2025 Community Health Needs Assessment

Methodist SM
Le Bonheur Healthcare

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EXECUTIVE SUMMARY

Methodist Le Bonheur Healthcare

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Methodist Le Bonheur Healthcare (MLH) conducted the 2025 Community Health Needs Assessment (CHNA) to meet federal requirements under the Affordable Care Act (ACA) and inform the system's Strategic Plan. The CHNA findings will serve as the basis for future community benefit investments and the development of facility and system-specific implementation strategies. This assessment meets the federal requirements of the Affordable Care Act (ACA). In accordance with federal requirements, this report is made widely available to the public on the MLH website at www.methodisthealth.org.

The mission of Methodist Le Bonheur Healthcare is to enhance health and well-being through high-quality, innovative and compassionate care, demonstrating its core values of service, quality, integrity, teamwork, and innovation.

MLH's Strategic Plan, *MLH Reimagined*, was launched in 2022. Built on six strategic imperatives: Workforce, Integrated Physician Network, Digitization, Centers of Excellence, Community Health & Partnerships, and Operational Efficiency, this strategic plan provides a bold roadmap to improve care delivery, strengthen communities, and meet the ever-evolving needs of patients, Associates and partners in health.

Since its launch in 2022, implementation of *MLH Reimagined* has met meaningful milestones from advancing clinical excellence and expanding access to care, to fostering innovation and supporting the community in living healthier lives. The impact of this work can be felt far beyond the walls of MLH's hospitals and clinics. By connecting people with the care, resources and information they need, MLH is facilitating healthier futures for individuals, families and communities throughout Memphis and the Mid-South.

Per IRS requirements, MLH's 2025 CHNA included feedback from the community and experts in public health and clinical care and took into account the health needs of vulnerable populations, including minorities, those with chronic illness, low-income populations, and medically underserved populations. The CHNA, and the resulting list of identified health needs, are to serve as the basis for future community benefit investments. The IRS requires that the hospital also adopt an implementation strategy for each of its facilities.

This report documents how the CHNA was conducted and describes the related findings.

CHNA PROCESS AND KEY FINDINGS

The 2025 CHNA utilized a comprehensive, integrative approach covering our primary geographic area, including Shelby County, Tennessee, and DeSoto County, Mississippi. The assessment incorporated:

- Results from a community health needs survey administered to 1,350 community members.
- Interviews conducted with 60-key industry and stakeholder informants.
- Thirteen focus groups comprised of a total of 109 diverse participants to gather in-depth knowledge of health and barriers to care, concentrated in high-poverty zip codes.

The assessment consistently highlighted that health outcomes are shaped by a complex web of medical, behavioral, and social factors. Poverty was cited as the single most significant community issue and a systemic problem underpinning the primary barriers to care.

The analysis of survey, interview, and focus group data converged on five critical themes:

1. Mental Health Crisis: This was cited as the top health need in the survey, with over 55% of stakeholder interviews citing mental health and related topics. Key gaps include a severe lack of affordable, accessible, and culturally competent providers, insufficient emergency psychiatric care, and the profound impact of community violence/trauma driving youth anxiety and depression.

2. Access to Care: Difficulty navigating complex health systems was raised by nearly 50% of stakeholders. Obstacles include transportation challenges, a shortage of specialty and behavioral health providers, and poor navigation support. Cost and out-of-pocket expenses were identified by 23% of respondents as the single most significant barrier to care.

3. Chronic Disease Persistence: High rates of diabetes and obesity are linked directly to food deserts, poor nutrition access, and safety concerns limiting physical activity.

4. Violence and Community Safety: Identified as a profound stressor, these issues impact both physical and mental health, particularly gun violence and its contribution to community trauma and reduced outdoor activity.

5. Social Determinants of Health: Fully 40% of stakeholders raised social and economic factors as key health drivers. Poverty, food insecurity, and housing/homelessness were identified as root causes that force residents to prioritize basic needs over long-term health, with systemic inequities highlighted as compounding factors.

Leading Causes of Death (2021 Data)

Health outcome data for Shelby and DeSoto Counties confirm the urgency of chronic disease intervention. The top three causes of death are consistent across both counties and for both Black and White groups:

Rank	Shelby County, TN (All Races)	DeSoto County, MS (All Races)
1	Diseases of the Heart (2,187 deaths; 236.6 per 100,000)	Diseases of the Heart (437 deaths; 231.7 per 100,000)
2	Cancer (all types) (1,547 deaths; 167.3 per 100,000)	Cancer (all types) (331 deaths; 175.5 per 100,000)
3	COVID-19 (1,465 deaths; 158.5 per 100,000)	COVID-19 (276 deaths; 146.3 per 100,000)

Note: The death rate for Homicide in Shelby County (36.9 per 100,000) is notably higher than in DeSoto County (15.4 per 100,000).

RACIAL DISPARITIES IN SHELBY COUNTY

The data reveals significant disparities, where Blacks experience notably higher mortality rates from key preventable and systemic causes compared to Whites:

- **Homicide:** 59.4 per 100,000 for Blacks versus 10.7 per 100,000 for Whites.
- **COVID-19:** 187.5 per 100,000 for Blacks versus 134.2 per 100,000 for Whites.
- **Diabetes:** 44.7 per 100,000 for Blacks versus 27.3 per 100,000 for Whites.

COMMUNITY STRENGTHS AND CRITICAL GAPS

The assessment acknowledged significant community resilience and infrastructure that can be leveraged, including non-profit and faith-based health hubs, strong collaboration and advocacy among organizations, and improvements to physical assets such as parks and greenlines.

However, critical gaps in services were also identified, including:

- **Environmental Protection:** Demand for stronger public health measures, including mandatory child blood lead testing.
- **Substance Use and Addiction Services:** Clear need for greater recovery housing capacity.

- **Family and Child Services:** Acute shortages in childcare, recurring food shortages, and lack of support for uninsured individuals.
- **Housing and Public Safety Enforcement:** Inadequate code enforcement and lack of tenant rights advocacy.

IMPROVING COMMUNITY HEALTH AND EQUITY

The 2025 CHNA confirms that health outcomes in the Mid-South are deeply impacted by socioeconomic factors, with poverty cited as the primary driver of poor health. Addressing these needs requires sustained collaborative investment, focusing on:

1. Integrating Behavioral and Primary Care to address the mental health crisis by expanding capacity for affordable behavioral health services.

2. Elevating Social Drivers to prioritize coordinated cross-sector efforts on affordable housing, transportation equity, and food systems.

3. Improving Navigation and Trust by leveraging community partnerships and deploying more Community Health Workers.

4. Targeted Prevention to focus on reducing maternal mortality disparities and strengthening environmental protections. The CHNA calls for expanded community wellness initiatives, school-based health education, and equitable investment in safe physical activity spaces. It will serve as the foundation for the community's health improvement planning efforts over the next three years, requiring continued partnership between healthcare systems, government agencies, community organizations, and residents.

CONCLUSION

The 2025 Community Health Needs Assessment (CHNA) serves as both a sobering reflection of the current health landscape in the Mid-South and a strategic blueprint for the future of Methodist Le Bonheur Healthcare (MLH). The findings underscore a fundamental truth: health does not exist in a vacuum. It is deeply intertwined with the social and economic realities of the communities we serve.

FROM DATA TO ACTION

The data reveals a stark reality regarding health equity in Shelby County. The significant racial disparities in mortality rates—most notably the homicide rate of 59.4 per 100,000 for Black residents compared to 10.7 for White residents, and the disproportionate impact of Diabetes (44.7 vs. 27.3)—demand more than clinical intervention. They require a systemic response that addresses poverty as the primary driver of poor health outcomes.

These findings suggest that addressing the region's health disparities requires a shift toward proactive, community-centered care. The data highlights three critical areas for impact:

- **Targeted Intervention:** Building on the success of the "Healthier 901" initiative, which helped Memphis fall out of the "top 10 most obese cities" list and saw over 13,000 pounds lost by participants.
- **Clinical Excellence:** Expanding our Centers of Excellence to provide high-performing care in Oncology and Cardiology, the region's leading causes of death.
- **Systems Navigation:** Addressing the 23% of residents who identified cost as their primary barrier to care by improving navigation and building trust through Community Health Workers.

A SHARED RESPONSIBILITY

While this report fulfills federal ACA and IRS requirements, its true purpose is to ignite collaborative change. The identified gaps—ranging from mental health access and substance use recovery to environmental protections and public safety—cannot be solved by any single institution.

As MLH implements its system-wide strategies over the next three years, we remain dedicated to our mission of enhancing well-being through high-quality, compassionate care. By leveraging community strengths and fostering cross-sector partnerships, we will continue to build a Mid-South where every individual, regardless of zip code or background, has the opportunity to live a healthy, dignified life.

2025 Community Health Needs Assessment

Methodist Le Bonheur Healthcare

INTRODUCTION

A Community Health Needs Assessment (CHNA) is a critical tool that aids hospital systems in identifying the most pressing health issues of their community. The Internal Revenue Service (IRS) requires all nonprofit hospitals to complete a CHNA every three years. Following the completion of each CHNA, the hospital must submit an Implementation Plan, detailing how the agency and its staff plan to prioritize and resolve health issues identified within the assessment.

The 2025 CHNA will be a key component of Methodist Le Bonheur Healthcare's (MLH) ongoing commitment to unite Mid-Southerners to tackle the region's biggest health challenges and address the Social Determinants of Health (SDOH)—those external factors which extend beyond the clinical environment and affect patient health outcomes.

The CHNA is a key component of Methodist Le Bonheur Healthcare's 2026-2028 strategic plan, MLH Reimagined. Built on six strategic imperatives—Workforce, Integrated Physician Network, Digitization, Centers of Excellence, Community Health & Partnerships, and Operational Efficiency—this strategic plan provides a bold roadmap to improve care delivery, strengthen communities, and meet the ever-evolving needs of patients, Associates, and partners in health.

REPORT CONTENTS

This report is the technical research document that describes the methodologies and results of Methodist Le Bonheur Healthcare's 2025 Community Health Needs Assessment (CHNA). It includes an individual report for each methodology undertaken by the MLH Program Evaluation team. Each report is formatted so it can stand alone and be shared with stakeholders, either separately or as part of the dissemination of the full CHNA.

The entire CHNA covers the health needs of the residents of Shelby County, Tennessee; DeSoto County, Mississippi and surrounding areas. All source material is cited and can be found in the references at the end of each report. This document is intended as a resource for MLH grant writers, foundation staff, marketing and planning teams, and community agencies to help shape their response to community health needs.

The following reports are included in the 2025 CHNA:

- Executive Summary
- Organizational Background
- Methodology and Results
- Health Priorities for 2022 and 2025
- Secondary Data & Stakeholder Interviews
- Community Survey & Focus Groups

METHODIST LE BONHEUR HEALTHCARE MISSION/VISION/VALUES

Mission The mission of Methodist Le Bonheur Healthcare (MLH) is to enhance your health and well-being through high-quality, innovative, and compassionate care.

Vision Methodist Le Bonheur Healthcare will be nationally recognized for excellence in clinical quality, patient safety, and compassionate care to improve every life we touch.

Values MLH's core values are Service, Quality, Integrity, Teamwork, and Innovation.

ABOUT METHODIST LE BONHEUR HEALTHCARE

Based in Memphis, Tennessee, Methodist Le Bonheur Healthcare has been caring for patients and families regardless of ability to pay for more than 100 years. Guided by roots in the United Methodist Church and founded in 1918 to help meet the growing need for quality healthcare in the greater Memphis area, MLH has grown from one hospital into a comprehensive healthcare system with 11,500 Associates supporting six hospitals, ambulatory surgery centers, outpatient facilities, hospice residence and physician practices serving communities across the Mid-South. From transplants and advanced heart procedures to expert neurology services and compassionate cancer care, MLH offers clinical expertise with a focus on improving every life it touches. In 2023-2024, MLH facilities conducted 27,458 Surgeries, 26,552 telehealth visits, 21,701 home healthcare visits, and 51,960 minor med visits, cared for 56,124 total inpatients, served 1,072 hospice patients, and delivered 5,118 babies.

Methodist Le Bonheur Healthcare's Tennessee-based adult hospitals have been recognized by U.S. News & World Report as the highest-ranked in the Memphis Metro area and No. 2 in the state of Tennessee (tied for both designations) in the 2025-2026 Best Regional Hospitals edition.

MLH has also received recent accolades for its workplace environment, including being named to Becker's Hospital Review's 2023 list of 150 Top Places to Work in Healthcare (for which it has been recognized for over a decade) and being named among the Top Nine Organizations for Diversity by Modern Healthcare in 2022.

Methodist University Hospital is the largest, most comprehensive hospital in the Methodist Le Bonheur Healthcare system. It is a 583 bed licensed acute care facility in the heart of the Memphis Medical District. As an academic campus, partnering with the University of Tennessee Health Science Center (UTHSC), Meharry Medical College and Lincoln Memorial University, it brings together research, medicine and innovation. These partnerships support multidisciplinary collaboration among doctors and clinical team members, leading to more advanced medical care for our patients. At Methodist University, a staff of more than 2,000 Associates focuses on providing patient and family-centered healthcare services. Methodist University Hospital has established areas of focus to provide comprehensive regional tertiary care for cardiac, cancer, neurologic and transplant patients.

Methodist South Hospital has served south Shelby County and the surrounding areas for 50 years. Methodist South currently has 156 licensed acute beds and provides a full complement of general acute care services, including critical care, surgery, 24-hour emergency department, cardiac, orthopedic, dialysis, and wound healing.

Methodist North Hospital opened in 1978 in the Raleigh community to support the needs of north Shelby County and neighboring Tipton County. Methodist North currently has 280 licensed acute beds. Methodist North provides general acute care services including critical care, same-day surgery, 24-hour emergency care, limb preservation and wound care; cardiac services; orthopedic surgery and a behavioral health center.

Methodist Germantown Hospital is a 319-bed, full-service hospital serving east Shelby County and surrounding communities. Among the many services offered by Methodist Germantown are maternity services with a Level III neonatal intensive care unit (NICU), comprehensive cardiology program, critical care services, orthopedic surgery program, rehabilitation services, an outpatient diagnostic imaging center and a 24-hour emergency department staffed and equipped to meet the healthcare needs of both children and adults.

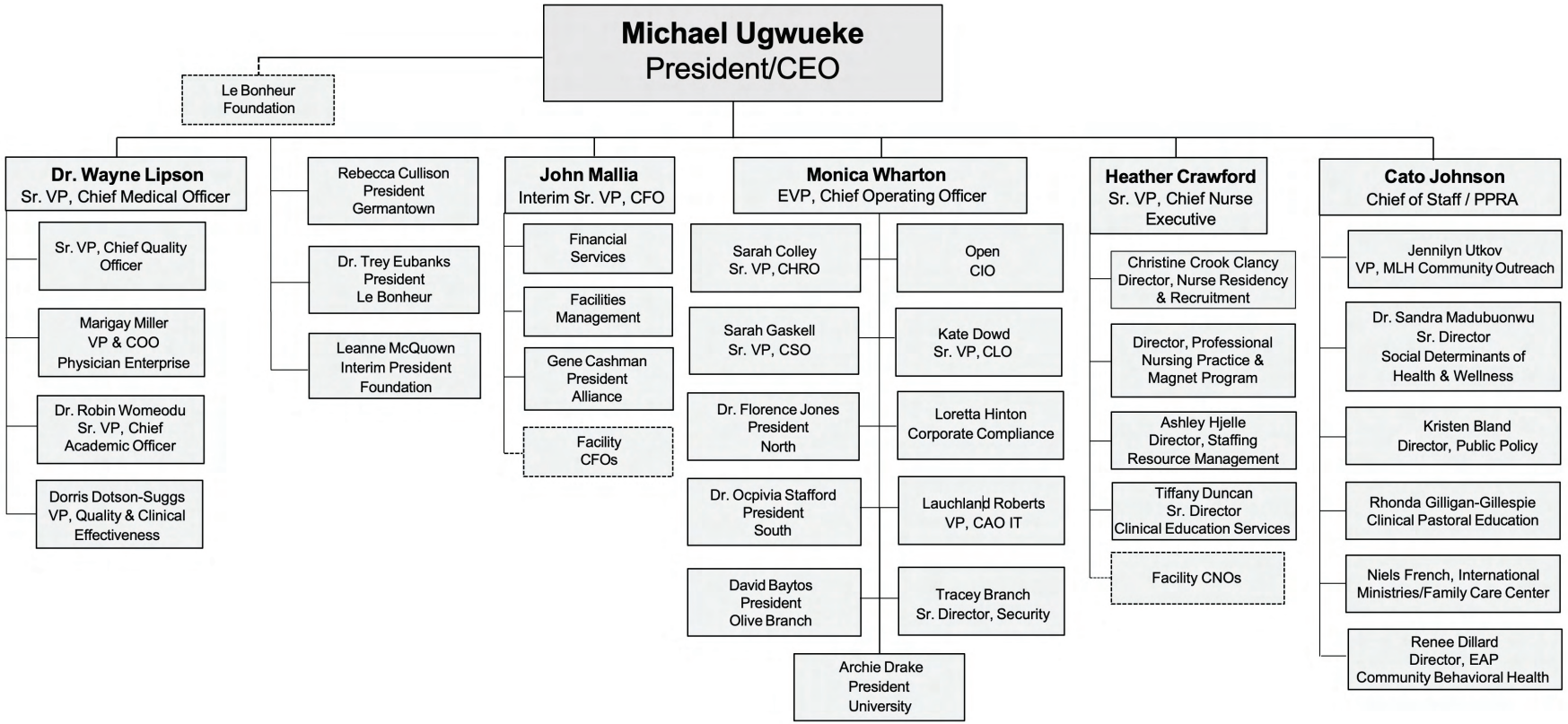
Le Bonheur Children's Hospital treats more than 500,000 children each year through community programs, regional clinics, a 255-bed state-of-the-art hospital, as well as a 21-bed satellite location in Jackson, Tennessee. A medical staff of more than 240 physicians provides expert care in 45 subspecialties. Le Bonheur Children's Hospital has consistently been ranked as a "Best Children's Hospital" by U.S. News and World Report. The Mid-South's only comprehensive pediatric facility, Le Bonheur Children's operates the only pediatric ACS Level 1 trauma center and Level IV NICU in the region. The hospital provides numerous specialty services including heart, liver and kidney transplantation, brain tumor resections and cardiothoracic surgery. Various outpatient centers provide urgent care, outpatient surgery and subspecialty clinics throughout the Mid-South in ambulatory settings and partners with various West Tennessee school systems to provide school-based nursing services, health screenings and health education.

Le Bonheur Children's is also committed to educating the next generation of pediatric providers, as the primary pediatric teaching hospital for the University of Tennessee Health Science Center (UTHSC). In addition, the Children's Foundation Research Institute, a partnership of UTHSC, Le Bonheur and the Children's Foundation of Memphis, works to further the prevention, treatment and elimination of pediatric disease by supporting researchers looking for new discoveries in pediatrics. Medical scientists perform research in many areas including neuroscience, cardiology and infectious and respiratory diseases.

Methodist Olive Branch Hospital opened in 2013 and is a five-story, 69-bed hospital designed to care for communities in north Mississippi. Methodist Olive Branch Hospital provides emergency services, maternity services, obstetrics, cardiology, gastroenterology, nephrology, rehabilitation services and imaging and diagnostic services. The hospital also supports MLH's commitment to sustainability by being designed in accordance with U.S. Green Building Council (USGBC) Leadership in Energy and Environmental Design (LEED) certification.

Methodist Medical Group brings together internal, family medicine and specialty physicians in a collaborative effort to provide premier comprehensive patient-center care. In addition, Specialty Physician Group (SPG) is composed of cardiologists from Sutherland Cardiology.

METHODIST LE BONHEUR HEALTHCARE ORGANIZATIONAL CHART



METHODOLOGY ABSTRACTS

The 2025 CHNA utilized a multi-pronged approach to evaluate the complex factors influencing health and quality of life in the Mid-South.

- **Secondary Data:** A review of public health data from the CDC, Tennessee and Mississippi Departments of Health, and the National Center for Health Statistics. This includes racial and gender breakdowns to identify specific disparities.
- **Stakeholder Interviews:** 60 interviews with 68 internal and external leaders representing 56 organizations, including community advocates, government officials, and healthcare providers.
- **Community Survey:** 1,350 responses from community members regarding health needs, concerns, and barriers to care.
- **Focus Groups:** 13 sessions with 109 participants, including first responders, faith leaders, and residents, to capture lived experiences and qualitative insights.

Through this comprehensive process, MLH continues its mission to enhance health and well-being through high-quality, innovative, and compassionate care.

2025 CHNA METHODOLOGY AND SCOPE

The 2025 CHNA was undertaken to comprehensively evaluate the complex factors influencing health and quality of life in Shelby County, Tennessee, and DeSoto County, Mississippi (MLH's primary service area). This assessment utilized a multi-faceted approach, incorporating a large-scale community survey, in-depth focus groups, comprehensive stakeholder interviews, and an analysis of secondary public health data.

The analysis was synthesized across 1350 community surveys, 13 focus groups, and 60 stakeholder interviews.

CHNA Component	Methodology & Key Themes (2025)
Secondary Data	Thorough review of original data (e.g., state health departments, CDC) for Shelby and DeSoto Counties, including racial and gender breakdowns. Data tables and dashboards compare local outcomes to state and national rates.
Stakeholder Interviews	60 interviews with internal and external stakeholders (e.g., government officials, healthcare providers, community partners). Top themes were Access to Care (48% of interviews), Mental and Behavioral Health (~55% of all discussions), and Social & Economic Determinants (40% of interviews).
Community Survey	Obtained 1,350 responses from Shelby County community members. Top health needs cited were Mental Health, Overweight/Obesity, and Diabetes. The top community concerns were Poverty, Access to Care/Uninsured, and Homicide/Violent Crime. The most significant barriers to care were cost/out-of-pocket expenses and basic needs not being met.
Focus Groups	13 focus groups with 109 community members of varying age, race, and gender. Top themes included the need for improved healthcare navigation and cultural humility, enhanced mental health resources, and addressing homelessness and housing instability.

KEY FINDINGS AND COMMUNITY STRENGTHS (2025)

The findings reflect a critical landscape of persistent challenges intertwined with notable community strengths.

TOP HEALTH CONCERNS AND SOCIAL DETERMINANTS

The analysis of data across all methodologies consistently demonstrates that community health is shaped by interconnected social, economic, behavioral, and environmental influences.

CHNA Theme (Stakeholder Interviews)	Prevalence	Key Issues Cited
Access to Care	Most Cited (48%)	Financial barriers, transportation challenges, provider shortages, and lack of awareness/navigation.
Mental and Behavioral Health	Crisis-Level Concern (~55%)	Escalating youth anxiety/depression, unaddressed trauma/ACEs, and the intertwined nature of substance use/violence.
Social and Economic Determinants	Highly Cited (40%)	Poverty as the underlying driver of disparities, Food Insecurity, and unstable Housing/Homelessness.

LEADING CAUSES OF DEATH (2021)

Secondary data analysis highlighted the most serious health outcomes in the region. In 2021 (the most recent data available), the leading causes of death for the total population in both counties were **Diseases of the Heart** and **Cancer** (all types). Data on the leading causes of death can be found in Tables 18-24 in the Secondary Data Analysis report of this CHNA.

- **Shelby County, TN:** Diseases of the Heart (Rate: 236.6 per 100,000) and Cancer (Rate: 167.3 per 100,000).
- **DeSoto County, MS:** Diseases of the Heart (Rate: 231.7 per 100,000) and Cancer (Rate: 175.5 per 100,000).

Racial Disparities: Significant disparities persist, notably with Homicide being the 6th leading cause of death for African Americans in Shelby County (Rate: 59.4 per 100,000), a rate not seen in the top 13 for Caucasians.

COMMUNITY STRENGTHS AND GAPS ANALYSIS

Every community has challenges to address, and strengths to leverage in addressing them. Below are the strengths and challenges identified by the participants in the CHNA survey and focus groups.

1. Community Strengths
Despite significant challenges, respondents cited numerous strengths contributing to community well-being:

- **Trusted Anchors—non-profit and faith-based health hubs:** Free/low-cost clinics (e.g., Church Health, Christ Community) and local churches were widely praised for filling critical service gaps.
- **Community Collaboration and Advocacy:** Strong partnerships exist, and the use of Community Health Workers is effectively bridging health gaps and improving navigation.
- **Improvement of Physical Assets:** Noted improvements to the built environment include strong park systems, well-maintained greenlines, and the expansion of bike lanes to support community gathering and physical activity.
- **Outreach, Education, and Screening Efforts:** There is a growing number of initiatives utilizing mobile/pop-up opportunities for health education and free services.

2. Critical Gaps in Services
Analysis of a community-driven flip chart activity during the focus group sessions revealed that the community is resourceful, but its efforts are constrained by systemic issues:

- **Housing and Environmental Safety:** Persistent concerns include inadequate follow-up on housing conditions, inadequate code enforcement, the lack of tenant rights advocacy, and a strong demand for mandatory child lead testing and free water testing kits.
- **Healthcare Access and Equity:** Gaps were frequently attributed to lack of funding, language barriers, and poor community knowledge/navigation, alongside explicit calls for clinics not requiring insurance.
- **Family-Centered Needs:** Significant unmet needs were cited in childcare and early education and substance use/addiction facilities.
- **Substance Use Services:** The explicit lack of dedicated facilities and the need for greater capacity for recovery housing were cited by participants.

SERVICE AREA AND KEY DEMOGRAPHICS

This report presents information describing the demographics and health status of residents within **Shelby County, Tennessee**, and **DeSoto County, Mississippi**, Methodist Le Bonheur Healthcare's primary service area.

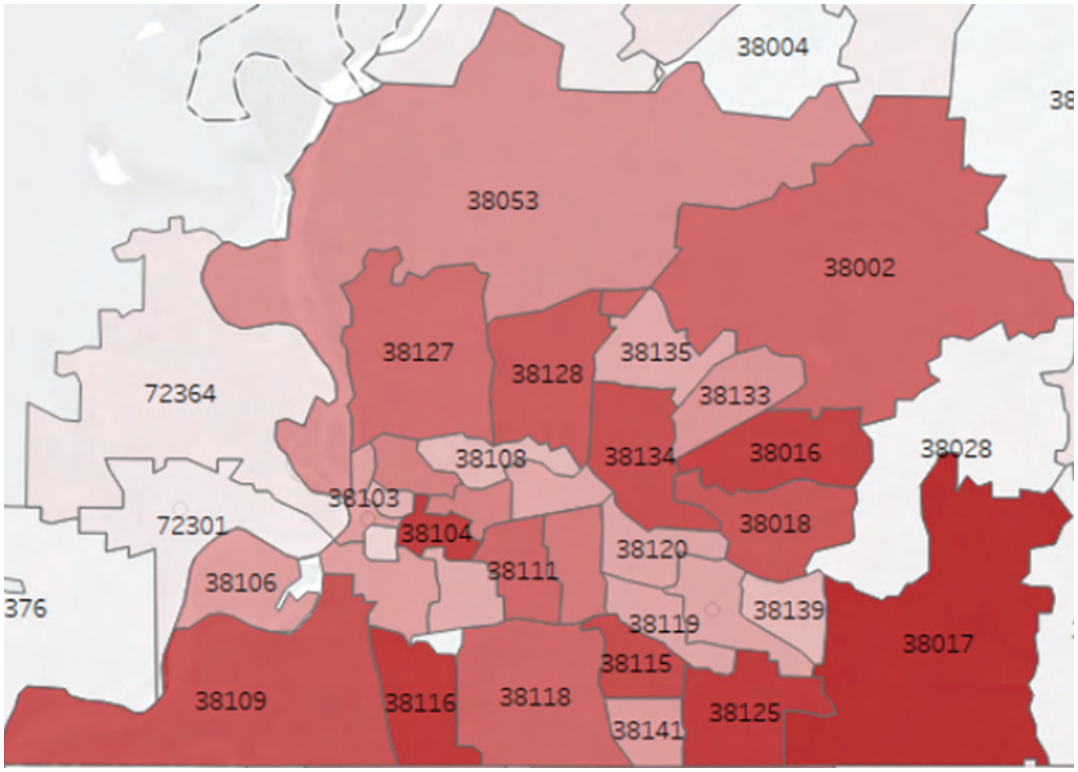
Shelby County has a population of 922,195 and DeSoto County has a population of 188,598. The racial split for Shelby County is 50% Black and 35% White, while DeSoto County is 30% Black and 60% White. Hispanic ethnicity makes up 8% of Shelby County and 5% of DeSoto County. About a quarter of the populations of both counties are children under age 18.

The table below shows how the percentage of the focus group and survey respondents compare to key community demographics. Close to 60% of the CHNA input participants were Black and 32% were White. An estimated 14% (based on survey participation) of CHNA participants had annual household incomes less than $30,000. Of note in terms of the survey demographics was that the respondents were disproportionately female, and that respondents overall reported higher educational and income levels compared to the general population.

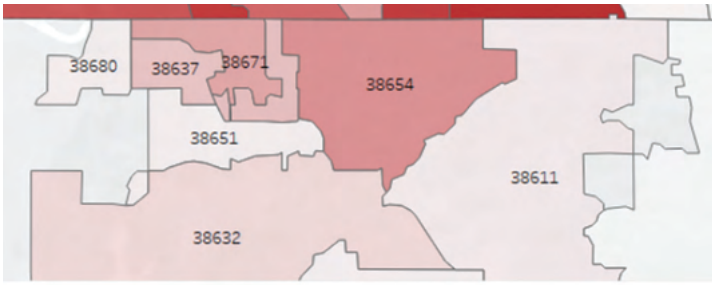
Key Demographics	Shelby County Population Percentage	DeSoto County Population Percentage	2025 CHNA Participants Percentage
African American (Black)	52-54%	30-32%	58%
Caucasian (White)	33-35%	55-63%	32%
Hispanic	6-9%	5-6%	3%
Female	52-53%	52%	84% (Survey) 61% (Focus Group)
Adults Uninsured	~12%	Data Varies	4% (Survey estimate)
< $30,000 Household Income	Data Varies	Data Varies	14% (Survey estimate)

SURVEY RESPONDENTS BY ZIP CODE

Shelby County, Tennessee



Desoto County, Mississippi



HEALTH PRIORITIES ADDRESSED IN PREVIOUS CHNAS

In the 2019 MLH Community Health Needs Assessment, five priority areas were identified:

- Access to health services
- Behavioral/mental health
- Maternal, infant and child health
- Cardiovascular disease and stroke
- Cancer

(The narrative detailing actions taken from 2020 to 2022 under the previous priorities—Access to Health Services, Behavioral/Mental Health, Maternal, Infant and Child Health, Cardiovascular Disease and Stroke, and Cancer—remains relevant as a historical record of implementation before the 2025 CHNA.)

The results of the 2022 CHNA were presented to the Community Health and Partnership (CHP) Steering Committee, which is responsible for the community imperative of the system's 2022-2026 strategic plan. Information from each of the CHNA assessment methods was presented to this group, with findings organized around each health and health factor topic. CHNA findings on mortality, morbidity, disparities, importance ratings, and examples from the community were also presented. The CHP recommended the following six key community issues to the MLH System Leadership Team:

- Mental health
- Cardiovascular disease
- Cancer
- Poverty
- Healthcare access and insurance
- Homicide

One of the initiatives MLH implemented to address health priorities from the 2022 CHNA was the Chronic Disease Self-Management Program (CDSMP), which offers a free resource for individuals with chronic conditions and their caregivers. The program empowers people living with conditions like cancer, asthma, diabetes, heart disease and others, helping them better manage their health and daily routines.

Participants gain valuable skills in areas such as stress management, sleep hygiene, healthy eating and medication decisions. Classes are led by trained facilitators in community settings, fostering a supportive environment where participants share experiences and learn together. Each participant also creates a personalized action plan to improve their health after the program. With nearly 600 enrolled in its first nine months, CDSMP has expanded significantly.

Another initiative ,Healthier 901, engages the community in healthy living practices through an app-driven challenge to lose one million pounds. While the Healthier 901 app is a powerful tool for tracking progress, the Healthier 901 Fest is the true heartbeat of the movement. This massive, family-friendly event—fully funded and hosted by Methodist Le Bonheur Healthcare (MLH)—is completely free to the public and serves as a rallying point for the entire Mid-South. The Fest isn't just a celebration; it's a direct response to the community's most pressing health challenges. By tackling obesity—a root cause of cancer, diabetes, and heart disease—the initiative aims to change the trajectory of health in the 901 area.

At the time CDSMP and Healthier 901 were launched, Memphis was listed as the 2nd most overweight city in the U.S. per the 2022 CHNA and WalletHub stats. As of 2025, Memphis is no longer in the Top 10. (It is now #11). MLH credits this change in part to its leadership across the city in raising obesity awareness and garnering community enthusiasm to make healthier choices and live healthier lives.

HEALTH PRIORITIES ADDRESSED: 2023 TO 2025

Methodist Le Bonheur Healthcare's previous Community Health Needs Assessment identified heart disease and cancer as the top causes of death in Shelby and DeSoto Counties. Data also indicated that obesity affects more than one-third of the Mid-South community, meaning at least one out of every three residents faces a significantly higher risk of life-threatening conditions.

Guided by the 2022-2025 Strategic Plan, which included a dedicated "Community Health and Partnerships" pillar, MLH maintained a system-wide commitment to enhancing regional well-being. Under the oversight of the Community Health Steering Committee, significant progress was made in the following areas:

OBESITY AND WEIGHT MANAGEMENT: "HEALTHIER 901"

After the 2022 CHNA identified overweight and obesity as a critical community concern, MLH launched Healthier 901. This initiative encourages year-round weight loss through fitness, nutrition, and wellness.

- **Impact:** Since its inception, the program has recorded 13,098 pounds lost by participants and reached 14,932 registrants on the Healthier 901 application.
- **National Ranking:** When the program launched, Memphis ranked 2nd in the nation for most obese/overweight cities. By 2025, Memphis' ranking significantly improved, falling out of the top 10.
- **2025 Healthier 901 Festival:** This annual event hosted 25+ community wellness vendors, 52 free health screenings in partnership with Cigna, and healthy cooking demonstrations.

CANCER AND HEART DISEASE: CENTERS OF EXCELLENCE

The Strategic Plan prioritized the development of Centers of Excellence in Cardiovascular Care and Oncology to address the leading causes of mortality in the region. By July 2025, MLH received "High Performing" recognitions from U.S. News and World Report in:

- **Oncology:** Colon, Gynecological, Leukemia, Lymphoma, and Melanoma.
- **Cardiology:** Heart Failure, Heart Bypass surgery, Heart Arrhythmia, Pacemaker Implantation, and Transcatheter Aortic Valve Replacement.

GAPS ANALYSIS: COMPARISON OF 2022 VS. 2025 FINDINGS

The transition from 2022 to 2025 marks a strategic shift from addressing specific clinical diseases to a more holistic focus on the systemic drivers of health and accessibility.

Priority Area	2022 CHNA Priorities	2025 CHNA Findings & Priorities	Key Strategic Shift
Primary Focus	**Clinical Disease Management:** Specifically Cardiovascular Disease and Cancer.	**Social & Economic Drivers:** Poverty, Housing, and Food Insecurity.	From treating outcomes to addressing root causes (SDOH).
Healthcare Access	Focus on building Centers of Excellence for tertiary care (Heart, Cancer, Transplant).	**Focus on Navigation & Literacy:** Reducing financial barriers and improving ease of use.	From facility expansion to reducing barriers to entry.
Behavioral Health	Identified as a "top concern" but secondary to physical disease priorities.	**Crisis-Level Trauma:** Cited in ~55% of discussions; specific focus on youth trauma and anxiety.	Elevated to a primary imperative due to escalating community need.
Target Population	General adult population with focus on high-mortality demographics.	**Maternal, Infant & Child Health:** Emphasis on prenatal care, pediatric trauma, and childcare.	Increased focus on early intervention and family-centered care.
Obesity/ Wellness	Healthier 901 launch; focus on weight loss and fitness education.	**Nutrition & Prevention:** Moving toward long-term management of chronic disease prevention.	Integration of weight management into broader chronic disease strategy.
Community Safety	Acknowledged as a disparity (Homicide).	**Violence as Public Health:** Deepening the link between community safety and mental health.	Recognizing violence as an interconnected driver of poor health outcomes.

OBSERVATIONS FOR THE 2026-2028 IMPLEMENTATION PLAN

While the leading causes of death (Heart Disease and Cancer) remain consistent in the secondary data, the 2025 CHNA has identified that the barriers to addressing these diseases have changed.

The 2025 findings suggest that even with high-performing clinical “Centers of Excellence,” community members struggle with navigation, cost, and basic needs (housing/transportation).

CONCLUSION

The 2025 CHNA found that health outcomes are fundamentally tied to a complex web of social and economic factors. Strategies to address them must be collaborative, with a focus on integration and equity. A sustained partnership across healthcare, government, and community organizations is essential to move from assessment to meaningful, equitable action. The results underscore that residents and stakeholders feel current programs, while valuable, are fragmented or inadequate to meet the scale of issues like poverty, mental health, and access to affordable care.

Addressing these needs will require continued collaboration between healthcare systems, government agencies, community organizations, and residents themselves, with a sustained investment in prevention, access, and equity to ensure that every individual has the opportunity to achieve optimal health and well-being.

About the Program Evaluation Team

Rowland D. Yancey is the director of program evaluation at Methodist Le Bonheur Community Outreach where he has worked since 2016. He leads a team of program evaluators who design and implement research and evaluation projects for health outreach programs. Rowland has a master's degree in education from the University of North Carolina at Greensboro, and a bachelor's degree in psychology from University of North Carolina at Chapel Hill. Prior to working with Le Bonheur Children's, Rowland worked as a research data manager, where he specialized in submission oversight.

August C. Marshall holds a master's degree in applied anthropology from the University of Memphis. August has been at Methodist Le Bonheur Healthcare for over 13 years, previously working in grant administration and as a program evaluator for the organization's partnerships for wellness division, where she worked with multiple programs focusing on maternal-child health, adverse childhood experiences, and social determinants of health. She currently serves a dual role as administrator and evaluator for a program focused on maternal care coordination in rural West Tennessee.

John Tubbs is a Program Evaluator II at Methodist Le Bonheur Community Outreach where he specializes in data analytics, program evaluation, and translating complex health and community data into actionable insights. His work focuses on supporting community health initiatives through thoughtful evaluation design, stakeholder engagement, and equity-centered analysis. He holds a Master of Science in Data Analytics from Western Governors University and brings extensive experience collaborating with hospitals, nonprofits, and community partners to ensure data is used not just for reporting, but for meaning-making, accountability, and improved outcomes for children and families.

Emma Draluck Hickman is a program evaluator at Le Bonheur Children's Hospital where she has worked since 2023. She designs and implements research and evaluation projects for health outreach programs. Emma has a master's degree in public health from the University of Memphis (2016), and a bachelor's degree in psychology from Washington State University (2013). Prior to working with Le Bonheur, Emma worked as an assistant professor of public health at the University of Memphis and a research administrator at the Baptist Cancer Center.

Evan Wilson serves as a Program Evaluator II at Methodist Le Bonheur Healthcare, where he has worked since November 2021. He specializes in designing comprehensive evaluation frameworks and synthesizing complex data into actionable insights and was a previous co-leader in the MLH 2022 Community Health Needs Assessment. Evan holds a Master of Arts in Applied Anthropology (2019) and a Bachelor of Arts in Anthropology (2015) from the University of Memphis.

Virginia Christman received her Master of Public Health in Epidemiology from Emory University in 2025. She joined Methodist Le Bonheur Community Outreach as a Program Evaluator in June 2025, where she contributes to the design and implementation of evaluation strategies for community health initiatives. Prior to this role, Virginia worked in health communication and data management roles for both nonprofit and academic institutions.

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Marie Z. Branch, AICP, is the Grant Development Director at Methodist Le Bonheur Community Outreach and has over 30 years of experience in the public, private, and nonprofit sectors as a grant professional and urban planner. Ms. Branch earned a Bachelor of Arts in Urban Geography and a Master of City and Regional Planning from the University of Memphis and worked as an urban planner in several locations in Memphis and the Mid-South. Prior to joining the staff at MLCO in 2024, Ms. Branch was an independent grant professional for 12 years, providing grant research, writing, and management services to Memphis-area nonprofit organizations.

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We would like to acknowledge the following Methodist Le Bonheur Community Outreach Associates and students and their tireless help in administering surveys at community events, creating recruitment materials, taking notes, transcribing focus group and stakeholder interviews and analyzing the qualitative information from the community. We could not reach as many community members without them.

- **Marlyn Holguin**, Master of Public Health intern with a concentration in Epidemiology at The University of Memphis
- **Laura Rodriguez**, Master of Public Health intern at The University of Memphis
- **Abhishek Pavin Patel**, Master of Public Health intern at The University of Memphis
- **Kehinde Olaosebikan**, Master of Health Administration intern, Georgia State University
- **Dekeidra Austin**, Outreach Coordinator, MLCO-TN HIV Prevention
- **Ashley Box**, Community Health Educator I, MLCO-RWD Family Care Program
- **Tianna Reese**, Community Health Educator I MLCO-TN HIV Prevention

Methodist Le Bonheur Community Outreach would also like to thank the following agencies and organization leaders who provided meeting space for Community Health Needs Assessment focus group sessions, helped us reach out to constituents, and encouraged them to share their health needs and concerns:

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The following agencies were gracious and allowed the researchers and interns to set up tables at their events so that we could solicit responses to the community survey, or distributed the survey link electronically:

Collierville Farmer's Market, Black Farmers Market Memphis, South Memphis Farmer's Market, Memphis Farmer's Market, Cooper Young Farmer's Market and Belltower Coffee and Studio, University of Memphis School of Public Health, Nextdoor (VECA), Buy Nothing Memphis, Teach901, African American Clergy Collective of TN, Memphis Black Healers Collective, Fathers First Memphis, Cooper Young Java Cabana, Shelby County Office of Child Safety, Harris Chapel Church of God In Christ, Beulah Baptist Church, Memphis Adventist Academy, Benjamin Hooks Library, Frayser Branch Library, Whitehaven Community Center, The Stax Museum, the City of Memphis, Shelby County Government and Downtown Memphis Commission.

Graphic Design, Shannon Persell

We would like to thank our community stakeholder interviewees, for dedicating their valuable time to offer perspectives on community health, and identify the most significant health issues affecting the community. It is their leadership and dedication to the health and well-being of the community that has allowed us to gain a deeper understanding of the disparities facing our most vulnerable populations.

The following are members of the Community Health and Partnership Steering Committee who provided guidance and rich discussion surrounding the community needs:

- **Cato Johnson**, CHP chairman, chief of staff and senior vice president, public policy and regulatory affairs, Methodist Le Bonheur Healthcare
- **Laura Barden**, program director, Community Development, Methodist Le Bonheur Germantown Hospital
- **Cindy Black**, director, treasury and bond compliance officer, Methodist Le Bonheur Healthcare
- **Kristen Bland**, director, public policy and regulatory affairs, Methodist Le Bonheur Healthcare
- **Sara Burnett**, director, institutional advancement, Le Bonheur Children's Hospital
- **Madelyn Cook**, program director, community development, Methodist Olive Branch Hospital
- **Vickye Ford**, program director, community development, Methodist South Hospital
- **Shandrian Guinn**, manager, community outreach, Le Bonheur Community Health and Wellness
- **Karen Hamburger**, director, community engagement and social determinants of health, Methodist University Hospital
- **Sandra Madubuonwu**, senior director, social determinants of health, health and wellbeing, Methodist Le Bonheur Healthcare
- **Dexter McKinney**, director, talent planning and strategies, Methodist Le Bonheur Healthcare
- **Maureen O'Connor**, vice president, institutional advancement, Le Bonheur Children's Hospital
- **Christina Underhill**, director, Chronic Disease Programming, Methodist Le Bonheur Community Outreach
- **Jennilyn Utkov**, vice president, community outreach, Methodist Le Bonheur Healthcare
- **Dr. Robin Womeodu**, senior vice president and chief academic officer, Methodist Le Bonheur Healthcare

2025 Community Health Needs Assessment

SECONDARY DATA

Methodist Le Bonheur Healthcare

2025

Community Health Needs Assessment

Secondary Data

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SECONDARY DATA CONTENTS

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ABSTRACT

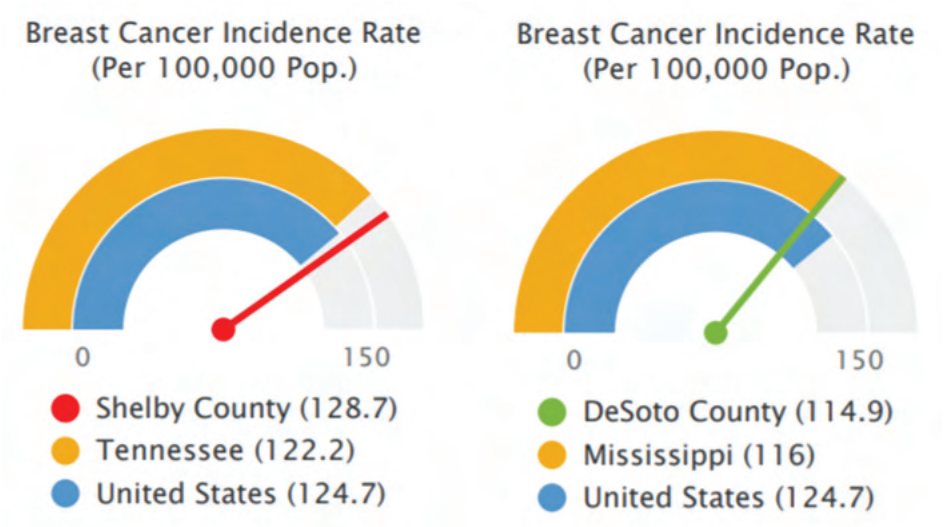
Between April and August of 2025, a thorough review of secondary data (data collected by another agency) was conducted for Shelby County, Tennessee and DeSoto County, Mississippi, (Methodist Le Bonheur Healthcare's [MLH] primary service area). Original data sources such as the Tennessee Department of Health, the Mississippi State Department of Health, the Tennessee Bureau of Investigation, the National Center for Health Statistics, and the Centers for Disease Control were used heavily throughout the report. Applications and websites that incorporate secondary datasets into a user-friendly interface were also sources for this report. These sources included Healthy Shelby, ExploreTNHealth, Kids Count Data Center, State Cancer Profiles, County Health Rankings, and HDPulse. Whenever possible, racial and gender breakdowns of health conditions are provided. Information on the health issues of the MLH service area include- examining population impact and disparities of specific health issues, and social determinants of health such as education, economic stability, social context, transportation and housing, food security and physical activity. In addition to data tables, a comparison of certain health outcomes of Shelby and DeSoto Counties to their state and national rates are represented visually via dashboards.

