



2022 Regional Community Health Needs Assessment Rehab Survey

Thank you for taking the time to help us better understand the needs of people with disabilities in southeastern Pennsylvania.

Every three years, non-profit hospitals are required by federal law to do a Community Health Needs Assessment. This assessment looks at the health needs in the community the hospital serves. A group of hospitals in southeastern Pennsylvania are working together on the 2022 assessment. As part of the assessment, hospitals want to hear from individuals living with a disability about what they need to be healthy. Your response to this survey helps hospitals plan how to better meet your needs to improve health.

The survey will take 15 minutes to complete. If possible, the survey should be completed by the individual with the disability. However, if you are filling out this form on behalf of someone else, please answer ALL questions from the perspective of the individual with the disability.

All responses are anonymous and will remain that way unless you choose to identify yourself at the end of the survey. All those who complete the survey and provide an email address will be entered in a drawing for a \$50 Visa gift card. We will keep the information you provide private. All of the collaborating institutions will have access to the data to perform analyses that will help them better understand unmet needs and design their services accordingly.

Thank you again for your time!

Please contact the team at the Health Care Improvement Foundation at rCHNA2022@gmail.com if you have any questions.

Collaborators:

- Bryn Mawr Rehab Hospital
- Good Shepherd Penn Partners
- Magee Rehabilitation Hospital – Jefferson Health
- MossRehab
- St. Mary Rehabilitation Hospital

Part 1. About You

1) Have you been told by a doctor or other healthcare professional that you have a disability that is permanent?

Yes

No

2) Which of the following categories best describes this health condition, disability, or functional limitation? Check all that apply.

Mobility or physical disability limiting use of my legs, arms, or hands

Cognitive disability (my thinking, memory, problem-solving, ability to learn etc. is affected)

Psychological, psychiatric, or emotional disability (e.g., bipolar disorder, schizophrenia, depression, autism)

Chronic pain

Blindness, severe vision impairment, auditory disability, deafness, or severe hearing impairment

Speech disability, oral motor disability, speech impairment, or inability to speak

3) How long have you had your disability or health condition?

Less than 1 year

1-2 years

3-4 years

5 or more years, but I was not born with my disability

I was born with my disability

4) Which of the following major life activities are currently affected by this health condition, disability, or functional limitation? Check all that apply.

My major life activities are not currently affected by this health condition

Self-care, such as bathing, dressing, preparing meals, or eating

Mobility (including walking, climbing stairs, bending, or carrying something)

Communicating, such as talking with or listening to other people

Learning any new skills or activities

Remembering and/or concentrating

Interacting socially, such as developing friendships

5) Do you require personal assistance for any of the items above?

Yes

No

If you require personal assistance for the items above, who generally provides this care? Check all that apply.

Family members or friends (paid)

Family members or friends (unpaid)

Home health aides (paid)

6) Are there activities for which you need help, but are not able to get the help you need?

Yes

No

If yes, for what activities do you need help that you cannot get?

Part 2. Your Health

7) In general, how would you rate your health?

Excellent

Very Good

Good

Fair

Poor

Not sure

8) Please check the box that matches your response for each statement below:

I have fallen in the past 12 months.

I have been told by a doctor or other health professional that I have or had diabetes or high blood sugar.

I have been told by a doctor or other health professional that I have asthma.

I have been told by a doctor or other health professional that I have high blood pressure or hypertension.

I have been diagnosed with a mental health condition (such as clinical depression, anxiety disorder or bipolar disorder).

If you have been diagnosed with a mental health condition, are you currently receiving treatment for it?

Part 3. Accessing Health Services

9) Please indicate whether you have received or are currently receiving medical, therapy, or support services from any of the organizations below. Select all that apply.

- Bryn Mawr Rehab Hospital
- Good Shepherd Penn Partners
- Magee Rehabilitation Hospital - Jefferson Health
- MossRehab
- St. Mary Rehabilitation Hospital
- Not applicable

10) Please check off the health services you've used in the past 12 months. Check all that apply.

