

# New Hanover County Community Survey 2018



**NEW HANOVER COUNTY**  
PUBLIC HEALTH



**New Hanover**  
Regional Medical Center



SCHOOL OF NURSING

*We are conducting a survey of our county to learn more about the health and quality of life in New Hanover County and will use the results of this survey to help address the major health and community issues in our county.*

*The survey is completely voluntary, and it should take no longer than 15 minutes to complete. Your answers will be completely confidential. The information you give us will not be linked to you in any way.*

## Eligibility

1. How old are you?

- 17 or younger
- 18 - 24
- 25 - 44
- 45 - 64
- 65 or older

2. Do you live or work in New Hanover County?

- Live and Work
- Live Only
- Work Only
- Neither

3. What is the zip code where you live?

- |                             |  |
|-----------------------------|--|
| <input type="radio"/> 28401 | <input type="radio"/> 28410                        |
| <input type="radio"/> 28402 | <input type="radio"/> 28411                        |
| <input type="radio"/> 28403 | <input type="radio"/> 28412                        |
| <input type="radio"/> 28404 | <input type="radio"/> 28428                        |
| <input type="radio"/> 28405 | <input type="radio"/> 28429                        |
| <input type="radio"/> 28406 | <input type="radio"/> 28449                        |
| <input type="radio"/> 28407 | <input type="radio"/> 28480                        |
| <input type="radio"/> 28408 | <input type="radio"/> Other (please specify) _____ |
| <input type="radio"/> 28409 |  |

***If you are 17 years old or younger, and/or neither live or work in New Hanover County, please do not go any further in this survey.***

***We are only accepting responses from adults 18 years or older, and live and/or work in New Hanover County.***

## Part 1: Community and Personal Health

4. In your opinion, what is the one main health issue of concern in New Hanover County? (*Check only one*)

- |  |  |
|--|--|
| <input type="radio"/> Chronic Disease (including Cholesterol/<br>Blood Pressure/Diabetes/Stroke) | <input type="radio"/> Dental Health                            |
| <input type="radio"/> Cancer   | <input type="radio"/> Unsafe Driving                           |
| <input type="radio"/> Drug Misuse  | <input type="radio"/> Gangs/Violence                           |
| <input type="radio"/> Alcohol Misuse   | <input type="radio"/> Teen Pregnancy                           |
| <input type="radio"/> Obesity  | <input type="radio"/> Child Abuse                              |
| <input type="radio"/> Mental Health  | <input type="radio"/> Malnutrition/Lack of food                |
| <input type="radio"/> Tobacco Use  | <input type="radio"/> Environmental Health Exposures           |
| <input type="radio"/> Asthma/Lung Disease  | <input type="radio"/> Other ( <i>please specify</i> )<br>_____ |

5. What are the top five most needed health screenings or education/information services in your community? (*Check only five*)

- |  |   |
|--|---|
| <input type="checkbox"/> Cholesterol/Blood<br>Pressure/Diabetes/Stroke   | <input type="checkbox"/> Pregnancy Prevention                                     |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> HIV/Sexually Transmitted Diseases                        |
| <input type="checkbox"/> Mental Health (including<br>depression/anxiety) | <input type="checkbox"/> Vaccinations/Immunizations                               |
| <input type="checkbox"/> Dental Screenings                               | <input type="checkbox"/> Emergency Preparedness                                   |
| <input type="checkbox"/> Vision Screenings                               | <input type="checkbox"/> Disease Outbreaks  |
| <input type="checkbox"/> Learning Disabilities Screenings                | <input type="checkbox"/> Safe Driving   |
| <input type="checkbox"/> Child Growth and Development<br>Screenings      | <input type="checkbox"/> Seatbelts  |
| <input type="checkbox"/> Substance Misuse                                | <input type="checkbox"/> Child Car Seats  |
| <input type="checkbox"/> Addiction/Recovery                              | <input type="checkbox"/> Reading understanding/English language<br>skill level    |
| <input type="checkbox"/> Nutrition/Healthy Eating                        | <input type="checkbox"/> Cognitive Disorders (including Dementia,<br>Alzheimer's) |
| <input type="checkbox"/> Physical Activity                               | <input type="checkbox"/> Unknown/Unsure   |
| <input type="checkbox"/> Eating Disorders                                | <input type="checkbox"/> Other ( <i>please specify</i> ) _____                    |

6. People in my community work together to solve community problems.

- Strongly agree
- Agree
- Disagree
- Strongly disagree
- Unsure/I don't know

7. In your opinion, which three issues most negatively affects the quality of life in New Hanover County?  
(Select only 3)

