Oroville Hospital Community Health Survey 2019

Thank you for choosing to participate in the 2019 Oroville Hospital Community Health Survey. By completing this survey, we will get a better understanding of the community we serve, and what health concerns are most important to residents like yourself. With this information we will construct and implement an action plan that addresses these concerns, and make Oroville and its surrounding communities a healthier and happier place to call home.

This is an **anonymous** survey and we want to assure you that your responses will be kept **strictly confidential**. If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank. The survey will take about 5-10 minutes to complete.

## SECTION 1: About You and Your Family

Check the boxes that best apply for you, your spouse or partner, and/or your child(ren)

1. About how tall are you (without shoes)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

About how much do you weigh (without shoes)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How would you classify your gender identity?

 Male Female

 Transgender Male (assigned female at birth, identifies as male)

 Transgender Female (assigned male at birth, identifies as female)

If your identity is not listed above, please self-identify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your home zip code? \_\_\_\_\_\_\_\_\_\_\_\_
2. Your age:

 25 or less 26-39 40-54

 55-64 65 or older

1. What is your race?

 White Black/African American American Indian/ Alaska Native

 Hispanic/Latino Hmong Asian (other than Hmong)

 Multiple Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Native Hawaiian/Other Pacific Islander

1. What is your marital status?

 Single/Never married Married Divorced

 Unmarried couple Separated Widowed

 No answer

1. Are you currently employed?

 Not employed Self-employed Employed part-time

 Employed full-time Disabled Retired

1. Do you have a child or children under the age of 18?

 Yes No

If yes, what type of school is your child(ren) enrolled in?

 Public Faith-based Charter

 Homeschool Other: \_\_\_\_\_\_\_\_\_\_\_\_

1. What is your highest level of education?

 Elementary school Middle school High school

 Some college Associate degree Bachelor’s degree

 Graduate school Technical/Trade school Union apprenticeship

 Other: \_\_\_\_\_\_\_\_\_\_\_\_

1. What is your annual household income before taxes?

 Less than $30,000 $30,000-$60,000 $60,001-$90,000

 $90,001-$120,000 Over $120,000 Not sure

 No answer

1. How would you describe the overall health of each member of your family?

**You**:

 Very good Good Fair

 Poor Not sure

**Spouse/Partner:**

 Very good Good Fair

 Poor Not sure

**Child(ren):**

 Very good Good Fair

 Poor Not sure

1. On average, how many days per week do you get at least 30 minutes of exercise or other physical activity?

Examples: walking, running, weight-lifting, team sports or gardening

**You:**

 5-7 days 3-4 days 1-2 days

 Only occasionally Not at all

**Spouse/Partner:**

 5-7 days 3-4 days 1-2 days

 Only occasionally Not at all

**Child(ren):**

 5-7 days 3-4 days 1-2 days

 Only occasionally Not at all

1. What obstacles prevent you from getting regular exercise?

 Not enough time in the day

 I don’t know how to properly exercise

 I don’t know where to go for exercise

 I am not healthy enough to exercise

 It’s hard to stay motivated

 Not sure

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you use, or have you used, any of the following substance?

Check each box that applies:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Every day | Most days | Occasionally | Past use | Never |
| Alcohol |  |  |  |  |  |
| Cigarettes |  |  |  |  |  |
| Electronic cigarettes |  |  |  |  |  |
| Cigars, chew, or snuff |  |  |  |  |  |
| Cocaine |  |  |  |  |  |
| Crystal Methamphetamine (Meth) |  |  |  |  |  |
| Heroin |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Unprescribed prescriptions |  |  |  |  |  |

1. If you are a current or former smoker, are you aware of Oroville Hospital’s smoking cessation program?

 Yes No

 Are you interested in joining the program?

 Yes No

 Maybe Currently or formerly enrolled

## SECTION 2: About Your Health and Health Care

1. Do you have a Primary Care Physician (PCP)?

**You:**

 Yes No Yes, but I don’t see him/her regularly

**Spouse/Partner:**

 Yes No Yes, but I don’t see him/her regularly

**Child(ren):**

 Yes No Yes, but I don’t see him/her regularly

1. If you answered “yes” please list your doctor’s name:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. If you do not see a primary health provider regularly, please tell us why.

Check all that apply.

 I don’t know how to find a good doctor I am uncomfortable with doctors

 My doctor has inconvenient hours Language, racial, or cultural barriers

 It costs too much money Lack of transportation

 I am no longer able to see my doctor due to the Camp Fire Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What other kinds of health care professionals do you visit regularly?

Check all that apply.

**You:**

 Medical specialist Dentist Eye doctor

 Mental Health Professional Home care nurse Spiritual healer

 Alternative healer ( ex: Chiropractor) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spouse/Partner:**

 Medical specialist Dentist Eye doctor

 Mental Health Professional Home care nurse Spiritual healer

 Alternative healer ( ex: Chiropractor) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child(ren):**

 Medical specialist Dentist Eye doctor

 Mental Health Professional Home care nurse Spiritual healer

 Alternative healer ( ex: Chiropractor) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where do you and your family members receive routine health care services?

