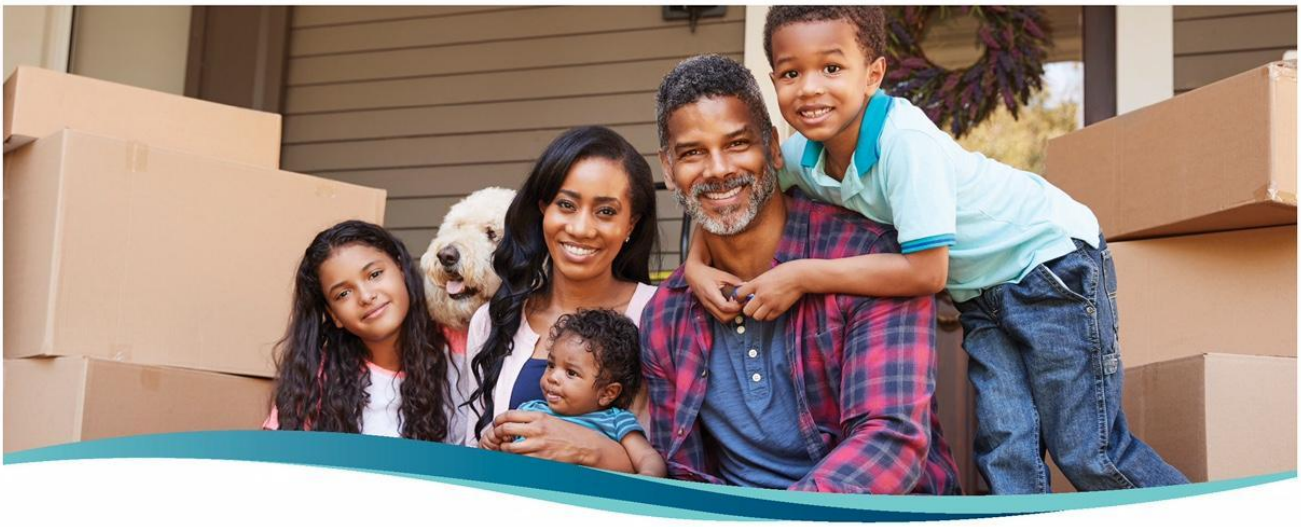

– 2021 –

Community Health Care Needs Assessment

CHESAPEAKE REGIONAL HEALTHCARE

ChesapeakeRegional.com

This Community Health Needs Assessment was conducted by The Planning Council.

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- Behavioral Health
- Lifestyle Center
- Chief Executive Officer
- Chief Nursing Officer
- Emergency Department
- Sleep Center
- Women's Wellness Wednesdays

CHIP of South Hampton Roads
City Manager's Office – Chesapeake
Coastlands Community Church

Chesapeake Care Clinic
Chesapeake Department of Human Services
Chesapeake Public Health Department

- Director's Office
- Environmental Health

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Chesapeake Redevelopment and Housing Authority
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EXECUTIVE SUMMARY

Located within the heart of the city, Chesapeake Regional Healthcare (CRH) continues to grow and expand avenues for providing healthcare outside the walls of the Chesapeake Regional Medical Center that was established in 1976 as an independent, community-based hospital. The hospital is also conveniently located just 15 miles above the state border with North Carolina, and central to the five cities of South Hampton Roads in Virginia, accessible by main freeways and roads. Chesapeake Regional consists of 310 licensed and staffed beds, over 600 physicians, and a full staff of over 2,300 persons. The hospital is a key provider for residents not only in Chesapeake, but throughout eleven counties of northeastern North Carolina (more than 13% of total patients), and surrounding cities in South Hampton Roads.

Since the last Community Health Needs Assessment was conducted in 2018, Chesapeake Regional Healthcare has been successful in adding multiple new services to better serve its communities, including:

- Establishing a Wellness Hub and Retail Pharmacy in South Norfolk to address gaps in services and access to care;
- Partnering with Chesapeake Integrated Behavioral Health, the Police and Sheriff's Departments to stand up a Crisis Intervention Team Assessment Center to address mental health emergencies;
- OB Hospitalists Program;
- Neurosurgery / Stroke Program;
- Stereotactic Radiosurgery partnership with University of Virginia and Riverside Health;
- OB Emergency Department;
- Birth Place's Ask-a-Nurse video visits for L & D, lactation, newborn, and postpartum care;
- Pain Management;
- Fixed PET/CT Imaging;
- Expanded Diagnostic imaging;
- PROUD program to treat those with opioid addiction;
- Expanded Primary Care and Specialty care practices in Virginia and North Carolina; and
- Numerous health promotion outreach events, including Women's Wellness Wednesdays.

Chesapeake Regional is committed to expanding service delivery and meeting the evolving needs of the community by implementing new technologies and interventions, delivering care where and when it is most effective.

Collective Impact in Chesapeake

Residents of Chesapeake benefit from a strong collaborative partnership established between Chesapeake Regional, the Health Department, and Healthy Chesapeake. With strong support from city leadership, these three entities work together to improve the health outcomes of all they serve, sharing the responsibility of reducing health burdens and implementing health promotion activities. This partnership consistently conducts comprehensive studies that engage the community and create community ownership for public health issues.

In 1962, Norfolk County and the City of South Norfolk merged to form the City of Chesapeake and thus was born the **Chesapeake Health Department**. In the early days, the health department did not hold clinics within the health department building. Instead, nurses would travel to schools and neighborhood front porches to give immunizations carried in a square wooden box with a leather handle. Nurses also served as home visiting health educators teaching families modern medical techniques and midwifery. Public health leaders understood the importance that relationships, trust, and community involvement played in the prevention and spread of disease.

Today, this concept is more important than ever. A diverse coalition of stakeholders, constituents, civic and private partners working together towards a common goal fosters a dynamic understanding of the roadblocks and rewards inherent in the pursuit of societal wellbeing. Mental, physical, emotional, financial, and educational health play a fundamental role in overall population health. Strong community partnerships enable public health to reach people when and where they need help the most, build trust, encourage progress, and enable sustainable change for a healthier future.

The Chesapeake Health Department ensures access to public health services such as:

- Family Planning Clinics
- Sexually Transmitted Infections Clinic
- Immunization Clinics
- Women Infant Children (WIC)
- Environmental Health
- Vital Records
- Home Visiting
- Long Term Services and Supports (LTSS)

Healthy Chesapeake is a non-profit that was established in 2016 as a multi-agency initiative to address areas identified by the Virginia Health Opportunities Index where Chesapeake needed improvement. Healthy Chesapeake serves as the designated Population Health manager for the Health Department and works toward fulfilling its mission to build a culture of wellness that supports, sustains, and advocates for a healthier Chesapeake. Key programs include:

- Addressing food insecurity through community gardening, healthy food donations, and nutrition education
- Chronic disease management and education through The Hub in South Norfolk
- Art and entertainment programs for youth and seniors
- Mobile Integrated Healthcare Program to serve those without transportation

As the COVID-19 pandemic effected Virginia in 2020, all three entities acted quickly to safely provide their services in new ways. Testing, education, infectious disease treatment, and the provision of regular services were affected

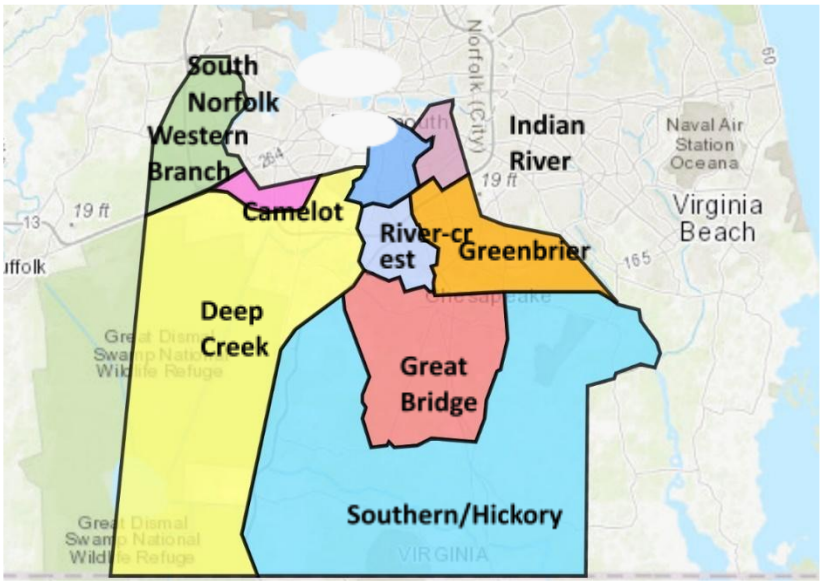
and, in most cases, expanded to meet the changing needs. In addition, new partnerships were quickly established or strengthened to provide much needed food to an overwhelming number of people in need. Additionally, agencies offered activities to address isolation and disparities that were magnified by the public health emergency and continue to do so today.

In just a few short years, Healthy Chesapeake has improved health and exercise behaviors for both young and older citizens. Managed by a staff of five persons, along with volunteer support and dozens of partnerships, it has engaged hundreds of citizens who have learned how to grow their own fresh food, access affordable healthcare, and manage their own health conditions at home. The most recent evaluation of its work also demonstrated decreased hospital stays and emergency room utilization for patients who participated in the mobile integrated healthcare program.

In 2008, establishing a community engagement and planning process was identified as a Strategic Issue that Chesapeake has addressed head on. By solidifying partnerships with faith-based organizations, city agencies, citizens and other service providers, the city has made great strides to improve service delivery coordination. With these collaborations, all agencies can continue to design innovative approaches that address numerous areas of health concern. And by expanding these pilot programs, the hospital can reach more of the efforts of all parties move Chesapeake forward to being the healthiest community in Virginia.

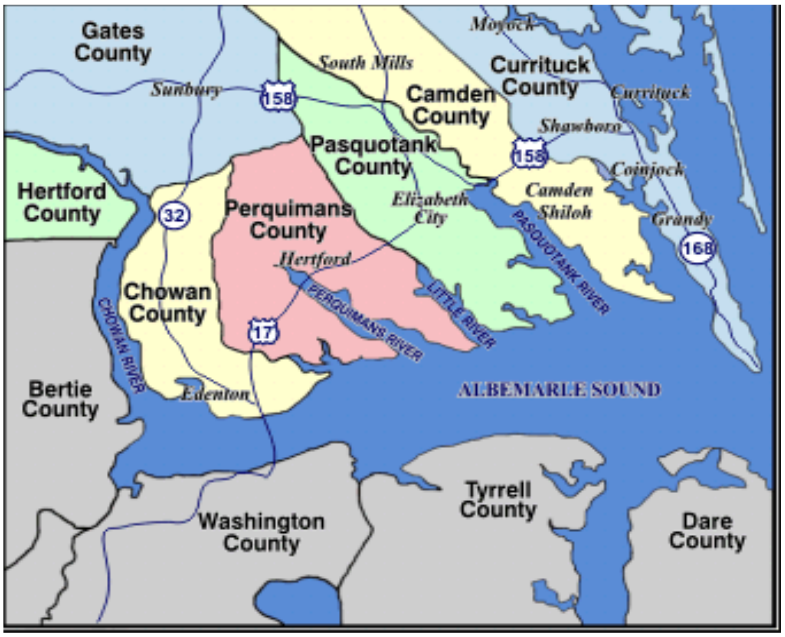
Service Area

Below are maps of the primary service area which include the 9 boroughs of Chesapeake and 11 counties in northeastern North Carolina that CRH serves.



Virginia

North Carolina



INTRODUCTION

A Community Health Needs Assessment (CHNA) is an examination of the health status of a population as well as key assets and challenges related to health in a community. The assessment process engages community members and local public health system partners to collect and analyze health-related data from many sources. Data gathered is both quantitative and qualitative to include experiences and opinions of the residents within the communities. This is used to assist with prioritization of health service delivery and to design new strategies where gaps are identified.

This CHNA identifies health-related needs and strengths identified within the City of Chesapeake, Virginia, and eleven counties of northeastern North Carolina. This study informs the development of community health improvement plans and new services. The CHNA describes health broadly to include clinical health, health behaviors, social and economic factors, and environmental factors that impact the health status of community residents. The CHNA process is a collaborative effort of Chesapeake Regional Healthcare, the Chesapeake Health Department, and Healthy Chesapeake, and is updated every three years.

Methodology

Within this Community Health Needs Assessment is input from over 1,900 persons living and working in Chesapeake, northeastern North Carolina, and neighboring localities of Hampton Roads. To gather feedback and input into both social and health issues, several tools were utilized to reach a large audience.

- Quantitative data analysis utilizing the ***Community Health Status Assessment***
- Qualitative data collection and analysis through a ***Community Needs Survey*** and ***Key Stakeholder Interviews***
- ***Local Public Health System Assessment***

Community Health Status Assessment

The **Community Health Status Assessment** gathers information regarding health status, quality of life, disease trends and risk factors that affect a community. The data can be used to demonstrate the foundation of health issues that need to be addressed in order to allow for citizens to live a healthy lifestyle and seek care for any physical, mental, or emotional health issues.

The data in this report are gathered from various federal, state, and local sources. In some graphs, multiple years of data are displayed to show any increase or decrease in data elements, as well as a comparison of numbers and rates to the state level (and sometimes national) to demonstrate where the City of Chesapeake fares better or worse.

Within this CHNA data was collected and reported separately for Virginia and North Carolina where possible. Graphs, tables, and charts represent demographic and population data, health rankings, hospital data, community health profiles, socioeconomic factors, and health behaviors and outcomes.

Community Themes and Strength Assessment

A comprehensive **Community Needs Survey** was developed and, in collaboration with multiple agencies and partners, advertised widely and available for 90 days, both online and in hard copy throughout Chesapeake and North Carolina counties. An outreach consultant (Bibbs Consulting, LLC) was also engaged to distribute the survey

in low-income communities, and particularly in communities of color, to explain the survey, relay the goals of the assessment and foster a sense of trust toward gathering information for the hospital.
The community survey was completed by 1,857 people throughout the service area; 1,333 (75% of respondents) were from Chesapeake, 287 (16%) were from northeastern North Carolina, and 148 (8%) reported working but not living in Chesapeake. Thirty-five (35) key stakeholder interviews were conducted with representatives of local government, healthcare, and community partner agencies within the City of Chesapeake and counties of northeastern North Carolina, including regional service providers.

Data analytics and related information were provided by an intern from the University of North Carolina Wilmington about sample size and margin of error to help determine if the demographics of survey respondents are representative of the demographics of the community residents. This is important so that the *reported* community needs can be considered reflective of the *true* community needs. Calculations were made for three historically underserved populations in Chesapeake: Blacks/African Americans, Hispanic or Latino persons, and those living in the northern boroughs of Chesapeake. Based on the number of Black/African American and Hispanic or Latino survey respondents, we can say with 95% confidence that the survey is reflective of the Black/African American population (2.5% margin of error) and Hispanic or Latino population (2.48% margin of error). The number of survey respondents from each of Chesapeake's boroughs varied widely, and the margin of error at a confidence level of 95% ranged from 2.44% in Camelot to 9.79% in Rivercrest. A margin of error of 3% or less is excellent, and between 4% and 8% is generally considered acceptable.

The survey was made available at several community events with hospital, Health Department and Healthy Chesapeake representatives on hand to discuss the survey and help answer questions. The survey was also published and distributed in Spanish with a distinct link; however, only 4 surveys were completed in the Spanish language.

A copy of the complete survey results is included in Appendix A. A version of the survey results that only includes northeastern North Carolina is also included as Appendix B for those who would like to see those results separately. Open-ended survey responses are provided in Appendices C -G.

Throughout the summer and fall of 2021, thirty-five **Key Stakeholder Interviews** were conducted via telephone and virtual meeting platforms to elicit insight and opinions of persons holding key positions in the Chesapeake and North Carolina communities. They included heads of governmental departments, regional service providers, as well as leadership from the hospital, health department, cities, and counties.

Questions posed in these interviews focused on the strengths and weaknesses of the city and asked which issues should be prioritized in order to move forward. The diversity of expertise brought to light such issues as the environment, chronic disease management, mental health and substance use, land and economic development, early childhood education, safety, preventative care, underserved and at-risk populations, and highlighted notable disparities. Each person interviewed provided valuable input on the *why* and the *how* Chesapeake Regional could begin confronting community health weaknesses.

The Key Stakeholder Interview responses have been aggregated and reported for both Virginia and North Carolina separately. They are included as Appendix H and I.

Local Public Health System Assessment (LPHSA)

Through periodic assessment guided by model performance standards, health leaders can improve collaboration and integration among the many components of a public health system, and more effectively and efficiently use resources while improving health intervention services. The LPHSA is a valuable tool in identifying areas for system improvement, strengthening state and local partnerships, and assuring that a strong system is in place for effective response to day-to-day public health issues as well as public health emergencies. Communities who have conducted the LPHSA report numerous benefits, including:

- Improving organizational and community communication and collaboration by bringing partners to the same table;
- Educating participants about public health and the interconnectedness of activities, which can lead to a higher appreciation and awareness of the many activities related to improving the public's health;
- Strengthening the diverse network of partners within state and local public health systems, which can lead to more cohesion among partners, better coordination of activities and resources, and less duplication of services;
- Identifying strengths and weaknesses that can be addressed in quality improvement efforts;
- Providing a benchmark for public health practice improvements, by setting a "gold standard" to which public health systems can aspire.

The LPHSA tool describes an optimal level of performance and capacity to which all public health systems should aspire. Optimal standards provide every public health system – whether more or less sophisticated – with benchmarks by which the system can be judged. In comparing the current status to optimal benchmarks, systems are able to identify strengths and areas for improvement. In addition, optimal standards provide a level of expectation that can be used to advocate for new resources or needed improvements in order to better serve the population within a jurisdiction.[1]

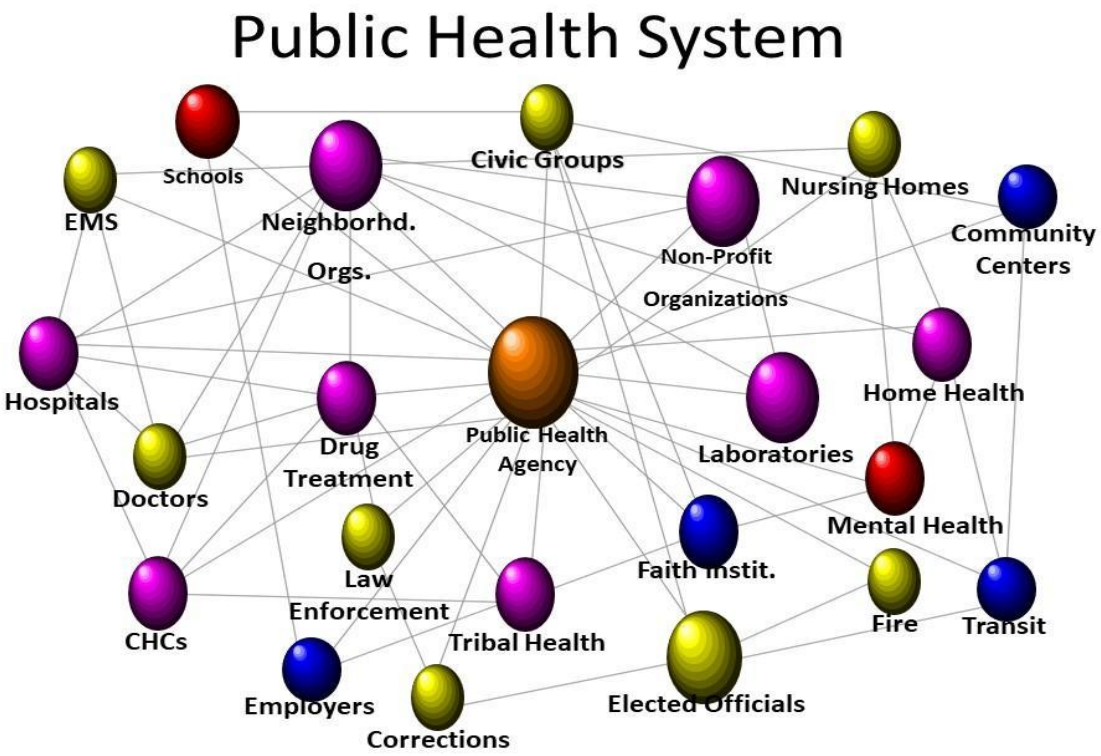
The ten Essential Public Health Services that are evaluated are:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

[1] National Association of City and County Health Officials guidance: https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp/phase-3-the-four-assessments

8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

The standards focus on the overall public health system, rather than a single organization. A public health system includes all public, private, and voluntary entities that contribute to public health activities within a given area. By focusing on the public health system, the contributions of all entities are recognized in assessing the provision of the Essential Public Health Services. All of these organizations play a role in working to improve the public's health.



Assessment meetings were held virtually throughout November 2021 with local representatives from Chesapeake city departments and leadership, health department staff, higher education and research partners, and various community agencies. Those who attended the meetings represent the primary organizations involved in the Chesapeake public health system and were able to confidently address most of the questions contained within the questionnaire. Results of the LPHSA are captured in Appendix J.

Social Determinants of Health

Health is affected by many conditions in the environment in which people live, learn, work, and play. Understanding and considering the many factors that affect health is critical to community health planning efforts. This CHNA is structured around the social determinants of health, aiming to address health in a broad sense.

Healthy People is a 10-year set of national objectives for health published by the Office of Disease Prevention and Health Promotion of the United States Department of Health and Human Services. Each decade, a new version of Healthy People is published with goals and objectives set for the decade. Since 2010, Social Determinants of Health has been added as a new topic. This highlights the impact of environmental and social factors on health outcomes. Examples of environmental and social factors that affect health include the availability of resources such as safe housing and local food retailers, access to education and job opportunities, public safety, transportation, and green space. Healthy People 2020 identified five key domains of social determinants: economic stability, neighborhood and built environment, health and health care, education, and social and community context. Social determinants of health can affect large groups of people disproportionately and are important to address in order to reduce health disparities.

Source: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

Data Limitations

As with the 2018 CHNA, this CHNA covers a broad range of topics; however, it is important to note the limitations to the research methods and data presented. The CHSA data, while comprehensive, does not include all data important to the health of Chesapeake and North Carolina residents. Secondary data were selected based on availability and are not necessarily prioritized. Survey results are also examined by respondent neighborhood and by annual income level to identify any additional findings that may be helpful to the hospital's planning process.

Additionally, self-report survey data is subject to scientific bias because it relies on individuals to recall information accurately and not to misrepresent information or misinterpret questions. Self-report questions are commonly used to measure health behaviors in national health surveillance and can generally be compared over time based on their consistent use and large sample sizes. While not statistically significant due to non-random sampling methods and small sample size, extensive efforts were made to include a wide variety of community participants with a range of experiences and perspectives.

Data in this report are often reported in categories of race and ethnicity to identify racial disparities. Data sources identify and report race and ethnicity categories in many different ways. The United States Census Bureau defines race as, "a person's self-identification with one or more social groups" and ethnicity as "whether a person is of Hispanic origin or not." Race and ethnicity are combined in the graphs and tables to demonstrate any disparities among potentially minoritized persons. Because Hispanic or Latino respondents can be of any race, their responses are already included in the totals for each table (and are not duplicated).

Every effort was made to identify and remove fraudulent survey responses that are becoming more common in online surveys. The Pew Research Center defines survey bots as "computer algorithms designed to complete online surveys automatically," and notes that if bots account for a few percentages of survey responses, that is often within the margin of error.[2]

[2] Pew Research Center website, Assessing the Risks to Online Polls From Bogus Respondents, February 2020. Bogus respondents and online polls - Pew Research Center Methods | Pew Research Center

STRATEGIC ISSUES

Strategic issues are those fundamental policy choices or critical challenges that must be addressed in order for a community to achieve its vision. A strategic issue is a key issue that is also long-term, has community impact, requires community resources, and will have consequences if not addressed. Throughout this entire assessment, certain themes were repeated – by key stakeholders during interviews, in open-ended responses within community surveys, and in research around community indicators. These are summarized here with supporting data and findings to support the issues identified throughout the assessments.

The top 5 Strategic Issues that emerged from survey respondents are:

1. **Access to care:** Of 978 survey respondents, 244 (25%) reported a need for more clinics, urgent care and primary care locations that are closer to their homes and easier to access. Many noted that current facilities are too far away, and some suggested mobile units that could provide in-home care and visits. In Chesapeake, there are 1,230 residents for every primary care provider which is similar to the state ratio of 1,330 residents per provider. But in northeastern North Carolina, there more patients per doctor, ranging from 1,390 in Hertford County to 6,710 residents per doctor in Perquimans County.[3] A closely related concern was the ability to get an appointment in a timely manner – many respondents noting a need for more doctors because it can take 3-6 months to get an appointment.

   In addition, survey respondents and those interviewed noted the need for more pharmacies, urgent care, medical specialty care, and primary care sites in northeastern North Carolina.

   Compared to the 2008 Strategic Issues noted in Chesapeake, access to medical care has improved, including the establishment of a Federally Qualified Community Health Center and a Retail Pharmacy in South Norfolk, as well as expanded medical and dental services at the Chesapeake Free Clinic.

2. **Mental health services:** Behavioral health, including depression and anxiety disorders, remain priorities for residents and professionals engaged in this CHNA, cited by many as a more urgent public health crisis since the start of the COVID-19 pandemic. Health professionals identified the lack of inpatient beds at Chesapeake Regional as a major gap and have worked toward the launch of a new unit of twenty beds, hiring appropriate medical staff, and complementing the work done at Chesapeake Integrated Behavioral Health. Specifically noted were children who are burdened by more behavioral health issues, and the effect of long-term isolation on all citizens, but on the elderly population, in particular. The pivot to virtual platforms for communicating and learning for these populations has posed additional stress and emotional distress. Long-term impacts remain to be seen but are something health and education professionals are aware of and working to diminish.

   Of 978 survey respondents, 240 (25%) also reported the need for more mental health care for people of all ages. Anxiety and depression were among the top concerns listed for respondents and their families, and the need for more mental health services was one of the most requested items in open-ended responses, as well as by key stakeholders. Chesapeake has 820 residents for every mental health provider, compared to just 530 residents per provider for Virginia.[4]

[3] Robert Wood Johnson Foundation, County Health Rankings and Roadmaps, 2021.
[4] Ibid.

3. **Affordable healthcare:** Participants interviewed and surveyed in this assessment were keenly aware of the burden of poverty on low-income households within Chesapeake, exacerbated and made more evident by the COVID-19 pandemic. Overall, the percent of poverty for All Households (9%), for Children (12%), and in particular for Single Parent Households (29%) has increased. Specifically noted as needs for low-income households were the affordability of fresh food and basic items, health insurance, prescription medications, and access to affordable and appropriate healthcare. Health data also illustrates that, typically, having a low income is associated with health risk factors, such as smoking, physical inactivity, and low participation in health screenings and health insurance.

   Of 978 survey respondents, 202 (21%) listed affordable healthcare as a top unmet need, citing a lack of insurance as a barrier to treatment, the inability to pay for doctor and hospital bills, and the high cost of all types of healthcare.

4. **Customer Service:** When asked how the community healthcare system can be improved, the 3 issues listed above were again at the top of the list. However, of 904 survey respondents to this question, 122 (13%) asked that the hospital and other healthcare providers improve their customer service. This included: 1) taking more time to listen to patients; 2) providing equitable treatment for patients from all races and socioeconomic backgrounds; and 3) improving bedside manner. Many survey respondents reported feeling ignored, rushed, and treated unfairly by the healthcare system. In a related survey question, 25% of Black/African American respondents reported that racial discrimination was a concern for themselves and their families.

5. **Transportation to Medical Appointments**

   Lack of public transportation is a widespread problem throughout the southeastern Virginia and northeastern North Carolina regions. However, survey respondents focused on *transportation to medical appointments* rather than a general need for transportation for other activities.

   While regional transportation agencies have focused on establishing bus routes in more populated areas that link residents to employment, other lifestyle elements - such as accessing schools, healthcare, and entertainment – are not typically offered. The infrequency of buses, and that they do not run many routes late or on weekends, limits the quality of life for many who do not own a personal vehicle. Both Chesapeake and North Carolina have made strides in the past decade to improve roads that were deemed insufficient for easy access and travel. Transportation options for the disabled remain lacking and are noted as an area of concern for many living on a fixed income.

Additional issues listed below have not been prioritized and are not presented in any particular order.

Chronic Diseases

There is cause for concern across Chesapeake and North Carolina for the prevalence of obesity and chronic diseases, along with related deaths, such as diabetes, Hypertension, and heart disease. In Chesapeake, there has been a decline between 2007 and 2018 in death rates due to Diabetes and Cerebrovascular and Lower Respiratory Diseases. However, disparities between African Americans and Whites demonstrate the progress is not always made equally. Public perception gathered during this assessment points out that lower income households and certain neighborhoods are perceived to have higher rates of chronic diseases and obesity, often due to the lack of access to parks and spaces to exercise, and healthy, fresh foods.

Substance Abuse

Due to decades of prescribing more opioids at higher doses, residents of both Chesapeake and North Carolina have all been affected by the opioid crisis. It is an epidemic that invaded households in every community and knows no barriers. Overdose and mortality rates in both states have increased since 2011, reaching as high as 20.4 per 100,000 in Chesapeake, and 49.1 per 100,000 in Hertford County, North Carolina. Anxieties and other behavioral health issues exacerbated by the pandemic are often named as the root cause of the most recent spike; however, the trend has been on the increase for a solid decade now. To tackle this issue, cities and counties are looking to expand prevention programs and community supports, while outpatient and inpatient treatment capacity are still very much lacking.

Housing

More than 35% of households in Chesapeake pay more than 40% of their gross monthly income on rent and utilities. For those 65 and older, the percent increases to 61%. In northeastern North Carolina counties range between 12 – 63%. Growth in population and housing developments continue at a steady rate but the affordability does not tend to keep pace with salaries and wages.

Fresh food/Nutrition

A food desert is often defined as any area where at least one-third of the population is located more than one mile or more from a supermarket. These citizens lack access to fresh, healthy, and affordable food, and are more likely to suffer longer-term health consequences due to it. Food deserts remain in Chesapeake although several entities are focused on increasing access through donations, prepared meal deliveries, starting community gardening and education programs for youth and elderly alike, and making Seed Libraries available in public libraries.

Elderly/Seniors

Numerous concerns about the quality of life for the aging population have become evident throughout these assessments, including access to affordable housing and health care; isolation; depression and anxiety; living on a fixed income; dental care; mobility and fragility issues, and securing affordable long-term care options. In rural northeastern North Carolina where services are sparse, regional agencies noted limitations in their ability to meet the need for programs such as in-home care and meal deliveries. The local EMS units are consistently called on to conduct simple tasks for elderly living alone who have mobility issues. Chesapeake is currently developing its updated plan to address the elderly population and preparing to adjust and increase services where needed.

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COMMUNITY HEALTH STATUS ASSESSMENT

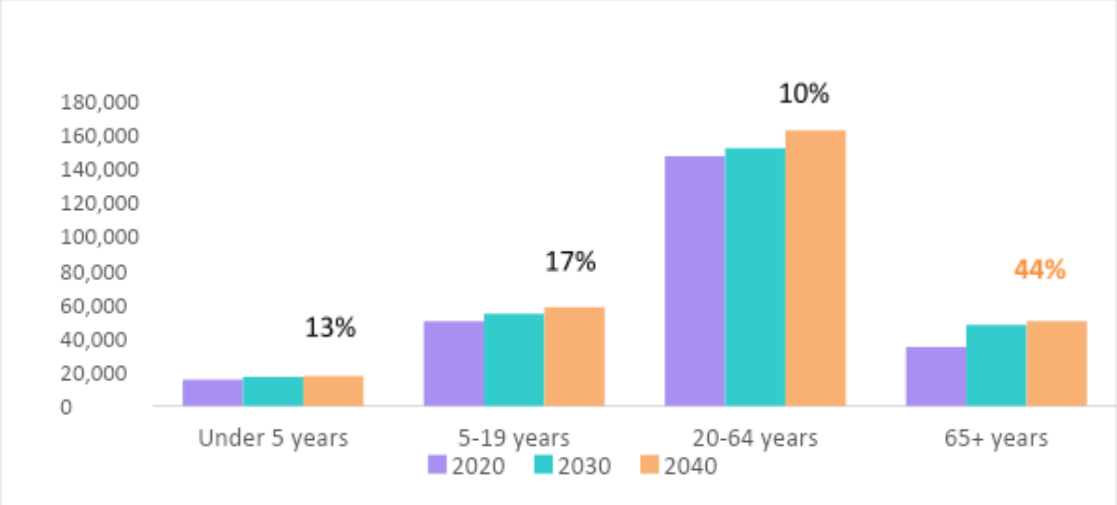
Demographics of Service Area

Chesapeake Population

The primary service area for Chesapeake Regional Healthcare includes the City of Chesapeake and eleven counties in northeastern North Carolina. The total service area population is 477,788 and population trends by age, race and ethnicity are demonstrated on the following pages.

The 2020 population of Chesapeake is 247,011, which is 3% higher than in 2017 when the last CHNA was conducted. By 2040, Chesapeake is expected to see its population grow to 287,913, an increase of 17% over 2020. The City's population is anticipated to increase in the age categories seen in the table and graph below, with an increase of 44% in the population aged 65 and older. The University of Virginia's Welden Cooper Center projects that by 2040, 18% of Chesapeake's residents will be over age 65, and 1 in 5 Virginians will be age 65 or older.

2020-2040 Chesapeake: Estimated Population Change by Age



Source: University of Virginia, Welden Cooper Center. Note: these estimates do not contain data from the 2020 Decennial Census.

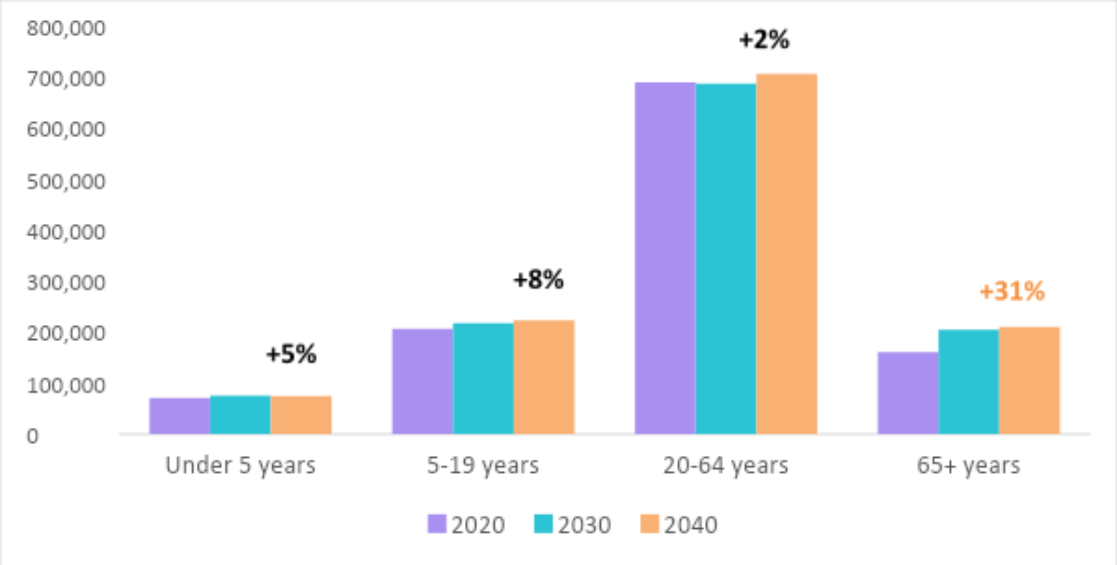
2020-2040 Chesapeake: Estimated Population Change by Age

Age	2020	2030	2040	Projected Growth 2020-2040
Under 5 years	15,489	17,001	17,543	13%
5-19 years	49,831	54,139	58,114	17%
20-64 years	147,083	151,715	162,433	10%
65+ years	34,608	47,651	49,823	44%
Total	**247,011**	**270,506**	**287,913**	**17%**

Source: University of Virginia, Welden Cooper Center. Note: these estimates do not contain data from the 2020 Decennial Census.

Because Chesapeake has the second largest population among the neighboring jurisdictions in the South Hampton Roads region, it is helpful to compare its population trends to those of nearby cities. The 2020 regional population grew by 1% from 2017 compared to Chesapeake's growth of 3%. By 2040, regional growth is projected to increase by 12% compared to Chesapeake's projected growth of 17%. The region's population change is anticipated in age categories seen in the graph and table below, with an increase of 31% in the population age 65 and older, ***compared to Chesapeake's growth of 44% in the population aged 65 and older.***

2020-2040 South Hampton Roads: Estimated Population Change by Age



Source: University of Virginia, Welden Cooper Center, Data Set: 7/1/2020 County Characteristics Resident Population Estimate, Note: these estimates do not contain data from the 2020 Decennial Census.

2020-2040 South Hampton Roads: Estimated Population Change by Age

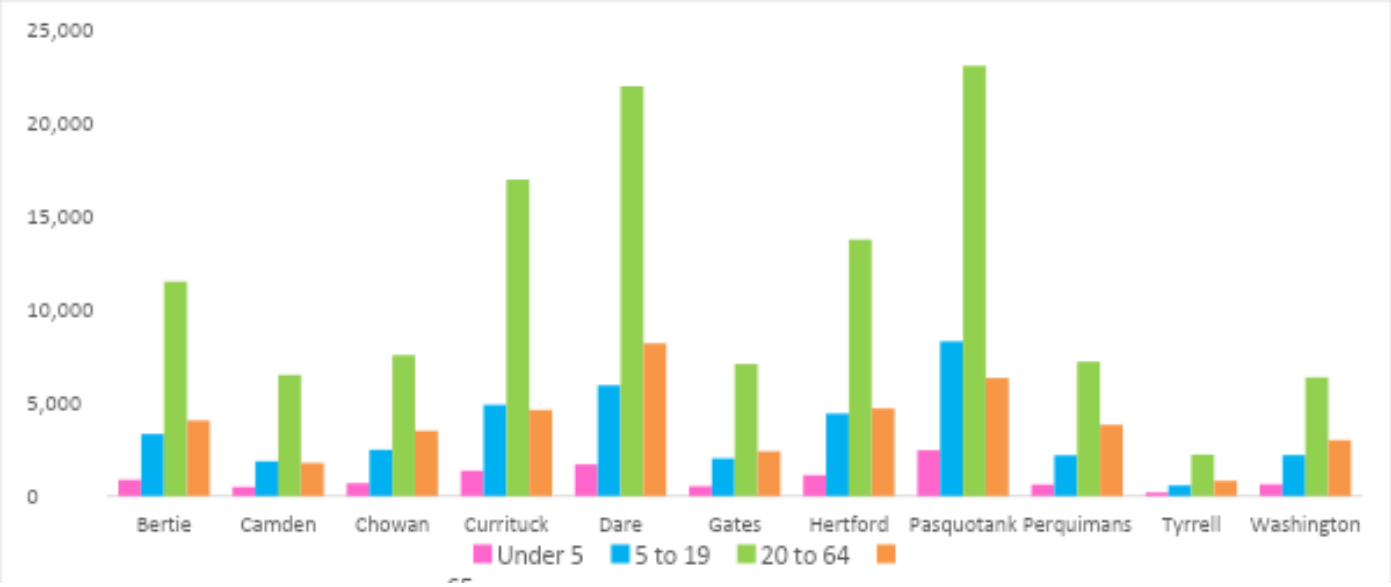
Age	2020	2030	2040	Projected Growth 2020 - 2040
Under 5 years	71,353	75,589	74,993	5%
5-19 years	207,001	218,361	223,326	8%
20-64 years	690,975	688,494	707,569	2%
65+ years	160,723	205,277	210,276	31%
Total	**1,130,052**	**1,187,721**	**1,267,317**	**12%**

Source: University of Virginia, Welden Cooper Center. Note: these estimates do not contain data from the 2020 Decennial Census.

Northeastern North Carolina Population

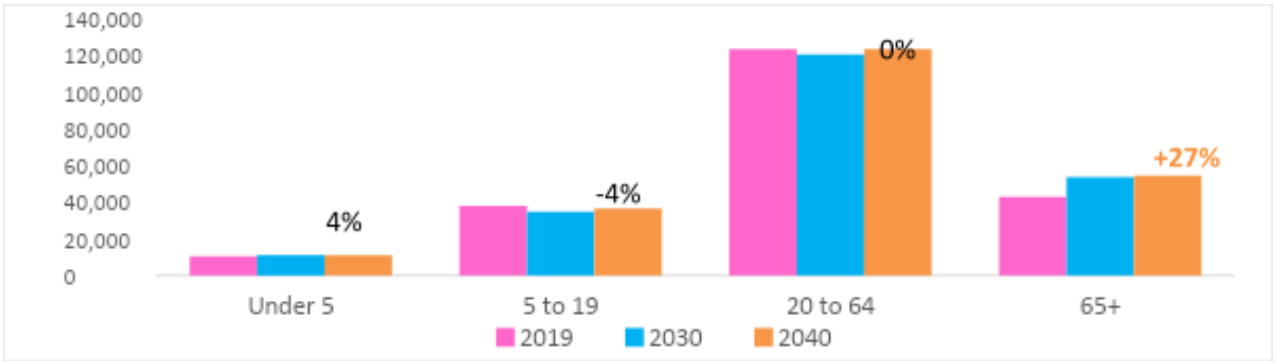
The eleven northeastern North Carolina counties included in this report are in the graph below and their combined 2019 population is 214,996. Between 2019 and 2040, the total population of this region is projected to increase by 5%, yet the population aged 65 and older is projected to increase by 27%.

2019 Northeastern North Carolina Estimated Population by Age



Source: North Carolina Office of State Budget and Management, Population and Demographics. 2019 was the most current year for population by age for each county.

2019-2040 Northeastern North Carolina: Estimated Population Change by Age



Source: North Carolina Office of State Budget and Management, Population and Demographics

2019-2040 Northeastern North Carolina: Estimated Population Change by Age

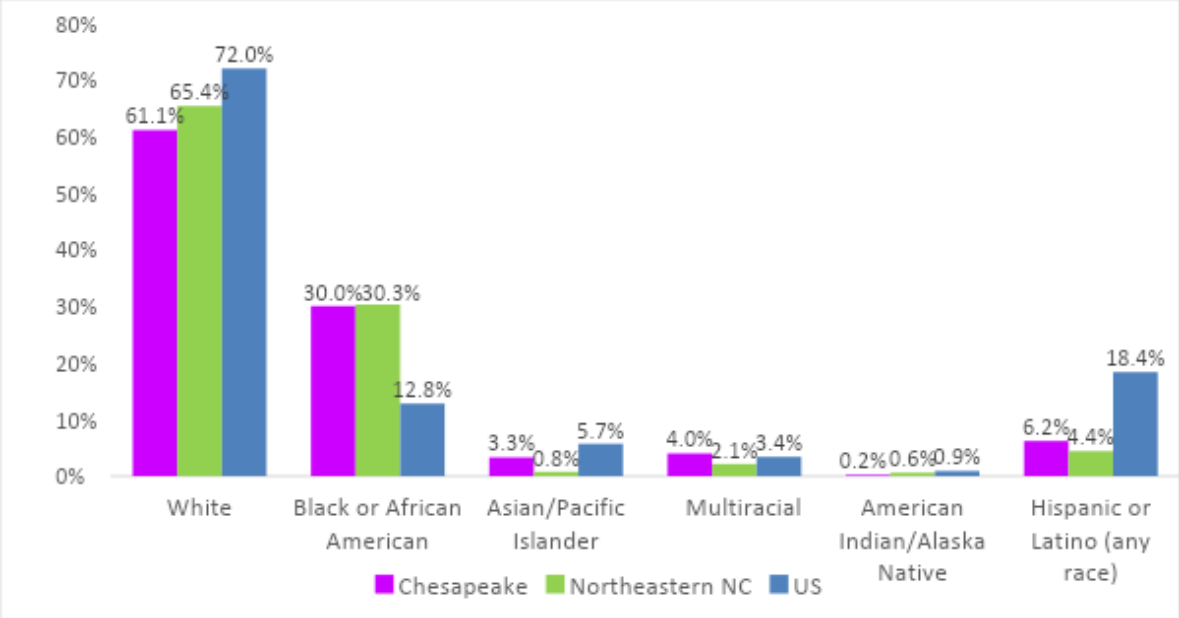
Age	2019	2030	2040	Projected Growth 2020 - 2040
Under 5 years	10,572	11,163	10,975	4%
5-19 years	37,956	34,990	36,468	-4%
20-64 years	123,529	120,807	12,715	0%
65+ years	42,939	53,701	54,502	27%
Total	**214,996**	**220,661**	**225,660**	**5%**

Source: North Carolina Office of State Budget and Management, Population and Demographics

Race and Ethnicity

In 2019, Chesapeake's population was 61% White, 30% African American, 4% Multiracial, and 3.2% Asian.

Race and Ethnicity: 2019 Comparison Among Chesapeake, Northeastern NC, and the US



Source: U.S. Census Bureau, American Community Survey, 2014-2019 5-Year Estimates, Table DP05

Chesapeake has a smaller percentage of Whites (61%) than northeastern North Carolina (65%) and the US (72%). Chesapeake has the same percentage of African Americans (30%) as the combined counties in northeastern North Carolina (30%) but a much higher percentage than the US (13%). In 2019, Chesapeake's Hispanic or Latino population was 6%, which is larger than the North Carolina region (4%) but much smaller than the US (18%).

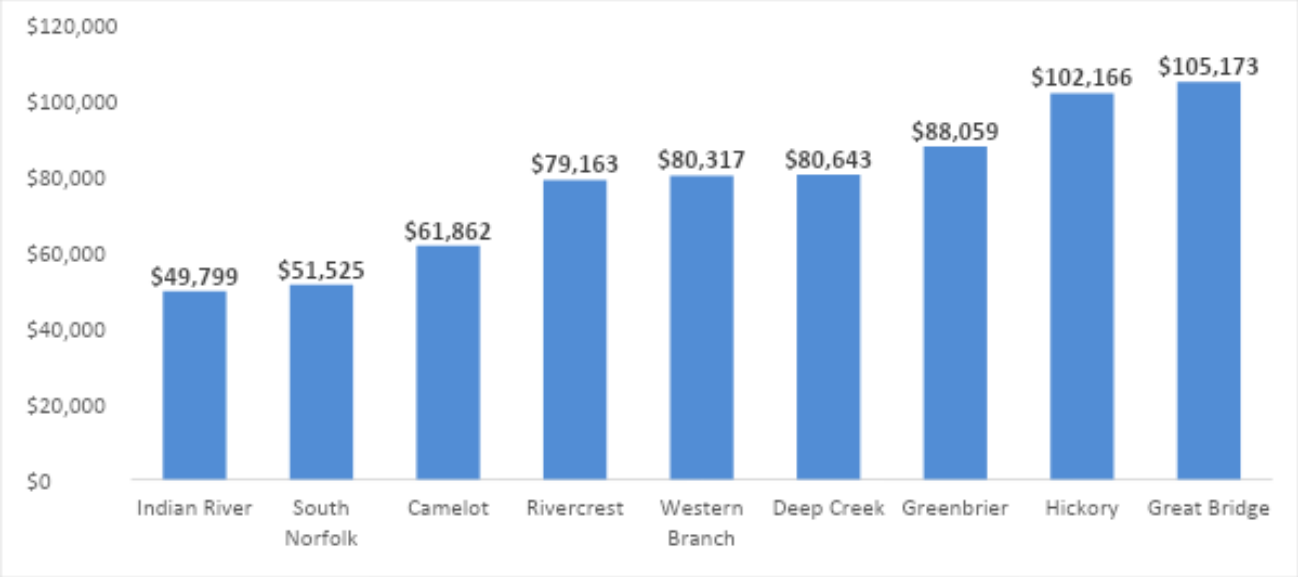
Race/Ethnicity	Chesapeake	Northeastern NC	Total Service Area
White	149,594	138,021	287,615
Black/African American	73,451	63,874	137,325
Asian/Pacific Islander	7,835	1,685	9,520
American Indian/Alaska Native	490	973	1,463
Multiracial/Other Race	13,466	4,523	17,989
Hispanic or Latino	14,824	9,313	24,137
Total	**244,835**	**211,134**	**453,912**

Source: U.S. Census Bureau, American Community Survey, 2014-2019 5-Year Estimates, Table DP05

Median Income

The 2019 median income in Chesapeake was $77,847, which is average for the South Hampton Roads region but higher than the state median income of $76,456. Median incomes in Chesapeake's boroughs range from $49,799 in Indian River to $105,173 in Great Bridge.

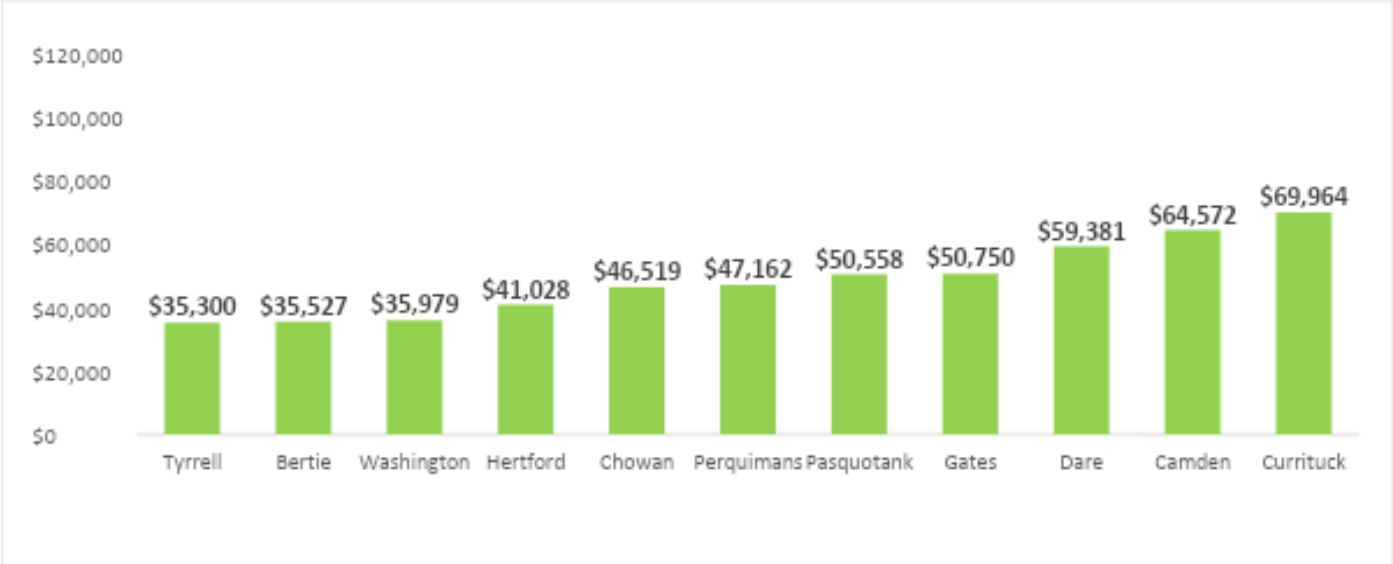
Chesapeake Median Income by Neighborhood



Source: Chesapeake, Virginia and South Hampton Roads data from U.S. Census Bureau, American Community Survey, 2019 1-Year Estimate, Table S1901; Neighborhood data from City-Data.com.

Northeastern NC Median Income by County

The median income in northeastern North Carolina ranges from $35,300 in Tyrrell County to $69,964 in Currituck County.



Source: U.S. Census Bureau, American Community Survey, 2014- 2019 5-Year Estimates, Table S1901.+

Emergency Department

Nationally, visits to Emergency Rooms have increased since the implementation of the Affordable Care Act in 2014.[5] However, in spring of 2020, the global COVID-19 pandemic resulted in a decrease of Emergency Room visits by 42% in the US. While visits did increase during 2020, they remain below pre-pandemic levels, most likely because people are wary of exposure to COVID-19 in the ER setting.[6]

Similarly, Chesapeake Regional's Emergency Room saw 38,843 unique patients in 2019 but just 32,320 in 2020. The table below demonstrates the various emergency care services provided since 2019 at Chesapeake Regional's Emergency Room. Infusions, Evaluation and Management, and Radiology continue to comprise the largest percentage of encounters for the ER.

