WCMC
IRB APPROVED
Approved:
06/17/2010
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04/12/2011

The NYC Elder Abuse Center

Brooklyn Geriatric Mental Health and Medical Provider Survey

You can also complete this survey online:
http://www.surveymonkey.com/s/geriatricproviders

PLEASE PRINT CLEARLY

Preamble

A. You are invited to participate in a project to assess the capacity and interest of geriatric health care and mental health providers in Brooklyn to work with the NYC Elder Abuse Center on providing assessment of, and treatment for, elder abuse victims. You have been selected as a participant because of your interest/expertise in the medical and/or mental health issues of older adults.

B. If you decide to participate, please complete the below to determine the capacity and interest of you/your organization to address the physical and/or mental health needs of elder abuse victims. The survey will take about 15-20 minutes to complete. You may choose not to finish completing the survey at any time without any consequence to you. **If you choose to complete this survey, please submit it by June 21.**

C. Your participation in this project will involve minimal risks. Completing the survey might make you feel bored or you may be disappointed if you do not think you/your organization will not be able to adequately complete the survey and/or collaborate with the Center. Your participation will not pose any physical risk. If you would like to end completing the survey, you may do so at any time.

D. Your participation in this planning project occurs at no cost to you, and there will be no compensation for your participation.

E. The primary benefit of participation will be having contributed to the mapping of Brooklyn-based geriatric health and mental health providers as part of the planning efforts of the NYC Elder Abuse Center. We cannot and do not guarantee that you will receive any benefits from this mapping project.

F. By completing and submitting the survey, you are consenting to your information being shared with the members of the NYC Elder Abuse Project's Mental Health Survey Advisory Committee and the Executive Council of the NYC Elder Abuse Center. If at the end of the survey you consent to your provider information being included in a directory, then that information will be shared with the public.

G. This survey has been approved by the Weill Cornell Medical College's Institutional Review Board.

Thank you!

General Information

Organization/Provider Name:	
Address:	
City/State/Zip Code:	
Contact Person:	
Area Served:	
Telephone Number:	
Fax:	
Email:	
Hours of Operation:	
Intake Process:	
Average time on wait list before initial visit:	

Scope of Services

1. What degree certifications do you and/or your staff have at your organization/private practice? *Please include on the blank line how many staff members have each degree.*

   CHECK ALL THAT APPLY

   ☐ Nurse – Clinical Specialist (CNS) _____

   ☐ Nurse – Practitioner (NP) _____

   ☐ Nurse – Psychiatric Mental Health Practitioner (PMHNP) _____

   ☐ Physician (M.D.) _____

   ☐ Physician Assistant (PA) _____

   ☐ Psychiatrist (M.D.) _____

   ☐ Psychologist (Ph.D.) _____

   ☐ Social Worker - Licensed Clinical Social Worker (LCSW) _____

   ☐ Social Worker - Licensed Master Social Worker (LMSW) _____

   ☐ Other (please specify certification and number of staff) _____
   _____

2. Does your organization/practice specialize in the assessment, intervention, and/or management of older persons (60+) with:

   physical disorders?

   ☐ YES ☐ NO

   mental disorders?

   ☐ YES ☐ NO

   If yes, please select your type of organization/practice. ***CHECK ALL THAT APPLY***

   Type of Organization/Practice

   Mental Health

   - ☐ Community mental health clinic
   - ☐ Continuing day treatment program
   - ☐ Hospital based mental health clinic
   - ☐ Inpatient psychiatric facility or unit
   - ☐ Mental health faculty practice plan
   - ☐ Partial hospitalization program
   - ☐ Personalized recovery oriented service (PROS)
   - ☐ Private group mental healthcare practice
   - ☐ Private individual mental healthcare practice
   - ☐ Psychiatric Rehabilitation Program
   - ☐ Other Please specify: _____

   Health

   - ☐ Adult medical day program
   - ☐ Community health clinic
   - ☐ Emergency medical service
   - ☐ Health faculty practice plan
   - ☐ Home care agency (Please be specific on type of agency, e.g. CHHA, etc.) _____
   - ☐ Hospital based health clinic
   - ☐ Hospital
   - ☐ Nursing home

☐ Private individual healthcare practice

☐ Private group healthcare practice

☐ Other Please specify: _____

3. Does your organization/practice have language capacity other than English?

   ☐ YES ☐ NO

   If yes, please specify which languages:_____
   _____

4. Does your organization/practice have available translator services?

   ☐ YES ☐ NO

5. Is your facility wheelchair accessible?

   ☐ YES ☐ NO ☐ N/A

6. Does your organization/practice make visits to patients' homes?

   ☐ YES ☐ NO

7. Does your organization/practice provide services in other locations besides the office and the home, such as nursing homes, assisted living facilities, and/or senior centers? If, yes, **please list the locations**:

   ☐ YES ☐ NO

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8. What kinds of insurance does your organization/practice accept? ***CHECK ALL THAT APPLY***.

