



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at University Hospital in
Cincinnati, Ohio*

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

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The Legal Aid Society of Greater Cincinnati provides free legal services to low-income persons in Brown, Butler, Clermont, Hamilton and Warren Counties in Southwestern Ohio. Founded in 1908, Legal Aid provides a wide range of civil legal services. These include health-related legal services, such as appealing denials of Medicaid eligibility, and advocacy for health policy, including a successful effort in 1999 to expand Medicaid eligibility to Ohio parents below the poverty line. Legal Aid represented clients in litigation that challenged the conversion of University Hospital in Cincinnati from a public to a private non-profit hospital. Legal Aid is part of the Greater Cincinnati Healthcare Access Project (G-CHAP), a coalition of individuals and organizations working to improve access to health care for low-income uninsured and underinsured persons.

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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, Cincinnati, Ohio. The survey was conducted in the summer of 2000 and gathered information from 101 uninsured patients who obtained health care at University Hospital in the previous year. The report also compares their experiences with those of uninsured patients surveyed at other CAMS sites across the country who received care at similar facilities.

The survey results indicate the following:

- ◆ Most of the respondents used University Hospital more than once in the last year; a third used the hospital five or more times. Four out of five used the emergency room at least once, and two out of three used the outpatient clinic. By contrast, only about one in five respondents had been admitted as an inpatient. Half of the respondents used the hospital to treat a chronic condition.
- ◆ On most measures related to the hospital's openness to treating the uninsured and to satisfaction with providers, responses for University Hospital were similar to the averages for all urban and suburban hospitals included in the CAMS study nationally. However, 17 percent of University Hospital respondents said they were "unsatisfied" or "very unsatisfied" with the care they received from doctors, about twice the rate for comparison hospitals.

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- ◆ About one-fifth of the respondents reported that they had problems with the hospital's hours and location, as well as getting transportation assistance when needed. In addition, more than half stated that they had problems with waiting times at least sometimes.
- ◆ Nearly all of the respondents had medications prescribed, and two-thirds of those who received prescriptions reported needing assistance paying for them. About two in five reported receiving their medications for free, while a similar percentage said they paid for them out-of-pocket at a pharmacy. Twelve percent of respondents said they were unable to fill any of their prescriptions because of cost.
- ◆ Three-quarters of respondents found paying their medical bills to be "very difficult," a higher percentage than for all urban and suburban hospitals included in CAMS. Four in five said that they needed assistance in paying their bills and, of those, half reported that staff had not offered assistance. Among those who were offered assistance, about a third had their bill reduced or waived, 21 percent were referred to a charitable organization, 14 percent were offered a monthly billing plan, and 40 percent said they were offered other forms of assistance.
- ◆ Three of four respondents said they owed money to the hospital, and a quarter of those said that this debt would deter them from seeking care there again. Overall, one in seven said that their past experiences paying bills at the hospital would discourage them from using the hospital in the future. Four-fifths of the respondents said they would use the facility again if they had health insurance, a percentage similar to that of respondents for all urban and suburban hospitals included in CAMS.

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 general research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Cincinnati, Ohio. The survey was conducted by the Legal Aid Society of Greater Cincinnati in the Spring of 2000, and gathered information from uninsured individuals who received care at University Hospital in Cincinnati in the previous year. Along with providing the results of the survey for this facility, 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

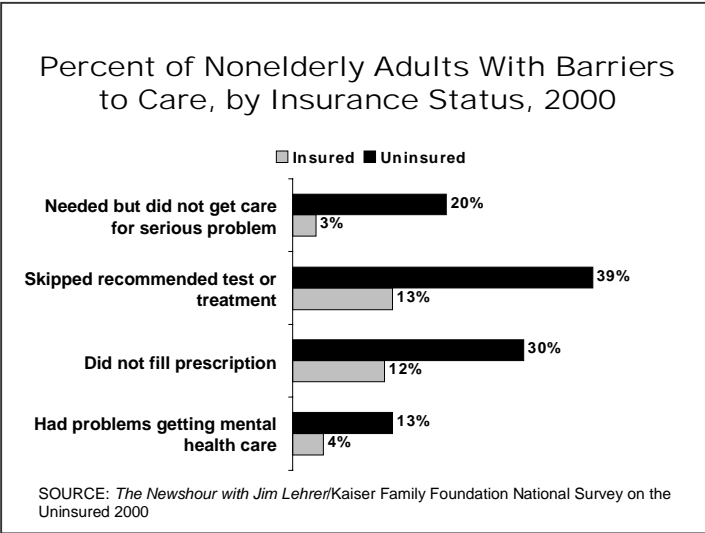
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the 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 the Legal Aid Society of Greater Cincinnati.

Cincinnati has undergone tremendous change in the delivery of health care in the last decade. Two urban hospitals closed. Between 1990 and 1996, the total number of public hospital beds declined by 34.7 percent, and the number of nonprofit hospital beds by 17.7 percent.³¹ All but one of Cincinnati's private hospitals have entered alliances with other hospitals. The employer community organized to negotiate lower managed care premiums, which reduced insurance reimbursement rates to hospitals to below national averages.³² In addition, the implementation of welfare reform in Ohio has been associated with a rapid decrease in Medicaid enrollment, creating significant financial pressure on hospitals and public health clinics by increasing the number of uninsured.

Welfare reform was implemented in Ohio in November 1997. Between July 1997 and July 1999, the number of parents covered by Medicaid in the state dropped by 34 percent. During the same period, despite the implementation of the Children's Health Insurance Program in January 1999, which significantly increased financial eligibility for coverage for children, the number of children covered by Medicaid in Ohio increased only slightly, by 2.5 percent.³³ According to a Families USA study, between January 1996 and October 1999, 42 percent of Ohio's parents on Medicaid, or 95,854 low-income adults, lost coverage when they left welfare. This placed Ohio behind only Georgia and Texas in the number of parents losing Medicaid coverage.³⁴

University Hospital was founded as General Hospital in 1823. It has historically been the main source of health care for Cincinnati's poor and uninsured. In 1996, ownership of the hospital transferred from the University of Cincinnati to the Health Alliance of Cincinnati, and the hospital's status changed from public to private nonprofit. Legal Aid represented clients in litigation to challenge conversion of the hospital. The City, which once owned the hospital, and a group of taxpayers also challenged the conversion.

During the early 1990s, Cincinnati, like many other cities, faced a number of significant challenges to well being. According to census data, more than one in five people lived in high poverty areas and over 36 percent of children lived in poverty. In addition, Cincinnati ranked 91st among the nation's 100 largest cities in the concentration of the population living in high poverty areas. Moreover, among the 100

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largest U.S. cities, in 1995 Cincinnati ranked 95th in its rate of infant mortality (14.93 per 1,000 live births), and 82nd in its rate of low birth weight babies (105.41 per 1000 births).³⁵ These statistics underlie concerns over the effect of University Hospital's conversion on its continued commitment to providing care to the uninsured in the county. That these concerns are a public matter is reinforced by the fact that the hospital receives \$30 million annually in support from a \$40 million annual county property tax levy that is used to support both University Hospital and Children's Hospital Medical Center.

This survey was undertaken as one of many efforts by the Legal Aid Society and other concerned organizations in the Cincinnati area to gather information about the availability of care for those in the community without health insurance, and about the experiences of the uninsured in accessing that care. Its goal was to gather information that would help identify areas in which improvements might be made in caring for the uninsured.

SURVEY METHODOLOGY

The surveys were conducted by four surveyors – graduate students from the University of Cincinnati and a community volunteer. Prior to conducting the interviews, the surveyors attended a full-day training session in survey administration, which was conducted by trainers from the Health Training Innovations Program of The Medical Foundation in Boston.