Encounters	2019	2020	2021 Pro-Rated	Total Encounters
Miscellaneous Services OP (+95% Infusions)	19,462	16,487	16,944	52,893
Evaluation and Management OP	13,158	11,314	10,241	37,714
Radiology OP (+90% X-Rays and CTs)	8,640	6,376	5,944	20,960
Cardiology OP	5,603	4,590	5,155	15,348
Orthopedics OP	1,816	1,307	1,135	4,258
Trauma OP	1,629	1,323	1,271	4,223
Vascular OP	1,577	1,161	1,313	2,474
Pulmonology OP	1,398	639	361	2,398
Dermatology OP	572	413	351	1,336
Urology OP	402	322	371	1,095
General Surgery OP	261	288	303	852
ENT OP	324	207	180	711
Gastroenterology OP	189	156	184	529
Pain Management OP	176	141	121	438
Nephrology OP	163	105	155	423
Gynecology OP	78	69	56	203
Spine OP	91	51	49	191
Lab OP	13	39	160	212
Obstetrics OP	36	43	56	135
Podiatry OP	40	15	13	68
Ophthalmology OP	26	23	20	69
Physical Therapy/Rehabilitation OP	31	21	16	68
Neurology OP	31	19	8	27
Oncology OP	20	10	7	37
Thoracic Surgery OP	9	4	9	22
Endocrinology OP	1	0	0	1
Grand Total	**55,746**	**45,123**	**44,423**	**145,292**

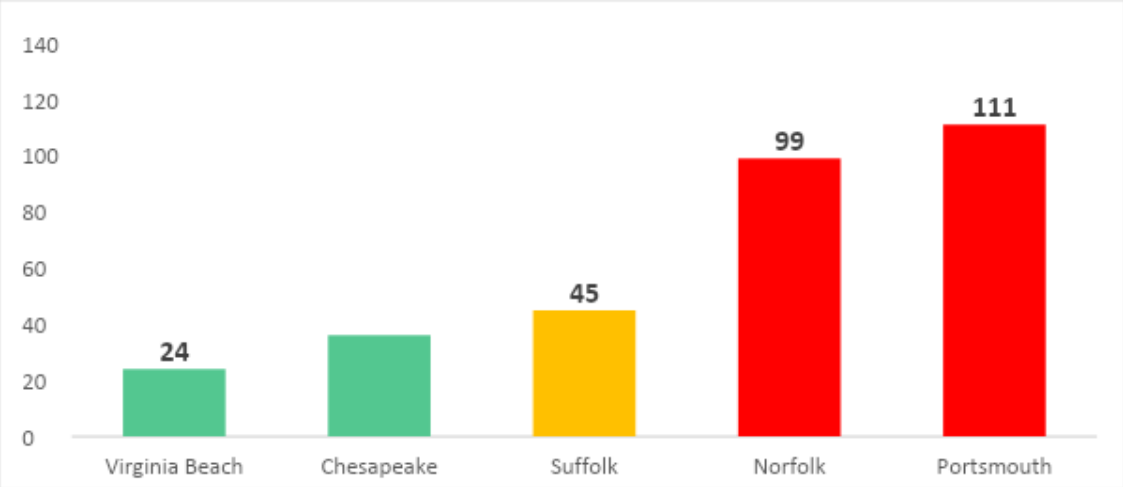
Notes: Excludes DRG 795 Normal Newborn and Ungroupable Service Lines. Data does not factor in ED patients that were admitted, patient acuity, seasonality, or any impact weighting due to COVID/change in mix of patients. 2021 data is pro-rated through September 2021.

[5] Centers for Disease Control and Prevention
[6] Ibid.

Community Health Profiles

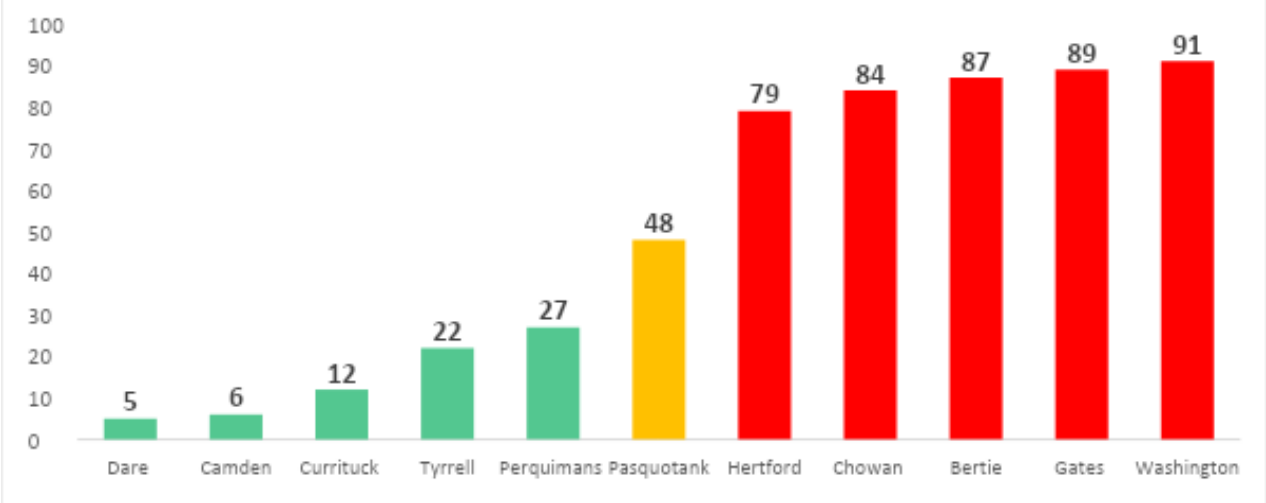
In 2021, the Robert Wood Johnson Foundation's *County Health Rankings and Roadmaps* rated **Chesapeake as the 36th healthiest city among Virginia's 133 counties**. Compared to its peer cities, Chesapeake ranked healthier than Norfolk, Suffolk, and Portsmouth, and slightly less healthy than Virginia Beach. In the same year, the northeastern North Carolina counties ranked between 5th and 91st healthiest of North Carolina's 100 counties. It is noteworthy that Dare, Camden, Currituck, Tyrrell, and Perquimans counties ranked among the healthiest while Hertford, Chowan, Bertie, Gates, and Washington counties ranked among the least healthy. Pasquotank ranked near the middle.

Robert Wood Johnson Ranking of Health For 133 Counties in Virginia



Source: *2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF).*

Robert Wood Johnson Ranking of Health For 100 Counties in North Carolina



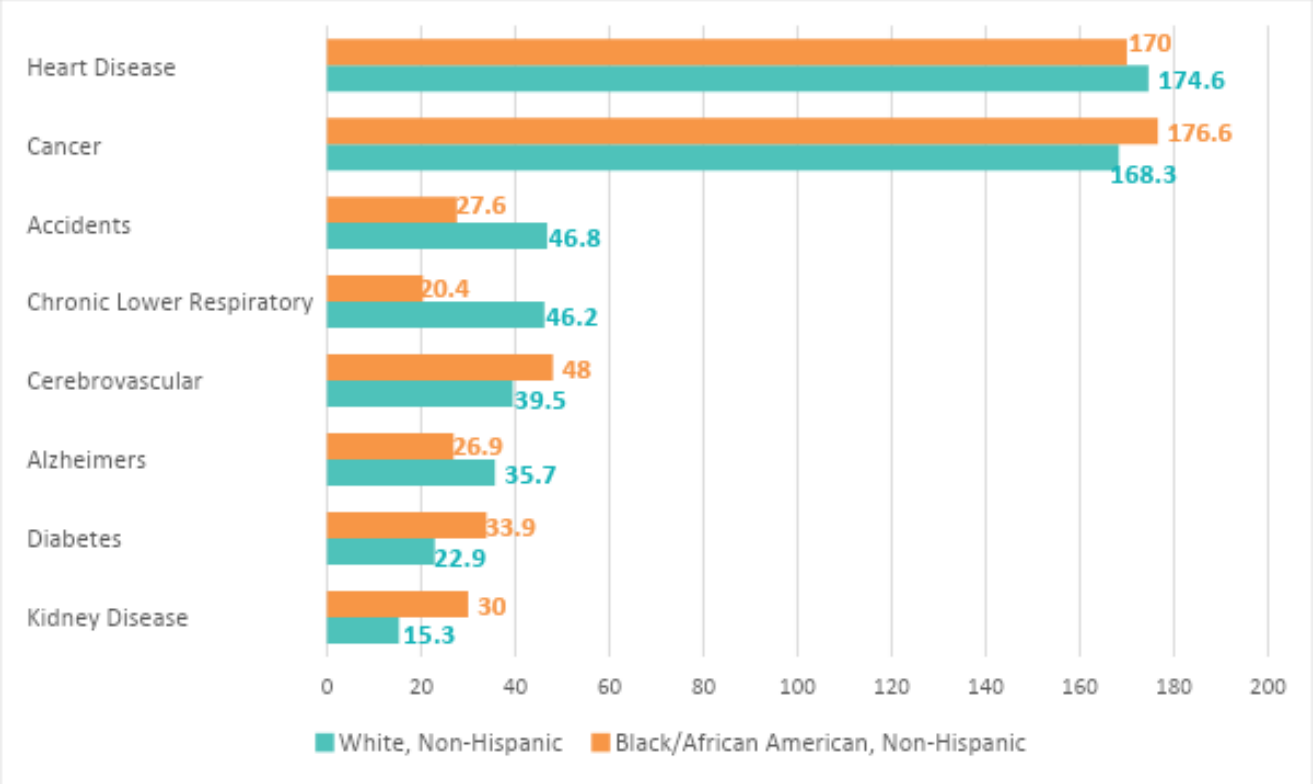
Source: *2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF).*

Leading Causes of Death

The hospital is actively assessing racial equity within the communities it serves as well as potential racial disparities in health care and health outcomes. The graph below shows the mortality rates for the leading causes of death by race for the City of Chesapeake. Data on race is not available consistently in the eleven counties of northeastern North Carolina to make comparisons.

The mortality data on the following pages is for 2014-2018.

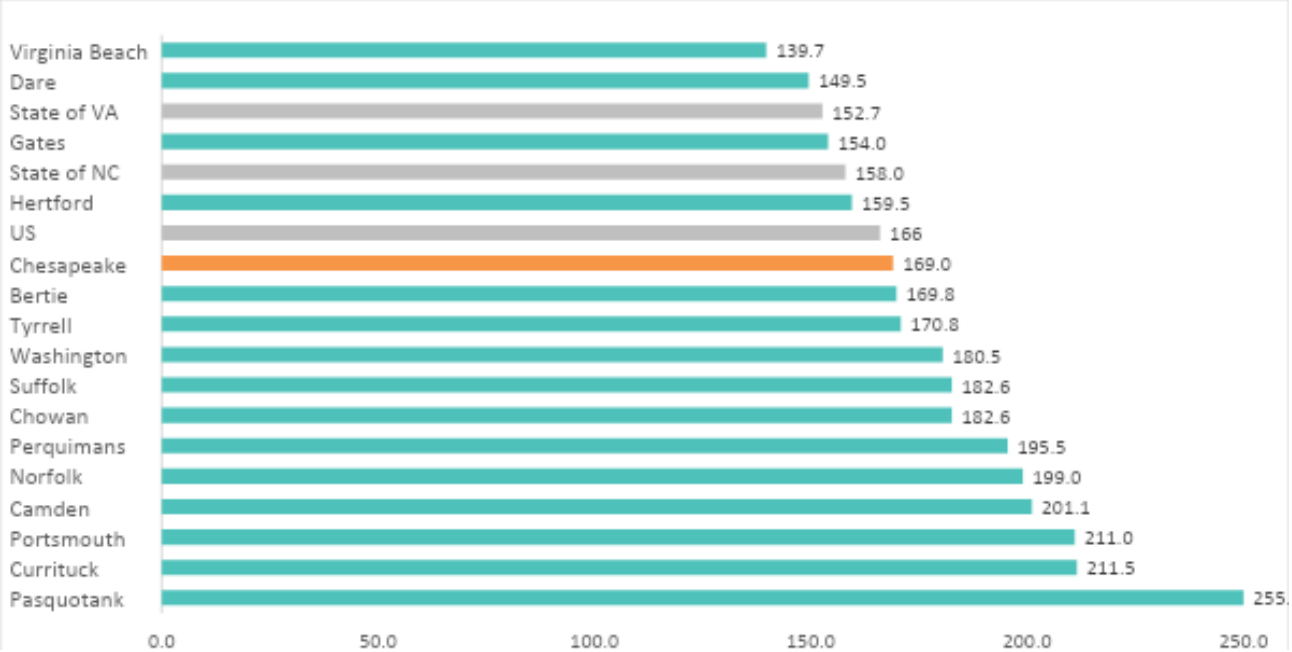
Leading Causes of Death by Race for Chesapeake – Rate per 100,000 Population



Source: National Institute on Minority Health and Health Disparities.

This report also compares death rates across Chesapeake and northeastern North Carolina to show how the various cities and counties compare. The leading causes of death are heart disease and cancer of all types, and are compared among Chesapeake, its peer cities in South Hampton Roads, and the hospital's service area in northeastern North Carolina. Virginia and North Carolina state rates are shown in gray as benchmarks.

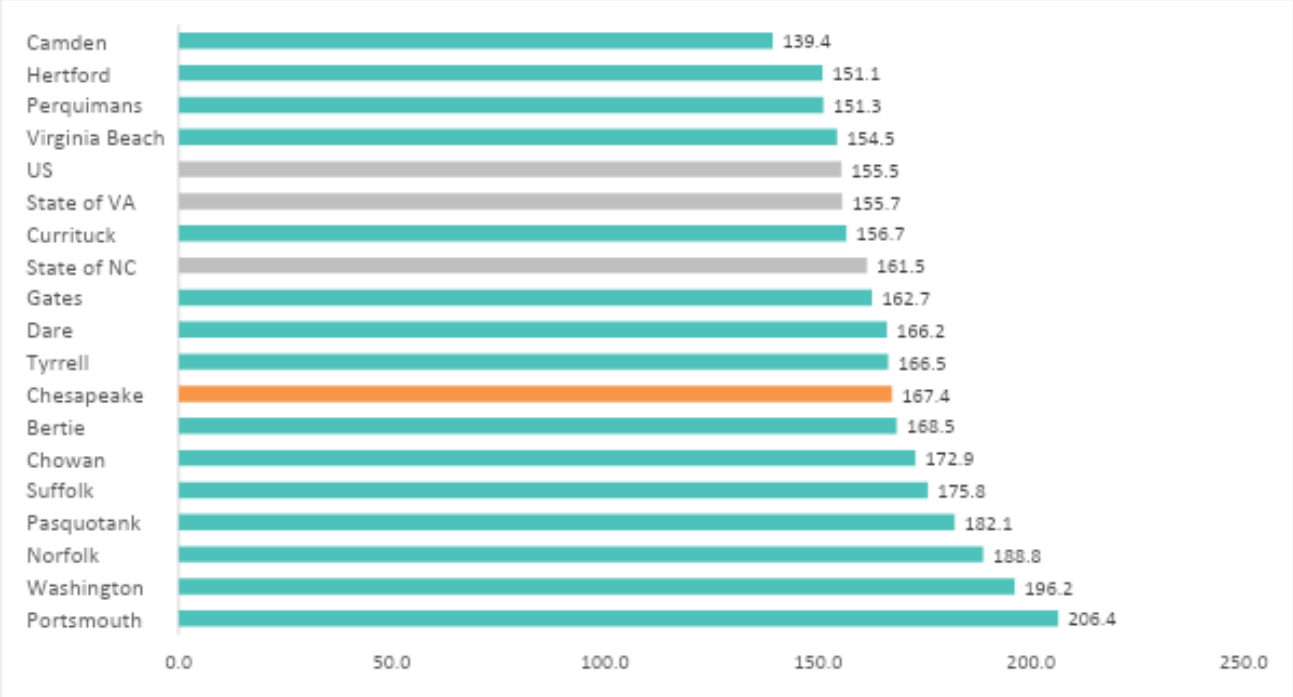
Heart Disease Deaths: Rate/100,000 population



Source: National Institute on Minority Health and Health Disparities.

Cancer Deaths: Rate/100,000 population

A recent report notes that Black/African American women in Chesapeake have incidence and mortality rates that are among the highest in the Hampton Roads region.[7]



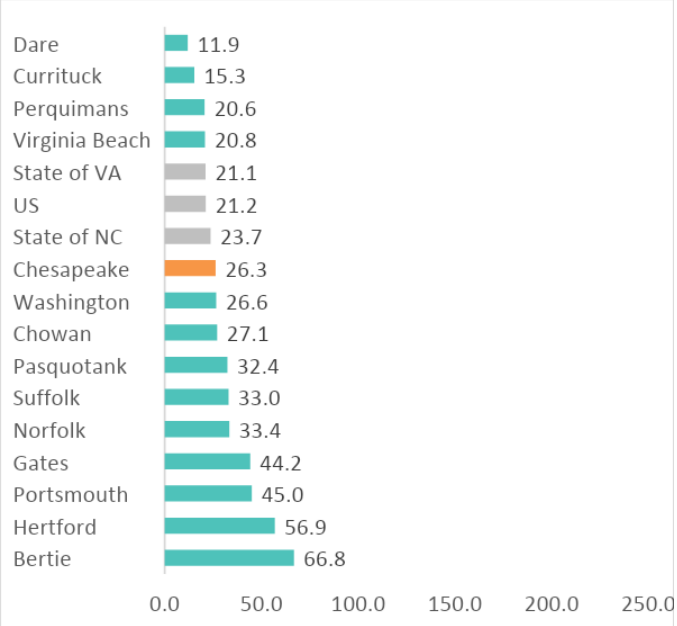
[7] *Susan G. Komen. (2021, August 4). Closing the Breast Cancer Gap: A Roadmap to Save the Lives of Black Women in America, Tidewater, VA.*

Source: National Institute on Minority Health and Health Disparities

Other Causes of Death

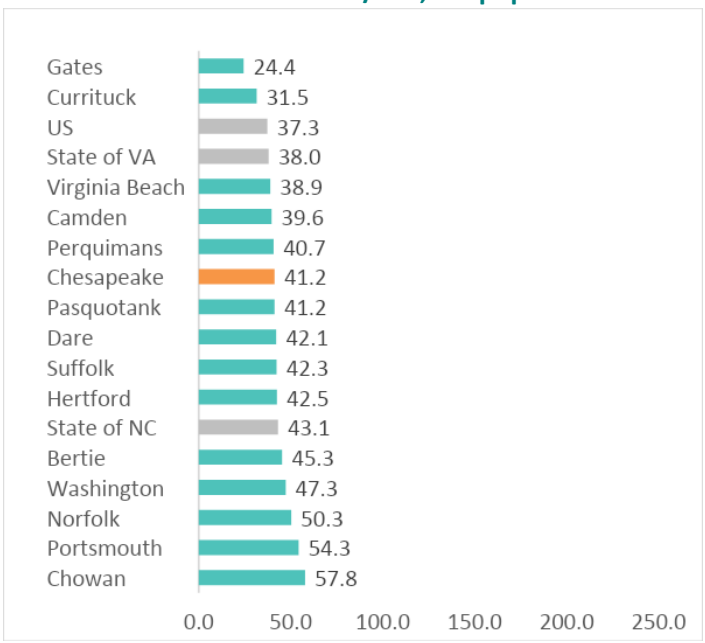
Although the mortality rates below are smaller than heart disease and cancer, they represent death from chronic illnesses that are often mentioned in key stakeholder interviews and the community surveys and are concerns for residents. Data for all North Carolina counties was not available for all graphs.

Diabetes Deaths: Rate/100,000 pop.



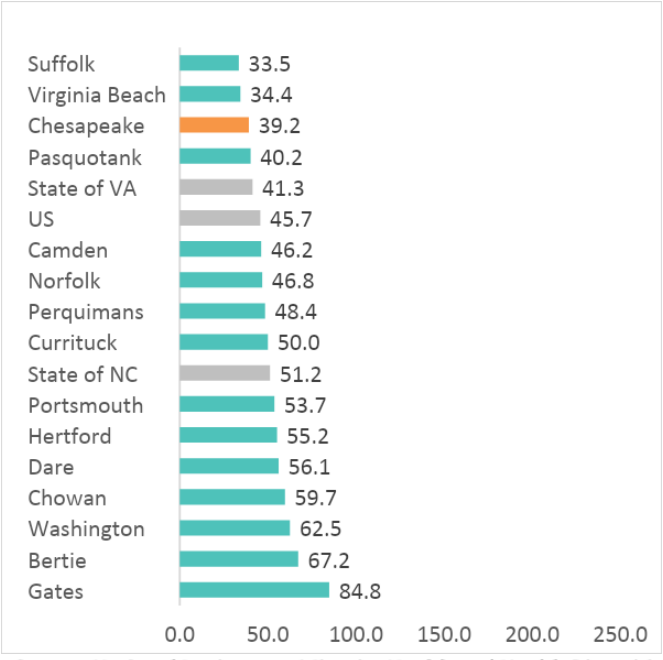
Source: National Institute on Minority Health and Health Disparities.

Cerebrovascular Deaths: Rate/100,000 pop.



Source: National Institute on Minority Health and Health Disparities.

Accidents: Rate/100,000 population

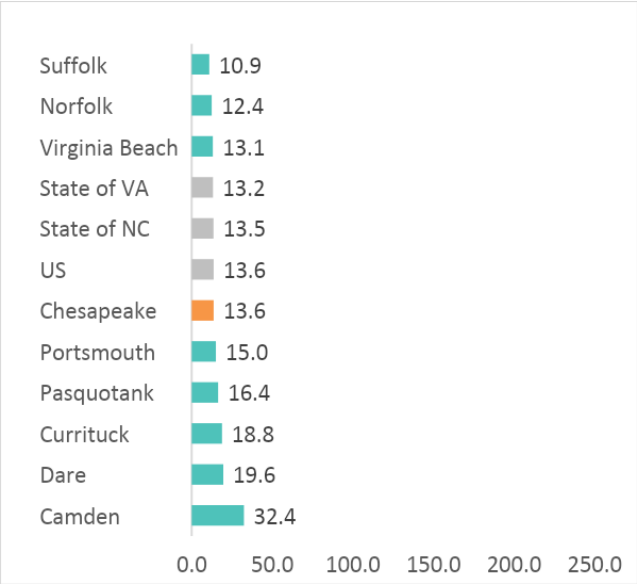


Source: National Institute on Minority Health and Health Disparities.

Chronic Lower Respiratory Deaths: Rate/100K pop.

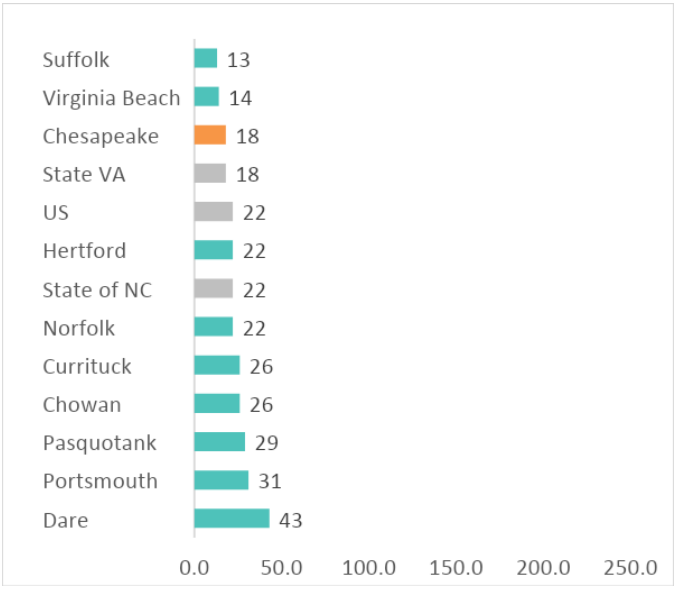
Source: National Institute on Minority Health and Health Disparities.

Suicide Deaths, All ages: Rate/100,000 pop.



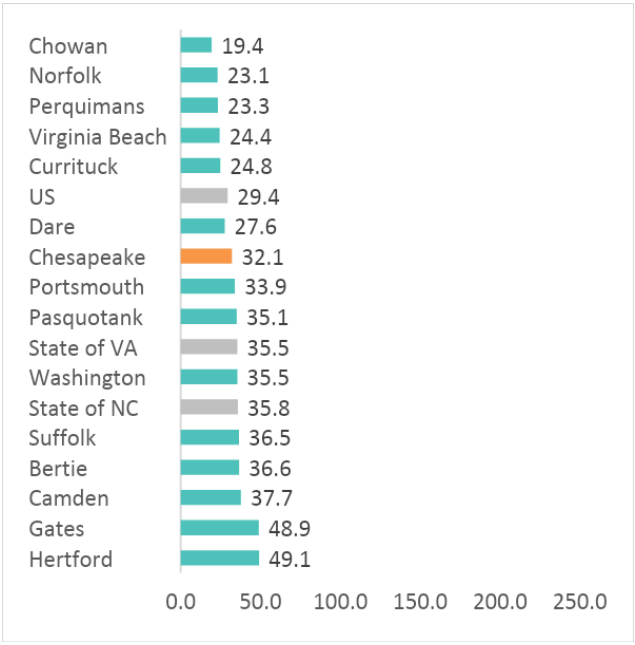
Source: National Institute on Minority Health and Health Disparities.

Drug Overdose Deaths: Rate/100,000 pop.



Source: National Institute on Minority Health and Health Disparities.

Alzheimer's Deaths: Rate/100,000 pop.



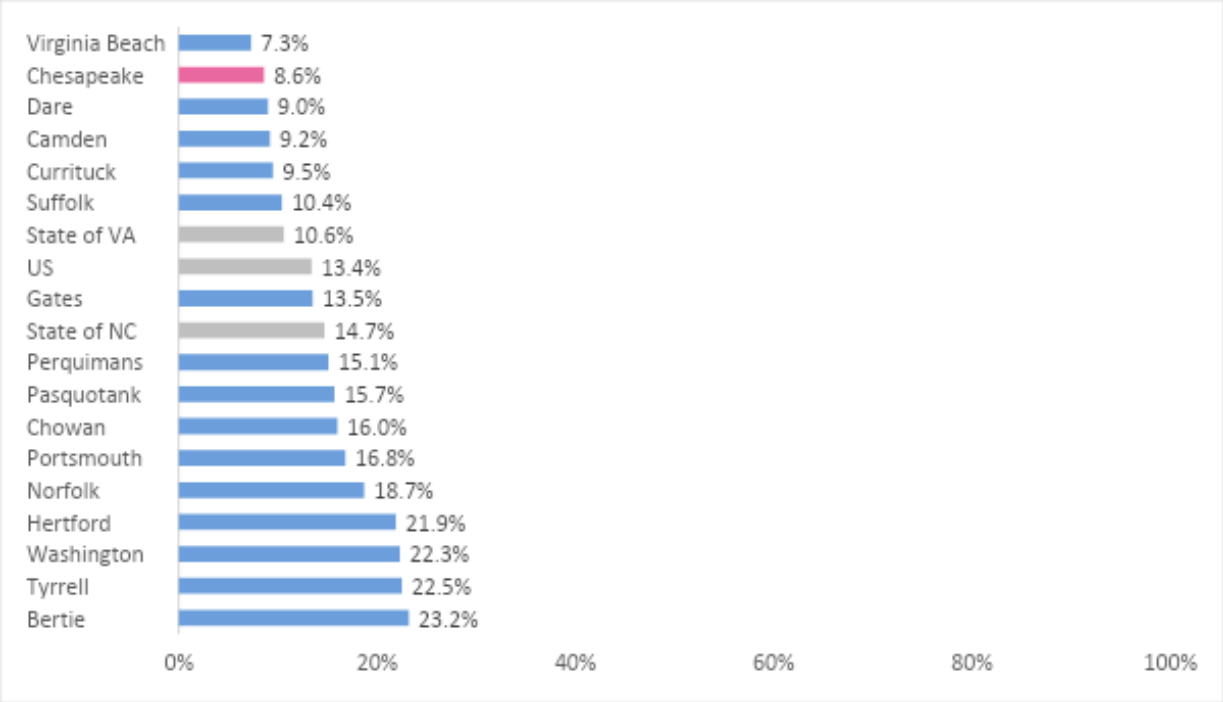
Source: National Institute on Minority Health and Health Disparities.

Kidney Disease Deaths: Rate/100,000 pop.

Socioeconomic Profiles

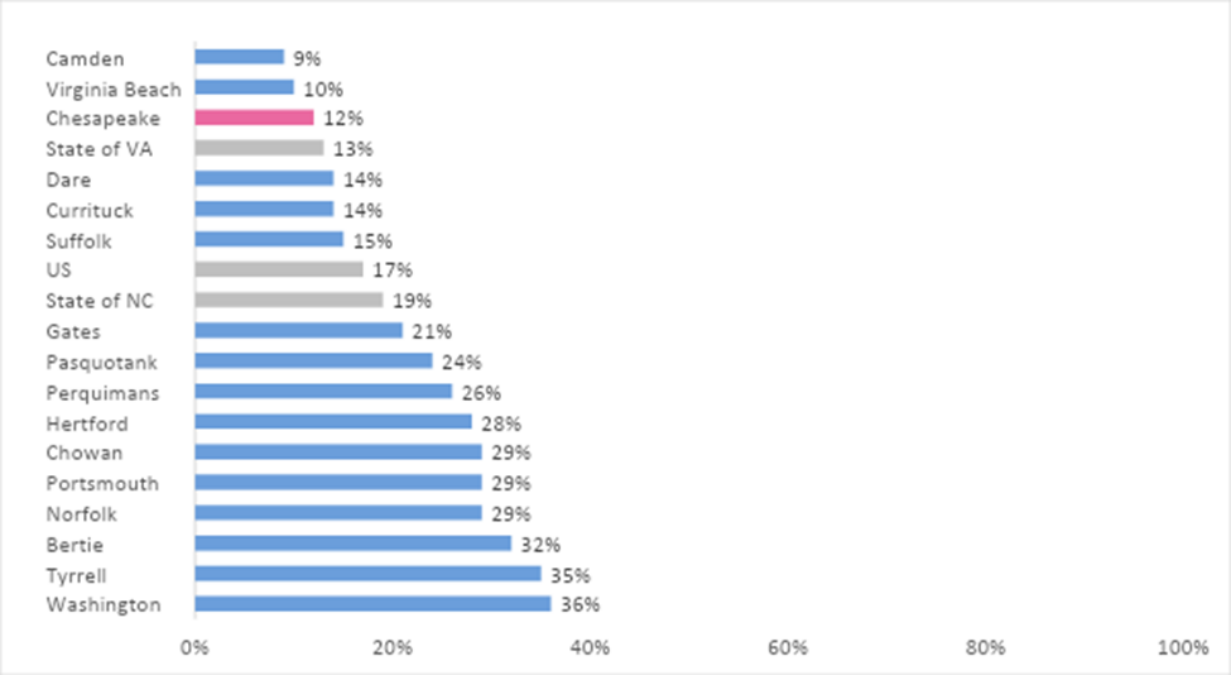
Chesapeake tends to fare well in the various socioeconomic measures below, ranking above most other jurisdictions or near the middle range.

Poverty Rate



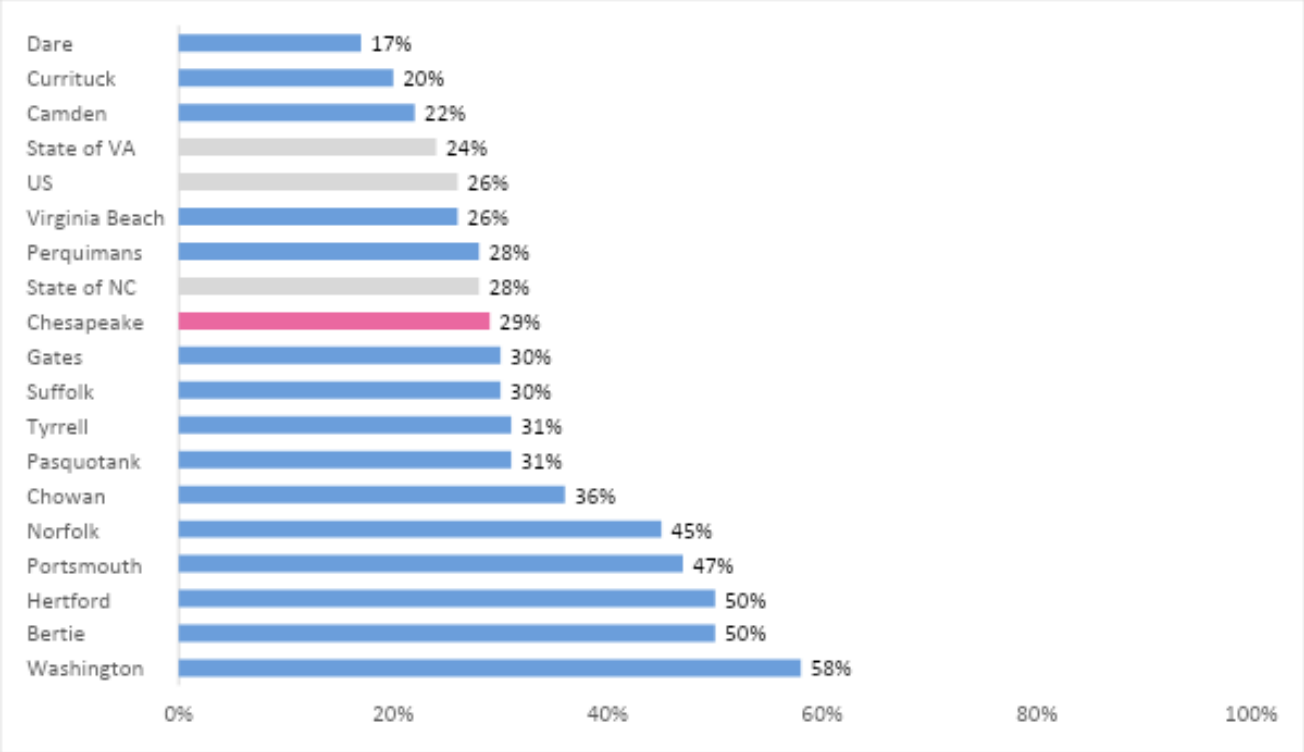
Source: US Census Bureau, American Community Survey, 2014-2019 5-Year Estimates, Table S1701.

Child Poverty Rate



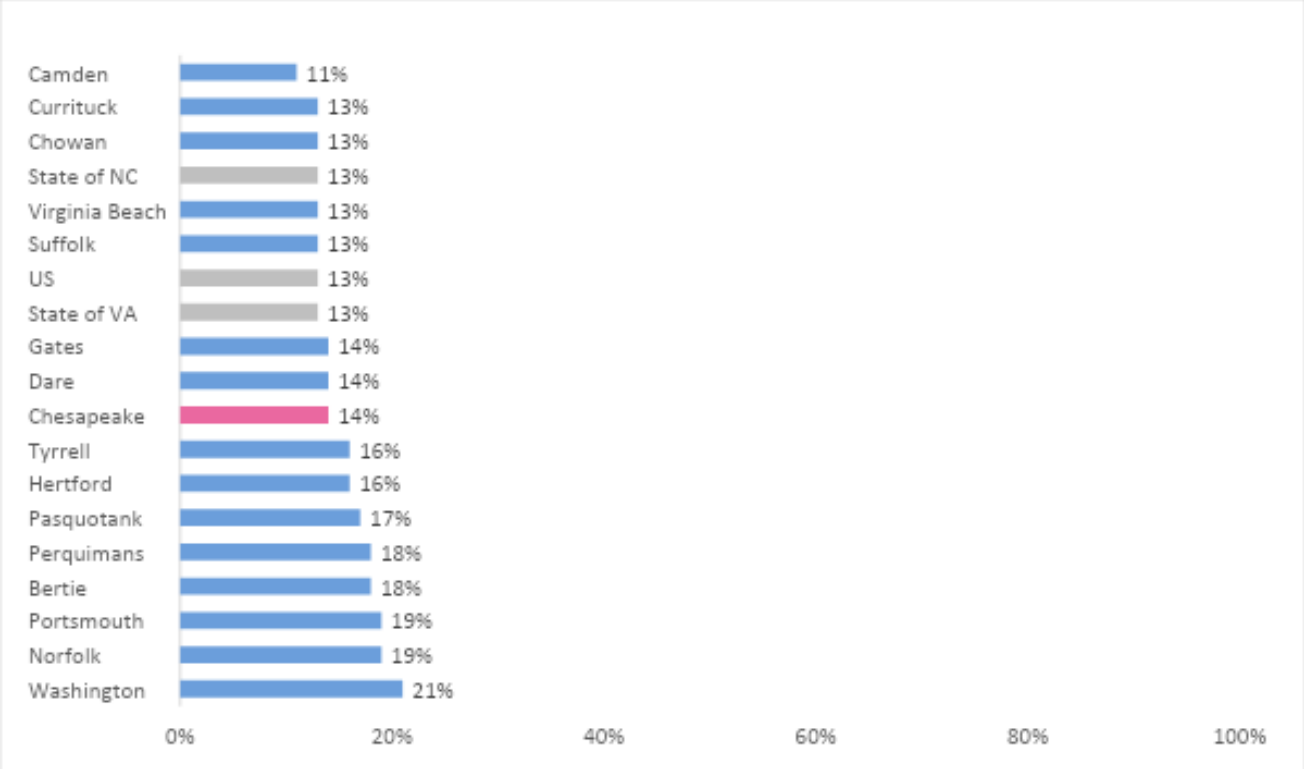
Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Children in Single Parent Households



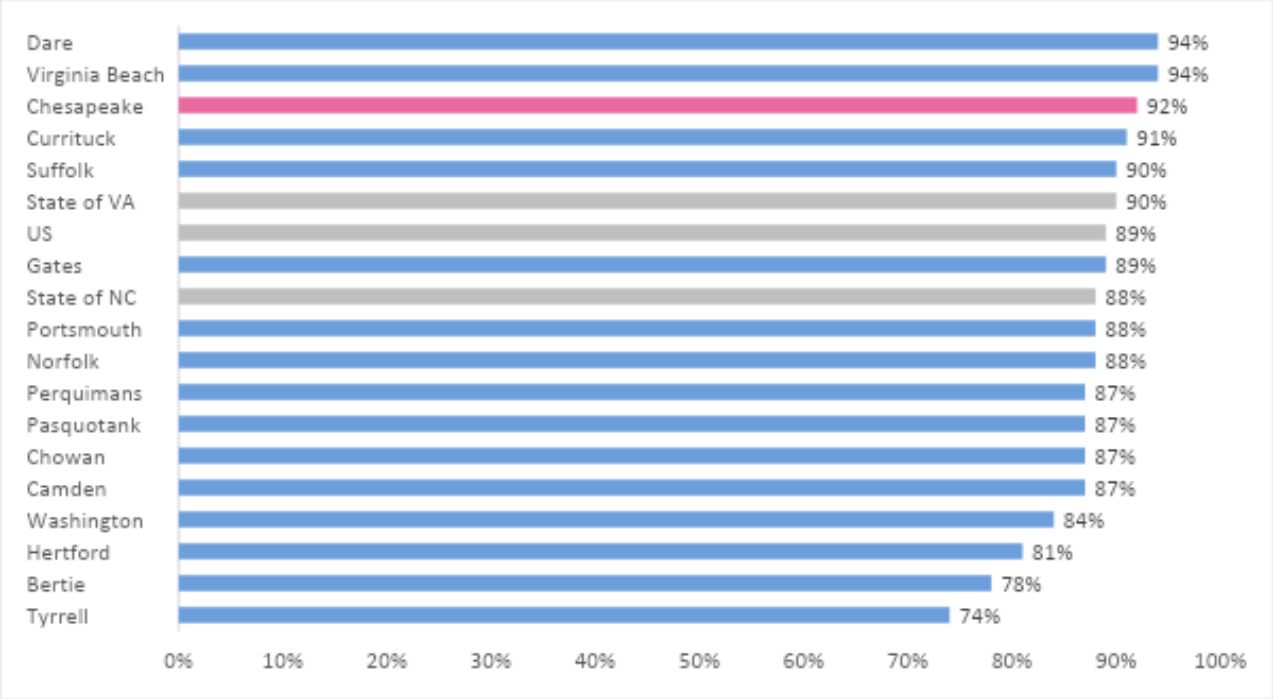
Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF).

Households Spending More than 30% of Income on Rent



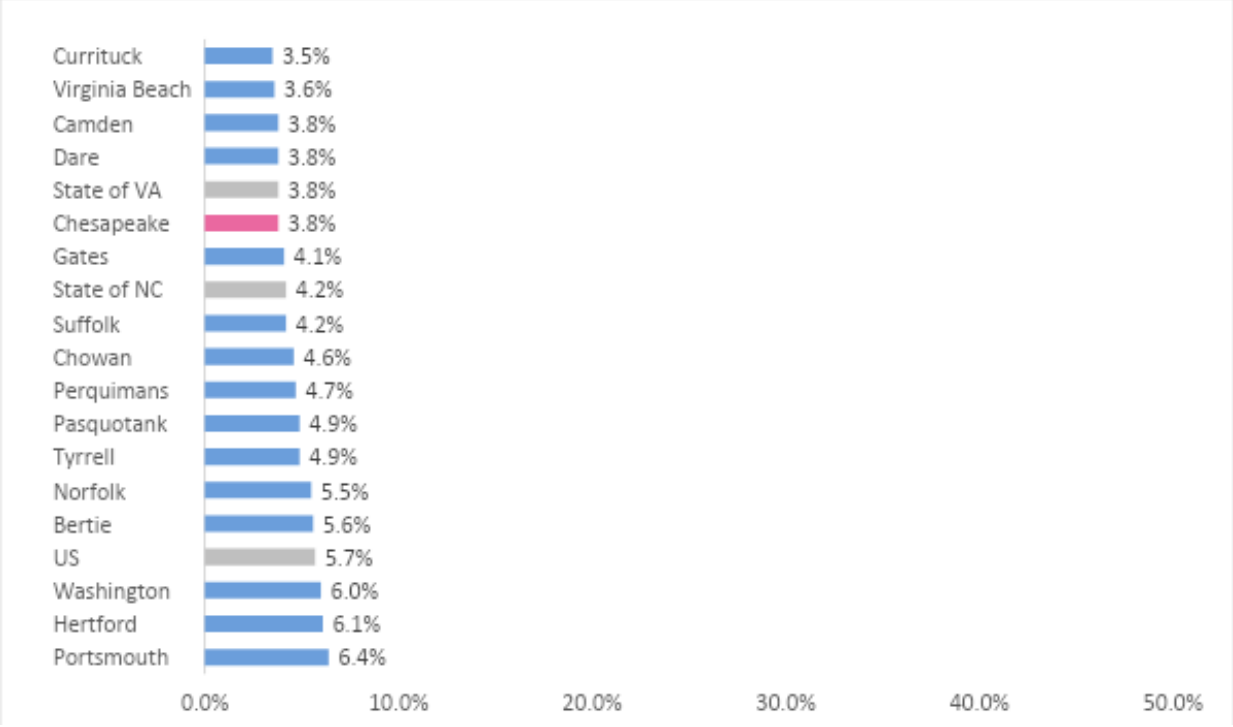
Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF).

Adults Aged 25 and Older with a High School Diploma or Equivalent



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF).

2021 Unemployment Rate



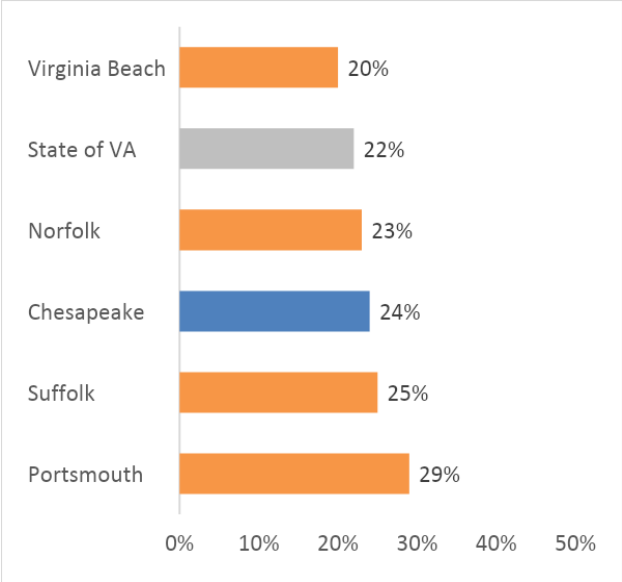
Source: Bureau of Labor Statistics

Health Behaviors

The County Health Rankings and Roadmaps state that caution should be used if comparing the data below across states; therefore, separate graphs for Virginia and North Carolina are provided. This can occur when different data collection methods or dates are used.

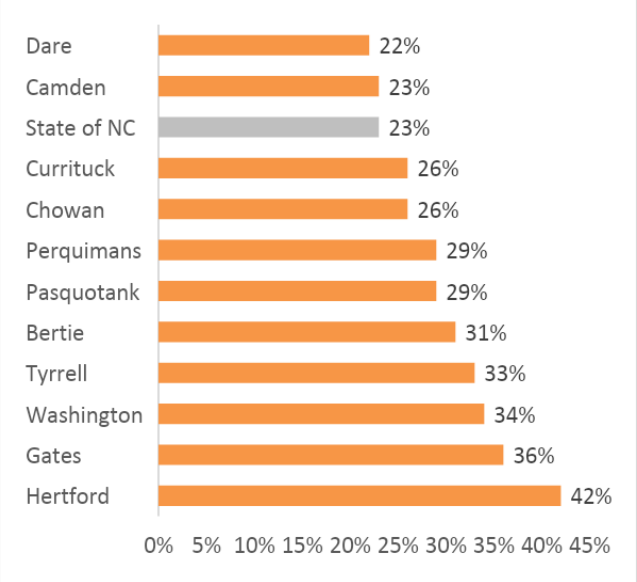
Adults 20 and Older Reporting No Leisure-time Physical Activity

Virginia



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

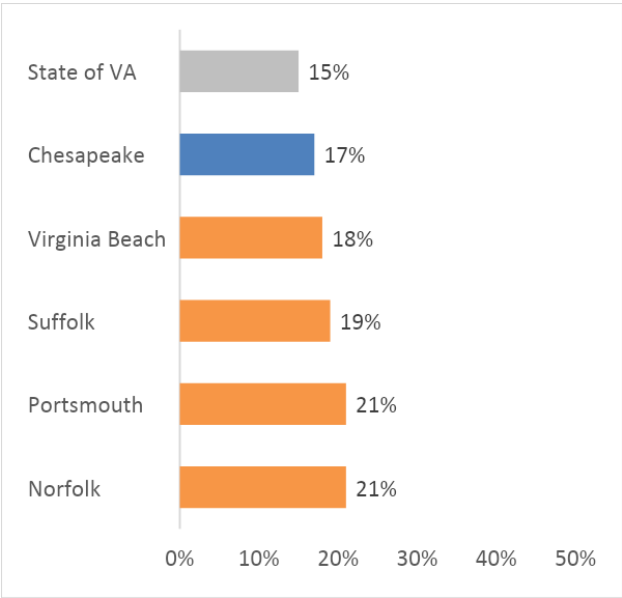
Northeastern North Carolina



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

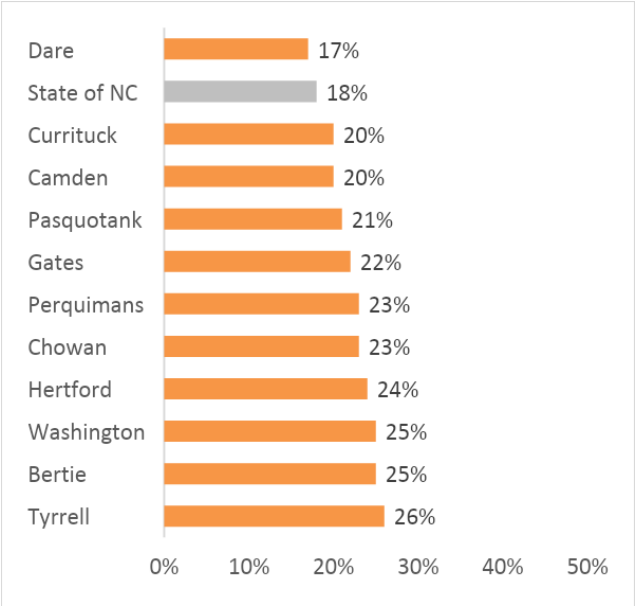
Adult Smoking

Virginia



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

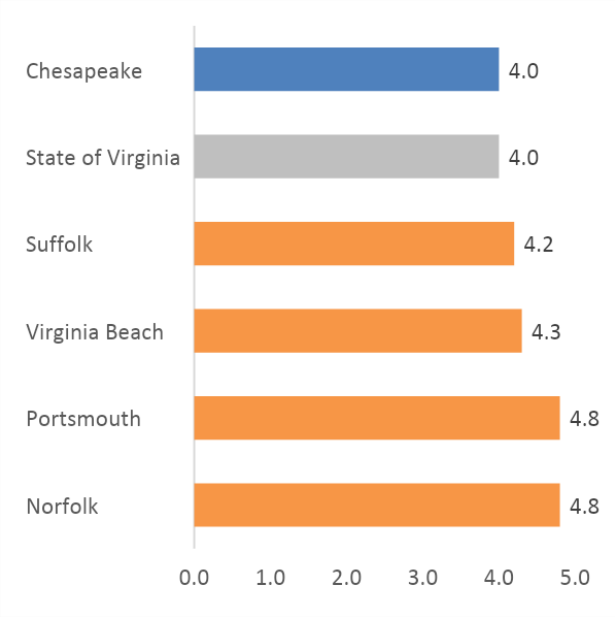
Northeastern North Carolina



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

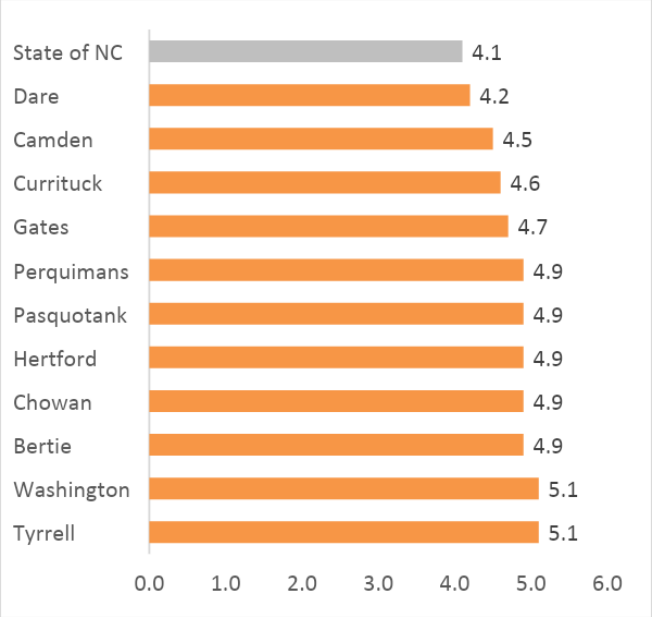
Poor Mental Health Days in Past Month

Virginia



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

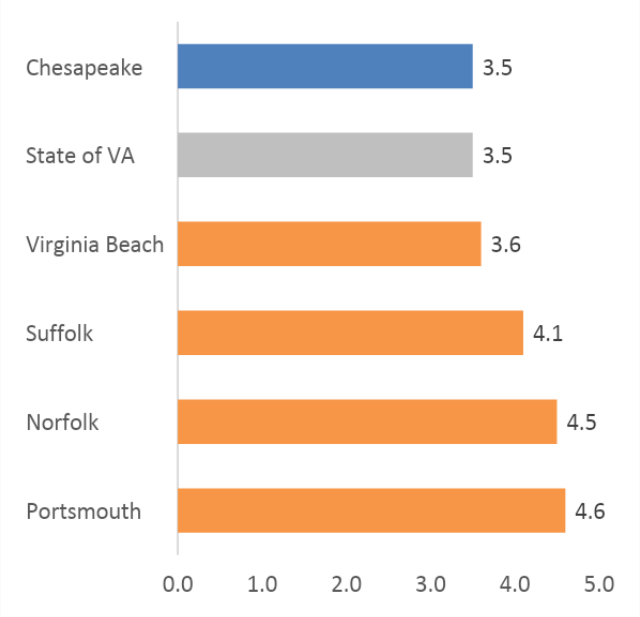
Northeastern North Carolina



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

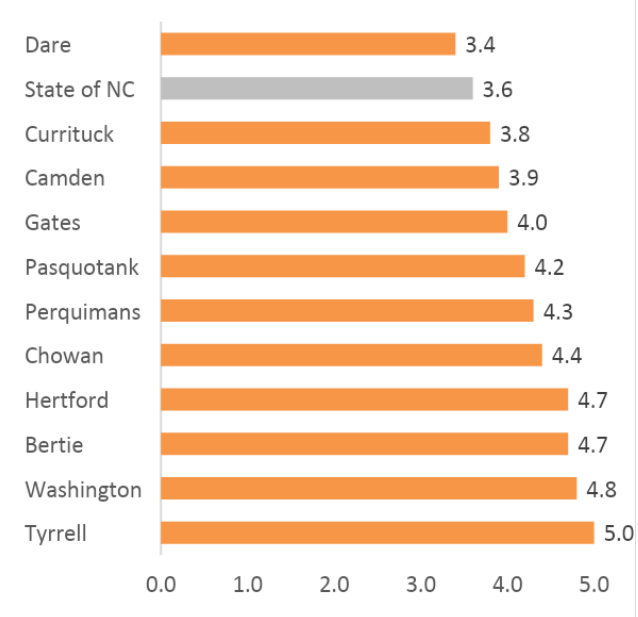
Poor Physical Health Days in Past Month

Virginia



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Northeastern North Carolina



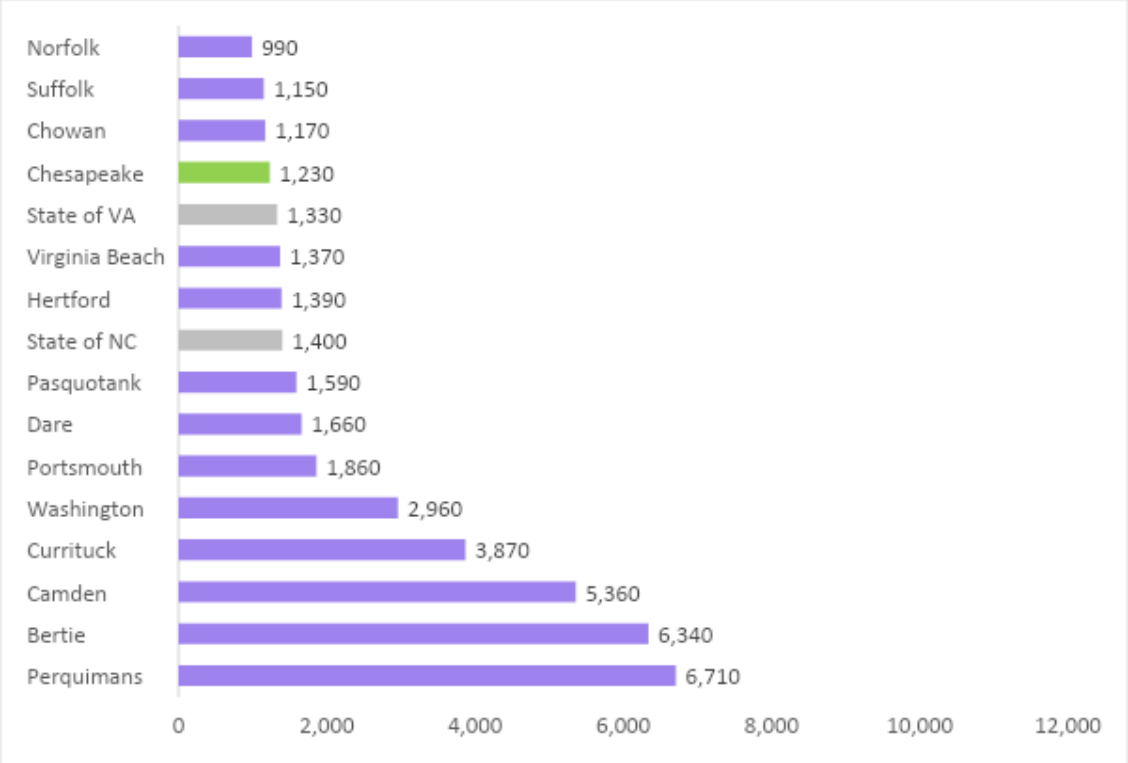
Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Access to Care

Access to healthcare is important for all communities, especially those farther away from medical facilities. Chesapeake residents in the northern part of the city tend to have more limited access to health care services than in other parts of the city. In the past ten years, the city has worked to address this by adding both a Federally Qualified Health Center and a neighborhood pharmacy in South Norfolk.

