



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at Six Health Care Facilities in
Fresno, California*

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This report was produced in collaboration with Central California Legal Services, Inc.

November 2000

The Access Project is a national initiative supported by the Robert Wood Johnson Foundation and the Annie E. Casey Foundation. It works in partnership with the Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that improve healthcare access and promote universal coverage, with a focus on people who are without health insurance.

If you have any additional questions, or would like to learn more about our work, please contact us.

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Central California Legal Services, Inc. (CCLS) is the major provider of free civil legal services in Central California on domestic violence, landlord/tenant conflicts, health access, education/youth issues, economic development, immigration, elder abuse prevention, consumer issues, homeless concerns, and public benefits. It was established over thirty years ago and services the central valley counties of Fresno, Merced, Tuolumne, Mariposa, Tulare, and Kings. Nearly one quarter of a million low income individuals reside in these counties, which are home to some of the poorest communities in the state. In 1998, CCLS established a project called the Fresno Health Consumer Center (FHCC) to assist low-income consumers with health access problems through community education or individual assistance. Through its newly designed health consumer database, FHCC tries to identify broad trends affecting low-income consumers' access to health care in Fresno County.

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EXECUTIVE SUMMARY

The number of uninsured Americans rose significantly over the last decade—according to current estimates, 43 million people are now without health insurance. While it is often assumed that the uninsured can easily obtain health care, much research demonstrates that lack of insurance leads to reduced access to health care and poorer health outcomes. Moreover, recent changes in the healthcare market have exposed healthcare providers to financial pressures that may be limiting their ability to provide care for the uninsured. However, access to care for the uninsured varies greatly across regions and communities.

The Community Access Monitoring Survey (CAMS) project, an initiative of The Access Project, provided support to organizations in 24 communities to survey uninsured patients receiving care at local facilities. The goals of the project were to investigate the effectiveness of local facilities in responding to the needs of the uninsured and to document barriers the uninsured face when seeking care.

This report summarizes national data on the impact of health insurance on access to care and health outcomes, and presents the results of the survey in one community, Fresno, California. The survey was conducted in the summer of 2000 and gathered information from 1,040 people who in the previous year obtained health care while uninsured at one of six facilities in the region. These included two hospitals, the University Medical Center and Community Medical Center; two urban clinics, Sequoia Health Foundation Clinics and Poverello House/ Holy Cross Center for Women; and two rural clinics, United Health Centers-Parlier and United Health Centers-Mendota. The report also compares the experiences of Fresno respondents with those of uninsured patients surveyed at other CAMS sites across the country who received care at similar facilities.

UNIVERSITY MEDICAL CENTER AND COMMUNITY MEDICAL CENTER

Respondents for both hospitals described difficulties related to openness to the uninsured and indigent, staff encounters, and payment for care.

- ◆ Only 18% of respondents for Community Medical Center, and 36% for University Medical Center (UMC) said their hospital was open and accepting even if they couldn't pay, compared to the 61% average for respondents for all urban and suburban hospitals included in the CAMS project nationwide. An even smaller proportion--14% at Community Medical Center and 29% at UMC--

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said their hospital had a reputation for providing "a lot" of care to the uninsured, compared to the national CAMS average of 44%.

- ◆ Nearly half of Community Medical Center respondents expressed dissatisfaction with encounters with receptionists/admitting clerks and billing clerks, while the averages for these indicators for all CAMS urban and suburban hospitals were under 20%. Moreover, only 10% of Community Medical Center respondents, and 29% of UMC respondents, said they were "always" treated with respect, compared to the average of 61%.
- ◆ Significant proportions of respondents for Community Medical Center found the facility's hours and location a problem, at least sometimes. The average waiting time to see a provider at both hospitals--over 80 minutes--was much higher than the 63 minute average for similar CAMS facilities. The average numbers of days to get an appointment at UMC--19--was almost double the average for Community Medical Center.
- ◆ Respondents for UMC who said they needed help paying for their medications or medical care were more likely to receive assistance than respondents for Community Medical Center. However, more than half of respondents at both hospitals who needed help paying for medications, and more than 4 in 10 who needed help paying for medical care, said that staff "never" offered assistance. One-third of Community Medical Center respondents who received prescriptions said they did not fill any of them because of cost. This compared to 9% at UMC.
- ◆ Over half of respondents for both hospitals who owed money to their facility said their debt would make them not seek care there in the future. In comparison, the average for similar CAMS facilities was 28%. Only 31% of respondents for Community Medical Center, and 51% for UMC, said they would use their facility if they were insured. The average for similar CAMS facilities was 77%.

SEQUOIA HEALTH CLINICS AND POVERELLO HOUSE/HOLY CROSS CENTER

Respondents for Poverello House, a free clinic, expressed very high levels of satisfaction with almost all aspects of clinic care, including openness to the uninsured, encounters with staff, interpreter services, and assistance with payment. While respondents for Sequoia Health Clinics also expressed satisfaction with staff encounters and interpreter services, they were much more likely to report issues related to openness to the uninsured and assistance with payment.



- ◆ 97% of Poverello House respondents said the clinic was open to caring for them even if they couldn't pay, compared to only 45% of Sequoia respondents.
- ◆ Over 80% of respondents at both clinics reported being satisfied or very satisfied with their encounters with staff. 92% of Poverello House respondents said they were "always" treated with respect.
- ◆ Almost all Poverello respondents who needed help paying for medications received their medications at no cost, compared to two in five at Sequoia. Almost all Poverello respondents who needed help paying for medical care reported that staff "always" offered help, compared to 17% of Sequoia respondents.
- ◆ No Poverello respondents said their experience paying for care at the clinic would deter them from seeking care there in the future, compared to 11% of Sequoia respondents. Almost half of Sequoia respondents who owed money to the clinic said their debt would make them not seek care there in the future.

UNITED HEALTH CENTERS: PARLIER AND MENDOTA

Respondents for both of these rural clinics expressed satisfaction with staff encounters, interpreter services, clinic hours, and location. Almost all felt their payment experience would not deter them from seeking care at their clinic in the future. However, Mendota respondents rated their clinic higher than Parlier respondents with respect to openness to the uninsured and indigent, and were more likely to say they received assistance from staff if they needed help paying bills. However, they also reported longer waiting times to see providers.

- ◆ Over 90% of Mendota respondents, but only around 50% of Parlier respondents, reported that the clinic was open to them even if they could not pay, and that it had a reputation for providing care to the uninsured.
- ◆ Over 90% of respondents at both clinics said they were "always" treated with respect by staff.
- ◆ At both clinics, all respondents who said they needed help with translations reported that interpreters were available, and around 90% rated the ability of interpreters as very good.
- ◆ About two of five respondents at both clinics reported problems with the waiting times to see a provider. The average time reported by Mendota respondents was 45 minutes longer, and by Parlier respondents 18 minutes longer, than the average reported

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by respondents for all rural clinics included in the CAMS project nationwide.

- ◆ Among respondents who said they needed help paying their medical bills, 91% of Mendota respondents said staff "always" offered help, compared to 29% of Parlier respondents. However, only 12% of Parlier respondents said they were "never" offered help. Few respondents who owed money to either clinic said it would deter them from seeking care there in the future.
- ◆ 97% of Mendota respondents, and 72% of Parlier respondents, said they would use the clinic again if they were uninsured. The average for all rural clinics included in the CAMS project was 90%.



INTRODUCTION

In 1998, 44 million people in the United States were uninsured, representing a 38% increase in the number of uninsured since 1987.¹ While this number fell slightly between 1998 and 1999, according to current estimates 43 million people are still without health insurance.² The ability of the uninsured to gain access to health care is thus a major national issue, but it is at the community level that the consequences are most apparent.

Many assume that even when people are uninsured, they are readily able to obtain health care. A 1999 survey of college-educated people in the United States found that 57 percent believed that uninsured people are able to get the care they need from doctors and hospitals, up from 43 percent in 1993.³ However, research has consistently demonstrated that individuals without insurance see health providers less frequently, receive fewer preventive health services, and delay care. As a result, when the uninsured do get care, they often require more expensive care. For example, the uninsured tend to come into the hospital more severely ill, and are hospitalized more frequently for conditions that could have been treated on an ambulatory, and less costly, basis.

Structural changes in the health care environment over the last decade have only increased the barriers to care facing the uninsured. Managed care companies have negotiated aggressively with health care providers to reduce their fees; as a result, providers have fewer financial resources available to subsidize care for the uninsured. At the same time, the number of uninsured has risen, increasing the demand for services, while various direct and indirect public subsidies that in the past helped support care for the uninsured have been eroding. All types of health care providers are affected by these changes, but perhaps the hardest hit are the "safety net" providers—those that, either by legal mandate or explicitly adopted mission, are dedicated to providing health care regardless of patients' ability to pay—as they generally treat the largest number of uninsured patients.

The situation, however, is not uniform across communities. Comparing the provision of care in different metropolitan statistical areas (MSAs), the author of a recent study said, "One of the most striking findings from our analysis...is the tremendous variation in the provision of uncompensated care by MSAs across the country. Our MSA-level analysis indicates that there are pockets in the country where the uninsured have very limited access to hospital care."⁴

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COMMUNITY ACCESS MONITORING SURVEY PROJECT

To gather information about the barriers to care facing the uninsured in particular communities and at particular facilities, The Access Project initiated the Community Access Monitoring Survey (CAMS) project. The CAMS project funded 24 organizations across the country to survey uninsured individuals who received care at key facilities in their communities.

PROJECT GOALS

The goals of the project were to

- ◆ Learn directly from those without health insurance about their experiences and perceptions when obtaining health care
- ◆ Investigate the effectiveness of local facilities in responding to the needs of the uninsured
- ◆ Document barriers to care for the uninsured
- ◆ Use survey data to stimulate dialogue and promote change
- ◆ Put a local face on the problem of the uninsured

THE SURVEY DESIGN

The survey instrument was developed by Dennis Andrulis, Ph.D., Research Professor at SUNY Health Science Center in Brooklyn, NY. It was used to gather information about the experiences of over 10,000 uninsured patients at 58 facilities nationwide, and results were reported for each of the participating communities. The survey asked respondents a range of questions about their experiences when they received care at a particular facility while they were uninsured, such as their perceptions of the facility's willingness to provide care, satisfaction with interactions with staff, waiting times for appointments, ability to obtain needed medications, and difficulties paying for care.

Survey Limitations

The survey was designed to gather data about key providers that care for the uninsured in various communities. It was not intended to provide definitive conclusions, and readers should be aware of the limitations of the methodology.

The survey was based on a convenience rather than a random sample. Respondents were recruited at a variety of local sites, such as homeless shelters, employment offices, and housing projects, sometimes with the intent of collecting information from a particular group or groups, and the number of people who were eligible but refused to participate was not recorded. For these reasons, survey

responses cannot be generalized either to all uninsured people or to all uninsured patients who used a given facility--rather, they reflect the experiences only of those surveyed.

In addition, while all surveyors received uniform training in administration of the survey, it was not possible to evaluate actual implementation at each site. The authors also did not have access to other sources of data, such as medical records, that might have added to or verified individuals' reports, and they were not able to assess environmental factors, such as the volume of uninsured patients treated, operating budget, and staff size, which might have affected a facility's provision of care. Finally, the surveys gathered information only from uninsured individuals who were able to access care at particular facilities; they did not capture either the numbers or the experiences of those who were unable or never tried to access care.

Intended Uses of the Survey

The survey was intended to provide information on a frequently overlooked topic, the actual experiences of the uninsured when they obtain care. Notwithstanding its limitations, the authors expect that the results will be useful to providers, local officials, community representatives, and others in suggesting issues related to the provision of care for the uninsured in their communities that may benefit from further discussion or more rigorous and comprehensive study, in order to assist them in improving access to care for this population.

