

WESTCHESTER COUNTY PROVIDER SURVEY

We want to hear your thoughts about important health issues in the community you serve. Together, the Westchester County Health Department and hospitals throughout Westchester County, NY, will use the results of this short survey and other information to help improve health programs. You may also take the survey at <https://www.surveymonkey.com/r/ProviderSurvey2016> if you prefer. Thank you for your participation!

Agency Name:	_____	
Zip code of site location:	_____	
Optional:		
Your name _____	Phone # _____	Email address _____
How would you best describe your title/role in your agency?		
<input type="checkbox"/> Advocate	<input type="checkbox"/> Board member	<input type="checkbox"/> Office manager
<input type="checkbox"/> Alcohol/substance provider	<input type="checkbox"/> Dental provider	<input type="checkbox"/> Primary care provider
<input type="checkbox"/> Allied health professional	<input type="checkbox"/> Executive director	<input type="checkbox"/> Program administrator/manager
<input type="checkbox"/> Behavioral health care provider	<input type="checkbox"/> Health educator	<input type="checkbox"/> Specialty care provider
<input type="checkbox"/> Other (please specify) : _____		

Please check the categories that best describe your agency. (Please check all that apply)		
<input type="checkbox"/> Alcohol/substance Abuse Agency	<input type="checkbox"/> Dental Practice	<input type="checkbox"/> Medical Practice
<input type="checkbox"/> Community-based Organization	<input type="checkbox"/> Home Care Agency	<input type="checkbox"/> Mental Health Agency
<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Hospital	<input type="checkbox"/> Outpatient Clinic
<input type="checkbox"/> Other (please specify) : _____		

Please check the type of services provided by your agency. (Please check all that apply)		
<input type="checkbox"/> Breastfeeding support	<input type="checkbox"/> Family planning	<input type="checkbox"/> Prenatal/PCAP services
<input type="checkbox"/> Case management	<input type="checkbox"/> Food access	<input type="checkbox"/> Primary care services- adults
<input type="checkbox"/> Childcare	<input type="checkbox"/> Health insurance enrollment	<input type="checkbox"/> Primary care services- children
<input type="checkbox"/> Community education	<input type="checkbox"/> Health screenings	<input type="checkbox"/> Rehabilitation services
<input type="checkbox"/> Dental services	<input type="checkbox"/> Home care services	<input type="checkbox"/> Smoking/tobacco services
<input type="checkbox"/> Domestic violence prevention	<input type="checkbox"/> Housing	<input type="checkbox"/> Transportation
<input type="checkbox"/> Drug/alcohol services	<input type="checkbox"/> Immigrant support services	<input type="checkbox"/> Violence/bullying/gang prevention
<input type="checkbox"/> Elder care/senior services	<input type="checkbox"/> Immunization	<input type="checkbox"/> Other (please specify) : _____
<input type="checkbox"/> Exercise/ weight loss programs	<input type="checkbox"/> Mental health services	

Please check all persons served by your agency. (Check all that apply)		
<input type="checkbox"/> Adults	<input type="checkbox"/> Immigrants	<input type="checkbox"/> Seniors
<input type="checkbox"/> Children	<input type="checkbox"/> Low-income	<input type="checkbox"/> Other (please specify) : _____
<input type="checkbox"/> Disabled	<input type="checkbox"/> Uninsured	

What are the THREE biggest ongoing health concerns for the people/community you serve?		
<input type="checkbox"/> Access to immunizations	<input type="checkbox"/> Dental care	<input type="checkbox"/> Mental health/depression/ suicide
<input type="checkbox"/> Access to primary health care	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nutrition/eating habits
<input type="checkbox"/> Access to specialty care	<input type="checkbox"/> Disability	<input type="checkbox"/> Overweight/obesity
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Distracted driving	<input type="checkbox"/> Preventable injury/falls
<input type="checkbox"/> Asthma/breathing problems	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Smoking/tobacco use
<input type="checkbox"/> Cancer	<input type="checkbox"/> Family planning/teen pregnancy	<input type="checkbox"/> Violence
<input type="checkbox"/> Care for the elderly	<input type="checkbox"/> Healthy environment	<input type="checkbox"/> Women's health
<input type="checkbox"/> Child health & wellness	<input type="checkbox"/> Heart disease/stroke	
<input type="checkbox"/> Dementia/Alzheimer's	<input type="checkbox"/> HIV/AIDS & Sexually Transmitted Infections	<input type="checkbox"/> Other (please specify) : _____

What THREE things would be most helpful to improve the health concerns of the community you serve?

