



Health Systems Quality Assurance, Office of Community Health Systems
Mental Health Provider Survey

To complete this survey online: <https://fortress.wa.gov/doh/opinio/s?s=HPSAMentalHealth>

MENTAL HEALTH PROVIDER SURVEY			
1. Last Name, Suffix (e.g. Sr., Jr.)		2. First Name	3. Middle Name
			4. Birth Year
5. Credentials:	<input type="checkbox"/> M.D. (Doctor of Medicine) <input type="checkbox"/> D.O. (Doctor of Osteopathy)		
6. Practice Name		7. Phone Number	
8. Practice Street Address		9. City	10. ZIP Code
		11. County	
12. Practice Mailing Address (if different)		13. City	14. ZIP Code
		15. County	
16. Mental Health Type:	<input type="checkbox"/> General Psychiatry <input type="checkbox"/> Child Psychiatry <input type="checkbox"/> Other: _____		
17. Provider Program or Status: (Mark any that apply)	<input type="checkbox"/> National Health Service Corps <input type="checkbox"/> Resident or Intern <input type="checkbox"/> State Loan Repayment/Scholarship <input type="checkbox"/> Hospitalist: _____ % of practice <input type="checkbox"/> J-1 Visa Holder <input type="checkbox"/> Faculty/Instructor/Research <input type="checkbox"/> H-1B Visa Holder <input type="checkbox"/> Locum Tenens <input type="checkbox"/> Federal Employee (e.g. IHS, PHS) <input type="checkbox"/> Other: _____		
18. Within the next six months, does the provider plan to:	<input type="checkbox"/> Retire <input type="checkbox"/> Move out of state <input type="checkbox"/> Decrease hours <input type="checkbox"/> Increase hours <input type="checkbox"/> Move to different practice <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
19. Does the provider have hospital admitting privileges?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
20. Please estimate the weekly hours this provider spends on each of the following: (Please list whole numbers)	Psychiatric Clinical Care: _____ hours/week (Includes general direct adult/child <i>outpatient</i> care) Sub-Specialty Care: _____ hours/week (Includes forensics, research, on staff at a hospital, correctional facility, or other inpatient facilities) Non-Clinical Duties: _____ hours/week (Clinic administration, continuing education, lecturing, hospital meetings, instruction, etc.)		
21. In a typical workweek, please estimate the number of patients seen by this provider for outpatient psychiatric services.	Average number of patients: _____		
22. Please estimate the number of days it takes to schedule a routine, non-urgent appointment.	Established patient day(s)	New patients day(s)	
	<input type="checkbox"/> < 5 days, <input type="checkbox"/> 5 to 10 days <input type="checkbox"/> 11 to 20 days <input type="checkbox"/> 21 to 30 days <input type="checkbox"/> > 30 days	<input type="checkbox"/> < 5 days, <input type="checkbox"/> 5 to 10 days <input type="checkbox"/> 11 to 20 days <input type="checkbox"/> 21 to 30 day <input type="checkbox"/> > 30 days	

23. On average, if the patient arrives on time for their appointment how many minutes does it typically take to see the provider?	Established patients minute(s) <input type="checkbox"/> < 5 minutes <input type="checkbox"/> 5 to 10 minutes <input type="checkbox"/> 11 to 20 minutes <input type="checkbox"/> 21 to 30 minutes <input type="checkbox"/> > 30 minutes	New patients minute(s) <input type="checkbox"/> < 5 minutes <input type="checkbox"/> 5 to 10 minutes <input type="checkbox"/> 11 to 20 minutes <input type="checkbox"/> 21 to 30 minutes <input type="checkbox"/> > 30 minutes
24. How are multilingual interpretative services provided? (check all that apply)	<input type="checkbox"/> Clinic employee <input type="checkbox"/> Computer <input type="checkbox"/> None <input type="checkbox"/> Telephone <input type="checkbox"/> Family or Friend <input type="checkbox"/> Other: _____ <input type="checkbox"/> Community services <input type="checkbox"/> Unknown	
25. Does this provider serve the following patients? If yes, please estimate the percentage of the patient population.	Migrant Farm Workers: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate) Homeless People: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate) Apple Health (Medicaid): <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate) Sliding Fee Scale: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ % (best estimate) Is the Sliding Fee Scale posted and visible to all patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure	
26. Is the provider accepting:	Any <i>new</i> patients? <input type="checkbox"/> No <input type="checkbox"/> Yes Any <i>new</i> Apple Health (Medicaid) patients? <input type="checkbox"/> No <input type="checkbox"/> Yes Any <i>new</i> Sliding Fee Scale patients? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<p><i>Survey completed by:</i></p> <p>Name: _____ Title: _____</p> <p>Phone: _____ Email: _____</p> <p>Questions: Contact Randy Saylor at (360)236-2865 or Randall.Saylor@doh.wa.gov or Laura Olexa at (360)236-2811 or Laura.Olexa@doh.wa.gov</p> <p>Return by mail or fax to: Department of Health, Community Health Systems P.O. Box 47853 Olympia, WA 98504-7853 Fax (360)236-2830</p>		