❖SECTION 3.ATTACHMENT 4 STRIPPS CNA MARKET RESEARCH

Southern Tier Rural Integrated Performing Provider Systems (STRIPPS)

DSRIP Community Needs Assessment (CNA)

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Background and Methodology
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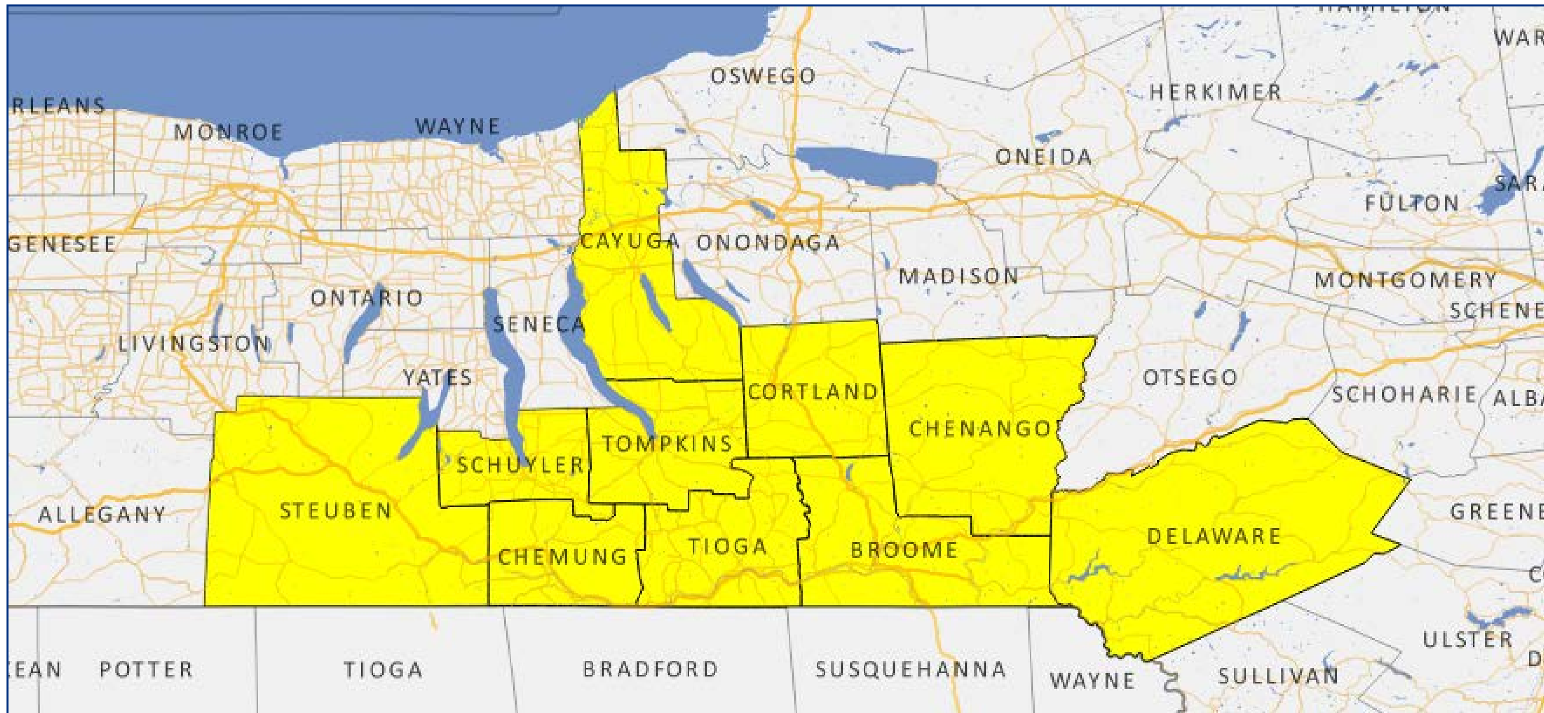
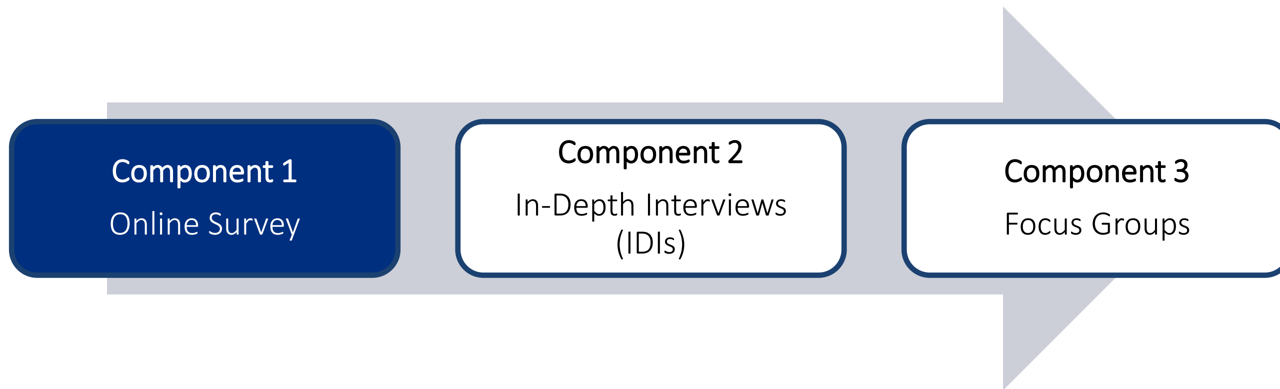
- In September of 2014, several health systems and organizations partnered with Research & Marketing Strategies, Inc. (RMS) as part of its Delivery System Reform Incentive Payment (DSRIP) Program application process. Partnering organizations in this process were United Health Systems (UHS), Lourdes Hospital, Guthrie, Cayuga Medical Center, Cortland Regional Medical Center, and Schuyler Hospital. This regional group is known as the Southern Tier Rural Integrated PPS (STRIPPS). A core function of this DSRIP application process was a Community Needs Assessment (CNA). The CNA addresses a market area size of 10 counties in the Central and Southern region of New York State commonly referred to as the Southern Tier. Specifically the STRIPPS team was looking to better understand the needs and barriers related to area healthcare services from the Medicaid and uninsured population, as well as healthcare providers and community organizations. In particular they wanted to learn what it would take to help this population segment reduce its inappropriate (unnecessary) emergency room utilization.

- The Community Needs Assessment spanned across a 10-county area including: Broome County, Cayuga County, Chemung County, Chenango County, Cortland County, Delaware County, Schuyler County, Steuben County, Tioga County, and Tompkins County. In order to get a full representation of the healthcare marketplace in the STRPPS market area, RMS conducted a 3-tier qualitative and quantitative market research study: (1) an online survey shared with healthcare providers, community leaders across many organizations, and to the general community, (2) telephone in-depth interviews with healthcare providers and community leaders, and (3) focus groups across the 10-county area with recruited community residents. Full data files for the online survey and in-depth interviews (IDIs) were delivered as separate documents to the client. Transcripts were also passed to the DSRIP co-chairs as separate files.

10 County PPS	
Broome	Delaware
Cayuga	Schuyler
Chemung	Steuben
Chenango	Tioga
Cortland	Tompkins



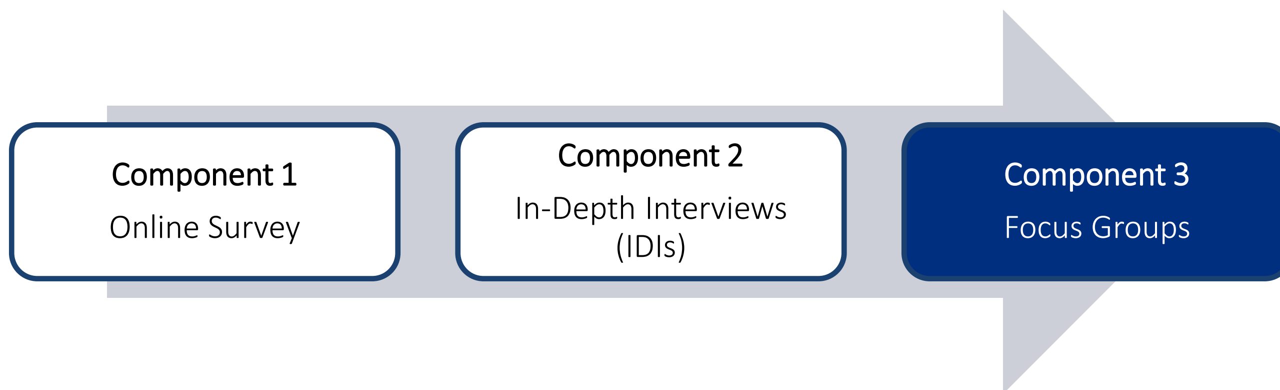


- The first component of the market research study for the CNA was an **online survey**. The online survey had three separate branches of questions depending on the type of respondent taking the survey. The first audience was comprised of healthcare providers, physicians, or practice managers in organizations that provide healthcare. The second audience was comprised of respondents working in community outreach, long-term care services, or I work as non-clinical healthcare employee. The third audience consisted of general community members that did not self-select into the first two audiences. These community member completes included those with Medicaid insurance or those uninsured.

- The online survey took approximately **7 to 10 minutes to complete**. A variety of different invitation tactics were used including email, general survey links posted to healthcare organization websites, links posted through paid and organic social media boosts, links placed in various newspapers, newsletters and publications across the 10-county area, and flyers posted at various healthcare and community organizations (including provider offices, walk-ins, outpatient programs, and the Department of Social Services (DSS)). Fieldwork for the online survey began on October 10th and lasted through November 14th (approximately 1 month). A total of **2,011 surveys were completed** for the CNA quantitative portion of this market research. Survey participants were offered entry into a raffle to win one of five separate $100 gift cards.

- The second component of the market research study for the CNA was **telephone in-depth interviews (IDIs)**. The IDIs were focused solely to the first two audiences from the online survey which were (1) healthcare providers, physicians, or practice managers in organizations that provide healthcare or (2) respondents working in community outreach, long-term care services, or work as non-clinical healthcare industry employee. Efforts were also made to recruit individuals that could provide meaningful data and experiences relative to the DSRIP projects. This included obtaining input from individuals who had experience in serving patients with chronic diseases, mental health issues, long-term care knowledge, primary care and prevention specialization. Ultimately, recruits were targeted to better understand inappropriate hospital admissions and ED visits.

- The IDIs took approximately **20 to 30 minutes** to complete. Participants from the online survey were asked to opt-into future research opportunities for the healthcare research. RMS used its on-site data center to place recruitment calls and conduct the IDIs with each audience. Fieldwork for the IDIs began on October 21st and lasted until November 11th. A total of **90 IDIs** were completed: **38 from the healthcare provider audience and 52 from the community leader audience**. As a thank you for their time participants in the first audience were offered a $200 honorarium and the community organization participants were offered a $100 honorarium.



- The third component of the market research study for the CNA was **focus groups**. The focus groups were comprised of the Medicaid and uninsured audiences from the online survey which were recruited from the community resident respondent pool, and those recruited from the DSS. A total of **15 focus groups were held across the STRIPPS 10-county market area**. Participants from the online survey were asked to opt-into future research opportunities for the healthcare research. RMS used its on-site data center to place recruitment calls for the focus groups with this audience. Participants were also recruited through intercept surveys conducted at several local Department of Social Service (DSS) locations. Focus group participants were screened to ensure they: (1) currently have either Medicaid or are insured (or had a child with Medicaid), (2) had the ability to read, write, and listen without limitations; and (3) lived in one of the 10 designated counties for the research study. A mix of parameters were sought as part of the recruitment process. These parameters included a variety of age groups, employment status, educational attainment, marital status, ethnicities, health status, rural versus urban residence, and home ownership versus rental status. Efforts were also made to recruit individuals that could provide meaningful data and experiences relative to the DSRIP projects. This included patients with a mix of mental health and chronic conditions to help the client better understand inappropriate hospital admissions and ED visits.

- RMS and STRIPPS worked collaboratively to develop a Moderator's Guide and Participation Packet used in the groups. Copies of these documents are included in the appendix of this report. The focus group sessions totaled **90 minutes in duration** and were held throughout the 10-county area. A **total of 127[1] respondents participated in the focus group sessions**. The focus group were held at a variety of community organizations, libraries, churches, and fire halls. Participants were paid an honorarium of $75 for their time.

[1] One focus group in Corning, NY was replaced with an in-person IDI. Others from this group were moved into the second of two consecutive groups.

- The number of focus groups were broken down to account for counties with higher populations of Medicaid residents. The chart below details how RMS and STRIPPS estimated the proportion of focus groups needed by county among the 16 planned sessions. The data shows that multiple groups were warranted for Broome, Chemung, and Steuben counties. The breakdown of focus groups was approved by STRIPPS.

Social Services District	Total Medicaid Enrollees 2013	% of PPS 10 County Market	Expected Number of FGs (n16)	Actual Number of FGs (n16)
Broome	46,527	28.2%	4.5	5
Cayuga	15,461	9.4%	1.5	1
Chemung	22,234	13.5%	2.2	2
Chenango	11,831	7.2%	1.1	1
Cortland	10,923	6.6%	1.1	1
Delaware	9,746	5.9%	0.9	1
Schuyler	4,268	2.6%	0.4	1
Steuben	20,973	12.7%	2.0	2
Tioga	9,775	5.9%	0.9	1
Tompkins	13,443	8.1%	1.3	1
	165,181	100.0%	16.0	16

- The focus group were held across a series of three consecutive days. To mitigate barriers of participation including transportation, childcare, and employment constraints, both morning and evening sessions were held across the 10-county market area for STRIPPS. Where possible, focus groups were held at locations that required a minimal (if any) fee, and were along bus routes. The focus groups were moderated by Mark Dengler (President and Owner of RMS), George Kuhn (Director of Research Services at RMS), Michele Treinin (Healthcare Analyst at RMS), and Erica Winters (Research Analyst at RMS).

Date	County	City & Location	Start Time
Tuesday 11/4/15	Broome	Binghamton (Your Home Library)	9:30 AM, 11:00 AM, 2:30 PM, 4:00 PM
	Chemung	Elmira (Steele Memorial Library)	9:30 AM, 11:00 AM
	Tioga	Owego (Owego United Methodist Church)	2:30 PM
Wednesday 11/5/14	Delaware	Delhi (First Presbyterian Church)	11:00 AM
	Broome	Vestal (Vestal Public Library)	3:30 PM
	Steuben	Corning (United Way of the Southern Tier)	9:30 AM, 11:30 AM
	Schuyler	Watkins Glen Public Library)	2:30 PM
Thursday 11/6/14	Chenango	Norwich (Guernsey Memorial Library)	11:00 AM
	Cortland	Cortland (Phillips Free Library)	3:30 PM
	Tompkins	Ithaca (Office of the Aging)	11:00 AM
	Cayuga	Moravia (Moravia Volunteer Fire Department)	3:30 PM

Online Survey Audience	Completes
I am a healthcare provider, physician, or work in an organization that provides healthcare.	345
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.	505
Neither of the above statements, I am a community resident.	1,161[1]
Total	**2,011**

In-Depth Interview (IDI) Audience	Completes
I am a healthcare provider, physician, or work in an organization that provides healthcare.	38
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.	52
Total	**90**

Focus Group Participants by County	Completes
Broome	54
Tompkins	12
Delaware	11
Chemung	10
Schuyler	9
Cayuga	8
Steuben	8
Chenango	7
Tioga	7
Cortland	5
Total	**131[2]**

[1] Among the 1,161 community resident completes, 375 were Medicaid or uninsured.
[2] Of the 131, 4 were participation packet completes only.

Executive Summary
Online Survey
In-Depth Interviews
Focus Groups
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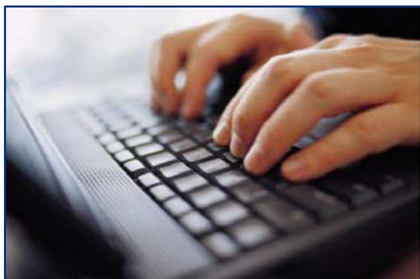
- Participants in the STRIPPS Community Needs Assessment (CNA) found the process engaging and mentioned it was a valuable way to provide feedback on healthcare needs in their community. Community residents **particularly found the focus group and small group discussion format as an informal and informative way to share needs, challenges, barriers, and opportunity areas for improvement in the healthcare community**. Many opted into future research opportunities with STRIPPS and enjoyed being paid for their time. Social media (particularly Facebook) played a major role in recruiting Medicaid and uninsured residents to participate in the online survey and in the focus groups. **Social media needs to play a prominent role in future outreach, communication, and engagement** among the Medicaid and uninsured audience.

- The STRIPPS needs to work on **promoting awareness of its community based organizations, assistance organizations, and the 2-1-1 phone helpline** among the Medicaid and uninsured populations. These service resources all had minimal awareness among residents in both urban and rural counties of the STRIPPS geography. Education of these resources needs to be built through word-of-mouth, healthcare settings, and through the internet (websites and social media). In addition to building general awareness of resources, an **educational campaign should also be built around appropriate usage of the Emergency Department (ED)**. Many **Medicaid and uninsured residents were unaware of other non-ED healthcare provider options available to them** in their area such as free clinics, after-hours care, and urgent care centers. This information could also be shared by primary care physicians (PCPs) with patients to help them understand a step-by-step process to manage potential complications including explanations of when it is and is not appropriate to use the ED.

- Transportation proved to be a major barrier to accessing appropriate healthcare services among the Medicaid and uninsured population. In addition to no up-front cost and financial savings for using the ED, many residents also chose the ED because of convenience reasons related to no access to transportation. STRIPPS should **consider working with Medicaid to create more availability of taxi vouchers or improving no or low cost and convenient travel options to non-ED related medical facilities**.

- It is clear that the Medicaid recipients do not fully understand the Medicaid program. Many reported frustration in signing up, minimum income levels, and other limitations with the program. There is a perception that Medicaid participants feel as though they are "owed" quality, free care by the healthcare system because they believe they have been hampered by other life challenges and healthcare barriers. As a result, there is little to no incentive to remove themselves from Medicaid and obtain a different type of healthcare coverage. In the end, the financial benefits of being on Medicaid outweigh the barriers. STRIPPS needs to **work to align financial benefits and lifestyle benefits to encourage recipients to remove themselves from Medicaid**.

- The DSRIP project initiatives (in general) will incur some barriers and challenges on a global level across the STRIPPS geography. A major draw to using the ED by the Medicaid population is the no up-front cost to receive treatment. Up front out-of-pocket cost to receive healthcare is a major concern for the Medicaid population. These **benefits for Medicaid participants seem to be misaligned with the goals of DSRIP**. DSRIP is attempting to discourage inappropriate usage of the ED, while using the ED is highly beneficial for Medicaid recipients (potential ambulance transport, no out-of-pocket cost, immediacy of being seen, visiting with doctors, receiving medications). There is no strong disincentive or penalty for using the ED according to Medicaid recipients.



- The Medicaid and uninsured populations are very comfortable with the internet and online platforms. When healthcare services are needed, most attempt to self-treat by going online to seek out condition information, symptoms, and treatment options. This type of behavior **highly supports an online or telephone navigator resource to assist Medicaid and uninsured recipients in searching for healthcare options, finding solutions, and receiving treatment** (e.g., a regional WebMD or online chat with triage nurses).

- STRIPPS should work on **training and educating its physicians on the importance of provider-to-patient communication. RMS's client HCAHPS® and CG-CAHPS® scores continually reaffirm that (1) a provider's ability to communicate with the patient and (2) the provider's ability to answer questions are the two largest predictors of likelihood to recommend a hospital or a provider and overall patient satisfaction (PSAT) in healthcare**. Providers should look to spend adequate time with patients regardless of insurance status or coverage and promote preventive behavior rather than treating patients pharmacologically. Medicaid participants believed physicians knew they were Medicaid recipients, and as a result their quality of care was impacted negatively and they were offered limited availability of appointments.

- STRIPPS should look to continually **recruit talented physicians and specialists** to the geography. A special focus should be paid to **specialties in need such as dental and mental health**. Furthermore, an emphasis should be placed on accepting Medicaid patients and a system to incentivize physicians should be created for doing so. STRIPPS should also look to increase the availability and quality of mid-level providers to handle less critical Medicaid healthcare needs.

- **Preventive behavior and promoting healthy lifestyles among the Medicaid and uninsured populations should begin in schools**. Many participants in the focus groups suggested that healthy eating and healthy living promotions should be encouraged and taught in school. This long-term recommendation would help future Medicaid recipients learn how to live a healthy lifestyle from an early age. It would also help current children in school teach these habits to at-home parents in the short-term.

- Much of **DSRIP is tightly aligned with the benefits of adopting a Patient-Centered Medical Home (PCMH) model** of care. STRIPPS should promote the dissemination of PCMH and PCMH-N among its Performing Provider System ambulatory settings. The clinical integration encouraged by NCQA standards touches upon many of the projects recommended by STRIPPS. The power of PCMH is **improving quality, cost, and the experience of the patient**. It focuses on various aspects of patient care including: access and communication, managing patient populations, planning and managing patient care, providing self-care support and community resources, and tracking and coordinating care. The PCMH journey is one in which physician practices transform care to be that which adopts a model that emphasizes care coordination, as well as provider-patient communication. Practices focus their efforts on patient outreach to ensure compliance with preventive health services, such as immunizations, annual physicals (as age appropriate), and mammogram services. Practices also reach out to patients that are overdue for testing or who are at risk based upon clinical indicators, such as elevated blood pressure, elevated cholesterol, and hemoglobin A1Cs. The goal is to improve compliance with services and to bring clinical laboratory results to normal ranges. Performance reports are shared among providers and staff to emphasize the care-team approach to managing patients. The care team model is well integrated in practices through daily team huddles, regularly scheduled staff meetings as well as specific in-services which emphasize population management and chronic disease management. Ultimately, the goal is to focus on coordinated patient care with a goal to better manage patients at risk, those that are high risk, and the vulnerable population.

STRIPPS DSRIP IDENTIFIED NEEDS
Updated 12/5/12

	General Needs	Description		IDIs: Healthcare Providers	IDIs: Community Leaders	Focus Groups: Medicaid Recipients	Online Survey: Healthcare Providers	Online Survey: Community Leaders	Online Survey: Medicaid Recipients	Online Survey: General Residents
A	Need ready access to mental health and substance abuse services	Those residents in need are seeking solutions for mental health and substance abuse conditions but running into barriers. Constituent groups indicated need for more providers, improved ability to get timely appointments, and the ability to see appropriate providers for appropriate condition(s).	*Data*	43% rated mental health as the most critical need	19% rated mental health as the most critical need	Yes, confirmed as a need	10% rated mental health as the most pressing need	9% rated mental health as the most pressing need	3% rated mental health as the most pressing need	3% rated mental health as the most pressing need
			Rank	1 of 5	3 of 5	-	1 of many	4 of many	10 of many	4 of many
			Question #	Q7, Q12, Q14, Q21, Q41, Q47, Q55, Q56, Q58, Q60, Q63, Q72	Q25, Q27, Q29, Q37, Q41, Q43, Q44, Q46, Q47, Q51, Q52, Q53, Q54, Q62, Q72, Q76	-	Q51, Q52, Q69, Q70, Q71	Q51, Q52, Q68, Q69, Q70, Q71	Q52, Q87, Q92	Q51, Q87, Q94
B	Access to transportation for non-ED related healthcare provider and community resource services	Constituencies indicated there were not enough transportation options and current options are unreliable and time consuming to seek out. This proves to be a barrier to access any non-ED options.	*Data*	18% rated it as the most critical need	29% rated it as the most critical need	Yes, confirmed as a need	10% rated transportation as the most pressing need	14% rated transportation as the most pressing need	2% rated transportation as the most pressing need	4% rated transportation as the most pressing need
			Rank	3 of 5	1 of 5	-	1 of many	1 of many	9 of many	6 of many
			Question #	Q3, Q14, Q21, Q39, Q40, Q41, Q46, Q47, Q52, Q53, Q56, Q57, Q58, Q60, Q62, Q63, Q68, Q72	Q23, Q25, Q29, Q37, Q39, Q40, Q41, Q43, Q44, Q46, Q47, Q52, Q53, Q58, Q60, Q62, Q64, Q68, Q72, Q76	-	Q51, Q52, Q66, Q67	Q51, Q52	Q45, Q52, Q82, Q91	Q45, Q51, Q91
C	More awareness of available healthcare service options beyond the ED	Constituencies recognized that many ED visits were in fact inappropriate. Many users were unaware of other available healthcare options they could utilize at the time of need.	*Data*	13%	15%	Yes, confirmed as a need	9% rated accessibility as the most pressing need	10% rated accessibility as the most pressing need		9% rated accessibility as the most pressing need
			Rank			-	2 of many	3 of many		2 of many
			Question #	Q16, Q20, Q21, Q41, Q46, Q47, Q52, Q53, Q54, Q56, Q58, Q72	Q41, Q52, Q53, Q56, Q72	-	Q51, Q52	Q51, Q52	Q43, Q52, Q61	Q43, Q51, Q61
D	More providers who accept those with Medicaid or have no insurance	Research participants indicated that the supply of providers in the STRIPPS geography who accept Medicaid or accept those with no insurance is too small relative to the demand, particularly in key specialty, sub-specialty, and dental care service areas.	*Data*	21% rated it as the most critical need	25% rated it as the most critical need	Yes	9% rated accessibility as the most pressing need	10% rated accessibility as the most pressing need	3% rated access to doctors as the most pressing need	
			Rank	2 of 5	2 of 5	-	2 of many	3 of many	3 of many	
			Question #	Q41	Q41, Q44, Q52, Q53	-	Q51, Q66, Q67	Q51, Q52, Q66, Q67	Q52, Q82, Q83	Q51
E	Healthcare needs to be more affordable to promote engagement	Medicaid recipients indicated that any out-of-pocket cost is a deterrent to accessing healthcare services. Any point-of-service (POS) cost outlay for the patient is a barrier (e.g., co-pays to seeking or receiving care). The healthcare audience and community leaders agreed Medicaid recipients and the uninsured abuse the ED for this reason.	*Data*	5% rated it as the most critical need	12% rated it as the most critical need	Yes, confirmed as a need	8% rated affordable healthcare as the most pressing need	10% rated affordable healthcare as the most pressing need	7% rated affordable healthcare as the most pressing need	18% rated affordable healthcare as the most pressing need
			Rank	5 of 5	5 of 5	-	3 of many	3 of many	1 of many	1 of many
			Question #	Q41	Q41	-	Q51, Q52, Q66, Q67	Q51, Q52, Q66, Q67	Q52	Q51

Community Needs Assessment Overview (Page 2) – Summary from All 3 Components of the CNA

STRIPPS DSRIP IDENTIFIED NEEDS

Updated 12/5/12

	General Needs	Description		IDIs: Healthcare Providers	IDIs: Community Leaders	Focus Groups: Medicaid Recipients	Online Survey: Healthcare Providers	Online Survey: Community Leaders	Online Survey: Medicaid Recipients	Online Survey: General Residents
F	Preventive care and wellness lifestyle	Medicaid recipients and those uninsured recognize the need to take ownership of one's health however they do not regularly engage in preventative care and/or wellness efforts. About two-thirds of Medicaid recipients and those uninsured see a PCP regularly, so the ability to discuss prevention and wellness options are limited for some but not most. Among those who see a PCP regularly, residents believe the PCPs need to better communicate preventative actions and discuss healthy lifestyle choices beyond solely treating the condition which warranted the patient's visit. Those with Medicaid and no insurance need to feel more accountable to be proactive with regard to healthy lifestyles.	*Data*			Yes, confirmed as a need	9% rated prevention and wellness as the most pressing need	6% rated preventiion and wellness as the most pressing need		
			Rank			-	2 of many	7 of many		
			Question #	Q54, Q63, Q64	Q29, Q30b, Q37, Q43, Q44, Q47, Q52, Q53, Q55, Q56, Q58, Q63, Q64, Q72	-	Q51, Q52	Q51, Q52	Q52	Q51
G	Need for accessible primary care outlets where a physician can be seen	The ED is a highly used source of care for the uninsured and Medicaid population in the STRIPPS PPS. Among those with a PCP, many still visit the ED outside of PCP office hours as needed or when they feel the wait time for an appointment is too long.	*Data*			Yes, confirmed as a need	7% rated focus on primary care as the most pressing need	4% rated focus on primary care as the most pressing need	3% rated access to doctors as the most pressing need	9% rated accessibility as the most pressing need
			Rank			-	4 of many	8 of many	3 of many	2 of many
			Question #		Q25, Q52, Q53, Q72	-	Q52	Q52	Q87	Q87
H	An improved and equitable provider reimbursement system for Medicaid	The healthcare participants, community leaders, and Medicaid recipients were all aware of the current low reimbursement offerings to providers for Medicaid visits. Many recipients believed this notion impacts their quality of care. As a result, in some cases recipients believed providers would attempt to maximize revenue from each Medicaid patient per visit.	*Data*			Yes, confirmed as a need	5% rated better reimbursement as the most pressing need			
			Rank			-	6 of many			
			Question #	Q3, Q7, Q21, Q44, Q46, Q47, Q55, Q72, Q76	Q25, Q29, Q44, Q46, Q47, Q56	-	Q52			
I	Providers offering better visitation hours to access non-emergent healthcare services, including weekend hours	Medicaid recipients stated that after-hours options for care were limited or unavailable particularly in rural counties. Among the STRIPPS geographies that offered after-hours care options, the hours were not extended enough. The fact that the ED offers 24/7 availability results in a consistently available option of choice for the Medicaid and uninsured population.	*Data*			Yes, confirmed as a need	9% rated accessibility as the most pressing need	10% rated accessibility as the most pressing need	3% rated access to doctors as the most pressing need	9% rated accessibility as the most pressing need
			Rank			-	2 of many	3 of many	3 of many	2 of many
			Question #	Q47, Q52, Q54, Q56, Q72	Q44, Q52, Q55, Q57, Q68, Q72	-	Q66, Q67	Q66, Q67	Q57, Q89, Q90	Q57, Q89, Q90
J	A need for delivery system integration and care coordination	All constituencies indicated that current healthcare is delivered in a silo model, very segregated. There needs to be more coordination and clinical integration across all healthcare entities to improve care and reduce redundancy.	*Data*			Yes, confirmed as a need		8% rated communication and coordination as the most pressing need	3% rated coordination of care as the most pressing need	
			Rank			-		6 of many	5 of many	
			Question #	Q36, Q38, Q47, Q53, Q57, Q58, Q72	Q30b, Q37, Q54, Q55, Q56, Q57, Q72	-		Q52	Q82	

Community Needs Assessment Overview (Page 3) – Summary from All 3 Components of the CNA

STRIPPS DSRIP IDENTIFIED NEEDS
Updated 12/5/12

	General Needs	Description		IDIs Healthcare Providers	IDIs Community Leaders	Focus Groups Medicaid Recipients	Online Survey Healthcare Providers	Online Survey Community Leaders	Online Survey Medicaid Recipients	Online Survey General Residents
K	Improved provider-to-patient communication	Medicaid recipients and those with no insurance had a perception that their provider was aware of their status as a Medicaid beneficiary and as a result, this caused a perceived lower-level of care and less attention spent on the patient. Many Medicaid participants believed providers did not spend an appropriate amount of time communicating with them and were too quick to push prescriptions as a solution.	*Data*			Yes, confirmed as a need		8% rated communication and coordination as the most pressing need	2% rated better quality doctors as the most pressing need	
			Rank			-		6 of many	10 of many	
			Question #		Q44, Q57, Q62, Q68, Q72	-		Q51	Q82	Q51
M	Improved integration of mental health and other provider blended treatment approaches, particularly around follow-up care	Constituencies indicated that mental healthcare needs to become entwined with traditional clinical care and blended more. Not all treatment needs to be cared for through a pharmalogical solution. Respondents desired a more holistic approach to treating patients.	*Data*			Yes, confirmed as a need		8% rated communication and coordination as the most pressing need	3% rated coordination of care as the most pressing need	
			Rank			-		6 of many	5 of many	
			Question #	Q43, Q53, Q56, Q63, Q72	Q30b, Q32, Q34, Q35, Q36, Q37, Q40, Q43, Q47, Q53, Q56, Q64, Q72	-	Q51, Q66, Q67	Q51, Q52, Q66, Q67	Q82	Q51
N	More offered awareness of community support organizations and the services	There was low awareness of the 2-1-1 directory and various support organizations throughout the community. Organizations need to better work to promote their services throughout various channels including social media.	*Data*			Yes, confirmed as a need				
			Rank			-				
			Question #	Q75	Q52, Q53, Q54, Q58, Q60	-	Q66, Q67	Q51, Q66, Q67		
O	Need to fix the basics of the Medicaid program from referral process to reduce visits to ED	Constituencies agreed that Medicaid as it exists today actually incentivizes recipients to receive care from the ED by removing any out-of-pocket costs.	*Data*			Yes, confirmed as a need		4% stated coverage as the most pressing need		8% stated coverage as the most pressing need
			Rank			-		10 of many		4 of many
			Question #	Q7, Q40, Q44, Q52, Q54, Q60, Q62, Q63, Q66, Q67, Q68, Q72	Q46, Q60, Q66, Q67, Q72, Q76	-	Q66, Q67	Q66, Q67	Q45, Q51, Q57	Q45, Q52, Q57
P	Need to have centralized resource to advise patients where to go for appropriate care	The Medicaid population needs to have reference resources that can teach and guide them where to receive the most appropriate care. Focus group participants described this as a "fast track" style system whereby patients are triaged and then are sent to the most appropriate setting for care. The PCMH model of care was well-received.	*Data*			Yes, confirmed as a need				
			Rank			-				
			Question #	Q54, Q69, Q70	Q54, Q69, Q70	-	Q73, Q74	Q73, Q74	Q60	Q59, Q60, Q73, Q98
Q	Need for greater education around the appropriate setting for healthcare	Constituencies indicated that they believe the Medicaid and uninsured population need to be told and coached as to the most appropriate setting for care.	*Data*	13% rated it as the most critical need	15% rated it as the most critical need	Yes, confirmed as a need	10% rated education as the most pressing need	12% rated education as the most pressing need	2% rated education as the most pressing need	4% rated education as the most pressing need
			Rank	4 of 5	4 of 5	-	1 of many	2 of many	7 of many	7 of many
			Question #	Q37, Q40, Q41, Q43, Q44, Q47, Q52, Q53, Q54, Q56, Q60, Q62, Q72, Q76	Q25, Q30b, Q37, Q41, Q47, Q53, Q54, Q55, Q56, Q72	-		Q51	Q52	Q51
R	Need for improved education regarding the quality of Medicaid clinical providers such as Nurse Practitioners and Physician's Assistants	Many Medicaid recipients wanted to see a physician and were disappointed when they to visit a mid-level. Some felt they received lesser quality care. Rural residents were more understanding and receptive to mid-level provider visits.	*Data*			Yes, confirmed as a need				
			Rank			-				
			Question #	Q53	Q53	-				

Project 3ai: Integration of Behavioral Health and Primary Care
Objective: Integrate behavioral health (BH) and substance abuse care with primary healthcare services to ensure coordination of care for both services and a more comprehensive approach to healthcare delivery.
Update: Will focus primarily on a model that brings BH into PCMH primary care practices. Level of patient activation will be measured as well as the number of BH screenings performed in the PCP setting.

- **Part 1:** In the in-depth interview (IDI) portion of the CNA research, participants in both the healthcare audience and community leader audience confirmed that there were significant communication issues between primary care physicians (PCPs) and mental health providers. Communication between these two particular specialty segments is worse than among the other segments. The healthcare audience in the IDIs also referenced the availability of mental health services as the most critical healthcare need (43%) for the Medicaid and the uninsured. In addition both the healthcare audience and community leader online survey respondents believed that mental health conditions were the number one reason for ED visits and readmissions among the Medicaid and uninsured populations. Substance abuse issues ranked 3rd among the community leader audience during the IDI research, in which 9% stated it was the number one reason for ED visits or readmissions.

  The project (3ai) would primarily focus on a delivery model that brings BH into PCMH (Patient-Centered Medical Home) primary care practices to better serve patients under one roof for clinical healthcare needs. When the healthcare audience was asked if its practice was PCMH, only 19% were certain their respective practice was PCMH recognized or accredited which indicates that only 1 out of every 5 practices have adopted a PCMH model currently based on the online survey data in the CNA. The vast majority knew their recognition or accreditation was from NCQA. Less than 20% reported Level 1 recognition (14%), 12% reported a Level 2 recognition, and 41% reported a Level 3 recognition. About one-third were unsure of their level. This indicates a baseline and opportunity for future measurable improvements to higher levels of PCMH among primary care practices in the STRIPPS allowing for stronger enhancement of behavioral health offerings.

In addition to the strong need for better mental health and PCP collaboration, there is an evident need among Medicaid recipients for increased availability of mental health services. In the online survey portion of the CNA, general community residents (those insured with a non-Medicaid plan), 87% rated their mental health as excellent or near excellent (a 4 or 5 on a 1 to 5 scale). However, only 60% of those with Medicaid or no insurance rated it excellent or near excellent (a 4 or 5 on a 1 to 5 scale). This represents a 27% point gap between community resident audiences with regard to mental health services which indicates further need for better coordination and behavioral health screenings and management from PCPs. When asked about chronic diseases, 29% of those with Medicaid or no insurance stated they have a mental health chronic condition with was 19% points higher than the general population (10% having chronic mental health conditions).

- **Part 2:** Potential challenges facing this project to better integrate behavioral health and primary care start with communication and delivery system integration issues. Medicaid recipients in the focus groups were skeptical of the multiple providers being able to share patient data between healthcare systems or across providers without issues. Only two-thirds of Medicaid recipients or those without insurance visit a PCP on a regular basis so patient activation and screenings might not be able to reach all Medicaid recipients through a PCMH model. Among those with Medicaid or no insurance who see PCPs on a regular basis report a lack of patient attention at the visit and a feeling of being rushed so medications can be pushed to the patient and the doctor can move to the next patient. Addressing behavioral health concerns in addition to routine primary care will force physicians to spend more time with Medicaid recipients which may be a barrier for PCPs due to lower reimbursement. Medicaid recipients also reported long wait times, PCPs not accepting new Medicaid patients, and other barriers that may not allow the integrated mental health and PCP design to be fully vetted as intended. Low adoption of the PCMH model may be a provider barrier. Benefits of PCMH and higher reimbursement will need to be communicated to practices. The project must work to increase PCP access and eliminate patient barriers for visiting PCPs. A larger portion of the Medicaid population needs to be encouraged to visit a PCP regularly by eliminating usage barriers among patients. In addition, PCPs and mental health providers need to embrace a patient-centered medical home model and be willing to communicate with patients and spend the time needed to fully treat a patient for all of his or her needs beyond simply primary care. Regular training and continuing medical education sessions need to focus on providing PCPs with tools to better integrate BH into their services and open a dialogue between the BH and primary care provider communities.

Project 2ci: Development of Community Based Health Navigation Services
Objective: Develop community-based healthcare navigation services to assist patients in accessing appropriate healthcare services efficiently.
Update: Will use existing 211 infrastructure to identify individuals in need of navigation services. Will cover entire STRIPPS geographic region.

- **Part 1:** Low healthcare literacy, low awareness of community resources, language barriers, and lack of engagement with one's health care providers can result in avoidable use of hospital services. People who do not understand how to access and use the healthcare system cannot be expected to use it effectively. This project is targeted to persons utilizing the healthcare system but doing so ineffectively or inappropriately. The intended navigation services will provide bridge support until the patient has the confidence to self-manage his/her health. These community resources will not necessarily be provided by licensed health care providers, but persons trained to understand and access the community care system. The navigators will most likely be persons from the particular community. For example, navigators will assist patients with scheduling appointments and obtaining community services. Navigators will be resourced in-person, telephonically, or online. They will also have access to language services and low literacy educational materials. Medicaid and uninsured survey respondents recognized that many ED visits were in fact inappropriate. Many users were unaware of other available healthcare options they could utilize at the time of need, supporting the need for community-based health navigation services to assist patients in accessing appropriate healthcare services efficiently. On scale of 1-5 (5 being very life threatening and 1 being not at all life threatening), only 28% of Medicaid and uninsured survey respondents felt their condition was life threatening (rating of a 4 or 5) for their most recent visit to the ED, and 48% did not consider alternate options besides the ED for that visit. There appears to be a lack of awareness for alternative treatment options, as 41% of Medicaid and uninsured survey respondents feel most people do not know other treatment options besides the ED for non-life threatening conditions. More than half of Medicaid and uninsured survey respondents (68%) have not received after hours care at any location other than the ED.

Provider and community leader IDI respondents believe there is a low level of awareness for the 2-1-1 directory and various support organizations throughout the community. A large majority of Medicaid and uninsured survey respondents (84%) have never dialed the 2-1-1 directory, and 70% do not turn to community resources for assistance with chronic conditions. Organizations need to better work to promote their services throughout various channels including social media. A significant number of focus group participants were recruited through social media publicity, so it is apparent that these platforms (particularly Facebook) are effective for reaching the Medicaid and uninsured populations.

The Medicaid population needs to have reference resources that can teach and guide them where to receive the most appropriate care. There was a general sense from the focus groups that the Medicaid recipients would like resources which will guide them on where they can receive the most appropriate care. Focus group participants suggested a potential solution would be a "fast track" style system where patients are triaged and sent to the most appropriate setting for care. IDI participants supported this finding of resource needs for the Medicaid population to determine an appropriate setting for care), with 13% of the Healthcare audience and 15% of the Community Non-Clinical audience indicating that they believe the most critical need to address is providing education for the Medicaid and uninsured population to make them aware of healthcare options. The Medicaid population largely indicated that they are not aware of community organizations and resources (including 2-1-1) and as a result, do not turn to community resources. Until awareness can be built and the Medicaid population learns how these services will benefit them without incurring an out of pocket cost, our research indicates that these will not be beneficial.

- **Part 2:** Potential challenges with implementing community-based health navigation services and using the 2-1-1 directory lie with awareness. The Medicaid and uninsured population is largely unaware of the existence of 2-1-1 today and do not turn to community resources for assistance with medical needs. Promoting and building awareness among these populations on the currently available healthcare resources should be a priority, with emphasis being placed on options that do not incur an out-of-pocket cost. Among focus group participants who were knowledgeable regarding healthcare options other than the ED, the upfront cost of a walk-in clinic or urgent care facility was enough of a deterrent to make the long wait in the ED a more attractive option. Education on available resources will be beneficial, but ultimately the out-of-pocket cost to the Medicaid or uninsured patient will undoubtedly be the key driver behind the final choice of where they receive healthcare.

Project 2di: Patient Activation ("Project 11")
Objective: Engage and activate the uninsured (UI), non-utilizing (NU) and low-utilizing populations to increase utilization of primary and preventative care services and increase the level of patient engagement across these populations.
Update: Project will be closely linked to community navigation team initiative (2ci). Outreach workers and patient activation training teams will be employed by community-based organizations. By selecting this project, PPS will serve the uninsured across ALL projects.

- **Part 1:** The need to engage and activate the UI, NU, and low-utilizing populations to increase utilization of primary and preventative services is evident. Among online survey participants, 61% of the uninsured respondents do not visit any provider regularly (PCP, specialist, or Care Manager). However, nearly half (43%) of uninsured respondents noted that they or someone in their household have visited the ED in the past 12 months. Only 30% of uninsured respondents felt their most recent trip to the ED was for a life-threatening ailment, but 50% did not consider any other treatment options before heading to the ED. The bulk of uninsured respondents (71%) feel they do not get the healthcare services they need when they need it, and 89% have not turned to any community resources to assist with chronic conditions.

  IDIs with the healthcare audience revealed a perception that the uninsured population does not have access to primary care which will result in more ED visits among the uninsured population. Interestingly, 76% of the Healthcare audience indicated that their practice accepts uninsured patients, but only 56% currently serve uninsured patients, with an average uninsured patient segment base of only eight percent. The Healthcare audience believes the uninsured population waits to seek healthcare until the need is urgent, and will forego preventative care due to up-front costs. The Community Non-Clinical IDI audience felt that the uninsured population abused the ED due to lack of alternative affordable choices, leaving the ED as the only available healthcare option available. There is a perception among the Community Non-Clinical IDI audience that most doctors will not accept uninsured patients, and they believe that the uninsured population will avoid primary care due to the high out of pocket costs and up front expenses. Both IDI audiences believe increased access to primary care through free or reduced cost clinics for the uninsured would reduce the number of non-emergent ED visits by giving this segment an alternative to the ED.

During IDIs, the Community Non-Clinical IDI audience also noted that it is difficult to access the uninsured population regarding primary and preventative care because healthcare is not a primary concern for this population. The Community audience believes that the uninsured population is more focused on day-to-day living expenses. This perception was supported during focus group discussions, where uninsured participants noted that they avoid seeking healthcare until the need is urgent due to lack of financial resources for out-of-pocket expenses. This project also ranked highest among all proposed STRIPPS healthcare initiatve projects during the focus group discussions.

- **Part 2:** Research participants indicated that the supply of providers in the STRIPPS geography who accept those with no insurance is too small relative to the demand, particularly in key specialty, sub-specialty, and dental care service areas. Focus group discussions revealed that the lack of providers for the uninsured will be a significant challenge to overcome, as many participants believe the incentives for providers to accept the uninsured is sub-par. To overcome this barrier, providers in these geographical areas would need to be properly incentivized to accept uninsured patients.

  Another potential challenge for this project lies in the ability to reach the uninsured population to provide education on available healthcare options. Education would need to include the heavy promotion of free or reduced cost options such as free clinics or reduced fee walk-ins. Internet mediums such as social media appear to be the most effective, since this population is not accessible through the network of providers or community organizations due to their general lack of engagement with primary care. Based on the focus group results and online survey, the Medicaid population has low involvement with providers and specifically primary care physicians (about half see a PCP on a regular basis). Minimal awareness of the CNA efforts was built through in-office flyers. The majority of the recruits for the focus group portion of the CNA were developed through social media efforts on Facebook. Any future engagement regarding this or any project should involve social media as a core education function for the targeted audience(s).

Project 3bi: Evidence-Based Strategies for Disease Management
Objective: Support the implementation of evidence-based best practice strategies for cardiovascular (CV) disease management (adults only).
Update: May utilize tele-monitoring technology to track patient indicators in the home. Project requires sharing of clinical info through the RHIOs across PPS by DY 3.

- **Part 1**: The goal of this project will be to ensure clinical practices in the community and ambulatory care settings use evidenced based strategies to improve the management of cardiovascular disease among high risk affected population. The project will be targeted to medical practices serving adults. The project will also focus on improving practitioner population management and the adoption of activities that will increase patient self-efficacy and confidence in self-management. It is the intent that 80% of the primary care practices in the 10-county region will participate in the evidenced based strategies as appropriate. Strategies from the "Million Hearts" (Hypertension Control) campaign and Stanford Model for chronic disease management will be implemented. Strategies that will be considered for implementation include: development and use of patient registries, standardized treatment practices for hypertension, cholesterol monitoring, follow up blood pressure management, linkage to support groups, and medication adherence.

Online survey data revealed that 8% of the Healthcare audience and 6% of the Community Non-Clinical audience feels that heart disease contributes the most to ED visits and hospital re-admissions among Medicaid and uninsured populations. Among the Medicaid and uninsured survey respondents, 11% visit a cardiologist regularly, 29% cope with hypertension, and 12% have heart disease. A large majority of Medicaid and uninsured patients with these chronic conditions are receiving help from a healthcare professional to manage the condition (92% for heart disease; 89% for hypertension), but Medicaid and uninsured recipients consistently indicated that any out-of-pocket cost is a deterrent to accessing healthcare services. Any point-of-service (POS) cost outlay for the patient is a barrier (e.g., co-pays to seeking or receiving care). The healthcare audience and community leaders agreed that Medicaid recipients and the uninsured abuse the ED for this reason. The Healthcare audience suggested the need to identify non-medical barriers (e.g., lifestyle, behavioral) for the Medicaid and uninsured population to be able to effectively manage a chronic disease. This sentiment was supported by the Non-Clinical audience, who felt that poor lifestyle choices among the Medicaid and uninsured populations correlate with poor management of chronic diseases. Focus group participants suggested that support groups could help with the management of chronic diseases. This may be an area of opportunity for the utilization of tele-monitoring technology, by offering a disease management option that is convenient for the Medicaid and uninsured populations.

- **Part 2:** Out-of-pocket costs to the patient will be a primary deterrent for this project's success. The implementation of tele-monitoring technology has the potential to serve a currently underserved population dealing with cardiovascular disease and hypertension, but will only be effective if the solution is affordable to the Medicaid and uninsured.

Project 4aiii: Strengthen MH and Substance Abuse Infrastructure
Objective: Strengthen chronic Mental Health (MH)/Substance Abuse (SA) disease prevention, treatment and recovery and infrastructure for mental/emotional/behavioral (MEB) health promotion and disorder prevention.
Update: Will expand existing prevention programs across the PPS and develop targeted intervention and screening.

- **Part 1**: This project will be designed to support collaboration among leaders, professionals and community members working in MEB (mental, emotional and behavioral) health promotion, substance abuse and other MEB disorders and chronic disease prevention, treatment and recovery. The project will also focus on strengthening the infrastructure for MEB health promotion and prevention. MEB is a relatively new field which requires a paradigm shift in approaching prevention and treatment of mental, emotional and behavioral conditions. The project may focus on (1) implementing "collaborative" care between mental and primary care providers in the primary care setting; and (2) the applicability of tele-health and the emerging field of tele-addictionist services.

- There is a substantial demand for management, prevention, and treatment of MEB health in the STRIPPS geographical area. Those residents in need are seeking solutions for mental health and substance abuse conditions but running into barriers. All constituent groups indicated need for more providers, improved ability to get timely appointments, and the ability to see appropriate providers for appropriate condition(s). Increasing access to mental health services is the most pressing need to improve healthcare in the community among 43% the online survey Healthcare audience, while 19% of the Non-Clinical audience believes it is the most pressing need. There is a perception that Mental Health and Substance Abuse significantly contribute to ED visits and hospital re-admissions among the Medicaid and uninsured. Survey data revealed that 29% of Medicaid and uninsured respondents deal with a chronic mental health condition while 6% have a chronic substance abuse condition, and 13% have left the geographical area in order to receive mental health services.

During IDIs, the Healthcare audience acknowledged a decrease in available mental health and substance abuse services within the geography. Facilities are cutting services, reducing staff, or closing altogether, resulting in an inability to keep up with a growing mental health and substance abuse crisis in the communities. The lack of known resources to aid in these conditions is resulting in improper ED usage among Medicaid and uninsured populations dealing with mental health and substance abuse issues. IDI participants noted that improvements to provider collaboration and follow-up care for mental health and substance abuse patients will be critical to a patient's successful recovery, providing support for the implementation plan of this project.

Focus group participants specified a lack of access to mental health and substance abuse services as the primary concern during discussions. Participants indicated that facilities are either not available in their region (forcing patients to travel outside the geographical area for assistance) or the facility is booking appointments with excessive wait times (often weeks or months into the future).

- **Part 2:** The primary barriers faced by this project are the lack of currently available mental health and substance abuse services in the STRIPPS geographical region, as well as the infrastructure to support providers. This number of providers is significantly below the expected demand level. Collaborative care between primary physicians and mental health specialists will be crucial, but a new infrastructure will need to be in place to support successful and efficient transfer of information once a sufficient number of mental health and substance abuse providers are available to serve patients. Awareness education and promotion to ensure adoption among Medicaid and uninsured populations will be key.

Project 4bii: Chronic Disease Preventative Care and Management (COPD)
Objective: Increase access to high quality chronic disease preventive care and management in both clinical and community settings for the chronic disease – chronic obstructive pulmonary disease (COPD).
Update: Will include a more robust screening and education effort across the PPS.

- **Part 1:** The project is looking for primary care practices to utilize EMRs (Electronic Medical Records) to improve prevention, early identification, and management of this condition among the patient population. The EMR can be used to develop a patient registry and trigger patient reminders for follow up care. Management is focused on disease prevention through partnering with community resources including community health departments, and improved collaboration between patients' PCP office and other external agencies which can assist patients in adherence with their plan of care, avoiding unnecessary ED visits and preventable hospitalizations. It is unknown at this time if the COPD prevention services will offered at no cost. The intent of the project will be to remove or reduce barriers to care. Providers will also have feedback on their respective patient panel so as to reinforce their efforts in targeting patients with additional needs.

- During focus group discussions, Medicaid recipients and those uninsured recognized the need to take ownership of one's health however they do not regularly engage in preventive care and/or wellness efforts. About two-thirds of Medicaid recipients and those uninsured that completed the online survey see a PCP regularly, so the ability to discuss prevention and wellness options are limited for some but not most. Among those who see a PCP regularly, residents believe the PCPs need to better communicate preventative actions and discuss healthy lifestyle choices beyond solely treating the condition which warranted the patient's visit. Medicaid populations need to feel more accountable to be proactive with regard to healthy lifestyles. Focus group participants indicated that Medicaid's co-pay amounts were a barrier to fill prescriptions. Some providers shared samples which helped. Drug costs prevented some from filling or receiving prescriptions. Several Medicaid respondents indicated that they had difficulty in managing adoption of healthy lifestyles, particularly with smoking cessation. Medicaid participants said they would like to stop smoking but have not been successful.

- **Part 2**: Potential challenges that this project will face include the availability of after-hours care, and the perceived expertise of the healthcare professional on behalf of the patient. During focus groups, Medicaid recipients stated that after-hours options for care were limited or unavailable particularly in rural counties. Among the STRIPPS geographies that offered after-hours care options, the hours were not extended enough. The ED offers 24/7 availability resulting in a consistently available option for the Medicaid and uninsured population. Many Medicaid recipients wanted to see a physician and were disappointed when they were seen by a mid-level provider, and some felt they received lesser quality care. Rural residents were more understanding and receptive to mid-level provider visits. Out-of-pocket costs of prescriptions and maintenance visits will be a barrier that impacts healthy lifestyle compliance.

Project 2ai: Integrated Delivery System
Objective: Create a clinically integrated delivery system focused on evidence-based medicine and population health management.
Update: Conducting a survey to determine PCMH, EHR, RHIO connectivity/readiness status of all providers. Project requires that all participating PCP's attain PCMH Level 3 recognition by end of DY 3.

- **Part 1**: In all three research modalities of the CNA research (focus groups, online survey and in-depth interviews), participants stated that the ED is a highly used source of care for the uninsured and Medicaid population in the STRIPPS geography. Among those with a PCP, many still visit the ED outside of PCP office hours as needed or when they feel the wait time for an appointment (with the PCP) is too long. Nearly all of the healthcare provider audience and community leader audience stated that they "somewhat agreed" or "strongly agreed" that there was an issue with today's population utilizing the ED (95%, 93% respectively) and over three-quarters of both audiences felt that it was more common among the Medicaid and uninsured populations to inappropriately utilize the ED for something that could have been handled at a PCP's office. Participants from all research methodologies stated that the lack of access to a PCP was a key reason why Medicaid beneficiaries and the uninsured utilize the ED inappropriately. Ten percent (10%) of the community leader audience rated accessibility to healthcare services as the most pressing healthcare need for the Medicaid and uninsured population in their community. Access to healthcare services can be defined as patients not having transportation to appointments, the inability to make a timely appointment with physician and not having office hours that are convenient to a patient's schedule.

  The Healthcare participants, Community Leaders, and Medicaid recipients were all aware of the current low reimbursement to providers for Medicaid visits. Many Medicaid recipients believed this fact impacts their quality of care. As a result, in some cases Medicaid recipients believed providers would attempt to maximize visit revenue. There is a significant opportunity for healthcare providers in the area to become PCMH recognized; only 19% of practices that responded were recognized with an additional 62% of respondents stating they were "unsure" as to whether or not they were recognized. Carrying PCMH recognition assures that practices have gone through stringent review and are held to the highest standards. Practices receive more reimbursement if they are recognized and the medical homes serve to create an integrated delivery system centered on the primary care physician.

This project would primarily focus on expanding access to community primary care services and developing integrated care teams (physicians, and other practitioners, behavioral health providers, pharmacists, nurse educators and care managers. The goal of this project is to implement pre-emptive interventions so that patients do not need to over-utilize services. It is expected that providers will be certified as level 3 Patient Centered Medical Homes (PCMH), have an EMR (achieve meaningful use) and become an Advanced Primary Care Practice in the first 3 years of DSRIP.

- **Part 2:** Practice resource time, commitment, and costs are the potential challenges facing this project. Focus group participants liked the idea that care was integrated through their primary care physician but acknowledged that communication tended to be an issue between providers within the community. Area providers do not talk to each other and care often seems to be delivered in silos. Several focus group participants also stated they were uncomfortable with their healthcare information being located in one place electronically (EHR) across multiple providers but agreed that communications between doctors was very important. Only two-thirds of Medicaid recipients or those without insurance visit a PCP on a regular basis so there is concern that patient activation may not occur through the PCMH model. Medicaid recipients who visited a PCP reported feeling rushed during the appointment, long wait times and felt providers wanted to push pharmaceuticals on them to solve problems immediately as opposed to a more natural approach. Other challenges that this project could face could be the resistance to adopt the PCMH model. The benefits of recognition must be known especially in regards to higher reimbursement.

Project 3gi: Palliative Care in PCMH
Objective: Increase access to palliative care programs in Patient Centered Medical Homes (PCMH).
Update: Will rely on a PCMH readiness or recognition survey and implementation plan to determine which practices within the STRIPPS geography initially.

- **Part 1**: Focus group participants were very receptive to integrated palliative care into PCMH and it was rated of high importance when tested. The goal of this project is to increase access to palliative care programs for persons with serious, advanced illness and those at the end-of-life. This initiative is seeking to help ensure that healthcare and end-of-life planning needs are understood, addressed and met prior to decisions to enter hospice or seek further aggressive care. This project will assist in ensuring that pain needs are met and further health changes can be planned for. Focus group participants stated that this would work well for people who are in extreme pain and shouldn't have to be, this type of care could lead to a higher quality of life away from pain. Participants noted that there is high utilization of the ED for pain management. Even among those with a PCP, many are unable to wait for their next scheduled appointment to manage pain and are using the ED to receive treatment.

  When healthcare is delivered through the PCMH model, patient treatment is coordinated through the patient's primary care physician to ensure that they are receiving care in: (1) a way they can understand, (2) receiving it appropriately, and (3) receiving care in the most appropriate setting. Most importantly, embedding palliative care into the PCMH model ensures that delivered care is managed and coordinated.

- **Part 2:** Similar to other care methods that are looking to be integrated with the PCMH model, some challenges that this project may face is the fact that only two-thirds of Medicaid and uninsured participants visit a PCP regularly. PCMH focuses solely on the PCP. Oftentimes patients needing palliative care need to receive it from specialty providers. Therefore a fully clinically integrated network encompassing both the PCP and specialists needs to be built. This will require moving from a PCMH to a PCMH-N (neighborhood) model. Reasons that the Medicaid and uninsured do not regularly remain engaged with their PCP lies with the fact that the wait time is too long, patients often feel rushed, and out-of-pocket cost in general. Another barrier that this project may face is opposition from providers and their unwillingness to become recognized or even accept Medicaid patients. To decrease the likelihood of this happening, the PCMH program must be well communicated and highlighted with the fact that doctors may receive significantly higher reimbursements for Medicaid patients if they are recognized. There are other reasons that doctors may not accept Medicaid patients but research shows the lack of adequate financial reimbursement tends to be a primary driver.

Project 2bvii: INTERACT
Objective: Implement the Interventions to Reduce Acute Care Transfers (INTERACT) model in all participating skilled nursing facilities.
Update: Approximately 23 skilled nursing facilities participating ~2,400 covered lived attributed from long term care facilities.

- **Part 1:** Online survey participants from the long term care segment stated that "better" nursing homes were one of the most pressing healthcare needs for the community and also stated that keeping people in their homes was a preferred alternative to skilled nursing facilities. The term "better" was not defined but undoubtedly relates to quality, attentiveness, innovations and responsiveness for long term care patients. The project is also looking for primary care practices to utilize EMR Systems (Electronic Medical Record) in order to improve the identification and management of this patient population and understand the needs that are associated with them. INTERACT stands for "Interventions to Reduce Acute Care Transfers." These interventions and tools represent a quality improvement program that is designed to improve the identification, evaluation and communication related to changes in long term care resident status

- Focus group participants were very receptive to this project idea because they were aware of the costs and complications involved especially with a vulnerable population. The trends indicate that people are staying in their homes longer and the need for home healthcare is increasing. Some focus group participants shared stories of experiencing the transfer situation with a loved one first-hand and how difficult that process was. Approximately 2% of the community leader audience respondents from the online survey worked in nursing homes in the STRIPPS geography.

- **Part 2:** The overall goal of the INTERACT program is to reduce the frequency of transfers to the acute hospital setting since these transfers can be emotionally and physically difficult on the patient and costly. The biggest challenge that this project will face will be accurately allocating resources at all times of the day. The INTERACT model allows skilled nursing facilities to mitigate risk and improve quality of patient care when most residents are being transferred out of the facility to the ED. By using INTERACT tools, skilled nursing facilities are able to identify situations that may force them to better plan for shifts that may need additional staff coverage or different types of staff, staff education as needed and necessary training to reduce ED admissions. When moving some types of acute care in-house, there needs to be appropriate personnel on staff 24/7 to handle any incident which may affect how the skilled nursing facility is staffed and budgeted. There is also the possibility of numerous complications from the hospital transfer which can prove to be detrimental to the patient. Some challenges that this project may encounter is that certain incidents may be misdiagnosed and they should have been transferred to another facility to better receive care. When moving this type of care in-house, there needs to be appropriate personnel on staff 24/7 to handle any incident which may affect how the skilled nursing facility is staffed and budgeted. Communication will be key in this project in order for it to be successful. It is imperative to use INTERACT correctly and constantly evaluate the model to ensure that the project is successful.

Project 3aii: Crisis Stabilization
Objective: Provide readily accessible behavioral health crisis services that will allow timely access to the appropriate provider(s).
Update: Proposed model includes a layered continuum of crisis stabilization services within the STRIPPS geography.

- **Part 1:** Participants in the focus groups stated that having a behavioral health crisis stabilization team would be helpful to diffuse and address situations that occurred specifically due to mental and behavioral health issues. The availability of mental and behavioral health services for the Medicaid and uninsured populations is one of the largest and most pressing needs for the community with it being listed at or near a top priority in all research methodologies. Nearly a quarter (22%) of healthcare providers stated that mental health contributed to the most ED visits and readmissions for the Medicaid and uninsured population.

  This project will help increase access to behavioral crisis stabilization services in select counties within the STRIPPS geography, thus allowing or facilitating access to the appropriate levels of service and providers. This would support a rapid de-escalation of the crisis. This project might include the creation of a mobile crisis team that will assist with moving patients safely from the community to an appropriate location for services. The mobile crisis team might provide follow-up care after stabilization to ensure continued wellness. The project will require the development of strong community linkages. In-depth interview and focus group participants indicated that this type of project would be appropriate because of the lack of after-hours care available for Medicaid recipients.

  In addition to the teams' ability to diffuse a crisis, teams would also be able to transport patients to appropriate healthcare facilities. Constituencies indicated there were not enough transportation options. Also, current options are unreliable and time consuming to seek out. The primary research found that transportation proves to be a barrier to access any non-ED options especially in both emergent and non-emergent situations.

- **Part 2:** The challenges that this project may face during implementation is how to provide service to rural areas in the STRIPPS geography. The 10 county area consists of many rural geographies that make transportation times long. Another challenge that this project may encounter is funding if multiple crisis teams are needed for availability. If all Medicaid recipients are able to utilize this resource, it may be very difficult to ensure appropriate use of the service, similar to non-emergent ED usage driving the DSRIP initiatives.

Project 2biv: Care Transitions for Chronic Diseases
Objective: Provide 30-day transition support after hospitalization to reduce risk for readmission – targeting cardiac, renal, diabetes, respiratory and/or behavioral health disorders.
Update: Working to expand the "BIP" (Balancing Incentive Plan) model currently used in Tompkins County – to cover the entire STRIPPS region.