Residents in rural areas of northeastern North Carolina have much less access to health care services than those in Chesapeake. Data was not available for Tyrrell and Gates counties.

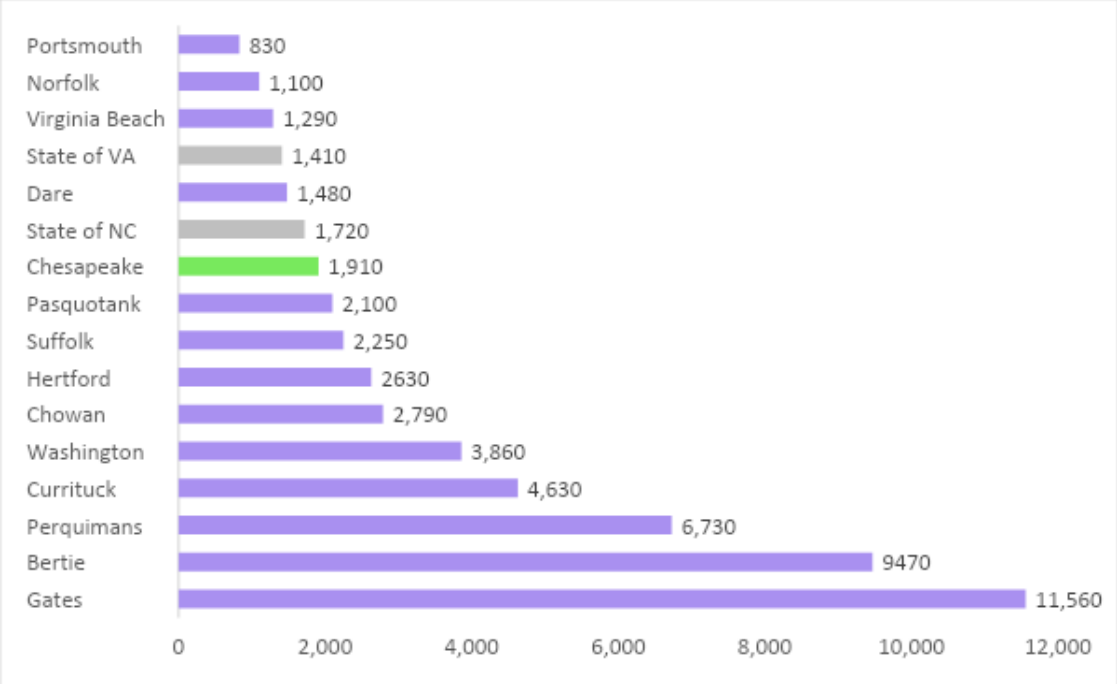
Number of Residents for Every 1 Primary Care Physician



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Number of Residents for Every 1 Dentist

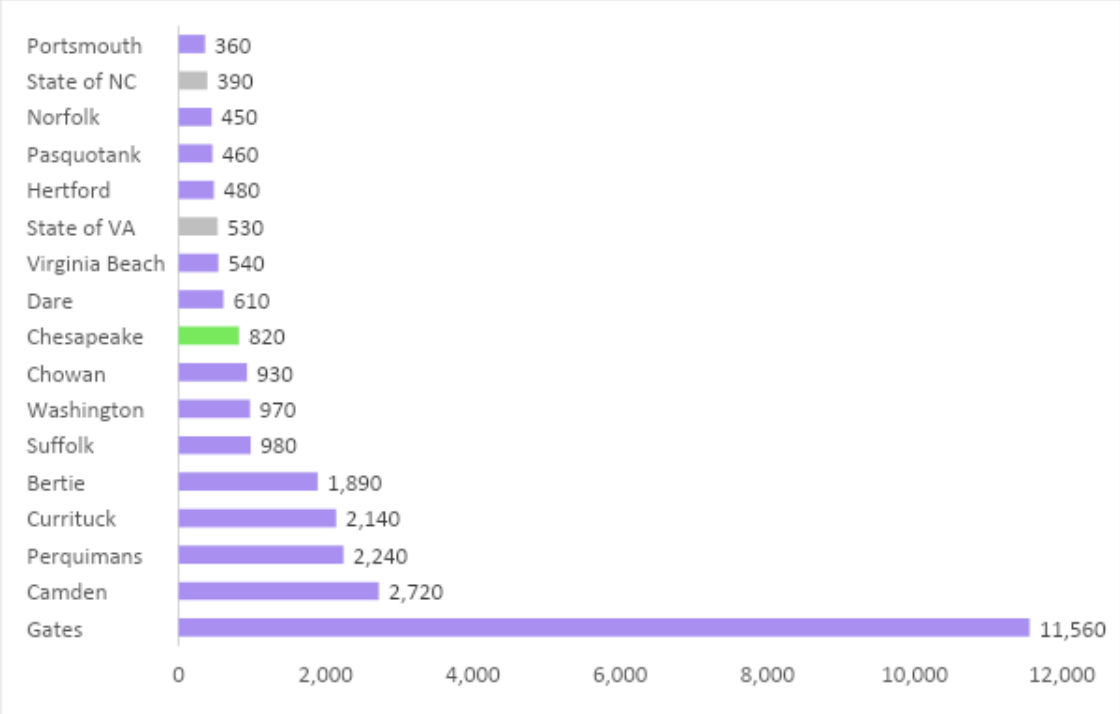
Data was not available for Bertie, Hertford, and Tyrrell counties.



Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Number of Residents for Every 1 Mental Health Provider

Data was not available for Bertie, Hertford, and Tyrrell counties.

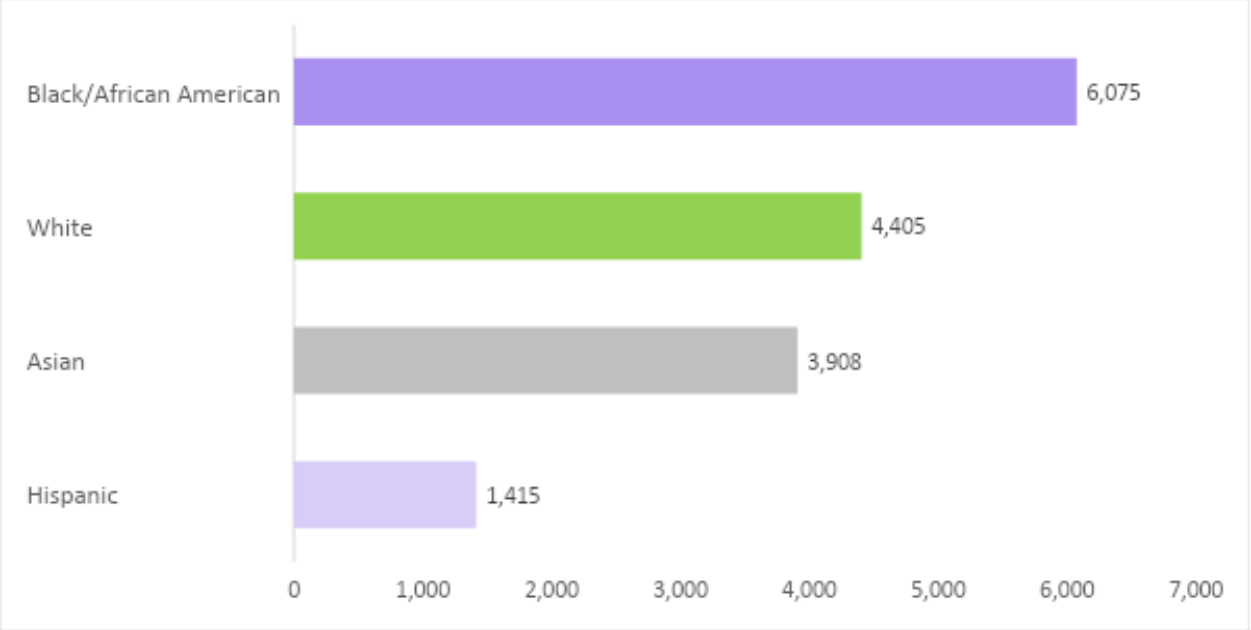


Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Preventable Hospital Stays in Chesapeake, Rate per 100,000 Medicare Enrollees

County Health Rankings notes that this measure may represent "a tendency to overuse emergency rooms and urgent care as a main source of care. Preventable Hospital Stays could be classified as both a quality and access measure, as some literature describes hospitalization rates for ambulatory care-sensitive conditions primarily as a proxy for access to primary health care." In Chesapeake, it may indicate that Black/African American residents have limited access to care compared to other races.

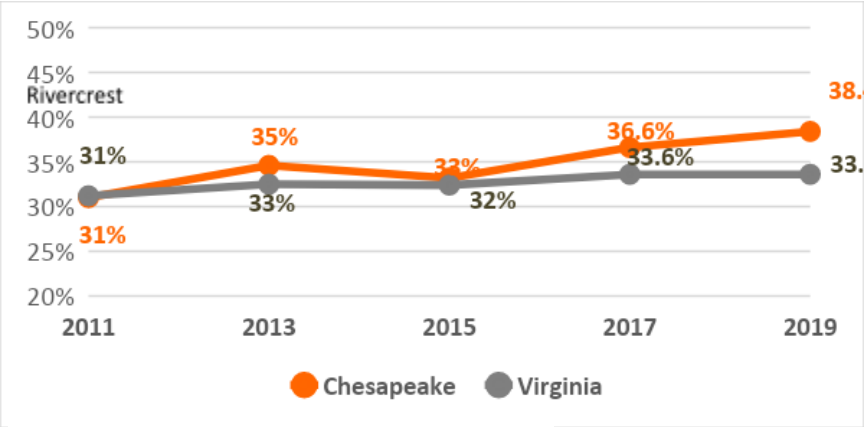
Preventable Hospital Stays, Rate per 100,000 Medicare Enrollees



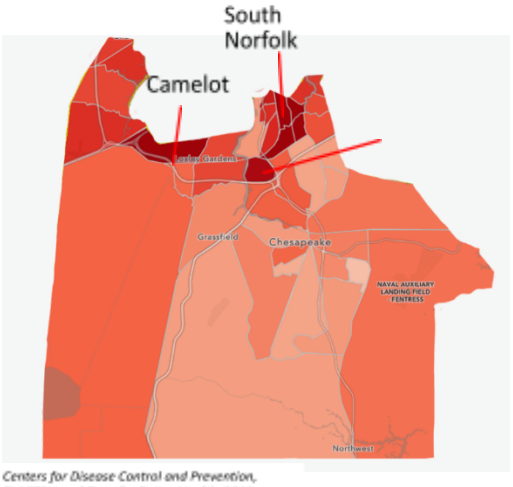
Source: 2021 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Chronic Illness Prevalence and Trends

High Blood Pressure: Chesapeake & Virginia



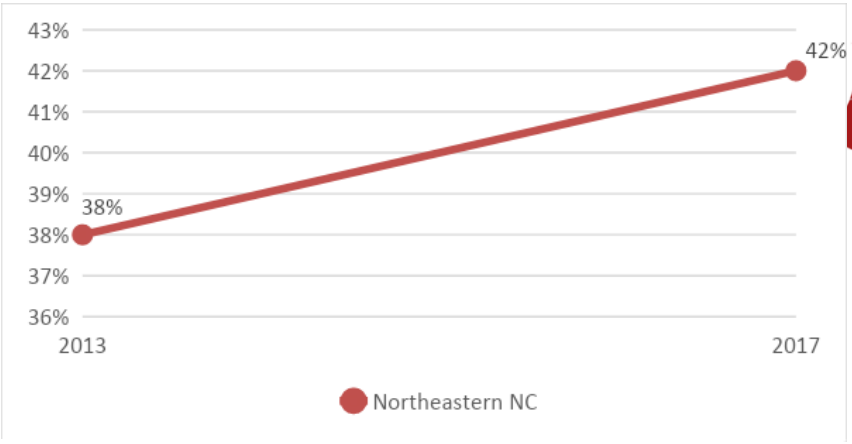
Source: Virginia Department of Health, 2011-2019



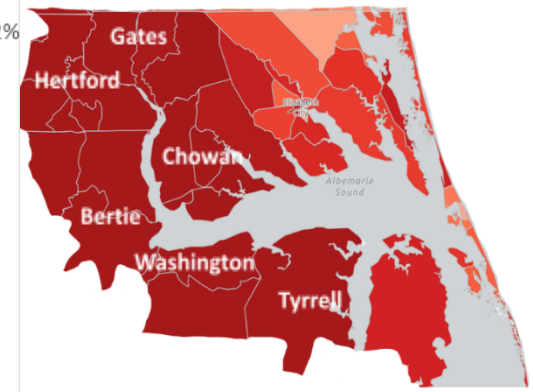
Centers for Disease Control and Prevention, PLACES, Local Data for Better Health, 2019

The most recent data available from the Virginia Department of Health show that in 2019, 38% of Chesapeake's population had high blood pressure. This is higher than the state rate and an increase from the City's rate of 37% 2017. The dark orange areas on the map below indicate higher rates of hypertension in Camelot, Rivercrest, and South Norfolk boroughs.

High Blood Pressure: Northeastern North Carolina



Source: North Carolina State Center for Health Statistics, Behavioral Risk Factor Surveillance System, 2017.

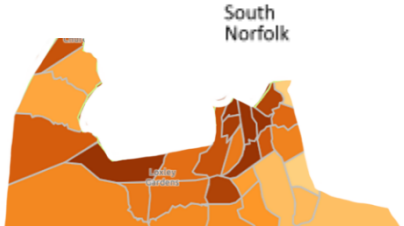


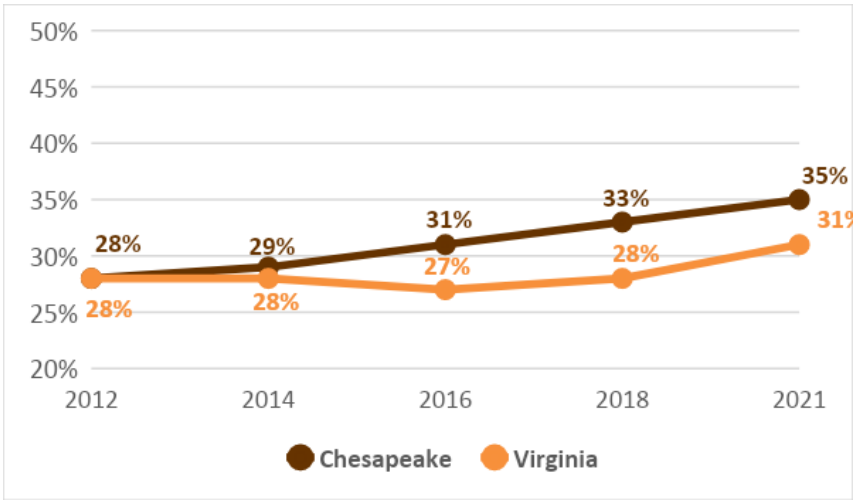
ADULT OBESTIY: Chesapeake &

Centers for Disease Control and Prevention, PLACES, Local Data for Better Health, 2019

Hypertension data was only available for the combined counties in northeastern North Carolina, so the graph below represents the average increase in prevalence for the region between 2013 and 2017. The Centers for Disease Control and Prevention's 2019 health map on the right indicates that counties with the highest rate of hypertension (between 38% and 45%) were Gates, Hertford, Bertie, Chowan, Washington, and Tyrrell counties.

Adult Obesity: Chesapeake & Virginia



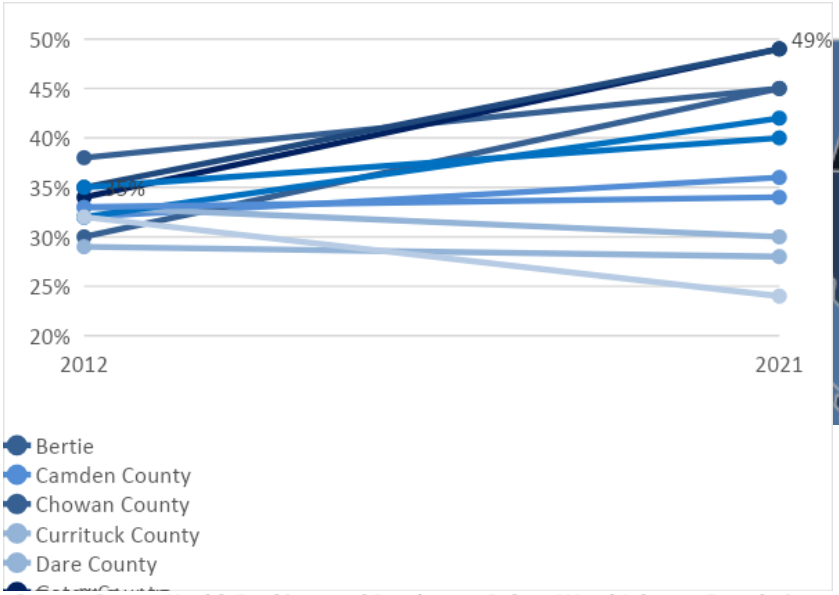


Source: County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF), 2012 – 2021

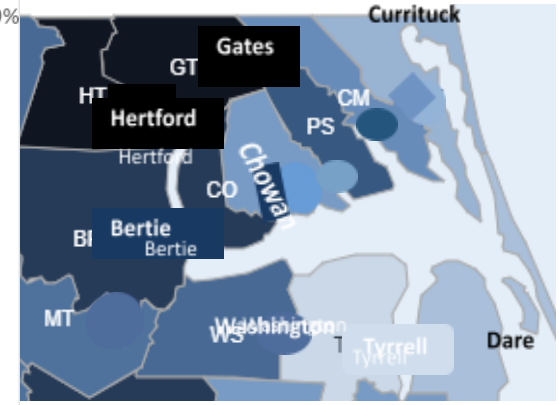
Centers for Disease Control and Prevention, PLACES, Local Data for Better Health, 2019

Adult obesity in Chesapeake has steadily increased since 2012, from 28% to 35%. The darkest shaded areas on the map below indicate higher rates of obesity in Camelot, Rivercrest, and South Norfolk boroughs.

Adult Obesity: Northeastern North Carolina



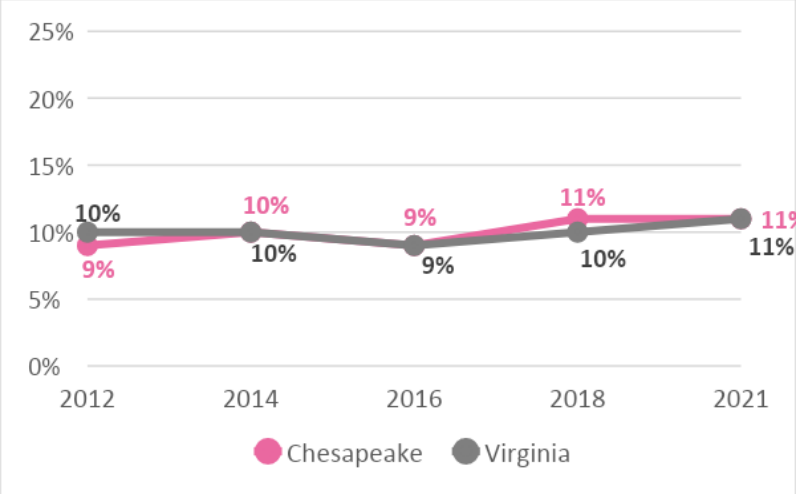
Source: County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF), 2012 – 2021

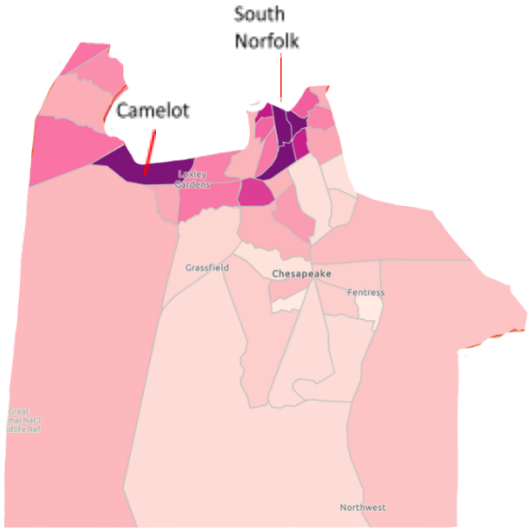


Source: County Health Rankings and Roadmaps, Robert Wood Johnson Foundation, 2019

Since 2012, adult obesity has increased in most counties except for Currituck, Dare and Tyrrell. In 2021, obesity ranged between a low of 24% in Tyrrell County to a high of 49% in Hertford County. The darkest blue areas on the 2019 map below indicate higher rates of obesity in Gates, Hertford, Bertie, and Chowan counties.

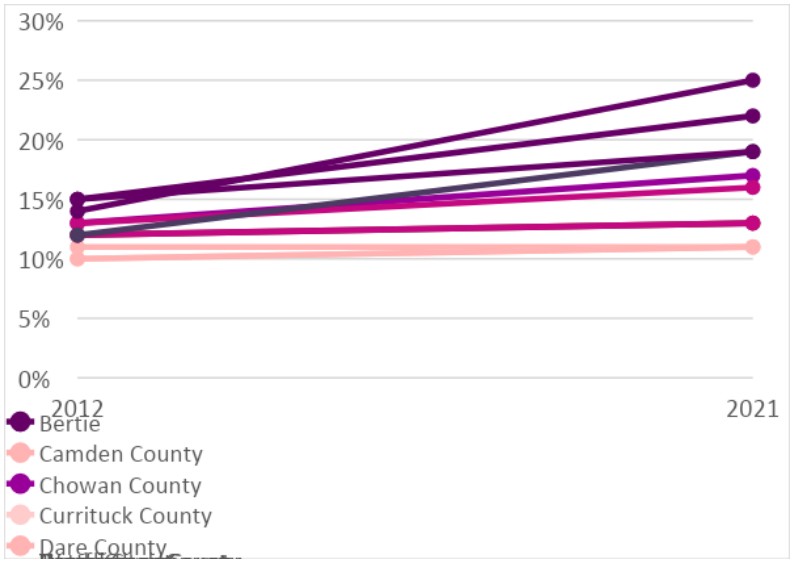
Diabetes: Chesapeake & Virginia

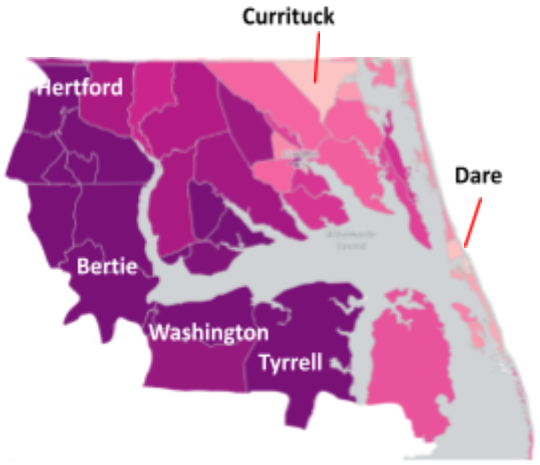




The percentage of adults with diabetes in Chesapeake and the state has slightly increased from 2012; from 10% to 11%. The darker purple and pinks in the map below show higher diabetes rates in the Camelot and South Norfolk boroughs.

Diabetes: Northeastern North Carolina



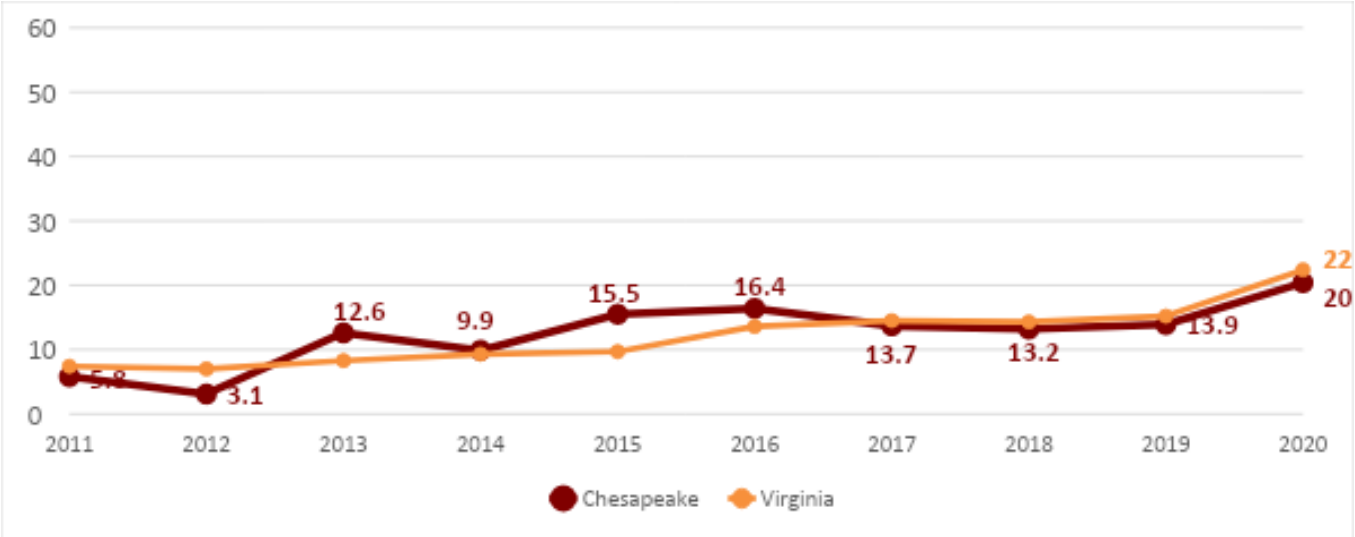


Centers for Disease Control and Prevention, PLACES, Local Data for Better Health, 2019

Source: County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF), 2012 – 2021

Since 2012, diabetes prevalence has increased in most counties. In 2021, the diabetes rate ranged between a low of 11% in Dare County to a high of 25% in Hertford County. Dark purple on the map below shows higher diabetes rates in the counties of Hertford, Bertie, Washington, and Tyrrell. Lighter pink in Currituck and parts of Dare County indicates a lower diabetes rate.

Opioid Mortality Rate: Chesapeake & Virginia, Rate per 100,000

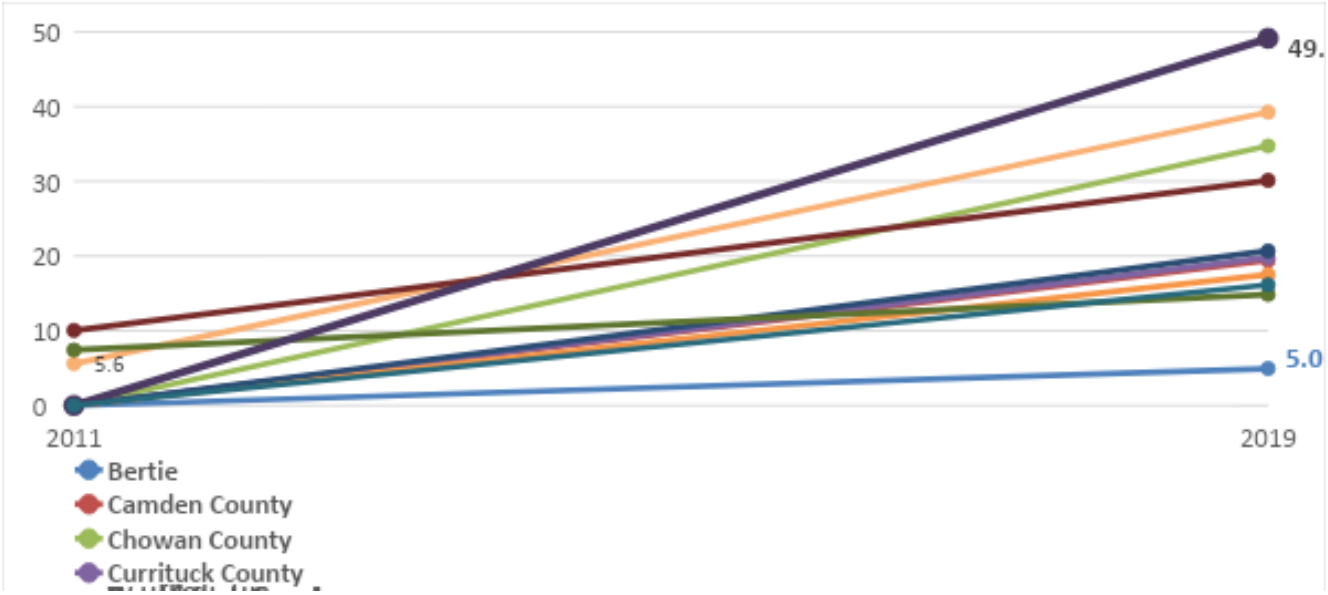


Source: Virginia Department of Health

The overdose death rate from opioids in Chesapeake has increased since 2011 and reached a high of 20.4 per 100,000 in 2020. Virginia has followed a similar trend, increasing from 5.8 per 100,000 to 22.4 per 100,000.

Opioid Mortality Rate: Northeastern North Carolina, Rate per 100,000

Since 2011, all the northeastern North Carolina counties have seen an increase in the rate of opioid mortality. Bertie County increased the least, from 0 to 5 per 100,000.

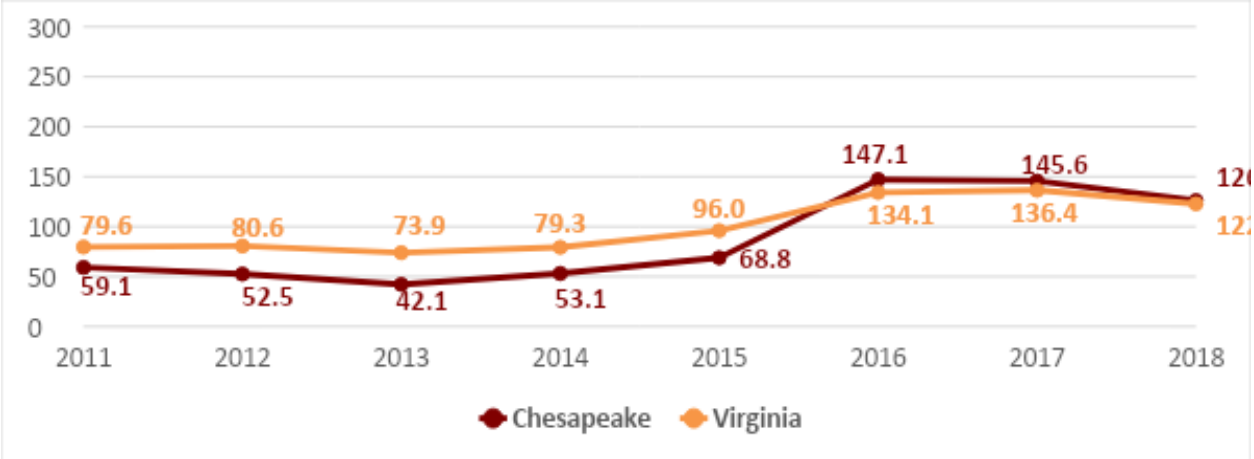


Source: North Carolina Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention.

Hepatitis C

Closely related to the opioid epidemic is a significant increase in the prevalence of Hepatitis C. The Centers for Disease Control and Prevention (CDC) report that new Hepatitis C cases are increasing the most among younger adults as injection drug use increases. The CDC also states that for more than half of those who become infected, Hepatitis C can be a long-term chronic illness that can lead to death.

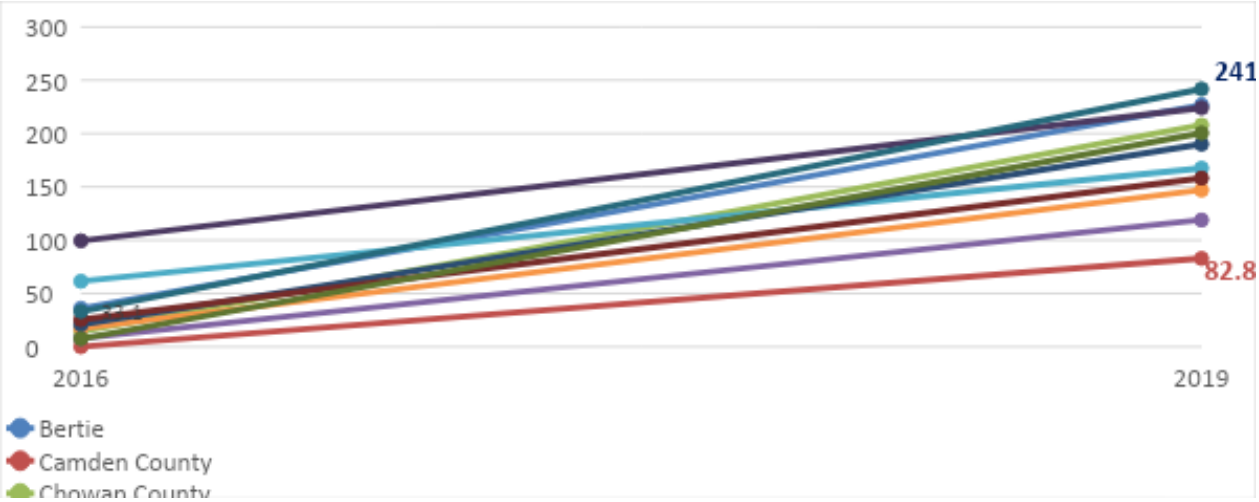
Chronic Hepatitis C: Chesapeake & Virginia, Rate per 100,000



Source: Virginia Department of Health

Between 2011 and 2018, the Hepatitis C rate in Chesapeake increased from 59.1 to 126.0, exceeding the state rate of 122.8.

Chronic Hepatitis C: Northeastern North Carolina, Rate per 100,000



Source: North Carolina Department of Health and Human Services, HIV/STD/Hepatitis Surveillance Unit, Division of Public Health. November 2020. North Carolina Hepatitis B/C Surveillance Report

Chronic hepatitis C became reportable in North Carolina in October 2016 and is only reported from laboratories reporting electronically. Since 2016, chronic hepatitis C has steadily increased in all counties, with the highest rate of 241.8 in Washington County and the lowest rate of 82.8 in Camden County.

COMMUNITY NEEDS SURVEY RESULTS

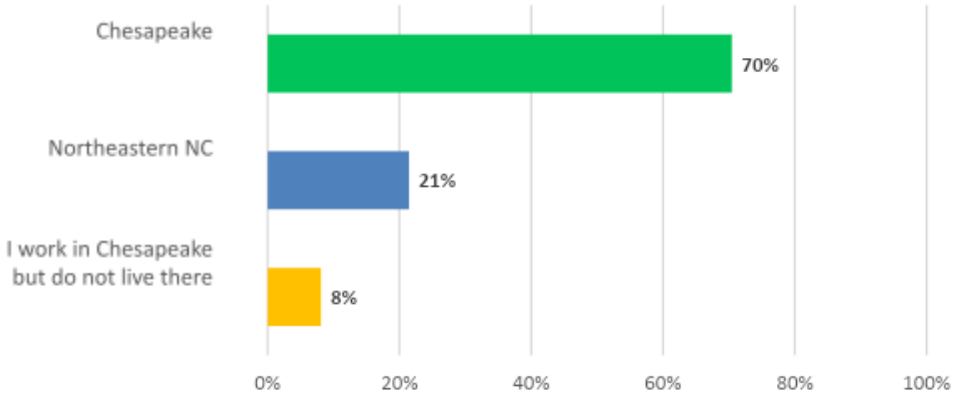
Demographics

The survey was available through Survey Monkey from July 15, 2021, to October 31, 2021, and yielded 1,857 responses. This is an increase of 47% over the 2018 CHNA survey response of 986. In addition, there was significant outreach across the community in 2021, and a consultant from Bibbs Consulting, LLC was able to garner 575 survey responses in low-income communities, especially those of color, which were lacking in adequate representation in the 2018 survey. NOTE: Not all survey questions are included in this report but are included in Appendix A. Also, survey questions are grouped by theme rather than numerical order.

The following graphs show the demographics of the 2021 survey respondents along with comparisons to the 2018 survey, and margin of error data where relevant.

Q1: Do you live in Chesapeake or northeastern North Carolina?

Of the 1,857 respondents, 1,287 live in Chesapeake, 392 live in northeastern North Carolina, and 148 work in Chesapeake but do not live there.

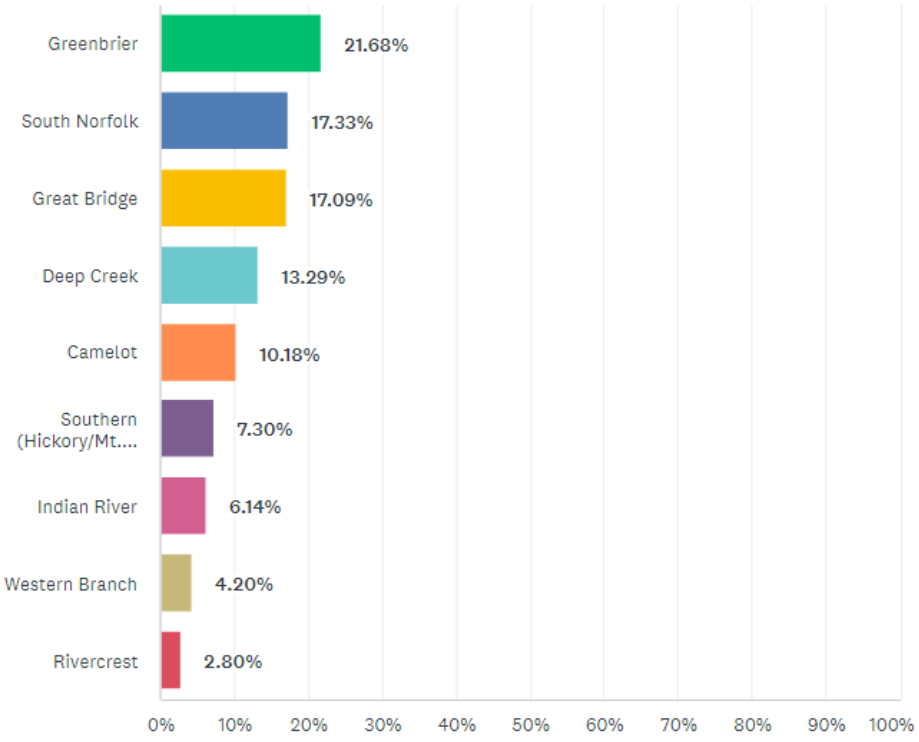


ANSWER CHOICES		
Chesapeake	70%	1,287
Northeastern NC	21%	392
Work in Chesapeake but do not live there	8%	148
TOTAL	**100%**	**1,827**

Q2: Which part of Chesapeake do you live in?

Most Chesapeake respondents were from Greenbrier, South Norfolk, and Great Bridge.

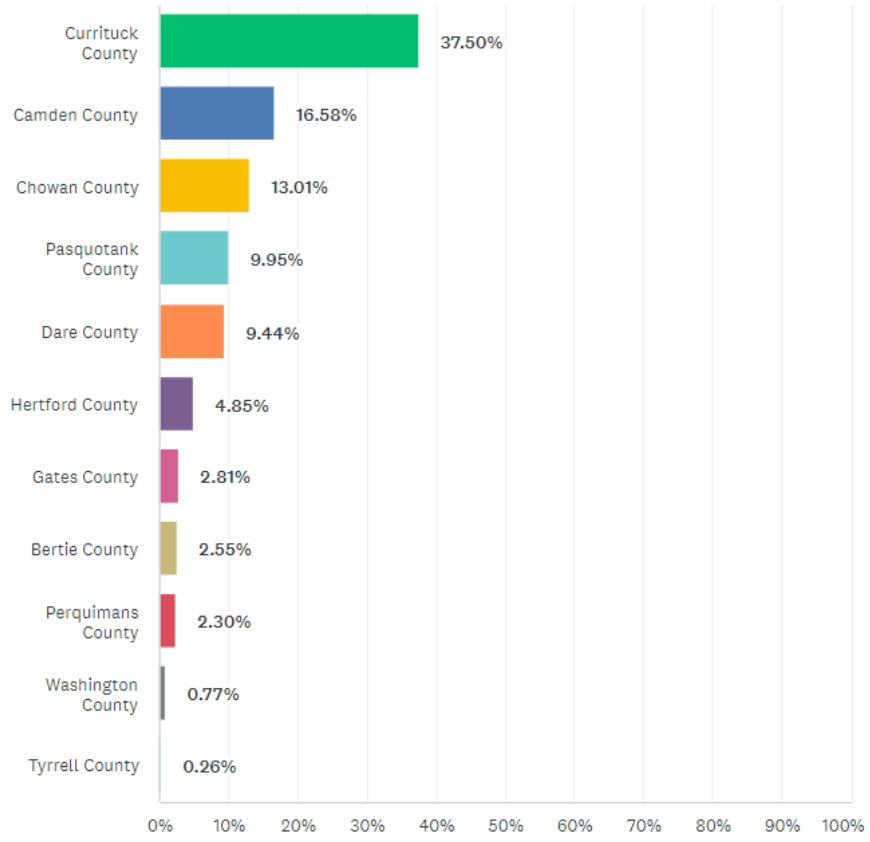
Answered: 1,287 Skipped: 569



ANSWER CHOICES	RESPONSES	
Greenbrier	21.68%	279
South Norfolk	17.33%	223
Great Bridge	17.09%	220
Deep Creek	13.29%	171
Camelot	10.18%	131
Southern (Hickory/Mt.Pleasant)	7.30%	94
Indian River	6.14%	79
Western Branch	4.20%	54
Rivercrest	2.80%	36
TOTAL		1,287

Q3: Which part of northeastern North Carolina do you live in?

The largest share of respondents from the North Carolina service area lives in Currituck County, followed by Camden County and Chowan County. Tyrrell and Washington counties are the farthest distance from the hospital and represent about 1.5% of total responses.

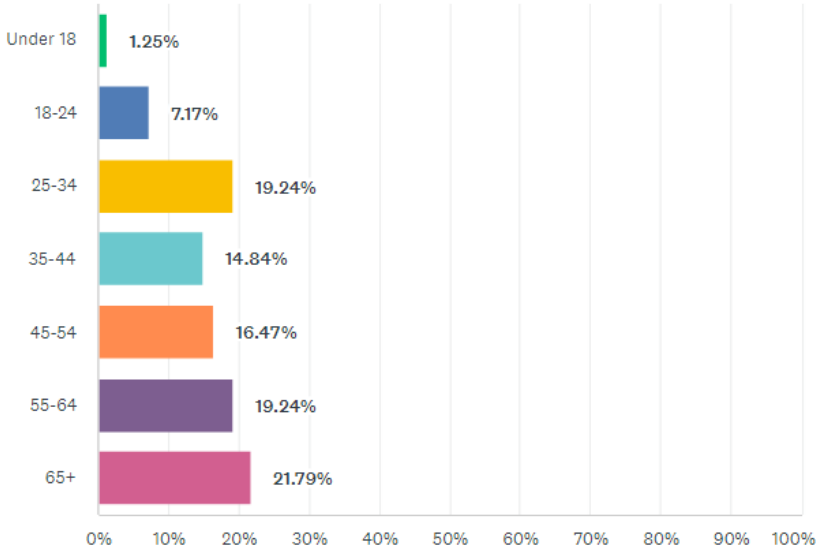


ANSWER CHOICES	RESPONSES	
Currituck County	37.50%	147
Camden County	16.58%	65
Chowan County	13.01%	51
Pasquotank County	9.95%	39
Dare County	9.44%	37
Hertford County	4.85%	19
Gates County	2.81%	11
Bertie County	2.55%	10
Perquimans County	2.30%	9
Washington County	0.77%	3
Tyrrell County	0.26%	1
TOTAL		392

Q4: What is your age?

Respondents reflect all age ranges well, with fewer in the 18–24-year-old group.

Answered: 1,840 Skipped: 16

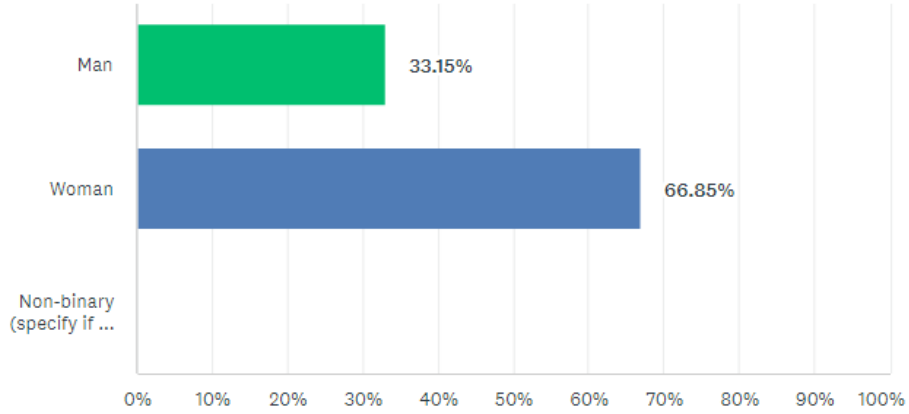


ANSWER CHOICES	RESPONSES	
Under 18	1.25%	23
18-24	7.17%	132
25-34	19.24%	354
35-44	14.84%	273
45-54	16.47%	303
55-64	19.24%	354
65+	21.79%	401
TOTAL		1,840

Q5: What is your gender identity?

Survey respondents identified as 67% woman and 33% man. This is a significant improvement over the 2018 respondents of 82% woman and just 16% man. No respondents identified as non-binary.

Answered: 1,840 Skipped: 16

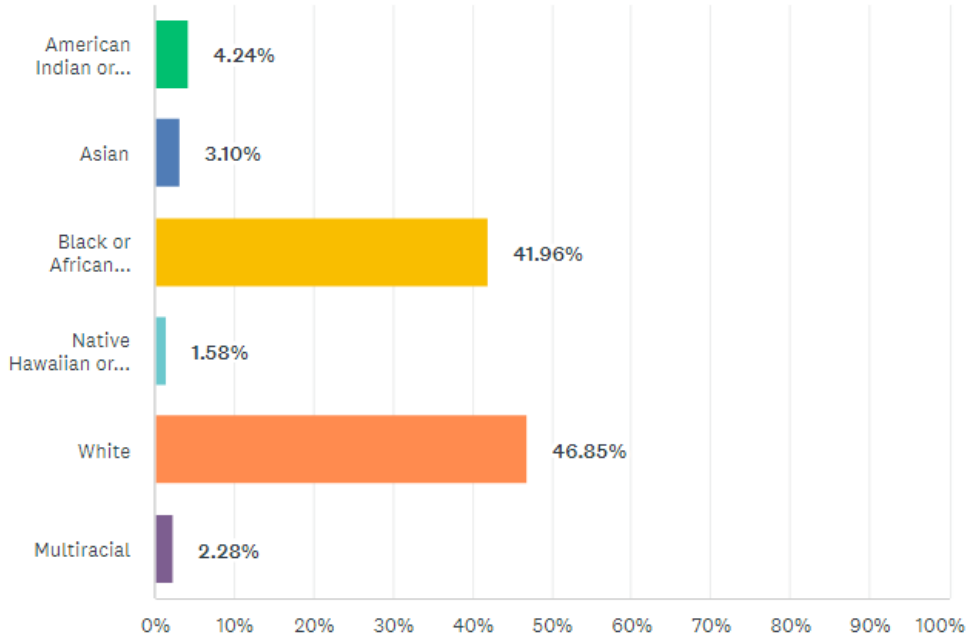


ANSWER CHOICES		RESPONSES	
Man		33.15%	610
Woman		66.85%	1,230
Non-binary (specify if you wish)	Responses	0.00%	0
TOTAL			1,840

Q6: What is your race?

Survey respondents were racially diverse, with 42% identifying as Black/African American and 47% as White. Efforts made to expand outreach to this population made an improvement over the 2018 survey in which just 16% of respondents identified as Black/African American and the majority were White (75%).

