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ACE YOUR HEALTH

2026 | Community Wellness Survey Report

March 2026

CREDITS

RESEARCH LEADERSHIP AND CORE TEAM:

Dr. Chris Pernell (Director, NAACP Center for Health Equity), Dr. Tony C. Price Jr. (Senior Fellow, NAACP Center for Health Equity), Dr. Alicia Simmons (Vice President, HART Research), Dr. Rebecca Naser (Partner, HART Research), Dr. Rhonda Wells-Wilbon (Lead Researcher), Dr. Melissa Amos (Lead Quantitative Data Analyst)

ADVISORY COMMITTEE/SUBJECT-MATTER EXPERTS:

Dr. Chris Pernell
Tanisha Sullivan
Dr. Tony C. Price Jr.
Amaya Conner
Anissa Rivera
Dr. Marjorie Innocent
Clinton G. Johnson
Koya Brown
EquityWorks Institute
Esri

COMMUNITY, CITY, OR INSTITUTIONAL PARTNERS:

NAACP Branches representing Pasadena, CA; Philadelphia, PA; Washington, D.C.; Houston, TX; Cleveland, OH; Detroit, MI; Dallas, TX; Boston, MA, Memphis, TN; Chicago, IL (Southside); Newark, NJ; New York City, NY; Atlanta, GA; Charlotte, NC; and Miami-Dade County, FL.

DATA COLLECTION PARTNERS:

Essential Outreach Strategies, LLC
HART Research

DATA ANALYSIS PARTNERS:

Rhonda Wilbon Consulting, LLC
Lachelle Group LLC

DESIGN, LAYOUT, AND VISUALIZATION CREDITS:

The Kulur Group
Attune LLC
Grafico Design

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COMMUNITY MEMBERS AND SURVEY PARTICIPANTS:

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Mobilizing efforts to support a nationwide initiative was a major commitment, and the project's success was largely due to NAACP frontline leaders. We are grateful to our NAACP units for their dedication to helping us cross the finish line.

STATEMENT ACKNOWLEDGING LIVED EXPERIENCE AS VALID DATA:

The lived experiences described in this report reflect real health situations and lend authenticity to the analysis, which is grounded in valid human experiences. Community narratives and storytelling are among our greatest assets for driving social change.

FOREWORD

The NAACP has stood at the forefront of the fight for equity and justice for over a century, recognizing that health is a fundamental pillar of civil rights. Today, we mark a historic milestone in that journey with the release of the ACE Your Health Community Wellness Survey report. This initiative is more than a collection of statistics; it is a profound mosaic of the lives, challenges, and aspirations of the nearly 23,000 individuals who shared their truths between January and September 2025. This was a national initiative, with some focus on 15 priority geographies, that captured a definitive snapshot of health equity in modern America.

This data arrives at a critical juncture. For too long, the health outcomes of our communities have been dictated by forces beyond our control. At a time when critical health data is being erased, this report bridges the gap between anecdotal lived experience and empirical evidence, providing the "receipts" necessary to demand institutional accountability. We need this information because it gives our communities a voice and demystifies the barriers to health and wellness, proving that neighborhood quality, housing affordability, and resource accessibility are not just "lifestyle" issues but the very blueprints for public health.

The findings within these pages are both sobering and clarifying. The information presented here is not mere numbers — they represent the daily realities of families in cities across the nation, underscoring the urgent need for targeted, culturally proficient intervention.

Beyond the numerical data, our focus groups in Newark, NJ, and Charlotte, NC, provided a voice to the ACE Your Health Initiative. In these intimate settings, participants shared candidly about their struggles and their resilience. Their voices remind us that behind every data point is a human story — a parent navigating a food desert or a senior seeking reliable transportation to a clinic. These narratives ensure that our policy recommendations are not formed in a vacuum but are rooted in the authentic expertise of the people we serve.

We invite you to use this report as a tool for liberation. This data is designed to be a catalyst for local organizers, public health officials, and policymakers alike. It is a roadmap for all those involved and a template for the nation. Whether you are advocating for better park spaces in Memphis, more affordable housing in Los Angeles County, or improved healthcare infrastructure in Dallas, let these findings be the wind at your back.

The ACE Your Health Initiative proves that when we listen to our communities, we gain the clarity required to lead them. Now that we have the data, we must have the discipline to act. I encourage you to take these findings to your town halls, state capitals, and community centers. Together, we will transform these insights into impact, ensuring that wellness is not a privilege for a few but a reality for us all.

— **Dr. Dwayne Proctor**, Chair of the NAACP Foundation Board and National Health Committee

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EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

The ACE Your Health Community Wellness Survey represents a large grassroots assessment of community health resources among Black and other communities across the United States. Led by the NAACP Center for Health Equity in collaboration with Sanofi, the initiative sought to understand how neighborhood resources, housing, transportation, and healthcare access shape health and well-being.

Nearly 23,000 residents from 47 states, Washington, D.C., and Puerto Rico shared their perspectives through online, paper, and canvasser surveys. Recruitment prioritized fifteen metropolitan areas with large Black populations, ensuring that historically marginalized communities were meaningfully represented.

Key findings include:

- **Neighborhood strengths:** Nearly all respondents reported access to green spaces (92%) and grocery stores offering healthy, affordable food (94%), indicating strong neighborhood infrastructure in many communities.
- **Persistent inequities:** Income and race continued to shape access. Lower-income respondents were less likely to live near grocery stores or quality hospitals and more likely to experience difficulty paying for housing or appointments.
- **Health burden:** Sixty-three percent of respondents reported living with at least one chronic health condition. The prevalence of multiple chronic conditions increased with age and decreased with income.
- **Perceptions of safety and environment:** Seventy-one percent of respondents felt safe in their neighborhoods, but perceptions of air and water quality were uneven, especially among lower-income and Hispanic or Latino respondents.
- **Digital access:** Broadband connectivity was widespread (72%) but less common among lower-income households, who relied more on cellular or public Wi-Fi connections.
- **Cultural competency:** Most respondents (76%) believed local healthcare providers understood their community's cultural needs at least somewhat, though gaps remain for some racial and gender-diverse groups.

Collectively, these insights highlight both progress and persistent barriers to health equity. They provide community organizations, policymakers, and health leaders with data to inform strategies that build more equitable, resource-rich neighborhoods.

I. INTRODUCTION

The ACE Your Health Community Wellness Survey is part of a collaboration between the NAACP Center for Health Equity and Sanofi, a global healthcare company, to advance health equity. This collaboration elevates the commitment of both organizations to address health disparities in Black and historically marginalized communities through authentic community engagement, innovative public policy, financial investments, and programmatic solutions.

The survey was designed to help us understand the available community-level resources that enable all people to achieve optimal health and live their healthiest lives. It identified both community assets and gaps across various social determinants of health, including access to healthy food, quality healthcare, housing, transportation, and green spaces. The survey was organized into four categories:

- **Demographics**
- **Neighborhood Resources and Assets**
- **Health and Health Care**
- **Neighborhood Quality and Affordability**

Nearly 23,000 people across the United States shared their perspectives through online, paper, canvasser, and leave-behind surveys. While responses came from across the United States, 15 American cities and counties were determined as priority communities and grouped into three tiers. Canvassing efforts were undertaken in three of these cities: Atlanta, GA; Houston, TX; and Detroit, MI. Canvassers prioritized predominantly African American neighborhoods to ensure the voices of historically marginalized communities were centered. This design reflected the survey's commitment to equity and elevating perspectives that are too often overlooked.

With a goal of collecting 12,000 responses, the survey surpassed expectations, receiving nearly double that goal, with participation from 47 states across the United States, the District of Columbia, and Puerto Rico. These data and insights play a vital role in advancing health equity by guiding the development of targeted community, government, and private-sector interventions and policy solutions, as well as advocacy for resources to help improve health outcomes and well-being.

To that end, this report aims to serve as a resource for public health leaders, policy makers, and other community stakeholders, offering actionable, data-driven insights and city-specific addenda to support local planning. Ultimately, this report identifies solutions that can build stronger, healthier, and more equitable communities.

2. METHODS

SURVEY DESIGN AND DATA COLLECTION

The NAACP Center for Health Equity conducted a cross-sectional, community-based survey to characterize neighborhood resources, neighborhood quality and affordability, and health and health care experiences among U.S. residents. The survey was fielded nationally and intentionally prioritized 15 metropolitan areas, organized into three tiers: Tier 1 (Los Angeles County, CA; Cleveland, OH; Philadelphia, PA; Washington, D.C.; Houston, TX); Tier 2 (Detroit, MI; Memphis, TN; Dallas, TX; Boston, MA; Chicago, IL); and Tier 3 (Newark, NJ; New York City, NY; Atlanta, GA; Charlotte, NC; Miami-Dade County, FL). Although recruitment emphasized these locations, participation was open nationwide.

The survey was mobilized using nonprobability, community-based recruitment. Participants were reached through NAACP units, neighborhood canvassing in Houston, TX, Detroit, MI, and Atlanta, GA (with a focus on historically Black and other communities of color), community-based organizations, social media promotion, and peer-to-peer referrals (e.g., individuals shared the survey links with their personal networks). Paper surveys were distributed as needed to increase accessibility for residents with limited internet access. Eligibility criteria included residing in the United States or its territories. No monetary incentive was provided. Before beginning the survey, all respondents viewed a disclaimer that described the purpose of the survey, voluntary participation, and data privacy. The survey captured the experiences of children under age 18. During survey distribution, instructions stated that parents should fill out the survey on behalf of their children to ensure that information was accurately captured. Individuals younger than 18 were not directly solicited. For example, during the canvassing portion of the survey distribution, if a canvasser approached a family of three (assuming two parents and one child under 18), then each parent would fill out the survey once for themselves, and again once for the child under 18.

Data collection occurred from January 30, 2025, through September 30, 2025. The online survey was accessible via a mobile-optimized link and QR code. To expand reach and ensure accessibility, the survey was also distributed in paper format through NAACP Branches. Paper surveys collected at NAACP Branches were scanned and digitized using optical character recognition, then manually verified for accuracy. A secondary quality-assurance review was conducted to check for legibility, coding consistency, and duplicate entries. All paper surveys were received and integrated into the master dataset by October 31, 2025. The combined dataset represents all verified responses from both digital and paper submissions.

Across all survey modes, respondents had the opportunity to indicate their geographical location (e.g., zip code, city, or current address). Of 22,993 respondents, we received valid geographical information from 22,656 (99%). Invalid geographic location information included invalid address or zip code information (e.g., addresses or zip codes outside of the US), incomplete address or zip code information, and individuals who did not submit their address or zip code information.

The ACE Your Health Survey reached individuals in 47 states, Washington, D.C., and Puerto Rico, with especially strong participation in the tier cities. There were no respondents from the states of Montana, North Dakota, and Wyoming. Nearly three-quarters of respondents came from Texas (24%), Michigan (24%), and Georgia (24%), reflecting heavy canvassing efforts in some of the tier cities such as Houston (Tier 1), Detroit (Tier 2), and Atlanta (Tier 3).

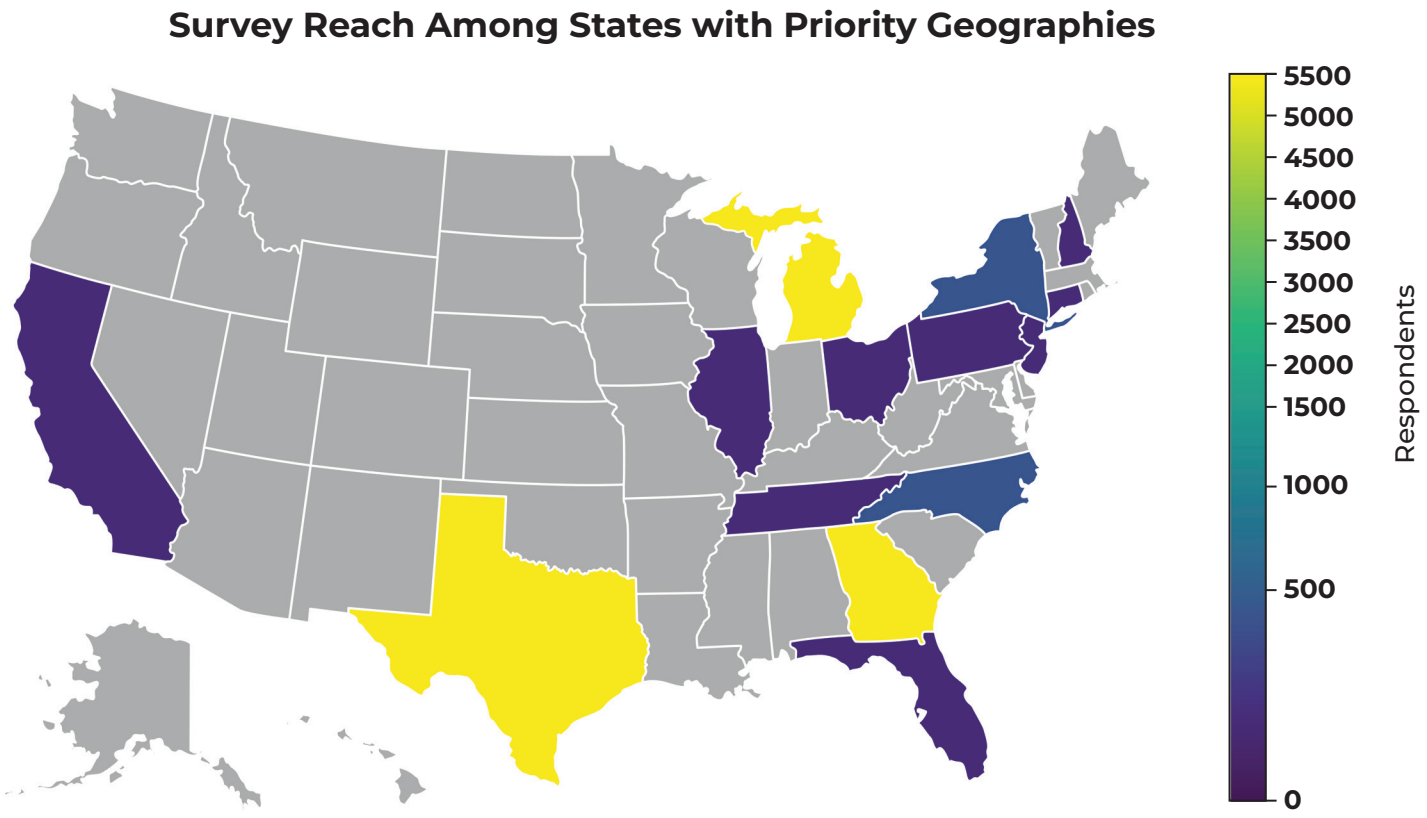
TABLE 2.1 NUMBER OF RESPONDENTS BY STATE

STATE	NUMBER OF RESPONDENTS
Alabama	121
Alaska	11
Arizona	75
Arkansas	74
California	455
Colorado	36
Connecticut	58
Delaware	54
District of Columbia	49
Florida	408
Georgia	5,334
Hawaii	6
Idaho	1
Illinois	329
Indiana	79
Iowa	26
Kansas	35
Kentucky	74
Louisiana	81
Maine	3

STATE	NUMBER OF RESPONDENTS
Maryland	308
Massachusetts	141
Michigan	5,504
Minnesota	21
Mississippi	149
Missouri	83
Nebraska	12
Nevada	35
New Hampshire	15
New Jersey	419
New Mexico	57
New York	767
North Carolina	953
Ohio	237
Oklahoma	24
Oregon	33
Pennsylvania	269
Puerto Rico	1
Rhode Island	14
South Carolina	210

STATE	NUMBER OF RESPONDENTS
South Dakota	5
Tennessee	121
Texas	5,409
Utah	6
Vermont	6
Virginia	429
Washington	67
West Virginia	16
Wisconsin	36
TOTAL	**22,656**

FIGURE 2.2 SURVEY REACH BY STATE



The survey reached all 15 priority communities across the three tiers. These distributions reflect where canvassing and partner outreach were most active among the 15 states with priority geographies rather than population size. City-level findings for communities with small counts, such as Boston, Dallas, Memphis, Charlotte, and Miami-Dade County, should be interpreted as descriptive. In the addenda reports, we will present raw counts alongside percentages and note when small sample sizes limit city comparisons.

TABLE 2.2 NUMBER OF RESPONDENTS BY TIER CITIES

TIER	CITY/COUNTY	STATE	NUMBER OF RESPONDENTS
Tier 1	Chicago	IL	57
Tier 1	Houston	TX	4,478
Tier 1	Los Angeles County	CA	102
Tier 1	Philadelphia	PA	84
Tier 1	Washington, D.C.	D.C.	49
Total			**4,770**
Tier 2	Boston	MA	30
Tier 2	Cleveland	OH	63
Tier 2	Dallas	TX	34
Tier 2	Detroit	MI	2,387
Tier 2	Memphis	TN	25
Total			**2,539**
Tier 3	Atlanta	GA	2,983
Tier 3	Charlotte	NC	415
Tier 3	Miami-Dade County	FL	48
Tier 3	New York City	NY	213
Tier 3	Newark	NJ	77
Total			**3,736**

DATA COLLECTION AND INSTRUMENTS

The questionnaire was developed by public health researchers at the NAACP Center for Health Equity. The survey included the following four domains: (1) Neighborhood Resources and Assets, (2) Neighborhood Quality and Affordability, (3) Health and Health Care, and (4) Demographics. Items consisted of single- and multi-select formats and write-in options. Three versions of the instrument were administered to accommodate different field contexts. The first version was the main survey (delivered both in online and paper formats), the second was a shortened canvasser version for rapid data collection, and the third was a leave-behind version for respondents to complete later. Table 2.3 displays the number of respondents by each survey mode.

TABLE 2.3 NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER OF RESPONDENTS	PERCENT
Main (online)	7, 256	32%
Main (paper)	561	2%
Canvasser	15,124	66%
Leave Behind	52	<1%
Total	**22,993**	

For the canvasser data, differences between the total number of canvasser responses and the tier city counts reflect several factors. Some respondents listed addresses in nearby municipalities rather than the tier city itself (e.g., Decatur and College Park for Atlanta; Warren and Oak Park for Detroit; and Humble and Katy for Houston). Other responses included missing, partial, or unclear location information, such as blank entries or state-only responses. Additionally, a subset of respondents listed cities well outside the geographic boundaries of any tier city, including locations several hours away (e.g., Andrews, TX, is more than four hours away from both Houston and Dallas) or cities outside the state entirely (e.g., Lincoln, NE; Saucier, MS; and Las Vegas, NV). In all cases, these respondents were retained in the overall canvasser totals but were not assigned to a specific tier city.

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Core items of the survey were identical across all modes; however, several items were omitted in the canvasser and leave-behind versions to reduce respondent burden and reflect the data collection context. A detailed comparison of items across survey versions is provided in Appendix A.

DATA PROCESSING AND PREPARATION FOR ANALYSIS

Data from all survey modes were consolidated into a single analytic file. A respondent's record was included in the survey analytical file if the respondent answered at least one survey item. Cleaning included standardizing categorical labels and parsing multi-select responses into separate indicators. Demographic variables included age group, gender identity, race and ethnicity, educational attainment, employment status, housing tenure, individual's income, zip code, and city or individual's current address. Analyses were conducted and are presented in the report at the item level, with the denominator varying by the number of respondents who answered each question.

In the charts in this report, the data points presented are rounded to the nearest whole number while the visual depictions reflect the raw data to show more nuanced comparisons. Due to rounding, certain datasets may not total exactly 100%.

It is important to note that although the gender identity question appeared in all modes of survey modes, more individuals were missing information on this item. That is due to an issue during the early administration of the main online version of the survey. The gender question did not appear on the main online version of the survey for the first 2,286 respondents. Once the NAACP staff identified the issue, it was corrected, and gender information was collected as intended. To recover the missing gender information, the NAACP staff contacted individuals who did not receive the gender question via email, whose email addresses they had access to. These individuals had shared their contact information voluntarily during survey completion, and 313 completed a one-question follow-up survey to obtain their gender identity.

As the data collection approach was intentionally designed to oversample 15 focal jurisdictions in communities with high populations of diverse racial and ethnic groups, and given the nonprobability nature of the recruitment, no weighting was applied. All analyses were descriptive, summarizing survey participants' responses as counts and percentages. Results are a representation of survey participants and not population-representative, emphasizing internal contrasts and practical significance.

Cross tabulations were generated for each item by demographic characteristics and geography, where applicable. Because the survey used nonprobability community-based recruitment, inferential testing was not conducted to avoid overstating precision. Differences discussed in the report reflect practical or meaningful contrasts rather than statistical significance. Quantitative analyses and visualizations were conducted using Stata 19 and Python 3.14.

3. SURVEY RESULTS BY CATEGORY

DEMOGRAPHICS

Across all survey modes, respondents were invited to share their race or ethnicity, with the option to select multiple categories. Race and ethnicity were reported by 22,850 respondents. The sample reflects the intentional focus on the experiences of Black or African American individuals, as 78% of the respondents identified as Black or African American. The next largest racial group was White (11%), followed by individuals who identified as Hispanic or Latino and Multiracial or Multiethnic, each at four percent of the sample. Individuals who identified as American Indian or Alaskan Native, Asian, Middle Eastern or North African, Native Hawaiian or Pacific Islander, or preferred not to provide their racial or ethnic identity each accounted for no more than one percent of the sample.

TABLE 3.1 RACIAL OR ETHNIC GROUP

RACIAL OR ETHNIC GROUP	NUMBER	PERCENT
American Indian or Alaska Native	91	<1%
Asian	139	1%
Black or African American	17,886	78%
Hispanic or Latino	883	4%
Middle Eastern or North African	110	<1%
Multiracial and/or Multiethnic	848	4%
Native Hawaiian or Pacific Islander	6	<1%
White	2,607	11%
Prefer not to answer	280	1%
Total	**22,850**	

Across all survey modes, respondents were also invited to share their gender identity, with the option to select multiple categories. Gender identity was reported by 20,289 respondents. The survey provided an expansive list of gender options for respondents to choose, including the option to self-describe their gender. Fifty-seven percent of the respondents identified as women, and 42% identified as men. One percent of the respondents, combined, identified their gender as either cisgender (without specifying their gender assigned at birth), non-binary or gender non-conforming, transgender, or preferred not to answer the gender question.

TABLE 3.2 GENDER IDENTITY

GENDER IDENTITY	NUMBER	PERCENT
Cisgender (not specified)	34	<1%
Man	8,479	42%
Non-binary/gender non-conforming	55	<1%
Transgender	74	<1%
Woman	11,624	57%
Prefer not to answer	23	<1%
Total	**20,289**	

Across all modes of the survey, respondents were invited to share their age via seven pre-specified age ranges. The results revealed that respondents in the sample spanned all age ranges, with the smallest group specifying they were aged 17 or younger. The largest group of respondents was between the ages of 25 and 40, nearly 30% of the sample. One percent of the sample declined to share which age range their age at the time of the survey belonged to.

TABLE 3.3 AGE DISTRIBUTION

GENDER IDENTITY	NUMBER	PERCENT
17 and under	577	3%
18 – 24	2,382	10%
25 – 40	6,484	28%
41 – 50	4,103	18%
51 – 60	3,600	16%
61 – 70	3,302	14%
71 and over	2,213	10%
Prefer not to answer	147	1%
Total	**22,808**	

Across all modes of the survey, respondents were invited to share their age via seven pre-specified age ranges. The results revealed that respondents in the sample spanned all age ranges, with the smallest group specifying they were aged 17 or younger. The largest group of respondents was between the ages of 25 and 40, nearly 30% of the sample. One percent of the sample declined to share which age range their age at the time of the survey belonged to.

TABLE 3.4 SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	211	3%
Gay	95	1%
Heterosexual or straight	6,723	88%
Lesbian	100	1%
Prefer to self-describe	112	1%
Prefer not to answer	433	6%
Total	**7,674**	

On the main and leave-behind surveys, respondents were asked to indicate their sexual orientation. The survey provided an expansive list of sexual preference options for respondents to choose, including the option to self-describe their preference. The majority of respondents identified as heterosexual or straight (88%). Of the 112 individuals who chose to self-describe their sexual orientation, 59 respondents responded. The responses included the following identifiers: pansexual, demisexual, asexual, polyamorous, fluid, and queer. Additional responses included terms and phrases that were related to other demographic characteristics like racial and ethnic identity, gender, and age.

TABLE 3.5 HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	588	8%
$20,000 – $39,999	810	10%
$40,000 – $59,999	1,102	14%
$60,000 – $79,999	1,106	14%
$80,000 – $99,999	868	11%
$100,000 or more	2,196	28%
Prefer not to answer	1,093	14%
Total	**7,763**	

On the main and leave-behind surveys, respondents were asked to indicate their total household income. Reported total household income was spread across all specified income ranges, with the lowest percentage of individuals reporting total household income less than $20,000. Twenty-eight percent of respondents reported earning $100,000 or more.

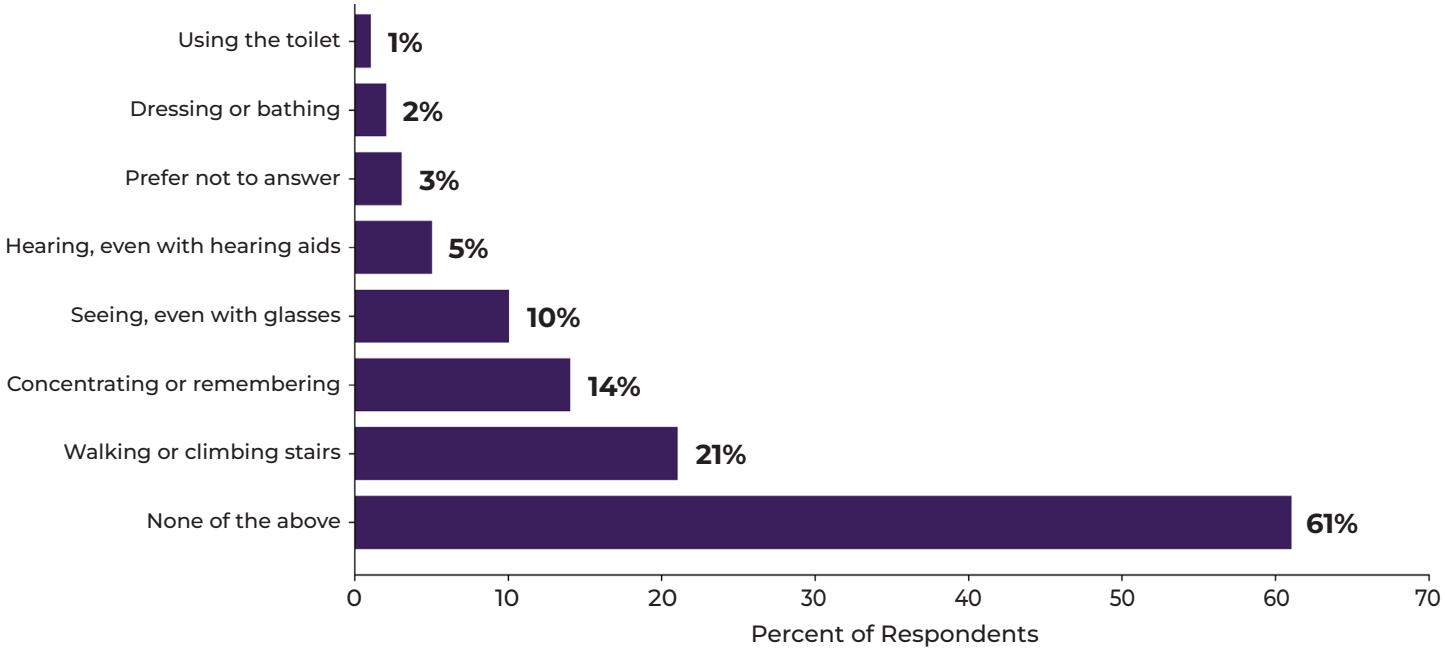
TABLE 3.6 HIGHEST EDUCATION COMPLETED

HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	19	<1%
Some high school	105	1%
GED or high school graduate	501	6%
Some college	1,657	21%
Bachelor's degree	2,020	26%
Graduate degree or higher	3,346	43%
Prefer not to answer	136	2%
Total	**7,784**	

On the main and leave-behind surveys, respondents were invited to share the highest level of education they had completed. The sample largely included individuals with varying degrees of postsecondary education. Particularly, nearly half the sample (43%) indicated they earned a graduate degree or higher. Two percent of respondents preferred not to disclose the highest level of education they completed.

The main and leave-behind surveys also asked individuals to indicate if they experienced difficulties with activities due to a physical, mental, or sensory condition. Almost two-thirds (61%) of respondents indicated they did not have difficulties with any of the activities listed. However, respondents who reported experiencing difficulty with the listed activities, walking or climbing stairs (21%), concentrating or remembering (14%), and seeing even with glasses (10%) were the top three reported difficulties of the respondents' experience.

FIGURE 3.1 DIFFICULTIES WITH ACTIVITIES



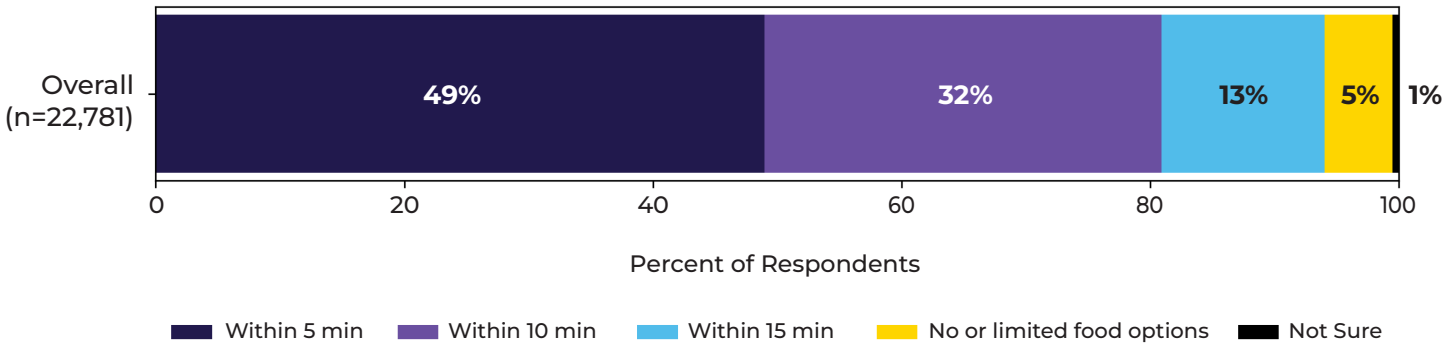
Note: Respondents could select all that apply. Percentages should not be summed. (n - 7,374)

4. NEIGHBORHOOD RESOURCES AND ASSETS

GROCERY STORE ACCESS

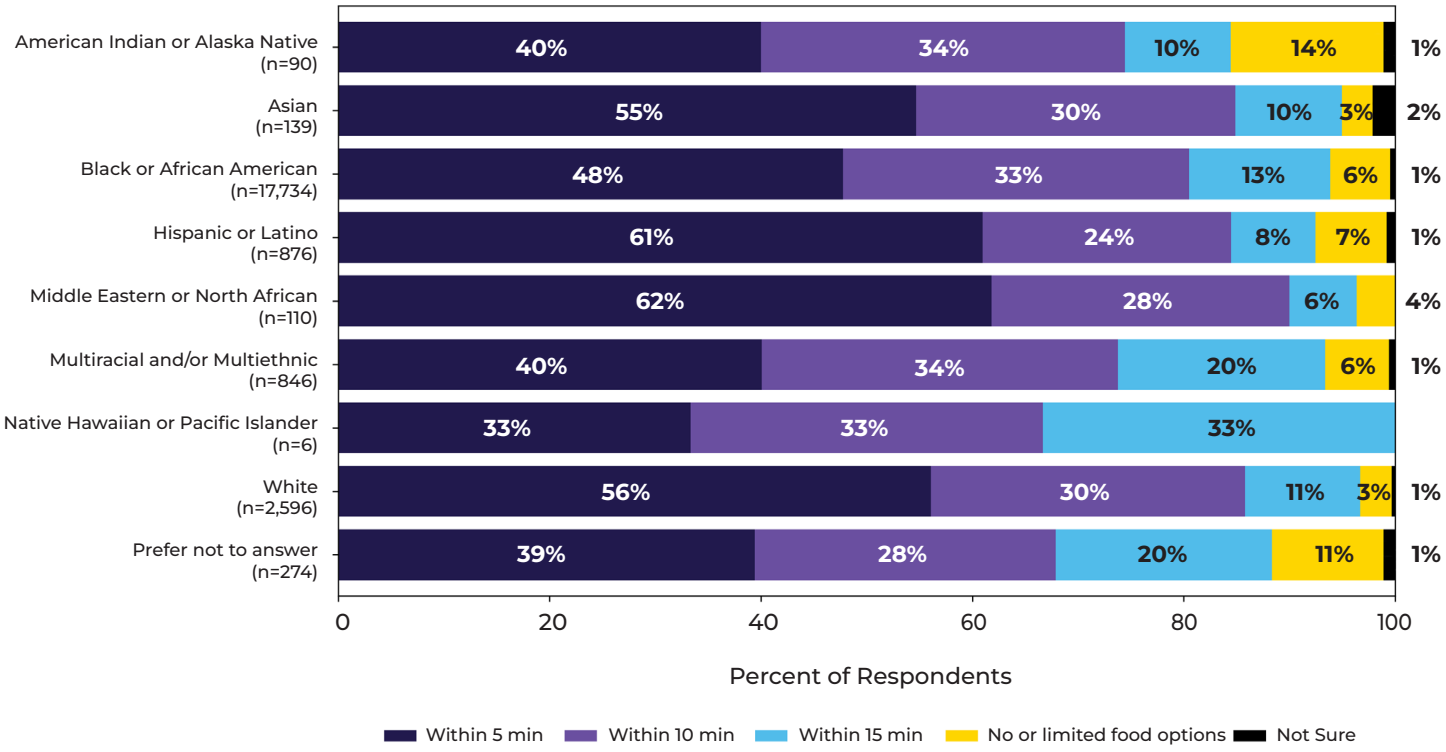
All modes of the survey included the question: Is there a grocery store in your neighborhood where you can buy healthy, affordable food? The majority of the respondents, 94%, reported having access to a grocery store within a short distance of their home. Out of these respondents, 49% reported within a five-minute distance, 32% reported within a ten-minute distance, and 13% reported within a 15-minute distance. Five percent reported that there was not a grocery store in their neighborhood with healthy, affordable options, while less than 1% were unsure of their proximity to a grocery store with healthy and affordable options.

FIGURE 4.1. GROCERY STORE ACCESS (OVERALL)



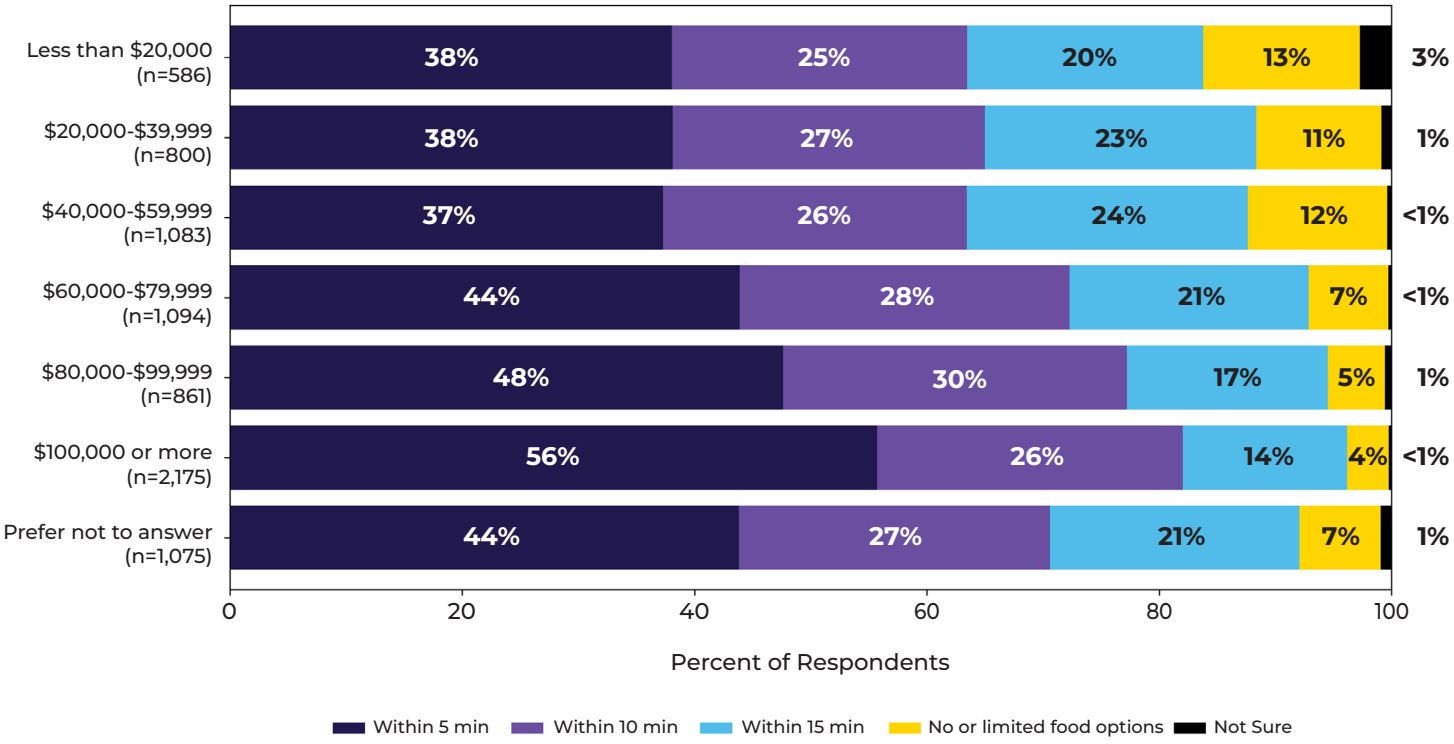
Most respondents across racial and ethnic groups indicated that a grocery store offering healthy food was available within five to ten minutes of travel. However, some differences highlighted unequal access patterns. More than half of the respondents who identified as Asian (55%), White (56%), Hispanic or Latino (61%), and Middle Eastern or North African (62%) reported the highest immediate access, with a grocery store within five minutes. In contrast, smaller racial or ethnic groups in the sample, such as American Indian or Alaska Native, reported lower overall access within five minutes (40%), and higher percentages of respondents in these racial or ethnic groups indicated limited or no grocery options nearby. Of African American respondents, the largest racial group in the sample, a little less than half (48%) reported grocery access within a five-minute distance. These findings suggest that while grocery access appears relatively widespread, certain racial and ethnic groups may face greater barriers to reaching stores offering nutritious foods.

FIGURE 4.2 GROCERY STORE ACCESS BY RACIAL OR ETHNIC GROUP



The results also revealed there was an increasing gradient of proximity to grocery stores and household income. Fifty-six percent of respondents earning $100,000 or more reported a grocery store within five minutes. Comparatively, only 38% of respondents earning less than $20,000 reported a store within five minutes. The percentage of respondents reporting limited healthy food options was highest among the lowest-income respondents (13%) and lowest among those in the highest income group (4%).

FIGURE 4.3 GROCERY STORE ACCESS BY TOTAL HOUSEHOLD INCOME



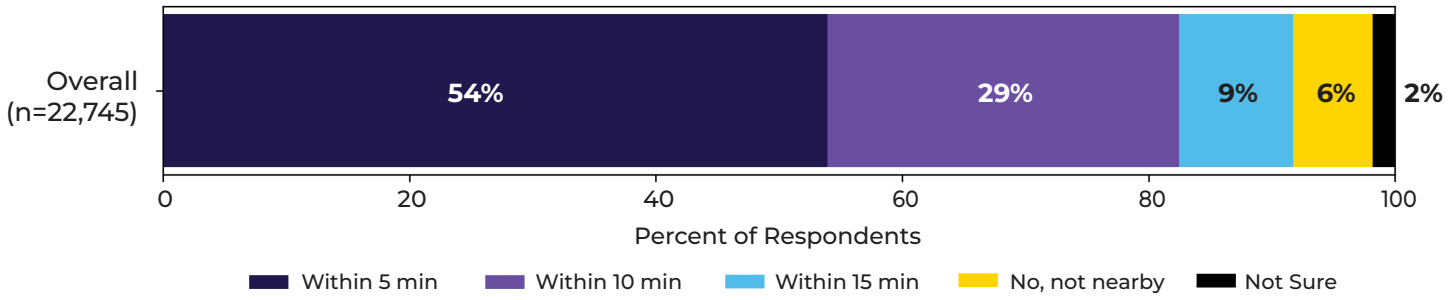
Grocery store access by gender, age, and sexual orientation was largely consistent with the overall population. Grocery access by the highest education level completed was largely consistent with the results of grocery access by total household income.

ACCESS TO GREEN SPACES

Across all survey modes, respondents were asked: Are there green spaces like parks, walking trails, or grassy areas in your neighborhood? Nearly all respondents (92%) reported access to green spaces, such as parks, trails, or grassy areas, within 15 minutes of travel. More than half (54%) indicated a green space was within five minutes, 29% said within ten minutes, and 9% said within 15 minutes. Only 6% reported no nearby green space, while 2% were unsure. These findings suggest that most respondents live in neighborhoods with accessible outdoor or recreational areas, although a small share experience limited proximity to green spaces.

The percentage of respondents in closer proximity to green spaces increased with total household income. More than two-thirds of respondents in households with a total income of $100,000 or more lived near a green space within five minutes (71%), while those earning less than $20,000 reported lower proximity (49%) and higher rates of no nearby green space (13%).

FIGURE 4.4 ACCESS TO GREEN SPACES (OVERALL)



The percentage of respondents in closer proximity to green spaces also increased with educational attainment. Respondents with a graduate degree or higher were most likely to report immediate access (65% reported being within five minutes). Those with a high school education or less had lower proximity (between 39% and 43%) and higher rates of no nearby green space (up to 18%). More than half of respondents with some college (53%) or a bachelor's degree (58%) reported being within five minutes.

FIGURE 4.5 ACCESS TO GREEN SPACES BY TOTAL HOUSEHOLD INCOME

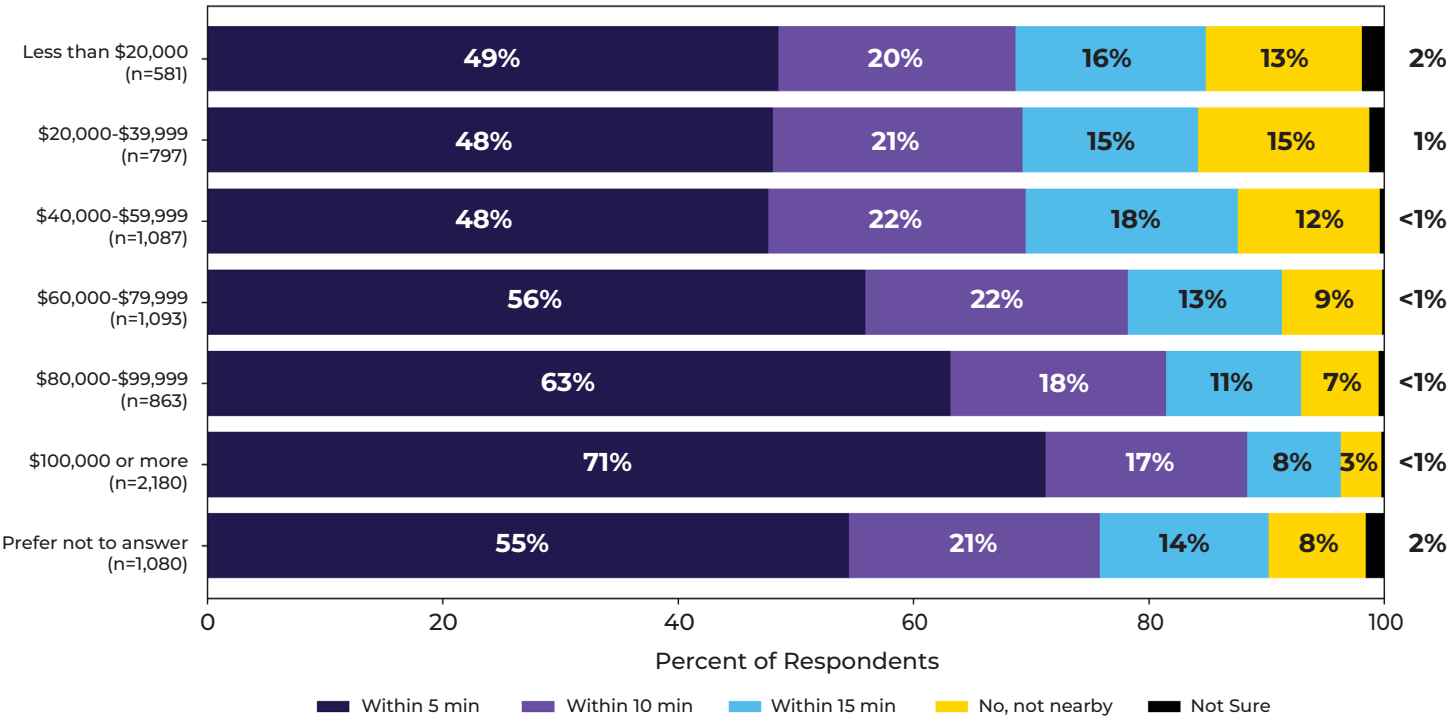
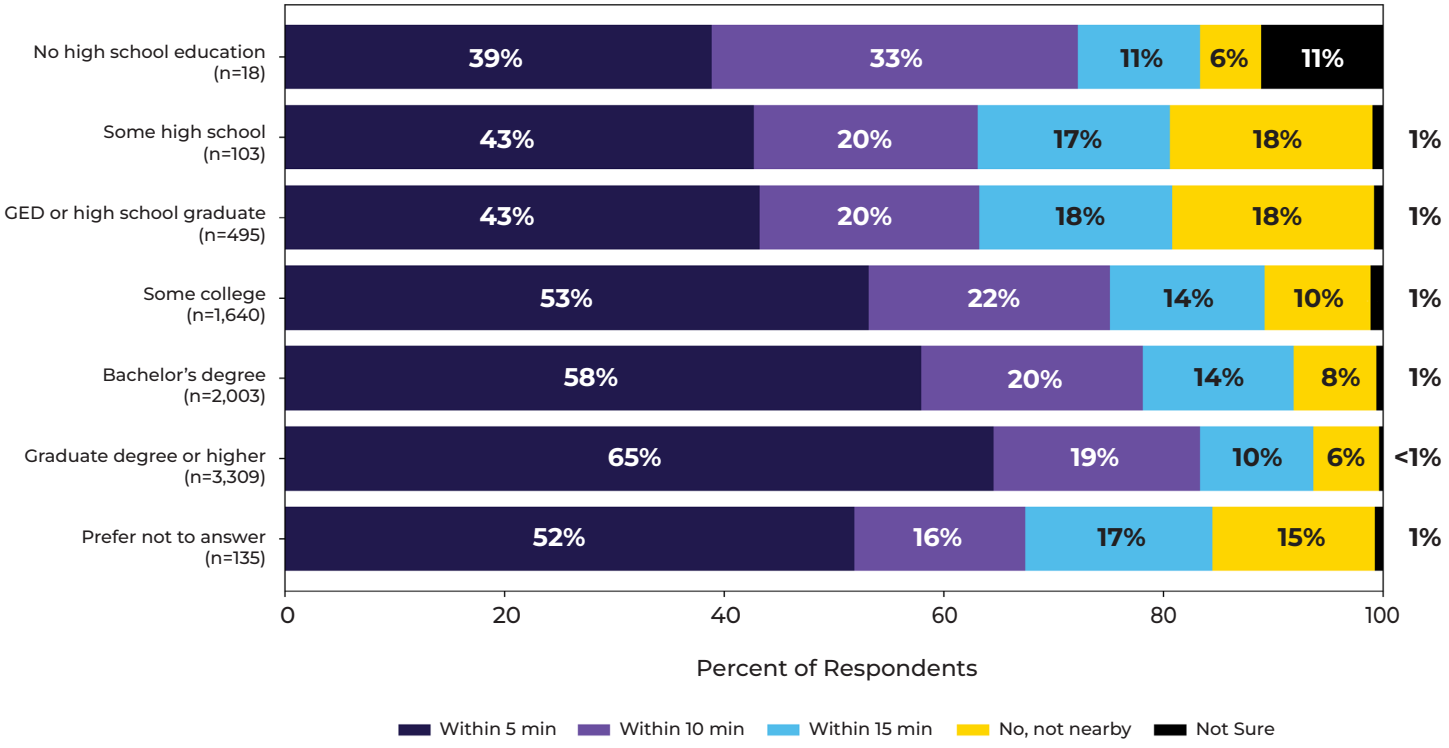
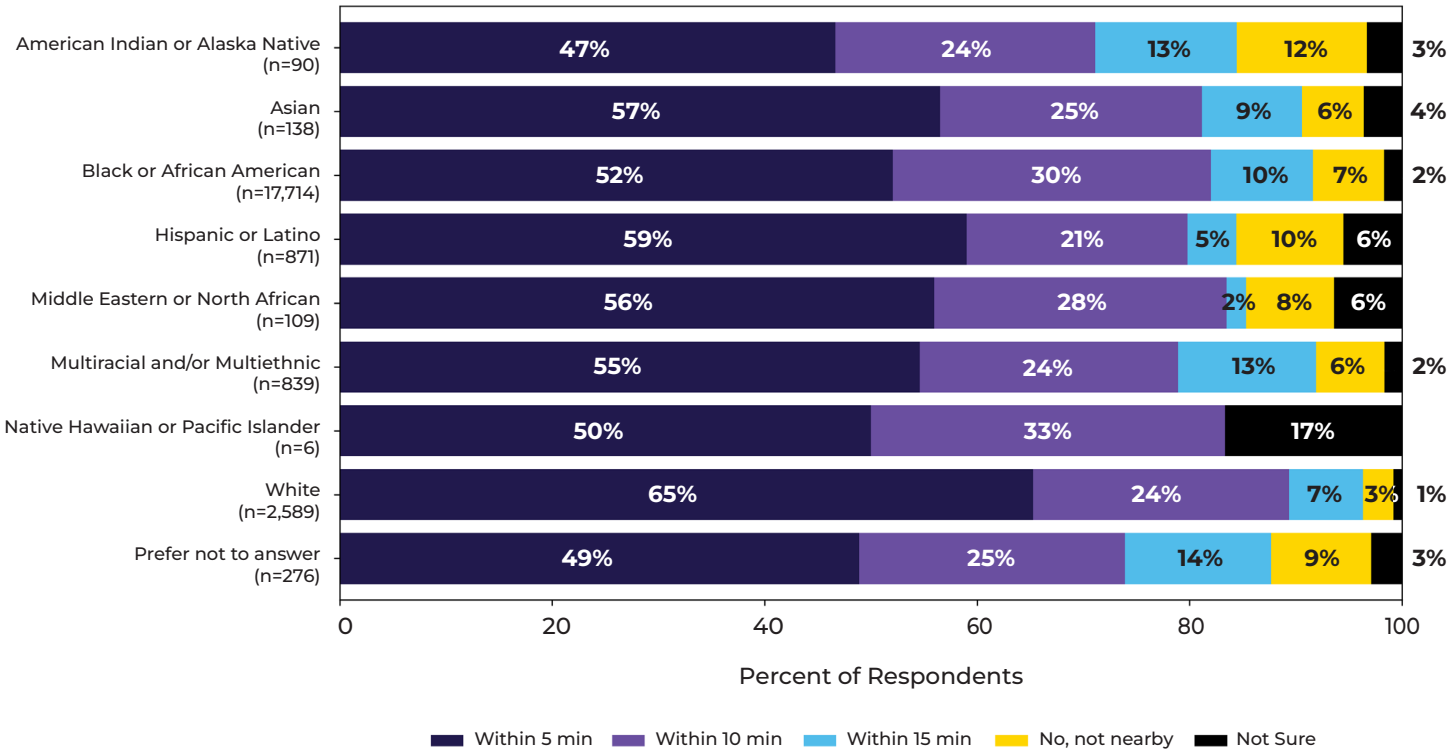


FIGURE 4.6 ACCESS TO GREEN SPACES BY HIGHEST EDUCATION LEVEL



The percentage of respondents who reported being in proximity to green spaces was generally high across racial and ethnic groups, with some variations. White respondents were most likely to report a green space within five minutes (65%), followed by Hispanic/Latino, Middle Eastern or North African, and Asian respondents (between 56% and 59%). Fifty-two percent of Black or African American respondents reported being within five minutes of a green space. For most groups, over 80% reported access within 15 minutes, although "No, not nearby" reports were somewhat higher among Middle Eastern and Hispanic or Latino respondents, 8 and 10%, respectively.

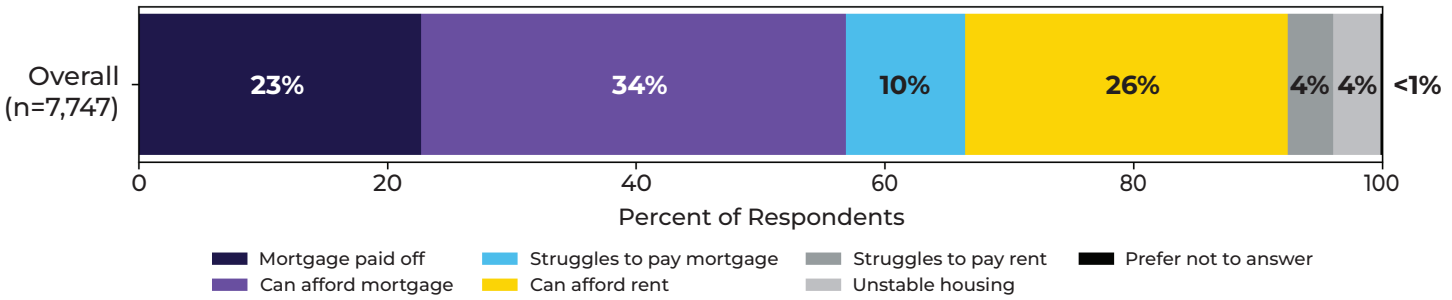
FIGURE 4.7 ACCESS TO GREEN SPACES BY RACIAL OR ETHNIC GROUP



HOUSING ARRANGEMENTS

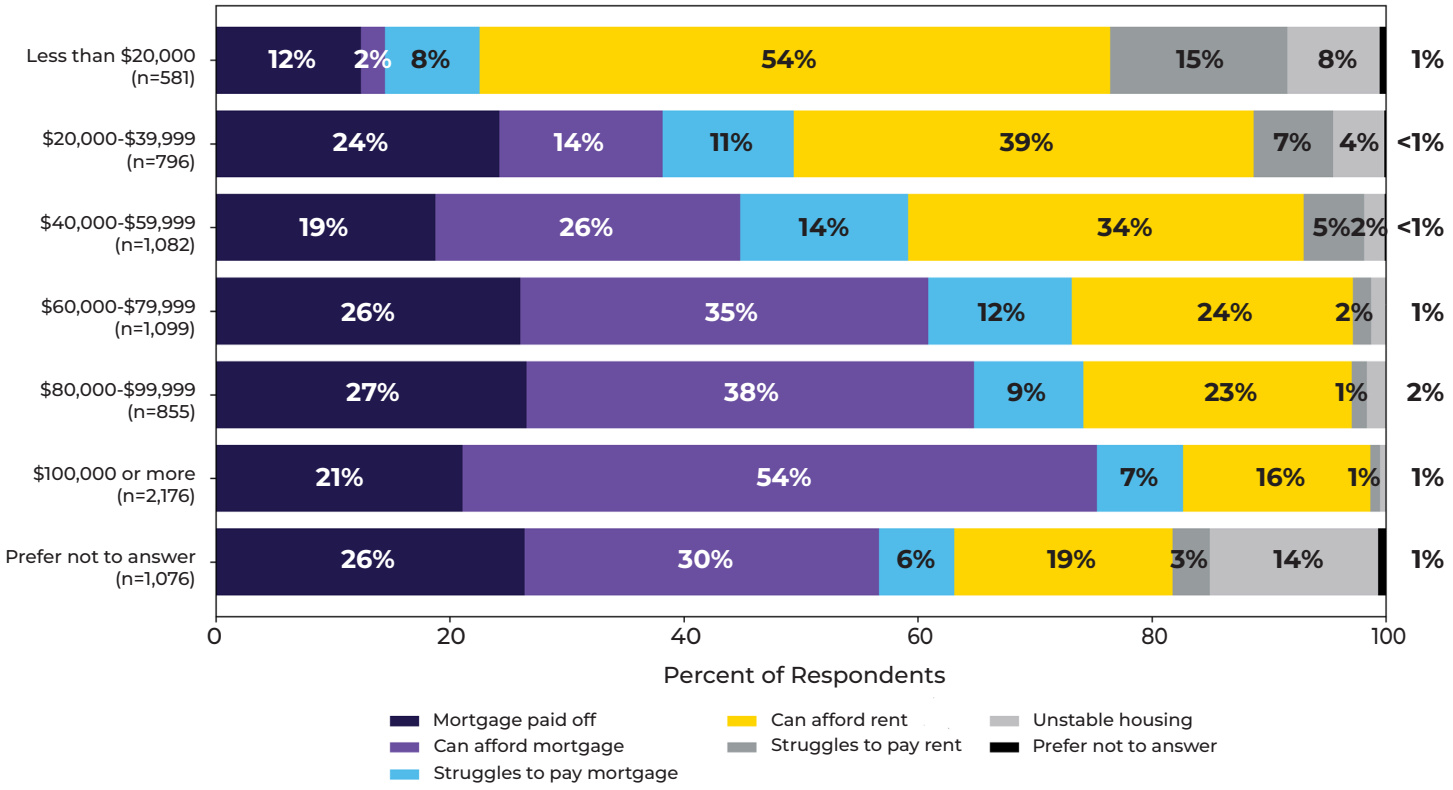
The main and leave-behind surveys included the question: Which of the following best describes your current housing situation? Sixty-seven percent of respondents were homeowners, 29% were renters, and four percent indicated they did not have stable housing at the time of the survey. Among individuals with affordable housing, whether homeowners or renters, 83% had stable, affordable housing, while 14% struggled to pay their rent or mortgage. Less than one percent of the respondents preferred not to answer the housing arrangement question.

FIGURE 4.8 HOUSING ARRANGEMENTS (OVERALL)



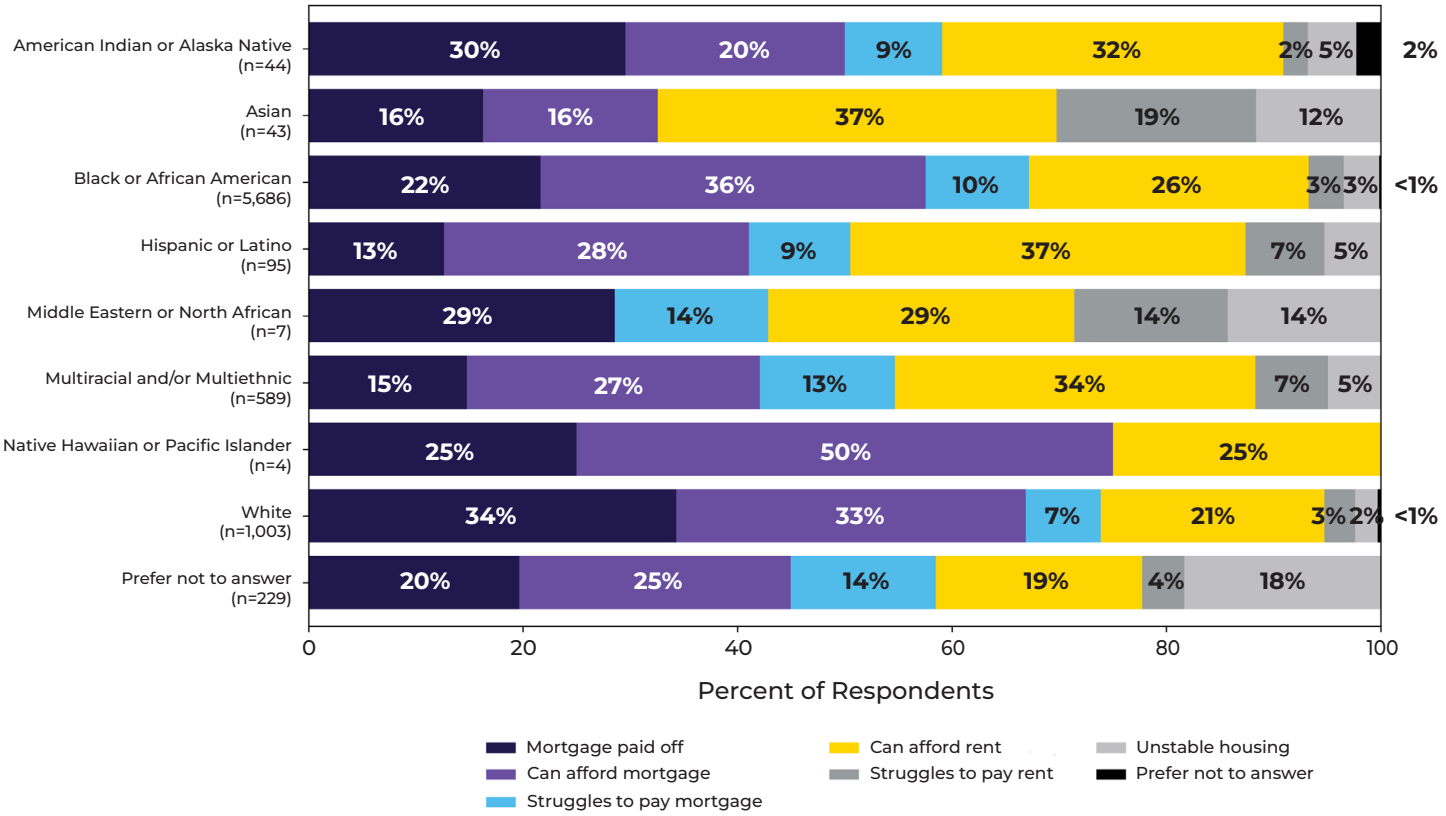
Differences in housing stability by total household income were observed. More than half (54%) of respondents earning $100,000 or more were homeowners who said they could afford their mortgage, and one in five owned their homes outright. Higher percentages of respondents earning less than $20,000 in total household income were renters (69%). Of these respondents, 54% said they could afford rent, while the other 15% reported struggling to pay it. Respondents who preferred not to share their total household income reported the largest percentage of individuals who experienced unstable housing arrangements, almost double that of respondents in households earning less than $20,000 total.

FIGURE 4.9 HOUSING ARRANGEMENTS BY TOTAL HOUSEHOLD INCOME



Looking across racial and ethnic groups, approximately two-thirds (67%) of White respondents reported homeownership with a paid-off or affordable mortgage, compared to a little more than half (58%) of Black or African American respondents and 42% of Multiracial and Multiethnic respondents. Of these three racial and ethnic groups, Multiracial and Multiethnic respondents were also more likely to report unstable housing or difficulty paying rent.

FIGURE 4.10 HOUSING ARRANGEMENTS BY RACIAL OR ETHNIC GROUP

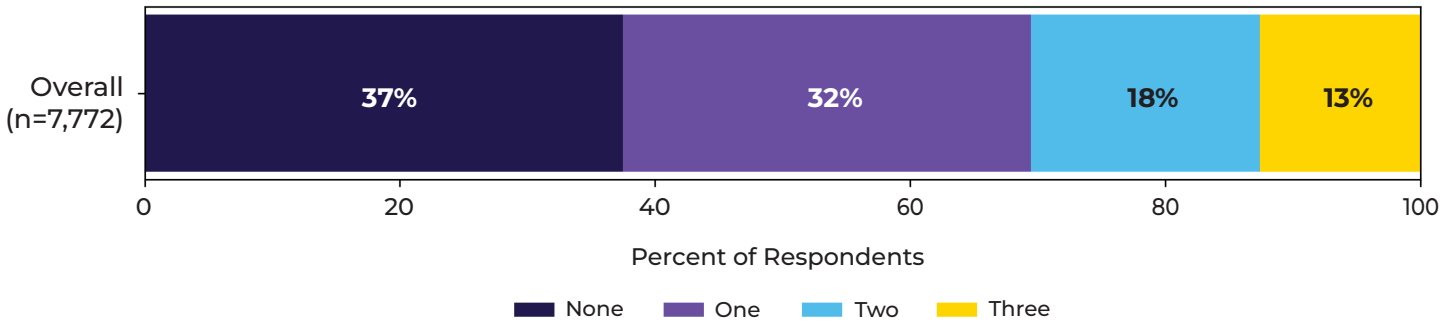


5. HEALTH AND HEALTH CARE

LIVING WITH CHRONIC HEALTH CONDITIONS

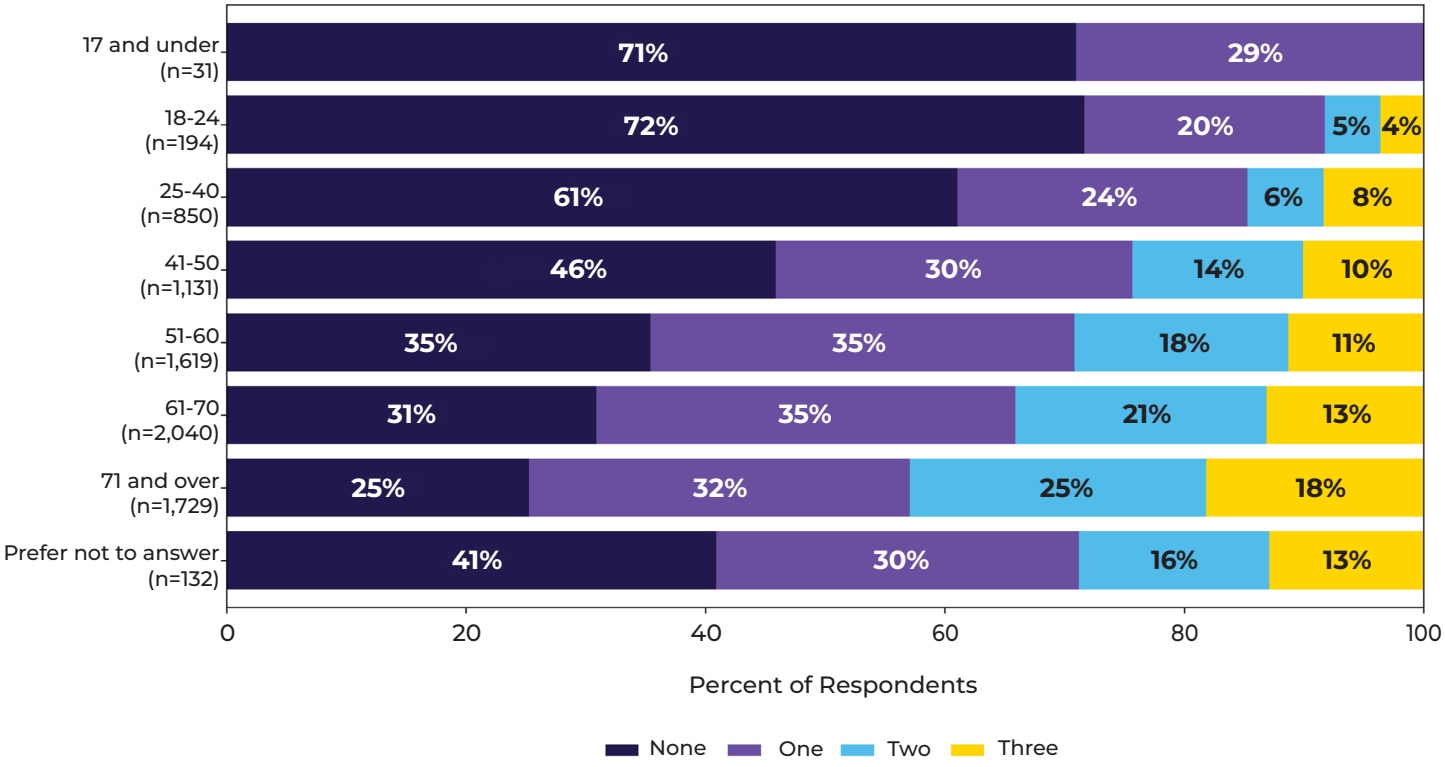
The main and leave behind surveys asked respondents the following question: Do you live with one or more chronic health conditions? (ex, arthritis, asthma, diabetes, etc.). Sixty-three percent of the sample reported that they are living with one or more chronic health conditions. Specifically, about one in three respondents (32%) reported having one chronic condition, while 18% had two, and 13% had three. These findings highlight that chronic health concerns are a common feature of daily life for many respondents.

FIGURE 5.1 CHRONIC HEALTH CONDITIONS (OVERALL)



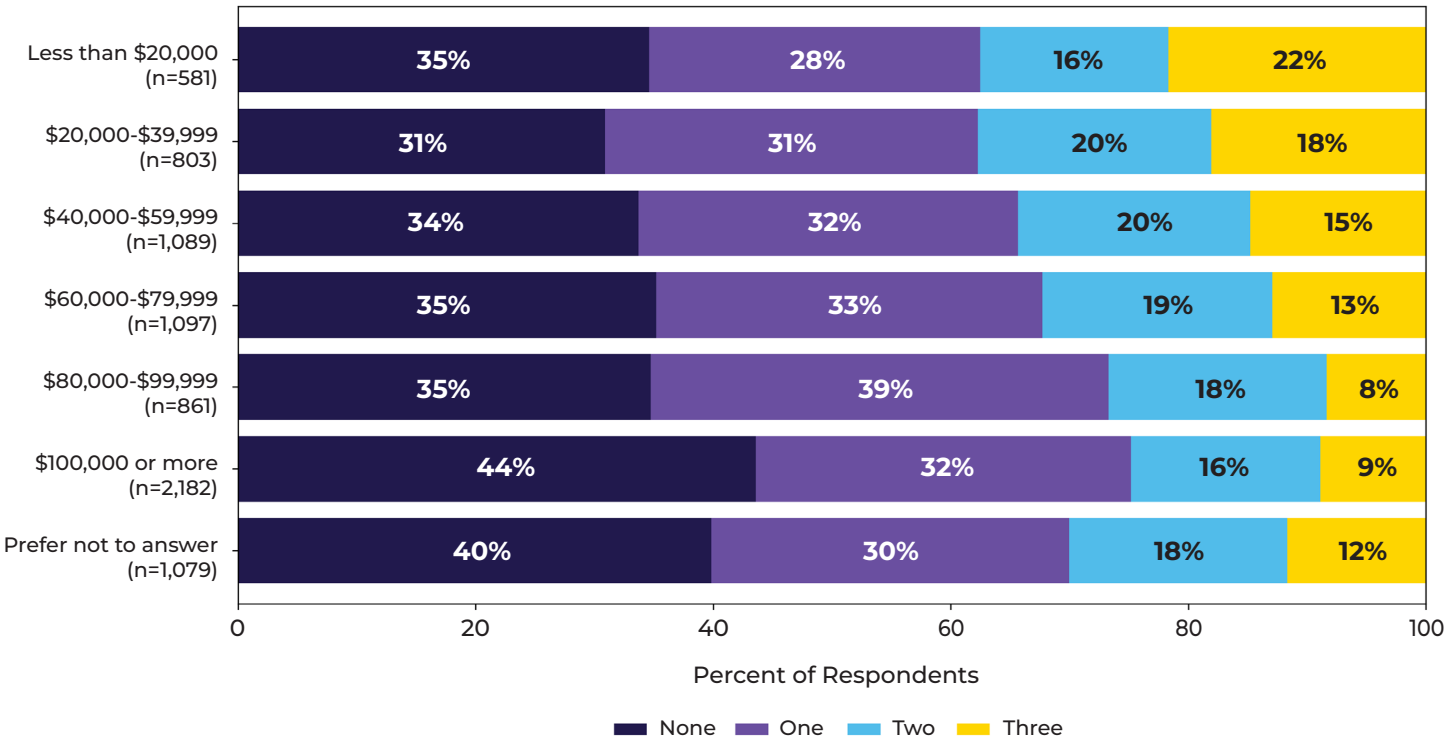
The percentage of respondents living with one or more chronic health conditions increased with age. For younger respondents under the age of 25, a little more than 70% reported no chronic conditions. This proportion declines consistently across the other age groups, most notably, only one in four adults aged 71 and over reported not living with a chronic health condition. The percentages of respondents reporting multiple chronic health issues also consistently increased by age groups.

FIGURE 5.2 CHRONIC HEALTH CONDITIONS BY AGE RANGE



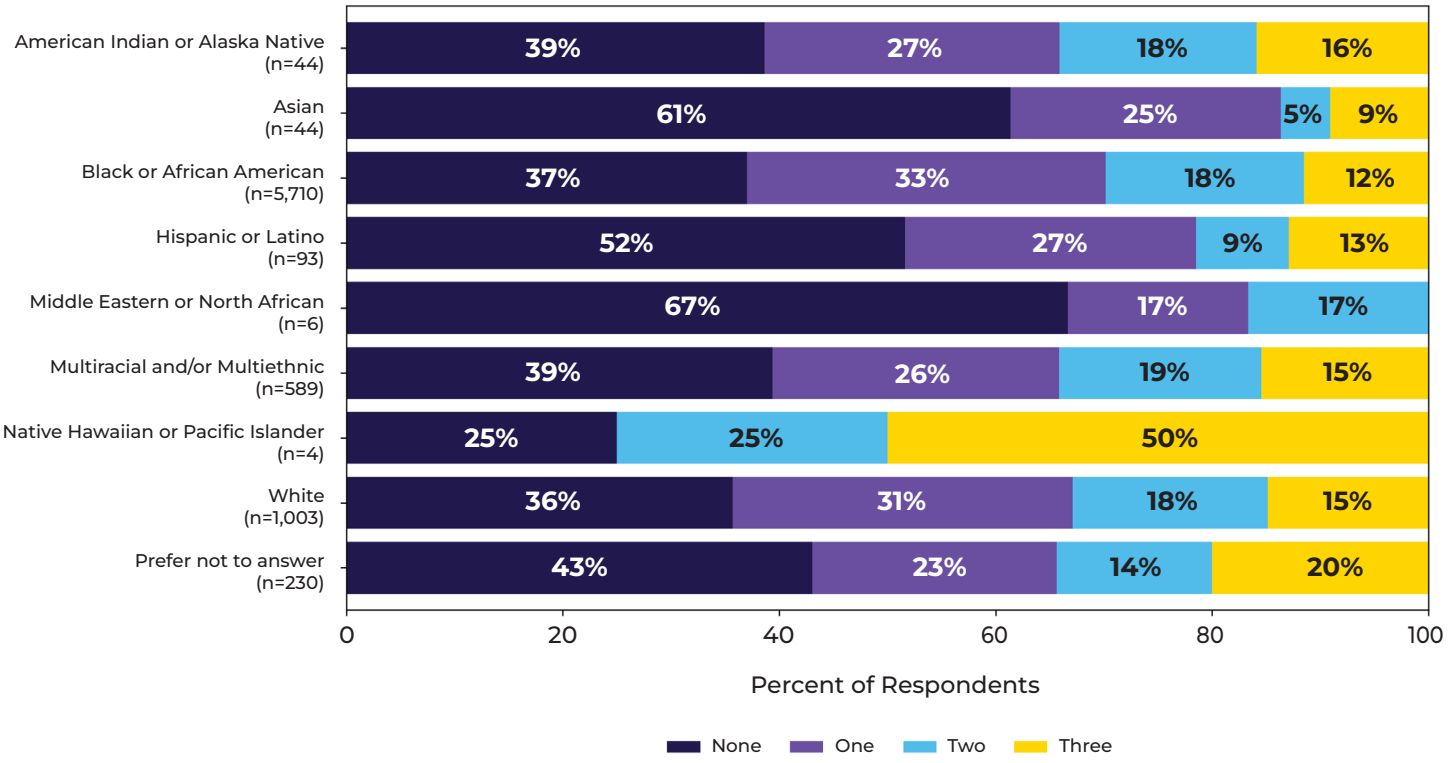
The tabulation of total household income and chronic health conditions shows a clear gradient in chronic health burden. Among respondents earning less than $20,000 per year, about one in five (22%) reported that they live with three chronic health conditions. In contrast, the percentage of respondents in households earning $80,000 or more living with three chronic health conditions was less than ten. Additionally, larger percentages of respondents with higher incomes reported no chronic conditions. For example, 44% of respondents earning $100,000 or more reported none, compared to just 35% among those with annual incomes below $20,000.

FIGURE 5.3 CHRONIC HEALTH CONDITIONS BY TOTAL HOUSEHOLD INCOME



The results of chronic health conditions by racial or ethnic group were similar to the overall results, with a few exceptions. Asian (61%) and Hispanic or Latino (52%) individuals had higher percentages of reporting not living with a chronic health condition.

