This Community Health Needs Assessment was prepared by The Planning Council

The Planning Council

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ACKNOWLEDGMENTS

The work described in this report is possible because of the energy and support of the following individuals and organizations who generously gave their time to take part in interviews and offered guidance and support throughout the assessment:

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Virginia:

Agape Feast
Bethany Baptist Church
Chesapeake Regional Healthcare
CHIP of South Hampton Roads
Chesapeake Care Clinic
Chesapeake Department of Human Services
Chesapeake Parks, Recreation & Tourism
Chesapeake Public Health Department
Chesapeake Redevelopment and Housing Authority
Chesapeake Police Department
Chesapeake Public Schools
Chesapeake Thrives
ForKids
Hampton Roads Community Foundation
Hampton Roads Planning District Commission
Healthy Chesapeake
HER Shelter
New Mount Olive Baptist Church
Old Dominion University
Sankofa Family Center
Senior Services of Southeastern Virginia
The Mount Global Fellowship of Churches
Tull Financial Group
United Way of South Hampton Roads
Virginia Beach Community Development Corporation
Virginia Cooperative Extension
YMCA of South Hampton Roads

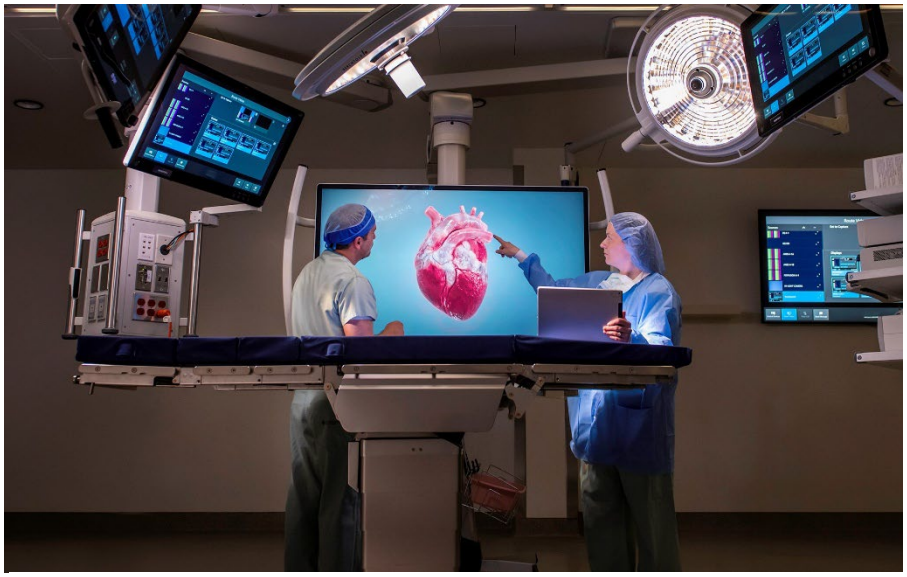
Residents from Deep Creek & Western Branch

North Carolina:

North Carolina Community Foundation
College of the Albemarle
Currituck County Chamber of Commerce
Outer Banks Hospital
Community Care Clinic of Dare
Camden County
Elizabeth City Area Chamber of Commerce

Resident of Gates County

Executive Summary



The hospital conducted its first open-heart surgery in 2024.

Chesapeake Regional Medical Center, now known as Chesapeake Regional Healthcare, was established in 1976 as an independent, community-based hospital in the heart of Chesapeake. The organization, which now includes two surgery centers, a cancer center, imaging centers, and a robust medical group, is 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 320 licensed and staffed beds, over 600 physicians, over 40 practice locations, and a full staff of approximately 2,400 people. The hospital is a key provider for residents of Chesapeake, the surrounding cities in Greater Hampton Roads, as well as in eleven counties of northeastern North Carolina (more than 11% of total patients in 2024).

Recent Accomplishments

Since the last Community Health Needs Assessment was conducted in 2021, Chesapeake Regional Healthcare has received new certifications, awards, and accreditations, while successfully adding critical new services to respond to the needs in their communities, including:

- New Priority Toyota Cancer Center
- Lymphedema & oncology rehabilitation clinic
- Breast Care services in Virginia Beach
- State-of-the-art Richard S. Bray Critical Care Tower
- Comprehensive Stroke Certification
- New Mobile Medical Clinic
- Commonwealth of Virginia grant of $3.7m to fund the Emergency Department Behavioral Health unit

- Magnet® recognition, recognizing excellence in nursing and patient care
- Neonatal intensive care unit is upgraded to level iii
- Renovated mother-baby unit opens
- The bra-ha-ha® debuts in Elizabeth City
- Reese Jackson, president & CEO, awarded 2022 First Citizen of Chesapeake
- The birthplace at Chesapeake Regional is recognized among the top 5% of hospitals by Healthgrades
- Listed among Money's best hospitals of 2024
- Healthgrades 2024 Patient Safety Excellence Award™
- Conducted it first open-heart surgery
- IBCLC Care Award honoring excellence in staffing international board-certified lactation consultants®
- Baby Expo 2024
- Began offering the Acessa procedure for treating fibroids
- Began offering Aquablation therapy for enlarged prostate
- Diaper distribution to hundreds of families

Robust Medical Group with over 160 providers across various specialties

- Harbour View Primary Care – New Practice, October 2022
- South Norfolk Primary Care – New practice, August 2023
- Pulmonary New Office location, October 2022
- Infectious Disease New Office location, June 2024

Dr. John Baker, neurologist at Chesapeake Regional Healthcare.

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

Purpose and Scope

A Community Health Needs Assessment (CHNA) examines the overall health status of a population while identifying key assets and challenges that influence well-being. The process actively engages community members and local public health partners to collect and analyze data from a wide range of sources. Both quantitative and qualitative information is included, combining statistical measures with the lived experiences and perspectives of residents. This approach supports the prioritization of health services and the development of strategies to address identified gaps.

The hospital's Neonatal Intensive Care Unit offers Level III care.

The purpose of a CHNA is to:

1. Understand the community's health status – Identify the most pressing health needs, challenges, and risk factors affecting residents.
2. Recognize community strengths and assets – Highlight existing resources, programs, and partnerships that can be leveraged to improve health.
3. Prioritize issues – Use data and community input to determine which health concerns should be addressed first based on urgency, impact, and feasibility.
4. Inform planning and decision-making – Guide hospitals, health departments, and community organizations in developing targeted health improvement plans, policies, and services.
5. Promote collaboration – Bring together stakeholders from healthcare, government, education, business, and community groups to align efforts and share resources.
6. Meet regulatory requirements – For nonprofit hospitals, CHNAs are required by the Affordable Care Act (ACA) every three years to maintain tax-exempt status.

In short, a CHNA provides a roadmap for improving community health by combining data, community voices, and cross-sector collaboration to drive meaningful, equitable change. This CHNA focuses on the City of Chesapeake, Virginia, and eleven counties in northeastern North Carolina. It is a collaborative effort between Chesapeake Regional Healthcare, the Chesapeake Health Department, and Healthy Chesapeake, and is updated every three years.

Methodology

This CHNA reflects input from over 1,000 people 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 a Community Health Status Assessment
- Qualitative data collection and analysis through a:
    - Community Needs Survey; and
    - Key Informant Interviews

Community Health Status Assessment

This assessment provides information on overall health status, quality of life, disease trends, and risk factors that influence the well-being of a community. These data form the foundation for identifying the health issues that must be addressed to ensure residents can live healthier lives and access care for physical, mental, and emotional health needs.

Data in this report were compiled from federal, state, and local sources. Where available, multiple years of data are included to illustrate trends over time, along with comparisons to state and, in some cases, national benchmarks. This allows for a clearer understanding of how Chesapeake and North Carolina compare to other communities and where opportunities for improvement exist.

For this CHNA, data were collected and reported separately for Virginia and North Carolina where possible. Information is presented through graphs, tables, and charts, covering demographic and population statistics, health rankings, hospital data, community health profiles, socioeconomic indicators, and health outcomes and behaviors.

Community Themes and Strength Assessment

A comprehensive Community Needs Survey was developed and, in partnership with multiple agencies, distributed widely in English and Spanish languages over a 6-month period both online and in hard copy throughout Chesapeake and the North Carolina service areas. The Spanish-language version of the survey was made available through a separate link, but only seven responses were completed in Spanish.

In total, 919 complete surveys were received:

- 651 (74%) from Chesapeake residents
- 116 (13%) from northeastern North Carolina residents
- 110 (13%) from individuals working but not living in Chesapeake

Additionally, 33 key informant interviews were conducted with representatives of local government, healthcare organizations, and community partner agencies across Chesapeake and seven northeastern North Carolina counties, including regional service providers. To assess representativeness, a statistical analysis on sample size and margin of error is provided. This ensures the results could reasonably reflect the demographics of the community. For historically underserved populations in Chesapeake, results showed:

- Black/African American respondents: 2.5% margin of error (95% confidence)
- Hispanic/Latino respondents: 2.48% margin of error (95% confidence)
- Borough-level responses: margins of error ranged from 2.44% (Camelot) to 9.79% (Rivercrest). A margin of error of 3% or less is considered excellent, while 4–8% is generally acceptable.

Complete survey results are included in **Appendix B**. A version of the results for only northeastern North Carolina is also included as **Appendix C**. Heat maps showing the range of respondent answers for several survey questions by Chesapeake borough are included in **Appendix D**, and survey results separated out for each borough are included in **Appendices E through N**. Sentara Healthcare generously shared data related to Chesapeake from its 2025 CHNA report and those responses are included in **Appendix 0**.

Throughout the winter and spring of 2025, thirty-three Key Informant 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, higher education, foundations, as well as leadership from the hospital, health department, cities, and counties.

Interview questions centered on identifying the city's strengths and weaknesses and determining which issues should be prioritized to improve community health. Participants raised a wide range of concerns, most notably access to care, chronic disease management, mental health and substance use, and the needs of underserved and at-risk populations. Access to care and transportation were also cited as top issues in the 2008 CHNA, indicating that population growth in Chesapeake and northeastern North Carolina has outpaced the expansion of medical and transportation services. These discussions further highlighted persistent health disparities. Each interviewee offered valuable perspective on both the root causes of these challenges and potential approaches Chesapeake Regional could take to address them.

The Key Informant interview responses are included as **Appendix A**.

Collective Impact in Chesapeake

Residents of Chesapeake benefit from a strong collaborative partnership between Chesapeake Regional, the Health Department, Healthy Chesapeake and most recently, through a citywide initiative named Chesapeake Thrives. Backed by the support of city leadership, these organizations work together to improve community health outcomes, sharing responsibility for reducing health burdens and advancing health promotion efforts. Through comprehensive studies and active community engagement, the partnership fosters a sense of ownership and collective action around social determinants and public health issues.

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. 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.

In 1962, the **Chesapeake Health Department** was established and provided services in the field rather than inside the walls of the agency. 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. The Health Department continues to be an integral part of the entire community and offer care in various locations.

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

- Sexual Wellness Clinic
- Immunization Services
- Tuberculosis Screenings
- School Entrance Exams
- Women Infant Children (WIC)
- Environmental Health
- Vital Records
- BabyCare Home Visiting
- Long-Term Care Screening, Services and Supports (LTSS)
- Friday Farmers Market
- Medical Reserve Corps

Healthy Chesapeake (HC) is a nonprofit organization dedicated to advancing the health and well-being of Chesapeake residents of all ages, with a focus on those most in need. HC serves as the Population Health Manager for the Chesapeake Health Department and addresses the multiple and complex drivers of health disparities—particularly unequal access to nutritious food, healthcare, and healthy lifestyles—through wide-ranging programs and partnerships. HC collaborates and oversees programs that address both current and emerging health challenges, strengthen workforce readiness, support cognitive and mental well-being, and reduce barriers

to social connection. Their strength also lies with initiatives focused on reducing food insecurity, improving dietary behaviors, and preventing chronic disease—ultimately improving quality of life and lowering costs for families, businesses, and government.

Key initiatives include:

- Food Security & Nutrition: Partnering with local organizations to distribute healthy foods, supporting 19 community gardens in public spaces, and offering free hands-on cooking classes to promote nutrition literacy.
- Chronic Disease Support: Operating a no-cost weekly HUB clinic for low-income residents living with diabetes, hypertension, and other chronic conditions.
- Community Health Coalitions: Leading collaborative working groups to improve outcomes in under-resourced neighborhoods, with efforts targeting maternal and infant health, healthcare access, health literacy, gun violence prevention, and expanding opioid overdose prevention and treatment.

Despite operating with a small staff of six, HC leverages volunteer power and strong partnerships to deliver broad community impact. Hundreds of residents have learned to grow fresh food, access affordable healthcare, and better manage chronic conditions. Recent evaluations of HC's programs show measurable improvements, including healthier lifestyle behaviors across age groups, improvements in health outcomes like lowering A1Cs, and reductions in the length of hospital stays and emergency room visits.

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. Most notably, the City has established **Chesapeake Thrives**, a public/private partnership that seeks to connect residents to services at any stage of their life by addressing the priority areas of:

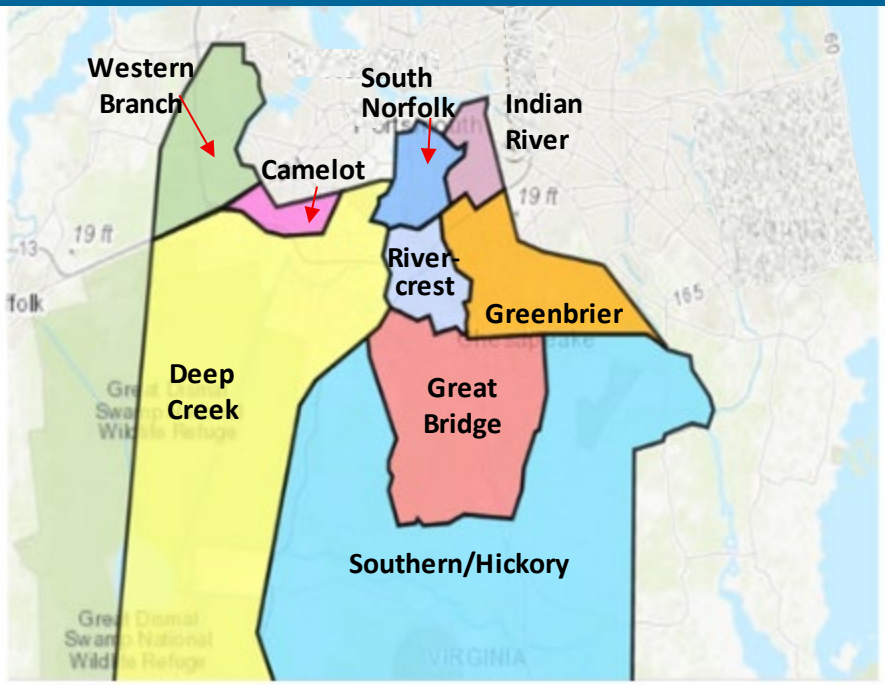
- Aging in the Community
- Behavioral Health
- Early Childhood
- Health
- Housing
- Poverty and Economic Support
- School-Age Programs and Support
- Workforce Development
- Safety and Security

Through these collaborations, all agencies can design innovative approaches that address a wide range of health concerns. By building on and expanding these programs, the hospital and its partners can extend their collective impact—advancing the shared goal of making Chesapeake the healthiest community in Virginia.

Service Area

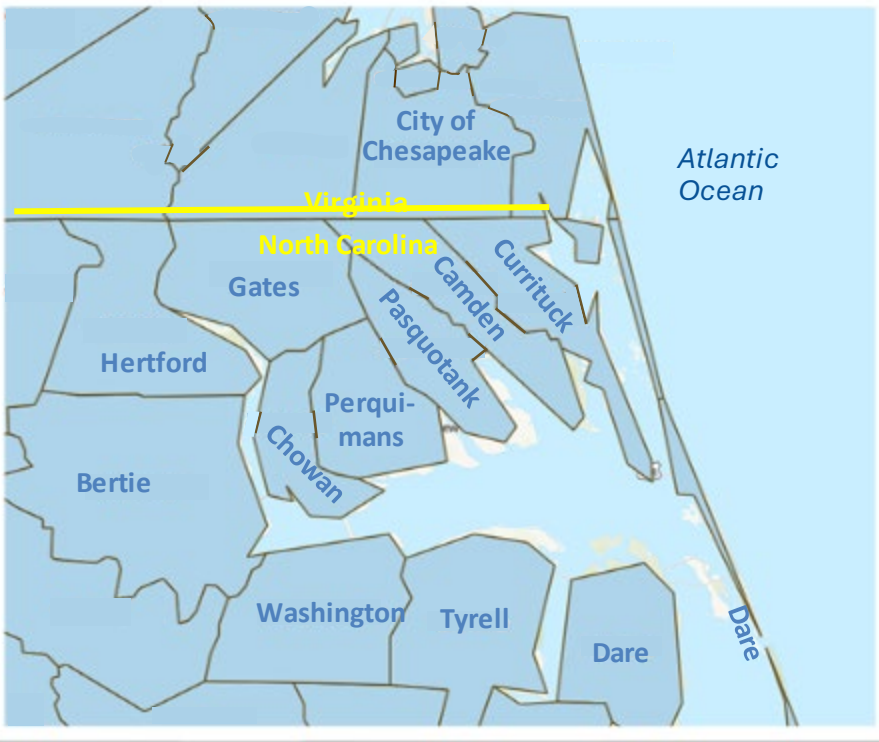
The primary service area of Chesapeake Regional Healthcare includes the 9 boroughs of Chesapeake and 11 counties in northeastern North Carolina shown in the maps below.

Service Area: City of Chesapeake



Chesapeake Boroughs
Camelot
Deep Creek
Great Bridge
Greenbrier
Indian River
Rivercrest
South Norfolk
Southern/Hickory
Western Branch

Service Area: City of Chesapeake and North Carolina Counties



North Carolina Counties
Bertie County
Camden County
Chowan County
Currituck County
Dare County
Gates County
Hertford County
Pasquotank County
Perquimans County
Tyrrell County
Washington County

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, an updated 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. The Healthy People 2030 initiative has five key domains, which are categories of social determinants of health (SDOH) used to set data-driven national objectives. These domains provide a framework for addressing the root causes of health disparities and promoting well-being for all people.

Data Limitations

As with the previous CHNA, this assessment 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 were not necessarily prioritized. Survey results are also examined by respondent neighborhood and by annual income level and race 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 is 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 have become 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, which is often within the margin of error.[1]

[1] 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 Priorities

Strategic priorities represent the fundamental policy choices and critical challenges a community must address in order to achieve its vision. These priorities are long-term in nature, have broad community impact, require collective resources, and carry significant consequences if left unaddressed.

Throughout this assessment, several themes consistently emerged—raised by key informants during interviews, echoed in survey responses, and reinforced through community indicator data. The following section summarizes the **top 5 Strategic Priorities** that emerged from the 2025 assessment.

- **Chronic Health Conditions**

In Chesapeake, the leading cause of death is heart disease, with diabetes ranking the fourth. Of the 919 survey respondents, 47% (391 people) listed chronic diseases as their top health concern. Across Chesapeake and North Carolina, there is growing concern about the prevalence of obesity and chronic diseases, particularly diabetes, hypertension, and heart disease, which are also contributing to related deaths. One key informant called it a "high blood pressure and obesity belt."

Managing chronic diseases involves several strategies that can slow the overall disease progression and improve the quality of life for individuals. These can include the following components:

- Personalized care plan
- Multidisciplinary care teams
- Patient self-management
- Lifestyle behavior change
- Regular monitoring and follow-up
- Health technology

- **Access to healthcare:**

40% (337 people) reported a need for more specialty, urgent care and primary care locations that are closer to their homes and easier to access. This is a significant increase from 2021 when 25% noted access as the biggest need. Question 36 from the Community Needs Survey found later in this report details the various issues and barriers respondents experienced when in need of health services.

A healthy primary care workforce is critical to ensure a healthy Virginia. According to the Virginia Plan for Wellbeing, Chesapeake has 78 Primary Care providers per 100,000 population, lagging

behind the state and nation. Ten additional primary care physicians (PCPs) per 100,000 residents can increase life expectancy by 51.5 days.[5] Following the end of the COVID-19 pandemic, burnout remains high for primary care providers, and Virginia is starting to see a decline in its workforce while also facing stark distributional variation in the primary care workforce across Virginia's counties and cities.

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. Currently, 27 primary care providers can be accessed within the Chesapeake Regional Medical Group. CRH has also added a mobile medical clinic to help meet the needs on-site in some of the most underserved communities.

- **Mental health services:**

40% (335 people) of those who responded to the community needs survey listed mental health as the top unmet healthcare need. Of 919 survey respondents, 32% stated that they or someone in their family had accessed mental health services within the past year. 19% noted their child had been diagnosed with mental health and emotional problems.

According to the County Health Rankings and Scorecard, Chesapeake has 480 mental health providers for every resident, which is more than both the state and nation. The city also recorded 5.6 average mentally unhealthy days reported in the past 30 days. Primary care is often the entry point for Virginians to access behavioral healthcare. With significant shortages in behavioral health providers, primary care providers are increasingly caring for Virginians with significant behavioral health needs.

Behavioral health, including depression and anxiety disorders, remains a top priority for residents and professionals engaged in this CHNA. Many described it as a more urgent public health crisis since the COVID-19 pandemic. Interviewees highlighted its prevalence among individuals experiencing homelessness, noting it as a major barrier to sustaining housing and employment. In response, Chesapeake Regional has made efforts to launch a new 20-bed behavioral health unit, recruit specialized medical staff and strengthen partnerships with Chesapeake Integrated Behavioral Healthcare. At the same time, the pandemic's pivot to virtual platforms for communication and learning created additional stress and emotional strain, particularly for vulnerable populations. While the long-term impacts are still unfolding, health and education professionals remain focused on mitigating these effects.

- **Older Adults / Elderly**

40% (334 people) of those who responded to the survey reported aging health concerns. Elderly adults in Virginia face issues including rising healthcare costs and a higher prevalence of chronic conditions like hypertension and arthritis. Financial insecurity is also a significant challenge, with many seniors on fixed incomes experiencing hardship due to rising costs for food and housing. Additionally, older adults may struggle with mobility and disability, making it difficult to maintain independence in their homes. Local EMS units are regularly called on to conduct simple tasks for elderly living alone who have mobility issues. All of these issues also lead to isolation, another high-risk factor for elderly adults.

The AARP Livabilty Score, which promotes livability for everyone, regardless of factors such as income, ability level, and background, for all neighborhoods in Chesapeake, is 51. Life expectancy is 78 years old.[2] In North Carolina, scores ranged from 36 in Bertie County to 56 in Dare County, reflecting the concentration of populations and available resources in those locations.

- **Substance Abuse**

In the community needs survey, over half (51%) ranked alcohol and drug use as the number one problem having the greatest negative impact on health. 24% named it as a top health concern in their community. The rate in Chesapeake for fatal drug overdoses for all substances in 2023 was 15.6, a significant increase from the rate of 9.6 in 2007. Those interviewed stated concerns about the increase in substance use and substance use deaths, in both Virginia and North Carolina. It was also noted there is a lack of pain management options, leaving those addicted to opioids no option but to turn to illegal drugs.

Chesapeake Integrated Behavioral Healthcare delivers a wide range of assessment, treatment, and prevention services for residents, including individual and group counseling for adults as well as individual therapy for adolescents. Chesapeake Public Schools complement these efforts by providing activities and learning experiences that highlight the impacts of cannabis, alcohol, nicotine/vaping, and other substance use on students' lives. In addition, Healthy Chesapeake is evaluating community knowledge and resources related to opioids to better inform strategies that address this ongoing challenge.

[2] American Association of Retired Persons: Livability Index, 2024. Website: https://livabilityindex.aarp.org/search/Chesapeake,%20Virginia,%20United%20States

Community Health Status Assessment

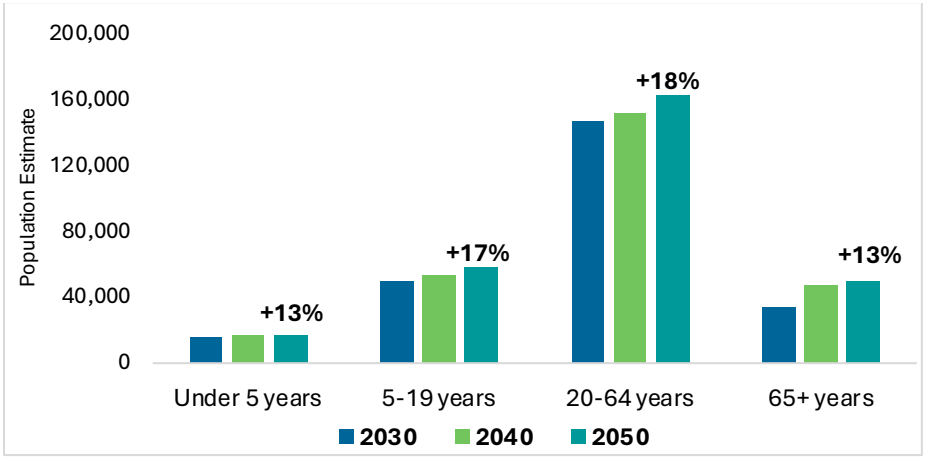
Demographics of Service Area
Population: *Chesapeake and South Hampton Roads*

In 2024, the total service area population is approximately 464,200[3] and population trends by age, race and ethnicity are demonstrated on the following pages.

According to the University of Virginia's Weldon Cooper Center, Chesapeake's population in 2024 is estimated at **253,261**, marking a **2% increase** since 2020. The city's population is projected to grow to **318,516 by 2050**, reflecting a **17% increase** from its 2030 population. Notably, the **working-age population (18–64)** is expected to see the greatest growth at **18%**, while the **65+ age group** is projected to increase by **13%** between 2030 and 2050. The Welden Cooper Center projects that in 2030, Chesapeake's population will be among the top 10 largest in the state along with counties in northern Virginia and the Richmond metro area.

Graph 1

2030-2050 Chesapeake: Estimated Population Change by Age



Source: University of Virginia, Welden Cooper Center.

Table 1

2030-2050 Chesapeake: Estimated Population Change by Age

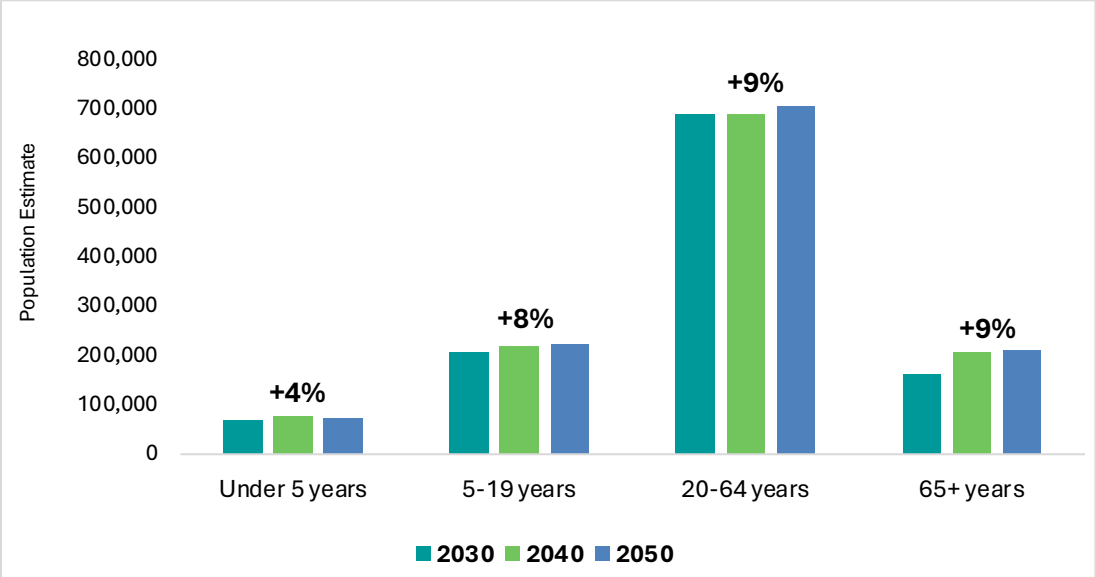
Age	2030	2040	2050	Projected Growth 2030-2050
Under 5 years	16,420	17,164	18,597	13%
5-19 years	53,886	58,680	62,847	17%
20-64 years	151,526	163,573	179,402	18%
65+ years	50,838	53,981	57,670	13%
Total	**272,670**	**287,913**	**318,516**	**17%**

Source: University of Virginia, Welden Cooper Center.

[3] Source: Data for Virginia is from The University of Virginia's Weldon Cooper Center; Data for North Carolina counties is from the U.S. Census Bureau QuickFacts Table, accessed at https://www.census.gov/quickfacts/fact/table/

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. In 2024 the region's population was 1,216,391[4] which is a slight decrease of 1% from 2020. Thus, Chesapeake's population grew slightly more (2%) than the region's population (1%) between 2020 and 2024. By 2050, regional growth is projected to increase by 9% compared to Chesapeake's projected growth of 13%. The region's population change is anticipated in the age categories seen in the graph and table below.[5]

2030-2050 South Hampton Roads: Estimated Population Change by Age



Source: University of Virginia, Welden Cooper Center.

2030-2050 South Hampton Roads: Estimated Population Change by Age

Age	2030	2040	2050	Projected Growth 2030 - 2050
Under 5 years	75,589	74,993	78,319	4%
5-19 years	218,361	223,326	239,991	8%
20-64 years	688,494	707,569	772,550	9%
65+ years	205,277	210,276	259,339	9%
Total	**1,187,721**	**1,267,317**	**1,350,199**	**9%**

Source: University of Virginia, Welden Cooper Center.

[4] The University of Virginia's Welden Cooper Center
[5] Ibid.

Population: *Northeastern North Carolina*

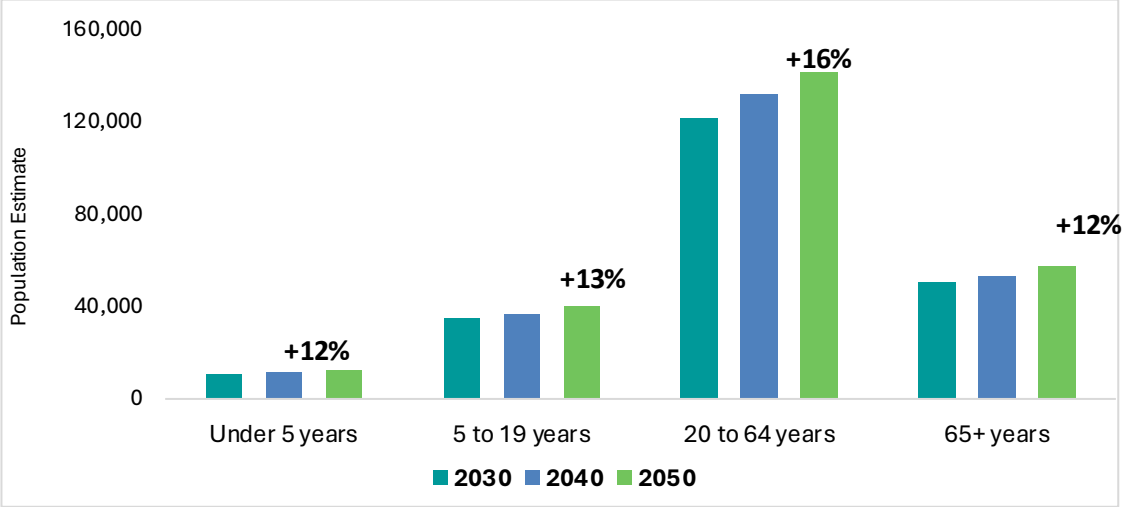
The eleven northeastern North Carolina counties included in this report are in the graphs. In 2024, the U.S. Census reports that this region's combined population is 210,992, which is a decrease of 2% from 2020. However, between 2030 and 2050, the total population of this region is projected to increase by 15%, with the largest increase in the 20–60-year-old age group (16%).

2024 Population of Northeastern North Carolina Counties Included in This Report

County	Population by Size
Pasquotank	41,418
Dare	38,183
Currituck	32,278
Hertford	19,169
Bertie	16,939
Chowan	13,891
Perquimans	13,460
Camden	11,184
Washington	10,654
Gates	10,299
Tyrrell	3,517
Total	**210,992**

Source: U.S. Census Bureau, QuickFacts

2030-2050 Northeastern North Carolina: Combined Estimated Population Change by Age



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

2030-2050 Northeastern North Carolina: Estimated Population Change by Age

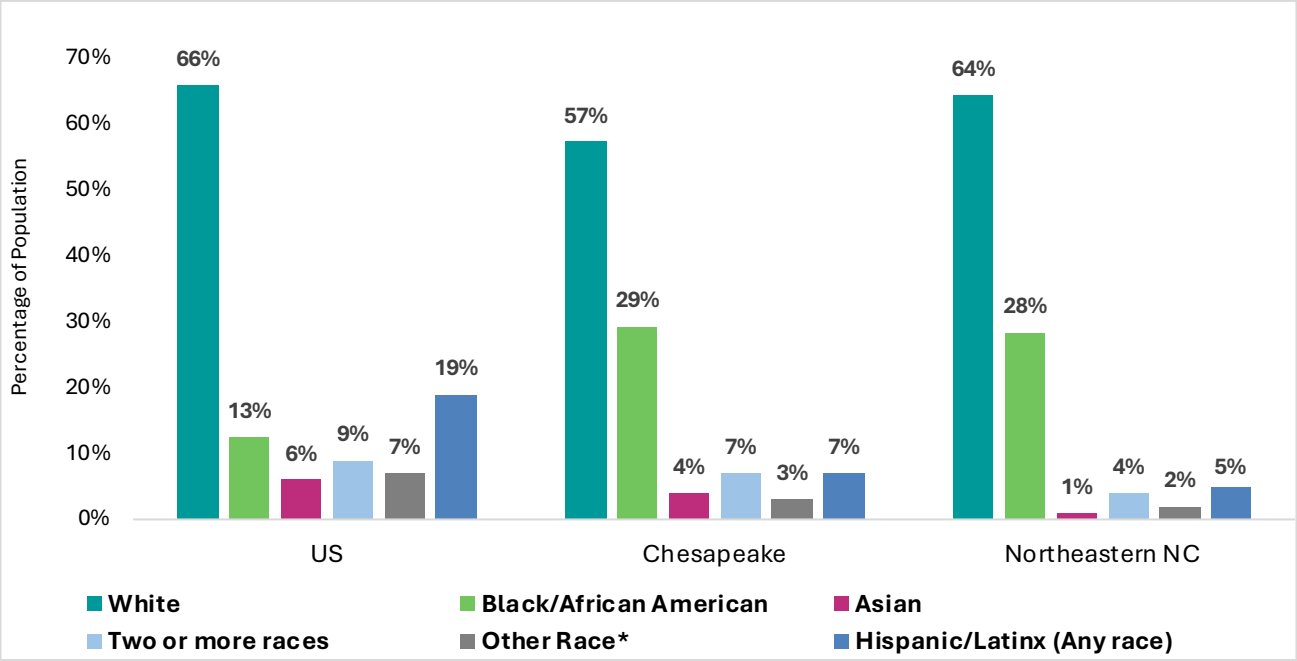
Age	2030	2040	2050	Projected Growth 2030 - 2050
Under 5 years	11,163	10,975	12,257	12%
5-19 years	34,990	36,468	39,997	13%
20-64 years	120,807	12,715	141,756	16%
65+ years	53,701	54,502	57,363	12%
Total	**220,661**	**225,660**	**251,373**	**15%**

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

Race and Ethnicity: *Chesapeake and North Carolina*

Chesapeake has a smaller percentage of Whites (57%) than northeastern North Carolina (64%) and the US (66%). Chesapeake has a slightly larger percentage of African Americans (29%) than the combined counties in northeastern North Carolina (28%) but a much higher percentage than the US (13%). In 2024, Chesapeake's Hispanic/Latinx population was 7%, which is larger than the North Carolina region (5%) but much smaller than the US (19%).

Race and Ethnicity: 2023 Comparison Among Chesapeake, Northeastern NC, and the US



Source: U.S. Census Bureau, American Community Survey, 2019-2023 5-Year Estimates, Table DP05

Race and Ethnicity: 2023 Comparison Among Chesapeake, Northeastern NC, and the US

Race/Ethnicity	Chesapeake	Northeastern NC	Total Service Area
White	142,840	138,021	287,615
Black/African American	73,034	63,874	137,325
Asian	9,179	1,685	9,520
Multiracial	17,786	973	1,463
Other Race	6,538	4,523	17,989
Hispanic or Latino	17,578	9,313	24,137
Total	**249,377**	**211,134**	**453,912**

Source: U.S. Census Bureau, American Community Survey, 2019-2023 5-Year Estimates, Table DP05

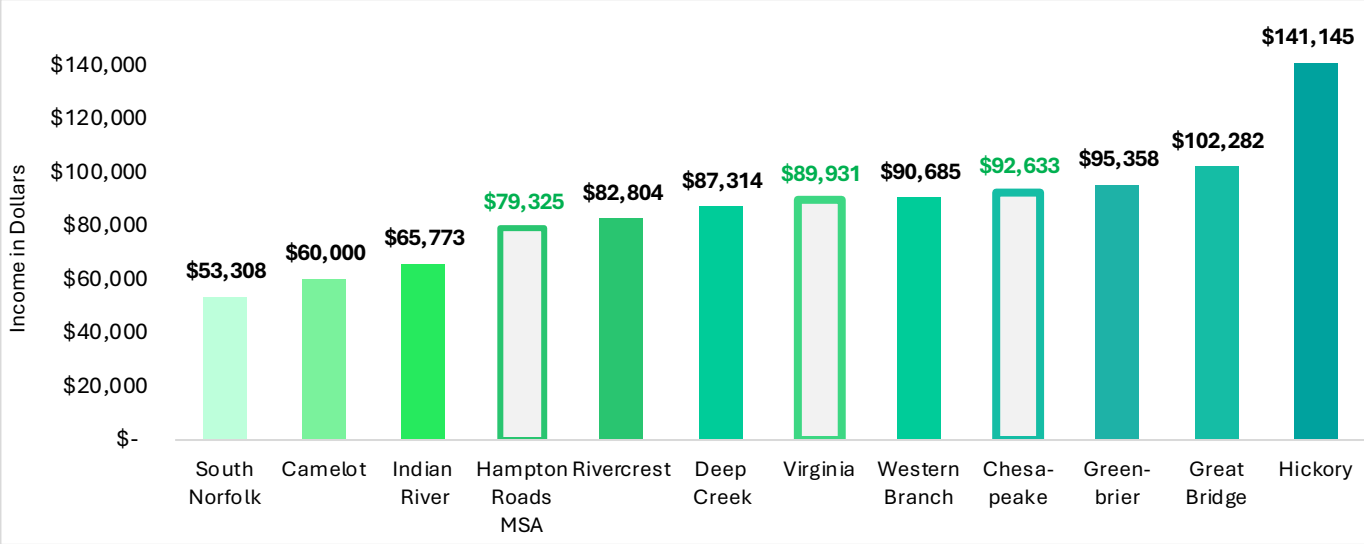
Median Income: *Chesapeake and North Carolina*

The 2023, the median income in Chesapeake was $92,633, which is higher the Hampton Roads MSA region and the state. Median incomes in Chesapeake's boroughs range from $53,308 in South Norfolk to $141,145 in Hickory.

The median income in northeastern North Carolina ranges from $46,100 in Tyrrell County to $86,000 in Currituck County. The Robert Wood Johnson Foundation provides state and county level median income data.

Graph

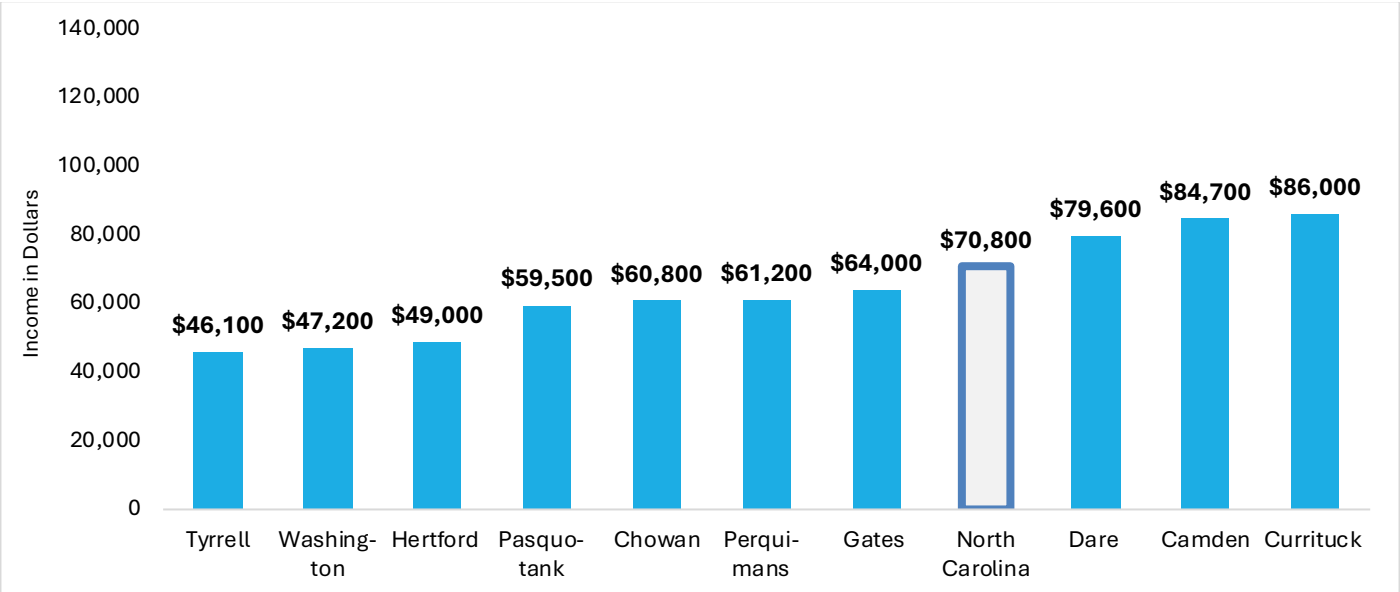
Chesapeake Median Income by Neighborhood



Source: Data for Chesapeake, Virginia, and the Virginia Beach-Newport News MSA is from the U.S. Census Bureau, 2023 1-year estimate, Table S1901. Data for the Chesapeake boroughs were compiled from the following real estate source: Data for Camelot is from Movoto.com; data for Rivercrest and Greenbrier are from CityData.com; data for Great Bridge is from HomeSnacks.com. All other borough data are from Homes.com.

Graph

Northeastern NC Median Income by County



Source: Robert Wood Johnson Foundation, 2025 County Health Rankings and Roadmaps.

Emergency Department

Chesapeake Regional Healthcare's Emergency Department saw 34,212 unique patients in 2023 growing to 34,878 in 2024. The table below demonstrates the various emergency care services provided since 2023 at Chesapeake Regional's ED. Infusions, Evaluation and Management, and Radiology continue to comprise the largest percentage of encounters for the ED.

CRH Outpatient Emergency Department Volume by Service Line

CRMC Advisory Board Service Line	CY 2023	CY 2024	CY 2025 Pro-Rated
Miscellaneous Services OP (+95% Infusions)	17,076	17,672	17,810
Evaluation and Management OP	11,238	10,801	10,360
Radiology OP (+90% X-rays and CTs)	6,682	7,418	7,584
Cardiology OP	5,868	6,270	7,098
Trauma OP	1,366	1,427	1,470
Vascular OP	1,218	1,219	1,082
Pulmonology OP	580	723	714
Orthopedics OP	769	705	630
Urology OP	394	457	464
General Surgery OP	303	323	396
Dermatology OP	429	496	370
ENT OP	254	236	282
Lab OP	130	117	188
Gastroenterology OP	181	176	172
Nephrology OP	108	107	160
Pain Management OP	110	97	88
Physical Therapy/Rehabilitation OP	23	22	66
Gynecology OP	65	70	56
Spine OP	59	41	38
Obstetrics OP	43	47	24
Podiatry OP	27	26	24
Ophthalmology OP	25	36	20
Neurology OP	11	17	18
Thoracic Surgery OP	9	18	14
Oncology OP	8	9	12
Cosmetic Procedures OP	1	0	0
Neurosurgery OP	2	2	0
Grand total	**46,979**	**48,532**	**49,140**

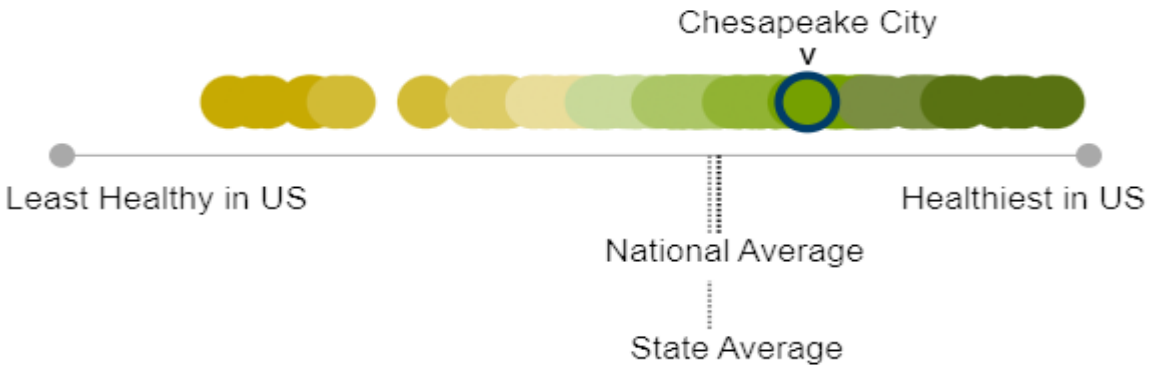
Note: Excludes DRG 795 Normal Newborn and Ungroupable Service Lines. Data does not factor in ED patients that were admitted, patient acuity, seasonality, or any impact weighting due to COVID/change in mix of patients, which officially ended in May 2023. 2025 data is pro-rated using data through June 2025.

Community Health Comparisons

Population health and well-being is something we create as a society, not something an individual can attain in a clinic or be responsible for alone. Health is more than being free from disease and pain; health is the ability to thrive. Well-being covers both quality of life and the ability of people and communities to contribute to the world. Population health involves optimal physical, mental, spiritual, and social well-being.[6]

County Health Rankings & Roadmaps

Chesapeake City Population Health and Well-being - 2025



Chesapeake City is faring better than the average county in Virginia for Population Health and Well-being, and better than the average county in the nation.

Community conditions include the social and economic factors, physical environment, and health infrastructure in which people are born, live, learn, work, play, worship and age. Community conditions are also referred to as the social determinants of health.[6]

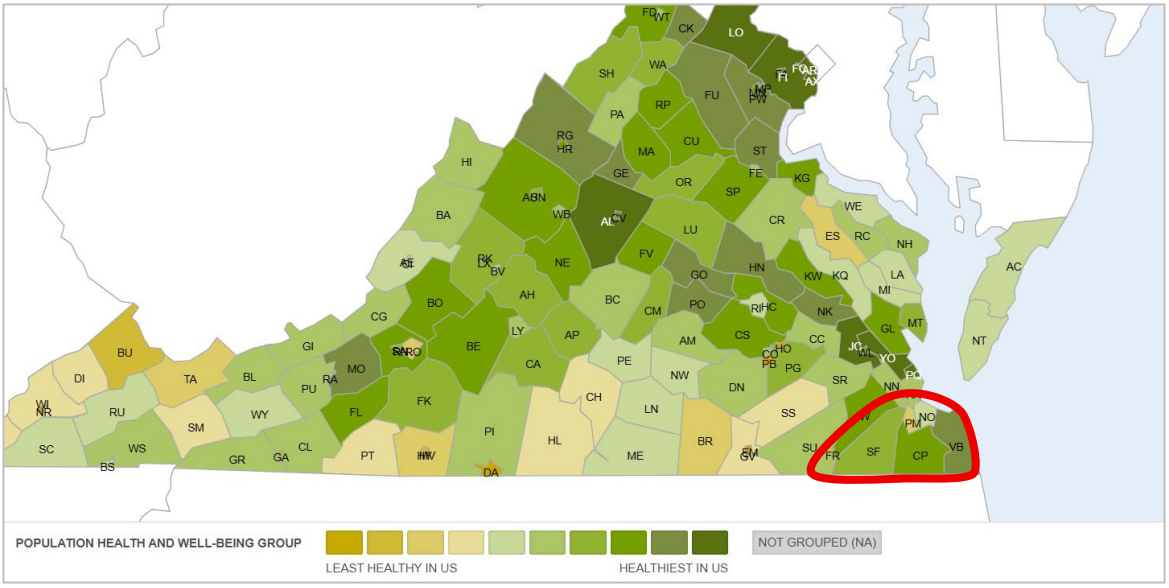
[6] County Health Rankings and Road Maps: Chesapeake City, VA. 2025. *Website:* https://www.countyhealthrankings.org/health-data/virginia/chesapeake-city?year=2025

In 2025, the Robert Wood Johnson Foundation's *County Health Rankings and Roadmaps* changed its method of comparing the health of localities. In the maps below, the darker green areas represent cities and counties with the healthiest status in the nation, and those in decreasing shades of green and tan show the least healthy areas in the country.

In Virginia, Virginia Beach and Chesapeake are among the healthiest localities. In North Carolina, Currituck County, Dare County, Camden County and Tyrrell County are among the healthiest while Hertford County, Bertie County, and Washington County rank among the least healthy in the nation.

Map

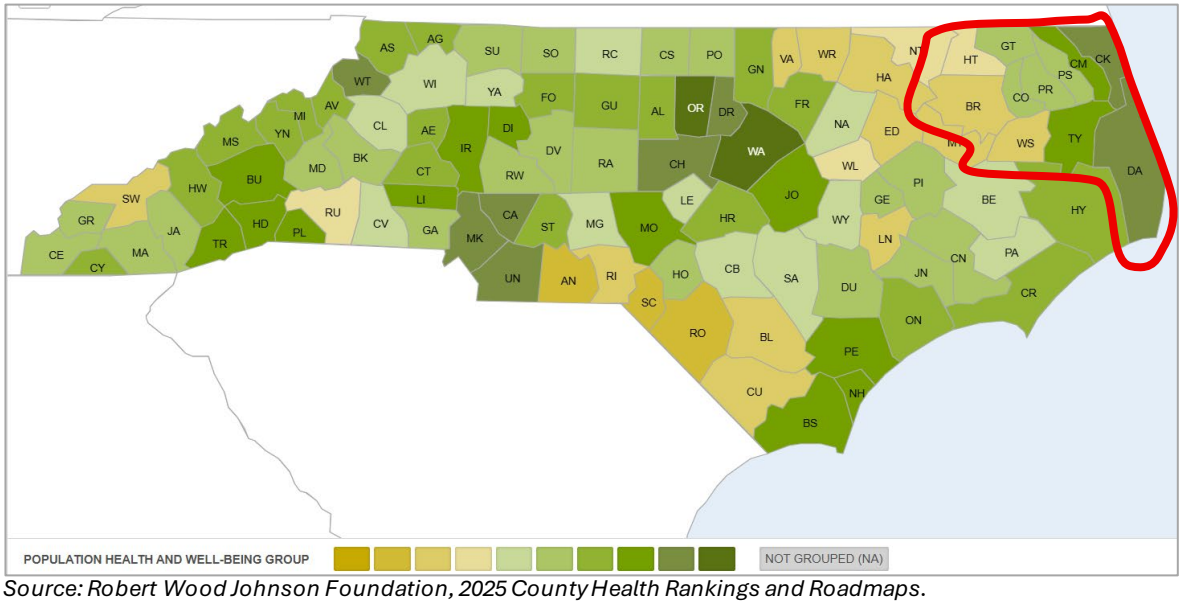
Robert Wood Johnson Health Map for Virginia and Detail of Hampton Roads Area



Source: Robert Wood Johnson Foundation, 2025 County Health Rankings and Roadmaps.

Map

Robert Wood Johnson Health Map for North Carolina and Detail of Northeastern North Carolina



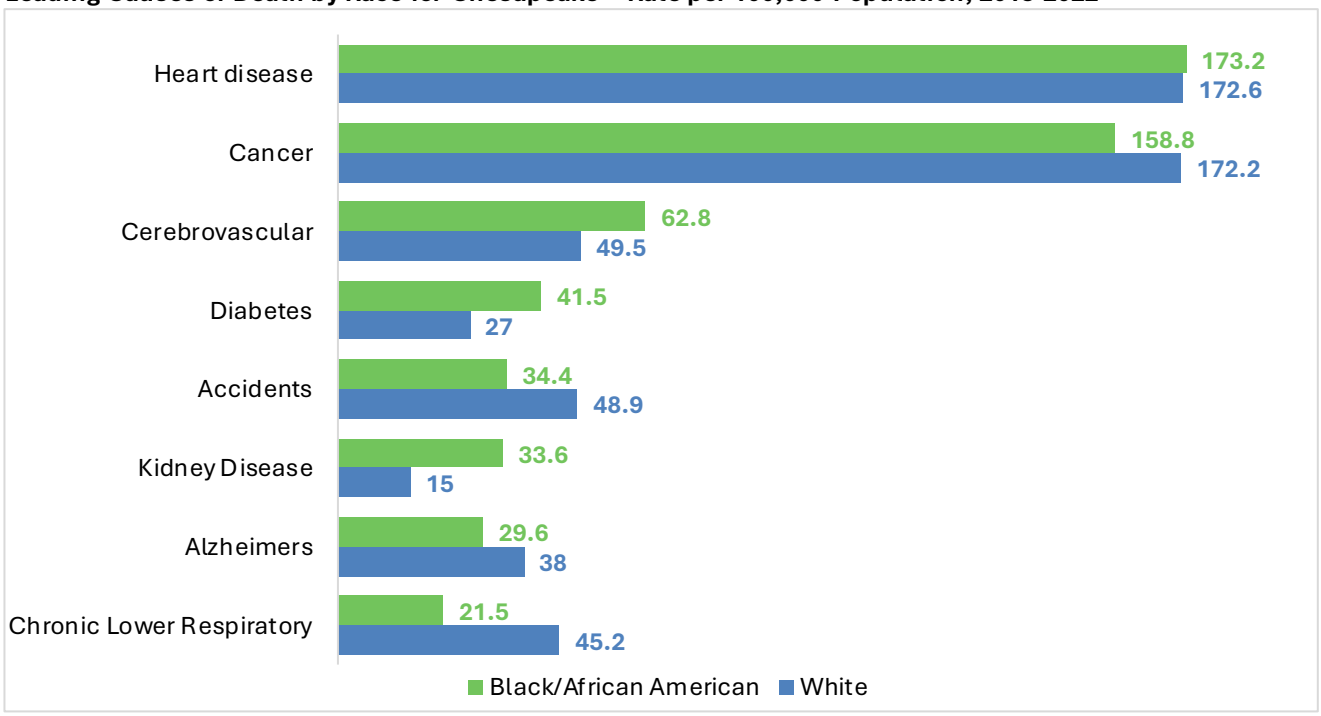
Source: Robert Wood Johnson Foundation, 2025 County Health Rankings and Roadmaps.

LEADING CAUSES OF DEATH BY RACE

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. The mortality data below is from 2018-2022. Heart disease and cancers are by far the greatest causes of death in the City of Chesapeake for both Black/African Americans and Whites.

Graph

Leading Causes of Death by Race for Chesapeake – Rate per 100,000 Population, 2018-2022



Source: National Institute on Minority Health and Health Disparities.

Regionally combined data for the eleven northeastern North Carolina counties was not available to graph, but the table below shows the death rates for each county by race. As in Virginia, ***heart disease*** and ***cance***r are the leading causes of death in North Carolina, with the other causes of death at much lower rates. Data was not available for all counties/diseases where there were fewer than 16 deaths.

There are some differences by race for some diseases. For example, Black/African Americans have higher mortality rates for heart disease in most counties, and for diabetes for counties where data is available.

Table

Leading Causes of Death by Race for Northeastern North Carolina- Rate per 100,000 Population, 2018- 2022

County	Race	Heart Disease	Cancer	Accidents	Chronic Lower Respiratory	Cerebro-vascular	Alzheimer's	Diabetes	Kidney Disease
Bertie	Black	205.1	169.7	66.4	22.2	62.1	48.4	90.8	33.3
	White	199.3	197.4	77.0	43.0	38.3	49.3	58.3	23.2
Camden	Black	239.4	181.8	-	-	-	-	-	-
	White	207.1	168.3	60.3	31.5	36.0	-	31.7	-
Chowan	Black	257.3	157.7	-	-	57.5	-	78.4	-
	White	189.4	159.1	79.9	48.3	38.3	40.0	32.6	
Currituck	Black	377.8	151.5						
	White	220.8	147.3	55.7	47.3	38.1	25.4	18.5	
Dare	Black	-	-	-	-	-	-	-	-
	White	149.4	151.2	96.5	31.6	43.0	26.3	14.9	9.2
Gates	Black	220.0	174.0	112.9	na				
	White	220.4	157	76.8	49.8	na	65.1		
Hertford	Black	212.5	153.6	47.1	30.6	52.8	69.4	87.0	21.6
	White	171.9	189.6	135.5	66.9	30.3	62.0	45.0	
Pasquotank	Black	236.0	157.7	60.1	27.0	56.9	24.1	54.8	20.4
	White	236.2	165.2	80.1	47.3	38.6	29.3	34.0	9.9
Perquimans	Black	230.6	160.1	-	-	-	-	-	-
	White	188.5	158.1	95.2	34.9	47.6	23.5	17.1	-
Tyrrell	Black	-	248.7	--	-	-	-	-	-
	White	212.0	185.1	-	-	-	-	-	-
Washington	Black	244.3	203.9	71.4	-	58.0	-	89.1	-
	White	181.7	180.2	77.7	58.8	40.1	45.5	-	-
State of NC	Black	193.0	175.5	65.6	28.4	59.5	37.5	49.8	33.3
	White	160.3	152.9	73.1	44.5	42.4	37.9	22.7	13.3

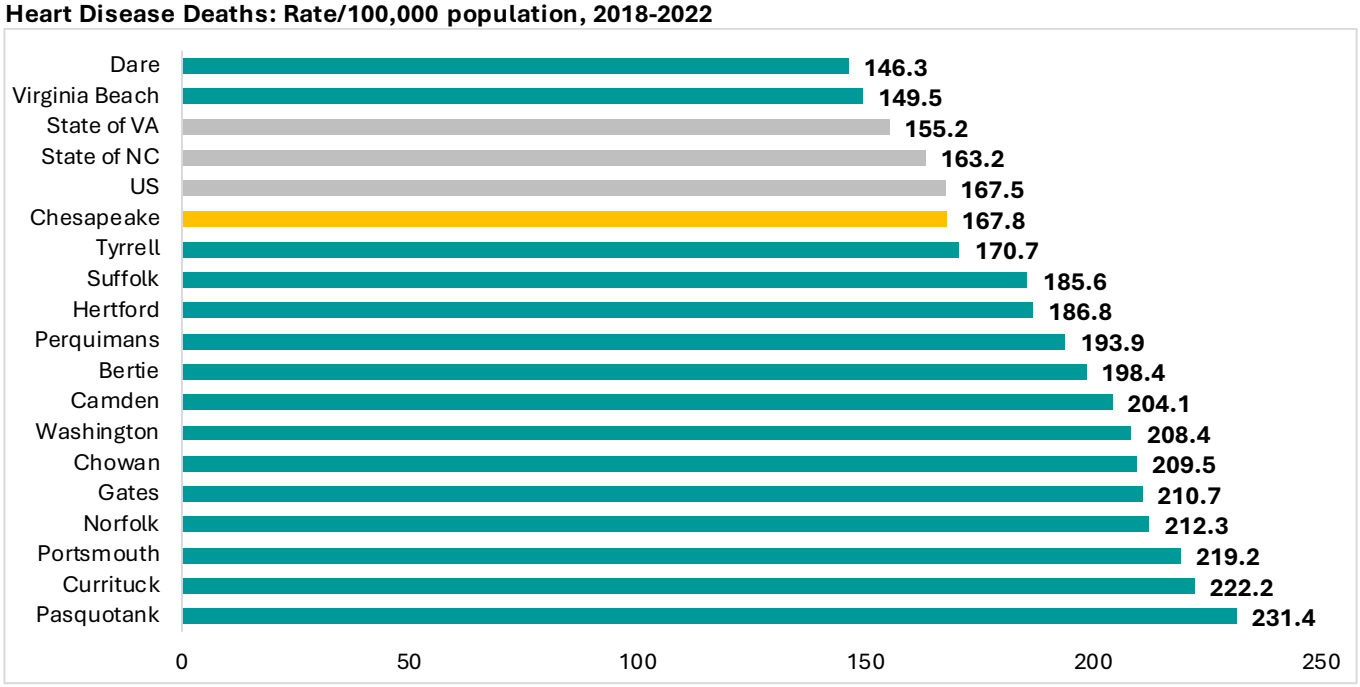
Source: National Institute on Minority Health and Health Disparities.

LEADING CAUSES OF DEATH BY LOCALITY

For ease in comparing the mortality rates among the full-service area, the graphs on the following pages provide comparisons among the various cities and counties in the hospital's service area for the period of 2018-2022. Rates for Virginia, North Carolina and the US are shown in gray as benchmarks and Chesapeake is in orange.

Graph

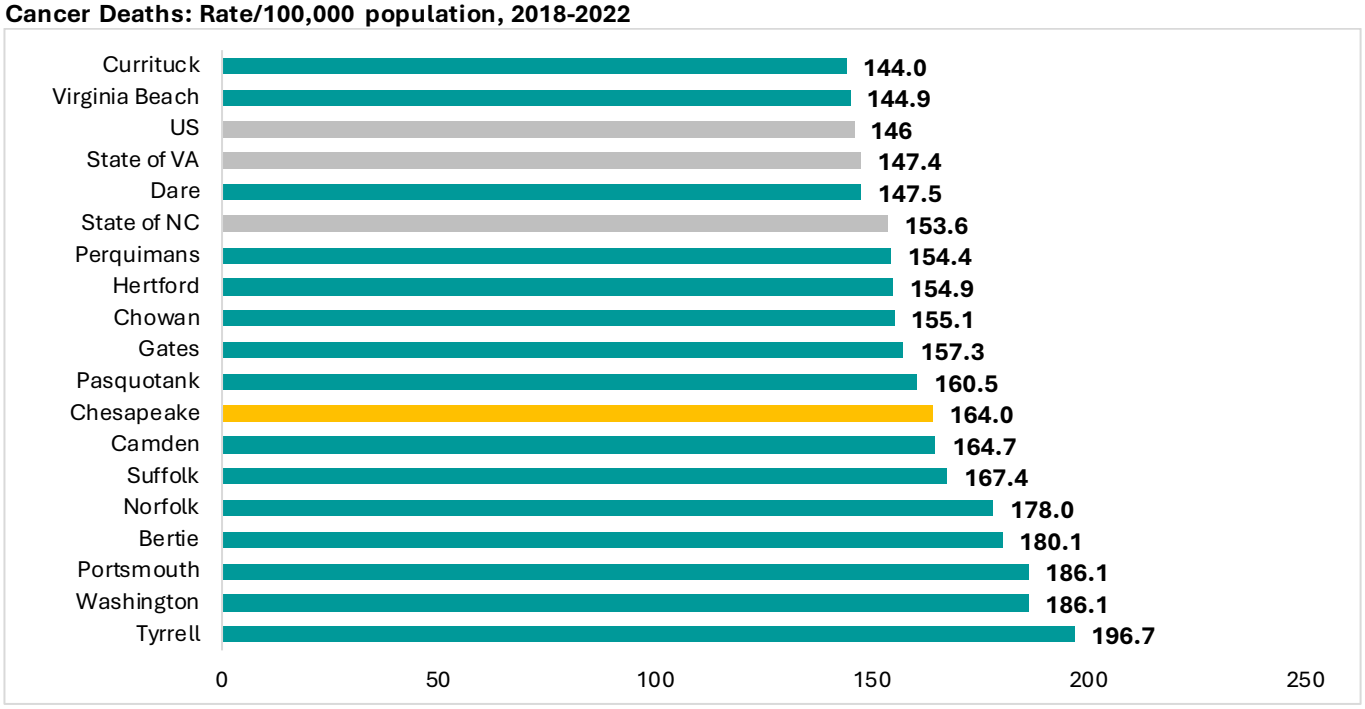
Heart Disease Deaths: Rate/100,000 population, 2018-2022



Source: National Institute on Minority Health and Health Disparities.

Graph

Cancer Deaths: Rate/100,000 population, 2018-2022



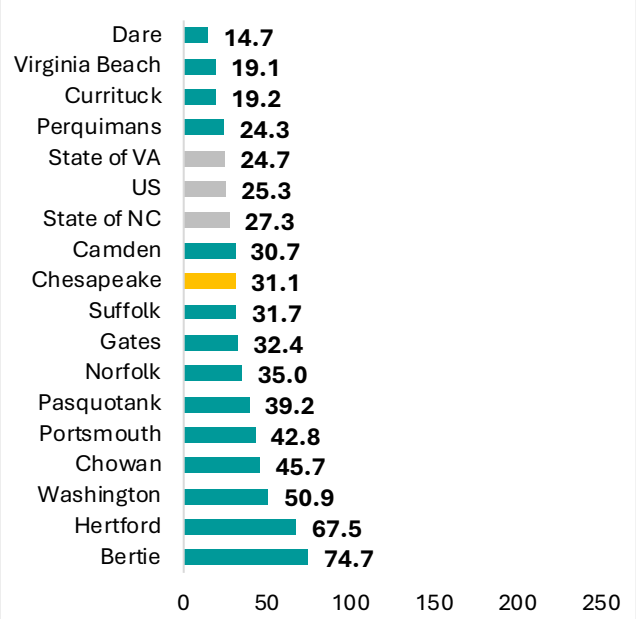
Source: National Institute on Minority Health and Health Disparities.

LEADING CAUSES OF DEATH BY LOCALITY, CONTINUED

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 Virginia and North Carolina are included in the graphs below. Data from all North Carolina counties was not available for all graphs.

Graph

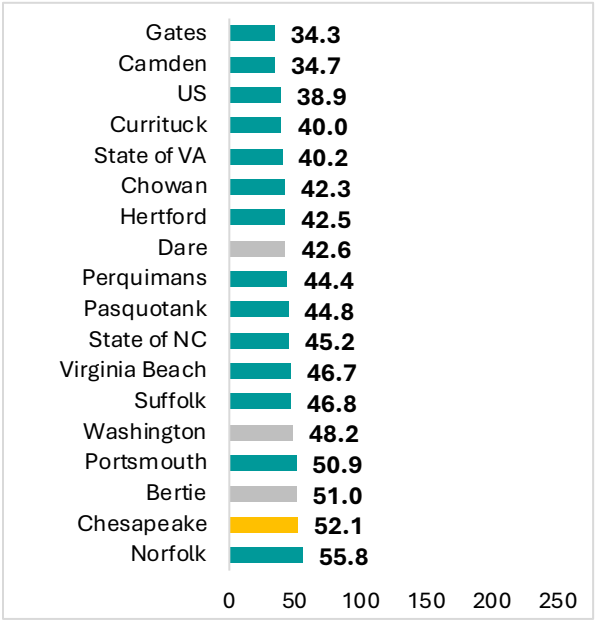
Diabetes: Rate/100,000 pop. 2018-2022



Source: National Institute on Minority Health and Health Disparities.

Graph

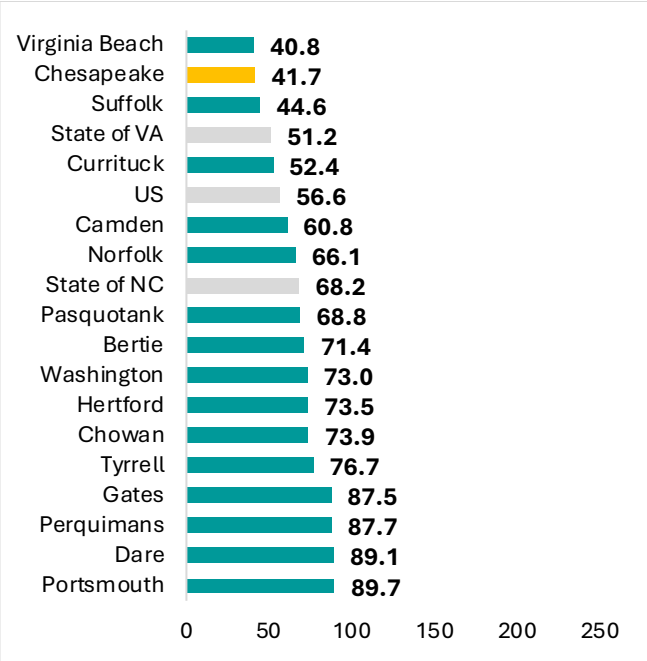
Cerebrovascular: Rate/100,000 pop. 2018-2022



Source: National Institute on Minority Health and Health Disparities.

Graph

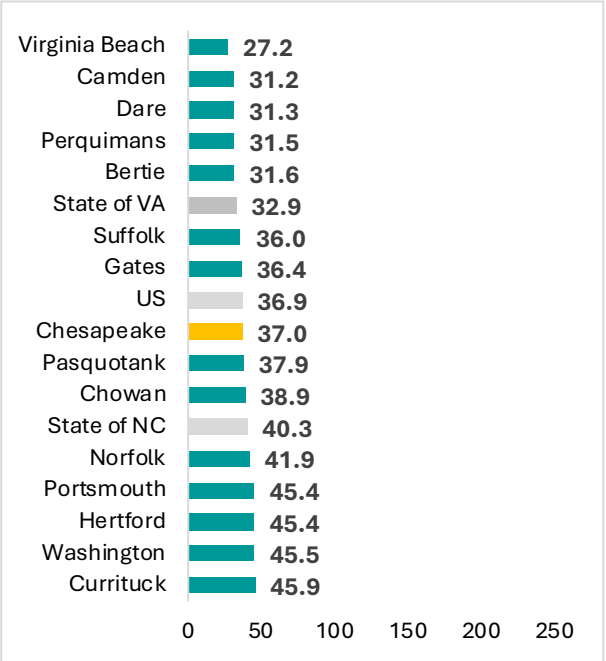
Accidents: Rate/100,000 population, 2018-2022



Source: National Institute on Minority Health and Health Disparities.

