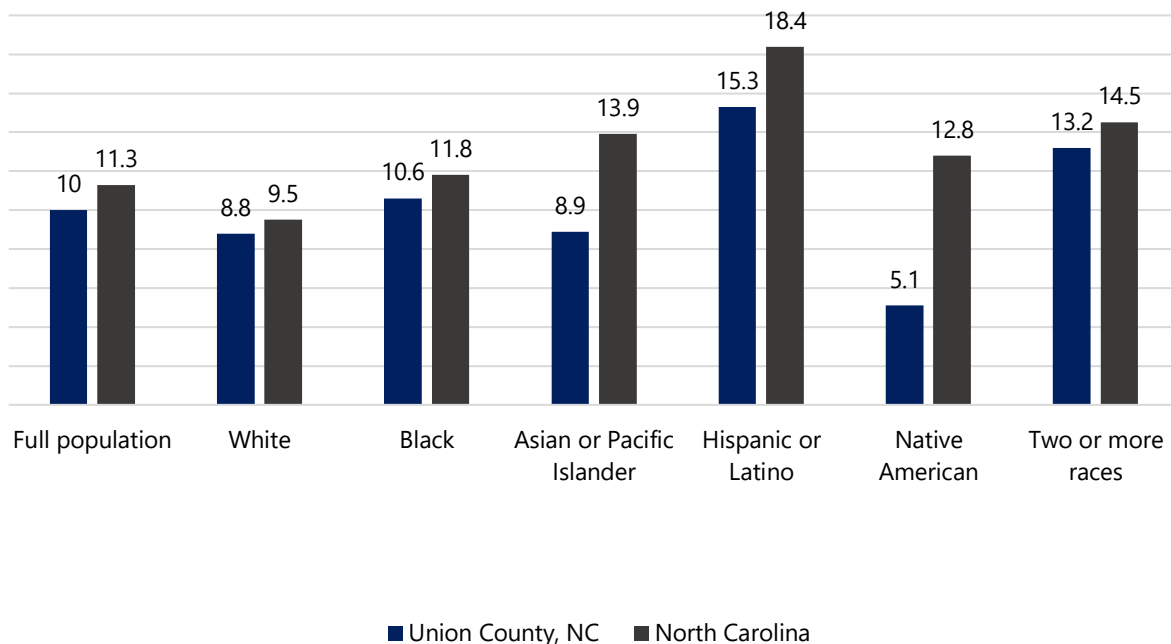


Across racial and ethnic groups, Union County's live birth rates are generally lower than the state averages. Hispanic or Latino residents have the highest birth rate in Union County at 15.3 per 1,000 population, though this remains below the statewide rate of 18.4. The overall live birth rate in Union County is 10.0 per 1,000, compared to the North Carolina average of 11.3. The Asian or Pacific Islander population in Union County has a notably lower birth rate (8.9 per 1,000) compared to the state average of 13.9 (NC SCHS, 2024).

Union County consistently reports the lowest teen birth rate among the comparison counties and the state over the past decade. The rate declined from 14.6

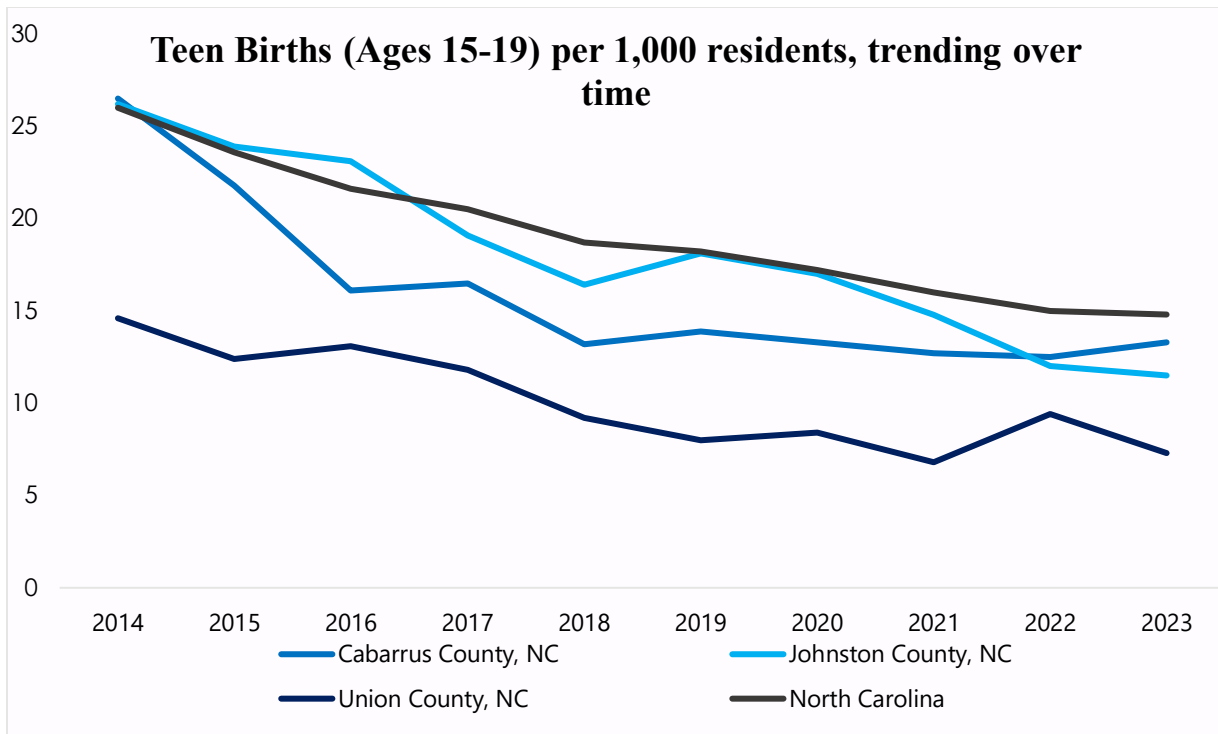
births per 1,000 females ages 15–19 in 2014 to 7.3 in 2023, representing a 50% reduction (NC SCHS, 2024). By comparison, the statewide rate decreased from 26.0 to 14.8 over the same period, while Johnston County declined from 26.0 to 11.5 and Cabarrus County from 26.2 to 13.3 (NC SCHS, 2024). Union County's trend shows a steady, sustained decline, with only minor year-to-year fluctuations. Teen birth rates in Union County remain lower than those in peer counties and the state across most racial and ethnic groups, with the highest rates observed among Hispanic or Latino females. Data for American Indian/Alaska Native and Asian or Pacific Islander populations are suppressed due to small population sizes (NC SCHS, 2024).

### Live Birth rate by Race and Ethnicity, 2019-2023



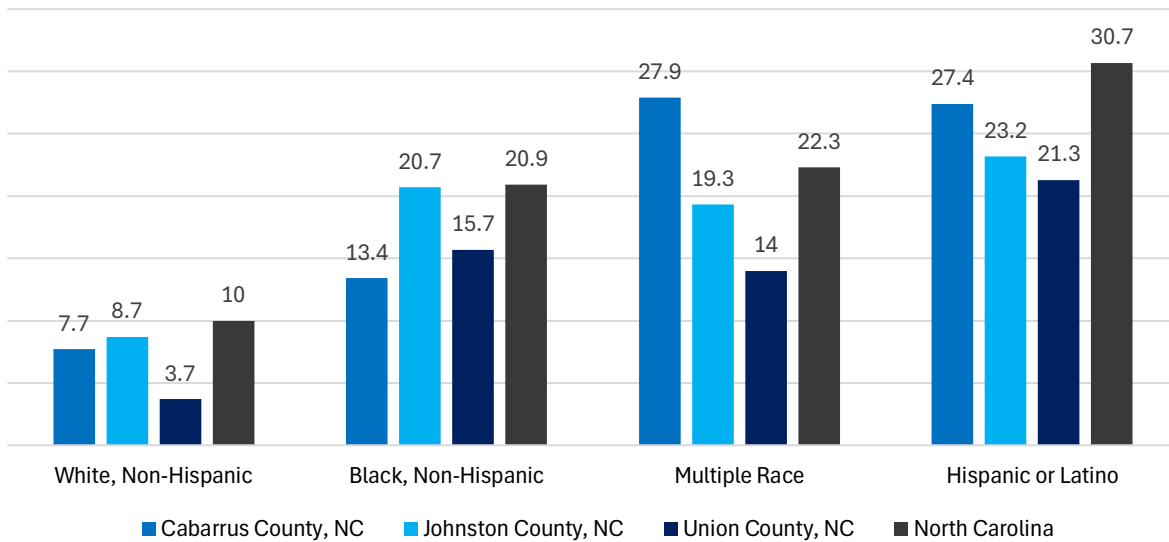
Data Source: North Carolina State Center for Health Statistics (NC SCHS), North Carolina Vital Statistics Volume 1: Population, Births, Deaths, Marriages, Divorces, 2023





Data Source: NCDHHS, Division of Public Health, North Carolina State Center for Health Statistics. Analysis of 2014-2023 Birth Certificate data & Census Bureau Population estimates.

### Teen Births (Ages 15-19) per 1,000 people, by Race and Hispanic Origin, 2019-2023



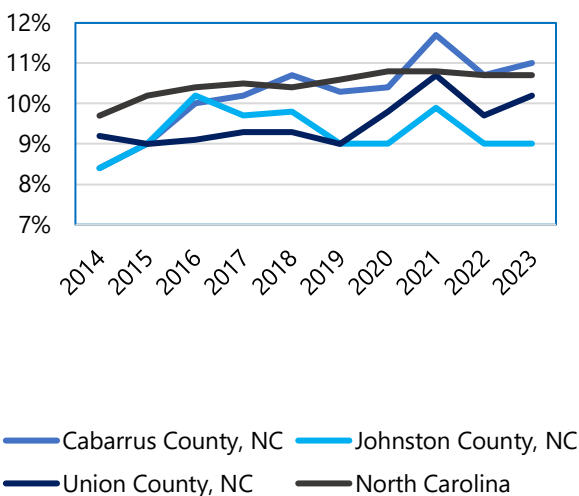
Data Source: NCDHHS, Division of Public Health, North Carolina State Center for Health Statistics. Analysis of 2019-2023 Birth Certificate data & Census Bureau Population estimates



## Pre-term Births

Pre-term births are defined as live births delivered before 37 completed weeks of gestation. This indicator is important because pre-term birth is a leading contributor to infant illness, disability, and mortality. Babies born too early are at higher risk for complications such as respiratory distress, infections, brain hemorrhage, and jaundice. They may experience long-term developmental delays, learning difficulties, or neurological disorders. In Union County, racial and ethnic disparities are evident. Based on the five-year average, approximately 14.0% of births among non-Hispanic Black residents and 10.5% among Hispanic residents were pre-term, both higher than the overall county average of 9.9% and above rates observed in some comparison counties (NC SCHS, 2024).

**Percent of Preterm (<37 weeks gestation) births, trending over time**



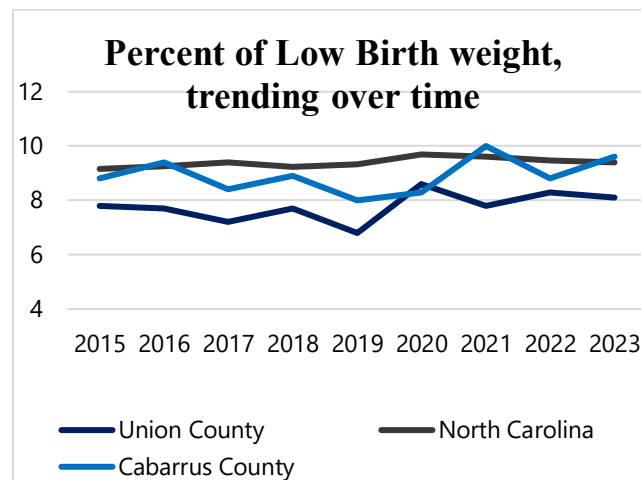
Data Source: NCDHHS, Division of Public Health, [Maternal and Infant Health Data Dashboard](#). Title V Office Analysis of 2014-2023 Birth Certificate data. 2023.

## Low Birth Weight and Very Low Birth Weight

Infants born at low birth weight are defined as live births weighing less than 2,500 grams (5 pounds, 8 ounces), while very low birth weight refers to infants weighing less than 1,500 grams (3 pounds, 4 ounces). Low and very low birth weight are associated with increased risks of respiratory distress, jaundice, infections, and brain hemorrhage in infancy, as well as long-term outcomes such as developmental delays, heart disease, and other chronic conditions later in life (CDC, 2023).

In 2023, Union County reported a low-birth-weight rate of 8.1%, lower than both the North Carolina rate (9.4%) and Cabarrus County (9.6%). Union County's rate has fluctuated in recent years, ranging from a low of 6.8% in 2019 to a high of 8.6% in 2020. Overall, the county has maintained a lower birth weight rate than the state and Cabarrus County, though variability persists across years (NC SCHS, 2024).

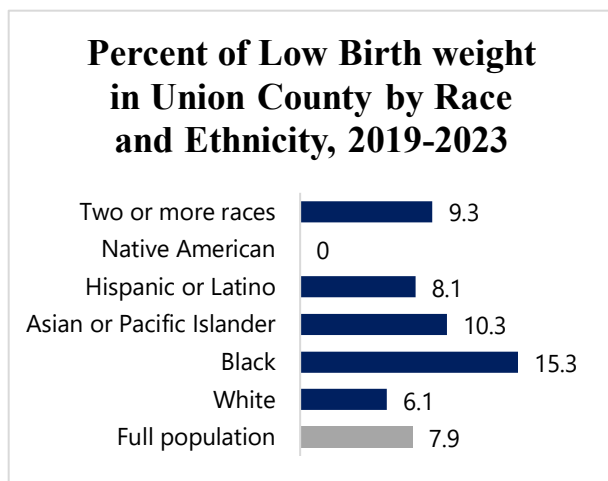
**Percent of Low Birth weight, trending over time**



Data Source: North Carolina State Center for Health Statistics (NC SCHS), North Carolina Vital Statistics Volume 1: Population, Births, Deaths, Marriages, Divorces, 2023



. Significant racial and ethnic disparities are evident. The highest rate is observed among Black individuals at 15.3%, while Native American individuals have the lowest rate at 0.0%. The overall population rate is 7.9%, indicating a notable disparity in low-birth-weight rates across racial and ethnic groups. Hispanic or Latino and Asian or Pacific Islander groups also show lower rates compared to the overall population (NC SCHS, 2024).

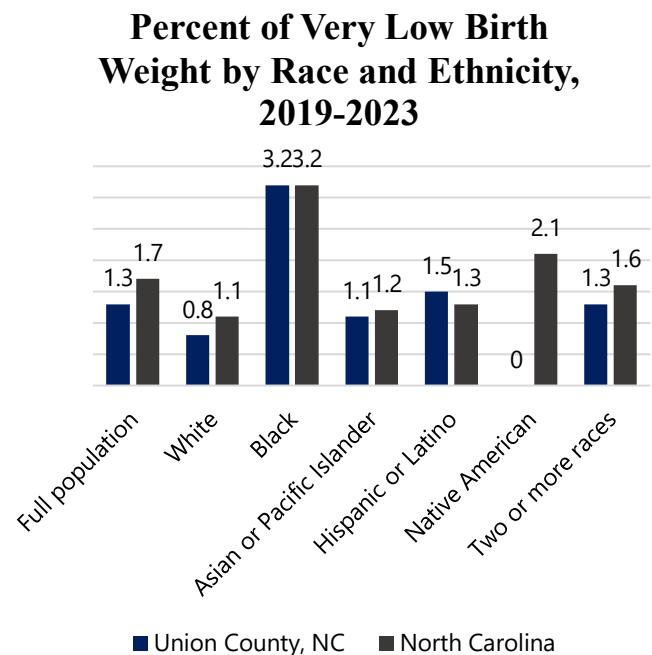


*Data Source: North Carolina State Center for Health Statistics (NC SCHS), North Carolina Vital Statistics Volume 1: Population, Births, Deaths, Marriages, Divorces, 2023*

Very low birth weight (VLBW) refers to infants born weighing less than 1,500 grams (3 pounds, 4 ounces). These infants face substantially higher risks of serious medical complications, including respiratory distress, infections, developmental delays, and long-term chronic health conditions (CDC, 2023).

Overall, very few infants are born at very low birth weights. North Carolina’s statewide VLBW rate is 1.7%, while Cabarrus County and Union County report lower rates at 1.4% and 1.3%, respectively (NC SCHS, 2024).

As with low birth weight, racial and ethnic disparities are evident. Black individuals in Union County have the same VLBW percentage as the state average at 3.2%. Hispanic or Latino individuals in Union County have a lower VLBW percentage (1.5%) compared to the state average (1.3%). The full population in Union County has a lower VLBW rate (1.3%) than the state average (1.7%). Two or more races in Union County have a slightly higher VLBW rate (1.3%) than the state average (1.6%). Asian or Pacific Islander individuals in Union County have a lower VLBW rate (1.1%) than the state average (1.2%). White individuals in Union County have a lower VLBW rate (0.8%) than the state average (1.1%). Native American individuals in Union County have a significantly lower VLBW rate (0.0%) than the state average (2.1%) (NC SCHS, 2024).



*Data Source: North Carolina State Center for Health Statistics (NC SCHS), North Carolina Vital Statistics Volume 1: Population, Births, Deaths, Marriages, Divorces, 2023*



The 2023 birth data for Union County highlights significant differences in maternal health and social risk factors across racial and ethnic groups.

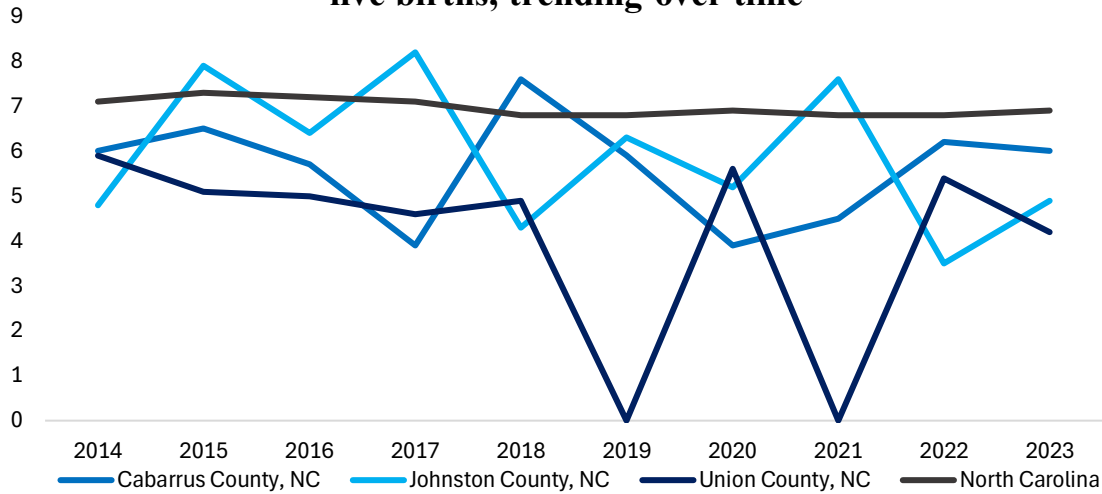
- Maternal hypertension was highest among Black mothers (15.6%) and White mothers (12.8%) and lower among Hispanic (8.7%) and Asian mothers (7.7%) (NC SCHS, 2024).
- Pre-pregnancy overweight or obesity was most common among Black and Hispanic mothers (67.7%) and lower among White (52.1%) and Asian mothers (38.5%) (NC SCHS, 2024).
- Educational attainment also varied considerably: 29.5% of Hispanic mothers had less than a high school education, compared to 10% of Black mothers and only 2.3% of White mothers (NC SCHS, 2024).
- Severe maternal morbidity (SMM)—including conditions such as hemorrhage, sepsis, eclampsia, pulmonary embolism, and the need for interventions like blood transfusions or hysterectomy—is highest among Black mothers and those aged 35 and older (NC SCHS, 2024; CDC, 2023).
- The percentage of mothers who smoked during pregnancy declined steadily from 4.5% in 2019 to 1.6% in 2023 (NC SCHS, 2024).
- Marital status also reflects disparities: 61.6% of Black mothers were unmarried, compared to 45.5% of Hispanic mothers and 18% of White mothers (NC SCHS, 2024).
- Gestational diabetes was more common among Asian or Pacific Islander mothers (16.7%) and Hispanic mothers (12.2%) than among Black (8.0%) or White mothers (7.7%) (NC SCHS, 2024).
- The percentage of mothers with one or more documented mental health conditions during delivery hospitalization increased from 15.2% in 2020 to 18.1% in 2023, indicating growing behavioral health needs among pregnant and postpartum women (NC SCHS, 2024).

### **Infant Mortality**

Infant death is defined as the death of a live-born infant before reaching one year of age, expressed as a rate per 1,000 live births. This indicator is important because infant mortality reflects a population's overall health and well-being and can signal issues related to maternal health, access to care, and broader social, economic, and environmental conditions. Disparities in infant deaths often highlight underlying racial, ethnic, and geographic inequalities in healthcare access and social support (CDC, 2023; NC SCHS, 2024). In Union County, the infant mortality rate fluctuated between 2.2 and 5.6 deaths per 1,000 live births from 2014 to 2023, with an overall downward trend. Rates in Union County remain lower than those observed statewide and, by comparison, in counties such as Cabarrus and Johnston (NC SCHS, 2024).



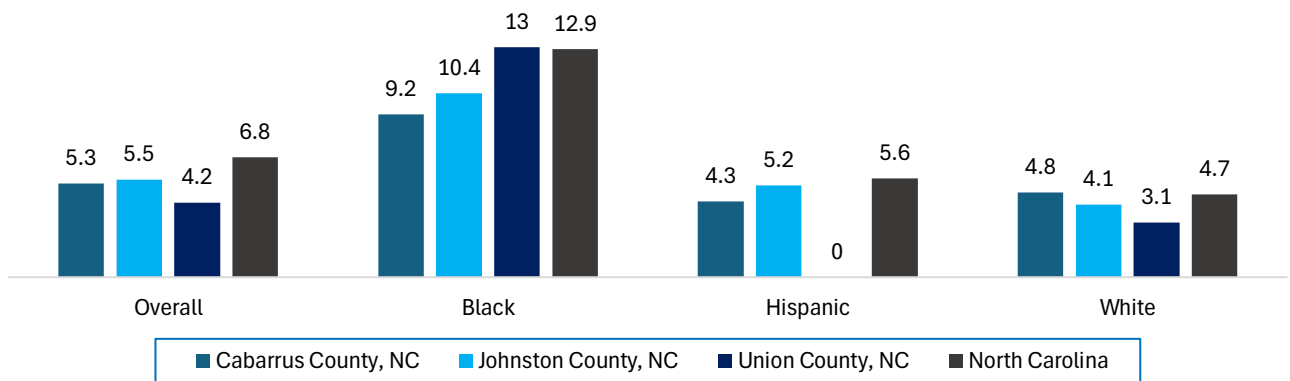
### Infant death rate per 1,000 resident live births, trending over time



Data obtained from NC DHSS. The North Carolina State Center provides analysis of Vital Statistics records for Health Statistics. Title V Office Analysis of 2023 Birth Certificate data

The infant mortality rate in Union County, over the five-year average, is 4.2 per 1,000 live births, which is lower than the state average of 6.8 and the peer counties. The highest rate is among non-Hispanic Black infants at 13, above the state average of 12.9 for this group. This may be due to multiple factors, including systemic racism, socioeconomic disparities, and healthcare access. Along with low birth weight and prematurity, higher mortality among Black infants could be caused by Black mothers’ health conditions, barriers to quality care, and chronic stress. In contrast, Asian or Pacific Islander infants have the lowest rate at 0.0, well below the state average of 3.8. Hispanic or Latino infants also have a lower rate (suppressed) compared to the state average of 5.6.

### Infant death rate per 1,000 resident live births, by Race and Hispanic Origin, 2019-2023



Data Source: NCDHHS, Division of Public Health, Maternal and Infant Health Data Dashboard. Data obtained from NC DHSS. The North Carolina State Center provides an analysis of Vital Statistics records for the Health Statistics—Title V Office, using 2023 Birth Certificate data.



## Mental Health

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act, and influences how we handle stress, relate to others, and make healthy choices throughout life (CDC, 2024). Mental health disorders involve changes in thinking, mood, and/or behavior and can affect how individuals function in daily life and relate to others. These conditions affect people of all ages and backgrounds and are common, often recurrent, and sometimes serious. However, many mental health disorders are treatable, and many individuals experience recovery with appropriate care and support (CDC, 2024).

There is no single cause of mental illness. Factors that may increase risk include adverse or traumatic life experiences, chronic medical conditions, biological or chemical imbalances, alcohol or drug use, and social factors such as loneliness or isolation (CDC, 2024). A range of interconnected social, economic, and individual risk factors influences mental health. These include social drivers such as interpersonal and institutional discrimination, limited access to housing, healthcare, education, employment, and economic opportunity, as well as adverse childhood experiences and other forms of interpersonal violence. Social isolation, poor coping skills, and ongoing or chronic medical conditions—such as traumatic brain injury, cancer, or diabetes—can further increase risk. The use of alcohol or other drugs is also closely associated with poorer mental health outcomes, underscoring the importance of addressing social

determinants of health alongside clinical care to improve mental well-being and reduce disparities (CDC, 2024).

## Prevalence

Mental health conditions are common across the United States and affect individuals across the lifespan. According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (2022-2023) and Health Resources and Services Administration (HRSA) National Survey of Children's Health (2023):

- 23% (nearly 1 in 5) U.S. adults live with a mental health condition.
- 6% (about 1 in 18) U.S. adults live with a serious mental health condition—such as schizophrenia, bipolar disorder, or major depression—that substantially interferes with daily functioning.
- 20% (nearly 1 in 5) adolescents ages 12–17 have a current, diagnosed mental or behavioral health condition.

In North Carolina, mental health needs mirror national trends. According to the Mental Health America Survey (2023):

- 21.3% of adults in North Carolina experienced any mental illness (AMI) in the past year.
- 4.45% of adults reported serious thoughts of suicide.
- 19.14% of youth (ages 12–17) experienced a major depressive episode (MDE) in the past year.
- 12.51% of youth (ages 12–17) reported serious thoughts of suicide in the past year.



The Youth Risk Behavior Survey (YRBS) provides insight into trends in emotional distress among North Carolina students. According to the 2023 YRBS:

- The percentage of NC high school students who felt sad or hopeless increased from 30.6% (2003) to 39.1% (2023), peaking at 43.4% in 2021.
- Females report substantially higher rates than males.
- Rates increase by grade level.
- Higher prevalence is observed among Asian and Hispanic/Latino students, compared with White students.
- 23.2% of middle school students and 18.2% of high school students reported seriously thinking about suicide (2023).
- About 10% of middle school students and 9.5% of high school students reported attempting suicide.

(North Carolina Department of Public Instruction, 2023)

Local data indicate that mental health challenges are also prevalent in Union County. Based on the CDC Behavioral Risk Factor Surveillance System (BRFSS) estimates:

- 28.4 percent of adults report feeling socially isolated
- 20.6 percent report a lack of social or emotional support.
- 21.5 percent of adults report feeling depressed

- 14.8 percent report frequent mental distress, defined as poor mental health on 14 or more days in the past month.
- Adults in Union County report an average of 4.5 poor mental health days per month.

(CDC, 2023).

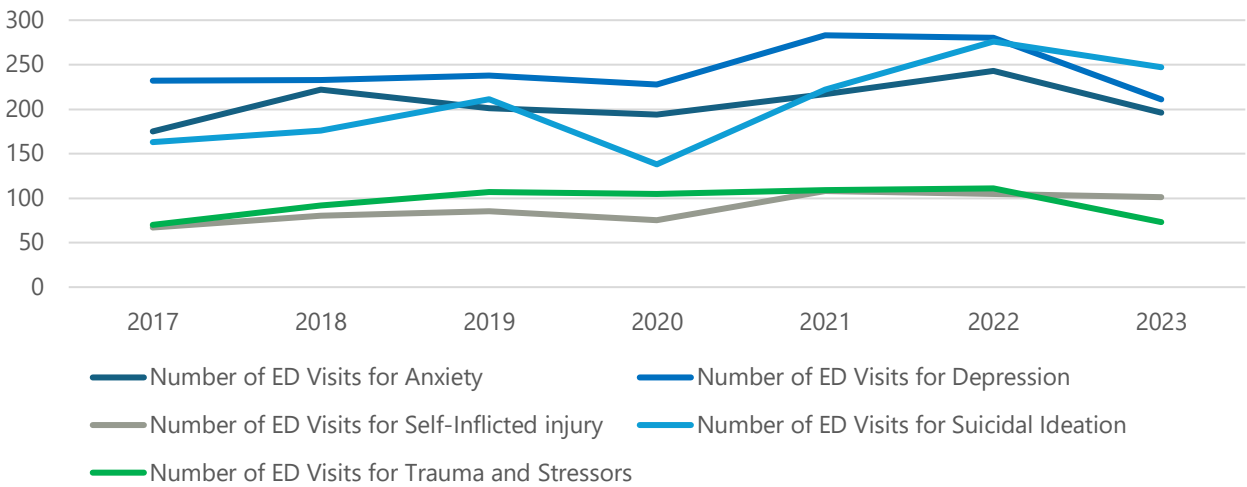
Together, these data demonstrate that mental health conditions are widespread at the national, state, and local levels and are closely linked to social isolation, lack of support, and broader social and economic stressors.

### **Emergency Department Visits**

Emergency department visit data indicate sustained and concerning mental health-related utilization in Union County across both youth and adult populations from 2017 to 2023. Among children and adolescents ages 0–17, ED visits for anxiety, depression, suicidal ideation, trauma and stressors, and self-inflicted injury increased overall during this period, with notable spikes beginning in 2021 and peaking in 2022. Although some categories declined slightly in 2023, visit counts remain higher than pre-pandemic levels, suggesting persistent unmet mental health needs among youth (NCDHHS, 2024).