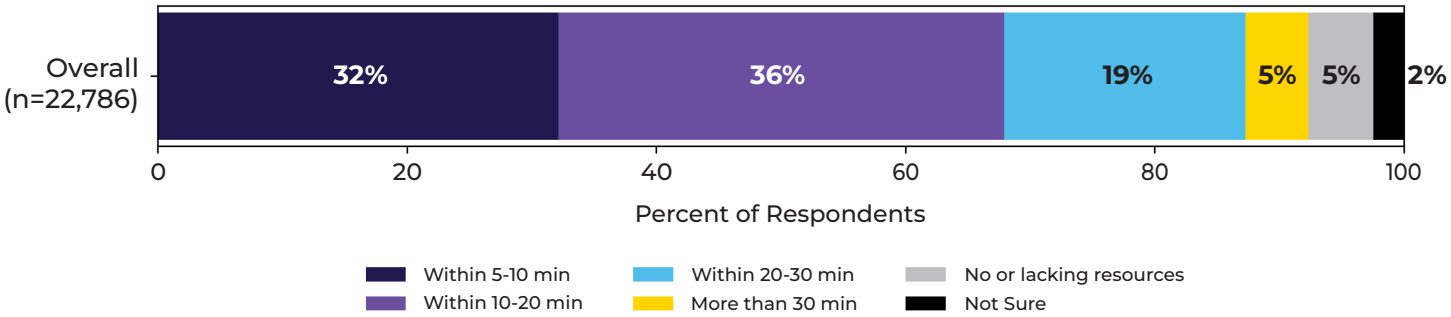
FIGURE 5.4 CHRONIC HEALTH CONDITIONS BY RACIAL OR ETHNIC GROUP



PROXIMITY TO A QUALITY HOSPITAL

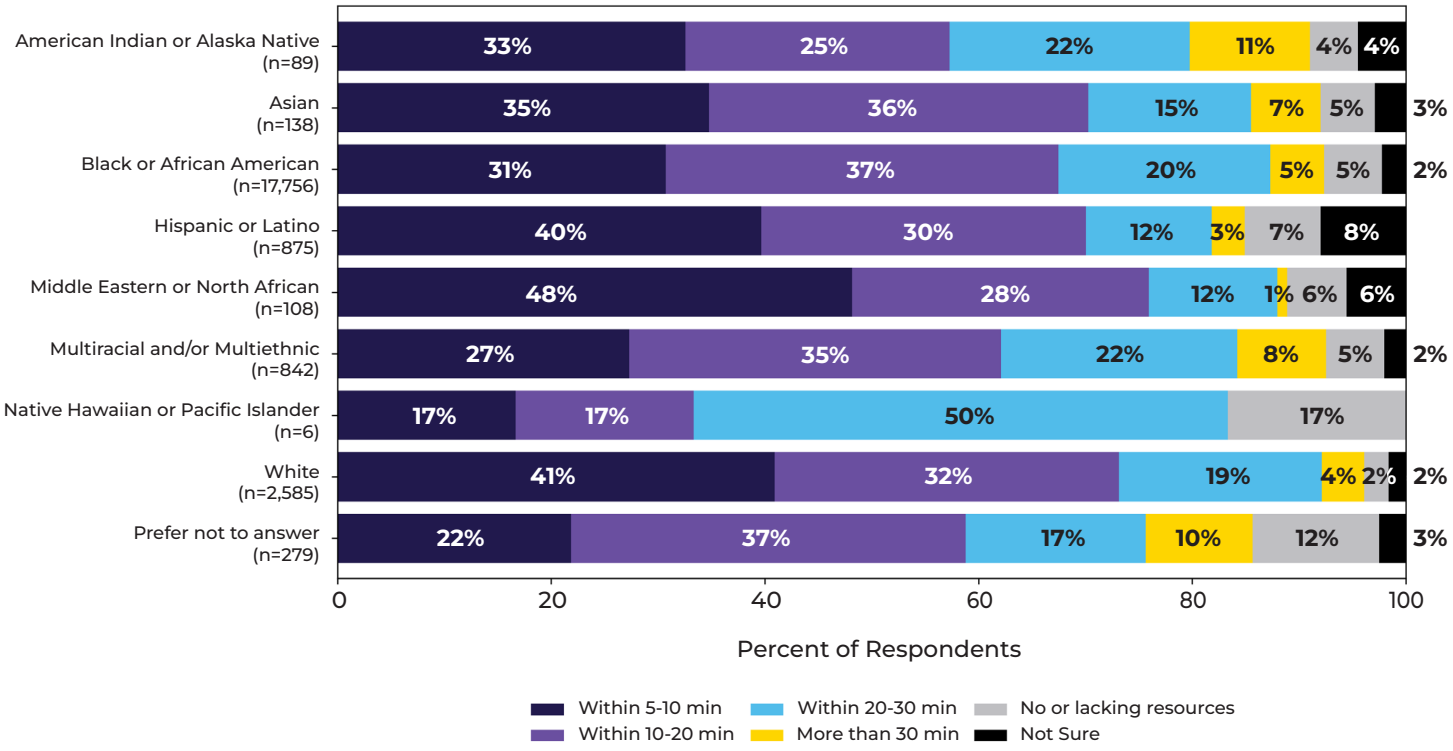
Across all survey modes, respondents were asked, Is there a quality hospital in your neighborhood? Respondents were told to consider quality based on the type of treatments and available resources, such as respectful and effective care, low wait times, clean spaces, a safe environment, and advanced equipment. Most respondents reported living within a reasonable distance of a hospital they considered high quality. Nearly one-third of respondents had access to a quality hospital within five to ten minutes of travel.

FIGURE 5.5 PROXIMITY TO A QUALITY HOSPITAL (OVERALL)



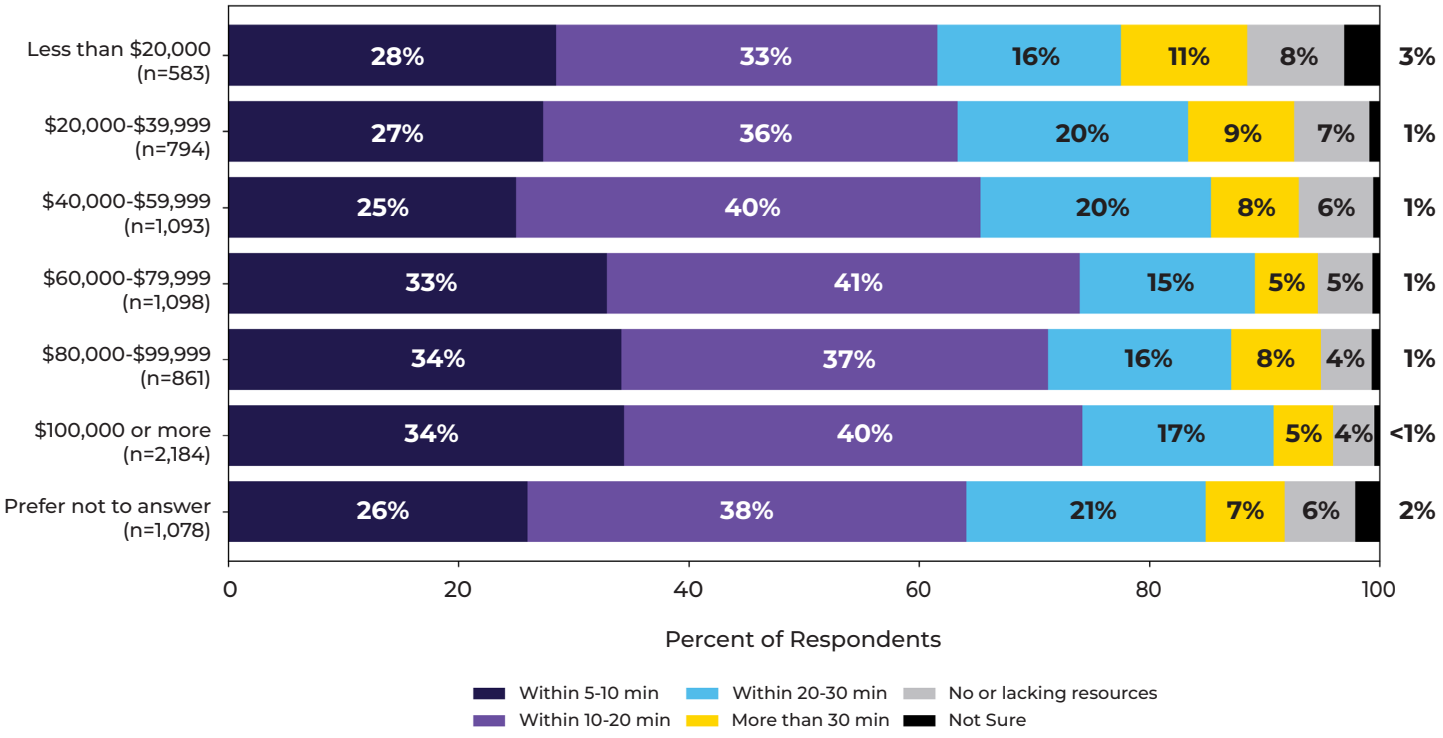
There were some differences between the demographic subgroups. When considering racial or ethnic groups, higher percentages of Middle Eastern or North African, White, and Hispanic or Latino respondents reported short-distance access, with 48%, 41%, and 40%, respectively, living within five to ten minutes of a quality hospital. In contrast, only 31% of Black or African American respondents reported the same level of proximity.

FIGURE 5.6 PROXIMITY TO A QUALITY HOSPITAL BY RACIAL OR ETHNIC GROUP



When considering total household income, respondents in higher income ranges reported closer proximity to a hospital they considered to be of quality. Among respondents with household incomes of $60,000 or more, about one-third lived within five to ten minutes of a quality hospital, compared to 28% of those earning less than $20,000.

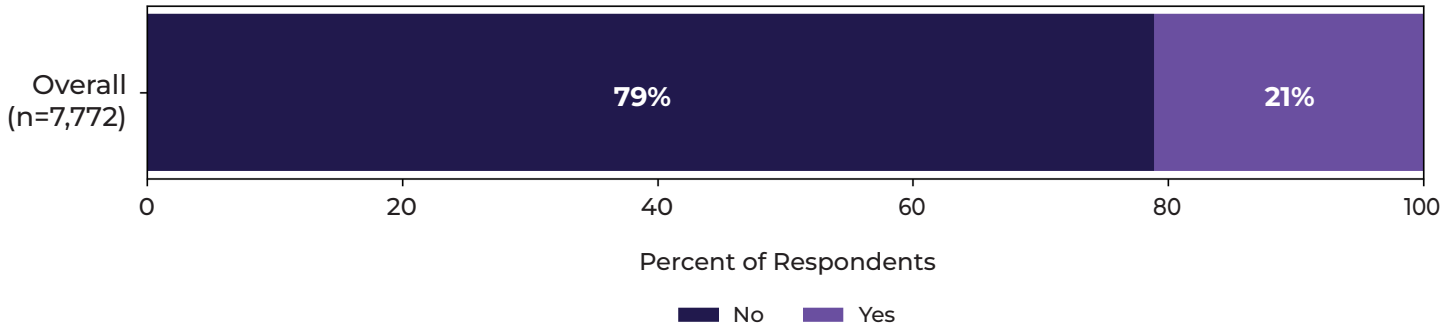
FIGURE 5.7 PROXIMITY TO A QUALITY HOSPITAL BY TOTAL HOUSEHOLD INCOME



ISSUES ACCESSING APPOINTMENTS OR PRESCRIPTIONS

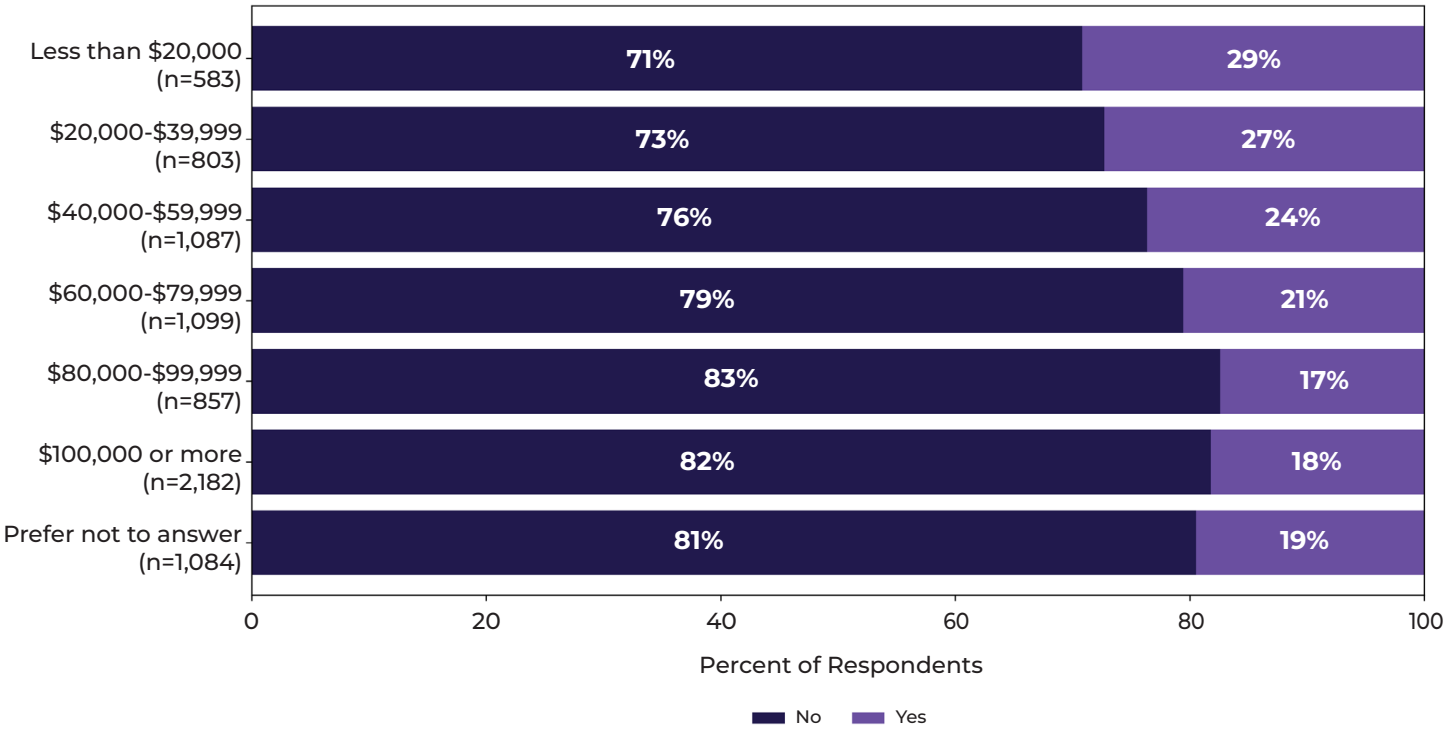
Most respondents to the main and leave-behind surveys (79%) reported no recent issues accessing medical appointments or prescriptions, while 21% said they had encountered such difficulties.

FIGURE 5.8 ISSUES ACCESSING APPOINTMENTS OR PRESCRIPTIONS (OVERALL)



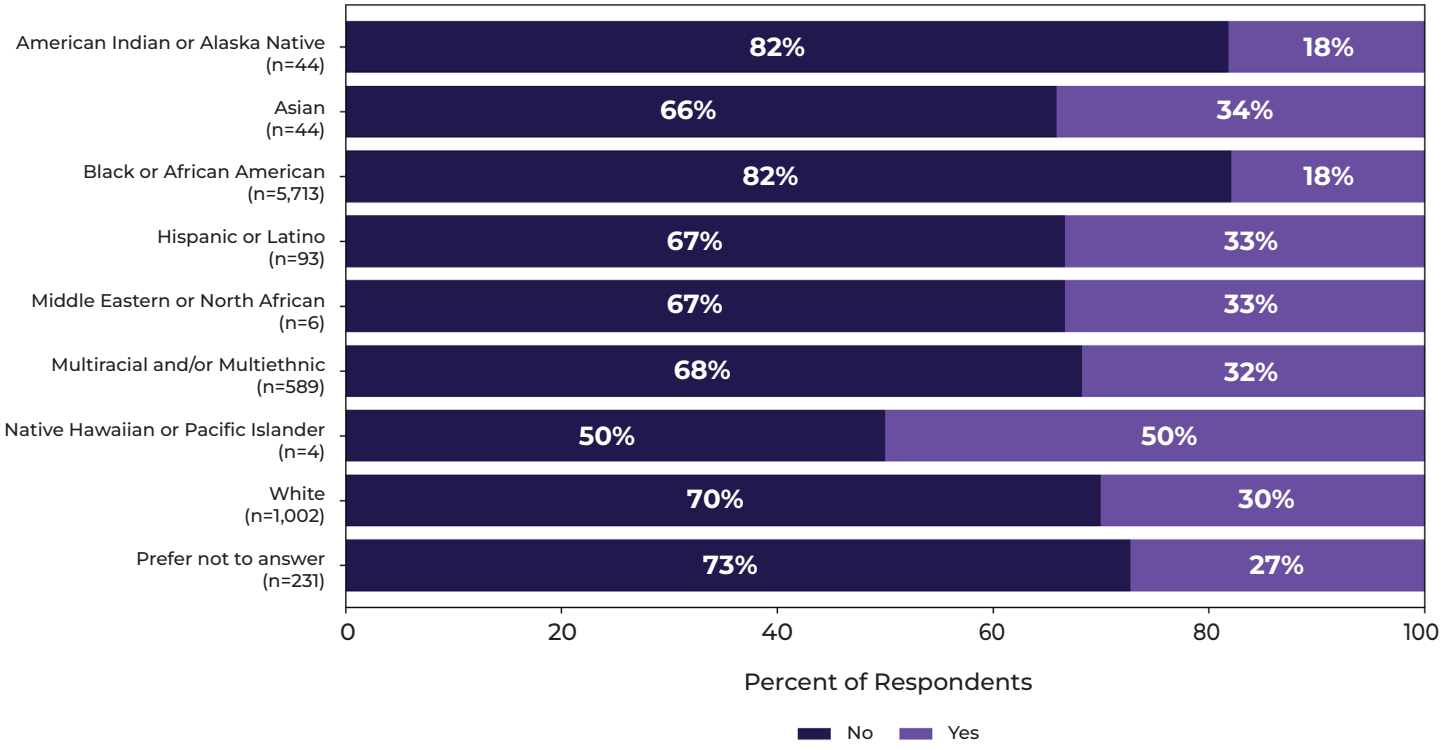
Across income levels, the percentage of respondents reporting challenges decreased as household income increased. Twenty-nine percent of respondents earning less than $20,000 per year reported difficulties, compared to 17% among those earning $80,000 or more.

FIGURE 5.9 ISSUES ACCESSING APPOINTMENTS OR PRESCRIPTIONS BY TOTAL HOUSEHOLD INCOME



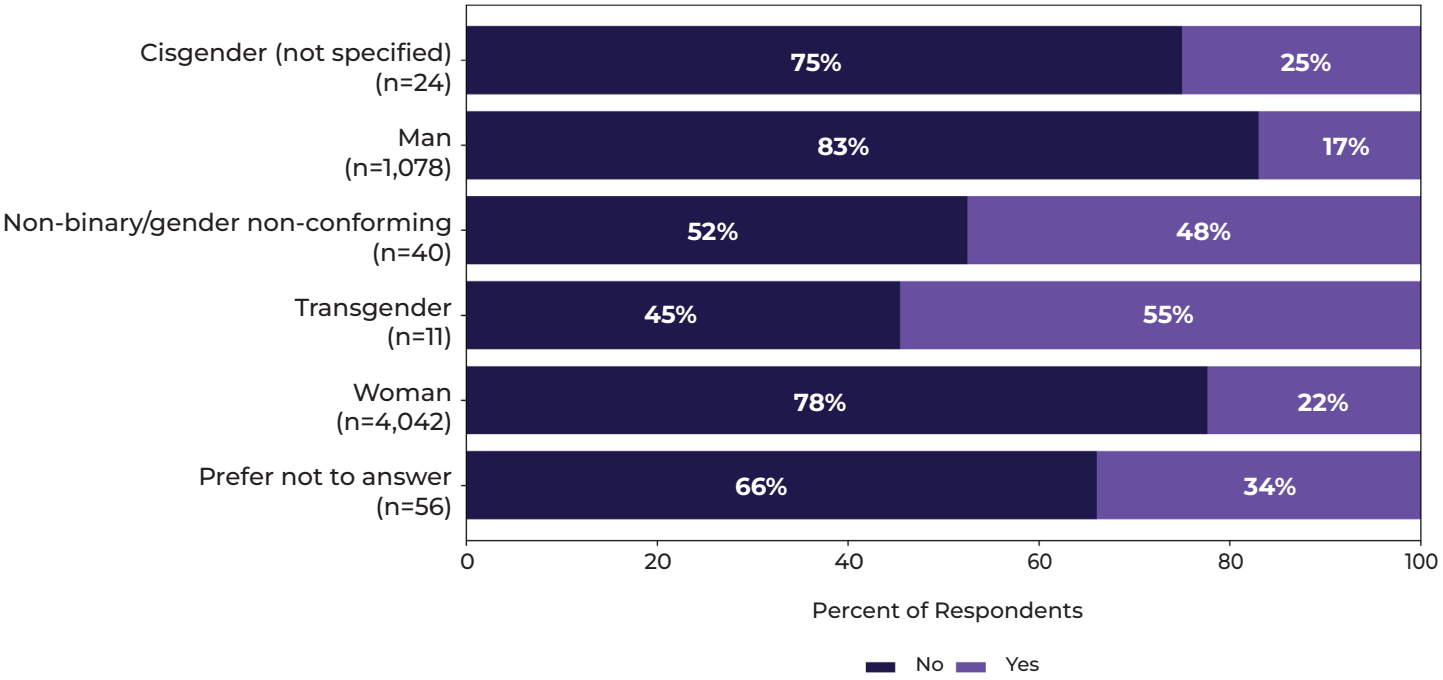
Responses varied by race and ethnicity. Black or African American and American Indian or Alaska Native respondents reported experiencing issues with access to appointments or prescriptions at a similar rate as the overall sample (18%). For other racial or ethnic groups, nearly one in three reported issues with accessing medical appointments or prescriptions.

FIGURE 5.10 ISSUES ACCESSING APPOINTMENTS OR PRESCRIPTIONS BY RACIAL OR ETHNIC GROUP



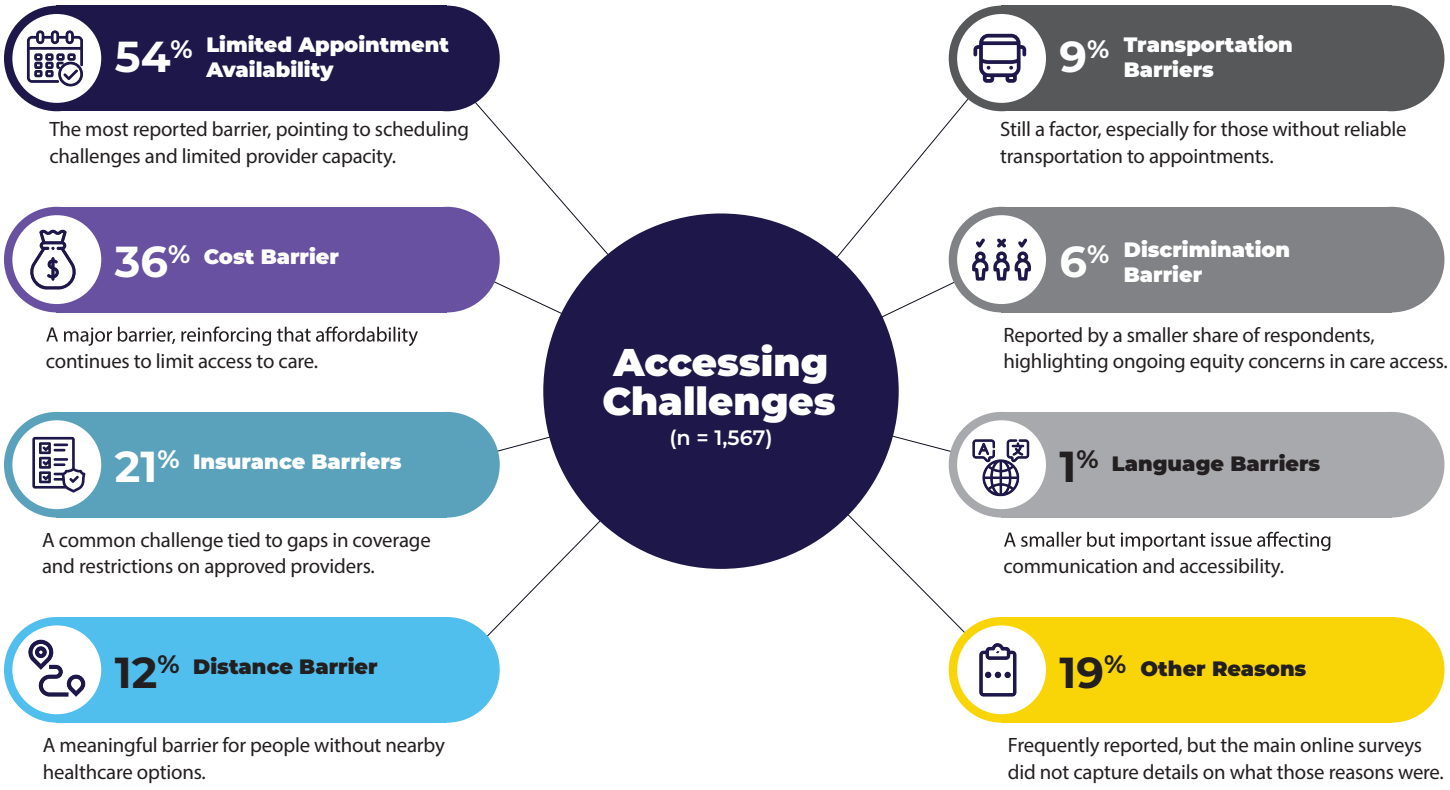
By gender, men (17%) were the least likely to report access issues, while transgender (55%) and non-binary or gender non-conforming respondents (48%) were the most likely to report difficulties obtaining appointments or prescriptions. Women (22%) fell between these two ranges.

FIGURE 5.11 ISSUES ACCESSING APPOINTMENTS OR PRESCRIPTIONS BY GENDER



The main and leave-behind surveys also invited respondents to share what types of challenges they encountered with health appointments and securing prescriptions. Among the 1,567 respondents who shared they had challenges accessing appointments or prescriptions, several reasons were identified:

FIGURE 5.12 REPORTED BARRIERS TO ACCESSING HEALTHCARE APPOINTMENTS AND PRESCRIPTIONS

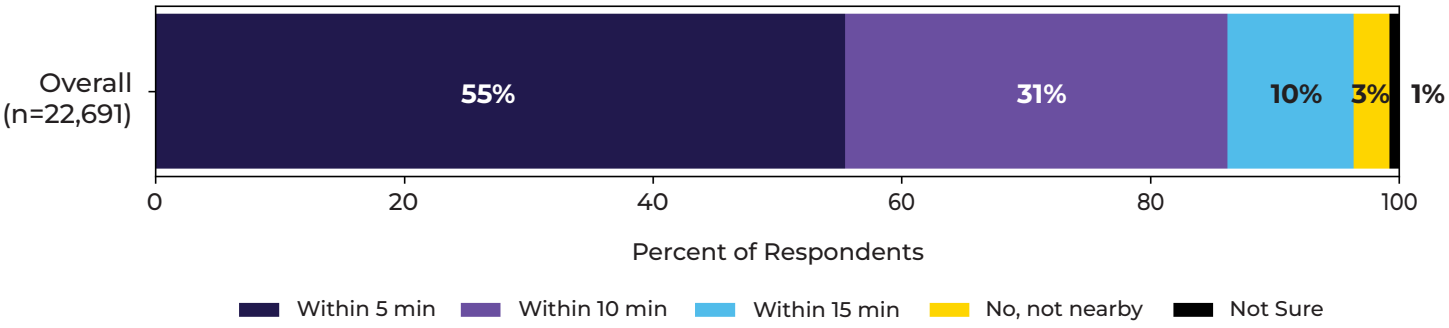


These findings suggest that, while transportation and proximity play a role, the most frequent barriers were affordability, insurance, and scheduling constraints, which may reflect broader systemic issues in healthcare access and delivery.

PHARMACY PROXIMITY (OVERALL)

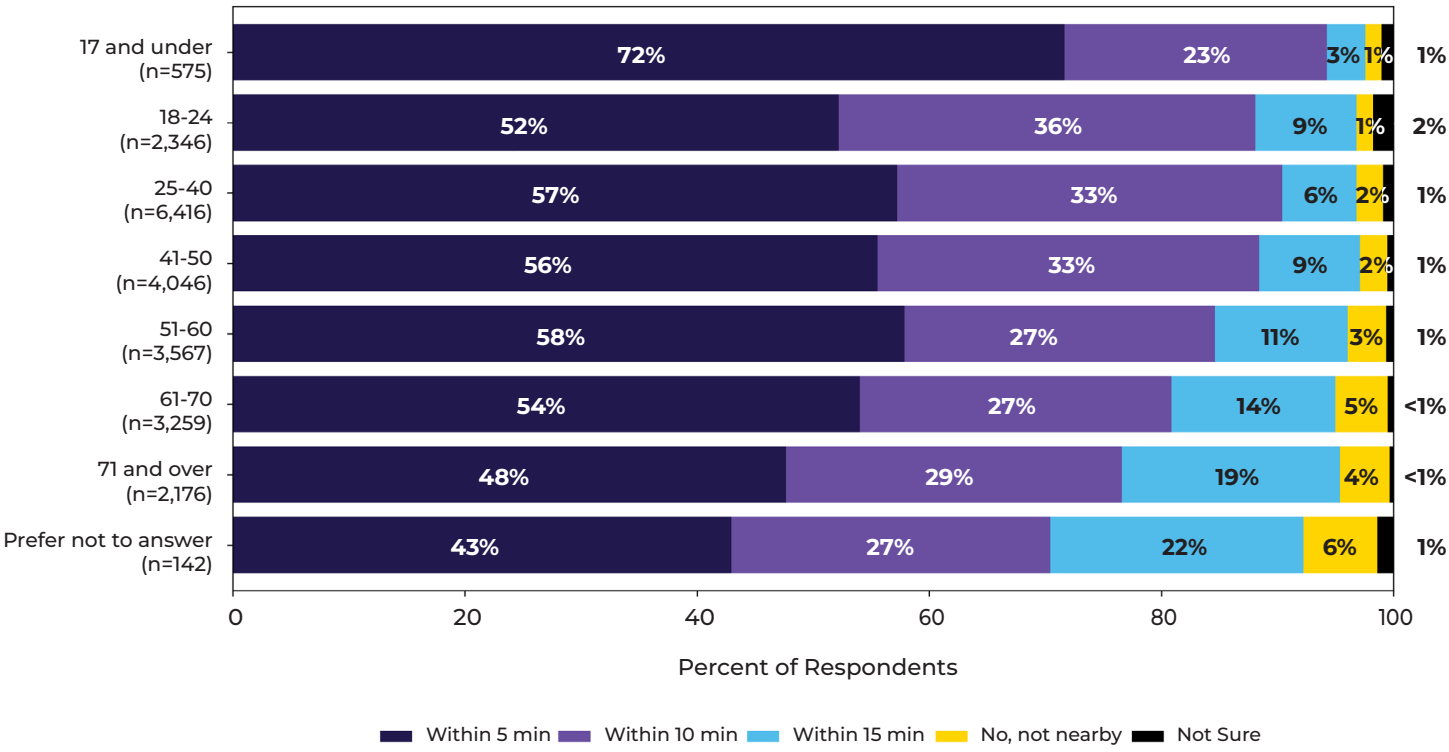
Across all survey modes, respondents were asked, Is there a pharmacy or drugstore in your neighborhood where you can get prescription medications? More than half of survey respondents (55%) reported having a pharmacy or drugstore within five minutes of travel, and another 31% said they could reach one within ten minutes. Only three percent indicated that no pharmacy was nearby, and less than one percent were unsure of the time to reach a pharmacy in their neighborhood. These findings suggest that, overall, most respondents have relatively convenient access to prescription medications within their communities.

FIGURE 5.13 PHARMACY PROXIMITY OVERALL



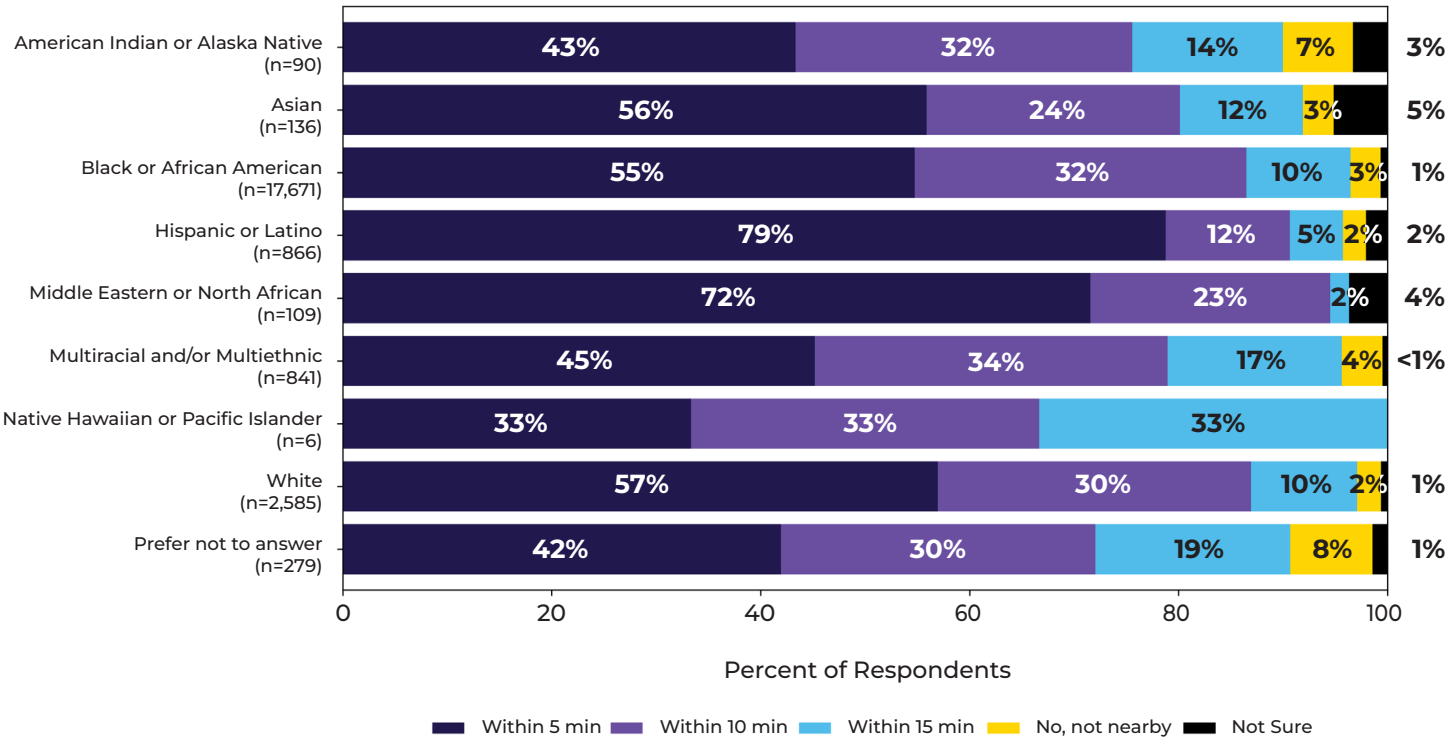
Access to nearby pharmacies varied by age group. Youth under 17 reported the highest proximity, with 72% living within five minutes of a pharmacy. Among adults, the percentage of respondents with accessibility within a shorter distance remained high but declined slightly with age. For example, 58% of respondents aged 51 to 60 and 54% of those aged 61 to 70 reported having a pharmacy within five minutes, compared to 48% of those aged 71 and older. Older adults were also more likely to report longer travel times or uncertainty about pharmacy access, which may reflect mobility or transportation challenges.

FIGURE 5.14 PHARMACY PROXIMITY BY AGE RANGE



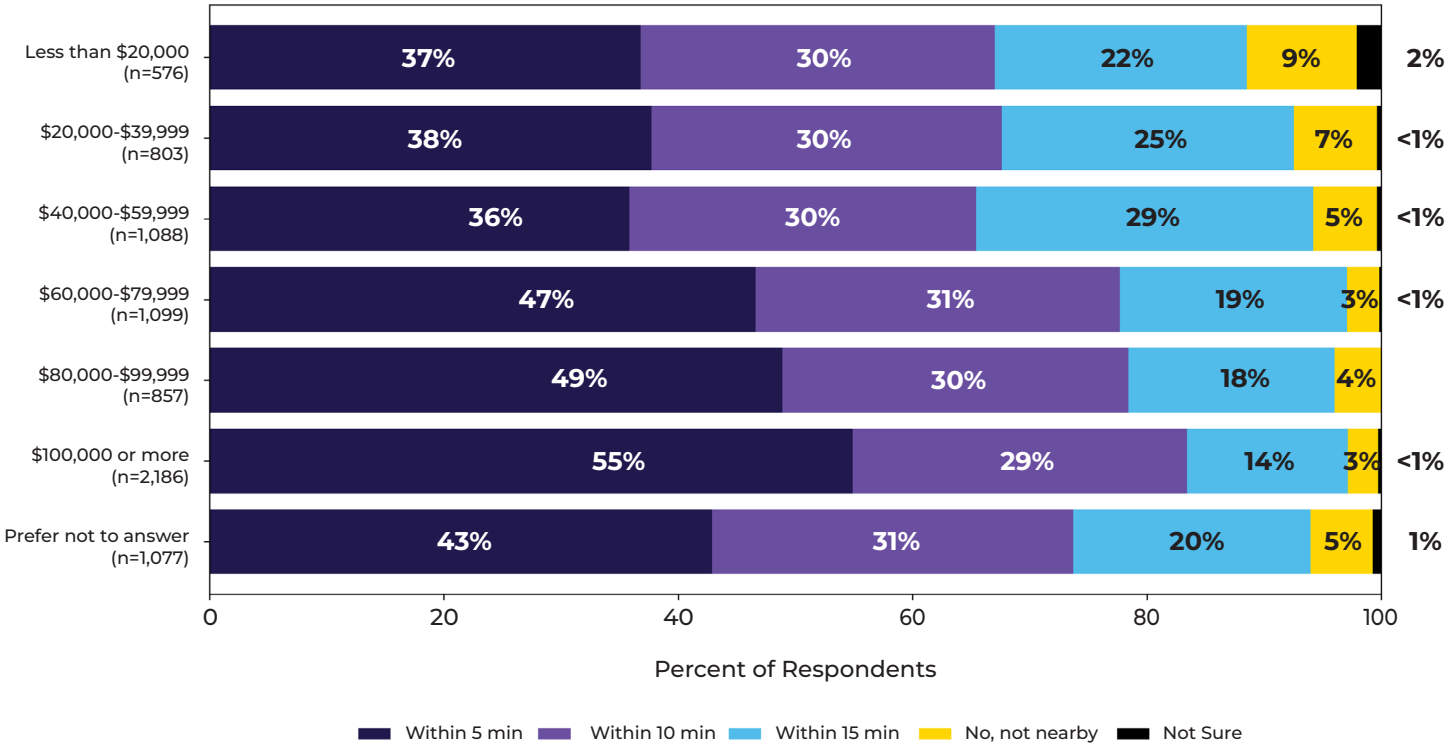
Pharmacy access differed across racial and ethnic groups. Hispanic or Latino respondents reported the highest proximity, with 79% living within five minutes of a pharmacy, followed by Middle Eastern or North African respondents (72%). In contrast, American Indian or Alaska Native respondents reported the lowest proximity, with only 43% within five minutes of a pharmacy and 7% stating that none were nearby. Black or African American and White respondents had higher percentages of respondents (55% and 57%, respectively) within five minutes, suggesting that pharmacy availability is generally strong but uneven across some communities of color.

FIGURE 5.15 PHARMACY PROXIMITY BY RACIAL OR ETHNIC GROUP



The percentage of respondents with access to nearby pharmacies increased with income. Thirty-seven percent of respondents earning less than $20,000 per year lived within five minutes of a pharmacy, compared to 55% of those earning $100,000 or more. Lower-income respondents also had higher percentages of respondents who reported that no pharmacy was nearby (9%) versus 3% among the highest earners. These findings indicate that pharmacy access may be influenced by economic resources and neighborhood infrastructure.

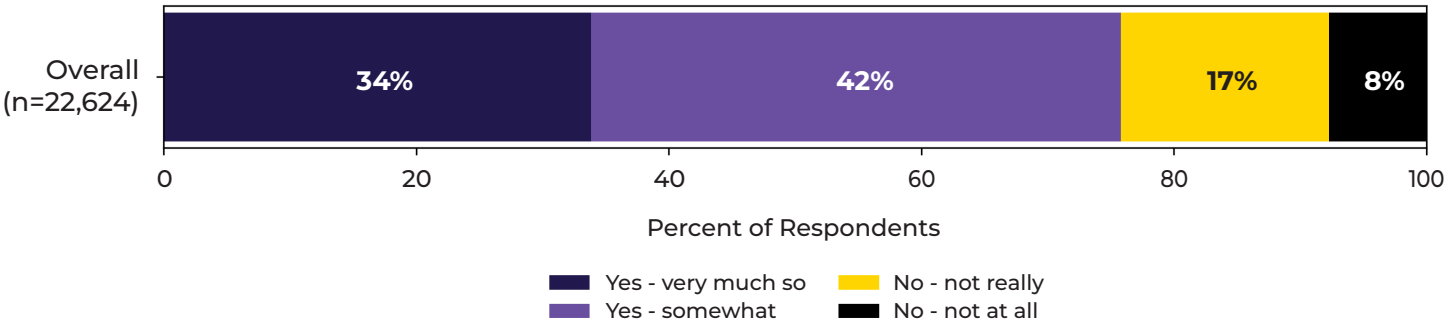
FIGURE 5.16 PHARMACY PROXIMITY BY TOTAL HOUSEHOLD INCOME



PERCEIVED CULTURAL UNDERSTANDING OF PROVIDERS

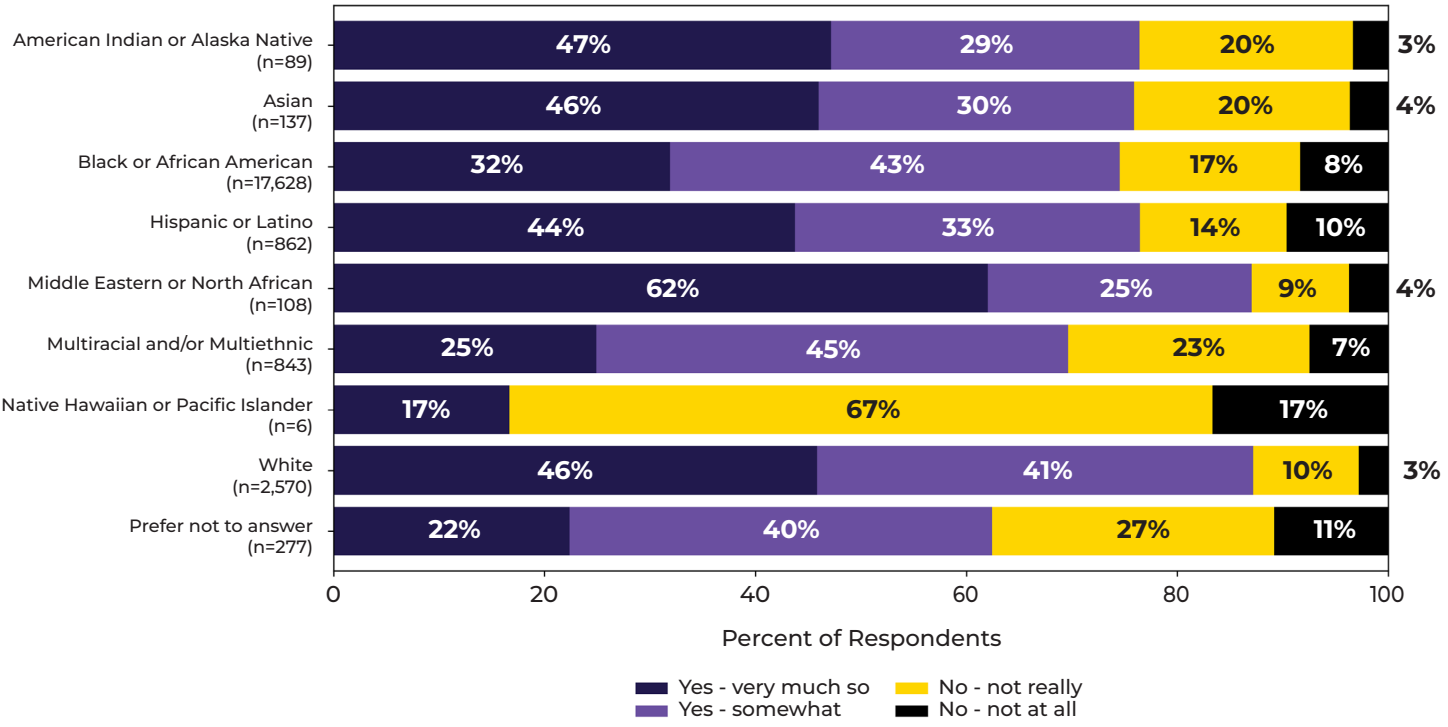
Across all survey modes, respondents were asked: "Do you believe healthcare providers in your neighborhood understand the cultural needs of your community?" Most respondents felt that healthcare providers had at least some understanding of the cultural needs of their communities. Overall, 34% said providers understood "Very much so," while 42% said "Somewhat." About one in four respondents expressed some level of doubt: 17% said "Not really," and eight percent said, "Not at all." These findings suggest that while most individuals perceive a degree of cultural awareness among local providers, some gaps remain.

FIGURE 5.17 PERCEIVED CULTURAL UNDERSTANDING OF PROVIDERS (OVERALL)



Perceptions varied across racial and ethnic groups. Higher percentages of Middle Eastern or North African (62%), American Indian or Alaska Native (47%), and White (46%) respondents reported that providers understood their communities "Very much so." By contrast, only about one in three Black or African American respondents (32%) felt that providers understood their cultural needs "Very much so," while another 43% said "somewhat." Roughly one in four respondents from Black or African American and Hispanic or Latino communities chose one of the "No" options, disagreeing that local providers understand their cultural needs.

FIGURE 5.18 PERCEIVED CULTURAL UNDERSTANDING OF PROVIDERS BY RACIAL OR ETHNIC GROUP

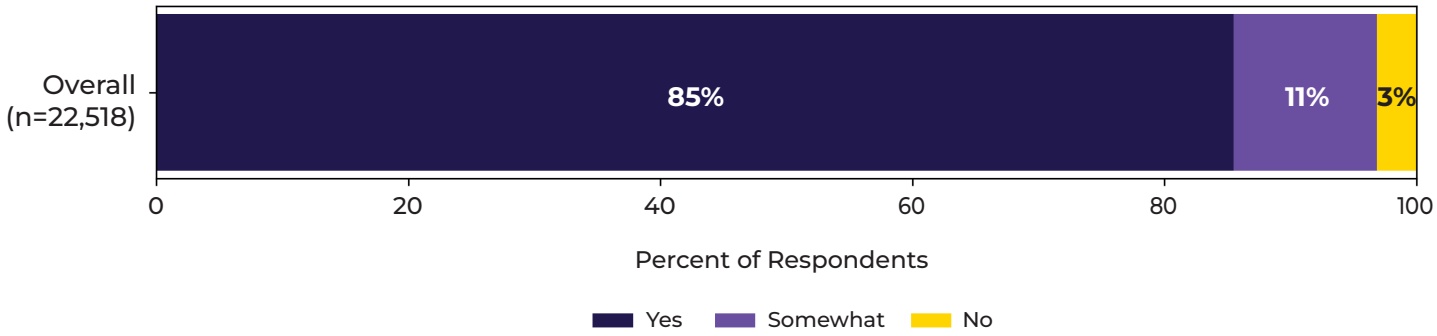


6. NEIGHBORHOOD QUALITY AND AFFORDABILITY

ACCESS TO AFFORDABLE AND RELIABLE TRANSPORTATION

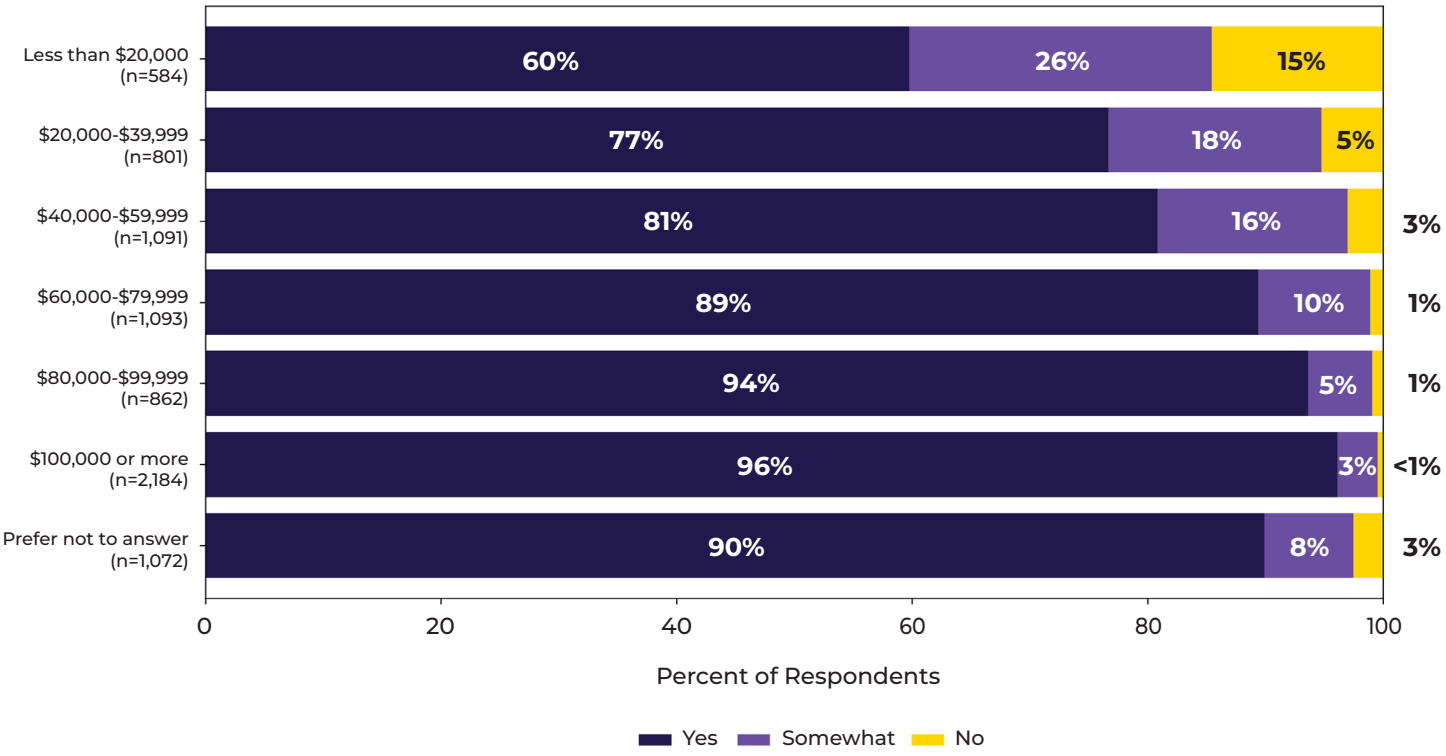
On the main, canvasser, and leave-behind surveys, respondents were asked: "Do you have access to affordable and reliable transportation? Affordability should be considered as something that doesn't strain your budget, whether it's public transit, a car, ride-share, or other options." Most respondents (85%) reported that they have access to affordable and reliable transportation, while 11% said that they have somewhat reliable or affordable options, and three percent said they do not.

FIGURE 6.1 ACCESS TO AFFORDABLE AND RELIABLE TRANSPORTATION (OVERALL)



The results revealed differences in access to affordable and reliable transportation by total household income. The percentage of respondents who answered "Yes" to having affordable and reliable transportation consistently increased among the total household income ranges. Nearly all respondents with annual household incomes of $100,000 or more (96%) said they had reliable and affordable transportation, compared to 60% among those earning less than $20,000. Additionally, the percentage of respondents in households earning less than $20,000 that reported "No" was often triple the percentage of respondents reporting "No" in other total household income ranges.

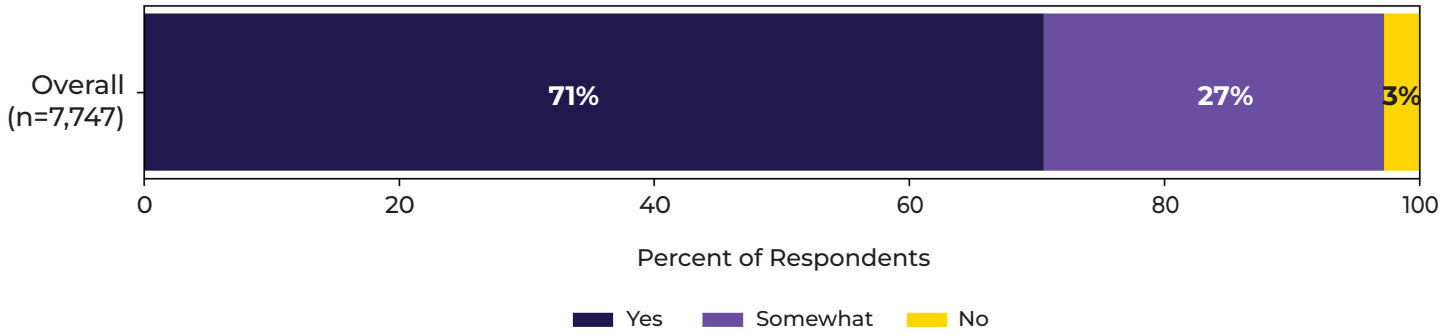
FIGURE 6.2 PROXIMITY TO A QUALITY HOSPITAL BY INCOME



PERCEIVED NEIGHBORHOOD SAFETY

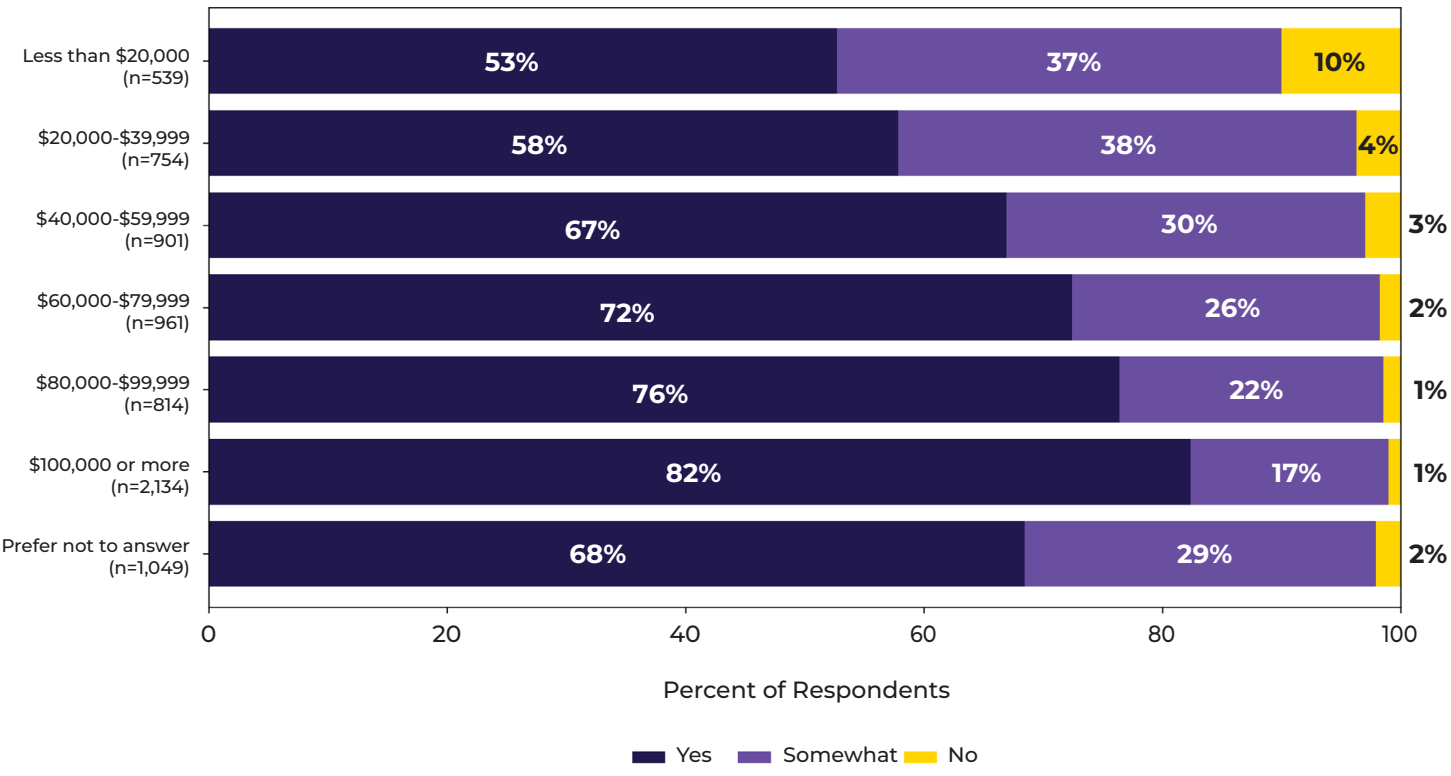
On the main and leave-behind surveys, respondents were asked: "Do you feel safe in your neighborhood?" Across all respondents, nearly three-quarters (71%) reported feeling safe in their neighborhoods, while about one-quarter (27%) felt only somewhat safe, and three percent said they did not feel safe.

FIGURE 6.3 PERCEIVED NEIGHBORHOOD SAFETY (OVERALL)



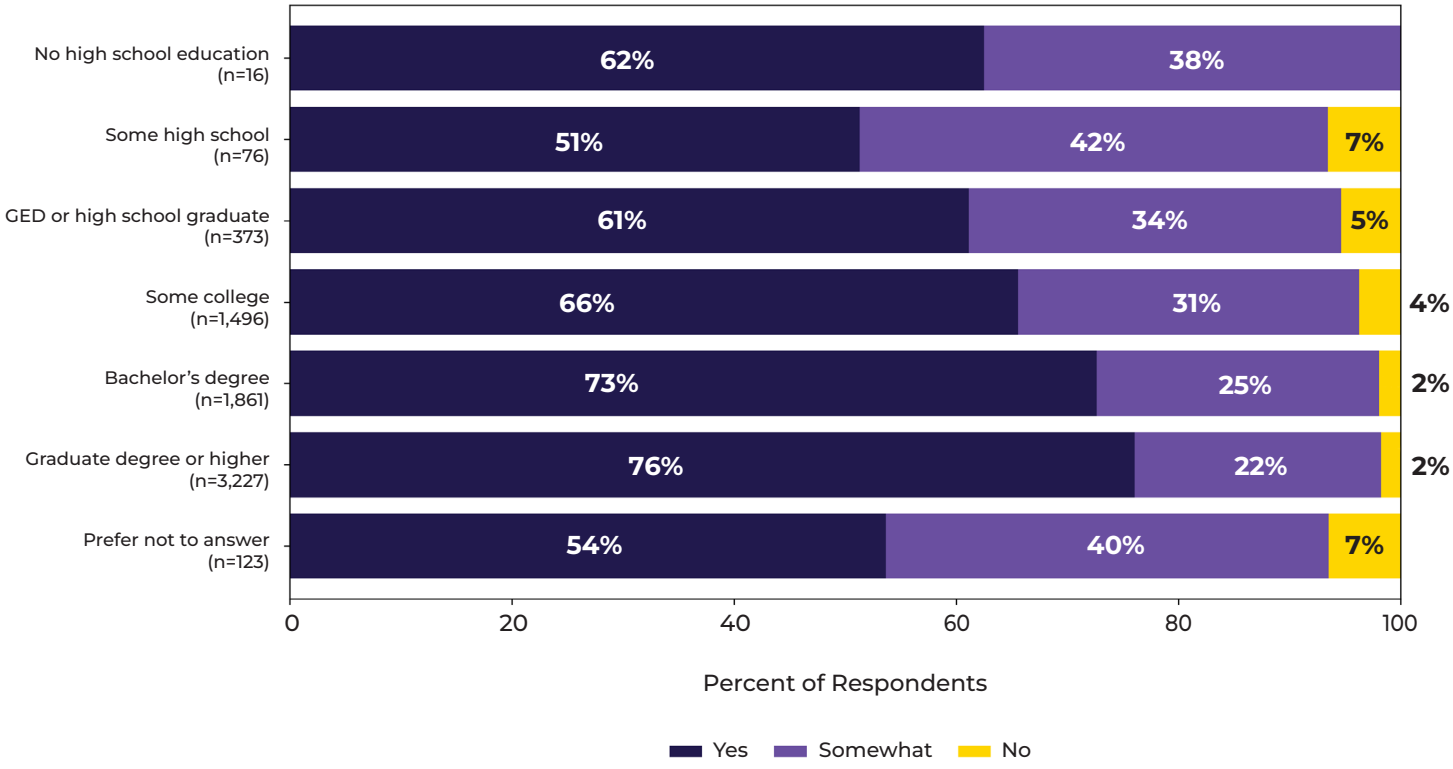
Patterns by income indicate that respondents with higher household earnings were more likely to feel safe in their neighborhoods. Among those earning less than $20,000 per year, just over half (53%) said they felt safe, compared to 82% of those with annual incomes of $100,000 or more.

FIGURE 6.4 PERCEIVED NEIGHBORHOOD SAFETY BY TOTAL HOUSEHOLD INCOME



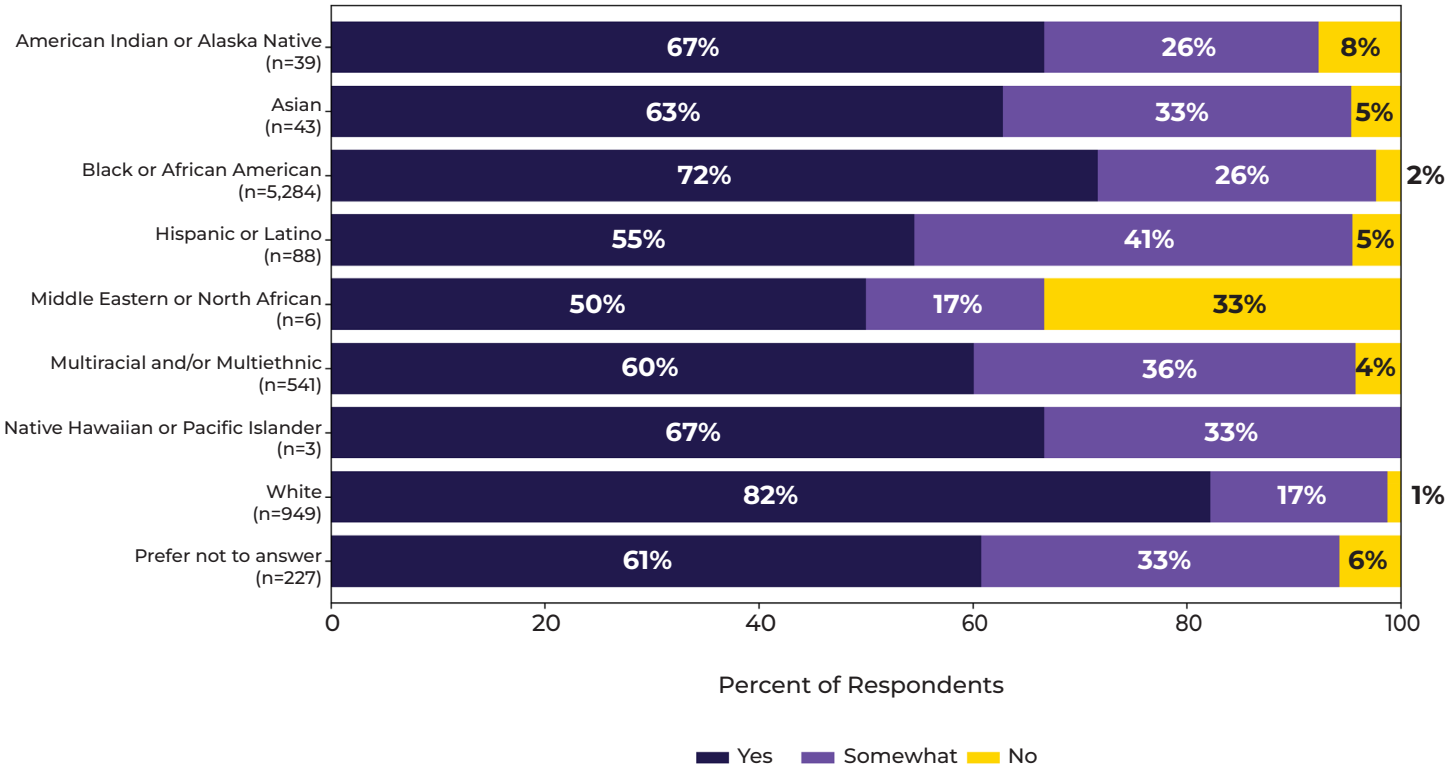
Perceptions of safety also varied by educational attainment. Less than two-thirds of respondents without a high school diploma said they felt safe, compared with 76% of those who had earned a graduate degree or higher.

FIGURE 6.5 PERCEIVED NEIGHBORHOOD SAFETY BY HIGHEST EDUCATION LEVEL



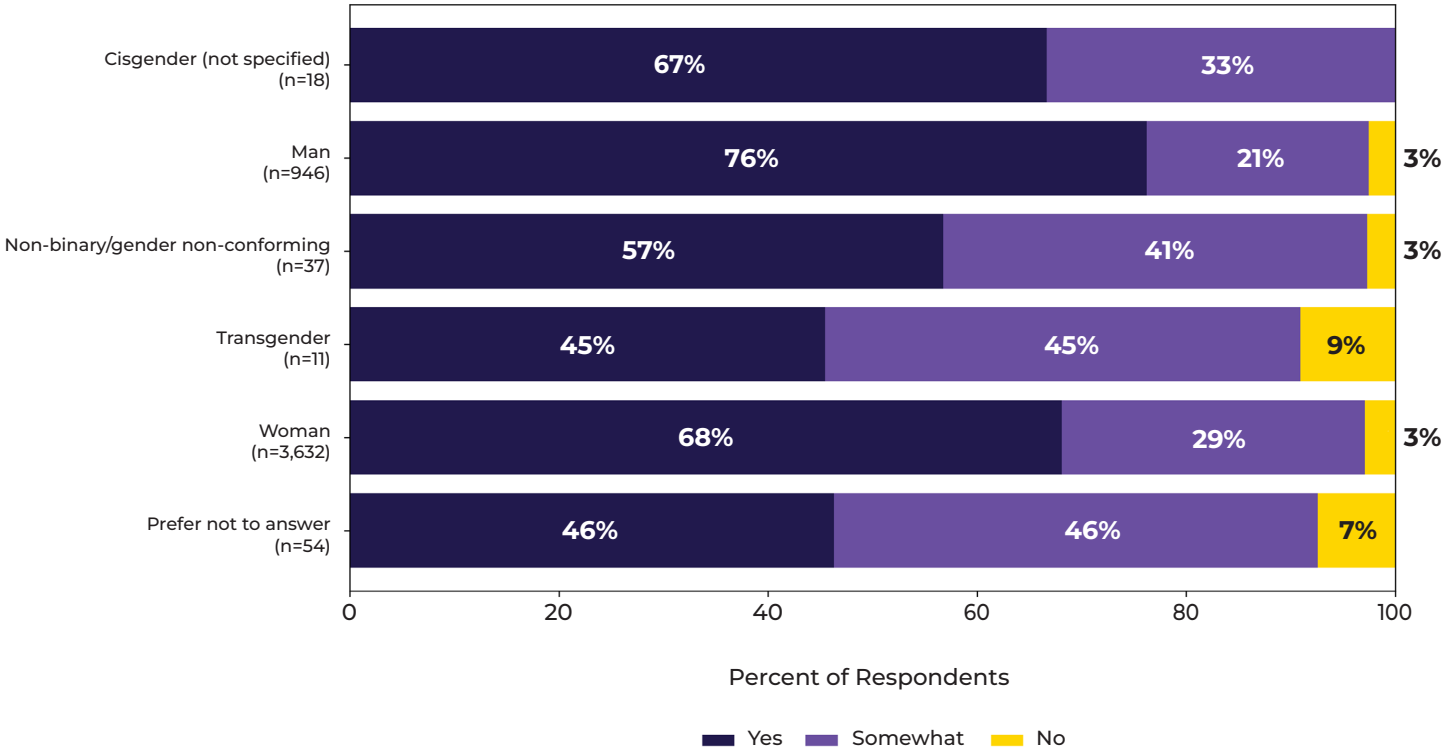
Differences by race and ethnicity were also observed. White respondents were the most likely to report feeling safe (82%), followed by Black or African American respondents (72%) and Asian respondents (63%). Hispanic or Latino respondents (55%) and those identifying as Middle Eastern or North African (50%) were less likely to report feeling safe, though results for smaller groups should be interpreted with caution.

FIGURE 6.6 PERCEIVED NEIGHBORHOOD SAFETY BY RACIAL OR ETHNIC GROUP



Among gender groups, 76% of men compared to 68% of women said they felt safe in their neighborhoods. Fewer transgender respondents (45%) reported feeling safe, suggesting this group may experience lower perceptions of safety where they live.

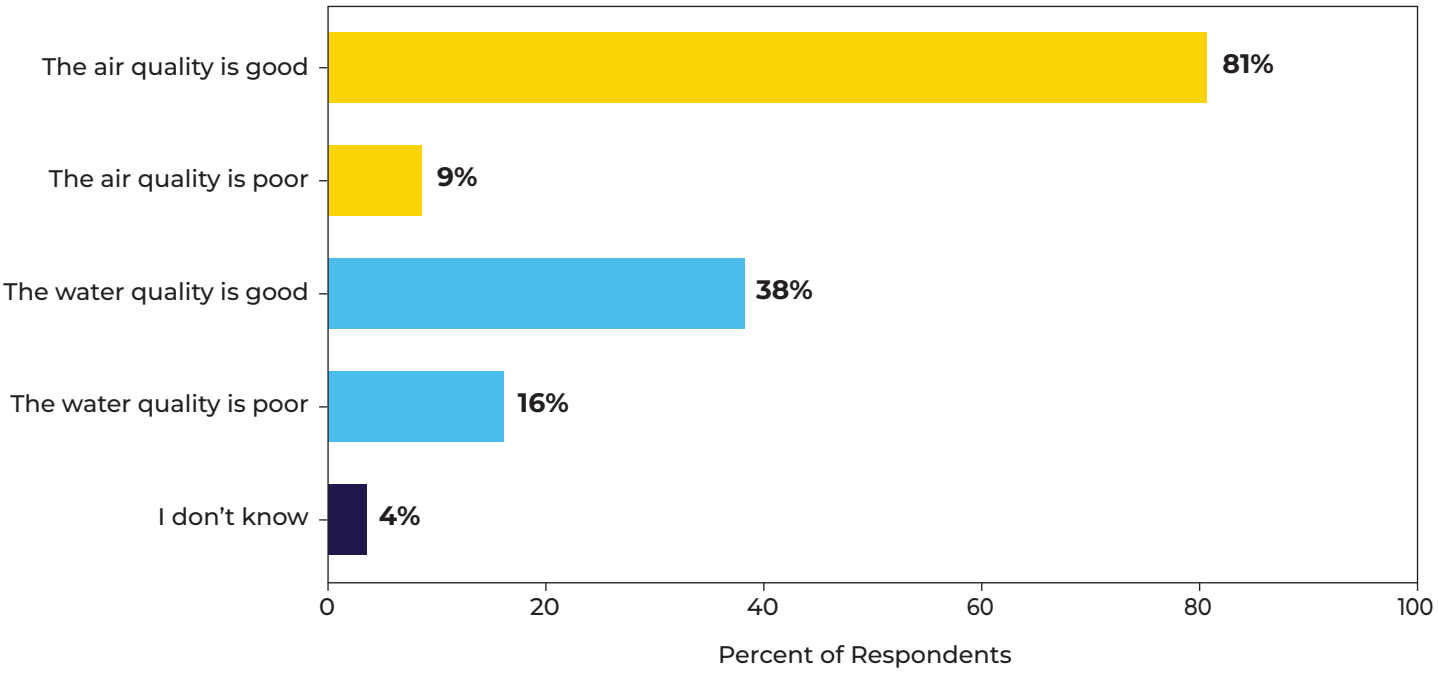
FIGURE 6.7 PERCEIVED NEIGHBORHOOD SAFETY BY GENDER



AIR AND WATER QUALITY

On the main and leave-behind surveys, respondents were asked: "How would you describe the air and water quality in your neighborhood? (Select all that apply)." Overall, the majority of respondents reported positive perceptions of air quality; 81% of respondents said the air quality in their neighborhood is good most of the time. In contrast, only 38% said the same about their water quality. Nine percent described the air quality as poor, and 16% said their water quality is poor. Very few respondents, four percent, said they were unsure about the quality of air or water in their community.

FIGURE 6.8 AIR AND WATER QUALITY (OVERALL)



Perceptions of air quality varied by total household income. For example, 64% of respondents in households earning less than $20,000 described the air quality as good compared with 87% among respondents earning $100,000 or more. Reports of poor air quality were lower among respondents in higher-income households, where 6% of respondents in households earning $100,000 or more reported poor air quality, versus 16% of respondents in households earning less than $20,000. Views of water quality followed a similar, though less pronounced, pattern. Looking at differences by total household income, 31% of respondents earning less than $20,000 said their water quality was good compared to 40% of those earning $100,000 or more. Concerns about poor water quality were more common among lower-income respondents (27%) than among those with higher incomes (10%).

TABLE 6.1 AIR AND WATER QUALITY BY TOTAL HOUSEHOLD INCOME

HOUSEHOLD INCOME (N)	THE AIR QUALITY IS GOOD	THE AIR QUALITY IS POOR	THE WATER QUALITY IS GOOD	THE WATER QUALITY IS POOR	I DON'T KNOW
Less than $20,000 (n = 542)	64%	16%	31%	27%	7%
$20,000 – $39,999 (n = 767)	74%	11%	39%	22%	5%
$40,000 – $59,999 (n = 899)	80%	8%	40%	18%	3%
$60,000 – $79,999 (n = 967)	82%	7%	37%	17%	3%
$80,000 – $99,999 (n = 818)	83%	8%	38%	14%	3%
$100,000 or more (n = 2,147)	87%	6%	40%	10%	2%
Prefer not to answer (n = 1,055)	78%	10%	37%	17%	7%

Patterns by race and ethnicity revealed some differences in environmental quality. Ninety percent of White respondents rated their air quality as good compared to 80% Black or African American respondents, 77% of Multiracial or Multiethnic respondents, and 70% of Hispanic or Latino respondents. Furthermore, a higher percentage of Hispanic or Latino respondents reported poor water quality.

TABLE 6.2 AIR AND WATER QUALITY BY RACIAL OR ETHNIC GROUP

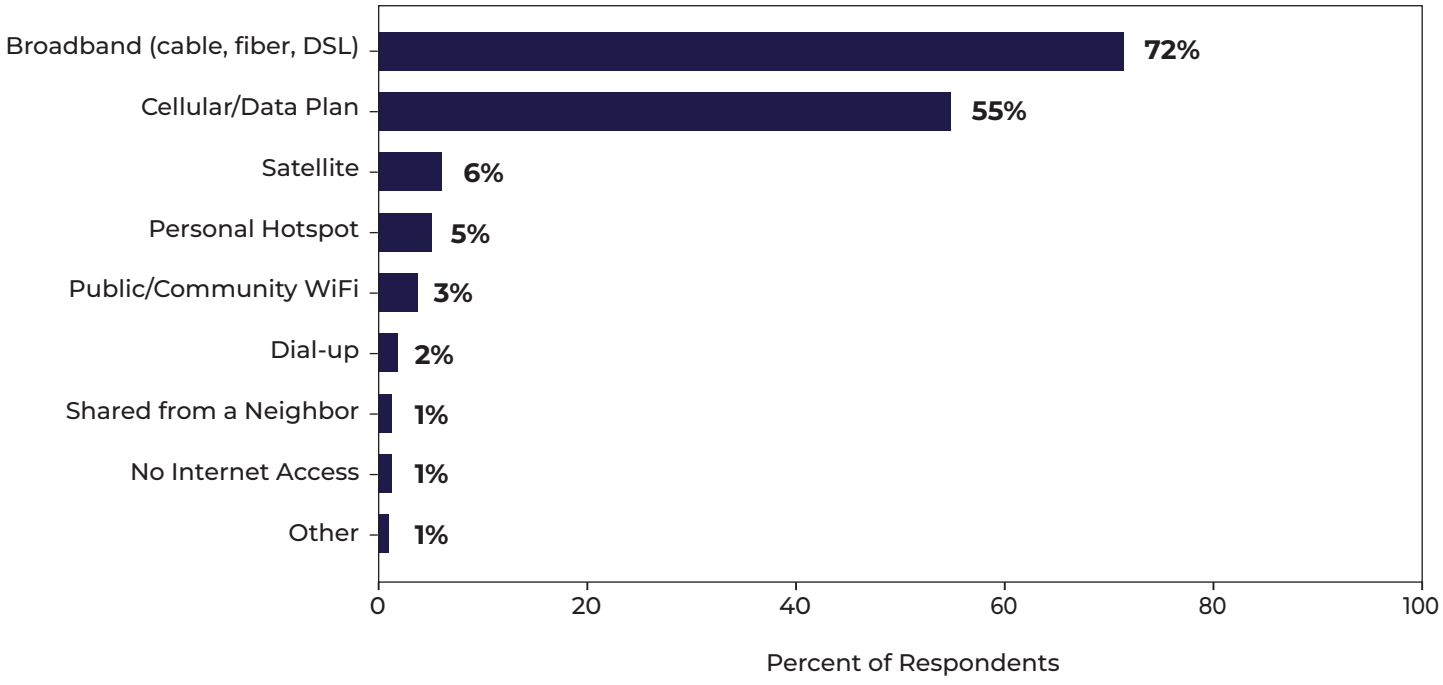
RACE/ETHNICITY (N)	THE AIR QUALITY IS GOOD	THE AIR QUALITY IS POOR	THE WATER QUALITY IS GOOD	THE WATER QUALITY IS POOR	I DON'T KNOW
American Indian or Alaska Native (n = 40)	65%	18%	28%	35%	3%
Asian (n = 43)	79%	16%	35%	16%	2%
Black or African American (n = 5,331)	80%	8%	36%	16%	4%
Hispanic or Latino (n = 88)	70%	9%	36%	25%	5%
Middle Eastern or North African (n = 6)	83%	17%	17%	50%	0%
Multiracial and/or Multiethnic (n = 542)	77%	12%	44%	22%	5%
Native Hawaiian or Pacific Islander (n = 3)	33%	0%	67%	33%	0%
White (n = 948)	90%	5%	50%	12%	2%
Prefer not to answer (n = 225)	69%	15%	35%	22%	7%

Overall, these findings indicate that while air quality is viewed favorably by most respondents, perceptions of water quality are notably less positive and more unequal across demographic groups. Gender, age, and sexual orientation did not show strong or consistent differences in perceptions of air and water quality.