HOW TO READ THE DASHBOARDS

The dashboards in this report serve as visual representation to demonstrate how certain health outcomes of Shelby and DeSoto Counties compare to their state and national rates.

To differentiate against the various health ratings among the national, state and local data:

- National health rates are displayed within the inner, blue arc of the dashboard.
- State health rates, (either Tennessee or Mississippi), are displayed within the outer, yellow arc of the dashboard.
- The speedometer gauge stick displays the county health rates, demonstrating how the county health rate compares to the national and state rates. If a county's health measurement is equal to or less than its state rate, the speedometer gauge stick will appear green. (See below, DeSoto County.) However, if the county's rate is greater than that of its state rate, the speedometer gauge stick will appear red. (See below, Shelby County.)



UNDERSTANDING RATES

Throughout the report, all rates are age adjusted. Age adjusted death rates facilitate the comparison of death rates in populations with different age structures. These rates are calculated with statistical methods of standardizing rates to U.S. population datasets. For example, most diseases or illnesses occur at different rates within each age group. Older people get cancer and heart disease more often than younger people. A community with a very large number of older citizens may have more cases of cancer or heart disease and therefore a larger rate of these diseases. To be able to compare the rate of diseases with other communities such as ones with smaller populations of older citizens, adjustments of the rates are done based on statistical calculations within each age grouping and disease or illness. The authors of this Community Health Needs Assessment reported rates that were already calculated and reported in source material as referenced.

Another note to consider, the leading causes of death are ordered by the number of people who died and not by rate. Sometimes in the original source material, the reported age adjusted rates do not increase or decrease in relationship to an increase or decrease in the raw number of people who died. For example, 19 people may have died from unintentional injuries and another 19 died from stroke, but the rates are vastly different. This is due to the calculations that are made behind the scenes to adjust the rates based on age distributions within the community. Rates should be used to compare health issues across communities.

DEMOGRAPHICS OF SERVICE AREA

Shelby County, Tennessee has a racial composition of approximately 51% African American and 35% Caucasian. In DeSoto County, there are more Caucasians (59.93%) than African Americans (30.3%). Hispanic residents make up 8.36% of Shelby County and 5.48% of DeSoto County. About a quarter of the populations of both counties are children under age 18.

Table 1. Racial composition of Shelby County, Tennessee, 2020 – 2024

Race	Caucasian		African American		Asian		Other		Multiple Races	
	#	%	#	%	#	%	#	%	#	%
Shelby Co	326,077	35.07	477,321	51.34	28,149	3.03	48,800	5.25	45,719	4.92
Tennessee	4,990,938	72.22	1,092,948	15.81	135,615	1.96	246,282	3.56	412,898	5.97

Note: Data are from source [1].

Table 2. Racial composition of DeSoto County, Mississippi, 2020 – 2024

Race	Caucasian		African American		Asian		Other		Multiple Races	
	#	%	#	%	#	%	#	%	#	%
DeSoto Co	110,064	59.39	56,205	30.33	3,045	1.64	6,024	3.25	9,310	5.02
Mississippi	1,658,893	56.02	1,084,481	36.62	32,709	1.1	56,860	1.92	110,732	3.74

Note: Data are from source [1].

Table 3. Percent and total of ethnicity in Shelby County and DeSoto Counties, Census 2020

Ethnicity	Shelby County, TN		DeSoto County, MS	
	#	%	#	%
Hispanic	77,707	8.36	10,161	5.48
Non-Hispanic	852,037	91.64	175,153	94.52

Note: Data are from source [1].

Table 4. Population by age groups within Shelby County, 2019 – 2023

	Total Population	Under 18		18 to 64		65 and older	
	#	#	%	#	%	#	%
Shelby Co	922,195	234,894	25.47	554,695	60.15	132,606	14.38
Tennessee	6,986,082	1,558,006	22.3	4,255,336	60.91	1,172,740	16.79

Note: Data are from source [1].

Table 5. **Population by age groups within Desoto County, 2019 – 2023**

	Total Population	Under 18		18 to 64		65 and older	
	#	#	%	#	%	#	%
DeSoto Co	188,598	47,511	25.19	116,013	61.51	25,074	13.29
Mississippi	2,951,438	692,335	23.46	1,763,988	59.77	495,115	16.78

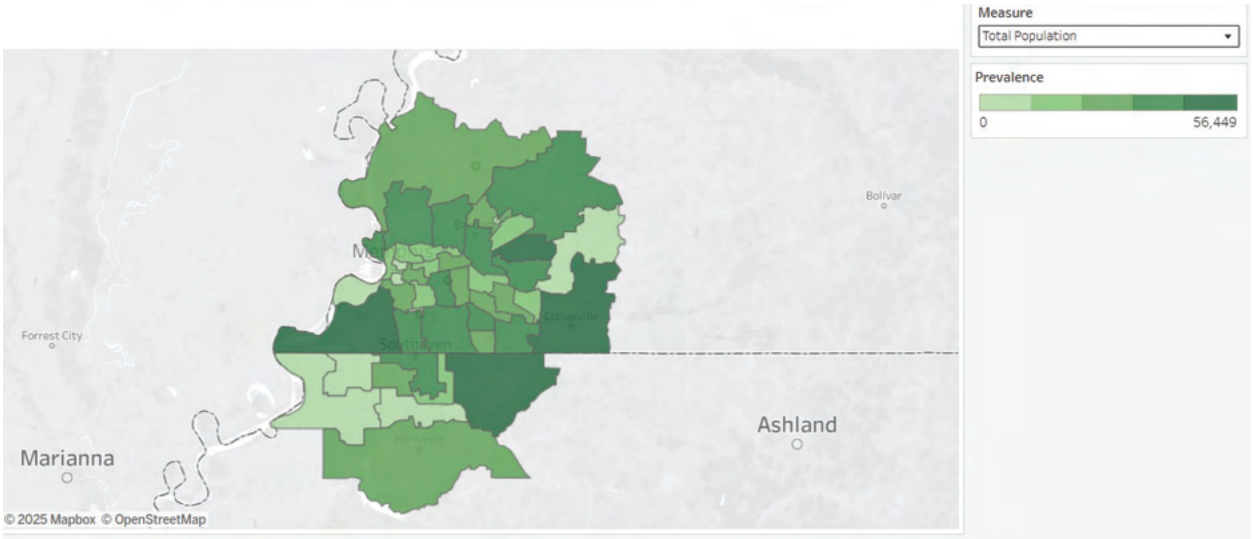
Note: Data are from source [1].

Table 6. **Children under 18 by race and ethnicity in Shelby and Desoto Counties, 2019 – 2023**

	Caucasian		African American		Hispanic	
	#	%	#	%	#	%
Shelby Co	63,336	19.62	128,989	26.48	33,729	43.1
DeSoto Co	24,924	22.2	16,163	26.81	3,698	34.85

Note: Data are from source [1].

Figure 1. **Total population for Shelby and Desoto Counties by Zip Code**



Note: Map was developed by MLCO Program Evaluation

ECONOMIC STABILITY

MEDIAN INCOME

The median annual household income for Shelby County is $62,337 and $82,980 for DeSoto County. Racial disparities exist in both counties for median household income. In Shelby County, median income for Caucasians is 1.7 times higher than that of Hispanics and 2.0 times higher than that of African Americans. In DeSoto County, the median income for Caucasians is 1.3 times higher than that of Hispanics and African Americans.[1]

Figure 2. Median Household Income within Shelby and DeSoto Counties, 2019-2023[1]

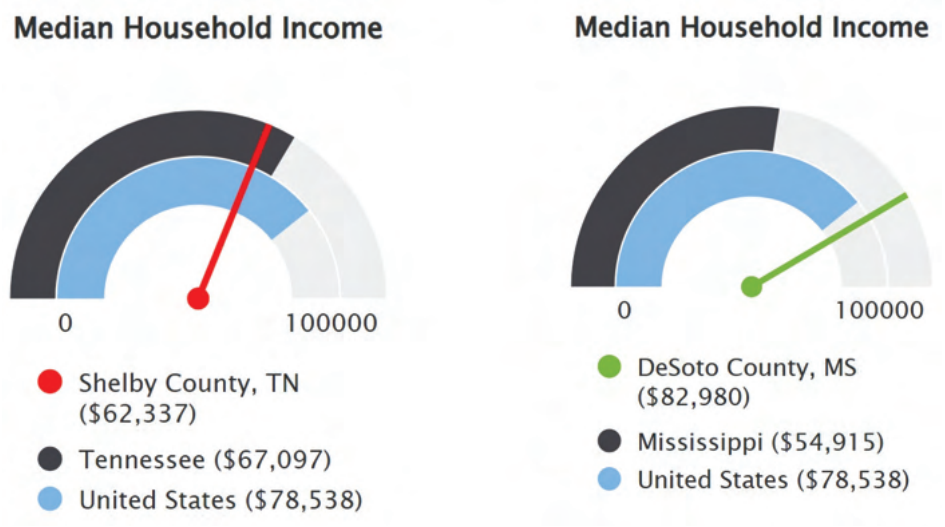


Table 7. Median Household Income by Race and Location, 2019 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
Caucasian	$93,555	$71,897	$91,096	$68,254
African American	$47,347	$49,163	$69,963	$37,897
Hispanic	$55,849	$61,180	$68,940	$49,266

Note: Data are from sources [1].

Table 8. Percent of Population by Income and Location, 2019 – 2023

Income	Shelby County	Tennessee	DeSoto County	Mississippi
Less than $25,000	19.86	17.25	12.28	23.94
$25,000 to $49,999	21.04	20.25	16.34	22.38
$50,000 to $99,999	28.18	30.64	31.10	28.65
$100,000 to $199,999	21.52	23.56	32.08	19.77
More than $200,000	9.41	8.30	8.21	5.26

Note: Data are from sources [1].

UNEMPLOYMENT

In 2025, the unemployment rate for Shelby County was 3.8% and 3.5% for DeSoto County. The unemployment rate for DeSoto County is the same as the rate for Mississippi while the unemployment rate for Shelby County was 1.3 times the rate for Tennessee.[1]

Figure 3. Unemployment Rates within Shelby and DeSoto Counties, 2025[1]

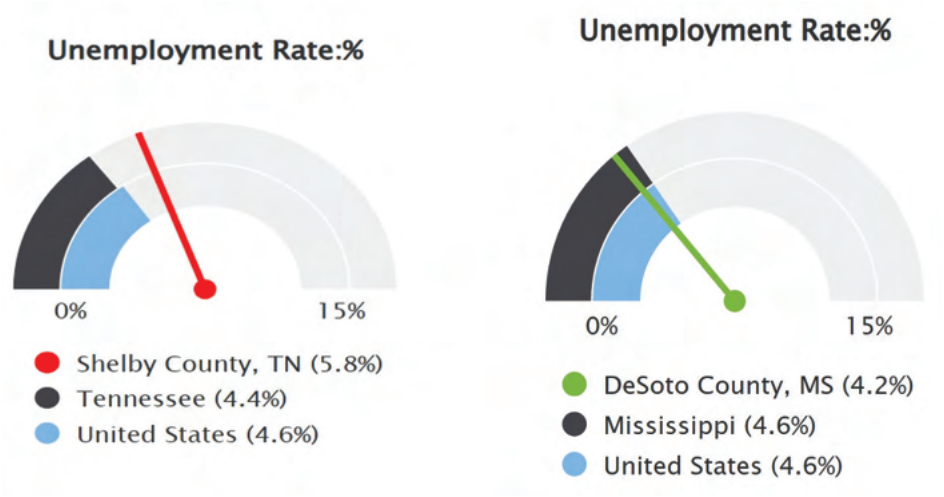
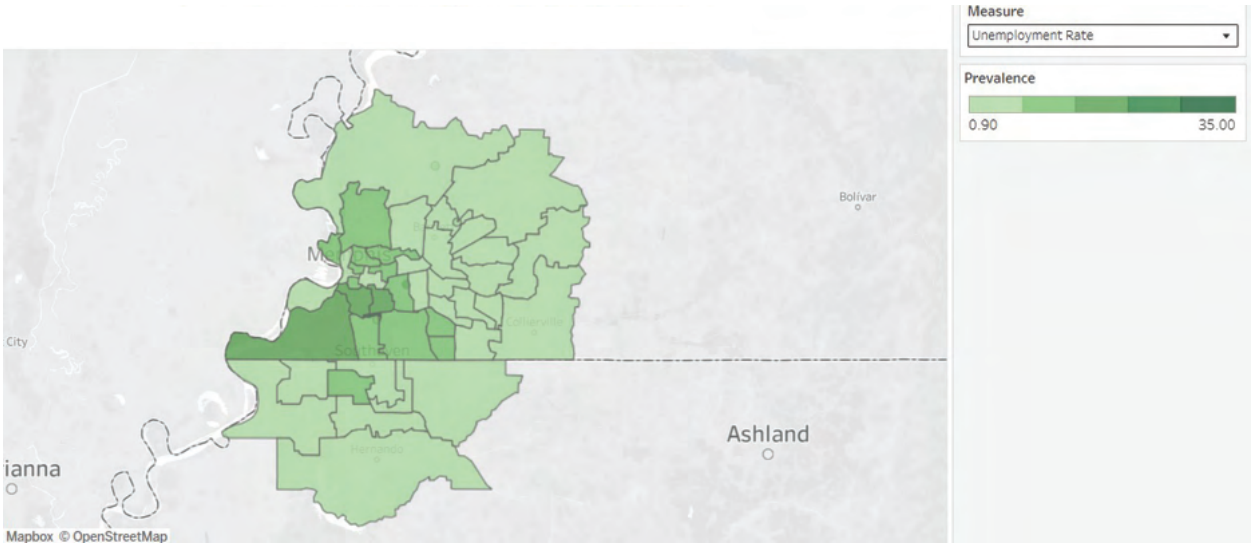


Figure 4. Unemployment Rates within Shelby and DeSoto Counties, 2025



Note: Map was developed by MLCO Program Evaluation

POVERTY

The rate of poverty in Shelby County is 17.5% (158,883) and is higher than both the state (13.7%) and national figures (12.4%). In DeSoto County, 10% (18,650) of the overall population lives in poverty, which is less than both the state (19.1%) and national percentages (12.4%) of poverty.[1]

Figure 5. Population in Poverty within Shelby and DeSoto Counties, 2019-2023[1]

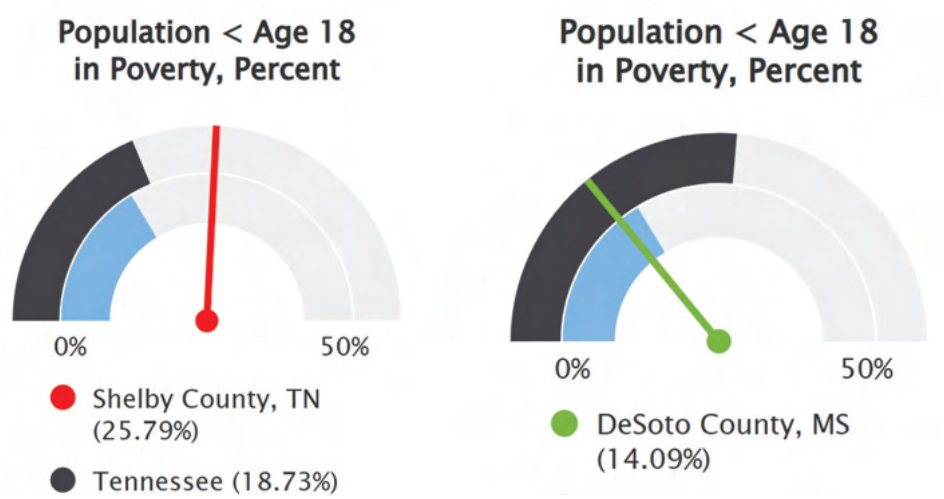
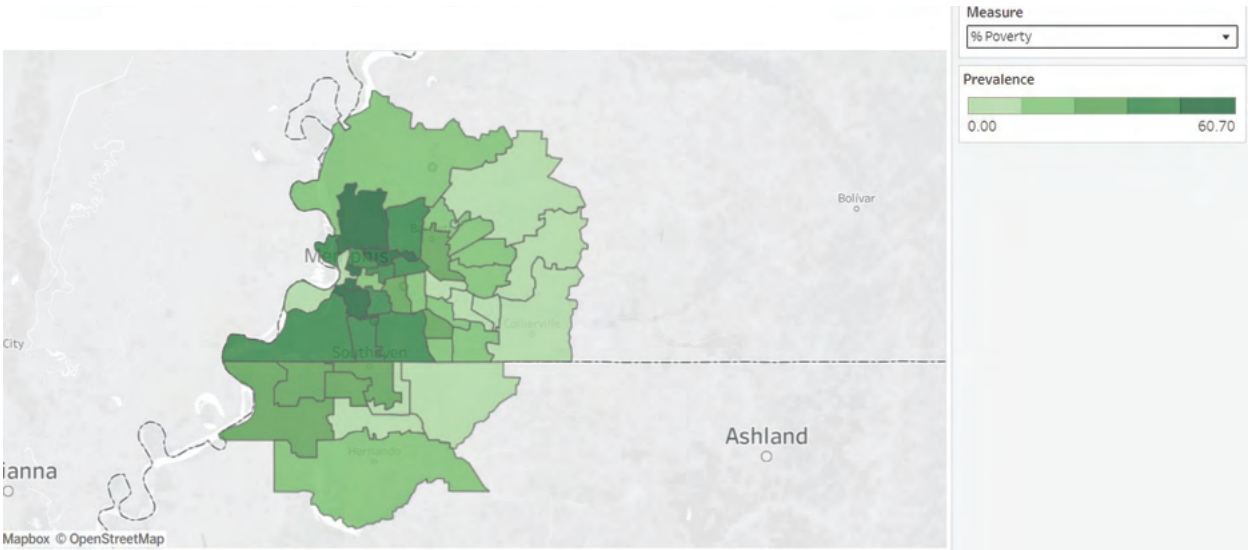


Figure 6. Percentage of People in Poverty in Shelby and DeSoto Counties



Note: Map was developed by MLCO Program Evaluation

There is significant racial disparity with regards to poverty. In Shelby County, the percentage of African Americans living in poverty is 3 times greater than Caucasians. The percentage of Hispanics living in poverty is 2.9 times greater than Caucasians. In DeSoto County, the percentage of African Americans living in poverty is 2.2 times greater than Caucasians, and the Hispanic population living in poverty is 1.8 times greater than Caucasians.

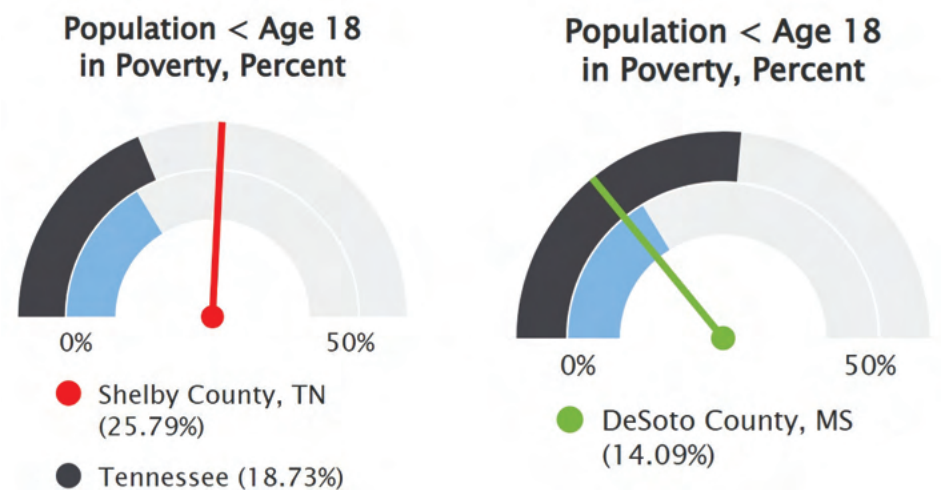
Table 9. Population in poverty by race and location, 2019 – 2023

Race/Ethnicity	Shelby Number	Shelby Percentage	DeSoto Number	DeSoto Percentage
All	158,883	17.5%	18,115	10.0%
Caucasian	25,353	8.0%	7,792	7.0%
African American	112,905	23.6%	8,976	15.0%
Hispanic	17,831	23.3%	1,351	12.8%

Note: Data are from sources [1].

In Shelby County, 25.8% of all children are living in poverty compared to 14.1% of children in DeSoto County who live in poverty.

Figure 7. Children in Poverty within Shelby and DeSoto Counties, 2019 – 2023[1]



There is a significant racial disparity among children in poverty in both counties. Compared to Caucasian children, African American children in Shelby County, are 6.1 times more likely to live in poverty. In DeSoto County, African American children are 2.1 times more likely to live in poverty than Caucasian children. Hispanic children in Shelby County are 5.3 times more likely than Caucasian children to live in poverty and in DeSoto County, they are 1.8 times more likely to live in poverty.[1]

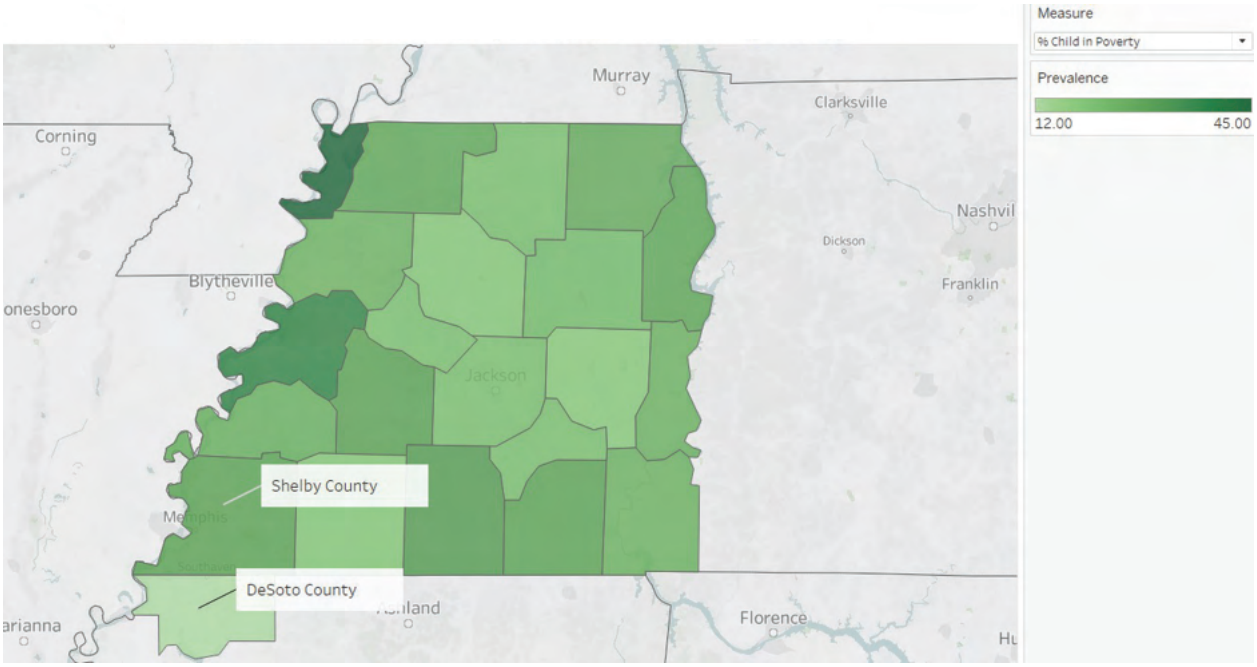
Table 10. Number and percent of children in poverty by race and location, 2019 – 2023

Race/Ethnicity	Shelby Number	Shelby Percentage	DeSoto Number	DeSoto Percentage
All	59,593	25.8%	6,634	14.1%
Caucasian	3,208	5.7%	2,385	10.1%
African American	44,383	34.9%	3,327	20.7%
Hispanic	9,860	30.2%	651	17.7%

Note: Data are from sources [1].

Within Shelby County, 27.9% of all children under five are living in poverty (2019 to 2023). Approximately 40% of all African American children under the age of 5 are living in poverty, and 29.3% of all Hispanic children under 5 are living in poverty compared to only 6.0% of Caucasian children under age 5.[2]

Figure 8. Percentage of Children in Poverty for West Tennessee and DeSoto County



Note: Map was developed by MLCO Program Evaluation

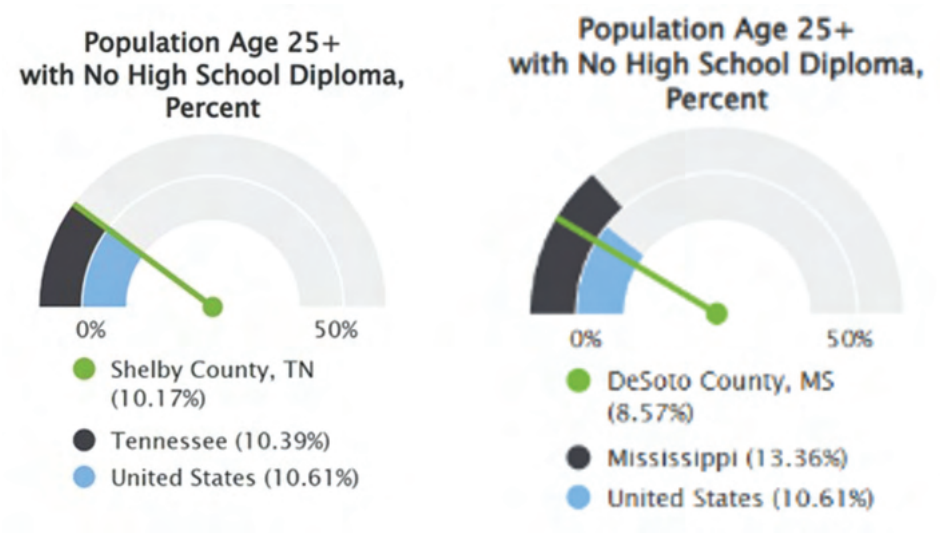
EDUCATION

HIGH SCHOOL DIPLOMA

The average annual high school graduation rate between 2019 and 2023 for both Shelby County and Tennessee was 90%.[3] The high school graduation rate for DeSoto County is slightly better than for Mississippi, where 91% of students graduated in DeSoto County compared to 87% across Mississippi.[4]

Lack of a high school diploma limits career opportunities and contributes to poverty. In Shelby County, 10.2% of the population and 8.6% of the population in DeSoto County do not have a high school diploma or equivalent. These figures are slightly better than each state's percentage of people who lack a high school diploma.[1]

Figure 9. No High School Diploma within Shelby and DeSoto Counties, 2019-2023[1]



There is a notable racial disparity for those who do not finish high school. African Americans in Shelby County are 2.3 times more likely than Caucasians to not receive a diploma. Hispanics are 9.3 times more likely than Caucasians to not have a diploma. African Americans in DeSoto County are 1.1 times more likely than Caucasians to not have a high school diploma, and Hispanics are 5.0 times more likely than Caucasians to not have a diploma.[1]

Table 11. Percentage of population without high school diploma by location, 2019 – 2023

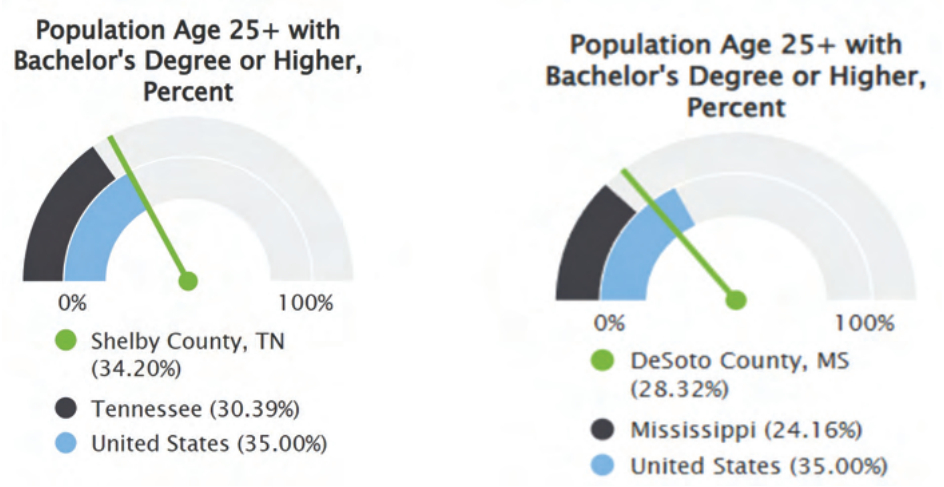
Race/Ethnicity	Shelby County	DeSoto County
All	10.2%	8.5%
Caucasian	4.7%	7.3%
African American	10.9%	7.7%
Hispanic	43.9%	36.6%

Note: Data are from sources [1].

BACHELOR'S DEGREE

Approximately 34% of adults over the age of 25 in Shelby County hold a bachelor's degree, which is slightly higher than the Tennessee state average of 30.4%. In comparison, only 28.3% of adults over 25 in DeSoto County have earned a bachelor's degree. While this figure falls below the national average of 35%, it is still higher than Mississippi's statewide rate of 24.2%. Overall, both Shelby and DeSoto Counties exceed the state averages, but lag behind the national rate.[1]

Figure 10. Bachelor's Degree or Higher Within Shelby and DeSoto Counties, 2019-2023[1]



DISCONNECTED AND UNEMPLOYED YOUTH

Teens unemployed and not in school are disconnected from major social connections. The percentage of disconnected youth who are neither employed or in school within Shelby County (9.7%) is greater than that of Tennessee (6.9%); while in DeSoto County, 7.1% of youth are disconnected compared to 8.4% in Mississippi.[1]

Figure 11. Youth Neither in School Nor Employed within Shelby and DeSoto Counties, 2019-2023[1]

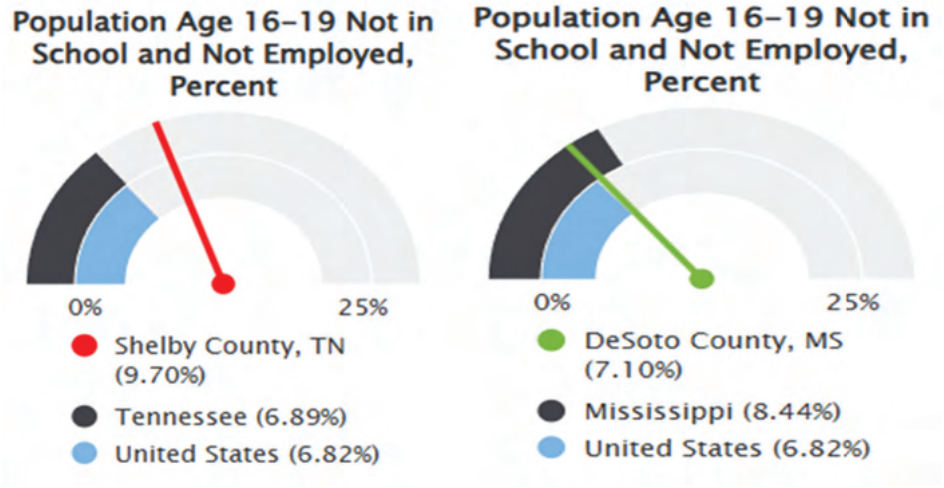


Table 12. **Percentage of unemployed youth by year for Shelby County**

Year	Shelby County	Tennessee
2021	20.5%	12.9%
2022	17.6%	10.2%
2023	14.6%	9.8%

Note: Data are from sources [8,20].

FOOD SECURITY

FOOD INSECURITY

Almost 22% of children under 18 in Shelby County lived with food insecurity in 2021, which was greater than the 13% of children across Tennessee. In DeSoto County, almost 10% of children lived with food insecurity in 2021.

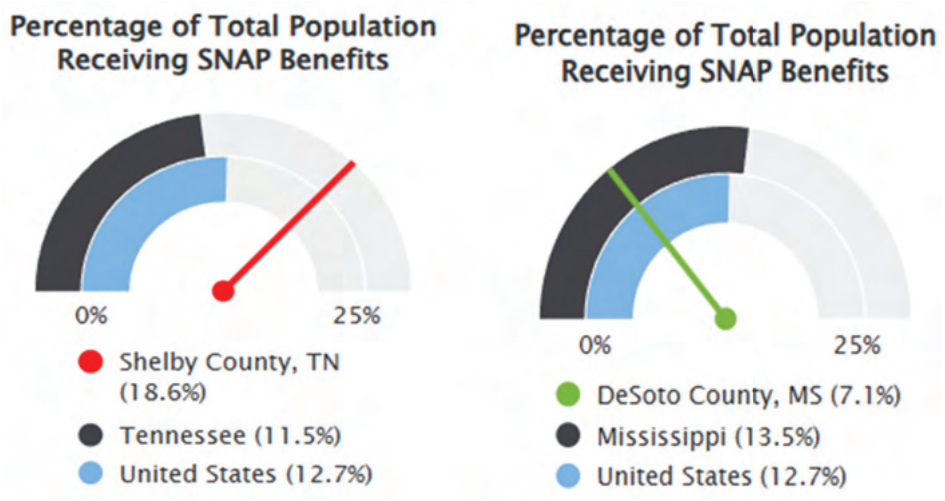
Table 13. **Percent of people with food insecurity by location, 2021**

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
All Ages	11.1%	11.5%	10.8%	16.3%
Children under Age 18	21.7%	12.8%	9.5%	18.8%

Note: Data are from sources [6,7].

In Shelby County, 18.6% of the population and 7.1% of residents in DeSoto County receive supplemental nutrition assistance. The percentage for Shelby County is higher than the percentage for Tennessee (11.5%) and higher than the national average of 12.7%. DeSoto County is lower compared to both Mississippi (13.5%) and the national average.[1]

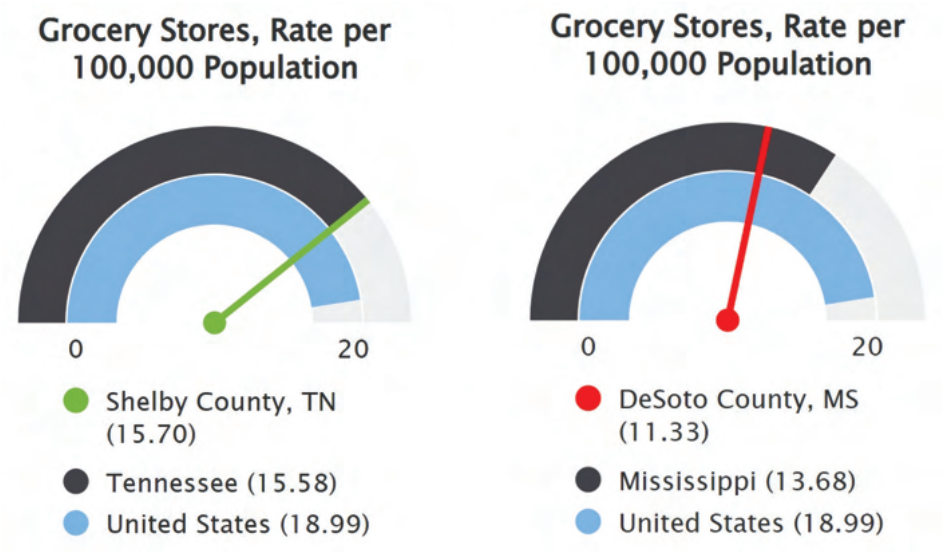
Figure 12. **Population receiving Snap benefits within Shelby and DeSoto counties, 2022[1]**



FOOD FACILITIES

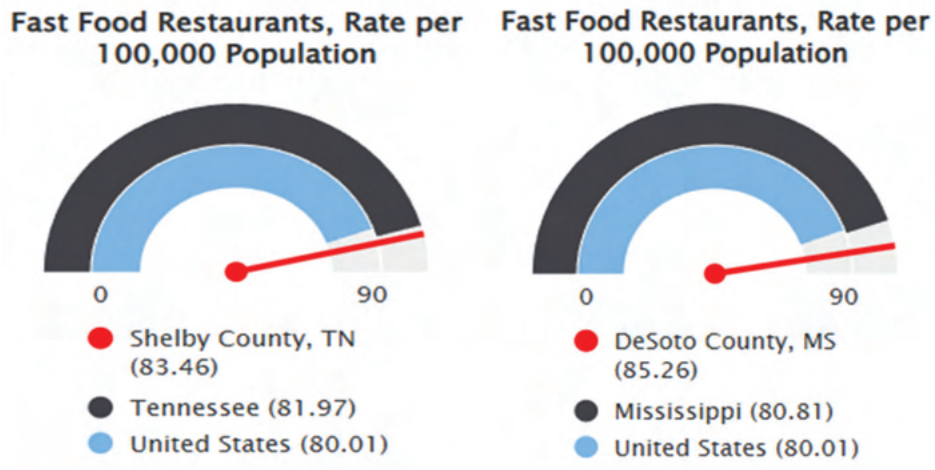
Both counties are below the national grocery store rate, indicating fewer available grocery stores compared to the rest of the United States. As of 2022, in DeSoto County, there were 11.9 grocery stores for every 100,000 people. In Shelby County, there were 16.2 grocery stores per 100,000 people. The national rate of grocery stores is 18.9 per 100,000 people.[1]

Figure 13. Grocery Stores within Shelby and DeSoto Counties, 2022[1]



When looking at the rate of fast-food facilities per 100,000 people, Shelby County has a rate of 83.5 and DeSoto County a rate of 85.3. Both counties have a higher rate of fast food than the state and national rates.[1]

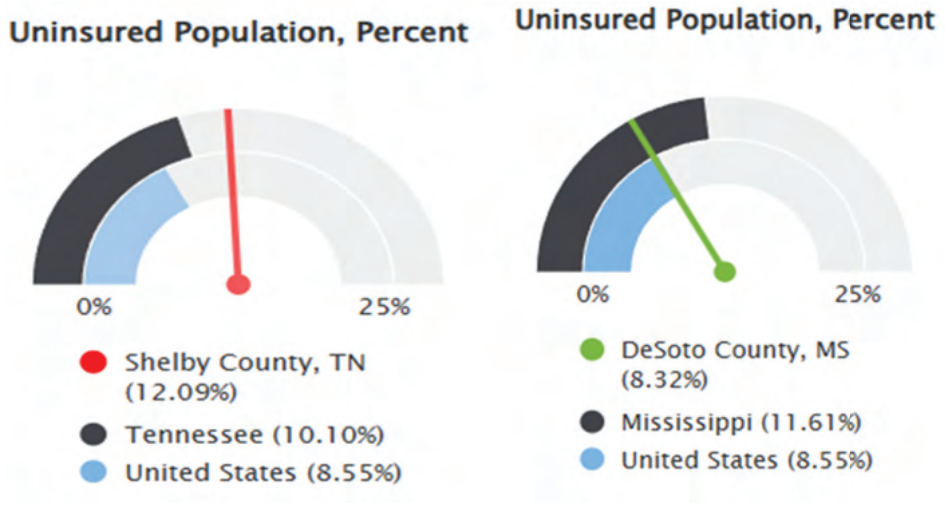
Figure 14. Fast Food Restaurants within Shelby and DeSoto Counties, 2022[1]



HEALTH INSURANCE

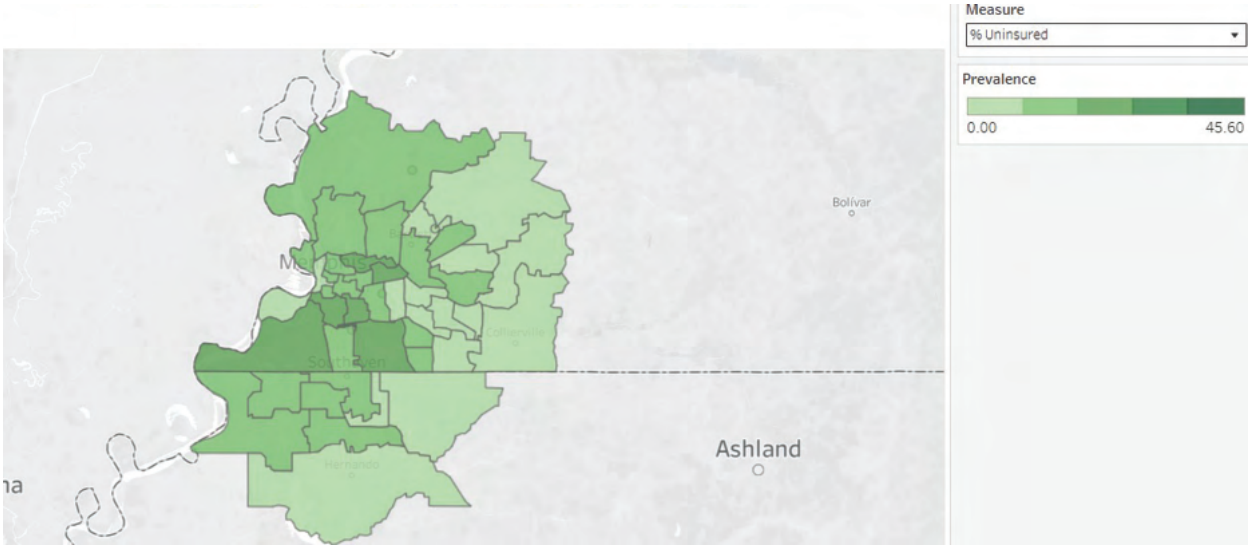
Of the entire population in Shelby County, 12.1% are uninsured compared to 10.1% throughout Tennessee. In DeSoto County, 8.3% of the population is uninsured compared to 11.6% within Mississippi. The percentage uninsured in DeSoto County is similar to the United States (8.6%) while the percentage for Shelby County is higher than the national percentage.[1]

Figure 15. Uninsured Population within Shelby and DeSoto Counties, 2019–2023[1]



In Shelby County, African American adults are 1.9 times more likely to be uninsured than Caucasian adults. Hispanic adults in Shelby County are uninsured at a rate 5.7 times greater than Caucasians. In DeSoto County, African Americans are 1.4 times as likely, and Hispanics are 2.9 times more likely to be uninsured than Caucasians.[1]

Figure 16. Percentage of People Uninsured within Shelby and DeSoto Counties



Note: Map was developed by MLCO Program Evaluation

Table 14. Percentage of Uninsured Populations by Race and Location, 2019 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
All	12.1%	10.1%	8.3%	11.6%
Caucasian	6.5%	7.9%	5.7%	9.5%
African American	12.0%	11.1%	9.1%	12.8%
Hispanic	37.9%	31.0%	28.9%	29.1%

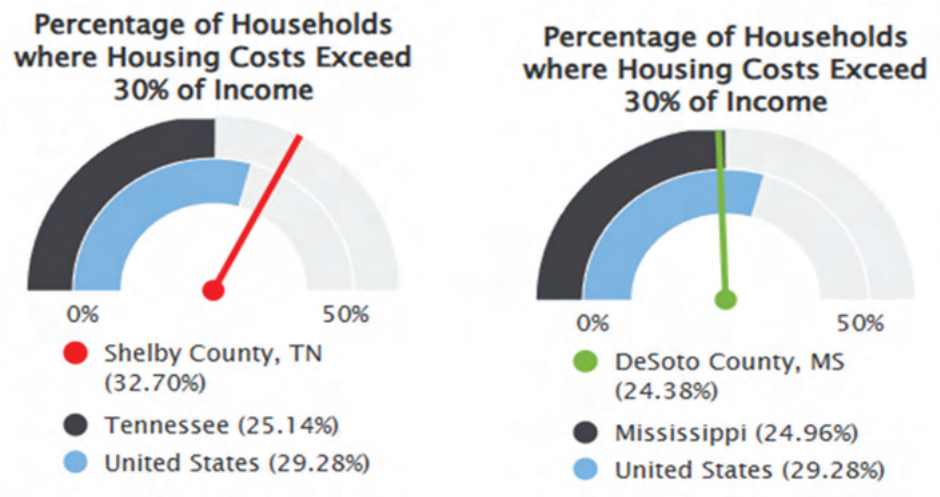
Note: Data are from sources [1].