ABOUT THIS REPORT

This report, along with reviewing some of the research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Fresno, California. The survey was conducted by Central California Legal Services, Inc. in the summer of 2000, and gathered information from uninsured individuals who received care at one of six health care facilities in Fresno County in the previous year. Along with providing the results of the survey for these facilities, the report compares the results with aggregate responses at all similar facilities surveyed as part of the CAMS project nationwide. A report presenting the overall findings for all surveyed sites will be released in Spring 2001.



LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

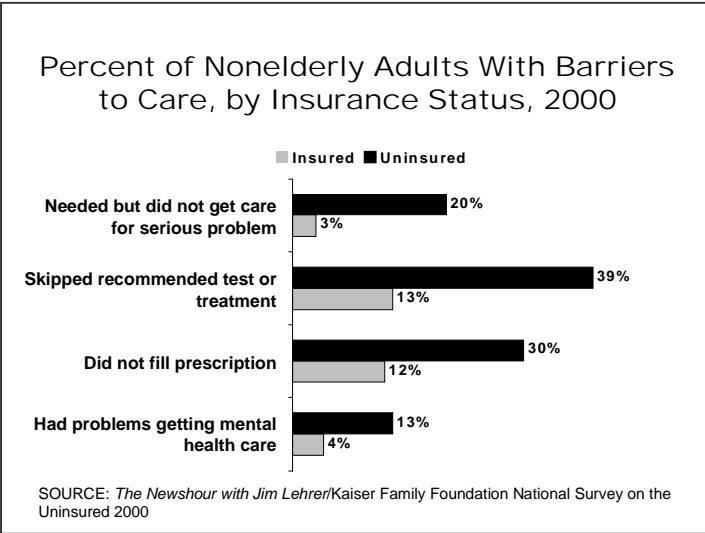
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the last decade have increased the difficulties the uninsured face in obtaining care.

LACK OF INSURANCE AND ACCESS TO CARE

Research has shown that lack of insurance is associated with reduced utilization of health services. Some studies have found that:

- ◆ One third of uninsured U.S. residents reported problems of access to care, and about two-thirds had delayed care, because of problems in paying for health services;⁵
- ◆ The uninsured were almost six times more likely than the insured to have postponed health care for a serious condition because they couldn't afford it;⁶
- ◆ Uninsured pregnant women were at greatest risk for starting prenatal visits late and having an inadequate number of visits compared to both privately insured women and those with Medicaid;⁷
- ◆ Among persons with severe mental illnesses, the uninsured were less likely to access needed health care than those covered by insurance;⁸
- ◆ Uninsured adolescents were twice as likely as insured adolescents not to have had a doctor's visit in the past year;⁹
- ◆ Lack of insurance was related to substandard care, such as using fewer procedures and having shorter inpatient stays.^{10,11}

A recent national survey by the Kaiser Family Foundation, for example, found that the uninsured were much more likely than the insured to not have gotten care for a serious problem, skipped a recommended test or treatment, not filled prescriptions, and had problems getting mental health care.¹²



LACK OF INSURANCE AND HEALTH OUTCOMES

Research has also found that lack of health insurance correlates with poorer health outcomes. Some studies have shown, for example, that

- ◆ Children living in poverty were more likely to receive lower quality care and to die in infancy;¹³
- ◆ Uninsured children were much more likely not to have received medical care for common conditions like ear infections—illnesses that if left untreated could lead to more serious health problems;¹⁴
- ◆ The uninsured were more likely to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes.¹⁵
- ◆ Patients without insurance were more likely to die in the hospital,¹⁶ suggesting that they had postponed care until it was too late;
- ◆ Uninsured women were at significantly greater odds of late stage diagnosis of cervical cancer;¹⁷ while those with breast cancer had lower survival rates;¹⁸
- ◆ Young adults without insurance had higher mortality rates because they were unable to obtain needed care.¹⁹

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BENEFITS OF IMPROVED ACCESS TO HEALTH CARE

While lack of insurance is a serious barrier to receiving care, making health services available to the uninsured has been shown to lead to significant improvement in the use of critical services and in health status. One recent study found, for example, that uninsured individuals who obtained insurance coverage had better access to care based on indicators such as having a usual source of care, higher satisfaction with providers, and a greater number of physician visits in the previous year.²⁰ Another study in the Seattle area found that having insurance was strongly related to ease of access to care, and was the strongest predictor for having a regular source of care.²¹ When previously uninsured individuals were enrolled in a managed care program, investigators found their use of health care services similar to that of a commercially enrolled group.²²

Increased access to care for individuals infected with HIV represents one of the most recent dramatic instances of improvements in both mortality and morbidity. According to the Centers for Disease Control and Prevention, the first decrease in AIDS-related opportunistic infections occurred in 1997.²³ One of the major reasons cited was increased availability of new anti-retroviral therapies. The proportion of patients using this treatment regimen—for which many rely on public sector support through Medicaid and other programs—increased from 24% to 60% in just one year (1995 to 1996). This dramatic change is one demonstration of how access to critical treatments can make the difference between life and death.

Making health related services available to the uninsured at little or no cost has also led to improved outcomes. For example, the Women, Infants, and Children program, which provides food assistance to low-income children starting with the prenatal period, has helped reduce the prevalence of iron-deficiency anemia in infants and children.²⁴ Similarly, a study in Wisconsin showed that children at an initial preventive health visit who did not have access to the free Early and Periodic Screening, Diagnosis, and Treatment program had a greater number of medical and dental health problems and fewer preventive dental care visits than their contemporaries who had had continual access to the program.²⁵



THE HEALTH CARE MARKET AND CARE FOR THE UNINSURED

Over the last decade, changes in the health care market have significantly affected the provision of care to the uninsured.²⁶ Rising premiums and eroding employer-offered coverage have left increasing numbers of workers, especially low-income workers in small firms, without access to affordable health insurance. The rising numbers of uninsured increase the demand for uncompensated care on "safety net" providers—those that are charged by legal mandate or by mission with providing care to all regardless of ability to pay—as well as on other charity providers.

This increased demand is occurring simultaneously with other market changes that make it more difficult for providers to respond. An increasingly competitive health care environment, increased efforts to contain costs, and the growth of managed care have reduced the financial resources available to providers to subsidize care for the uninsured.

For example, many states have enrolled Medicaid recipients in managed care plans in an effort to reduce costs. These plans generally negotiate with providers for lower fees and also contract with multiple providers to provide services to Medicaid clients in order to obtain the best rates. However, while these changes may help reduce the overall costs of the program, they can have indirect effects on the ability of charity providers to care for the uninsured. Because major charity providers usually treat large numbers of both Medicaid and uninsured patients, they have traditionally depended on Medicaid revenues to help subsidize care for those who are unable to pay. If their Medicaid revenues decline, both because they see fewer Medicaid patients and because they receive lower fees for those they do treat, less money is available to cross-subsidize uncompensated care for the uninsured.

Research studies have in fact found that the penetration of managed care plans in a market and pressure on reimbursements are associated with reduced access to care for the uninsured. They have shown that

- ◆ In general, access to health care for low-income uninsured people is lower in states with high Medicaid managed care penetration, compared to uninsured persons in states with low Medicaid managed care penetration; access to care for low-income uninsured persons is also lower in areas with high uninsurance rates.²⁷
- ◆ Physicians involved with managed care plans and those who practice in areas with high managed care penetration tend to provide less charity care.²⁸

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- ◆ Between 1988 and 1997, while national hospital costs for uncompensated care remained around 6% of annual operating costs, the ratio of per capita expenses for the uninsured to per capita expenses overall declined by 22%. This change, which was associated with reductions in Medicaid reimbursement rates, indicated that the uninsured were losing ground compared to the insured in the number, level, or quality of services received.²⁹

In this environment, some safety net providers have in fact been forced to close, raising the question, "Where...will the safety net reside for the large number of uninsured in the community who do not qualify for [public] programs?"³⁰



COMMUNITY CONTEXT

Note: Information in this section was provided by Central California Legal Services, Inc.

Fresno County, with an estimated population of 793,800, has a 28.1% poverty rate. For children under five, the poverty rate is 42.2%, the third highest in California.³¹ The UCLA Center for Health Policy Research estimated that 17% of the combined populations of Fresno, Merced, and Madera counties were without health coverage of any kind.³²

These predominantly rural counties share a number of characteristics, including agriculture-based economies, high public assistance rates, weak economic development, inadequate transportation services, poor access to health care, high teen pregnancy rates, and limited economic and social resources.

Because the economy of the region is largely agricultural and service-related, many central valley residents work in low-skilled, low wage jobs that do not offer health benefits. Unemployment rates in Fresno County are in the double digits and have surpassed both state and national rates for the past 20 years. In January, 2000, the Fresno County unemployment rate was 15.2%, significantly higher than the statewide rate of 4.7%, which was at its lowest since 1969.³³ The high county unemployment rate is partly a reflection of the seasonal nature of much of the area's employment in industries such as agriculture.

FRESNO AREA HEALTH FACILITIES

Community Medical Centers, founded in 1897, is a not-for-profit, privately owned and operated health care provider with multiple acute, long-term and outpatient care facilities, including Sante Physicians and Community Medical Providers. The system is governed by a volunteer board of directors composed of civic leaders, business professionals, and physicians. **Community Medical Center-Fresno** is a 408-bed hospital that offers 24-hour emergency care and has an intensive care unit, a cardiovascular care unit, a birth center, and an inpatient cancer center.

In 1996, Fresno County turned over the operation of the county hospital, Valley Medical Center, to Community Medical Centers, and the facility was renamed **University Medical Center**. University is a 334-bed hospital providing a broad range of inpatient and outpatient services, including 24-hour emergency and urgent care, and Level 1 Burn and Trauma Centers. The transfer agreement called for

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Community Medical Centers to continue to operate the highly acclaimed Burn Center and Trauma Center, as well as to provide indigent care.

Sequoia Community Health Foundation, Inc. was established in 1978 as a private, non-profit corporation and is a Federally Qualified Health Center (FQHC). Sequoia operates three health care clinics within the City and County of Fresno and serves a large urban and rural population of mostly low-income residents and farm worker families. Hispanics, African-Americans, and Southeast Asians are equally represented in the population the Sequoia centers serve.³⁴

The Holy Cross Clinic is a free clinic located within the Poverello House in Fresno. The clinic opened in 1983 when Saint Agnes Medical Center, responding to the expressed need of the Poverello House, provided basic staffing and supplies. The clinic provides free medical and dental care on an episodic basis to persons without health insurance and to the medically indigent. In the year 1998-1999, Holy Cross Clinic had 5,516 medical visits and 1,018 dental visits.

United Health Centers of the San Joaquin Valley, Inc. (UHC) was established in 1971 by a group of community members who wanted to improve the health conditions of rural families. Centers were established in the rural communities of Sanger, Orange Cove, Kerman, Huron, Earlimart, Parlier, and Mendota. The clinics are FQHCs and primarily serve Hispanic farm worker families, most of whom are uninsured and for whom the clinics provide the only available medical care.³⁵

For the CAMS project in Fresno, Central California Legal Services, Inc. surveyed patients who received health care in the previous year while uninsured at one of the following facilities: University Medical Center, Community Medical Center, Sequoia Health Clinics, Poverello House/Holy Cross Clinic, United Health Centers-Parlier, and United Health Centers-Mendota.



SURVEY METHODOLOGY

Surveys were administered by five trained administrators and community volunteers, and took an average of 20 minutes to complete. All interviews were conducted between May 12 and July 14, 2000. Hmong, Cambodian and Spanish-speaking personnel were hired to help administer the survey.

Survey interviews were conducted at the Community Medical Center-Fresno, University Medical Center, Sequoia Health Clinics, and at the Parlier and Mendota United Health Clinics, as well as at various health fairs, community-based organizations, and the Fresno Adult Class at John Burroughs Elementary School. Survey administrators also identified respondents by going door to door.