INTERNET CONNECTIVITY

Across all survey modes, respondents were asked: "How do you connect to the internet where you live? (Select all that apply)." Most of the survey respondents reported that they connect to the internet via Broadband connections (e.g., cable, fiber optic, DSL) (72%), followed by cellular connections (e.g., from a smartphone or other mobile device) (55%). Very few respondents rely on personal hotspots (five percent), dial-up (two percent), or have no internet access (one percent).

FIGURE 6.9 INTERNET CONNECTIVITY (OVERALL)



Internet access showed clear generational trends by age group. Nearly all youth under 18 (91%) have cellular access, but fewer have broadband (28%). Broadband access rises steadily among adults, peaking between ages 41–60 (75%), while cellular reliance declines slightly with age. This pattern suggests younger respondents may depend on mobile connections, whereas middle-aged adults are more likely to maintain broadband subscriptions.

TABLE 6.3 INTERNET CONNECTIVITY BY AGE RANGE

AGE RANGE	CELLULAR	BROADBAND	SATELLITE	DIAL-UP	SHARED	PUBLIC WI-FI	HOTSPOT	NONE	OTHER
17 and under (n=577)	91%	28%	2%	<1%	1%	1%	6%	<1%	<1%
18 – 24 (n=2,360)	69%	64%	6%	1%	2%	4%	5%	<1%	<1%
25 – 40 (n=6,420)	60%	71%	5%	1%	1%	3%	4%	1%	<1%
41 – 50 (n=4,064)	52%	75%	5%	2%	1%	3%	5%	1%	<1%
51 – 60 (n=3,566)	48%	76%	5%	2%	1%	4%	6%	1%	<1%
61 – 70 (n=3,262)	46%	74%	8%	2%	1%	5%	6%	2%	<1%
71 and over (n=2,197)	49%	71%	10%	2%	1%	5%	5%	2%	1%
Prefer not to answer (n=147)	50%	69%	14%	1%	3%	5%	10%	3%	4%

Patterns of access differ by race and ethnicity. Black or African American respondents (72%) and Hispanic or Latino respondents (74%) report strong broadband access, yet both groups show elevated satellite and cellular use, indicating ongoing affordability and reliability challenges. American Indian or Alaska Native respondents have somewhat lower broadband access (60%) and the highest satellite reliance (nine percent), highlighting persistent connectivity gaps for tribal communities.

Internet access improves steadily with higher household income. Only about 63% of respondents earning $20,000–$39,999 report broadband access, compared with 85% among those earning $100,000 or more. Lower-income respondents also report higher reliance on public Wi-Fi and hotspots, underscoring the role of economic inequality in shaping digital access. These findings suggest affordability remains a barrier to reliable broadband service for many households.

Broadband access is highest among respondents with graduate degrees (80%) and lowest among those with a high school diploma or less (52%). Individuals with lower educational attainment were also more likely to depend on public Wi-Fi (15%) or have no internet access at all (three percent). This reinforces the broader link between education, employment, and access to digital resources that support health and community engagement.

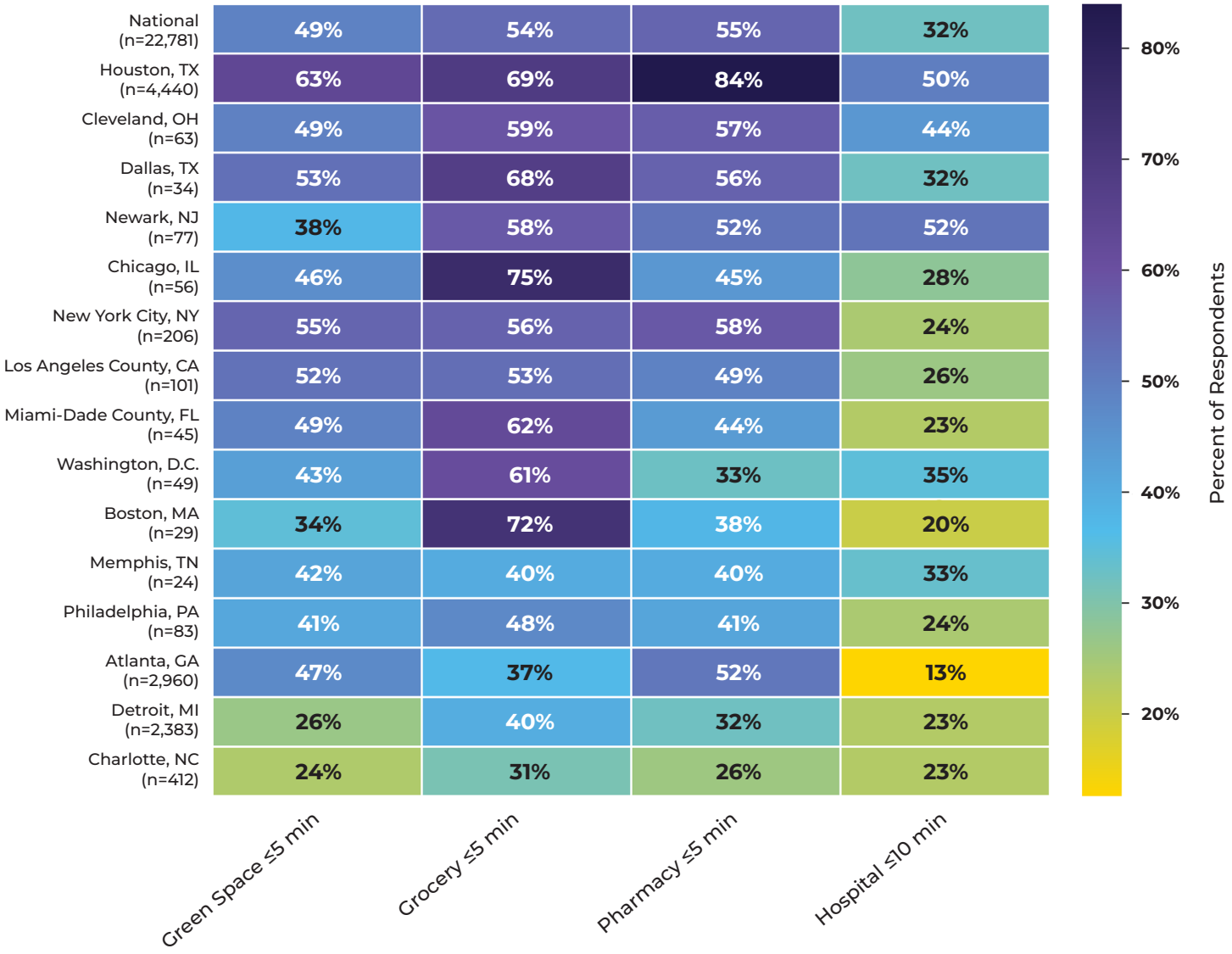
7. CROSS-CUTTING AND CITY-SPECIFIC INSIGHTS

In this section, we compare the national results with those of the 15 priority cities and counties. We provide insights from across the major survey domains (i.e., neighborhood resources and assets, health and health care, and neighborhood quality and affordability) to highlight where local experiences align with or diverge from the national patterns. The percentages in this section reflect the share of respondents in each geography who report a given experience, for example, having a grocery store or pharmacy within five minutes of travel. Because the data are aggregated by geography and drawn from separate survey questions, results describe city-level tendencies, not the experiences of the same individuals or neighborhoods. Readers should interpret these findings as patterns of overall accessibility rather than co-located amenities. Furthermore, given that most city-level samples contained fewer than 100 respondents, the analysis prioritizes geographic patterns over demographic subgroup breakouts.

PROXIMITY TO NEIGHBORHOOD AND HEALTH CARE RESOURCES

Proximity to resources like grocery stores, pharmacies, green spaces, and hospitals is essential for overall well-being. Communities where residents can reach these amenities within a short distance support healthier, more convenient, and connected lives. This analysis compares each city's reported proximity across four resources to the national average, offering a snapshot of overall accessibility within each geography.

FIGURE 7.1 PROXIMITY TO KEY NEIGHBORHOOD RESOURCES BY PRIORITY COMMUNITY



Note: To improve readability, percent labels are displayed only for response categories representing 2% or more of respondents.

At the national level, approximately half of respondents reported being able to reach these essential services within five minutes of travel, with the exception of proximity to a quality hospital. Nearly one-third of respondents reported that they could reach a quality hospital within five to 10 minutes of travel. However, when looking across the 15 priority communities, proximity to key neighborhood resources varied widely. Respondents in Houston, TX, Dallas, TX, and Cleveland, OH, consistently reported strong proximity across all four resources. Residents in these cities are more likely to live near grocery stores, pharmacies, and healthcare facilities, and to have access to nearby green spaces.

In contrast, respondents in Atlanta, GA, Detroit, MI, and Charlotte, NC, reported lower proximity across multiple categories. These overlapping access gaps point to structural challenges that residents in these cities may experience. For example, historic disinvestment refers to long-standing patterns of underinvestment in predominantly Black neighborhoods, such as limited grocery retail development and fewer maintained parks following decades of redlining and segregation. Rapid growth without infrastructure alignment is evident in cities like Charlotte, where population growth and new housing development have outpaced investments in walkable retail corridors, public transit, and neighborhood amenities. Uneven urban development reflects situations where revitalization is concentrated in select areas, while surrounding neighborhoods see limited improvements in access to essential services.

In Charlotte, for instance, limited access to grocery stores and parks is not evenly distributed across the city. Respondents identifying longer travel times were concentrated in zip codes 28208, 28216, 28206, and 28213, areas that include West, Northwest, and North Charlotte neighborhoods such as Reid Park and the Beatties Ford Corridor, historically African American communities that have experienced decades of divestment. Despite recent revitalization efforts, equitable access to fresh foods and safe, walkable parks remains limited in these areas.

A similar pattern emerged in Memphis, TN, and Washington, D.C., where proximity gaps reflect long-standing economic and geographic inequities. In Memphis, limited grocery access was concentrated in Midtown and South Memphis, neighborhoods that have historically experienced higher poverty and fewer retail investments. In Washington, D.C., the greatest concentration of limited access to healthy grocery options was reported east of the Anacostia River in Wards 7 and 8. These communities have been widely recognized as food deserts within the District. These patterns illustrate how geographic inequity persists even within cities undergoing redevelopment or growth, reinforcing that the issue is not only about distance but also about where investment occurs and whom it serves.

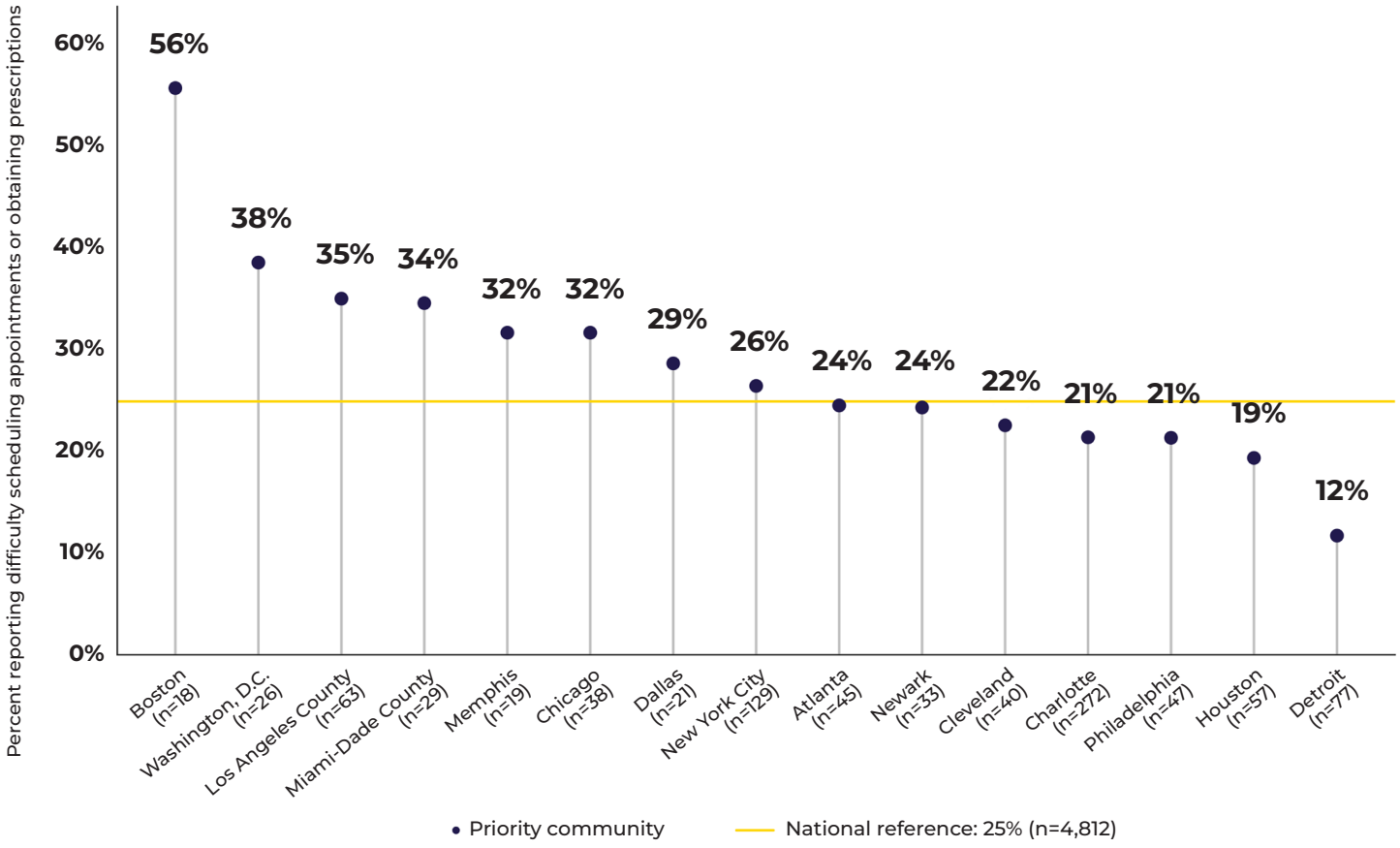
These findings suggest that the presence of one type of neighborhood asset does not guarantee access to others and shape how residents experience convenience, health, and opportunity where they live.

HEALTH SYSTEM USABILITY AND TRUST

Managing a chronic health condition requires consistent, timely access to medical care. This analysis examines the experience of individuals living with at least one chronic health condition in one of the 15 priority communities, with comparisons to the national sample. Particularly, the ability to manage chronic health conditions can be complicated by experiencing issues with scheduling medical appointments, accessing prescriptions, and navigating perceptions of how well health care providers understand the cultural needs of a community.

Nationally, three out of four respondents living with at least one chronic health condition reported no difficulty scheduling appointments or obtaining prescriptions, suggesting that for most, healthcare systems are accessible. Overall, this finding was consistent across the 15 priority communities. However, notable exceptions exist. For example, in Boston, MA, over half of the respondents who reported living with a chronic health condition also reported difficulties with scheduling appointments or getting prescriptions. These findings suggest that even in cities with strong healthcare infrastructure, navigating the system and accessing care can remain significant barriers for residents managing ongoing health needs.

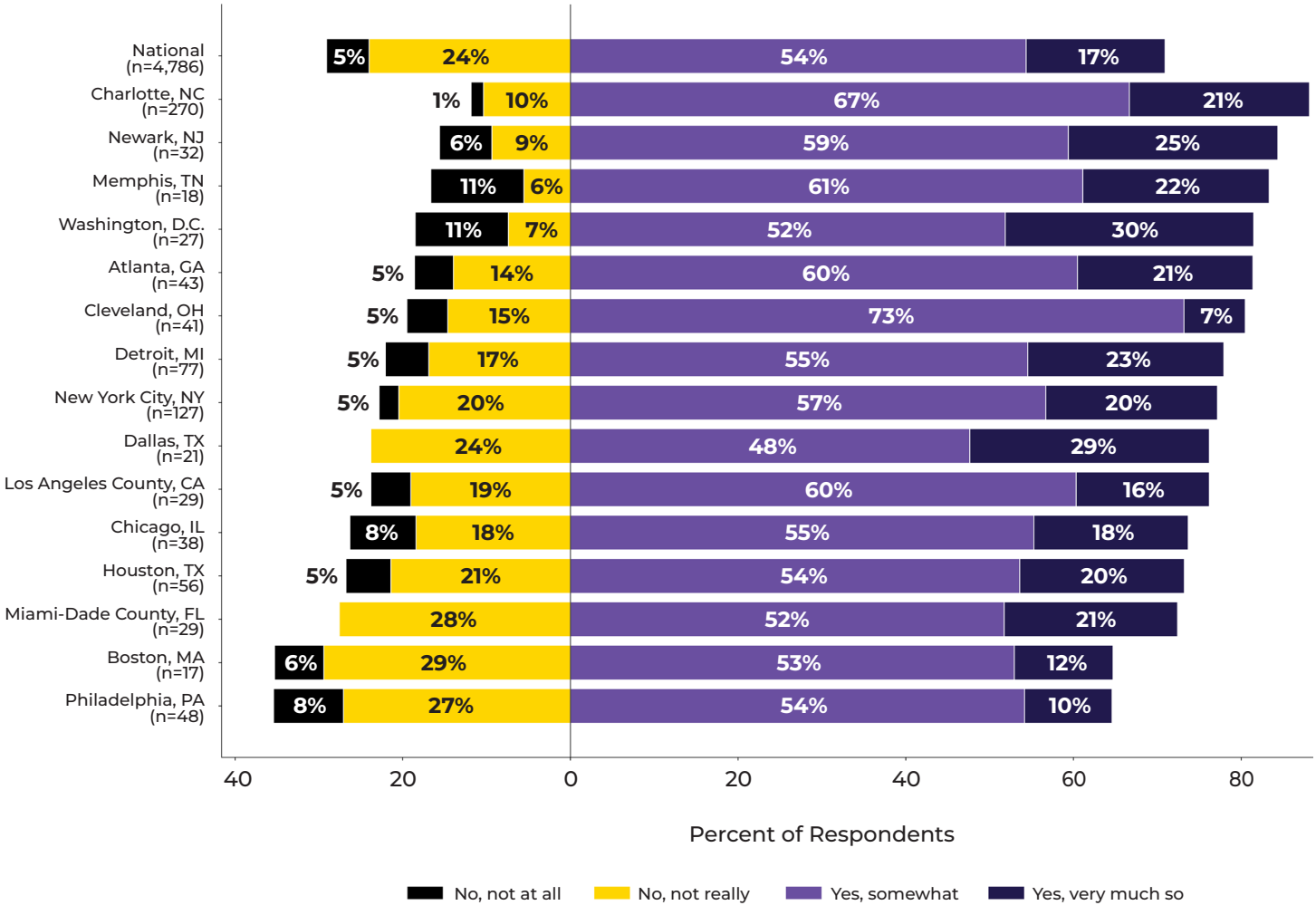
FIGURE 7.2 APPOINTMENT AND PRESCRIPTION ACCESS FOR RESPONDENTS WITH CHRONIC HEALTH CONDITIONS BY PRIORITY COMMUNITY



Note: Percent reflects respondents living with at least one chronic health condition who reported difficulty scheduling appointments or obtaining prescriptions.

While most respondents manage chronic health conditions and reach and schedule care, many remain uncertain about how deeply their providers understand their lived experiences. Nationally, seven in ten respondents (71%) said their healthcare providers understand their cultural needs "somewhat" or "very much so," but only 17% felt that understanding was strong. Across cities, perceptions varied. For instance, in Charlotte, NC, and Detroit, MI, more than three-quarters of respondents managing chronic illness felt their providers demonstrated cultural understanding, suggesting trust-based relationships may enhance long-term engagement in care. By contrast, residents in Boston, MA, Philadelphia, PA, and Cleveland, OH, were more likely to say their providers "not really" or "not at all" understood their culture, underscoring persistent disconnects in how care is experienced across communities.

FIGURE 7.3 PERCEPTIONS OF PROVIDERS' UNDERSTANDING OF CULTURAL NEEDS FOR RESPONDENTS WITH CHRONIC HEALTH CONDITIONS BY PRIORITY COMMUNITY



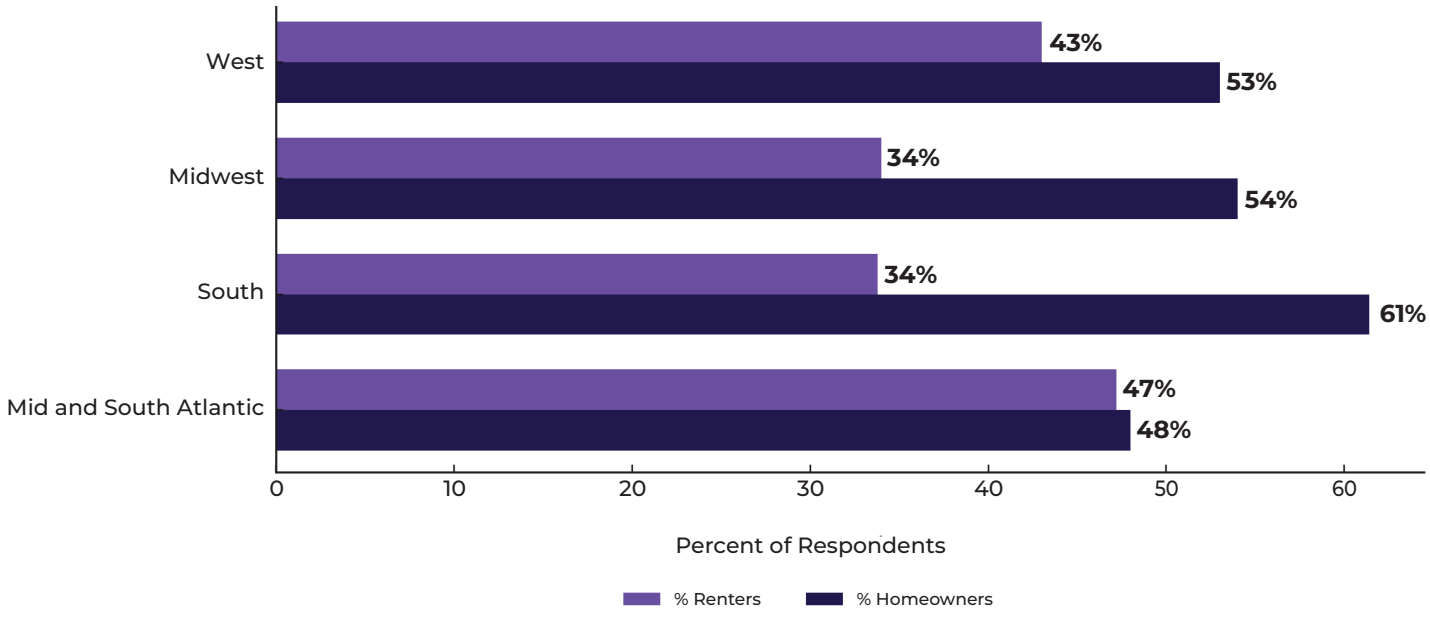
Note: Percent reflects respondents living with at least one chronic health condition. Responses indicate whether providers understand respondents' cultural needs.

HOUSING STABILITY AND NEIGHBORHOOD QUALITY

Stable, affordable housing is the foundation for physical and mental health. Across the fifteen priority communities, residents' experiences with housing affordability and neighborhood infrastructure reveal how place-based inequities continue to shape health outcomes. In the analysis that follows, examinations of housing arrangements by region, perceptions of air and water quality, and ways respondents connect to the internet shape how local infrastructure, geography, and historical investment patterns shape day-to-day living conditions.

Nationally, about two-thirds of respondents (67%) were homeowners, while almost one-third (30%) were renters. However, when viewed by region, distinct patterns emerge that mirror broader housing and affordability trends across the United States.

FIGURE 7.4 HOUSING ARRANGEMENTS BY REGION: HOMEOWNERSHIP VERSUS RENTING



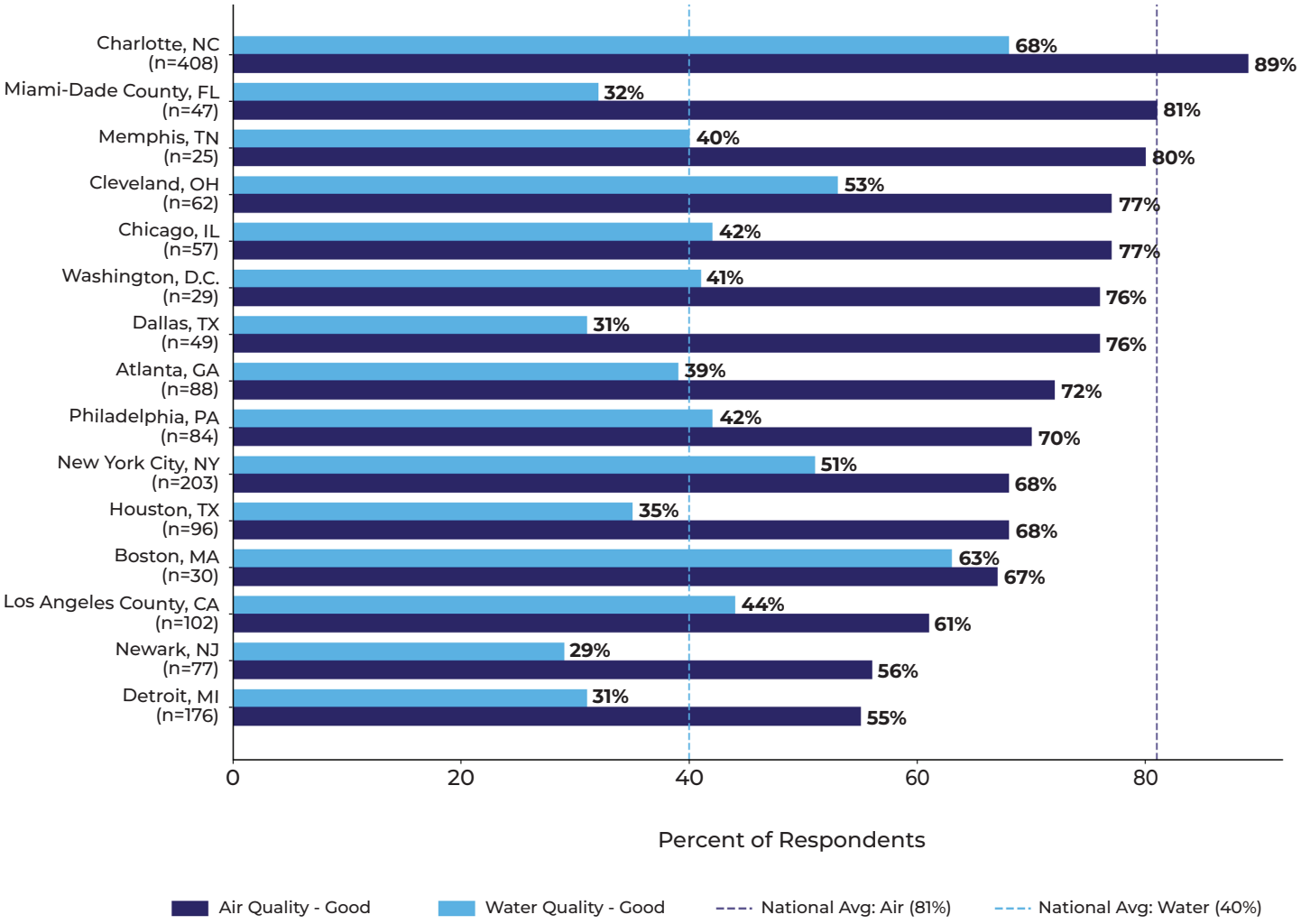
Respondents from Mid and South Atlantic cities, which include major East Coast and Southeastern urban areas like New York City, NY, Newark, NJ, Philadelphia, PA, Washington, D.C., and Miami-Dade County, FL, reported nearly equal rates of homeownership and renting (48% homeowners and 47% renters), distinguishing this region from others where homeownership more clearly exceeds renting. This pattern likely reflects the high housing costs and dense urban housing markets that characterize many East Coast and coastal communities.

By contrast, respondents from the South (i.e., Atlanta, GA, Charlotte, NC, Dallas, TX, Houston, TX, and Memphis, TN), and Midwest (i.e., Chicago, IL, Cleveland, OH, and Detroit, MI), reported higher rates of homeownership, consistent with these regions' lower cost of living and greater housing availability. The West, represented here primarily by Los Angeles County, CA, tracked closely with national averages, underscoring the variation within coastal markets. Overall, these results suggest that homeownership remains deeply shaped by geography, affordability, and access, with residents in more expensive urban centers facing barriers to buying and retaining homes.

PERCEIVED ENVIRONMENTAL QUALITY

Perceptions of environmental quality vary widely across the fifteen priority communities, reflecting how local infrastructure, geography, and historical investment patterns shape day-to-day living conditions. Nationally, most respondents rated their air quality (81%) and water quality (40%) as good, but these averages mask sharp contrasts among cities.

FIGURE 7.5 PERCEPTIONS OF AIR AND WATER QUALITY BY PRIORITY COMMUNITY



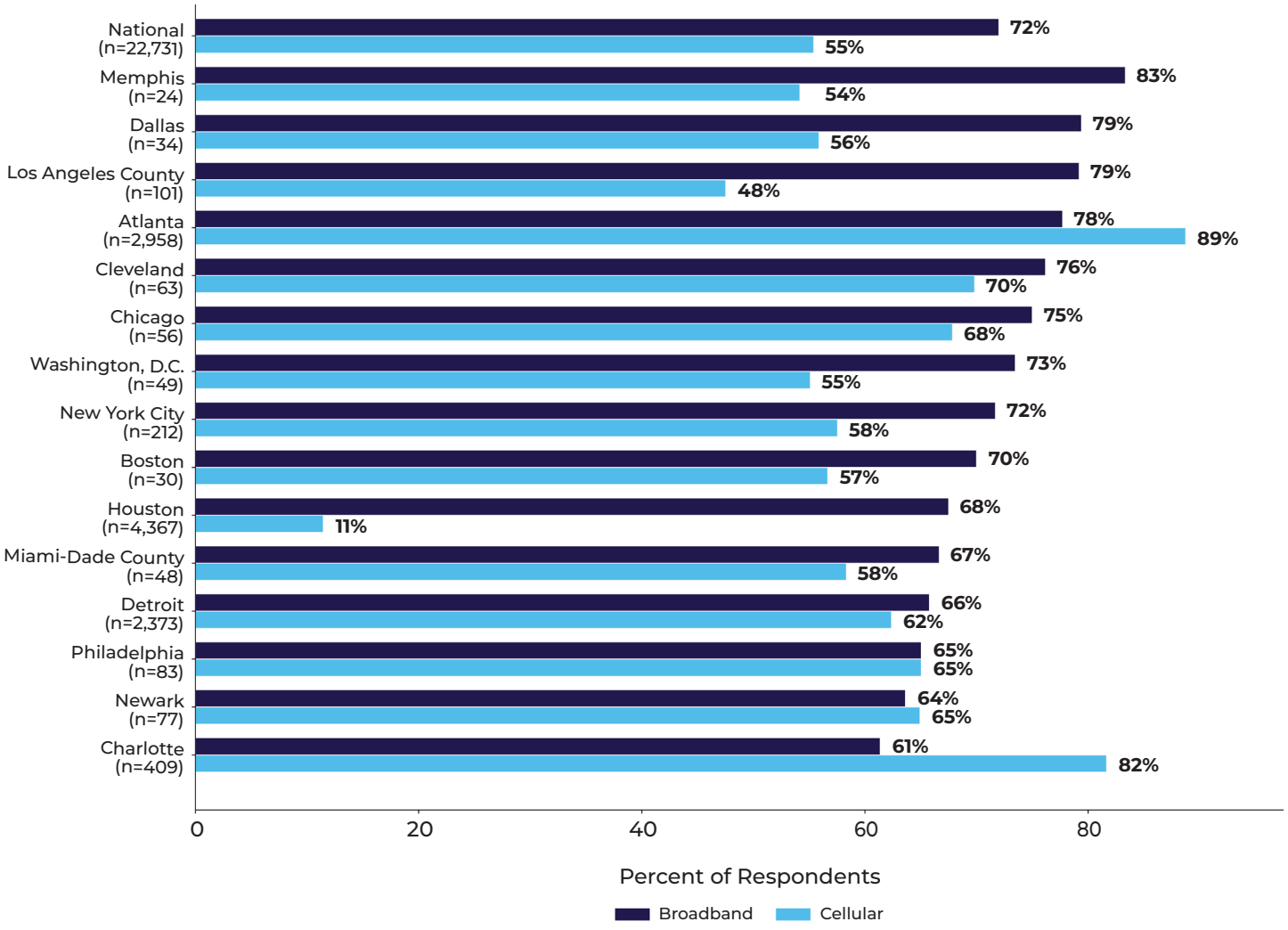
Charlotte, NC, stood out as a positive outlier, with nearly nine in ten respondents (89%) who rated their air quality as good, and two-thirds (68%) said the same for water quality, exceeding national levels. In contrast, residents in Newark, NJ, and Detroit, MI, expressed far lower satisfaction. In Newark, NJ, respondents who rated their air or water quality as poor were concentrated in zip codes 07104, 07112, and 07108, spanning neighborhoods such as Lower Broadway, Weequahic, and Clinton Hill. Historically, these areas have been burdened by industrial corridors and aging water infrastructure. Yet residents in these same zip codes also appeared among those reporting positive environmental conditions, signaling that there may be some improvement efforts reaching pockets of these neighborhoods.

A similar pattern emerged in Detroit, MI, where respondents in zip codes such as 48235, 48214, and 48224 appeared among both those reporting good and those reporting poor environmental quality. Residents in Northeast Detroit (e.g., zip codes 48205, 48213, and 48238) were more likely to report poor conditions, aligning with long-term disinvestment, older housing stock, and proximity to industrial sites. In contrast, respondents from Southwest and Northwest neighborhoods, including those in zip codes 48209, 48219, and 48223, were more likely to rate their air and water quality positively, reflecting areas with newer housing, more green space, and lower industrial exposure.

While respondents in both Newark, NJ, and Detroit, MI, reported evidence of progress, their perceptions of air purity and water reliability revealed close alignment with historical patterns of underinvestment. Achieving equitable environmental health will require localized attention to infrastructure renewal, pollution mitigation, and housing stability to ensure that progress is evenly felt across all neighborhoods, not just those already experiencing revitalization.

In addition, reliable internet access is a foundational component of health and economic opportunity. Nationally, 72% of respondents reported access to broadband internet, and 55% reported access through cellular connections. While this shows that most households have access to high-speed connections, it also highlights that 25 to 30% of households rely on slower, less stable, or public connections. As such, a digital divide could possibly shape how respondents access telehealth appointments, education, and employment. While most respondents reported access to broadband or cellular internet, the stability and quality of that access differ by geography.

FIGURE 7.6 INTERNET CONNECTIVITY TYPES BY PRIORITY COMMUNITY



Note: Percent reflects respondents reporting access to each internet connectivity type. Broadband indicates more stable high-speed connections; cellular indicates mobile acce

Respondents in Memphis, TN, Dallas, TX, and Los Angeles County, CA, reported the highest broadband connectivity rates. These areas exceeded the national average, suggesting stronger infrastructure coverage. In contrast, slightly less than two-thirds of respondents in Charlotte, NC, reported broadband access and heavier reliance on cellular connections. Atlanta, GA, respondents also reported a heavy reliance on cellular internet connections; however, their report of broadband connectivity was similar to the national average.

EMERGING NEEDS AND OPPORTUNITIES

The findings reveal a layered picture of inequity and opportunity across communities. Residents in cities where they reported longer travel times to everyday resources often also showed lower levels of broadband access, suggesting that residents in these neighborhoods face compounded barriers to both physical and digital infrastructure. Additionally, the data underscore that physical access alone does not guarantee equitable care. In several cities, respondents expressed concerns about whether their healthcare providers understood their cultural backgrounds or communication needs. This dimension of trust and usability points to a structural challenge that extends beyond coverage and location. Even where clinics and hospitals are available, gaps in cultural understanding can discourage residents from seeking care or following through on treatment, particularly in places where health systems have not historically served all communities equitably. Regional differences in affordability and environmental quality further complicate this landscape. The contrast between higher homeownership rates in southern and midwestern cities and lower rates in coastal regions highlights how the cost of living, housing availability, and infrastructure investments continue to shape neighborhood stability. Likewise, perceptions of air and water quality indicate that environmental progress remains uneven, with cities like Charlotte and Cleveland outperforming industrial centers such as Newark and Detroit.

Overall, these patterns suggest that health equity cannot be addressed through any single system or sector. Efforts to strengthen neighborhoods must weave together investments in housing, infrastructure, and healthcare. By doing so, cities can move toward a more integrated vision of community health, where residents not only have access to resources but also trust and benefit from them.

To provide additional place-based context, the Cross-Cutting Insights section also includes city addenda that present city-specific findings alongside the national results. These addenda are organized by tier, with cities listed alphabetically within each tier. Each city addendum includes a narrative summary of key patterns observed in the data, followed by supporting demographic and topical analyses.

CITY ADDENDA

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CLEVELAND, OH

Respondents in Cleveland, OH, completed the survey online. Respondents were predominantly Black and mostly women, with representation across young, middle-aged, and older adults. Educational attainment was high, with nearly four in five residents reporting a bachelor's degree or higher. While most respondents reported no difficulties with daily functioning, a notable portion described challenges with walking or climbing stairs and difficulty concentrating. These patterns suggest that although the sample is highly educated, some residents experience functional limitations that may affect their navigation of neighborhood and health care environments.

Compared with national data, Cleveland residents had stronger immediate access to green space, with more respondents living within a five-minute walk than in the national sample. However, Cleveland had a higher share of residents reporting no nearby green space, indicating uneven availability across neighborhoods. Grocery access was nearly identical to national patterns, but residents reported slightly less access to nearby pharmacies and hospitals. Cleveland respondents also experienced high levels of chronic health conditions and some difficulty securing timely appointments. A portion of residents felt that providers did not fully understand their cultural background, suggesting gaps in cultural alignment within the health system.

To address these patterns, Cleveland, OH, could benefit from investments that expand access to essential resources in neighborhoods where gaps persist, particularly in areas lacking green space and nearby medical services. Enhancing transportation options, including reliable routes to pharmacies and health care facilities, may help residents who experience mobility or concentration challenges. Community-based chronic disease programs and culturally responsive care initiatives could strengthen trust and improve health management. These targeted strategies reflect Cleveland's specific needs and can promote healthier, more accessible neighborhoods across the city.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	63	100%
Main (paper)	-	-
Total Respondents	**63**	

RACIAL OR ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	63	100%
American Indian or Alaska Native	-	-
Asian	-	-
Black or African American	55	87%
Hispanic or Latino	-	-
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	4	6%
Native Hawaiian or Pacific Islander	-	-
White	3	5%
Prefer not to answer	1	2%
Total Respondents	**63**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	15	27%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	41	73%
Prefer not to answer	-	-
Total Respondents	**56**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	2	3%
25 – 40	17	27%
41 – 50	15	24%
51 – 60	10	16%
61 – 70	12	19%
71 and over	7	11%
Prefer not to answer	-	-
Total Respondents	**63**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	2	3%
Gay	-	-
Heterosexual or straight	54	87%
Lesbian	1	2%
Prefer to self-describe	3	5%
Prefer not to answer	2	3%
Total Respondents	**62**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	3	5%
$20,000 – $39,999	11	17%
$40,000 – $59,999	7	11%
$60,000 – $79,999	10	16%
$80,000 – $99,999	4	6%
$100,000 or more	24	38%
Prefer not to answer	4	6%
Total Respondents	**63**	

HIGHEST EDUCATION COMPLETED

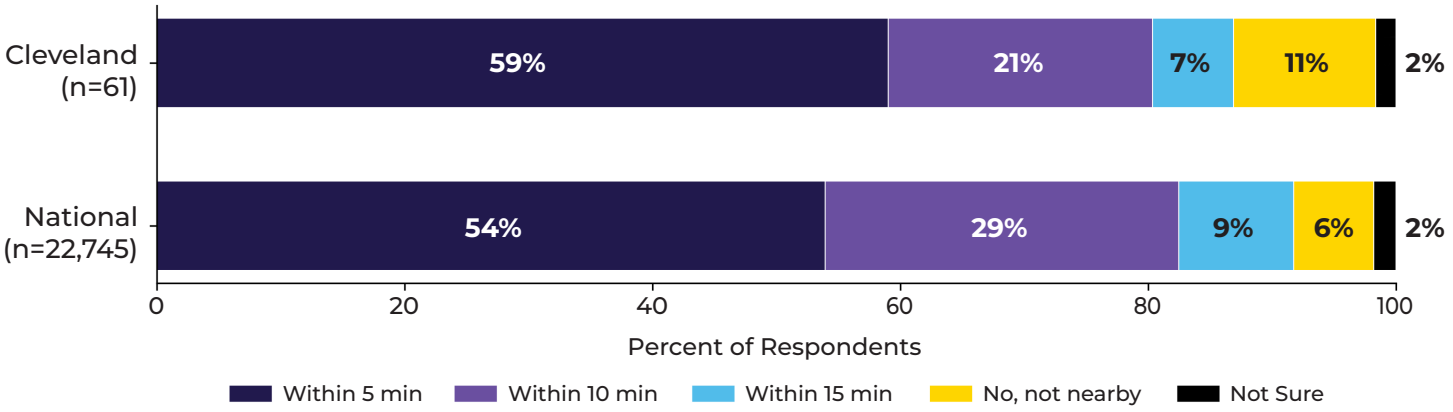
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	2	3%
Some college	12	19%
Bachelor's degree	25	40%
Graduate degree or higher	24	38%
Prefer not to answer	-	-
Total Respondents	**63**	

DIFFICULTIES WITH ACTIVITIES

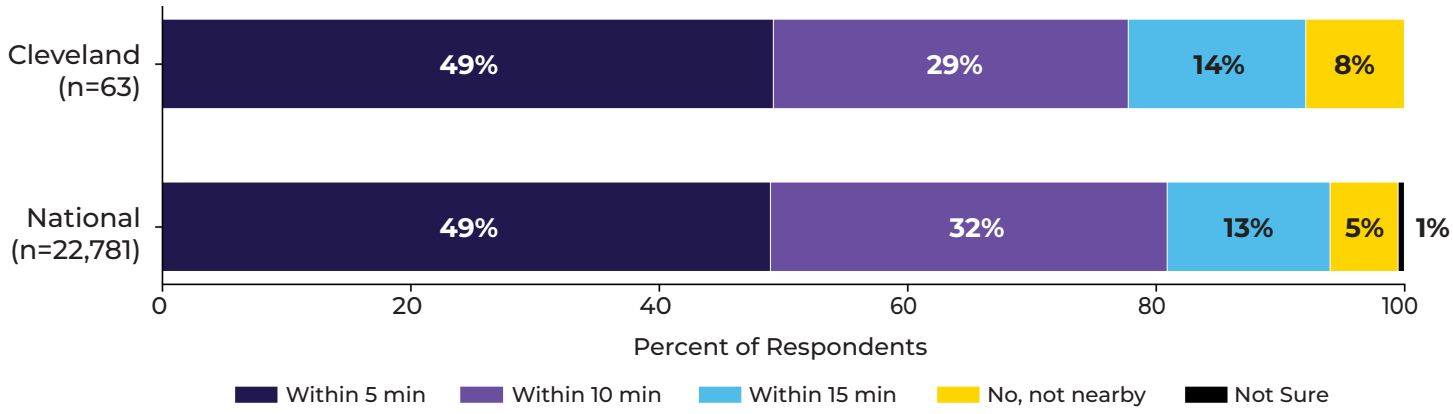
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	4	7%
Seeing, even with glasses	2	3%
Walking or climbing stairs	12	20%
Dressing or bathing	1	2%
Using the toilet	1	2%
None of the above	41	69%
Prefer not to answer	-	-
Concentrating or remembering	10	17%
***Total Respondents**	**59**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

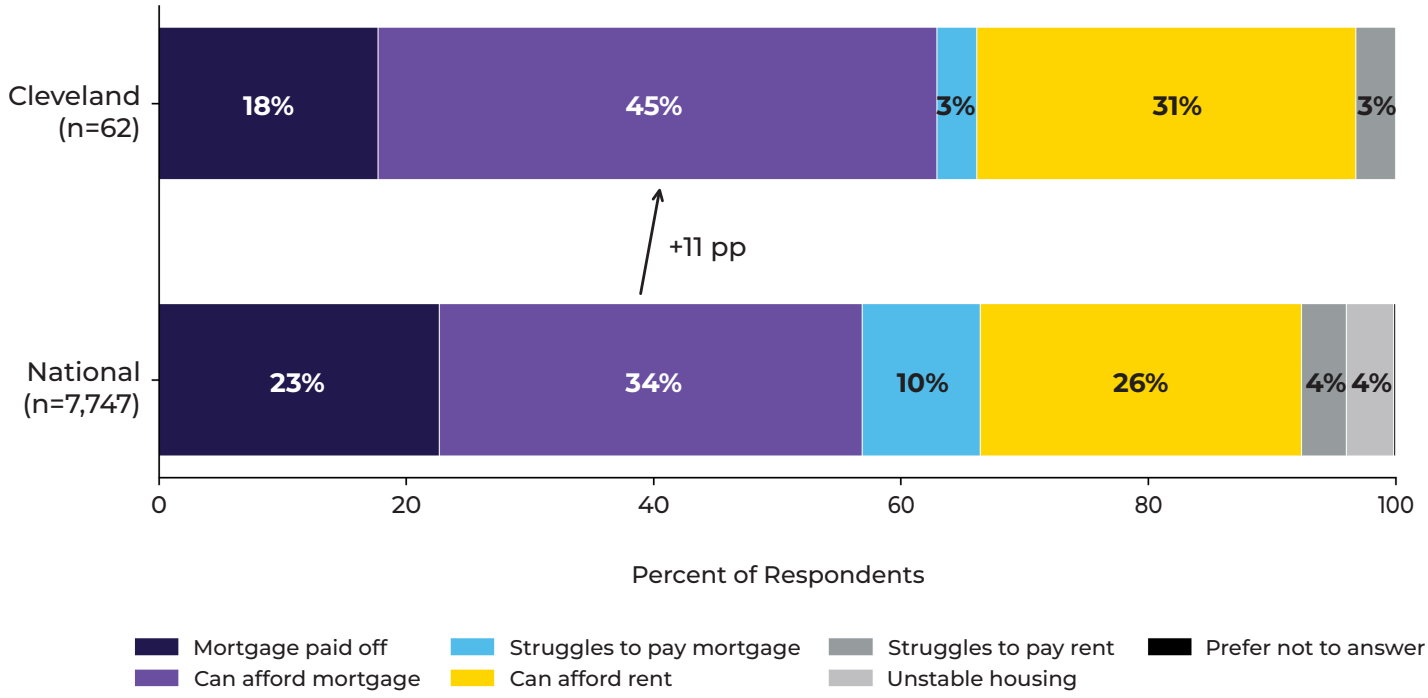
Green Space Access — National vs Cleveland



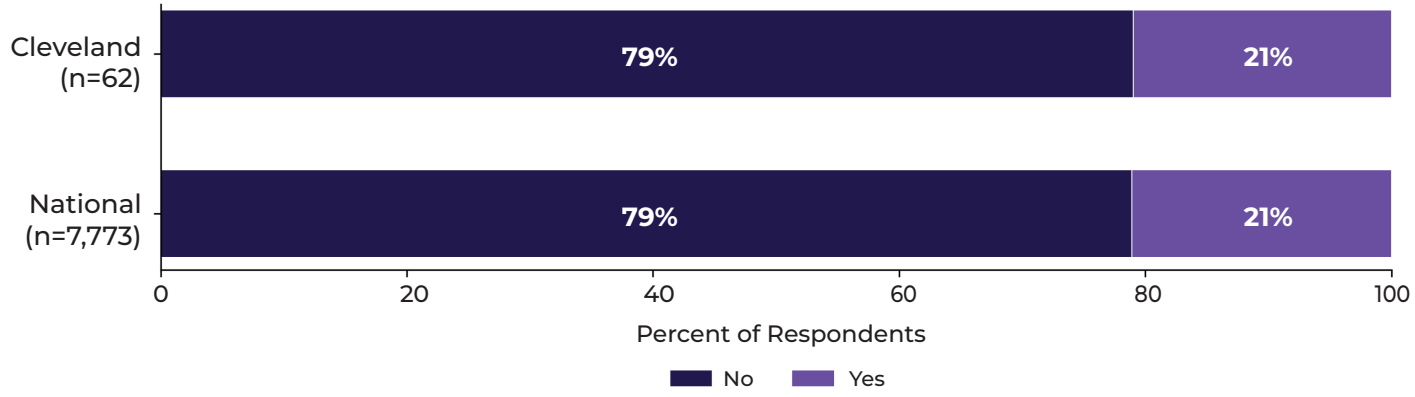
Grocery Store Access — National vs Cleveland



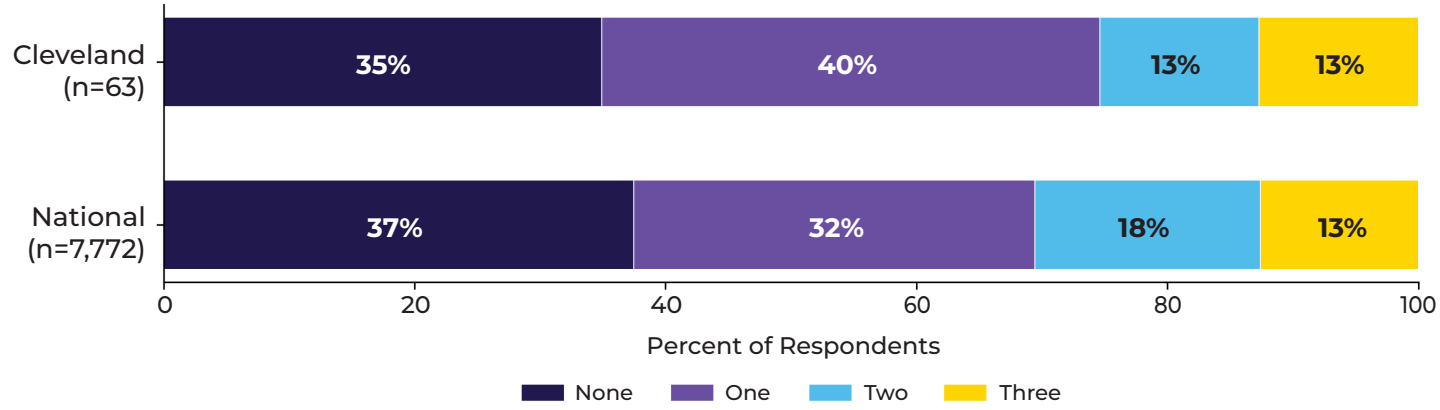
Housing Arrangements — National vs Cleveland



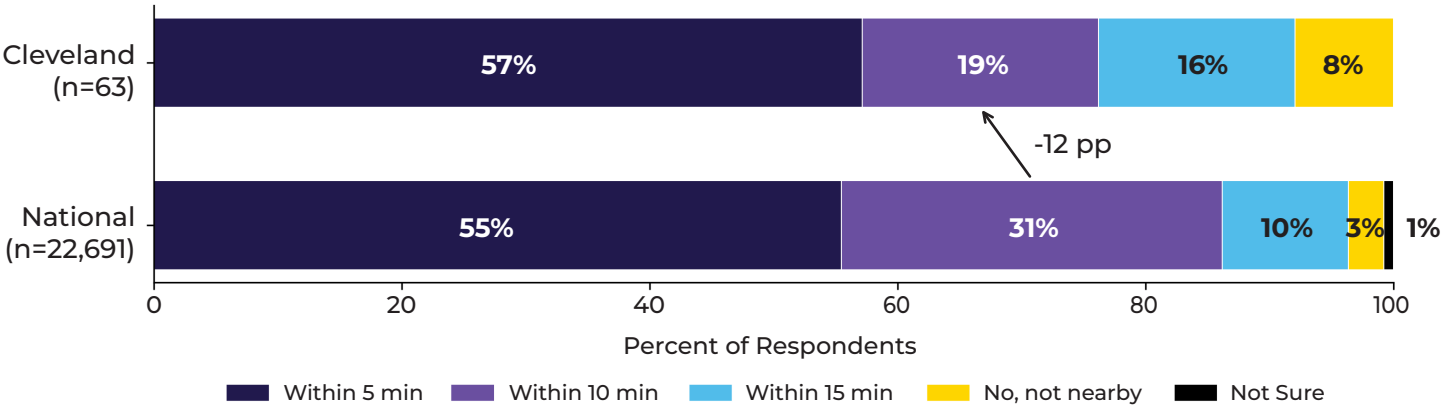
Issues Accessing Appointments or Prescriptions — National vs Cleveland



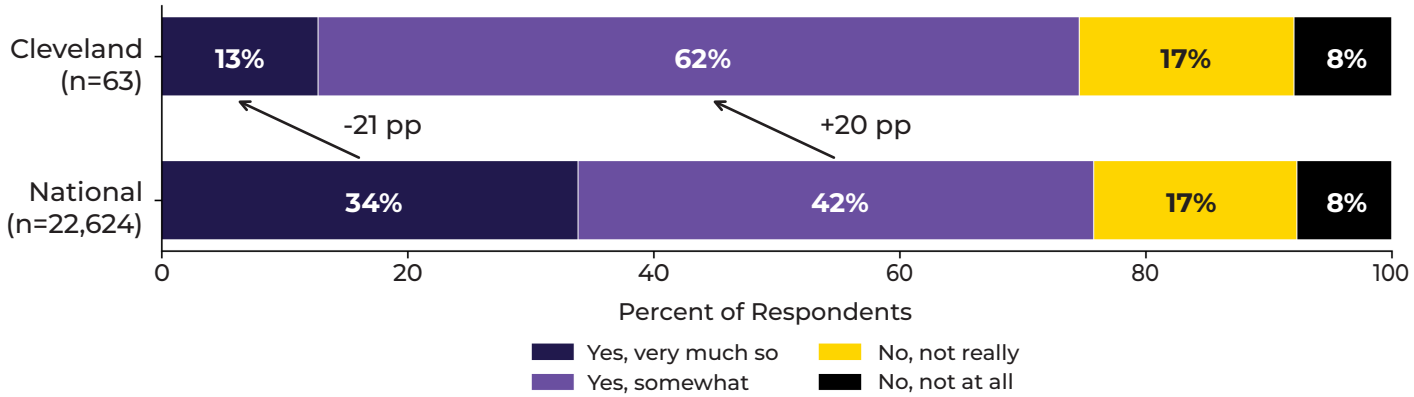
Chronic Health Conditions — National vs Cleveland



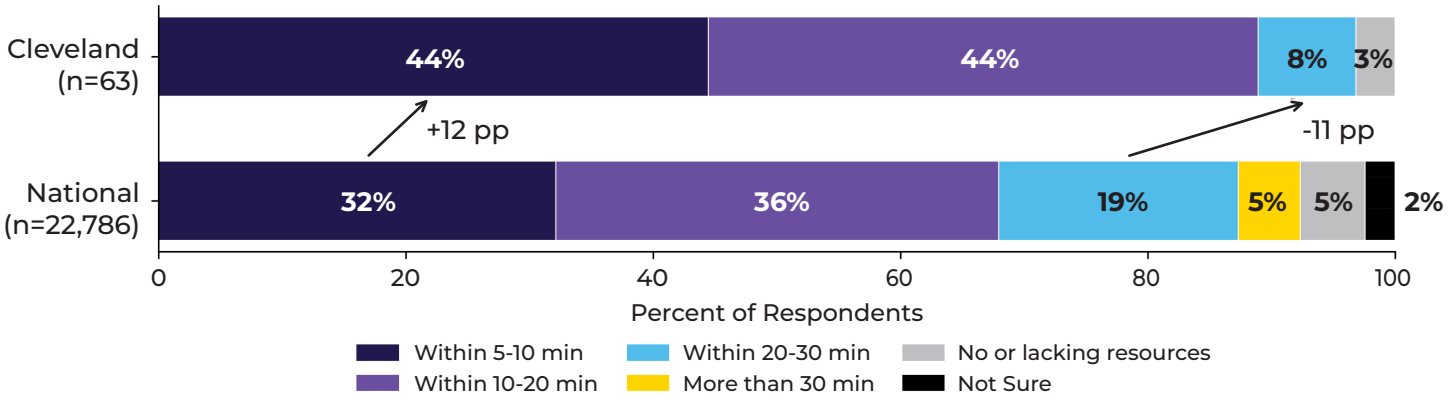
Pharmacy Proximity — National vs Cleveland



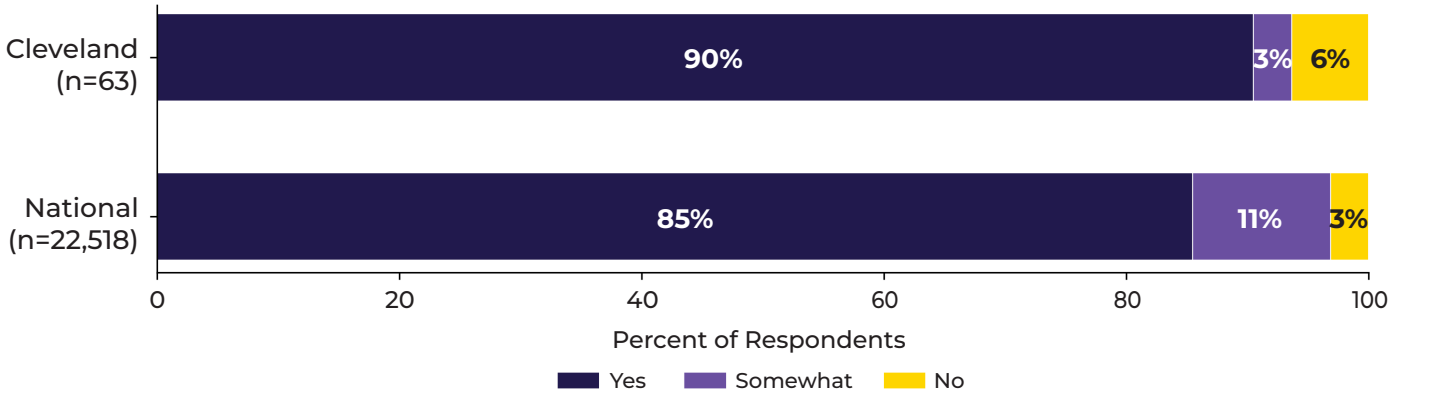
Perceived Cultural Understanding of Providers — National vs Cleveland



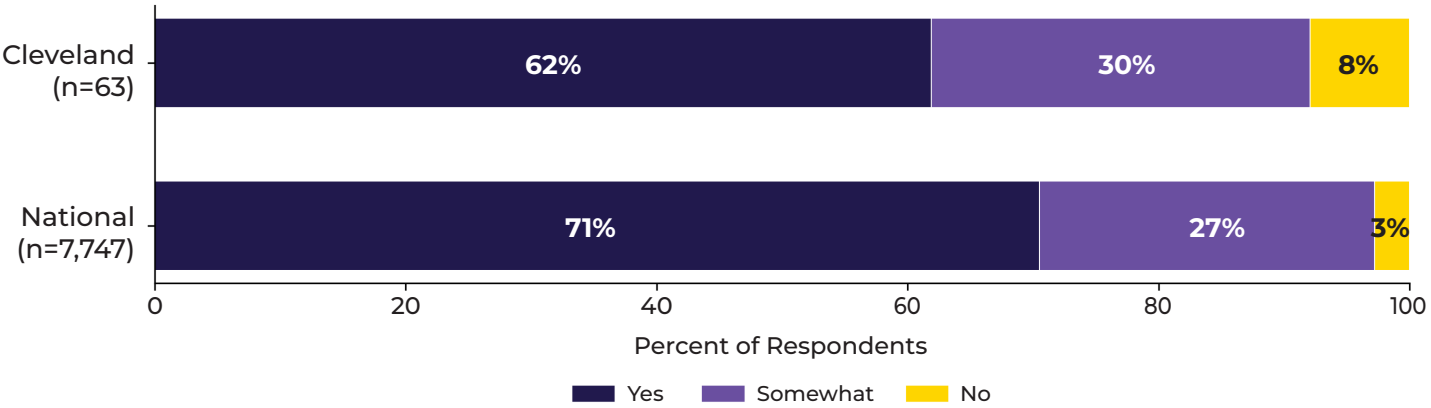
Proximity to a Quality Hospital — National vs Cleveland



Access to Affordable and Reliable Transportation — National vs Cleveland



Perceived Neighborhood Safety — National vs Cleveland



HOUSTON, TX

Respondents from Houston, TX, completed the survey in various formats, including the canvasser, leave-behind, and online versions. Neighborhood canvassing data collection targeted historically Black neighborhoods throughout the metropolitan area. However, across all survey modes, only respondents whose addresses are located in Houston, TX, are included in the analyses in the Houston, TX, addenda.

Houston, TX, respondents reported neighborhoods with both strong assets and persistent gaps in access to key resources. The sample was predominantly Black, evenly split by gender, and with a wide age distribution. Educational attainment was high, with more than two-thirds of respondents holding a bachelor's or graduate degree. Most residents did not report difficulties with daily activities, yet their experiences with neighborhood amenities revealed varying access to green space, grocery stores, and stable housing. These patterns point to structural differences across communities that can influence health and day-to-day well-being.

Compared with national results, Houston, TX, residents reported greater access to grocery stores, green spaces, hospitals, and pharmacies within a short walking distance. At the same time, perceptions of neighborhood safety were lower than national averages, and a larger share of respondents reported chronic health conditions.

Notably, Houston respondents were slightly more likely than respondents nationally to report that their health care providers understood their cultural background. This suggests an existing foundation of culturally responsive care that can be leveraged in comparable large, racially diverse metropolitan areas and in neighborhoods facing safety concerns and chronic disease burden. Specifically, culturally responsive provider practices may help strengthen trust, improve continuity of care, and support engagement in prevention and chronic disease management—even in environments where structural stressors persist. These findings point to opportunities for scaling culturally grounded approaches across similar urban contexts rather than treating them as isolated strengths.

The findings highlight several opportunities for investment and policy action. Expanding affordable transportation options, increasing the availability of nutritious food retailers, and improving neighborhood safety could support healthier and more stable environments. Strengthening partnerships between health systems and community organizations may also expand access to preventive care and culturally aligned services. Targeted efforts in neighborhoods with the greatest gaps can help reduce disparities and enhance the overall quality of life for Houston, TX, residents.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	4,380	98%
Leave Behind	3	<1%
Main (online)	95	2%
Main (paper)	-	-
Total Respondents	**4,478**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	19	<1%
Asian	32	1%
Black or African American	3,540	80%
Hispanic or Latino	542	12%
Middle Eastern or North African	54	1%
Multiracial and/or Multiethnic	60	1%
Native Hawaiian or Pacific Islander	-	-
White	190	4%
Prefer not to answer	3	<1%
Total Respondents	**4,440**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	1	<1%
Man	2,197	50%
Non-binary/gender non-conforming	-	-
Transgender	7	<1%
Woman	2,202	50%
Prefer not to answer	2	<1%
Total Respondents	**4,409**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	2	<1%
18 – 24	424	10%
25 – 40	1,393	32%
41 – 50	856	19%
51 – 60	814	18%
61 – 70	665	15%
71 and over	258	6%
Prefer not to answer	6	<1%
Total Respondents	**4,418**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	2	2%
Gay	2	2%
Heterosexual or straight	86	91%
Lesbian	-	-
Prefer to self-describe	1	1%
Prefer not to answer	4	4%
Total Respondents	**95**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	4	4%
$20,000 – $39,999	9	9%
$40,000 – $59,999	11	11%
$60,000 – $79,999	13	13%
$80,000 – $99,999	15	15%
$100,000 or more	30	31%
Prefer not to answer	15	15%
Total Respondents	**97**	

HIGHEST EDUCATION COMPLETED

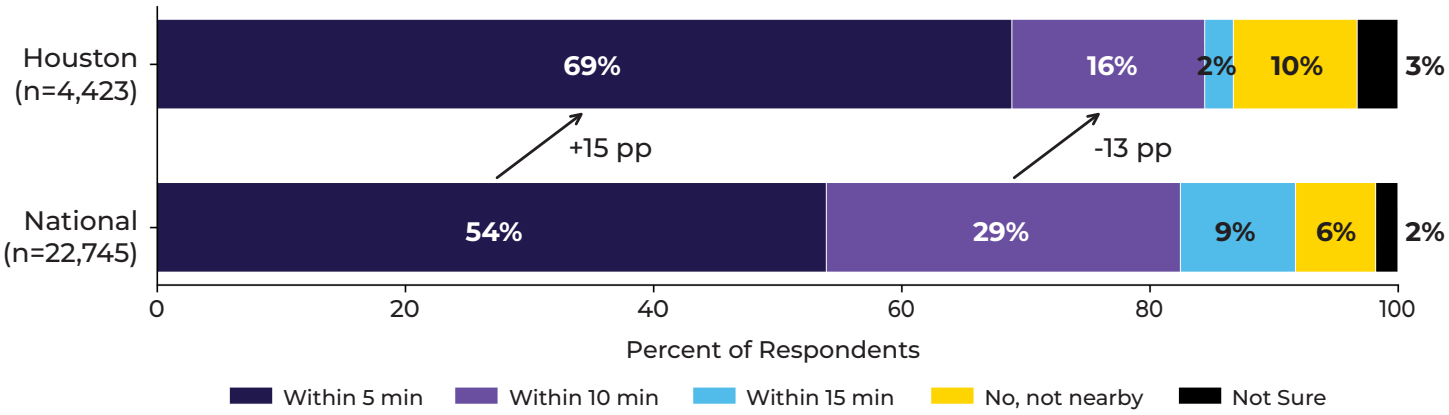
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	4	4%
Some college	20	21%
Bachelor's degree	28	29%
Graduate degree or higher	42	44%
Prefer not to answer	2	2%
Total Respondents	**96**	

DIFFICULTIES WITH ACTIVITIES

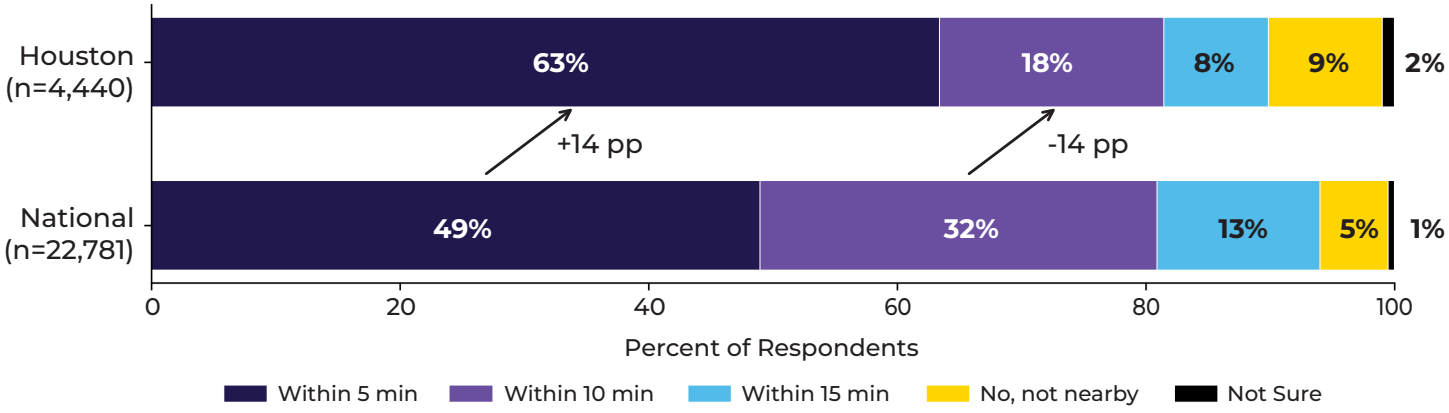
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	3	3%
Seeing, even with glasses	10	10%
Walking or climbing stairs	13	14%
Dressing or bathing	3	3%
Using the toilet	1	1%
None of the above	70	73%
Prefer not to answer	2	2%
Concentrating	7	7%
***Total Respondents**	**96**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

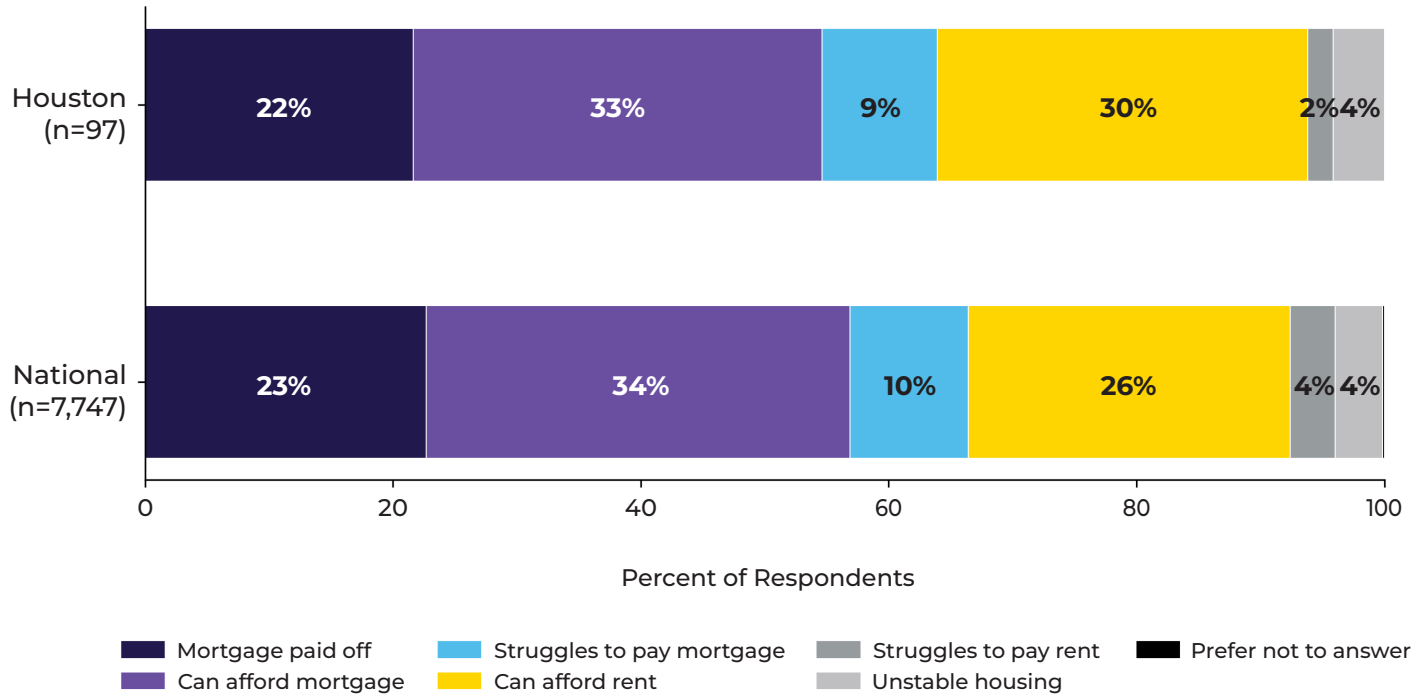
Green Space Access — National vs Houston



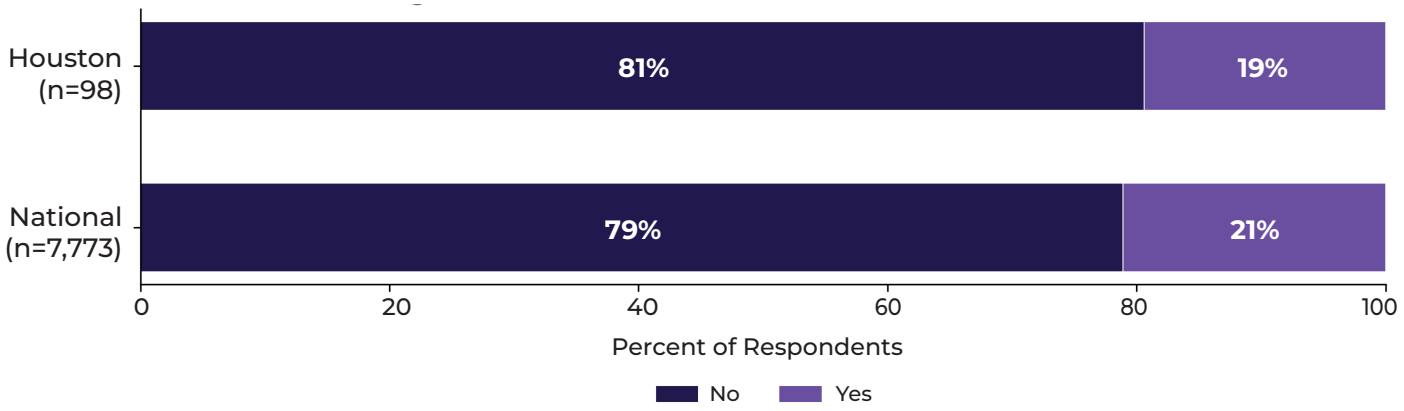
Grocery Store Access — National vs Houston



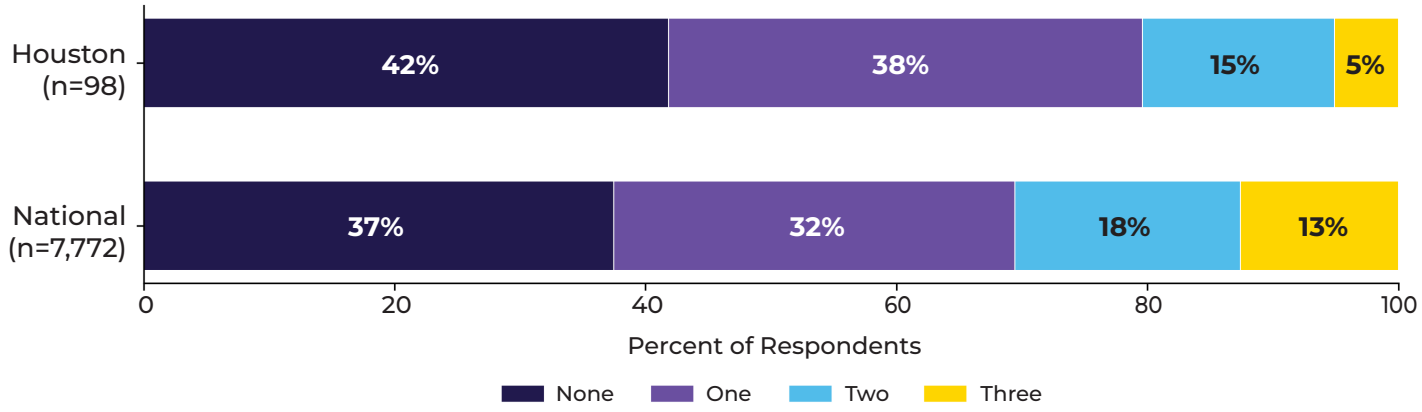
Housing Arrangements — National vs Houston



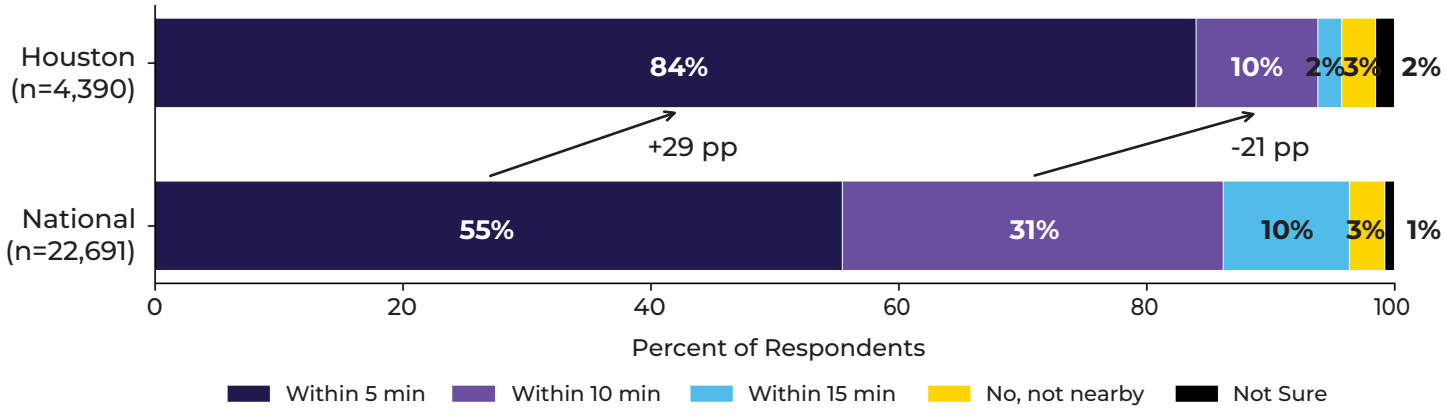
Issues Accessing Appointments or Prescriptions — National vs Houston



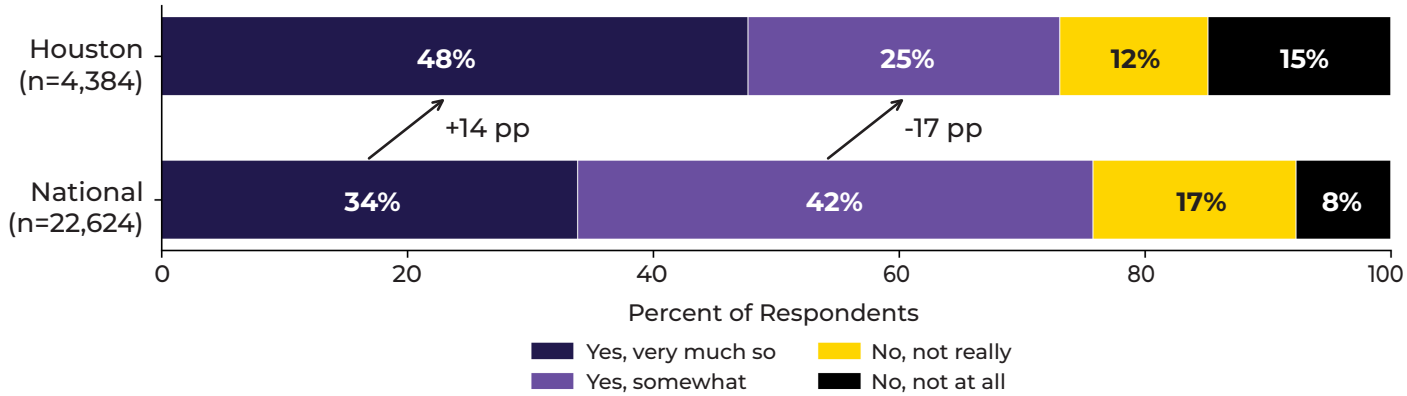
Chronic Health Conditions — National vs Houston



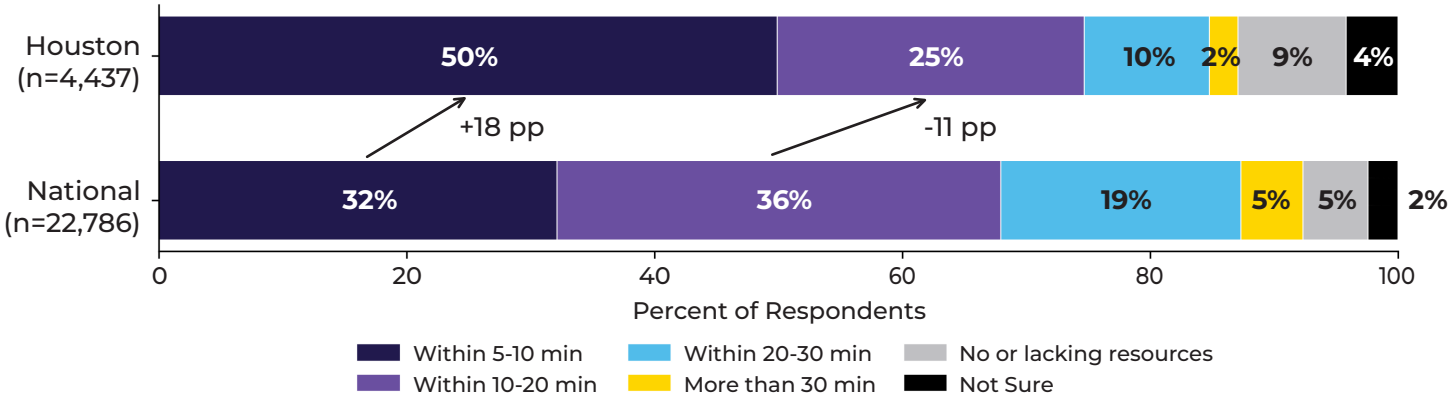
Pharmacy Proximity — National vs Houston



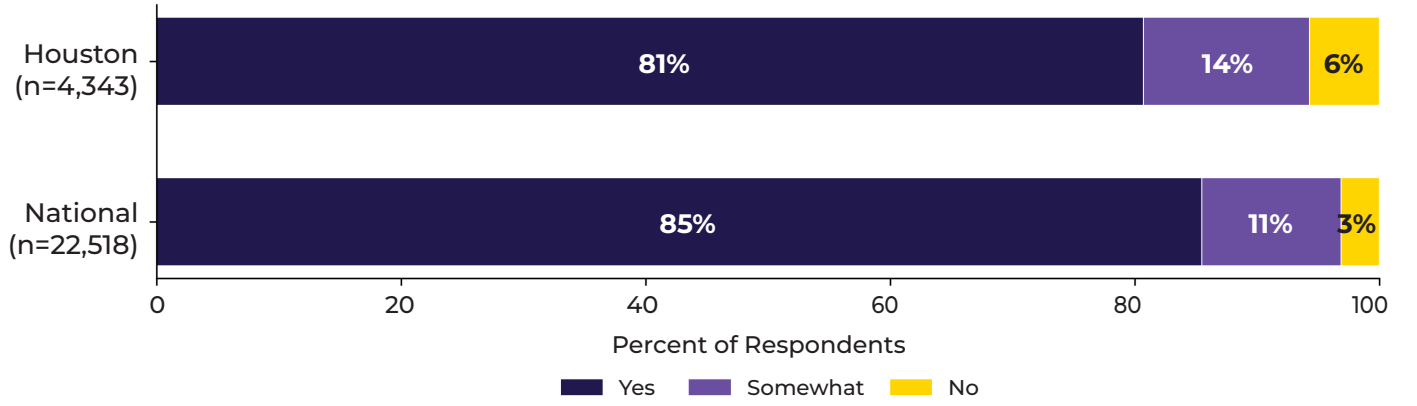
Perceived Cultural Understanding of Providers — National vs Houston



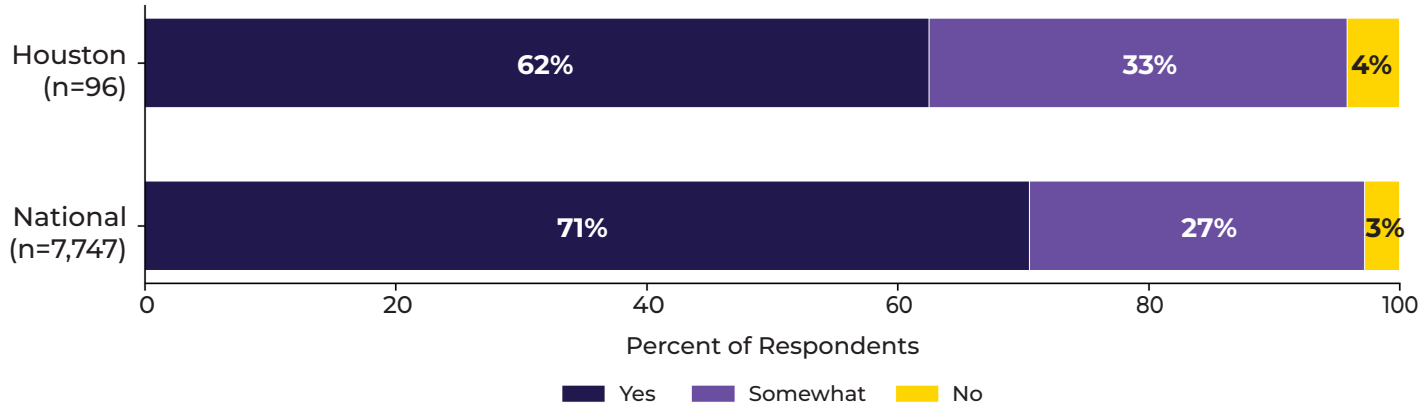
Proximity to a Quality Hospital — National vs Houston



Access to Affordable and Reliable Transportation — National vs Houston



Perceived Neighborhood Safety — National vs Houston



LOS ANGELES COUNTY, CA

Respondents in Los Angeles County, CA, completed the survey online. Residents of Los Angeles County, CA, described neighborhoods with both notable strengths and clear resource gaps. The sample was largely Black, predominantly women, and spanned a wide age range, with most respondents between 51 and 70 years old. Educational attainment was high, with more than two-thirds reporting at least a bachelor's degree. While most respondents did not report difficulty with daily activities, nearly one-third experienced challenges with walking or climbing stairs. These demographic patterns provide important context for understanding how residents navigate their neighborhoods and health systems.