- **Part 1:** In the in-depth interviews (IDIs) from Healthcare Providers participants stated the Medicaid and uninsured population needs to be more responsible for their existing health conditions. The majority of respondents in the focus groups think that they are ultimately responsible for their own health but data suggests they are not acting responsibly. Over two-thirds (68%) of healthcare providers who participated in the online survey either strongly or somewhat agreed that there was an issue with hospital readmissions within 30 days of discharge. Over one-third (41%) of healthcare providers felt that re-admission within a 30 day timeframe was more common with the Medicaid population. Less than half of the Medicaid and uninsured populations follow instructions after they have visited a doctor (only 47% stated they 'always' do). Medicaid recipients and those with no insurance had a perception that their provider was aware of their status as a Medicaid beneficiary and as a result, this caused a perceived lower-level of care and less attention spent on the patient. Many Medicaid participants in the focus groups believed providers did not spend an appropriate amount of time communicating with them and could have done better at explaining instructions prior to discharge. Nearly a quarter (22%) of healthcare providers stated that mental health contributed to the most ED visits and readmissions for the Medicaid and uninsured population which is most-likely contributed to the lack of available services for mental and behavioral health in the STRIPPS geography.

  Mental and behavioral healthcare must be entwined with traditional clinical care. Not all treatment needs to be cared for through a pharmacological solution. Respondents from the focus groups desired a more holistic approach to treating patients but indicated that follow-up was needed.

A significant cause of avoidable readmissions was a patient's non-compliance with specified discharge regiments. Non-compliance is a result of many factors including healthcare literacy, language barriers, and lack of engagement within the community health care system. Many of these can be addressed by a transition case manager working one-on-one with the patient to identify the relevant factors and find solutions. By expanding the "BIP" model across all other counties, patients who have been recently discharged can be more readily transitioned into community based settings. The "BIP" target population includes individuals who have lived in nursing homes, adult homes, state operated community residences, or state psychiatric centers for longer than 6 months and who have been recently discharged back into the community.

- **Part 2**: The main barrier to this project's success is the access that patients have to follow-up care from their doctor. Transportation is a barrier especially in the rural counties so patients aren't always able to make it to their follow-up appointments conveniently. Another issue with follow-up care is scheduling a PCP visit in a timely manner or at an appointment time that is convenient for them. Nearly two-thirds (61%) of Medicaid and uninsured respondents stated that it took weeks to get an appointment with a doctor. With about one-third of Medicaid or uninsured respondents not visiting a PCP on a regular basis or not having a PCP, it may be even more difficult for the patient to receive appropriate follow-up care.

The emergency room (ER) is viewed by participants as an "always available" option for health and dental care services, and is often visited because of convenience and accessibility. Many participants indicated that they consider the ER as an acceptable location to receive "any type" of medical care, not just when life-threatening healthcare is needed. Key drivers to ER use, identified by the participants, are: (1) its **24/7 access** for everyone, (2) ability to **always "be seen by a doctor"** (3) **lack of knowledge** as to **where** else **to go** to receive care, (4) **shortage of** other healthcare resources (**providers**), and (5) **no out-of-pocket**, up front **costs**. Other significant drivers also include: **ready transportation** to the ER, **one stop shopping** with multiple services available (X-ray, lab, specialists, medications) all under one roof, and the participants have **an existing relationship** with the provider(s) at the ER.

Selected Comments

- ✓ *The ER is always available. You can go to the ER, but the follow-up is virtually non-existent.*
- ✓ *Well, depending on what kind of insurance and stuff you have, there's not very good availability right in Cortland.*
- ✓ *Lack of specialists in the area.*
- ✓ *A lack of transportation (to healthcare providers) in the rural areas.*
- ✓ *Transportation is a joke. There's one company around here that was eligible to do Medicaid transports, and there were times where I've had to wait two to three hours after my appointment for the transportation to come back, pick me up and take me home. You always had to be there, they'd pick you up at least an hour early before your appointment. If it was local, you'd be there within 5 to 10 minutes, so you were there at least 45 minutes, 50 minutes early for your appointment, and then still have to wait after the appointment for your ride back home. It just wastes your entire day.*
- ✓ *The doctors have a say in how many Medicaid patients they'll accept. "We're not accepting any more Medicaid patients right now" is a common response from doctors.*
- ✓ *There is a lack of doctors that will accept Medicaid and Medicare in this county. There are absolutely none that take it.*
- ✓ *The transportation of (a) Medicaid (patient), that's sometimes a month in a advance you gotta book it and that's not always guaranteed.*
- ✓ *Well, it's one of the things that I know that they won't turn me away 'cause I can't pay.*
- ✓ *It's easier to get into the emergency room than it is to actually get into the doctor. Doctors takes 24+ hours to get in.*
- ✓ *Well if it is something that you're probably going to get admitted to the hospital for, just go to the ER first. If you go to a convenient care, they are just going to transfer you there anyway.*

Participants feel that the majority of patients visiting an ER are there for symptoms/conditions that could be treated at other healthcare venues, and for non-life threatening conditions. The majority of participants acknowledged that the **ER is not** always **the most appropriate place for care**, however it may be the only perceived health care provider in the area. A significant majority of participants indicated that they, themselves, had visited an ER with a non-life threatening condition. Some indicated that they know people who went to the ER to **obtain medication**, **receive attention**, to **obtain a meal**, receive **mental health care**, and/or to **get warm** and **find shelter**. Several felt people went there because it **(the ER) was most convenient** to them.

Selected Comments

- ✓ *You know they – they're hypochondriacs you know, because I – I used to go when I drank, you know, I'm in recovery and I would get panic attacks you know and I would just run to the emergency room, 'cause I felt like I was having a heart attack.*
- ✓ *I mean, the emergency room is open all night long. The Prompt Care closes, I want to say, at 10 or 11.*
- ✓ *Sometimes their (personal) doctors won't prescribe them what they're looking for, so they go to the ER.*
- ✓ *If we don't think that two days' waiting is gonna be helpful and we're gonna get worse, then I would choose to go to the ER.*
- ✓ *I would've done that same thing if I was without insurance (Medicaid). I would've gone to the emergency room first.*
- ✓ *I didn't know where else to go. Thanksgiving night at 7:30, really no other options.*
- ✓ *I went to the ER because…It was 10:00 on a Saturday night, I mean, if I hadn't been so stubborn and gone to the dentist earlier in the week, but I figured the pain would just eventually go away and it didn't.*
- ✓ *At night it is the only alternative. Yeah. I have three teenagers. You really think they keep normal hours? {laughs}*
- ✓ *I saw that there's an urgent care down on Meadow (Ithaca Group), but I don't know – I haven't ever been there.*
- ✓ *(I go to the ER…) 'Cause you can't get turned away. You can't get denied care. They will eventually have to see you.*
- ✓ *I just use home remedies. If I'm having – My second step is usually I'm gonna have to go to the emergency room to get an antibiotic. I'm waiting three weeks. I'm giving it three weeks to the point where it's just not gonna work. Can't afford to go anywhere but the ER.*
- ✓ *I tried to go to Guthrie. You have to be a patient at Guthrie. You have to have a doctor over there. A lot of doctors in Guthrie aren't accepting (Medicaid patients)– Like oh my gosh, I have a sore throat. I feel like I'm gonna die.*
- ✓ *Pure laziness, because they don't want to take them(selves) during the day or through the hours. They think, "Awe, its easier – let's go to the ER instead."*

Participants reported that many times when they **called their primary care office before seeking care, they were told to go to the emergency room**, even though they knew their condition was not life threatening. Participants indicated that often it was **after hours**, or they could not get a same-day appointment or they simply got the answering service for their physician. Many participants acknowledged that they were aware they could have gone to a physician, urgent care, walk-in for care but they wanted immediate medical attention and believed that the ER would give them that. In each focus group we asked participants what percentage of people in the ER were there with a non-life threatening condition. The majority of participants said that most were there with non-life threatening conditions. On average, people felt that **75% to 90% of the participants in the ER had non-life threatening conditions**.

Selected Comments

- ✓ *We kind of agreed that we think 80 percent of the time people in the ER don't probably need to be there.*
- ✓ *I believe people need to be educated on that. What constitutes as an emergency and what constitutes as a non-emergency.*
- ✓ *(The doctor) Did not listen to me one single bit*.
- ✓ *Prefer to go to the one (PCP) that knows the whole deal.*
- ✓ *Some of the copays are a little pricey, especially like me, I don't have a job right now. I'm in the middle of looking for a job. Like if I was going to the doctor I'd have a $75.00 copay. The ER is free.*
- ✓ *A lot of them(physician office hours) are like 8:00 to 4:00 or 8:00 to 4:30. My fiancé works 6:00 to 6:00. I work nightshift so I try to sleep during the day, but a lot of times the only time I can go to a doctor was during those hours.*
- ✓ *I tried to go to the "free clinic." I was turned away 'cause I had insurance (Medicaid). They told me to go to the ER.*
- ✓ *I have a specialist that I see. They say when it gets bad enough, "Go to the hospital (ER)." So I go there.*
- ✓ *It was the middle of the night, so I knew the doctor's office wasn't open, and they're just gonna tell you to go there anyway because they're not open, so I went to he ER.*

The responsibility for one's health rests primarily with that individual. Participants said that each individual has the responsibility to stay healthy, but that this is not easy to do. Society is skewed toward unhealthiness, from fast food, to television, to high cost fitness memberships. The participants acknowledged responsibility, but took minimal accountability to be healthy. Many acknowledged that they can't always stay focused on being healthy. **Barriers include time, costs, and entrenched bad habits**.

Selected Comments

- ✓ *Ourselves. Or if we're parents and it's a child, then it's us, still.*
- ✓ *Because ain't nobody else gonna give a damn.*
- ✓ *A constant struggle, you know, this back and forth about eating well, eating right, doing what feels good, or what tastes good—or what's good for me or what tastes good.*
- ✓ *My family keeps me going.*
- ✓ *Having somebody to talk to, somebody that you can trust to talk to.*
- ✓ *I use Facebook groups a lot, especially for the stuff that's wrong with me and my fiancé and stuff. I use Facebook groups.*
- ✓ *I tried using an online application – Logging into My Fitness Pal. It just became too much.*

Participants perceived that their Medicaid health insurance coverage meant that they were getting "lower quality" care and had more difficulty accessing providers than others (with the exception of the uninsured). They said that participating **physicians were limited**, particularly in specialty care areas. They feel that they see mid-level providers more frequently than others, and really want to see the doctor. The **visit with the doctor is often rushed**. The majority of participants felt that the doctor was trying to get them out the door and the doctor **doesn't really listen** to them. Moreover, the **physician was quick to treat with medications** rather than other approaches.

Selected Comments

- ✓ *You call, and they say, "No. We don't accept that (Medicaid). Sorry."*
- ✓ *I do think there's plenty of healthcare services, but it's just the insurance – a lot of them don't take Medicaid.*
- ✓ *They need more specialists and providers to accept Medicaid and people without insurance.*
- ✓ *Sometimes if you go to the emergency room for something, they'll say, "We're not a full something hospital." It makes you feel like they don't care about your health or whatever.*
- ✓ *I don't know if there's more, but they just don't get the treatment. People with the insurance can go to the doctor and they can get the treatment and manage their chronic diseases.*
- ✓ *It's a health clinic, not a walk-in clinic. That's across the street.*
- ✓ *I will not see a Cortland doctor. I had one several years ago that nearly kill me.*
- ✓ *Dental stuff. I know I had to go—where in the heck was that? Oh, I don't know, at least an hour and a half away to go see a dentist.*
- ✓ *I called my primary care and they said "Oh, we can't get you in for four weeks."*
- ✓ *So then, any time you're really sick or really need to see a doctor, you end up going over to Cayuga Medical, it's a walk-in place. I'm sitting there waiting three hours, sitting there, you know? I went in, and he goes, "Well, you're already on a water pill. There's nothing we can do for you."*
- ✓ *I had a doctor tell me everything was in my head years ago, switched to a doctor in Ithaca who ran my blood and said, "Oh my God; how are you even walking?" My B12 level was below 50; it should've been 250 or above.*
- ✓ *I think there's a really high demand in this area for mental health services.*
- ✓ *I've noticed from being on regular insurance, having my own insurance, then being on Medicaid, you get treated 10 times differently than – you're not believed if you're on Medicaid.*

The vast majority of the participants were very supportive of any initiatives that sought to improve access and increase health care services in hopes of decreasing inappropriate ER usage. They stated that there needs to be more health care resources available to them (particularly local resources), better communication and coordination amongst providers, and more access to non-life threatening services. They **supported** promoting **health education** regarding **where to go for appropriate health care** services. They also like the idea of having a navigator to help them with understanding where to go for care.

Selected Comments

- ✓ *Sometimes it takes five business days for the doctor's office to get back to the pharmacy.*
- ✓ *I thought food pantries (would be a good idea). And pharmacies and whatever , they give flu shots now, that's not old, that's kinda new. So I mean, that just seems like a natural progression.*
- ✓ *I don't think there's very good education for—like, health education in general, people don't know the availability.*
- ✓ *Honestly, I think from my own experience more information could be put out there as far as Medicaid. I have had Medicaid for like four years and had no idea that I had Medicaid transportation available to me.*
- ✓ *Put a free clinic in this County with extended hours. In the free clinic that I go to, its only open Monday and Thursday evenings between 4:30 and 7:30.*

The actual or perceived lack of access and available physicians, dentists and mental health providers throughout the community was identified as a major reason why the participants go directly to the emergency room for care. Many indicated that they are **unaware of which providers within the community** will see them when they feel the need to be seen. Individuals stated that they **did not know where to go** to find resources or if they found a provider, they **could not get** the healthcare **provider to see them** within the timeframe that they wanted to be seen. Some also liked the fact **the ER has everything under one roof**.

Selected Comments

- ✓ *An alternative to an ER needs to be open 24/7.*
- ✓ *I think my daughter, my grandchildren, they definitely need more mental health (providers).*
- ✓ *I tried to get her in with her primary, but he wasn't available, and the appointment that they gave me was at 3:30 in the afternoon. This was 8:00 in the morning.*
- ✓ *No, I think that my primary care would've been the most appropriate place to go, but the availability for me to get in there wasn't there. It would've been two weeks for me to get into my primary care*
- ✓ *Would like a 24 hour clinic that you could go to for things that aren't necessarily an emergency, but something that you need to be seen for .*
- ✓ *They should expand Convenient Care hours to 24 hours a day. I think Convenient Care hours are limited (currently).*
- ✓ *Maybe they could have a clinic right at the ER so you don't go to the ER. You go right to the clinic right there at the same property.*
- ✓ *I'm not sure of options for after-hours care. I could drive all the way to Elmira to urgent care, But I still think they close at 7:00 PM. Ithaca is more than 20 miles away. So for me to go to Elmira or Ithaca, its probably a good 45 minutes to an hour. The ER is open 24/7.*
- ✓ *The ER gives you a lot of services. You have your lab there, your X-rays there. You have everything – all the services right in that one building. Whereas if you go to your primary care, he's gonna say I need lab work, go there, I need an Xray, go there.*

Participants wanted a reliable resource (an individual) to help them access providers and direct them where they could/should go to receive appropriate care. When discussed they all embraced the idea of going to the emergency room and then being directed to an urgent care clinic "down the hall" if it meant faster, more appropriate care. They also thought that a **nurse help line** would be well utilized. Participants indicated that at they **do not really know how to navigate the healthcare system on their own** and often wait until their situation becomes critical (in their minds) to receive care. Very few of the participants were aware of the 2-1-1 telephone line assistance.

Selected Comments

- ✓ *They should have some kind of fast track program, like when you come in there with a non-emergency, you go to a different spot – your fast tracked.*
- ✓ *It'll be faster than the ER*
- ✓ *The ER won't be the best option because they're gonna have – they're gonna get hit by a staff shortage.*
- ✓ ***Moderator**: So one of the other things you're saying is just give them more knowledge? **Participant:** Right. Giving alternatives to people.*
- ✓ *Like we understand you're sick and you don't feel good but this is for emergencies and let me direct you to the closest place that can help you, 'cause we only deal with life and death issues.*
- ✓ *Like somebody with a cold that really doesn't seem to have really bad symptoms.*
- ✓ Go into triage, and they screen you and decide whether you're an emergency or if you're a Prompt Care person. They're pretty good about that.
- ✓ *Have a hotline to call. If they wonder whether or not they should be going to the emergency room, call a hotline*.
- ✓ *So maybe when people show up to the emergency room with a non-life threatening illness somebody like a representative, could be there and say "Oh, I see you have a rash. Let me schedule you an appointment with so-and-so and do it right now right here while you're here. Can you see Dr. Smith tomorrow?" So that way that person feels taken care of, but they're not using emergency resources.*

Most participants indicated that they don't do well or find it difficult in planning scheduled healthcare visits and following preventive activities, unless it was for their children. A number of barriers to engagement were identified. They stated that their **lives are too busy**, **scheduling transportation**, or **having available copay dollars** are all deterrents to being compliant and healthy. Due to transportation issues and not being able to pay the copay, patients try to treat their healthcare symptoms at home, however when these become severe they head to the emergency room because they now need immediate relief.

Selected Comments

- ✓ *For a fever, certain things that you can't really take care of yourself at home. That's when I need to talk with someone or go the Internet.*
- ✓ *Send stuff home with the kids, you know, from school. A pamphlet in the mail with what's available and different examples of reasons to go.*
- ✓ *Well, I think the physicians could maybe explain better. I don't think people always finish their medications or—they don't understand fully what the situation is.*
- ✓ *Okay, Bassett has I think a – its not like an urgent care thing, it's more like by an appointment, where Fox Care is an actual urgent care walk-in. They're trying to get people to utilize that, but guess what? If I don't have transportation, I can call an ambulance and I can go to the emergency room. I'll get a slap for this (using an ambulance) but…*
- ✓ *I use the services from Cornell Cooperative Extension and they have a lot of food programs there where you can buy from local farmers and they have groups – and they accept food stamps.*
- ✓ *My mom (also on Medicaid) has emphysema and her doctor has told her to do this lung rehab program, but its all the way in Cortland. We can't do that.*
- ✓ *They should remind me of my appointment. Call or send me a text.*
- ✓ *I work every day. I can't get to the doctor during the day. There's nothing available at night.*

Many participants indicated that they do not like walk-in clinics because they do not always see a physician for their medical visit and the (walk-in) clinic hours typically are not convenient for them. Participants recounted stories regarding having to try and coordinate transportation to go to a clinic. They stated that **transportation is difficult**, unreliable and inconvenient. It was also reported that it is **difficult to obtain appointments** that are convenient. Some participants reported that they are happy with receiving their healthcare at a walk-in clinic. They stated that they preferred this venue to the emergency room. Some key clinics touted include Lourdes (Owego); Guthrie (Ithaca); Fox Care –Bassett (Delhi).

Selected Comments

- ✓ *"Well I have an NP. I haven't had a regular physician – I want a regular physician, you know."*
- ✓ *"At the walk-ins there is mid-levels – there's not physicians really that I'm aware of, the one I go to."*
- ✓ *The incompetence. It's just like how they treat you and they just aren't open to even learning about other things.*
- ✓ *Well, I get into my primary , but it takes a long time. I don't normally go to the doctor unless I'm sick or have something pressing. But then when I am feeling that way and I feel like I haven't been there in six months and I'm calling because I don't want--- I really need to go. They're going to tell me to wait a week. Then I'm upset.*
- ✓ *I want to be able to know that if I am sick, I want to get in tomorrow. You know, if not today.*
- ✓ *Now the walk-in clinic that's on Water Street, if they took Medicaid, which they don't do or are closed to new Medicaid, they'd see less people at the ER because non-emergent care. They have an X-ray machine, they have everything that they need.*
- ✓ *Why are they still going to the ED? 'Cause you call for an appointment and they constantly say, "we have none available." So what's your option?*
- ✓ *Accessibility is a problem (at walk in clinics) getting to actually see the doctor. Getting someone to listen to you.*
- ✓ *I would definitely use it (a walk-in clinic) 100 times over from – more of us, my kids and my grandkids, if they took Medicaid. I would never go back to the emergency room. They do take Medicaid in North Carolina, but not up here.*
- ✓ *Well it comes back to the waiting list or not taking new patients. What's the deal with that?*

Communications between physicians and other healthcare providers is not streamlined and does not always go well. Several participants felt that the medical community does not talk with each other. This was particularly true with regard to mental health and the use of pharmaceuticals. Participants expressed concern that **physicians order medications and do not always know what else a patient is on** and things might interact. There was minimal familiarity with the electronic medical and/or health record concept (EMR/EHR). Participants did not always understand that this could mean streamlined communications, however some did. Several **participants were nervous and expressed concerns about privacy with regard to the medical record. They were nervous about keeping the information secure** and protected.

Selected Comments

- ✓ "(what our healthcare)…*doesn't have and that's doctors talking to other doctors*."
- ✓ *The doctors do not communicate. Pretty much with me they'll refer me and they'll write a note why they referred me and then its up to me to try and backtrack and explain everything that has been going on. And then it's up to that doctor to believe what I'm saying or not.*
- ✓ *Well, so that all the ---all the facilities, there's gotta be some kind of a system where they can all communicate – where your medical records are accessible no matter where they are. Now, I know a lot of people are afraid of a system like that because if your medical records are accessible anywhere, then you don't know who might be tapping into 'em that you don't want tapping 'em. But from a medical standpoint, I think accessibility to the patient record is critical.*

Cost is a significant driver for participants, determining where they decide to go for care. Many participants indicated that they look to use free clinics or ERs because there is no up-front out of pocket costs. **Participants also stated they use a number of sources to find healthcare locations including: on-line, word of mouth, family and friends and provider recommendations.** In all of the groups, several participants indicated that they regularly use the web to explore healthcare topics and visit sites such as WebMD and participate in social network groups.

Selected Comments

- ✓ *I went to the free clinic. I don't have any insurance, and my husband was taken off his .*
- ✓ *I look online a lot.*
- ✓ *Word of mouth.*
- ✓ *Daughter, family, friends.*
- ✓ *I don't go to urgent care because, you have to pay $95 just to be seen, like up front.*
- ✓ *Bottom line, cost is most important in deciding where to go. What you're gonna have to pay out of pocket. If you have a co-pay and stuff, then there are some places that are higher than others.*
- ✓ *It comes down to money, I guess.*
- ✓ *If there is an urgent care center that charges $90 up front 10 minutes away at 11:00 PM and a hospital ER 10 minutes away that charges nothing up-front, I will always choose the ER.*

Online Survey
In-Depth Interviews
Focus Groups
Appendix

Online Survey
Healthcare Audience
I am a healthcare provider, physician, or work in an organization that provides healthcare.

Q1: Which of the following statements best applies to you? n345; Single Response		
Category	n	%
I am a healthcare provider, physician, or work in an organization that provides healthcare.	345	100%
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.	-	-
Neither of the above statements, I am a community resident.	-	-

Q2: What is your title? n345; Single Response		
Category	n	%
Nurse	98	28%
Physician	78	23%
Nurse Practitioner	25	7%
Practice Manager	21	6%
Physician's Assistant	4	1%
Dentist	5	1%
Other[1]	114	34%

[1] Common Other responses include: Social worker (9), Clinical Social Worker (8), Director (8), Dietitian (5), Physical Therapist (5).

Q3: In which county do you primarily work or practice? n345; Single Response		
Category	n	%
Broome	129	37%
Cortland	61	18%
Tompkins	49	14%
Schuyler	32	9%
Tioga	16	5%
Chenango	13	4%
Delaware	11	3%
Steuben	11	3%
None of the above	9	3%
Chemung	8	2%
Cayuga	6	2%

Q5: What is your specialty? n345; Select All That Apply					
Category	n	%	Category	n	%
Family Medicine	52	15%	Pain Management	6	2%
Pediatrics	34	10%	Pulmonology	6	2%
Geriatrics	31	9%	Hospitalist	5	1%
Internal Medicine	23	7%	ENT – Otolaryngology	4	1%
Psychiatry	23	7%	Infectious Disease	4	1%
Emergency Medicine	19	6%	Urology	4	1%
Obstetrics and Gynecology	18	5%	Dermatology	3	1%
General Surgery	17	5%	Neurology	2	1%
Orthopedics	14	4%	Nethrology	2	1%
Dentistry	11	3%	Pathology	2	1%
Gastroenterology	9	3%	Rheumatology	2	1%
Endocrinology	8	2%	Oral Surgery	1	0%
Radiology	8	2%	Other[1]	133	39%
Cardiology	7	2%	Unsure	7	2%
Hematology or Oncology	7	2%			

[1] Common Other responses include: Home care (10), Mental Health (8) Ophthalmology (6), Social Work (4)

Q6: Is your practice a solo or group practice? n345; Single Response		
Category	n	%
Group	184	53%
Neither	114	33%
Solo	32	9%
Unsure	15	5%

Q7: Which of the following best describes your practice setting? n345; Single Response		
Category	n	%
Hospital	126	37%
Private Practice	74	21%
Federally Qualified Health Center (FQHC)	17	5%
Ambulatory Surgery Center	4	1%
Urgent Care Center	4	1%
Other[1]	120	35%

[1] Common Other responses include: Home Care (16), Nursing Home (12), Clinic (6), County Mental Health (5), Hospice (5)

Q8: Do you consider your practice a primary care physician practice? n345; Single Response		
Category	n	%
Yes	87	25%
No	258	75%

Q9: What type(s) of insurance does your practice accept? n345; Select All That Apply		
Category	n	%
Self Insured	252	73%
Medicare	267	77%
Commercial	278	81%
Medicaid	285	83%
Private Pay	290	84%
Other	98	28%
Do Not Accept Insurance	15	4%
Unsure	17	5%

Q9: What type(s) of insurance does your practice accept? n345; Select All That Apply											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	129	6	8	13	61	11	32	16	16	49	9
Commercial	87%	67%	63%	85%	72%	91%	78%	73%	88%	80%	67%
Medicaid	88%	83%	63%	77%	82%	91%	81%	73%	75%	78%	78%
Medicare	81%	67%	75%	69%	79%	73%	84%	73%	75%	74%	56%
Private Pay	88%	83%	88%	85%	82%	82%	81%	82%	88%	86%	44%
Self Insured	79%	67%	63%	62%	72%	82%	69%	64%	63%	76%	44%
Other	33%	33%	13%	31%	21%	46%	41%	36%	31%	14%	11%
Do Not Accept Insurance	2%	-	-	-	-	-	13%	18%	13%	8%	-
Unsure	2%	-	-	15%	15%	9%	-	9%	-	-	11%

Q10: What percentage of your patient base has Medicaid? n167[1]; Open-Ended		
Category	n	%
Blank	7	3%
1% - 10%	13	8%
11% - 20%	21	13%
21% - 30%	24	14%
31% - 40%	28	17%
41% - 50%	17	10%
51% - 60%	11	7%
61% - 70%	13	8%
71% - 80%	16	10%
81% - 90%	8	5%
91% - 100%	9	5%

[1] 123 No Reply

Q10: What percentage of your patient base has Medicaid? n167[1]; Open-Ended											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	66	4	4	9	27	8	12	2	5	20	5
1% - 10%	9%	-	-	12%	-	-	8%	-	-	20%	-
11% - 20%	15%	-	-	-	7%	-	17%	-	20%	25%	20%
21% - 30%	15%	25%	-	-	-	25%	25%	-	40%	25%	20%
31% - 40%	21%	25%	25%	22%	15%	-	17%	50%	-	10%	20%
41% - 50%	12%	-	-	22%	11%	49%	-	-	40%	5%	-
51% - 60%	4%	-	-	22%	19%	-	-	-	-	5%	-
61% - 70%	12%	-	50%	11%	7%	-	-	-	-	5%	-
71% - 80%	6%	-	-	11%	26%	13%	25%	-	-	-	-
81% - 90%	-	-	25%	-	-	13%	8%	50%	-	5%	20%
91% - 100%	6%	50%	-	-	15%	-	-	-	-	-	20%

[1] 123 No Reply

Q11: Over the past two years has this percentage of Medicaid patients increased, decreased, or remained the same? n162; Single Response		
Category	n	%
Increased	89	55%
Decreased	5	3%
Remained the same	47	29%
Unsure	21	13%

Q11: Over the past two years has this percentage of Medicaid patients increased, decreased, or remained the same?
n162; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	66	4	4	9	27	8	12	2	5	20	5
Increased	60%	50%	100%	67%	40%	62%	50%	50%	40%	50%	40%
Decreased	3%	25%	-	-	4%	-	-	-	-	-	20%
Remained the same	26%	25%	-	22%	30%	38%	42%	50%	40%	30%	40%
Unsure	11%	-	-	11%	26%	-	8%	-	20%	20%	-

Q12: Have you ever served the Medicaid population? n60; Single Response		
Category	n	%
Yes	46	77%
No	12	20%
Unsure	2	3%

Q12: Have you ever served the Medicaid population? n60; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	15	1	3	3	11	1	6	3	4	11	2
Yes	73%	-	67%	67%	91%	100%	83%	67%	75%	82%	50%
No	20%	100%	33%	33%	9%	-	-	33%	25%	18%	50%
Unsure	7%	-	-	-	-	-	17%	-	-	-	-

Q13: How many years have you been in practice? n345; Single Response		
Category	n	%
Less than 5 years	52	15%
5 to 14 years	80	23%
15 to 24 years	87	25%
25 years or more	126	37%

Q14: How many years have you served the Medicaid population? n331; Single Response		
Category	n	%
Less than 5 years	46	14%
5 to 14 years	80	24%
15 to 24 years	82	25%
25 years or more	123	37%

Q15: Do you serve uninsured patients? n330; Single Response		
Category	n	%
Yes	284	86%
No	26	8%
Unsure	20	6%

Q15: Do you serve uninsured patients? n330; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	126	6	8	13	61	11	28	9	14	45	9
Yes	87%	50%	87%	84%	91%	82%	92%	78%	93%	85%	56%
No	11%	50%	-	8%	2%	9%	4%	11%	7%	4%	11%
Unsure	2%	-	13%	8%	7%	9%	4%	11%	-	11%	33%

Q16: What percentage of your patient base is uninsured? n125[1]; Open-Ended		
Category	n	%
Blank	2	2%
1% - 10%	84	65%
11% - 20%	25	20%
21% - 30%	7	6%
31% - 40%	2	2%
41% - 50%	1	1%
51% - 60%	0	-
61% - 70%	0	-
71% - 80%	1	1%
81% - 90%	1	1%
91% - 100%	2	2%

[1] 159 No Reply

Q17: Over the past two years has this percentage of uninsured patients increased, decreased, or remained the same? n125; Single Response		
Category	n	%
Increased	35	28%
Decreased	20	16%
Remained the same	54	43%
Unsure	16	13%

Q17: Over the past two years has this percentage of uninsured patients increased, decreased, or remained the same? n125; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	47	2	4	10	22	7	10	1	3	16	3
Increased	38%	-	-	30%	27%	29%	20%	-	33%	13%	33%
Decreased	11%	50%	25%	10%	18%	14%	20%	-	67%	13%	33%
Remained the same	34%	50%	75%	50%	23%	57%	60%	100%	-	74%	34%
Unsure	17%	-	-	10%	32%	-	-	-	-	-	-

Q18: Does your practice use electronic medical records (EMR)? EMR is similar to EHR and are often used interchangeably. n345; Single Response		
Category	n	%
Yes	280	81%
No	51	15%
Unsure	14	4%

Q18: Does your practice use electronic medical records (EMR)? EMR is similar to EHR and are often used interchangeably. n345; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	129	6	8	13	61	11	32	11	16	49	9
Yes	81%	78%	50%	63%	62%	90%	82%	94%	73%	88%	82%
No	15%	19%	33%	38%	31%	3%	9%	-	27%	13%	18%
Unsure	4%	3%	17%	-	8%	7%	9%	6%	-	-	-

Q19: What is the name of your EMR system?

n238[1]; Open-Ended

1. Meditech
2. Next Gen
3. Medent

[1] 42 No Reply

Q20: Is your practice PCMH recognized or accredited? n345; Single Response		
Category	n	%
Yes	64	19%
No	65	19%
Unsure	216	62%

Q21: Is your PCMH recognition from NCQA (National Committee For Quality Assurance)? n60[1]; Single Response		
Category	n	%
Yes	58	97%
No	2	3%

[1] 4 No Reply

Q22: What level of PCMH recognition or accreditation has your practice received? n58; Single Response		
Category	n	%
Level 1	8	14%
Level 2	7	12%
Level 3	24	41%
Unsure	19	33%

Q46: Which of the following best represents your age? n344[1]; Single Response		
Category	n	%
Under 25	2	1%
25 to 34	28	8%
35 to 44	65	19%
45 to 54	104	30%
55 to 64	118	34%
65 to 74	22	6%
75 or older	4	1%
Refused	1	1%

[1] 1 No Reply

Q47: What is your gender? n345; Single Response		
Category	n	%
Male	104	30%
Female	236	69%
Refused	5	1%

Q51: What is the most pressing need to improve healthcare for our community? n266[1]; Open-Ended		
Top 10 Responses	n	%
Access to mental health services	40	15%
Education/Prevention	30	11%
Access to medical services	26	10%
Lack of physicians	25	9%
Affordable health care	15	6%
Coordination of care between providers	13	5%
Access to reliable transportation	8	3%
Access to specialists	8	3%
Home based medical services	8	3%
Access to dental care	6	2%

[1] 79 No Reply

Note: Q48 through Q50 were sweepstake entry questions.

Q52: What is the most pressing need to improve healthcare for the Medicaid and uninsured population within our community? n264; Open-Ended		
Top 10 Responses	n	%
Education/Resources	27	10%
Mental Health	26	10%
Transportation	26	10%
Accessibility - Healthcare Services	23	9%
Prevention/Wellness	23	9%
Affordable Health Care	20	8%
Focus On Primary Care	18	7%
Accessibility - Dental	12	5%
Better Reimbursement	12	5%
Accessibility - Specialty	10	4%

[1] 81 No Reply

Q62: To what extent do you agree with this statement: "There is an issue with today's population accessing the Emergency Department for non-emergent conditions (meaning that care could have been provided effectively in another healthcare setting)." n301[1]; Single Response		
Category	n	%
Strongly agree	225	75%
Somewhat agree	60	20%
Neither agree nor disagree	7	2%
Somewhat disagree	2	1%
Strongly disagree	1	0%
Unsure	6	2%

[1] 44 No Reply

Q62: To what extent do you agree with this statement: "There is an issue with today's population accessing the Emergency Department for non-emergent conditions (meaning that care could have been provided effectively in another healthcare setting)."
n301[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	115	6	8	13	56	9	24	8	15	39	8
Strongly agree	75%	82%	50%	88%	77%	68%	89%	71%	75%	80%	64%
Somewhat agree	20%	14%	17%	13%	23%	25%	11%	25%	13%	13%	33%
Neither agree nor disagree	2%	3%	33%	-	-	2%	-	-	-	-	-
Somewhat disagree	1%	1%	-	-	-	-	-	4%	-	-	-
Strongly disagree	0%	-	-	-	-	2%	-	-	-	-	-
Unsure	2%	1%	-	-	-	4%	-	-	13%	7%	3%

[1] 44 No Reply

Q63: Do you feel the issue of accessing the Emergency Department for non-emergent conditions is more common among the Medicaid and uninsured population? n301[1]; Single Response		
Category	n	%
Yes	252	84%
No	8	2%
Unsure	41	14%

[1] 44 No Reply

Q63: Do you feel the issue of accessing the Emergency Department for non-emergent conditions is more common among the Medicaid and uninsured population? n301[1]; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	115	6	8	13	56	9	24	8	15	39	8
Yes	84%	84%	100%	88%	77%	89%	89%	83%	88%	87%	77%
No	3%	4%	-	-	8%	-	-	4%	-	-	-
Unsure	14%	12%	-	13%	15%	11%	11%	13%	13%	13%	23%

[1] 44 No Reply

Q64: To what extent do you agree with this statement: "There is an issue with patients being re-admitted to the hospital within a 30-day timeframe." n301[1]; Single Response		
Category	n	%
Strongly agree	84	28%
Somewhat agree	120	40%
Neither agree nor disagree	51	17%
Somewhat disagree	13	4%
Strongly disagree	3	1%
Unsure	30	10%

[1] 44 No Reply

Q64: To what extent do you agree with this statement: "There is an issue with patients being re-admitted to the hospital within a 30-day timeframe."
n301[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	115	6	8	13	56	9	24	8	15	39	8
Strongly agree	28%	31%	50%	50%	31%	38%	-	8%	13%	13%	21%
Somewhat agree	40%	44%	17%	13%	46%	45%	56%	42%	38%	47%	26%
Neither agree nor disagree	17%	16%	17%	13%	15%	2%	22%	25%	38%	27%	23%
Somewhat disagree	4%	4%	-	13%	8%	-	-	13%	-	7%	8%
Strongly disagree	1%	-	-	-	-	2%	-	4%	-	-	3%
Unsure	10%	5%	17%	13%	-	14%	22%	8%	13%	7%	21%

[1] 44 No Reply

Q65: Do you feel the issue of patients being re-admitted to the hospital within a 30-day timeframe is more common among the Medicaid and uninsured population? n301[1]; Single Response		
Category	n	%
Yes	122	41%
No	51	17%
Unsure	128	42%

[1] 44 No Reply

Q65: Do you feel the issue of patients being re-admitted to the hospital within a 30-day timeframe is more common among the Medicaid and uninsured population? n301[1]; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	115	6	8	13	56	9	24	8	15	39	8
Yes	41%	39%	50%	25%	53%	48%	45%	38%	25%	53%	28%
No	17%	17%	-	25%	8%	11%	22%	25%	50%	33%	8%
Unsure	42%	44%	50%	50%	39%	41%	33%	37%	25%	14%	64%

Q66: Please rate the following healthcare factors among the general population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.
Single Response Per Factor

Question	n	Unsure	1	2	3	4	5	% 4 or 5
The number of healthcare providers available	298	2%	2%	15%	27%	28%	26%	54%
Availability of after-hours and emergency care	297	2%	4%	20%	28%	24%	22%	46%
Healthcare providers that have convenient office hours for patients	298	3%	2%	18%	33%	28%	16%	44%
Travel time to healthcare provider locations	298	4%	4%	17%	34%	26%	15%	41%
Healthcare providers that are accepting new patients	299	8%	5%	19%	31%	23%	14%	37%
The variety of specialty care providers available	297	1%	10%	26%	28%	21%	14%	35%
Ability for patients to make a timely appointment	298	4%	7%	24%	37%	19%	9%	28%
Availability of community based resources for patients	297	6%	10%	23%	34%	18%	9%	27%
Communication among healthcare providers	294	4%	14%	24%	33%	17%	8%	25%
Availability of transportation to a healthcare provider practice	297	6%	17%	33%	27%	13%	4%	17%
The out-of-pocket healthcare costs to patients	295	9%	15%	37%	26%	11%	2%	13%

Q66: Please rate the following healthcare factors among the general population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.

Single Response Per Factor; %4-5 by county

Question	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	112	6	8	13	56	9	24	8	15	39	8
The number of healthcare providers available	61%	83%	50%	15%	41%	11%	58%	75%	53%	59%	50%
The variety of specialty care providers available	34%	67%	50%	8%	18%	11%	38%	50%	36%	54%	50%
Ability for patients to make a timely appointment	24%	50%	38%	15%	25%	22%	46%	50%	40%	24%	25%
Healthcare providers that have convenient office hours for patients	45%	83%	38%	39%	27%	22%	71%	75%	53%	41%	25%
Healthcare providers that are accepting new patients	39%	50%	75%	8%	23%	22%	71%	50%	40%	33%	25%
The out-of-pocket healthcare costs to patients	9%	33%	-	23%	9%	-	17%	50%	33%	5%	38%
Availability of transportation to a healthcare provider practice	18%	33%	25%	15%	11%	22%	38%	-	7%	13%	25%
Communication among healthcare providers	28%	33%	25%	15%	9%	22%	48%	38%	20%	27%	38%
Availability of after-hours and emergency care	43%	33%	50%	46%	47%	25%	54%	63%	-	64%	63%
Availability of community based resources for patients	27%	50%	13%	31%	24%	-	33%	25%	20%	33%	25%
Travel time to healthcare provider locations	49%	33%	75%	8%	45%	-	38%	38%	20%	36%	38%

Q67: Now, please rate the following healthcare factors among the Medicaid and uninsured population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.
Single Response Per Factor

Question	n	Unsure	1	2	3	4	5	% 4 or 5
Availability of after-hours and emergency care	283	10%	5%	22%	24%	22%	17%	39%
Travel time to healthcare provider locations	280	12%	8%	22%	30%	19%	9%	28%
The out-of-pocket healthcare costs to patients	283	20%	13%	16%	24%	12%	15%	27%
The number of healthcare providers available	284	8%	13%	28%	27%	14%	10%	24%
Healthcare providers that have convenient office hours for patients	284	10%	6%	22%	38%	15%	9%	24%
Availability of community based resources for patients	282	11%	11%	23%	31%	15%	9%	24%
Communication among healthcare providers	282	8%	12%	28%	29%	15%	8%	23%
Ability for patients to make a timely appointment	283	9%	14%	29%	28%	12%	8%	20%
Availability of transportation to a healthcare provider practice	283	13%	21%	27%	19%	10%	10%	20%
Healthcare providers that are accepting new patients	284	13%	16%	29%	23%	10%	9%	19%
The variety of specialty care providers available	284	9%	22%	32%	20%	11%	6%	17%

Q67: Now, please rate the following healthcare factors among the Medicaid and uninsured population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.

Single Response Per Factor; %4-5 by county

Question	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	110	5	8	12	51	9	20	8	14	39	8
Availability of after-hours and emergency care	32%	80%	38%	50%	40%	33%	45%	63%	7%	46%	50%
The out-of-pocket healthcare costs to patients	29%	40%	38%	25%	18%	11%	35%	50%	21%	32%	25%
Travel time to healthcare provider locations	28%	60%	63%	17%	26%	-	40%	50%	21%	21%	14%
Healthcare providers that have convenient office hours for patients	26%	80%	38%	8%	14%	22%	55%	50%	14%	13%	-
Availability of community based resources for patients	25%	60%	13%	58%	12%	-	37%	38%	21%	23%	13%
The number of healthcare providers available	24%	60%	25%	17%	8%	11%	50%	38%	57%	18%	13%
Communication among healthcare providers	23%	20%	25%	25%	12%	25%	45%	25%	29%	18%	25%
Availability of transportation to a healthcare provider practice	20%	60%	25%	25%	10%	33%	35%	25%	14%	15%	13%
The variety of specialty care providers available	17%	40%	38%	8%	8%	-	30%	38%	7%	21%	13%
Healthcare providers that are accepting new patients	17%	60%	13%	-	12%	22%	45%	38%	29%	15%	13%
Ability for patients to make a timely appointment	16%	60%	38%	8%	14%	22%	55%	38%	21%	10%	-

Q68: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the general population? n300[1]; Single Response		
Category	n	%
COPD	52	17%
Heart Disease	51	17%
Chronic Pain (migraines, joint pain, back aches)	48	16%
Mental Health	29	10%
Substance Abuse	15	5%
Diabetes	14	5%
Obesity	10	3%
Asthma	7	2%
Hypertension (high blood pressure)	5	2%
Cancer	1	0%
HIV or AIDS	-	-
Other(s) [1]	7	2%
Unsure	61	21%

[1] Other responses include: acute injury and illnesses (1), cardiac issues and dyspnea (1), chronic pelvic pain and vaginal bleeding (1), combination of mental health and social status/resources at home (1), congestive heart failure (1), injury (1), trauma and wound care (1)

[1] 45 No Reply

Q68: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the general population?

n300[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	114	6	8	13	56	9	24	8	15	39	8
Heart Disease	19%	33%	-	15%	11%	33%	25%	13%	33%	10%	-
Chronic Pain (migraines, joint pain, back aches)	17%	33%	33%	8%	14%	22%	8%	-	13%	18%	38%
COPD	11%	-	33%	23%	41%	11%	25%	38%	7%	-	13%
Diabetes	6%	-	-	8%	2%	-	-	13%	7%	8%	-
Asthma	4%	-	-	-	-	-	-	-	7%	3%	-
Cancer	-	17%	-	-	-	-	-	-	-	-	-
HIV or AIDS	-	-	-	-	-	-	-	-	-	-	-

Q68: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the general population?
n300[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	114	6	8	13	56	9	24	8	15	39	8
Hypertension (high blood pressure)	2%	-	13%	8%	-	-	-	-	-	-	13%
Mental Health	12%	-	13%	-	9%	-	13%	-	7%	10%	13%
Obesity	4%	-	-	-	4%	-	-	13%	-	3%	13%
Substance Abuse	4%	-	-	15%	4%	22%	8%	-	13%	3%	-
Other(s) [1]	4%	-	-	-	-	-	-	-	-	5%	-
Unsure	16%	17%	38%	23%	16%	11%	21%	25%	13%	41%	13%

[1] Other responses include: acute injury and illnesses (1), cardiac issues and dyspnea (1), chronic pelvic pain and vaginal bleeding (1), combination of mental health and social status/resources at home (1), congestive heart failure (1), injury (1), trauma and wound care (1)
[1] 45 No Reply

Q69: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the general population? n286[1]; Single Response		
Category	n	%
HIV or AIDS	106	37%
Obesity	26	9%
Cancer	16	6%
Chronic Pain (migraines, joint pain, back aches)	11	4%
Hypertension (high blood pressure)	11	4%
Mental Health	11	4%
Heart Disease	10	4%
Substance Abuse	9	3%
Asthma	6	2%
Diabetes	5	2%
COPD	2	1%
Other(s) [1]	1	0%
Unsure	72	24%

[1] Other responses include: post-surgical patients-elective surgeries (1)

[1] 59 No Reply

Q69: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the general population? n286[1]; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	111	6	8	12	53	9	20	8	14	38	7
Asthma	5%	-	-	-	-	-	-	-	-	3%	-
Cancer	9%	-	-	-	4%	-	-	-	-	11%	-
Chronic Pain (migraines, joint pain, back aches)	3%	17%	-	-	8%	-	-	13%	-	3%	14%
COPD	2%	-	-	-	-	-	-	-	-	-	-
Diabetes	3%	-	-	-	2%	-	-	13%	-	-	-
Heart Disease	5%	-	-	-	2%	11%	5%	-	7%	3%	-
HIV or AIDS	32%	50%	38%	33%	47%	44%	50%	38%	43%	24%	43%

Q69 Continued: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the general population?

n286[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	111	6	8	12	53	9	20	8	14	38	7
Hypertension (high blood pressure)	3%	-	-	17%	2%	-	5%	-	21%	-	14%
Mental Health	4%	-	-	-	4%	-	15%	-	7%	3%	-
Obesity	12%	17%	-	17%	6%	-	10%	-	7%	8%	14%
Substance Abuse	2%	-	13%	8%	6%	11%	-	-	-	-	14%
Other(s) [1]	1%	-	-	-	-	-	-	-	-	-	-
Unsure	22%	17%	50%	25%	21%	33%	15%	38%	14%	47%	-

[1] Other responses include: post-surgical patients-elective surgeries (1)

[1] 50 No Reply

Q70: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations? n295[1]; Single Response		
Category	n	%
Mental Health	46	16%
Chronic Pain (migraines, joint pain, back aches)	40	14%
COPD	37	13%
Substance Abuse	24	8%
Heart Disease	22	8%
Diabetes	21	7%
Obesity	12	4%
Asthma	8	3%
Hypertension (high blood pressure)	5	2%
HIV or AIDS	1	0%
Cancer	-	-
Other(s) [1]	7	2%
Unsure	72	23%

[1] Other responses include: abdominal pain (1), colds/UTIs (1), congestive heart failure (1), dental (1), mental health effects on chronic illnesses/end of life issues/lack of caregiver (1), pelvic pain and chronic vaginal bleeding (1), respiratory/colds/coughs (1)

[1] 50 No Reply

Q70: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations?

n295[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	113	6	8	13	54	9	23	8	15	38	8
Asthma	4%	-	-	8%	-	-	-	-	7%	5%	-
Cancer	-	-	-	-	-	-	-	-	-	-	-
Chronic Pain (migraines, joint pain, back aches)	11%	33%	13%	8%	11%	22%	13%	13%	27%	13%	38%
COPD	9%	17%	13%	8%	32%	-	17%	13%	-	5%	-
Diabetes	9%	-	-	8%	4%	-	17%	13%	7%	5%	-
Heart Disease	9%	17%	-	8%	-	22%	9%	13%	20%	5%	-
HIV or AIDS	-	-	-	-	-	11%	-	-	-	-	-

Q70 Continued: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations?

n295[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	113	6	8	13	54	9	23	8	15	38	8
Hypertension (high blood pressure)	1%	-	-	8%	2%	11%	4%	-	-	-	-
Mental Health	22%	-	13%	15%	13%	-	13%	-	13%	13%	13%
Obesity	6%	-	-	-	4%	-	-	13%	-	3%	13%
Substance Abuse	4%	-	25%	15%	9%	33%	4%	-	13%	8%	13%
Other(s) [1]	5%	-	-	-	2%	-	-	-	-	-	-
Unsure	20%	33%	38%	23%	24%	-	22%	38%	13%	42%	25%

[1] Other responses include: abdominal pain (1), colds/UTIs (1), congestive heart failure (1), dental (1), mental health effects on chronic illnesses/end of life issues/lack of caregiver (1), pelvic pain and chronic vaginal bleeding (1), respiratory/colds/coughs (1)

[1] 50 No Reply

Q71: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations? n284[1]; Single Response		
Category	n	%
HIV or AIDS	91	32%
Cancer	29	10%
Obesity	17	6%
Chronic Pain (migraines, joint pain, back aches)	9	3%
Diabetes	9	3%
Heart Disease	8	3%
Hypertension (high blood pressure)	8	3%
Mental Health	8	3%
Substance Abuse	7	3%
COPD	2	1%
Asthma	1	0%
Unsure	95	33%

[1] 61 No Reply

Q71: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations?
n284[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	110	6	8	13	52	9	21	8	15	36	6
Asthma	-	-	-	-	-	-	-	-	7%	-	-
Cancer	16%	-	-	-	-	-	14%	-	13%	11%	33%
Chronic Pain (migraines, joint pain, back aches)	-	17%	13%	-	4%	11%	-	13%	7%	-	33%
COPD	1%	17%	-	-	-	-	-	-	-	-	-
Diabetes	4%	-	-	8%	-	-	5%	13%	7%	-	17%
Heart Disease	7%	-	-	-	-	-	-	-	-	-	-
HIV or AIDS	20%	50%	38%	31%	60%	22%	48%	38%	20%	25%	17%
Hypertension (high blood pressure)	2%	-	-	8%	2%	11%	-	-	13%	3%	-
Mental Health	4%	-	-	-	-	-	5%	-	7%	6%	-
Obesity	8%	-	-	8%	2%	11%	10%	-	13%	3%	-
Substance Abuse	3%	-	-	-	6%	11%	-	-	-	-	-
Unsure	36%	17%	50%	46%	27%	33%	19%	38%	13%	53%	-

[1] 61 No Reply

Q72: Does your practice or organization use a community resource directory for patients? n301[1]; Single Response		
Category	n	%
Yes	157	52%
No	63	21%
Unsure	81	27%

[1] 44 No Reply

Q72: Does your practice or organization use a community resource directory for patients? n301[1]; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	115	6	8	13	56	9	24	8	15	39	8
Yes	61%	83%	-	69%	54%	56%	33%	13%	67%	41%	38%
No	16%	-	88%	15%	13%	33%	25%	50%	27%	26%	25%
Unsure	23%	17%	12%	16%	33%	11%	42%	37%	6%	33%	37%

[1] 44 No Reply

Q73: Are you aware of the 2-1-1 human resources directory for your area? n301[1]; Single Response		
Category	n	%
Yes	111	37%
No	190	63%

[1] 44 No Reply

Q73: Are you aware of the 2-1-1 human resources directory for your area? n301[1]; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	115	6	8	13	56	9	24	8	15	39	8
Yes	25%	50%	25%	46%	41%	33%	33%	38%	33%	72%	13%
No	75%	50%	75%	54%	59%	67%	67%	63%	67%	28%	87%

[1] 44 No Reply

Q74: Please rate how aware you are of the 2-1-1 human resources directory for your area using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor. n111; Single Response						
Unsure	1	2	3	4	5	% 4 or 5
32%	4%	6%	19%	23%	16%	39%

Q75: Are there enough community resources to support the healthcare needs for your area? n301[1]; Single Response		
Category	n	%
Yes	54	18%
No	175	58%
Unsure	72	24%

[1] 44 No Reply

Q75: Are there enough community resources to support the healthcare needs for your area? n301[1]; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	115	6	8	13	56	9	24	8	15	39	8
Yes	17%	17%	38%	15%	18%	11%	21%	25%	-	28%	-
No	56%	50%	50%	62%	61%	89%	54%	50%	87%	49%	62%
Unsure	27%	33%	12%	23%	21%	-	25%	25%	13%	23%	38%

[1] 44 No Reply

Q76: In your practice, is there someone who assists patients with finding community resources? n301[1]; Single Response		
Category	n	%
Yes	200	67%
No	73	24%
Unsure	28	9%

[1] 44 No Reply

Q77: To what extent do patients or residents in the general population engage in preventive health behavior? n111; Single Response		
Category	n	%
Never	-	-
Sometimes	74	67%
Usually	30	27%
Always	2	2%
Unsure	5	4%

Q77: To what extent do patients or residents in the general population engage in preventive health behavior? n111; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	29	3	2	6	23	3	8	3	5	28	1
Never	-	-	-	-	-	-	-	-	-	-	-
Sometimes	65%	100%	100%	67%	52%	67%	75%	67%	60%	75%	-
Usually	35%	-	-	33%	26%	33%	25%	33%	20%	21%	100%
Always	-	-	-	-	4%	-	-	-	20%	-	-
Unsure	-	-	-	-	18%	-	-	-	-	4%	-

Q78: Over the past 3 years has this preventive behavior among the general population... n111; Single Response		
Category	n	%
Increased	43	39%
Decreased	5	4%
Remained the same	44	40%
Unsure	19	17%

Q78: Over the past 3 years has this preventive behavior among the general population... n111; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	29	3	2	6	23	3	8	3	5	28	1
Increased	52%	67%	50%	50%	30%	-	25%	-	20%	43%	-
Decreased	10%	-	-	17%	4%	-	-	-	-	-	-
Remained the same	31%	33%	50%	33%	35%	67%	63%	33%	60%	39%	100%
Unsure	7%	-	-	-	31%	33%	12%	67%	20%	18%	-

Q79: To what extent does the Medicaid and uninsured population engage in preventive health behavior? n111; Single Response		
Category	n	%
Never	9	8%
Sometimes	91	82%
Usually	2	2%
Always	1	1%
Unsure	8	7%

Q79: To what extent does the Medicaid and uninsured population engage in preventive health behavior? n111; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	29	3	2	6	23	3	8	3	5	28	1
Never	10%	-	-	17%	4%	-	13%	33%	20%	4%	-
Sometimes	83%	100%	100%	83%	78%	100%	87%	33%	80%	86%	-
Usually	3%	-	-	-	-	-	-	-	-	-	100%
Always	-	-	-	-	4%	-	-	-	-	-	-
Unsure	4%	-	-	-	14%	-	-	34%	-	10%	-

Q80: Over the past 3 years has this preventive behavior among the Medicaid and uninsured population... n111; Single Response		
Category	n	%
Increased	7	6%
Decreased	15	14%
Remained the same	58	52%
Unsure	31	28%

Q80: Over the past 3 years has this preventive behavior among the Medicaid and uninsured population... n111; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	29	3	2	6	23	3	8	3	5	28	1
Increased	10%	-	-	-	4%	-	-	-	-	11%	10%
Decreased	24%	-	50%	33%	9%	-	25%	-	20%	-	24%
Remained the same	48%	100%	-	67%	52%	67%	63%	33%	60%	50%	48%
Unsure	18%	-	50%	-	35%	33%	12%	67%	20%	39%	18%

Online Survey
Community Non-Clinical Audience
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.

