

Appendix B. 2019 Community Health Needs Survey

2019 Health Survey

Our local not-for-profit hospitals and the department of health want to hear from you! The results of this survey will be used to help us to understand your community health concerns so that improvements can be made. We encourage you to take 15 minutes to fill out the survey below. Your voice is important to ensure these organizations have the best understanding of the needs of our community. Thank you!

You must be 18 years of age or older to complete this survey. COMPLETE THIS SURVEY ONLY FOR YOURSELF. If someone else would like to complete the survey, please have that person complete a separate survey. Remember, your answers are completely anonymous. We will not ask for your name or any other information which can be used to identify you. If you have any questions, please contact Lisa Bell at 727-519-1282 or lisa.bell@baycare.org.

These first few questions tell us about you. They will be used only to help us better understand the people who live in your community so that we can provide better health care services. This information will not be used to identify you.

1. In which county do you live? (Please choose only one)

- Hillsborough Pasco Pinellas Polk Sarasota
 Other

2. In which ZIP code do you live? (Please write in)

3. What is your age? (Please choose only one)

- 18 to 24 25 to 34 35 to 44 45 to 54 55 to 64 65 to 74 75 or older

4. Are you of Hispanic or Latino origin or descent? (Please choose only one)

- Yes, Hispanic or Latino No, not Hispanic or Latino Prefer not to answer

5. Which race best describes you? (Please choose only one)

- American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Pacific Islander White More than one race
 Other Prefer Not to Answer

6. Do you identify your gender as:

- Male Female Transgender (if so: Male to Female or Female to Male)
 Other /Gender non-Conforming

7. Which of the following best describes your sexual orientation? (Please choose only one)

- Heterosexual (Straight) Gay or Lesbian Bisexual Other

8. What language do you MAINLY speak at home? (Please choose only one)

- Arabic Chinese English French German
 Haitian Creole Russian Spanish Vietnamese Other

9. How well do you speak English? (Please choose only one)

- Very well Well Not Well Not at all

10. What is the highest level of school that you have completed? (Please choose only one)

- Less than high school Some high school, but no diploma High school diploma (GED)
 Some college, no degree 2 – Year College Degree 4 – Year College Degree
 Graduate -Level Degree or Higher None of the above

11. How much total combined money did all people living in your home earn last year? (Please choose only one)

- | | | |
|---|---|---|
| <input type="checkbox"/> \$0 to \$9,999 | <input type="checkbox"/> \$10,000 to \$24,999 | <input type="checkbox"/> \$25,000 to \$49,999 |
| <input type="checkbox"/> \$50,000 to \$74,999 | <input type="checkbox"/> \$75,000 to \$99,999 | <input type="checkbox"/> \$100,000 to \$124,999 |
| <input type="checkbox"/> \$125,000 to \$149,999 | <input type="checkbox"/> \$150,000 to \$174,999 | <input type="checkbox"/> \$175,000 to \$199,999 |
| <input type="checkbox"/> \$200,000 and up | <input type="checkbox"/> Prefer not to answer | |

12. Which of the following categories best describes your employment status? (Please choose only one)

- | | |
|---|---|
| <input type="checkbox"/> Employed, working full-time | <input type="checkbox"/> Student |
| <input type="checkbox"/> Employed, working part-time | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Not employed, looking for work | <input type="checkbox"/> Disabled, not able to work |
| <input type="checkbox"/> Not employed, NOT looking for work | |

13. What transportation do you use most often to go places? (Please choose only one)

- | | |
|---|--|
| <input type="checkbox"/> I drive my own car | <input type="checkbox"/> Someone drives me |
| <input type="checkbox"/> I take the bus | <input type="checkbox"/> I walk |
| <input type="checkbox"/> I ride a bicycle | <input type="checkbox"/> I take a taxi cab |
| <input type="checkbox"/> I ride a motorcycle or scooter | <input type="checkbox"/> I take an Uber/Lyft |
| <input type="checkbox"/> Some other way | |

14. Are you

- A Veteran In Active Duty National Guard/Reserves Neither (Skip to question 16)