Compared with national results, Los Angeles County respondents reported greater access to grocery stores and similar access to green spaces within a short travel distance. However, respondents from Los Angeles County, CA, were more likely to rent their homes and afford their rent than the national sample. They also reported slightly less nearby access to pharmacies and hospitals, which may affect timely care-seeking and chronic disease management. Neighborhood safety perceptions were slightly lower than national patterns, and a larger share of respondents reported chronic health conditions. Although some residents felt their health care providers understood their cultural background, this sentiment was less consistent than in other locations, indicating opportunities to strengthen culturally aligned care.

These findings point to several policy and investment priorities for Los Angeles County, CA. Expanding reliable transportation options, increasing access to nutritious foods, and improving the availability of green spaces can support healthier neighborhood environments. Partnerships between community-based organizations and health systems can help address chronic health needs and improve cultural responsiveness in clinical settings. Investments focused on mobility, access, and trust-building may strengthen the overall well-being of residents across Los Angeles County, CA.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	102	100%
Main (paper)	-	-
Total Respondents	**102**	

RACIAL OR ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	1	1%
Asian	2	2%
Black or African American	70	69%
Hispanic or Latino	3	3%
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	7	7%
Native Hawaiian or Pacific Islander	-	-
White	8	8%
Prefer not to answer	10	10%
Total Respondents	**101**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	10	14%
Non-binary/gender non-conforming	2	3%
Transgender	1	1%
Woman	58	78%
Prefer not to answer	3	4%
Total Respondents	**74**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	4	4%
25 – 40	4	4%
41 – 50	11	11%
51 – 60	25	25%
61 – 70	36	36%
71 and over	18	18%
Prefer not to answer	3	3%
Total Respondents	**101**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	1	1%
Gay	3	3%
Heterosexual or straight	85	83%
Lesbian	1	1%
Prefer to self-describe	1	1%
Prefer not to answer	11	11%
Total Respondents	**102**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	9	9%
$20,000 – $39,999	11	11%
$40,000 – $59,999	8	8%
$60,000 – $79,999	11	11%
$80,000 – $99,999	11	11%
$100,000 or more	30	30%
Prefer not to answer	20	20%
Total Respondents	**100**	

HIGHEST EDUCATION COMPLETED

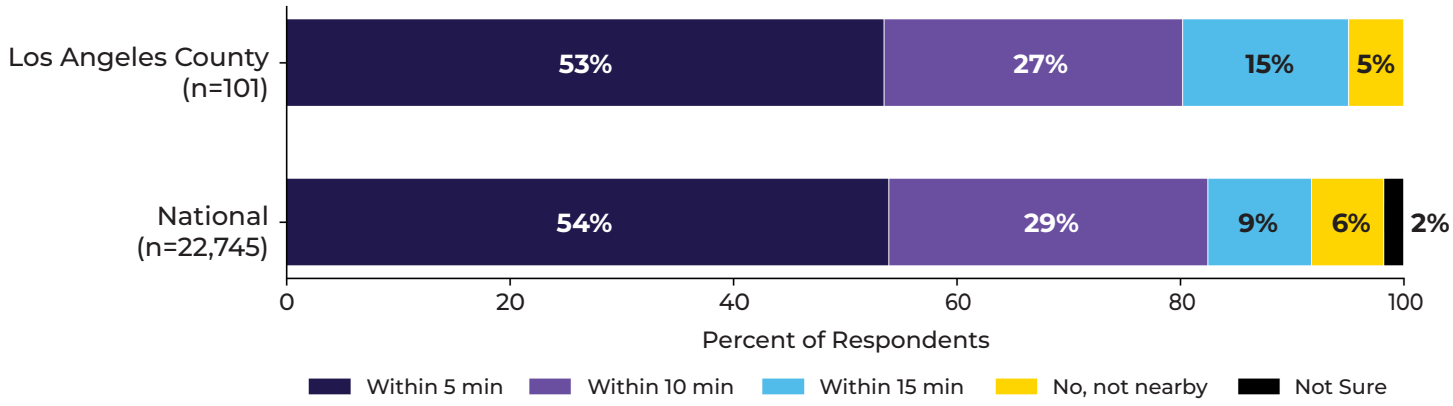
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	5	5%
Some college	26	26%
Bachelor's degree	23	23%
Graduate degree or higher	45	45%
Prefer not to answer	2	2%
Total Respondents	**101**	

DIFFICULTIES WITH ACTIVITIES

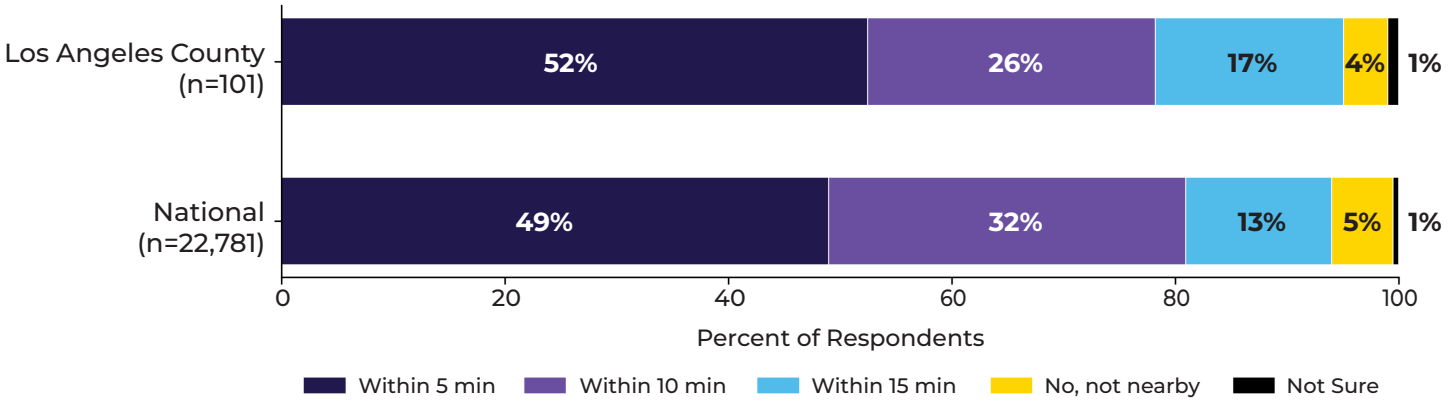
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	2	2%
Seeing, even with glasses	7	7%
Walking or climbing stairs	28	28%
Dressing or bathing	3	3%
Using the toilet	1	1%
None of the above	59	59%
Prefer not to answer	2	2%
Concentrating	14	14%
***Total Respondents**	**100**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

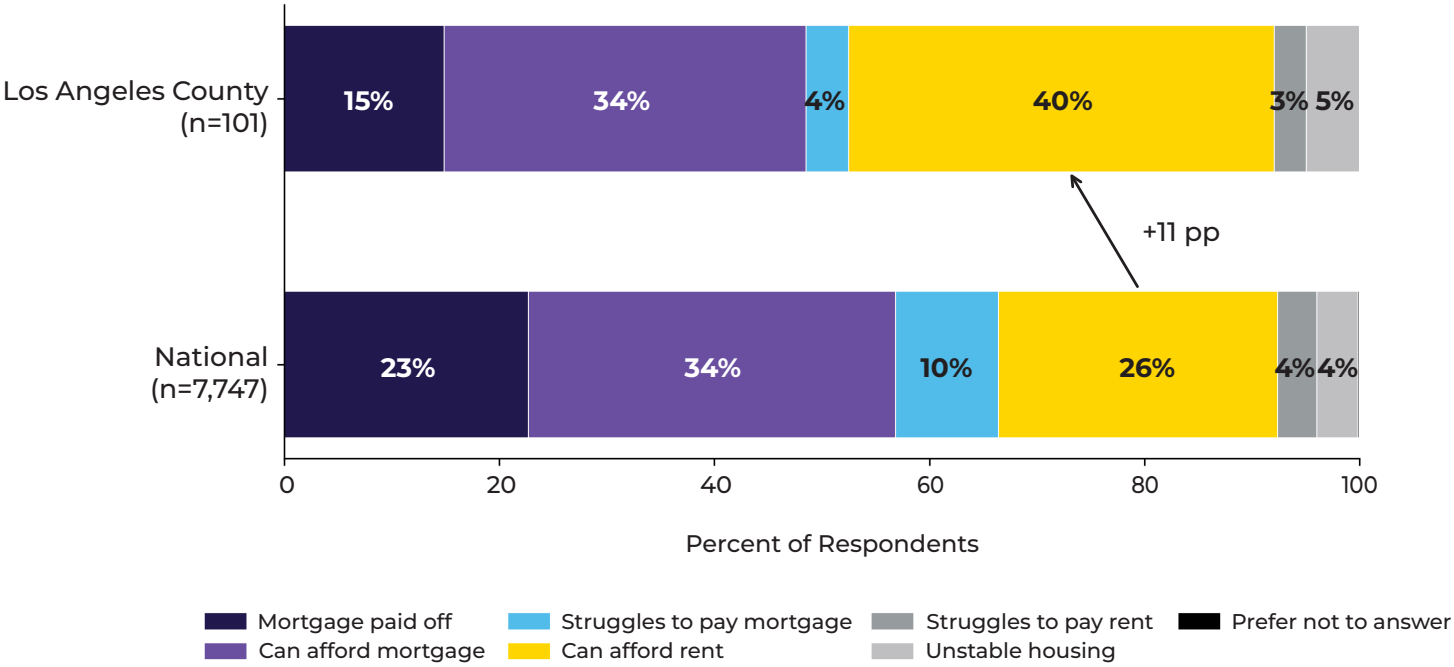
Green Space Access — National vs Los Angeles County



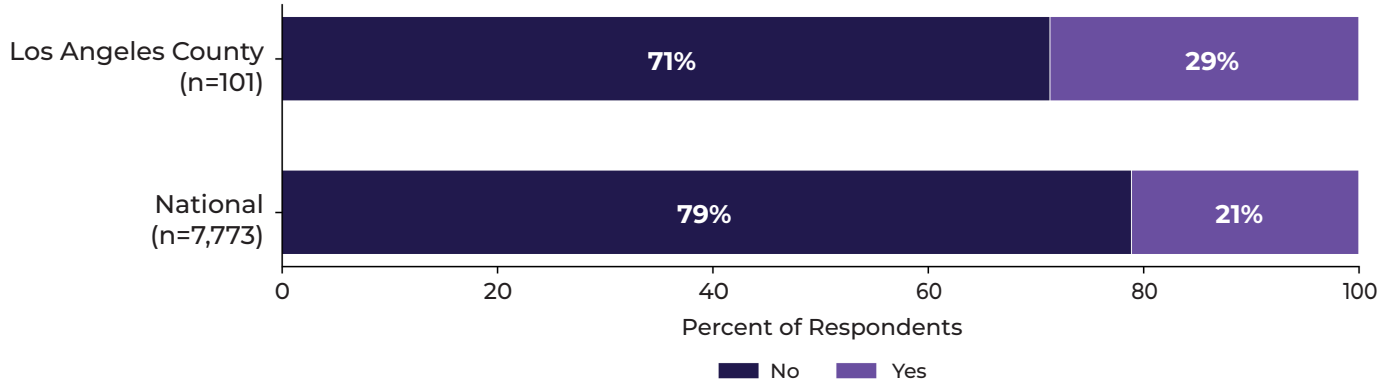
Grocery Store Access — National vs Los Angeles County



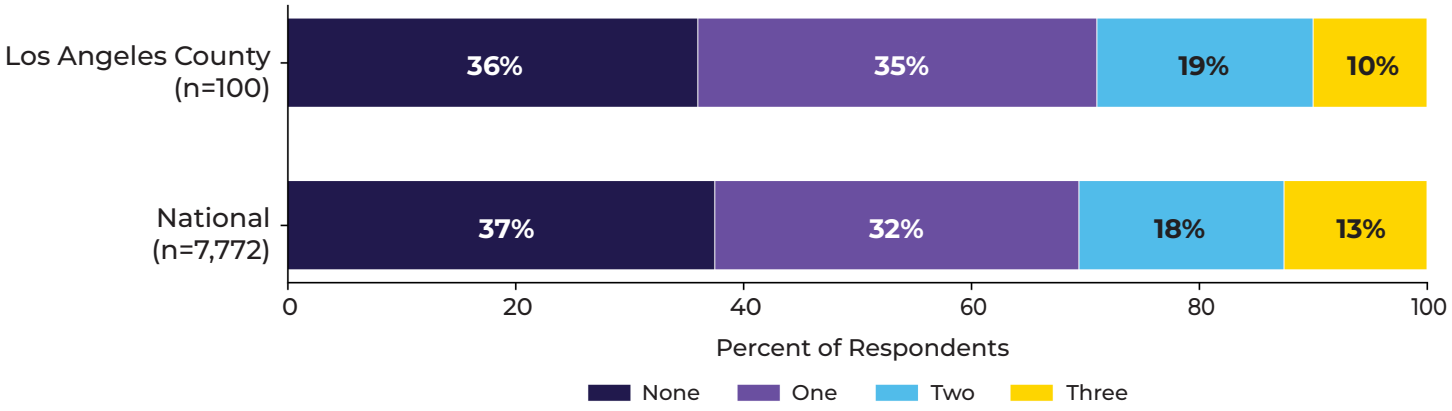
Housing Arrangements — National vs Los Angeles County



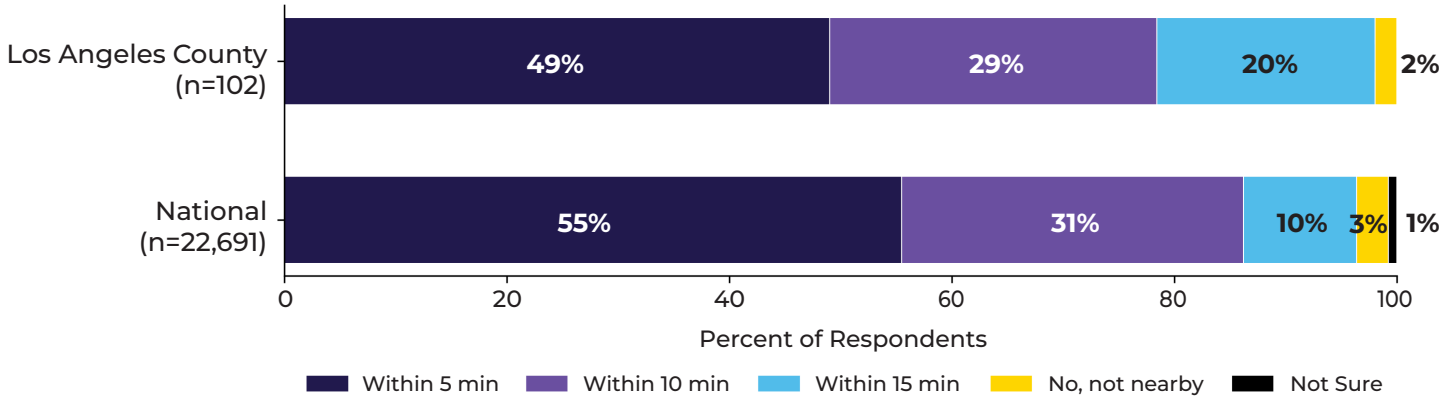
Issues Accessing Appointments or Prescriptions — National vs Los Angeles County



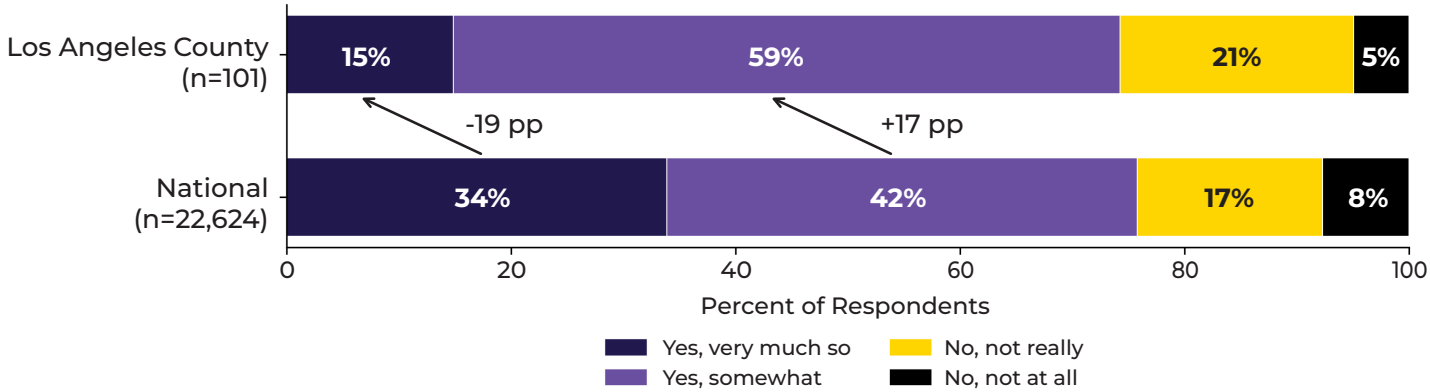
Chronic Health Conditions — National vs Los Angeles County



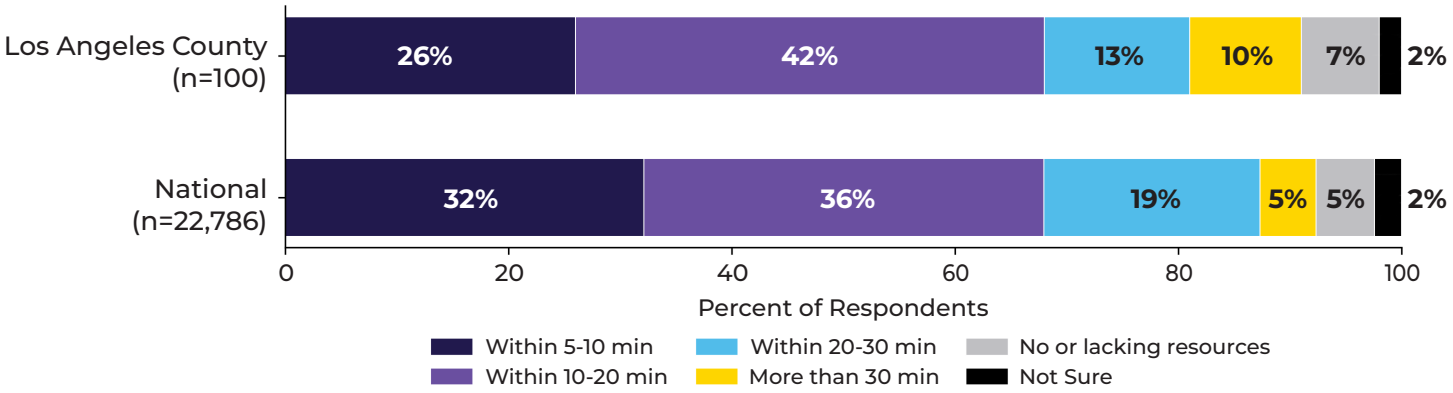
Pharmacy Proximity — National vs Los Angeles County



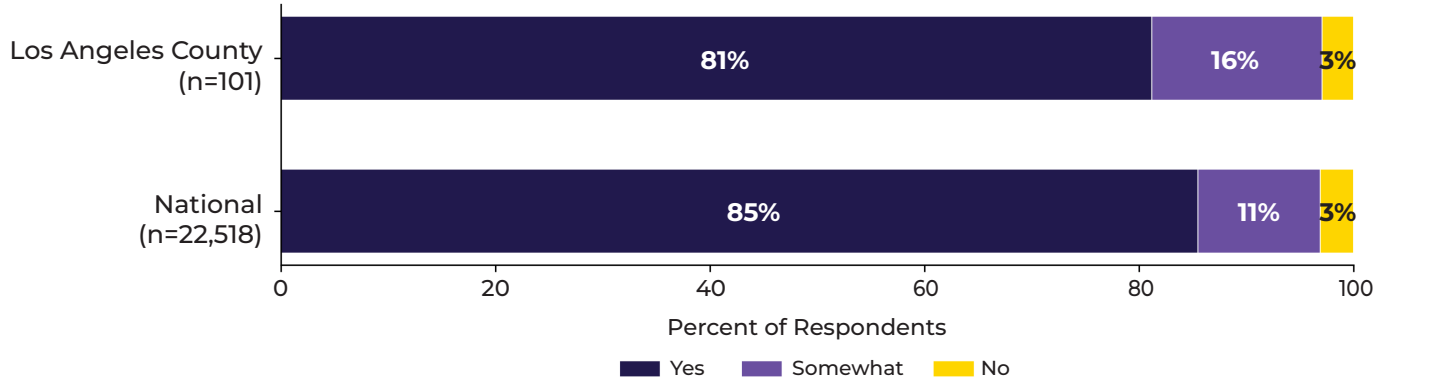
Perceived Cultural Understanding of Providers — National vs Los Angeles County



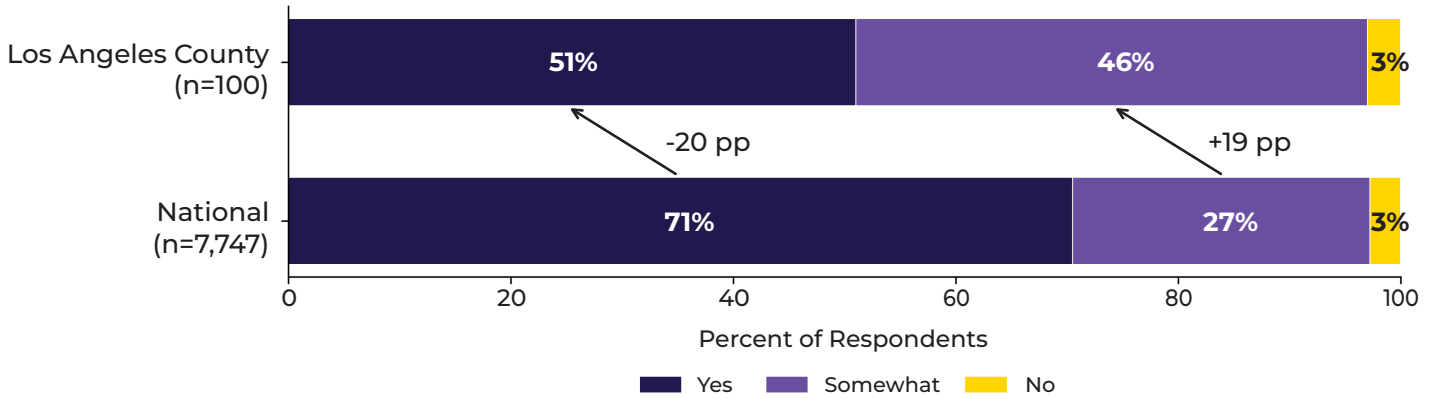
Proximity to a Quality Hospital — National vs Los Angeles County



Access to Affordable and Reliable Transportation — National vs Los Angeles County



Perceived Neighborhood Safety — National vs Los Angeles County



PHILADELPHIA, PA

Respondents in Philadelphia, PA, completed the survey online. The Philadelphia, PA, sample was predominantly Black or African American, with 79% of respondents identifying as such, alongside smaller shares identifying as multiracial (11%), White (4%), or Hispanic or Latino (1%). Women comprised the majority of participants, while 19% identified as men and 1% as non-binary. The age distribution was older overall, with nearly 70% aged 51 or above, including sizeable shares aged 71 or older. Most respondents identified as heterosexual, though a small portion identified as bisexual or lesbian. Educational attainment varies: almost one-third hold a graduate degree, and another one-third report some college. Household income was mixed, with 14% earning less than $20,000 and another 14% earning $100,000 or more. More than half reported no difficulties with daily activities, though mobility challenges and difficulty concentrating appear at higher rates than in some other cities.

Compared with national results, Philadelphia, PA, showed meaningful differences across neighborhood access and health-related measures. Access to green space appears lower than national levels, with fewer residents reporting access within five or ten minutes. Grocery access was also somewhat weaker, with smaller proportions of respondents reporting stores within a short walking or travel distance. Housing arrangements differ from national patterns, with a lower share of residents owning their homes comfortably and a larger share renting or experiencing housing difficulties. Health care experiences showed several gaps: provider cultural understanding is lower than national averages, fewer respondents live close to hospitals, and pharmacy proximity is limited for many. Philadelphia respondents also reported lower perceptions of affordable transportation and significantly lower feelings of neighborhood safety, indicating broader structural and environmental concerns.

These findings highlight several policy and programmatic priorities for Philadelphia, PA. Investments to expand access to green space and full-service grocery stores may reduce disparities in environmental and nutritional resources. Strengthening culturally responsive health care, expanding clinic and hospital accessibility, and improving pharmacy distribution can help address care gaps. Efforts to enhance neighborhood safety and increase the affordability and reliability of transportation will be critical for supporting daily mobility and well-being. Finally, strategies that expand pathways to stable, affordable housing for renters and low- to moderate-income households may bolster long-term community stability and health.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	84	100%
Main (paper)	-	-
Total Respondents	**84**	

RACIAL OR ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	2	2%
Asian	-	-
Black or African American	66	79%
Hispanic or Latino	1	1%
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	9	11%
Native Hawaiian or Pacific Islander	-	-
White	3	4%
Prefer not to answer	3	4%
Total Respondents	**84**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	13	19%
Non-binary/gender non-conforming	1	1%
Transgender	-	
Woman	55	79%
Prefer not to answer	1	1%
Total Respondents	**70**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	2	2%
25 – 40	12	14%
41 – 50	9	11%
51 – 60	16	19%
61 – 70	25	30%
71 and over	17	20%
Prefer not to answer	2	2%
Total Respondents	**83**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	5	6%
Gay	-	-
Heterosexual or straight	70	84%
Lesbian	1	1%
Prefer to self-describe	2	2%
Prefer not to answer	5	6%
Total Respondents	**83**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	12	14%
$20,000 – $39,999	11	13%
$40,000 – $59,999	15	18%
$60,000 – $79,999	9	11%
$80,000 – $99,999	9	11%
$100,000 or more	12	14%
Prefer not to answer	15	18%
Total Respondents	**83**	

HIGHEST EDUCATION COMPLETED

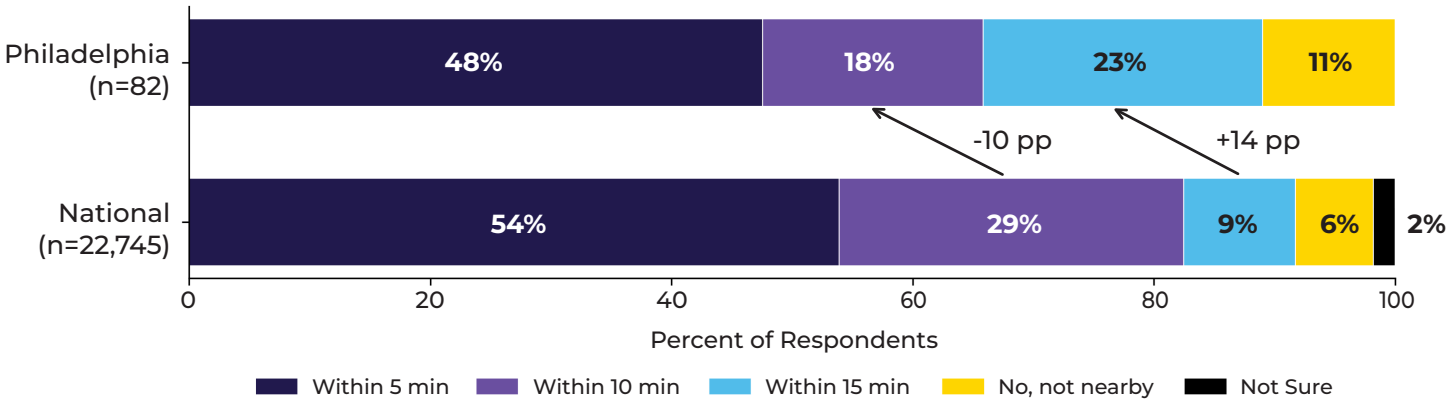
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	2	2%
GED or high school graduate	11	13%
Some college	26	31%
Bachelor's degree	16	19%
Graduate degree or higher	27	32%
Prefer not to answer	2	2%
Total Respondents	**84**	

DIFFICULTIES WITH ACTIVITIES

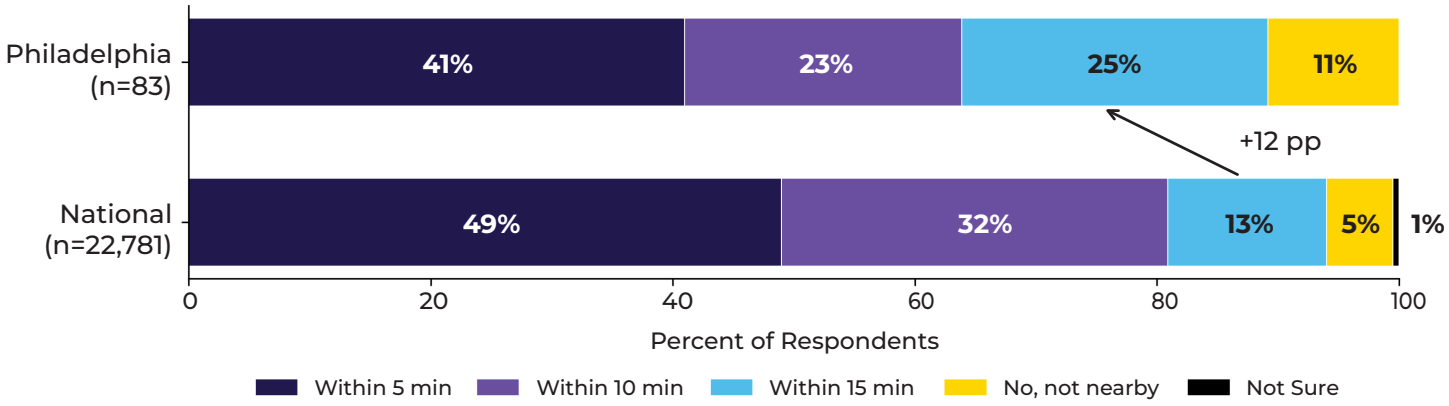
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	3	4%
Seeing, even with glasses	10	12%
Walking or climbing stairs	23	28%
Dressing or bathing	2	2%
Using the toilet	1	1%
None of the above	45	55%
Prefer not to answer	2	2%
Concentrating	13	16%
***Total Respondents**	**82**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

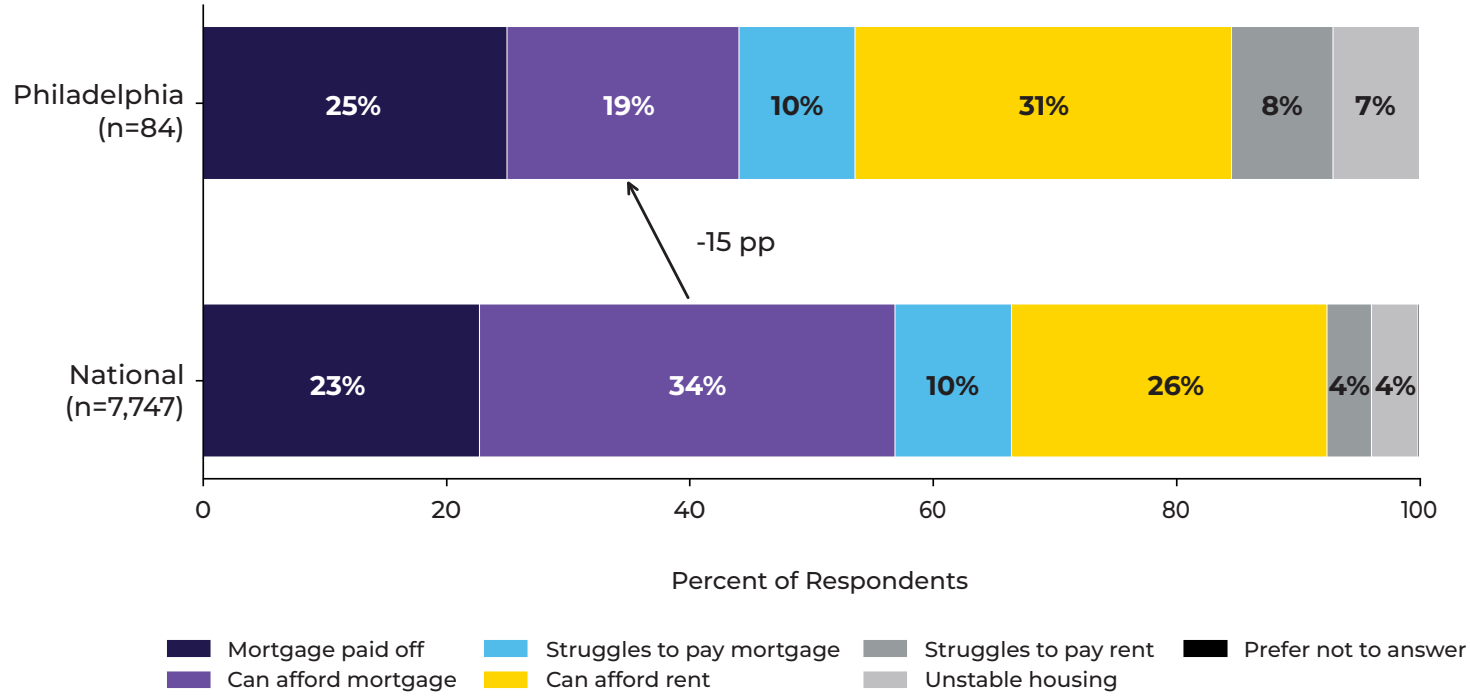
Green Space Access — National vs Philadelphia



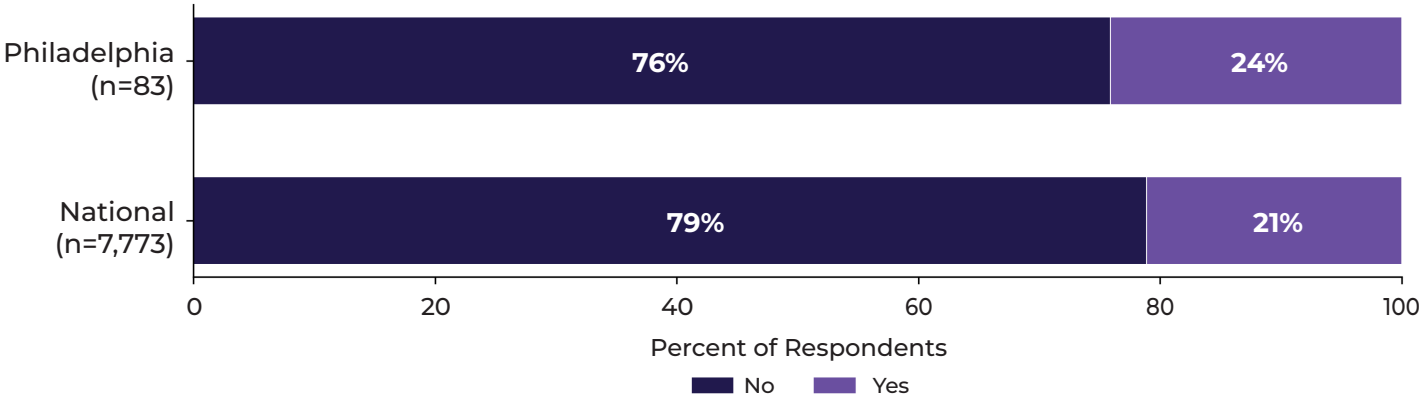
Grocery Store Access — National vs Philadelphia



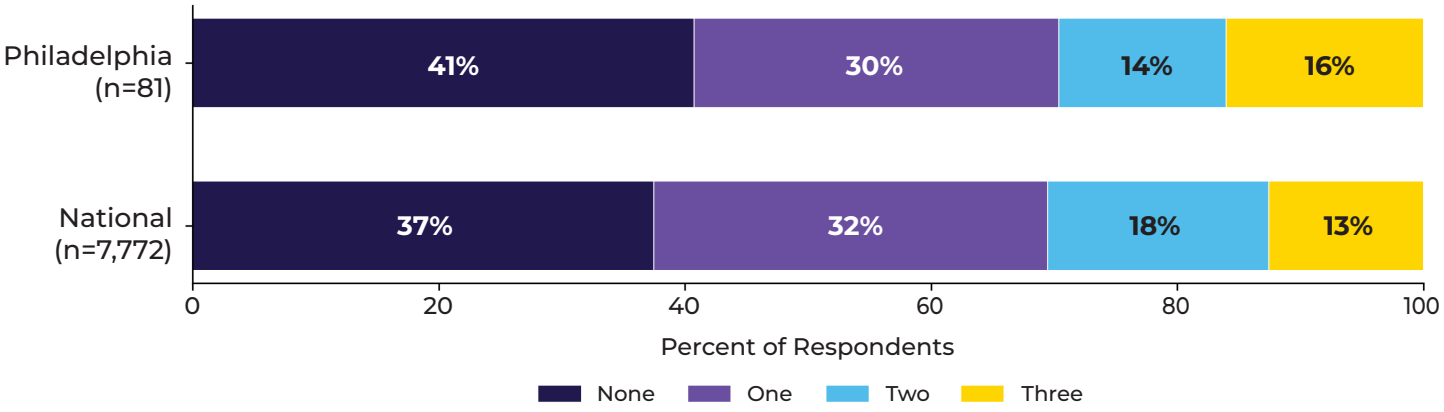
Housing Arrangements — National vs Philadelphia



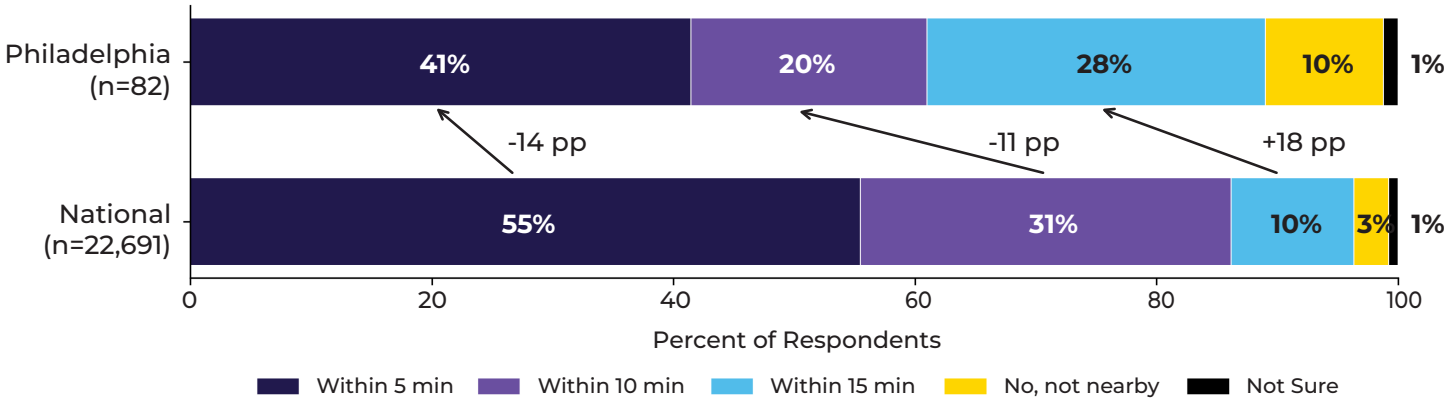
Issues Accessing Appointments or Prescriptions — National vs Philadelphia



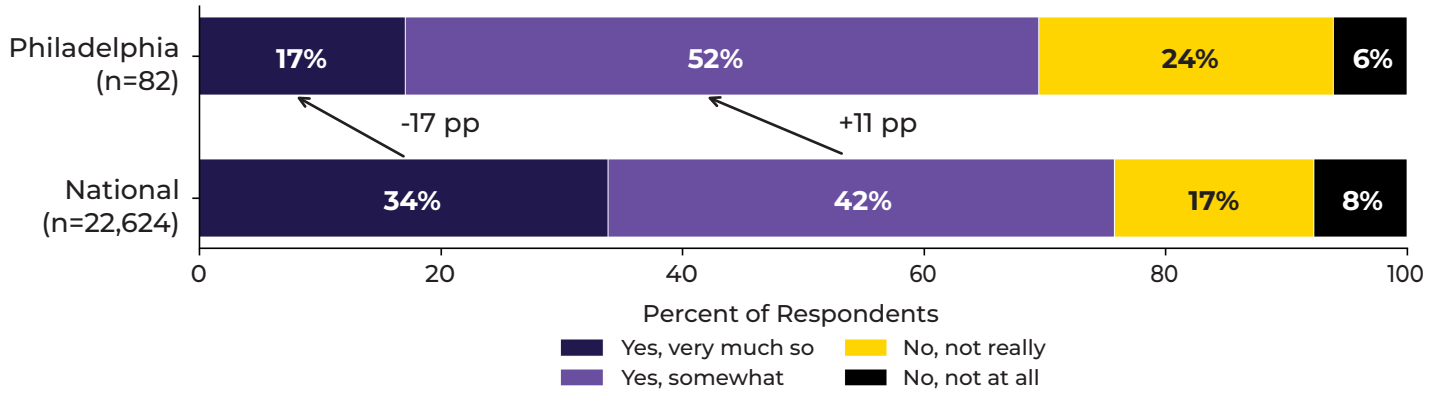
Chronic Health Conditions — National vs Philadelphia



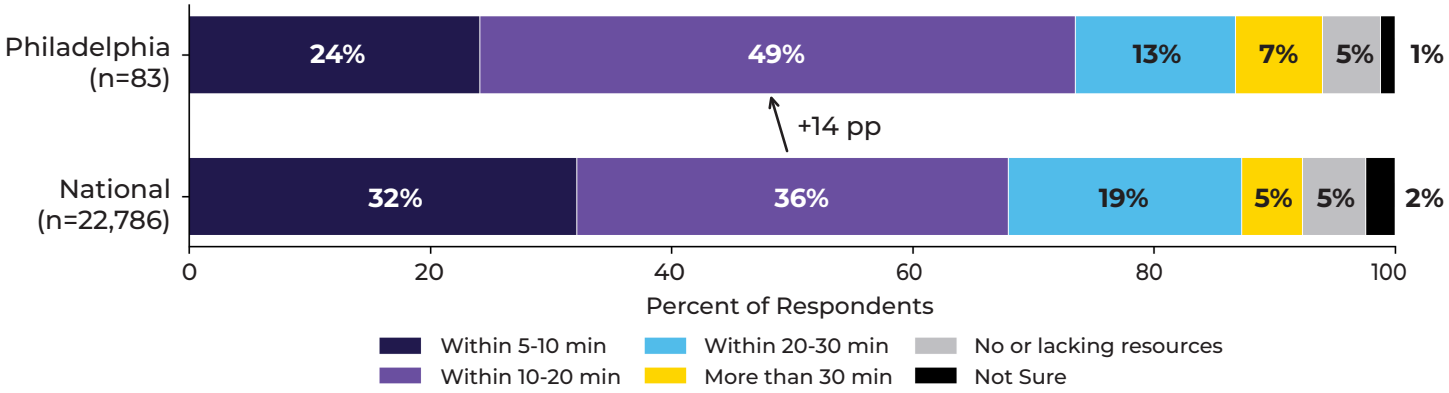
Pharmacy Proximity — National vs Philadelphia



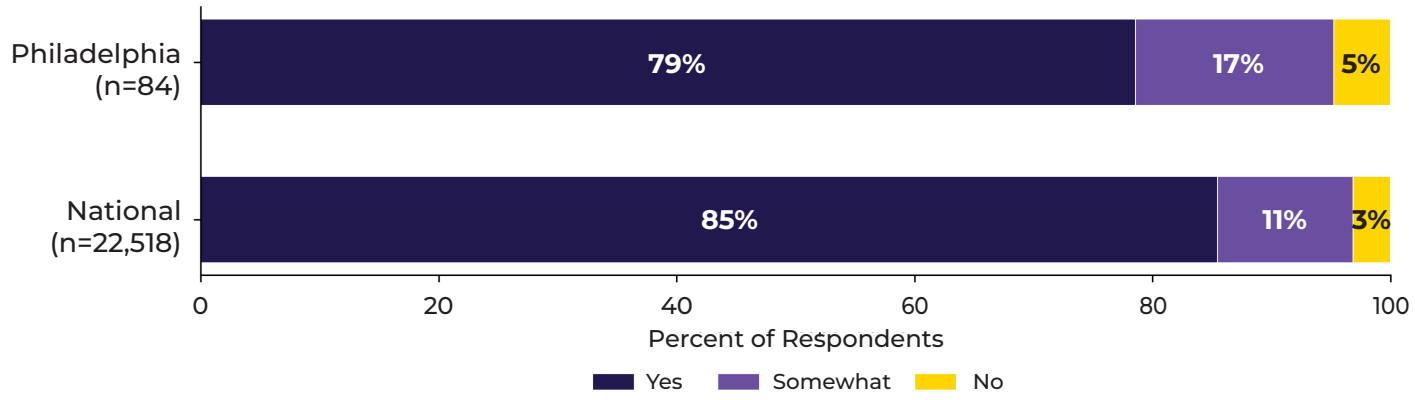
Perceived Cultural Understanding of Providers — National vs Philadelphia



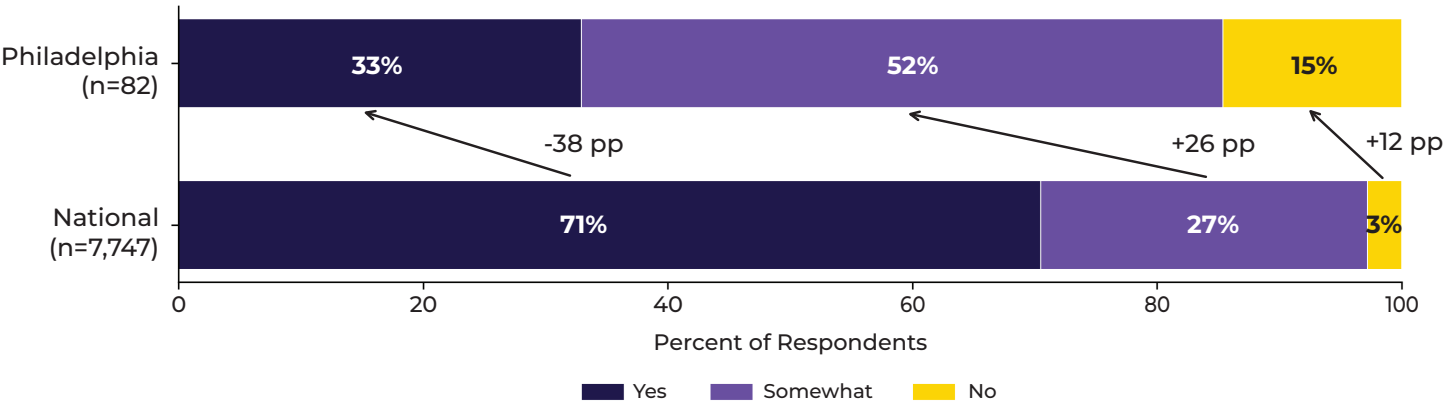
Proximity to a Quality Hospital — National vs Philadelphia



Access to Affordable and Reliable Transportation — National vs Philadelphia



Perceived Neighborhood Safety — National vs Philadelphia



WASHINGTON, D.C.

Respondents in Washington, D.C., completed the survey online. Residents of Washington, D.C., reported strong educational attainment and economic diversity within the sample, but also noted meaningful challenges related to mobility and access to neighborhood resources. The majority of respondents were Black and women, with many aged 51 and older. Educational levels were high, with most respondents having at least some college education and more than half holding a graduate degree. Despite these strengths, a significant share reported difficulty with daily physical activities, particularly walking or climbing stairs, which may influence how residents move through their communities and access essential services.

Compared with national findings, Washington, D.C., respondents reported limited proximity to grocery stores, green spaces, pharmacies, and hospitals. These gaps indicate that even within a city with dense infrastructure, access to everyday resources remains uneven. Respondents also reported higher levels of chronic health conditions and mobility challenges than the national sample. Neighborhood safety perceptions were mixed, and fewer residents felt that health care providers understood their cultural background. Together, these patterns suggest that resource accessibility and care experiences vary substantially across Washington, D.C.

To address these challenges, Washington, D.C., would benefit from investments that strengthen access to essential services and support residents with mobility limitations. Expanding the availability of grocery stores, pharmacies, and nearby hospital services can improve opportunities for preventive care and chronic disease management. Improvements to pedestrian infrastructure, neighborhood safety initiatives, and age-friendly design may help residents navigate their environments more easily. Strengthening culturally informed care through provider training and deeper partnerships with trusted community organizations can also help improve the patient's experience. These efforts can work together to advance health equity and enhance the well-being of residents across Washington, D.C.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	49	100%
Main (paper)	-	-
Total Respondents	**49**	

RACIAL OR ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	-	-
Asian	-	-
Black or African American	40	83%
Hispanic or Latino	2	4%
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	6	13%
Native Hawaiian or Pacific Islander	-	-
White	-	-
Prefer not to answer	-	-
Total Respondents	**48**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	10	23%
Non-binary/gender non-conforming	1	2%
Transgender	-	-
Woman	32	74%
Prefer not to answer	-	-
Total Respondents	**43**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	-	-
25 – 40	10	20%
41 – 50	8	16%
51 – 60	10	20%
61 – 70	7	14%
71 and over	14	29%
Prefer not to answer	-	-
Total Respondents	**49**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	2	4%
Gay	2	4%
Heterosexual or straight	40	83%
Lesbian	1	2%
Prefer to self-describe	1	2%
Prefer not to answer	2	4%
Total Respondents	**48**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	7	14%
$20,000 – $39,999	4	8%
$40,000 – $59,999	1	2%
$60,000 – $79,999	2	4%
$80,000 – $99,999	8	16%
$100,000 or more	21	43%
Prefer not to answer	6	12%
Total Respondents	**49**	

HIGHEST EDUCATION COMPLETED

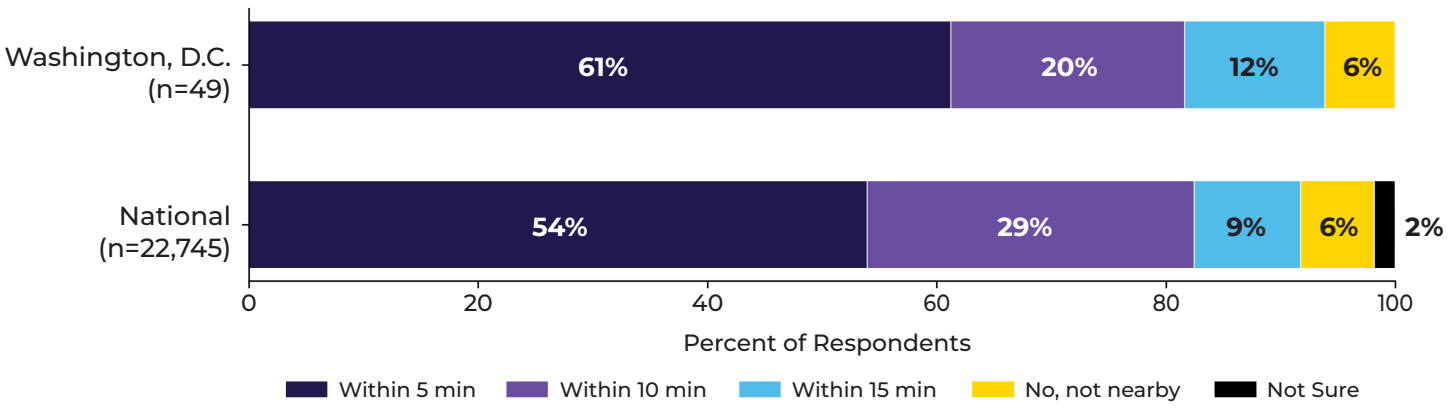
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	2	4%
Some college	7	14%
Bachelor's degree	14	29%
Graduate degree or higher	26	53%
Prefer not to answer	-	-
Total Respondents	**49**	

DIFFICULTIES WITH ACTIVITIES

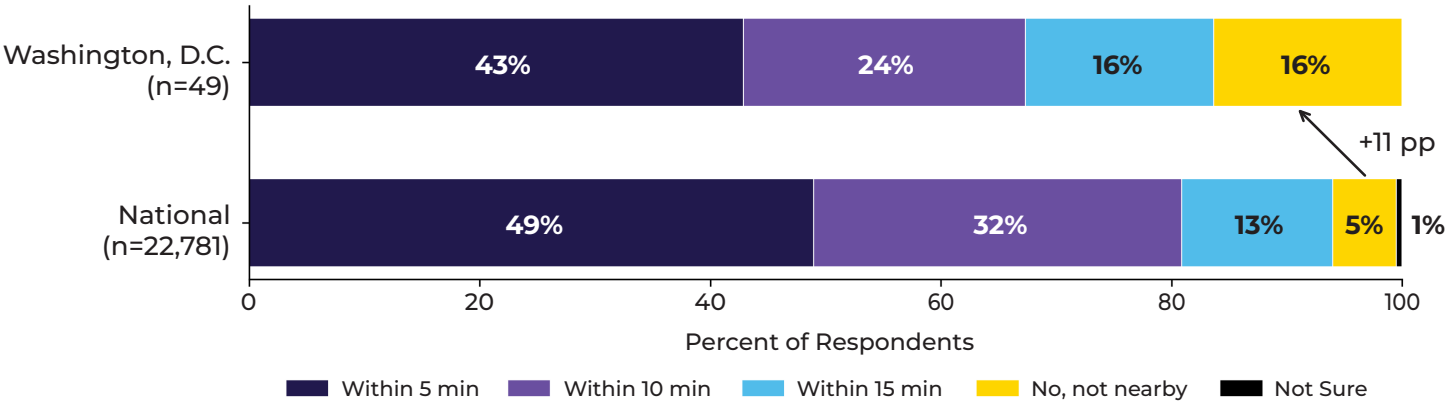
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	1	2%
Seeing, even with glasses	7	15%
Walking or climbing stairs	15	32%
Dressing or bathing	5	11%
Using the toilet	2	4%
None of the above	25	53%
Prefer not to answer	-	-
Concentrating	5	11%
***Total Respondents**	**47**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

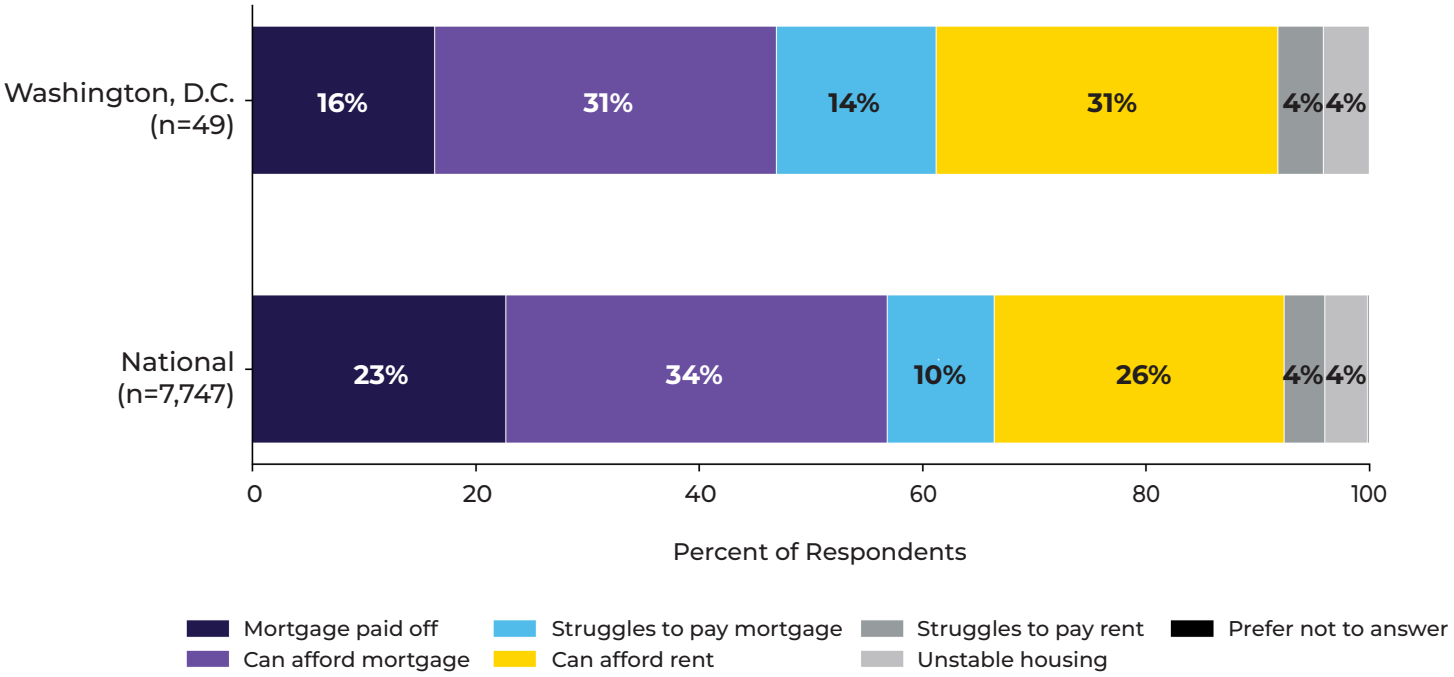
Green Space Access — National vs Washington, D.C.



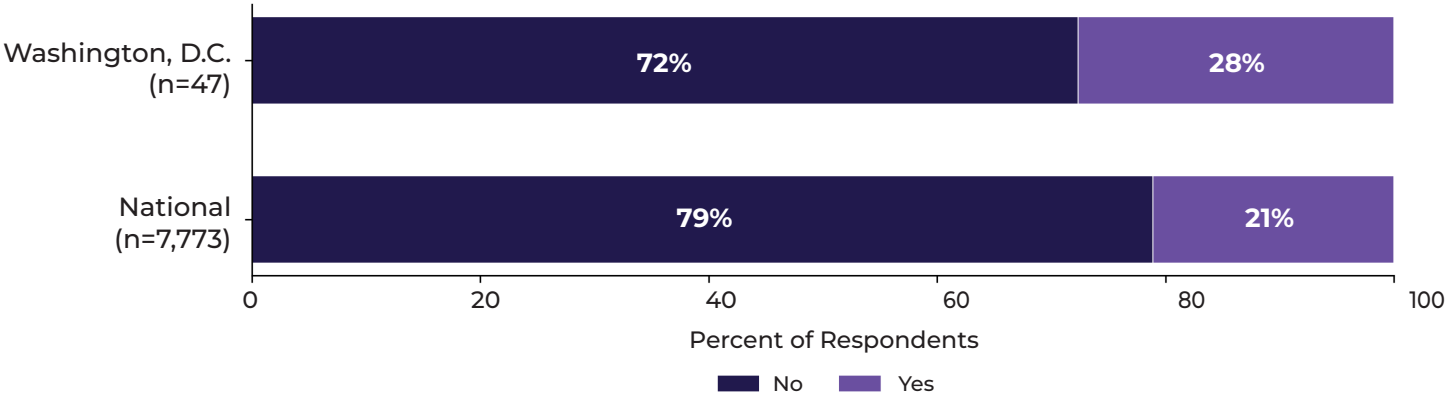
Grocery Store Access — National vs Washington, D.C.



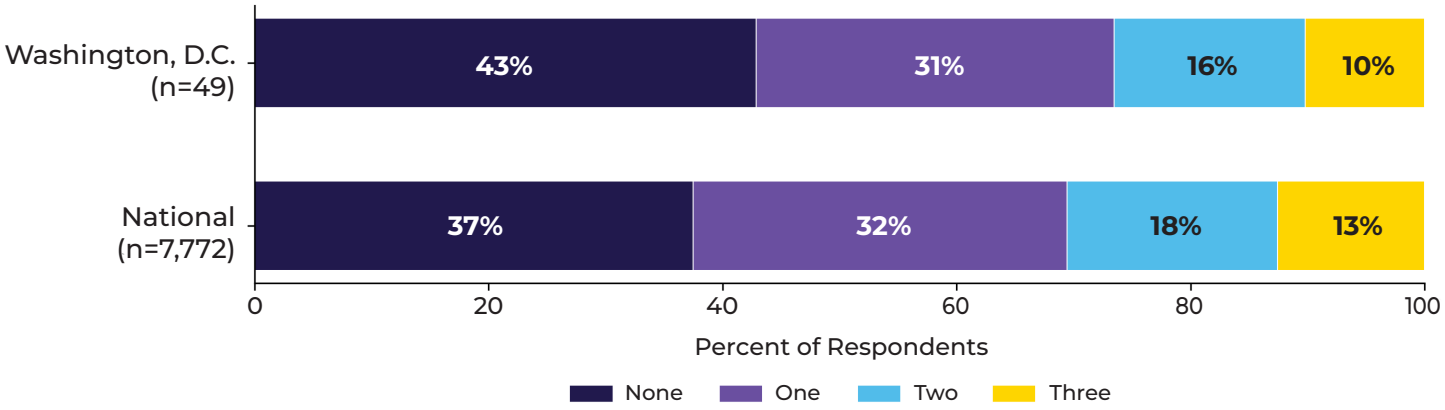
Housing Arrangements — National vs Washington, D.C.



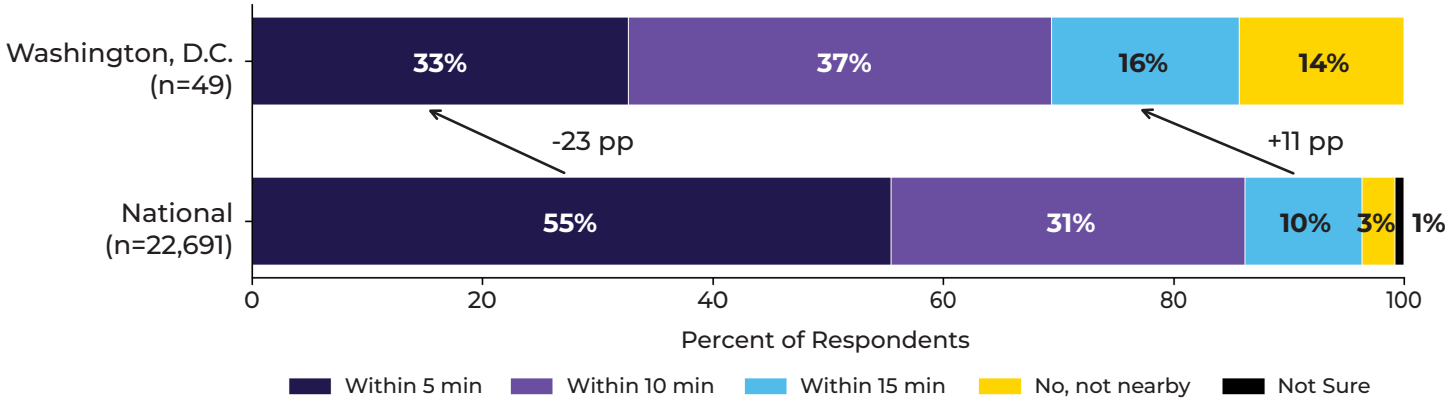
Issues Accessing Appointments or Prescriptions — National vs Washington, D.C.



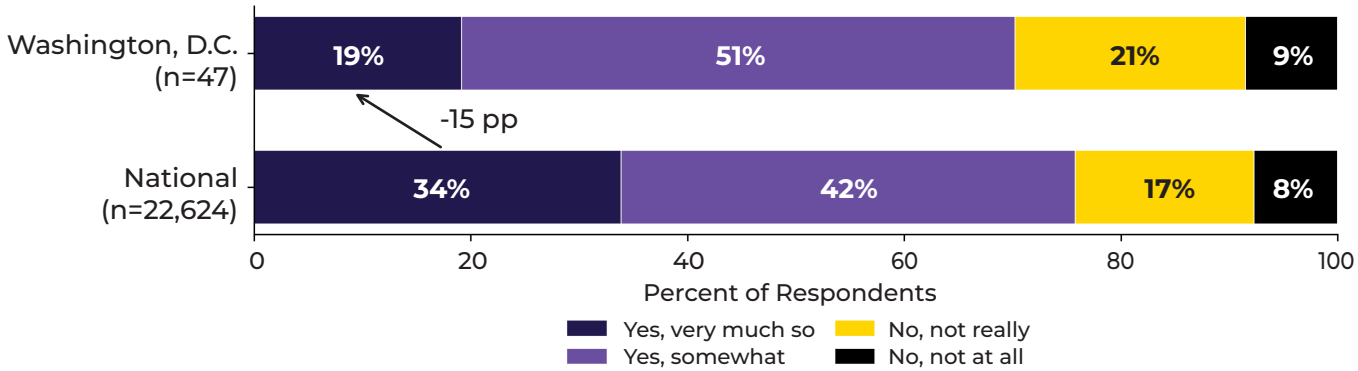
Chronic Health Conditions — National vs Washington, D.C.



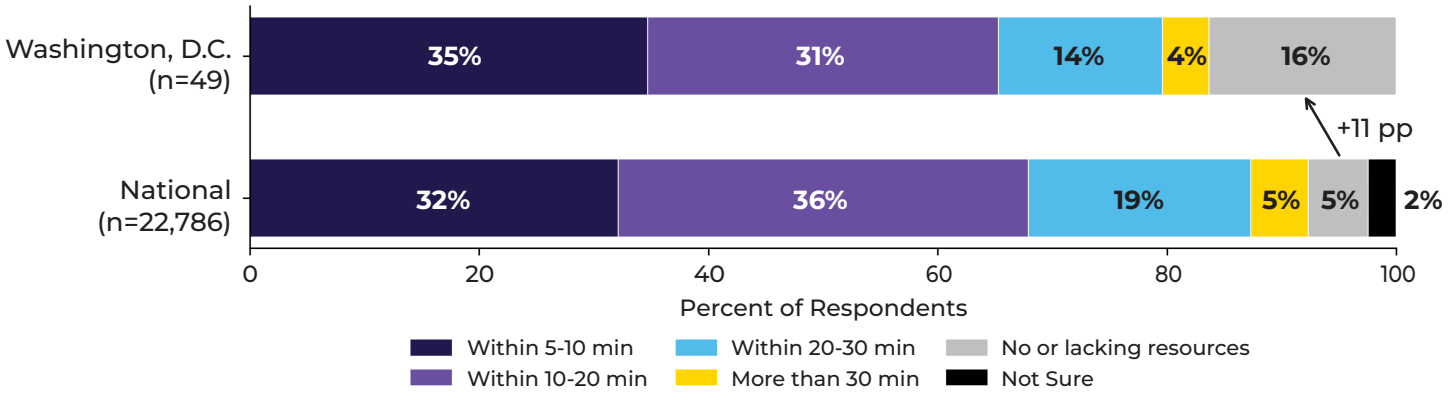
Pharmacy Proximity — National vs Washington, D.C.



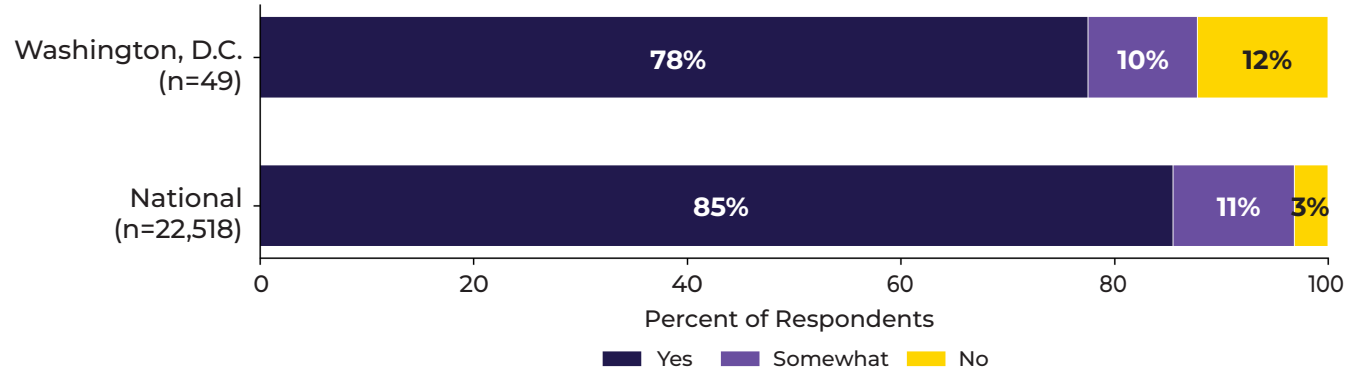
Perceived Cultural Understanding of Providers — National vs Washington, D.C.



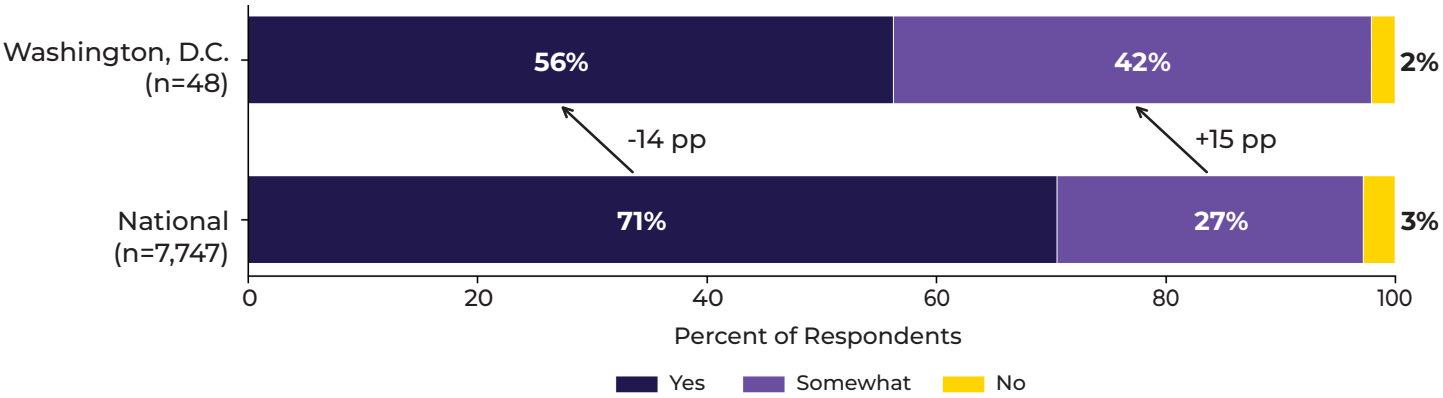
Proximity to a Quality Hospital — National vs Washington, D.C.



Access to Affordable and Reliable Transportation — National vs Washington, D.C.



Perceived Neighborhood Safety — National vs Washington, D.C.



BOSTON, MA

Respondents in Boston, MA, completed the survey online. Residents in Boston, MA, represented a small but diverse group, with respondents spanning young adulthood to older age and a notable share aged 70 and above. The sample was majority Black and mostly women. Many residents reported challenges with daily functioning, including difficulty walking or climbing stairs and difficulty concentrating. These challenges, combined with the age distribution, suggest that some Boston respondents may require additional support to navigate their neighborhoods and health services.