HOUSING AND TRANSPORTATION

HOUSING BURDEN

In Shelby County, 32.7% of the households have housing costs that exceed 30% of their family's income; and in DeSoto County 24.4% of the population has a high housing burden.[1]

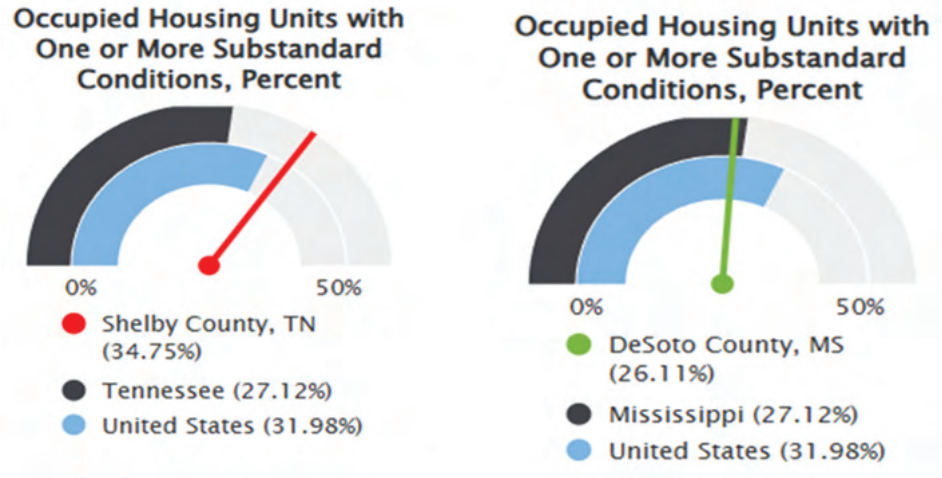
Figure 17. Percent of Households with Excessive Housing Costs within Shelby and DeSoto Counties, 2019-2023[1]



SUBSTANDARD HOUSING

In Shelby County, 34.8% of the population lives in substandard housing compared to 26.1% of the population in DeSoto County. The percentage of substandard housing in Shelby County is 1.3 times greater than that of Tennessee while the percentage in DeSoto County is lower than the percentage in Mississippi who live in substandard housing.[1]

Figure 18. **Occupied Housing Units with Substandard Conditions within Shelby and DeSoto Counties, 2019-2023[1]**



NO MOTOR VEHICLES

Across Mississippi and Tennessee, about 6% of the adult population does not have a motor vehicle for transportation in the household. Over 25,000 households in Shelby County do not have access to a motor vehicle.[32] The statistics for DeSoto County are much better, where only 3,330 households do not have household transportation.[45]

Figure 19. **Households with No Motor Vehicle within Shelby and DeSoto Counties, 2019-2023[1]**

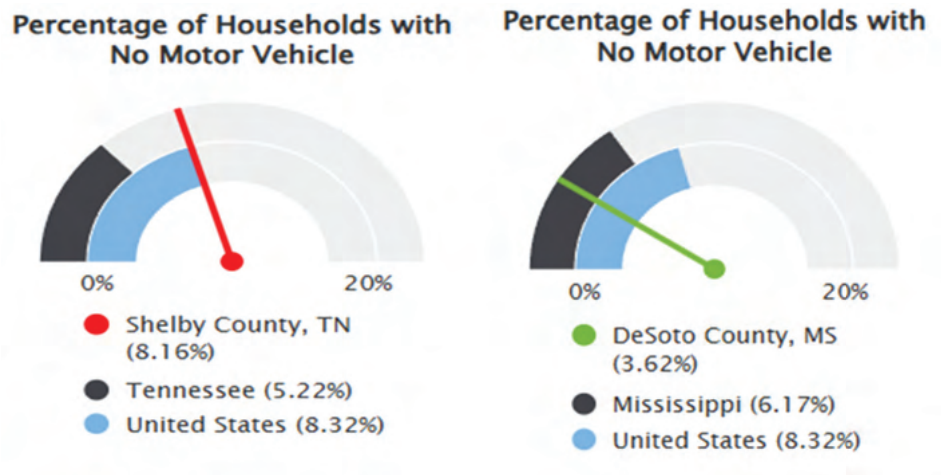
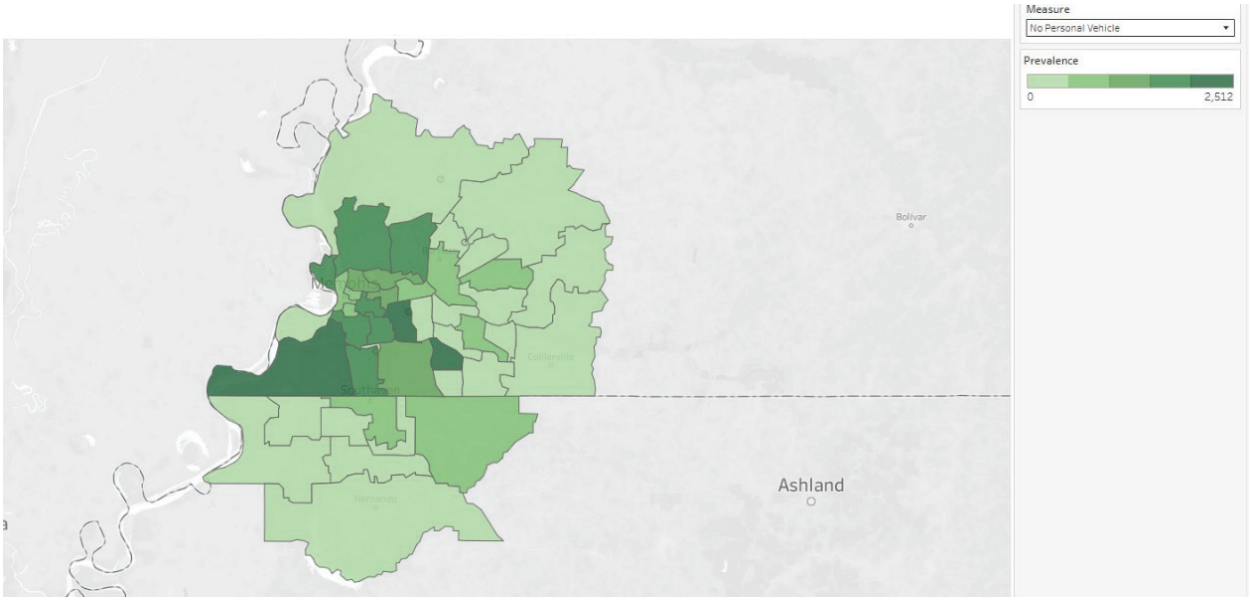


Figure 20. **Number of People with No Household Vehicle for Shelby and DeSoto Counties**



VIOLENT CRIME

Manifestations and prevalence of violent crimes indicate how threatening the social environment is on a person's well-being, which has a negative effect on health outcomes. Violent crime includes homicide, rape, assault, aggravated assault, and robbery. Between 2019 to 2021, within the United States, 4.5 out of every 1,000 emergency department visits were due to assault. [14]

In 2024, the violent crime rate for Shelby County was 1.644.8 per 100,000 people.[2] In DeSoto County, this rate was 107.3.[46] The rate for Shelby County was 2.6 times higher than Tennessee's violent crime and rate and 4.5 times higher than the United States rate. DeSoto County's rate was much lower than the rate for Mississippi and also lower than the United States.[1]

Table 15. **Violent Crime Rate by Year, 2021-2024[2]**

Year	Shelby County	Tennessee	United States
2021	1,638.1	648.4	392.0
2022	1,560.3	617.5	390.0
2023	1,638.4	607.1	380.0
2024	1,644.8	582.7	359.0

Note: Data are from sources [1].

In 2024, there were over 13,000 reported incidents of violent crime in Shelby County.[47] Of those incidents, 70% were committed with the use of a firearm. A significant number of aggravated assaults is what drives Shelby County's violent crime rate. In 2024, 81% of reported violent crime in Shelby County was due to aggravated assaults. Of those incidents, 33% were between intimate partners or family members.[9]

African American children are 6.4 times more likely to be victims of aggravated assault than Caucasian children. In 2024, The Shelby County Sheriff's office received 89 reports of aggravated assault against African American children under age 18 compared to 14 Caucasian children.[9]

HOMICIDES

Across the United States from 2019 to 2023, there were 22,830 deaths from homicide, with a rate of 7.1 per 100,000.[10] Homicide was the 6th leading cause of death (341 deaths) in Shelby County, and the 11th leading cause of death (29 deaths) in DeSoto County (rate 15.4) in 2021.[11,12] The rate of homicides for Shelby County was 3.2 times greater than Tennessee and 4.8 times greater than the U.S.[1] The figures below show the annual average rate of homicide for the years 2019 to 2023.

Figure 21. Homicide Rate within Shelby and DeSoto Counties, 2019-2023[1]

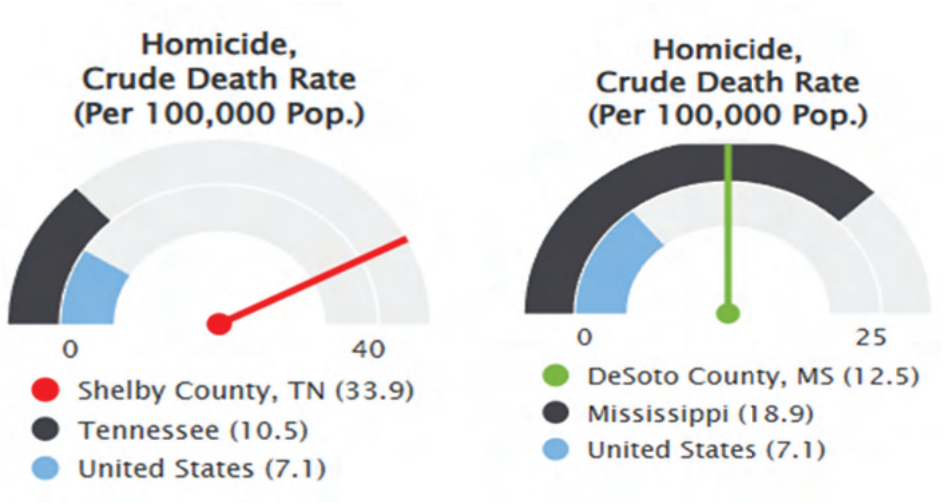
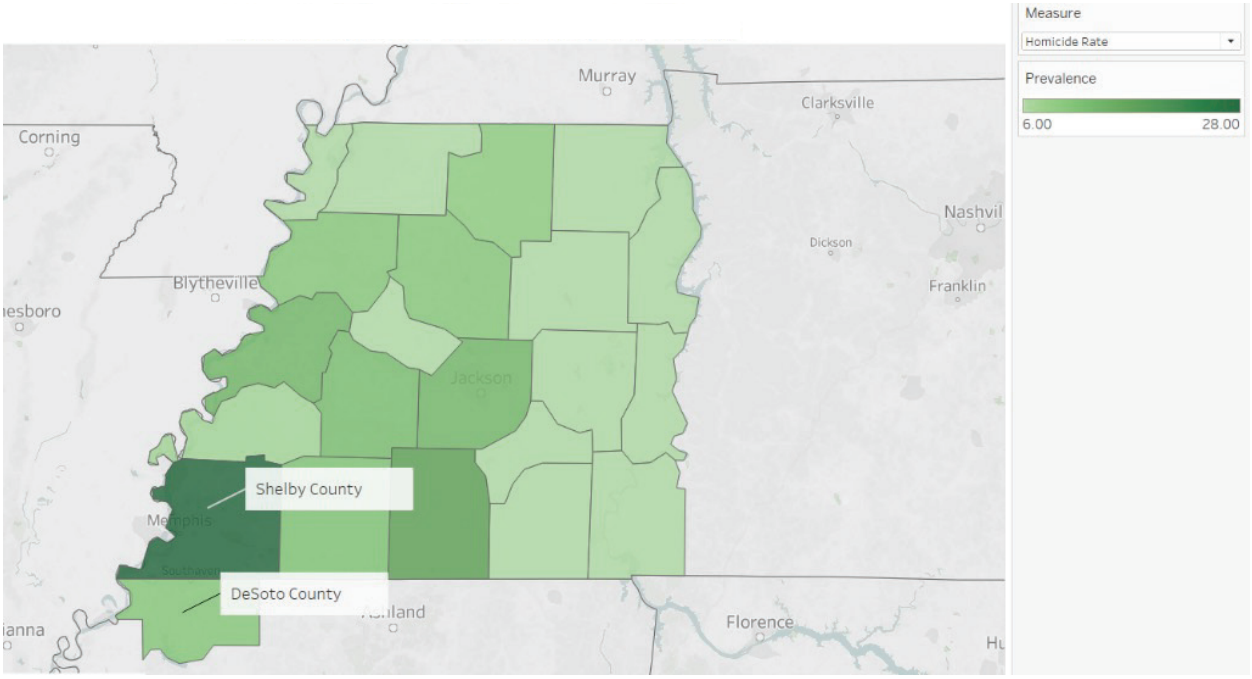


Figure 22. Homicide Rates for West Tennessee and DeSoto County



Note: Map was developed by MLCO Program Evaluation

There is a stark racial disparity between homicide victims in both counties. In Shelby County, African Americans are 9.2 times more likely than Caucasians and 2.2 times more likely than Hispanics to die from homicide. In DeSoto County, African Americans die from homicide at a rate 4.3 times greater than Caucasians. There is also a gender disparity in crime victims in Shelby and DeSoto County. Males in Shelby County are 7.2 times more likely to die from homicide than females.[1]

Table 15. Homicide Rates by Race within Shelby County and DeSoto County, 2019 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	33.9	10.5	12.5	18.9	7.1
Caucasian	6.0	4.2	6.1	6.6	3.0
African American	55.2	40.4	26.4	39.2	30.2
Hispanic	25.1	10.2	-	8.8	6.5

Note: Data are from sources [1]. Rates are per 100,000 people.

Table 16. Homicide Rates by Gender and Location, 2019 – 2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	61.3	17.2	21.7	32.2	11.5
Females	9.1	4.1	-	6.3	2.7

Note: Data are from sources [1]. Rates are per 100,000 people.

FIREARM CRIMES

There were 297 homicides in Shelby County in 2024. Of these murders, 243 involved the use of a firearm. In 2022, there were 25 homicides in DeSoto County, and 21 involved the use of a firearm.[9] In 2024 in Shelby County, 25% of all assaults where a firearm was used in the perpetration of the crime involved victims under the age of 18.[9]

Across the United States in 2023, the firearm homicide rate was 5.4 deaths per 100,000 persons, with 17,927 dying by firearms.[10] The annual average firearm death rate between 2018 and 2022 for Shelby County was 36 deaths per 100,000, which was 1.8 times greater than for Tennessee. The annual average death rate during this same time for DeSoto County was 21 per 100,000, which was less than for Mississippi.[3,4]

Table 17. Firearm Mortality Rates by Race within Shelby and DeSoto County, 2018 – 2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	36	20	21	23	13
Caucasian	17	-	19	-	-
African American	52	-	27	-	-
Hispanic	24	-	-	-	-

Note: Data are from sources [3,4]. Rates are per 100,000 people.

In Shelby County, the annual average death rate due to firearms for the years 2018 to 2022 was 36. Males (rate 61.5) died from firearms at a rate 7.6 times greater than females (rate 8.1). African Americans had a death rate of 52, which is 3.1 times greater than Caucasians, who had a rate of firearms deaths of 17. Hispanics in Shelby County had a death rate of 24 per 100,000, which was 1.4 times greater than Caucasians. [2]

The rate of death due to firearms has been increasing over time. For the years 2015 to 2017, the rate was 24.4 compared to the rate of 36 for 2018 to 2022. The firearm rate of death for Shelby County was 2.8 times greater than for the United States (rate of 13.0) and 1.8 times greater than for Tennessee (rate of 20). [2]

LEADING CAUSES OF DEATH

ALL RACES

Table 18. Leading Causes of Death Shelby County, Tennessee, 2021

Rank	Cause of Death	Number	Rate
1	Diseases of the Heart	2,187	236.6
2	Cancer (all types)	1,547	167.3
3	COVID-19	1,465	158.5
4	Unintentional Injuries	1,002	108.4
5	Cerebrovascular Disease	495	53.5
6	Homicide	341	36.9
7	Diabetes	332	35.9
8	Chronic Lower Respiratory Diseases	311	33.6
9	Septicemia	267	28.9
10	Alzheimer's Disease	236	25.5
11	Kidney Diseases	184	19.9
12	Hypertension and Renal Disease	168	18.2
13	Pneumonia and Influenza	160	17.3

Note: Data are from source [11]. Rates are per 100,000 people.

Table 19. Leading Causes of Death DeSoto County, Mississippi, 2021

Rank	Cause of Death	Number	Rate
1	Diseases of the Heart	437	231.7
2	Cancer (all types)	331	175.5
3	COVID-19	276	146.3
4	Chronic Lower Respiratory Diseases	163	86.4
5	Unintentional Injuries	146	77.4
6	Cerebrovascular Disease	85	45.1
7	Alzheimer's Disease	75	39.8
8	Chronic Liver Disease and Cirrhosis	55	29.2
9	Diabetes	38	20.1
10	Kidney Disease	37	19.6
11	Homicide	29	15.4
12	Suicide	26	13.8
13	Pneumonia and Influenza	24	12.7
15	Hypertension	20	10.6

Note: Data are from source [12]. Rates are per 100,000 people.

AFRICAN AMERICANS

Table 20. Leading Causes of Death for African Americans in Shelby County, Tennessee, 2021

Rank	Cause of Death	Number	Rate
1	Diseases of the Heart	1,250	247.5
2	COVID-19	947	187.5
3	Cancers	832	164.7
4	Unintentional Injuries	624	123.6
5	Cerebrovascular Disease	303	60.0
6	Homicide	300	59.4
7	Diabetes	226	44.7
8	Septicemia	147	29.1
9	Kidney Diseases	133	26.3
10	Chronic Lower Respiratory Diseases	124	24.6
10	Hypertension and Renal Disease	124	24.6
12	Alzheimer's Disease	87	17.2
13	Pneumonia and Influenza	71	14.1

Note: Data are from source [11]. Rates are per 100,000 people.

Table 21. Leading Causes of Death for African Americans in DeSoto County, Mississippi, 2021

Rank	Cause of Death	Number	Rate
1	Diseases of the Heart	85	138
2	COVID-19	64	103.9
3	Cancers	60	97.4
4	Unintentional Injuries	28	45.5
5	Cerebrovascular Disease	19	30.9
6	Chronic Lower Respiratory Disease	18	29.2
7	Homicide	16	26
8	Diabetes	25	24.4
9	Pneumonia and Influenza	7	11.4
9	Hypertension	7	11.4
11	Kidney Diseases	5	8.1

Note: Data are from source [12]. Rates are per 100,000 people.

CAUCASIANS

Table 22. Leading Causes of Death for Caucasians in Shelby County, Tennessee, 2021

Rank	Cause of Death	Number	Rate
1	Disease of the Heart	916	245.4
2	Cancer	691	185.2
3	COVID-19	501	134.2
4	Unintentional Injuries	367	98.3
5	Cerebrovascular Disease	189	50.6
6	Chronic Lower Respiratory Diseases	182	48.8
7	Alzheimer's Disease	149	39.9
8	Septicemia	118	31.6
9	Diabetes	102	27.3
10	Pneumonia and Influenza	86	23.0
11	Kidney Diseases	50	13.4
12	Hypertension and Renal Disease	43	11.5
13	Homicide	40	

Note: Data are from source [11]. Rates are per 100,000 people.

Table 23. Leading Causes of Death for Caucasians in DeSoto County, Mississippi, 2021

Rank	Cause of Death	Number	Rate
1	Disease of the Heart	916	245.4
2	Cancer	691	185.2
3	COVID-19	501	134.2
4	Unintentional Injuries	367	98.3
5	Cerebrovascular Disease	189	50.6
6	Chronic Lower Respiratory Diseases	182	48.8
7	Alzheimer's Disease	149	39.9
8	Septicemia	118	31.6
9	Diabetes	102	27.3
10	Pneumonia and Influenza	86	23.0
11	Kidney Diseases	50	13.4
12	Hypertension and Renal Disease	43	11.5
13	Homicide	40	

Note: Data are from source [11]. Rates are per 100,000 people.

UNITED STATES

Table 24. Leading Causes of Death in United States, 2023

Rank	Cause of Death	Number	Rate
1	Diseases of the Heart	702,880	167.2
2	Cancers	608,371	142.3
3	Unintentional Injuries	227,039	64.0
4	Cerebrovascular Disease	165,393	39.5
5	Chronic Lower Respiratory Disease	147,382	34.3
6	Alzheimer's Disease	120,122	28.9
7	Diabetes	101,209	24.1
8	Kidney Diseases	101,209	24.1
9	Liver Disease	54,803	13.8
10	COVID-19	186,552	44.5

Note: Data are from source [5]. Rates are per 100,000 people.

OVERALL HEALTH AND PREMATURE DEATHS

ADULTS WITH POOR HEALTH

In Shelby County, 22% of the adult population and in DeSoto County, 19% report "poor" to "fair" to describe their overall health status. In Shelby County, adults report an average of 3.7 days of poor physical health each month, and 14% of the population report 14 or more days of physical distress. In DeSoto County, adults report an average of 3.6 days of poor physical health each month, and 12% of the population report 14 or more days of physical distress. [3,4]

Table 25. Percentage of Adults with Poor or Fair Health by location and Year[3,4]

Year	Shelby County	Tennessee	DeSoto County	Mississippi	United States
2022	22	19	19	23	17
2021	21	18	18	21	14
2020	18	16	15	19	12

Note: Data are from sources [3,4].

LIFE EXPECTANCY

Life expectancy is the average number of years a person can expect to live. Life expectancy for Shelby County is 71.8 years, which is slightly lower than the 73.5-year life expectancy for Tennessee. In DeSoto County, the life expectancy is 73.9 years compared to 71.9 years for Mississippi. Hispanics have a higher life expectancy than both Caucasians and African Americans in Shelby and DeSoto Counties.[3,4]

Table 25. Life Expectancy in Years by Race and Location, 2020 – 2022

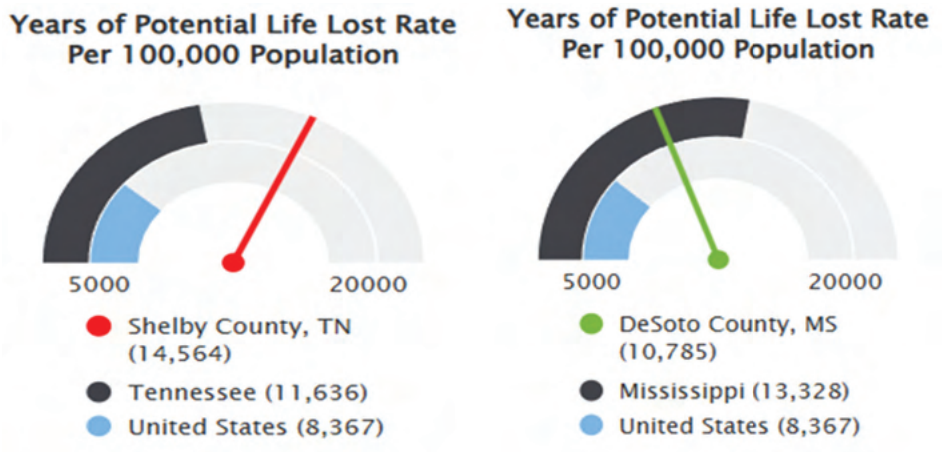
Race/Ethnicity	Shelby County	DeSoto County
All	71.8	73.9
Caucasian	75.9	73.5
African American	68.3	73.5
Hispanic	79.5	81.1

Note: Data are from sources [3,4].

YEARS OF POTENTIAL LIFE LOST/PREMATURE DEATH

There are multiple ways to measure premature deaths. For years of potential life lost, if the average life expectancy is 75 and someone dies before they reach 75 then the difference between their age and 75 is calculated. This difference is summed for the entirety of people who die before 75 during the period being measured, and rate of years lost is calculated per 100,000 people. The rate of potential years lost for DeSoto County (10,785) is better than the rate for Mississippi (13,328), while Shelby County (14,564) is worse than the rate for Tennessee (11,636).[1]

Figure 23. Years of Potential Life Lost within Shelby and DeSoto Counties, 2020-2022[1]



In Shelby County, African Americans have a rate of years of life lost 2 times worse than Caucasians. [1]

Table 26. Years of Potential Life Lost by Race and Location, 2020 – 2022

Race/Ethnicity	Shelby County	DeSoto County
All	14,564	10,785
Caucasian	9,575	11,135
African American	18,943	10,959
Hispanic	10,478	7,733

Note: Data are from sources [1]. Rates are per 100,000 people.

ALZHEIMER'S DISEASE

In 2023, Alzheimer's Disease was the sixth leading cause of deaths nationally. There were 114,034 people in the U.S. who died from the disease with a death rate of 34 per 100,000. [13]

Alzheimer's is the 10th leading cause of death in Shelby County and the 7th leading cause of death in DeSoto County (2021).[11,12] In Shelby County in 2021, 236 people died from Alzheimer's at a rate of 25.5.[11] In DeSoto County, Alzheimer's Disease led to 75 deaths for a death rate of 39.8.[12]

There is a racial disparity in Alzheimer's deaths in Shelby County. Caucasians die from Alzheimer's at a rate 1.3 times greater than African Americans.[11]

In both Shelby and DeSoto Counties, females die from Alzheimer's at a rate 1.4 and 1.5 times greater than males, respectively. Across Mississippi, the death rate for females is 1.5 times greater than males.

Table 27. Alzheimer's Mortality Rates by Race and Location, 2019-2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	31.2	40.7	48.9	53.1	30.8
Caucasian	34.6	42.3	50.5	56.3	32.2
African American	27.6	34.5	43.3	46.9	28.8
Hispanic	-	20.9	-	19.0	28.1

Note: Data are from sources [48,49]. Rates are per 100,000 people.

Table 28. Alzheimer's Mortality Rates by Gender and Location, 2019-2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	25.2	31.7	36.3	40.7	24.9
Females	34.1	46.1	55.6	60.2	34.4

Note: Data are from sources [48,49]. Rates are per 100,000 people.

CANCER (ALL TYPES)

Cancer, (of all types), is the second leading cause of death within the United States.[5] The rate of cancer deaths is 183.1 per 100,000 people, resulting in 613,352 people dying from cancer in 2023.[15] In 2024, 10.3% of the adult population had been diagnosed with cancer. Cancer accounts for 26.3 million physician office visits annually. [15]

Across the United States in 2023, the incidence rate of new cancers was 464.4 per 100,000, and the mortality rate was 142.3 per 100,000.[16]

Rate of new cancers (2022) [16]:
- Breast 132.9
- Prostate 119.1
- Lung 49.4
- Colon 36.7

Rate of cancer deaths (2023) [16]:
- Breast 18.6
- Prostate 18.6
- Lung 29.3
- Colon 12.7

Cancer is the second leading cause of death in both Shelby County and in DeSoto County. In 2021, cancer contributed to 377 of all deaths in DeSoto County and 1,547 deaths in Shelby County.[11,12]

The annual four-year Shelby County average (2017-2021) cancer incidence rate per 100,000 people was 438.2, and the mortality rate for all cancers was 177.0 per 100,000 people.[1] In DeSoto County, the annual four-year average (2017-2021) cancer incidence rate per 100,000 people was 446.6 and the mortality rate was 179.7 per 100,000 people.[1]

Figure 24. Cancer Incidence and Mortality Rates within Shelby County, 2017-2021[1]

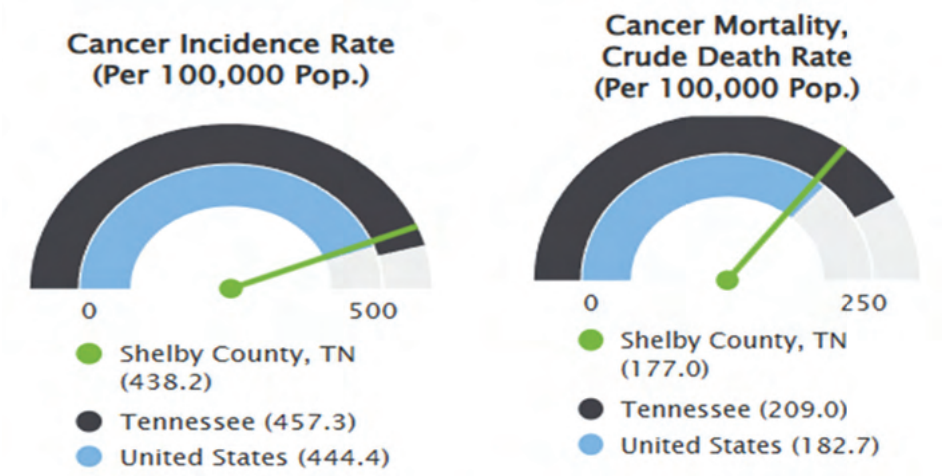
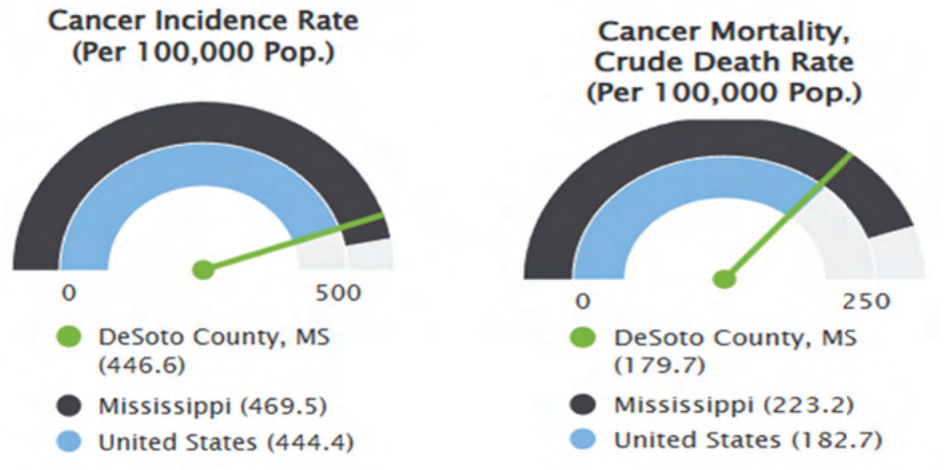


Figure 25. Cancer Incidence and Mortality Rates within DeSoto County, 2017-2021[1]



There are slight disparities among cancer mortality rates in Shelby and DeSoto Counties. In Shelby County, African Americans die from cancer at a rate 1.3 times greater than Caucasians, while there is not a significant different between mortality rates in DeSoto County.

Table 29. All Cancer Mortality Rates by Race and Location, 2018-2022

Race/Ethnicity	Shelby County	DeSoto County
All	162.1	178.1
Caucasian	143.5	182.6
African American	185.8	176.0
Hispanic	97.7	90.3

Note: Data are from sources.[11,12] Rates are per 100,000 people.

There is a noticeable difference of cancer mortality rates between the genders, with males dying from cancer at a rate 1.4 and 1.2 times greater than that of females in both Shelby and DeSoto Counties, respectively.

Table 30. All Cancer Mortality Rates by Gender and Location, 2022

Gender	Shelby County	Tennessee	DeSoto County	Mississippi
Male	185.6	199.1	214.0	246.2
Female	137.0	135.0	180.4	208.4

Note: Data are from sources.[11,12] Rates are per 100,000 people.

In Shelby County, the African American mortality rate is slightly lower than the African American mortality rate in Tennessee but higher than the African American rate across the United States. The Caucasian mortality rate in Shelby County for cancer is less than the Caucasian mortality rate in Tennessee and less than the Caucasian mortality rate in the United States. In DeSoto County, the African American mortality rate is lower than the African American mortality rate in Mississippi and lower than the national African American mortality rate due to cancer.[17]

Table 31. All Cancer Mortality Rates by Race and Location, 2022

Gender	Tennessee	Mississippi	United States
All	166.3	179.8	146.0
Caucasian	167.9	174.6	151.3
African American	179.2	199.4	168.6
Hispanic	77.1	65.8	106.8

Note: Data are from sources.[17] Rates are per 100,000 people.

BREAST CANCER

Between 2018 and 2022 in Shelby County, there were 3,466 new cases of breast cancer with an incidence rate of 125 for every 100,000 women. Over these years, 695 people died of breast cancer for a death rate of 25.8 per 100,000 people.[17]

Between 2018 and 2022 in DeSoto County, there were 633 new cases of breast cancer. The incidence rate for breast cancer in DeSoto County is 122.4 per 100,000 persons. Over this period, 120 people died of breast cancer for a death rate of 25 per 100,000 people.[17]

The incidence rate of breast cancer is similar across races in Shelby County. Caucasians have a rate of 127.4 and African Americans have a rate of 134.6 per 100,000 women. The rates for Shelby County are similar to the national rates overall and by race where African Americans had breast cancer at a rate of 124 and Caucasians had a rate of 132. In DeSoto County, there is little difference between African Americans and Caucasians concerning the rate of new breast cancer incidences.[17]

While the incidence rates between African American and Caucasian women do not show significant disparity, there is a very noticeable disparity when it comes to rate of death due to breast cancer. In Shelby County, African American women die at a rate 1.5 times greater than Caucasian women, and in DeSoto County, they die at a rate 1.1 times greater than Caucasian women. Nationally African Americans die at a rate 1.4 times greater than Caucasians due to breast cancer.

Table 32. Breast Cancer Incidence by Race and Location, 2017 – 2021

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	125.0	124.6	122.4	124.6	129.8
Caucasian	129.3	126.4	116.9	124.0	135.7
African American	122.1	122.2	147.9	129.7	128.8
Hispanic	106.5	88.6	-	51.1	101.0

Note: Data are from source [17]. Rates are per 100,000 people.

Table 33. Breast Cancer Mortality Rates by Race and Location, 2018 – 2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	25.8	21.7	25.0	23.4	19.3
Caucasian	20.8	20.9	24.0	20.1	19.4
African American	31.8	28.8	27.0	30.4	26.8
Hispanic	-	10.3	-	14.9	13.7

Note: Data are from source [17]. Rates are per 100,000 people.

BREAST CANCER SCREENING

Mammography screening is a vital tool in order to detect breast cancer at an early stage. In 2023 across the nation, 62.1% of women aged 40-49 and 80% of women aged 50-74 received a mammogram in the last two years. These visits accounted for 27.3 million physician office visits.[18]

In Shelby County, 38% of all female Medicare recipients aged 65 to 74 received a mammogram, an amount less than the 48% of women across Tennessee who got a mammogram. In DeSoto County, 37% of all female Medicare recipients aged 65 to 74 received a mammogram, which is slightly lower than 42% of all women across Mississippi. In both counties in 2023, Caucasian and African American women were more likely to get a mammography than Hispanic women were.

Table 34. Medicare Enrollees (ages 65 – 74) with Annual Mammogram Percentages by Race and Location, 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
All	38%	48%	37%	42%
Caucasian	38%	-	36%	-
African American	40%	-	42%	-
Hispanic	15%	-	9%	-

Note: Data are from sources [3,4]. Rates are per 100,000 people.

COLON AND RECTAL CANCER

The incidence rate of colon and rectal cancer in Shelby County is 41.0 and 44.7 in DeSoto County. Shelby County's incidence rate is higher than both the state and national rates. The incidence rate of colon and rectal cancer for DeSoto County is less than Mississippi but greater than the United States.[17]

Between 2019 and 2023 in Shelby County, there were 2,032 new cases of colon and rectal cancer with an incidence rate of 41 for every 100,000 people. Over those years, 806 people died of colon and rectal cancer for a death rate of 16.4 per 100,000 people.[17]

Between 2019 and 2023 in DeSoto County, there were 440 new cases of colon and rectal cancer with an incidence rate of 44.7 per 100,000. Over those years, 160 people died of colon and rectal cancer for a death rate of 17.2 per 100,000 people.[17]

In Shelby County, African Americans get colon and rectal cancer at a rate slightly higher than Caucasians, and males regardless of race get this type of cancer more often than females. Specifically, African American males get colon and rectal cancer 1.2 times more frequently than Caucasian males in Shelby County.[17]

In DeSoto County, African Americans get colon and rectal cancer at a rate 1.1 times greater than Caucasians, and males regardless of race get this type of cancer more often than females at a rate 1.3 higher. Specifically, African American males get colon and rectal cancer 1.2 times more frequently than Caucasian males.[17]

Table 35. Rate of New Colon and Rectal Cancers by Race and Location, 2018 – 2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	41.0	38.7	44.7	46.4	36.4
Caucasian	38.2	38.7	44.8	43.9	36.5
African American	44.8	42.5	47.5	53.0	41.0
Hispanic	24.3	22.2	-	26.4	32.8

Note: Data are from source [17]. Rates are per 100,000 people.

Table 36. Rate of New Colon and Rectal Cancers by Location, Gender, and Race, 2018 – 2022

	Shelby County			DeSoto County		
Race/Ethnicity	All	Male	Female	All	Male	Female
All	41.0	47.4	36.2	44.7	53.9	40.1
Caucasian	38.2	43.9	33.3	44.8	47.0	42.5
African American	44.8	51.7	40.3	47.5	54.9	41.6
Hispanic	24.3	38.2	-	-	-	-

Note: Data are from source [17]. Rates are per 100,000 people.

The racial disparity is even greater when examining rates of death in Shelby County due to colon and rectal cancer. African Americans die at a rate 1.6 greater than Caucasians. Males die at a rate of 1.2 times greater than females. African American males die 1.6 times more often from colon and rectal cancer than Caucasian males.[17] The racial and gender disparity of colon and rectal cancer death rates in DeSoto County is not as significant as it is in Shelby County.

Table 37. Colon and Rectal Cancer Mortality Rates by Race and Location, 2018 – 2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	16.4	14.7	17.2	17.6	12.9
Caucasian	13.1	14.4	16.2	16.1	12.9
African American	20.5	18.8	23.0	21.8	16.7
Hispanic	-	6.3	-	6.5	10.7

Note: Data are from source [17]. Rates are per 100,000 people.

Table 38. Colon and Rectal Cancer Mortality Rates by Location, Race and Gender, 2018 – 2022

	Shelby County			DeSoto County		
Race/Ethnicity	All	Male	Female	All	Male	Female
All	16.4	14.7	17.2	17.6	12.9	16.4
Caucasian	13.1	14.4	16.1	16.2	12.9	13.1
African American	20.5	18.8	23.0	21.8	16.7	20.5
Hispanic	-	6.3	-	6.5	10.7	-

Note: Data are from source [17]. Rates are per 100,000 people.

LUNG CANCER

Between 2018 and 2022, the incidence rate for new lung cancer cases was 54.5 per 100,000 in Shelby County which was less than the rate for Tennessee but greater than the rate across the United States.[17]

In Shelby County, African Americans have lung cancer at a rate slightly greater than Caucasians and a rate of death 1.1 times greater than Caucasians. Males in Shelby County die from lung cancer at a rate 1.5 times greater than females.

Table 39. Rate of New Lung Cancers by Race and Location, 2018 – 2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	54.5	68.1	70.7	68.9	53.1
Caucasian	53.1	70.6	77.8	71.4	57.5
African American	56.2	60.6	51.6	66.7	54.7
Hispanic	40.1	30.4	-	19.5	27.6

Note: Data are from source [17]. Rates are per 100,000 people.

Table 40. Rate of New Lung Cancers by Location, Gender, and Race, 2018 – 2022

	Shelby County			DeSoto County		
Race/Ethnicity	All	Male	Female	All	Male	Female
All	54.5	67.1	45.6	70.7	77.7	66.3
Caucasian	53.1	61.8	47.0	77.8	82.9	74.7
African American	56.2	73.4	44.7	51.6	73.7	39.8
Hispanic	40.1	53.7	34.4	-	-	-

Note: Data are from source [17] profile. Rates are per 100,000 people.

Between 2019 and 2023 in Shelby County, there were 2,802 new cases of lung cancer with an incidence rate of 54.5 for every 100,000. Over those years, 1,850 people died of lung cancer for a death rate of 35.5 per 100,000 people.[17]

Between 2019 and 2023 in DeSoto County, there were 701 new cases of lung cancer. The incidence rate for lung cancer in DeSoto County is 70.7 per 100,000 persons. Over those years, 484 people died of lung cancer for a death rate of 52.2 per 100,000 people. The DeSoto County incidence rate of new lung cancer cases was greater than Mississippi and the rate across the United States.[17]

Unlike Shelby County, Caucasians in DeSoto County have a lung cancer incidence and death rate greater than African Americans. Caucasians have lung cancer at a rate 1.5 times higher than African Americans and their rate of death is 1.2 times greater than African Americans. Males in DeSoto County die from lung cancer at a rate 1.4 times greater than females regardless of race.[17]

Table 41. Lung Cancer Mortality Rates by Race and Location, 2018 – 2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	35.5	44.1	52.2	47.5	32.4
Caucasian	33.0	46.0	55.5	48.7	35.4
African American	38.5	39.9	45.7	46.8	34.3
Hispanic	17.5	12.0	-	10.6	14.6

Note: Data are from source [17]. Rates are per 100,000 people.

Table 42. Lung Cancer Mortality Rates by Location, Race and Gender, 2018 – 2022

	Shelby County			DeSoto County		
Race/Ethnicity	All	Male	Female	All	Male	Female
All	35.5	46.0	28.0	52.2	63.6	44.8
Caucasian	33.0	39.2	28.6	55.5	66.6	44.8
African American	38.5	54.3	28.2	45.7	59.1	39.2
Hispanic	17.5	-	-	-	-	-

Note: Data are from sources [17]. Rates are per 100,000 people.

PROSTATE CANCER

Between the years of 2017 and 2021, the rate of prostate cancer per 100,000 for Shelby County was 140.4 and 124 for DeSoto County.[17] In Shelby County, the incidence rate was 1.2 times higher than the national rate. For every 100,000 men, 27.5 die of prostate cancer in Shelby County.[17]

Like many other cancers, there is a racial disparity in the incidence rate for prostate cancer. In Shelby County, the prostate cancer incidence rate for African Americans is 1.5 times higher than for Caucasians, and in DeSoto County, this rate is 2 times greater than Caucasians.[17]

In Shelby County, African Americans die from prostate cancer at a rate 2.1 times greater than Caucasians. In DeSoto County, African Americans die from prostate cancer 2.2 times greater than Caucasians. Nationally, African Americans die 2.1 times more often than Caucasians from prostate cancer.[17]

The incidence rate for prostate cancer in Shelby County is greater than both Tennessee and the United States' incident rate. The rate for Caucasians in Shelby County is also greater than both Tennessee and the national rate. The rate for African Americans is less than Tennessee but greater than the Unites States.

The incidence rate for prostate cancer in DeSoto County is less than Mississippi but greater than the United States. For Caucasians the rate is less than Mississippi and the United States. The rate for African Americans in DeSoto County is greater than both Mississippi and the United States.

Table 43. Prostate Cancer Incidence by Race and Location, 2017 – 2021

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	140.4	115.1	124.0	135.2	113.2
Caucasian	116.4	106.5	104.9	110.2	107.9
African American	176.7	181.9	208.1	199.8	179.7
Hispanic	45.7	70.8	-	46.6	86.9

Note: Data are from source [17]. Rates are per 100,000 people.

Between 2017 and 2021 in Shelby County, there were 3,502 new cases of prostate cancer with an incidence rate of 140.4 for every 100,000. Over those years, 518 people died of prostate cancer for a death rate of 27.5 per 100,000 people.[17]

Between 2017 and 2021 in DeSoto County, there were 623 new cases of prostate cancer. The incidence rate for prostate cancer in DeSoto County is 124 per 100,000 persons. Over those years, 90 people died of prostate cancer for a death rate of 24.2 per 100,000 people.[16]

Table 44. Prostate Cancer Mortality Rates by Race and Location, 2017 – 2021

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	27.5	19.6	24.2	24.5	19.0
Caucasian	19.1	17.9	21.8	18.5	18.1
African American	40.2	38.7	48.3	44.3	37.2
Hispanic	-	8.5	-	-	15.4

Note: Data are from source [17]. Rates are per 100,000 people.

CARDIOVASCULAR DISEASE: HEART DISEASE, HYPERTENSION AND STROKE

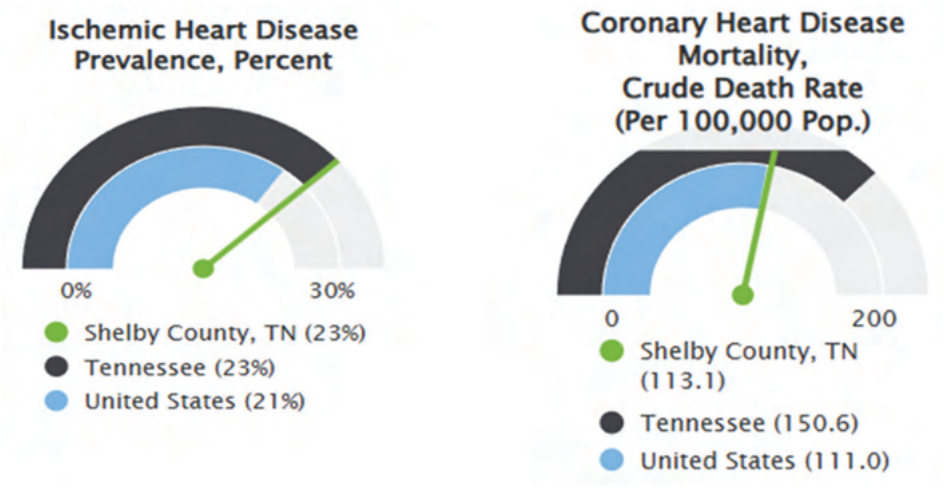
Heart disease is the number one leading cause of death in the United States.[5] There were 680,981 deaths due to heart disease in 2023, a rate of death 203.3 per 100,000 persons.[19] In 2024, there were 17 million adults or 5% of the U.S. adult population who had been diagnosed with heart disease.[19] The racial breakdown among the prevalence of heart disease is 5.6% of Caucasians, 2.8% of Hispanics, and 4.0% of African Americans in 2024.[21] Heart disease accounted for 6.9% of physician office visits and 7.2% of all emergency department visits in 2019.[19]

HEART DISEASE

Heart disease is the number one cause of death in Shelby County and in DeSoto County. In 2021, heart disease accounted for 2,187 deaths in Shelby County and 437 deaths in DeSoto County.[11,12]

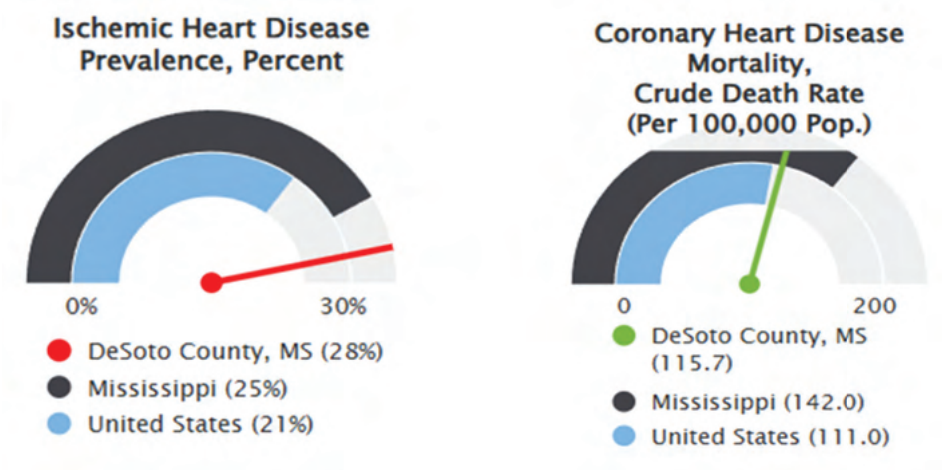
In 2023, 23% of Shelby County's population were diagnosed with heart disease. Of DeSoto County's population, 28% were diagnosed with heart disease.[1]

Figure 26. Adults with Heart Disease within Shelby County, 2023[1]



DeSoto County's heart disease mortality rate is slightly higher than the U.S. but lower than Mississippi.