Q1: Which of the following statements best applies to you? n505; Single Response		
Category	n	%
I am a healthcare provider, physician, or work in an organization that provides healthcare.	-	-
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.	505	100%
Neither of the above statements, I am a community resident.	-	-

Q3: In which county do you primarily work or practice? n505; Single Response		
Category	n	%
Broome	143	28%
Cortland	105	21%
Tompkins	72	14%
Schuyler	55	11%
Tioga	40	8%
Chenango	22	4%
Steuben	20	4%
Chemung	16	3%
Cayuga	13	3%
Delaware	11	2%
None of the above	8	2%

Q23: What type(s) of services does your organization provide? n505; Select All That Apply					
Category	n	%	Category	n	%
Assistance to vulnerable populations	263	52%	Transportation services	92	18%
Advocacy	239	47%	Safe and affordable housing	65	13%
Mental health services	195	39%	Blood donation	57	11%
Long-term care services	194	38%	Workforce assistance	54	11%
Care giving services	174	35%	Disaster relief	51	10%
Health and safety courses	128	25%	Religious services	44	9%
Family enrichment services	117	23%	Contraceptive services	30	6%
Rural residents health outreach	112	22%	Computer training services	26	5%
Community helpline	108	21%	International humanitarian services	9	2%
Free or low-cost medical services	102	20%	Military family support	6	1%
Help with addiction	102	20%	Other(s)[1]	144	29%
Developmentally disabled services	93	18%	Unsure	7	1%

[1] Common Other responses include: child advocacy (7), durable medical equipment (6), emergency assistance-food/housing (6), hospital (6), health insurance navigation and assistance (5), prevention services (5)

Q24: How often does your organization interact with healthcare providers? n505; Single Response		
Category	n	%
Never	4	1%
Sometimes	90	18%
Usually	101	20%
Always	298	59%
Unsure	12	2%

Q24: How often does your organization interact with healthcare providers?
n505; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	143	13	16	22	105	11	55	20	40	72	8
Never	1%	-	-	-	-	-	-	5%	-	3%	-
Sometimes	11%	8%	25%	32%	9%	9%	18%	20%	30%	35%	25%
Usually	15%	39%	6%	14%	24%	36%	11%	20%	30%	26%	13%
Always	72%	46%	63%	50%	65%	55%	71%	50%	35%	36%	62%
Unsure	1%	7%	6%	4%	2%	-	-	5%	5%	-	-

Q25: How often does your organization interact with the Medicaid and uninsured population? n505; Single Response		
Category	n	%
Never	6	1%
Sometimes	43	9%
Usually	119	24%
Always	326	64%
Unsure	11	2%

Q25: How often does your organization interact with the Medicaid and uninsured population?
n505; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	143	13	16	22	105	11	55	20	40	72	8
Never	-	-	-	5%	2%	-	-	5%	-	3%	-
Sometimes	4%	-	19%	9%	7%	8%	9%	10%	5%	19%	25%
Usually	15%	46%	19%	45%	20%	46%	20%	15%	25%	32%	62%
Always	81%	46%	56%	41%	66%	46%	69%	65%	70%	44%	13%
Unsure	-	8%	6%	-	5%	-	2%	5%	-	2%	-

Q26: What is your job title at your organization?

n364[1]; Open-Ended

- account processor (Broome)
- Addiction Counselor (Broome)
- Administration (Broome)
- Administrative Assistant (Broome)
- administrative assistant (Broome)
- Administrative Manager (Broome)
- Administrative Secretary (Broome)
- Aide (Broome)
- Aide Team Assistant (Broome)
- Administrative Assistant (Broome)
- Associate (Broome)
- Billing Manager (Broome)
- business rep (Broome)
- Care Coordinator (Broome)
- care manager (Broome)
- care manager (Broome)
- Case Manager (Broome)
- Center Director (Broome)
- Certified Home Health Aide (Broome)
- clerical medical office assistant (Broome)
- CMA (Broome)
- CNA (Broome)
- Community Health Services Director (Broome)
- Confirming Specialist (Broome)
- coordinator (Broome)
- Counselor (Broome)
- counselor (Broome)
- Customer Service Associate (Broome)
- Deputy Commissioner, Assistance Programs (Broome)
- Development Assistant (Broome)
- Development Assistant (Broome)
- Director (Broome)
- Director of Community Health (Broome)
- Director of Development (Broome)
- Director of Programs (Broome)
- Education Advocate/Parent Mentor (Broome)
- Education Coordinator (Broome)
- E-Learning Specialist (Broome)
- Equipment Management (Broome)
- Executive assistant (Broome)
- Executive Director (Broome)
- Executive Director (Broome)
- Executive Director (Broome)
- Executive Director (Broome)
- Finance Director (Broome)
- Habilitation Coordinator (Broome)
- Health and Well Being Associate (Broome)
- Health Care Access Associate (Broome)
- Health Care Access Facilitator (Broome)
- Health Home Care Management (Broome)
- Health Home Care Manager (Broome)
- health information specialist (Broome)

[1] 141 No Reply

Q26: What is your job title at your organization?

n364[1]; Open-Ended

- Human Resources Business Partner (Broome)
- IT Manager (Broome)
- Library Director (Broome)
- Manager Substance Abuse Prevention (Broome)
- Manager (Broome)
- Medicaid Service Coordinator (Broome)
- Medicaid Service Coordinator (Broome)
- medical librarian (Broome)
- Medical office assistant (Broome)
- medical social worker (Broome)
- Medical Social Worker (Broome)
- MFP Outreach Specialist (Broome)
- Nurse Care Coordinator of the Medicaid Health Home at UHS (Broome)
- Nurse case Manager (Broome)
- Nursing Assistant (Broome)
- Nutrition educator (Broome)
- Office Manager (Broome)
- outreach representative (Broome)
- outreach representative (Broome)
- patient acct rep (Broome)
- PCAP accounts manager (Broome)
- Peer Counselor (Broome)
- Performance Manager (Broome)
- personal care aide (Broome)
- Personal Care Aide (Broome)
- Program Aid (Broome)
- Program Coordinator (Broome)
- Program Coordinator (Broome)
- Program Management (Broome)
- PTA (Broome)
- Public Health Educator (Broome)
- Resident Counselor (Broome)
- RN (Broome)
- rn (Broome)
- RN, staff nurse (Broome)
- RNSupervisor (Broome)
- Senior Regional Leader (Broome)
- social worker (Broome)
- social worker (Broome)
- Social Worker (Broome)
- Social Worker (Broome)
- Supervisor (Broome)
- Systems Trainer (Broome)
- Team Assistant (Broome)
- Unit Coordinator (Broome)
- V.P. Quality & Risk Mgmt / CRO (Broome)
- Vice President, Human Resources and Support Services (Broome)
- VP Finance (Broome)
- was Social Service Director (Broome)
- Website Coordinator (Broome)

[1] 141 No Reply

Q26: What is your job title at your organization?

n364[1]; Open-Ended

- women services specialist (Broome)
- Administrator of Day Hab services (Cayuga)
- Assistant Director of Vocational Services (Cayuga)
- Coordinator of Community Relations (Cayuga)
- dental assistant (Cayuga)
- Director (Cayuga)
- Director of Social Services (Cayuga)
- Executive Director (Cayuga)
- Marketing (Cayuga)
- production manager (Cayuga)
- Senior Employment Specialist (Cayuga)
- Access Director (Chemung)
- Director (Chemung)
- Director (Chemung)
- Director of nursing (Chemung)
- dsa (Chemung)
- DSP (Chemung)
- dsp (Chemung)
- Local Food Associate Representative (Chemung)
- LPN (Chemung)
- manager (Chemung)
- Medical Records Clerk (Chemung)
- Pharmacist (Chemung)
- receptionist (Chemung)
- Recreation Director (Chemung)
- Recreation Therapist (Chemung)
- cancer outreachspecialist (Chenango)
- Coordinator of Services (Chenango)
- crisis prevention specialist (Chenango)
- Development/Clinical Outreach (Chenango)
- Director (Chenango)
- Director of Environmental Health Services (Chenango)
- Director of Special Projects/Foundation Executive Director (Chenango)
- Executive Assistant to the President (Chenango)
- Executive Director (Chenango)
- Executive Director (Chenango)
- LCSW (Chenango)
- mental health counselor (Chenango)
- Prescription Assistance Specialist (Chenango)
- Prevention Counselor (Chenango)
- Program Director (Chenango)
- Vocational Educational Specialist (Chenango)
- Administrator (Cortland)
- Admitting Rep (Cortland)
- ADMITTING REP (Cortland)
- Admitting Representative (Cortland)
- Applications Analyst (Cortland)
- billing/customer service (Cortland)
- care transition manager (Cortland)
- caseworker (Cortland)
- caseworker long term care (Cortland)

[1] 141 No Reply

Q26: What is your job title at your organization?

n364[1]; Open-Ended

- CEO (Cortland)
- children mental health intensive case manager (Cortland)
- Children's Intensive Case Manager (Cortland)
- Clinical Documentation Nurse (Cortland)
- CNA (Cortland)
- Compliance Auditor (Cortland)
- computer tech 1 (Cortland)
- Computer Technician (Cortland)
- CUSTOMER SERVICE/ORDER ENTRY/PRE- BILLING (Cortland)
- Director (Cortland)
- director (Cortland)
- director (Cortland)
- director (Cortland)
- Director of Administration and Community Services (Cortland)
- Director of Community Services (Cortland)
- Director of Vocational Services (Cortland)
- education director (Cortland)
- Evaluation services (Cortland)
- Executive Assistant (Cortland)
- Executive Assistant (Cortland)
- Executive Director (Cortland)
- Executive Director (Cortland)
- Food Service Director (Cortland)
- IMAGING REPRESENTAIVE (Cortland)
- Independent Living Coordinator (Cortland)
- IT Manager (Cortland)
- lpn (Cortland)
- Media Specialist (Cortland)
- MSC supervisor (Cortland)
- network admin (Cortland)
- Outpatient records processor (ER) (Cortland)
- PATIENT ACCESS (Cortland)
- PATIENT REGISTRATION (Cortland)
- PATIENT REGISTRATION REP (Cortland)
- Per Diem - Residental Counselor (Cortland)
- phelbotomist (Cortland)
- Pre-K Coordinator (Cortland)
- Program Manager (Cortland)
- Project Assistant (Cortland)
- Project Assistant (Cortland)
- Project coordinator (Cortland)
- QA (Cortland)
- recovery support spcialist (Cortland)
- Registered dietitian (Cortland)
- REGISTRATION (Cortland)
- Residential Advisor. (Cortland)
- Rn Field Supervisor (Cortland)
- Sales (Cortland)

[1] 141 No Reply

Q26: What is your job title at your organization?

n364[1]; Open-Ended

- SECRETARY (Cortland)
- Secretary II to the DCS (Cortland)
- Security/Safety Manager (Cortland)
- Senior Account Clerk (Cortland)
- Special Projects Coordinator (Cortland)
- SPOA coordinator, Youth Development Services Director (Cortland)
- Sr Caseworker (Cortland)
- Sr. Corrspondent (Cortland)
- Supervisory Service Corodinator (Cortland)
- supply processing tech (Cortland)
- Supported Housing Coordinator (Cortland)
- Supportive Apartment Coordinator (Cortland)
- Therapist (Cortland)
- VP Finance (Cortland)
- VP Services (Cortland)
- Account Clerk Typist (Delaware)
- Assistant Director (Delaware)
- Caseworker (Delaware)
- DCP (Delaware)
- Program Coordinator (Delaware)
- Project Manager (Delaware)
- Business Development (None of the above)
- Executive Director (None of the above)
- resident assistant (None of the above)
- Accounting clerk (Schuyler)
- ADMISSIONS CLERK (Schuyler)
- Agency Director (Schuyler)
- C N A (Schuyler)
- Case Manager (Schuyler)
- coder (Schuyler)
- Coordinator (Schuyler)
- Coordinator of Business/Computers Services (Schuyler)
- Development Assistant (Schuyler)
- Development/Marketing Assistant (Schuyler)
- Direct support professional (Schuyler)
- Director (Schuyler)
- Director (Schuyler)
- Director (Schuyler)
- Director (Schuyler)
- Director of Community Relations (Schuyler)
- Director of Service Coordination (Schuyler)
- Discharge Planner/ Utilization Review House Supervisor (Schuyler)
- Emergency Department Patient Navigator (Schuyler)
- Executive Assistant (Schuyler)
- Executive Director (Schuyler)
- Executive Director (Schuyler)
- Facilities Director (Schuyler)
- Financial Analyst (Schuyler)
- Financial Reimbursement Analyst (Schuyler)
- Fiscal Coordiantor (Schuyler)

[1] 141 No Reply

Q26: What is your job title at your organization?
n364[1]; Open-Ended

- Fundraising & Development Assistant; Community Relations Assistant (Schuyler)
- Human Resources Assistant (Schuyler)
- Intensive Case manager for children and youth (Schuyler)
- IT Applications Supervisor, BAR Administrator, NPR Programmer (Schuyler)
- Keyboard Specialist (Schuyler)
- LPN, applications analyst and information (Schuyler)
- MEDICAL CODER (Schuyler)
- Medicare Biller (Schuyler)
- Outreach Director (Schuyler)
- Patient Service Representative (Schuyler)
- Pharmacy Technician (Schuyler)
- Radiology Receptionist (Schuyler)
- Regional Coordinator (Schuyler)
- RN (Schuyler)
- RN (Schuyler)
- Senior Account Clerk Keyboard Specialist (Schuyler)
- Social Worker (Schuyler)
- Victim Advocate (Schuyler)
- assistant program coordinator (Steuben)
- Cancer Services Program Coordinator (Steuben)
- CEO (Steuben)
- Director (Steuben)
- Executive Director (Steuben)
- Executive Director (Steuben)
- Manager of Communications and Volunteer Support (Steuben)
- Mobility Manager (Steuben)
- non-union janitor (Steuben)
- Outreach Coordinator (Steuben)
- President and CEO (Steuben)
- Public Health Director (Steuben)
- Registration (Steuben)
- Respiratory Therapist (Steuben)
- Rural Care Management Supervisor (Steuben)
- Slp (Steuben)
- Vice President (Steuben)
- Care Manager (Tioga)
- Case Coordinator (Tioga)
- CNA (Tioga)
- committee chairman (Tioga)
- criminal court supervisor (probation) (Tioga)
- disability case worker (Tioga)
- Family outreach specialist (Tioga)
- Fiscal & Operations Director (Tioga)
- Medicaid Service Coordintaor Team Leader (Tioga)
- Navigation Contract Coordinator (Tioga)
- Navigator (Tioga)
- Parent Educator (Tioga)
- Parent Educator (Tioga)

[1] 141 No Reply

Q26: What is your job title at your organization?

n364[1]; Open-Ended

- Primary & Prevent Secretary (Tioga)
- Program Coordinator (Tioga)
- Program Director (Tioga)
- Program Manager (Tioga)
- Public Health Educator (Tioga)
- Public Health Sanitarian (Tioga)
- Records Management (Tioga)
- Reimbursement Coordinator (Tioga)
- Residency Program Coordinator (Tioga)
- secretary (Tioga)
- secretary to the director of community services (Tioga)
- Senior Caseworker/RN (Tioga)
- Socail Welfare Examiner (Tioga)
- Social Welfare Examiner (Tioga)
- Social Welfare Examiner (Tioga)
- Social Worker (Tioga)
- Sr. Caseworker-Trainer (Tioga)
- Supervisor (Tioga)
- supervisor child welfare (Tioga)
- Support Investigator (Tioga)
- Administrator (Tompkins)
- Adult Protective Case Worker (Tompkins)
- Aging Services Specialist (Tompkins)
- Aging Services Specialist (Tompkins)
- aging services specialist (Tompkins)
- Care Coordinator (Tompkins)
- Case Manager (Tompkins)
- Caseworker (Tompkins)
- CEO (Tompkins)
- Chaplain (Tompkins)
- Chief Transportation Planner (Tompkins)
- Director (Tompkins)
- Director (Tompkins)
- director of development (Tompkins)
- Director of Social Work (Tompkins)
- Educator (Tompkins)
- Envoy (Tompkins)
- Exec. Director (Tompkins)
- Executive Director (Tompkins)
- Executive Director (Tompkins)
- Executive Director (Tompkins)
- General Executive (Tompkins)
- Health Access Navigator (Tompkins)
- HR Manager (Tompkins)
- Improvement Advisor (Tompkins)
- Independent contractor (Tompkins)
- Kitchen manager (Tompkins)
- medical social worker (Tompkins)
- Navigator (Tompkins)
- nurse supervisor (Tompkins)
- ommunity Outreach Liaison (Tompkins)
- Pastor (Tompkins)

[1] 141 No Reply

Q26: What is your job title at your organization?

n364[1]; Open-Ended

- Peer Counselor- 14 yrs Finger Lakes Independence Center, Ithaca, NY (Tompkins)
- President / CEO (Tompkins)
- Program Coordinator (Tompkins)
- Program Director (Tompkins)
- Program educator (Tompkins)
- Psychologist (Tompkins)
- Registered Dietitian/Assistant Director (Tompkins)
- RN (Tompkins)
- Senior Customer service Technician (Tompkins)
- Site Manager (Tompkins)
- Social Worker (Tompkins)
- Social Worker (Tompkins)
- supevisory RN (Tompkins)

[1] 141 No Reply

Q27: How long have you worked at your organization? n505; Single Response		
Category	n	%
Less than 1 year	64	12%
1 to 5 years	148	29%
6 to 10 years	114	23%
11 to 15 years	65	13%
More than 15 years	114	23%

Q28: How long have you worked in your current position? n505; Single Response		
Category	n	%
Less than 1 year	89	18%
1 to 5 years	199	39%
6 to 10 years	109	22%
11 to 15 years	53	10%
More than 15 years	55	11%

Q46: Which of the following best represents your age? n505; Single Response		
Category	n	%
Under 25	11	2%
25 to 34	76	15%
35 to 44	103	21%
45 to 54	137	27%
55 to 64	145	29%
65 to 74	30	6%
75 or older	1	0%

Q47: What is your gender? n505; Single Response		
Category	n	%
Male	80	16%
Female	419	83%
Refused	6	1%

Q51: What is the most pressing need to improve healthcare for our community? n393[1]; Open-Ended		
Top 10 Responses	n	%
Making healthcare more affordable	74	19%
Increased access to medical services	70	18%
Access to mental health services	53	14%
Higher quality of service from healthcare providers	34	9%
Increased healthcare education	34	9%
Access to physicians or specialists	29	7%
Access to reliable transportation	21	5%
Access to community support organizations	15	4%
Practicing preventative healthcare	15	4%
Effective provider communication	13	3%

[1] 112 No Reply

Note: Q48 through Q50 were sweepstake entry questions.

Q52: What is the most pressing need to improve healthcare for the Medicaid and uninsured population within our community? n382; Open-Ended		
Top 10 Responses	n	%
Transportation	53	14%
Education/Resources	47	12%
Affordable Health Care	40	10%
Accessibility - Healthcare Services	39	10%
Mental Health	36	9%
Communication/Coordination	32	8%
Prevention/Wellness	24	6%
Focus On Primary Care	15	4%
More Doctors/Clinics/Options	15	4%
Coverage	14	4%

[1] 123 No Reply

Q62: To what extent do you agree with this statement: "There is an issue with today's population accessing the Emergency Department for non-emergent conditions (meaning that care could have been provided effectively in another healthcare setting)." n441[1]; Single Response		
Category	n	%
Strongly agree	279	63%
Somewhat agree	131	30%
Neither agree nor disagree	9	2%
Somewhat disagree	6	1%
Strongly disagree	5	1%
Unsure	11	3%

[1] 64 No Reply

Q62: To what extent do you agree with this statement: "There is an issue with today's population accessing the Emergency Department for non-emergent conditions (meaning that care could have been provided effectively in another healthcare setting)."
n441[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	20	94	9	46	17	36	68	6
Strongly agree	73%	62%	54%	50%	71%	22%	52%	59%	67%	50%	67%
Somewhat agree	22%	38%	31%	30%	25%	78%	37%	29%	25%	41%	33%
Neither agree nor disagree	2%	-	8%	10%	2%	-	4%	-	-	-	-
Somewhat disagree	1%	-	-	-	-	-	2%	6%	3%	3%	-
Strongly disagree	2%	-	-	-	1%	-	-	-	3%	2%	-
Unsure	-	-	7%	10%	1%	-	5%	6%	2%	4%	-

[1] 64 No Reply

Q63: Do you feel the issue of accessing the Emergency Department for non-emergent conditions is more common among the Medicaid and uninsured population? n441[1]; Single Response		
Category	n	%
Yes	353	80%
No	25	6%
Unsure	63	14%

[1] 64 No Reply

Q63: Do you feel the issue of accessing the Emergency Department for non-emergent conditions is more common among the Medicaid and uninsured population?
n441[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	20	94	9	46	17	36	68	6
Yes	86%	75%	85%	75%	80%	89%	70%	88%	83%	74%	83%
No	4%	13%	-	10%	5%	-	11%	-	3%	9%	-
Unsure	10%	12%	15%	15%	15%	11%	19%	12%	14%	17%	17%

[1] 64 No Reply

Q64: To what extent do you agree with this statement: "There is an issue with patients being re-admitted to the hospital within a 30-day timeframe." n441[1]; Single Response		
Category	n	%
Strongly agree	101	23%
Somewhat agree	146	33%
Neither agree nor disagree	86	20%
Somewhat disagree	23	5%
Strongly disagree	5	1%
Unsure	80	18%

[1] 64 No Reply

Q64: To what extent do you agree with this statement: "There is an issue with patients being re-admitted to the hospital within a 30-day timeframe."
n441[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	20	94	9	46	17	36	68	6
Strongly agree	39%	25%	23%	10%	21%	22%	9%	24%	17%	12%	33%
Somewhat agree	30%	25%	46%	15%	32%	45%	28%	41%	31%	46%	33%
Neither agree nor disagree	21%	25%	23%	25%	21%	11%	26%	-	19%	13%	17%
Somewhat disagree	1%	13%	-	-	5%	11%	15%	6%	3%	9%	-
Strongly disagree	1%	-	-	-	1%	11%	-	-	3%	2%	-
Unsure	8%	12%	8%	50%	20%	-	22%	29%	27%	18%	17%

[1] 64 No Reply

Q65: Do you feel the issue of patients being re-admitted to the hospital within a 30-day timeframe is more common among the Medicaid and uninsured population? n441[1]; Single Response		
Category	n	%
Yes	166	37%
No	69	16%
Unsure	206	47%

[1] 64 No Reply

Q65: Do you feel the issue of patients being re-admitted to the hospital within a 30-day timeframe is more common among the Medicaid and uninsured population?
n441[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	20	94	9	46	17	36	68	6
Yes	41%	-	23%	15%	38%	56%	26%	59%	47%	34%	100%
No	13%	25%	31%	15%	15%	22%	26%	-	11%	18%	-
Unsure	46%	75%	46%	70%	47%	22%	48%	41%	42%	48%	-

[1] 64 No Reply

Q66: Please rate the following healthcare factors among the general population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.

Single Response Per Factor

Question	n	Unsure	1	2	3	4	5	% 4 or 5
The number of healthcare providers available	437	2%	4%	14%	29%	29%	22%	51%
Availability of after-hours and emergency care	435	5%	10%	20%	28%	25%	12%	37%
Travel time to healthcare provider locations	436	5%	6%	18%	35%	23%	13%	36%
Healthcare providers that have convenient office hours for patients	437	3%	6%	19%	37%	25%	10%	35%
The variety of specialty care providers available	436	2%	11%	28%	28%	21%	10%	31%
Availability of community based resources for patients	433	7%	9%	21%	33%	21%	9%	30%
Ability for patients to make a timely appointment	436	4%	7%	26%	34%	21%	8%	29%
Healthcare providers that are accepting new patients	436	12%	7%	24%	31%	18%	8%	26%
Availability of transportation to a healthcare provider practice	430	12%	21%	29%	21%	11%	6%	17%
Communication among healthcare providers	432	8%	16%	30%	29%	12%	5%	17%
The out-of-pocket healthcare costs to patients	435	13%	15%	29%	30%	10%	3%	13%

Q66: Please rate the following healthcare factors among the general population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.

Single Response Per Factor; %4-5 by county

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	18	94	9	45	17	36	67	6
The number of healthcare providers available	60%	38%	69%	33%	34%	22%	51%	47%	56%	66%	17%
The variety of specialty care providers available	41%	38%	31%	6%	20%	22%	27%	29%	28%	42%	17%
Ability for patients to make a timely appointment	27%	25%	46%	11%	18%	11%	40%	35%	39%	41%	0%
Healthcare providers that have convenient office hours for patients	35%	38%	39%	17%	30%	11%	42%	35%	39%	45%	0%
Healthcare providers that are accepting new patients	29%	13%	39%	22%	17%	11%	31%	35%	31%	33%	0%
The out-of-pocket healthcare costs to patients	14%	0%	31%	6%	9%	11%	13%	18%	23%	17%	17%
Availability of transportation to a healthcare provider practice	18%	0%	23%	0%	12%	11%	30%	35%	17%	20%	0%
Communication among healthcare providers	16%	0%	31%	11%	19%	11%	31%	18%	20%	11%	0%
Availability of after-hours and emergency care	44%	0%	23%	28%	41%	22%	38%	41%	20%	40%	0%
Availability of community based resources for patients	32%	13%	39%	18%	29%	11%	26%	47%	17%	43%	0%
Travel time to healthcare provider locations	48%	13%	69%	11%	41%	0%	38%	24%	22%	28%	0%

Q67: Now, please rate the following healthcare factors among the Medicaid and uninsured population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.
Single Response Per Factor

Question	n	Unsure	1	2	3	4	5	% 4 or 5
Availability of after-hours and emergency care	421	11%	11%	21%	30%	17%	10%	27%
The out-of-pocket healthcare costs to patients	421	20%	16%	17%	21%	11%	15%	26%
Availability of community based resources for patients	418	11%	12%	23%	29%	15%	10%	25%
Healthcare providers that have convenient office hours for patients	419	11%	11%	22%	34%	16%	6%	22%
Travel time to healthcare provider locations	422	14%	12%	24%	29%	14%	7%	21%
The number of healthcare providers available	422	11%	16%	29%	24%	12%	8%	20%
Availability of transportation to a healthcare provider practice	422	12%	24%	27%	19%	10%	8%	18%
Ability for patients to make a timely appointment	421	13%	18%	25%	27%	12%	5%	17%
Communication among healthcare providers	421	15%	18%	29%	24%	10%	4%	14%
The variety of specialty care providers available	422	10%	25%	32%	20%	9%	4%	13%
Healthcare providers that are accepting new patients	420	19%	19%	27%	22%	9%	4%	13%

Q67: Now, please rate the following healthcare factors among the Medicaid and uninsured population in your county using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor.

Single Response Per Factor; %4-5 by county

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	122	8	12	19	87	8	43	17	36	64	6
The number of healthcare providers available	28%	0%	17%	11%	14%	0%	42%	6%	25%	14%	0%
The variety of specialty care providers available	17%	0%	8%	0%	8%	0%	30%	12%	8%	11%	0%
Ability for patients to make a timely appointment	16%	0%	25%	5%	9%	0%	37%	24%	19%	22%	0%
Healthcare providers that have convenient office hours for patients	20%	0%	42%	11%	17%	38%	37%	18%	32%	19%	0%
Healthcare providers that are accepting new patients	14%	0%	18%	11%	5%	13%	30%	13%	22%	13%	0%
The out-of-pocket healthcare costs to patients	25%	0%	50%	37%	19%	25%	33%	18%	25%	29%	17%
Availability of transportation to a healthcare provider practice	21%	0%	33%	0%	15%	25%	33%	12%	14%	13%	17%
Communication among healthcare providers	12%	0%	25%	17%	13%	0%	33%	12%	20%	8%	0%
Availability of after-hours and emergency care	26%	0%	25%	21%	34%	13%	37%	24%	17%	25%	0%
Availability of community based resources for patients	27%	13%	42%	5%	23%	29%	33%	29%	17%	25%	0%
Travel time to healthcare provider locations	30%	0%	17%	0%	25%	0%	30%	6%	17%	13%	0%

Q68: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the general population?
n438[1]; Single Response

Category	n	%
Heart Disease	71	16%
Chronic Pain (migraines, joint pain, back aches)	67	15%
Mental Health	52	12%
COPD	51	12%
Substance Abuse	32	7%
Diabetes	19	4%
Obesity	17	4%
Asthma	13	3%
Hypertension (high blood pressure)	13	3%
Cancer	2	1%
HIV or AIDS	-	-
Other(s) [1]	9	2%
Unsure	92	21%

[1] Other responses include: accident (1), behavior/lack of support (1), chest pain and/or celulitis (1), cold/flu symptoms (1), dental pain (1), MH for ED/heart disease for re-admissions, lack of knowledge of knowing what will wait for an office appointment or unwilling to be inconvenienced (1), elderly people that don't have anyone to fight for them (1)

[1] 67 No Reply

Q68: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the general population?

n438[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	20	93	9	45	17	36	67	6
Asthma	3%	-	8%	-	4%	-	4%	-	-	2%	17%
Cancer	-	-	-	5%	-	-	-	-	3%	-	-
Chronic Pain (migraines, joint pain, back aches)	16%	25%	15%	-	16%	-	18%	-	14%	18%	50%
COPD	8%	13%	15%	10%	26%	-	20%	-	-	5%	-
Diabetes	4%	-	8%	5%	4%	11%	-	12%	8%	2%	17%
Heart Disease	21%	-	-	15%	14%	-	13%	29%	11%	21%	-
HIV or AIDS	-	-	-	-	-	-	-	-	-	-	-
Hypertension (high blood pressure)	2%	13%	8%	5%	4%	-	4%	-	3%	2%	-
Mental Health	16%	-	8%	5%	11%	22%	4%	6%	14%	15%	-
Obesity	6%	-	8%	-	3%	11%	4%	-	8%	-	-
Substance Abuse	7%	13%	8%	10%	3%	22%	7%	6%	6%	12%	17%
Other(s) [1]	2%	-	-	5%	2%	11%	4%	-	-	-	-
Unsure	15%	38%	23%	40%	12%	22%	20%	47%	33%	25%	-

[1] Other responses include: accident (1), behavior/lack of support (1), chest pain and/or celulitis (1), cold/flu symptoms (1), dental pain (1), MH for ED/heart disease for re-admissions, lack of knowledge of knowing what will wait for an office appt or unwilling to be inconvenienced (1), elderly people that don't have anyone to fight for them (1)

[1] 67 No Reply

Q69: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the general population? n418[1]; Single Response		
Category	n	%
HIV or AIDS	117	28%
Obesity	45	11%
Cancer	43	10%
Chronic Pain (migraines, joint pain, back aches)	21	5%
Hypertension (high blood pressure)	14	3%
Asthma	13	3%
COPD	11	3%
Substance Abuse	11	3%
Heart Disease	7	2%
Mental Health	7	2%
Diabetes	4	1%
Other(s) [1]	1	0%
Unsure	124	29%

[1] Other responses include: symptoms typically associated with viruses, etc (1)

[1] 87 No Reply

Q69: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the general population?

n418[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	117	8	12	19	91	9	43	17	32	64	6
Asthma	6%	-	-	-	2%	-	2%	-	3%	2%	17%
Cancer	15%	-	17%	-	6%	22%	7%	18%	9%	13%	-
Chronic Pain (migraines, joint pain, back aches)	2%	-	17%	5%	7%	-	9%	6%	3%	5%	17%
COPD	3%	-	-	-	7%	-	2%	6%	-	-	-
Diabetes	-	-	8%	-	2%	-	2%	-	-	-	-
Heart Disease	3%	-	-	-	3%	-	-	-	-	2%	-
HIV or AIDS	24%	50%	8%	47%	37%	33%	26%	24%	28%	20%	17%
Hypertension (high blood pressure)	6%	-	-	-	2%	-	2%	6%	3%	3%	-
Mental Health	3%	-	-	-	2%	-	-	-	-	3%	-
Obesity	12%	13%	17%	11%	7%	-	19%	-	9%	9%	49%
Substance Abuse	5%	-	-	-	1%	11%	2%	6%	-	2%	-
Other(s) [1]	-	-	-	-	-	-	-	-	-	2%	-
Unsure	21%	37%	33%	37%	24%	34%	29%	34%	45%	39%	-

[1] Other responses include: symptoms typically associated with viruses, etc (1)

[1] 87 No Reply

Q70: In your opinion, which of the following conditions and/or chronic diseases contributes to the most Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations?
n434[1]; Single Response

Category	n	%
Mental Health	88	20%
Chronic Pain (migraines, joint pain, back aches)	69	16%
Substance Abuse	41	9%
COPD	36	8%
Diabetes	29	7%
Heart Disease	24	6%
Obesity	20	5%
Asthma	7	2%
HIV or AIDS	3	1%
Cancer	2	1%
Hypertension (high blood pressure)	2	1%
Other(s) [1]	14	3%
Unsure	99	21%

[1] Other responses include: aches and pains (1), common colds (3), convenience (1), dental pain (1), everyday sore throats/many uninsured & Medicaid use the ER as the doctor's office (1), mental health and symptoms associated with pregnancy that would not bring general population in (1), possible injury (1), primary care (1), same as before (1), unspecified diagnosis of presenting problems (1)

[1] 71 No Reply

Q71: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations? n417[1]; Single Response		
Category	n	%
HIV or AIDS	96	23%
Cancer	43	10%
Obesity	36	9%
Hypertension (high blood pressure)	16	4%
Substance Abuse	16	4%
Asthma	14	3%
Chronic Pain (migraines, joint pain, back aches)	11	3%
COPD	9	2%
Mental Health	8	2%
Diabetes	6	1%
Heart Disease	5	1%
Other(s) [1]	2	1%
Unsure	155	37%

[1] 88 No Reply

Q71: In your opinion, which of the following conditions and/or chronic diseases contributes to the least Emergency Department visits and hospital re-admissions for the Medicaid and uninsured populations?

n417[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	120	7	12	19	89	9	42	17	35	62	5
Asthma	5%	-	-	-	1%	22%	-	-	6%	5%	-
Cancer	13%	-	25%	5%	6%	33%	7%	12%	9%	11%	-
Chronic Pain (migraines, joint pain, back aches)	2%	-	-	5%	2%	-	5%	12%	-	3%	-
COPD	4%	-	-	-	2%	-	2%	-	3%	-	-
Diabetes	1%	-	17%	-	-	-	5%	-	3%	-	-
Heart Disease	1%	14%	-	5%	1%	-	-	-	-	2%	-
HIV or AIDS	23%	29%	8%	37%	30%	11%	17%	24%	23%	16%	20%
Hypertension (high blood pressure)	5%	14%	8%	-	6%	-	-	-	3%	3%	-
Mental Health	2%	-	-	-	5%	-	-	-	3%	2%	-
Obesity	11%	-	-	-	9%	-	7%	6%	9%	10%	40%
Substance Abuse	3%	-	-	-	3%	11%	7%	6%	3%	5%	20%
Other(s)	-	-	-	-	-	-	5%	-	-	-	-
Unsure	30%	43%	42%	48%	35%	23%	45%	40%	38%	43%	20%

[1] 88 No Reply

Q72: Does your practice or organization use a community resource directory for patients? n441[1]; Single Response		
Category	n	%
Yes	263	60%
No	61	13%
Unsure	117	27%

[1] 64 No Reply

Q73: Are you aware of the 2-1-1 human resources directory for your area? n441[1]; Single Response		
Category	n	%
Yes	282	64%
No	159	36%

[1] 64 No Reply

Q73: Are you aware of the 2-1-1 human resources directory for your area?
n441[1]; Single Response

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	20	94	9	46	17	36	68	6
Yes	65%	63%	62%	60%	60%	11%	39%	88%	58%	96%	-
No	35%	37%	38%	40%	40%	89%	61%	12%	42%	4%	100%

[1] 64 No Reply

Q74: Please rate how aware you are of the 2-1-1 human resources directory for your area using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor. n282; Single Response						
Unsure	1	2	3	4	5	% 4 or 5
20%	3%	6%	18%	27%	26%	53%

Q75: Are there enough community resources to support the healthcare needs for your area? n441[1]; Single Response		
Category	n	%
Yes	75	17%
No	253	57%
Unsure	113	26%

[1] 64 No Reply

Q75: Are there enough community resources to support the healthcare needs for your area? n441[1]; Single Response											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	124	8	13	20	94	9	46	17	36	68	6
Yes	17%	13%	31%	5%	11%	11%	17%	12%	11%	32%	17%
No	61%	50%	15%	75%	55%	89%	57%	77%	61%	47%	50%
Unsure	22%	37%	54%	20%	34%	-	26%	11%	28%	21%	33%

[1] 64 No Reply

Online Survey
Community Resident
Neither of the above statements, I am a community resident.

Q1: Which of the following statements best applies to you? n1,161; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
I am a healthcare provider, physician, or work in an organization that provides healthcare.	-	-	-
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.	-	-	-
Neither of the above statements, I am a community resident.	100%	32%	68%
Total n	1,161	375	786

Q4: In which county do you live? n1,159; Single Response			
Category	Total n[1]	Medicaid/Uninsured n	General Community n[1]
Broome	23%	38%	17%
Tioga	11%	14%	9%
Chemung	9%	8%	9%
Tompkins	15%	8%	18%
Schuyler	11%	7%	12%
Cortland	8%	6%	8%
Cayuga	5%	5%	5%
Steuben	7%	5%	8%
Chenango	5%	4%	6%
Delaware	5%	4%	6%
None of the above	1%	1%	2%

[1] Total 2 No Reply
[1] General Community 2 No Reply

Q29: Using a scale of 1 to 5 where "5" indicates excellent and "1" indicates poor, how would you describe your overall health? n1,161; Aided; Single Response						
Audience	1	2	3	4	5	% 4 or 5
General Community	1%	6%	25%	52%	16%	68%
Total	2%	7%	29%	46%	16%	62%
Medicaid/Uninsured	5%	9%	38%	32%	16%	48%

Q30: Using a scale of 1 to 5 where "5" indicates excellent and "1" indicates poor, how would you describe your mental health? n1,161; Aided; Single Response							
Audience	Refused	1	2	3	4	5	% 4 or 5
General Community	-	1%	2%	10%	43%	44%	87%
Total	-	3%	5%	15%	39%	38%	78%
Medicaid/Uninsured	1%	6%	10%	24%	31%	29%	60%

Q31: Do you currently have healthcare coverage? n1,161; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	92%	78%	99%
No	7%	22%	-
Unsure or Refused	1%	-	1%

Q32: How do you receive your healthcare coverage? n1,070; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Medicaid	25%	90%	-
Medicare	25%	21%	27%
Employer based	56%	7%	74%
Health exchange	3%	1%	4%
Other[1]	9%	6%	11%
Unsure or Refused	1%	1%	1%

[1] Other responses include: spouse's insurance (11), pay for insurance out of pocket (8), BCBS (8), AARP (6), VA (6)

Q33: Are you covered under Medicaid? n807; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	3%	100%	-
No	96%	-	99%
Refused	1%	-	1%

Q34: Do you have any children under the age of 18 that are covered under Medicaid? n898; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	6%	22%	4%
No	94%	78%	96%

Q35: As an adult, how long have you been a Medicaid recipient? Note: Since the age of 18. n263; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Less than 1 year	15%	15%	-
1 to 5 years	37%	37%	-
6 to 10 years	20%	20%	-
11 to 20 years	15%	15%	-
More than 20 years	11%	11%	-
Unsure or Refused	2%	2%	-

Q36: Which of the following do you visit regularly? n1,161; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Primary Care Physician (PCP) (Note: This would be a family doctor or internist)	77%	68%	81%
Specialist (Note: This is a doctor that specializes in a specific area of care)	39%	33%	42%
I do not visit any of these regularly	17%	24%	14%
Care Manager, Care Coordinator, or Healthcare Advocate	2%	6%	1%

Q36: Which of the following do you visit regularly? n375; Select All That Apply Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	145	17	30	14	22	13	27	18	52	30	7
Primary Care Physician (PCP) (Note: This would be a family doctor or internist)	74%	71%	67%	57%	73%	46%	74%	44%	60%	67%	71%
Specialist (Note: This is a doctor that specializes in a specific area of care)	30%	47%	30%	14%	41%	23%	33%	28%	33%	63%	14%
Care Manager, Care Coordinator, or Healthcare Advocate	5%	-	3%	-	9%	-	-	6%	12%	10%	14%
I do not visit any of these regularly	21%	24%	27%	43%	14%	46%	19%	44%	27%	20%	14%

Q37: What kind of specialists do you visit regularly? n458; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Gynecologist (Female)	31%	27%	33%
Psychiatrist	11%	23%	6%
Gastroenterologist (Stomach)	11%	17%	9%
Neurologist (Brain and Nervous System)	12%	17%	10%
Ophthalmologist (Eye)	26%	17%	29%
Cardiologist (Heart)	17%	11%	19%
Sleep Disorders	8%	11%	7%
Pulmonologist (Lung and Breathing)	6%	10%	5%
Pain Management Specialist	8%	9%	7%
Allergist (Immunologist)	6%	7%	6%
Endocrinologist (Hormones)	10%	7%	11%
Oncologist (Cancer)	8%	7%	8%
Dermatologist (Skin)	19%	6%	24%
Otolaryngologist (Ear, Nose, and Throat)	5%	6%	5%
Rheumatologist (Joint Diseases)	7%	6%	8%

Q37 Continued: What kind of specialists do you visit regularly? n458; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Urologist	10%	6%	11%
Hematologist (Blood)	4%	5%	3%
Pediatrician (Children)	6%	5%	6%
Hospitalist (Hospital Care)	1%	4%	0%
Nephrologist (Kidney)	5%	4%	5%
Addiction Psychiatrist	1%	3%	1%
Adolescent Medicine Specialist	1%	2%	0%
Anesthesiologist	0%	2%	-
Hepatologist (Liver)	1%	2%	1%
Cardiovascular Surgeon (Heart Surgeon)	1%	1%	2%
Colon and Rectal Surgeon	2%	1%	3%
Obstetrician (Pregnancy)	2%	1%	2%
Pathologist (Tissue and Blood Samples)	0%	1%	0%
Sports Medicine	2%	1%	3%
Other(s) [1]	25%	32%	23%
Unsure or Refused	0%	1%	-

[1] Common Other responses include: orthopedist (22), podiatrist (7), chiropractor (6)

Q37: What kind of specialists do you visit regularly? n125; Select All That Apply; Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	43	8	9	2	9	3	9	5	17	19	1
Addiction Psychiatrist	9%	-	-	-	-	-	-	-	-	-	-
Adolescent Medicine Specialist	5%	-	-	-	-	-	-	-	-	-	-
Allergist (Immunologist)	-	13%	-	-	44%	-	11%	40%	-	5%	-
Anesthesiologist	-	-	11%	-	-	-	11%	-	-	-	-
Cardiologist (Heart)	7%	-	44%	50%	11%	-	-	-	6%	21%	-
Cardiovascular Surgeon (Heart Surgeon)	2%	-	-	-	-	-	-	-	-	-	-
Colon and Rectal Surgeon	-	-	-	-	-	-	11%	-	-	-	-
Dermatologist (Skin)	5%	-	-	50%	11%	-	-	-	6%	11%	-
Endocrinologist (Hormones)	7%	13%	11%	-	-	-	11%	20%	-	11%	-
Gastroenterologist (Stomach)	12%	13%	11%	-	33%	-	33%	-	29%	16%	-
Gynecologist (Female)	26%	13%	11%	-	22%	-	22%	60%	41%	37%	-
Hematologist (Blood)	7%	-	11%	-	11%	-	-	-	6%	-	-
Hepatologist (Liver)	5%	-	-	-	-	-	-	-	-	-	-
Hospitalist (Hospital Care)	5%	-	-	-	-	-	11%	20%	6%	-	-
Nephrologist (Kidney)	7%	-	11%	-	-	-	-	-	6%	-	-

Q37 Continued: What kind of specialists do you visit regularly?

n125; Select All That Apply; Medicaid/Uninsured

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	43	8	9	2	9	3	9	5	17	19	1
Neurologist (Brain and Nervous System)	26%	38%	22%	-	22%	-	11%	-	6%	5%	-
Obstetrician (Pregnancy)	2%	-	-	-	-	-	-	-	-	-	-
Oncologist (Cancer)	9%	-	-	-	11%	33%	22%	20%	-	-	-
Ophthalmologist (Eye)	7%	25%	33%	-	11%	33%	11%	40%	29%	16%	-
Otolaryngologist (Ear, Nose, and Throat)	2%	-	22%	-	11%	-	11%	20%	-	5%	-
Pain Management Specialist	2%	25%	11%	-	11%	33%	33%	-	6%	-	100%
Pathologist (Tissue and Blood Samples)	2%	-	-	-	-	-	-	-	-	-	-
Pediatrician (Children)	7%	-	-	-	-	-	11%	-	6%	5%	-
Psychiatrist	9%	13%	22%	-	33%	-	33%	20%	47%	37%	-
Pulmonologist (Lung and Breathing)	16%	-	-	-	11%	-	-	20%	6%	11%	-
Rheumatologist (Joint Diseases)	5%	13%	-	-	-	-	-	-	24%	-	-
Sleep Disorders Specialist	14%	13%	11%	-	11%	-	-	20%	-	21%	-
Sports Medicine Specialist	2%	-	-	-	-	-	-	-	-	-	-
Urologist	5%	-	11%	-	11%	-	-	-	12%	11%	-
Other(s)	42%	13%	11%	-	33%	100%	11%	40%	18%	42%	-

Q38: In a typical year, how many different doctors do you see? n963; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
1	21%	24%	20%
2	30%	27%	31%
3	25%	21%	27%
4	12%	13%	12%
5	6%	7%	6%
6	2%	3%	2%
7	1%	3%	1%
8	1%	0%	1%
9	0%	-	0%
10 or more	1%	1%	0%
Unsure or Refused	1%	1%	0%

Q39: Do the multiple doctors communicate between each other regarding your condition(s)? n759; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	53%	52%	53%
No	20%	17%	22%
Unsure	27%	31%	25%

Q39: Do the multiple doctors communicate between each other regarding your condition(s)? n216; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	84	9	15	6	15	5	15	8	30	23	6
Yes	58%	56%	53%	67%	60%	20%	20%	75%	47%	44%	50%
No	18%	11%	27%	-	13%	20%	33%	13%	13%	17%	17%
Unsure	24%	33%	20%	33%	27%	60%	47%	12%	40%	39%	33%

Q40: Does your doctor give you instructions for follow-up care after you visit? n958; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	94%	96%	94%
No	4%	3%	5%
Unsure	2%	1%	1%

Q40: Does your doctor give you instructions for follow-up care after you visit? n279; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	114	13	22	8	18	7	22	9	36	24	6
Yes	96%	92%	96%	100%	83%	86%	95%	100%	100%	92%	100%
No	3%	-	-	-	17%	14%	5%	-	-	4%	-
Unsure	1%	8%	4%	-	-	-	-	-	-	4%	-

Q41: Do you usually understand what you need to do for follow-up care after your visit? n904; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	99%	97%	99%
No	1%	3%	1%

Q41: Do you usually understand what you need to do for follow-up care after your visit? n266; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	110	12	21	8	15	6	21	9	36	22	6
Yes	98%	92%	95%	100%	93%	100%	95%	100%	94%	100%	100%
No	2%	8%	5%	-	7%	-	-	-	6%	-	-
Unsure	-	-	-	-	-	-	5%	-	-	-	-

Q42: How often do you follow these instructions after your visit? n904; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Never	-	-	-
Sometimes	8%	13%	7%
Usually	45%	40%	48%
Always	45%	47%	45%

Q42: How often do you follow these instructions after your visit? n266; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	110	12	21	8	15	6	21	9	36	22	6
Never	-	-	-	13%	-	-	-	-	-	-	-
Sometimes	19%	17%	-	-	13%	17%	10%	10%	11%	-	33%
Usually	36%	33%	48%	13%	54%	50%	47%	44%	39%	46%	34%
Always	44%	50%	52%	74%	33%	33%	43%	44%	50%	54%	33%
Unsure	1%	-	-	-	-	-	-	-	-	-	-

Q43: Which setting best describes the location of the physician or specialist you visit most frequently? n958; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Private Practice or Office	73%	58%	79%
Community Health Center	13%	18%	11%
Hospital	9%	13%	7%
Urgent Care Center	1%	1%	1%
Ambulatory Surgery Center (ASC)	-	1%	-
Other[1]	2%	5%	1%
Unsure	2%	4%	1%

[1] Other responses include: cancer center (1), dialysis center (1), Guthrie medical center (2), Ivy Clinic at Ithaca Free Clinic (1), Kendal (2), monthly pain management clinic (1), multi-specialty group practice (1), OBGYN Associates of Ithaca (1), Oneonta specialty services (1), pain management (1), planned parenthood (1), primary care office (2), some private practice/some hospital (1), specialist (1), university clinic (1), VA clinic (2)

Q44: In the past 12 months, have you or a member of your household had a dental check-up? n1,161; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	77%	61%	85%
No	22%	37%	14%
Unsure	1%	2%	1%

Q44: In the past 12 months, have you or a member of your household had a dental check-up? n375; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	145	17	30	14	22	13	27	18	52	30	7
Yes	60%	59%	67%	57%	68%	69%	56%	61%	56%	67%	71%
No	37%	35%	33%	43%	27%	31%	44%	39%	40%	30%	29%
Unsure	3%	6%	-	-	5%	-	-	-	4%	3%	-

Q45: What was the main reason(s) you did not have a dental check-up in the past 12 months? n250; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
I did not have insurance	31%	33%	28%
I could not afford it	34%	22%	49%
I could not find a dentist that took my insurance	13%	16%	10%
I do not like going/afraid of the dentist	16%	14%	19%
I did not have the time	12%	13%	11%
The dentist was too far away	4%	7%	2%
I did not have transportation	6%	7%	4%
My insurance did not cover check-ups	14%	6%	23%
I am healthy and do not need to see a dentist	4%	4%	5%
I did not have childcare	0%	-	1%
Other(s) [1]	14%	15%	12%
Unsure or Refused	4%	6%	3%

[1] Common Other responses include: I have dentures (14), insurance won't cover the dental care I need (4), I do not have any teeth (2), can't find a good dentist that accepts my insurance (2)

Q45: What was the main reason(s) you did not have a dental check-up in the past 12 months? n137; Select All That Apply Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	54	6	10	6	6	4	12	7	21	9	2
I could not afford it	13%	33%	20%	50%	-	-	33%	43%	29%	33%	-
I did not have insurance	26%	50%	60%	67%	-	50%	8%	71%	24%	44%	50%
The dentist was too far away	2%	-	20%	50%	-	25%	8%	-	5%	-	-
I did not have the time	19%	-	10%	17%	-	50%	-	-	10%	22%	-
I do not like going/afraid of the dentist	11%	-	10%	-	17%	-	17%	29%	29%	11%	-
My insurance did not cover check-ups	4%	33%	10%	-	-	-	8%	-	5%	11%	-
I could not find a dentist that took my insurance	7%	-	40%	17%	-	-	50%	-	29%	11%	-
I did not have transportation	7%	17%	20%	-	17%	25%	-	-	-	11%	-
I am healthy and do not need to see a dentist	2%	-	-	-	33%	-	-	-	-	11%	50%
I did not have childcare	-	-	-	-	-	-	-	-	-	-	-
Other(s) [1]	17%	17%	-	17%	33%	-	25%	14%	5%	33%	-
Unsure or Refused	9%	-	10%	-	-	-	8%	-	5%	-	-

[1] Common Other responses include: I have dentures (14), insurance does not cover the dental services I need (3), I do not have any teeth (2)

Q46: Which of the following best represents your age? n1,158; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Under 25	6%	14%	2%
25 to 34	16%	28%	11%
35 to 44	15%	21%	12%
45 to 54	22%	18%	23%
55 to 64	22%	13%	27%
65 to 74	15%	5%	20%
75 or older	4%	1%	5%
Refused	-	-	-

[1] Total 3 No Reply
[1] Medicaid/Uninsured 1 No Reply
[1] General Community 2 No Reply

Q47: What is your gender? n1,160[1]; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Male	25%	31%	22%
Female	75%	69%	78%

[1] Total 1 No Reply
[1] Medicaid/Uninsured 1 No Reply

Q51: What is the most pressing need to improve healthcare for our community? n375[1]; Open-Ended		
Top 10 Responses	n	%
Affordable health care	27	7%
Universal access to health care	13	3%
Access to doctors who accept Medicaid insurance	11	3%
Access to mental health services	10	3%
Coordination of care between providers	10	3%
Lack of physicians	8	2%
Education/prevention	7	2%
Access to dental services	6	2%
Access to reliable transportation	6	2%
Better quality doctors	6	2%

[1] Medicaid/Uninsured 15 No Reply

Note: Q48 through Q50 were sweepstake entry questions.

Q52: What is the most pressing need to improve healthcare for the Medicaid and uninsured population within our community? n180; Open-Ended; Medicaid and Uninsured Only		
Top 10 Responses	n	%
Affordable Health Care	33	18%
Accessibility - Dental	17	9%
More Doctors/Clinics/Options	17	9%
Coverage	14	8%
Accessibility - Healthcare Services	8	4%
Transportation	8	4%
Education/Resources	7	4%
Accessibility - Specialty	6	3%
Availability (Appts/Wait Times)	5	3%
Mental Health	5	3%

[1] 195 No Reply

Q53: Have you or anyone in your household visited the Emergency Room in the past 12 months? Note: The Emergency Department is technically the same as Emergency Room (ER) and it is used the same. n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	46%	62%	41%
No	53%	36%	58%
Unsure	1%	2%	1%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q53: Have you or anyone in your household visited the Emergency Room in the past 12 months?
Note: The Emergency Department is technically the same as Emergency Room (ER) and it is used the same.
n209[1]; Single Response
Medicaid/Uninsured

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	84%	60%	61%	46%	70%	50%	67%	67%	43%	52%	80%
No	16%	40%	36%	46%	30%	50%	29%	25%	57%	48%	20%
Unsure	-	-	3%	8%	-	-	4%	8%	-	-	-

[1] 166 No Reply

Q54: Was the Emergency Department visit(s) for? n414; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
You	52%	60%	48%
Your child	29%	29%	29%
Your significant other	24%	21%	25%
Other	14%	14%	13%

Q54: Was the Emergency Department visit(s) for? n414; Select All That Apply Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	27	6	17	5	14	5	16	8	13	14	4
You	63%	83%	35%	60%	71%	60%	75%	50%	31%	79%	50%
Your significant other	22%	50%	18%	20%	-	40%	25%	50%	15%	7%	25%
Your child	26%	17%	35%	40%	21%	-	31%	38%	31%	36%	25%
Other	4%	33%	35%	40%	14%	-	6%	-	31%	-	-

Q55: Think about your most recent visit to the Emergency Department, using a scale of 1 to 5, where "5" means very life-threatening and "1" means not at all life-threatening, how life-threatening was the condition? n414; Single Response							
Audience	Unsure	1	2	3	4	5	% 4 or 5
Medicaid/Uninsured	1%	30%	19%	22%	17%	11%	28%
Total	2%	28%	20%	24%	17%	9%	26%
General Community	2%	27%	21%	24%	17%	9%	26%

Q55: Think about your most recent visit to the Emergency Department, using a scale of 1 to 5, where "5" means very life-threatening and "1" means not at all life-threatening, how life-threatening was the condition? n129; Single Response; **% rated 4 or 5 by county** Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	27	6	17	5	14	5	16	8	13	14	4
Medicaid/Uninsured	30%	17%	29%	40%	50%	20%	19%	25%	23%	21%	25%

Q56: Did you consider any other healthcare treatment options or locations besides the Emergency Department (ED) for your most recent visit? n414; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes	42%	49%	39%
No	56%	48%	60%
Unsure	2%	3%	1%

Q56: Did you consider any other healthcare treatment options or locations besides the Emergency Department (ED) for your most recent visit?
n129; Single Response
Medicaid/Uninsured

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	27	6	17	5	14	5	16	8	13	14	4
Yes	59%	50%	29%	60%	14%	60%	56%	50%	46%	71%	50%
No	37%	50%	65%	20%	86%	40%	44%	38%	54%	29%	50%
Unsure	4%	-	6%	20%	-	-	-	12%	-	-	-

Q57: Why did you choose the Emergency Department (ED) for your most recent visit? n414; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
My symptoms occurred on the weekend or after-hours	43%	46%	41%
I felt my condition was life-threatening	22%	26%	20%
I was encouraged to by my family, friends, or a doctor	24%	20%	26%
I could not get a timely appointment with my doctor	12%	15%	11%
I knew I would be seen at the ED	8%	14%	5%
I was taken there by someone else	9%	11%	8%
The ED is the closest place for me to go	9%	10%	8%
The ED has easier access to testing	6%	5%	6%
The ED at the hospital offers better access to specialists	5%	5%	6%
I did not know where to go	2%	5%	1%
I did not want to miss a day or work	2%	2%	3%
No doctors take my insurance	1%	2%	-
I thought other locations would be more expensive	1%	1%	0%
Other(s) [1]	18%	15%	19%
Unsure or Refused	1%	4%	-

[1] Other responses include: needed immediate care (23), instructed to go to ER by healthcare professional (15), brought by ambulance (9), all other places were closed (6), workers comp injury (3)

Q57: Why did you choose the Emergency Department (ED) for your most recent visit? n129; Select All That Apply; Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	27	6	17	5	14	5	16	8	13	14	4
I felt my condition was life-threatening	19%	-	41%	20%	36%	-	31%	25%	15%	36%	25%
The ED is the closest place for me to go	11%	17%	18%	40%	7%	-	6%	-	-	7%	25%
My symptoms occurred on the weekend or after-hours	52%	50%	29%	80%	36%	60%	56%	50%	31%	43%	50%
The ED has easier access to testing	11%	-	-	20%	-	-	6%	-	-	7%	25%
I could not get a timely appointment with my doctor	15%	17%	6%	-	-	20%	13%	25%	15%	36%	25%
The ED at the hospital offers better access to specialists	4%	17%	-	20%	-	-	-	-	8%	7%	25%

Q57: Why did you choose the Emergency Department (ED) for your most recent visit? n129; Select All That Apply; Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	27	6	17	5	14	5	16	8	13	14	4
I was encouraged to by my family, friends, or a doctor	26%	17%	12%	60%	7%	40%	19%	25%	15%	14%	25%
I was taken there by someone else	19%	-	6%	20%	-	20%	13%	13%	-	21%	-
I did not want to miss a day or work	-	-	-	-	7%	-	6%	-	-	-	-
I thought other locations would be more expensive	-	-	-	-	7%	-	-	-	-	-	-
No doctors take my insurance	-	-	-	-	-	20%	-	13%	-	-	-
I did not know where to go	4%	-	12%	-	7%	-	-	13%	8%	-	-
I knew I would be seen at the ED	15%	33%	12%	40%	7%	-	6%	13%	8%	21%	25%
Other(s) [1]	7%	-	18%	20%	14%	-	25%	-	23%	29%	-
Unsure or Refused	4%	-	6%	-	7%	-	6%	-	8%	-	-

[1] Common Other responses include: needed immediate care (25), instructed to go to ER by healthcare professional (17), all other places were closed (7), brought by ambulance (6)

Q58: Did you follow your discharge instructions after you left the Emergency Department (ED)? n414; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
Yes, completely	79%	75%	81%
Yes, somewhat	14%	16%	13%
No	2%	2%	1%
I was not provided discharge instructions	4%	5%	4%
Unsure	1%	2%	1%

Q58: Did you follow your discharge instructions after you left the Emergency Department (ED)? n129; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	27	6	17	5	14	5	16	8	13	14	4
Yes, completely	89%	50%	77%	100%	57%	100%	87%	49%	69%	65%	75%
Yes, somewhat	7%	50%	12%	-	21%	-	13%	13%	23%	21%	25%
No	-	-	6%	-	7%	-	-	13%	-	-	-
I was not provided discharge instructions	4%	-	-	-	7%	-	-	25%	8%	14%	-
Unsure	-	-	5%	-	8%	-	-	-	-	-	-

Q59: Do you feel most people know there are other healthcare provider treatment options for non-life-threatening conditions? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	58%	59%	58%
No	42%	41%	42%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q59: Do you feel most people know there are other healthcare provider treatment options for non-life-threatening conditions?

n209[1]; Single Response

Medicaid/Uninsured

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	66%	60%	50%	64%	75%	60%	71%	42%	60%	44%	40%
No	34%	40%	50%	36%	25%	40%	29%	58%	40%	56%	60%

[1] 166 No Reply

Q60: Have you ever received after-hours care at any location other than the Emergency Department (ED) at a hospital? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	43%	30%	47%
No	55%	68%	51%
Unsure	2%	2%	2%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q60: Have you ever received after-hours care at any location other than the Emergency Department (ED) at a hospital? n209[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	34%	70%	18%	18%	45%	10%	8%	33%	23%	44%	40%
No	66%	30%	79%	82%	55%	90%	83%	58%	73%	52%	60%
Unsure	-	-	3%	-	-	-	9%	9%	4%	4%	-

[1] 166 No Reply

Q61: Where did you receive care? n383; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Urgent Care Center	79%	79%	79%
Private Practice or Office	17%	11%	18%
Community Health Center	7%	8%	7%
Ambulatory Surgery Center (ASC)	1%	2%	1%
Other	7%	15%	5%
Unsure	1%	-	1%

Q61: Where did you receive care? n62; Select All That Apply Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	11	7	5	2	9	1	2	4	7	12	2
Ambulatory Surgery Center (ASC)	-	14%	-	-	-	-	-	-	-	-	-
Community Health Center	9%	14%	-	50%	-	-	-	-	29%	-	-
Private Practice or Office	36%	-	20%	-	-	-	-	50%	-	-	-
Urgent Care Center	64%	86%	60%	50%	89%	100%	50%	100%	57%	100%	100%
Other	27%	-	40%	50%	11%	-	50%	-	14%	-	-

Q64: To what extent do you agree with this statement: "There is an issue with patients being re-admitted to the hospital within a 30-day timeframe." n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Strongly agree	14%	14%	15%
Somewhat agree	24%	25%	24%
Neither agree nor disagree	24%	25%	23%
Somewhat disagree	5%	4%	6%
Strongly disagree	3%	5%	3%
Unsure	30%	27%	29%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q64: To what extent do you agree with this statement: "There is an issue with patients being re-admitted to the hospital within a 30-day timeframe."
n209[1]; Single Response
Medicaid/Uninsured

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Strongly agree	13%	20%	4%	18%	30%	-	17%	17%	17%	11%	-
Somewhat agree	16%	30%	21%	18%	25%	40%	21%	50%	17%	33%	40%
Neither agree nor disagree	25%	40%	25%	46%	25%	40%	29%	17%	17%	19%	20%
Somewhat disagree	9%	-	4%	9%	-	-	-	8%	7%	-	-
Strongly disagree	9%	-	7%	-	-	10%	4%	-	7%	-	20%
Unsure	28%	10%	39%	9%	20%	10%	29%	8%	35%	37%	20%

[1] 166 No Reply

Q65: Do you feel the issue of patients being re-admitted to the hospital within a 30-day timeframe is more common among the Medicaid and uninsured population? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	43%	45%	43%
No	10%	14%	8%
Unsure	47%	41%	49%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q65: Do you feel the issue of patients being re-admitted to the hospital within a 30-day timeframe is more common among the Medicaid and uninsured population?

n209[1]; Single Response

Medicaid/Uninsured

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	59%	80%	39%	46%	35%	60%	29%	33%	47%	33%	60%
No	3%	-	29%	18%	10%	10%	13%	8%	23%	15%	20%
Unsure	38%	20%	32%	36%	55%	30%	58%	59%	30%	52%	20%

[1] 166 No Reply

Q81: Do you always get the healthcare you need when you need it? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	68%	52%	73%
No	28%	43%	24%
Unsure	4%	5%	3%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q81: Do you always get the healthcare you need when you need it? n209[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	63%	50%	50%	54%	60%	40%	42%	25%	63%	52%	20%
No	28%	50%	46%	46%	35%	50%	54%	58%	30%	48%	80%
Unsure	9%	-	4%	-	5%	10%	4%	17%	7%	-	-

[1] 166 No Reply

Q82: What prevents you from getting the healthcare you need when you need it? n239[1]; Open-Ended		
Top 10 Responses	n	%
Lack of insurance	23	10%
Lack of doctor availability	18	8%
Financial barriers	12	5%
Lack of providers who take my insurance	8	3%
The services I need are unavailable	8	3%
Low quality of service from healthcare providers	6	3%
Personal barriers	6	3%
Lack of transportation	6	3%
Lack of health provider communication	3	1%
Other	4	2%

[1] Medicaid/Uninsured 7 No Reply

Q83: Are there enough doctors that take your health insurance? n856; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	75%	49%	82%
No	14%	34%	9%
Unsure	11%	17%	9%

[1] Total 214 No Reply
[1] Medicaid/Uninsured 123 No Reply
[1] General Community 91 No Reply

Q83: Are there enough doctors that take your health insurance?
n171[1]; Single Response
Medicaid/Uninsured

Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	29	8	20	7	18	7	19	8	26	24	5
Yes	48%	13%	40%	71%	67%	29%	58%	25%	69%	38%	20%
No	38%	50%	40%	29%	22%	57%	26%	50%	12%	42%	60%
Unsure	14%	37%	20%	-	11%	14%	16%	25%	19%	20%	20%

[1] 123 No Reply

Q84: Are there any specialty areas for which you could not find a doctor? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	20%	26%	18%
No	67%	58%	69%
Unsure	13%	16%	13%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q85: Which one(s)? n176; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Psychiatrist	13%	20%	10%
Dermatologist (Skin)	21%	16%	22%
Neurologist (Brain and Nervous System)	11%	13%	11%
Pain Management Specialist	12%	11%	12%
Gynecologist (Female)	9%	7%	9%
Ophthalmologist (Eye)	6%	7%	5%
Sleep Disorders	5%	7%	3%
Allergist (Immunologist)	6%	6%	7%
Pediatrician (Children)	2%	6%	1%
Rheumatologist (Joint Diseases)	9%	6%	10%
Adolescent Medicine Specialist	3%	4%	3%
Gastroenterologist (Stomach)	5%	4%	6%
Addiction Psychiatrist	5%	2%	7%
Cardiologist (Heart)	5%	2%	6%
Hepatologist (Liver)	1%	2%	1%

Q85 Continued: Which one(s)? n176; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Obstetrician (Pregnancy)	2%	2%	3%
Otolaryngologist (Ear, Nose, and Throat)	3%	2%	3%
Pulmonologist (Lung and Breathing)	5%	2%	6%
Anesthesiologist	1%	-	2%
Cardiovascular Surgeon (Heart Surgeon)	2%	-	3%
Colon and Rectal Surgeon	2%	-	3%
Endocrinologist (Hormones)	9%	-	12%
Hematologist (Blood)	3%	-	5%
Hospitalist (Hospital Care)	2%	-	3%
Nephrologist (Kidney)	2%	-	3%
Oncologist (Cancer)	4%	-	6%
Pathologist (Tissue and Blood Samples)	2%	-	3%
Sports Medicine	3%	-	4%
Urologist	2%	-	3%
Other(s)	38%	47%	34%
Unsure	2%	2%	2%

[1] Common Other responses include: dental (16), Lyme disease specialist (3), orthopedist (3)

Q86: In the past 12 months, have you ever left your area to access healthcare services? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	37%	40%	36%
No	62%	57%	64%
Unsure	1%	3%	-

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q86: In the past 12 months, have you ever left your area to access healthcare services? n209[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	38%	60%	25%	46%	55%	60%	50%	42%	30%	30%	60%
No	62%	40%	64%	54%	40%	40%	50%	58%	70%	67%	20%
Unsure	-	-	11%	-	5%	-	-	-	-	3%	20%

[1] 166 No Reply

Q87: What type(s) of care have you left the area for? n330; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Specialty care from a doctor	80%	69%	84%
Dental care from a doctor	21%	32%	17%
Primary care from a doctor	14%	19%	12%
Mental healthcare	9%	13%	7%
Other [1]	9%	8%	9%

[1] Other responses include: mammography (3), emergency care (2), optical (2)

Q87: What type(s) of care have you left the area for? n84; Select All That Apply Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	12	6	7	5	11	6	12	5	9	8	3
Primary care from a doctor	17%	33%	14%	20%	36%	17%	17%	40%	11%	-	-
Specialty care from a doctor	75%	83%	43%	80%	55%	67%	75%	80%	89%	38%	100%
Dental care from a doctor	25%	33%	57%	20%	9%	67%	42%	60%	11%	25%	33%
Mental healthcare	8%	17%	-	20%	18%	-	8%	40%	11%	25%	-
Other [1]	25%	-	-	-	9%	-	8%	-	11%	13%	-

[1] Common Other responses include: OBGYN (4), emergency care (3), fertility specialist (2)

Q88: Are doctors' office hours convenient for you? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	81%	78%	82%
No	17%	17%	17%
Unsure	2%	5%	1%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q88: Are doctors' office hours convenient for you? n209[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	84%	70%	82%	82%	65%	90%	79%	67%	77%	82%	60%
No	16%	30%	18%	18%	30%	10%	13%	25%	17%	7%	20%
Unsure	-	-	-	-	5%	-	8%	8%	6%	11%	20%

[1] 166 No Reply

Q89: Are you able to make and schedule appointments with your doctor(s) when needed? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	82%	76%	83%
No	15%	18%	15%
Unsure	3%	6%	2%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q89: Are you able to make and schedule appointments with your doctor(s) when needed? n209[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	81%	80%	82%	55%	80%	60%	67%	58%	77%	85%	80%
No	9%	20%	14%	27%	20%	30%	21%	42%	20%	7%	20%
Unsure	10%	-	4%	18%	-	10%	12%	-	3%	8%	-

[1] 166 No Reply

Q90: Usually, how long do you have to wait for an appointment? n138; Single Response			
Category	Total n	Medicaid/Uninsured n	General Community n
No wait, usually I can be seen immediately	-	-	-
Days	28%	24%	30%
Weeks	47%	61%	42%
Months	17%	8%	21%
Longer than months	2%	-	3%
Not able to schedule	1%	3%	1%
Unsure	5%	4%	3%

Q91: Is there adequate transportation in the community for you to visit healthcare providers? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	55%	54%	55%
No	20%	25%	19%
Unsure	25%	21%	26%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q91: Is there adequate transportation in the community for you to visit healthcare providers? n209[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	69%	40%	57%	55%	60%	40%	50%	33%	50%	56%	40%
No	6%	30%	29%	36%	25%	30%	38%	25%	30%	15%	60%
Unsure	25%	30%	14%	9%	15%	30%	12%	42%	20%	29%	-

[1] 166 No Reply

Q92: Which of the following chronic conditions do you have? n899; Select All That Apply			
Category	Total n	Medicaid/Uninsured n	General Community n
Chronic Pain (migraines, joint pain, back aches)	27%	37%	23%
Hypertension (high blood pressure)	29%	29%	29%
Mental Health	15%	29%	10%
Obesity	21%	28%	19%
Asthma	14%	24%	10%
Diabetes	13%	17%	11%
Heart Disease	9%	12%	8%
COPD	4%	7%	3%
Substance Abuse	2%	6%	1%
Cancer	3%	4%	3%
HIV or AIDS	0%	1%	0%
Other[1]	22%	28%	19%
None of the above	29%	17%	33%

[1] Common Other responses include: multiple conditions/too many to name (30), thyroid (12), chronic kidney disease (9), high cholesterol (8), hypothyroidism (8), GERD (5)

Q92: Which of the following chronic conditions do you have? n209; Select All That Apply Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Asthma	25%	20%	36%	18%	30%	30%	29%	25%	13%	19%	20%
Cancer	13%	-	4%	-	-	10%	8%	8%	-	-	-
Chronic Pain (migraines, joint pain, back aches)	53%	50%	29%	36%	40%	40%	29%	42%	27%	33%	60%
COPD	13%	-	4%	-	10%	10%	8%	8%	7%	7%	-
Diabetes	16%	20%	11%	36%	20%	20%	4%	50%	17%	11%	-
Heart Disease	13%	10%	18%	9%	15%	10%	8%	8%	10%	11%	-
HIV or AIDS	-	-	-	-	-	-	-	-	3%	4%	-
Hypertension (high blood pressure)	25%	40%	36%	36%	40%	40%	21%	25%	37%	15%	-
Mental Health	31%	30%	29%	18%	25%	-	17%	17%	47%	37%	40%
Obesity	28%	30%	32%	36%	15%	20%	21%	17%	30%	41%	20%
Substance Abuse	3%	-	-	-	20%	10%	-	-	17%	4%	20%
Other[1]	41%	50%	21%	27%	15%	-	42%	25%	30%	22%	20%
None of the above	3%	-	25%	27%	5%	20%	21%	25%	20%	30%	-

[1] Common Other responses include: thyroid condition (23), high cholesterol (9), chronic kidney issues (8), fibromyalgia (7), sleep apnea (7)

Q92a: Are efforts being made by a healthcare professional to help you control these conditions? Select All That Apply				
Category	n	Total n "Yes"	Medicaid/Uninsured n "Yes"	General Community n "Yes"
HIV or AIDS	3	100%	100%	100%
COPD	36	92%	93%	91%
Heart Disease	77	91%	92%	91%
Asthma	121	88%	90%	87%
Cancer	29	97%	89%	100%
Hypertension (high blood pressure)	261	94%	89%	96%
Diabetes	113	90%	86%	92%
Substance Abuse	22	77%	85%	67%
Mental Health	131	79%	77%	80%
Chronic Pain (migraines, joint pain, back aches)	237	74%	72%	75%
Obesity	184	56%	53%	57%

Q93: Have you turned to any community resources to help with your chronic condition(s)? n639; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	22%	30%	19%
No	78%	70%	81%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q93: Have you turned to any community resources to help with your chronic condition(s)? n173[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	31	10	21	8	19	8	19	9	24	19	5
Yes	26%	10%	19%	13%	47%	25%	26%	22%	33%	58%	20%
No	74%	90%	81%	87%	53%	75%	74%	78%	67%	42%	80%

[1] 166 No Reply

Q94: Which one(s)? n139; Select All That Apply					
Category	Total n	Medicaid/ Uninsured n	Category	Total n	Medicaid/ Uninsured n
Mental health services	44%	64%	Assistance to vulnerable populations	3%	4%
Free or low-cost medical services	18%	35%	Long-term care services	3%	4%
Religious services	15%	17%	Blood donation	2%	-
Safe and affordable housing	9%	17%	Computer training services	1%	-
Advocacy	15%	15%	Disaster relief	-	-
Workforce assistance	7%	15%	Health and safety courses	7%	-
Help with addiction	10%	14%	International humanitarian services	1%	-
Community helpline	11%	10%	Military family support	-	-
Care giving services	5%	8%	Rural residents health outreach	1%	-
Contraceptive services	4%	6%	Other[1]	32%	17%
Family enrichment services	4%	6%	Unsure	9%	6%
Handicapped services	5%	6%			

[1] Common Other responses include: exercise (5), chiropractor (3), support group (3), alternative medicine (2), nutritionist (2), weight watchers (2)

Q95: Have you used any alternative healthcare provider options (such as yoga, massage therapy, acupuncture, etc.)? n894; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	39%	28%	42%
No	61%	72%	58%

[1] Total 267 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 101 No Reply

Q96: How likely would you be to consider alternative healthcare provider options? n544; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Very likely	22%	33%	17%
Somewhat likely	47%	37%	51%
Not at all likely	31%	30%	32%

[1] Total 4 No Reply
[1] Medicaid/Uninsured 1 No Reply
[1] General Community 3 No Reply

Q97: Briefly explain three activities you have participated in over the past 6 months to stay healthy. n375[1]; Open-Ended		
Top 10 Responses	n	%
Walking	106	28%
Eating Healthy	80	21%
Exercising	53	14%
Bicycling	18	5%
Swimming	18	5%
Being Active	15	4%
Dieting	15	4%
Running/Jogging	15	4%
Yoga	11	3%
Physical Therapy	8	2%

[1] Total 335 No Reply
[1] Medicaid/Uninsured 188 No Reply
[1] General Community 149 No Reply

Q98: Have you ever dialed 2-1-1? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	11%	16%	9%
No	89%	84%	91%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q98: Have you ever dialed 2-1-1? n209[1]; Single Response Medicaid/Uninsured											
Category	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins	None of the above
n	32	10	28	11	20	10	24	12	30	27	5
Yes	25%	10%	18%	-	10%	-	4%	33%	3%	41%	20%
No	75%	90%	82%	100%	90%	100%	96%	67%	97%	59%	80%

[1] 166 No Reply

Q99: Do you talk about your healthcare with others? n899; Single Response			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Yes	76%	73%	77%
No	24%	27%	23%

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

Q100: What sources do you use for healthcare advice (not including your doctor)? n899; Select All That Apply			
Category	Total n[1]	Medicaid/Uninsured n[1]	General Community n[1]
Friends or family	77%	76%	77%
Internet	72%	65%	75%
Pharmacist or drug store	45%	49%	44%
Magazines	16%	14%	17%
Television	12%	14%	11%
Health Department	10%	12%	9%
Newspapers	9%	6%	10%
Church	3%	4%	3%
School	2%	2%	3%
Other(s) [1]	10%	12%	9%

[1] Common Other responses include: journal articles (8), books (6), colleagues (6), magazines/newsletters (5), none (5)

[1] Total 262 No Reply
[1] Medicaid/Uninsured 166 No Reply
[1] General Community 96 No Reply

In-Depth Interviews
Focus Groups
Appendix

Q1: Which of the following statements best applies to you? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	90	15	3	1	12	14	9	10	6	9	11
I am a healthcare provider, physician, or work in an organization that provides healthcare.	42%	53%	67%	100%	33%	36%	67%	40%	33%	22%	36%
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.	58%	47%	33%	0%	67%	64%	33%	60%	67%	78%	64%

In-Depth Interviews
Healthcare Audience
I am a healthcare provider, physician, or work in an organization that provides healthcare.