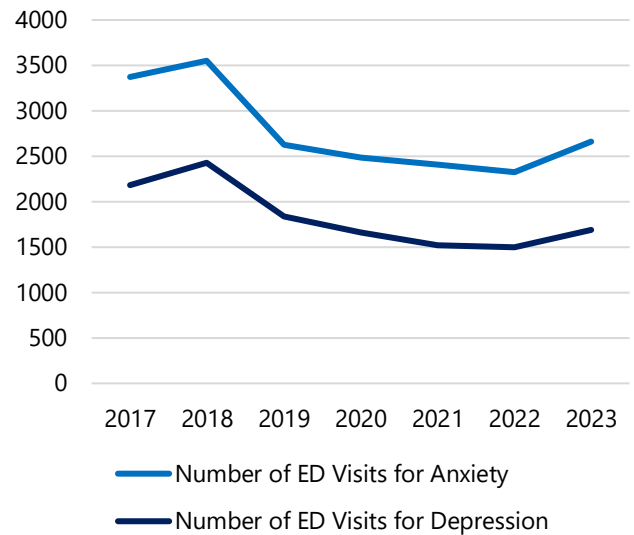
### Number of Emergency Department Visits in Union County for 0-17 year-olds, trending over time



Data Source: North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT), 2024

Among adults ages 18 and older, ED visits for anxiety and depression declined between 2018 and 2021 but began rising again by 2023. More concerning, ED visits related to suicidal ideation increased steadily after 2020 and reached their highest levels in 2022–2023. Visits for self-inflicted injury and trauma-related conditions also show upward trends. These patterns suggest that emergency departments continue to serve as a critical safety net but are increasingly used for mental health crises that may reflect gaps in timely access to preventive and outpatient services (NCDHHS, 2024).

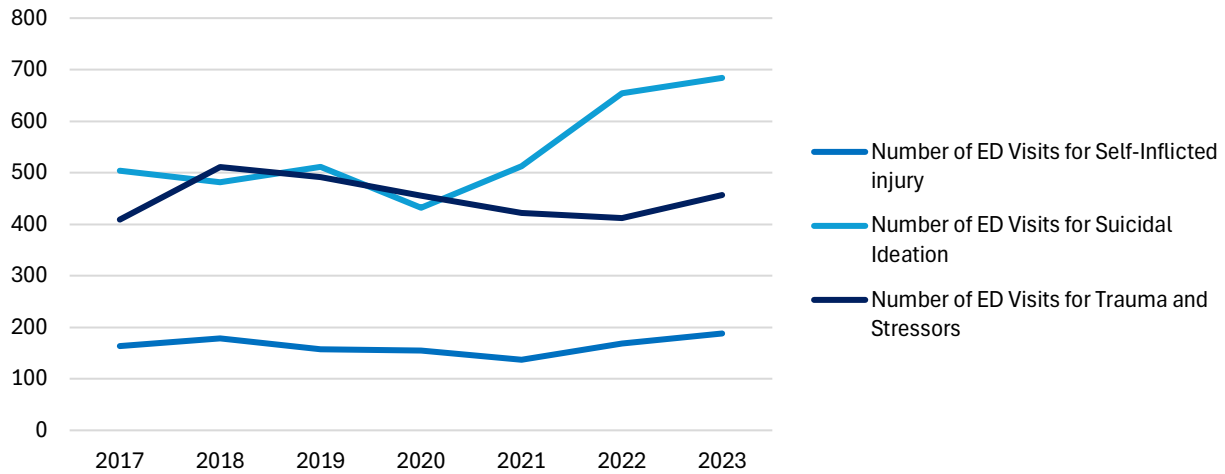
### Number of Emergency Department Visits for Anxiety and Depression in Union County for Adults Ages 18+, trending over time



Data Source: North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT), 2024



## Number of Emergency Department Visits in Union County for Self-Inflicted Injury, Suicidal Ideation, Trauma and Stressors for Adults Ages 18+, trending over time



Data Source: North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT), 2024

### Progress on CHIP – Mental Health

Mental Health was identified as a priority area in the 2022 Community Health Assessment. The 2022–2025 Union County Community Health Improvement Plan (CHIP) outlines the community’s strategies to address this need. Key initiatives include strengthening the continuum of mental health care providers in Union County, expanding mental health awareness and community education, supporting the Behavioral Health Collaborative, implementing the Community Resilience Model, and providing evidence-based training such as Mental Health First Aid and Question, Persuade, and Refer (QPR). Progress notes from 2023, 2024, and 2025 document the implementation and outcomes of these strategies across the CHIP period. Click the links below to review the progress notes for each strategy and program:

- [Develop a plan to improve the continuum of mental health providers in Union County](#)
- [Mental Health Awareness & Community Education](#)
- [Behavioral Health Collaborative](#)
- [Community Resilience Model](#)
- [Mental Health First Aid](#)
- [Question, Persuade, and Respond](#)



## Safety and Injury

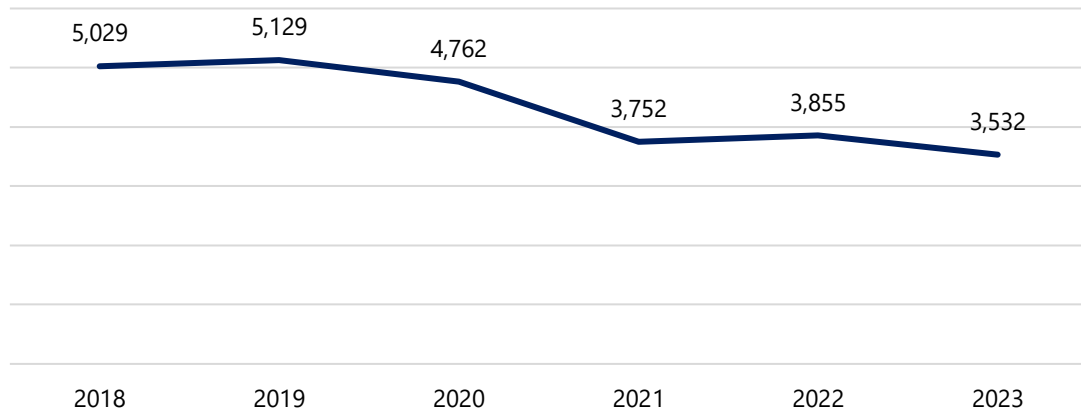
### Crime and Violent Deaths

Community safety is an important social determinant of health. Exposure to violence, crime, or unsafe environments is associated with increased injury, stress, mental health challenges, and reduced quality of life (CDC, 2023).

Index crime refers to the combined total of violent and property crimes. Violent crime includes murder, forcible rape, robbery, and aggravated assault, while property crime includes burglary, larceny, and motor vehicle theft. Arson is also considered an index crime but is not always included in total index crime calculations (North Carolina State Bureau of Investigation [NCSBI], 2023).

In 2023, the total population affected by index crime in Union County was 3,532, down from 3,855 in 2022. The highest number of residents affected by index crime occurred in 2019, with 5,129 individuals. Overall, index crime in Union County has shown a general downward trend in recent years (NCSBI, 2023).

### Crime Index in Union County



Data Source: North Carolina State Bureau of Investigation (NCSBI), 2023

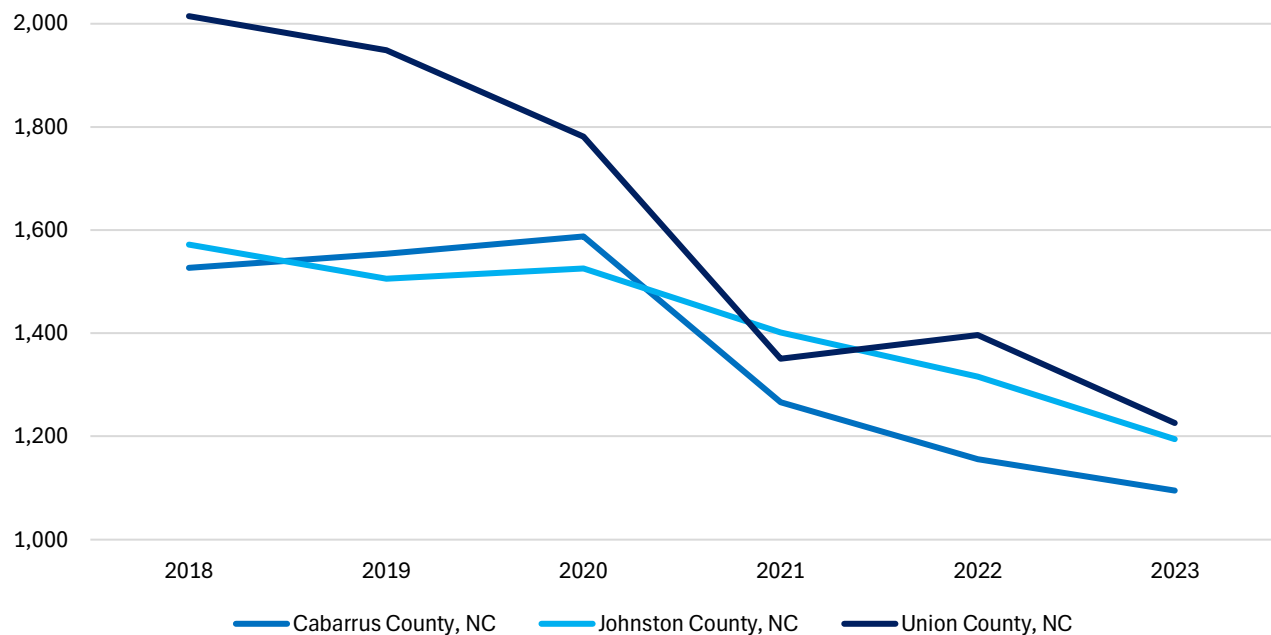


## Property Crimes

Property crimes account for most index crimes and include burglary, larceny, motor vehicle theft, and arson. From 2018 to 2023, Union, Johnston, and Cabarrus Counties all experienced declines in property crime rates (NCSBI, 2023). Union County began the period with the highest rate among the three counties—over 2,000 incidents per 100,000 residents in 2018—but experienced a notable decline after 2020, reaching approximately 1,200 incidents per 100,000 residents by 2023 (NCSBI, 2023).

Despite these improvements, Union County still reports higher property crime rates than some peer counties; however, rates remain lower than the North Carolina average. In Union County, reported rates per 100,000 residents include 200.6 burglaries (compared to 340.1 statewide), 916.9 larcenies (compared to 1,433.8 statewide), 108.5 motor vehicle thefts (compared to 233.6 statewide), and 8.6 arsons (compared to 12.5 statewide) (NCSBI, 2023). These trends suggest that while property crime is decreasing, disparities across counties and communities remain.

**Property crime rate per 100,000 residents in Union County, trending over time**



Data Source: North Carolina State Bureau of Investigation, *North Carolina State Bureau of Investigation, 2023*

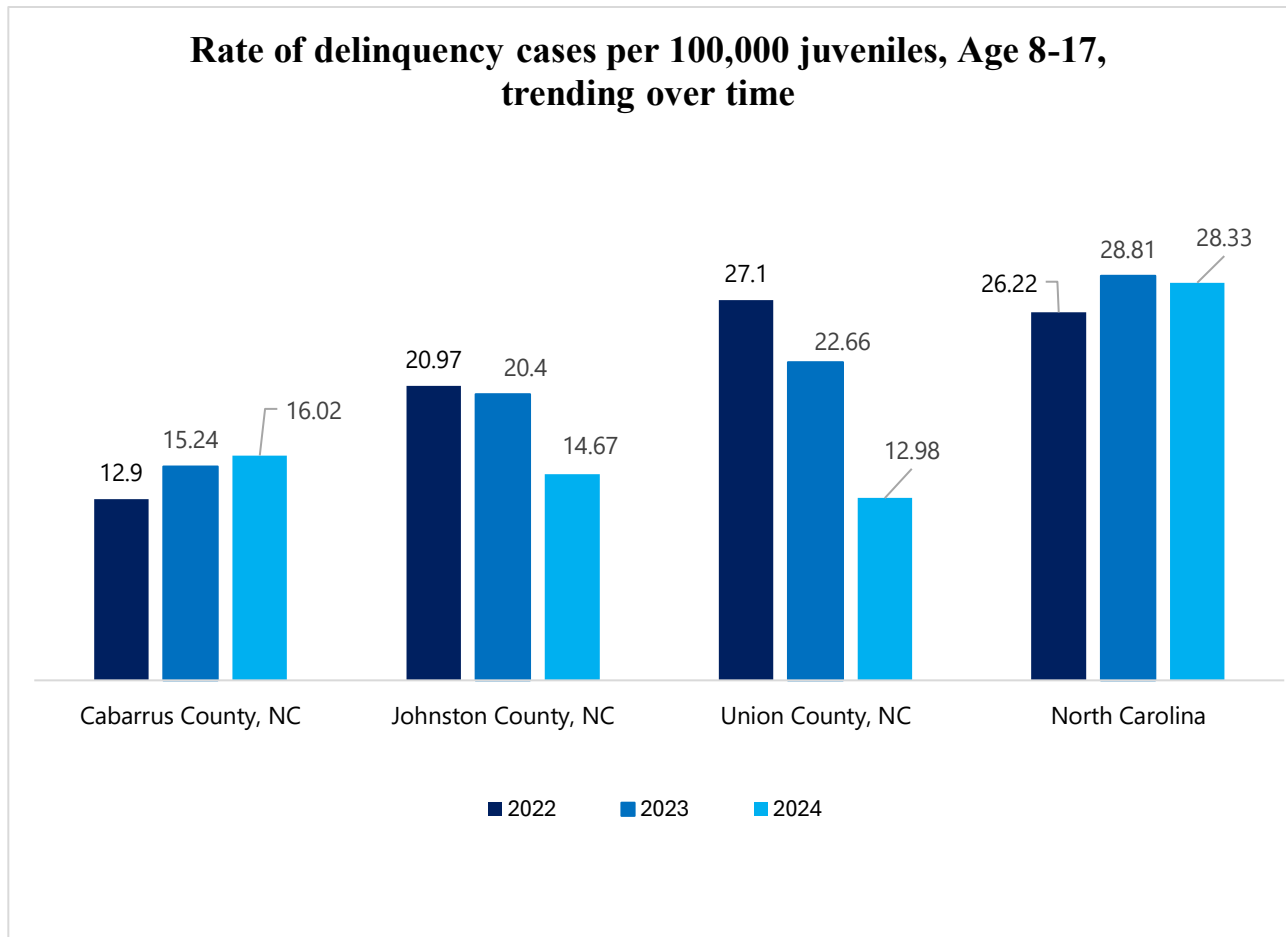


## Juvenile Complaints and Crimes

The rate of juvenile delinquency complaints per 1,000 youth ages 8–17 in Union County has fluctuated over time. The rate peaked at 24.4 complaints per 1,000 youth in 2017 and again at 27.1 in 2022 before declining slightly to 22.7 in 2023 (North Carolina Division of Juvenile Justice and Delinquency Prevention [NCDJJD], 2024).

Compared to neighboring counties, Union County has generally reported higher juvenile complaint rates. By 2024, rates declined in both Union and Johnston Counties, but Cabarrus County showed a gradual increase. Statewide rates remained relatively stable at approximately 27–29 complaints per 1,000 juveniles (NCDJJD, 2024). These differences may reflect variations in enforcement practices, prevention programs, and underlying social and economic conditions.

Data Source: North Carolina Department of Public Safety, [North Carolina Division of Juvenile Justice and Delinquency Prevention](#).

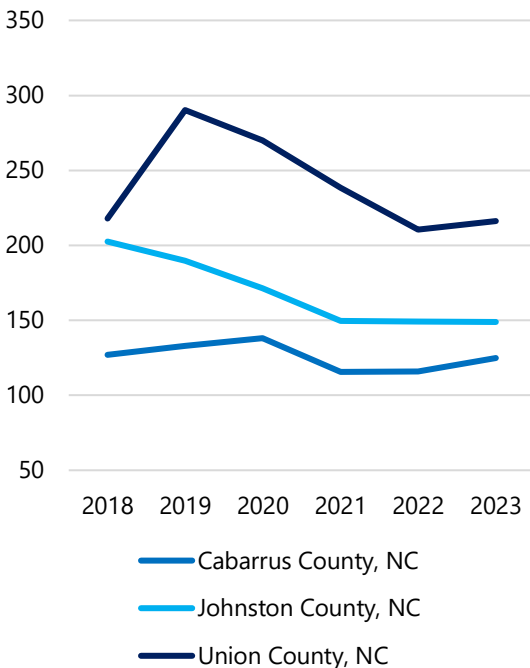


## Violent Crimes

Violent crimes involve the use or threat of physical force against another person and include murder, rape, robbery, and aggravated assault (NCSBI, 2023).

Union County's violent crime rate declined overall from 2018 to 2023, though rates remain higher than in neighboring Cabarrus and Johnston Counties. Compared with the state, Union County reports lower rates for murder (3.3 vs. 7.9 per 100,000), robbery (17.3 vs. 51.1 per 100,000), and aggravated assault (163.6 vs. 294.6 per 100,000). However, the county reports a higher rate of rape at 32.1 per 100,000 compared with the state rate of 27.3 per 100,000 (NCSBI, 2023).

**Violent crime rate per 100,000 residents, trending over time**



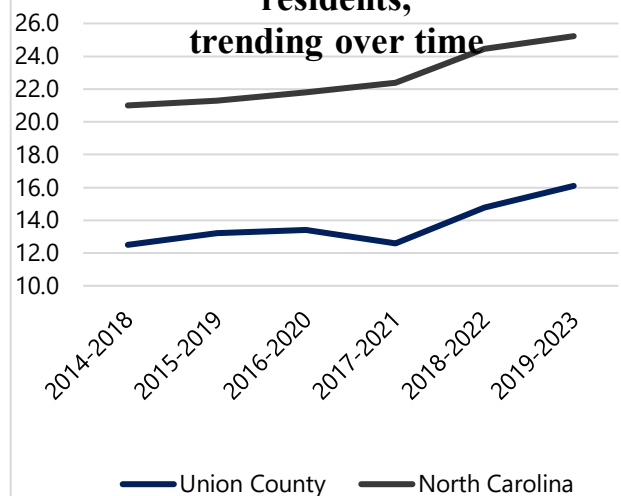
Data Source: North Carolina State Bureau of Investigation, *North Carolina State Bureau of Investigation*. 2023.

## Violent Crime Deaths

The North Carolina Violent Death Reporting System (NC-VDRS) is a CDC-funded surveillance system that collects detailed information on deaths resulting from violent causes, including homicide, suicide, unintentional firearm deaths, legal intervention, and deaths of undetermined intent (NCDHHS, 2024). Between 2014 and 2023, there were 304 violent deaths in Union County. Of these, 219 were suicides (72.0%), 73 were homicides (24.0%), two were unintentional firearm deaths (0.7%), three were legal intervention deaths (1.0%), and seven were deaths of undetermined intent (2.3%) (NCDHHS, 2024).

Union County's violent death rate has remained consistently lower than the state average, ranging from 12.5 to 16.1 per 100,000 residents, compared to 21.0–25.2 per 100,000 statewide (NCDHHS, 2024).

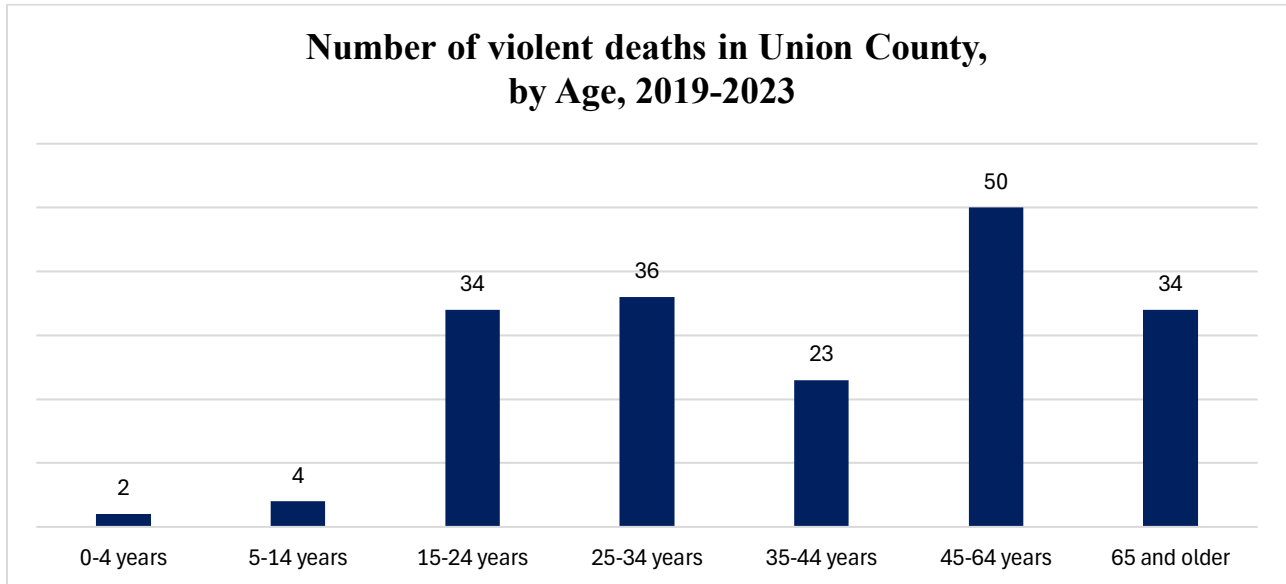
**Violent death rate per 100,000 residents, trending over time**



Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina Violent Death Reporting System (NC-VDRS) 2023



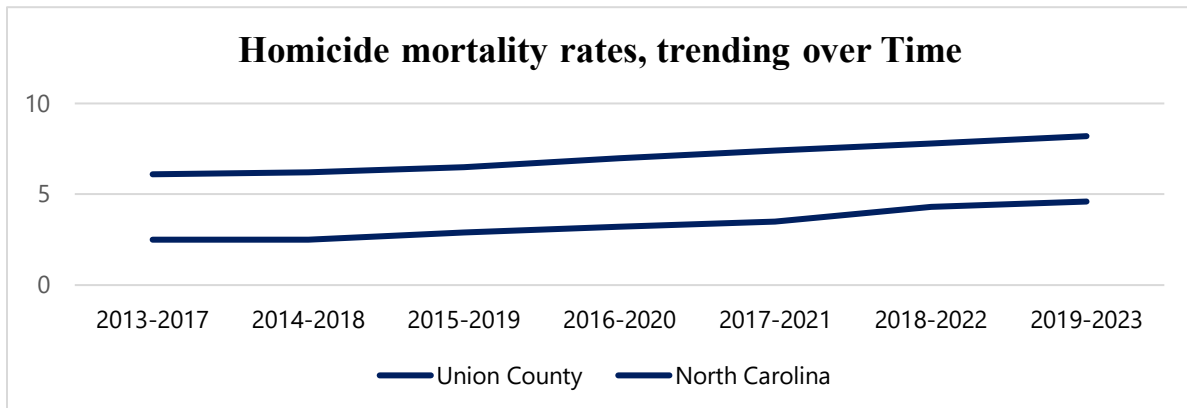
The highest number of violent deaths is observed in the 45-64 years age group, with 50 cases. This is followed by the 25-34-year age group, with 36 cases, and the 15-24-year age group, with 34 cases. The age groups of 65 and older, and 35-44 years, also show notable numbers of violent deaths, with 34 and 23 cases, respectively. The younger age groups, 5-14 years and 0-4 years, have significantly fewer cases, with 4 and 2 cases, respectively (NCDHHS, 2024).



Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina Violent Death Reporting System (NC-VDRS) 2023

### Homicides

Homicide mortality rates in Union County have fluctuated over the past decade, ranging from 2.5 to 4.6 deaths per 100,000 residents (NCDHHS, 2024). Rates increased between 2019 and 2023, mirroring broader statewide and national trends (CDC, 2023).

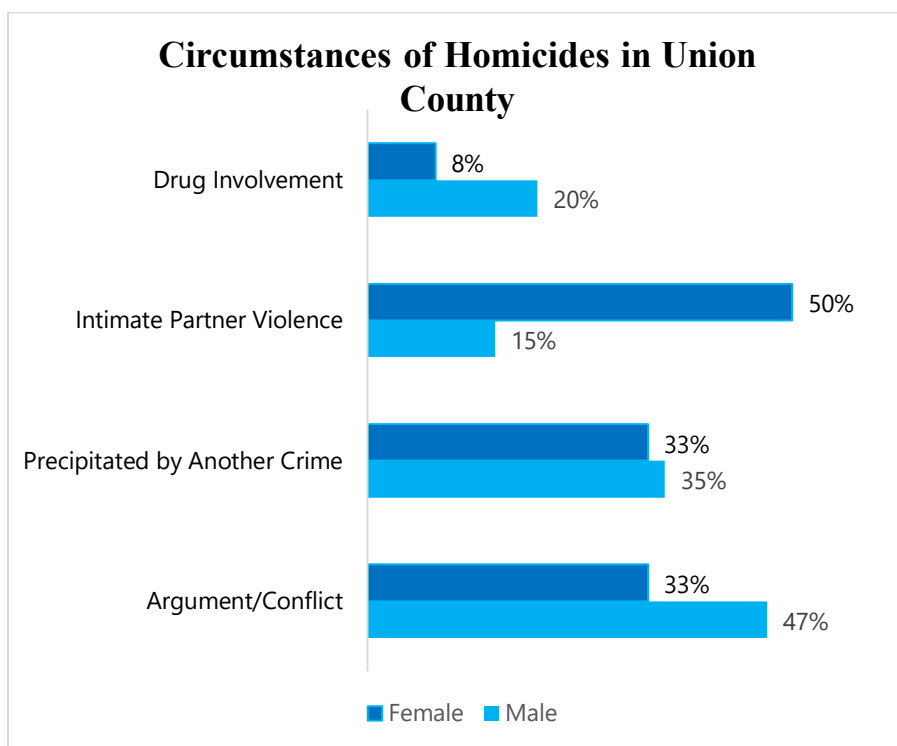


Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina Violent Death Reporting System (NC-VDRS) 2023



In Union County, 73.7% of homicide deaths involved firearms, and the homicide rate was 4.6 times higher among males than females. Rates were highest among non-Hispanic Black and Hispanic residents, with the highest age-specific rate occurring among adults ages 25–34 (NCDHHS, 2024).

Circumstances surrounding homicides also varied by sex. Intimate partner violence contributed to 50.0% of female homicides compared to 14.6% of male homicides. Arguments or conflicts were a contributing factor in 47.3% of male homicides and 33.3% of female homicides. Approximately one-third of homicides were precipitated by another crime, such as robbery, burglary, or drug trafficking (NCDHHS, 2024).



Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina Violent Death Reporting System (NC-VDRS) 2014- 2023

## Suicide

Suicide is the act of intentionally taking one’s life and is a serious public health problem with long-lasting effects on individuals, families, and communities (CDC, 2024). In North Carolina, suicide is the second leading cause of death among youth ages 10–18 and the third leading cause of death among young adults ages 19–34 (NCDHHS, 2024).

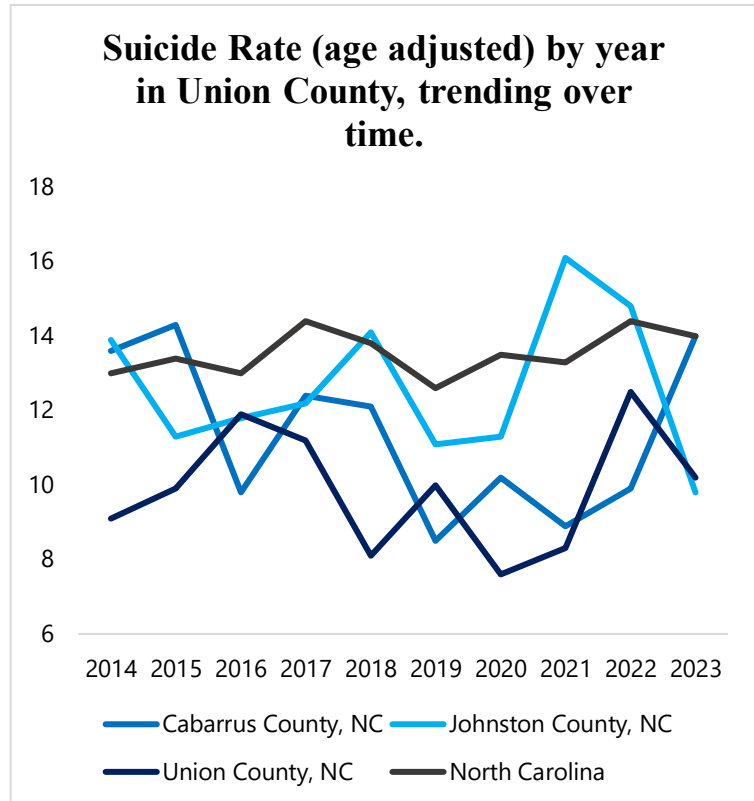
In 2023, there were 1,593 suicide-related deaths among North Carolina residents. Suicide deaths have increased by approximately 22% over the past decade, including a 17% increase since 2019 (NCDHHS, 2024). On average, four people die by suicide each day in North Carolina (NCDHHS, 2024).



Age-adjusted suicide rates in Union County have fluctuated over the past decade, generally remaining below the statewide average but showing notable year-to-year volatility. Rates increased from 2014–2017, declined in 2018, rose again in 2019, decreased in 2020, then increased sharply in 2022 before declining in 2023. These trends indicate ongoing suicide risk and the need for sustained prevention and access to care (NCDHHS, 2023).

Data from the North Carolina Violent Death Reporting System (NC-VDRS) show clear disparities by sex, age, race, and method. Males experience suicide rates approximately 3.6 times higher than females. Male rates are highest among those aged 85 and older, while female rates peak among those aged 45–54. Overall, the highest suicide rate is observed among adults aged 85 and older (26.3 per 100,000). By race and ethnicity, rates are highest among non-Hispanic White residents (NCDHHS, 2023).