Answered: 1,840 Skipped: 16

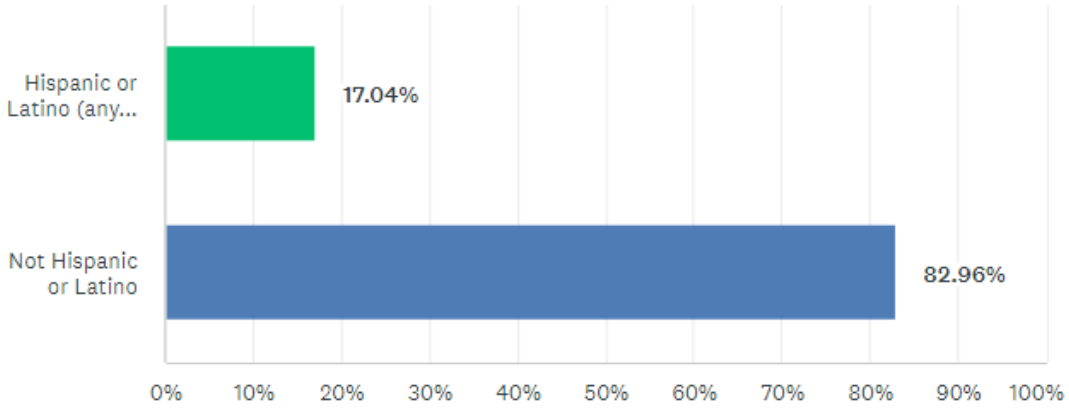


ANSWER CHOICES	RESPONSES	
American Indian or Alaskan Native	4.24%	78
Asian	3.10%	57
Black or African American	41.96%	772
Native Hawaiian or other Pacific Islander	1.58%	29
White	46.85%	862
Multiracial	2.28%	42
TOTAL		1,840

Q7: What is your ethnicity?

For this survey, ethnicity refers to those identifying as Hispanic or Latino of any race; therefore, respondents to this question can be any of the races listed in Question 6. Survey respondents were more ethnically diverse than in the 2018 CHNA survey. In 2021, 17% of respondents identified as Hispanic or Latino, compared to just 3% in the 2018 survey.

Answered: 1,725 Skipped: 131

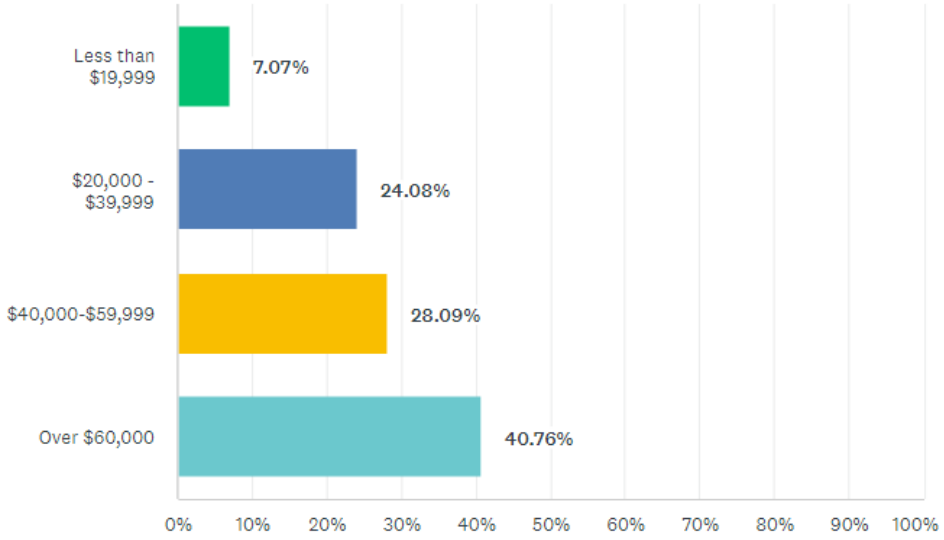


ANSWER CHOICES	RESPONSES	
Hispanic or Latino (any race)	17.04%	294
Not Hispanic or Latino	82.96%	1,431
TOTAL		1,725

Q8: What is your total household income?

More than 30% of respondents reported earning less than $40,000 per year, and 69% reported earning over $40,000 per year.

Answered: 1,769 Skipped: 87

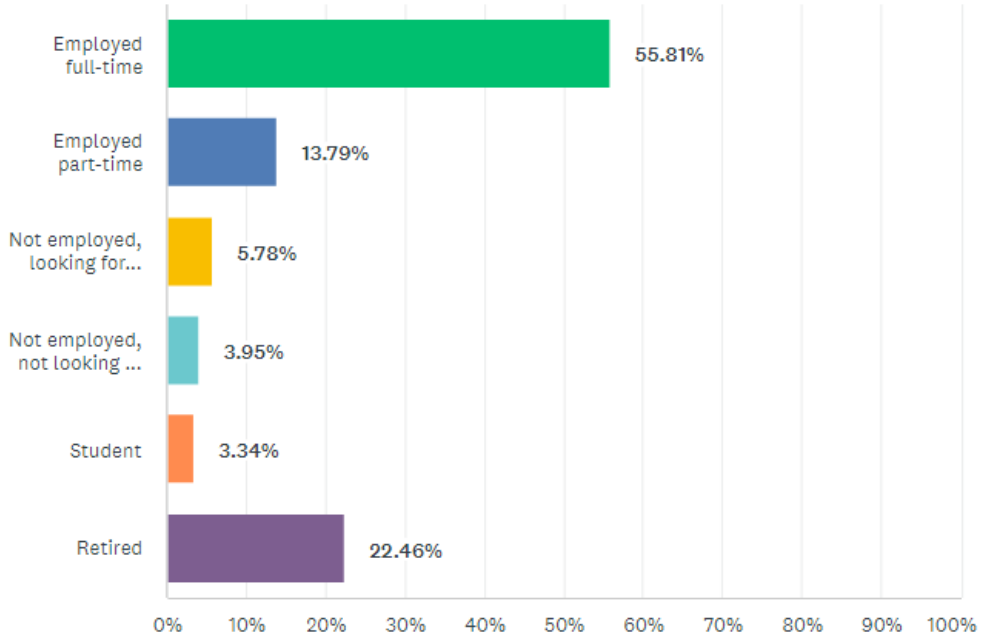


ANSWER CHOICES	RESPONSES	
Less than $19,999	7.07%	125
$20,000 - $39,999	24.08%	426
$40,000-$59,999	28.09%	497
Over $60,000	40.76%	721
TOTAL		1,769

Q9: Which best describes your employment situation?

Most respondents are employed full-time (56%), with 14% employed part-time and 22% being retired.

Answered: 1,799 Skipped: 57

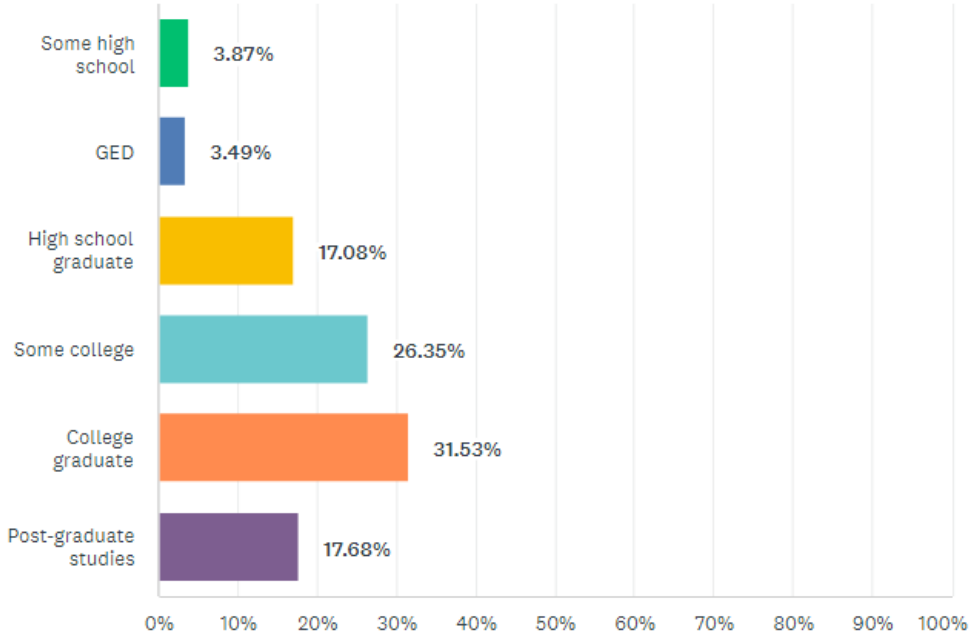


ANSWER CHOICES	RESPONSES	
Employed full-time	55.81%	1,004
Employed part-time	13.79%	248
Not employed, looking for work	5.78%	104
Not employed, not looking for work	3.95%	71
Student	3.34%	60
Retired	22.46%	404
Total Respondents: 1,799		

Q10: Which best describes your education level?

More than half of respondents (58%) reported having some college (26%) or having a college degree (32%). There were slightly more with post-graduate studies (17.68%) than with only a high school diploma (17.08%).

Answered: 1,833 Skipped: 23



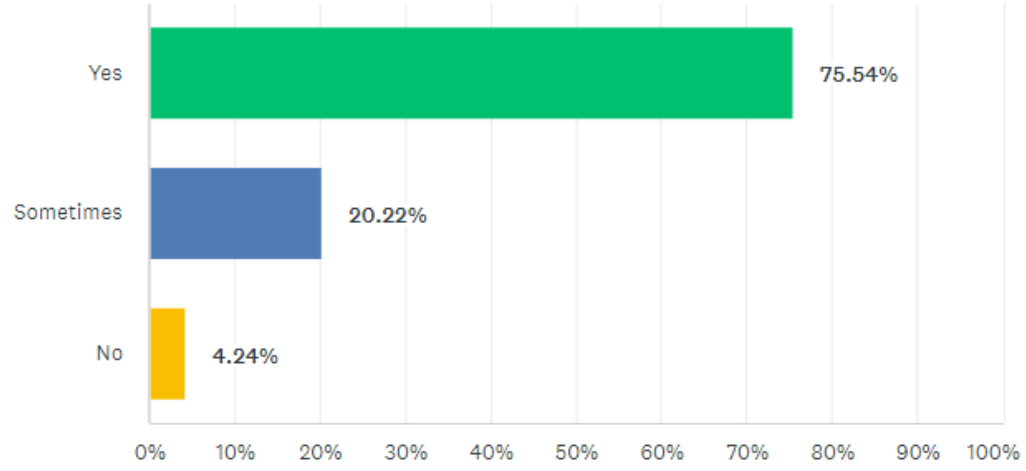
ANSWER CHOICES	RESPONSES	
Some high school	3.87%	71
GED	3.49%	64
High school graduate	17.08%	313
Some college	26.35%	483
College graduate	31.53%	578
Post-graduate studies	17.68%	324
TOTAL		1,833

QUALITY OF LIFE and ACCESS TO CARE

Q12: Do you have enough money to pay for housing, food, clothing, and medicine?

Overall, most respondents (76%) can afford the basic essentials of living. However, 372 respondents (20%) were only sometimes able to afford these, and 78 respondents (4%) are not able to afford them.

Answered:1,840 Skipped:16

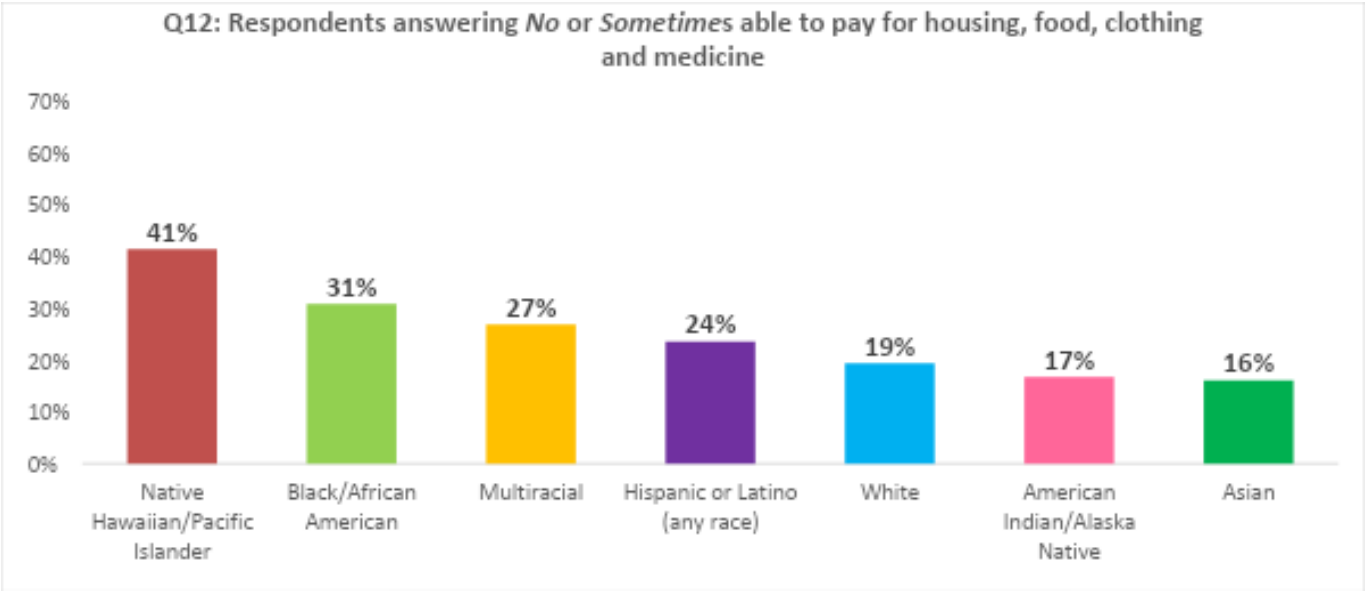


ANSWER CHOICES	RESPONSES	
Yes	75.54%	1,390
Sometimes	20.22%	372
No	4.24%	78
TOTAL		1,840

The following graphs demonstrate how respondents answered this question by race, neighborhood, and income level.

- ***Unable/Sometimes* Able to Pay for Food, Clothing, Housing and Medicine by Race & Ethnicity**

  To assess any potential racial disparities in the ability to pay for necessities, the graph below shows the percentage of survey respondents of each race and ethnicity who reported being *unable* or only *sometimes able* to pay for food, clothing, housing, and medicine. For example, 41% of Native Hawaiian/Pacific Islander respondents, (12 of 29) indicated being unable or only sometimes able to pay for necessities. This population was followed by 31% Black/African Americans (236 of 766), 27% Multiracial persons (11 of 41), 24% Hispanic persons of any race (69 of 293), 19% Whites (166 of 858), 17% American Indians/Alaska Natives (13 of 78), and 16% Asians (9 of 56).

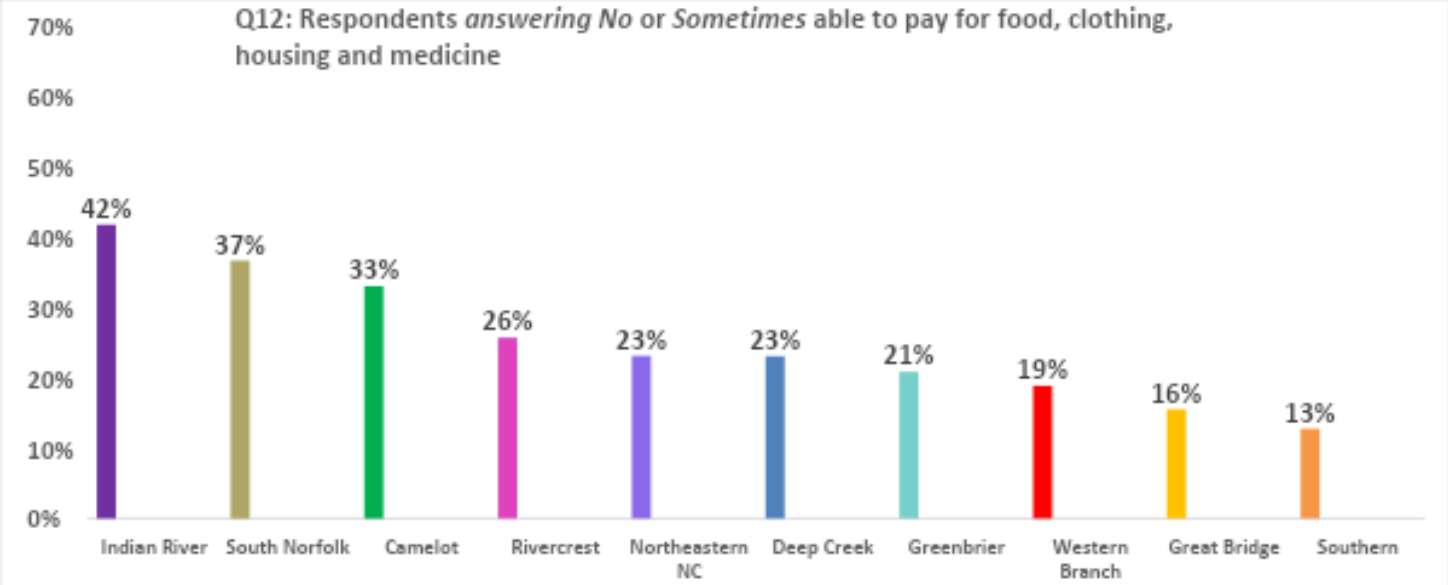


Race/Ethnicity	# Answered Yes	# Answered *No* or *Sometimes*	Total Respondents by Race/Ethnicity Who Answered Q12	% Answered *No* or *Sometimes* by Race/Ethnicity
Native Hawaiian/Pacific Islander	17	12	29	41%
Black/African American	530	236	766	31%
Multiracial	30	11	41	27%
Hispanic or Latino (any race)	224	69	293	24%
White	692	166	858	19%
American Indian/Alaska Native	65	13	78	17%
Asian	47	9	56	16%
Race/ethnicity unknown *(not included in graph)*	9	3	12	25%
TOTAL	**1,390**	**450**	**1,840**	**24%**

- ***Unable/ Sometimes* Able to Pay for Food, Clothing, Housing and Medicine by Location**

To assess how residents of each neighborhood are faring on this issue, the graph below shows the percentage of survey respondents from each Chesapeake borough and from northeastern North Carolina who struggle to pay for necessities.

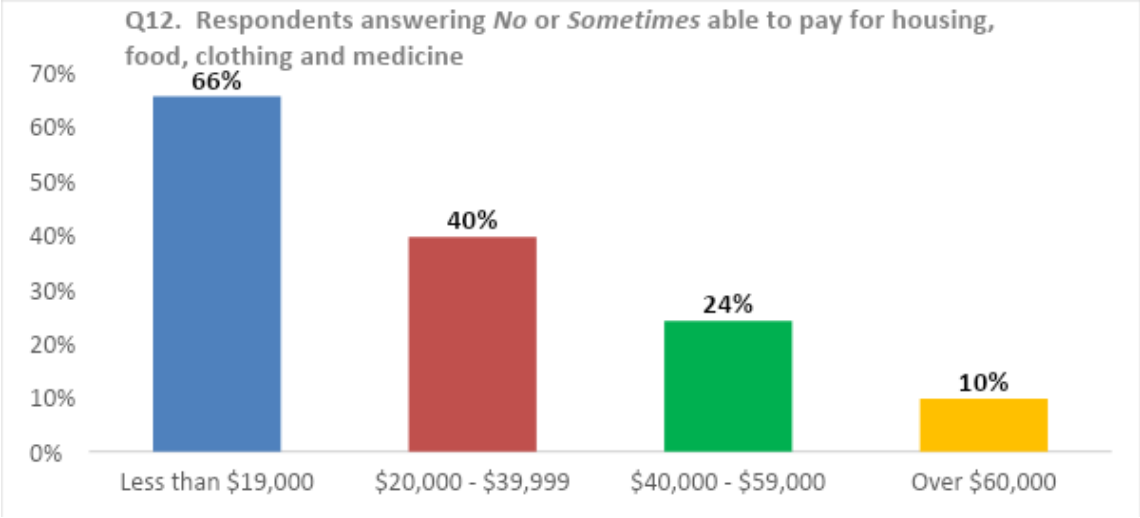
Forty-two percent (42%) of respondents from Indian River (33 of 79) were unable or only sometimes able to cover these costs, as were 37% of respondents from South Norfolk (81 of 221), 33% of respondents from Camelot (43 of 130), 26% of respondents from Rivercrest (9 of 35) ,23% of respondents from northeastern North Carolina (68 of 294), 23% of respondents from Deep Creek (39 of 169), 21% or respondents from Greenbrier (58 of 278), 19% of respondents from Western Branch (10 of 53), 16% of respondents from Great Bridge (34 of 219) and 13% of respondents from the Southern/Hickory area (12 of 94).



Neighborhood	# Answered Yes	# Answered *No* or *Sometimes*	Total Respondents by Borough Who Answered Q12	% Answered *No* or *Sometimes*
Indian River	46	33	79	42%
South Norfolk	140	81	221	37%
Camelot	87	43	130	33%
Rivercrest	26	9	35	26%
Northeastern NC	226	68	294	23%
Deep Creek	130	39	169	23%
Greenbrier	220	58	278	21%
Western Branch	43	10	53	19%
Great Bridge	185	34	219	16%
Southern/Hickory	82	12	94	13%
Other/Unknown *(not in graph)*	205	63	268	24%
TOTAL	**1,390**	**450**	**1,840**	**24%**

- ***Unable/ Sometimes* Able to Pay for Food, Clothing, Housing and Medicine by Income Level**

Those with lower incomes are clearly less able to afford the necessities, but it is concerning that 66% (82 of 125) of those with an annual household income less than $19,000 are unable or only sometimes able to afford the basics. The percentage decreases as income increases, yet 10% (70 of 718) of those with an income over $60,000 state that they still struggle to cover these costs.

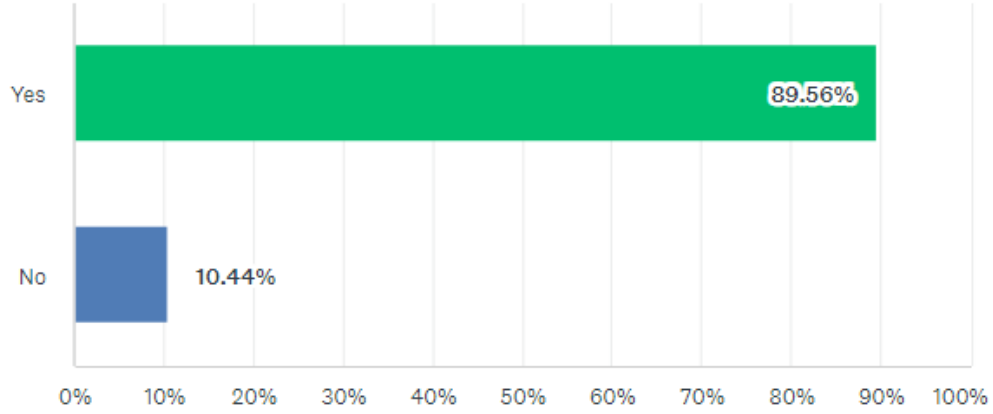


Annual Household Income	# Answered Yes	# Answered *No* or *Sometimes*	Total Respondents by Income Who Answered Q12	% Answered *No* or *Sometimes* by Income
Less than $19,000	43	82	125	66%
$20,000 - $39,999	255	167	422	40%
$40,000 - $59,999	375	119	494	24%
Over $60,000	648	70	718	10%
Income not provided *(not in graph)*	69	12	81	15%
TOTAL	**1,390**	**450**	**1,840**	**24%**

Q13: Are you able to afford your prescriptions?

Answered: 1,820 Skipped: 36

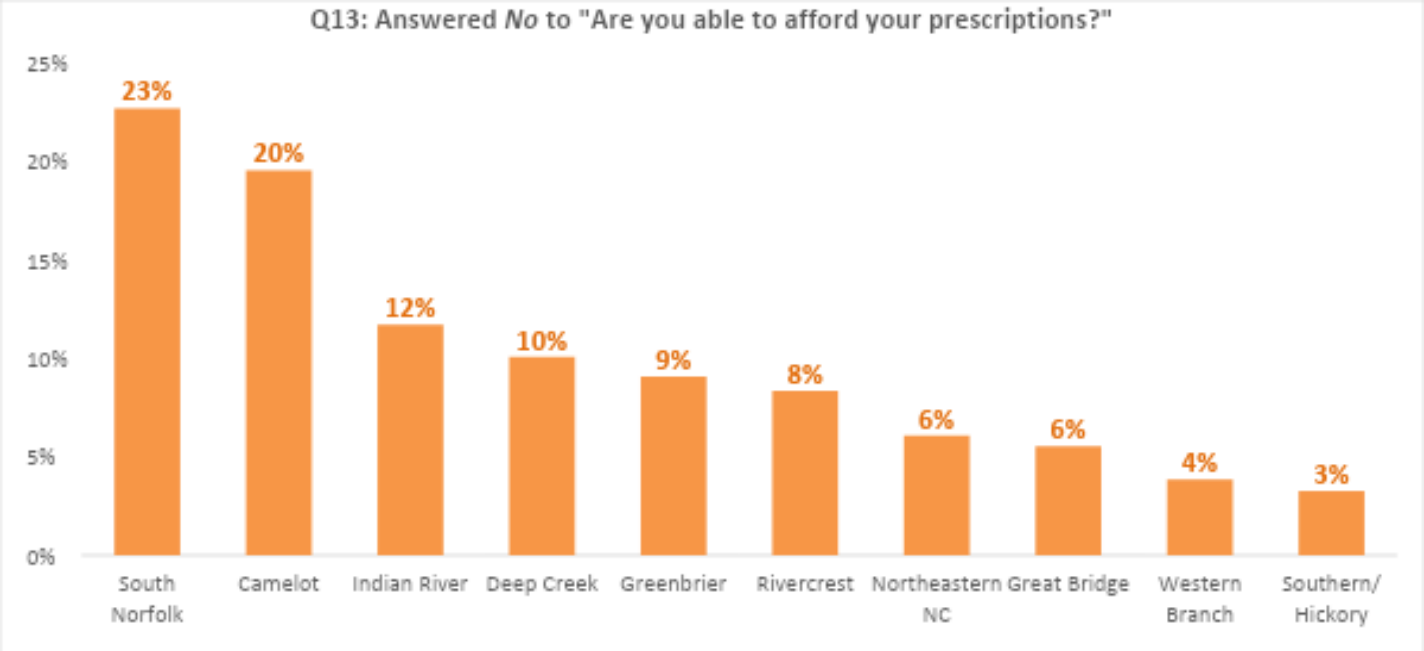
Ninety percent of respondents answered Yes to being able to afford prescriptions. However, the graphs and tables that follow provide a breakdown by neighborhood, race/ethnicity, and income level to identify any populations that struggle with this expense.



ANSWER CHOICES	RESPONSES	
Yes	89.56%	1,630
No	10.44%	190
TOTAL		1,820

Q13: Ability to afford prescriptions by neighborhood

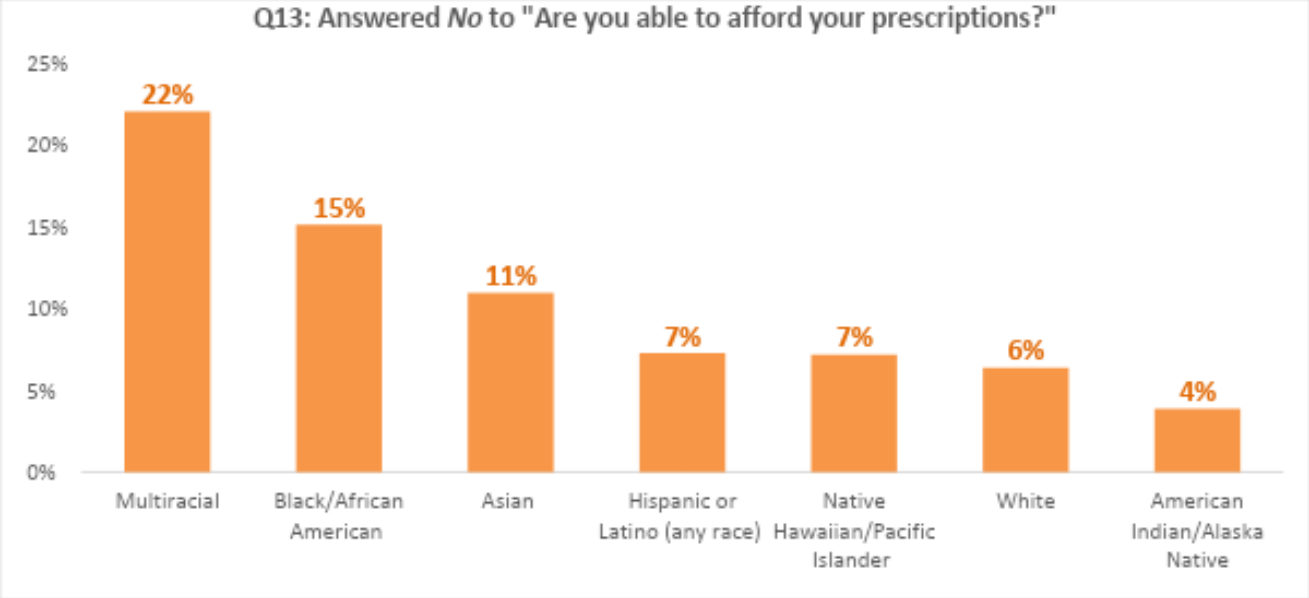
Respondents from South Norfolk and Camelot indicate a greater inability to afford prescriptions.



Neighborhood	# Respondents	Yes		No	
		#	%	#	%
South Norfolk	216	167	77%	49	23%
Camelot	128	103	80%	25	20%
Indian River	77	68	88%	9	12%
Deep Creek	169	152	90%	17	10%
Greenbrier	276	251	91%	25	9%
Rivercrest	36	33	92%	3	8%
Northeastern NC	280	263	94%	17	6%
Great Bridge	217	205	94%	12	6%
Western Branch	52	50	96%	2	4%
Southern/Hickory	92	89	97%	3	3%
Other/Unknown *(not in graph)*	277	249	90%	28	10%
Total	**1,820**	**1,630**	**90%**	**190**	**10%**

Q13: Ability to afford prescriptions by race and ethnicity

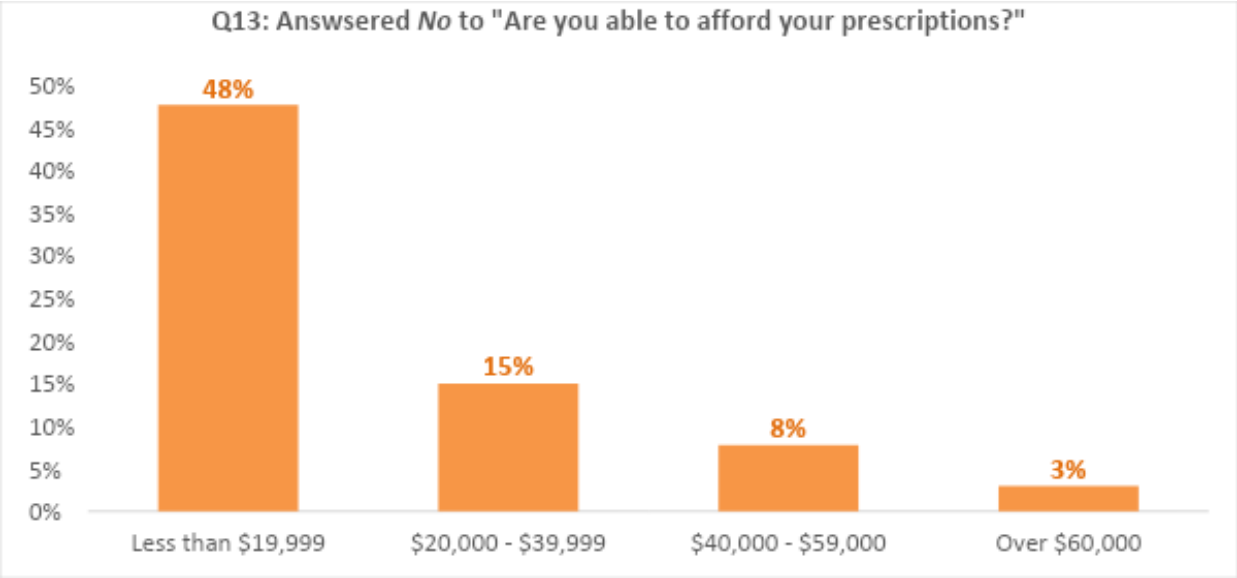
Multiracial respondents the least able to afford prescriptions (22%), followed by Black/African American respondents (15%) and Asian respondents (11%).



Race/ethnicity	# Respondents	Yes		No	
		#	%	#	%
Multiracial	41	32	78%	9	22%
Black/African American	756	642	85%	114	15%
Asian	55	49	89%	6	11%
Hispanic or Latino (any race)	290	269	93%	21	7%
Native Hawaiian/Pacific Islander	28	26	93%	2	7%
White	850	796	94%	54	6%
American Indian/Alaska Native	78	75	96%	3	4%
Race/ethnicity unknown (not included in graph)	12	10	83%	2	17%
Total	**1,820**	**1,630**	**90%**	**190**	**10%**

Q13: Ability to afford prescriptions by income level

Not surprisingly, the lowest income group reported the highest percentage of not being able to afford prescriptions.

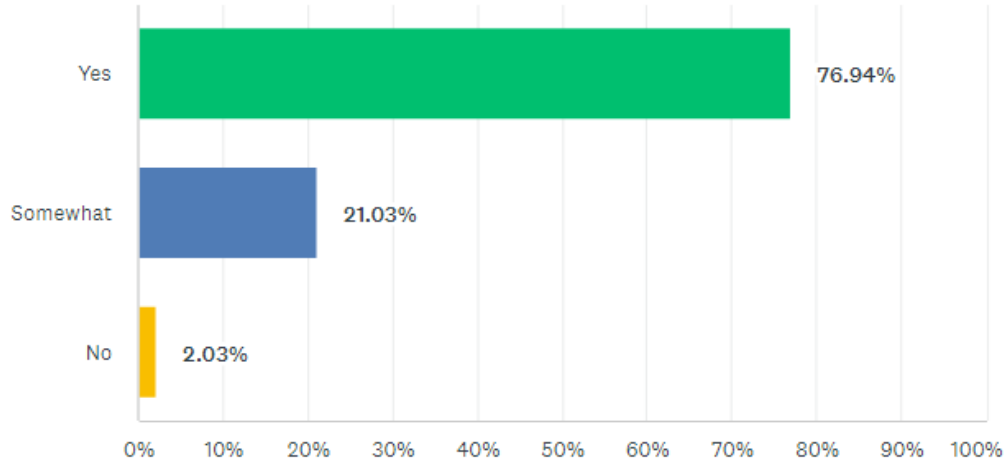


Annual Household Income	# Respondents	Yes		No	
		#	%	#	%
Less than $19,999	124	65	52%	59	48%
$20,000 - $39,999	415	353	85%	62	15%
$40,000 - $59,000	489	451	92%	38	8%
Over $60,000	713	692	97%	21	3%
Income not provided *(not in graph)*	79	69	87%	10	13%
Total	**1,820**	**1,630**	**90%**	**190**	**10%**

Q21: Overall, do you feel your community is a safe place to live?

Answered: 1,826 Skipped: 30

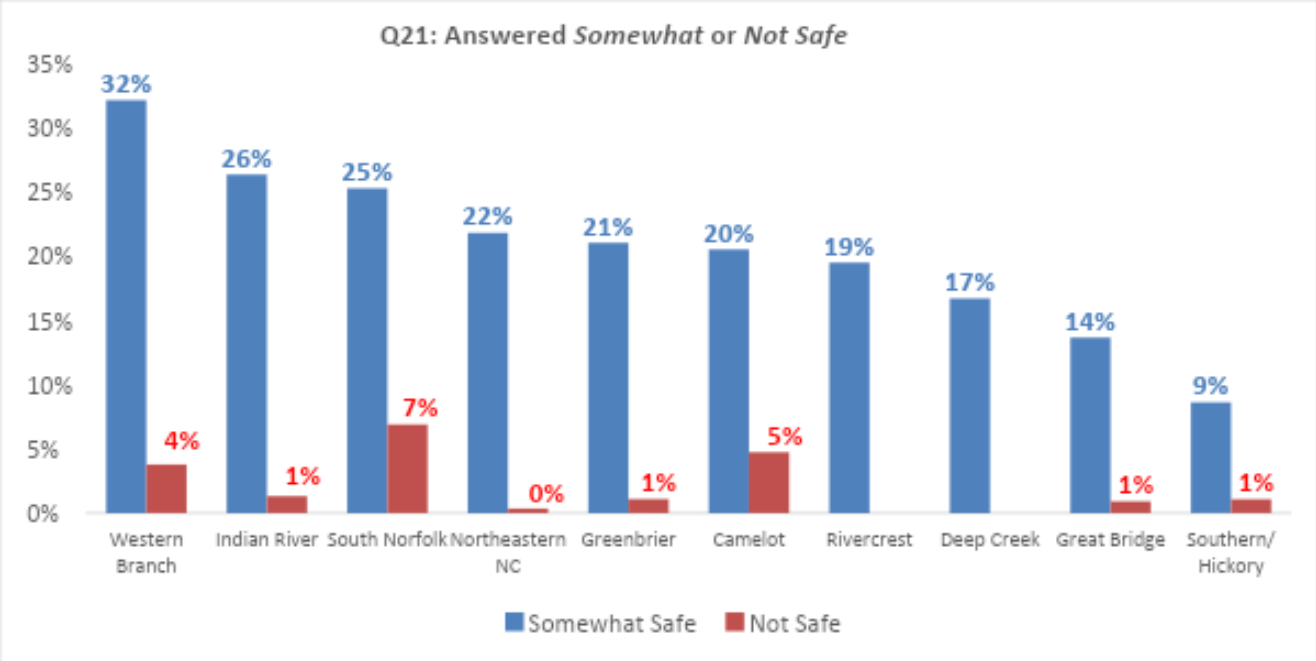
Although many residents feel that their communities are safe, 23% answered Sometimes or No to this question. The main reasons stated in the comments section were gun violence, crime, and drug activity.



ANSWER CHOICES	RESPONSES	
Yes	76.94%	1,405
Somewhat	21.03%	384
No	2.03%	37
TOTAL		1,826

Q21: Community safety by neighborhood

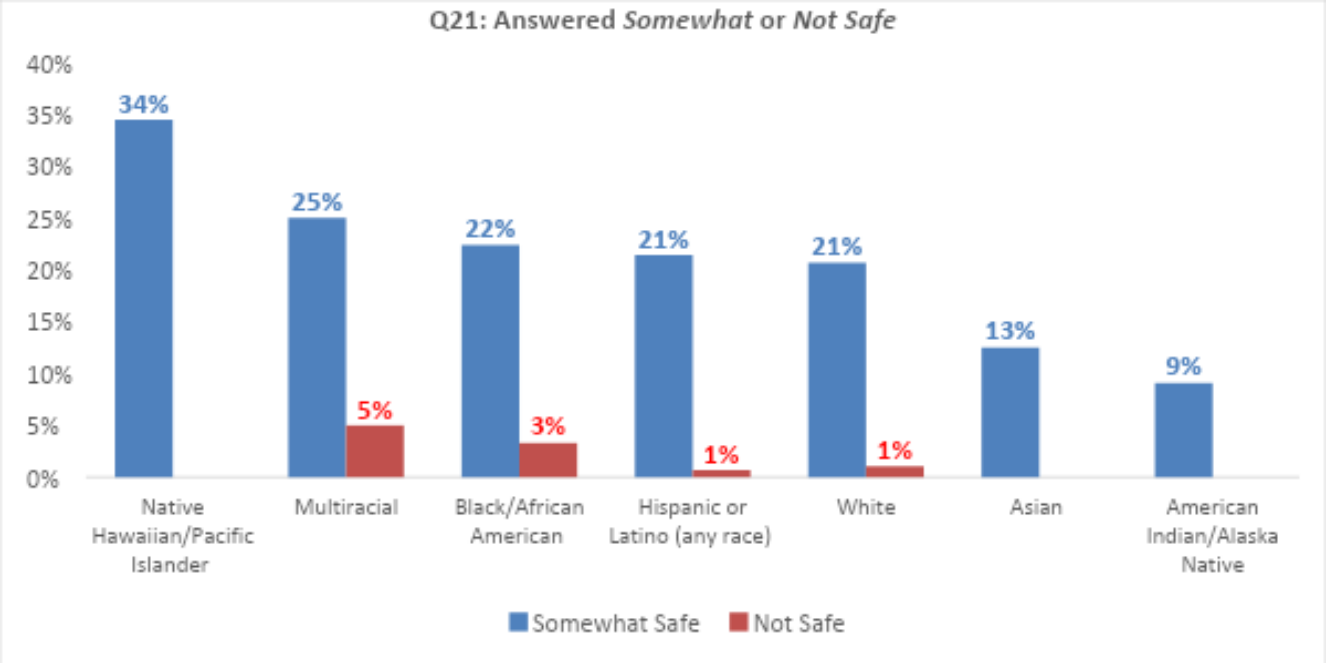
Respondents from Western Branch reported the highest percentage of feeling that their neighborhood is *Somewhat* safe (32%), and respondents from Southern/Hickory reported the highest percentage of feeling that their neighborhood was safe (90%).



Neighborhood	# Respondents	Yes		Somewhat Safe		Not Safe	
		#	%	#	%	#	%
Western Branch	53	34	64%	17	32%	2	4%
Indian River	76	55	72%	20	26%	1	1%
South Norfolk	218	148	68%	55	25%	15	7%
Northeastern NC	285	222	78%	62	22%	1	0%
Greenbrier	276	215	78%	58	21%	3	1%
Camelot	127	95	75%	26	20%	6	5%
Rivercrest	36	29	81%	7	19%	0	0%
Deep Creek	168	140	83%	28	17%	0	0%
Great Bridge	220	188	85%	30	14%	2	1%
Southern/Hickory	93	84	90%	8	9%	1	1%
Other/Unknown *(not in graph)*	274	195	71%	73	27%	6	2%
Total	**1,826**	**1,405**	**77%**	**384**	**21%**	**37**	**2%**

Q21: Community Safety by Race and Ethnicity

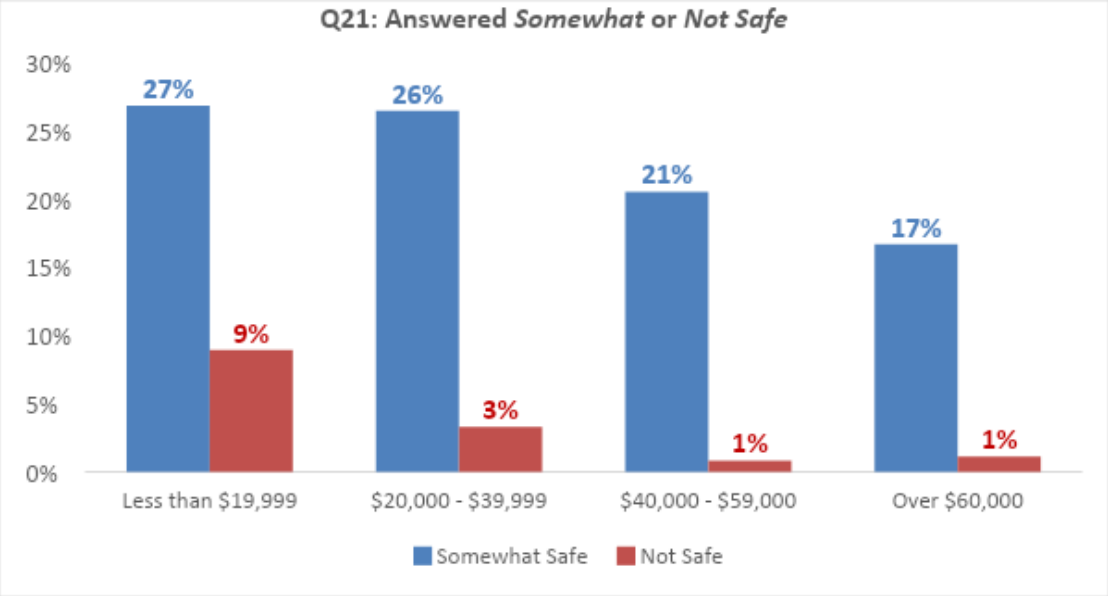
Native Hawaiian/Pacific Islander respondents reported the highest percentage of feeling *Somewhat* safe in their community (34%) and American Indian/Alaska Native respondents reported the highest percentage of feeling safe (91%).



Race/Ethnicity	# Respondents	Yes		Somewhat Safe		Not Safe	
		#	%	#	%	#	%
Native Hawaiian/Pacific Islander	29	19	66%	10	34%	0	0%
Multiracial	40	28	70%	10	25%	2	5%
Black/African American	758	563	74%	170	22%	25	3%
Hispanic or Latino (any race)	289	225	78%	62	21%	2	1%
White	855	669	78%	177	21%	9	1%
Asian	56	49	88%	7	13%	0	0%
American Indian/Alaska Native	77	70	91%	7	9%	0	0%
Race/ethnicity unknown *(not included in graph)*	11	7	64%	3	27%	1	9%
Total	**1,826**	**1,405**	**77%**	**384**	**21%**	**37**	**2%**

Q21: Community Safety by Income Level

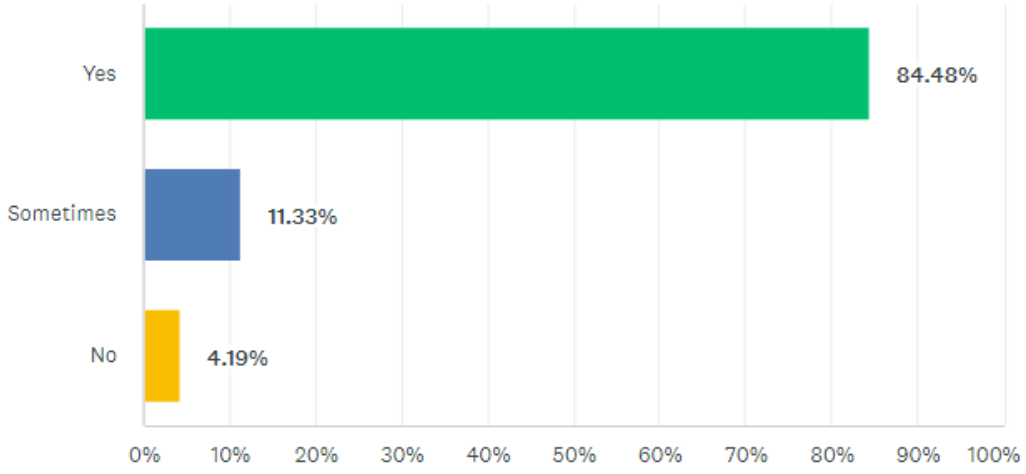
Respondents in the lower two income groups reported the highest percentages of feeling *Somewhat* safe and *Not Safe*. However, even among the higher two income groups, some still reported feeling only *Somewhat or Not Safe* in their communities.



Annual Household Income	# Respondents	Yes		Somewhat Safe		Not Safe	
		#	%	#	%	#	%
Less than $19,999	123	79	64%	33	27%	11	9%
$20,000 - $39,999	423	297	70%	112	26%	14	3%
$40,000 - $59,000	487	383	79%	100	21%	4	1%
Over $60,000	714	587	82%	119	17%	8	1%
Income not provided *(not in graph)*	79	59	75%	20	25%	0	0%
Total	**1,826**	**1,405**	**77%**	**384**	**21%**	**37**	**2%**

Q23: Do you get available vaccinations?

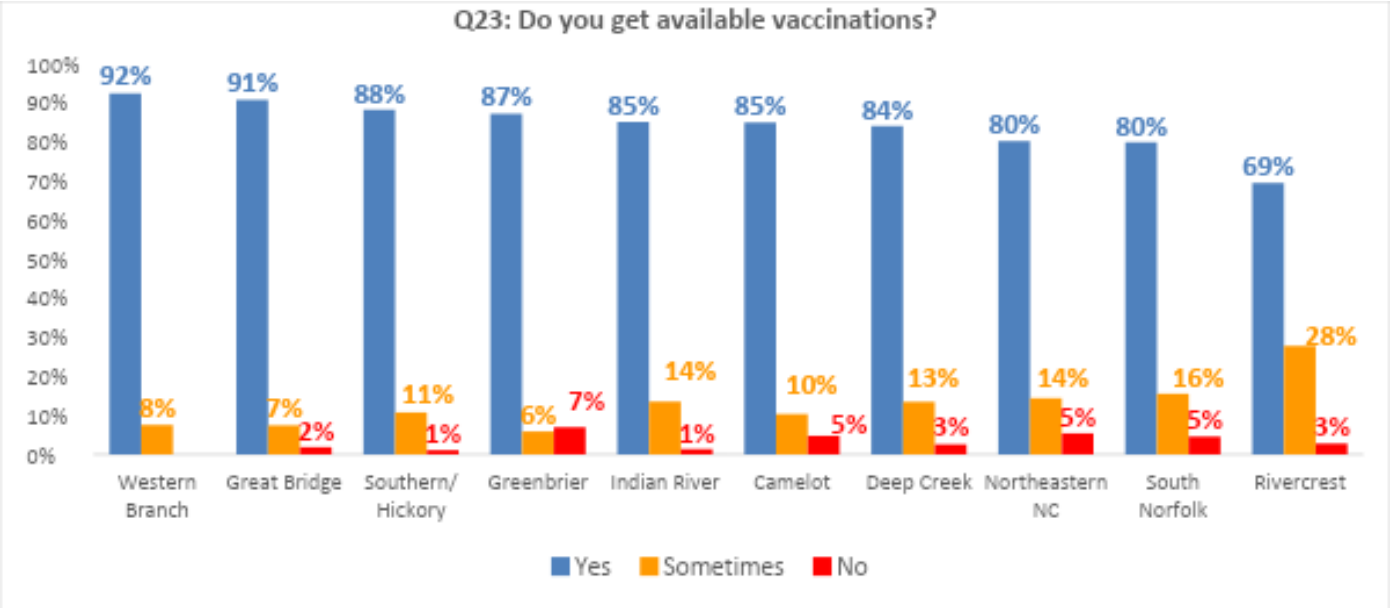
Answered: 1,791 Skipped:65



ANSWER CHOICES	RESPONSES	
Yes	84.48%	1,513
Sometimes	11.33%	203
No	4.19%	75
TOTAL		1,791

Q23: Vaccinations by Neighborhood

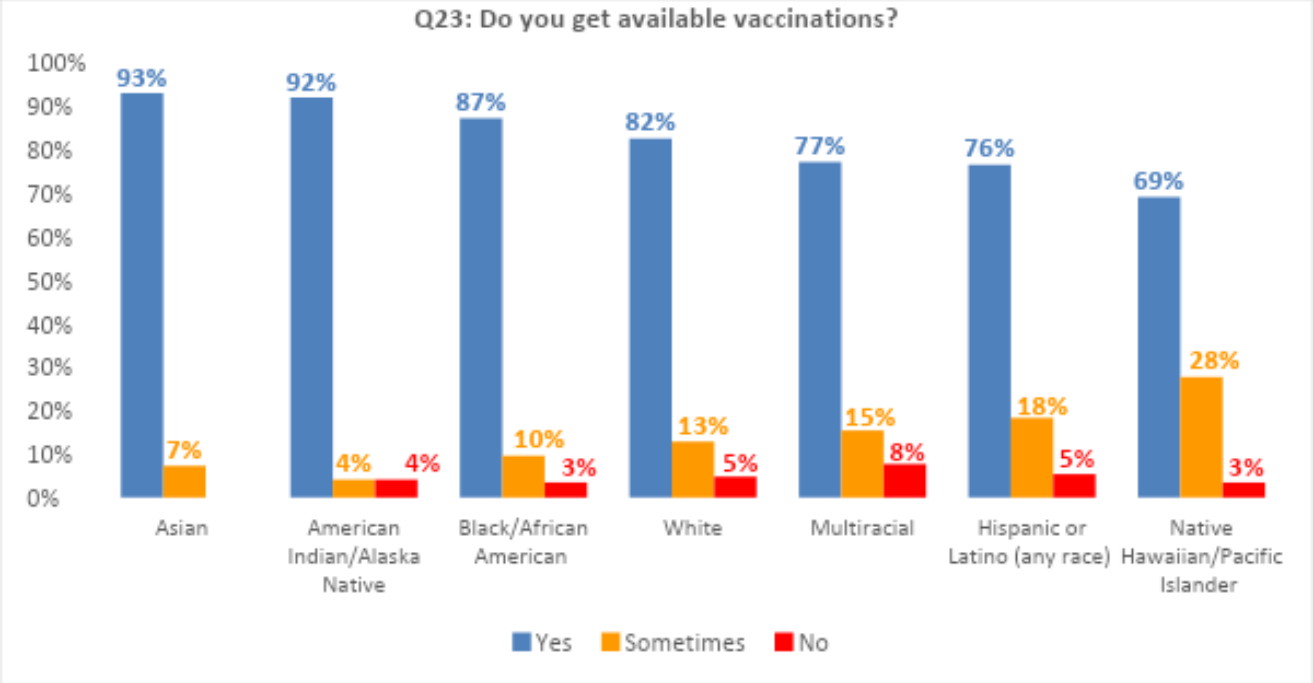
Respondents from Rivercrest reported both the smallest percentage of getting available vaccinations (69%) as well as the largest percentage of *Sometimes* getting vaccinations (28%).