15. If Veteran, Active Duty, National Guard, or Reserves, are you receiving care at the VA?

- Yes No

16. How do you pay for most of your health care? (Please choose only one)

- | | |
|--|---|
| <input type="checkbox"/> I pay cash / I don't have insurance | <input type="checkbox"/> TRICARE |
| <input type="checkbox"/> Medicare or Medicare HMO | <input type="checkbox"/> Indian Health Services |
| <input type="checkbox"/> Medicaid or Medicaid HMO | <input type="checkbox"/> Commercial health insurance (HMO, PPO) |
| <input type="checkbox"/> Veteran's Administration | <input type="checkbox"/> Some other way |

17. Including yourself, how many people currently live in your home? (Please choose only one)

- 1 2 3 4 5 6 or more

18. Are you a caregiver to an adult family member who cannot care for themselves in your home? (Please choose only one)

- Yes No

19. Including yourself, how many people 65 years or older currently live in your home? (Please choose only one)

- None 1 2 3 4 5 6 or more

20. How many CHILDREN (under age 18) currently live in your home? (Please choose only one)

- None (Skip to question 32) 1 2 3 4 5 6 or more

- Begin Children's Section -

21. Was there a time in the PAST 12 MONTHS when children in your home needed medical care but did NOT get the care you needed?
 Yes No (skip to question 23)
22. What is the MAIN reason they didn't get the medical care they needed? (Please choose only one)
 Can't afford it / Costs too much I had transportation problems
 I don't have a doctor I don't know where to go
 I had trouble getting an appointment I don't have health insurance
 Other
23. Was there a time in the PAST 12 MONTHS when children in your home needed DENTAL care but did NOT get the care you needed?
 Yes No (skip to question 25)
24. What is the MAIN reason they didn't get the dental care they needed? (Please choose only one)
 Can't afford it / Costs too much I had transportation problems
 I don't have a dentist I don't know where to go
 I had trouble getting an appointment I don't have dental insurance
 Other
25. Was there a time in the PAST 12 MONTHS when children in your home needed mental health care but did NOT get the care you needed?
 Yes No (skip to question 27)
26. What is the MAIN reason they didn't get the mental health care they needed? (Please choose only one)
 Can't afford it / Costs too much I had transportation problems
 I don't have a doctor / counselor I don't know where to go
 I had trouble getting an appointment I don't have health insurance
 Other
27. I feel safe walking in my neighborhood.
 Yes (skip to question 29) No
28. If you answered "no", check all reasons you do not feel safe walking:
 Traffic No sidewalks
 Poor condition of roads or sidewalks Dogs not on a leash
 Stopped by police Violent Crime or theft
29. Check all the health issues children in your home have faced (CHECK ALL THAT APPLY)
- | | |
|---|--------------------------|
| My children have not faced any health issues | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> |
| Bullying | <input type="checkbox"/> |
| Unintentional injuries or accidents that required immediate medical care (such as a concussion from playing sports) | <input type="checkbox"/> |
| Behavioral Health / Mental health | <input type="checkbox"/> |
| Children overweight | <input type="checkbox"/> |
| Children underweight | <input type="checkbox"/> |

Birth-related (such as low birthweight, prematurity, prenatal, and others)	<input type="checkbox"/>
Dental Problems (such as cavities, root canals, extractions, surgery, and others)	<input type="checkbox"/>
Autism	<input type="checkbox"/>
Child abuse / child neglect	<input type="checkbox"/>
Diabetes / Pre-diabetes / High Blood Sugar	<input type="checkbox"/>
Using drugs or alcohol	<input type="checkbox"/>
Using tobacco, e-cigarettes, or vaping	<input type="checkbox"/>
Teen pregnancy	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

