ONE CARE 2014 MEMBER EXPERIENCE SURVEY

Please answer each question by marking the box to the left of your answer.

You are sometimes told to skip over some questions in this survey. When this happens, you will see a note that tells you what question to answer next, like this:

☐ Yes
☒ No...........**If No, Go to #1 on Page 1**

1. One Care plans are offered by Commonwealth Care Alliance, Fallon Total Care and Network Health Unify. Which plan are you enrolled in?

[1] ☐ Commonwealth Care Alliance
[2] ☐ Fallon Total Care
[3] ☐ Network Health Unify
[4] ☐ I don't know which One Care plan I'm in
[5] ☐ None, I am not in a One Care plan....**If None, Go to #32 on Page 7**

2. Did you choose your One Care plan or did MassHealth choose a plan for you?

[1] ☐ I chose my plan..........**If You Chose, Go to #4**
[2] ☐ MassHealth chose my plan

3a. MassHealth mailed letters to members to let them know about the plan chosen for them. Do you recall receiving a letter from MassHealth about the One Care plan chosen for you?

[1] ☐ Yes
[2] ☐ No..........................**If No, Go to #7 on Page 2**

3b. How easy or difficult was it to understand the information you received from MassHealth about the One Care plan that was chosen for you?

[1] ☐ Very Easy
[2] ☐ Somewhat Easy
[3] ☐ Somewhat Difficult
[4] ☐ Very Difficult

} **Go to #7 on Page 2**

Enrolling in One Care

The following questions ask about your initial experience with enrolling in One Care.

4. How easy or difficult was it to choose a One Care plan?

[1] ☐ Very Easy
[2] ☐ Somewhat Easy
[3] ☐ Somewhat Difficult
[4] ☐ Very Difficult

5. Overall, how easy or difficult was it for you to enroll in One Care?

[1] ☐ Very Easy
[2] ☐ Somewhat Easy
[3] ☐ Somewhat Difficult
[4] ☐ Very Difficult

6. What were the main reasons you enrolled in One Care? *(Check all that apply)*

[1] ☐ To get better health care
[2] ☐ To get additional services
[3] ☐ To get a Care Coordinator
[4] ☐ To get a Long Term Services (LTS) Coordinator
[5] ☐ To get better dental care
[6] ☐ To lower the costs I pay for health care
[7] ☐ To have one plan rather than two
[8] ☐ Someone recommended One Care
[9] ☐ Other *(Please specify)*: _________________

Your Care Team

7. *A* ***Primary Care Provider (PCP)*** *is a medical professional you see if you need a check-up, want advice about a medical or behavioral health problem, or get sick or hurt. This might be a doctor, a nurse practitioner, or a physician's assistant.*

a. Which of the following best applies to you since you enrolled in One Care? *(Select one)*

- [1] ☐ I have stayed with the same PCP
- [2] ☐ My PCP changed
- [3] ☐ I didn't have a PCP before, but I do now
- [4] ☐ I didn't have a PCP, and I still don't
- [5] ☐ Don't know/Not sure

If you selected one of these options (4 or 5), Go to #8

b. <u>Since</u> enrolling in One Care have you met with your **Primary Care Provider**?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

c. How satisfied are you with the **Primary Care Provider** you have under One Care?

- [1] ☐ Extremely Satisfied
- [2] ☐ Somewhat Satisfied
- [3] ☐ Somewhat Dissatisfied
- [4] ☐ Extremely Dissatisfied
- [5] ☐ Don't know/Not sure

8. *A* ***Care Coordinator*** *is a person who helps make sure that you get the health care services you need and helps you manage your care (some plans may call this person a* ***Navigator****).*

a. Since enrolling, have you been contacted by a **Care Coordinator** from your One Care plan?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

If you selected one of these options (2 or 3), Go to #9

b. Have you met with your **Care Coordinator**?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

If you selected one of these options (2 or 3), Go to #9

c. What was the length of time between enrolling in One Care and meeting with your **Care Coordinator**?

- [1] ☐ Less than 1 month
- [2] ☐ 1 month to less than 2 months
- [3] ☐ 2 months to less than 3 months
- [4] ☐ 3 months or more
- [5] ☐ Don't know/Not sure

d. How satisfied are you with your **Care Coordinator**?

- [1] ☐ Extremely Satisfied
- [2] ☐ Somewhat Satisfied
- [3] ☐ Somewhat Dissatisfied
- [4] ☐ Extremely Dissatisfied

9. *Long Term Services and Supports include a variety of services that help people with disabilities meet their daily needs and improve quality of life in the community.* ***A Long Term Services (LTS) Coordinator*** *helps you get the long term services and supports that you need.*

a. Do you need or want an **LTS Coordinator** to help you get long term services and supports?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

b. Were you offered an **LTS Coordinator** by your One Care plan?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

If you selected one of these options (2 or 3), Go to #10 on Page 3

c. Since enrolling in One Care, have you met with an **LTS Coordinator**?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

If you selected one of these options (2 or 3), Go to #10 on Page 3

d. How long was it between enrolling in One Care and meeting with the **LTS Coordinator**?