Compared with national findings, Boston residents reported more limited proximity to everyday resources, including grocery stores, pharmacies, hospitals, and green spaces. Boston respondents were also more likely to report chronic health conditions and difficulty securing timely medical appointments. Perceptions of neighborhood safety were mixed, and several respondents indicated that their providers did not fully understand their cultural background. These patterns point to gaps in the availability, accessibility, and cultural responsiveness of essential services for Boston residents.

To address the specific challenges reflected in Boston, MA, data, local leaders could focus on strengthening supports for older adults and residents with cognitive or mobility limitations. Community-based programs that help with appointment navigation, transportation to care, and chronic disease management may reduce the barriers residents described. Investments in integrated primary and behavioral health services could also address the high levels of chronic conditions and difficulty concentrating. Improving trust and communication in the health system, particularly for Black residents and LGBTQ+ individuals, may enhance engagement and continuity of care. These targeted strategies align with the needs surfaced in Boston's data and can help create a more accessible and supportive environment for residents across Boston, MA.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	30	100%
Main (paper)	-	-
Total Respondents	**30**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	-	-
Asian	1	3%
Black or African American	21	70%
Hispanic or Latino	-	-
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	4	13%
Native Hawaiian or Pacific Islander	-	-
White	-	-
Prefer not to answer	4	13%
Total Respondents	**30**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	7	33%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	14	67%
Prefer not to answer	-	-
Total Respondents	**21**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	-	-
25 – 40	7	23%
41 – 50	8	27%
51 – 60	2	7%
61 – 70	4	13%
71 and over	7	23%
Prefer not to answer	2	7%
Total Respondents	**30**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	2	7%
Gay	3	10%
Heterosexual or straight	20	67%
Lesbian	-	-
Prefer to self-describe	1	3%
Prefer not to answer	4	13%
Total Respondents	**30**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	3	10%
$20,000 – $39,999	6	20%
$40,000 – $59,999	3	10%
$60,000 – $79,999	4	13%
$80,000 – $99,999	2	7%
$100,000 or more	5	17%
Prefer not to answer	7	23%
Total Respondents	**30**	

HIGHEST EDUCATION COMPLETED

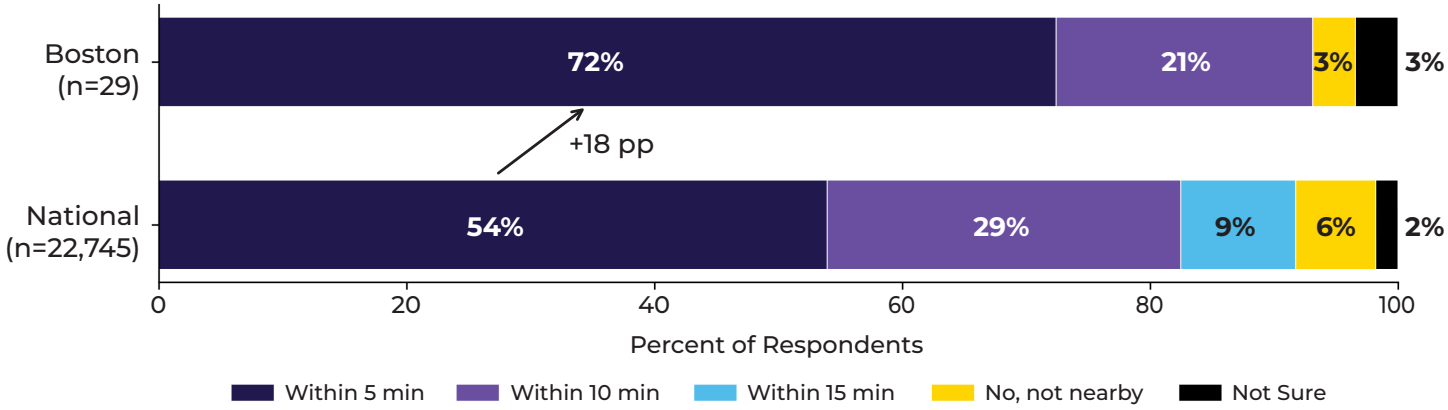
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	2	7%
Some college	5	17%
Bachelor's degree	5	17%
Graduate degree or higher	15	50%
Prefer not to answer	3	10%
Total Respondents	**30**	

DIFFICULTIES WITH ACTIVITIES

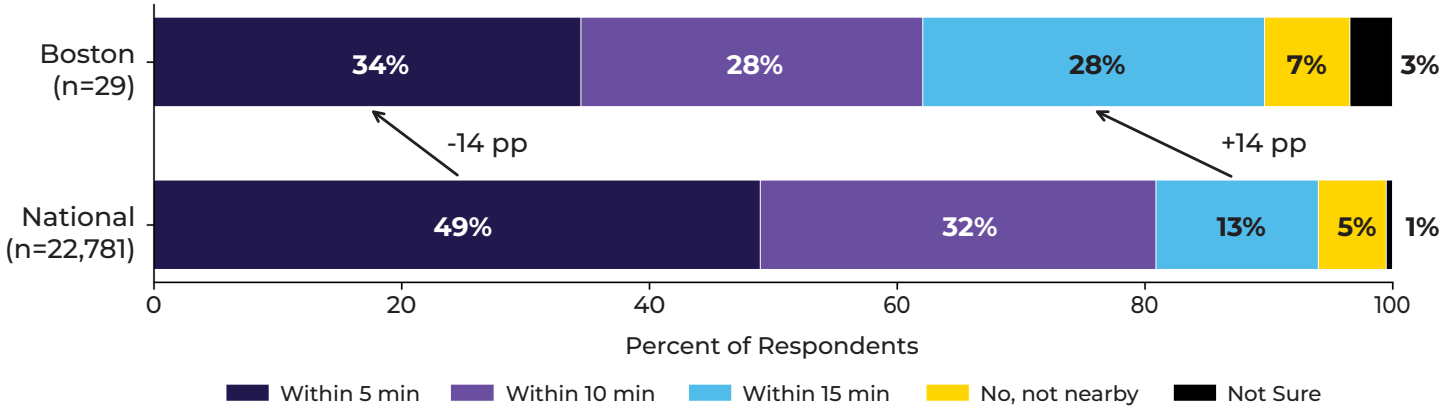
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	1	3%
Seeing, even with glasses	3	10%
Walking or climbing stairs	8	28%
Dressing or bathing	1	3%
Using the toilet	1	3%
None of the above	11	38%
Prefer not to answer	5	17%
Concentrating	9	31%
***Total Respondents**	**29**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

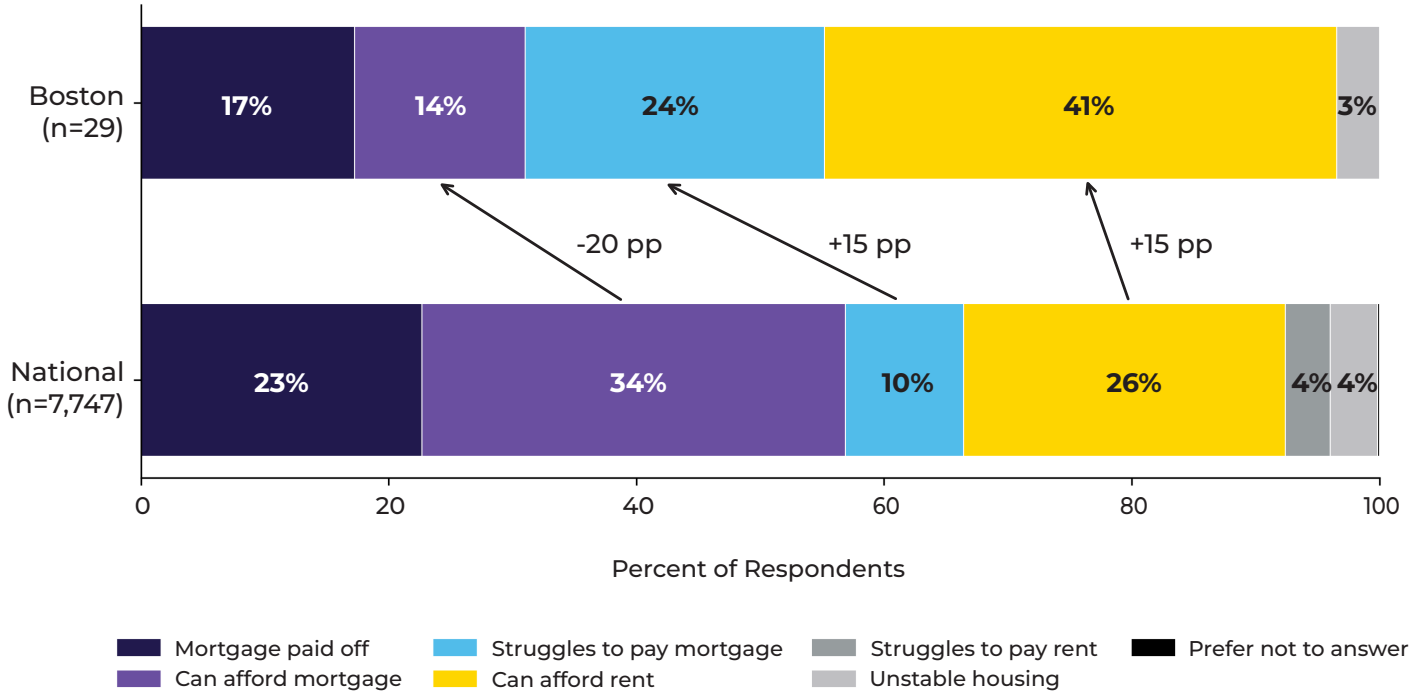
Green Space Access — National vs Boston



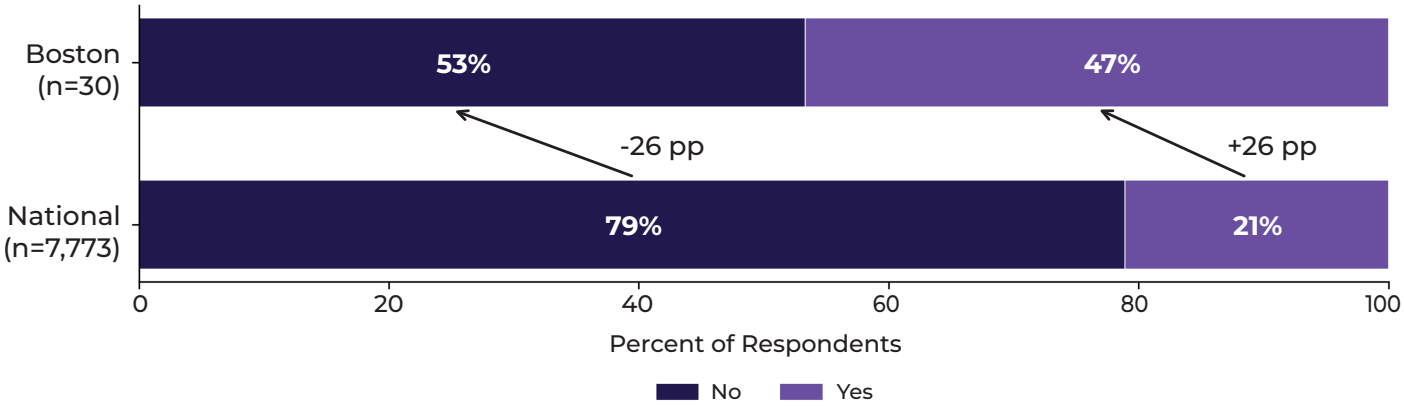
Grocery Store Access — National vs Boston



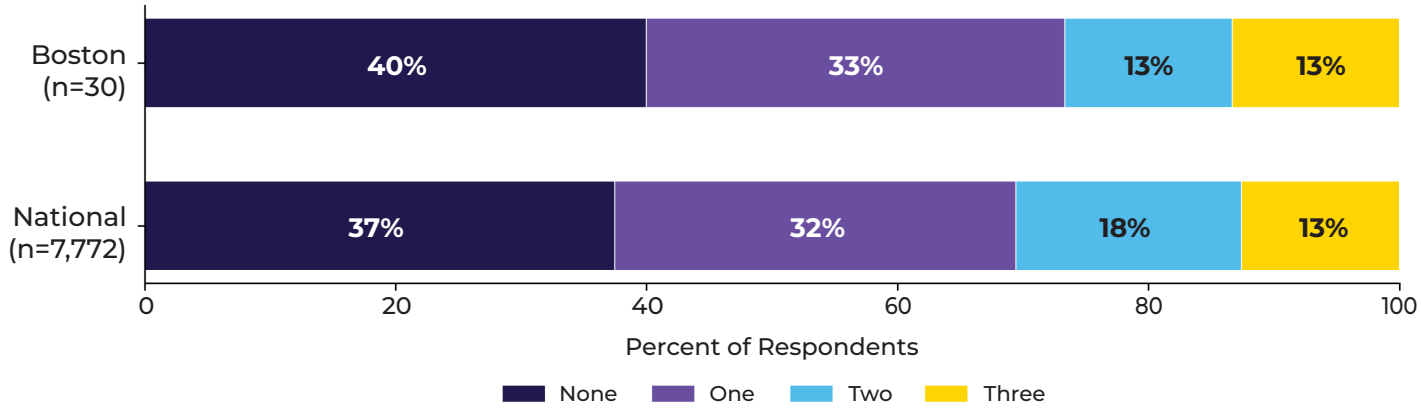
Housing Arrangements — National vs Boston



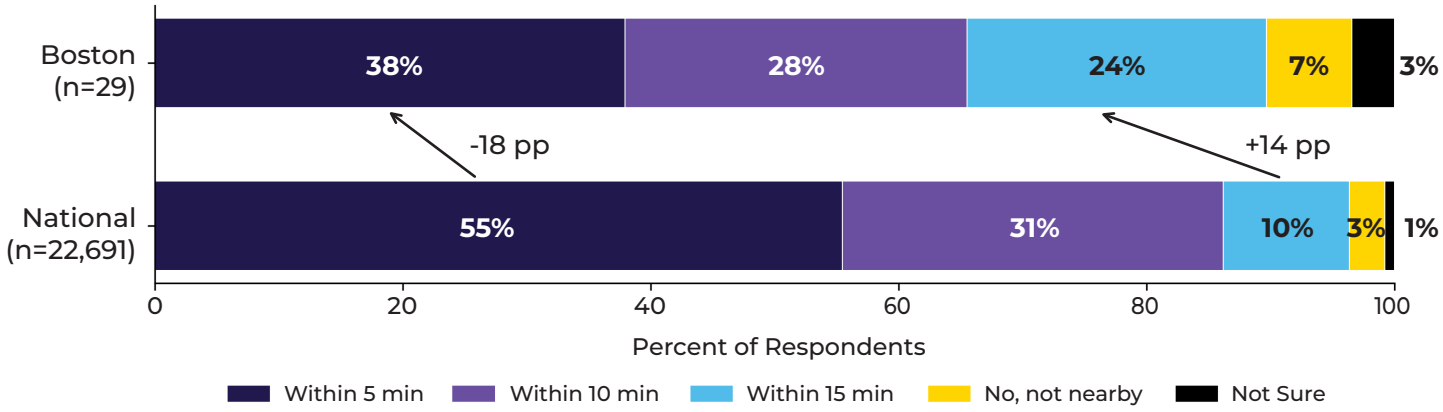
Issues Accessing Appointments or Prescriptions — National vs Boston



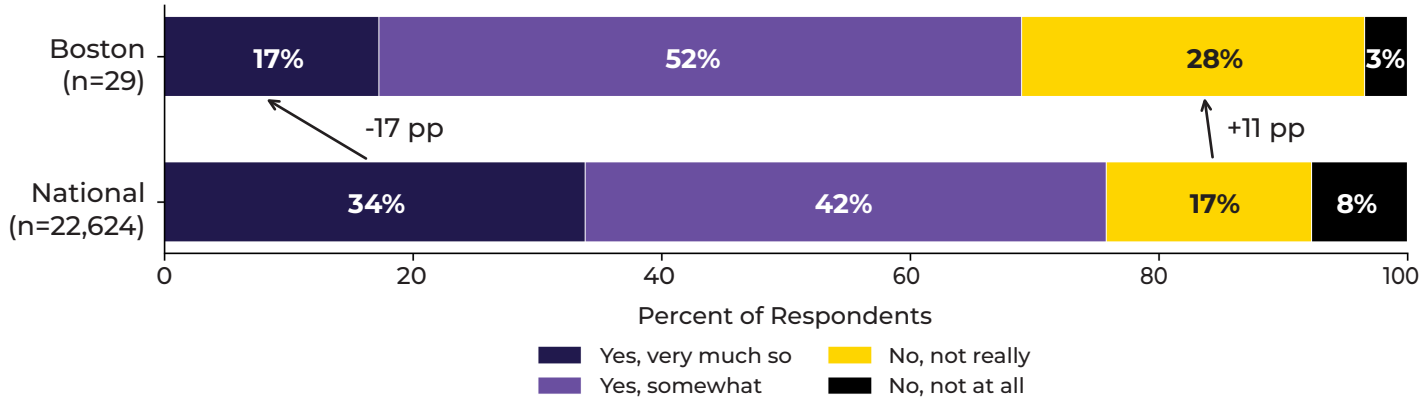
Chronic Health Conditions — National vs Boston



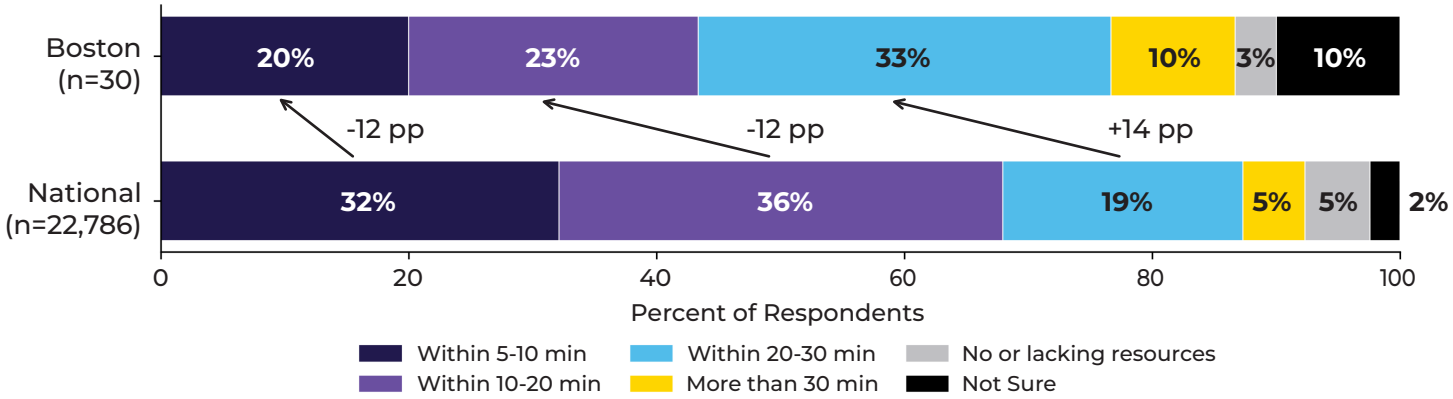
Pharmacy Proximity — National vs Boston



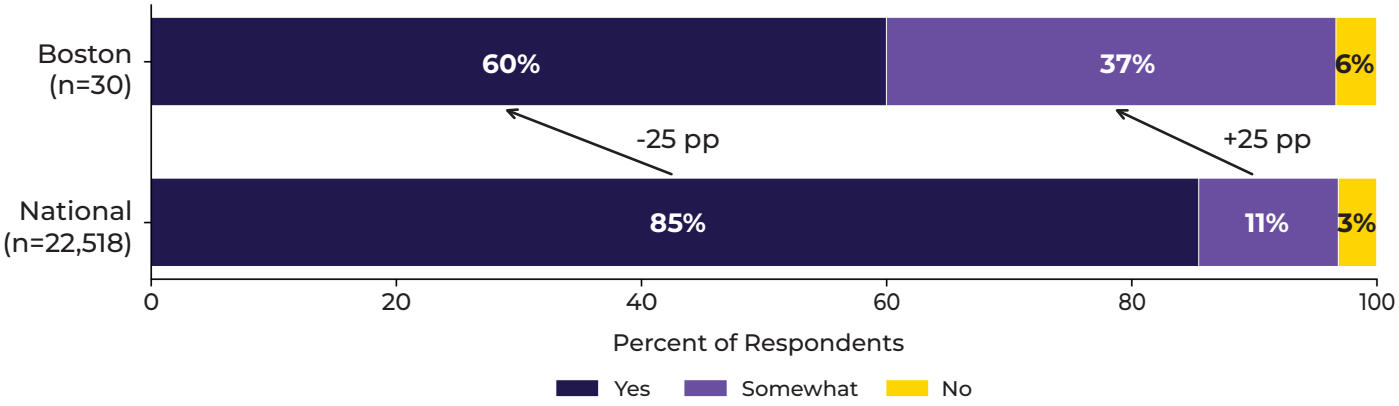
Perceived Cultural Understanding of Providers — National vs Boston



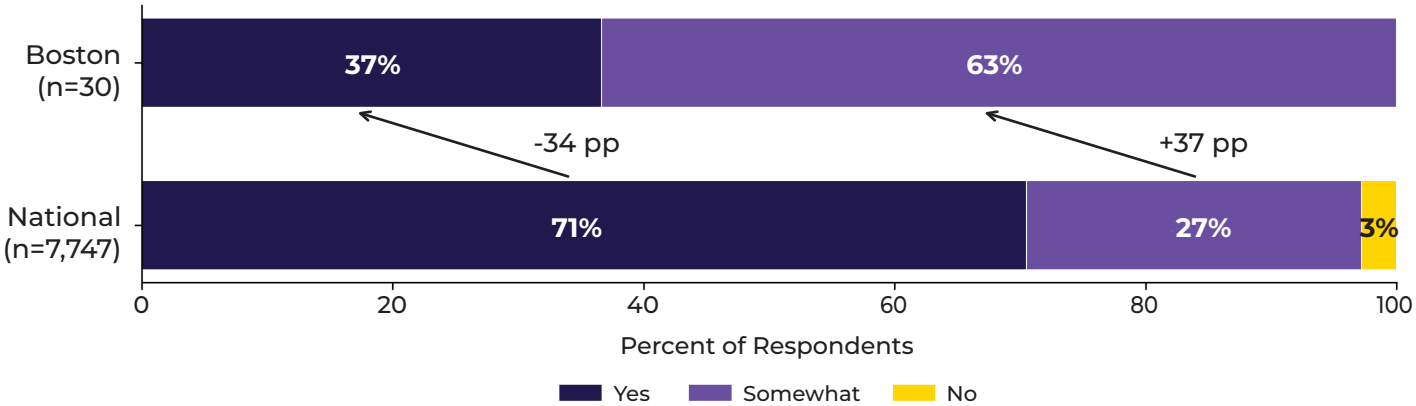
Proximity to a Quality Hospital — National vs Boston



Access to Affordable and Reliable Transportation — National vs Boston



Perceived Neighborhood Safety — National vs Boston



CHICAGO, IL

Respondents in Chicago, IL, completed the survey online. The Chicago, IL, sample reflected a predominantly Black community, with 86% of respondents identifying as Black or African American and nine percent identifying as White. Women comprised the majority of participants, and nearly all respondents identified as heterosexual. The age distribution was older, with most respondents aged 41 and above, including large shares between 51 and 70. Educational attainment was particularly high: more than half of respondents held a graduate degree, and nearly one quarter had a bachelor's degree. Income levels varied widely, with roughly one-third earning $100,000 or more and almost a quarter earning less than $40,000. Most individuals reported no difficulties with daily activities, though some experienced challenges with mobility or concentration.

Compared to national trends, Chicago, IL, shows stronger access to green space, with 75% of residents living within five minutes of a park or recreational area, a 22-percentage point advantage over national results. Grocery access is comparable to the national profile, with slightly fewer Chicago respondents reporting five-minute access but a higher share reporting access within 15 minutes. Housing arrangements differ notably from national patterns: Chicago respondents are less likely to own their homes and more likely to rent, though mortgage strain among owners is not disproportionately high. Chicago also reports lower levels of cultural understanding among health care providers, greater distance to hospitals, fewer residents who believe transportation is affordable, and lower perceptions of neighborhood safety.

These findings highlight several priorities for action in Chicago, IL. Strengthening culturally responsive health care and expanding hospital and clinic accessibility may help address gaps in care experiences. Investments in transportation affordability and neighborhood safety initiatives could improve mobility and daily well-being. Maintaining Chicago's strong access to green space and bolstering grocery availability in moderately served areas will also support community health. Finally, policies that expand pathways to stable homeownership, particularly for renters and lower-income households, may help strengthen housing stability and reduce long-term economic vulnerability.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	57	100%
Main (paper)	-	-
Total Respondents	**57**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaskan Native	-	-
Asian	-	-
Black or African American	49	86%
Hispanic or Latino	-	-
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	-	-
Native Hawaiian or Pacific Islander	-	-
White	5	9%
Prefer not to answer	3	5%
Total Respondents	**57**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	-	-
Non-binary/gender non-conforming	9	22%
Prefer not to answer	-	-
Transgender	-	-
Woman	32	78%
Total Respondents	**41**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	-	-
25 – 40	7	12%
41 – 50	10	18%
51 – 60	14	25%
61 – 70	15	26%
71 and over	9	16%
Prefer not to answer	2	4%
Total Respondents	**57**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	1	2%
Gay	1	2%
Heterosexual or straight	53	93%
Lesbian	-	-
Prefer to self-describe	-	-
Prefer not to answer	2	4%
Total Respondents	**57**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	6	11%
$20,000 – $39,999	7	12%
$40,000 – $59,999	5	9%
$60,000 – $79,999	5	9%
$80,000 – $99,999	8	14%
$100,000 or more	17	30%
Prefer not to answer	9	16%
Total Respondents	**57**	

HIGHEST EDUCATION COMPLETED

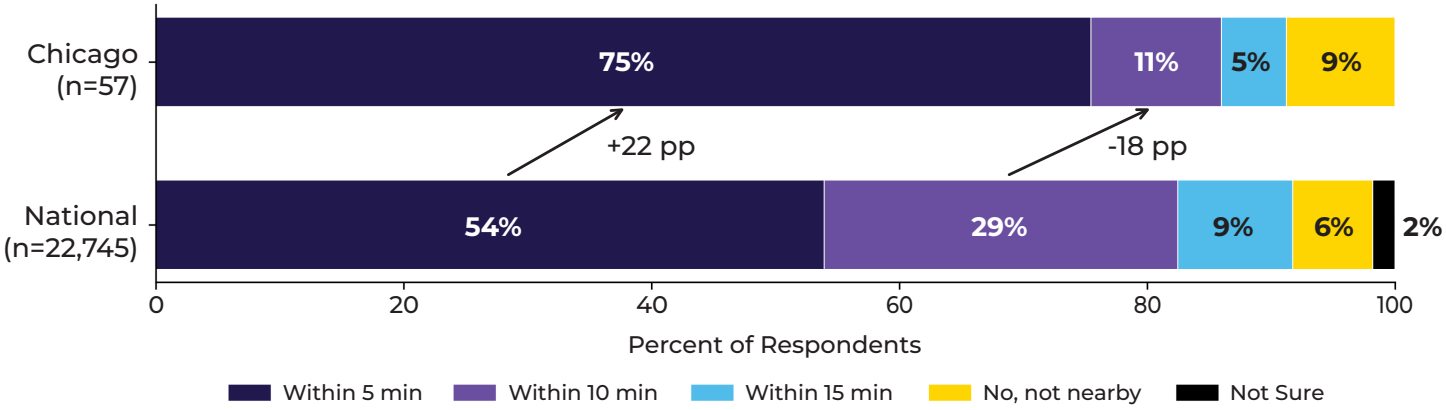
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	-	-
Some college	12	21%
Bachelor's degree	13	23%
Graduate degree or higher	29	52%
Prefer not to answer	2	4%
Total Respondents	**56**	

DIFFICULTIES WITH ACTIVITIES

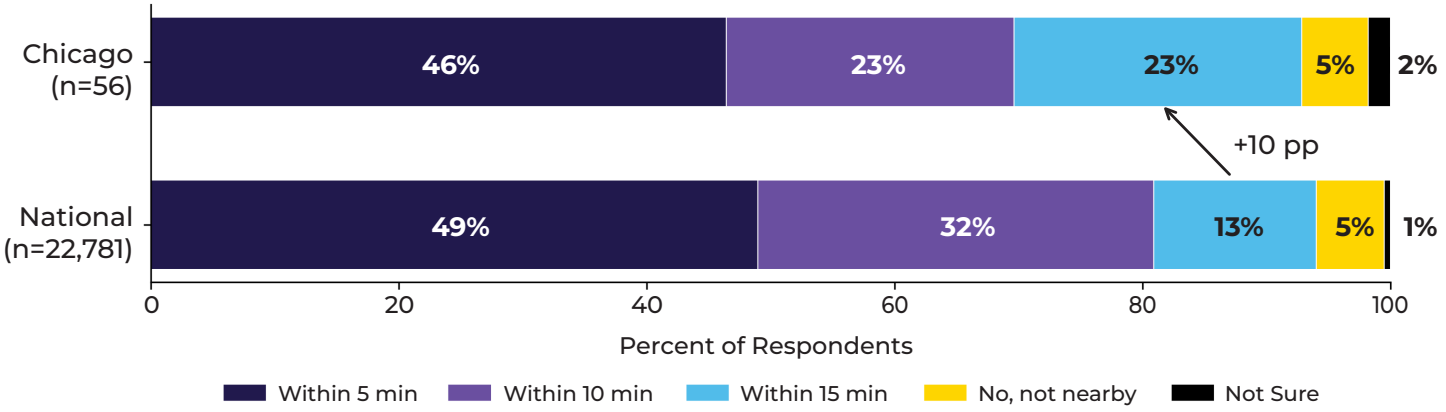
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	1	2%
Seeing, even with glasses	4	7%
Walking or climbing stairs	8	15%
Concentrating or remembering	6	11%
Dressing or bathing	1	2%
Using the toilet	-	-
None of the above	40	73%
Prefer not to answer	2	4%
***Total respondents**	**55**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

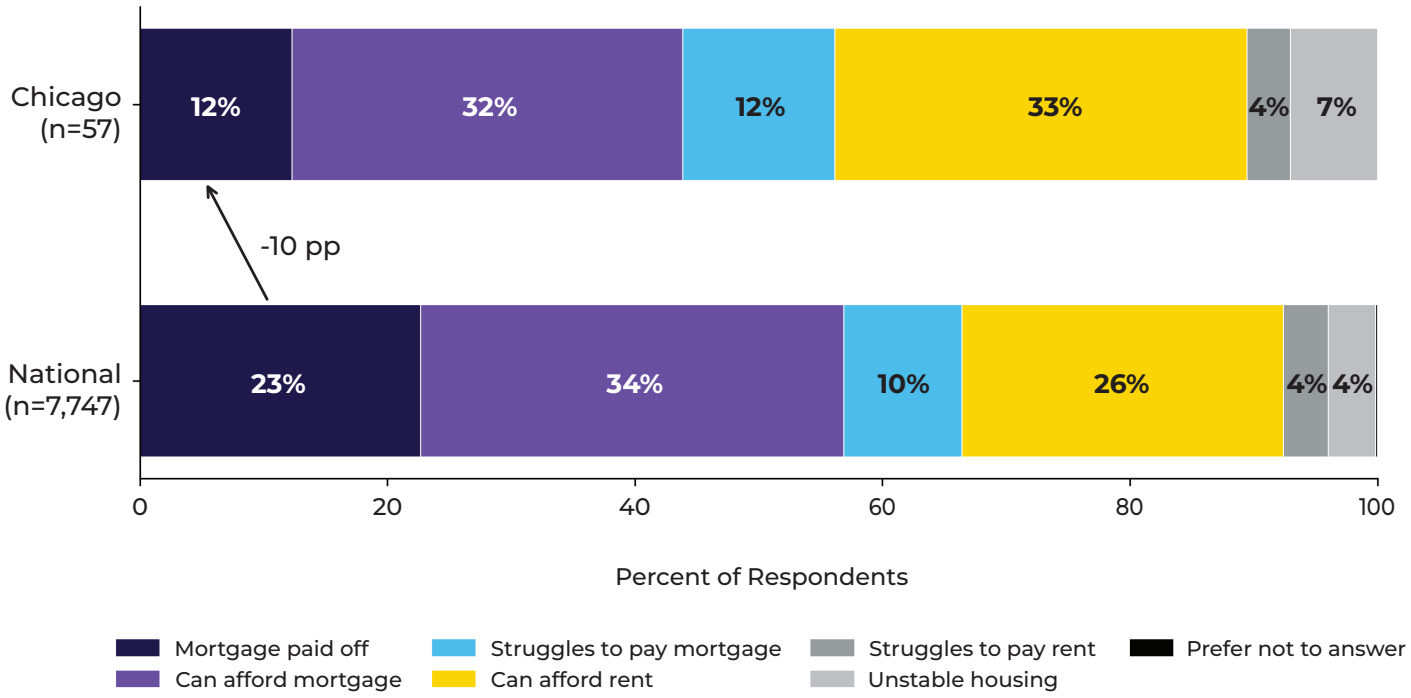
Green Space Access — National vs Chicago



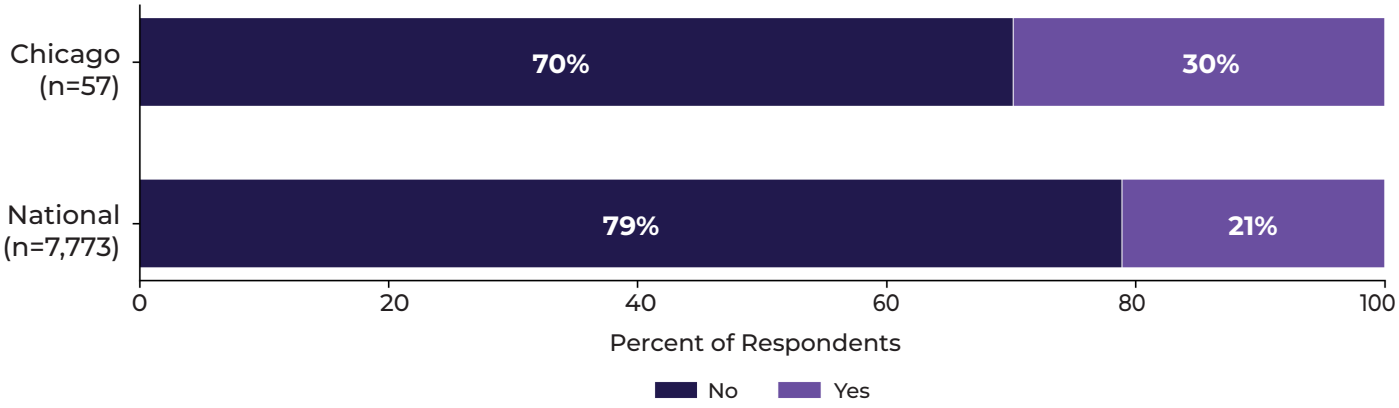
Grocery Store Access — National vs Chicago



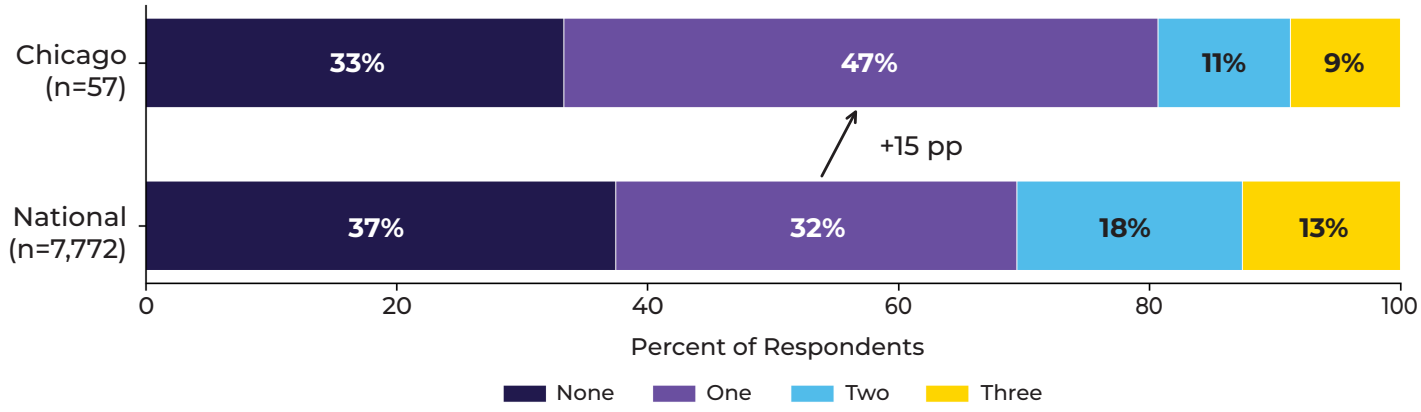
Housing Arrangements — National vs Chicago



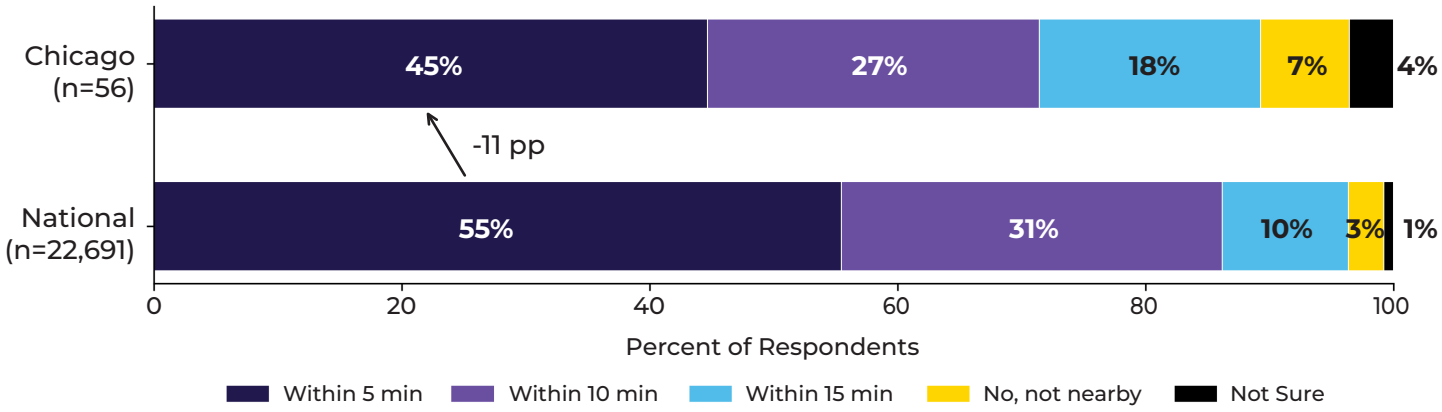
Issues Accessing Appointments or Prescriptions — National vs Chicago



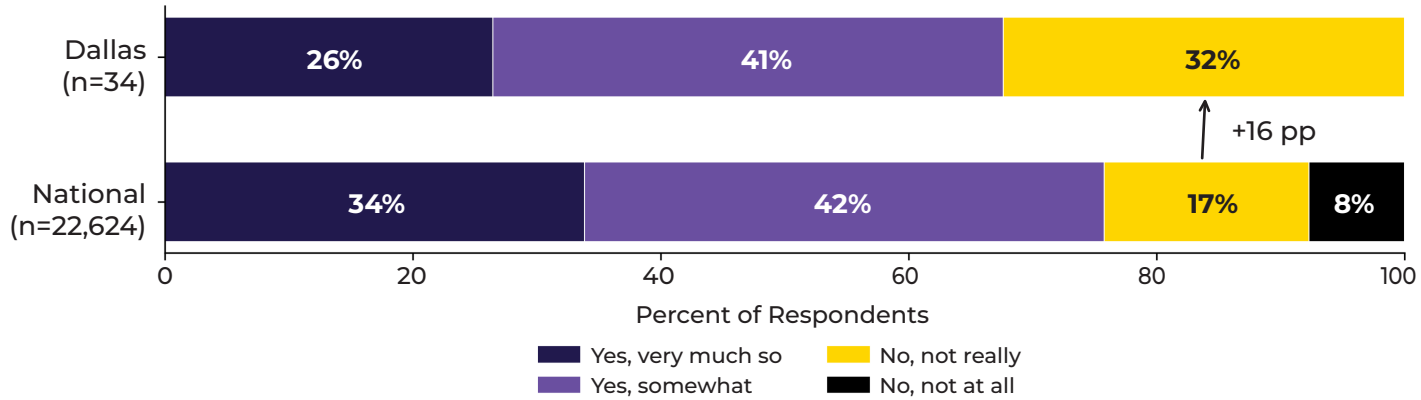
Chronic Health Conditions — National vs Chicago



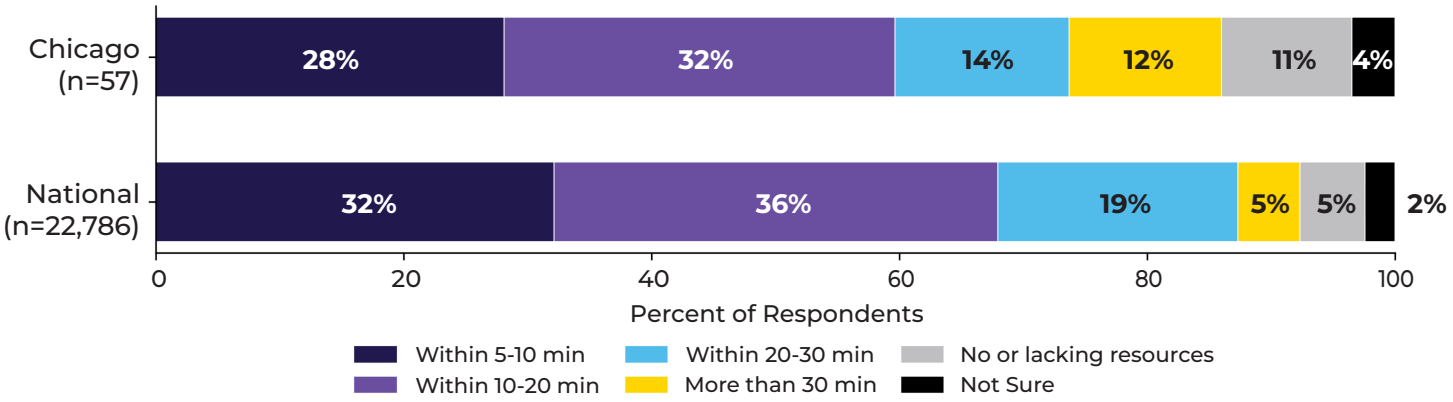
Pharmacy Proximity — National vs Chicago



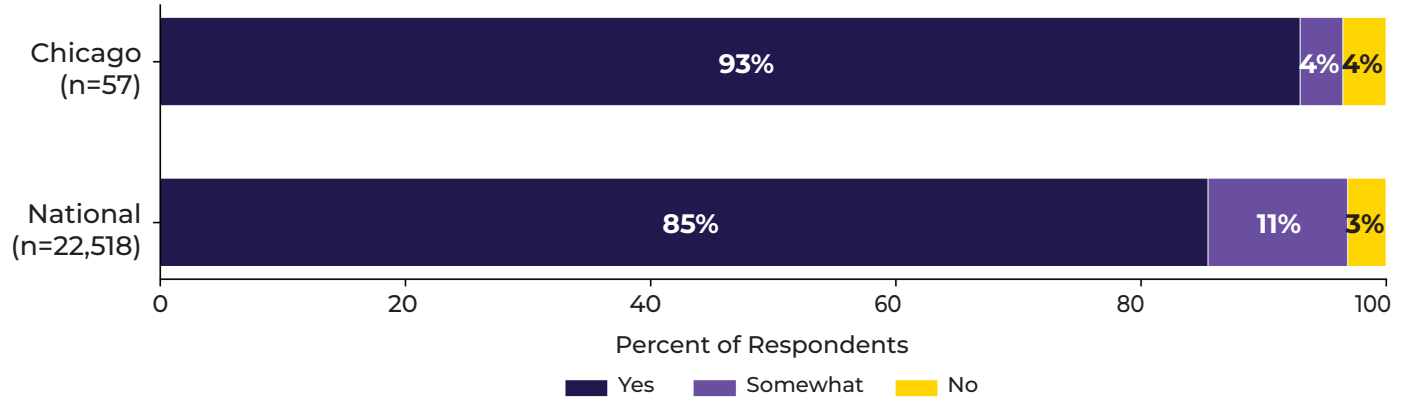
Perceived Cultural Understanding of Providers — National vs Dallas



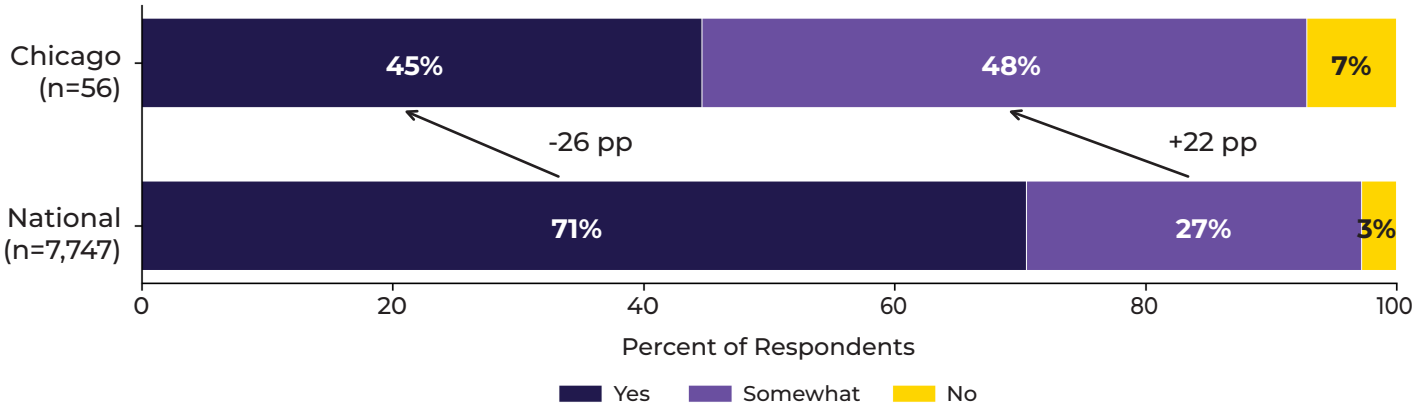
Proximity to a Quality Hospital — National vs Chicago



Access to Affordable and Reliable Transportation — National vs Chicago



Perceived Neighborhood Safety — National vs Chicago



DALLAS, TX

Respondents from Dallas, TX, completed the survey via the canvasser and online versions. Though canvassing recruitment was not conducted in Dallas, TX, if an individual whose address was in Dallas, TX, was approached and completed the survey in one of the cities where canvassing was conducted, their information was retained. Residents in Dallas, TX, represented a small but diverse sample, with most identifying as Black and women. The age distribution leaned older, with more than one-third of respondents aged 61 to 70 and additional representation among adults over 70. Educational attainment varied, with many reporting some college education or holding bachelor's or graduate degrees. While most residents did not report difficulty with daily activities, about one quarter experienced challenges walking or climbing stairs, which may influence how they navigate neighborhood amenities and health care settings.

Compared with national findings, Dallas residents reported stronger access to several key neighborhood resources. A higher share lived within a five-minute distance of grocery stores and green spaces, and pharmacy access exceeded national patterns across every travel time category. Dallas residents also reported better proximity to quality hospitals, with far more respondents living within a 10 to 20-minute distance, and none reporting that they lacked hospital resources. Despite these strengths, Dallas respondents described somewhat higher levels of chronic health conditions and more difficulty securing timely medical appointments than the national sample. Fewer residents felt that their providers understood their cultural background, highlighting opportunities to strengthen communication and responsiveness within the health care system.

These patterns suggest that policy efforts in Dallas, TX, should focus on improving the care experience rather than on the physical availability of resources. Investments that enhance culturally responsive care, build trust, and improve care coordination may be especially impactful. Community-based programs that support chronic disease management, appointment navigation, and transportation assistance could help residents with mobility limitations engage more fully in care. Continuing to improve access to medical services, particularly through partnerships with local clinics and community organizations, can further support health equity. These efforts align with the needs reflected in the Dallas data and can help ensure that residents benefit fully from the strong neighborhood infrastructure already in place.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	4	12%
Leave Behind	-	-
Main (online)	30	88%
Main (paper)	-	-
Total Respondents	**34**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	-	-
Asian	1	3%
Black or African American	27	79%
Hispanic or Latino	1	3%
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	2	6%
Native Hawaiian or Pacific Islander	-	-
White	2	6%
Prefer not to answer	1	3%
Total Respondents	**34**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	8	26%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	23	74%
Prefer not to answer	-	-
Total Respondents	**31**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	2	6%
25 – 40	4	12%
41 – 50	5	15%
51 – 60	7	21%
61 – 70	13	38%
71 and over	3	9%
Prefer not to answer	-	-
Total Respondents	**34**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	-	-
Gay	1	3%
Heterosexual or straight	26	90%
Lesbian	-	-
Prefer to self-describe	-	-
Prefer not to answer	2	7%
Total Respondents	**29**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	-	-
$20,000 – $39,999	7	24%
$40,000 – $59,999	4	14%
$60,000 – $79,999	3	10%
$80,000 – $99,999	3	10%
$100,000 or more	10	34%
Prefer not to answer	2	7%
Total Respondents	**29**	

HIGHEST EDUCATION COMPLETED

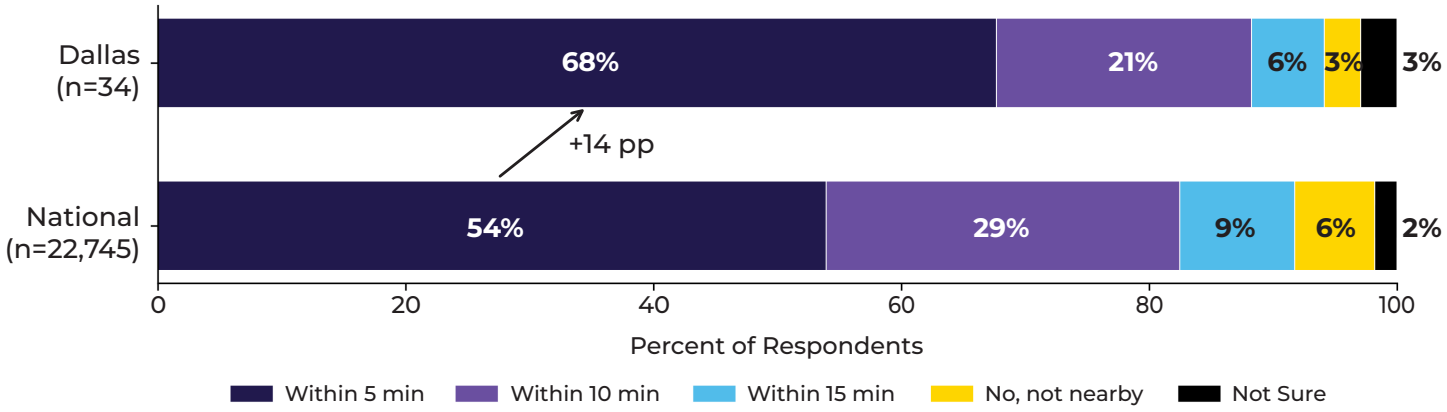
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	2	7%
Some college	12	40%
Bachelor's degree	7	23%
Graduate degree or higher	9	30%
Prefer not to answer	-	-
Total Respondents	**30**	

DIFFICULTIES WITH ACTIVITIES

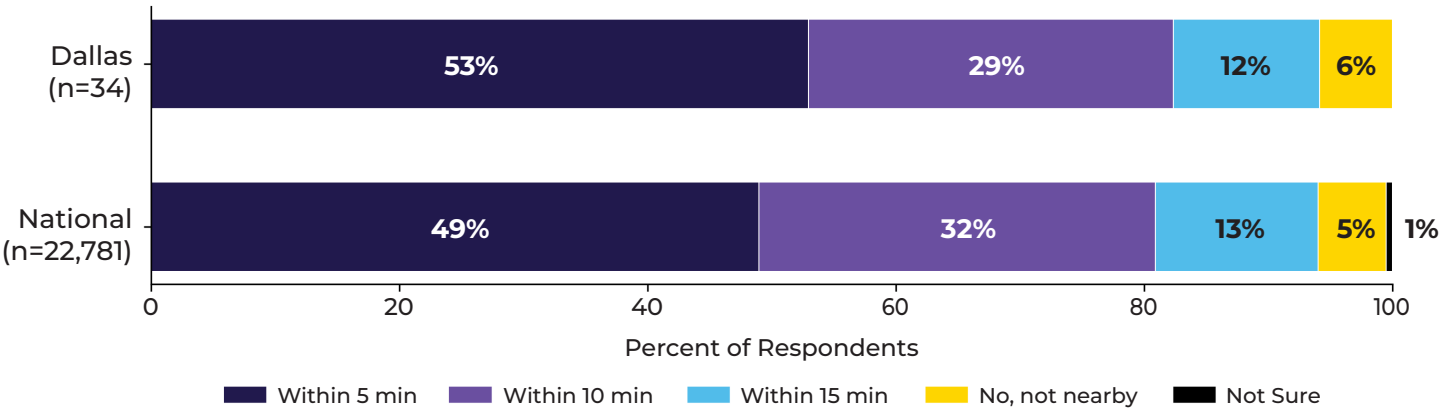
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	-	-
Seeing, even with glasses	3	10%
Walking or climbing stairs	7	24%
Dressing or bathing	-	-
Using the toilet	-	-
None of the above	18	62%
Prefer not to answer	-	-
Concentrating or remembering	2	7%
***Total Respondents**	**29**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

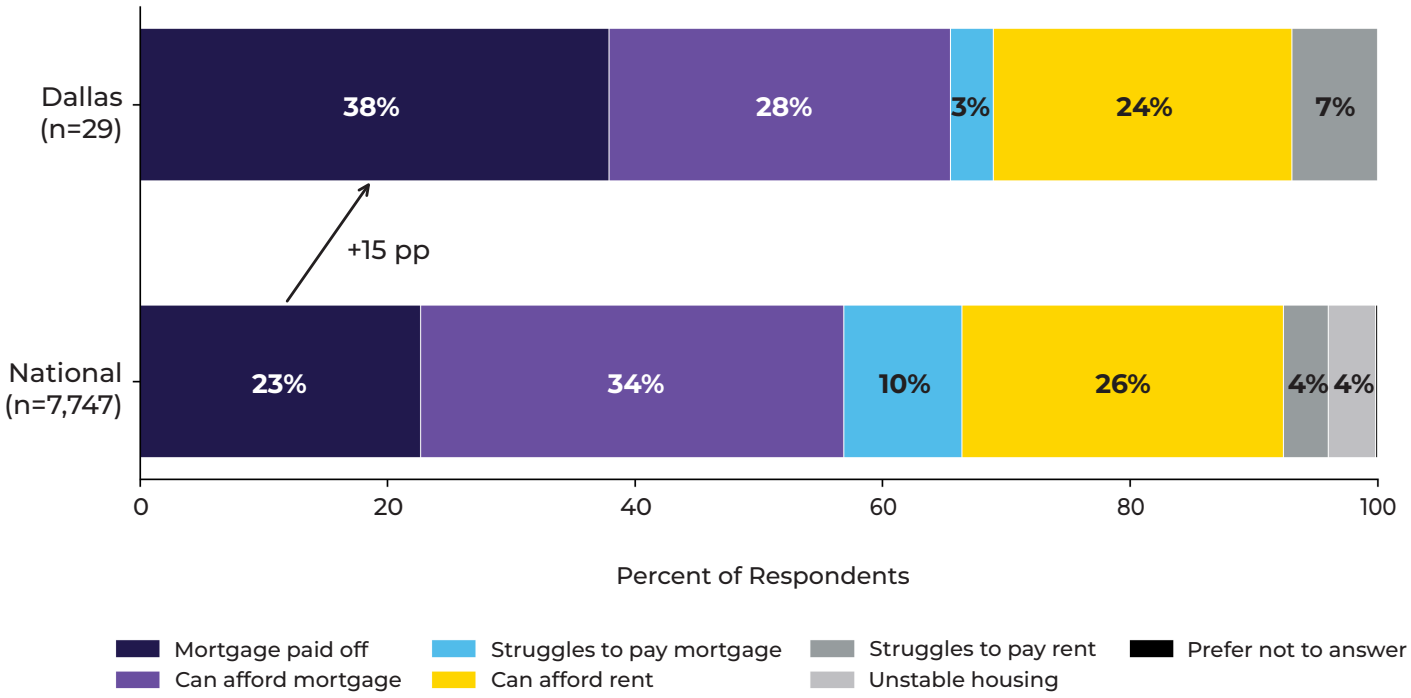
Green Space Access — National vs Dallas



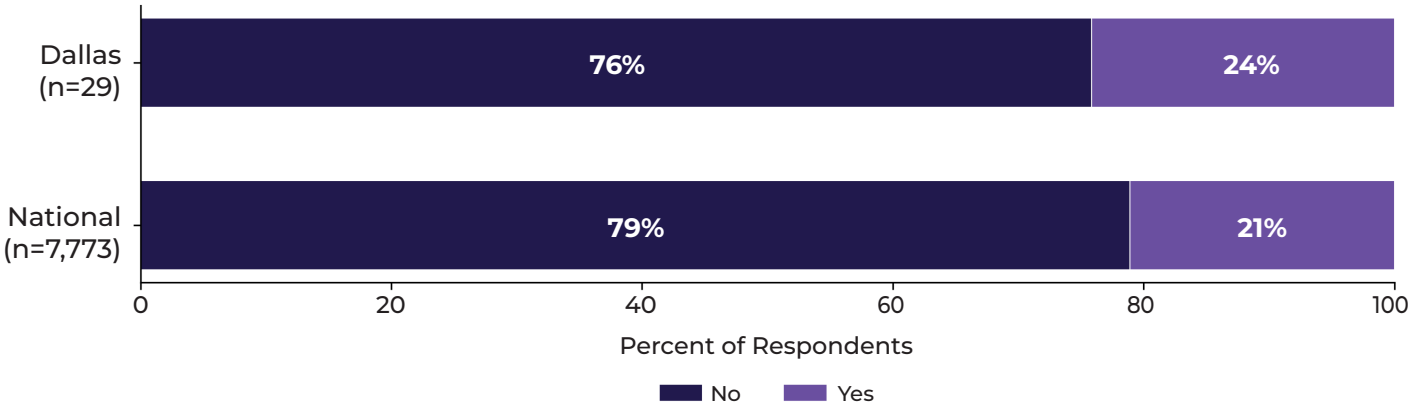
Grocery Store Access — National vs Dallas



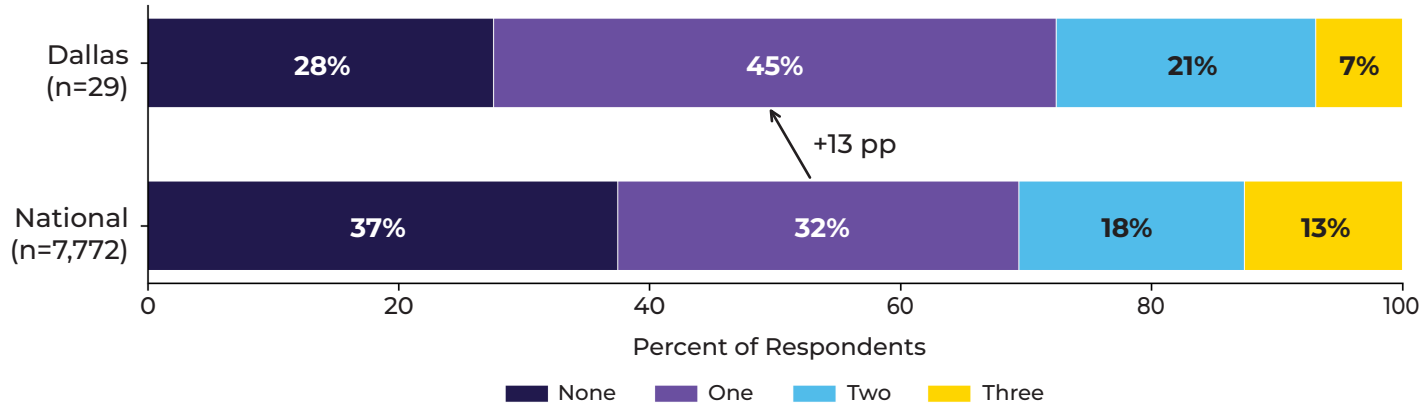
Housing Arrangements — National vs Dallas



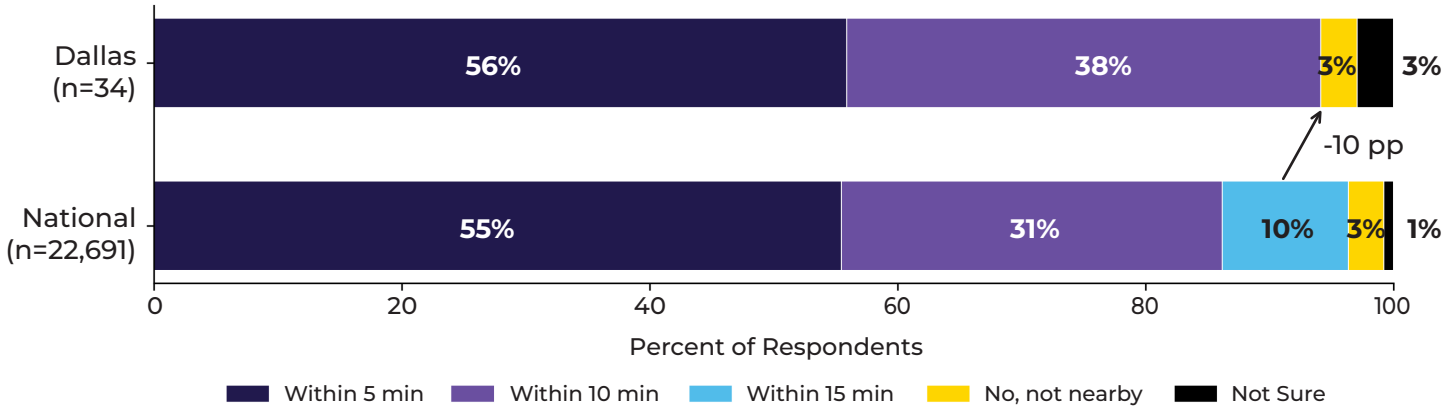
Issues Accessing Appointments or Prescriptions — National vs Dallas



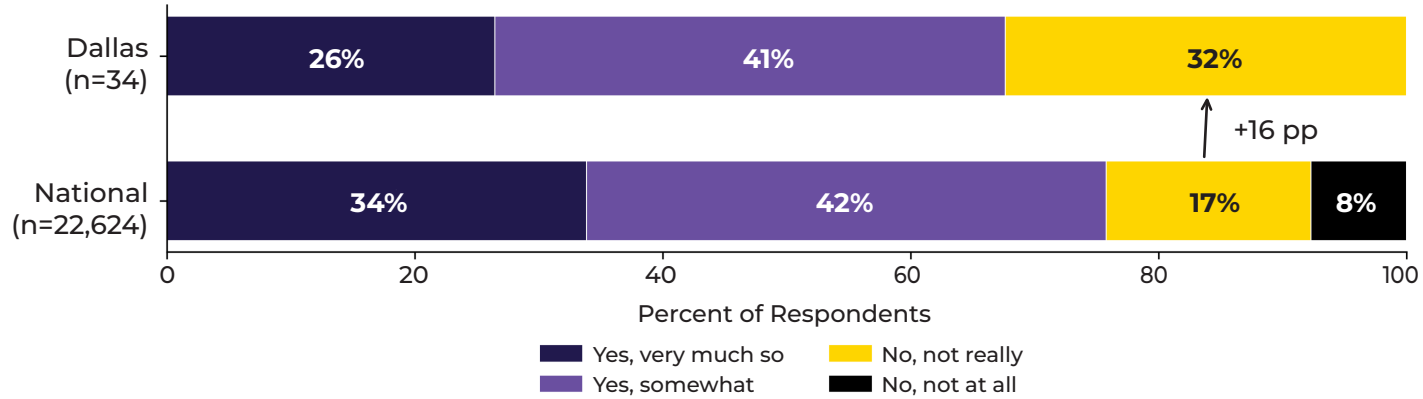
Chronic Health Conditions — National vs Dallas



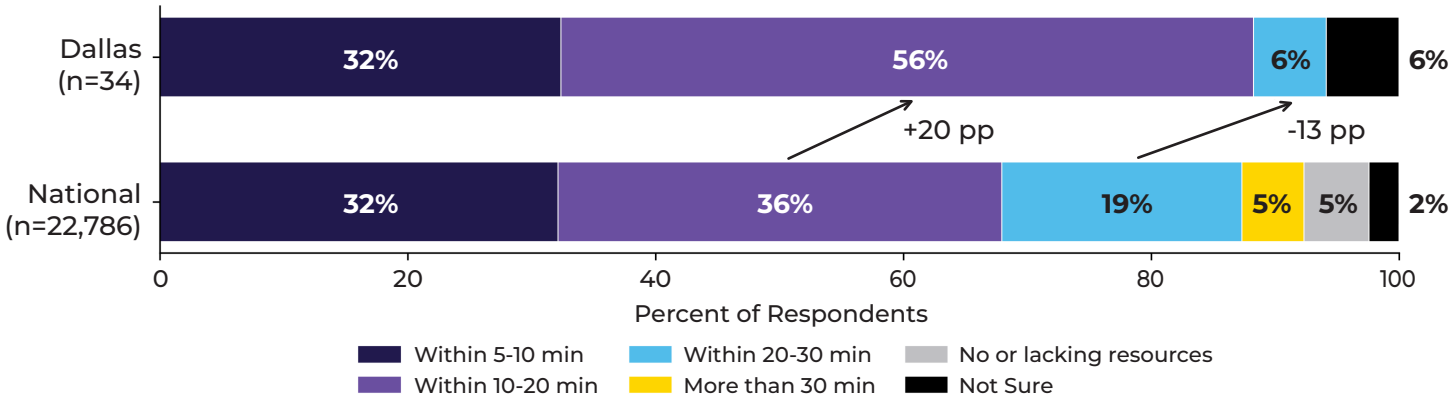
Pharmacy Proximity — National vs Dallas



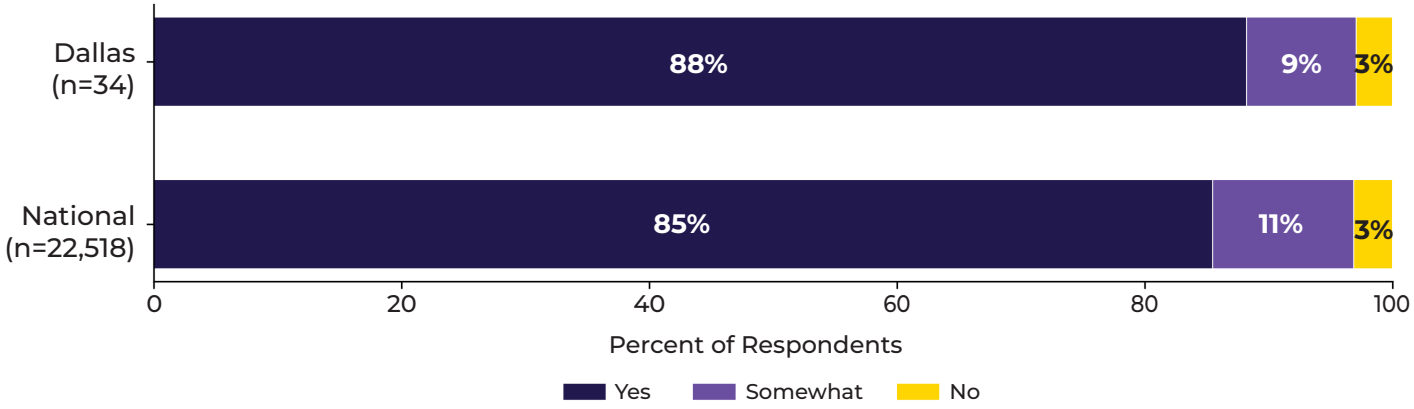
Perceived Cultural Understanding of Providers — National vs Dallas



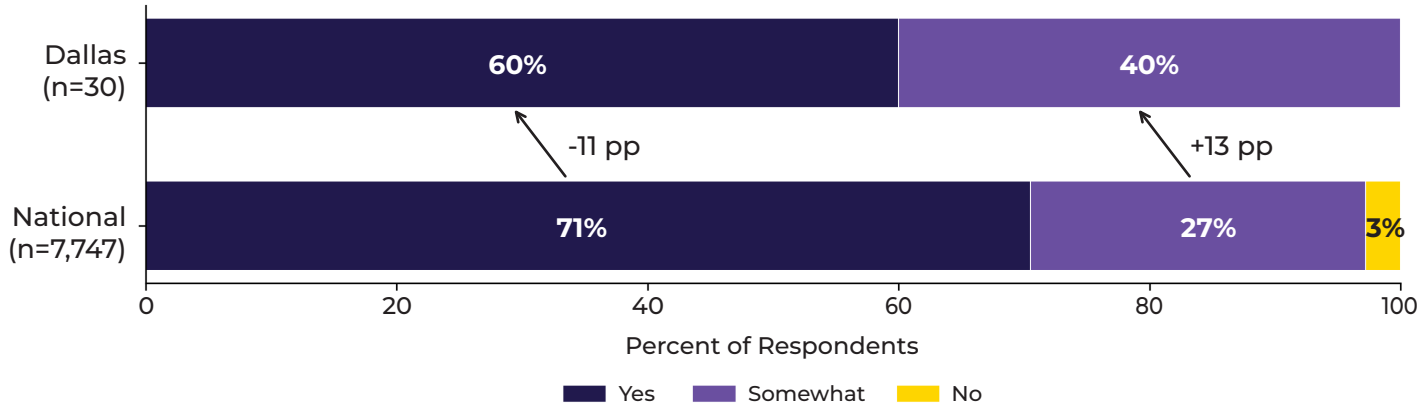
Proximity to a Quality Hospital — National vs Dallas



Access to Affordable and Reliable Transportation — National vs Dallas



Perceived Neighborhood Safety — National vs Dallas



DETROIT, MI

Respondents in Detroit, MI, completed the survey in various formats, including the canvasser, leave-behind, and online versions. Neighborhood canvassing data collection targeted historically Black neighborhoods throughout the metropolitan area. However, across all survey modes, only respondents whose addresses are in Detroit, MI, are included in the analyses in the Detroit, MI, addenda. Respondents in Detroit, MI, represented a large, predominantly Black sample, with nearly equal shares of men and women and strong representation across young and middle-aged adults. Four in ten respondents were between 25 and 40 years old, and another 20% were ages 18 to 24, creating one of the youngest age distributions among the cities surveyed. Household income levels were modest, with more than one-third reporting less than $20,000 annually. Educational attainment varied, with many residents holding a GED or high school diploma, some college, or a bachelor's or graduate degree. Most respondents did not report difficulties with daily functioning, although a notable share experienced mobility challenges such as walking or climbing stairs.

Across neighborhood and health-related measures, Detroit showed several areas where residents faced greater barriers than the national sample. Access to nearby full-service grocery stores and green spaces was lower, with more residents reporting that these resources were not close to home. Detroit respondents were also more likely to report chronic health conditions and greater difficulty securing timely medical appointments. Proximity to hospitals and pharmacies was also weaker compared with national averages, suggesting that many residents must travel farther to reach essential health services. Perceptions of neighborhood safety were significantly lower in Detroit, indicating broader concerns about environmental conditions and daily well-being. Fewer residents felt that providers understood their cultural background, pointing to gaps in communication, trust, and culturally responsive care.

