Community Health Implementation Plan

2025 - 2027

Novant Health Ballantyne Medical Center

NOVANT HEALTH

Approved by the Novant Health Southern Piedmont Region Board of Trustees on October 16, 2025.

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INTRODUCTION

Novant Health Ballantyne Medical Center, in partnership with the Mecklenburg County Public Health Department and the Central Carolina Community Collaborative, conducted a health needs assessment in 2025 to identify the most pressing health needs in our community. Novant Health Ballantyne Medical Center will enhance the community's health by offering health and wellness programming, collaborative services and financial support to meet identified health needs.

Organization Overview

Novant Health is an integrated network of more than 900 locations, including 19 hospitals, more than 750 physician clinics and urgent care centers, outpatient facilities, and imaging and pharmacy services. This network supports a seamless and personalized healthcare experience for communities in North Carolina and South Carolina. Novant Health is nationally recognized for commitment to safety and quality for all patients, and we serve as a catalyst for healthcare transformation through clinical trials, leading-edge research, innovative care delivery models and robust virtual care networks. The expertise and empathy of our 41,000 team members along with more than 8,600 independent and employed clinicians are at the heart of Our Cause as industry leaders caring for communities across the Carolinas.

Mission

Novant Health exists to create a healthier future and bring remarkable experiences to life. We are committed to providing a remarkable experience for our patients, our team members and the communities we serve. We demonstrate this commitment to our communities through the four pillars of Our Cause:

- **Discover.** We consistently seek to innovate, courageously transform ourselves and find new ways to add value for our patients, communities and one another.
- **Empower.** We provide one another, our patients, families and communities with the resources and environment to create shared accountability and action.
- **Thrive.** We demonstrate empathy, safety and quality to help each other and our communities, grow and succeed.
- **Together.** We work as a trusted team with our unique perspectives, life experiences and expertise to bring remarkable to life in every interaction.

Novant Health Ballantyne Medical Center is a 36-bed not-for-profit community hospital that opened in 2023. The hospital provides patients with convenient and neighborhood-like access to emergency and inpatient services, diagnostic and surgical care and maternity care, as well as a variety of specialty services including orthopedics and cancer.

OUR DEFINED COMMUNITY

Primary and Secondary Service Areas

The Primary Service Area for Novant Health Ballantyne Medical Center is defined by the ZIP codes that represent at least 75% of the hospital's inpatient population as outlined below:

ZIP CODE	COUNTY
29707	Lancaster
28277	Mecklenburg
28173	Union
28720	Lancaster
28273	Mecklenburg
28278	Mecklenburg
28226	Mecklenburg
28134	Mecklenburg

Mecklenburg County contains seven municipalities including the city of Charlotte, and the towns of Cornelius, Davidson, Huntersville, Matthews, Mint Hill and Pineville. There are three counties in the Novant Health Ballantyne Medical Center Primary Service Area (PSA): Mecklenburg, Union and Lancaster, SC. 50% of patients in the PSA reside in Mecklenburg County and 49% of patients in the Primary and Secondary Service Areas reside in Mecklenburg County. **As most patients reside in Mecklenburg County, and it represents the highest population of potential individuals with less healthcare access, individuals with lower income, and minority individuals from the PSA, Mecklenburg County will be the sole focus of demographic, health and social indicators.** The Secondary Service Area covers a three-county radius, including York, Mecklenburg and Union counties.

Demographic Characteristics: Mecklenburg County

Mecklenburg County has a population of 1,163,701, a significant share of the total North Carolina population of 10,835,491.

The county includes six municipalities (Cornelius, Davidson, Huntersville, Matthews, Mint Hill and Pineville) along with the city of Charlotte. Nearly 80% of county residents live in Charlotte. The chart on the following page outlines key demographic factors in Mecklenburg County in comparison to North Carolina and the United States.