Q2: What types of insurance does your practice accept? Select All That Apply											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Commercial	90%	88%	50%	100%	100%	80%	100%	100%	100%	100%	75%
Medicaid	90%	100%	100%	100%	100%	80%	100%	100%	50%	100%	50%
Medicare	82%	100%	50%	100%	100%	80%	67%	100%	100%	100%	25%
Private Pay	87%	100%	50%	100%	100%	80%	83%	75%	100%	100%	75%
Self Insured	87%	88%	50%	100%	100%	80%	83%	100%	100%	100%	75%
Uninsured	76%	88%	0%	100%	75%	80%	83%	100%	50%	50%	75%
Do not accept insurance	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	25%
Other[1]	21%	25%	50%	100%	25%	20%	17%	25%	0%	0%	25%

Q3: Why do you accept Medicaid?

n34; Open-Ended

- Community need. (Broome)
- Due to the organization accepting it as a whole. (Broome)
- It is the hospital's decision to accept Medicaid and uninsured patients in the ED. It also depends on if the patient has an emergent medical screening, if so then they must be treated in the ED of any hospital. (Broome)
- It's people's primary insurance. I don't know the exact reasons, but I feel that if we didn't accept Medicaid, we would be turning away around 80% of patients. It's also a pretty good payer source. (Broome)
- My employer is Lourdes hospital, a faith based hospital, and our mission is to serve the poor. Furthermore, everyone needs healthcare, it doesn't matter the source of insurance. (Broome)
- One of our main goals and objectives is to help the poor and vulnerable (aka Medicaid). (Broome)
- Policy. Our mission is to accept Medicaid. Speaking for myself, I don't feel it should be legal to 'not' accept Medicaid. (Broome)
- This program is meant to take care of everyone regardless of insurance plan. (Broome)
- There's a waiver service provided and we accept it; possibly just a NYS program. (Cayuga)
- We have a Medicaid population. (Cayuga)
- Because we are a hospital. (Chemung)
- Assumes it is accepted because it makes sense. Works for non-profit, probably breaks even on Medicaid patients. (Chenango)
- There is huge need in our demographics and we have a lot of patients that have Medicaid. If we didn't take it, due to the lack of transportation, they would not be able to be serviced. (Chenango)
- We are a Hospice Facility. That need goes across all payers. (Chenango)
- We are home health caregivers. (Chenango)
- As a home care agency, we participate with all insurances to be able to provide services to patients in their homes. (Cortland)
- Because we are largely a Medicaid community it's a very rural and poor community. (Cortland)
- Large population of this community is a Medicaid user. (Cortland)
- Pay pretty decently, most timely payer. Initially accepted Medicaid because I thought it was the right thing to do. (Cortland)
- About 75 to 80 percent of our patients are Medicaid. (Delaware)
- Because we are a public agency funded by New York State. We receive funds from and are a licensed facility with the state. (Delaware)
- Covers the majority of recipients. It is the predominate coverage that is accepted. (Delaware)
- I work for a hospital that accepts Medicaid. (Delaware)
- It is the primary payer for most of our folks. (Delaware)

Q3: Why do you accept Medicaid?

n34; Open-Ended

- We are an emergency department, we are obligated by to see everyone regardless of how they pay. (Delaware)
- A big part of our community has Medicaid; we try not to discriminate against any insurance. (Schuyler)
- As a way to help patients on Medicaid; it's a low reimbursement and many patients don't show up for appointments, but we're providing a service to the community. (Schuyler)
- If we didn't, we couldn't survive because of our small rural county. Nursing Home/LTC Residents/Chronic Care Patients make up most of the Medicaid population. (Schuyler)
- We are a hospital. We have to accept everybody. (Schuyler)
- They need the service as much as anyone else. We will do Medicare and they will have dual Medicare/Medicaid. (Steuben)
- We accept it because it is one of the most prevalent carriers in this area. (Tioga)
- We must accept Medicaid due to Article 28 (Tioga)
- The university realized that there is a group of students that are already receiving Medicaid from the state and they decided that to serve them best, they should accept Medicaid. (Tompkins)
- Want to serve the community as a Non-Profit Community Hospital Service. (Tompkins)

Q4: Why do you not accept Medicaid?

n4; Open-Ended

- Accept Fidelis and Total Care; take Medicare after Medicaid but do not accept straight Medicaid - only through Total Care or Fidelis. (Cortland)
- We're a campus health center. We started a pilot this year; we have a self-insured student insurance plan, which is arranged with the state in lieu of Medicaid for the student. While we don't accept Medicaid, we have an alternate insurance plan for the student. (Tompkins)
- Do not charge; Medicaid services get the same as everyone else. (Tompkins)
- Paperwork, restriction and non-compliance. (Steuben)

Q5: (IF NO TO MEDICAID) Have you ever served the Medicaid population? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	4	0	0	0	0	1	0	0	1	0	2
Yes	100%	-	-	-	-	100%	-	-	100%	-	100%
No	-	-	-	-	-	-	-	-		-	-

Q6: Do you feel most providers accept Medicaid? Single Response[1]											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	37	7	2	1	4	5	6	4	2	2	4
Yes	49%	57%	0%	0%	50%	40%	33%	50%	50%	100%	75%
No	51%	43%	100%	100%	50%	60%	67%	50%	50%	0%	25%

[1] 1 No Reply

Q7: Why do you feel this way?

n37; Open-Ended

- Easily make referrals between PCPs, and understand the community and needs of Medicaid recipients. (Broome)
- I feel like Medicaid is more common than commercial insurance-not accepting it would be turning away a large portion of the population. (Broome)
- Many do not; some will accept ER referrals for a single follow-up only but not as a continuing patient. (Broome)
- Medicaid system is difficult to navigate, low reimbursement, and difficult patient population. (Broome)
- Probably a majority do but I think 60% of all providers accepts this insurance. (Broome)
- Reimbursement rates. (Broome)
- We commonly get overwhelmed with people who have Medicaid and we will reach out to other providers, but many providers we reach out to turn us down. (Broome)
- Reimbursement is poor for Medicaid. Okay for certain practices. (Cayuga)
- They don't get reimbursed as much. (Cayuga)
- I had a personal experience with my niece. She could not get a PCP for 6 months because she was on Medicaid. (Chemung)
- I think that for the most part, the majority accept it, except for when it comes to dental care. (Chenango)
- Medicaid doesn't pay the doctors well enough for it to be worth their while. (Chenango)
- The reimbursement is low and the overhead is high. (Chenango)
- We are familiar with the population of this county. (Chenango)
- I am talking about Medicaid administered through Fidelis and Total Care - as the Medicaid computer science organization as a whole, needs an overhaul. (Cortland)
- I'm part of a group of local private practice therapists-most of them take it. (Cortland)
- Non compliance and payment. (Cortland)
- Not as many that should. (Cortland)
- We work with most providers in the area and most of their patients have Medicaid. Most providers don't accept all Medicaid, but they accept some. (Cortland)

Q7: Why do you feel this way?
n37; Open-Ended

- As a private physician, they pay only 50%. (Delaware)
- Because I do not think that the emergency room would be used as much if other providers in the community accepted Medicaid. (Delaware)
- Because of delay in reimbursement and regulatory hoops that need to be jumped through. (Delaware)
- Because there are so few providers in the county that there are no other options but to except Medicaid. (Delaware)
- Because UHS Mental Health Service, substance abuse services all accept Medicaid and some PCPs do not accept Medicaid. (Delaware)
- My patients tell me that they can't get into specialty care and certain practioners. (Delaware)
- Again, it's because of the population large number are Medicaid/Medicare insured. (Schuyler)
- Sometimes it's a problem; some doctors don't accept Medicaid. It's a problem with dental and eye care, so they have to travel long distances for care. We deal with elderly patients. (Schuyler)
- The reimbursements are terrible and the patients are challenging. (Schuyler)
- There are people on Medicaid that are turned down by some physicians. (Schuyler)
- I have heard a lot of patients say they can't find services, but most of them do. (Steuben)
- Non-compliance of patients/ paper work is frustrating (Steuben)
- Because of the social economics, that is all they have for coverage. (Tioga)
- Most providers work for larger medical groups. (Tioga)
- Enhanced Medicaid made it very easy to accept it over standard Medicaid. (Tompkins)
- I would hope that they would because they would want everyone to have access to services. (Tompkins)
- Limited reimbursement. (Tompkins)
- Still exceptions, but situation is improving. Expected numbers of uninsured to go down, but they haven't. However, still many uninsured w/o physician access. (Tompkins)

Q8: (IF ACCEPT MEDICAID) What percentage of your patient base has Medicaid? Open-Ended[1]; Quantity											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	33	8	2	1	4	4	6	3	1	2	2
Average Percent:	44%	34%	60%	40%	27%	44%	61%	75%	30%	38%	25%

[1] 1 No Reply

Q9: How many years have you been in practice? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Less than 5 years	21%	25%	-	100%	25%	40%	17%	-	-	-	25%
5 to 14 years	18%	43%	100%	-	-	-	-	25%	50%	-	-
15 to 24 years	21%	25%	-	-	25%	-	17%	50%	-	50%	25%
25 years or more	40%	7%	-	-	50%	60%	66%	25%	50%	50%	50%

Q10: (IF ACCEPT MEDICAID CURRENTLY OR IN THE PAST) For approximately how many years have you served the Medicaid population? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Less than 5 years	21%	37%	-	100%	25%	20%	17%	-	-	-	25%
5 to 14 years	18%	25%	100%	-	-	-	17%	25%	50%	-	-
15 to 24 years	21%	25%	-	-	25%	20%	-	50%	-	50%	25%
25 years or more	40%	13%	-	-	50%	60%	66%	25%	50%	50%	50%

Q11: Does your practice specialize in working with any particular type of Medicaid patients or uninsured patients that all have similar characteristics? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	36	8	2	1	4	5	6	4	1	2	3
Yes	47%	50%	50%	-	50%	20%	50%	75%	-	50%	67%
No	53%	50%	50%	100%	50%	80%	50%	25%	100%	50%	33%

Q12: (IF YES) What are those characteristics that your populations exhibit?

n17; Open-Ended

- All diagnosed with the same condition. (Broome)
- Currently we focus on children and family members. We are trying to expand to adults. (Broome)
- DePaul and Dinero clinics; for Gynecology/pre-maternity and pediatric care. (Broome)
- Practice palliative medicine; most have advance illness. (Broome)
- Many have Alzheimer's or TBI (Traumatic Brain Injury). (Cayuga)
- A lot diabetics. (Chenango)
- Terminal Diagnosis of less than 6 months. (Chenango)
- Mental health patients. (Cortland)
- Focuses on specific opiate patients. (Delaware)
- Substance abuse treatment issues. (Delaware)
- They have mental health and substance abuse needs. (Delaware)
- Elderly and rehab patients. (Schuyler)
- Eye care practice; many diabetics. (Schuyler)
- The population is White/Anglo-American/Protestant and mainly that have hit hard times due to losing jobs and not being able to find new jobs. (Schuyler)
- Substance abuse and mental health. (Tioga)
- Chronic Diseases (Tompkins)
- College students. (Tompkins)

Q13: Are your Medicaid or uninsured patients unique or distinct from the other types of patients that you see? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	36	8	2	1	4	5	6	4	1	2	3
Yes	50%	63%	100%	-	50%	20%	33%	50%	100%	50%	67%
No	50%	37%	-	100%	50%	80%	67%	50%	-	50%	33%

Q14: (IF YES) How are your Medicaid patients unique or distinct?

n18; Open-Ended

- Education level, socioeconomic status, degree of follow-up care, communication level and ability to contact patient (Broome)
- I see a lot of patients on Medicaid that have diabetes (that goes unmanaged). I don't know if it's from a lack of proper nutrition or education. Also see a lot of people with substance abuse problems. (Broome)
- In the southern tier many patients move here to easily get Medicaid and they get better benefits in the southern tier. (Broome)
- They tend to have more psychological and social problems. (Broome)
- We notice a high no show rate and struggles with transportation. (Broome)
- They don't have as much money; Medicaid patients usually cannot afford private insurance. I also work with people with dementia and Alzheimer's. I believe the Office of the Aging covers some or part of these illnesses, but the major expense is out-of-pocket. But the main thing is they are being kept out of nursing homes. (Cayuga)
- Very demanding. Don't expect to pay for anything. Diabetes, congestive heart failure, COPD (Cayuga)
- Their lives tend to be more chaotic. Don't seem to have the social network and family/friend support that other people have. More dependent on help from agencies. Lower income demographic. (Chenango)
- They utilize more services. (Chenango)
- Most of them have chronic care needs--non-Medicaid and non-uninsured patients usually come for acute concerns (Cortland)
- These are the only patients we see. They normally have the same diagnoses. (Delaware)
- They tend to be more multi-problem families and usually involve themselves in preventive care. (Delaware)
- Limited understanding of healthcare in general, limited coping skills, limited personal resources. (Schuyler)
- They have more disease and no show rates; compliance is lower. (Schuyler)
- They get more community based services. Education Levels. (Steuben)
- Generally may not show up for appointments, may not understand their condition, takes a bit more work to take care of them. (Tioga)
- They have long standing chronic issues and co-morbid issues. They also have a lot of life stress that impacts their health and the ability to comply. (Tompkins)
- They struggle with issues like transportation, access to good food, dental care. (Tompkins)

Q15: (IF ACCEPT MEDICAID) Over the past two years has your percentage of Medicaid patients increased, decreased, or remained the same? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	34	8	2	1	4	4	6	4	1	2	2
Increased	65%	50%	100%	100%	50%	75%	50%	75%	-	100%	100%
Decreased	3%	-	-	-	-	-	-	-	100%	-	-
Remained the same	29%	50%	-	-	50%	-	50%	25%	-	-	-
Unsure	3%	-	-	-	-	25%	-	-	-	-	-

Q16: Why do you feel that way?

n34; Open-Ended

- Demographics of the area have not changed. (Broome)
- I don't have a good answer for that; I'm on salary, so don't worry about that. (Broome)
- People are forced to go to the ER or urgent care because they can't get continuing care from a private physician. (Broome)
- Seeing less of BCBS, seeing more people out of work and seeking insurance. Seeing less and less commercial insurance. (Broome)
- The percentage of Medicaid patients hasn't gone up right now but I do feel that it will go up, I see more uninsured people coming in. (Broome)
- There is always a need for Medicaid even if the population fluctuates. (Broome)
- We began to focus more on serving Medicaid patients. (Broome)
- We've expanded from more rural counties into a lot of urban areas with higher population densities. With that, we've seen our Medicaid go up. (Cayuga)
- We've taken on more clients; most of them are on Medicaid. (Cayuga)
- We have more coming in, repeaters. Same diagnosis. We have a lot more children. (Chemung)
- Maybe the economy and eligibility criteria has changed. (Chenango)
- Not a lot of people moving into the area or out of the area. Believes that in Upstate NY, things pretty much stay the same. (Chenango)
- Private providers have stopped seeing Medicaid patients. (Chenango)
- The age demographic. Medicare has a Hospice benefit. There are more end stage chronic care. (Chenango)
- Because of the economy and the number of people that are migrating to Cortland because they can get benefits easier and usually there is less of a wait time. (Cortland)
- Reviews records and knows the numbers. Supposes it is due to the difficulty patients are finding in having their primary care physicians meets all their chronic care needs. (Cortland)
- Sees more people in her area which are "situational" poor versus "chronically/traditionally" poor. (Cortland)
- Because if the economy is good or bad, the population of people that use Medicaid are about the same and the usage of Medicaid patients stays about same. (Delaware)
- I think the changes in healthcare and I think we are working harder to have people be insured. (Delaware)
- That's the reality of my community and patient base. (Delaware)
- That's what the numbers show. (Delaware)

Q16: Why do you feel that way?

n34; Open-Ended

- The economy and price of insurance. (Delaware)
- The practice has increased in accepting patients. Practice is regulated by the regulatory body through the DEA. (Delaware)
- The managed care makes more people eligible. (Schuyler)
- The nursing home side has stayed the same; middle class Medicaid has had hard economics times. (Schuyler)
- There's not a change in the patient base we see. We are a nursing home; people are living longer and many people run out of their own funds, so Medicaid is needed eventually. (Schuyler)
- We have had several businesses in the area close. (Schuyler)
- When they switched NYS to managed Medicaid we were not part of those plans. (Steuben)
- Because this is a primary care facility within a large medical group, and as more people have access to Medicaid, they tend to see more. (Tioga)
- Lack of viable employment in this area. (Tioga)
- Bariatric programs are now accepting Medicaid/Medicare. (Tompkins)
- Because the facility just realized that was a group that needed services. (Tompkins)

Q17: Do you serve uninsured patients? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	9	1	2	0	1	1	1	0	1	1	1
Yes	56%	100%	-	-	-	100%	-	-	100%	100%	100%
No	44%	-	100%	-	100%	-	100%	-	-	-	-

Q18: (IF YES) What percentage of your patient base is uninsured? Open-Ended; Quantity											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	34	8	0	1	3	5	5	4	2	2	4
Average Percent:	8%	7%	-	10%	6%	4%	12%	8%	18%	5%	4%

Q19: Over the past two years has this percentage of uninsured patients increased, decreased, or remained the same? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	34	8	0	1	3	5	5	4	2	2	4
Increased	27%	38%	-	-	33%	-	40%	50%	50%	-	-
Decreased	27%	25%	-	-	-	40%	20%	25%	-	100%	25%
Remained the same	38%	39%	-	100%	67%	40%	40%	25%	50%	-	25%
Unsure	8%	-	-	-	-	20%	-	-	-	-	50%

Q20: Why do you feel that way?

n34; Open-Ended

- Affordable Care Act (Broome)
- As part of the Affordable Care Act, people need to have insurance; when someone without insurance comes to our office, we provide them with financial resources and insurance providers. (Broome)
- I've seen more and more people come into the ED because they know they will be seen, instead of going to an urgent care facility. They figure that the flu may be very serious. In the last 10-15 years, more people are tuned into their health and this is thanks to the media and other sources. The commercials on television make every disease or medical issue a huge deal. (Broome)
- Many employers in the area are dropping healthcare as a benefit, or the premiums are too high and folks opt-out of healthcare benefits. (Broome)
- Patients can not make an appointment without insurance. (Broome)
- People are in the situation they're in: uninsured, working poor or Medicaid. They're in the situation and remain that way. (Broome)
- People are losing jobs, maybe haven't been on any form of public assistance and don't know where to go to receive it. Maybe they avoid insurance for a little while and go uninsured. (Broome)
- Unemployment levels have not changed. (Broome)
- They don't just come in or go to the ED. They don't want to rack up bills. We see them when it is a definite emergency. (Chemung)
- I think the loss of jobs in the area has lead to unemployment and people are not too savvy about how to apply for Medicaid and Healthy NY. (Chenango)
- People are pretty savvy about how to get on Fidelis and Total Care. The waiting period is another reason I feel it has remained the same. (Chenango)
- The age demographic. Medicare has a Hospice benefit. There are more end stage chronic care. (Chenango)
- Because of the benefits that are available in Cortland County. (Cortland)
- Has clients which were previously uninsured but were able to secure insurance under the ACA. (Cortland)
- If the government tells you to do something, the patient will try to do it. If our office, private practice, tells people that are uninsured that payment is due up front, they usually will not use our practice. (Cortland)
- Reviews records, knows the numbers. Not sure of the cause for this one. (Cortland)
- Unsure (Cortland)
- Because I think our population that we serve economically stays about the same and there are not a lot of folks that move in or out of the county. (Delaware)
- Because the data shows that. (Delaware)
- The Affordable Care Act is not as affordable as we were lead to believe. People cannot afford insurance. (Delaware)

Q20: Why do you feel that way?

n34; Open-Ended

- The economy and the eligibility gap for Medicaid. (Delaware)
- We are doing a better job at making sure people have coverage and the health care reform act. (Delaware)
- Because of jobs lost; initially organizations like Fidelis and Total Care were not around when the economy started going down, they are doing a better job of getting people insured. (Schuyler)
- Same patient base. (Schuyler)
- There are more choices for insurance now that it is readily available. (Schuyler)
- We have several businesses in the area close. (Schuyler)
- More people have retired and no longer have insurance. (Steuben)
- We have not had any more or any less. (Steuben)
- The Affordable Care Act has provided access to more patients who previously had no insurance. (Tioga)
- With the implementation of Obamacare. (Tioga)
- Big push with the Affordable Care Act to enroll people. Not sure of how enrollment has allowed for better access to physicians. Did not increase the number of primary care physicians. Still sees same number of patients at free clinic. (Tompkins)
- Doesn't apply. (Tompkins)
- Insurance is not imperative for a "life style change". (Tompkins)
- There is no data to demonstrate, but I feel it may have increased. (Tompkins)

Q21: What, if any, trends have been developing over the last several years regarding the Medicaid and uninsured populations?

n37[1]; Open-Ended

- Dealing with children with Medicaid; the parents of these children have healthcare issues that have gone undiagnosed and untreated for many years. (Broome)
- I think a big part of increases are people not knowing if they are seriously ill or not, they may not have a doctor, they may not know who to call, they do know that they will be seen in the ED. The uninsured/Medicaid patients are not sure how to handle their chronic health problems. (Broome)
- I'm seeing younger people on Medicaid (kids that are 18 and below). More of the younger population are now Medicaid users. (Broome)
- Increase in substance abuse. (Broome)
- Lack of compliance with medications and recommendations - Not showing for appointments. (Broome)
- More complex healthcare needs. (Broome)
- Overall, the populations are getting bigger. (Broome)
- We hear from PCPs that the reimbursement is less and the paperwork is burdensome, so there's an increased refusal of these populations. (Broome)
- I see a lot of older people transitioning to Medicaid as their retirement plan. People who didn't save enough and are in need of care liquidate their assets and go on Medicaid and say that was their original plan. (Cayuga)
- I'm not aware of any. (Cayuga)
- The increased use of the Emergency Room. (Chemung)
- In general, my Medicaid patients have a much harder time managing their illnesses because they can't get to their doctors. Thus overuse of the ER. (Chenango)
- It's more difficult to provide people with actual prescriptions that have been dispensed; the formulary has changed and people are not used to dealing with formulary changes. (Chenango)
- The whole reason is over-utilization of the system. We have to be fiscally responsible. This is an ethical dilemma. I can gain by costing the taxpayers more. (Chenango)
- For our office, I set rules in place so that we are paid, we don't have a lot of balances, it is a business, our fees are flatly rated, and should a patient not have the ability to pay, they usually shop around for another doctor. (Cortland)
- Former middle class people (educated, working, have post-graduate degrees) are getting Medicaid because they cannot afford insurance in the marketplace. (Cortland)
- Increase in the Medicaid population. Increase in their needs for home visits in place of nursing home use. Many agencies in this county provide Medicaid waiver services, so many patients come from other counties for these services. (Cortland)
- The trends I see are mostly negative trends; we see a lot more addicts and parolees. (Cortland)

[1] 1 No Reply

Q21: What, if any, trends have been developing over the last several years regarding the Medicaid and uninsured populations?
n37[1]; Open-Ended

- Uninsured wait until they are so sick they are in critical condition before attending the hospital/Medicaid patience use the Hospital as primary care. (Cortland)
- I think that as a society we expect things right now, like when it comes to medical care they can go to the ED and get care right away. Also, if they choose to go to a PCP, then they are expected to pay a co-pay, whereas with the ED they don't. (Delaware)
- More complex cases. (Delaware)
- More people are seeking and becoming eligible for Medicaid. (Delaware)
- Nothing really. (Delaware)
- The increase of heroin usage. (Delaware)
- The trend of moving from fee to service Medicaid managed care. (Delaware)
- It is younger and larger. (Schuyler)
- It's the Fidelis and other organizations doing a much better job of advertising what they offer, and normalizing that being uninsured is okay. (Schuyler)
- More Medicaid and less uninsured. (Schuyler)
- Our patients are getting more complicated; not necessarily Medicaid patients. (Schuyler)
- To try to encourage Urgent Care versus the ED. I hope that is continuing. (Steuben)
- Unsure (Steuben)
- I think more people are seeking out those services than they have in the past. (Tioga)
- Unsure (Tioga)
- Because of financial concerns, they're avoiding care more frequently. In 2008, 17% said they avoided care and it increased to 21% in 2011. (Tompkins)
- I think that the co-morbid issues and the difficulties accessing services have become more apparent. (Tompkins)
- Inappropriate utilization of hospital beds, ER appropriation, unavailable transportation, lack of access to counseling, lack of familiarity with Medicaid counseling. Not all are purely medical in nature. (Tompkins)
- Medicaid users are moving into this area more. SNAP benefits are getting cut. Harder for people to get into primary care doctors. (Tompkins)

[1] 1 No Reply

Q31: On a scale of 1 to 5 where "1" represents poor and "5" represents excellent, based on your knowledge how would you rate the sharing of healthcare information within the provider community? Aided; Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
1	13%	25%	-	-	-	20%	17%	-	-	50%	-
2	24%	37%	-	-	-	40%	33%	-	-	-	25%
3	21%	-	100%	100%	25%	-	33%	-	-	50%	50%
4	37%	13%	-	-	75%	40%	17%	100%	100%	-	25%
5	5%	25%	-	-	-	-	-	-	-	-	-
% 4 or 5	42%	38%	-	-	75%	40%	17%	100%	100%	-	25%

Q32: Over the past 3 years, is provider communication getting better, staying the same, or getting worse? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Getting better	50%	50%	100%	100%	75%	20%	33%	75%	50%	50%	25%
Staying the same	34%	37%	-	-	25%	40%	34%	25%	50%	50%	50%
Getting worse	16%	13%	-	-	-	40%	33%	-	-	-	25%

Q33: Do you think providers ever have difficulty in accessing records or tests of patients electronically? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	82%	88%	50%	100%	100%	80%	83%	100%	50%	50%	75%
No	18%	12%	50%	-	-	20%	17%	-	50%	50%	25%

Q34: Is communication between certain provider segments worse than others? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	79%	88%	100%	100%	75%	100%	67%	50%	-	100%	100%
No	21%	12%	-	-	25%	-	33%	50%	100%	-	-

Q36: Would better communication among providers impact the number of non-emergent ED visits from the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	74%	100%	50%	100%	75%	80%	83%	25%	50%	100%	50%
No	26%	-	50%	-	25%	20%	17%	75%	50%	-	50%

Q38: Should community organizations play a role in promoting effective provider communications? Single Response[1]											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	37	7	2	1	4	5	6	4	2	2	4
Yes	82%	86%	50%	100%	75%	100%	100%	50%	100%	50%	100%
No	18%	14%	50%	-	25%	-	-	50%	-	50%	-

[1] 1 No Reply

Q41: Which of the following healthcare needs are **MOST CRITICAL** to address for the Medicaid and uninsured populations? Single Response											
Category	Total	County									
		Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Access to transportation	18%	-	-	-	50%	20%	33%	-	50%	50%	-
Access to providers who accept Medicaid or uninsured patients	21%	25%	50%	100%	25%	20%	17%	-	-	-	25%
Provide education to Medicaid and uninsured patients to make them aware of their healthcare options	13%	-	50%	-	-	-	17%	50%	50%	-	-
Healthcare needs to be more affordable for the Medicaid and uninsured populations	5%	13%	-	-	-	-	-	25%	-	-	-
There is a need for mental health services for the Medicaid and uninsured populations	43%	62%	-	-	25%	60%	33%	25%	-	50%	75%

Q42: Are there needs that are missing or that are more critical? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	61%	75%	50%	-	25%	40%	67%	75%	50%	50%	100%
No	39%	25%	50%	100%	75%	60%	33%	25%	50%	50%	-

Q45: Are these barriers unique to your county or geography served? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	18%	14%	-	-	25%	20%	33%	-	50%	50%	-
No	82%	86%	100%	100%	75%	80%	67%	100%	50%	50%	100%

Q46: Why or why not?

n38; Open-Ended

- I think it's a problem with our national healthcare - healthcare facilities charge what they want too - there is no ceiling on any service/tests/office visits - needs to be. There is a free clinic around here but it's not a facility you go to with critical conditions - you will go to the ED for critical issues. (Broome)
- I work within the community and live in another community. Through talking to people around the state, this is a common issue. (Broome)
- I would think that it would be similar throughout the state. (Broome)
- People are poor everywhere; we don't do well for poor people. (Broome)
- The same problems extend over many counties. (Broome)
- These are problems that similar areas would face due to the higher level of Medicaid population. (Broome)
- We do have services, but that has been decreasing. The mental health clinic in our area laid off many social workers. Services have been cut. Psychiatric services have been cut, which leads to ED admission for psychiatric conditions down the road. (Broome)
- We hear it from all over. (Broome)
- There have always been physicians who do not accept Medicaid, as they do not get reimbursed properly. (Cayuga)
- We don't have public transportation or affordable taxi services in rural areas. Not enough services outside of these either. (Cayuga)
- This is a nationwide problem. (Chemung)
- I think that most rural communities have problems with transportation and that the state has pulled back a lot in the facilitated enrollment process. (Chenango)
- Plans are in place, but obstacles prevent the system from working for my patients. Everyday crises and chaos in my patients' lives prevent them from making use of the systems. Because I am in a rural area, patients have to plan farther ahead of time to get to doctors that are located far away. Doesn't meet individual needs or timeliness of access (cannot respond to immediate needs). (Chenango)
- They are unique to rural areas. (Chenango)
- We have a limited amount of Medicaid providers and no Urgent Care. (Chenango)
- Any time I have accessed a patient with transportation needs, we have never been successful in securing out-of-county transportation. (Cortland)
- Because it's a rural community and the choices are limited. (Cortland)
- It's all across the country. (Cortland)

Q46: Why or why not?

n38; Open-Ended

- Not just held to a particular area. (Cortland)
- Public transportation (bus) system is terrible. There are cabs, but they are expensive. (Cortland)
- Because Delaware county is the size of Rhode Island with a low population density. (Delaware)
- Delaware County is 90 miles from end to the other and it's a mountain region. There is a general lack of trust from any government involvement in government services. The biggest problem is transportation. (Delaware)
- It is the same in each population. (Delaware)
- It's a problem in all states. (Delaware)
- It's pretty common throughout the United States; it's an issue. (Delaware)
- We are a very poor county. (Delaware)
- It is everywhere. Unemployment is everywhere. No job no coverage. (Schuyler)
- It's a problem in all states. (Schuyler)
- Most providers are not incentivized to accept Medicaid. (Schuyler)
- The whole region is poor and rural to some degree. Upstate NY is in the same boat! (Schuyler)
- Fees and paperwork are too involved for providers to bother accepting the coverage. (Steuben)
- Other states have similar issues. (Steuben)
- Because the county is so spread out. (Tioga)
- These are issues that could arise anywhere. (Tioga)
- Blanket programs attempt to address needs without consideration of unique situations in Tompkins County. (Tompkins)
- I think that they are pretty universal. (Tompkins)
- It's a state-wide issue; low reimbursement. (Tompkins)
- This problem is a universal issue. (Tompkins)

Q47: What needs to be done to overcome these barriers for the Medicaid and uninsured populations?

n38; Open-Ended

- Education on the importance of healthcare and follow-up care/ Communication to have patients attend visits. (Broome)
- I think transportation is a big, big thing for people. There are people in our community living independently who maybe shouldn't be living independently--maybe they need assistance. We should have more housing with staff that aware of mental health issues, etc. (Broome)
- If reimbursement rates are lower, then maybe a supplement for doctors who have more Medicaid patients or change reimbursement. (Broome)
- Increase payments. (Broome)
- Mental health services becoming more accessible to this population, and available transportation for these populations. (Broome)
- More coordination of care, and stronger alliances between providers. Providers have got to be more open to working together. (Broome)
- Patients need to be held accountable for their own health; incentives to taking care of themselves; penalties for not complying with their health-care benefit plan. (Broome)
- There needs to be more PCP support for these populations, offer free clinics fill it with PCP's, pay the PCP's something, make it affordable for Medicaid/uninsured, we need to have some kind of PCP setting where chronic illnesses will be treated and keep them under control so that they do not have to go to the ED when the chronic condition is out of control. (Broome)
- State could step in with better reimbursement to caregivers so it will be more readily accepted. (Cayuga)
- They need to establish a transportation system and fund it better. (Cayuga)
- Full cycle. Better job market. More people to get off Medicaid. (Chemung)
- Get case management so that the patient can be monitored. After hours care. If there was an Urgent care it would take care of that. More DR's office that are open after hours. (Chenango)
- Policy change. (Chenango)
- Reliable convenient public transportation would be a huge step and education on the enrollment process and how stay on it. (Chenango)
- System for them to access transportation in a timely manner with the possibility of immediate response. For example, if a nurse sees a patient and needs another outside doctor to check a patient's vitals that afternoon, that is not a possibility with the county's current transportation system. (Chenango)
- Different assessment tools for people to qualify for Medicaid. Some sort of sliding scale. (Cortland)
- I chose my office location knowing it was easy for people to get to. People need to know what is available, that a lot of private practitioners take Medicaid. (Cortland)
- I think that the reimbursement rate is too low. Also the patients have a lot of transportation problems with getting into the city. (Cortland)

Q47: What needs to be done to overcome these barriers for the Medicaid and uninsured populations?

n38; Open-Ended

- It is a very complex situation - it's about how you were brought up, what you teach your children, habits that do not go away within the family generations, we must be politically correct these days and can't speak the truth. (Cortland)
- Need to have a system in place where there is access to transportation to specialty officers. Specialty and primary care providers need to be under some kind of umbrella so as to facilitate transportation needs. Perhaps specialists should have satellite offices in other counties where they visit on a regular basis. (Cortland)
- Change the laws. Make sure Medicaid patients pay more than a $2 co-pay and make sure to have penalties, something to lose for not paying. (Delaware)
- Developing rural resources and support them financially. (Delaware)
- Give more incentive to health care providers to accept Medicaid and make the process of providing transportation a bit easier to the Medicaid population. (Delaware)
- Increase in employment opportunities; the rural area is vulnerable, and transportation needs. (Delaware)
- Need to expand transportation services and have more providers spread out geographically. (Delaware)
- Some type of public transportation that would help and some type of regional urgent care services. (Delaware)
- Education (Schuyler)
- I don't know. (Schuyler)
- Increase reimbursements; tighten up the system so the people who need it get it. (Schuyler)
- We need to make smaller clinics, have more advertising normalizing things like being uninsured is ok and educate on how to go about applying, eliminating the fear people have with such a vast industry. (Schuyler)
- Addressing the fees and restrictions of Medicaid for providers to serve their patients. (Steuben)
- Transportation. Consistent, reliable. Taxi service. Price. Education. (Steuben)
- Better transportation/ More volunteers to help. (Tioga)
- More transportation. (Tioga)
- Education on basic healthcare/ healthy life styles. (Tompkins)
- I feel behavioral health is a vehicle that could help overcome some of those barriers. A part of my job is to assist my patients with basic daily living skills and obstacles. (Tompkins)
- The DSRIP grant will open up possibilities; integrating medical and mental health services. (Tompkins)
- Think outside normal healthcare programs. DSRIP needs to look at the specific community which it addresses. Not keeping up with huge mental health needs. (Tompkins)

Q48: Do you think language is a barrier to receive healthcare services for most of the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	18%	25%	-	-	-	20%	17%	-	-	50%	50%
No	82%	75%	100%	100%	100%	80%	83%	100%	100%	50%	50%

Q49: Is language a barrier to receiving healthcare when English is not the patient's primary language (difficulty comprehending English)? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	7	2	-	-	-	1	1	-	-	1	2
Yes	86%	100%	-	-	-	100%	-	-	-	100%	100%
No	14%	-	-	-	-	-	100%	-	-	-	-

Q50: Do you believe doctors explain care in a way that the patient can understand? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	7	2	-	-	-	1	1	-	-	1	2
Yes	29%	-	-	-	-	-	100%	-	-	100%	-
No	71%	100%	-	-	-	100%	-	-	-	-	100%

Q51: Do you think racial diversity or lack of cultural sensitivity is a barrier to receiving healthcare services among the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	29%	38%	-	-	-	40%	17%	-	-	50%	100%
No	71%	62%	100%	100%	100%	60%	83%	100%	100%	50%	-

Q52: For what reason(s) do the Medicaid and uninsured populations use the ED even though it is unnecessary?

n38; Open-Ended

- A perception that they will have faster access and get their problem resolved. (Broome)
- Lack of knowledge and lack of transportation (using an ambulance); lack of knowledge for Medicaid subscriber that encourages ED usage instead of PCP. (Broome)
- May not have a PCP, No clinic or walk-in urgent care access. Education of what is considered life-threatening. (Broome)
- Medicaid pays for an ambulance, but not a taxi; you can't take an ambulance to a walk-in. Transportation is a big issue to them. They don't have a PCP that they can call. Doctors' office schedules don't have room for 'sick calls' and patients know they don't need the ED, but they're sick and can't get seen for several days. Scheduling access is a problem. (Broome)
- One reason is the health literacy that they don't understand - when to go when not to go - second reason is that they do not have a place to go no PCP, no after hours facilities, and when they call PCP's after hours/weekends they are told to go to the ED. (Broome)
- People come to the ED to obtain a pregnancy test. People also come for anxiety medication or belief that they are having a heart attack (when it is actually anxiety). Diabetes management. COPD. People with COPD that acts up when they smoke. The ED is becoming more and more of a primary care setting. People bring their children when it might be more appropriate to use their physician or a walk-in. (Broome)
- They call their primary care providers and are told to go to the ED. Many reasons for that, like the way calls are handled; not triaged the way they should be. They're worried about legal ramifications. There's no real access to an alternate place to be accessed about the illness. A lot of places are staffed by pas and nps, who do not have the necessary skills to determine who should go to the ED. (Broome)
- They don't have the same co-pay when visiting the ED. (Broome)
- Sometimes the ED is more convenient because no appointment is necessary; it's more convenient. (Cayuga)
- They use the ED because it is the easiest and it doesn't cost them anything. Trouble breathing, stomach ache, fever are common conditions. (Cayuga)
- Pain, Headache or backache. Ultrasound. They will say they fell to get an ultrasound when pregnant. They want placement at assisted living or nursing homes. They will claim that they can not take care of themselves. (Chemung)
- Back Pain, Upper respiratory, Headaches, pain in general. (Chenango)
- Many of them are very reactive, instead of proactive. They wait until there is a crisis and do not plan ahead. They are not established with a PCP. (Chenango)
- Not linked to PCP's. Availability to PCP on off hours. Lack of 24 hour Urgent Care centers. Behavioral health issues. (Chenango)

Q52: For what reason(s) do the Medicaid and uninsured populations use the ED even though it is unnecessary?

n38; Open-Ended

- There isn't access to immediate transportation. Even if they wanted to go to a walk-in, there would be no one to get them there. They often don't have the cash or a credit card to pay for a taxi. (Chenango)
- Because they know they will be assessed, and they will be stabilized. Quicker service. Larger open hours. (Cortland)
- Convenience (because it is open 24/7). If they have a primary and the doctor can't see them until the next day, they go to the ED. Lack of education (importance of having a primary care provider that understands the patient's specific needs and issues, about insurance and Medicaid, about what is an emergency and what can wait). Habit (patient is accustomed to visiting ER without appointment and having needs met right then). Family members will often make ED trips together and have their varying problems treated. Often medicine is immediately available at the ER, whereas a primary would need a prescription and send the patient to the pharmacy. (Cortland)
- Most likely because the ED is there. (Cortland)
- Part of me wonders if it is too hard to get an appointment, and a convenient appointment at that. A lot of people are at the ED at night because it's when they're not working. Cough, cold, flu, things that might be better served by urgent care. (Cortland)
- They may not have a PCP. They may have burned their bridges going from one practice to the next, due to not listening to the doctor and not following through their diagnoses. We ask patients when they leave one practice to come to ours, the reason why they are leaving that practice, non payment, or not following doctors orders. (Cortland)
- Because they see no other options. (Delaware)
- Convenience. Poor time management; they go to the ED because they didn't take time to see the doctor during office hours. (Delaware)
- Immediacy of service. Attitude and demeanor of personnel of the walk in clinics. The time the walk in clinics are available. Colds. They go to the ED because of the wait time and the distance of the walk in clinics. (Delaware)
- It is out of complete and total convenience. (Delaware)
- Lack of urgent care and timely urgent care locations. (Delaware)
- They use it as their PCP. (Delaware)
- If they don't have a physician, they go to the ED. Primary care will not accept them so they go to the ED. Pay first PCP's they will go to the ED. (Schuyler)
- It would be good to see whether a facility has a clinic; it would that reduce the ED use. (Schuyler)
- Their fear keeps them reactive verses proactive - they wait until something is very bad then seek help. (Schuyler)

Q52: For what reason(s) do the Medicaid and uninsured populations use the ED even though it is unnecessary?

n38; Open-Ended

- They're not aware of services that have reduced fees so they wait and the problem becomes worse and ED visits become necessary. (Schuyler)
- Access to service. Access to providers outside of a ED setting. (Steuben)
- They might be unsure of where else to go. The Urgent Care units don't have the same hours. Conditions related to injury, diabetes. Respiratory. (Steuben)
- Easy Access- Lack of follow-up care- Health care is not a priority until it is a serious condition. (Tioga)
- Most don't have primary care physicians or a designated center or an area to go to. (Tioga)
- Because they cannot see a primary care provider or the provider is not equipped to handle their complex issues. (Tompkins)
- Don't understand there are other resources NYS only allows to transport directly to hospital--not to clinic or physician Mental health, sore throat Congestive heart failure, diabetes--could be assessed in the home instead. (Tompkins)
- Lack of understanding of the system and not trusting the system. A piece of not being able to access medical care often, they go to the ED with mental health related issues. (Tompkins)
- No incentive to follow "the correct steps". No penalty for abusing the system. (Tompkins)

Q53: What can done to reduce inappropriate ED utilization among the Medicaid and uninsured populations?

n38; Open-Ended

- Change reimbursement for transportation so they can choose to go to a walk-in when appropriate. Promote PCPs to accept them for continuing care so they have a doctor to go to regularly. (Broome)
- Education, preventive healthcare with PCP and mental health providers, alternatives for PCP transportation and this population needs to be held accountable for using the ED instead of going to a PCP. (Broome)
- Hot line to educate patients on what is life-threatening/ a triage hot-line/ A walk-in Clinic that is readily accessible 24 hours a day. (Broome)
- I try to always make sure we provide linkage to a primary care provider. They always get follow-up within a few days. We can set them up with a primary care provider. We also refer them to Catholic Charities' Medicaid Health Home where they can have case management services for their chronic conditions that make sure they use primary care options. (Broome)
- It starts by having PCP's facilities available strictly for uninsured/Medicaid populations, funding would be needed by a third party like businesses/government - DO NOT TELL them to go to the ED when calling to the doctor's office - the ED will not change, they will always be open and will always see a sick patient - if someone cannot breathe that comes to the ED they will be seen/treated and probably admitted to the hospital - if there was someone who knows the patient (PCP) and the ED doctors can reach out to, maybe this could reduce unnecessary visits. (Broome)
- Penalties for abusing the ED. (Broome)
- Relates to all of the above. A better method of handling calls and access to places that are staffed by people who can assess the patient appropriately. Have better communication among all providers that see patients, including medicines and how to take those medicines. (Broome)
- They need to be educated and informed. Then we needs to enforce these new rules. (Broome)
- Make them fiscally responsible with a $100 penalty or copay or something like that. (Cayuga)
- Not sure. (Cayuga)
- Fast track different than Emergency. More hospitals should have it. It is more of an Urgent Care than Emergency. (Chemung)
- Case management and Urgent care. Convenient care availability. (Chemung)
- If they mandated that they obtain a PCP. (Chenango)
- Nesting things like Behavioral Health, Palliative Care. (Chenango)
- Transportation. Can get doctor's appointments once they find someone who takes Medicaid, but getting there is the issue. (Chenango)

Q53: What can done to reduce inappropriate ED utilization among the Medicaid and uninsured populations?

n38; Open-Ended

- Education during Medicaid application process (about the advantages of having a primary care provider and how to maintain a relationship with their primary). Having a mechanism within primary care offices that explains Medicaid and how the primary fits in with that service. Primaries should also make patients aware of other agencies that might be helpful to them. (Cortland)
- Expanded prompt care hours/ Access to providers. (Cortland)
- Getting them out of bed earlier in the day, so that they can seek healthcare. (Cortland)
- I think that making these patients liable for whatever it is they have to pay for and should they not follow what they have been told to do for their own health - they might have to be turned away by the ED. (Cortland)
- I wonder about physicians talking with their clients about what to do it something crops up during non-regular hours. Letting people know about urgent care. Maybe evening hours for local physicians. (Cortland)
- Better medical screening on the behavioral health side and better behavioral health screening on the medical side. There needs to be better communication between the two. (Delaware)
- Charge a high co-pay for ED visits, if the diagnosis does not warrant the ED visit. Example: Heart attack, waive the co-pay; non-emergency visits, charge a high co-pay. (Delaware)
- I would love to see urgent care; we have no urgent care in this county. (Delaware)
- Implement some type of co-pay system; it might make the Medicaid population think about using the ED inappropriately. (Delaware)
- Provide walk in services that are actually available. Management of front end medical staff in customer service. How to be nice. Professional oversight of the front end of the walk in clinics. (Delaware)
- You should have a pre-screen triage, and if not acute care need refer to PCP setting and turn away. (Delaware)
- Extended hours of primary care medical services. Call-in information to determine if an ED visit is necessary, with a nurse on call who could give advice. (Schuyler)
- Free Clinics. (Schuyler)
- More education and information provided to the population about their options and getting them set up with a primary doctor from the start. (Schuyler)
- People who receive Medicaid must be told that it is mandatory to receive 2 well care visits per year in order to keep the benefit, if not, they are in jeopardy of loosing services. (Schuyler)
- Education of what is available in the community. Providers tell them where they can go when they can't see their PCP. (Steuben)
- Incentives for providers to care for these populations, straighten out restrictions and fees for providers. (Steuben)

Q53: What can done to reduce inappropriate ED utilization among the Medicaid and uninsured populations?

n38; Open-Ended

- If they could be assigned specific sites for services based on their locations. (Tioga)
- Unable to say- more of a case by case issue. (Tioga)
- community-level services outside the hospital setting, better education about resources and how to utilize them correctly Community Para medicine programs. (Tompkins)
- I think providing them a service in one setting that would be helpful if they could have like a one stop shop medical facility. (Tompkins)
- Make sure there are enough providers and support with case management and behavioral health. (Tompkins)
- Some costs implemented for patients to go to the ED for every ache and pain. (Tompkins)

Q54: What would help the Medicaid population better understand when and when not to use the ED?

n38; Open-Ended

- Access to case management and PCP to help them manage their health needs. (Broome)
- Better advice. (Broome)
- Better education by providers when they first see a PCP. (Broome)
- Community out-reach or social center where someone can help educate people with what is an appropriate ED visit. (Broome)
- Education regarding their condition and how/where/when/how it can be appropriate managed. There is a certain abuse that is occurring--there should be some kind of consequence for such misuse. There should be a reward for utilizing services appropriately. (Broome)
- Hot line to speak with nurse. Local promotion/ social media/ on what is considered an emergency. (Broome)
- Literacy - educate patients on their conditions better - for example if someone is having chest pain - have them take a nitro and the pain will go away - I don't believe that these patients are getting information from their doctors or that they understand that a chest pain doesn't always mean a stroke or heart attack. (Broome)
- Public education; ads indicating what is urgent so they understand options. (Broome)
- An education--programs to educate Medicaid population on proper ED use. (Cayuga)
- Education; flyers or their physician can offer information so patients are more aware of what is an emergency situation and must be taken to the ED and what can be handled through their physician's office. (Cayuga)
- They know. They need to understand that their illness is not going to be accepted if it is not life threatening. (Chemung)
- Educating them. (Chenango)
- Education and a knowledge of other available services. (Chenango)
- Education, if it cost them something. If there was going to be a bill associated with the ED visit. A copay. (Chenango)
- I think they understand, but they don't feel like they have options. They can't get to the doctor until they feel worse. Once they get worse, they panic and call 911, which takes them to the ER. There are no 24-hour walk-ins nearby--maybe we need one of them. (Chenango)
- Again, someone talking to them about it. If you have these certain symptoms, go to the hospital. If you have other certain symptoms, here's how to deal with them. (Cortland)
- Educate them on proper usage. (Cortland)
- Education from primary care provider--explain when to use ED, when to use primary, what other support systems may be available. (Cortland)
- Penalty for abusing the system. (Cortland)

Q54: What would help the Medicaid population better understand when and when not to use the ED?

n38; Open-Ended

- Education and before giving them any of their benefits, make sure that they understand the proper use of the ED and maybe have a reduction of their benefits for every time they inappropriately use the ED. (Cortland)
- Using a company like Fidelis who works closely with both providers and patients to make sure they complete preventative care, tell them what the valid illness is to go to the ED, mandatory training about what is included in the coverage, whenever you give something for free there normally isn't any accountability. (Cortland)
- Education. (Delaware)
- Education and identification of other resources to use instead. (Delaware)
- Education, possibly through some sort of case management to provide teaching. (Delaware)
- If there was some way to provide them where and when these clinics are open. (Delaware)
- It is so ingrained in folks to just use the ED. I am not sure what would make them stop using the ED. (Delaware)
- There needs to be another level of medical care between PCPs and ED. (Delaware)
- Education about Free Clinics. (Schuyler)
- Education that can be given by the doctor offices when they are in for an appointment - literature can be handed out anywhere they receive visits. (Schuyler)
- Education; not just telling, but a pamphlet giving examples for reference. If all clinics and providers, as well as the ED were on the same page and not encourage ED visits. Make more urgent care facilities available at convenient hours. ER is available 24/7. (Schuyler)
- Just providing more information on what qualifies as an emergency. Most don't know where to go or if their primary doctor has emergency services and availability after hours. (Schuyler)
- Education at a young age, including in school. (Steuben)
- Specific examples and guidelines. (Steuben)
- Only through time and education will things improve. There needs to be a retraining on the thought process. (Tioga)
- Public announcements on TV or radio, geared to the types of TV or Radio those populations are watching. (Tioga)
- Clearly defining nontraditional services People to work with others on understanding use of resources--community education (Tompkins)
- Clinicians taking the time to provide education, explaining their health conditions and coming up with a treatment plan collaboratively. (Tompkins)
- Education on what is life-threatening/ Change the culture of using ED for everything. (Tompkins)
- Information accessible to them 24/7; nurse advice line would be amazing. (Tompkins)

Q55: What can healthcare providers do to help the Medicaid and uninsured populations better understand when to appropriately use the ED?

n38; Open-Ended

- Clear and specific instructions about what to watch for and what signs indicate improvement or problems. High temps, how high, for how long? Instructions need to be specific. (Broome)
- Education. Linkage to appropriate providers for follow-up. If someone doesn't have a primary, we should provide them with one or show them how to get access to one. (Broome)
- Encourage that the Medicaid population talk to nurses to determine whether or not to go to a PCP or the ER. (Broome)
- Letting patients know there is an on-call person available to discuss symptoms/ pamphlets/ posters in major public places listing reasons to go to the ED. (Broome)
- Patient care instructions about their conditions - takes time from the doctor but this is a step that needs to be taken - plan a longer visit with a patient not just 15 minutes - see less patients throughout the day - don't cram them into 15 minute increments so that a longer time can be taken with the patient. (Broome)
- Providers are already trying their best. (Broome)
- Providers being consistent and truthful. They need to trust us. (Broome)
- Talk to them! Identify who they are and have a plan (case management) for how to help them. (Broome)
- Direct communication with case workers to facilitate education about vitals. (Cayuga)
- Education; flyers or their physician can offer information so patients are more aware of what is an emergency situation. Follow up after the ED to explain why the ED visit was not necessary. Often, they don't offer this information, so Medicaid recipients are aware of alternatives. (Cayuga)
- It has to be a system wide rule with the structure that is the same every time. (Chemung)
- By educating them. (Chenango)
- Clarify for the patient what would be a life-threatening condition. We do this when seeing someone in home care. Sometimes people don't know what an emergency situation is, but I think a lot of my Medicaid patients have some social issues--they panic easily, don't have coping skills. They don't recognize pain on a gradual scale. And, honestly, where else are they going to get care? Most doctors don't take the uninsured, so where else are they to go? I think a lot of patients have some mental health issues--depression, psychiatric conditions, but I don't think better mental health services would address this, as I believe a lot of patients lack the self-awareness and ability to reflect on their own behaviors to make changes to their chaotic lifestyles. (Chenango)
- Create alternate service sites and educate the population about those sites. (Chenango)

Q55: What can healthcare providers do to help the Medicaid and uninsured populations better understand when to appropriately use the ED?

n38; Open-Ended

- We can't. We try repeatedly and it doesn't matter. They don't listen. (Chenango)
- All of our patients are told what signs to look out for and when to go the ED. (Cortland)
- Educating their own patients about when to use the ED. Also, some patients don't even have a PCP. (Cortland)
- Education on what is and is not a life threatening situation. (Cortland)
- Make a point to discuss this whenever the patient is seen. Make the conversation a routine part of patient visits (like how to quit smoking). (Cortland)
- Talk to clients. Be open an honest. Troubleshoot a bit. (Cortland)
- At point of contact, complete some teaching. When a PCP sees the patient, take the time to explain that seeing the PCP first rather than the ED for a problem; educate/show them at the PCP Office as to what visit was good by not going to ED. (Delaware)
- Doctors do not have or take the time to explain. They wouldn't listen; a consequence would educate them quickly. (Delaware)
- Educate them. (Delaware)
- Have that information available. (Delaware)
- To follow up on talking with them subsequent to an ED visit to explain to them on how they could have done that differently. (Delaware)
- Try to educate them on what constitutes an emergency and when to use the ED. Also, explain how continuity of care if vital, therefore it is important to see their PCP consistently. (Delaware)
- Again, educating the patients, make it a conversation at time of visits. They talk about getting flu shots and other things, they should discuss proper usage of the ED. (Schuyler)
- Education; put resources in the community that are accessible. Educate providers. Make sure outreach programs have option information available. (Schuyler)
- Make sure the providers are educating patients while they're in the office. Give them more information about their health condition so they know when it's appropriate to go to the ER and when it's not. (Schuyler)
- More education at their visits to the provider. (Schuyler)
- Educate the patient using specific examples. Individualize. (Steuben)
- Providers can work with community out-reach organizations to highlight when and when not to use the ED. Mass media promotion/ TV/ Radio. (Steuben)
- A little bit more of empathetic or sympathetic front end staff; referring them back their PCPs or having a triage system set up and explaining to them that what a true ED visit is. (Tioga)

Q55: What can healthcare providers do to help the Medicaid and uninsured populations better understand when to appropriately use the ED?

n38; Open-Ended

- Making the information of when and when not to more appealing. An Incentive to learn/have that info. (Tioga)
- Explain what a life-threatening condition is. (Tompkins)
- Make themselves more accessible to the patient; contact the patient so they see the provider before the ED. (Tompkins)
- Provide education of when it is appropriate and give them options. (Tompkins)
- Providers must understand traditional and nontraditional services (like acupuncture, etc.) If there are clearly successful programs that help reduce ER bed uses, consider reimbursement (acupuncture is not covered by Medicaid). (Tompkins)

Q56: What will have the largest impact on reducing the number of non-emergent ED visits by Medicaid and uninsured patients?

n38; Open-Ended

- Access to PCP. (Broome)
- Access to the services that they need (more hours, easy access). (Broome)
- Education on what is life-threatening- Accessibility to other options after hours. (Broome)
- Maybe transportation to follow-up visits. (Broome)
- Private access to physicians. (Broome)
- Telling physician groups to educate their patients - when to go to ED and when not to - more time more detail to the patient by the physician. (Broome)
- The institution of penalties for abusing the ED. (Broome)
- We have to figure this out. (Broome)
- Education will reduce some of it, but some people will still use ED. (Cayuga)
- Make patients pay for ED use. (Cayuga)
- Having a payment plan with Urgent Care and having a rule that non emergency visits will be sent to Urgent Care and not seen in ED. (Chemung)
- Better access to PCPs. (Chenango)
- Case management and the availability of convenient care, and a co-pay for ER visit. (Chenango)
- Making sure they are receiving primary care services. (Chenango)
- Transportation for the people who have Medicaid. For the uninsured, there probably needs to be more free clinics and help for them to get on Medicaid if they qualify. (Chenango)
- Access to providers - Number of physical providers and more who accept Medicaid/uninsured. (Cortland)
- An increased number of primary care providers that participate in Medicaid. (Cortland)
- If they have a PCP that will accept Medicaid, that would help. (Cortland)
- Letting clients know what the alternatives are and having a plan. (Cortland)
- Practical teaching, if you have a problem call your PCP early in the day instead of waiting until the end of the day, try to think ahead, not sure about everyone's transportation needs. (Cortland)
- Accessibility. Mental Health services and screenings that are legitimate. Behavioral health specialist available on site. (Delaware)
- Development of other resources that they can use and meet their needs. (Delaware)
- Go back to better screening with behavioral health and medical screening and also to have some other place for patients to go like an urgent care facility. (Delaware)

Q56: What will have the largest impact on reducing the number of non-emergent ED visits by Medicaid and uninsured patients?

n38; Open-Ended

- Increase the ED co-pay for non emergency visits. (Delaware)
- Scenario: if I ran to the ED for every sniffle and was turned away a few times, I would understand not to go to the ED for this problem. (Delaware)
- The Medicaid patients would have some kind of repercussion. (Delaware)
- Clinic accessibility, better after hours care available, and again educating the patient. (Schuyler)
- Education, so people with ailments know what their options are. Often it's hard to communicate with case workers or caregivers. We need more availability of people who can guide the population with whatever questions they have. (Schuyler)
- Get them set up with a primary care doctor from the start. (Schuyler)
- More Free Clinics. (Schuyler)
- Educating the community. (Steuben)
- Having more providers who are willing to work with Medicaid and uninsured patients. (Steuben)
- More availability of Urgent Care or walk-ins. (Tioga)
- Redirection of services. (Tioga)
- Access to other resources that meet their needs. (Tompkins)
- Patient-Centered-Home services. People to check in on patients to help with basic understanding of providers instructions, help follow a healthy life style, check they are taking their medications properly. (Tompkins)
- The one stop shop would probably help a lot. (Tompkins)
- There's such a high percentage of behavioral issues that having behavioral health support for primary caregivers will have a huge impact. (Tompkins)

