

15. What is your gender?
 Female Male

16. How would you identify yourself?
 White or Caucasian
 Black or African American
 Latino/Hispanic
 American Indian
 Asian American
 Other

17. How would you describe your household?
 Single
 Married
 Married with children at home
 Married with children no longer at home
 Divorced
 Retired

18. What type of health insurance coverage is your primary plan? (choose one)
 Private insurance you purchase
 Medicare
 Medicaid
 Insurance covered by employer (employer pays total cost)
 Insurance covered by employer (you and employer share cost)
 I have no insurance

19. What is your family's total income?
 under \$24,999
 \$25,000 to \$49,999
 \$50,000 to \$74,999
 \$75,000 to \$99,999
 \$100,000 to \$124,999
 \$125,000 to \$149,999
 \$150,000 to \$174,999
 \$175,000 to \$199,999
 over \$200,000

* 20. In what zip code is your home located? (enter 5-digit zip code)

Thank you! Please return the completed survey in the enclosed envelope.
 Thank you again for providing us with valuable information.

Loring Hospital's 2022 Community Health Needs Assessment - Sac County, Iowa

We'd like your input! Loring Hospital is conducting a Community Health Needs Assessment gathering information regarding all health care services, needs, and preferences in Sac City.

With U.S. Health Reform, comes legislation to collect public opinion regarding all services related to community health care services. As a major stakeholder in the health care field in Sac County, we invite you to take part in our confidential survey. If you prefer, you may complete this survey online at <https://www.surveymonkey.com/r/loring-hosp2022>

Your response is greatly appreciated by April 30, 2022. Thank you for taking the time to fill out our survey!
 Loring Hospital's 2022 Community Health Needs Assessment - Sac County, Iowa

PART 1: YOUR HEALTH CARE PERCEPTIONS

1. In general, how would you rate the overall quality of the healthcare delivered to your community?

very good good fair poor very poor

2. How satisfied are you with the following:

| | completely satisfied | very satisfied | somewhat satisfied | not at all satisfied | N/A - neither satisfied or dissatisfied |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| Ambulance Service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Child Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chiropractor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dentist | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emergency Service | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Family Planning Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Home Health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hospice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Inpatient Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Health Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nursing Home | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Optometrist/eye doctor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Outpatient Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pharmacy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Primary Care/Clinics | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Public Health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| School Nurse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specialist Physician Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgery Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. Over the past 2 years, did you or someone in your household receive healthcare services outside of your county?
 yes no

If yes, please specify the healthcare services you received:

4. Are there healthcare services in your community that you feel need to be improved and/or changed?

5. In your opinion, how much of a problem are the following causes of disease or disability in your community?

| | not a problem | somewhat a problem | major problem | don't know |
|------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs/alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Obesity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pneumonia/flu | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicide | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Trauma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| COVID-19 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (please specify) | | | | |

6. How well do you feel our local health care providers are doing in addressing the health needs of the following age groups? (check one box per row)

| | very good | good | fair | poor | very poor | don't know |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Infants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Age 1-12 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Age 13-17 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Age 18-44 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Age 45-64 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Age 65-84 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Over 85 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

7. In your opinion, what areas need additional education or attention in your community: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Abuse/violence | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Aging | <input type="checkbox"/> Poverty |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Preventative healthcare |
| <input type="checkbox"/> Alternative medicine | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Child care | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Chronic diseases | <input type="checkbox"/> Teen pregnancy |
| <input type="checkbox"/> Family planning/birth control | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Lead exposure | <input type="checkbox"/> Uninsured |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Vaccinations |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Water quality |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Wellness education |
| <input type="checkbox"/> Obesity | |

8. Does your community need additional healthcare providers?

- yes no

If yes, please specify what is needed:

PART 2: YOUR HEALTH CARE PRACTICES

9. In general, how would you best describe your health? (choose one)

- very good good fair poor very poor

10. Compared to a year ago, how would you rate your overall health in general now?

- better than a year ago the same as a year ago worse than a year ago

11. Does your household have a provider you use for primary care?

- yes no

If yes, please provide physician's name and city (information is kept confidential)

12. Have you had a physical in the past 12 months?

- yes no

If no, why not (be specific)

13. Do you follow these health practices:

| | Yes | No | n/a |
|--|--------------------------|--------------------------|--------------------------|
| If over 50, have you had a colonoscopy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If male over 50, do you have an annual prostate exam? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If female over 40, do you have an annual mammogram? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If female, do you have a pap smear every other year? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get 2.5 hours a week of physical activity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If over 18, do you get 7 to 9 hours of sleep every night? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If under 18, do you get 10 to 11 hours of sleep every night? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you make healthy meal choices? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If you drink alcohol, do you drink in moderation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If you drink alcohol, do you drink excessively? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PART 3: A LITTLE INFORMATION ABOUT YOU

14. What is your age?

- under 18 19-44 45-64 65-74 over 75