YEAR	DEMOGRAPHIC INDICATORS	MECKLENBURG COUNTY	NC	US
2023	Population	1,163,701	10,835,491	334,914,896
2020	Population change from 2010 to 2020	21.30	9.5	7.1
2030	Projected % population change from 2020 to 2030	16.0	12.5	n/a
2023	Median Age	35.6	39.4	39.2
2023	% Ages 0-4	6.3	5.5	5.5
2023	% Ages 5-17	16.2	16.0	16.2
2023	% Ages 18-39	34.2	29.3	29.4
2023	% Ages 40-64	30.9	31.6	31.2
2023	% Ages 65 and older	12.4	17.7	17.7
2023	% of Householders living alone (all ages)	33.1	29.2	28.5
2023	% of Householders living alone (65+)	7.9	11.5	11.6
2023	% with a disability	8.65	13.58	13.56
2023	% Veterans	4.98	7.32	6.06
2023	High School graduation rate	91.49	90.57	89.78
2023	Higher degree graduation rate	59.73	46.87	44.99
2023	% of young children enrolled in preschool	55.12	41.03	48.45
2023	% with limited English proficiency	9.81	4.9	8.39
2012-2017	Poor literacy and functionally illiterate	19.4	21.3	21.8

Sources: U.S. Census Bureau, American Community Survey (ACS) 5-Year Estimates (2019–2023); Decennial Census (2010 & 2020), via Metopio.; North Carolina State Center for Health Statistics, NC Department of Health and Human Services; North Carolina Office of State Budget and Management.

Key insights include:

Population Growth – Mecklenburg's population grew more than twice the national rate from 2010–2020 (21.3% vs. 7.1%) and is projected to continue outpacing North Carolina through 2030. This means the demand for health services, housing and infrastructure will outpace state and national trends, and there should be plans to expand healthcare capacity and preventative services. With its younger demographic profile than the North Carolina average, Mecklenburg has a lower median age (35.6 vs. 39.4 in North Carolina and 39.2 nationally), a larger share of residents under 40, and fewer adults 65+). With this, there may be an especially rising demand for maternal/child health, behavioral health and preventive education for younger adults. Investments in childhood focused services, maternal health engagement and behavioral health support will help sustain long-term outcomes.

Race/Ethnicity Demographics – 42.9% of Mecklenburg residents identify as non-Hispanic White, compared to 59.75% in North Carolina and 57.13% nationally, reflecting a more diverse population. Non-Hispanic Black

communities comprise 29% of the county and Hispanic or Latino communities account for another 15%. Higher rates of limited English proficiency (9.81%) and cultural perspectives may exacerbate barriers to care access and health literacy and underscore the need for expanded language access, health education for all and community partnerships to reduce clinical care gaps.

Social Factors – Mecklenburg reports fewer residents with disabilities (8.65% vs. 13%+ in North Carolina and the U.S.) and lower veteran representation, but higher rates of householders living alone and limited English proficiency. This may elevate risks of social isolation, mental health concerns and limited support networks. Thoughtful community engagement initiatives and accessible mental health services are important.

Health Indicators: Mecklenburg County

YEAR	HEALTHY LIFESTYLES & CHRONIC DISEASES	MECKLENBURG COUNTY	NC	US
2023	% with private health insurance	70.42	67.29	67.01
2023	% with public health insurance	25.97	36.44	37.41
2023	% Uninsured	11.36	9.23	7.93
2023	Medicaid coverage	14.28	19.12	21.31
2020-2022	Life expectancy	78.5	75.9	77.6
1990-1992	Life expectancy	75.1	74.8	n/a
2022	% of adults with obesity	34.1	33.9	33.2
2022	% of adults with diabetes	10.6	10.6	10.8
2022	% of adult residents reporting no physical activity	18.9	22.6	23.1
2024	Access to exercise opportunities	88.74	77.97	84.45
2022	Coronary heart disease	5.20	4.10	3.76
2022	Residents with high blood pressure	30.30	32.16	30.32
2021	Chronic kidney disease	2.8	3.1	2.9
2023	Heart disease mortality	109.0	161.2	162.1
2023	Diabetes mortality	19.2	25.3	22.4
2023	Kidney disease mortality	12.6	15.7	13.1
2023	CLRD mortality rate	19.5	37.9	33.4
Cancer				
2023	Cancer mortality *deaths per 100,000*	117.8	150.7	144.1
2021	Cancer diagnoses	462.4	475.5	444.4
2022	Colorectal cancer screening - *Percentage of adults*	60.40	60.96	58.85
2022	Mammography use - *Percentage of adults*	80.30	78.6	76.38
Infectious Diseases				
2023	Chlamydia diagnosis rate	890.09	616.00	n/a
2023	Gonorrhea diagnosis rate	397.94	246.58	n/a
2023	HIV diagnosis rate	28.3	15.5	n/a