**You:**

 Doctor’s office Urgent/prompt care Emergency room

 Free/low-cost clinic Homeless shelter School-based clinic

 Tribal Health Center No routine health care

**Spouse/Partner:**

 Doctor’s office Urgent/prompt care Emergency room

 Free/low-cost clinic Homeless shelter School-based clinic

 Tribal Health Center No routine health care

**Child(ren):**

 Doctor’s office Urgent/prompt care Emergency room

 Free/low-cost clinic Homeless shelter School-based clinic

 Tribal Health Center No routine health care

1. Did you have health insurance during all, part or none of the past year?

**You:**

 All year Part of the year No insurance all year

**Spouse/Partner:**

 All year Part of the year No insurance all year

**Child(ren):**

 All year Part of the year No insurance all year

1. Currently, what is your primary type of health care coverage?

**You:**

 Employer-sponsored plan Private insurance Medicare

 Medi-Cal No health insurance Not sure

**Spouse/Partner:**

 Employer-sponsored plan Private insurance Medicare

 Medi-Cal No health insurance Not sure

**Child(ren):**

 Employer-sponsored plan Private insurance Medicare

 Medi-Cal No health insurance Not sure

1. Which hospital do you normally go to for care?

 Oroville Hospital Enloe Medical Center Orchard Hospital

 Adventist Health Rideout Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR WOMEN, AGE 21 AND OLDER:

1. How long has it been since your last pap smear (a screening exam for cervical cancer)?

 Within 1 year Within 2 years Within 3 years

 Within 4 years 5 or more years Never

 Not sure N/A

FOR WOMEN, AGE 40 AND OLDER:

1. How long has it been since your last mammogram (a screening exam for breast cancer)?

 Within 1 year Within 2 years Within 3 years

 Within 4 years 5 or more years Never

 Not sure N/A

FOR MEN, AGE 50 AND OLDER:

1. How long has it been since your last rectal exam (a screening used to examine the prostate)?

 Within 1 year Within 2 years Within 3 years

 Within 4 years 5 or more years Never

 Not sure N/A

1. How long has it been since you had a prostate cancer screening blood test?

 Within 1 year Within 2 years Within 3 years

 Within 4 years 5 or more years Never

 Not sure N/A

FOR MEN AND WOMEN, AGE 50 AND OLDER:

1. How long has it been since your last colonoscopy (a screening exam for colon cancer)?

 Within 1 year Within 2 years Within 5 years

 Within 10 years Over 10 years Never

 Not sure N/A

 How long has it been since your last sigmoidoscopy (a screening exam for colorectal cancer)?

 Within 1 year Within 2 years Within 5 years

 Within 10 years Over 10 years Never

 Not sure N/A

FOR EVERYONE:

1. Have you ever considered suicide?

 Yes No Not sure

1. Do you have an advance care plan, living will or health care power of attorney?

**You:**

 Yes No Not sure

 N/A

**Spouse/Partner:**

 Yes No Not sure

 N/A

**Child(ren):**

 Yes No Not sure

 N/A

1. Have you ever been told by a doctor or health care professional that you have any of the following conditions, diseases or challenges? Check all that apply.

**You:**

 Asthma Cancer Diabetes

 Heart Disease Substance Abuse Overweight/Obesity

 Eating Disorder Genetic Disorder Birth Defect

 Mental/Emotional Condition (including Depression)

 Developmental & Learning Concerns (including Autism)

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A

**Spouse/Partner:**

 Asthma Cancer Diabetes

 Heart Disease Substance Abuse Overweight/Obesity

 Eating Disorder Genetic Disorder Birth Defect

 Mental/Emotional Condition (including Depression)

 Developmental & Learning Concerns (including Autism)

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A

**Child(ren):**

 Asthma Cancer Diabetes

 Heart Disease Substance Abuse Overweight/Obesity

 Eating Disorder Genetic Disorder Birth Defect

 Mental/Emotional Condition (including Depression)

 Developmental & Learning Concerns (including Autism)

 Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A

1. Within the past year, what types of mental health services did you or anyone in your family use?

Check all that apply.

 Counseling/Therapy Hospitalization Crisis care/Emergency mental health services

 Residential treatment Psychiatric Medication Management

 Behavioral/Mental Health Clinic

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 N/A

If you were in need of services, but were unable to access them, please explain why:

­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you feel that you have adequate access to quality health care?

 Always Often Sometimes Rarely Never

If you feel you do not have adequate access, what is the biggest problem?

Please write in your 1st, 2nd, and 3rd choice.

­­­­\_\_ Transportation \_\_ Cost \_\_ Long wait times

\_\_ Cultural/language barriers \_\_ Lack of specialty doctors \_\_ Inadequate or no insurance

\_\_ Doctors not accepting new patients

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where do you receive information about local health services?