Figure 27. Adults with Heart Disease within DeSoto County, 2023[1]



Current data from 2019 to 2023 indicates that African Americans in Shelby County die from heart disease at a rate 1.4 times greater than Caucasians. This disparity is greater than across Tennessee where African Americans die from heart disease at a rate 1.1 times greater than Caucasians. [48,49]

Table 45. Heart Disease Mortality Rates by Race and Location, 2019-2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All Races	218.3	219.4	230.3	245.2	168.9
Caucasian	182.9	220.3	228.4	236.3	172.9
African American	259.1	248.2	245.4	267.6	217.6
Hispanic	68.3	72.4	127.5	82.8	118.4

Note: Data are from sources [48,49]. Rates are per 100,000 people.

Within both Shelby and DeSoto Counties, heart disease mortality rates are also significantly different for males and females. In Shelby County, males die at a rate 1.8 times greater than that of females, while in DeSoto County males die of heart disease at a rate 1.6 times higher than females. [48,49]

Across Tennessee, African American males die of heart disease at a rate 1.5 times greater than Caucasian males and 1.9 times greater than that of African American females. [48]

Table 46. Heart Disease Mortality Rates by Gender and Location, 2019 - 2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Male	295.6	278.9	293.6	314.2	216.8
Female	162.3	170.9	181.6	191.0	130.3

Note: Data from sources [48,49] Rates are per 100,000 people.

Table 47. Heart Disease Mortality Rates by Location, Gender, and Race, 2019 - 2023

	Shelby County			DeSoto County		
Race/Ethnicity	All	Male	Female	All	Male	Female
All	218.3	295.6	162.3	230.3	293.6	181.6
Caucasian	182.9	246.0	135.4	228.4	289.5	180.5
African American	259.1	358.3	191.3	245.4	330.2	191.0
Hispanic	68.3	96.1	44.4	127.5	-	-

Note: Data are from source [48,49] Rates are per 100,000 people.

HIGH BLOOD PRESSURE/HYPERTENSION

Nearly half of all adults in the United States have been diagnosed with high blood pressure. In 2023, high blood pressure was a primary or contributing cause of 664,470 deaths in the United States.[23] The mortality rate was 12.7 per 100,000 people. [22] Almost half of adults over 18 years of age, 49.1%, (2021-2023) are on medication for hypertension, and this condition accounted for 56.8 million office visits and 1.1 million emergency department visits in 2022. [22,23]

In Shelby County, 71% of the population has high blood pressure while 74% of DeSoto County residents have high blood pressure.[1]

Figure 28. Adults with High Blood Pressure within Shelby and DeSoto Counties, 2023[1]

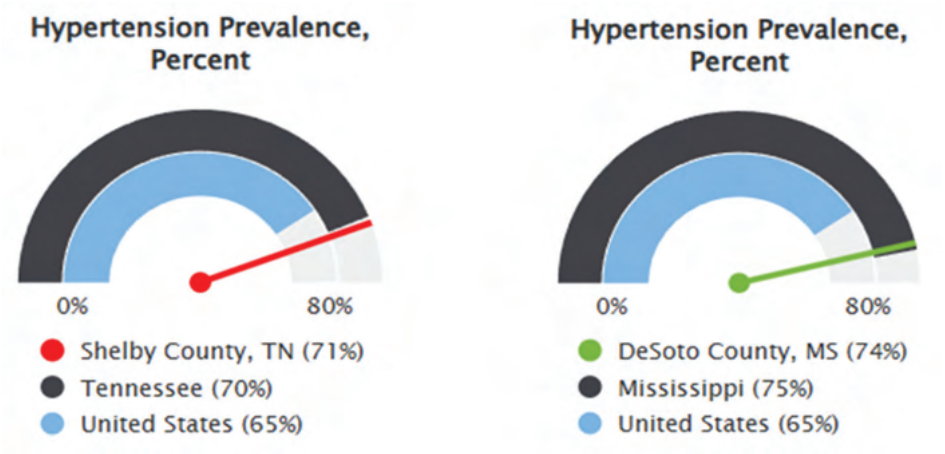


Figure 29. Percentage of the population with High Blood Pressure in Shelby County

Note: Map was developed by MLCO Program Evaluation

In 2021, the rate of death attributed to high blood pressure for all races across Tennessee was 13.1, and nationally, 12.7.[5,11] Shelby County's rate of death due to hypertension is greater than both the state and national rates. Hypertension was the 12th leading cause of death in Shelby County, accounting for 168 deaths at a rate of 18.2 per 100,000 people.[11]

In Shelby County, African Americans die at 2.1 times the rate of Caucasians from hypertension.[10] In DeSoto County in 2021, African Americans died of hypertension at 1.1 times the rate of Caucasians. DeSoto County's experience of Caucasians and African Americans dying of hypertension at similar rates differs from the state rates where African Americans die from hypertension at 1.5 times the rate of Caucasians.[11,12]

Table 48. Hypertension Mortality Rates by Race within Shelby County and DeSoto County, 2021

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	18.2	13.1	10.6	20.4	12.7
Caucasian	11.5	7.3	10.8	14.6	-
African American	24.6	21.4	11.4	21.4	-

Note: Data are from sources [5,11,12]. Rates are per 100,000 people.

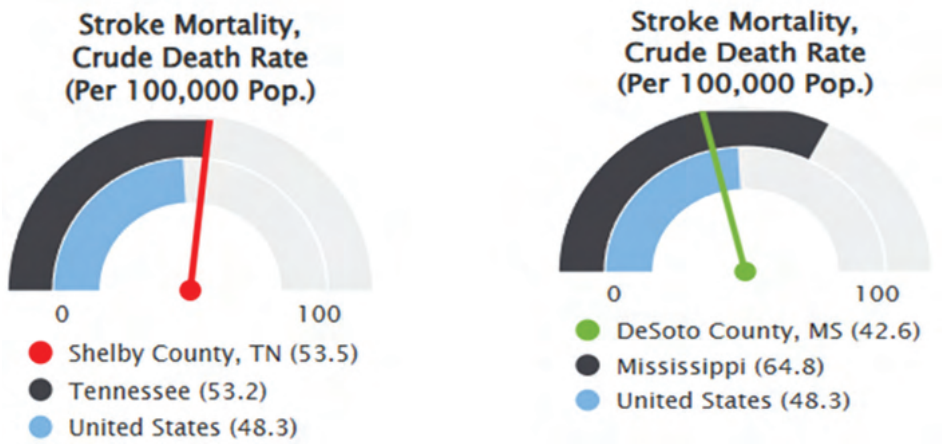
STROKE/CEREBROVASCULAR DISEASE

Stroke is the 4th leading cause of death in the United States and accounted for 165,393 deaths in 2021. The stroke mortality death rate is 49.5 per 100,000 people.[5] Every year, more than 795,000 people in the United States have a stroke.[25] In 2022, stroke symptoms accounted for 2.2 million visits to a primary care office and 686,000 emergency department visits.[25]

In Shelby County in 2021, cerebrovascular disease or stroke contributed to 2,187 deaths and was the 5th leading cause of death.[11] In DeSoto County for the same year, cerebrovascular disease was the 6th leading cause of death, where 85 people died.[12]

The average annual mortality rate from 2019 to 2023 is higher in Shelby County (53.5 per 100,000 people) than in DeSoto County (42.6).[1]

Figure 30. Stroke Mortality Rate within Shelby and DeSoto Counties, 2019-2023[1]



Nationally, African Americans die from strokes at a rate 1.5 times greater than Caucasians. African Americans die from stroke at a rate 1.8 times greater than that of Caucasians in Shelby County, and in DeSoto County they die at a rate 1.5 times greater than Caucasians.[11,12]

Table 49. Stroke Mortality Rates by Race by Location, 2019-2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	53.0	45.9	47.6	54.8	39.8
Caucasian	39.7	43.9	44.6	48.2	38.3
African American	69.5	63.8	67.5	70.2	57.0
Hispanic	19.9	18.6	-	19.5	35.8

Note: Data are from sources [48,49]. Rates are per 100,000 people.

Table 50. Stroke Mortality Rates by Gender by Location, 2019-2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Male	58.3	46.2	46.5	59.7	41.0
Female	48.2	44.8	47.1	50.2	38.3

Note: Data are from sources [48,49]. Rates are per 100,000 people.

In Shelby County African American males die from strokes at a rate 2 times greater than Caucasian males, while African American females die at a rate 1.6 times greater than Caucasian females.[48]

Table 51. Stroke Mortality Rates by Location, Gender, and Race, 2019-2023

	Shelby County		Tennessee	
Race/Ethnicity	Male	Female	Male	Female
All	58.3	48.2	46.2	44.8
Caucasian	40.3	38.4	43.3	43.7
African American	82.3	60.1	74.4	55.9
Hispanic	25.6	-	17.4	18.6

Note: Data are from source [48]. Rates are per 100,000 people.

CHILD MORTALITY

In 2023 across the U.S., 4,059 children aged 1 to 4 died, a rate of 27.3 per 100,000. The leading causes were accidents, congenital abnormalities and homicide. In addition, 6,005 children aged 5 to 14 died, a rate of 14.7 per 100,000.[24] Leading causes among 5 to 9-year-olds were accidents, cancer and congenital abnormalities. For children aged 10-14, leading causes were accidents, suicide and cancer.[24]

LEADING CAUSES OF CHILD DEATHS BY AGE GROUP ACROSS THE UNITED STATES, 2023 24

Children aged 1 – 4

- Accidents (unintentional injuries)
- Congenital malformations, deformations and chromosomal abnormalities
- Assault (homicide)

Children aged 5 – 9

- Accidents (unintentional injuries)
- Cancer
- Congenital malformations, deformations and chromosomal abnormalities

Children aged 10 – 14

- Accidents (unintentional injuries)
- Intentional self-harm (suicide)
- Cancer

Table 52. Leading Causes of Child Deaths (ages 1 – 14) Tennessee, 2021

Rank	Cause of Death	Number	Rate
1	Unintentional Injuries	89	7.5
2	Homicide	20	1.7
3	Cancer	18	1.5
4	Congenital Anomalies	17	1.4
5	Suicide	14	1.2

Note: Data are from source [11]. Rate per 100,000.

The child mortality rate for Shelby County is 90 deaths per 100,000 children, a rate which is higher than the mortality rate across Tennessee of 70 deaths per 100,000 children. Also in Shelby County, African American children have a mortality rate of 130, and die at a rate 3.3 times more than the rate of Caucasian children. Hispanic children die at a rate 2 times greater than Caucasian children do. The child mortality rate for DeSoto County (80) is greater than the state of Mississippi (70). The child mortality rate for African Americans (100) is greater than that for Caucasians (70) in DeSoto County.[3,4]

Table 53. Child Mortality Rates by Race and Location, 2019-2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
All	90	70	80	90
Caucasian	40	30.3	70	41.3
African American	130	70.3	100	63.1
Hispanic	80	36.9	80	33.5

Note: Data are from sources [3,4]. Rates are per 100,000 children.

Table 54. Child Death Rates (ages 1 to 14) in Shelby County by Year

	2017	2018	2019	2020	2021
Shelby County	26	27	31	25	36
Tennessee	22	21	20	19	21

Note: Data are from sources [6]. Rate per 100,000 children.

TEEN AND YOUNG ADULT DEATHS

Teens age 15 to 19 in Shelby County die at a rate much higher than teens in Tennessee. In 2021 the rate in Shelby County (116.5) was 1.7 times greater than Tennessee (69.7). [6]

Table 55. Teen Deaths (ages 15 to 19) in Shelby County by Year

	2017	2018	2019	2020	2021
Shelby County	64.2	93.4	60.1	113.0	116.5
Tennessee	52.5	55.7	48.3	61.7	69.7

Note: Data are from sources [6]. Rate per 100,000 children.

Table 56. Leading Causes of Teen and Young Adult Deaths (ages 15 – 24) Tennessee, 2021

Rank	Cause of Death	Number	Rate
1	Unintentional Injuries	516	58.2
2	Homicide	211	23.8
3	Suicide	146	16.5
4	COVID-19	43	4.8
5	Diseases of the Heart	29	3.3

Note: Data are from source [11]. Rate per 100,000.

COVID-19

COVID-19 was the third leading cause of death across the U.S. in 2021. In total, 416,893 people died of COVID-19, accounting for 12% of all deaths.[5] It was the 3rd leading cause of death in both Shelby and DeSoto Counties in 2021.

In Shelby County, African Americans died from COVID-19 at a rate 1.4 times greater than Caucasians. In DeSoto County, Caucasians died from COVID-19 at a rate 1.7 times greater than African Americans. The death rate in 2021 for Shelby County was less than for Tennessee but greater than the United States. In DeSoto County, the death rate was the same as Mississippi but greater than the United States.

Table 57. COVID-19 Mortality Rate by Race and Location, 2021

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	158.5	203	146.3	146.3	111.4
Caucasian	134.2	198	175.2	185.6	91.1
African American	187.5	196	103.9	160.1	136.2
Hispanic	-	73	-	-	155.3

Note: Data are from sources [10,11,12]. Rates are per 100,000 people.

Table 58. COVID-19 Mortality Rates by Gender and Location, 2021

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	-	225	188.9	188.9	130.5
Females	-	181	156.6	156.6	79.8

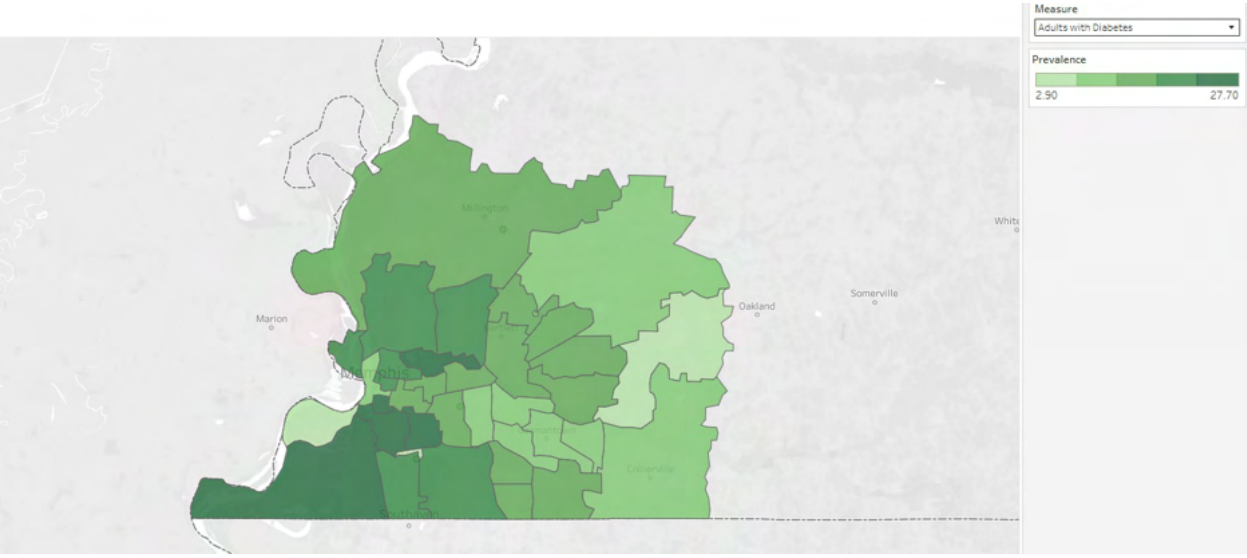
Note: Data are from sources [10,11,12]. Rates are per 100,000 people.

DIABETES

In 2021 across the United States, 101,209 people died from diabetes. Diabetes is the eighth leading cause of death across the country with a death rate of 24.1 per 100,000 people. Diabetes accounted for 14.2% of all physician office visits and 564,000 emergency room visits across the country in 2022.[10,26]

Nationally, there is an estimated 4.5% of the population with undiagnosed diabetes. From 2021 to 2023, 15.8% of the population was living with diagnosed diabetes.[26]

Figure 31. Percentage of the population with Diabetes in Shelby County by ZIP Code

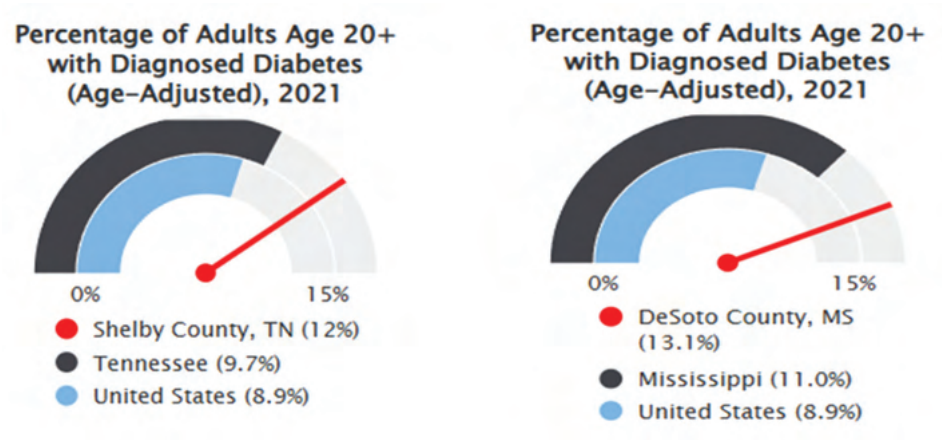


Note: Map was developed by MLCO Program Evaluation

In 2021, diabetes was the 7th leading cause of death in Shelby County, with 332 deaths. Diabetes was the 9th leading cause of death in DeSoto County, with 38 deaths. In 2023, the rate of death per 100,000 people due to diabetes was 30.5 in Shelby County and 14.6 in DeSoto County.[11,12]

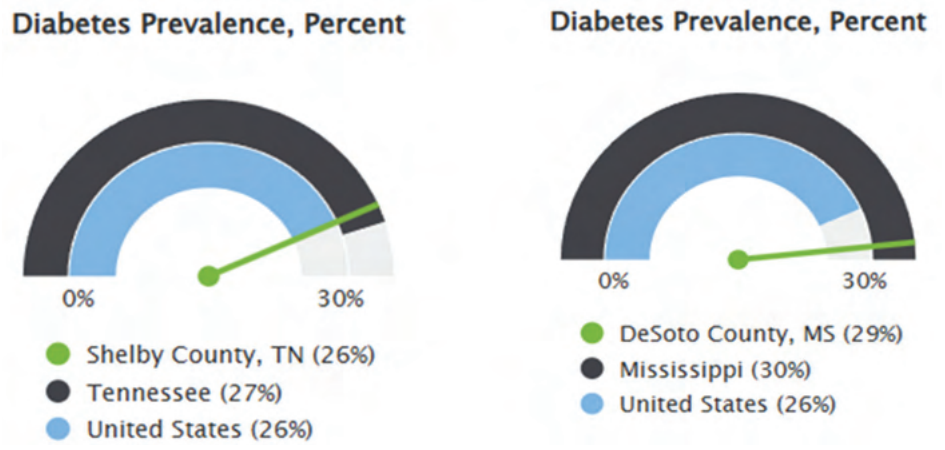
Over 130,000 people in Shelby and DeSoto counties combined, live with diabetes. Twelve percent of the population in Shelby County and 13.1% of DeSoto County live with diabetes. Shelby County's percentage of people living with diabetes is slightly greater than for Tennessee (9.7%) and greater than the national percentage (8.9%). DeSoto County (13.1%) has a percentage higher than both Mississippi and the United States.[1]

Figure 32. Adults with Diabetes within Shelby and DeSoto Counties, 2021[1]



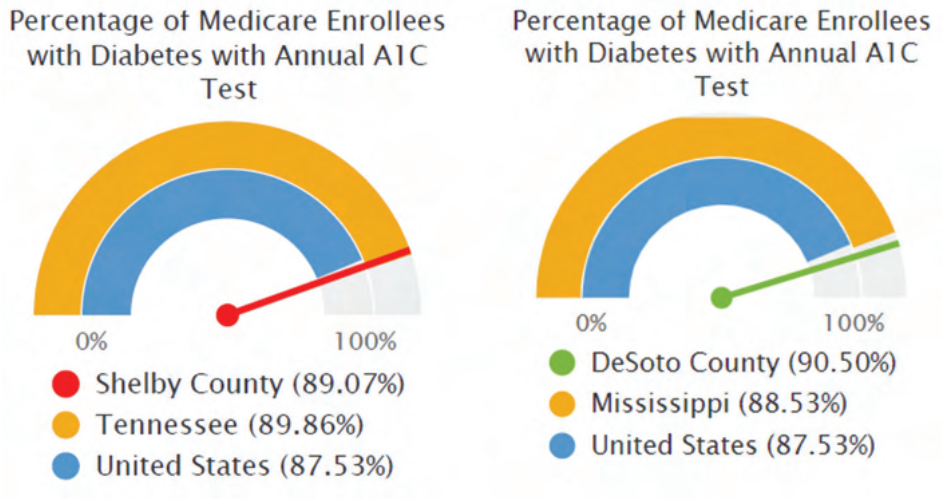
Of the Medicare populations, 26% in Shelby County and 29% in DeSoto County have diabetes. These percentages are similar to the national percentage of Medicare recipients who have diabetes, which is 26%.[1]

Figure 33. Medicare Beneficiaries with Diabetes within Shelby and DeSoto Counties, 2023[1]



Of the Medicare population with diabetes in both counties, 89% or more get their A1C checked annually. Recipients in DeSoto County are much better at getting an annual A1C test than residents across Mississippi and the United States. Shelby County on the other hand, has a slightly smaller percentage of recipients who get an annual exam than residents across Tennessee and the United States.[1]

Figure 34. Medicare Enrollees with an Annual Diabetic Exam within Shelby and DeSoto Counties, 2019[1]



African Americans in Shelby County die from diabetes at a rate 1.7 times greater than Caucasians. In DeSoto County, African Americans die from diabetes at a rate 2.2 times greater than Caucasians. For Shelby County in 2021, diabetes was the 7th leading cause of death for African Americans (rate 44.7 per 100,000 people) and the 9th leading cause of death for Caucasians (rate 27.3). During this same time in DeSoto County, diabetes was the 8th leading cause of death for African Americans (rate 24.4), and 10th leading cause of death for Caucasians (rate 19.2).[48,49]

Table 59. Diabetes Mortality Rates by Race and Location, 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	30.5	30.1	14.6	36.8	23.9
Caucasian	28.1	28.1	11.7	25.5	20.8
African American	48.2	48.2	26.2	63.2	42.7
Hispanic	16.8	16.8	-	14.9	28.6

Note: Data are from sources [48,49]. Rates are per 100,000 people.

In Shelby County, males die from diabetes at a rate 1.6 times greater than females. In DeSoto County, males die from diabetes at a rate 1.3 times greater than females, while across Mississippi and the United States males die from diabetes at a rate 1.5 and 1.6 times greater than females, respectively.

Table 60. Diabetes Mortality Rates by Gender and Location, 2019-2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	39.0	37.9	16.6	44.9	30.2
Females	24.2	23.9	13.1	30.3	18.6

Note: Data are from sources [48,49]. Rates are per 100,000 people.

DRUGS AND ALCOHOL

DRUG OVERDOSE

In 2023 across the United States, 105,007 people died of drug overdoses at a rate of 31.4 per 100,000 people.[27]

Between 2020 and 2022, the average annual drug overdose death rate for Shelby County was 57 per 100,000 people. The state of Tennessee had a drug overdose death rate of 51, noticeably higher than the rate for the United States, which was 31. In DeSoto County, there were 33 deaths due to drugs for every 100,000 people, which was higher than the rate of 24 per 100,000 for the state of Mississippi.[3,4]

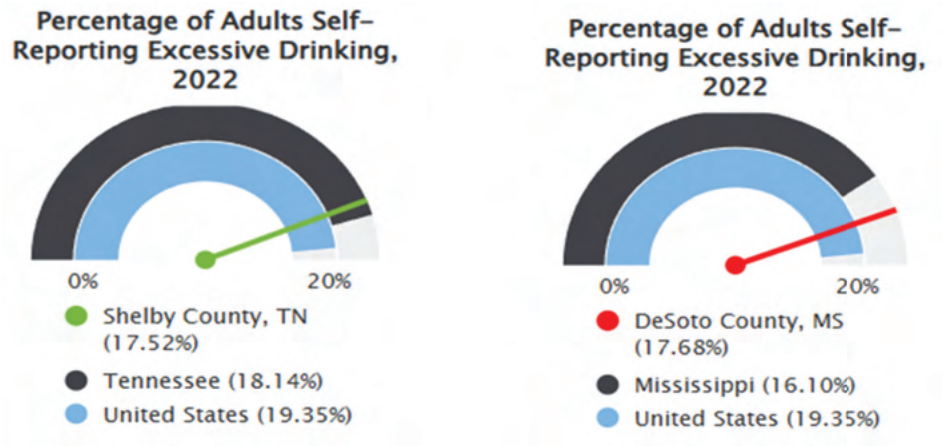
In the 2020 to 2022 timeframe, Hispanics had a lower rate of drug overdose deaths compared to other racial groups. Caucasians and African Americans both died from overdoses at a rate of 61 per 100,000. Hispanics in Shelby County died from drug overdoses at a rate of 39 per 100,000 people.[3,4]

ALCOHOL USE

Alcohol use is a contributor to many health issues that, if not directly the cause of death, contributes to death. In 2023 across the United States, 28,632 people died from alcoholic liver disease at a rate of 8.5 per 100,000. An additional 47,938 people died from alcohol-induced deaths for a rate of 14.3 per 100,000. These alcohol-induced deaths excluded accidents and homicides.[28]

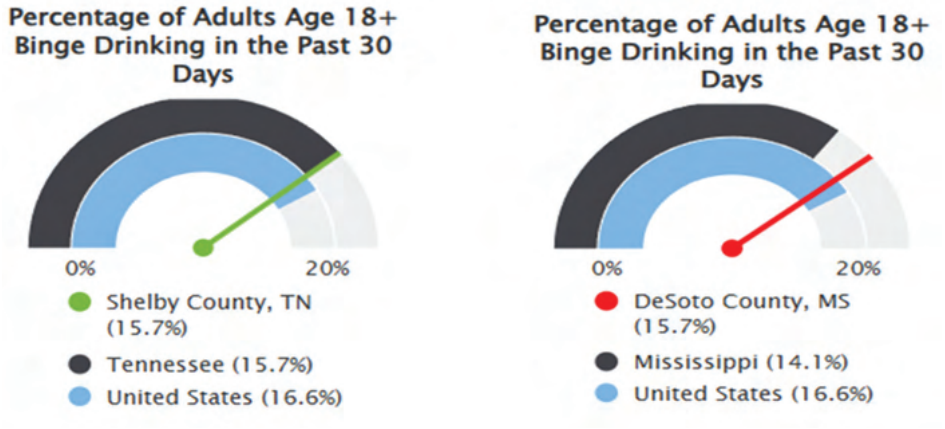
Approximately 19% of adults nationally report drinking excessively. Information from 2022 indicates that 17.52% of Shelby County adults and 17.86% of DeSoto County adults reported excessive drinking.[1]

Figure 35. Adults Drinking Excessively within Shelby and DeSoto Counties, 2022[1]



The percentage of adults in Shelby County who reported binge drinking in the past 30 days is the same as the state's percentage. In DeSoto County, the percentage of adults who reported binge drinking in the past 30 days is slightly greater than the state's average.

Figure 36. Adults Binge Drinking in Past 30 Days within Shelby and DeSoto Counties, 2022[1]



FLU AND PNEUMONIA MORTALITY

In 2023 across the United States, 45,185 people died from the flu and pneumonia for a rate of 13.5 per 100,000 people and was the 12th leading cause of death. [129] In 2021, flu and pneumonia was the 13th leading cause of death in Shelby County and the 13th leading cause of death in DeSoto County. The death rate from flu and pneumonia in Shelby and DeSoto Counties was higher than the rate across the United States. [48,49]

Table 61. Flu and Pneumonia Mortality Rates by Race within Shelby and DeSoto Counties, 2019-2023

Flu					
Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	24.3	22.5	20.2	30.5	13.0
Caucasian	28.4	24.2	22.9	34.4	12.8
African American	23.2	19.9	16.9	25.9	16.8
Hispanic	-	14.5	-	-	12.1
Pneumonia					
Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	17.9	14.9	15.6	20.4	10.7
Caucasian	17.5	15.1	15.7	19.8	10.5
African American	18.3	16.0	18.9	22.1	13.0
Hispanic	11.0	6.1	-	6.1	9.4

Note: Data are from sources [48,49]. Rates are per 100,000 people.

Table 62. Flu and Pneumonia Mortality Rates by Gender and Location, 2019-2023

Flu					
Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	1.3	1.6	-	1.4	1.1
Caucasian	1.2	1.5	-	1.2	1.1
African American	1.6	1.7	-	1.6	1.2
Hispanic	1.3	1.6	-	1.4	1.1
Pneumonia					
Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	17.9	14.9	15.6	20.4	10.7
Caucasian	14.8	13.0	13.3	17.2	8.9
African American	22.7	17.7	18.4	25.1	13.1
Hispanic	17.9	14.9	15.6	20.4	10.7

Note: Data are from sources [48,49]. Rates are per 100,000 people.

FLU VACCINATIONS

Despite communication campaigns encouraging flu vaccination, just half (50%) of the adult residents in Shelby County, and 42% in DeSoto County, received an annual flu vaccination in 2022-2023. When looking specifically at racial differences in flu vaccinations, 56% of Caucasians in Shelby County and 51% in DeSoto County got a flu vaccination, while a little more than a third of African Americans and Hispanics in both counties got a flu vaccine.[3,4] Nationally in 2022, 48% of adults 18 and older received a flu vaccine.

Table 63. Percent of People who Received a Flu Vaccination by Race and Location, 2022-2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
All	50	49	42	49
Caucasian	56	44	51	33
African American	37	36	40	34
Hispanic	34	43.1	28	43

Note: Data are from sources [3,4]. Rates are per 100,000 people.

HEALTH PROVIDERS

PRIMARY CARE PROVIDERS

In 2021 in Shelby County, there were 1,170 people for every primary care provider compared to 1,140 people for every primary care provider in Tennessee. In DeSoto County, the rate of people to primary care providers was 3,850 and the rate of people to primary care provider in Mississippi was 1,880 in 2021.[3,4]

MENTAL HEALTH PROVIDERS

There is a lack of mental health providers across the country and within the service areas of both Shelby and DeSoto Counties. In Shelby County, there are 490 residents for every one mental health provider. In DeSoto County, there are 700 residents for every one mental health provider. In Tennessee and Mississippi, the ratio is 500:1 and 440:1, respectively. Shelby County's rate of mental health providers is 1.6 times worse than for the United States. DeSoto County's rate of mental health providers is 2.3 times worse than the rate for the United States. Across the United States, there are 300 people for every 1 mental health provider.[3,4]

DENTAL HEALTH PROVIDERS

In 2022, the rate of dental providers in Shelby County was 1,290 people for every one dentist in the county. In DeSoto County, the rate of dental providers was 2,590 people per every one dentist in the county.[3,4]

Table 64. Ratio of Residents to Health Providers by Location

Type of Provider	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Primary Care (2021)	1,170:1	1,440:1	3,850:1	1,880:1	1,330:1
Non-Primary Care (2021)	650:1	640:1	1,210:1	730:1	870:1
Mental Health (2024)	490:1	500:1	700:1	440:1	300:1
Dentist (2022)	1,290:1	1,780:1	2,590:1	1,940:1	1,360:1

Note: Data are from sources [3,4].

INFANT AND MATERNAL HEALTH

ADEQUATE PRENATAL CARE

Access and utilization of adequate prenatal care helps to reduce the risk of complications before, during, and after pregnancy. The lack of prenatal care contributes to short gestation and low birth weight, which is the second leading cause of death for infants nationwide. Lack of prenatal care also contributes to maternal complications, which is the 5th leading cause of death for infants nationally.[30]

The percentage of women receiving adequate prenatal care in Shelby County has increased from 55% in 2018 to 61% in 2021. While the numbers are increasing, the percentage is still lower than Tennessee's 75% of women receiving adequate prenatal care in 2022. From 2021 to 2023, 67.4% of African American women received adequate prenatal care compared to 77.1% of Caucasian women.[6]

Table 65. Percent of Mothers Receiving Adequate Prenatal Care in Shelby County by Year

Race	2018	2019	2020	2021	2022
Shelby County: All	55%	60%	61%	61%	-
Tennessee: All	75%	75%	73%	76%	75%

Note: Data are from sources [6].

The percentage of women in DeSoto County receiving prenatal care has stayed relatively the same from 71% in 2018 to 70.9% in 2022.[12]

Table 66. Percent of Mothers Receiving Adequate Prenatal Care in DeSoto County by Year

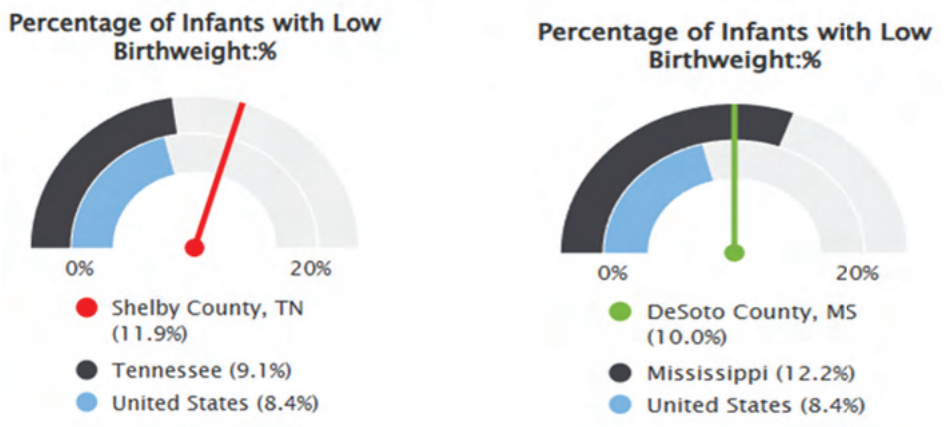
Race	2018	2019	2020	2021	2022
DeSoto County: All	71.0%	70.3%	69.0%	70.1%	70.9%
Mississippi: All	75.5%	75.9%	75.2%	75.6%	75.4%

Note: Data are from sources [7,12].

LOW BIRTHWEIGHT BABIES

Low birth weight is the second leading cause of infant deaths across the US.[30] Shelby County has a rate of low birthweight babies 1.4 times worse than the rate for the US and 1.3 times worse than for Tennessee. Since 2019, the percentage of low-birth-weight babies in Shelby County has remained the same, nearly 12% of all live births are born low weight.[6]

Figure 37. Low Birth Weight Births within Shelby and DeSoto Counties, 2017-2023.[1]



A higher percentage of babies, 11.9%, in Shelby County, are born with low birth weight compared to 9.1% across Tennessee. DeSoto County has a better percentage than the state of Mississippi where 10% of babies were born with low birth weight compared to 12.2% in Mississippi. [3,4]

In Shelby County, the percentage of babies with low birth weight for African Americans is 2.1 times greater than that of Caucasians and 2.1 times that of Hispanics.[3] Across the state of Mississippi, 12% of babies are born with low birth weight. African Americans had low birth weight babies at a rate1.9 times greater than Caucasians and 2.26 times greater than Hispanics.[3,4]

Table 67. Percent of Babies Born with Low Birth Weight by Race and Location, 2017 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	12%	9%	10%	13%	9%
Caucasian	7%	8%	8%	9%	7%
African American	15%	16%	14%	18%	15%
Hispanic	7%	7%	7%	8%	8%

Note: Data are from sources [3.4.]

PREMATURE BIRTHS

In Shelby County, 12.5% of all live births are preterm. The premature birth rate for Shelby County is similar to the rate for Tennessee. Within Shelby County, the percentage of preterm births for non-whites is 1.6 times that of Caucasians.[2] The percentage of premature births in 2022 for DeSoto County was 14.2%, and African Americans had premature births at a rate 1.7 times greater than that of Caucasians.[7,12]

Table 68. Percent of Premature Births by Race and Location, 2022

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
All	12.5%	11.2%	14.2%	14.8%
Caucasian	9.5%	10.5%	11.0%	12.5%
Non-white	15.1%	15.3%	18.5%	17.7%

Note: Data are from sources [2,7,12].

INFANT MORTALITY

The national infant mortality rate in 2023 was 5.6 per 1,000 births,[30] and this rate has implications for the medical, social and environmental factors that affect an infant's health, well-being, and ability to survive and thrive during the first year of their life.

LEADING CAUSES OF INFANT DEATHS IN THE UNITED STATES, 2022[30]

- Congenital malformations, deformations, and chromosomal abnormalities
- Disorders related to short gestation and low birthweight
- Sudden infant death syndrome

Shelby County's infant mortality rates have been consistently higher than Tennessee's rates from 2016, 2022. In 2022, Shelby County's infant mortality rate was 9 compared to Tennessee's rate of 7.[6]

There exists a racial disparity for infant mortality in both Shelby and DeSoto Counties. African American babies in Shelby County die at a rate 3 times higher than Caucasian babies. In DeSoto County, African American babies die at a rate 1.8 times greater than Caucasian babies.[3,4]

While the infant mortality rate in DeSoto County increased from 6.9 (2015-2018) to 8.2 (2018-2022), the rate is still slightly better than the overall infant mortality rate for Mississippi of 8.8 (2018-2022).[4]

Table 69. Infant Mortality Rates by Race and Location, 2021 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi
All	8.3	6.4	8.2	9.1
Caucasian	4.1	5.3	6.2	6.9
African American	11.4	11.1	11.3	12.4
Hispanic	4.7	4.6	-	6.0

Note: Data are from sources [3,4]. Rates are per 1,000 births.

Table 70. Infant Mortality Rate by Years and Race in Shelby County

Race		2017	2018	2019	2020	2021-23
Shelby	All	10.0	8.7	9.8	7.1	8.3
	Caucasian	6.6	4.7	5.8	-	4.1
	African American	12.6	11.4	12.8	-	11.4
Tennessee	All	7.4	6.9	7.0	6.3	6.4
	Caucasian	5.9	5.6	5.3	-	5.3
	African American	12.9	12.3	13.5	-	11.1

Note: Data are from sources [50]. Rate is per 1,000 births.

Table 71. Infant Mortality Rate by Years and Race in DeSoto County

Race		13-17	14-18	15-18	18-22
DeSoto	All	5.9	5.5	6.9	8.2
	Caucasian	5.3	4.9	6.2	6.2
	African American	7.0	7.3	8.6	11.3
Mississippi	All	8.9	8.6	8.8	8.8
	Caucasian	6.5	6.2	6.3	6.2
	African American	12	11.8	11.9	11.9

Note: Data are from sources [7]. Rate is per 1,000 births.

MATERNAL MORTALITY

Nationally, in 2023, the maternal mortality rate was 18.4 per 100,000 live births. Racial and ethnic gaps exist in maternal mortality. African American women had a maternal mortality rate of 37.3 deaths per 100,000 live births compared to a rate of 14.9 for Caucasians and 11.8 for Hispanic mothers.[31] In 2020, the rate of African American women dying of a pregnancy-related issue increased to 55.3 per 100,000 live births. This was a rate 2.9 times greater than that of Caucasian women, at 19.1. The overall maternal mortality rate for all races nationwide was 23.8 in 2020 compared to 20.1 in 2019.[31]

KIDNEY DISEASE

In 2023, there was an estimated 35.5 million adults in the United States (14% of the population) with chronic kidney disease. The death rate for kidney disease was 16.5 per 100,000. In 2023, 55,253 people died from kidney related illnesses, making kidney disease the 8th leading cause of death in the nation.[33] In Shelby County in 2021, 3.5% of adults were living with chronic kidney disease.[2]

Hypertension/Kidney disease was the 12th leading cause of death in Shelby County in 2021, contributing to 168 deaths in the county for a rate of 18.2 per 100,000 people.[11] Kidney disease was the 10th leading cause of death for DeSoto County in 2021, with a death rate of 19.6 per 100,000.[12]

Hypertension/Kidney disease was the 10th leading cause of death for African Americans and 15th leading cause of death for Caucasians in Shelby County in 2021. In DeSoto County, kidney disease was the 11th leading cause of death for African Americans and 9th leading cause of death for Caucasians in 2020. [11,12]

Table 72. Kidney Disease Mortality Rates by Race and Location, 2019-2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	18.4	14.2	20.1	21.4	13.4
Caucasian	10.5	12.7	18.4	16.5	12.0
African American	27.6	26.3	28.4	33.4	26.3
Hispanic	-	5.9	-	5.8	12.3

Note: Data are from sources [48,49]. Rates are per 100,000 people.

Table 73. Kidney Disease Mortality Rates by Gender and Location, 2019-2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	22.1	16.9	26.8	25.3	16.3
Females	15.9	12.2	15.1	18.6	11.2

Note: Data are from sources [48,49]. Rates are per 100,000 people.

LIVER DISEASE

Within the United States, 4.5 million adults, or 1.8% of the population, live with liver disease. In 2023, 52,222 people died from this disease for a mortality rate of 15.6 per 100,000 people.[34] It was the 9th leading cause of death in the United States in 2023. [34]

In both counties, Caucasians died from liver disease at a higher rate than African Americans or Hispanics. In Shelby County, Caucasians liver disease mortality rate was 1.8 times higher than African Americans, and in DeSoto County, the Caucasian liver disease mortality rate was 1.4 times greater than African Americans. Males in DeSoto County have the highest mortality rate from liver disease in our service area.

Table 74. Liver Disease Mortality Rates by Race and Location, 2019-2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	10.4	15.8	19.3	15.6	13.1
Caucasian	14.1	17.8	26.5	18.6	13.8
African American	7.9	8.9	-	9.6	8.6
Hispanic	10.4	8.4	-	9.3	16.2

Note: Data are from sources [48,49]. Rates are per 100,000 people.

Table 75. Liver Disease Mortality Rates by Gender and Location, 2019-2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	15.3	21.0	27.8	20.7	17.1
Females	6.3	10.9	12.2	11.1	9.4

Note: Data are from sources [48,49]. Rates are per 100,000 people.

LUNG AND RESPIRATORY DISEASES

Across the country in 2023, chronic lower respiratory disease was the 5th leading cause of death. The death rate was 34.3 per 100,000 people, and a total of 147,382 people died.[35] Chronic Obstructive Pulmonary Disease (COPD), which includes Bronchitis and Emphysema, contributed to 854,000 visits to an emergency department and accounted for 4.1% of all visits to primary care offices in 2022.[35] There were a total of 8.6 million people with bronchitis and over 3 million people with emphysema. For other chronic lower respiratory diseases (excluding asthma), the rate is 39.8 deaths per 100,000 population.[35]

In 2021, lung and respiratory disease was the 8th leading cause of death in Shelby County and 4th leading cause of death in DeSoto County. The rate of death in 2021 from lung disease was 33.6 per 100,000 in Shelby County and 86.4 in DeSoto County.[11,12]

Caucasians have lung disease 1.4 times greater than African Americans at 28.7. Across Tennessee and Mississippi, Caucasians have lung disease at rates 1.8 times greater than African Americans. Caucasians in DeSoto County have a rate of lung disease 3.0 times greater than African Americans.[1]

Table 76. Chronic Lower Respiratory Mortality Rates by Race and Location, 2019 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	31.9	63.3	68.1	72.6	44.9
Caucasian	53.2	79.7	104.3	104.8	65.2
African American	24.4	27.9	18.3	35.2	27.3
Hispanic	-	3.3	-	6.9	9.1

Note: Data are from sources [1]. Rates are per 100,000 people.