YEAR	HEALTHY LIFESTYLES & CHRONIC DISEASES	MECKLENBURG COUNTY	NC	US
2023	Syphilis diagnosis rate	66.61	35.95	n/a
2023	Medicare flu vaccination rate	51.00	48.00	44.13
2019-2023	COVID mortality	38.2	46.3	n/a
2019-2023	Pneumonia and influenza mortality	8.2	13.1	n/a
Maternal and Child Health				
2023	% Women of childbearing age (15-44)	44.3	38.6	38.9
2023	Teen (females 15-19) birth rate	5.67	8.87	8.79
2023	Pregnancy rate	76.7	69.0	n/a
2023	Teen pregnancy rate	24.4	20.8	n/a
2020-2022	Low birth weight	9.6	9.4	8.4
2020-2022	% Receiving prenatal care in the first trimester	70.5	74.1	78.1
2024	Kindergarten immunizations	92.05	92.83	n/a
Behavioral Health				
2023	Alcohol-related mortality	10.7	11.1	12.6
2023	Suicide mortality rates	10.9	14.3	14.1
2022	% of adults with depression	21.1	23.1	22.5

Sources: North Carolina State Center for Health Statistics; U.S. Census Bureau, American Community Survey (2019–2023) and Decennial Census (2010 & 2020), via Metopio; North Carolina Office of State Budget and Management; Centers for Disease Control and Prevention, National Center for Health Statistics, United States Diabetes Surveillance System, Behavioral Risk Factor Surveillance System, PLACES Project, and Mapping Medicare Disparities, via Metopio; County Health Rankings, University of Wisconsin Population Health Institute, via Metopio; National Cancer Institute, State Cancer Profiles, via Metopio; NC Department of Health and Human Services, HIV/STD/Hepatitis Surveillance Reports, via Metopio; Health Resources & Services Administration: Maternal and Child Health Bureau (MCHB) via Metopio; National Vital Statistics System-Mortality (NVSS-M); North Carolina Annual Immunization Report, NC Department of Health and Human Services, via Metopio; Maternal and Infant Health Data Dashboard, North Carolina Department of Health and Human Services; Opioid and Substance Use Dashboard, NC Department of Health and Human Services. via Metopio.

Key insights include:

Healthcare Access Gaps – Mecklenburg residents are more likely to have private insurance but face a higher uninsured rate (11.36%) than state and national averages, with nearly half of those delaying care citing cost barriers. This points to the need for clear financial navigation services and strengthened safety-net care access for uninsured and underinsured residents.

Behavioral Health Needs – While suicide and overdose mortality are lower than state and national rates, over one in four surveyed residents (27%) report unmet mental health needs, highlighting a treatment access gap. Mecklenburg shows a high share of overdose deaths linked to illicit opioids (79%), though fewer households report being negatively affected by substance (3.5%). Scaling up community-based mental health services and intensifying opioid harm reduction strategies could help.

Maternal Health - Mecklenburg's large population of women of childbearing age and high pregnancy rates highlight strong demand for maternal and infant health services. However, elevated teen pregnancy, higher low birth weight rates and delayed prenatal care access present critical community health challenges. Access to prenatal care continues to have clinical gaps by race and ethnicity, with Black/African American and Latino/Hispanic pregnant patients having fewer prenatal care visits.

Chronic Disease and Lifestyle – Cancer mortality is markedly lower than state and national levels, and residents report healthier behaviors (greater physical activity and fruit/vegetable intake), though obesity and diabetes rates remain comparable. Expanding chronic disease prevention through community nutrition programs, physical activity promotion and access to early detection and treatment is essential.