- Primary care
- Emergency care (including urgent care)
- Hospital inpatient services
- Home health care
- Dental care
- Psychological and/or counseling services
- Sexual and/or reproductive health services

11) If there was a time in the past 12 months when you needed medical care but did not get it,

please tell us why. Check all that apply.

Not applicable. I got the care I needed.

I couldn't get an appointment.

I did not know a good doctor/clinic.

It is too difficult to get to the doctor's office/clinic.

I couldn't find a doctor or other healthcare provider who understood my condition.

I didn't have health insurance.

The problem or treatment was not covered by insurance.

I couldn't find a doctor or other healthcare provider that would accept my insurance.

I couldn't afford to get the medical care I needed.

I had transportation issues that made it too difficult to get to the doctor's office/clinic.

I needed more information about available resources.

I was concerned about getting COVID-19 at the health care setting.

12) Have you used telehealth services (using your smart phone, tablet, or computer to video chat/talk with your doctor or other health professional) in the past 12 months?

Yes

No

If yes, did you find the appointment beneficial?

Yes

No

Share any additional details here.

If no, please tell us why. Check all that apply.

I haven't had a need to use telehealth services.

I want to see my doctor in person, not on a smartphone, tablet, or computer.

I don't have a smartphone, tablet, or computer.

I don't reliable broadband internet services at home.

I am not sure how to use my smartphone, tablet, or computer to access telehealth services.

13) In general, are you able to get the medications you need?

Yes

No

I don't take any medications.

If no, please tell us why not. Check all that apply.

Some or all of my medications are too costly.

It is difficult for me to go out and pick up my medications.

Some of my medications are not available at my local pharmacy.

14) Please let us know how long it's been since you've last...

One year or less	More than one year, up to 3 years	3-5 years	More than 5 years	Never had one	Not sure	Not applicable
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...been screened for
colorectal cancer?

...had a pap smear?

...had a mammogram?

...been screened for
prostate cancer?

Part 4. Health Behaviors

15) How often do you participate in exercise or fitness activities for at least 30 minutes (excluding physical therapy)?

Never

1 day per week

2 days per week

3 or more days per week

16) What prevents you from being more physically active? Check all that apply.

The facilities near my home are not accessible or do not have special equipment to meet my needs.
I do not have the physical capability to participate in ANY exercise program.
I have no interest in participating in any regular fitness program.
I have no transportation to a gym or other fitness facility.
I cannot afford membership to a gym or other fitness facility.
I do not know what types of exercises are appropriate for my condition.
There are no places in my community to exercise.

17) How many servings of fruits and vegetables do you eat on a typical day? (A serving of a fruit or vegetable is equal to a medium apple, half a cup of peas, or half a large banana.)

18) Do you currently use tobacco (e.g., smoke cigarettes, use hookah or e-cigarettes/vape)?

Yes

No

19) Do you feel as though use of drug or alcohol impacts your daily life?

Yes

No

Not sure

Part 5. Non-Medical Needs

For the next two questions, please respond whether the statement is often true, sometimes true, or never true.

20) Within the past 12 months, we worried whether our food would run out before we got money to buy more.

Often true

Sometimes true

Never true

21) Within the past 12 months, the food we bought just didn't last, and we didn't have money to get more.

Often true

Sometimes true

Never true

22) In the past year, have you needed the services of an attorney but found that you could not afford one?

Yes

No

If yes, what was the legal issue(s) you needed to address?

Planning Documents (writing or revising a will, power of attorney, living will, etc.)

Mortgage Foreclosure

Domestic Relations (e.g. divorce, custody, and support)

Domestic Violence

Public Benefits (SSI/SSDI, Medicare, Medicaid, food stamps and cash assistance)

Landlord/Tenant Issues

23) Do your primary means of transportation meet your current needs? Think about whether you are able to get to where you need to go most of the time, how regularly or frequently you experience delays, how much it costs to use this form of transportation, etc.