These patterns identify several opportunities for targeted action in Detroit, MI. Expanding access to nearby grocery stores, green spaces, and health care facilities would address some of the most pressing resource gaps. Investments in affordable transportation and improved pedestrian infrastructure could also support younger adults, working families, and residents experiencing mobility limitations. Strengthening culturally informed care through provider training and partnerships with trusted community organizations may enhance communication and improve care engagement. Programs that support chronic disease management, preventive care, and appointment navigation could help reduce health burdens in communities with limited access. Collectively, these strategies can help foster safer, healthier, and more resource-rich environments for Detroit residents.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	2,211	93%
Leave Behind	25	1%
Main (online)	151	6%
Main (paper)	-	-
Total Respondents	**2,387**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	4	<1%
Asian	1	<1%
Black or African American	2,277	95%
Hispanic or Latino	13	1%
Middle Eastern or North African	1	<1%
Multiracial and/or Multiethnic	45	2%
Native Hawaiian or Pacific Islander	-	-
White	35	1%
Prefer not to answer	9	<1%
Total Respondents	**2,385**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	4	<1%
Man	1,113	47%
Non-binary/gender non-conforming	10	<1%
Transgender	1	<1%
Woman	1,239	52%
Prefer not to answer	4	<1%
Total Respondents	**2,371**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	143	6%
18 – 24	465	20%
25 – 40	955	40%
41 – 50	418	18%
51 – 60	222	9%
61 – 70	110	5%
71 and over	66	3%
Prefer not to answer	5	<1%
Total Respondents	**2,384**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	4	3%
Gay	1	1%
Heterosexual or straight	116	80%
Lesbian	-	-
Prefer to self-describe	4	3%
Prefer not to answer	20	14%
Total Respondents	**145**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	59	34%
$20,000 – $39,999	23	13%
$40,000 – $59,999	23	13%
$60,000 – $79,999	16	9%
$80,000 – $99,999	11	6%
$100,000 or more	9	5%
Prefer not to answer	33	19%
Total Respondents	**174**	

HIGHEST EDUCATION COMPLETED

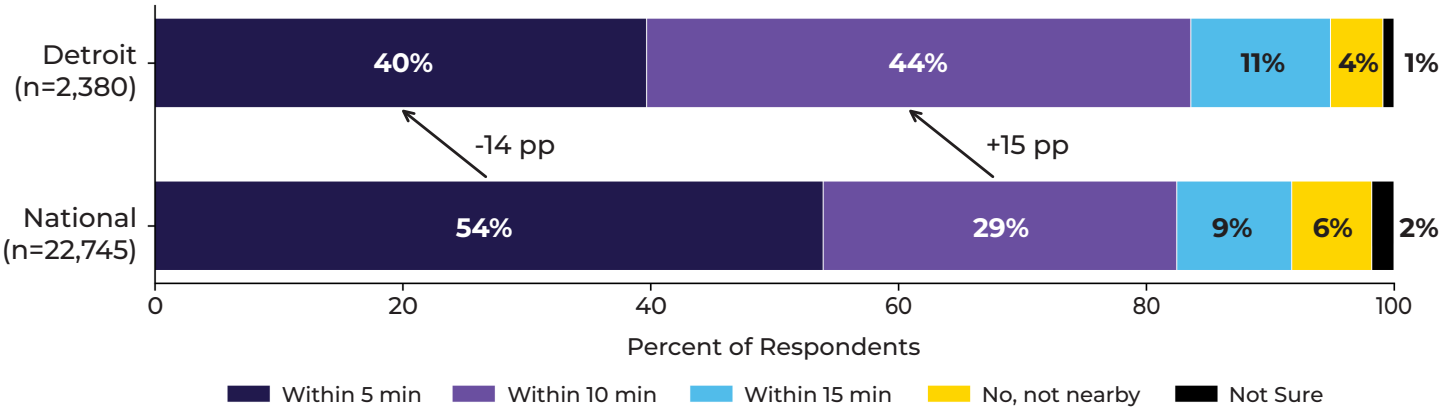
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	4	2%
Some high school	22	13%
GED or high school graduate	42	24%
Some college	33	19%
Bachelor's degree	27	15%
Graduate degree or higher	38	22%
Prefer not to answer	9	5%
Total Respondents	**175**	

DIFFICULTIES WITH ACTIVITIES

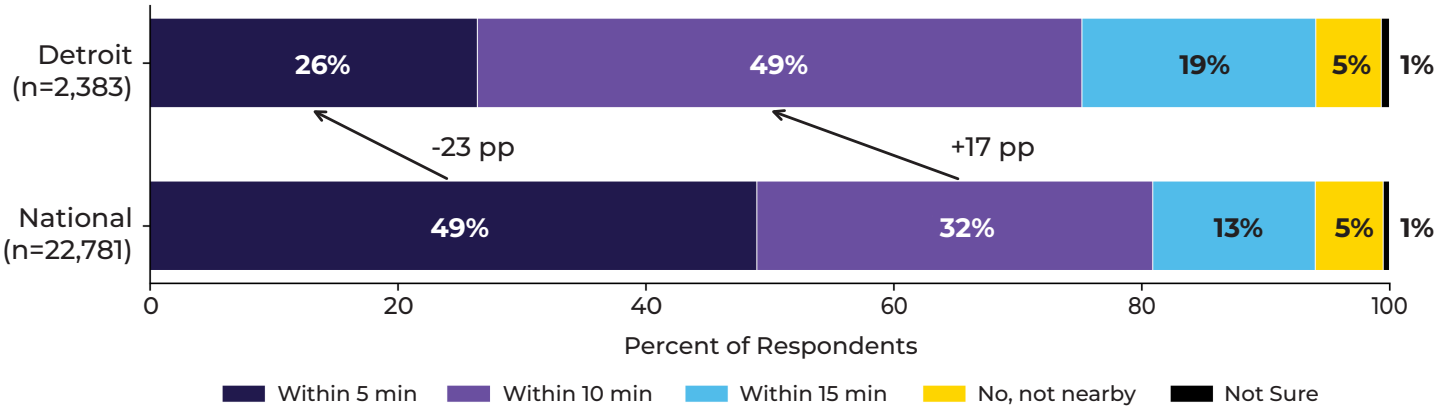
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	4	2%
Seeing, even with glasses	16	9%
Walking or climbing stairs	25	15%
Dressing or bathing	5	3%
Using the toilet	4	2%
None of the above	113	66%
Prefer not to answer	13	8%
Concentrating	13	8%
***Total Respondents**	**171**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

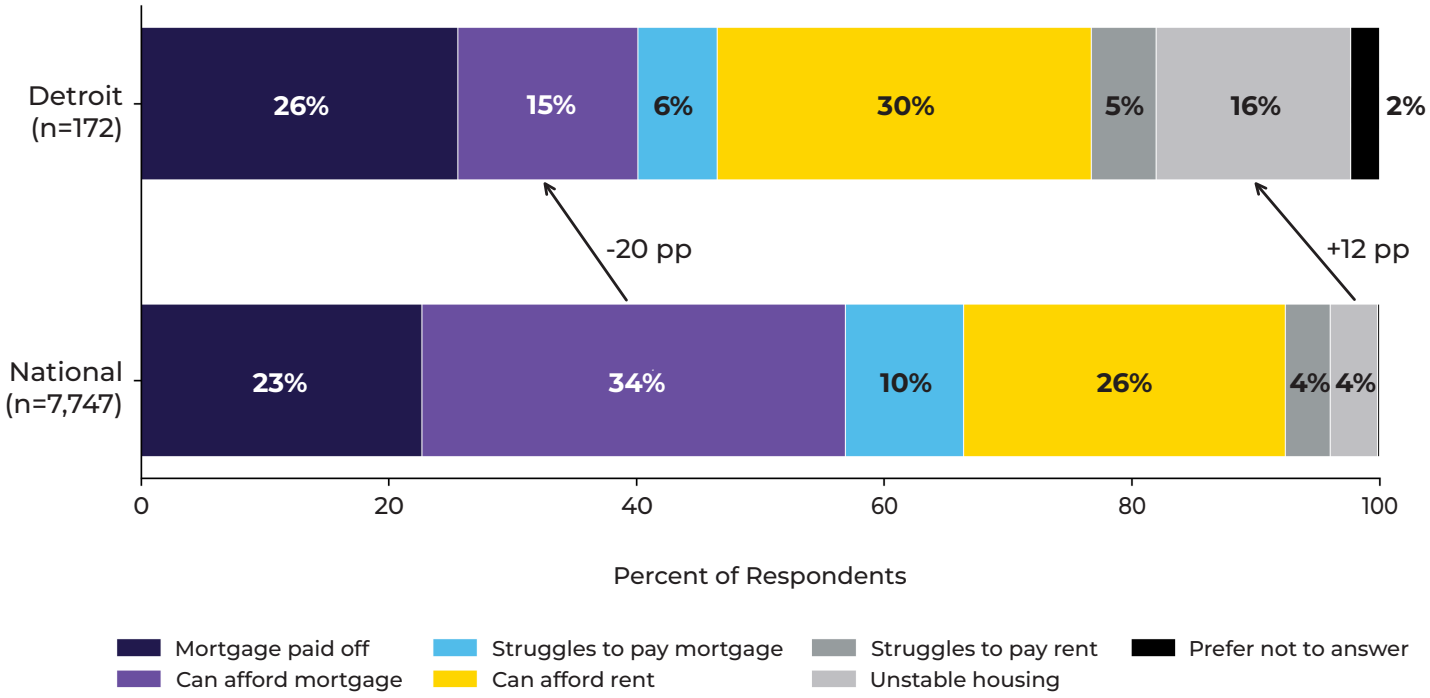
Green Space Access — National vs Detroit



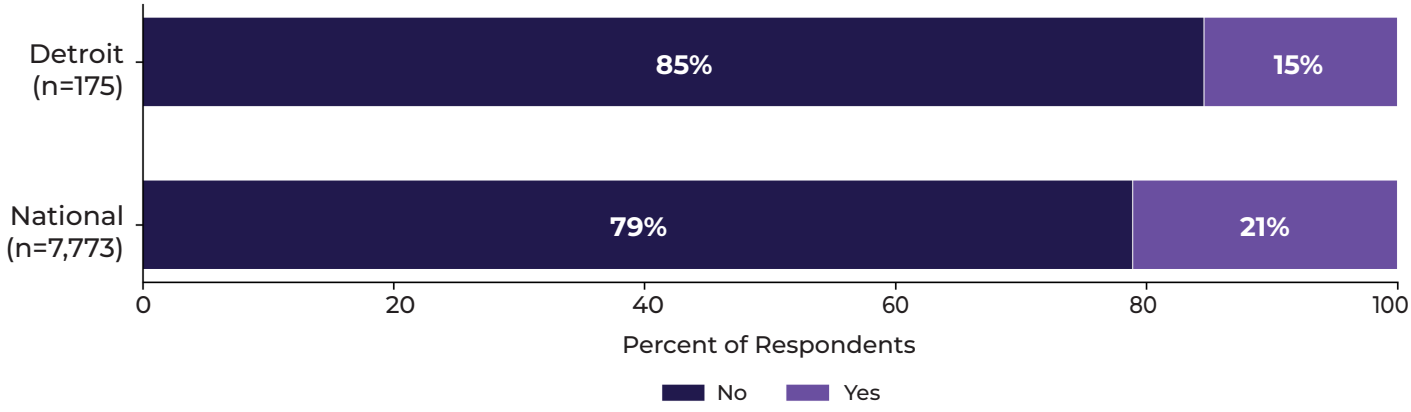
Grocery Store Access — National vs Detroit



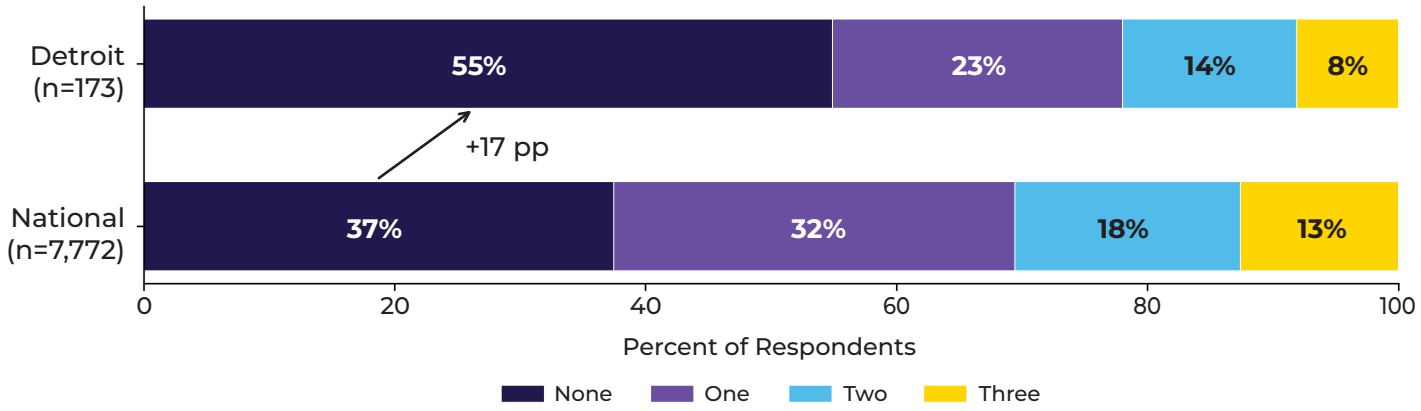
Housing Arrangements — National vs Detroit



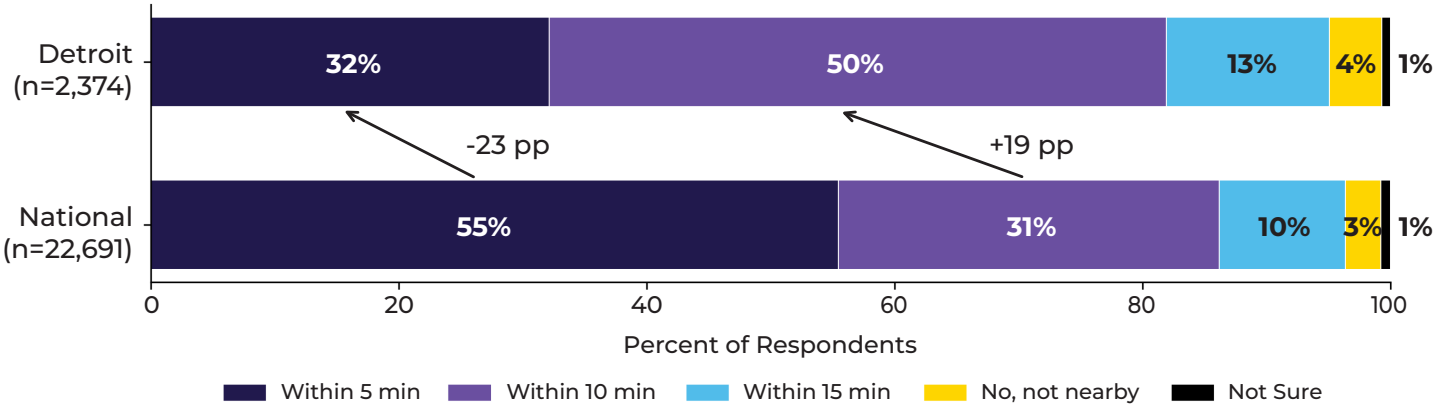
Issues Accessing Appointments or Prescriptions — National vs Detroit



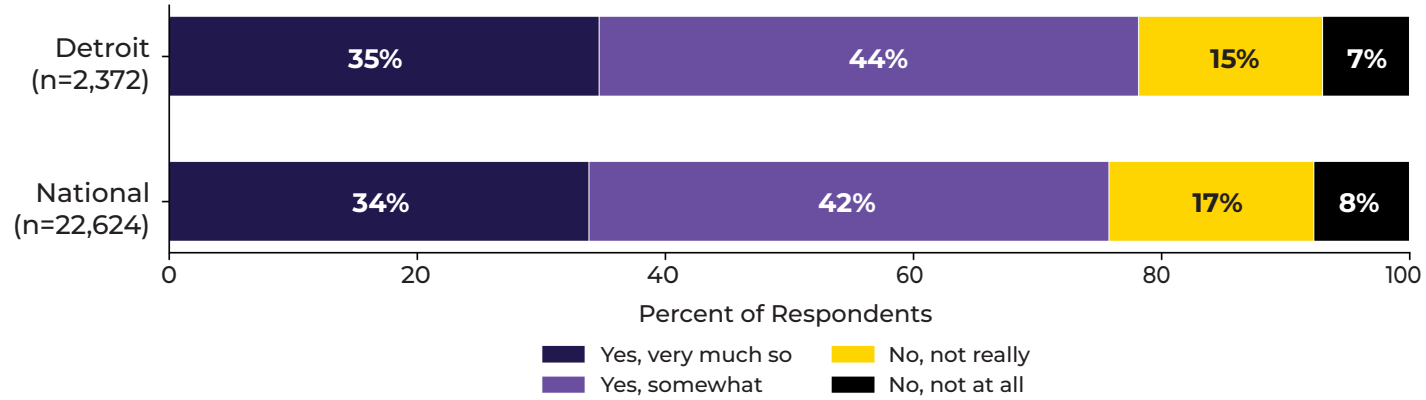
Chronic Health Conditions — National vs Detroit



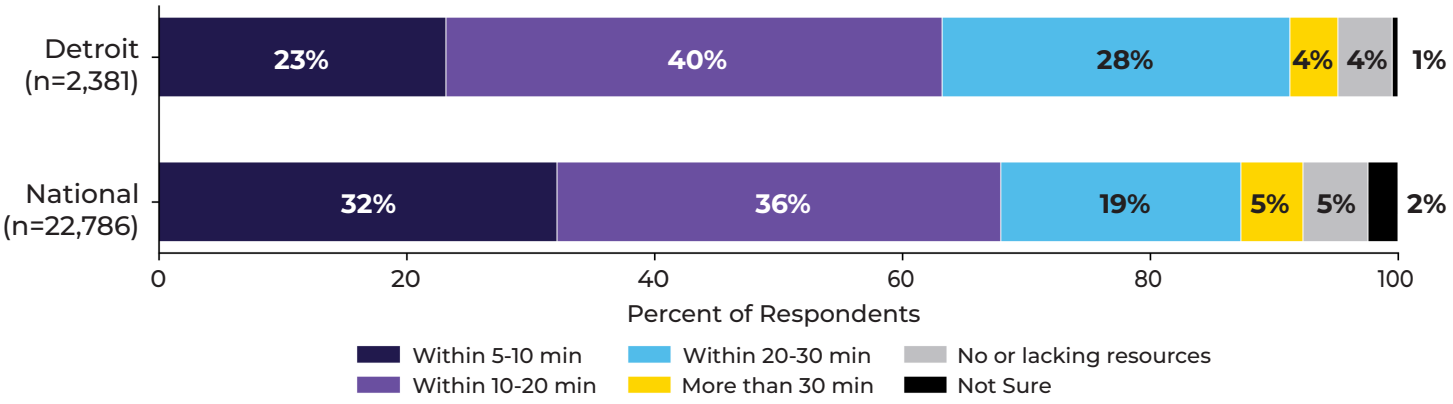
Pharmacy Proximity — National vs Detroit



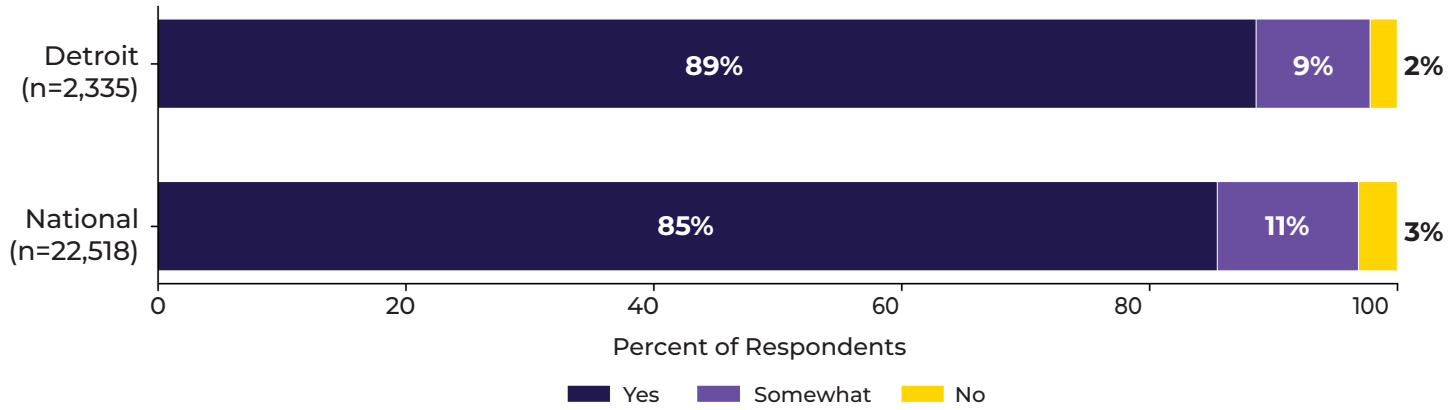
Perceived Cultural Understanding of Providers — National vs Detroit



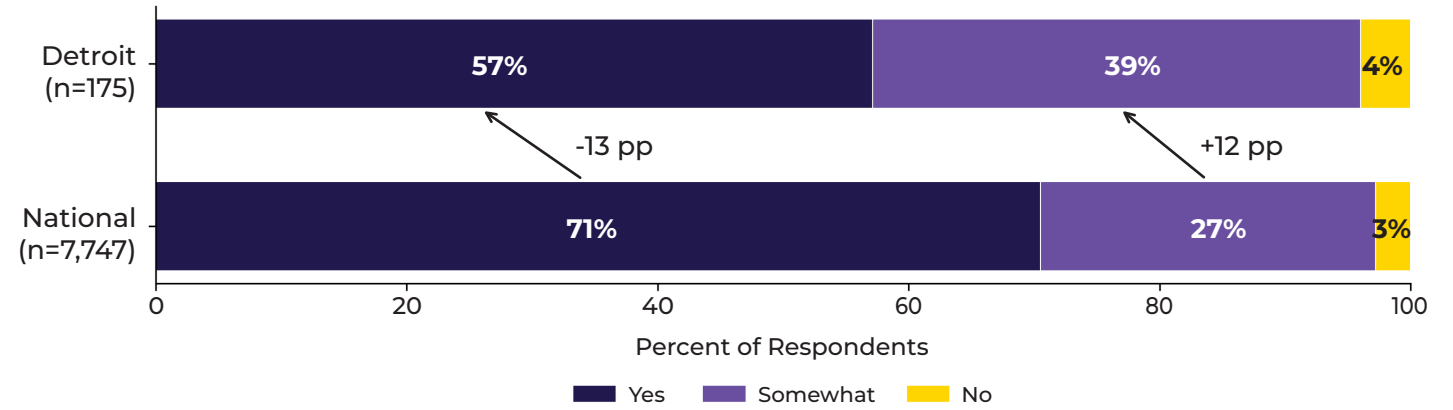
Proximity to a Quality Hospital — National vs Detroit



Access to Affordable and Reliable Transportation — National vs Detroit



Perceived Neighborhood Safety — National vs Detroit



MEMPHIS, TN

Respondents in Memphis, TN, completed the survey online. Respondents in Memphis, TN, represented a small but predominantly Black sample, with most identifying as women and a large share aged 51 and older. Educational attainment was strong, with more than half of respondents having completed some college and nearly one-third holding a graduate degree. Despite these strengths, many residents reported notable challenges with daily functioning. Roughly half had trouble walking or climbing stairs, and three in ten reported difficulty concentrating. These functional limitations, combined with the older age distribution, suggest that some of Memphis' residents may face barriers when navigating their neighborhoods and accessing health and social resources.

Across neighborhood resources, Memphis, TN, respondents reported more limited access compared with national patterns. Fewer residents lived within a short distance of grocery stores or green spaces, and a larger share indicated that these amenities were not located nearby. Perceptions of neighborhood safety were also lower. On health care measures, Memphis residents were more likely than national respondents to report chronic health conditions and difficulty securing timely medical appointments. Access to pharmacies and hospitals was weaker, with more residents living farther away from these services. A smaller share felt that health care providers understood their cultural background, indicating opportunities to strengthen communication, trust, and cultural responsiveness.

These patterns highlight several opportunities for targeted investments in Memphis, TN. Improving access to grocery stores, green spaces, pharmacies, and medical facilities would address the most immediate resource gaps. Strengthening transportation support and walkable infrastructure could benefit older adults and residents experiencing mobility limitations. Expanding culturally informed care, through provider training and stronger partnerships with community-based organizations, may help improve the patient experience and increase engagement in preventive and chronic disease management. Together, these investments can support healthier, safer, and more accessible environments for Memphis residents.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	25	100%
Main (paper)	-	-
Total Respondents	**25**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	-	-
Asian	-	-
Black or African American	22	92%
Hispanic or Latino	-	-
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	1	4%
Native Hawaiian or Pacific Islander	-	-
White	1	4%
Prefer not to answer	-	-
Total Respondents	**24**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	7	35%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	13	65%
Prefer not to answer	-	-
Total Respondents	**20**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	-	-
25 – 40	3	12%
41 – 50	5	20%
51 – 60	6	24%
61 – 70	6	24%
71 and over	5	20%
Prefer not to answer	-	-
Total Respondents	**25**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	1	4%
Gay	-	-
Heterosexual or straight	22	88%
Lesbian	1	4%
Prefer to self-describe	1	4%
Prefer not to answer	-	-
Total Respondents	**25**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	2	8%
$20,000 – $39,999	3	12%
$40,000 – $59,999	9	36%
$60,000 – $79,999	6	24%
$80,000 – $99,999	1	4%
$100,000 or more	3	12%
Prefer not to answer	1	4%
Total Respondents	**25**	

HIGHEST EDUCATION COMPLETED

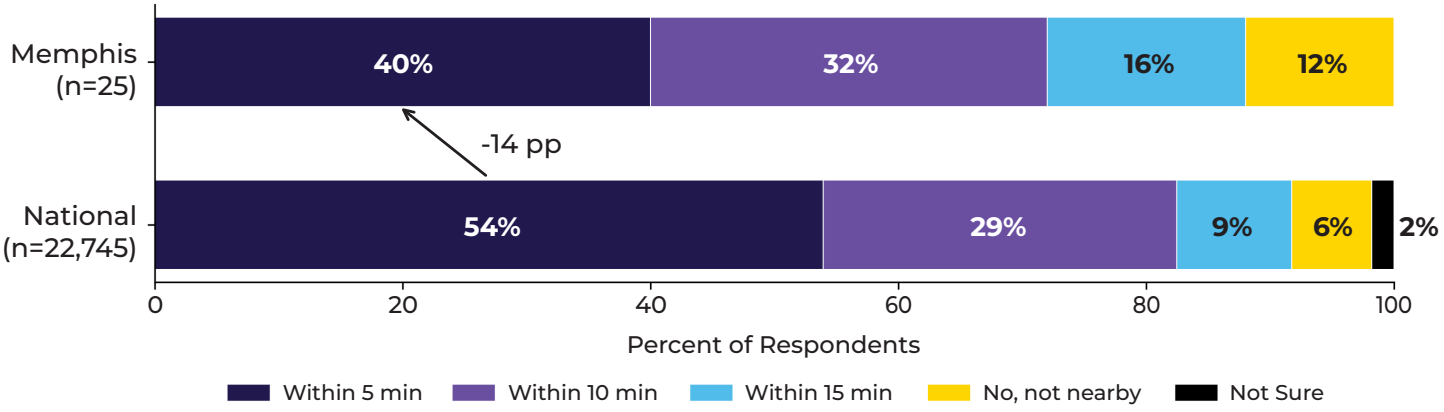
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	-	-
Some college	13	52%
Bachelor's degree	4	16%
Graduate degree or higher	8	32%
Prefer not to answer	-	-
Total Respondents	**25**	

DIFFICULTIES WITH ACTIVITIES

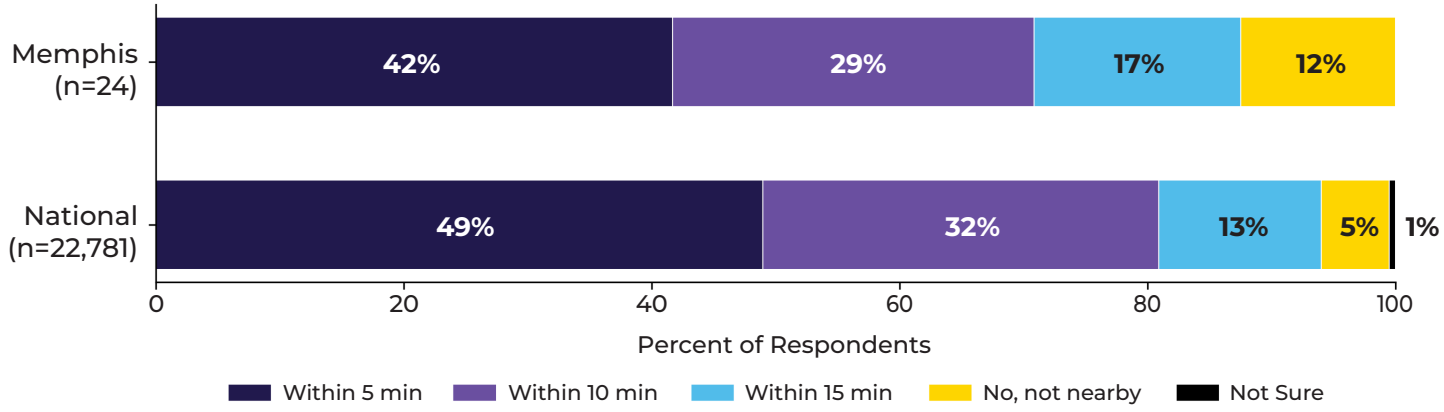
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	3	13%
Seeing, even with glasses	4	17%
Walking or climbing stairs	11	48%
Dressing or bathing	2	9%
Using the toilet	-	-
None of the above	7	30%
Prefer not to answer	-	-
Concentrating	7	30%
***Total Respondents**	**23**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

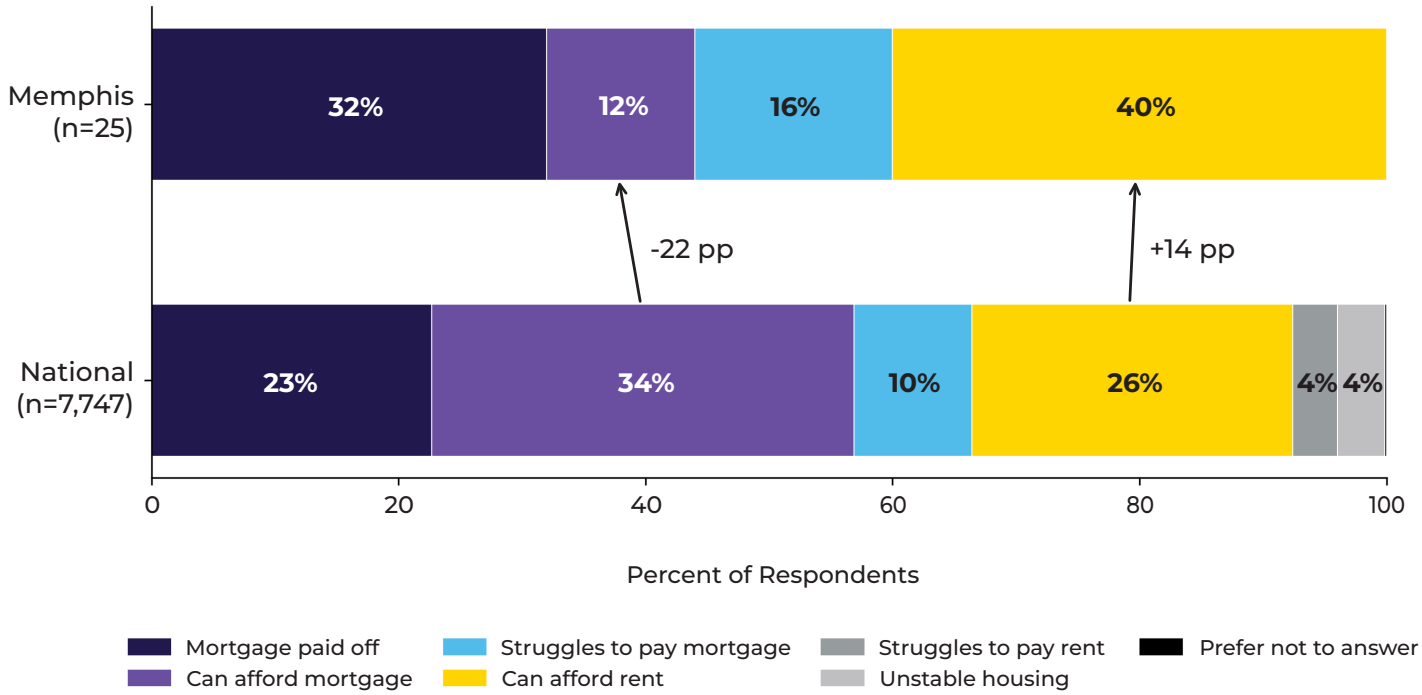
Green Space Access — National vs Memphis



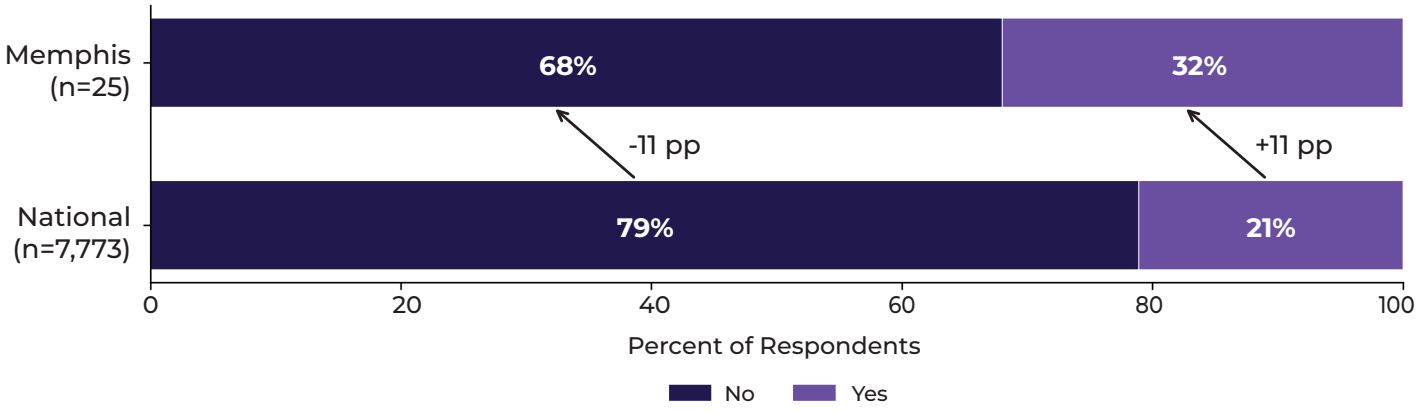
Grocery Store Access — National vs Memphis



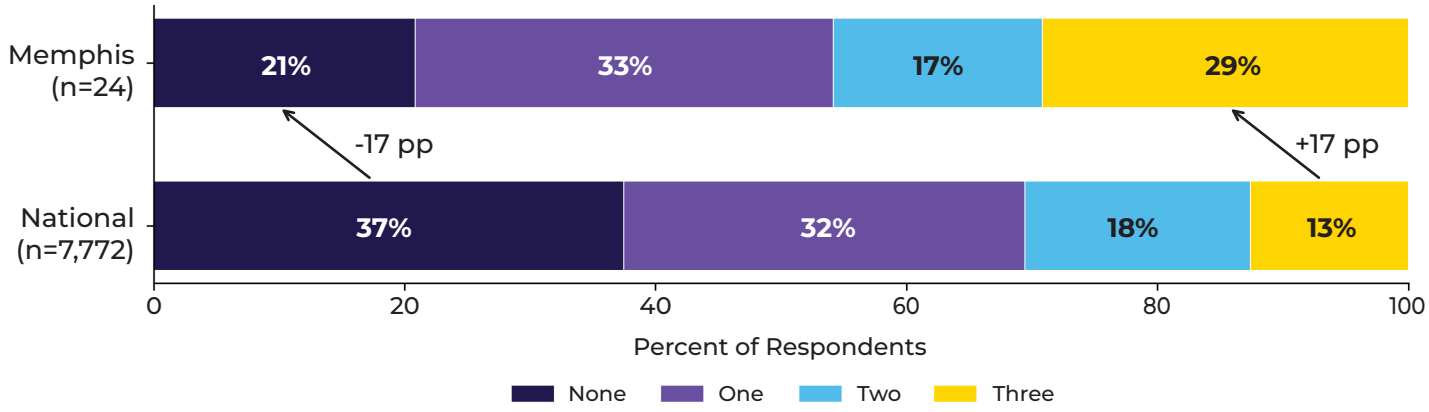
Housing Arrangements — National vs Memphis



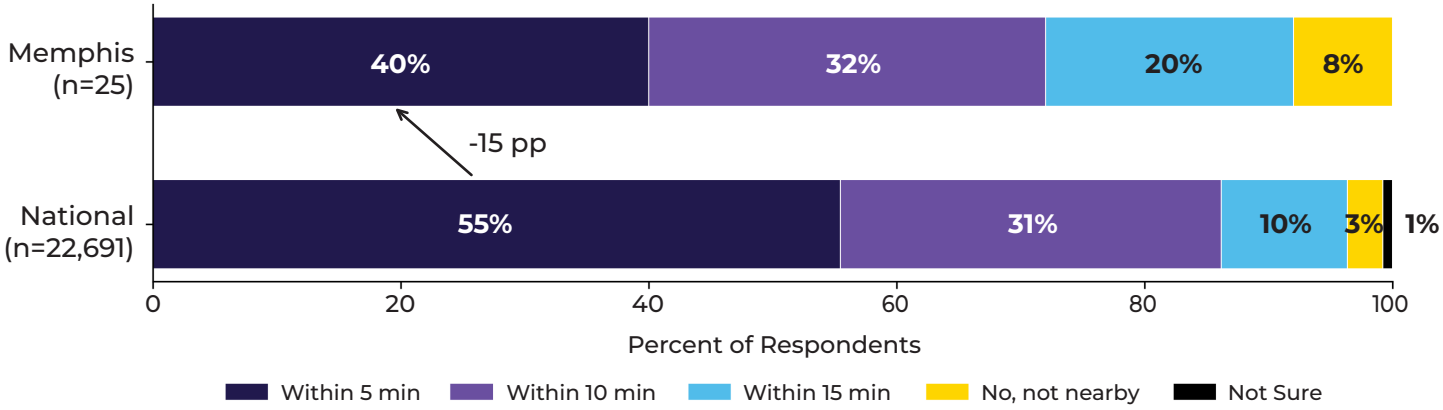
Issues Accessing Appointments or Prescriptions — National vs Memphis



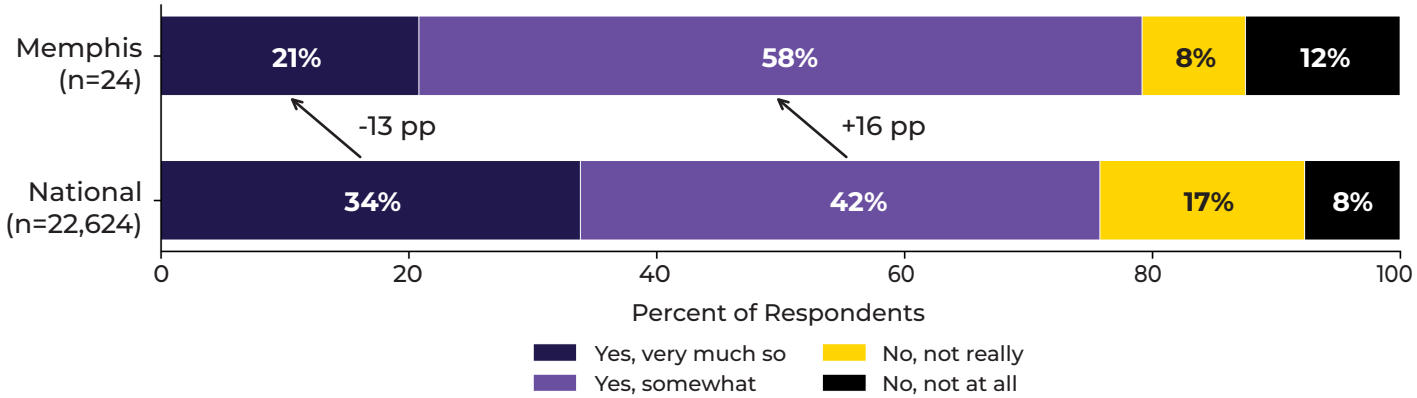
Chronic Health Conditions — National vs Memphis



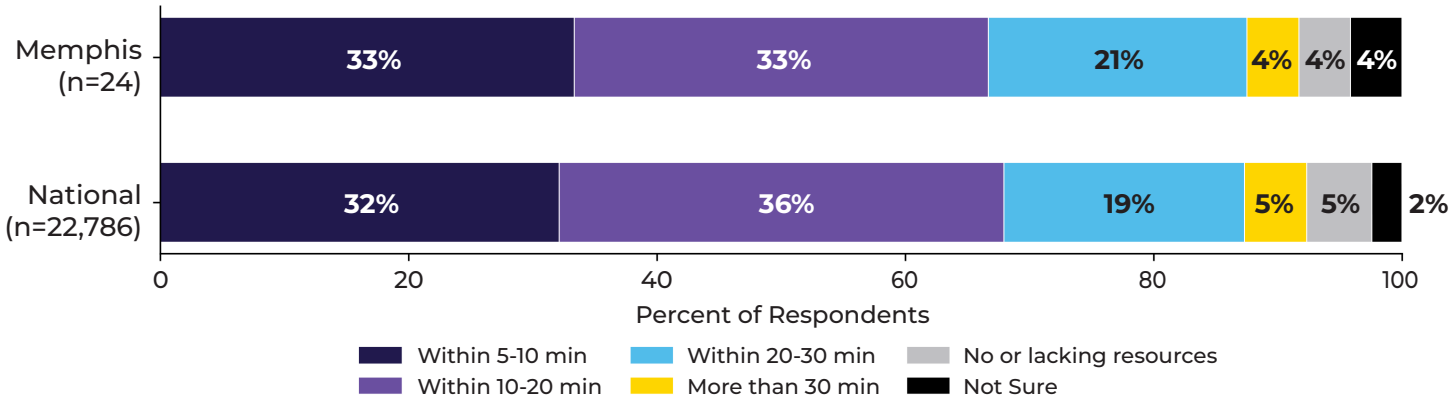
Pharmacy Proximity — National vs Memphis



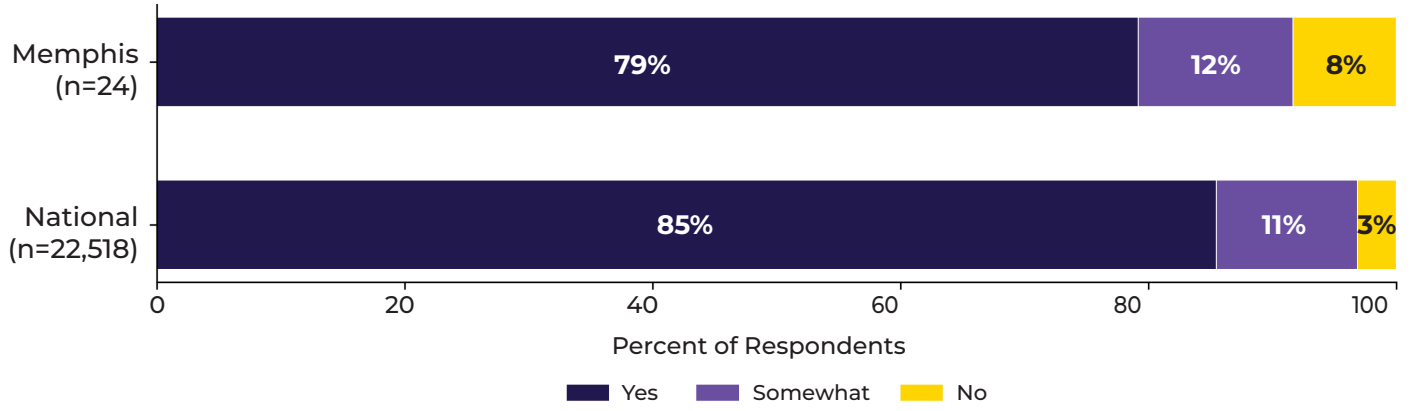
Perceived Cultural Understanding of Providers — National vs Memphis



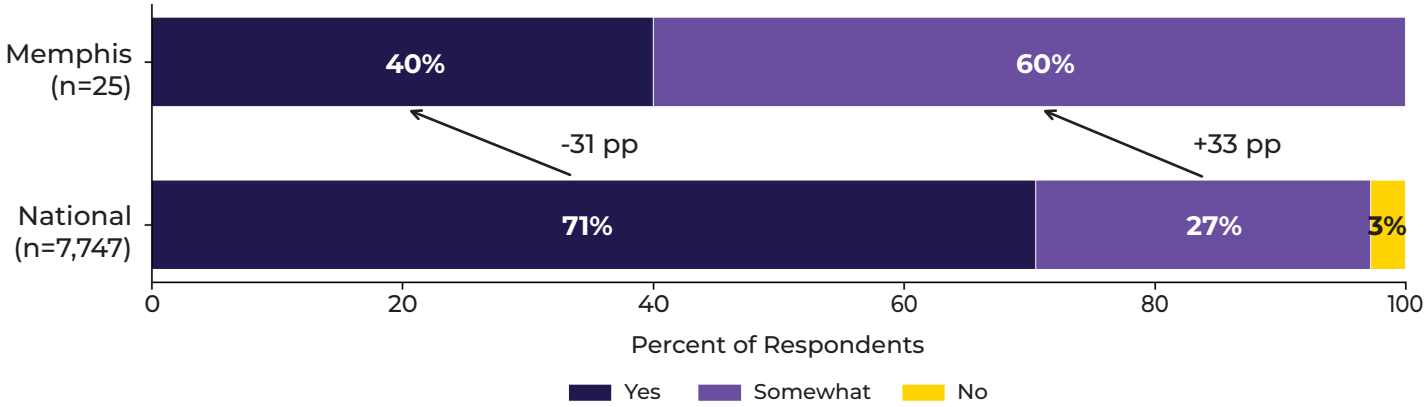
Proximity to a Quality Hospital — National vs Memphis



Access to Affordable and Reliable Transportation — National vs Memphis



Perceived Neighborhood Safety — National vs Memphis



ATLANTA, GA

Respondents in Atlanta, GA, completed the survey in various formats, including the canvasser, leave-behind, and online versions. Neighborhood canvassing data collection targeted historically Black neighborhoods throughout the metropolitan area. However, across all survey modes, only respondents with addresses located in Atlanta, GA, are included in the analyses in this addendum. Respondents in Atlanta, GA, represented a large and predominantly Black sample with an even gender distribution. The age profile skewed younger and middle-aged, with nearly half of all respondents between 25 and 40 years old and another 20% between 41 and 50. Educational attainment among the smaller subgroup that provided complete demographic information was high, with nearly six in 10 holding a graduate degree. Most respondents reported no difficulty with daily functioning. However, some indicated challenges with walking or climbing stairs or difficulty concentrating, which may shape how they move through their neighborhoods and interact with community resources.

Across neighborhood resources, Atlanta residents reported stronger access than the national sample in several areas. More respondents lived within a five-minute distance of full-service grocery stores and green spaces, and pharmacy proximity was also higher. Hospital access was notably strong, with a larger share of Atlanta respondents living within 10-20 minutes of quality medical care and far fewer reporting that these services were unavailable. However, residents were somewhat more likely than the national sample to report challenges securing timely medical appointments, and a larger share reported living with chronic health conditions. Perceptions of neighborhood safety were mixed, and fewer Atlanta respondents felt that their health care providers understood their cultural background.

These findings highlight opportunities for targeted investments in Atlanta, GA, that build upon existing strengths while addressing persistent gaps. Although residents benefit from strong access to grocery stores, green spaces, pharmacies, and hospitals, efforts to improve the care experience remain important. Strengthening culturally informed practices, improving care coordination, and expanding access to preventive services may help reduce the burden of chronic health conditions. Community-based programs that support appointment navigation, transportation, and health literacy could further enhance health engagement. These tailored strategies can help advance health equity and support overall well-being across Atlanta, GA.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	2,895	97%
Leave Behind	6	<1%
Main (online)	82	3%
Main (paper)	-	-
Total Respondents	**2,983**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	5	<1%
Asian	18	1%
Black or African American	2,615	88%
Hispanic or Latino	47	2%
Middle Eastern or North African	8	<1%
Multiracial and/or Multiethnic	43	1%
Native Hawaiian or Pacific Islander	2	<1%
White	228	8%
Prefer not to answer	4	<1%
Total Respondents	**2,970**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	1	<1%
Man	1,463	50%
Non-binary/gender non-conforming	2	<1%
Transgender	1	<1%
Woman	1,471	50%
Prefer not to answer	1	<1%
Total Respondents	**2,939**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	54	2%
18 – 24	467	16%
25 – 40	1,273	43%
41 – 50	596	20%
51 – 60	334	11%
61 – 70	173	6%
71 and over	59	2%
Prefer not to answer	5	<1%
Total Respondents	**2,961**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	6	7%
Gay	2	2%
Heterosexual or straight	66	80%
Lesbian	2	2%
Prefer to self-describe	3	4%
Prefer not to answer	3	4%
Total Respondents	**82**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	3	3%
$20,000 – $39,999	9	10%
$40,000 – $59,999	11	12%
$60,000 – $79,999	8	9%
$80,000 – $99,999	9	10%
$100,000 or more	36	41%
Prefer not to answer	12	14%
Total Respondents	**88**	

HIGHEST EDUCATION COMPLETED

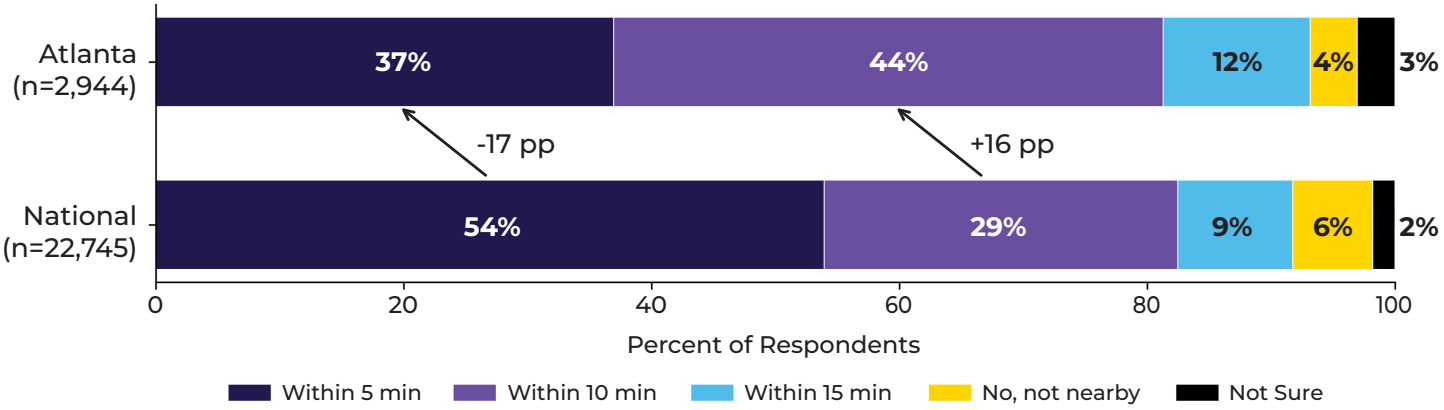
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	3	3%
Some college	12	14%
Bachelor's degree	18	20%
Graduate degree or higher	52	59%
Prefer not to answer	3	3%
Total Respondents	**88**	

DIFFICULTIES WITH ACTIVITIES

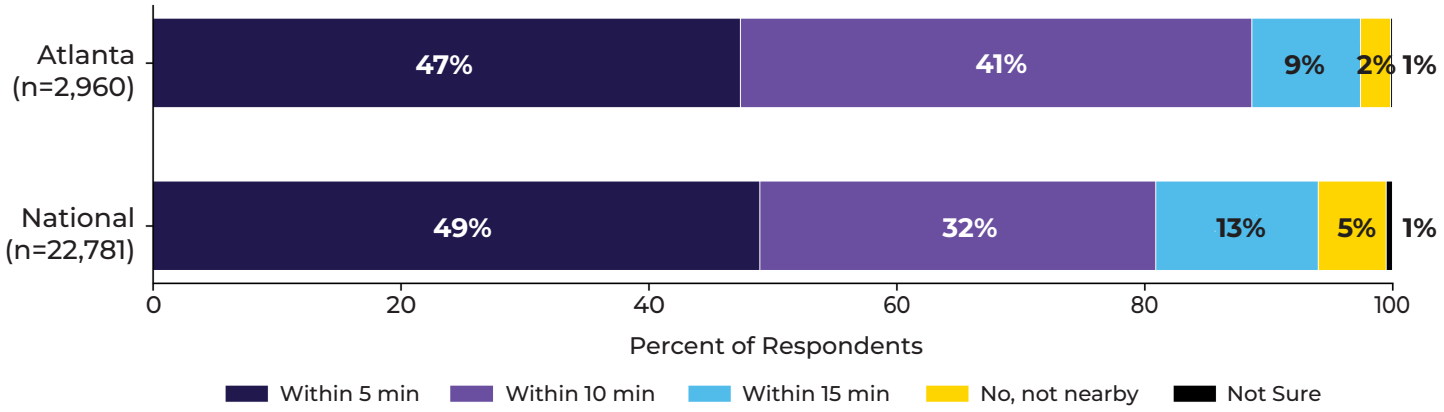
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	1	1%
Seeing, even with glasses	6	7%
Walking or climbing stairs	15	17%
Dressing or bathing	1	1%
Using the toilet	-	-
None of the above	59	69%
Prefer not to answer	1	1%
Concentrating	16	19%
***Total Respondents**	**86**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

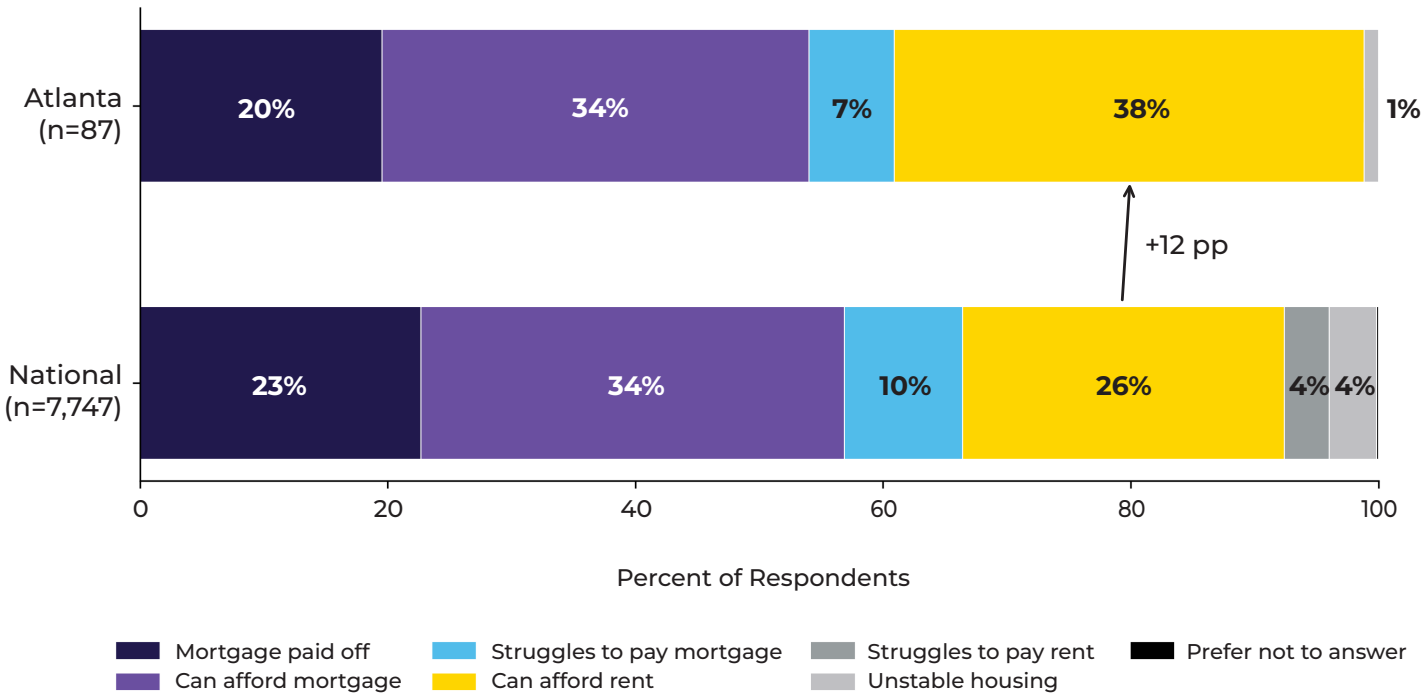
Green Space Access — National vs Atlanta



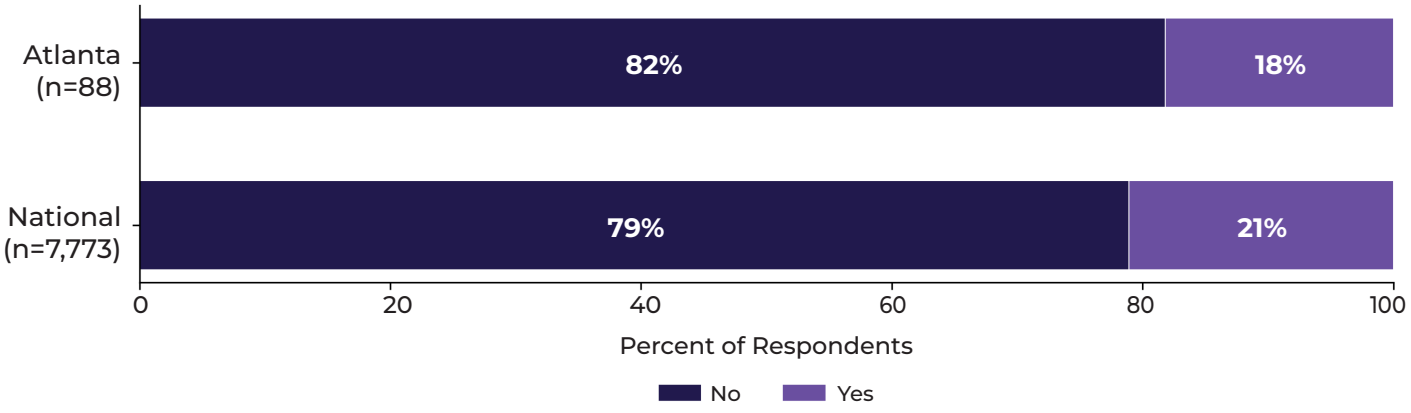
Grocery Store Access — National vs Atlanta



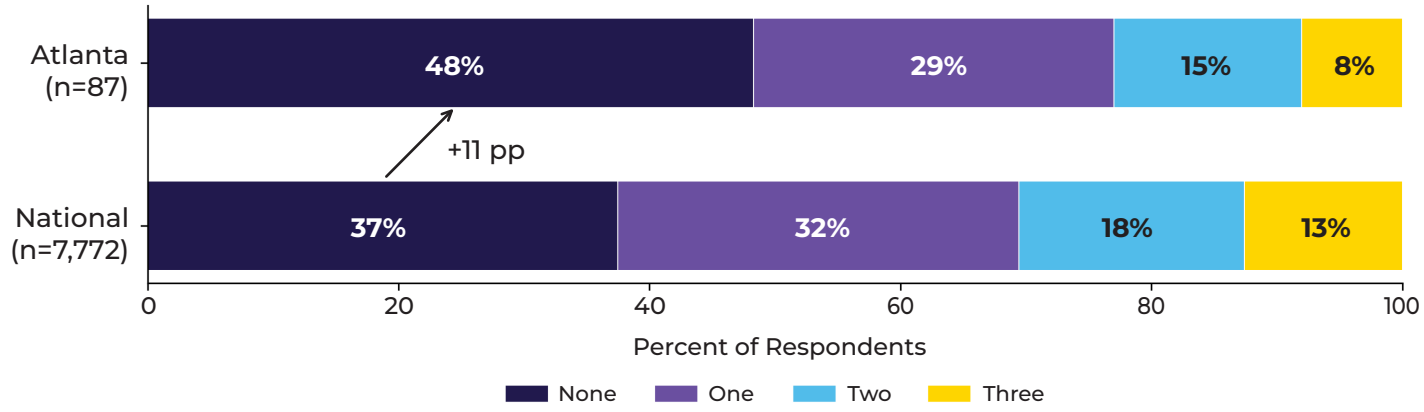
Housing Arrangements — National vs Atlanta



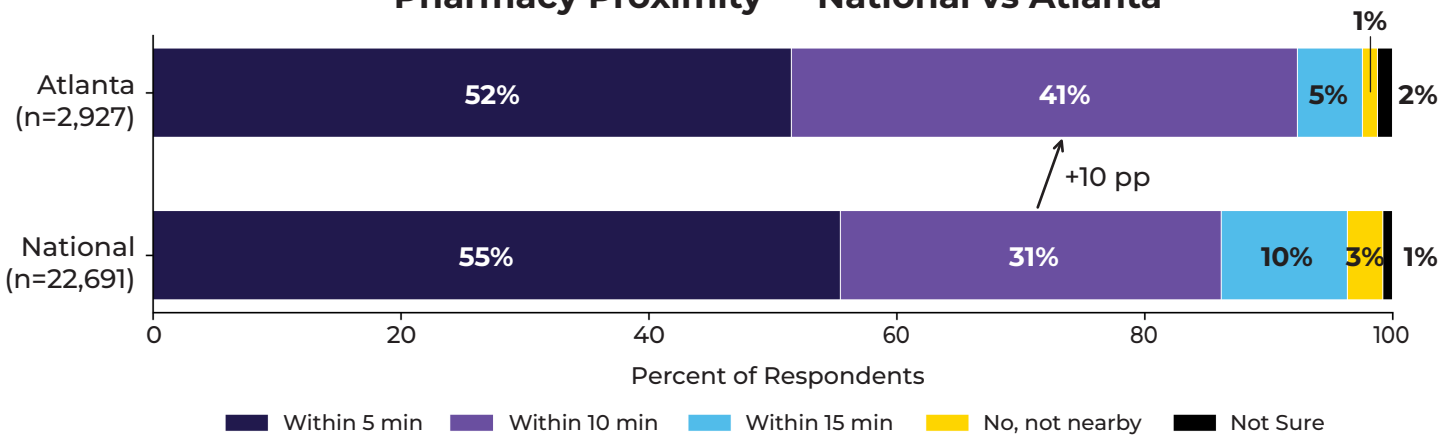
Issues Accessing Appointments or Prescriptions — National vs Atlanta



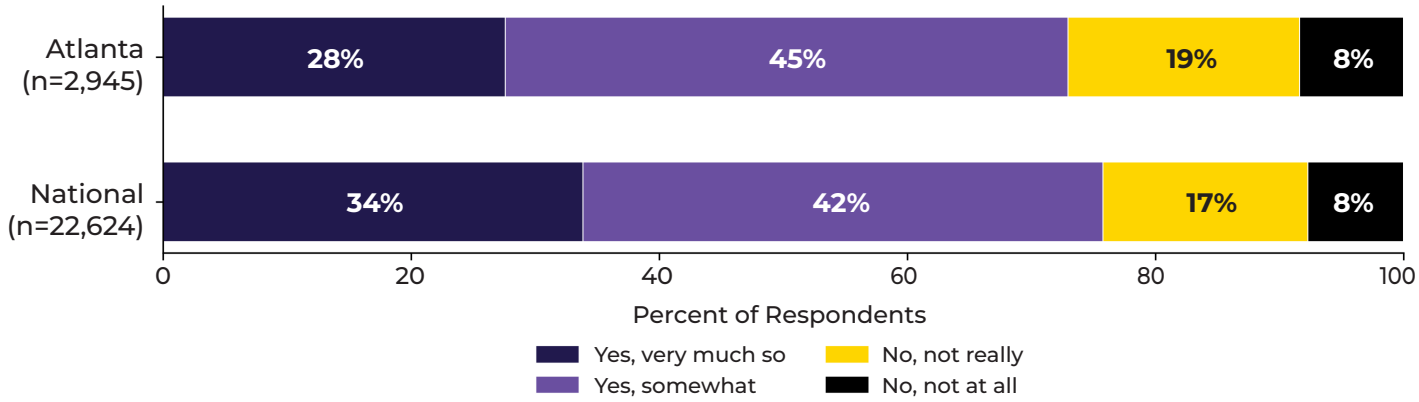
Chronic Health Conditions — National vs Atlanta



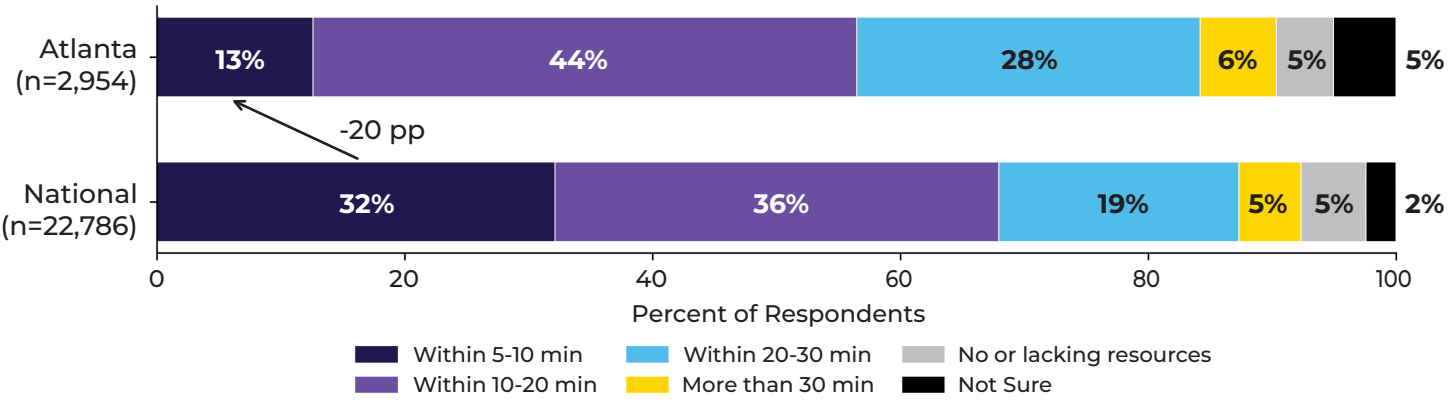
Pharmacy Proximity — National vs Atlanta



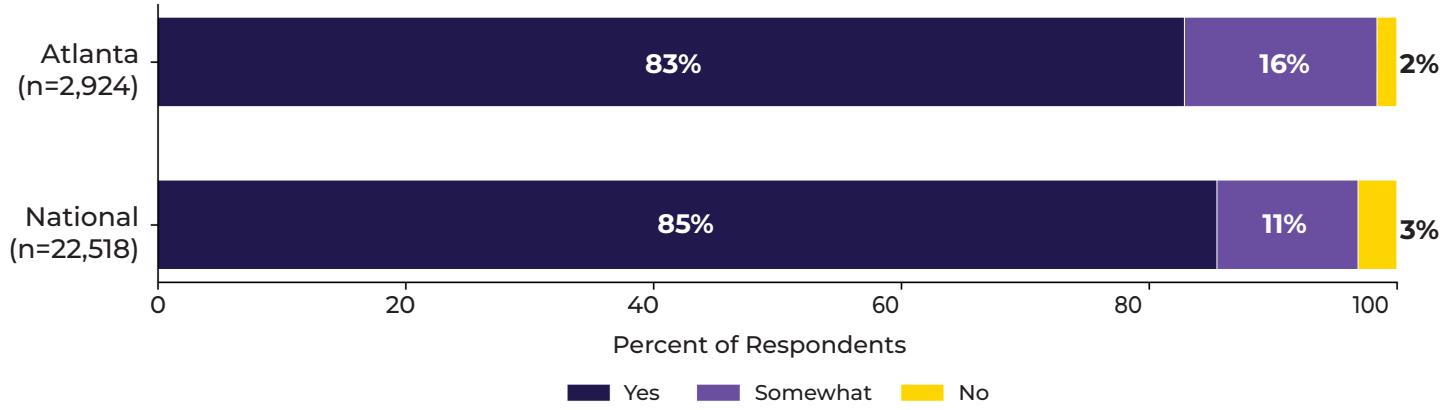
Perceived Cultural Understanding of Providers — National vs Atlanta



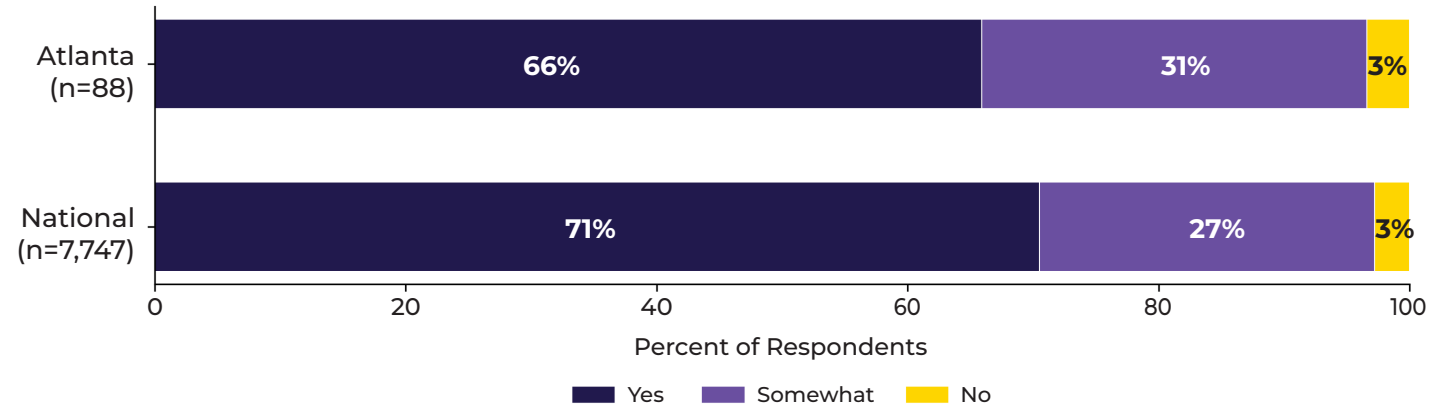
Proximity to a Quality Hospital — National vs Atlanta



Access to Affordable and Reliable Transportation — National vs Atlanta



Perceived Neighborhood Safety — National vs Atlanta



CHARLOTTE, NC

Respondents in Charlotte, NC, completed the survey via the online and paper versions. Respondents in Charlotte, NC, were predominantly Black and mostly women, with substantial representation among adults aged 41 to 70. Educational attainment varied, with many residents holding some college education or a bachelor's degree, and one quarter holding a graduate degree or higher. Household income levels were moderately distributed, with the largest share of respondents reporting incomes between $40,000 and $59,000. While most residents did not report difficulty with daily functioning, one in five experienced challenges walking or climbing stairs, and nearly the same share reported difficulty seeing, which may shape how they navigate neighborhood and health resources.

Compared with national results, Charlotte residents reported lower access to green spaces, with a higher share, indicating that green spaces were not nearby. Grocery store access was also weaker, with fewer residents living within five or 10 minutes of a full-service grocery store and more reporting limited availability. Pharmacy access in Charlotte was slightly lower than the national pattern, and residents had to travel farther to reach hospitals compared with national respondents. Charlotte residents were also more likely to report chronic health conditions and difficulty securing timely medical appointments. Perceptions of neighborhood safety were mixed, and a smaller share of residents felt that their health care providers understood their cultural background, suggesting opportunities to strengthen culturally responsive care.

These findings highlight several priorities for improving health and neighborhood conditions in Charlotte, NC. Investments that increase the availability of grocery stores, green spaces, pharmacies, and accessible hospital services can help address the resource gaps identified in the data. Strengthening transportation networks and walkable infrastructure may also support residents with mobility limitations. Given the higher prevalence of chronic health conditions, community-based health management programs and improved care coordination may help residents better manage their health. Enhancing culturally informed care through provider training and partnerships with trusted local organizations can further support communication, trust, and patient engagement. These strategies align with the needs reflected in the Charlotte data and can contribute

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	62	15%
Main (paper)	353	85%
Total Respondents	**415**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	3	1%
Asian	1	0%
Black or African American	328	80%
Hispanic or Latino	3	1%
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	38	9%
Native Hawaiian or Pacific Islander	1	<1%
White	35	9%
Prefer not to answer	1	<1%
Total Respondents	**410**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	4	1%
Man	95	24%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	305	75%
Prefer not to answer	-	-
Total Respondents	**404**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	6	1%
18 – 24	8	2%
25 – 40	56	14%
41 – 50	96	23%
51 – 60	111	27%
61 – 70	80	20%
71 and over	52	13%
Prefer not to answer	1	<1%
Total Respondents	**410**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	3	1%
Gay	5	1%
Heterosexual or straight	384	95%
Lesbian	3	1%
Prefer to self-describe	3	1%
Prefer not to answer	7	2%
Total Respondents	**405**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	28	7%
$20,000 – $39,999	35	9%
$40,000 – $59,999	161	39%
$60,000 – $79,999	89	22%
$80,000 – $99,999	31	8%
$100,000 or more	39	10%
Prefer not to answer	25	6%
Total Respondents	**408**	

HIGHEST EDUCATION COMPLETED

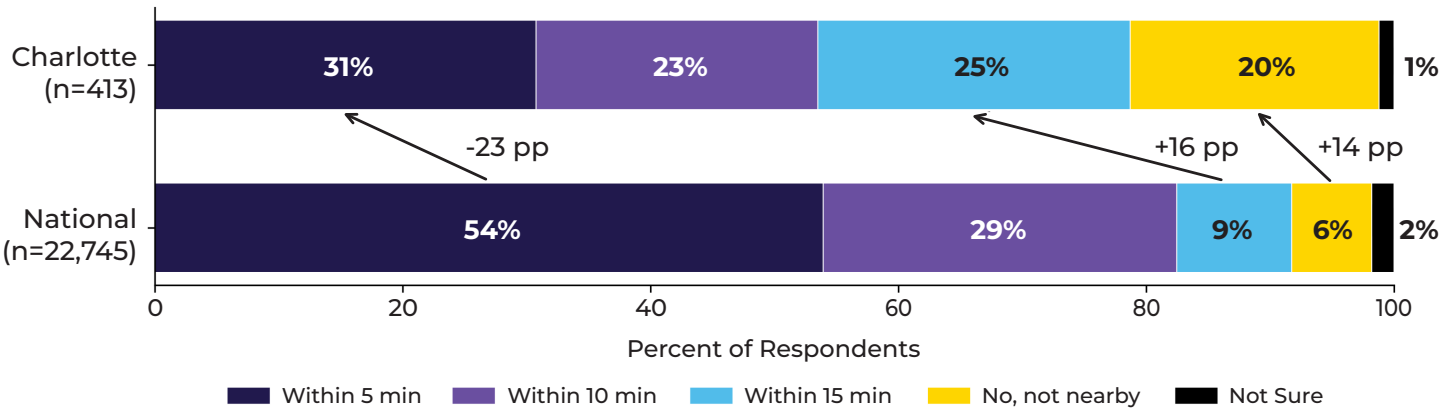
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	2	<1%
Some high school	21	5%
GED or high school graduate	98	24%
Some college	110	27%
Bachelor's degree	98	24%
Graduate degree or higher	74	18%
Prefer not to answer	7	2%
Total Respondents	**410**	

DIFFICULTIES WITH ACTIVITIES

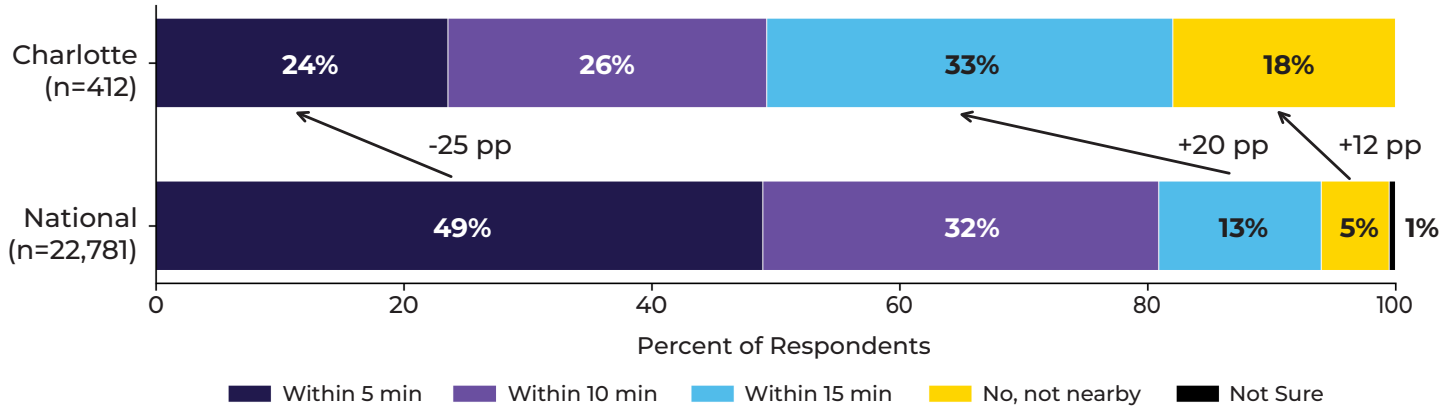
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	25	6%
Seeing, even with glasses	72	18%
Walking or climbing stairs	80	20%
Dressing or bathing	1	25%
Using the toilet	1	25%
None of the above	254	64%
Prefer not to answer	3	75%
Concentrating	29	7%
***Total Respondents**	**400**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

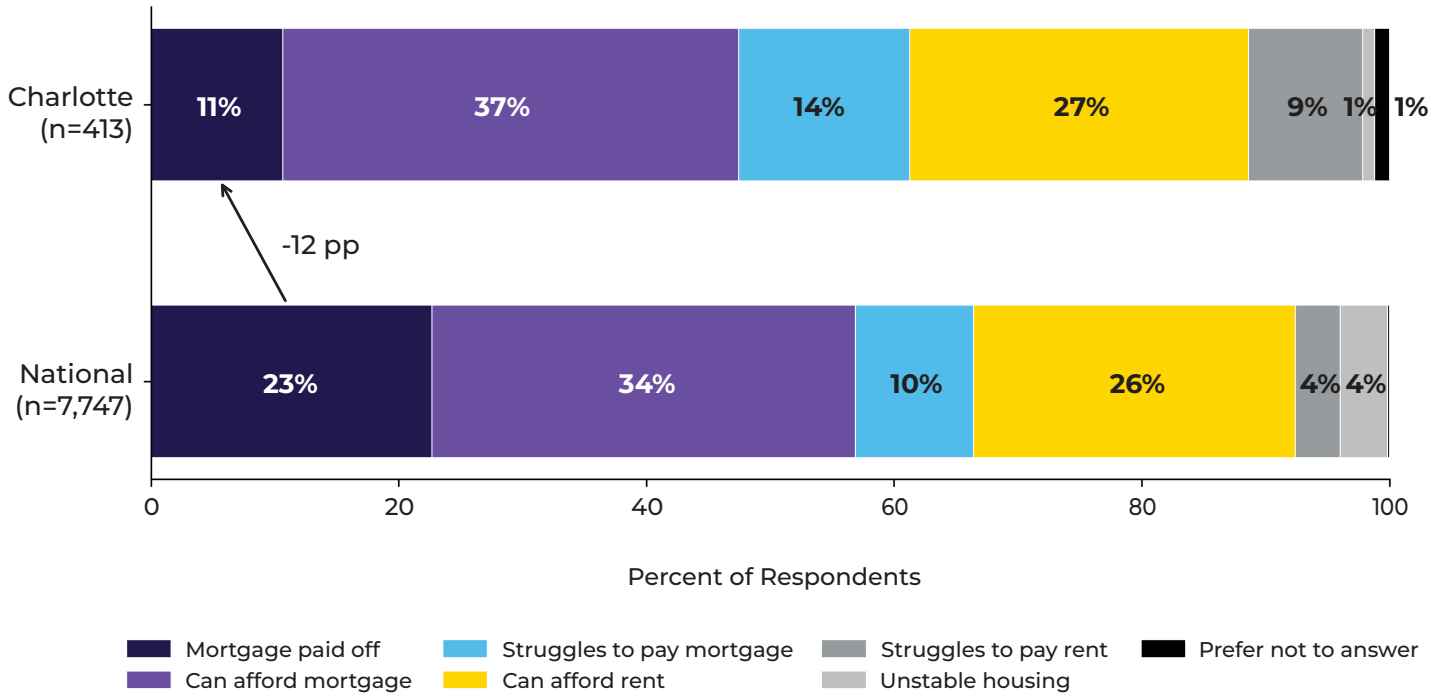
Green Space Access — National vs Charlotte



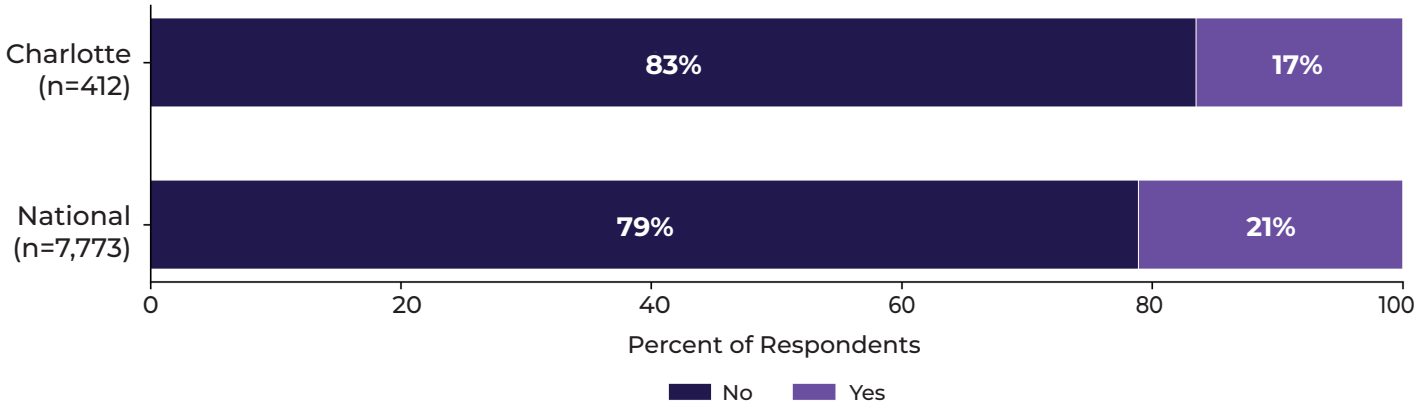
Grocery Store Access — National vs Charlotte



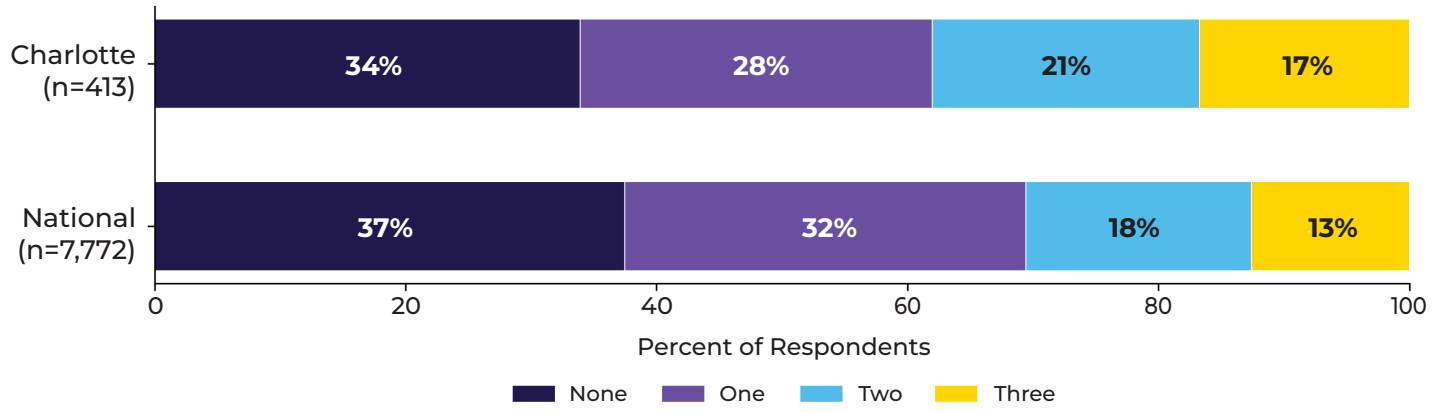
Housing Arrangements — National vs Charlotte



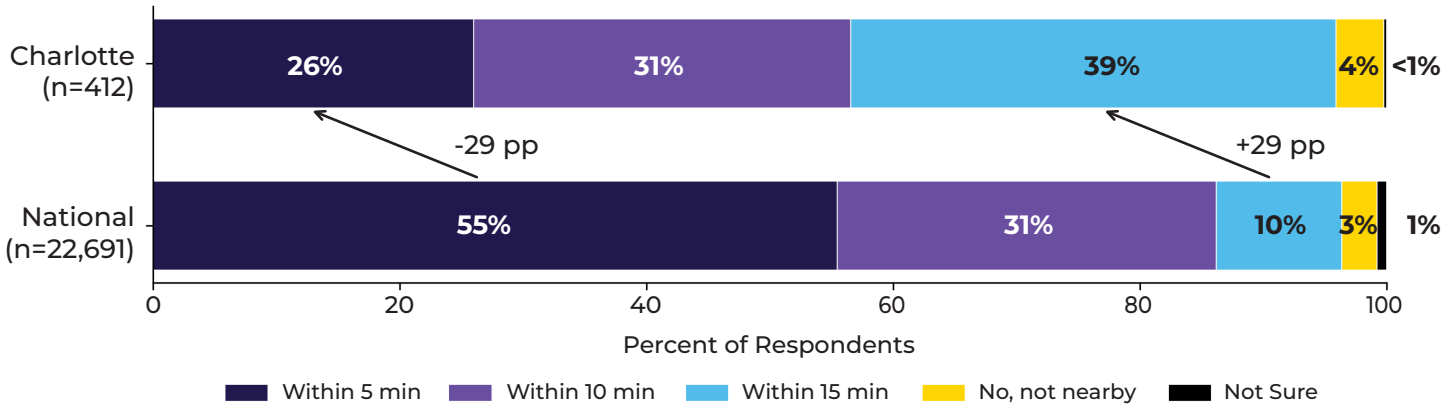
Issues Accessing Appointments or Prescriptions — National vs Charlotte



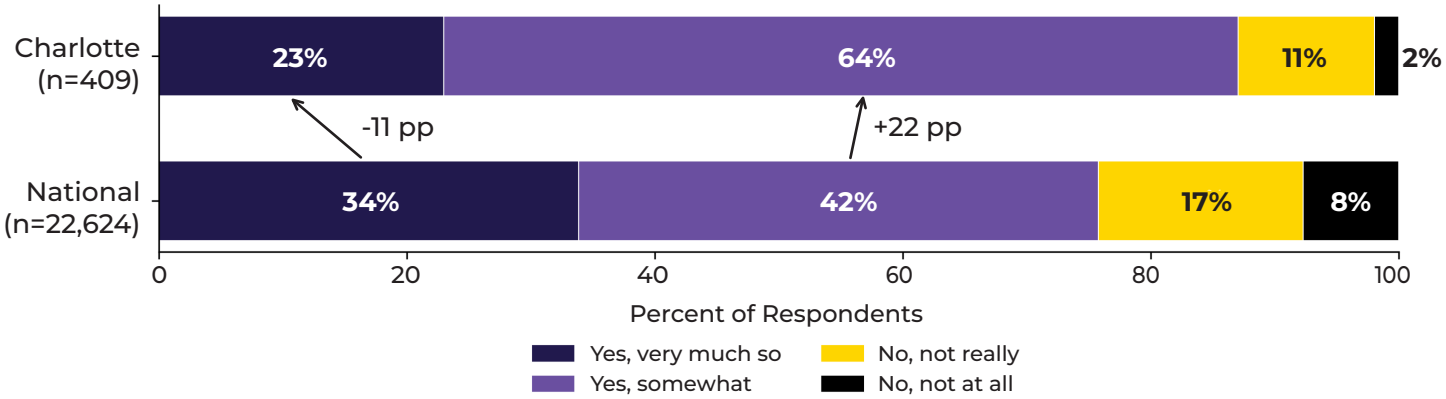
Chronic Health Conditions — National vs Charlotte



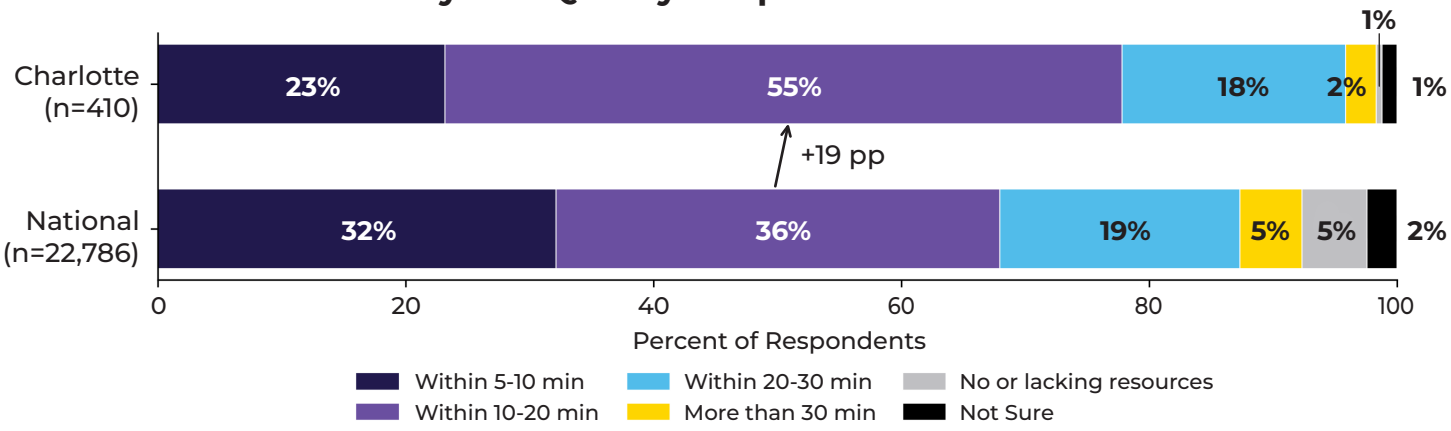
Pharmacy Proximity — National vs Charlotte



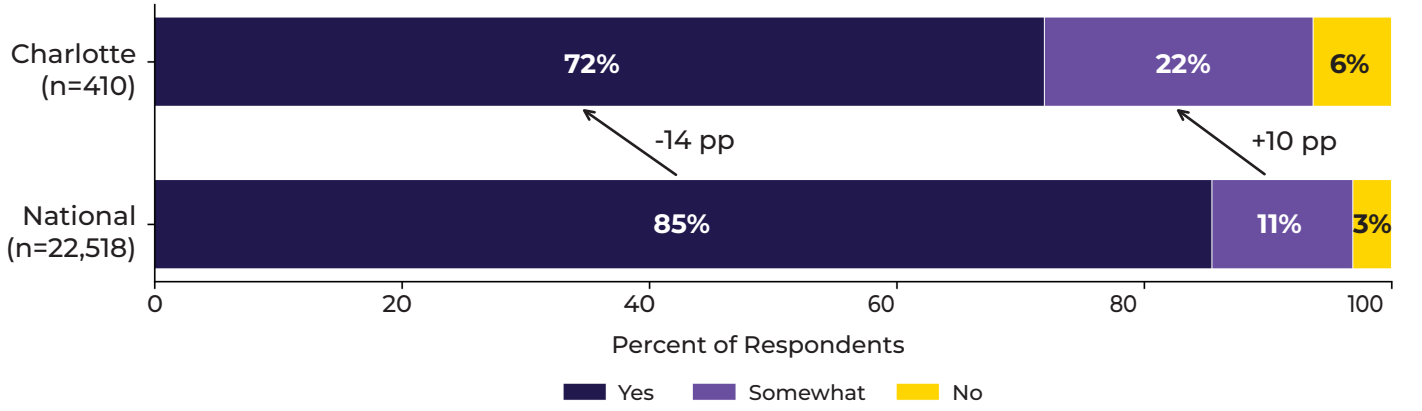
Perceived Cultural Understanding of Providers — National vs Charlotte



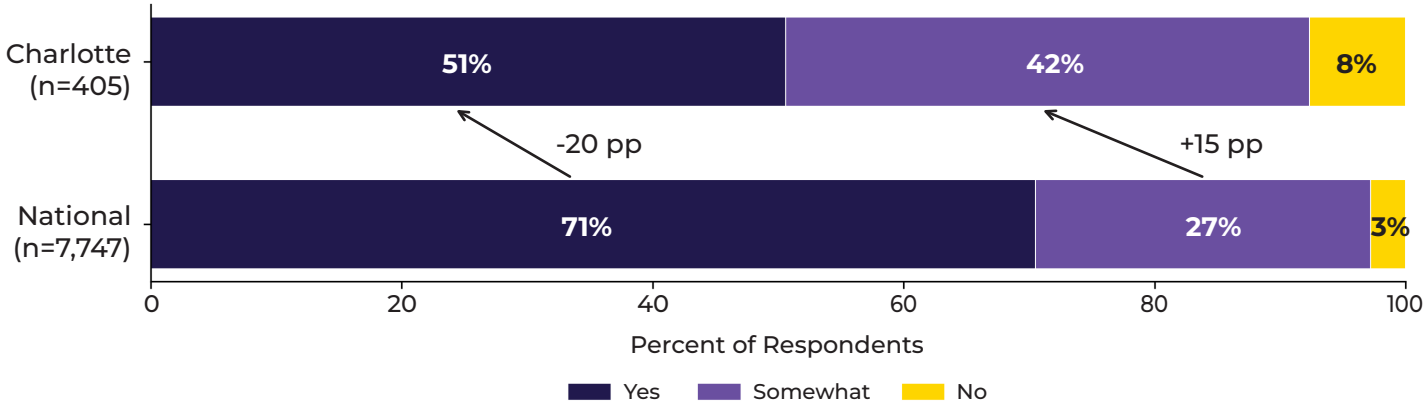
Proximity to a Quality Hospital — National vs Charlotte



Access to Affordable and Reliable Transportation — National vs Charlotte



Perceived Neighborhood Safety — National vs Charlotte



MIAMI-DADE COUNTY, FL

Respondents in Miami-Dade County, FL, completed the survey online. Respondents in Miami-Dade County, FL, were predominantly Black and mostly women, with a noticeably older age distribution. More than half of residents were aged 61 or older, and educational attainment within the sample was very high, with nearly two-thirds holding a graduate degree. Household income levels were mixed, with representation across moderate-and higher-income categories. Most respondents reported no difficulty with daily functioning, though nearly one-quarter experienced mobility challenges such as walking or climbing stairs. These age- and mobility-related characteristics shape how residents engage with neighborhood amenities and health care services.