Social Indicators: Mecklenburg County

YEAR	SOCIAL INDICATORS	MECKLENBURG COUNTY	NC	US
2023	Median household Income	$84,593	$ 70,804	$ 77,719
2023	Poverty rate	10.41	12.79	12.46
2023	Unemployment rate	3.39	4.03	4.31
2024	% of workforce employed in industries with the lowest wages*	19.3	22.5	n/a
2024	Average weekly wage	$1,691	$1,504	n/a
2023	% of Households on SNAP	8.52	12.54	11.77
2023	Food insecurity	13.2	15.0	14.5
2023	Households in poverty not receiving food stamps	67.11	58.15	59.40
2023	% of cost burdened housing units	33.66	28.04	31.86
2023	% of severely cost burdened housing units	15.92	12.72	15.12
2022	Housing insecurity	13.9	14.3	n/a
2022	Lack of transportation	8.4	9.0	n/a
2023	Households with no vehicle access	6.12	5.48	8.44
2023	Workers traveling outside the county or state for work	13.91	29.61	28.48

** Accommodation and Food Services; Retail Trade; Arts Entertainment and Recreation; and Agriculture, Forestry, Fishing and Hunting.*
Sources: American Community Survey (ACS) 2019, 2023 5-Year Estimates, U.S. Census Bureau, via Metopio;
Quarterly Census of Employment and Wages (QCEW), NC Department of Commerce, Labor and Economic Analysis Division; PLACES Project, Centers for Disease Control and Prevention (CDC), via Metopio; Map the Meal Gap, Feeding America, via Metopio; White House Council on Environmental Quality, Climate & Economic Justice Screening Tool (Version 2.0), via Metopio; Multi-Resolution Land Characteristics Consortium, U.S. Geological Survey via Metopio.

Key insights include:

Housing Affordability and Cost Burden – Despite higher median incomes, over 33% of Mecklenburg households are cost burdened, and severe cost burden rates (16%) mirror national levels. Supporting housing stability and wraparound social services that mitigate health risks tied to unstable housing can improve Mecklenburg County residents' health.

Food and Transportation Access – Food insecurity affects 13.2% of residents, and two-thirds of households in poverty are not receiving SNAP benefits, signaling underutilization of nutrition assistance. At the same time, transportation barriers persist: 8.4% report lacking reliable transportation, and only 24.5% are satisfied with public transit. Strengthening outreach for SNAP enrollment and food access programs and collaborating with

transportation planners to improve mobility to and from healthcare and other essential services will support residents' overall health.

PRIORITIZED HEALTH NEEDS

After data was collected and analyzed from the primary and secondary data sources, CCCC and localized steering committee members determined the following identified needs from which the priority health needs would be selected:

- Access to healthcare
- Access to healthy food
- Affordable housing & homelessness
- Aging-related issues/services
- Childcare
- Chronic disease prevention and management (including diabetes, obesity and heart disease)
- Disability
- Discrimination
- Education, employment and workforce opportunities
- Emerging and re-emerging health issues/Infectious diseases
- Healthy environment
- HIV and STD prevention
- Injury prevention
- Maternal and child health
- Mental health
- Safety/violence prevention
- Social isolation
- Substance use
- Transportation to essential health and human services
- Youth support

County Prioritized Health Needs

At the time of this report's creation, Mecklenburg County Public Health had not yet selected prioritized needs. Anticipated needs include:

- Access to care
- Food Security
- Mental health

Facility Prioritization

In addition to the primary and secondary data, Novant Health Ballantyne Medical Center leadership reviewed the top five diagnosis codes for inpatient readmissions and hospital emergency room returned visits from August 2024-July 2025 among patients with government insurance or no health insurance.