Prospective respondents were pre-qualified using a brief screening survey. Eligible respondents who completed the surveys received a \$10 food certificate from Food 4 Less Supermarket.

Because respondents were not randomly selected, the survey results cannot be generalized to the entire population of uninsured persons or of individuals receiving care at the targeted facilities. The results reflect the experiences only of those surveyed.

In all, 1,040 surveys were completed. They included 229 for patients who received care at Community Medical Center-Fresno, 226 who received care at University Medical Center, 151 who received care at Sequoia Health Clinics, 139 who received care at United Health Centers-Parlier, 142 who received care at United Health Centers-Mendota, and 153 who received care at Poverello House/Holy Cross.

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SURVEY RESULTS

This section describes and compares the survey results for respondents who received care while uninsured at the two hospitals and four clinics included in the CAMS project in Fresno, California: University Medical Center, Community Medical Center-Fresno, United Health Centers Parlier, United Health Centers Mendota, Sequoia Health Clinics, and Poverello House/Holy Cross Center. The results for each facility are compared with the results for similar facilities included in the Fresno CAMS project, as well as with the aggregate results for all similar facilities included in the CAMS project nationwide. All comparisons were statistically significant unless otherwise indicated (ns=non-significant).

See Appendix A for tables of the results for each of the Fresno hospitals and clinics, as well as for the aggregate results.

UNIVERSITY MEDICAL CENTER AND COMMUNITY MEDICAL CENTER

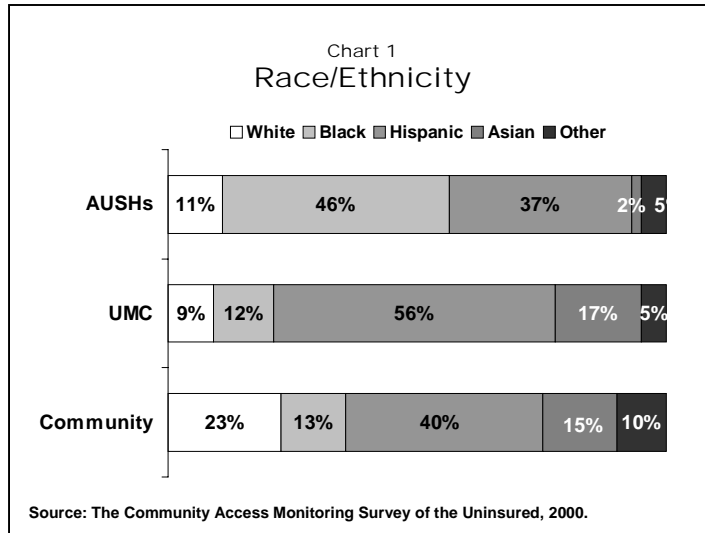
This section presents survey results for respondents who received care at one of the two hospitals included in the Fresno CAMS project and compares them with averages for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide.

RESPONDENT CHARACTERISTICS

Respondents varied in age and were ethnically diverse. Most of the respondents preferred to take the survey in English.

University Medical Center (UMC) and Community Medical Center respondents varied in age and one-fifth of each respondent group answered on behalf of a child. In comparison, the average proportion answering on behalf of a child for AUSHs was 15 percent.

A larger proportion of respondents who received care at UMC identified themselves as Hispanic than at Community Medical Center or AUSHs (56% vs. 40% and 37%). A smaller proportion of those who received care at both UMC and Community Medical Center identified themselves as African-American than at AUSHs. The proportion of Asian-American respondents for both hospitals was significantly higher than the AUSH average. Seventeen percent of UMC respondents and 15 percent of Community Medical Center respondents identified themselves as Asian-American, while the average for AUSHs was only two percent. (Chart 1)



Despite the large percentage of Hispanic respondents in both groups, relatively few respondents--only 13 percent of UMC respondents and five percent of Community Medical Center respondents--chose to take the survey in Spanish. The average for AUSHs was 28 percent.

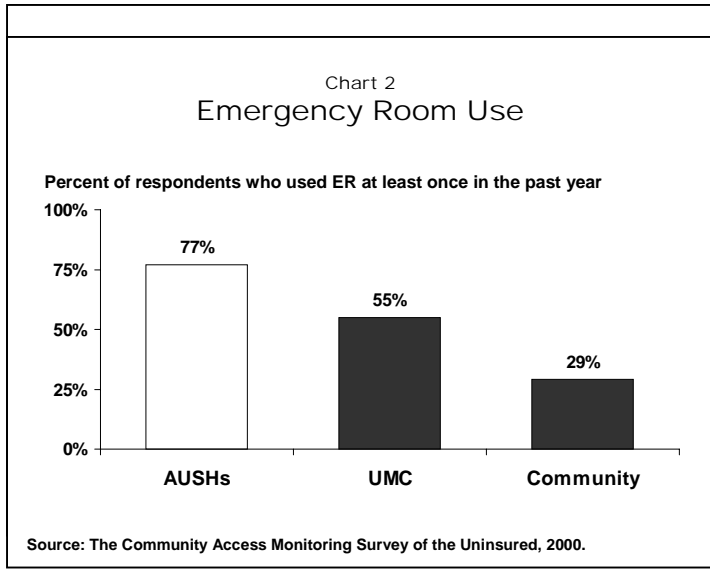
USE OF HEALTH SERVICES

Respondents for both hospitals reported emergency room utilization that was lower than the AUSH average. UMC respondents were more likely than Community Medical Center respondents to report that they used the facility more than once in the past year.

Both respondents groups were less likely to state that they sought care to treat a chronic problem than the average for AUSHs.

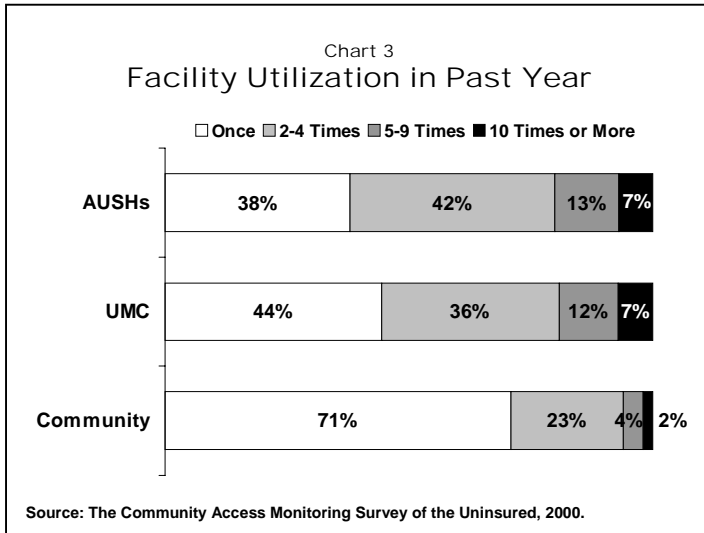
Emergency Room Use. Over half of the UMC respondents and 29 percent of Community Medical Center respondents reported using the emergency room at least once in the past year. In comparison, the average for AUSHs was much higher. (Chart 2)

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Outpatient Clinic Use and Hospitalization. Sixteen percent of Community Medical Center respondents said they had been to an outpatient clinic and 16 percent said that they had been admitted to the hospital at least once in the past year. These figures were much lower than the proportions for UMC and AUSHs, which were between 32 to 45 percent.

Frequency of Use. More than half of the UMC respondents used the facility more than once in the past year, while only three of ten Community Medical Center respondents reported using the facility multiple times. For AUSHs, the average proportion of respondents using a facility only once was 38 percent. (Chart 3)



Chronic Health Problems. One of five (19%) respondents for UMC and nine percent of Community Medical Center respondents said they sought care to treat a chronic problem. The average for AUSHs was much higher (32%).

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

In general, respondents for both facilities were not likely to report that their facility had been open and accepting to them or that it had a reputation for providing care to the uninsured. Respondents' satisfaction with staff varied.

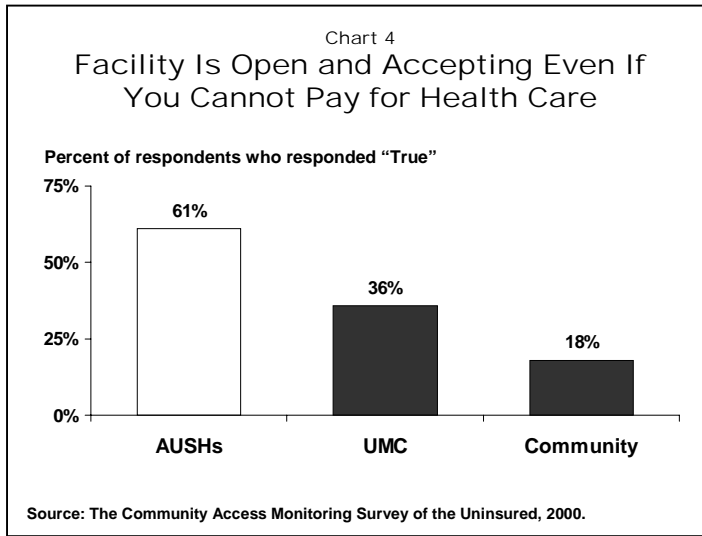
Facility Openness. Both groups of respondents rated their hospital's openness to the uninsured well below the AUSH average on two measures. First, both groups were much less likely than the AUSH average to state that the hospital had been open and accepting to them if they were unable to pay. Only 36 percent of UMC respondents and 18 percent of Community Medical Center respondents saw their hospital as open and accepting, compared with 61 percent for AUSHs. Second, respondents in both groups were more likely than the AUSH average to say that, in their experience, these hospitals offered only "some care" for those who couldn't pay (UMC 24%, Community 21%, AUSH average 12%). (Chart 4)

During the time I was there, they turned away several people who had no insurance. I feel they treated me because I lost a lot of blood and my situation was an emergency.
Community Medical Center Respondent

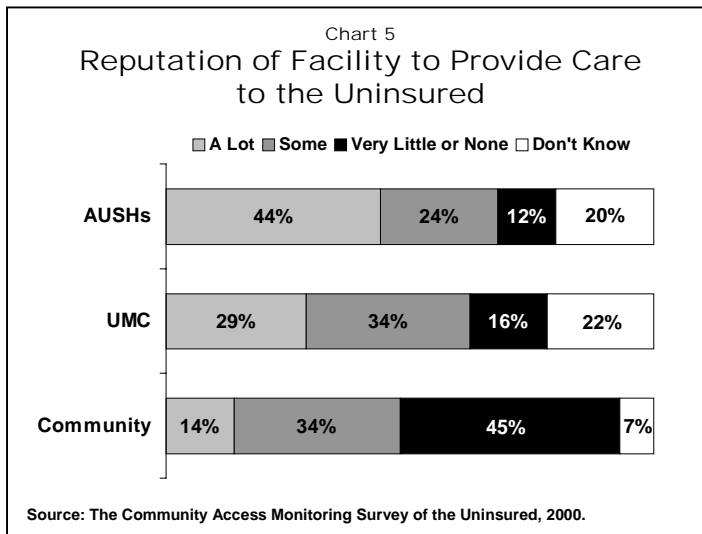
I couldn't afford payments so they got rude and referred me to UMC.
Community Medical Center Respondent

The billing clerk was very unfriendly. She made my financial situation seem worse than what it actually was. It's embarrassing enough to not be able to afford insurance. But someone being rude to you because you don't have money makes matters worse.
UMC Respondent

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Facility Reputation. Respondents were also asked about the reputation in the community of their respective hospitals for providing care to the uninsured. Twenty-nine percent of UMC respondents said their hospital provided "a lot" of care to the uninsured, compared to only 14 percent of Community Medical Center respondents, while the average for AUSHs was 44 percent. In addition, slightly less than half of Community Medical Center respondents said that the facility provides very little or no care. (Chart 5)



The staff don't seem like they have a true concern for the people in need, especially the ones with financial problems.

