



Getting Health Care
When You Are
Uninsured:

*A Survey of Uninsured Patients
at Fannin Family Planning Clinic
in Houston, Texas*

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The mission of **Planned Parenthood of Houston and Southeast Texas, Inc. (PPHSET)** is to ensure the right and ability of all individuals to manage their sexual and reproductive health by providing health services, education and advocacy. Planned Parenthood has been a strong community presence since 1936. Today, it operates 10 clinic sites in diverse communities throughout southeast Texas – serving rural women in the East Texas area of Lufkin, newly arrived Hispanic immigrants in southwest Houston, college students in Bryan-College Station, and a wide range of other socioeconomic and ethnic groups. Its educational programs provide teens and adults with the knowledge they need to make responsible choices about sexuality and health. Its advocacy efforts work to ensure that access to comprehensive reproductive health care is available to everyone – regardless of age, race or income level. Each year, PPHSET provides more than 80,000 medical visits and reaches more than 10,000 people through educational programs. PPHSET clients reflect the diversity of southeast Texas: 38% being Anglo, 26% Hispanic, 17% African American and 19% of other ethnicities.

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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, Houston, Texas. The survey was conducted in the summer of 2000 and gathered information from 198 uninsured patients who obtained health care at the Planned Parenthood of Houston and Southeast Texas Fannin Family Planning Clinic 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.

KEY FINDINGS

- ◆ The overwhelming majority of respondents reported that they were satisfied or very satisfied with the care they received at the clinic, and that they were “always” treated with respect by the staff.
- ◆ The proportions of respondents reporting that the clinic was “open and accepting” even if they couldn't pay, or that it had a reputation for providing “a lot” of care to the uninsured, were lower than the averages for all urban and suburban clinics included in CAMS nationwide. These lower than average proportions, however, may reflect the relatively high proportions of respondents reporting that they “didn't know.” Few respondents said the clinic was not open and accepting or that it provided little care for the uninsured.
- ◆ More than half of the 73 percent of respondents who had medications prescribed received them free of cost. Nearly all (94%) said they understood the instructions for using the medications.

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Only 20 percent of respondents reported needing help paying for medications, but of those who needed help, 57 percent said staff “never” asked if they needed assistance.

- ◆ Thirty-three percent of respondents said they needed help paying for their medical care, but of those needing help, 41 percent said they were “never” asked if they needed assistance.
- ◆ Despite these figures, Planned Parenthood respondents were much less likely than respondents for all urban and suburban clinics included in CAMS to say that paying for medical care and for medications was “very difficult” for them.
- ◆ Only 3 percent of Planned Parenthood respondents owed money to the clinic, compared with 20 percent of respondents for all urban and suburban clinics included in CAMS.
- ◆ Only 4 percent of respondents said their experience paying for care would make them not seek care at the clinic again, while nearly 60 percent said that it would make it easier to seek care. Fully 85 percent of respondents reported that they would seek care at Planned Parenthood in the future even if they had health insurance.
- ◆ About one-fourth of respondents said that the clinic's hours were a problem for them at least sometimes. A little over half said the waiting time to see a provider on the day of an appointment was a problem at least sometimes. These proportions were similar to those for all urban and suburban clinics included in CAMS. Thirty percent said the location of the clinic was a problem at least sometimes.



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, Houston, Texas. The survey was conducted by Planned Parenthood of Houston and Southeast Texas, Inc. in the summer of 2000, and gathered information from uninsured individuals who received care at Fannin Family Planning Clinic in Houston 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