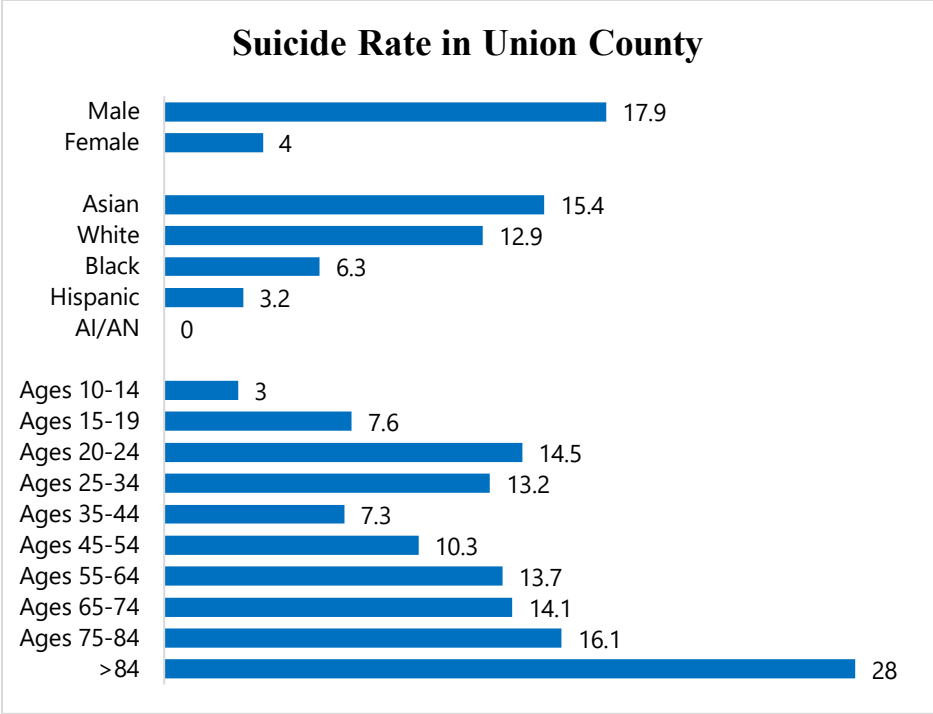
Firearms were involved in most suicide deaths (59%), followed by hanging (25.6%) and poisoning (11.1%). Suspicion of intoxication was reported in 20.1% of suicides (NCDHHS, 2023; CDC, 2024).



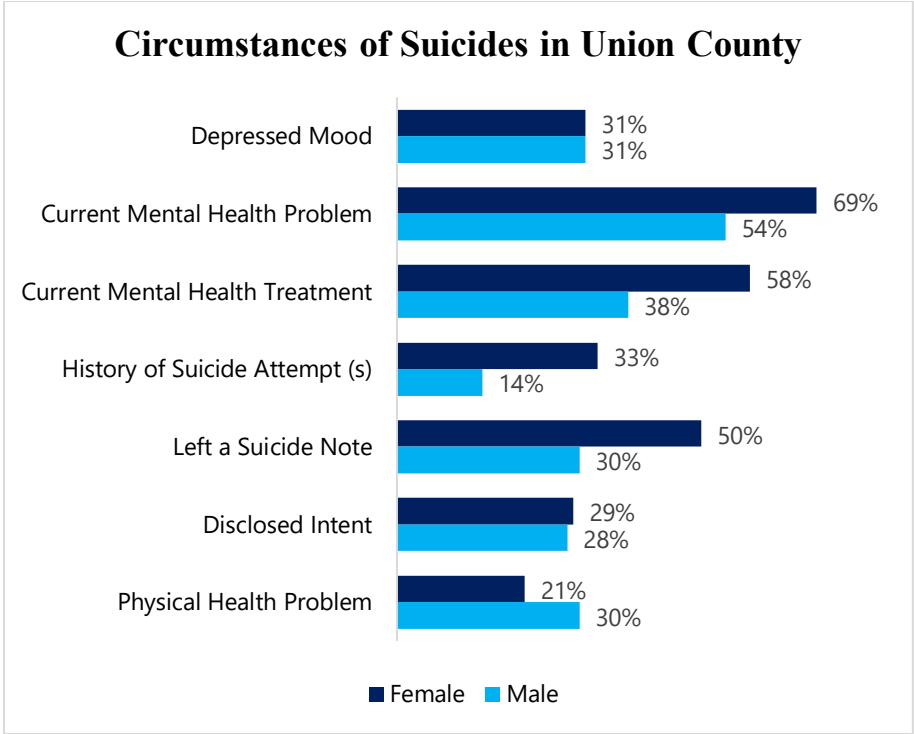
*Data Source: North Carolina Department of Health and Human Services, North Carolina State Center for Health Statistics, 2024*

Analysis of suicide deaths in Union County from 2014 to 2023 shows that mental health–related circumstances were common. A current mental health problem was documented in most cases, affecting 69% of females and 54% of males. Depressed mood was noted in approximately one-third of suicides for both sexes. Females were more likely than males to have a history of prior suicide attempts (33% vs. 14%) and to leave a suicide note. Disclosure of suicidal intent occurred in nearly three in ten cases. These findings underscore the importance of early identification, continuity of care, and timely intervention (NCDHHS, 2023)





Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina Violent Death Reporting System (NC-VDRS), 2019-2023, 5-year average



Data Source: North Carolina Department of Health and Human Services (NCDHHS), North Carolina Violent Death Reporting System (NC-VDRS) 2014- 2023



## Health Behaviors

### Substance Use Disorder

Substance use disorder (SUD) is a treatable, chronic disease characterized by cognitive, behavioral, and physiological symptoms indicating continued substance use despite significant substance-related problems (American Psychiatric Association, 2022; Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). SUD can affect people of any race, sex, income level, or social class. No single factor leads to SUD; risk factors may include stress, trauma, mental health conditions, and exposure to prescription opioids. Repeated substance use can cause changes in the brain that lead to cravings and continued use. SUDs range from mild to severe and may involve alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, or other substances (National Institute on Drug Abuse, 2023; American Psychiatric Association, 2022).

### Alcohol

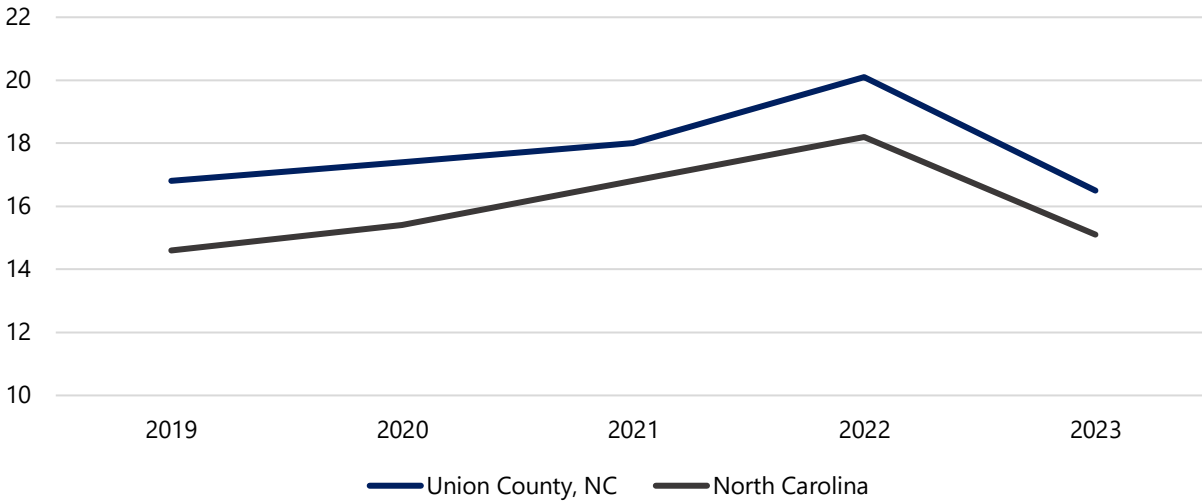
The misuse of alcohol, tobacco, illicit drugs, and prescription medications affects the health and well-being of millions of Americans. Nationally, an estimated 17.7% of adults had a substance use disorder in the past year, totaling more than 46 million people, and 7.8% of youth ages 12–17 experienced a SUD (Mental Health America, 2025; SAMHSA, 2023).

Excessive alcohol use is an important public health concern in North Carolina and Union County. Binge drinking is defined as adults aged 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days. Binge drinking rates in Union County, NC, have consistently been higher than the state average over the past five years. In 2022, Union County reported a rate of 20.1%, compared to North Carolina's 18.2%.

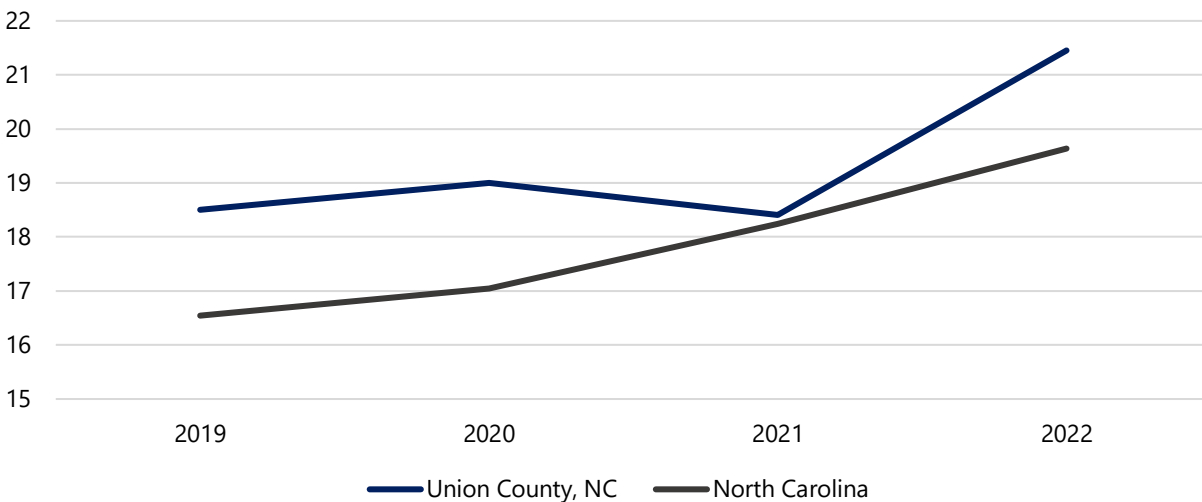
Excessive drinking is defined as the percentage of adults who report at least one binge drinking episode in the past 30 days or heavy drinking, defined as more than two drinks per day for men and more than one drink per day for women. Excessive drinking rates in Union County have also remained higher than the state average over the past five years. In 2022, Union County reported a rate of 21.45%, compared to North Carolina's 19.64% (CDC, 2022; BRFSS, 2018–2022).



### Percent of adults who Binge Drink, trending over time



### Percent of adults who drink excessively, trending over time



Data Source: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC), 2022

Excessive alcohol consumption poses serious risks to both immediate safety and long-term health. In the short term, heavy drinking increases the likelihood of overdose, motor vehicle crashes, and suicide by impairing judgment, coordination, and emotional regulation (Centers for Disease Control and Prevention, n.d.; National Institute on Alcohol Abuse and Alcoholism [NIAAA], n.d.). Over time, continued

excessive alcohol use significantly raises the risk of chronic diseases, including several types of cancer, liver disease, and hypertension (World Health Organization, 2018). These short- and long-term effects highlight alcohol misuse as a major public health concern with largely preventable consequences (CDC, n.d.).

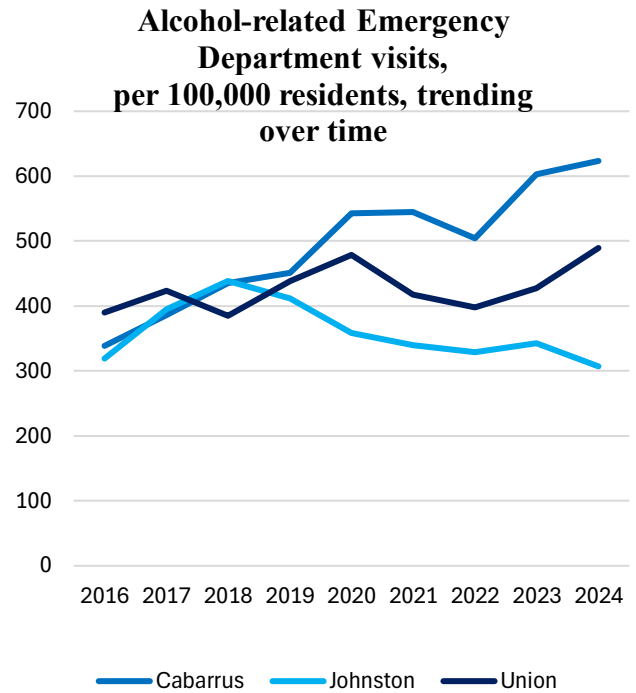


Alcohol-related emergency department (ED) visits remain a significant and growing public health concern in Union County. From 2016 to 2024, the county's alcohol-related ED visit rate increased overall, rising from approximately 390 visits per 100,000 residents to nearly 490 per 100,000 by 2024. In recent years, Union County's rates were near or above the statewide average (NCDHHS, 2024; NC DETECT, 2024).

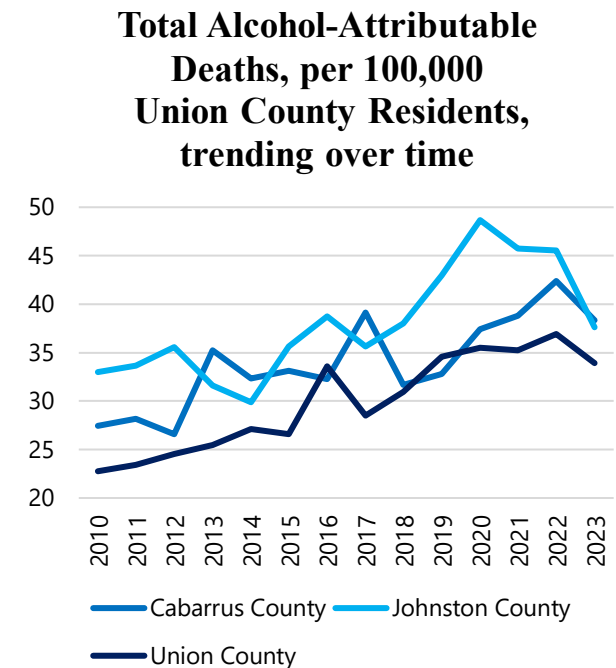
Substantial racial disparities are evident. During 2020–2024, Black, non-Hispanic residents experienced the highest alcohol-related ED visit rates in Union County, averaging approximately 761 visits per 100,000 residents, well above rates among White residents and the county overall (NC SCHS, 2024).

Alcohol-related ED visit rates also varied by age. Rates were lowest among youth under age 21 and increased substantially with age, with the highest rates observed among adults ages 50–64, averaging approximately 748 visits per 100,000 residents. Elevated rates were also observed among adults aged 35–49 and adults aged 65 and older (NC DETECT, 2024).

Alcohol-attributable deaths include both acute (e.g., injuries, poisonings) and chronic (e.g., liver disease, cancers) conditions caused or contributed to by alcohol use. The alcohol-attributable death rate in Union County was 33.9 deaths per 100,000 residents in 2023, representing 87 deaths. These rates have trended upward since 2010 (North Carolina State Center for Health Statistics, 2023).



Data Source: [The North Carolina State Center for Health Statistics](#), 2023.



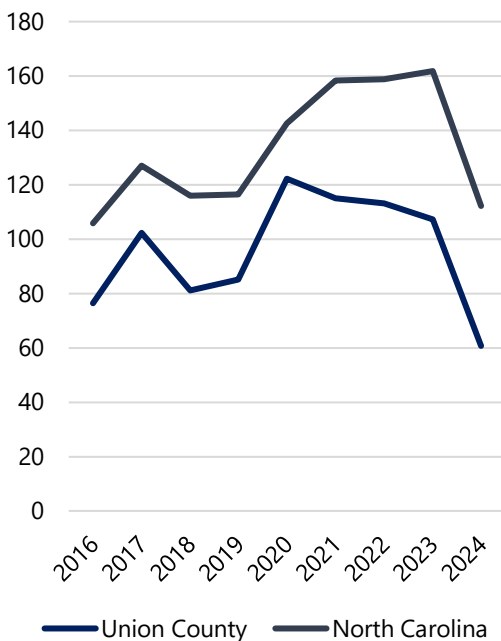
Data Source: [The North Carolina State Center for Health Statistics](#), 2023.



## Overdoses

Deaths, hospitalizations, and emergency department (ED) visits due to medication or drug overdose have become a growing public health concern. From 2016 to 2020, both Union County and North Carolina saw sharp increases in overdose-related ED visits. Union County's rate rose from 76.3 per 100,000 residents in 2016 to 122.2 in 2020, mirroring state-level increases tied to the escalating opioid and fentanyl crises. North Carolina peaked at 161.8 per 100,000 residents in 2023, while Union County peaked earlier and began to decline, dropping from 107.8 in 2023 (NC DETEC, 2025; NCDHHS, 2025).

**Rate of Drug Overdose  
Emergency Department  
Visits, per 100,000  
residents, trending over  
time**



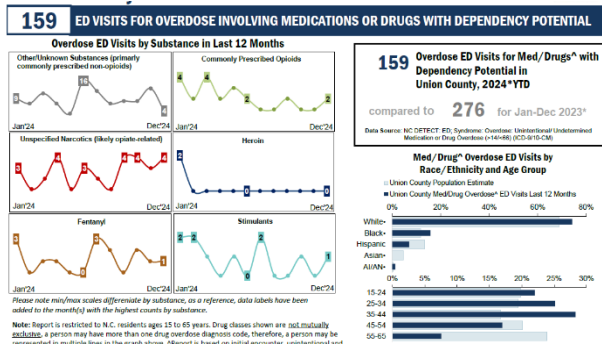
Data Source: North Carolina Disease Event Tracking and Epidemiologic Collection Tool. 2024

In 2024, Union County recorded 159 overdose-related emergency department visits, representing a substantial decrease from 276 visits in 2023. Although this decline is encouraging, overdoses continued to occur across multiple drug categories, indicating that substance misuse remains a significant public health concern (NC DETECT, 2024).

Unspecified narcotics—likely opioid-related—accounted for the largest share of overdose-related ED visits, averaging three to four visits per month. Prescribed opioids, sedatives, antidepressants, and fentanyl also contributed to ongoing overdose activity, underscoring continued risk from both prescription and illicit substances (NC DETECT, 2024).

By race and age, most overdose-related ED visits involved White residents, consistent with county demographics, while increasing representation among Hispanic residents highlights the need for culturally responsive outreach. The highest overdose-related ED visit rates occurred among adults ages 25–44, followed by youth and young adults ages 15–24, indicating priority populations for prevention, harm reduction, and treatment access (NC DETECT, 2024).





Data Source: North Carolina Department of Health and Human Services (NCDHHS), Injury and Violence Prevention Branch, 2025

Drug overdose deaths include fatalities resulting from the unintentional or intentional ingestion of prescription medications, over-the-counter drugs, and illicit substances. Overdose mortality is a critical public health indicator, as drug overdose remains a leading cause of preventable death and reflects the continuing impact of the opioid epidemic and broader substance use challenges. Monitoring overdose deaths informs prevention efforts, supports harm reduction strategies, and guides allocation of resources for treatment and recovery services (NC SCHS, 2024; CDC, 2023).

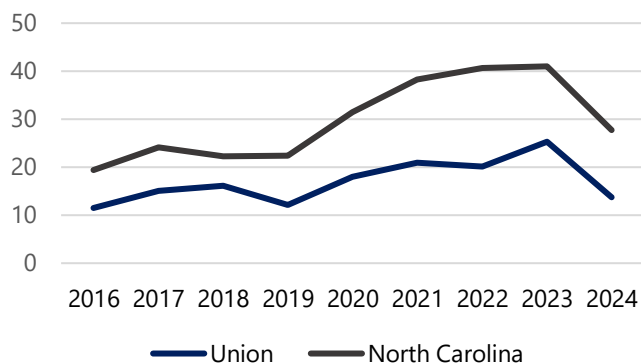
In Union County, the rate of drug overdose deaths increased substantially from 11.5 per 100,000 in 2016 to 25.3 per 100,000 in 2023, reflecting a similar upward trend statewide (NC SCHS, 2024). Racial disparities were evident. Union County reported lower overdose death rates among White residents (approximately 15.5–23.1 per 100,000) and among Hispanic residents (7.29 per 100,000); however, national and state data indicate widening racial disparities associated with fentanyl and

synthetic opioids (NC SCHS, 2024; CDC, 2023).

Gender disparities were also present. Men are roughly three times more likely than women to die from an overdose. In Union County, overdose death rates are lower than state averages for both genders, with 28.98 per 100,000 for men and 9.82 per 100,000 for women (NC SCHS, 2024).

The overdose crisis in Union County continues to disproportionately affect working-age adults, particularly those between the ages of 25 and 44. Overdose mortality is highest among working-age adults ages 25–44, though at lower rates than the state overall (approximately 35.3 per 100,000 among adults ages 35–44) (NC SCHS, 2024). Overdose death rates are lower among youth under age 25 and adults age 65 and older; however, these populations remain important prevention targets given emerging risks associated with counterfeit pills and prescription medication misuse (NC SCHS, 2024).

### Overdose Death rate per 100,000 residents, trending over time



Data Source: North Carolina Disease Event Tracking and Epidemiologic Collection Tool, 2024



## Opioids

Opioids are a class of drugs used to reduce pain and include some prescription pain medications, heroin, and synthetic opioids such as fentanyl. All opioids affect the brain by reducing the intensity of pain signals and influencing areas that control emotion and breathing. Depending on dose and method of use, opioids can cause serious risks and side effects, including overdose (Centers for Disease Control and Prevention, 2023; National Institute on Drug Abuse, 2023).

Prescription medications were a major early driver of the opioid epidemic, but illicit drugs—particularly heroin and synthetic fentanyl—now account for most overdose deaths. Fentanyl was involved in approximately 77% of overdose deaths

among North Carolina residents in 2023 (NCDHHS 2024). Additionally, fentanyl and opioid analogues are increasingly identified in other illicit drugs, including cocaine, methamphetamine, and counterfeit pills, placing individuals at risk of unintentional opioid exposure and overdose (NCDHHS, 2024).

From January through September 2025, Union County experienced 66 opioid-related emergency department visits, a 12% increase from the same period in 2024. While overall visits remain well below the 2021 peak of 205 cases, the data show a small rebound after declines in 2022 and 2023, reflecting the ongoing cyclical nature of the opioid crisis (NC DETECT, 2025).

### Union County Emergency Department (ED) Visits for Opioid Overdose: September 2025\* Update

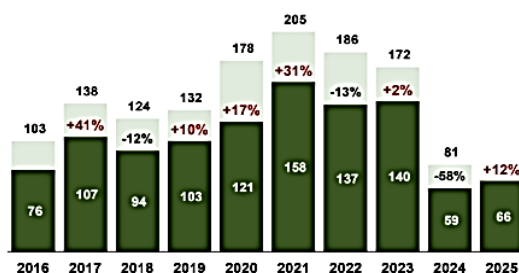
**66** Opioid overdose ED visits in Union County for 2025 YTD compared to Jan to Sep of 2024.

**59**

Note: Counts based on ICD-10-CM diagnosis code of an opioid overdose: T40.0 (Opium), T40.1 (Heroin), T40.2 (Other Opioids), T40.3 (Methadone), T40.4 (Other Synthetic Narcotics) and T40.6 (Other and Unspecified Narcotics) restricted to North Carolina residents.

**Year to year: Opioid overdose ED visits are up 12% for 2025 compared to last year this time.**

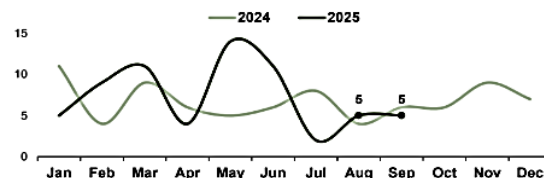
Percent change is YTD total compared to this time last year.



\*Data for 2024-2025 ED visits are provisional.

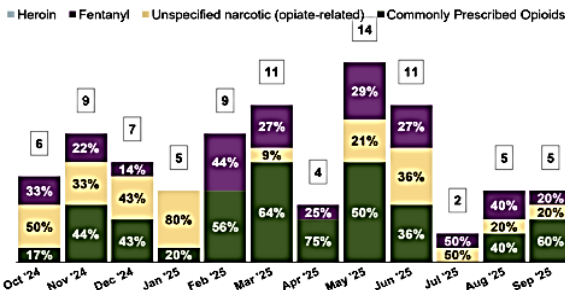
**Month to month: From Aug '25 to Sep '25 visits stayed the same.**

Counts may fluctuate month-to-month. Please reference YTD percent change for overall trends.



**Commonly prescribed opioids were the largest contributor to opioid overdose ED visits this month.**

Total opioid overdose ED visits are shown below. Percentages indicate the proportion each

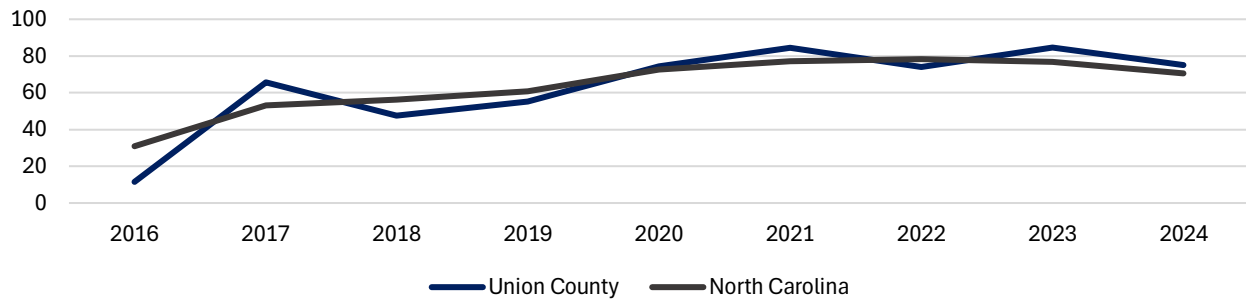


Note: ED data are not based on toxicology testing, therefore opioid drug class may not be an accurate depiction of the substances contributing to opioid overdose.



Overdose deaths linked to illicit opioids, including fentanyl, heroin, and other non-prescribed synthetics, have risen dramatically in Union County over the past decade. Illicit opioids accounted for fewer than 10% of overdose deaths in 2011 but surged to 60–80% by 2018–2019 and have remained high, between 70% and 85%, in recent years (NCDHHS, 2025).

### Percent of Overdose Deaths due to Illicit Opioids



Union County trends mirror neighboring counties, with fentanyl as a primary driver of fatal overdoses. Fourteen fentanyl-positive deaths were reported in early 2025, a 27% increase from the same period in 2024. Month-to-month data indicate ongoing risk throughout the year, with men and adults ages 25–44 disproportionately affected (NC OCME, 2025).

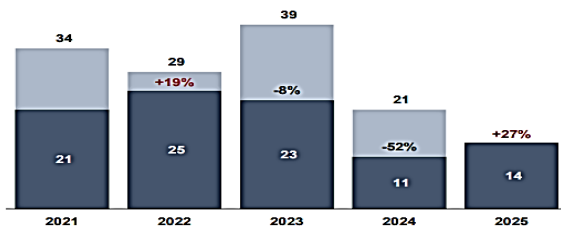
### Union County Fentanyl-Positive Deaths: August 2025\* Update

**14** Fentanyl-Positive Deaths^ in Union County for 2025 YTD compared to **11** Jan to Aug of 2024.

\*Results are based on analytical testing of specimens performed by NC OCME Toxicology. The detection of fentanyl by the laboratory may not necessarily be the ultimate cause of death as determined by the pathologist. YTD (Year to date).

**Year to year: Fentanyl-Positive Deaths are up 27% for 2025 compared to last year this time.**

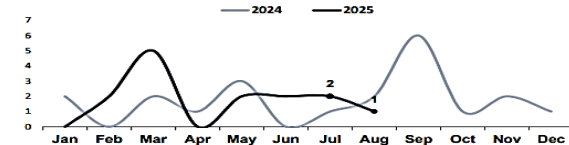
Percent change is YTD total compare to this time last year.



Data Source: Data Source: NC OCME Toxicology, accredited by the College of American Pathologists. The laboratory provides forensic analytical testing of specimens for all 100 counties of the statewide medical examiner system.

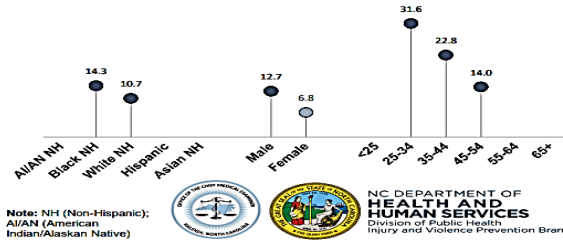
\*2024-2025 Data are provisional and subject to change.

**Month to month: From Jul '25 to Aug '25 there was 1 less visit.** Counts may fluctuate month-to-month. Please reference YTD percent change for overall trends.



**Residents who are Black, white, male, ages 25-54 had a higher rate of fentanyl-positive deaths compared to the statewide rate of 9.8.**

Rates calculated for last 24 months, Jul '23 - Aug '25. Rate per 100,000 county residents.



Notes: NH (Non-Hispanic); AI/AN (American Indian/Alaskan Native)

NC Office of the Chief Medical Examiner (OCME) Toxicology

ocme.dhhs.nc.gov

10/16/2025

Data Source: North Carolina Department of Health and Human Services (NCDHHS), Office of the Chief Medical Examiner, 2025



## Opioid Settlement

In July 2021, the North Carolina Attorney General announced a historic \$26 billion national opioid settlement to provide long-term resources to communities harmed by the opioid epidemic. In North Carolina, a Memorandum of Agreement (MOA) between the State and participating local governments governs how these funds are distributed and used. Under the MOA, 15 percent of settlement funds are allocated to the State, while the remaining 85 percent flow directly to North Carolina's 100 counties and 17 eligible municipalities to support local opioid abatement efforts (North Carolina Department of Justice, 2021; North Carolina Association of County Commissioners, 2022).

Union County is projected to receive approximately \$17.7 million from Phase One and Phase Two settlement funds over 18 years (2022–2038) and received notice of a third phase with an estimated \$2.1 million over the next 15 years—bringing the anticipated total to just over \$19.8 million (North Carolina Association of County Commissioners, 2025). Consistent with the MOA, all funds must be used for opioid abatement, aligned with the allowable strategies in Exhibits A and B, and managed with transparency, accountability, and strong fiscal stewardship (North Carolina Department of Justice, 2021).