UMC Respondent

Satisfaction with Providers. Levels of satisfaction with staff varied, especially in comparison to AUSH averages. Respondents at both facilities were more likely to rate their encounters with admitting clerks/receptionists, billing clerks, physician assistants and, to a lesser extent, examining physicians as unsatisfactory or very unsatisfactory



than the AUSH average. In some categories, these ratings were given by almost half of the respondents. For example, among respondents who received care at Community Medical Center, 46 percent said their encounters with receptionists/admitting clerks were unsatisfactory or very unsatisfactory, while 42 percent rated encounters with billing clerks at this level.

I was very disappointed with the service I received at Community Medical Center. The doctors were excellent. But the receptionist at the front desk wasn't courteous at all. This was my first impression of this facility. Not to mention the billing clerk had a very bad attitude once she found out I had no insurance. I don't plan on going there again. They didn't make me feel comfortable at all.
Community Medical Center
Respondent

With respect to pharmacist encounters, UMC respondents differed significantly from both Community Medical Center respondents and AUSH averages; one in five (21%) UMC respondents voiced dissatisfaction with their pharmacist encounters, compared to 5 percent for Community Medical Center and an AUSH average of 6 percent.

Finally, respondents at both facilities were significantly less likely to state that they were always treated with respect than the AUSHs average. In fact, only one of ten respondents for Community Medical Center said they were “always” treated with respect, compared to 29 percent of UMC respondents (AUSH average: 61%).

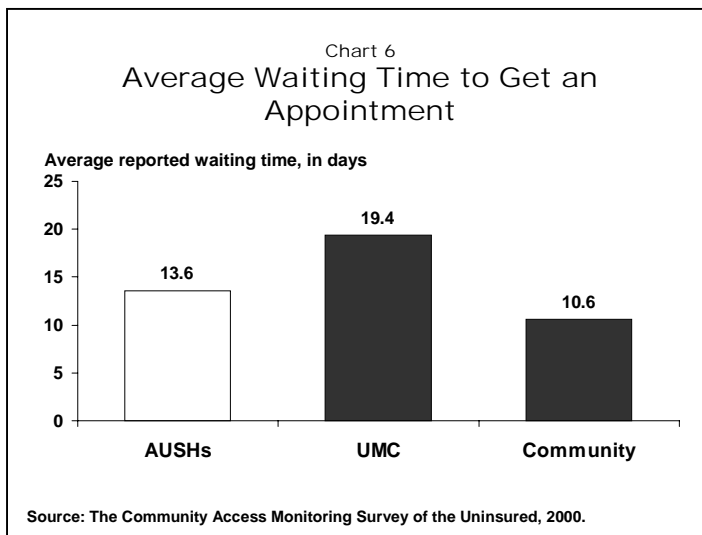
ACCESSIBILITY

Community Medical Center respondents were more likely to report difficulties on accessibility measures than UMC respondents. However, many respondents for both facilities reported various problems with access.

Ratings on accessibility tended to differ significantly both between the two hospitals and between the hospitals and the AUSH average. A higher proportion of Community Medical Center respondents said that facility hours, emergency room hours and location were “sometimes a problem” (28%, 32% and 44% respectively) than either UMC respondents (3%, 3% and 16%) or the AUSH average (9%, 6% and 21%). Both UMC (60%) and Community Medical Center (64%) respondents were more likely to rate convenience to public transportation as satisfactory than the AUSH average (43%).

Waiting Time for Appointments. Respondents for both hospitals ranked their facilities lower than the AUSH average with respect to waiting times to see the provider on the day of the appointment; over half of the UMC respondents (55%) said that waiting times were “often” or “always” a problem (AUSH average: 26%; Community Medical Center: 19%). The average number of days to get an appointment reported by UMC respondents was more than 19--well above both the AUSH average and the average number of days reported by Community Medical Center respondents. (Chart 6)

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In the outpatient clinic you make your appointment. I arrived 15 minutes early for my appointment and still had to wait for an hour and a half before seeing the doctors.
UMC Respondent

Waiting Times to See Providers. Respondents for both facilities reported significantly longer average waiting times to see a provider on the day of a visit than the AUSH average (UMC: 85 minutes; Community Medical Center: 82 minutes; AUSH average: 63 minutes).

LANGUAGE ISSUES

One of five UMC respondents reported needing assistance with translations. Of these respondents, close to half said interpreters were not very available, but almost all rated the quality of interpreter services they received as very good or fair.

You need to bring an interpreter or you will have a longer wait to receive care.
UMC Respondent

The small number of respondents for UMC who needed help with translations (21%) limits interpretation of responses on questions related to language. Of the small UMC group needing help, 42 percent stated that an interpreter was not very available, while almost 90 percent stated that the ability of the translator was very good or fair. (Fewer than 10% of Community Medical Center respondents reported needing help with translations.)

OBTAINING PRESCRIPTION MEDICATIONS

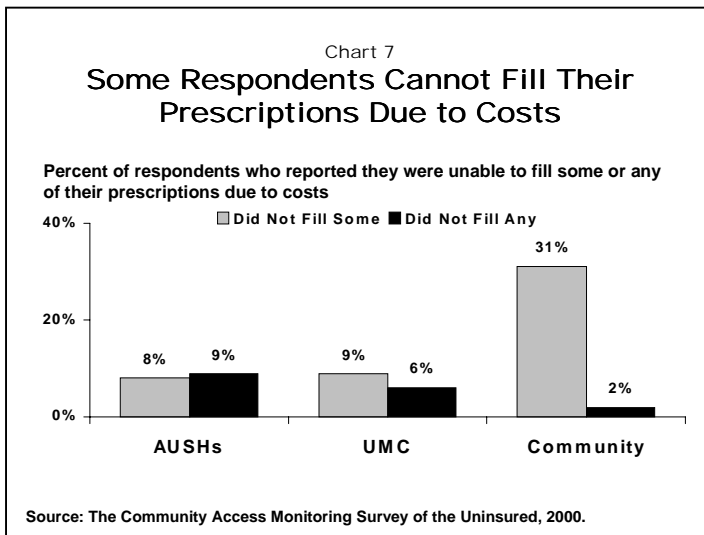
Lower proportions of Community Medical Center and UMC respondents reported receiving prescriptions for medications than the AUSH average. Among those who did receive prescriptions, one-third received their medications free. However, one-third of Community Medical Center respondents said they did not fill any of their prescriptions because of cost.



Nevertheless, UMC respondents were more likely to report difficulty paying for medications.

UMC respondents were much more likely than Community Medical Center respondents to receive prescriptions for medications (56% versus 20%; AUSH average: 74%). For those who did receive prescriptions, about one-third at each facility reported that they received medications at no cost (AUSH average: 27%). Although the number of respondents was small, 31 percent of those needing medications at Community Medical Center said they were unable to fill some of them because of cost. (Chart 7)

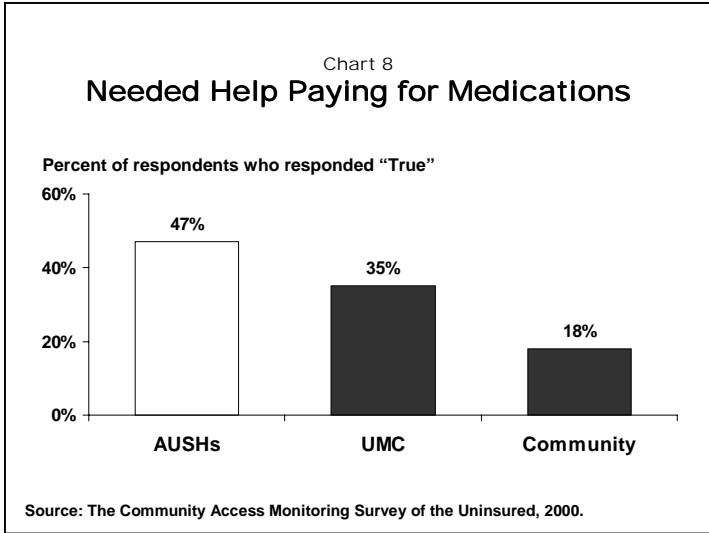
I got free medicine at the hospital but when they sent me to the pharmacy I couldn't afford it
Community Medical Center Respondent



One in ten Community Medical Center respondents and 8 percent of UMC respondents who received prescriptions said they did not understand the instructions for using them.

Three of ten (29%) respondents for UMC and 17 percent of respondents for Community Medical Center said paying for their medications was “very difficult.” The average for AUSHs was 40 percent. Similar proportions of respondents reported that they needed financial assistance to obtain their medications. (Chart 8)

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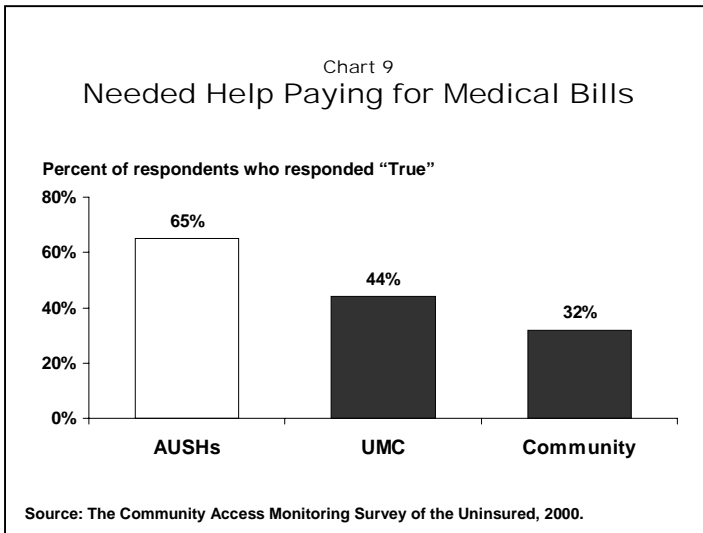
I had a difficult time getting medicine. They gave me Tylenol #3 but I didn't have the money for a few days, so I had to endure the pain.
Community Medical Center Respondent

Notably, UMC respondents were more likely than those using Community Medical Center or the AUSH average to report that staff “always” offered help in paying for their medications (32%, 18% and 16% respectively).

CONCERNS OVER PAYMENT FOR HEALTH CARE

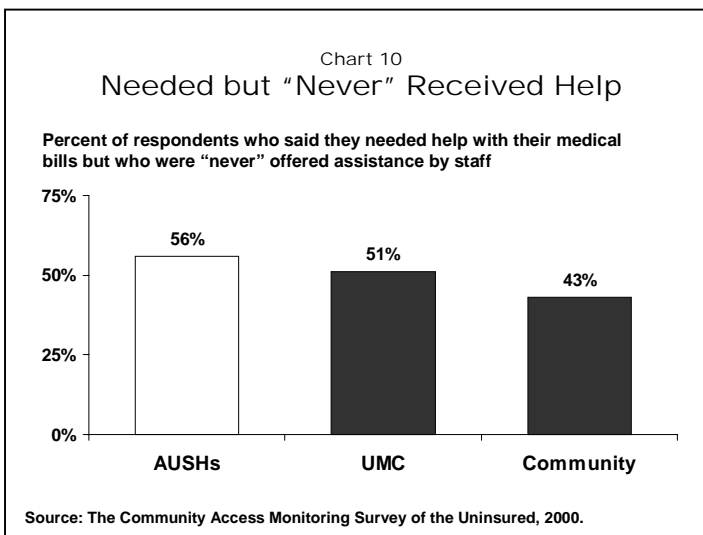
Although both Community Medical Center and UMC respondents were less likely than the AUSH average to report that paying their medical bills was very difficult, UMC respondents were more likely to have difficulty than Community Medical Center respondents.