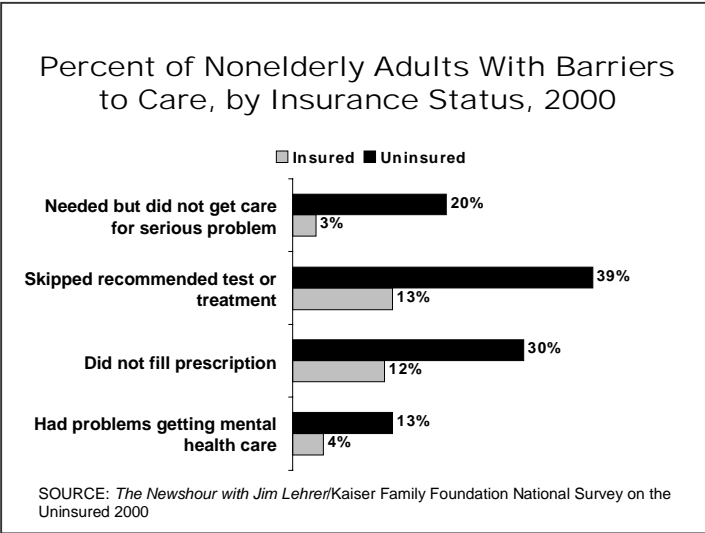
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the 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 Planned Parenthood of Houston and Southeast Texas, Inc.

In 1998, Texas had the highest percentage of residents without health insurance of any state in the nation, with almost one out of four Texans uninsured.³¹ At the same time, Texas ranks 48th in the nation in per capita spending for public health.³² In the Houston-Galveston-Brazoria area, the situation is even worse. The area ranks lowest in the nation for health insurance coverage; nearly one-third of area residents have no insurance at all.³³ Thousands more are underinsured, meaning that they have some coverage but cannot afford the out-of-pocket costs that their insurance does not cover.³⁴

The impact of this lack of health insurance on the state and city is widespread and dramatic. An article in *The New York Times* recently pointed out that “[Texas] ranks near the top of the nation in rates of AIDS, diabetes, tuberculosis and teenage pregnancy and near the bottom in immunizations, mammograms and access to physicians.”³⁵

For women, family planning services and gynecological care are critical elements of basic, preventive health maintenance. Not only do these services prevent unintended pregnancies, but they may also be the only access to health care for some low-income women. Since family planning visits include screening for a number of potentially deadly health problems, including breast and cervical cancer, diabetes, anemia, kidney disease and infection, hypertension, and sexually transmitted infections, lack of access to these services can cause infertility or be life-threatening.

Yet Texas invests little public money in the provision of family planning and reproductive health care to low-income women, despite a 2000 poll showing that more than two-thirds of Texans support an increase in funding for these services.³⁶ The state ranks 36th in the provision of contraceptive services to women in need. Its publicly supported family planning clinics, which serve 483,000 women, provide services to only 37 percent of all Texas women in need,³⁷ and annually, up to 22,000 low-income Texas women who seek services are turned away due to lack of program funds.³⁸ For women who are uninsured and ineligible for these benefits, access to affordable care is even more difficult. Almost all family planning funding in Texas is appropriated from federal funds.³⁹ In the past few years, however, Congress has made severe cuts in the Title XX Social Services Block Grant, which funds many of these programs. As a result, according to the Women’s Health and Family Planning Association of Texas, in

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state fiscal year 1999 providers in the state were forced to close clinics, reduce staff and turn away clients.

The consequences of providing insufficient preventive care are severe, not only for the individuals and families unable to afford basic medical care, but also for the entire community. Unintended pregnancy is the leading cause of welfare dependency in the state, and also results in increased state expenditures for deliveries, newborn care, WIC and other related social services. In 1997, the Texas Medicaid program paid \$458 million overall just for deliveries, which included 48% of all births in the state.⁴⁰ According to the National Institute of Medicine, one half of all pregnancies are unintended.⁴¹ Reducing the number of such pregnancies would clearly contribute to reductions in costs. In fact, the Texas Department of Health has found that for every \$1 spent on subsidized family planning care, \$3.00 is saved in the first year alone in Medicaid prenatal, delivery, and newborn care, and WIC.⁴² Yet, despite a budget surplus, the 1999 Texas Legislature did not fund the Texas Campaign for Women's Health, which would have provided additional funding for health care services for low-income women.

The mission of Planned Parenthood of Houston and Southeast Texas, Inc. (PPHSET) is to ensure the right and ability of all individuals to manage their sexual and reproductive health by providing health services, education and advocacy. It operates 10 clinic sites in diverse communities throughout southeast Texas, providing more than 80,000 medical visits annually. At all clinic locations, PPHSET clients are primarily low-income and uninsured women.