Across neighborhood resources, Miami-Dade County residents experienced a blend of strengths and gaps compared with national patterns. Green space access was stronger than national averages, with a larger share of residents living within five minutes of a park and fewer reporting that green spaces were not nearby. Grocery store access was comparable to national results, with similar proportions living within a short distance of a full-service grocery store. Housing arrangements, however, differed substantially: Miami-Dade County residents were far more likely to rent than own, with 42% able to afford their rent and a much smaller share holding an affordable mortgage than the national sample. Mortgage struggles aligned with national rates, and unstable housing was slightly less common. In contrast to strong green space and grocery access, pharmacy and hospital access were weaker, with more residents living farther from these health services. Miami-Dade County respondents also reported higher levels of chronic health conditions, more difficulty securing timely medical appointments, lower perceptions of neighborhood safety, and fewer experiences of culturally understood care.

These patterns highlight several opportunities for investment in Miami-Dade County, FL, that support both neighborhood infrastructure and health system access. Expanding the availability of pharmacies, nearby medical facilities, and reliable transportation options can help address the longer health care travel times reported by residents. Given the older age profile and mobility limitations, investments in walkable infrastructure, public transit, and age-friendly community design may improve safety and access. Strengthening culturally informed care through provider training and partnerships with trusted community organizations can help improve communication, trust, and engagement in preventive and chronic disease management. Additionally, addressing elevated reliance on rental housing and supporting housing stability may further contribute to improved well-being. Together, these strategies can help create safer, more accessible, and health-supportive neighborhoods across Miami-Dade County, FL.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	48	100%
Main (paper)	-	-
Total Respondents	**48**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	-	-
Asian	-	-
Black or African American	41	85%
Hispanic or Latino	1	2%
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	2	4%
Native Hawaiian or Pacific Islander	-	-
White	4	8%
Prefer not to answer	-	-
Total Respondents	**48**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	4	18%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	18	82%
Prefer not to answer	-	-
Total Respondents	**22**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	2	4%
25 – 40	5	10%
41 – 50	9	19%
51 – 60	7	15%
61 – 70	13	27%
71 and over	12	25%
Prefer not to answer	-	-
Total Respondents	**48**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	2	4%
Gay	4	9%
Heterosexual or straight	33	73%
Lesbian	3	7%
Prefer to self-describe	1	2%
Prefer not to answer	2	4%
Total Respondents	**45**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	6	12%
$20,000 – $39,999	4	8%
$40,000 – $59,999	7	15%
$60,000 – $79,999	6	12%
$80,000 – $99,999	10	21%
$100,000 or more	13	27%
Prefer not to answer	2	4%
Total Respondents	**48**	

HIGHEST EDUCATION COMPLETED

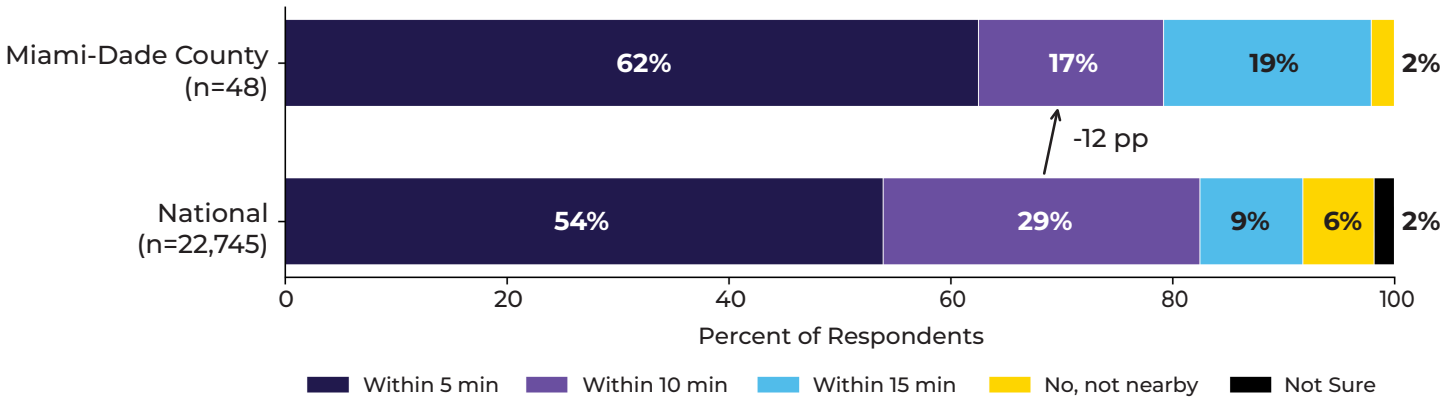
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	2	4%
GED or high school graduate	-	-
Some college	10	21%
Bachelor's degree	6	12%
Graduate degree or higher	30	62%
Prefer not to answer	-	-
Total Respondents	**48**	

DIFFICULTIES WITH ACTIVITIES

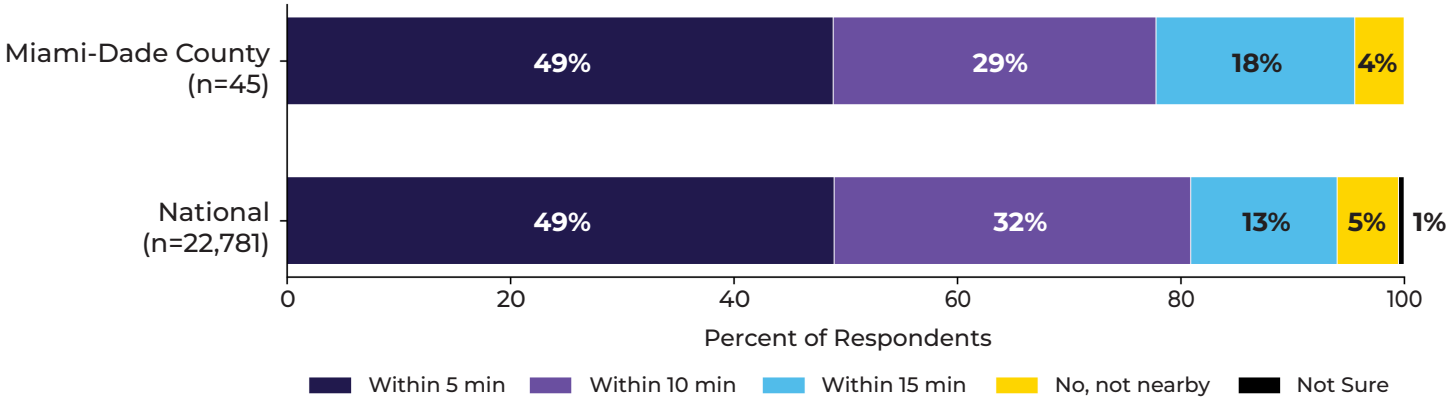
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	3	6%
Seeing, even with glasses	3	6%
Walking or climbing stairs	11	23%
Dressing or bathing	-	-
Using the toilet	-	-
None of the above	33	70%
Prefer not to answer	-	-
Concentrating	4	9%
***Total Respondents**	**47**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

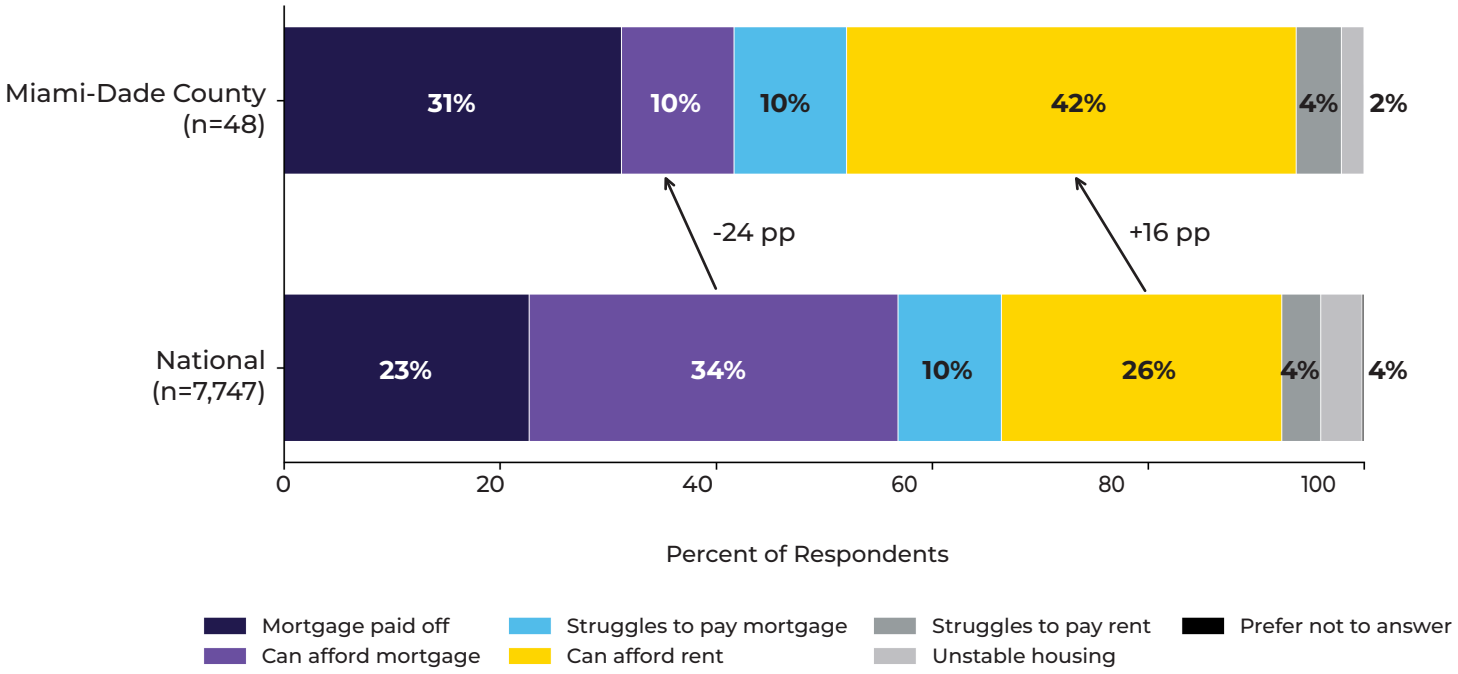
Green Space Access — National vs Miami-Dade County



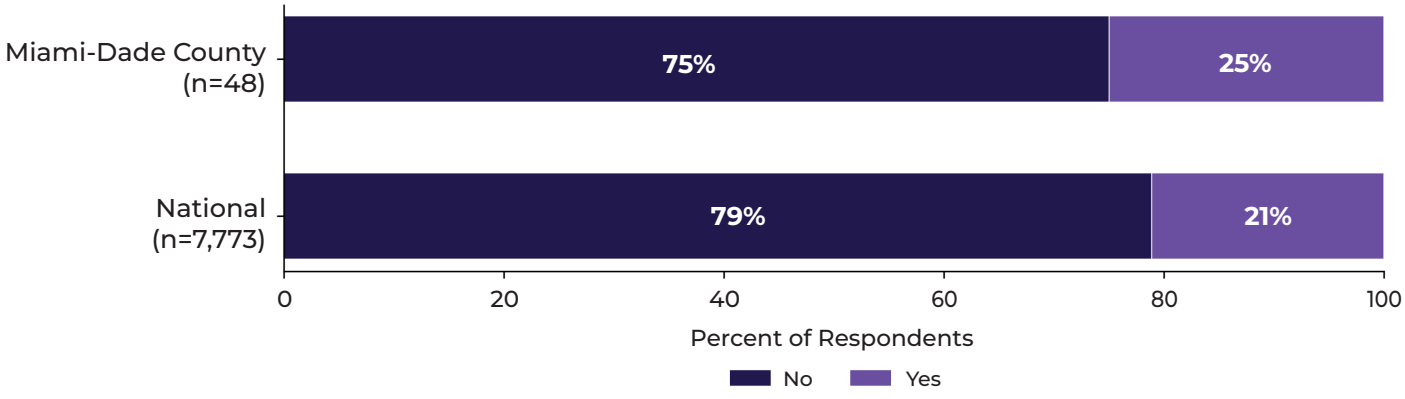
Grocery Store Access — National vs Miami-Dade County



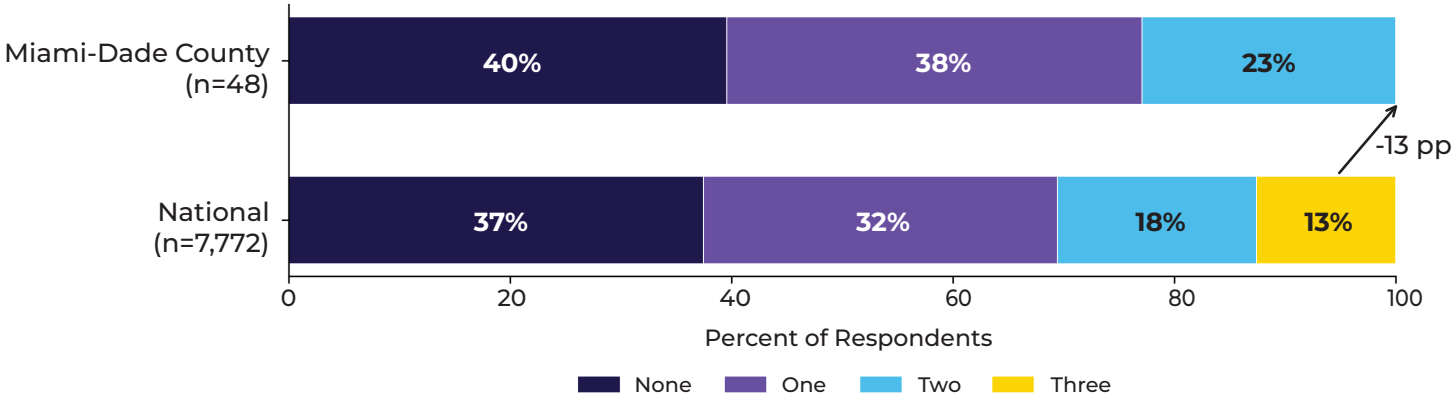
Housing Arrangements — National vs Miami-Dade County



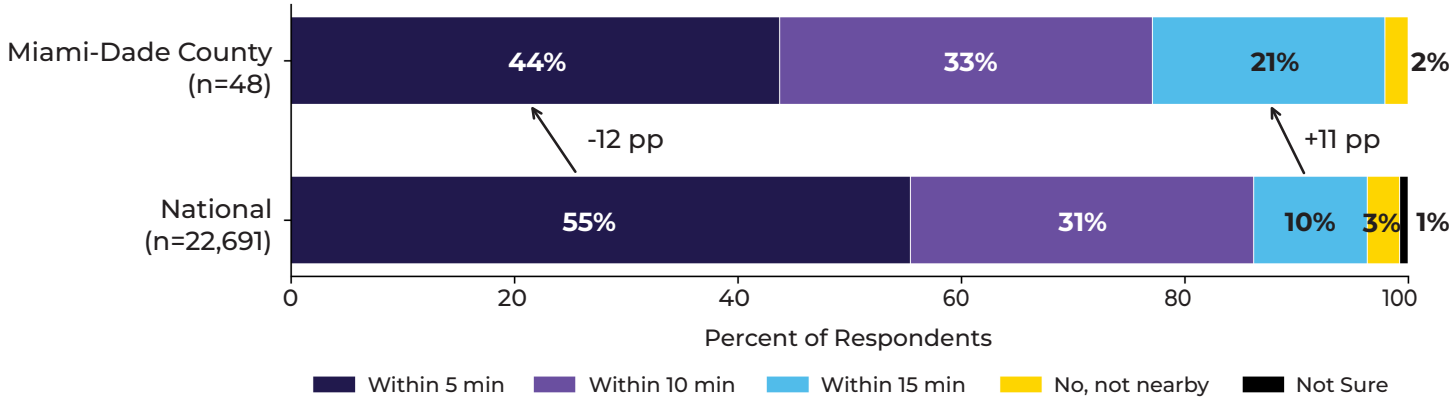
Issues Accessing Appointments or Prescriptions — National vs Miami-Dade County



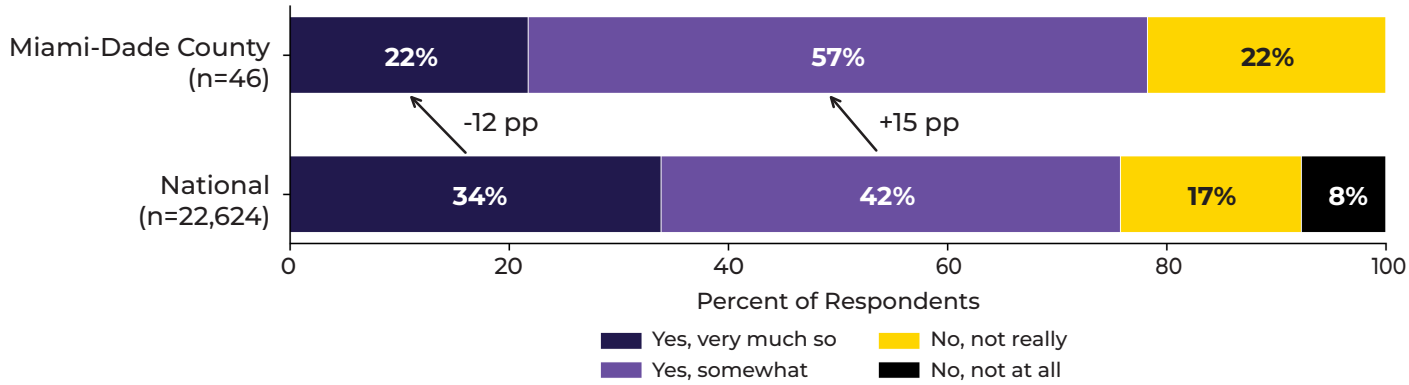
Chronic Health Conditions — National vs Miami-Dade County



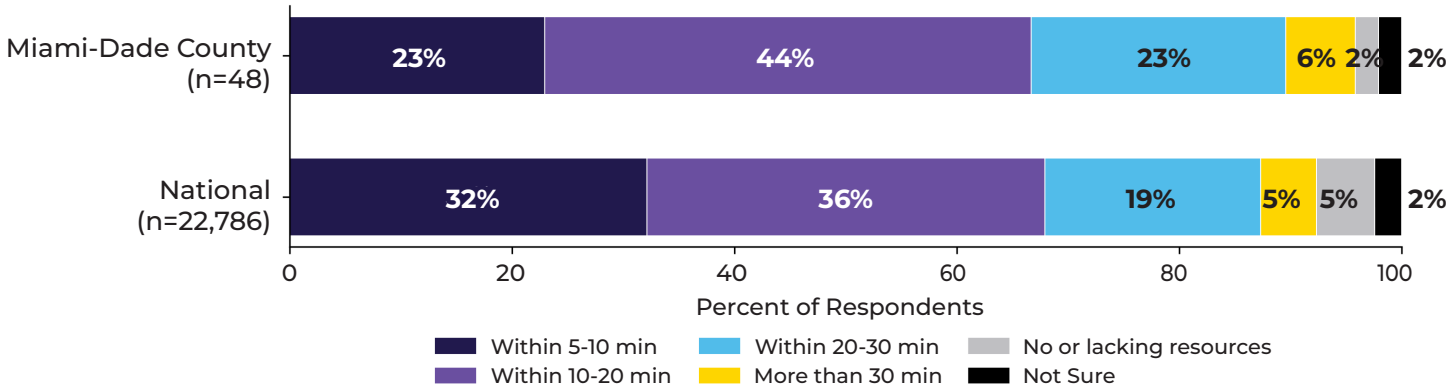
Pharmacy Proximity — National vs Miami-Dade County



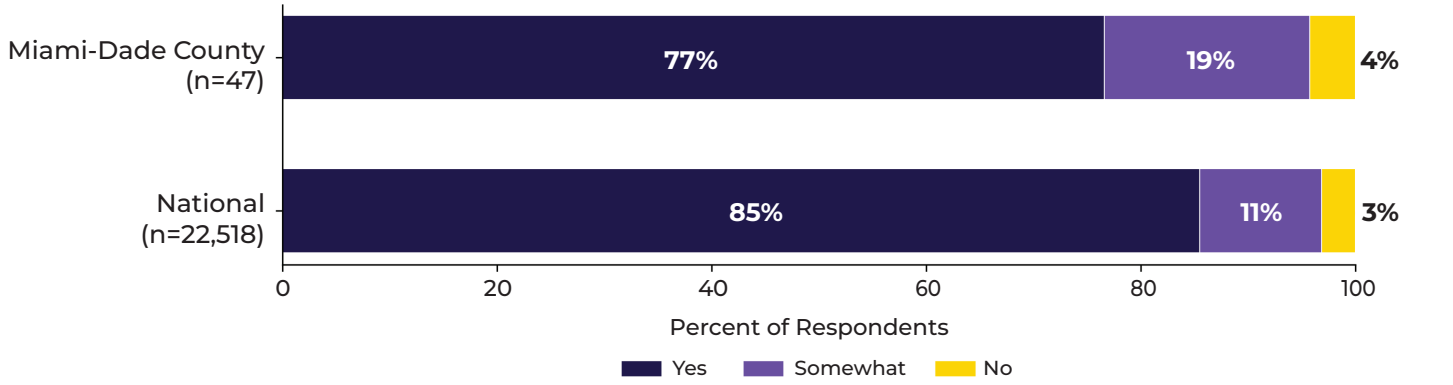
Perceived Cultural Understanding of Providers — National vs Miami-Dade County



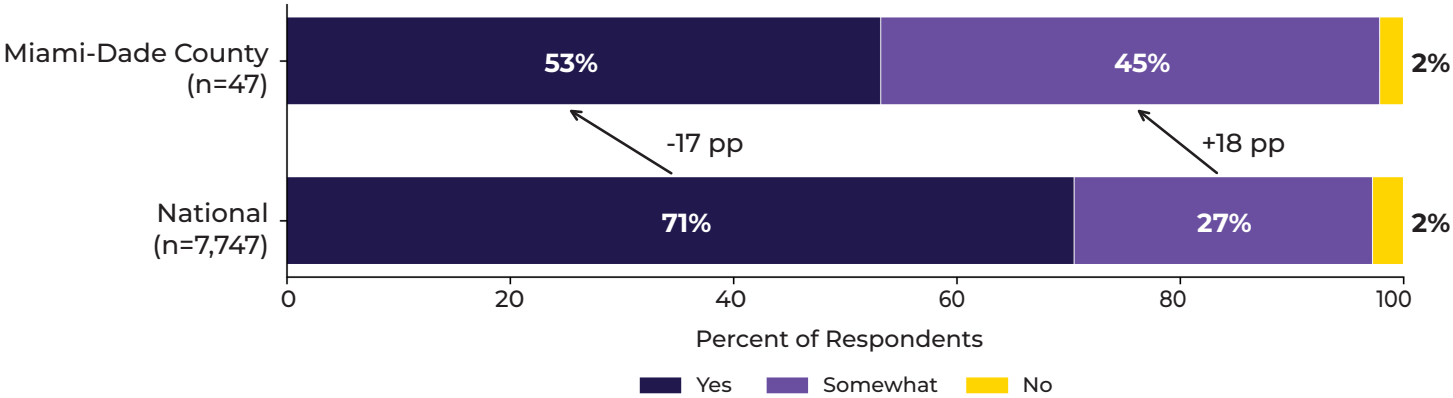
Proximity to a Quality Hospital — National vs Miami-Dade County



Access to Affordable and Reliable Transportation — National vs Miami-Dade County



Perceived Neighborhood Safety — National vs Miami-Dade County



NEW YORK CITY, NY

Respondents in New York City, NY, completed the survey via the canvasser and online versions. Although door-to-door canvassing was not conducted in New York City, NY, if an individual whose address was in New York City, NY, was approached and completed the survey in one of the cities where canvassing was conducted, their information was retained. Respondents in New York City, NY, were predominantly Black and mostly women, with strong representation across adults aged 51 and older. Nearly half of the sample was aged 61 or above, and educational attainment was high, with almost half holding a graduate degree and another quarter holding a bachelor's degree. Household income levels varied widely, ranging from less than $20,000 to well over $100,000, reflecting the city's economic diversity. While more than half of respondents reported no difficulties with daily functioning, more than one quarter experienced challenges walking or climbing stairs, and more than one in ten reported difficulty concentrating. These patterns suggest that functional limitations may shape how many New York City, NY, residents navigate their neighborhoods and access health and community resources.

Across neighborhood and health access indicators, New York City, NY, showed a mix of strengths and notable gaps when compared with national averages. Residents generally had strong access to grocery stores, with a larger share living within a five-minute walk than national respondents. Green space access, however, was weaker, with fewer residents reporting parks or recreational areas nearby and more indicating that these spaces were not close to home. Housing arrangements reflected a heavy reliance on renting, with a significantly larger proportion reporting they could afford rent than those with a mortgage. Access to pharmacies and hospitals was moderately strong, although some residents indicated longer travel times. New York City, NY, respondents were also more likely than the national sample to report chronic health conditions and more difficulty securing timely medical appointments. Perceptions of neighborhood safety were notably lower, and fewer residents reported that their health care providers understood their cultural background, highlighting gaps in both environmental conditions and culturally responsive care.

These patterns point to several investment opportunities in New York City, NY. Expanding access to nearby green spaces and strengthening park infrastructure could address one of the clearest resource gaps identified in the data. Efforts to improve neighborhood safety may also increase residents' ability to utilize available amenities and support overall well-being. Given the city's older population and the functional challenges reported by many respondents, age-friendly design, walkability improvements, and transportation supports could enhance access to essential services. Strengthening culturally informed care through deeper partnerships with trusted community organizations and provider training may help improve communication, trust, and engagement with preventive and chronic health services. These targeted strategies can support healthier, safer, and more accessible environments for residents across New York City, NY.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	9	4%
Leave Behind	204	96%
Main (online)	-	-
Main (paper)	-	-
Total Respondents	**213**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	2	1%
Asian	1	<1%
Black or African American	166	78%
Hispanic or Latino	4	2%
Middle Eastern or North African	-	-
Multiracial and/or Multiethnic	26	12%
Native Hawaiian or Pacific Islander	-	-
White	5	2%
Prefer not to answer	8	4%
Total Respondents	**212**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	-	-
Man	27	16%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	141	82%
Prefer not to answer	4	2%
Total Respondents	**172**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	-	-
18 – 24	7	3%
25 – 40	19	9%
41 – 50	32	15%
51 – 60	45	21%
61 – 70	50	23%
71 and over	50	23%
Prefer not to answer	10	5%
Total Respondents	**213**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	2	1%
Gay	7	3%
Heterosexual or straight	174	85%
Lesbian	1	<1%
Prefer to self-describe	1	<1%
Prefer not to answer	19	9%
Total Respondents	**204**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	16	8%
$20,000 – $39,999	17	8%
$40,000 – $59,999	26	13%
$60,000 – $79,999	21	10%
$80,000 – $99,999	27	13%
$100,000 or more	52	26%
Prefer not to answer	43	21%
Total Respondents	**202**	

HIGHEST EDUCATION COMPLETED

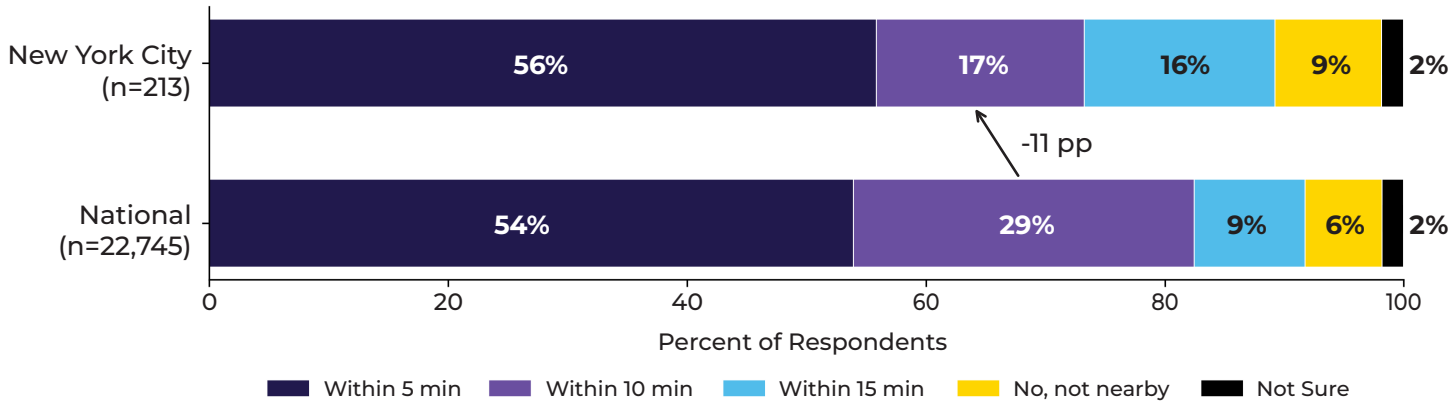
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	-	-
Some high school	-	-
GED or high school graduate	9	4%
Some college	36	18%
Bachelor's degree	54	26%
Graduate degree or higher	97	48%
Prefer not to answer	8	4%
Total Respondents	**204**	

DIFFICULTIES WITH ACTIVITIES

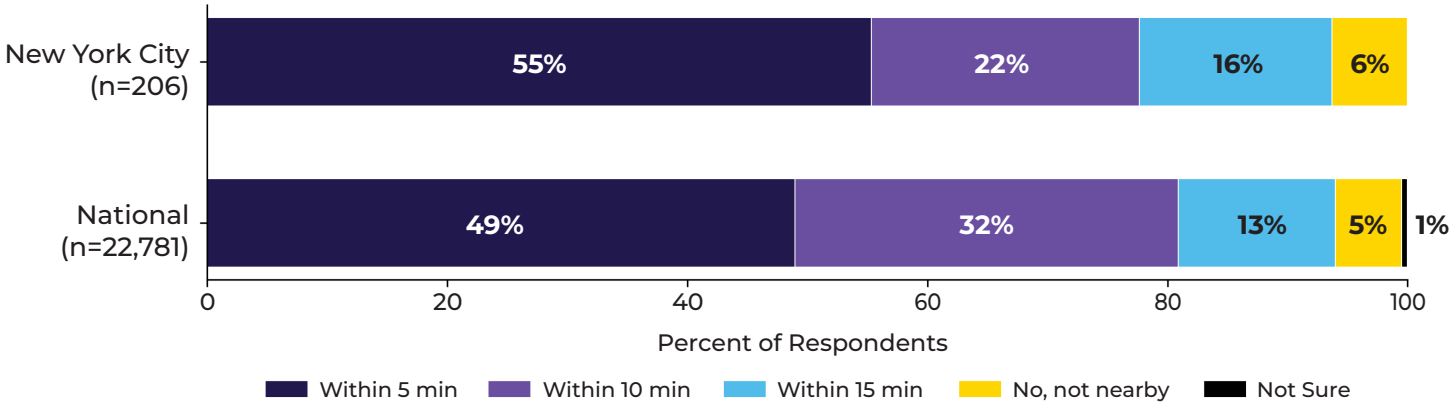
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	6	3%
Seeing, even with glasses	16	8%
Walking or climbing stairs	54	27%
Dressing or bathing	5	2%
Using the toilet	4	2%
None of the above	114	57%
Prefer not to answer	10	5%
Concentrating	22	11%
***Total Respondents**	**200**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

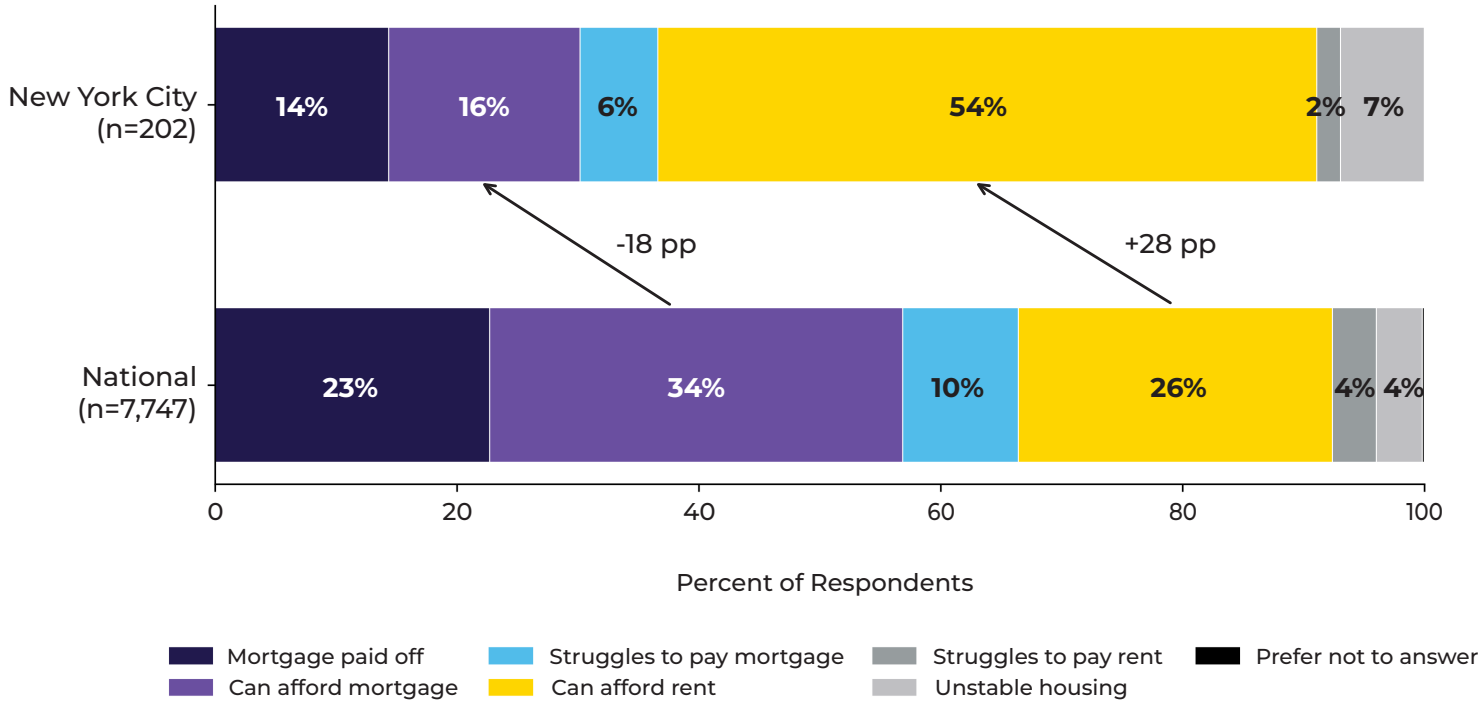
Green Space Access — National vs New York City



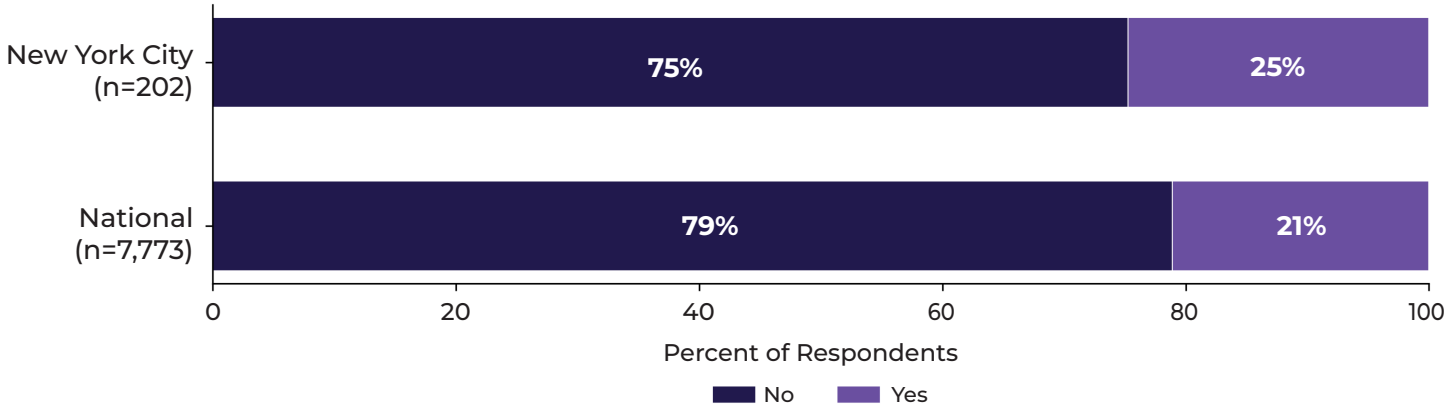
Grocery Store Access — National vs New York City



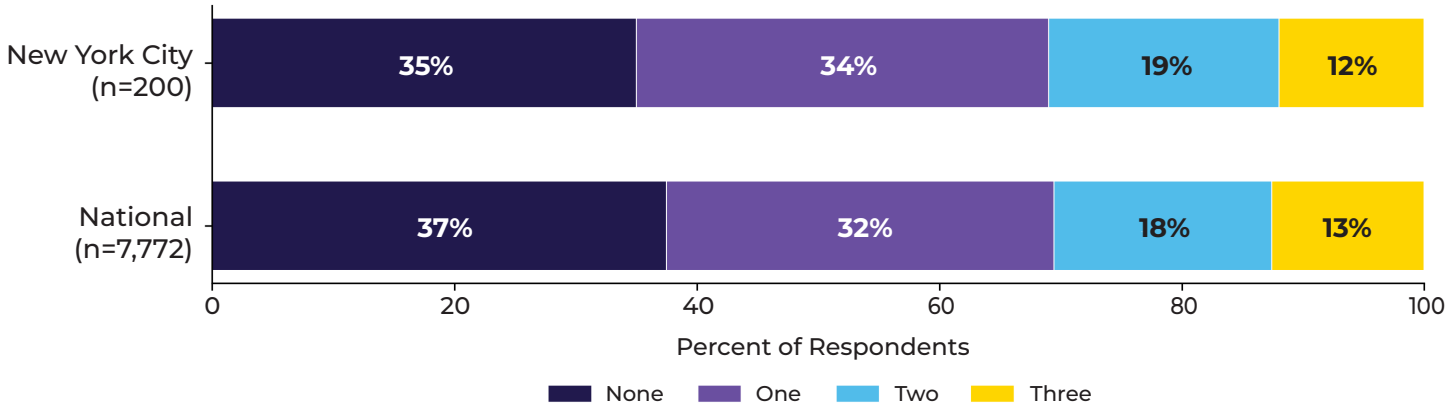
Housing Arrangements — National vs New York City



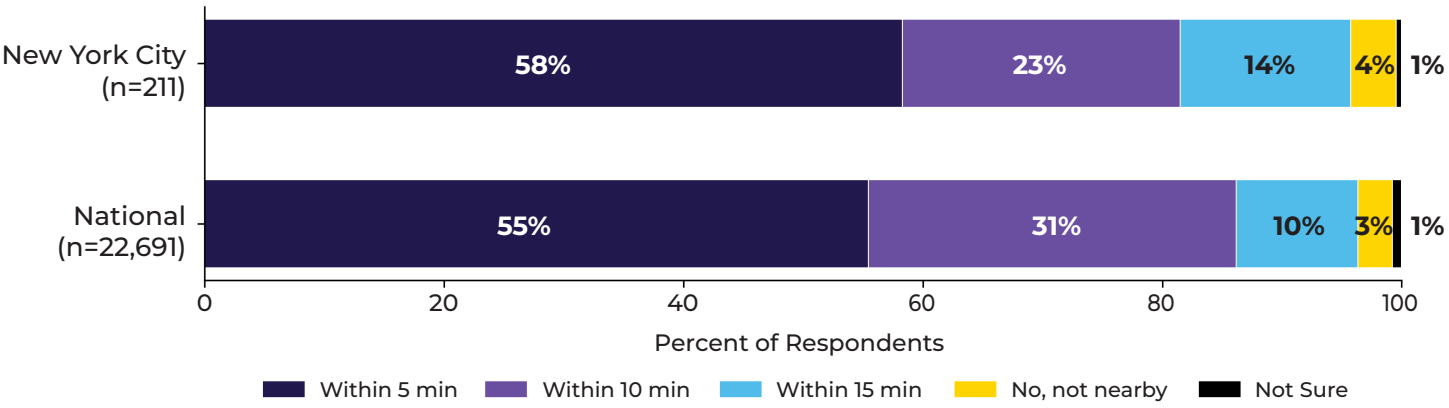
Issues Accessing Appointments or Prescriptions — National vs New York City



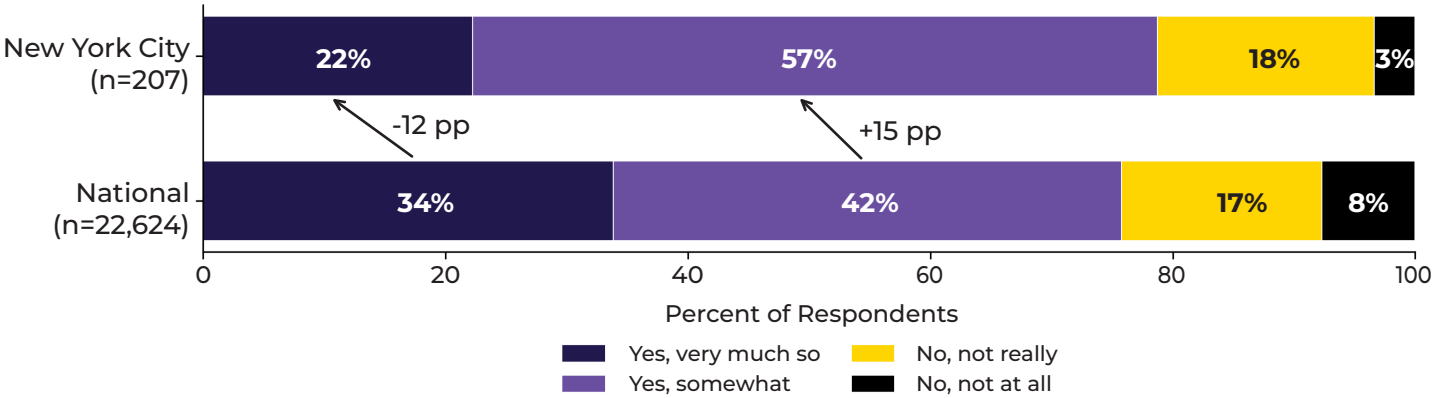
Chronic Health Conditions — National vs New York City



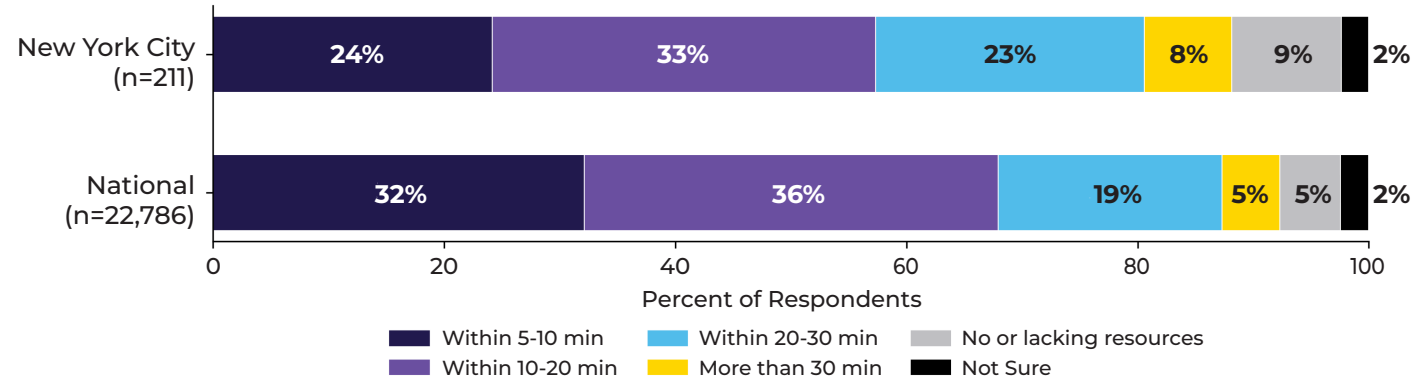
Pharmacy Proximity — National vs New York City



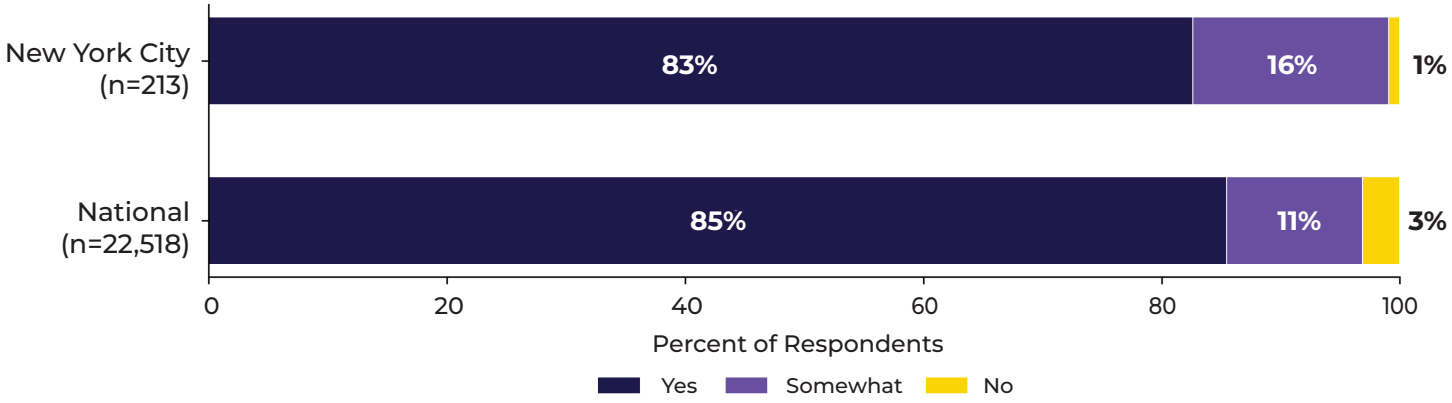
Perceived Cultural Understanding of Providers — National vs New York City



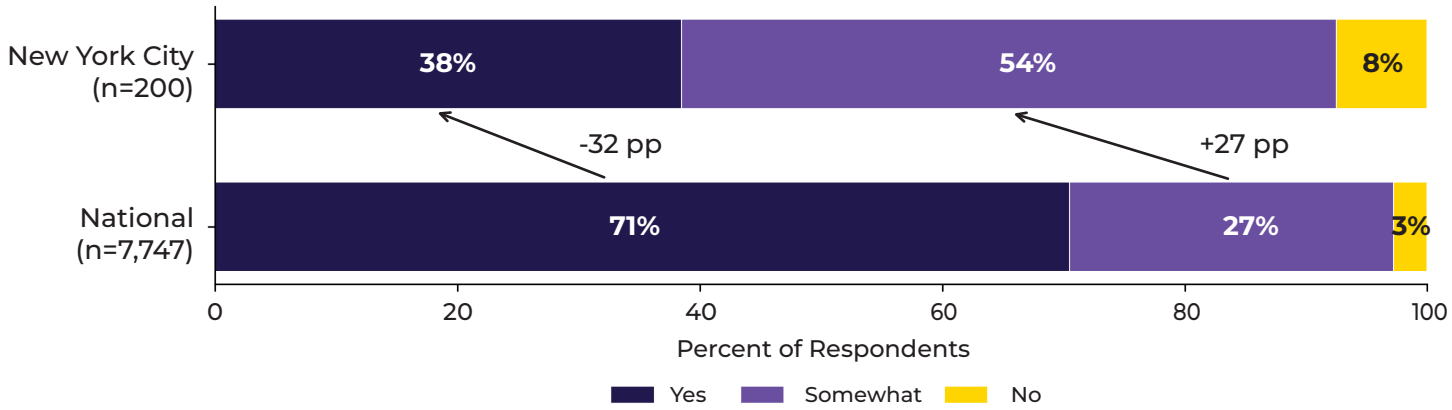
Proximity to a Quality Hospital — National vs New York City



Access to Affordable and Reliable Transportation — National vs New York City



Perceived Neighborhood Safety — National vs New York City



NEWARK, NJ

Respondents in Newark, NJ, completed the survey online. Respondents in Newark, NJ, were predominantly Black and mostly women, with representation across young, middle-aged, and older adults. More than half of the respondents were between the ages of 25 and 50, and almost one quarter were aged 61 or older. Household income levels varied widely, with notable representation at the lower end of the distribution; nearly one-third of respondents reported earning less than $40,000 annually. Educational attainment was diverse, with a large share reporting some college or a bachelor's degree, and nearly one-fifth holding a graduate degree. Most residents reported no difficulties with daily activities, though some indicated mobility challenges and difficulty concentrating, which may shape their ability to engage with neighborhood resources.

Across neighborhood conditions and access indicators, Newark, NJ, exhibited several notable gaps when compared with national findings. Access to green space was weaker, with fewer residents living within a short distance of parks and more reporting that green spaces were not nearby. Access to full-service grocery stores was also limited, with lower shares living within ten minutes of a store and higher shares indicating limited availability. Housing arrangements reflected a mixed pattern: more residents struggled with rent than the national rates, and fewer reported owning homes with paid-off mortgages. Access to pharmacies and hospitals was weaker, and residents were more likely to live farther from them. Newark respondents were also more likely to report chronic health conditions and difficulty securing timely medical appointments. Perceptions of neighborhood safety were lower than national averages, and fewer residents felt their health care providers understood their cultural backgrounds, indicating gaps in both environmental conditions and culturally responsive care.

These findings highlight priority areas for investment in Newark, NJ. Increasing the availability of nearby green spaces and full-service grocery stores would address some of the most immediate access barriers. Strengthening transportation options and enhancing walkability can better support residents with mobility limitations and those facing longer travel distances to pharmacies and medical facilities. Efforts to expand housing stability strategies, including support for renters and pathways to homeownership, may improve neighborhood stability. Strengthening culturally informed care through provider training and partnerships with trusted community organizations may improve communication, trust, and engagement in preventive care. These targeted strategies can help address the access challenges surfaced in the Newark data and support healthier, safer, and more equitable neighborhood conditions across Newark, NJ.

DEMOGRAPHICS

NUMBER OF RESPONDENTS BY SURVEY MODE

SURVEY TYPE	NUMBER	PERCENT
Canvasser	-	-
Leave Behind	-	-
Main (online)	77	100%
Main (paper)	-	-
Total Respondents	**77**	

RACIAL AND ETHNIC GROUP

RACE/ETHNICITY	NUMBER	PERCENT
American Indian or Alaska Native	-	-
Asian	2	3%
Black or African American	59	77%
Hispanic or Latino	4	5%
Middle Eastern or North African	1	1%
Multiracial and/or Multiethnic	3	4%
Native Hawaiian or Pacific Islander	-	-
White	3	4%
Prefer not to answer	5	6%
Total Respondents	**77**	

GENDER IDENTITY

GENDER	NUMBER	PERCENT
Cisgender (not specified)	2	4%
Man	11	22%
Non-binary/gender non-conforming	-	-
Transgender	-	-
Woman	37	74%
Prefer not to answer	-	-
Total Respondents	**50**	

AGE DISTRIBUTION

AGE RANGE	NUMBER	PERCENT
17 and under	1	1%
18 – 24	7	9%
25 – 40	21	27%
41 – 50	18	23%
51 – 60	13	17%
61 – 70	10	13%
71 and over	6	8%
Prefer not to answer	1	1%
Total Respondents	**77**	

SEXUAL ORIENTATION

SEXUAL ORIENTATION	NUMBER	PERCENT
Bisexual	1	1%
Gay	-	-
Heterosexual or straight	67	89%
Lesbian	1	1%
Prefer to self-describe	1	1%
Prefer not to answer	5	7%
Total Respondents	**75**	

TOTAL HOUSEHOLD INCOME

TOTAL HOUSEHOLD INCOME	NUMBER	PERCENT
Less than $20,000	13	17%
$20,000 – $39,999	9	12%
$40,000 – $59,999	11	14%
$60,000 – $79,999	13	17%
$80,000 – $99,999	8	10%
$100,000 or more	10	13%
Prefer not to answer	13	17%
Total Respondents	**77**	

HIGHEST EDUCATION COMPLETED

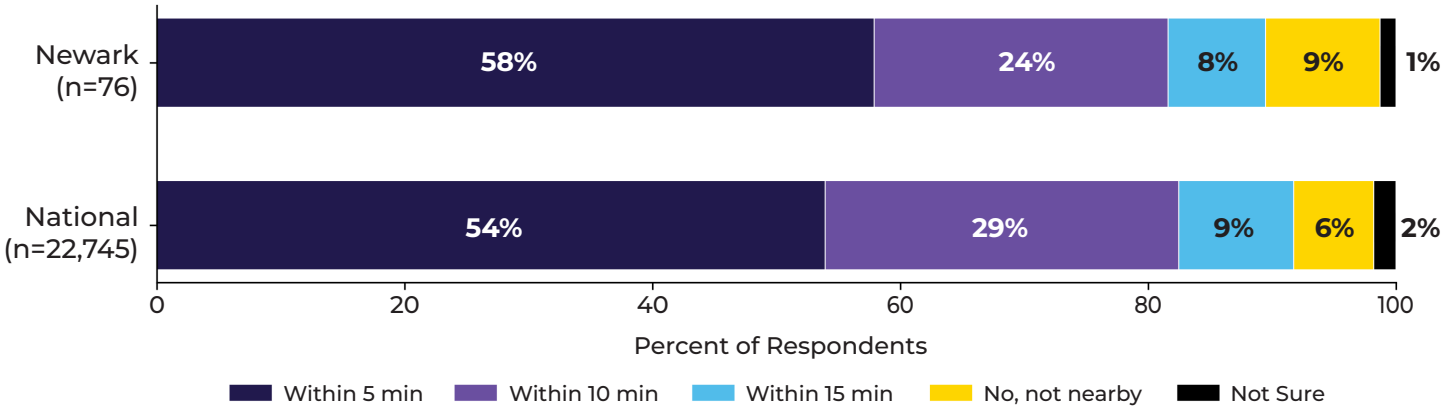
HIGHEST EDUCATION COMPLETED	NUMBER	PERCENT
No high school education	1	1%
Some high school	3	4%
GED or high school graduate	14	18%
Some college	25	32%
Bachelor's degree	19	25%
Graduate degree or higher	15	19%
Prefer not to answer	-	-
Total Respondents	**77**	

DIFFICULTIES WITH ACTIVITIES

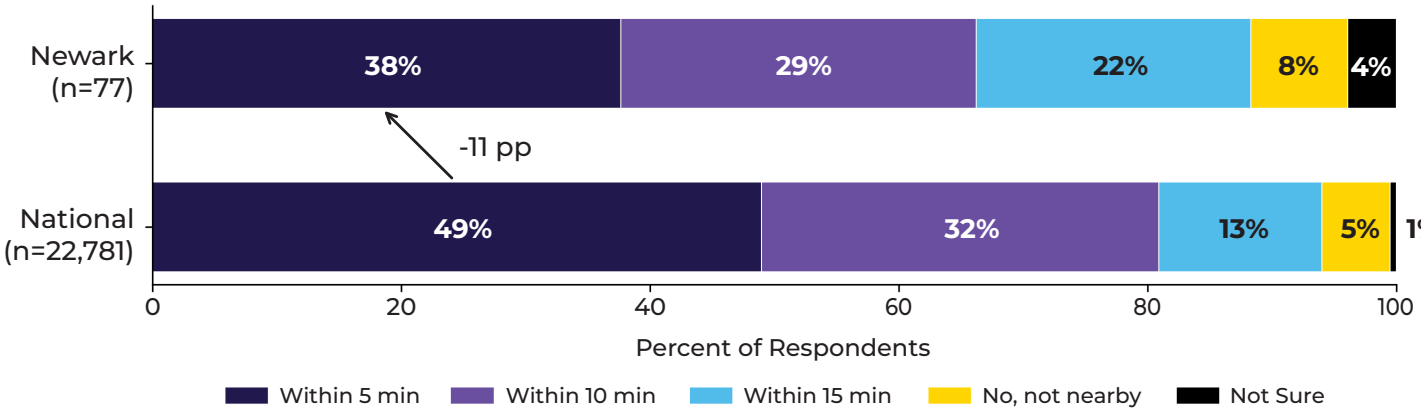
DIFFICULTY TYPE	NUMBER	PERCENT
Hearing, even with hearing aids	1	1%
Seeing, even with glasses	6	8%
Walking or climbing stairs	9	12%
Dressing or bathing	-	-
Using the toilet	-	-
None of the above	51	69%
Prefer not to answer	1	1%
Concentrating	10	14%
***Total Respondents**	**74**	

*Total respondents represent the number of individuals who provided a valid response to this question. It is not the sum of respondents in each category.