UMC respondents were more likely than Community Medical Center respondents to state that paying for their care was very difficult (41% and 29%, respectively). Both were well below the AUSH average of 61 percent. The proportion of respondents for each facility who said they needed financial assistance with their medical bills was similar. (Chart 9)



Of those needing help, more than one in three respondents for UMC stated that they were “always” asked if they needed assistance. This proportion was much higher than both Community Medical Center (16%) and the average for AUSHs (19%). Nonetheless, respondents for both facilities, as well as for AUSHs, also had high proportions stating that they “never” were offered help (UMC: 51%; Community Medical Center: 43%; AUSH average: 56%). (Chart 10)

I was well treated at the hospital, the only thing is that they didn't offer me any help with the bill and medicines.
UMC Respondent



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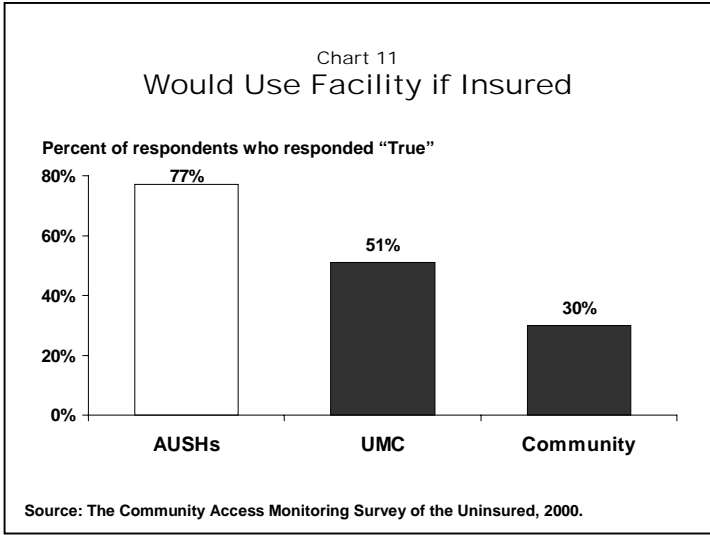
Among those who received assistance, one-third of UMC respondents had their bill waived, which was significantly higher than the proportion for both Community Medical Center (12%) and AUSHs (8%). Community Medical Center respondents were more likely to be offered a monthly installment plan than those for UMC (62% vs. 31%, respectively).

SEEKING CARE IN THE FUTURE

Community Medical Center respondents were much more likely than UMC respondents to report that they owed money to their facility. However, half of both Community Medical Center and UMC respondents who had unpaid bills said the debt would deter them from seeking care at the facility again. Compared with the AUSH average, both respondent groups were less likely to report that they would use the facility again if they had health insurance.

Community Medical Center had a significantly higher proportion of respondents who said they owed money to the facility (68%) than UMC (39%) (AUSH average: 61%). However, both UMC and Community Medical Center had similarly high proportions of respondents who stated that their debt would deter them from using the facility in the future (59% and 52%, respectively—proportions much greater than the AUSH average of 28%).

A very high proportion of respondents at both facilities, but especially at Community Medical Center, said they would **not** use the facility if they were insured. Only 30 percent of those using Community Medical Center and half of those using UMC said they would use the facility if insured, compared to an AUSH average of over 75 percent. (Chart 11)



SEQUOIA HEALTH CLINICS AND POVERELLO HOUSE/HOLY CROSS CENTER

This section presents survey results for respondents who received care at one of the two urban clinics included in the Fresno CAMS project and compares them with averages for All Urban and Suburban Clinics (AUSCs) included in CAMS nationwide.

RESPONDENT CHARACTERISTICS

Respondents varied in age and ethnicity. Poverello respondents were more likely to be male. The majority of the respondents took the survey in English.

Respondents varied in age. One of five respondents for Sequoia answered on behalf of a child, while only five percent of Poverello respondents answered on behalf of a minor.

Overall, respondents at both clinics were more diverse than the AUSC average: only 7 percent of Poverello respondents and 15 percent of Sequoia respondents were white, compared with 22 percent for AUSCs. For both clinics, Hispanics comprised the majority of those completing the surveys (Sequoia 61% and Poverello 54%).

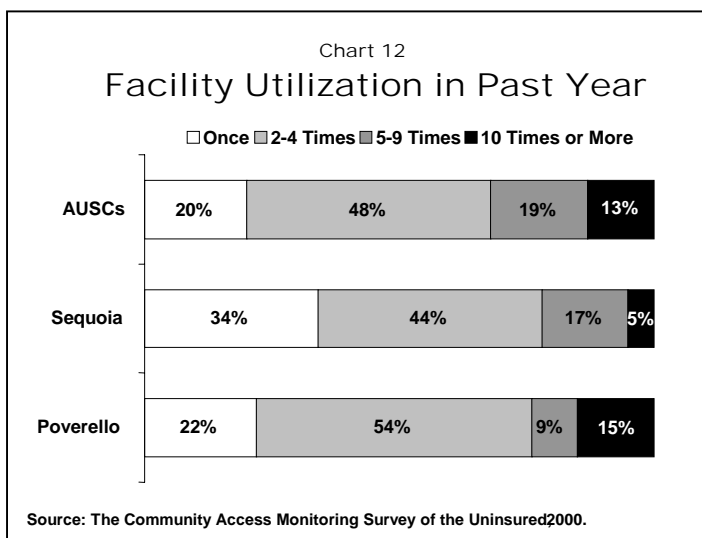
While most respondents took the survey in English, 29 percent of Sequoia respondents and 11 percent of Poverello respondents chose to take it in Spanish.

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USE OF HEALTH SERVICES

Poverello respondents were more likely to report having used the facility more than once in the past year than Sequoia respondents. Poverello respondents were less likely to report seeking treatment for a chronic health problem than Sequoia respondents.

Frequency of Use. While two out of three Sequoia respondents reported that they used the clinic more than once in the past year, the proportions for Poverello and AUSCs were even higher (78% and 80%, respectively). (Chart 12)



Chronic Health Problems. One of four (26%) respondents for Sequoia and 17 percent of respondents for Poverello stated that they used the clinic to treat a chronic problem such as asthma or diabetes. These proportions were lower than the 38 percent average for AUSCs.

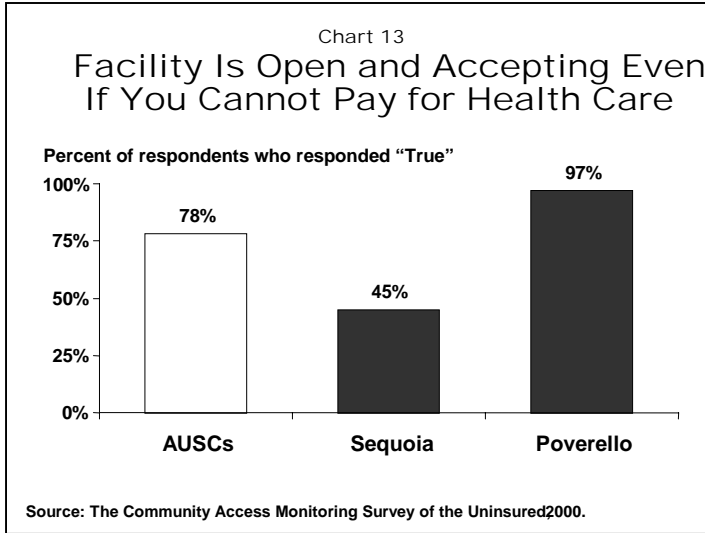
OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

Poverello respondents were much more likely to report that the clinic had been open to them and that it had a favorable reputation in the community for providing care for the uninsured than either Sequoia respondents or the averages for AUSCs. However, staff satisfaction ratings for both respondents groups were very high.

Facility Openness. The two clinics differed significantly with respect to respondents' perceptions of their openness to and provision of care for the uninsured. While almost all (97%) respondents reported that in their experience Poverello was open to and accepting of them even if they were unable to pay, only 45 percent of Sequoia respondents



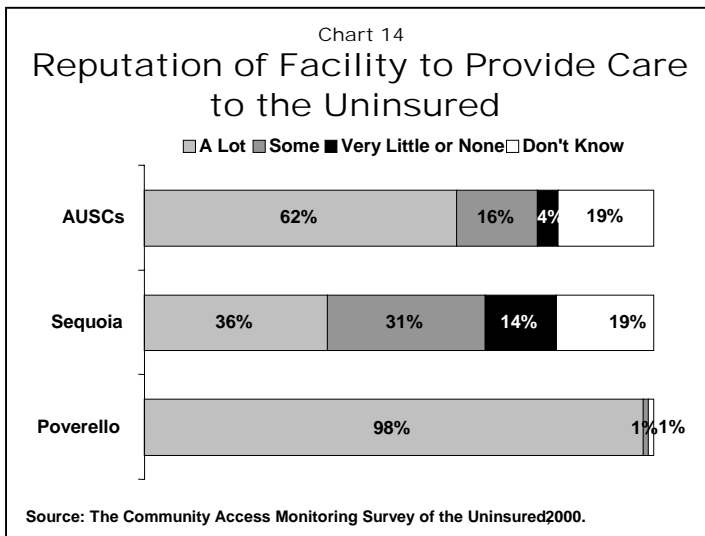
reported similar perceptions. The average for AUSCs was 78 percent. (Chart 13)



Facility Reputation. A similar pattern emerged regarding reputation in the community. Virtually all Poverello respondents felt that the clinic had a reputation for providing “a lot” of care for those who cannot pay, while only 36 percent of Sequoia respondents felt the same. The AUSC average was 62 percent. (Chart 14)

They treat all sorts of people. It doesn't matter in what economic state you are.
Poverello Respondent

I love it here. Poverello House is free and they really care. I still get my prenatal vitamins and visits when I need to go.
Poverello Respondent



Sequoia treats you with respect and dignity regardless -- with or without benefits. That's what makes Sequoia a good place to go for any problem you may have.
Sequoia Respondent

Satisfaction with Providers. In general, Poverello respondents tended to rate their satisfaction with providers higher than both Sequoia respondents and the averages for AUSC. However, ratings at both of the clinics were high. Between 85 and 99 percent of the respondents for both clinics reported that they were either “very satisfied” or

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“satisfied” with the care and service they received from receptionists, nurses, physician assistants, and doctors.

Notably, a small proportion of Sequoia respondents reported that they were unsatisfied with the service they received from receptionists and billing clerks (15% and 20%, respectively). These proportions were more than twice as high as the average for AUSCs (7%).

ACCESSIBILITY

In general, between one-fourth and one-half of Sequoia respondents stated that they had problems with hours, location, waiting time, and transportation. Poverello respondents were much more likely to report that these issues were “never a problem” than either Sequoia respondents or the averages for AUSCs.

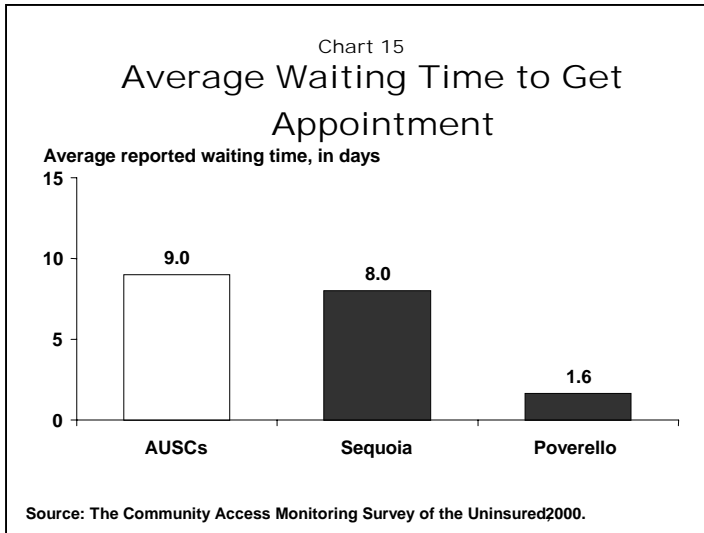
*They have good service
and they are prompt.*
Poverello Respondent

Sequoia respondents (41%) were about four times more likely to report that the location of the facility was a problem for them at least sometimes than Poverello respondents (11%), and twice as likely as the average for AUSCs (21%). Indeed, the average reported travel time for Sequoia respondents was 29 minutes, while the averages for AUSCs and Poverello were 10 to 15 minutes shorter, respectively.