Q57: What can be done by providers to ensure Medicaid and uninsured patients are not re-admitted to the hospital within a 30-day timeframe?

n38; Open-Ended

- Accessibility to a PCP post-hospitalization and follow-up visits by PCPs. (Broome)
- Better discharge planning; quick follow up with primary care provider and communication with primary care before the visit, so the care is agreed on. (Broome)
- Hospitals already have a good plan for this. The non-compliance issue with what makes patients come back faster. (Broome)
- I think sometimes we're guilty of prematurely discharging people without the proper services. Sometimes it happens because of insurance guidelines. Perhaps some of these patients need to stay longer, but the population needs to be responsible for managing their conditions and health needs. (Broome)
- No easy answer - sometimes people are sick and they just get sicker - sometimes the physicians will tell them to go to the hospital again - maybe they need to have a home health agency check on them at home - someone needs to go into the home and find out what will be needed by the patient to stay on the healing pathway, without depending on a friend or family member, a medical professional needs to see the whole picture. (Broome)
- They have to been seen by their PCP after they leave, and then the care manager needs to follow up after that. (Broome)
- Very clear parameters and discharge instructions. Access for feedback to physicians; some touch-point with their PCP without going to the ER. Possibly phone contact for questions or concerns to avoid re-admittance. (Broome)
- Work with case management to follow- up/ provide prescriptions with extended date. (Broome)
- Along the chain of command, some people suffer when a person is readmitted. Personal physicians do not suffer when patients are sent to the ED, so they often refer them there when they cannot take care of the patient. Similar penalties for patients and providers should be in place. (Cayuga)
- Just check up on the patient within a week or two to see that the patient is progressing. (Cayuga)
- What do we do with the people that are admitted. Who are we letting into the ED. (Chemung)
- Better communication with auxiliary healthcare providers, such as myself. (Chenango)
- Case management. Transitional Care calls. (Chenango)
- Providing preventive care. Linking up patients to Palliative care and hospice. (Chenango)
- Refer them to home care so they have some kind of follow-up. A lot of times the doctor doesn't have time to call them up and see how they're doing. Home care can do follow-ups and educate on how to deal with conditions.. Also give them safety equipment if they need it. (Chenango)
- Develop relationships with other agencies in the community (like waiver agencies, home care agencies) as an extension of themselves to educate patients on how to deal with chronic conditions and how to distinguish them from acute conditions. (Cortland)

Q57: What can be done by providers to ensure Medicaid and uninsured patients are not re-admitted to the hospital within a 30-day timeframe?

n38; Open-Ended

- I think it goes back to compliance again, so the patients must be told when to call PCP and let them know the issue should not mean another trip to the ED. (Cortland)
- Keeping them until they are well. (Cortland)
- Reinforce teachings of hospital discharge and follow-up with compliance. Starting at young ages with education on healthy behavior. (Cortland)
- See them right away. Sometimes they leave with that paper that tells them to visit their physician/therapist, but it's our job to make sure they come in and follow up. Part of the discharge plan should be that patients leave with an appointment already set. (Cortland)
- Allow doctors to keep patients in the hospital. Stop making medicine a business. (Insurance companies dictate length of stays allowed under many policies.) (Delaware)
- Appropriate discharge plans, following through with the discharge plans and connecting with community resources. (Delaware)
- Better record keeping is needed. ED Specialist Guidelines need to be very clear on what would re-admit a patient. (Delaware)
- Follow up contacts with patients. (Delaware)
- Having perhaps some type of home monitoring, if the provider can provide that and have some follow up with the patient. (Delaware)
- Provide actual follow up appointments. (Delaware)
- Easy as making a phone call to the patient to see how everything is going. Some sort of structured survey, touch on mental health, social issues, return to work issues if any; being responsive to the phone calls should be another requirement by the patient in order to continue to receive benefits. (Schuyler)
- Education and discharge instructions; elaborate on those instructions. Give more choices and see that there is an understanding of options available. (Schuyler)
- See them in their office. (Schuyler)
- Try to stress the importance of the directions they get from the medical staff. Explain that if they have questions they can contact the doctor first. Establish a team of appropriate communication. (Schuyler)
- Better communication regarding discharge and follow up care needs. (Steuben)
- Connect patients with providers for follow-up care after discharge. (Steuben)
- Better discharge management. (Tioga)
- More effective follow-ups. Have some type of protocol in place when someone is discharged; have someone contacting that person via home visits or phone calls validating their needs. (Tioga)

Q57: What can be done by providers to ensure Medicaid and uninsured patients are not re-admitted to the hospital within a 30-day timeframe?

n38; Open-Ended

- Being informed that they've been hospitalized. Doing proactive follow-up and being reimbursed. (Tompkins)
- Monitor patients, work with them, ensure they keep appts, have transportation, understand medications. Coaching patients at community level. (Tompkins)
- Prompt follow-up. (Tompkins)
- Referrals for common diagnosis that trend re-admittance to services that can aide in education and life style choices. (Tompkins)

Q58: What can be done by community-based organizations and community outreach to ensure Medicaid and uninsured patients are not re-admitted back to the hospital within a 30-day timeframe?

n38; Open-Ended

- Community Outreach can see if there are any social services they could provide to not have the patient feel that there only answer is not going back to the ED. (Broome)
- Education and support for the importance of follow-up care, medications, nutrition, general health and wellness. (Broome)
- Education and their ability to help them within the community. Help the individual find the root causes for their healthcare issues and then help them overcome these issues. (Broome)
- Expansion of services such as outpatient services (like therapies, rehab, and dietitians). (Broome)
- Home care services and evaluations are helpful; close monitoring. Critical dialog and follow-up by a nurse to review and confirm that instructions are being followed. (Broome)
- I think in making sure that they have transportation--but we can't always make sure that they utilize it. If they have a case manager, it can be ensured that appropriate follow-up is given to the patient. (Broome)
- Use an organization to arrange care for the patient by going to the home and make the assessment - I think these organizations are key in keeping the patient out of the hospital. (Broome)
- Who are these people? There needs to be better communication on goals of care; what are we doing and why. (Broome)
- Having closer contact with the patients. A lot of the time patients visit the ER when they are unsure of what is happening or how to deal with it. Community services can coordinate this--keep in contact with patients, get referrals (Cayuga)
- I don't know how these organizations could reach out to Medicaid patients due to HIPAA regulations; release of personal information is limited. (Cayuga)
- Delivery of prescriptions. (Chemung)
- Communication with Case Management. (Chenango)
- Compliance packaging of their prescriptions. Doing a MTM or medical reconciliation upon their discharge. (Chenango)
- If they can find a system where people can get swifter access to transportation. That would probably help. (Chenango)
- Work with providers so patient needs can be met across the continuum.. (Chenango)
- Developing a system where physicians don't have to sign orders for each individual agency (home care, waiver program). This becomes burdensome because primaries have to navigate all the agencies used by the patient, or information is duplicated. (Cortland)
- Encourage providers to make a plan or some discussion about discharge planning. Community organizations could also remind patients. (Cortland)
- Guess I would have to know who is giving access to the patients and who is telling them, do we not have enough PCP's, do the patients know they need to start with their PCP's, stay with one doctor and not keep moving around, I don't think that it's just Medicaid patients, it seems to be any type of state insurances that people are using. (Cortland)

Q58: What can be done by community-based organizations and community outreach to ensure Medicaid and uninsured patients are not re-admitted back to the hospital within a 30-day timeframe?

n38; Open-Ended

- Follow-up by home care nursing. (Cortland)
- More frequent home-visits/ More patient education (Cortland)
- Advocate for transportation services. More emergency mental health services, alcohol, and drug abuse services. (Delaware)
- Being advocates and also assisting to provide education. (Delaware)
- Community outreach can educate patients in small groups, and support home health. Follow-up with family doctors within so many days of the hospital visit. (Delaware)
- I am not sure what those resources are in this county, besides providers and the fact that there are not that many community resources in this area. (Delaware)
- The outreach program has to support the patient education of when and when not to use the ED. (Delaware)
- To educate the patient on if they have questions about how to care for themselves after discharge. (Delaware)
- It's totally different for non-insured versus Medicaid. For non-insured, they can't afford to start or refill medication. Medicaid should have access to what they need for free. Maybe provide more education on life skills to increase compliance, responsibility, nutrition, etc. (Schuyler)
- Maybe help patients understand what signs to look out for to avoid re-admittance. Provide lists of urgent care centers. Maybe they waited too long because they didn't know where the centers were located. (Schuyler)
- Set up visits in the clinics. (Schuyler)
- They can help in having free clinics, like mental health clinics, Office of the Aging can hold clinics, DSS can hold clinics, in order to educate this population. (Schuyler)
- Providing resources. Transportation, education, support groups. (Steuben)
- Unsure (Steuben)
- Community Organizations need to be made aware when patients are discharged. More support socially and with transportation. Education and help maintaining basic health. (Tioga)
- Continue to follow-up and contacts. (Tioga)
- Being alerted that the individual was hospitalized, but there may be HIPAA issues. Have training to identify individuals who may not be thriving after discharge. Encourage them to contact their PCP. (Tompkins)
- Find a way to reach the patients that have been released recently and track their follow-up care. (Tompkins)
- Look at root cause for re-admittance Consider counseling sessions (Tompkins)
- Reinforcing the healthy choices/ providers instructions/ follow-up care/ support (Tompkins)

Q59: How well do you feel the Medicaid and uninsured populations manage their chronic conditions compared to the general population?
Single Response

Category	Total	County									
		Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Medicaid and uninsured manage them better	-	-	-	-	-	-	-	-	-	-	-
Medicaid and uninsured manage them the same	16%	25%	-	-	50%	20%	17%	-	-	-	-
Medicaid and uninsured manage them worse	84%	75%	100%	100%	50%	80%	83%	100%	100%	100%	100%

Q60: Why do you feel that way?

n38; Open-Ended

- For 2 reasons, the first is socio-economic - they don't have a lot of money to buy prescriptions and are more worried about putting food on the table and keeping a roof over their head. Second - they live a harder life then most. (Broome)
- I think there are socio-economic barriers (such as proper nutrition and transportation). Also, there are barriers that stems from them understanding or learning of their condition. Also mental health needs and factors. (Broome)
- Lack of follow-up care, and no PCP. (Broome)
- Looking at the demographics of that group they are have a lack of education, poor socio-economic status, and they don't understand what doctors are telling them. (Broome)
- The issues dealing with a chronic condition apply to all patients. (Broome)
- There are barriers for them, such as prescriptions that are denied for these populations on a regular basis. Also, they have a lack of resources to help them take better care of their health. (Broome)
- They have fewer resources, cut corners, and often don't follow the best care instruction due to lack of money. (Broome)
- Unsure (Broome)
- A lot of factors, including lack of education, lack of resources/money, and lack of motivation. They don't suffer as much by being in poor health because they don't have to pay for their service, or a job to worry about. (Cayuga)
- They don't have the access to physicians due to the lack of physicians. They don't get into their doctors often enough to monitor their conditions. (Cayuga)
- Folks know that they can go back to the ED on Medicaid. Uninsured will not because they will get a bill. (Chemung)
- I think they don’t understand how important medications are; they’re just not comprehending to the same degree as the general public. (Chenango)
- It evens out. I have patients that come routinely. They are well managed because they do what I tell them. Then, I have others who don't do what they are told no matter what. (Chenango)
- Some people are really good at managing their chronic illness, some people aren't. Despite "everyday chaos" of Medicaid patients, those who strive to manage their condition will do so regardless. There are others that, despite incentives and resources, will not manage their condition. (Chenango)
- There is not a strong connection to primary care. Lack of alternate services in off hours. Not hooked up to primary care. (Chenango)
- Because they are not financially able to do what they need to do. (Cortland)

Q60: Why do you feel that way?

n38; Open-Ended

- It's not everybody who is under this umbrella. If a person has Medicaid they haven't aspired to take care of themselves and someone else is taking care them - why do we expect them to take care of themselves - a normal person has a job goes to that job maybe gets an education, normal responsible living is not part of this population. This population were not taught by their families and the practices go on for generations. They are not taught about being responsible and what all that entails. (Cortland)
- Lack of education on basic health care. Lack of education on their condition. Lack of reasoning in personal choices (Cortland)
- Someone on Medicaid is just as likely to not follow through things as the general population. People with Medicaid can afford to follow through. Uninsured have higher co pays, out-of-pocket deductibles, etc., so they manage them worse. (Cortland)
- Sporadically attend doctor's appointments, less often than patients with commercial insurance. This makes it difficult for physicians to track patient's condition. Medicaid and uninsured also tend to exhibit more problems related to alcohol abuse, smoking, and substance abuse. The also have difficulty in obtaining medication. (Cortland)
- Due to limitations, they are unable to provide themselves with healthy opportunities and choices. (Delaware)
- Education and lack of financial consequences for abuses. (Delaware)
- I think it's a complicated question. The issues are around poverty and lack of understanding of resources and as well as accessibility issues. (Delaware)
- I think that people with private insurance or no insurance are just as non compliant as the Medicaid population. I just don't a see a huge difference. (Delaware)
- It is dependent on the patient (the person themselves) and how other conditions are managed. Some patients manage all conditions well and others do not. (Delaware)
- Lack of resources and knowledge. Special diet. Food stamps doesn't allow for special foods. (Delaware)
- Because they run out of medicine and can't afford to buy it. (Schuyler)
- Lack of education about their condition, they live for the day in many ways, so chronic might mean something different to this population. They may have problems down the road, but they don't make plans to take care of them. I can't place blame them, because if you must worry about the heat bill or the diabetes down the road, you are going to worry about the heat bill today and then think about what might happen down the road. (Schuyler)
- Lack of education. (Schuyler)
- They have other issues with time management, life skills, and responsibilities. Chronic disease also falls into the area of difficulty. (Schuyler)

Q60: Why do you feel that way?

n38; Open-Ended

- Lack of education, and lack of providers to properly care for the condition. (Steuben)
- They tend to put off care or cannot afford medicines. (Steuben)
- Lack of education. Lack of finances to care for themselves. Bad lifestyle choices. (Tioga)
- Poor diet/nutrition and entitlement. They know that the ED services are going to be provided at no cost to them and they will just use them with no regards. (Tioga)
- I feel that a lot of factors are not taken into account when offering care to the patients. I feel that providers are less inclined to spend more time and offer more options to people that are uninsured or on Medicaid. (Tompkins)
- Lack an understanding of options and resources and probably don't have the means to live their lives effectively (lack of understanding of proper diet, cultural diet options). (Tompkins)
- Lack of education, and lower level of function. (Tompkins)
- They don't have access to the care they need. They're more likely to be fired by their PCP when they become difficult or non-compliant, and they do not address the underlying issues. (Tompkins)

Q61: Are there unique challenges that the Medicaid and uninsured populations face with regard to managing chronic conditions? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	87%	75%	100%	-	75%	100%	83%	100%	100%	100%	100%
No	13%	25%	-	100%	25%	-	7%	-	-	-	-

Q62: What are those challenges?

n33; Open-Ended

- Being able to keep up with the stuff you need for the condition - like prescriptions, Medicaid has restricted what can and what will not be covered by Medicaid. It's tough for Medicaid patients to get some specialized medicine for their chronic conditions. (Broome)
- Lack of education and understanding of how to manage health. (Broome)
- Lack of family support, low education level, lack of transportation. (Broome)
- Lack of resources. For example, they can't afford the diet they need to follow, or they can't afford their co-pay. (Broome)
- Many people assign a stigma to this population in that they have different lifestyles and desires that are not mainstream. This may affect their self-esteem. (Broome)
- They have worse psycho-social support. They have less financial ability to have a wider variety of care choices. (Broome)
- Access to physicians. (Cayuga)
- Lack of education and lack of money. (Cayuga)
- Access to behavioral health services, and support services like nutritional and poverty. And access transportation. (Chenango)
- If the pharmacist could be approved to be compensated for MTM. (Chenango)
- More dependent on help from agencies, which can be a benefit or a problem. If they have to rely on an unreliable friend, relative, or spouse for this same kind of help. They might get a worse quality of service. (Chenango)
- Dealing with pharmacies, obtaining medications, finding transportation to get to specialist appointments. (Cortland)
- Financial and education challenges. They do not understand why they need to take care of themselves. (Cortland)
- Intelligence, and following up on care can be complicated. It's complicated for everybody, and the provider system can be enabling. (Cortland)
- Literacy, lack of understanding of their condition, complications with affording a healthy life style, and lack of understanding what a healthy lifestyle is. (Cortland)
- Transportation issues. Out-of-pocket costs for the uninsured. (Cortland)
- Basically investing in the discipline it takes to live in chaos verses the cure. (Delaware)
- Medicaid populations may or may not use their prescribed medicines and waste supplies; they don't take care seriously, so Medicaid dollars are wasted. The uninsured work for what they have. They don't waste and they use medicines and medical advice to the best of their ability. (Delaware)
- The bureaucracy they have to deal with. Specialty referral waits are outrageous. (Delaware)
- They do not know how to navigate the system, and there isn't much for them to navigate to. (Delaware)

Q62: What are those challenges?

n33; Open-Ended

- They may need to visit the PCPs more often, but transportation is a barrier and money is also an issue. (Delaware)
- Having access to the proper nutrition, not having the ability to pay for durable medical equipment, not having the money to pay co-pays. They are faced with many monetary issues everyday. (Schuyler)
- Less education and more understanding. Lack of online access, and inability to read well. (Schuyler)
- Money and lack of insurance. (Schuyler)
- Trying to prioritize correctly. Clearly there are financial issues, childcare issues, employment issues, and other demands. It is difficult managing priorities such as transportation, finances, time, etc. (Schuyler)
- Socio-economic. Co-pays. Non supportive home environment. Substandard living conditions. Transportation. The ability to seek out medical care. (Steuben)
- They can not afford, or do not know enough about how to live a healthy lifestyle to maintain their health. (Steuben)
- Lack of access to specialties needed to care for a chronic condition. (Tioga)
- Lack of education and information. (Tioga)
- Access to information and access to care. (Tompkins)
- Difficulties affording co-pays for medication, difficulty in even getting their medications, and the financial piece is pretty significant. (Tompkins)
- Economic issues, and cultural barriers. (Tompkins)
- They struggle financially and can not afford the lifestyle changes they need to manage their condition. (Tompkins)

Q63: What suggestions do you have for getting the Medicaid and uninsured populations to better manage their chronic conditions?

n38; Open-Ended

- An incentive to better manage their condition(s), and certain consequences for not managing condition(s). Some people have access to transportation and other resources, but choose not to use them for convenience reasons. (Broome)
- Case management, and more comprehensive case management. Ensure that these patients are using services and seeing their doctors. (Broome)
- Institute penalties for not following through with their care plans. (Broome)
- Make sure the education is adequate and emphasizes what they should do for themselves. (Broome)
- Medication reminders via text or phone call, having a case manager, social media used to educate patients, and using commercials to cover general info for certain chronic conditions. (Broome)
- Nurse or social worker assigned to them to make sure they have their medications and appointments setup, check in about every 2 to 3 weeks, review medications, and see if they can use a mail order pharmacy which might be cheaper. (Broome)
- They need to be part of their treatment planning, have ownership in it. Also, they need to have it explained better to them. (Broome)
- You're assuming that they don't manage them well - you need to ask them. (Broome)
- No thoughts. (Cayuga)
- Some kind of incentive (Cayuga)
- Set them up with a PCP and let them know that it is manageable by the PCP and not an ED condition. (Chemung)
- Case Management. (Chenango)
- Education on why it is important. (Chenango)
- It's just human nature. We educate people to the consequences of human behavior, but there's only so much you can do. Kind of a leading a horse to water scenario. (Chenango)
- Link to a PCP, education, and availability of services. (Chenango)
- Continue with education. (Cortland)
- Easier access to services. Making sure not so much is done on the computer. Computers shouldn't be the only option. A lot of appointments are only setup online, which isn't a barrier now, but could be in the future. (Cortland)
- Education. (Cortland)

Q63: What suggestions do you have for getting the Medicaid and uninsured populations to better manage their chronic conditions?

n38; Open-Ended

- Finding some type of system where all providers, pharmacies, mental health care providers, waiver providers, etc. share information and are aware of medications provided and appointments attended. That way issues may be identified early on (Ex. patient never picks up certain medication because of transportation issues) (Cortland)
- Through education. (Cortland)
- By educating them. (Delaware)
- Medicaid users need to be educated to not waste. Uninsured users need to allow doctors to adjust prices to what they can afford. (Delaware)
- Providers need to be able to hold patients accountable. With my program we have an agreement spelled out clearly (in writing) of what is expected of the patient in order to be able to participate in the program. (Delaware)
- Targeting case management for specialty chronic diagnosis. (Delaware)
- There really needs to be people that can reach this population and connect them to where they need to go instead of expecting them to come to us. (Delaware)
- Try to provide themselves with the healthiest lifestyle that they can, to follow up with the PCPs instructions, and be compliant with the PCPs therapy. (Delaware)
- Better way of getting medications to them. Lower costs. (Schuyler)
- Have better education regarding services available. There are patients who are aware but others don't know about the services. Outreach or insurance needs to better educate the population on what services they cover and is available. (Schuyler)
- Home healthcare should be available because there is not enough help. The patients get sent home, but they don't get enough follow-up care because the condition isn't severe enough for follow-up home care. (Schuyler)
- Physicians need to layout a simple and reasonable plan (and provide to the patient in writing) "How we are going to manage your care for the next 6 months (chronic conditions)?", and discuss with the patient in a normal conversation (not medical terminology). PCPs should ask patients upon their return appointment the reasons why or why not they were not able to complete the required healthcare plan. (Schuyler)

Q63: What suggestions do you have for getting the Medicaid and uninsured populations to better manage their chronic conditions?

n38; Open-Ended

- Education on what is considered a healthy lifestyle for that particular condition. (Steuben)
- Providing the education, resources they need, transportation, and regular routes in certain neighborhoods. (Steuben)
- More access to providers. (Tioga)
- More preventative measures. (Tioga)
- Community-level resources that work with patients in home or just outside of hospital setting. Community assessment to identify areas of improvement and come up with programs which may address these problems. (Tompkins)
- I feel that behavioral health could help with that. I take the time to explain to them how we need to manage their conditions, and then I work with them to find a solution that will work for them. (Tompkins)
- Put resources in community services that they are likely to access, like in food pantries. Information regarding managing chronic conditions. (Tompkins)
- Weight issues need to be addressed immediately, promote activity in day to day life, and increase access to mental health services. (Tompkins)

Q64: What can be done to promote preventative and healthy behaviors among the Medicaid and uninsured populations?

n38; Open-Ended

- Build more parks, provide better housing, and make it safer to live in poor neighborhoods. (Broome)
- Community education programs with targeted information based on the Medicaid and uninsured populations' current information. (Broome)
- Educate them on what will and will not help their health conditions. (Broome)
- Educating them. (Broome)
- I really don't know. I'm not sure how to get the general population to do things. Keep telling people to stop smoking, sexless drinking, and using drugs. No one really listens. Maybe attach a monetary incentive somehow. (Broome)
- Mobile units that provide general health clinic options and preventative services in areas of large Medicaid populations. Assistance in making appointments. (Broome)
- More social outlets and more community-based social avenues that help with getting people jobs, sober, and stable (support groups). (Broome)
- Some sort of incentive or reward for going to their primary and specialists. Consequences for not doing what they should. (Broome)
- Doctors should education them on healthy habits and lifestyles. (Cayuga)
- Restrictions on their food stamps (can only be used for certain kinds of foods, healthier foods). Screening or testing so they're not using drugs, drinking, and smoking cigarettes-with penalties if these are done. (Cayuga)
- Making sure that they have an established PCP who keeps them educated. (Chemung)
- Connect patient with healthy and motivating peer groups or support groups. I attempt to encourage patients to connect with the use of a computer, but some are uninterested. (Chenango)
- Educating them on the pro and cons. (Chenango)
- Education, transpiration, and healthy food. (Chenango)
- Rewards. They get a bonus or gift card for going to well visits. (Chenango)
- Better nutrition. Cortland is a food desert during the winter. Improve access to healthier food options. (Cortland)
- Education at a young age in schools. (Cortland)
- Education that should start in school, from elementary school on up. (Cortland)
- Having agencies and educational opportunities available to patients. Expand what Medicaid covers (such as exercise programs). (Cortland)
- With Fidelis and Total Care Products - they offer $50.00 to get a GYN checkup among other cash incentives. That is awesome! (Cortland)

Q64: What can be done to promote preventative and healthy behaviors among the Medicaid and uninsured populations?

n38; Open-Ended

- Assist them in actually getting access to nutritional foods and tangible things that are needed to be healthy. (Delaware)
- Community outreach programs. PCP and the health care systems should speak out in one voice saying that they want to partner with the Medicaid population by having them healthiest lifestyle by telling them no smoking, no drugs, and eating healthy. (Delaware)
- Education and follow up. (Delaware)
- Medicaid users should be educated to discontinue bad behavior. Uninsured users should do the best they with limited resources. (Delaware)
- My practice provides constant positive feedback of their accomplishments. Our staff makes a big deal when patients reach milestones. (Delaware)
- There has to be incentives because people are not going to change behaviors unless their is something in it for them. (Delaware)
- Clinics can have education for them. (Schuyler)
- I think this should really start within the school systems at an early age. They need to break the family cycle of poverty and being under educated. (Schuyler)
- More life skills coaching overall. Time management skills - they have trouble with health and diet which could get them out of their unhealthy situation. Nutrition counseling is critical - information given on what they should eat and how to make it affordable. (Schuyler)
- Provide education to impress on the importance of healthy behavior, and to encourage taking care of chronic illness early to avoid disastrous circumstances later in life because of lack of long term good habits. (Schuyler)
- Education for the healthcare providers and community based as well. Food Banks. Education from providers. (Steuben)
- Promoting good lifestyle choices via mass media. Reach out to teach patients good life skills to help them take care of themselves. (Steuben)
- Education them early starting in schools. Ex. have a carrot instead of cigarette. (Tioga)
- Instructional materials located in public places where those populations frequent. (Tioga)
- Behavioral health can help with that by talking with them about exercise, healthy eating, and self care. (Tompkins)
- Incentives to participate in healthy behaviors (Tompkins)
- Put resources in community services that they are likely to access such as food pantries. Information managing chronic conditions provide information where they'll be and be open to the information. (Tompkins)
- Starts at young age in school system. Educate about healthy diets, healthy living, and how to integrate that throughout school years (school vending machines used to sell junk food, now sell healthier options). Community educational resources should be available as well. (Tompkins)

Q65: Who needs to take the initiative in getting the Medicaid and uninsured populations to better manage their chronic conditions? Single Response											
Category	Total	County									
		Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Healthcare providers	3%	13%	-	-	-	-	-	-	-	-	-
Community Organization	-	-	-	-	-	-	-	-	-	-	-
Patient	13%	13%	-	100%	25%	-	17%	25%	-	-	-
All of the above	71%	74%	50%	-	50%	80%	66%	75%	100%	100%	75%
Other[1]	13%	-	50%	-	25%	20%	17%	-	-	-	25%

[1] Other responses include: Administrators of Medicaid and Medicare (1), The company/organization that issues the medicaid card to the patient - this is where the education of the patient starts (1), Those who run the Medicaid program. The others can play a role in assisting, but Medicaid is mainly culpable (1), The entire system needs to be re-worked to allow patients the amount of care and attention they need to prevent further chronic issues (1), Government needs to relax laws and regulations. We cannot help the uninsured by legally adjusting fees (1)

Q67: Are there any patient engagement techniques that may be effective with the Medicaid or uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Yes	71%	63%	-	-	75%	80%	83%	75%	100%	100%	75%
No	29%	37%	100%	100%	25%	20%	17%	25%	-	-	25%

Q68: (IF YES) What techniques are effective?

n27; Open-Ended

- Group setting and shared medical appointments. Education available by nurse or dietitian at appointment. All information available in the same place. (Broome)
- I always try to provide education and awareness. I also do follow-up phone calls to see how patients are doing. (Broome)
- Keep educating about their chronic condition and telling them what it will do to them if they don't treat it now. (Broome)
- Treat them with respect. Make it fun to follow healthy habits. (Broome)
- Treating them with dignity and respect. (Broome)
- Empower them to make decisions for themselves. (Chenango)
- Having motivation for the patient and having them feel that someone cares about their welfare. There are some support groups in Broome county, but transportation is an issue. Computer-based forums are good for rural residents where transportation is not readily available. (Chenango)
- Incentives. (Chenango)
- Find people that were in the system but are now out, they could encourage or inspire others. (Cortland)
- Group Support Systems and group education. (Cortland)
- To utilize the community organizations more. (Cortland)
- Written plan where every client that I see has a safety plan, which covers everything from "I'm having a bad day" to "I'm thinking of hurting myself." It provides solutions for situations that may arise outside of my office hours. (Cortland)
- Contingency management is kind of an incentive management program, like good rewards for following through on behaviors, like keeping appointments and practicing healthy living habits. (Delaware)
- Person centered techniques. (Delaware)
- Provide Food and child care. Not at DSS. (Delaware)
- Reinforcement and empowerment. (Delaware)
- Treat them like human beings. It doesn't matter what color the card is that they carry. Treat them like a person first. (Delaware)
- Do more local events, like for kids, strong kids safe kids event. Also, need information booths like at the Italian American Festival in the summer - it's a huge event and everyone goes. Also, need to have more information at these types of events. Get local hospital, and private practices involved. (Schuyler)
- Invite people to a group education activity; provide day care or transportation if needed. For a group education activity, make it easy for them to attend. (Schuyler)

Q68: (IF YES) What techniques are effective?

n27; Open-Ended

- Provide things to take with them from the visit, like hand-outs and emphasize the status of the condition and how to prepare, as well as the consequences of non-compliance. (Schuyler)
- Group Education (Steuben)
- Reach out to them on a level that they can understand. Having someone who understands their socio-economic situation. (Steuben)
- Some kind of incentive for improved behaviors. (Tioga)
- Tailoring the information to the individual. (Tioga)
- Incentives and penalties for services and abuse of services. Motivational Interviewing. (Tompkins)
- Motivational interviewing and collaborative approaches, as well as culturally sensitive approaches. (Tompkins)
- Working one-on-one with a particular patient to understand their motivations and thoughts. Engage patient in home - observe living situation, identify transportation needs. Better discharge planning (look more at individual, family support, transportation needs for patient). Spend more time in conversation with patient. (Tompkins)

Q69: How familiar are you with the 2-1-1 directory in your area? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	38	8	2	1	4	5	6	4	2	2	4
Very familiar	18%	13%	-	-	-	-	50%	25%	50%	-	25%
Somewhat familiar	39%	37%	50%	100%	75%	40%	-	25%	-	50%	75%
Not at all familiar	43%	50%	50%	-	25%	60%	50%	50%	50%	50%	

Q70: The 2-1-1 directory is a listing of community resources and community-based organizations in the area that residents can access. How could the county boost awareness of the 2-1-1 directory?

n38; Open-Ended

- Advertising on billboards and radio. (Broome)
- Billboards (Broome)
- Education for hospital administration and staff (Broome)
- I have just moved into the area but I am an ED Physician and I would think I should be made aware of it. Needs to be a campaign so that everybody knows it exists. (Broome)
- It should be posted about in churches, grocery store, waiting rooms, and drug stores. Common places where this population will see it. (Broome)
- Pamphlets available, posted in waiting rooms and offices explaining it, ads on social media, posted info in waiting room of ED. (Broome)
- Someone who can educate the community. Give providers an incentive to have someone on staff designated to this type of education. (Broome)
- There could be an increase in advertising. (Broome)
- No idea. (Cayuga)
- We put it on all our literature. Some training for providers to use the 211 hotline might be helpful. (Cayuga)
- Set it up with local health care agencies and have a community wide information session open to the community. (Chemung)
- 211 directory is provided to people visited by home care services. Could boost awareness by having it around more. Maybe change the title as well? No one knows what 211 means-maybe refer to it as a "Community Resource Brochure." (Chenango)
- Public awareness campaign. Ads in the paper. Bulletin boards. Community bulletin boards on TV. Flood the area. Infographics. (Chenango)
- They could put it in the paper. A community outreach at local community centers. Pools. (Chenango)
- Through existing community partners, such as, WIC, Catholic Charities and Public Health Department. (Chenango)
- All community agencies should provide 211 related information to anyone who receives their services. It is in the newspaper, but the population in question does not often read the newspaper. (Cortland)
- By advertising. (Cortland)
- Let all providers know about it. (Cortland)
- Not sure what it is - have never seen/heard of it, but maybe through a phone book, a Smartphone app, or local news. It's a good idea to send these directories out to churches, food pantry's etc. (Cortland)

Q70: The 2-1-1 directory is a listing of community resources and community-based organizations in the area that residents can access. How could the county boost awareness of the 2-1-1 directory?
n38; Open-Ended

- Radio or TV advertising. (Cortland)
- By sending out promotional information regarding it's availability and where to find it. (Delaware)
- First, we have to obtain it, which we are in the process of having it in our county and then it's just a matter of advertisement. (Delaware)
- Let people know that it exists. (Delaware)
- Social media. (Delaware)
- The county has just agreed to participate so they are just getting it off the ground; advertising and social media would help. (Delaware)
- Work through organizations to publicize and educate their patrons to the 211 resources. (Delaware)
- Advertising it. (Schuyler)
- Community groups, doctors' offices, nursing home, and discharge planners to get information to them so they're aware. Maybe in-service training to educate organizations. (Schuyler)
- Send out mailings, and flyers put in other mailers and surveys. (Schuyler)
- Sending out in a mailing right to the patients homes. Again having booths around the county like at the Wal-Mart. Meet the people where they go and where they shop, worship, or entertain themselves. (Schuyler)
- Mass media promotion. Post information at charity buildings and DSS offices. (Steuben)
- Some specific examples of what options are available. (Steuben)
- Have some type of system linked with the issuing of their benefits. (Tioga)
- Modeling it's use. (Tioga)
- Educating providers on what 211 is. Pamphlets and posters. (Tompkins)
- Having more posters and flyers around town. (Tompkins)
- Responder is teaming up with 211 to educate public on proper use of directory in emergency situations. (Tompkins)
- They do a pretty good job; just make sure the information is where these populations are likely to congregate. (Tompkins)

Q71: What other resources are you aware of that would help identify support organizations for the Medicaid and uninsured populations?

n38; Open-Ended

- Ask the social worker, who should know all that. (Broome)
- Catholic Charities, UHS Medicaid Health Home (nurses work with Medicaid recipients), and Medicaid caseworkers. (Broome)
- None (Broome)
- None (Broome)
- Nurse Direct - Stay Healthy Center (Broome)
- Unsure (Broome)
- Unsure (Broome)
- Unsure (Broome)
- None (Cayuga)
- Seems like there are a million of small, segmented agencies or groups. I don't think they work in concert very often. Area Agency on Aging, CPAP, or something like that. (Cayuga)
- Case managers and social workers. (Chemung)
- Chenango Health Network (Chenango)
- Doctors refer patients to certain agencies which can connect them to resources. (Chenango)
- None (12) (Chenango)
- Office of the Aging. (Chenango)
- Churches and Food Pantries (Cortland)
- Handouts of some kind and have community organizations that are available in the area. (Cortland)
- Monthly overview of services received (Cortland)
- Primary care providers, Office of the Aging, and Access to Independence (Cortland)
- Seven Valleys Health Coalition, and Cortland Prevention Services. (Cortland)
- Local opportunities programs. (Delaware)
- Small community based organizations. In large cities, use neighborhood organizations. It must be a personal endeavor with one-on-one contact with people who know their participants. (Delaware)
- Social media and advertisement. (Delaware)
- The Internet! (Delaware)
- Unsure (Delaware)

Q71: What other resources are you aware of that would help identify support organizations for the Medicaid and uninsured populations?

n38; Open-Ended

- Unsure (Delaware)
- Catholic Charities, among others. (Schuyler)
- Public health nurse program, and Catholic Charities. (Schuyler)
- There is NYS Connect and Office of the Aging. (Schuyler)
- Unsure (Schuyler)
- Discharge planners and social workers. (Steuben)
- Unsure (Steuben)
- None (Tioga)
- Rural Health Network, and Social Services (Tioga)
- Cooperative Extension (Tompkins)
- Emergency medical services. Community service organizations, like Rotary or Kiwanis, that promote educational programs. Also, the free clinic in Ithaca. (Tompkins)
- None (Tompkins)
- Unsure (Tompkins)

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n38[1]; Single Response

- At the ED educate them on proper usage (Broome)
- Awareness of what is an emergency and what can be dealt with by a PCP. (Broome)
- Better access to private continuing care; PCP that will see them when they're sick. (Broome)
- Better communication among electronic medical records. (Broome)
- Better discharge planning and follow-up. (Broome)
- Community discussion between providers, organizations and the patients. (Broome)
- Financial reimbursement from Medicaid providers to healthcare providers. (Broome)
- Hot line to guide patients (Broome)
- Improved triage. (Broome)
- Improving healthcare literacy by PCP spending more time with the patient (Broome)
- Increase in consequences of mismanagement of ED use (Broome)
- Increase in mental health and substance abuse services (Broome)
- Increase in transportation services (Broome)
- Institute penalties for using the ED inappropriately (Broome)
- Limit ED prescriptions for Narcotics (Broome)
- Make the patient responsible for understanding the rules of what is appropriate in use of the ED. (Broome)
- Making sure these patients have a PCP that they can use immediately (Broome)
- Mental health/substance abuse providers or assistance (Broome)
- More access to PCPs (non traditional office hours) (Broome)
- There needs to be different rules in the long-term care dept. There are a lot of unnecessary ED visits in this dept. (Broome)
- Those with chronic conditions have a nurse or an HH organization look in on the patient instead of depending on family members (Broome)
- Walk in clinics available in highly Medicaid populated areas (Broome)
- Working with providers to see what their barriers are to seeing these patients. (Broome)
- Charge more for Medicaid patients (out of pocket) that use ER services (Cayuga)
- Education (Cayuga)

[1] 3 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n38[1]; Single Response

- Make the penalties equal for all providers, especially for re-hospitalization or overuse of ED (Cayuga)
- More uniform communication between all parties involved (Cayuga)
- Provide more money to physicians. (Cayuga)
- Better access to PCP's that accept Medicaid (Chemung)
- Better access to walk-in or Urgent Care. (Chemung)
- ER stop admitting non emergent patients in the ER (Chemung)
- Appropriate referral to hospice. (Chenango)
- Availability of 24-hour walk-in next to ER with available up-front prices for the uninsured. Maybe doesn't need to be staffed with doctors--maybe LPNs or EMTs. (Chenango)
- Availability of "Convenient care" in this community. (Chenango)
- Better access to PCPs. (Chenango)
- Better access to their pharmaceutical needs. (Chenango)
- Case Management (Chenango)
- Connection to Primary care practitioners (Chenango)
- Co-pays for ER visits for Medicaid patients. (Chenango)
- Educate people as to what is an emergency and what isn't. (Chenango)
- Embedding additional services within the Primary care services. Mental health. (Chenango)
- Reduce coverage for ED visits to maybe one per year. (Chenango)
- Transportation for people with Medicaid. (Chenango)
- Access to better hours from providers (Cortland)
- Access to transportation to secondary or specialty providers (Cortland)
- Another urgent care facility (Cortland)
- Appropriate transportation to get to a medical provider. (Cortland)
- Education at time of receiving medical care benefit (Cortland)
- Everyone needs to have a plan with their physician/therapist (Cortland)

[1] 3 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n38[1]; Single Response

- Improved communication system among all the providers and agencies in the county (Cortland)
- Increased number for providers (Cortland)
- Increased number of primary care providers (Cortland)
- Less government involvement - work with Fidelis/Total Care Companies as their staff seem to be very knowledgeable - I have never seen anyone from the federal government Medicaid office. (Cortland)
- Obtain a medical provider. (Cortland)
- Practicing psychiatrists in the county (Cortland)
- Seeking healthcare before they need to go to the ED. (Cortland)
- The overhaul of the Medicaid program as a whole - very complicated system to receive reimbursement. (Cortland)
- Transportation (Cortland)
- Access to non ED services (Delaware)
- Allow doctors to do their jobs. (Delaware)
- Change the laws. (Delaware)
- Developing resources based on that data that would meet the needs of that person instead of them going to the ED. (Delaware)
- Educate both populations. (Delaware)
- I think accurate data collection from the EDs of patients habits. (Delaware)
- Increase the amount of PCPs that accept Medicaid. (Delaware)
- Local conversation about brainstorming and getting new ideas. (Delaware)
- Make non emergency walk in centers welcoming (Delaware)
- Make referrals for Mental health issues. (Delaware)
- Medical services available within the behavioral health system. (Delaware)
- Provider Awareness to Patient Teach (Delaware)
- Recipient Education (Delaware)
- Screening for behavioral health issues and medical. (Delaware)
- Some type of urgent care. (Delaware)

[1] 3 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n38[1]; Single Response

- Stating your goal publicly and trying to enlist the Medicaid population in that goal. (Delaware)
- Stronger ED Guidelines (Delaware)
- Transportation becoming more accessible and easier to get to the providers. (Delaware)
- Conversations that should be occurring in the physicians offices (Schuyler)
- Doctors offering more after hours and emergency care from the office. (Schuyler)
- Educating providers to make sure patients understand; offer resources and written instructions and phone numbers to call. (Schuyler)
- Educating the patients. (Schuyler)
- Education of the patient of exactly what to take where (Schuyler)
- no third answer. (Schuyler)
- Physicians accepting Medicaid and uninsured in their practices. (Schuyler)
- Provide better education regarding health issues, so they can put themselves in a position not to end up in the ER. (Schuyler)
- Providing better availability of clinical services at convenient and varied hours. (Schuyler)
- Set up with primary care doctor for point of contact. (Schuyler)
- System mandatory requirements in order to keep the coverage (Schuyler)
- Consistent Community resources. (Steuben)
- Education (Steuben)
- Education (Steuben)
- More providers to accept Medicaid/uninsured (Steuben)
- Transportation (Steuben)
- Availability of Mental Health Care (Tioga)
- Availability of Substance Abuse Help (Tioga)
- Have access to care on the same site where the triage center is located. (Tioga)
- Put a triage in place immediately. (Tioga)
- Some kind of incentive for them to not to use the ED and to utilize or obtain a pcp. (Tioga)

[1] 3 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n38[1]; Single Response

- Transportation (Tioga)
- Access to Provider Care (Tompkins)
- Behavioral health. (Tompkins)
- Healthcare and community patient education about how to effectively utilize resources (Tompkins)
- Identify non-medical barriers to effectively managing a disease or illness (Tompkins)
- Improved communication among various providers and PCPs. (Tompkins)
- Improving communication among providers. (Tompkins)
- Incentives and Penalties (Tompkins)
- Increased availability of PCPs. (Tompkins)
- Increased support to those PCPs. (Tompkins)
- Integrative care. (Tompkins)
- Utilizing non-traditional community resources already in existence (Tompkins)

[1] 3 No Reply

Q76: Is there anything that we have missed among these DSRIP projects or in this interview that you would like to discuss?

n32[1]; Open-Ended

- Family education and support for families of people with chronic illness. Hospitals could offer shuttles to appointments, or raise awareness of medication delivery. (Broome)
- I think that expanding palliative medicine would help in reducing readmissions; not in every case, but there's a place for expanding and following-up with patients who have issues that might go unaddressed, like mental health issues and articulating goals of care. Palliative care is a process that lays the ground work now, for something that may happen later. Also, it's important to have training. Many nursing home and long term care facilities don't have people trained in these services. It's more effective when these people are trained and work with physicians who are also trained in palliative medicines. It is worse in long term care facilities as they don't meet the criteria for palliative medicine. (Broome)
- Keeping people out of nursing homes. Medicaid should be available by providing home companions, but they are not reimbursed because the care is non-medical. (Cayuga)
- I just hope that the powers that be really consider pharmacies; they are a really large player in this. I can't gain access to the patients' providers to get questions answered about medications, blood work and therapeutic choices. (Chenango)
- Our healthcare system is the way it is. I think it's a problem that we've lost the direct connection between the patient and the doctor. Insurance often gets in the way--doctors will refuse to see a patient because of it or a patient won't be able to see a doctor because a lack of up-front available prices for services (last one applies to uninsured especially). (Chenango)
- It all stems from sign up - are people told that they are receiving benefits for nothing and being taught how not to abuse these services? They must go to classes to learn how to use their benefits before receiving them. There should also be follow up required classes if they don't show, and then their benefits should be taken away. (Cortland)
- Medicaid/uninsured populations are too different to be placed in the same category, and should be looked into separately. (Cortland)
- How this work with the DSRIP planning team is going to look very different in rural counties versus the larger populated centers. (Delaware)
- I understand the concept of DSRIP and the reduction of 25% of Medicaid patients using the ED. The problem that I have is that healthcare is local and each of the problems needs to be solved locally and not regionally, based on each counties needs. (Delaware)
- Mobile mental health thing is ridiculous. Not safe. who would call. What would they do it there was a problem. (Delaware)
- It's a big trend in New York State - that the Medicaid population is shrinking is only because they're shifting them to managed care. It may not be doing the patient justice to have fewer options for managed care and reimbursement/quality of materials, etc. (Schuyler)

47 No/Unsure

[1] 6 No Reply

Q76: Is there anything that we have missed among these DSRIP projects or in this interview that you would like to discuss?
n32[1]; Open-Ended

- Maybe the Medicaid office staff needs further training; the case workers may need training to guide their clients. (Schuyler)
- Some kind of wage increase for the people that are providing these direct care services. (Tioga)
- Making a big mistake in regionalization, putting together disparate counties. One size fits all is not a good approach (Tompkins)
- Patient-Centered-Home for good follow-up and basic health actions. (Tompkins)

47 No/Unsure

[1] 6 No Reply

In-Depth Interviews
Community Non-Clinical Audience
I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee.

Q22: Does your agency or organization work with the Medicaid and uninsured populations now? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	98%	86%	100%	-	100%	100%	100%	100%	100%	100%	100%
No	2%	14%	-	-	-	-	-	-	-	-	-

Q23: (IF YES) How does your organization interact with the Medicaid and uninsured populations?
n51; Open-Ended

- 25% of my practice is Medicaid that I see for free. (Broome)
- Advocacy/Education/Peers/Health-Home programs/Mentoring programs/Child and Adolescent Programs (Broome)
- Our mental health clinic interacts with Medicaid and the uninsured population and the hospital has a community education department. (Broome)
- Provide primary care prescriptions. (Broome)
- We have OPWDD - Office for People with Developmental Disabilities and at Home and Community Based Services - HCBS. The HCBS waiver basically is we provide home and community based programs through Medicaid and we have Medicaid based workers. (Broome)
- We provide fall prevention services; like a wellness program. (Broome)
- We have a department of social workers who work directly with the population throughout the hospital. (Cayuga)
- Alcohol and Drug Addiction Services (Chenango)
- Our population is specific to Chenango County and people in need of mental health services and drug and alcohol services. (Chenango)
- They are enrolled in the insurance exchange program and the Medicaid program. (Chenango)
- Through outreach education, immunization clinics and referrals. (Chenango)
- We are an emergency services center and we provide food, furniture, household goods, clothing and we do some case management for housing for the homeless. We also have nutritional services tied in with the food stamp program. (Chenango)
- We enroll people into public insurance through the NYS Marketplace, even before the marketplace existed. Even prior, we enlisted people in Medicaid, Child Health Plus and Family Health Plus Programs. Also we help people receive assistance from PAPS Pharmaceutical manufacturers, which is need or financial based. And we have a community health advocacy to help them understand insurance. (Chenango)
- We provide in-home services for these populations; advocacy, prescription drug and insurance counseling. (Chenango)
- We support people and find the best resources to supply their needs. (Chenango)
- Community Outreach, Recovery Center, Take people to appointments, 1 on 1 peer counseling. (Cortland)
- Emergency assistance program, residency program, food pantry program, wellness center, many other programs. (Cortland)
- Outpatient Mental Health Treatments (Cortland)
- Provide funding/Chairman for Mental Hygiene/Developmental Disabilities Facilities (Cortland)
- Provide self-management courses for chronic conditions/transportation needs/promotes oral and dental health in elementary schools. (Cortland)
- Providing health education. (Cortland)

Q23: (IF YES) How does your organization interact with the Medicaid and uninsured populations?
n51; Open-Ended

- We provide child care so that families can work and/or receive protective services for their children. (Cortland)
- We provide community based services. (Cortland)
- We provide homecare services. We will accept the uninsured if they are pending Medicaid. (Cortland)
- Billing department. Bill Medicaid for people on Medicaid. (Delaware)
- Provide services for mentally ill adults. (Delaware)
- We provide information, assistance and referrals for individuals that are looking for long-term care services and supports. (Delaware)
- Health Center in two different locations. (Schuyler)
- Provide prescription assistance for people who would not be able to afford to purchase them otherwise. We also have a food pantry and rent assistance. (Schuyler)
- Provide Transportation and Emergency Transport to area hospitals. (Schuyler)
- Public health department - do immunizations, run intervention programs. (Schuyler)
- They set them up with Medicaid if qualified or they have a sliding scale for the uninsured. (Schuyler)
- Through the health insurance counseling program; those who are dually eligible. (Schuyler)
- We are a sole community hospital and a significant portion of our population is Medicaid or uninsured and dual eligible. (Steuben)
- We have a clinic and we provide support services to, such as transportation and food services (food pantry). (Steuben)
- We pay for breast, cervical and colorectal patients that do not have insurance. We are the connection in the county to get them appointments. (Steuben)
- We provide housing services and case management to Medicaid eligible people. (Steuben)
- Community outreach and clinics. Immunizations, physical exams. Some STD testing. (Tioga)
- My organization is a rural health network of South Central New York. We work with helping people enroll in Obamacare and help them get their chronic health care needs addressed. We target populations that have chronic diseases, like diabetes. (Tioga)
- Providing Case Management and Residential Placement. Pre-school services. Therapies as needed. (Tioga)
- We assess anyone at the time that they need services, to see if they are eligible for Medicaid or Affordable Care Act and if not, then we have them apply for financial assistance with the hospital. We also do follow-up calling, after they have had services and outreach services. (Tioga)
- We provide healthcare. (Tioga)
- We provide housing to people with severe and persistent mental illness; we also offer a home health program which provides care management. (Tioga)

Q23: (IF YES) How does your organization interact with the Medicaid and uninsured populations?
n51; Open-Ended

- We provide residential, social and vocational programs, as well as care management. (Tioga)
- By providing clinical coordination of care or care coordination. (Tompkins)
- Help uninsured people sign up for health coverage and help inform people of 2-1-1. (Tompkins)
- Primary care providers. (Tompkins)
- Provide network of home and community based support for individuals with long term care needs; medical alert machines, PERP, meals on wheels. (Tompkins)
- We offer at our Free Clinic primary and holistic care to patients that Medicaid won't cover. We offer care to patients that are uninsured or waiting to qualify for Medicaid. (Tompkins)
- We provide long-term care and rehabilitation services to Medicaid recipients. (Tompkins)
- We provide mental health services, and health-home care coordination. (Tompkins)

Q24: How often does your organization interact with the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	51	6	1	0	8	9	3	6	4	7	7
Never	2%	-	-	-	-	-	-	-	-	-	14%
Sometimes	8%	17%	-	-	-	11%	-	33%	-	-	-
Usually	16%	-	-	-	25%	22%	33%	-	-	14%	29%
Always	74%	83%	100%	-	75%	67%	67%	67%	100%	86%	57%

Q25: How can that interaction be improved?

n50; Open-Ended

- Easier to be able to work with Medicaid and be paid rather than give services for free. (Broome)
- If we were able to offer a wider array of services. We need to increase funding and amount of providers. (Broome)
- It can be improved with better transportation, with getting people to doctors' appointments and assistance with housing and basic life needs. (Broome)
- More support in Mental Health field from providers that offer Mental Health services. (Broome)
- There has to be education out their and a better way of triage the Medicaid and uninsured. (Broome)
- We reach out to church groups and community organizations. (Broome)
- Simplify rules with communicating with these populations. (Cayuga)
- Access to that population through one of our education programs if we can reach out to this group we might have some effect. (Chenango)
- Having a better delivery system by letting the patients know what services are available to them and how they can access them and if they can afford them. (Chenango)
- More available funding. (Chenango)
- More outreach to let people know where they can go. (Chenango)
- My agency is doing a good job. (Chenango)
- Unsure (Chenango)
- We don't have adequate staff resources to meet the need. (Chenango)
- Word of mouth. Our organization does not have public relations/marketing budget. We are a governmental agency. (Chenango)
- Better communication. (Cortland)
- Education and awareness among providers on what is available. Often the clients that we service have to go to multiple locations to get the proper assistance which can cause frustration with both staff and clients. (Cortland)
- For families to allow more time at the beginning and the end of the day, to communicate more efficiently. (Cortland)
- Increasing contact with schools/promoting contact with service providers to reduce fear or hesitation when contacting this type of assistance. (Cortland)
- It seems hardest to get the people who most need help to acknowledge and accept those services. It could be improved by getting them in for those services. We have limited resources. (Cortland)
- Reach-ability can be difficult as transportation needs are not always addressed. (Cortland)
- We are looking at that from the point of contact up and to the point when they are discharged; from what engagements and what type of issues are in the way of patients not getting to their appointments, and things like that. We are looking at different things that would prohibit a patient from keeping appointments. (Cortland)

Q25: How can that interaction be improved?

n50; Open-Ended

- We need more at home care. Our goal is to prevent unnecessary ED visits. We have a 24 hour nurse line for Medicaid patients. We need to get them to call it. We communicate with the physician about our patients but they still say to send them to the ED. (Cortland)
- We need to get the word out more that we are here. (Cortland)
- Have Medicaid respond back faster with payments. (Delaware)
- If we had more staff, money and more time. If the reporting and paperwork requirements were less we would be able to give more time the actual services to the people. (Delaware)
- Trying to get more people off Medicaid and to another option - the marketplace or some other system. (Delaware)
- Better understanding of the system, as far as what is covered and what is not covered (for Medicaid, SNAP, and other programs.) Increase in education of support services. (Schuyler)
- I am not sure. (Schuyler)
- Make Medicaid billing less cumbersome - organization spends a lot of time securing money. (Schuyler)
- Outreach into the community and reaching the Amish or Mennonite communities. Better transportation. (Schuyler)
- There are areas that misuse Medicaid. The Falls Home, they send people to the ER with a hang nail because they don't want to deal with them. They could have gone to Primary Care. (Schuyler)
- Through educating the people and letting them know we are here to assist. (Schuyler)
- Accessing the uninsured is difficult. They are hard to find. This is not their priority. Groceries and utilities are first. Healthcare is not high on their list. Provide methods to access their communities to teach that their healthcare is a priority. Rural areas are harder to access. (Steuben)
- Having greater staff resources. We often end up with not enough staff to provide the level of services that the population needs. (Steuben)
- In general, the population does not know that these services are available; so overall, all healthcare workers who deal with these populations could do a better job communicating these services. (Steuben)
- There is always room for greater access by the population to our services. (Steuben)
- Better accountability from the Medicaid recipients and what rules they need to follow. (Tioga)
- More funding. (Tioga)
- More non-judgmental. (Tioga)
- No idea at this time. (Tioga)
- The ability to access Medicaid and get medical aid. Having more providers and specialists that accept Medicaid. Make it easier for families to retain their Medicaid services. (Tioga)
- Training and knowing their needs. (Tioga)

Q25: How can that interaction be improved?
n50; Open-Ended

- We do a pretty good job; I don't see where we need to improve anything. (Tioga)
- Better communication as far as current contact information from patients. (Tompkins)
- Improvements with collaboration between other providers such as PCPs. Being able to have a shared treatment plan that all providers can access. (Tompkins)
- Increasing focus on patients health management or skill building with the patient. (Tompkins)
- More funding; they receive any reimbursements from CMS. (Tompkins)
- More promotion of the organizations services (Tompkins)
- There is always room for improvement. We need more funding to be able to increase our capacity. More volunteers. (Tompkins)

Q26: Does your agency or organization specialize in working with any particular type of Medicaid patients or uninsured patients that all have similar characteristics? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	51	6	1	0	8	9	3	6	4	7	7
Yes	63%	83%	-	-	50%	67%	67%	50%	75%	86%	43%
No	37%	17%	100%	-	50%	33%	33%	50%	25%	14%	57%

Q27: What are those characteristics that your populations exhibit?

n32; Open-Ended

- Mental health issues. (Broome)
- Our programs are specific to people with disabilities. (Broome)
- People of need of dental services and mental health services. (Broome)
- People receiving mental health services/chronic illness. (Broome)
- We work with participants that have balance issues, partly due to aging or a disease that affects their balance. (Broome)
- Alcoholism/Drug Abuse (Chenango)
- Developmental disabilities, mental health issues and socio-economic status. (Chenango)
- Poverty stricken population. (Chenango)
- We work with the dual eligible population; Medicaid and ineligible for Medicaid. (Chenango)
- Chronic diseases/Diabetes (Cortland)
- Chronic medical, mental health, substance abuse and teen & children population. (Cortland)
- COPD, CHS Cases and Mental Health Diagnosis. (Cortland)
- Mental health diagnosis and/or chronic health condition. (Cortland)
- Mental illness and/or substance abuse and sometimes developmentally disabled. (Cortland)
- People receiving mental health services, developmental services, and drug and alcohol services. (Cortland)
- Mental illness. (Delaware)
- Usually people with mental health or substance abuse problems. (Delaware)
- Early intervention program - works with young children (infancy to three years old) (Schuyler)
- Just the dually eligible patients. (Schuyler)
- Migrant farm workers. (Schuyler)
- Adults with psychiatric disabilities and some with substance abuse issues. (Steuben)
- Started out in an HIV-AIDs outreach healthcare. Have expanded into chronically ill healthcare. (Steuben)
- They all have the 3 areas that we work with. Cervical, Colorectal and breast screening. (Steuben)
- Adults with psychiatric disabilities. (Tioga)
- Cognitive Delays. (Tioga)
- Poverty. (Tioga)
- They all have to have a severe or persistent mental illness. (Tioga)
- Those that are poor and those that are in need. (Tioga)

Q27: What are those characteristics that your populations exhibit?

n32; Open-Ended

- We work with people that are from a rural setting. (Tioga)
- Geriatric; diseases (pneumonia, factures, heart disease, etc.) (Tompkins)
- Primarily working with long term care patients; also increase awareness in the Medicaid population with screening for cancer, patients usually over 50 yrs old. (Tompkins)
- We service people with mental health issues (Tompkins)

Q28: Are your Medicaid or uninsured patients unique or distinct from any other types of populations that you may interact or work with? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	51	6	1	-	8	9	3	6	4	7	7
Yes	47%	67%	-	-	50%	56%	33%	50%	75%	29%	29%
No	53%	33%	100%	-	50%	44%	67%	50%	25%	71%	71%

Q29: (IF YES) How are your Medicaid or uninsured patients unique or distinct?
n24; Open-Ended

- Because sometimes, the people that we are doing preventative education for, those recipients have substance abuse disorders. (Broome)
- Not eligible for insurance. Don't have the finances to get the medication they need. They lack in particular mental health and dental services. (Broome)
- They are motivated to take care of their health, to remain in the community. (Broome)
- They have any kind of disability and of any age. (Broome)
- Having access to a professional that can provide them with the appropriate medications change. General medical services are available. We have a diverse population from cultural to criminal standings. (Chenango)
- Unsure. (Chenango)
- We target programming to Medicaid and the uninsured population. (Chenango)
- We work with the 60+ population who are not eligible for the Medicaid programs due to their financial circumstances. (Chenango)
- Cortland County has many people living in rural conditions, limited to preventative services due to distance and are unable to travel to appointments. (Cortland)
- The reason why people come here is for treatment of mental illnesses, for diagnosis or treatment to have something ruled out. (Cortland)
- The uninsured use the ER for non emergencies because a Doctor won't see them. (Cortland)
- They have limited means to access needs, monetary and transportation. The standard of living is very low. (Cortland)
- Transportation issues. (Cortland)
- We are a very rural part of the region and that puts additional barriers and access to services for those people that are living in low income and/or poverty. (Delaware)
- Some of those are the younger patients. (Schuyler)
- Struggling young families - securing jobs, healthcare, childcare, a place to rent. Lack of education leads to informational needs about how healthcare affects them in the long term. (Schuyler)
- They face different challenges as far as insurance goes. Because they don't have insurance, they don't see a doctor regularly, so instead, they go to the ER. (Schuyler)
- Specific conditions. Education makes them unique. Education of their general world around them is difficult. (Steuben)
- They don’t always have the same access that other populations have. (Steuben)
- We deal with a variety of people. Many are coming out of hospitals or restrictive settings and they often have other disabilities. We help people buy homes. We deal with a lot of people with psychiatric disabilities as well. (Steuben)
- They have severe and persistent mental illnesses. (Tioga)

Q29: (IF YES) How are your Medicaid or uninsured patients unique or distinct?
n24; Open-Ended

- They have severe psychiatric diagnosis and need medications. (Tioga)
- Health literacy is low, the engagement with the patient is often lower, social economic things that other populations do not deal with. (Tompkins)
- Only that they are eligible for certain reimbursements where general population would not be; they do a lot of health insurance counseling which is very different then other populations. (Tompkins)

Q30: Is it appropriate for your organization to interact with healthcare providers? (Providers include nurses, dieticians, mental health providers and anyone who may interact on a clinical level with a patient).
Single Response

Category	Total	County									
		Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	0	8	9	3	6	4	7	7
Yes	94%	100%	100%	-	88%	89%	100%	100%	100%	100%	86%
No	6%	-		-	12%	11%	-	-	-	-	14%

Q30a: (IF YES) How often does your organization interact with healthcare providers? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	49	7	1	0	7	8	3	6	4	7	6
Never	-	-	-	-	-	-	-	-	-	-	-
Sometimes	14%	29%	-	-	29%	-	33%	-	-	-	33%
Usually	31%	29%	-	-	29%	38%	34%	33%	25%	29%	34%
Always	55%	42%	100%	-	42%	62%	33%	67%	75%	71%	33%

Q30b: How can that interaction be improved?

n52; Open-Ended

- Better communication. (Broome)
- Communication and Team-Coordination needs work. (Broome)
- I do not interact first hand with providers. (Broome)
- It is easy for me to reach these providers; no improvement needed on my side. (Broome)
- More effective communication; need to use electronic medical records. (Broome)
- That is up to the practice and the doctors' offices because it works on a referral basis. However, it is up to the patients to follow up with the referrals and most of the time that does not happen. (Broome)
- There has to be a Medicaid reform; I feel that they are not always motivated and able to access preventative services. (Broome)
- The simplification of communication. When someone else is paying the bill (for healthcare) there are many rules you have to follow which limits communication. (Cayuga)
- Better access to health information, like the medical providers having easier access to reach them for feedback. (Chenango)
- Electronic record keeping needs a lot of improvement. (Chenango)
- Increase access to those providers. (Chenango)
- Interaction with providers would help; if we had a proper designated staff to interact on behalf of a patient, more focused or adequate staffing on both sides, but everyone is short staffed. (Chenango)
- It doesn't apply to my organization. (Chenango)
- It's actually pretty good, if there were a consolidated/electronic records to access community based and clinical providers, but not everyone has access to that system. (Chenango)
- More availability to the providers. (Chenango)
- Sometimes it's difficult to reach the providers so that may slow things down. Getting information sometimes is prompt, other times not so, depending on the practitioner. (Chenango)
- Better connections/communication between all entities - conduct a joint meeting between county physicians/office administrations/hospital physicians/private practice physicians. We are the board who hire and oversee the county's Director of Human Services. There seems to be no joint meetings between the county physicians that we can have easy access to in order to ask questions and share ideas. (Cortland)
- Educating doctors to alternatives other than visits to the ED. RHIO. Electronic holding base for patient information so all can access. (Cortland)
- Here at the Recovery Center, it can be improved just by knowing who their healthcare providers are and allowing us to speak with them and the providers willingness to work with us. (Cortland)
- It doesn't apply to my organization. (Cortland)