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol, drugs or medication misuse and abuse           | <input type="checkbox"/> Lack of recreational facilities (parks, trails, community centers, pools, etc.) |
| <input type="checkbox"/> Child neglect and abuse                                 | <input type="checkbox"/> Lack of education opportunities   |
| <input type="checkbox"/> Discrimination/racism                                   | <input type="checkbox"/> Low income/poverty  |
| <input type="checkbox"/> Domestic/sexual violence                                | <input type="checkbox"/> Motor vehicle injuries including bicyclists and pedestrians                     |
| <input type="checkbox"/> Dropping out of school                                  | <input type="checkbox"/> Poor air/water/land quality   |
| <input type="checkbox"/> Gang involvement  | <input type="checkbox"/> Poor housing conditions   |
| <input type="checkbox"/> Homelessness  | <input type="checkbox"/> Smoking/tobacco use   |
| <input type="checkbox"/> Lack of affordable housing                              | <input type="checkbox"/> Social isolation/loneliness   |
| <input type="checkbox"/> Lack of employment opportunities                        | <input type="checkbox"/> Theft   |
| <input type="checkbox"/> Lack of childcare or recreational programs for youth    | <input type="checkbox"/> Traffic   |
| <input type="checkbox"/> Lack of healthy food choices or affordable healthy food | <input type="checkbox"/> Unsafe driving  |
| <input type="checkbox"/> Lack of/inadequate health insurance                     | <input type="checkbox"/> Violent crime (murder, assault)   |
| <input type="checkbox"/> Lack of places to exercise                              | <input type="checkbox"/> Other (please specify)  |
- 

8. In your opinion, what do you think is the main reason that keeps people in your community from seeking medical treatment? (Check only one)

- |  |   |
|--|---|
| <input type="radio"/> Lack of insurance/Unable to pay  | <input type="radio"/> Culture/Health beliefs            |
| <input type="radio"/> Lack of knowledge/understanding of the need  | <input type="radio"/> Lack of culturally competent care |
| <input type="radio"/> Fear (not ready to face health problem)  | <input type="radio"/> Lack of LGBTQ+ focused care       |
| <input type="radio"/> No appointments available when needed/Have to wait too long to get medical treatment | <input type="radio"/> Process issues with referrals     |
| <input type="radio"/> Cannot get off work/need appointment hours outside of 8:00 am – 5:00 pm              | <input type="radio"/> Health services too far away      |
| <input type="radio"/> Waiting too long at provider's office  | <input type="radio"/> Lack of transportation            |
| <input type="radio"/> Medical treatment here does not meet my needs  | <input type="radio"/> Not important                     |
|  | <input type="radio"/> None/ no barriers                 |
|  | <input type="radio"/> Unknown/Unsure                    |
|  | <input type="radio"/> Other (please specify)            |
- 

9. Which of these personally impacts you/ your household? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Chronic Disease (including Cholesterol/ Blood Pressure/Diabetes/Stroke) | <input type="checkbox"/> Unsafe Driving                      |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Gangs/Violence                      |
| <input type="checkbox"/> Drug Misuse   | <input type="checkbox"/> Teen Pregnancy                      |
| <input type="checkbox"/> Alcohol Misuse  | <input type="checkbox"/> Child Abuse                         |
| <input type="checkbox"/> Obesity   | <input type="checkbox"/> Malnutrition/Lack of food           |
| <input type="checkbox"/> Mental Health   | <input type="checkbox"/> Environmental Health Exposures      |
| <input type="checkbox"/> Tobacco Use   | <input type="checkbox"/> Does not apply; I/We have no impact |
| <input type="checkbox"/> Asthma/Lung Disease   | <input type="checkbox"/> Other (please specify)              |
| <input type="checkbox"/> Dental Health   |  |
-

10. How confident are you that you can manage most of your current health problems?

- Very confident
- Somewhat confident
- Not very confident
- I do not have any health problems

11. How would you rate your health?

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know/Unsure

12. I would like to improve my health.

- Yes
- No (*Skip to question 14*)

13. If yes, how would you like to improve your health? (*Check all that apply*)

- |  |   |
|--|---|
| <input type="checkbox"/> Change unhealthy habits (diet, exercise, smoking)                     | <input type="checkbox"/> Access to mental health provider         |
| <input type="checkbox"/> Learn more about healthy living and/or manage my disease or condition | <input type="checkbox"/> Access to preventative screenings        |
| <input type="checkbox"/> Access to primary care providers (family doctor, medical doctor)      | <input type="checkbox"/> Access to healthy foods                  |
|  | <input type="checkbox"/> Access to substance misuse treatment     |
|  | <input type="checkbox"/> Other ( <i>please specify</i> )<br>_____ |