30. Check all the special needs children in your home have faced (CHECK ALL THAT APPLY)

My children do not have any special needs	<input type="checkbox"/>
Attention deficit / hyperactivity disorder (AD/HD)	<input type="checkbox"/>
Autism / pervasive development disorder (PDD)	<input type="checkbox"/>
Blindness / visual impairment	<input type="checkbox"/>
Cerebral palsy	<input type="checkbox"/>
Child who uses a wheelchair or walker	<input type="checkbox"/>
Deaf / hearing loss	<input type="checkbox"/>
Developmental delay (DD)	<input type="checkbox"/>
Down syndrome	<input type="checkbox"/>
Emotional disturbance	<input type="checkbox"/>
Epilepsy / Seizure disorder	<input type="checkbox"/>
Intellectual disability (formerly mental retardation)	<input type="checkbox"/>
Learning disabilities / differences	<input type="checkbox"/>
Speech and language impairments	<input type="checkbox"/>
Spina bifida	<input type="checkbox"/>
Traumatic brain injury	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

31. Do any children in your home... (CHECK ALL THAT APPLY)

	Yes	No	Not Sure
Know how to swim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear a bike/skate helmet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use a car/booster seat (under age 8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear a seatbelt at all times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have access to a pool where you live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive all shots to prevent disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have a history of being bullied (including social media)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receive gun safety education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Sunscreen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat at Least 3 Servings of Fruits and Vegetables Every Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise at Least 60 Minutes Every Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get 8 Hours or More of Sleep Every Night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat Fast Food Every Week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink Sugary-Sweetened Sodas, Energy Drinks, or Sports Drinks Every Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat Junk Food Every Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stay Home from School 5 or More Days a Year Because of Health Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need Regular Access to a School Nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attend a Public or Charter School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

--End Children's Section --

These next questions are about your view or opinion of the community in which you live.

32. Overall how would you rate the health of the community in which you live? (Please choose only one)
 Very unhealthy Unhealthy Somewhat healthy Healthy Very healthy Not sure

33. – 32. Please read the list of risky behaviors listed below. Which three do you believe are the most harmful to the overall health of your community?

Mark which you think are:

1 Most harmful; 2 Second-most harmful; 3 Third-most harmful

Please mark **only three**, using 1, 2 and 3

	Your Top 3	Example
Alcohol abuse		
Dropping out of school		
Drug abuse		1
Lack of exercise		
Poor eating habits		
Not getting "shots" to prevent disease		
Not wearing helmets		
Not using seat belts/not using child safety seats		3
Tobacco use / E-cigarettes / Vaping		2
Unsafe sex including not using birth control		
Distracted driving (texting, eating, talking on the phone)		
Not locking up guns		
Not seeing a doctor while you are pregnant		

33 – 35. Read the list of health problems and think about your community. Which of these do you believe are most important to address to improve the health of your community?

Mark which you think are:

1 Most important; 2 Second-most important; 3 Third-most important

Please mark **only three**, using 1, 2 and 3

	Your Top 3	Example
Aging Problems (for example: difficulty getting around, dementia, arthritis)		
Cancers		
Child Abuse / Neglect		1
Clean Environment / Air and Water Quality		
Dental Problems		
Diabetes / High Blood Sugar		
Domestic Violence / Rape / Sexual Assault		
Gun-Related Injuries		3
Being Overweight		2
Mental Health Problems Including Suicide		
Heart Disease / Stroke / High Blood Pressure		
HIV/AIDS / Sexually Transmitted Diseases (STDs)		
Homicide		
Infectious Diseases Like Hepatitis and TB		
Motor Vehicle Crash Injuries		
Infant Death		
Respiratory / Lung Disease		
Teenage Pregnancy		
Tobacco Use / E-cigarettes / Vaping		

36. – 38. Please read the list of factors below. Which do you believe are most important to improve the quality of life in a community?

Mark which you think are:

1 Most important;

2 Second-most important;

3 Third-most important

Please mark **only three**, using 1, 2 and 3

	Your Top 3	Example
Good Place to Raise Children		
Low Crime / Safe Neighborhoods		
Good Schools		1
Access to Health Care		
Parks and Recreation		
Clean Environment / Air and Water Quality		
Low-Cost Housing		
Arts and Cultural Events		3
Low-Cost Health Insurance		2
Tolerance / Embracing Diversity		
Good Jobs and Healthy Economy		
Strong Family Life		
Access to Low-Cost, Healthy Food		
Healthy Behaviors and Lifestyles		
Sidewalks / Walking Safety		
Public Transportation		
Low Rates of Adult Death and Disease		
Low Rates of Infant Death		
Religious or Spiritual Values		
Disaster Preparedness		
Emergency Medical Services		
Access to Good Health Information		

39. Below are some statements about your local community. Please tell us how much you agree or disagree with each statement.