From 2022 through 2025 (Phase I), Union County applied a deliberate, data-driven approach to investing opioid settlement funds, grounded in the State's required Collaborative Strategic Planning methodology (North Carolina Association of County Commissioners, 2022). Through a structured planning process and ongoing oversight, the County established a shared vision and mission, identified priority strategies, and funded a balanced portfolio of prevention, treatment, recovery, and harm-reduction initiatives. Phase I investments supported community partners delivering evidence-based and evidence-informed services, including treatment and recovery programs, Family Treatment Court, youth prevention efforts, naloxone distribution, and recovery support for justice-involved individuals (North Carolina Association of County Commissioners, 2022).

To ensure accountability and continuous improvement, Union County developed an initial performance and evaluation framework in partnership with Wingate University. This framework includes logic models, standardized performance measures, quarterly reporting, and a publicly accessible data dashboard. Phase I data collection captured both quantitative and qualitative information to ensure a full understanding of program reach, outcomes, and community impact. Quantitative metrics included demographic characteristics of individuals served, service utilization and engagement data, adverse childhood experiences (ACE) scores, education levels, and population-level indicators such as opioid-related emergency department visits and fentanyl-positive overdose deaths (North Carolina Association of County Commissioners, 2022).

Equally important, the County has begun intentionally collecting qualitative impact data, including participant narratives, family perspectives, and lived-experience feedback. These stories provide critical context to the numbers—illustrating how opioid settlement



investments translate into real-world outcomes such as sustained recovery, family reunification, increased stability, and renewed hope. Together, these quantitative metrics and qualitative impact stories demonstrate how opioid settlement funds are improving the lives of Union County residents affected by substance use disorder while also identifying persistent gaps in access, coordination, and system capacity that require continued attention (North Carolina Association of County Commissioners, 2022).

Building on lessons learned in Phase I, Union County conducted a second strategic planning process from September through December 2025 to guide Phase II investments (2026–2030 / FY2027–2031). This process incorporated updated epidemiological data, funded-partner performance reports, surveys, focus groups, and lived-experience input. Stakeholders reaffirmed the County’s mission, vision, and goals and prioritized 11 strategies aligned with the NC MOA Exhibits A and B, with an emphasis on scaling effective programs, closing critical service gaps, strengthening coordination, and maintaining transparency and accountability (North Carolina Association of County Commissioners, 2025).

The next step is to release a formal Request for Applications (RFA) to solicit proposals from qualified community providers aligned with these prioritized strategies. The Phase II RFA will clearly define eligibility requirements, funding guardrails, performance and reporting expectations, and equity and sustainability standards to ensure continued responsible use of settlement funds. Following Board of County Commissioners’ review of the proposed Vision, Mission, Goals, and Strategies in January 2026, the County will release the RFA in February 2026, hold a public meeting for potential applicants, and present funding recommendations to the Board in April 2026—positioning Union County for a strong, transparent, and impactful Phase II implementation (Union County Government, 2026).

## **Tobacco**

Tobacco use remains a significant public health concern, particularly among youth and young adults, due to the rapid rise of electronic vapor products. Data from the North Carolina Youth Risk Behavior Survey show that experimentation with e-cigarettes increased substantially among both middle and high school students between 2015 and 2023, with high school students consistently reporting higher rates of ever and current use (North Carolina Department of Public Instruction & NCDHHS, 2023).

The 2022 North Carolina Youth Tobacco Survey indicates approximately one in eight high school students currently use a tobacco product, with e-cigarettes far exceeding all other products in prevalence, while susceptibility to future use remains high among non-users. Poly-tobacco use and indicators of nicotine dependence are common, particularly among middle school students, and most youth who use tobacco report unsuccessful quit attempts without evidence-based support. Flavored and disposable e-cigarettes dominate youth use, and a substantial share of youth tobacco users also report vaping marijuana, highlighting overlapping substance use behaviors (NCDHHS, 2022).



Overall, the data demonstrate that while combustible cigarette use among youth remains relatively low, early nicotine exposure through vaping is widespread and reinforces the need for comprehensive, evidence-based tobacco prevention and cessation strategies consistent with NC DHHS priorities (NCDHHS, 2022; CDC, 2023).

Adult tobacco use continues to contribute to preventable disease and mortality. From 2017 to 2022, a notable share of adults in North Carolina reported current cigarette smoking, reinforcing tobacco's role as a leading cause of cardiovascular disease, cancer, and respiratory illness (BRFSS, 2017–2022; CDC, 2023). The continued prevalence of adult smoking, combined with rising youth vaping, underscores the need for comprehensive, evidence-based tobacco prevention and cessation strategies. These strategies should prioritize youth prevention, reduce access to and appeal of nicotine products, address disparities in tobacco use, and support cessation through education, policy, and community-based interventions (CDC, 2023; NCDHHS, 2022).

### **Progress on the CHIP – Substance Use**

Substance Use was identified as a priority area in the 2022 Community Health Assessment. The 2022–2025 Union County Community Health Improvement Plan (CHIP) outlines the community's strategies to address this need. Key initiatives include coordination through the Opioid Settlement Work Group and the Substance Use Disorder Task Force, expansion of recovery and treatment services through partners such as Bridge to Recovery, Cameron's House of Hope, Ground 40 Recovery Center, and the New Beginnings Medication-Assisted Treatment (MAT) Program, and support for justice-involved individuals through the Family Treatment Court. Additional strategies focus on prevention and harm reduction, including naloxone distribution, school-based efforts through the UCPS and School Resource Officer (SRO) Program, and policy approaches such as the Tobacco-Free Ordinance.

Progress notes from 2023, 2024, and 2025 document the implementation and outcomes of these strategies across the CHIP period. Click the links below to review the progress notes for each strategy and program:

- [Opioid Settlement Work Group](#)
- [Substance Use Disorder Task Force](#)
- [Bridge to Recovery](#)
- [Cameron's House of Hope](#)
- [Family Treatment Court](#)
- [Ground 40 Recovery Center](#)
- [Naloxone Distribution](#)
- [New Beginnings MAT Program](#)
- [UCPS and SRO Program](#)
- [Tobacco Free Ordinance](#)



## Clinical Care

### Access to Care

Access to care refers to “the timely use of personal health services to achieve the best possible health outcomes” (Agency for Healthcare Research and Quality [AHRQ], 2023). Factors that influence access to care include transportation, availability of healthcare providers, proximity to service facilities, and health insurance coverage. Barriers in any of these areas can negatively affect physical and mental health outcomes (AHRQ, 2023; Healthy People, 2030).

### Healthcare Workforce

According to recent data from the Centers for Medicare & Medicaid Services (CMS), the number of providers per capita in Union County is significantly lower than statewide rates in North Carolina (Centers for Medicare & Medicaid Services [CMS], 2025). This shortage spans multiple provider types, including physician assistants, nurse practitioners, dentists, optometrists, and mental health providers. In addition to provider supply, factors such as availability, geographic distribution, and service capacity also affect overall access to care (Health Resources and Services Administration [HRSA], 2024).

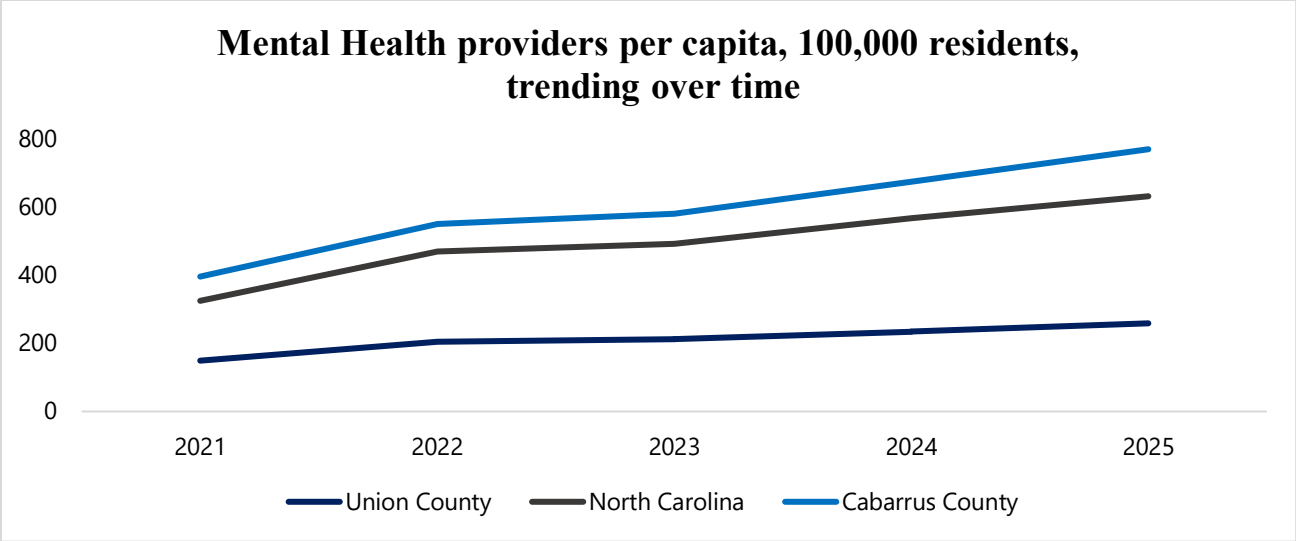
### Mental Health

Among adults with any mental illness, 14.5% are uninsured, meaning they have no financial coverage for treatment. Even among those with insurance, coverage gaps persist—nearly 16% report that their private insurance does not include mental or emotional health care. In addition, nearly one in four adults (24.6%) report an unmet need for mental health treatment, indicating that cost, stigma, and limited provider availability continue to prevent access to care when it is needed (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023; Mental Health America, 2023).

For youth, the picture is similarly concerning. More than 11% of youth ages 12–17 with private insurance lack coverage for mental health treatment, and half (50.1%) of youth who experienced a major depressive episode in the past year did not receive any mental health services. These findings demonstrate that insurance coverage alone is insufficient and that systemic barriers to access persist for both adults and children (SAMHSA, 2023; Mental Health America, 2023).

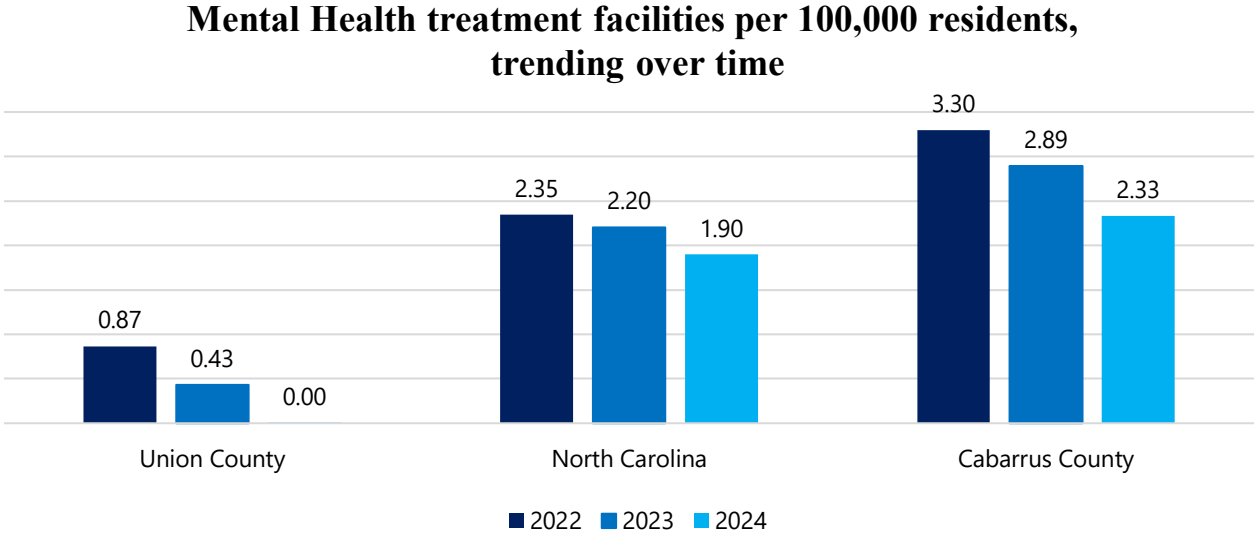
Despite growth over time, Union County continues to have substantially fewer mental health providers per 100,000 residents than both North Carolina as a whole and neighboring Cabarrus County. While Union County's provider rate increased from approximately 149 per 100,000 in 2021 to 259 per 100,000 in 2025, it remained less than half the statewide rate (632 per 100,000) and was far below Cabarrus County's rate (771 per 100,000) by 2025. This persistent gap suggests ongoing challenges in accessing timely mental health care, particularly specialty services, and may contribute to longer wait times, increased reliance on emergency departments, and unmet behavioral health needs (CMS, 2025; HRSA, 2024).





Data Source: Centers for Medicare & Medicaid Services (CMS), 2025

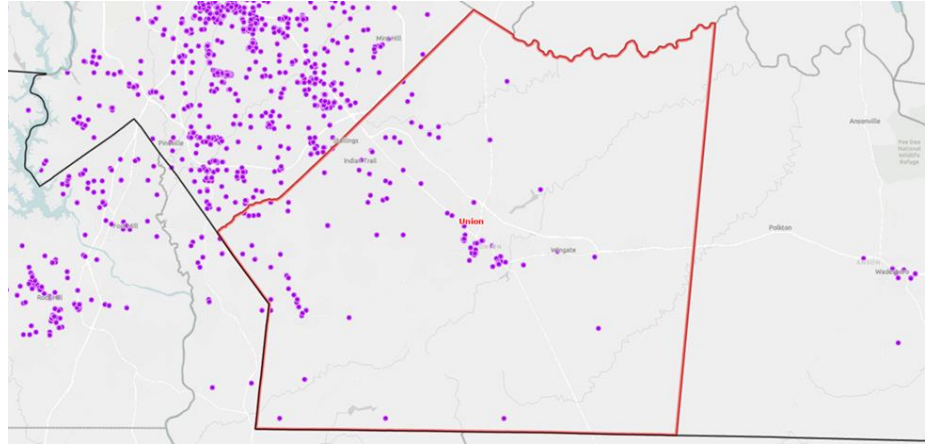
Union County also has extremely limited access to licensed mental health treatment facilities compared to both the state and neighboring counties. Between 2022 and 2024, the county’s rate of mental health treatment facilities declined from 0.87 per 100,000 residents to zero, indicating no licensed treatment facilities available locally by 2024. In contrast, North Carolina and Cabarrus County maintained between 1.9 and 2.33 facilities per 100,000 residents during the same period. This disparity suggests that many residents must seek care outside the county or rely on emergency departments, primary care, or crisis services, highlighting a significant infrastructure gap in the local behavioral health system (HRSA, 2024; CMS, 2025).



Data Source: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), 2024



This map illustrates a pronounced geographic maldistribution of mental health providers, with Union County showing far fewer providers compared to surrounding counties, suggesting persistent access barriers despite regional increases in provider supply (Centers for Medicare & Medicaid Services [CMS], 2025).



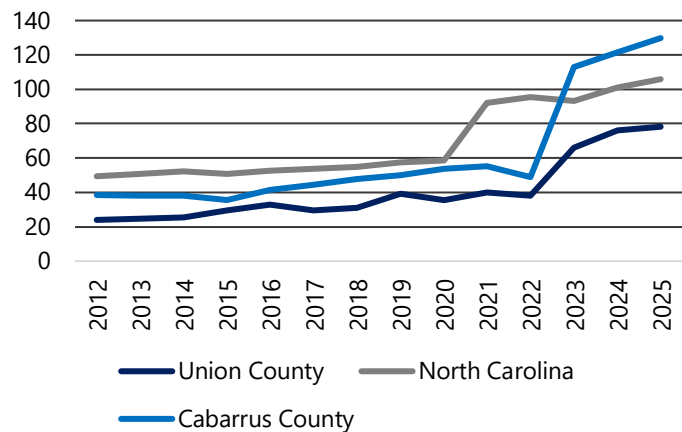
Recent data estimates that more than 34,000 residents are affected by mental health provider shortages, resulting in limited treatment access or long wait times.

that can worsen symptoms and increase the likelihood of crises (HRSA, 2024).

### Dentist

Dental providers are also limited, contributing to unmet oral health needs. In Union County, the number of dentists per capita has increased significantly over the years, from 24.0 in 2012 to 78.2 in 2025. Similarly, North Carolina has also seen an increase in dentists per capita, rising from 47.4 in 2010 to 105.9 in 2025. Despite this, an estimated 8,600 residents in Union County lack access to necessary dental services. Lack of access to dental care can lead to preventable pain and infections, missing school or work, and increased use of emergency departments for dental conditions (HRSA, 2024; CDC, 2023).

**Dentists per 100,000 residents, trending over time**



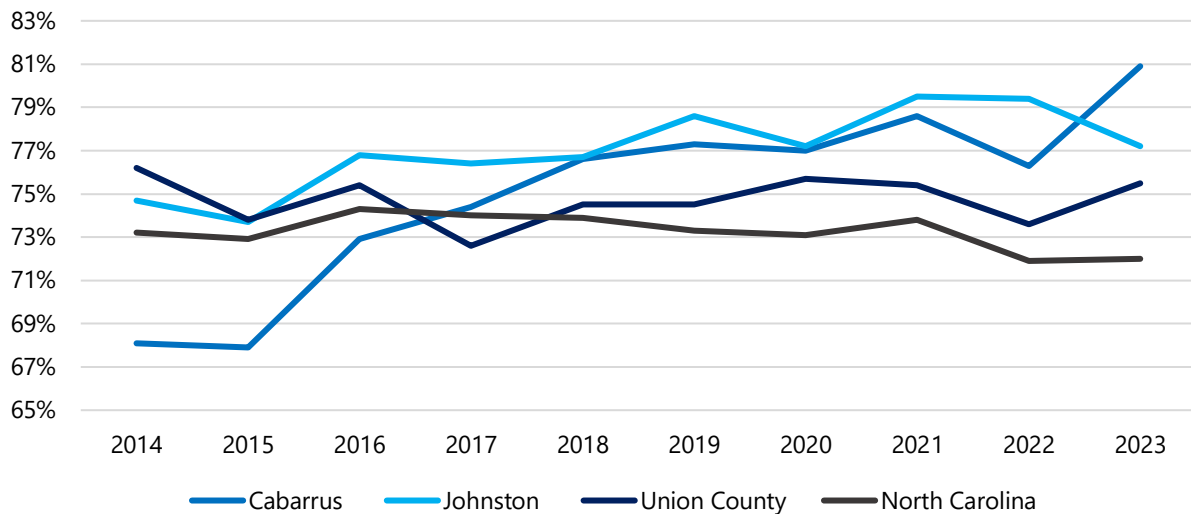
Data Source: Health Resources & Services Administration Area Health Resources Files (AHRF), 2025



## Prenatal Care

Prenatal care in the first trimester is a critical indicator of health because early care helps ensure healthier pregnancies and better outcomes for both mothers and babies. Early care allows healthcare providers to monitor development, address medical concerns, and offer timely education and support throughout pregnancy. Union County's rate of mothers receiving early prenatal care has remained steady, but slightly below that of neighboring Cabarrus and Johnston counties. The county saw moderate improvement over time, rising from approximately 74.7% in 2014 to 75.5% in 2023. North Carolina overall remained below county averages, fluctuating around 72% in 2023. Union County's data also show persistent disparities by race and ethnicity in early prenatal care access. While rates for White and multiracial mothers align with or slightly exceed state averages, Hispanic and American Indian/Alaska Native mothers receive prenatal care later and less often. Overall, Union County's rates remain lower than those of peer counties (NCDHHS, 2024a; NCDHHS, 2024b).

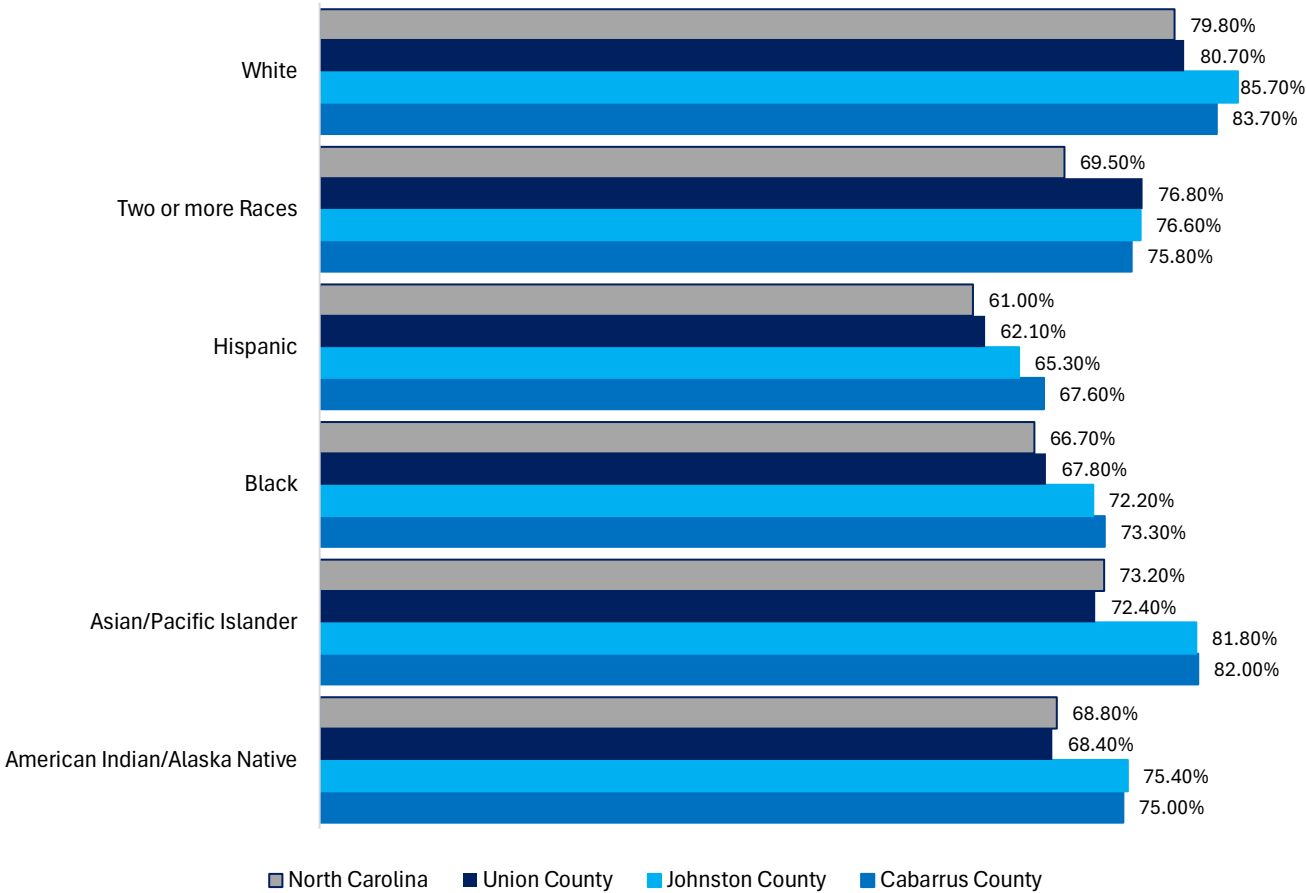
**Percent of births where mother received Prenatal Care in the 1st trimester, trending over time**



Data Source: NCDHHS, Division of Public Health, [Maternal and Infant Health Data Dashboard](#). Title V Office Analysis of 2014-2023 Birth Certificate data.



### Percent of Resident Births Where Mother Received Prenatal Care in the 1st Trimester by Race and Hispanic Origin, 2019-2023



Data Source: NCDHHS, Division of Public Health, [Maternal and Infant Health Data Dashboard](#). Title V Office Analysis of 2019-2023 Birth Certificate data

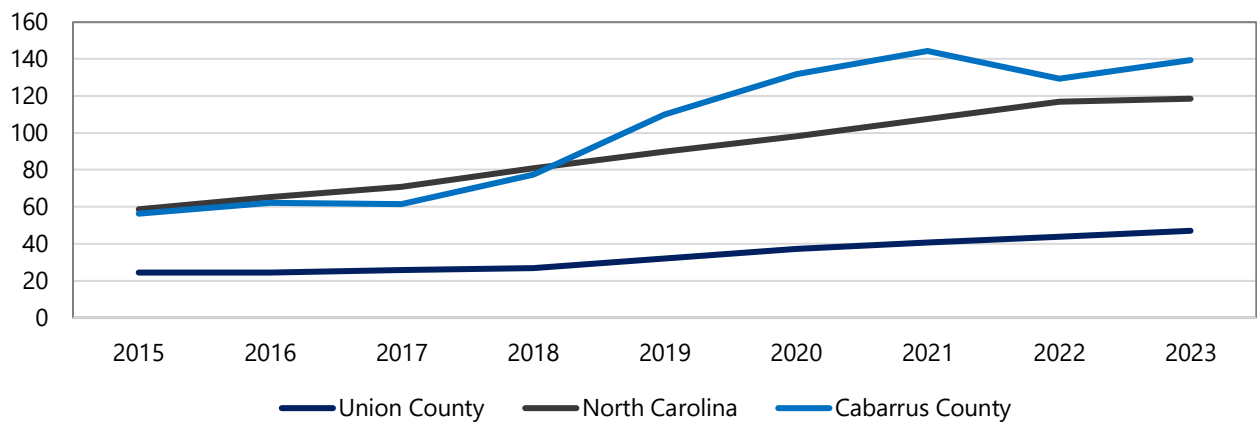


### Primary Care

Primary care providers, including physicians, nurse practitioners, and physician assistants, are unevenly distributed across Union County. While some areas appear adequately served, other communities experience much higher patient-to-clinician ratios. Approximately 6,000 residents face unmet primary care needs, limiting early detection and management of chronic

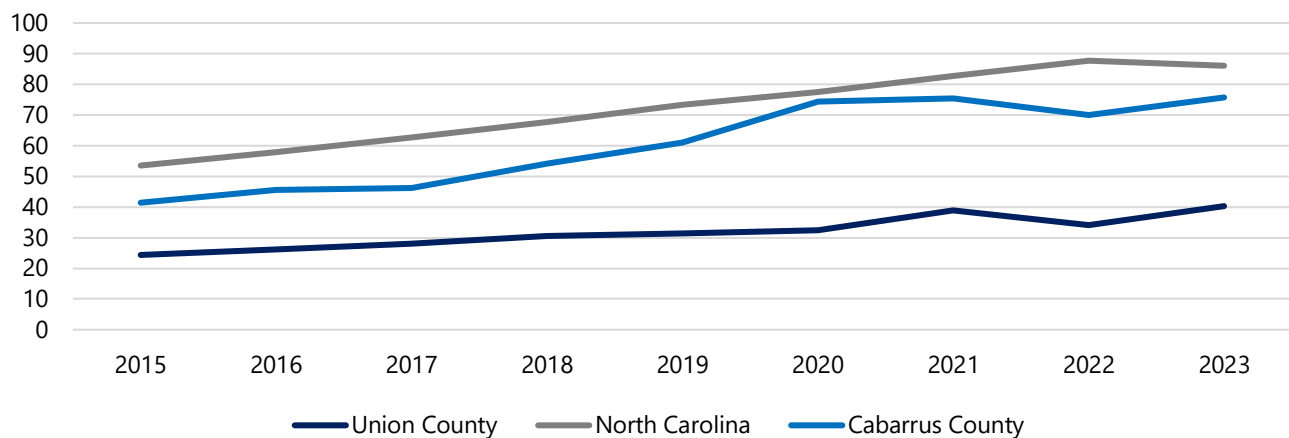
diseases such as diabetes, hypertension, and asthma. Despite increased demand for specialized providers, data also suggest shortages in certain fields, including optometry and other specialty services (County Health Rankings & Roadmaps, 2024; Health Resources and Services Administration [HRSA], 2024).

### Nurse Practitioners per 100,000 residents, trending over time



Data Source: Centers for Medicare & Medicaid Services (CMS), 2025

### Physician Assistants per 100,000 residents, trending over time



Data Source: Centers for Medicare & Medicaid Services (CMS), 2025

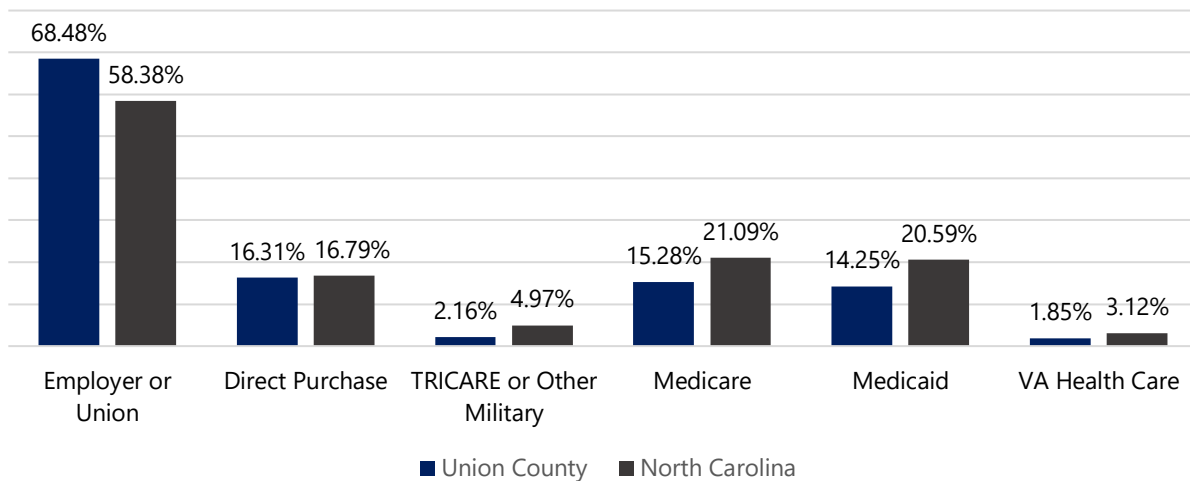


## Insurance Coverage

In Union County, 92.1% of residents are insured, compared to 89.6% statewide (U.S. Census Bureau, 2023). Of those insured, 83.0% have private coverage—such as employer-sponsored plans, direct-purchase plans, or military-related coverage—compared to 74.8% statewide. In contrast, 28.5% of residents rely on public insurance, compared with 39.4% statewide. Public coverage includes Medicare, Medicaid, VA Health Care, and the Children’s Health Insurance Program (CHIP) (U.S. Census Bureau, 2023).