1 ☐ Less than 1 month
2 ☐ 1 month to less than 2 months
3 ☐ 2 months to less than 3 months
4 ☐ 3 months or more
5 ☐ Don't know/not sure

e. How satisfied are you with your **LTS Coordinator**?

1 ☐ Extremely Satisfied
2 ☐ Somewhat Satisfied
3 ☐ Somewhat Dissatisfied
4 ☐ Extremely Dissatisfied

Assessment and Care Planning Process

10. *Under One Care, your Care Team works with you to identify the services you need by doing an* ***assessment****. During the assessment, someone from your Care Team meets with you to review your medical and other needs, and to discuss your goals, preferences, and concerns.*

a. Did someone from your Care Team meet with you to assess your medical and other needs?

1 ☐ Yes
2 ☐ No……………………**If No, Go to #15 on Page 4**

b. To what extent did the person(s) doing the assessment ask about your personal preferences and goals?

1 ☐ Completely
2 ☐ Somewhat
3 ☐ Not at all

c. To what extent did the person(s) doing the assessment ask about your personal strengths (your skills and abilities, support system, available resources, family support, etc.)?

1 ☐ Completely
2 ☐ Somewhat
3 ☐ Not at all

11. Did the person(s) doing the assessment ask about your needs in each of the following areas? *(Please check a response for each item)*

Medical Services	Yes	No	Not Sure
a. Specialty medical care (Neurology, Podiatry, Orthopedic, Vision, Rheumatology, Gynecology, etc.)	1 ☐	2 ☐	3 ☐
b. Mental health services	1 ☐	2 ☐	3 ☐
c. Substance abuse services	1 ☐	2 ☐	3 ☐
d. Oral and/or dental care	1 ☐	2 ☐	3 ☐
e. Prescription medications	1 ☐	2 ☐	3 ☐
f. Transportation to medical appointments	1 ☐	2 ☐	3 ☐
Long Term Services and Supports	**Yes**	**No**	**Not Sure**
g. Help with personal care (dressing, bathing, etc.) or with everyday tasks (housework, shopping, etc.)	1 ☐	2 ☐	3 ☐
h. Medical equipment (wheelchair, walker, etc.) or medical supplies (catheters, syringes, bandages, etc.)	1 ☐	2 ☐	3 ☐
i. Assistive technology (special software, keyboards, etc.)	1 ☐	2 ☐	3 ☐
j. Help with doing things in the community (going to work, doing leisure activities, etc.)	1 ☐	2 ☐	3 ☐
k. Help with transportation and getting to places you want to go	1 ☐	2 ☐	3 ☐
l. Day program services (Day Habilitation, Clubhouse, Recovery Learning Communities, etc.)	1 ☐	2 ☐	3 ☐

12. To what extent do you feel your needs were identified and discussed during the assessment?

- [1] ☐ Completely
- [2] ☐ Somewhat
- [3] ☐ Not at all

13a. Which of the following types of assistance, if any, did you need to participate in the assessment? *(Check all that apply)*

- [1] ☐ Transportation to appointment
- [2] ☐ American Sign Language interpreter
- [3] ☐ Language interpreter
- [4] ☐ Special physical accommodation
- [5] ☐ Special technology or equipment
- [6] ☐ Peer, friend or family member support
- [7] ☐ Other *(Please specify)*: _______________
- [8] ☐ None of the above……….**If None, Go to #14**

13b. Did the One Care plan provide the help or assistance you needed?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Not applicable. I didn't need One Care to provide the assistance.

14. *Please indicate your level of agreement with each of the following three statements:*

a. I feel the person(s) doing the assessment cared about and listened to my personal preferences, goals, strengths and interests.

- [1] ☐ Agree Completely
- [2] ☐ Agree Somewhat
- [3] ☐ Somewhat Disagree
- [4] ☐ Disagree Completely

b. The person(s) doing the assessment treated me with respect.

- [1] ☐ Agree Completely
- [2] ☐ Agree Somewhat
- [3] ☐ Somewhat Disagree
- [4] ☐ Disagree Completely

c. Overall, I was satisfied with the assessment process.