NOVANT HEALTH BALLANTYNE MEDICAL CENTER			
Inpatient Diagnosis	**Volume**	**Emergency Room Diagnosis**	**Volume**
Sepsis, unspecified organism	183	Weakness	7
Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD, or unspecified CKD	59	Chest pain, unspecified	5
Pneumonia, unspecified organism	45	Nausea with vomiting, unspecified	5
Hypo-osmolality and hyponatremia	38	Hypo-osmolality and hyponatremia	5
COVID-19	35	Other chest pain	4

Upon a comprehensive review of the primary and secondary data, the Novant Health Ballantyne Medical Center leadership team and Southern Piedmont Region Board of Trustees evaluated this information based on the scope, severity, clinical gaps associated with the need and the estimated feasibility and effectiveness of possible interventions. Through this thorough evaluation, the team agreed on the following significant health priorities for Novant Health Ballantyne Medical Center:

1. Access to care
2. Behavioral health (including mental and health and substance use)
3. Chronic disease management and prevention
4. Social Drivers of Health (including specific focus on food, housing, education and transportation)

ADDRESSING NEEDS

Novant Health remains committed to ensuring that all populations receive the care they need. Novant Health Ballantyne Medical Center is committed to working to address the identified areas of need through resource allocation and support of the following programs and actions. By working together, we can create a healthier and more inclusive community for everyone.

PRIORITY 1	**ACCESS TO CARE**	
Priority Goal:	Enhance access to high-quality primary care, maternal and infant care, and medication for medically underserved* populations through community-based events, collaboration and investment.	
Resources and Collaboration:	Novant Health Ballantyne Medical Center will invest personnel resources (subject matter experts and clinical staff), facility resources (mobile health units, supplies, education materials) and financial resources (charitable contributions and/or sponsorships). The facility will work in collaboration with Mecklenburg County Public Health, community-based organizations providing and expanding healthcare access and educational and research institutions training future healthcare professionals.	
Strategy:	**Desired outcome:**	
Enhance community-based access through outreach events and programs.	1.1 Increase number of medically underserved children receiving school-readiness vaccines.	**Program Action (Description):**
Enhance community-based access through outreach events and programs. Engage in meaningful nonprofit partnership through charitable investments and in-kind support.	1.2 Increase capacity of community partners to provide free and reduced cost healthcare access for medically underserved communities.	1.1.1. Deliver Vaccine for Children (VFC) program childhood immunizations and health assessments via mobile and community health services outreach.
	1.2 Increase capacity of community partners to provide free and reduced cost healthcare access for medically underserved communities. 1.3 Enhance community partner capability to increase number of community members connected to appropriate venues of care.	1.2.1 Collaborate with healthcare access focused nonprofits, expanding capabilities through non-cost use of Novant Health's mobile and community-based outreach. 1.2.2. Participate in community-based events that encourage access to medication, support for pregnant patients and babies and enhanced access to primary care.
Engage in meaningful nonprofit partnership through charitable investments and in-kind	1.3 Enhance community partner capability to increase number of community members connected to appropriate	1.3.1. Provide charitable contributions and sponsorships in support of aligned community nonprofit organizations and events, increasing access to care for community members with

support. Provide evidence-based education and resource connections to enhance community health.	venues of care. 1.4 Increase resource awareness and health literacy for individuals with barriers to care.	access and outcome barriers.
		1.3.2. Provide technology, supply, and volunteer support, including subject matter experts, to nonprofit organizations, alleviating barriers with access to primary, pregnancy and specialty care for community members.
Provide evidence-based education and resource connections to enhance community health.	1.4 Increase resource awareness and health literacy for individuals with barriers to care. 1.5 Enhance health outcomes for all patient groups in support of quality and safety aims.	1.4.1. Host health education and screening events and facilitate referrals to care and/or resources.
		1.4.2. Provide education within communities on access to care, maternal care, healthy lifestyle recommendations and other health topics.

*As defined by section 501-R of IRS regulation, medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured, or due to geographic, language, financial, or other barriers. Populations with language barriers include those with limited English proficiency. Medically underserved populations also include those living within a hospital facility's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers. CHNAs and Implementation strategies must include members of medically underserved, low-income, and minority populations.