Neighborhood	# Respondents	Yes		Sometimes		No	
		#	%	#	%	#	%
Western Branch	53	49	92%	4	8%	0	0%
Great Bridge	215	195	91%	16	7%	4	2%
Southern/Hickory	93	82	88%	10	11%	1	1%
Greenbrier	273	238	87%	16	6%	19	7%
Indian River	74	63	85%	10	14%	1	1%
Camelot	126	107	85%	13	10%	6	5%
Deep Creek	156	131	84%	21	13%	4	3%
Northeastern NC	278	223	80%	40	14%	15	5%
South Norfolk	219	175	80%	34	16%	10	5%
Rivercrest	36	25	69%	10	28%	1	3%
Other/unknown *(not in graph)*	268	225	84%	29	11%	14	5%
Total	**1,791**	**1,513**	**84%**	**203**	**11%**	**75**	**4%**

Q23: Vaccinations by Race and Ethnicity

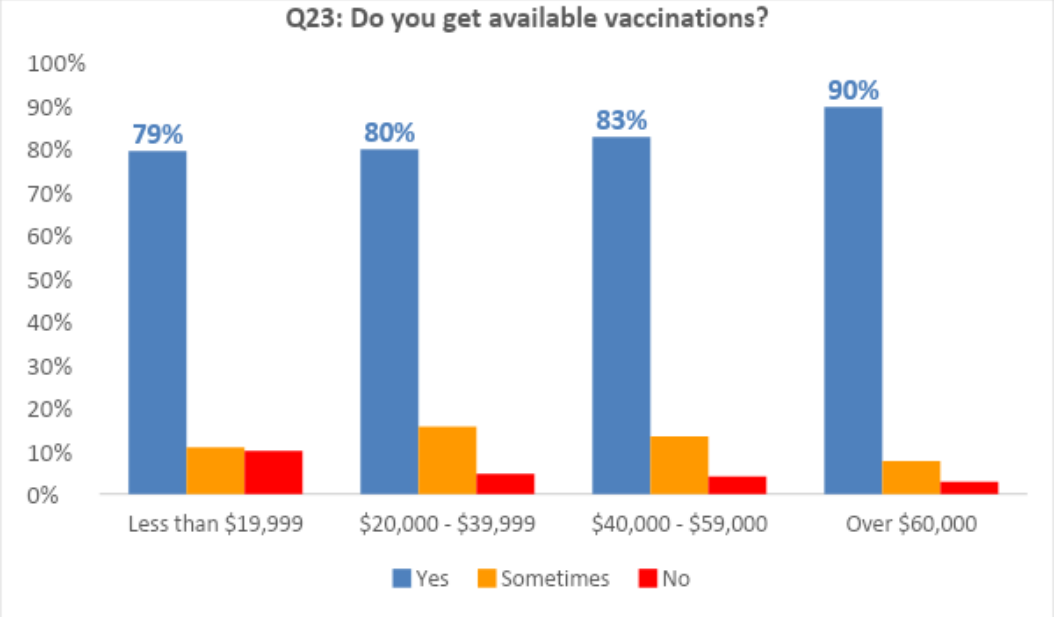
Asian and American Indian/Alaska Native respondents reported the highest percentages of getting available vaccinations (93% and 92%). Native Hawaiian/Pacific Islander respondents reported the lowest percentage of getting available vaccinations (69%) and the highest percentage of *Sometimes* getting vaccinations (28%).



Race/Ethnicity	# Respondents	Yes		Sometimes		No	
		#	%	#	%	#	%
Asian	55	51	93%	4	7%	0	0%
American Indian/Alaska Native	73	67	92%	3	4%	3	4%
Black/African American	751	653	87%	72	10%	26	3%
White	834	687	82%	107	13%	40	5%
Multiracial	39	30	77%	6	15%	3	8%
Hispanic or Latino (any race)	279	213	76%	51	18%	15	5%
Native Hawaiian/Pacific Islander	29	20	69%	8	28%	1	3%
Race/ethnicity unknown *(not included in graph)*	10	5	50%	3	30%	2	20%
Total	**1,791**	**1,513**	**84%**	**203**	**11%**	**75**	**4%**

Q23: Vaccinations by Income Level

Survey results show that reports of getting vaccines increases with income. Those with higher incomes may have greater access and financial ability to get vaccines.

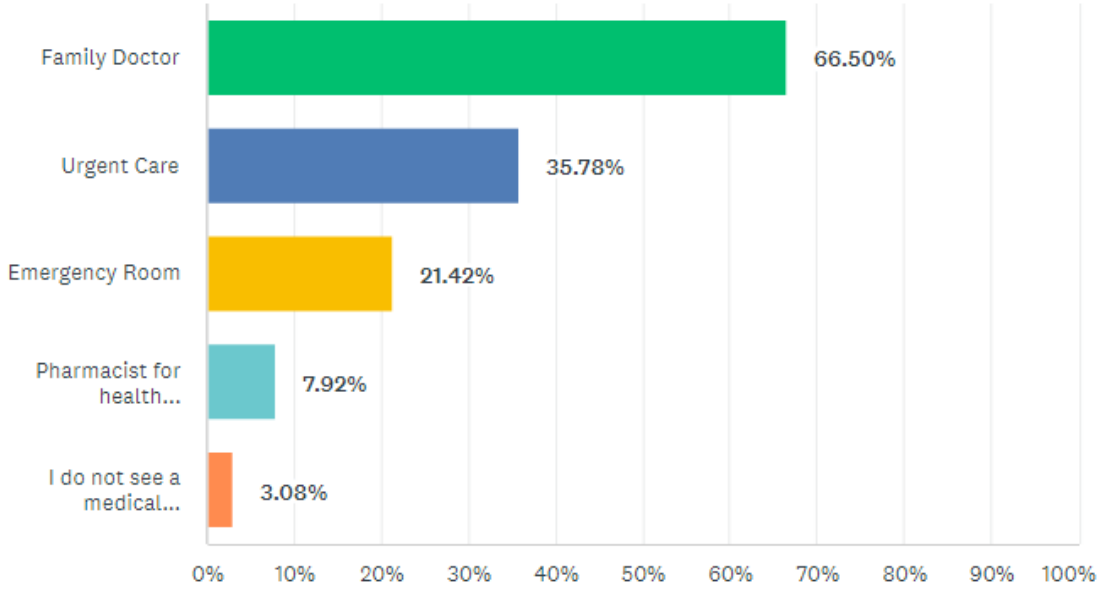


Annual Household Income	# Respondents	Yes		Sometimes		No	
		#	%	#	%	#	%
Less than $19,999	121	96	79%	13	11%	12	10%
$20,000 - $39,999	410	327	80%	64	16%	19	5%
$40,000 - $59,000	489	404	83%	65	13%	20	4%
Over $60,000	698	625	90%	53	8%	20	3%
Income not provided *(not in graph)*	73	61	84%	8	11%	4	5%
Total	**1,791**	**1,513**	**84%**	**203**	**11%**	**75**	**4%**

Q27: Where do you usually go when you do not feel well?

Approximately one-third of respondents (67%) see a family doctor when they do not feel well. This is an indication of having a medical home with regular check-ups. Respondents were asked to check all that apply, so in addition to many having a family doctor, 36% of respondents use an Urgent Care, followed by 21% going to the Emergency Room, 8% seeing a pharmacist for health information, and 3% who do not see a medical provider.

Answered: 1,755 Skipped: 101

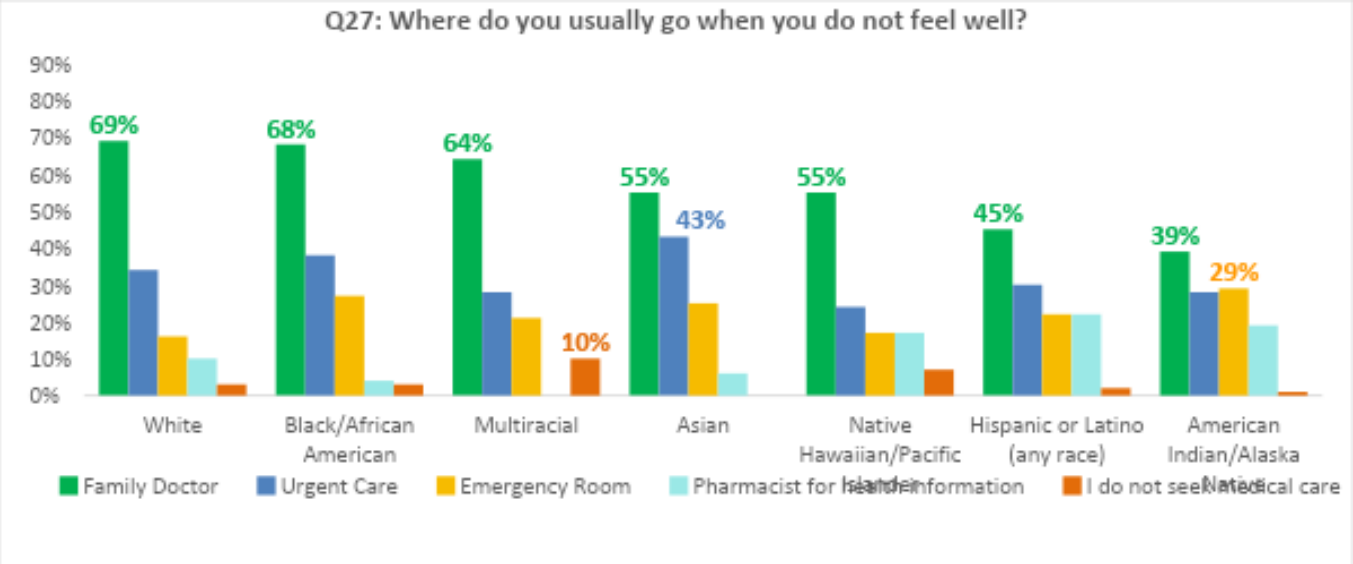


ANSWER CHOICES	RESPONSES	
Family Doctor	66.50%	1,167
Urgent Care	35.78%	628
Emergency Room	21.42%	376
Pharmacist for health advice/medication only	7.92%	139
I do not see a medical professional	3.08%	54
Total Respondents: 1,755		

- **Type of Routine Medical Care Usually Sought, by Race & Ethnicity**

The graph below indicates where respondents of different races and ethnicities reported seeking medical care when they do not feel well. This question was designed to indicate access to regular health care rather than emergency care. An overreliance on the Emergency Room or Urgent Care may indicate limited access to regular medical care, which may indicate potential disparities among races.

Black/African American and White respondents (68% and 69%, respectively) reported the highest percentage of having a family doctor, and American Indian/Alaska Native respondents had the lowest percentage (39%). Asian respondents (43%) reported using the Urgent Care more than other races. Twenty-nine percent (29%) of American Indian/Alaska Native respondents reported using the Emergency Room more than other races, and Multiracial respondents (10%) reported the highest percentage of respondents who do not seek medical care.

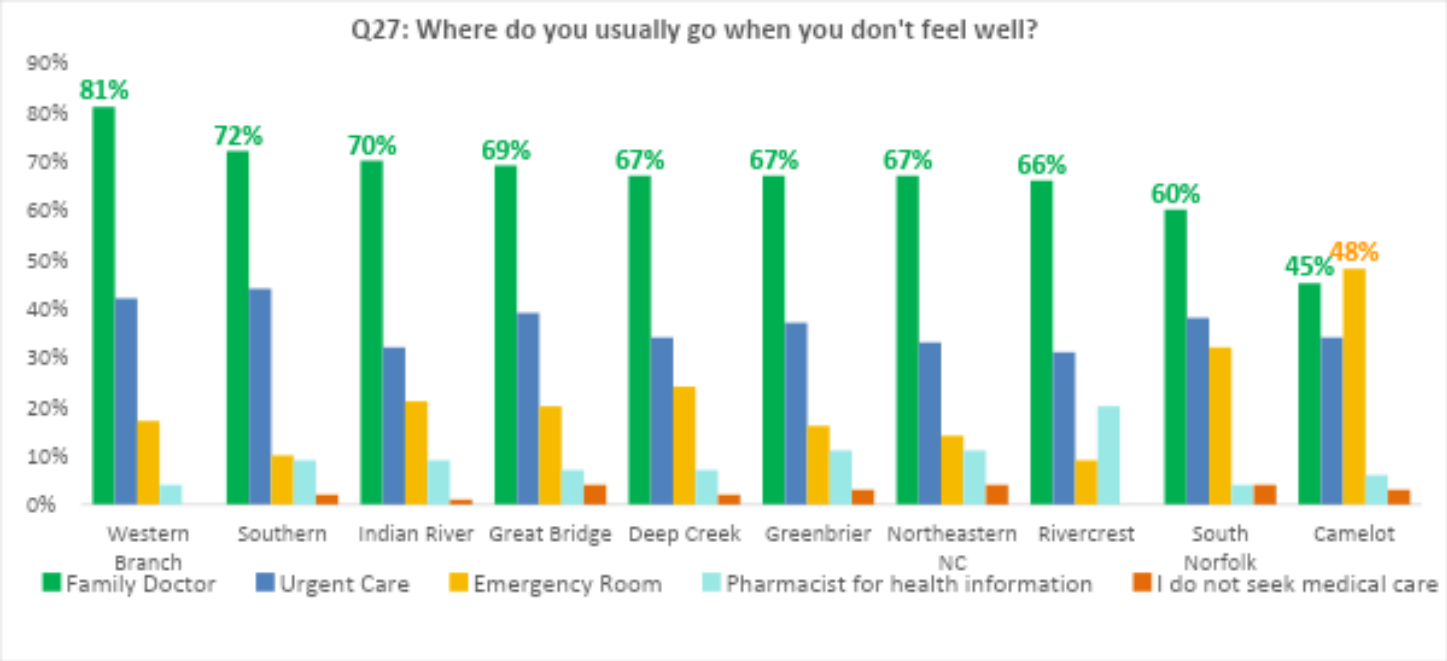


Race/Ethnicity	# Respondents	Family Doctor		Urgent Care		Emergency Room		Pharmacist		Do not seek medical care	
		#	%	#	%	%	#	#	%	#	%
White	813	559	69%	280	34%	129	16%	85	10%	24	3%
Black/African American	738	505	68%	283	38%	197	27%	30	4%	22	3%
Multiracial	39	25	64%	11	28%	8	22%	0	0%	4	10%
Asian	53	29	55%	23	43%	13	25%	3	6%	0	0%
Native Hawaiian/Pacific Islander	**29**	16	55%	7	24%	5	17%	5	17%	2	7%
Hispanic or Latino (any race)	**277**	126	45%	83	30%	60	22%	62	22%	6	2%
American Indian/Alaska Native	**72**	28	39%	20	28%	21	29%	14	19%	1	1%
Race/ethnicity unknown *(not in graph)*	**11**	5	45%	4	36%	3	27%	2	18%	1	9%
Total	**1,755**	**1,167**	**67%**	**628**	**36%**	**376**	**21%**	**139**	**8%**	**54**	**3%**

Respondents could check all that apply.

- **Type of Routine Medical Care Usually Sought, by Neighborhood**

  Respondents in Western Branch reported the largest percentage of seeing a family doctor. Respondents from Camelot reported the smallest percentage of having a family doctor (45%) and the highest percentage of using the Emergency Room (48%) when they do not feel well. Similarly, respondents in South Norfolk reported a lower-than-average percentage of having a family doctor (60%) and a higher-than-average percentage of using the Emergency Room (32%) for routine care. This pattern tends to indicate an inverse relationship between having access to routine care and use of the Emergency Room for routine care.

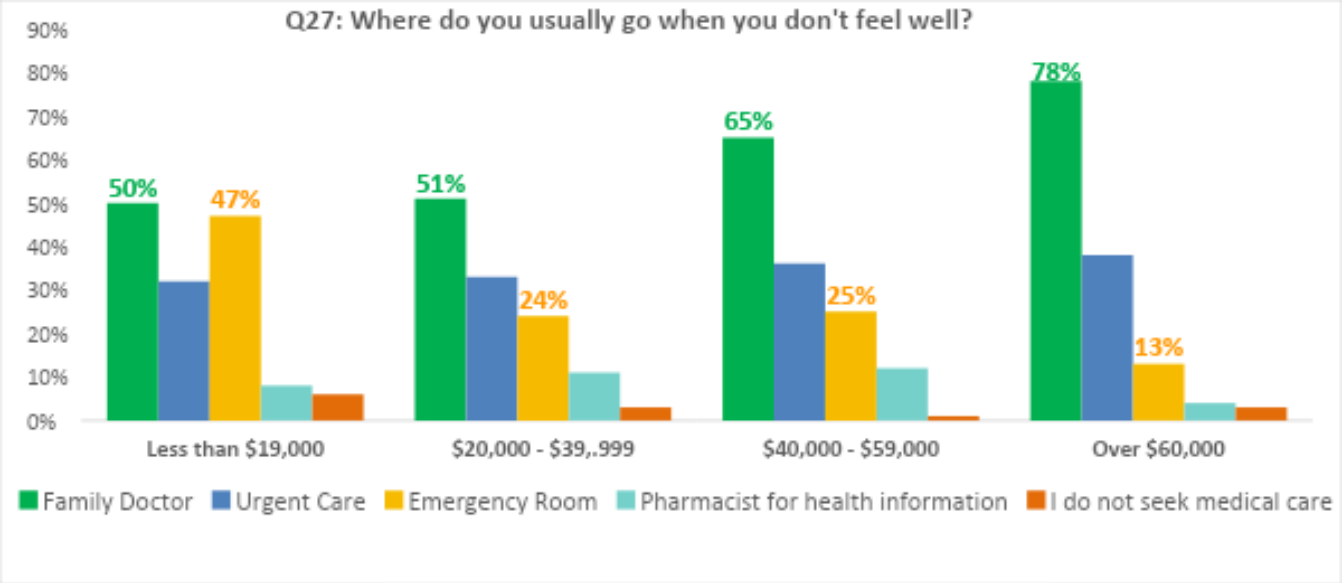


Neighborhood	# Respondents	Family Doctor		Urgent Care		Emergency Room		Pharmacist		I do not seek medical care	
		#	%	#	%	%	#	#	%	#	%
Western Branch	**53**	43	81%	22	42%	9	17%	2	4%	0	0%
Southern/Hickory	**90**	65	72%	40	44%	9	10%	8	9%	2	2%
Indian River	**77**	54	70%	25	32%	16	21%	7	9%	1	1%
Great Bridge	**211**	146	69%	83	39%	42	20%	15	7%	8	4%
Deep Creek	**150**	100	67%	51	34%	36	24%	10	7%	3	2%
Greenbrier	**265**	178	67%	97	37%	43	16%	30	11%	9	3%
Northeastern NC	**269**	179	67%	88	33%	38	14%	30	11%	11	4%
Rivercrest	**35**	23	66%	11	31%	3	9%	7	20%	0	0%
South Norfolk	**212**	128	60%	81	38%	67	32%	9	32%	8	4%
Camelot	**128**	57	45%	44	34%	61	48%	8	6%	4	3%
Other/Unknown *(not in graph)*	**265**	194	73%	86	34%	52	20%	13	5%	8	3%
Total	**1,755**	**1,167**	**67%**	**628**	**36%**	**376**	**21%**	**139**	**8%**	**54**	**3%**

Respondents could check all that apply.

● Type of Routine Medical Care Usually Sought, by Income Level

Based on survey responses at the four income levels below, there tends to be a clear relationship between income and access to routine medical care. Just 50% of respondents with a household income below $19,000 have access to a family doctor, and 47% reported using the Emergency Room when they did not feel well. This compares to 78% of respondents with a household income of over $60,000 having a family doctor and just 13% using the Emergency Room for regular care.



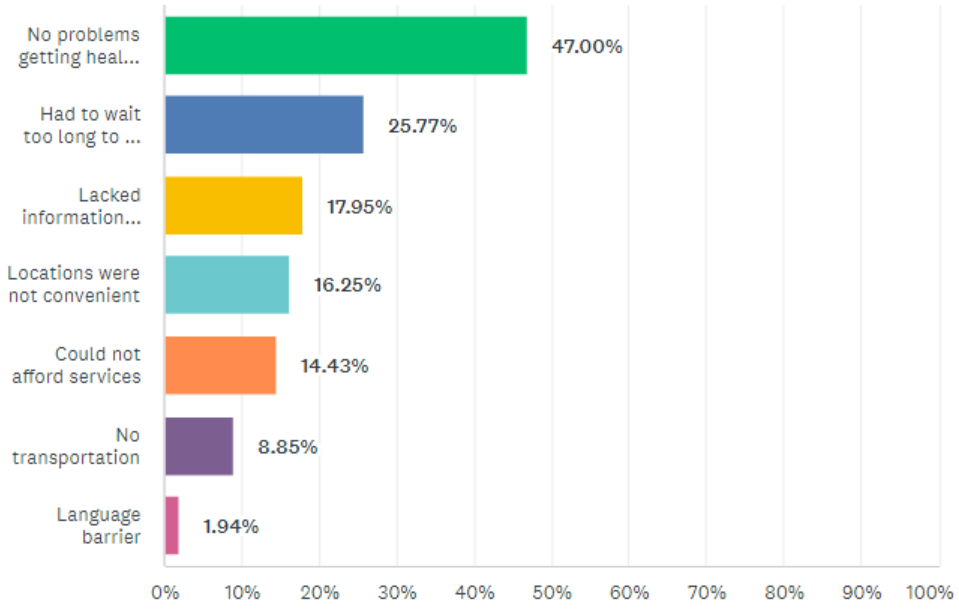
Annual Household Income	# Respondents	Family Doctor		Urgent Care		Emergency Room		Pharmacist		Do not seek medical care	
		#	%	#	%	%	#	#	%	#	%
Less than $19,000	**116**	58	50%	37	32%	54	47%	7	6%	9	8%
$20,000 - $39,000	**405**	207	51%	132	33%	99	24%	42	10%	14	3%
$40,000 - $59,000	**482**	314	65%	174	36%	119	25%	60	12%	6	1%
Over $60,000	**681**	532	78%	262	38%	91	13%	28	4%	23	3%
Income not provided *(not included in graph)*	**71**	56	79%	23	32%	13	18%	2	3%	2	3%
TOTAL	**1,755**	**1,167**	**67%**	**628**	**36%**	**376**	**21%**	**139**	**8%**	**54**	**3%**

Respondents could check all that apply.

Q34: Have you ever had any of the following problems when trying to use health services in Chesapeake? Check all that apply.

Nearly half of respondents (47%) reported having no problems getting health services in Chesapeake. However, 26% (425 of 1,649) of respondents reported having to wait too long to get services.

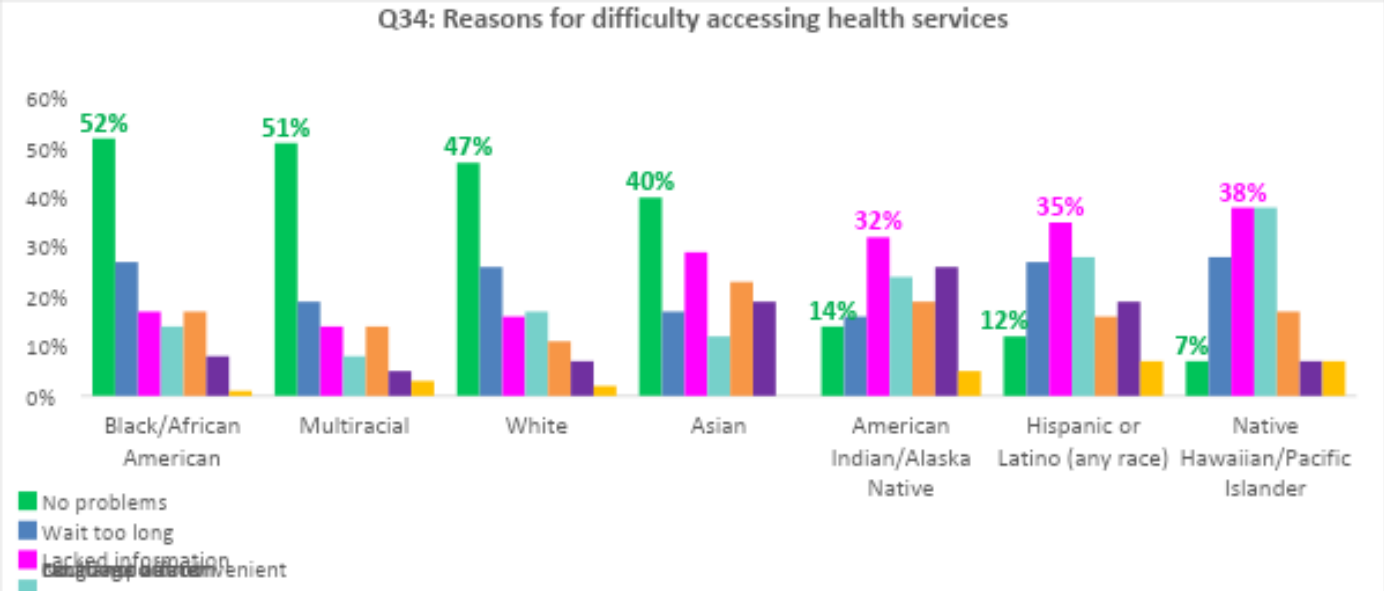
Answered: 1,649 Skipped: 207



ANSWER CHOICES	RESPONSES	
No problems getting health services	47.00%	775
Had to wait too long to get help	25.77%	425
Lacked information about services	17.95%	296
Locations were not convenient	16.25%	268
Could not afford services	14.43%	238
No transportation	8.85%	146
Language barrier	1.94%	32
Total Respondents: 1,649		

- **Difficulty Accessing Health Services in Chesapeake, by Race & Ethnicity**

Over half of Black/African American (52%), Multiracial (51%), White (47%) and Asian (40%) respondents reported no problems accessing services, it is important to note that among respondents who identified as American Indian/Alaska Native (32%), Hispanic (35%) and Native Hawaiian/Pacific Islander (38%) reported a lack of information about health services in Chesapeake. This may indicate the benefit of greater outreach and community education targeting these populations.

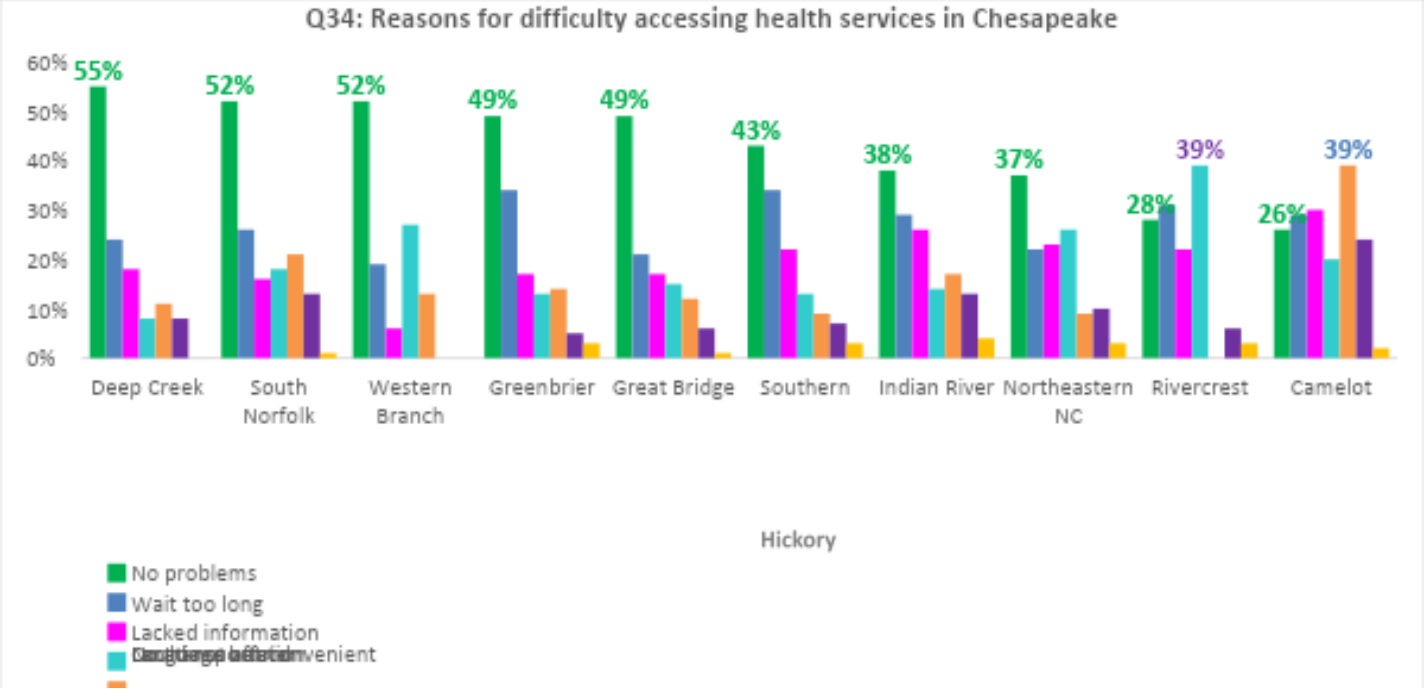


# Respondents by Race/Ethnicity	No Problems		Wait too long		Lacked information		Locations not convenient		Could not afford		No transpor-tation		Language barrier	
	#	%	#	%	%	#	#	%	#	%				
Black/African American (n=688)	361	52%	184	27%	116	17%	98	14%	114	17%	57	8%	5	1%
Multiracial (n=37)	19	51%	7	19%	5	14%	3	8%	5	14%	2	5%	1	3%
White (n=759)	358	47%	201	26%	125	16%	131	17%	84	11%	55	7%	19	2%
Asian (n=52)	21	40%	9	17%	15	29%	6	12%	12	23%	10	19%	0	0%
American Indian/Alaska Native (n=73)	10	14%	12	16%	23	32%	17	23%	14	19%	19	26%	4	5%
Hispanic or Latino (any race) (n=278)	33	12%	74	27%	97	35%	78	28%	45	16%	52	19%	19	7%
Native Hawaiian/Pacific Islander (n=29)	2	7%	8	28%	11	38%	11	38%	5	17%	2	7%	2	7%
Race/ethnicity unknown *(n=11)* *(not included in graph)*	4	36%	4	36%	1	9%	2	18%	4	36%	1	9%	1	9%
TOTAL: n=1,649	**775**	**47%**	**425**	**26%**	**296**	**18%**	**268**	**16%**	**238**	**14%**	**146**	**9%**	**32**	**2%**

Respondents could check all that apply.

● Difficulty Accessing Health Services in Chesapeake, by Neighborhood

Respondents from most neighborhoods reported no difficulty in getting health services. However, 39% of respondents from Rivercrest reported that locations were not convenient and 39% of respondents in Camelot reported that they could not afford health services.

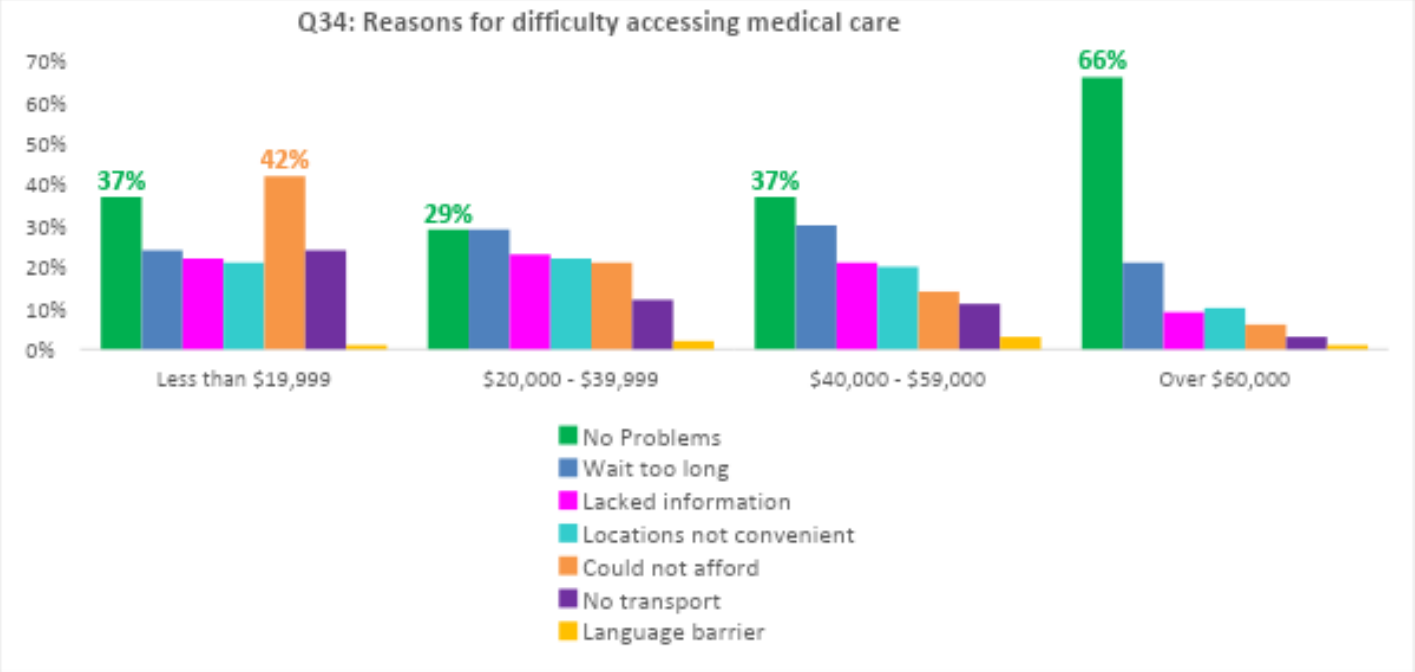


# Respondents by Neighborhood	No Problems		Wait too long		Lacked information		Locations not convenient		Could not afford		No transpor-tation		Language barrier	
	#	%	#	%	%	#	#	%	#	%				
Deep Creek (n=144)	79	55%	35	24%	26	18%	12	8%	16	11%	12	8%	0	0%
South Norfolk (n=200)	103	52%	52	26%	31	16%	36	18%	41	20%	26	13%	1	0.5%
Western Branch (n=48)	25	52%	9	19%	3	6%	13	27%	6	12%	0	0%	0	0%
Greenbrier (n=261)	127	49%	88	34%	45	17%	34	13%	37	14%	14	5%	7	3%
Great Bridge (n=193)	94	49%	41	21%	32	17%	28	15%	23	12%	11	6%	3	2%
Southern/Hickory (n=86)	37	43%	30	34%	19	22%	11	13%	8	9%	6	7%	3	3%
Indian River (n=69)	26	38%	20	29%	18	26%	10	14%	12	17%	9	13%	3	4%
Northeastern NC (n=248)	92	37%	55	22%	57	23%	65	26%	23	9%	26	10%	7	3%
Rivercrest (n=36)	10	28%	11	31%	8	22%	14	39%	0	0%	2	6%	1	3%
Camelot (n=126)	33	26%	37	29%	38	30%	25	20%	49	39%	30	24%	3	2%
Other/Unknown (n=238) *(not in graph)*	112	47%	72	30%	64	27%	37	18%	65	9%	42	18%	*3*	*1%*
TOTAL: n=1,649	**775**	**47%**	**425**	**26%**	**296**	**18%**	**268**	**16%**	**238**	**14%**	**146**	**9%**	**32**	**2%**

Respondents could check all that apply.

- **Difficulty Accessing Health Services in Chesapeake, by Income Level**

Respondents in the lower income groups reported more difficulties accessing services while respondents I in the over $60,000 income group reported the highest percentage of having not problems accessing services.



# Respondents by Annual Household Income	No Problems		Wait too long		Lacked information		Locations not convenient		Could not afford		No transport-ation		Language barrier	
	#	%	#	%	%	#	#	%	#	%	#	%	#	%
Less than $19,000 (n= 111)	41	37%	27	24%	24	22%	23	21%	47	42%	27	24%	1	1%
$20,000 - $39,000 (n=383)	111	29%	111	29%	89	23%	86	22%	81	21%	46	12%	9	2%
$40,000 - $59,000 (n=466)	171	37%	139	30%	123	21%	96	20%	65	14%	51	11%	14	3%
Over $60,000 (n=627)	412	66%	129	21%	57	9%	60	10%	39	6%	18	3%	8	1%
Income not provided *(not included in graph)* ***(n=62)***	40	65%	19	31%	3	5%	3	5%	6	10%	4	6%	0	0%
TOTAL: n=1,649	**775**	**47%**	**425**	**26%**	**296**	**18%**	**268**	**16%**	**238**	**14%**	**146**	**9%**	**32**	**1%**

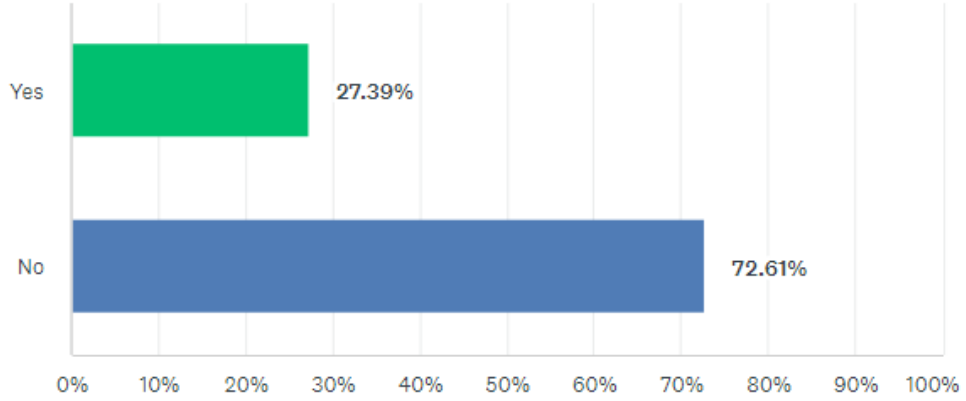
Respondents could check all that apply.

REPORTED HEALTH CONDITIONS

Q14: Have you or someone in your family received mental health services in the past year?

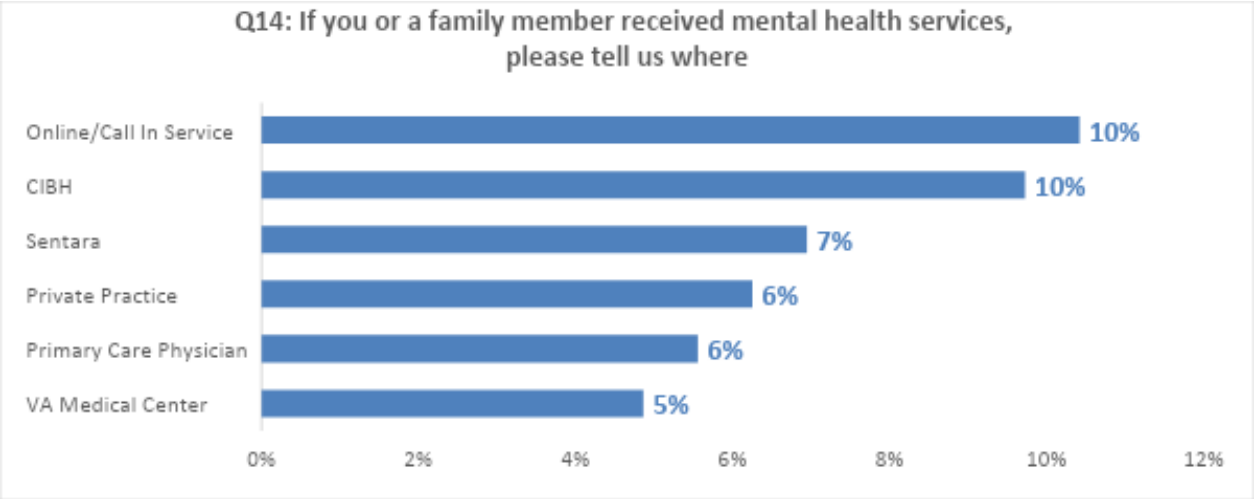
Of 1,818 responses, 1,320 (73%) reported no one in the family receiving mental health services in the past year, and 498 (27%) reported either self or a family member receiving mental health services.

Answered: 1,818 Skipped: 38



ANSWER CHOICES	RESPONSES	
Yes	27.39%	498
No	72.61%	1,320
TOTAL		1,818

Of 144 respondents who specified where they or their family received mental health services, the largest percentage specified an online or telehealth service due to the difficulty of in-person visits due to the COVID-19 pandemic and Chesapeake Integrative Behavioral Healthcare (CIBH). A complete list of facilities that were named are in Appendix C.



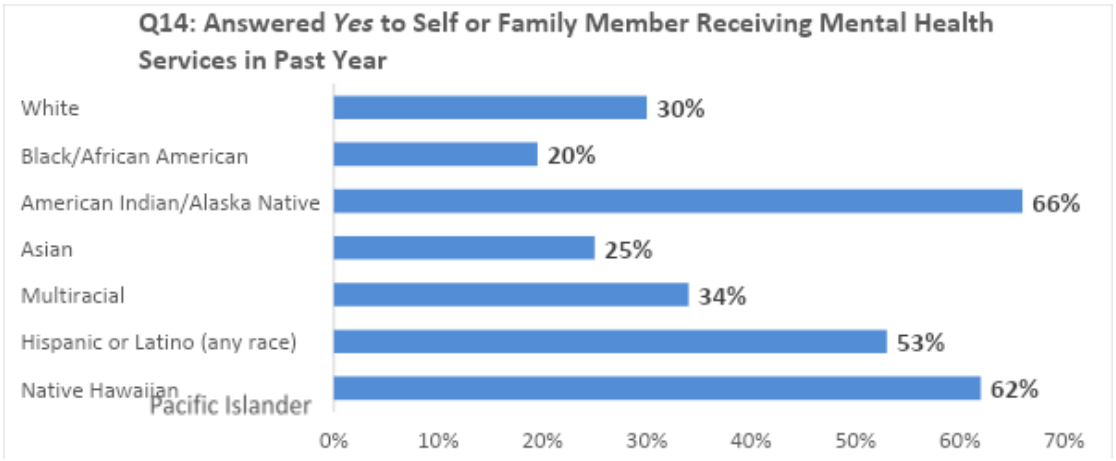
The tables and graphs that follow analyze this data by race, ethnicity, neighborhood, income, and other health issues that co-occur with mental health concerns.

- **Self or Family Received Mental Health Services in Past Year by Race & Ethnicity**

  Although the total number of American Indian/Alaska Native and Native Hawaiian/Pacific Islander respondents is small, these population groups reported the highest percentages receiving mental health services. According to the American Psychiatric Association (APA), "Research indicates that American Indian/Alaska Native populations have disproportionately higher rates of mental health problems than the general US population. Some of these mental health problems have been directly linked to the intergenerational historical trauma forced upon this population.[8] In addition, the APA notes that Black/African Americans have similar rates of mental illness as the general population, but often have difficulty accessing services.

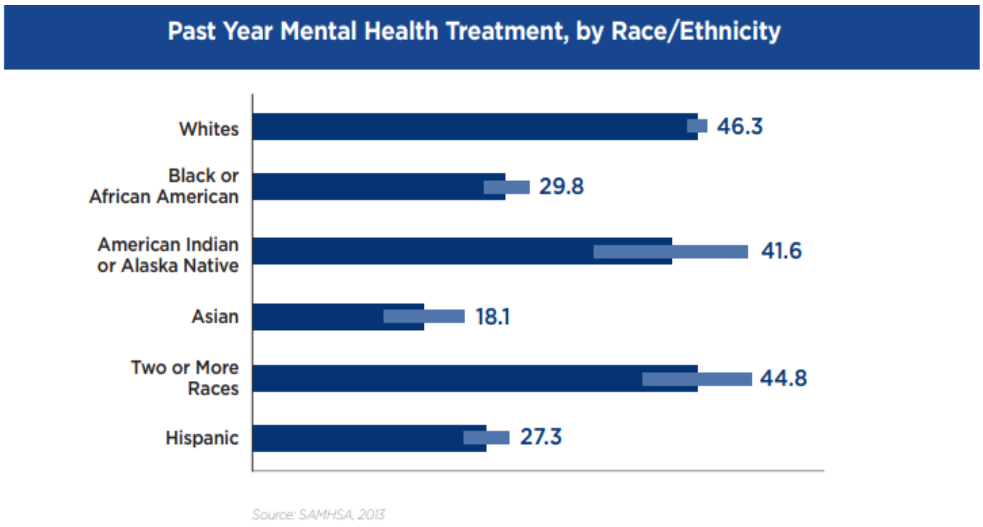
  The CHNA survey results graphed below shows similar patterns of mental health services by race and ethnicity as the graph provided by the American Psychiatric Association.

  CHNA Survey



[8] American Psychiatric Association website, Mental Health Disparities: Diverse Populations. Accessed November 17, 2021.

American Psychiatric Association

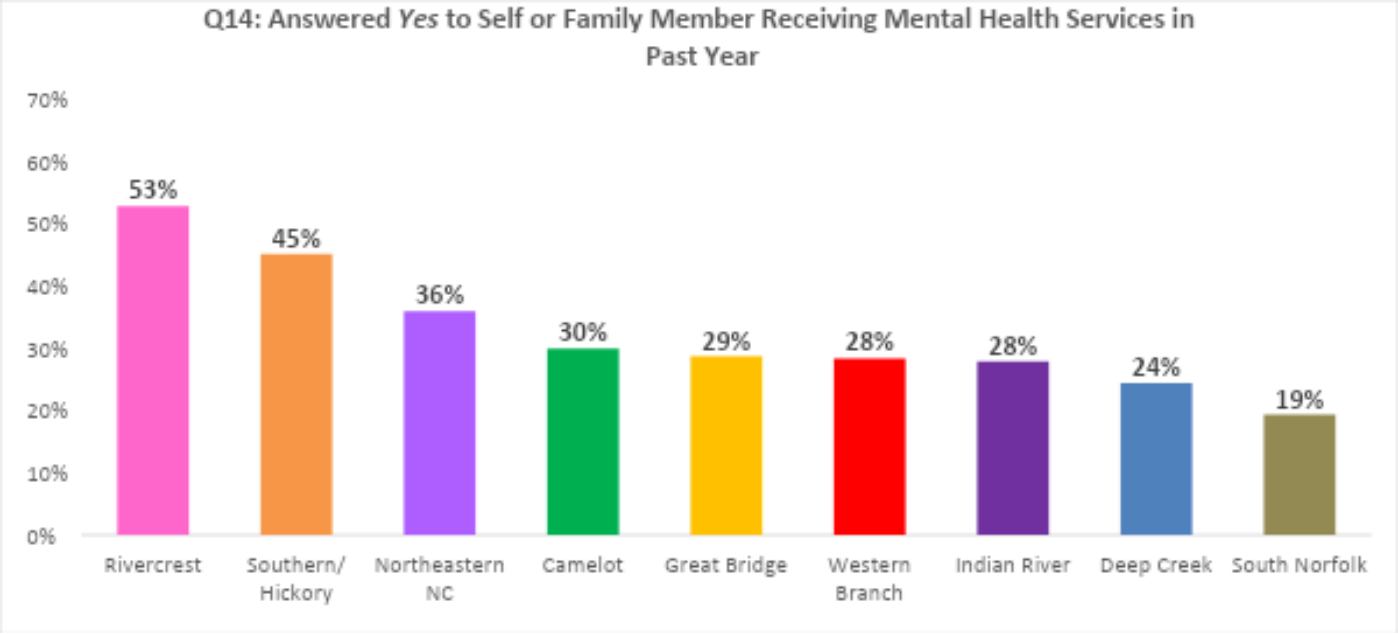


The table below shows the race and ethnicity of respondent answers about receiving mental health services in the past year.

Race/Ethnicity	# Respondents	# Self or family member received mental health services	% Self or family member received mental health services
American Indian/Alaska Native	77	51	66%
Native Hawaiian/Pacific Islander	29	18	62%
Hispanic or Latino (any race)	290	153	53%
Multiracial	38	13	34%
White	847	251	30%
Asian	56	14	25%
Black/African American	758	148	20%
Race/ethnicity unknown *(not included in graph)*	13	3	25%
Total	**1,818**	**498**	**27%**

- **Self or Family Received Mental Health Services in Past Year by Neighborhood**

The graph and table below show the percentage of respondents in each neighborhood who answered *Yes* to themselves or a family member receiving mental health services in the past year.

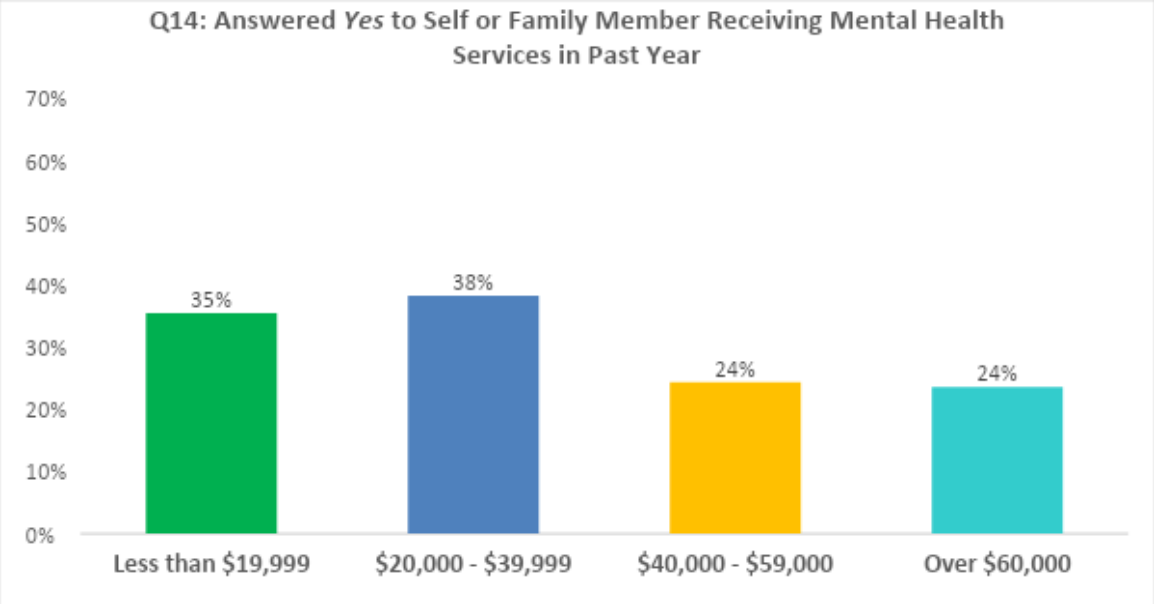


Neighborhood	# Respondents	# *Yes* to Self or family member received mental health services	% Self or family member received mental health services
Rivercrest	36	19	53%
Southern/Hickory	91	41	45%
Northeastern NC	284	102	36%
Camelot	127	38	30%
Great Bridge	213	61	29%
Western Branch	53	15	28%
Indian River	79	22	28%
Deep Creek	168	41	24%
South Norfolk	218	42	19%
Greenbrier	274	48	18%
Other/Unknown *(not in graph)*	275	69	25%
Total	**1,818**	**498**	**27%**

● Self or Family Received Mental Health Services in Past Year by Income Level

The graph and table below compare the percentages of respondents who answered *Yes* to self or a family member receiving mental health services in the past year for four different income levels.

Between the income levels shows, there is just an 11-percentage point difference in respondents who reported self or family member receiving mental health services. However, as seen in the previous two graphs, there is a forty-six-percentage point difference among race and ethnicity and a thirty-four-percentage point difference among various neighborhoods. This data may highlight a key theme that race, ethnicity and location have a greater impact than income on who receives mental health services.