The survey collected data from 101 people who obtained health care at University Hospital while uninsured between May 1999 and June 2000. Respondents were identified from a list of individuals who called the Legal Aid Society of Greater Cincinnati seeking legal assistance on a variety of matters and told an intake screener that someone in their household lacked health insurance. Surveyors made telephone calls to individuals on this list and identified those who had sought care at University Hospital when they did not have health insurance in the previous year. Respondents who completed the survey were given a grocery gift certificate for their time.

The Access Project arranged for entry of the data by an independent firm. The data were analyzed by Dennis Andrulis and Christina An of the State University of New York, Health Science Center at Brooklyn.

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 University Hospital. *The results reflect the experiences only of those surveyed.*

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SURVEY FINDINGS

This section describes and compares the survey results for respondents who received care while uninsured at University Hospital and compares them with averages for All Urban and Suburban Hospitals (AUSHs) included in the CAMS project nationwide. All comparisons were statistically significant unless otherwise indicated (ns = non-significant).

See Appendix A for a table of the results for University Hospital, as well as for the aggregate results for all similar facilities included in CAMS.

Note: For the purpose of analysis, all facilities included in the CAMS project were grouped by type (hospital or clinic), and by location (urban/suburban or rural.) These designations were determined by the organizations that sponsored the surveying. See Appendix B for a list of all facilities included in the project nationally.

RESPONDENT CHARACTERISTICS

Respondents varied in age. About three of four respondents were African-American, and the majority of respondents were women.

Respondents varied in age, but only seven percent answered on behalf of a child.

Seventy-two percent of the respondents identified themselves as African American, while the average for AUSHs was 46 percent. All the respondents chose to take the survey in English.

Most of the respondents—84 percent—were women, which was a larger proportion than the average for AUSHs (60%).

USE OF HEALTH SERVICES

The majority of the University Hospital respondents used the emergency room at least once in the past year. About one-third of the respondents used the hospital more than once. Nearly half of the respondents stated that they sought care to treat a chronic problem.

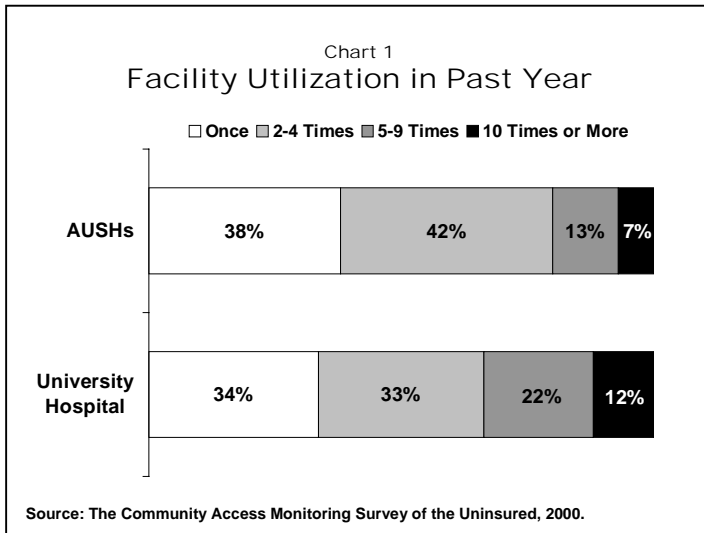
Emergency room use: Four of five (79%) respondents for University Hospital reported that they used the emergency room at least once in

the past year. This proportion was similar to the average for AUSHs (77%).

Inpatient hospital use: University Hospital respondents were less likely to report that they had been admitted to the hospital even once in the past year than the average for AUSHs (19% vs. 32%, respectively).

Outpatient clinic use: Two of three (64%) respondents for University Hospital reported that they used the outpatient clinic at least once, a proportion much larger than the AUSH average (45%).

Frequency of facility use: About one-third (34%) of the respondents reported that they used the facility five or more times in the past year. In comparison, the average for AUSHs was 20 percent. (Chart 1)



University Hospital respondents were more likely to say that they sought care to treat a chronic problem than the average for AUSHs (47% vs. 32%, respectively).

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

About half of the University Hospital respondents stated that the facility had been open and accepting to them even if they could not pay for care, and two of five (41%) reported that the clinic had a reputation in the community for providing a lot of care to the uninsured. In addition, most of the respondents reported that they were satisfied with their interactions with staff.

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“They gave me an in-house medical card for zero cost on the same day.”
University Hospital Respondent

More than half (55%) of the University Hospital respondents reported that, based on their experience, the facility had been “open and accepting” to them even if they were unable to pay for care. In comparison, the average for AUSHs was 61 percent (ns).

“They used to provide more care. But since this privatization there are fewer people going there.”
University Hospital

Two of five (41%) respondents for University Hospital said that the facility had a reputation in the community for providing “a lot” of care to the uninsured, a proportion similar to the AUSH average (44%). Notably, ten percent of the University Hospital respondents reported that the facility had a reputation for providing “very little or no care” to the uninsured (AUSHs average: 12%).

About four of five respondents for University Hospital reported that they were either “satisfied” or “very satisfied” with the care and service they received from receptionists, nurses, and physician assistants. The averages for AUSHs were very similar. In addition, satisfaction ratings for social workers and billing clerks did not differ significantly from the averages for AUSHs.

“I think they treated me and my son good. They made me feel comfortable to put my baby in their hands.”
University Hospital Respondent

Eighty-two percent of the respondents for University Hospital stated that they were satisfied with the care they received from their doctors, a proportion slightly smaller than the average for AUSHs (90%). Notably, however, 17 percent of the respondents said they were “unsatisfied” or “very unsatisfied” with the care they received from doctors, while the average for AUSHs was eight percent.

Two-thirds of the University Hospital respondents said that they were “always” treated with respect by staff, similar to the average for AUSHs (64% and 61%, respectively).

ACCESSIBILITY

About one-fifth of the University Hospital respondents reported that they had problems with the hours and location of the facility, as well as with getting transportation assistance when needed. In addition, more than half of the respondents stated that they had problems at least sometimes with waiting times.

Although most of the respondents reported that the facility’s hours were never a problem for them, about one of five (21%) reported that they had been a problem for them at least sometimes. The AUSH average was similar.

Seventy-six percent of University Hospital’s respondents stated that the location of the facility was “never a problem” for them, but 22 percent said that it was a problem at least sometimes. The average



reported travel time was 23 minutes, one minute longer than the average for AUSHs.

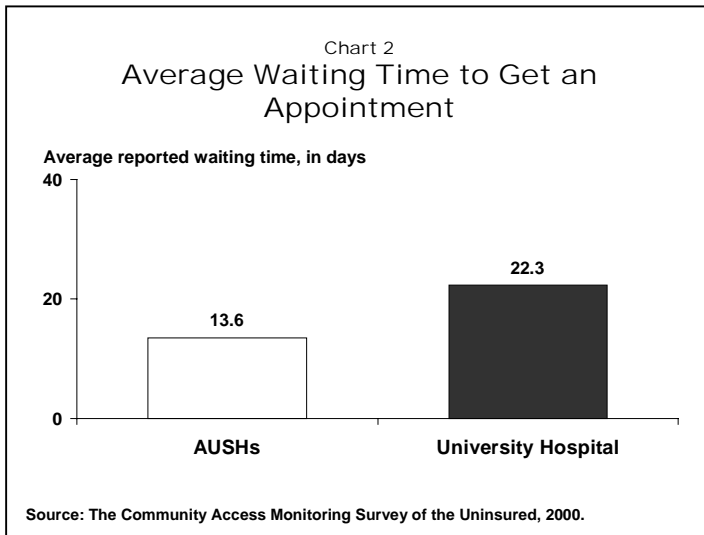
Convenience of the hospital to public transportation was a problem at least sometimes for 15 percent of the respondents. Twenty-two percent reported the availability of transportation assistance, when needed, was a problem at least sometimes.