Graph

Chronic Lower Respiratory: Rate/100K pop.2015-2022

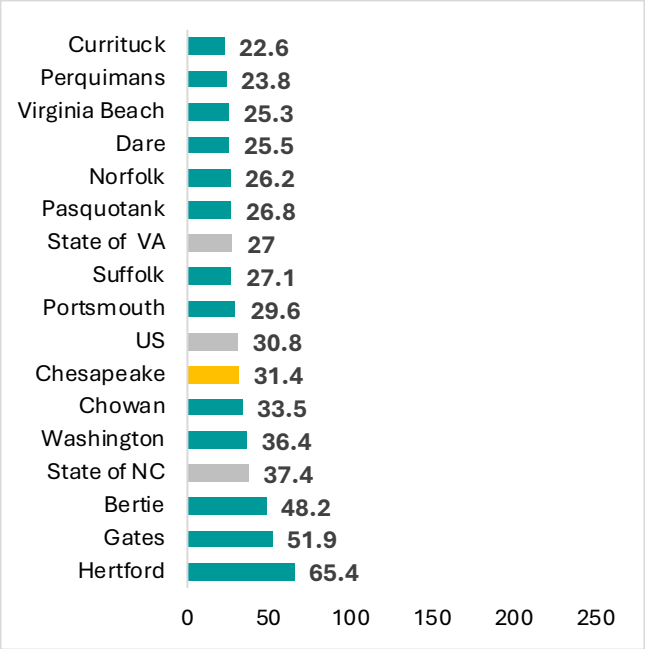


Source: National Institute on Minority Health and Health Disparities.

OTHER CAUSES OF DEATH BY LOCALITY

Graph

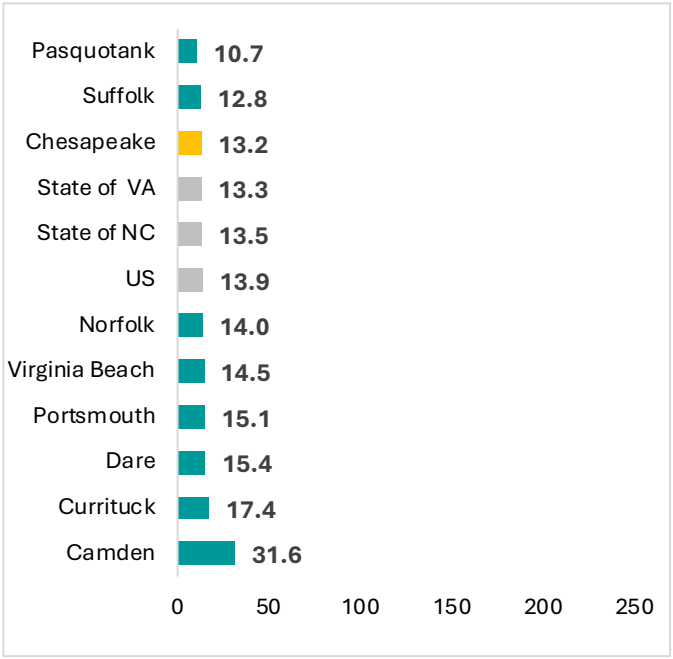
Alzheimer's: Rate/100,000 pop. 2018-2022



Source: National Institute on Minority Health and Health Disparities.

Graph

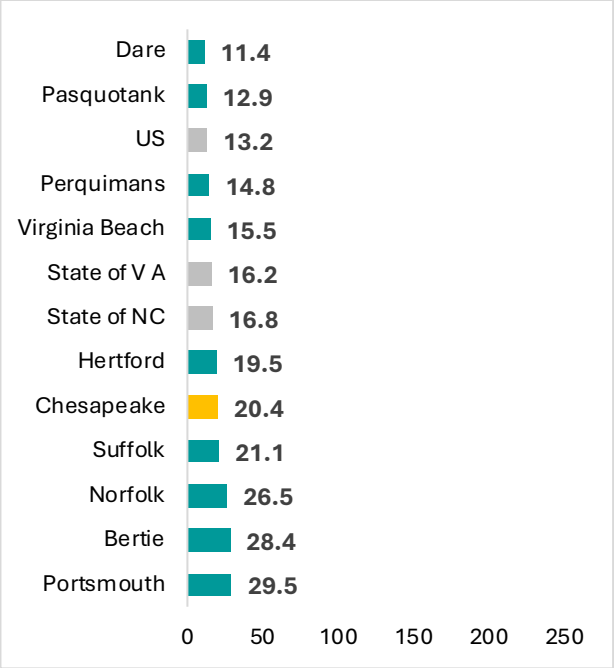
Suicide: Rate/100,000 pop. 2018-2022



Source: National Institute on Minority Health and Health Disparities.

Graph

Kidney Disease: Rate/100,000 pop. 2018-2022



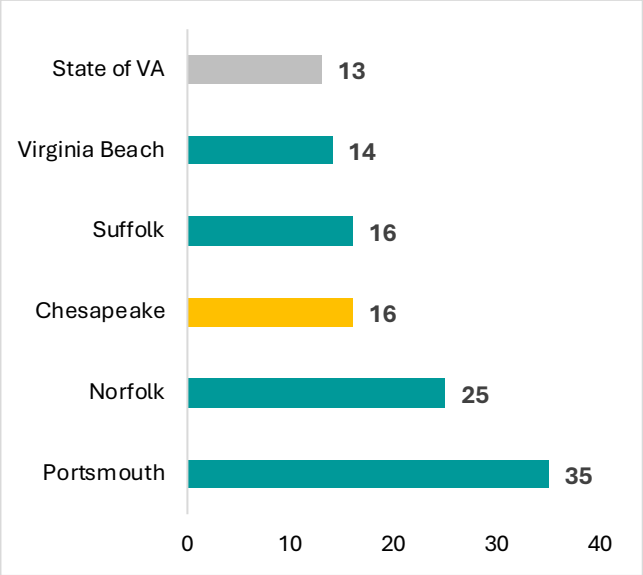
Source: National Institute on Minority Health and Health Disparities.

Firearm Fatalities

Data for firearm fatalities and drug overdose deaths cannot be compared across states, so the graphs below show separate data for each state.

Graph

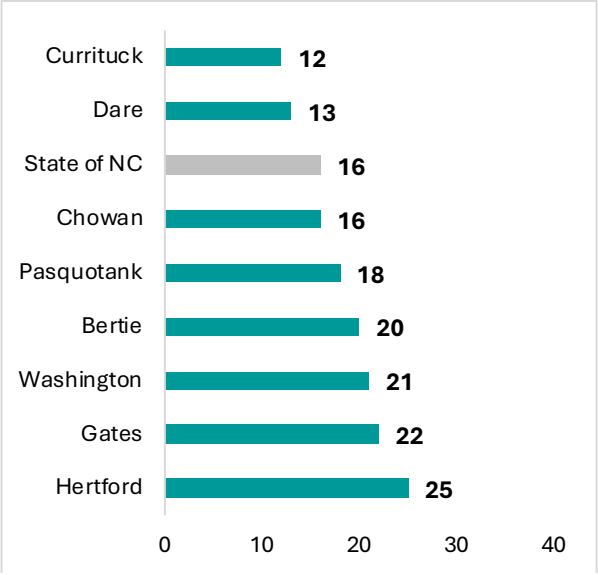
Firearm Fatalities per 100,000 persons, 2025
Virginia



Source: 2025 Robert Wood Johnson County Health Rankings and Roadmaps

Graph

Firearm Fatalities per 100,000 persons, 2025
Northeastern North Carolina



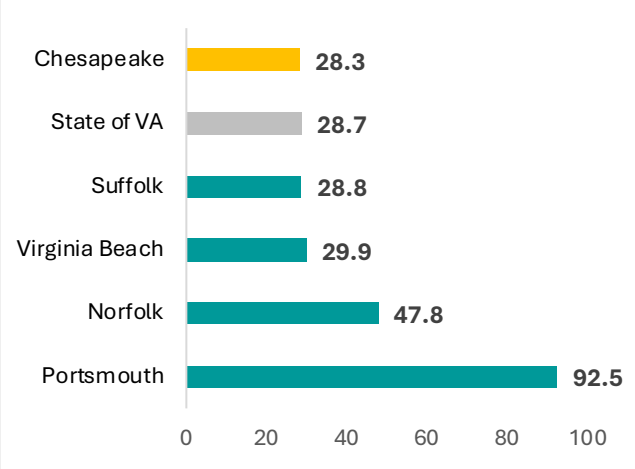
Source: 2025 Robert Wood Johnson County Health Rankings and Roadmaps

Drug Overdoses

In Hampton Roads, ***Chesapeake has the lowest drug overdose death rate in the region*** compared to the highest rate of 92.5 in Portsmouth. In Northeastern North Carolina, the overdose death rate ranges from the lowest rate of 7.5 in Perquimans County to 86.4 in Chowan County.

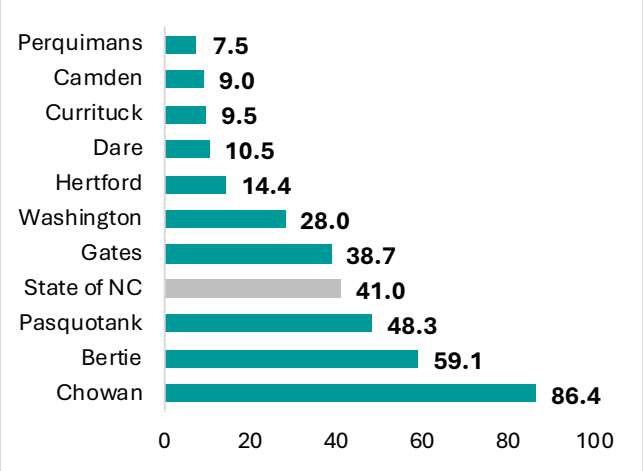
Data from the Virginia Department of Health shows that ***fentanyl and other opioids remain the leading causes of drug overdose deaths in Virginia.*** The North Carolina Division of Public Health also reports that in 2023, fentanyl and illicit opioids were the primary causes of drug overdose deaths in Currituck, Camden, Pasquotank, Perquimans, Gates, Hertford, and Bertie counties, but only 25% to 33% of overdose deaths in Dare, Tyrrell, and Washington counties.

Graph
Virginia
Any Drug, Rate per 100,000 population



Source: Virginia Department of Health

Graph
Northeastern North Carolina
Any Drug, Rate per 100,000 population



Source: North Carolina Department of Health and Human Services

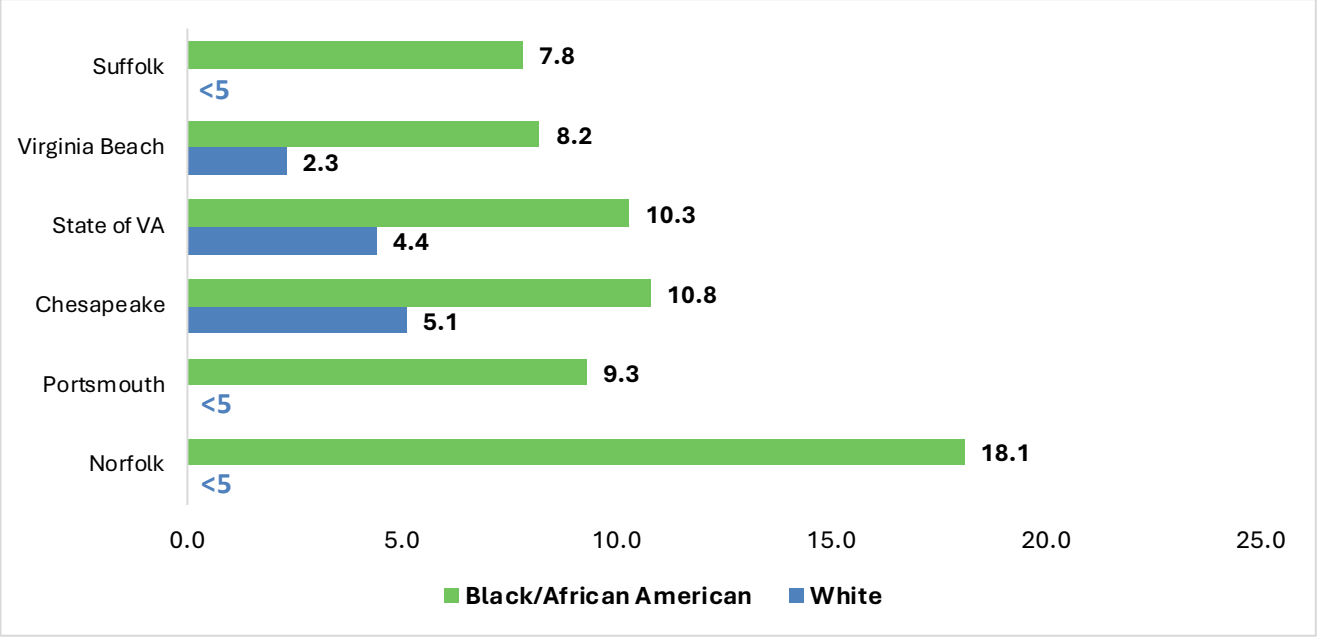
Infant Mortality

Infant mortality is defined as a death occurring during the first year of life, and according to the March of Dimes, in the U.S., Black/African American babies have an infant mortality rate that is nearly twice that of the all other babies in nation.[7] As this measure is also used to indicate the overall health of a society, this reflects a maternal and child health crisis for the Black/African American population.

Similarly, a 2023 study by the Virginia Department of Health (VDH) reports that the infant mortality rate for Black/African American infants in Virginia ***is two and a half times greater*** than that of White infants in the state and that that the leading cause of infant mortality low birth weight and pre-term births. The VDH study reports that the likely cause of this disparity in birth outcomes is due to racial discrimination and harassment faced by mothers, and other studies note that environmental and social risks can also have a negative impact on birth outcomes.[8]

These findings are reflected in the graphs below. The Virginia Department of Health did not provide data for White infant mortality rates for Suffolk, Portsmouth, and Norfolk, because there were fewer than five deaths.

Graph
Infant Mortality per 1,000 Births by Race
Virginia and Hampton Roads, 2024

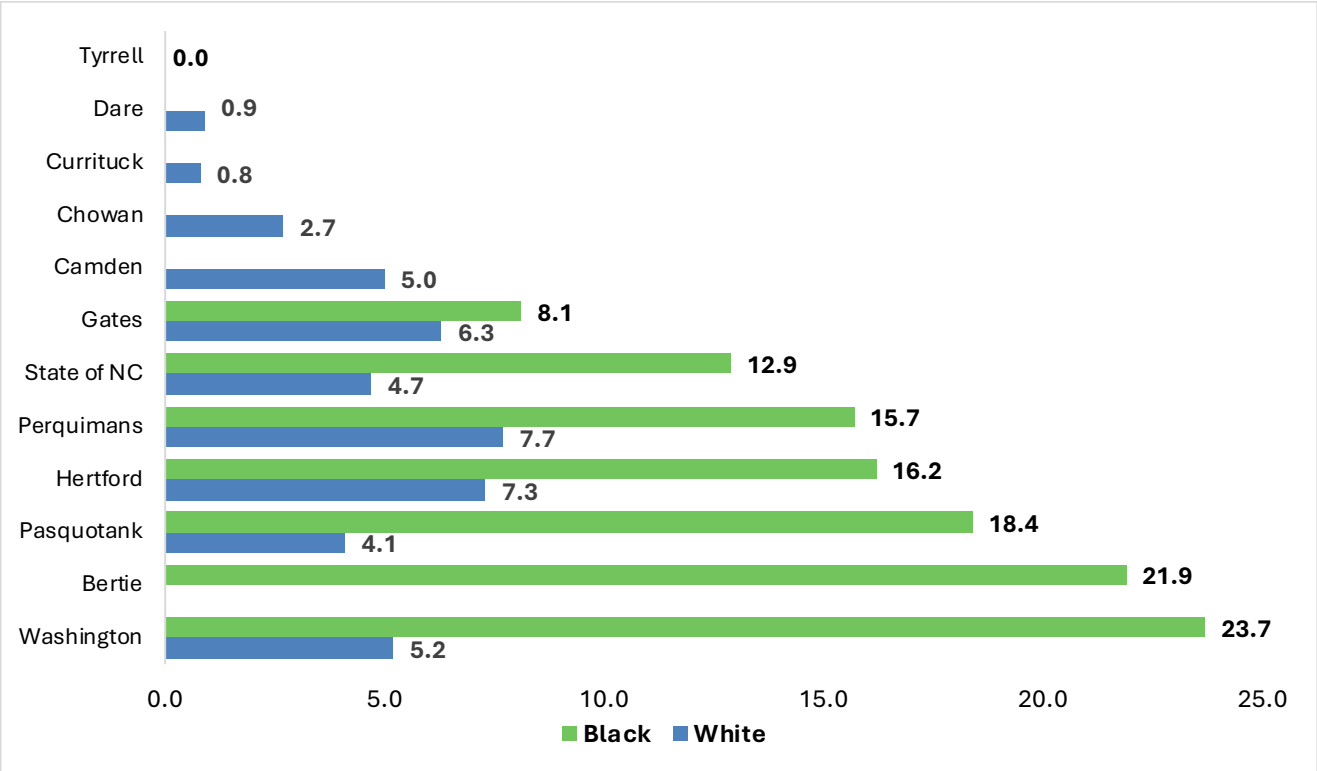


Source: Virginia Department of Health, 2023.

[7] March of Dimes Peristats. 2024 Report Card. https://www.marchofdimes.org/peristats/reports/united-states/report-card
[8] Kenesha Smith Barber and Meagan Robinson Mayno, "Examining the Influence of Racial Discrimination on Adverse Birth Outcomes: An Analysis of the Virginia Pregnancy Risk Assessment Monitoring System (PRAMS)", 2016, Virginia Department of Health website, July 2023, accessed at https://www.vdh.virginia.gov/content/uploads/sites/110/2023/08/OFHS-Discrimination-and-birth-outcomes.pdf

Infant Mortality per 1,000 Births by Race

Northeastern North Carolina, 2023



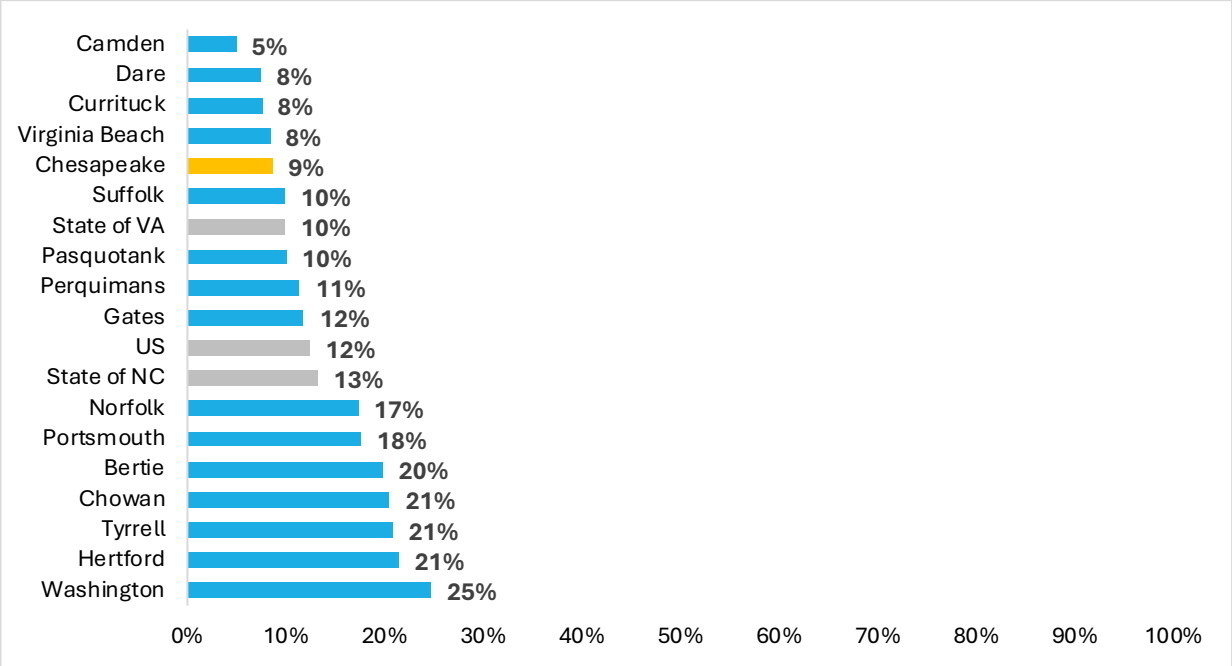
Source: North Carolina State Center for Health Statistics 2023.

SOCIOECONOMIC PROFILES

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

Graph

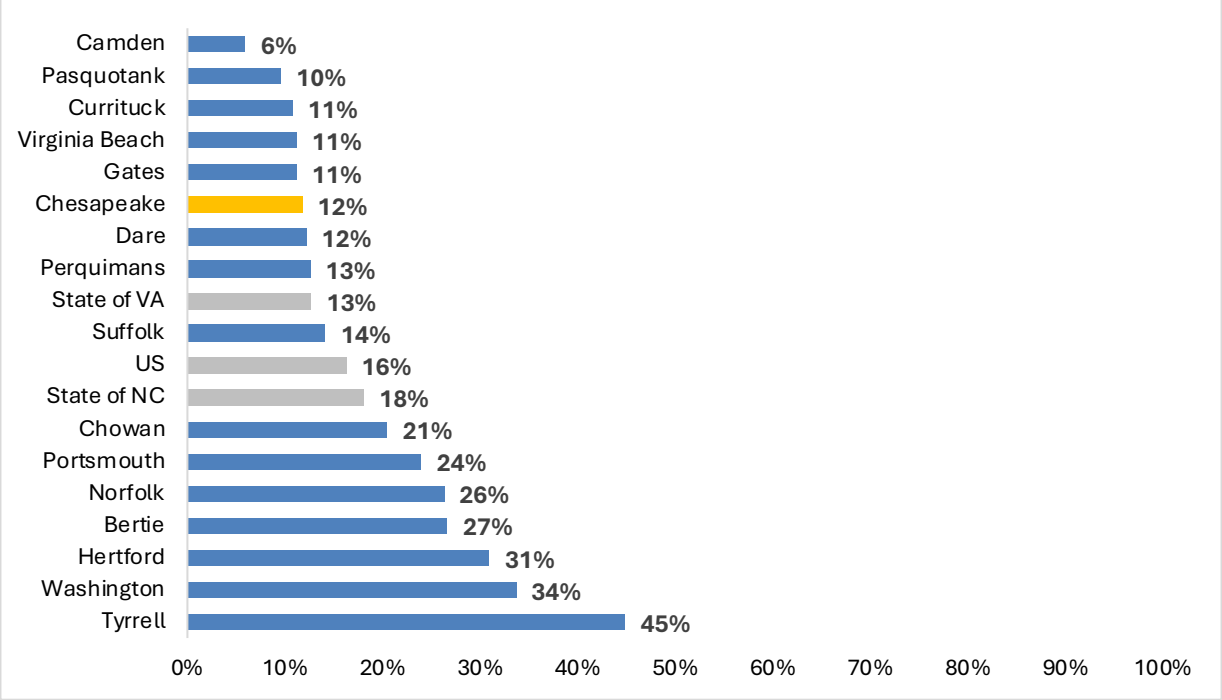
Percent of Persons in Poverty, 2019-2023



Source: US Census Bureau, American Community Survey, 2019-2023 5-Year Estimates, Table S1701.

Graph

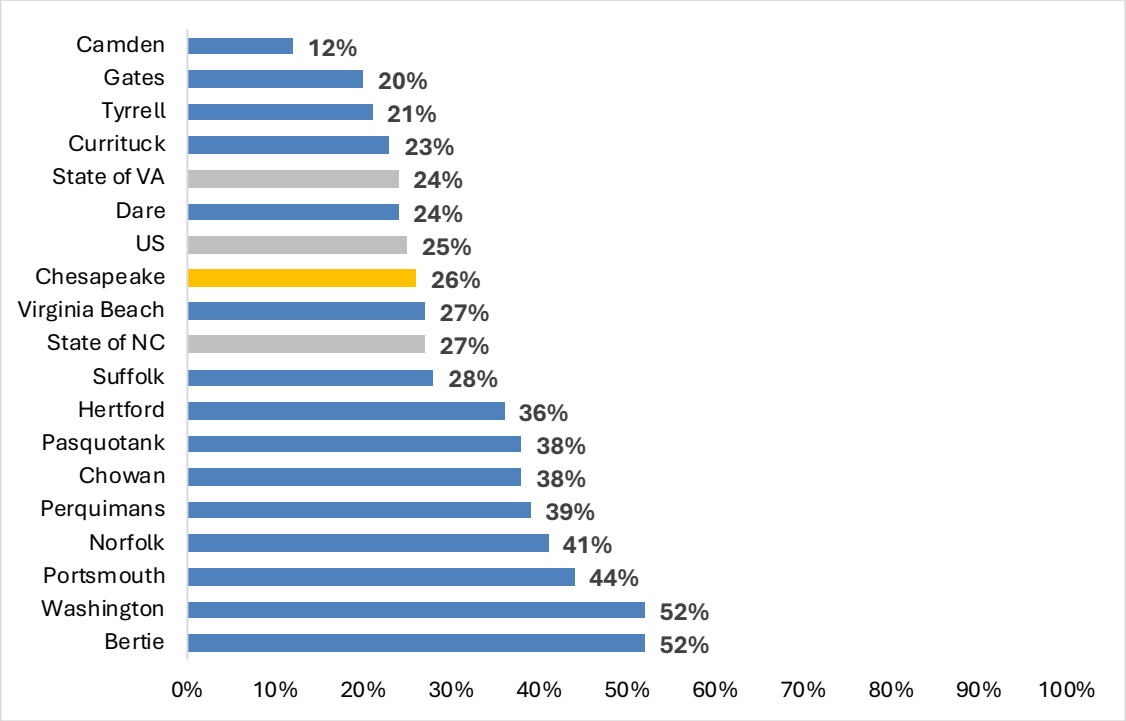
Percent of Children Under Age 18 in Poverty, 2019-2023



Source: US Census Bureau, American Community Survey, 2019-2023 5-Year Estimates, Table S1701.

Graph

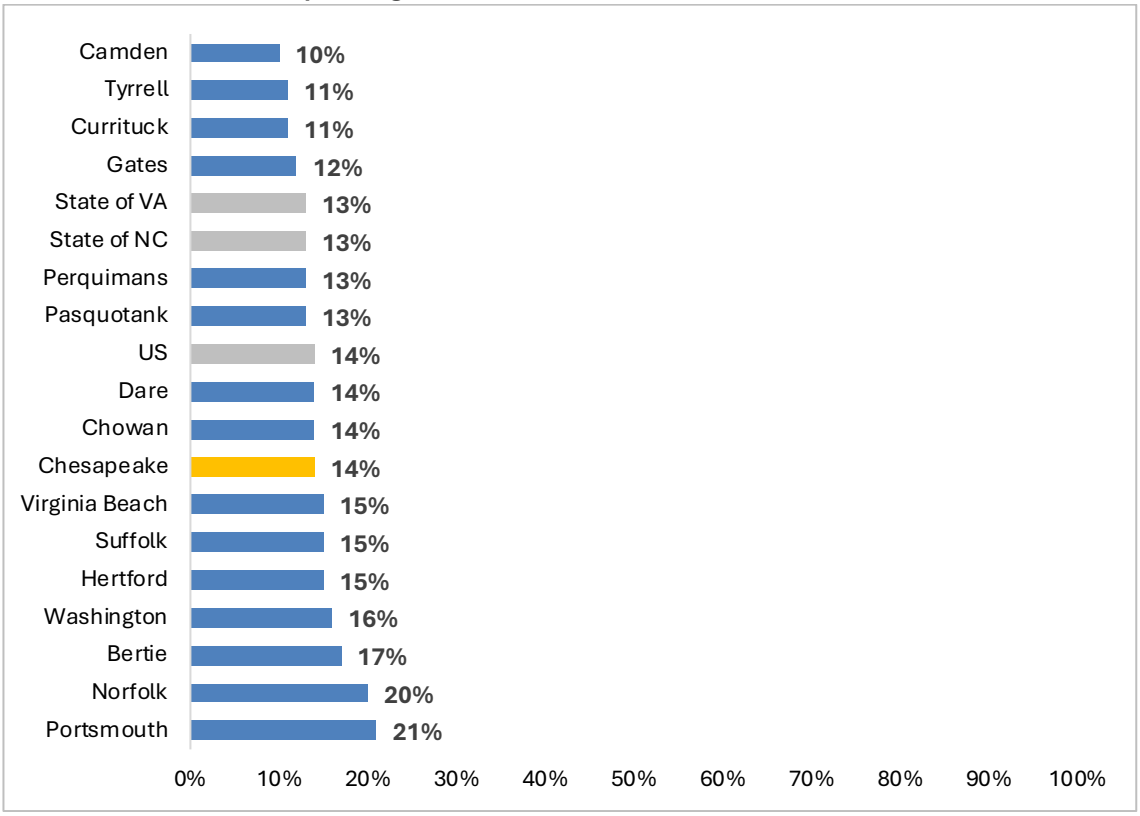
Percent of Children in Single Parent Households, 2025



Source: 2025 Robert Wood Johnson County Health Rankings and Roadmaps

Graph

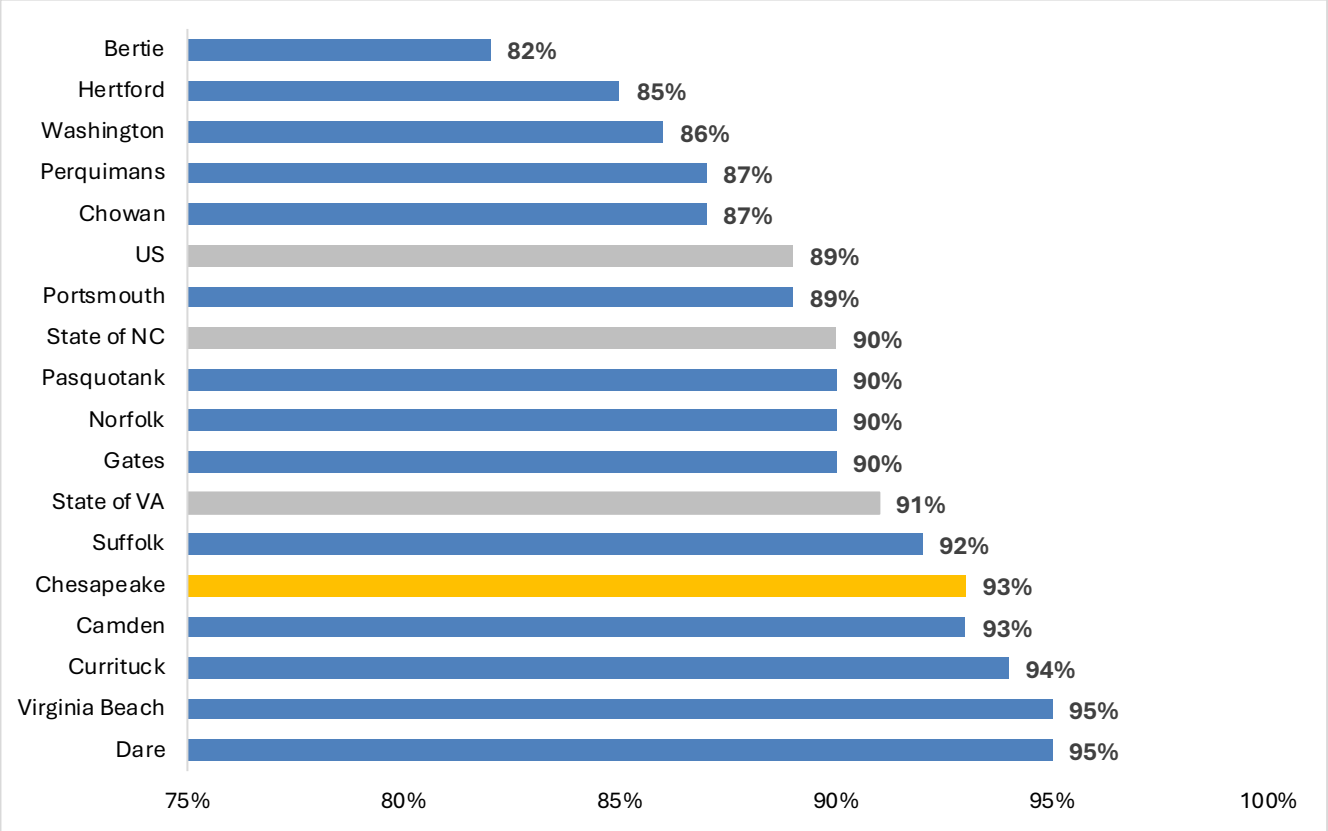
Percent of Households Spending More than 50% of Income on Rent, 2025



Source: 2025 Robert Wood Johnson County Health Rankings and Roadmaps

Graph

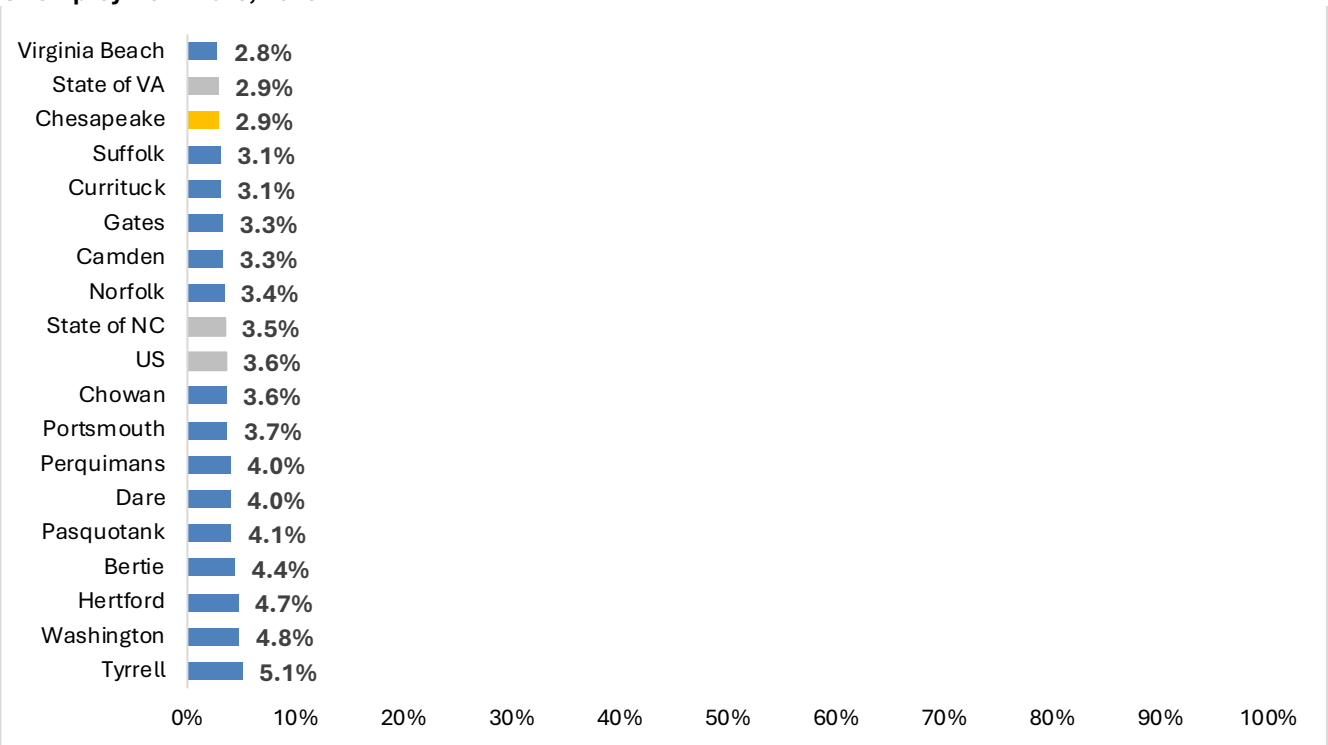
Percent of Adults Aged 25 and Older with a High School Diploma or Equivalent, 2025



Source: 2025 Robert Wood Johnson County Health Rankings and Roadmaps

Graph

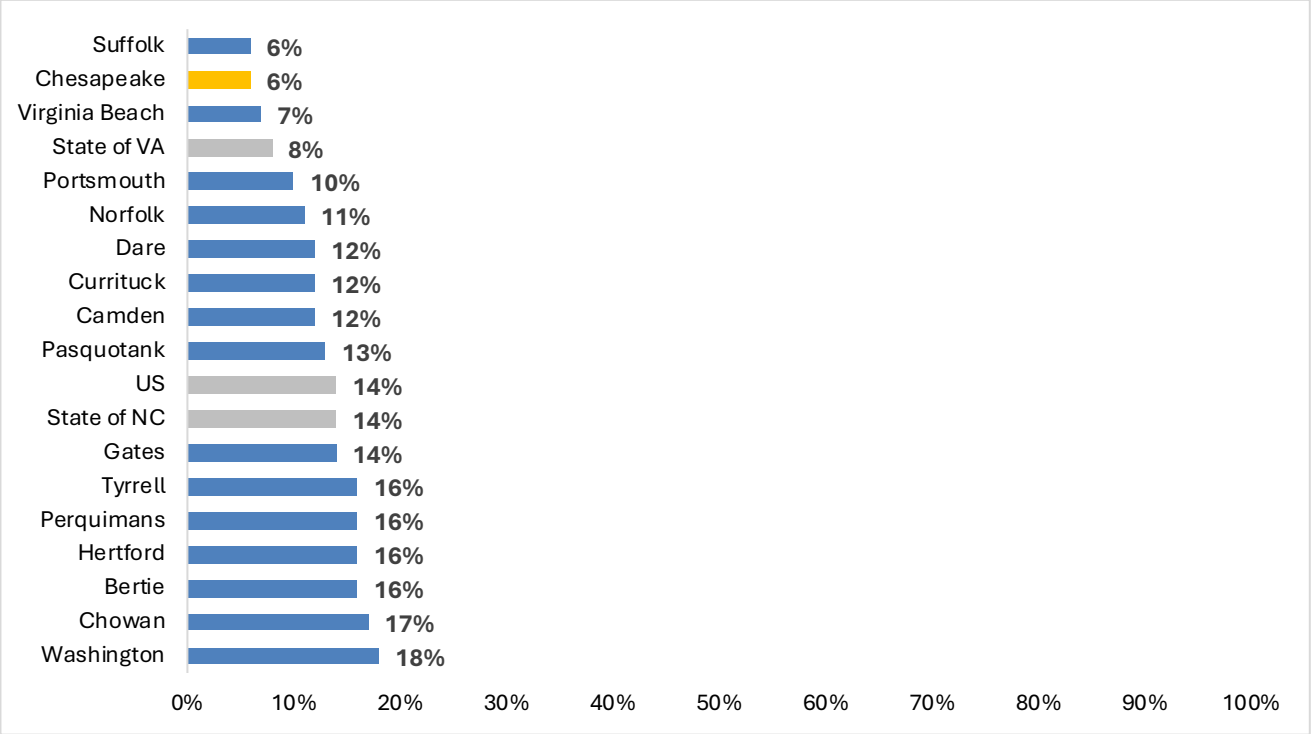
Unemployment Rate, 2025



Source: 2025 Robert Wood Johnson County Health Rankings and Roadmaps

Graph

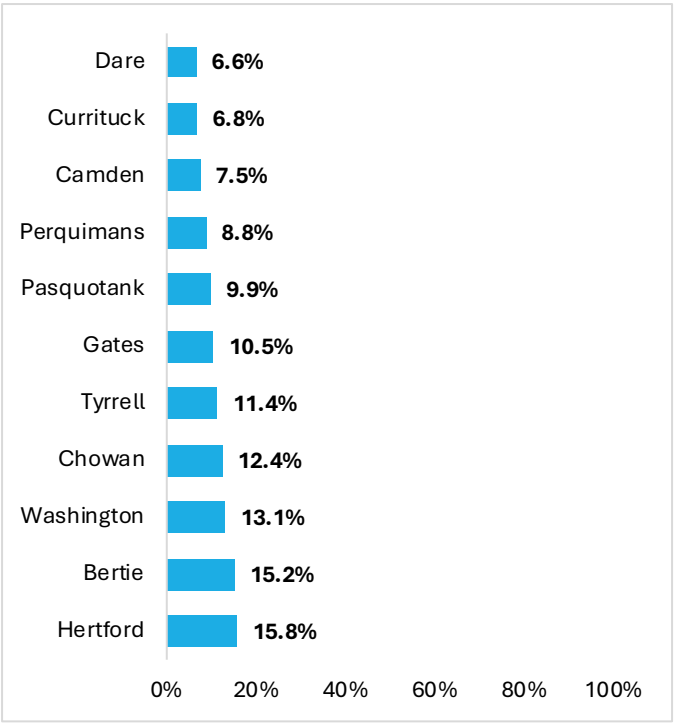
Food Insecurity (Percentage of population who lack a reliable source of food), 2025



Source: 2025 Robert Wood Johnson County Health Rankings and Roadmaps

Graph

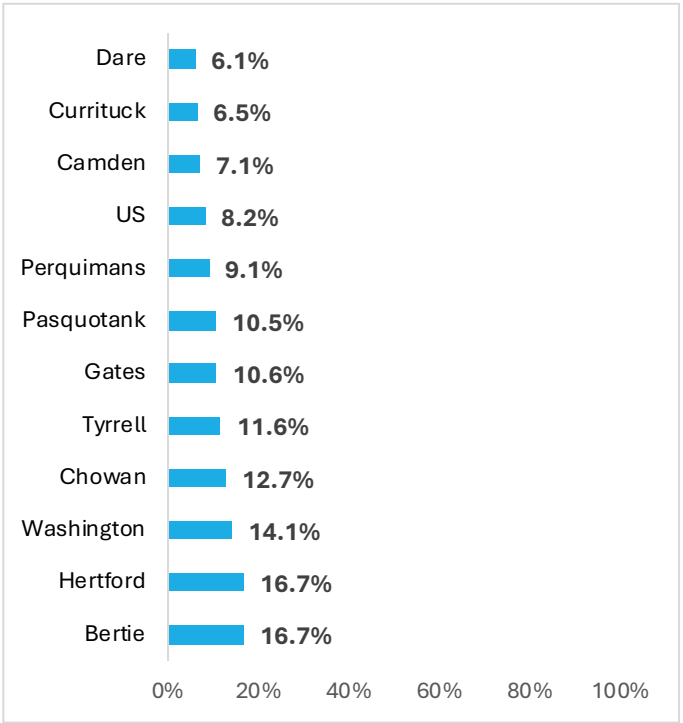
Transportation Barriers, 2025



Source: Centers for Disease Control and Prevention, PLACES. Data reflects the percentage of adults who reported a lack of reliable transportation keeping them from medical appointments, work or for accessing necessities for daily living in the past 12 months.
NOTE: The state of Virginia did not participate in this survey project so there is no data

Graph

Utility Service Cut Off Threat, 2025



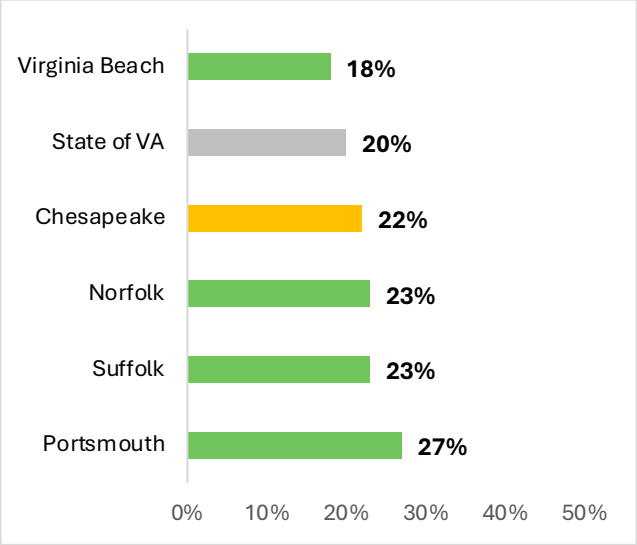
Source: Centers for Disease Control and Prevention, PLACES. Data reflects the percentage of adults who reported that an electric, gas, oil, or water company threatened to shut off services at any time during the prior 12 months.
NOTE: The state of Virginia did not participate in this survey project so there is no data

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.

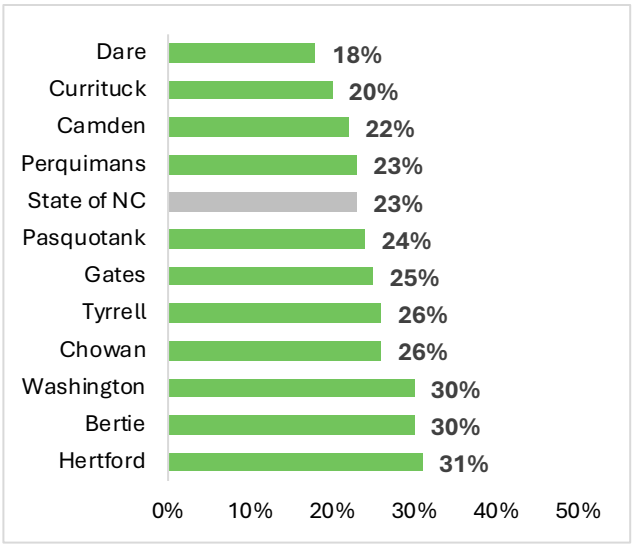
Adults 20 and older reporting no leisure-time physical activity

Graph
Virginia



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

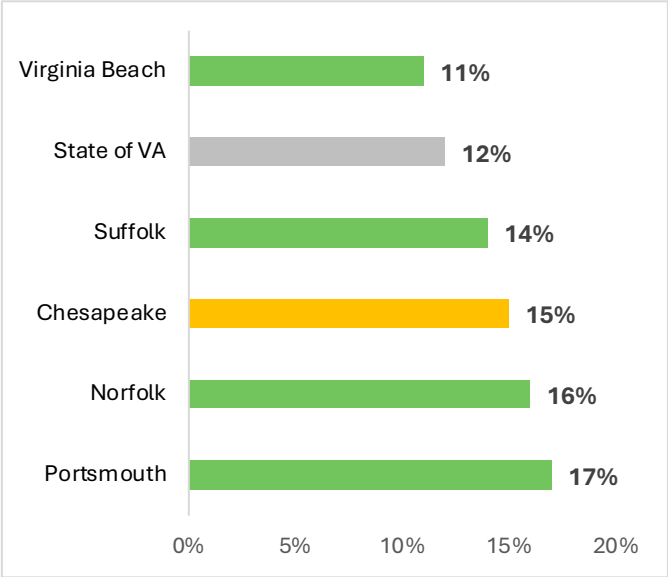
Graph
Northeastern North Carolina



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

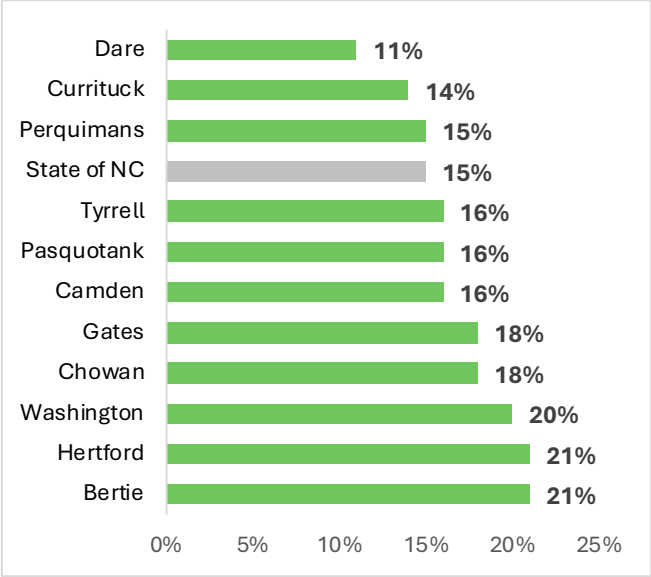
Adult Smoking

Graph
Virginia



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

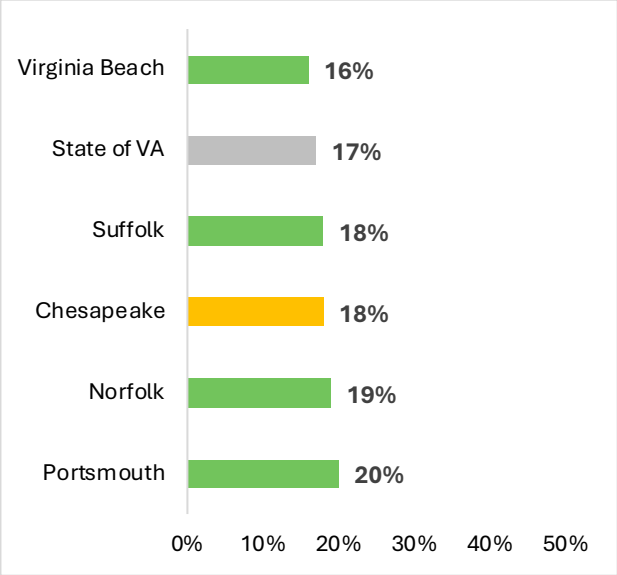
Graph
Northeastern North Carolina



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

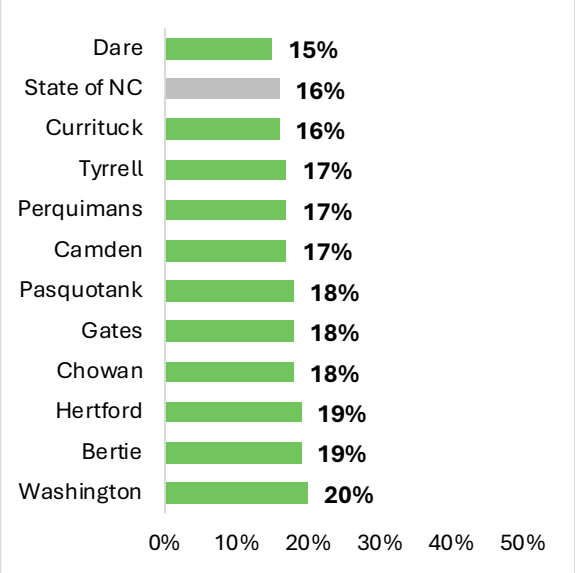
Frequent Mental Distress:
Percentage of adults reporting 14 or more days of poor mental health per month

Graph
Virginia



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

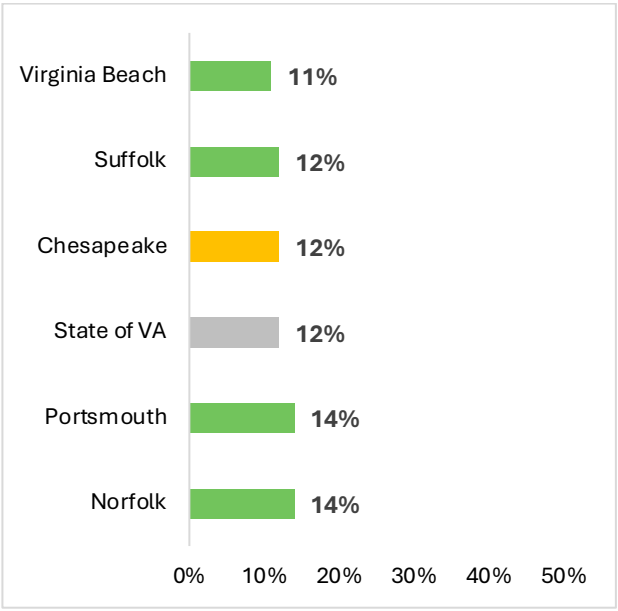
Graph
Northeastern North Carolina



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

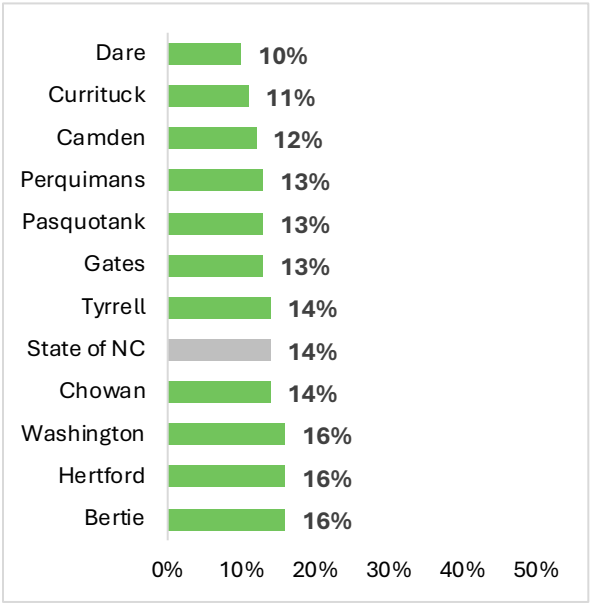
Frequent Physical Distress:
Percentage of adults reporting 14 or more days of poor physical health per month

Virginia



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Northeastern North Carolina



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

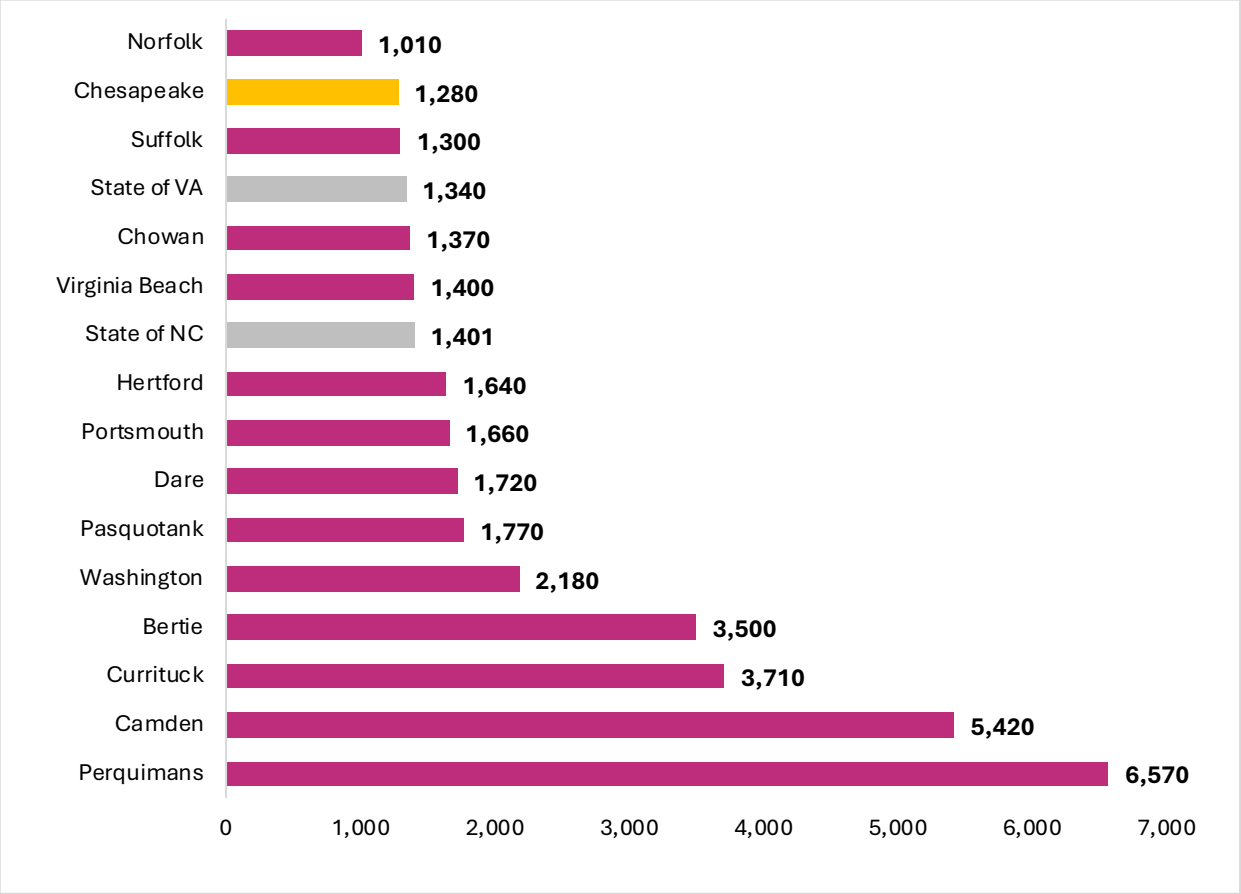
Access to Care

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 is not available for all North Carolina counties.

Graph

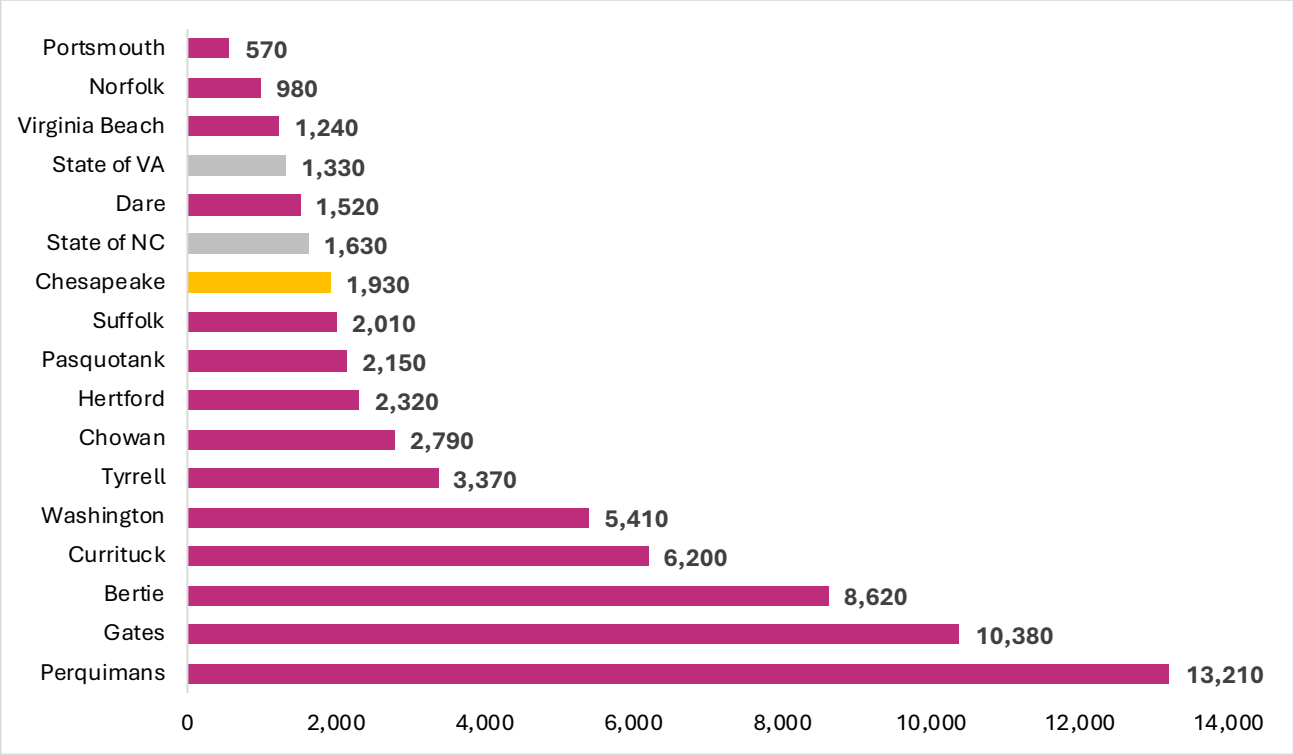
Number of Residents for Every 1 Primary Care Physician, 2025



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Graph

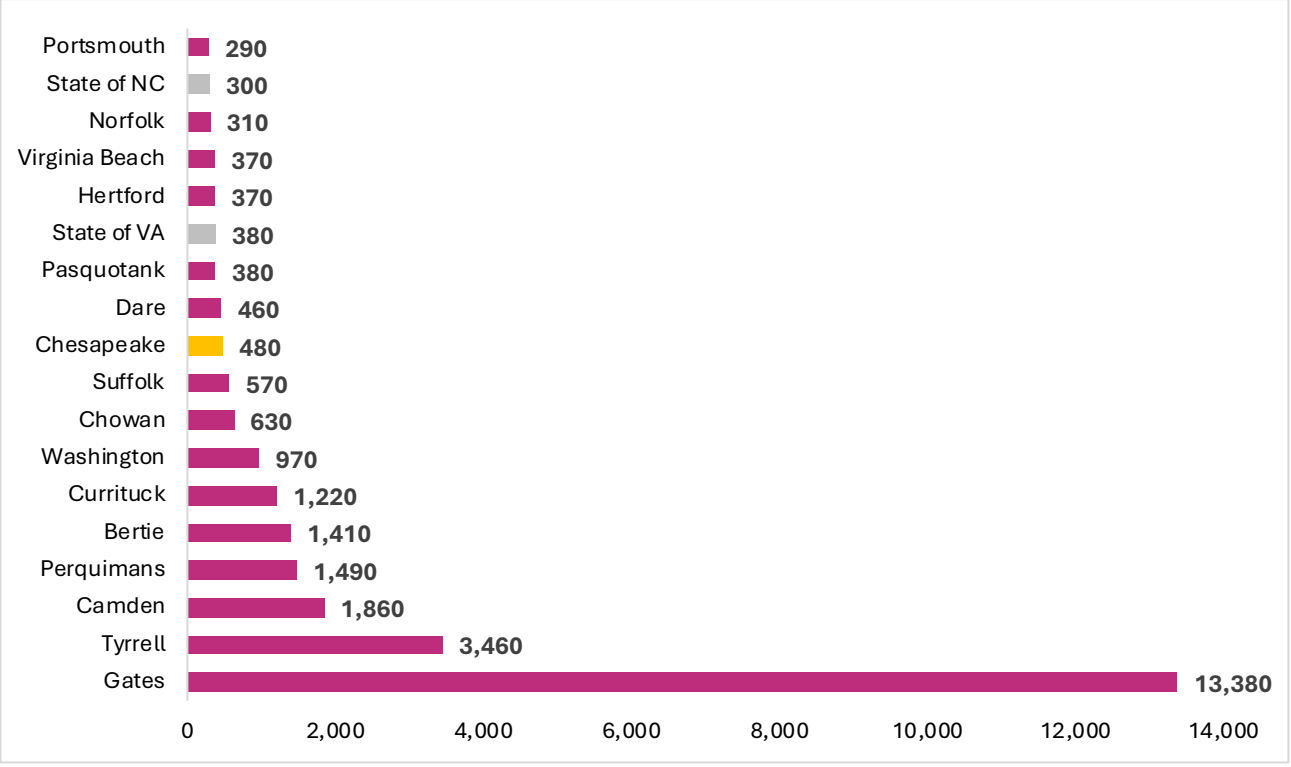
Number of Residents for Every 1 Dentist, 2025



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Graph

Number of Residents for Every 1 Mental Health Provider, 2025



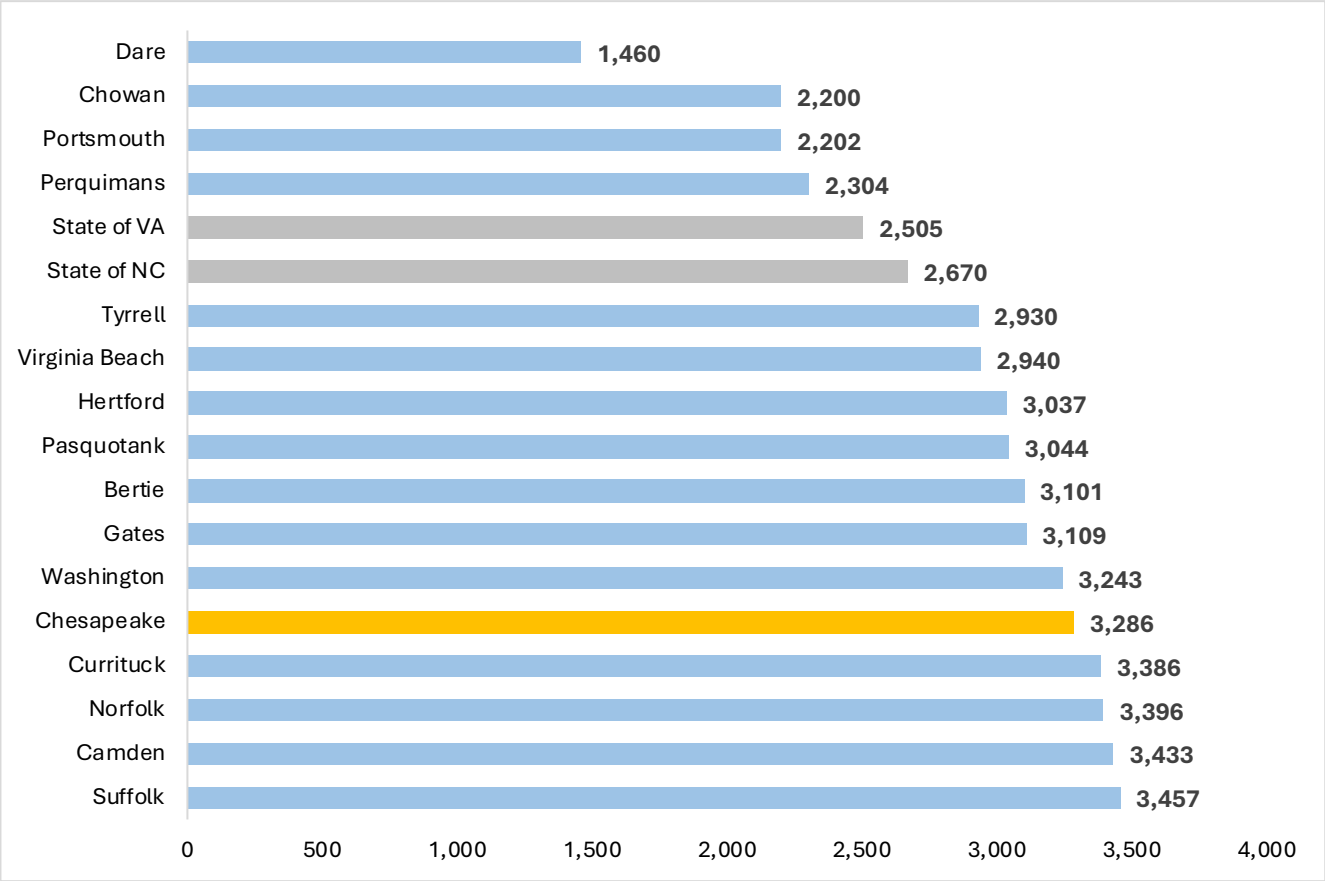
Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Preventable Hospital Stays

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."

Graph

Preventable Hospital Stays, Rate per 100,000 Medicare Enrollees



Source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

CHRONIC ILLNESSES

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 localities are provided. This can occur when different data collection methods or dates are used.

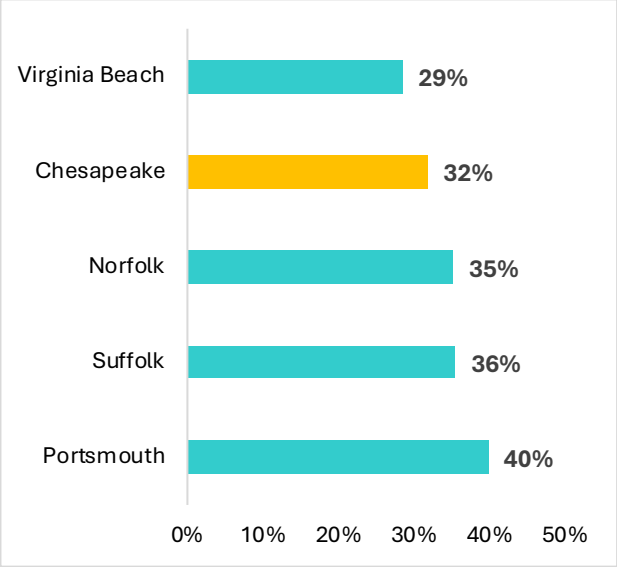
Hypertension

Localities in Virginia and Northeastern North Carolina have similar rates of hypertension, ranging between 29% in Virginia Beach and Dare County to 43% in Bertie County. The CDC did not provide state level data for this measure. These localities also show similar rates of diabetes, ranging from 8% in Dare County to 43% in Bertie County.

Hypertension

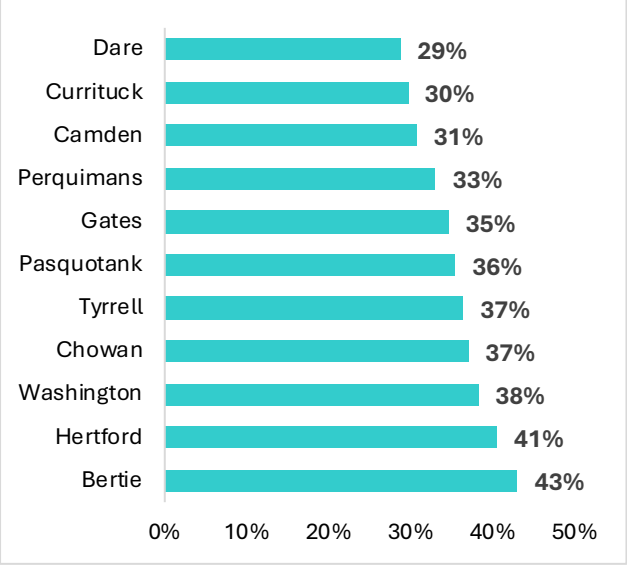
Graph

Virginia



Graph

Northeastern North Carolina

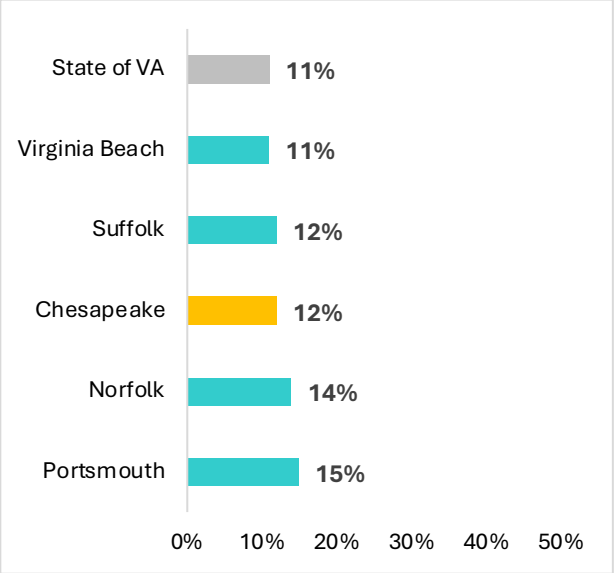


Hypertension data source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health.