PPHSET conducted the Community Access Monitoring Survey at its Fannin Family Planning Clinic, located in midtown Houston. This clinic provided nearly 10,000 medical visits during the 1999 fiscal year to a racially diverse mix of Anglos, African Americans, Hispanics, Vietnamese and other ethnic groups. Twenty-two percent of these visits were not covered by insurance or family planning programs, so women paid out of pocket for their health care. (PPHSET charges deeply discounted fees on a sliding scale, and offers charitable funding for those with no resources.)

PPHSET undertook the CAMS project to evaluate and improve services in its clinic, and to help government officials and others gain a clearer picture of the experiences and needs of low-income women when accessing health care.

SURVEY METHODOLOGY

The survey was conducted at the PPHSET Fannin Family Planning Clinic between June and July, 2000. PPHSET recruited and trained five survey administrators; most were college students and two were bilingual in Spanish. 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.

All respondents were uninsured women who had received care at the Fannin Clinic, were over the age of 19, and were living independently of their parents. To be included in the survey, women had to have received services at the clinic while they were uninsured.

Survey administrators approached clients as they waited for their appointments and determined if they met the survey criteria. Women who were willing to be surveyed, but were first time visitors to the clinic, were interviewed after their appointment rather than before. Interviews were conducted on site in a private room, and respondents were informed of the confidentiality of their answers. Interviews lasted a maximum of 20 minutes. 198 surveys were completed for uninsured patients who had received care at the clinic.

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 the Fannin Clinic. *The results reflect the experiences only of those surveyed.*

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SURVEY FINDINGS

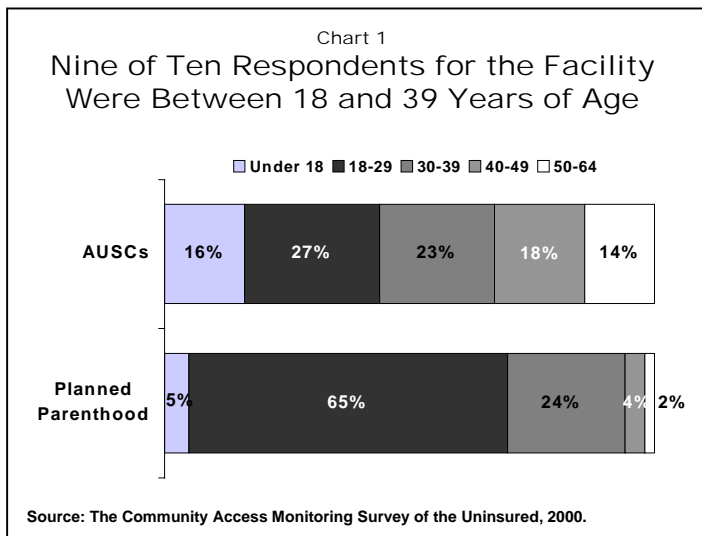
This section describes the survey results for respondents who received care while uninsured at Planned Parenthood’s Fannin Clinic and compares them with averages for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide. All comparisons were statistically significant unless otherwise indicated (ns = non-significant). See Appendix A for a table of the results for Planned Parenthood respondents, as well as aggregate results for AUSCs.

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

The overwhelming majority of respondents for Planned Parenthood were ethnically diverse women between 18 and 39 years of age.

Two of three respondents were women between the ages of 18 and 29. An additional one-fourth of respondents (24%) were between the ages of 30 and 39. Overall, respondents were disproportionately young compared with the average age for AUSC respondents. (Chart 1)



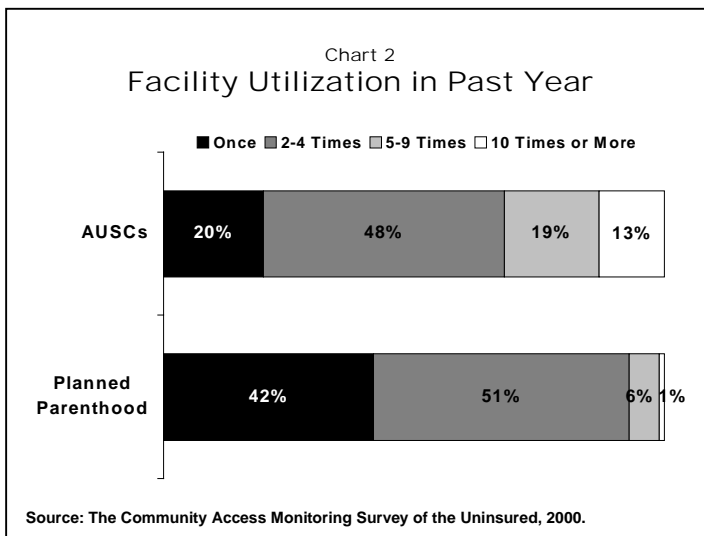
As expected, almost all (99%) of the respondents were women, whereas the average for AUSCs was 68 percent.