Waiting time on the day of an appointment was more likely to “often” or “always” be a problem for University Hospital respondents (35%) than the average for AUSHs (26%). The average waiting time for University Hospital respondents was about 20 minutes longer than the average for AUSHs (82 vs. 63 minutes, respectively).

University Hospital respondents were more than twice as likely to report that the waiting time to get an appointment was “often” or “always” a problem for them than the AUSH average (37% vs. 16%, respectively). Indeed, the average reported waiting time for an appointment was 22 days, more than eight days longer than the average for AUSHs. (Chart 2)

“The wait is the biggest aggravation.”
University Hospital Respondent

“People come in at 8AM and don’t get treated until 5PM. They need to learn how to manage their time. If a person makes an appointment it should be kept. The staff needs to be trained better.”
University Hospital



OBTAINING PRESCRIPTION MEDICATIONS

Nearly all respondents received prescriptions for medications, and more than a third of these respondents received their medications free. More than two-thirds of the respondents said that they needed help paying for their medications, but more than half of these respondents reported that they never received any help.

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“Free one time. Then I had to speak to the collection ladies.”
University Hospital Respondent

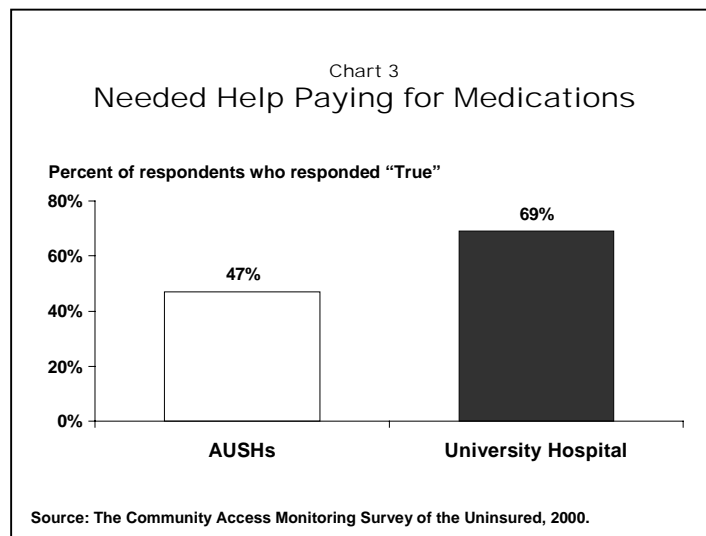
The vast majority of University Hospital respondents—93 percent—said that they had medications prescribed. Of the respondents who needed medications, more than one-third (37%) reported that they were given their medications free, a higher proportion than the average for AUSHs (27%).

“It wasn’t too much of a problem, but you have to wait a couple of hours to get meds because they were busy down there.”
University Hospital Respondent

Nearly two of five (38%) stated that they obtained their medications at a drug store and paid for the prescriptions themselves. This figure was much lower than the average for AUSHs (57%).

Twelve percent of the University Hospital respondents who received prescriptions stated that they were unable to fill *any* of them because of costs. In comparison, the average for AUSHs was eight percent (ns).

One-half (49%) of the University Hospital respondents reported that paying for their medications was “very difficult,” nearly the same as the average for AUSHs (40%). Moreover, University Hospital respondents were more likely to report that they needed help paying for their medications than respondents for AUSHs. (Chart 3)



“The problem was getting medication. They have a lack of concern here. They didn’t care about not being able to pay. They were of no help.”
University Hospital Respondent

Among the respondents who needed financial assistance, while many were asked by staff if help was needed, more than half (55%) reported that they were “never” offered assistance.



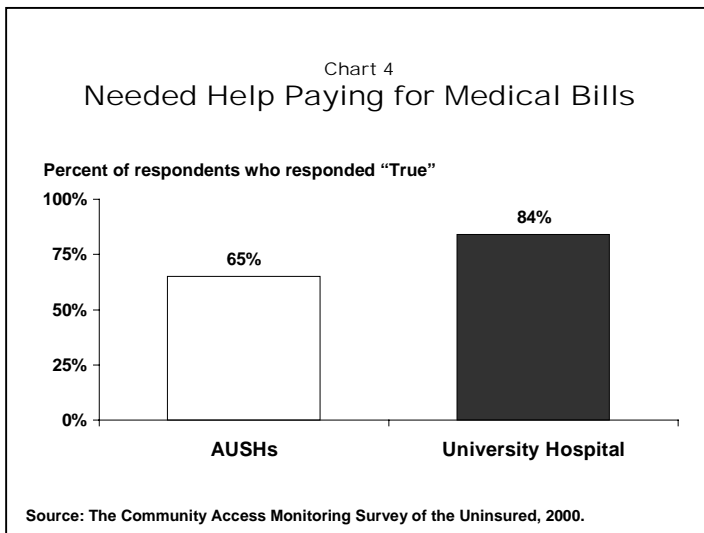
CONCERNS OVER PAYMENT FOR HEALTH CARE

The majority of respondents found paying for their medical care very difficult and more than eight in ten needed help paying the bills. About half of the respondents who needed help said staff never offered any assistance.

University Hospital respondents were more likely to report that paying for their medical bills was “very difficult” than the average for AUSHs (77% vs. 61%, respectively).

“It took me a year to pay off one bill.”
University Hospital Respondent

Four of five respondents for University Hospital stated that they needed financial assistance with their medical bills. The average for AUSHs was 65 percent. (Chart 4)

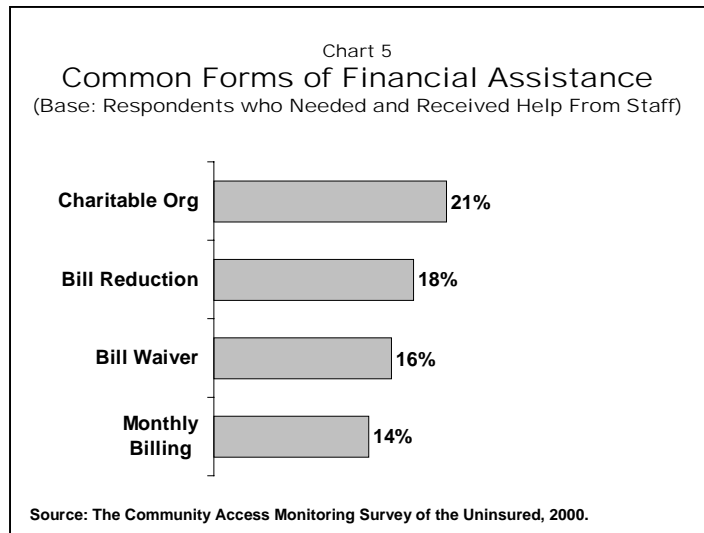


“I signed a paper saying I didn’t have any insurance and gave them my income. They said I get a discount, but they are still sending bills.”
University Hospital Respondent

Among the University Hospital respondents who needed help with their medical bills, 49 percent stated that staff “never” offered any assistance. Among those who were offered help, 14 percent said they were offered monthly billing plans, which was lower than the 52 percent average for AUSHs. Twenty-one percent of respondents were referred to a charitable organization. (Chart 5) In addition, 41 percent said they had been offered other forms of assistance.

“I saw the paper to fill out if you need help to pay. I asked for it. She didn’t tell me about it.”
University Hospital Respondent

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SEEKING CARE IN THE FUTURE

Although the majority of respondents said that their past experiences paying bills would not affect whether they sought care at University Hospital in the future, 15 percent said it would cause them to not seek care there again. However, four of five respondents said that they would use the facility again if they had health insurance.