Q30b: How can that interaction be improved?

n52; Open-Ended

- It would help to hear from them, to see how services could be improved. (Cortland)
- More investment from providers to bettering communication. (Cortland)
- Not a lot of doctors in the area that accept Medicaid, so it is difficult for Medicaid patients to find care. Those physicians that do accept Medicaid are often booked for appointments. (Cortland)
- On our end, being aware of what concerns healthcare providers might have in regards to communication and what barriers the PCP might have with our organization; increased awareness of what each entity can and cannot do, for instance medication changes for treating mental illness and medications that treat a patients general health. (Cortland)
- Pure technology; unified system that could communicate between each other and have secure messaging. There is a free service that providers could use for secured messaging through the RHIO - Regional Health Information Organization. (Cortland)
- By having a centralized system where medical records are available, like a centralized database. I know it's already in place, but not for everyone just yet. (Delaware)
- Having more providers around that accept Medicaid. (Delaware)
- It can be improved if both parties understood each others different perspectives better. (Delaware)
- Better understanding of both sides. Why doesn't the healthcare provider want to take a Medicaid patient? Help us understand why these providers do not want to accept Medicaid patients. Many doctors do not provide enough education for these populations and this is something we could take on. (Schuyler)
- By educating them. (Schuyler)
- Integration of clinical records is key going forward in realizing the potential and better managing patients care. (Schuyler)
- It's working well; an improved computer system. (Schuyler)
- Providers are busy and hard to get a hold of--more time for them to do community planning with us (to improve population health) would be helpful. Don't always have time for follow-up/reminders for patients, especially with lead testing. (Schuyler)
- The level of healthcare could be better. Physicians Assistants are seeing patients instead of doctors. (Schuyler)
- Better communication about our services and referral patterns. (Steuben)
- It's a 2 way street. We know that we all have to be aware of appropriate communications. Staff turnover is a problem as well as time. Old-school providers have gate keepers that are impossible to get through. (Steuben)
- Staffing; resources and time on both sides. Have a more integrated treatment process. Often, healthcare providers or social workers are separate from the housing people. The population would be better served if services were integrated. (Steuben)
- The providers could do a better job communicating services available to these populations. (Steuben)

Q30b: How can that interaction be improved?

n52; Open-Ended

- A more central communication process online that many can access quickly. (Tioga)
- Continuous communication. (Tioga)
- If the Medicaid or uninsured population has particular disabilities, that they have someone help them through the process. (Tioga)
- It's a pretty good interaction; our agency is lucky. (Tioga)
- More early response time; call them back sooner. (Tioga)
- More funding. (Tioga)
- Timely responses from providers. (Tioga)
- A streamlined approach with the providers, providers may need a certain amount of compensation which they are not receiving now. There are a lot of services performed behind the scenes that providers are not being paid for. (Tompkins)
- Having more providers who are willing to take more Pro Bono or low fee patients. Providers making it easier for patients in general. (Tompkins)
- I think shared medical records on particular cases, also including any long term care services a patient may be utilizing along with clinical records would help keep people out of the hospital would be great. Knowing about chronic illnesses for a patient would assist in all other needs required. (Tompkins)
- It is difficult to interact with providers at times due to how busy the doctors are. There needs to be a way to share key patient information between providers. (Tompkins)
- Just in general, practitioners don't take the time to let Medicaid recipients feel they're heard; it just feels 'rushed'. (Tompkins)
- Promote organizations services more (Tompkins)
- We really do a good job in the community keeping in touch. Case management. (Tompkins)

Q31: On a scale of 1 to 5 where “1” represents poor and “5” represents excellent, based on your knowledge how would you rate the sharing of healthcare information within the provider community? Aided; Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
1	12%	14%	-	-	25%	11%	-	17%	-	14%	-
2	10%	29%	-	-	-	11%	-	17%	-	-	14%
3	61%	57%	-	-	75%	56%	67%	32%	100%	72%	58%
4	13%	-	100%	-	-	22%	33%	17%	-	14%	14%
5	4%	-	-	-	-	-	-	17%	-	-	14%
% 4 or 5	17%	-	100%	-	-	22%	33%	34%	-	14%	28%

Q32: Over the past 3 years, is provider communication getting better, staying the same, or getting worse? Single Response[1]											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	51	7	1	-	8	8	3	6	4	7	7
Getting better	41%	29%	100%	-	25%	63%	33%	33%	25%	57%	43%
Staying the same	35%	42%	-	-	37%	25%	34%	50%	25%	14%	57%
Getting worse	24%	29%	-	-	38%	12%	33%	17%	50%	29%	-

[1] 1 No Reply

Q33: Do you think providers ever have difficulty in accessing records or tests of patients electronically? Single Response[1]											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	47	7	1	-	6	9	2	6	4	6	6
Yes	79%	86%	-	-	83%	67%	50%	83%	100%	83%	83%
No	21%	14%	100%	-	17%	33%	50%	17%	-	17%	17%

[1] 5 No Reply

Q34: Is communication between certain provider segments worse than others? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	73%	71%	-	-	75%	89%	100%	67%	75%	57%	71%
No	27%	29%	100%	-	25%	11%	-	33%	25%	43%	29%

Q35: (IF YES) Which ones?

n68; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- Across the board, from the PCP to mental health providers; we have issues with releasing information. (Broome)
- Getting ER records to primary care providers is difficult. (Broome)
- Independent specialties; they don't seem to have a consciousness that that should be done. They don't seem to get that medicine is a 'team sport'. (Broome)
- Information shared between hospitals is difficult. (Broome)
- PCP's and ED electronic records is a challenge when access is needed to treat patients. The ED uses one system the hospital uses another and there is a third system being used, and the software doesn't talk with each other, causing long usage times in all three systems, it is very timely and will not get completed usually due to not having enough time. (Broome)
- Private practices communicating with larger institutions. (Broome)
- The largest gap is between private attending and acute care. Office services are good, but getting a history from the PCP to the acute care is a large gap. (Broome)
- Between nurses and caregivers; nurses may not explain fully to the caregiver or home aide about the prescriptions being left. (Cayuga)
- Smaller family practices tend to invest less in technology for records purposes. (Cayuga)
- Long term care is definitely a problem. Emergency to emergency room is a real problem. (Chemung)
- PCPs and pharmacies. (Chenango)
- Specialists. (Chenango)
- The hardest is accessing Mental Health records. There is a law that hinders primary care from viewing mental health records. (Chenango)
- Communication between physicians and psychiatrists is difficult for mid-level providers. (Cortland)
- It's not about one segment it's about individual facilities with our practice. Like Cortland Regional Medical is great, however, Cayuga Medical is awful nobody cares, nobody calls, when we need medical records it usually means someone is coming into the office to be seen and Cayuga Medical is horrible. And this doesn't matter what population of patients you're talking about, insured/uninsured/Medicare/Medicaid etc. (Cortland)
- Patients that are discharged from the hospitals. (Cortland)
- Primary care providers have trouble getting info from specialty providers (even if they made the referral). As a home care agency, I also have difficulty getting records. (Cortland)
- Standardize accessibility across all healthcare providers. (Cortland)
- Behavior health and medical, especially primary care, due to time factors and how busy the providers are. (Delaware)

Q35: (IF YES) Which ones?

n68; Open-Ended

- In this area, we have basically two medical health care systems and if the patients see medical care outside of those two health systems that is when the communication is poor. (Delaware)
- Independent providers. (Delaware)
- Private PCPs. (Delaware)
- Medical Specialties are hard to deal with - they don't share very nicely. (Schuyler)
- They're all pretty good; I can't say it's one more than the other. In general, they're all pretty good about communication. (Schuyler)
- Hospitals and private providers or PCP (Tioga)
- The medical providers directly; they tend to have less communication with those of their same ilk. (Tioga)
- Mental health. (Tompkins)
- Providers are mandated to have electronic medical records, but smaller providers still do not use electronic records. Primary care physicians do not care for patients in hospital - hospital does, and physician instructions are not followed by hospitals, and discharge info is not relayed back to physician. (Tompkins)
- Providers are too busy to stop and talk to someone. (Tompkins)
- Urgent care and primary care centers have the biggest breakdown. (Tompkins)

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- All providers struggle to communicate with each other despite the segment. (Broome)
- Between substance abuse treatment centers, mental health providers and psychiatric providers. (Broome)
- Communication between specialists or hospitals is ineffective. Have no way of knowing if the patient goes to see another/different doctor. (Broome)
- Mental health and physicians offices for chronic disease; there is a disconnect as to who is going to take charge. (Broome)
- Mental health, long term care, specialists and hospitalists. (Broome)
- Between specialists and occasionally the general practitioners. (Chenango)
- Certain health services do not connect directly to primary providers. (Chenango)
- Mental health professionals and PCPs. (Chenango)
- Mental health providers/system; which is somewhat segregated from primary care. There are a lot of regulatory barriers. (Chenango)
- Mental health system; lack of services for those folks and developmental difficulties. Lack of communication due to lack of understanding of what different organizations do. (Chenango)
- Mental health, long term care, specialists, hospitalists and PCPs. (Chenango)
- Any of the Physicians in the community. They don't or can't access the patient information. Specialty providers and PCP. (Cortland)
- Between the hospital and outpatient services in the community; this is one of the bigger gaps. (Cortland)

Q35: (IF YES) Which ones?

n68; Open-Ended

- Communication between clinic physicians is difficult (for those patients who have more than one physician). (Cortland)
- Hospitalists. It is really hard to get information back and forth. (Cortland)
- Hospitals (Cortland)
- Mental Health to the PCP, and vice versa. (Cortland)
- Primary care, hospitalists and specialists. (Cortland)
- Private Providers/Specialists do not reach out or connect with PCPs. Community Services Board has difficulty receiving information from the states agency. (Cortland)
- Long-term care. (Delaware)
- Medical departments connected to correctional facilities. (Delaware)
- Segments run by the county - mental health clinics, dental services. (Delaware)
- Between the hospital and nursing homes. (Schuyler)
- Primary healthcare providers have worse communication than mental healthcare providers. (Schuyler)
- Private Practices. (Schuyler)
- Single/family practitioners are still working with paper records - no known plan for them to move to electronic records, as they are not as regulated in that regard. (Schuyler)
- Locations dictate your resources. (Steuben)
- Mental health, long term care, etc., basically every segments communication could be improved. (Steuben)
- Psychiatrists and general practitioners in healthcare settings. (Steuben)
- Mental health and primary care. (Tioga)
- Mental Health and Substance Abuse providers and Robert Packer Hospital. (Tioga)
- Primary care and hospitalized patient; getting information back to the primary doctor is often not smooth. (Tioga)
- Specialists to Primary care providers. (Tioga)
- Community based providers is not that good, along with the mental health providers. Using Upstate Hospital as example - communication is very bad between those providers - very large providers systems is cause for less communication if you are not part of that system. (Tompkins)
- Hospitalists, Specialists. (Tompkins)
- Primary care physicians. (Tompkins)
- There is not good communication between mental health providers and all other providers; PCP's, Specialists, or Hospitalists normally do not share patient information with that patients mental health provider. (Tompkins)
- We struggle with receiving information from PCPs. (Tompkins)

Q36: Would better communication among providers impact the number of non-emergent ED visits from the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	94%	100%	100%	-	100%	100%	100%	83%	100%	86%	86%
No	6%	-	-	-	-	-	-	17%	-	14%	14%

Q37: Why do you feel that way?

n90; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- As an example, I broke my ankle, and I was in the hospital for 6 days, when I was discharged two weeks ago, the ONLY reason I was okay when discharged is because I am a doctor - the average patient, along with the Medicaid/uninsured patients, don't know what they are looking at or how to go about all the discharge orders, arranging for PT, scheduling the follow up visits with PCP, the way the system is setup it is not user friendly at all for the average patient, let alone uninsured/Medicaid patients. (Broome)
- Better communication can better facilitate non-emergent care being taken care of outside the ED. (Broome)
- Facilities are not aware of ED visits from other hospitals. (Broome)
- If I could get a hold of a surgeon, and they would be able to see a patient that day, then we wouldn't have to send them to the ER. (Broome)
- If there is more open communication, then more education can be given to the patient. However, the patient can also visit the ED and there will be nothing the physician can do about it. (Broome)
- Primary care doesn't know what changes took place when the patient was hospitalized. (Broome)
- Providers need to work together to educate this population on when and when to not use the ED. Also, a lot of mental health patients tend to use the ED as a resource due to their conditions. (Broome)
- The patient doesn't understand or is unsure about whether to be seen and doesn't express them self well, so they get an unnecessary referral to the ED. (Broome)
- I think that population tends to go in that direction regardless of what is communicated (Cayuga)
- If the seriousness of an issue is not well communicated, the ED visit might have been avoided originally. I see that more in facilities than in home care. (Cayuga)
- We have too many folks coming in for non emergencies and real emergencies are having to wait. (Chemung)
- Absolutely. Communication up front prevents people from going to the ED promotes collaborative care. (Chenango)
- I could refer someone to case management but I wouldn't know that if I don't have access to their records. (Chenango)
- It's very difficult to obtain information once the patient has been discharged, to do a medical reconciliation on what their medication was before and to see what medications would be best for them now. (Chenango)
- With our patients, if their vital signs are off or the condition is changing, we're in contact with the doctor immediately to see if their need an appointment or ER services or etc. Cites transportation issues as a bigger cause. If they could call someone like a taxi service even to get to the doctor, it would help a lot. (Chenango)
- A lot of times we can handle some of these problems before they blow up. A lot of times people wait for things until they are an emergency and that's when they go to the emergency room. (Cortland)

Q37: Why do you feel that way?

n90; Open-Ended

- Because if we know that they are ill before they get to the hospital, then we can usually help them out. (Cortland)
- If the provider had information available to them, they could make decisions regarding a patient's medication, etc. and have them take care of these issues in their own home or elsewhere. (Cortland)
- No repetition in services and diagnostic testing. (Cortland)
- People act independently, it is the patient's perception if and when they use the ED - our office normal hours are 8am-4:45pm Monday-Friday with no weekend hours. (Cortland)
- Because, if you are proactive in the needs of the patients care, then their needs would not escalate to where they would need to go to the ED. (Delaware)
- I think it would help understanding how to better provide care for the Medicaid patients if we had better communication and would help in regards to unique things that an individual may need. (Delaware)
- Medicaid patients have nothing to lose. Healthcare is worth what you pay for it; if they pay nothing they will over-utilize the service. Years ago, if the patient missed an appointment but came to the ER, a $25 missed doctor's office visit became $250 ER visit. (Delaware)
- The more communication we can have the better we can intervene in issues that could lead from hospitalization. (Delaware)
- The population I deal with are manipulators and know how to weave themselves throughout the system. (Delaware)
- The problem is with the proactively addressed. (Delaware)
- A lot of people get lost in translation/in the mix of things/a lot of this population does not know how to advocate for themselves. (Schuyler)
- It doesn't have a lot to do with it. Medicaid patients tends not to listen well to what's being discussed, they don't remember and end up back in the ED. (Schuyler)
- It's community education rather than a provider issue. (Schuyler)
- The population will go to the ED no matter what you do. (Schuyler)
- As patients get older and have multiple conditions they see more providers and all providers may not know about all conditions. (Steuben)
- It's not a matter of communication but more a problem with the fees and coverage for the patient. (Steuben)
- If people were actually on the same page with their patients there would be less of a need for their patients to feel that they need to go the ED. (Tioga)
- It will help some, but it is not the whole issue. (Tioga)
- Better use of non-community medical resources in conjunction with better communication is the answer (Tompkins)
- Having a primary care provider empowers that PCP to act in a more meaningful way. (Tompkins)
- I feel that a lot of ED visits are triggered by mental health factors or difficulties with them adhering to medical treatment plans, those factors trend to trigger ED visits. (Tompkins)
- It's more an issue of communications between patients and providers. (Tompkins)

Q37: Why do you feel that way?
n90; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- A lot of the people that go to EDs have social cultural ways; that is how they are raised. (Broome)
- Because if we are communicating with each other, we can avoid the ER visits because we are able to prevent that visit to the ER. (Broome)
- Better communication would help providers respond better to patient's needs. (Broome)
- Communication would be better if governing bodies would give some regulatory relief. (Broome)
- Just in general, if you are trying to prevent an ED visit, it could be prevented through better communication. And consumer communication could be better with the providers being more accessible with evening hours. (Broome)
- Patients often do not know what they should be doing in terms of healthcare. There is no consistent message given to them, as in where they should go for certain types of health issues/problems. (Broome)
- The patient would be better informed and have knowledge about when it's appropriate to use ED. Communication would help. (Broome)
- We have members of our community who will always go to the ED, so in some cases, better communication may not help. However, it will work for others. (Cayuga)
- Because I think that they are unreachable; it is very hard to get a hold of providers, so people just go to the ED. (Chenango)
- Better knowledge of medical records for patients would prevent this; better follow-up/more education on addiction. (Chenango)
- I think that better communication equals better care management and that would improve health and then decrease ED visits. (Chenango)
- It's not just between mental health and non-mental health; there could be better healthcare for people before they get to the emergency room. It's the coordination and the communication between patient and different providers. For many different reasons, sometimes patents are not accessing the specialty care doctors in a timely manner and referrals could be made to a specialty program to avoid ED visits. (Chenango)
- Lack of information and access to the healthcare professionals during off hours. (Chenango)
- Maybe they could do some preventative stuff and provide some education on proper ED usage. (Chenango)
- More information and collaboration is important for the client's benefit. (Chenango)
- The clients who see a primary physician and a specialist may not share client records, diagnosis, current medications and/or plan of action for the patient. (Chenango)
- Better communication will allow for all providers and clients lives to be on the same page. (Cortland)
- I think it allows them to see a pattern. (Cortland)

Q37: Why do you feel that way?

n90; Open-Ended

- If everyone is communicating and on the same page and I have a patient that wants to go to the ER and I know from their provider and this has been an ongoing problem with them we can educate them not to go to the ER. (Cortland)
- If people are capable of having regular preventative care, it should change that number considerably. (Cortland)
- If people have a shared understanding with these patients, what needs are not being met, where they are struggling in their life etc. If the PCP knows more about the patient as a person and their everyday lives, they may be able to provide better health care. (Cortland)
- If we know what is going on with a patient, issues may be resolved more efficiently before the patient feels the need to visit the emergency room. (Cortland)
- It's all with discharge planning; if communication is there, they're more likely to get the services rather than revisiting the ED. Mental health, substance abuse and chronic diseases are the biggest areas where there is not good communication; it's one of the biggest gaps. (Cortland)
- Often a patient has a specialty provider and they give a med and may not follow up and the PCP may change the med or the ED may change the med and no one talks to the other to know about the change in meds. (Cortland)
- There is a lack of communication between patients and providers, and between providers about each patient. (Cortland)
- Because the communication style needs to take into account the context of people’s lives; there needs to be more listening and less talking. Problems often come from not asking if the follow up doable. (Delaware)
- Better knowledge of medical records for patients would prevent this. (Delaware)
- If we have better communication, we can redirect and point out recommendations the doctors have already made so that patients do not keep seeking reevaluation. (Delaware)
- Because I think that when there is an issue, the staff, if reaching out to the health providers and they are not receiving the guidance they need. Also, that is why some of the Medicaid and uninsured end up back in the ED. (Schuyler)
- Educating these populations on the importance of seeing healthcare providers on a regular basis would lead to less ED visits. (Schuyler)
- People are taken to Schuyler hospital then taken to another facility in the area. The services there are limited. (Schuyler)
- Providers are first to identify "frequent flyers" to the ED. (Schuyler)
- Sometimes, the doctors don’t see the patients in a timely manner, so they go to the ED. There’s often not enough room or time to get people in. (Schuyler)
- When a patient visits the ED, the hospital does not communicate. Most single/family practitioners do not offer after-hours care. Those that might be visited are often outside of the patient's usual regimen and cannot look up the patient's medical history and suggest proper services. Discharge forms are not specific about medications. (Schuyler)

Q37: Why do you feel that way?

n90; Open-Ended

- The discussions with uninsured are difficult. There can be confusion for the patient. If provider and patient are on the same page they will have a better idea of their situation, expectations and compliance. Less rerouting would happen. (Steuben)
- Communication is the key. If we had providers that could communicate universal needs or assessment tools and have a common goal. That would reduce ED visits. (Tioga)
- If the doctors were on the same page, there would not be misdiagnoses; there may be a way to prevent situations for getting worse. (Tioga)
- If they could speak with someone sooner, it may prevent emergency visits or psychiatric evaluations in the ER. (Tioga)
- One of the big problems is the lack of and poor transportation throughout the county. (Tioga)
- The person is still going to do what they have always done, which is go to the ED. (Tioga)
- They would be able to pull their medical records better and know what medications they are taking and they would know their medical history much faster. (Tioga)
- Well, because communication always helps and I think that if the providers had the records, that would provide better results for the patients. (Tioga)
- Having a collaborative approach is best for the patient. (Tompkins)
- I am not sure. (Tompkins)
- I think it would improve care, but not necessarily decrease the number of unnecessary ED visits. (Tompkins)
- I think that would help to a certain percentage, would it eliminate all visits - no. (Tompkins)
- Physicians; by not communicating with Medicaid and uninsured populations. They don't know their current medications and specialists recently seen. (Tompkins)
- There is certainly a disconnect between PCP, specialty care, hospitalists, etc. needs improvement. At times these providers don't even know that the patients they may be treating are even in ED or in the hospital. (Tompkins)
- When there is better communication they are likely to get better care. (Tompkins)

Q38: Should community organizations play a role in promoting effective provider communications? Single Response[1]											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	51	7	1	-	8	9	3	6	4	7	6
Yes	92%	86%	100%	-	100%	100%	100%	67%	100%	100%	83%
No	8%	14%	-	-	-	-	-	33%	-	-	17%

[1] 1 No Reply

Q39: Why do you feel that way?

n89; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- A community that has good inter-community communications will better take care of the people in that area. (Broome)
- A lot of community organizations contact the population that providers see, and yet providers and community organizations do not communicate well together. (Broome)
- If they can somehow coordinate communication that would be great and someone has to take the lead. (Broome)
- It's not just providers', it's also pharmacies with automatic renewals. They have automated phone calls to refill prescriptions. They don't realize that the prescriptions have changed or been deleted. Pharmacies are important, but are a large part of the problem; to make things easier, they may be hurting patients. (Broome)
- Providers' being able to speak with community organizations managing the patients' conditions would be more helpful for reducing ED visits. (Broome)
- There are already a lot of governmental initiatives aiming toward that; it should come about soon. (Broome)
- There should be one venue where all patients should have access to communicating with all providers. (Broome)
- These organizations will be more successful trying to affect change. (Broome)
- In general, the more effective communication is between providers and the community, the less services are wasted on the same thing. (Cayuga)
- Should be kept within the medical community, between patient and provider. (Cayuga)
- Initiative to increase communication through email and interoffice communication. Huddle groups. (Chemung)
- Doesn't see community organizations getting involved as a solution--would get more people involved in confidential patient information, make situations more confusing. (Chenango)
- Healthcare providers have to be upfront to understand community organizations to link care. (Chenango)
- Somebody has got to educate them. (Chenango)
- That is tricky. You have to get a signed release form everyone to communicate. (Chenango)
- All people who work to help people need to be on the same page so things are not repeated/ people don't fall through the cracks, and limited resources get to those who need them most. Limited recourses do not get abused. (Cortland)
- Because if issues are found soon enough, then they can be resolved without needing hospitalization. (Cortland)
- Community organizations already play a role in supporting patient communication with providers--without them, more patients would fall through the cracks. (Cortland)
- If there is a known place for people to visit - community organizations should promote to providers what it is they do for patients, i.e.., drug/alcohol dependency etc. (Cortland)

Q39: Why do you feel that way?
n89; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- There is a culture of sharing information that needs to be addressed.. I think HIPAA is great in empowering clients to take control of their information, but it also kind of gives them an excuse not to cooperate. (Cortland)
- Because there is some movement towards better sharing of electronic medical records throughout different medical systems and the community organizations can make the public more aware that this is happening and assist with helping push for this more. For example; there is a system called Hicks Me that allows medical records to be shared. This is something that the patients would be involved with as well and maybe the community organizations can help make it more aware. (Delaware)
- Community organizations work with small groups of people in small communities; they know more about the groups they see. (Delaware)
- If patients are advocating for themselves, things are going to happen. (Delaware)
- It might help. (Delaware)
- The more people we have wrapped around these patients the better. (Delaware)
- They are stakeholders. (Delaware)
- An additional non-doctor person is not needed; we get enough from insurance companies. (Schuyler)
- If they had providers educate patients more or a pamphlet for Medicaid people that describes what to do for various illnesses; a reference guide for patients. (Schuyler)
- The community should not. (Schuyler)
- We are all in this together, it makes my job harder when the providers are not communicating - we are a partnership anything we can do would help. (Schuyler)
- Community Organizations have the communication skills to connect providers and community organizations to create community out-reach programs. (Schuyler)
- The Medicaid patients are out in the community and they can help with that communication. (Schuyler)
- Community Organizations may interfere with HIPPA laws. (Tioga)
- I have no idea. (Tioga)
- Community Organizations should help re-enforce the providers teachings. (Tompkins)
- Compliance with information sharing will be increased by providers when it's perceived as a community norm or expectation. (Tompkins)
- I feel that if we start from the systemic perspective, then it would easier for providers to communicate. (Tompkins)
- Rural needs an urban needs differ for ambulance services. Nationwide attention towards how community programs may be better utilized. Mobile-integrated healthcare. (Tompkins)

Q39: Why do you feel that way?

n89[1]; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- Because pretty much the community organizations are a provider in some way or another. (Broome)
- Because we are all supposed to be working together. (Broome)
- Community Organizations are key players in patients care. Patients have an easier time communicating with community organizations where they may be fearful of speaking to their providers. (Broome)
- Don't think providers don't understand what issues might prevent them from completing the treatment plan that was suggested to them; lack of transportation. (Broome)
- I don't how they would be able to due to that with the privacy act/HIPAA rules. (Broome)
- The more information and the more people that can be reached, the more effective the healthcare system could be. (Broome)
- We all need to work together and encourage that communication. Make sure that we, along with other provides, work together and have a team approach which will improve the health of the community. (Broome)
- It's a team. It is team work. Everyone needs to do their part. (Cayuga)
- Community organizations are case managing clients; seeing them more frequently than a physician would see the patient. We can advocate to the primary and the specialist. There is some interaction between organizations, but there is also a disconnect. (Chenango)
- Community Organizations have the knowledge to help get everyone on the same page. (Chenango)
- Each organization has different staff and supports that they can offer. (Chenango)
- Feedback from community organizations can help the medical community better understand the 'world of their patients' by recognizing other factors such as: No heat? No transportation? Or other problems? These all contributes to reasons for ED visits. (Chenango)
- I think that we would have a better take on what people are going through and I think that the providers should get our opinions. (Chenango)
- It comes to supporting the individual clients need. Often it's confusing because the different organizations don't communicate with each other about needs for the client. (Chenango)
- The more they hear it, maybe they will start to understand it better. (Chenango)
- Those organizations have the ear of target populations; they facilitate more effective communication. (Chenango)
- Cortland has a lot of patients who may have challenges in understanding, and community organizations need to play a role in helping to educate people on what their providers are telling them and how to take care of themselves. (Cortland)
- If I get a referral and take the discharge, I send it directly to the PCP for better sharing of information. (Cortland)
- If the community organizations are not playing a role, that it is not going to happen. (Cortland)
- If we want the results, we have to work for them. (Cortland)

[1] 1 No Reply

Q39: Why do you feel that way?

n89[1]; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- It is hard for Medicaid/uninsured clients to advocate for themselves in securing appointments and communicating issues to doctors--this is often where community organizations step in. (Cortland)
- No one agency can be one thing to all people, everybody has the ability to play a role with that communication. (Cortland)
- There is no entity at this point that has taken responsibility to promote connection between providers. (Cortland)
- They're more 'out there'; they're more neutral and have a broader, more 'front line' access with the community they interact with. (Cortland)
- You don't want to double services. (Cortland)
- Because despite what they are saying, they are not listening. (Delaware)
- I believe that our agency really tries to encourage people to play a role in their own healing process instead of going to the ED all the time. (Delaware)
- We're an in-between point for patients that have difficulties in finding sources for advocacy and answers. (Delaware)
- Because I think that coming from an agency, there is creditability and as opposing to just hearing it from their patients. (Schuyler)
- Community organizations should communicate informational needs to providers/hospitals. (Schuyler)
- I don't think they understand. I think they need to be involved to know what it needed. More communication needs to happen between the people in the facilities. (Schuyler)
- Not a good idea because of HIPAA laws. (Schuyler)
- The management of the social determinants are certainly important to a persons healthcare. (Schuyler)
- We work closely with patients and providers to ensure effective communication. (Schuyler)
- Community organizations work directly with the clients and would be a great asset with communication with the clients. (Steuben)
- I think that often times the Medicaid and uninsured populations will reach out to community agencies before reaching out to providers. (Steuben)
- If people don't ask, nothing will happen. As long as it is not a conflict of interest. (Steuben)
- It's a community issue; there should be awareness and communication at all levels. (Steuben)
- I think that more education within the community; the stronger the community will be and they are linked together. (Tioga)
- I think they could act as advocates for people. (Tioga)
- It would cut down on a lot of the ED visits. (Tioga)

[1] 1 No Reply

Q39: Why do you feel that way?

n89[1]; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- I've worked for one and we have the most knowledge of the peoples' needs and the most frequent contact. (Tioga)
- They need to support the providers in the community. They are the resources that they are using in the communities. (Tioga)
- To help the patients get the best of care. They don't understand what the Dr. is recommending. We can help them get follow up and help direct them. (Tioga)
- We all have to do our part to help others; if all agencies try to communicate, making information more accessible should help the population get better care. (Tioga)
- Community organizations have more time to offer to spend with patients/ can dedicate more time to help with follow-ups and connect them with the services they need. (Tompkins)
- Community organizations reinforce the messages that come from the patients provider/providers. Community organizations should be at the table with the providers when the Medicaid/uninsured populations are being discussed. Will we be able to get all providers together, PCP's, Cardiologists, Etc., probably not. (Tompkins)
- If they are part of the overall healthcare system it would be beneficial if they were included. (Tompkins)
- It's not happening now; if there's not a third party involved, it's not going to happen. (Tompkins)
- Primarily they can support providers in understanding patient needs and how to reach out to that patient - still work is needed on the provider end. (Tompkins)
- Social Services, Drug and Alcohol should be separate unless patient consents. (Tompkins)

[1] 1 No Reply

Q40: What do you suggest for promoting better communication among the provider community and community-based organizations?
n89; Open-Ended

<u>I am a healthcare provider, physician, or practice manager in an organization that provides healthcare</u>

- A standardized electronic medical records system that would be shared between providers, community organizations and the patients themselves. (Broome)
- Computers need to talk to each other. There also needs to be teamwork with all members of the medical team, we all need to work together. (Broome)
- Continuing and increased uses of various portals like Info Help Link; data transmissions funnel into regional health records and are retrievable. (Broome)
- Having an incentive where someone in the community can take a position of leadership to help the community be aware of what is available and how to get it. (Broome)
- If everybody was using the same system for electronic records, that would help, realize not all practices can afford that, maybe supplementing cost would be helpful but not sure where the money would come from, having everyone on the same system is the best way to go-will take us all some time- maybe NYS could kick in some money! (Broome)
- Make a recourse guide online where providers could create entrees for organizations to provide medical information and recourses to patients. (Broome)
- Sharing records between hospitals at a distance from one another reduces the need for transportation as well as the time commitment. Use of a patient's primary physician should also be promoted. There should be one standard form with which patient information is recorded.(Broome)
- There needs to be a way to share communication between these populations. There are also HIPAA issues that restrict communication. There is also a time constraint between certain hospitals which limits access to information. (Broome)
- Everybody should adopt decent technology--emails, texting, electronic records. (Cayuga)
- No suggestions. (Cayuga)
- Decreasing the competition in healthcare. Focus more on the patient. (Chemung)
- A good review of what is authorized to share and remain HIPAA compliant. (Chenango)
- Education. So everyone understands how that links to ED visits and repeat hospital stays. (Chenango)
- Mentions HMO Kaiser Prominent (sp?) as example. Thinks patient info should be stored in one central unit with national reach (instead of one piece of info stored with a cardiologist, another with another doctor, etc.). Thinks this system would also help prevent medical fraud. (Chenango)
- More Case Management. They are the liaisons for the providers. (Chenango)

Q40: What do you suggest for promoting better communication among the provider community and community-based organizations?
n89; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- Food always works!! Promote seminars, use the pharmacy representatives. (Cortland)
- Given that most organizations use electronic records, being able to develop a software system that allows for better access to necessary information. (Cortland)
- It would be nice if they had a liaison that could take care of that because most of them are too busy to take care of that on their own. (Cortland)
- There needs to be a mechanism for us to talk to each other. We're all so busy that it is difficult to prioritize. Even in a small practice like mine, it is difficult to get a hold of me. I think this is where electronic information needs to come in, even thought many people get nervous about sharing information electronically. (Cortland)
- There should be a health-network-provider day where everyone can get together and share knowledge and ideas. (Cortland)
- Coalitions with purposes that are clear in English, not unclear what the purpose is and locally based. (Delaware)
- Go back to the way it was 25 yrs ago: doctors in private practice competed for patients and saw them when they needed to be seen. People looked for good doctors. Now insurance determines how to reimburse doctors; Medicaid does not reimburse properly. (Delaware)
- I think that if they had network meetings and after the meetings have discussion time where they can get to know each other and understand what the missions are. (Delaware)
- I think that there has to be some type of funding element; there needs to be some changes in regulatory requirements and get providers to buy in for better communication. (Delaware)
- Mandate relief from requirements that the state has on certain providers. (Delaware)
- More in service presentations; going out and talking to providers of what my office does; there is a lack of knowledge of specialty services. (Delaware)
- In Chemung County they have a group where "discharge planners" from the nursing homes to the hospital, meet and discuss patients that are being discharged from care. It's like an idea session and a good start. (Schuyler)
- It would help if the community based organizations would reach out to independent doctors to let them know about their services. (Schuyler)
- Providers to know more about them would help. (Schuyler)
- The Medicaid office can do some teaching with the physicians; that can be shared with the community. Education to people using the ER, when they don't need to. (Schuyler)

Q40: What do you suggest for promoting better communication among the provider community and community-based organizations?

n89; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- Education between both. (Steuben)
- Have some organization put together to promote services to the under-served by working together. (Steuben)
- More electronic communication. (Tioga)
- The more services the providers are aware of, the easier it is for providers to communicate their needs to the Community Based Organizations. (Tioga)
- At hospital level: starts with better discharge planning in trying to I'd. nonmedical needs that might result in readmission or ER visit. Patients are slipping through the cracks, especially in the relay of info to primary care physician. (Tompkins)
- Community support that helps teach patients to follow their providers orders and change lifestyles. (Tompkins)
- Maybe having meetings twice a year, so that providers can get to know each other and perhaps share perspectives. (Tompkins)
- Some sort of venue to connect the organizations; a care management meeting or something similar would probably be helpful. (Tompkins)

Q40: What do you suggest for promoting better communication among the provider community and community-based organizations?

n89[1]; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- Because we have the same patients. (Broome)
- Greater connectivity between providers via access to electronic health records, an example is automatic alerts to offices detailing when patients go to the ER. (Broome)
- Having a Health-Home organization/ Having a contact between the Community and the Provider to reach out to patients and providers as a go-between. (Broome)
- I think technology to some extent would be good, but in addition, it has got to be regulatory relief. (Broome)
- Patient-centered medical homes (a model); all treatment goes through a provider, so all is channeled through the PCP who decides on the patients needs and refers the patient accordingly. (Broome)
- Public service help (community outreach) on both client and provider ends; the better the communication, the better the health of patients. (Broome)
- The ability to share health records and information on the patients that have been seen, so that there could be a continue PCP medical record for all medical professionals to view. (Broome)
- You have to go to the people you want to reach, in their environment. Actually, in Wegman's there is a person who specializes in Medicaid services that is there and is able to talk to the public about this service. We need to provide people instead of paper work as a resource. (Cayuga)
- Having an Alcohol and Drug committee would help connect the lose ends between the two groups. (Chenango)
- I think that we should have meetings with community based organizations or surveys, even if it's a couple times a year. (Chenango)
- If they could develop a one-stop-shop for help within different health areas. (Chenango)
- Medical providers tend to be short staffed and they're just trying to stay ahead of the day-to-day patients needs. A bridge needs to be in place between the community/patient/provider. There's a huge demand on the practices. Attitudes need to change and infrastructure needs to improve, so there is more help and time to see what's actually needed. (Chenango)
- More flyers and pamphlets handed out; maybe the public health can handle that. Also, have a bulletin board posted in the ED waiting room area. (Chenango)
- Regular dialogue between the two. (Chenango)
- Sometimes it takes a firm commitment; there may not be follow through in some cases and issues fall by the wayside. (Chenango)

[1] 1 No Reply

Q40: What do you suggest for promoting better communication among the provider community and community-based organizations?

n89[1]; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- The providers need to have a better understanding of what's out there for their patients in the community and community based organizations should not try to be medical providers. Everybody should know their role and do what they can collectively to assist the patients. Providers don't always know what's available, for example, that can provide case management and advocacy. These resources have time that the medical community does not have. (Chenango)
- Computerization of medical records has improved communication, but there is still room for improvement. The patient portal is helpful, but not to those without computers. (Cortland)
- DSRIP is a good start- Promote electronic communication more- local paper promotion for greater interest in communication between health providers. (Cortland)
- Having the ability to have electronic communications. (Cortland)
- I don't know. (Cortland)
- In Cortland, we have offered educational series for PCP's, offers targeted operations, provides networking within health care providers, we have sat around the table to discuss what can be done to assist those patients in need. (Cortland)
- Incentives for providers to meet with community organizations more frequently. (Cortland)
- More transparency and less tart orally uses of resources. (Cortland)
- The hospital and Doctors' need to work together so hospital information can be live and can be accessed anytime during patient stays. Agencies need to put emphasis on sharing all information. (Cortland)
- Treatment team meetings between providers and community based organization. We are all working toward a common goal. It benefits the consumer. (Cortland)
- Faster responses--if we need answers now, we need them relatively soon, not days or weeks from now. (Delaware)
- I think that we need to be at the same place at the same time. (Delaware)
- Set up a network that is accessible to all healthcare and mental health providers. (Delaware)
- A way for providers to have more and easier communication (on behalf of the patients) with community based organizations, to get everyone on the same page and helping the community have a better lifestyle. Community organizations should lead this communication. (Schuyler)
- Participation of provider community with us in design of systems to service patients. (Schuyler)
- Regular meetings need to happen between organizations on a monthly basis. (Schuyler)
- Staffing. Once the computer systems get better state-wide with patient records and familiarity with using the records, things will improve. (Schuyler)

[1] 1 No Reply

Q40: What do you suggest for promoting better communication among the provider community and community-based organizations?

n89[1]; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- Tella-Health uses real-time encrypted technology for timely conferencing around patients including PCP, specialists, and community organizations which is particularly critical in rural areas. (Schuyler)
- The long term care council would be great place to start. (Schuyler)
- A communication program to share electronic information between all healthcare providers; and an easier way to communicate with providers. (Steuben)
- More single approach; there's so much information from various sectors. Somehow, information should be captured and become consistent, coming from one source. (Steuben)
- More time. I see it all the time. We can take the time to communicate things clearly. Providers do not have the time to do that well.   Things get lost in the translation, especially when the round hole and the square peg situations are there. Not enough follow up with support staff once orders are written. (Steuben)
- Perhaps some sort of initiative or incentive. (Steuben)
- All different forms of media, email, phone, newsletter, forums, meetings and follow up. Possibly having 1 person co-ordinate messages. (Tioga)
- Awareness of all employees of the available resources to advocate to the population. (Tioga)
- I think some kind of coordinated feedback from the community organizations to the providers, that is efficient in time management. (Tioga)
- If they could have something like a universal electronic record. (Tioga)
- Maybe a sharing of the statistics of what makes up the foundation of what brings the patients to the ED and maybe even a report going back to the provider to inform them that their patients are utilizing the ED. (Tioga)
- Some kind of universal consent so people don't need so many consent forms but can comply with HIPAA, but without so much red tape. Educate people on its existence so people can honor it. (Tioga)
- A shared goal or outcome - incentives are not aligned between these two groups - nothing right now to cause these groups to come together. (Tompkins)
- Ability to share electronic healthcare records, and bring these people together and have a discussion about promoting better communication. (Tompkins)
- An effective gathering to look at trends throughout the community to get collaborative feed back from both ends. (Tompkins)
- Can't think of any. (Tompkins)

[1] 1 No Reply

Q40: What do you suggest for promoting better communication among the provider community and community-based organizations?

n89[1]; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- Going through the local office managers committee to send out the same information to all practices. (Tompkins)
- I would suggest that providers interact with Community based organizations and listen to what they say and share what they are seeing. (Tompkins)
- Meet and discuss with all types of providers, especially mental health, the true meaning of HIPAA how it can be used as a road block to truly serve instead of how it was intended to be used. (Tompkins)

[1] 1 No Reply

Q41: Which of the following healthcare needs are **MOST CRITICAL** to address for the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Access to transportation	29%	14%	-	-	37%	34%	34%	33%	25%	43%	14%
Access to providers who accept Medicaid or uninsured patients	25%	14%	-	-	37%	11%	33%	-	50%	43%	29%
Provide education to Medicaid and uninsured patients to make them aware of their healthcare options	15%	14%	-	-	13%	22%	-	50%	-	-	14%
Healthcare needs to be more affordable for the Medicaid and uninsured populations	12%	29%	100%	-	-	11%	-	-	-	-	29%
There is a need for mental health services for the Medicaid and uninsured populations	19%	29%	-	-	13%	22%	33%	17%	25%	14%	14%

Q42: Are there needs that are missing or that are more critical? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	54%	71%	100%	-	50%	33%	33%	67%	50%	43%	71%
No	46%	29%	-	-	50%	67%	67%	33%	50%	57%	29%

Q43: What needs are most critical?

n51; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- All of this list important but number two would be access to providers. (Broome)
- Diabetes management. (Broome)
- Education is important. (Broome)
- Increasing awareness and education of mental health services. (Broome)
- More flexible provider hours; walk-in clinics are not as available in Medicaid populated areas. (Broome)
- One of the reasons it may not be affordable is abuse of the system, which drives up cost and decreased availability. (Broome)
- There are so few providers who accept Medicaid and those providers are overwhelmed. There are not many local provider options; so many Medicaid patients have to travel to Syracuse. (Cayuga)
- Uninsured people can be charged double what an insured patient would be charged. (Chenango)
- Education. (Cortland)
- Mental Health Issues. (Cortland)
- Access to providers. (Delaware)
- Alcohol and Substance abuse. (Delaware)
- In the rural counties, there are no psychiatric medication providers and general lack of professional work force. (Delaware)
- The patient education is important and more screening for behavioral health problems within the medical side of things. (Delaware)
- Access to affordable medications. (Schuyler)
- Access to specialty care is lacking in this area, possibly because they don't accept Medicaid and there are not a lot of specialists nearby. (Schuyler)
- Many providers don't accept Medicaid which makes it difficult to get care. Healthcare needs to be more affordable for everyone. (Schuyler)
- Getting Medicare fees and coverage sorted out more clearly to benefit the patient and provider. (Steuben)
- Substance abuse (Tioga)
- Housing is an issue that needs to be addressed. (Tompkins)
- Nutritional education and access to healthy food. (Tompkins)
- Those providers need to be supported in delivering care to the population from both a financial and a case management support. They don't get paid enough. Having support will help. (Tompkins)
- Use of nonmedical resources, how to apply them to community. (Tompkins)

Q43: What needs are most critical?

n51; Open-Ended

<u>I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee</u>

- Having healthcare be more accessible; examples include: if people have disabilities like language barriers, people in wheelchairs and cognitive disabilities. (Broome)
- I do think behavioral health is becoming an area where they need more access. (Broome)
- Making providers more accessible through Medicaid. (Broome)
- Mental health, dental, and access to specialists. (Broome)
- Time is important. Patients need a way to get to their appointments. (Broome)
- Preventative healthcare action is key to the pediatric population. (Cayuga)
- Case management services. (Chenango)
- Folks in mental crisis are told that no one can see you 'today'; they may need immediate crisis intervention. If people in crisis were able to get help to put things in perspective, a lot of situations can be turned positive. (Chenango)
- Some services are missing in the community, so people have to travel to get to the care that they need. They need convenient specialty care, especially dental care; it's impossible for this population and that leads to other issues. Also, there is a shortage of providers in general, as well as mental health providers and skilled counselors/physicians, regardless of your insurance. (Chenango)
- There is an education piece that's important to the consumer and Medicaid. Transportation is huge in this county, specifically lack of affordable means to reach providers. Medicaid pays for transports over 30 miles and I have clients who fall just 2-3 miles short of that. (Chenango)
- Housing for Medicaid or uninsured people. They are sent to homeless shelters. The problem of housing overtakes the need for healthcare. (Cortland)
- Make them understand their own responsibility and how to make them accountable. (Cortland)
- Of the list, transportation is definitely an issue and mental health and substance abuse issues are critical. We do not have any detox facilities in this area. Homelessness is also becoming a huge issue; it's all connected. (Cortland)
- Environmental issues; to reduce unhealthy living conditions. (Delaware)
- Access to Oral/Dental care. (Schuyler)
- Greater availability of dental services in the area and dentists that accept Medicaid. (Schuyler)
- Healthcare education. (Schuyler)
- I don't think the problem is with Medicaid. But, the uninsured are people who need to be made aware of what's out there and how they can get services that they cannot afford. They're not getting full checkups because of the cost of tests and blood work. (Schuyler)

Q43: What needs are most critical?

n51; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- All of the previous issues are critical. Home health managers are bridging the gap. We need staffing in this rural area; there are no dentists that accept Medicaid. We can't reduce ER visits without resources. (Steuben)
- Dental services. (Steuben)
- Overuse of pain Medication. Follow up to see if the person is using the controlled substance correctly. (Tioga)
- They have problems with finding dentists that take Medicaid and the same with eye care. (Tioga)
- Transportation; for the rural community, it is a huge barrier to accessing services. (Tioga)
- Culturally Competent care. (Tompkins)
- Equally as critical is having access to provider patient records who accept and treat the Medicaid/uninsured population. (Tompkins)
- Medication management. (Tompkins)
- Substance Abuse (Tompkins)
- The struggle for understand what to do in issues with substance abuse with this population. (Tompkins)

Q44: What are the largest barriers that Medicaid and uninsured patients face when seeking healthcare services?

n90; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- Accessing clinics or providers that accept Medicaid. Many private practices do not accept Medicaid. (Broome)
- Affordability. (Broome)
- More economics - they are not likely to just call a doctor to schedule a visit in private practices due to the likely hood of not being able to pay - they think about cost first. (Broome)
- Prejudice. People think they're less compliant. Poverty contributes to that. These populations cut corners and provider bias has come from that. They prefer not to care for them as reimbursement is so poor they don't want a large portion of Medicaid patients. (Broome)
- Provider hours/ Education level of patient. (Broome)
- Their own failure to act on good advice. (Broome)
- Transportation, lack of mental health care, lack of substance abuse care, lack of diabetes education. (Broome)
- Depending on where they live, finding ways to get themselves to where they need to be (due to a lack of a car and public transportation). (Cayuga)
- Hard to get a provider; there are few local choices. (Cayuga)
- Medicaid doesn't reimburse very well. They will pick the patients that have insurance that will reimburse. (Chemung)
- Availability. (Chenango)
- Lack of education. Transportation. Mental Health. Location of Providers. (Chenango)
- Lack of transportation and lack of education about the process; enrollment and maintaining their eligibility. (Chenango)
- Uninsured can't find out costs of prescription refills and medical services ahead of time, so they can't budget medical costs. Free clinic in Binghamton is inaccessible by those without transportation. People on Medicaid are usually low-income and therefore don't have their own transportation--have to use alternative methods which are often unreliable. Not all primary physicians take Medicaid. Those that do are often difficult to set appointments with. (Chenango)
- Discrimination. (Cortland)
- Failure of providers to accept Medicaid. (Cortland)
- Significant lack of specialists. When patients are able to access their primary care physician and are referred to a specialist, they often have to way to get there, as it is often out of county. Most primary care offices do offer assistance for patients to get to the referred specialists. (Cortland)
- Social Issues - broken families. (Cortland)

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n90; Open-Ended

I am a healthcare provider, physician, or practice manager in an organization that provides healthcare

- Total Care and Fidelis do a pretty good job of sending material, but there is a lack of understanding among patients that they call these organizations and ask for help. Part of me thinks that is out of shame. Getting around, particularly in Cortland, is extremely difficult if you don't have a vehicle. Public transportation is time-consuming--it takes 3 hours just to get to the grocery store and back. A lot of people can't take that kind of time out to visit a physician or specialist due to their jobs. (Cortland)
- Economic issues are large. (Delaware)
- Financial. Medicaid patients need a larger co-pay, so as not to abuse the system. Doctors need to charge uninsured patients less than the insured, but they cannot because that's considered insurance fraud. (Delaware)
- I think the limited supply of resources as well as the distance in geography to get to those resources. (Delaware)
- Physical access. (Delaware)
- That a lot of providers don't accept their insurance and transportation is a barrier. (Delaware)
- The uninsured face transportation issues and the Medicaid they need to have more education on the services available. (Delaware)
- Distance and inconvenience; transportation is an issue. If services are not local, the choices become limited. Pre-approval for special services. (Schuyler)
- Fear of the healthcare system as a whole - where do I go, how am I going to pay, where do I start, etc. (Schuyler)
- Finding providers that accept Medicaid. (Schuyler)
- Money. (Schuyler)
- No one accepts Medicaid or uninsured patients. (Steuben)
- Transportation is pretty significant. Education as to why they need to seek services. (Steuben)
- Financial Status, Limitations as to how they can function in society. (Tioga)
- Longer wait times. (Tioga)
- lack of options for community resources and how resources could help them, cultural mindset of ER preference, specialized services that people might not be able to access (considers this a smaller problem). (Tompkins)
- Self-advocacy, they have not been taught how to take responsibility for their own health. (Tompkins)
- Still not having enough providers to choose from. (Tompkins)
- Transportation issues, not being able to afford medications, co-payments, healthier foods and not able to access appropriate mental health services. (Tompkins)

Q44: What are the largest barriers that Medicaid and uninsured patients face when seeking healthcare services?
n90; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- Access to transportation to get them to their appointments, lack of knowledge about what good health is like, be aware of certain health symptoms and need to be more educated on certain areas like poor health habits. (Broome)
- Economic issues/ Social status/ Language/ Transportation. (Broome)
- Finding a provider, availability of clinics, finding the "right" provider. (Broome)
- Lack of money. (Broome)
- Medicaid services could be limited on what they offer; a lot is free, but dental is very limited (there may be others). Financial issues could be critical. (Broome)
- Trying to find a provider that accepts Medicaid and this way they wouldn't have to go to the ED. (Broome)
- What Medicaid will cover for Medicaid recipients. (Broome)
- The largest problem is that they do not have a doctor. They can't even pay a co-pay, even if they have insurance. People who are on Medicaid go to the ER because they know they don't have to worry about paying for it. (Cayuga)
- For the uninsured patients, it's the cost and for Medicaid, it's the access to coordinated care. (Chenango)
- They have no idea what is available to them and what their coverage is. (Chenango)
- Time; waiting for an appointment. (Chenango)
- Transportation and available providers that accept Medicaid. (Chenango)
- Transportation and available providers. (Chenango)
- Transportation in rural areas. (Chenango)
- Transportation, but it's improving. Cost for uninsured people or under insured, they are less inclined to seek help because of the costs. (Chenango)
- Understanding the system of how to use it and when to use it. When trying to figure out who is available, they are not always seeking help in a timely or preventative manner and wait until the situation is critical. This includes the care, medicines and behaviors. (Chenango)
- Access to transportation to get them to their appointments. (Cortland)
- Accessibility to the services that exist. (Cortland)
- Education- knowing what is available to them/ Transportation. (Cortland)
- Finding nearby quality regular physicians and specialists that accept just Medicaid or uninsured patients. (Cortland)
- Housing and education. Mental Health services. Alternatives for Mothers of children who need Mental health treatment so they are not afraid that Child Protective Services are called. (Cortland)

Q44: What are the largest barriers that Medicaid and uninsured patients face when seeking healthcare services?
n90; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- I think part of it is, from the mental health area, is that treatment is available and people do not realize this, economics play a large part with what Medicaid/uninsured patients face on a day to day basis. Patients must decide where it is best to spend their monies, transportation to appointments, groceries, gas to go to an appointment. (Cortland)
- Providers that accept Medicaid; the working poor on Medicaid and the primary care services are not readily available on weekends and evenings. (Cortland)
- Transportation/General accessibility to PCPs. (Cortland)
- Uninsured patients need access to somewhere other than the ER. There is no other option for them. We need healthcare for people who work PT and have no insurance and are in the gap where they don't qualify for Medicaid and they can't afford Obama care. (Cortland)
- Access to providers that accept them. Economic issue because Medicaid and uninsured on the lower end of the economy. (Delaware)
- Need free or cheap transportation options. Low-income people cannot afford most current transportation services. They also might have to take on another job or find a babysitter. (Delaware)
- Transportation and lack of information of services available. Also, they have not been treated well in the past so there is a lack of trust. (Delaware)
- Finding a PCP that will assist them. (Schuyler)
- Housing--patients can't further improve themselves (via mental health services or healthcare services) if they have to devote their efforts to maintaining housing. Someone to help patients navigate the current healthcare system and keep their physicians and specialists informed (which is the patient's responsibility). (Schuyler)
- Stereotype or previous experiences providers have had with these populations. For example, if a provider has seen a lot of Medicaid patients not show up to appointment, they may feel more inclined to not take these patients. (Schuyler)
- The hours of availability. (Schuyler)
- Transportation, Access to providers who accept Medicaid/uninsured, Lack of care management. (Schuyler)
- We won't turn anyone down for lack of insurance. The ones that abuse the system take away from the ones that really need it. (Schuyler)
- Access to transportation. (Steuben)
- Access to Transportation. Cost of the actual services themselves. (Steuben)
- Major issue here is from home health managers who understand what is expected and what they have to do. Not all people read well or understand they need extra support. (Steuben)

Q44: What are the largest barriers that Medicaid and uninsured patients face when seeking healthcare services?

n90; Open-Ended

I work for an organization that provides community outreach, long-term care services, or I work as a non-clinical healthcare industry employee

- Transportation and not understanding how 'things work' in terms of healthcare services and understanding the processes. (Steuben)
- Availability of providers that will accept Medicaid and transportation. (Tioga)
- The mental health clients are not educated enough in preventative care or understanding the importance in going to the ED. Also, due to their medical illnesses, they are sometime too paranoid to go. (Tioga)
- Transportation access. (Tioga)
- Transportation and fear; some people on Medicaid don't feel they're getting good care. (Tioga)
- Transportation to providers. (Tioga)
- Transportation. Access to care. Cost. Lack of knowledge. (Tioga)
- Accessing PCPs and dentists. (Tompkins)
- Affordability, transportation are very large barriers. Taking off work for patients who do work. Bureaucracy. Cultural Competency - knowing how to speak to people in a manner that they experience as respectful. Whether because of their ethnicity, their gender, their socio-economic status. When people need out of County medical services transportation is difficult. (Tompkins)
- Limited provider access. Therefore they don't get second opinions; they have to rely on the advice of one provider. (Tompkins)
- More providers/ Transportation (Tompkins)
- Poverty creates a lack of options for people, it's more than just one health need that's the issue, social issues factor in, critical needs meaning quite often there are multiple and chronic needs such as chronic disease combined with mental health issues; all of this together makes it very difficult for someone to navigate a confusing healthcare system; when needs arise after hours and weekends you cannot get these needs met in the community so the only resource is the ED which drives people to use it more often. (Tompkins)
- There are a lot of people waiting to receive Medicaid which is a barrier; there is a real lack of mental health support; and a real lack of focus on self management. (Tompkins)
- They don't comply with the same rules that the commercial would have to follow. (Tompkins)

Q45: Are these barriers unique to your county or geography served? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	21%	14%	-	-	25%	33%	-	17%	25%	29%	14%
No	79%	86%	100%	-	75%	67%	100%	83%	75%	71%	86%

Q46: Why or why not?

n52; Open-Ended

- An externally high need for patients to have better access to services such as an interpreter/better transportation/ providers that accept Medicaid or Uninsured. (Broome)
- Don't practice beyond the county. (Broome)
- I think it's due to the Medicaid reimbursement system. (Broome)
- It pretty much is spread throughout the Southern Tier. (Broome)
- Just because of doing research and feedback from attending conferences. (Broome)
- The plan (Medicaid) is consistent across the board and has limits. (Broome)
- We don't have the monopoly on uninsured patients. I think this population has similar problems/issues with healthcare. (Broome)
- In my opinion, the populations who use Medicaid share this mindset. (Cayuga)
- All rural areas. (Chenango)
- Because I really feel that the majority of people that are on Medicaid are uneducated and a poorer community. (Chenango)
- Because it's a problem everywhere; at least in upstate NY. (Chenango)
- Because we are so rural. (Chenango)
- I think that the cost for uninsured folks are high, no matter where they are and the Medicaid folks deal with a lack of providers. (Chenango)
- It's not unique to the area; it's a reflection of our national healthcare system as a whole. The economics of healthcare: insurance, lack of insurance, limited funds. Money is always a factor. (Chenango)
- not regional; this problem exists in at least four counties I work in. (Chenango)
- There have been a lot of cut-backs and the number of providers that are accepting Medicaid patients is declining; that leads them to the ED. Also, they can get a free taxi to ED, but not to the providers. (Chenango)
- I am not familiar with other counties barriers. (Cortland)
- I don't believe so. (Cortland)
- It is a universal problem. (Cortland)
- It's a system issue, everywhere. (Cortland)
- Just the way the public transportation is set up; they don't have the funding needed to address those needs. (Cortland)
- Most counties included in the STRIPPS are geographically the same. (Cortland)
- Services are available, but in other counties. (Cortland)
- These are issues that could arise anywhere. (Cortland)

Q46: Why or why not?

n52; Open-Ended

- We work with TBI waiver. Traumatic Brain Injury. We are the largest. We import people from NY, NJ. because there aren't allot of resources. They fail out or decide not to participate and they become our homeless. (Cortland)
- Doesn't think they are unique to her county. Service is lacking, not enough providers. (Delaware)
- For our agency, we are the only substance abuse agency in the whole county, and we are difficult to get to. (Delaware)
- I think a lot of this has to do with lack of training to prepare people to work with high risk populations. (Delaware)
- It's all through the country. (Schuyler)
- I've spoken with healthcare providers in other counties and they feel the same. (Schuyler)
- Lack of availability of affordable housing. Also, the state has a home health initiative (case management) which is loosely in place, but it is purely voluntary--most patients in the program are difficult to engage with or unwilling due to mental health issues. (Schuyler)
- These issues are very wide spread to people who are on public insurance. (Schuyler)
- This county is one of the poorest in the state. (Schuyler)
- We do not have an urgent care center like they do in some of the larger areas. (Schuyler)
- Barriers are consistent everywhere; cost of public transportation is most difficult and varies between rural and urban areas. (Steuben)
- I think they are common in rural areas. (Steuben)
- In the rural areas transportation is much more of an issue than in the cities. (Steuben)
- Our program is statewide. But urban or rural everyone has trouble paying for their services. They can't take time off. It is all about cost. (Steuben)
- I think that they are unique within the rural community. (Tioga)
- I think these would be the common obstacles. (Tioga)
- The larger community looks down on people on Medicaid; it happens everywhere. (Tioga)
- These barriers are more geared to the population that we serve. (Tioga)
- They are in all areas. (Tioga)
- This area is primarily rural. (Tioga)
- Because no matter where you are, the barrier exists. (Tompkins)
- Happens everywhere. (Tompkins)
- I think that these are just typical of healthcare currently. (Tompkins)
- I've worked in different counties and these issues have remained the same. (Tompkins)

Q46: Why or why not?

n52; Open-Ended

- They are more unique to rural Upstate New York. (Tompkins)
- Transpiration is particularly difficult in Upstate NY. (Tompkins)
- We are more rural then some counties. (Tompkins)
- We are more rural then some counties. (Tompkins)

Q47: What needs to be done to overcome these barriers for the Medicaid and uninsured populations?
n52; Open-Ended

- 1) Make Medicaid simpler by having the ability to bill directly. Eliminate complicated billing. 2) Easier to be able to do through offices (private practices.) (Broome)
- Advocacy and More Funding/ More communication from providers. (Broome)
- Having the clinical providers be able to send consumers to the appropriate resources in the community. (Broome)
- Insurance reform. (Broome)
- Need to have a basic healthcare program (basic level of healthcare) that does not have any co-pays. I think uninsured populations do not think about their day to day healthcare needs and instead think of the catastrophic, because those are the plans they can afford. (Broome)
- Start out with the educating of the community and access to affordable medical care. (Broome)
- There have to be more providers involved in the Medicaid program. Options tend to be limited once one is on Medicaid versus people who have commercial insurance and then get into the situation where Medicaid is their only option. (Broome)
- Healthcare needs to be more affordable. They need to have their own doctor and practice preventative healthcare. (Cayuga)
- By educating them. (Chenango)
- Coordinated care programs, either through outreach agencies or providers. (Chenango)
- Funding for transportation. (Chenango)
- I have no specific ideas at this time. (Chenango)
- I think we need to improve the public transportation for the Medicaid population and bring in more providers that accept Medicaid. (Chenango)
- It will take a long time. There needs to be a huge change in the healthcare delivery system to make it better functioning. (Chenango)
- More providers that accept these patients, especially the uninsured and make a workable payment plan. (Chenango)
- There is a level of personal responsibility. We as a society need to get rid of bad habits and manage chronic diseases that stem from poor life styles. Awareness of how it affects health. More education about what diseases do to a person. People need a basic level of healthcare. (Chenango)
- Education, education and education of the client. (Cortland)
- Having affordable insurance. (Cortland)
- Health home needs a case manager and they have to touch base twice a month, maybe just a phone call. It really needs to be more frequent and also should require them to go to the home. (Cortland)

Q47: What needs to be done to overcome these barriers for the Medicaid and uninsured populations?

n52; Open-Ended

- Many of these barriers are so large that it is going to take leadership starting from state government level on down. These aren't easy or simple problems. It requires investment up front, with both political and agency advocates, should be at the forefront of the solutions. (Cortland)
- More availability of providers who take Medicaid; locating services available evenings and weekends. (Cortland)
- More time spent in the provider/patient relationship; more accessible healthcare/preventative care. (Cortland)
- Our county needs to agree to use some tax money or funding to assist with transportation problems. (Cortland)
- Transportation (there is some Medicaid sponsored transportation, but it is not sufficient), or more locally available physicians and specialists. (Cortland)
- Transportation needs to reach out to more rural locations to ensure access to healthcare- Possibly a pay differential to make up for distance. (Cortland)
- Government-funding for satellite offices for community agencies. Better spread of localized services. (Delaware)
- There needs to be a better connection between healthcare providers and the targeted population. There needs to be more outreach and community based outreach connecting with people where they live. (Delaware)
- Threshold--look at what we rate as poor and eligible for benefits. Top of threshold is way too low. There are people who make too much to qualify for Medicare and just do without. (Delaware)
- Better communication--hospitals need to look outside their walls and look to community organizations for help. Some kind of incentive or education for the Medicaid populations to engage with help (community organizations, healthy living practices like exercise). The onus is all on the system--perhaps some of this should be transferred to the patients. (Schuyler)
- Care management for both children and adults. (Schuyler)
- Communication with the proper people to see what can be done. (Schuyler)
- Educating and helping them understand the importance of the yearly doctor visit and following-up with doctors. Also, making health a priority. (Schuyler)
- Make something more affordable for the hard working people that cannot afford insurance. For Medicaid, reducing the service, like paying for non-emergency visits to the ED. (Schuyler)
- We need to expand the hours for of the free clinic that we have in this area. Also, we need an urgent care center. (Schuyler)
- I think that we need state funding support to provide transportation options. (Steuben)