One-third (34%) of the respondents were white and another third (33%) were black, compared with AUSC averages of 22% and 44%, respectively. One of four respondents (25%) identified themselves as Hispanic. All but a few (4%) of the respondents preferred to take the survey in English and no respondent answered on behalf of a child.

USE OF HEALTH SERVICES

Respondents for Planned Parenthood were likely to have used the clinic between one and four times in the past year. Few respondents sought care to treat a chronic problem.

More than two of five (42%) respondents reported that they used the clinic only once in the past year. An additional 51 percent said they used the clinic between two and four times. Planned Parenthood respondents were less likely than respondents for AUSCs to have used the clinic five or more times (7% vs. 32%, respectively). (Chart 2)



Fully 90 percent of the respondents sought care to treat a problem or condition that was not chronic. Put another way, only ten percent of respondents said they sought care to treat a chronic problem, compared with an average of 38 percent for AUSCs.

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

About half of the respondents found the clinic open and accepting to the uninsured and believed that the clinic had a reputation for providing a lot of care to the uninsured. Reported satisfaction with providers was very high.

“Very easy to get help. This is the best clinic I have used in Houston for medical care for women and teens.”
Planned Parenthood Respondent

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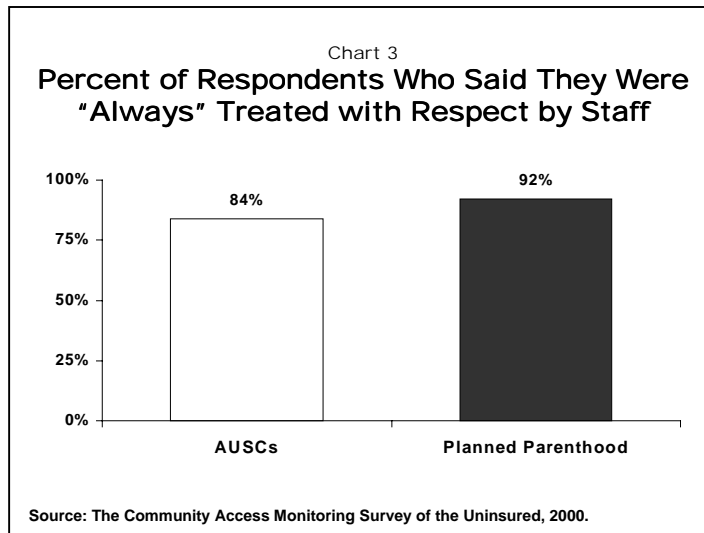
"I think they really try to help you out to get medical care – even if you have the money or not."

Planned Parenthood Respondent

One of two (52%) respondents said that based on their experience Planned Parenthood had been "open and accepting" to them even if they were unable to pay for their care. The average for AUSCs was 78 percent. Similarly, one-half of the respondents reported that the clinic had a reputation for providing "a lot" of care to those who cannot pay, compared with 62 percent of respondents for AUSCs.

The overwhelming majority (90% or more) of the respondents reported that they were either "very satisfied" or "satisfied" with the care and service they received from receptionists, nurses, and doctors at Planned Parenthood. Very few (3% or less) respondents reported being dissatisfied with any category of staff.

Nearly all the respondents for Planned Parenthood reported that they were "always" treated with respect by clinic staff. (Chart 3)



ACCESSIBILITY

Between one-fourth and one-half of the respondents for Planned Parenthood said that the hours, location, and waiting times were a problem for them at least sometimes.