14. Do you have challenges that make improving your health difficult?

- Yes
- No (*Skip to question 16*)

15. If yes, what challenges do you have that make improving your health difficult? (*Check all that apply*)

- |   |  |
|---|--|
| <input type="checkbox"/> Lack of insurance/Unable to pay              | <input type="checkbox"/> Cannot get off work/need appointment hours outside of 8:00 am – 5:00 pm |
| <input type="checkbox"/> Lack of knowledge/ understanding of the need | <input type="checkbox"/> Health services too far away  |
| <input type="checkbox"/> Fear (not ready to face health problem)      | <input type="checkbox"/> Transportation  |
| <input type="checkbox"/> Time constraints                             | <input type="checkbox"/> Not important   |
| <input type="checkbox"/> Culture/Health beliefs                       | <input type="checkbox"/> None/No challenges  |
| <input type="checkbox"/> Lack of LGBTQ+ focused care                  | <input type="checkbox"/> Unknown/Unsure  |
| <input type="checkbox"/> Process issues with referrals                | <input type="checkbox"/> Other ( <i>please specify</i> )<br>_____                                |

16. Including yourself, how many people live in your household? (*Circle only one*)

- 1      2      3      4      5      6      7      8      9      10      11      12+

17. What is/are your current health insurance plan(s)? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Private health insurance plan purchased from employer or workplace                                      | <input type="checkbox"/> Medicaid                  |
| <input type="checkbox"/> Medicare or Medicare supplement plan  | <input type="checkbox"/> Tricare, CHAMPUS          |
| <input type="checkbox"/> Other private health insurance plan purchased directly from an insurance company or the Health Exchange | <input type="checkbox"/> The Indian Health Service |
|  | <input type="checkbox"/> I do not have insurance   |
|  | <input type="checkbox"/> Other (please specify)    |
- 

18. What additional health insurance plan(s) currently cover other members of your household? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Does not apply/No other household members                          | <input type="checkbox"/> Other private health insurance plan purchased directly from an insurance company or the Health Exchange |
| <input type="checkbox"/> Other members of my household do not have insurance                | <input type="checkbox"/> Medicaid  |
| <input type="checkbox"/> Private health insurance plan purchased from employer or workplace | <input type="checkbox"/> Tricare, CHAMPUS  |
| <input type="checkbox"/> Medicare or Medicare supplement plan                               | <input type="checkbox"/> The Indian Health Service   |
|   | <input type="checkbox"/> Other (please specify)  |
- 

19. Do you have children living at home under the age of 18?

- Yes
- No (Skip to question 23)

20. If yes, how many children under the age of 18 live in your home at least ½ of the year? (Circle only one)

- 1    2    3    4    5    6    7    8    9    10    11    12    13    14    15

21. For the child/children aged 12 and under in your household, what type of childcare are you using? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Does not apply, I do not have a child/children aged 12 and under | <input type="checkbox"/> After school program                   |
| <input type="checkbox"/> I do not use childcare   | <input type="checkbox"/> Cared for by family members or friends |
| <input type="checkbox"/> Private, licensed childcare center/family child care home        | <input type="checkbox"/> Half day non-licensed preschool        |
| <input type="checkbox"/> Licensed faith-based program                                     | <input type="checkbox"/> Other non-licensed care                |
| <input type="checkbox"/> NC Pre-K/Head Start  | <input type="checkbox"/> Other (please specify)                 |
- 

22. Was there any time in the past 12 months that your child/children did not have health coverage?

- Yes
- No

23. Where do you go most often when you are sick? (Check only one)

- |  |   |
|--|---|
| <input type="radio"/> Doctor's office    | <input type="radio"/> Community Health Center/Free Clinic |
| <input type="radio"/> Health Department  | <input type="radio"/> Pharmacy Clinic                     |
| <input type="radio"/> Hospital Clinic    | <input type="radio"/> Other (please specify)              |
| <input type="radio"/> Emergency Room     |   |
| <input type="radio"/> Urgent Care Center |   |
-

24. What are the problems that prevent you and/or members of your household from getting health care?  
*(Check all that apply)*