Yes

No

Not sure

If no, please share why not.

24) The next question asks about your housing costs. Housing costs refer to the money that you and your household spend on utility bills, rent, mortgage payments and/or property taxes. Overall, how difficult was it for you to afford your housing costs during the past year?

Very difficult

Somewhat difficult

Not very difficult

Not difficult at all

I do not pay for housing costs

Not sure

25) During the last 12 months, was there a time when you were not able to pay your mortgage, rent, or utility bills?

Yes

No

Not sure

26) If you have a physical disability, can you enter or leave your home without assistance from someone else?

Yes

No

Not applicable

27) Does your current housing meet your needs? Think about whether you are in need of home repair, help with accessing different parts of the home, more space, etc.

Yes

No

Not sure

If no, please share why not.

Part 6. Employment

28) What is your current employment/life status? Check all that apply.

Working full-time (36-40 hours a week)

Working part-time (1-35 hours a week)

Retired

Volunteer

Full-time student

Part-time student

Not currently working

If you are not currently working, please select the options that best describe how your disability affects your ability to work:

I have physical limitations due to my disability that prevent me from working.

I would like to work, but I will lose my attendant care and other benefits if I work.

Part 7. Technology & Assistive Devices

29) Is there any special equipment or type of assistive device (e.g. ramp, hearing aid, computer/software) that you currently need but do not have?

Yes

No

If yes, what is preventing you from getting this equipment?

30) What kind of special equipment or assistive device do you need but do not have? Check all that apply.

- | | |
|---|--|
| Motorized wheelchair/carts/scooter | Walker/cane |
| Wheelchair (manual) | Lift/carrier to handle wheelchair/scooter in or onto car |
| Vehicle big enough to handle wheelchair/scooter | Ramp at home/apartment |
| Lifts/chairs/other mechanized assists | Artificial limb |
| Railing/bar/other non-mechanized assists | Brace/orthotic |
| Voice-activated control device | Hearing aid device |
| Computer/software | Vision assistance |
| Guide dog | |

Part 8. Community Participation & Resource Needs

31) For each of the following, please check YES or NO to indicate if you typically:

Yes No

- Socialize with close friends, relatives, or neighbors
- Feel there are people you are close to
- Go to restaurants to eat
- Go to church, synagogue, mosque, or other place of worship
- Go to a show, movie, sports event, club meeting, class or other group event
- Feel your daily life is full of things that are interesting to you

32) Are there other things (not covered in this survey) that you would like to do in your life but are unable to do because of your disability? If so, please describe.

33) The following is a list of potential resources to help you and your caregivers. Please check the box that best describes your need for this resource:

	Currently using	Not currently using/not interested	Not currently using but interested in getting this resource
Support Groups			
Peer Mentors			
Transportation Assistance			
Support for caregivers (relief support or respite)			
Adaptive sports program			
Complementary therapy (e.g., art therapy, dance therapy, pet therapy)			

Part 9. Individual Information

34) What is your gender?

Male

Female

35) Please select your age group.

Under 18

18-39

40-59

60-70

Over 70

36) What is your relationship status?

Married

Living with a partner

Widowed

Divorced

Separated

Single

37) What race do you identify as? Check all that apply.

American Indian or Alaskan Native

Asian

Black or African-American

Native Hawaiian or other Pacific Islander

White

38) Do you identify as Hispanic, Latinx, or of Spanish origin?

Yes

No

39) What is the highest level of school you have completed or the highest degree you have received?

Less than high school degree

High school degree or equivalent (e.g., GED)

Some college

Associate degree

40) What zip code do you live in?

Thank you for taking the time to complete this important survey. We expect to post our findings by the summer of 2022. If you would like to participate in a drawing for a \$50 Visa gift card , please provide your email address here:

Email Address