	Yes	No	Not Sure
Drug abuse is a problem in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have no problem getting the health care services I need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We have great parks and recreational facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public transportation is easy to get to if I need it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are plenty of jobs available for those who want them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crime in my area is a serious problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air pollution is a problem in my community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe in my own neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are affordable places to live in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The quality of health care is good in my neighborhood.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are good sidewalks for walking safely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to get healthy food easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Below are some statements about your connections with the people in your life. Please tell us how much you agree or disagree with each statement.

	Yes	No	Not Sure
I am happy with my friendships and relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have enough people I can ask for help at any time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My relationships are as satisfying as I would want them to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. Over the past 12 months, how often have you had thoughts that you would be better off dead or of hurting yourself in some way?

- Not at All Several Days More than half the days Nearly Every Day None of the time.

If you would like help with or would like to talk about these issues, please call the National Suicide Prevention Hotline at 1-800-273-8255.

42. In the past 12 months, I worried about whether our food would run out before we got money to buy more. (Please choose only one)

- Often true Sometimes true Never true

43. In the past 12 months, the food that we bought just did not last, and we did not have money to get more. (Please choose only one)

- Often true Sometimes true Never true

44. In the last 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen? (Please choose only one)
 Yes No
45. Now think about the past 7 days. In the past 7 days, how many times did you eat fast food? Include fast food meals eaten at work, at home, or at fast-food restaurants, carryout or drive-through. (Please choose only one)
 ___ # of times in past 7 days Don't know
46. Has there been any time in the past 2 years when you were living on the street, in a car, or in a temporary shelter? (Please choose only one)
 Yes No
47. Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household? (Please choose only one)
 Yes No
48. In the past 12 months has your utility company shut off your service for not paying your bills? (Please choose only one)
 Yes No
49. In the past 12 months, have you used a prescription pain medicine (morphine, codeine, hydrocodone, oxycodone, methadone, or fentanyl) without a doctor's prescription or differently than how a doctor told you to use it? (Please choose only one)
 Yes No

These next questions are about your personal health and your opinions about getting health care in your community.

50. Overall, how would you rate YOUR OWN PERSONAL health? (Please choose only one)
 Very unhealthy Unhealthy Somewhat healthy Healthy Very healthy Not sure
51. Was there a time in the PAST 12 MONTHS when you needed medical care but did NOT get the care you needed? (Please choose only one)
 Yes No (Skip to question 53)
52. What is the MAIN reason you didn't get the medical care you needed? (Please choose only one)
- | | |
|---|--|
| <input type="checkbox"/> Can't afford it / Costs too much | <input type="checkbox"/> I had transportation problems |
| <input type="checkbox"/> I don't have a doctor | <input type="checkbox"/> I don't know where to go |
| <input type="checkbox"/> I had trouble getting an appointment | <input type="checkbox"/> I don't have health insurance |
| <input type="checkbox"/> Other | |
53. Thinking about your MENTAL health, which includes stress, depression, and problems with emotions, how would you rate your overall mental health? (Please choose only one)
 Excellent Very good Good Fair Poor
54. Was there a time in the PAST 12 MONTHS when you needed mental health care but did NOT get the care you needed? (Please choose only one)
 Yes No (Skip to question 56)

55. What is the MAIN reason you didn't get the mental health care you needed? (Please choose only one)

- | | |
|---|--|
| <input type="checkbox"/> Can't afford it / Costs too much | <input type="checkbox"/> I had transportation problems |
| <input type="checkbox"/> I don't have a doctor / counselor | <input type="checkbox"/> I don't know where to go |
| <input type="checkbox"/> I had trouble getting an appointment | <input type="checkbox"/> I don't have health insurance |
| <input type="checkbox"/> Other | |