Union County residents are more likely to have employer-based insurance (68.5%) than the North Carolina average (58.4%), reflecting higher local employment rates and household incomes. Direct-purchase coverage rates are similar between the county and state, but Union County shows lower reliance on Medicaid (14.3% vs. 20.6%) and Medicare (15.3% vs. 21.1%). Military-related coverage is also less common locally. Overall, the data indicate that Union County’s population relies more on employer-provided insurance and less on public or military coverage than the state (U.S. Census Bureau, 2023).

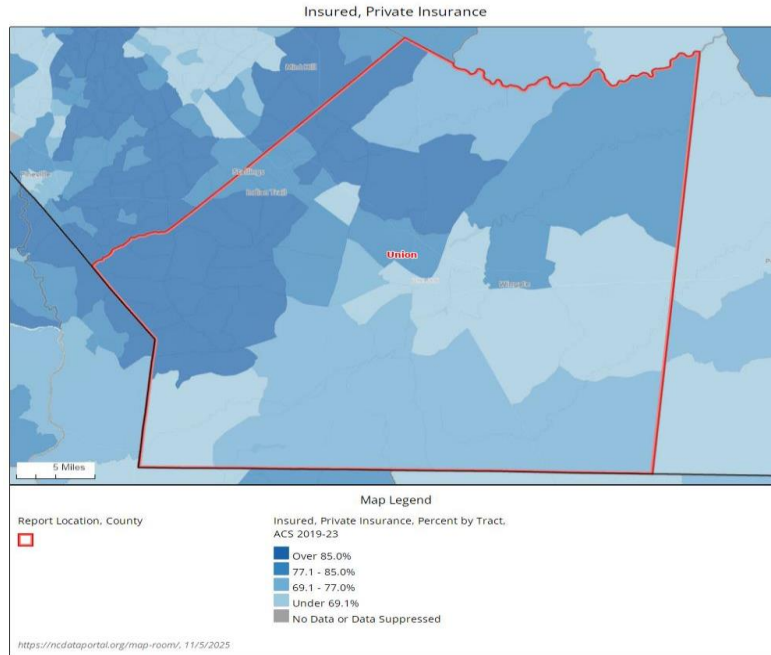
**Percent of Population with Insurance by Insurance Type, 2019-2023**



*Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023*

Private health insurance coverage varies significantly across municipalities. Weddington and Marvin report the highest coverage rates, at approximately 92.0% and 91.7%, respectively, while JAARS has the lowest rate at 37.2%. Other towns, including Indian Trail, Stallings, and Waxhaw, also report coverage rates above 81%, highlighting substantial geographic disparities across the county (U.S. Census Bureau, 2023).

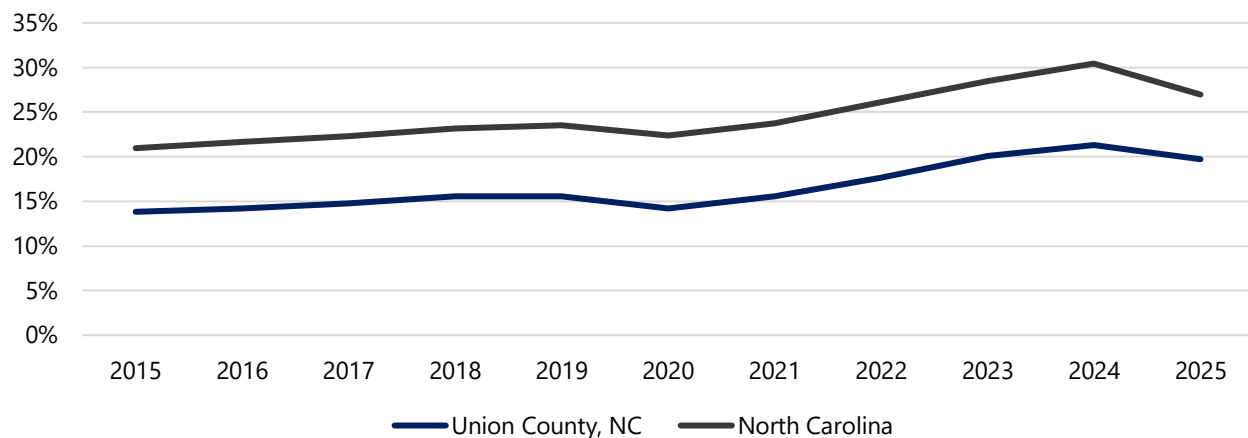




Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

Medicaid enrollment increased in both Union County and North Carolina from 2015 to 2025, with the state consistently maintaining a higher share of residents enrolled. Statewide enrollment rose from approximately 21% in 2015 to a peak of nearly 31% in 2024, then declined slightly in 2025. In Union County, enrollment increased from about 14% in 2015 to roughly 21% in 2024, then declined slightly. These trends likely reflect economic conditions, population changes, and the impact of Medicaid expansion (North Carolina Department of Health and Human Services, 2025).

### Percent of Medicaid Enrollment, 2015-2025

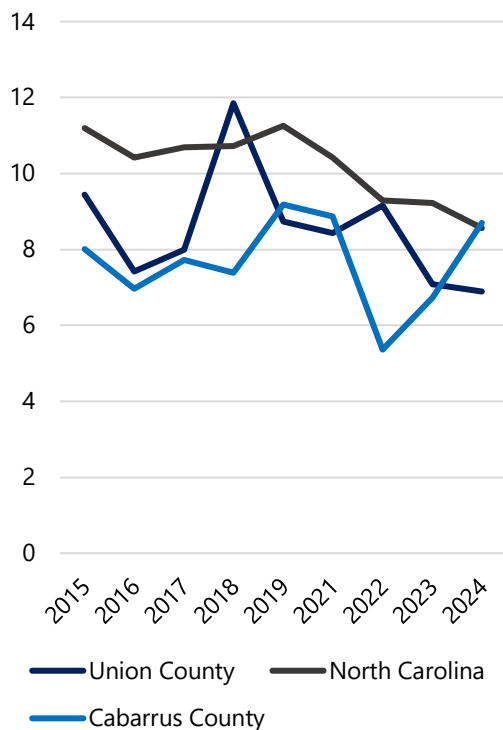


*North Carolina Medicaid Enrollment Reports, 2025*



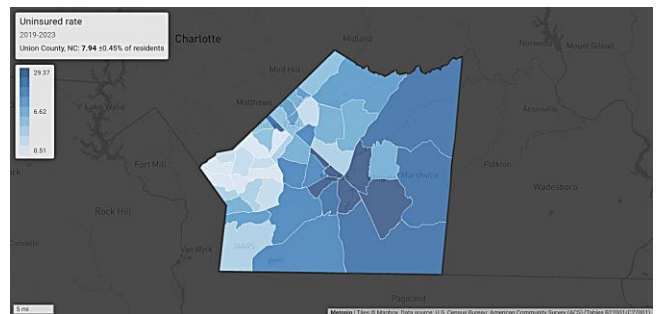
Medicaid coverage also varies across municipalities. Hemby Bridge and Marshville show relatively high enrollment rates at approximately 20.2% and 33.4%, respectively. Unionville (ZIP code 28110) and Monroe (ZIP code 28112) report rates above 19%, while Weddington has the lowest enrollment at approximately 3.9%, reflecting differences in income and eligibility across communities (NCDHHS, 2025).

### Percent of Uninsured residents, trending over time



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

Significant disparities persist across demographic and socioeconomic groups. Hispanic/Latino residents experience the highest uninsured rates in Union County, followed by non-Hispanic Black residents. Uninsured rates are highest among working-age adults ages 18–39 and 40–64, while children and adults age 65 and older have substantially lower rates due to Medicaid/CHIP and Medicare eligibility. Men are more likely to be uninsured than women, and income is a strong predictor of coverage status. Nearly one in five residents with incomes below \$25,000 lack health insurance, compared with just over 4% of those with incomes above \$100,000 (U.S. Census Bureau, 2023).



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

These coverage gaps limit access to preventive care, mental health services, and substance use treatment and are associated with delayed care and poorer health outcomes, underscoring the need for targeted outreach and enrollment efforts focused on lower-income, working-age, and historically marginalized populations (U.S. Census Bureau, 2023; Kaiser Family Foundation, 2024).



# Physical Environment

## Environmental Health

### Air and Water Quality

Clean air and safe water are essential for health. Poor air or water quality can be particularly detrimental to vulnerable populations, including young children, older adults, and individuals with chronic health conditions (U.S. Environmental Protection Agency [EPA], 2023; CDC, 2023).

#### Air Quality Index

The Air Quality Index (AQI) is a standardized measure used to report daily air quality and communicate how clean or polluted the air is, as well as the potential health effects associated with exposure to different pollutants (EPA, 2023). In North Carolina, the Division of Air Quality monitors a network of air quality stations in the Charlotte–Mecklenburg regional monitoring zone, which includes Union County, to track levels of ground-level ozone and particulate matter—two key pollutants in the Piedmont region (North Carolina Department of Environmental Quality [NCDEQ], 2024).

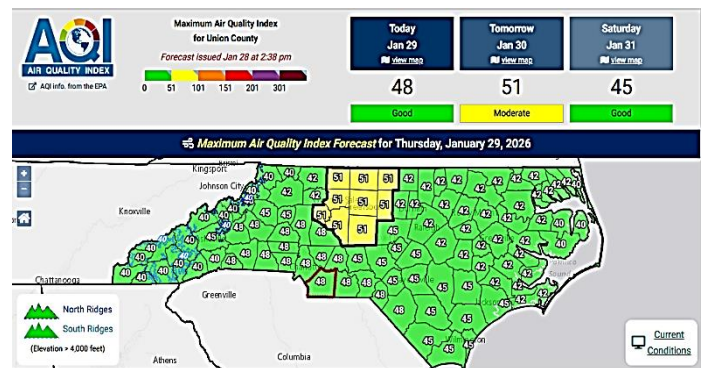
#### Why is the Air Quality Index important for community health?

While stratospheric ozone helps protect the Earth from harmful ultraviolet radiation, ground-level ozone is a harmful air pollutant. It forms through chemical reactions between pollutants in the presence of sunlight. Common sources include emissions from industrial facilities and power plants, motor vehicle exhaust, gasoline vapor, and chemical solvents (EPA, 2023).

Breathing ground-level ozone can harm health, particularly among children, older adults, and individuals with asthma or other lung diseases (CDC, 2023; EPA, 2023). Particulate matter—tiny particles or droplets in the air—can also harm the heart and lungs when inhaled, contributing to respiratory and cardiovascular problems (EPA, 2023).

Union County experiences occasional high-ozone days during the ozone season (March 1 to October 31), although overall regional air quality has generally improved over time due to emission reductions and regulatory efforts (NCDEQ, 2024; EPA, 2023)

#### Air Quality Index: Union County, North Carolina



Data Source: United States Environmental Protection Agency, 2026.



## Toxic Release Inventory

The Toxic Release Inventory (TRI) tracks the management of toxic chemicals in the environment. Designated industrial facilities are required by law to report annually on the handling, storage, disposal, or recycling of certain toxic chemicals. In Union County, there are 19 TRI facilities, and North Carolina ranks 13th (out of 56 states and territories) for the highest toxic releases per square mile (U.S. Environmental Protection Agency [EPA], 2024).

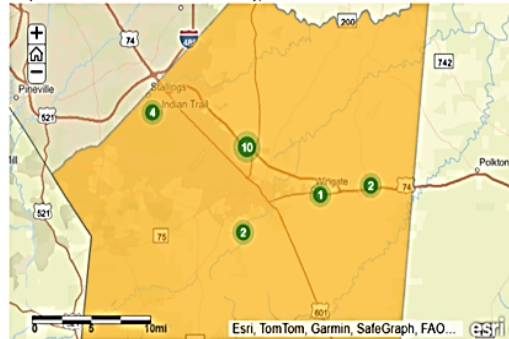
### Toxic Release Inventory: Union County

#### 2023 TRI Factsheet: County – Union, NC

Data Source: 2024 Dataset (released November 2025)

The Toxics Release Inventory (TRI) tracks the management of certain toxic chemicals that may pose a threat to human health and the environment. Certain industrial facilities in the U.S. must report annually how much of each chemical is recycled, combusted for energy recovery, treated for destruction, and disposed of or otherwise released on- and off-site. This information is collectively referred to as production-related waste managed.

Map of TRI Facilities in Union County, NC



North Carolina ranks 13 out of 56 states/territories nationwide based on total releases per square mile (Rank 1 = highest releases)

Quick Facts for 2023

	Union County, NC	United States
<b>Number of TRI Facilities:</b>	19	21,870
<b>Total Production-Related Waste Managed:</b>	881.3 thousand lbs	35.0 billion lbs
<b>Total On-site and Off-site Disposal or Other Releases:</b>	46.1 thousand lbs	3.4 billion lbs
<b>Total On-site:</b>	28.3 thousand lbs	2.9 billion lbs
• Air:	28.3 thousand lbs	522.9 million lbs
• Water:	23 lbs	187.0 million lbs
• Land:	0 lbs	2.2 billion lbs
<b>Total Off-Site:</b>	17.8 thousand lbs	419.9 million lbs

Looking at production-related waste managed over time helps track progress in reducing waste generated and moving toward safer waste management methods. EPA encourages facilities to first eliminate waste at its source (source reduction). For waste that is generated, the preferred management method is recycling, followed by energy recovery, treatment, and as a last resort, disposing of or otherwise releasing the waste. Under the Pollution Prevention Act of 1990, TRI collects information to track industry progress in reducing waste generation and moving towards safer waste management alternatives. Learn more about Pollution Prevention and TRI.

Data Source: U.S. Environmental Protection Agency, 2024.

## Community Water Systems

Union County's public water system provides drinking water services to nearly 60,000 customer accounts and wholesale water to the City of Monroe and the Town of Wingate. The County provides wastewater service to approximately 43,000 customers, including wholesale service to the Town of Wingate and a portion of the Town of Marshville. [Union County Public Water's 2025 Annual Drinking Water Quality Report](#) is available on its website (Union County Public Works, 2025).

While the County is the largest water and wastewater provider in Union County, the service area does not include the entire county. The City of Monroe supplies water to customers within its jurisdiction. The water used by the City of Monroe comes from several sources, primarily the Monroe lakes, with an intermittent supply from the Catawba River located in Lancaster County, South Carolina. These sources include Lake Twitty, Lake Lee, and Lake Monroe. The City of Monroe's 2024 Water Quality Report is publicly available (City of Monroe, 2024).



### Per- and Polyfluoroalkyl Substances (PFAS) in Drinking Water

In April 2024, the U.S. Environmental Protection Agency (EPA) established enforceable limits on six PFAS compounds—PFOA, PFOS, PFHxS, PFNA, PFBS, and GenX—in public water systems. These regulations require continuous monitoring and public notification when PFAS levels exceed established standards (EPA, 2024).

In response, the North Carolina Department of Environmental Quality (DEQ) has proposed state-specific standards to complement federal regulations. In September 2024, the DEQ presented revised proposals to the Environmental Management Commission (EMC) for groundwater standards targeting three PFAS compounds: PFOA, PFOS, and GenX. These proposed standards aim to reduce PFAS contamination at the source, thereby protecting public health and minimizing treatment costs for drinking water systems (North Carolina Department of Environmental Quality [NCDEQ], 2024).

Union County, North Carolina, is actively addressing the presence of per- and polyfluoroalkyl substances (PFAS) in drinking water. Residents are encouraged to stay informed about their water quality and consult local health officials for guidance on reducing PFAS exposure. The county's Environmental Health department offers resources and testing services for private wells to ensure safe drinking water (Union County Environmental Health, 2025).

### Private Drinking Water Wells

In 2006, the North Carolina General Assembly enacted legislation (S.L. 2006-202) directing the Emergency Management Commission to adopt rules governing the permitting and inspection of drinking water wells. The North Carolina Commission for Public Health was directed to adopt rules governing the sampling and testing of water from private drinking water wells. The North Carolina Safe Drinking Water from Wells Act was passed in 2008. Standards are now in place for well permitting and inspection, construction, and water quality sampling (North Carolina General Assembly, 2008).

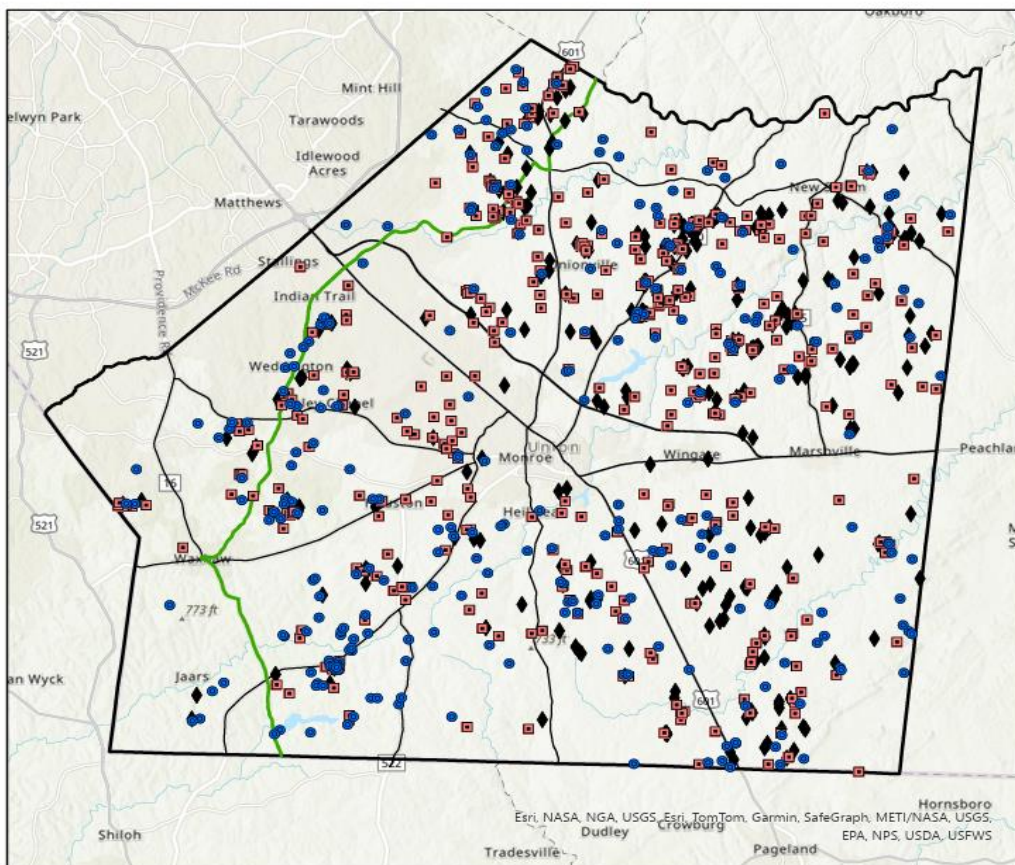
State law requires a minimum level of water quality sampling for newly constructed wells, including bacteriological testing (coliforms and *E. coli*) and analysis of inorganic contaminants and nitrate/nitrite (N.C. Gen. Stat. §87-97). Since implementing these rules, Union County Environmental Health has collected thousands of well-water samples. Results indicate exceedances for several contaminants of concern. Environmental Health collects, analyzes, maps, and reports water quality data and provides well owners with educational information on wells, water treatment options, and the need for routine testing.



## Common Contaminants of Concern in Union County Wells

- Coliform: 32% (MCL present/absent)
- E. coli: 4.5% (present/absent)
- Arsenic: 22% (MCL: 0.010ppm)

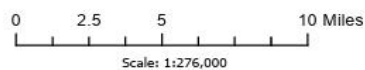
Most of Union County lies within the Carolina Slate Belt, where underlying metasedimentary and metavolcanic rock formations contain naturally occurring arsenic, iron, and manganese. Due to the prevalence of contaminants at or above maximum contaminant levels, treatment may be necessary for some private wells (North Carolina Geological Survey, 2022; Union County Environmental Health, 2025).



**Arsenic Concentrations in Private Wells**  
**Union County, NC**  
**August 2008 - May 2024**

### Arsenic Levels in Well Water

- Arsenic level 0.005 mg/L - 0.009 mg/L Below EPA MCL
- Arsenic level 0.010 mg/L - 0.029 mg/L Exceeds EPA MCL
- ◆ Arsenic level  $\geq 0.03$  mg/L Severely Exceeds MCL
- Carolina Slate Belt Dividing Line



### **Private Drinking Water Well Rehabilitation and Repair Program**

Union County Environmental Health's Pilot Private Drinking Water Well Rehabilitation and Repair Program was developed to help reduce public health impacts from elevated contaminants in well water. Recognizing and addressing concerns with drinking water wells can be expensive, and with approximately 25% of Union County residents obtaining their drinking water from wells, it is a critical public health issue. Applications were accepted from Union County residents who own and live in a residence with a private well and whose household income is less than 80 percent of the area median income. Program services include a well and site assessment, including the collection of panel water samples. Based on the assessment and sampling results, a weighted rating scale is used to assign a health risk rating to each well and determine possible remedies. Once work on the well is completed, follow-up water sampling is conducted to confirm the correction, and a final report is issued to the property owner. The report includes test results and helpful information on protecting the well from potential sources of contamination, routine water testing, and treatment system maintenance. The program, now expanded to include a partnership with Union-Anson Habitat for Humanity, is vital for identifying potential exposure to contaminants and taking protective action.

### **On-site Wastewater Dispersal Systems (OSWW)**

Approximately 35% of Union County residents use OSWW systems to treat wastewater from their homes and businesses. System age, poor maintenance, and complex soil and site conditions contribute to the increasing number of malfunctioning OSWW systems. Addressing these failing systems and their associated public health risks requires a heightened response from Environmental Health, including soil/site assessments, permit issuance, and, in some cases, legal enforcement actions. With escalating repair costs and limited public sewer accessibility, this trend will continue. To address urgent public health concerns about malfunctioning septic systems in Union County, Environmental Health implemented a pilot program to repair and replace them.

### **Septic System Repair Program**

The Union County Septic System Repair Program, which had been paused, resumed in 2024. Through the County's Community Development Block Grant (CDBG) initiative, the program provides financial assistance to low- and moderate-income homeowners to rehabilitate their septic systems, protecting public health and the environment, extending system longevity, and preserving property values.

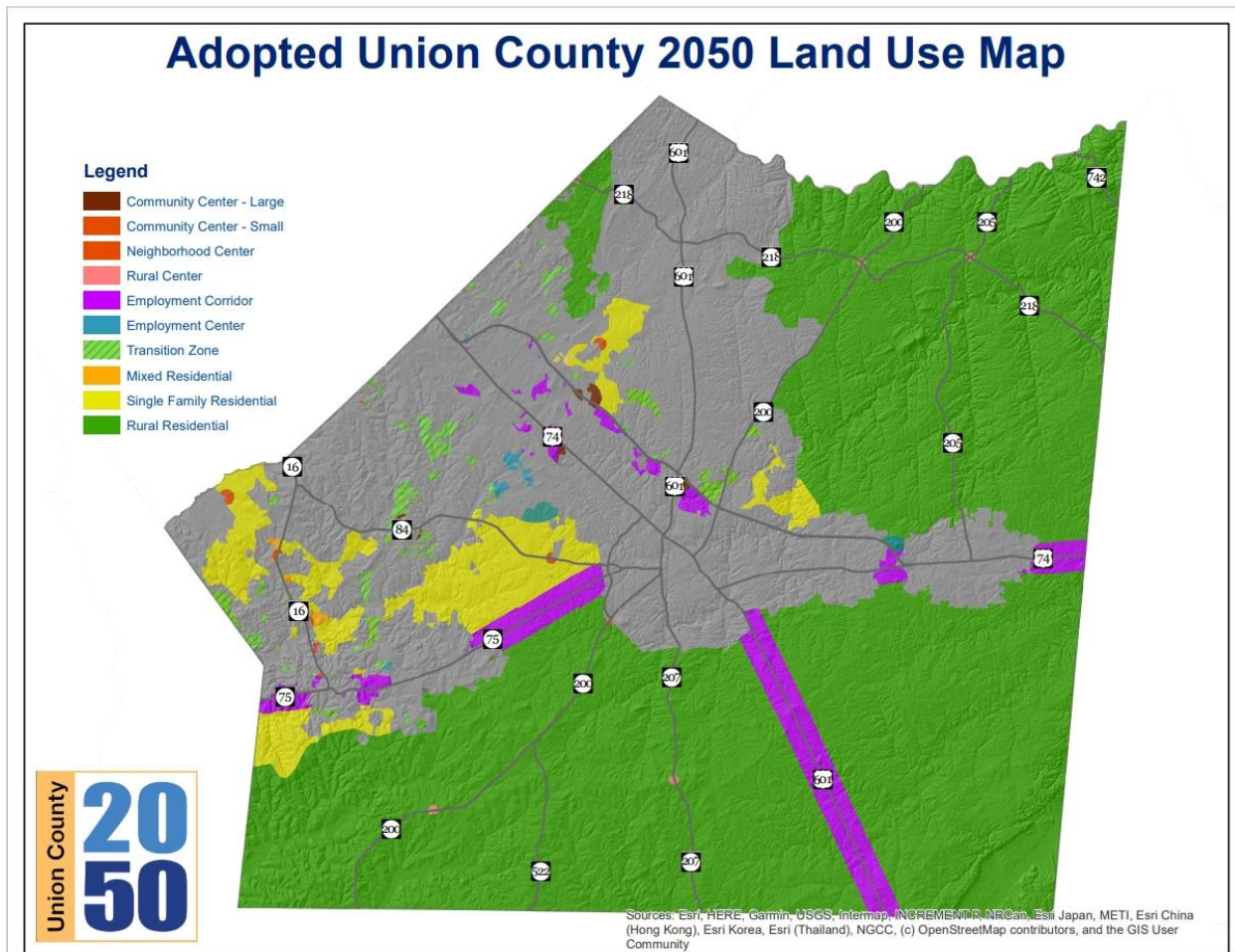


## Land-Use and Greenspace

### Union County Vision 2050

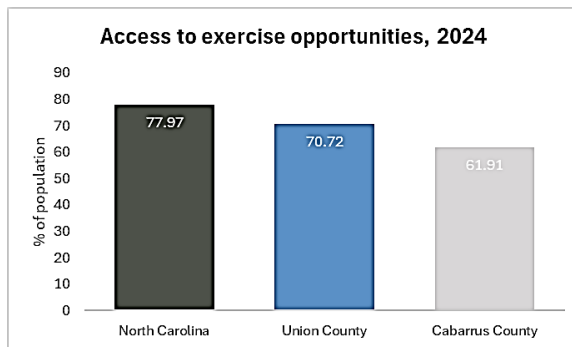
[Union County Vision 2050](#) is a comprehensive plan that guides growth, public health, safety, environmental protection, infrastructure, and economic development through 2050. The plan was developed through a citizen-led process with input from residents, business leaders, and stakeholders and includes recommendations for land use, stormwater management, and open space preservation (Union County Planning Department, 2022). Rural Land Use Plan Strategy Development

In 2024, the Union County Board of Commissioners directed the Planning Department to develop a rural land-use plan to provide additional guidance on appropriate development patterns and land-use strategies. This effort was recommended in the Vision 2050 comprehensive plan. A seven-member steering committee was appointed in 2024, and the plan is scheduled for completion in March 2026 (Union County Planning Department, 2025).



## Access to Exercise

Access to safe, convenient spaces for physical activity is an important contributor to overall health and the prevention of chronic disease. In 2024, approximately 70.7% of Union County residents lived within a reasonable distance of a location for physical activity. This is lower than the North Carolina average (78.0%) but higher than neighboring Cabarrus County (61.9%). Limited access to exercise opportunities can reduce physical activity levels and increase the risk of obesity, cardiovascular disease, and other chronic conditions (University of Wisconsin Population Health Institute [UWPHI], 2024).



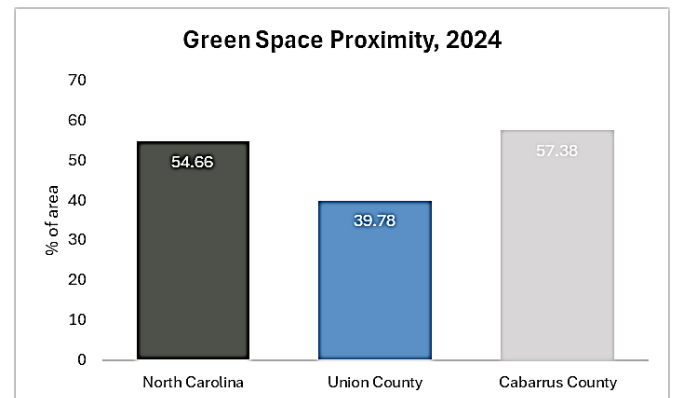
Data Source: University of Wisconsin Population Health Institute: County Health Rankings, 2024

Access to green space is also more limited in Union County compared to peer geographies.

In 2024, an estimated 39.8% of Union County's land area was within one mile of green space, compared to 54.7% statewide and 57.4% in Cabarrus County.

Reduced proximity to parks and natural spaces may limit opportunities for outdoor physical activity and has been associated with poorer physical and mental health outcomes, particularly in rural or lower-density communities (UWPHI, 2024).

Together, these indicators suggest that while many Union County residents have access to opportunities for physical activity, gaps remain—especially in the availability of green space. This highlights the importance of continued investment in parks, trails, and community-based physical activity infrastructure to support equitable access to healthy environments.