- [1] ☐ Agree Completely
- [2] ☐ Agree Somewhat
- [3] ☐ Somewhat Disagree
- [4] ☐ Disagree Completely

Your Individual Care Plan

15. *Your **Individual Care Plan** organizes your care to make sure that you receive all the care you need. The plan may include primary and specialty medical care, mental health services, medications, Long Term Services and Supports and other services you need.*

a. Do you have an **Individual Care Plan** under One Care?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

If you selected one of these options, Go to #16 on Page 5

b. Did you agree with what is in your **Individual Care Plan**?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

c. Did you receive a written copy of your **Individual Care Plan**?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

d. Did your Care Team discuss ways to change your **Individual Care Plan,** if needed?

- [1] ☐ Yes
- [2] ☐ No
- [3] ☐ Don't know/Not sure

e. *Please indicate your level of agreement with the following statement*:

Overall, my **Individual Care Plan** includes the services I need.

[1] ☐ Agree Completely
[2] ☐ Agree Somewhat
[3] ☐ Somewhat Disagree
[4] ☐ Disagree Completely

Your Care: Medical Services

The following questions ask whether your needs for certain medical services are being met under One Care.

16. ***Specialty Care***

a. Do you currently use or have a need for **specialty medical care** (Neurology, Podiatry, Orthopedic, Vision Rheumatology, Gynecology or Reproductive Health, etc.)?

[1] ☐ Yes
[2] ☐ No……………………………………**If No, Go to #17**

b. How well are your **specialty medical care** needs being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

17. ***Mental Health Services***

a. Do you currently use or have a need for **mental health** services?

[1] ☐ Yes
[2] ☐ No……………………………………**If No, Go to #18**

b. How well are your **mental health** service needs being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

18. ***Substance Abuse Services***

a. Do you currently use or have a need for **substance abuse** services?

[1] ☐ Yes
[2] ☐ No……………………………………**If No, Go to #19**

b. How well are your **substance abuse** service needs being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

19. ***Oral Health and/or Dental Care***

a. Do you currently use or have a need for **oral health and/or dental care**?

[1] ☐ Yes
[2] ☐ No……………………………………**If No, Go to #20**

b. How well are your **oral health and/or dental care** needs being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

20. ***Prescription Medications***

a. Do you currently use or have a need for **prescription medications**?

[1] ☐ Yes
[2] ☐ No……………………………………**If No, Go to #21**

b. How well are your needs for **prescription medications** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

21. ***Transportation to Medical Appointments***

a. Do you currently use or have a need for help with **transportation to medical appointments**?

[1] ☐ Yes
[2] ☐ No……………………**If No, Go to #22 on Page 6**

b. How well are your needs for help with **transportation to medical appointments** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

Your Care: Long Term Services and Supports

The following questions ask whether your needs for certain long term services and support are being met under One Care.

22. ***Personal Care and Everyday Tasks***

a. Do you currently use or have a need for **help with personal care and/or everyday tasks**?

[1] ☐ Yes
[2] ☐ No……………………………….....**If No, Go to #23**

b. How well are your needs for help with **personal care and/or everyday tasks** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

23. ***Medical Equipment and Supplies***

a. Do you currently use or have a need for **medical equipment** (wheelchair, walker, etc.) **and/or medical supplies** (catheters, syringes, bandages, etc.)

[1] ☐ Yes
[2] ☐ No…………………………………...**If No, Go to #24**

b. How well are your needs for **medical equipment and/or supplies** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

24. ***Assistive Technology***

a. Do you currently use or have a need for **assistive technology** (special software, keyboards, etc.)?

[1] ☐ Yes
[2] ☐ No…………………………………...**If No, Go to #25**

b. How well are your needs for **assistive technology** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

25. ***Doing Things in the Community***

a. Do you currently use or have a need for **help with doing things in the community** (going to work, doing leisure activities, etc.)?

[1] ☐ Yes
[2] ☐ No…………………….…………….**If No, Go to #26**

b. How well are your needs for help **doing things in the community** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

26. ***Transportation and Getting Places***

a. Do you currently use or have a need for help with **transportation and/or getting to places** in the community?

[1] ☐ Yes
[2] ☐ No…………………….…………….**If No, Go to #27**

b. How well are your needs for help with **transportation and getting to places** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

27. ***Day Program Services***

a. Do you currently use or have a need for **day program services** (Day Habilitation, Clubhouse, Recovery Learning Community programs, etc.)?

[1] ☐ Yes
[2] ☐ No…………………….**If No, Go to #28 on Page 7**

b. How well are your needs for **day program services** being met under One Care?

[1] ☐ Very well
[2] ☐ Somewhat
[3] ☐ Not at all

Moving Into One Care

28. *The following questions ask about your experiences during the period while you moved from your previous care into One Care.*

a. Overall, how easy or difficult was it to move into One Care?