PRIORITY 2	**BEHAVIORAL HEALTH**	
Priority Goal:	Improve access to mental health and substance use education, resources and treatment through community-based outreach, collaboration and investment.	
Resources and Collaboration:	Novant Health Ballantyne Medical Center will invest personnel resources (subject matter experts, clinical staff and resource connection staff), facility resources (resource connection technology) and financial resources (charitable contributions and/or sponsorships). The facility will work in collaboration with community-based organizations providing and expanding behavioral health awareness and access.	
Strategy:	**Desired outcome:**	**Program Action (Description):**
Enhance community awareness and access through outreach events and programs.	2.1 Increase capacity of community partners to provide affordable, inclusive behavioral support.	2.1.1. Participate in community-focused events that encourage medication takeback, behavioral health advocacy, stigma reduction and resource awareness.
Engage in meaningful nonprofit partnership through charitable investments and in-	2.2 Enhance community partner capability to increase chronic disease awareness and reduce	2.2.1. Provide charitable contributions and sponsorships in support of community-based organizations and events enhancing access to and awareness of behavioral health.

kind support.	incidence rates.	2.2.2. Provide technology, materials and volunteer support, including subject matter experts, to nonprofit organizations enhancing access to and awareness of behavioral health.
Provide evidence-based education and resource connections to enhance community health.	2.3 Increase resource awareness and behavioral health literacy for individuals and communities.	2.3.1. Provide verbal and printed education on topics including mental health first aid, postpartum depression, caregiver support and substance use disorders in accessible community locations.
		2.3.2 Provide peer support and navigation assistance to individuals with mental health or substance use disorders and utilize FindHelp platform to support resource connections.

PRIORITY 3	**CHRONIC DISEASE MANAGEMENT AND PREVENTION**	
Priority Goal:	Enhance awareness of chronic disease risks, prevention and management tools, through community-based events, collaboration and investment to reduce chronic disease prevalence.	
Resources and Collaboration:	Novant Health Ballantyne Medical Center will invest personnel resources (subject matter experts and clinical staff), facility resources (mobile health units, supplies, education materials) and financial resources (charitable contributions and/or sponsorships). The facility will work in collaboration with Mecklenburg County Public Health, community-based organizations providing and expanding healthcare access and educational and research institutions training current and future healthcare professionals.	
Strategy:	**Desired outcome:**	**Program Action (Description):**
Enhance community-based awareness, management and prevention through outreach events and programs.	3.1 Increase number of community members aware of their chronic disease risk factors.	3.1.1. Deliver free and reduced cost Remarkable You biometric, mammography and colorectal cancer screenings through mobile and community health services outreach.
	3.2 Increase capacity of community partners to enhance community and clinical awareness of chronic disease management and prevention.	3.2.1. Collaborate with chronic disease focused nonprofits to expand clinical expertise, healthy lifestyle changes and access to treatment for medically underserved populations.
		3.2.2. Participate in community-based events that encourage increased awareness and provide resources addressing chronic disease.
Engage in meaningful nonprofit partnership through charitable	3.3 Enhance community partner capability to reduce chronic disease	3.3.1. Provide charitable contributions and sponsorships in support of aligned community nonprofit organizations and events addressing chronic disease.

investments and in-kind support.	prevalence.	3.3.2. Provide technology, supplies and volunteer support, including subject matter experts, to nonprofit organizations aiding community members with access and outcome barriers.
Provide evidence-based education and resource connections to enhance community health.	3.4 Increase resource awareness and health literacy for all communities, particularly those most at risk.	3.4.1. Provide education during screening events and facilitate connections to care and resources.
		3.4.2. Provide education within communities on diabetes prevention, hypertension, cancer and healthy lifestyle recommendations,
	3.5 Enhance health outcomes for all patient groups in support of safety and quality aims.	3.5.1 Collaborate with Novant Health providers and team members on chronic disease care and resources to enhance health outcomes for all.