Figure 38. Lung Disease Mortality Rates within Shelby and DeSoto Counties, 2019-2023[1]

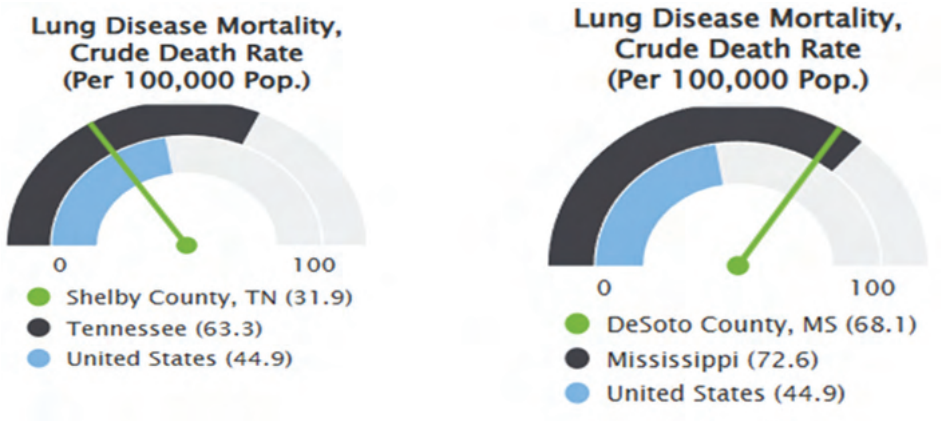


Table 77. Lung and Respiratory Mortality Rates by Gender and Location, 2019 – 2023

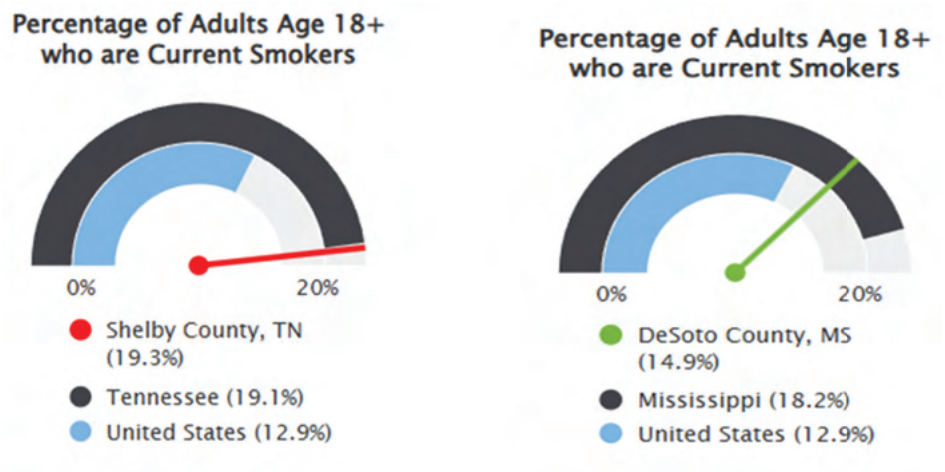
Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	30.1	58.9	69.6	71.2	42.8
Females	33.6	67.5	66.8	73.9	47.0

Note: Data are from sources [1]. Rates are per 100,000 people.

TOBACCO USE

In Shelby County, 19.3% of adults smoke compared to 19.1% across Tennessee. In DeSoto County, 14.9% of adults smoke, which is less than the 18.2% of adults across Mississippi who smoke.[1] Both counties have a greater percentage of residents who smoke than the United States.

Figure 39. **Adults Smoking Cigarettes within Shelby and DeSoto Counties, 2022**[1]



ASTHMA

In 2024, 8.6% of adults and 6.5% of children across the United States had asthma. Asthma accounted for 6.3% of physician office visits and 1.4 million emergency department visits. [8] In 2023, 3,624 people died of asthma within the United States, for a rate of 1.1 per 100,000 people.[36]

Table 78. **Adults and children with asthma by location, 2021-2023**

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Adults	74,584	614,808	10,506	161,450	24,748,581
Children	22,503	139,190	3,293	42,710	-

Note: Data are from sources[37]. Rates are per 100,000 people.

MENTAL HEALTH

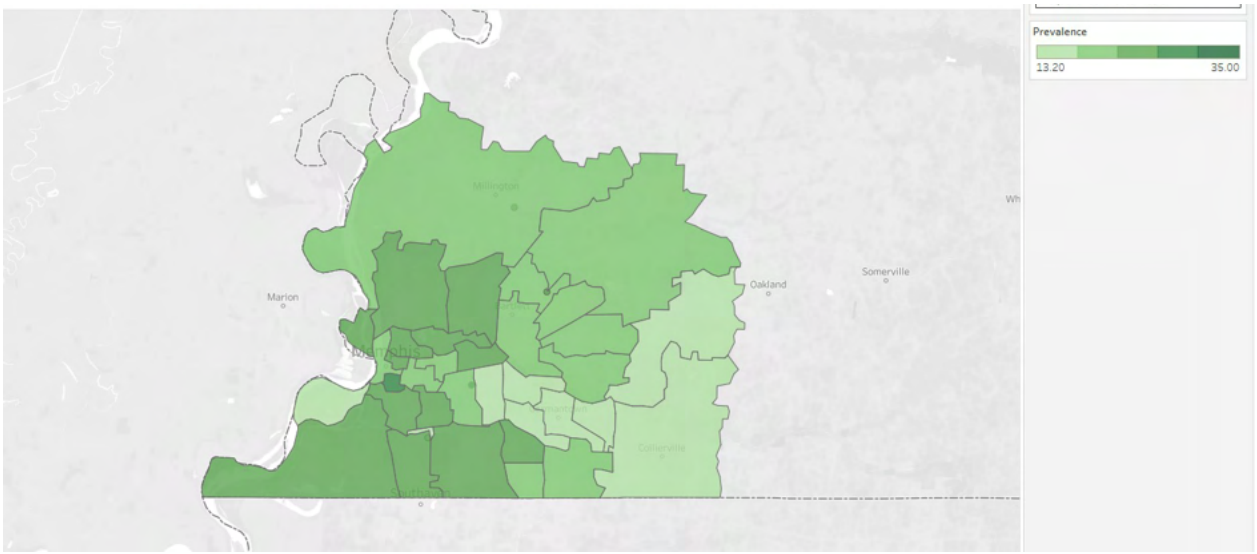
There is great importance in assessing the mental health status of a community. Mental health plays a vital role affecting the overall health outcome of individuals and the community. Negative indicators of mental health are seen among high rates of suicide, depression, alcohol and substance abuse, where positive indicators of mental health are displayed with high rates of access to mental health providers, more utilization of mental health services, and an overall positive perception of mental well-being.

POOR MENTAL HEALTH

Across the United States 12.1% of adults (aged 18 years and older) reported regular feelings of worry, nervousness, or anxiety (2024).[38] Mental, behavioral, and neurodevelopmental disorders accounted for 57.2 million visits to a physician office and 5.9 million visits to an emergency department in 2022.[38]

In 2022, 21% of adults in Shelby County and 16% of adults in DeSoto County reported 14 or more days of poor mental health a month. The percentage of frequent mental distress was 21% for the state of Tennessee and 17% for Mississippi. All county and state percentages were equal to or higher than the national percentage of 16% of residents reporting frequent mental distress in the past 30 days. [3,4]

Figure 40. Percentage of People with Frequent Poor Mental Health in Shelby County by ZIP Code



Note: Map was developed by MLCO Program Evaluation

In 2022, 25.2% of adult residents in Shelby County reported experiencing depression at one point in time. Between the years 2018 and 2020, 15.8% of adults in Shelby County had a diagnosed mental illness. [2]

Across the state of Tennessee in 2020-2021, an estimated 49.3% of children aged 3 to 17 with a diagnosed behavioral or mental health condition were receiving counseling. In Mississippi between 2020 and 2021, 47.2% of children aged 3 to 17 with a diagnosed behavioral or mental condition were receiving counseling.[39] This means that half of the children in both Tennessee and Mississippi with a diagnosed condition were not receiving counseling.

SUICIDE

Across the United States in 2023, suicide was the 11th leading cause of death and accounted for 616,000 emergency department visits for suicide attempts.[8] In 2023, 49,316 people died from suicide for a rate of 14.7 per 100,000 people nationally. [40]

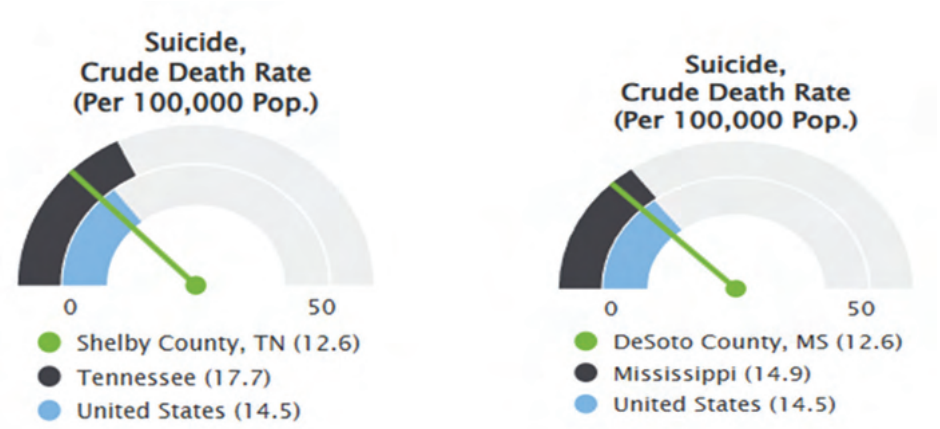
The rate of suicide mortality in both Shelby and DeSoto Counties is 12.6 deaths per 100,000 people. Shelby and DeSoto Counties' suicide rates were less than both the rate for Tennessee and the rate of the United States. In 2021, suicide was the 12th leading cause of death in DeSoto County where Caucasians died of suicide at a rate 1.4 times greater than African Americans.[1]

Table 79. Suicide Rates by Race and Location, 2019 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	12.6	17.7	12.6	14.9	14.5
Caucasian	21.8	21.1	17.6	20.8	18.8
African American	8.0	9.1	-	7.0	8.5
Hispanic	6.6	8.2	-	7.7	7.7

Note: Data are from sources [1]. Rates are per 100,000 people.

Figure 41. Suicide Death Rates within Shelby and DeSoto Counties, 2019-2023[1]



There is a significant difference in suicide rates between genders. Across the nation, males have a suicide rate 3.9 times greater than that of females. For Tennessee, the rate of suicide for males is 4.1 times greater than that of females. The suicide mortality rate in Shelby County for males is 3.8 times higher than that of females.[2] In DeSoto County, the rate of suicide is 3.8 times greater than females, compared to Mississippi where males have a rate 4.5 times greater than females.[1]

Table 80. Suicide rates by gender and location, 2019 - 2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	U.S.
Males	20.6	28.8	20.2	24.9	23.3
Females	5.4	7.1	5.5	5.5	6.0

Note: Data are from sources [1]. Rates are per 100,000 people.

OBESITY AND OVERWEIGHT

ADULT OBESITY

Obesity is a significant problem in Shelby and DeSoto Counties. A third of adults in both Shelby County and DeSoto County are obese. Shelby County's obesity rate is slightly worse than Tennessee and the United States. The percentage of obese adults in DeSoto County is worse than both Mississippi and the national percentage.[1]

Figure 42. Adults with Obesity within Shelby and DeSoto Counties, 2021[1]

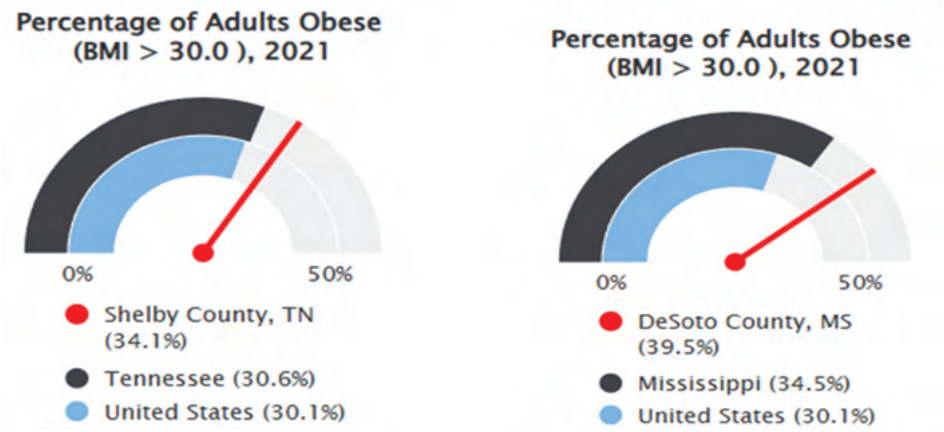


Figure 43. Percentage of Adults with Obesity in Shelby County by ZIP Code

CHILD OBESITY

Across the United States, obesity is a health problem for children. Nationally, an estimated 32.2% of children ages 6 to 17 are overweight or obese. This health problem is even more pronounced in Tennessee and Mississippi. In 2022-2023, 35.4% of children ages 6 to 17 in Tennessee are estimated to be overweight or obese. During the same time frame, it is estimated that 43.1% of children aged 6 to 17 across Mississippi are overweight or obese.[39]

Table 80. Percentage of Children (ages 6 to 17) who are Overweight /Obese by Race in Tennessee, 2022 - 2023

Weight Status	All Races	African American	Caucasian	Hispanics
Overweight	15.5%	23.8%	14.5%	12.4%
Obese	19.9%	21.7%	16.5%	36.2%
Overweight and Obese	35.4%	45.5%	31.0%	48.6%

Note: Data are from source [39].

Note: Data are from source [39].

Table 81. Percentage of Children (ages 6 to 17) who are Overweight /Obese by Race in Mississippi, 2022 – 2023

Weight Status	All Races	African American	Caucasian	Hispanics
Overweight	18.1%	19.3%	17.7%	21.7%
Obese	25.0%	34.0%	17.6%	38.8%
Overweight and Obese	43.1%	53.3%	35.3%	60.5%

Note: Data are from source [39].

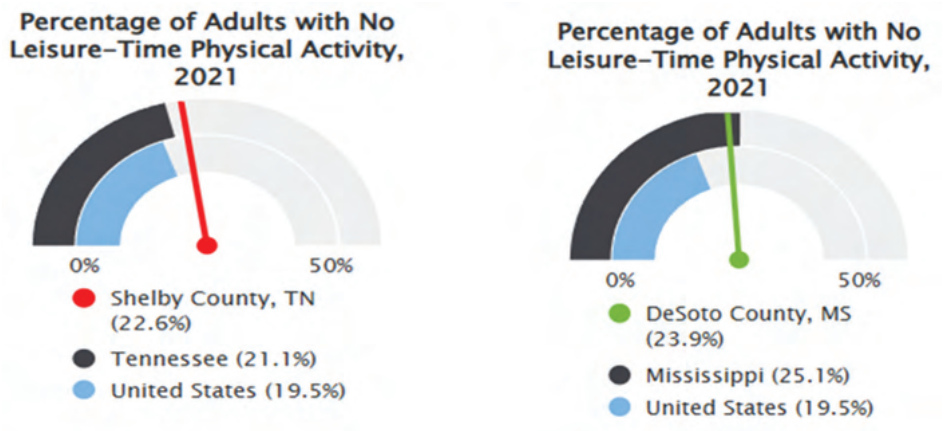
Note: Data are from source [39].

PHYSICAL EXERCISE

Physical activity is important for healthy living. In Shelby County 22.6% of adults engage in no leisure time physical activity compared to 23.9% in DeSoto County. Shelby County's percentage of inactive people is greater than Tennessee and the national percentage, while DeSoto County's percentage is lower than Mississippi but higher than the U.S.

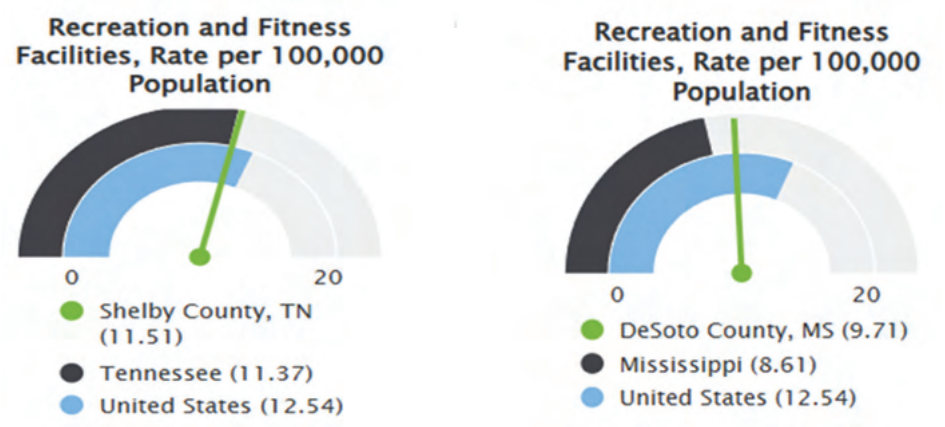
The rate of fitness facilities for Shelby County is 11.51 per 100,000 people, compared to 11.37 for Tennessee and 12.54 for the United States. DeSoto County has a rate of 9.71 exercise facilities per 100,000 people, which is greater than Mississippi's 8.61, but lower than the country as a whole.[1]

Figure 44. Population with No Physical Activity within Shelby and DeSoto Counties, 2021[1]



EXERCISE FACILITIES

Figure 45. Recreation and Fitness Facilities within Shelby and DeSoto Counties, 2023[1]

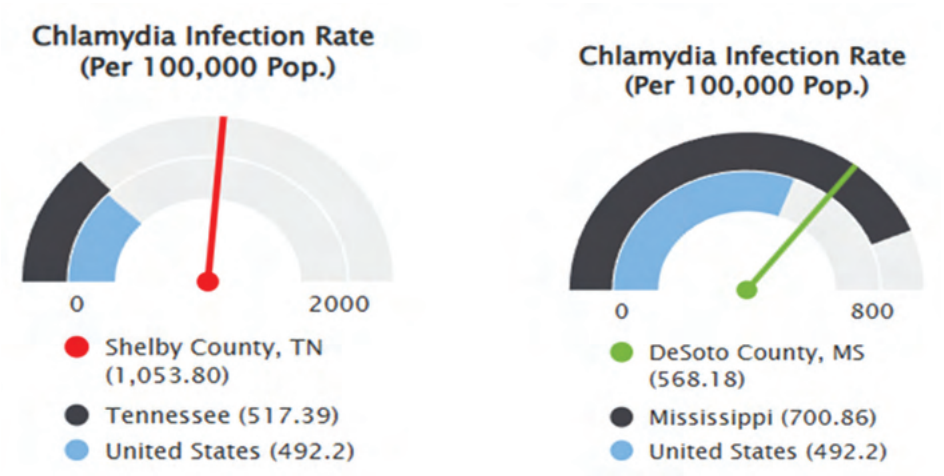


SEXUALLY TRANSMITTED DISEASES

CHLAMYDIA

The rate of chlamydia in Shelby County in 2023 was 2 times the rate for Tennessee and 2.1 times the rate for the United States.[1] In DeSoto County, the rate was lower than Mississippi's rate, but still greater than the United States.

Figure 46. Chlamydia Infection Rates within Shelby and DeSoto Counties, 2023[1]



From 2021-2022, African Americans in Shelby County had chlamydia at a rate 8.1 times higher than Caucasians. The rate of Chlamydia for Hispanics was 2.3 times greater than that of Caucasians. There is also a gender disparity, where the rate for females with chlamydia is 1.9 times that of males.[41]

Table 82. Chlamydia Infection Rates by Race and Gender within Shelby County, 2021-2022

Race/Ethnicity	Shelby County All	Shelby County Male	Shelby County Female	Tennessee All
All	1027.9	697.3	1323.7	538.1
Caucasian	204.2	133.6	270.5	279.9
African American	1644.4	1163.3	2050.3	1,600.3
Hispanic	477.0	305.0	1031.0	725.7

Note: Data are from source [41,42]. Rates are per 100,000 people.

HIV/AIDS

In 2022, Shelby County had an HIV/AIDS prevalence rate 2.8 times greater than Tennessee and 2.3 times greater than the United States. DeSoto County had a lower prevalence rate than both Mississippi and the U.S.[1]

Figure 47. Population with HIV/AIDS within Shelby and DeSoto Counties, 2022[1]

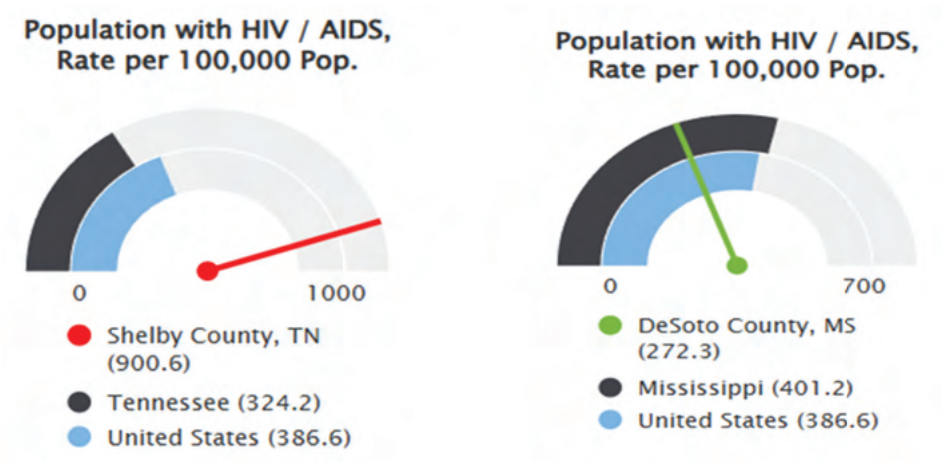
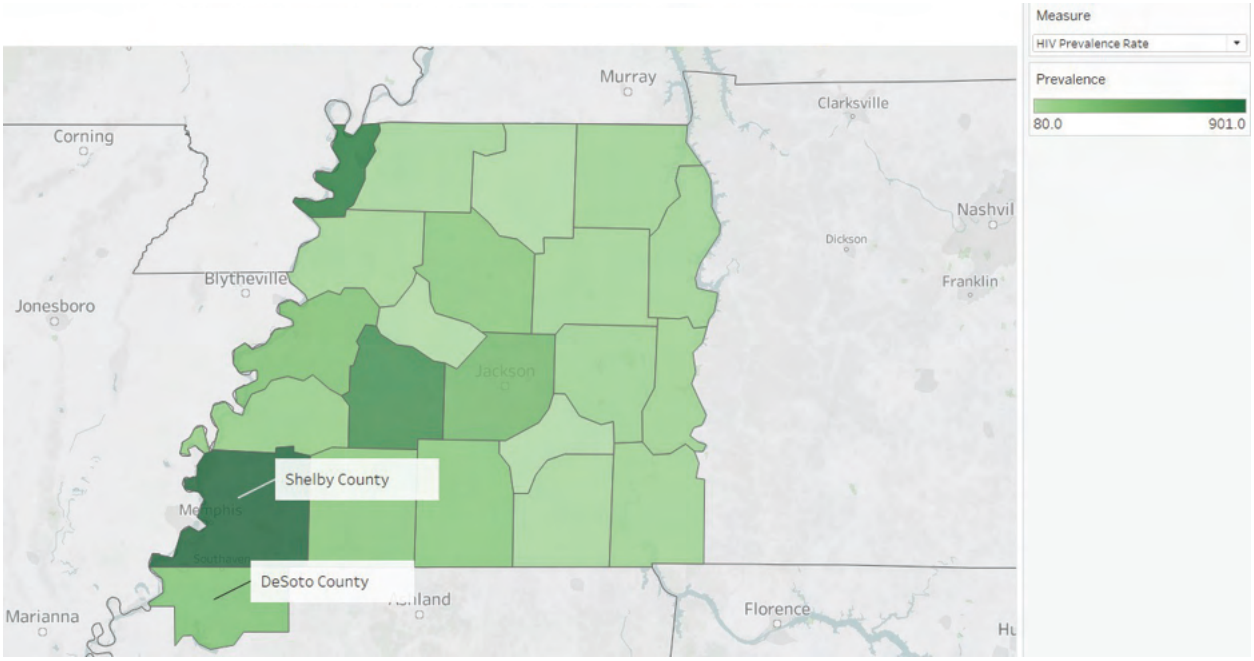


Table 83. People Living with HIV/AIDS (PLWHA) by Race and Gender within Shelby County, 2022

Race/Ethnicity	Shelby County All	Shelby County Male	Shelby County Female	Tennessee All
All	743.7	1090.6	402.7	279.9
Caucasian	209.1	364.4	58.0	-
African American	1130.1	1656.5	637.8	-
Hispanic	377.6	558.1	170.2	-

Note: Data are from source [41]. Rates are per 100,000 people.

Figure 48. HIV Prevalence Rates for West Tennessee and DeSoto County



The greatest growth rate of new HIV infections in Shelby County is occurring among African American males. The rate of new infections for this group is 84.1 per 100,000. African American females have the second highest rate of new infections at 18.8.[41]

In Shelby County, the rate of new HIV cases for African Americans is 6.5 times greater than the rate for Caucasians and 2.9 times higher than the rate for Hispanics. The rate of new HIV cases for Hispanics is 2.2 times greater than the rate for Caucasians. Shelby County has a new HIV case rate 2.9 times higher than Tennessee.[41]

Table 84. New HIV cases by Race and Gender within Shelby County, 2021

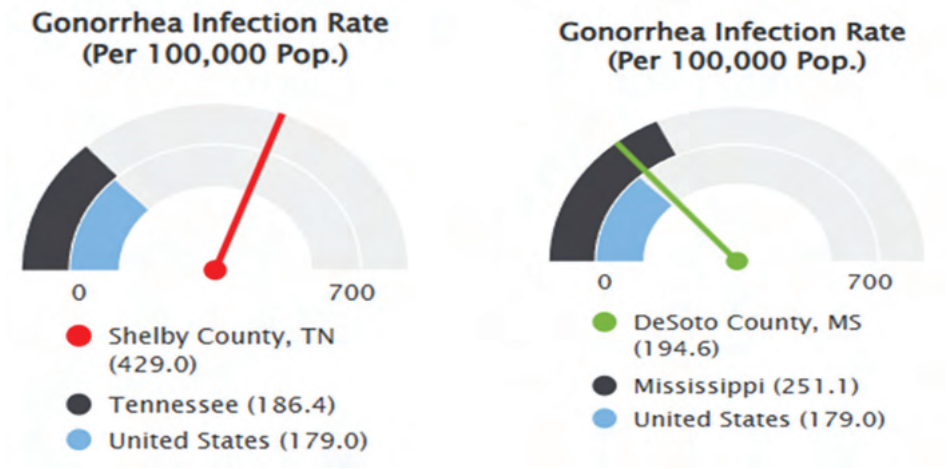
Race/Ethnicity	Shelby County All	Shelby County Male	Shelby County Female	Tennessee All
All	32.3	52.8	11.6	11.0
Caucasian	7.8	14.2	-	5.9
African American	50.9	84.1	18.8	38.1
Hispanic	17.5	-	-	19.1

Note: Data are from source [41]. Rates are per 100,000 people.

GONORRHEA

The rate of gonorrhea in Shelby County is 2.3 times that of Tennessee and 2.4 times that of the United States. In DeSoto County, the rate of gonorrhea is less than Mississippi but slightly higher than that of the United States.[1]

Figure 49. Gonorrhea Infection Rates within Shelby and DeSoto Counties, 2023[1]



One of the largest racial disparities in Shelby County health is the rate of gonorrhea among African Americans compared to Caucasians. African Americans have gonorrhea at a rate 13.4 times greater than Caucasians and 9.3 times greater than the rate for Hispanics.[41]

Table 85. Gonorrhea Rates by Race and Gender within Shelby County, 2021-2023

Race/Ethnicity	Shelby County All	Shelby County Male	Shelby County Female	Tennessee All
All	534.2	476.4	597.8	186.4
Caucasian	68.0	71.4	63.7	73.0
African American	913.8	787.1	1062.5	624.6
Hispanic	98.0	100.1	97.6	105.6

Note: Data are from source [41]. Rates are per 100,000 people.

SYPHILIS

In Shelby County, males acquire new cases of syphilis at a rate 2.5 times greater than females. African Americans in Shelby County acquire syphilis 6.7 times more frequently than Caucasians. The rate of new syphilis cases in Shelby County is 2.3 times the rate of Tennessee.[41]

Table 86. Rate of New Syphilis Cases by Race and Gender within Shelby County, 2021-2023

Race/Ethnicity	Shelby County	Shelby County Male	Shelby County Female	Tennessee All
All	31	47.2	18.9	14.3
Caucasian	7.8	12.4	3.5	8.5
African American	52.6	77.7	31.5	45.2
Hispanic	-	-	-	11.4

Note: Data are from source [41,43]. Rates are per 100,000 people.

TEEN BIRTHS

In Shelby County, the average annual teen birth rate for the years 2017 to 2023 was 30 per every 1,000 females aged 15 to 19. Shelby County's teen birth rate was 1.3 times greater than Tennessee and 1.9 times greater than the rate for the United States. The Shelby County teen birth rate for African Americans was 4.9 times greater than for Caucasians. The teen birth rate for Hispanics in Shelby County was 6.9 times greater than Caucasians.[1]

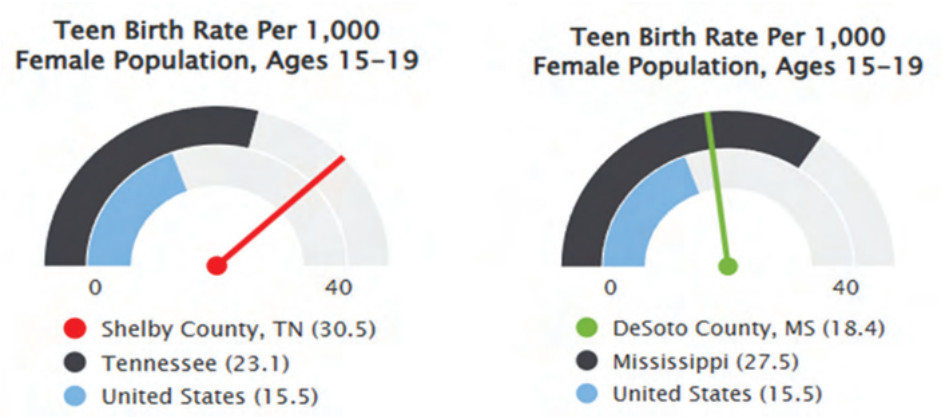
In DeSoto County, the average annual teen birth rate for the years 2017 to 2023 was 18 per every 1,000 females aged 15 to 19. This birth rate was lower than the teen birth rate across Mississippi but higher than the national rate of teen births. In DeSoto County, African Americans and Hispanics have a teen birth rate 1.6 and 1.2 times greater than Caucasians, respectively.[1]

Table 87. Teen Birth Rates by Race and location, 2017 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	30.0	23.0	18.0	28.0	16.0
Caucasian	8.0	15.9	15.0	20.9	9.0
African American	39.0	27.4	24.0	31.9	20.2
Hispanic	55.0	46.9	18.0	39.8	21.3

Note: Data are from sources [3-4]. Rates are per 1,000 females age 15-19.

Figure 50. Teen Births within Shelby and DeSoto Counties, per 1,000 Teens, 2017-2023[1]



TEEN AND YOUNG ADULT SEXUALLY TRANSMITTED DISEASES (STDs)

In Shelby County in 2021, the rate for teens with STDs was 39.4 for every 1,000 teens. The Shelby County rate was 2.4 times greater than the rate of teens across Tennessee with an STD, which was 16.6.[6] The rate of Shelby County teens with STDs has consistently been 2 times greater than the rate for Tennessee since 2017. Data was not available for DeSoto County, Mississippi.

Table 88. Teens (ages 15 to 17) with STDs in Shelby County by Year

Race	2017	2018	2019	2020	2021
Shelby	39.0	47.3	51.1	42.2	39.4
Tennessee	17.3	19.0	20.5	18.6	16.6

Note: Data are from sources [6]. Rate per 1,000 teens.

In Shelby County from 2020 to 2021, there were 2,540 cases of chlamydia for teens ages 15 to 19, 3,518 cases for young adults age 20 to 24, and an additional 2,699 cases for adults aged 25 to 34.[41] Young adults aged 20 to 24 have the highest chlamydia incidence rate in Shelby County.

Table 89. Chlamydia Numbers and Rates for Teens in Shelby County, Tennessee, 2020-2021

Age	Number of Cases in Shelby County	Rate in Shelby County
Under 15	101	51.7
15 to 19	2,540	4285.1
20 to 24	3,518	5704.7
25 to 34	2,699	1910.7

Note: Data are from source [41]. Rates are per 100,000 people.

In Shelby County in 2019, there were over 1,149 cases of gonorrhea for teens ages 15 to 19, 1,550 for young adults aged 20-24, and another 1,636 cases for adults aged 25 to 34. The rate of gonorrhea for teens ages 15 to 19 was 2.6 times higher than for the same age across Tennessee. The rate for young adults ages 20 to 24 was 2.1 times higher than for the same ages in Tennessee. The rate for 25 to 34 year olds was 1.7 times that for Tennesseeans of that age. [41]

Table 90. Gonorrhea Numbers and Rates for Teens in Shelby County, Tennessee, 2020-2021

Age	Number of Cases in Shelby County	Rate in Shelby County	Rate in Tennessee	Rate in United States
Under 15	39	20.0	-	-
15 to 19	1,149	1,938.4	744.3	443.5
20 to 24	1,550	2,513.5	1,205.2	750.2
25 to 34	1,636	1,158.2	666.1	577.3

Note: Data are from source [41,42]. Rates are per 100,000 people.

The average rate in Tennessee and the United States has been adjusted between 25-34.

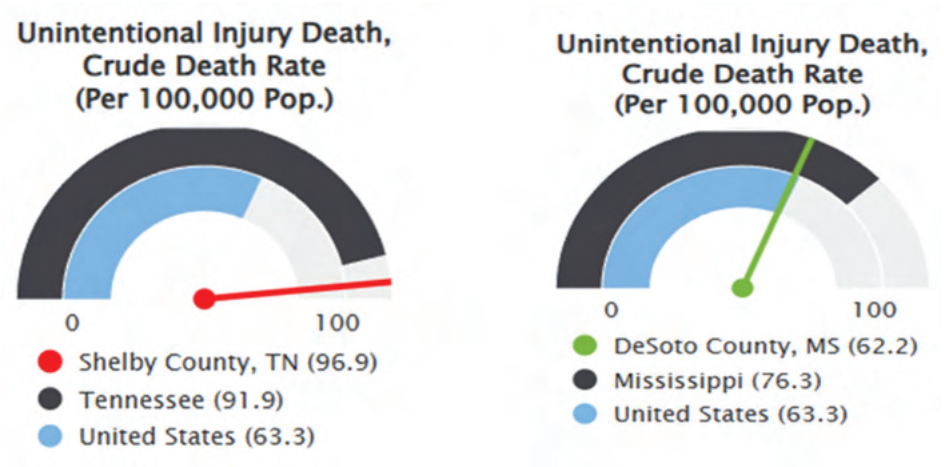
UNINTENTIONAL INJURIES

In 2023, unintentional injuries (e.g., falls, motor vehicle accidents, and accidental poisonings) were the 3rd leading cause of death in the United States, with 222,698 people dying. The death rate for unintentional injuries across the United States is 66.5 per 100,000 people. Unintentional injuries accounted for 24.8 million visits to a primary care office and 26.2 million visits to an emergency department in 2022.[44]

Unintentional injuries were also the 4th leading cause of death for Shelby County and the 5th leading cause of death for DeSoto County in 2021. In Shelby County, 1,002 people died of unintentional injuries, for a rate of 108.4.[11] In DeSoto County in 2021, 146 people died from unintentional injuries for a rate of 77.4.[12]

The accident mortality rate in Shelby County for 2019-2023 was higher than the rate for both Tennessee and the United States. The rate in DeSoto County was lower than the State rate, but above the U.S. rate.

Figure 51. Unintentional Injury Mortality within Shelby and DeSoto Counties, 2019-2023[1]



Men die from unintentional injuries at a rate more than twice that of females in both Shelby and DeSoto Counties, at 2.5 and 2.2 respectively.

Table 91. Unintentional Injuries Mortality Rates by Gender and Location, 2019 – 2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	141.2	123.5	86.5	103.8	84.9
Females	56.9	61.6	39.7	50.4	42.1

Note: Data are from sources [1]. Rates are per 100,000 people.

MOTOR VEHICLE

Across the United States, the rate for motor vehicle deaths was 12.9 per 100,000 people and accounted for 43,273 deaths in 2023.[44] The average annual rate of death from 2019 to 2023 in both Shelby and DeSoto Counties from motor vehicle deaths was 26.2 and 17.0 per 100,000, respectively. In Shelby County, African Americans (34.2 per 100,000) die from motor vehicle accidents at a higher rate than Caucasians (15.5 per 100,000).

Table 92. Motor Vehicle Mortality Rates by Race and Location, 2019 – 2023

Race/Ethnicity	Shelby County	Tennessee	DeSoto County	Mississippi	United States
All	26.2	18.3	17.0	26.5	12.8
Caucasian	15.5	17.3	15.8	25.0	12.8
African American	34.2	26.4	20.2	30.1	17.9
Hispanic	26.3	17.2	-	24.3	11.9

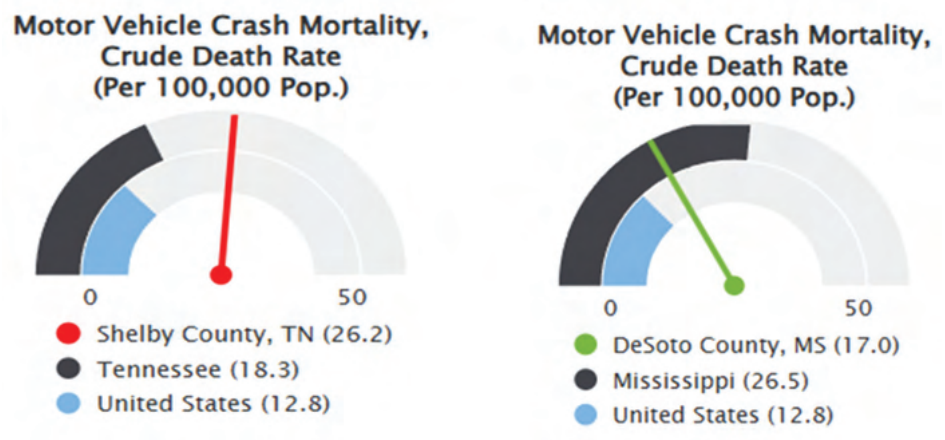
Note: Data are from sources [1]. Rates are per 100,000 people.

Table 93. Motor Vehicle Mortality Rates by Gender and Location, 2019 – 2023

Gender	Shelby County	Tennessee	DeSoto County	Mississippi	United States
Males	-	26.7	24.8	38.6	18.5
Females	-	10.2	9.8	15.2	7.1

Note: Data are from sources [1]. Rates are per 100,000 people.

Figure 52. Motor Vehicle Crash Mortality Rate within Shelby and DeSoto Counties, 2019-2023.[1]



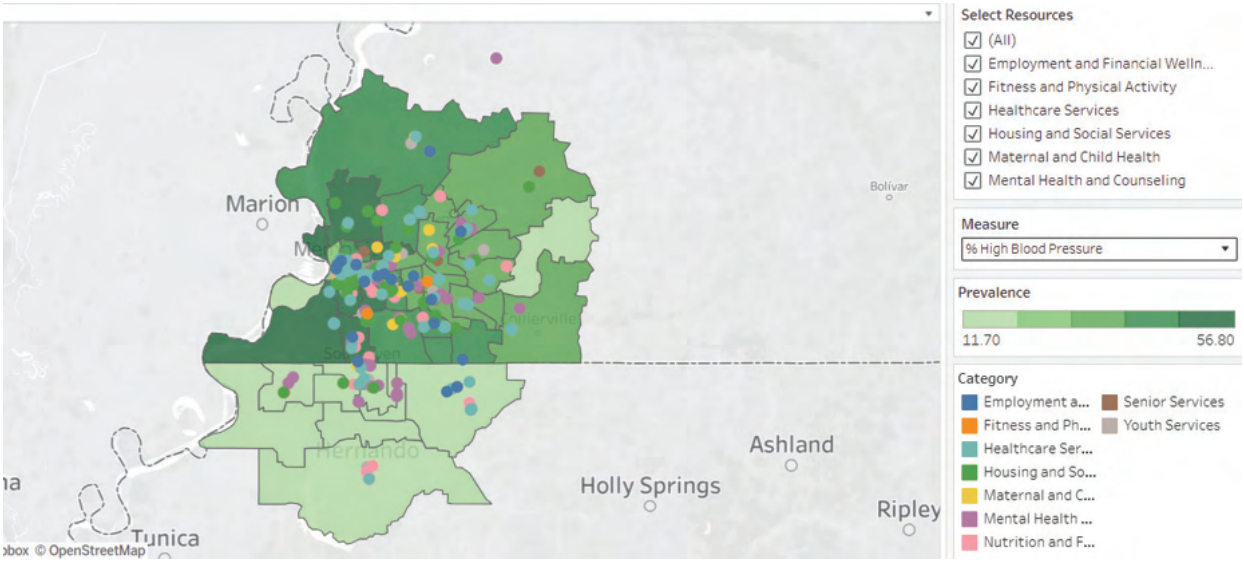
COMMUNITY ASSETS

Community resources play a vital role in supporting the health and well-being of residents by connecting individuals to essential services such as healthcare, nutrition assistance, mental health support, and preventive programs. However, many residents often struggle to find and navigate these resources. Barriers such as lack of awareness, transportation challenges, and complex service systems can prevent individuals from accessing available support. Improving the visibility and coordination of these resources can help to close the gaps in care and promote equitable health outcomes.

INTERACTIVE ASSET MAP

An interactive map was developed to illustrate the geographic distribution of key health concerns identified in Shelby and DeSoto Counties, overlaid with the locations of community resources that address these issues. The interactive map is available at: https://public.tableau.com/shared/Q34BXSNSS?:display_count=n&:origin=viz_share_link

Figure 53. Community Asset Map for Shelby and DeSoto Counties



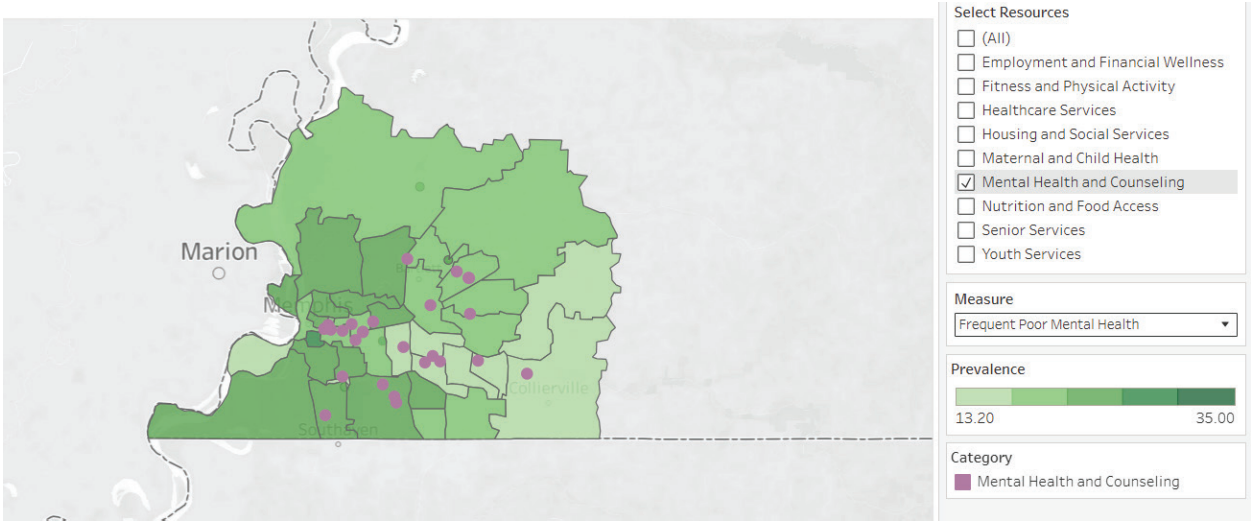
The base layer heat map highlights areas by ZIP code where specific health concerns or socioeconomic factors related to health are most concentrated. Warmer colors indicate higher levels of reported need of concern. To complement this, health-related community resources, including healthcare services, food assistance programs, and mental health services, are plotted on top of the heat map. This combined visualization aims to provide a clear picture of where community needs are greatest and where resources are currently available, helping to identify potential service gaps and opportunities for targeted intervention and partnership.

GAPS IN RESOURCES

An example of using this map to identify gaps in community resources can be seen when comparing prevalence of frequent poor mental health across Shelby County to the availability of mental health resources. From the map, it appears that higher concentrations of poor mental health are found in the central and southern zip codes of Shelby County.