Check all that apply:

 Mail and flyers Online Social media

 TV advertisements Radio advertisements

 Print advertisements (ex: newspaper, Upgraded Living)

1. How would you prefer to receive your health information?

Check all that apply.

 Traditional mail Email Phone calls

 Text message

## SECTION 3: Social and Community Context

1. Has anyone made you feel afraid for your personal safety or physically hurt you?

 Yes No Not sure

If yes, what relationship is this person (or people) to you?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How often do you experience unwanted stress?

 Always Often Sometimes Rarely Never

1. How satisfied are you with Oroville’s school system?

 Very satisfied Satisfied Neutral

 Dissatisfied Very dissatisfied

If you are not satisfied, what do you think could be improved?

Please write in your 1st, 2nd, and 3rd choice.

\_\_ Curriculum \_\_ Breakfast/lunch programs \_\_ Extra-curricular activities

\_\_ After school programs \_\_ Educators \_\_ Safety

­\_\_ Infrastructure (ex: classrooms, playgrounds) \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you feel that there are enough extra-curricular activities available to children in Oroville and the surrounding communities?

 Always Often Sometimes Rarely Never

What improvements do you think would be beneficial?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE WRITE IN YOUR 1ST, 2ND, AND 3RD CHOICE FOR EACH OF THE FOLLOWING:

1. Most important factors for a “Healthy Community”

\_\_ Low crime/safe neighborhoods \_\_ Good schools

\_\_ Access to affordable health care \_\_ Lots of parks & recreation opportunities

\_\_ Affordable housing \_\_ Good jobs/Healthy economy

\_\_ Healthy behaviors and lifestyles \_\_ Clean environment

\_\_ Access to affordable fresh/natural foods \_\_ Access to mental health services

\_\_ Access to substance abuse programs/support \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Greatest needs affecting “Children’s Health”

\_\_ Access to immunizations \_\_ Access to health care services

\_\_ Access to mental health services \_\_ Access to affordable fresh/natural foods

\_\_ Affordable healthy lifestyle programs \_\_ Affordable health insurance

\_\_ Affordable services for special needs \_\_ Better school-lunch programs

\_\_ Better child/day care options \_\_ Access to free health screenings

\_\_ Lack of physical activity \_\_ Safe places to play

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most important “Health Problems” facing our community

\_\_ Cancer \_\_ Diabetes \_\_ Heart disease/High blood pressure

\_\_ Stroke \_\_ Overweight/Obesity \_\_ Mental Health Issues

\_\_ Respiratory/Lung disease \_\_ Dental hygiene \_\_ Sexually transmitted infections (STIs)

\_\_ Suicide \_\_ Teen pregnancy \_\_ Infectious diseases (ex: Hepatitis, TB)

\_\_ Shortage of Primary Care Doctors \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most challenging “Risky Behaviors” facing our community

\_\_ Alcohol abuse \_\_ Drug abuse \_\_ Driving while under the influence

\_\_ Child abuse/neglect \_\_ Lack of exercise \_\_ Tobacco use/secondhand smoke

\_\_ Poor eating habits \_\_ Dropping out of school \_\_ Not wearing a helmet

\_\_ Not wearing a seatbelt \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## SECTION 4: Neighborhood and Built Environment

1. Do you feel that you have adequate access to affordable and healthy food?

 Always Often Sometimes Rarely Never

If you feel you do not have adequate access, why not?

Please write in your 1st, 2nd, and 3rd choice.

\_\_ Too costly \_\_ No transportation \_\_ Not available in grocery stores

\_\_ Not enough time to shop \_\_ Don’t know what to buy \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you satisfied with your current housing situation?

 Yes No

If no, why not?

Please write in your 1st, 2nd, and 3rd choice.

\_\_ Too small \_\_ Too expensive \_\_ Too many people living in the same home

\_\_ Problems with neighbors \_\_ Too far from town/services \_\_ Too run down, unsafe, or unhealthy

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Were you forced to relocate as a result of the recent Camp Fire?

 Yes No Temporarily

1. What resources do you think Butte County residents need post Camp Fire?

Please write in your 1st, 2nd, and 3rd choice.

\_\_ Housing \_\_ Health care \_\_ Emotional support

\_\_ Jobs \_\_ Schools \_\_ Rebuilding resources

\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you feel safe in the environment that you live in?

 Always Often Sometimes Rarely Never

1. What changes would you like to see made in order to improve the neighborhood you live in?

 Better roads Better lighting Better parks/playgrounds

 More sidewalks Increased security Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where did you learn about this survey?

 At the hospital At my church At a health fair

 From a friend Online From my doctor

 At a community meeting At a retail store At work

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## IS THERE ANYTHING WE’VE OVERLOOKED?

Feel free to write in additional information you think we should know about the health of our community.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Thank you for your time!

Your anonymous response will be used by Oroville Hospital to better serve the health needs of our community’s residents.