- |  |  |
|--|--|
| <input type="checkbox"/> Does not apply; I/We do get health care           | <input type="checkbox"/> Process issues with referrals   |
| <input type="checkbox"/> No health insurance                               | <input type="checkbox"/> No appointments available when needed/Have to wait too long to get an appointment |
| <input type="checkbox"/> Insurance does not cover what I/We need           | <input type="checkbox"/> Cannot get off work/need appointment hours outside of 8:00 am – 5:00 pm           |
| <input type="checkbox"/> Share of the cost (deductible/co-pay) is too high | <input type="checkbox"/> The wait is too long in the provider's office                                     |
| <input type="checkbox"/> Do not know where to go                           | <input type="checkbox"/> Lack of culturally competent care   |
| <input type="checkbox"/> Doctor will not take my/our insurance             | <input type="checkbox"/> I/We do not have childcare  |
| <input type="checkbox"/> Hospital will not take my/our insurance           | <input type="checkbox"/> Other <i>(please specify)</i>   |
| <input type="checkbox"/> Dentist will not take my/our insurance            | _____  |
| <input type="checkbox"/> No way to get there                               |  |
| <input type="checkbox"/> Needed services are not available in NHC          |  |
| <input type="checkbox"/> Not enough providers offer the services I/We need |  |

25. In the past 12 months, have you gone to the emergency room with a non-emergency?

- Yes
- No *(skip to question 27)*

26. If yes, why? \_\_\_\_\_

27. Do you currently smoke cigarettes or use tobacco on a daily basis?

- Yes
- No *(skip to question 29)*

28. If yes, where would you go for help if you wanted to quit?

- |  |   |
|--|---|
| <input type="radio"/> Quitline (1-800-QuitNow) | <input type="radio"/> Health Department             |
| <input type="radio"/> Doctor                   | <input type="radio"/> Unknown/I don't know          |
| <input type="radio"/> Pharmacy                 | <input type="radio"/> Other <i>(please specify)</i> |
| <input type="radio"/> Private Therapist        | _____   |

29. Do you currently use smokeless tobacco products such as e-cigarettes, vape pens or juuls?

- Yes
- No *(skip to question 31)*

30. If yes, where would you go for help if you wanted to quit?

- |  |   |
|--|---|
| <input type="radio"/> Quitline (1-800-QuitNow) | <input type="radio"/> Health Department             |
| <input type="radio"/> Doctor                   | <input type="radio"/> Unknown/I don't know          |
| <input type="radio"/> Pharmacy                 | <input type="radio"/> Other <i>(please specify)</i> |
| <input type="radio"/> Private Therapist        | _____   |

31. Within the past 12 months, where did you participate in physical activity/exercise? *(Check all that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> I do not exercise                          | <input type="checkbox"/> Faith Community               |
| <input type="checkbox"/> Public recreation center, parks, or trails | <input type="checkbox"/> Mall                          |
| <input type="checkbox"/> Home                                       | <input type="checkbox"/> School setting                |
| <input type="checkbox"/> Neighborhood                               | <input type="checkbox"/> Other <i>(please specify)</i> |
| <input type="checkbox"/> Private gym/pool                           | _____  |
| <input type="checkbox"/> Work                                       |  |

32. Our community is a safe place to be physically active.
- Strongly agree
  - Agree
  - Disagree
  - Strongly disagree
  - Unknown/Unsure
33. Within the past 12 months, did you worry that your food would run out before you got money to buy more?
- Yes
  - No
34. Within the past 12 months, did the food you bought not last and you did not have money to buy more?
- Yes
  - No
35. What makes eating healthy meals difficult for you or members of your household? *(Check all that apply)*
- I/We do not have difficulty eating healthy meals
  - Healthy food does not taste good
  - Healthy foods cost too much
  - I/We do not know how to prepare food in a healthy way
  - I/We do not know what foods are healthy
  - It takes too much time to shop for healthy foods
  - It takes too much time to prepare healthy foods
  - It is hard to find healthy food options when going out to eat
  - Nobody else in my family/household would eat healthy foods
  - There are no options to buy healthy foods near my/our home
  - I/We have a restricted diet
  - I/We have dental problems that make eating/chewing food difficult
  - Other *(please specify)* \_\_\_\_\_
36. Within the past 12 months, has lack of reliable or affordable transportation kept you from medical appointments, getting medicines, non-medical meetings or appointments, work, or from getting things that you need?
- Yes
  - No
37. What type of transportation do you most often rely on? *(Choose only one)*
- Personal/family vehicle
  - Vehicle of family member/friend
  - Public transportation (Wave Transit)
  - Other *(please specify)*: \_\_\_\_\_
38. Do you have housing?
- Yes
  - No *(skip to question 41)*
39. Are you worried about losing your housing?
- Yes
  - No

40. Within the past 12 months, have you or members of your household been unable to get utilities (heat, electricity) when it was really needed?