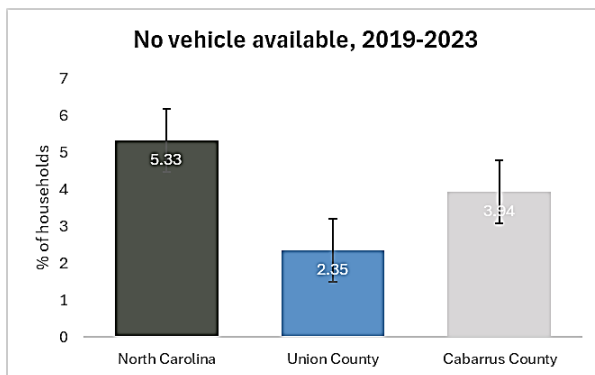


Data Source: University of Wisconsin Population Health Institute: County Health Rankings, 2024



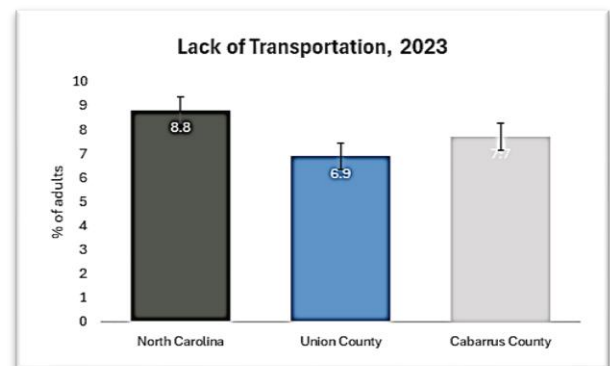
## Access to Transportation

Access to reliable transportation remains an important social determinant of health in Union County. Between 2019 and 2023, an estimated 2.4% of occupied households in Union County lacked a vehicle, a lower share than North Carolina overall (5.3%) and Cabarrus County (3.9%). While vehicle ownership rates are relatively high, the lack of a vehicle among some households remains a significant barrier to accessing employment, health care, food, and other essential services—particularly in a predominantly car-dependent county (U.S. Census Bureau, 2023).



Data Source: U.S. Census Bureau, American Community Survey, ACS 5-Year Estimates, 2019-2023

Self-reported transportation barriers further highlight access challenges. In 2022, 6.7% of adults in Union County reported that a lack of reliable transportation prevented them from attending medical appointments, work, or meetings, compared to 9.0% statewide. Although Union County's rate is lower than the state average, thousands of residents are still affected. These barriers disproportionately impact individuals with lower incomes, older adults, people with disabilities, and residents without consistent access to a personal vehicle. Limited access to transportation can delay preventive care, disrupt treatment continuity, and exacerbate existing health inequities (CDC, 2022).



Data Source: Centers for Disease Control and Prevention (CDC): PLACES 2022



## Primary Data

### Surveys

#### Methodology

Surveys are essential for collecting data from a specific population and analyzing trends, attitudes, or opinions through questionnaires or interviews. They can help identify health behaviors, mental health issues, and community needs within Union County. A subcommittee of the Central Carolina Community Collaborative developed the survey questions. Union County added questions to the survey to gather additional information about the community's health. The surveys were developed in English and translated into both Spanish and Russian. The survey instrument is included in Appendix A.

Convenience sampling was used for this survey, and participants were selected based on ease of access or availability. To engage the Union County Community, the survey was distributed from February through April 2025 to residents and promoted via social media, websites, community partners, and local events, both electronically and on paper when requested. Over 7,400 completed surveys were taken throughout the Central Carolina Community Collaborative footprint, and 784 surveys were taken locally. Another 200 surveys were partially completed in Union County but were excluded from the survey analysis. The data was then analyzed and compiled to understand the community's needs.

#### Data Limitations

The findings presented in this section reflect the responses of individuals who participated in the Union County Community Health Survey and may not fully represent the experiences of all residents. Although survey responses were weighted to reflect county-level demographic characteristics better, the results remain subject to limitations inherent in survey-based data, including self-report and nonresponse bias.

Subgroup analyses by race/ethnicity, income, gender, and municipality were conducted where sample sizes permitted and are presented descriptively. In accordance with NC DHHS Community Health Assessment guidance, results for groups with small sample sizes were interpreted cautiously, and some estimates may not capture the full range of experiences within smaller populations. Municipality-level findings reflect respondent perceptions and may be influenced by uneven response distribution across geographic areas.

Primary data findings should be interpreted alongside population-based secondary data sources to provide a more complete and accurate understanding of community health needs and disparities in Union County.



## Demographics

The demographics of survey participants differed from those of the community.

Compared to their proportion in the total population of Union County:

- Older adults (65+) are substantially over-represented in the survey (33% vs ~13% in the general population), and this likely reflects higher engagement among retirees and older residents.
- White residents are over-represented, even after weighting, while Latino/a residents are under-represented (6% vs 13% countywide). Black representation is slightly lower but closer to ACS proportions. Asian representation aligns closely. Community needs and barriers affecting Latino/a residents—including

language access, affordability, and immigration-related concerns—are likely under-captured.

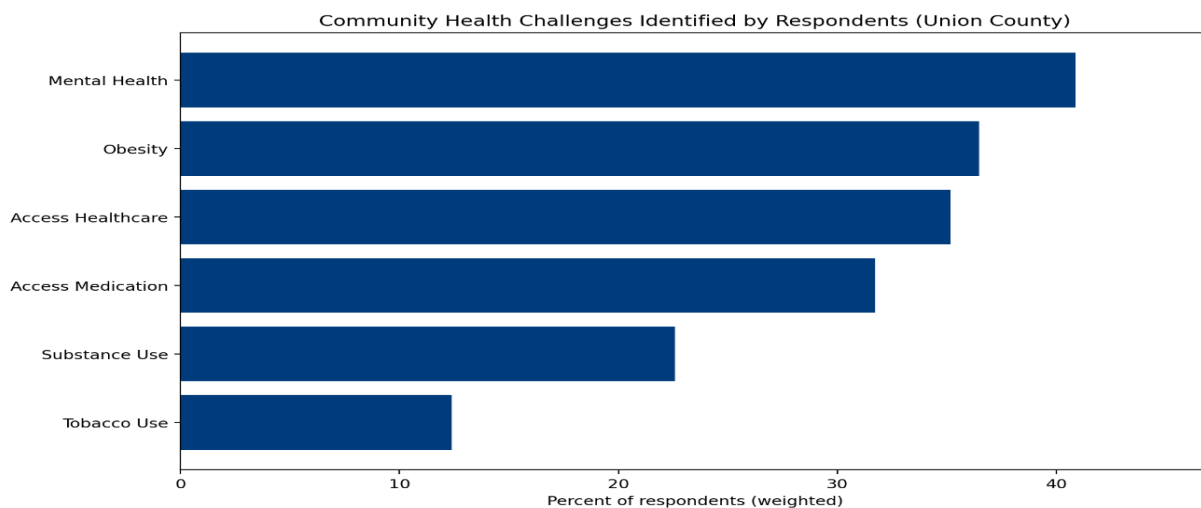
- College-educated respondents are more prevalent than in the general population, whereas Lower educational attainment groups are under-represented. Survey results may underestimate challenges related to health literacy, workforce access, and navigation of social services.
- Survey respondents are generally more affluent than the overall county population.

Economic stressors such as housing insecurity, food access, and affordability of care may be understated in survey findings.

## Results

### Most Important Health-Related Challenges in the Community

When asked to identify the three most important health-related challenges facing their community, Union County respondents most frequently selected mental health issues, access to health care, obesity, and access to affordable medication. These findings underscore the combined influence of behavioral health needs, chronic disease burden, and access to care on community health.



Notable variation was observed across racial and ethnic groups, income levels, age, and geographic locations, though findings should be interpreted cautiously for groups with smaller sample sizes.

- Mental health issues were consistently identified as a top concern among Asian (42.6%), Black (43.6%), and White (42.4%) respondents, but were selected less frequently by Latino/a respondents (20.9%), suggesting differing prioritization or perceptions of community health challenges.
- Access to health care emerged as a particularly prominent concern among Asian respondents (69.0%) and was also frequently identified by Latino/a respondents (42.4%), indicating heightened concern about availability, affordability, or navigation of services within these communities.
- Access to affordable medication was reported at similar levels among Asian (40.8%), Black (43.4%), and Latino/a (40.1%) respondents, compared to a lower proportion among White respondents (29.4%), pointing to disparities in medication affordability and coverage.
- Obesity was more frequently identified by White (38.3%), Latino/a (36.5%), and Black (33.9%) respondents than by Asian respondents (4.8%), aligning with patterns observed in secondary data on chronic disease risk.
- Substance use was more commonly identified by White (24.9%) and Latino/a (22.3%) respondents, compared to lower proportions among Black (11.7%) and Asian (11.9%) respondents.
- Cancers were identified at notably higher levels among Asian respondents (54.5%) compared to other groups, suggesting differing perceptions of disease burden or risk within this population.

### **Personal Health Concerns**

When asked to identify personal health concerns affecting themselves or their household, Union County respondents most frequently selected cancer, obesity, high blood pressure, diabetes, and Alzheimer's disease/dementia. These findings highlight the substantial burden of chronic disease, age-related conditions, and preventive care needs among county residents.



# Rating Personal Health

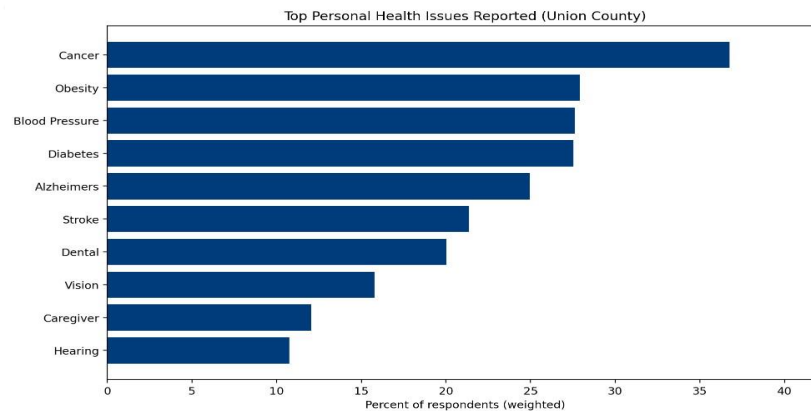


Figure 1. Self-rated health status among Union County respondents.

Figure 1. Top personal health issues reported by Union County respondents.  
*Note: Results are weighted. Responses reflect self-reported conditions.*

Reported personal health concerns varied across racial and ethnic groups, income, age, and place, though findings should be interpreted cautiously due to small subgroup sizes.

- Asian respondents most frequently reported dental health concerns, cancer, obesity, diabetes, and stroke or heart disease, suggesting a combination of chronic disease burden and unmet preventive or oral health needs.
- Black respondents were more likely to report high blood pressure, dental health concerns, diabetes, and cancer, aligning with well-documented disparities in cardiovascular risk and chronic disease prevalence.
- Latino/a respondents reported especially high levels of diabetes, obesity, Alzheimer’s disease or dementia, and cancer, highlighting the importance of chronic disease prevention, early detection, and culturally responsive education and outreach. Among
- White respondents, cancer, high blood pressure, Alzheimer’s disease or dementia, obesity, and stroke or heart disease were most frequently reported, reflecting the influence of an aging population and the growing impact of age-related and chronic conditions in Union County.
- Lower-income respondents were more likely to report personal health concerns related to chronic disease and unmet preventive care, including diabetes, high blood pressure, obesity, and dental health issues. These patterns suggest that financial barriers, limited access to preventive services, and challenges managing chronic conditions may disproportionately affect lower-income households.



- Middle-income respondents also reported high levels of chronic conditions, while additionally expressing concern about conditions that can interfere with daily functioning, such as caregiver stress and vision or hearing issues.
- Higher-income respondents more frequently reported age-related conditions, including cancer and Alzheimer’s disease or dementia, reflecting both longer life expectancy and increased awareness or diagnosis of chronic and cognitive conditions.
- Younger adults were more likely to report concerns related to obesity, diabetes, and dental health, highlighting opportunities for early prevention and risk reduction.
- Middle-aged adults frequently report high blood pressure, diabetes, cancer, and caregiver stress, reflecting the combined impact of chronic disease risk and caregiving responsibilities.
- Older adults were more likely to report cancer, Alzheimer’s disease or dementia, stroke or heart disease, vision and hearing issues, and fall-related concerns, underscoring the need for services focused on aging, chronic disease management, and caregiver support.
- More rural or outlying municipalities showed higher reporting of chronic disease-related concerns, such as diabetes, high blood pressure, and heart disease, which may reflect barriers to preventive care and disease management.
- More suburban or higher-growth municipalities reported higher levels of cancer, obesity, and caregiver stress, potentially associated with population aging and family caregiving demands.
- Municipalities with larger older adult populations were more likely to report Alzheimer’s disease or dementia, sensory impairments, and fall-related concerns, highlighting the importance of age-friendly services and support.

### Most Important Community Issues

When asked to identify the three most important community issues, Union County respondents most frequently selected affordable and safe housing, access to affordable, healthy food, aging-related issues, and transportation. These findings highlight the central role of social and structural determinants of health in shaping community well-being.

### What are Most Important Community Issues

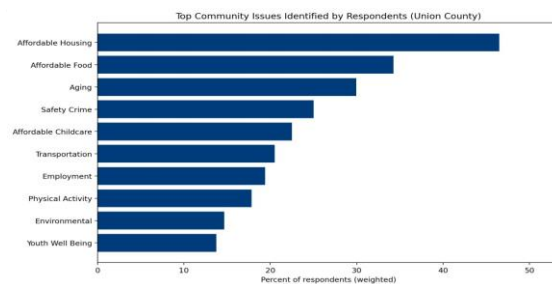


Figure 11. Top community health priorities identified by respondents.

Figure 8. Top community issues identified by Union County respondents.  
 Note: Results are weighted. Multiple responses were allowed.



Community priorities varied across racial and ethnic groups, income levels, age groups, and geographic locations, though findings should be interpreted cautiously given the small sample sizes for some groups.

- Affordable and safe housing emerged as a leading community concern, particularly among Black, Latino/a, and White respondents, indicating widespread challenges related to housing affordability and stability.
- Access to affordable healthy food was reported more frequently by Black and Latino/a respondents than by White respondents, suggesting disproportionate food access concerns among communities of color.
- Transportation was identified as a particularly prominent issue among Asian respondents and was also frequently cited by Latino/a respondents, highlighting mobility and access challenges that can affect employment, health care, and daily activities. Issues related to aging were most often identified by Asian and White respondents, reflecting concerns related to older adult services, caregiving, and age-friendly infrastructure.
- Safety or crime was reported more frequently by White and Black respondents than by Latino/a respondents. At the same time, racism or other discrimination was selected at substantially higher levels by Black and Latino/a respondents, indicating important differences in lived experience and perceived community challenges.
- Environmental health concerns were reported less frequently overall but were more commonly identified by White respondents compared to other groups.
- Lower-income respondents were more likely to identify affordable and safe housing, access to affordable, healthy food, transportation, and access to childcare as top community issues. These concerns point to challenges related to daily stability and access to essential services.
- Middle-income respondents more frequently identified access to employment opportunities, child and youth well-being, and safety or crime, suggesting a focus on economic mobility, family support, and neighborhood conditions.
- In contrast, higher-income respondents were more likely to prioritize issues related to aging, environmental health, and access to physical activity opportunities, reflecting greater emphasis on quality-of-life considerations and long-term health and environmental conditions.
- Younger adults were more likely to identify affordable housing, childcare, employment opportunities, and transportation as key issues, aligning with challenges related to workforce participation, family formation, and housing affordability
- Middle-aged adults frequently select access to affordable and healthy food, child and youth well-being, safety or crime, and transportation, reflecting the competing demands of caregiving, employment, and household management.



- Older adults were more likely to prioritize issues related to aging, access to social support and engagement, environmental health, and transportation, underscoring the importance of aging-friendly communities, mobility, and opportunities for social connection.
- More rural or outlying municipalities showed higher concern for transportation, access to employment opportunities, and access to affordable, healthy food, suggesting geographic barriers related to distance, infrastructure, and service availability.
- More suburban or higher-growth municipalities more frequently identified affordable and safe housing, access to childcare, and safety or crime, reflecting pressures associated with population growth, rising housing costs, and increased demand for family services.
- Municipalities with older populations were more likely to report concerns related to aging, environmental health, and access to social support and engagement, highlighting the need for age-friendly planning and community-based support.

### **Social and Emotional Support and Loneliness**

Survey responses indicate mixed levels of social and emotional support among Union County residents, alongside notable experiences of loneliness. While most respondents reported having enough social and emotional support always (26.9%) or usually (39.7%), approximately one in three residents reported having it only sometimes, rarely, or never. This suggests that a substantial portion of the population may lack consistent emotional or social resources, which can negatively affect mental health and overall well-being.

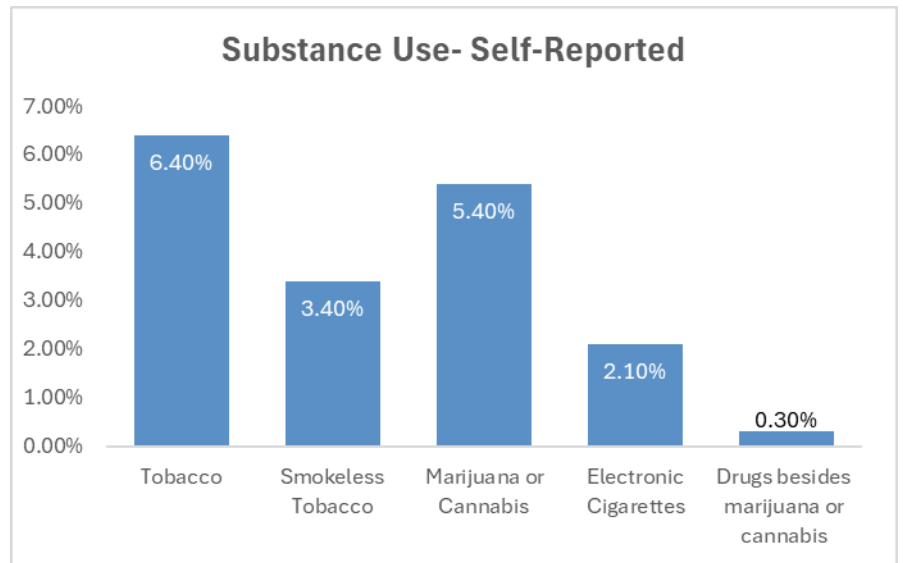
Feelings of loneliness were also common. Although a quarter of respondents reported never feeling lonely (25.3%), and a small proportion reported feeling lonely always or usually (4.6%), the majority reported feeling lonely sometimes (32.3%) or rarely (36.5%). Together, these findings suggest that while persistent loneliness affects a smaller share of residents, intermittent loneliness is widespread.

Experiences of social and emotional support and loneliness varied by age, income, and demographic characteristics. Younger adults more commonly reported experiencing loneliness intermittently, while older adults were more likely to report a lack of consistent social and emotional support. Lower-income respondents were more likely to report limited social support and higher levels of loneliness, reflecting broader social and economic stressors. Differences by race and ethnicity suggest that communities of color may face greater challenges in social connection, though findings should be interpreted cautiously, given the small subgroup.



### Substance Use

Self-reported substance use among Union County respondents was most related to tobacco and marijuana/cannabis. In contrast, use of electronic cigarettes, smokeless tobacco, and other drugs was reported at lower levels. Although the overall reported prevalence was modest, these findings should be interpreted cautiously, as self-reporting may underestimate use due to stigma or nonresponse.



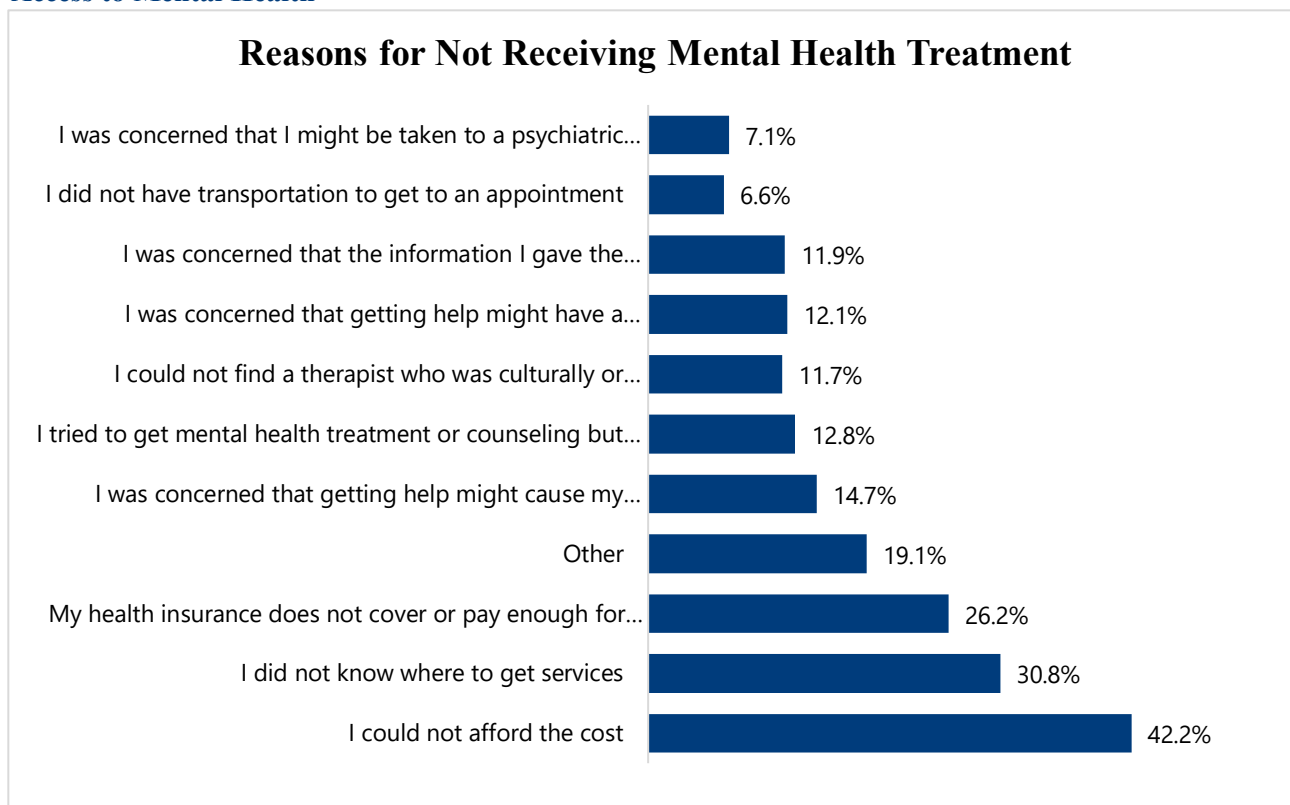
Patterns in self-reported substance use varied by household income, age, and geography, reflecting differences in exposure, access, and life stage. Lower-income respondents were more likely to report use of tobacco and marijuana/cannabis, which may reflect higher exposure to stressors and fewer resources for prevention and cessation. Middle-income respondents also reported tobacco and marijuana use, though at lower levels, suggesting that substance use is present across economic groups. Higher-income respondents were less likely to report substance use overall, particularly for tobacco products.

Differences were also observed by age group. Younger adults were more likely to report marijuana/cannabis and electronic cigarette use, consistent with broader state and national trends. Middle-aged adults more frequently reported tobacco and smokeless tobacco use, while older adults reported lower overall substance use, with tobacco remaining the most reported substance in this group.

Geographic patterns indicate that substance use was reported across municipalities, though prevalence and substance type varied by location. More rural or outlying areas more often reported tobacco and smokeless tobacco use, while more suburban or higher-growth municipalities reported higher levels of marijuana/cannabis and electronic cigarette use.



## Access to Mental Health



Approximately one-quarter of respondents reported needing mental health treatment within the past year. Among Union County respondents who reported needing mental health treatment but not receiving it, the most frequently cited barriers were cost, insurance coverage limitations, and lack of information about where to obtain services, indicating that financial and system navigation challenges are the primary obstacles to care. More than one-third of respondents reported being unable to afford the cost of treatment, and nearly one-third indicated that their health insurance did not cover or adequately pay for mental health services. A smaller but meaningful share reported not knowing where to seek services, highlighting gaps in awareness and referral pathways.

Barriers varied across racial and ethnic groups, income levels, age groups, and geographic locations, though findings should be interpreted cautiously given the small subgroup sizes.

- Latino/a respondents were particularly likely to report cost barriers, difficulty knowing where to obtain services, and challenges finding culturally or disability-competent providers, suggesting a need for more affordable, culturally responsive, and navigable mental health services.
- Black respondents more frequently selected insurance limitations and “other” reasons, which may reflect experiences not fully captured by predefined response options.
- White respondents were more likely to report insurance barriers, waitlists, and concerns related to stigma, privacy, employment impacts, or



potential hospitalization, indicating both system capacity issues and perceived risks associated with seeking care. Transportation barriers were reported infrequently overall, but appeared in limited cases, underscoring access challenges for some individuals.

- Lower-income respondents were more likely to report cost-related barriers, including inability to afford treatment and insurance coverage that does not adequately cover mental health services. A lack of information about where to obtain services also emerged more frequently among lower-income respondents, suggesting challenges with navigating the system in addition to affordability.
- Middle-income respondents reported a mix of financial barriers and system capacity issues, including waitlists and difficulty securing appointments.
- Higher-income respondents were less likely to cite cost as the primary barrier, but more frequently reported insurance limitations, waitlists, and concerns related to stigma, privacy, or potential negative consequences, indicating that access challenges persist even when financial barriers are reduced.
- Younger adults were more likely to report not knowing where to get services and concerns related to cost or insurance coverage, suggesting gaps in awareness and affordability early in the care-seeking process.
- Middle-aged adults more frequently cited insurance limitations, waitlists, and concerns about the impact of seeking treatment on employment, reflecting competing work and family responsibilities and fear of workplace consequences.
- Older adults were more likely to report difficulty finding appropriate providers, including concerns related to provider availability, cultural or disability competence, and worries about medication or hospitalization, highlighting access and suitability challenges within the mental health system for older residents.
- More rural or outlying municipalities showed greater emphasis on transportation barriers, limited provider availability, and lack of information about where to obtain services, suggesting challenges related to distance, service concentration, and infrastructure.
- More suburban or higher-growth municipalities more frequently reported insurance-related barriers, waitlists, and concerns about privacy or stigma, reflecting capacity constraints in a growing service system and heightened concern about confidentiality.
- Municipalities with older populations were more likely to report barriers related to finding appropriate providers and concerns about treatment approaches, reinforcing the need for age-responsive and accessible mental health services.



## Delayed or Avoided Health Care

Most respondents reported having health insurance and a usual source of care; however, approximately one in five Union County respondents (20.7%) reported delaying or avoiding needed health care, while the majority (77.5%) reported no delay. This indicates that although most residents can access care when needed, a substantial minority still face barriers that prevent timely use of health services.

Among respondents who delayed care, the most frequently cited reasons were cost of services (39.1%), wait times for appointments (28.3%), and inconvenient hours (24.1%), highlighting the combined impact of affordability, system capacity, and scheduling constraints. Nearly one-quarter of respondents selected “other” reasons, suggesting that additional barriers not fully captured by predefined categories may also affect access. affordability, waiting times, and transportation remained significant barriers for many residents.

### Access to Care

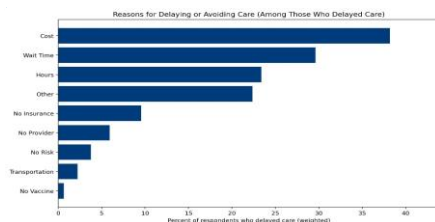


Figure 7. Reasons for delaying or avoiding medical care.

Figure 5. Reasons for delaying or avoiding medical care among respondents who reported delayed care.  
Note: Results are weighted and limited to respondents reporting delayed or avoided care.

Patterns in reasons for delayed care varied across racial and ethnic groups, income, age, and geographic location, though findings should be interpreted cautiously due to small subgroup sizes.

- Latino/a respondents were especially likely to report cost-related barriers and lack of insurance, indicating disproportionate financial and coverage-related obstacles to care. They were also more likely than other groups to cite transportation barriers, suggesting compounded access challenges.
- Black respondents more frequently identified wait times for appointments, cost, and lack of provider availability, pointing to system capacity constraints and provider access issues.
- White respondents most often reported cost, wait times, and inconvenient hours, reflecting both affordability challenges and difficulties accessing care within available service hours.
- Responses among Asian respondents were limited and should not be generalized; however, these results underscore the importance of cautious interpretation for small samples.
- Lower-income respondents were more likely to cite the cost of services and lack of insurance as primary reasons for delaying care. These findings suggest that financial barriers and coverage gaps remain significant obstacles to timely access.



- Middle-income respondents reported a mix of financial barriers and system-level challenges, including waiting times for appointments and inconvenient hours, indicating that affordability and service availability both affect access for this group.
- Higher-income respondents were less likely to report insurance-related barriers but more frequently cited wait times, inconvenient hours, and other system constraints, suggesting that capacity and scheduling issues limit access even when financial barriers are reduced.
- Younger adults were more likely to report delaying care due to cost, lack of insurance, or uncertainty about perceived risk, reflecting lower coverage rates and competing financial priorities.
- Middle-aged adults frequently cited wait times, inconvenient hours, and work-related scheduling conflicts, consistent with balancing employment and family responsibilities.
- Older adults were more likely to report challenges related to provider availability and appointment accessibility, including difficulty securing timely care, highlighting the importance of provider capacity and age-responsive services for an aging population.
- More rural or outlying municipalities showed greater emphasis on transportation barriers, provider shortages, and longer travel distances to care, which can delay timely access.
- More suburban or higher-growth municipalities more frequently reported wait times for appointments and inconvenient hours, reflecting demand pressures on local health care systems.

These patterns suggest that both geographic isolation and capacity constraints in the health care system contribute to delayed care across different parts of the county.

### **Access to Affordable Housing**

Survey responses indicate widespread concern about housing affordability in Union County. Fewer than one in five respondents agreed or strongly agreed (19.9%) that there are affordable places to live in their community, while a majority disagreed or strongly disagreed (53.8%). Nearly one-quarter of respondents (23.1%) selected neither agree nor disagree, suggesting uncertainty or mixed experiences with local housing conditions.

These findings suggest that many residents perceive a lack of affordable housing options, which may contribute to housing instability and increased financial stress. Perceptions of limited housing affordability are consistent with other survey findings identifying affordable and safe housing as one of the most important community issues. Together, these results highlight housing affordability as a key social determinant of health affecting Union County residents.



Perceptions of housing affordability varied by household income, age, and geography.