- 1☐ Very Easy
- 2☐ Somewhat Easy
- 3☐ Somewhat Difficult
- 4☐ Very Difficult

b. Which of the following, if any, happened to you when you moved from your previous care to One Care? *(Check all that apply)*

- 1☐ A change in provider(s)
- 2☐ Couldn't access needed provider(s)
- 3☐ Got a new service I didn't have before
- 4☐ Loss of a needed service
- 5☐ Disruption in service
- 6☐ None of the above

Your Overall Perception of One Care

The following questions ask about your overall perception of One Care.

29. Overall, how satisfied are you with your **One Care Plan** (Commonwealth Care Alliance, Fallon Total Care, or Network Health Unify)?

Not at all satisfied									**Completely satisfied**
1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

30. Overall, how satisfied are you with the **medical and other services** you are getting under One Care?

Not at all satisfied									**Completely satisfied**
1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

31a. Did anyone tell you that you have the option to drop out of One Care at any time?

- 1☐ Yes
- 2☐ No

31b. Do you plan to stay in One Care?

- 1☐ Yes
- 2☐ No
- 3☐ Don't know/Not sure

About You

The following questions ask about you.

32. Please check yes or no to indicate if you have any of the following disabilities or health conditions.

	Yes	**No**
a. Physical disabilities that make it difficult to walk, move or get around	1☐	2☐
b. Mental or psychiatric problems (depression, anxiety, etc.)	1☐	2☐
c. Problems with alcohol or drug abuse	1☐	2☐
d. Long-term illness (diabetes, heart disease, etc.)	1☐	2☐
e. Developmental disability including intellectual disability or autism	1☐	2☐
f. Learning disability	1☐	2☐
g. Visual impairment or blindness	1☐	2☐
h. Hearing loss or deafness	1☐	2☐
i. Other *(Please specify)*: ________________________	1☐	2☐

33. During the past 12 months, have you experienced homelessness?

- 1☐ Yes
- 2☐ No

34a. What is your age now?

- 1☐ 18 to 24
- 2☐ 25 to 34
- 3☐ 35 to 44
- 4☐ 45 to 54
- 5☐ 55 to 64
- 6☐ 65 or older

34b. What is your gender?

- [1] ☐ Male
- [2] ☐ Female
- [3] ☐ Transgender
- [4] ☐ Intersex
- [5] ☐ Other

34c. What is your sexual orientation?

- [1] ☐ Heterosexual (straight)
- [2] ☐ Gay or Lesbian
- [3] ☐ Bisexual
- [4] ☐ Asexual

35. What is the highest grade or level of school you have completed?

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college degree
- [6] ☐ More than 4-year college degree

36a. Have you worked for pay in the last 12 months?

- [1] ☐ Yes
- [2] ☐ No……………………………………**If No, Go to #37a**

36b. Are you currently working at a job for pay?

- [1] ☐ Yes
- [2] ☐ No

37a. Are you of Hispanic or Latino origin or descent?

- [1] ☐ Yes, Hispanic or Latino
- [2] ☐ No, not Hispanic or Latino

37b. What is your race? *(Check all that apply)*

- [1] ☐ White
- [2] ☐ Black or African-American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or other Pacific Islander
- [5] ☐ American Indian or Alaska Native
- [6] ☐ Other *(Please specify)*: ________________________

37c. What language do you **mainly** speak at home?

- [1] ☐ English
- [2] ☐ American Sign Language (ASL)
- [3] ☐ Arabic
- [4] ☐ Cambodian
- [5] ☐ Chinese
- [6] ☐ Haitian / Creole
- [7] ☐ Laotian
- [8] ☐ Portuguese
- [9] ☐ Russian
- [10] ☐ Spanish
- [11] ☐ Vietnamese
- [12] ☐ Other *(Please specify)*: _______________

38a. Did someone help you complete this survey?

- [1] ☐ Yes
- [2] ☐ No……………………………………**If No, go to END**

38b. Who is the person that helped you? *(Check all that apply)*

- [1] ☐ Legal guardian (could be family member)
- [2] ☐ Other family member
- [3] ☐ Friend
- [4] ☐ Personal care attendant or other provider
- [5] ☐ Other *(Please specify)*: _______________

38c. How did that person help you? *(Check all that apply)*

- [1] ☐ Read the questions to me
- [2] ☐ Wrote down the answers I gave
- [3] ☐ Answered the questions for me
- [4] ☐ Translated the questions into my language
- [5] ☐ Helped in some other way *(Please specify)*: ___________________________

END: Thank you! Please return the completed survey in the postage-paid envelope to:

Office of Survey Research
University of Massachusetts Medical School
333 South Street
Shrewsbury, MA 01545-9803

If you have any questions, please call this toll-free number: 1-888-368-7157.