"I just hate that I have debt there."

University Hospital Respondent

"Depending on the situation, I'd pretty much rather die than go back there."

University Hospital Respondent

"It would be nice if they didn't bill you separately for each part of care. It's hard for people to get 20 separate bills for 1 hospital visit."

University Hospital Respondent

When asked how their past experiences paying bills at the hospital would affect their future care, one of seven (15%) respondents for University Hospital said that it would deter them from seeking care there again, and 13 percent said they would use a different facility. These figures were similar to the AUSH averages. Three of five (60%) respondents said their past payment experiences would make no difference in where they sought care in the future.

Three of four respondents—73 percent—said they had owed the hospital money. Among these respondents, 26 percent said the indebtedness would deter them from seeking care at the hospital again. These findings were similar to the averages for AUSHs.

About four-fifths (78%) of the respondents said they would use the facility again if they had health insurance, similar to the average for AUSHs (77%).

DISCUSSION

This section discusses some of the perceived strengths of University Hospital suggested by the survey results. In addition, it highlights issues that might warrant further discussion.

STRENGTHS

- ◆ University Hospital respondents were less likely to report inpatient use and more likely to report clinic outpatient use than respondents for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationally.
- ◆ More than one-half (55%) of the respondents reported that the facility had been open and accepting to them even if they were unable to pay for their care. Two of five respondents said that the facility had a reputation in the community for providing “a lot” of care to the uninsured.
- ◆ The proportions of University Hospital respondents who reported that they had been treated with respect and were satisfied with their interactions with staff were similar to the averages for AUSHs.
- ◆ Nearly four of five respondents for University Hospital said they would use the hospital again if they had health insurance.

ISSUES FOR FURTHER CONSIDERATION

- ◆ Four-fifths of the respondents reported that they used the emergency room at least once in the past year, similar to the average for AUSHs. In addition, one-third of the respondents said they used the hospital five or more times in the past year.
- ◆ Nearly half the respondents sought care to treat a chronic health problem.
- ◆ The average waiting time to get an appointment reported by University Hospital respondents was more than a week longer than the average for AUSHs. In addition, the average reported waiting time to see a provider was 20 minutes longer than the average for AUSHs.
- ◆ Among respondents who received prescriptions, about two of five received their medications free, but roughly the same proportion reported that they paid for their medications out-of-pocket at a pharmacy. Twelve percent of the respondents who needed to fill a

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prescription reported that they were unable to get any of their medications due to cost.

- ◆ One-half of the respondents said paying for medications was “very difficult,” while 77 percent reported that paying for medical care was “very difficult.” University Hospital respondents were much more likely than the averages for AUSHs to report that they needed help paying for their medical care and their medications. Among the respondents who said they needed financial assistance, a little more than half stated that staff “never” offered help. Among those who were offered help, only 14 percent were offered a monthly billing plan, compared with the 52 percent average for AUSHs. Notably, 40 percent said they were offered “other” forms of assistance.
- ◆ Fifteen percent of the University Hospital respondents stated that their past experiences paying for care at the hospital would deter them from seeking care there again, and 13 percent said they would use a different facility. About three out of four respondents said they owed the hospital money, and more than a quarter of these respondents said that their indebtedness would deter them from seeking care at the hospital again.

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.

REFERENCES

- ¹ Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, *America's Health Care Safety Net: Intact but Endangered*, Institute of Medicine, National Academy Press, Washington D.C., 2000.
- ² U.S. Census Bureau, *Health Insurance Historical Tables*, Washington D.C., 2000.
- ³ Harvard/Robert Wood Johnson Foundation Report on Public Attitudes Towards Access to Health, 1999, cited in "RWJF Steps Up Insurance Coverage Initiatives," *Advances: The Robert Wood Johnson Foundation Quarterly Newsletter*, 1 (2000): 2.
- ⁴ G. Melnick, cited in "Hospitals' Uncompensated Care Expenses Not Keeping Pace with Per Capita Spending," *Health Care Financing & Organization News & Progress*, The Alpha Center, Washington D.C., March 2000: 6.
- ⁵ K. Donelan, R. Blendon, J. Benson, R. Leitman, and H. Taylor, "All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations," *Health Affairs* (Millwood), 15 (1996): 254-265.
- ⁶ Health Desk, *National Survey on the Uninsured, 2000*, Newshour with Jim Lehrer/Kaiser Family Foundation, Menlo Park, April 2000.
- ⁷ B. Spillman, "The Impact of Being Uninsured on Utilization of Basic Health Care Services," *Inquiry*, 29 (1992): 457-466.
- ⁸ D.D. McAlpine and D. Mechanic, "Utilization of Specialty Mental Health Care Among Persons with Severe Mental Illness: The Roles of Demographics, Need, Insurance, and Risk," *Health Serv Res*, 35(1 Pt 2) (2000): 277-92.
- ⁹ P.W. Newacheck, C. Brindis, C.U. Cart, K. Marchi, and C.E. Irwin, "Adolescent Health Insurance Coverage: Recent Changes and Access to Care," *Pediatrics*, 104 (1999): 195-202.
- ¹⁰ H. Burstein, S. Lipsitz, and T. Brennan, "Socioeconomic Status and Risk for Substandard Medical Care," *JAMA*, 268 (1992): 2383-2387.
- ¹¹ J. Weissman, and A. Epstein, "Case Mix and Resource Utilization by Uninsured Hospital Patients in the Boston Metropolitan Area," *JAMA*, 261 (1989): 3572-3576.
- ¹² Kaiser Commission on Medicaid and the Uninsured, *Uninsured Facts*, The Henry J. Kaiser Family Foundation, May 2000.
- ¹³ National Academy on Aging, "One in Four: Child Poverty in America," *The Public Policy and Aging Report*, 1997, 8.
- ¹⁴ Kaiser Family Foundation, *The Uninsured and Their Access to Health Care*, May 2000.
- ¹⁵ Kaiser Commission on Medicaid and the Uninsured, *op cit*.

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- ¹⁶ J. Hadley, E. Steinberg, and J. Feder, "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome," *JAMA*, 265 (1991): 374-379.
- ¹⁷ J.M. Ferrante, E.C. Gonzalez, R.G. Roetzheim, N. Pal, L. Woodward, "Clinical and Demographic Predictors of Late-Stage Cervical Cancer," *Arch Fam Med* 9(5): (2000): 439-45.
- ¹⁸ J. Ayanian, B. Kohler, T. Abe, and A. Epstein, "The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer," *New England Journal of Medicine*, 329: (1993): 326-331.
- ¹⁹ P. Franks, C. Clancy, and M. Gold, "Health Insurance and Mortality: Evidence from a National Cohort," *JAMA*, 270 (1993): 737-741.
- ²⁰ J.D. Kasper, T.A. Giovannini, and C. Hoffman, "Gaining and Losing Health Insurance: Strengthening the Evidence for Effects on Access to Care and Health Outcomes," *Med Care Res Rev*, 57(3): (2000): 298-318; discussion 319-25.
- ²¹ B. Saver and N. Peterfreund, "Insurance, Income and Access to Ambulatory Care in King County, Washington," *American Journal of Public Health*, 83 (1993): 1583-1588.
- ²² H. Bograd, D. Ritzwoller, N. Calonge, K. Shields, and M. Hanrahan, "Extending Health Maintenance Organizations to the Uninsured: A Controlled Measure of Health Care Utilization," *JAMA*, 277 (1997): 1067-1072.
- ²³ "Update: Trends in AIDS Incidence—United States, 1996," *Morbidity and Mortality Weekly Report*, 46 (1997): 861-867.
- ²⁴ B.L. Devaney, M.R. Ellwood, and J.M. Love, "Programs that Mitigate the Effects of Poverty on Children," *Future Child*, 7(2): (1997) 88-112.
- ²⁵ B.R. Clarridge, B.J. Larson, and K.M. Newman, "Reaching Children of the Uninsured and Underinsured in Two Rural Wisconsin Counties: Findings from a Pilot Project," *Journal of Rural Health*, 9(1): (1993), 40-49.
- ²⁶ See for example Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, *op cit*.
- ²⁷ P. Cunningham, "Pressures on Safety Net Access: The Level of Managed Care Penetration and Uninsurance Rate in a Community," *Health Services Research*, 34 (1998): 255-270.
- ²⁸ P. Cunningham, et al, "Managed Care and Physicians' Provision of Charity Care," *JAMA*, 281 (1997): 1087-1092.
- ²⁹ G. Melnick, *op cit*.
- ³⁰ D. Andrulis and M. Gusmano, *Public-Private Community Initiative and Partnership in Designing and Financing Health Care for the Uninsured*, New York Academy of Medicine, 2000.