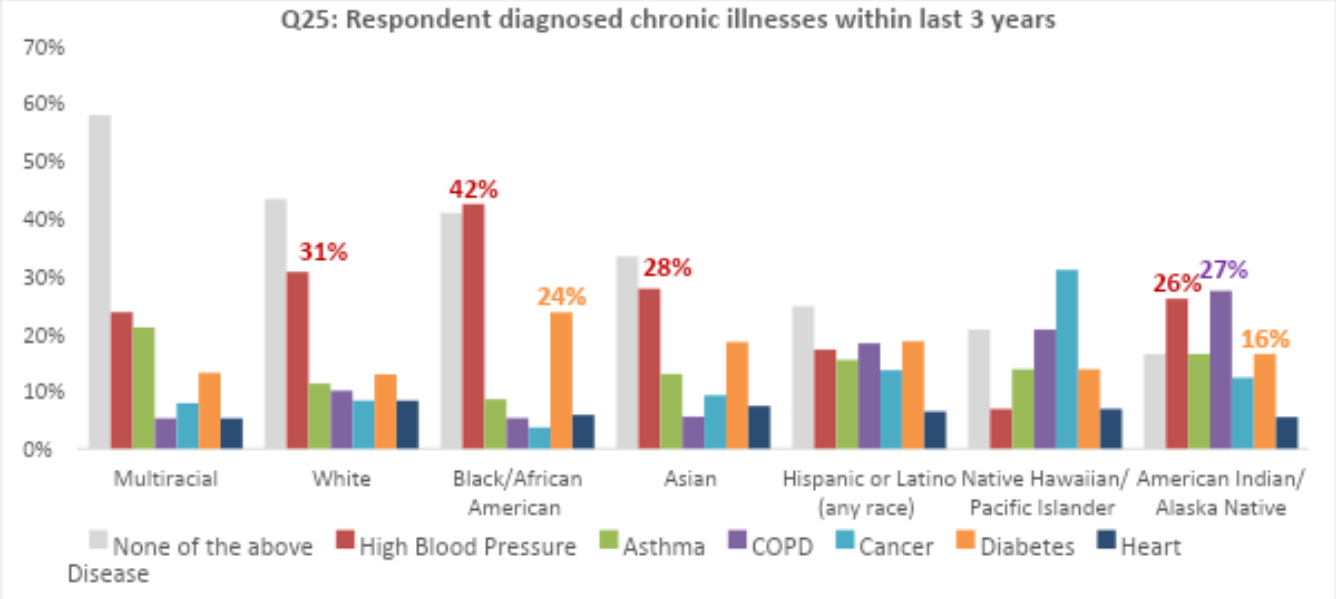


Annual Household Income	# Respondents	# *Yes* to Self or family member received mental health services	% Self or family member received mental health services
Less than $19,999	124	44	35%
$20,000 - $39,999	415	159	38%
$40,000 - $59,000	484	118	24%
Over $60,000	716	169	24%
Income not provided *(not included on graph)*	79	8	10%
TOTAL	**1,818**	**498**	**27%**

Q25: In the last 3 years, has a doctors told you that you have any of the following chronic illnesses?

Chronic Illness by Race and Ethnicity

Overall, 41% of respondents reported that they have none of the chronic illnesses listed in the table and graph below. However, there are some large differences by race in the percentages of those reporting high blood pressure, cancer, and COPD. Discussion of these findings by race/ethnicity, borough and income level are on the following pages.



- **Black/African American** respondents reported the highest percentage among all races and ethnicities of high blood pressure (42%) and of diabetes (24%). The Centers for Disease Control and Prevention states "…African Americans are more likely to have high blood pressure, diabetes and general poor health than a typical person in the United States."[9] According to the Center for African American Health, the causes can be disparities in the healthcare system, the cost of healthy foods and neighborhood food deserts.[10] The American Heart Association reports that 46% of Americans have high blood pressure.[11]
- **Native Hawaiian/Pacific Islander** respondents reported the highest percentage of cancer, (9 of 29 respondents, or 31%). The survey did not ask for the specific type of cancer, so it is unclear if there may be a correlation between this population and a specific type of cancer. However, the National Cancer Institute found "higher rates of liver cancer among Asian and Native Hawaiian/Pacific Islanders than other racial/ethnic groups.[12]

[9] Tamara E. Holmes, February 3, 2020. AARP website. *African Americans More Likely to Have High Blood Pressure, Diabetes, CDC says. Available at* Steps to Address the Health Needs of African Americans (aarp.org)

[10] Ibid.

[11] American Heart Association website, January 2018. More than 100 million Americans have high blood pressure, AHA says | American Heart Association

[12] National Cancer Institute website, Cancer Disparities Research, available at Research Areas - Cancer Health Disparities - National Cancer Institute

- **American Indian/Alaska Native** respondents disproportionately reported COPD, 20 of 73 (27%), which is the highest rate among respondents of all races. The International Journal of Chronic Obstructive Pulmonary Disease states: "Nationwide, the US Native American (NA) population has among the highest prevalence proportions of smoking, DM, and obesity, placing the population at high risk of poor outcomes for COPD. COPD prevalence among NAs, including American Indians and Alaska Natives, was 11% in 2011. This rate was higher than that among Non-Hispanic Whites (NHWs), non-Hispanic Blacks, Hispanics, or Asian and Native Hawaiian/Pacific Islanders.[13] In the survey, American Indian/Alaska Native respondents reported a lower rate of diabetes than other races. ***However, 52 of 73 (71%) of American Indian/Alaska Native respondents, reported using tobacco products, and an additional 7 (10%) reported sometimes using tobacco products. This is higher than any other race reporting tobacco use.***

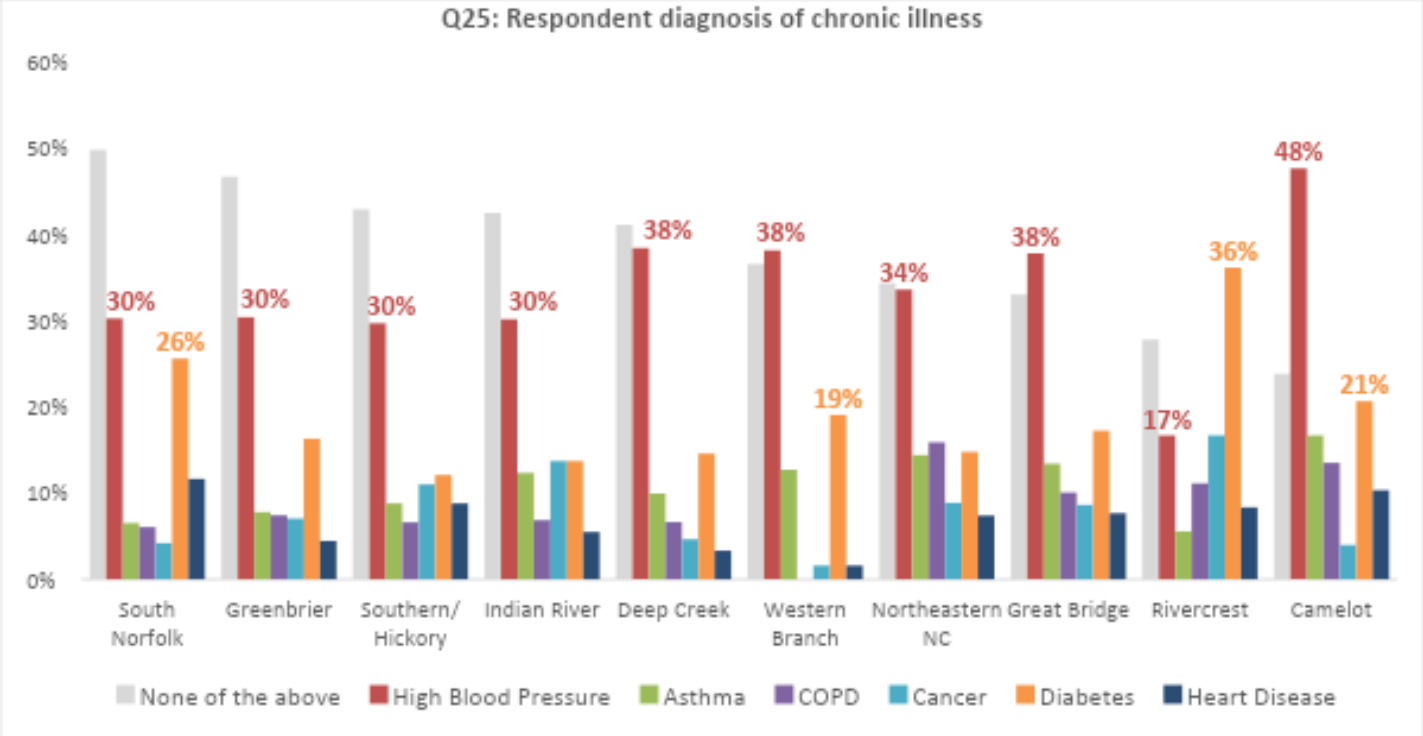
# Respondents by Race/Ethnicity	None of the above		High Blood Pressure		Asthma		COPD		Cancer		Diabetes		Heart Disease	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Black/African American (n=735)	301	41%	312	42%	63	9%	39	5%	27	4%	174	24%	43	6%
Multiracial (n=38)	22	58%	9	24%	8	21%	2	5%	3	8%	5	13%	2	5%
White (n=815)	353	43%	250	31%	92	11%	82	10%	68	8%	105	13%	68	8%
Asian (n=54)	18	33%	15	28%	7	13%	3	6%	5	9%	10	19%	4	7%
American Indian/Alaska Native (n=73)	12	16%	19	26%	12	16%	20	27%	9	12%	12	16%	4	5%
Native Hawaiian/Pacific Islander (n=29)	6	21%	2	7%	4	14%	6	21%	9	31%	4	14%	2	7%
Hispanic or Latino (any race) (n=279)	69	25%	48	17%	43	15%	51	18%	38	14%	52	19%	18	6%
Race/ethnicity not provided (n=34) *(not included in graph)*	8	100%	2	25%	0	0%	0	0%	1	13%	1	13%	0	0%
Total: n=1,755	**720**	**41%**	**609**	**35%**	**186**	**11%**	**152**	**9%**	**122**	**7%**	**311**	**18%**	**123**	**7%**

Respondents could check all that apply.

[13] Huimin Wu, Dorothy A Rhoades, Sixia Chen, and Brent Brown. *Native American Patients with Chronic Obstructive Pulmonary Disease Exacerbations in a Tertiary Academic Medical Center – A Pilot Study.* 2021. International Journal of Chronic Obstructive Pulmonary Disease.

Chronic Illness by Neighborhood

Overall, half of all respondents reported "none of the above" when asked to identify any diagnosed chronic illness.

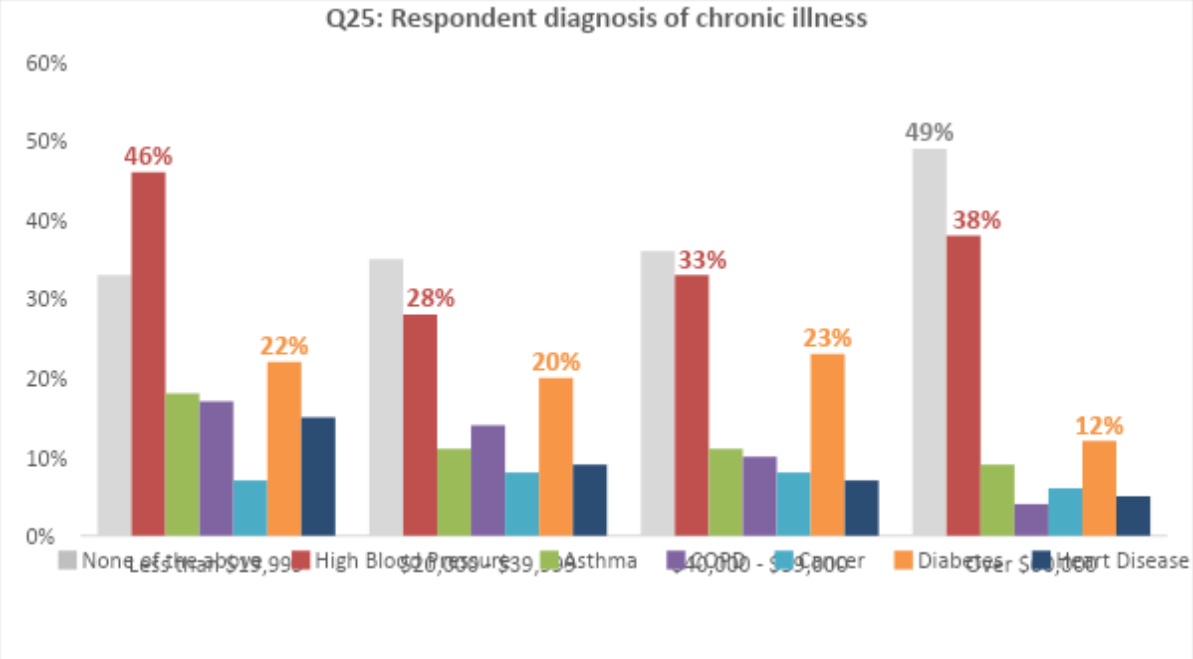


# Respondents by Neighborhood	None of the above		High Blood Pressure		Asthma		COPD		Cancer		Diabetes		Heart Disease	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Camelot (n=126)	30	24%	60	48%	21	17%	17	13%	5	4%	26	21%	13	10%
Deep Creek ((n=151)	62	41%	58	38%	15	10%	10	7%	7	5%	22	15%	5	3%
Great Bridge (n=209)	69	33%	79	38%	28	13%	21	10%	18	9%	36	17%	16	8%
Greenbrier (n=270)	126	47%	82	30%	21	8%	20	7%	19	7%	44	16%	12	4%
Southern/Hickory (n=91)	39	43%	27	30%	8	9%	6	7%	10	11%	11	12%	8	9%
Indian River (n=73)	31	42%	22	30%	9	12%	5	7%	10	14%	10	14%	4	5%
Rivercrest (n=36)	10	28%	6	17%	2	6%	4	11%	6	17%	13	36%	3	8%
South Norfolk (n=215)	107	50%	65	30%	14	7%	13	6%	9	4%	55	26%	25	12%
Western Branch (n=52)	23	37%	24	38%	8	13%	0	0%	1	2%	12	19%	1	2%
Northeastern NC (n=271)	93	34%	91	34%	39	14%	43	16%	24	9%	40	15%	20	7%
Other/Unknown (n=261) *(not included in graph)*	130	50%	95	36%	21	8%	13	5%	13	5%	42	16%	16	6%
Total: n=1,755	**720**	**41%**	**609**	**35%**	**186**	**11%**	**152**	**9%**	**122**	**7%**	**311**	**18%**	**123**	**7%**

Respondents could check all that apply.

Chronic Illness by Income Level

High blood pressure was highest among respondents in the lowest (less than $19,000) and highest income group (over $60,000). This may be due to lower-income households having limited access to healthy foods and healthcare, as well as facing greater financial stress.



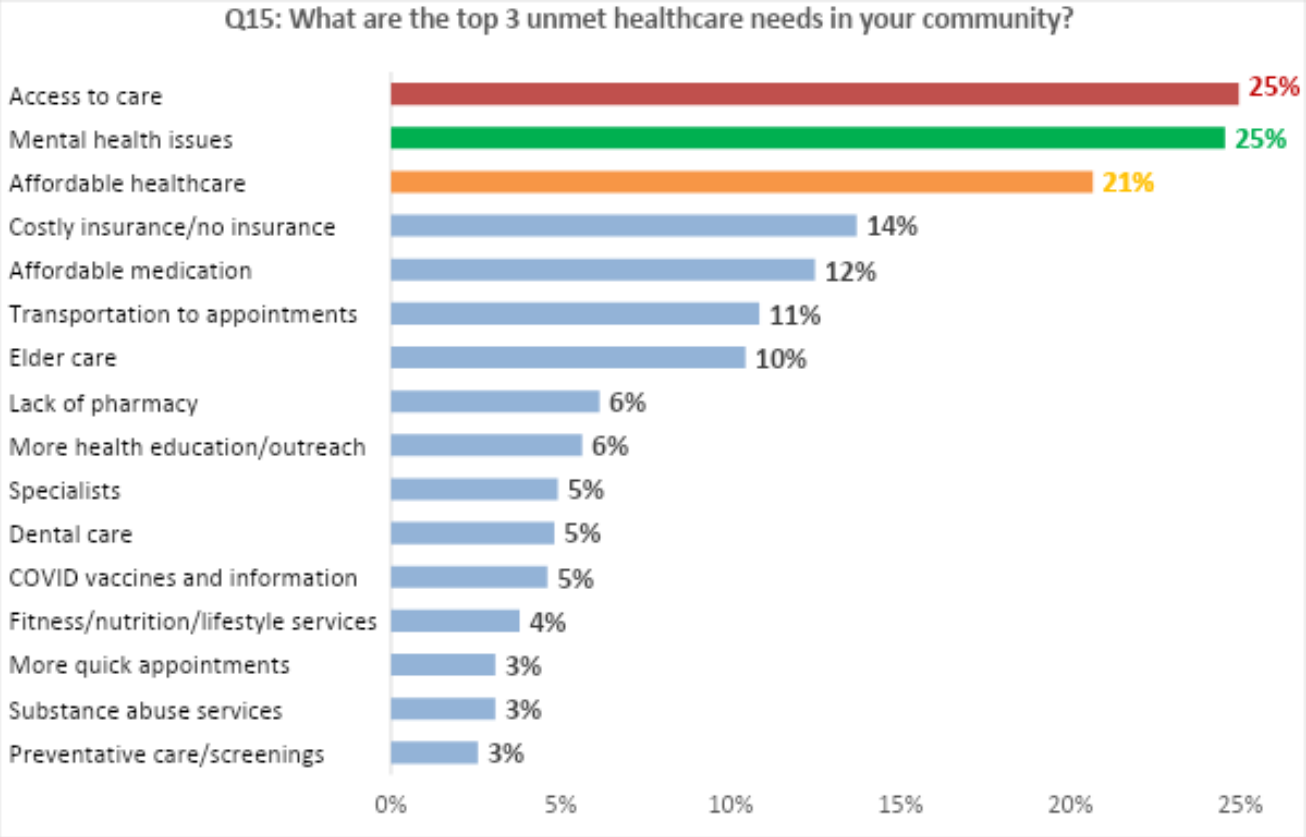
Annual Household Income	# Respondents	None of the above		High Blood Pressure		Asthma		COPD		Cancer		Diabetes		Heart Disease	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%
Less than $19,999	117	39	33%	54	46%	21	18%	20	17%	8	7%	26	22%	18	15%
$20,000 - $39,999	405	143	35%	112	28%	46	11%	55	14%	33	8%	81	20%	35	9%
$40,000 - $59,000	482	172	36%	156	33%	54	11%	47	10%	39	8%	110	23%	35	7%
Over $60,000	681	332	49%	262	38%	62	9%	25	4%	38	6%	83	12%	31	5%
Income not provided *(not in graph)*	70	34	49%	25	36%	3	4%	5	7%	4	6%	11	16%	4	6%
Total	**1,755**	**720**	**41%**	**609**	**35%**	**186**	**11%**	**152**	**9%**	**122**	**7%**	**311**	**18%**	**123**	**7%**

Respondents could check all that apply.

Unmet Healthcare Needs

Q15: What are the top three biggest unmet healthcare needs in your community?

Of 978 respondents who answered this question, the top three healthcare needs mentioned in open-ended comments were: **Access to healthcare (25% of respondents), Mental health services (25%) and Affordable healthcare (21%).** Access to healthcare focused on distance to nearby health resources, and affordable healthcare included affordability of services and lack of insurance. Affordable medications are a separate category.



Question 15 on the survey asked for open-ended responses to the biggest unmet healthcare needs. The responses were cataloged by topic and the results are shown in the graphs and tables that follow. A complete list of these comments is provided in Appendix D.

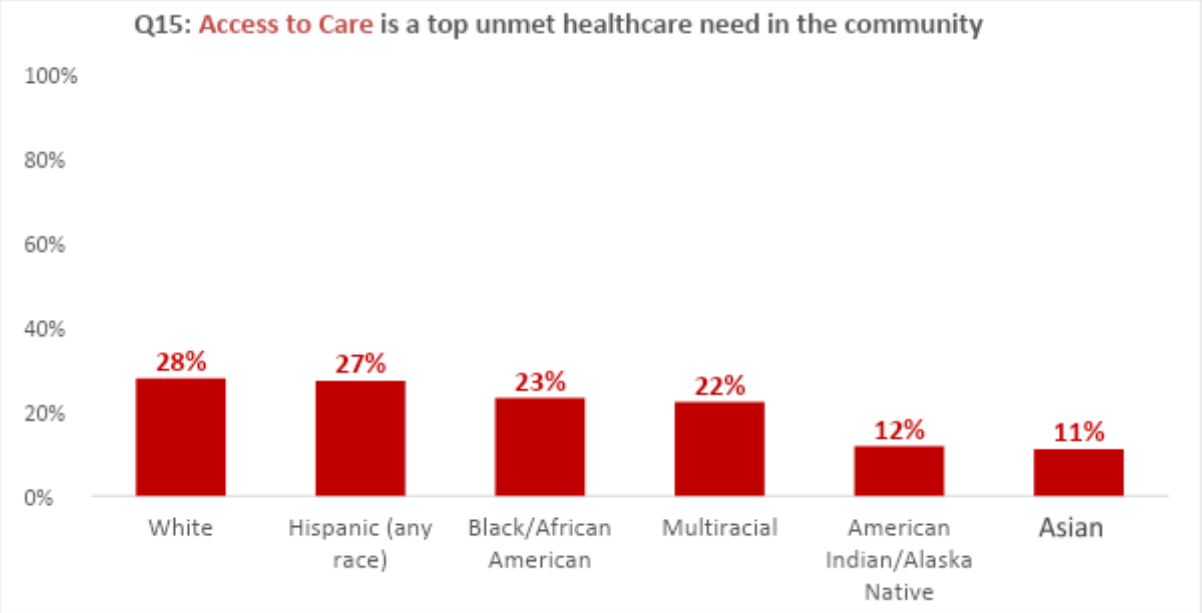
The number and percentage of each response to Question 15 is in the table below.

Responses to Question 15	# Times mentioned	%
Access to healthcare	**244**	**25%**
Mental health issues	**240**	**25%**
Affordable healthcare	**202**	**21%**
Costly insurance/no insurance	134	**14%**
Affordable medication	122	**12%**
Transportation to appointments	106	**11%**
Elder care	102	**10%**
Lack of pharmacy	60	**6%**
More health education/outreach	55	**6%**
Specialists	48	**5%**
Dental care	47	**5%**
COVID vaccines and information	45	**5%**
Fitness/nutrition/lifestyle services	37	**4%**
Substance abuse services	30	**3%**
More quick appointments	30	**3%**
Preventative care/screenings	25	**3%**

The top three unmet healthcare needs are graphed by race/ethnicity, location, and income level to help identify where the resources are needed.

#1 Unmet Healthcare Need: *Access to Care* by Race/Ethnicity

Of the 244 respondents who listed Access to Care as a top unmet need, 28% were White, 27% were Hispanic or Latino (any race), 23% were Black/African American, 22% were Multiracial, 12% were American Indian/Alaska Native and 11% were Asian.



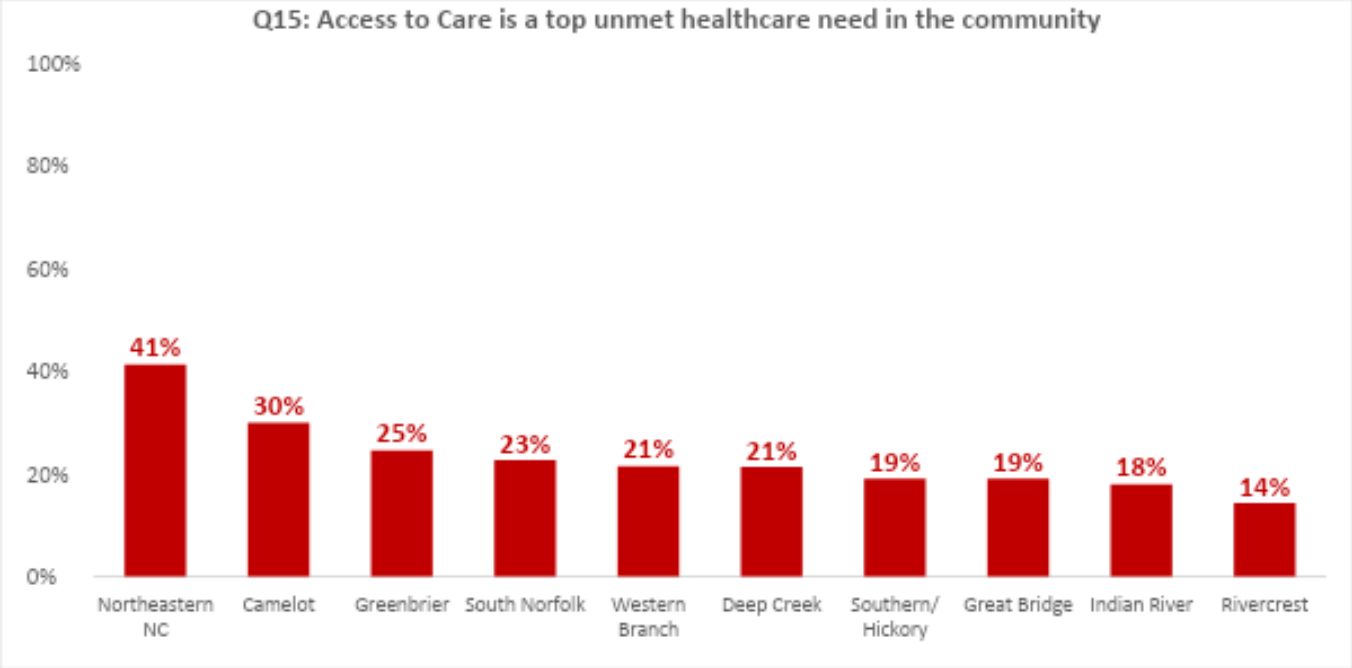
There were no Native Hawaiian/Pacific Islander respondents who listed Access to Care as a top unmet need.

Race/Ethnicity	# Respondents listing *Access to Care* as an unmet need	# Who answered Question 15	% Race/Ethnicity listing *Access to Care* as top unmet need
	#	#	%
White	127	455	28%
Hispanic (any race)	9	33	27%
Black/African American	107	461	23%
Multiracial	6	27	22%
American Indian/Alaska Native	2	17	12%
Asian	2	18	11%
Total	**244**	**978**	**25%**

All respondents to this question provided a race and/or ethnicity.

#1 Unmet Healthcare Need: *Access to Care* by Community

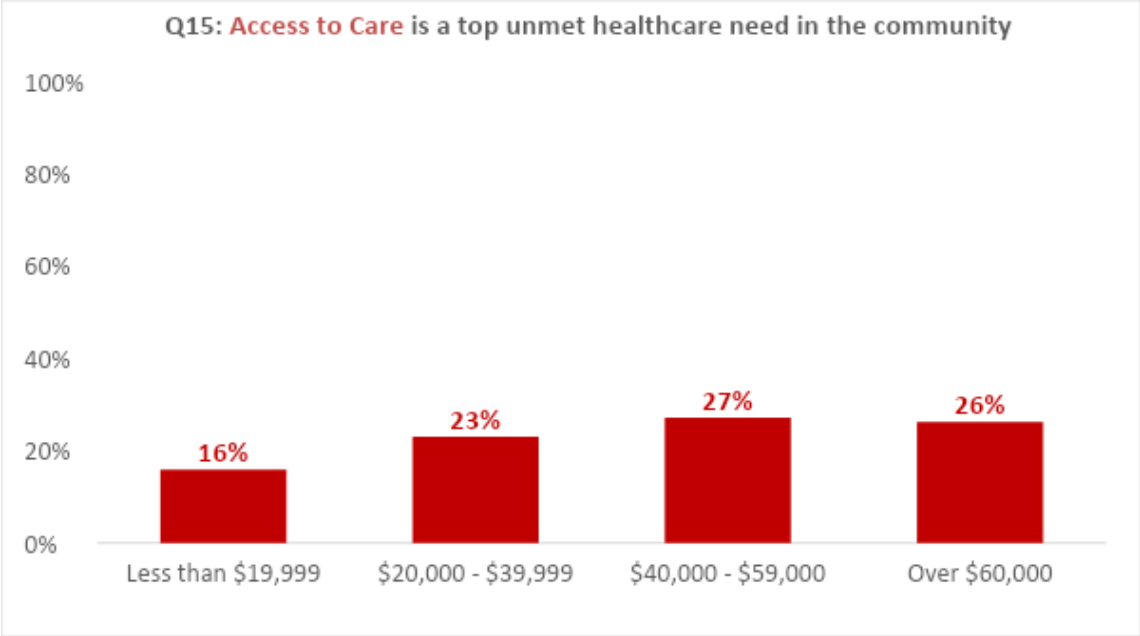
The 244 respondents who stated that access to healthcare is an unmet need live in the following communities. The largest share of these respondents (41%) lives in northeastern North Carolina, and the majority of those respondents live in Currituck or Camden counties.



Neighborhood	# Respondents listing *Access to Care* as an unmet need	# Who answered Question 15	% Listing *Access to Care* as top unmet need
	#	#	%
Northeastern NC	63	153	41%
Camelot	20	67	30%
Greenbrier	38	155	25%
South Norfolk	36	159	23%
Western Branch	6	28	21%
Deep Creek	16	75	21%
Southern/Hickory	12	63	19%
Great Bridge	19	100	19%
Indian River	7	39	18%
Rivercrest	2	14	14%
Other/Unknown *(not in graph)*	25	125	20%
Total	**244**	**978**	**25%**

#1 Unmet Healthcare Need: *Access to Care* by Income Level

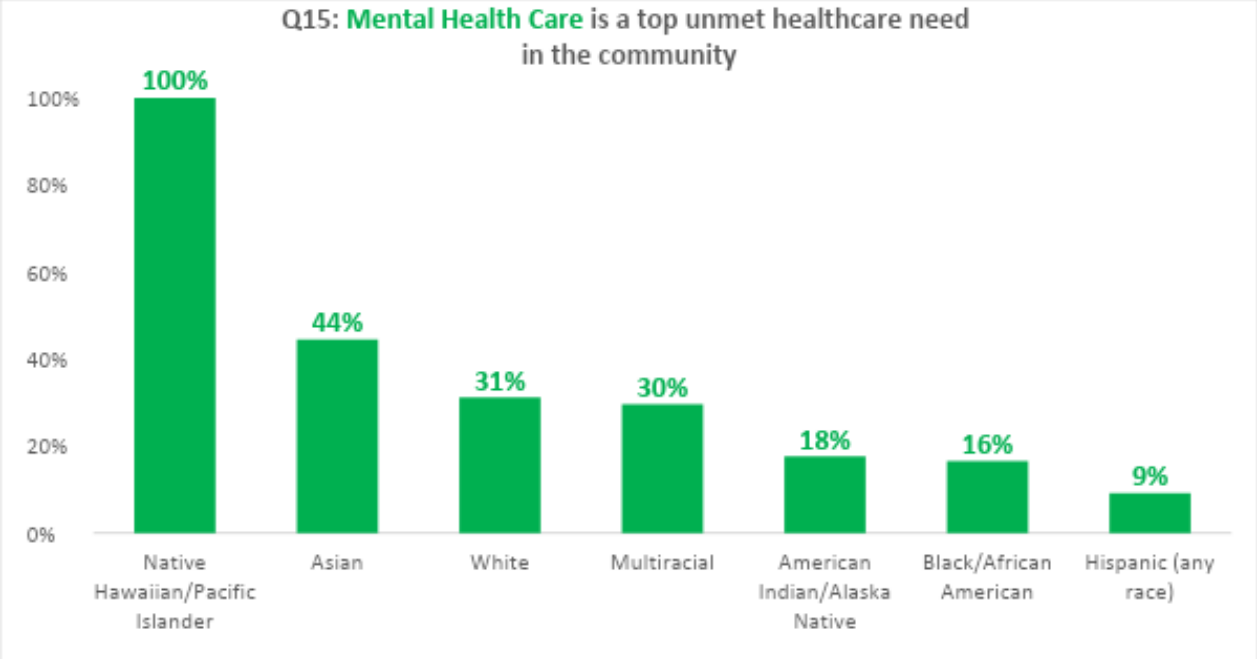
Of the 244 respondents who listed Access to Care as a top unmet need, the income levels are below.



Annual Household Income	# Respondents listing *Access to Care* as unmet need	# Who answered Question 15	% Listing *Access to Care* as top unmet need
Less than $19,999	10	63	16%
$20,000 - $39,999	37	161	23%
$40,000 - $59,000	67	247	27%
Over $60,000	124	472	26%
Income not provided *(not included on graph)*	6	35	17%
Total	**244**	**978**	**25%**

#2 Unmet Need: *Mental Health Care* by Race and Ethnicity

There were 240 respondents who listed mental health care as an unmet need. Respondents by race and ethnicity are in the table and graph below. Although Asian respondents (44%) were the largest group to list mental health care as a gap, the number of respondents is small and may not be representative. See the table below for the number and percent of responses by race and ethnicity.

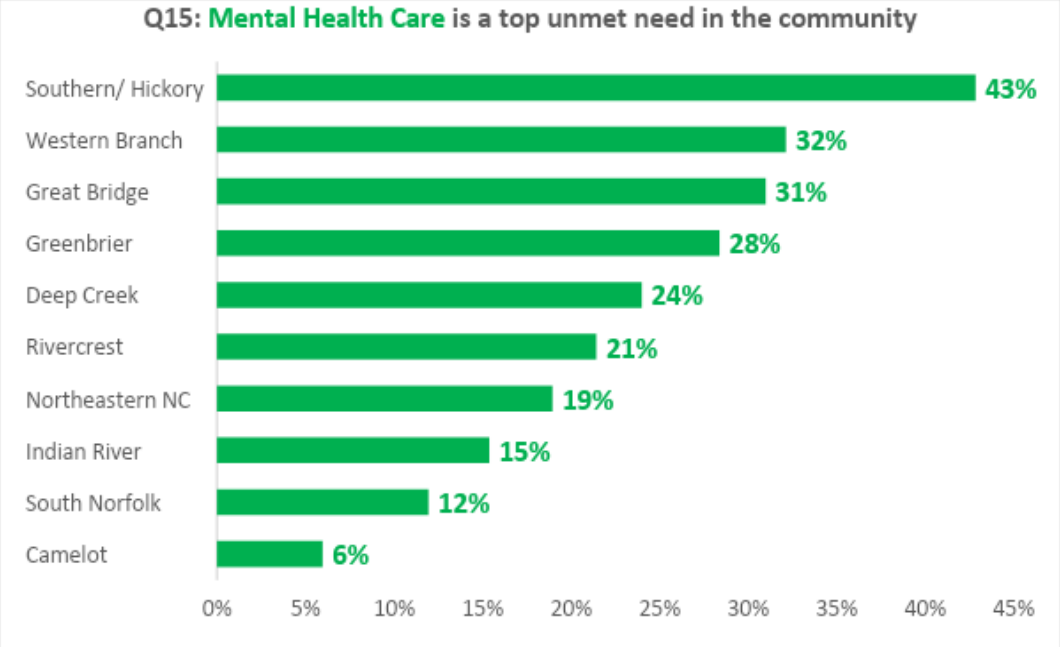


Race/Ethnicity	# Respondents listing *Mental Health Care* as an unmet need	# Who answered Question 15	% Listing *Mental Health Care* as top unmet need
	#		%
Native Hawaiian/Pacific Islander	3	3	100%
Asian	8	18	44%
White	144	455	32%
Multiracial	8	27	30%
American Indian/Alaska Native	3	17	18%
Black/African American	77	461	17%
Hispanic (any race)	3	33	9%
Total	**240**	**978**	**25%**

All respondents to this question provided a race and/or ethnicity.

#2 Unmet Need: *Mental Health Care* by Community

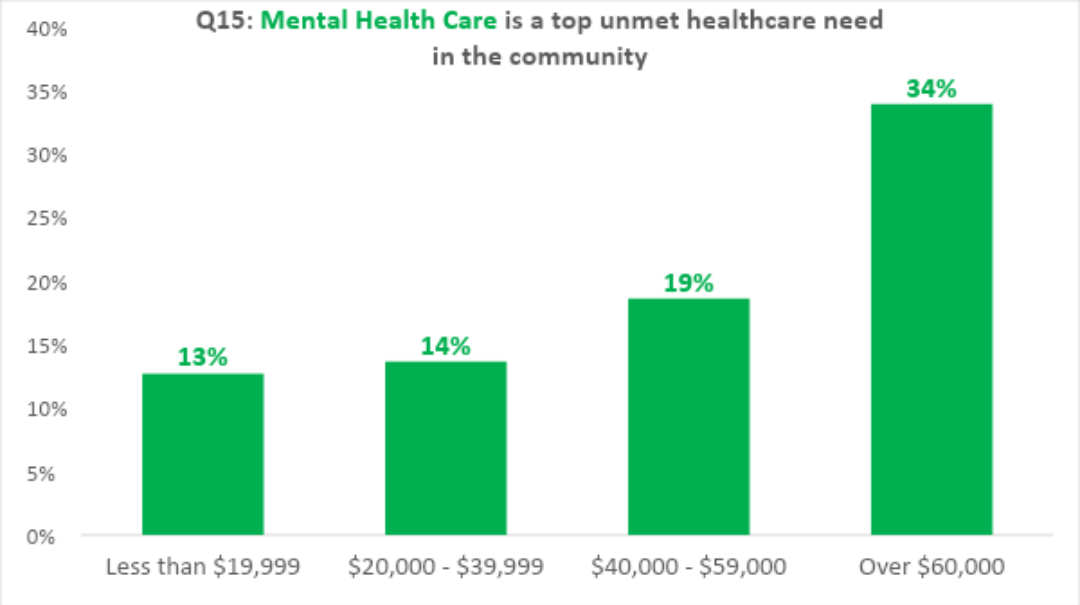
The 240 respondents who stated mental health care is an unmet need live in the following communities. The greatest percentage of respondents listing mental health care as a health gap work in Chesapeake but do not live there. This may indicate a lack of mental health services throughout the region.



Neighborhood	# Respondents listing *Mental Health Care* as an unmet need	# Who answered Question 15	% Listing *Mental Health Care* as top unmet need
	#		%
Southern/Hickory	27	63	43%
Western Branch	9	28	32%
Great Bridge	31	100	31%
Greenbrier	44	155	28%
Deep Creek	18	75	24%
Rivercrest	3	14	21%
Northeastern NC	29	153	19%
Indian River	6	39	15%
South Norfolk	19	159	12%
Camelot	4	67	6%
Other/Unknown *(not in graph)*	**4**	**33**	**12%**
Total	**240**	**978**	**25%**

#2 Unmet Need: *Mental Health Care* by Income Level

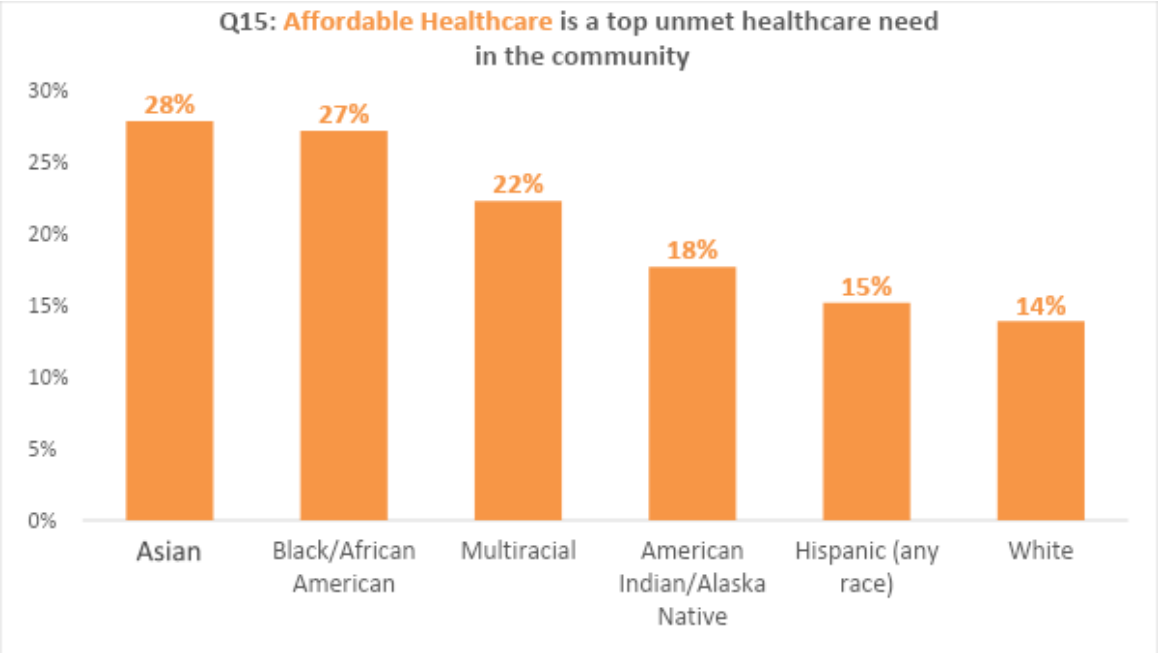
Of the 240 respondents listing mental health care as an unmet need, the income levels are below. It is interesting to note that mental health care is sited as a gap as income level increases.



Annual Household Income	# Respondents listing *Mental Health Care* as unmet need	# Who answered Question 15	% Listing *Mental Health Care* as top unmet need
Less than $19,999	8	63	13%
$20,000 - $39,999	22	161	14%
$40,000 - $59,000	46	247	19%
Over $60,000	160	472	34%
Income not provided *(not in graph)*	4	35	11%
Total	**240**	**978**	**25%**

#3 Unmet Healthcare Need: *Affordable Healthcare* by Race and Ethnicity

Asian respondents comprised the largest percentage (28%) of the 202 respondents listing affordable healthcare as an unmet need. However, this population is small and may not be representative.



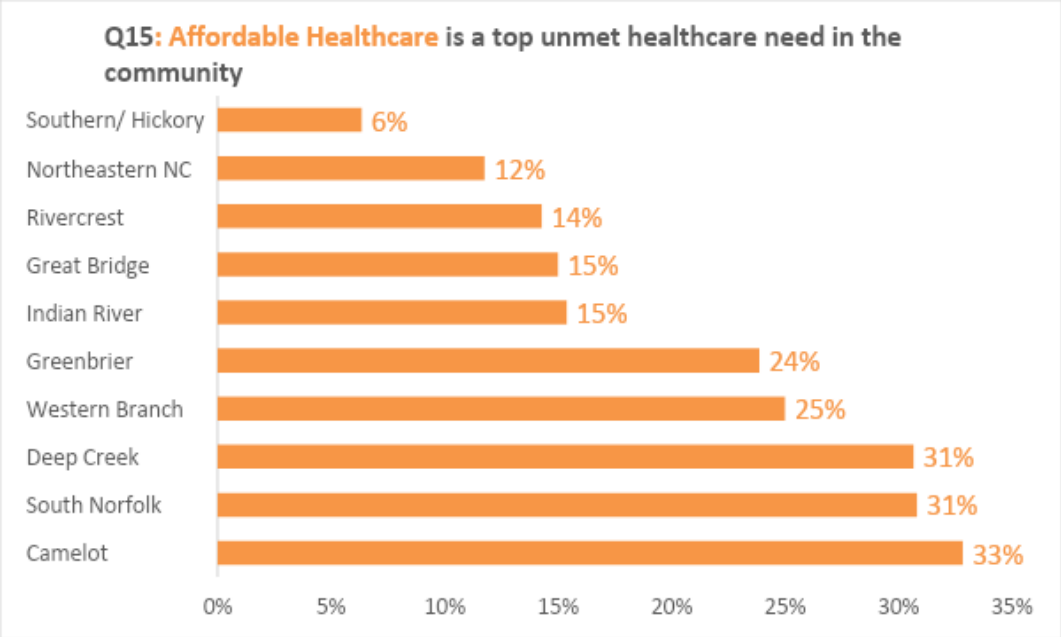
There were no Native Hawaiian/Pacific Islander respondents who listed Affordable Healthcare as a top unmet need.

Race/Ethnicity	# Respondents listing *Affordable Health Care* as an unmet need	# Who answered Question 15	% Listing *Affordable Health Care* as top unmet need
	#		%
Asian	5	18	28%
Black/African American	125	461	27%
Multiracial	6	27	22%
American Indian/Alaska Native	3	17	18%
Hispanic (any race)	5	33	15%
White	63	455	14%
Total	**202**	**978**	**21%**

All respondents to this question provided a race and/or ethnicity.

#3 Unmet Healthcare Need: Affordable Healthcare by Community

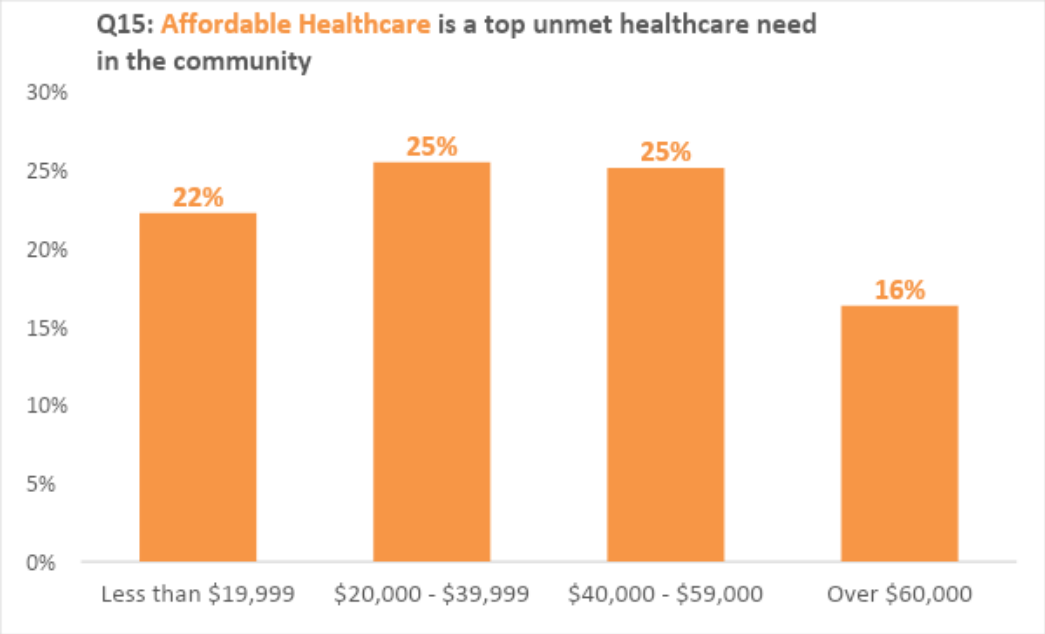
The 202 respondents who answered this question live in the following communities. Those most impacted by the cost of healthcare live in Camelot, South Norfolk, Western Branch and Greenbrier. The least impacted by the cost of healthcare live in the Southern/Hickory area of Chesapeake.



Neighborhood	# Respondents listing *Affordable Healthcare* as an unmet need	# Who answered Question 15	% Listing *Affordable Healthcare* as top unmet need
	#		%
Camelot	22	67	33%
South Norfolk	49	159	31%
Deep Creek	23	75	31%
Western Branch	7	28	25%
Greenbrier	37	155	24%
Indian River	6	39	15%
Great Bridge	15	100	15%
Rivercrest	2	14	14%
Northeastern NC	18	153	12%
Southern/Hickory	4	63	6%
Other /Unknown *(not in graph)*	19	125	27%
Total	**202**	**978**	**21%**

#3 Unmet Healthcare Need: Affordable Healthcare by Income Level

The 202 respondents who answered this question reported the following household income levels.



Annual Household Income	# Respondents listing *Affordable Healthcare* as unmet need	# Who answered Question 15	% Listing *Affordable Healthcare* are as top unmet need
Less than $19,999	14	63	22%
$20,000 - $39,999	41	161	25%
$40,000 - $59,000	62	247	25%
Over $60,000	77	472	16%
Income not provided *(not in graph)*	8	35	23%
Total	**202**	**978**	**21%**

Ways to Improve the Healthcare System

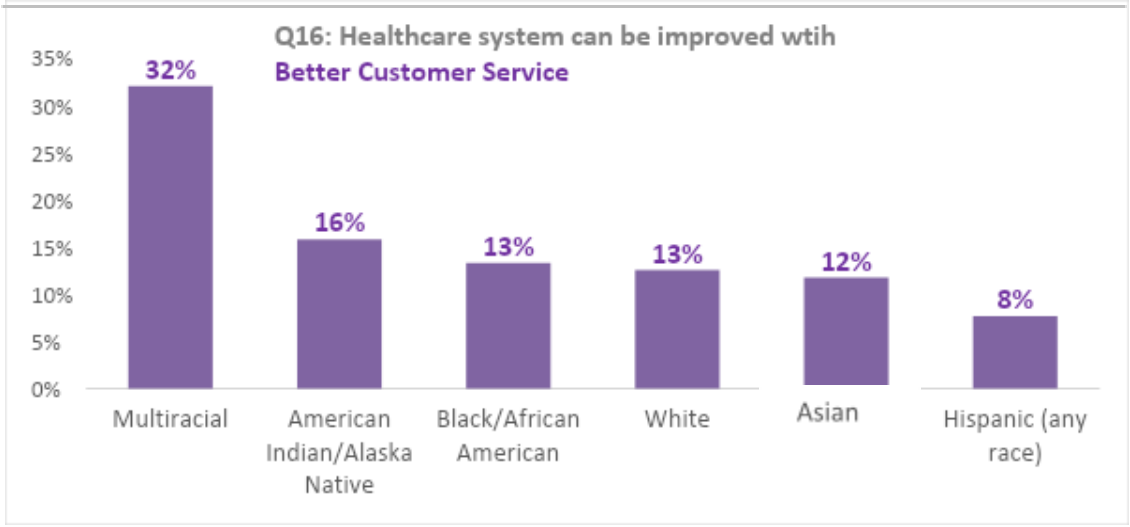
Q16: How do you think the healthcare system in your community could be improved?

Question 16 on the survey asked for open-ended responses about ways to improve the healthcare system. The responses were cataloged by topic and included in the graphs and tables that follow.
Of the 904 respondents who answered Question 16, many listed the same top 3 responses as noted in Question 15. Since the data is similar, graphs and tables for race and ethnicity, community, and income level are not repeated for Question 16.

However, the next most frequently listed topic was a need to *Improve Customer Service*, which included listening to patients to understand their needs, improving people skills, being more attentive and sensitive, and fostering greater trust. Of the 904 respondents to Question 16, 122 (13%) suggested *Improve Customer Service.* Although Multiracial respondents reported a high percentage of this, the sample size was small (just 8 of 25 respondents) so the results may not be representative for that population.

These responses are in the graphs and tables that follow by race, community, and income level.

 # Suggestion: *Improve Customer Service* by Race and Ethnicity



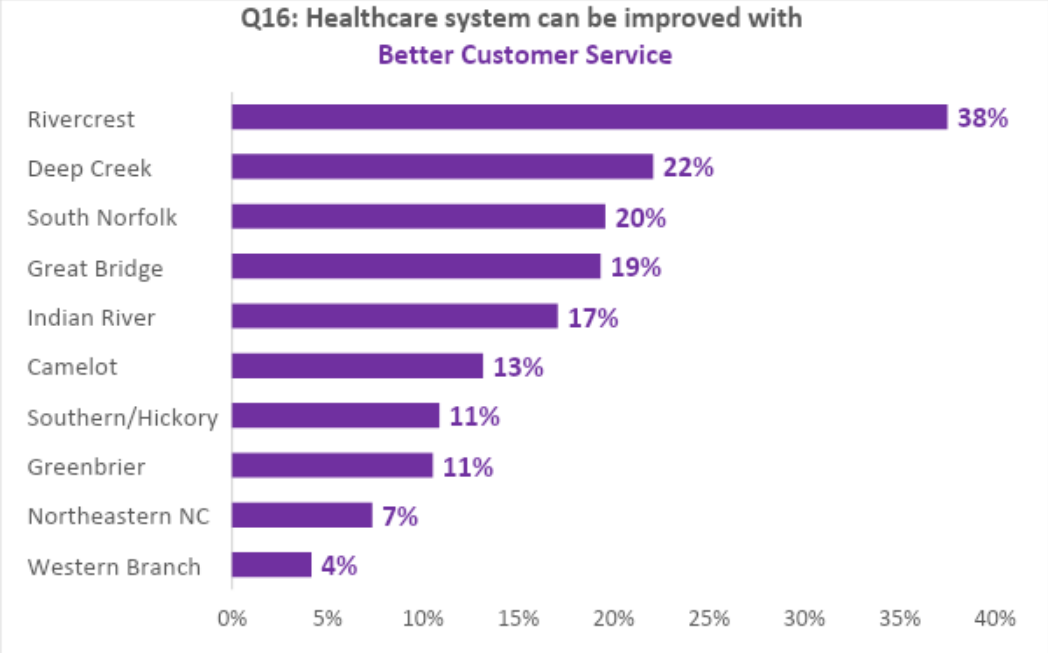
There were no Native Hawaiian/Pacific Islander respondents identifying Customer Service as an improvement.