- Lower-income respondents were more likely to disagree that affordable places to live are available in their community, reflecting greater exposure to housing cost burden and limited housing options.
- Middle-income respondents also expressed concern, suggesting that rising housing costs affect a broad range of households, not only those with the lowest incomes
- Higher-income respondents were somewhat more likely to agree or remain neutral, though many still expressed concern about affordability, indicating countywide pressure on the housing market.
- Younger adults were more likely to report difficulty finding affordable housing, consistent with challenges related to entering the housing market, rising rents, and home prices.
- Middle-aged adults frequently express concern about affordability as it relates to family housing needs. In contrast, older adults were more likely to express uncertainty or mixed perceptions, potentially reflecting differences in housing tenure or fixed-income considerations.
- Higher-growth or more suburban municipalities more frequently reported concerns related to housing costs and availability. At the same time, more rural or outlying areas also expressed affordability concerns tied to limited housing supply and fewer rental options.

### Access to Dental Care Needs

Most Union County respondents reported that they did not need or could not access dental care; however, nearly one in five residents (18.8%) reported needing dental care but not going, indicating a significant level of unmet oral health need. These findings highlight oral health as an important access issue with implications for overall health and chronic disease prevention.

Among respondents who needed dental care but did not go, the most frequently cited barrier was cost. More than half of respondents (56.1%) reported they did not have the money to go, making affordability the dominant obstacle to dental care. Insurance-related barriers were also common, including lack of insurance (16.0%) and insurance that does not pay for dental services (19.2%), reflecting gaps in dental coverage even among insured residents. Other frequently reported reasons included fear or dislike of going to the dentist (17.3%), inconvenient office hours (12.8%), and other unspecified barriers.

- Latino/a respondents were especially likely to report cost barriers (74.8%) and lack of insurance (47.5%), indicating substantial financial and coverage-related obstacles to dental care.
- Black respondents frequently cited cost (59.4%), insurance that does not cover dental services (33.4%), and office hours that were not convenient (25.1%), suggesting both affordability and system-level access challenges.



- White respondents most often reported cost (51.8%), followed by fear or dislike of going to the dentist (22.1%) and insurance-related barriers, highlighting the role of both financial and non-financial factors.
- Transportation, trust, and language barriers were reported less frequently overall but represent important access issues for some residents.
- Lower-income respondents were more likely to report dental care. Still, they were not going, most often due to cost and lack of insurance, indicating significant financial and coverage barriers to oral health services.
- Middle-income respondents also reported unmet dental needs, frequently citing a combination of cost, insurance limitations, and clinic hours that were not convenient, suggesting that affordability and system accessibility affect a broad range of households.
- Higher-income respondents were less likely to report financial barriers but more likely to cite fear or dislike of going to the dentist and other non-financial reasons, indicating that psychosocial factors also influence dental care utilization.
- Younger adults were more likely to report unmet dental needs related to cost, lack of insurance, or uncertainty about where to go, reflecting lower rates of dental coverage and competing financial priorities.
- Middle-aged adults more frequently cited cost, insurance gaps, and scheduling barriers, consistent with balancing employment and family responsibilities.
- Older adults were more likely to report concerns related to insurance coverage, provider availability, and discomfort or fear related to dental care, highlighting the importance of age-responsive dental services.

Geographic patterns suggest that unmet dental care needs were present across municipalities, though the nature of barriers varied by location. More rural or outlying areas more often reported challenges related to provider availability, transportation, and limited clinic options, while more suburban or higher-growth municipalities more frequently cited cost, insurance coverage, and inconvenient office hours, reflecting demand pressures on dental providers.



### Access to Public Transportation

Survey responses indicate substantial challenges related to public transportation access in Union County. Only 12.4% of respondents agreed or strongly agreed that public transportation is easy to use when needed, while a clear majority (62.8%) disagreed or strongly disagreed. Nearly one-quarter of respondents (23.9%) selected neither agree nor disagree, suggesting limited familiarity with public transportation services or uncertainty about their availability.

These findings suggest that public transportation is not widely perceived as accessible or user-friendly, which may limit residents' ability to access employment, health care, education, and other essential services—particularly for individuals without reliable personal transportation. Perceived challenges with public transportation are consistent with other survey findings identifying transportation as a key community issue and a contributor to delayed or avoided care.

Perceptions of public transportation access varied by household income, age, and geography.

- Lower-income respondents were more likely to disagree that public transportation is easy to use if needed, reflecting greater reliance on public or shared transportation options and fewer alternatives when service is limited.
- Middle-income respondents also expressed difficulty with public transportation access, suggesting that usability challenges extend beyond those with the greatest financial need.
- Higher-income respondents were more likely to select neutral responses, potentially indicating limited use of public transportation rather than perceived ease of access.
- Younger adults were more likely to report challenges using public transportation, consistent with work-related travel needs and limited flexibility in scheduling.
- Middle-aged adults frequently cite difficulty accessing public transportation in the context of employment and caregiving responsibilities.
- Older adults were more likely to report that public transportation is difficult to use, reflecting mobility limitations, service availability, and the need for age-friendly transportation options.
- More rural or outlying areas more often report difficulty accessing public transportation due to limited routes, longer distances, and fewer service options.
- More suburban or higher-growth municipalities also expressed challenges related to coverage, frequency, and convenience, suggesting that transportation barriers affect residents across the county.

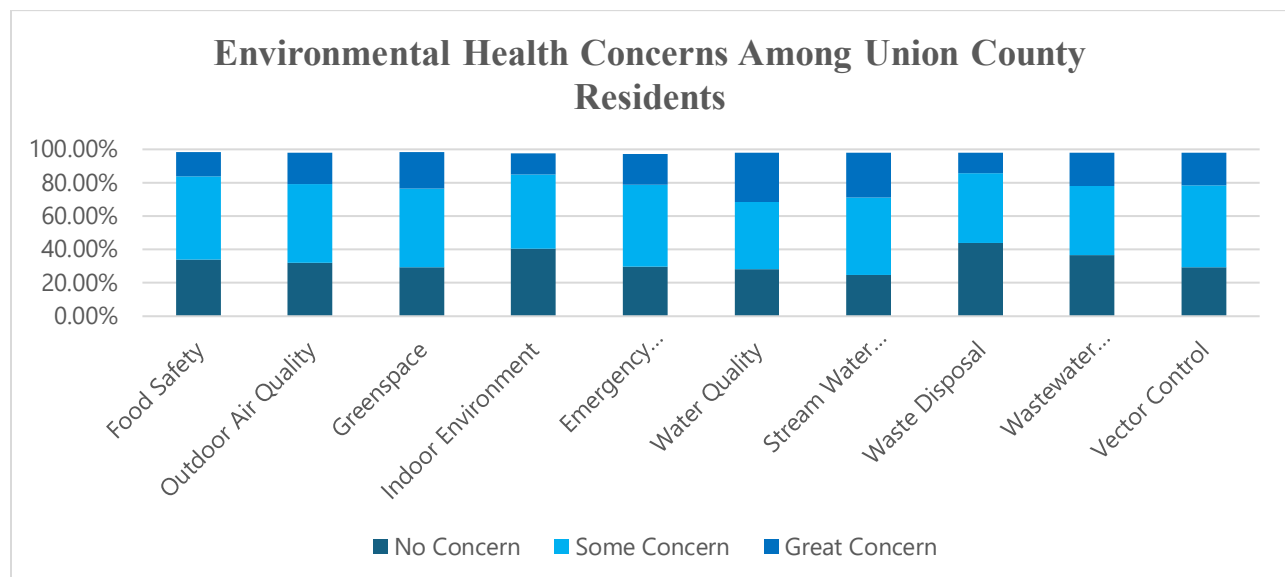


### Environmental Health Concerns

Survey respondents reported moderate but widespread concern across multiple environmental health domains, with most issues rated “some concern” rather than “great concern.” This pattern suggests that while environmental health may not be perceived as an immediate crisis by most residents, it is an important background condition that influences quality of life, safety, and long-term health.

Across nearly all environmental topics, including food safety, outdoor air quality, green space, water quality, stream water quality, wastewater disposal, vector control, indoor environment, and emergency weather issues, between 40% and 50% of respondents reported some level of concern. Areas with the highest combined levels of concern included water quality (69.8%), stream water quality (73.1%), greenspace (69.0%), vector control (68.9%), and emergency weather issues (67.8%). These findings indicate that environmental conditions related to water, land use, climate, and pests are salient concerns for many residents.

Concerns about waste and wastewater disposal were more mixed, with larger proportions reporting no concern, suggesting variability in environmental conditions or service coverage across the county. Indoor environmental concerns, including housing quality, mold, air quality, and other indoor exposures, were reported by more than half of respondents, highlighting the intersection of environmental health and housing conditions.



Perceptions of environmental health concerns varied by household income, age, and geography, reflecting differences in exposure, vulnerability, and daily interaction with environmental conditions.

- Lower-income respondents were more likely to report concerns related to water quality, indoor environment, wastewater disposal, and emergency weather, suggesting heightened exposure to environmental risks and fewer resources to mitigate impacts.
- Middle-income respondents frequently identified concerns related to food safety, outdoor air quality, and vector control, indicating sensitivity to environmental conditions affecting daily living and family health.
- Higher-income respondents were more likely to report concerns related to greenspace, environmental quality, and emergency weather, reflecting greater focus on quality-of-life and long-term environmental conditions.
- Younger adults more often reported concerns related to food safety, outdoor air quality, and indoor environmental conditions, which may reflect housing instability, rental housing quality, and proximity to environmental stressors.
- Middle-aged adults frequently identified concerns related to water quality, wastewater disposal, and emergency weather, consistent with household and caregiving responsibilities.
- Older adults were more likely to report concerns related to environmental quality, vector control, and emergency weather, highlighting vulnerabilities related to health status, mobility, and climate-related risks.
- More rural or outlying areas more often reported concerns related to water quality, wastewater disposal, and vector control, reflecting reliance on private wells, septic systems, and greater exposure to environmental conditions.
- More suburban or higher-growth municipalities more frequently identified concerns related to greenspace, indoor environment, and emergency weather, reflecting development pressures, housing density, and infrastructure strain.



## Focus Groups

In addition to the survey tool, focus groups were facilitated as part of primary data collection for the 2025 Community Health Assessment (CHA). Over 3 months, 9 groups were held, with a total of 82 participants from various communities throughout Union County. Participants ranged in age from 13 to 95 years, with strong representation from Latino/Hispanic (40%), White (33%), and Black/African American (15%) residents. Females comprised approximately 61% of participants.

Focus Group	Population
Atrium Faith Ambassadors	Faith-Based Communities
Bazemore Senior Center	Older Adults
Iglesia El Shaddai (3 Groups)	Latino Residents (Teen, Young Adult, Adult)
Mineral Springs Senior Nutrition Program	Older Adults
Transforming Youth Movement	Youth / Teen
Union County Community Shelter	Unhoused Residents
Union County Teen Advisory Group	Youth / Teen

In partnership with trusted community leaders, focus groups were facilitated to capture the perspectives of underrepresented communities in survey data. Furthermore, focus groups were the only method used to capture the voices of individuals younger than 18 years old (teens) who did not participate in the survey.

Participants were asked six key questions to facilitate discussion of health issues, service gaps, and potential areas for improvement.

1. What does an ideal healthy community look like to you?
2. How well-informed do you feel about health issues and available services in your community?
3. What are the barriers to being healthy in Union County?
4. Think back over the last 5 years. What are some changes that have taken place in Union County that have had an impact on your health?
5. Pretend you have a magic wand. What resource or service would you improve or bring to Union County?
6. Out of everything we discussed today, what do you think is most important for county leadership to hear and prioritize?



## Themes and Key Mentions

Residents provided a variety of perspectives and insights drawn from their lived experiences in Union County. Focus group

facilitation sessions were audio-recorded and transcribed for further analysis of themes and key mentions. Below are the major themes identified across groups, but additional topics discussed included infrastructure, land development, economic stressors, and housing insecurity.

### Adult Participants:

- **Access to Resources and System Navigation-** In discussions related to resource and service improvement, participants cited community support and access fourteen times as the only topic discussed in every focus group. Participants identified a top priority and an actionable issue: a lack of awareness of existing services, limited ways to access information, and reliance on word of mouth for health information. Participants further elaborated, noting that “individuals in the Hispanic community may not be aware of some resources or feel they may not have access to them based on language barriers.”
- **Transportation Access and Barriers -** Throughout group discussions, transportation was the most mentioned topic for a total of fourteen times. Union County operates the only public transit available to residents and provides free rides to medical care, employment, and resources by appointment. Residents cited a need for more flexible scheduling for riders and the potential to expand rural routes, as many residents live outside the City of Monroe. Participants acknowledged the existing service and cited “the need for more (services) for the elderly to get to the doctor’s appointments and so forth. Furthermore, the need for faster access to specialty care appointments was a major focus.
- **Mental Health and Substance Use-** In alignment with the discussion around health issues and available services, mental health and homelessness were discussed twelve times throughout the groups. Key mentions in this theme included emphasized destigmatization of mental health in our community and knowledge of generalized hotlines, but a lack of therapists in the immediate community. As mental health was discussed in conjunction with substance use and early intervention, participants stated, “mental health resources are very limited in our region,” and there is a need for more to prevent negative long-term health outcomes.
- **Healthcare Affordability and Insurance-** When asked about barriers to being healthy, respondents cited healthcare providers and services eleven times in discussion. Insurance was discussed as a component of healthcare and referred to as “a barrier because many workplaces do not offer insurance, and when you arrive at the clinic, they cannot treat you.” Additionally, the availability of specialty care providers in Union County was noted, as most are based in Charlotte. The overall lack of awareness of providers was a major concern among English and Spanish-speaking groups, citing language barriers and a lack of Latino-serving providers.



Topic	Total Mentions
Access to Resources and Services	29
Transportation and Infrastructure	23
Mental Health and Substance Use	12
Homeless and Housing Insecurity	11
Healthcare and Insurance Affordability	11
Economic Insecurity	11
Recreation and Community Space	10
Cultural Competence and Language Barriers	9

### Youth Participants:

- Youth Engagement and Solutions-** Throughout discussions, a unique theme formed by teen participants was the lack of engagement in teens to help craft solutions that impact teens. This concern was cited 8 times and mentioned a lack of involvement in planning events for which they (teens) were the target audience. This engagement ranged from socialization to youth-led advocacy to reduce risk behaviors, such as vaping and tobacco use. One student stated, "If you are trying to solve vaping among teens, you have to communicate with teens".
- Community Safety and Connectivity-** In conjunction with general engagement, many participants described their community as safe but lacking opportunities for socialization. Several cited negative experiences in the school setting and a lack of perceived support among their teachers. Among Latino participants, youth cited strong connections between family and faith but limited culturally relevant spaces for connection. Additionally, teen participants reiterated the value of social media, noting that it "reaches a wide range of audiences, especially if you use Facebook and Instagram".
- Mental Health and Therapy Access-** When discussing the components of a healthy community, teen participants heavily focused on mental health and access to trustworthy providers. Participants across groups reported difficulty finding affordable, effective services that addressed their unique needs. Furthermore, the connection between mental health and substance use among teens was cited more than seven times across groups as a point of discussion.
- Access to Information and Resources-** Across every teen group, access to information was tied directly to social media platforms and peer networks. For teen participants, knowledge and awareness of resources often stemmed from peer word-of-mouth. As a key topic of discussion, the need for expanded online communication was cited seven times, underscoring that "it is hard actually to use resources if you do not know about them."



Topic	Total Mentions
Youth Engagement and Solutions	8
Community Safety and Connectivity	8
Mental Health and Therapy Access	7
Drug Use and Vaping	7
Access to Information and Resources	7
Cultural and Community Support	6
Transportation and Infrastructure	6
Food Access and Economic Stress	5

## Key Informant Interviews

In coordination with our regional partnership (Central Carolina Community Collaborative), Union County participated in an innovative pilot to facilitate Key Informant Interviews (KII) via Artificial Intelligence (AI) software. This methodology was in addition to the survey tool and focus groups to gain a unique perspective from community leaders across target sectors. This AI-facilitated interview can be conducted at any time that works for participants, enabling greater participation and the use of customized discussion guides. Eighteen Union County partners from various sectors, including healthcare, judicial, business, education, housing, aging services, law enforcement, and nonprofit organizations, were sent requests to participate. Reminders were sent out weekly via email. Ten of the eighteen completed the interviews.

Sector	Name	Organization
Community Safety	Tony Underwood	Union County Sheriff's Office
Education	Kelly Stegall	South Piedmont Community College
Education	Shanta Dube	Wingate University
Food Insecurity	Keith Adams	Common Heart
Healthcare	Christina Olmstead	HealthQuest
Homelessness	Melissa McKeown	Community Shelter of Union County
Housing	Isabelle Gillespie	Monroe Community Development Corporation
Latino Community	Dora Sanchez	Faith-based Leader
Mental Health / Youth	Kasha Giddens	Union County Public School
Older Adults and Caregivers	Andrew Friend	Union County Council on Aging

## Themes and Key Mentions

- **Collaboration and Network Strength** - In conjunction with each key theme, participants identified the community's collaborative culture as a major strength for the well-being of Union County residents. With nine mentions, key examples cited existing multi-sector partnerships and prioritized outreach

efforts to meet residents where they are. Participants cited the benefits of more formalized partnerships to address specific gaps in clinical care, with a specific focus on lower-income and rural populations.



- Access to Healthcare and Affordability**  
 The need for improvement in healthcare access was the most frequently mentioned theme among interviewees, totaling nine key examples. This theme was commonly associated with transportation, specialized services, and health education for residents. Participants cited a lack of reliable transportation as a recurring obstacle to medical appointments and a common reliance on emergency services due to cost as primary examples in this discussion. By promoting healthier behaviors and improving access to resources, participants noted opportunities to improve health outcomes, specifically by preventing chronic diseases and supporting the well-being of caregivers for aging family members.
- Mental Health and Substance Use**  
 Across age groups, mental health concerns were frequently expressed in interviews for a total of eight key mentions. Participants discussed limitations in access to mental health services, including provider shortages and a lack of long-term treatment facilities for substance misuse. “Breaking the intergenerational cycle of substance use disorder” was cited regarding

increased risk for school-age children and young adults in Union County. Existing programs such as the Behavioral Health Collaborative, Daymark, and opioid settlement workgroups were cited as critical initiatives to address this health concern. The need for additional effort was reiterated.

- Transportation Access and Barriers**  
 Limitations in reliable and flexible public transportation were a frequently cited concern throughout informant interviews. In seven key mentions, participants associated a lack of transportation as a recurring obstacle for residents seeking medical care, education, and employment opportunities, including “many Latino community members that work long hours in low-paying jobs, leaving them with little time or resources to take care of their health”. Older adults, low-income individuals, and rural residents were specifically mentioned in suggestions to reduce disparities for vulnerable communities in Union County. These insights reiterated the need for targeted efforts to improve the built environment and ensure that all community members have access to resources.

Topic	Total Mentions
Collaboration and Network Strength	17
Access to Healthcare and Affordability	15
Mental Health and Substance Use	13
Transportation Barriers	7
Economic Insecurity and Low Wages	7
Aging Population and Senior Care	6



## Inventory of Community Resources

### Health and Resource Guide

The Union County Division of Public Health annually updates the Health and Wellness Resource Guide, which lists county agencies and community organizations that provide health, wellness, safety, fitness, and nutrition resources to residents. The guide includes services related to crisis intervention, disabilities, family support, healthcare, nutrition, pregnancy, substance use, transportation, senior services, and recreation. The guide is available online in English, Spanish, and Russian (Union County Public Health, 2025). Residents can access the Health and Resource Guide online [here](#) in English, Spanish, and Russian.

### UC CARES

Union County also maintains UC CARES (Union County Community Assistance & Resources Emergency Support), an online directory that helps individuals and families quickly locate assistance. The directory includes local, state, and federal programs, as well as services from private and nonprofit organizations. Resources cover a wide range of needs, including behavioral health, emergency and financial assistance, employment, food, healthcare, housing, insurance, legal services, substance use treatment, and transportation (Union County Community Support & Outreach, 2025). Residents can access UC CARES at: [UC CARES resource directory](#)



## Priority Setting and Priority Selection

The Healthy Union Advisory Coalition used a multi-criteria prioritization process combining structured discussion and dot voting to select the final priority areas. The HUAC met on Sept. 30<sup>th</sup> and October 28<sup>th</sup>, 2025, at Union County Human Services, to complete the 2025 priority-setting process. Thirty people attended the meeting in September and thirty-six in October. Each meeting lasted five hours. The following presentations were delivered:

Date	Topic	Presenter
9/30/25	Union County Profile	Stephanie Starr
9/30/25	Morbidity & Mortality Data; Chronic Disease	Ana Diaz
9/30/25	Pregnancy, Maternal and Infant Health	Ashley Burts
9/30/25	Communicable Diseases and Sexually Transmitted Infections	Maegan Trull
9/30/25	Access to Care	Stephanie Starr
9/30/25	Safety and Injury	Ana Diaz
10/28/25	Mental Health	Malisha Ross and Stephanie Starr
10/28/25	Substance Use Disorder	Stephanie Starr
10/28/25	Housing and Homelessness	Stephanie Starr and Melissa McKeown
10/28/25	Environmental Health	Traci Colley and Charlotte Keziah
10/28/25	Primary Data	Kristine Gross

Input gathered from both the primary and secondary data was combined and analyzed to determine the top four focus areas to consider for prioritization:

- Access to Care (including provider, food, and transportation)
- Affordable Housing
- Chronic Disease Prevention
- Environmental Health
- Mental Health
- Substance Use Disorder

While these focus areas are not the only important public health factors in the community, they were the areas that had the most substantial combination of supporting primary and secondary data.



Following the presentations on 10/28/25, participants were given 30 minutes to have discussions on two assigned priority areas and were given six criteria to consider during these discussions:

1. Magnitude: Proportion of the population that is affected or vulnerable.
2. Severity: Impact on mortality, morbidity, disability, and quality of life.
3. Intervention Effectiveness: Proven interventions exist that are feasible from a practical, economic, and political viewpoint.
4. Public Concern: Degree of public concern and/or awareness.
5. Urgency: Need for action based on degree and rate of growth (decline); Potential for affecting and amplifying other health or socioeconomic issues; timing for public awareness, collaboration, and funding availability.
6. What efforts are currently underway or planned to begin to address this focus area?

Each table reported out. After the report-out, each member was given two dots and told to “spend” them to determine which priority area (or areas) they deemed most important for the community to focus on.

The final priority areas selected included:

- Access to Care
- Affordable Housing
- Substance Use Disorder



## Next Steps: Community Health Improvement Plan

Based on the findings of the 2025 Community Health Assessment and the priorities selected through the community-driven process, Union County will begin development of the Community Health Improvement Plan (CHIP) in spring and summer 2026. The HUAC will serve as the lead planning body, working with community partners, residents, healthcare systems, and local agencies to develop goals, strategies, and performance measures for each priority area. This approach aligns with North Carolina public health accreditation requirements and the North Carolina Community Health Assessment Guidebook (NCIPH, 2023).

The CHIP will focus on the three identified priorities:

- Access to Care
- Affordable Housing
- Substance Use Disorder

The coalition will use the Results-Based Accountability (RBA) framework to guide strategy development, performance measurement, and continuous improvement (Clear Impact, 2022). RBA emphasizes measurable population-level results, evidence-informed strategies, and shared accountability among partners.

Workgroups will be formed for each priority area, and community members will be invited to participate in planning and implementation efforts. Ongoing community engagement reflects best practices in community health improvement and aligns with national guidance from the Centers for Disease Control and Prevention and Healthy People 2030 on collaborative, equity-focused public health planning (CDC, 2023; Healthy People 2030, 2023).

The CHIP will include:

- Clear goals and measurable objectives
- Evidence-based or evidence-informed strategies
- Performance measures and data sources
- Identified lead agencies and partners
- An implementation timeline

The completed CHIP will be released in late 2026 and will guide collaborative action to improve health outcomes and reduce disparities across Union County.



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# **Appendix A**

## **Community Surveys**



# 2025 Community Health Needs Survey

This survey will take less than 10 minutes. We will ask you questions about the health needs of your community. Community is where you live, work, play and engage. The information will help us:

- Understand problems that affect our community
- Better understand the needs of our community
- Work together to find solutions to our needs

The answers you give are important and kept confidential. We thank you for your time and input.

---

## Introduction

### 1) What county do you live in?

Alexander

Ashe

Brunswick

Cabarrus

Carroll (VA)

Davidson

Davie

Duplin

Forsyth

Gaston

Grayson (VA)

Guilford

Iredell

Lancaster

Lincoln

Mecklenburg

New Hanover

Onslow

Pender

Randolph

Rockingham

Rowan

Scotland

Stanly

Stokes

Surry

Union

Wilkes

Yadkin

York

Other



**2) If “Other” in Question 1, please list your county**

---

**3) In which Union County Town or Municipality do you reside?**

- |  |  |
|--|--|
| <input type="checkbox"/> Altan           | <input type="checkbox"/> Monroe                      |
| <input type="checkbox"/> Fairview        | <input type="checkbox"/> New Salem                   |
| <input type="checkbox"/> Goose Creek     | <input type="checkbox"/> Stallings                   |
| <input type="checkbox"/> Hemby Bridge    | <input type="checkbox"/> Unionville                  |
| <input type="checkbox"/> Indian Trail    | <input type="checkbox"/> Waxhaw                      |
| <input type="checkbox"/> Lake Park       | <input type="checkbox"/> Weddington                  |
| <input type="checkbox"/> Marshville      | <input type="checkbox"/> Wesley Chapel               |
| <input type="checkbox"/> Marvin          | <input type="checkbox"/> Wingate                     |
| <input type="checkbox"/> Matthews        | <input type="checkbox"/> Unincorporated Union County |
| <input type="checkbox"/> Mineral Springs | <input type="checkbox"/> Out of County               |

**4) What is your home zip code?**

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**5) What is your age?**

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## Your Community

### 6) What do you believe are the most important health related challenges in your community? Please select 3.

- |   |  |
|---|--|
| <input type="checkbox"/> Access to affordable medication                                      | <input type="checkbox"/> Mental health issues including anxiety and depression   |
| <input type="checkbox"/> Access to health care (availability and accessibility)               | <input type="checkbox"/> Obesity   |
| <input type="checkbox"/> Autoimmune Disorders   | <input type="checkbox"/> Oral Health   |
| <input type="checkbox"/> Cancers - all types  | <input type="checkbox"/> Sexually Transmitted Infections (STDs) including chlamydia, gonorrhea, hepatitis, syphilis, HIV |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Substance use (drug or alcohol use)   |
| <input type="checkbox"/> Hearing and vision loss  | <input type="checkbox"/> Tobacco use including vaping  |
| <input type="checkbox"/> Heart disease (high blood pressure, stroke)                          | <input type="checkbox"/> Women's health including maternity care and other issues that are unique to women               |
| <input type="checkbox"/> Infectious diseases (tuberculosis or TB, flu, COVID-19)              | <input type="checkbox"/> Other (Please list):  |
| <input type="checkbox"/> Lung disease (asthma, chronic obstructive pulmonary disease or COPD) | _____  |
|   | _____  |

### 7) What are the most important community issues? Please select 3.

- |   |   |
|---|---|
| <input type="checkbox"/> Access to affordable healthy food            | <input type="checkbox"/> Issues related to aging (Older Adults)   |
| <input type="checkbox"/> Affordable and safe housing                  | <input type="checkbox"/> Racism or other discrimination   |
| <input type="checkbox"/> Access to affordable childcare               | <input type="checkbox"/> Safety or crime  |
| <input type="checkbox"/> Access to educational opportunities          | <input type="checkbox"/> Environmental Health including clean air and water                               |
| <input type="checkbox"/> Access to employment opportunities           | <input type="checkbox"/> Transportation (the ability to get to medical appointments, work, errands, etc.) |
| <input type="checkbox"/> Access to arts and cultural events           | <input type="checkbox"/> Other (Please list):   |
| <input type="checkbox"/> Access to physical activity opportunities    | _____   |
| <input type="checkbox"/> Access to social support and engagement      | _____   |
| <input type="checkbox"/> Issues related to child and youth well-being |   |



**8) What does your community need to be healthy?**

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**9) Please rate your agreement with the following statements.**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neither</b>	<b>Agree</b>	<b>Strongly Agree</b>
There are affordable places to live in my community	—	—	—	—	—
I am satisfied with the healthcare system in this community	—	—	—	—	—
Public transportation is easy to use if I need it	—	—	—	—	—
I feel safe in my community	—	—	—	—	—
There are enough well-paying jobs in my community	—	—	—	—	—



### 10) Environmental Health (Check one answer per row)

	<b>Great Concern</b>	<b>Some Concern</b>	<b>No Concern</b>
Food Safety	—	—	—
Greenspace for Physical Activity	—	—	—
Water Quality and/or Quantity Issues (wells or public water)	—	—	—
Wastewater Disposal (septic systems or public sewer)	—	—	—
Indoor Environment (safety, moisture/mold, lead, asbestos, radon, allergens, etc.)	—	—	—
Outdoor Air Quality/Environment (safety, noise, contaminants, etc.)	—	—	—
Waste Disposal (household garbage or bulky items)	—	—	—
Stream Water Quality (erosion, stormwater run-off, over-development)	—	—	—
Vector Control (mosquitoes, mice/rats, bed bugs, etc.)	—	—	—
Emergency Weather Issues (flooding, wind, power outages, extreme heat, etc.)	—	—	—



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## Your Health

**11) In the past week, how many days did you eat fruit and/or vegetables. Please think about all forms of fruits and vegetables including cooked or raw, fresh, frozen, or canned.**

- None
- 1-2
- 3-5
- More than 5
- I don't know

**12) How easy or difficult is it for you to get fresh fruits and vegetables?**

- Very difficult
- Somewhat difficult
- Somewhat easy
- Very easy

**13) If “Very Difficult” or “Somewhat Difficult” what are the reasons it is difficult to get fresh fruits and vegetables? Select all that apply.**

- The store(s) within a mile of where I live don't sell fresh fruits and vegetables
- The quality of fresh fruits and vegetables where I shop is poor
- Fresh fruits and vegetables are too expensive where I shop
- The store(s) where I use my EBT/SNAP benefits does not sell fresh fruits and vegetables
- I don't have transportation to get to a store that sells fresh fruits and vegetables
- I don't have the ability to store or prepare food