PRIORITY 4	**SOCIAL DRIVERS OF HEALTH**	
Priority Goal:	Assess and address social drivers of health, particularly housing, transportation, food security and education among medically underserved patients and communities.	
Resources and Collaboration:	Novant Health Ballantyne Medical Center will invest personnel resources (volunteers, subject matter experts and resource connection staff), facility resources (resource connection technology) and financial resources (charitable contributions and/or sponsorships). The facility will work in collaboration with community-based organizations addressing social needs and educational and research institutions training future social work professionals.	
Strategy:	**Desired outcome:**	**Program Action (Description):**
Engage in meaningful nonprofit partnership through charitable investments and in-kind support.	4.1 Enhance community partner capability to address social needs, especially among medically underserved populations.	4.1.1. Provide charitable contributions and sponsorships in support of aligned community nonprofit organizations and events addressing social needs for medically underserved individuals and groups.
		4.1.2. Provide technology, supplies, and volunteer support, including subject matter experts, to nonprofit organizations aiding community members with social risks.
Provide evidence-based education and resource connections to address social	4.2 Increase social needs resource awareness in all communities, particularly those most at risk.	4.2.1. Provide education and resource connections for communities and individuals on access to housing, education, transportation, food and other social resources.

needs.	4.3 Provide resource connections to medically underserved patients with social needs.	4.3.1 Provide food, transportation and other support for medically underserved patients with urgent social needs.

Health Needs Not Selected and Community Resources to Address Health Needs

NHBALMC will focus resource allocation on the prioritized needs based on careful consideration of estimated feasibility and effectiveness of possible interventions. Other needs that were identified as significant are listed below. While NHBALMC will not prioritize the remaining eleven significant health needs, it will raise awareness, support and collaborate with community partners as appropriate for the purpose of improving outcomes for identified needs that are better aligned with their scope of service:

- Education and outreach to address infectious disease, STD/STI prevention, and injury prevention will be incorporated into broader access to care initiatives led by Novant Health or community resources.
- Aging-related issues, childcare, healthy environment, youth support and social isolation are quality of life factors. While committed to improving the health of individuals throughout their lifespan, NHBALMC recognizes these issues are broader than clinical needs and did not identify these as priorities so it could focus efforts on the top issues selected.
- Addressing disability and discrimination is embedded throughout Novant Health programming, as Novant Health remains committed to ensuring that all populations receive the care they need.

In the table below, significant needs not selected for prioritization are marked with an asterisk.
In addition to the programs and services offered to the community through Novant Health Ballantyne Medical Center, there are various existing community assets available throughout the Mecklenburg County community that have additional programs and resources tailored to meet all the identified health needs.

While not all-encompassing, the following is a list of several valued community agencies that address those prioritized and non-prioritized needs:

Identified Significant Health Needs	Local Community Resources Addressing Needs
Health needs: • Access to care and medication • Chronic disease prevention and management • HIV & other STIs* • Healthy pregnancy • Infectious diseases* • Aging-related issues/services* • Injury Prevention*	Age-Friendly Mecklenburg Alzheimer's Association American Heart Association American Diabetes Association American Lung Association Bee Mighty Breakthrough T1D Bright Blessings Blood Cancer United Charlotte Community Health Clinic Care Ring Cook Community Clinic Charlotte Speech and Hearing

	Compare Foods Charlotte Mecklenburg Schools CW Williams Community Health Center DeAngelo Williams Foundation Colon Cancer Coalition Go Jen Go Foundation Isabella Santos Foundation Latin American Coalition Levine Senior Center Lions Services March of Dimes Mecklenburg County Health Department Mecklenburg County Parks and Recreation National African American Male Wellness Agency NC Med Assist Nothing Pink Inc RAIN Parkinsons Foundation Ronald McDonald House Shepherd's Center St. Judes Childres Research Teal Diva
Social Drivers of Health, including: • Housing • Food • Childcare* • Education and employment • Transportation access • Violence prevention (including safety and crime) * • Disability* • Discrimination* • Healthy environment* • Youth Support* • Social Isolation*	Ada Jenkins Augustine Literacy Project - Charlotte Heal Charlotte Second Harvest Metrolina Nourish Up Goodwill Industries Caterpillar Ministries Charlotte Bilingual Preschool Charlotte Center for Legal Advocacy Charlotte Mecklenburg Libraries Classroom Central Communities in Schools Crisis Assistance Ministry Dottie Rose Foundation Roof Above Crittenton of NC Latin American Coalition Leading on Opportunity NC DHHS Disability Services Muggsy Bogues Foundation Shepherd's Center Supportive Housing Communities The Charlotte Post Foundation Uptown Farmers Market