Diabetes: Adults ages 20+

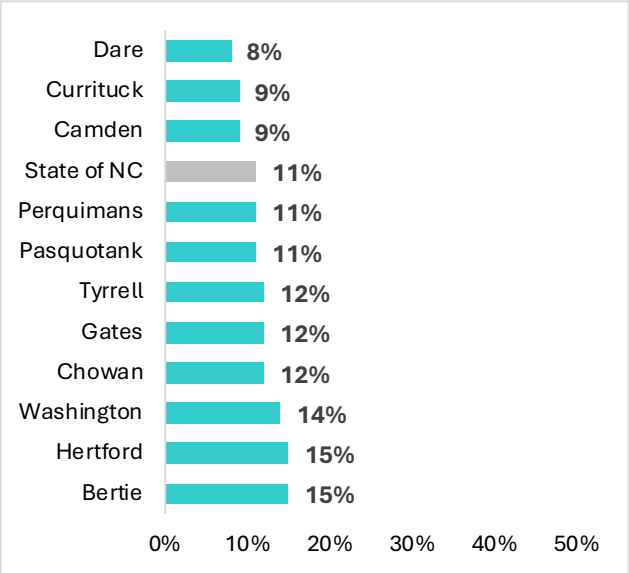
Graph

Virginia



Graph

Northeastern North Carolina



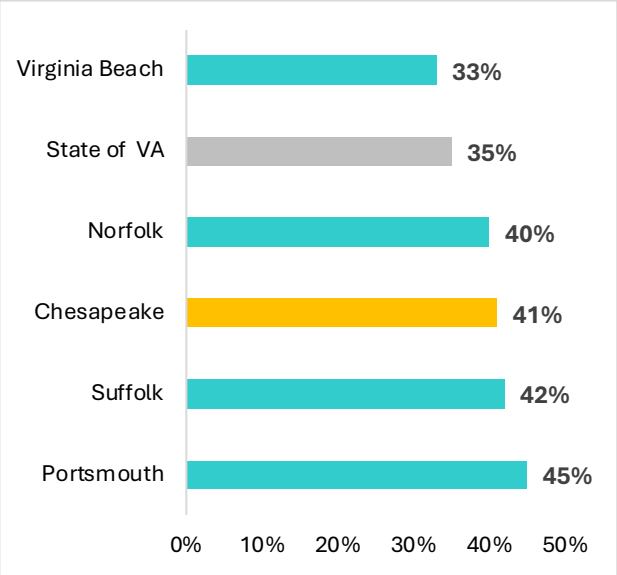
Diabetes data source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Adult obesity

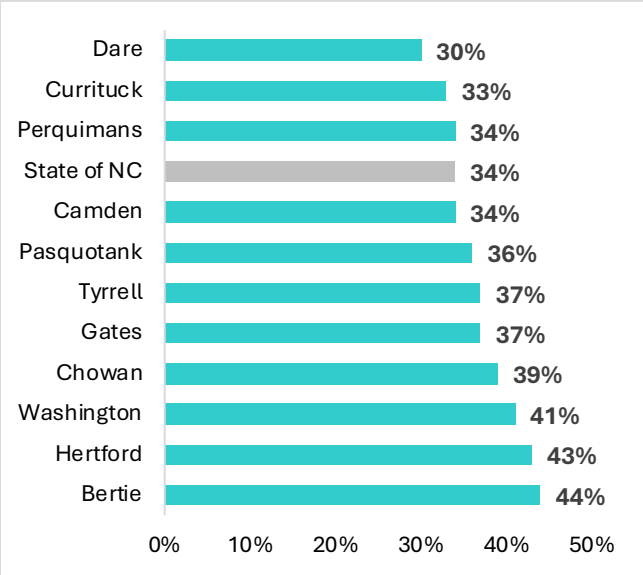
Adult obesity is measured as adults with a Body Mass Index (BMI) of 30 or greater. Virginia and Northeastern North Carolina have similar percentages of adults who are obese, ranging between 30% in Dare County to 45% in Portsmouth.

Adult obesity

Graph
Virginia



Graph
Northeastern North Carolina



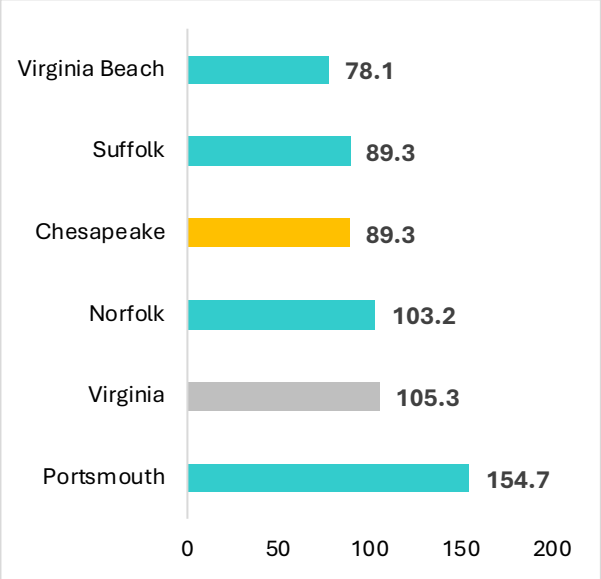
Obesity data source: 2025 County Health Rankings and Roadmaps, Robert Wood Johnson Foundation (RWJF)

Hepatitis C

The Virginia Department of Health reports that Hepatitis C can be caused by heavy alcohol use, some medications, and certain medical conditions. In the US, the most common means of transmission is injection drug use. VDH also notes that "Hepatitis C is one of the three most common bloodborne pathogens in the United States."[9]

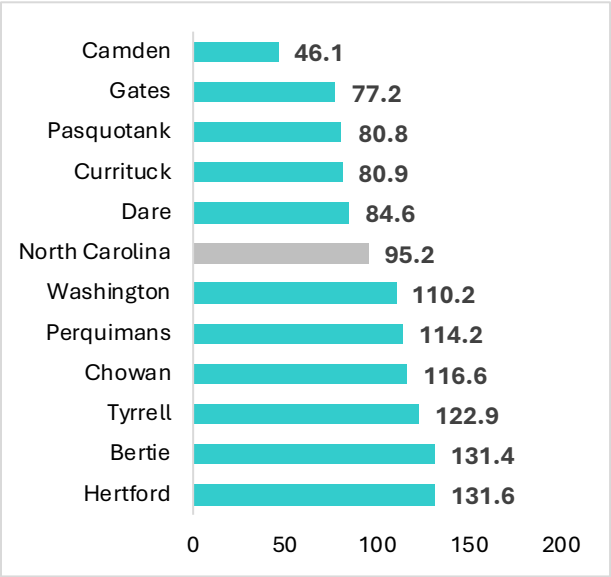
Hepatitis C: Rate per 100,000 all adult population

Graph
Virginia



Source: Virginia Department of Health

Graph
Northeastern North Carolina



Source: North Carolina Electronic Disease Surveillance System (NC EDSS)

[9] "Viral Hepatitis," Virginia Department of Health, last updated June 24, 2025, https://www.vdh.virginia.gov/disease-prevention/disease-prevention/viral-hepatitis/#hepc

Community Themes and Strengths Assessment

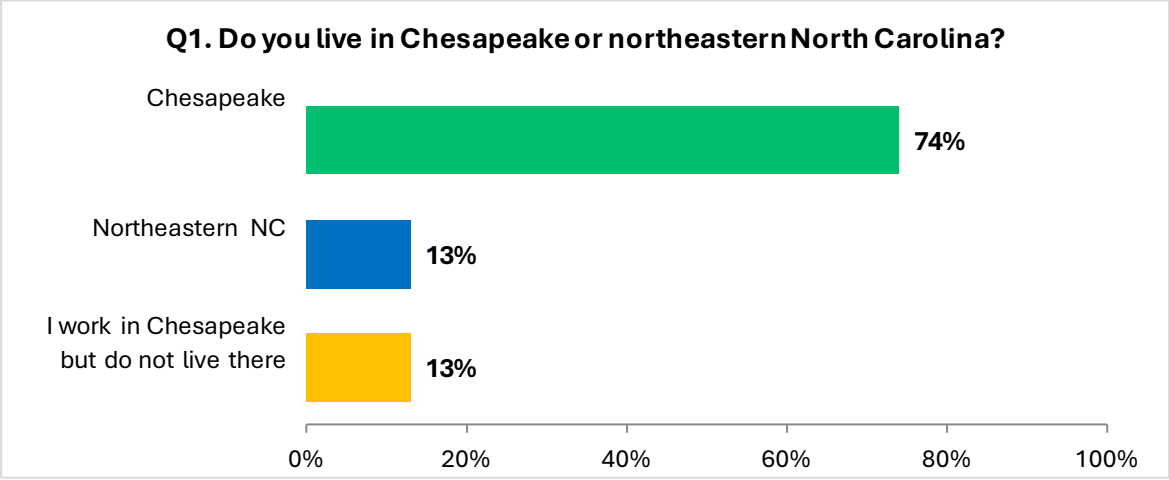
Community Needs Survey Results

DEMOGRAPHICS

The survey was available through Survey Monkey from January 20, 2025, to July 31, 2025, and yielded 919 complete responses. The following graphs show the demographics of the 2025 survey respondents.

Q1: Do you live in Chesapeake or northeastern North Carolina?
Answered: 877 Skipped: 42

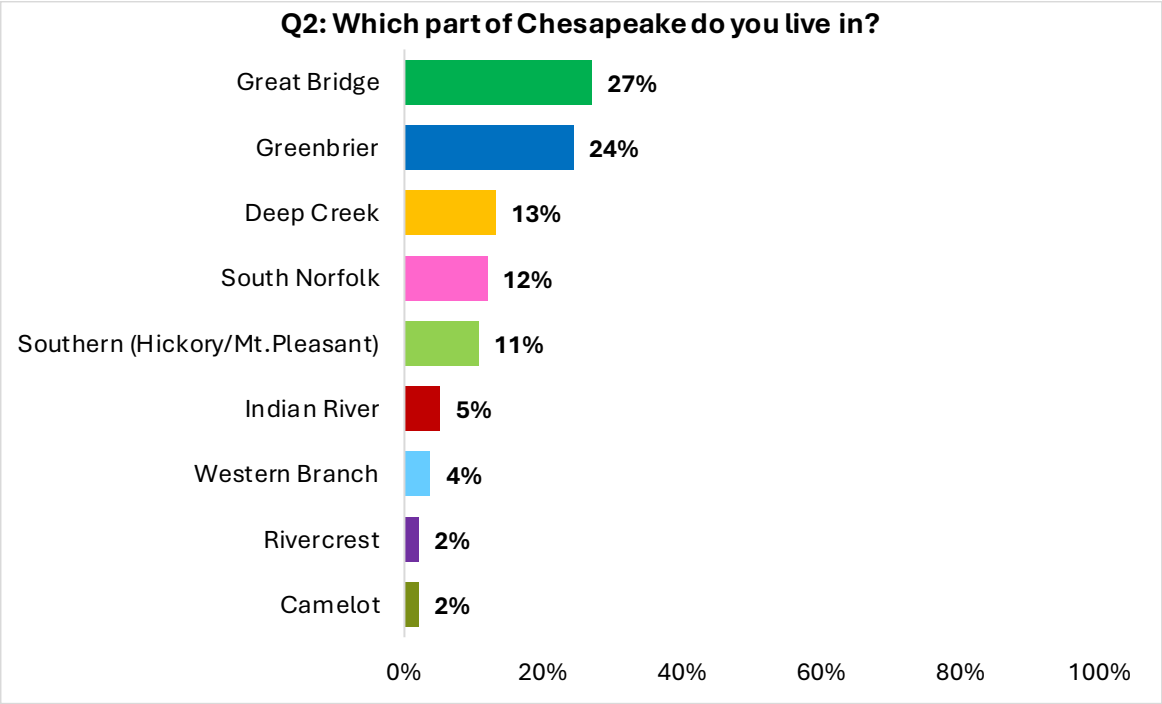
Of the 919 respondents, live in Chesapeake, 392 live in northeastern North Carolina, and 148 work in Chesapeake but do not live there. North Carolina patients represented 12% of the hospital's patient population and 13% of survey respondents.



ANSWER CHOICES	RESPONSES	
Chesapeake	74%	651
Northeastern NC	13%	116
Work in Chesapeake but do not live there	13%	110
Skipped question	5%	42
TOTAL	**100%**	**919**

Q2: Which part of Chesapeake do you live in?
Answered: 645 Skipped: 274

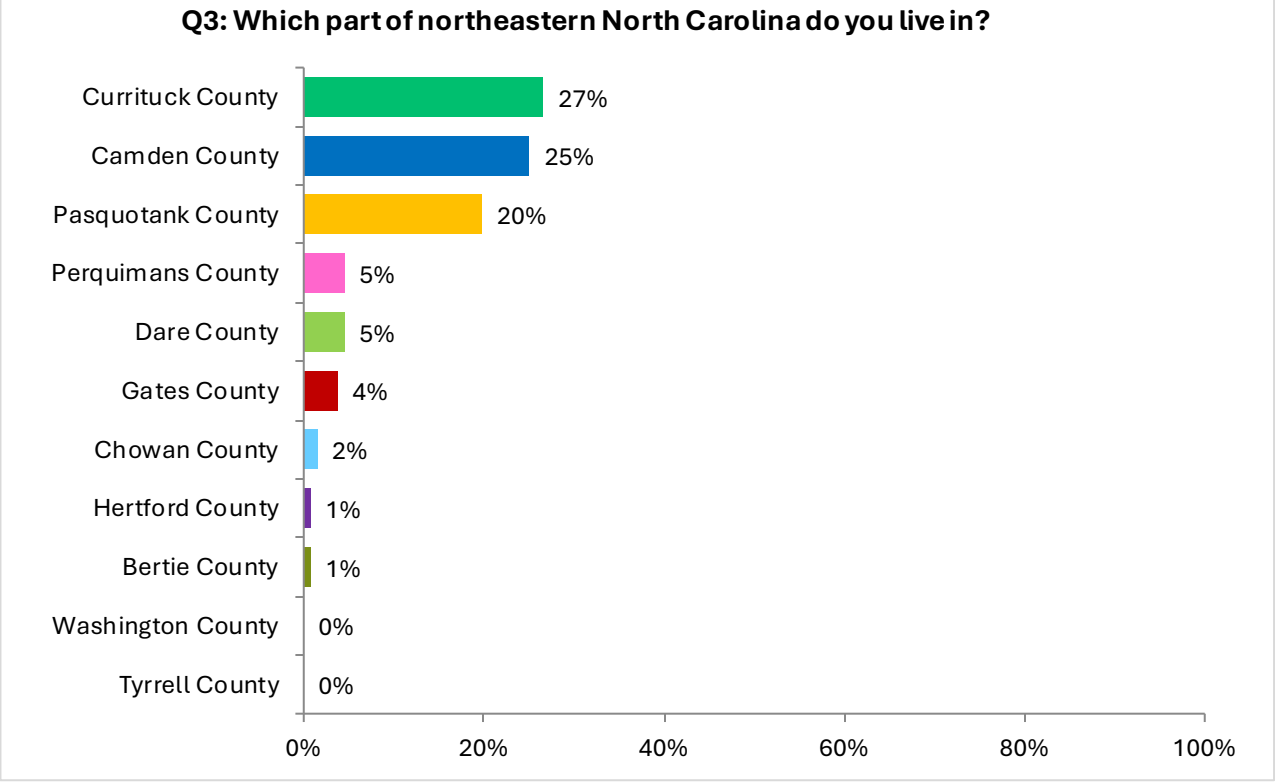
Most Chesapeake respondents were from Greenbrier, Deep Creek, and South Norfolk.



ANSWER CHOICES	RESPONSES	
Great Bridge	27%	174
Greenbrier	24%	157
Deep Creek	13%	85
South Norfolk	12%	77
Southern/Hickory/Mt. Pleasant	12%	69
Indian River	5%	33
Western Branch	4%	24
Rivercrest	2%	13
Camelot	2%	13
TOTAL	**100%**	**645**

Q3: Which part of northeastern North Carolina do you live in?
Answered: 116 Skipped: 804

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 0% of total responses.

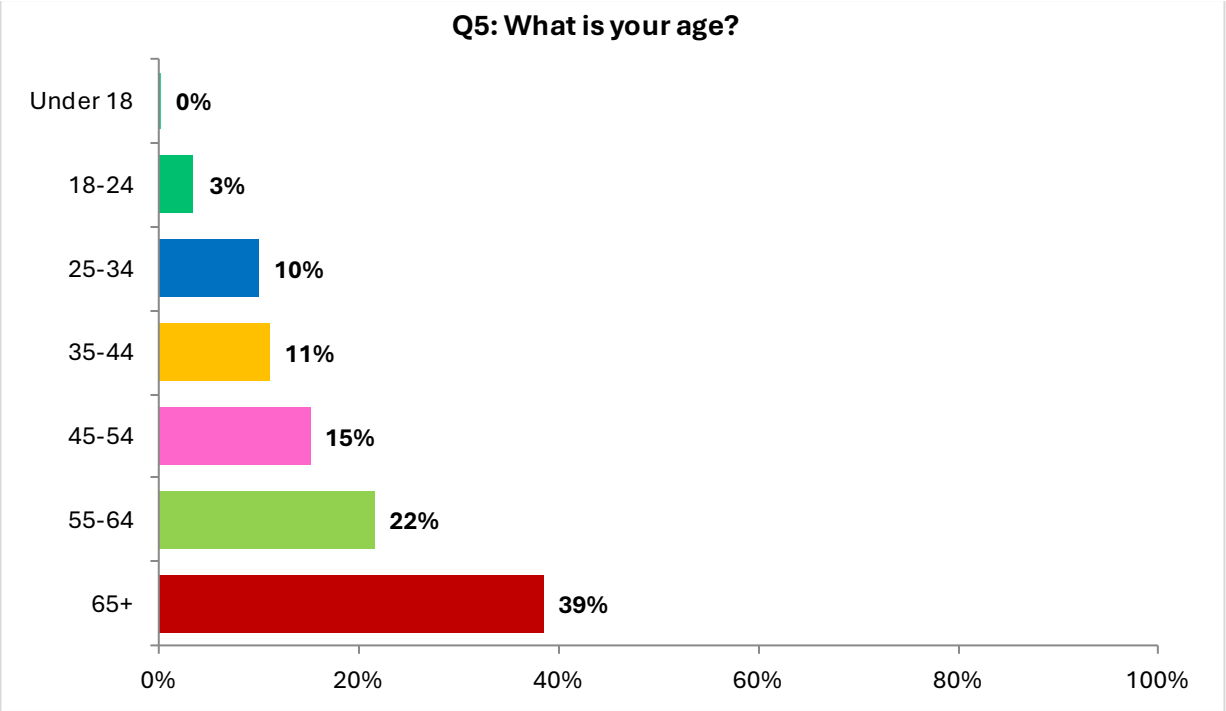


ANSWER CHOICES	RESPONSES	
Currituck County	27%	35
Camden County	25%	33
Pasquotank County	20%	26
Perquimans County	5%	6
Dare County	5%	6
Gates County	4%	5
Chowan County	2%	2
Hertford County	1%	1
Bertie County	1%	1
Tyrrell County	0%	0
Washington County	0%	0
TOTAL	**100%**	**116**

Question 4 of the survey is not portrayed here as it asked the respondents for Zip Codes.

Q5: What is your age?
Answered: 917 Skipped: 2

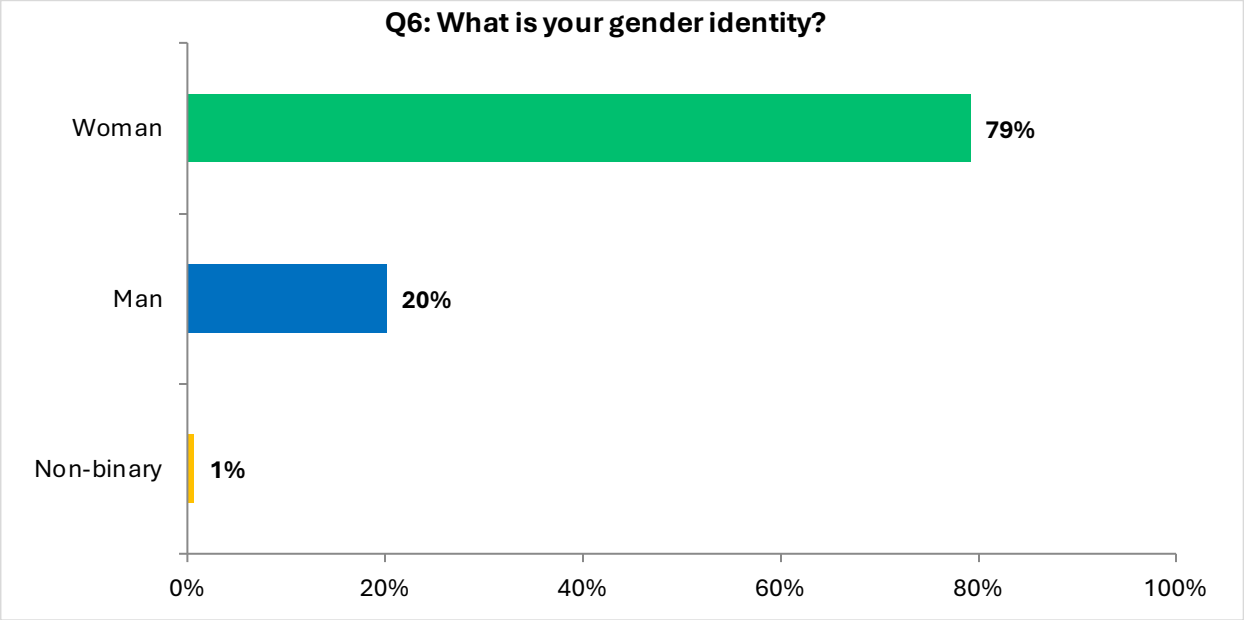
Respondents reflect all ranges, with senior citizens/retirees age 65 and over as the largest group of respondents and just one respondent in the 18–24-year-old group.



ANSWER CHOICES	RESPONSES	
Under 18	0.1%	1
18-24	4%	32
25-34	10%	92
35-44	11%	102
45-54	15%	139
65+	39%	353
TOTAL	**100%**	**917**

Q6: What is your gender identity?
Answered: 913 Skipped: 6

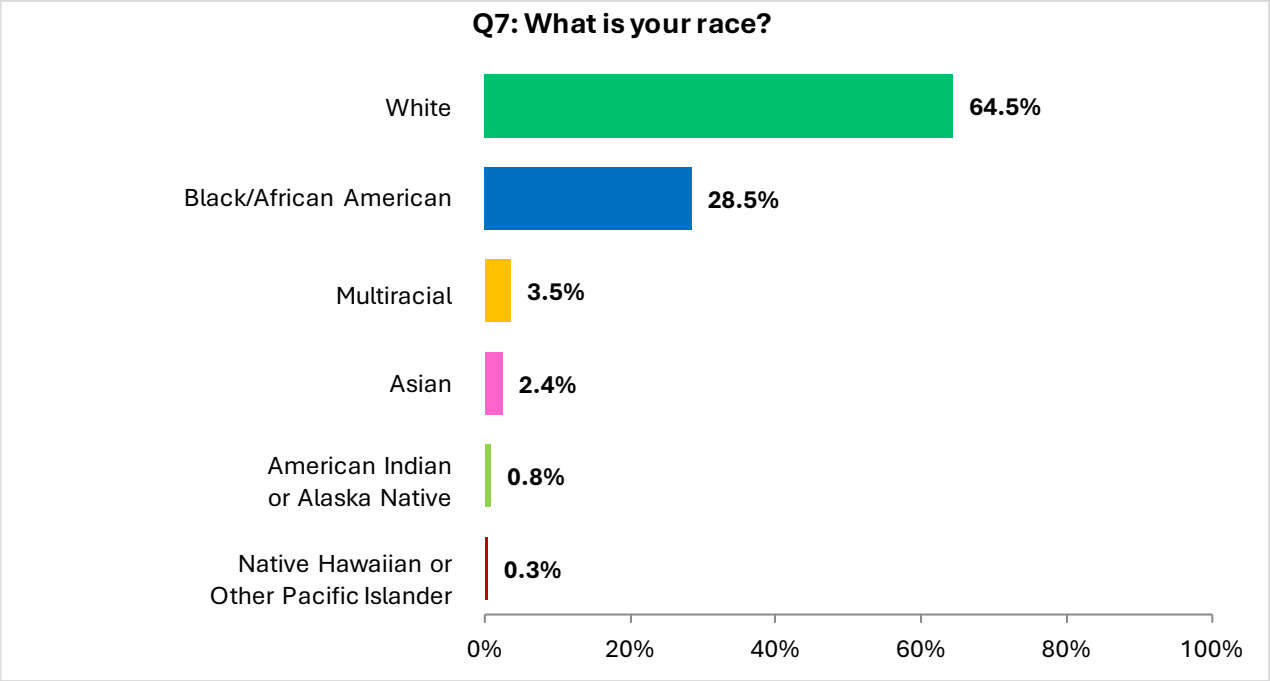
Survey respondents identified as 79% woman and 20% man. Six respondents identified as non-binary.



ANSWER CHOICES	RESPONSES	
Woman	79%	723
Man	20%	184
Non-binary	0.7%	6
TOTAL	**100%**	**913**

Q7: What is your race?
Answered: 878 Skipped: 41

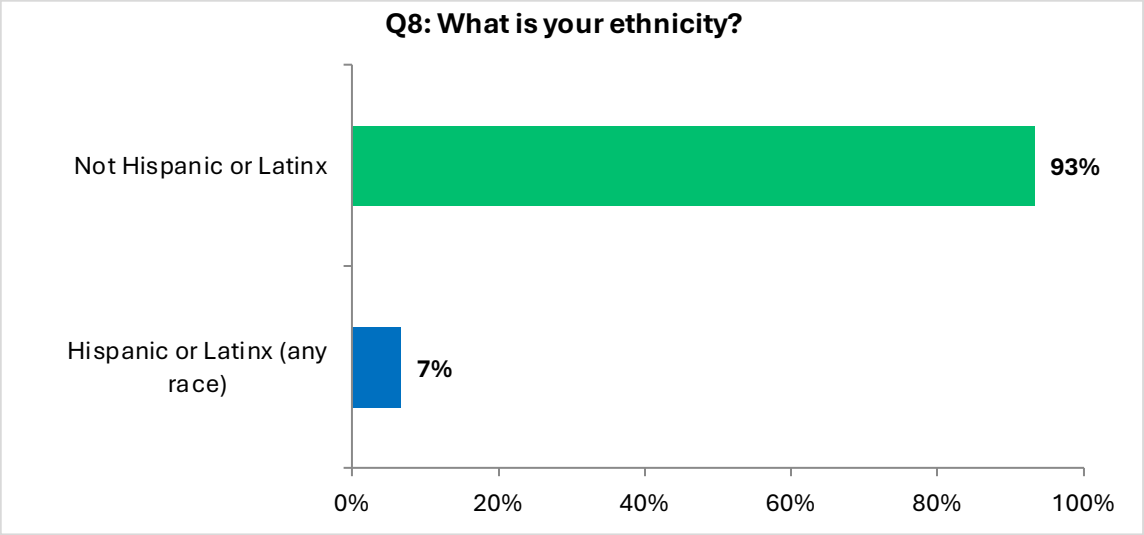
More than half of survey respondents were White (64%) and just over a quarter (28%) identified as Black/African American.



ANSWER CHOICES	RESPONSES	
White	64.5%	566
Black/African American	28.5%	250
Multiracial	3.5%	31
Asian	2.4%	21
American Indian or Alaska Native	0.8%	7
Native Hawaiian or Other Pacific Islander	0.3%	3
TOTAL	**100%**	**878**

Q8: What is your ethnicity?
Answered: 842 Skipped:77

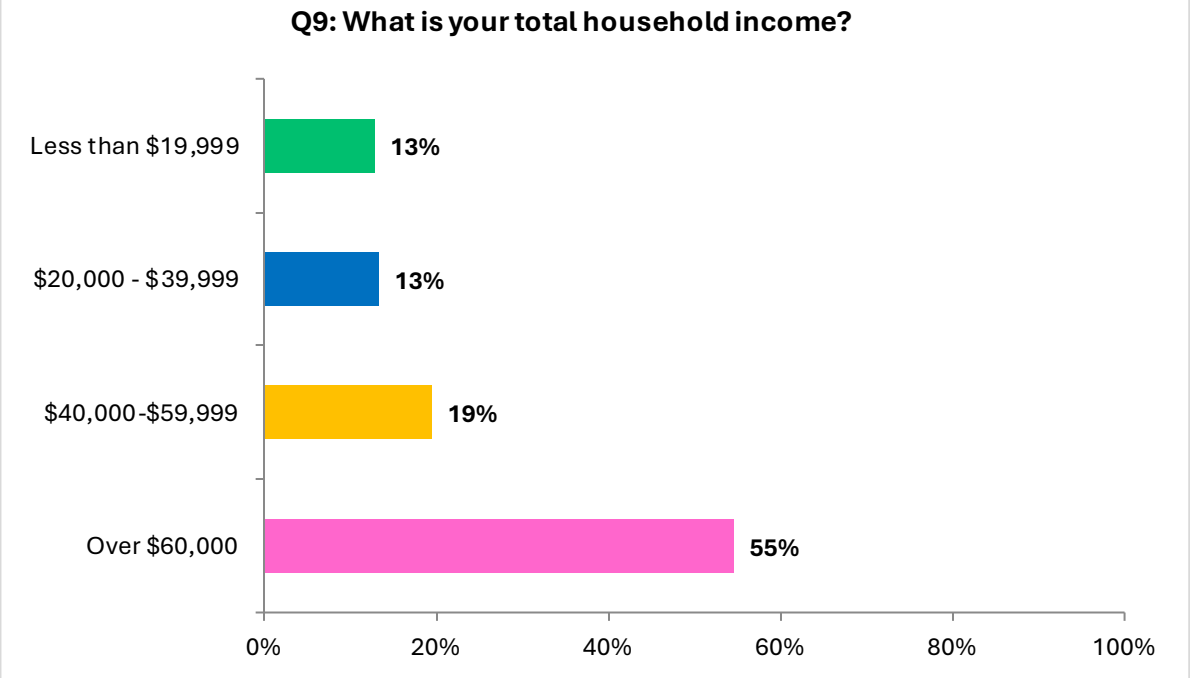
For this survey, ethnicity refers to those identifying as Hispanic or Latinx of any race; therefore, respondents to this question can be any of the races listed in Question 6. The 2025 survey was available in Spanish, and there were 13 respondents to the Spanish version of the survey. The percentage of Hispanic or Latinx respondents in 2025 was 7% compared to 17% in the 2021 CHNA survey.



ANSWER CHOICES	RESPONSES	
Non-Hispanic or Latinx	93%	786
Hispanic or Latinx	7%	56
TOTAL	**100%**	**842**

Q9: What is your total household income?
Answered: 860 Skipped:59

Approximately one quarter of respondents (26%) reported earning less than $40,000 per year, and nearly three quarters (74%) reported earning over $40,000 per year.

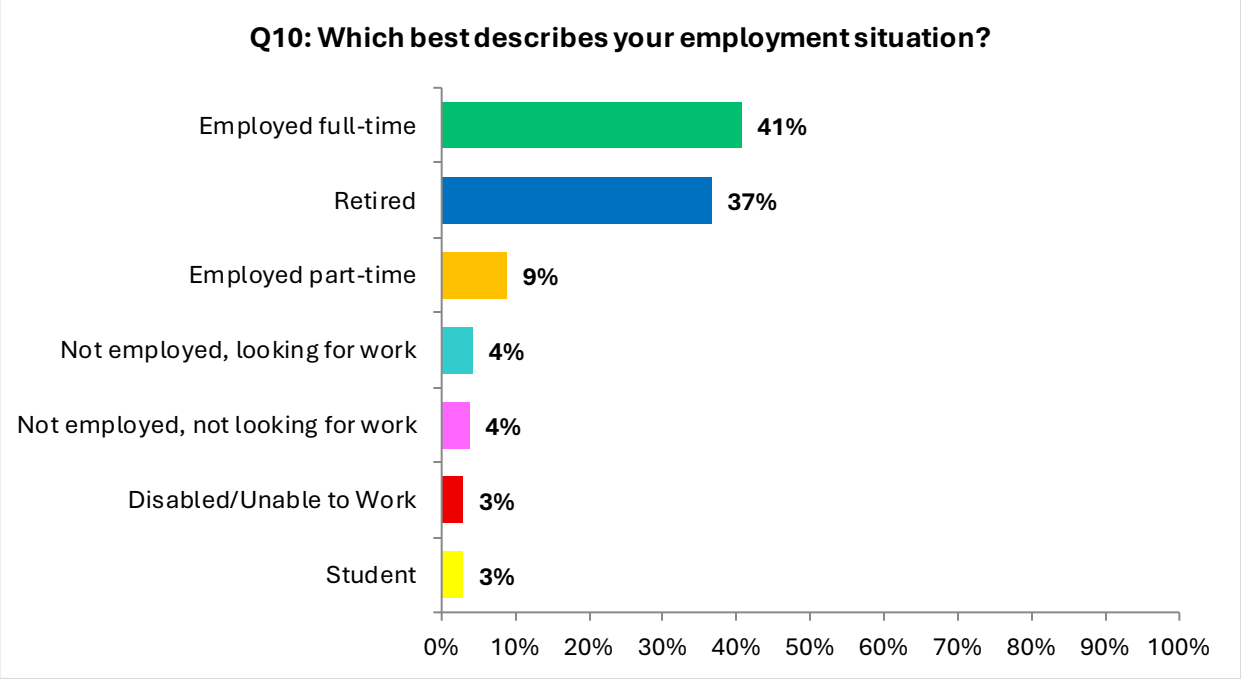


ANSWER CHOICES	RESPONSES	
Less than $19,000	13%	110
$20,000 to $39,000	13%	114
$40,000 to $59,000	19%	167
Over $60,000	55%	469
TOTAL	**100%**	**860**

Q10: Which best describes your employment situation?
Answered: 868 Skipped:51

Respondents could select all that apply to their employment situation, and many selected more than one answer. Most respondents were employed full-time (44%), with 39% retired, 9% employed part-time and 3% disabled and unable to work.

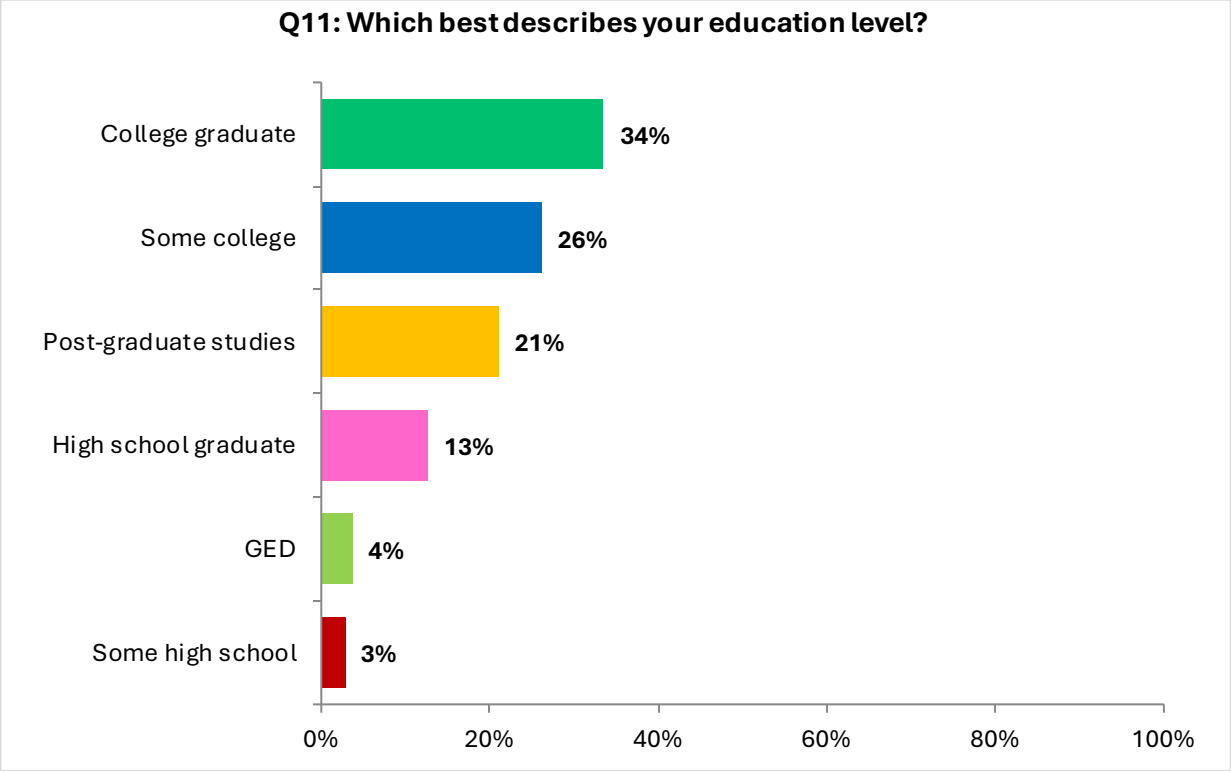
Those who are *not employed and not looking* for work are not considered unemployed or in the workforce, while those who are *not employed, looking for work* are in the unemployed category.



ANSWER CHOICES	RESPONSES	
Employed full-time	41%	379
Retired	37%	341
Employed part-time	9%	82
Not employed, looking for work	4%	39
Not employed, not looking for work	4%	35
Disabled/Unable to Work	3%	27
Student	3%	27
TOTAL	**100%**	**930**

Q11: Which best describes your education level?
Answered: 903 Skipped:16

College graduates (34%) were the largest group of respondents. Twenty-six percent reported having some college. There were more respondents with post-graduate studies (21%) than those with only a high school diploma or GED (17%).



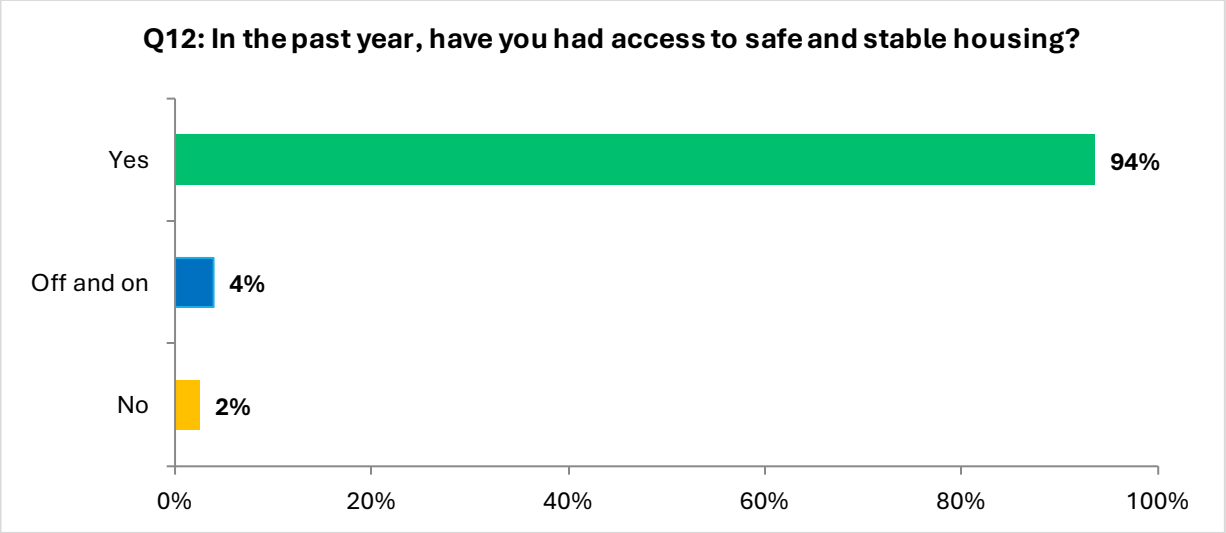
ANSWER CHOICES	RESPONSES	
College Graduate	33%	303
Some College	26%	236
Post-Graduate Studies	21%	190
High School Graduate	13%	114
GED	4%	34
Some High School	3%	26
TOTAL	**100%**	**903**

QUALITY OF LIFE and ACCESS TO CARE

Q12: In the past year, have you had access to safe and stable housing?
Answered:892 Skipped:27

Research shows that housing is a critical social determinant of health, significantly impacting physical and mental well-being. Poor quality, unaffordable, or unstable housing can lead to a range of health issues, while adequate, safe, and affordable housing can promote positive health outcomes. To assess how residents of each neighborhood are faring on this issue, the graph below shows whether survey respondents had access to safe and stable housing in the past year.

Residents from Camelot reported having the greatest difficulty accessing safe and stable housing, with 17% of survey respondents answering either *Off and On,* or *No*. By contrast, none of the respondents from Rivercrest answered *Off and On*, or *No*.

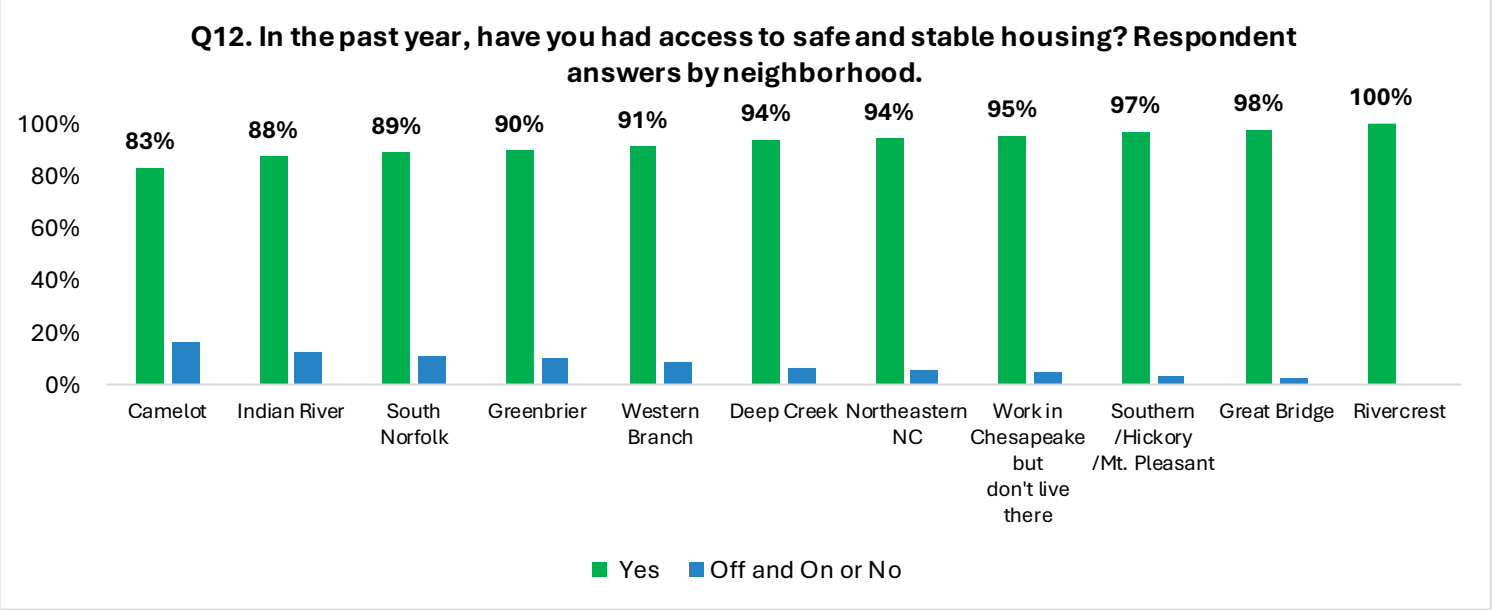


ANSWER CHOICES	RESPONSES	
Yes	94%	835
Off and on	4%	35
No	2%	22
TOTAL	**100%**	**892**

The graphs and tables on the following pages demonstrate how respondents answered the **Quality of Life** and **Access to Care** questions by race, neighborhood, and income level.

Q12. Able to access safe and stable housing by NEIGHBORHOOD
Answered:892 Skipped:27

The graph below shows the percentage of survey respondents by neighborhood who answered *Yes, Off and On*, or *No* regarding access to safe and stable housing. In all neighborhoods, at least 83% or more of respondents were able to access safe and stable housing. Respondents living in Camelot reported the highest percentage of people accessing housing off and on.

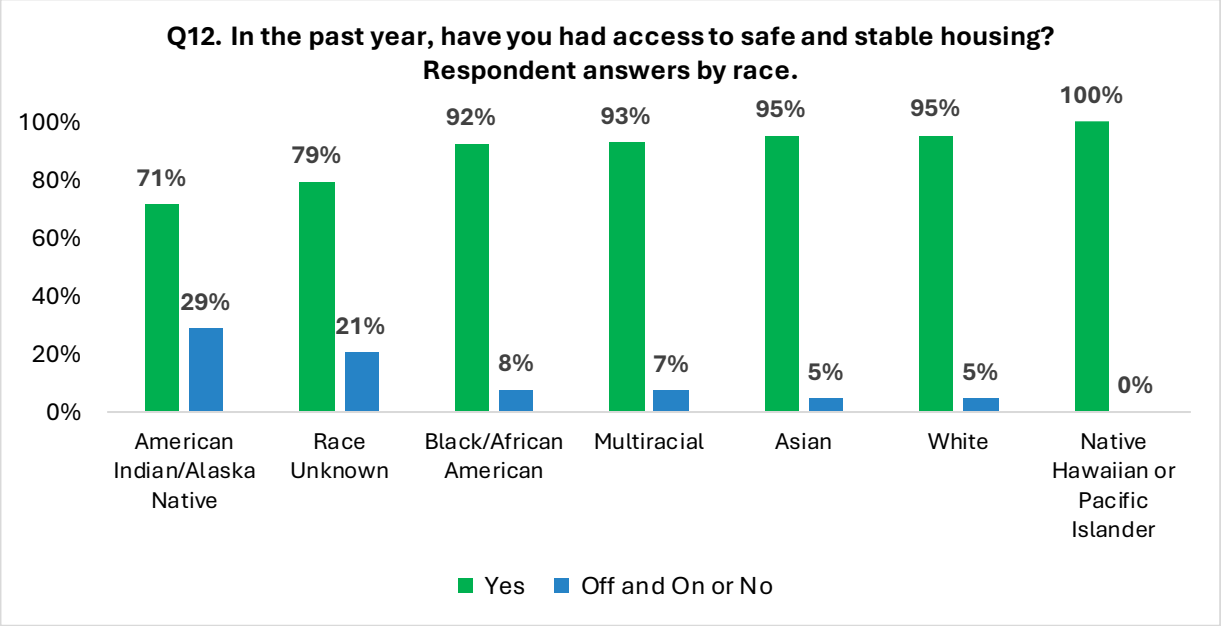


Neighborhood	% Yes	% Off and On or No	# Yes	# Off and on/No	# Respondents
Camelot	83%	17%	10	2	12
Indian River	88%	13%	28	4	32
South Norfolk	89%	11%	65	8	73
Greenbrier	90%	10%	138	16	154
Western Branch	91%	9%	21	2	23
Deep Creek	94%	6%	78	5	83
Northeastern NC	94%	6%	102	6	108
Work in Chesapeake but don't live there	95%	5%	102	5	107
Southern/Hickory /Mt. Pleasant	97%	3%	66	2	68
Great Bridge	98%	2%	169	4	173
Rivercrest	100%	0%	13	0	13
Residence not provided	93%	7%	43	3	46
TOTAL	**94%**	**6%**	**835**	**57**	**892**

Q12. Able to access safe and stable housing by RACE
Answered:892 Skipped:27

To assess any potential racial disparities in the ability to access safe and stable housing, the graph below shows respondent answers by race.

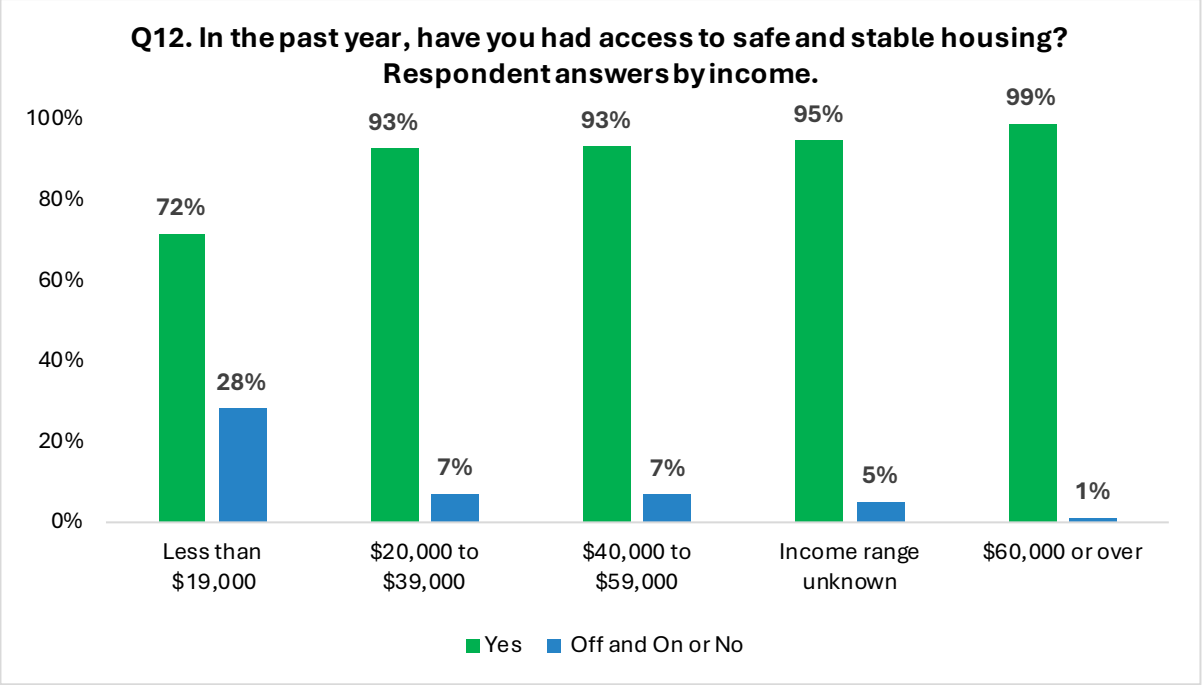
Although the sample size of American Indian/Alaska Native respondents is small, a greater percentage of this population (29%) reported difficulty accessing safe and stable housing in the past year. Similarly, 21% of respondents of unknown race answered "no" or "off and on" to this question. Over 90% of respondents of other races reported that they were able to access safe and stable housing.



Race	% Yes	% Off and On or No	# Yes	# Off and On or No	# Respondents
American Indian/Alaska Native	71%	29%	5	2	7
Race Unknown	79%	21%	27	7	34
Black/African American	92%	8%	228	19	247
Multiracial	93%	7%	25	2	27
Asian	95%	5%	20	1	21
White	95%	5%	527	26	553
Native Hawaiian or Pacific Islander	100%	0%	3	0	3
TOTAL	**94%**	**6%**	**835**	**57**	**892**

Q12. Able to access safe and stable housing by INCOME
Answered:892 Skipped:27

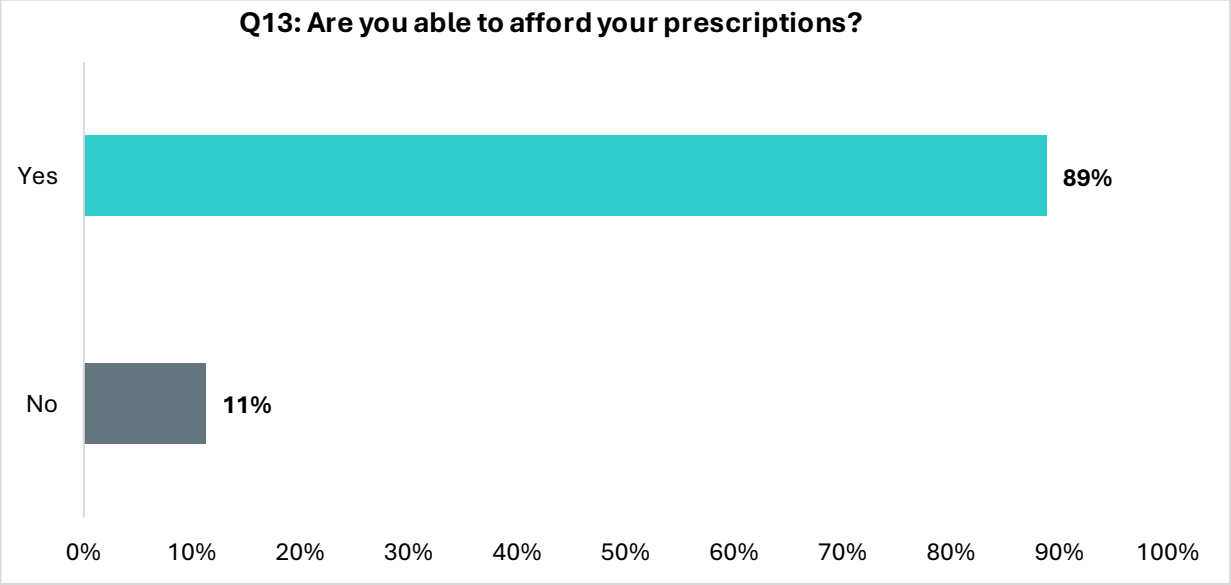
It is not surprising that respondents earning less than $19,000 per year would report more difficulty accessing safe and stable housing than those in higher income ranges. However, it is interesting to note that some respondents(5% to 7%) in higher income ranges still report a lack of access to adequate housing.



Income	% Yes	% Off and On or No	# Yes	# Off and On or No	# Respondents
Less than $19,000	72%	28%	76	30	106
$20,000 to $39,000	93%	7%	102	8	110
$40,000 to $59,000	93%	7%	150	11	161
$60,000 or over	99%	1%	453	5	458
Income range unknown	95%	5%	54	3	57
TOTAL	**94%**	**6%**	**835**	**57**	**892**

Q13: ARE YOU ABLE TO AFFORD YOUR PRESCRIPTIONS?
Answered:889 Skipped:30

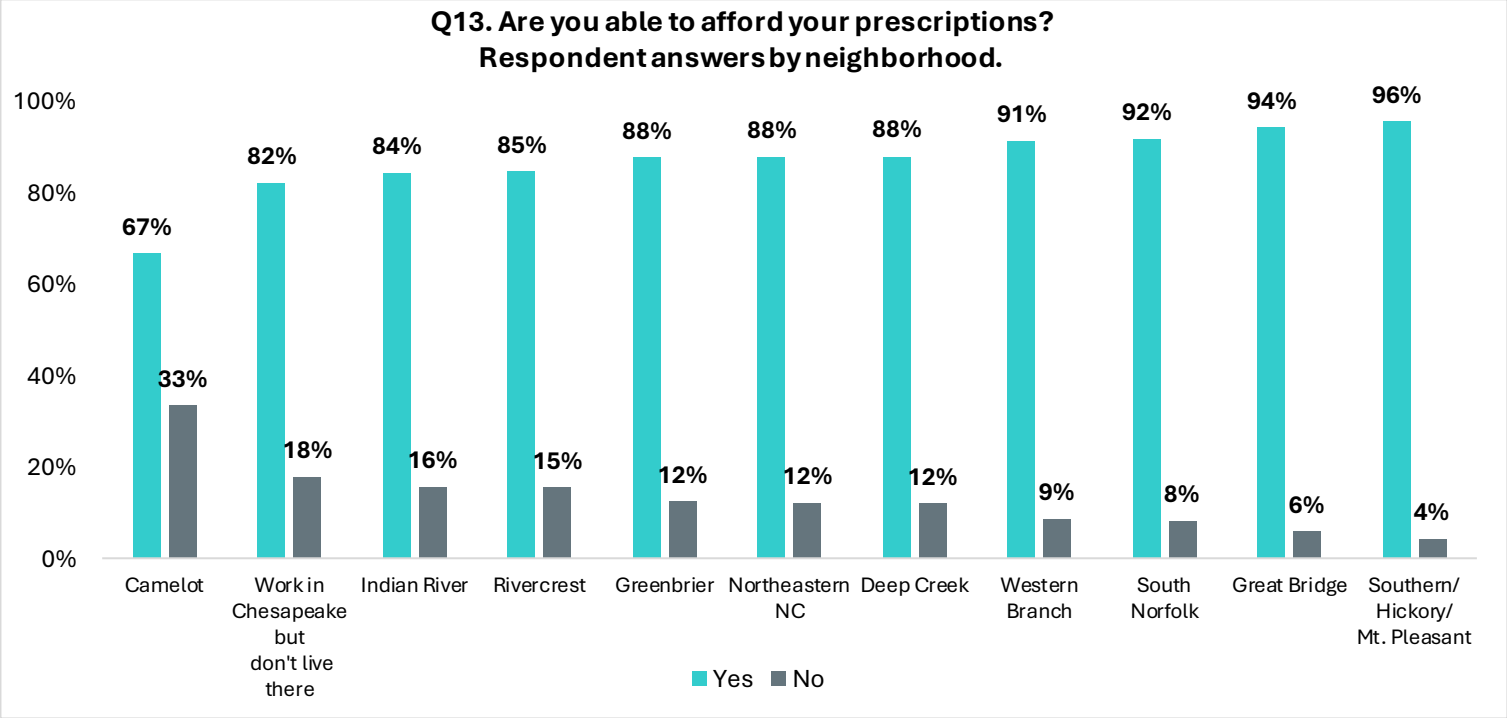
Almost 90% of respondents answered Yes to being able to afford prescriptions. However, the graphs and tables that follow provide a breakdown by neighborhood, race/ethnicity, and income level to identify any population that struggles with this expense.



ANSWER CHOICES	RESPONSES		CHNA 2021
Yes	89%	789	⇔ 90%
No	11%	100	⇔ 10%
TOTAL	**100%**	**889**	**100%**

Q13. Affordability of Prescriptions by NEIGHBORHOOD
Answered:889 Skipped:30

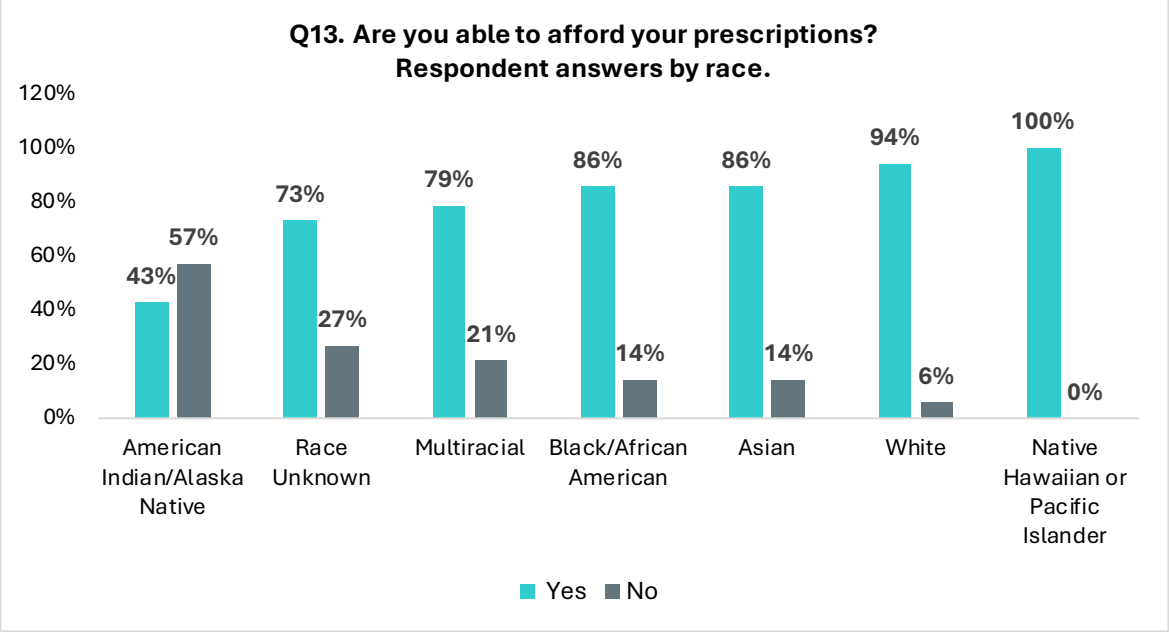
Respondents from Camelot indicate a greater inability to afford prescriptions than those in other neighborhoods.



Neighborhood	% Yes	% No	# Yes	# No	# Respondents
Camelot	67%	33%	8	4	12
Work in Chesapeake but don't live there	82%	18%	88	19	107
Indian River	84%	16%	27	5	32
Rivercrest	85%	15%	11	2	13
Greenbrier	88%	12%	134	19	153
Northeastern NC	88%	12%	109	15	124
Deep Creek	88%	12%	73	10	83
Western Branch	91%	9%	21	2	23
South Norfolk	92%	8%	67	6	73
Great Bridge	94%	6%	162	10	172
Southern/ Hickory/ Mt. Pleasant	96%	4%	65	3	68
Residence not provided	83%	17%	24	5	29
TOTAL	**89%**	**11%**	**789**	**100**	**889**

Q13. Affordability of Prescriptions by RACE
Answered:889 Skipped:30

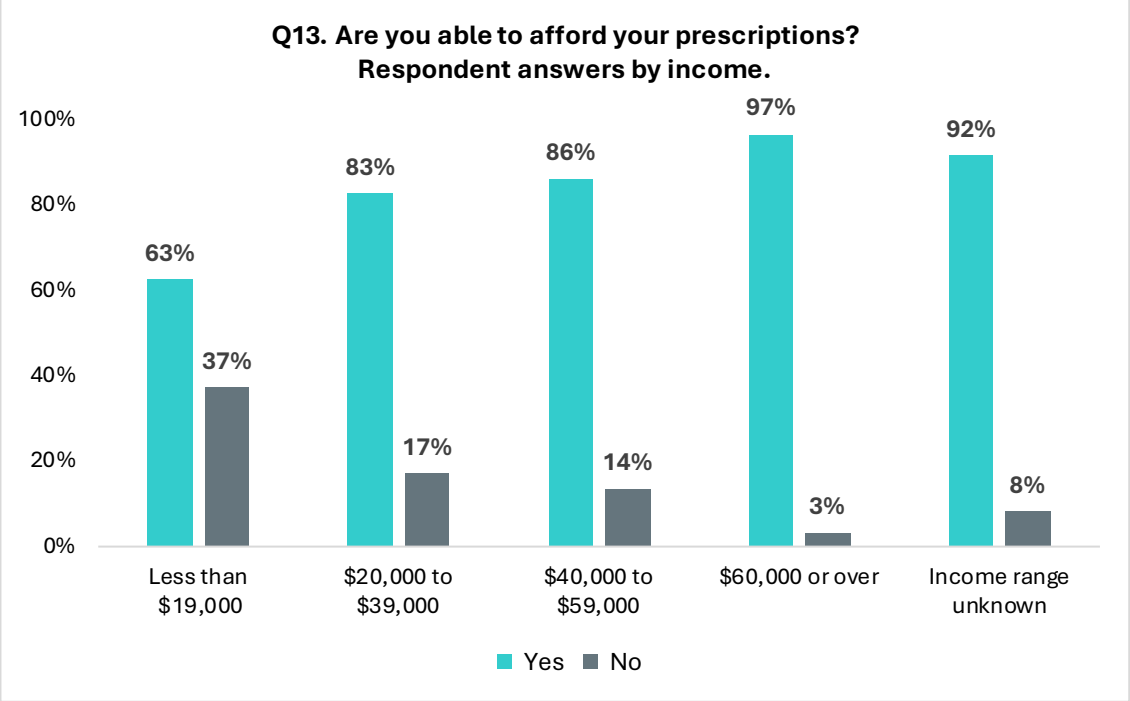
Although the sample size of just seven respondents is small, those identifying as American Indian/Native Alaskan had the highest percentage (57%) of not being able to afford prescriptions. Twenty-seven percent (27%) of those who did not identify their race reported being unable to afford their medicine, followed by 21% of Multiracial respondents, 14% of Black/African Americans and 6% of Whites.



Race	% Yes	% No	# Yes	# No	# Respondents
American Indian/Alaska Native	43%	57%	3	4	7
Race Unknown	73%	27%	27	10	37
Multiracial	79%	21%	22	6	28
Black/African American	86%	14%	213	36	249
Asian	86%	14%	18	3	21
White	94%	6%	513	31	544
Native Hawaiian or Pacific Islander	100%	0%	3	0	3
TOTAL	**89%**	**11%**	**799**	**90**	**889**

Q13. Affordability of Prescriptions by INCOME
Answered:889 Skipped:30

Not surprisingly, the lowest income group reported the highest percentage (37%) of not being able to afford prescriptions. The percentage of those unable to afford prescriptions decreased as income increased.

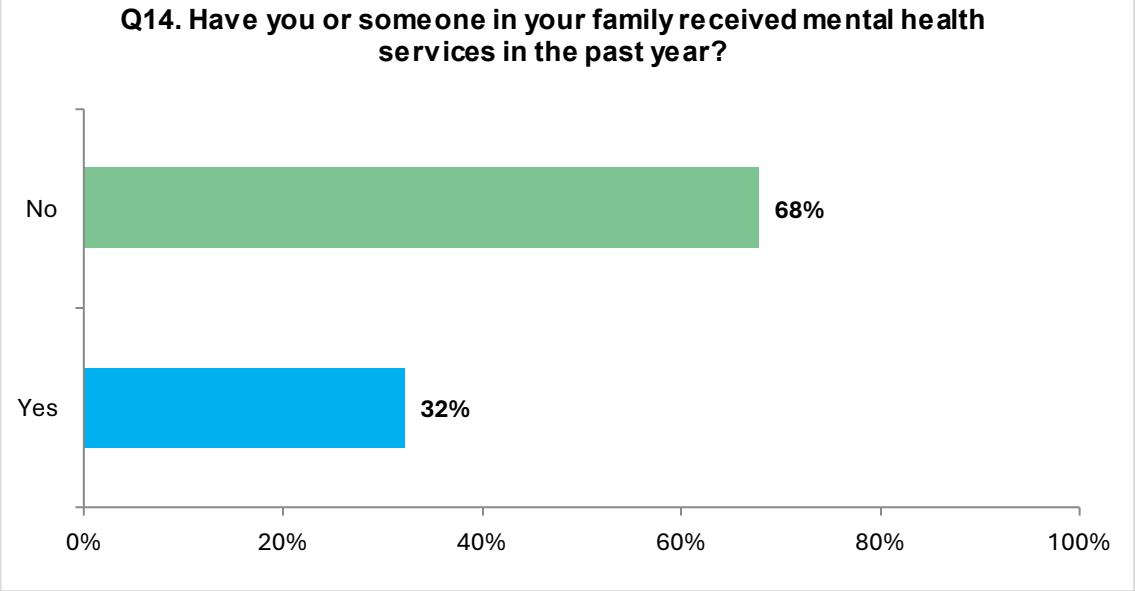


Income	% Yes	% No	# Yes	# No	# Respondents
Less than $19,000	63%	37%	67	40	107
$20,000 to $39,000	83%	17%	92	19	111
$40,000 to $59,000	86%	14%	140	22	162
$60,000 or over	97%	3%	446	15	461
Income range unknown	92%	8%	44	4	48
TOTAL	**89%**	**11%**	**789**	**100**	**889**

Q14: HAVE YOU OR SOMEONE IN YOUR FAMILY RECEIVED MENTAL HEALTH SERVICES IN THE PAST YEAR?

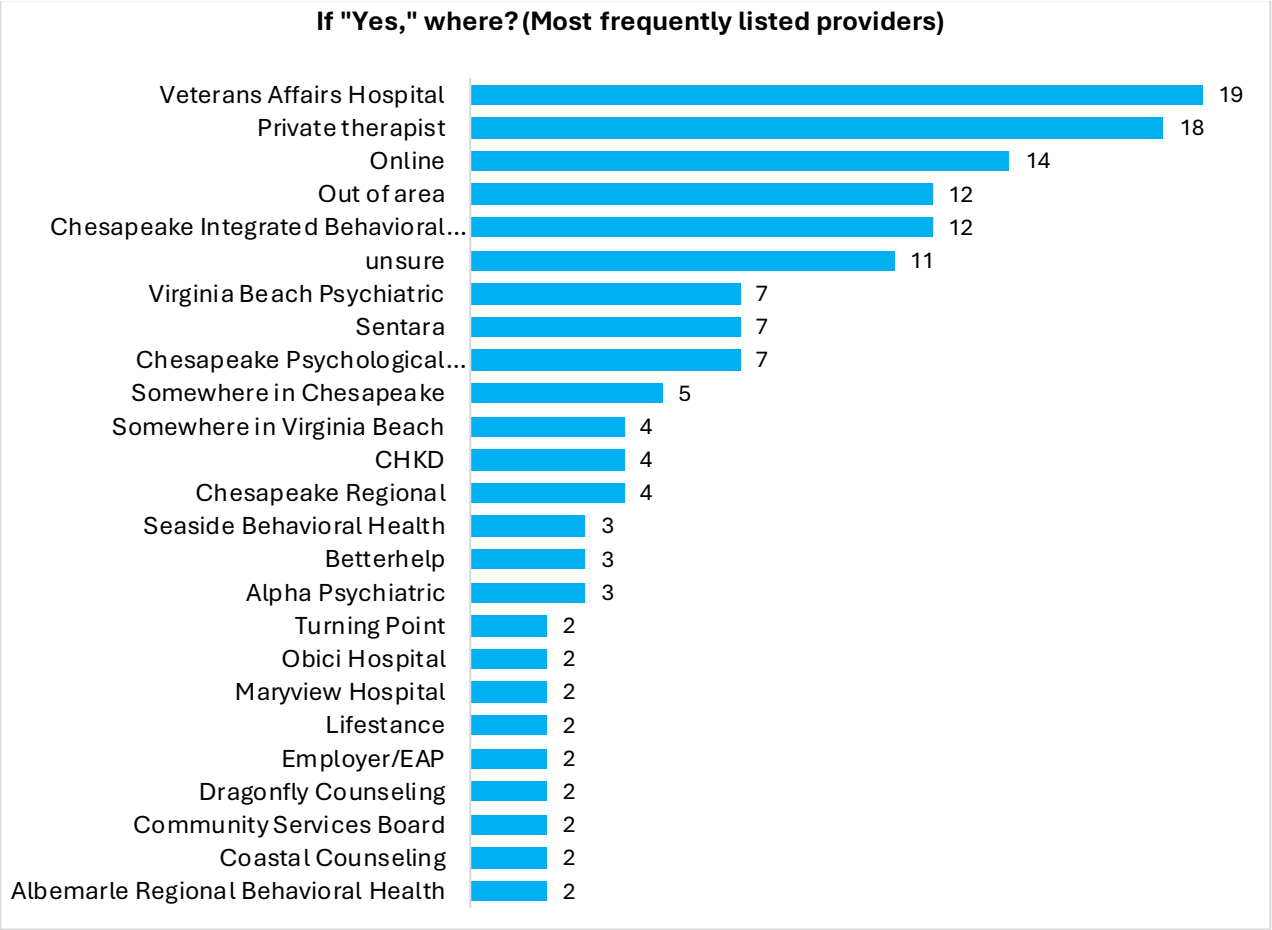
Answered:891 Skipped:28

Of 919 survey responses, 604 (68%) reported that no one in the family received mental health services in the past year, and 287 (32%) reported either self or a family member receiving mental health services. The number of those receiving services is slightly higher than in the 2021 CHNA survey in which just 27% answered Yes, and 73% answered No.