**14) In the past 30 days, have you used**

	<b>Yes</b>	<b>No</b>
Marijuana or cannabis	—	—
Drugs besides marijuana or cannabis	—	—
Tobacco (cigarettes, cigarillo, cigar)	—	—
Smokeless tobacco (chew, dip, snuff)	—	—
Electronic cigarettes, such as JUUL or blu (also known as e-cigarettes or vapes)	—	—

**15) How often does substance use by someone in your household negatively affect your usual activities?**

Daily       Weekly       Monthly       Rarely       Never

**16) How often do you get the social and emotional support you need?**

Always  
 Usually  
 Sometimes  
 Rarely  
 Never



**17) How often do you feel lonely?**

- Always
- Usually
- Sometimes
- Rarely
- Never

**18) How many days a week do you normally get 30 minutes of exercise for fitness?**

- None
- One
- Two
- Three
- Four
- Five or more

**19) Below are health concerns. Please check three that MOST concern you regarding YOUR health.**

- |   |   |
|---|---|
| <input type="checkbox"/> Alzheimer's Disease/Dementia | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Obesity  |
| <input type="checkbox"/> Caregiver Stress             | <input type="checkbox"/> Respiratory Illness / COPD   |
| <input type="checkbox"/> Dental health                | <input type="checkbox"/> Stroke / Heart Disease   |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Sexually transmitted infections (STDs) such as Chlamydia, Gonorrhea, Syphilis, HIV |
| <input type="checkbox"/> Drug Abuse/Overdose          | <input type="checkbox"/> Unplanned Pregnancy  |
| <input type="checkbox"/> Excessive/binge drinking     | <input type="checkbox"/> Vision issues  |
| <input type="checkbox"/> Falling                      | <input type="checkbox"/> Other (please specify):  |
| <input type="checkbox"/> Hearing issues               | _____   |
| <input type="checkbox"/> High blood pressure          |   |
| <input type="checkbox"/> Influenza / Pneumonia        |   |

**20) Did you receive a flu vaccine within the past year?**

- Yes
- No



**21) If you did not receive a flu vaccine, please indicate why. Check ALL that apply.**

- Concerned that I would get the flu from the vaccine
- Concerned that I would have a serious reaction to the flu vaccine
- Could not afford the flu vaccine
- Generally healthy, so I do not feel that I need the flu vaccine
- I do not believe that the flu vaccine is effective
- I have a chronic medical condition(s) and am afraid the flu vaccine will make me sick
- I have a medical condition(s) or allergy that prevents me from getting the flu vaccine
- Not sure where to get the flu vaccine or lack of transportation
- Religious objection to vaccines
- Other (please specify)

**22) If you have a child or children aged 6 or younger, is your child up to date on recommended immunizations?**

- Yes
- No
- I do not have a child aged 6 or younger

**23) If "No" to Question 22, what are the reasons your child is not up to date on recommended immunizations?**

- |   |   |
|---|---|
| <input type="checkbox"/> Believe my child's immune system will be stronger if they contract a preventable disease             | <input type="checkbox"/> Do not want my child to have multiple shots in one doctor's office visit |
| <input type="checkbox"/> Concerned my child will have a serious reaction to the vaccine(s)/vaccines are unsafe                | <input type="checkbox"/> My child does not have a primary doctor                                  |
| <input type="checkbox"/> Concerned there is a link between vaccines and autism Desire more information from my child's doctor | <input type="checkbox"/> My child is not in daycare, so he/she is not exposed to diseases         |
| <input type="checkbox"/> Do not believe vaccines are necessary because the diseases are not serious or are uncommon           | <input type="checkbox"/> No money for vaccines and/or my child is uninsured                       |
|   | <input type="checkbox"/> Religious objection to vaccines  |
|   | <input type="checkbox"/> Other (please specify)<br>_____  |



## Access to Care

**24) Do you have a doctor or clinic where you go for care when you need it?**

Yes

No

**25) Please choose the type(s) of health insurance you currently have. Select all that apply.**

I don't have health insurance

Medicaid

Insurance purchased through the Marketplace, Affordable Care Act or Obamacare

I'm on my parent's insurance

Insurance from an employer

Other (Please list):

Medicare

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**26) If you have insurance, how well does it meet your needs?**

Very Dissatisfied

Dissatisfied

Neutral

Satisfied

Very Satisfied

Not Applicable

**27) Do you have dental insurance?**

Yes

No

**28) Do you have vision insurance?**

Yes

No



**29) In the past 12 months, have you delayed any medical care such as annual physicals?**

Yes

No

**30) If “Yes” to Question 29, what were the reasons you delayed medical care?**

Wait time for appointment

Cost of service

Transportation

Inconvenient hours

Lack of provider

No insurance

I am not at risk

Did not want to get vaccinated

Other (Please list): \_\_\_\_\_

\_\_\_\_\_

**31) During the past 12 months, was there any time when you needed mental health treatment or counseling?**

Yes

No

**32) If “Yes” to Question 31, were you able to get the mental health treatment you needed?**

Yes

No



**33) If “No” to Question 32, please select the reason(s) you did not get the mental health treatment or counseling you needed. Select all that apply.**

- |  |   |
|--|---|
| <input type="checkbox"/> I could not afford the cost   | <input type="checkbox"/> I was concerned that I might be taken to a psychiatric hospital or have to take medicine |
| <input type="checkbox"/> I was concerned that getting help might cause my family or community to have a negative opinion of me | <input type="checkbox"/> I tried to get mental health treatment or counseling but was put on a waitlist           |
| <input type="checkbox"/> I was concerned that getting help might have a negative effect on my job                              | <input type="checkbox"/> I could not find a therapist who was culturally or disability competent                  |
| <input type="checkbox"/> My health insurance does not cover or pay enough for mental health treatment or counseling            | <input type="checkbox"/> I did not have transportation to get to an appointment                                   |
| <input type="checkbox"/> I did not know where to get services  | <input type="checkbox"/> Other (Please list):   |
| <input type="checkbox"/> I was concerned that the information I gave the counselor might not be kept private                   | _____   |
|  | _____   |

**34) Within the past 12 months, has a lack of transportation kept you from medical appointments, work, or other important things that you need to do?**

- Yes  
 No

**35) Was there a time during the last 12 months when you needed to see a dentist but did not?**

- Yes  
 No

**36) If “Yes” to Question 35, what was the main reason you did not see a dentist?**

- |   |  |
|---|--|
| <input type="checkbox"/> I did not have the money to go                   | <input type="checkbox"/> Language Barrier                              |
| <input type="checkbox"/> I did not know who to call or where to go        | <input type="checkbox"/> My insurance does not pay for dental services |
| <input type="checkbox"/> I do not trust dentists                          | <input type="checkbox"/> Office was not open when I could get there    |
| <input type="checkbox"/> I have no insurance                              | <input type="checkbox"/> Other reason (please specify):                |
| <input type="checkbox"/> I have no transportation                         | _____  |
| <input type="checkbox"/> I was afraid / I don't like to go to the dentist | _____  |



**37) How prepared do you feel your household is to handle an emergency or disaster (such as natural disaster, power outage, or public health crisis)?**

- Very prepared – We have an emergency plan, supplies, and know what to do
- Somewhat prepared – We have some supplies and an idea of what to do but could use more information.
- Not very prepared – We have limited supplies and no clear plan
- Not prepared at all – We do not have supplies or a plan in place

**38) What resources, training, or information would help you feel more prepared for emergencies? Please specify.**

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## About You

**39) What sex were you assigned at birth?**

- Female
- Male
- Another term: \_\_\_\_\_

**40) What is your race and/or ethnicity group? Select all that apply.**

- American Indian or Alaskan Native
- Asian
- Black or African American
- Middle Eastern or Northern African
- Native Hawaiian or Pacific Islander
- Latino or Hispanic
- White
- Prefer to self-describe: \_\_\_\_\_



**41) What kind of place do you live in?**

- Own my home
- Rent my home
- Emergency shelter
- Living outside
- Living with a friend or family member
- Hotel or Motel
- Something else: \_\_\_\_\_

**42) How many people in each age group are currently in your household (including yourself)?**

- Children 0-5 years old: \_\_\_\_\_
- Children 6-10 years old: \_\_\_\_\_
- Children/Teenagers 11-14 years old: \_\_\_\_\_
- Children/Teenagers 15-18 years old: \_\_\_\_\_
- Young adults 19-24 years old: \_\_\_\_\_
- Adults 25-64 years old: \_\_\_\_\_
- Adults 65 and older: \_\_\_\_\_

**43) Is a language other than English spoken in your home?**

- Yes
- No

**44) If “Yes” to Question 43, what language(s) other than English are spoken in your home?**

\_\_\_\_\_

**45) What is the highest level of education you have completed?**

- |  |   |
|--|---|
| <input type="checkbox"/> Less than high school       | <input type="checkbox"/> Vocational or technical school |
| <input type="checkbox"/> Some high school            | <input type="checkbox"/> Some college                   |
| <input type="checkbox"/> High school graduate or GED | <input type="checkbox"/> College graduate or higher     |



**46) What is your yearly household income?**

- Less than \$10,000
- \$10,000 to \$14,999
- \$15,000 to \$24,999
- \$25,000 to \$34,999
- \$35,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$149,999
- \$150,000 to \$199,999
- \$200,000 or more
- I don't know

**47) What is your current employment status?**

- Employed (full-time)
- Employed (part-time)
- Retired
- Student
- Self-employed
- Not employed

**48) What county do you work in if different than where you live?**

- I live and work in the same county
- I work in: \_\_\_\_\_

**49) Does anyone in your house live with a physical, mental, or intellectual disability?**

- Yes, a child 0 to 17 years old
- Yes, an adult 18 or older
- No

**50) Are you a veteran or have you served in the military?**

- Yes
- No



**Thank you for taking our survey!**

**Your response is very important to us and will help us  
plan ways to improve health in your community.**

**If you have any questions about the survey,  
please email [survey@metop.io](mailto:survey@metop.io).**

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**UNIONCOUNTY**  
north carolina



# Encuesta de Necesidades de Salud Comunitarias 2025

Le llevará menos de 10 minutos completar esta encuesta. Le haremos preguntas sobre las necesidades de salud de su comunidad. La comunidad es el lugar donde usted vive, trabaja, juega y participa. La información nos ayudará a lograr lo siguiente:

- Comprender los problemas que afectan a nuestra comunidad.
- Comprender mejor las necesidades de nuestra comunidad.
- Trabajar juntos en busca de soluciones para abordar dichas necesidades.

Las respuestas que nos proporcione son importantes para nosotros y se mantendrán confidenciales. Le agradecemos por su tiempo y sus aportes.

---

## Introduction

### 1) ¿En qué condado vive?\*

Alexander

Ashe

Brunswick

Cabarrus

Carroll (VA)

Davidson

Davie

Duplin

Forsyth

Gaston

Grayson (VA)

Guilford

Iredell

Lancaster

Lincoln

Mecklenburg

New Hanover

Onslow

Pender

Randolph

Rockingham

Rowan

Scotland

Stanly

Stokes

Surry

Union

Wilkes

Yadkin

York



**2) Si respondió «Otro» a la pregunta 1, indique su condado.**

---

**3) ¿En qué pueblo o municipio del Condado de Union reside usted?**

- |  |  |
|--|--|
| <input type="checkbox"/> Altan           | <input type="checkbox"/> Monroe                      |
| <input type="checkbox"/> Fairview        | <input type="checkbox"/> New Salem                   |
| <input type="checkbox"/> Goose Creek     | <input type="checkbox"/> Stallings                   |
| <input type="checkbox"/> Hemby Bridge    | <input type="checkbox"/> Unionville                  |
| <input type="checkbox"/> Indian Trail    | <input type="checkbox"/> Waxhaw                      |
| <input type="checkbox"/> Lake Park       | <input type="checkbox"/> Weddington                  |
| <input type="checkbox"/> Marshville      | <input type="checkbox"/> Wesley Chapel               |
| <input type="checkbox"/> Marvin          | <input type="checkbox"/> Wingate                     |
| <input type="checkbox"/> Matthews        | <input type="checkbox"/> Unincorporated Union County |
| <input type="checkbox"/> Mineral Springs | <input type="checkbox"/> Out of County               |

**4) ¿Cuál es el código postal de su domicilio?\***

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**5) ¿Cuál es su edad?\***

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## Su comunidad

### 6) ¿Cuáles considera que son los desafíos más importantes relacionados con la salud en su comunidad? Seleccione 3.

- |   |  |
|---|--|
| <input type="checkbox"/> Acceso a medicamentos asequibles   | <input type="checkbox"/> Obesidad  |
| <input type="checkbox"/> Acceso a atención médica (disponibilidad y accesibilidad)                  | <input type="checkbox"/> Salud bucal   |
| <input type="checkbox"/> Trastornos autoinmunes   | <input type="checkbox"/> Infecciones de transmisión sexual (ETS), como clamidia, gonorrea, hepatitis, sífilis y VIH        |
| <input type="checkbox"/> Cánceres: todos los tipos  | <input type="checkbox"/> Uso de sustancias (consumo de drogas o alcohol)   |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Consumo de tabaco, incluido el vapeo  |
| <input type="checkbox"/> Pérdida de la audición y la visión   | <input type="checkbox"/> Salud de la mujer, incluida la atención de maternidad y otros problemas exclusivos de las mujeres |
| <input type="checkbox"/> Enfermedad cardíaca (presión arterial alta, accidente cerebrovascular)     | <input type="checkbox"/> Otros (especificar):<br>_____<br>_____  |
| <input type="checkbox"/> Enfermedades infecciosas (tuberculosis o TB, gripe, COVID-19)              |  |
| <input type="checkbox"/> Enfermedad pulmonar (asma, enfermedad pulmonar obstructiva crónica o EPOC) |  |
| <input type="checkbox"/> Problemas de salud mental, como ansiedad y depresión                       |  |

### 7) ¿Cuáles son los problemas más importantes en la comunidad? Seleccione 3.

- |  |   |
|--|---|
| <input type="checkbox"/> Acceso a alimentos saludables y asequibles                  | <input type="checkbox"/> Cuestiones relacionadas con el envejecimiento (adultos mayores)                                |
| <input type="checkbox"/> Viviendas asequibles y seguras                              | <input type="checkbox"/> Racismo u otro tipo de discriminación  |
| <input type="checkbox"/> Acceso a guarderías asequibles                              | <input type="checkbox"/> Seguridad o delitos  |
| <input type="checkbox"/> Acceso a oportunidades educativas                           | <input type="checkbox"/> Salud ambiental, incluidos aire y agua limpios   |
| <input type="checkbox"/> Acceso a oportunidades de empleo                            | <input type="checkbox"/> Transporte (la capacidad de acudir a las citas médicas, al trabajo, a hacer diligencias, etc.) |
| <input type="checkbox"/> Acceso a eventos artísticos y culturales                    | <input type="checkbox"/> Otros (especificar):<br>_____<br>_____   |
| <input type="checkbox"/> Acceso a oportunidades para hacer actividad física          |   |
| <input type="checkbox"/> Acceso a apoyo y participación social                       |   |
| <input type="checkbox"/> Cuestiones relacionadas con el bienestar de niños y jóvenes |   |



## 8) ¿Qué necesita su comunidad para ser saludable?

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## 9) Califique en qué medida está de acuerdo o en desacuerdo con las siguientes afirmaciones.

	Totalmente en desacuerdo	En desacuerdo	Ni de acuerdo ni en desacuerdo	De acuerdo	Totalmente de acuerdo
Hay lugares asequibles para vivir en mi comunidad.	—	—	—	—	—
Estoy conforme con el sistema de salud de esta comunidad.	—	—	—	—	—
El transporte público es fácil de usar si lo necesito.	—	—	—	—	—
Me siento seguro en mi comunidad.	—	—	—	—	—
Hay suficientes trabajos bien remunerados en mi comunidad.	—	—	—	—	—



## 10) Salud Ambiental (Marque una respuesta por fila)

	<b>Gran preocupación</b>	<b>Algo de preocupación</b>	<b>No te preocupes</b>
Seguridad alimentaria	—	—	—
Espacio verde para la actividad física	—	—	—
Problemas de calidad y/o cantidad de agua (pozos o agua pública)	—	—	—
Eliminación de aguas residuales (sistemas sépticos o alcantarillado público)	—	—	—
Ambiente interior (seguridad, humedad/moho, plomo, amianto, radón, alérgenos, etc.)	—	—	—
Calidad del aire exterior/medio ambiente (seguridad, ruido, contaminantes, etc.)	—	—	—
Eliminación de residuos (basura doméstica o artículos voluminosos)	—	—	—
Calidad del agua de los arroyos (erosión, escorrentía de aguas pluviales, desarrollo excesivo)	—	—	—
Control de vectores (mosquitos, ratones/ratas, chinches, etc.)	—	—	—
Problemas climáticos de emergencia (inundaciones, viento, cortes de energía, calor extremo, etc.)	—	—	—



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## Su Salud

**11) En la última semana, ¿cuántos días comió frutas o verduras? Piense en todas las formas de frutas y verduras, incluso cocidas o crudas, frescas, congeladas o enlatadas.**

- Ninguno
- 1-2
- 3-5
- Más de 5
- No sé

**12) ¿Qué tan fácil o difícil le resulta conseguir frutas y verduras frescas?**

- Muy difícil
- Algo difícil
- Algo fácil
- Muy fácil

**13) Si le resulta «muy difícil» o «algo difícil», ¿cuáles son las razones por las que es difícil conseguir frutas y verduras frescas? Seleccione todas las opciones que correspondan.**

- Las tiendas que se encuentran a menos de una milla de donde vivo no venden frutas y verduras frescas.
- La calidad de las frutas y verduras frescas donde hago las compras es mala.
- Las frutas y verduras frescas son demasiado caras donde hago las compras.
- Las tiendas en las que uso mis beneficios EBT/SNAP no venden frutas y verduras frescas.
- No tengo transporte para ir a una tienda que vende frutas y verduras frescas.
- No tengo la capacidad de almacenar o preparar alimentos.



**14) In the past 30 days, have you used**

	<b>Sí</b>	<b>No</b>
Marihuana o cannabis	—	—
Drogas además de la marihuana o el cannabis	—	—
Tabaco (cigarrillos, cigarros, puros)	—	—
Tabaco sin humo (para masticar, mojar, rapé)	—	—
Cigarrillos electrónicos, como JUUL o blu (también conocidos como vapeadores)	—	—

**15) ¿Con qué frecuencia el consumo de sustancias por parte de alguien de su hogar afecta negativamente sus actividades habituales?**

- Diariamente
- Semanalmente
- Mensualmente
- Rara vez
- Nunca

**16) ¿Con qué frecuencia recibe el apoyo social y emocional que necesita?**

- Siempre
- Por lo general
- A veces
- Rara vez
- Nunca



**17) ¿Con qué frecuencia se siente solo?**

- Siempre
- Por lo general
- A veces
- Rara vez
- Nunca

**18) ¿Cuántos días a la semana practica 30 minutos de ejercicio para estar en forma?**

- Ninguno
- Uno
- Dos
- Tres
- Cuatro
- Cinco o más

**19) A continuación se presentan los problemas de salud. Por favor, marque tres que MÁS le preocupan con respecto a SU salud.**

- |   |  |
|---|--|
| <input type="checkbox"/> Enfermedad de Alzheimer/Demencia | <input type="checkbox"/> Nefropatía  |
| <input type="checkbox"/> Cáncer                           | <input type="checkbox"/> Obesidad  |
| <input type="checkbox"/> Estrés del cuidador              | <input type="checkbox"/> Enfermedad pulmonar, enfermedad pulmonar obstructiva crónica (EPOC)       |
| <input type="checkbox"/> Salud bucal                      | <input type="checkbox"/> Accidente cerebrovascular o enfermedad cardíaca                           |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Infecciones de transmisión sexual (ETS), clamidia, gonorrea, sífilis, VIH |
| <input type="checkbox"/> Consumo de drogas                | <input type="checkbox"/> Unplanned Pregnancy   |
| <input type="checkbox"/> Consumo excesivo de alcohol      | <input type="checkbox"/> Problemas de visión   |
| <input type="checkbox"/> Caídas                           | <input type="checkbox"/> Otros (especificar):  |
| <input type="checkbox"/> Problemas de audición            | _____  |
| <input type="checkbox"/> Presión arterial alta            |  |
| <input type="checkbox"/> Influenza o neumonía             |  |

**20) Durante los últimos 12 meses, ¿recibió la vacuna contra la gripe?**

- Sí
- No

**21) Si tiene un hijo de 6 años o menos, ¿su hijo está al día con las vacunas recomendadas?**



- Me preocupaba que me diera la gripe por la vacuna
- Me preocupaba tener una reacción grave a la vacuna contra la gripe
- No podía pagar la vacuna contra la gripe
- En general, estoy sano, por lo que no siento que necesite vacunarme contra la gripe
- No creo que la vacuna contra la gripe sea eficaz
- Tengo una o varias afecciones crónicas y tengo miedo de que la vacuna contra la gripe me enferme
- Tengo una afección médica o una alergia que me impide vacunarme contra la gripe
- Not sure where to get the flu vaccine or lack of transportation
- No está seguro de dónde conseguir la vacuna contra la gripe o falta de transporte
- Objeción religiosa a las vacunas
- Otros (especificar)

**22) Si tiene un hijo de 6 años o menos, ¿su hijo está al día con las vacunas recomendadas?**

- Sí
- No
- No tengo un hijo de 6 años o menos



**23) Si respondió «No» a la pregunta 22, ¿cuáles son las razones por las que su hijo no está al día con las vacunas recomendadas?**

Creo que el sistema inmunitario de mi hijo será más fuerte si contrae una enfermedad que se puede prevenir.

Me preocupa que mi hijo tenga una reacción grave a las vacunas o que las vacunas no sean seguras.

Me preocupa la existencia de una relación entre las vacunas y el autismo. Quisiera obtener más información del médico de mi hijo.

No creo que las vacunas sean necesarias porque las enfermedades no son graves o son poco frecuentes.

No quiero que mi hijo reciba varias inyecciones en una misma visita al consultorio del médico.

Mi hijo no tiene un médico de cabecera.

Mi hijo no está en la guardería, por lo que no está expuesto a enfermedades.

No tengo dinero para las vacunas, o mi hijo no tiene seguro médico.

Objeción religiosa a las vacunas

Otros (especifique):

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## Acceso a la Atención

**24) ¿Tiene un médico o una clínica a la que acudir para recibir atención cuando la necesita?**

Sí

No

**25) Elija los tipos de seguro médico que tiene actualmente. Seleccione todas las opciones que correspondan.**

No tengo seguro médico

Seguro adquirido a través del Mercado de Seguros Médicos, la Ley de Cuidado de Salud Asequible u Obamacare

Seguro a través de un empleador

Medicare

Medicaid

Tengo el seguro de mis padres

Otros (especificar):

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**26) Si tiene seguro, ¿en qué medida está satisfecho?**

- Muy insatisfecho
- Insatisfecho
- Neutral
- Satisfecho
- Muy satisfecho
- No es aplicable

**27) ¿Tiene seguro dental?**

- Sí
- No

**28) ¿Tiene seguro de la vista?**

- Sí
- No

**29) En los últimos 12 meses, ¿ha demorado algún tipo de atención médica, como el chequeo físico anual?**

- Sí
- No

**30) Si respondió «Sí» a la pregunta 29, ¿cuáles fueron las razones por las que demoró la atención médica?**

- |  |   |
|--|---|
| <input type="checkbox"/> Tiempo de espera para la cita | <input type="checkbox"/> No estoy en riesgo   |
| <input type="checkbox"/> Costo del servicio            | <input type="checkbox"/> Preferí no vacunarme |
| <input type="checkbox"/> Transporte                    | <input type="checkbox"/> Otros (especificar): |
| <input type="checkbox"/> Horarios inoportunos          | _____   |
| <input type="checkbox"/> Falta de un proveedor         | _____   |
| <input type="checkbox"/> Falta de seguro               |   |



**31) Durante los últimos 12 meses, ¿hubo algún momento en el que necesitó tratamiento o asesoramiento de salud mental?**

Sí  
 No

**32) Si respondió «Sí» a la pregunta 31, ¿pudo recibir el tratamiento de salud mental que necesitaba?**

Sí  
 No

**33) Si respondió «No» a la pregunta 31, seleccione los motivos por los que no recibió el tratamiento o asesoramiento de salud mental que necesitaba. Seleccione todas las opciones que correspondan.**

No podía pagar el costo.

Me preocupaba que recibir ayuda pudiera hacer que mi familia o comunidad tuvieran una opinión negativa de mí.

Me preocupaba que recibir ayuda pudiera tener un efecto negativo en mi trabajo.

Mi seguro médico no cubre o no paga lo suficiente el tratamiento o la terapia de salud mental.

No sabía dónde obtener los servicios.

Me preocupaba que la información que le diera al terapeuta no fuera confidencial.

Me preocupaba que me llevaran a un hospital psiquiátrico o que tuviera que tomar medicamentos.

Intenté recibir tratamiento o terapia de salud mental, pero me incluyeron en una lista de espera.

No **encontré** un terapeuta que fuera culturalmente competente o en cuanto a una discapacidad.

No disponía de transporte para acudir a la cita.

Otros (especificar):

\_\_\_\_\_  
\_\_\_\_\_

**34) En los últimos 12 meses, ¿la falta de transporte le ha impedido acudir a las citas médicas, trabajar o hacer otras cosas importantes?**

Sí  
 No

**35) ¿Hubo algún momento durante los últimos 12 meses en el que necesitó ver a un dentista pero no lo hizo?**

Sí  
 No



**36) Si respondió «Sí» a la pregunta 35, ¿cuál fue la razón principal por la que no acudió al dentista?**

- |  |   |
|--|---|
| <input type="checkbox"/> No tenía dinero para ir.                | <input type="checkbox"/> Barrera idiomática                                       |
| <input type="checkbox"/> No sabía a quién llamar ni adónde ir.   | <input type="checkbox"/> Mi seguro no paga los tratamientos dentales.             |
| <input type="checkbox"/> No confío en los dentistas.             | <input type="checkbox"/> El consultorio no estaba abierto cuando yo podía acudir. |
| <input type="checkbox"/> No tengo seguro.                        | <input type="checkbox"/> Otro motivo (especifique):                               |
| <input type="checkbox"/> No tengo transporte.                    | _____   |
| <input type="checkbox"/> Tenía miedo/No me gusta ir al dentista. | _____   |

**37) ¿Qué tan preparada cree que está su familia para hacer frente a una emergencia o un desastre (como un desastre natural, un corte de energía o una crisis de salud pública)?**

- Muy preparados: tenemos un plan de emergencia, suministros y sabemos qué hacer.
- Un poco preparados: tenemos algunos suministros y una idea de qué hacer, pero nos vendría bien más información.
- No estamos muy preparados: tenemos suministros limitados y no tenemos un plan claro.
- No estamos preparados en absoluto: no tenemos suministros ni un plan.

**38) Qué recursos, capacitación o información lo ayudarían a sentirse más preparado frente a una emergencia? Especifique:**

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## Preguntas sobre usted

### 39) ¿Qué sexo le asignaron al nacer?

- Femenino
- Masculino
- Otro término: \_\_\_\_\_

### 40) ¿Cuál es su raza o grupo étnico? Seleccione todas las opciones que correspondan.

- Indio americano o nativo de Alaska
- Asiático
- Negro o afroamericano
- Medio Oriente o del norte de África
- Nativo de Hawái o de las islas del Pacífico
- Latino o hispano
- Blanco
- Prefiero autodescribirme: \_\_\_\_\_

### 41) ¿En qué tipo de lugar vive?

- Soy propietario de mi **Vivienda**
- Alquilo la **Vivienda**
- Vivo en un refugio de emergencia
- Vivo al aire libre
- Vivo con un amigo o familiar
- Hotel o motel
- En otro lugar: \_\_\_\_\_

### 42) ¿Cuántas personas de cada grupo de edad viven actualmente en su hogar (incluido usted)?

- Niños de 0 a 5 años: \_\_\_\_\_
- Niños de 6 a 10 años: \_\_\_\_\_
- Niños/adolescentes de 11 a 14 años: \_\_\_\_\_
- Niños/adolescentes de 15 a 18 años: \_\_\_\_\_
- Adultos jóvenes de 19 a 24 años: \_\_\_\_\_
- Adultos de 25 a 64 años: \_\_\_\_\_
- Adultos de 65 años o más: \_\_\_\_\_



**43) ¿Se habla otro idioma que no sea inglés en su hogar?**

Sí

No

**44) Si respondió «Sí» a la pregunta 43, ¿qué idiomas además del inglés se hablan en su hogar?**

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**45) ¿Cuál es el nivel educativo más alto que ha completado?**

Menos que la escuela secundaria

Escuela técnica o vocacional

Escuela secundaria incompleta

Estudios universitarios incompletos

Graduado de la escuela secundaria o diploma de educación general básica

Título universitario o superior

**46) ¿A cuánto ascienden sus ingresos familiares anuales?**

Menos de \$10 000

Entre \$10 000 y \$14 999

Entre \$15 000 y \$24 999

Entre \$25 000 y \$34 999

Entre \$35 000 y \$49 999

Entre \$50 000 y \$74 999

Entre \$75 000 y \$99 999

Entre \$100 000 y \$149 999

Entre \$150 000 y \$199 999

\$200 000 o más

No sé

**47) ¿Cuál es su situación laboral actual?**

Empleado (tiempo completo)

Estudiante

Empleado (tiempo parcial)

Trabajo por cuenta propia

Jubilado

Desempleado



**48) Si está empleado, ¿en qué condado trabaja si es diferente al lugar donde vive?**

Vivo y trabajo en el mismo condado.

Trabajo en: \_\_\_\_\_

**49) ¿Alguien en su casa vive con una discapacidad física, mental o intelectual?**

Sí, un niño de entre 0 y 17 años

Sí, un adulto mayor de 18 años

No

**50) ¿Es usted un veterano o ha prestado servicio en el ejército?**

Sí

No

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**¡Gracias por responder a nuestra encuesta!**

**Su respuesta es muy importante para nosotros y nos ayudará a planificar formas de mejorar la salud en su comunidad.**

**Si tiene alguna pregunta sobre la encuesta, envíe un correo electrónico a [survey@metop.io](mailto:survey@metop.io).**