³¹ D. Andrulis and N. Goodman, National Public Health and Hospitals Institute, *The Social and Health Landscape of Urban and Suburban America*, American Hospital Association Press, 1999

³² T. Bonfield, "Study: Health Reforms Working: Business-driven Changes Praised," *The Cincinnati Enquirer*, June 23, 1998.

³³ L. Ranbom, *Insurance Status of Children in Low Income Families: An Examination of Medicaid Caseload and Low-income Population Trends*, Ohio Department of Human Services, Office of Medicaid, 1999.

³⁴ R. Pear, "A Million Parents Lost Medicaid, Study Says," *The New York Times*, June 19, 2000.

³⁵ D. Andrulis and N. Goodman, *op cit*.

APPENDIX A: TABLE OF SURVEY RESULTS

This table presents the results of the surveys of patients at University Hospital in Cincinnati, Ohio. For comparison purposes, it also presents results of surveys of patients at all urban and suburban hospitals that were included in the CAMS project nationally.

Asterisks in the *Inter-site p value* column indicate statistically significant differences between University Hospital and the average for all urban and suburban hospitals included in the national CAMS project. A single asterisk (*) indicates $p < 0.05$. Two asterisks (**) indicate $p < 0.01$. (An explanation of p-values is provided at the end of the table.)

	Cincinnati Hospital		CAMS Hospitals
	Inter-site p-value	University Hospital	All Urban & Suburban Hospitals
Number of survey respondents		101	4522
		%^a	%^a
RESPONDENT CHARACTERISTICS			
Age			
Under 18		6	17
18-29 years		28	27
30-39 years		27	25
40-49 years		27	19
50-64 years		10	11
65 or older		1	1
Race/Ethnicity			
	**		
White		21	11
Black		72	46
Hispanic		-	37
Other ^b		7	7
Gender			
	**		
Male		16	40
Female		84	60
Language in which survey administered			
	**		
English		100	72
Spanish		-	28
Answered on behalf of child			
	*	7	15
FACILITY UTILIZATION			
Used hospital emergency room			
		79	77
Admitted to hospital as inpatient			
	**	19	32
Used outpatient clinic			
	**	64	45
Use of facility in past year			
	**		
Once		34	38
2-4 times		33	42
5-9 times		22	13
10 or more times		12	7
Reason for visit(s)			
	**		
Chronic problem or Mixed (chronic and non-chronic)	—	47	32
Other problem (non-chronic)		53	68

	Cincinnati Hospital		CAMS Hospitals
	Inter-site p-value	University Hospital	All Urban & Suburban Hospitals
PERCEPTION OF FACILITY			
Experience of facility's openness to uninsured			
Open and accepting even if can't pay		55	61
Reluctant but accepts you even if can't pay		21	19
Offers some care if can't pay		17	12
Provides no assistance if can't pay	—	5	3
Don't know		7	9
Opinion of facility's reputation for treating uninsured			
Provides a lot of care for those who can't pay		41	44
Provides some care		26	24
Provides very little or no care		10	12
Don't know		24	20
SATISFACTION WITH PROVIDERS/COURTESY OF STAFF			
Receptionists/ Admitting clerks			
Very satisfactory or satisfactory		85	84
Unsatisfactory or very unsatisfactory		11	14
Don't know		4	2
Nurses			
Very satisfactory or satisfactory		83	88
Unsatisfactory or very unsatisfactory		16	11
Don't know		1	1
Physician assistants			
Very satisfactory or satisfactory		77	78
Unsatisfactory or very unsatisfactory		11	9
Don't know		12	14
Examining physicians **			
Very satisfactory or satisfactory		82	90
Unsatisfactory or very unsatisfactory		17	8
Don't know		1	2
Social worker			
Very satisfactory or satisfactory		41	36
Unsatisfactory or very unsatisfactory		7	10
Don't know		53	54
Billing Clerks			
Very satisfactory or satisfactory		53	49
Unsatisfactory or very unsatisfactory		17	18
Don't know		31	33
Pharmacist **			
Very satisfactory or satisfactory		59	37
Unsatisfactory or very unsatisfactory		10	6
Don't know		31	57
Treated with respect —			
Always		64	61
Sometimes		28	32
Never		4	4
Don't know		4	3

	Cincinnati Hospital		CAMS Hospitals
	Inter-site p-value	University Hospital	All Urban & Suburban Hospitals
ACCESSIBILITY OF SERVICES			
Hours facility open			
Never a problem		79	85
Sometimes a problem		9	9
Often/always a problem		12	2
Don't know		-	5
Hours ER open			
Never a problem		83	84
Sometimes a problem		4	6
Often/always a problem		3	2
Don't know		10	8
Location			
Never a problem		76	69
Sometimes a problem		14	21
Often/always a problem		8	8
Don't know		2	2
Waiting time to get appointment	**		
Never a problem		28	23
Sometimes a problem		19	20
Often/always a problem		37	16
Don't know		17	40
Waiting time to see provider on day of appointment	*		
Never a problem		31	26
Sometimes a problem		22	26
Often/always a problem		35	26
Don't know		12	22
Convenient to public transportation	**		
Never a problem		67	43
Sometimes a problem		6	10
Often/always a problem		9	13
Don't know		18	35
Transportation assistance if needed	*		
Never a problem		32	22
Sometimes a problem		5	6
Often/always a problem		17	13
Don't know		47	59
MEDICATIONS			
Medication prescribed	**	93	74
If yes, how obtained			
Supplied free	*	37	27
Used a pharmacy card		7	8
Used a drug store and paid	**	38	57
Didn't get /couldn't afford		12	8
Got some/couldn't afford all		10	9
Other		10	6
Medication instructions			
Understood instructions	—	96	92
No instructions given		1	3
Did not understand instructions		2	4
Did not need medicine for home		1	1