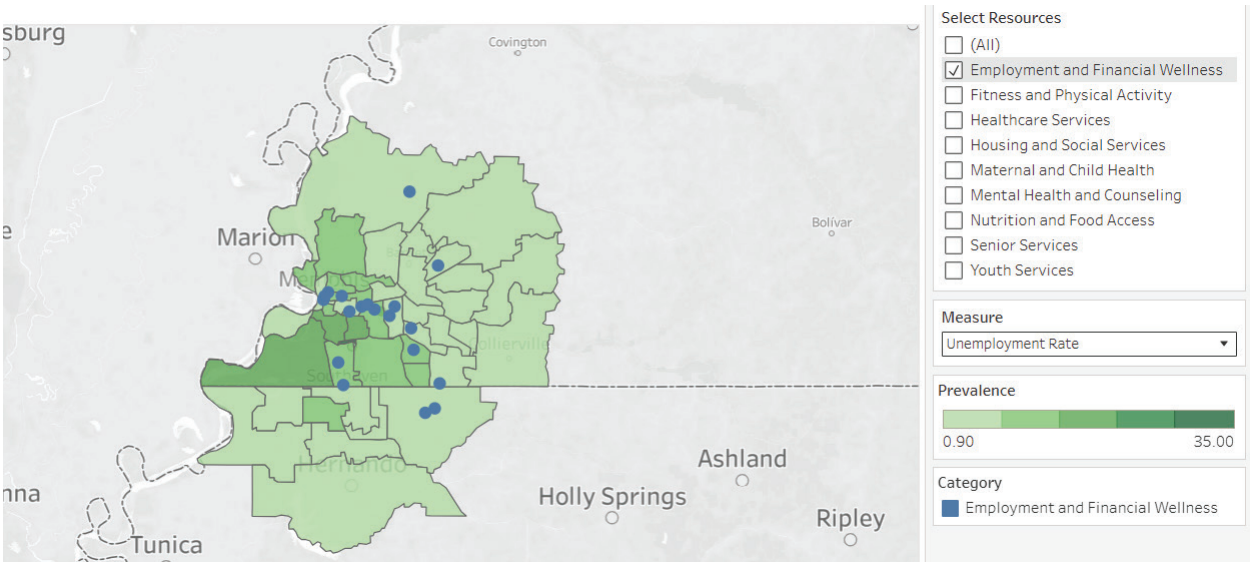
While there are several mental health services locations in and around the central urban areas, fewer services are visible in the outer zip codes, despite some of those areas also having elevated rates of poor mental health. This pattern suggests uneven access to mental health resources and potential gaps between need and service availability.

Figure 54. Concentration of Frequent Poor Mental Health by ZIP Code in Shelby County



Similarly, the map can also be used to examine the concentration of socioeconomic factors which relate to health and wellbeing. The figure below displays the unemployment rate by ZIP Code throughout Shelby and DeSoto Counties. When overlaying available resources relating to employment or financial wellness, it appears that areas with higher concentrations of employment may lack direct access to beneficial resources.

Figure 55. Unemployment Rate for Shelby and DeSoto Counties by ZIP Code



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2025 Community Health Needs Assessment

STAKEHOLDER INTERVIEWS

Methodist Le Bonheur Healthcare

2025

Community Health Needs Assessment

Stakeholder Interviews

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ABSTRACT

Over a five-month period, from May – August 2025, Methodist Le Bonheur Community Outreach (MLCO) held 60 interviews with 68 community stakeholders representing 56 organizations. These interviews were conducted with internal stakeholders such as Methodist associates and executives, and external stakeholders, including community partners, service providers, community advocates, government officials and healthcare providers. Across all the interviews, many similar themes emerged. First, was the issue of access to care; second, was the need for improved mental health services; third was the burden of chronic and preventable diseases; fourth, the impact of social and economic factors on health and wellbeing; and fifth a need for expanded maternal, infant, and childcare. These themes revealed the community's concerns and understandings of the impact "non-medical" factors can have on the community's health. Overall, community stakeholders felt that helping with healthcare accessibility and addressing other social barriers was an opportunity for healthcare organizations to improve health outcomes.

STAKEHOLDER INTERVIEWS SUMMARY

As part of the 2025 Community Health Needs Assessment (CHNA), Methodist Le Bonheur Community Outreach (MLCO) held multiple stakeholder interviews over a four-month period. The purpose of these interviews was to discuss community health issues and concerns in a robust and open-ended fashion. One-on-one interviews also allow for more organic discussion, and for the facilitators to delve further into select responses.

Interview participants were recruited from MLCO programs, existing community partner connections, personal connections of the Program Evaluation team, recommendations from Methodist Le Bonheur Healthcare (MLH) leadership, and suggestions from stakeholders from this interview cycle. MLCO held a total of 60 stakeholder interviews with 68 participants between May and August of 2025, which were conducted face-to-face, virtually, or over the phone. These community stakeholders played varying roles across 56 (internal & external) organizations, including representatives from community-based organizations, social service providers, government officials, business owners, community advocates, healthcare providers, and MLH executives and associates. In total, 33 community organizations and 14 government organizations (including state universities) were represented among the interviewees, along with staff from nine Methodist programs including executives from four of the six MLH hospitals.

Although the focus area of stakeholders varied, five homogenous themes emerged throughout these interviews. The first theme was the need for improved access to affordable, timely, and appropriate healthcare services, and the barriers that prevent community members from accessing them. Interviewees expressed concerns about the financial burden that comes with healthcare, even for those with insurance; difficulty finding reliable transportation to and from care; a general lack of providers in the Memphis area; and the difficulty navigating the complicated healthcare system. The second theme was mental and behavioral health, particularly among adolescents. The third theme focused on the burden of long-term chronic conditions such as diabetes, obesity, and heart disease, and efforts to prevent them. The fourth theme revolved around the social and economic drivers of health. Poverty plays a significant role in health and often directly correlates with health outcomes. Community stakeholders also listed economic issues as a barrier to care in their community, including inability to afford care and its contribution to other social determinants of health, such as adequate housing or transportation. The fifth was maternal, infant, and child health.

These themes, among others that appeared in the stakeholder interviews, revealed the community's awareness of the impact many non-health factors (e.g. economic condition, transportation availability) can have on someone's health. This aligns with the increasing understanding of the importance of the social determinants of health. Furthermore, stakeholders felt strongly that healthcare organizations could do more than just provide care, and that offering assistance in navigation and finding proper social service programs would improve patient satisfaction and health outcomes.

BACKGROUND

To ensure comprehensive and representative data collection for the 2025 CHNA, the Program Evaluation team conducted one-on-one interviews with identified stakeholders across Shelby County and the surrounding areas. While both focus groups and one-on-one interviews allow for reaching a more robust group of participants about their perceptions of community needs, in-depth qualitative interviews allow for the same information to be gathered without the effect of group dynamics.1 Since both internal and external stakeholders were considered to be the top of their fields, it was imperative they were given adequate time and opportunity to answer the interview questions based on their own experiences with the populations they serve. Individual interviews also strengthen the buy-in of the assessment process to both internal and external partners and help lay the groundwork for the dissemination process of the completed report.

METHODOLOGY

Interviews were led by Program Evaluators from the MLCO Program Evaluation team, all of whom had received prior training on note taking and facilitating discussions. Questions for the interview scripts were adapted from the 2023 CHNA Stakeholder Interview script, originally created by the MLCO Program Evaluation team using selected questions from other regional hospital scripts. The final interview script centered on community health and the greatest health and quality of life issues faced by community members. This script can be found in Appendix B. Questions were amended or removed during some interviews for time and engagement purposes when needed.

PROCEDURES

Between May and September 2025, a total of 60 stakeholder interviews were conducted by MLCO Program Evaluation staff as part of the triennial CHNA. Some stakeholder interviews included multiple participants. Interview participants represented 51 community organizations, including 15 Methodist Le Bonheur associates, capturing a wide range of voices from across Memphis and Shelby County.

Each interview was conducted by a trained member of the MLCO Program Evaluation team, typically supported by a note-taker. Interviews were held in person, virtually, or by phone, depending on participant preference and accessibility. In-person sessions were conducted at locations convenient for participants, such as their workplace, community sites, or MLCO offices. Prior to each session, verbal consent was obtained from all participants. Interviews were audio-recorded with permission and transcribed using Otter.ai for accuracy.

Transcripts were coded and summarized into an analysis matrix developed by the evaluation team. To enhance consistency and reliability, each transcript and summary was reviewed by a secondary evaluator. The analysis process incorporated the use of ChatGPT as a qualitative coding assistant, which helped identify emerging patterns, refine thematic groupings, and ensure comprehensive coverage of participant responses. Final codes and themes were reviewed and validated by the evaluation team to ensure alignment with CHNA

standards and accuracy of interpretation. All findings were aggregated and anonymized for inclusion in this report.

Stakeholders were recruited through existing community partnerships, recommendations from Methodist leadership, and referrals from other interviewees, ensuring a broad and diverse representation across sectors. Internal participants included hospital presidents, program directors, and other key associates from all six Methodist Le Bonheur hospitals. External stakeholders represented a variety of organizations spanning mental and behavioral health, early childhood education, food access, transportation, housing, violence prevention, veterans' services, and LGBTQ+ health advocacy. Special emphasis was placed on organizations serving vulnerable or underrepresented populations, including low-income families, individuals experiencing homelessness, those living with HIV, and aging community members.

Interview questions explored participants' organizational roles, populations served, and partnership networks, as well as their perspectives on community strengths, barriers to care, and pressing health priorities. Participants were also invited to share their views on social drivers of health, emerging challenges since 2022, and the perceived role of MLH in addressing community health needs.

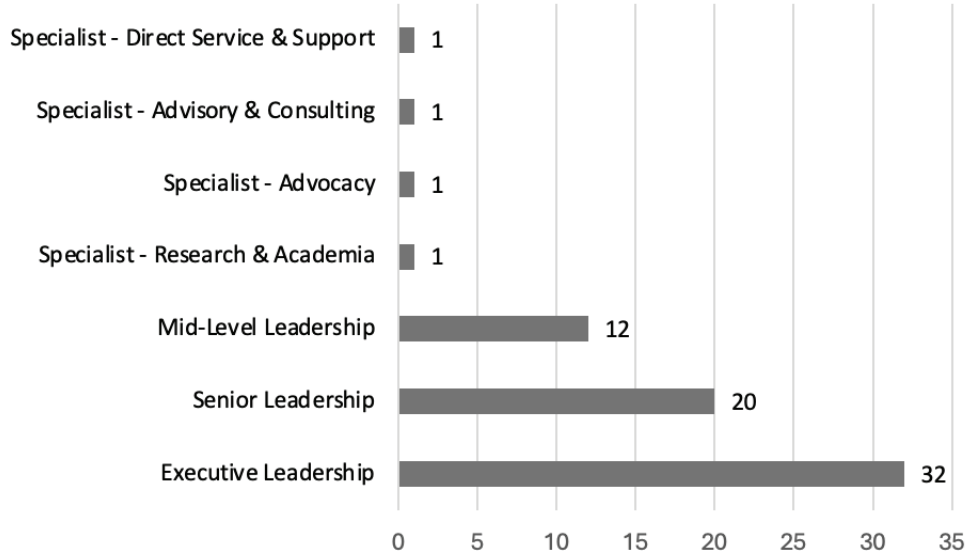
Following transcription and quality review, the evaluation team conducted iterative thematic coding to identify common and unique themes across interviews. Thematic analysis was guided by the CHNA framework and informed by prior assessment cycles. Findings were then compared against other CHNA data sources—including community surveys and secondary health data—to identify consistent trends, data gaps, and opportunities for further exploration.

While the following section focuses specifically on findings from stakeholder interviews, the themes identified strongly align with other CHNA data sources, underscoring the interconnected nature of the region's health challenges and opportunities.

PARTICIPANTS

Stakeholder interviews (n=60) sometimes included multiple interviewees or occurred with different representatives from the same organization, resulting in a total of 68 participants representing 56 organizations. Most stakeholders held executive or senior leadership roles (76%) with the remainder in mid-level operations (18%) or specialist roles (6%). Interviewees represented organizations that varied in focus area, with the largest related to health & human services (27%). Appendix C: Stakeholder Representation offers a comprehensive list of participating organizations.

Figure 1. Stakeholder Interview Participants by Role



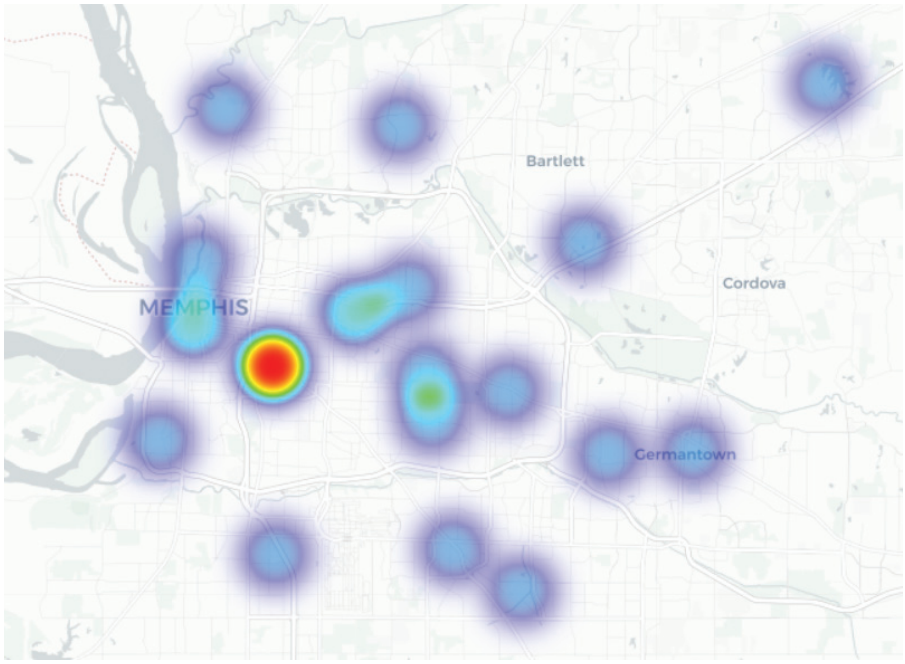
This figure shows the distribution of the roles held by the 68 stakeholder interview participants. Note that some interviews included multiple participants.

Table 1. Stakeholder Interviews by Field of Focus

Focus Category	Field of Focus	Number of Interviews	% of Total (n=60)
Health & Human Services	Healthcare, Mental Health, Reproductive Health, Disability Services, Senior Services, Veteran Services	16	27%
Education & Youth	Education, Youth	9	15%
Government & Public Safety	Government, Public Safety	9	15%
Economic & Community Development	Local Business, Community Development, Housing & Homelessness, Transportation	9	15%
Social Support & Inclusion	LGBTQ+, Social Support, Poverty	8	13%
Healthcare Leadership	MLH Leadership	6	10%
Food & Nutrition	Food & Nutrition	3	5%

This table shows the distribution of the 60 interviews across various community sectors, with Health & Human Services representing the largest groups.

Figure 2. **Organizational Density Heat Map**



This heat map illustrates the geographic distribution of organizations across Memphis by Zip code. Darker areas indicate higher concentrations. Note that not all organizations are represented in this map (n=52), and that this represents the headquarters of an organization and not necessarily its service area.

KEY FINDINGS

Figure 3: **Prevalence of Top 5 Interview Themes**

This figure illustrates the high consensus on the most pressing issues, with Access to Care being the most frequently cited concern.

Table 2: Detailed Breakdown of Top Interview Themes and Sub-Themes

Theme	Subtheme	Brief Description
Access to Care	Transportation Challenges	Inadequate or unreliable transportation, including MATA and medical transport barriers.
	Nonprofit & Faith-Based Organizations	Churches, ministries, and nonprofits providing support and health navigation when formal systems fall short.
	Financial Barriers	Out-of-pocket costs, underinsurance, TennCare eligibility, and affordability challenges.
	Resource Awareness & Navigation	Difficulty finding, understanding, or navigating available services and referrals.
	Provider Shortages	Long waits and limited availability of primary, specialty, and behavioral health providers.
	Cultural Barriers & Trust	Mistrust, language barriers, and lack of culturally responsive care environments.
Mental & Behavioral Health	Adolescent Behavioral Health	Escalating behavioral and emotional health challenges among youth.
	Substance Use	Opioid, alcohol, and marijuana use; need for prevention and treatment programs.
	Trauma & ACEs	Childhood and intergenerational trauma, toxic stress, and ACE exposure.
	Community Violence & Safety	Exposure to shootings, neighborhood violence, and domestic abuse causing trauma.
	Crisis Response & Stabilization	Limited crisis resources and coordination in behavioral health emergencies.
	Stigma	Promoting emotional well-being, normalizing therapy, and community resilience.
Chronic & Preventable Disease Burden	Prevention Gaps	Missed screenings, lack of education, and poor engagement in preventive care.
	Diabetes & Obesity	Common chronic conditions tied to access, cost, and nutrition barriers.
	Cardiovascular & Hypertension	Adult chronic diseases related to stress, diet, and limited primary care access.
Social & Economic Determinants of Health	Poverty & Economic Hardship	Low wages, unemployment, and financial instability shaping health access.
	Housing Instability & Homelessness	Evictions, unaffordable rent, and lack of supportive or transitional housing.
	Food Insecurity	Limited access to affordable, nutritious food and reliance on food assistance.
	Social Inequities	Structural inequities and disinvestment driving disparities in access and outcomes.
Maternal, Infant, & Child Health	Pediatric Illness	Asthma, developmental delays, and pediatric access challenges.
	Family Support	Childcare, parenting education, and family stability programs.
	School-Based Health	On-site school clinics, nurses, and mental health counselors.
	Perinatal & Postpartum Support	Doulas, lactation, postpartum mental health, and home visiting.

This table distills the core sub-themes and specific concerns raised by stakeholders for the top five themes.

THEME 1: ACCESS TO CARE

Access to care was the most frequently cited theme, raised in 70% of stakeholder interviews (42 of 60), and increasing in prevalence since 2023, when it was third most mentioned theme. The topic of access to healthcare encompasses multiple larger issues, including health literacy, availability and quality of care, and the barriers that prevent individuals from accessing it. While barriers varied across populations, several consistent sub-themes emerged: insurance and financial barriers, lack of awareness about resources, transportation challenges, provider shortages, cultural barriers, and navigation difficulties. The populations most affected by these barriers tended to be low-income families, TennCare recipients, rural residents, minorities, and seniors.

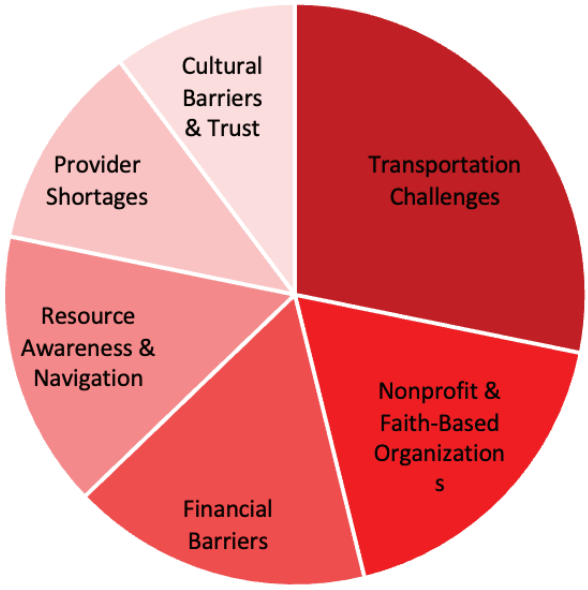
Stakeholders repeatedly cited financial aspects of healthcare (22%), such as medical debt, lack of insurance, and TennCare coverage gaps as the primary obstacles to care. Lower income families may prioritize basic needs (food, rent) over long-term health and preventive care, ultimately leading to deferred care and worsened health outcomes.

In instances where individuals do seek care, interviewees explained how a lack of transportation (37%) serves as a significant barrier. Limited public transit, unreliable schedules, and long travel distances (especially rural areas) were highlighted as major access gaps. One stakeholder stated how "transportation inequities and access to care go hand-in-hand — if you can't get there, it doesn't matter if the service exists." In addition to transportation difficulties, stakeholders also cited a shortage of healthcare providers (15%) as a significant limitation to care access. Stakeholders emphasized shortages in primary care, pediatrics, and specialty care providers. Hospital leaders shared challenges with workforce recruitment and retention, especially with patients' desire to access medical providers of the same race or ethnicity. Provider shortages mean long wait times, limited continuity of care, and difficulty managing chronic or complex cases. Stakeholders found a growing concern for how this will impact those with behavioral health issues (20%) with a shortage of crisis treatment facilities and psychiatric providers.

Interviewees shared the belief that non-profit and faith-based organizations in Memphis offer a considerable number of community resources (23%) that reduce stigma, provide food, shelter, and wraparound care. Faith-based clinics and volunteer providers help bridge some gaps, but resources are but are often siloed, directories outdated, and navigation support is insufficient. Even when services exist, many residents and providers don't know about them or how to access them. A lack of centralized information about available services prevents providers from encouraging individuals to utilize them, and poor health literacy among community members may prevent individuals from asking the questions that would route them to the resources. Poor awareness and navigation of existing resources (20%) further exacerbate the gap between health services and the community members that most rely on them. One stakeholder explained, "family planning and contraceptive access change the trajectory for young women and their families — but too many still don't know these resources exist."

Finally, stakeholders expressed that language and cultural barriers (13%) may prevent some from accessing care. One stakeholder expressed a wish that "people knew the resources that they have access to, trusted the resources, and actually tapped into them." Immigrant and refugee communities face challenges with limited bilingual providers and translation services and some communities may not engage with healthcare due to a lack of trust. Cultural stigma about healthcare can delay seeking services or reduce follow-up.

Figure 4. **Distribution of Access to Care Subthemes**



This pie chart shows the distribution of sub themes in interviews where access to care was discussed.

THEME 2: MENTAL & BEHAVIORAL HEALTH

Mental and behavioral health surfaced as a crisis-level concern in the 2025 Community Health Needs Assessment. When combined with overlapping topics, such as youth mental health, substance use, trauma, and violence, appeared in over half of all stakeholder discussions (63%). Nearly every participant, regardless of sector, described behavioral health as the thread running through the community's broader challenges: poverty, housing insecurity, maternal health, and chronic disease.

Stakeholders spoke of an escalating need for mental health services and a system struggling to keep pace. Across hospitals, schools, and community agencies, they described families facing long waits, few affordable options, and persistent gaps in crisis response. The consensus was clear; mental and behavioral health are not isolated issues but forces that ripple through every part of life in Memphis and Shelby County.

Concerns around adolescent behavioral health dominated these conversations, appearing in roughly 42% of all interviews. Teachers, healthcare providers, and parents described an alarming increase in youth anxiety, depression, ADHD, and self-harm. They noted that schools have become de facto mental health hubs yet often lack the staff or funding to meet demand. One community instructor captured the emotional toll starkly: "Gun violence is still the leading cause of death for children and teens in the United States… my phone only rings when grace has run out." Others emphasized how overlapping struggles, chronic illness, homelessness, and food insecurity add layers of stress that students carry into the classroom. Additionally, perinatal and maternal mental health concerns, while less common (5% of interviews), revealed another layer of vulnerability. Stakeholders spoke about postpartum depression and the absence of long-term support for mothers facing economic hardship, domestic violence, or housing instability.

At the system level, stakeholders highlighted emergency psychiatric care gaps, mentioned in about 25% of interviews. Hospitals, police, and nonprofit partners all described the same pattern: too few psychiatric beds, too few crisis clinicians, and too many people slipping through the cracks. Without timely options, families often turn to law enforcement or emergency rooms; spaces ill-equipped for sustained behavioral health care.

Discussions of trauma and Adverse Childhood Experiences (ACEs) appeared in 35% of interviews, cutting across youth services, public safety, and healthcare. Many described trauma as the invisible foundation of nearly every behavioral health challenge. Providers called for trauma-informed systems that recognize not just individual pain but generational cycles. As one violence intervention worker shared, "When victims come in beat up or shot up, it is critical that we get to them and their family, so they do not continue that cycle of violence. Too often the mantra we hear is 'revenge, revenge, revenge.'"

Community violence and the juvenile justice overlap emerged as another major theme, also cited in 30% of interviews. Stakeholders described a direct link between exposure to violence, unaddressed trauma, and youth involvement with the justice system. Community leaders noted, "I focus on violence and find a way to end violence at all levels… from child abuse to parents and children, to children against children." Together, these voices painted a picture of neighborhoods where violence and fear have become self-perpetuating, and where behavioral health support is as much about safety as it is about healing.

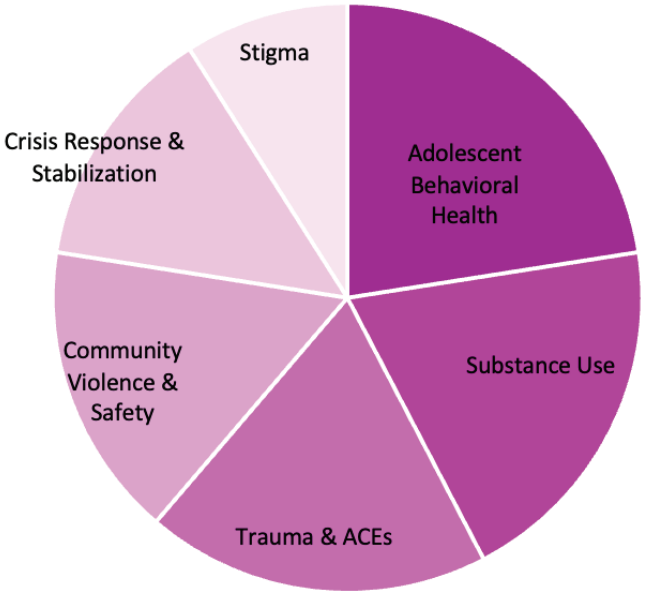
Substance use and addiction were intertwined with these themes, appearing in about 37% of interviews. Stakeholders described an evolving crisis marked by the continued spread of fentanyl and opioids, as well as a resurgence of cocaine and methamphetamine use. Recovery housing remains scarce, and while Narcan distribution and training save lives, most participants emphasized that prevention and treatment capacity have not kept pace.

Although stigma no longer dominated the conversation as it did in previous CHNA cycles, it continues to shape access and attitudes. Roughly 17% of stakeholders described stigma as a lingering barrier, particularly within faith communities, immigrant populations, and communities of color. "When the pastor and the people at church are saying violence is not the answer, but everybody in the neighborhood, family members, neighbors, friends, are saying violence is the answer — it's the loudest voice, and it's the voice they hear most often," said one stakeholder, describing how competing social norms can silence those seeking help. Still, several participants observed that the pandemic and the rise of telehealth have begun to normalize conversations around mental health, especially among younger generations.

Throughout these interviews, another theme recurred: the need for coordination and prevention. Stakeholders urged hospitals, schools, nonprofits, and public agencies to work together rather than in isolation, emphasizing that effective behavioral health care must reach people before a crisis. Many pointed to Methodist Le Bonheur Healthcare's role as a convener—an institution capable of expanding access, advocating for integrated care, and elevating behavioral health as a shared community priority.

As one stakeholder summarized, "We can't separate mental health from any other part of health — it's the foundation for everything else we're trying to fix."

Figure 5. Distribution of Mental & Behavioral Health Subthemes



This pie chart shows the distribution of sub themes in interviews where mental and behavioral health was discussed.

THEME 3: CHRONIC & PREVENTABLE DISEASE BURDEN

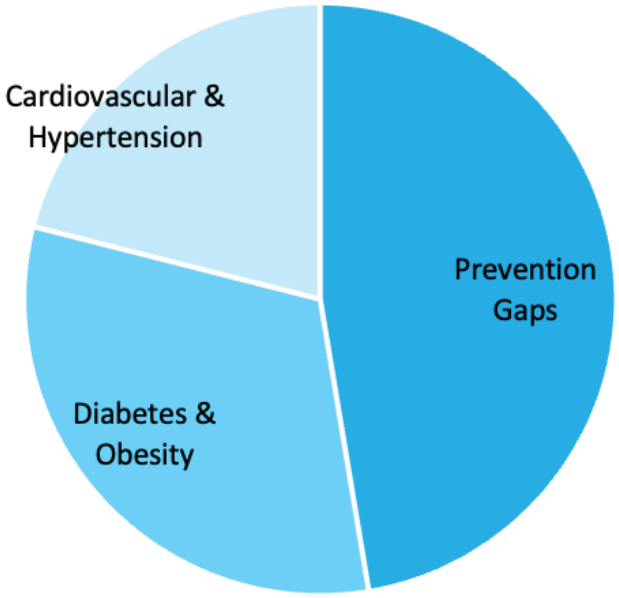
Chronic disease remains a major health burden in Memphis and Shelby County, particularly among low-income and minority residents. In this 2025 CHNA, chronic disease ranked as the fourth most frequently identified health concern, whereas in the 2022 assessment, it was the third highest. While the issue appears less prominently in this cycle's interviews, stakeholders emphasized that chronic conditions continue to drive inequities and remain deeply intertwined with social drivers of health.

Including references to related topics such as nutrition, preventive care, and health literacy, 55% of stakeholders (33 of 60) identified chronic disease as a primary theme. Interviewees consistently linked high rates of diabetes, obesity, asthma, and hypertension to food insecurity, delayed preventive screenings, and barriers to affordable, continuous care.

Diabetes and obesity were cited most often, appearing in 20% of interviews. Participants described food deserts and poor nutrition access as key contributors, noting that long-term solutions must include community-driven food systems. Asthma and other pediatric conditions were also raised as major barriers to student health and attendance, particularly for TennCare-insured children. "Asthma, obesity, malnutrition, those can coexist," explained one clinical pediatric stakeholder, adding that few providers are willing to take on complex care cases. In 30% of interviews, participants also pointed to low preventive screening rates and limited health literacy as drivers of late diagnosis and poor outcomes, especially among uninsured and rural populations.

Across interviews, there was consensus that chronic disease cannot be separated from its social context. Stakeholders called for stronger investment in prevention, nutrition, and education, emphasizing that sustainable progress depends on addressing the underlying conditions that shape health behaviors and access across Memphis and Shelby County.

Figure 6. **Distribution of Chronic & Preventable Disease Burden Subthemes**



This pie chart shows the distribution of sub themes in interviews where chronic and preventable disease burden was discussed.

THEME 4: SOCIAL & ECONOMIC DETERMINANTS OF HEALTH

More than half (31 of 60) raised social and economic determinants as key health drivers. They emphasized that health outcomes are shaped not only by medical care but by social and economic conditions, and that health cannot be improved without addressing root causes such as inequities, poverty, and lack of access to food and housing.

During their interviews, stakeholders spoke on the effects that poverty has on community health (28%). One stakeholder explained how "poverty is a big barrier… when you have to prioritize basic needs over your long-term health." Individuals may forgo care to pay for food, rent, or utilities, but interviewees dove further into the ways in which poverty acts as a driver for other negative aspects of health and wellbeing, some even describing it as the underlying driver of health disparities. Factors such as availability of transportation, diet and exercise, mental health, adverse childhood experiences and having health insurance all affect patients that live in low-income communities.

Stakeholders often explained the complicated relationship poverty has with social inequities. "Poverty is a huge thing… there's classism, racism, all those things impact the health of the community. With so many households living below the poverty line, that impacts how healthy our community is." In 15% of interviews, stakeholders emphasized that current social structures are disadvantageous to minority groups, and felt that inequities in health outcomes, such as racial inequities in maternal health and chronic disease, illustrate how these social structures are drivers of poor health.

Food insecurity (17%) was another top community concern among stakeholders. They discussed how the cost of food and transportation barriers create food deserts, where families are forced to shop for food in smaller and more expensive stores with fewer

options for nutritious food. Food deserts and poor access to affordable, healthy food were cited as direct drivers of obesity, diabetes, and heart disease, and stakeholders felt the lack of healthy food was a pressing concern for their communities. Food banks, farmer's markets, and school nutrition were named as important interventions, and one stakeholder believed that "healthy food access and community ownership of food systems [were] key to addressing disparities."

Housing and homelessness were mentioned by 20% of interviewees, explaining how a lack of stable, safe, and affordable housing acts as a negative contributor to health and is a major problem in Memphis. Stakeholders specifically mentioned the importance of housing for families and youth, individuals in recovery for addiction, and HIV patients.

Figure 7. Distribution of Social & Economic Determinants of Health Subthemes

This pie chart shows the distribution of sub themes in interviews where social and economic determinants of health were discussed.

THEME 5: MATERNAL, INFANT & CHILD HEALTH

Maternal, infant, and child health surfaced as a significant, cross-cutting theme in the 2025 stakeholder interviews. While it was explicitly identified in 30% of all interviews (18 of 60) as a primary concern, youth-related health issues were broadly mentioned in all interviews (100%), reflecting the interconnectedness of maternal well-being, child development, and adolescent health. Stakeholders emphasized the urgent need to address maternal mortality disparities, expand perinatal supports, strengthen school-based health access, and confront the overlapping challenges of pediatric chronic disease and disability that affect families throughout Shelby County.

Stakeholders repeatedly described maternal mortality and racial disparities as unacceptable and preventable. Memphis remains one of the most dangerous cities in the nation for Black mothers to give birth, a reality participants called "deeply unjust." Health leaders and clinic providers pointed to the need for structural change and culturally responsive care that centers the voices of Black mothers. As one stakeholder emphasized, "We have to do a better job of listening to Black mothers... the disparities in maternal health are unacceptable." Several interviewees also noted that policy and legal restrictions on reproductive healthcare continue to widen gaps in access and outcomes.

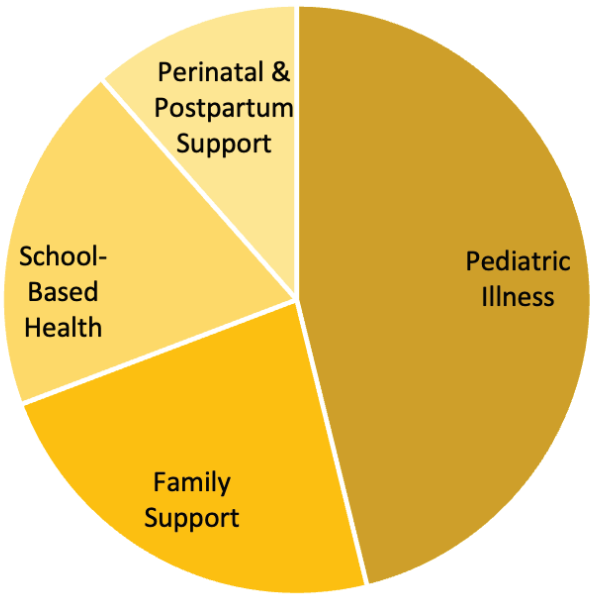
Perinatal and postpartum support were discussed in 5% of interviews, with nonprofits citing gaps in case management, home visiting, and wraparound support for mothers experiencing postpartum depression, domestic violence, or economic stress. These issues were described as deeply intertwined with poverty and isolation.

Families of children with disabilities and special needs also voiced concern about access to education, adaptive programs, and transition planning. Cited in a few interviews, these discussions extended beyond healthcare to issues of independence, inclusion, and long-term support. "Disability advocacy means more than healthcare access, it's independence, peer support, and dignity."

Finally, several stakeholders described schools as the primary point of health access for children, a theme raised in 8% of interviews. School systems increasingly manage immunizations, screenings, mental health referrals, and even Narcan and HIV prevention training. Teachers and school nurses emphasized that health and learning are inseparable, and that schools often serve as the first and only consistent contact families have with the healthcare system.

Collectively, these insights portray a continuum of need that stretches from preconception through adolescence. Stakeholders agreed that improving maternal and child health requires coordinated, culturally responsive systems of care that link to hospitals, schools, and community organizations. Priorities included reducing racial disparities in maternal outcomes, expanding perinatal and family planning supports, and reinforcing schools as essential partners in promoting child health and well-being.

Figure 8. **Distribution of Maternal, Infant, & Child Health Subthemes**



This pie chart shows the distribution of sub themes in interviews where maternal, infant and child health were discussed.

CONCLUSION

Common themes across all 60 stakeholder interviews highlighted the impact of non-health factors on patients' health status, including economic conditions, food insecurity, insurance status, and housing stability. Compared to the 2022 CHNA, the prevalence of access to care emerged as a significantly increased concern, alongside continued focus on mental health and the new emergence of maternal, child, and infant health as a key priority. Stakeholder interviewees praised Memphis community organizations for their programming that serves patients outside the hospital walls but also highlighted barriers to accessing healthcare for many community members. When community stakeholders were asked how they thought MLH could continue to engage with the community going forward, answers primarily included expanding community partnerships and serving as a community service information hub. Stakeholders viewed these as possible areas of growth for Methodist Le Bonheur Healthcare and all local healthcare systems in patient engagement, as well as addressing the social factors that negatively impact health outcomes.

REFERENCES

1. Minichiello, V., Aroni, R., Timewell, E., Alexander, L., 1995. In-depth Interviewing: Principles, Techniques, Analysis. Longman, South Melbourne

2. Bor, J., Cohen, G. H., & Galea, S. (2017). Population health in an era of rising income inequality

APPENDIX A: STAKEHOLDER INTERVIEWS THEMATIC ANALYSIS

Theme	Subtheme	Brief Description	# Interviews	% Interviews
Access to Care 70% of interviews (42 of 60)	Transportation Challenges	Inadequate or unreliable transportation, including MATA and medical transport barriers.	22	37%
	Nonprofit & Faith-Based Organizations	Churches, ministries, and nonprofits providing support and health navigation when formal systems fall short.	14	23%
	Financial Barriers	Out-of-pocket costs, underinsurance, TennCare eligibility, and affordability challenges.	13	22%
	Resource Awareness & Navigation	Difficulty finding, understanding, or navigating available services and referrals.	12	20%
	Provider Shortages	Long waits and limited availability of primary, specialty, and behavioral health providers.	9	15%
	Cultural Barriers & Trust	Mistrust, language barriers, and lack of culturally responsive care environments.	8	13%
Mental & Behavioral Health 63% of interviews (38 of 60)	Adolescent Behavioral Health	Escalating behavioral and emotional health challenges among youth.	25	42%
	Substance Use	Opioid, alcohol, and marijuana use; need for prevention and treatment programs.	22	37%
	Trauma & ACEs	Childhood and intergenerational trauma, toxic stress, and ACE exposure.	21	35%
	Community Violence & Safety	Exposure to shootings, neighborhood violence, and domestic abuse causing trauma.	18	30%
	Crisis Response & Stabilization	Limited crisis resources and coordination in behavioral health emergencies.	15	25%
	Stigma	Promoting emotional well-being, normalizing therapy, and community resilience.	10	17%
Chronic & Preventable Disease Burden 55% of interviews (33 of 60)	Prevention Gaps	Missed screenings, lack of education, and poor engagement in preventive care.	18	30%
	Diabetes & Obesity	Common chronic conditions tied to access, cost, and nutrition barriers.	12	20%
	Cardiovascular & Hypertension	Adult chronic diseases related to stress, diet, and limited primary care access.	8	13%
Social & Economic Determinants of Health 52% of interviews (31 of 60)	Poverty & Economic Hardship	Low wages, unemployment, and financial instability shaping health access.	17	28%
	Housing Instability & Homelessness	Evictions, unaffordable rent, and lack of supportive or transitional housing.	12	20%
	Food Insecurity	Limited access to affordable, nutritious food and reliance on food assistance.	10	17%
	Social Inequities	Structural inequities and disinvestment driving disparities in access and outcomes.	9	15%
Maternal, Infant, & Child Health 30% of interviews (18 of 60)	Pediatric Illness	Asthma, developmental delays, and pediatric access challenges.	12	20%
	Family Support	Childcare, parenting education, and family stability programs.	6	10%
	School-Based Health	On-site school clinics, nurses, and mental health counselors.	5	8%
	Perinatal & Postpartum Support	Doulas, lactation, postpartum mental health, and home visiting.	3	5%

APPENDIX B: STAKEHOLDER INTERVIEW SCRIPT

STANDARD STAKEHOLDER INTERVIEW QUESTIONS

1. The individual's role and work
   - Could you tell me about your current role and the core mission of your organization or program?
   - What does a typical day look like for you?
   - Which programs, services, or initiatives are you personally most involved in right now?

2. The population served & their needs
   - Who are the primary populations you serve (age, geography, identity, condition, etc.)?
   - What are the top two or three health-related challenges you see in this population?
   - Are there social or structural barriers—transportation, housing, insurance, language, trust—that make access to care harder for them?

3. Perceptions of needs in Memphis/Shelby County overall
   - Looking beyond your clients, what do you see as the biggest health or wellbeing gaps across Memphis and Shelby County?
   - Have you noticed any emerging issues in the past few years (post-COVID, economic shifts, policy changes)?
   - Where do you feel the community is making progress—and where are we falling behind?

4. Methodist's current work & possible support
   - How familiar are you with Methodist Le Bonheur Healthcare's community outreach or Healthier 901 work?
   - Where do you see gaps that Methodist could help fill?

5. "The Magic Question"
   - If you had a magic wand and could change one thing about the health and well-being of Memphis/Shelby County, what would it be and why?

METHODIST LE BONHEUR HEALTHCARE EXECUTIVE INTERVIEW QUESTIONS

1. Role and Priorities
   - What is your role? How does your role shape MLH's priorities around community health and engagement?
   - Which major areas of health and wellbeing and/or initiatives are you most focused on right now that impact public health?

2. Population Concern and Needs
   - Which populations or communities do you see as most critical for us to reach in the next few years
   - What is the top health-related challenges you see in this population?
   - What is the top health-related strengths you see in this population?
   - Are there social or structural barriers—transportation, housing, insurance, language, trust—that make access to care harder for them?

3. Perceptions of Needs in Memphis/Shelby County Overall
   - From your perspective, how would you describe the overall state of health and wellbeing in Memphis and Shelby County?
   - Where do you see progress being made, and where are we falling behind?
   - What are there emerging challenges we should prepare for?

4. MLH's Role in Community Health
   - Can you describe how MLH's brand and outreach reflect our commitment to community health?
   - What stories or successes should we share more widely to show our impact?

5. Hopes for Future
   - If you had a magic wand and could change one thing about the health and well-being of Memphis/Shelby County, what would it be and why?

APPENDIX C: STAKEHOLDER REPRESENTATION

A Step Ahead Foundation

Alliance Healthcare Services

Alpha Omega Veterans Services, Inc.

Apple Seeds, Inc.

Assisi Foundation of Memphis

Black Farmer's Market

Black Seeds Urban Farms

Catholic Charities of West Tennessee

CHOICES Center for Reproductive Health

Christ Community Health Services

Church Health

City of Germantown

Community Alliance for the Homeless

Community Foundation of Greater Memphis

Courageous Climb

Disability Connection Midsouth

Endurance Krav Maga

Heal the Hood Foundation of Memphis

Memphis Child Advocacy Center

Memphis Fire Department – Community Wellness Committee

Memphis Medical District Collaborative

Memphis Muslim Medical Clinic

Memphis Police Department

Memphis Police Department – Community Outreach Program

Memphis Shelby County Schools – Health Services

Memphis Transit Coalition

Methodist Le Bonheur Healthcare

Methodist Le Bonheur Healthcare – Behavioral Health

Methodist Le Bonheur Healthcare – Community Outreach

Methodist Le Bonheur Healthcare – Faith and Health

Methodist Le Bonheur Healthcare – Germantown

Methodist Le Bonheur Healthcare – Le Bonheur Children's Hospital

Methodist Le Bonheur Healthcare – Memphis CHILD Medical Legal Partnership

Methodist Le Bonheur Healthcare – North

Methodist Le Bonheur Healthcare – South

Mid-South Food Bank

OUT Memphis

Porter Leath

Salus Benefits Group

SHARE for Seniors

Shelby County Health Department

Shelby County Trustee

Slingshot Memphis

St. Jude Children's Research Hospital – Psychological Services

State of Tennessee House of Representatives – 9th District Memphis/Shelby County

Tennessee Bureau of Investigation

Tennessee Nonprofit Network

The Broom Closet

Tiger Bookstore

Town of Arlington

Jad Davis

University of Memphis – School of Public Health

University of Tennessee Extension

University of Tennessee Health Science Center – College of Health Professions

University of Tennessee Health Science Center – College of Nursing

Urban Child Institute

2025 Community Health Needs Assessment

SURVEY REPORT

Methodist Le Bonheur Healthcare

2025

Community Health Needs Assessment

Survey Report

PREPARED BY:
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ABSTRACT

From June to August 2025, Methodist Le Bonheur Healthcare surveyed community members in Shelby County, DeSoto County, and surrounding areas regarding community health topics via a Community Health Survey. In total, 1,350 responses were received and evaluated by program evaluation staff at Methodist Le Bonheur Community Outreach. Overall, survey respondents identified diabetes, high blood pressure, and overweight/obesity as top health needs in their community; and poverty, access to care/uninsured, and community safety/crime as top community concerns. When asked about barriers to accessing health care in the community, cost/out of pocket expenses, basic needs not being met, and lack of or insufficient health insurance coverage were identified as the most significant. These results held true to findings across the other Community Health Needs Assessment (CHNA) assessment methods as well. This CHNA highlights an opportunity for Methodist Le Bonheur and other healthcare and community outreach organizations in Shelby County to better serve patients by making health care (including mental healthcare) more accessible to community members who lack the resources necessary to fully engage with the healthcare system.

SURVEY REPORT SUMMARY

As part of the 2025 Community Health Needs Assessment (CHNA), Methodist Le Bonheur Healthcare distributed a Community Health Survey comprised of 30 questions related to community health topics and one additional question asking for respondents' contact information so they could receive an electronic version of the final CHNA document. Survey questions fell into five different categories: Survey Respondent Demographics, Personal Health and Wellness, Community Health and Wellness, Barriers to Accessing Care and Suggestions/Comments. The survey was open to all Mid-South residents and was dispersed throughout Methodist Le Bonheur Healthcare and the community through social and traditional media, email campaigns, and tabling at community events and health fairs. An abbreviated (16 question) survey was created for select events. The longer survey received 1,167 responses, and the abbreviated survey received 183 responses, which were merged for the CHNA analysis.

In total, 1,350 survey responses were received through the online survey platform and paper survey copies. The majority of respondents were female (84%), 25-64 years old, and married. Seventy-six percent were employed full-time and listed employer-sponsored healthcare as their main form of health insurance. The top ZIP codes represented by participants were Collierville (38017), Whitehaven (38116), and Germantown (38125).