- Yes
- No

41. Within the past 12 months, how often would you say that you were worried or stressed?

- Never
- Rarely
- Sometimes
- Often
- Always

42. Within the past 12 months, how often would you say that you were depressed?

- Never
- Rarely
- Sometimes
- Often
- Always

43. Where would you go (or direct someone to go) for mental health help or services? *(Check all that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> Private Counselor or Therapist   | <input type="checkbox"/> Minister/Religious Official/Church  |
| <input type="checkbox"/> Support Group (e.g. AA, Al-Anon) | <input type="checkbox"/> Emergency room                      |
| <input type="checkbox"/> School Counselor                 | <input type="checkbox"/> Crisis Hotline                      |
| <input type="checkbox"/> Doctor                           | <input type="checkbox"/> Unsure/Unknown                      |
| <input type="checkbox"/> Family/Friends                   | <input type="checkbox"/> Other <i>(please specify)</i> _____ |
| <input type="checkbox"/> Community Agency                 |  |

44. Where would you go (or direct someone to go) for drugs/alcohol misuse help or services? *(Check all that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> Private Counselor or Therapist   | <input type="checkbox"/> Minister/Religious Official/Church  |
| <input type="checkbox"/> Support Group (e.g. AA, Al-Anon) | <input type="checkbox"/> Emergency room                      |
| <input type="checkbox"/> School Counselor                 | <input type="checkbox"/> Crisis Hotline                      |
| <input type="checkbox"/> Doctor                           | <input type="checkbox"/> Unsure/Unknown                      |
| <input type="checkbox"/> Family/Friends                   | <input type="checkbox"/> Other <i>(please specify)</i> _____ |
| <input type="checkbox"/> Community Agency                 |  |

45. In the past 12 months, did you or a member of your household have a problem getting needed mental health services or substance use treatment?

- Yes
- No *(skip to question 47)*



46. If yes, what are the problems that prevent you and/or members of your household from getting necessary mental health care or substance use treatment? *(Check all that apply)*

- |   |  |
|---|--|
| <input type="checkbox"/> No health insurance  | <input type="checkbox"/> Cannot get off work/need appointment hours outside of 8:00 am – 5:00 pm |
| <input type="checkbox"/> Insurance does not cover what I/we need  | <input type="checkbox"/> The wait is too long at provider's office                               |
| <input type="checkbox"/> Share of the cost (deductible/co-pay) was too high                                   | <input type="checkbox"/> Culture/Health beliefs  |
| <input type="checkbox"/> Provider will not take my/our insurance  | <input type="checkbox"/> Lack of culturally competent care                                       |
| <input type="checkbox"/> No providers are available   | <input type="checkbox"/> Social stigma   |
| <input type="checkbox"/> Treatment here does not meet my needs  | <input type="checkbox"/> Fear (not ready to face health problem)                                 |
| <input type="checkbox"/> Provider is too far away   | <input type="checkbox"/> Do not have childcare   |
| <input type="checkbox"/> No way to get there  | <input type="checkbox"/> Other (please specify)  |
| <input type="checkbox"/> Do not know where to go  | _____  |
| <input type="checkbox"/> No appointments available when needed/Have to wait too long to get medical treatment |  |

47. Where do you go when you need dental care? *(Check all that apply)*

- |  |   |
|--|---|
| <input type="checkbox"/> Private Dentist's office            | <input type="checkbox"/> Local College          |
| <input type="checkbox"/> Emergency room                      | <input type="checkbox"/> Nowhere                |
| <input type="checkbox"/> Urgent Care Center                  | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Community Health Center/Free Clinic | _____   |

48. Why do you not seek dental care? *(Check all that apply)*

- |  |  |
|--|--|
| <input type="checkbox"/> Does not apply; I do seek dental care               | <input type="checkbox"/> Process issues with referrals   |
| <input type="checkbox"/> No dental insurance                                 | <input type="checkbox"/> No appointments available when needed/Have to wait too long to get an appointment |
| <input type="checkbox"/> Dental insurance does not cover the services I need | <input type="checkbox"/> Cannot get off work/Need appointment hours outside of 8:00 am – 5:00 pm           |
| <input type="checkbox"/> Share of the cost (deductible/co-pay) is too high   | <input type="checkbox"/> The wait is too long in the dentist office  |
| <input type="checkbox"/> Do not know where to go                             | <input type="checkbox"/> Lack of culturally competent care   |
| <input type="checkbox"/> Dentist will not take my insurance                  | <input type="checkbox"/> I do not have childcare   |
| <input type="checkbox"/> No way to get there                                 | <input type="checkbox"/> Other (please specify)  |
| <input type="checkbox"/> Needed dental services are not available in NHC     | _____  |
| <input type="checkbox"/> Not enough dentists offer the services I need       |  |