About one-fourth of Planned Parenthood respondents found the clinic's hours to be a problem at least sometimes, and three of ten respondents said the location was a problem.

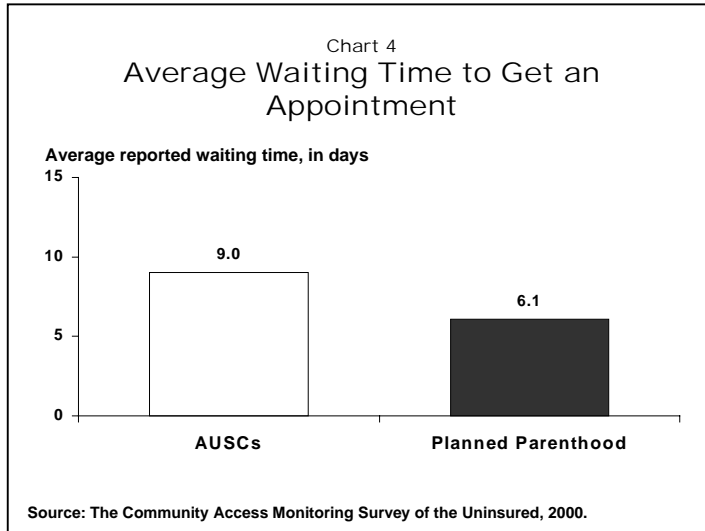
"I like coming here. The people are very friendly and helpful, but it's hard to get an appointment."

Planned Parenthood Respondent

Waiting time was likely to be an issue for many of the respondents. Indeed, more than half (53%) said the waiting time on the day of the appointment, and two of five respondents (40%) said the waiting time to get an appointment, was a problem at least sometimes. These proportions were slightly higher than the average for AUSCs.

However, the average of reported waiting times to get an appointment at Planned Parenthood was about 3 days *less* than the average for AUSCs.

(Chart 4)



OBTAINING PRESCRIPTION MEDICATIONS

Nearly three of four Planned Parenthood respondents had medications prescribed and slightly more than half received their medications free. Compared to the average for AUSCs, Planned Parenthood respondents were less likely to say they needed help paying for their medications, and very few found paying for them very difficult.

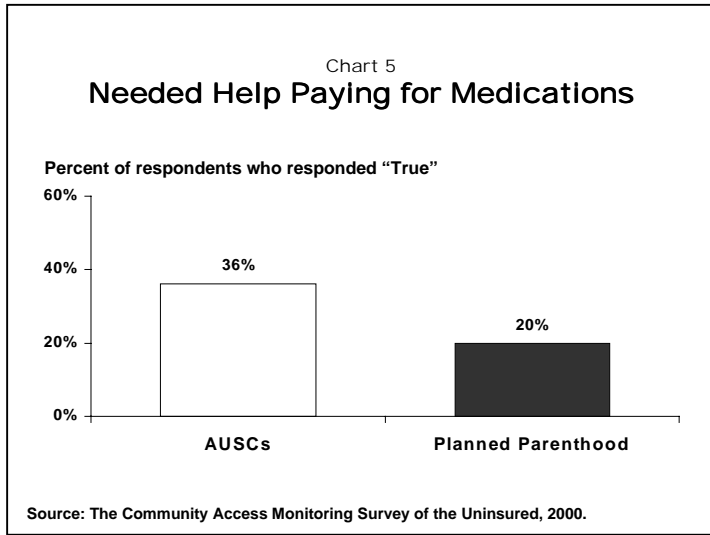
Seventy-three percent of the Planned Parenthood respondents said they had medications prescribed at least once in the past year. Among those who had medications prescribed, about half (53%) obtained them free. Nearly all (94%) of the respondents said they understood their medication instructions.