Race/Ethnicity	# Respondents suggesting *Improve Customer Service*	# Who answered Question 16	% Suggesting *Improve Customer Service*
Multiracial	8	25	32%
American Indian/Alaska Native	3	19	16%
Black/African American	57	429	13%
White	52	414	13%
Asian	2	17	12%
Hispanic (any race)	4	52	8%
Total	**122**	**904**	**13%**

All respondents to this question provided a race and/or ethnicity.

#1 Suggestion: *Improve Customer Service* by Community

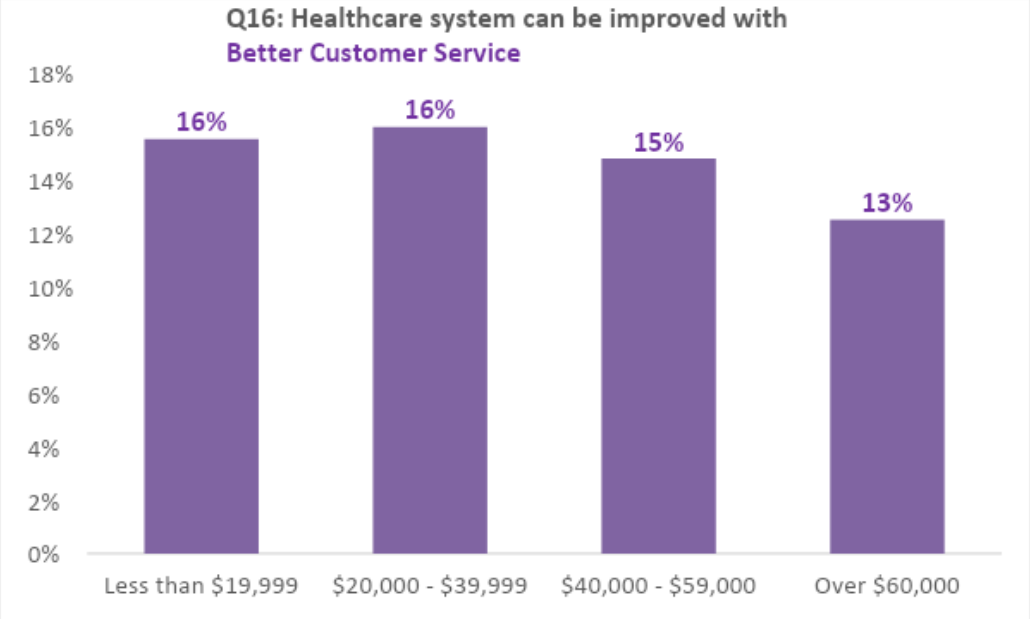
Although Rivercrest had the highest percentage of respondents suggesting that the hospital Improve Customer Service, the population size was small and may not be representative. It is interesting to note that respondents from northeastern North Carolina were less likely to list customer service as an issue to be improved.



Neighborhood	# Respondents Suggesting *Improve Customer Service*	# Who answered Question 16	% Suggesting *Improve Customer Service*
Rivercrest	3	8	38%
Deep Creek	17	77	22%
South Norfolk	27	138	20%
Great Bridge	17	88	19%
Indian River	7	41	17%
Camelot	10	76	13%
Southern/Hickory	5	46	11%
Greenbrier	16	152	11%
Northeastern NC	10	136	7%
Western Branch	1	24	4%
Other/Unknown *(not in graph)*	9	118	7%
Total	**122**	**904**	**13%**

#1 Suggestion: *Improve Customer Service* by Community

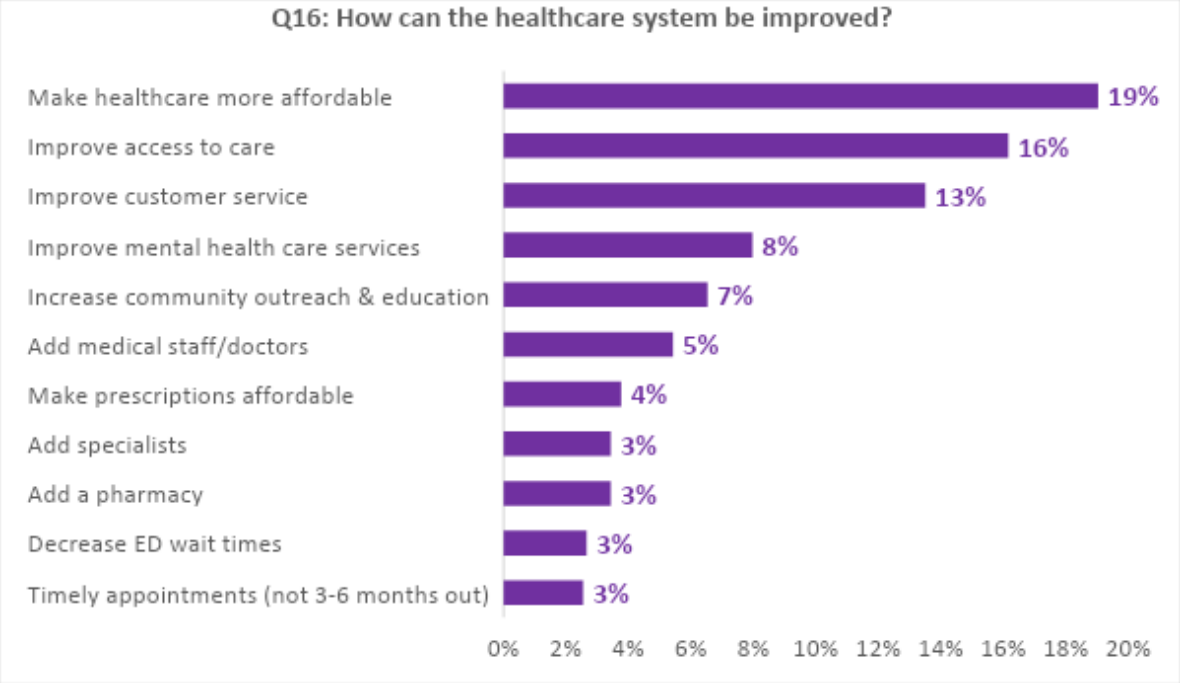
Improving customer service was listed fairly evenly across all income levels.



Annual Household Income	# Respondents Suggesting *Improve Customer Service*	# Who answered Question 16	% Suggesting *Improve Customer Service*
Less than $19,999	9	58	16%
$20,000 - $39,999	27	169	16%
$40,000 - $59,000	34	230	15%
Over $60,000	52	416	13%
Did not provide income *(not in graph)*	0	31	0%
Total	**122**	**904**	**13%**

Other Topics Suggested in Question 16

Several respondents mentioned the loss of Todd's Pharmacy in North Carolina and the need for a new pharmacy in northeastern North Carolina. Additional topics listed most frequently in Question 16 are in the graph and table below. Because these numbers and percentages are small there is no breakdown by race/ethnicity, neighborhood, or income level. A complete list of responses is in Appendix E.

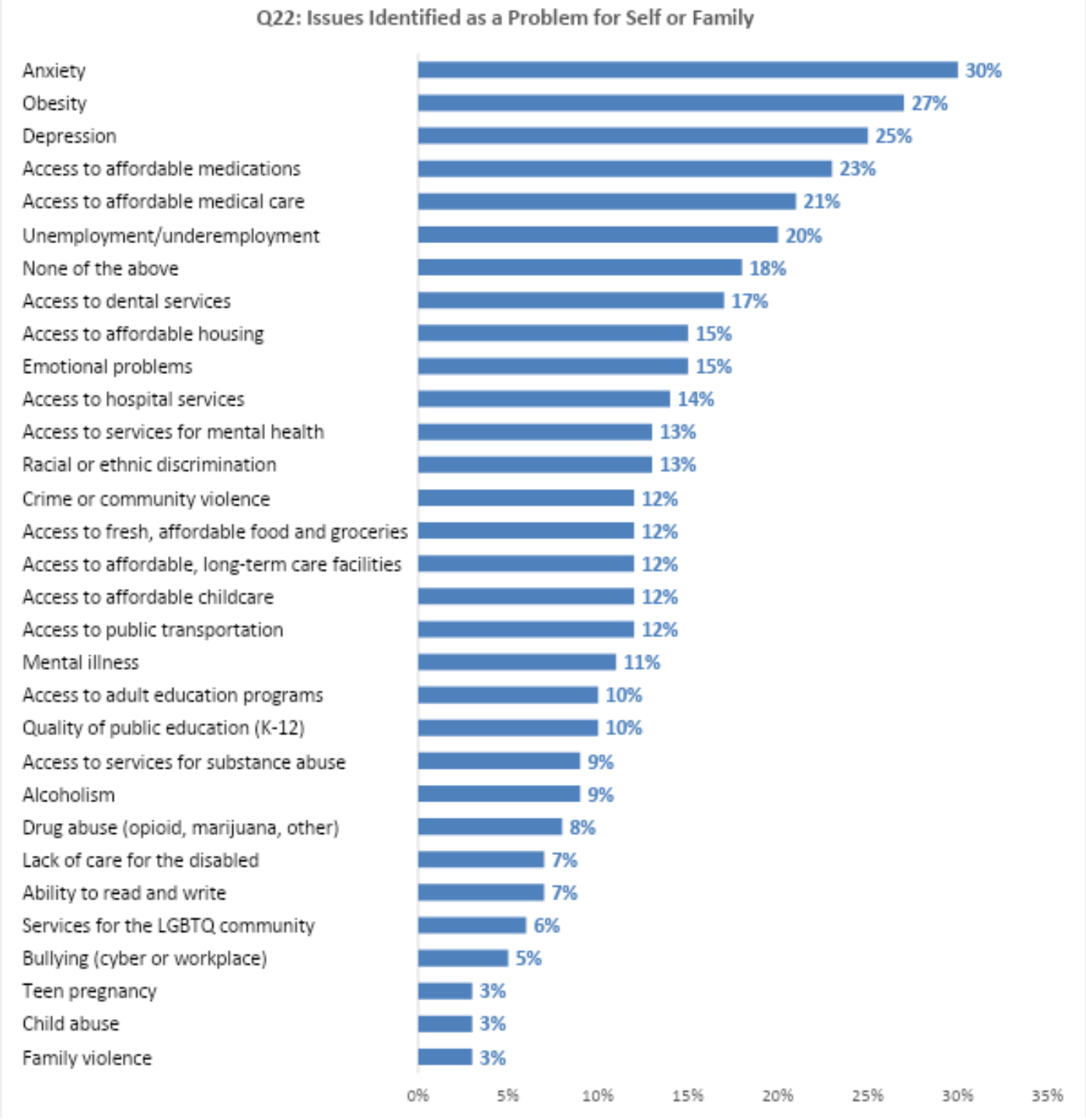


Suggestions for improvement in healthcare system	# Respondents	% Respondents
Make healthcare more affordable	172	19%
Improve access to care	146	16%
Improve customer service	122	13%
Improve mental health care services	72	8%
Increase community outreach & education	59	7%
Add medical staff/doctors	49	5%
Make prescriptions affordable	34	4%
Add a pharmacy	31	3%
Add specialists	31	3%
Decrease ED wait times	24	3%
Timely appointments (not 6 months out)	23	3%

Self and/or Family Problems Reported

Q22: Are any of the following a problem for you or your family?

Among the 1,721 respondents who answered Question 22, the following graph shows the percentage that each issue was mentioned. Anxiety, obesity, and depression were the top 3 problems listed.



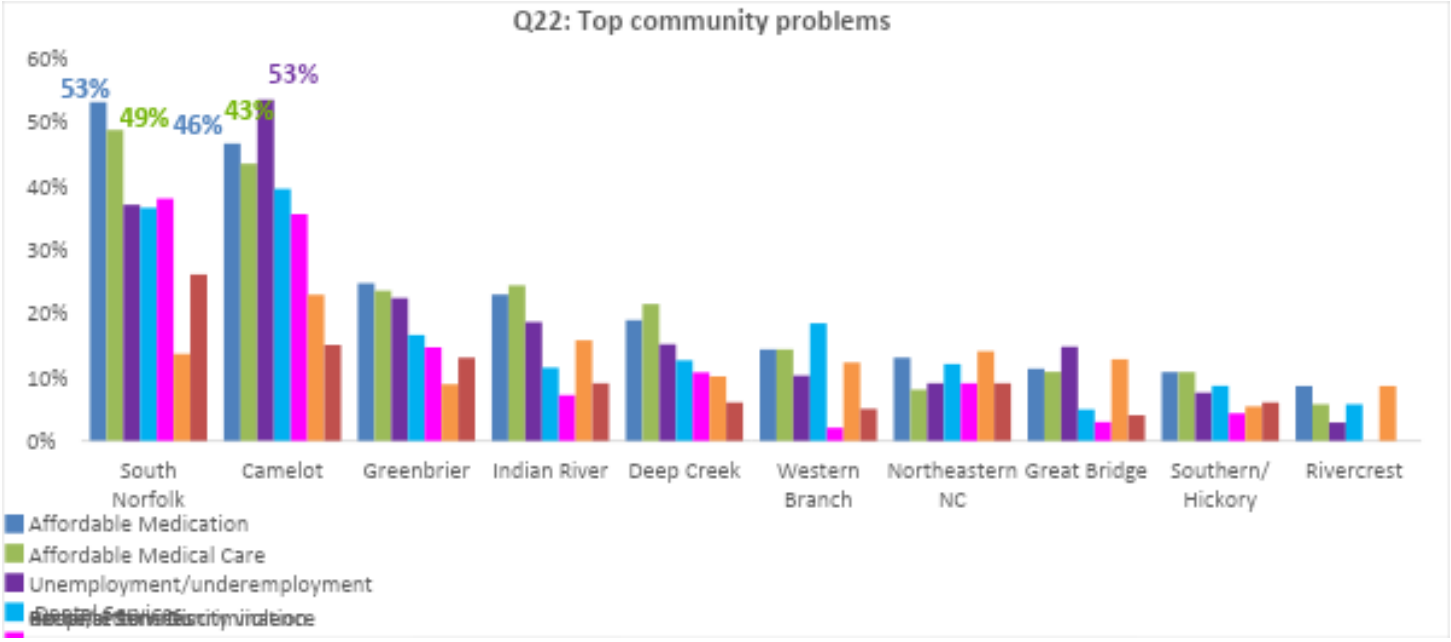
The table below provides the number of responses and the percentages for each issue.

ANSWER CHOICES	RESPONSES	
Anxiety	30.10%	518
Obesity	27.25%	469
Depression	24.52%	422
Access to affordable medications	22.78%	392
Access to affordable medical care	21.32%	367
Unemployment/underemployment	19.70%	339
None of the above	18.42%	317
Access to dental services	16.62%	286
Emotional problems	15.34%	264
Access to affordable housing	14.82%	255
Access to hospital services	13.77%	237
Racial or ethnic discrimination	13.36%	230
Access to services for mental health	13.36%	230
Access to public transportation	12.38%	213
Access to affordable childcare	12.26%	211
Access to affordable, long-term care facilities	12.14%	209
Access to fresh, affordable food and groceries	12.09%	208
Crime or community violence (gun violence, gangs, human trafficking, etc.)	11.97%	206
Mental illness	11.45%	197
Quality of public education (K-12)	10.40%	179
Access to adult education programs	10.28%	177
Alcoholism	8.72%	150
Access to services for substance use	8.54%	147
Drug abuse (opioid, marijuana, or other)	7.84%	135
Ability to read and write	7.44%	128
Lack of care for the disabled	6.80%	117
Services for the LGBTQ community	5.98%	103
Bullying (cyber or workplace)	4.53%	78
Family violence	3.20%	55
Child abuse	2.96%	51
Teen pregnancy	2.56%	44
Total Respondents: 1,721		

Question 22: Community Problems by Neighborhood

The graph below compares the top issues listed in Question 22 for each neighborhood. The issues listed are grouped by Community Issues and those that are Behavioral Health in nature.

More than half (53%) of the respondents from South Norfolk listed Access to Affordable Medication, followed by 49% listing Access to Affordable Medical Care as a problem. Over half of the respondents from Camelot listed Unemployment/underemployment as the greatest problem, followed by 46% who listed Access to Affordable Medication as a problem.

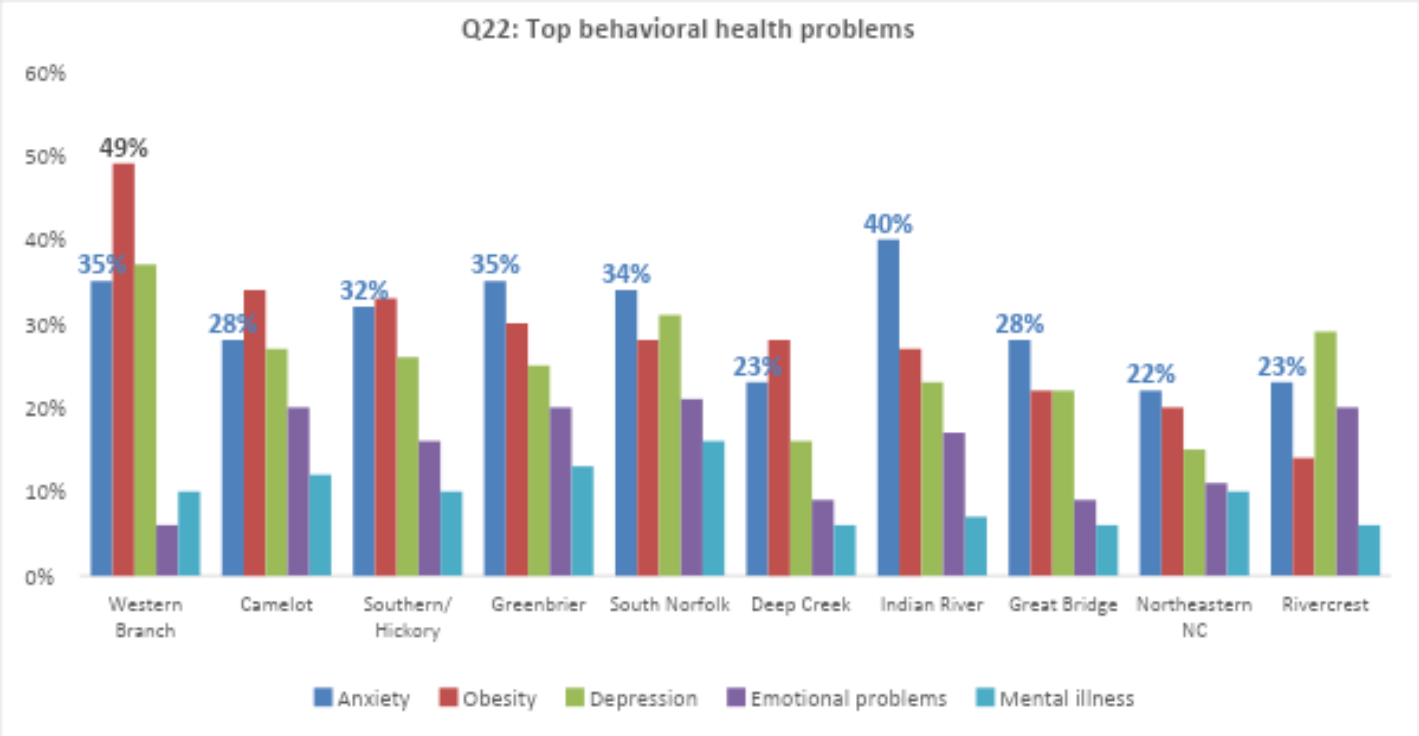


Neighborhood	# Res-pond-ents	Affordable Medication		Affordable Medical Care		Un/under-employed		Dental Services		Hospital Services		Crime/ Community Violence		Racial/ Ethnic Discrimination	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%
Camelot	127	59	46%	55	43%	68	53%	50	39%	45	35%	29	23%	40	32%
Deep Creek	159	30	19%	34	23%	24	15%	20	13%	17	11%	16	10%	17	11%
Great Bridge	204	23	11%	22	11%	30	15%	10	5%	6	3%	26	13%	13	6%
Greenbrier	260	64	25%	61	23%	58	22%	43	17%	38	15%	23	9%	35	13%
Indian River	70	16	23%	17	24%	13	19%	8	11%	5	7%	11	16%	6	9%
Northeastern NC	266	35	13%	21	8%	25	9%	32	12%	25	9%	38	14%	16	6%
Rivercrest	35	3	9%	2	6%	1	3%	2	6%	0	0%	3	9%	1	3%
South Norfolk	206	109	53%	100	49%	76	37%	75	36%	78	38%	28	14%	50	24%
Southern/ Hickory	93	10	11%	10	11%	7	8%	8	9%	4	4%	5	5%	5	5%
Western Branch	49	7	14%	7	14%	5	10%	9	18%	1	2%	6	12%	1	2%
Other/Unknown (*not in graph*	252	36	14%	38	15%	32	13%	29	12%	18	7%	21	8%	29	12%
Total	**1,721**	**392**	**23%**	**367**	**21%**	**339**	**20%**	**286**	**17%**	**237**	**14%**	**206**	**12%**	**230**	**13%**

Respondents could check all that apply.

Question 22: Behavioral Health Problems by Neighborhood

For many neighborhoods, anxiety, obesity, and depression were the top three problems listed.

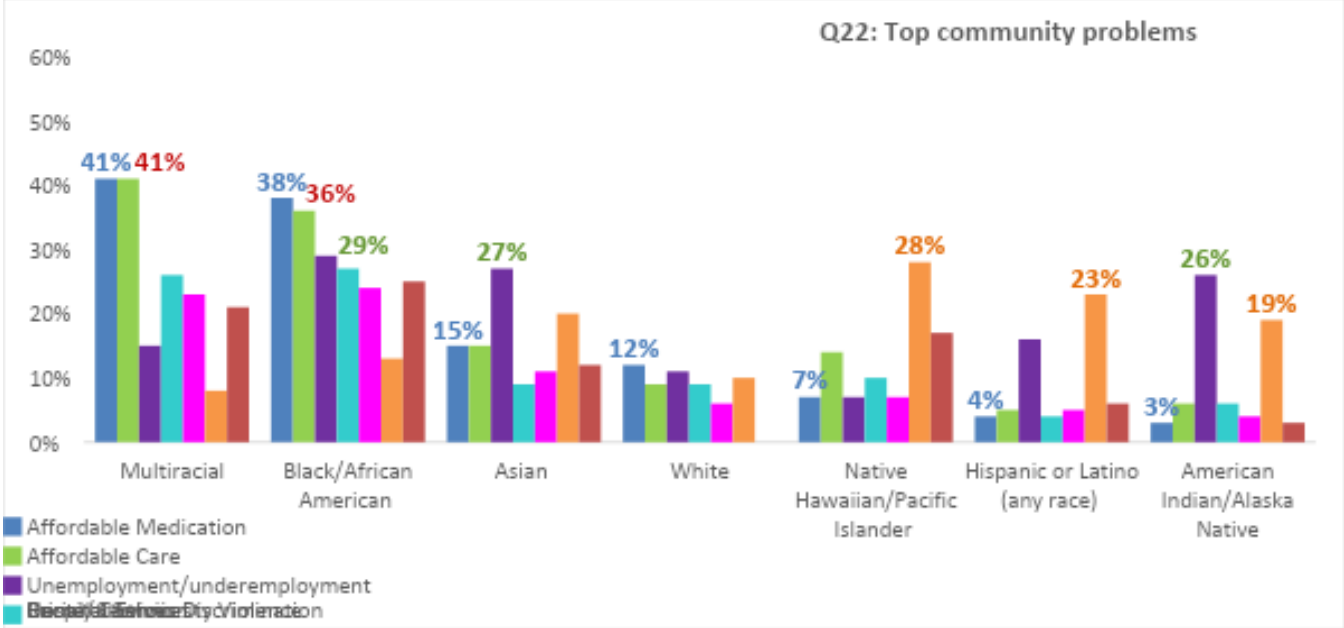


Neighborhood	# Respondents	Anxiety		Obesity		Depression		Emotional Problems		Mental Illness	
		#	%	#	%	#	%	#	%	#	%
Western Branch	49	17	35%	24	49%	18	37%	3	6%	5	10%
Camelot	127	35	28%	43	34%	34	27%	25	20%	15	12%
Southern/Hickory	93	30	32%	31	33%	24	26%	15	16%	19	10%
Greenbrier	260	91	35%	77	30%	64	25%	51	20%	33	13%
South Norfolk	206	71	34%	58	28%	63	31%	44	21%	33	16%
Deep Creek	159	36	23%	45	28%	26	16%	15	9%	10	6%
Indian River	70	28	40%	19	27%	16	23%	12	17%	5	7%
Great Bridge	204	57	28%	44	22%	45	22%	18	9%	13	6%
Northeastern NC	266	59	22%	54	20%	41	15%	28	11%	26	10%
Rivercrest	35	8	23%	5	14%	10	29%	7	20%	2	6%
Other/Unknown *(not in graph)*	252	86	34%	69	27%	81	32%	46	18%	36	14%
Total	**1,721**	**518**	**30%**	**469**	**27%**	**422**	**25%**	**264**	**15%**	**197**	**11%**

Respondents could check all that apply.

Question 22: Community Problems by Race/Ethnicity

Multiracial and Black/African American resondents reported the highest percentages of Affordable Medication and Affordable Care as top problems for themselves or the families. Black/African American, Asian and American Indian/Alaska Native reported high percentages of Unemployment or Underemployment as problems for themselves or their families. Native Hawaiian/Pacific Islanders, Hispanic or Latino and American Indian/Alasak Native responddents reported Crime and Community Violence as problems.

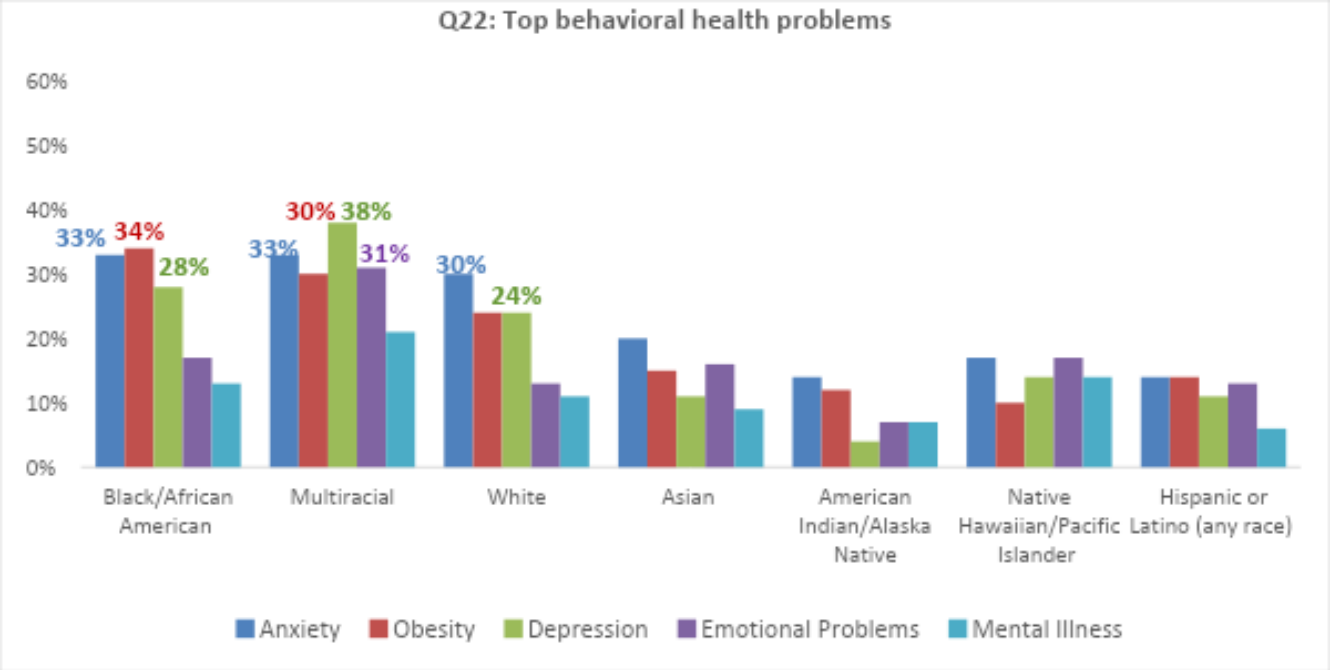


Race/Ethnicity	# Respon-dents	Affordable Medication		Affordable Medical Care		Un/under-employed		Dental Services		Hospital Services		Crime/ Community Violence		Racial/ Ethnic Discrimin-ation	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%
Black/African American	709	267	38%	258	36%	209	29%	188	27%	168	24%	89	13%	176	25%
Multiracial	39	16	41%	16	41%	6	15%	10	26%	9	23%	3	8%	8	21%
White	804	95	12%	72	9%	86	11%	73	9%	47	6%	79	10%	30	4%
Asian	55	8	15%	8	15%	15	27%	5	9%	6	11%	11	20%	7	12%
American Indian/Alaska Native	73	2	3%	5	6%	19	26%	5	6%	3	4%	14	19%	2	3%
Native Hawaiian/ Pacific Islander	29	2	7%	4	14%	2	7%	3	10%	2	7%	8	28%	5	17%
Hispanic or Latino (any race)	288	12	4%	13	5%	45	16%	12	4%	13	5%	66	23%	16	%
Race/ethnicity not provided *(not in graph)*	12	2	17%	4	33%	2	17%	2	17%	2	17%	2	17%	0	0%
Total	**1,721**	**392**	**23%**	**367**	**21%**	**339**	**20%**	**286**	**17%**	**237**	**14%**	**206**	**12%**	**228**	**13%**

Respondents could check all that apply.

Question 22: Behavioral Health Problems by Race

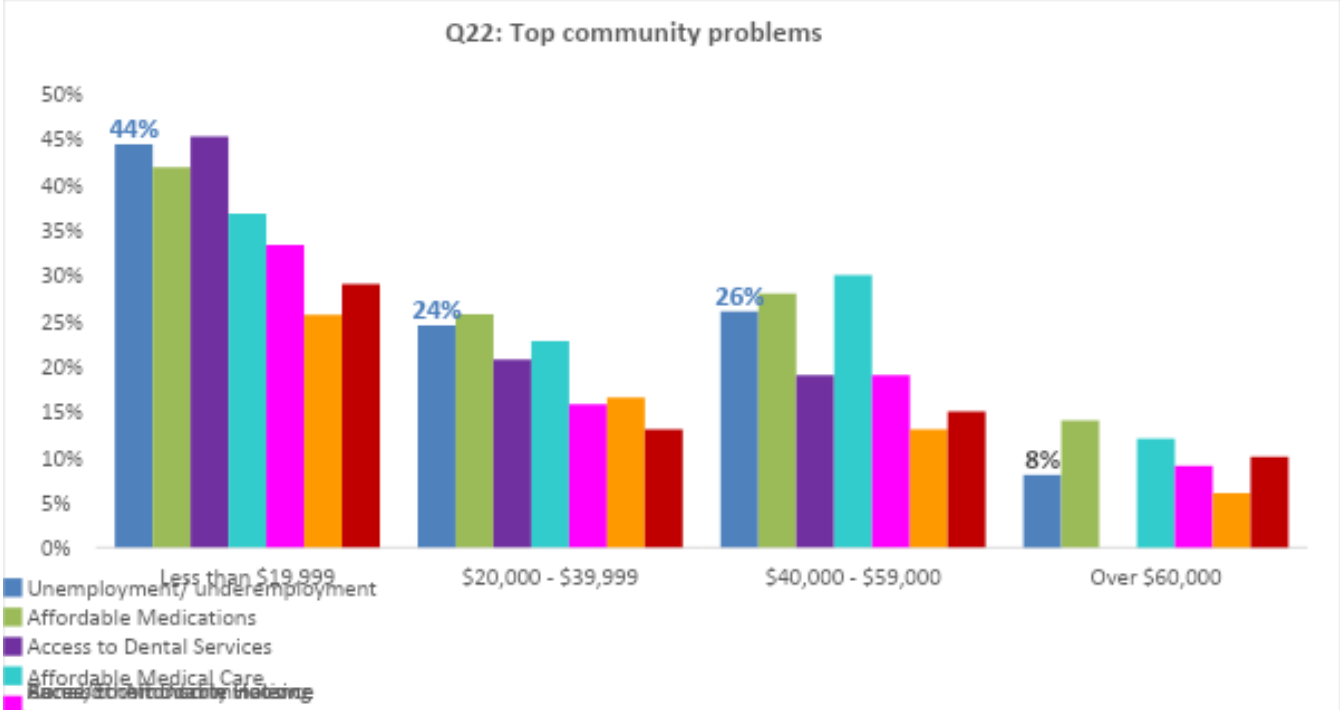
Black/African American and Multiracial respondents reported slightly higher percentages of all behavioral problems than White respondents. These three racial groups reported higher percentages of behavioral problems than Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander and Hispanic or Latino respondents.



Race/Ethnicity	# Respondents	Anxiety		Obesity		Depression		Emotional Problems		Mental Illness	
		#	%	#	%	#	%	#	%	#	%
Black/African American	709	235	33%	241	34%	200	28%	124	17%	89	13%
Multiracial	39	13	33%	12	30%	15	38%	12	31%	8	21%
White	804	240	30%	194	24%	192	24%	105	13%	85	11%
Asian	55	11	20%	8	15%	6	11%	9	16%	5	9%
American Indian/Alaska Native	73	10	14%	9	12%	3	4%	5	7%	5	7%
Native Hawaiian/Pacific Islander	29	5	17%	3	10%	4	14%	5	17%	4	14%
Hispanic or Latino (any race)	288	39	14%	40	14%	31	11%	38	13%	18	6%
Race/ethnicity not provided *(not in graph)*	12	4	33%	2	17%	2	17%	4	33%	1	8%
Total	**1,721**	**518**	**30%**	**469**	**27%**	**422**	**25%**	**264**	**15%**	**197**	**11%**

Respondents could check all that apply.

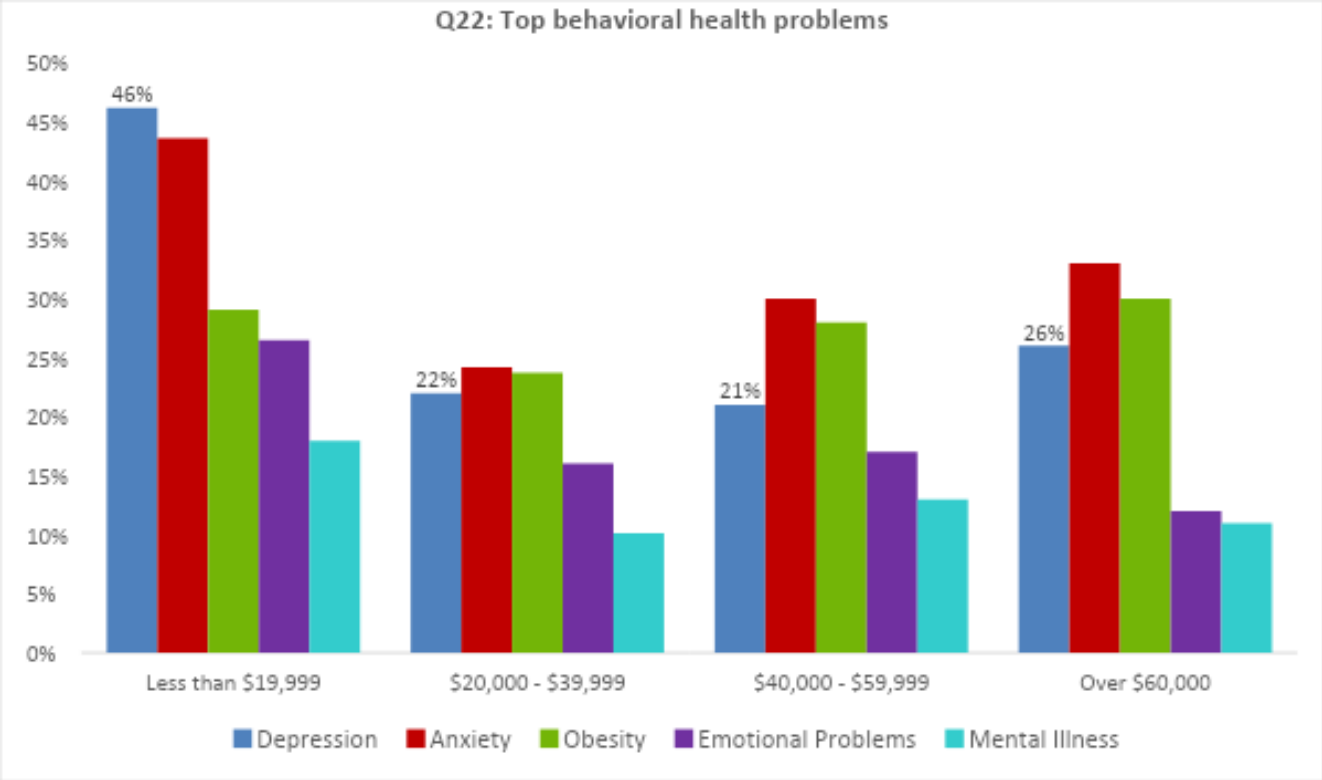
Question 22: Community Problems by Income Level



Annual Household Income	# Respon-dents	Affordable Medication		Affordable Medical Care		Un/under-employed		Dental Services		Hospital Services		Crime/ Community Violence		Racial/ Ethnic Discrimin-ation	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%
Less than $19,999	117	49	42%	43	37%	52	44%	53	45%	30	26%	30	26%	34	29%
$20,000 - $39,999	405	104	26%	92	23%	99	24%	84	22%	58	16%	69	17%	53	13%
$40,000 - $59,000	470	132	28%	139	30%	124	26%	91	19%	104	22%	62	13%	69	15%
Over $60,000	657	90	14%	79	12%	55	8%	55	8%	38	6%	37	6%	66	10%
Income not provided *(not in graph)*	72	17	24%	14	19%	9	13%	3	4%	7	10%	8	11%	8	11%
Total	**1,721**	**392**	**23%**	**367**	**21%**	**339**	**20%**	**286**	**17%**	**237**	**14%**	**206**	**12%**	**230**	**13%**

Respondents could check all that apply.

Question 22: Behavioral Health Problems by Income Level



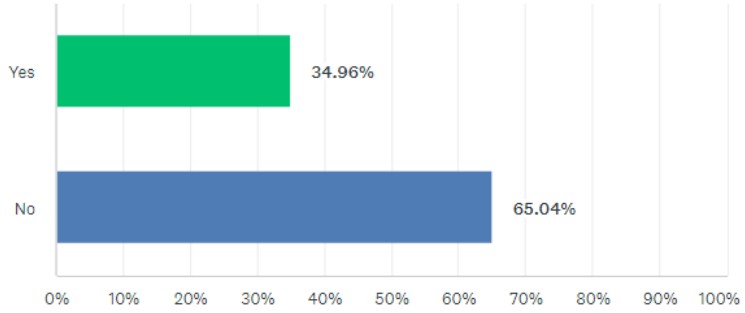
Annual Household Income	# Respondents	Anxiety		Obesity		Depression		Emotional Problems		Mental Illness	
		#	%	#	%	#	%	#	%	#	%
Less than $19,999	117	51	44%	34	34%	54	46%	31	27%	21	18%
$20,000 - $39,999	405	98	24%	96	24%	89	22%	65	16%	41	10%
$40,000 - $59,000	470	143	30%	131	28%	100	21%	82	17%	63	13%
Over $60,000	657	217	33%	198	30%	172	26%	79	12%	70	11%
Income not provided *(not in graph)*	72	9	13%	10	14%	7	10%	7	10%	2	3%
Total	**1,721**	**518**	**30%**	**469**	**27%**	**422**	**25%**	**264**	**15%**	**197**	**11%**

Respondents could check all that apply.

Survey Profile for Households with Children Under 18

Question 30: Do you have children under 18?

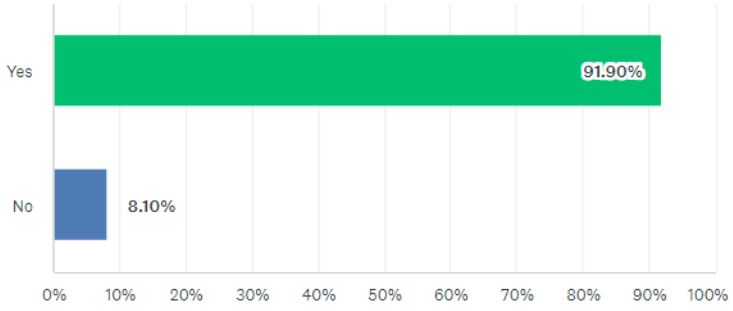
Answered: 1,742 Skipped: 114



ANSWER CHOICES	RESPONSES	
Yes	34.96%	609
No	65.04%	1,133
TOTAL		1,742

Question 31: In the past 12 months, have all of your children had a checkup?

Answered: 617 Skipped: 1,239

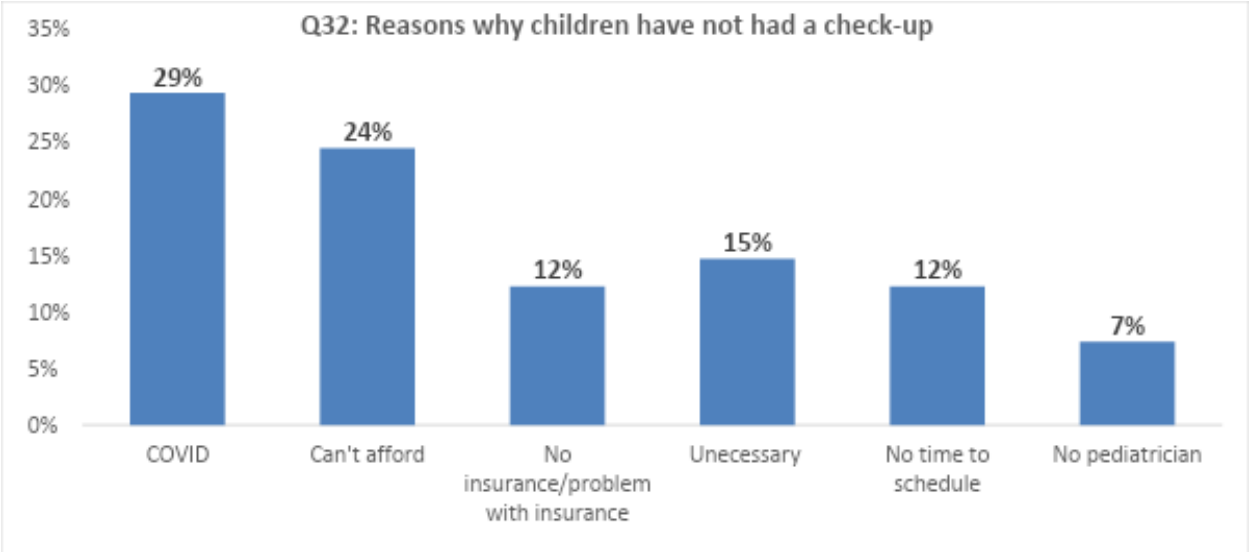


ANSWER CHOICES	RESPONSES	
Yes	91.90%	567
No	8.10%	50
TOTAL		617

NOTE: 609 respondents answered Yes to having children under the age of 18, but 617 answered the question about getting their children checkups. The graphs and tables that follow are based on the 617 respondents who answered Question 31.

Q32: If you answered *No* in the previous question, please describe why your children have not had a checkup in the last 12 months.

Answered: 40 Skipped: 10



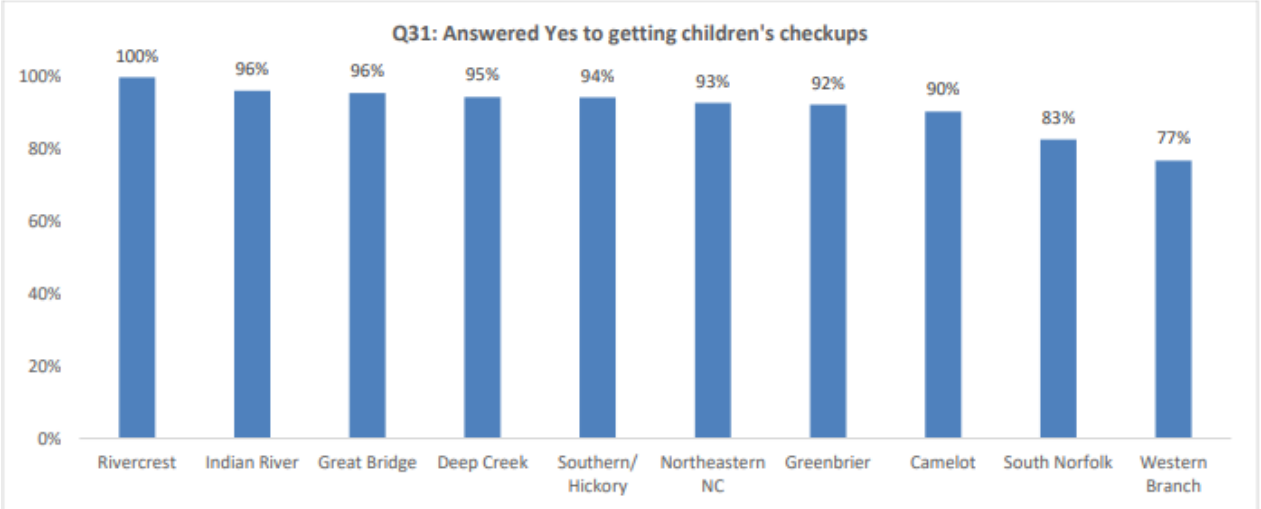
Reason for children not having a check-up	#	%
COVID	12	29%
Can't afford	10	24%
No insurance/problem with insurance	5	12%
No need – children are healthy	6	15%
No time to schedule	5	12%
No pediatrician	3	7%
Total responses	**41**	100%

Respondents could provide multiple reasons.

Question 31: Children's Checkups by Neighborhood

Answered: 609

Respondents from Western Branch indicated the smallest percentage (77%) of households getting their children checkups in the past 12 months.



Neighborhood	# Respondents	Yes	
		#	%
Rivercrest	20	20	100%
Indian River	27	26	96%
Great Bridge	69	66	96%
Deep Creek	55	52	95%
Southern/Hickory	36	34	94%
Northeastern NC	127	118	93%
Greenbrier	66	61	92%
Camelot	63	57	90%
South Norfolk	58	48	83%
Western Branch	13	10	77%
Other/Unknown *(not in graph)*	83	75	100%
Total	**617**	**567**	**92%**

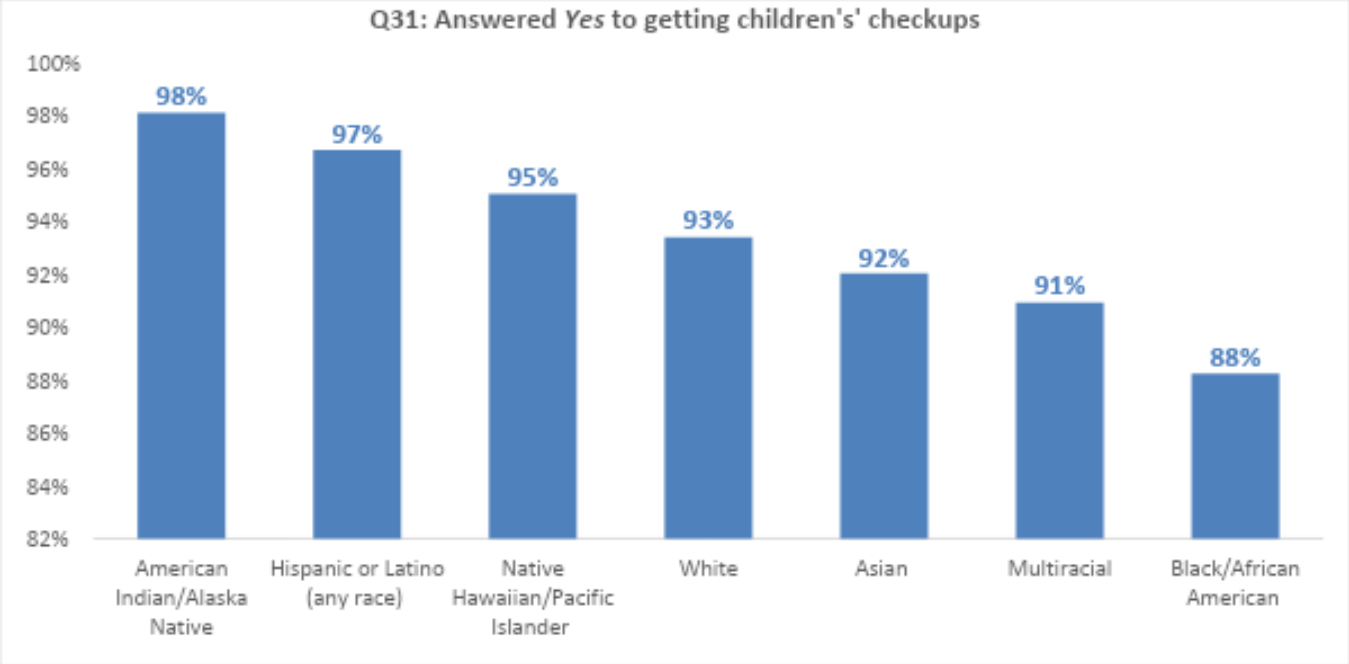
Several respondents who did not get their children checkups provided the reasons below by neighborhood:

- **Western Branch:** Tricare Prime makes it difficult to see provider of choice, takes too long to get appointment
- **South Norfolk:** COVID-19, busy schedule
- **Indian River:** COVID-19
- **Deep Creek:** COVID-19, lack of insurance, child is healthy/checkup not needed
- **Northeastern North Carolina:** lack of insurance, child is healthy/checkup not needed, can't afford, no pediatrician in area.
- **Greenbrier:** cannot afford, COVID-19

Question 31: Children's Checkups by Race and Ethnicity

Answered: 617

Black/African American households reported the smallest percentage of having children's checkups. Respondents who provided a reason noted that they cannot afford it, COVID-19 limitations, and lack of insurance.