One of four respondents for Sequoia stated that convenience to public transportation and assistance with transportation when needed were a problem for them at least sometimes. In contrast, very few (3% or less) Poverello respondents reported similar problems. The averages for AUSCs were 10 percent or less.

About one-fourth (27%) of the respondents for Sequoia reported that the clinic’s hours were a problem for them at least sometimes. In contrast, 41 percent of Poverello respondents reported that the hours presented a problem.

Waiting Time to Get an Appointment. Sequoia respondents were much more likely to report that the waiting time to get an appointment was a problem for them at least sometimes than Poverello respondents and the average for AUSCs (51% vs. 7% and 39%, respectively). While the average reported waiting time by Poverello respondents was almost two days, the average waiting time for Sequoia respondents was eight days. (Chart 15)



Waiting Time on Day of Appointment. Three of five respondents for Sequoia reported that waiting time on the day of an appointment was a problem for them at least sometimes. In contrast, only 15 percent of Poverello respondents reported similar difficulties. Nevertheless, the average reported waiting time by respondents for both groups was very similar—about 53 minutes.

Sequoia is where anyone who wants good care can be seen in minutes. Appointments in a few days. Sequoia is the one for you, I wouldn't change Sequoia for any other clinic.
Sequoia Respondent

LANGUAGE ISSUES

Between 30 and 40 percent of respondents for both facilities said they needed help with translations. Among those who needed help, almost all of the respondents said that interpreters were available and were satisfied with the interpreters' ability.

Three of ten (29%) respondents for Poverello and 38 percent of respondents for Sequoia stated that they required assistance with translations. Among these respondents, nearly all reported that an interpreter was either "very available" or "available." Notably, however, 91 percent of Poverello respondents said interpreters were "very available." Similarly, while nearly all the respondents for both clinics said that the ability of the interpreter was either "very good" or "good," 93 percent of the Poverello respondents said their interpreters were "very good."

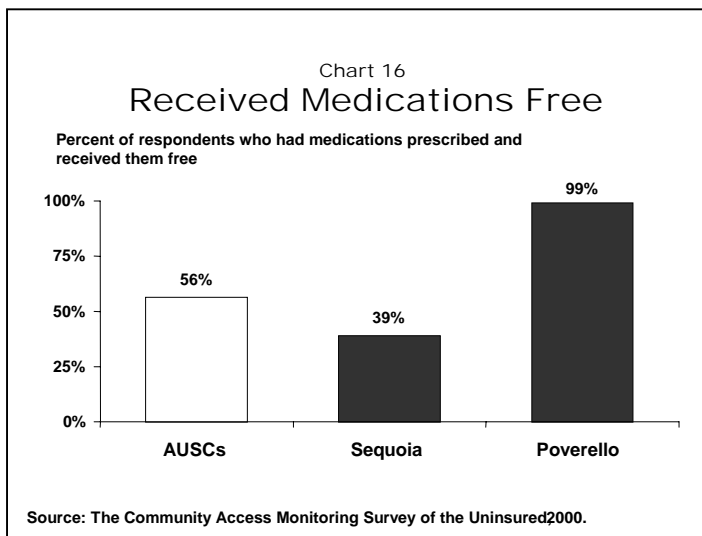
Eighty-five percent or more of the respondents who needed assistance with translations said they noticed signs in their language in the waiting areas and were provided with written information in their language.

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OBTAINING PRESCRIPTION MEDICATIONS

The majority of respondents for both clinics received prescriptions for medications. Nearly all the Poverello respondents received their medications free. About one-third of the respondents for both clinics stated that paying for their medications was very difficult and that they needed financial assistance.

Respondents' experiences with respect to medications differed significantly between the clinics. The great majority of Poverello respondents—87 percent—stated that they were prescribed medications, compared with 56 percent at Sequoia (the AUSC average was 70 percent). Almost all Poverello respondents who had medications prescribed received their medications free, while the proportion was 39 percent for Sequoia respondents and 56 percent for AUSCs. (Chart 16)



Sequoia respondents were more likely to report that they received medications using a pharmacy card or that they paid for them at a drug store than Poverello respondents (26% and 35%, respectively). For those needing medications, 100 percent of Poverello respondents and 85 percent of Sequoia respondents reported understanding their instructions (ns). However, one in six Sequoia respondents reported either that they were not provided with medication instructions (13%) or did not understand the instructions they received (2%).

About one in three respondents for each facility reported that paying for medications was very difficult, which was similar to the AUSC average (27%). For those needing help, at Poverello nine in ten

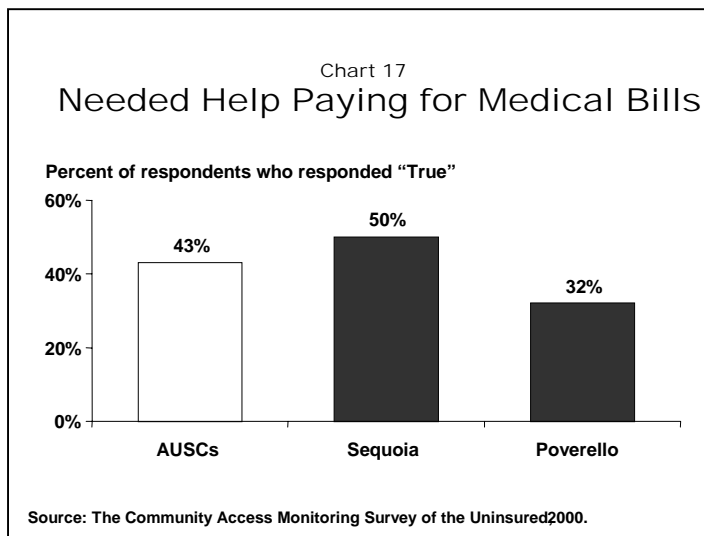


reported they “always” received it—a proportion significantly higher than the 42 percent AUSC average.

CONCERNS OVER PAYMENT FOR HEALTH CARE

About one-third of the respondents for both clinics reported that paying their medical bills was very difficult. Sequoia respondents were more likely to report that they needed help paying their bills, but Poverello respondents were much more likely to report that they always received help.

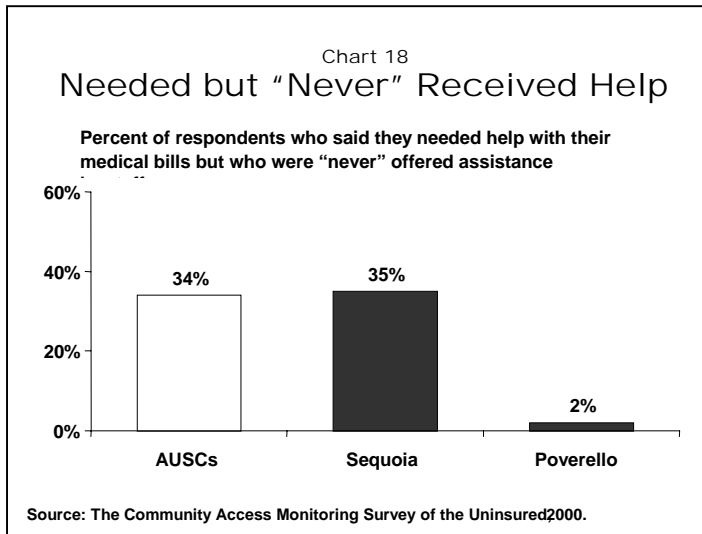
About half of Poverello respondents (51%) reported that paying for medical care was “easy,” while 36 percent stated it was “very difficult” (compared with 28% for Sequoia). Half of Sequoia and one third of Poverello respondents stated they needed help paying their medical bill. (Chart 17)



Almost all Poverello respondents who needed help were offered assistance by staff (94%) and virtually all had their bills waived. These proportions were significantly higher than for Sequoia and the AUSC average. At Sequoia, only 17 percent of respondents reported that staff “always” offered to find out if financial assistance was available, and when it was offered, such assistance usually came in the form of paying in monthly installments (65%) rather than waiving the bill (18%). Conversely, a little more than one-third of Sequoia respondents and only two percent of Poverello respondents reported that they were “never” offered help. (Chart 18)

Arranged it so I may seek help by putting down payment and monthly payments.
Sequoia Respondent

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SEEKING CARE IN THE FUTURE

One of ten respondents for Sequoia said their past experiences paying for care would deter them from seeking care at the clinic again. Most of the respondents reported that they would use the clinics again if they had health insurance.

Compared with Poverello and AUSCs, a small but significant percent of Sequoia respondents stated that their experience paying for care would make them not seek care at the clinic again (11%, compared with 0% for Poverello and 4% for AUSCs).

Similarly 35 percent of Sequoia respondents stated that they owed money to the facility, and almost half (45%) of that group commented that this debt would make them not seek care there in the future (the proportion at Poverello was negligible). These proportions were well above the AUSC averages (20% and 23% respectively).

Finally, about four in five of the Sequoia respondents stated that they would use the facility if they were insured, which was comparable to the AUSC average and modestly higher than the proportion for Poverello (70%).



UNITED HEALTH CENTERS: PARLIER AND MENDOTA

This section presents survey results for respondents who received care at one of the two rural clinics included in the Fresno CAMS project and compares them with averages for All Rural Clinics (ARCs) included in CAMS nationwide.

RESPONDENT CHARACTERISTICS

Respondents varied in age. The majority of respondents identified themselves as Hispanic and over half of the Mendota respondents chose to take the survey in Spanish.

Respondents for both United Health Centers Parlier (Parlier) and United Health Centers Mendota (Mendota) varied in age. Three of ten respondents for Mendota and 24 percent for Parlier answered on behalf of a child.

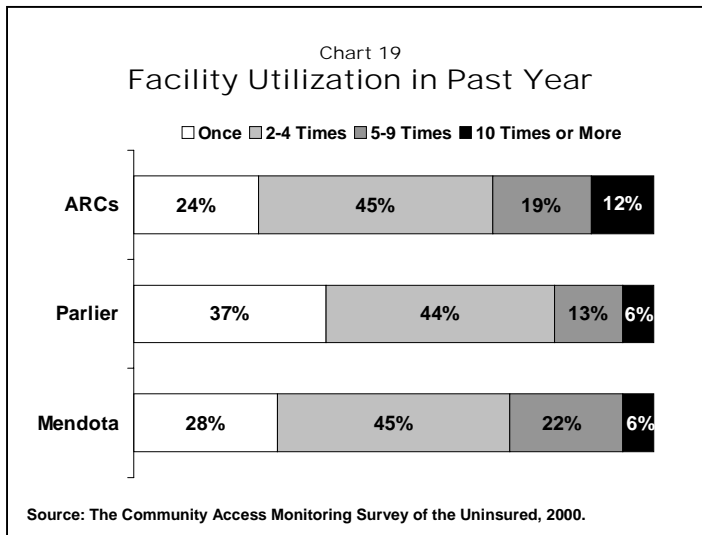
About nine of ten respondents identified themselves as Hispanic (Parlier 87% and Mendota 94%). In comparison, the average for ARCs was 53 percent. Notably, although the proportion of Hispanic respondents was similar in both groups, only six percent of Parlier respondents, but 54 percent of Mendota respondents, chose to take the survey in Spanish.