Only five percent of Planned Parenthood respondents reported that paying for their medications was “very difficult,” lower than the AUSC average of 27 percent. Similarly, respondents for Planned Parenthood were less likely than the average for AUSCs to say that they needed help paying for their medications (20% vs. 36%, respectively). (Chart 5)

“It was low-cost, much lower than in the store.”
Planned Parenthood Respondent

“They supplied whatever was needed and helped me understand how to take the medication.”
Planned Parenthood Respondent

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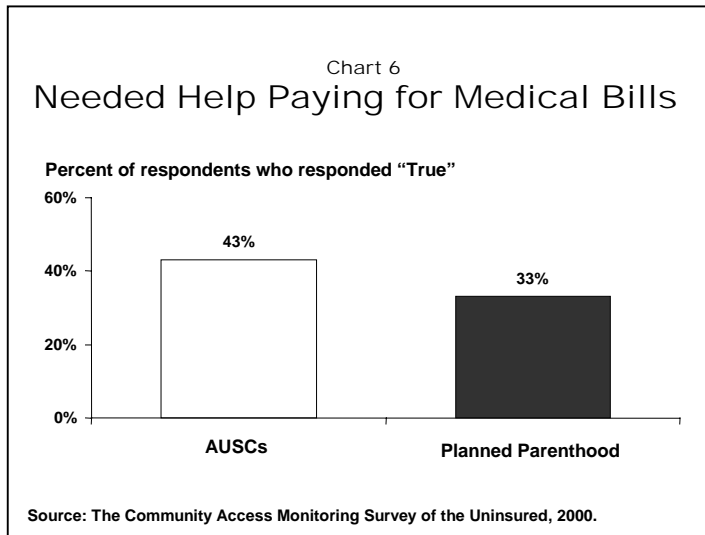
Notably, however, among those who did say they needed help, 57 percent of the Planned Parenthood respondents said they were “never” asked if they needed help (AUSC average 34%).

CONCERNS OVER PAYMENT FOR HEALTH CARE

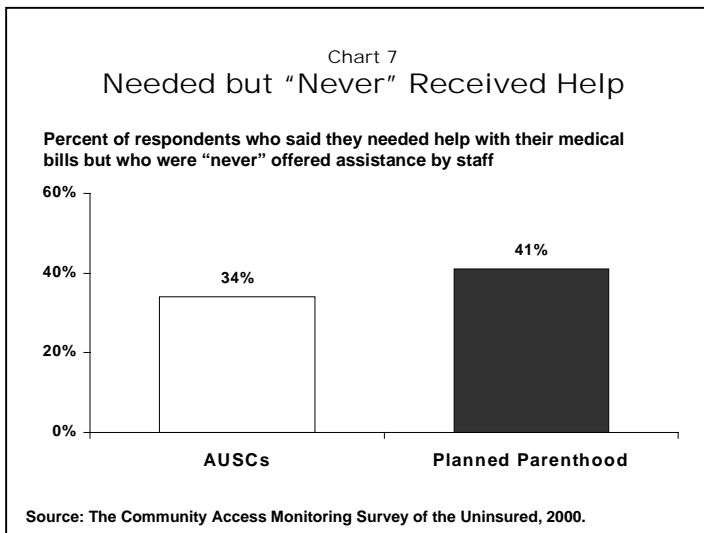
Comparatively few Planned Parenthood respondents said that paying for their medical care very difficult, and they were less likely than the AUSC average to need help paying their bills.

“I pay, but it’s the bare minimum. You have to pay something.”
Planned Parenthood
Respondent

One of ten (11%) respondents for Planned Parenthood said that paying for their medical care was “very difficult,” compared with an average of 33 percent for AUSCs. Furthermore, 53 percent said that paying their medical bills was “not so difficult.” One-third of the respondents said they needed help paying the bill, while the average for AUSCs was 43 percent. (Chart 6)



Among the Planned Parenthood respondents who needed help paying their bill, more than half said staff offered to find out if financial assistance was available at least sometimes, but 41 percent said they were "never" asked if they required assistance. (Chart 7)



Among those who received assistance, Planned Parenthood respondents were *more* likely to have their bill reduced (66% vs. 35%), and *less* likely to be offered monthly billing plans (5% vs. 41%) or have their bill waived (3% vs. 26%) than the average for AUSCs.

SEEKING CARE IN THE FUTURE

Most respondents said they would use the clinic again if they were insured. Very few respondents said they owed money to the clinic or that they would not seek care there again.