- | | | |
|---|--|--|
| <input type="checkbox"/> Access to dental care | <input type="checkbox"/> Domestic violence prevention | <input type="checkbox"/> Mental health services |
| <input type="checkbox"/> Access to healthier food | <input type="checkbox"/> Drug/alcohol services | <input type="checkbox"/> Safer childcare options |
| <input type="checkbox"/> Access to primary care | <input type="checkbox"/> Elder care services | <input type="checkbox"/> Safer places to walk/play |
| <input type="checkbox"/> Affordable housing | <input type="checkbox"/> Exercise/weight loss programs | <input type="checkbox"/> Smoking/tobacco services |
| <input type="checkbox"/> Breastfeeding support | <input type="checkbox"/> Health Insurance enrollment | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Caregiver support | <input type="checkbox"/> Health screenings | <input type="checkbox"/> Violence/bullying/gang prevention |
| <input type="checkbox"/> Clean air & water | <input type="checkbox"/> Home care services | <input type="checkbox"/> Other (please specify) : _____ |
| <input type="checkbox"/> Community education | <input type="checkbox"/> Immigrant support services | |
| <input type="checkbox"/> Dementia/Alzheimer's screening | <input type="checkbox"/> Job opportunities | |

How would you rate the health of the people/community you serve?

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Very healthy | <input type="checkbox"/> Somewhat healthy | <input type="checkbox"/> Very unhealthy |
| <input type="checkbox"/> Healthy | <input type="checkbox"/> Unhealthy | <input type="checkbox"/> Other (please specify) : _____ |

What are the THREE most significant barriers impacting YOUR ABILITY to provide services to your patients/clients?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cultural competency issues | <input type="checkbox"/> Limited or lack of access to specialists | <input type="checkbox"/> Patient non-adherence to treatment |
| <input type="checkbox"/> High no-show rate | <input type="checkbox"/> Limited space and/or equipment | <input type="checkbox"/> Staff time constrains |
| <input type="checkbox"/> Inadequate insurance reimbursement | <input type="checkbox"/> Limited staffing resources | <input type="checkbox"/> Other (please specify) : _____ |
| <input type="checkbox"/> Lack of funding | <input type="checkbox"/> Patient cannot afford prescription medications | |
| <input type="checkbox"/> Limited bi-lingual staff | | |

For the patients/clients you serve, what are the top THREE barriers impacting YOUR CLIENTS' ability to access your services?

- | | | |
|--|--|--|
| <input type="checkbox"/> There are no issues | <input type="checkbox"/> Don't understand need to see a provider | <input type="checkbox"/> Lack of/or limited staff who speak their language |
| <input type="checkbox"/> Cannot afford services | <input type="checkbox"/> Inconvenient hours | <input type="checkbox"/> No transportation/too far |
| <input type="checkbox"/> Co-pay/deductible too high | <input type="checkbox"/> Insurance does not cover service | <input type="checkbox"/> No childcare |
| <input type="checkbox"/> Cultural/religious beliefs | <input type="checkbox"/> Lack of time | <input type="checkbox"/> No insurance |
| <input type="checkbox"/> Don't know how to access services | <input type="checkbox"/> Lack of/or limited staff/service | <input type="checkbox"/> Unaware of services available |
| <input type="checkbox"/> Don't like going/afraid to go | | <input type="checkbox"/> Other (please specify) : _____ |

Where do community members you serve get most of their health information? (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Community-based organization | <input type="checkbox"/> Internet | <input type="checkbox"/> School/college |
| <input type="checkbox"/> Doctor/Health professional | <input type="checkbox"/> Library | <input type="checkbox"/> Social media (Facebook, Twitter, etc.) |
| <input type="checkbox"/> Family or friends | <input type="checkbox"/> Newspaper/magazine | <input type="checkbox"/> Television |
| <input type="checkbox"/> Health department | <input type="checkbox"/> Radio | <input type="checkbox"/> Worksite |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Religious organization | <input type="checkbox"/> Other (please specify) : _____ |

Please return the survey by **June 10th, 2016**.

Email: bqlc@westchestergov.com Fax: 914-813-4303.

Mail: Bonnie Lam, Department of Health, 10 County Center Road, 2nd Floor, White Plains, NY 10607-1541

Can we contact you so you can tell us more about your ideas regarding health problems in Westchester County and what should be done about them?	<input type="checkbox"/> Yes _____
	<input type="checkbox"/> No _____