ANSWER CHOICES	PERCENT	NUMBER	CHNA 2021
Yes	32%	287	↑ 27%
No	68%	604	↓ 73%
TOTAL	**100%**	**891**	**100%**

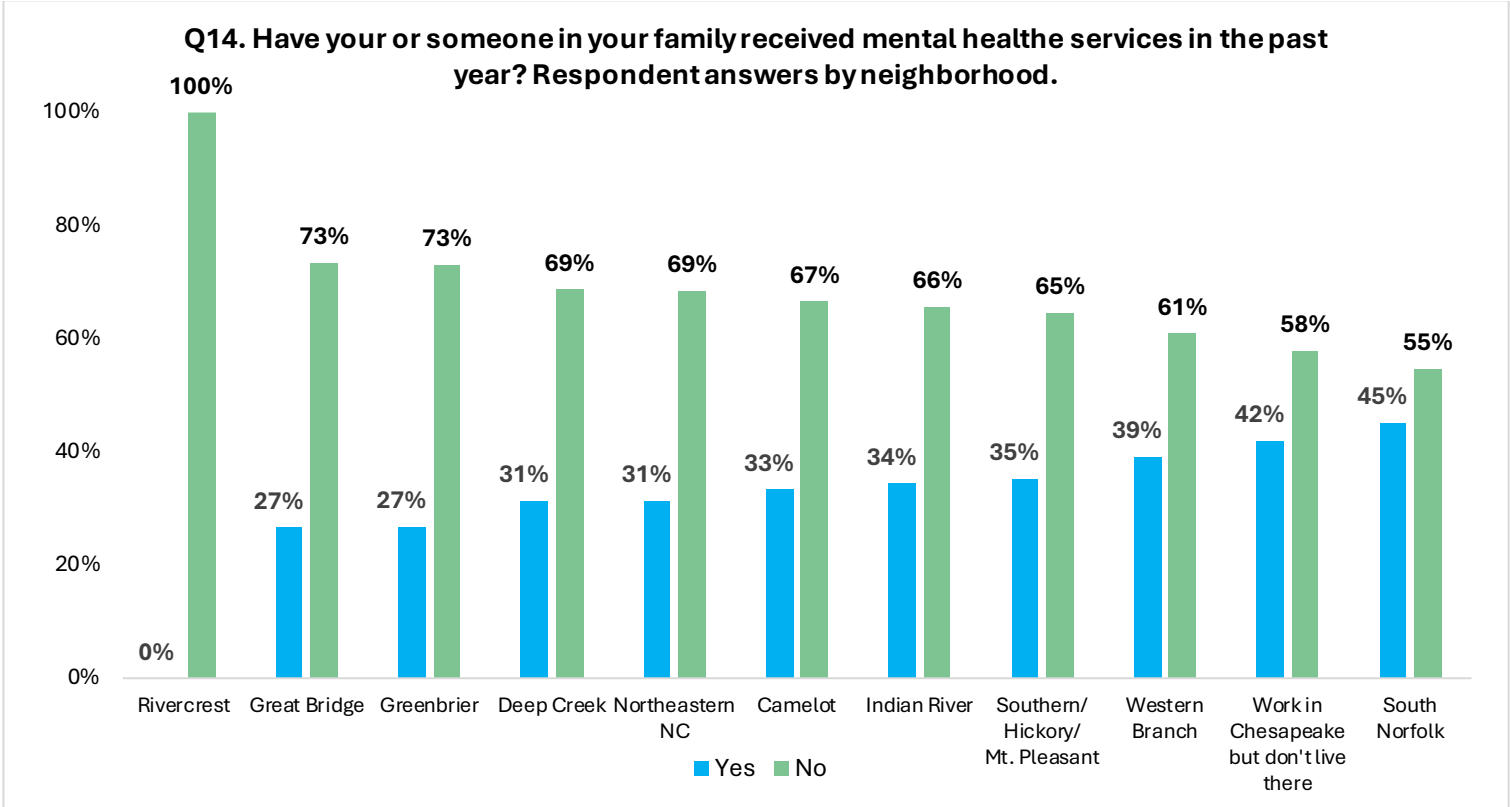
Of those who answered Yes to the question, the table below indicates the practice or location where mental health services were accessed.



Additional Mental Health Providers Listed (Providers below were listed one time)			
All Heart Psychiatric	Federal probation	Kempsville Center for Behavioral Health	Restorer of Broken Walls
Chesapeake Health Department	Gateway Community Services	Leva Psychiatric	Roots and Connections
Church	Grow Therapy	Lighthouse Counseling	SonderMind
Churchland Psychology	Haven Mental Wellness	Mermaid Counseling	Thrive
CSW in Churchland	Hopewell Counseling	Piece by Piece	Transformation Health
EVMS	Integrated Minds	Pride	Tricare

Q14. Mental Health Services by NEIGHBORHOOD
Answered:891 Skipped:28

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.

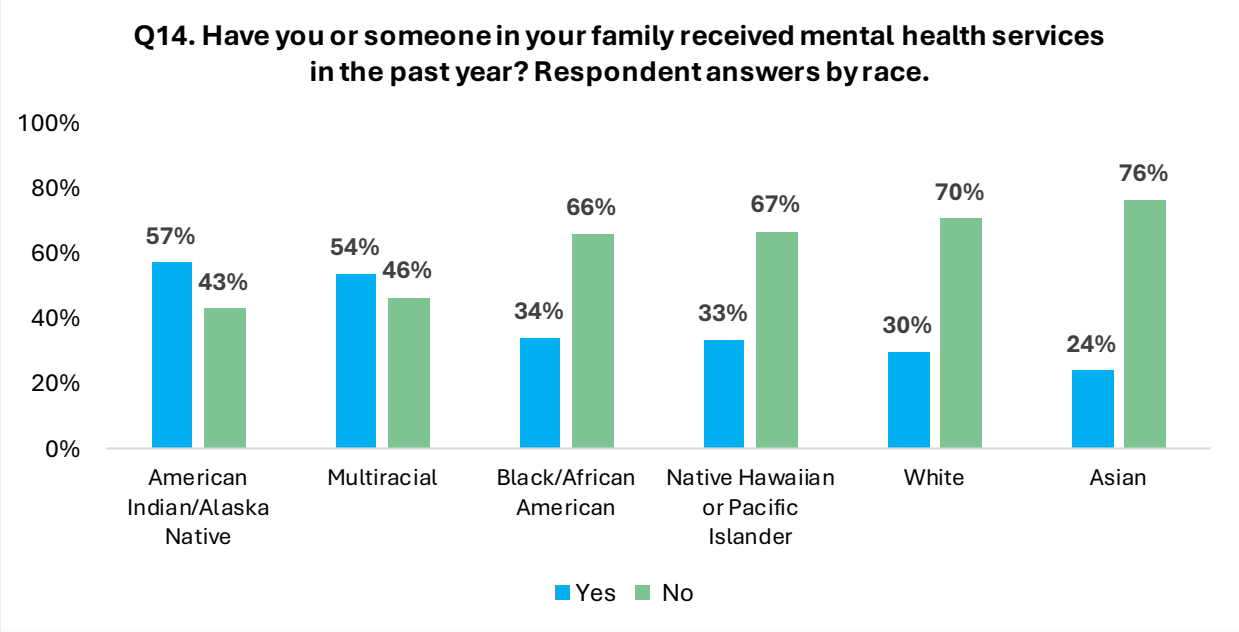


Neighborhood	% Yes	% No	# Yes	# No	# Respondents
Rivercrest	0%	100%	0	13	13
Great Bridge	27%	73%	46	127	173
Greenbrier	27%	73%	41	112	153
Deep Creek	31%	69%	26	57	83
Northeastern NC	31%	69%	39	85	124
Camelot	33%	67%	4	8	12
Indian River	34%	66%	11	21	32
Southern/ Hickory/Mt. Pleasant	35%	65%	24	44	68
Western Branch	39%	61%	9	14	23
Work in Chesapeake but don't live there	42%	58%	45	62	107
South Norfolk	45%	55%	33	40	73
Residence not provided	30%	70%	9	21	30
TOTAL	**32%**	**68%**	**287**	**604**	**891**

Q14. Mental Health Services by RACE
Answered:891 Skipped:28

Although the total number of American Indian/Alaska Native respondents is small, this population reported the highest percentage (57%) of receiving mental health services followed by Multiracial (54%), Black/African American (34%), Native Hawaiian/Pacific Islander (33%), White, (30%) and Asian (24%).

According to the U.S. Department of Health and Human Services, the American Indian/Alaska Native (AI/AN) demographic has higher rates of mental health conditions, such as depression, anxiety, post-traumatic stress disorder, suicide, and substance use disorders, than the general population. These problems are often linked to historical trauma, discrimination, and poverty.

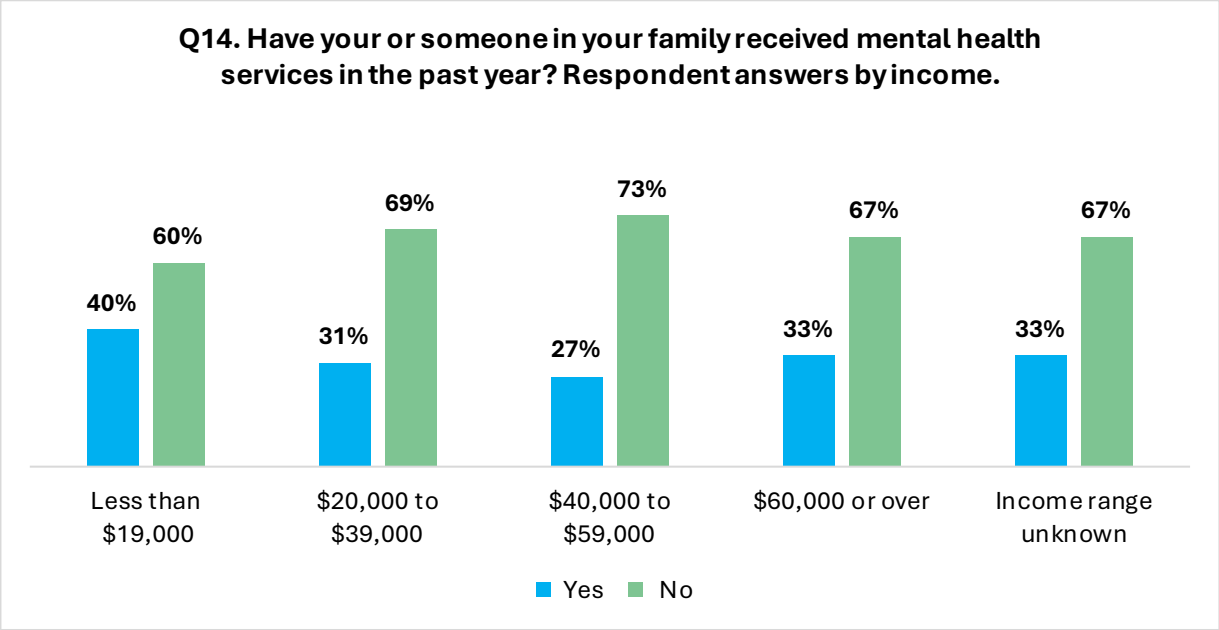


Race	% Yes	% No	#Yes	# No	# Respondents
American Indian/Alaska Native	57%	43%	4	3	7
Multiracial	54%	46%	15	13	28
Black/African American	34%	66%	83	161	244
Native Hawaiian or Pacific Islander	33%	67%	1	2	3
White	30%	70%	164	390	554
Asian	24%	76%	5	16	21
Race Unknown	44%	56%	15	19	34
TOTAL	**32%**	**68%**	**287**	**604**	**891**

Q14. Mental Health Services by INCOME
Answered:891 Skipped:28

Between the income levels, there is a13-percentage point difference in respondents who reported self or family member receiving mental health services, from 40% of those earning less than $19,000 to 27% among those earning $27,000.

However, as seen in the previous two graphs, there is a thirty-three-percentage point difference among races and an 18-percentage point difference among various neighborhoods. This data may highlight a key theme that race may have a greater impact than neighborhood and income on who accesses mental health services.

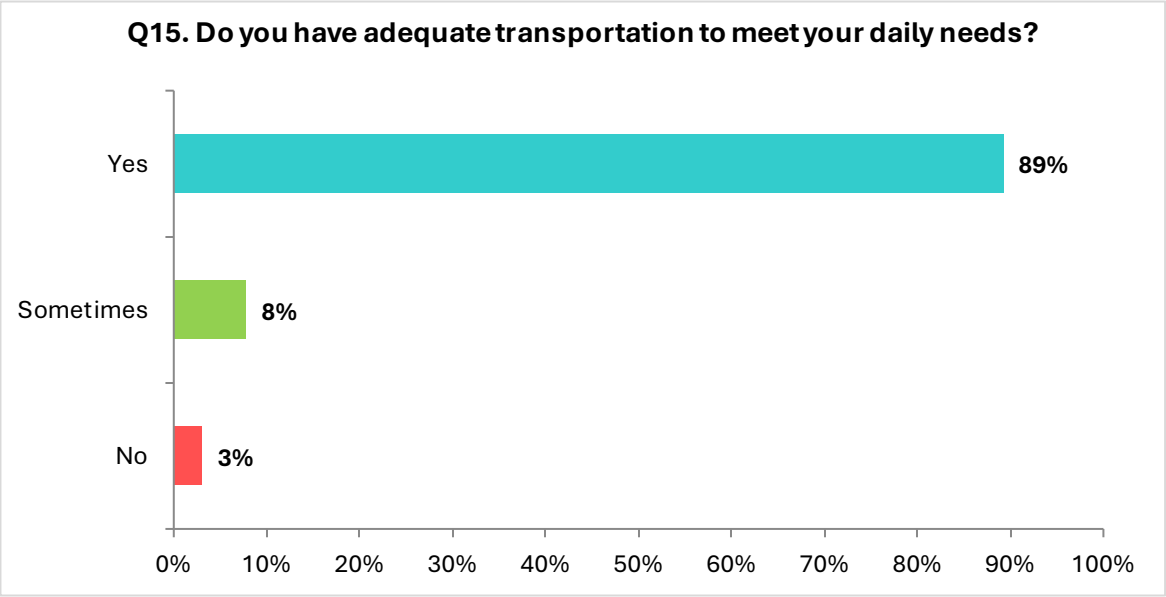


Income	% Yes	% No	# Yes	# No	# Respondents
Less than $19,000	40%	60%	43	64	107
$20,000 to $39,000	31%	69%	34	77	111
$40,000 to $59,000	27%	73%	43	119	162
$60,000 or over	33%	67%	151	311	462
Income range unknown	33%	67%	16	33	49
TOTAL	**32%**	**68%**	**287**	**604**	**891**

Q15: DO YOU HAVE ADEQUATE TRANSPORTATION TO MEET YOUR DAILY NEEDS?
Answered:892 Skipped:27

According to the American Hospital Association, "Transportation issues can affect a person's access to health care services. These issues may result in missed or delayed health care appointments, increased health expenditures and overall poorer health outcomes. Transportation also can be a vehicle for wellness. Developing affordable and appropriate transportation options, walkable communities, bike lanes, bike-share programs and other healthy transit options can help boost health.[10]

Most survey respondents (89%) reported adequate transportation while 8% reported having it sometimes, and 3% reported not having adequate transportation.

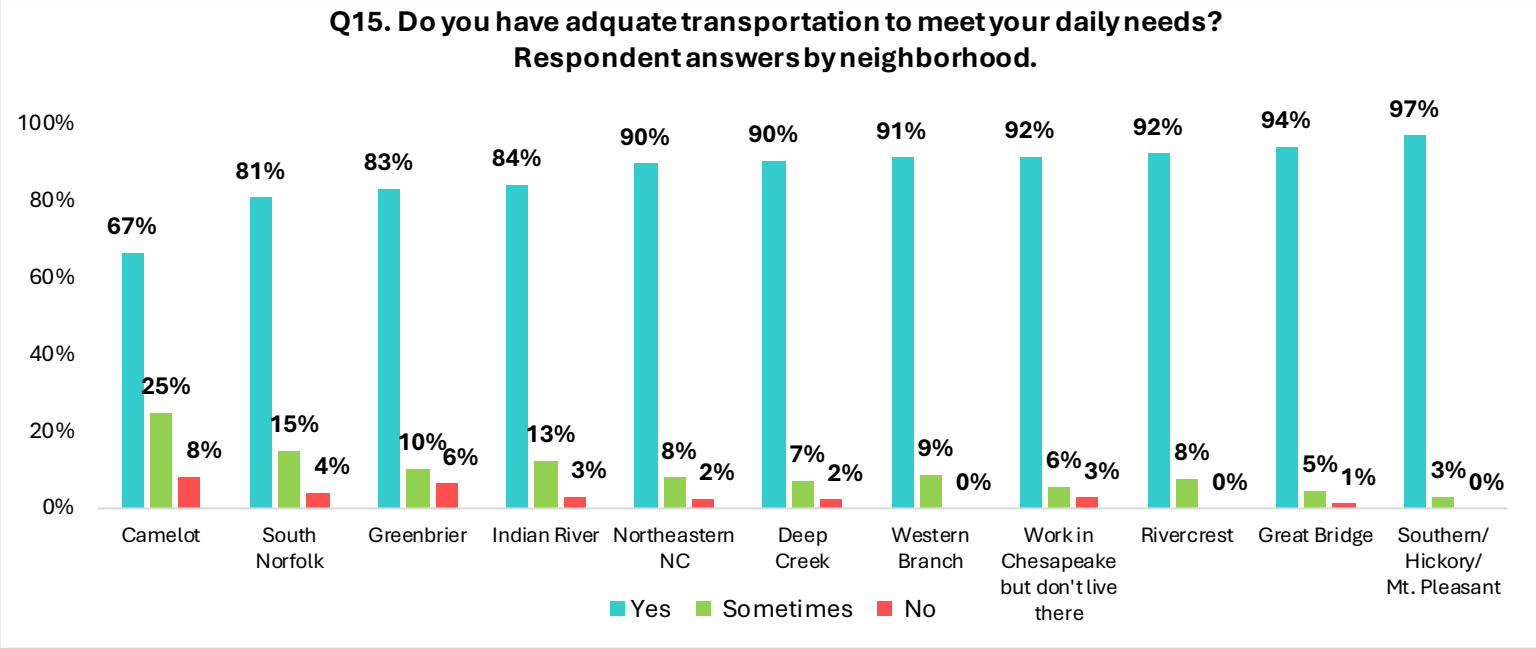


ANSWER CHOICES	PERCENT	NUMBER
Yes	89%	796
Sometimes	8%	69
No	3%	27
Total	**100%**	**892**

[10] American Hospital Association. 2025. Accessed at https://www.aha.org/ahahret-guides/2017-11-15-social-determinants-health-series-transportation-and-role-hospitals#:~:text=Because%20transportation%20touches%20many%20aspects,options%20can%20help%20boost%20health

Q15: Adequate Transportation by NEIGHBORHOOD
Answered:892 Skipped:27

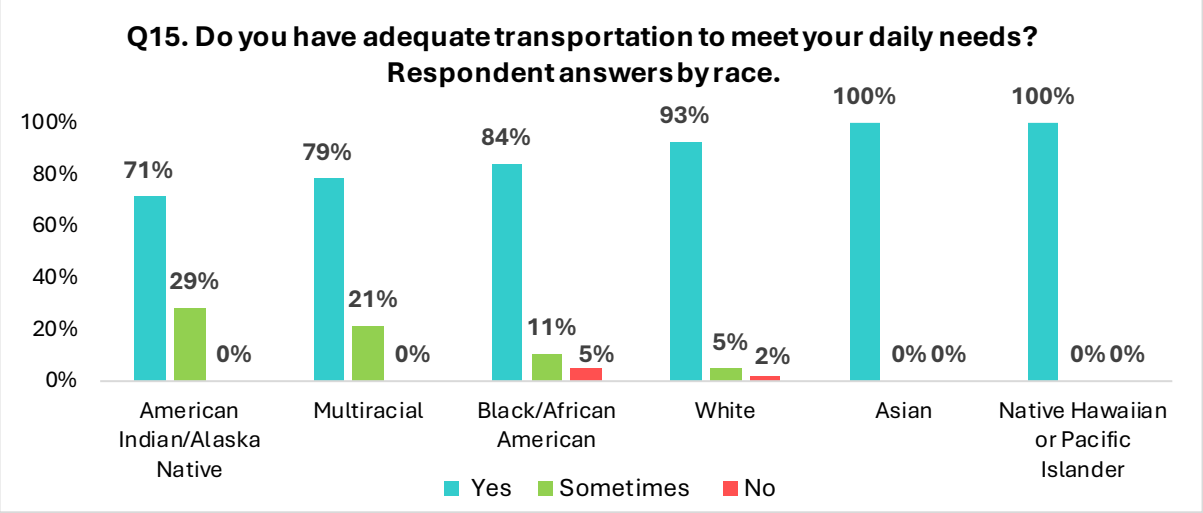
A smaller percentage of respondents living in Camelot (67%) reported having adequate transportation compared to 81% or more in all other locations.



Neighborhood	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
Camelot	67%	25%	8%	8	3	1	12
South Norfolk	81%	15%	4%	59	11	3	73
Greenbrier	83%	10%	6%	128	16	10	154
Indian River	84%	13%	3%	27	4	1	32
Northeastern NC	90%	8%	2%	112	10	3	125
Deep Creek	90%	7%	2%	76	6	2	84
Western Branch	91%	9%	0%	21	2	0	23
Work in Chesapeake but don't live there	92%	6%	3%	97	6	3	106
Rivercrest	92%	8%	0%	12	1	0	13
Great Bridge	94%	5%	1%	162	8	2	172
Southern/Hickory/ Mt. Pleasant	97%	3%	0%	66	2	0	68
Residence not provided	3%	0%	0%	28	0	2	30
TOTAL	**89%**	**8%**	**3%**	**796**	**69**	**27**	**892**

Q15: Adequate Transportation by RACE
Answered:892 Skipped:27

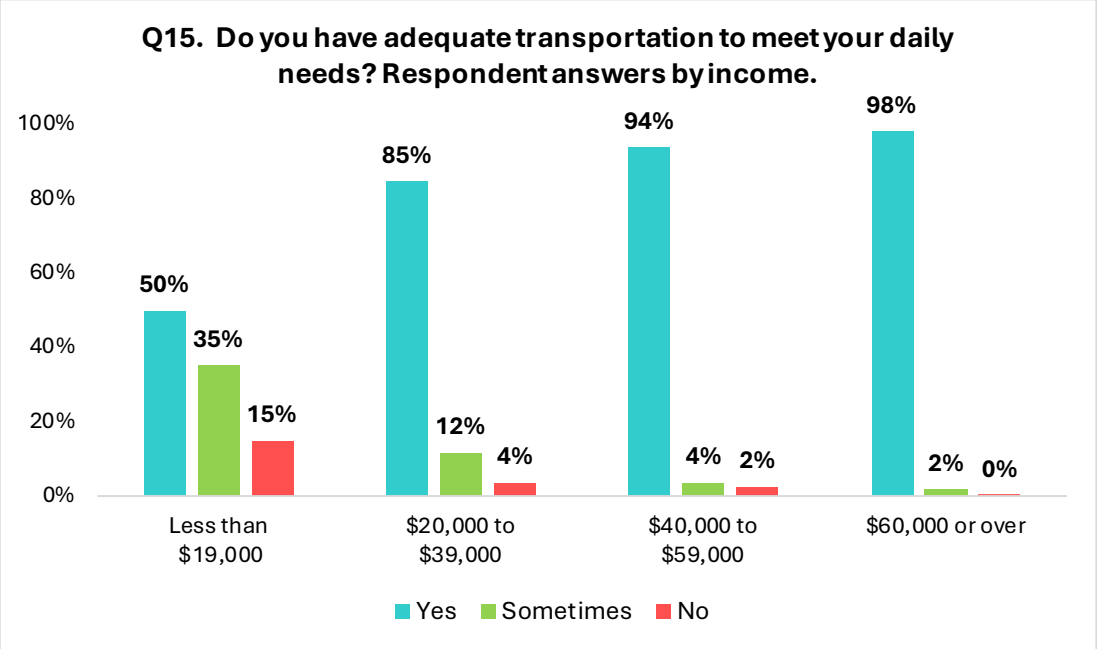
The sample size of American Indian/Alaska Natives is very small yet indicates that a larger percentage of this population only has adequate transportation sometimes. Only 27 respondents reported not having adequate transportation, and these were 13% Black/African American, 13% White and 3% race unknown.



Race	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
American Indian/Alaska Native	71%	29%	0%	5	2	0	7
Multiracial	79%	21%	0%	22	6	0	28
Black/African American	84%	11%	5%	206	26	13	245
White	93%	5%	2%	514	27	13	554
Asian	100%	0%	0%	21	0	0	21
Native Hawaiian or Pacific Islander	100%	0%	0%	3	0	0	3
Race Unknown	74%	24%	3%	25	8	1	34
Total	**89%**	**8%**	**3%**	**796**	**69**	**27**	**892**

Q15: Adequate Transportation by INCOME
Answered:892 Skipped:27

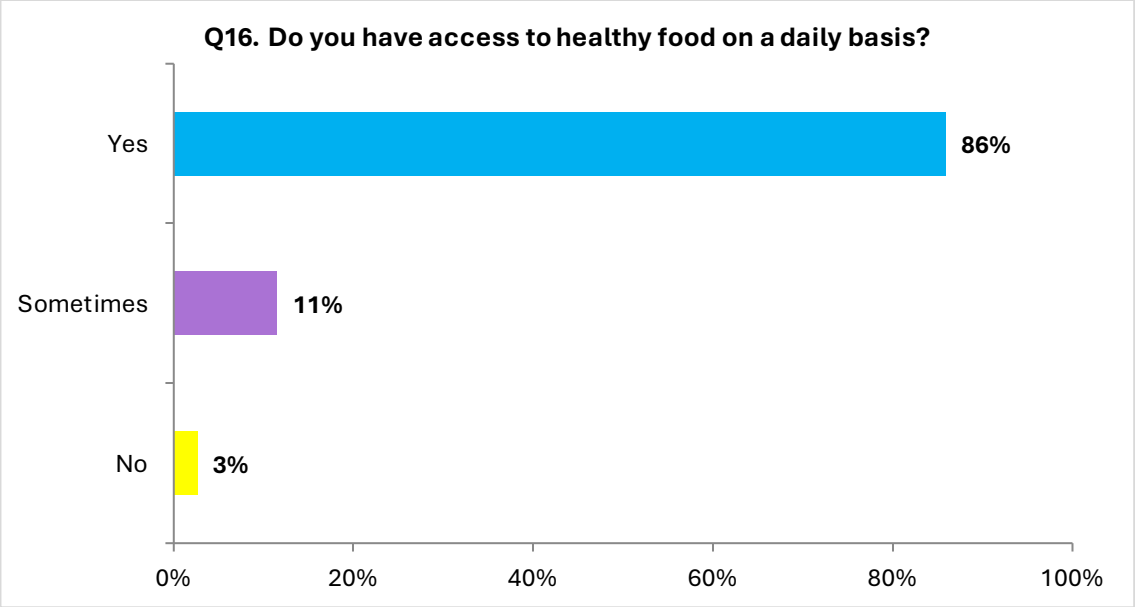
Respondents earning less than $19,000 reported the greatest challenges with transportation. Just 50% of respondents in this income bracket reported adequate transportation and 50% reported having transportation only sometimes or not at all. The percentages of respondents with adequate transportation increased with income.



Income	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
Less than $19,000	50%	35%	15%	54	38	16	108
$20,000 to $39,000	85%	12%	4%	94	13	4	111
$40,000 to $59,000	94%	4%	2%	152	6	4	162
$60,000 or over	98%	2%	0%	451	8	1	460
Income range unknown	88%	8%	53%	45	4	2	51
TOTAL	**89%**	**8%**	**3%**	**796**	**69**	**27**	**892**

Q16: DO YOU HAVE ACCESS TO HEALTHY FOOD ON A DAILY BASIS?
Answered:897 Skipped:22

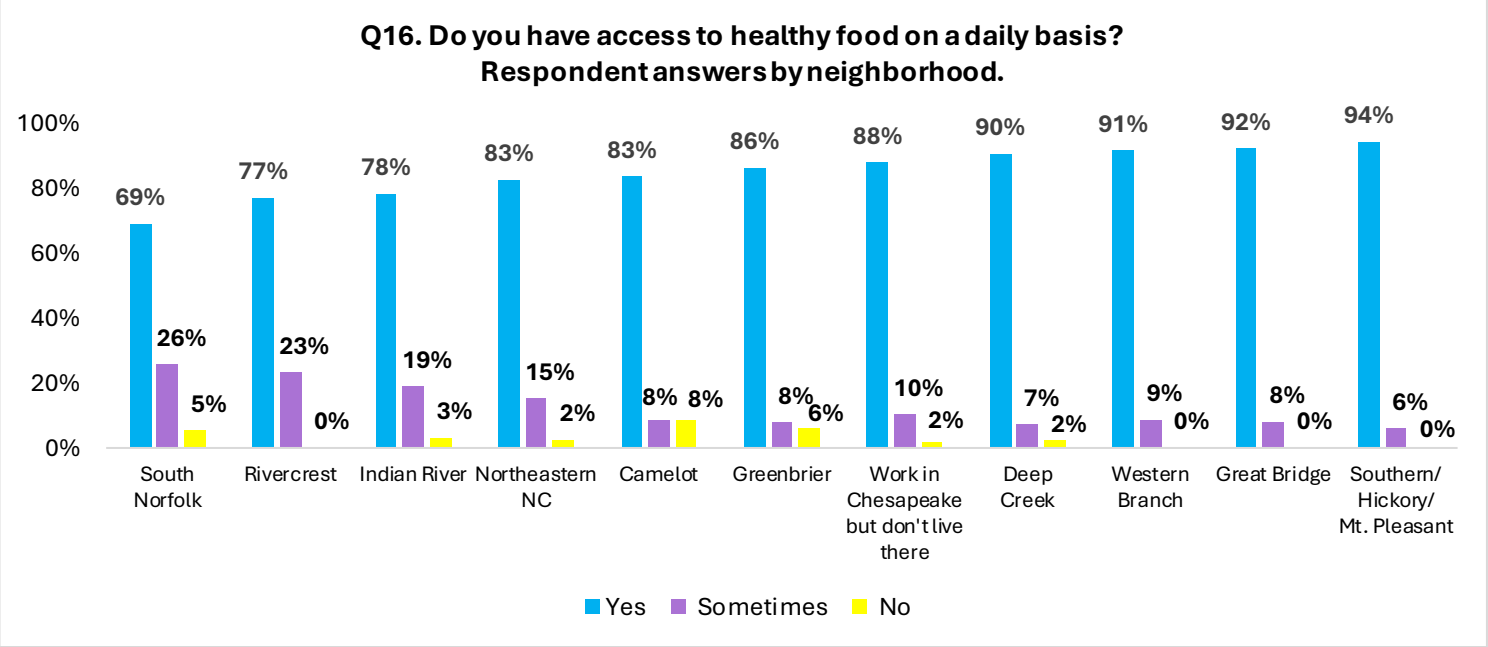
Overall, 86% of respondents reported having healthy food on a daily basis. Eleven percent (11%) stated they sometimes have access to healthy food, and 3% reported they did not have regular access to nutritious food.



ANSWER CHOICES	PERCENT	NUMBER
Yes	86%	770
Sometimes	11%	103
No	3%	24
TOTAL	**100%**	**897**

Q16: Access to healthy food by NEIGHBORHOOD

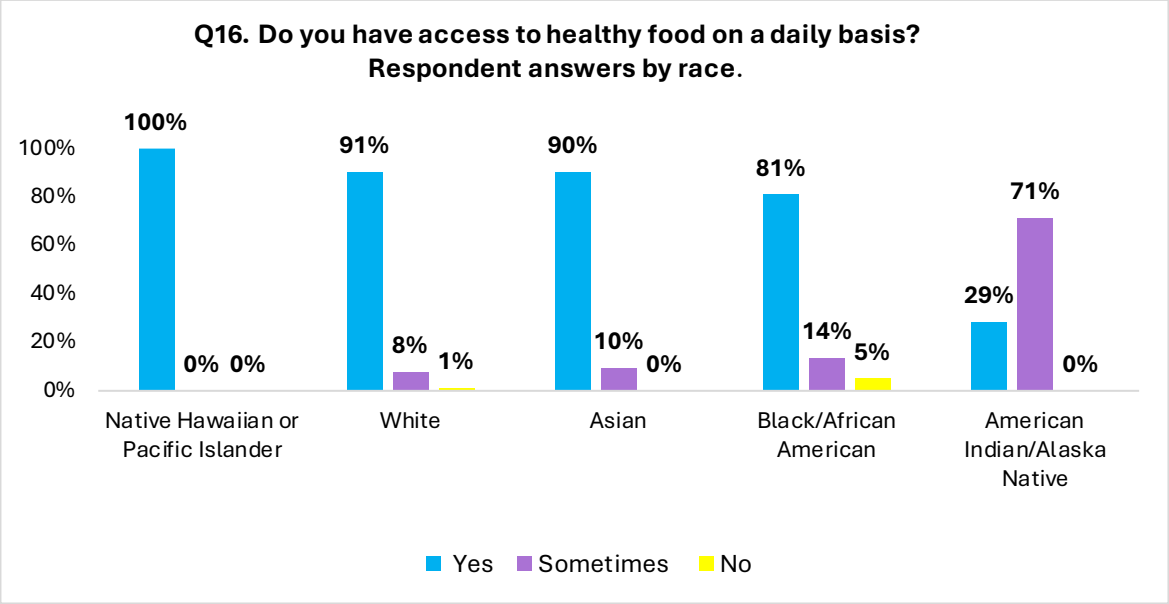
Answered:897 Skipped:22



	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Responses
South Norfolk	69%	26%	5%	51	19	4	74
Rivercrest	77%	23%	0%	10	3	0	13
Indian River	78%	19%	3%	25	6	1	32
Northeastern NC	83%	15%	2%	104	19	3	126
Camelot	83%	8%	8%	10	1	1	12
Greenbrier	86%	8%	6%	132	12	9	153
Work in Chesapeake but don't live there	88%	10%	2%	94	11	2	107
Deep Creek	90%	7%	2%	76	6	2	84
Western Branch	91%	9%	0%	21	2	0	23
Great Bridge	92%	8%	0%	159	14	0	173
Southern/Hickory/ Mt. Pleasant	94%	6%	0%	64	4	0	68
Residence not provided	3%	1%	0%	24	6	2	32
TOTAL	**86%**	**11%**	**3%**	**770**	**103**	**24**	**897**

Q16: Access to healthy food by RACE
Answered:897 Skipped:22

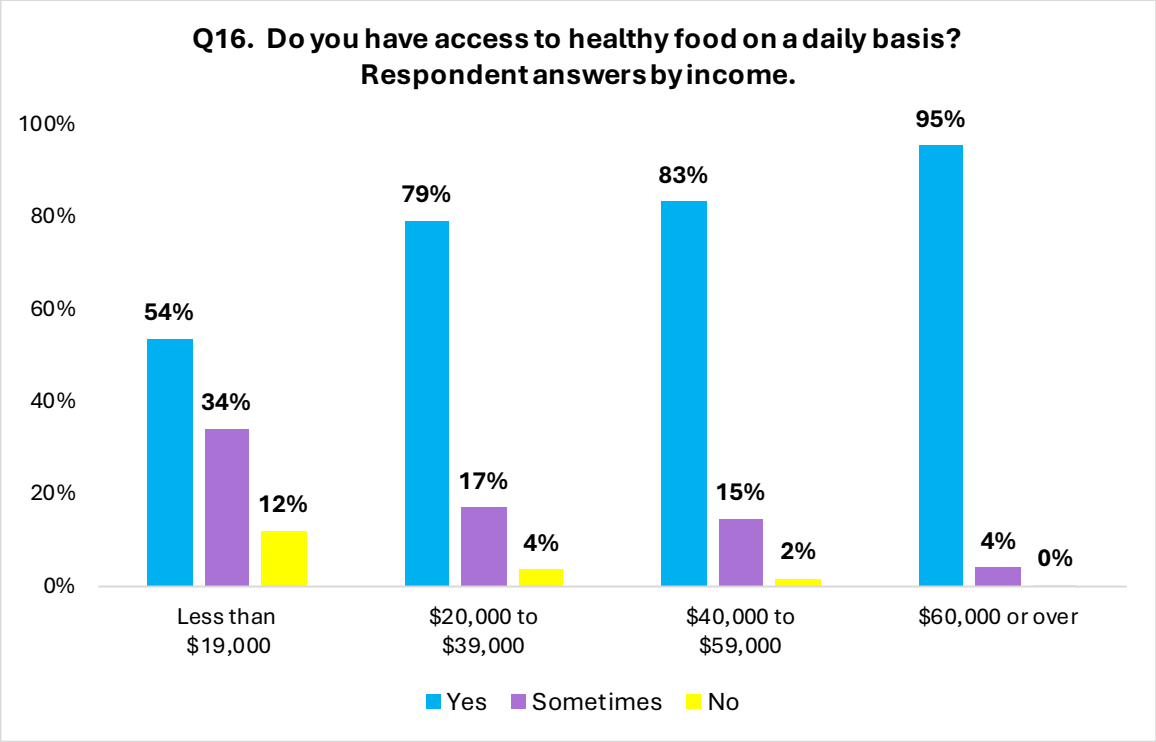
American Indian/Alaska Native respondents reported the having the least access to health food, with 29% reporting *Yes* and 71% reporting *Sometimes*. Again, the sample size of this population was just 7 people so the findings may not be representative. At least 81% of other races reported being able to access healthy food.



Race	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
American Indian/Alaska Native	29%	71%	0%	2	5	0	7
Asian	90%	10%	0%	19	2	0	21
Black/African American	81%	14%	5%	199	34	12	245
Multiracial	68%	21%	11%	19	6	3	28
Native Hawaiian or Pacific Islander	100%	0%	0%	3	0	0	3
White	91%	8%	1%	504	45	7	556
Race Unknown	65%	30%	5%	24	11	2	37
TOTAL	**86%**	**11%**	**3%**	**770**	**103**	**24**	**897**

Q16: Access to healthy food by INCOME
Answered:897 Skipped:22

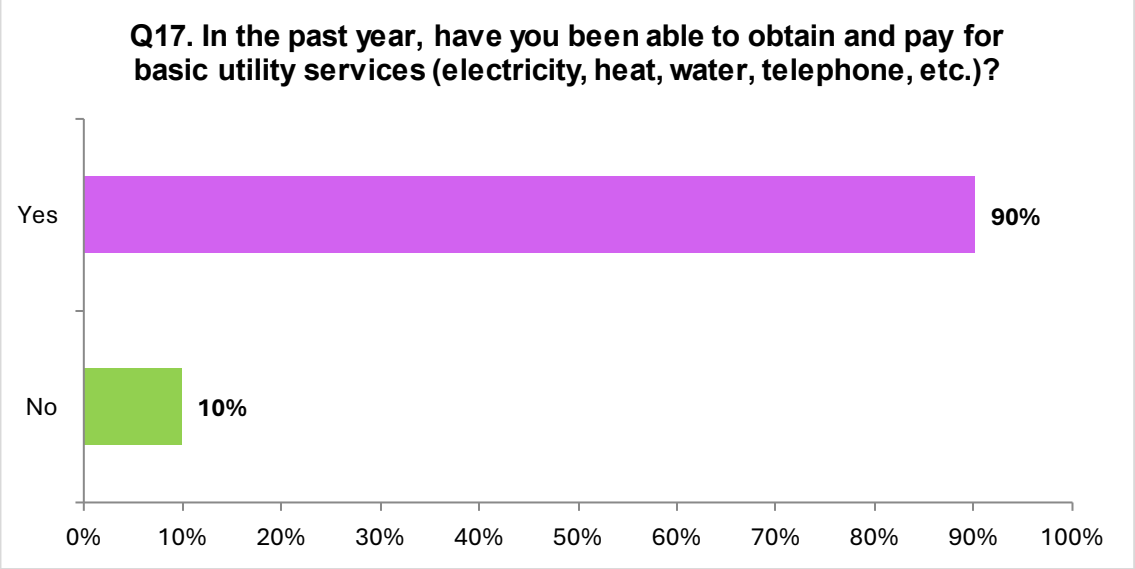
Not surprisingly, respondents in the lowest income group reported the least ability to access healthy food on a daily basis. Just 54% of those earning less than $19,000 answered *Yes* to this question, 34% answered *Sometimes*, and 12% answered *No*.



Income	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
Less than $19,000	54%	34%	12%	58	37	13	108
$20,000 to $39,000	79%	17%	4%	88	19	4	111
$40,000 to $59,000	83%	15%	2%	135	24	3	162
$60,000 or over	95%	4%	0%	440	19	2	461
Income range unknown	89%	7%	44%	49	4	2	55
TOTAL	**86%**	**11%**	**3%**	**770**	**103**	**24**	**897**

Q17: IN THE PAST YEAR, HAVE YOU BEEN ABLE TO OBTAIN AND PAY FOR BASIC UTILITY SERVICES (ELECTRICITY, HEAT, WATER, TELEPHONE, ETC.)?
Answered:892 Skipped:27

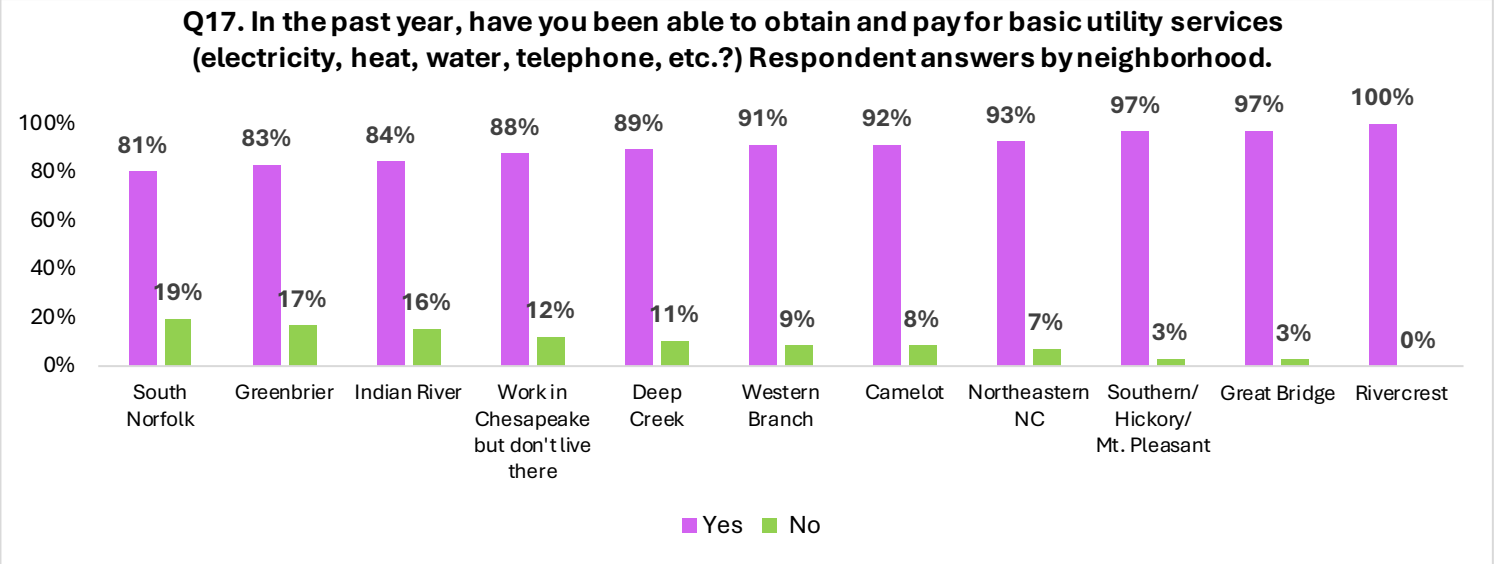
Ninety percent of respondents reported having access to basic utility services, and just 10% reported not being able to obtain and pay for services.



ANSWER CHOICES	PERCENT	NUMBER
No	10%	88
Yes	90%	804
TOTAL	**100%**	**892**

Q17: Ability to pay for utilities by NEIGHBORHOOD
Answered:892 Skipped:27

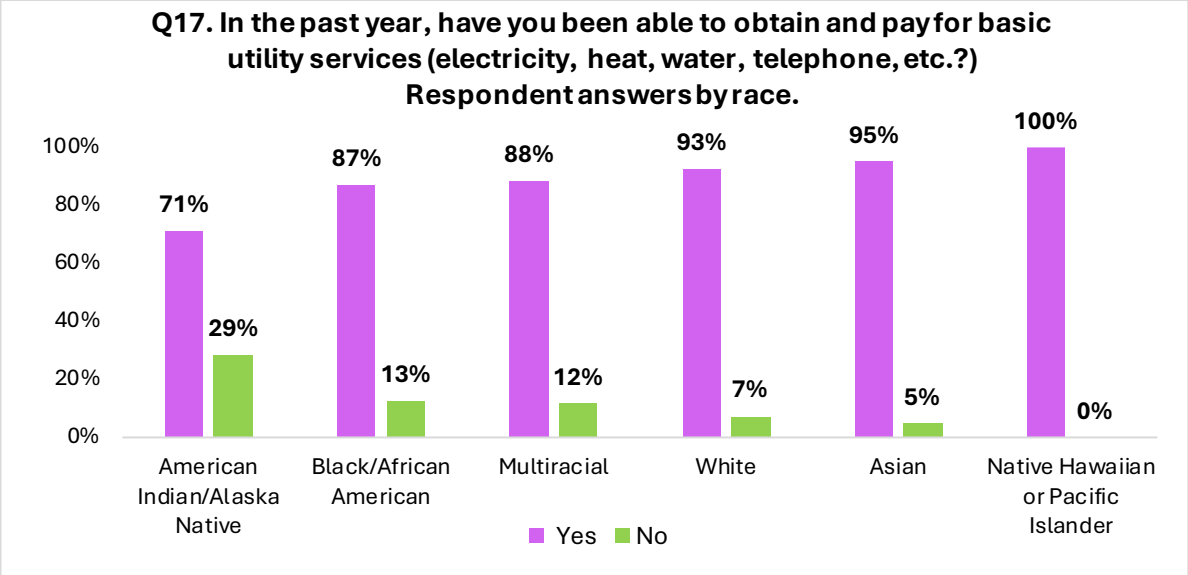
Of respondent unable to access utility services, the greatest percentage live in South Norfolk (19%), Greenbrier (17%), and Indian River (16%).



Neighborhood	% Yes	% No	# Yes	# No	# Respondents
South Norfolk	81%	19%	58	14	72
Greenbrier	83%	17%	125	25	150
Indian River	84%	16%	27	5	32
Work in Chesapeake but don't live there	88%	12%	94	13	107
Deep Creek	89%	11%	75	9	84
Western Branch	91%	9%	21	2	23
Camelot	92%	8%	11	1	12
Northeastern NC	93%	7%	117	9	126
Southern/Hickory/ Mt. Pleasant	97%	3%	66	2	68
Great Bridge	97%	3%	168	5	173
Rivercrest	100%	0%	13	0	13
Residence not provided	91%	9%	29	3	32
TOTAL	**90%**	**10%**	**804**	**88**	**892**

Q17: Ability to pay for utilities by RACE
Answered:892 Skipped:27

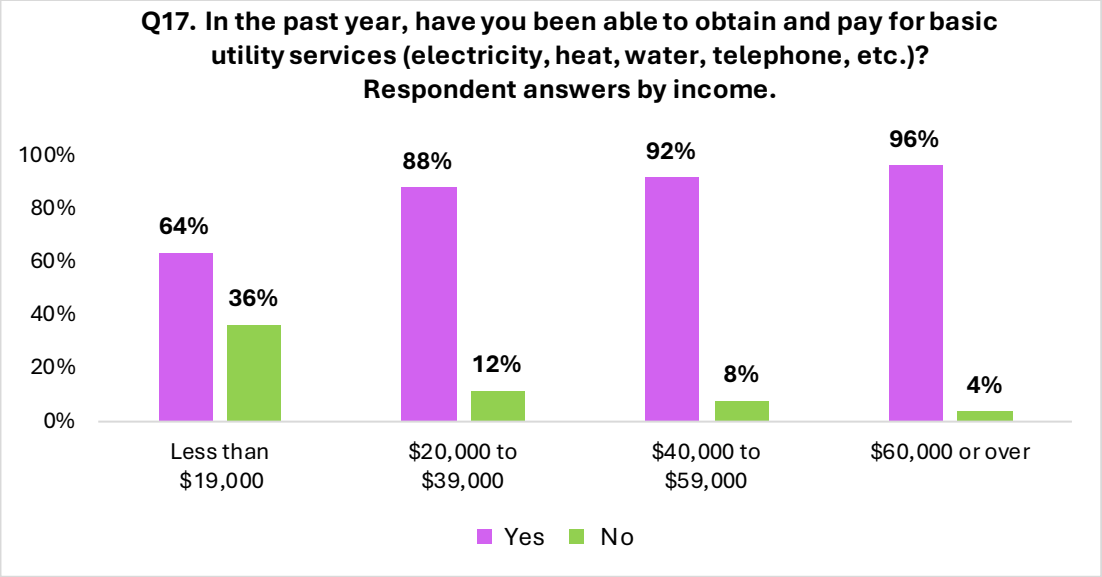
The American Indian/Native Alaska population reported the smallest percentage (71%)of ability to obtain and pay for basic utilities compared to 87% or higher by other race populations.



Race	% Yes	% No	# Yes	# No	# Respondents
American Indian/Alaska Native	71%	29%	5	2	7
Black/African American	87%	13%	212	31	243
Multiracial	88%	12%	23	3	26
White	93%	7%	514	41	555
Asian	95%	5%	20	1	21
Native Hawaiian or Pacific Islander	100%	0%	3	0	3
Race Unknown	73%	27%	27	10	37
TOTAL	**90%**	**10%**	**804**	**88**	**892**

Q17: Ability to pay for utilities by INCOME
Answered:892 Skipped:27

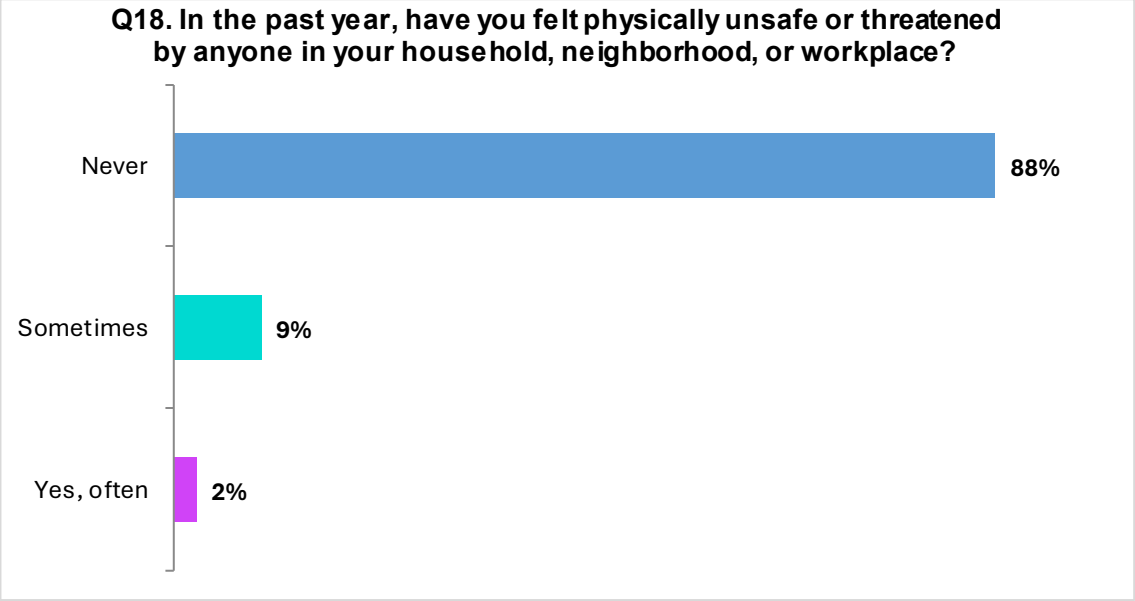
According to survey results, the ability to obtain and pay for basic utilities is directly proportional to income. Those earning less than $19,000 report the least ability to pay for these services and the cost burden tends to decrease as income rises.



Income	% Yes	% No	# Yes	# No	# Respondents
Less than $19,000	64%	36%	68	39	107
$20,000 to $39,000	88%	12%	97	13	110
$40,000 to $59,000	92%	8%	149	13	162
$60,000 or over	96%	4%	442	17	459
Income range unknown	89%	11%	48	6	54
TOTAL	**90%**	**10%**	**804**	**88**	**892**

Q18: IN THE PAST YEAR, HAVE YOU FELT PHYSICALLY UNSAFE OR THREATENED BY ANYONE IN YOUR HOUSEHOLD, NEIGHBORHOOD, OR WORKPLACE?

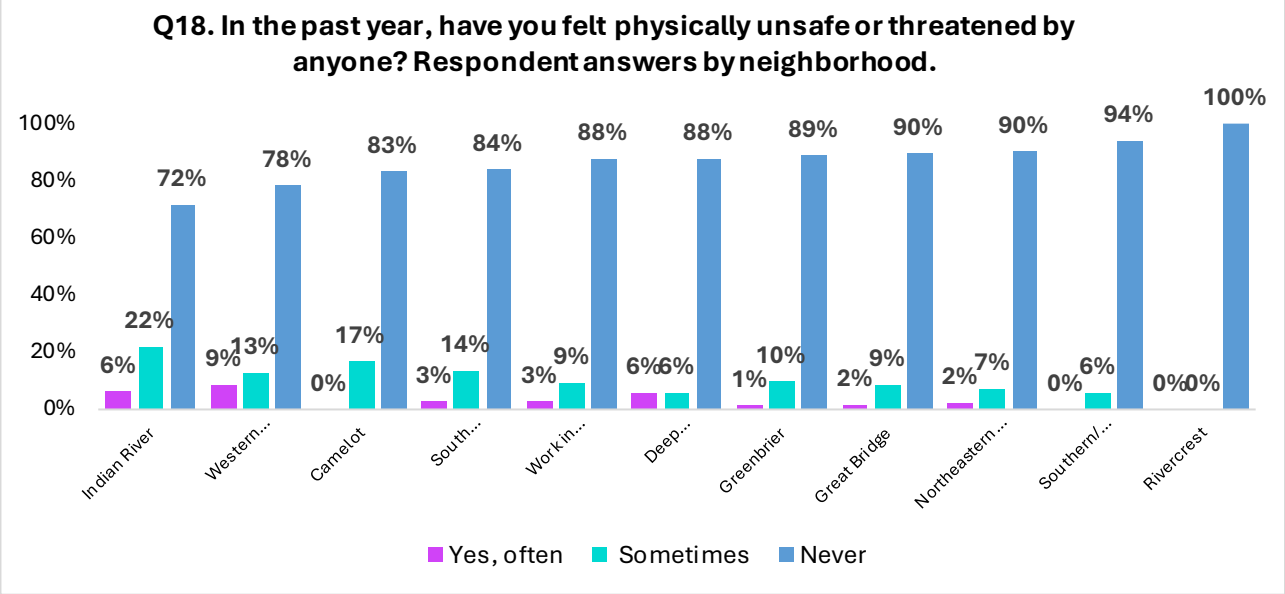
Answered:894 Skipped:25



ANSWER CHOICES	PERCENT	NUMBER
Yes, often	2%	22
Sometimes	9%	84
Never	88%	788
TOTAL	**100%**	**894**

Q18: Felt unsafe or threatened by NEIGHBORHOOD
Answered:894 Skipped:25

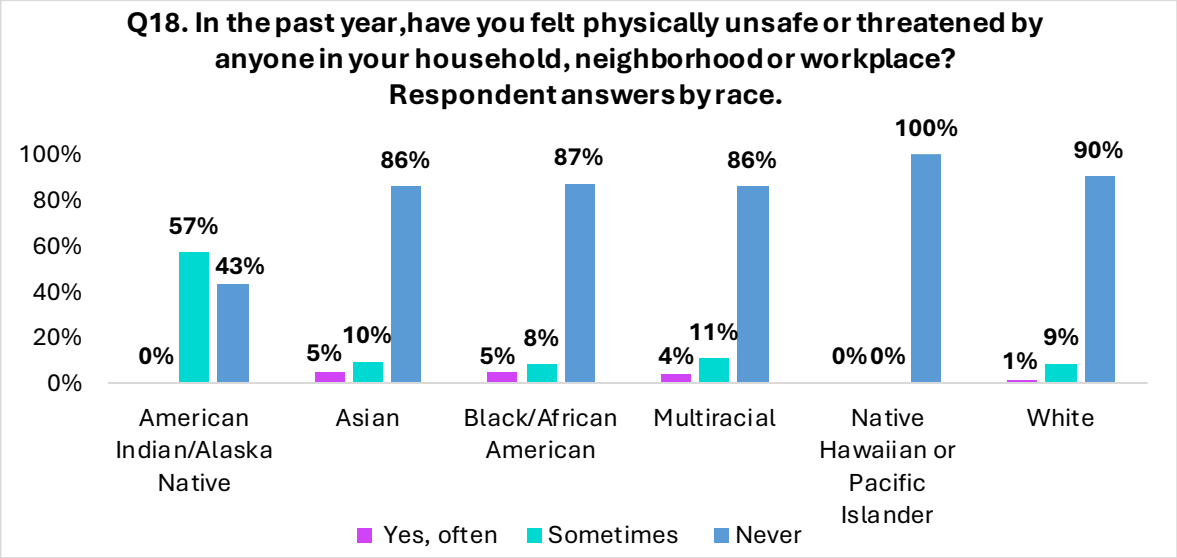
Respondent answers to this question ranged from 9% feeling unsafe or threatened in Western Branch to 0% of those living in Camelot, Southern/Hickory/Mt. Pleasant, and Rivercrest. Respondent answers from other neighborhoods ranged from 1% to 6%.



Neighborhood	% Yes, often	% Sometimes	% Never	# Answered Yes, often	# Answered Sometimes	# Answered Never	# Respondents
Indian River	6%	22%	72%	2	7	23	32
Western Branch	9%	13%	78%	2	3	18	23
Camelot	0%	17%	83%	0	2	10	12
South Norfolk	3%	14%	84%	2	10	62	74
Work in Chesapeake but don't live there	3%	9%	88%	3	10	93	106
Deep Creek	6%	6%	88%	5	5	73	83
Greenbrier	1%	10%	89%	2	15	136	153
Great Bridge	2%	9%	90%	3	15	155	173
Northeastern NC	2%	7%	90%	3	9	113	125
Southern/Hickory/ Mt. Pleasant	0%	6%	94%	0	4	64	68
Rivercrest	0%	0%	100%	0	0	13	13
Residence not provided	0%	0%	3%	0	4	28	32
TOTAL	**2%**	**9%**	**88%**	**22**	**84**	**788**	**894**

Q18: Felt unsafe or threatened by RACE
Answered:894 Skipped:25

Respondents reporting the highest percentage of feeling unsafe or threatened were Asian (5%), Black/African American (5%) and Asian (4%). One percent (1%) of American Indian/Alaska Native respondents reported feeling unsafe or threatened *Sometimes*. According to the National Congress of American Indians, "American Indian and Native Alaskan women and girls experience higher rates of violence" and this is often driven by historical trauma and systemic inequities.[11] Although the sample size of this population group was seven people, it does seem meaningful that 57% of these respondents reported sometimes feeling unsafe compared to just 11% of Multiracial respondents, 10% of Asian respondents, 9% of White respondents and 8% of Black/African American respondents.

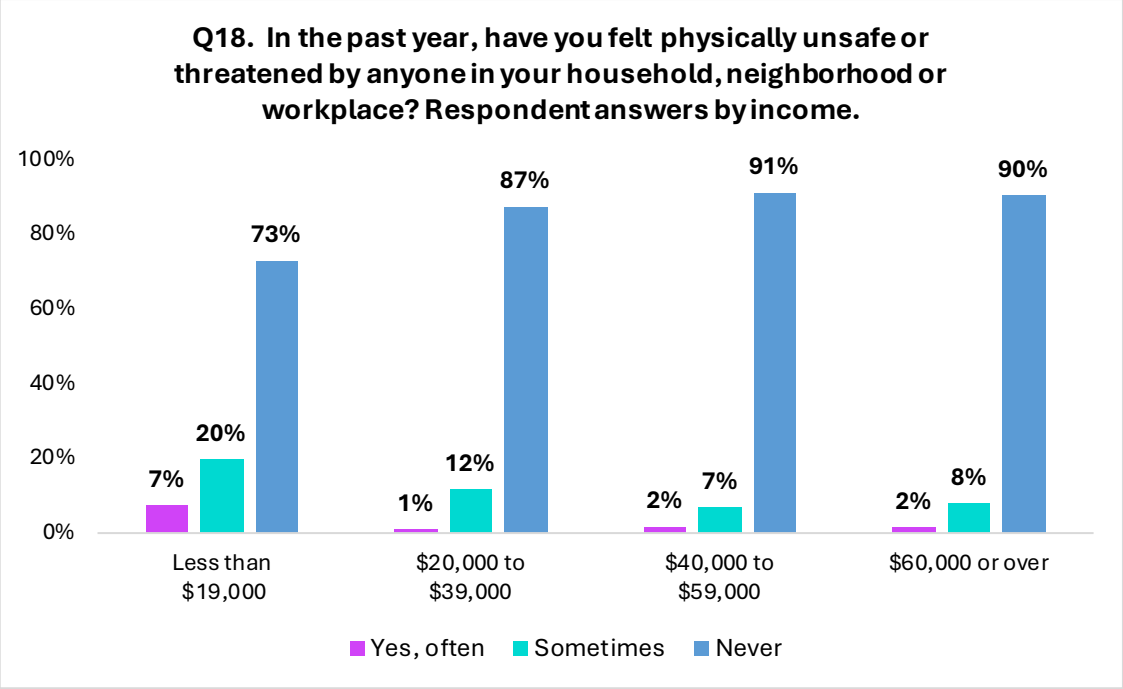


Race	% Yes, often	% Sometimes	% Never	# Yes, often	# Sometimes	# Never	# Respondents
American Indian/Alaska Native	0%	57%	43%	0	4	3	7
Asian	5%	10%	86%	1	2	18	21
Black/African American	5%	8%	87%	11	20	213	244
Multiracial	4%	11%	86%	1	3	24	28
Native Hawaiian or Pacific Islander	0%	0%	100%	0	0	3	3
White	1%	9%	90%	7	48	499	554
Race Unknown	5%	19%	76%	2	7	28	37
TOTAL	**2%**	**9%**	**88%**	**22**	**84**	**788**	**894**

[11] "Policy Research Update: State of the Data on Violence Against American Indian and Alaska Native Women and Girls," October 2021, National Congress of American Indians, https://cdn.sanity.io/files/raa5sn1v/production/edf33e8f528a50229887d7534e3943d1852aa65a.pdf.

Q18: Felt unsafe or threatened by INCOME
Answered:894 Skipped:25

Although those earning less than $19,000 reported the highest percentage of feeling unsafe or threatened (7%), at least some respondents in every income range also reported this.

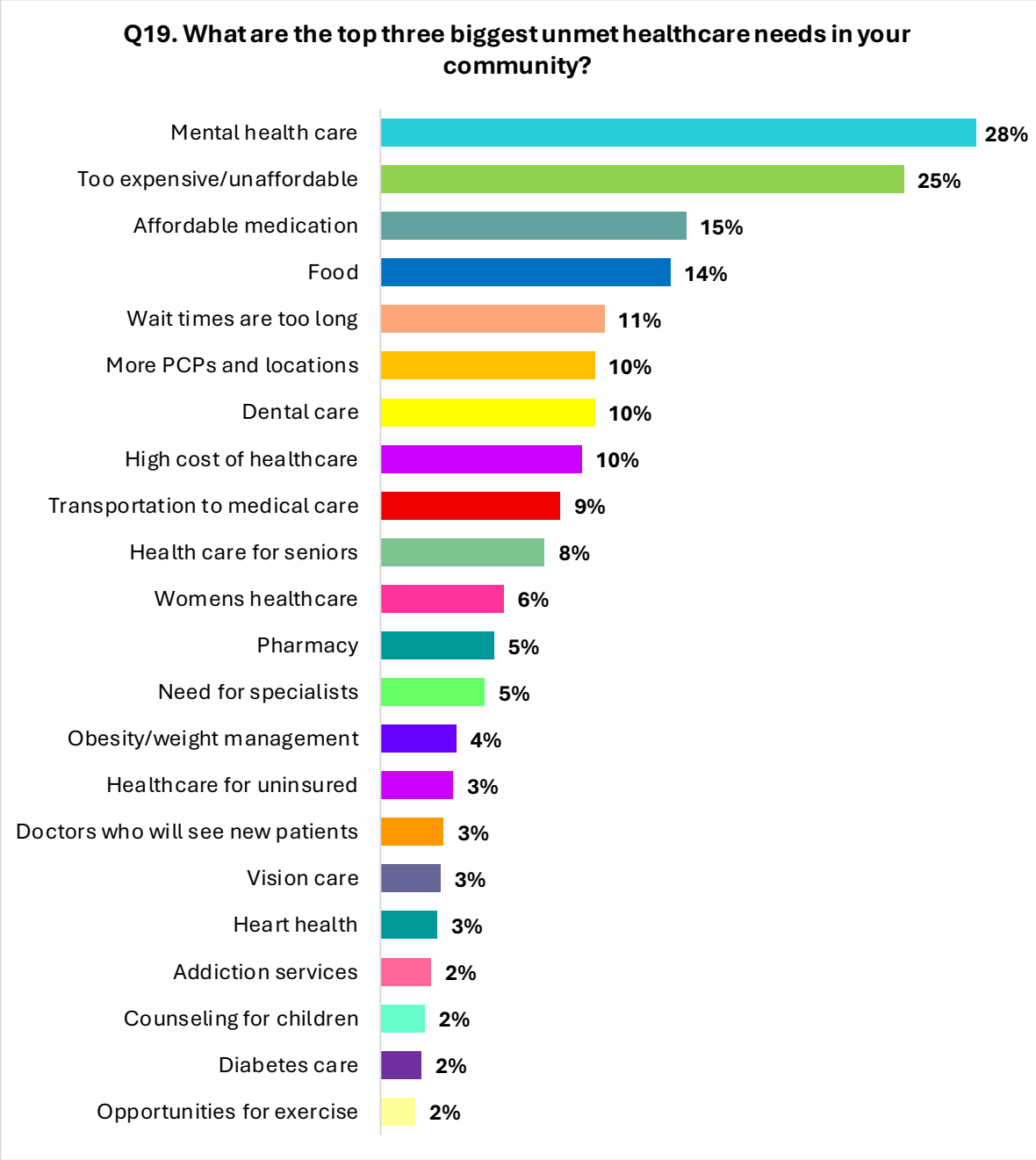


Income	% Yes, often	% Sometimes	% Never	# Yes, often	# Sometimes	# Never	# Respondents
Less than $19,000	7%	20%	73%	8	21	78	107
$20,000 to $39,000	1%	12%	87%	1	13	97	111
$40,000 to $59,000	2%	7%	91%	3	11	147	161
$60,000 or over	2%	8%	90%	7	37	417	461
Income range unknown	6%	4%	91%	3	2	49	54
TOTAL	**3%**	**9%**	**88%**	**22**	**84**	**788**	**894**

Q19. WHAT ARE THE TOP THREE BIGGEST UNMET HEALTHCARE NEEDS IN YOUR COMMUNITY?

Answered:674 Skipped:245

The most frequently reported unmet need was for more mental health services followed by unaffordable healthcare and a need for affordable prescriptions. Of the 667 survey respondents who answered this question, 189 (28%) listed mental health care, 166 (25%) stated that healthcare and insurance are too expensive, and 97 (15%) said that medications are not affordable.