	Cincinnati Hospital		CAMS Hospitals
	Inter-site p-value	University Hospital	All Urban & Suburban Hospitals
Difficulty paying for medications			
Very difficult		49	40
Not so difficult		18	32
Easy to pay		16	10
N/A		17	18
Needed help paying for medications	**	69	47
If yes, did staff offer help?			
Always		31	16
Often		-	7
Sometimes		13	13
Never		55	64
MEDICAL BILLS			
Difficulty paying for medical care			
	**		
Very difficult		77	61
Not so difficult		14	30
Easy to pay		9	10
Needed help paying the medical bill? If yes	**	84	65
Did staff offer to find out if financial assistance was available?			
	*		
Always		30	19
Often		1	6
Sometimes		20	19
Never		49	56
Type of help staff offered (If Always, Often, Sometimes to previous question)			
Pay in monthly installments	**	14	52
Reduce amount of bill		18	13
Waive bill	—	16	8
Find charitable organization to pay		21	22
Other	**	41	20
FUTURE CARE			
Effect of payment experience on seeking future care at facility			
Will not seek care at facility		15	13
Will use another facility		13	10
Easier to seek care at facility		12	17
Makes no difference		60	60
Currently owe facility money		73	61
If yes, will make not seek care in future		26	28
If had insurance, would use facility in future		78	77
TRAVEL AND WAIT TIMES			
Travel time, mean (minutes)		22.84	21.55
Travel time, median (minutes)		20.00	18.00
Days to get appointment, mean	**	22.32	13.55
Days to get appointment, median		14.00	7.00
Waiting time to see provider, mean (minutes)	*	81.73	63.24
Waiting time to see provider, median (minutes)		60.00	45.00

LEGEND

- a Persons with missing values were excluded from analysis.
- b “Other” includes Asian/Pacific Islander, Native American, and “mixed.”
- * $p < 0.05$ for overall chi-square test among facilities for each characteristic listed.
- ** $p < 0.01$ for overall chi-square test among facilities for each characteristic listed.
- The cell size was insufficient to conduct an overall chi-square test (more than 20 percent of the cells have expected counts less than five).

SO WHAT IS A P-VALUE?

Statistics based on samples are always subject to “sampling error,” that is, there is most likely some difference between the value that a sample yields and the *true* value in the population that the sample represents. Statistics are often given with a range (for example, “plus or minus 3%”) for this reason. Because of sampling error, two numbers based on samples, which appear to be different, may not actually be different; their ranges might overlap.

The p-value is a statistical measure to determine if there is a true, significant difference between compared numbers. The value of $p < 0.05$, which is a standard accepted level of significance, says that the likelihood is small - 5% or less - that the comparison between two sample statistics is *not* the same as the population comparison. The difference is said to be “statistically significant.” The lower the p-value (e.g., $p < 0.01$), the more likely that the differences are significant.

APPENDIX B: SURVEYED FACILITIES BY CAMS SPONSORING ORGANIZATION AND BY TYPE

SURVEYED FACILITIES BY CAMS SPONSORING ORGANIZATION

<i>CAMS SPONSORING ORGANIZATION</i>	<i>SURVEYED FACILITIES</i>
Puentes de Amistad/ Bridges in Friendship Somerton, Arizona	Sunset Health Center Yuma Regional Medical Center
Central CA Legal Services Fresno, California	Community Hospital Poverello House/Holy Cross Center for Women Sequoia Health Foundation Clinics United Health Centers-Mendota United Health Centers-Parlier University Medical Center
LifeLong Medical Care Berkeley, California	Berkeley Primary Care Access Clinic The LifeLong Clinic West Berkeley Family Practice
The Volusia County Access Project Volusia County, Florida	Halifax Keech Health Center Halifax Medical Center Memorial Hospital-West Volusia Volusia County Health Department Clinic, DeLand
Human Services Coalition of Dade County, Inc. Miami, Florida	Jefferson Reaves, Jr. Health Center Dr. Rafael A. Peñalver Clinic
Capital Medical Society Foundation, Inc. Tallahassee, Florida	Bond Community Health Center Leon County Health Department Neighborhood Health Services Tallahassee Memorial Healthcare Emergency Room The We Care Network of the Capital Medical Society Foundation
Southwest Georgia Community Health Institute Albany, Georgia	Albany Area Primary Health Care Palmyra Medical Center Phoebe Putney Memorial Hospital's Emergency Center Southwest Georgia Regional Medical Center
Idaho Primary Care Association Boise, Idaho	Family Health Services Magic Valley Regional Medical Center Mercy Medical Center Terry Reilly Health Services
Campaign for Better Health Care Chicago, Illinois	Mile Square Health Center
Westside Health Authority Chicago, Illinois	Austin Cook County Health Center Circle Family Care/R.M. Gunnar Clinic
Lake Cumberland District Health Department Somerset, Kentucky	Clinton County Hospital Russell County Hospital Wayne County Hospital

Department of Family Medicine, Louisiana State University Healthcare Services Division Baton Rouge, Louisiana	Earl K. Long Medical Center
Health Care Centers in Schools, Inc. Baton Rouge, Louisiana	Istrouma School-Based Health Center
Northern Berkshire Community Coalition North Adams, Massachusetts	North Adams Regional Hospital
Progressive Leadership Alliance of Nevada (PLAN) Las Vegas, Nevada	Sunrise Hospital and Medical Center University Medical Center
The Northwest Bronx Community & Clergy Coalition Commission on the Public's Health System in New York City Bronx, New York	North Central Bronx Hospital
North Carolina Fair Share Raleigh, North Carolina	Wake Medical Center
Universal Health Care Action Network of Ohio (UHCAN) Cleveland, Ohio	Cleveland Clinic Huron Hospital MetroHealth Hospital University Hospital
Legal Aid Society of Greater Cincinnati Cincinnati, Ohio	University Hospital
Project Equality/Oregon Health Access Project Lincoln County, Oregon	Pacific Communities Hospital North Lincoln Hospital
Latino Memphis Conexion Memphis, Tennessee	The Memphis Regional Medical Center
Planned Parenthood of Houston and Southeast Texas, Inc. Houston, Texas	Fannin Family Planning Clinic
Texas Institute for Health Policy Research Austin, Texas	CHRISTUS Jasper Memorial Hospital
Tenants' and Workers' Support Committee Alexandria, Virginia	INOVA Alexandria Hospital
West Virginia Community Voices Partnership Charleston, West Virginia	Boone Memorial Hospital Cabin Creek Health Center Clay County Primary Care West Virginia Health Right, Inc. WOMENCARE