   ☐ Medicare (Fee-for-service or HMO)

   ☐ Medigap

   ☐ Medicaid

   ☐ Commercial insurance

   ☐ Self-pay only

   ☐ No insurance accepted

   ☐ Free/sliding scale

9. Does your organization/practice accept the uninsured?

   ☐ YES ☐ NO ☐ OTHER

If you selected Other, please specify:_____

_____

10. Please select your organization's/practice's specialties. ***CHECK ALL THAT APPLY***.

☐ Addictions	☐ Domestic violence	☐ Neuropsychological testing
☐ Aging-general	☐ Eating disorders	☐ Pain management
☐ Anger management	☐ Elder abuse and neglect	☐ Palliative care
☐ Anxiety and phobias	☐ Emergency medicine	☐ Personality disorders
☐ Assertiveness training	☐ Expert witness	☐ Pharmacotherapy
☐ Bipolar disorder	☐ Falls	☐ Physical therapy/ rehabilitation
☐ Cardiac diseases	☐ Gay and lesbian issues	☐ Post-traumatic stress disorder
☐ Cancer care	☐ Gender identity	☐ Psychotic disorders
☐ Caregiver stress	☐ Grandparents raising grandchildren	☐ Relationship problems
☐ Case management	☐ Grief and loss	☐ Sexual assault/rape crisis srvs
☐ Chronic illness and disabilities	☐ Hearing loss	☐ Sexual dysfunction
☐ Comprehensive psychiatric evaluation	☐ Hoarding	☐ Skin disorders
☐ Continence	☐ Holocaust survivorship	☐ Sleep problems
☐ Crisis intervention	☐ Home care	☐ Social isolation
☐ Death and dying	☐ Housing options	☐ Spirituality
☐ Dementia	☐ Immigration issues	☐ Stress management
☐ Dependent adult children	☐ Job/career	☐ Suicide
☐ Depression	☐ Joint & soft tissue disorders	☐ Tumors
☐ Developmental disabilities	☐ Kidney disease	☐ Vision loss
☐ Diminished capacity evaluation (undue influence, mental capacity)	☐ Long-term care	☐ Other Please specify:_____ _____ _____ _____
☐ Disease prevention and health Promotion	☐ Neurological disorders	

11. If your organization/practice provides mental health services, please select your therapeutic orientations. ***CHECK ALL THAT APPLY***.

- ☐ Cognitive behavioral therapy
- ☐ ECT
- ☐ EMDR
- ☐ Hypnosis
- ☐ Psychoanalysis
- ☐ Psychodynamic psychotherapy
- ☐ Other_____

12. If your organization/practice provides mental health services, please select your treatment modalities. ***CHECK ALL THAT APPLY***.

- ☐ Assertive community treatment
- ☐ Family counseling
- ☐ Individual psychotherapy
- ☐ Martial counseling
- ☐ Mobile crisis
- ☐ Support group services
- ☐ Other_____

13. Do staff members of your organization/practice **receive** training in elder abuse detection, assessment, and/or intervention?

☐ YES ☐ NO

If yes, please specify the type of training:_____
_____

14. Do staff members of your organization/practice **provide** elder abuse case consultations to professionals from other organizations?

☐ YES ☐ NO

15. Does your organization/practice have resources to address the mental health and/or medical needs of elder abuse **victims**?

☐ YES ☐ NO

If yes, please specify:_____
_____

16. Does your organization/practice have resources to address the mental health needs of the **abuser**?

☐ YES ☐ NO

If yes, please specify:_____

_____

17. Do staff members of your organization/practice have experience in participating in the investigation and/or prosecution of elder abuse cases?

☐ YES ☐ NO

18. Is your organization/practice interested in collaborating with the NYC Elder Abuse Center to address the medical and/or mental health needs of elder abuse victims? Opportunities for collaboration include case consultation, and assessment and treatment of the physical and/or mental health needs of elder abuse victims.

☐ YES ☐ NO

19. In your opinion, please list (other than yourself) the **top three geriatric mental health service experts and/or organizations** and the top three **geriatric medical service experts and/or organizations** in Brooklyn.

Top three geriatric *mental health* experts

1. _____
2. _____
3. _____

Top three generic *mental health* organizations

1_____
2._____
3._____

Top three geriatric *medical* experts

4. _____
5. _____
6. _____

Top three generic *health* organizations

1._____
2._____
3._____

20. Do you want your/your organization's information included in a Brooklyn-based directory of health and mental health providers?

☐ YES ☐ NO

THANK YOU FOR YOUR PARTICPATION!

Please submit your response by June 21, 2010 to Kim Williams at:
FAX: 212-964-7302 or EMAIL: kwilliams@mhaofnyc.org or MAIL:
Geriatric Mental Health Alliance of New York, 50 Broadway, 19th Floor, New York, NY 10004