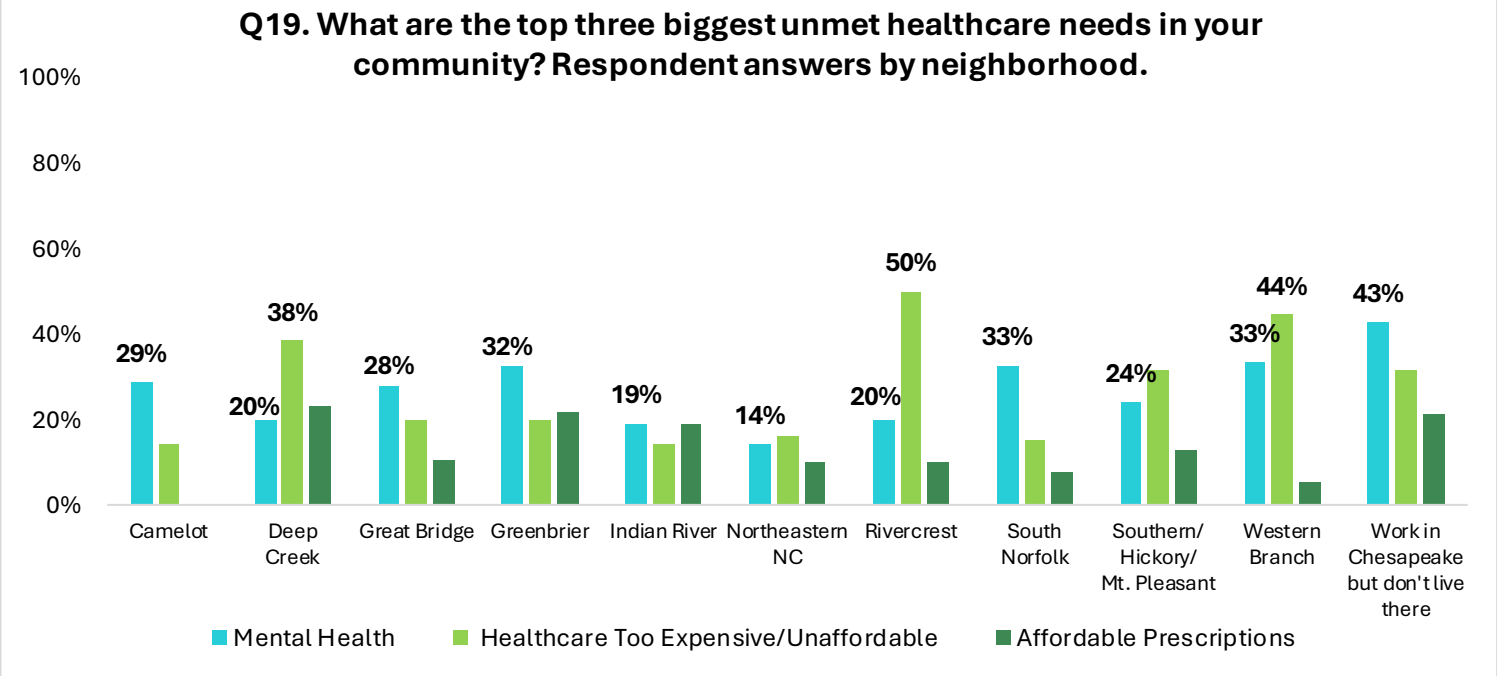


ANSWER CHOICES	PERCENT	NUMBER
Mental health care	28%	189
Healthcare is too expensive/unaffordable	25%	166
Affordable medication	15%	97
Food	14%	92
Wait times are too long	11%	71
More PCPs and locations	10%	68
Dental care	10%	68
High cost of healthcare	10%	64
Transportation to medical care	9%	57
Health care for seniors	8%	52
Women's healthcare	6%	39
Pharmacy	5%	36
Need for specialists	5%	33
Obesity/weight management	4%	24
Healthcare for uninsured	3%	23
Affordable healthcare	3%	21
Doctors who will see new patients	3%	20
Vision care	3%	19
Heart health	3%	18
Addiction services	2%	16
Counseling for children	2%	14
Diabetes care	2%	13
Opportunities for exercise	2%	11
Nutrition education	1%	10
Healthcare for children	1%	9
More health screenings	1%	8
Shorter wait times in ER	1%	6
Dementia services/resources	1%	5
Veteran care	1%	5
Holistic healthcare	0.4%	3
Black/diverse doctors and medical professionals	0.4%	3
Pain management services	0.3%	2

Compared to the 2021 CHNA, respondents identified the five greatest unmet healthcare needs as: 1) Access to healthcare (25%), 2) Mental health issues (25%), 3) Affordable healthcare (21%), 4) Costly or no health insurance (14%), and 5) Affordable medications (12%).

Q19. Top three unmet healthcare needs by NEIGHBORHOOD
Answered:674 Skipped:245

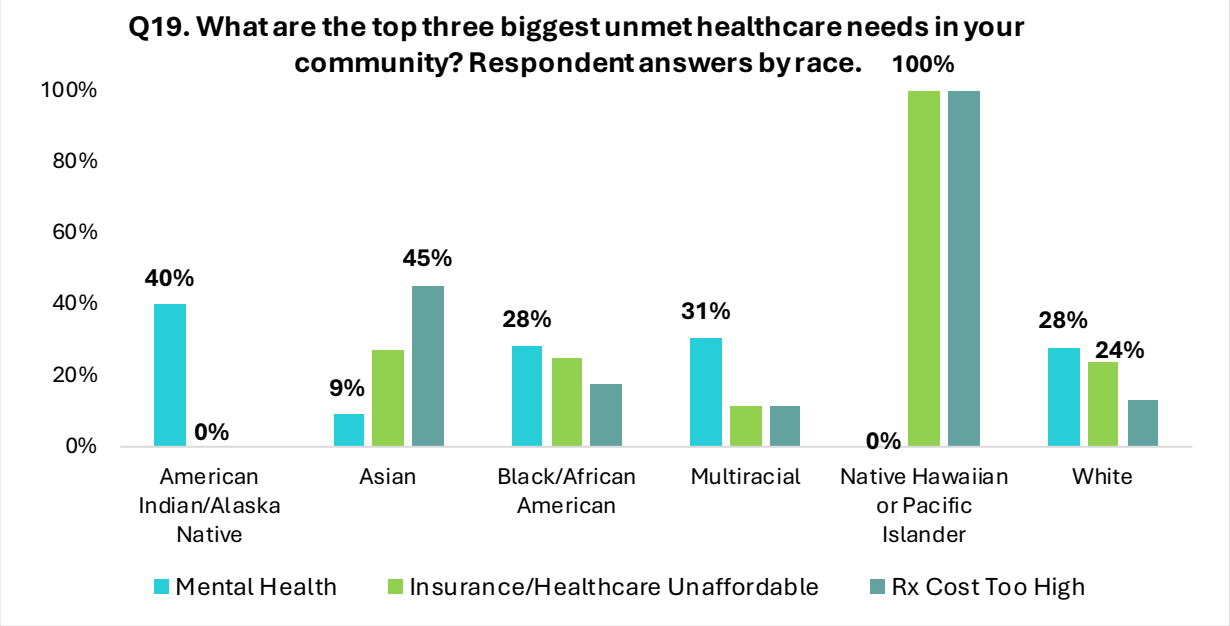
Although mental healthcare was the overall most frequently cited unmet healthcare need, filtering by neighborhood shows that unaffordable healthcare was cited more frequently by survey respondents living in Deep Creek, Rivercrest and Western Branch. Respondents in Greenbrier, Western Branch and those who work but do not live in Chesapeake reported this issue in higher percentages than the overall average of 28%.



Neighborhood	Mental Health		Healthcare Too Expensive/ Unaffordable		Affordable Prescriptions		# Respondents
	#	%	#	%	#	%	
Camelot	2	29%	1	14%	0	0%	7
Deep Creek	12	20%	23	38%	14	23%	60
Great Bridge	35	28%	25	20%	13	10%	125
Greenbrier	36	32%	22	20%	24	22%	111
Indian River	4	19%	3	14%	4	19%	21
Northeastern NC	14	14%	16	16%	10	10%	99
Rivercrest	2	20%	5	50%	1	10%	10
South Norfolk	17	33%	8	15%	4	8%	52
Southern/Hickory/ Mt. Pleasant	13	24%	17	31%	7	13%	54
Western Branch	6	33%	8	44%	1	6%	18
Work in Chesapeake but don't live there	38	43%	28	31%	19	21%	89
Residence not provided	10	48%	10	48%	0	0%	21
TOTAL	**104**	**29%**	**95**	**26%**	**46**	**13%**	**364**

Q19. Top three unmet healthcare needs by RACE
Answered:674 Skipped:245

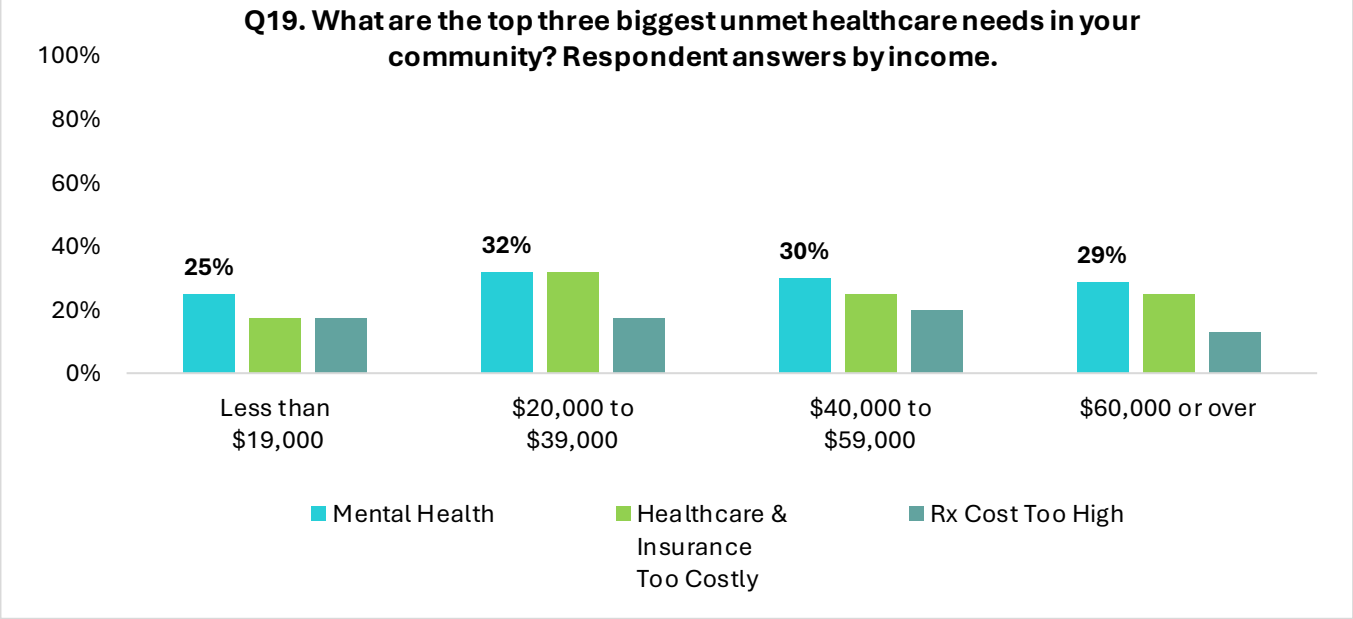
When filtering responses to this question by race, the two racial populations with the largest sample size (Black/African American and White) show similar percentages of listing mental health as the greatest unmet healthcare need, 28% and 31%, respectively. One Native Hawaiian/Alaska Native respondent listed mental health, so the percentage for this population is 100% and may not be representative. The percentage of American Indian/Alaska Native respondents who listed mental health (40%) is higher than the overall average of 28%.



Race	Mental Health		Insurance/Healthcare Unaffordable		Rx Cost Too High		# Respondents
	#	%	#	%	#	%	
American Indian/Alaska Native	2	40%	0	0%	0	0%	5
Asian	1	9%	3	27%	5	45%	11
Black/African American	53	28%	47	25%	33	18%	187
Multiracial	8	31%	3	12%	3	12%	26
Native Hawaiian or Pacific Islander	0	0%	1	100%	1	100%	1
White	118	28%	100	24%	55	13%	421
Race Unknown	7	44%	12	75%	0	0%	16
TOTAL	**189**	**28%**	**166**	**25%**	**97**	**15%**	**667**

Q19. Top three unmet healthcare needs by INCOME
Answered:674 Skipped:245

When sorting this question by income level, respondents of all income ranges listed mental health as the greatest unmet healthcare need and in similar percentages.

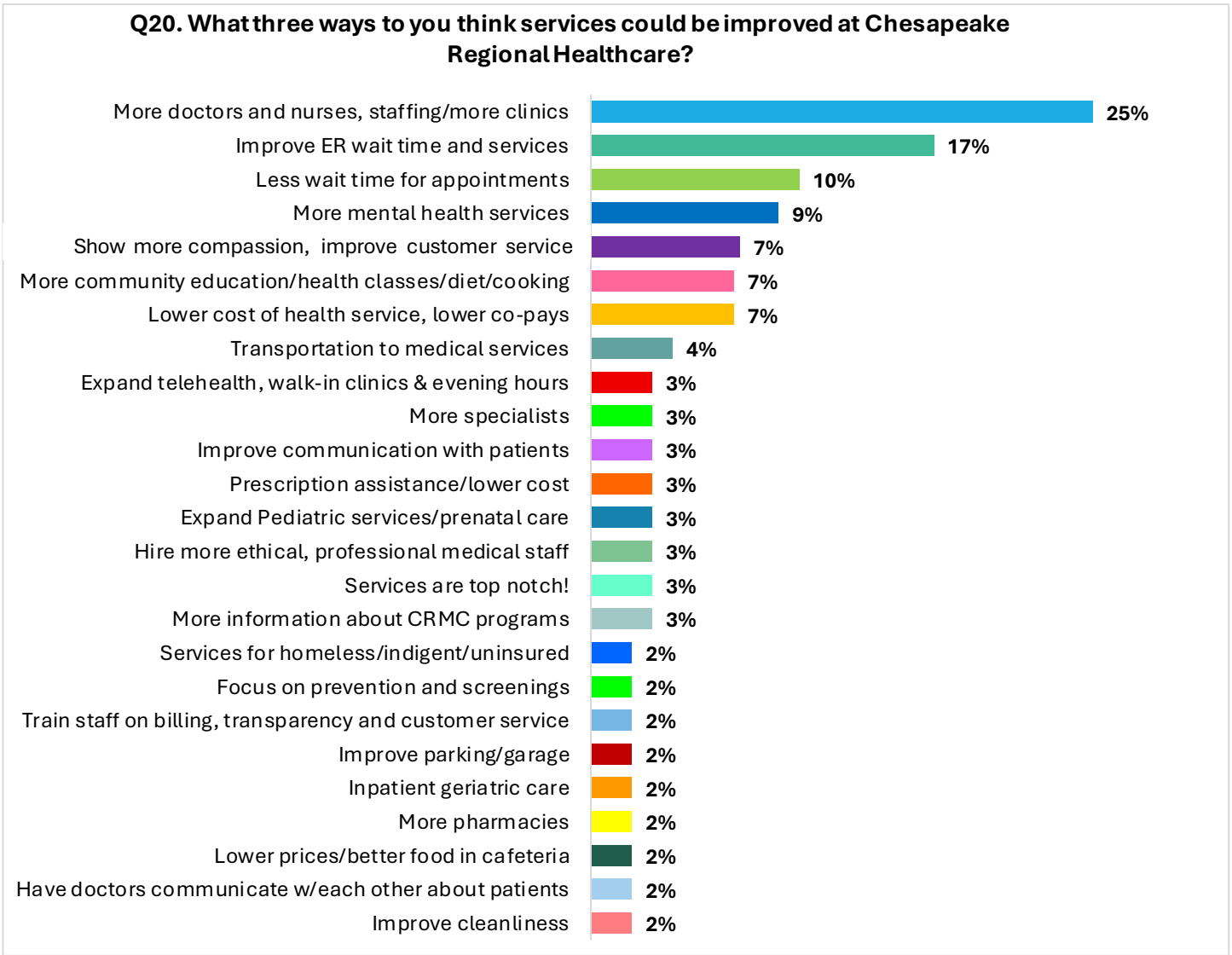


Income	Mental Health		Healthcare & Insurance Too Costly		Rx Cost Too High		# Respondents
	#	%	#	%	#	%	
Less than $19,000	20	25%	14	18%	14	18%	80
$20,000 to $39,000	24	32%	24	32%	13	17%	75
$40,000 to $59,000	36	30%	30	25%	24	20%	120
$60,000 or over	105	29%	91	25%	46	13%	364
Income range unknown	4	14%	7	25%	0	0%	28
TOTAL	**189**	**28%**	**166**	**25%**	**97**	**15%**	**667**

Q20. WHAT THREE WAYS DO YOU THINK SERVICES COULD BE IMPROVED AT CHESAPEAKE REGIONAL HEALTHCARE?
Answered:576 Skipped:343

The most frequently suggested improvement for the hospital was to increase the number of doctors and nurses. Of the 576 respondents who answered this question, 142 (25%) specifically requested more medical staff. A closely related concern was reducing wait times for appointments, noted by 59 respondents (10%). While it is possible that respondents had both issues in mind, requests for additional staff and shorter appointment wait times were recorded separately.

The second most frequently cited issue was reducing wait times in the Emergency Room and making overall improvements to the department. Among the 576 respondents, 97 (17%) identified this as a priority. Similarly, in Question 19, which was answered by 674 respondents, 71 (11%) also mentioned long Emergency Room wait times.



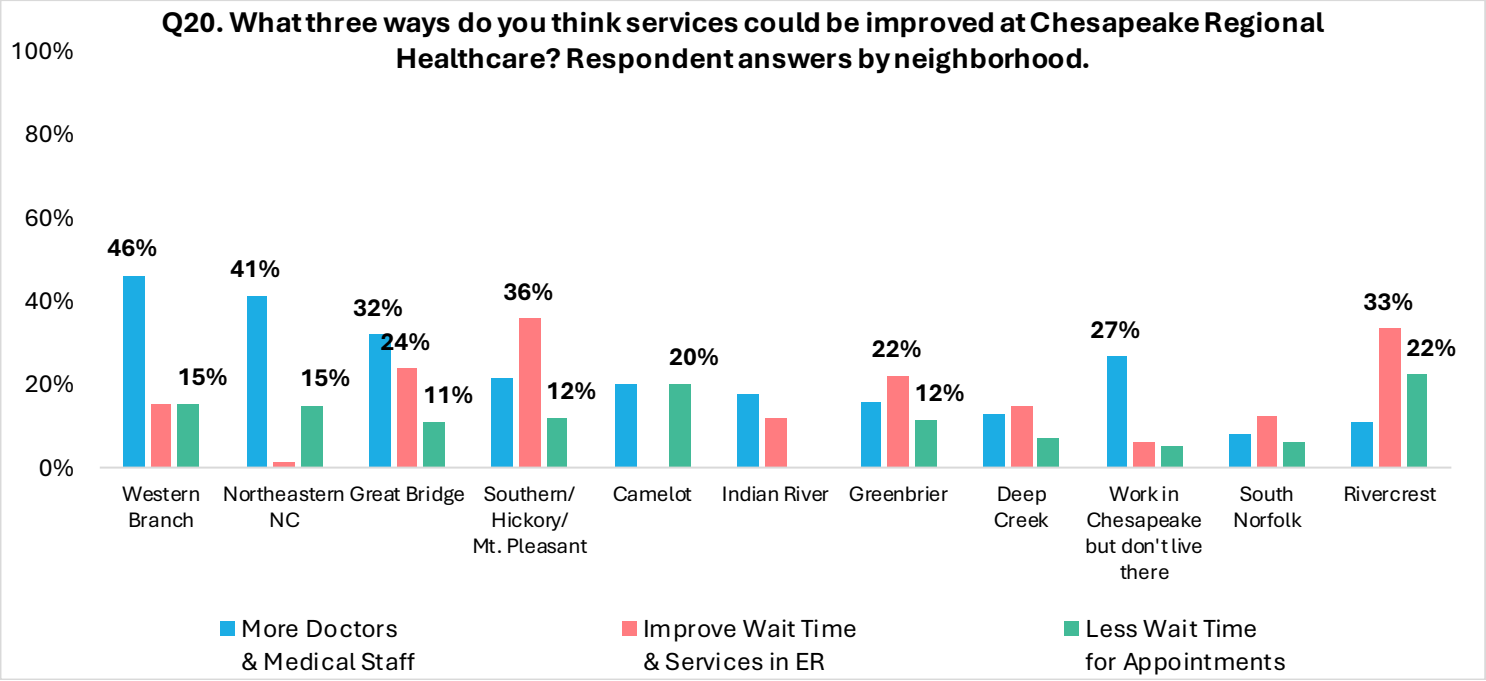
For comparison, in the 2021 CHNA the three most frequently suggested improvements to the community's healthcare system were: making healthcare more affordable (19%), improving access to care (16%), and improving customer service (13%).

ANSWERS TO QUESTION 20	PERCENT	NUMBER
More doctors and nurses, staffing/more clinics	25%	142
Improve ER wait time and services	17%	97
Faster service and appointments	10%	59
More mental health services	9%	53
Show more compassion to all, improve customer service & follow up	7%	42
More community education/health classes/diet/cooking	7%	39
Lower cost of health service, lower co-pays	7%	38
Transportation to medical services	4%	22
Expand telehealth, walk-in clinics & evening hours	3%	19
Improve communication with patients	3%	17
More specialists	3%	17
Prescription assistance/lower cost	3%	16
More information about CRMC programs	3%	15
Services are top notch!	3%	15
Hire more ethical, professional medical staff	3%	15
Expand Pediatric services/prenatal care	3%	15
Focus on prevention and screenings	2%	14
Services for homeless/indigent/uninsured	2%	14
Train staff on billing, transparency, and customer service	2%	13
Inpatient geriatric care	2%	12
Improve parking/garage	2%	12
Have doctors communicate w/each other about patients	2%	11
Lower prices/better food in cafeteria	2%	11
More pharmacies	2%	11
Improve cleanliness	2%	10
Mobile health care in South Norfolk, Camden	1%	6
Lifestyle Center open on weekend day	1%	6
Improve scheduling system	1%	5
Acquire additional MRI and CT scanners	1%	5
Disclose all findings on tests, diagnosis, and treatment	1%	5
More heart specialists, heart care	1%	5
More beds	1%	5
Security	1%	5
Allow family members with patient/family engagement	1%	3
Online access to providers/appointments	1%	3
Diversity training (race, obesity, elderly, etc.)	1%	3
Pain management	1%	3
Functional medicine/alternative therapies	1%	3

Don't leave patients in hallways - exposes to infection	1%	3
More volunteers	0.30%	2
Portal for tutorials and encouragement	0.30%	2
Keep outpatient pharmacy open 24 hrs.	0.30%	2
One bill instead of many	0.30%	2
Mobile school health clinics	0.30%	2
More dentists accepting Medicaid	0.30%	2
Merge electronic records with other healthcare systems	0.30%	2
Addiction services	0.30%	2
Renovate Lifestyle Center	0.30%	2
Space for minor emergency care	0.30%	2
Have interpreters	0.30%	2
Classes for bariatric patients	0.20%	1
Chef led food preparation classes	0.20%	1
Easier access to personal information	0.20%	1
Emergency services at hospital	0.20%	1
Outreach to medical schools	0.20%	1
Allow personal trainers to develop individual programs	0.20%	1
Offer payment options	0.20%	1
Update and upgrade facilities	0.20%	1
Contract with ambulances for immediate service	0.20%	1
Heart Health Newsletter	0.20%	1
More Chesapeake Rx locations	0.20%	1
Onsite prescription refill	0.20%	1
Infection control	0.20%	1
Help people gain insurance	0.20%	1
Information on elder care	0.20%	1
Add imaging and services in North Carolina	0.20%	1
Home visiting for newborns	0.20%	1
Using medical students as interns	0.20%	1
More dental hours	0.20%	1
Stronger partnership with EVMS	0.20%	1
Go over medications	0.20%	1
Mobile screening events	0.20%	1
Inservice education for staff	0.20%	1
More signage	0.20%	1
Room for grieving family members	0.20%	1
Online check-in	0.20%	1
Expand food and nutrition programs	0.20%	1
Separate waiting areas for infectious illnesses	0.20%	1
Add free standing pharmacy	0.20%	1
Opening a hospital in NC	0.20%	1
TOTAL		

Q20. Ways to improve services at Chesapeake Regional Healthcare by NEIGHBORHOOD
Answered:576 Skipped:343

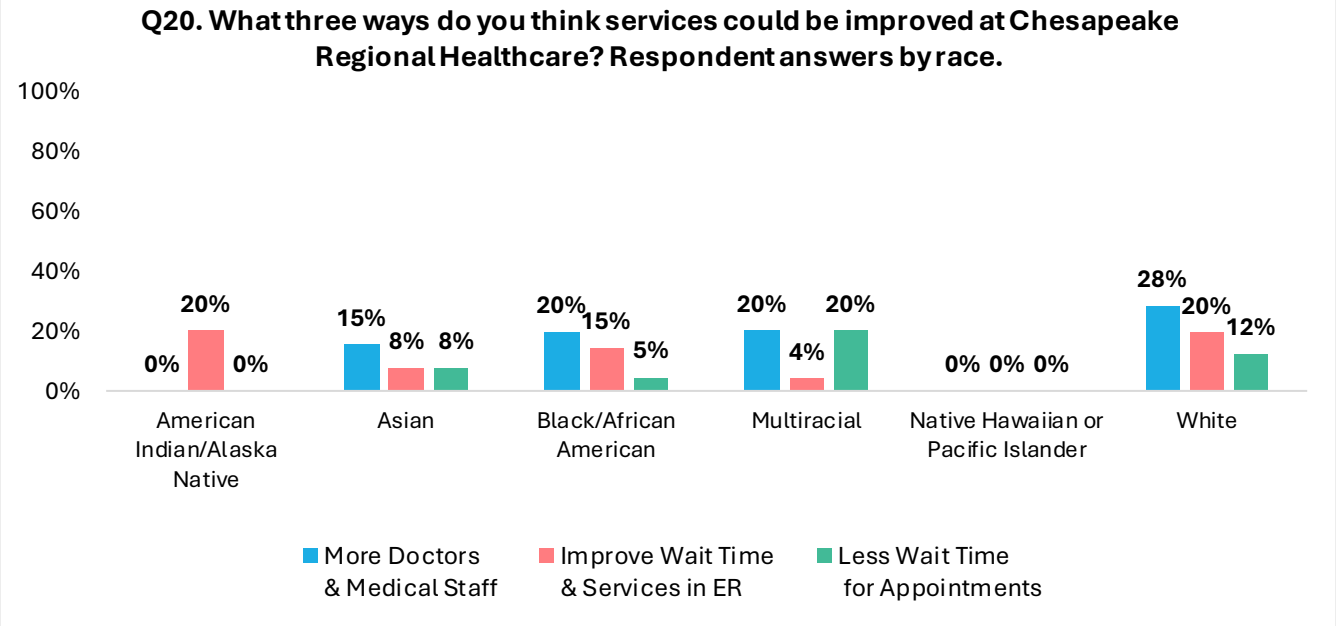
Responses to this question varied by neighborhood. Those living in Western Branch, North Carolina, Great Bridge, and those who live outside of Chesapeake but work in the city listed the need for more medical professionals at higher percentages than the average of 25%. Respondents living in Great Bridge, Southern/Hickory/Mt. Pleasant, Greenbrier and Rivercrest noted the need for improved Emergency Room wait times/services at higher percentages than the survey average of 17%. Respondents living in Western Branch, North Carolina, Great Bridge, Southern/Hickory/Mt. Pleasant, Greenbrier and Rivercrest listed faster appointment times as a necessary improvement.



Neighborhood	More Doctors & Medical Staff		Improve Wait Time & Services in ER		Less Wait Time for Appointments		# Respondents
	#	%	#	%	#	%	
Western Branch	6	46%	2	15%	2	15%	13
Northeastern NC	33	41%	1	1%	12	15%	80
Great Bridge	35	32%	26	24%	12	11%	110
Southern/Hickory/ Mt. Pleasant	9	21%	15	36%	5	12%	42
Camelot	1	20%	0	0%	1	20%	5
Indian River	3	18%	2	12%	0	0%	17
Greenbrier	15	16%	21	22%	11	12%	95
Deep Creek	7	13%	8	15%	4	7%	55
Work in Chesapeake but don't live there	21	27%	5	6%	4	5%	79
South Norfolk	4	8%	6	12%	3	6%	49
Rivercrest	1	11%	3	33%	2	22%	9
Residence not provided	7	47%	9	60%	3	20%	15
TOTAL	**142**	**25%**	**96**	**17%**	**59**	**10%**	**569**

Q20. Ways to improve services at Chesapeake Regional Healthcare by RACE
Answered:576 Skipped:343

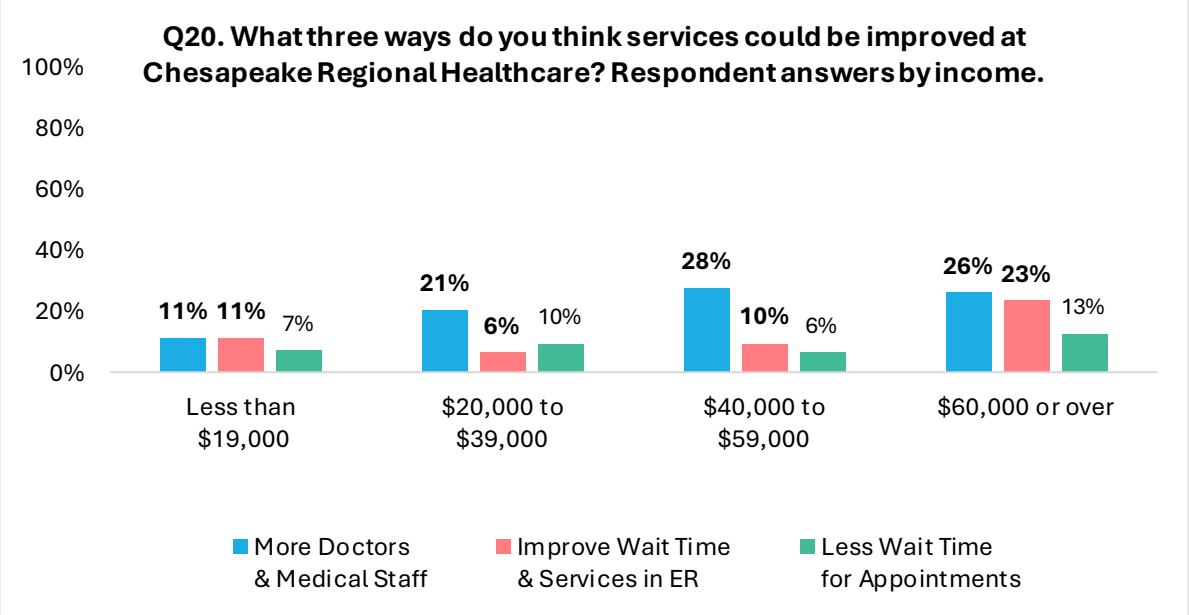
Of the 576 respondents who answered this question, White respondents (103, or 28%) reported the highest percentage of those citing the need for more doctors and medical staff. Respondents identifying as American Indian/Alaska Native and White mentioned reducing Emergency Room wait times at higher rates than the overall survey average of 17%. Similarly, Multiracial and White respondents cited faster appointment scheduling at higher rates than the survey average of 10%.



Race	More Doctors & Medical Staff		Improve Wait Time & Services in ER		Less Wait Time for Appointments		# Respondents
	#	%	#	%	#	%	
American Indian/Alaska Native	0	0%	1	20%	0	0%	5
Asian	2	15%	1	8%	1	8%	13
Black/African American	30	20%	22	15%	7	5%	151
Multiracial	5	20%	1	4%	5	20%	25
Native Hawaiian or Pacific Islander	0	0%	0	0%	0	0%	2
White	103	28%	71	20%	45	12%	363
Race Unknown	2	20%	0	0%	1	10%	10
TOTAL	**142**	**25%**	**96**	**17%**	**59**	**10%**	**569**

Q20. Ways to improve services at Chesapeake Regional Healthcare by INCOME
Answered:576 Skipped:343

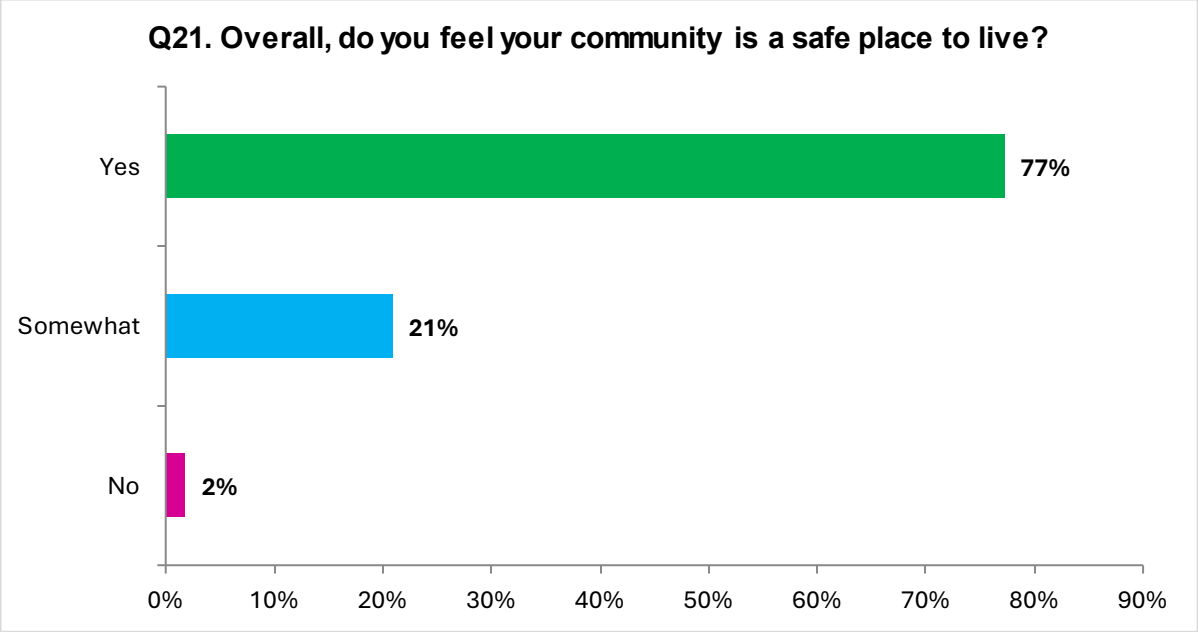
When sorting by income level, respondents earning over $40,000 reported the highest percentage of listing more doctors and medical staff as an improvement for the hospital. Those earning over $60,000 reported the highest percentage of reducing ER wait time/improving ER services at the highest percentage of all income groups (23%) and greater than the survey average of 17%.



Income	More Doctors & Medical Staff		Improve Wait Time & Services in ER		Less Wait Time for Appointments		# Respondents
	#	%	#	%	#	%	
Less than $19,000	8	11%	8	11%	5	7%	71
$20,000 to $39,000	13	21%	4	6%	6	10%	63
$40,000 to $59,000	26	28%	9	10%	6	6%	94
$60,000 or over	83	26%	74	23%	40	13%	316
Income range unknown	12	48%	2	8%	2	8%	25
TOTAL	**142**	**25%**	**97**	**17%**	**59**	**10%**	**569**

Q21: OVERALL, DO YOU FEEL YOUR COMMUNITY IS A SAFE PLACE TO LIVE?
Answered:886 Skipped:25

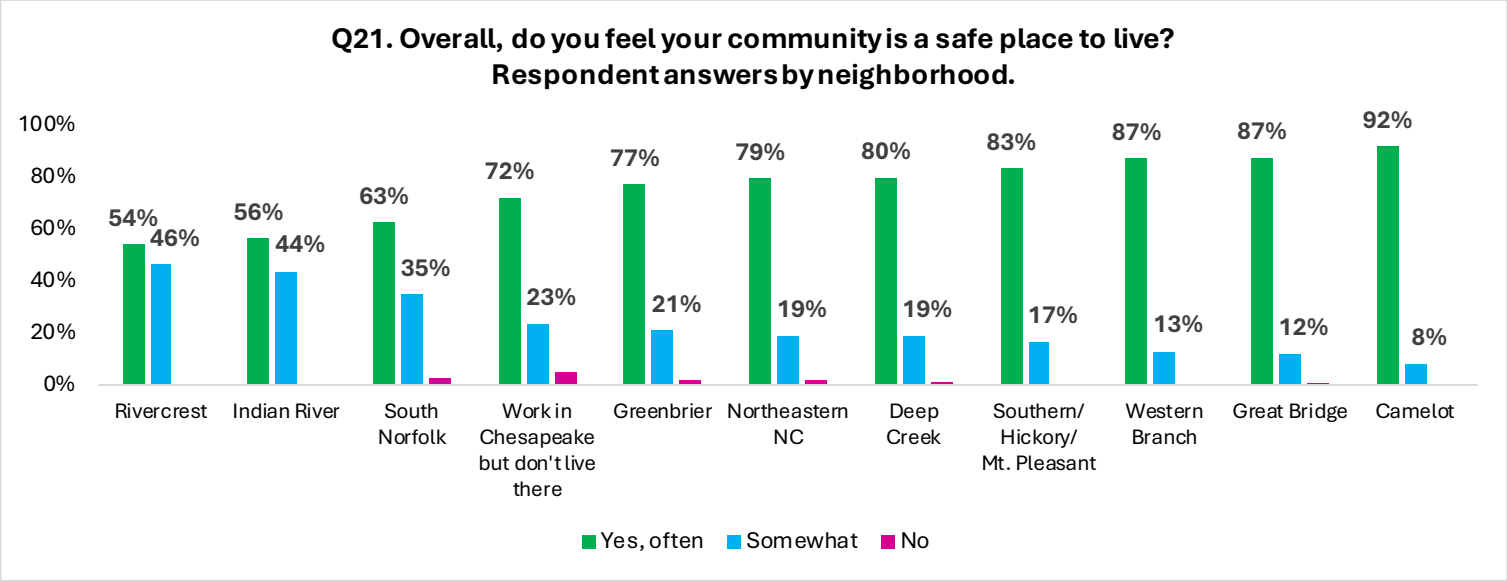
Although many residents (77%) feel that their communities are safe, 23% answered *Somewhat* or *No* to this question. The main reasons stated in the comments section were drug activity, lack of police presence, gun violence, and gang activity.



ANSWER CHOICES	PERCENT	NUMBER	CHNA 2021
No	2%	16	⇔ 2%
Somewhat	21%	184	⇔ 21%
Yes	77%	686	⇔ 77%
TOTAL	**100%**	**886**	**100%**

Q21: Community safety by NEIGHBORHOOD
Answered:893 Skipped:26

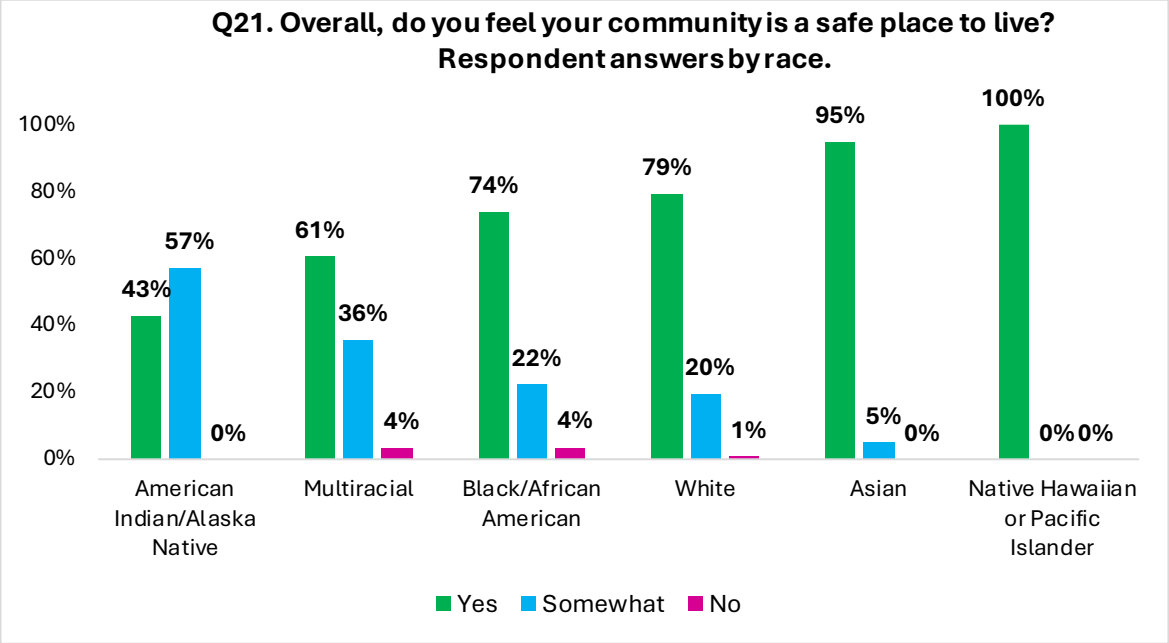
Respondents from Rivercrest (46%), Indian River (44%) and South Norfolk (35%) reported the lowest percentages of feeling that their neighborhoods are safe and the highest percentages of feeling that their neighborhoods are only *Somewhat* safe. Respondents from Camelot reported the highest percentage of people feeling that their neighborhood is safe (92%).



Neighborhood	% Yes, often	% Somewhat	% No	# Yes, often	# Somewhat	# No	# Respondents
Rivercrest	54%	46%	0%	7	6	0	13
Indian River	56%	44%	0%	18	14	0	32
South Norfolk	63%	35%	3%	45	25	2	72
Work in Chesapeake but don't live there	72%	23%	5%	77	25	5	107
Greenbrier	77%	21%	2%	118	32	3	153
Northeastern NC	79%	19%	2%	100	24	2	126
Deep Creek	80%	19%	1%	67	16	1	84
Southern/Hickory/ Mt. Pleasant	83%	17%	0%	55	11	0	66
Western Branch	87%	13%	0%	20	3	0	23
Great Bridge	87%	12%	1%	151	21	1	173
Camelot	92%	8%	0%	11	1	0	12
Residence not provided	2%	1%	0%	17	6	2	32
TOTAL	**77%**	**21%**	**2%**	**690**	**184**	**16**	**886**

Q21: Community safety by RACE
Answered:893 Skipped:26

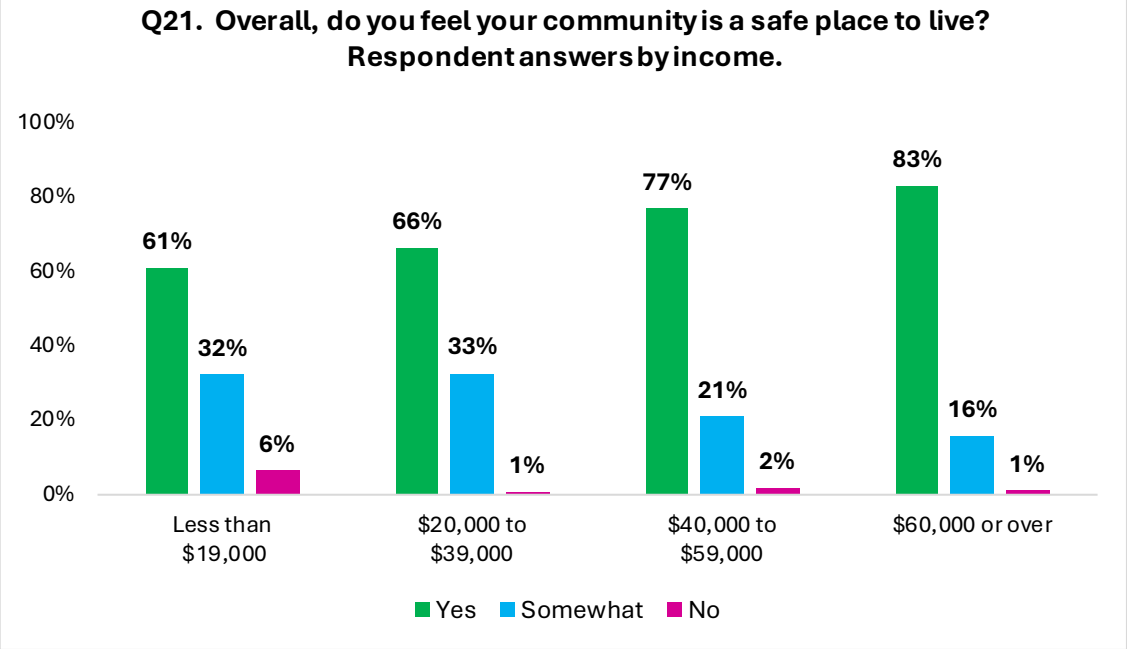
American Indian/Alaska Native (43%) and Multiracial (61%) respondents reported the lowest percentages of feeling that their neighborhoods are safe and reported the highest percentages of feeling that their neighborhoods are only *Somewhat* safe (57% and 36% respectively). Black/African American and White respondents reported similar percentages about community safety, and Asian and Native Hawaiian/Pacific Islander respondents reported the highest percentages of feeling safe.



Race	% Yes	% Somewhat	% No	# Yes	# Somewhat	# No	# Respondents
American Indian/Alaska Native	43%	57%	0%	3	4	0	7
Multiracial	61%	36%	4%	17	10	1	28
Black/African American	74%	22%	4%	182	55	9	246
White	79%	20%	1%	440	109	5	554
Asian	95%	5%	0%	19	1	0	20
Native Hawaiian or Pacific Islander	100%	0%	0%	3	0	0	3
Race Unknown	74%	23%	3%	22	5	1	35
TOTAL	**77%**	**21%**	**2%**	**686**	**184**	**16**	**886**

Q21: Community safety by INCOME
Answered:886 Skipped:25

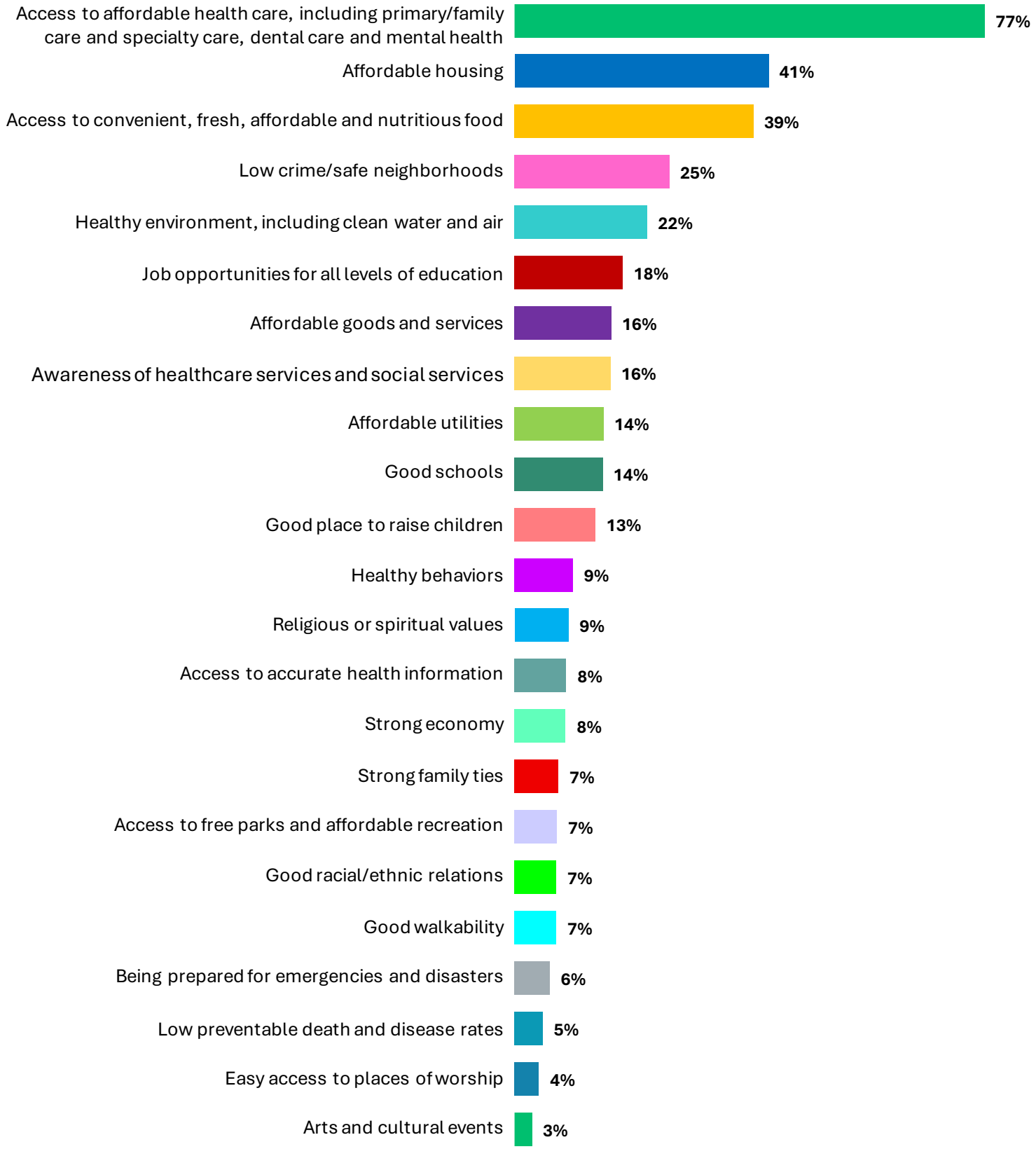
Although there seems to be a correlation between income and community safety, respondents in all income categories reported some degree of feeling that their community is not completely safe. Those earning less than $19,000 may live in low-income housing communities where crime is present or more visible.



Income	% Yes	% Somewhat	% No	# Yes	# Somewhat	# No	# Respondents
Less than $19,000	61%	32%	6%	66	35	7	108
$20,000 to $39,000	66%	33%	1%	73	36	1	110
$40,000 to $59,000	77%	21%	2%	124	34	3	161
$60,000 or over	83%	16%	1%	382	73	5	460
Income range unknown	83%	17%	0%	41	6	0	54
TOTAL	**77%**	**21%**	**2%**	**686**	**184**	**16**	**886**

Q22. WHAT DO YOU THINK CONTRIBUTES MOST TO A HEALTHY COMMUNITY? CHOOSE THREE.

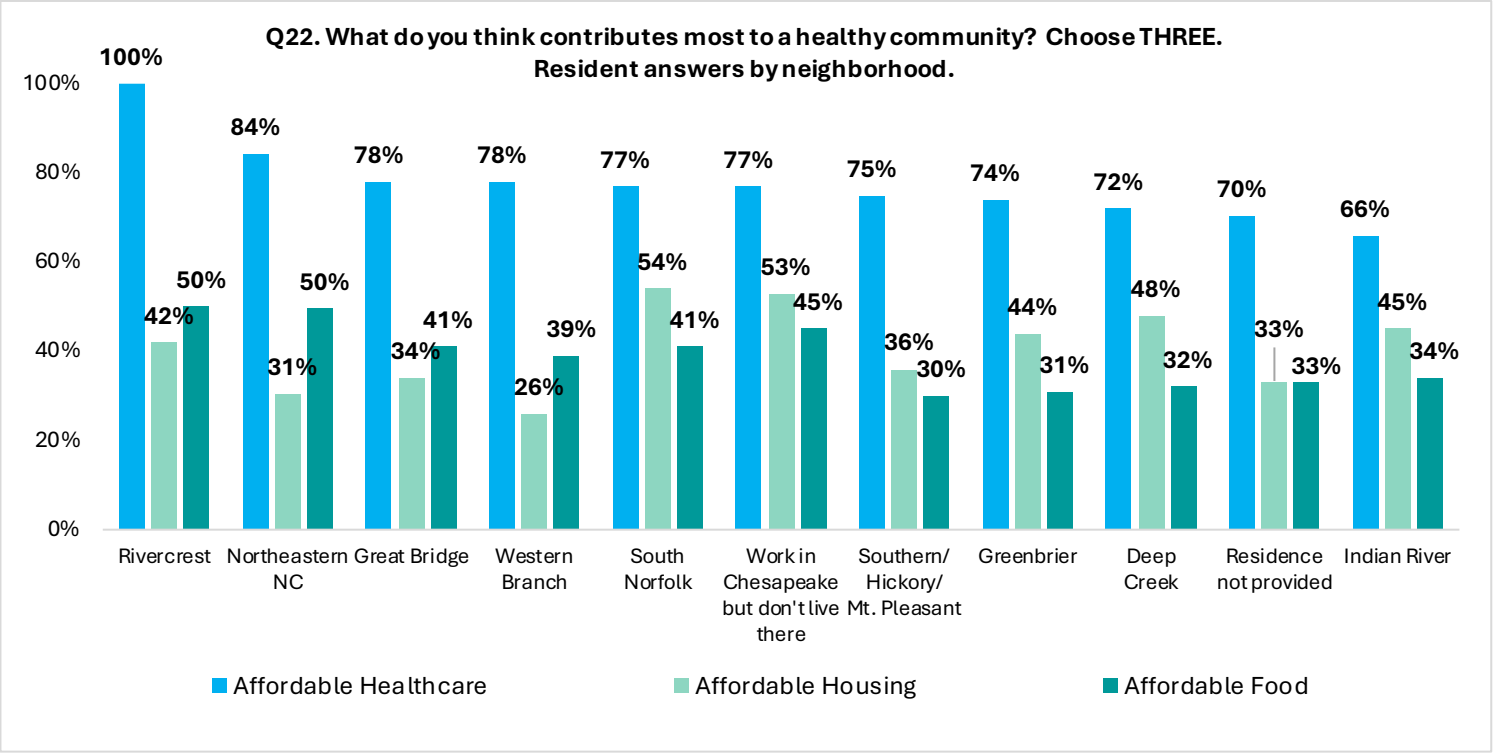
Answered:856 Skipped:63



ANSWER CHOICES FOR Q22:	PERCENT OF 856 RESPONDENTS WHO LISTED THIS ANSWER	NUMBER OF MENTIONS
Access to affordable health care, including primary/family care and specialty care, dental care, and mental health	77%	655
Affordable housing	41%	354
Access to convenient, fresh, affordable, and nutritious food	39%	333
Low crime/safe neighborhoods	25%	216
Healthy environment, including clean water and air	22%	185
Job opportunities for all levels of education	18%	151
Affordable goods and services	16%	135
Awareness of healthcare services and social services	16%	134
Affordable utilities	14%	124
Good schools	14%	123
Good place to raise children	13%	113
Healthy behaviors	9%	81
Religious or spiritual values	9%	75
Access to accurate health information	8%	72
Strong economy	8%	71
Strong family ties	7%	61
Access to free parks and affordable recreation	7%	59
Good racial/ethnic relations	7%	58
Good walkability	7%	58
Being prepared for emergencies and disasters	6%	49
Low preventable death and disease rates	5%	39
Easy access to places of worship	4%	34
Arts and cultural events	3%	24
OTHER:		
Communities that have things in place that make healthy behaviors possible. Can't walk after work, for instance, if there isn't a safe place to do so or infrastructure like lighting or sidewalks		1
Having a tribe/village for support, especially in this military area		1
Ability to have help with daycare payments to our small business Daycare facilities, not the large cooperations and help with utilities.		1
More music in the park on Sunday evenings that's a plus for anxiety.		1
Remove harmful food choices		1
TOTAL		

Q22: What Contributes to a Healthy Community by NEIGHBORHOOD
Answered:856 Skipped:63

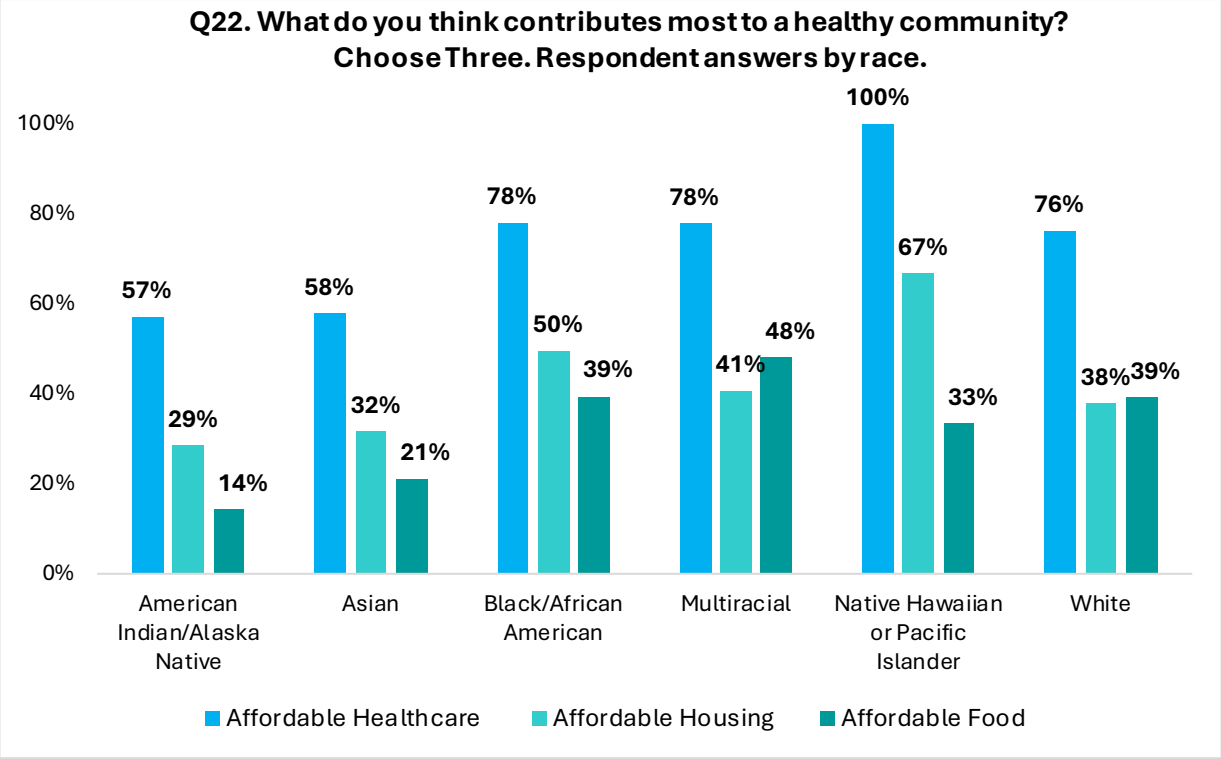
Among the 856 respondents who answered this question, the top three answers were 1) Affordable healthcare, 2) Affordable housing, and 3) Affordable healthy food. These three answers are represented by the graphs and tables that follow, and the complete answers are provided in the table above. A list of answers by neighborhood is in APPENDIX X to see if there are other important issues raised for people living in specific locations.



Neighborhood	%Affordable Healthcare	%Affordable Housing	%Affordable Food	#Affordable Healthcare	#Affordable Housing	#Affordable Food	# Respondents
Rivercrest	100%	42%	50%	12	5	6	12
Northeastern NC	84%	31%	50%	102	37	60	121
Great Bridge	78%	34%	41%	131	57	69	167
Western Branch	78%	26%	39%	18	6	9	23
South Norfolk	77%	54%	41%	55	38	29	71
Work in Chesapeake but don't live there	77%	53%	45%	81	56	47	105
Southern/Hickory/ Mt. Pleasant	75%	36%	30%	48	23	19	64
Greenbrier	74%	44%	31%	106	64	44	144
Deep Creek	72%	48%	32%	58	39	26	81
Indian River	66%	45%	34%	19	13	10	29
Camelot	50%	58%	42%	6	7	5	12
Residence not provided	70%	33%	33%	19	9	9	27
TOTAL	**77%**	**41%**	**39%**	**655**	**354**	**333**	**856**

Q22: Healthy Community by RACE
Answered:856 Skipped:63

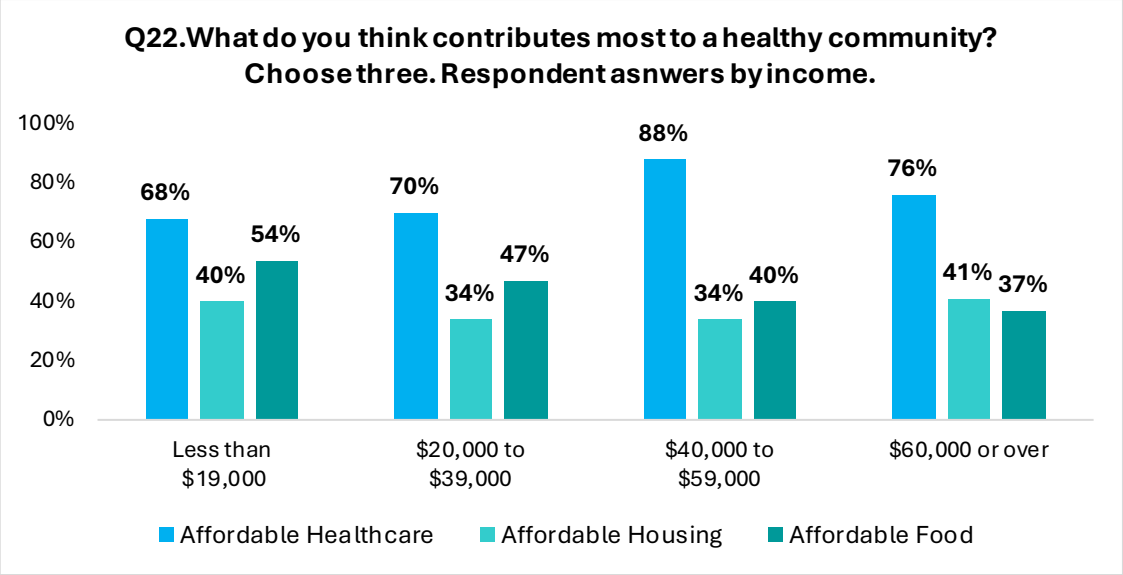
Respondents of all races ranked affordable healthcare as their top priority yet varied in how they ranked affordable housing and affordable healthy food.



	% Affordable Healthcare	% Affordable Housing	% Affordable Food	# Affordable Healthcare	# Affordable Housing	# Affordable Food	# Respondents
American Indian/ Alaska Native	57%	29%	14%	4	2	1	7
Asian	58%	32%	21%	11	6	4	19
Black/African American	78%	50%	39%	186	118	94	238
Multiracial	78%	41%	48%	21	11	13	27
Native Hawaiian or Pacific Islander	100%	67%	33%	3	2	1	3
White	76%	38%	39%	406	201	208	532
Race Unknown	80%	47%	40%	24	14	12	30
TOTAL	**77%**	**41%**	**39%**	**655**	**354**	**333**	**856**

Q22: Healthy Community by INCOME
Answered:856 Skipped:63

Respondents in all income categories also ranked affordable healthcare as their number one priority, with variations in how they ranked the other two indicators.

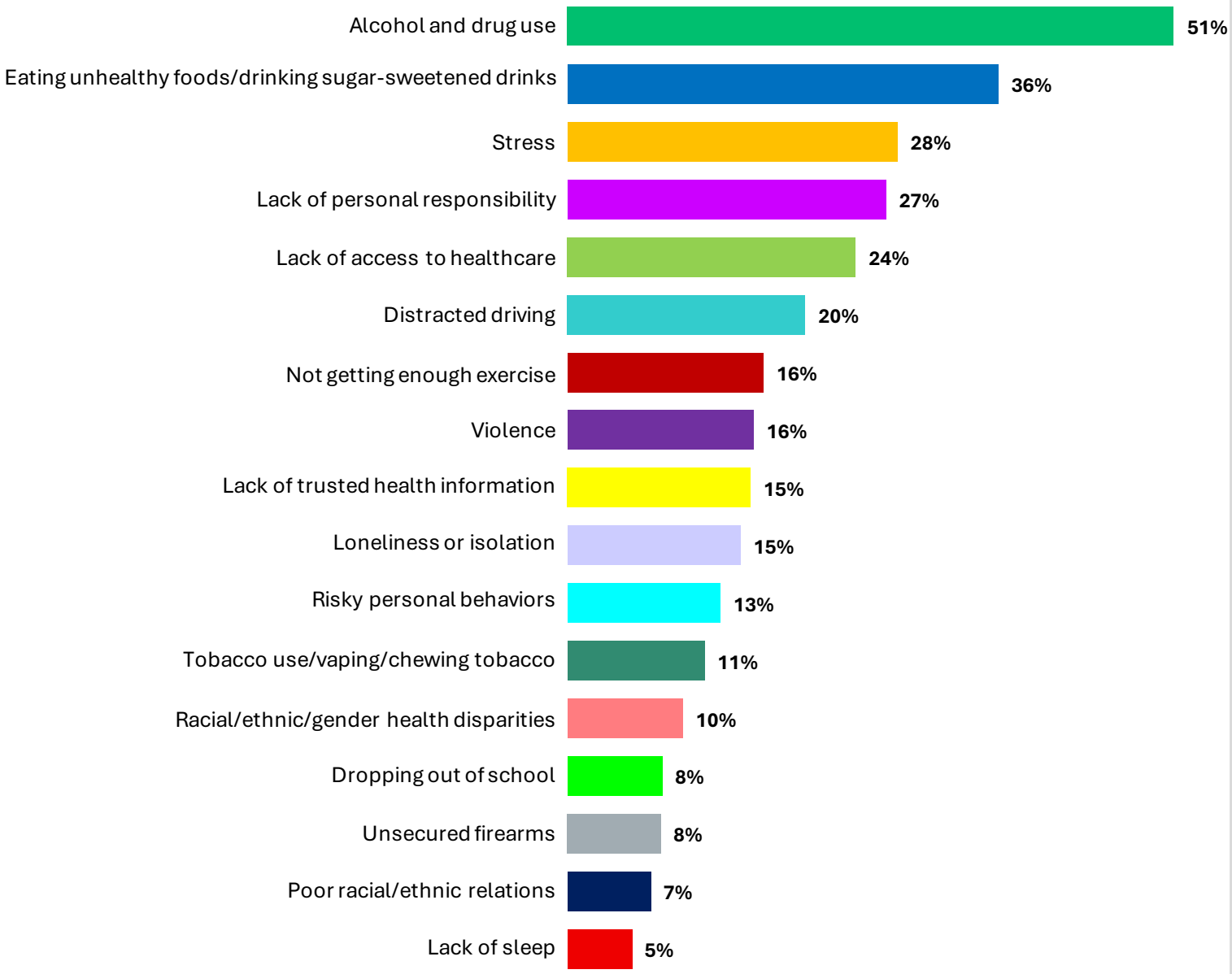


Income	% Affordable Healthcare	% Affordable Food	% Affordable Housing	# Affordable Healthcare	# Affordable Food	# Affordable Housing	# Respondents
Less than $19,000	68%	40%	54%	73	43	58	108
$20,000 to $39,000	70%	34%	47%	73	36	49	105
$40,000 to $59,000	88%	34%	40%	137	53	62	156
$60,000 or over	76%	41%	37%	332	180	164	439
Income range unknown				40	21	21	47
TOTAL	**77%**	**39%**	**41%**	**655**	**333**	**354**	**856**

Q23. WHAT HAS THE GREATEST NEGATIVE IMPACT ON THE HEALTH OF PEOPLE IN YOUR COMMUNITY? CHOOSE THREE.
Answered:827 Skipped:92

Respondents were asked to choose three issues from the list in the graph that they believe have the greatest negative impact on their community. Over half (51%) ranked alcohol and drug use as the number one problem. This was followed by unhealthy food/sugar-sweetened drinks (36%) and stress (28).

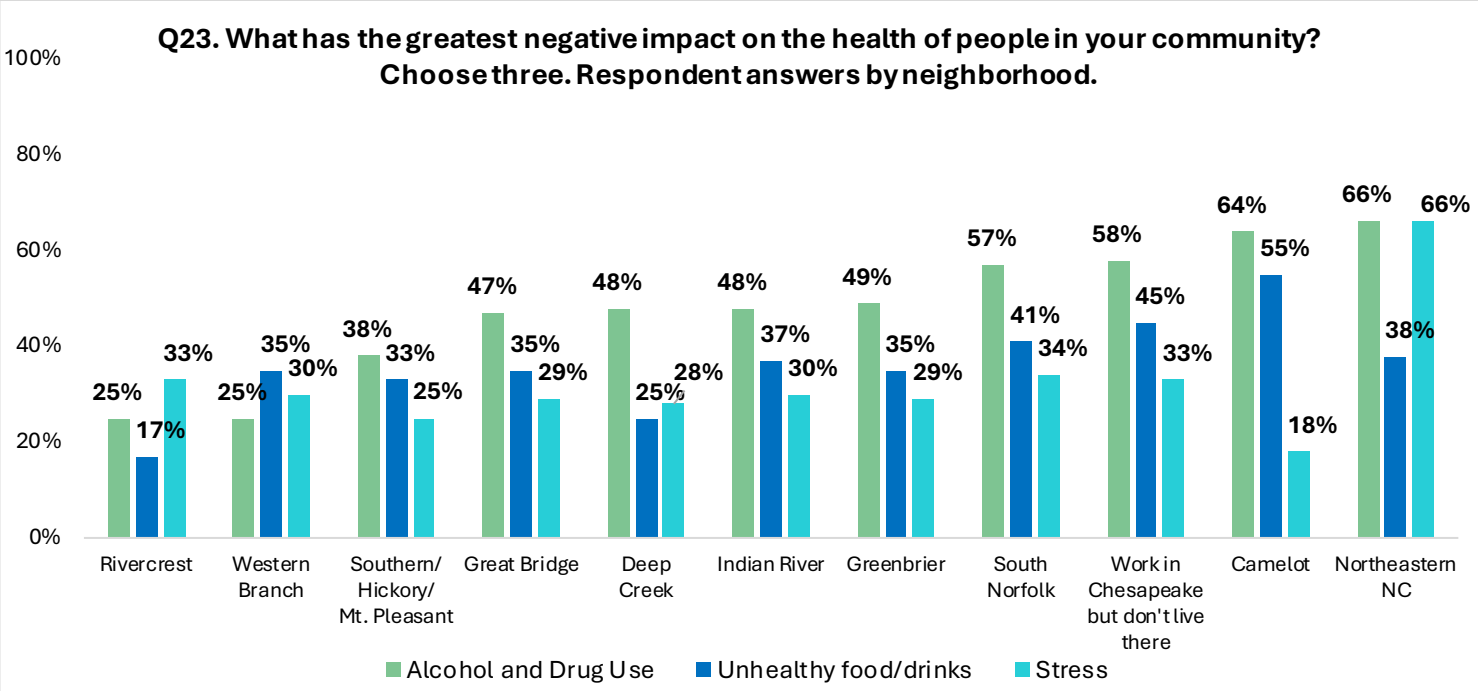
Q23. What has the greatest negative impact on the health of people in your community?



ANSWER CHOICES FOR Q23:	PERCENT OF 827 RESPONDENTS WHO GAVE THIS ANSWER	NUMBER OF MENTIONS
Alcohol and drug use	51%	421
Eating unhealthy foods/drinking sugar-sweetened drinks	36%	299
Stress	28%	229
Lack of personal responsibility	27%	221
Lack of access to healthcare	24%	200
Distracted driving	20%	165
Not getting enough exercise	16%	136
Violence	16%	129
Lack of trusted health information	15%	127
Loneliness or isolation	15%	120
Risky personal behaviors	13%	106
Tobacco use/vaping/chewing tobacco	11%	95
Racial/ethnic/gender health disparities	10%	80
Dropping out of school	8%	66
Unsecured firearms	8%	65
Poor racial/ethnic relations	7%	58
Lack of sleep	5%	45
OTHER:		
Mental health issues		
Lack of social connections.		
Limited access to anyone who can help guide them in the right direction. Unable to find anyone willing to help explain resources and how to get access to them. A list is great, but I find most people have no idea what they need and no one willing to help them find the resources to allow them to meet their goals.		
Educating underserved areas of resources in their local community.		
Negative media.		
High costs.		
Lack of hope and purpose in young folks.		
Legalized gambling - leading to lost household income.		
Lack of insurance.		
Not getting key yearly checkups, not having health insurance.		