Limitations to the survey include a disproportionate number of female respondents (84% female) and missing or incomplete data on health need questions. In the health issues and community concerns sections, participants were asked to identify the top three needs, then select one need as most significant; however, some participants did not select one item as most significant, or selected multiple items on that question instead, thus lowering the sample size on select questions.

Participants were asked to identify top health issues as well as top social issues within their community. The health issue identified as most significant by participants was mental health, followed by overweight/obesity, and diabetes. The most significant community issue identified by participants was poverty, followed by access to care/uninsured, and community safety/crime. Similarly, the most significant barrier to health care access was cost/out-of-pocket expenses, followed by basic needs not being met (e.g. food, shelter), and lack of or insufficient healthcare coverage. These results were similar to the findings across other CHNA methodologies, including focus groups and stakeholder interviews.

STUDY OBJECTIVE/PURPOSE

The Community Health Needs Assessment (CHNA) survey was created to ensure that the agency assesses the health need of a community, per IRS requirements. The survey was created by the Methodist Le Bonheur Community Outreach Program Evaluation team, and the final format of the survey included 30 questions about several topics related to community health.

METHODOLOGY

The Community Health Needs Assessment survey was available online for all partners and the community from June through August 2025. Paper copies and QR codes for electronic surveys were also available. Survey distribution events included, but were not limited to:

- Le Bonheur Daily Bulletin
- MLH Today newsletter
- Le Bonheur Social Media
- Methodist Le Bonheur Social Media
- MLH Intranet, MOLLI
- Healthier 901 Fest
- Whitehaven Gun Violence Awareness Day Event
- Fatherhood Impact Expo
- Black Farmer's Market Memphis
- Senior Health Fair
- Community Health Fairs
- School Nurse Conference
- Collierville Farmer's Market
- Stax Back to School Family Day
- Le Bonheur Back to School Backpack Giveaway
- 901 Day

Overall, the survey received 1,350 responses. Not all survey respondents answered all questions, and thus some data may be missing.

SURVEY INSTRUMENT

Questions were created to gather information on specific health topics. See Table 1 below for a breakdown on the health topics and their purpose.

Table 1. Survey Instrument Questions by Topic Area

Health Topic	Number of questions related to Health Topic	Purpose of questions regarding Health Topic
Demographics	8 questions	To collect participant demographic information (e.g., age, income, marital status, employment).
Personal Health and Wellness	8 questions	To gather data on participant's health care access (insurance, primary care provider) and their perception of their overall physical and mental health.
Community Health and Wellness	6 questions	To ask participants to identify top health and social issues in their community and rate their community's overall health.
Barriers to Accessing Care	5 questions	To ask participants to identify the top barriers to care, rate statements about healthcare access, identify underserved populations, and identify missing services in the community.
Suggestions/Comments	2 questions	To elicit feedback on community strengths regarding health and quality of life, and to identify specific actions Methodist Le Bonheur can take to improve healthcare.

See Appendix A for the complete instrument used.

SUMMARY OF FINDINGS

DEMOGRAPHICS

Most respondents were young to middle aged adults. According to data obtained from SparkMap for Shelby County, 14.4% of the population is 65 or older1. Respondents to the CHNA were disproportionately female (84%). The Shelby County SparkMap data reported that 53% of the Shelby County population is female1. Just under half (44.8%) of CHNA respondents were married.

Table 2. Age Categories

Age	Total	Percent
18 - 24	63	4.7%
25 - 34	229	17.0%
35 - 44	297	22.0%
45 - 54	300	22.3%
55 - 64	296	22.0%
65 – 74	135	10.0%
75 +	27	2.0%
TOTALS:	**1,347**	**100%**

Table 3. Sex

Sex	Total	Percent
Female	1,120	84.0%
Male	204	15.3%
Non-Binary/Other	9	0.7%
TOTALS:	**1,333**	**100%**

Table 4. Marital Status of Survey Respondents

Marital Status	Total	Percent
Married	594	44.8%
Never married	408	30.8%
Divorced	196	14.8%
Widowed	52	3.9%
Separated	39	2.9%
Other	37	2.8%
TOTALS:	**1,326**	**100%**

Table 5. Race of Survey Respondents

Race	Total	Percent
Black/African American	774	57.7%
White/Caucasian	424	31.6%
Mixed or Multiple Races	46	3.4%
Asian/Pacific Islander	43	3.2%
Hispanic or Latino	37	2.8%
American Indian or Alaska Native	11	0.8%
Other	6	0.4%
Native Hawaiian or other Pacific Islander	1	0.1%
TOTALS:	**1,342**	**100%**

CHNA respondents were primarily Black/African American, followed by White/Caucasian. According to Shelby County SparkMap data, 51.3% of residents are Black or African American, 35.1% are white, 8.3% are Hispanic/Latino, 3.0% are Asian, and 0.2% are American Indian or Alaskan Native[1].

Table 6. Education Level of Survey Respondents

Education	Total	Percent
Graduate degree or higher	376	28.1%
College graduate	403	30.1%
Some college, but no degree	240	17.9%
Associate degree	142	10.6%
High school diploma or GED	151	11.3%
Less than a high school degree	13	1.0%
Other	15	1.1%
TOTALS:	**1,340**	**100%**

The respondents to the CHNA skewed towards higher levels of education compared to the Shelby County population (34.2% of individuals 25 years or older held a Bachelor's degree or higher)[1]. Other write-in options included trade or vocational school and certification programs.

Table 7. Employment Status of Survey Respondents

Employment	Total	Percent
Employed, working full-time	1,024	76.7%
Employed, working part-time	121	9.1%
Retired	91	6.8%
Disabled, not able to work	33	2.5%
Unemployed	26	1.9%
Student	22	1.6%
Homemaker	18	1.3%
TOTALS:	**1,335**	**100%**

Over two-thirds (76.7%) of CHNA respondents were employed full time.

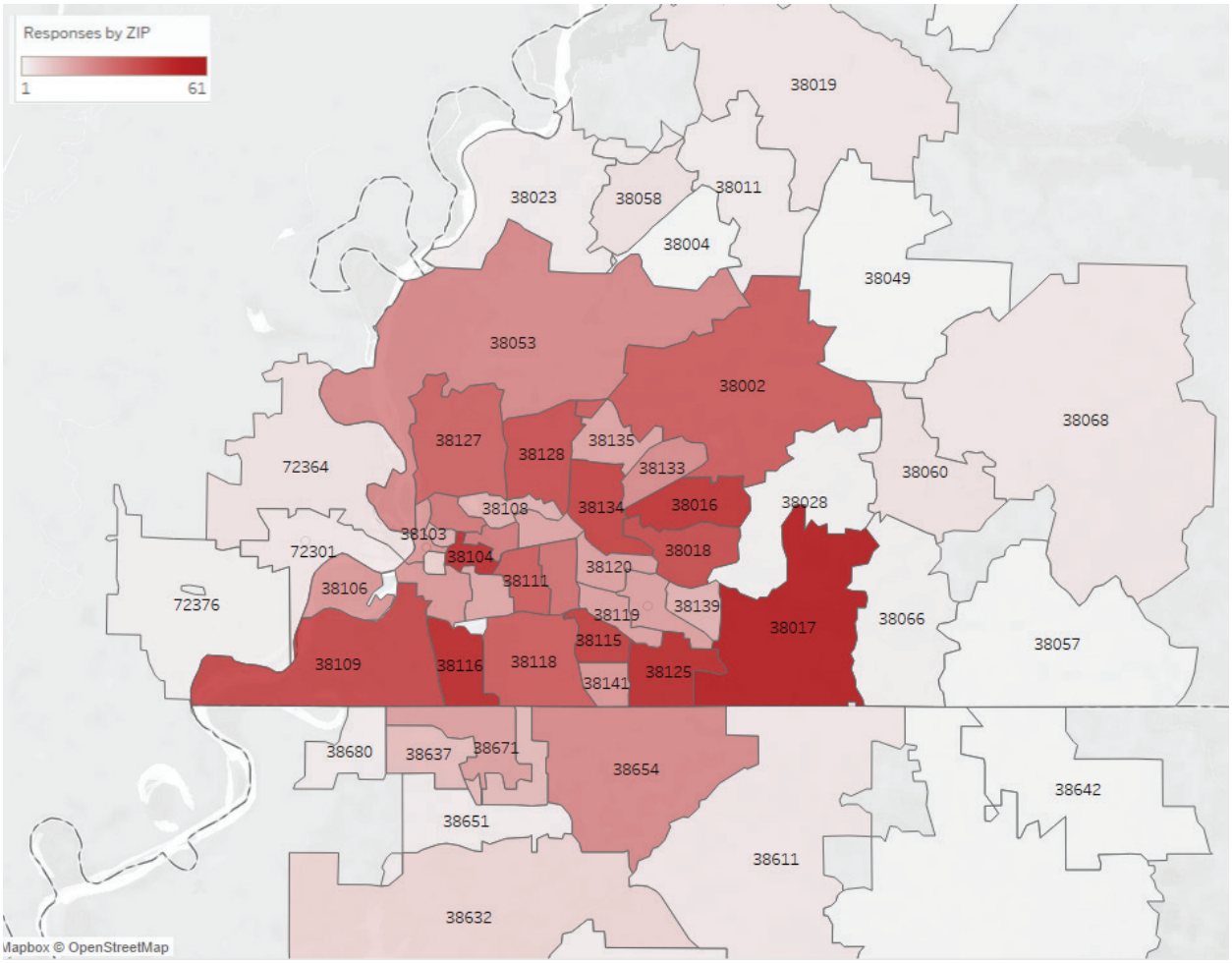
Table 8. Income Level

Income	Total	Percent
$100,000 or more	361	27.7%
$50,000 - $99,999	506	38.9%
$30,000 - $49,999	250	19.2%
$15,000 - $29,999	92	7.1%
Less than $15,000	92	7.1%
TOTALS:	**1,301**	**100%**

Over 65% of CHNA respondents reported an income of over $50,000. The median household income for Shelby County was $62,337 in 20231.

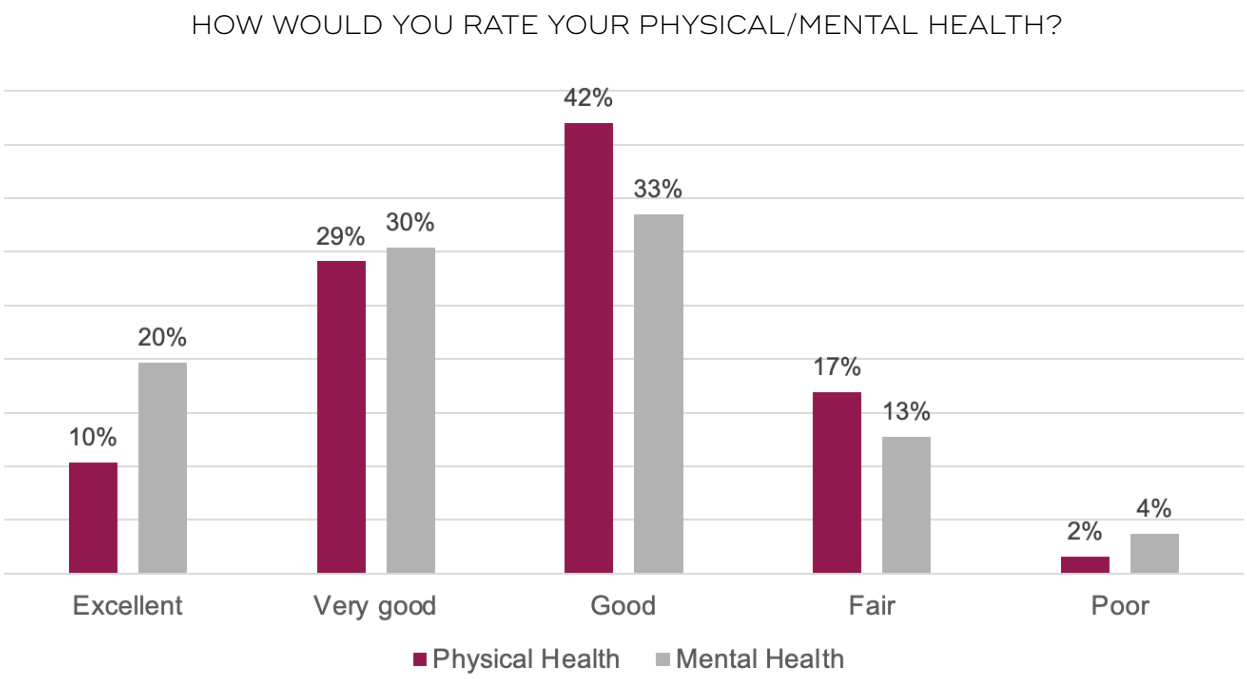
Figure 1: CHNA Respondents by ZIP Code

The map above shows the Memphis–Forrest City Combined Statistical Area by ZIP code. The highest density of CHNA responses came from Collierville (38017), Whitehaven (38116), and Germantown (38125).



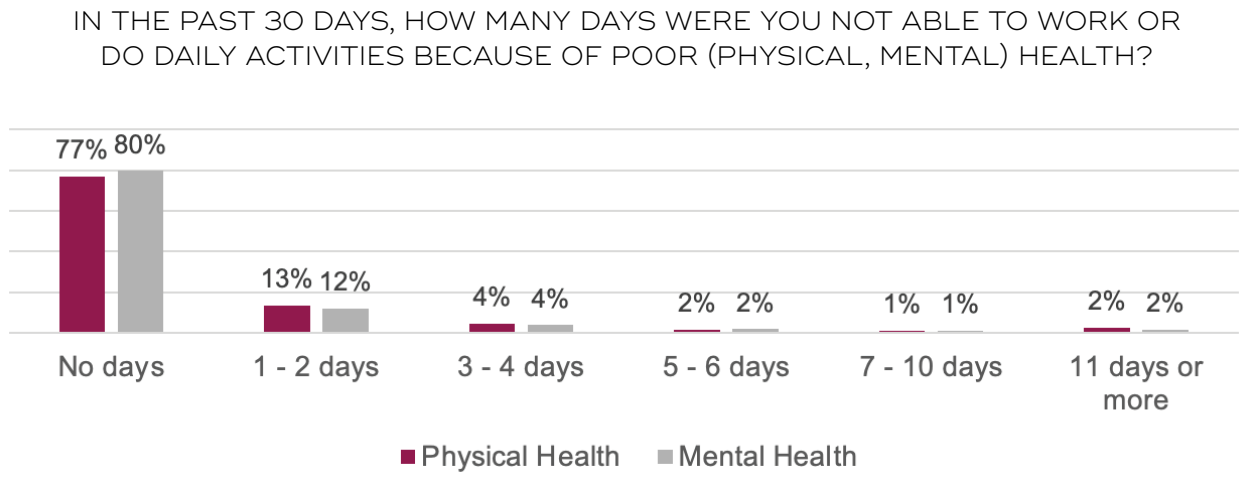
PERCEPTION OF OWN HEALTH

Figure 2. Overall Health, Physical/Mental



Respondents were asked to rate both their physical and mental health. Most rated both their physical and mental health in the "good" category. Compared to the 2022 CHNA, a higher number of respondents rated their mental health as 'excellent' in 2025 (16.3% in 2022 vs. 20% in 2025).

Figure 3. Health Over 30 Days



Respondents were also asked how many days of work or daily activities they had missed due to poor physical and mental health. The majority (77% for physical health, 80% for mental

health) reported missing no days. A slightly higher percentage of respondents reported missing work or daily activities due to poor physical health compared to poor mental health. In 2022, a higher percentage of respondents reported missing 11 days or more due to physical health (4.9% in 2022 vs. 2% in 2025).

INDIVIDUAL ACCESS TO CARE

Table 9. Respondents with a Primary Care Physician

Primary Care Physician	Total	Percent
Yes	1,123	84.8%
No	201	15.2%
TOTALS:	**1,324**	**100%**

Table 10. Insurance Providers

Primary Care Physician	Total	Percent
Yes	1,123	84.8%
No	201	15.2%
TOTALS:	**1,324**	**100%**

Write-in answers under "Other" included being on student insurance or on a parent's insurance, among others. In regard to the Shelby County general population, in 2023 it was estimated that 46% had employer coverage, 19% had Medicaid/TennCare, 10% had Medicare, 12% had private/individual market, 1.5% had insurance through the military/VA/Tricare/CHAMPUS, and 12% were uninsured2.

Respondents who indicated they had no health insurance were further prompted for the reason they did not have health insurance today at the time of the survey (n = 41). Over 65% said that health insurance was too expensive, followed by their employer not offering health insurance (17.1%).

Table 11. Delayed Needed Medical Care

Have you delayed getting needed medical care for any of the following reasons in the past 12 months?	Total	Percent
Could not afford care	105	23.1%
Could not take time off work/household duties	83	18.2%
No available/convenient appointments	82	18.0%
Lack of trust in healthcare system/providers	38	8.4%
Other	33	7.3%
Could not get through to provider to make appointment	27	5.9%
Unsure who to contact/where to go for care	25	5.5%
Provider would not take your insurance	24	5.3%
Did not have childcare	19	4.2%
Did not have transportation	14	3.1%
The clinic/doctor's office wasn't open when you went there	3	0.7%
Language barrier	2	0.4%
TOTALS:	**455**	**100%**

Respondents were asked if they had delayed needed health care in the past 12 months. The most common reasons for delaying care were due to inability to afford care, following by being unable to take time off of work, and no available or convenient appointments. The issue of being unable to take time off work or household duties has risen considerably since 2022, where only 9.3% of respondents cited it as a reason for delay, compared to over 18% in 2025.

BARRIERS TO CARE

Table 12. Community Barriers to Accessing Health Care When Needed (Pick 3)

	Total	Percent
Cost/Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	808	18.0%
Lack/Insufficient Health Insurance Coverage	626	14.0%
Basic Needs Not Met (Food/Shelter)	552	12.3%
Lack of Transportation	485	10.8%
Difficulty Navigating the Healthcare System	390	8.7%
Time Limitations	374	8.3%
Availability of Providers/Appointments	343	7.7%
Lack of Trust in Healthcare System/Providers	335	7.5%
Can't Find Doctor/Can't Get Appointment	240	5.4%
Lack of Child Care	176	3.9%
Language/Cultural Barriers	151	3.4%
Other	21	0.5%
Lack of Health Education	8	0.2%
TOTALS:	**4,480**	**100%**

Other write-in reasons included understaffed healthcare facilities, lack of concern about one's health, and misinformation on the news and social media. The top three reasons overall were cost and/or paying out of pocket, lack of health insurance coverage, and basic needs not being met.

Table 13. Community Barriers to Accessing Health Care When Needed (Most Significant)

	Total	Percent
Cost/Out of Pocket Expenses (Co-pays, Prescriptions, etc.)	297	31.1%
Basic Needs Not Met (Food/Shelter)	195	20.4%
Lack of/Insufficient Health Insurance Coverage	161	16.8%
Difficulty Navigating the Healthcare System	66	6.9%
Availability of Providers/Appointments	53	5.5%
Lack of Trust in Healthcare Providers	42	4.4%
Lack of Transportation	41	4.3%
Time Limitations	39	4.1%
Other	23	2.4%
Lack of Child Care	19	2.0%
Can't Find Doctor/Can't Get Appointment	15	1.6%
Language/Cultural Issues	5	0.5%
TOTALS:	**956**	**100%**

When asked to select the most significant of these barriers to care, the top answers remained much the same as the answers in the pick three question: prioritizing cost, basic needs not being met, and a lack of or insufficient health insurance coverage.

HEALTH ISSUES IN THE COMMUNITY

For the 2025 CHNA survey, health issues were divided into two categories: health issues and community concerns to more holistically capture health issues in the community. In both categories, respondents were asked to first select their top three issues, and then of those three, select one issue as the most significant.

Diabetes, high blood pressure, and overweight/obesity were the most frequently selected health issues. When asked to pick a single issue, over 17% of participants selected mental health as the most pressing health issue, followed by overweight/obesity and diabetes. This is similar to what we saw in the 2022 CHNA.

Table 14. Top Health Issues in the Community (Pick 3)

	Total	Percent
Diabetes	628	15.6%
High Blood Pressure	583	14.5%
Overweight/Obesity	418	10.4%
Mental Health	369	9.2%
Heart Disease	309	7.7%
Cancer	297	7.4%
Drug Abuse/Alcohol Abuse	274	6.8%
Food Insecurity/Nutrition	169	4.2%
Firearm Related Injuries	124	3.1%
Alzheimer's Disease/Aging Issues	111	2.8%
Asthma	91	2.3%
Drug Overdoses/Deaths	77	1.9%
HIV/AIDS	74	1.8%
STIs	73	1.8%
Stroke	64	1.6%
Dental Health	63	1.6%
Tobacco Use/Smoking	51	1.3%
Maternal/Infant Health	38	0.9%
COVID-19	37	0.9%
Other	31	0.8%
Respiratory/Lung Disease	31	0.8%
Vision/Eye Care	29	0.7%
Suicide	27	0.7%
Kidney Disease	24	0.6%
Infectious Diseases	14	0.3%
Stress/Burnout	9	0.2%
Infant Death	7	0.2%
High Cholesterol	3	0.1%
Lead Poisoning	1	0.0%
TOTALS:	**4,026**	**100%**

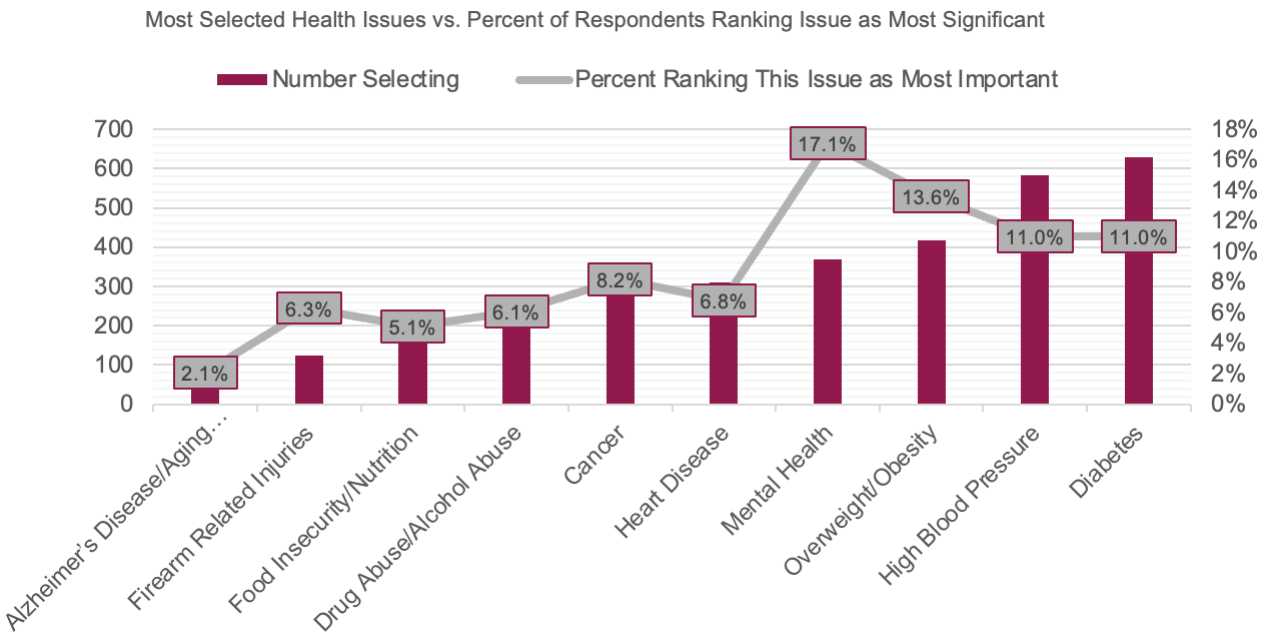
Table 15. Most Pressing Health Issue to Address (Most Significant)

	Total	Percent
Mental Health	174	17.1%
Overweight/Obesity	138	13.6%
Diabetes	112	11.0%
High Blood Pressure	112	11.0%
Cancer	83	8.2%
Heart Disease	69	6.8%
Firearm Related Injuries	64	6.3%
Drug Abuse/Alcohol Abuse	62	6.1%
Food Insecurity/Nutrition	52	5.1%
HIV/AIDS	27	2.7%
Alzheimer's Disease/Aging Issues	21	2.1%
Asthma	15	1.5%
Drug Overdoses/Deaths	13	1.3%
Sexually Transmitted Infections (STIs)	12	1.2%
Other	11	1.1%
Maternal/Infant Health	11	1.1%
Dental Health	10	1.0%
Tobacco Use/Smoking	5	0.5%
Kidney Disease	5	0.5%
Vision/Eye Care	5	0.5%
COVID-19	4	0.4%
Suicide	4	0.4%
Stroke	2	0.2%
Infant Death	2	0.2%
Respiratory/Lung Disease	1	0.1%
Infectious Diseases (i.e. hepatitis, TB, etc.)	1	0.1%
TOTALS:	**1,015**	**100%**

Although it was the fourth most frequently selected health issue, when asked which singular issue was the most significant, 17.1% of respondents cited mental health as the most significant health issue. This was followed by overweight/obesity and diabetes. Mental health was also cited as the most pressing issue in 2022, however, in 2025 there was an increased number of respondents citing high blood pressure (6.2% in 2022 vs. 11% in 2025) as a pressing issue to address.

The figure below compares the most frequently selected health issues to the percent of survey respondents who ranked that issue as most important, highlighting the importance the community places on mental health.

Figure 4. Most selected health issues vs. percent of respondents ranking issue as most significant



For community/social concerns, the most frequently selected issue from respondents was access to care/uninsured (18.6%), followed by concerns around community safety and crime, and access to healthy food. When asked to select the most pressing concern to address, however, 22.4% of respondents identified poverty as the most pressing issue, following by access to care and community safety. Poverty was also the most pressing issue cited in 2022.

Table 16. Top Community Issues (Pick 3)

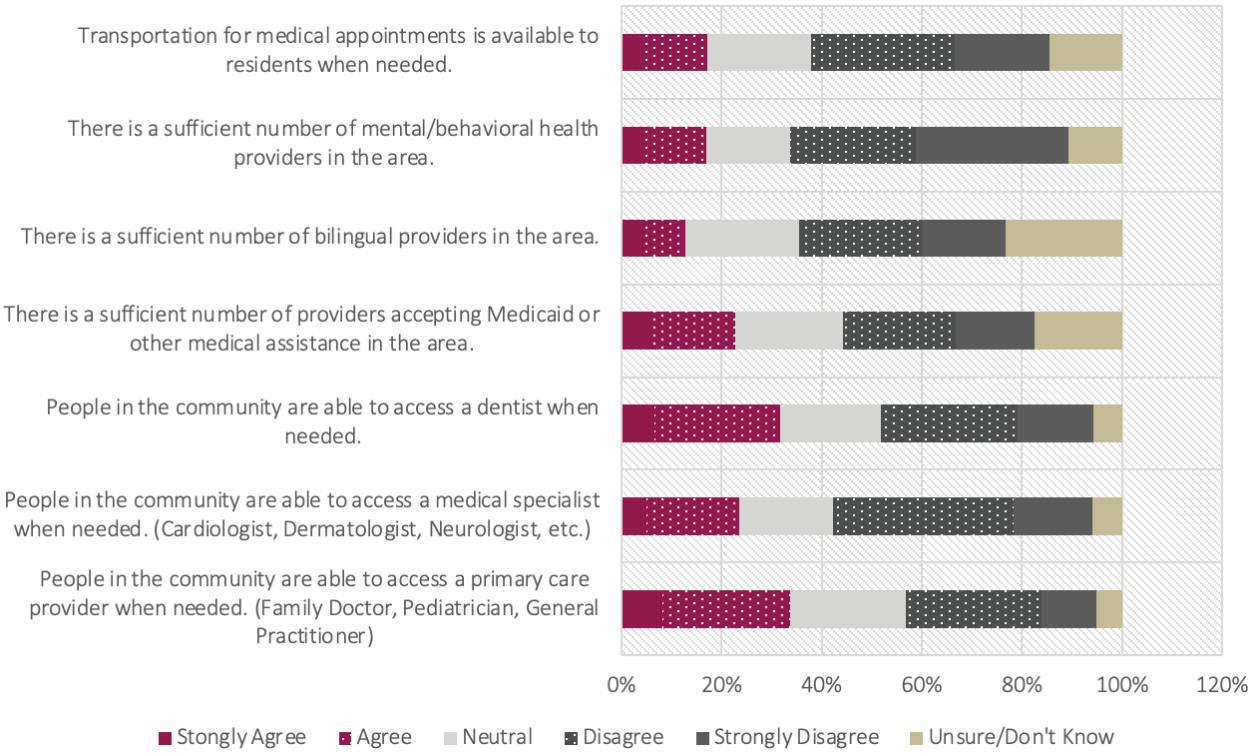
	Total	Percent
Access to Care/Uninsured	661	18.6%
Community Safety/Crime	522	14.7%
Access to Healthy Food	487	13.7%
Poverty	481	13.5%
Homelessness	289	8.1%
Homicide/Violent Crime	261	7.3%
Community Support	213	6.0%
Lack of Childcare and/or Elder Care	162	4.6%
Domestic Violence	160	4.5%
Child Abuse/Neglect	133	3.7%
Motor Vehicle Crashes	37	1.0%
Teenage Pregnancy	37	1.0%
Rape/Sexual Assault	28	0.8%
Lack of Internet Access	23	0.6%
Lack of Education	21	0.6%
Other	14	0.4%
Lack of Employment/Available Jobs	8	0.2%
Built Environment (e.g., blight)	8	0.2%
Transportation	8	0.2%
Cost of Living/Economic Instability	7	0.2%
TOTALS:	**3.560**	**100%**

Table 17. Most Pressing Community Issue to Address (Most Significant)

	Total	Percent
Poverty	225	22.4%
Access to Care/Uninsured	214	21.3%
Community Safety/Crime	145	14.5%
Homicide/Violent Crime	98	9.8%
Homelessness	84	8.4%
Access to Healthy Food	64	6.4%
Child Abuse/Neglect	44	4.4%
Community Support	36	3.6%
Domestic Violence	26	2.6%
Lack of Childcare and/or Elder Care	26	2.6%
Other	10	1.0%
Rape/Sexual Assault	7	0.7%
Motor Vehicle Crashes	7	0.7%
Lack of Education	7	0.7%
Teenage Pregnancy	6	0.6%
Lack of Internet Access	2	0.2%
Lack of Employment/Available Jobs	2	0.2%
TOTALS:	**1,003**	**100%**

ACCESS TO CARE IN THE COMMUNITY

Figure 5. **Provider Availability**



Respondents were asked a series of 5-point Likert scale questions about access to a variety of healthcare providers in the area. Respondents frequently indicated an insufficient number of specific providers, especially around mental/behavioral health care, with 63.1% of respondents selecting “disagree” or “strongly disagree,” and a lack medical specialists, with 51% disagreeing or strongly disagreeing.

Table 18. Underserved Populations in Healthcare

Are there specific populations in the community who you think are not being adequately served by local health services?	Total	Percent
Yes	810	72.3%
Unsure/Don't Know	226	20.2%
No	84	7.5%
TOTALS:	**1,049**	**100%**
Which populations are underserved?	**Total**	**Percent**
Low-income	775	17.8%
Uninsured/underinsured	651	15.0%
Homeless/housing insecure	573	13.2%
Black/African American	512	11.8%
Hispanic/Latino	405	9.3%
Seniors/aging/elderly	374	8.6%
Disabled	351	8.1%
Immigrant/refugee	322	7.4%
Children/youth	191	4.4%
Young adults	176	4.0%
Other	14	0.3%
LGBTQIA+ Population	5	0.1%
TOTALS:	**3,680**	**100%**

Over 70% of respondents felt that there were populations in the community who were underserved in healthcare. When asked to specify which populations in a check all that apply prompt, the low-income population was the most frequently selected, aligning with the other themes of poverty and limited access to healthcare that have been seen throughout the CHNA. Other write-in answers included individuals with mental health issues and the working-class population (families who make too much to receive government support but not enough to get by).

Table 19. Resources Missing in the Community

Related to health and quality of life, what resources or services do you think are missing in the community?	Total	Percent
Free/Low-Cost Medical Care	714	9.6%
Free/Low-Cost Dental Care	677	9.1%
Mental Health Services	535	7.2%
Transportation	464	6.2%
Housing Assistance	464	6.2%
Prescription Assistance	445	6.0%
Mobile Health Services/Pop-Up Clinics	443	6.0%
Child Care and/or Elder Care	420	5.6%
Preventive Care Services	419	5.6%
Wellness Programs	386	5.2%
Health Screenings	355	4.8%
Health Education/Information/Outreach	347	4.7%
Food Banks	333	4.5%
Substance Abuse Services	324	4.4%
Bilingual Services	310	4.2%
Primary Care Providers	307	4.1%
Healthcare Navigation Services	282	3.8%
Medical Specialists	211	2.8%
TOTALS:	7,436	100%

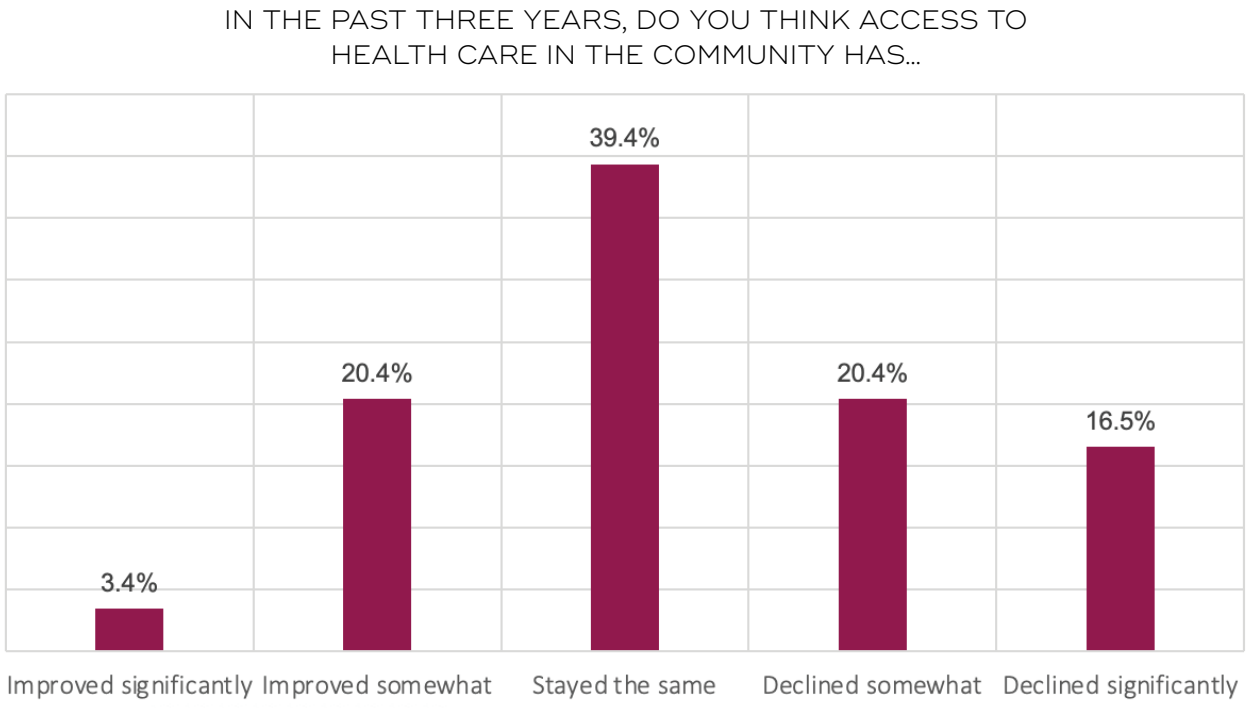
When asked what resources and/or services related to health and quality of life were missing in the community, the most frequently selected options by respondents were free or low cost medical care, free or low cost dental care, and mental health services.

Table 20. Community Health Rating

How would you rate your community's overall health?	Total	Percent
Excellent	23	1.9%
Very good	60	4.9%
Good	263	21.4%
Fair	510	41.5%
Poor	372	30.3%
TOTALS:	1,228	100%

Similar to how the survey asked respondents to rate their own physical and mental health, participants were asked to rate the overall health of their community. Most (41.5%) rated their community's health as "fair," similar to the 2022 CHNA (44.6%).

Figure 6. **Access to Health Care Over Time**



Respondents were asked how they felt access to health care in the community has changed in the past three years. Almost 40% of respondents felt it stayed about the same, and 20.4% felt it had declined somewhat. Respondents were also asked to expand on their answers.

Of respondents who felt access had improved significantly or somewhat, reasons included increased access to health resources, increased outreach, changes to TennCare, and technological improvements.

Among the respondents who felt access had declined significantly or somewhat, reasons listed included issues with access and capacity (fewer providers, facility closures), lack of affordability (rising insurance premiums, inflation), systemic dysfunction (funding cuts, service rollbacks), and social deterioration (increased crime, rising poverty rates, and food insecurity).

COMMUNITY STRENGTHS

One of the final questions the community survey asked respondents was an open-ended question asking, “In regards to health and quality of life, what is being done **well** in the community?” Responses were coded and sorted into larger themes, which are expanded on below. Select quotes from respondent answers are also included.

OUTREACH, EDUCATION, AND SCREENING EFFORTS

- "Community outreach and community health & wellness events are prevalent in the community."
- "Community health outreach – Methodist is here [Black Farmer's Market] right now conducting surveys!"

A number of respondents felt that there is a growing number of outreach initiatives for the community, and increased access to screening for some populations. Examples included the prevalence of health education efforts and free services and seeing more mobile/pop up opportunities.

SOCIAL AND BASIC NEEDS SUPPORT

- "[The community is] attempting to provide healthier foods in dollar general and farmers markets."
- "Programs are more accessible which provide an array of wraparound services to various communities."

Respondents mentioned seeing improved efforts around providing basic needs, citing the effective provision of some social services necessary for health, especially around food assistance (e.g. farmer's markets, food banks) and community outreach programs addressing needs such as housing or childcare.

NON-PROFIT AND FAITH-BASED HEALTH HUBS

- "Community Health and volunteer clinics run by private individuals/entities like mosques and churches are filling some gaps."

Many respondents praised the strength of the community's free/low-cost clinics, such as Church Health and Christ Community. Respondents also mentioned the willingness of local churches to provide support for the community's health and social needs.

IMPROVEMENT OF PHYSICAL ASSETS

- "[We have] access to third spaces – strong park systems, well maintained greenlines, expansion of bike lanes."
- "Outdoor spaces like parks and trails are being updated; there are several organizations and events that help those with low income like Church Health and initiatives at the university."

Respondents noted improvements in the built environment, including hospitals and university research. They also noted improvements to green spaces and community gathering areas, such as community centers and libraries, and an increase in bike lanes.

COMMUNITY COLLABORATION AND ADVOCACY

- "People are becoming more vocal about what they need."
- "[We are] being innovative in trying to reach populations that don't have access to care."
- "Memphis community members are good at sharing resources with their networks. Community organizations are good at partnering and working together to increase access of services."
- "I think the amount of people wanting to make a difference is growing."

Finally, respondents noted the ongoing efforts witnessed between diverse organizations such as hospitals, churches, and schools to build partnerships for more effective programming. Respondents also mentioned the increased utilization of Community Health Workers as a way to bridge health gaps and assist in health navigation. Respondents also denoted the community's willingness to advocate for systemic change.

LIMITATIONS

As in 2022, the 2025 CHNA made a concentrated effort to survey a diverse population representative of the mid-south area. However, respondents were still disproportionately female and reported higher educational and income levels compared to the Shelby County population as a whole. There were also some minor structural issues in the survey itself that led to missing data. In the health issues and community issues sections, participants were asked to first identify the top three needs, then select one need as most significant; however, a number of participants did not select one item as most significant, or selected multiple items on that question instead, thus lowering the sample size on select questions. This occurred more frequently on paper surveys than online, likely due to the formatting of the paper survey and questions being easier to inadvertently skip.

DISCUSSION

The results and themes that emerged from the analysis of the CHNA community survey fall in line with many health issues that arose during other portions of the CHNA. Respondents expressed concerns about chronic health issues, such as diabetes and high blood pressure. Mental health was also identified as a top health need and was cited as the most important to address when respondents were prompted.

When looking at the community concerns, poverty was cited as the most significant issue, followed by access to care and community safety/crime. These issues continue to appear in the barriers to care that were identified by survey respondents. The most significant barrier to care was cost and out of pocket expenses, followed by basic needs not being met and lack of or otherwise insufficient health insurance coverage. All three of these barriers can be linked back to the issue of poverty, which itself frequently contributes to many of the significant health conditions identified in the survey.

In addition to identifying top health and community concerns, respondents demonstrated mixed feelings about the health of their community overall. Many indicated a lack of providers in the community, especially affordable, accessible mental/behavioral health providers, and medical specialists. Many also indicated a lack of available options for low-income and uninsured or underinsured populations, citing a need for more free or low-cost medical and dental care and mental health services. Over 35% of respondents felt that access to health care in the community had declined, citing limitations around access and capacity in healthcare, such as fewer providers and rising insurance costs. In addition to these access issues, respondents identified economic and systemic dysfunction, including inflation, funding cuts, and service rollbacks, which subsequently contribute to social issues, such as poverty and rising crime rates.

Although responses from the CHNA survey demonstrate a multitude of issues impacting health and quality of life in the community, many positives were cited as well. Respondents praised an increase in community outreach and education effort around health and well-being from a variety of programs. They also noted an increase in community collaboration and advocacy, citing the diverse partnerships between community organizations, churches, schools, and other organizations. Non-profit and faith-based health hubs were praised for helping families for free or lost costs, and respondents felt like there have been improved efforts around providing basic needs. Finally, respondents noted seeing some improvement in the built environment, including and increase in bike lanes and more green spaces for families to enjoy.

The 2025 CHNA community survey worked diligently to gather feedback from the community. The CHNA team attended close to 20 separate community events over two months to distribute the survey and engaged many community partners in distribution, which successfully resulted in a diverse pool of respondents and more complete picture of health needs and quality of life in the Mid-South area.

REFERENCES

1. Center for Applied Research and Engagement Systems (CARES) University of Missouri Extension. (2025). [Community Health Needs Assessment Report with data dashboards and maps for Shelby County, Tennessee and DeSoto County, Mississippi]. SparkMap. Retrieved from sparkmap.org.

2. Data USA. (2023). *Shelby County, TN*. Retrieved October 14, 2025, from https://datausa.io/profile/geo/shelby-county-tn#health

APPENDIX A: SURVEY INSTRUMENT

2025 COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

Methodist Le Bonheur Hospital is conducting this Community Health Needs Assessment (CHNA) to learn more about the health of people in the community. The insights gathered will help us better understand the health needs of Memphis/Shelby County residents and inform our efforts to improve community health programs and services. We would love to hear from you!

This survey will take approximately 15 to 20 minutes to complete. Your answers will remain completely anonymous, and individual responses will not be linked back to you.