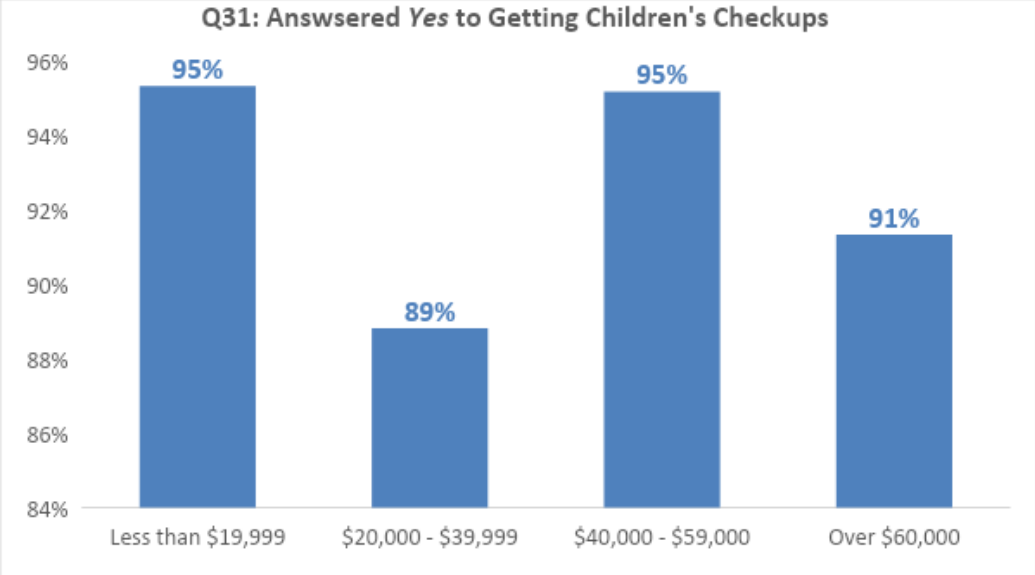


Race/Ethnicity	# Respondents	Yes	
		#	%
Asian	25	23	92%
American Indian/Alaska Native	52	51	98%
Black/African American	187	165	88%
White	317	296	93%
Multiracial	11	10	91%
Hispanic or Latino (any race)	180	174	97%
Native Hawaiian/Pacific Islander	20	19	95%
Race/ethnicity unknown *(not in graph)*	5	3	60%
Total	**617**	**567**	**92%**

Question 31: Children's Checkups by Income Level

Answered: 617

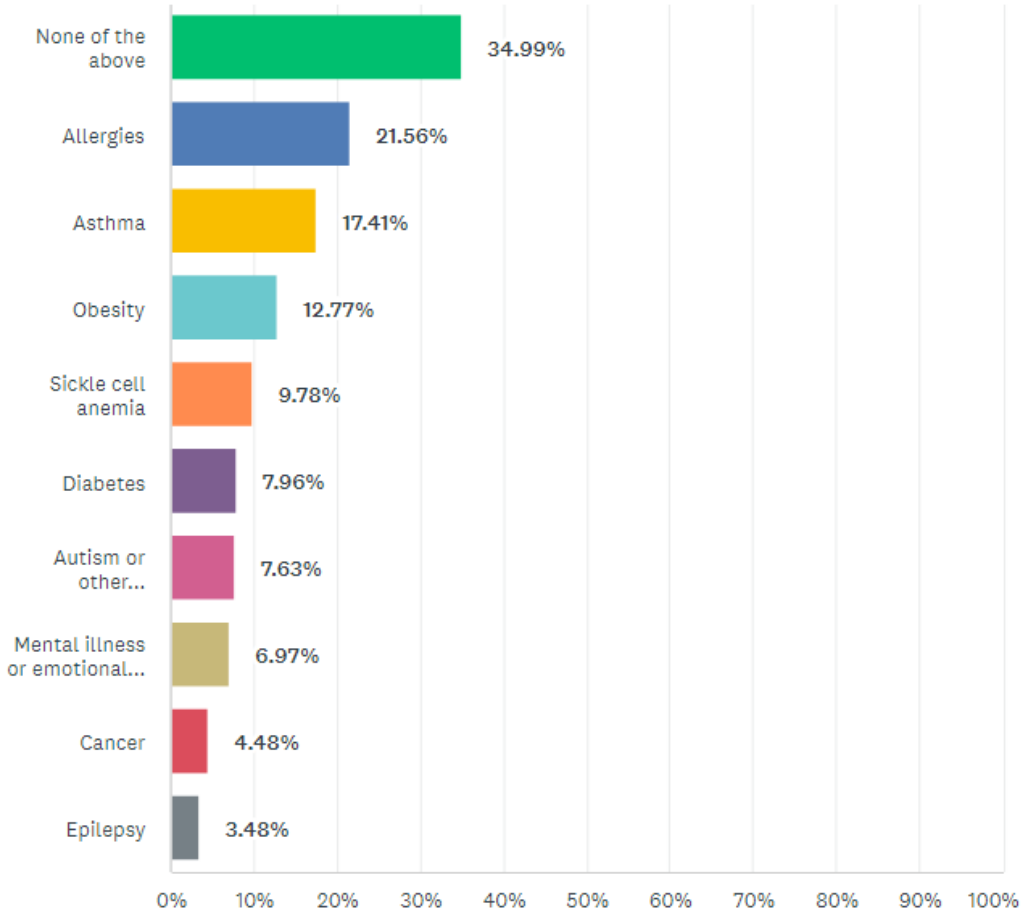
Respondents in the $20,000 - $39,000 income group reported the smallest percentage (89%) of getting children's checkups. Respondents who provided reasons noted cost, lack of insurance, busy schedules, and COVID-19 as barriers.



Annual Household Income	# Respondents	Yes	
		#	%
Less than $19,999	43	41	95%
$20,000 - $39,999	188	167	89%
$40,000 - $59,000	187	178	95%
Over $60,000	185	169	91%
Income not provided *(not in graph)*	14	12	86%
Total	**617**	**567**	**92%**

Q33: Have any of your children been diagnosed with any of the following? Check all that apply.

Answered:603 Skipped: 1,253

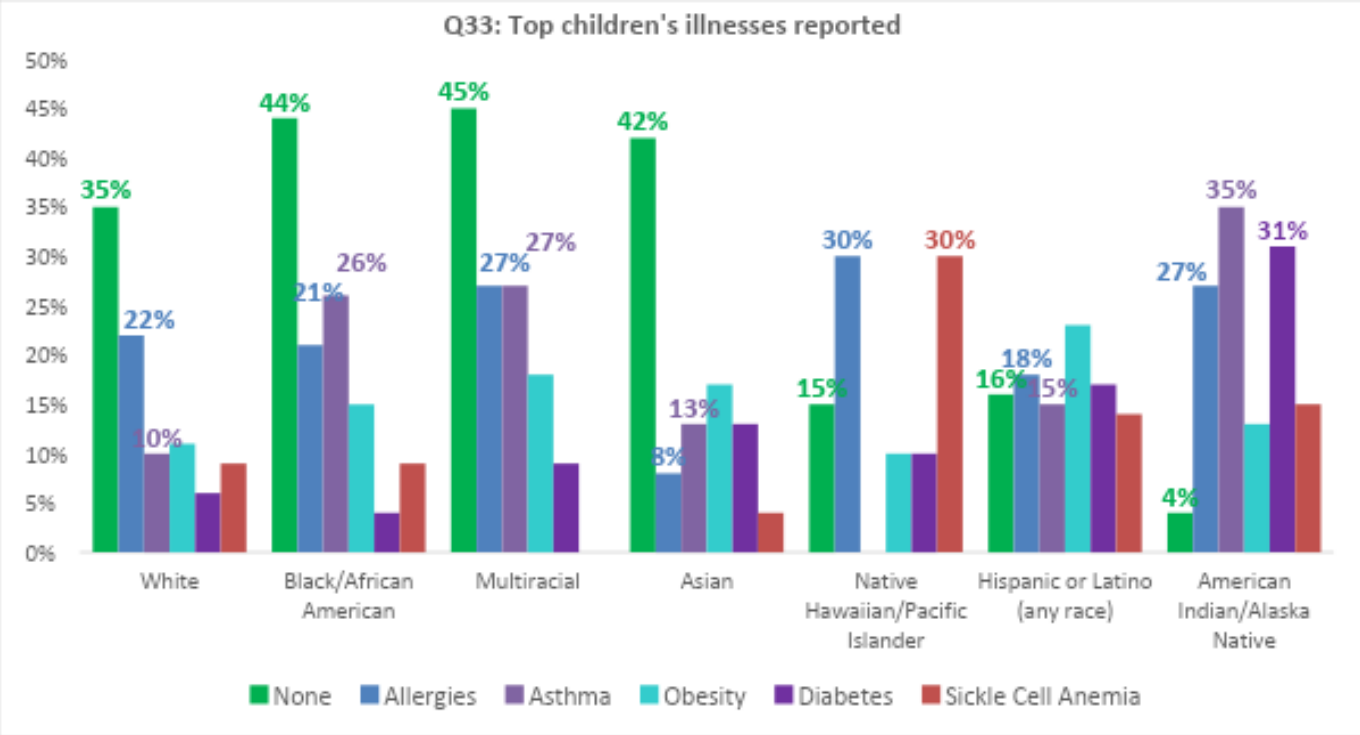


ANSWER CHOICES	RESPONSES	
None of the above	34.99%	211
Allergies	21.56%	130
Asthma	17.41%	105
Obesity	12.77%	77
Sickle cell anemia	9.78%	59
Diabetes	7.96%	48
Autism or other Intellectual/Developmental disability	7.63%	46
Mental illness or emotional problems	6.97%	42
Cancer	4.48%	27
Epilepsy	3.48%	21
Total Respondents: 603		

Children's Diagnoses by Race and Ethnicity

Answered: 603 Skipped: 14

White, Black/African American, Multiracial and Asian respondents reported the greatest percentage of their children having no chronic illness. Multiracial, Native Hawaiian/Pacific Islander and American Indian/Alaska Native respondents reported the highest percentage of Asthma. Native Hawaiian/Pacific Islander respondents indicated by far the highest percentage of children with sickle cell anemia.



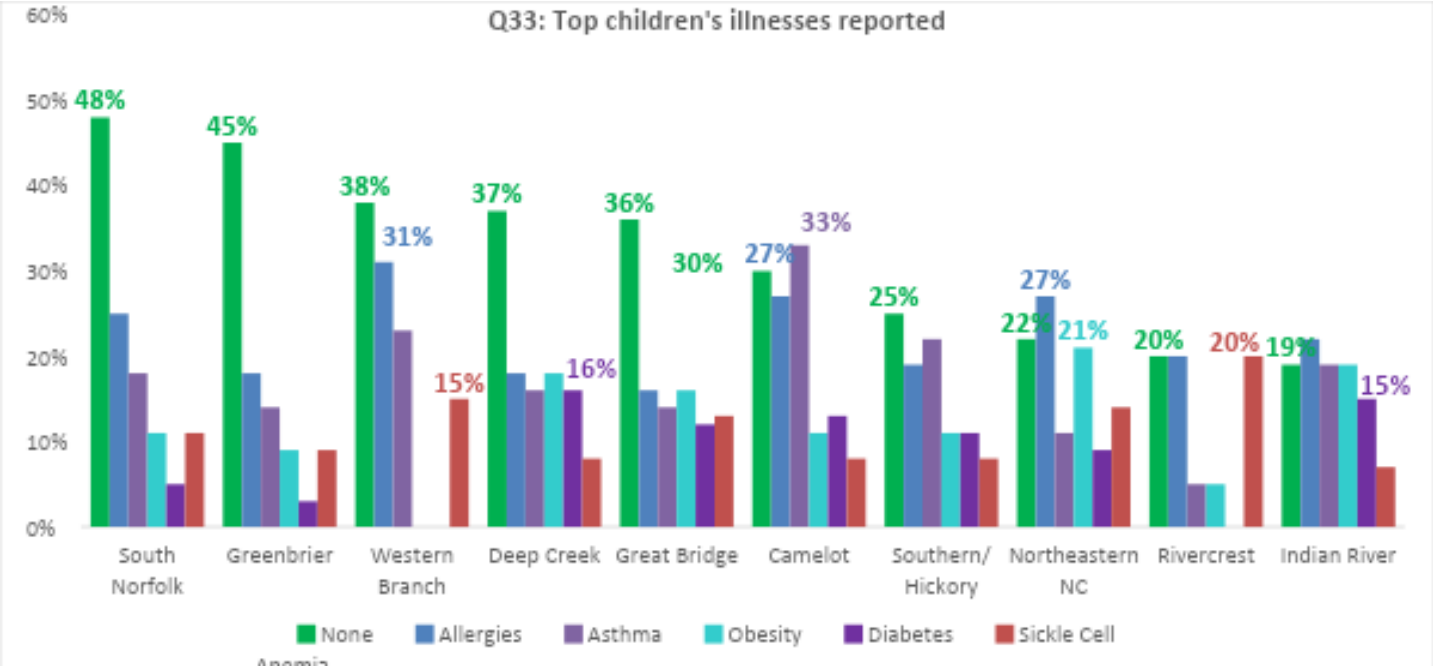
Race/Ethnicity	# Respondents	None		Allergies		Asthma		Obesity		Diabetes		Sickle Cell Anemia	
		#	%	#	%	#	%	#	%	#	%	#	%
White	**307**	107	35%	67	22%	31	10%	35	11%	19	6%	28	9%
Black/African American	**185**	81	44%	38	21%	48	26%	27	15%	7	4%	16	9%
Multiracial	**11**	5	45%	3	27%	3	27%	2	18%	1	9%	0	0%
Asian	**24**	10	42%	2	8%	3	13%	4	17%	3	13%	1	4%
Native Hawaiian/Pacific Islander	**20**	3	15%	6	30%	0	0%	2	10%	2	10%	6	30%
Hispanic or Latino (any race)	**180**	29	16%	33	18%	27	15%	42	23%	31	17%	25	14%
American Indian/Alaska Native	**52**	2	4%	14	27%	18	35%	7	13%	16	31%	8	15%
Race/ethnicity unknown *(not included in graph)*	**4**	3	75%	0	0%	2	50%	0	0%	0	0%	0	0%
Total	**603**	**211**	**35%**	**130**	**22%**	**105**	**17%**	**77**	**13%**	**48**	**8%**	**59**	**10%**

Respondents could check all that apply.

Children's Diagnoses by Neighborhood

Answered: 603 Skipped: 14

When comparing across neighborhoods, Camelot had the highest percentage of co-occurring allergies (27%) and asthma (33%). Along with Camelot, Western Branch and northeastern North Carolina had the highest percentage of children with allergies. Rivercrest had the highest percentage of reported diagnoses of children with sickle cell anemia (20%). Indian River and Deep Creek showed the highest percentage of obesity and diabetes. Northeastern North Carolina had the highest percentage of obesity (21%).



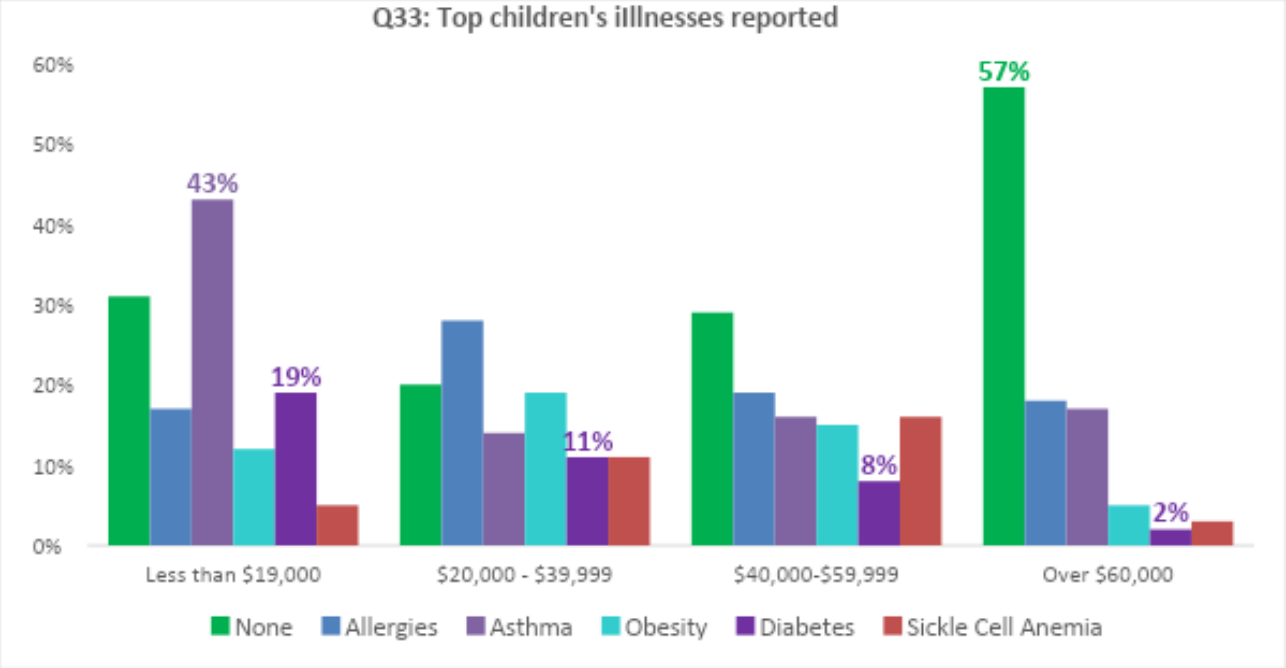
Neighborhood	# Respondents	None		Allergies		Asthma		Obesity		Diabetes		Sickle Cell Anemia	
		#	%	#	%	#	%	#	%	#	%	#	%
South Norfolk	56	27	48%	14	25%	10	18%	6	11%	3	5%	6	11%
Greenbrier	65	29	45%	12	18%	9	14%	6	9%	2	3%	6	9%
Western Branch	13	5	38%	4	31%	3	23%	0	0%	0	0%	2	15%
Deep Creek	51	19	37%	9	18%	8	16%	9	18%	8	16%	4	8%
Great Bridge	69	25	36%	11	16%	10	14%	11	16%	8	12%	9	13%
Camelot	64	19	30%	17	27%	21	33%	7	11%	8	13%	5	8%
Southern/Hickory	36	9	25%	7	19%	8	22%	4	11%	4	11%	3	8%
Northeastern NC	125	27	22%	34	27%	14	11%	26	21%	11	9%	17	14%
Rivercrest	20	4	20%	4	20%	1	5%	1	5%	0	0%	4	20%
Indian River	27	5	19%	6	22%	5	19%	5	19%	4	15%	2	7%
Other/Unknown (not in graph)	77	42	61%	12	13%	16	22%	2	0%	0	0%	1	0%
Total	**603**	**211**	**35%**	**130**	**22%**	**105**	**17%**	**77**	**13%**	**48**	**8%**	**59**	**10%**

Respondents could check all that apply.

Children's Diagnoses by Income Level

Answered: 603 Skipped: 14

The highest income level reported considerably fewer diagnoses of children with obesity and diabetes than other income groups. The percentage of children with diabetes (purple bar) decreased as income level increased. Respondents earning less than $19,000 annually reported the highest percentage of children with asthma.



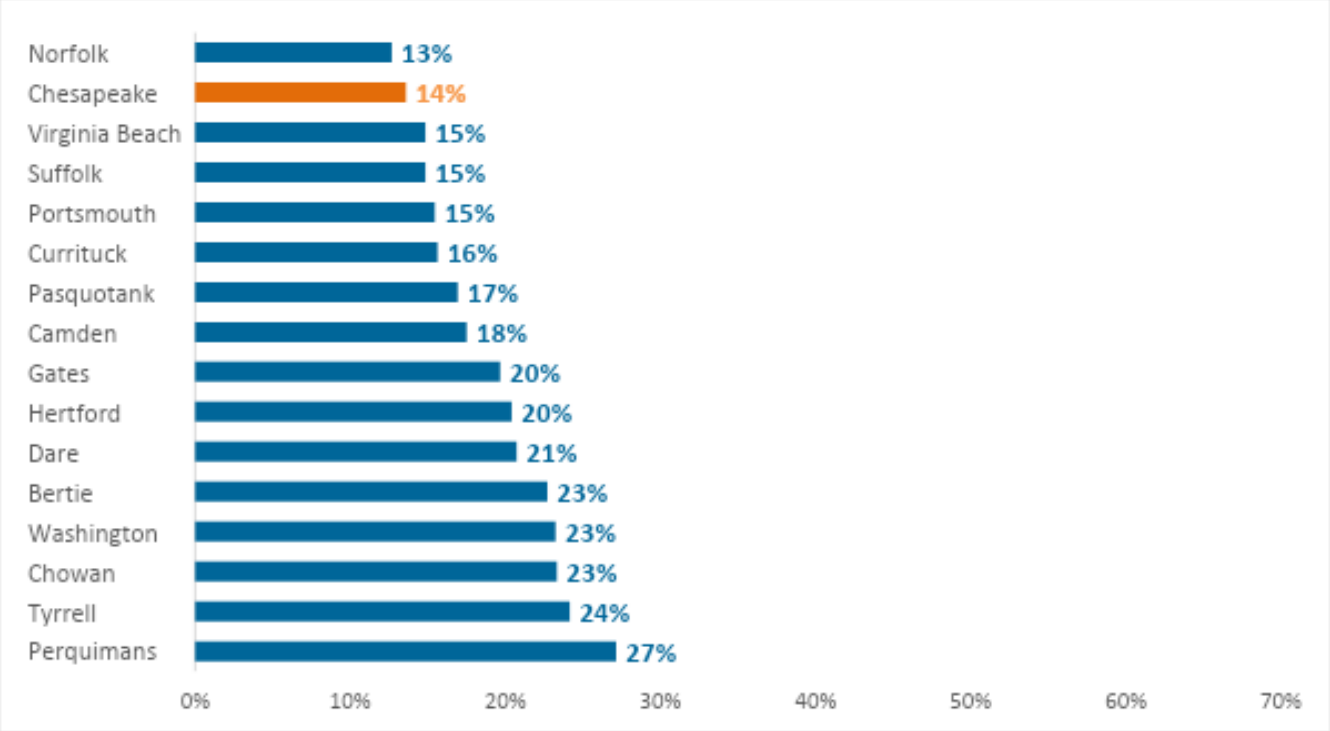
Income	# Respondents	None		Allergies		Asthma		Obesity		Diabetes		Sickle Cell Anemia	
		#	%	#	%	#	%	#	%	#	%	#	%
Less than $19,000	42	13	31 %	7	17 %	18	43 %	3	12 %	8	19 %	2	5%
$20,000 - $39,999	188	38	20 %	53	28 %	26	14 %	36	19 %	20	11 %	21	11 %
$40,000-$59,999	185	54	29 %	35	19 %	30	16 %	27	15 %	15	8%	29	16 %
Over $60,000	175	100	57 %	31	18 %	29	17 %	8	5%	4	2%	6	3%
Income not provided *(not in graph)*	13	6	46 %	4	31 %	2	15 %	3	23 %	1	8%	1	8%
Total	**603**	**211**	**35 %**	**130**	**22 %**	**105**	**17 %**	**77**	**13 %**	**48**	**8%**	**59**	**10 %**

Respondents could check all that apply.

Survey Profile on Seniors Aged 65 and Older

Persons age 65+ as a percent of total population

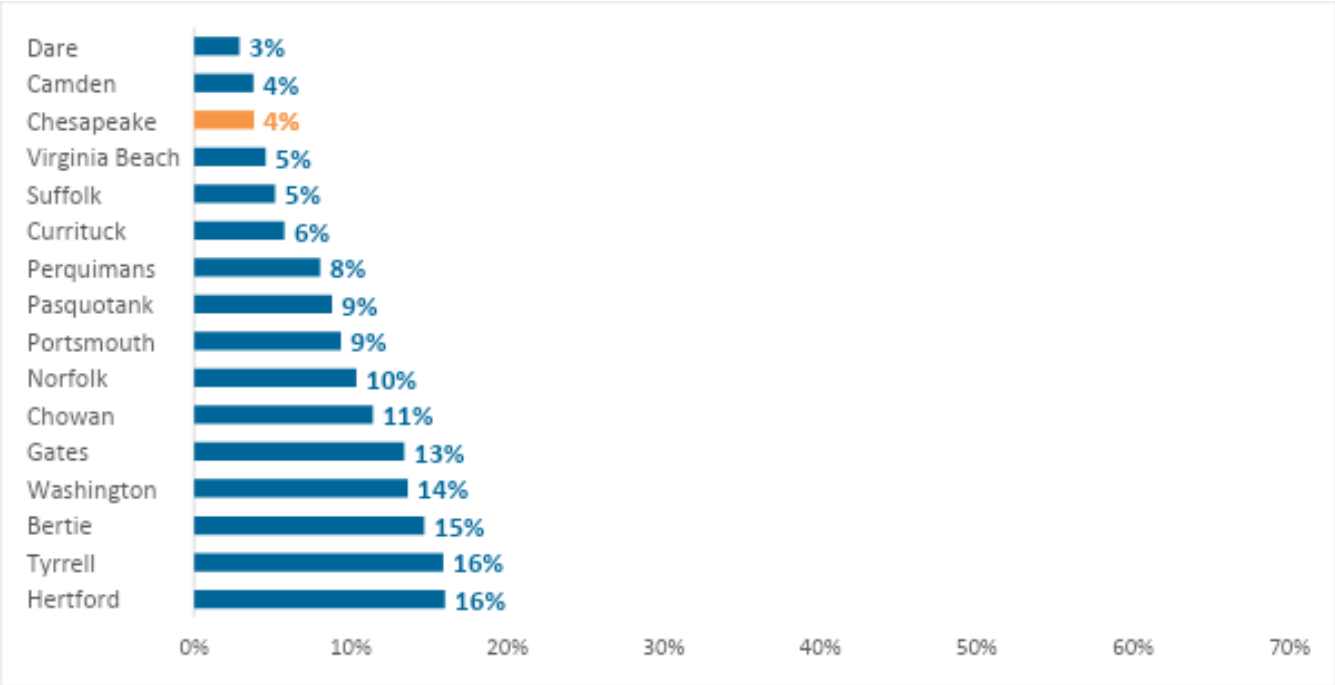
Compared to northeastern North Carolina and other South Hampton Roads jurisdictions, the percentage of senior citizens is among the smallest.



Source: U.S. Census, American Community Survey, 2014-2019 5-Year Estimates, Table B17001.

Percent of Seniors Age 65+ Below Poverty

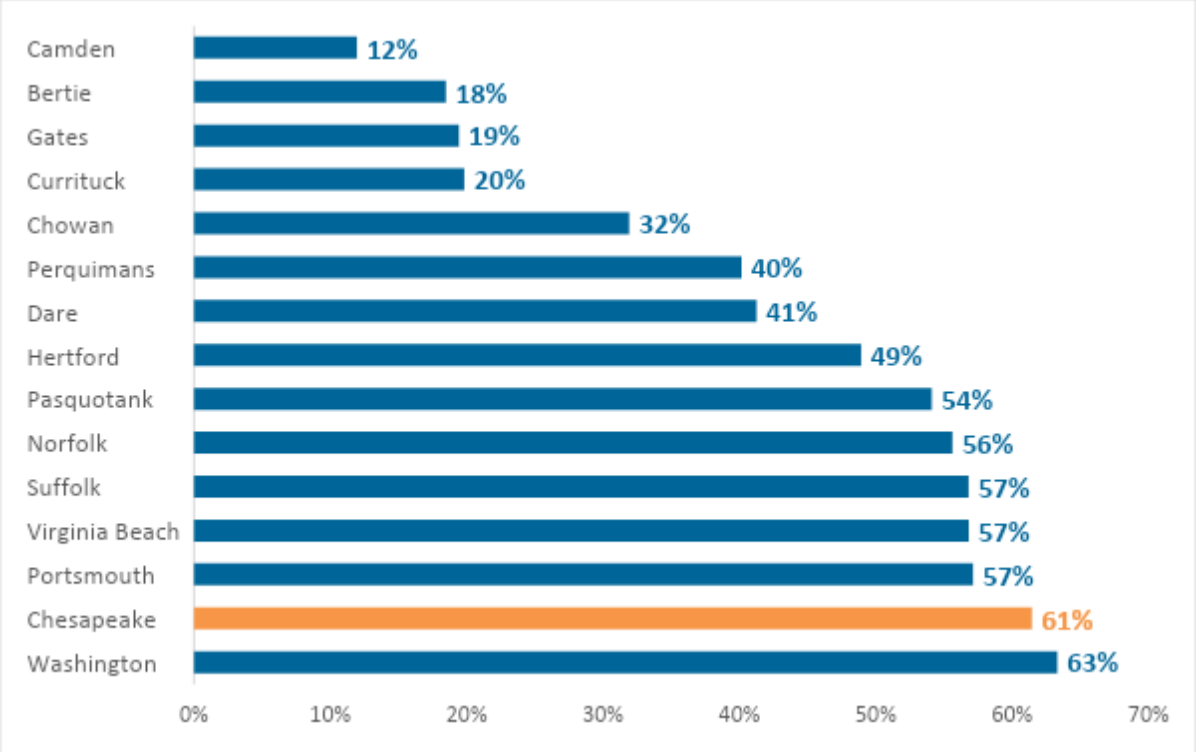
Chesapeake has one of the lowest percentages of senior citizens living below poverty level.



Source: U.S. Census, American Community Survey, 2014-2019 5-Year Estimates, Table B17001.

Renter Households Age 65+ Paying 30% or More of Income on Rent

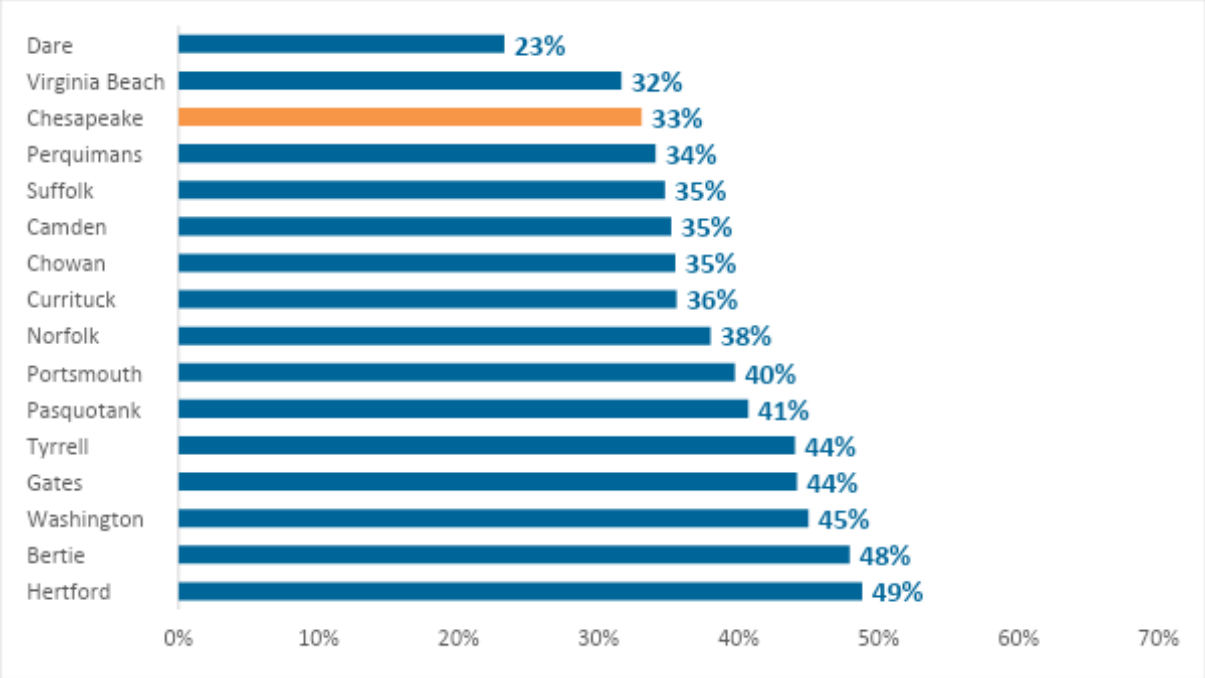
The percentage of seniors paying 30% or more of their income on rent is among the highest in the South Hampton Roads cities of Norfolk, Suffolk, Virginia Beach, Portsmouth, and Chesapeake. Except for Washington County, northeastern North Carolina has a lower percentage of rent-burdened seniors.



Source: U.S. Census, American Community Survey, 2014-2019 5-Year Estimates, Table B25072.

Seniors 65+ Who Have a Disability

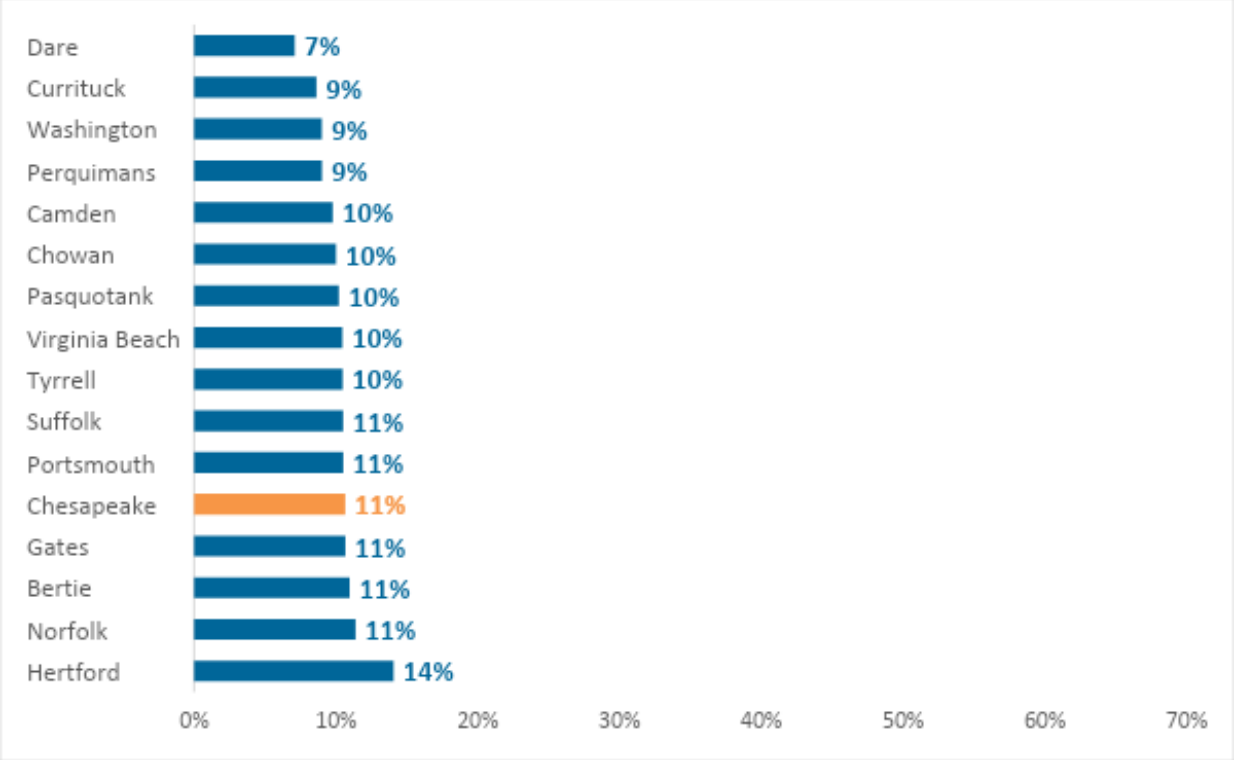
Chesapeake has a lower percentage of disabled seniors than most jurisdictions in the hospital's services area.



Source: U.S. Census, American Community Survey, 2014-2019 5-Year Estimates, Table B1801.

Percent of Alzheimer's Disease among Medicare Beneficiaries

Within the jurisdictions in this study, Chesapeake has an average percentages of Medicare enrollees with Alzheimer's Disease.



Source: Centers for Medicare and Medicaid Services, Medicare Chronic Conditions Dashboard, 2018

Survey Results for Respondents Age 65+

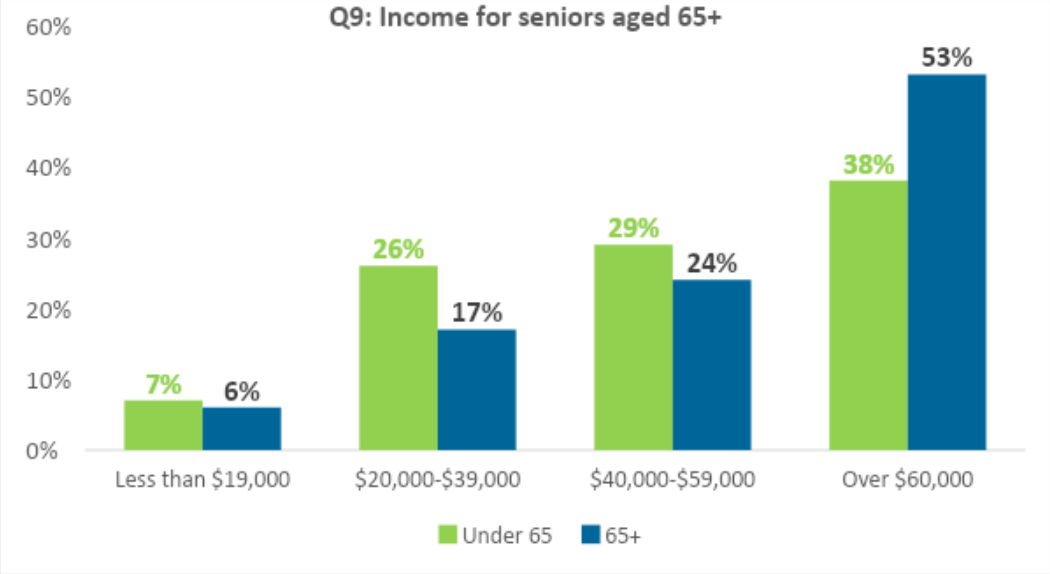
Overall, the survey results for this population indicates that they are faring well compared to respondents under the age of 65.

Q9. What is your total household income?

Answered: 1,402 respondents under age 65, 357 respondents aged 65+

Over half of senior citizens reported total household income of over $60,000 compared to 38% for those under age 65.

Income Level of Respondents Aged 65+

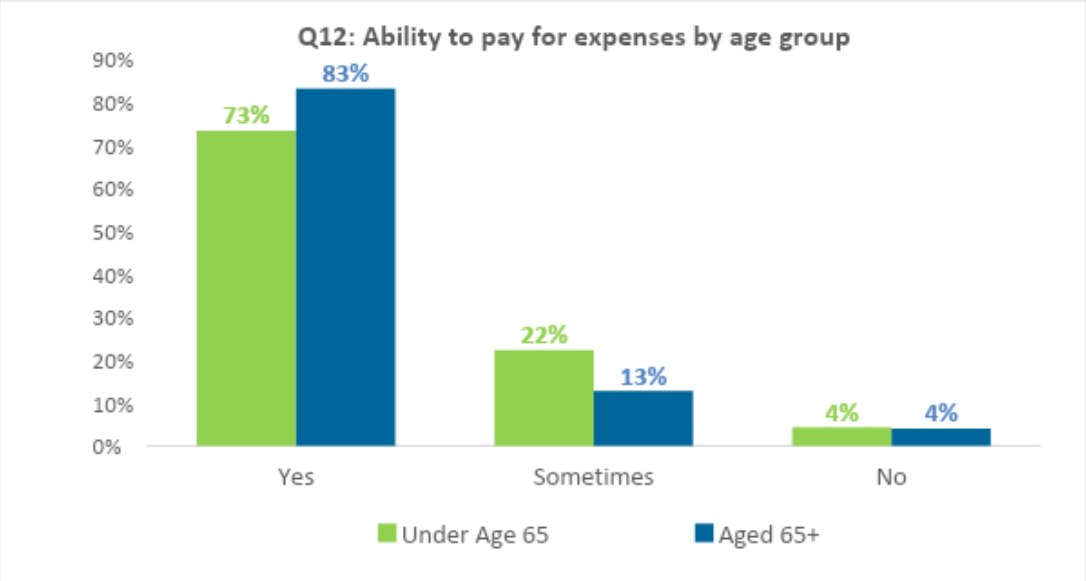


Annual Household Income	Respondents Under Age 65		Respondents Aged 65+	
	#	%	#	%
Less than $19,000	103	7%	21	6%
$20,000-$39,000	364	26%	61	17%
$40,000-$59,000	408	29%	86	24%
Over $60,000	527	38%	189	53%
Total	**1,402**	**100%**	**357**	**100%**

Q12. Do you have enough money to pay for housing, food, clothing, and medicine?

Answered: 1,428 respondents under age 65, 400 respondents aged 65+

The graph below indicates that 83% of respondents aged 65 and older reported being able to pay for essentials compared to 73% of respondents in combined other age groups.



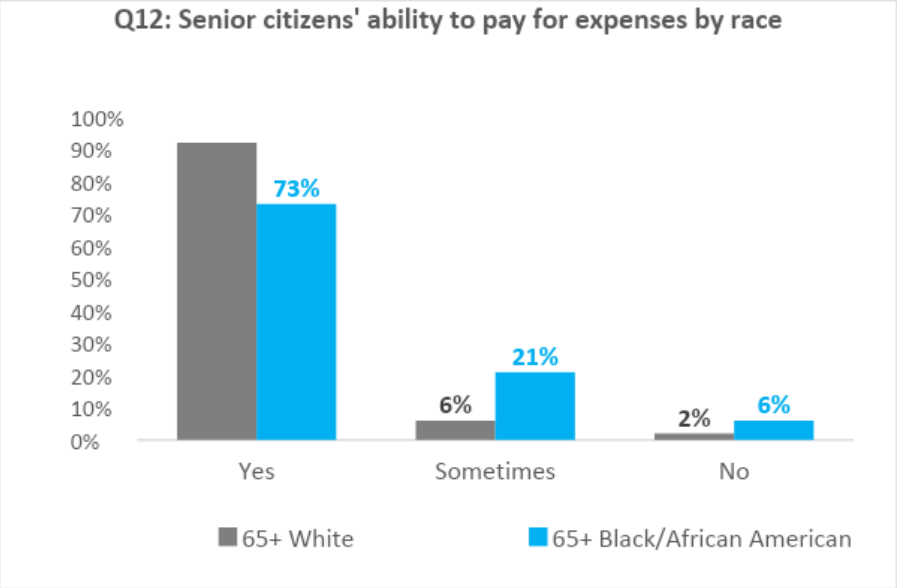
Do you have enough money to pay for housing, food, clothing, and medicine?	Respondents Under Age 65		Respondents Aged 65+	
	#	%	#	%
Yes	1,048	73%	333	83%
Sometimes	318	22%	51	13%
No	62	4%	16	4%
Total	**1,428**	*	**400**	**100%**

**Total does not equal 100% due to rounding*

Q12. Do you have enough money to pay for housing, food, clothing, and medicine?

Answered: 185 Black/African American respondents aged 65+, 206 White respondents aged 65+

When comparing by race, the graph shows that 92% of White respondents reported being able to afford the basic cost of living (housing, food, clothing, and medicine) compared to 73% of Black/African American respondents. Further, a larger percentage of Black/African American respondents (27%) also list financial insecurity in their ability to afford these necessities, compared to White respondents (12%).



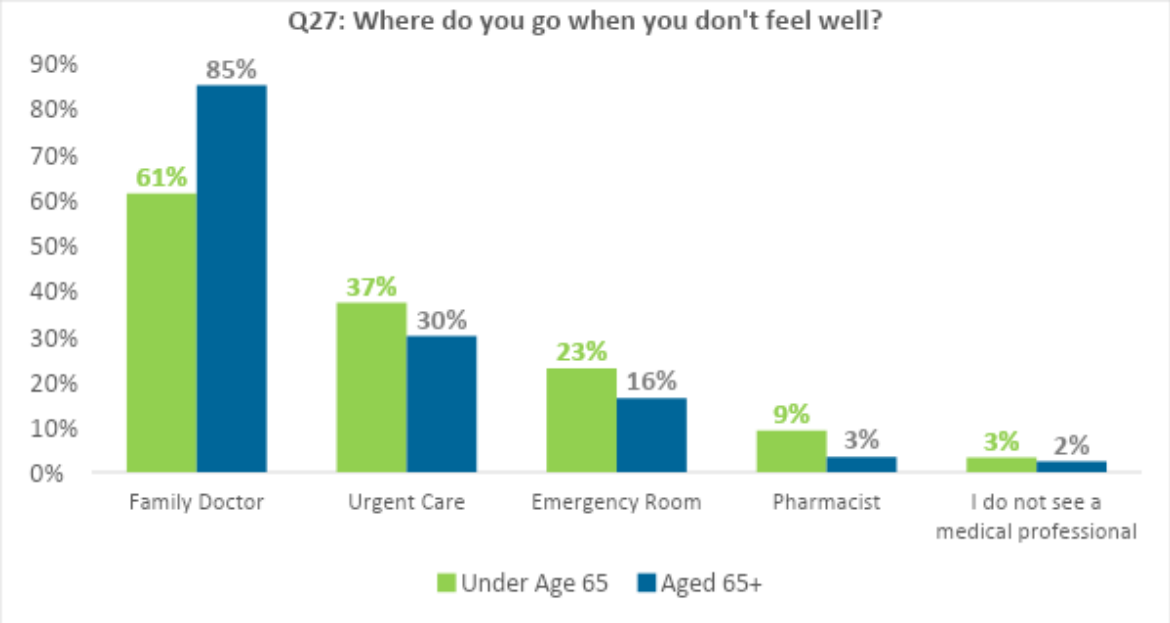
Do you have enough money to pay for housing, food, clothing, and medicine?	Respondents Aged 65+ Black/African American		Respondents Aged 65+ White	
	#	%	#	%
Yes	136	73%	190	92%
Sometimes	39	21%	12	6%
No	11	6%	4	2%
Total	**186**	**100%**	**206**	**100%**

Q27. Where do you usually go when you do not feel well?

Answered: 1,365 respondents under age 65, 380 respondents aged 65+

A higher percentage of senior respondents reported having a family doctor (85%) compared to just 61% of those under age 65.

When comparing by race, 82% of Black/African American respondents and 88% of White respondents reported having a family doctor.



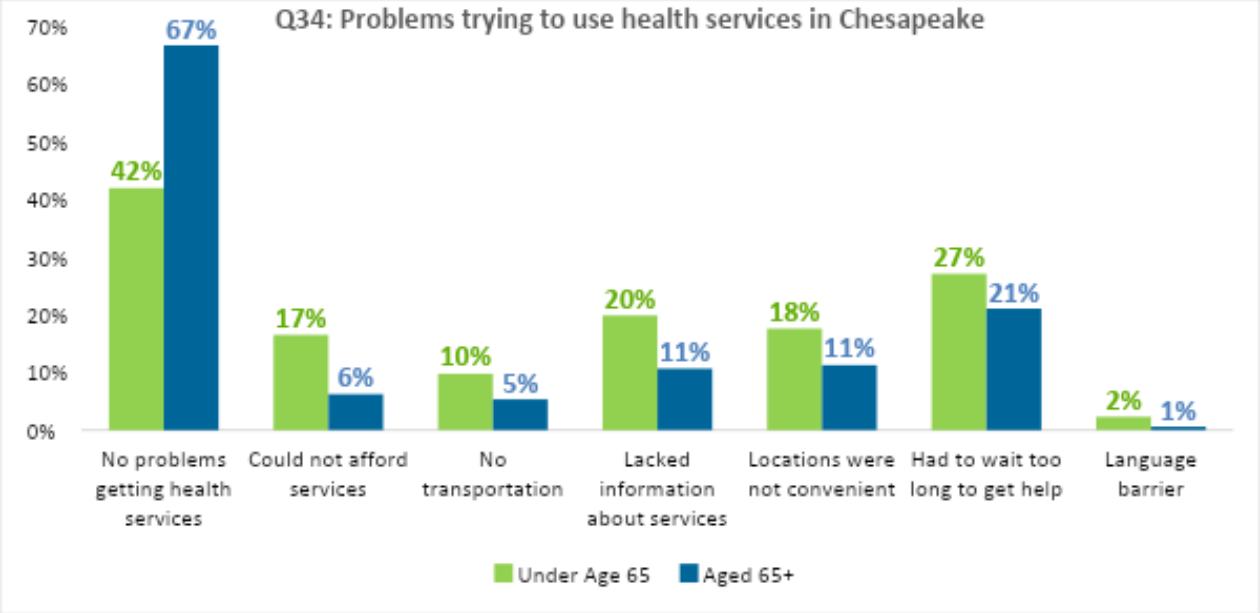
Where do you usually go when you don't feel well?	Under Age 65		Aged 65+	
	#	%	#	%
Family Doctor	837	61%	323	85%
Urgent Care	509	37%	114	30%
Emergency Room	312	23%	62	16%
Pharmacist	126	9%	13	3%
I do not see a medical professional	45	3%	9	2%
Total responses	**1,365**		**380**	

Respondents could check all that apply.

Q34. Have you even had any of the following problems when trying to use health services in Chesapeake? Check all that apply.

Answered: 1,365 respondents under age 65, 380 respondents aged 65+

Respondents aged 65 and older reported fewer problems trying to access healthcare than other age groups. This remains true for both Black/African American and White respondents.



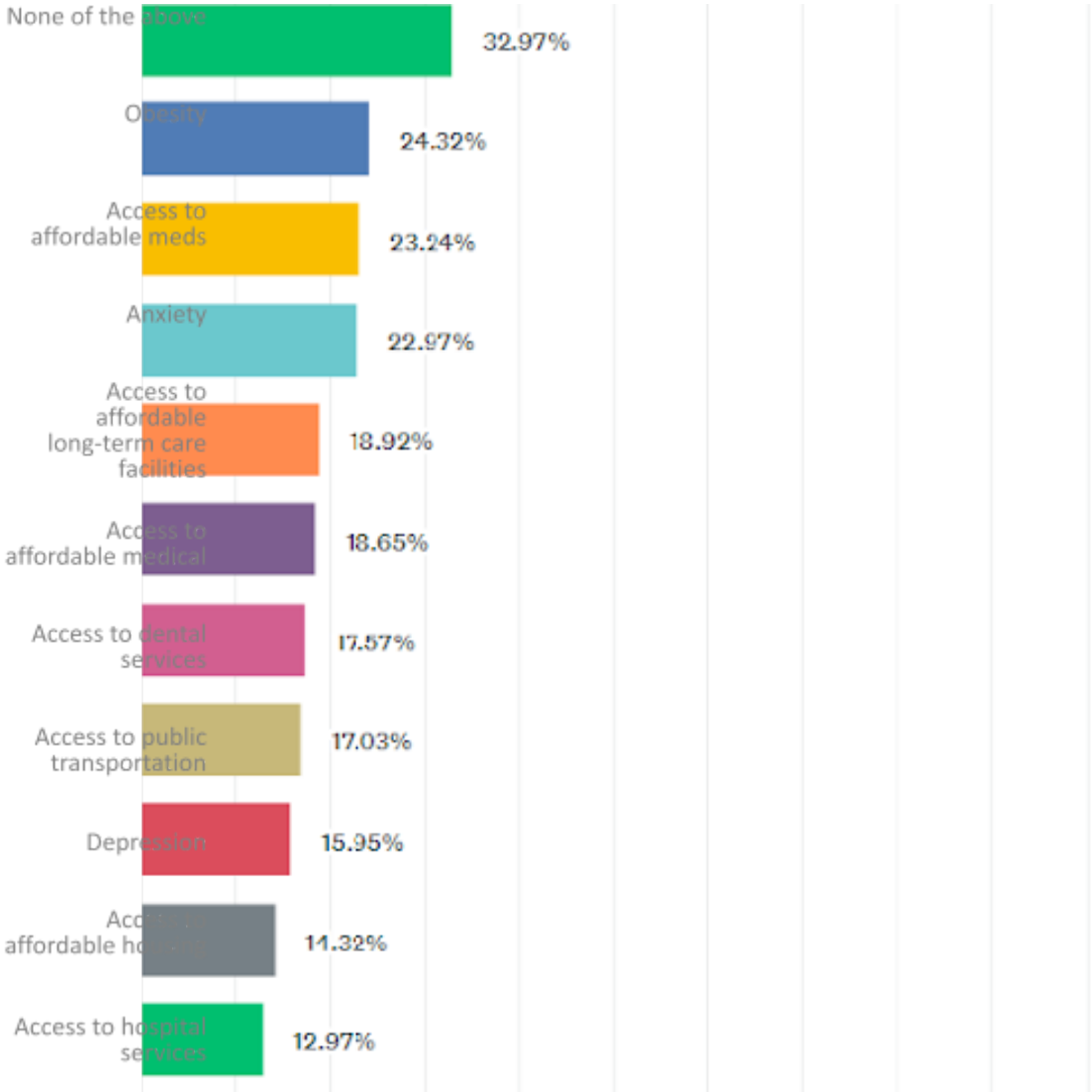
Have you ever had any of the following problems when trying to use health care in Chesapeake?	Under Age 65		Aged 65+	
	#	%	#	%
No problems getting health services	546	42%	225	67%
Could not afford services	215	17%	21	6%
No transportation	127	10%	18	5%
Lacked information about services	259	20%	36	11%
Locations were not convenient	229	18%	38	11%
Had to wait too long to get help	353	27%	71	21%
Language barrier	30	2%	2	1%
Total	**1,303**		**338**	

Respondents could check all that apply.

Q22: Are any of the following a problem for you or your family?

The graph below shows the top ten problems that respondents aged 65 and older reported. More seniors reported no problems (33%) than any other issue. When comparing by race, Black/African American and White respondents reported the same top issues, but in slightly different order.

Answered: 370 Skipped: 31



The table below provides the number and percentages of each response.

ANSWER CHOICES	RESPONSES	
None of the above	32.97%	122
Obesity	24.32%	90
Access to affordable medications	23.24%	86
Anxiety	22.97%	85
Access to affordable, long-term care facilities	18.92%	70
Access to dental services	18.65%	69
Access to affordable medical care	17.57%	65
Depression	17.03%	63
Access to public transportation	15.95%	59
Access to affordable housing	14.32%	53
Access to hospital services	12.97%	48
Access to fresh, affordable food and groceries	11.35%	42
Emotional problems	10.54%	39
Unemployment/underemployment	10.27%	38
Access to services for mental health	9.46%	35
Racial or ethnic discrimination	9.19%	34
Access to adult education programs	7.84%	29
Crime or community violence (gun violence, gangs, human trafficking, etc.)	7.03%	26
Access to services for substance use	7.03%	26
Access to affordable childcare	6.49%	24
Quality of public education (K 12)	5.95%	22
Mental illness	5.95%	22
Alcoholism	5.95%	22
Lack of care for the disabled	5.68%	21
Drug abuse (opioid, marijuana, or other)	4.86%	18
Bullying (cyber or workplace)	2.97%	11
Ability to read and write	1.62%	6
Services for the LGBTQ community	1.62%	6
Family violence	1.35%	5
Child abuse	1.08%	4
Teen pregnancy	1.08%	4
Total Respondents: 370		