Q47: What needs to be done to overcome these barriers for the Medicaid and uninsured populations?

n52; Open-Ended

- In this county, we have worked very hard to give more programs to help these populations with transportation. Perhaps these issues could be addressed when communicating with providers. Also, there could be an increase in bus routes. (Steuben)
- Increased communication and a holistic approach for both providers and clients. (Steuben)
- We need to rethink how we deliver what they need, their services in general. Office hours. Availability of appointments. Do we need to re-evaluate how we do this? Laws of rule and order say that things need to make sense. But what if I have time now and do not have time later, this is what happens with appointments and ED visits. They cannot take time off from work. (Steuben)
- A coordinated system for transportation that considers both the providers and the patients and increasing Medicaid rates for PCPs. (Tioga)
- Expand the number of taxi services or additional companies throughout the county that serves Medicaid clients. (Tioga)
- Huge social issue; there should be better PR. There are many people on Medicaid; down on their luck and need the services. (Tioga)
- Just more education. (Tioga)
- More opportunities for people to get help, education and hand holding. (Tioga)
- More people working together with more money with a common goal to help. (Tioga)
- More professionals in the area. (Tioga)
- Larger numbers of accessible providers (Tompkins)
- More physicians accepting Medicaid and more awareness of the Affordable Care Act by the uninsured populations; outreach at food pantries, etc. (Tompkins)
- Opening up the pool of providers who can and will treat these patients; I believe it is the incredibly low reimbursement that providers receive - especially mental health services. (Tompkins)
- Reduce poverty. Medicare for all. The way that our food system incentivizes non healthy food especially for people who are poor. (Tompkins)
- There are a number of providers who do not want to take Medicaid clients due to the characteristics that this population has. (Tompkins)
- They should be held responsible for missing an appointment and not being compliant. (Tompkins)
- To reach the goal there needs to be viable community based alternatives for people to access and they need to be accessible after hours and on weekends. (Tompkins)

Q48: Do you think language is a barrier to receive healthcare services for most of the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	29%	43%	-	-	25%	11%	33%	33%	50%	29%	29%
No	71%	57%	100%	-	75%	89%	67%	67%	50%	71%	71%

Q49: Is language a barrier to receiving healthcare when English is not the patient's primary language (difficulty comprehending English)? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	15	3	-	-	2	1	1	2	2	2	2
Yes	87%	100%	-	-	100%	100%	100%	100%	100%	-	100%
No	13%	-	-	-	-	-	-	-	-	100%	-

Q50: Do you believe doctors explain care in a way that the patient can understand? Single Response[1]											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	14	3	-	-	2	1	1	2	2	2	1
Yes	27%	33%	-	-	-	-	-	-	50%	50%	-
No	73%	67%	-	-	100%	100%	100%	100%	50%	50%	100%

[1] 1 No Reply

Q51: Do you think racial diversity or lack of cultural sensitivity is a barrier to receiving healthcare services among the Medicaid and uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	44%	43%	-	-	13%	44%	67%	83%	50%	14%	71%
No	56%	57%	100%	-	87%	56%	33%	17%	50%	86%	29%

Q52: For what reason(s) do the Medicaid and uninsured populations use the ED even though it is unnecessary?

n52; Open-Ended

- Access to the ED is 24/7 and if they need something, critical or not, the ED is a 'fall back.' There are patients with issues who go to the ED rather than a walk-in center or wait for the PCP office to open. Transportation is provided to the ED by Medicaid. (Broome)
- Because they do not have a connection to the clinic; it's a tradition to go there and hospitals have a bigger presence in the community. (Broome)
- First off, it's because the PCPs and specialists are not available to address their healthcare needs. Unmet mental health care needs bring people to the ED and chronic illnesses are not addressed appropriately and the consumer doesn't seek medical assistance when they should. (Broome)
- It's easy. They know they will be treated, they don't need to have an appointment, and they will receive everything they need in terms of healthcare. (Broome)
- Largely due to reimbursable services; the ED shouldn't be as reimbursable, preventative care is cultural. (Broome)
- Quick access/ can not be turned away/ ED has open hours. (Broome)
- They don't have an established PCP and can't find a provider to accept Medicaid. There is also a transportation problem. (Broome)
- There is a certain population who will use the ED for stupid reasons and this is the problem that needs to be worked on. This population has grown up with this mindset and the healthcare industry knows and understands that this will be the case. (Cayuga)
- Because it's paid for; it is free for the Medicaid population. (Chenango)
- Because they don't have their own doctor. The emergency room is there and it's quick. Insured people have their own doctor and get regular check-ups. There's a lack of understanding in the uninsured and Medicaid populations about why this is important. (Chenango)
- It's accessible/open; the doctor is not available at 1AM, but the ED is available. (Chenango)
- It's easy and convenient. (Chenango)
- The primary reason is because they do not have access to any providers besides the ED and the ED will not turn them down. (Chenango)
- There are times when their employers request a written documentation that they are not able to work due to an illness. (Chenango)
- They can not be turned away, may not have a PCP, not good at planning for future appointments. (Chenango)
- We have no other options, there are very few other options and providers are full. (Chenango)
- "Quick-fix" mentality/ lack of support system. (Cortland)
- A lack of connectivity to a PCP or therapist, some of it is not having adequate community support to help them, for some it is a social void and going to an ED may help the person fill that void. It goes back to the decision making that these patients have to make, money for gas to get to a medical appointment or buying groceries and medications, etc., or going to the ED, prompt care etc. (Cortland)

Q52: For what reason(s) do the Medicaid and uninsured populations use the ED even though it is unnecessary?

n52; Open-Ended

- Because it is convenient. (Cortland)
- Emergency transportation will only take them to the ED for example, they will not transport to urgent care. Also, there is a lack of natural and/or peer support during off hours. (Cortland)
- Inability to use preventative services/ transportation not available in rural locations/people looking for more intrapersonal contact/long waits and overbooking by PCP's. (Cortland)
- Patients aren't able to get an appointment for 2+ days, so they use the ER. Some patients visit because of loneliness. (Cortland)
- Somebody to talk to. Lonely, no one to talk to. All alone. They just want company. (Cortland)
- Someone who is not literate and gets instructions. They cannot read them or follow them. CHS, weight gain. No primary care physician. Depression. (Cortland)
- They don't know any better, it is how they've always done it. They need to be better educated on ways to get care. There needs to be better access to care. (Cortland)
- Easier, don't have to keep providers. Feeling frustrated with being able to get providers. Weekends and evenings are the hardest for population with mental health needs because that is when support is unavailable. (Delaware)
- Most people on Medicaid or without insurance believe that emergency care will be covered without prior approval, while other care would not. Substance abuse scenarios are often seen in the ED. (Delaware)
- That population tends to be inexperienced when it comes to planning and either they think that they cannot afford the services or they delay their issues until the health condition really hurts. (Delaware)
- Assisted living is sending people to ED for non emergency situations.. Patients looking for pain medications. (Schuyler)
- ED is open 24/7, while doctors' offices aren't--doctors should offer more hours, and more nontraditional hours. Transportation is also an issue, so patients pick a nearby option, which is the ED. Dental problems and children's health issues often result in ED visits. (Schuyler)
- Lack of access to providers who accept Medicaid/uninsured. People who have substance abuse issues/mental health issues or both who can not develop a primary care relationship. (Schuyler)
- Medicaid patients don't worry about costs and they want to get services when they want them. Uninsured probably do not have a regular doctor. (Schuyler)
- Perhaps it might be the hours of availability. (Schuyler)
- They might go for a migraine, dental issues or child care issues. (Schuyler)
- Access to basic care, dental emergency and behavioral health issues. (Steuben)

Q52: For what reason(s) do the Medicaid and uninsured populations use the ED even though it is unnecessary?

n52; Open-Ended

- It's easier to get a friend to take you to the ER rather than a medical appointment and some urgent care providers do not take Medicaid populations. Also, if you do not have a provider that you see on a regular basis, they may choose the ER. In their minds, the ER is just easier. (Steuben)
- Many reasons. They don't have access to services; limited doctors for Medicaid patients. The system is complicated; often it's a culture issue. The ER is the easiest resource where needs are always met. That approach must be broken to get them access to care providers that offer those services. Our population is not often well received. (Steuben)
- There is a struggle where they don't know the difference between an Urgent Care and an ED. It's a waiting time. When they want to go they want to go now. No wait time. It is something they try to do at night because they work. The ED is more anonymous than a doctors office. Uninsured, not for profits can't turn you away. Doctors offices can turn uninsured away. (Steuben)
- A lot of times they are going to the ED for something they don't need emergency services for like a rash that they think needs immediate attention at the ED, which is not a necessity. (Tioga)
- Because they can get an ambulance, so they have transportation. Lack of preventative care. In some cases, it's easier to get pain medications or narcotics in the emergency room. Lack of other services during evenings and weekends; primary care, walk-ins. (Tioga)
- I think one big component is for dental issues, substance abuse, mental health and primary care services. (Tioga)
- Lack of hours that are convenient for the patients, lack of urgent care in a reasonable geographical area, lack of transportation, mental health needs and assurance that you will be seen by an emergency room doctor. (Tioga)
- They don't have a medical home so they use the ED. They go for a cold, ear infections, headaches. (Tioga)
- They will use emergency medical transport (ambulance) to Lourdes just to get a ride downtown. (Tioga)
- Transportation; ambulances can pick up and get to the ER. They wait too long; something simple becomes a crisis because the patients wait too long. They can't turn you away when you show up at the ED. Doctors may do that. At lease at the ED, they know they'll be seen. (Tioga)
- For lack of understanding of the need of the ED - there seems to be a habitual routine from these populations - the lack of PCP's available to this population - mentality of patients thinking this is a one stop shop instead of having to go to several different appointments. (Tompkins)
- For the rural, transportation is an issue; they rely on the ambulance. Also, knowledge of what type of doctor to see for their current problems. Poor chronic disease management. (Tompkins)

Q52: For what reason(s) do the Medicaid and uninsured populations use the ED even though it is unnecessary?

n52; Open-Ended

- It is common practice for providers to refer some patients to the ED that may be suicidal or threatening harm to others; lack of other options; after hours/weekends availability; lack of regular relationship with a PCP. (Tompkins)
- Lack of providers; the time it takes to get into a providers office; lack of knowledge of when an ED visit is needed; providers direct patients they don't have time to see to the ED. (Tompkins)
- People feel they have nowhere else to go. Not aware of other resources. 1/4 of our patients say that if the free clinic wasn't here they would go to the ED. Uninsured with no PCP. (Tompkins)
- They will go for any primary care needs. Particularly if they cannot find a PCP that will accept them. Also, the system has been trained to send people there, and the Medicaid population will then use the ER for a toothache instead of a dentist. (Tompkins)
- Upper Respiratory, pain management, stomach pain, gastro, high fever. Common cold things. (Tompkins)

Q53: What can done to reduce inappropriate ED utilization among the Medicaid and uninsured populations?

n52; Open-Ended

- Case management; preventative programs that involve education. (Broome)
- Communication; identify why they're going to the ED. Some situations may be appropriate, but others not. (Broome)
- Follow-up care/ More social-work interaction. (Broome)
- Get them established with a PCP and have the ability to make the appointment. (Broome)
- It's a matter of education and making sure people are aware of clinics they can use instead of the ED. Also, they can be educated on preventative healthcare. (Broome)
- They need to be using healthcare by seeing their doctors and better communication between the doctors and consumers. There needs to be some case management put into place and if they are high risk, have a case manager follow up with them until they are stable. (Broome)
- To make less expensive places to receive urgent care. These places need to be as easy (in terms of no appointment and money upfront) as the ED. They also need to be informed about this new option. (Broome)
- It would be nice to be able to say, "You are not here for an emergency, please leave." There needs to be education on what and what not to use the ED for. (Cayuga)
- A better understanding of disease and ailments; being able to prioritize and better discern if it's something that needs hospital attention or can be treated by OTC medications. (Chenango)
- Better access and more providers; if the providers could get reimbursed a percentage for accepting the at-risk, uninsured or Medicaid population. (Chenango)
- Education is critical. (Chenango)
- Increased PCP care, accessible PCP care and a non-emergency after-hours clinic. (Chenango)
- Maybe penalize them for unnecessary ED visits. (Chenango)
- More accessibility to walk-in clinics / Education on what is considered life-threatening/ Learning not to ignore symptoms. (Chenango)
- More education. (Chenango)
- Some patients have mental health or drug/alcohol issues; if there was something in place instead of the ER. If we had the rest of the healthcare as easy or accessible to use, it would reduce. Also, some illnesses are managed better by the primary care doctor and it could be avoided. (Chenango)
- Beside education, they have to held accountable and directed elsewhere. (Cortland)

Q53: What can done to reduce inappropriate ED utilization among the Medicaid and uninsured populations?

n52; Open-Ended

- Community support. They are not available on weekends. They are not available at night. Crisis lines are called because they just want to talk. Connect people with their peers so they had someone to reach out to. (Cortland)
- For chronic ED abusers, we tell them to think longer on their decision to use the ER or consider if they would still visit the ER if they would have to pay for the service. However, patients don't really retain this in the long run. (Cortland)
- Hot-line to be advised on what to do until they have access to a provider. (Cortland)
- I would say from the moment the individual starts receiving care, ask why do they use the ED instead of the PCP, find out who is a high user and work backwards to find out why. (Cortland)
- In the heat of the summer we see a lot of respiratory problems because they have no air conditioning. There is a community action program funding for air conditioners but it runs out quickly. (Cortland)
- Increasing accessibility to PCPs (greater number of PCPs available)/ Increasing rural transportation/assist local agencies in promoting/funding peer support groups or general support groups. (Cortland)
- More community based prevention services. (Cortland)
- Some sort of transportation option to, like urgent care versus the ED and additional development of support services in the community during the off hours. (Cortland)
- Crisis line for mental health--peer sponsored for lonely, scared, etc. Having services past the 9-5 time frame that most doctors offer. Communication and education about alternate methods of taking care of mental health & related issues. (Delaware)
- More accessible, affordable alternative services. More satellite offices of substance abuse agency. (Delaware)
- The establishment of more PCPs and clinics throughout the area; community health educators that can reach people where they live and educating them on the value of preventive care and how to manage their conditions. (Delaware)
- By educating them so that they can understand all of their options and expanding transportation options. (Schuyler)
- Developing a successful relationship with Primary Care Providers. (Schuyler)
- Having Medicaid patients find a PCP that they are comfortable with and having a resource that they could call and ask questions to, instead of going to the ED. (Schuyler)
- Healthcare clinics, so the uninsured can get a lower cost. Medicaid may use it, if put into their contract to use them or pay out of pocket to use the ED. (Schuyler)
- More accessible hours for family practitioners within walking distance. Someone to help patients navigate the healthcare system could help set up appointments. (Schuyler)

Q53: What can done to reduce inappropriate ED utilization among the Medicaid and uninsured populations?

n52; Open-Ended

- You can't refuse to send them in an ambulance. I don't know. (Schuyler)
- I don't know. (Steuben)
- I think more available options and better access. (Steuben)
- Increased community services; home health managers to educate and work with individuals. (Steuben)
- Letting them know the difference between the ED and Urgent Care. Reduce the barriers for them to get to their PCP. (Steuben)
- Address the needs; lack of hours that are convenient for the patients, lack of urgent care in a reasonable geographical areas, lack of transportation, mental health needs, assurance that you will be seen by an emergency room doctor and talk to the Medicaid and uninsured populations about their concerns and problems. (Tioga)
- Charge a co-pay. Better education and insistence on preventative care by Medicaid or the funding company. Provide a care manager. Insure transportation to the preventative services. (Tioga)
- Education. (Tioga)
- Education. (Tioga)
- Increase primary or urgent care facilities that accept Medicaid. (Tioga)
- Just more of the education. (Tioga)
- Maybe they need some cost sharing to be implemented. (Tioga)
- Access to more providers; education on the different levels of service where the appropriate place to access help would be; advocacy by providers to offer better options then directly attending the ED; i.e., urgent care or on-call nurse (Tompkins)
- Education or targeted outreach may not work, but maybe satellite physician offices in key areas. There are probably hubs that see more uninsured and Medicaid patients than others. (Tompkins)
- Everything I mentioned above along with private practices changing the way they have conducted business, expand hours/days of week opened, etc. Improve literacy and educate the Medicaid/uninsured population as to what a true "emergency" is and what it is not. (Tompkins)
- Increased provider communication, increase access to more appropriate areas of care evenings/weekends, reducing the barriers by trying not to bundle patients needs. (Tompkins)
- More access to healthcare. And reeducation to providers and Medicaid population on how to use ED. (Tompkins)
- Reduce poverty. More Primary care providers. Improve health literacy. (Tompkins)
- They should have a copay to go there based on their income. (Tompkins)

Q54: What would help the Medicaid population better understand when and when not to use the ED?

n52; Open-Ended

- Communication, which should start at the provider's office. Public service ads or commercials could help educate the population about appropriate ED usage. (Broome)
- Get the provider in place to educate the Medicaid and uninsured population. (Broome)
- Have the doctors educate the consumers on what kind of ailments they should be going to the ED for. (Broome)
- Having someone they can call to say this is my issue and can my medical need wait; being able to educate them on when the best times to use ED services. (Broome)
- I think they use it because they sense an unavailability of other options. So they need to be educated on other options (like this free clinic) that they do not currently know exist. (Broome)
- More education by providers. (Broome)
- Public service announcements; what works and what is important and this is the place to go to for this, that is the place to go to for that. (Broome)
- A personal relationship with a PCP or with a clinic would help. (Cayuga)
- A combination of education and regulation; if folks were referred to an appropriate facility and outreach education. (Chenango)
- Availability to providers and outreach agencies; have a document that they can use to educate their clients. (Chenango)
- By educating them and also having more walk-in clinics available. (Chenango)
- Easy to understand directions. (Chenango)
- Education; services should be outlined for patients when at the ED, so they understand their options if this occurs again. (Chenango)
- Maybe posters, advertising and public service announcements. Advice in public areas with simple suggestions like hand washing, stay home with a fever and don't send Johnny to school with a temperature. Public health push using cartoons on posters/pictures; something flashy or catchy; people may pay more attention. (Chenango)
- More education on what is life threatening. (Chenango)
- People need to understand who and when to go to get medical care. Education and knowing that there is care available and not just instruction. The availability of easy access care is critical as an alternate to the ED. (Chenango)
- A combination of education from the service providers and some examples from peers and supports services. (Cortland)
- Education and awareness of what a true emergency is and what is not. Goes back to sharing between the providers that the patient is involved with, both physical and mental providers. (Cortland)

Q54: What would help the Medicaid population better understand when and when not to use the ED?

n52; Open-Ended

- Education by case management on when an ED visit is appropriate. (Cortland)
- Education. (Cortland)
- Education--understanding what kind of symptoms require an ED visit. Educate patients on what symptoms are common to their chronic condition, how to cope with anxieties and mental symptoms. (Cortland)
- I think it's an education issue; provide incentives for them. If they're getting good care in the primary care community with follow-up, they shouldn't need to be using the ED as much. (Cortland)
- Not admitting people when they are using the ED improperly. Call the 24 hour nurse line. (Cortland)
- PCPs educating patients/ Community education/ Case coordinator-manager directing their patients. (Cortland)
- Important to let patients/consumers know that there are alternate solutions--often it is possible to wait overnight and get in touch with providers the next day. Build support groups around patients/consumers. (Delaware)
- More information available for the public. Maybe a general mailing tool for those currently on Medicaid. (Delaware)
- Providing more education in a way that people can understand. (Delaware)
- Education coming from their PCP. Many people in the population are living in an emergency state, and PCPs need to educate this population on what medical issues are and are not an emergency. Also, PCPs need to educate them on how to be proactive about their health. (Schuyler)
- Education has been tried, but the patients live so in the moment that it is hard for them to plan ahead. Having a personal "navigator" for patients who could assess them and redirect them to appropriate services. Perhaps a kind of pre-triage function to assess the needs of the patient in an office setting before flagging. (Schuyler)
- Education. They want the attention. They will call an ambulance. (Schuyler)
- Effective care management, for example, telephone triage with a nurse, making care management available 24/7, co-location between primary care and substance abuse centers. (Schuyler)
- Maybe give them a printed list. (Schuyler)
- When they get on Medicaid they should be told to only use the ED after they've called the doctor (maybe print a magnet) so they understand this. If they abuse the ED services, they should be charged at least a minimal amount to reinforce the guidelines. (Schuyler)
- At the time folks apply for their insurance coverage, they could have that conversation. These conversations could also happen with healthcare providers. (Steuben)

Q54: What would help the Medicaid population better understand when and when not to use the ED?

n52; Open-Ended

- Education. (Steuben)
- Education Campaigns. Full participation for all providers. It has to be everybody. Long term consistent education. (Steuben)
- Providers can help with that in educating patients. (Steuben)
- Education. (Tioga)
- Feedback at the emergency room, especially when they were seen and it was not necessary. If people were charged a co-pay after a second unnecessary visit, it would reduce the ER visits. Or, if there was a financial incentive to see their primary doctor, when they've done something positive. (Tioga)
- Having a regular medical doctor and the ambulance services need to put a stop to it. (Tioga)
- I don't know. (Tioga)
- Maybe some education and training. (Tioga)
- Primary care with walk-in service that they knew was available at any time; should be more accessible and knowing they would not be turned away. (Tioga)
- Some kind of a reward system for not using the ED at inappropriate times, with assurances that true ED emergency visits will still go to the ED and if they could have some type of triage system to determine when it is appropriate to go and when not to go. (Tioga)
- A very involved publicity campaign/ Public Education/ Real-life examples in educational material. Cohesive message across the board. (Tompkins)
- Better education, a care coordination plan where they can talk to someone about where to go to get all of their needs met. (Tompkins)
- If they feel like they have someone they can call that is encouraging them to call when they need to figure out what they need to do. (Tompkins)
- Patient education about specific conditions, for example, diabetes, chronic disease management, cardiac heart failure, educate as to what the warning signs are of a diabetic episode or heart/stroke warnings, the patient needs to know when to contact their PCP for direction and when the issue might be able to wait until daytime or weekday when the PCP is available and not going to the ED because they are not sure. This is especially true when it comes to children with breathing problems, ear aches, temperatures etc. (Tompkins)
- Right now there is no consequences when patients use the ED instead of their PCP - changes within the ED need to be made, educate patient what the ED is used for, turn patients away when needed. (Tompkins)
- The emergency department refusing to see them and having someone there to find them a PCP to see the next day. (Tompkins)
- When they make an inappropriate ED visit, being told that next time this happens, this is what you should do. (Tompkins)

Q55: What can healthcare providers do to help the Medicaid and uninsured populations better understand when to appropriately use the ED?

n52; Open-Ended

- Communication; education with the patient who has inappropriately used the ED. They need to learn their options. (Broome)
- Educational fact sheets; fevers, pain, follow up phone calls, better communication and doctors available after-hours. (Broome)
- Encourage them to use the right services. Give feedback on their ED habits. (Broome)
- Greater coordination and ongoing contact between patients and providers. (Broome)
- Teaching the signs and symptoms of when to use the ED and follow up with doctor visits and educate them. (Broome)
- They basically can reach out to the consumers and educate them by giving them written materials or something on audio if they cannot read for them to review. (Broome)
- Training on what is life-threatening/ in home discussions/ in-office counseling about what the ED is for and when to use it. (Broome)
- Providers need to educate them on how to react to certain healthcare issues. (Cayuga)
- Better communications with their patients. (Chenango)
- Discernment; information about when to access ED care and where to access other care. (Chenango)
- Everyone needs to give them the same message. This is when and why you should go to the Emergency Room. (Chenango)
- Having time to explain to the patient of when and who to call. Patients need a clear 'road map' to available care and access to providers. (Chenango)
- I don't think there is anything that can be done, not until the other issues are addressed. (Chenango)
- Medical providers should take extra time to explain what to do 'next time.' Provide medical care and counseling for future similar situations. Offer simple ideas on prevention, such as: 'try this at home'. (Chenango)
- Offering public education/ flyers and pamphlets located in ED. (Chenango)
- To tell them when they are abusing it or not. (Chenango)
- Education and awareness between providers, both PCP, Mental Health Providers, and Specialty Groups. (Cortland)
- Education by service providers, it is really critical. (Cortland)
- Explain things in easier to understand language and be very specific in relation to their diagnosis. (Cortland)
- Having health educators in the offices and the community, like case management; to teach people on an individual basis and to teach people what the ED is for and what it's not for. A small group seems to massively abuse the services, so case management may be able to teach them alternatives. (Cortland)
- Having pamphlets/ something in print available to explain - 211 availability- triage nurses working to explain if ED visit is necessary. Drug stores hold clinics for non-emergency situations, for example "the common cold." (Cortland)

Q55: What can healthcare providers do to help the Medicaid and uninsured populations better understand when to appropriately use the ED?

n52; Open-Ended

- If all of the agencies were on board for the effort, it would really make a difference. If all agencies repeatedly told the Medicaid or Uninsured the same thing repeatedly. (Cortland)
- Make sure people understand what physical conditions are normal and abnormal for individual patients, what conditions can wait and what can't, and how to deal with small problems on their own. Most doctors do not seem to have time for this. (Cortland)
- Providers should go over in more detail what is to be done if any difficulties should arise after a visit/ written information. (Cortland)
- They could have some sort of system that could identify them ahead of time so that they can be recognized for their poor habit of using the ED. (Cortland)
- Education--providers need to have appointments accessible for Medicaid and uninsured patients. Providers must also communicate. (Delaware)
- Explain to them what reasons to use the ED and possible alternatives. (Delaware)
- They can become part of the community that plans and develops community education. (Delaware)
- A follow-up by the doctor after the ED visit to explain why the ED visit was unnecessary. (Schuyler)
- During a doctor's visit the provider can guide them to know what an ED visit is or not. When they are applying and approved for Medicaid, give them a printed guideline of ED visits versus PCP visits. (Schuyler)
- Education in their offices and working with community organizations to increase communication. Perhaps PCPs could hand out information to community organization clients at events or on open food pantry days. PCPs need to put information where the Medicaid population can find them. (Schuyler)
- Effective patient education using health literacy best practices and cross-culturally confident staff. (Schuyler)
- Perhaps a kind of pre-triage function to assess the needs of the patient in an office setting before flagging. By diverting the patient before treatment, resources and time could be spared. Pro-active healthcare habits like regular physicals should be promoted. (Schuyler)
- They try to correct it but hit brick walls. The office of the Aging provides but they are terribly understaffed. DSI is also understaffed. (Schuyler)
- I think that is an educational process and that has to do with referrals and preventative care. (Steuben)
- Practices can talk about options that are available and steps to take. Create relationships with those clients. (Steuben)
- They are limited on time so it can be mentioned at a well visit. Business card flyer that is a reminder of what to do after hours if there is an emergency. List options for these populations. They must tell them, "Don't forget". Reminders and reinforcement at each visit. (Steuben)

Q55: What can healthcare providers do to help the Medicaid and uninsured populations better understand when to appropriately use the ED?

n52; Open-Ended

- They should have a conversation about it with all Medicaid recipients and the uninsured populations. Providers are told when patients use the ER, so this conversation should happen appropriately. (Steuben)
- Educate the populations and offer incentives when preventative measures were taken. (Tioga)
- Give more knowledge about their health issues and encourage them to use the answering service to see if the ER visit is necessary. A doctor may be able to advise over the phone, the reassurance may prevent ED visits. (Tioga)
- Just educate them. (Tioga)
- More information and training to let people know when to call. Community medical care. Longer office hours, open visits. (Tioga)
- Promote a medical home. Educate. (Tioga)
- Reviewing the cases and the times that they've used the ED for the individual patient and go over this with the patients. (Tioga)
- They can communicate and role play to make sure that the patient can respond appropriately; making sure that they are understanding what appropriate ED usage is. (Tioga)
- Again, education, care coordination, and retraining providers on appropriate ED usage. (Tompkins)
- Education in the moment of working with each patient. (Tompkins)
- I believe I answered this in the question above, but all healthcare providers should spend more time on educating the patient either at discharge from the ED but most importantly healthcare providers need to educate more during regular office visits. (Tompkins)
- If they follow-up with the healthcare provider after an emergency room visit, the provider should emphasize why the visit was unnecessary. (Tompkins)
- It's not just these populations who overuse the ED - providers need to understand and educate the patients as to what is appropriate and what is not. (Tompkins)
- Make it clear to them how to appropriately use the resources available at their PCP. Making it possible for people without insurance to have a one time annual well care visit. Reducing poverty. (Tompkins)
- More pamphlet information given to patients when they get Medicare. (Tompkins)

Q56: What will have the largest impact on reducing the number of non-emergent ED visits by Medicaid and uninsured patients?

n52; Open-Ended

- Care Management/ Care Coordination (Broome)
- Community based services and basically accessible affordable healthcare. (Broome)
- Education and public service announcements. (Broome)
- Getting the appropriate providers to accept Medicaid and adjusting the reimbursement rate; they need to be more appropriate. (Broome)
- Goes back to communicating to the patient so they know what is acceptable for an ED visit. (Broome)
- Having affordable other options available that are well publicized and known to the population. (Broome)
- Medicaid reform; if they refuse to approve to pay for those unnecessary services, that will motivate them to use their PCPs. (Broome)
- Actual free and affordable clinics and doctors available, with longer hours. (Cayuga)
- Alternative providers and somewhere to seek non-emergency care. (Chenango)
- Education (Chenango)
- Everyone; it would be a huge savings on our state and government. (Chenango)
- Have a stronger system to help with mental health as well as people with chronic illnesses that are hard to manage. (Chenango)
- It won't change overnight; educate the public with a publicity campaign: radio spots and public service announcements, so that people can make a better judgment before going to the ED. (Chenango)
- It would reduce the cost for the county and/or state. (Chenango)
- Providers or all who work with individuals need to pass along the same messages. (Chenango)
- Quality of life will improve. (Chenango)
- Education and financial responsibility. (Cortland)
- Education on when it is appropriate to use the ED. (Cortland)
- Faster appointment times. It is difficult to get an appointment. There are no walk in appointments. (Cortland)
- I would worry about the hospitals being able to surviving. (Cortland)
- Identifying integrated care among healthcare providers, from medical records staff to all physicians to behavioral health system - consistent message on how to treat the individual throughout all who treats the patients. (Cortland)
- Immediate access to PCPs directly. (Cortland)
- Mental health and substance abuse population is overusing ED, so that's the group most needing focused help. (Cortland)
- Repetition by every agency that encounters them. (Cortland)
- The rest of the population who will not be able to get in and see a PCP when they need to. (Cortland)

Q56: What will have the largest impact on reducing the number of non-emergent ED visits by Medicaid and uninsured patients?

n52; Open-Ended

- Having more walk-in appointments available with PCPs. (Delaware)
- Having providers available during off hours. (Delaware)
- Social service departments could organize informational days or meetings for Medicaid clients at signup or another time. (Delaware)
- All aspects of health care working in sync. (Schuyler)
- Education; getting information out to as many people in this population as possible. Also, encouraging them to tell their friends, since people in this population tend to be closely knit. (Schuyler)
- For Medicaid, the rules should be enforced by a co-payment. The uninsured should have a clinic for care at reduced cost. (Schuyler)
- It's hard to say unless all groups are together and know what all are doing. (Schuyler)
- Pre-triage service. (Schuyler)
- The ED refusing a visit that does not constitute an emergency. (Schuyler)
- Health Prevention in general. Knowing what would be appropriate. Better educated about their own health. I would go where I am not going to get a lot of questions and where I would not get pressure about how I am going to pay for it. Getting insurance for everyone would break all those barriers. Better access to their regular doctor. (Schuyler)
- Provide resources and discuss options with patients. (Schuyler)
- The presence of alternative services such as urgent care and continued education. (Schuyler)
- The services that healthcare support organizations provide. Care management is a big asset to reducing this. (Schuyler)
- A lot of programs simultaneously doing intervention. (Tioga)
- Being educated, possibly having a case management support staff that they can reach out to or maybe having something like a direct nurse line to call. (Tioga)
- Financial disincentive; it's expensive and time consuming to utilize an ER versus more appropriate preventative care. (Tioga)
- Having the on-call doctor reassure them, rather than suggesting the ED. Possibly, suggesting a visit during office hours; after getting information from the patient to determine if an ED visit is really necessary. (Tioga)
- If the ED visits weren't paid for or certain things were covered and eligible. (Tioga)
- It affects the cost. (Tioga)
- Ongoing medical care and people to be more educated. (Tioga)

Q56: What will have the largest impact on reducing the number of non-emergent ED visits by Medicaid and uninsured patients?

n52; Open-Ended

- Better patient self management and care coordination. (Tompkins)
- Having a coordinated system wide approach to change including non hospital providers who must be included in the mix. (Tompkins)
- Having a co-pay. (Tompkins)
- In depth, cohesive educational campaign. (Tompkins)
- Making sure that there are appropriate and accessible services available to this population within the community. (Tompkins)
- Reducing poverty and making healthcare accessible for everyone. Education can help. (Tompkins)
- The satellite/physician offices open for a few hours a week in different communities. (Tompkins)

Q57: What can be done by providers to ensure Medicaid and uninsured patients are not re-admitted to the hospital within a 30-day timeframe?

n52; Open-Ended

- Care coordination is the key! Poor follow-up when these patients are discharged from the hospital. (Broome)
- Clinical staff following up after discharge from the ED and care coordinating/case management and access to community based services and support. (Broome)
- Coordination of care; the PCP must diagnose the patient's needs and then direct them appropriately. Quality of care is important. Healthcare providers are looking at bundled payments; you check a patient for the episode (i.e., broken arm/specific illness.) Look at the event and the care/follow-up that will be required (i.e., surgery, hospital time, therapy) and then bundle all costs to ensure that the patient knows in advance what costs to expect for the procedure. Geisinger Health System is an example of bundled payments. (Broome)
- Follow up care/access to after hours for PCPs/at-home check-ins. (Broome)
- It is not all the providers' responsibility; it should be shared with the staff in the hospital and the appropriate follow up care should be in place. (Broome)
- That patients get enough time in the hospital. Physicians may feel pushed to get them out early. (Broome)
- The ability to get more timely appointments with PCPs, or PCPs providing extended hours to serve the working Medicaid and uninsured recipients. (Broome)
- Providers can be a patient's advocate for staying in the hospital to continue to get treatment in order to get healthy. (Cayuga)
- Good discharge planning. (Chenango)
- Increase identification of root cause analysis. (Chenango)
- Make sure there is a follow-up with the patient, by someone at the hospital or the doctor to make sure the issue that put them in the ED doesn't reoccur. (Chenango)
- Make themselves more available. (Chenango)
- Proper care at discharge and follow up. (Chenango)
- Take time to emphasize the discharge plan and make sure the patient understands it. Mention consequences of not following the discharge plan, but there is no control once they get home. Hopefully, they've understood the discharge plan. (Chenango)
- Teaching the patient basic health-care routines. (Chenango)
- With follow-up care. (Chenango)
- A delay in giving them their benefits. (Cortland)
- Following up appointments after discharge. (Cortland)

Q57: What can be done by providers to ensure Medicaid and uninsured patients are not re-admitted to the hospital within a 30-day timeframe?

n52; Open-Ended

- Follow-up contact by case coordinator to verify proper actions taken after discharge. (Cortland)
- Frequent general follow-ups with patients. (Cortland)
- Homecare referral. Care transition coordinators. More case management after discharge. More case management at the PCP level. (Cortland)
- I don't know. (Cortland)
- If people are eligible for care coordination, making sure all healthcare providers are aware of the patients time in the ED, and follow up. If there is some sort of tool that brought you here in the first place that could be shared among all involved. (Cortland)
- Immediate follow up on their discharge from the hospital, as well as the patients being active in the discharge plan. (Cortland)
- Quick follow-up care with education on how to deal with the problem for which the patient was originally admitted. (Cortland)
- Immediately transfer all information from ER to primary physician, encourage physician follow-up. However, doctors will not follow up if they aren't paid. (Delaware)
- Part of re-admittance is caused by patients being chased out of hospitals earlier than necessary, partly for money/insurance reasons. Providers must look at patients more as individuals rather than costs to a hospital. (Delaware)
- That has a lot to do with the follow-up care after the discharge and how it is handled. (Delaware)
- Active use of patient registries that are built around certain chronic conditions, and use of health-care teams that work more efficiently, especially in rural areas. More effective and efficient use of electronic records systems. (Schuyler)
- Better treatment. Qualified people in there. The PA's do not seem qualified. I wouldn't want to be seen by them. (Schuyler)
- I'm not sure on this one. (Schuyler)
- Make sure patients are stable before sending them home. Communicate with patient or caretaker after discharge to reinforce proper use of medications, proper self-care, etc. A better on-call system after hours (like home care) would allow patients to receive services without visiting the ED again. (Schuyler)
- Making sure that they follow and understand the discharge instructions. (Schuyler)
- When leaving, they should have a follow-up appointment set up with a PCP within a few days. Stress the importance of this follow-up. (Schuyler)
- Communication and being more inclusive, regarding the treatment options. Better follow-up after the hospital to avoid additional visits. (Steuben)

Q57: What can be done by providers to ensure Medicaid and uninsured patients are not re-admitted to the hospital within a 30-day timeframe?

n52; Open-Ended

- Following up with the patients and making sure they understand what they were told when they were discharged. (Understanding discharge papers.) (Steuben)
- Greater follow-up and outreach into the homes; perhaps maybe have better case management in place. (Steuben)
- They need to work on policy so the insurance companies cannot control things so they are not being discharged too early. Proper education while they are in the hospital. Educate them on what they need to do so they do not come back. They leave early and are not ready and they go back to their "environment" they will just end up back if it is too soon. They are insecure and panic, so they come back. Doctors need to join together and fight for better policy for insurance companies and hospitals. (Steuben)
- Appropriate care upon discharge and follow up care. Come back and be seen. More Home Health Care Nurses would be awesome. (Tioga)
- Education and checking in on the person to make sure they are doing alright; maybe by giving them a case worker or social worker. (Tioga)
- Encouraging them to follow-up with their physician, either in-person or by phone. Remediation and care services; it makes people feel like their being cared about.(Tioga)
- Making sure that they have their medications and refills. (Tioga)
- Making sure they are receiving the right care the first time. Clear discharge instructions. (Tioga)
- Some type of care manager upon discharge who can follow-up with the patient on discharge recommendations. Do a better job ensuring that the patient understands the discharge recommendations and plans to following-up to ensure that the recommendations are followed. If there was a care manager in the ER, patients could work with the care manager at discharge to resolve any barriers such as how to get to follow up appointments, get medications, etc. Verify that the person's benefits will cover the medications that are prescribed and if a prescription cannot be filled, patients disregard and don't fill prescriptions. This leads to being re-admitted because the original problem was never resolved/cured. (Tioga)
- They have to be responsive to the patients complaints and educate them better about their health conditions and what to expect. (Tioga)
- Being accurate with discharges plans - medications, follow-up, This takes time and our current way does not allow for this extra time needed. (Tompkins)
- Collaboration with community services/ More communication with community services. (Tompkins)
- Follow-up after getting out of the hospital is really important. Ensuring that patients understand their own follow up care. (Tompkins)

Q57: What can be done by providers to ensure Medicaid and uninsured patients are not re-admitted to the hospital within a 30-day timeframe?

n52; Open-Ended

- Hospitals need to have people in the community, like a case manager. Once someone is discharged, follow-up with patients that they are concerned with may come back. A case worker can follow-up to see that medical/safety recommendations are being followed to avoid repeat visits. (Tompkins)
- If it is serious enough they should be kept for observation and make sure they are ready to leave the hospital. (Tompkins)
- Make sure it is easy for the patient to follow up in a timely and affordable and accessible way. (Tompkins)
- See if patient has accessibility to care management like a home health agency, to coordinate all aspects of their care and to work with a family caregiver if the patient has someone appointed. Utilize proven care transitions including coordinated care at discharge; ensuring medications are disbursed and what to look out for at home, and when to call the PCP etc. (Tompkins)

Q58: What can be done by community-based organizations and community outreach to ensure Medicaid and uninsured patients are not re-admitted back to the hospital within a 30-day timeframe?

n52; Open-Ended

- A mobile crisis team and case management making sure that they follow through with the discharge plans. (Broome)
- A need for visiting nurses and case management. (Broome)
- Education, advocacy, support, and peer networking. (Broome)
- For the high risk patients, they should be passed along to certified home health agencies. (Broome)
- Have a role to educate people on what their options are and ensuring that their other needs that are impacting their care can be taken care of. For example, if someone was discharged from the hospital and could not go to the grocery store to get food, there is a way for them to get someone to help them get food from the grocery store. (Broome)
- Patient communicating needs; improving communicating skills. (Broome)
- That this population gets support by negotiating with a doctor to get extended hospital stays. Need support available at home to follow-up with home care. (Broome)
- Follow-ups and education to keep on top of what brought them into the hospital and what needs to be done to not let that happen again. (Cayuga)
- At discharge, a referral could be made to a community based organization so the organization can do follow-up at home visits or telephone follow-up. Questions that a doctor may not have time to follow-up on. (Chenango)
- Better communication between the healthcare field and outreach organizations. (Chenango)
- Follow their care and making sure that they are taking their medications. (Chenango)
- Follow through on discharge plans. Sometimes people don't understand what's expected of them. (Chenango)
- Provide some follow-up with home visits and phone calls. (Chenango)
- Really good in discharge planning activities; these organizations should be part of the discharge planning and "connecting the loop" (Chenango)
- Teaching basic health routines/ Public Health out-reach/ Teaching the importance of preventative care and follow-ups. (Chenango)
- Work with providers to address the issues that cause readmissions. (Chenango)
- Assurance that some level of contact is made to follow-up on after-care. Sharing medical information between medical and community services to better ensure support. (Cortland)
- Better support with future care. (Cortland)

Q58: What can be done by community-based organizations and community outreach to ensure Medicaid and uninsured patients are not re-admitted back to the hospital within a 30-day timeframe?

n52; Open-Ended

- Certain community services and support can help. Since they're not a medical provider it could be a tricky insurance area. Maybe utilize the 211 system, which will help people find available services rather than the ED. (Cortland)
- Communication between provider and community organizations in the discharge process. Sometimes our clients are in the hospital and we are not aware of it, so we can't follow up. (Cortland)
- Easier access. Weekend and night hours. Encouraging them to use other support. Connections. (Cortland)
- Homecare referral. Care transition co-ordinators. More case management after discharge. and at the PCP level. (Cortland)
- Just more education. (Cortland)
- Making sure the staff is connecting with individuals immediately upon discharge from the hospitals and that they are following up with the discharge plans. (Cortland)
- Part of the same story - if patients are shared throughout community organizations - must take the time to research and are aware that their patient has been in the ED and follow through with the ED, providers involved and the patient. (Cortland)
- A better partnership with providers. (Delaware)
- MCAT (mobile crisis assessment team) is used. MCAT took over crisis hotline, have a representative in a mental health clinic from four of the nearby counties. Does face-to-face assessment of patients in crisis situations. Based out of Herkimer county area. If patients know there are alternative services out there, that may help. (Delaware)
- More involvement from public organizations. Not a lot of funding for groups that help people in recovery. People need more interaction with smaller community-based services--this might pull them away from ED use. (Delaware)
- Educating them, providing services, and support. (Schuyler)
- Follow up when they are released. (Schuyler)
- Getting the population to understand that support programs exist which could prevent them from having to go back to the hospital. (Schuyler)
- Help support the patient after discharge--make sure patient understands medications, follows prescribed diet, has proper housing, practices self-management of chronic conditions and practices pro-active health habits. (Schuyler)
- If they were contacted by the ED, to follow-up with the patient in a home visit. Give them information to avoid re-admitting. (Schuyler)
- More community organization participation within DSRIP. (Schuyler)
- Access to services and resources as well as communication to ensure that all parties know what is available. (Steuben)
- For them to be aware of what their community and local resources are so that when help is asked for they can redirect them to these services. They need to be more aware of each other. (Steuben)

Q58: What can be done by community-based organizations and community outreach to ensure Medicaid and uninsured patients are not re-admitted back to the hospital within a 30-day timeframe?

n52; Open-Ended

- Greater access to better services, clinical care and participating in case management. (Steuben)
- Insuring these organizations follow-up with these populations after they are released from the hospital. (Steuben)
- Assist in the education. (Tioga)
- Encouraging a healthy life style, and keep checking with a recent ED patient. HIPAA can be a barrier, but just some basic non-invasive follow questions may be helpful. (Tioga)
- Making sure that they have an appropriate amount of contact for follow up. (Tioga)
- Perhaps let the community know of community resources to assist them in recovering. (Tioga)
- Release of information from providers to let us know that the patient was discharged we could follow up with the patient to follow up on discharge instructions. (Tioga)
- They can take on the role of being a contact to the patients to ensure that things are going well, so that they do not have to be readmitted back into the hospital. (Tioga)
- Try to connect them to a care manager or referral to care management. Education on what transportation is available. Sometimes, advocating with managed care companies to see that the medication is available and payment arrangements are made. (Tioga)
- Better connections with the hospitals - making sure that the hospital can support that patient after discharge. (Tompkins)
- Educate them on steps to take after. They need more informational brochures. They should take an informational test when filing for Medicaid. (Tompkins)
- Knowing who this population is and keeping in contact with them/ Provide support (Tompkins)
- Making sure these patients understand what the doctor's directions are for follow up care. (Tompkins)
- More support in place for chronic disease and self-management programs. Sometimes it is regimented and too difficult for people to follow. (Tompkins)
- Partner with the hospital to provide needs/services such as transportation, home delivered meals, etc. The community based organizations along with the providers need to share patient information in order to provide services. (Tompkins)
- They can work with patients to address the issues that they have. Essential for providers to communicate what is important to their health and ask how they can make that happen. (Tompkins)

Q59: How well do you feel the Medicaid and uninsured populations manage their chronic conditions compared to the general population? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Medicaid and uninsured manage them better	8%	-	100%	-	13%	-	33%	-	-	14%	-
Medicaid and uninsured manage them the same	6%	-	-	-	-	-	-	-	25%	-	29%
Medicaid and uninsured manage them worse	86%	100%	-	-	87%	100%	67%	100%	75%	86%	71%

Q60: Why do you feel that way?

n52; Open-Ended

- Because of the nature of chronic conditions themselves. They require more time and attention and they affects their lifestyles. (Broome)
- Health literacy is low. (Broome)
- Hypertension, obesity, and smoking are chronic conditions which are expensive. It's hard for this population to be well educated enough to make positive changes for themselves to prevent continued and worsening of the condition. Patients sometimes need small goals to help them improve themselves. (Broome)
- I don't think this population visits their doctors often enough. They are not educated about their chronic condition, or they cannot afford to do what they need to for their chronic condition. (Broome)
- These populations are uneducated on how to care for a chronic condition, and have no support (Broome)
- They don't have the follow up steps in progress. They also don't have the necessary prescriptions, and they don't take the medication once they are discharged. (Broome)
- They often cannot afford access to a healthier lifestyle, which precludes them from being able to maintain a healthier lifestyle. (Broome)
- If Medicaid persons have coverage, they are quick to come in and get it taken care of. However, uninsured persons are the exact opposite and should not be included. (Cayuga)
- A combination of many things going on in personal lives and managing chronic illness is a 24/7 activity. It takes a lot of hard work and the population doesn’t always have the resources to manage the stress of the illness and care of same. (Chenango)
- Because when things are going well they are able to get the treatment and devices that they need. (Chenango)
- I feel that the lack of knowledge and importance of their health is why. (Chenango)
- It's a mix of education, personality, and physical capacity. (Chenango)
- So much is going on for those families that something must take a back seat. Often it comes down to the health issues. Issues like heating, clothing, and feeding the family are the priority. When there's a toothache or cough/cold the health issue will come last. (Chenango)
- The uninsured have the issue of money. It’s a matter of socio-economic circumstances. Not everyone on Medicaid is well educated, which may be an issue. (Chenango)
- They don't understand the importance of it, can’t afford it, and have other things on their minds. (Chenango)
- They seem less educated about healthcare. (Chenango)
- I have seen it. Someone with Hepatitis, knows he has it and won't follow up with his diagnosis. Providers tell patients that if they don't follow up they will be dropped from their practice. Providers need to be more compassionate and less strict. (Cortland)

Q60: Why do you feel that way?

n52; Open-Ended

- It's the education issue; with knowledge comes awareness. Fewer resources; they're busy struggling with daily needs: buying food, cooking, ability to get to work. Choices become critical and it's cheaper to eat poorly than well. Transportation is an issue; keeping a car running as low income people have a whole host of issues. (Cortland)
- Lack of health literacy, and priorities. (Cortland)
- That their judgment is not always so accurate. (Cortland)
- The lack of resources. (Cortland)
- These patients have a greater amount of barriers then general population. They may not have the same information, or know how to access to find out about their conditions. (Cortland)
- They do not have access to as many environmental supports that could help them manage basic care. (Cortland)
- They often have more complicated needs that are more difficult to address in general. Level of understanding on what the condition is and how to manage it may not be the same with the Medicaid/uninsured populations. Unfortunately they also seem to lead less healthy life styles. (Cortland)
- Uninsured are much worse. If they don't have insurance, they don't go to have chronic conditions managed and wait until there is an emergency. Medicaid patients manage them about the same as the general population because finances are not a huge concern. They manage to get some regular routine care about every few months. (Cortland)
- Because they lack the experience and the resources. (Delaware)
- Medicaid and uninsured have easier access to EDs. Instead of trying to deal with their symptoms and working with a therapist or doctor for coping skills they run to the hospital. (Delaware)
- Medicaid system is less complicated than private insurance. (Delaware)
- Because of the emergency state of mind they are living in. They do not feel empowered to take care of their health. (Schuyler)
- I think that when the Medicaid and uninsured are having to worry about how they are going to take care of themselves and their basic needs. Their health is one of last things they are focused on. (Schuyler)
- Income and family stability. (Schuyler)

Q60: Why do you feel that way?

n52; Open-Ended

- Medicaid manages better and the uninsured manage the worse. (Schuyler)
- There is a certain percentage of patients that lack planning abilities and foresight. This percentage is also health illiterate. The uninsured also don't manage their conditions because they cannot afford to do so and therefore wait until an ED visit to have the conditions looked at. (Schuyler)
- They abuse the medications and they let themselves go. They don't take their health as a priority. (Schuyler)
- Access to resources. Understanding options that are available. (Steuben)
- From experience; I think there are people who manage it well and people who don't on both ends of the spectrum. (Steuben)
- I think there are challenges to accessing medical services, and they don't practice preventative care. (Steuben)
- Lifestyle, education, resources. (Steuben)
- I think they are trained to come to the ED as their safe guard, and don't have as much support in their homes. (Tioga)
- I think they wait until it gets to the worse scenario because they don't have money to cover the cost. It could also be their education level. (Tioga)
- Less access to services, knowledge, and opportunities. (Tioga)
- Many do not take medications, or see doctors because of access or affordability. (Tioga)
- Many people have Medicaid due to a disability that impacts their ability to manage their care needs. (Tioga)
- Not knowing what to do, the information or having the ability to reach a doctor or transportation. (Tioga)
- They tend to get in to see their specialists more versus someone who is not insured. (Tioga)
- Because of the effects of poverty. Poverty makes it more challenging and creates fewer options for people. (Tompkins)
- I assume they don't go to the doctor as often, possibly they're uninsured, so they wait until it gets bad and then go the ER. (Tompkins)
- I think that the general, Medicaid, and uninsured populations manage all the same - I think we hear about chronic conditions more often now a days through the media mostly. (Tompkins)
- It varies so much. (Tompkins)
- Less resources emotionally, physically, and financially. (Not enough money means they will not have access to healthy food). (Tompkins)
- They manage them better because they know how to work the system. (Tompkins)
- Unsure (Tompkins)

Q61: Are there unique challenges that the Medicaid and uninsured populations face with regard to managing chronic conditions? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	92%	86%	100%	-	100%	100%	100%	83%	100%	71%	100%
No	8%	14%	-	-	-	-	-	17%	-	29%	-

Q62: What are those challenges?
n48; Open-Ended

- Access to provider care and make the appointment. Or, have an established PCP, nurse practitioner, or physician assistant make an appointment. (Broome)
- Accessibility to physicians and lack of transportation. (Broome)
- Financial challenges, such as co-pays or other things they cannot afford. (Broome)
- Their life situation is a challenge; changes in eating habits, smoking, etc. may not be of high priority versus living expenses, rent, and transportation. Cooperative Extension may offer education on how to improve diet/eating habits at a lower cost. (Broome)
- What they can afford via lifestyles. (Broome)
- Wider range of challenges that affect their health. So, if someone on Medicare needs to get to a doctor a Medicaid taxi will take them to the ER instead of an urgent care or primary care doctor. (Broome)
- It's a lifestyle issue. They need education on their condition and to learn how to manage it. (Cayuga)
- Access to healthcare, education on how to care for one's self, and access to affordable healthcare. (Chenango)
- Education. It's more about what they understand about the condition itself. (Chenango)
- Low or fixed income. There's no money for nutritional groceries. They buy what they can afford, which affects health. Maybe not fill prescriptions because the money for medicine can be used better for food, etc. (Chenango)
- Poverty, eating well, having a safe home, heat, moving comfortably, access to decent food, and access basic environmental issues (transportation). Often it depends on how many people are in the household. (Chenango)
- Reduced personal and financial capacity. (Chenango)
- The availability of medication that is covered under Medicaid. The medications that they cover need to be broadened, and the patients should not have to jump through so many hoops. (Chenango)
- The lack of knowledge of available resources. (Chenango)
- They have less access. (Chenango)
- Convenience of accessibility to PCPs. (Cortland)
- Durable medical equipment is not always covered. Huge rural population, which may not have a phone or transportation. Access to providers of durable medical equipment. (Cortland)
- Eating right, exercising, and taking good care of yourself is harder with less money/low income. (Cortland)
- Education, money, and access to information about their condition. (Cortland)
- It's related to the lack of resources that can help support a healthier lifestyle. (Cortland)

Q62: What are those challenges?

n48; Open-Ended

- Lack of frequent transportation. (Transportation to out-off-area specialists such as upstate clinics). (Cortland)
- Location. (Cortland)
- Medications. Doctors prescribe medications that Medicaid won't cover. So the patient doesn't take it. (Cortland)
- Understanding chronic conditions and maintenance of health and education in those areas. Transportation to specialists. (Cortland)
- Culturally and economically and in rural areas that need to have more accessibility. (Delaware)
- Getting better information on how to deal with chronic conditions on their own. There should be more information on no-ED and non-physician options. (Delaware)
- When Medicaid and uninsured patients start to feel better, they cease taking medication that should be continued. They don't associate medication with improvement in condition. (Delaware)
- Access to quality care that is well trained in understanding these populations. (Schuyler)
- For Medicaid, it's trying to find someone who accepts Medicaid. For the uninsured, it's not being able to afford specialists and the testing that goes with it. (Schuyler)
- Getting the medication that they need may be a challenge. (Schuyler)
- Lack of understanding of medical terminology, and their chaotic lifestyles (such as their lack of affordable healthy food and housing). (Schuyler)
- Well, for the uninsured, access to medications and using their medication inappropriately. (Schuyler)
- Continued access to care and lack of a routine healthcare. (Steuben)
- Economic resources are needed to fill in gaps to achieve what they need. Many incomes are just Social Security and they don't have resources that the general population may have. (Steuben)
- Lifestyle. If you have a chronic condition, and your lifestyle of living is not proper. They can't afford to eat healthy, or just don't eat healthy. Not taking medications, or going to the doctor when you should. (Steuben)
- More substance abuse. (Steuben)
- Availability to specialists, and having the right medications approved by Medicaid. (Tioga)
- I think to have the ability to get necessary supplies and education about their disease. (Tioga)
- Lack of education, opportunities, and services. (Tioga)

Q62: What are those challenges?

n48; Open-Ended

- My patients have psychiatric issues. Psychiatric medications create side effects that include higher risk for diabetes and/or obesity. (Tioga)
- They are worrying about paying bills that is going to be more important than their health. (Tioga)
- A lack of financial resources usually leads to a lack of options, access to information, and a lack of providers to accept Medicaid as payment. (Tompkins)
- Access to physicians on a regular basis, and to medications. (Tompkins)
- Difficulty accessing healthy food. Stress of living in poverty. (Tompkins)
- Health literacy. We have not managed chronic conditions. (Tompkins)
- Number of providers available. (Tompkins)
- Showing up to appointments. (Tompkins)
- There are prescription and medication challenges that this population faces in terms of brands, dosage, and cost. (Tompkins)

Q63: What suggestions do you have for getting the Medicaid and uninsured populations to better manage their chronic conditions?

n52; Open-Ended

- Care management, access to providers, access to the correct types of medications, access to verify the condition, and proper referrals. (Broome)
- Community based supports and services. (Broome)
- Cooperative Extension may offer education on how to improve diet and eating habits at a lower cost. Scored health - Start with small, achievable goals so the patient can see progress and be encouraged to continue better habits (such as eating less, losing weight slowly, and steadily). (Broome)
- It's a matter of utilizing and coordinating community services to make sure that logistical issues (ex. transportation, place to live, food they are supposed to be eating) are taken care of. (Broome)
- More community based prevention services. (Broome)
- The education, once they get to the PCP and make sure they follow up on the changes they need to make. (Broome)
- Understand the best follow-up communication, and understand what they can afford to do after a visit that Medicaid will cover. (Broome)
- I think there needs to be longer clinic hours, and access to a doctor’s office. (Cayuga)
- Being able to obtain most of their chronic health need requirements from their PCPs and the PCPs monitoring the patients more closely. (Chenango)
- Better access to specialists. (Chenango)
- Follow medical advice that's given, but there should be no penalty for not following that advice. Upon follow-up, positive reinforcement of health advice should be given. (Chenango)
- Home visits, calls, and more education. (Chenango)
- It’s complicated because populations range from the homeless to people who are just 'getting by' with no financial resources. This population has low income and more understanding of the complete situation is needed. (Chenango)
- More communication to each patient, more support for their condition, more follow-up. (Chenango)
- Robust education and coordinated care. (Chenango)
- Team approach. (Chenango)
- Begins with providers asking questions about the overall physical and mental health of the patient as soon as they walk through their door. Do thorough screenings of patient and share recommend treatment plans with all healthcare staff who treats the patients. (Cortland)
- Being well informed. Dr's talk to them in a way they can understand. Support from Community Outreach people. (Cortland)

Q63: What suggestions do you have for getting the Medicaid and uninsured populations to better manage their chronic conditions?

n52; Open-Ended

- Greater access to PCPs and better cooperation in keeping appointments and adhering to treatment plans and working with case managers. (Cortland)
- Have someone appointed as part of a support system to help manage continued care. (Cortland)
- Having some kind of advocate for a patient to set up appointments, communicate with doctors, and understand what is communicated to the patient. (Cortland)
- Honey program, case manager, increased interaction with agencies and service providers, require that as an in-service, and there is a need health literacy. (Cortland)
- More community based chronic disease prevention programs. There's limited money to provide increased access to programs to teach people healthily habits like how to cook and use fresh produce/foods. Also, need more walking paths and bike lanes. Walking trails don't cost money, but encourage health habits. (Cortland)
- There needs to be some sort of an incentive for them. (Cortland)
- Using a variety of media to educate that population. (Cortland)
- Easier access to community-based programs. Maybe also more availability of self-help organizations. (Delaware)
- Education and having providers available to patients when they're having symptoms. (Delaware)
- More effective outreach and education. (Delaware)
- Communication. Some people just don't have the money. They need to contact the groups that can help them. (Schuyler)
- Doctors helping Medicaid patients find specialists that accept Medicaid. For the uninsured, give information on what's available for lower cost. (Schuyler)
- More education about how to manage these conditions coming from the PCPs. (Schuyler)
- Participation in available chronic disease programs. (Schuyler)
- Spread of chronic disease self management. (Schuyler)
- We should spend more time with them and present information in a form which they can understand--and make sure they definitely understand! (Schuyler)
- I don't know. (Steuben)
- Increased community services and support. (Steuben)

Q63: What suggestions do you have for getting the Medicaid and uninsured populations to better manage their chronic conditions?

n52; Open-Ended

- Maybe insurance companies can be more open to approving medications. They don't get proper tests because they're not approved by insurance/Medicaid. (Tioga)
- Maybe some type on incentive. (Tioga)
- More education. (Tioga)
- Ongoing community information and education. Community resources here are over utilized, and are not really helping the people that live here. (Tioga)
- Teach disease management. (Tioga)
- Better collaboration between healthcare providers. A consistent message is needed between all providers. And a holistic care plan given to the patient which addresses all of their healthcare needs. (Tompkins)
- Have some sort of regular check-in with their physicians, like monthly/quarterly visits or even a phone call. (Tompkins)
- Having access to a care manager and good support. (Tompkins)
- Make it easier for them to do it. Combination of removing barriers and empowering them. (Tompkins)
- More compliance with case management and appointments. (Tompkins)
- Need to tie the behavior to how they feel on a daily basis. (Tompkins)
- Provide greater access to better options and information; improve patient education; provide comprehensive care management when needed help people understand what their chronic conditions are and how they should be managed. (Tompkins)

Q64: What can be done to promote preventative and healthy behaviors among the Medicaid and uninsured populations?

n52; Open-Ended

- Better access to those services like Medicaid paying for things like gym services or fresh vegetables. (Broome)
- By having health education and counseling on good health care. Providers and community based organizations should reach out them. (Broome)
- Education in all languages, in literature, and Community Information Groups. (Broome)
- Education. Offer examples of what bad habits can lead to. Similar to public service TV announcements. (Broome)
- Ongoing and direct contact with PCP and care coordinators to make sure they are maintaining their health. (Broome)
- PSAs, education from community service based organization and provider offices. (Broome)
- This area does a pretty good job through the Health Department and the programs that they are able to offer. (Broome)
- A lot of stuff we are already doing such as anti-smoking, hand washing, and healthy diets. (Cayuga)
- Better access to rehab programs readily available. Looking at home environment to resolve issues. (Chenango)
- If they had incentives that might help. (Chenango)
- Large support groups, care groups, and outreach (Chenango)
- Make programs available to educate them. (Chenango)
- More educational programs. (Chenango)
- Public education, commercials, and posters. (Chenango)
- We find that incentive programs work well as with education. (Chenango)
- We know that the food that the Medicaid population can afford is not necessarily the healthiest. (Chenango)
- More community based chronic disease prevention programs. There's limited money to provide increased access to programs to teach people how to cook and use fresh produce. More walking paths, bike lanes, and walking trails. These don't cost money and encourage good habits. (Cortland)
- Peer support network and communication between providers and support networks. Case manager promotion of proper care. (Cortland)
- Positive reinforcement from everyone. (Cortland)
- Promoting good habits from a young age. (Cortland)
- Reasonable access to gym services, availability of community groups which educate about affordable healthy cooking and exercise. (Cortland)
- Reward them the way some corporations do, like some type of incentive program. (Cortland)
- Smoking, stigmatize, and ad campaigns. Do that for other illnesses and other behaviors. (Cortland)

Q64: What can be done to promote preventative and healthy behaviors among the Medicaid and uninsured populations?