1. What is your age range?
   - ❑ 18 – 24
   - ❑ 25 – 34
   - ❑ 35 – 44
   - ❑ 45 – 54
   - ❑ 55 – 64
   - ❑ 65 – 74
   - ❑ 75 +

2. What is your gender?
   - ❑ Male
   - ❑ Female
   - ❑ Non-binary
   - ❑ Prefer not to say
   - ❑ Other (please specify): _____

3. Which one of these groups best describes your race?
   - ❑ American Indian or Alaska Native
   - ❑ Asian/Pacific Islander
   - ❑ Native Hawaiian or other Pacific Islander
   - ❑ Black or African American
   - ❑ Hispanic or Latino/a
   - ❑ White or Caucasian
   - ❑ Mixed or Multiple Races
   - ❑ Other (please specify): _____

4. What is the highest level of school you have completed or the highest degree you have received?
   - ❑ Less than a high school degree
   - ❑ High school degree or equivalent (e.g., GED)
   - ❑ Some college but no degree
   - ❑ Associate degree
   - ❑ Bachelor's degree
   - ❑ Graduate degree
   - ❑ Other (please specify): _____

5. Which of the following categories best describes your employment status?
- ❑ Employed, working full-time
- ❑ Employed, working part-time
- ❑ Retired
- ❑ Disabled, not able to work
- ❑ Student
- ❑ Homemaker
- ❑ Unemployed

6. Please enter your home ZIP code: _____

7. What is your marital status?
- ❑ Divorced
- ❑ Married
- ❑ Never married
- ❑ Separated
- ❑ Widowed
- ❑ Other (please specify) _____

8. What is your annual household income?
- ❑ Less than $15,000
- ❑ $15,000 - $29,999
- ❑ $30,000 - $49,999
- ❑ $50,000 - $99,999
- ❑ $100,000 or more

9. What is your main health insurance plan? This is the plan which pays the medical bills first or pays most of the medical bills. Private health insurance could include Blue Cross/Blue Shield, Kaiser, Aetna, etc.
Select only one.
- ❑ Private health insurance plan (Blue Cross/Blue Shield, Kaiser, Aetna, COBRA, etc.) provided through employer or workplace
- ❑ Private health insurance plan (Blue Cross/Blue Shield, Kaiser, Aetna, etc.) purchased directly from an insurance agency
- ❑ Medicare
- ❑ Medicaid
- ❑ Military, Tricare, CHAMPUS, or the VA
- ❑ Indian Health Service
- ❑ No health insurance of any kind
- ❑ Don't know / Not sure
- ❑ Other (please specify) _____

10. For those of you who selected no health insurance, why do you not have health insurance?
- ❑ Too expensive
- ❑ It does not include all the health care needs that I have now, or might have in the future
- ❑ I have a pre-existing condition that is not covered
- ❑ I am healthy and do not need health insurance today
- ❑ I don't know how to get health insurance
- ❑ Employer does not offer health insurance
- ❑ I recently lost my job/income

11. Do you have a primary care physician?
- ❑ Yes
- ❑ No

12. Have you delayed getting needed medical care for any of the following reasons in the past 12 months? **Select the most important reason.**
- ❑ Did not have childcare
- ❑ Did not have transportation
- ❑ Could not afford care
- ❑ Could not get through to provider to make appointment
- ❑ Could not take time off work
- ❑ Lack of trust in healthcare system/providers
- ❑ Language barrier
- ❑ No available/convenient appointments
- ❑ Provider would not take your insurance
- ❑ The clinic/doctor's office wasn't open when you went there
- ❑ Unsure who to contact/where to go for care
- ❑ N/A, did not delay getting medical care/did not need medical care
- ❑ Other (please specify) _____

13. How would you rate your overall **physical** health?
- ❑ Excellent
- ❑ Very good
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Don't know / Not sure

14. In the past 30 days, how many days were you unable to work or do daily activities because of poor **physical** health?
- ❑ No days
- ❑ 1 - 2 days
- ❑ 3 - 4 days
- ❑ 5 - 6 days
- ❑ 7 - 10 days
- ❑ 11 days or more

15. How would you rate your overall **mental** health?

- ❑ Excellent
- ❑ Very good
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Don't know / Not sure

16. In the past 30 days, how many days were you unable to work or do daily activities because of poor **mental** health?

- ❑ No days
- ❑ 1 - 2 days
- ❑ 3 - 4 days
- ❑ 5 - 6 days
- ❑ 7 - 10 days
- ❑ 11 days or more

SECTION 2. COMMUNITY HEALTH

17. What do you think are the top 3 most pressing health conditions affecting people in your area?

- ❑ Alzheimer's Disease/Aging Issues
- ❑ Asthma
- ❑ Cancer
- ❑ COVID-19
- ❑ Dental Health
- ❑ Diabetes
- ❑ Drug Abuse/Alcohol Abuse
- ❑ Drug Overdose/Deaths
- ❑ Firearm Related Injuries
- ❑ Food Insecurity/Nutrition
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Infectious Diseases (i.e. hepatitis, TB, etc.)
- ❑ Infant Death
- ❑ Kidney Disease
- ❑ Lead Poisoning
- ❑ Maternal/Infant Health
- ❑ Mental Health
- ❑ Overweight/Obesity
- ❑ Respiratory/Lung Disease
- ❑ Sexually Transmitted Infections (STIs)
- ❑ Stroke
- ❑ Suicide
- ❑ Tobacco Use/Smoking
- ❑ Vision/Eye Care
- ❑ Other (specify) _____

18. Of the three issues you selected above, which issue do you think is the **most** important to address? _____

19. What do you think are the **top 3** most pressing **community** conditions affecting people in your area?

- ❑ Access to Care/Uninsured
- ❑ Access to Healthy Food
- ❑ Child Abuse/Neglect
- ❑ Community Safety/Crime
- ❑ Community Support
- ❑ Domestic Violence
- ❑ Homelessness
- ❑ Homicide/Violent Crime
- ❑ Lack of Child Care and/or Elder Care
- ❑ Lack of Internet Access
- ❑ Motor Vehicle Crashes
- ❑ Poverty
- ❑ Rape/Sexual Assault
- ❑ Teenage Pregnancy
- ❑ Other (specify) _____

20. Of the three issues you selected above, which issue do you think is the **most** important to address? _____

21. In your opinion, what are the most significant barriers that keep people in the community from accessing health care when they need it (check all that apply)?

- ❑ Availability of Providers/Appointments
- ❑ Basic Needs Not Met (Food/Shelter)
- ❑ Can't Find Doctor/Can't Get Appointment
- ❑ Cost/Out of Pocket Expenses (Co-pays, Prescriptions, etc.)
- ❑ Difficulty Navigating the Healthcare System
- ❑ Lack of Child Care
- ❑ Lack of/Insufficient Health Insurance Coverage
- ❑ Lack of Transportation
- ❑ Lack of Trust in Healthcare Providers
- ❑ Language/Cultural Barriers
- ❑ Time Limitations (long wait times, limited office hours, unable to get time off work)
- ❑ None/No Barriers
- ❑ Don't Know
- ❑ Other (specify) _____

22. Of the issues you selected above, which issue do you think is the **most** important to address?

23. On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements about **Health Care Access** in your community.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Unsure/ Don't Know
People in the community are able to access a dentist when needed.	❑	❑	❑	❑	❑	❑
There is a sufficient number of providers accepting Medicaid or other medical assistance in the area.	❑	❑	❑	❑	❑	❑
There is a sufficient number of bilingual providers in the area.	❑	❑	❑	❑	❑	❑
There is a sufficient number of mental/behavioral health providers in the area.	❑	❑	❑	❑	❑	❑
Mental health services are affordable and accessible when needed.	❑	❑	❑	❑	❑	❑
Transportation for medical appointments is available to residents when needed.	❑	❑	❑	❑	❑	❑

24. Are there specific populations in the community who you think are not being adequately served by local health services?

- ❑ Yes
- ❑ No
- ❑ Unsure/Don't Know

25. If yes, which populations are underserved? (select all that apply)

- ❑ Uninsured/Underinsured
- ❑ Low-income
- ❑ Hispanic/Latino
- ❑ Black/African American
- ❑ Immigrant/Refugee
- ❑ Disabled
- ❑ Children/Youth
- ❑ Young Adults
- ❑ Seniors/Aging/Elderly
- ❑ Homeless/Housing Insecure
- ❑ None
- ❑ Other (please specify) _____

26. What health services or help do you think our community needs that it doesn't have now? (select all that apply)

- ❑ Free/Low-Cost Medical Care
- ❑ Free/Low-Cost Dental Care
- ❑ Primary Care Providers
- ❑ Preventive Care Services
- ❑ Wellness Programs
- ❑ Child Care and/or Elder Care
- ❑ Medical Specialists
- ❑ Healthcare Navigation Services
- ❑ Mental Health Services
- ❑ Mobile Health Services/Pop-up Clinics
- ❑ Substance Abuse Services
- ❑ Bilingual Services
- ❑ Transportation
- ❑ Prescription Assistance
- ❑ Housing Assistance
- ❑ Food Banks
- ❑ Health Education/Information/Outreach
- ❑ Health Screenings
- ❑ None
- ❑ Other (please specify) _____

27. How would you rate your community's overall health?

- ❑ Excellent
- ❑ Very good
- ❑ Good
- ❑ Fair
- ❑ Poor
- ❑ Don't know / Not sure

28. In the past three years, do you think access to health care in the community has...

- ❑ Improved significantly
- ❑ Improved somewhat
- ❑ Stayed the same
- ❑ Declined somewhat
- ❑ Declined significantly
- ❑ Unsure/Don't Know

Please expand on your answer to the above question: _____

29. In your opinion, what is being done **well** in the community in terms of health and quality of life? (Community Assets/Strengths/Successes)

_____

30. What can Methodist Le Bonheur Healthcare do to improve health and quality of life in the community?

_____

Thank you for taking the time to help Methodist Le Bonheur learn about the health needs of our community.

Would you like to see the final report when it is finished?

- ❏ Yes
- ❏ No

If yes, please enter your email address: _____

APPENDIX B: SURVEY RESPONDENT ZIP CODE TABLE

TENNESSEE		
County	ZIP Code	Count
Shelby	38002	40
Shelby	38016	53
Shelby	38017	61
Shelby	38018	45
Shelby	38028	2
Shelby	38053	27
Shelby	38103	23
Shelby	38104	55
Shelby	38105	17
Shelby	38106	23
Shelby	38107	32
Shelby	38108	16
Shelby	38109	47
Shelby	38110	1
Shelby	38111	40
Shelby	38112	31
Shelby	38114	19
Shelby	38115	50
Shelby	38116	57
Shelby	38117	34
Shelby	38118	40
Shelby	38119	21
Shelby	38120	21
Shelby	38122	19
Shelby	38125	56
Shelby	38126	9
Shelby	38127	38
Shelby	38128	44
Shelby	38133	26
Shelby	38134	48
Shelby	38135	20
Shelby	38138	21
Shelby	38139	16
Shelby	38141	24
Shelby	38152	1

Shelby	38173	1
Shelby	38183	1
Shelby	38184	1
Shelby	38186	1
Shelby	38190	1
Carroll	38321	1
Carroll	38355	1
Crockett	38006	2
Crockett	38337	1
Dyer	38024	1
Fayette	38057	1
Fayette	38060	5
Fayette	38068	4
Fayette	38381	1
Gibson	38343	3
Gibson	38358	2
Gibson	38369	1
Gibson	38382	1
Hardeman	38067	1
Haywood	38066	2
Haywood	38069	1
Haywood	38315	1
Lauderdale	38063	1
Lauderdale	38340	1
Madison	38301	1
Madison	38305	2
Obion	38260	1
Tipton	38004	1
Tipton	38008	1
Tipton	38011	3
Tipton	38019	4
Tipton	38023	3
Tipton	38049	1
Tipton	38058	5
Weakley	38225	1
TN TOTAL:		**1,136**

MISSISSIPPI		
County	**ZIP Code**	**Count**
Chickasaw	38846	1
DeSoto	38620	1
DeSoto	38631	1
DeSoto	38632	8
DeSoto	38637	13
DeSoto	38651	3
DeSoto	38654	27
DeSoto	38671	21
DeSoto	38672	14
DeSoto	38680	3
Grenada	38930	1
Itawamba	38824	1
Lafayette	38601	1
Lawrence	39654	1
Marshall	38611	4
Marshall	38635	1
Marshall	38638	1
Marshall	38642	1
Marshall	38655	1
Marshall	38658	1
Panola	38622	1
Panola	38666	1
Tate	38617	1
Tate	38618	3
Tate	38668	2
MS TOTAL:		**113**

ARKANSAS		
County	**ZIP Code**	**Count**
Craighead	72404	1
Crittenden	72301	4
Crittenden	72303	1
Crittenden	72364	5
Crittenden	72376	2
Crittenden	72396	1
Mississippi	72315	1
Mississippi	72360	1
Pulaski	72227	1
AR TOTAL:		**17**

2025 Community Health Needs Assessment

FOCUS GROUPS

Methodist Le Bonheur Healthcare

2025

Community Health Needs Assessment

Focus Groups

PREPARED BY:
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ABSTRACT

The 2025 Community Health Needs Assessment (CHNA) was conducted to identify and better understand the leading health concerns, barriers, and social influences affecting residents within Shelby County and surrounding areas. Through a series of focus groups representing diverse populations—including healthcare professionals, first responders, educators, faith leaders, community organizations, and residents—participants shared their experiences and perspectives on what most impacts health and well-being in their communities.

This assessment revealed that health outcomes in Shelby County are shaped by both clinical factors and broader social and environmental conditions. Focus group participants consistently emphasized that access to care, mental and behavioral health, economic stability, housing, nutrition, and safety are interconnected components of community health.

FIVE KEY THEMES EMERGED ACROSS ALL FOCUS GROUPS:

1. Mental Health and Substance Use – A growing need for accessible, affordable behavioral health services and stronger drug prevention and recovery support.

2. Access to and Navigation of Healthcare Services – Persistent barriers related to cost, care coordination, health literacy, and trust in medical systems.

3. Nutrition, Physical Activity, and Chronic Disease Prevention – Ongoing challenges related to food insecurity, limited fitness opportunities, and preventable chronic illness.

4. Violence and Community Safety – Increasing concern about gun violence, trauma exposure, and the impact of unsafe environments on physical and emotional health.

5. Housing and Social Drivers of Health – Recognition that stable, affordable housing and supportive social conditions are foundational to overall well-being.

Together, these findings highlight the ongoing need for a coordinated, equity-focused approach to community health improvement. Addressing the social, behavioral, and environmental factors identified in this assessment will require cross-sector collaboration, investment in prevention, and sustained engagement with the communities most affected.

FOCUS GROUPS SUMMARY

The 2025 Community Health Needs Assessment (CHNA) gathered extensive input from community members, healthcare professionals, first responders, faith leaders, educators, and service providers across Shelby County and surrounding areas. The goal was to better understand the most significant factors influencing community health and to identify opportunities for collaboration and improvement.

Through 13 focus group discussions with 109 participants, several recurring themes emerged that reflect both persistent and evolving challenges since the previous CHNA cycle. Participants highlighted that community health is shaped by a combination of behavioral, social, and environmental influences that extend beyond the clinical setting. The top five themes identified were: Mental Health and Substance Use, Access to Healthcare and

Navigation of the healthcare system, Nutrition, Physical Activity, and Chronic Disease Prevention, Violence and Community Safety, and Housing and Social Drivers of Health.

Mental health and substance use were described as critical and interconnected issues across all groups. Participants cited a growing need for mental health services, limited access to affordable care, and ongoing stigma surrounding mental illness. Substance use—particularly opioid and fentanyl-related overdoses—was viewed as both a symptom and driver of community distress. Respondents emphasized the need for early intervention, better crisis response systems, and stronger integration of behavioral health within primary care settings.

Access to healthcare and navigation of healthcare services remained a significant concern. Residents frequently described difficulties understanding the healthcare system, affording services, and obtaining follow-up care after hospital discharge. Participants stressed that improved patient navigation, culturally responsive care, and expanded partnerships with community-based organizations are essential for addressing these barriers and building trust among underserved populations.

Nutrition, physical activity, and chronic disease prevention were repeatedly linked to poor community health outcomes. Participants noted that food insecurity, limited access to affordable fresh foods, and sedentary lifestyles contribute to rising rates of obesity, diabetes, and cardiovascular disease. They called for expanded community wellness initiatives, school-based health education, and equitable investment in parks, recreation, and safe physical activity spaces.

Violence and community safety were also viewed as key social and health concerns. Gun violence, domestic violence, and youth exposure to trauma were reported as ongoing issues with lasting physical and emotional effects. Participants urged that violence prevention be treated as a public health priority, advocating for early intervention, mentorship programs, and greater coordination between hospitals, law enforcement, and local organizations.

Finally, housing and social drivers of health were identified as foundational to improving overall well-being. Participants described how housing instability, unsafe living conditions, and rising costs of rent undermine health at every level. Broader social drivers—including transportation, education, and employment—were also recognized as interconnected challenges that limit opportunities for health and stability. Participants recommended coordinated, cross-sector efforts to expand affordable housing, improve infrastructure, and strengthen community-based support.

Taken together, these findings demonstrate that health in Shelby County is shaped by a complex web of medical, behavioral, and social factors. Addressing these needs will require continued collaboration between healthcare systems, government agencies, community organizations, and residents. The 2025 CHNA underscores the importance of sustained investment in prevention, access, and equity to ensure that every individual, regardless of income, geography, or background, may achieve the highest possible level of health and well-being.

FOCUS GROUP DEMOGRAPHICS AND GEOGRAPHIC DISTRIBUTION

The 2025 Community Health Needs Assessment (CHNA) included a diverse representation of participants across multiple community sectors. In total, 13 focus groups were conducted with 109 participants. Participants spanned 12 professional and community-based categories, including first responders, childcare providers, health educators, faith leaders, disability advocates, and neighborhood organizations. This diverse participation ensured that perspectives were collected from individuals serving a wide range of populations and geographic areas within Shelby County.

Figure 1: Dashboard of Focus Group Participant Demographics

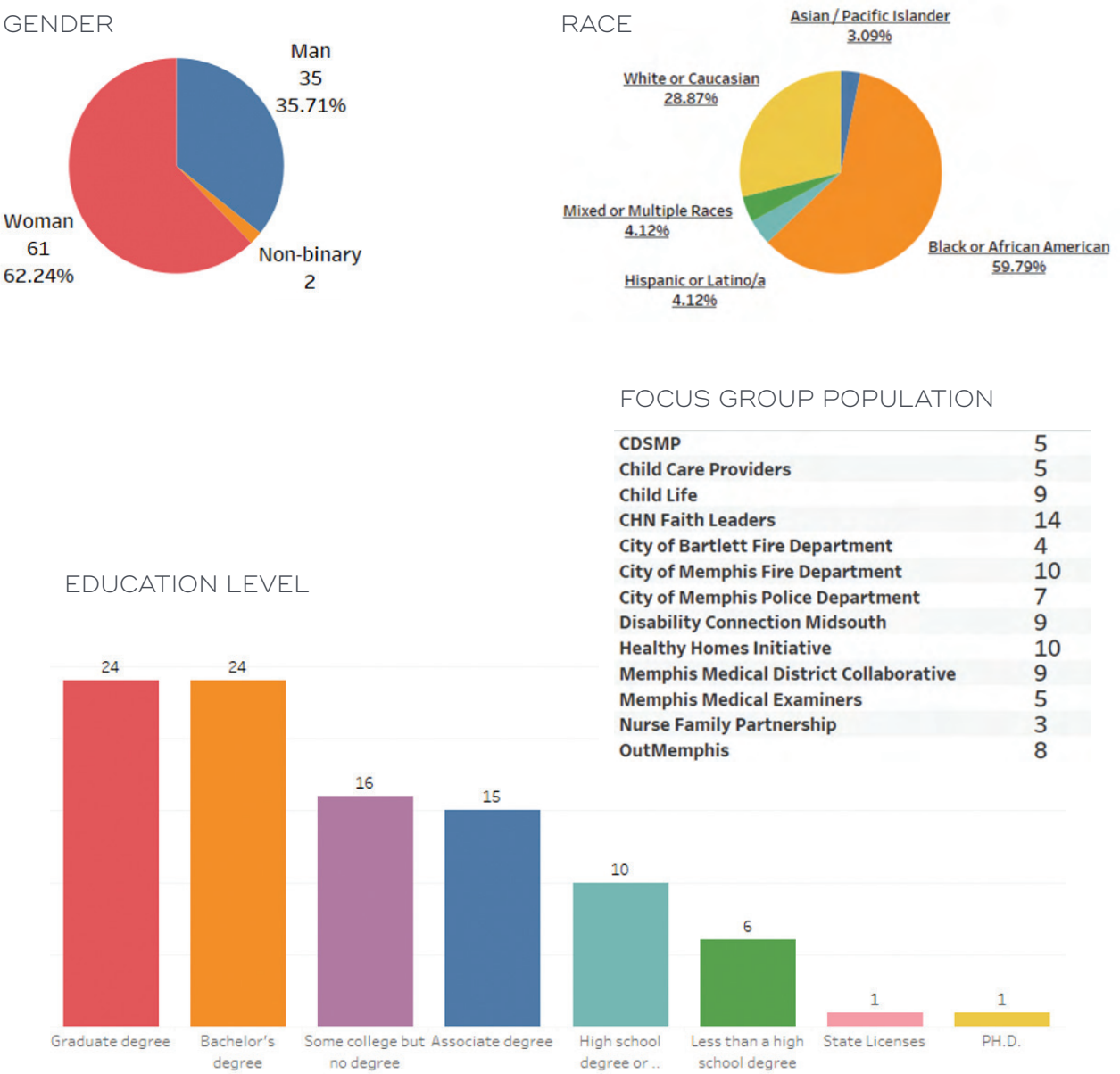
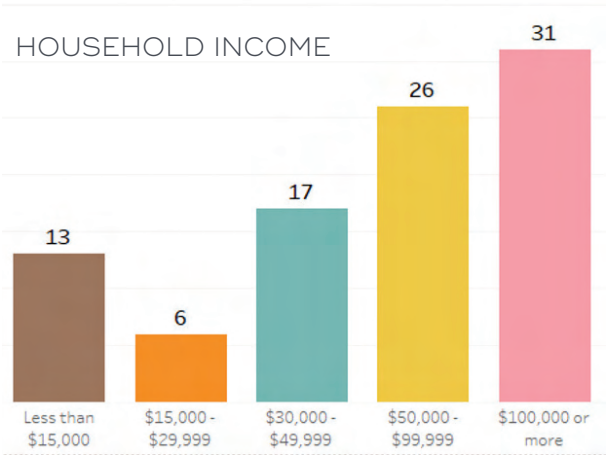
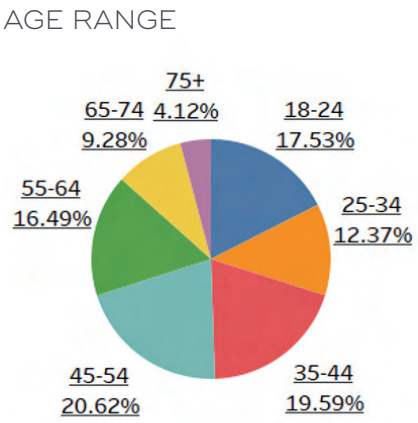


Figure 1 continued: Dashboard of Focus Group Participant Demographics





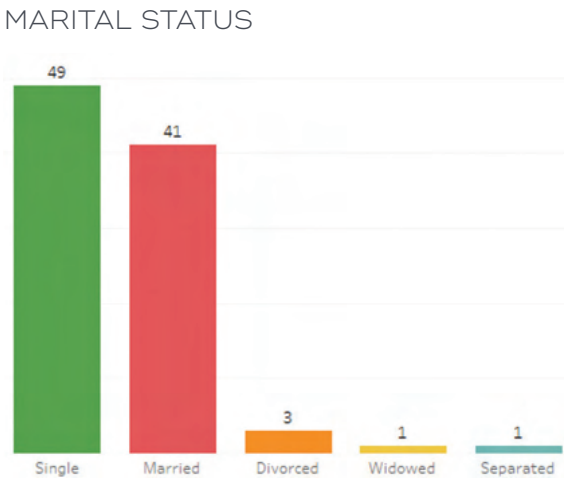
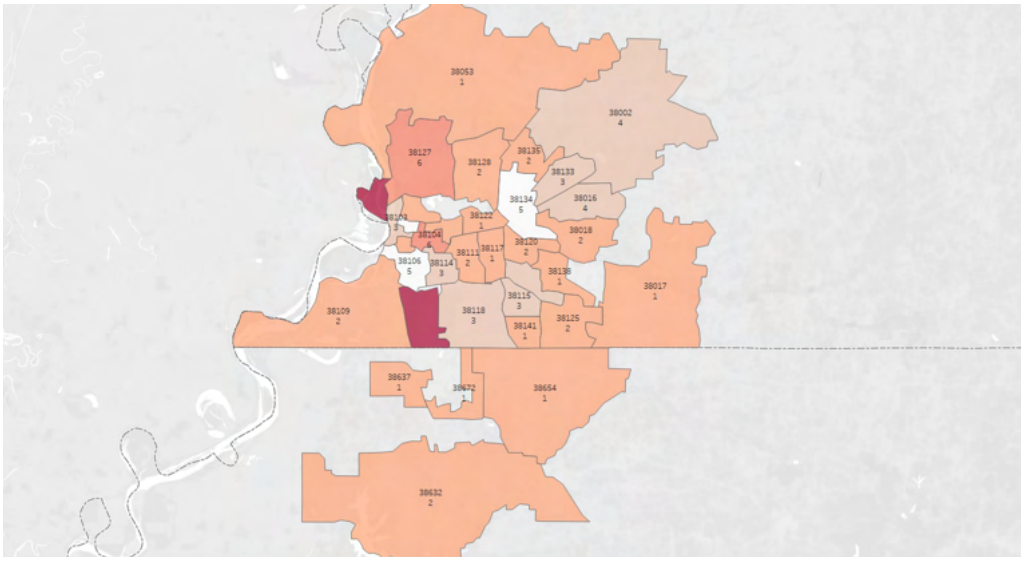


Figure 2: Participant Zip Code Map



DEMOGRAPHIC OVERVIEW

Participants were predominantly female (62%, followed by male (36%) and non-binary (2%) individuals. The racial composition included a majority of Black or African American (60%) participants and White or Caucasian (29%) participants, with smaller representation from Hispanic/Latino/a, Asian/Pacific Islander, and multiracial individuals (11%). This racial distribution aligns closely with the demographics of the communities most impacted by health disparities within Shelby County, particularly in high-poverty zip codes.

EDUCATIONAL ATTAINMENT

Educational attainment among focus group members was generally high, with the largest share holding bachelor's or graduate degrees, followed by those with associate's degrees or some college experience.

HOUSEHOLD INCOME

Household income varied widely, with the highest proportion reporting incomes of $100,000 or more, followed by mid-range earners between $50,000 and $99,999. A smaller portion reported incomes below $30,000, representing participants from community-facing organizations and service providers who work closely with vulnerable populations. This is compared to the Shelby County median income of $51,211 as of 2025.

AGE AND MARITAL STATUS

Age distribution showed a balanced mix across working-age adults, with the largest groups between 35–44 (19 participants) and 45–54 (20 participants), followed by younger participants aged 18–24 (17) and older adults aged 55–64 (16). Most participants identified as single (49) or married (41), with a small number separated, divorced, or widowed. This mix contributed to diverse perspectives across life stages and family structures.

GEOGRAPHIC REPRESENTATION

The geographic distribution map illustrates participation across a wide range of Memphis and Shelby County zip codes, with notable concentrations in 38104, 38106, 38114, and 38127—areas historically associated with higher rates of poverty, chronic disease, and limited access to healthcare. Additional representation came from suburban and outlying zip codes such as 38134, 38133, and 38002, offering valuable insight into health concerns across urban and suburban populations.

Overall, the demographic and geographic data affirm that the 2025 CHNA focus groups captured input from a broad and representative cross-section of the community. This diverse participation strengthens the reliability of the themes identified—particularly around mental health, access to care, nutrition, safety, and housing—and ensures that the findings reflect both professional expertise and lived community experience.

TOP 5 THEMES PRESENTED IN 2025 FOCUS GROUPS

1. MENTAL HEALTH AND SUBSTANCE USE

Across nearly all 2025 CHNA focus groups (92%), participants identified mental health as one of the most pressing issues affecting Shelby County residents. Focus group participants repeatedly expressed concern about the limited availability of affordable, accessible, and culturally competent mental health resources. They emphasized that, while awareness of mental health has grown in recent years, services remain difficult to obtain—particularly for low-income families, youth, and uninsured adults. Participants noted that crisis response options are inadequate, and many individuals in mental distress rely on emergency departments or law enforcement as their only point of intervention putting a strain on law enforcement and EMS services where mental health professionals are needed

Several community members highlighted that stigma surrounding mental illness continues to deter individuals from seeking help. Others pointed to the absence of mental health professionals in schools and workplaces, stressing that early intervention and prevention are essential. First responders reported increased calls related to suicide attempts, depression, and anxiety, often exacerbated by social isolation, financial strain, and the lingering effects of the COVID-19 pandemic. Law enforcement and fire department representatives noted that they frequently encounter individuals experiencing mental health crises without adequate training or resources to connect them to care.

Substance use was described as a parallel and compounding concern. Participants reported a rise in opioid-related overdoses, particularly involving fentanyl and counterfeit prescription pills. They also noted ongoing alcohol misuse, especially among older adults, and a general normalization of substance use as a coping mechanism for stress or trauma. First responders described scenarios in which multiple doses of Narcan were required to revive a single individual, underscoring the potency of current street drugs. There were also mentions of growing abuse of prescription medications and the persistence of stigma and fear that prevent families from calling for help during overdoses.

Overall, participants linked mental health and substance use as interconnected challenges rooted in broader social and economic stressors. They called for expanded behavioral health integration within primary care settings, improved community education to reduce stigma, and more wraparound supports—such as case management, crisis stabilization units, and school-based counseling. Many recommended continued partnerships between hospitals, community organizations, and first responders to provide prevention, treatment, and recovery resources that are responsive to the needs of both youth and adults.

2. ACCESS AND NAVIGATION OF HEALTHCARE SYSTEMS

Multiple focus groups (83%) identified access to and navigation of healthcare as one of the greatest barriers to community well-being. Many community members described the healthcare system as confusing, overwhelming, and difficult to navigate—especially those managing chronic conditions, lacking insurance, or facing language and literacy barriers. A recurring sentiment was that people often “don’t know where to start” when seeking help, which leads to delayed treatment, unnecessary emergency room use, or untreated health conditions.

Several groups, including first responders, faith leaders, and disability advocates, emphasized the absence of consistent case management and follow-up support once individuals are discharged

from hospitals. Participants noted that although many hospitals provide discharge packets or referrals, the information is often inaccessible to patients in crisis or overwhelmed by medical jargon. This disconnect contributes to a cycle of readmissions, underutilized resources, and unmanaged chronic illness.

Affordability also surfaced as a major issue. Participants reported that even with insurance, high copays and limited provider networks discourage regular visits and preventive care. For uninsured or underinsured residents, the cost of medications, mental health counseling, and dental services were described as "prohibitive." Several groups discussed how transportation barriers, such as lack of personal vehicles or unreliable public transit, compounded these access challenges, particularly for those in rural or underserved neighborhoods.

Community members also stressed the need for healthcare systems to demonstrate greater cultural humility and to build trust among marginalized populations. Participants cited instances in which individuals felt dismissed, misunderstood, or discriminated against in medical settings. They recommended that hospitals and clinics increase their outreach through trusted community organizations, faith networks, and bilingual navigators who can guide patients through referrals, appointments, and health benefits enrollment.

Overall, focus group participants called for a more integrated, person-centered approach to healthcare access—one that combines affordability, education, and active navigation. They emphasized that improving communication, follow-up care, and cross-sector coordination between hospitals, nonprofits, and local agencies will be key to reducing preventable health disparities across Shelby County.

3. NUTRITION, PHYSICAL ACTIVITY, AND CHRONIC DISEASE PREVENTION

Focus groups participants frequently (#) discussed the relationship between nutrition, physical inactivity, and chronic disease prevention as a central concern for community health (67%). Many described unhealthy eating habits, limited access to affordable fresh foods, and a growing prevalence of sedentary lifestyles as driving factors behind rising rates of obesity, diabetes, and heart disease in Shelby County.

Residents and service providers highlighted the presence of "food deserts" in lower-income neighborhoods, where convenience stores and fast-food restaurants are far more accessible than grocery stores offering nutritious options. While some groups noted improvements—such as mobile food markets and community gardens—these efforts were seen as sporadic and not widespread enough to meet community demand. Affordability was also a major barrier, where even when healthy foods were available, the cost prohibitive for families struggling to meet basic needs.

Physical inactivity was another consistent theme. Participants noted that technological distractions (such as smartphones and iPads) and public safety concerns limit outdoor play for children and physical exercise for adults. Parents expressed that they are uncomfortable allowing their children to play outside, citing crime, traffic safety, and lack of well-maintained parks as concerns. Several community members commended municipalities for expanding green spaces and recreational events but noted that these opportunities are not equally distributed across Shelby County.

Healthcare professionals and first responders described how preventable chronic diseases—such as diabetes, hypertension, and cardiovascular illness—account for a large proportion of emergency calls and hospitalizations. They stressed the need

for earlier education about nutrition and exercise, starting in schools and extending into workplace wellness programs and senior services. Many also emphasized that healthy lifestyles must be framed as long-term habits, not short-term goals.

Overall, participants called for more coordinated community initiatives that make healthy living practical and affordable. Suggested strategies included expanding nutrition education, partnering with local grocers and farmers' markets, offering subsidized fitness programs, and improving walkability and recreational safety. Participants emphasized that promoting physical activity and good nutrition not only prevents chronic disease but also strengthens families, reduces stress, and builds a healthier, more connected community.

4. VIOLENCE AND COMMUNITY SAFETY

Violence and safety concerns emerged as major themes throughout the 2025 CHNA focus groups (75%). Participants across various professions—including first responders, educators, faith leaders, and parents—expressed that community violence continues to have a profound impact on both physical and mental health in Shelby County. Gun violence was identified as one of the most pressing and visible threats to public safety, affecting not only those directly involved but also families, neighborhoods, and children who experience chronic exposure to trauma.

Participants described an increase in firearm-related injuries, domestic violence incidents, and youth involvement in violent crime. Many linked these issues to underlying social stressors such as poverty, unemployment, substance abuse, and lack of positive outlets for young people. Several first responders and law enforcement officials noted that violence often intersects with mental health crises and substance use, creating complex situations that require coordinated, trauma-informed responses.

Community members voiced strong concerns about how fear of violence restricts daily life and contributes to broader health disparities. Parents shared that they are less comfortable allowing children to play outdoors or walk to nearby parks, limiting opportunities for physical activity and social connection. In some neighborhoods, participants said that ongoing gun violence has eroded trust among residents and created a sense of isolation. "You don't see kids on bicycles like you used to. Parents just aren't comfortable letting them play outside anymore—it's not like when we were growing up. Between traffic, crime, and all the stuff you hear on the news, most families keep their kids inside. It's sad because they miss out on being active and just being kids." (*Bartlett Fire Department Focus Group, 2025 CHNA Transcripts*)

Participants emphasized the need for violence prevention efforts that begin early and extend beyond policing. Suggestions included school-based programs, mentorship initiatives, conflict resolution education, and expanded youth engagement opportunities. Many also advocated stronger partnerships between hospitals, community organizations, and local government to address violence as a public health issue rather than solely a law enforcement matter.

Several groups commended ongoing outreach efforts, such as hospital-based violence intervention programs, firearm safety education, and the distribution of gun locks. They encouraged expanding these initiatives to reach more families and integrate them into broader community health strategies.

Overall, participants recognized that safety is foundational to health. Reducing violence and fostering safe environments were viewed as essential to improving mental well-being, encouraging outdoor activity, and rebuilding trust across communities. Participants urged continued collaboration

among public safety agencies, healthcare providers, and neighborhood organizations to create sustainable, community-driven solutions that address both the causes and consequences of violence.

5. HOUSING AND SOCIAL DRIVERS OF HEALTH

2025 CHNA focus groups (58%) identified housing and broader social drivers of health as critical factors influencing the well-being of residents across Shelby County. Participants described how inadequate, unstable, or unaffordable housing contributes to a cycle of poor health outcomes—exacerbating chronic disease, stress, and mental health challenges. Many participants emphasized that without stable housing and reliable access to basic needs, efforts to improve physical or behavioral health are often unsustainable.

Community members, social service providers, and faith leaders noted that many families are living in substandard housing conditions and experiencing issues with mold, pests, poor insulation, and inadequate heating or cooling systems. These environmental factors were linked to respiratory conditions such as asthma and other chronic illnesses, especially among children. Several groups cited the need for expanded partnerships with housing authorities, landlords, and code enforcement to improve living conditions and reduce preventable health hazards.

Affordability was a recurring theme. Participants explained that the cost of rent and utilities has risen sharply while wages have remained stagnant, leaving many working families on the brink of eviction or homelessness. The lack of affordable housing was described as a root cause of instability that impacts nearly every other aspect of health—from nutrition and medication adherence to access to education and employment. Some participants also noted that the stigma surrounding homelessness prevents many individuals from seeking assistance until they are in crisis. “A lot of people won’t ask for help until they’ve lost everything. There’s still so much judgment tied to being homeless or even just struggling to pay rent. Folks are embarrassed, so they try to handle it on their own until it becomes a crisis—and by then, it’s so much harder to get them stable again.” (CHN Faith Leaders Focus Group, 2025 CHNA Transcripts)

Broader social drivers such as transportation, education, and employment were also highlighted as contributors to community health and wellbeing. Participants described how limited public transit options make it difficult to reach healthcare providers, grocery stores, or job opportunities. Others emphasized that financial insecurity and low literacy levels restrict access to community resources and healthy lifestyles.

Focus group participants called for a holistic approach that recognizes social factors like housing, income, and neighborhood safety as essential components of community health. Recommendations included expanding affordable housing initiatives, increasing case management and rental assistance programs, improving public transportation routes, and strengthening cross-sector collaboration between hospitals, nonprofit organizations, and local government.

Overall, participants viewed housing stability and access to essential social support as the foundation upon which health equity must be built. By addressing these underlying social drivers of health, communities can move beyond temporary fixes and toward long-term improvements in health, safety, and quality of life for all residents.

QUALITATIVE ANALYSIS OF FLIP CHART ACTIVITY

ABSTRACT
This analysis summarizes findings from a participatory flip chart activity conducted with community focus group participants. The exercise gathered community perspectives on two key domains: (1) valuable resources currently available; and (2) gaps in services that hinder community well-being. Results indicate that participants identified a mix of formal institutional support (health programs, nonprofit services, government initiatives) and informal support (churches, community centers). Conversely, perceived gaps emphasize systemic issues—such as limited access to affordable health care, inadequate lead safety measures, insufficient childcare, and unmet needs in food security and substance use treatment. This dual focus reveals a resourceful and resilient community constrained by persistent service fragmentation and underfunding.

METHODOLOGY
Participants engaged in a flip chart/Post-It note activity at the conclusion of focus group discussions. Two categories were presented on large sheets of paper:

- "Valuable Resources" in the community
- "Gaps in Services" in the community

Each participant was given two Post-It notes—one for each category. They independently wrote their answers and posted them to the corresponding flip chart. The results were transcribed into Excel, with one tab for each category. A qualitative coding approach was used to identify recurring themes, patterns, and notable outliers within the lists of responses.

RESULTS

Valuable Resources
Participants highlighted a wide range of formal community resources, particularly:

- Health and Environmental Programs: City/County Lead Programs, Shelby County Lead Program, Healthy Homes Partnership, Lead Hazard Reduction Program (LHRP), Green & Healthy Homes Initiative.
- Nonprofit and Social Service Providers: MIFA, Boys and Girls Club, YMCA, CCR+R (ChildCare Resource & Referral).
- Faith-Based Networks: Churches repeatedly mentioned as trusted community anchors providing support, resources, and outreach.
- Hospital and Medical Institutions: Le Bonheur, local doctors, and healthcare providers named as central to resource availability.
- Targeted Grants and Housing Supports: Programs for families facing homelessness or housing insecurity.

Emerging Themes:

- Heavy reliance on lead abatement and healthy homes programs suggests the issue of environmental hazards remains top-of-mind.
- Churches are community hubs that serve communities beyond spiritual roles, filling gaps in material and social support.
- Youth development organizations (YMCA, Boys & Girls Clubs) are considered highly valuable for children's health and development.

Gaps in Services

Participants identified systemic gaps and pressing unmet needs:

- Housing and Safety Enforcement: Strategic code enforcement, tenant rights, and inadequate follow-up on housing conditions.
- Public Health and Environmental Protection: Calls for mandatory child lead testing (pre/post for school entry), free water testing kits, and stronger precautions around health and safety.
- Substance Use and Addiction Support/Recovery/Treatment Services: Explicit mentions of inadequate facilities for people struggling with drug addiction.
- Food Security: Food shortages remain a recurring concern.
- Childcare and Early Education: Lack of available providers, insufficient follow-ups, and gaps in parent understanding of programs. Disconnect noted between CLPPP and school support programs.
- Access and Equity Issues: Lack of funding, language barriers, and lack of knowledge cited as structural obstacles.
- Healthcare Access: Specific mention of a need for clinics not requiring insurance, plus shelters for uninsured individuals.

Emerging Themes:

- Strong demand for systematic lead screening and environmental protections indicates persistent worry about children's health.
- Resources are not equitably distributed and gaps can be attributed to lack of funding, inadequate infrastructure, or barriers in knowledge or accessibility.
- Family-centered needs such as childcare, food, and housing issues disproportionately affect the well-being of underserved families.

DISCUSSION

Several insights can be speculated when comparing the “resources” and “gaps” lists:

1. Lead Services: Both a Strength and a Weakness
Participants value existing lead prevention programs, but their presence in the “gaps” list suggests a perception of insufficient coverage, underfunding, or lack of coordination. This duality may reflect that programs exist but are inaccessible, fragmented, or inadequate to meet demand.

2. Churches as Fallback Institutions
While churches are praised as resources, this may also indicate service gaps left by formal institutions. This reliance could suggest insufficient investment in secular or government-backed programs.

3. Healthcare & Child Services as Persistent Barriers
The recurring concern with access to care for un/underinsured, childcare shortages, and parent education points to system-level gaps that individual organizations cannot fill alone. This suggests a need for policy reform or larger-scale investments.

4. Community Knowledge and Navigation
The mention of “lack of knowledge” as a gap suggests that information sharing, outreach, and service navigation are just as important as the services themselves. People may not know where to go or how to access available programs.

5. Food and Addiction Services as Underserved Domains
These were mentioned as critical but neglected areas, suggesting that while housing and environmental issues get attention, other health-related concerns remain sideline.

COMPARATIVE ANALYSIS: 2022 VS 2025 FOCUS GROUP RESULTS

NARRATIVE SUMMARY
A review of the 2022 and 2025 CHNA Focus Group findings reveals both continuity and evolution in community concerns. While ‘Mental Health’ and ‘Access to Healthcare’ remain among the top priorities, the 2025 findings demonstrate a growing emphasis on holistic approaches to addressing broader Social Drivers of Health (SDOH). Participants increasingly recognize that issues such as housing, violence, and food security are deeply intertwined with health outcomes.

Themes like ‘Violence and Community Safety’ emerged as standalone health priorities in 2025, reflecting the community’s evolving view of safety as a determinant of both mental and physical well-being. Housing has transitioned from being an isolated concern to a core foundation of health equity. Moreover, there is a stronger recognition of prevention strategies—nutrition education, chronic disease management, and youth engagement—as essential components of community wellness.

Comparison Table

THEME	2022 FINDINGS	2025 FINDINGS
Mental Health	High concern with stigma and lack of accessible, affordable mental health resources.	Continued as top concern; greater focus on substance use, trauma-informed care, and early intervention.
Healthcare access & navigation	Difficulty navigating healthcare system, distrust, affordability, and cultural barriers.	Stronger calls for patient navigation, follow-up care, and equitable access through community partnerships.
Housing	Homelessness and housing instability noted as barriers to health and safety.	Framed as central social driver affecting all other health domains; focus on affordability and environmental hazards.
Nutrition & physical activity	Emerging concern tied to poverty and chronic disease, limited resources for healthy foods.	Fully developed theme linking food insecurity, chronic illness prevention, and neighborhood safety.
Violence & community safety	Mentioned indirectly under stress and trauma.	Elevated as a distinct health determinant; emphasis on gun violence, trauma recovery, and prevention efforts.
Knowledge of resources	Low awareness of programs; participants desire clearer communication and guidance.	Progress toward improving outreach, education, and resource navigation through community organizations.
Poverty & economic stability	Persistent cross-cutting barrier affecting all aspects of health.	Integrated into SDOH framing; focus on sustainable solutions and policy-level collaboration.

FOCUS GROUP DEMOGRAPHICS

The CHNA included 13 focus groups with a total of 109 participants.

Table 1: Participant Demographics Overview
This table summarizes the participant data for sex and race/ethnicity, including the concrete numbers mentioned in the write-up.

Demographic Category	Group	Count (n=109)	Percentage
Sex	Female	61	56.0%
	Male	35	32.1%
	Non-binary	2	1.8%
	Not Reported/Other	11	10.1%
Race/Ethnicity	Black or African American	58	53.2%
	White or Caucasian	28	25.7%
	Hispanic/Latino/a	Smaller Representation	N/A
	Asian/Pacific Islander	Smaller Representation	N/A
	Multiracial	Smaller Representation	N/A
	Not Reported/Other	23	21.1%

Note: Percentages are approximations based on the total participant count of 109. The smaller racial/ethnic groups and the sex groups that do not sum to 109 are grouped into 'Not Reported/Other' for the purpose of this calculation.

Figure 3: Participant Age Distribution
The data shows a balanced mix of working-age adults, with the 35–54 age range being the largest segment.

Age Group	Count (n=109)
18–24	17
35–44	19
45–54	20
55–64	16
Other/Not Reported	37

Figure 4: Participant Marital Status
The majority of participants identified as single or married.

Marital Status	Count (n=109)
Single	49
Married	41
Separated, Divorced, or Widowed	Small Number
Other/Not Reported	19

TOP 5 THEMES AND GEOGRAPHIC REPRESENTATION

The focus groups captured input across 12 professional and community-based categories and a wide range of Memphis and Shelby County zip codes.

Table 2: Top 5 Themes from the 2025 CHNA Focus Groups

	Theme	Key Concerns Identified
1	**Mental Health and Substance Use**	Limited affordable/accessible resources, stigma, inadequate crisis response, rise in opioid/fentanyl overdoses.
2	**Access to Healthcare and Navigation**	Confusing system, affordability (high copays/uninsured costs), lack of case management/follow-up, transportation barriers, need for cultural humility.
3	**Nutrition, Physical Activity, and Chronic Disease Prevention**	Food deserts, high cost of healthy food, sedentary lifestyles, safety concerns limiting outdoor activity, rising rates of preventable chronic diseases.
4	**Violence and Community Safety**	Gun violence, domestic violence, youth trauma exposure, fear restricting daily life (e.g., outdoor play), need for early prevention.
5	**Housing and Social Drivers of Health**	Inadequate/unstable/unaffordable housing, substandard conditions (mold, pests), rising rent/utility costs, interconnected challenges with transportation, education, and employment.

GEOGRAPHIC DISTRIBUTION HIGHLIGHTS

Participation showed notable concentrations in zip codes historically associated with higher rates of health disparities:

- High-Concentration Areas (High-Poverty): 38104, 38106, 38114, and 38127.
- Suburban/Outlying Areas: 38134, 38133, and 38002.

Comparison of 2022 vs. 2025 CHNA Themes

Theme	2022 Key Focus	2025 Key Evolution
Mental Health	Stigma, lack of resources.	Stronger focus on **substance use**, trauma-informed care, and early intervention.
Healthcare Access & Navigation	Affordability, cultural barriers, navigation difficulty.	Stronger calls for **patient navigation**, follow-up care, and equitable community partnerships.
Housing	Instability/homelessness as a barrier.	**Framed as a central social driver** affecting all health; focus on affordability and environmental hazards.
Violence & Community Safety	Mentioned indirectly (under stress/trauma).	**Elevated as a distinct health determinant** (gun violence, trauma recovery, prevention).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