56. Was there a time in the PAST 12 MONTHS when you needed DENTAL care but did NOT get the care you needed? (Please choose only one)

- Yes No **(Skip to question 58)**

57. What is the MAIN reason you didn't get the dental care you needed? (Please choose only one)

- | | |
|---|--|
| <input type="checkbox"/> Can't afford it / Costs too much | <input type="checkbox"/> I had transportation problems |
| <input type="checkbox"/> I don't have a dentist | <input type="checkbox"/> I don't know where to go |
| <input type="checkbox"/> I had trouble getting an appointment | <input type="checkbox"/> I don't have dental insurance |
| <input type="checkbox"/> Other | |

58. In the past 12 months, how many times have you gone to a hospital emergency room (ER) about your own health?

- Yes, Number of times: _____
- I have not gone to a hospital ER in the past 12 months **(Skip to question 60)**

59. What is the MAIN reason you used the emergency room INSTEAD of going to a doctor's office or clinic? (Please choose only one)

- | | |
|--|---|
| <input type="checkbox"/> After hours / Weekend | <input type="checkbox"/> I don't have a doctor / clinic |
| <input type="checkbox"/> Long wait for an appointment with my regular doctor | <input type="checkbox"/> Cost |
| <input type="checkbox"/> Emergency / Life-threatening situation | <input type="checkbox"/> I don't have insurance |
| <input type="checkbox"/> Other | |

60. Have you ever been told by a doctor or other medical provider that you had any of the following health issues? (CHECK ALL THAT APPLY)

Cancer	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>

Heart disease	<input type="checkbox"/>
High blood pressure / Hypertension	<input type="checkbox"/>
Obesity	<input type="checkbox"/>
Stroke	<input type="checkbox"/>

61. How often do you smoke? (Please choose only one)

- | | |
|---|---|
| <input type="checkbox"/> I do not smoke cigarettes | <input type="checkbox"/> I smoke less than one pack per day |
| <input type="checkbox"/> I smoke about one pack per day | <input type="checkbox"/> I smoke more than one pack per day |

62. How often do you vape or use e-cigarettes? (Please choose only one)

- | | |
|--|--|
| <input type="checkbox"/> I do not vape or smoke e-cigarettes | <input type="checkbox"/> I vape or smoke e-cigarettes on some days |
| <input type="checkbox"/> I vape or smoke e-cigarettes everyday | |

The final questions are about events that happened during your childhood. This information will allow us to better understand how problems that may occur early in life can have a health impact later in life. This is a sensitive topic and some people may feel uncomfortable with these questions. If you prefer not to answer these questions, you may skip them.

For these questions, please think back to the time BEFORE you were 18 years of age.

BEFORE you were 18 years of age:

63. Did you live with anyone who was depressed, mentally ill, or suicidal?

Yes No

64. Did you live with anyone who was a problem drinker or alcoholic?

Yes No

65. Did you live with anyone who used illegal street drugs or who abused prescription medications?

Yes No

66. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?

Yes No

67. Were your parents separated or divorced?

Yes No

BEFORE you were 18 years of age:

68. How often did your parents or adults in your home slap, hit, kick, punch, or beat each other up?

Never Once More than once

69. How often did a parent or adult in your home hit, beat, kick, or physically hurt you in any way?

Never Once More than once

70. How often did a parent or adult in your home swear at you, insult you, or put you down?

Never Once More than once

71. How often did an adult or anyone at least 5 years older than you touch you sexually?

Never Once More than once

72. How often did an adult or anyone at least 5 years older than you try to make you touch them sexually?

Never Once More than once

73. How often did an adult or anyone at least 5 years older than you force you to have sex?

Never Once More than once

If you would like help with or would like to talk about these issues, please call the National Hotline for Child Abuse at 1-800-4-A-CHILD (1-800-422-4453).

That concludes our survey. Thank you for participating! Your feedback is important.