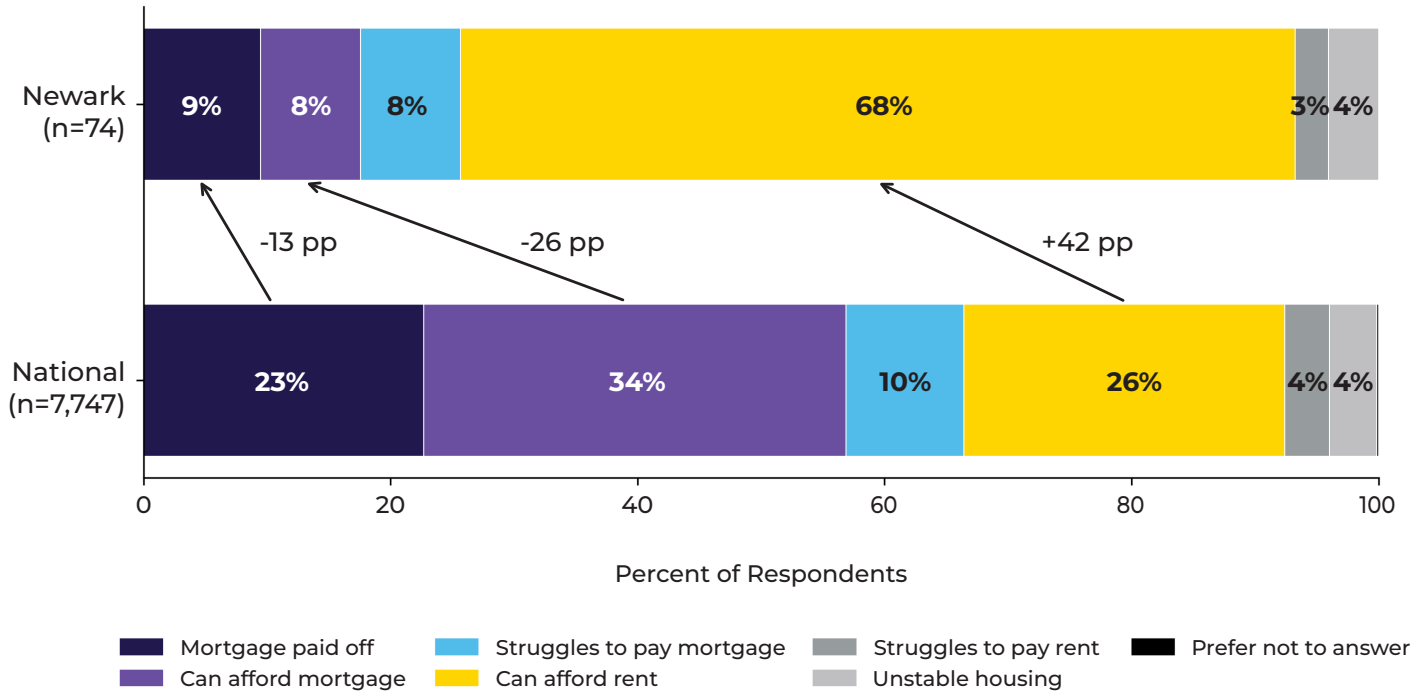
Green Space Access — National vs Newark



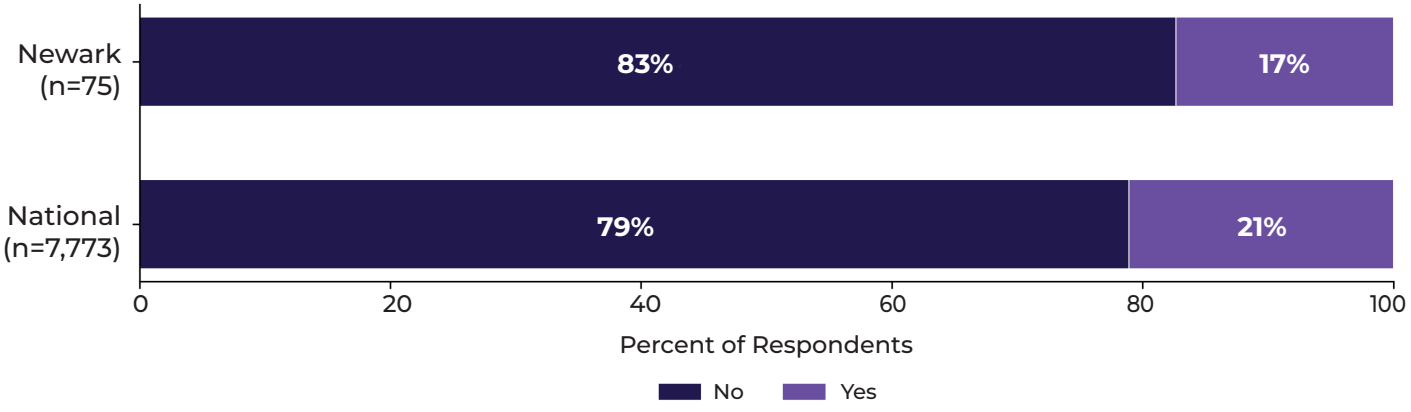
Grocery Store Access — National vs Newark



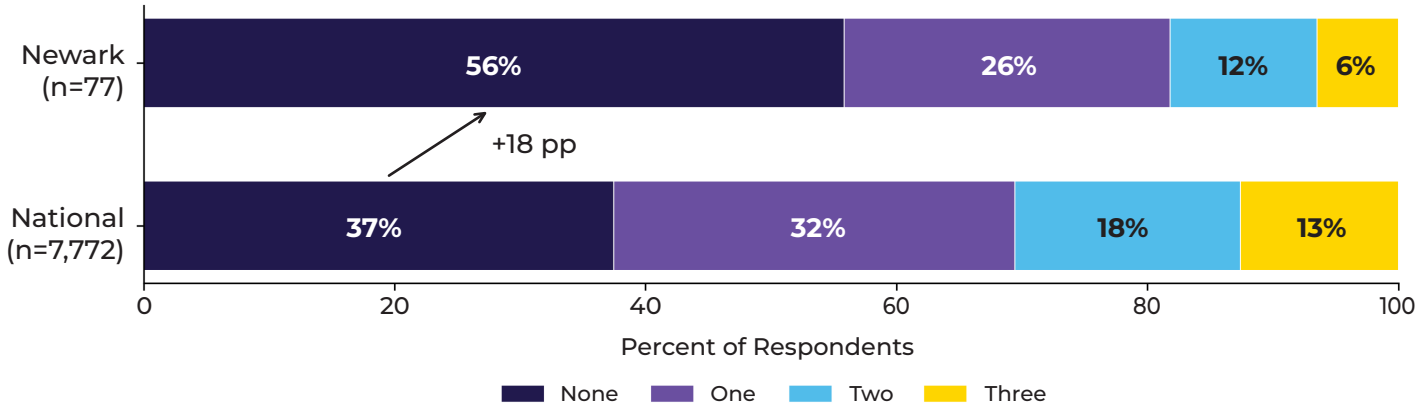
Housing Arrangements — National vs Newark



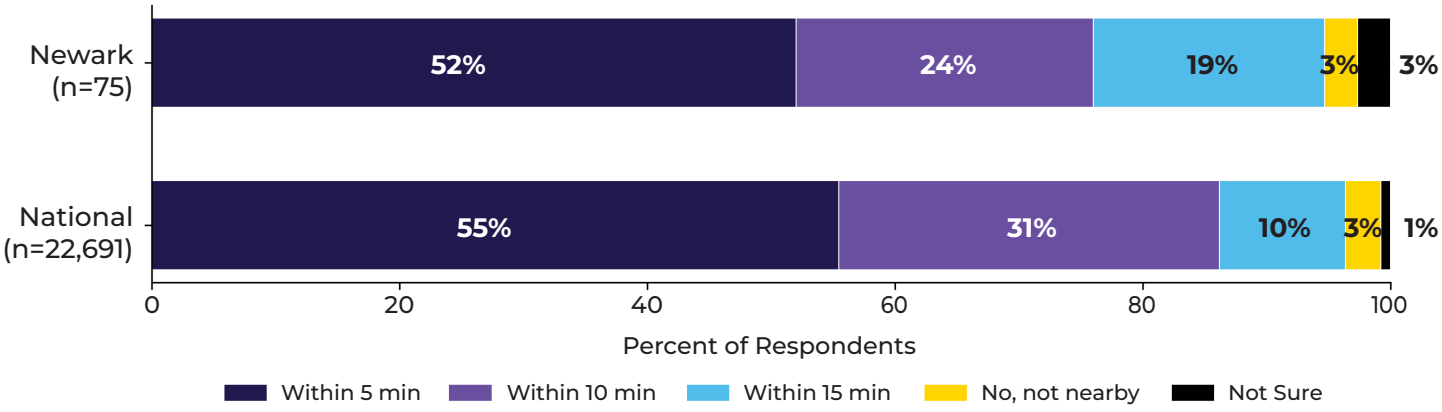
Issues Accessing Appointments or Prescriptions — National vs Newark



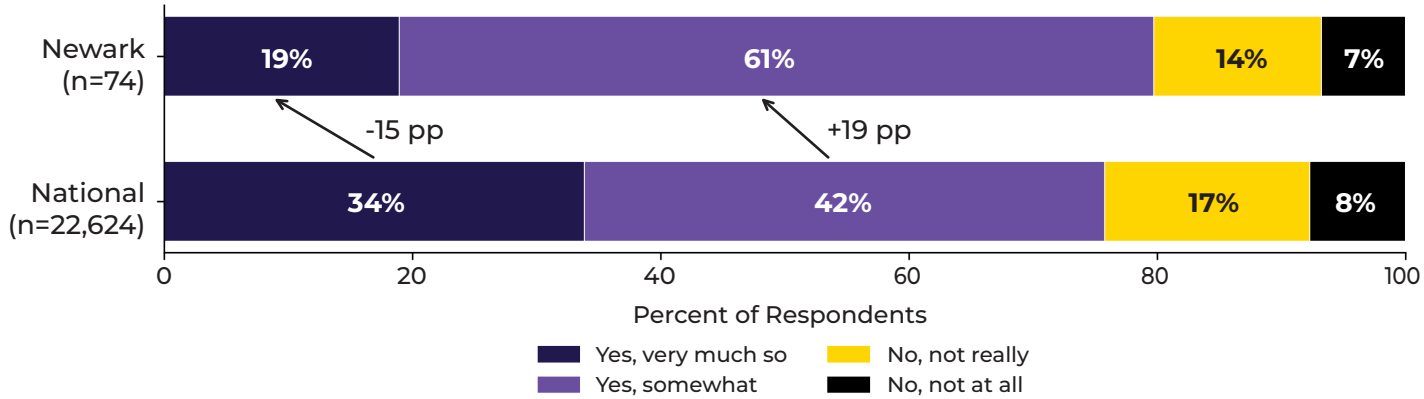
Chronic Health Conditions — National vs Newark



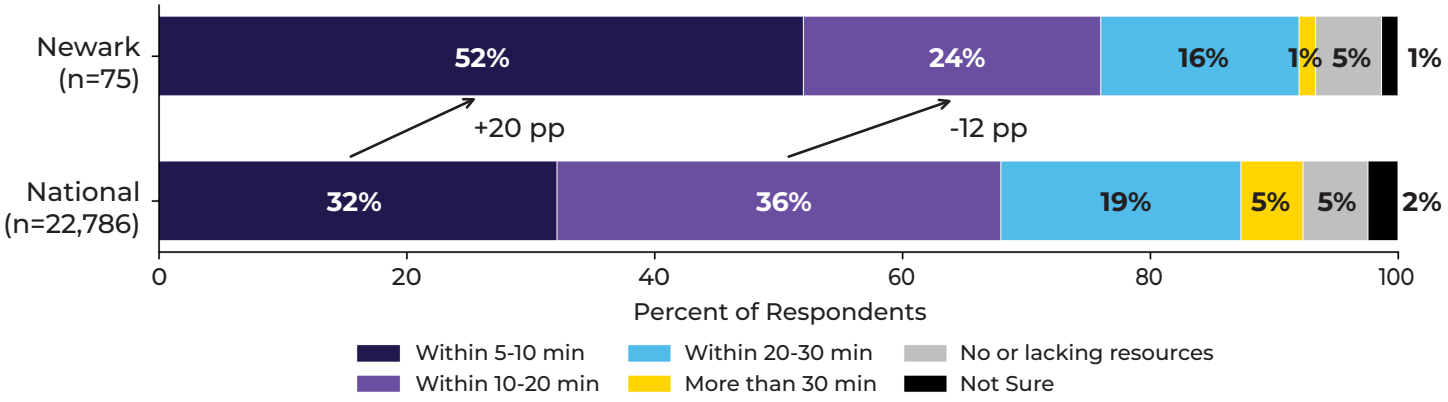
Pharmacy Proximity — National vs Newark



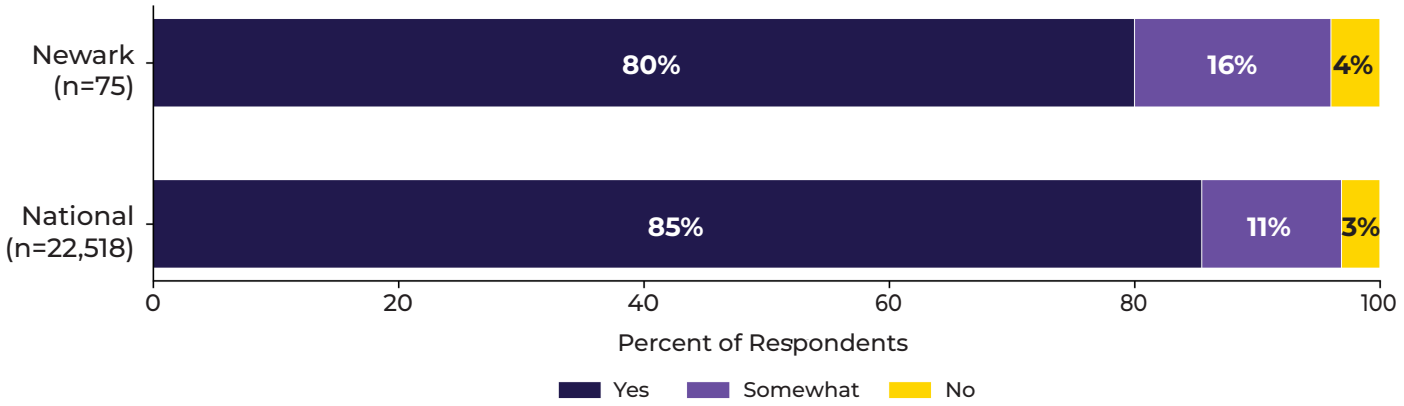
Perceived Cultural Understanding of Providers — National vs Newark



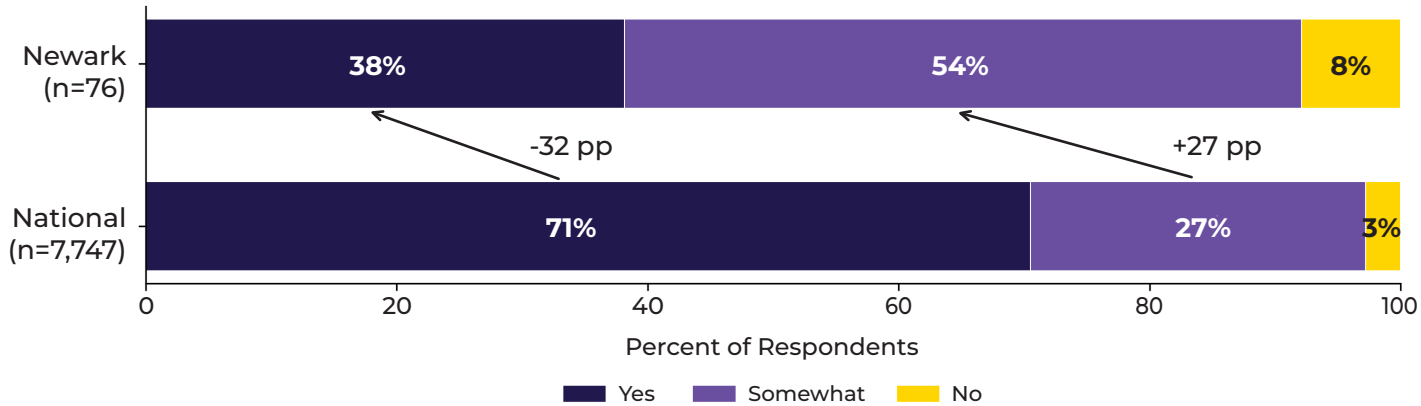
Proximity to a Quality Hospital — National vs Newark

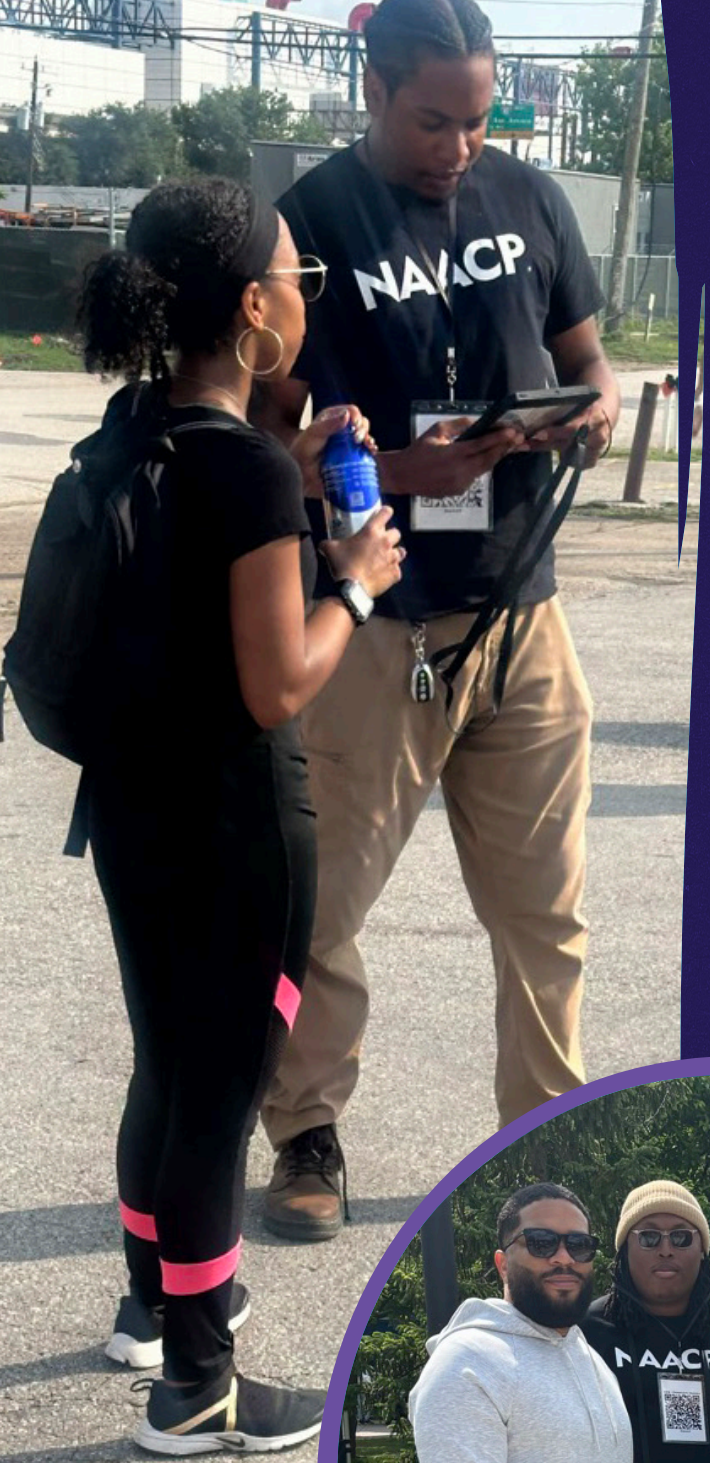


Access to Affordable and Reliable Transportation — National vs Newark



Perceived Neighborhood Safety — National vs Newark





CENSUS DATA FOR PRIORITY CITIES

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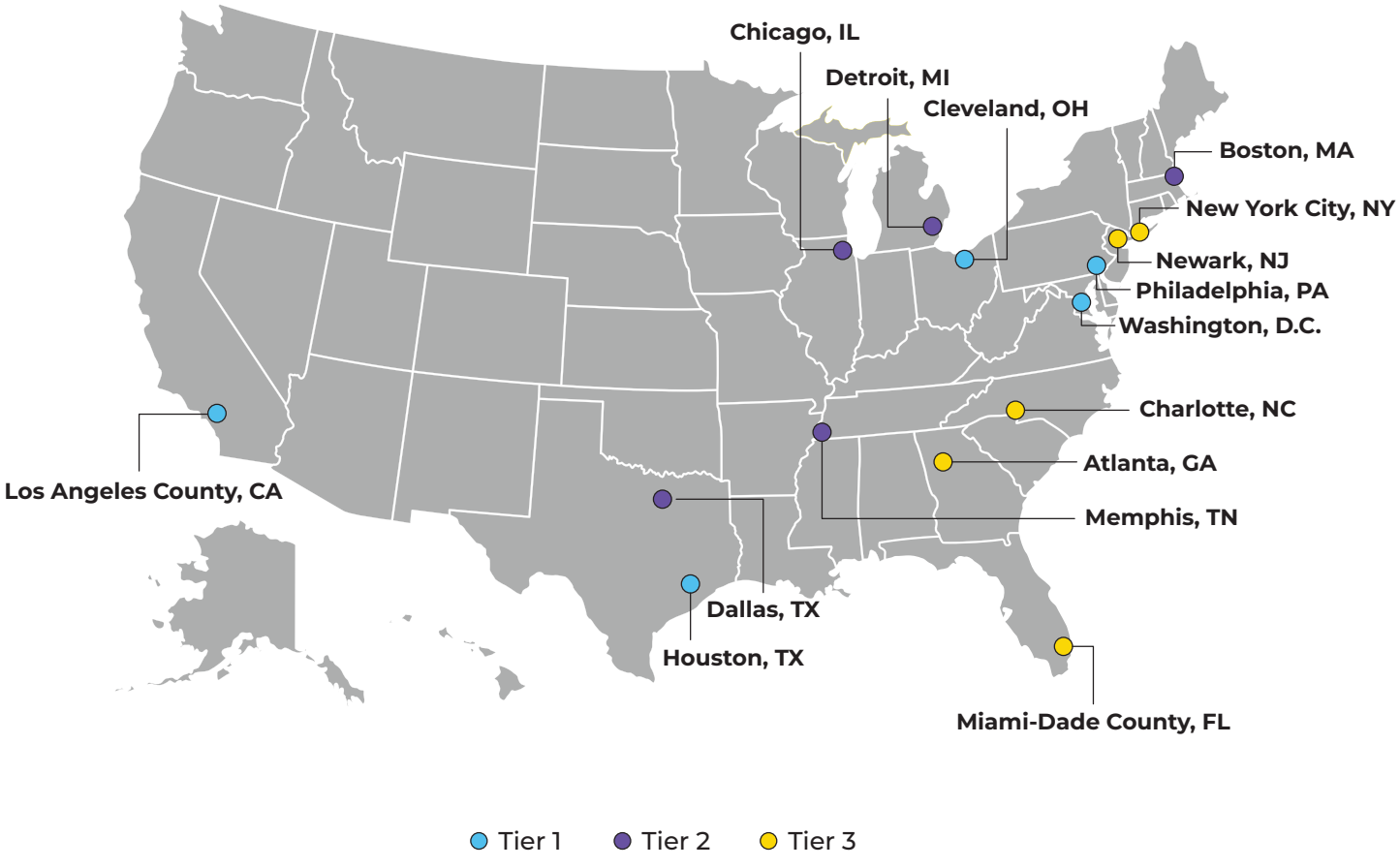
UNDERSTANDING CITY FINDINGS IN LOCAL AND NATIONAL CONTEXT

The city context comparisons that follow place survey findings alongside census-based demographic and socioeconomic data to support accurate interpretation of results. Across cities, survey respondents were often more educated and had a higher income than citywide averages, a pattern common in voluntary, community-based surveys. Despite these differences, respondents consistently reported challenges related to chronic health conditions, access to timely and culturally responsive care, and navigating complex systems. These findings underscore that the barriers identified in this report persist across socioeconomic levels and reflect broader structural conditions shaping health and well-being.

15 Priority Geographies



TIER 1

LOS ANGELES COUNTY, CA

Compared with Los Angeles County's overall population profile, survey respondents were disproportionately Black and substantially more educated and higher income than the countywide averages. In Los Angeles County, survey respondents reported a median household income of approximately $80,000, which is lower than the countywide median income of $90,800. This indicates that respondents may experience greater economic vulnerability relative to the broader county population. Despite these differences, respondents reported persistent challenges related to chronic health conditions, access to timely health care, and navigating complex systems, underscoring that health and access barriers remain salient even among residents with higher educational attainment and income.

LA County

- Age: Median age = 38.9
- Race/Ethnicity:
  - American Indian and Alaska Native: 163,464
  - Asian: 1,499,984
  - Black or African American: 794,364
  - Hispanic or Latino: 4,804,763
  - Native Hawaiian and Other Pacific Islander: 24,522
  - Not Hispanic or Latino: 2,563,609
  - Some Other Race: 2,784,180
  - Two or More Races: 1,488,068
  - White: 3,259,427
- Sex/Gender: https://tinyurl.com/mv7ztt8w
- Income: Median household income = $90,845
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	20.20%	± 0.3%
Some college, no degree	17.00%	± 0.3%
Associate's degree	7.00%	± 0.2%
Bachelor's degree	23.80%	± 0.3%
Graduate or professional degree	13.40%	± 0.2%

PHILADELPHIA, PA

Compared with Philadelphia's overall population profile, survey respondents were disproportionately Black, more highly educated, and had higher incomes than the citywide averages. While roughly one-third of Philadelphia adults hold a bachelor's degree or higher, and the city's median household income is approximately $60,500, a substantially larger share of survey respondents reported holding a bachelor's or graduate degree, with many reporting household incomes above $80,000. Despite these differences, respondents described ongoing challenges related to chronic health conditions, access to timely care, and navigating health systems, highlighting that these concerns persist even among residents with greater educational and economic resources.

Philadelphia

- Age: Median age = 35.7
- Race/Ethnicity:
- American Indian and Alaska Native: 6,212
- Asian: 133,533
- Black or African American: 630,462
- Hispanic or Latino: 238,277
- Native Hawaiian and Other Pacific Islander: 932
- Not Hispanic or Latino: 550,828
- Some Other Race: 139,102
- Two or More Races: 110,900
- White: 582,636
- Sex/Gender: https://tinyurl.com/mr45kwds
- Income: Median household income = $60,521
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Educational Attainment:**	**MoE**
High school or equivalent degree	31.00%	± 1.0%
Some college, no degree	14.90%	± 1.0%
Associate's degree	6.60%	± 0.6%
Bachelor's degree	19.70%	± 0.8%
Graduate or professional degree	16.60%	± 0.8%

HOUSTON, TX

Compared with Houston's overall population profile, survey respondents were disproportionately Black and more highly educated than the citywide averages. While approximately four in 10 Houston adults hold a bachelor's degree or higher, and the city's median household income is about $64,400, a much larger share of survey respondents reported holding bachelor's or graduate degrees, with a notable proportion reporting household incomes above $80,000. Despite these differences, respondents reported meaningful challenges related to chronic health conditions, timely access to care, and navigating health services, suggesting that health-related barriers cut across income and education levels in Houston.

Houston

- Age: Median age = 34.0
- Race/Ethnicity:
  - American Indian and Alaska Native: 27,428
  - Asian: 167,189
  - Black or African American: 520,389
  - Hispanic or Latino: 1,013,423
  - Native Hawaiian and Other Pacific Islander: 1,366
  - Not Hispanic or Latino: 545,989
  - Some Other Race: 476,667
  - Two or More Races: 371,668
  - White: 739,873
- Sex/Gender: https://tinyurl.com/4ze27v97
- Income: Median household income = $64,361
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	21.40%	± 0.7%
Some college, no degree	15.60%	± 0.7%
Associate's degree	5.70%	± 0.5%
Bachelor's degree	22.20%	± 0.7%
Graduate or professional degree	15.80%	± 0.6%

WASHINGTON, D.C.

Compared with the overall population profile of Washington, D.C., survey respondents were disproportionately Black and, on average, highly educated, reflecting but also exceeding the citywide educational attainment levels. Although Washington, D.C., is a highly educated and relatively high-income city overall, with a majority of adults holding a bachelor's degree or higher and a median household income of roughly $109,700, ACE survey respondents reflected even higher levels of educational attainment, with many also reporting household incomes exceeding $80,000. Despite these socioeconomic advantages, respondents continued to report challenges related to chronic health conditions, health system navigation, and perceptions of culturally responsive care, underscoring that access and trust remain critical issues even in resource-rich urban environments.

Washington D.C.

- Age: Median age = 34.9
- Race/Ethnicity:
  - American Indian and Alaska Native: 3,193
  - Asian: 33,545
  - Black or African American: 285,810
  - Hispanic or Latino: 77,652
  - Native Hawaiian and Other Pacific Islander: 432
  - Not Hispanic or Latino: 261,771
  - Some Other Race: 37,294
  - Two or More Races: 56,077
  - White: 273,194
- Sex/Gender: https://tinyurl.com/bzdwujud
- Income: Median household income = $109,707
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	14.30%	± 1.2%
Some college, no degree	10.20%	± 1.1%
Associate's degree	2.00%	± 0.5%
Bachelor's degree	27.10%	± 1.3%
Graduate or professional degree	38.30%	± 1.4%

CLEVELAND, OH

Compared with Cleveland's overall population profile, survey respondents were disproportionately Black, substantially more educated, and had higher incomes than the citywide averages. While approximately one-quarter of Cleveland adults hold a bachelor's degree or higher, and the city's median household income is about $43,400, nearly four in five survey respondents reported a bachelor's or graduate degree, and a sizable share reported household incomes above $80,000. Despite these differences, respondents reported meaningful challenges related to chronic health conditions, functional limitations, and access to timely and culturally responsive health care, underscoring that these barriers affect Cleveland residents across socioeconomic levels.

Cleveland

- Age: Median age = 37.7
- Race/Ethnicity:
  - American Indian and Alaska Native: 1,598
  - Asian: 10,517
  - Black or African American: 180,224
  - Hispanic or Latino: 48,699
  - Native Hawaiian and Other Pacific Islander: 162
  - Not Hispanic or Latino: 119,547
  - Some Other Race: 23,380
  - Two or More Races: 28,300
  - White: 128,443
- Sex/Gender: https://tinyurl.com/4tyax7hz
- Income: Median household income = $43,400
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	32.40%	± 1.7%
Some college, no degree	20.50%	± 1.6%
Associate's degree	7.80%	± 1.1%
Bachelor's degree	14.80%	± 1.4%
Graduate or professional degree	9.20%	± 1.1%

TIER 2

DETROIT, MI

Compared with Detroit's overall population profile, survey respondents were disproportionately Black, more highly educated, and had higher incomes than the citywide averages. While fewer than one in five Detroit adults hold a bachelor's degree or higher, and the city's median household income is approximately $39,200, a substantially large share of survey respondents reported holding bachelor's or graduate degrees, with many reporting household incomes above $80,000. Despite these differences, respondents reported significant challenges related to chronic health conditions, functional limitations, and access to timely and culturally responsive health care, underscoring that long-standing health inequities persist even among more socioeconomically advantaged residents.

Detroit

- Age: Median age = 35.9
- Race/Ethnicity:
  - American Indian and Alaska Native: 2,931
  - Asian: 10,193
  - Black or African American: 496,534
  - Hispanic or Latino: 51,269
  - Native Hawaiian and Other Pacific Islander: 160
  - Not Hispanic or Latino: 60,770
  - Some Other Race: 29,681
  - Two or More Races: 31,205
  - White: 68,407
- Sex/Gender: https://tinyurl.com/bdcwf5t2
- Income: Median household income = $39,209
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	32.10%	± 1.6%
Some college, no degree	25.30%	± 1.4%
Associate's degree	7.20%	± 0.9%
Bachelor's degree	11.00%	± 1.0%
Graduate or professional degree	7.80%	± 0.7%

MEMPHIS, TN

Compared with Memphis's overall population profile, survey respondents were disproportionately Black, more highly educated, and had higher incomes than the citywide averages. While roughly three in 10 Memphis adults hold a bachelor's degree or higher, and the city's median household income is approximately $52,700, a larger share of survey respondents reported bachelor's or graduate degrees, with many reporting household incomes above $80,000. Despite these differences, respondents described ongoing challenges related to chronic health conditions, access to care, and navigating health systems, highlighting that health and access barriers remain salient across socioeconomic levels in Memphis.

Memphis

- Age: Median age = 34.8
- Race/Ethnicity:
  - American Indian and Alaska Native: 2,501
  - Asian: 11,624
  - Black or African American: 389,779
  - Hispanic or Latino: 62,167
  - Native Hawaiian and Other Pacific Islander: 198
  - Not Hispanic or Latino: 151,581
  - Some Other Race: 41,075
  - Two or More Races: 29,547
  - White: 158,380
- Sex/Gender: https://tinyurl.com/3h3d68ju
- Income: Median household income = $52,679
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	30.10%	± 1.6%
Some college, no degree	21.70%	± 1.4%
Associate's degree	6.40%	± 0.9%
Bachelor's degree	16.50%	± 1.2%
Graduate or professional degree	12.00%	± 1.2%

DALLAS, TX

Compared with Dallas's overall population profile, survey respondents were disproportionately Black, somewhat more highly educated, and had a slightly higher income than the citywide averages. While approximately four in 10 Dallas adults hold a bachelor's degree or higher, and the city's median household income is about $74,700, a large share of survey respondents reported holding bachelor's or graduate degrees, with many reporting household incomes above $80,000. Despite these differences, respondents reported meaningful challenges related to chronic health conditions and timely access to health care, suggesting that these issues affect residents across educational and income levels in Dallas.

Dallas

- Age: Median age = 33.2
- Race/Ethnicity:
  - American Indian and Alaska Native: 15,376
  - Asian: 48,588
  - Black or African American: 303,577
  - Hispanic or Latino: 551,174
  - Native Hawaiian and Other Pacific Islander: 687
  - Not Hispanic or Latino: 366,393
  - Some Other Race: 253,858
  - Two or More Races: 211,474
  - White: 470,819
- Sex/Gender: https://tinyurl.com/3yypk53w
- Income: Median household income = $74,721
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	20.70%	± 1.1%
Some college, no degree	15.90%	± 1.0%
Associate's degree	5.50%	± 0.5%
Bachelor's degree	24.30%	± 1.0%
Graduate or professional degree	15.60%	± 0.8%

BOSTON, MA

Compared with Boston's overall population profile, survey respondents were disproportionately Black and highly educated, reflecting both the citywide educational attainment levels and exceeding them. While approximately half of adults in Boston hold a bachelor's degree or higher, and the city's median household income is approximately $97,800, ACE survey respondents reflected higher concentrations of advanced education, with a larger share reporting bachelor's and graduate degrees, and many reporting household incomes above $80,000. Despite these socioeconomic advantages, respondents reported challenges related to chronic health conditions, difficulties accessing timely care, and navigating complex health systems, underscoring that access and usability concerns persist even in cities with strong healthcare infrastructure.

Boston

- Age: Median age = 33.8
- Race/Ethnicity:
  - American Indian and Alaska Native: 2,824
  - Asian: 76,021
  - Black or African American: 138,870
  - Hispanic or Latino: 126,113
  - Native Hawaiian and Other Pacific Islander: 356
  - Not Hispanic or Latino: 301,464
  - Some Other Race: 68,274
  - Two or More Races: 71,201
  - White: 318,101
- Sex/Gender: https://tinyurl.com/muvp2z28
- Income: Median household income = $97,791
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	18.00%	± 1.2%
Some college, no degree	10.60%	± 1.0%
Associate's degree	4.60%	± 0.7%
Bachelor's degree	27.80%	± 1.2%
Graduate or professional degree	27.60%	± 1.5%

CHICAGO, IL

Compared with Chicago's overall population profile, ACE survey respondents were disproportionately Black and more highly educated. While nearly half of adults in Chicago hold a bachelor's degree or higher, and the city's median household income is approximately $80,600, survey respondents reported similar household income levels to the citywide median, alongside higher concentrations of bachelor's and graduate-level education. Despite these socioeconomic advantages, respondents reported challenges related to chronic health conditions, difficulties accessing timely care, and navigating complex health systems, underscoring that access and usability concerns persist even in cities with strong healthcare infrastructure.

Chicago

- Age: Median age = 35.9
- Race/Ethnicity:
  - American Indian and Alaska Native: 34,543
  - Asian: 192,586
  - Black or African American: 801,195
  - Hispanic or Latino: 819,518
  - Native Hawaiian and Other Pacific Islander: 1,087
  - Not Hispanic or Latino: 863,622
  - Some Other Race: 434,452
  - Two or More Races: 296,245
  - White: 986,280
- Sex/Gender: https://tinyurl.com/4t29b3s2
- Income: Median household income =$80,600
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	20.40%	± 0.8%
Some college, no degree	14.90%	± 0.5%
Associate's degree	5.70%	± 0.4%
Bachelor's degree	26.60%	± 0.9%
Graduate or professional degree	19.80%	± 0.7%

TIER 3

NEWARK, NJ

Compared with Newark's overall population profile, survey respondents were disproportionately Black, more highly educated, and had higher incomes than the citywide averages. While fewer than one-quarter of Newark adults hold a bachelor's degree or higher, and the city's median household income is approximately $58,500, a substantially large share of survey respondents reported holding bachelor's or graduate degrees, with many reporting household incomes above $80,000. Despite these differences, respondents reported meaningful challenges related to chronic health conditions, functional limitations, and access to timely and culturally responsive health care, underscoring that these barriers affect Newark residents across socioeconomic levels.

Newark

- Age: Median age = 33.8
- Race/Ethnicity:
  - American Indian and Alaska Native: 2,256
  - Asian: 5,047
  - Black or African American: 154,048
  - Hispanic or Latino: 113,374
  - Native Hawaiian and Other Pacific Islander: 190
  - Not Hispanic or Latino: 24,916
  - Some Other Race: 74,525
  - Two or More Races: 37,706
  - White: 37,777
- Sex/Gender: https://tinyurl.com/jtnn629f
- Income: Median household income = $58,490
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	37.90%	± 2.6%
Some college, no degree	14.20%	± 1.8%
Associate's degree	5.60%	± 1.1%
Bachelor's degree	14.00%	± 1.8%
Graduate or professional degree	7.50%	± 1.4%

NEW YORK CITY, NY

Compared with Boston's overall population profile, survey respondents were disproportionately Black and highly educated, reflecting both the citywide educational attainment levels and exceeding them. While just over four in 10 adults in New York City hold a bachelor's degree or higher, and the city's median household income is approximately $81,200, ACE survey respondents reported comparable household income levels to the citywide median, alongside higher concentrations of bachelor's and graduate-level education. Despite these similarities in income, respondents reported ongoing challenges related to chronic health conditions, access to care, and perceptions of culturally responsive services, underscoring that health barriers persist across socioeconomic strata in New York City.

New York City

- Age: Median age = 38.5
- Race/Ethnicity:
  - American Indian and Alaska Native: 86,218
  - Asian: 1,385,144
  - Black or African American: 1,943,645
  - Hispanic or Latino: 2,490,350
  - Native Hawaiian and Other Pacific Islander: 6,874
  - Not Hispanic or Latino: 2,719,856
  - Some Other Race: 1,494,267
  - Two or More Races: 887,097
  - White: 3,000,945
- Sex/Gender: https://tinyurl.com/4y58kj7k
- Income: Median household income = $81,228
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	22.70%	± 0.4%
Some college, no degree	12.40%	± 0.3%
Associate's degree	6.20%	± 0.2%
Bachelor's degree	24.40%	± 0.3%
Graduate or professional degree	18.10%	± 0.3%

ATLANTA, GA

Compared with Atlanta's overall population profile, ACE survey respondents were disproportionately Black and highly educated, reflecting both the citywide educational attainment levels and exceeding them. While more than six in ten adults in Atlanta hold a bachelor's degree or higher, and the city's median household income is approximately $88,200, survey respondents reported similarly high levels of educational attainment and household income. Despite these socioeconomic advantages, respondents continued to report challenges related to chronic health conditions, access to timely care, and perceptions of culturally responsive health services, underscoring that education and income alone do not eliminate health and access barriers.

Atlanta

- Age: Median age = 34.5
- Race/Ethnicity:
  - American Indian and Alaska Native: 1,406
  - Asian: 22,367
  - Black or African American: 235,513
  - Hispanic or Latino: 29,988
  - Native Hawaiian and Other Pacific Islander: 218
  - Not Hispanic or Latino: 192,148
  - Some Other Race: 11,921
  - Two or More Races: 29,050
  - White: 198,240
- Sex/Gender: https://tinyurl.com/yxcp8b22
- Income: Median household income = $88,165
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	14.90%	± 1.5%
Some college, no degree	13.10%	± 1.3%
Associate's degree	4.50%	± 0.7%
Bachelor's degree	34.70%	± 1.7%
Graduate or professional degree	27.50%	± 1.6%

CHARLOTTE, NC

Compared with Charlotte's overall population profile, ACE survey respondents were disproportionately Black and more highly educated. While nearly half of adults in Charlotte hold a bachelor's degree or higher, and the city's median household income is approximately $86,400, survey respondents reported household income levels similar to the citywide median, alongside higher concentrations of bachelor's and graduate-level education. Despite these differences, respondents reported meaningful challenges related to chronic health conditions, access to timely care, and navigating health systems, highlighting that health-related barriers affect Charlotte residents across socioeconomic levels.

Charlotte

- Age: Median age = 34.5
- Race/Ethnicity:
  - American Indian and Alaska Native: 5,674
  - Asian: 61,789
  - Black or African American: 289,062
  - Hispanic or Latino: 142,704
  - Native Hawaiian and Other Pacific Islander: 526
  - Not Hispanic or Latino: 347,363
  - Some Other Race: 83,682
  - Two or More Races: 68,735
  - White: 365,111
- Sex/Gender: https://tinyurl.com/2a24hjwd
- Income: Median household income = $86,416
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	17.30%	± 1.2%
Some college, no degree	15.40%	± 0.9%
Associate's degree	7.80%	± 0.7%
Bachelor's degree	31.70%	± 1.2%
Graduate or professional degree	17.70%	± 0.9%

MIAMI-DADE COUNTY, FL

Compared with Miami-Dade County's overall population profile, survey respondents were disproportionately Black, more highly educated, and had higher incomes than the countywide averages. While just over one-third of adults hold a bachelor's degree or higher, and the median household income is approximately $76,200, a substantially larger share of survey respondents reported holding bachelor's or graduate degrees, with many reporting household incomes above $80,000. Despite these differences, respondents reported ongoing challenges related to chronic health conditions, access to timely care, and navigating complex health systems, underscoring that health and access barriers persist across socioeconomic levels in Miami-Dade County.

Miami-Dade County

- Age: Median age = 40.6
- Race/Ethnicity:
  - American Indian and Alaska Native: 9,107
  - Asian: 44,124
  - Black or African American: 400,002
  - Hispanic or Latino: 1,856,938
  - Native Hawaiian and Other Pacific Islander: 641
  - Not Hispanic or Latino: 361,517
  - Some Other Race: 319,419
  - Two or More Races: 1,131,581
  - White: 796,893
- Sex/Gender: https://tinyurl.com/4852s32y
- Income: Median household income = $76,184
- Educational Attainment:

EDUCATIONAL ATTAINMENT (POPULATION 25 YEARS AND OLDER)	NUMBER	PERCENT
Measure	**Value**	**MoE**
High school or equivalent degree	26.10%	± 0.6%
Some college, no degree	12.20%	± 0.5%
Associate's degree	9.60%	± 0.5%
Bachelor's degree	23.10%	± 0.6%
Graduate or professional degree	13.80%	± 0.5%

QUALITATIVE ANALYSIS INSIGHTS

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INSIGHTS

OVERVIEW AND PURPOSE OF THE QUALITATIVE ANALYSIS

The qualitative findings presented in this section are intended to complement and deepen the quantitative results discussed earlier in the report. While the survey data describe patterns of access, conditions, and experiences across communities, the qualitative data provide insight into how residents understand and live those conditions in their daily lives. Together, these approaches offer a more complete picture of the factors shaping health and well-being across participating cities.

Rather than serving as a separate or parallel analysis, the qualitative findings help explain the meaning behind the numbers—how financial pressure, neighborhood conditions, healthcare experiences, and social environments intersect in ways that influence physical, emotional, and mental health. This section centers residents' voices while maintaining a clear, accessible narrative for readers.

QUALITATIVE DATA SOURCES

Qualitative Data Sources

The qualitative findings draw from two complementary data sources:

- Open-ended responses from the ACE Your Health Community Wellness Survey
- In-person focus groups conducted in Newark, NJ, and Charlotte, NC

Together, these sources provide both breadth and depth, capturing experiences shared across thousands of respondents as well as more detailed, place-based perspectives.

Open-Ended Survey Responses

The ACE Your Health Community Wellness Survey included one voluntary open-ended question: "What affects your health and well-being the most, whether positively or negatively?" A total of 5,247 respondents provided written responses. Prior to analysis, responses were reviewed to assess whether they meaningfully addressed the question. Entries that were blank, nonsensical, or non-substantive—such as "N/A," single-word responses, repeated characters, or text unrelated to health or well-being—were excluded before coding. After this initial screening, 4,233 valid narrative responses were included in the qualitative analysis.

Respondents represented all ACE Tier cities and reflected a wide range of demographic characteristics, including race and ethnicity, income, age, gender, and family structure. Given the volume of substantive responses, the analysis focused on identifying recurring themes and shared experiences rather than reproducing individual comments verbatim. Responses were synthesized to highlight patterns that consistently appeared across communities and demographic groups, ensuring that the findings reflect meaningful community input rather than non-responsive entries.

All narrative comments were reviewed and cleaned before analysis. The research team used an inductive qualitative approach, allowing themes to emerge from residents' own words rather than imposing preexisting categories. Initial code exploration was supported by a digital text-analysis tool (ChatGPT), while all final coding, theme development, interpretations, and synthesis were conducted and verified by the research team. The analytic process included open coding, grouping similar concepts, forming broader themes, and examining cross-cutting patterns across demographic groups. This process ensured that lived experience remained at the forefront of interpretation.

Focus Group Data

To deepen understanding of the survey data, the NAACP Center for Health Equity partnered with Hart Research to conduct four in-person exploratory focus groups: two in Newark, NJ (17 participants), and two in Charlotte, NC (18 participants), for a total of 35 participants. The focus groups included both mixed-demographic participants and groups composed exclusively of Black residents, allowing for intentional centering of voices from communities historically underrepresented in research.

In each city, Hart Research convened two in-person focus groups: one comprising a representative cross-section of city residents by race, gender, age, and geographic distribution, and a second containing a representative cross-section of Black residents. While the study did not collect or report detailed demographic tables, participant characteristics such as race/ethnicity, age, gender, and neighborhood were documented through quote attribution and informed interpretation of findings. This approach allowed for contextual understanding of perspectives while protecting participant confidentiality.

Each session lasted two hours. Newark groups were held on June 26, 2025, and Charlotte groups on August 14, 2025. Participants received a monetary incentive and a meal. Recruitment was conducted by third-party qualitative research vendors using proprietary participant panels. Eligibility required being over age 18 and residing in the focal city. Participant demographic characteristics are summarized in Appendix B.

The focus group discussion guide included four major domains: (1) Health and Well-Being; (2) Neighborhood and Built Environment; (3) Healthcare Access and Quality; and (4) Social and Community Context. Participants discussed housing quality and affordability, food access, green spaces, safety, environmental conditions, transportation, access to healthcare, experiences with discrimination, and community strengths.

Exercises were included to prompt reflection and encourage participants to think beyond their immediate experiences. The complete focus group discussion guide is included in Appendix C.

Together, the survey and focus group data provide a robust, multi-method qualitative understanding of what shapes well-being across ACE Tier cities.

APPROACH TO QUALITATIVE ANALYSIS

All qualitative data were analyzed using an inductive, theme-based approach that prioritized residents' own language and lived experiences. The initial review of the open-ended survey responses focused on identifying frequently occurring ideas and shared concerns across narratives. These ideas were grouped into broader thematic areas, which were then refined through iterative review by the research team.

Focus group insights were used to confirm, expand, and contextualize themes identified in the survey responses. This triangulation strengthened the interpretation by allowing the team to compare broad patterns with in-depth discussion of how those patterns are experienced locally.

The goal of the analysis was not exhaustive enumeration, but meaningful synthesis—highlighting the issues that residents most consistently identified as shaping their health and well-being.

EXECUTIVE SUMMARY OF KEY QUALITATIVE INSIGHTS

The ACE Your Health qualitative findings describe the everyday realities shaping well-being across participating cities. Over 4,000 survey narratives, combined with four in-depth focus group discussions, illuminate how stress, financial pressure, neighborhood conditions, environmental hazards, caregiving responsibilities, workplace challenges, and chronic illness intersect with access to care and long-standing inequities.

Stress was the most consistent theme across all data sources. Respondents described years of accumulated pressure tied to financial instability, caregiving demands, safety concerns, structural racism, chronic medical conditions, and difficulty accessing affordable, culturally competent healthcare. Stress manifested through insomnia, elevated blood pressure, depression, fatigue, and emotional exhaustion.

Financial strain shaped nearly every aspect of life. Respondents described rising costs for housing, food, medication, transportation, and utilities. Many shared that they delay preventive care, skip medications, or reduce food quality because of cost. Participants across focus groups echoed these challenges, describing the emotional strain of "trying to survive in a system that keeps everything expensive."

Neighborhood conditions—including violence, noise, pollution, abandoned buildings, pests, mold, and poor-quality rental housing—were major influences on health. Environmental hazards were especially pronounced in Newark, while Charlotte participants focused on the effects of gentrification, displacement, and rapid population growth.

Positive influences included spirituality, prayer, time in nature, community connections, cultural identity, and personal strength. Participants emphasized the importance of culturally grounded care that acknowledges their lived experiences, particularly for Black residents who reported frustration with dismissal, disrespect, and perceived bias in healthcare settings.

Together, these findings call for culturally responsive, community-informed, and equity-centered approaches to improving health and well-being across ACE cities.

FINDINGS FROM OPEN-ENDED SURVEY RESPONSES

Analysis of the survey narratives revealed thirteen interrelated themes describing the conditions that most strongly influence health and well-being across ACE Tier cities.

Thematic Findings (Survey Narratives)

Theme 1. Stress and Emotional Well-Being

Stress was the most dominant influence on health. Respondents described constant pressure tied to work, finances, caregiving, neighborhood safety, and chronic conditions. Symptoms included sleeplessness, fatigue, headaches, and difficulty concentrating. Women—especially mothers and multigenerational caregivers—carried the heaviest emotional load.

Theme 2. Financial Strain

Rising living costs shaped nearly every other theme. Many respondents described delaying care, rationing medications, and working long hours just to manage household needs.

Theme 3. Healthcare Costs and Insurance Barriers

Respondents described high deductibles, copays, medication prices, insurance denials, and surprise bills. Many avoided seeking care because of cost.

Theme 4. Access to Providers

Respondents described long waitlists, limited clinic hours, shortages in primary care and mental health services, and transportation barriers.

Theme 5. Quality of Care and Trust

Respondents explained that they want care that feels respectful. Many described rushed visits or being dismissed when reporting symptoms, particularly Black women.

Theme 6. Capacity for Healthy Behaviors

Many respondents know what they should do to be healthy, but stress, long work hours, caregiving, unsafe neighborhoods, and exhaustion limit their capacity.

Theme 7. Chronic Conditions

Chronic illnesses such as diabetes, hypertension, asthma, and chronic pain were common amongst respondents, often worsened by stress and inconsistent access to care.

Theme 8. Caregiving and Family Responsibilities

Caregiving is meaningful but heavy. Many respondents balance caring for children, elders, partners, and loved ones with disabilities or health needs.

Theme 9. Work and Employment Conditions

Long hours, low wages, limited flexibility, and workplace stress make it difficult for respondents to care for their health.

Theme 10. Neighborhood Conditions

Violence, unsafe streets, abandoned buildings, pests, mold, noise, and pollution were reported by many respondents as strongly influencing their health.

Theme 11. Food Access

Respondents described food deserts, high food prices, limited grocery options, and reliance on fast food due to affordability.

Theme 12. Racism and Structural Barriers

Respondents described racism influencing healthcare, work, neighborhood opportunities, and overall well-being.

Theme 13. Spirituality, Faith, and Cultural Strengths

Spirituality, prayer, cultural identity, nature, music, family, and community practices were grounding forces across respondent narratives.

COMPARATIVE INSIGHTS

Methodological Note: Interpreting City-Level Patterns in Open-Ended Responses

City-level qualitative insights in this section draw primarily from the open-ended survey responses, which were collected across multiple ACE Tier cities and linked to respondents' city of residence. This structure allows for examination of patterns in thematic emphasis by city, based on the frequency and salience of issues raised in respondents' own words. However, city names are not always identified when presenting findings from this open-ended question. This is intentional. The purpose of the item was to surface shared community experiences and cross-cutting themes, rather than to conduct a city-by-city comparison or ranking. In many cases, key themes—such as financial strain, chronic stress, caregiving demands, healthcare access challenges, and reliance on faith or community—emerged consistently across cities, making it analytically appropriate to present findings in aggregate. Where meaningful differences in emphasis by city were evident, city context is noted; where experiences were broadly shared, city identifiers are withheld to avoid overstating distinctions that were not substantively different across locations. Focus group findings are referenced separately and only for Newark, NJ, and Charlotte, NC, the two cities in which in-depth qualitative discussions were conducted. Together, these approaches balance transparency with analytic clarity and ensure that the findings reflect patterns of lived experience rather than artificial geographic segmentation.

City Differences

High-cost cities reported greater financial strain, provider-shortage cities emphasized long waitlists and limited mental health access, environmentally burdened cities described mold, pests, pollution, and asthma, and cities with strong faith traditions emphasized spirituality as protective.

Gender Differences

Women described caregiving strain, emotional fatigue, and dismissal in care. Men described financial pressure and delayed help-seeking. Nonbinary respondents emphasized the need for affirming care.

Age Differences

Young adults described mental health challenges and financial strain. Middle-aged adults described burnout, chronic illness, and caregiving. Older adults highlighted transportation, medication access, and chronic pain.

Race-Based Differences

Black respondents described cumulative stress across work, finances, caregiving, neighborhood conditions, and chronic illness, with frequent dismissal in healthcare.

White respondents emphasized mental health, work stress, and isolation.

Hispanic/Latino respondents described financial strain, long work hours, and insurance or language barriers.

Asian respondents described work pressure, expectations, and mental health stigma.

Multiracial respondents described blended, identity-related stress.

FOCUS GROUP FINDINGS

Participants described health as a holistic experience shaped by physical, mental, emotional, social, spiritual, and environmental conditions. Findings that differed by city are explicitly identified as specific to Newark or Charlotte. Findings that were consistent across both cities are presented in aggregate terms without city-level distinction.

Newark participants emphasized environmental hazards, including air pollution, water quality concerns, proximity to industrial sites, mold, and aging infrastructure. Charlotte participants more frequently described gentrification, displacement, rising rents, and the erosion of long-standing community networks. Across both cities, safety concerns limited outdoor activity and increased chronic stress.

Healthcare experiences echoed survey findings, with participants describing long wait times, affordability barriers, rushed visits, and difficulty establishing consistent care. Transportation barriers further limited access to healthcare, employment, and food resources—an issue widely recognized as a determinant of health access.

Key Insights at a Glance

Stress and emotional load influence daily well-being. Financial strain is the most consistent challenge. Healthcare access is constrained by cost and availability. Neighborhood conditions shape both mental and physical health. Spirituality, culture, and community are major sources of resilience.

COMMUNITY VOICE SPOTLIGHTS

OVERVIEW

The Community Voice Spotlights section elevates the qualitative depth of the HART focus group discussions, offering a nuanced understanding of how residents in Newark and Charlotte conceptualize health, experience structural barriers, navigate daily pressures, and envision healthier communities. These narratives deepen the survey themes by illustrating how patterns in the quantitative and open-text data manifest in real lives.

HEALTH AND WELL-BEING

How Participants Understand Health

Participants described health as a holistic experience shaped by the interplay of physical, mental, emotional, social, and spiritual dimensions. Good health was defined not simply as the absence of disease but as balance, energy, peace of mind, and the capacity to function effectively in daily life. Participants connected health to the ability to:

- Manage Stress
- Afford Medications and Healthy Foods
- Maintain Mobility
- Sleep Adequately
- Enjoy Stable Housing
- Participate in Family Life
- Access Trusted Medical Providers

Chronic conditions such as asthma, hypertension, diabetes, obesity, and chronic pain were widespread. Participants described lifelong struggles with managing these conditions amid limited resources, inconsistent care, and significant stress.

Mental and Emotional Health

Stress, anxiety, and depression were central to participants' discussions of well-being. Many described feeling "always on edge," "emotionally drained," or "constantly overwhelmed." Common sources of emotional strain included:

- Unstable Finances
- Caregiving Responsibilities
- Difficult Work Schedules
- Unsafe Neighborhoods
- Unresolved Trauma
- Poor Housing Conditions
- Limited Access to mental health care

Black participants, particularly Black women, described the emotional toll of balancing family leadership roles, work demands, and the expectation to remain strong even when exhausted.

Neighborhood and Environmental Impacts on Well-Being

Neighborhood environments had a profound effect on health. Residents described:

- Car Break-Ins
- Gunshots
- Harassment
- Vandalism
- Open Drug Use
- Abandoned Buildings
- Poorly Lit Streets
- Heavy Truck Traffic
- Illegal Dumping

Participants from Newark spoke extensively about environmental concerns such as air pollution, water safety, proximity to industrial sites, and pervasive mold in rental housing. They described how long-term exposure to pollution and toxic environments shaped chronic illness patterns in their families.

Charlotte participants discussed the emotional impact of gentrification—losing familiar neighbors and cultural anchors, rising rents, and the sense that “the city is changing and we no longer belong.”

Green Spaces and Physical Activity

While participants valued outdoor activity, many felt unsafe exercising outside. In Newark, participants said parks were limited, poorly maintained, or unsafe. In Charlotte, greenways existed but felt distant or increasingly occupied by new residents, leading to discomfort or exclusion. Participants explained that limited access to green space undermines both physical and mental health.

Daily Stress and Coping

Participants described accumulating layers of stress—financial, environmental, emotional, and physical. Many connected stress to chronic illness, poor sleep, weight fluctuations, and emotional exhaustion. Coping strategies included prayer, meditation, family support, occasional exercise, music, and time outdoors, though access to these resources varied.

HEALTHCARE ACCESS AND QUALITY

Accessing Care

Across both cities, participants described an overburdened healthcare system with barriers at every level. Many shared experiences of:

- Monthslong Wait Times
- Limited Provider Availability
- Rushed Appointments
- Confusing Scheduling Processes
- Lack of Evening or Weekend Hours
- Difficulty Establishing Primary Care

Charlotte participants emphasized that the city's rapid growth has outpaced healthcare infrastructure, making it harder to access timely care.

Affordability and Insurance Barriers

Participants also stressed that insurance does not guarantee affordable care. They described:

- High Deductibles
- Specialist Fees

- Copays
- Costs of Tests and Imaging
- High Prescription Prices
- Limited Mental Health Coverage
- Insufficient Dental and Vision Coverage

Many made painful trade-offs between paying bills, buying food, and accessing healthcare. Some delayed care until conditions worsened.

Cultural Competency and Provider Relationships

Black participants, specifically, described feeling dismissed, judged, or misunderstood by healthcare providers. They reported:

- Assumptions About Drug Use or Noncompliance
- Poor Communication
- Inadequate Examination or Testing
- Feeling Unheard or Rushed
- Discrimination in Emergency or Maternal Care Settings

While participants valued racial concordance, when possible, many emphasized that cultural competency, clear communication, respect, and genuine listening were more important than race alone.

Emergency and Urgent Care

Participants described long wait times, inconsistent triage processes, and concerns about the quality of care in emergency settings. Several described being misdiagnosed or feeling unsafe due to overcrowded conditions.

Barriers to Mental Health Care

Mental health services were described as highly inaccessible. Participants cited:

- Limited Supply of Culturally Competent Therapists
- Long Waitlists
- Prohibitive Costs

- Stigma
- Lack of Trust
- Difficulty Finding Consistent Care

Many expressed a desire for mental health support but lacked practical access.

SUPPORTING COMMUNITY HEALTH

Housing Quality and Affordability

Housing was one of the most important determinants of health. Participants described:

- Mold
- Pests
- Leaks
- Broken Plumbing
- Failing Heating and Cooling
- Absentee Landlords
- Widespread Code Violations
- Eviction Threats
- Overcrowding

Newark residents described aging infrastructure and decades of neglect. Charlotte residents described skyrocketing rents, displacement, and the loss of long-standing community networks.

Food Access and Nutrition

Participants described major affordability barriers. Newark residents reported heavy reliance on corner stores, limited access to full-service grocery stores, and low-quality produce. Charlotte participants noted that while grocery options existed, rising prices placed healthy food out of reach for many families.

Safety and Violence

Residents in both cities expressed deep concerns about:

- Gun Violence

- Assaults
- Car Break-Ins
- Dangerous Street Activity
- Domestic Conflict
- Lack of Police Presence or Inconsistent Response

These realities limited physical activity, increased trauma, and contributed to chronic emotional distress.

Environmental Health and Neighborhood Infrastructure

Participants described concerns about:

- Air Pollution
- Water Quality
- Industrial Emissions
- Illegal Dumping
- Trash and Debris
- Rodents and Pests
- Noise Pollution
- Poorly Maintained Sidewalks
- Limited Lighting

Environmental burdens were particularly severe in Newark, where residents described multi-generational health impacts from environmental hazards.

Transportation and Mobility

Across groups, participants shared frustration with:

- Unreliable Bus Service
- Long Wait Times
- Inadequate Weekend or Evening Routes
- Traffic Congestion
- Crowded Buses

- Expensive Fares
- Long Distances to Essential Services

Transportation challenges impacted access to jobs, childcare, medical care, healthy food, and community support.

Community Resources and Social Support

Participants expressed a desire for more community-based resources, including:

- Recreation Centers
- Youth Programming
- Elder Services
- Community Gatherings
- Accessible Exercise Opportunities
- Job Training
- Culturally Meaningful Programs
- Spaces That Foster Connection

They emphasized that stronger community ties improve mental health, reduce stress, and promote collective resilience.

CLOSING REFLECTIONS

Participants across cities shared powerful reflections about what they need to be healthy and what a healthy community should provide. These reflections include:

- Health must be understood holistically.
- Neighborhood conditions matter.
- Transportation is essential.
- Cultural identity and social connections anchor health.
- Racism and discrimination shape health outcomes.
- Community members are ready to be partners.

QUOTES AND COMMUNITY VOICES

Purpose of this Section

This section elevates community voices to illustrate how residents across ACE Tier cities experience health, stress, and well-being in their daily lives. The quotes presented here deepen the qualitative findings by grounding thematic patterns in lived experience and personal expression.

Community Strengths That Support Well-Being

Respondents described spirituality, prayer, cultural identity, family support, nature, creativity, and community bonds as essential sources of strength that help them navigate overwhelming stress and persistent life challenges. These protective factors emerged consistently across responses and reflect resilience rooted in connection, meaning, and shared responsibility.

Interpreting Community Voices Responsibly

These narratives reflect real experiences shaped by personal, cultural, social, environmental, and structural conditions. Lived experience constitutes valid qualitative data and should be understood within the broader context of systemic inequities, community-level constraints, and long-standing structural barriers that influence health outcomes.

Bridge to Quantitative Findings

The qualitative voices presented here deepen the quantitative survey results by illustrating how cost, access to care, neighborhood conditions, discrimination, and chronic stress manifest in everyday life. Together, the qualitative and quantitative findings offer a more complete and textured understanding of health and well-being across ACE Tier cities.

How the Quotes Were Selected

Quotes were selected through a structured review process to ensure clarity, relevance, and alignment with the major themes identified in the qualitative findings. Selection prioritized statements that reflected experiences expressed frequently across responses, conveyed emotional depth, and illustrated how social, cultural, and structural factors shape health and well-being. Unless otherwise specified, quotes reflect themes shared across focus groups and are not limited to a single racial group.

Top 10 Community Quotes

(Illustrative of recurring themes across responses)

1. “I’m always tired because I’m always worrying about something—money, my kids, my health.”
2. “It’s not that I don’t want to take care of myself. Life just doesn’t give me room to breathe.”
3. “I go to the doctor, and they rush me. They don’t listen.”
4. “I work two jobs to stay afloat.”
5. “My neighborhood feels unsafe.”
6. “Food is just too expensive.”
7. “My faith keeps me standing.”
8. “Caregiving is a blessing, but it’s heavy.”
9. “Stress makes my health worse.”
10. “I’m still trying. I’m not giving up.”

Representative Quotes

(Selected for narrative depth and resonance)

- “Sometimes I feel like I’m carrying the whole world on my back.”
- “When I go to the doctor, they treat me like I don’t know my own body.”
- “The stress never stops. I take care of everybody, and it shows up in my health.”
- “My neighborhood wears on me.”
- “My faith is how I keep going.”
- “I work so much just to stay afloat.”
- “I’m tired in my spirit.”
- “I want to be healthy, but everything costs too much.”

Top 10 Quotes Based on Frequency of Concepts

(Derived from repeated thematic patterns across responses)

1. "Stress affects everything—my sleep, my mood, my body."
2. "Everything is so expensive that it's hard to stay healthy."
3. "I can't get an appointment when I need one."
4. "My job drains me, and I'm exhausted all the time."
5. "Caregiving takes all my energy."
6. "My neighborhood doesn't feel safe to be outside."
7. "I avoid the doctor because I can't afford the bills."
8. "My chronic conditions flare when life gets stressful."
9. "It's hard to eat healthy when healthy food costs more."
10. "My faith and family keep me grounded when everything feels heavy."

Additional Quote Collections

See Appendix D for additional quotes collected.

Quotes by Race

Although the HART study included focus groups composed exclusively of Black residents, the qualitative findings were analyzed and presented across both Black-only and mixed-race groups unless otherwise specified. As a result, only sections that explicitly reference Black participants or are labeled as "Black Respondents" should be interpreted as race specific. Subsequent thematic discussions reflect shared experiences articulated across focus groups and are not limited to Black respondents alone.

Black Respondents

- "My doctor doesn't hear me."
- "I'm stressed from every direction."
- "My faith carries me."
- "The neighborhood affects my health."
- White Respondents
- "I'm overwhelmed by work and mental health issues."

- "I feel isolated."
- "Insurance is impossible to navigate."
- "The stress builds up and affects my body."

Hispanic/Latino Respondents

- "I work long hours and still can't afford care."
- "Language barriers make it hard to get help."
- "My family depends on me."
- "Costs keep me from going to the doctor."

Asian Respondents

- "I feel pressure to succeed, and it impacts my mental health."
- "There's stigma around getting help."
- "I need providers who understand my background."
- "I struggle quietly."

Multiracial Respondents

- "I feel pulled in different directions."
- "People make assumptions about me."
- "I experience stress from identity issues."
- "It's hard to find providers who understand my culture."

Voices of Black Respondents: Insights from Black-Only Focus Groups

To ensure that Black lived experience was examined with depth and cultural specificity, the HART study intentionally included focus groups composed exclusively of Black residents in both Newark, NJ, and Charlotte, NC. This section draws specifically from those Black-only focus groups, allowing participants to speak openly about how health, stress, and well-being are shaped by race, history, and daily realities in predominantly urban Black communities.

Across these discussions, Black respondents described health as a cumulative experience—one shaped by economic pressure, caregiving responsibilities, neighborhood conditions, healthcare encounters, and the persistent emotional toll of racism. Their reflections revealed not isolated challenges, but patterned experiences rooted in long-standing structural inequities, intergenerational responsibility, and cultural resilience. Participants frequently emphasized that these pressures compound over time, influencing both physical health and emotional well-being.

Why This Section Matters

- The Black-only focus groups surfaced experiences that were distinctive in their depth and consistency, particularly in the following areas:
- Feeling dismissed, unheard, or not taken seriously in healthcare settings
- Carrying high levels of chronic stress linked to work demands, caregiving, and financial strain
- Living in neighborhoods where safety concerns and environmental conditions limit daily activity
- Drawing strength from spirituality, faith, and cultural identity as essential sources of grounding and endurance

By centering voices from the Black-only focus groups, this section highlights how race-specific social conditions and historical context shape health experiences in ways that are not fully captured in mixed-race discussions. These insights deepen understanding of the structural and cultural factors influencing health among Black residents and underscore the importance of race-conscious approaches to health equity and community wellness.

FINAL THOUGHTS

Taken together, these themes reveal the realities shaping health across the ACE cities. People are navigating emotional, financial, cultural, environmental, and structural pressures every day, yet they draw strength from faith, culture, family, and community. These narratives remind us that health is influenced by the conditions in which people live, work, care for one another, worship, struggle, hope, and heal. The qualitative findings honor that truth and offer a fuller, more human understanding of what supports well-being and what gets in the way for the communities we serve.

9. CONCLUSION

The ACE Your Health Community Wellness Survey demonstrates the power of community-driven data collection in uncovering local realities that traditional datasets often miss. The findings reveal communities with strong social and physical infrastructure, like grocery stores, green spaces, and accessible healthcare. However, it also underscores how economic inequality and systemic barriers continue to shape daily life.

Across income, race, and geography, clear gradients emerged: respondents with higher incomes and education reported better access to healthcare, reliable transportation, and safe neighborhoods, while lower-income respondents were more likely to face financial strain, chronic illness, and limited digital access. These disparities emphasize the need for sustained investment in affordable housing, community health infrastructure, and culturally responsive care.

By combining grassroots reach with rigorous analysis, this survey provides actionable insights for local leaders, policymakers, and advocates committed to advancing health equity. The NAACP Center for Health Equity and its partners plan to use these findings to inform targeted interventions, advocate for equitable resource allocation, and continue empowering communities to define and shape their own health futures.

IMPLICATIONS FOR ACTION

The findings in this report point to a truth that communities across the country have been naming for decades: health is shaped long before a person steps into a clinic. Families are carrying layers of financial strain, environmental burdens, unstable housing, unreliable transportation, and chronic stress that show up in their bodies, spirits, and emotional well-being. These patterns are not individual failures. Instead, they reflect systems that were never designed with the lived realities, cultural identities, or daily pressures of Black, Brown, working-class, immigrant, and historically marginalized communities in mind.

Additionally, the stories and the data make one thing clear: these conditions are structural, and structural conditions can be changed. People voiced both exhaustion and resilience. Faith, culture, family, and community remain steady sources of strength in circumstances that no household should have to navigate alone. Their voices call for action that honors dignity, justice, and the wisdom already present in the community.

Meaning for Policymakers

For policymakers, the implications are direct. Health outcomes improve when the systems around people improve. That means:

- Policies that treat affordability as central to health
- Regulations that build prevention, continuity of care, and cultural responsiveness into everyday practice
- Coordination across health, housing, environment, transportation, education, and workforce systems
- Resource allocation that strengthens community-led strategies rooted in culture, experience, and local knowledge

Policy must reflect the full humanity of the communities it serves. Anything less will reproduce the very inequities this report names.

Opportunities for Targeted Investment

The data point to several areas where targeted investment would strengthen community well-being in real and measurable ways:

- Safe, stable, and healthy housing
- Affordable, culturally attuned mental health care
- Clean air, safe water, and environmental protections
- Transportation systems that connect residents to essential resources
- A diverse, culturally grounded healthcare workforce able to build trust

These investments are practical tools for building healthier families and stronger neighborhoods. They are also a moral commitment to the well-being of communities that have carried far too much for far too long.

A Call to Moral Leadership

This moment calls for leadership that pairs compassion with strategy and urgency with accountability. Health is shaped at kitchen tables, on public buses, in aging apartment buildings, and in neighborhoods burdened by pollution and chronic stress. Responding to those realities requires courage, investment, and a willingness to repair long-standing structural harms.

Communities deserve systems built with their full humanity and well-being at the center.

RECOMMENDATIONS AND NEXT STEPS

The findings point to several strategic opportunities for funders, policymakers, city and community leaders, healthcare systems, and cross-sector partners to strengthen health equity efforts through coordinated, data-informed approaches.

1. Integrating Quantitative and Qualitative Evidence

Quantitative data document the scale and distribution of health challenges, while qualitative narratives illuminate how those conditions are experienced in daily life. Mixed-methods approaches strengthen interpretation and decision-making by integrating statistical patterns with lived experience, particularly in complex community health initiatives (Centers for Disease Control and Prevention [CDC], 2024a; Fetters et al., 2013). Together, these data sources offer a robust foundation for informing investment decisions, program design, and evaluation frameworks.

2. Strategic Use of Geospatial Mapping and the Implementation Toolkit

Geospatial mapping makes visible the clustering of social, environmental, and health burdens across neighborhoods, supporting identification of areas experiencing cumulative disadvantage. When paired with implementation tools, spatial analysis enhances place-based planning, cross-sector coordination, and culturally responsive intervention design (Esri & NACCHO, n.d.; World Health Organization [WHO], n.d.). These tools support strategic targeting and alignment of resources across systems and partners.

3. Strengthening Culturally Grounded Healthcare and Mental Health Supports

Evidence consistently demonstrates that culturally responsive care improves engagement, trust, and outcomes for historically marginalized populations. Community-based and integrated behavioral health models that affirm culture, identity, and spirituality are associated with improved access and quality of care (American Psychological Association [APA], 2017; Substance Abuse and Mental Health Services Administration, 2016). Investment in culturally grounded approaches represents an important lever for improving care experiences and outcomes.

4. Addressing Financial Barriers That Undermine Health

Financial strain is a well-documented driver of delayed care, medication nonadherence, and worsening health outcomes. High out-of-pocket costs and affordability barriers increase stress and undermine both physical and emotional well-being (Dusetzina et al., 2023; Sommers et al., 2017). Reducing financial barriers aligns with broader health equity goals and supports more consistent access to care and preventive services.

5. Advancing Housing Quality, Environmental Safety, and Neighborhood Infrastructure

Housing conditions and environmental exposures are foundational determinants of population health. Poor housing quality, pollution, and unsafe neighborhood conditions are linked to chronic illness, respiratory disease, and psychological distress (Krieger & Higgins, 2002; WHO, 2018). Investments in housing quality, environmental remediation, and neighborhood infrastructure contribute to long-term improvements in health and well-being.

6. Recognizing Transportation as a Health Access Factor

Transportation access influences the ability to obtain healthcare, healthy food, employment, and social support. Transportation barriers have been shown to delay care and exacerbate inequities, particularly in low-income and urban communities (CDC, 2024c; Wolfe et al., 2020). Addressing transportation access supports continuity of care and broader health system effectiveness.

7. Centering Community Leadership and Partnership

Community engagement is most effective when it extends beyond consultation to shared leadership. Community-based participatory approaches strengthen relevance, trust, and sustainability by centering lived experience throughout planning, implementation, and evaluation (Agency for Healthcare Research and Quality, n.d.; Israel al., 2013). Community leadership enhances alignment between initiatives, local priorities, and long-term sustainability.

8. Supporting Tailored Citywide Action Planning

Health equity strategies are most effective when grounded in the local context rather than applied uniformly. Differences in cost of living, infrastructure, environmental burden, and social networks require approaches that reflect city-specific realities (CDC, 2024b; WHO, 2014). Locally tailored action planning supports responsiveness, efficiency, and relevance across diverse settings.

9. Emphasizing Accountability and Continuous Learning

Ongoing evaluation and transparent reporting are essential for sustaining impact and supporting learning over time. Public metrics, continuous feedback, and regular use of evaluation findings strengthen accountability and adaptive implementation (CDC, 2024a; Kidder et al., 2024). Continuous learning frameworks support refinement, scalability, and long-term return on investment.

COMMUNITY VOICES FROM FIELD CANVASSING

During canvassing, residents across multiple cities shared immediate concerns, hopes, and lived experiences related to health, neighborhood resources, and community well-being. We leave you with their voices reflect on-the-ground realities that reinforce the broader survey findings and highlight their imperatives and impressions for change. Pseudonyms were used to protect the identity of respondents.

Alana, school teacher: "Healthcare improvements are surely needed. I'm a school teacher and see the impact on the students."

Belinda, Mail Carrier: "Our city needs more parks and definitely healthier food options. You can only find those stores in the nicer neighborhoods, and that's unfair."

Alexis, Medical Professional: "Hospitals should be the number one priority in our communities, both urban and rural."

Jeff, School Bus Driver: "There's been a lot of pharmacy closures lately. Something needs to be done, so I'm very happy to see you asking the right questions and helping the community."

Jesse, Salon Owner: "We all need to do it if we want to see a change."

Derrick, Community Leader: "We need more stores that sell healthy food. That'll help keep us out the hospitals."

Sandra, Retired Nurse: "There needs to be improvement in the transportation for seniors to hospitals. We also need to have a choice of quality hospitals to choose from."

Marie, Assistant Living Case Manager: "We have less than they have in the other places. The food quality is terrible—even to the point that our stores have expired goods and rotting meat. We don't even have access to the same hospitals and emergency services. All the urgent care locations are in the non-Black neighborhoods."

AJ, Janitor: “Transportation is my biggest issue. It took me an hour to get to the hospital today.”

Dwyane, Public Safety Major, Northwestern State University: “I study similar matters because I want so much more for all of our communities. Glad to see this work being done.”

Mr. Dwight, Radio Station Representative: “I would love to work with the NAACP to help with some of their initiatives. You all are doing great work.”

APPENDICES

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APPENDICES

APPENDIX A. DATA COLLECTION AND PROCESSING DETAILS

This appendix outlines key definitions, coding decisions, and analytic business rules applied throughout the report. These parameters ensure consistency across sections and transparency in interpretation.

General Data Processing Rules

- **Survey Respondents**: Includes all respondents who provided a valid response to a given survey item.
- **City and Tier Assignment**: Respondents were assigned to a Tier (1, 2, or 3) based on their reported zip code or city location.
- **Missing Data**: Missing data were defined as cases in which the respondent did not select any of the pre-specified response options. Response choices such as “Other,” “Self-describe,” and “Prefer not to answer” were treated as valid and retained in calculations. Denominators (i.e., the total number of respondents who provided a valid response to a survey item), therefore, varied across items, as respondents with missing data were excluded from that item’s analysis.

Percentages

- **Overall Percentages**: calculated by dividing the total number of respondents who selected a given response choice by the total number of respondents who provided a valid response.
- **Subgroup Percentages**: calculated by dividing the total number of respondents in a given subgroup that selected a given response choice by the total number of respondents of that subgroup who provided a valid response. Only respondents who provided a valid response to both the given survey item and subgroup are included in these analyses.
- **Multi-Select/ (”Select all that apply”)**: calculated by dividing the total number of respondents that selected the given response choice by the total number of respondents that provided a valid response.
    - Race and Ethnicity: Respondents who selected more than one racial or ethnic identity were categorized as “Multiracial and/or Multiethnic.”
    - Gender: Responses were consolidated across the gender variables. Self-described entries were reviewed and recoded when clearly aligning with one of the gender categories (e.g., the respondent selected “prefer to self-describe” and then typed or wrote in “Trans”). Final categories included:

- Man
- Woman
- Cisgender (not specified): when Cisgender was the only option selected
- Transgender (any mention of “Transgender”, supersedes any other selected option)
- Non-binary/gender non-conforming (any mention of “Non-binary”, supersedes any other selected option)
- Prefer not to answer: when “Prefer not to answer” was selected

- Sexual Orientation: Responses were classified using a predefined set of logical coding rules to maintain consistent categories for analysis. Final categories included:
  - Heterosexual or straight
  - Lesbian
  - Gay
  - Bisexual
  - Prefer to self-describe (applied if respondents selected multiple standard categories or provided a self-description)
  - Prefer not to answer

- **Rounding**: Percentages were rounded to the nearest whole number. Total percentages may exceed 100% due to rounding. For multi-select items, percentages should not be summed or assumed to equal 100%, as respondents could choose more than one option. When a percentage was less than one percent, it was reported as “<1%.”
- **Weighting**: No weighting adjustments were applied because the survey used a nonprobability sampling design. Results describe the sample of respondents and are not generalized to the population.

Interpretation Note

These business rules ensured consistent handling of survey responses across sections. Results should be interpreted as descriptive summaries of the respondents’ experiences and perspectives, not as population-level estimates.

The two tables that follow provide details about the survey types and their questions.

COMPARISON OF ITEMS INCLUDED IN THE FULL ONLINE/PAPER, CANVASSER, AND LEAVE-BEHIND SURVEYS		
Survey Item (as it appeared on the main online and paper surveys)	Did the item appear on the Canvasser survey?	Did the item appear on the Leave-Behind survey?
What city or town do you live in?	Similar question: "What is your current address?"	Yes
What is your zip code?	Similar question: "What is your current address?"	No
Is there a grocery store in your neighborhood where you can buy healthy, affordable food?	Yes	Yes
Are there green spaces like parks, walking trails, or grassy areas in your neighborhood?	Yes	Yes
Which of the following best describes your current housing situation?	No	Yes
Do you live with one or more chronic health conditions? (e.g., arthritis, asthma, diabetes, etc.)	No	Yes
Is there a quality hospital in your neighborhood?	Yes	Yes
Have you had issues getting a healthcare appointment or prescription medication in the past year?	No	Yes
If yes, what were the main reasons? (Select all that apply)	No	Yes
Is there a pharmacy or drugstore in your neighborhood where you can get prescription medications?	Yes	Yes
Do you believe healthcare providers in your neighborhood understand the cultural needs of your community?	Yes	Yes
What affects your health and well-being the most, whether in a positive or negative way? Please explain.	No	Yes
Do you have access to affordable and reliable transportation?	Yes	Yes
Do you feel safe in your neighborhood?	No	Yes

COMPARISON OF ITEMS INCLUDED IN THE FULL ONLINE/PAPER, CANVASSER, AND LEAVE-BEHIND SURVEYS		
How would you describe the air and water quality in your neighborhood? (Select all that apply)	No	Yes
How do you connect to the internet where you live? (Select all that apply)	Yes	Yes
What is your age?	Yes	Yes
How would you describe your sexual orientation? (Select all that apply)	No	Yes
How would you describe your gender? (Select all that apply)	Yes	Yes
How would you describe your race/ethnicity? (Select all that apply)	Yes	Yes
What is your total household income?	No	Yes
What is the highest level of education you have completed?	No	Yes
Do you have difficulty with the following activities due to a physical, mental, or sensory condition? (Select all that apply)	No	Yes
First Name	No	Yes
Last Name	No	Yes
Email Address	No	Yes
Phone Number	No	No

APPENDIX B. FOCUS GROUP PARTICIPANT CHARACTERISTICS

Appendix A presents the demographic characteristics of participants in the HART focus groups conducted in Newark, NJ, and Charlotte, NC. A total of 35 adults participated across four in-person focus groups, with 17 participants in Newark and 18 participants in Charlotte. Newark focus groups were held on June 26, 2025, and Charlotte focus groups were held on August 14, 2025.

In each city, two focus groups were conducted. One group consisted of a demographically representative cross-section of city residents, reflecting variation in race, gender, age, and geographic location. The second group in each city consisted of a representative cross-section of Black residents, allowing for focused discussion of experiences shaped by race and place.

Eligibility criteria required participants to be 18 years of age or older and to reside in the focal city. Recruitment was conducted by third-party qualitative research vendors using proprietary participant panels. Participants received a monetary incentive and a meal in recognition of their time and contributions.

Across both cities, participants reflected a wide range of ages, racial and ethnic identities, genders, and neighborhood contexts, providing diverse perspectives on health, well-being, and the social determinants shaping everyday life. Demographic diversity was intentionally incorporated to ensure that findings reflected both shared and distinct experiences across communities.

APPENDIX C. FOCUS GROUP DISCUSSION GUIDE

This appendix includes the full focus group discussion guide used during the HART qualitative sessions. Each focus group session lasted approximately two hours and was designed to elicit in-depth discussion of factors shaping health and well-being at the individual, neighborhood, and community levels.

The discussion guide was organized around four primary domains:

Health and Well-Being, including physical health, mental health, stress, chronic conditions, and perceptions of what it means to be healthy.

Neighborhood and Built Environment, including housing quality and affordability, food access, green spaces, safety, environmental conditions, and transportation.

Healthcare Access and Quality, including access to providers, affordability of care, wait times, insurance coverage, provider interactions, cultural competency, and experiences of being listened to or dismissed.

Social and Community Context, including community relationships, social cohesion, neighborhood stability, discrimination, government responsibility, and perceived community strengths.

Participants discussed both structural determinants (such as housing conditions, environmental hazards, transportation systems, and healthcare access) and cultural and social determinants (such as neighbors, community norms, and personal responsibility).

Interactive exercises were incorporated throughout the sessions to prompt reflection and to encourage participants to think beyond participants' immediate personal experiences. These exercises supported discussion of neighborhood comparisons, perceived health impacts of place, and the relative importance of different social determinants of health.

Together, the discussion guide and facilitation approach were designed to surface shared themes, points of divergence, and contextual nuance, contributing to a robust qualitative understanding of how residents in ACE Tier cities conceptualize health and well-being.

APPENDIX D. ADDITIONAL QUOTE COLLECTION (TOP 20 QUOTES AND QUOTE WALL)

Purpose of This Appendix

The quotes presented in this appendix preserve the authentic voices of community members whose lived experiences informed the findings and recommendations in this report. While the main body of the report synthesizes patterns and themes across responses, these narratives provide additional depth and emotional context. Together, they illuminate how health and well-being are experienced in daily life—not as abstract concepts, but as realities shaped by stress, resources, environments, and systems.

How to Read These Quotes

The quotes included here were selected to illustrate recurring experiences and shared conditions expressed by respondents. They are not intended to represent individual prevalence, rank order, or city-specific frequency. Instead, they reflect patterns that appeared consistently across responses. Quotes were edited only for clarity and brevity, without altering meaning, to ensure that community voices remain intact and accessible.

What These Voices Reveal

Taken together, these narratives portray health as cumulative and interconnected. Respondents describe stress as something carried in the body and across time—shaped by financial strain, caregiving responsibilities, neighborhood conditions, and healthcare experiences. Many speak to the exhaustion of navigating systems that feel inaccessible, unaffordable, or dismissive, and to the emotional weight of environments that do not support rest, safety, or healing.

At the same time, these voices reflect perseverance and meaning-making. Faith, prayer, time in nature, and personal resolve emerge as sources of steadiness amid ongoing strain. These coping strategies do not eliminate structural challenges, but they help individuals endure them. Together, the quotes underscore both the burden placed on individuals and the strength they continue to draw upon in response.

Top 20 Community Quotes, Organized by Domain

Stress and Emotional Load

- "I feel overwhelmed most days."
- "My body never gets a chance to relax."
- "I'm mentally drained and physically tired."
- "The stress never lets up."

Financial Strain

- "I'm choosing between bills and medicine."
- "Healthy food is too expensive."
- "I work nonstop just to break even."
- "I avoid appointments because of cost."

Healthcare Access and Quality

- "I can't get an appointment for months."
- "I leave the doctor's office with more questions than answers."
- "They don't listen when I explain my symptoms."
- "Going to the ER feels like my only option."

Neighborhood and Environment

- “I don’t feel safe walking outside.”
- “There’s mold and pests in my building.”
- “The noise and chaos affect my sleep.”
- “We don’t have safe places to exercise.”

Spirituality and Coping

- “My faith keeps me steady.”
- “I pray to get through the hard days.”
- “Nature is where I breathe again.”
- “I keep trying even when life is difficult.”

Community Quote Wall

- “I’m tired, but I keep going.”
- “I want to be healthy, but everything is too expensive.”
- “My faith steadies me.”
- “I feel unseen in the doctor’s office.”
- “Stress sits on my shoulders.”
- “I do everything for everyone.”
- “My neighborhood affects my health.”
- “I’m doing the best I can.”
- “The cost of living is crushing.”
- “I’m trying to hold it all together.”
- “I need support, not judgment.”
- “Caregiving wears me down.”
- “Life keeps coming at me.”
- “I push through pain because I have to.”
- “I just want to feel better.”

APPENDIX E. REFERENCES FOR QUALITATIVE SECTION

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