49. Where do you go when you need vision care? *(Check all that apply)*

- |  |   |
|--|---|
| <input type="checkbox"/> Private Doctor's office             | <input type="checkbox"/> Nowhere                |
| <input type="checkbox"/> Emergency Room                      | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Urgent Care Center                  | _____   |
| <input type="checkbox"/> Community Health Center/Free Clinic |   |

50. Why do you not seek vision care? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Does not apply; I do seek vision care                 | <input type="checkbox"/> Process issues with referrals   |
| <input type="checkbox"/> No vision insurance                                   | <input type="checkbox"/> No appointments available when needed/Have to wait too long to get an appointment |
| <input type="checkbox"/> Vision insurance does not cover the services I need   | <input type="checkbox"/> Cannot get off work/Need appointment hours outside of 8:00 am – 5:00 pm           |
| <input type="checkbox"/> Share of the cost (deductible/co-pay) is too high     | <input type="checkbox"/> The wait is too long in the provider's office                                     |
| <input type="checkbox"/> Do not know where to go                               | <input type="checkbox"/> Lack of culturally competent care   |
| <input type="checkbox"/> Doctor will not take my insurance                     | <input type="checkbox"/> I do not have childcare   |
| <input type="checkbox"/> No way to get there                                   | <input type="checkbox"/> Other (please specify)  |
| <input type="checkbox"/> Needed vision services are not available in NHC       | _____  |
| <input type="checkbox"/> Not enough vision providers offer the services I need |  |

51. In the past 12 months, did you or members of your household have a problem getting a prescription filled?

- Yes  
 No (skip to question 53)

52. If yes, what were the problems that prevented you or a member of your household from getting your prescription medication? (Check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> No health insurance                               | <input type="checkbox"/> Process issues between doctor/provider and pharmacy |
| <input type="checkbox"/> Insurance does not cover what I/we need           | <input type="checkbox"/> The wait is too long at the pharmacy                |
| <input type="checkbox"/> Share of the cost (deductible/co-pay) is too high | <input type="checkbox"/> Other (please specify)                              |
| <input type="checkbox"/> No way to get there                               | _____  |

53. In the past 12 months, did you decide to not take a medication prescribed to you by your doctor?

- Yes  
 No (skip to question 55)

54. If yes, what was the reason? \_\_\_\_\_

55. How do you dispose of (or get rid of) expired or unwanted medications? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> I do not dispose of medication; I keep some or all of my medications | <input type="checkbox"/> Take medications to a permanent medication drop box |
| <input type="checkbox"/> Throw them in the trash  | <input type="checkbox"/> Use chemical/medicine disposal bags                 |
| <input type="checkbox"/> Flush pills down the toilet or sink                                  | <input type="checkbox"/> Other (please specify)                              |
| <input type="checkbox"/> Take medications to a community medication drop-off event            | _____  |

56. Is violence a concern for you or others in your community?

- Yes  
 No

57. Do you feel physically safe and emotionally safe in your community?

- Yes  
 No

58. Within the past 12 months, have you been humiliated, yelled at, insulted, put down or emotionally abused in other ways by your partner or ex-partner?