USE OF HEALTH SERVICES

Frequency of utilization was similar for both respondent groups and not appreciably different from the ARC average. The proportion of respondents who sought care to treat a chronic problem for both clinics was significantly lower than the ARC average.

Frequency of Use. Most respondents for both clinics made four or fewer visits to the facility—81 percent at Parlier and 73 percent at Mendota. These proportions were similar to the ARC average of 69 percent. Six percent of both Parlier and Mendota respondents said that they used their respective clinic ten or more times in the past year. In comparison, the average for ARCs was 12 percent. (Chart 19)

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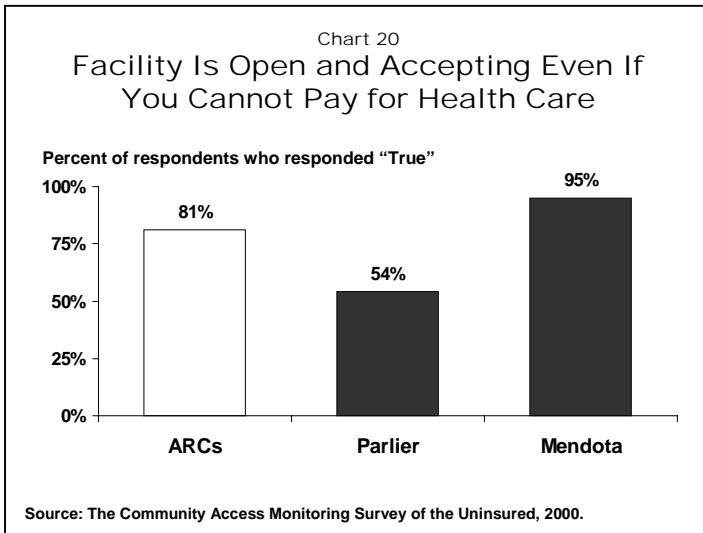
Chronic Health Problems. Parlier and Mendota respondents were more than half as likely to report that they sought care to treat a chronic problem such as asthma or diabetes as the ARC average (13% and 14% vs. 34%, respectively).

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

Compared to the ARC average, Mendota respondents were more likely and Parlier respondents much less likely to report that their facility had been open and accepting to them even if they could not pay or that it had a positive reputation for providing care for the uninsured. Respondent satisfaction with providers was very high and very few reported that they were unsatisfied with the care they received from staff.

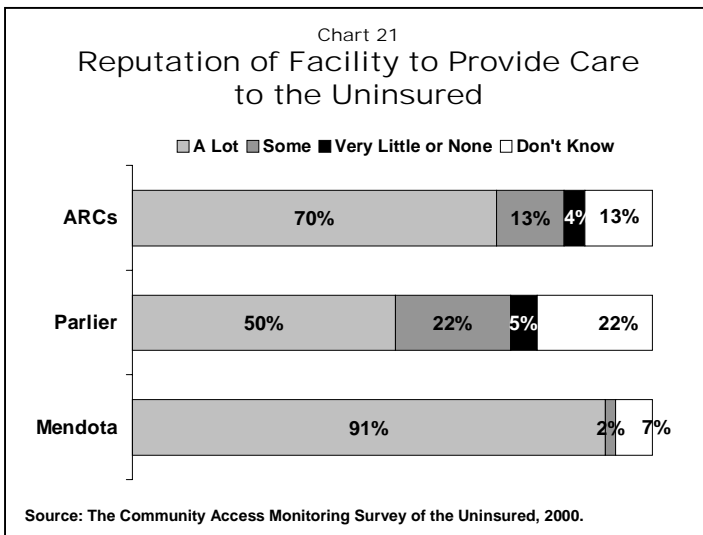
Facility Openness. Almost all of Mendota respondents (95%) stated the clinic had been open to them even if they were unable to pay, which was significantly higher than both the proportion at Parlier (54%) and the ARC average (81%). Notably, over one in five (22%) Mendota respondents commented that in their experience the facility offers “some care” to the uninsured (Parlier 1% and ARC average 7%). (Chart 20)

Mendota is good with many people who come here. They never say no.
Mendota Respondent



Facility Reputation. Over 90 percent of Mendota respondents reported that the clinic has a reputation in the community for providing a lot of care for those who cannot pay, compared with 50 percent of those using Parlier and a 70 percent average for ARCs. (Chart 21)

Parlier is only place that would help me without any kind of medical insurance and receive very good medical attention.
Parlier Respondent



Satisfaction with Providers. Satisfaction with providers was high at both clinics; satisfactory or very satisfactory ratings for receptionists, nurses, physician assistants and examining physicians approached or exceeded 90 percent. Fewer than ten percent of the respondents for both clinics stated that they had been unsatisfied with the care and services they received from any provider group. These percentages were similar to the ARC averages.

Arrived at clinic with my sick baby, as soon as I got there they took us right away in the back. Gave my baby check up, medicine. They are really fast. They were really nice to us.
Mendota Respondent

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Ninety percent or more of respondents stated that they were always treated with respect, similar to the ARC average of 92 percent.

ACCESSIBILITY

With the exception of waiting times, fewer than 15 percent of respondents for either clinic reported that accessibility was a problem even sometimes.

Good services, open 7 days a week, open late on some days. Spanish is spoken here fluently because many of us just speak Spanish. That's what makes UHC seek most of us -- farm labors, uninsured. Also they help or let us know where we may apply for medical or some kind of benefits.
Parlier Respondent

Generally, very few (less than 15%) of the respondents for either clinic reported that their clinic's hours, location, or convenience to public transportation were a problem even sometimes. However, the proportion of Mendota respondents that reported that these issues were "never a problem" was higher than both the proportion at Parlier and the averages for ARC, while for Parlier, a higher proportion of respondents reported that they "didn't know" when asked about these issues.

Mendota respondents were especially positive about transportation issues. Over three in four (76%) stated that convenience to public transportation was "never a problem" and 62 percent stated that assistance with transportation if needed was "never a problem." Higher proportions of Parlier respondents reported that they did not know if transportation was a problem.

Waiting Times to Get an Appointment. Two of five (42%) respondents for Parlier stated that the waiting time to get an appointment was a problem for them at least sometimes. In comparison, 29 percent of Mendota respondents found the waiting time to be a problem at least sometimes, and the ARC average was 34 percent. The average reported waiting times between the two respondent groups and between the two clinics and the ARC average did not differ significantly (between 7 and 9 days).

Waiting Time on Day of Appointment. About two of five respondents for both clinics (Parlier 37% and Mendota 41%) reported that the waiting time on the day of an appointment was a problem at least sometimes. The average for ARCs was only slightly higher: 45 percent. However, the average reported waiting time for Mendota respondents was 45 minutes longer, and for Parlier 18 minutes longer, than the ARC average.



LANGUAGE ISSUES

Many of the respondents for both facilities said that they needed help with translations. Among these respondents, nearly all reported favorable experiences with the availability and ability of interpreters.

Over 70 percent of Mendota respondents and 55 percent of Parlier respondents reported that they needed assistance with translations (ARC average 37%). All the respondents who needed help with translations stated that interpreters were “very available” or “available.” Moreover, about 90 percent of the respondents for both clinics rated the ability of the interpreters as “very good.”

I know they do have interpreters on staff and just about everyone speaks the language (Spanish)
Mendota Respondent

OBTAINING PRESCRIPTION MEDICATIONS

Nearly three of four respondents at both facilities received prescriptions for medications. The majority of respondents reported that they received their medications for free, paid for them out-of-pocket, or both.

Seventy-two percent of respondents at each clinic reported receiving prescriptions for medications. The ARC average was 80 percent.

For those needing medications, most received at least some of them at no cost (72% for Parlier, 78% for Mendota, ARC average: 59%). A high proportion of respondents also used a drug store and paid for some or all of their medications (66% for Parlier and 42% for Mendota; ARC average: 59%).

One of ten respondents for Parlier who had medications prescribed reported that they were unable to fill some of their prescriptions because of the cost, which was lower than the ARC average of 17 percent but higher than the proportion for Mendota (3%). Nearly all the respondents reported that they understood their medication instructions.

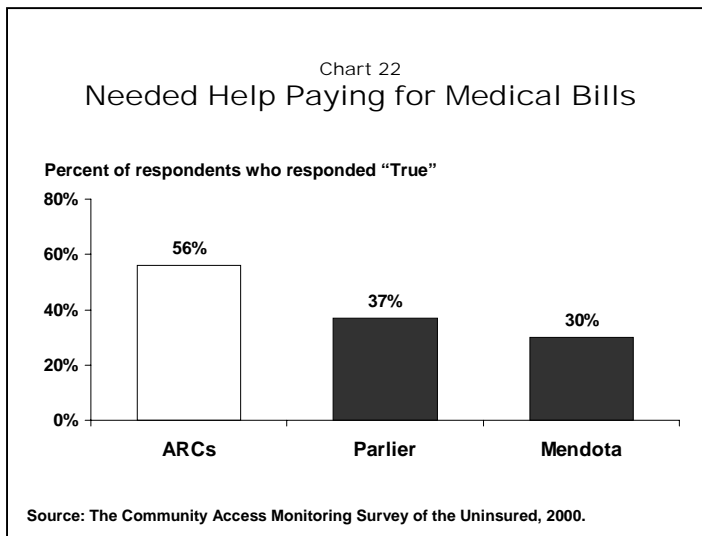
About one of four respondents for both clinics reported that paying for their medications was “very difficult.” This proportion was much lower than the ARC average (43%). Similar proportions (Parlier 27% and Mendota 25%) also reported that they needed financial assistance to help pay for their medications. Nearly nine of ten respondents who needed help received it at least sometimes. Indeed, 83 percent of Mendota respondents were “always” asked if help was needed.

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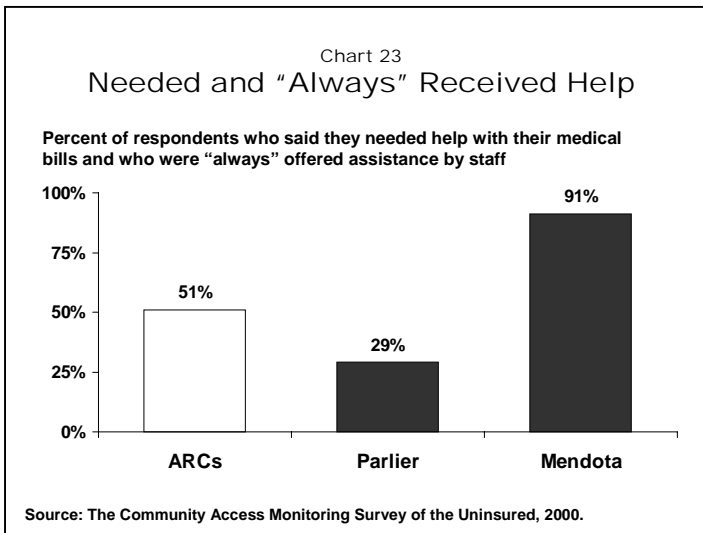
CONCERNS OVER PAYMENT FOR HEALTH CARE

Compared to the ARC averages, Parlier and Mendota respondents were less likely to report having difficulty or needing help paying their medical bills. However, among those respondents who did need financial assistance, Mendota respondents were much more likely to have received help than Parlier respondents or the average for ARCs.

Both Parlier and Mendota respondents were less likely to report that paying for their medical bills was “very difficult” than the average for ARCs (33% and 25% vs. 45%, respectively). Parlier and Mendota respondents were also less likely to need financial assistance paying their medical bills. (Chart 22)



Notably, among the 30 percent of Mendota respondents who said they needed help, 91 percent said staff “always” offered to find out if financial assistance was available. (Chart 23)



While this percentage was much higher than the responses for either Parlier respondents (29%) or the average for ARCs (51%), only 12 percent of Parlier respondents stated they were “never” asked if assistance was needed, compared with the ARC average of 23 percent.