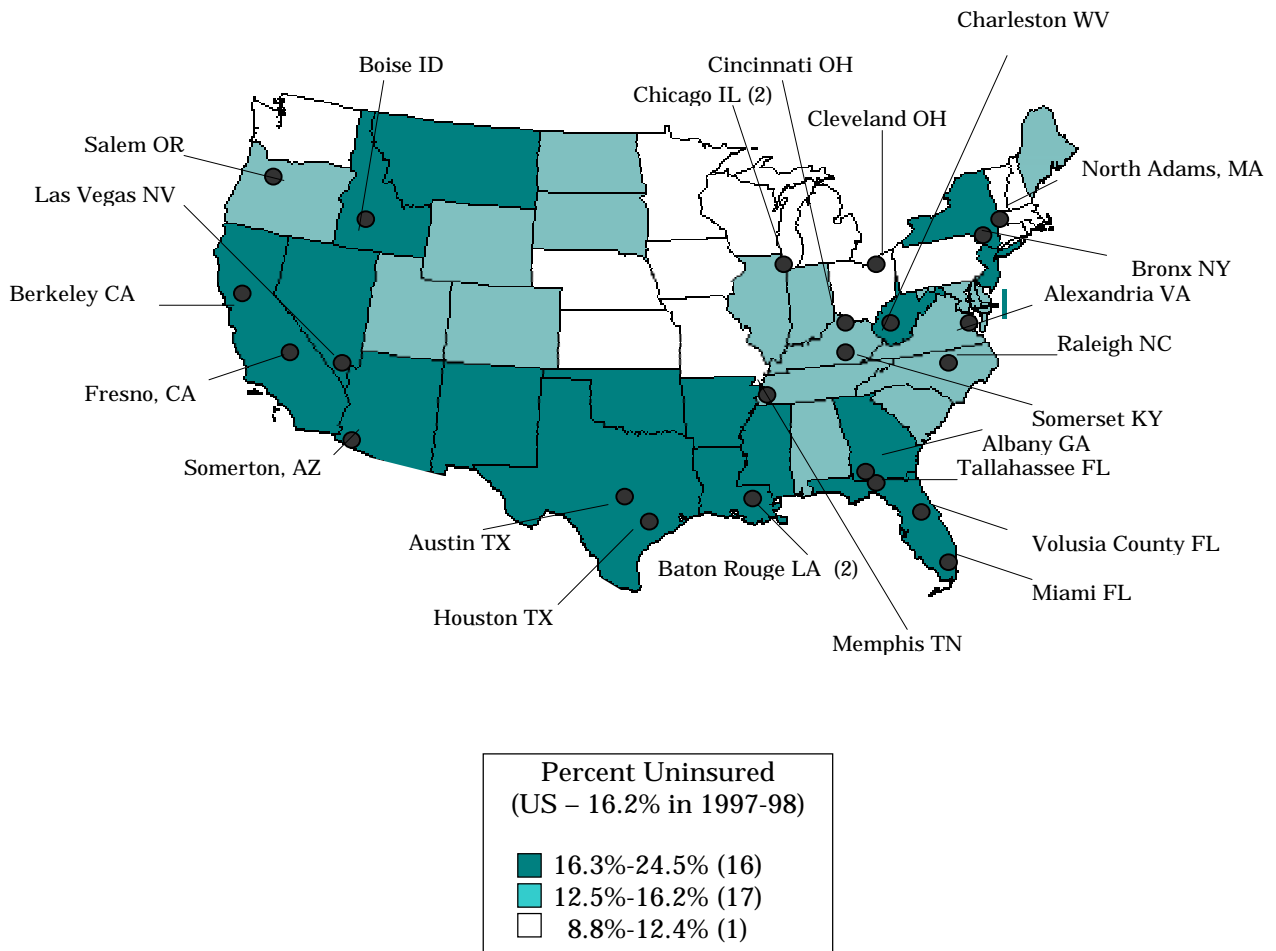
SURVEYED FACILITIES BY TYPE

<i>FACILITIES BY TYPE</i>	<i>LOCATION</i>
Urban/Suburban Hospitals	
Yuma Regional Medical Center	Yuma, AZ
Community Hospital	Fresno, CA
University Medical Center	Fresno County, CA
Halifax Medical Center	Halifax, FL
Tallahassee Memorial Healthcare Emergency Room	Tallahassee, FL
Memorial Hospital	West Volusia County, FL
Palmyra Medical Center	Albany, GA
Phoebe Putney Memorial Hospital's Emergency Center	Albany, GA
Mercy Medical Center	Nampa, ID
Magic Valley Regional Medical Center	Twin Falls, ID
Earl K. Long Medical Center	Baton Rouge, LA
Sunrise Hospital and Medical Center	Las Vegas, NV
University Medical Center	Las Vegas, NV
North Central Bronx Hospital	The Bronx, NY
Wake Medical Center	Raleigh, NC
University Hospital	Cincinnati, OH
Cleveland Clinic	Cleveland, OH
Huron Hospital	Cleveland, OH
Metrohealth Hospital	Cleveland, OH
University Hospital	Cleveland, OH
The Memphis Regional Medical Center	Memphis, TN
INOVA Alexandria Hospital	Alexandria, VA
Rural Hospitals	
Southwest Georgia Regional Medical Center	Cuthbert, GA
Clinton County Hospital	Albany, KY
Wayne County Hospital	Monticello, KY
Russell County Hospital	Russell Springs, KY
North Adams Regional Hospital	North Adams, MA
North Lincoln Hospital	Lincoln City, OR
Pacific Communities Hospital	Newport, OR
CHRISTUS Jasper Memorial Hospital	Jasper County, TX
Boone Memorial Hospital	Madison, WV
Urban/Suburban Clinics	
Berkeley Primary Care Access Clinic	Berkeley, CA
The Lifelong Clinic	Berkeley, CA
West Berkeley Family Practice	Berkeley, CA
Poverello House/Holy Cross Center for Women	Fresno, CA
Sequoia Health Foundation Clinics	Fresno County, CA
Volusia County Health Department Clinic	Deland, FL

Halifax Health Center	Halifax, FL
Bond Community Health Center	Leon County, FL
Leon County Health Department	Leon County, FL
Neighborhood Health Services	Leon County, FL
Dr. Rafael A. Peñalver Clinic	Miami-Dade County, FL
Jefferson Reaves, Jr. Health Center	Miami-Dade County, FL
Terry Reilly Health Services	Boise, ID
Family Health Services	Magic Valley Region, ID
Austin Cook County Health Center	Chicago, IL
Mile Square Health Center	Chicago, IL
Circle Family Care/R.M. Gunnar Clinic	Chicago, IL
Istrouma School-Based Health Center	Baton Rouge, LA
Fannin Family Planning Clinic	Houston, TX
West Virginia Health Right, Inc.	Charleston, WV
WomenCare	Scott Depot, WV
Rural Clinics	
Sunset Health Center	Somerton, AZ
United Health Centers - Mendota	Mendota, CA
United Health Centers - Parlier	Parlier, CA
Albany Area Primary Health Care	Dougherty, Lee, Terrell, and Baker, Calhoun Counties, GA
Clay Primary Care	Clay, WV
Other (Provider Network)	
The We Care Network	Leon County, FL

APPENDIX C: LOCATIONS OF CAMS SPONSORING ORGANIZATIONS AND STATE UNINSURANCE RATES 1997-98

The map below shows the locations of all of the organizations conducting Community Access Monitoring Surveys. It also indicates percentages without health insurance in each state for 1997-98.



APPENDIX D: SURVEY INSTRUMENT

Record time interview begins _____

[If the respondent is answering on behalf of his or her child, mark this box and change the wording in all of the following questions from *you* to *your child*.]

“First, I have a few background questions about your experience at (facility name)

_____:

I. BACKGROUND / DEMOGRAPHICS

1. How many times did you use (facility name) _____ in the past year?

- Once
- 2 - 4 times
- 5 - 9 times
- 10 or more times

Comments: _____

2. Why did you go there? (for what medical problem(s))

3. Did you visit this facility for a problem that bothers you frequently and that you often need care for, or for some other problem?

- For a problem that bothers you frequently like asthma, diabetes or arthritis
Please specify: _____
- Some other problem
- A mix of both

Comments: _____

4a. Did you use the hospital emergency room?

- Yes
- No
- Not applicable

4b. Were you admitted?

- Yes
- No
- Not applicable

4c. Did you visit a clinic as an outpatient?

- Yes
- No
- Not applicable

“Now I would like to ask you a few background questions”

5. Age:

Are you:

- Under 18
- 18-29
- 30-39
- 40-49
- 50-64
- 65 and over

6. Gender:

- Male
- Female

7. Ethnicity/Cultural Heritage:

Do you identify yourself as:

- African American/Black
- Asian/Pacific Islander
- Caucasian
- Hispanic/Latino
- Native American
- Mixed
- Other (Please Specify) _____

8. What is your zip code? _ _ _ _ _

“The next questions are more about (facility name) _____.”

II. PROVIDER HISTORY TOWARD CARING FOR THE UNINSURED

1. In your experience, how open has (facility name) _____ been in offering services to you if you can't pay for medical care? (Choose all that apply)

- Open and accepting even if you can't pay for health care
- Reluctant but accepts you even if you can't pay for health care
- Offers some care if you can't pay
- Provides no care if you can't pay
- Do not know

Comments: _____

2. In your opinion, what is the reputation of (facility name) _____ in providing treatment to people who can't pay for medical care in your community?