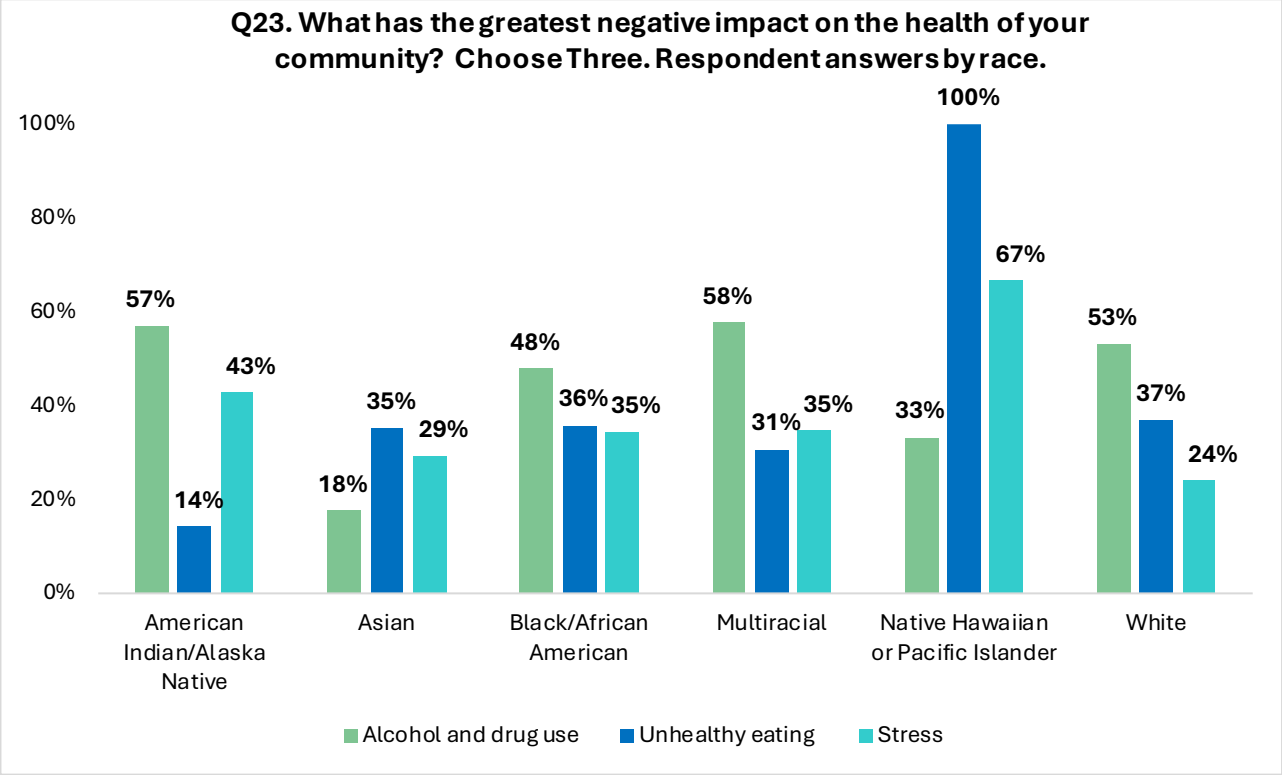
Q23: Negative Impact on Health by NEIGHBORHOOD
Answered:827 Skipped:92

Respondents from all neighborhoods ranked alcohol and drug use, unhealthy food/drinks, and stress as having a significant negative impact on their communities. The graph below shows the variations among how these factors ranked for each location.



Neighborhood	% Alcohol and Drug Use	% Unhealthy food/drinks	% Stress	# Alcohol and Drug Use	# Unhealthy food/drinks	# Stress	# Respondents
Rivercrest	25%	17%	33%	3	2	4	12
Western Branch	25%	35%	30%	5	7	6	20
Southern/Hickory/ Mt. Pleasant	38%	33%	25%	23	20	15	61
Great Bridge	47%	35%	29%	78	59	48	167
Deep Creek	48%	25%	28%	36	19	21	75
Indian River	48%	37%	30%	13	10	8	27
Greenbrier	49%	35%	29%	67	48	40	137
South Norfolk	57%	41%	34%	39	28	23	68
Work in Chesapeake but don't live there	58%	45%	33%	60	47	34	104
Camelot	64%	55%	18%	7	6	2	11
Northeastern NC	66%	38%	66%	77	44	21	116
Residence not provided	45%	31%	24%	13	9	7	29
TOTAL	**51%**	**36%**	**28%**	**421**	**299**	**229**	**827**

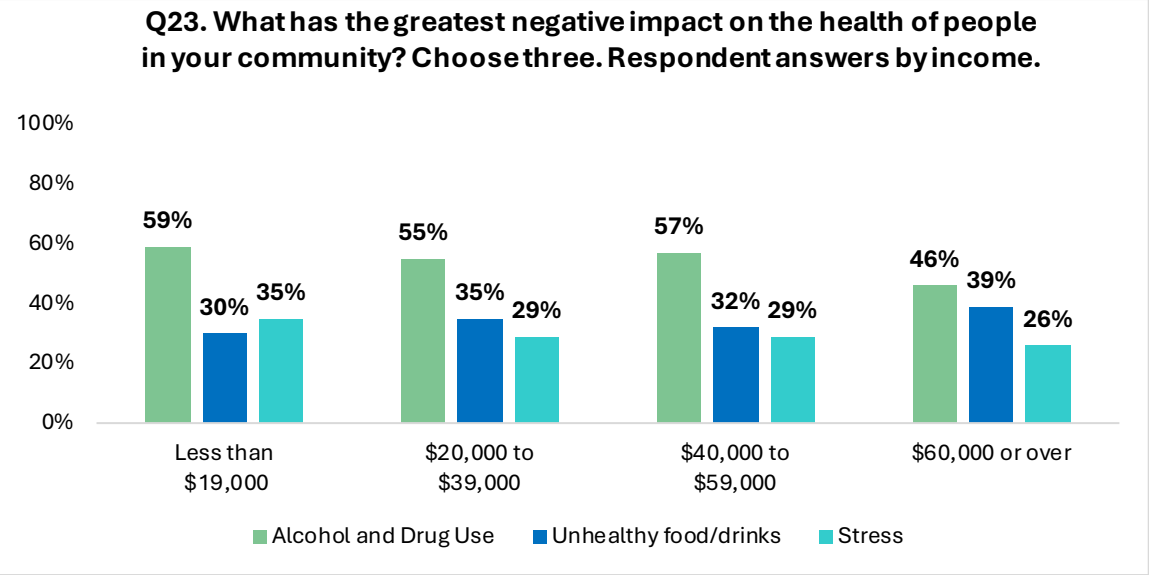
Q23: Negative Impact on Health by RACE
Answered:827 Skipped:92



Race	% Alcohol and Drug Use	% Unhealthy food/drinks	% Stress	# Alcohol and Drug Use	# Unhealthy food/drinks	# Stress	# Respondents
American Indian/ Alaska Native	57%	14%	43%	4	1	3	7
Asian	18%	35%	29%	3	6	5	17
Black/African American	48%	36%	35%	107	80	77	223
Multiracial	58%	31%	35%	15	8	9	26
Native Hawaiian or Pacific Islander	33%	100%	67%	1	3	2	3
White	53%	37%	24%	277	192	125	520
Race Unknown	45%	29%	26%	14	9	8	31
TOTAL	**51%**	**36%**	**28%**	**421**	**299**	**229**	**827**

Q23: Negative Impact on Health by INCOME
Answered:827 Skipped:92

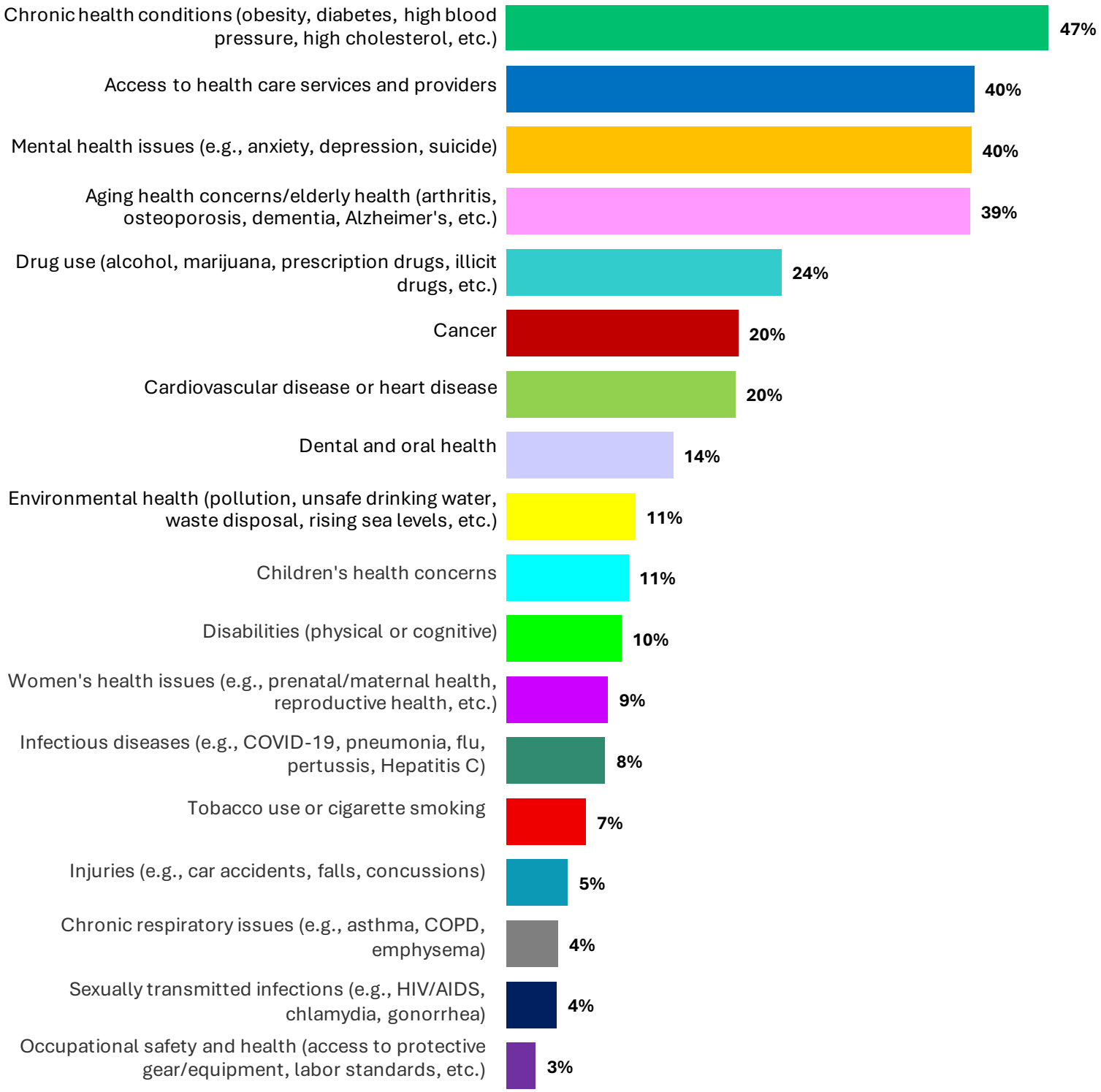
Respondents from all income categories responded similarly to how they ranked these three negative community impacts. These issues seem to cross economic boundaries.



Income	% Alcohol and Drug Use	% Unhealthy food/drinks	% Stress	# Alcohol and Drug Use	# Unhealthy food/drinks	# Stress	# Respondents
Less than $19,000	59%	30%	35%	61	31	36	104
$20,000 to $39,000	55%	35%	29%	54	35	29	99
$40,000 to $59,000	57%	32%	29%	85	48	43	150
$60,000 or over	46%	39%	26%	196	168	109	426
Income range unknown	52%	35%	25%	25	17	12	48
TOTAL	**51%**	**36%**	**28%**	**421**	**299**	**229**	**827**

Q24. WHAT ARE THE TOP 3 HEALTH CONCERNS IN YOUR COMMUNITY? CHOOSE THREE.

Answered:837 Skipped:82



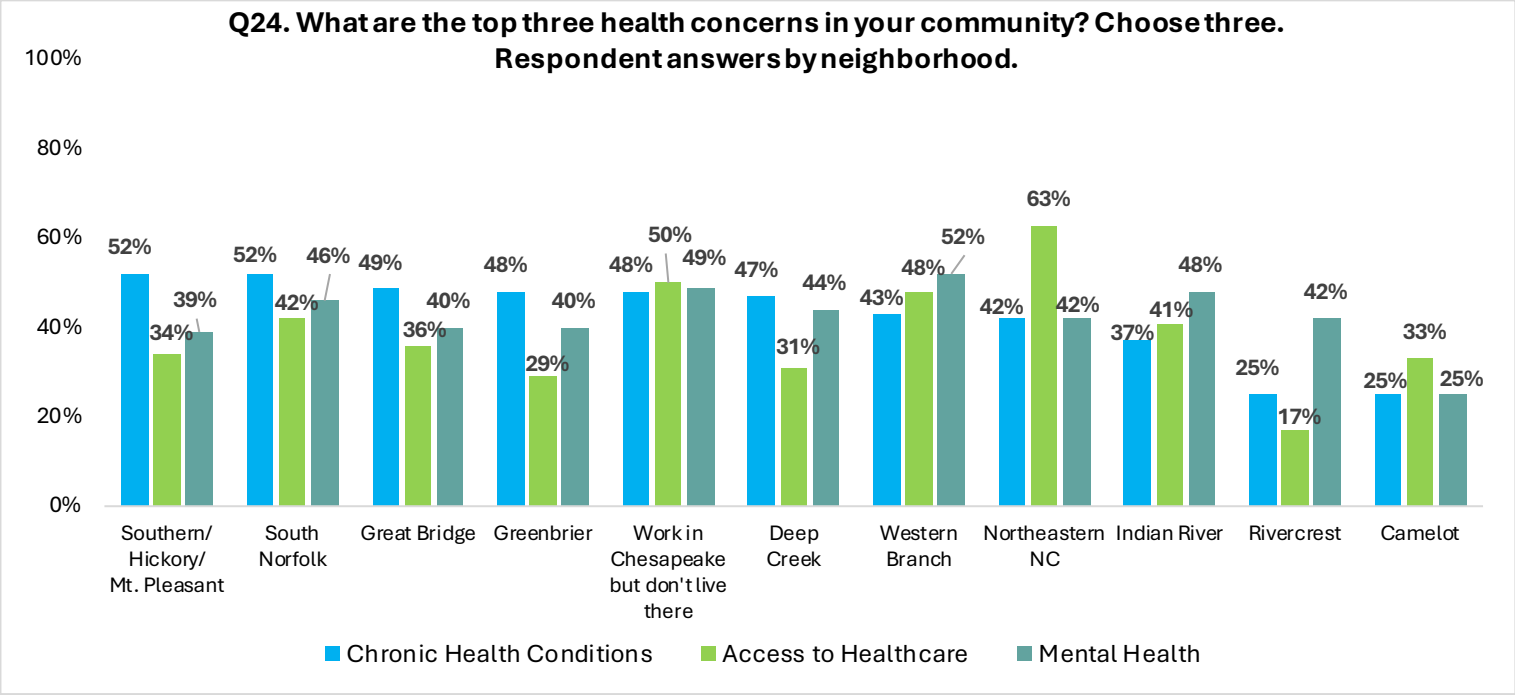
ANSWER CHOICES FOR Q24:	PERCENT OF 837 RESPONDENTS WHO LISTED THIS ANSWER	NUMBER
Chronic health conditions (obesity, diabetes, high blood pressure, high cholesterol, etc.)	47%	391
Access to health care services and providers	40%	337
Mental health issues (e.g., anxiety, depression, suicide)	40%	335
Aging health concerns/elderly health (arthritis, osteoporosis, dementia, Alzheimer's, etc.)	39%	334
Drug use (alcohol, marijuana, prescription drugs, illicit drugs, etc.)	24%	198
Cancer	20%	167
Cardiovascular disease or heart disease	20%	165
Dental and oral health	14%	120
Environmental health (pollution, unsafe drinking water, waste disposal, rising sea levels, etc.)	11%	93
Children's health concerns	11%	88
Disabilities (physical or cognitive)	10%	83
Women's health issues (e.g., prenatal/maternal health, reproductive health, etc.)	9%	73
Infectious diseases (e.g., COVID-19, pneumonia, flu, pertussis, Hepatitis C)	8%	71
Tobacco use or cigarette smoking	7%	57
Injuries (e.g., car accidents, falls, concussions)	5%	44
Chronic respiratory issues (e.g., asthma, COPD, emphysema)	4%	37
Sexually transmitted infections (e.g., HIV/AIDS, chlamydia, gonorrhea)	4%	36
Occupational safety and health (access to protective gear/equipment, labor standards, etc.)	3%	21

Additional write in answers for Q24:

Anemia	Hypothyroidism
Arthritis	Irritable Bowel Syndrome
Breast cancer	Kidney disease
Cardiac arrhythmia	Osteopenia
Celiac disease	Pre-diabetes
Crohn’s disease	Prostate issues
Chronic pain	Rheumatoid arthritis
Depression/Anxiety/PTSD	Sleep apnea
Fibromyalgia	Spinal cord injury
Hashimoto's Disease	Stroke
High cholesterol	Vein disease
Hyperlipidemia	Weight management

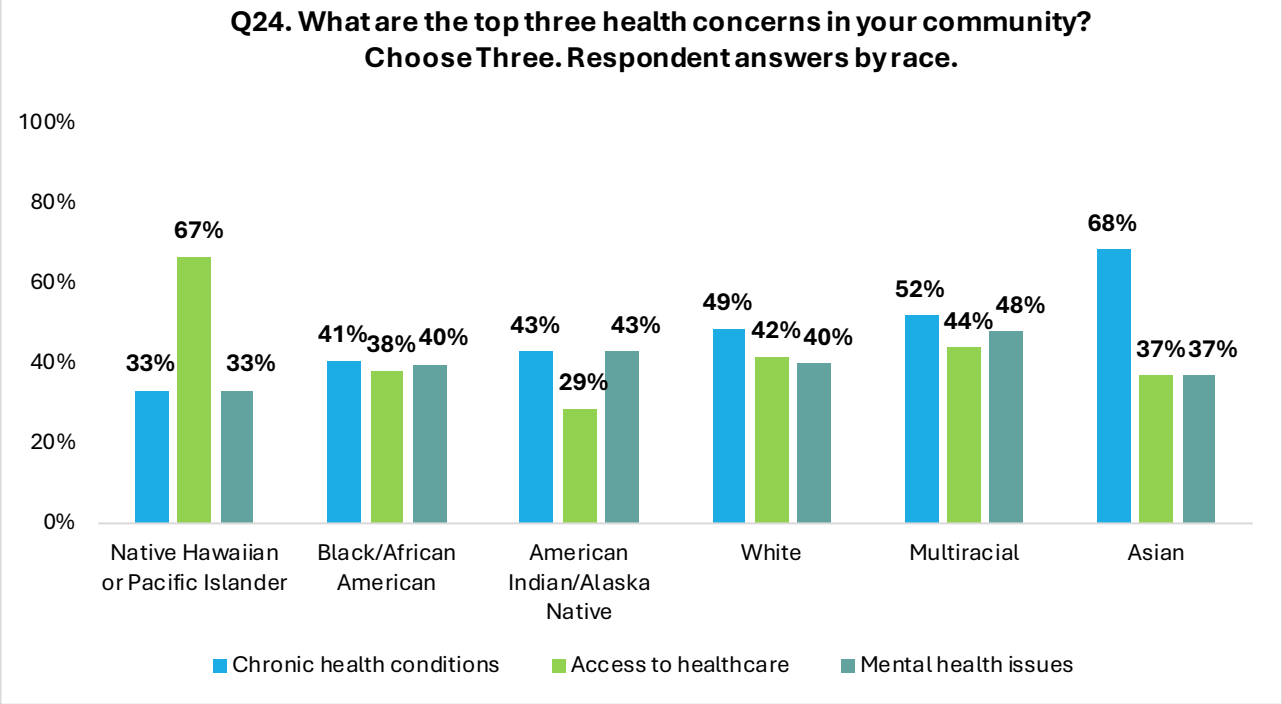
Q24. Top three health concerns by NEIGHBORHOOD
Answered:837 Skipped:82

Respondents were asked to write about what they believe to be the top three health concerns in their communities. Of the 837 people who answered this question, the top concerns were 1) Chronic health conditions, 2) Access to healthcare, and 3) Mental health. The graph below indicates that these issues are ranked similarly across the neighborhoods surveyed.



Neighborhood	% Chronic Health Conditions	% Access to Healthcare	% Mental Health	# Chronic Health Conditions	# Access to Healthcare	# Mental Health	# Respondents
Southern/Hickory/ Mt. Pleasant	52%	34%	39%	32	21	24	62
South Norfolk	52%	42%	46%	36	29	32	69
Great Bridge	49%	36%	40%	82	60	67	166
Greenbrier	48%	29%	40%	68	41	57	142
Work in Chesapeake but don't live there	48%	50%	49%	50	52	51	104
Deep Creek	47%	31%	44%	36	24	34	77
Western Branch	43%	48%	52%	9	10	11	21
Northeastern NC	42%	63%	42%	49	73	29	116
Indian River	37%	41%	48%	10	11	13	27
Rivercrest	25%	17%	42%	3	2	5	12
Camelot	25%	33%	25%	3	4	3	12
Residence not provided	45%	34%	45%	13	10	9	29
TOTAL	**47%**	**40%**	**40%**	**391**	**337**	**335**	**837**

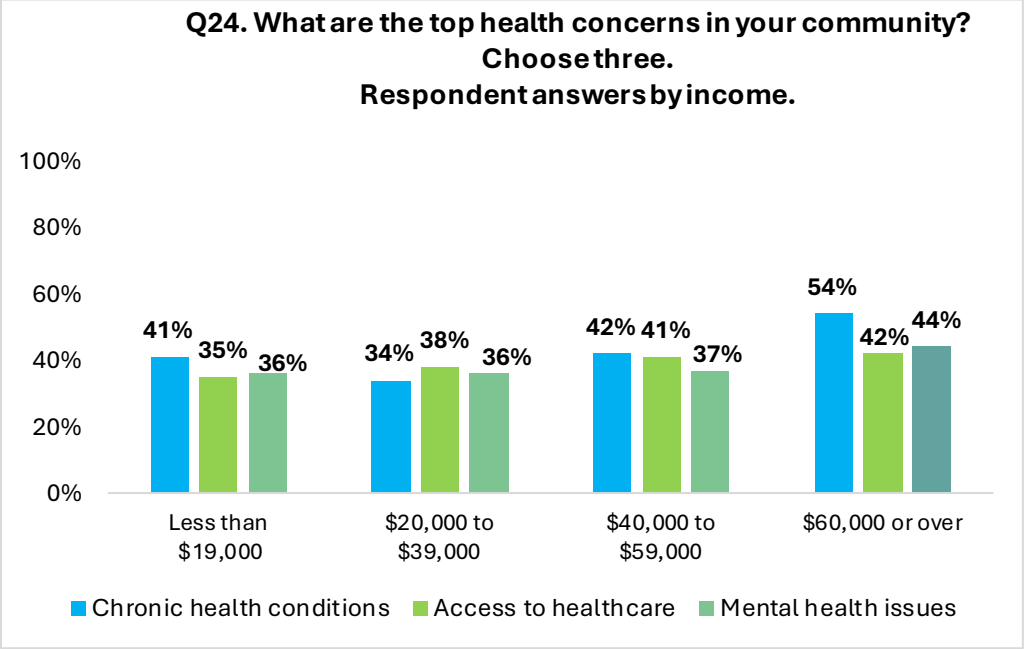
Q24. Top three health concerns by RACE
Answered:837 Skipped:82



Race	% Chronic Health Conditions	% Access to Healthcare	% Mental Health	# Chronic Health Conditions	# Access to Healthcare	# Mental Health	# Respondents
Native Hawaiian or Pacific Islander	33%	67%	33%	1	2	1	3
Black/African American	41%	38%	40%	94	88	92	231
American Indian/Alaska Native	43%	29%	43%	3	2	3	7
White	49%	42%	40%	254	218	209	523
Multiracial	52%	44%	48%	13	11	12	25
Asian	68%	37%	37%	13	7	7	19
Race Unknown	2%	1%	1%	13	9	11	29
TOTAL	**47%**	**40%**	**40%**	**391**	**337**	**335**	**837**

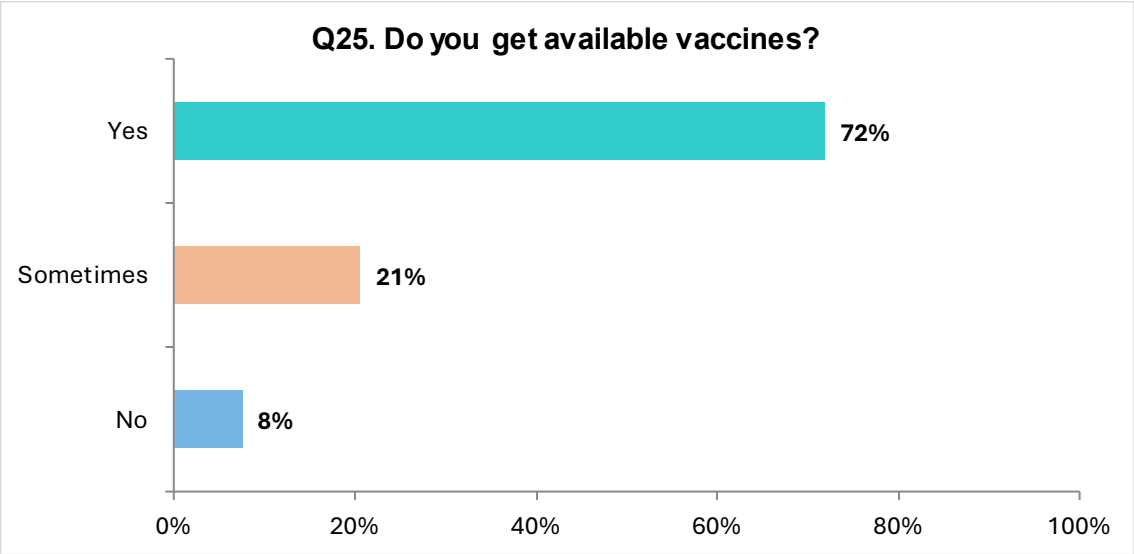
Q24. Top three health concerns by INCOME
Answered:837 Skipped:82

Respondents across all income levels reported these three concerns in similar percentages, and chronic health concerns were higher in the $60,000 income range which may include older persons.



Income	% Chronic Health Conditions	% Access to Healthcare	% Mental Health	# Chronic Health Conditions	# Access to Healthcare	# Mental Health	# Respondents
Less than $19,000	41%	35%	36%	44	37	39	107
$20,000 to $39,000	34%	38%	36%	34	38	36	101
$40,000 to $59,000	42%	41%	37%	65	62	57	153
$60,000 or over	54%	42%	44%	229	180	187	428
Income range unknown	40%	42%	33%	19	20	16	48
TOTAL	**47%**	**40%**	**40%**	**391**	**337**	**335**	**837**

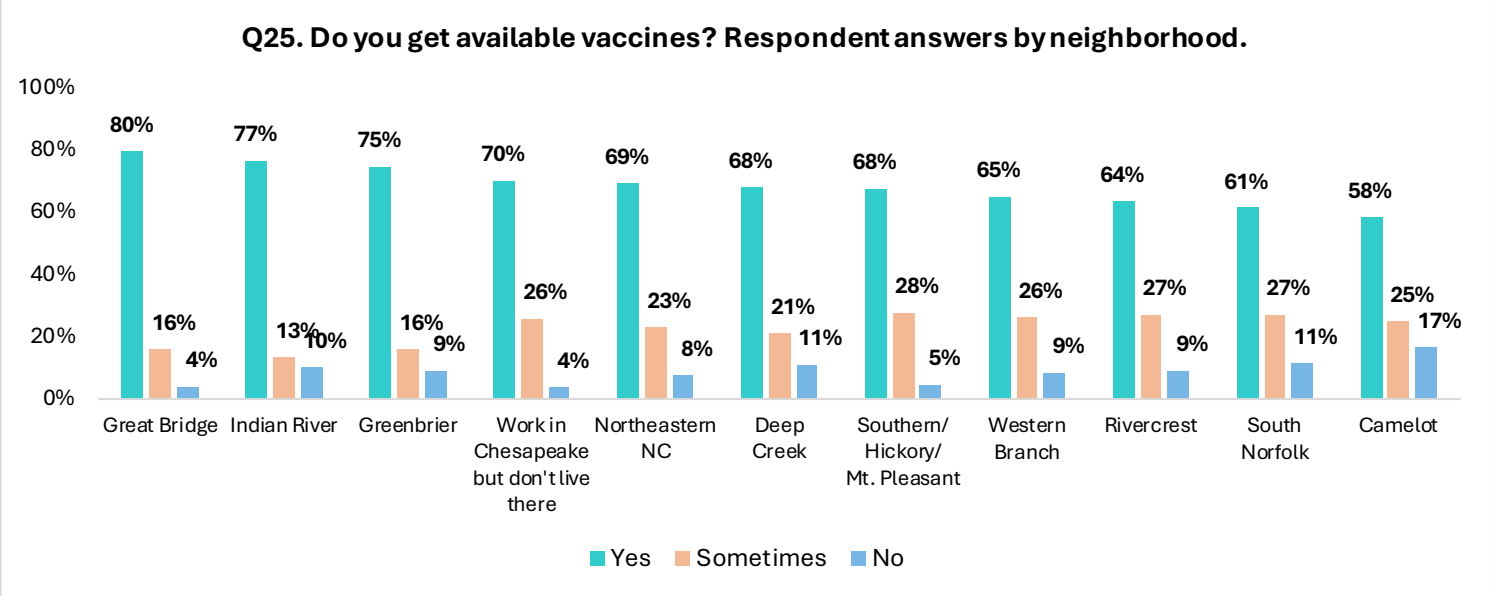
Q25. DO YOU GET AVAILABLE VACCINES?
Answered:855 Skipped:64



ANSWER CHOICES	PERCENT	NUMBER	CHNA 2021
Yes	72%	614	↓ 85%
Sometimes	21%	176	↑ 11%
No	8%	65	↑ 4%
TOTAL	**100%**	**855**	**100%**

Q25: Vaccines by NEIGHBORHOOD
Answered:855 Skipped:64

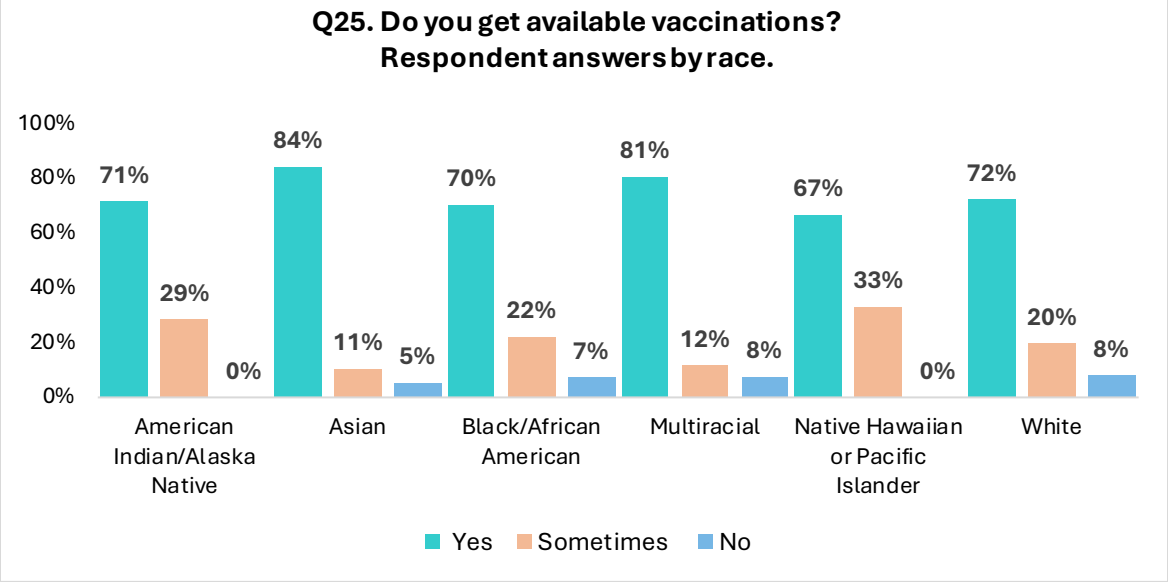
More than half of all respondents get available vaccines, and the percentage of those reporting *Yes* ranges from 80% of respondents in Great Bridge to 58% of respondents in Camelot.



Neighborhood	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
Great Bridge	80%	16%	4%	134	27	7	168
Indian River	77%	13%	10%	23	4	3	30
Greenbrier	75%	16%	9%	107	23	13	143
Work in Chesapeake but don't live there	70%	26%	4%	73	27	4	104
Northeastern NC	69%	23%	8%	72	24	8	104
Deep Creek	68%	21%	11%	55	17	9	81
Southern/Hickory/ Mt. Pleasant	68%	28%	5%	44	18	3	65
Western Branch	65%	26%	9%	15	6	2	23
Rivercrest	64%	27%	9%	7	3	1	11
South Norfolk	61%	27%	11%	43	19	8	70
Camelot	58%	25%	17%	7	3	2	12
Residence not provided	4%	1%	1%	34	5	5	44
TOTAL	**72%**	**21%**	**8%**	**614**	**176**	**65**	**855**

Q25: Vaccines by RACE
Answered:855 Skipped:64

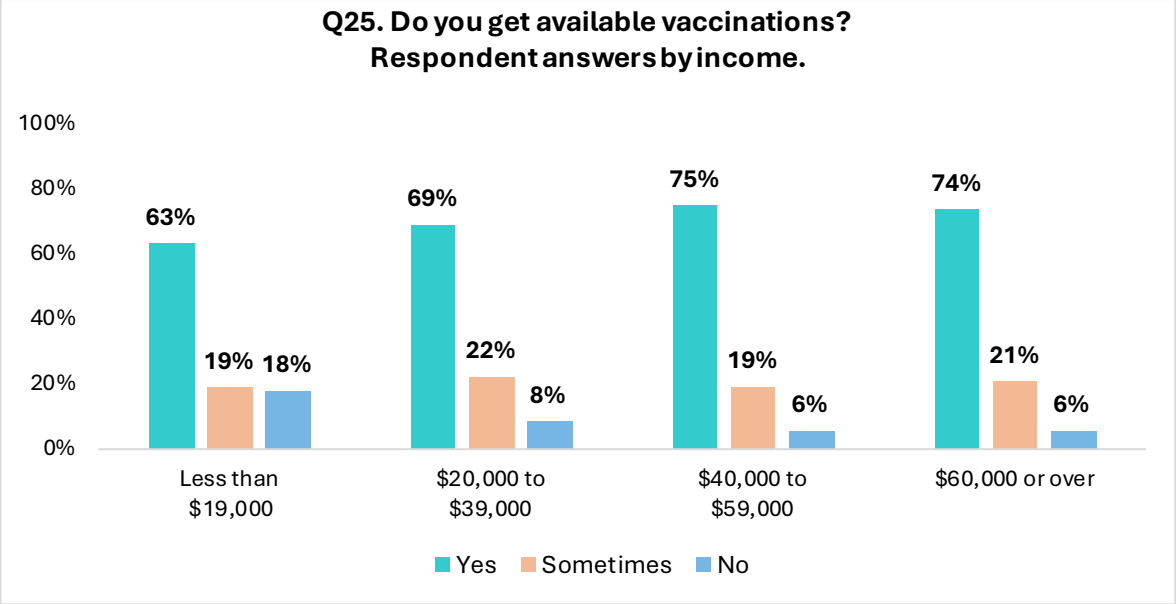
Over 67% of respondents across all races answered *Yes* to this question, indicating that race alone may not be a factor in getting vaccines.



Race	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
American Indian/Alaska Native	71%	29%	0%	5	2	0	7
Asian	84%	11%	5%	16	2	1	19
Black/African American	70%	22%	7%	167	53	17	237
Multiracial	81%	12%	8%	21	3	2	26
Native Hawaiian or Pacific Islander	67%	33%	0%	2	1	0	3
White	72%	20%	8%	384	105	42	531
Race Unknown	59%	31%	9%	19	10	3	32
Total	**72%**	**21%**	**8%**	**614**	**176**	**65**	**855**

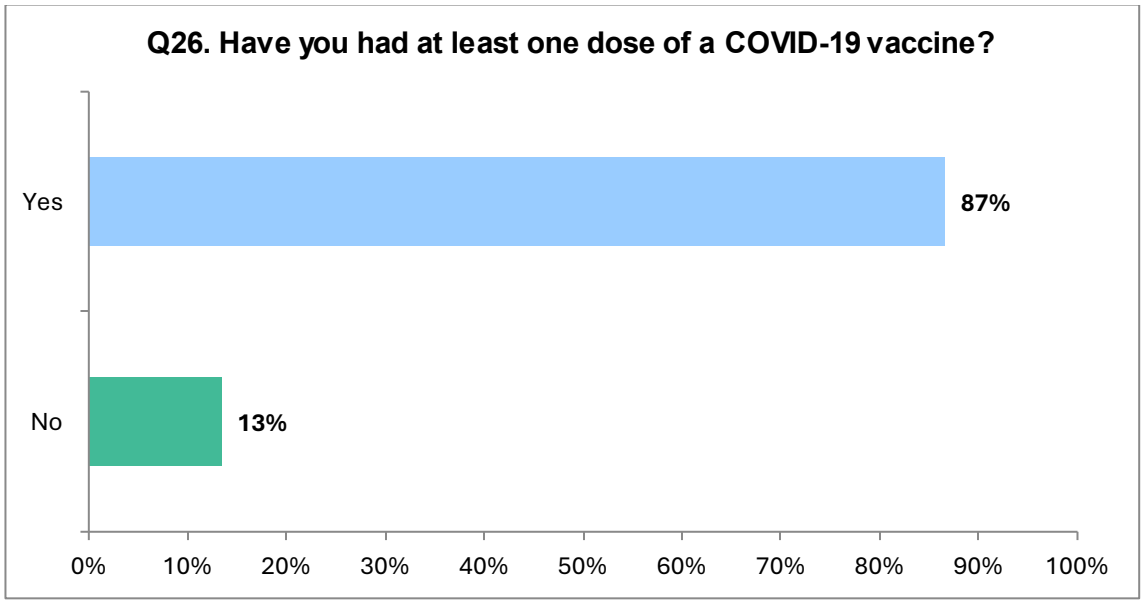
Q25: Vaccines by INCOME
Answered:855 Skipped:64

Respondents across all income groups reported similar answers to this question. Interestingly, there are *Yes, Sometimes* and *No* answers from respondents in each income group.



Income	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
Less than $19,000	63%	19%	18%	67	20	19	106
$20,000 to $39,000	69%	22%	8%	74	24	9	107
$40,000 to $59,000	75%	19%	6%	116	30	9	155
$60,000 or over	74%	21%	6%	324	91	25	440
Income range unknown	70%	23%	6%	33	11	3	47
TOTAL	**72%**	**21%**	**8%**	**614**	**176**	**65**	**855**

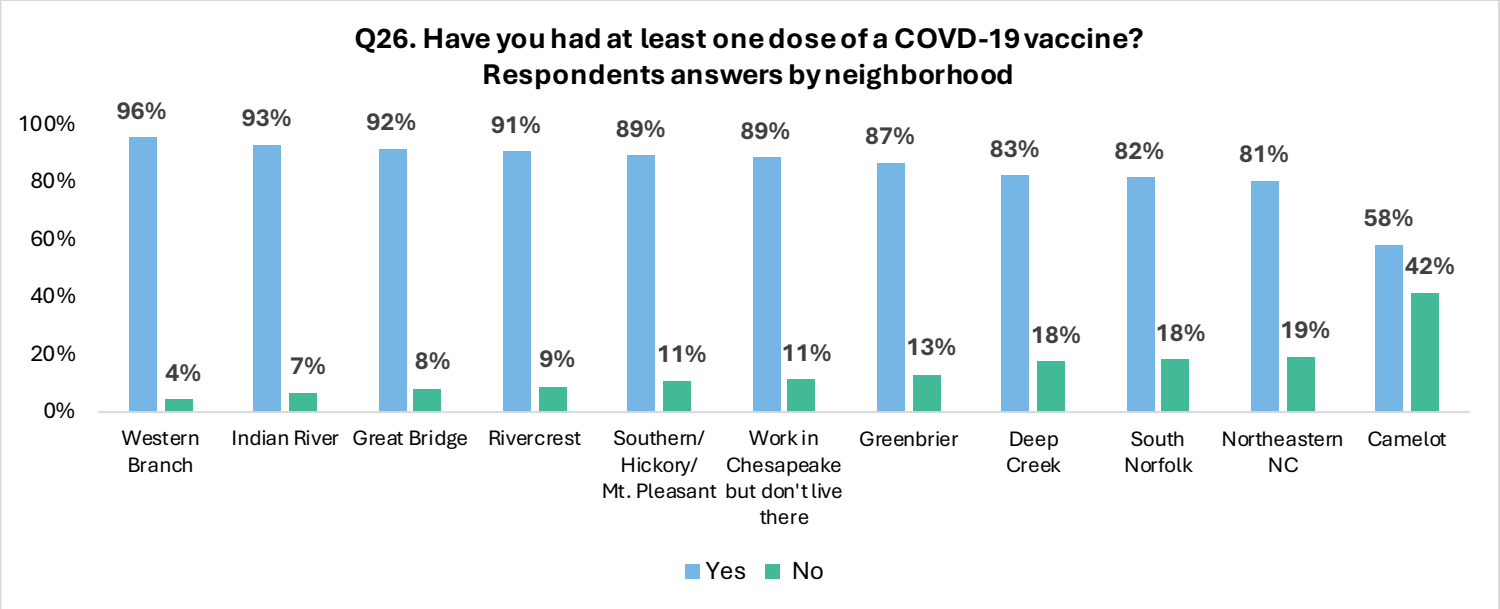
Q26. HAVE YOU HAD AT LEAST ONE DOSE OF A COVID-19 VACCINE?
Answered:857 Skipped:62



ANSWER CHOICES	PERCENT	NUMBER
No	13%	115
Yes	87%	742
TOTAL	**100%**	**857**

Q26: COVID-19 vaccine by NEIGHBORHOOD
Answered:857 Skipped:62

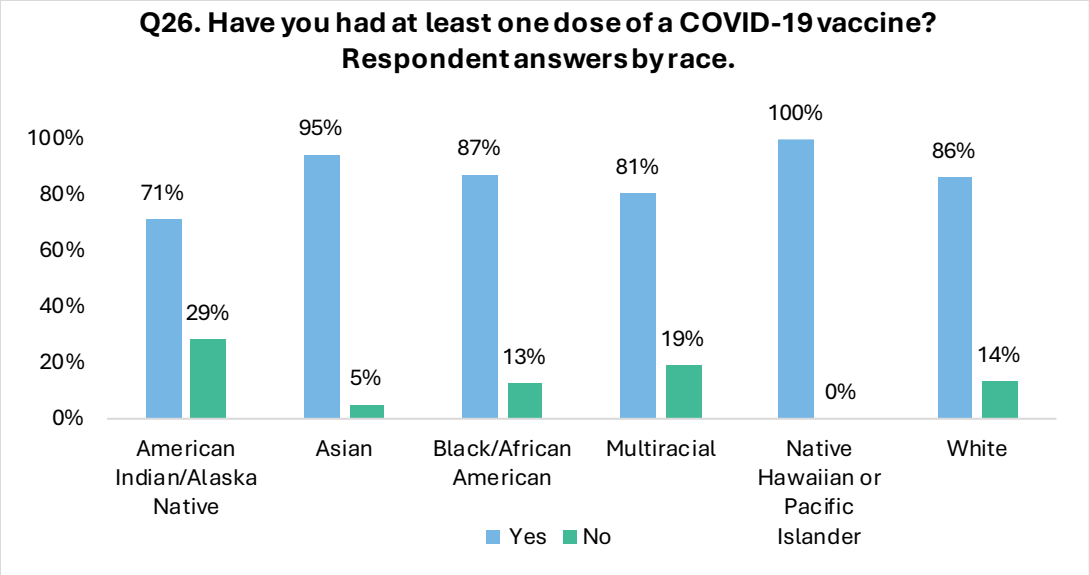
Respondents from Camelot reported the smallest percentage (58%) of having a COVID-19 vaccine. Over 80% of respondents from all other neighborhoods have received at least one dose.



Neighborhood	% Yes	% No	# Yes	# No	# Respondents
Western Branch	96%	4%	22	1	23
Indian River	93%	7%	28	2	30
Great Bridge	92%	8%	154	14	168
Rivercrest	91%	9%	10	1	11
Southern/Hickory/Mt. Pleasant	89%	11%	58	7	65
Work in Chesapeake but don't live there	89%	11%	93	12	105
Greenbrier	87%	13%	125	19	144
Deep Creek	83%	18%	66	14	80
South Norfolk	82%	18%	58	13	71
Northeastern NC	81%	19%	96	23	119
Camelot	58%	42%	7	5	12
Residence not provided	86%	14%	25	4	29
TOTAL	**87%**	**13%**	**742**	**115**	**857**

Q26: COVID-19 vaccine by RACE
Answered:857 Skipped:62

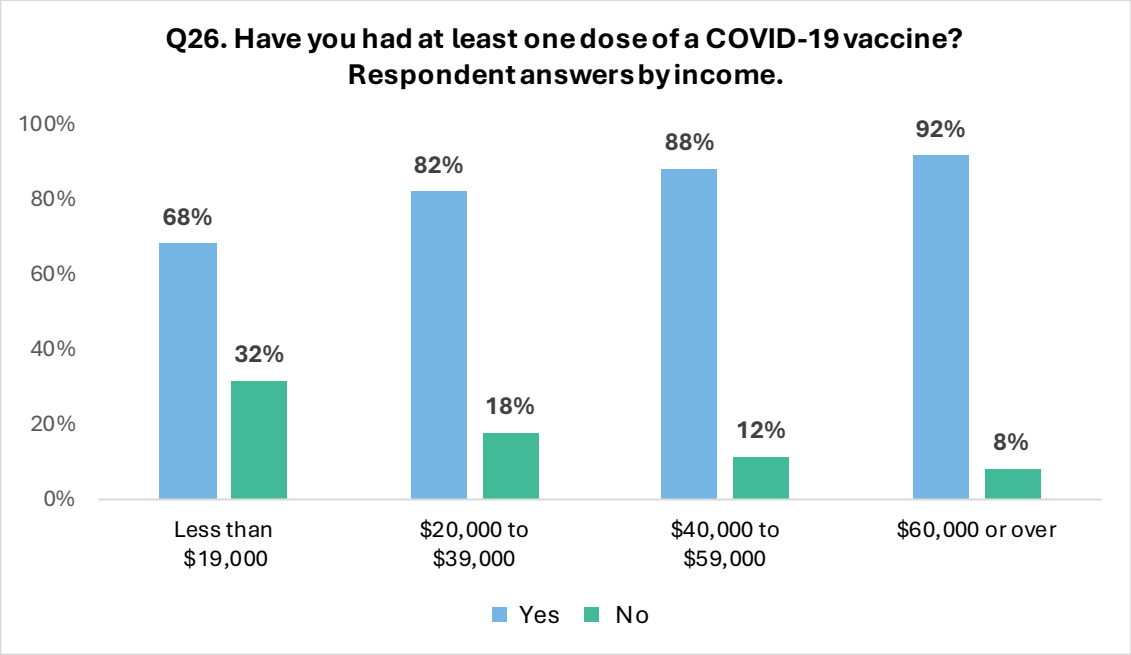
Over 70% of all respondents of any race reported having at least one dose of a COVID-19 vaccine. The smallest percentage was reported by American Indian/Alaska Native respondents at just 71%.



Race	Yes	No	Yes	No	# Respondents
American Indian/Alaska Native	71%	29%	5	2	7
Asian	95%	5%	18	1	19
Black/African American	87%	13%	209	30	239
Multiracial	81%	19%	21	5	26
Native Hawaiian or Pacific Islander	100%	0%	3	0	3
White	86%	14%	458	72	530
Race Unknown	85%	15%	28	5	33
TOTAL	**87%**	**13%**	**742**	**115**	**857**

Q26: COVID-19 vaccine by INCOME
Answered:857 Skipped:62

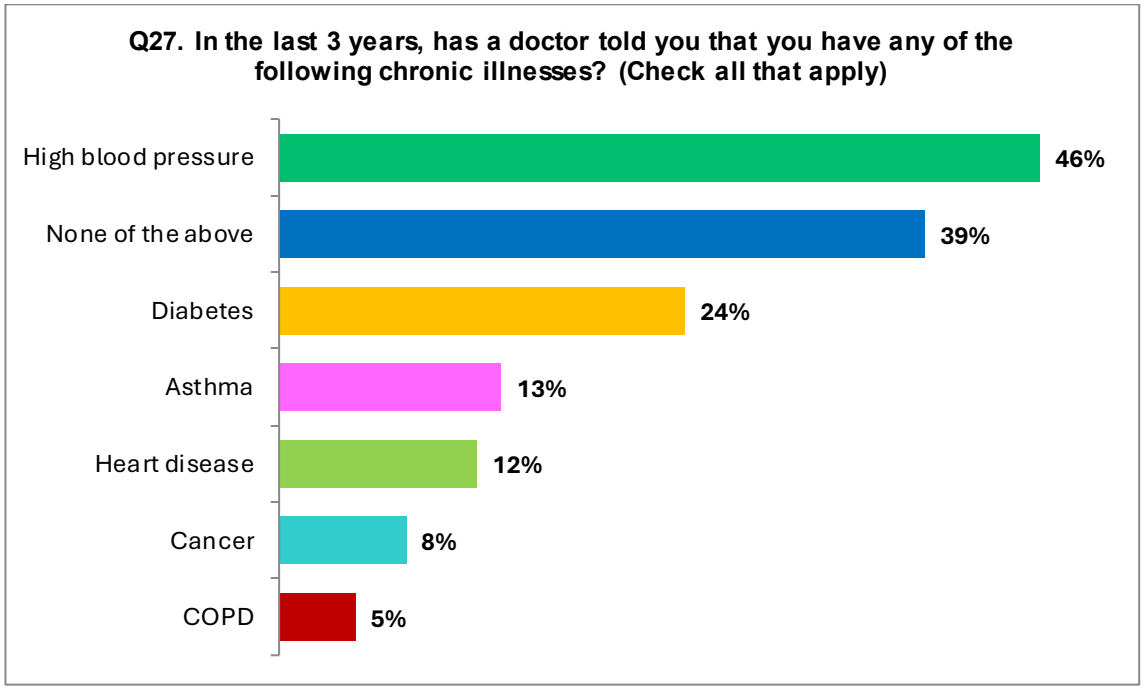
Getting a COVID-19 vaccine may be correlated to income level as the percentage of those answering *Yes* to this question increases with income. Those with higher incomes may have greater access and financial ability to get vaccines.



Income	% Yes	% No	# Yes	# No	# Respondents
Less than $19,000	68%	32%	73	34	107
$20,000 to $39,000	82%	18%	88	19	107
$40,000 to $59,000	88%	12%	138	18	156
$60,000 or over	92%	8%	403	36	439
Income range unknown	83%	17%	40	8	48
TOTAL	**87%**	**13%**	**742**	**115**	**857**

Q27. IN THE LAST 3 YEARS, HAS A DOCTOR TOLD YOU THAT YOU HAVE ANY OF THE FOLLOWING CHRONIC ILLNESSES? (CHECK ALL THAT APPLY).

Answered:824 Skipped:95



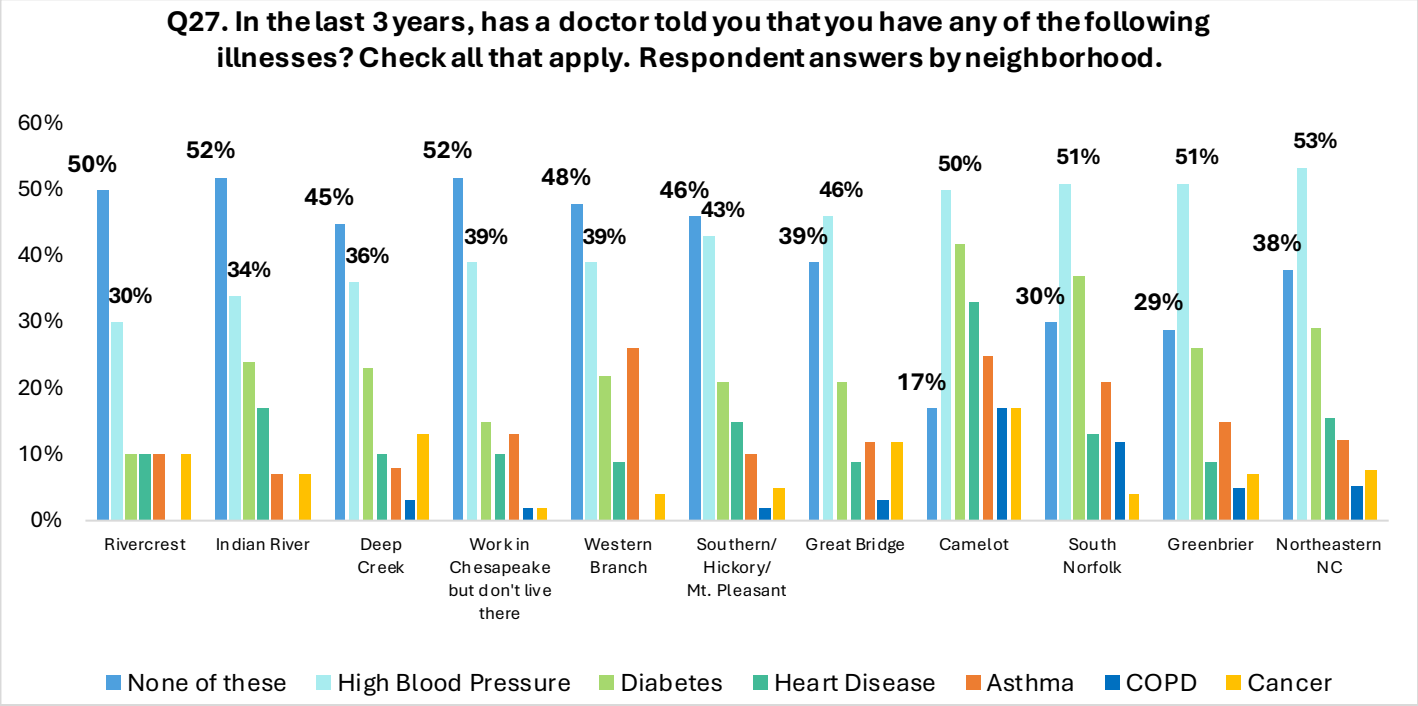
ANSWER CHOICES	PERCENT	NUMBER
High blood pressure	46%	377
None of the above	39%	320
Diabetes	24%	201
Asthma	13%	110
Heart disease	12%	98
Cancer	8%	63
COPD	5%	38
TOTAL		**824**

ADDITIONAL WRITE-IN ANSWERS TO Q27 and NUMBER OF TIMES LISTED:

High cholesterol - 19	Spinal cord injury - 2	Prostate issue - 1
Pre-diabetes - 7	Rheumatoid arthritis - 2	Irritable Bowel Syndrome-1
Depression/PTSD - 5	Stroke - 2	Hashimoto's disease - 1
Cardiac arrhythmia - 5	Fibromyalgia - 2	Celiac disease - 1
Kidney disease - 4	Crohn's disease - 2	Breast cancer - 1
Sleep apnea - 3	Hypothyroidism - 2	Chronic pain - 1
Arthritis - 3	Anemia - 2	Hyperlipidemia - 1
Reflux - 2	Osteopenia - 1	Blood clots - 1
Skin disease - 2	Osteoporosis - 1	Liver disease - 1

Q27. Chronic Illnesses by NEIGHBORHOOD
Answered:824 Skipped:95

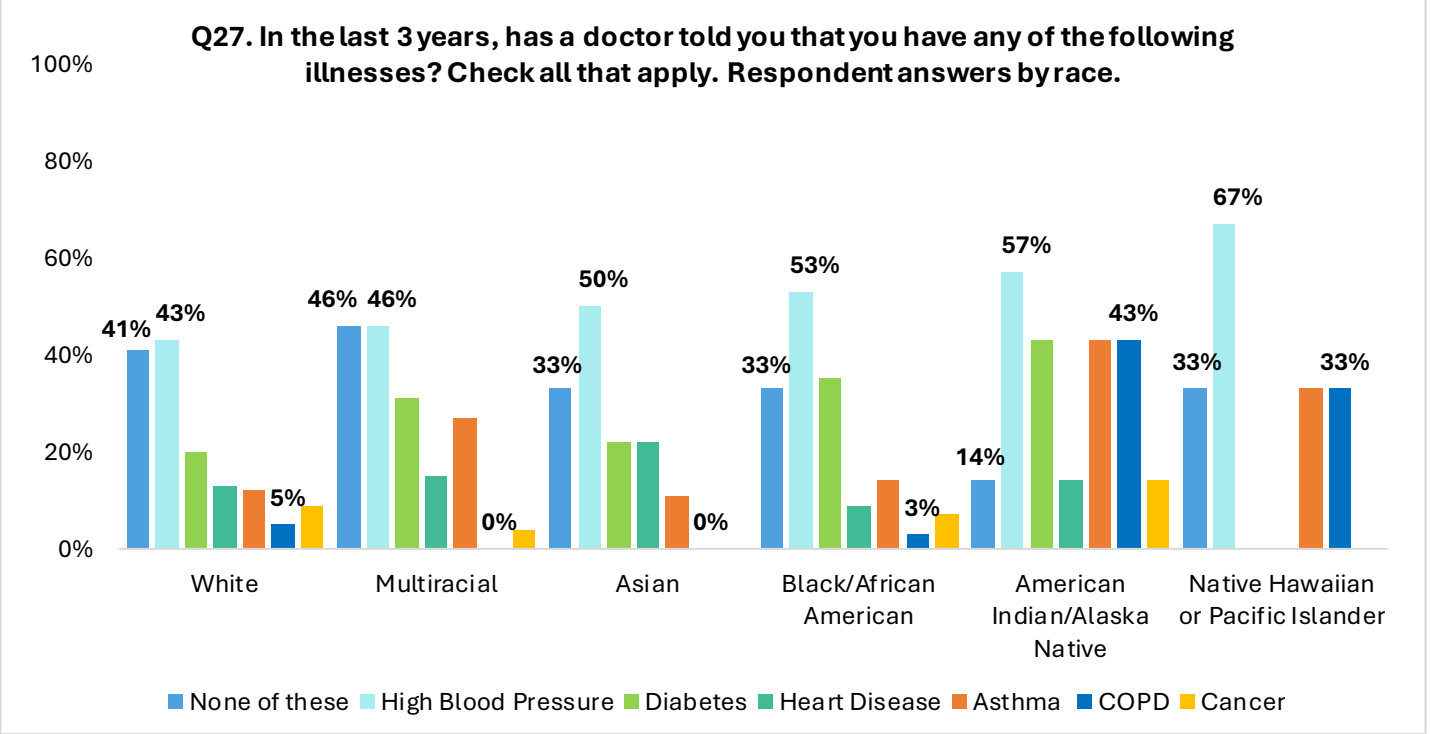
The graph below indicates the chronic illnesses respondents reported by neighborhood. Many indicated they have no chronic illnesses, but the most prevalent diseases reported are high blood pressure and diabetes.



Neighborhood	None of these		High Blood Pressure		Diabetes		Heart Disease		Asthma		COPD		Cancer		# Respondents
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Rivercrest	5	50%	3	30%	1	10%	1	10%	1	10%	0	0%	1	10%	10
Indian River	15	52%	10	34%	7	24%	5	17%	2	7%	0	0%	2	7%	29
Deep Creek	36	45%	29	36%	18	23%	8	10%	6	8%	2	3%	10	13%	80
Work in Chesapeake but don't live there	52	52%	39	39%	15	15%	10	10%	13	13%	2	2%	2	2%	100
Western Branch	11	48%	9	39%	5	22%	2	9%	6	26%	0	0%	1	4%	23
Southern/Hickory/ Mt. Pleasant	28	46%	26	43%	13	21%	9	15%	6	10%	1	2%	3	5%	61
Great Bridge	63	39%	74	46%	34	21%	14	9%	19	12%	4	3%	19	12%	160
Camelot	2	17%	6	50%	5	42%	4	33%	3	25%	2	17%	2	17%	12
South Norfolk	20	30%	34	51%	25	37%	9	13%	14	21%	8	12%	3	4%	67
Greenbrier	40	29%	70	51%	36	26%	12	9%	21	15%	7	5%	9	7%	136
Northeastern NC	44	38%	62	53%	34	29%	18	16%	14	12%	6	5%	9	8%	116
Residence not provided	4	13%	15	50%	8	27%	6	20%	5	17%	6	20%	2	7%	30
TOTAL	**320**	**38%**	**377**	**46%**	**201**	**24%**	**98**	**12%**	**110**	**13%**	**38**	**5%**	**63**	**8%**	**824**

Q27. Chronic Illnesses by RACE
Answered:824 Skipped:95

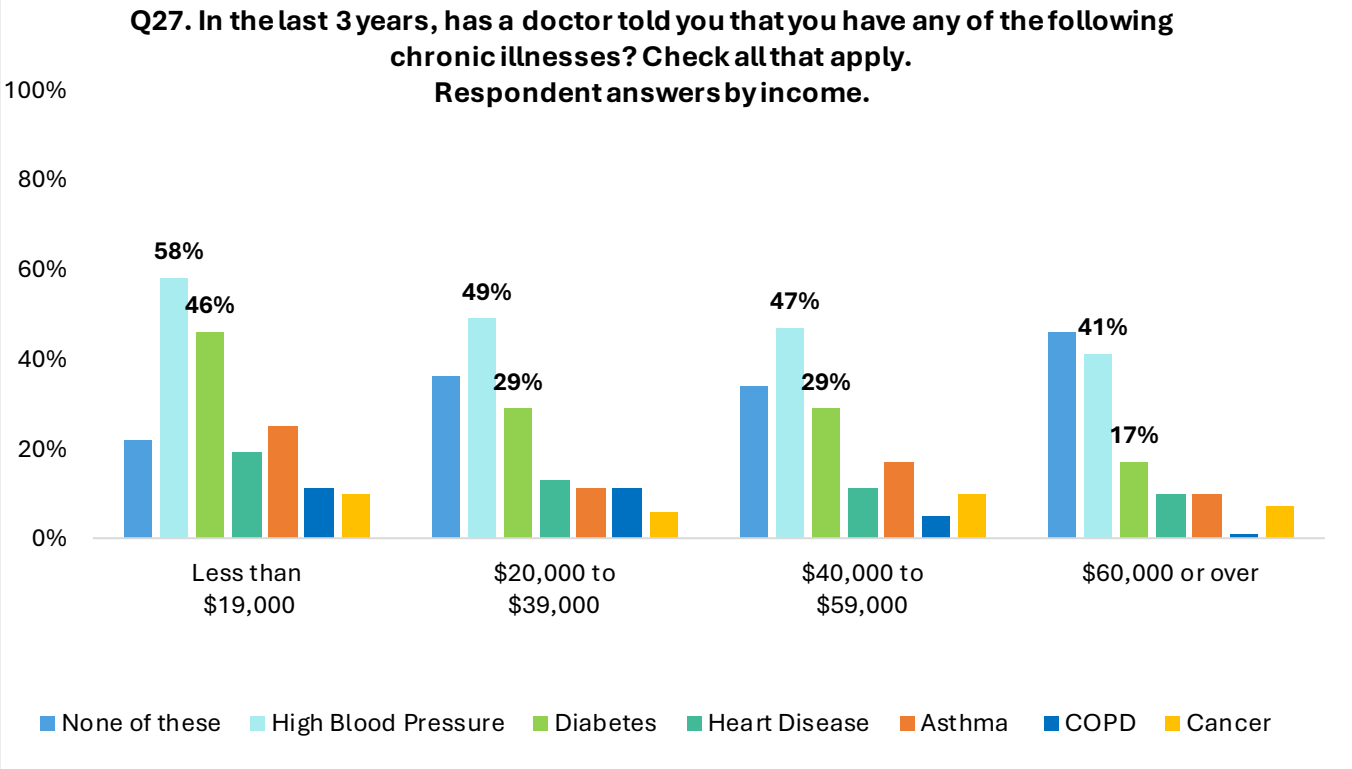
As noted above, the most prevalent chronic illnesses reported by respondents of all races are high blood pressure and diabetes. COPD is notably reported more by American Indian/Alaska Native and Native Hawaiian/Pacific Islanders.



Race	None of these		High Blood Pressure		Diabetes		Heart Disease		Asthma		COPD		Cancer		# Respondents
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
White	210	41%	216	43%	99	20%	67	13%	59	12%	25	5%	44	9%	507
Multiracial	12	46%	12	46%	8	31%	4	15%	7	27%	0	0%	1	4%	26
Asian	6	33%	9	50%	4	22%	4	22%	2	11%	0	0%	0	0%	18
Black/African American	77	33%	122	53%	81	35%	20	9%	33	14%	7	3%	16	7%	232
American Indian/Alaska Native	1	14%	4	57%	3	43%	1	14%	3	43%	3	43%	1	14%	7
Native Hawaiian or Pacific Islander	1	33%	2	67%	0	0%	0	0%	1	33%	1	33%	0	0%	3
Race Unknown	13	42%	12	39%	6	19%	2	6%	5	16%	2	6%	1	3%	31
TOTAL	**320**	**38%**	**377**	**46%**	**201**	**24%**	**98**	**12%**	**110**	**13%**	**38**	**5%**	**63**	**8%**	**824**

Q27. Chronic Illnesses by INCOME
Answered:824 Skipped:95

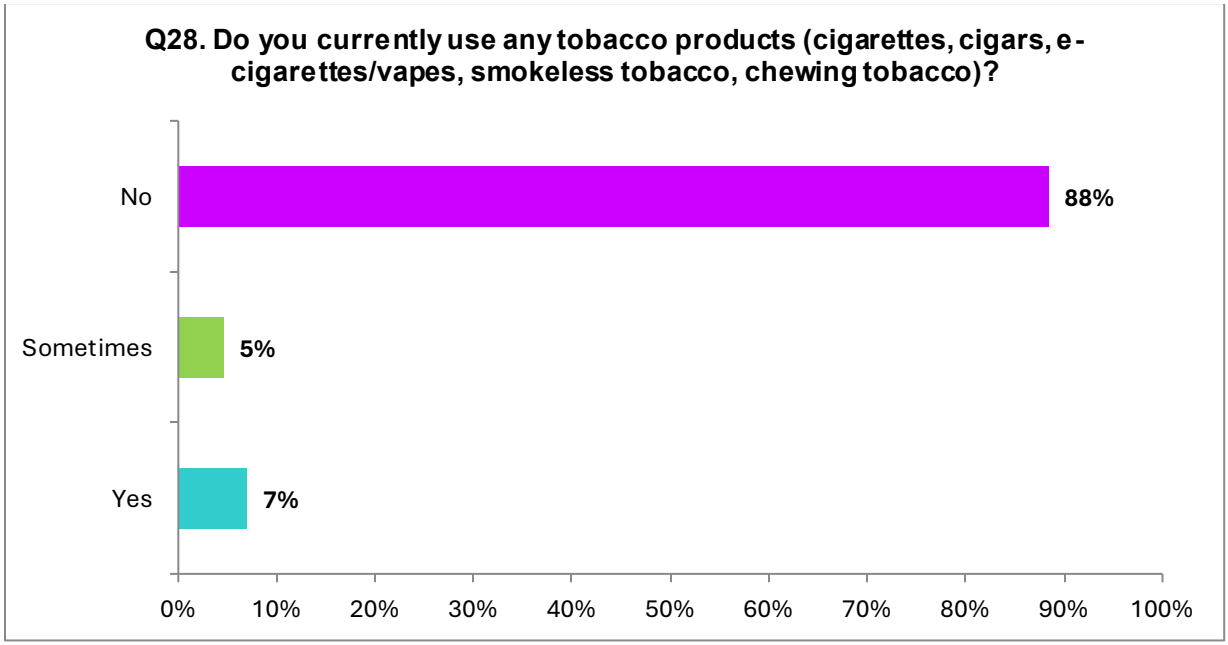
Across all income categories, high blood pressure is the most reported chronic illness, followed by diabetes. Respondents earning over $60,000 reported the highest percentage of people who have not had any chronic illnesses.