	Shelter Health Services Safe Alliance Rebuilding Together The Bulb YWCA Angels and Sparrows Habitat for Humanity Senior Citizens Nutrition Support
• Behavioral Health (including mental health and substance use disorder)	Charlotte Rescue Mission Crisis Assistance Ministry Mental Health America Living Waters RAIN Dilworth Center Center for Prevention Services Cook Community Clinic Blue Magic Mental Queen City Harm Reduction Safe Alliance Steve Smith Family Foundation Mitchell Bays Turner Pediatric KinderMourn Veterans Bridge Home

*Significant needs not selected for prioritization

For a full list of community resources, visit NovantHealth.org/MyCommunity

APPROVAL OF COMMUNITY HEALTH IMPLEMENTATION PLAN

The 2025 Novant Health Ballantyne Medical Center Community Health Implementation Plan (CHIP) has been reviewed and approved by the leadership of the Southern Piedmont Board of Trustees on October 16, 2025, in accordance with state and federal guidelines. The findings and priorities outlined in this report reflect a collaborative effort among public health professionals, community stakeholders and residents. The hospital facility affirms its commitment to using this assessment as a foundation for strategic planning, resource allocation, and community health improvement initiatives.

The Novant Health Southern Piedmont Region Board of Trustees and Novant Health Ballantyne Medical Center administration are active participants in the community benefit process. Through strategic planning initiatives, leadership provides direction on actions and intended impact and serves as the approving body for the community health needs assessment and community benefit implementation plan. Administrative leaders serve on the county assessment planning team and hospital board members participate and provide influence on the community benefit plans. All members are actively involved in the priority setting discussion and outreach planning process. Additionally, community benefit reports are provided to the board and facility leadership teams throughout the calendar year for ongoing education.

APPENDIX

Data Sources

The following is a list of sources used during the CHNA process. Many of the datasets were accessed via the Metopio platform. A URL for each dataset is available upon request.

Centers for Disease Control and Prevention. (2024). *PLACES Project*. Retrieved via Metopio.

Centers for Disease Control and Prevention. (2025). *National Vital Statistics System-Mortality (NVSS-M)*. Retrieved via Metopio

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Community Health Needs Assessment Steering Committee

The Live Well Steering Committee is convened by Mecklenburg County Public Health and includes over 20 representatives from organizations such as health systems and plans, academic institutes, community nonprofits and county offices.

AGENCY
Mecklenburg County Public Health*
Atrium Health
Alliance Health Plan
Cabarrus Rowan Community Health Centers**
Camino**
Leading on Opportunity**
Northeastern University
Novant Health
UNC Charlotte
YMCA Charlotte

Central Carolina Community Collaborative

The Central Carolina Community Collaborative brings together diverse voices including health systems, public health departments, academic institutions, United Way agencies and other community-based organizations to identify needs, share resources and implement meaningful solutions.

CENTRAL CAROLINA COMMUNITY COLLABORATIVE	
Agency	**County**
Alleghany Health	Alleghany
Anson County Health Department*	Anson
Atrium Health	Various
Cabarrus County Health Department*	Cabarrus
CaroMont Health	Various
Davidson County Health Department*	Davidson
Davie County Health Department*	Davie
Della Rae Consulting	Various
Forsyth County Health Department*	Forsyth
Gaston County Health Department*	Gaston
Hugh Chatham Health	Various
Iredell County Health Department*	Iredell
Novant Health	Various
Rowan County Health Department*	Rowan
Scotland Health	Various
Scotland County Health Department*	Scotland
Stanly County Health Department*	Stanly
UNC Charlotte Urban Institute	Various
UNC Gillings School of Public Health	Various
Union County Health Department*	Union
United Way -Lincoln	Lincoln
United Way-Davidson, Davie	Davidson, Davie
United Way-Rowan	Rowan
Wilkes County Health Department*	Wilkes

*Representative of a state, local, tribal, or regional governmental public health department (or equivalent department or agency)
** Members of medically underserved, low-income, and minority populations in the community served by the hospital facility, or individuals or organizations serving or representing the interests of such populations, as required by Internal Revenue Code section 501(r).