- Provides a lot of care in the community for people who can't pay
- Provides some care for people who can't pay
- Provides very little or no care for people who can't pay
- Do not know

Comments: _____

“The next questions ask about the staff at (facility name)

_____.”

3. In your experience, were the following staff courteous to you when medical care was needed:

Please rate the courtesy and helpfulness overall for (facility name) _____ on a scale from: 1 (Very Satisfactory), 2 (Satisfactory), 3 (Unsatisfactory), 4 (Very Unsatisfactory) or 5 (Don't Know/Not Applicable)

Repeat choices for each question

	<i>Very Satisfactory</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>	<i>Very Unsatisfactory</i>	<i>Don't Know/Not Applicable</i>
	1	2	3	4	DK/NA
a) Receptionists/ admitting clerks	1	2	3	4	DK/NA
b) Nurses	1	2	3	4	DK/NA
c) Physician's assistants	1	2	3	4	DK/NA
d) Examining physicians	1	2	3	4	DK/NA
e) Social workers	1	2	3	4	DK/NA
f) Billing clerks	1	2	3	4	DK/NA
g) Pharmacy staff	1	2	3	4	DK/NA
h) Others _____	1	2	3	4	DK/NA

4. Are there any special comments you want to make about the way you were treated in the Emergency Room, in any of the clinics, or as an in-patient at (facility name)

_____?

Now I would like to ask you about how easy it was for you to get the services you needed at (facility name) _____ when you were uninsured and trying to get medical care?"

III. ACCESS TO HEALTH SERVICES

1. Please rate the accessibility of services at (facility name) _____ on a scale from: 1 (Never a Problem), 2 (Sometimes a Problem), 3 (Often a Problem), 4 (Always a Problem) or 5 (Don't Know/Not Applicable)

Repeat choices for each question

	<i>Never a Problem</i>	<i>Sometimes a Problem</i>	<i>Often a Problem</i>	<i>Always a Problem</i>	<i>Don't Know/Not Applicable</i>
	1	2	3	4	DK/NA
a) How about the hours that (facility name) _____ is open?	1	2	3	4	DK/NA
b) How about the hours that the hospital emergency department is open?	1	2	3	4	DK/NA
c) How about the convenience of location? How long does it take for you to get there? Time: _____ (in minutes)	1	2	3	4	DK/NA
d) How about the waiting time to get an appointment with a health care provider? Time: _____ (in days)	1	2	3	4	DK/NA
e) How about the waiting time to see the health care provider on the day of your appointment? Time: _____ (in minutes)	1	2	3	4	DK/NA
f) How about getting an interpreter if you need one?	1	2	3	4	DK/NA
g) How about the convenience to public transportation lines?	1	2	3	4	DK/NA
h) How about transportation assistance if needed?	1	2	3	4	DK/NA

Comments: _____

“The next questions are about medications.”

2a. Was medicine prescribed during any of your visits when you were uninsured?

- Yes
- No *(if no, skip to question 4)*

2b. If medication was prescribed, did you get it? (Choose all that apply)

- Yes, supplied free by the staff
- Yes, used a pharmacy card
- Yes, went to pharmacy or drug store and paid
- No, did not get the medication because I could not afford it
- Some, did not get all my medications because I could not afford them
- Other _____

Comments:

3. If you needed medicine to take at home, how well did you understand the instructions on how to take the medicine?

- Yes, I understood the instructions
- No instructions were given
- I did not understand the instructions
- I did not need medicine for home

Comments:

4. Is there anything else you would like to say about how you were treated, or how easy it was for you to get services or medications at (facility name) _____?

“The next questions relate to language and culture issues at (facility name) _____.”

IV. LANGUAGE AND CULTURE NEEDS

Note: *If the interviewee is fluent in English please check “No” in Question 1 and go to Question 6a*

1. When you were treated at (facility name) _____ in the past year was help with translation needed because you spoke little or no English?

- Yes *(If yes, please answer the following questions.)*
- No *(If no, then please go to Question 6a)*

Comments: _____

2. If you did need help, how available was an interpreter to assist? (Choose one only)

- Very available*—the *doctor* or *nurse* spoke my language and was there for treatment
- Available*— an *interpreter* was there when I was treated
- Not very available*—the wait for someone who spoke my language was a long time
- Unavailable*—someone with me (a friend or family member) had to translate

Comments: _____

3. How good was the health care professional who spoke your language in talking to and understanding your problem? (Choose one only)

- Very good*—the health care person and I understood each other
- Fair*—the health care person and I mostly understood each other, but there was some difficulty in translating questions and in understanding the answers
- Poor*—the health care person and I for the most part could not understand each other

Comments: _____

4. Does (facility name) _____ have any signs in your language in the admitting area or waiting room?

- Yes
- No

Comments: _____

5. Did (facility name) _____ offer you information written in your language to assist in medical care?

- Yes
- No

Comments: _____

6a. Did you feel that the health care professionals treated you with respect?

- Always
- Sometimes
- Never
- Does not apply/Don't Know

Comments: _____

6b. Did the health care professionals who treated you ask you whether you are using traditional methods of healing, like herbs, acupuncture, other?

- Always
- Sometimes
- Never
- Does not apply/Don't Know

Comments: _____

7. Is there anything else you would like to say about language or culture issues at (facility name) _____?

“Finally, I would like to ask you some questions about payment of medical bills.”

V. PAYMENT FOR MEDICAL CARE

1. How difficult was it for you to pay for the cost of medical care at (facility name) _____? (Choose one only)

- Very difficult to pay for medical care
- Not so difficult to pay for medical care
- Easy to pay for medical care

Comments: _____

2. Did you need help in paying the medical bill?

- Yes -- *If yes, go to 2a*
- No -- *If no, go to 3*

2a. If yes, did the staff at (facility name) _____ ask if help was needed?

- Always
- Often
- Sometimes
- Never

Comments: _____

3. Did the staff at (facility name) _____ offer to help you find out if any financial assistance was available?

- Always
- Often
- Sometimes
- Never - *If never, go to 4*

Comments: _____

3a. When they did offer, what kind of financial assistance did they offer? (Choose all that apply)

- Pay some amount every month
- Reduce the amount that had to be paid
- Waived bill altogether
- Help find a charitable organization that would help pay the medical bill (please specify)_____
- Other (please describe)_____

Comments: _____

4. How difficult was it for you to pay for the cost of your medications? (Choose one only)

- Very difficult to pay for medications
- Not so difficult to pay for medications
- Easy to pay for medications
- Not applicable

Comments: _____

5. Did you need help in paying for your medication?

- Yes -- *If yes, go to 5a*
- No -- *If no, go to 6*

5a. If yes, did the staff at (facility name) _____ ask if help was needed?

- Always
- Often
- Sometimes
- Never

Comments: _____

**6. How will the amount of money and the way you had to pay for medical care at (facility name) _____ affect your choosing to seek care there in the future?
(Choose all that apply) (Read the following options to the interviewee)**

- The cost for medical care will make you not seek care at (facility name) _____
- The cost for medical care at (facility name) _____ will make you use another medical care facility
- The cost for medical care will make it easier to seek care at (facility name) _____
- It will not make a difference

Comments: _____

7. Do you currently have unpaid bills or debt owed to (facility name) _____?

- Yes (If yes, go to 7a)
- No (If no, go to 8)

Comments: _____

7a. Would these unpaid bills or debt make you not seek care there in the future?

- Yes
- No

Comments: _____

8. If you had insurance that paid for your medical care, would you use (facility name) _____ in the future?

- Yes
- No

Comments: _____

9. Are there any other comments you would like to make about payment of medical bills or about (facility name) _____ in general?

“Thank you very much for taking the time to complete this survey.”

Time Completed: _____

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