n52; Open-Ended

- Talking to them and explaining things. Supporting them. Keeping them connected. (Cortland)
- That has to start at the top, state levels, consistently funding around prevention. No matter what party is in office, community level providers need to be aware of what preventive care is available and what needs to be a cultural shift within healthcare providers starting with education and what is currently being taught to healthcare providers. (Cortland)
- Access for Medicaid and uninsured patients to EDs is far too easy. Have someone in the EDs to explain alternative options the next time they feel a need to visit the ED. (Delaware)
- Campaign about better foods, healthier ways of living (such as quitting smoking, better food options). (Delaware)
- More education and community based communications. (Delaware)
- Education. (Schuyler)
- For Medicaid, send out brochures with health tips. For the uninsured, the doctor or nurse should hand out information on healthy behaviors. (Schuyler)
- I think that if the medical providers could provide them with the options that are available and the community agencies could make this available to the providers. (Schuyler)
- Stanford Self-Management classes, and diabetes management classes. There needs to be some incentive for people to participate in these programs. (Schuyler)
- Using community organizations, like the food pantry to do some of that education. For example, telling these populations about good diet habits and benefits of fresh foods. (Schuyler)
- Using evidenced based health-promotion in and out of exam rooms. Social Media. Active use of support groups emphasizing best health practices. (Schuyler)
- Education of providers at all levels so they can educate Medicaid users. (Steuben)
- I think we have to reach out to them proactively in their homes and social locations. (Steuben)
- Outreach and programs in the communities. Education about food in the community. Incentives. Is there an incentive for them to help themselves. (Steuben)
- Support groups that they could attend. Transportation would need to be provided. And incentives would need to be provided to encourage them to take better care of their health. (Steuben)
- Better quality of food in schools from preschool is up to adults. (Tioga)
- Education. (Tioga)

Q64: What can be done to promote preventative and healthy behaviors among the Medicaid and uninsured populations?

n52; Open-Ended

- Educational classes providing information about certain medical condition they may have and by having more available informational classes. (Tioga)
- It's a social issue - junk food is cheaper. (Tioga)
- More opportunities for access. (Tioga)
- Offer incentives. (Tioga)
- Social work support with the families. (Tioga)
- Access to free fitness programs, and healthier foods. (Tompkins)
- Education, increase in providers giving patients hope, and improving resources. (Tompkins)
- I'm really not too sure. (Tompkins)
- Improve access to healthy food, reduce poverty, encourage people to have a sense of authentic agency. (Tompkins)
- Incentives to keep up with healthy behavior and preventative care. (Tompkins)
- They do a good job now. (Tompkins)
- Use of community based programs that provide incentives to participate in a "healthy lifestyle" program/seminar; providers need to take a part also. (Tompkins)

Q65: Who needs to take the initiative in getting the Medicaid and uninsured populations to better manage their chronic conditions? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Healthcare providers	2%	-	-	-	-	-	33%	-	-	-	-
Community Organization	2%	-	-	-	13%	-	-	-	-	-	-
Patient	4%	-	-	-	-	-	33%	-	-	-	14%
All of the above	90%	100%	100%	-	87%	100%	34%	100%	100%	86%	86%
Other[1]	2%	-	-	-	-	-	-	-	-	14%	-

[1] Other responses include: The Federal Government (1)

Q67: Are there any patient engagement techniques that may be effective with the Medicaid or uninsured populations? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Yes	89%	100%	100%	-	75%	78%	100%	83%	100%	86%	100%
No	11%	-	-	-	25%	22%	-	17%	-	14%	-

Q68: (IF YES) What techniques are effective?

n46; Open-Ended

- A program that checks in with the patient periodically has demonstrated to be effective. (Broome)
- Being honest about what you want to contact them about, and what you can offer them. Ensure patient that you are there to help. Meeting patients where it is comfortable for them so there is no pressure. Building trust and coming up with a plan to better care for themselves. (Broome)
- By having people that they trust working with them. (Broome)
- First you have to get the attention of the patient, then get them to the PCP to coordinate care and service options available. (Broome)
- Getting this population excited about their health and creating healthy habits. (Broome)
- Having them tied to their benefits mandating certain programs. (Broome)
- They need to start educating at a younger age, to take more responsibility in their health decisions. (Broome)
- An attitude of outreach and education. Increase easily accessible information. (Cayuga)
- Being direct with the patient about what conditions are and what actions will result in poor or better health conditions. A little compassion. (Chenango)
- Community education; offer a meal and child care as an incentive to get people to attend. Those are the two difficulties that this population has the most difficulty with. Then follow-up. (Chenango)
- Depends on the patient and the issues. (Chenango)
- Hands on demonstration types of things; more education. (Chenango)
- Motivational Interviewing. (Chenango)
- Working with them on a one-on-one setting versus a group setting. (Chenango)
- Disease self-management, to take care of self. Diabetes prevention education. (Cortland)
- Face-to-face meetings and having all information printed. (Cortland)
- Positive encouragement instead of punitive threats from providers. Positive reinforcement. (Cortland)
- Promote accessibility in school systems to overcoming fear and hesitation to receiving assistance in health care. (Cortland)
- Telephonic reminders, in the behavioral health area engage their peers to help patient not forget appointments. Follow-up by provider when appointments are missed. (Cortland)
- The use of peer services. (Cortland)

Q68: (IF YES) What techniques are effective?

n46; Open-Ended

- They can be given suggestions but they are fearful and have never done it. More hand holding. Case manager goes to the doctor with you. I will call the healthcare provider with you to talk in terms that can be understood by the Medicaid patient or uninsured. Team meetings with all providers. (Cortland)
- For anyone working with Medicaid and uninsured patients (community organizations, family), reinforcement of non-ED options is important. (Delaware)
- Informational evenings where people can go for a free meal and get the information they need. Or a government-sponsored agency or office where people can anonymously get more information. (Delaware)
- Peer education. (Delaware)
- Brochures about healthy habits, various conditions, and what bad habits cause long-term problems. (Schuyler)
- For them to participate in the chronic disease management programs. (Schuyler)
- It's difficult, but perhaps offering health education classes and offering childcare during the class as well. Also, mentoring would be great, so they could learn from another adult about how to live a healthy lifestyle. (Schuyler)
- Non-judgmental approach to working with Medicaid and uninsured populations and setting aside enough time for them. (Schuyler)
- Patient Activation Strategies and Patient Activation Management. (Schuyler)
- Better education and resources. We have to be aware that Medicaid has added layers to the system to reduce expenditures, but there will be less money to do more than was done before. It's about money and having resources. (Steuben)
- Consistency, talking points. Let them know you care. I think people get lost. Regular communications. Making them feel like we are invested in them. (Steuben)
- We are able to provide information to people who didn't know about certain services. (Steuben)
- We have to go where they are rather than wait for them to come to us. (Steuben)
- Educating them on their medical conditions. Also, provide hands on education in the home. (Tioga)
- Financial incentives or disincentives by Medicaid or care management companies. Maybe support groups for smoking cessation and diabetes management; transportation paid for by Medicaid, so they can get access to these programs. Managed care companies paying for Weight Watchers, and similar programs that are successful for the general population could help the Medicaid and the uninsured populations. (Tioga)

Q68: (IF YES) What techniques are effective?

n46; Open-Ended

- Giving some autonomy' give them options. The only places they have access to may be difficult for them to take pride in what they can do. (Tioga)
- Having health fairs, outreach opportunities by going out to their populated areas. (Tioga)
- Making sure that there are services available to allow them to follow through with mentoring and education at their convenience. (Tioga)
- Motivation and self management classes. (Tioga)
- Free programs. (Tompkins)
- I think the community health workers are effective in taking the coaching and mentoring position. They must learn to deal with their mental health also. (Tompkins)
- Putting the patient at the center of attention. (Tompkins)
- Recruiting community based volunteers or recruits to promote available services and establish trust and care within the community itself. (Tompkins)
- Taking the time to listen and talk to them without bureaucracy. (Tompkins)
- Total Care gift cards. (Tompkins)
- Utilizing peer led groups so that people can be with their peers and maybe feel more comfortable. (Tompkins)

Q69: How familiar are you with the 2-1-1 directory in your area? Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	52	7	1	-	8	9	3	6	4	7	7
Very familiar	45%	29%	-	-	38%	67%	33%	33%	75%	14%	71%
Somewhat familiar	38%	57%	100%	-	24%	33%	-	50%	25%	57%	29%
Not at all familiar	17%	14%	-	-	38%	-	67%	17%	-	29%	-

Q70: The 2-1-1 directory is a listing of community resources and community-based organizations in the area that residents can access. How could the county boost awareness of the 2-1-1 directory?

n51[1]; Open-Ended

- A lot of public service announcements on TV and daily programming. (Broome)
- By putting it in the news, sending out emails, have it on the internet advertisements, television and have handouts available in the doctors' offices. (Broome)
- Hand-books, packets, guides, and information in multiple languages. (Broome)
- Healthcare providers who have direct access to patients can make people more aware of it. (Broome)
- PSA announcements on the radio and television. Having bilingual speakers; let's use our universities for some of those resources. (Broome)
- Public service announcements, advertisements, and mass marketing. (Broome)
- They could advertise to providers or community organizations to deliver to the general population. (Broome)
- Personal communication within their community, such as in the doctor's office, hospital, ER or a grocery store. (Cayuga)
- Advertise it. (Chenango)
- Advertising and outreach. (Chenango)
- Everyone that works with an individual should give them the information and discuss it with them; maybe help them practice using the directory if they need it. (Chenango)
- Have a mailing and advertisement. (Chenango)
- Inform Community Organization (Chenango)
- Making it more available. (Chenango)
- No thoughts. (Chenango)
- Publicity; to increase public awareness. (Chenango)
- (Cortland)
- Local paper promotions and radio promotions. (Cortland)
- Making it part of the conversation from their providers or community outreach programs. (Cortland)
- My organization has a cheat card with a similar directory that is available to clients. We should review the 211 directory and incorporate it into our work. There are signs around the county with the 211 directory, so there is some visibility. (Cortland)
- Organizations should be familiar with 2-1-1 themselves to better explain it to patients/ Better maintaining 2-1-1 listing data base. (Cortland)

[1] 1 No Reply

Q70: The 2-1-1 directory is a listing of community resources and community-based organizations in the area that residents can access. How could the county boost awareness of the 2-1-1 directory?

n51[1]; Open-Ended

- They are doing all they can. The Medicaid and uninsured do not have internet or transportation, phones. (Cortland)
- Use a variety of media, including social media. (Cortland)
- Use it more. Like it on Facebook and going to it more to generate more for the database. Make sure information is complete and accurate, if not, update it. (Cortland)
- We have the funding to continue the service however, we don't have dedicated funding for promoting 211. There are no funds to advertise, and no consistent funds for printing materials etc. (Cortland)
- I do not have any feedback. (Delaware)
- If the 211 directory was communicated back to my company, we could distribute it. Put 211 directory in newspapers-not everyone reads, but word of mouth would help as well. (Delaware)
- It should be something that should be on the front page of the county website. Many do not have internet access, so there should be more brochures available at community organizations, government offices, etc. (Delaware)
- Active use of public media, billboards, posting in offices, and local places. (Schuyler)
- I think they do a pretty good job; perhaps radio ads. (Schuyler)
- Make sure our information is more accurate and keep it updated. (Schuyler)
- More information. Getting the word out. There is a bi-monthly newsletter that comes out from the Office of the Aging. (Schuyler)
- Posting notices. Kiosks set up in the mall. Hand-outs by volunteers. (Schuyler)
- We could add it to the web page and add it to the advertising. The county needs to invest in it financially. (Schuyler)
- Greater advertising, marketing, and PR. Use the United Way. (Steuben)
- I think that would be a provider education opportunity and marketing in locations where the Medicaid populations socialize. (Steuben)
- More advertising. (Steuben)
- They need to have a designated staff person that is out in the community to let people know. Someone who is always pounding the pavement with that information. Make it a household name. Running information on TV. (Steuben)
- Billboards (Tioga)
- I think they could put some stories about in the local Penny Savers. (Tioga)

[1] 1 No Reply

Q70: The 2-1-1 directory is a listing of community resources and community-based organizations in the area that residents can access. How could the county boost awareness of the 2-1-1 directory?

n51[1]; Open-Ended

- If they could try to condense it into a smaller brochure and try to distribute it that way. (Tioga)
- More PR, commercials, and signs in waiting rooms and phone access to 211 while in waiting rooms. (Tioga)
- Phone apps, which may already exist; include information on Medicaid and managed care mailings. (Tioga)
- Provide it to new employees at the time of hire. (Tioga)
- Providing to community providers as well as patients. Publicize it more. (Tioga)
- Caseworkers need to give them the 211 information pamphlet. (Tompkins)
- It's pretty well marketed. (Tompkins)
- More PSAs and a better idea of why you would call them instead of 9-1-1 (Tompkins)
- Our county (Tompkins) does a lot with 211 already, perhaps the healthcare community could promote it better. (Tompkins)
- Providers offering it as a resource. (Tompkins)
- There could be more marketing. I don't feel that it is very user friendly right now. (Tompkins)
- They have done a lot. There used to be more cards in food pantry's. They are expensive to produce. More outreach where people gather that are not places for services but where they hang out. Take another look at the way the language and graphics are presented. (Tompkins)

[1] 1 No Reply

Q71: What other resources are you aware of that would help identify support organizations for the Medicaid and uninsured populations?

n52; Open-Ended

- A pocket guide that is available through the community outreach services. Actually, advertising and letting community residence know what is out there and available to them. (Broome)
- Community based agencies should have a directory and clinical providers should have a directory of support organizations and keeping the directories up to date and consistent. (Broome)
- Community organizations that are aware and can lead them in the proper direction (church groups, dinners on holidays/special occasions by groups.) (Broome)
- Elder services guide could be used for all for general populations. (Broome)
- Increase awareness from providers. Providers need to get their patients aware of these support organizations. (Broome)
- Providers and community organizations need to have this information handy. (Broome)
- Social Services Offices, providers, and hospitals. (Broome)
- All of the social services and programs at schools that are in place. (Cayuga)
- I think it is community referrals, word of mouth and partner or agency referrals. (Chenango)
- Mothers and babies, WIC program, Catholic Charities, Department of Social Services, Health Department, the unemployment agencies and Chenango Health Network. (Chenango)
- My community does the best it can, but the county has lost many services like case management. (Chenango)
- NY Connects (Chenango)
- Primary offices have directories in office, ask the PCP, and posts in the DSS offices. (Chenango)
- Social services that work with Medicaid population and NY Connects. (Chenango)
- The Department of Social Services (Chenango)
- The Department of Social Services, HEAP, WIC and The Head Start Program. (Chenango)
- Different agencies that are in the area. (Cortland)
- Google, consulting the Cortland Area Chamber, and word-of-mouth. (Cortland)
- Just through word of mouth among the agencies. (Cortland)
- School districts, church groups, PCP groups, local radio, and newspaper promotion (Cortland)
- The Office for Aging has a book that goes out that has all of the agencies in town. DSS should have all of the agencies as well in layman's terms. (Cortland)

Q71: What other resources are you aware of that would help identify support organizations for the Medicaid and uninsured populations?

n52; Open-Ended

- There are some other lists, but they are probably not as comprehensive as 211. (Cortland)
- Use the communities that meet regularly and partnership and spread the word that way. Maybe put it on grocery bags or put it on the taxis and buses. (Cortland)
- We should all help and human service agencies in the community should be able to help on some level. (Cortland)
- Websites and other informational portals. There are many similar resources that are close to 211. (Cortland)
- A number of organizations have a resource directory in print and online that keep community services directories. They could share this directory. (Delaware)
- Hospitals have contacts to which they refer patients. The crisis hotline is building up a list of referable agencies. Delaware county is going to reopen its own WarmLine around the end of the year that is currently being serviced by another county. (Delaware)
- Most people just use the internet--Google informational needs. Some organizations advertise. (Delaware)
- Churches, school counselors, and employers (Schuyler)
- None (Schuyler)
- None (Schuyler)
- None (Schuyler)
- The Public Health Department (Schuyler)
- There is a Sunday Program for Seniors on PBS. (Schuyler)
- Hospitals, social workers, and the chambers of commerce. (Steuben)
- Local community service agencies. (Steuben)
- More enhanced 211; consolidating communication 211 and various providers so there is more awareness. (Steuben)
- Unsure (Steuben)
- Catholic Charities Cayuga Outreach. Rural Ministries in Owego (food pantries). Open Door Ministries, a managed shelter and food pantry. Cayuga Opportunities in Owego, they oversee HUD Grants and HEAP. (Tioga)
- Coalitions and groups that vary depending on the agency. (Tioga)
- If they could have more knowledge of the 211 directory listing and if they could have a 24 hour a day access to it as well. (Tioga)
- None (Tioga)
- None (Tioga)

Q71: What other resources are you aware of that would help identify support organizations for the Medicaid and uninsured populations?

n52; Open-Ended

- Referrals by agencies; take the time to know who you're working with and their issues. Any professional should be able to help connect with another agency. (Tioga)
- Using community outreach programs like Cornell Cooperative Extension - they hold cooking classes. New York State Food Smart has a social club that discusses things like healthy conditions and food recipes. (Tioga)
- I think each organization that helps patients are the best source for these patients. (Tompkins)
- Community based organizations. (Tompkins)
- Community organizations like Loaves and Fishes that have built trust and have a lot of communication with these populations. (Tompkins)
- Health Planning Council (Tompkins)
- None (Tompkins)
- NY Connects Program and the Office for the Aging provides linkages to long term care services and supports every community. (Tompkins)
- Social Services. (Tompkins)

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n52[1]; Single Response

- Advertise walk-in centers to increase awareness. (Broome)
- Affordability; a healthcare plan that provides sufficient coverage at an affordable price. (Broome)
- Better community buy-in; providers have to work together better. (Broome)
- Care coordination that originates in the PCP office. (Broome)
- Consistent follow up after a hospitalization. (Broome)
- Educating these populations on appropriate ED use. (Broome)
- Education on medications (Broome)
- Education through providers. (Broome)
- Enhance communication between providers. (Broome)
- Follow-up care (Broome)
- For people to have access to affordable healthcare. (Broome)
- For people to use their healthcare via encouragement through clinical providers. (Broome)
- Listing of transportation services that serve the Medicaid population for medical reasons. (Broome)
- Medicaid reform that focuses on preventative care versus urgent care. (Broome)
- More providers. (Broome)
- More support for these population for their chronic conditions. (Broome)
- Peer education. (Broome)
- Provide a directory of places that accept Medicaid patients. (Broome)
- Public service announcements. (Broome)
- To have more of a one on one relationship with clinical providers/doctors; working more consistently and thoroughly with the consumer. (Broome)
- Transportation to regular care (Broome)
- Education for this population for what is an emergency and what is not. (Cayuga)
- Expansion of local clinics; shifting the population to other places. (Cayuga)
- More doctors that accept Medicaid. (Cayuga)
- Access to non-emergency care. (Chenango)

[1] 1 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n52[1]; Single Response

- Accessibility to more providers. (Chenango)
- Better access to facilities that take Medicaid and that will see the uninsured. (Chenango)
- Better discharge planning and follow-up. (Chenango)
- Care coordination. (Chenango)
- Collaboration between providers and agency representatives. (Chenango)
- Coordination between community organizations and healthcare providers; who is out there and what services are offered. (Chenango)
- Education (Chenango)
- Education (Chenango)
- Education, education and education. (Chenango)
- Follow through. (Chenango)
- Funding to educate. (Chenango)
- Have an urgent care center. (Chenango)
- Plan in place to increase public awareness of ways to prevent illness. (Chenango)
- Prevention and education for the target population. (Chenango)
- Promote information to a committee or counsel (Chenango)
- Re-emphasize what diseases are and what they are doing to the individual and the healthcare system. (Chenango)
- Regulatory issues need to allow better communication/cooperation across the practices. (Chenango)
- Some kind of sliding scale from the patients for the providers. (Chenango)
- State or County run walk-in clinics. (Chenango)
- Strengthen the current community based medical infrastructure. (Chenango)
- To provide transportation to doctors appointments. (Chenango)
- Transportation (Chenango)
- Transportation being more available and reduce cost. (Chenango)
- Access to primary care physicians (Cortland)
- Access to the alternatives. Urgent care, late DR. hours. (Cortland)

[1] 1 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n52[1]; Single Response

- Alternative options to be seen by a physician (Cortland)
- Better communication between discharge planners and the community organizations for follow-up. (Cortland)
- Better Education on what ED should and should not be used for (Cortland)
- Communication amongst providers, community outreach organizations, and patients (Cortland)
- Community based prevention programs. (Cortland)
- Continued to make sure all parties are talking to each other starting with admin., medical records, physicians, mental health providers (Cortland)
- Develop an identification system that can track this population and have it accessible to other medical professionals. (Cortland)
- Disburse alternatives. (Cortland)
- Greater access to transportation to primary care. (Cortland)
- Improving Support Systems (Cortland)
- Insurance (Cortland)
- More timely Dr. Appointments (Cortland)
- Promotion of case coordination to have someone to guide patient (Cortland)
- Prompt follow up on discharges the from hospital. (Cortland)
- Shared platform for communications across providers, ED, PCP, Mental Health, Other Specialties (Cortland)
- Social media. (Cortland)
- Some incentive for people to want to get better. (Cortland)
- Stop ED use for PCP. (Cortland)
- Support for transportation (public) in rural areas (Cortland)
- To provide off hour transportation to urgent care centers. (Cortland)
- Transportation (Cortland)
- Transportation (Cortland)
- Transportation (Cortland)
- Triage them at the door, so that they're waiting a very long time, if it is truly not an ED visit. (Cortland)

[1] 1 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n52[1]; Single Response

- Being able to address behavioral health issues, mental health and substance abuse, they need more services to work with that population. (Delaware)
- Better communication among community based providers and healthcare providers. (Delaware)
- Better liaisons between providers and families. (Delaware)
- Community interaction (Delaware)
- Education (Delaware)
- Hospitals should advise people of alternative options in their EDs (Delaware)
- More accessibility to insurance options. Some people earn just a little too much to qualify for Medicaid, but cannot afford private insurance.. Uninsured also need better access to NYS marketplace. (Delaware)
- NYS healthcare marketplace should reach out more to people looking for information there (Delaware)
- Provider accessibility (Delaware)
- Advertise the 211 directory. (Schuyler)
- After-hours availability among non-ED providers (Schuyler)
- Better discharge instructions and connecting with support in the community after discharge (Schuyler)
- Better follow-up with providers and patients--if a patient misses an appointment, a provider should reach out and find out the cause (Schuyler)
- Education (Schuyler)
- Education at the ED; that the ED staff talks them through what is an ED visit and what is not. (Schuyler)
- Education for the providers and community organizations to work together and deliver the same messages. (Schuyler)
- Education for this population. (Schuyler)
- Find out who has a primary doctor to avoid the ED. (Schuyler)
- Improve the quality of care and access to care for Mental Health and Substance abuse (Schuyler)
- Improve the quality of care and access to Primary Care (Schuyler)
- Information to Medicaid patients about the ED. (Schuyler)
- Integrate both in a seamless manor (Schuyler)
- More enforcement to cope and cut abuses back of the system. (Schuyler)

[1] 1 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n52[1]; Single Response

- Review the situation / Better diagnosis (Schuyler)
- The hours need to be increased at the provider's office. (Schuyler)
- The local Social Services; when they come in for the face to face visit, the workers could advise them of it. (Schuyler)
- Addressing the monetary cost of their care. Is the ED more of a comfort and are they avoiding their PCP. (Steuben)
- Better case management. (Steuben)
- Better coordination between providers and service agencies. (Steuben)
- Community awareness. (Steuben)
- Consolidated information portal, for one accessible source for all information. (Steuben)
- Explain the difference in what type of services are given where. (Steuben)
- Find financial resources to do that. (Steuben)
- Have access to support services. Staffing to help educate and help matriculate the population so they don't reuse the ER. (Steuben)
- More transportation. (Steuben)
- Providers being informed of support services. (Steuben)
- Providing alternative services such as urgent care. (Steuben)
- Time. Getting access for them when they need it. More access to there PCP in the off hours. (Steuben)
- After-hours access to a walk-in; they assume the ER is the only option. (Tioga)
- Better communication with physicians. (Tioga)
- Better transportation. (Tioga)
- Communication (Tioga)
- Education (Tioga)
- Expanded hours for walk-ins and primary care practices. (Tioga)
- Expanded transportation to preventative services. (Tioga)
- Financial disincentives for repeated or inappropriate use of ER services. (Tioga)
- Follow up and community support. (Tioga)
- I think a 24 hours urgent care center in Tioga. (Tioga)
- I think they need to conduct a study on the needs of providers in the Tioga County area. (Tioga)

[1] 1 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n52[1]; Single Response

- I think transportation needs to be looked at immediately, the Department of Social Services recently revamped the transportation system and that has impacted everyone when it comes to transportation. (Tioga)
- If there could be a nurse's direct line instead of calling 911; have a line that goes directly to a nurse that can answer medical questions and maybe post it on the back of the Medicaid cards. (Tioga)
- If there was a way to have a universal electronic record system. (Tioga)
- More availability to see Physicians. (Tioga)
- More education. (Tioga)
- More education. (Tioga)
- People getting an assigned PCP. (Tioga)
- Prevention (Tioga)
- Transportation (Tioga)
- Transportation (Tioga)
- Better access to healthcare providers (even if only by phone). (Tompkins)
- Choosing a PCP at Social Service level. (Tompkins)
- Community outreach workers (Tompkins)
- Co-pays (Tompkins)
- Focus on the highest users of the ED and start there; maybe behavioral health is a good start (Tompkins)
- General health literacy for K-12 (Tompkins)
- Having outreach at organizations they frequent, with knowledge of what they can do. (Tompkins)
- How to deal with substance abuse instead of ER (Tompkins)
- How to provide ER services in a different way within a community (Tompkins)
- Implement - Care Transition Programs (Tompkins)
- Improve coordination of care between hospitals, behavioral health providers, and community based organizations. (Tompkins)
- Increased collaboration from providers (Tompkins)
- Make Patients feel comfortable calling their PCP for help (Tompkins)

[1] 1 No Reply

Q72: In summary, our goal is to reduce the number of non-emergent ED visits among the Medicaid and uninsured populations by 25%. What are the top 3 things that need to be done immediately for this to happen?

n52[1]; Single Response

- Patient self management (Tompkins)
- Public Education (Tompkins)
- Realign payment incentives (Tompkins)
- Reduce poverty (Tompkins)
- Retraining providers on how to handle mental health issues instead of ER (Tompkins)
- Satellite provider offices. (Tompkins)
- Stringent Rules and compliance (Tompkins)
- Stronger care coordination resources (Tompkins)

[1] 1 No Reply

Q76: Is there anything that we have missed among these DSRIP projects or in this interview that you would like to discuss?

n47[1]; Open-Ended

- One of the challenges for the uninsured population is that we have a pool of people that will never be able to receive healthcare (because they are undocumented) and there is no affordable healthcare option to them. Because of this, it will cause an overall decrease in the health of our communities. (Broome)
- They should also address obesity related health issues. (Broome)
- I think the uninsured and Medicaid are two very different populations that should have been researched separately. Also, healthcare in itself is just not affordable for anyone. (Cayuga)
- For the government to provide funding to educate. (Chenango)
- Phone procedures are often difficult to get through to a person. The entry point into the system is difficult, in regard to response time. At least at the ER there is a human response. (Chenango)
- They were very thought provoking questions. (Chenango)
- Crises are real and in certain areas there are no mobile crises facilities. Having other facilities to go to other than the ED is critical. (Cortland)
- If there was a link for the 211 program on our initial survey. (Cortland)
- Psychiatry access and substance addiction programs are non-existent. (Cortland)
- We have to attack substance abuse issues in our community. If Medicaid users can do urine test on employees, why can't they do it on this population before issuing benefits? As a condition to receive benefits, Medicaid users need to prove that they are substance free. (Cortland)
- We need to be more aware of transportation issues. Medicaid has redesigned the way people can get to their appointments. This could impact the availability of transportation. We need to pay attention to this issue. (Cortland)
- Healthcare cost in general is a problem. A more nationalized healthcare system could reduce the cost of healthcare. (Delaware)
- I think we have to look at the whole situation from a different perspective, particularly moving away from looking at this whole issue from a medical/disease model and to better understand the social/cultural environment of the people they are working with. I recently attended a DSRIP meeting in a different region to do a community needs assessment. A three hour meeting where they talked for about two and half hours and when it came time for feedback, their wasn't enough time for them to gather the important information. (Delaware)
- Access, Access, Access. (Steuben)
- Substance abuse care (Tompkins)

47 No/Unsure

[1] 5No Reply

Q76: Is there anything that we have missed among these DSRIP projects or in this interview that you would like to discuss?
n47[1]; Open-Ended

- No, it was very thorough but we must ensure that financial resources are available. Just reducing ER visits will not create additional funds for the extra layers of services that are needed. (Steuben)
- Clarify that mental healthcare is included, and give a definition to what "healthcare" is. (Tompkins)
- Substance abuse care (Tompkins)

47 No/Unsure
[1] 5No Reply

Focus Groups
Appendix

Total Focus Group Participation Packets by Location and County n131; Single Response	
County	Total
Broome (Binghamton & Vestal)	54
Tompkins (Ithaca)	12
Delaware (Delhi)	11
Chemung (Elmira)	10
Schuyler (Watkins Glen)	9
Cayuga (Moravia)	8
Steuben (Corning)	8
Chenango (Norwich)	7
Tioga (Owego)	7
Cortland (Cortland)	5
Total	**131**[1]

Note: Some participants did not complete all activities in the participation packet.

Aggregate Findings – Across All Groups

- The perception is the **mental health and dental care networks are in most need of immediate attention**. There are other specialty voids as well, however participants stated that they expect to have to travel out of the area for most specialties.
- The vast majority of participants had **ready access to social media and the Internet when queried**. Many were active Facebook users and reported it as the source of awareness of the survey and focus group efforts.
- Many indicated **a frustration with the Medicaid program** believing Medicaid is changing the rules regarding coverage. The system is increasing copays, requiring referrals, and not making it easy to move from one area to another within the state.
- The majority of **participants were very excited to be part of the discussion regarding healthcare delivery in their community**. They stated that they wanted to be engaged and would be interested in serving as an ambassador within their community. They want to continue to provide input as needed. It was perceived as a very positive thing that they were being involved in the discussion. This points to the potential success of the patient advisory panel.

Aggregate Findings – Across Rural Only Groups

- The overall rating of healthcare services (on a 1 “poor” to 5 “excellent” scale) within **rural areas was rated lower than urban areas**. Comments focused on the significant gap in the number of providers, key specialties, and access to obtaining an appointment.
- Rural participants indicated that they did not want to go to the ED for what they believed was not-life-threatening care, but feel that they often **have no other options when they need medical attention**. With the exception of Chenango and Delaware Counties, many rural participants did not know of any urgent or walk-in services available in their counties.

Unique Aggregate Findings – Across Chenango and Delaware County Only Groups

- Overall the focus group findings among these two counties were consistent with what we learned across all the counties. It was clear that these participants were aware that there are healthcare resources tied to the Bassett Healthcare system that directed them towards Oneonta and Albany and there were healthcare services from UHS and Lourdes that directed them towards the Binghamton area. In both situations, people had to leave the area and drive to receive more comprehensive healthcare "out-of the area." This was not the preference, however participants understood that there were a limited number of providers available within the local community. There were some comments that the Bassett, UHS and Lourdes providers could work more closely together and incorporate "best practices."
  - *CMH does not communicate with Lourdes so my primary knows nothing until I tell him and walk in and hand him a stack of papers.*
  - *I think that if you stay in the same network, like the Bassett network, it's good. But there's a new network now, the UHS network which nothing is linked together so that's sort of hard.*
- The participants in these counties seemed to need specialty care and mental health resources at a slightly lesser volume than the participants from the other eight counties. However, dental care services, dieticians and sites for chemical dependence detoxification (additional treatment locations) were identified as being a significant need within the region.
- The majority of participants did not know of an urgent care facilities and this is why many went to the ED, knowing that their condition wasn't a true emergency. Others stated that the hours associated with an urgent care facility were not convenient.
  - *I think we have (an urgent care facility here), yeah, that does open for like three hours after the ER like it doesn't open until like 11:00 in the afternoon and its closed by 2:00 or some dumb…*
  - *(I went to the ER) Because I had to go to work that day, too and if I didn't go to work then I wouldn't have a job, and I kind of need a job.*
  - *There is no urgent care here (in Delhi).*
  - *Emergency Department is most attractive because they (community residents) can get in – they think, right away. You do not have to wait for an appointment, you don't have to schedule an appointment.*
  - *They try to get us to use Fox Care but guess what? If I don't have transportation, I can call an ambulance and I can go to the emergency room.*

- Participants indicated long waiting lists, closed practices, long appointment wait times and limited supply of primary care physicians accepting "new patients" and a barrier to receiving routine and or non-urgent care. There was acknowledgement that Bassett has a significant presence in the area but many of the practices are closed.
  - *Yes, I noticed that there's a sign on the door that's been on there for about six months saying that they cannot take new patients. It's Norwich Family Clinic, or Norwich Family Care. It down in old Dr. Ward's old office.*
  - *You used to be able to walk in and now they're not – they're full.*
  - *I don't have a problem as far as my children. For myself, I'll wait a week to see my primary care physician who knows my medical conditions.*
  - *I get to my primary care bit it takes a long time. I want to be able to know that if I'm sick I want to get in tomorrow. You know, if it's not today.*
- Participants stated that they liked the idea of a facility that offered multiple services under one roof for walk-in and urgent care. They also wanted it to be like the ER in that you did not need an appointment to go.
  - *Some place that you could walk in if you thought that you had the flu.*
  - *I would want it equipped with something like an x-ray machine, a lab so that you don't have to send your stuff off. Do it right there, one building. Like a mini hospital.*
- There is some concern regarding the quality of the physicians in the Chenango and Delaware region. Some participants mentioned that this is because of the physician's low reimbursement, push to see many patients and rotating schedule.
  - *The physicians in Albany were much better than what I am finding right here in (our) small community. And that is a problem.*
  - *We do have a lot of them but most of them are on the system so you are getting these guys that are only getting paid fifty buck or less, so they're not terrible doctors but they're far from the best.*
  - *And they're only here once a week or whatever, they rotate between all of the different hospitals.*
  - *It's no offense and I'm not racist or anything but a lot of times at Bassett when I try to get a primary care, it's somebody that I can't even really understand.*

- Several participants indicated that they use the Internet and social media to stay abreast of their health appointments, learn about healthcare issues and to tap into resources that might help them with their healthcare needs.
  - *If somebody local doesn't put it on Facebook, I don't know about it. Because I don't get a newspaper.*
  - *Social media is very active.*
  - *Yeah, Bassett now has a website you can connect to your doctors and everything. You can renew your prescriptions*
  - *I get a text message and I just got opted into the women's clinic in Fox Care. I can now see my test results at the same time my doctor does and if they have a message for me it will be emailed to me.*
- There is minimal awareness of available healthcare focused community resources within the two counties, beyond knowing of specific churches that provide outreach and food pantry resources.
  - *There's no community resources right now. You're almost out there floundering unless you have the time and the patience to call and call. God forbid if you're sitting at your desk trying to do your job and things are only open Monday through Friday nine to five and those are your working hours.*
- The concept of a centralized advocacy resource or resource material to help individuals indentify and navigate the healthcare system was well received by all participants.
  - *I'm just thinking that in a centralized location like the library and/or grocery stores, if there was a bank of pamphlets that dealt with medical issues, when to see a doctor, when to go to the doctor,… diabetes?*
- Several participants were very leery of having their personal information electronically exchanged. They believed that there was a great risk posed to having this information "hacked into" and then misused.
  - *And I don't want to be putting my personal information in there either.*
  - *They want us to put our personal information over the Internet, and look at how many times the Internet has been hacked in the last couple of years.*
- Those participants without health insurance stated that they are going to pay the fine rather than go and purchase health insurance from the exchange. They stated that the insurance cost is still unaffordable to them and the fine is much less expensive. They also approach healthcare providers directly and try and work out a lower cost and payment schedule.

- Participants within these counties stated physicians were quick to use prescriptions to treat conditions. This was not always appreciated. Many felt that this medication approach is a means hurry the patient out of the office (so that the doctor can see someone else), and leads to over utilization of prescription drugs.
  - *And when they (the doctors) do get you, here, take these drugs, pay for them, you'll feel better. Come back to me when you're good, yeah.*
  - *Because a lot of people end up way overly medicated. It's here, we'll give you this for your problem, but now we need to give you this to take care of the side effects of this. And then here's this that we need to give you to take care of the side effects of this.*
- Overall, any out of pocket costs were a deterrent to receiving medical care. Some participants indicated that they are hesitant to share any income information for fear that this will be reported and "disqualify" them from a particular program.
  - *I don't get (healthcare) anywhere , and I can't pay out-of-pocket for that kind of stuff either. Its ridiculous.*
  - *And they want you to be honest when you really need the healthcare and when you can't get it, you can't afford it. Oh we're so sorry you're making twenty dollars too much, thank you for being honest.*

Activity 2 (Q1) How would you rate the overall availability of healthcare services in your area? Using a scale of 1 to 5 where "5" indicates very good and "1" indicates very poor. n128; Single Response											
		County									
Category	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
Average Rating	3.27	3.21	3.88	3.33	3.75	2.40	3.80	2.25	3.00	3.29	3.50

Why did you rate it that way? n123; Open-Ended; Coded											
		County Counts									
Barrier	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
n	123	49	8	10	7	5	11	8	8	6	11
Insurance coverage issues	20%	6	2	4	0	1	2	3	6	0	1
Everything is good	18%	5	3	3	2	0	4	0	0	2	3
Issues with doctors	9%	7	1	0	0	1	0	1	0	0	1
Lack of specialists	9%	0	1	0	1	1	3	2	0	0	3
No issues	9%	7	1	0	0	0	1	0	1	0	1
Not enough available appointments/services	7%	3	0	2	0	1	0	0	0	1	2
Costs	7%	3	1	0	0	0	0	1	1	1	1
Dental lacking	6%	1	0	2	0	1	1	0	1	0	1
Mixed experiences	6%	5	0	0	1	0	0	0	0	1	0
Could be better	4%	4	0	0	1	0	0	0	0	0	0
Wait times	4%	2	0	0	0	1	0	1	0	0	1
Mental health	2%	1	0	0	0	0	0	0	1	1	0
Travel	2%	0	0	0	1	0	0	1	1	0	0
Personal health issues	2%	1	0	1	0	0	0	0	0	0	0
Other(s)[1]	11%	8	0	0	1	0	2	1	1	0	0

[1] Other(s) include: No one specific reason, specific past experiences.

Activity 2 (Q2) What are the top 5 barriers that prevent you from receiving healthcare when you need it? n121; Open-Ended; Coded											
		County Counts									
Barrier	Total	Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
N	121	46	7	10	7	5	10	9	8	7	12
Availability of Doctors	40%	15	1	5	3	3	3	7	6	2	4
Transportation	40%	18	3	5	1	3	2	5	3	3	6
Financial Barriers	34%	16	3	3	2	1	4	2	2	2	6
Doctors Not Accepting Insurance	27%	2	2	5	1	2	5	4	4	1	7
Quality of Doctors	19%	10	1	-	-	3	1	3	3	2	-
Personal Barriers	17%	8	-	2	3	-	2	-	1	2	3
Lack of Insurance	16%	9	-	-	2	1	1	2	2	2	-
Long Wait Times	14%	10	1	1	2	-	-	2	-	-	1
Provider Communication	12%	11	2	1	-	-	-	-	-	-	1
Cost of Medications	11%	6	2	-	-	-	1	1	2	1	-
Insurance Applications	7%	7	-	-	-	-	-	-	-	-	1
Doctors Accepting Insurance	4%	5	-	-	-	-	-	-	-	-	-
Income Limits for Insurance	4%	4	-	-	-	-	-	-	-	-	1
Mental Health Availability	4%	3	-	-	-	-	-	-	-	1	1
Not Accepting Patients	3%	4	-	-	-	-	-	-	-	-	-
Prior Authorization	3%	2	1	-	-	-	-	-	-	1	-
Lack of Facilities	2%	3	-	-	-	-	-	-	-	-	-
No Support Services	2%	3	-	-	-	-	-	-	-	-	-
Providers Push Medications	2%	2	1	-	-	-	-	-	-	-	-
Referral Process	2%	2	-	-	-	-	-	-	-	-	-
Other[1]	4%	4	-	-	1	-	-	-	-	-	-

[1]Other(s) include: None/not applicable.

The following projects are proposed to help improve healthcare in your area. On a scale of 1 to 5 where "5" indicates being very successful and "1" indicates not at all successful, how successful would each project be in your county?
n119; Single Response

Project	Barrier	Total	County Counts									
			Broome	Cayuga	Chemung	Chenango	Cortland	Delaware	Schuyler	Steuben	Tioga	Tompkins
	n	119	42	8	10	7	5	11	9	8	7	12
2ai	Integrated Delivery System	4.3	4.5	3.8	4.0	4.6	4.4	4.7	3.7	3.9	4.0	3.9
2biv	Care Transitions for Chronic Diseases	4.4	4.6	4.1	3.8	4.7	5.0	4.8	4.2	4.3	3.9	4.1
2bvii	INTERACT	3.9	4.5	3.8	3.8	3.4	3.8	3.4	4.0	3.8	3.3	3.0
2ci	Development of Community Based Health Navigation Services	4.4	4.3	4.3	4.4	4.9	5.0	4.6	4.2	4.6	4.3	4.0
3ai	Integration of Behavioral Health and Primary Care	4.3	4.5	4.0	3.9	4.0	5.0	4.5	4.3	4.5	3.6	4.0
3aii	Crisis Stabilization	4.3	4.6	4.8	3.8	3.3	4.6	4.5	3.9	4.5	3.7	3.8
3bi	Evidence-Based Strategies for Disease Management	4.3	4.6	4.9	4.4	4.5	5.0	3.4	3.6	4.4	4.1	3.8
3gi	Palliative Care in PCMH	4.4	4.6	4.8	4.2	4.5	4.4	5.0	4.1	4.6	3.4	4.2
4aiii	Strengthen Mental Health and Substance Abuse Infrastructure	4.3	4.6	4.4	3.8	4.7	5.0	5.0	3.1	4.5	3.7	3.5
4bii	Chronic Disease Preventative Care and Management (COPD)	4.4	4.4	4.3	4.3	4.8	5.0	4.9	4.6	4.5	3.1	3.8
2di	Patient Activation	4.7	5.0	4.6	4.4	5.0	5.0	5.0	4.8	4.6	3.7	4.5

What could be done to reduce Emergency Department visits while continuing to improve healthcare for patients like you? n80; Single Response		
	n	%
Afterhours or 24/7 Care	12	15%
Education	11	14%
Ability to get appointments	10	13%
More Urgent Care/Walk Ins	10	13%
Longer office hours	8	10%
Preventative Care	8	10%
Expand coverage limits	7	9%
Improve/Expand Triage	6	8%
Urgent Care Facility	4	5%
Communication	3	4%
Financial Responsibility	2	3%
Affordable insurance	1	1%
Bedside Manner	1	1%
Other*	11	14%

*Other(s) include: No suggestion, hotline, more focused visits, nurse advocates, listen to primary care.

Appendix

DSRIP Community Residents
Focus Group Moderator's Guide
November 3rd, 2014 – Final

Focus Group Overview:

Date	County	City & Location	Start Time (Local)
Tuesday 11/4	Broome	Binghamton (Your Home Library)	9:30 AM
			11:00 AM
			2:30 PM
			4:00 PM
	Chemung	Elmira (Steele Memorial Library)	9:30 AM
			11:00 AM
	Tioga	Owego (Owego United Methodist Church)	2:30 PM
Date	County	City & Location	Start Time (Local)
Wednesday 11/5	Delaware	Delhi (First Presbyterian Church)	11:00 AM
	Broome	Vestal (Vestal Public Library)	3:30 PM
	Steuben	Corning (United Way of the Southern Tier)	9:30 AM
			11:30 AM
	Schuyler	Watkins Glen (Watkins Glen Public Library)	2:30 PM
Date	County	City & Location	Start Time (Local)
Thursday 11/6	Chenango	Norwich (Guernsey Memorial Library)	11:00 AM
	Cortland	Cortland (Phillips Free Library)	3:30 PM
	Tompkins	Ithaca (Office of the Aging)	11:00 AM
	Cayuga	Moravia (Moravia Volunteer Fire Department)	3:30 PM

RMS is recruiting 14 participants for 10 to be seated for each focus group. RMS will accept a minimum of 6 recruited to seat 4 for the focus group to be held.

Participant Qualifications:
- Agreed to participate in future research opportunities from the online survey response.
- Currently have either Medicaid or are uninsured.
- Ability to read, write, and listen without limitations.
- Live in one of the 10 designated counties for the research study.

Breakdown of Content: The focus group will begin with a five to ten minute warm-up where the group is introduced to the 75 to 90 minute process and individual introductions take place to get everyone accustomed to the session. The second section of the group will focus on a general community needs warm-up, followed by a staying healthy discussion, ED discussion, and conclusion section.

Duration: 75 minutes (up to 90 minute window)

1	Introduction	5 Minutes	Exact Time Varies

PP **Have group complete Participation Packet Activity 1 (handed out upon participants' arrival).** This should be filled out while the welcome and approach, logistics and rules, and confidentiality are explained by the moderator. Only fill out the pages specified.

Welcome and Approach:
- Have participants complete **Activity 1** as they are waiting for the groups to begin.
- Welcome everyone and thanks for coming today! A focus group is qualitative research, done to gather opinions and perceptions. I work for a market research firm, Research & Marketing Strategies (RMS) in Central New York. Introduce co-moderator or note taker who will be assisting us with the discussion. Our firm has been hired to conduct this session and to hear your feedback. A large group of regional hospitals and health organizations are working together with us to plan how they can better serve residents in the area. This regional group includes: UHS, Lourdes, Guthrie, Cayuga Medical Center, Cortland Regional Medical Center and Schuyler Hospital. The regional group is known as the Southern Tier Rural Integrated PPS. I will do my best to explain the terms. However, I am not a healthcare expert, so I may ask for an explanation or ask you to be more specific with what you are talking about. Today you are the experts. We will be chatting about your healthcare experiences.
- Explain that participants were selected randomly from a list of qualified individuals based on targeted criteria from the online survey.
- At no time will anyone try to sell you anything, this discussion is for research purposes only. Your participation is voluntary.
- Your $75 honorarium will be distributed at the conclusion of the discussion.
- Ask people to turn off cell phones and use bathroom if necessary (explain locations of bathrooms).
- Participants have a job to do – they need to share their thoughts and opinions related to the topics we are discussing. Everyone needs to participate in the discussion.
- At points during the discussion I will step outside with some of our observers here in the room. They are simply here to sit-in and listen to the discussion.
- Explain participation packet. Color coded; will collect at the end of session; write neatly.

Logistics and Rules:
- The discussion will be broken down into specific areas that I will guide you through.
- Introduce audio recording for research purposes and report writing only. Mention client viewers (if applicable in room).
- I ask that you speak loudly and clearly and try not to interrupt someone when he/she is talking. The final report is prepared from findings summarized in aggregate - your name won't be tied to anything we discuss – please speak freely about your thoughts and opinions.
- With a focus group there are no wrong answers. I'll look to hear from everyone in the group, if you hear something and you agree, please let me know that. Should you disagree, let me know that too.
- This group should take approximately 75 minutes. As we move through sections of the discussion I will ask you to refer to your Participation Packet which has specific written activities tied to our discussion. Please do not move ahead in the packet unless I direct you to. Also, please write legibly.

Confidentiality/HIPAA Compliance:
- There is no guarantee that the healthcare concepts we discuss today will be implemented in the industry or by our clients. However, we are looking to understand your thoughts and perceptions which might be explored for implementation in the future. As a key decision-maker we want your feedback early in this development process. This is an opportunity for you to express things they would like to see to meet your healthcare needs or express concerns with the current services you use.

- We do not want anyone to share any personal healthcare information; we want to discuss healthcare services in general. We ask that everyone in this group does not share anyone's health information. If asked, they state that they were in a group that talked about improving healthcare services.
- It is extremely important for you to remember that this material and discussion is confidential. Finally, the moderators will discuss the young maiden and old lady optical illusion. The intent of this exercise is to explain to the participants that there is no such thing as a wrong answer in a focus group. Ensure that there are no additional questions before moving to the next section.

2	General Community Needs	10 Minutes	Exact Time Varies

Moderator Read: All members of this focus group have a shared profile and you all share something in common. This study is being conducted across a 10 county area here in Upstate New York. For this focus group in particular we are looking to speak with population of individuals with Medicaid or individuals who are uninsured to receive your feedback on how healthcare is provided in your county.

1. Ask if anyone in the group has received healthcare in the last two months (show of hands). Where did they receive care? (Clinic, physician or provider office, urgent care, hospital, ED or other –explain.) Why did they go there? Ask how participants know where to receive care. What sources are used to help them "know where to go?" (Make a list)

PP **Have group complete Participation Packet Activity 2.** This should be filled out after the introduction. This activity will ask participants to rate the overall availability of healthcare services in their county. It will also ask them to list the top 5 barriers that prevent them from receiving healthcare when needed.

2. Using a scale of 1 to 5 where "5" indicated very good, how would you rate the overall availability of healthcare services in your county? **Marker board.**
3. Why did you rate in that way? **Probe.**
4. Do individuals in your county always get the healthcare they need? Why or why not?
5. What is preventing people from getting the healthcare they need? What are the barriers? **Probe by going over each barrier (lack of providers, specialties, transportation, hours, or locations) and explain.**
6. Which of those barriers are the easiest to fix? How can they be fixed? How quickly can they be fixed? **Probe.**
7. Are these barriers unique to your county? Why or why not? **Explain.**
8. What needs to be improved in your community regarding healthcare?
9. Are there any type(s) of services that are difficult to access for population of individuals with Medicaid or individuals who are uninsured? **Probe on specific specialties and services.**
10. Are behavioral (mental) health and substance abuse services available to those who need it? Why or why not? Were you emotionally supported if you used/did not use? What made you feel emotionally supported? What type(s) of support services do you think exist? (Specify if needed) Do you feel there are enough support services for mental health? Yes or no? Why or why not?
11. As a group, let's rank how important each of these items that need improvement are. **Moderator will use marker board to rank top five.** Why did you rank them this way? Why is this most important? **Probe.**
12. Are there any services missing in your area? Which one(s)? **Probe.**

3	Staying Healthy	10 Minutes	Exact Time Varies

1. Ask participants "who is ultimately responsible for one's health". If not mentioned, prompt participants. Is it not ultimately "you"? Everyone has the responsibility to try and stay healthy. They have to take the responsibility. Ask participants if most people feel this way. Why or why not?

2. What do you/do people do in your county to stay healthy? **Ask about activities, healthy eating, preventative care, etc. Probe.**
3. Why don't people visit with a primary care physician and/or dentist more regularly? **Explain primary care physician (if needed).** Do you receive mental health support from their primary care physician? If no, why don't you visit a mental health specialist more regularly?
4. Do you know anyone who has a chronic disease? If needed, chronic diseases are treated and stable but the health condition is never cured. For example diabetes, COPD, cardiovascular, breathing problems such as asthma, mental health problems like depression, high blood pressure, etc? Are these people doing anything different than people without a chronic disease? Yes or no? Why or why not?
5. Do people turn to any resources for assistance "to stay healthy" in the community? What resource(s)? How do they become aware of those resources? How do you like to receive information about staying healthy (doctor, TV, radio, social media, bill board)? **Explain. Note: Community resources are organizations or groups outside of the hospital that try to help with health or health related situations.**
6. Do you think the population of individuals with Medicaid or individuals who are uninsured are healthy? How can they get healthier? **Probe.**
7. Do you think the population of individuals with Medicaid or individuals who are uninsured have a higher rate of chronic diseases? Yes or no? What can be done to help people with chronic diseases better manage their care? Should more community resources be made available? Which one(s)? **Explain.**

4	Emergency Department	25 Minutes	Exact Time Varies

Explain to participants that you want to talk about healthcare at the area emergency room(s).

1. How many participants in this group have used the emergency department or ED? Read: The ED will be used the same as the ER or what you refer to as the emergency room. **Hand count.**
2. For those who have used the ED or had a family member, friend, or child that used the ED, how long ago did you use the ED? Was it recent (within the past year), within the past few years, more than a few years ago? For those who have, how many times have you or a family member used the ED in the past year?
3. Without getting into too many personal details, for what reason(s) did you use the ED for your most recent visit? What caused you to go? **Go around room and ask to explain.**
4. Among those experiences was the ED the most appropriate setting for you to receive care? Meaning for that specific condition you had that you went to the ED, could you have gotten care elsewhere (such as doctor's office, walk-in, etc.)? **Hand count.** Why or why not? **Explain and probe.**
5. Are there other healthcare settings in your county that could have handled your healthcare needs for that most recent ED visit? What are those settings? What type(s) of facilities are they? Where are they located? **Probe.**
6. When is it appropriate to visit the ED? For what reason(s)? **Explain and probe.**
7. When is it not appropriate to visit the ED? Give me specific conditions or examples where another healthcare setting should be chosen instead of the ED? **Probe. If needed, provide a variety of conditions or examples.** Why do you feel people still go to the ED for those type(s) of conditions or examples. **Probe in-depth on specific reasons, drivers, factors.**
8. When choosing a place to receive care, what factors are you considering? **Marker board. Make a list.**
9. Do you ever call someone or talk to someone before you receive care? Like a friend, family member, or doctor? Why or why not?
10. Do you think most people know when they should use the ED and when they should not? Why or why not? **Explain and probe.**
11. What other healthcare options should be considered if the condition is not life-threatening? What locations would be better suited for care?

12. What is the best way to educate the people on choosing the appropriate location for healthcare whether it be the ED, physician's office, urgent care center? Why? How would you like to be educated about this topic (radio, TV, doctors, etc.)?
13. If you were in charge of teaching people when to use and when not to use the ED, what would you do? What message(s) would you use? Where would you publicize those messages? Where would you want to learn about this (TV, radio, billboard, doctor, etc.)? Why?
14. Have you, a family member, friend or child ever been re-admitted to the hospital within 30 days of being discharged? Why? Were you able to follow up with your doctor after initially being discharged? Why or why not? Anyone you know from a nursing home that has been readmitted? Why?
15. What can be done to reduce hospital readmissions? **Probe on patient versus physician responsibility.**
16. How many of you see multiple doctors or physicians? How would you rate their communication about your conditions between each other? Good or poor? Why? How should it be improved? Do you think that there should collaboration between physicians and the community when it comes to specific health needs? If yes, which needs should be focused on? **Probe on specific diseases and other barriers/issues.**

5	Conclusion	15 Minutes	Exact Time Varies

PP

Have group complete Participation Packet Activity 3. This should be filled out after the conclusion discussion. In order to increase access to non-emergent care, we want to create a better system to serve patients like you. Our goal is not to reduce your access to care or healthcare benefits. We need to know what system, places, networks need to be put in place so you can be cared for elsewhere other than the ED. It will inquire about the best way for the county to reduce ED visits by 25% among the population of individuals with Medicaid or individuals who are uninsured in detail. It will also ask them to rate the predicted success of each of the 11 proposed projects on a 1 to 5 scale with "5" being very successful.

1. If our goal is to reduce ED visits among population of individuals with Medicaid or individuals who are uninsured by 25%, what is the best way to go about doing that? We must ensure that you have access to the healthcare that you need. What would you suggest? How could we reduce those numbers of visits? **Probe and explain.**
2. Using a scale of 1 to 5 where "5" indicates very important, how important are providers and doctors in helping reduce ED visits among the population of individuals with Medicaid or individuals who are uninsured? **Explain.**
3. Using a scale of 1 to 5 where "5" indicates very important, how important are community outreach agencies in helping reduce ED visits among the population of individuals with Medicaid or individuals who are uninsured? **Explain.**
4. Is there any other important group in the county that can help reduce the number of ED visits among the population of individuals with Medicaid or individuals who are uninsured? **Explain.**
5. Which of the 11 proposed projects on Activity 3 will be easiest to implement quickly? Which of the 11 projects will take the longest to complete and will be most difficult? Why?

Moderator: Thank you for your time and attendance. Now I will go around the room and ask you to sign a confidentiality agreement and a release form to receive your honorarium of $75 as a thank you for participating.

Participant Packet

Thank you for coming!

Please turn to the next page and complete Warm-Up Activity 1 while we wait for the discussion group to begin.

Activity 1

1. Name (First & Last): ______________________________
2. What is your favorite TV show? ______________________________
3. What do you see in the picture below?

____

____

Thank you! Please sit quietly until the group begins.

THIS IS THE END OF THIS ACTIVITY. PLEASE DO NOT TURN THE PAGE.

Activity 2

1. Using a scale of 1 to 5 where "5" is very good and "1" is very poor, how would you rate the overall availability of healthcare services in your area?

   1 2 3 4 5

2. Why did you rate it that way?

   ____

   ____

3. List the **TOP 5** barriers that prevent you from receiving healthcare when needed.

   1. ______________________________
   2. ______________________________
   3. ______________________________
   4. ______________________________
   5. ______________________________

THIS IS THE END OF THIS ACTIVITY. PLEASE DO NOT TURN THE PAGE.

Activity 3

1. What could be done to reduce Emergency Department visits while continuing to improve healthcare for patients like you?

   ____

   ____

2. The following projects are proposed to help improve healthcare in your area. On a scale of 1 to 5 where "5" indicates being very successful and "1" indicates not at all successful, how successful would each project be in your county?

   1. **Create integrated delivery systems that are focused on Evidence-Based Medicine/Population Health**
      This project would expand Medicaid Health Home services to a larger population of Medicaid patients who do not meet the current high-risk definition of existing Medicaid Health Home. This project would expand access to community primary care services and develop care teams (individuals would include physicians and other practitioners such as behavioral health providers, pharmacists, nurse educators and care managers) to meet the needs of higher-risk patients and patients who are at risk of developing one or more chronic disease. The goal of the project is to see patients before problems develop so they do not over use healthcare services.

      1 2 3 4 5

   2. **Care transitions intervention model to reduce 30-day re-admissions for chronic health conditions**
      This project would help provide a 30-day supported transition period after a hospitalization to make sure discharge directions are understood and done by patients who are at a high risk of going to the hospital again. These patients would have heart, kidney or lung problems as well as diabetics and patients with mental health disorders.

      1 2 3 4 5

   3. **Implementing the INTERACT project (Inpatient Transfer Avoidance Program for Skilled Nursing Facilities)**
      The overall goal of the INTERACT program is to reduce the frequency of transfers to the hospital from nursing home. Transfers to the hospital can be emotionally and physically difficult for patients and result in many complications of hospitalizations which are costly.

      1 2 3 4 5

   4. **Development of community-based health navigation services**
      This project will develop community-based health navigation services to help patients access healthcare services better.

      1 2 3 4 5

Activity 3 Continued

5. **Integration of Primary Care and Behavioral Health**
Integration of primary care services and behavioral health can serve to identify behavioral health diagnoses early which would allow for rapid treatment and making sure that treatments for medical and behavioral health conditions are compatible and do not conflict with each other. Care for all conditions are delivered under one roof by familiar healthcare providers. Increased healthcare access and coordination of care for both services are key objectives.

1 2 3 4 5

6. **Behavioral health community crisis stabilization services**
This project will help increase access to behavioral crisis stabilization services in select counties within the 10 county region which allows access to healthcare services and providers supporting a de-escalation of crisis. The project may include the creation of a mobile crisis team that will assist in moving patients safely from the community to services. The mobile crisis team may provide follow-up care after stabilization to ensure continued wellness.

1 2 3 4 5

7. **Evidence based strategies for disease management in high-risk/affect populations (Adults only)**
The goal of this project will be to ensure clinical practices in the community and ambulatory care (outpatient) setting using evidence-based strategies to improve the management of heart disease. Evidence-based strategies are when physicians or providers use research evidence along with clinical expertise and patient preferences. The project will work closely with medical practices serving adults. The project will also focus on improving doctor's population management and the adoption of activities that will help increase patient confidence and success.

1 2 3 4 5

8. **Integration of the palliative care into the PCMH model**
The goal of this project is to increase access to palliative care programs for persons with serious, advanced illness and those at end of life. Palliative care is medical care that relieves pain, symptoms and stress caused by serious illnesses, improving patients' quality of life. This is to help ensure that care and end of life planning needs are understood, addressed and met prior to decisions to enter hospice or seek further aggressive care. This project will assist in ensuring that pain needs are met and further health changes can be planned for.

1 2 3 4 5

Activity 3 Continued

9. **Strengthen mental health and substance abuse infrastructure access systems**
This project is designed to support collaboration among leaders, professionals and community members working in mental, emotional and behavioral health promotion, substance abuse and other disorders for chronic disease prevention, treatment and recovery. This project will also focus on strengthening the infrastructure for mental, emotional and behavioral health promotion and prevention. This project may focus on creating collaborative care between mental and primary care providers in the primary care setting and using telehealth services with the emerging field of tele-addictionist services. Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.

1 2 3 4 5

10. **Disease preventative care and management in both clinical and community settings**
This project is looking for primary care practices to utilize EMRs (Electronic Medical Records) in order to improve the prevention, early identification and management of the patient population. The EMR can be used to develop patient registries and reminders for follow-up care. Care is focused on disease prevention through partnering with the community resources including the community health department and chronic disease management through improved collaboration between the office and other agencies which can assist patients stick to their plan and avoid ED visits and preventable hospitalizations.

1 2 3 4 5

11. **Patient & Community Activation for Uninsured, non-Utilizing (NU), and low utilizing (LU) populations.**
Implementation of a Patient and Community Activation Activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care. This project will look to increase access to care for the uninsured and non-utilizing/low utilizing populations and change the way primary and preventative services are delivered so as to help the populations to encourage appropriate utilization of preventive and non-emergent services

THIS IS THE END OF THIS ACTIVITY. PLEASE DO NOT TURN THE PAGE.

Last Activity

1. Please check one.

   ○ I do not wish to remain engaged in this area's healthcare planning initiative.

   ○ I wish to remain engaged in this area's healthcare planning initiative.

2. The best way to contact me is: **Check One.**

   ○ By email: ______________________________
   (Please Print)

   ○ By Cell Phone: ______________________________
   (Number)

   ○ By Landline: ______________________________
   (Number)

THIS IS THE END OF THE PARTICIPATION PACKET. PLEASE REMAIN QUIET.
THANK YOU FOR YOUR PARTICIPATION.

We Want to Hear From You!

A large group of regional hospitals and health organizations are working together to plan how they can expand care and services to their patients and control costs.

In order to improve healthcare services in the communities served by these organizations, **we need feedback from the residents of our communities.** We need to hear about what the health needs of the communities are and what health resources are lacking.

Please complete an online survey found at: www.RMSresults.com/healthsurvey

This survey will take approximately 7 minutes. Upon completion, you will have the opportunity to participate in focus groups paying participants $75!!

The market research is being conducted by Research & Marketing Strategies, Inc. (RMS), an independent market research firm near Syracuse, NY. Your response will remain confidential and anonymous.

The online survey will remain open through early November 2014.

The information contained in this study has been obtained from primary sources and/or was furnished directly from the clients listed in this report. All source materials and information so gathered and presented herein are assumed to be accurate, but no implicit or expressed guarantee of data reliability can be assumed. This study has been prepared in the interest of a fair and accurate report, and therefore all of the information contained herein, and upon which opinions have been based, have been gathered from sources that Research & Marketing Strategies, Inc. (RMS) considers reliable.

RMS staff has reviewed and inspected the primary data results obtained from the surveyed individuals from the client. RMS has no undisclosed interests in the subject for which this analysis was prepared, nor does RMS have a financial interest in the client other than as a contracted vendor for this research. RMS' employment and compensation for rendering this research is not contingent upon the values found or upon anything other than the delivery of this report for a pre-determined fee.

The findings of this market study are indicators of the current opinions and perceptions of the surveyed individuals based on the designed methodology. They do not guarantee product or service success, but are to be considered a tool to supplement management activities. The contents of this study are for limited private use only. Possession of this report, or a copy thereof, does not carry with it the right of publication nor may it be used other than for its intended use by anyone other than the client, without the prior written consent of the client or RMS. No change of any item in this study shall be made by anyone other than RMS. Furthermore, RMS shall have no responsibility if any such change is made without its prior approval.

Certified by:

Mark Dengler, President
Research & Marketing Strategies, Inc.

Date: November 26th, 2014

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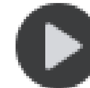
YouTube 

Join the thousands of RMS View**Point** members on our research panel that get paid to participate in market research surveys, focus groups, and other studies. Are you interested in joining? Visit us here:

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