2021 Rhode Island Medicaid Member Survey

Directions: Thank you for participating in this survey. Your feedback is very important and will help us improve and enhance the way we provide health care in Rhode Island. **Your responses will be kept confidential and your benefits will not be affected in any way by your answers. The survey will take about 4 or 5 minutes to complete.**

You can provide responses electronically by scanning the QR code with your mobile device or emailing/mailing responses described on page 4.

1. **Are you currently enrolled in Medicaid Managed Care and receive your benefits from Neighborhood Health Plan of Rhode Island – TRUST/ACCESS, United Healthcare Community Plan or Tufts Health Public Plan RI Together?**

   ◯ Yes ◯ No ◯ Not Sure / Don't Know

Please tell us about yourself.

2. **What is your age?**

   ◯ Under 18 ◯ 18-24 ◯ 25-34 ◯ 35-44 ◯ 45-54 ◯ 55-64 ◯ 65+

3. **What is your gender?**

   ◯ Female ◯ Male ◯ Non-binary ◯ Transgender ◯ Intersex ◯ Prefer not to answer

   ◯ Prefer to self-describe as: non-binary, gender-fluid, agender, or other (Please specify.)

   _____

4. **Which race/ethnicity best describes you?** *(Please choose only one.)*

   ◯ American Indian or Alaskan Native ◯ Asian ◯ Native Hawaiian or Other Pacific Islander

   ◯ Black or African American ◯ White ◯ Hispanic/Latino

   ◯ Multiple Ethnicities ◯ Prefer not to answer

   ◯ Other (Please specify.)

   _____

Please tell us about your health and health care needs.

5. **How would you describe your health, in general?**

   ◯ Excellent ◯ Good ◯ Fair/Ok ◯ Poor ◯ Very Poor

6. **Do you have a regular health care provider (doctor, nurse, health center, other) you usually go to when you need care?**

   ◯ Yes ◯ No ◯ No, but I would like one ◯ No, I don't need one

   ◯ Other (Please explain)

   _____

7. **In Medicaid Managed Care, a health plan (Neighborhood Health Plan, Tufts Health Plan, or United Healthcare) helps you manage your care. Did you choose the health plan you have now?**

◯ Yes ◯ No ◯ Not Sure / Don't Know

8. **What is most important to you when choosing your current health plan?** *(Choose one or more)*

☐ Whether my current health care provider (doctor, nurse, health center, other) accepts the plan
☐ All the health care providers (doctors, nurses, health centers, others) available to me in the plan
☐ Medicines and treatments covered by the plan
☐ Additional services and benefits offered by the plan (gym membership, gift cards, etc.)
☐ Which plan is considered "the best" or has the highest quality ratings
☐ My own past experience with this health plan
☐ Recommendations from friends/family
☐ Other (Please explain)

9. **If you could change your health plan, would you?**

◯ Yes ◯ No

10. **Do you have someone at your health plan who helps you with your care?**

◯ Yes, I Do ◯ No, but I would like help ◯ No, I don't need help ◯ Not Sure / Don't Know
◯ Other (Please explain)

11. **What do you need help with the most to stay healthy?** *(Choose one or more)*

☐ Finding a health care provider (doctor, nurse, health center, other)
☐ Getting an appointment
☐ Making an appointment
☐ Transportation to my healthcare provider's (doctor, nurse, health center, other) office
☐ Interpreter services
☐ Getting medicines
☐ Getting dental care
☐ Help with food or housing
☐ Help with alcohol or drug misuse
☐ Help with anxiety, depression, or other emotional issues

(continued on next page)

- [ ] Help with diabetes, heart disease, or other conditions
- [ ] Help with long-term services, care at home
- [ ] Hearing aids, glasses, or other medical supplies/equipment
- [ ] Others (Please explain)

- [ ] None of these

12. If you need help, who helps you the most with your health/health care?

- ◯ My health care provider/staff at my health care provider's (doctor, nurse, health center, other) office
- ◯ A home health nurse, aide, or other service provider
- ◯ Someone at my health plan
- ◯ A friend or family member
- ◯ I don't have help/I manage it myself
- ◯ I don't need help
- ◯ Others (Please explain)

13. In the past 6 months, have you stayed overnight as a patient in the hospital?

◯ Yes ◯ No ◯ Not Sure / Don't Know

14. Were you given instructions for how to take care of yourself after going home from the hospital?

- ◯ Yes, I understood what to do
- ◯ I got instructions, but did not understand them all
- ◯ No, I didn't get instructions before going home
- ◯ Others (Please explain)

15. In the past 6 months, have you gone to the Emergency Room for your health care?

◯ Yes ◯ No ◯ Not Sure / Don't Know

◯ Others (Please specify)

Please tell us how much you agree or don't agree with the sentences below:

	Strongly Agree	Agree	Neutral/No Opinion	Disagree	Strongly Disagree
My health plan, health care providers, (doctors, nurses, health center, others) and other caregivers work with me to help me stay healthy.	○	○	○	○	○
My health plan, health care providers, (doctors, nurses, health centers, others) and other caregivers listen to me when I talk about my health care needs.	○	○	○	○	○
My health plan, health care providers, (doctors, nurses, health centers, others) and other caregivers take the time to understand my personal situation/goals.	○	○	○	○	○
I know how to get help/information about my health when I need it.	○	○	○	○	○
I feel in control of my health/my care.	○	○	○	○	○

Thank you for sharing your opinion with Rhode Island Medicaid.

Please send the completed survey by mail to:

RI Executive Office of Health & Human Services
Managed Care Unit
3 West Road
Cranston, RI 02920

or email the completed survey to ohhs.mcooversight@ohhs.ri.gov

Language assistance services are available to you free of charge. Call 1-844-602-3469 (TTY 711).