Income	None of these		High Blood Pressure		Diabetes		Heart Disease		Asthma		COPD		Cancer		# Respondents
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Less than $19,000	23	22%	61	58%	49	46%	20	19%	27	25%	12	11%	11	10%	106
$20,000 to $39,000	39	36%	52	49%	31	29%	14	13%	12	11%	12	11%	6	6%	107
$40,000 to $59,000	49	34%	69	47%	43	29%	16	11%	25	17%	8	5%	15	10%	146
$60,000 or over	193	46%	172	41%	70	17%	41	10%	41	10%	6	1%	29	7%	421
Income range unknown	16	36%	23	52%	8	18%	7	16%	5	11%	0	0%	2	5%	44
TOTAL	**320**	**39%**	**377**	**46%**	**201**	**24%**	**98**	**12%**	**110**	**13%**	**38**	**5%**	**63**	**8%**	**824**

Q28. DO YOU CURRENTLY USE ANY TOBACCO PRODUCTS (CIGARETTES, CIGARS, E-CIGARETTES/VAPES, SMOKELESS TOBACCO, CHEWING TOBACCO)?
Answered:850 Skipped:69

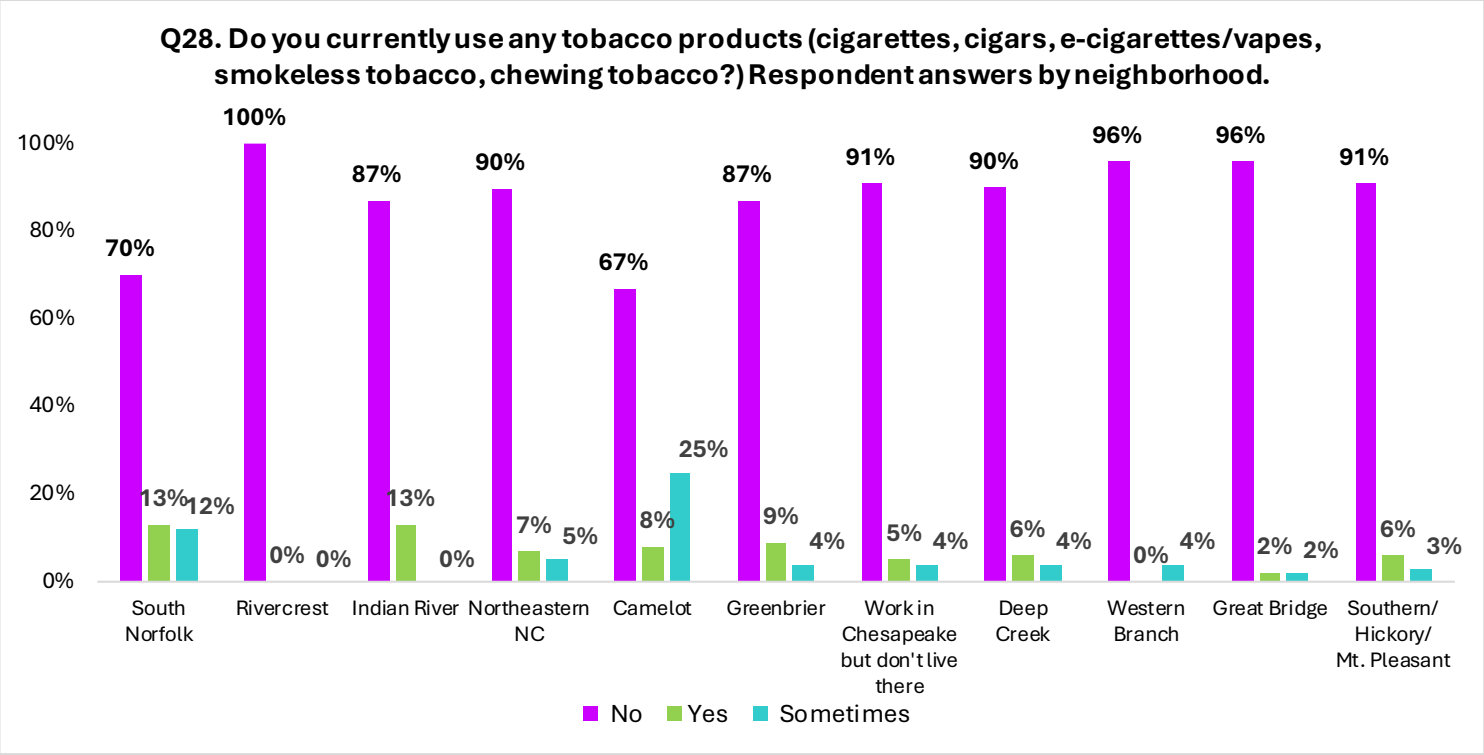
Most respondents (88%) reported not using any kind of tobacco products. Only 5% reported using them *Sometimes*, and 7% answered *Yes* to this question.



ANSWER CHOICES	PERCENT	NUMBER
No	88%	752
Yes	7%	59
Sometimes	5%	39
TOTAL	**100%**	**850**

Q28. Using tobacco products by NEIGHBORHOOD
Answered:850 Skipped:69

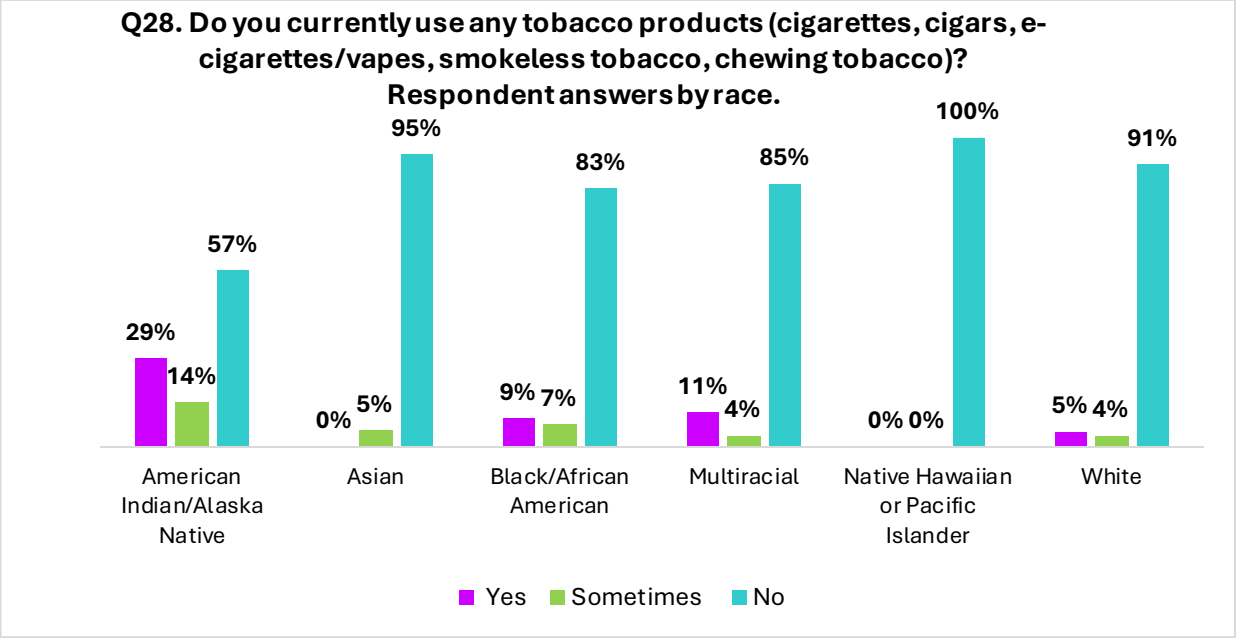
Respondents from Camelot reported the highest percentage of using tobacco products (25%), followed by respondents from South Norfolk (12%). Respondents from other neighborhoods largely reported not using any tobacco products.



Neighborhood	% Yes	% Sometimes	% No	# Answered Yes	# Answered Sometimes	# Answered No	# Respondents
South Norfolk	13%	12%	70%	13	8	48	69
Rivercrest	0%	0%	100%	0	0	11	11
Indian River	13%	0%	87%	4	0	26	30
Northeastern NC	7%	5%	90%	8	6	104	116
Camelot	8%	25%	67%	1	3	8	12
Greenbrier	9%	4%	87%	13	6	124	143
Work in Chesapeake but don't live there	5%	4%	91%	5	4	94	103
Deep Creek	6%	4%	90%	5	3	73	81
Western Branch	0%	4%	96%	0	1	22	23
Great Bridge	2%	2%	96%	4	3	160	167
Southern/Hickory/ Mt. Pleasant	6%	3%	91%	4	2	58	64
Residence not provided	6%	10%	77%	2	3	24	31
TOTAL	**7%**	**5%**	**88%**	**59**	**39**	**752**	**850**

Q28. Using tobacco products by RACE
Answered:850 Skipped:69

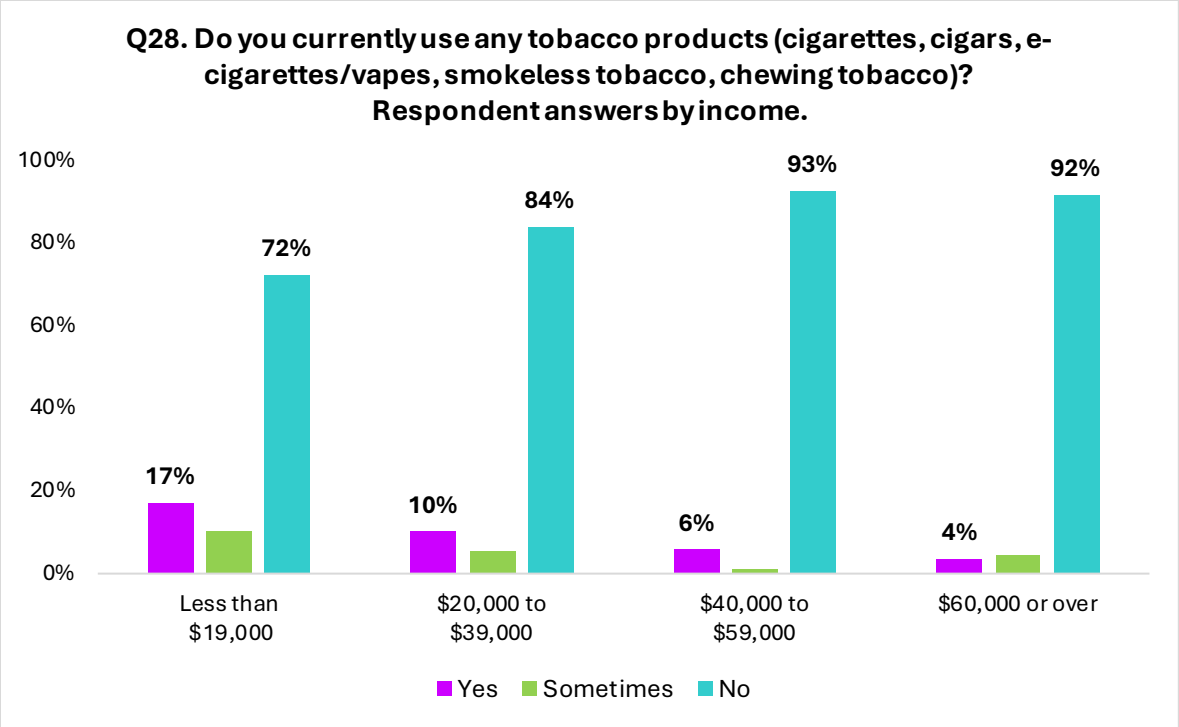
American Indian/Alaska Native respondents reported the highest use of tobacco products (29%). However, the sample for this population is seven people so the results may not be representative. A majority of those in other race populations reported not using any tobacco products.



Race	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
American Indian/Alaska Native	29%	14%	57%	2	1	4	7
Asian	0%	5%	95%	0	1	18	19
Black/African American	9%	7%	83%	22	17	197	236
Multiracial	11%	4%	85%	3	1	23	27
Native Hawaiian or Pacific Islander	0%	0%	100%	0	0	3	3
White	5%	4%	91%	26	19	483	528
Race Unknown	20%	0%	80%	6	0	24	31
TOTAL	**7%**	**5%**	**88%**	**59**	**39**	**752**	**850**

Q28. Using tobacco products by INCOME
Answered:850 Skipped:69

Respondents earning less than $19,000 reported a higher percentage of using tobacco products than those in higher income groups. The correlation of tobacco use decreases as income increases, indicating financial stressors that accompany tobacco use.



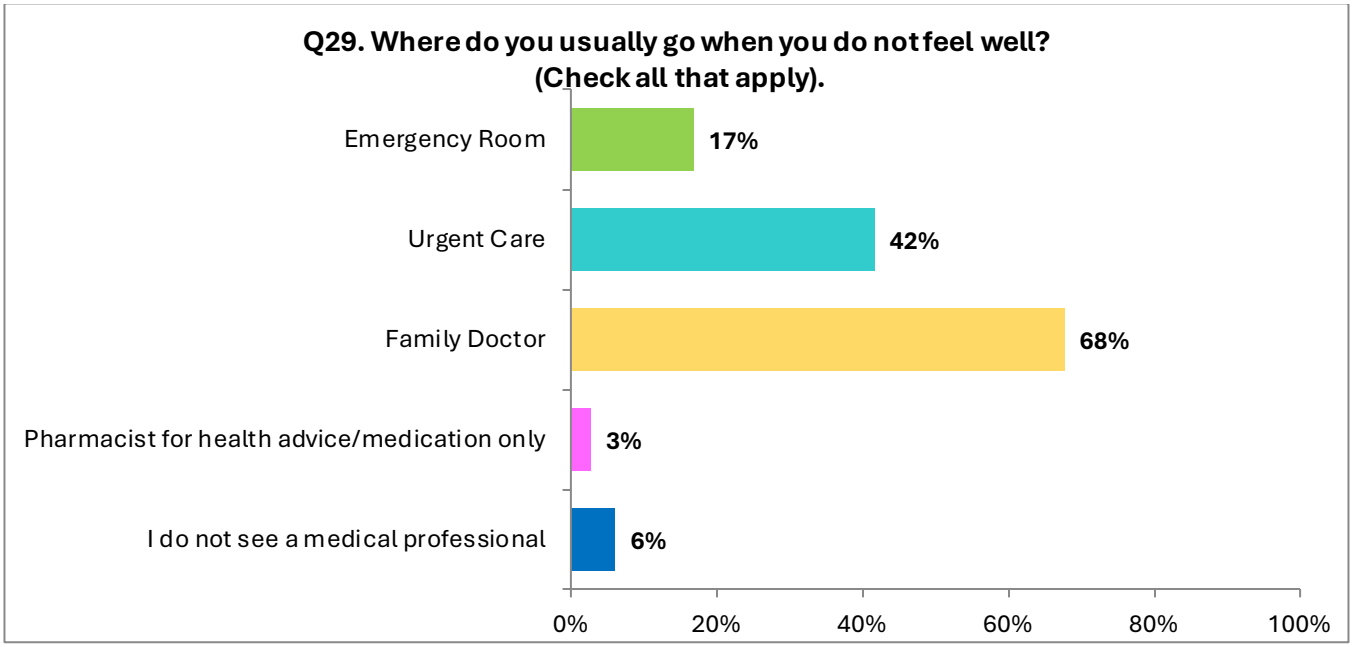
Income	% Yes	% Sometimes	% No	# Yes	# Sometimes	# No	# Respondents
Less than $19,000	17%	10%	72%	18	11	76	105
$20,000 to $39,000	10%	6%	84%	11	6	90	107
$40,000 to $59,000	6%	1%	93%	9	2	144	155
$60,000 or over	4%	5%	92%	16	20	401	437
Income range unknown	11%	0%	89%	5	0	41	46
TOTAL	**7%**	**5%**	**88%**	**59**	**39**	**752**	**850**

Q29. WHERE DO YOU USUALLY GO WHEN YOU DO NOT FEEL WELL? CHECK ALL THAT APPLY.

Answered:830 Skipped:89

The largest percentage of respondents (68%) reported visiting their family doctor when not feeling well. This was followed by 42% of respondents visiting Urgent Care facilities and 17% visiting the Emergency Room. Six percent (6%) reported not visiting a medical professional and 3% consulting a pharmacist for prescription advice.

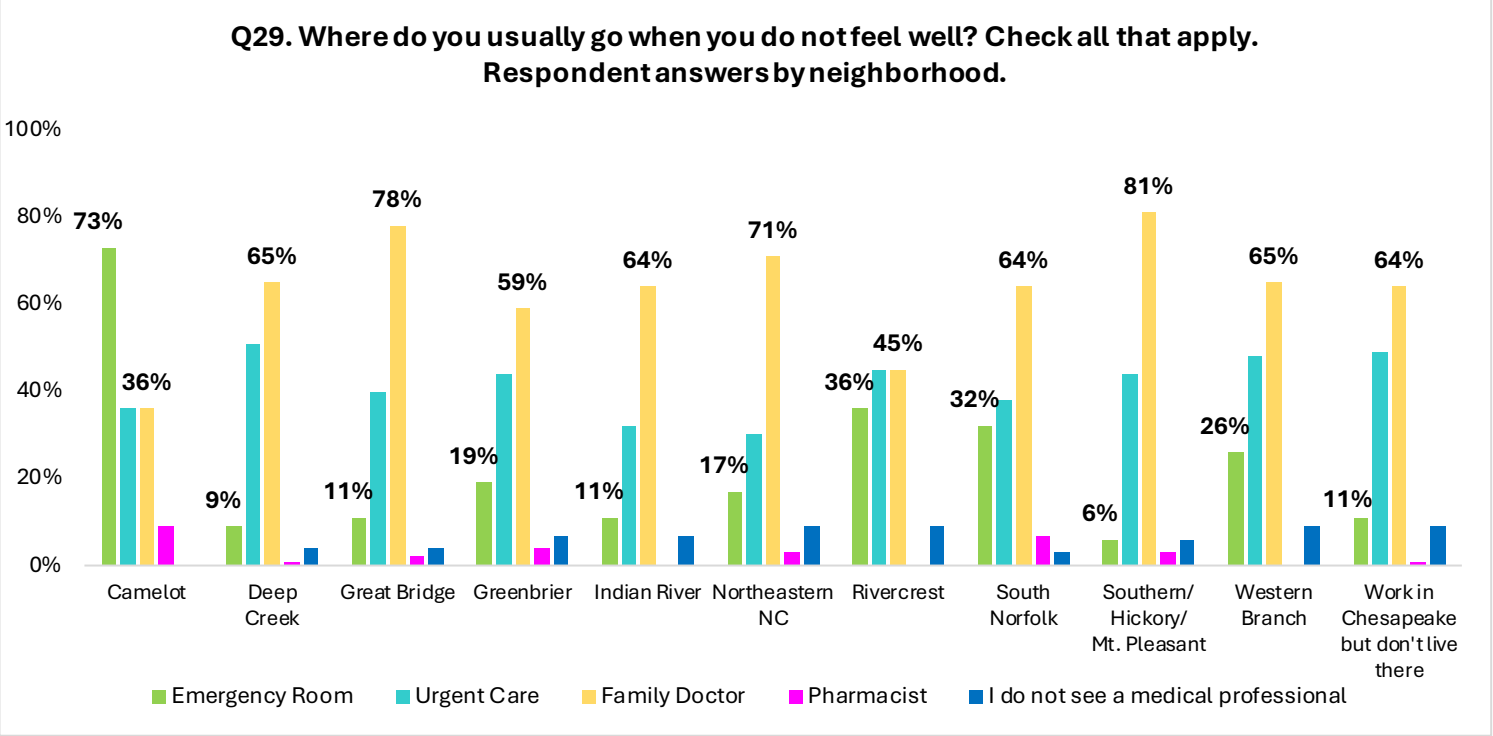
The table below includes additional responses about where people get medical advice when they don't feel well.



ANSWER CHOICES (CHECK ALL THAT APPLY)	PERCENT	NUMBER	CHNA 2021
Family Doctor	68%	563	⇔ 67%
Urgent Care	42%	346	↑ 36%
Emergency Room	17%	140	↓ 21%
I do not see a medical professional	6%	50	↑ 3%
Pharmacist for health advice/medication only	3%	22	↓ 8%
OTHER:			
I stay home and let illness run its course		11	
I prefer to see a doctor but cannot get appointment		7	
Primary Care Clinic		6	
Telehealth		5	
VA Hospital		3	
Chiropractor		2	
Acupuncturist		2	
Sentara Nurse Assistance Line		1	
EVMS		1	
TOTAL			

Q29. Where do you go when you don't feel well by NEIGHBORHOOD
Answered:830 Skipped:89

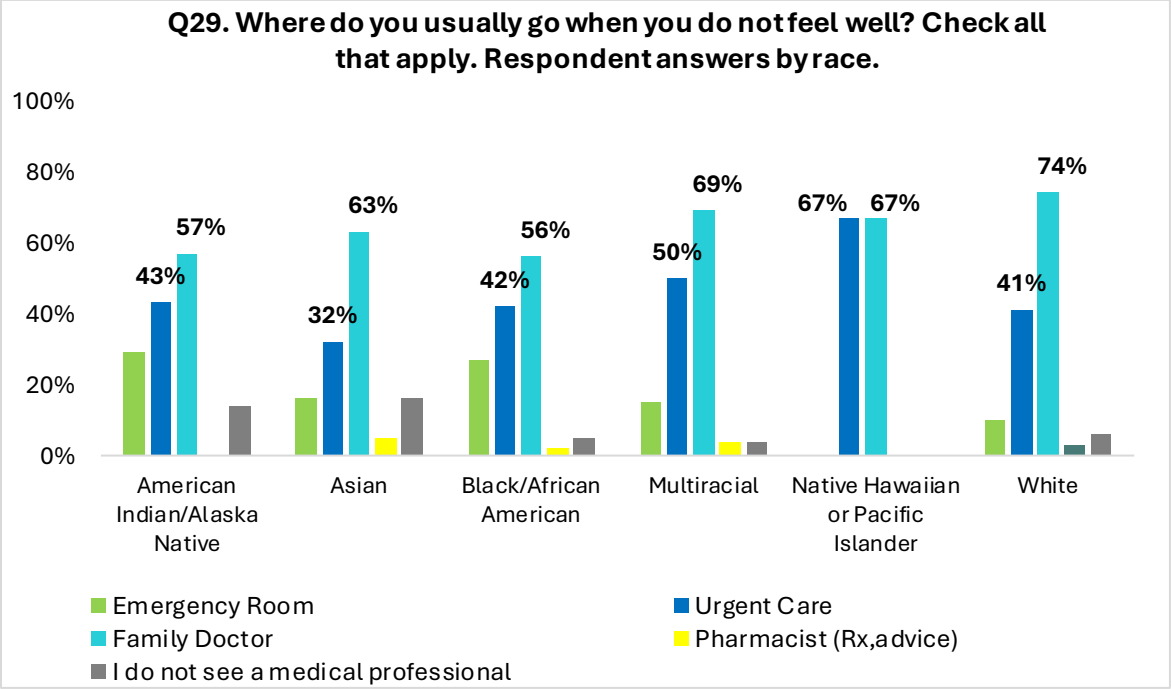
Respondents in Southern/Hickory/Mt. Pleasant reported the highest percentage of having a family doctor (81%). In contrast, respondents from Camelot reported the lowest percentage with a family doctor (36%) and the highest percentage of using the Emergency Room when unwell (73%).



Neighborhood	Emergency Room		Urgent Care		Family Doctor		Pharmacist (Rx, advice)		I do not see a medical professional		# Respondents
	#	%	#	%	#	%	#	%	#	%	
Camelot	8	73%	4	36%	4	36%	1	9%	0	0%	11
Deep Creek	7	9%	40	51%	51	65%	1	1%	3	4%	78
Great Bridge	18	11%	66	40%	128	78%	3	2%	6	4%	164
Greenbrier	26	19%	61	44%	83	59%	6	4%	10	7%	140
Indian River	3	11%	9	32%	18	64%	0	0%	2	7%	28
Northeastern NC	20	17%	35	30%	83	71%	3	3%	10	9%	117
Rivercrest	4	36%	5	45%	5	45%	0	0%	1	9%	11
South Norfolk	22	32%	26	38%	44	64%	5	7%	2	3%	69
Southern/Hickory/ Mt. Pleasant	4	6%	28	44%	52	81%	2	3%	4	6%	64
Western Branch	6	26%	11	48%	15	65%	0	0%	2	9%	23
Work in Chesapeake but don't live there	11	11%	49	49%	64	64%	1	1%	9	9%	99
Residence not provided	11	42%	12	46%	16	62%	0	0%	10	38%	26
TOTAL	**140**	**17%**	**346**	**42%**	**563**	**68%**	**22**	**3%**	**59**	**6%**	**830**

Q29. Where do you go when you don't feel well by RACE
Answered:830 Skipped:89

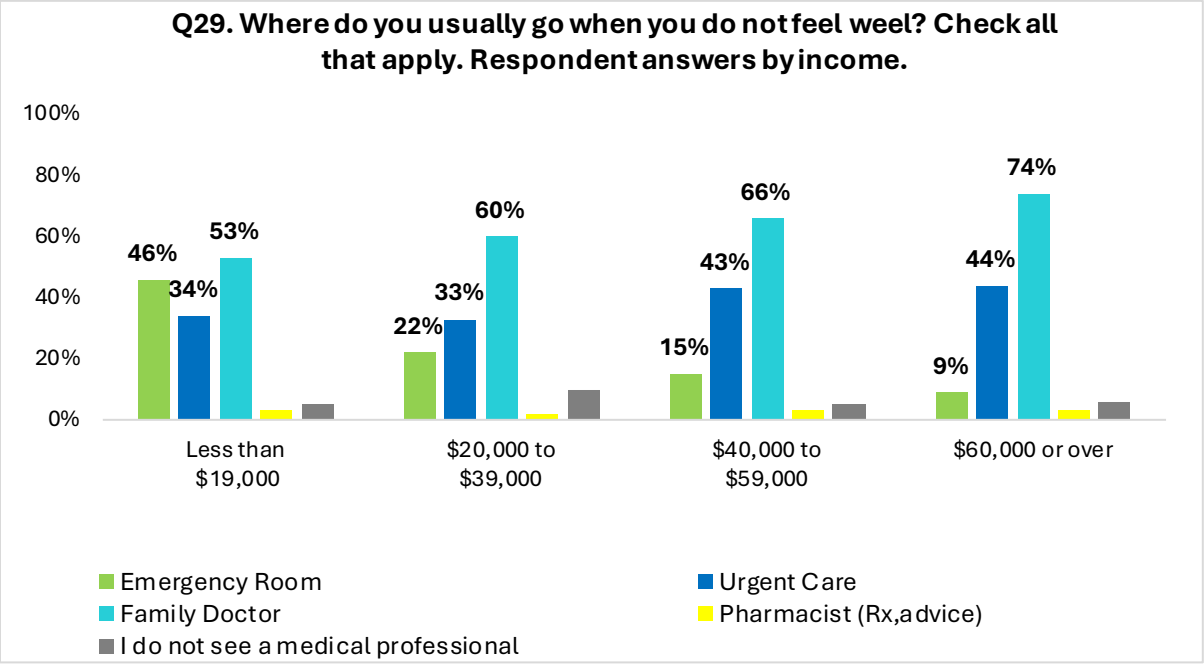
While over half of all respondents visit a family doctor when not feeling well, American Indian/Alaska Natives reported the lowest percentage (57%) compared to 74% of White respondents. The next most visited medical location is Urgent Care, which ranges between 32% by Asian respondents to 67% by Black/African American respondents.



Race	Emergency Room		Urgent Care		Family Doctor		Pharmacist (Rx, advice)		I do not see a medical professional		# Respondents
	#	%	#	%	#	%	#	%	#	%	
American Indian/Alaska Native	2	29%	3	43%	4	57%	0	0%	1	14%	7
Asian	3	16%	6	32%	12	63%	1	5%	3	16%	19
Black/African American	64	27%	99	42%	132	56%	5	2%	11	5%	234
Multiracial	4	15%	13	50%	18	69%	1	4%	1	4%	26
Native Hawaiian or Pacific Islander	0	0%	2	67%	2	67%	0	0%	0	0%	3
White	53	10%	211	41%	380	74%	15	3%	33	6%	515
Race Unknown	10		8		14		0		1		26
TOTAL	**136**	**17%**	**342**	**42%**	**562**	**68%**	**22**	**3%**	**50**	**6%**	**830**

Q29. Where do you go when you don't feel well by INCOME
Answered:830 Skipped:89

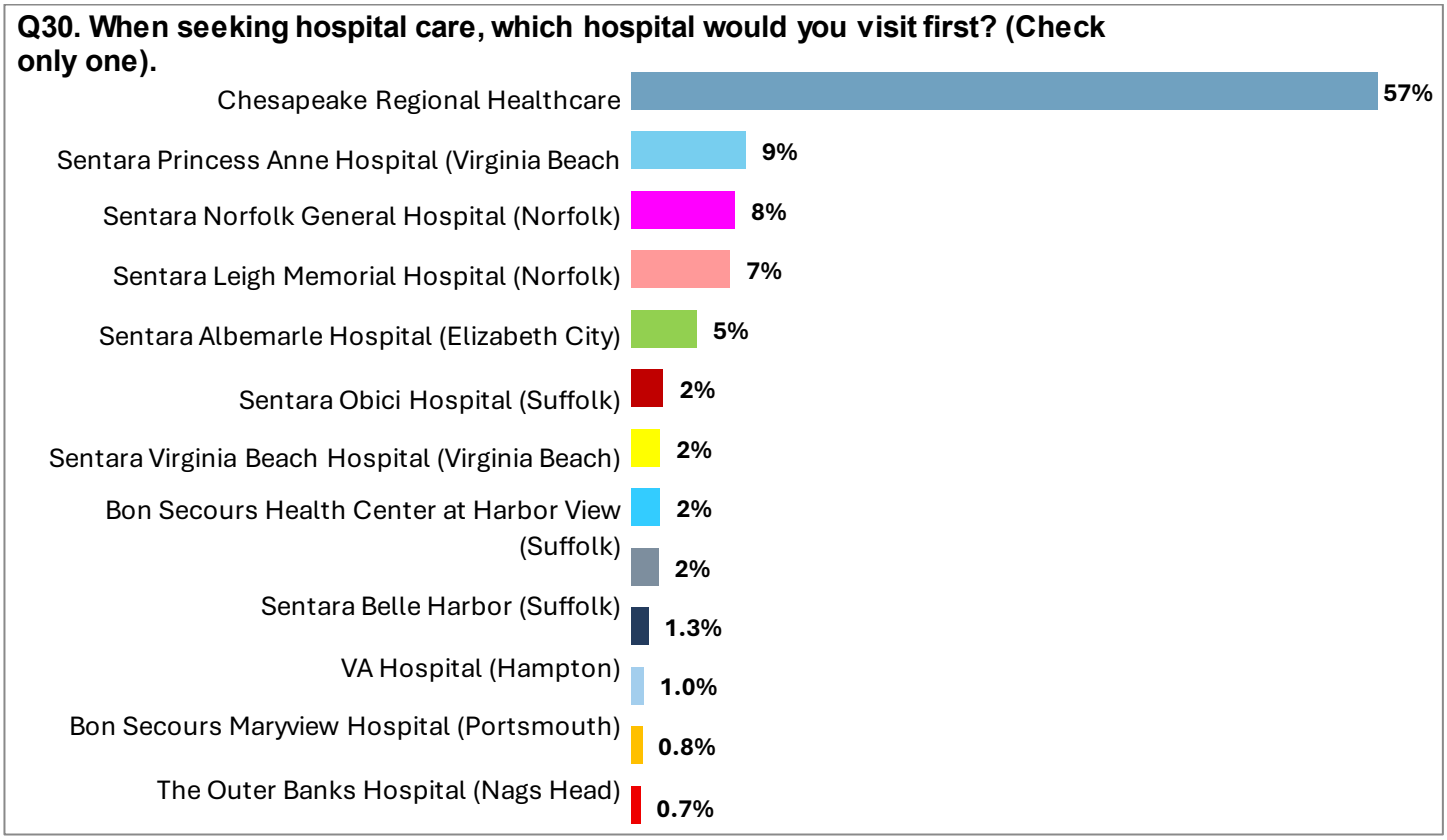
When filtering by income level, those earning less than $19,000 are more likely to use the Emergency Room (46%) than those in other income categories. Emergency Room usage decreases as income increases, and visits to a family doctor also increase with income. This may indicate that lower income respondents lack a medical home and only seek treatment in emergencies.



Income	Emergency Room		Urgent Care		Family Doctor		Pharmacist (Rx, advice)		I do not see a medical professional		# Respondents
	#	%	#	%	#	%	#	%	#	%	
Less than $19,000	47	46%	35	34%	54	53%	3	3%	5	5%	102
$20,000 to $39,000	23	22%	34	33%	62	60%	2	2%	10	10%	104
$40,000 to $59,000	22	15%	64	43%	98	66%	4	3%	7	5%	149
$60,000 or over	39	9%	190	44%	319	74%	12	3%	25	6%	429
Income range unknown	5	11%	19	41%	29	63%	1	2%	3	7%	46
TOTAL	**136**	**16%**	**342**	**41%**	**562**	**68%**	**22**	**3%**	**50**	**6%**	**830**

Q30. WHEN SEEKING HOSPITAL CARE, WHICH HOSPITAL WOULD YOU VISIT FIRST? CHECK ONLY ONE.

Answered:830 Skipped:89

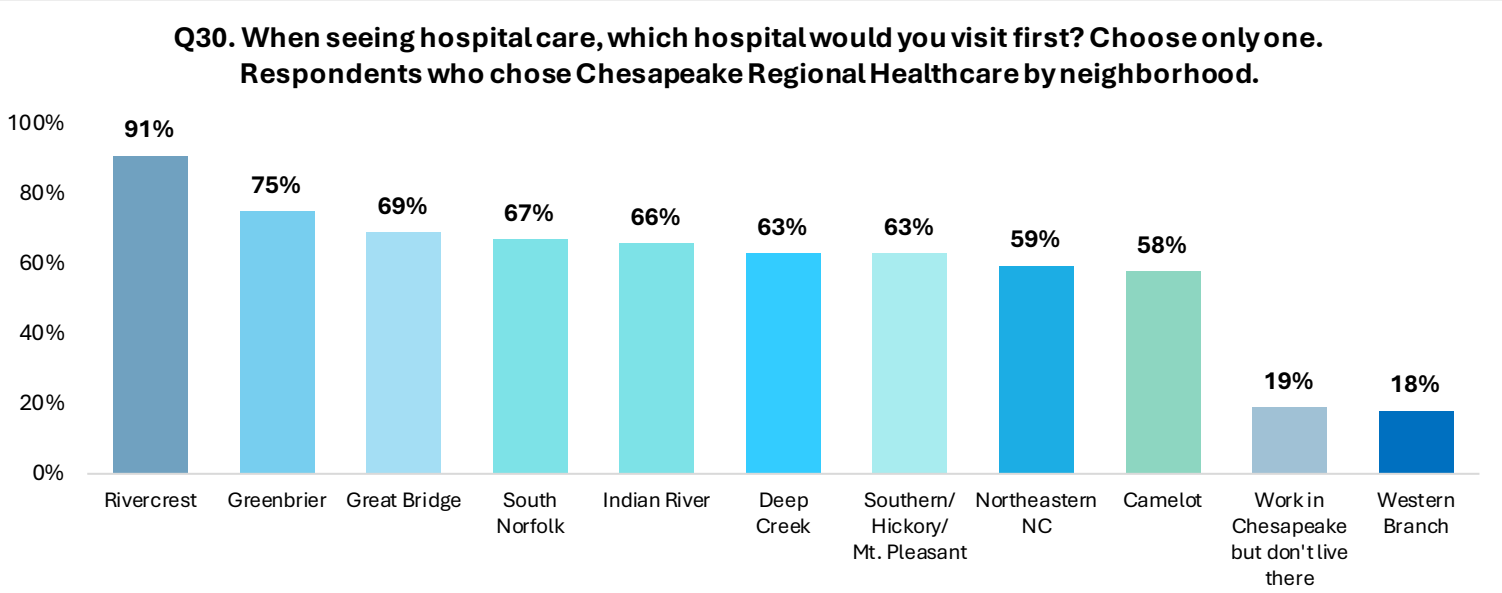


ANSWER CHOICES (CHOOSE ONE)		PERCENT	NUMBER
Chesapeake Regional Healthcare (Chesapeake)		57%	470
Sentara Princess Anne Hospital (Virginia Beach)		9%	72
Sentara Norfolk General Hospital (Norfolk)		8%	65
Sentara Leigh Memorial Hospital (Norfolk)		8%	62
Sentara Albemarle Medical Center (Elizabeth City)		5%	41
Sentara Obici Hospital (Suffolk)		2%	20
Bon Secours Health Center at Harbor View (Suffolk)		2%	18
Sentara Virginia Beach General Hospital (Viginia Beach)		2%	18
Sentara Belle Harbor (Suffolk)		2%	17
VA Hospital (Hampton)		1.3%	11
Bon Secours Maryview Hospital (Portsmouth)		1.0%	8
The Outer Banks Hospital (Nags Head)		0.8%	7
Naval Regional Medical Center (Portsmouth)		0.7%	6
Vidant Chowan Hospital (Edenton)		0.2%	2
Other:	*Beaufort County Hospital (Beaufort)*	0.2%	2
	Sentara Independence (Virginia Beach)	0.2%	2
	Duke University Hospital (Durham)	0.1%	1
	ECU Health Chowan Hospital (Edenton)	0.1%	1
	Riverside Regional Hospital (Newport News)	0.1%	1
	Sentara Franklin Hospital (Franklin)	0.1%	1
TOTAL		**100%**	**825**

Q30: Hospital choice by NEIGHBORHOOD

Answered:830 Skipped:89

Of the 830 respondents who answered this question, 57% (470 individuals) selected Chesapeake Regional Healthcare as their first choice of hospital. Preference for Chesapeake Regional varied by neighborhood: 91% in Camelot, 75% in Greenbrier, 69% in Great Bridge, 67% in South Norfolk, 66% in Indian River, 63% in both Deep Creek and Southern/Hickory/Mt. Pleasant, 59% in Northeastern North Carolina, 19% among those who work in Chesapeake but live elsewhere, and 18% in Western Branch.



Neighborhood	Chesapeake Regional Healthcare		Sentara Princess Anne		Sentara Norfolk General		Sentara Leigh Memorial		Sentara Albemarle		Sentara Obici		Sentara Virginia Beach General		# Respondents
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Rivercrest	10	91%	1	9%											11
Greenbrier	104	75%	11	8%	9	6%	13	9%			1	1%	1	1%	139
Great Bridge	113	69%	14	9%	10	6%	15	9%	1	1%					164
South Norfolk	46	67%	4	6%	9	13%	7	10%			1	1%	1	1%	69
Indian River	19	66%	2	7%	1	3%	3	10%			1	3%			29
Deep Creek	50	63%	4	5%	10	13%	5	6%			2	3%			79
Southern/Hickory/ Mt. Pleasant	39	63%	10	16%	5	6%	6	8%							62
Northeastern NC	47	59%	3	4%	2	3%	3	4%	37	47%	4	5%	5	6%	117
Camelot	7	58%			1	8%	1	8%							12
Work in Chesapeake but don't live there	19	19%	16	16%	15	15%	7	7%	3	4%	10	10%	9	9%	98
Western Branch	4	18%			2	9%			1	5%	2	9%			22
Residence not provided	12	41%	7	24%	4	14%	2	7%					2	7%	28
TOTAL	**470**	**57%**	**72**	**9%**	**68**	**8%**	**62**	**8%**	**42**	**5%**	**21**	**2%**	**18**	**2%**	**830**

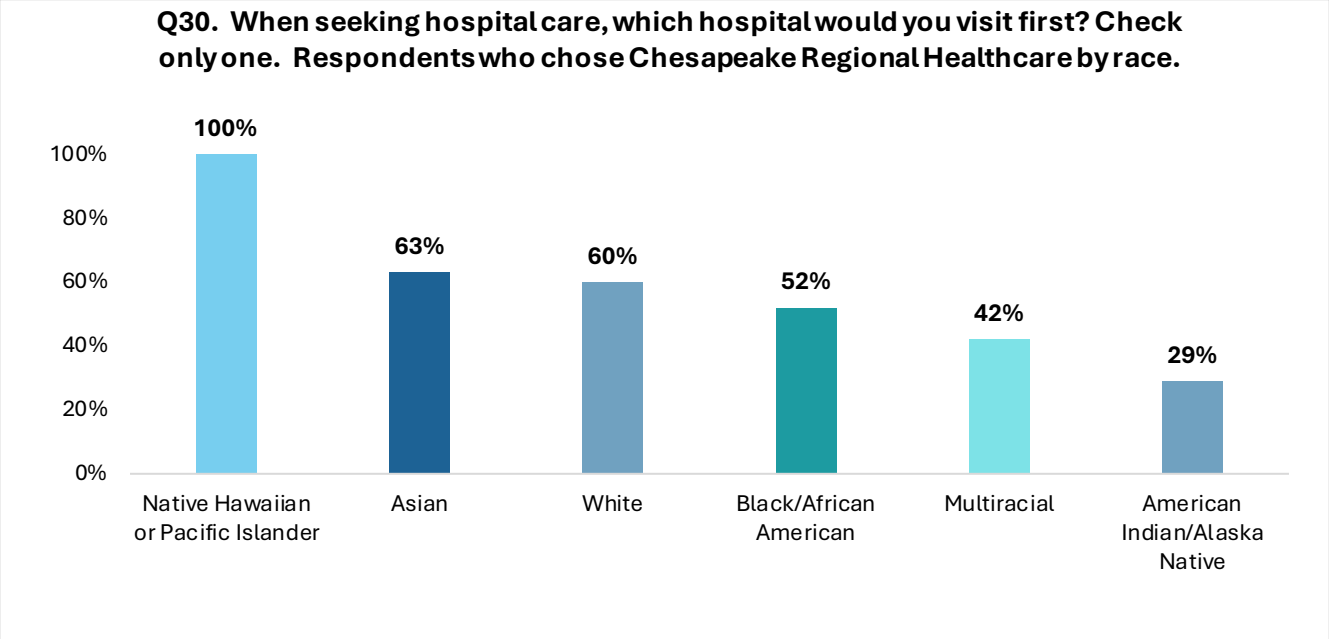
Table continued from previous page with additional hospital choices.

Neighborhood	Bon Secours at Harbor View		Sentara Belle Harbor		VA Hampton Hospital		Bon Secours Maryview		Outer Banks Hospital		Naval Regional Hospital		Other/ Out of area		Respondents #
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Rivercrest															11
Greenbrier	1	1%			2	1%							2	1%	139
Great Bridge	1	1%			2	1%	1	1%			2	1%			164
South Norfolk	1	1%			1	1%									69
Indian River	1	3%	1	3%							1	3%	1	3%	29
Deep Creek	2	3%	1	1%	2	3%	1	1%					2	3%	79
Southern/ Hickory/ Mt. Pleasant	1	2%									3				62
Northeastern NC			2	3%	3	4%	2	3%	7	9%			3	3%	117
Camelot							1	8%							12
Work in Chesapeake but don't live there	6	6%	4	4%			2	2%			1	1%	2	2%	98
Western Branch	4	18%	8	36%			1	5%							22
Residence not provided	1	3%	1	3%											28
TOTAL	**18**	**2%**	**17**	**2%**	**10**	**1%**	**8**	**1%**	**7**	**1%**	**7**	**1%**	**10**	**1%**	**830**

NOTE: The data above by neighborhood is shown to help identify the location of survey respondents who use Chesapeake Regional Healthcare for hospital services. Due to the size and complexity of the table above, it is not repeated for race and income.

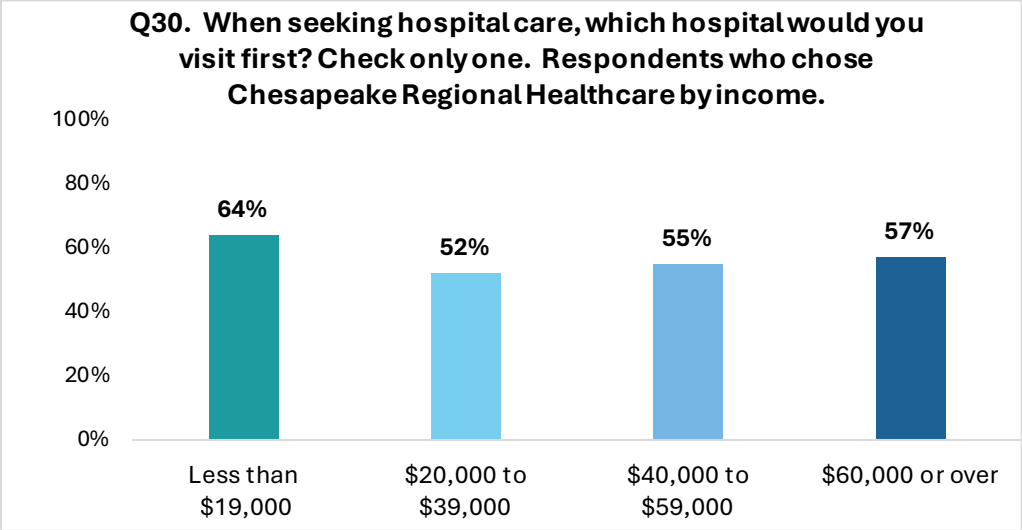
Q30: Hospital choice by RACE
Answered:830 Skipped:89

There was some variation in hospital preference across racial populations. While 100% of Native Hawaiian/Pacific Islander respondents (3 of 3) selected Chesapeake Regional Healthcare, the small sample size limits representativeness. Similarly, 29% of American Indian/Alaska Native respondents (2 of 7) chose Chesapeake Regional, and these results should also be interpreted with caution. Among larger groups, 63% of Asian respondents (12 of 19), 60% of White respondents (308 of 515), 52% of Black/African American respondents (119 of 231), and 42% of Multiracial respondents (11 of 26) selected Chesapeake Regional Healthcare as their first choice.



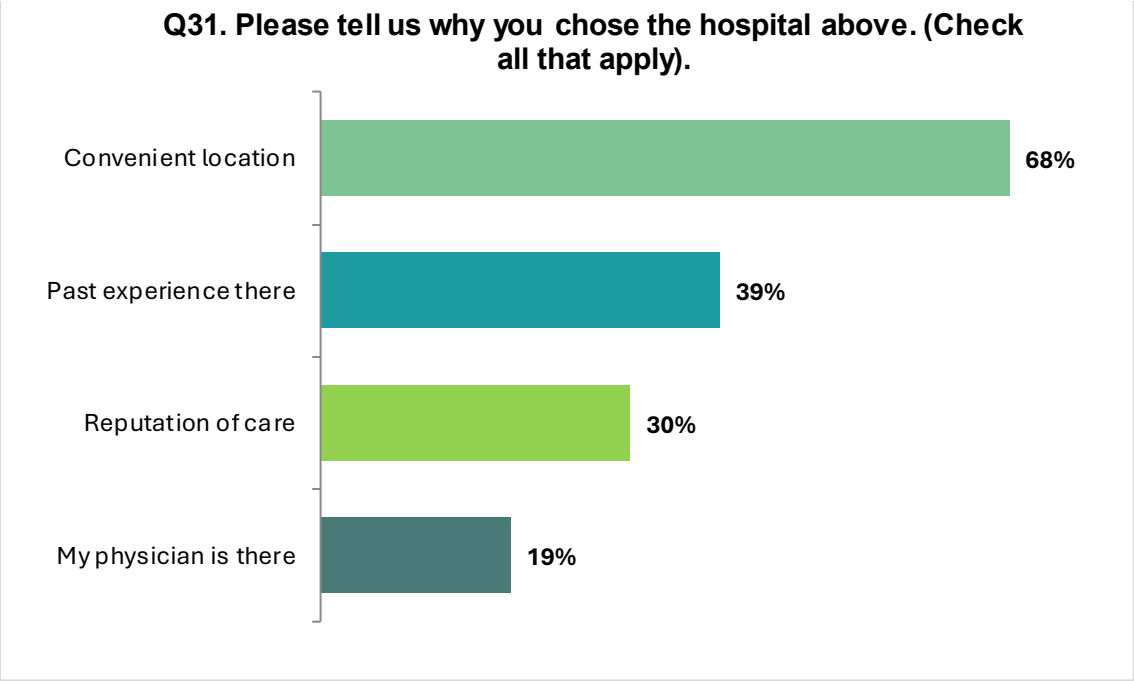
Q30: Hospital choice by INCOME
Answered:830 Skipped:89

The percentage of respondents across all income ranges was similar for choosing Chesapeake Regional Healthcare. The percentage of those earning less than $19,000 was the highest for choosing CRMG.



Q31. PLEASE TELL US WHY YOU CHOSE THE HOSPITAL ABOVE. CHECK ALL THAT APPLY.
Answered:807 Skipped:112

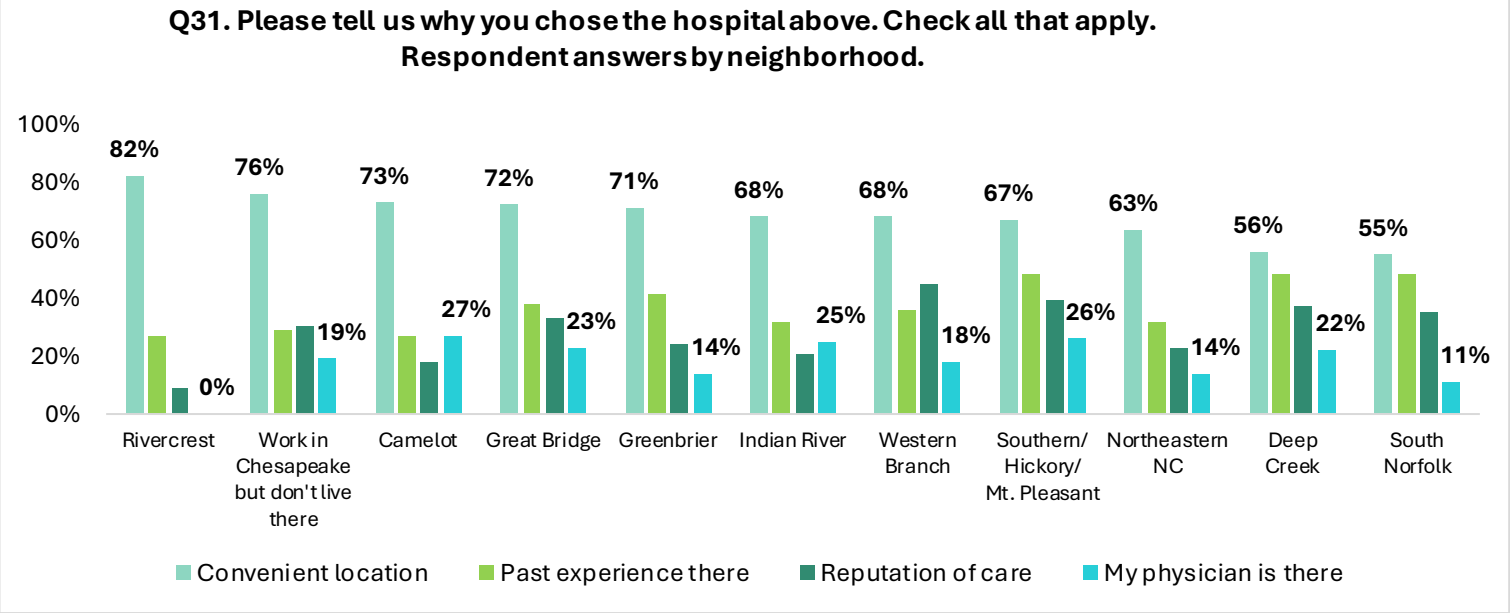
Most respondents (68%) selected convenient location as their reason for choosing a hospital, followed by past experience there (39%), reputation of care (30%) and lastly, because their physician is there (19%).



ANSWER CHOICES (CHECK ALL THAT APPLY)	PERCENT OF 807 RESPONDENTS WHO LISTED THIS ANSWER	NUMBER
Convenient location	68%	547
Past experience there	39%	317
Reputation of care	30%	246
My physician is there	19%	151
Other:		
I work at CRH/In network	2%	*15*
Excellent care at CRH	1%	*10*
TOTAL		

Q31. Reason for choosing the hospital above by NEIGHBORHOOD
Answered:807 Skipped:112

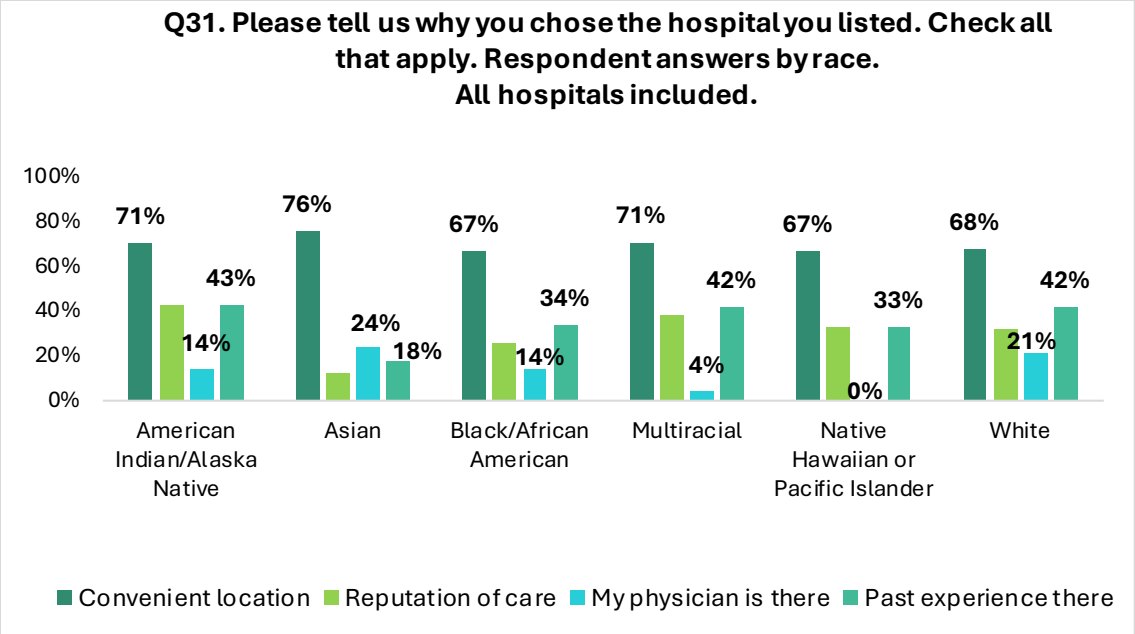
Location was the biggest factor in how respondents chose their hospitals, as seen with 82% of respondents in Rivercrest, 76% in Camelot, 72% in Great Bridge, 71% in Greenbrier and 76% of those who work in Chesapeake but do not live there. After location, respondents varied in the other factors used in choosing a hospital. Interesting, past experience and reputation of care ranked higher than having a physician at a hospital.



Neighborhood	Convenient location		Past Experience There		Reputation of care		My physician is there		Respondents #
	#	%	#	%	#	%	#	%	
Rivercrest	9	82%	3	27%	1	9%	0	0%	11
Residence not provided	23	35%	13	20%	9	14%	8	12%	30
Work in Chesapeake but don't live there	68	76%	26	29%	27	30%	17	19%	90
Camelot	8	73%	3	27%	2	18%	3	27%	11
Great Bridge	117	72%	61	38%	54	33%	37	23%	162
Greenbrier	96	71%	56	41%	32	24%	19	14%	136
Indian River	19	68%	9	32%	6	21%	7	25%	28
Western Branch	15	68%	8	36%	10	45%	4	18%	22
Southern/Hickory/ Mt. Pleasant	41	67%	29	48%	24	39%	16	26%	61
Northeastern NC	71	63%	43	32%	31	23%	19	14%	112
Deep Creek	44	56%	38	48%	29	37%	17	22%	79
South Norfolk	36	55%	31	48%	23	35%	7	11%	65
TOTAL	**547**	**68%**	**317**	**39%**	**246**	**30%**	**151**	**19%**	**807**

Q31. Reason for choosing the hospital above by RACE
Answered:807 Skipped:112

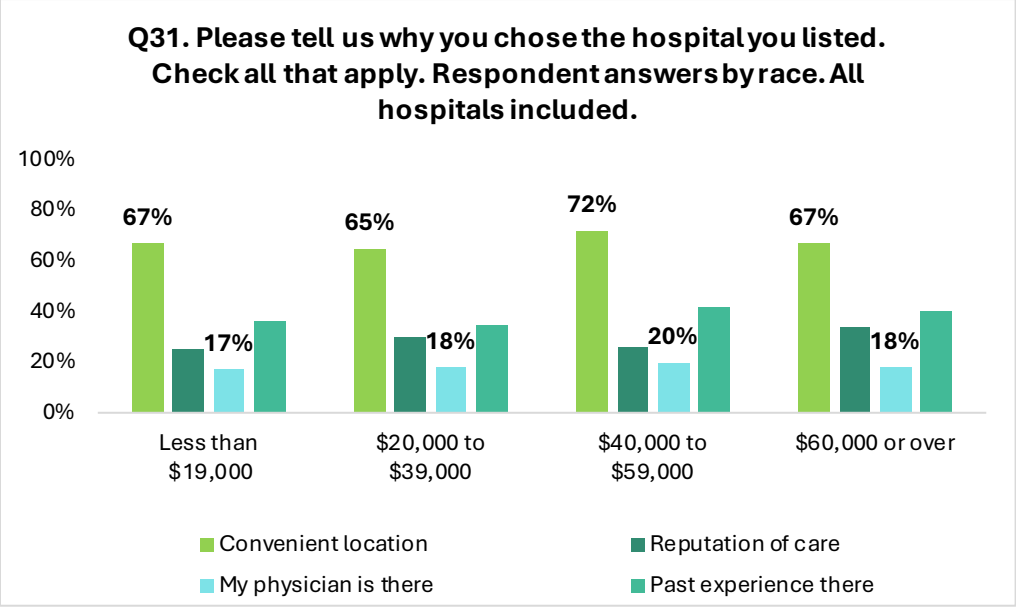
Although all races chose location as the greatest factor in choosing a hospital, there was some variation among the other reasons given. Again, past experience and reputation of care were more important in choosing a hospital than having one's physician there.



Race	Convenient location		Past experience there		Reputation of care		My physician is there		# Respondents
	#	%	#	%	#	%	#	%	
American Indian/Alaska Native	5	71%	3	43%	3	43%	1	14%	7
Asian	13	76%	3	18%	2	12%	4	24%	17
Black/African American	151	67%	76	34%	59	26%	31	14%	225
Multiracial	17	71%	10	42%	9	38%	1	4%	24
Native Hawaiian or Pacific Islander	2	67%	1	33%	1	33%	0	0%	3
White	341	68%	213	42%	160	32%	107	21%	503
Race Unknown	18	64%	11	39%	12	43%	7	25%	28
TOTAL	**547**	**68%**	**317**	**39%**	**246**	**30%**	**151**	**19%**	**807**

Q31. Reason for choosing the hospital above by INCOME
Answered:807 Skipped:112

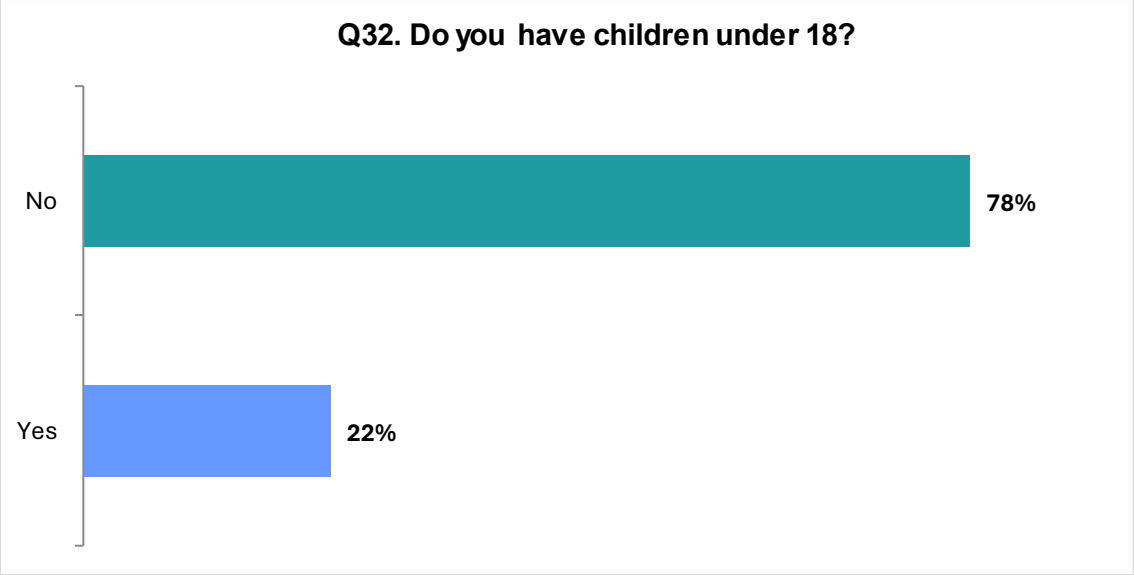
Convenient location was similarly important across all income categories. And as with the other breakdowns, location was followed by past experience, and reputation of care.



Income	Convenient location		Past experience there		Reputation of care		My physician is there		# Respondents
	#	%	#	%	#	%	#	%	
Less than $19,000	68	67%	37	36%	25	25%	17	17%	102
$20,000 to $39,000	64	65%	34	35%	29	30%	18	18%	98
$40,000 to $59,000	104	72%	61	42%	38	26%	29	20%	145
$60,000 or over	279	67%	167	40%	142	34%	77	18%	417
Income range unknown	32	71%	18	40%	12	27%	10	22%	45
TOTAL	**547**	**68%**	**317**	**40%**	**246**	**30%**	**151**	**19%**	**807**

Q32. DO YOU HAVE CHILDREN UNDER 18?
Answered:848 Skipped:71

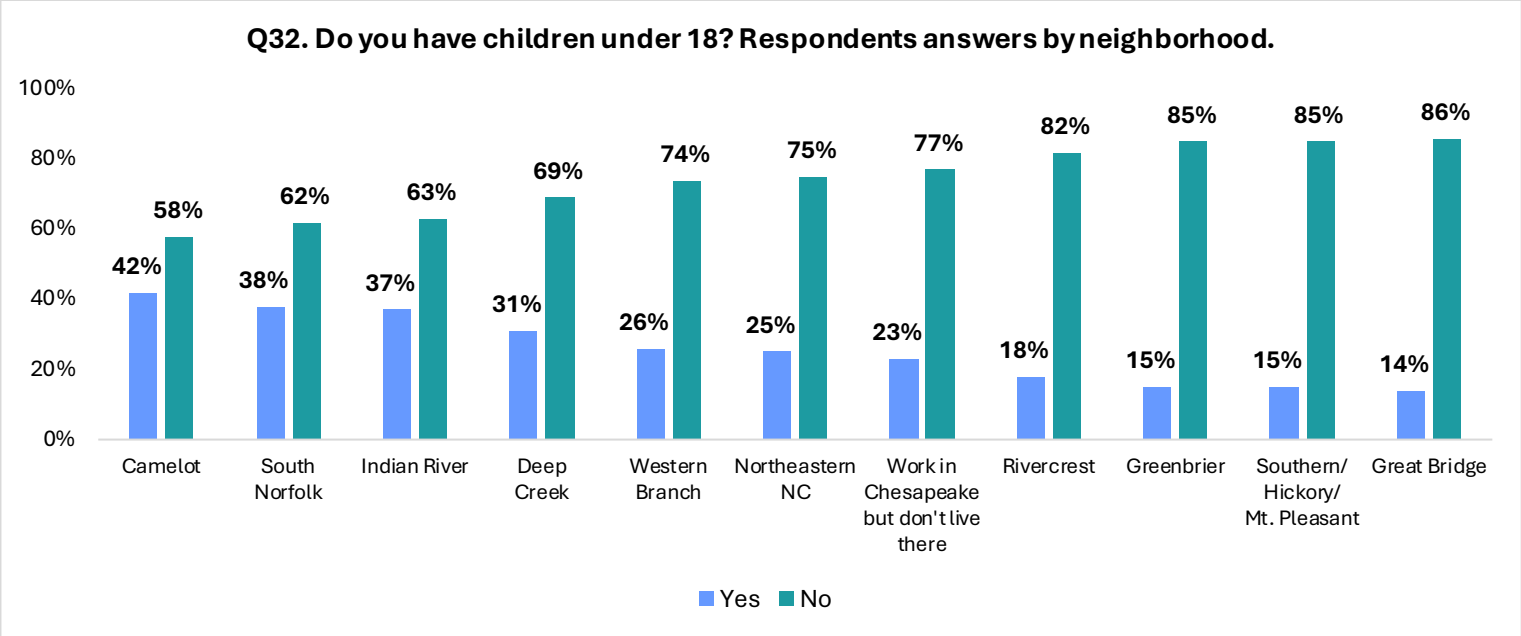
Over three-quarters (78%) of respondents reported not having children under age 18 while just 22% do have children within that age group.



ANSWER CHOICES	PERCENT	NUMBER
Yes	22%	185
No	78%	663
TOTAL	**100%**	**848**

Q32. Children under 18 by NEIGHBORHOOD
Answered:848 Skipped:71

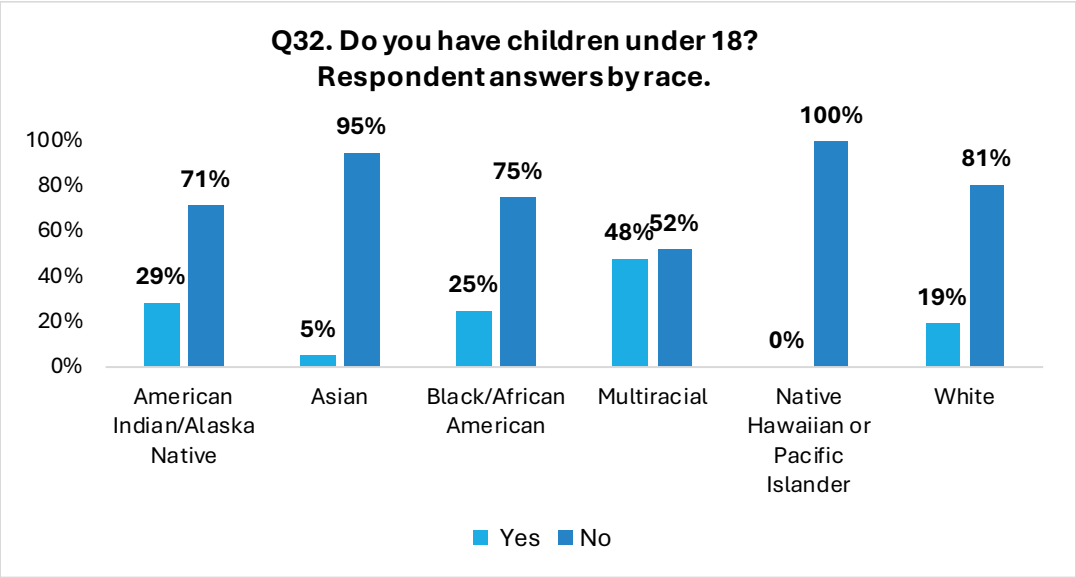
Of the 122 respondents who have children under 18, the neighborhoods reporting the largest percentage of children are Camelot (42%), South Norfolk (38%), Indian River (37%), and Deep Creek (31%).



Neighborhood	Yes		No		Respondents
	#	%	#	%	#
Camelot	5	42%	7	58%	12
Deep Creek	25	31%	56	69%	81
Great Bridge	24	14%	144	86%	168
Greenbrier	21	15%	122	85%	143
Indian River	11	37%	19	63%	30
Northeastern NC	29	25%	89	75%	118
Rivercrest	2	18%	9	82%	11
South Norfolk	26	38%	43	62%	69
Southern/Hickory/Mt. Pleasant	10	15%	55	85%	65
Western Branch	6	26%	17	74%	23
Work in Chesapeake but don't live there	23	23%	78	77%	101
Residence not provided	3	11%	24	89%	27
TOTAL	**185**	**22%**	**663**	**78%**	**848**

Q32. Children under 18 by RACE
Answered:848 Skipped:71

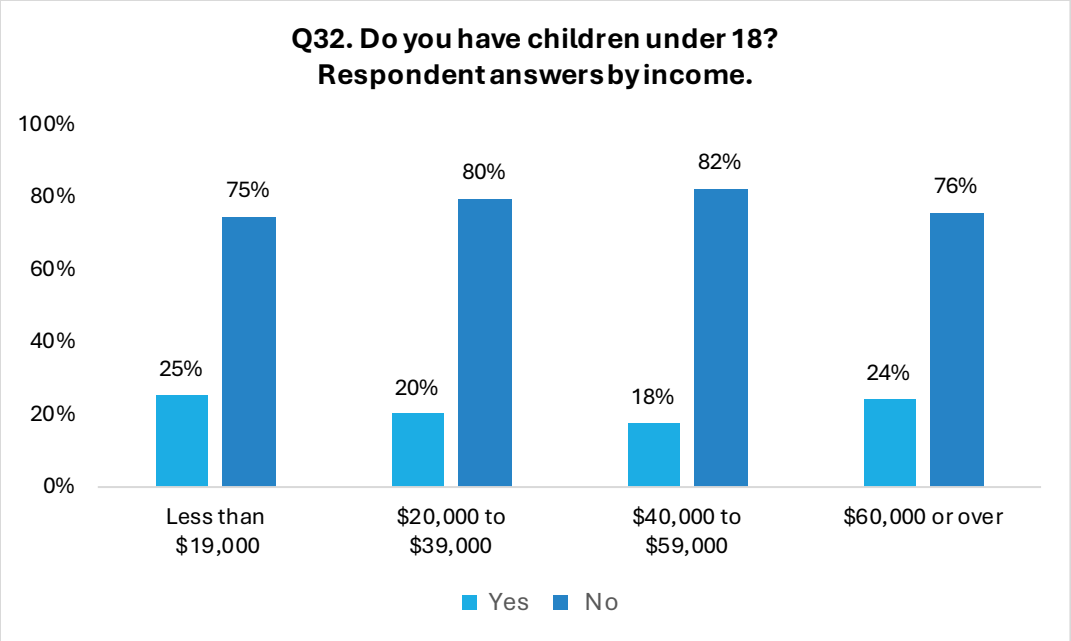
Multiracial respondents reported the highest percentage (48%) of children under 18. This is followed by American Indian/Alaska Native respondents (29%) and Black/African American respondents (25%).