Parlier is only clinic that would agree with my low payments. Still I receive good care here.
Parlier Respondent

Among those who received help at least sometimes, the most common form of help was monthly billing installments. More than a third (36%) of Mendota respondents and 11 percent of Parlier respondents reported that their bills were waived.

SEEKING CARE IN THE FUTURE

Two-thirds of the respondents said their past experiences paying for care would make it easier for them to seek care at the clinic in the future, and about half said it would make no difference or both. One-half of Parlier respondent owed money to the clinic. Nearly all Mendota respondents said they would use the clinic again if they had health insurance.

Over 60 percent of respondents at both facilities stated that their experiences paying for care would make seeking care at the clinic in the future easier. This was significantly higher than the average for ARCs (54%).

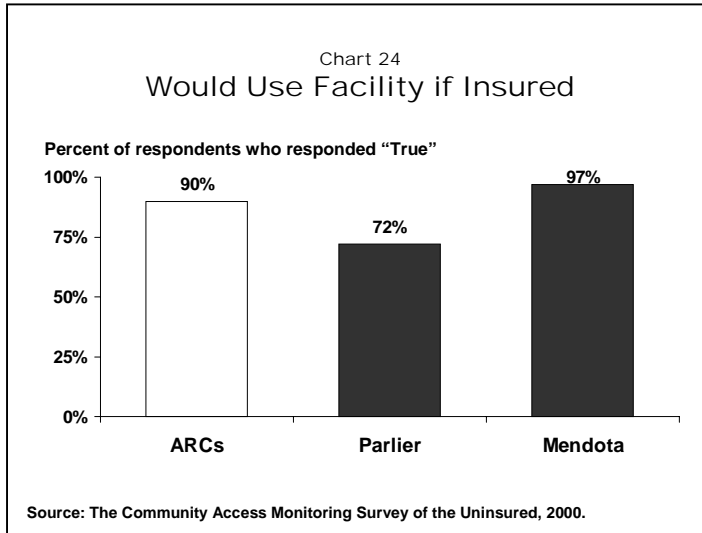
Over 50 percent of the Parlier respondents and only 18 percent of those using Mendota reported that they owed money to their respective clinics. However, the proportion reporting that this debt would deter them from using the clinic in the future was only four percent.

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Very good health clinic. I would be their patient with or without insurance.
Parlier Respondent

Very good people, good hospital. I will not change because I can't seek a better health clinic than this one.
Mendota Respondent

Almost all (97%) of the Mendota respondents stated they would use the facility if they were insured. This proportion was significantly greater than the ARC average (90%) and the proportion for Parlier respondents (72%). (Chart 24)



DISCUSSION

This section discusses some of the perceived strengths and areas for further discussion suggested by the survey results for each of the six facilities.

UNIVERSITY MEDICAL CENTER AND COMMUNITY MEDICAL CENTER

Respondents for UMC and Community Medical Center were racially diverse, but included a larger representation of Asian-Americans and a smaller proportion of African-Americans than the average for all urban and suburban hospitals (AUSHs) included in the CAMS project nationwide. Notably, although there was a sizeable Hispanic population for both facilities, comparatively few respondents chose to take the survey in Spanish.

Aggregated responses from respondents for both facilities indicate a mixed description of their experience(s) at their respective facilities. Specifically, while respondents were less likely than the average for AUSHs to state that they had difficulty paying for their prescriptions or medical bills and more likely to report lower overall utilization of health services, UMC and Community Medical Center respondents were less likely to report that the facilities had been open and accepting to them and that they have a reputation in the community for caring for the uninsured. In addition, respondents expressed higher rates of dissatisfaction with staff than the average and seemed to have more difficulty with accessibility issues such as waiting times.

Community Medical Center respondents were particularly likely to report low emergency room use and the majority of the respondents said they only used the facility once. These figures, taken together with the findings that only one of five found the hospital open and accepting and one of seven thought the hospital had a reputation for providing a lot of care to the uninsured, indicate that further research is warranted into whether there is an association among these results. Although results for UMC were closer to the AUSH average, the same question could be applied to UMC.

Several other findings also merit further consideration. For example, unsatisfactory or very unsatisfactory ratings for staff were significantly higher at both facilities compared with the AUSH average. In addition, only 10 percent of Community respondents and less than three in ten respondents for UMC stated they were always treated with respect by staff, while the average proportion for AUSHs was 61 percent.

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Respondents for both facilities also had difficulties with long waiting times both to get an appointment (particularly at UMC) and to see a provider on the day of an appointment. In addition, measures such as facility and emergency room hours were more likely to be a problem at least sometimes for Community Medical Center respondents than for UMC respondents or the average for AUSHs.

UMC respondents who needed financial assistance to pay for their medications or their medical bill were significantly more likely to receive assistance than Community Medical Center respondents or the AUSH average. One in three at that facility had their medical bill waived, significantly higher than the 8 percent for AUSHs and 12 percent using Community. However, almost half also stated they never were asked about assistance if they needed help paying the bill.

Of those who stated that they owed their respective facilities money, over half stated that such debt would deter them from seeking care there in the future, compared with 28 percent for AUSH respondents. Notably, only half of the UMC respondents and 30 percent of those using Community Medical Center stated they would use their respective facilities if they were insured, well below the 77 percent AUSH average.

SEQUOIA HEALTH CLINICS AND POVERELLO HOUSE/HOLY CROSS CENTER

In general, survey results based on the responses from the two groups indicate that these respondents had positive experiences, particularly those for Poverello. Poverello respondents were much less likely to have difficulty with bills and more likely to receive financial assistance if they needed help than Sequoia respondents. Nearly all the Poverello respondents agreed that the clinic had been very open and accepting to them and that it had a reputation for providing care to the uninsured. Although less positive than Poverello respondents in some areas, respondents for Sequoia seemed generally pleased with the service and experiences at their clinic.

Virtually all Poverello respondents felt that the facility had been open to them even if they were unable to pay for their care and had a positive reputation in the community. In comparison, less than half of the Sequoia group responded similarly. Satisfactory or very satisfactory ratings with both health professionals and other staff tended to be above 80 percent for both facilities, and were in line with the averages for all urban and suburban clinics (AUSCs) included in the CAMS project. In addition, 92 percent of Poverello respondents stated that they were always treated with respect by staff.

The most pronounced respondent differences for access measures between the facilities related to waiting times. Those using Poverello were more likely to state that waiting times both to get appointments and to see the provider on the day of the appointment were never a problem than those using Sequoia, although the estimated reported times to see a provider did not differ between the facilities. Three in five Poverello respondents stated that receiving transportation assistance was never a problem, which was significantly higher than the AUSC average of 22 percent.

Nearly all Poverello respondents needing medications stated that they received them at no cost, a proportion much higher than the two in five Sequoia respondents or the 56 percent AUSC average. In addition, virtually all Poverello respondents who stated that they needed help paying their medical bill were offered help by staff and virtually all stated their bills were waived—both well above the AUSC averages. Only 17 percent of the Sequoia group reported “always” receiving such assistance and fewer than one in five had their bills waived.

Not one Poverello respondent stated that their payment experience would deter them from seeking care at that facility in the future, compared with 11 percent at Sequoia. And about one in three Sequoia respondents (of about half who owed money to that facility) stated that such debt would deter future use.

UNITED HEALTH CENTERS: PARLIER AND MENDOTA

Overall, respondents for both facilities seemed to have very positive experiences at the clinics compared with the average for all rural clinics (ARCs) included in the CAMS project. However, Mendota respondents were much more likely to report fewer problems with access and financial issues. Two indicators of Mendota’s popularity were the nearly unanimous responses that the clinic had been open and accepting to the respondents even though they were uninsured and that the respondents would use the clinic if they had health insurance.

Over 90 percent of Mendota respondents reported that the facility had been open and accepting to them even if they were unable to pay for their care and that the clinic had a very positive reputation in the community. Only about half of the Parlier respondents shared these views, although this proportion was not considerably different from the ARC average. In addition, respondents at both facilities were very likely to state that they were satisfied with clinic staff. Those stating that they were always respected also exceeded 90 percent.

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Mendota and Parlier respondents expressed satisfaction on several accessibility measures in proportions similar to the all rural clinic (ARC) averages. Expressed concerns centered around waiting times for Mendota and, to a lesser extent Parlier, respondents.

All respondents who required interpreter services reported that both clinics made interpreters available, and the quality of the interpreters was perceived as very good or fair.

Proportions needing medications and receiving them at no cost exceeded 70 percent at both facilities, which was higher than the ARC average (59%). However, one in ten of the Parlier group stated they did not obtain any of their medications due to cost while over 80 percent of the Mendota respondents who needed assistance paying for their medications were offered help.

Almost 90 percent of those needing help paying for their medical care at Mendota were “always” offered assistance, compared to two in five at Parlier were offered such assistance. However, because the proportion who needed help was relatively low (less than 40 percent at both facilities), the differences were not statistically significant.

For those who stated they owed their respective facilities money, less than five percent at each clinic stated that this debt would deter future use. Notably, nearly all of the respondents for Mendota stated that they would use the facility if they were insured.

CONCLUSION

This report provides information on a topic that has not often been investigated, the experiences of the uninsured when they access health care at their local health facilities. Given the large numbers of uninsured in our country, it is a topic of increasing importance.

Because the survey was not based on a random sample, the results are more suggestive than definitive. Notwithstanding its limitations, however, the authors expect that the results will be useful in suggesting issues and questions that would benefit from further discussion and investigation as communities attempt to ensure and improve access to care for their uninsured residents.

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³³ State of California, Employment Development Department, Labor Market Information Division.

³⁴ Sequoia Community Health Foundation, Inc.

³⁵ United Health Centers of The San Joaquin Valley, Inc.



ACKNOWLEDGEMENTS

Central California Legal Services would like to thank the sites that provided access to their clients for interviews: University Medical Center, Community Medical Center-Fresno, Sequoia Community Health Foundation, Inc., United Health Centers- Parlier and Mendota, The Poverello House/Holy Cross Center for Women, and the Fresno Adult Class taught by Gretchen Donahue at Johnson Burroughs Elementary School.

We would also like to thank the surveyors for their dedication to this project: The **Fresno Health Consumer Center** staff--Manuel L. Romero, Marisa Cardenas-Rodriguez, May Vang, and Liz Rodriguez--assisted with surveys and administered the project. The survey interviewers were Kathy Castaneda, Angela Medina, Sidarith Sean, Lee Her, and Willis Hilton. Volunteers included the Fresno Adult Class at John Burroughs Elementary School, Carmen Hernandez, and Valta Pointer

The Access Project would especially like to thank the authors, Dennis Andrulis, Christina An, and Carol Pryor, for their dedication in creating not only this report, but the reports for all twenty four sites participating in the CAMS project nationwide.

The CAMS project involved our *entire* staff, and we would like to thank all of them for their tremendous effort in making the project a success. Special thanks are due to the following people:

- ◆ Bill Lottero, the Site Coordinator, who worked directly with Central California Legal Services, Inc. to help plan the project, and who provided extensive consultation throughout its duration.
- ◆ Nicole St. Clair, who assisted in the writing of the report
- ◆ Bill Hewett and Meg Baker, who provided invaluable administrative support in the production of the report
- ◆ Nancy Kohn, who provided overall coordination and attended to the myriad of details necessary to keep the project on track

In addition, we want to express our appreciation to our colleagues at Community Catalyst Inc., whose participation in the project was essential to its success, and to the committed team of trainers from The Medical Foundation's Health Training Innovations program. Laurie Jo Wallace, Moacir (Mo) Barbosa, and Jorge Armesto developed a standard curriculum and conducted interactive one-day training sessions at each site, in a very short period of time, to ensure consistent administration of the survey.