- Yes
- No

59. Within the past 12 months, have you intentionally been hit, slapped, kicked or otherwise physically hurt by someone?

- Yes
- No

60. I am able to adapt to changes when they occur.

- Never
- Rarely
- Sometimes
- Often
- Always

61. I am able to bounce back after illness, injury or other hardships.

- Never
- Rarely
- Sometimes
- Often
- Always

**Considering the people to whom you are related by birth, marriage, adoption, etc.:**

62. How many relatives do you see or hear from at least once a month?

None	1	2	3 or 4	5 to 8	9 or more
0	0	0	0	0	0

63. How many relatives do you feel at ease with that you can talk about private matters?

None	1	2	3 or 4	5 to 8	9 or more
0	0	0	0	0	0

64. How many relatives do you feel close to such that you could call on them for help?

None	1	2	3 or 4	5 to 8	9 or more
0	0	0	0	0	0

**Considering all of your friends including those who live in your neighborhood:**

65. How many of your friends do you see or hear from at least once a month?

None	1	2	3 or 4	5 to 8	9 or more
0	0	0	0	0	0

66. How many friends do you feel at ease with that you can talk about private matters?

None	1	2	3 or 4	5 to 8	9 or more
0	0	0	0	0	0

67. How many friends do you feel close to such that you could call on them for help?

None	1	2	3 or 4	5 to 8	9 or more
0	0	0	0	0	0

**Part 2: Community Health Program & Services**

**68. Are you aware of the following programs and services?**

	Not at all	Slightly	Moderately	Very
Recreation opportunities such as parks, activity centers, and public pools				
Free or low-cost medical or healthcare				
High School-based health care centers				
Mobile dental services offered at public schools				
Mobile crisis services for residents with mental health or substance use or disorders needs				
Diabetes prevention/management programs				
Senior (65 years and older) services and programs offered in NHC				
Affordable housing				
Public transportation				
Early childhood services (0-5 years, Childcare, parenting and/or developmental information and support)				

**69. How likely are you or your family to use the following programs and services?**

	Not at all	Slightly	Moderately	Very
Recreation opportunities such as parks, activity centers, and public pools				
Free or low-cost medical or healthcare				
High School-based health care centers				
Mobile dental services offered at public schools				
Mobile crisis services for residents with mental health or substance use or disorders needs				
Diabetes prevention/management programs				
Senior (65 years and older) services and programs offered in NHC				
Affordable housing				
Public transportation				
Early childhood services (0-5 years, Childcare, parenting and/or developmental information and support)				

### Part 3: Emergency Preparedness

70. What would be your main way(s) of getting information from authorities in a large-scale disaster or emergency? *(Check all that apply)*

- |  |  |
|--|--|
| <input type="checkbox"/> Television  | <input type="checkbox"/> Social media (e.g. Twitter, Facebook)     |
| <input type="checkbox"/> Text (Emergency Alerts)   | <input type="checkbox"/> 911                                       |
| <input type="checkbox"/> Radio   | <input type="checkbox"/> 211                                       |
| <input type="checkbox"/> Pre-registered emergency alert notifications through my County Emergency Management | <input type="checkbox"/> Neighbors/Friends/Family/Word of mouth    |
| <input type="checkbox"/> Internet  | <input type="checkbox"/> New Hanover County Special Needs Registry |
| <input type="checkbox"/> Telephone/Smartphone  | <input type="checkbox"/> Don't Know/Not Sure                       |
| <input type="checkbox"/> Print Media/Newspaper   | <input type="checkbox"/> Other (please specify)                    |
| <input type="checkbox"/> New Hanover County webpage  | _____  |

71. Do you or a household member have a disability that make storms or disasters difficult?

- Yes  
 No

72. If public authorities announced a mandatory evacuation from your neighborhood or community due to a large-scale disaster or emergency, where would you go? *(Check only one)*

- |  |  |
|--|--|
| <input type="radio"/> Friends/family/2nd home outside area | <input type="radio"/> Would not evacuate     |
| <input type="radio"/> Hotel or Motel                       | <input type="radio"/> Other (please specify) |
| <input type="radio"/> Community shelter                    | _____  |
| <input type="radio"/> Don't know/ Not sure                 |  |

73. What would be the main reason you might not evacuate if asked to do so? *(Check only one)*

- |   |   |
|---|---|
| <input type="radio"/> Not applicable, I would evacuate                    | <input type="radio"/> Health problems of self or those of a household member would make evacuating too difficult or impossible without assistance |
| <input type="radio"/> Concern about traffic jams and inability to get out | <input type="radio"/> I have prepared my home for emergencies and feel it will remain the safest place to be                                      |
| <input type="radio"/> Concern about leaving pets                          | <input type="radio"/> Don't know/Not sure   |
| <input type="radio"/> Concerns about leaving property behind              | <input type="radio"/> Other (please specify)  |
| <input type="radio"/> Concern about family safety                         | _____   |
| <input type="radio"/> Concern public officials are wrong                  |   |
| <input type="radio"/> Concern about personal safety                       |   |
| <input type="radio"/> Money/financial concerns                            |   |
| <input type="radio"/> Lack of transportation                              |   |
| <input type="radio"/> No place to go                                      |   |

74. Do you/members of your household have an emergency plan and/or a basic emergency supply kit? These kits include water, non-perishable food, any necessary prescriptions, first aid supplies, flashlights and batteries, non-electric can opener, blanket, pet food, etc.:

- Yes  
 No *(Skip to question 75)*

75. If you have an emergency supply kit, how many days do you think your emergency supply kit would likely last?

- Less than 3 days  
 More than 3 days  
 Unsure/Unknown

76. Do you/members of your household have any of the following emergency plans? *(Check all that apply)*

- |  |  |
|--|--|
| <input type="checkbox"/> Emergency communication plan such as a list of important phone numbers and a designated out-of-town contact | <input type="checkbox"/> Designated meeting place outside of your neighborhood if you cannot return home |
| <input type="checkbox"/> Designated meeting place immediately outside your home or close by in your neighborhood                     | <input type="checkbox"/> Multiple routes away from your home in case an evacuation is necessary          |
| <input type="checkbox"/> Copies of important documents in a safe location  | <input type="checkbox"/> I/We do not have emergency plans  |

77. What is the primary language spoken in the home? *(Check only one)*

- English  
 Spanish  
 Other *(please specify)* \_\_\_\_\_

78. Is there anyone in your household who does not speak English and/or would have difficulty understanding guidance provided in English?

- Yes  
 No

## Part 4: Demographics

*These set of questions will assist us in determining how we are doing in getting a representative survey sample from the population. All answers are confidential and anonymous.*

79. I am \_\_\_\_\_

- Male  
 Female  
 Transgender  
 Other *(please specify)* \_\_\_\_\_

80. Do you identify as LGBTQ+?

- Yes  
 No  
 Unsure/Unknown

81. I identify as: *(Check all that apply)*

- |   |   |
|---|---|
| <input type="checkbox"/> White or Caucasian               | <input type="checkbox"/> Other Asian including Japanese, Chinese, Vietnamese, and Filipino/a          |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Other Pacific Islander including Native Hawaiian, Samoan, Guamanian/Chamorro |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Other <i>(please specify)</i> _____  |
| <input type="checkbox"/> Asian Indian                     |   |

82. Are you of Hispanic, Latino or Spanish origin? *(Check only one)*

- |  |   |
|--|---|
| <input type="radio"/> No; I am not of Hispanic, Latino or Spanish origin | <input type="radio"/> Yes; Cuban or Cuban American                |
| <input type="radio"/> Yes; Mexican, Mexican American, Chicano            | <input type="radio"/> Yes; Central American                       |
| <input type="radio"/> Yes; Puerto Rican                                  | <input type="radio"/> Yes; South American                         |
|  | <input type="radio"/> Yes; Other <i>(please specify)</i><br>_____ |

83. What is your employment status? (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Employed full time (greater than 30 hours/week)     | <input type="checkbox"/> Unemployed short term (out of work less than 27 weeks) |
| <input type="checkbox"/> Employed part time (less than 30 hours/week)        | <input type="checkbox"/> A homemaker/ full-time caregiver                       |
| <input type="checkbox"/> Retired   | <input type="checkbox"/> Unable to work/ disabled                               |
| <input type="checkbox"/> A student   | <input type="checkbox"/> More than 1 job  |
| <input type="checkbox"/> Unemployed long term (out of work 27 weeks or more) | <input type="checkbox"/> Self employed  |

84. What is the highest grade or year of school you completed?

- |   |  |
|---|--|
| <input type="radio"/> Never attended school or only attended kindergarten | <input type="radio"/> Some College or Technical School |
| <input type="radio"/> Grades 1 through 8 (Elementary/Middle)              | <input type="radio"/> College Graduate                 |
| <input type="radio"/> Grades 9 through 11 (some High school)              | <input type="radio"/> Graduate-level degree or higher  |
| <input type="radio"/> Grade 12 or GED (High school graduate)              |  |

85. What was your total household income last year before taxes?

- |   |   |
|---|---|
| <input type="radio"/> Less than \$12,000  | <input type="radio"/> \$75,000 - \$99,999   |
| <input type="radio"/> \$12,000 - \$24,999 | <input type="radio"/> \$100,000 - \$149,000 |
| <input type="radio"/> \$25,000 - \$49,999 | <input type="radio"/> \$150,000 - \$249,000 |
| <input type="radio"/> \$50,000 - \$74,999 | <input type="radio"/> \$250,000 or more     |

***Thank you for completing our survey!***

*Survey results will be compiled and released in the  
2019 New Hanover County Community Health Assessment.*

*For more information on this assessment or to find community resources, visit:  
**health.nhcgov.com***