Race	% Yes	% No	# Yes	# No	# Respondents
American Indian/Alaska Native	29%	71%	2	5	7
Asian	5%	95%	1	18	19
Black/African American	25%	75%	59	178	237
Multiracial	48%	52%	13	14	27
Native Hawaiian or Pacific Islander	0%	100%	0	3	3
White	19%	81%	101	424	525
Race Unknown	30%	70%	9	21	30
TOTAL	**22%**	**78%**	**185**	**663**	**848**

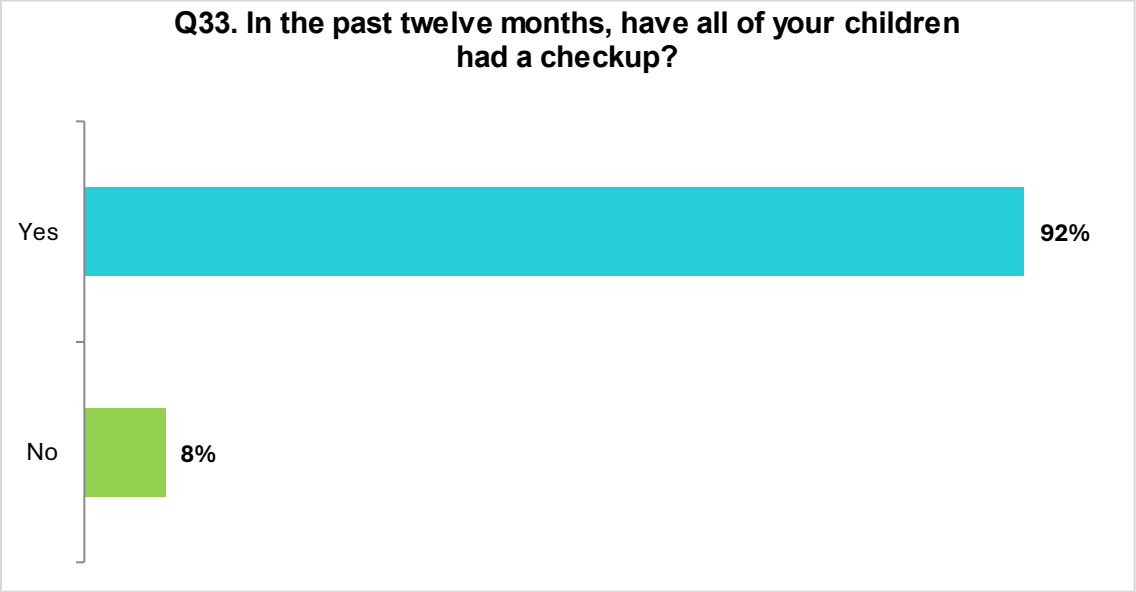
Q32. Children under 18 by INCOME
Answered:848 Skipped:71

Respondents across the income levels reported similar percentages of children under 18, from 18% to 25%. Those earning over $60,000 (24%) reported a similar percentage as those earning less than $19,000 (25%).



Income	% Yes	% No	# Yes	# No	# Respondents
Less than $19,000	25%	75%	27	80	107
$20,000 to $39,000	20%	80%	21	83	104
$40,000 to $59,000	18%	82%	27	127	154
$60,000 or over	24%	76%	106	331	437
Income range unknown	9%	91%	4	42	46
TOTAL	**22%**	**78%**	**185**	**663**	**848**

Q33. IN THE PAST TWELVE MONTHS, HAVE ALL OF YOUR CHILDREN HAD A CHECK-UP?
Answered:189 Skipped:730



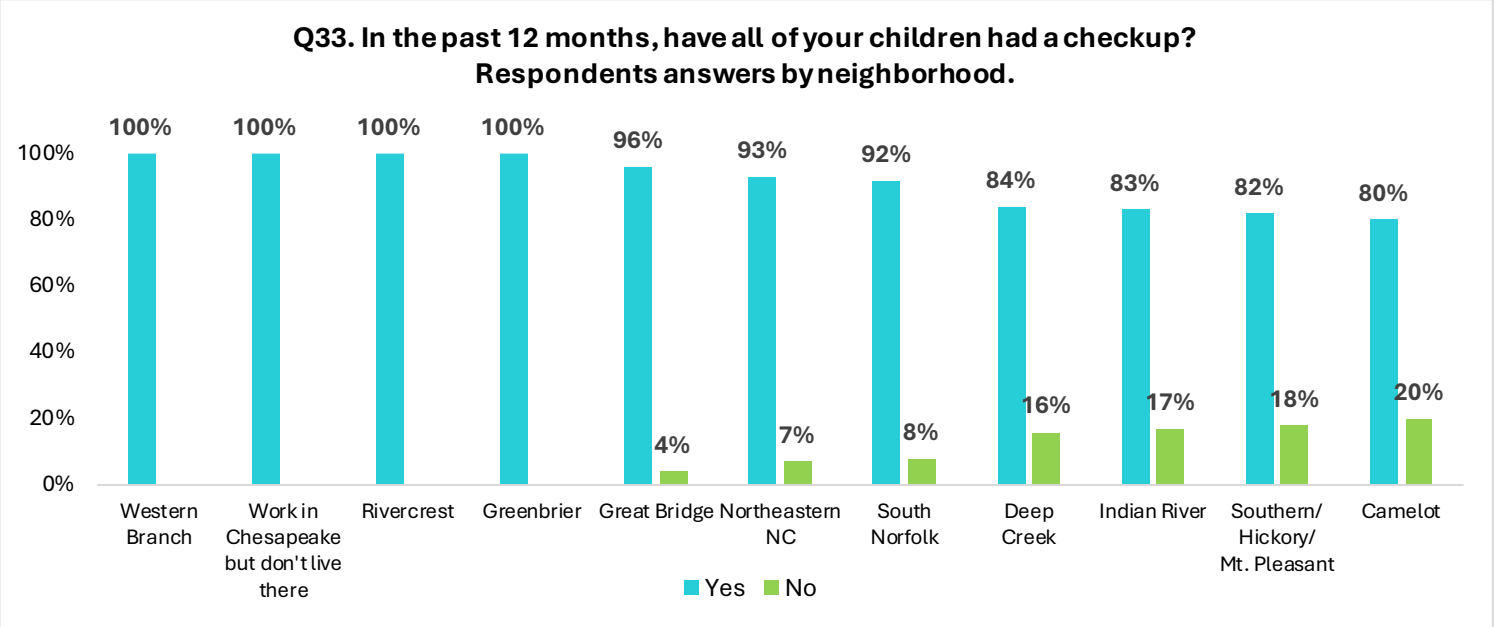
ANSWER CHOICES	PERCENT	NUMBER	CHNA 2021
Yes	92%	174	⇔ 92%
No	8%	15	⇔ 8%
TOTAL	**100%**	**189**	**100%**

Q34. IF YOU ANSWERED "NO" IN THE QUESTION ABOVE, PLEASE DESCRIBE WHY YOUR CHILDREN HAVE NOT HAD A CHECKUP IN THE LAST 12 MONTHS.
Answered: 8 Skipped:911

No female doctor is available for teen girl
I can't get off work
Family problems make it difficult
Financial constraint
No insurance
Scheduling difficulty
Recently moved and getting settled

Q33. Children's check up by NEIGHBORHOOD
Answered:189 Skipped:730

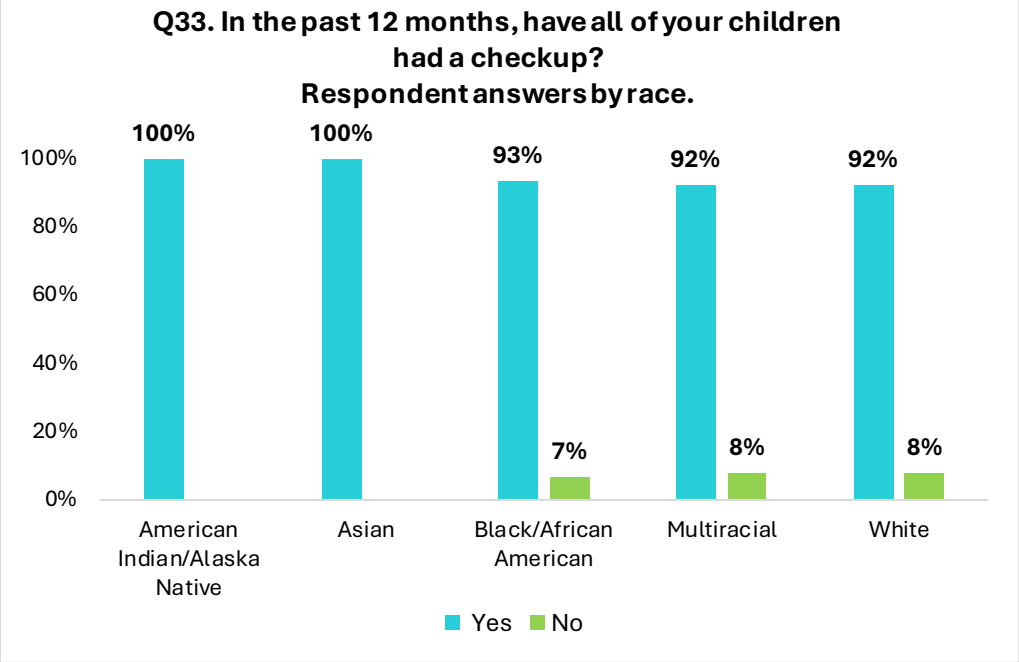
The majority (80% to 100%) of respondents in all neighborhoods reported that their children have had a checkup in the past year. Of 189 respondents, only 15 reported that their children have not had a checkup. The tables below show the number and percentage of these respondents by neighborhood, race, and income. Because the number of children is small, these tables show calculations and percentages were made.



Neighborhood	Yes		No		# Respondents
	#	%	#	%	
Western Branch	6 of 6	100%	0	0%	6
Work in Chesapeake but don't live there	24 of 24	100%	0	0%	24
Rivercrest	2 of 2	100%	0	0%	2
Greenbrier	21 of 21	100%	0	0%	21
Great Bridge	25 of 26	96%	1 of 26	4%	26
Northeastern NC	26 of 28	93%	2 of 28	7%	28
South Norfolk	24 of 26	92%	2 of 26	8%	26
Deep Creek	21 of 25	84%	4 of 25	16%	25
Indian River	10 of 12	83%	2 of 12	17%	12
Southern/Hickory/ Mt. Pleasant	9 of 11	82%	2 of 11	18%	11
Camelot	4 of 5	80%	1 of 5	20%	5
Residence not provided	2 of 3	67%	1 of 3	33%	3
TOTAL	**174**	**92%**	**15**	**8%**	**189**

Q33. Children's check up by RACE
Answered:189 Skipped:730

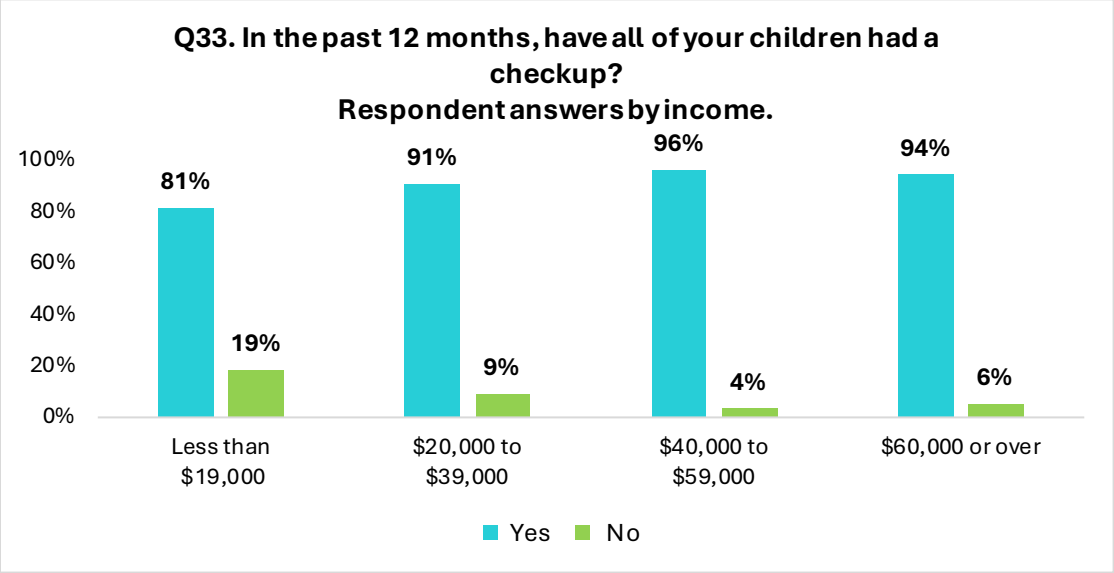
Of the 15 children who did not get checkups, there were 8 White, 4 Black/African American, 1 Multiracial and 2 race unknown. The numbers and percentages are in the table below.



Race	% Yes	% No	# Yes	# No	# Respondents
American Indian/Alaska Native	100%	0%	2 of 2	0	2
Asian	100%	0%	1 of 1	0	1
Black/African American	93%	7%	56 of 60	4	60
Multiracial	92%	8%	12 of 13	1	13
White	92%	8%	95 of 103	8	103
Race Unknown	80%	20%	8 of 10	2	10
TOTAL	**92%**	**8%**	**174 of 189**	**15 of 189**	**189**

Q33. Children's check up by INCOME
Answered:189 Skipped:730

Of the 15 children who did not get checkups, 5 were in households earning less than $19,000; 2 were in households earning $20,000 to $39,000; 1 was in a household earning $40,000 to $59,000 and 6 were in households earning over $60,000. The table below shows the number and percentages.

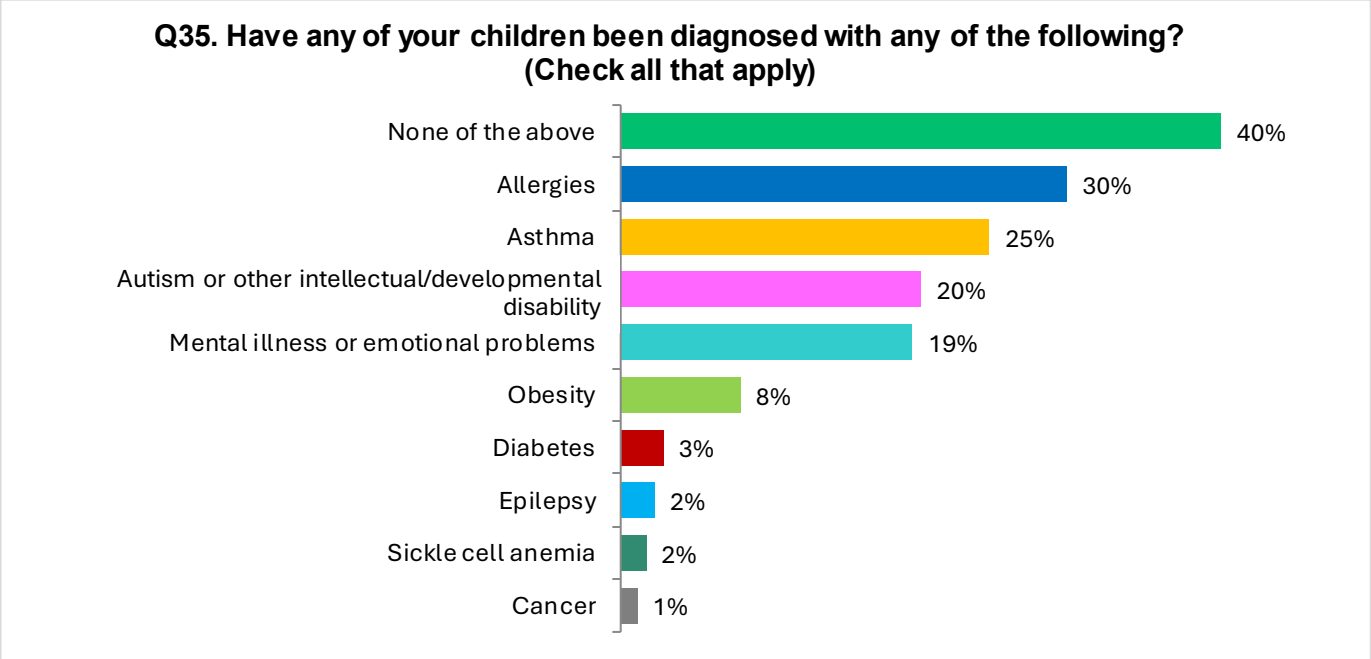


	Yes	No	#Answered Yes	# Answered No	# Respondents
Less than $19,000	81%	19%	22 of 27	5 of 27	27
$20,000 to $39,000	91%	9%	20 of 22	2 of 22	22
$40,000 to $59,000	96%	4%	27 of 28	1 of 28	28
$60,000 or over	94%	6%	102 of 108	6 of 108	108
Income range unknown	75%	25%	3 of 4	1 of 4	4
TOTAL	**92%**	**8%**	**174 of 189**	**15 of 189**	**189**

Q35. Have any of your children been diagnosed with any of the following? Check all that apply.

Answered:175 Skipped:744

Respondents of all races reported the greatest percentage of their children having no chronic illness (40%). Of the illnesses selected, the most frequently reported were Allergies (30%), Asthma (25%) and Autism/Intellectual or Developmental Disability (20%). Closely behind these are Mental Illness/Emotional Problems (19%).

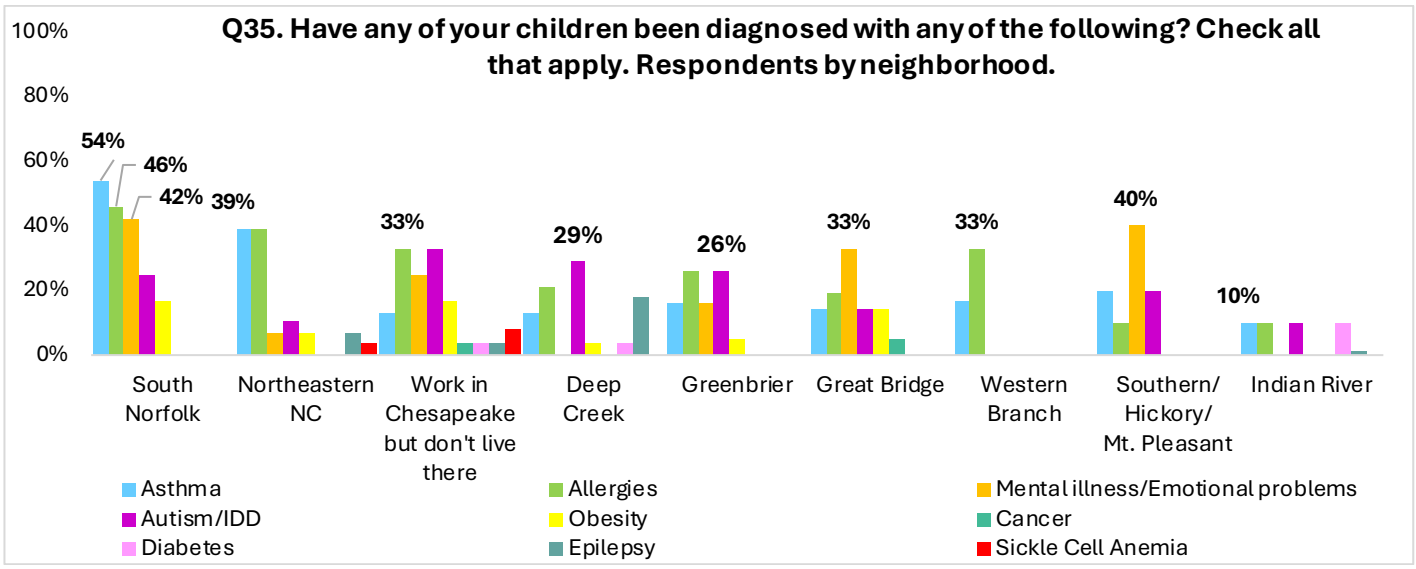


ANSWER CHOICES. CHECK ALL THAT APPLY	PERCENT OF 175 RESPONDENTS WHO GAVE THIS ANSWER	NUMBER OF RESPONSES
None of the above	40%	70
Allergies	30%	52
Asthma	25%	43
Autism or other intellectual/developmental disability	20%	35
Mental illness or emotional problems	19%	34
Obesity	8%	14
Diabetes	3%	5
Epilepsy	2%	4
Sickle cell anemia	2%	3
Cancer	1%	2
Other: ADHD	*3%*	5
Hypothyroidism	*0.5%*	1
Plagiocephaly, brachycephaly, torticollis, hypotonia	*0.5%*	1
Oppositional Defiant Disorder	*0.5%*	1
Cerebral Palsy and HIE	*0.5%*	1
Bleeding disorder	*0.5%*	1
Hashimoto's disease	*0.5%*	1
TOTAL		

Q35. Children's illnesses by NEIGHBORHOOD

Answered:175 Skipped:744

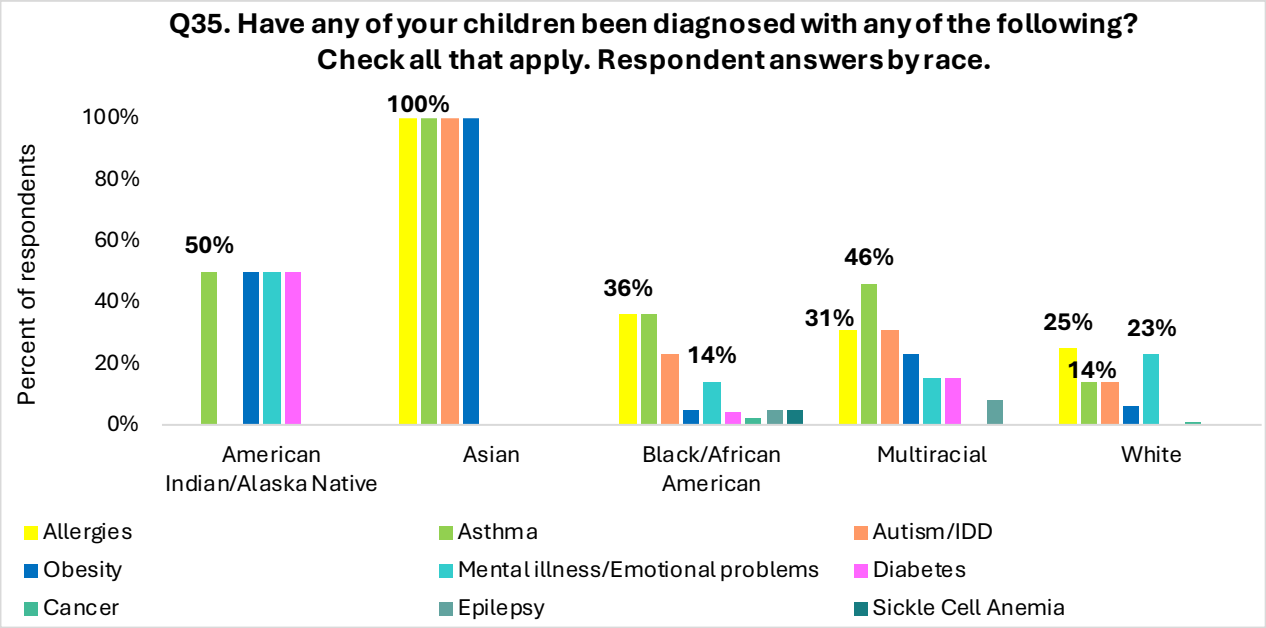
The graph and table below show how respondents answered this question by neighborhood. Children living in South Norfolk have the largest percentage of asthma (54%), allergies (46%), and mental illness/emotional problems (42%) of any other neighborhood. Southern/Hickory/Mt. Pleasant children show the next highest percentage of mental health problems (40%).



Neighborhood	Allergies		Asthma		Autism/IDD		Cancer		Diabetes		Epilepsy		Mental Illness/ Emotional Problems		Obesity		Sickle Cell Anemia		Total #
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Camelot	3	60%	3	60%	1	20%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	5
South Norfolk	11	46%	13	54%	6	25%	0	0%	0	0%	0	0%	6	42%	4	17%	0	0%	24
Northeastern NC	12	43%	11	39%	3	11%	0	0%	0	0%	2	7%	2	7%	2	7%	1	4%	28
Work in Chesapeake but don't live there	8	33%	3	13%	7	33%	1	4%	1	4%	0	4%	4	25%	3	17%	2	8%	24
Deep Creek	5	21%	3	13%	7	29%	0	0%	1	4%	2	18%	0	0%	1	4%	0	0%	24
Greenbrier	5	26%	3	16%	5	26%	0	0%	0	0%	0	0%	3	16%	1	5%	0	0%	19
Great Bridge	4	19%	3	14%	3	14%	1	5%	0	0%	0	0%	6	33%	3	14%	0	0%	21
Western Branch	2	33%	1	17%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	6
Southern/Hickory/ Mt. Pleasant	1	10%	2	20%	2	20%	0	0%	0	0%	0	0%	4	40%	0	0%	0	0%	10
Indian River	1	10%	1	10%	1	10%	0	0%	1	10%	0	1%	9	0%	0	0%	0	0%	10
Rivercrest	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0	0	0%	2
Residence not provided	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	2
TOTAL	**52**	**30%**	**43**	**25%**	**35**	**20%**	**2**	**1%**	**5**	**3%**	**4**	**2%**	**34**	**19%**	**14**	**8%**	**3**	**2%**	**175**

Q35. Children's illnesses by RACE
Answered:175 Skipped:744

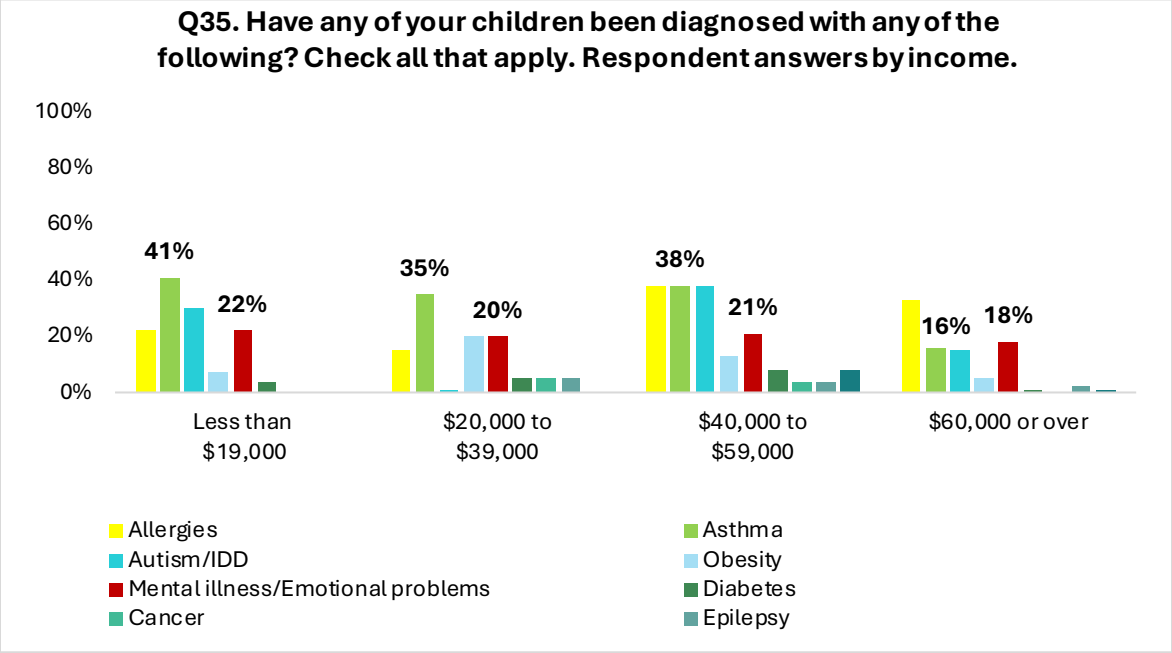
There was just one Asian respondent with a child under 18, and because this child also had several illnesses, the graph shows that 100% of children of Asian respondents have four illnesses, which is very misleading. The table below shows more clearly the number and percentage of children with their illnesses. For racial groups with larger sample sizes, such as Black/African American and White, we can glean more accurate information from the graph below. For example, 36% of Black/African American children were reported to have allergies and asthma compared to 25% and 14% respectively for White children. Yet 23% of White children were reported to have mental health or emotional problems compared to just 14% of Black/African American children.



Race	Allergies		Asthma		Autism/ IDD		Cancer		Diabetes		Epilepsy		Mental Illness/ Emotional problems		Obesity		Sickle Cell Anemia		Total children
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	0	0	
American Indian/Alaska Native	0	0%	1	50%	0	0%	0	0%	1	50%	0	0%	1	50%	1	50 %	0	0%	2
Asian	1	100%	1	100 %	1	100%	0	0%	0	0%	0	0%	0	0	1	10 0%	0	0%	1
Black/African American	20	36%	20	36%	13	23%	1	2%	2	4%	3	5%	8	14%	3	5%	3	5%	56
Multiracial	4	31%	6	46%	4	31%	0	0%	2	15%	1	8%	2	15%	3	23 %	0	0%	13
White	25	25%	13	14%	16	14%	1	1%	0	0%	0	0%	22	23%	6	6%	0	0%	95
Race Unknown	2	25%	2	25%	1	13%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	8
TOTAL	**52**	**30%**	**43**	**25%**	**35**	**20%**	**2**	**1%**	**5**	**3%**	**4**	**2%**	**34**	**19%**	**14**	**8%**	**3**	**2%**	**175**

Q35. Children's illnesses by INCOME
Answered:175 Skipped:744

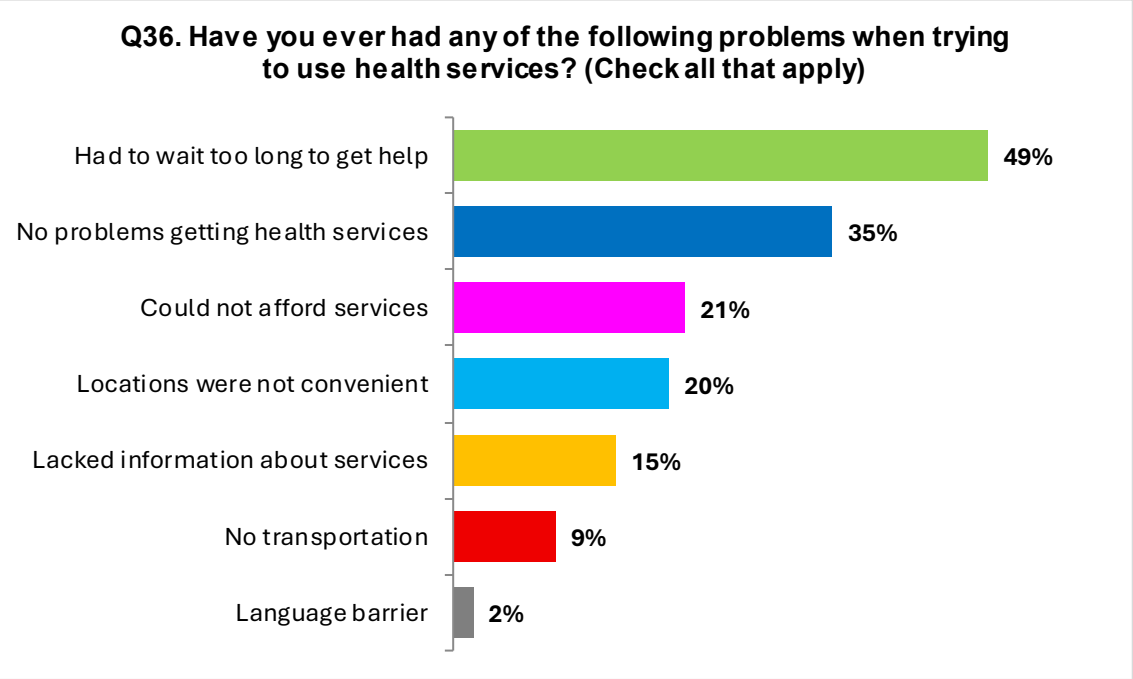
Children's illnesses seem to occur in all income groups. Asthma is the highest in households earning less than $19,000 at 41% compared to asthma in households earning over $60,000 (16%). However, mental health and emotional problems are consistent between 18% and 22% across all incomes.



Income	Allergies		Asthma		Autism/ IDD		Cancer		Diabetes		Epilepsy		Mental Illness/ Emotional problems		Obesity		Sickle Cell Anemia	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Less than $19,000	6	22%	11	41%	8	30%	0	0%	1	4%	0	0%	6	22%	2	7%	0	0%
$20,000 to $39,000	3	15%	7	35%	3	1%	1	5%	1	5%	1	5%	4	20	4	20%	0	0%
$40,000 to $59,000	9	38%	9	38%	9	38%	1	4%	2	8%	1	4%	5	21%	3	13%	2	8%
$60,000 or over	34	33%	16	16%	15	15%	0	0%	1	1%	2	2%	19	18%	5	5%	1	1%
Income range unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
TOTAL	**52**	**28%**	**43**	**25%**	**35**	**20%**	**2**	**1%**	**5**	**3%**	**4**	**2%**	**34**	**19%**	**14**	**8%**	**3**	**2%**

Q36. HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS WHEN TRYING TO USE HEALTH SERVICES? CHECK ALL THAT APPLY.
Answered:801 Skipped:118

Overall, the most frequently reported issue with getting health services was waiting too long to get an appointment, which was a top suggestion for how the hospital can improve services. Forty-nine percent of respondents (380 people) stated this as a problem. The next more frequent answer to this question was that there were no problems getting services (35%). This was followed by 21% of respondents who said they could not afford healthcare, 20% who said locations were not convenient, 15% who said they lacked information about services, 9% who stated they had no transportation, and 2% who reported a language barrier.



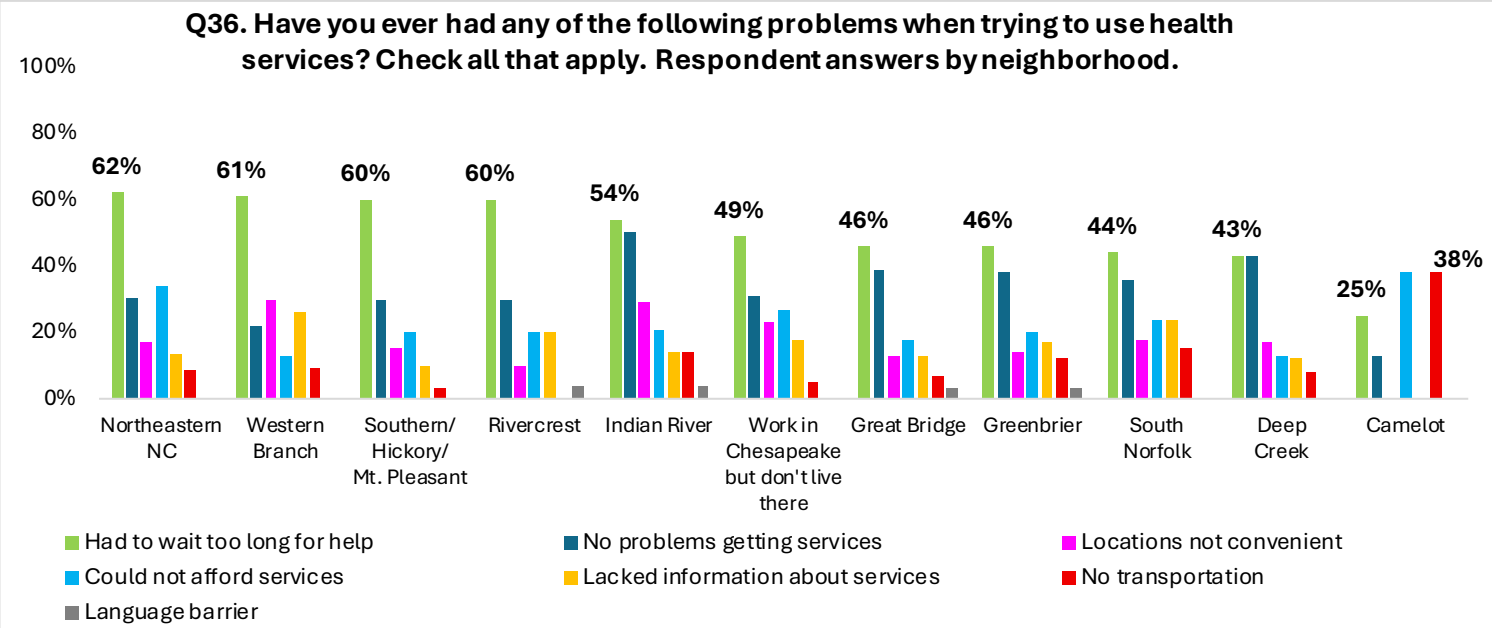
ANSWER CHOICES. CHECK ALL THAT APPLY	PERCENT	NUMBER	CHNA 2021
Had to wait too long to get help	49%	390	↑ 26%
No problems getting health services	35%	280	↓ 47%
Could not afford services	21%	171	↑ 14%
Locations were not convenient	20%	159	↑ 16%
Lacked information about services	15%	120	↓ 18%
No transportation	9%	76	↔ 9%
Language barrier	2%	15	↔ 2%
Other: See table on next page			

ADDITIONAL COMMENTS TO Q36:
Difficulty getting appointments with a specialist
Specialists are ridiculous to get in to
Electronic referrals were sent from PCP and never received to CRMC mammography on several occasions
Felt like doc not taking me seriously and acted like they didn't have the time - so frankly I just stopped going to my PCP and just go to urgent care when I have an acute issue that is readily apparent and I can "prove" because as a woman I am universally looked at as suspect if I have anything more vague going on or a concern that can't be "proven" with lab work or an Xray.
Qualified doctors or willingness to help
The act of going to the ER is so incredibly painful that I need to be near death to want to go there and deal with all of the hassle and hardship it's hard to have a place designated to go to when you need help and medical attention and you get nothing but paperwork paying ignorance and patience and then a massive bill
Insurance not accepted
Insurance issue
Insurance coverage was poor
No one takes my insurance
A lot of providers don't accept insurances that are common
doctor out of network
Routine appointment scheduled 3 months beyond last annual exam because of inadequate staffing. Appointment changed because of inadequate staffing
Staff has no patience for the people they are supposed to be caring for and this has been going on for years
Bad attitudes among support staff at medical providers/rude, careless, cancel appts in error. But I commend Erica and Nolene for going above to make classes fun and challenging. Great Golden Oldies Stretch Class.
Physicians gas lighting
Healthcare providers ignored concerns or treat symptoms but not the cause ex. birth control for ovarian cyst
Thinking I'm diabetic and I'm not!! Getting ready to give me insulin
Urgent care services in area have limited hours
Poor quality medical service / interventions.
Feelings of prejudiced
Not accepting new patients
Very limited information about resources. CIBH does an outstanding job, but more frequent visits or small group counseling would be helpful.

Q36. Problems getting healthcare services by NEIGHBORHOOD

Answered:801 Skipped:118

Respondents from North Carolina (62%), Western Branch 61%), Southern/Hickory/Mt. Pleasant and Rivercrest (60%) reported the high percentage of having to wait too long to get services. A smaller percentage of respondents from Camelot reported long wait time (25%) but reported higher percentages of not being able to afford services (38%) and not having transportation (38%).



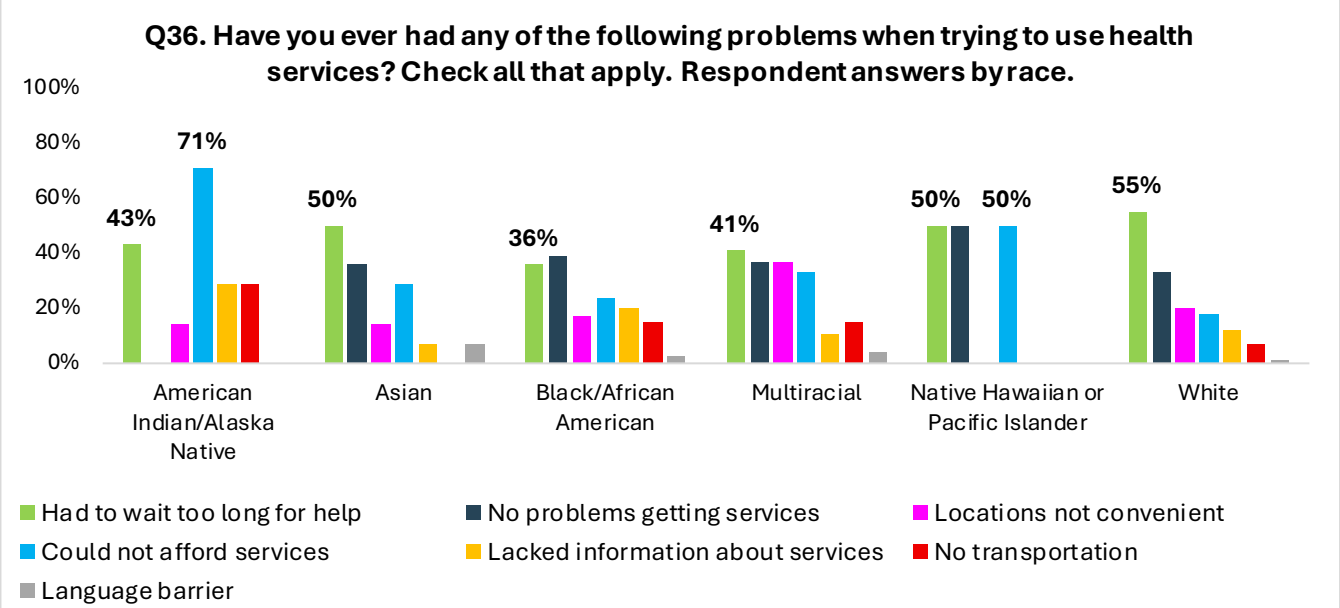
Neighborhood	Could not afford services		No transpor-tation		Lacked information about services		Locations not convenient		Had to wait too long for help		Language barrier		No problems getting services		Respondents
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#
Western Branch	3	13%	2	9%	6	26%	7	30%	14	61%	0	0%	5	22%	23
Southern/ Hickory/ Mt. Pleasant	12	20%	2	3%	6	10%	10	15%	36	60%	0	0%	18	30%	60
Rivercrest	2	20%	0	0%	2	20%	1	10%	6	60%	0	0%	3	30%	10
Indian River	6	21%	4	14%	4	14%	8	29%	15	54%	1	4%	14	50%	28
Northeastern NC	32	34%	8	8%	13	14%	16	17%	59	62%	2	2%	29	31%	113
Work in Chesapeake but don't live there	26	27%	5	5%	17	18%	23	23%	47	49%	4	4%	29	31%	95
Great Bridge	28	18%	11	7%	21	13%	21	13%	73	46%	0	0%	63	39%	160
Greenbrier	27	20%	16	12%	22	17%	18	14%	61	46%	4	3%	50	38%	133
South Norfolk	16	24%	10	15%	16	24%	12	18%	29	44%	2	3%	24	36%	66
Deep Creek	10	13%	6	8%	9	12%	14	17%	33	43%	0	0%	33	43%	76
Camelot	3	38%	3	38%	0	0%	0	0%	2	25%	0	0%	1	13%	8
Residence not provided	6	21%	9	31%	4	14%	29	100%	15	52%	2	7%	11	38%	29
TOTAL	**171**	**21%**	**76**	**9%**	**120**	**15%**	**159**	**20%**	**390**	**49%**	**15**	**2%**	**280**	**35%**	**801**

Q36. Problems getting healthcare services by RACE

Answered:801 Skipped:118

American Indian/Alaska Native respondents reported the highest percentage of not being able to afford services (71%). This was followed by Native Hawaiian/Pacific Islander respondents (50%).

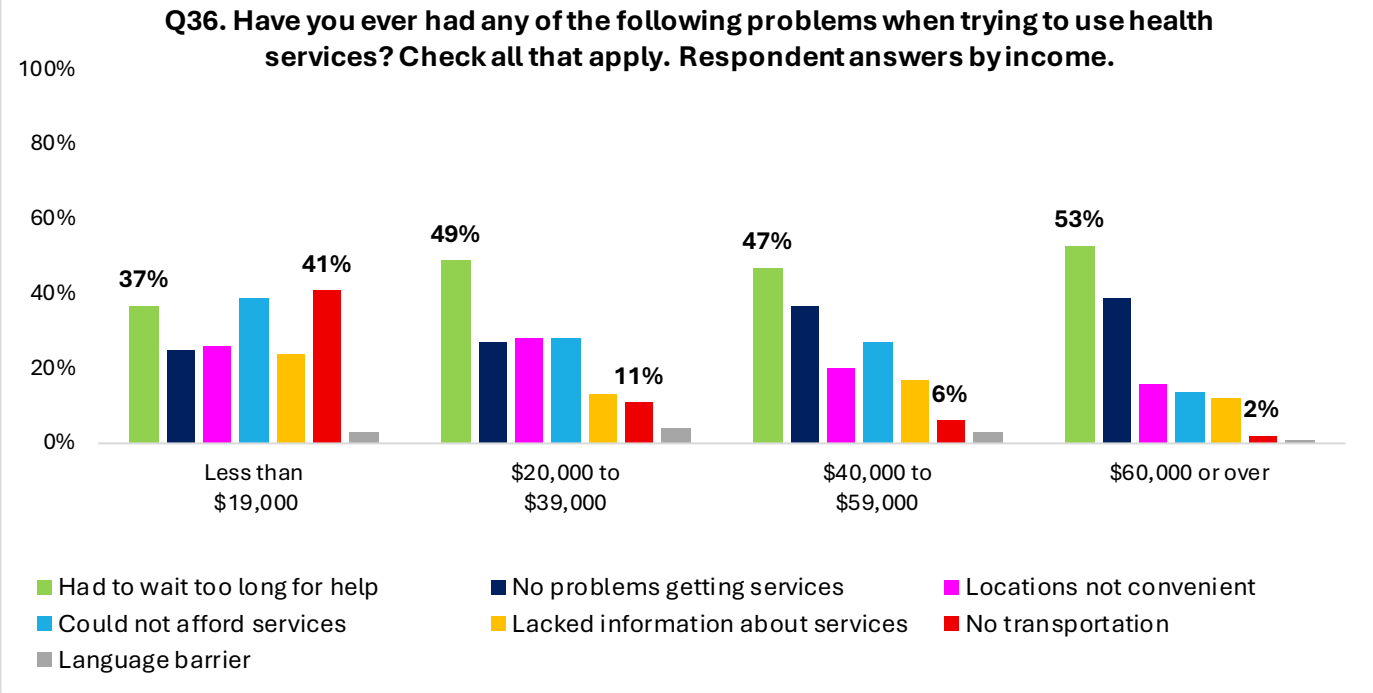
White respondents reported the highest percentage of having to wait too long for help (55%) compared to 50% of Asian respondents and 50% of Black/African American respondents.



Race	Had to wait too long for help		No problems getting services		Locations not convenient		Could not afford services		Lacked information about services		No transport-tation		Language barrier		# Respondents
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
American Indian/Alaska Native	3	43%	0	0%	1	14%	5	71%	2	29%	2	29%	0	0%	7
Asian	7	50%	5	36%	2	14%	4	29%	1	7%	0	0%	1	7%	14
Black/African American	81	36%	87	39%	38	17%	54	24%	44	20%	34	15%	6	3%	224
Multiracial	11	41%	10	37%	10	37%	9	33%	3	11%	4	15%	1	4%	27
Native Hawaiian or Pacific Islander	1	50%	1	50%	0	0%	1	50%	0	0%	0	0%	0	0%	2
White	272	55%	166	33%	101	20%	89	18%	62	12%	33	7%	5	1%	499
Race Unknown	15	54%	11	39%	7	25%	9	32%	8	29%	3	11%	2	7%	28
TOTAL	**390**	**49%**	**280**	**35%**	**159**	**20%**	**171**	**21%**	**120**	**15%**	**76**	**10%**	**15**	**2%**	**801**

Q36. Problems getting healthcare services by INCOME
Answered:801 Skipped:118

Waiting too long for services was also a top problem reported across income groups, however, just 37% of those earning less than $19,000 reported this compared to 53% of those earning over $60,000. For those earning less than $19,000, lack of transportation was the most frequently listed problem getting healthcare.



	Could not afford services		No Transpor-tation		Lacked information about services		Locations not convenient		Had to wait too long for help		Language barrier		No problems getting services		# Respond-ents
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Less than $19,000	41	39%	43	41%	25	24%	27	26%	38	37%	3	3%	26	25%	104
$20,000 to $39,000	28	28%	11	11%	13	13%	28	28%	49	49%	4	4%	27	27%	99
$40,000 to $59,000	39	27%	8	6%	24	17%	29	20%	67	47%	4	3%	53	37%	144
$60,000 or over	58	14%	7	2%	50	12%	65	16%	218	53%	2	1%	160	39%	410
Income range unknown	5	11%	7	16%	8	18%	10	23%	18	41%	2	5%	14	32%	44
TOTAL	**171**	**21%**	**76**	**10%**	**120**	**15%**	**159**	**20%**	**390**	**49%**	**15**	**2%**	**280**	**35%**	**801**

Key Informant Interviews

"Black women in Virginia have a 40% higher risk of breast cancer."

"I'm enthralled at the fact that we have Healthy Chesapeake who does what they do. They partner with so many people to address gaps."

"We are one community that tries to solve problems."

"Parks and Rec has a lot of assets. It goes full circle and people live happier and healthier lives. Making our city more connected and walkable is a huge opportunity."

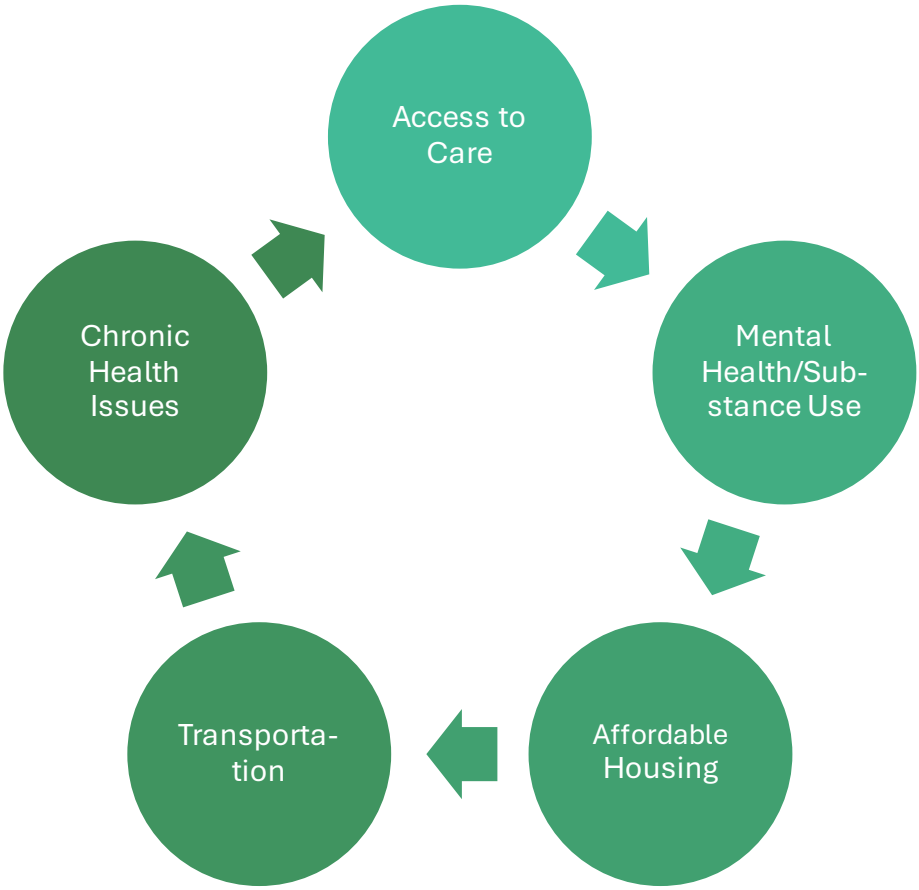
"There is almost a hidden emergency response team between city departments that rallies together to help individuals in crisis when it's brought to their attention."

"The hospital needs to do better to work with practitioners in the community to work together for high need patients."

Introduction

Hearing directly from community leaders and members provides critical context, uncovers hidden challenges, and ensures that assessments are both relevant and accurate. The lived experience of those navigating a community's strengths and shortcomings each day offers essential perspective that complements quantitative data, creating a fuller and more authentic picture. Between January and April 2025, thirty-three interviews were conducted with residents of Chesapeake and northeastern North Carolina, including private citizens, city and county officials, service providers, healthcare and education partners, funding agencies, clinics, and faith-based organizations. The six questions posed to each one provided an opportunity to include their unique perspectives and experience in this needs assessment. Complete responses by those interviewed can be found in **Appendix A.**

Within the responses gathered, certain key issues were highlighted by many that participated. The **top ten issues** are discussed below to allow for further discussion and clarity.



Access to Care

"It's heartbreaking when a person just had a life-threatening event and has nowhere to go," "The lack of availability for specialty care, such as urology, is a serious threat to patients." "The months people wait after a health incident are exceptionally long. Medical staffing is just not there, whether at the hospital or other."

Access to healthcare means having "the timely use of personal health services to achieve the best health outcomes." Access to comprehensive, quality healthcare services is important for promoting and maintaining health, preventing, and managing disease, reducing unnecessary disability and premature death, and achieving health equity for all Americans.[12] Attaining good access to care means having:

- Health insurance that facilitates entry into the healthcare system.
- Timely access to needed care.
- A usual source of care with whom the patient can develop a relationship.
- The ability to receive care when there is a perceived need.

7.6% or 530,000 of all nonelderly Virginians (ages 0-64) had no health insurance in 2023, with Chesapeake's rate at 7.7%.[1] About 1 in 10 people (9.4%) in the United States do not have health insurance. Sometimes people do not get recommended health care services, like cancer screenings, because they do not have a primary care provider. Other times, it is because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.[1]

Observations from the Interviews:

- Many people cite that access to primary and specialty care is limited, with long wait times (up to a year for some specialists)
- There is a lack of providers, especially in rural areas like Gates County
- The cost of care and insurance is a barrier for many
- Uninsured and undocumented individuals often do not seek care due to fear, lack of trust, and/or affordability
- Mobile clinics and outreach efforts were positively received, but increased support is requested

[12] Healthy People 2030, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.

Mental Health/Substance Use

"We need to address substance use deaths as we have a dramatic increase in percentage. We need to engage everyone at the Free Clinic, city departments and more to figure this out."
"When we separate mental health from physical and dental - that's wrong. They are very connected, and funding and insurances have created these problems to access."

In 2023, 39% of services provided by the Virginia Department of Behavioral Health and Developmental Services were for Mental Health while 7% were for Substance Use Disorders. The United States has been struggling to control the ongoing mental health crises for over a decade. Data has shown that COVID-19 only exacerbated the already stressed systems in place. The 2023 National Survey on Drug Use and Health (NSDUH) found that over 22% of adults aged 18 and older suffered from some form of mental health condition. These rates were notably highest amongst young adults aged 18 to 25 (33.8%). For those adults that did experience some form of mental health condition, only 53.9% of them received mental health treatment.

NSDUH also reported that among individuals aged 12 or older, 59.0% (or 167.2 million people) used tobacco products including vaping nicotine, alcohol, or used an illicit drug currently or in the past month- and that 17.1% of people aged 12 or older had a substance use disorder in the past year. [13]

There are ongoing concerns around public health as a priority issue among mayors in 2025. Ninety-nine percent of survey respondents indicated they were concerned about substance use (including responses indicating Slightly, Moderately, Very or Extremely Concerned). National drug overdose deaths increased greatly from 1999 to 2022, largely driven by the increase in opioid overdoses. Declining national overdose deaths may indicate that leaders are taking action to halt substance use issues in their communities, but more recent increased use of fentanyl and synthetic opioids poses severe and unforeseen challenges for communities. [14]

Observations from the interviews:

- Services are currently insufficient, often with long waitlists especially for children and teens
- Stakeholders noted a lack of outreach and peer support for people in crisis, specifically among the homeless and elderly
- Stigma, lack of awareness, and provider shortages are key barriers observed
- Increased prevalence of substance use, fentanyl and opioids are especially concerning
- Addiction services are also inadequate and lack appropriate street-level outreach
  Alcohol and tobacco abuse, in addition to illicit drug use, is also widespread and needs attention

[13] Key Substance Use and Mental Health Indicators in the United States: Results from the 2023 National Survey on Drug Use and Health. SAMHSA, July 2024.
[14] National League of Cities: 2025 State of the Cities Report. Website: https://www.nlc.org/resource/state-of-the-cities-2025/

Affordable Housing

"Affordability is the key issue – paying for food, power, water, or paying for the doctor."

In recent years, housing has emerged as a key issue for cities, towns, and villages across America. Housing stability is a significant factor in driving economic mobility and individual well-being. As housing crises continue to plague communities across the nation - challenges associated with inadequate housing supply, unaffordable options, low housing quality and more – municipalities are being asked more than ever to provide secure and accessible housing units for their residents. Housing supply and availability is the most severe concern for local leaders, with 57% of survey respondents rating the availability of housing in their community as Poor or Very Poor.

Nationally, there is a shortage of more than 7 million affordable homes for our nation's 10.8 million plus extremely low-income families.[15] The United States Department of Housing and Urban Development defines affordable housing as housing with monthly costs, including utilities other than telephone, that do not exceed 30% of a household's monthly income. To help put this into perspective, the Fair Market Rent for a two-bedroom apartment in Virginia in 2024 was $1,573. To afford this level of rent without being cost burdened – a household needs to make $62,925 annually.[16] In 2023, 31.3% of American households were cost burdened, including 27.1% of households with a mortgage and 49.7% of households that rent, according to 1-year estimates from the Census Bureau's American Community Survey.

Much like the rest of the country, Chesapeake struggles to provide affordable housing, notably experiencing a 38% rent increase in 2022.[17] Estimates for the average cost of rent in Chesapeake vary from $1,600 to $2,000 per month, and the median sale price of a home in Chesapeake was $430,000 in June 2025 (which is up 7.4% since last year).[18],[19],[20]

Observations from interviews:

- Stakeholders cited that there are over 5,000 households in Chesapeake that can't afford fair market rent, and that only 3,000 out of 9,000 low-income households receive support
- Housing vouchers are underutilized or ineffective due to landlord reluctance and lease renewal practices
- A lack of affordable senior housing was also noted

[15] National Low Income Housing Coalition, *The Problem*. 2025. Website: https://nlihc.org/explore-issues/why-we-care/problem
[16] Department of Housing and Community Development: Virginia's Homeless Programs 2023-2024 Program Year Report – November 2024.
[17] HOME-ARP Allocation Plan. City of Chesapeake. Feb 2023.
[18] Average Rental Price in Chesapeake, VA & Market Trends | Zillow Rental Manager. Published July 2025.
[19] Average Rent in Chesapeake, VA. Apartments.com. March 2025.
[20] Chesapeake, VA Housing Market. Redfin.com. July 2025.

Transportation

"Our region is large and rural and there is very minimal public transportation and it's a huge barrier."

Much of the United States, including Chesapeake and northeastern North Carolina, lacks a robust public transit system. Other options for transportation are limited and sometimes not affordable for those who are most at risk. Unfortunately, transportation barriers to health care have a disproportionate impact on individuals who are poor and who have chronic conditions. [21] Currently, Hampton Roads Transit offers only two bus routes throughout the city. The limited transportation options in Chesapeake also restrict the ability of individuals located within food deserts to have access to healthy food and other important services.

Some studies have shown that interventions such as providing bus passes, taxi/transport vouchers/reimbursement, and facilitating the patient and the transport provider can help mitigate transportation issues in regard to social determinants of health. Chesapeake Regional Healthcare has responded to this issue from past needs assessments by standing up a mobile medical clinic that now brings medical and mental health services to underserved areas around the city.

CDC also makes several recommendations in their Improving Health Through Transportation Policy including: [22]

- Promoting active transportation
    - Design, build, and maintain active transportation infrastructure that responds to community needs
- Encourage healthy community design
- Expand public transportation
    - Providing necessary transportation access for people with physical, economic, or other limitations
- Require research and surveillance
    - Help further understand who is affected by transportation systems, and if they are working as intended or not

<u>Observations from the interviews:</u>

- Transportation is especially an issue in rural and suburban neighborhoods where modes of transportation are extremely limited
- Even in the city center, public transportation is scarce or nonexistent, making access to healthcare, healthy food, and employment very difficult for some
- For health care transportation, many rely on medical transport or rideshare services but note current limitations

[21] Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings from the National Health Interview Survey, 1997–2017. American Journal of Public Health. 2020.
[22] CDC. Improving Health Through Transportation Policy. Transportation. November 2024.

Chronic Health Issues

"We're a high blood pressure and obesity belt that leads to long-term problems."

The U.S. Centers for Disease Control and Prevention defines chronic diseases as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. This includes heart disease, cancer, and diabetes which are the leading cause of disability and death in Virginia and the United States. 6 in 10 Americans have at least one chronic disease, and 4 in 10 have two or more.

Common chronic diseases in Chesapeake include diabetes, hypertension, COPD, and cardiovascular disease. The region also sees high rates of asthma and stroke. Initiatives like Healthy Chesapeake's HUB and the Mobile Integrated Healthcare program offer support for these conditions, with services available at local primary care clinics and through programs like the Chesapeake Care Clinic and at other community partner locations.

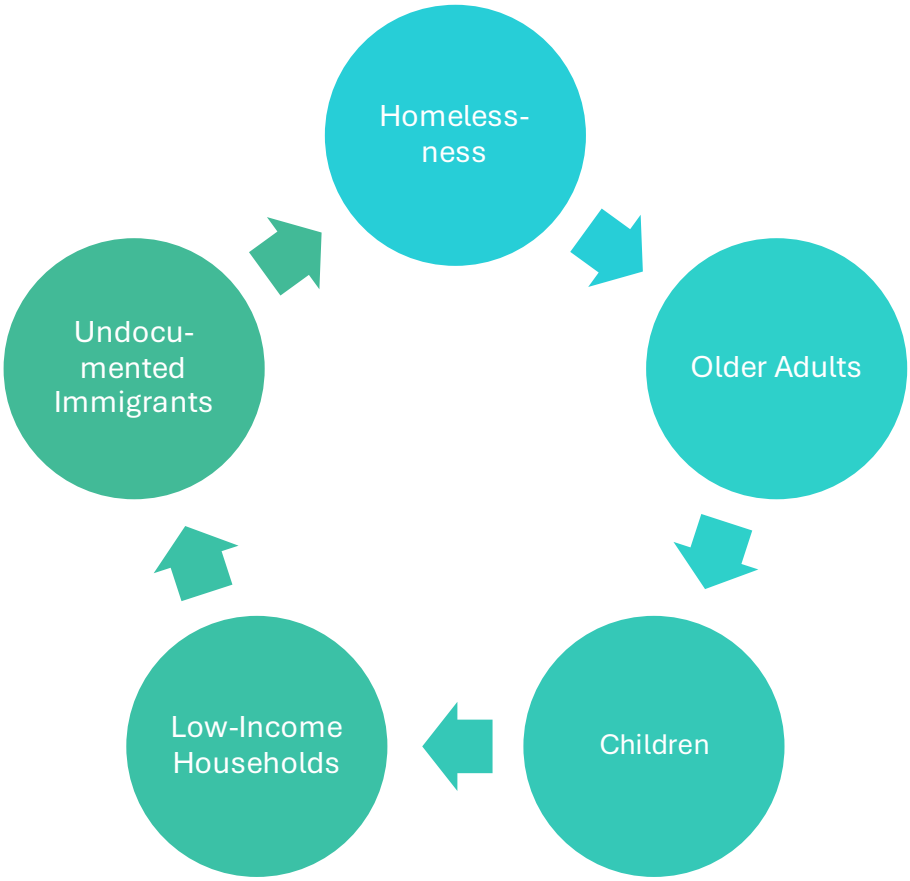
Best practices when it comes to prevention and treatment of chronic conditions include: [23]

- Current health policies emphasize the management of chronic conditions, which cannot be cured but can be controlled through medication, therapy, and lifestyle changes to prevent complications.
- Effective prevention and treatment of chronic diseases like hypertension and diabetes require comprehensive, multi-level interventions
- Addressing social determinants of health, such as poverty and access to care, is essential for improving health outcomes in socially disadvantaged populations.

Observations from the interviews:

- Diabetes, hypertension, and obesity are the most frequently cited chronic conditions of concern
- Have noticed people are being diagnosed with these conditions at younger *ages*

[23] Sikuła MD, Kurpas D. Enhancing Chronic Disease Management: Personalized Medicine Insights from Rural and Urban General Practitioner Practices. Journal of Personalized Medicine. 2024.



Homelessness

The U.S. federal government defines someone as being homeless or transient as an individual with no permanent living arrangement, i.e., no fixed place of residence. Someone who is transient is neither a member of a household nor a resident of an institution.
Those who are at risk of homelessness include individuals and families who:

- Have an annual income below 30 percent of median family income for the area.
- Do not have sufficient resources or support networks, immediately available to prevent them from moving to an emergency shelter or place not meant for habitation.
- Exhibit one or more risk factors of homelessness, including recent housing instability or exiting a publicly funded institution or system of care such as foster care or a mental health facility. [18]

The number of homeless people identified during the annual Point in Time Count each January has increased by 33% in the past ten years, totaling 95 in 2015 and 142 in 2025. Homeless veterans in Chesapeake have decreased by 50% since 2016, demonstrating the additional housing and voucher resources that Virginia has implemented to end veteran homelessness. The percentage of those reporting chronic homelessness or living without a permanent residence for more than one year has increased to 22% of the city's adult homeless population. [24]

[24] Southeastern Virginia Homeless Coalition – Point in Time Count Report, 2025. Website: https://www.hamptonroadsendshomelessness.org/homeless-data.html

The National Alliance to End Homelessness suggests focusing on several key issues: [25]

- Reducing unsheltered homelessness
- Decriminalizing homelessness
- Expanding resources to help people thrive
- Expanding the homeless workforce
- Addressing environmental justice

Observations about the interviews:

- A lack of year-round shelters, especially for families, is a critical gap
- Mental health and substance abuse are both causes and consequences of homelessness in the area
- Some who are homeless have trauma histories and distrust formal systems

Older Adults

"Our average age is around 65+ and with that population comes additional needs. All aspects of that population are needed."

10,000 people turn 65 every day in the U.S. By 2030, one in five Americans (~72.7 million) will be aged ≥65 years; this number is projected to reach 83.7 million by 2050. Within this group, the fastest growing age group will be persons aged ≥85 years. [26] The elderly population faces unique challenges including high prevalence of chronic diseases, mobility and transportation difficulties, social isolation, mental illness, financial insecurity, and nutritional issues.

Strategies to improve the wellbeing of older adults focus on their physical and mental health, encouraging social interaction as much as possible, routine medical care, and ensuring a safe and comfortable environment for them to live in.

Observations from the interviews:

- Aging population with unique needs including limited mobility, social isolation, difficulty accessing care, and lack of resources in general
- Stakeholders specifically noted a lack of senior centers where the elderly can socialize, lack of transportation, and limited home-based support services
- Some elderly are also caregivers themselves, compounding the burden

[25] Our Mission, Values, and History. National Alliance to End Homelessness. March 2025.
[26] Olivari BS, Baumgart M, Lock SL, et al. CDC Grand Rounds: Promoting Well-Being and Independence in Older Adults. MMWR Morbidity and Mortality Weekly Report. 2018.

Children

"Children rely on their parents to get help, and the parents may not know what to do or have preconceived ideas about what help is available."
"For mental health, it's the lack of providers and availability for children and teens. They wait over six months to be seen."

From 2013 to 2023 there were increases in high school students' experiences of violence, signs of poor mental health, and suicidal thoughts and behaviors.[27]
The CDC's "What Works in Schools" program promotes adolescent health and well-being. The program supports health education, connects students to health services, and improves school environments' safety and supportiveness. Middle and high schools using the program see improved physical and mental health among students.[28]

Ensuring children get timely developmental screenings and recommended health care services is key to detecting health issues early when they are typically easier to treat. In addition, positive health behaviors (such as getting enough sleep and eating healthy) can help prevent diseases and injuries in children. Safe, stable, and supportive relationships are also critical for children's health, development, and well-being. Family-level interventions can help keep children safe and healthy. Strategies focused on children's health and safety in early childhood education programs, at school, and in their neighborhoods can also help improve health outcomes for children.[29]

Observations from the interviews:

- Mental health, access to preventive care, and nutrition are major concerns amongst the stakeholders
- Vaccination and physical exams are hard to schedule for some families
- Some concerned voiced high trauma exposure among youth

Low Income Households

"Low incomes also only allow a person to buy so much food. And the high prices are just crazy, especially for fresh fruits and vegetables."
"Lower income households. They don't have healthcare; they have to move often, and the children don't get regular care."

Seventy percent of all extremely low-income families are severely cost-burdened, paying more than half their income on rent.[30] Low-income households face burdens including inability to afford basic needs like housing, food, healthcare, and childcare; pervasive stress and financial instability; reduced access to quality education and employment opportunities; and disproportionately higher costs for essentials like energy. Discrimination and systemic inequities, including lack of affordable housing and healthcare, exacerbate these burdens,

[27] CDC. YRBS Data Summary & Trends Report. Youth Risk Behavior Surveillance System (YRBSS). Published 2024.
[28] CDC. What Works in Schools. Adolescent and School Health. December 2024.
[29] Healthy People 2030. Children - Healthy People 2030 | Health.gov. Published 2020.
[30] National Low Income Housing Coalition, *The Problem*. 2025. Website: https://nlihc.org/explore-issues/why-we-care/problem

contributing to poor health outcomes, limited social capital, and difficulty in breaking the cycle of poverty.

Observations from the interviews:

- Shortage of rental assistance and subsidized housing
- LIHTC and Housing Choice Voucher programs are underfunded
- Developers lack incentives to build for low-income residents

Undocumented Immigrant Households

"In Outer Banks, probably some of the undocumented workers are also afraid to get healthcare. That is our most vulnerable population, and we have no idea what their true needs are and how many there are. Or how to connect with them. This is so different from our retirement community who is very affluent with multiple insurances."
"We are a conservative city, and we have a growing population of undocumented folks. Or even documented folks who may have someone undocumented living with them, and they are scared to reach out for things or do anything."

There are nearly 1.2 million immigrants in Virginia, including 501,000 who are non-citizens, and among those an estimated 275,000 who are undocumented.[31] Immigrants, including those without documentation, are a vital part of Virginia's communities and our economy. Detaining and deporting these workers would decrease the availability of important goods and services, further increasing costs. Over half of all crop workers in the United States are immigrants, and the majority of these immigrants are either undocumented or seasonal H-2A workers.[32] Additionally, In Virginia, 28% of all childcare workers are immigrants, both documented and undocumented.[33] Undocumented workers are part of Virginia's economy and workforce, but the city of Chesapeake is not a sanctuary city so they face risks through law enforcement encounters. This alone is a huge barrier to incorporating them into our communities to help their families thrive, grow, and prosper.

Observations from the interviews:

- Fear and distrust prevent many from accessing care
- Language barriers and lack of culturally competent providers are important
- Undocumented families face unique obstacles like unstable housing and work jobs without health benefits

[31] State-level data about all immigrants, documented and undocumented. Immigration Research Initiative analysis of the 2022 American Community Survey 5-year data
[32] National estimates of the number of undocumented workers were provided to IRI by Jeff Passel of the Pew Research Center and are based on an analysis of the 2022 American Community Survey, consistent with the analysis in "What We Know About Unauthorized Immigrants in the U.S.," Pew Research Center, July 2024.
[33] Immigrants are a Vital Part of Virginia's Future. Immigration Research Initiative, Economic Policy Institute, and The Commonwealth Institute, Oct 2024.