"They've been great with a sliding scale."
Planned Parenthood Respondent

"I know they have a sliding scale based on income. They're pretty open about low income."
Planned Parenthood Respondent

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Very few Planned Parenthood respondents (4%) said their experience paying for care would cause them to not seek care there again, nearly identical to the average for AUSCs. In fact, most respondents said their experience paying for care either made it easier for them to seek care (59%) or would make no difference (30%) on whether they seek care at Planned Parenthood in the future.

“They’re nice. I like coming here. Even if I did have insurance, I would prefer coming here to a doctor’s office.”

Planned Parenthood Respondent

Very few Planned Parenthood respondents said they owed money to the clinic, much lower than the average for AUSCs (3% vs. 20%, respectively).

Fully 85 percent of the respondents reported that they would seek care at Planned Parenthood in the future even if they had health insurance. The average for respondents for AUSCs was 82 percent.

DISCUSSION

This section discusses some of the perceived strengths suggested by the survey results for Planned Parenthood of Houston. It also highlights issues that might warrant further discussion

STRENGTHS

- ◆ The majority of respondents were either satisfied or very satisfied with their interactions with receptionists/admitting clerks, nurses, billing clerks, and doctors.
- ◆ Respondents were much less likely than the averages for respondents for All Urban and Suburban Clinics (AUSCs) included in CAMS nationwide to report that paying for medical bills and for medications was “very difficult” for them or that they needed help paying for them.
- ◆ Among the respondents who had medications prescribed, about half received them free and nearly all said that they understood the instructions for using them.
- ◆ Most respondents said their past experiences paying bills at Planned Parenthood would either make it easier or make no difference in their likelihood of seeking care there in the future.
- ◆ Respondents were much less likely to owe money to the clinic than the average for AUSCs.
- ◆ Eighty-five percent of the respondents said they would use the clinic again if they had health insurance.

ISSUES FOR FURTHER CONSIDERATION

- ◆ Although the proportions of Planned Parenthood respondents who said that the clinic had been “open and accepting” even if they couldn't pay and that the clinic had a reputation for providing “a lot of care” to the uninsured were smaller than for AUSC respondents overall, these findings should be interpreted with caution. The proportions of Planned Parenthood respondents reporting that the clinic provided little assistance or care were very small, while the proportions responding “don't know” were high. The high proportions of respondents answering “don't know” may partially explain why the proportions reporting that the facility had been open and accepting and had a reputation for providing a lot of care were lower than the AUSC average, while the proportions who said they were satisfied with the care they received was higher than the average.

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- ◆ Responses related to accessibility for Planned Parenthood respondents were very similar to those for AUSCs, and indicated that many experienced problems with accessibility. About one-fourth of Planned Parenthood respondents reported that the clinic's hours were a problem for them at least sometimes, and many reported that waiting times both to get an appointment and on the day of the appointment were likely to be a problem at least sometimes.
- ◆ While the proportions of respondents who needed help paying for their medical care (33%) or medications (20%) were relatively small, many of these respondents (41% and 57%, respectively) said they "never" received any assistance from staff. However, these findings may reflect a lack of awareness of Planned Parenthood billing policies on the part of some respondents. According to Planned Parenthood staff, while medical bills are seldom waived, fees for uninsured patients are based on a sliding scale and generally include large discounts. Thus, some respondents may not have been aware that their bills reflected these discounts.

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 U.S. Census Bureau, *Health Insurance Coverage: 1998 - State Uninsured Rates*, United States Department of Commerce, Washington D.C., 1998.

³² A. Clymer, "Bush and Texas Have Not Set a High Priority on Health Care," *The New York Times*, April 11, 2000

³³ B. Roth, "Nearly a third in area lack health insurance," *Houston Chronicle*, July 8, 1998.

³⁴ *Uneven and Unequal: Insurance Coverage of Reproductive Health Services*, The Alan Gutmacher Institute, New York, 1994.

³⁵ A. Clymer, *op cit*.

³⁶ *Scripps Howard Texas Poll*, June, 2000.

³⁷ *Contraception Counts: Texas Information*, The Alan Gutmacher Institute, New York, 1998.

³⁸ P. Romberg, Chief Executive Officer, Women's Health and Family Planning Association of Texas.

³⁹ Federal funding comes from programs such as TANF (Temporary Assistance to Needy Families), Title XX Social Services Block Grant, Title XIX – Medicaid and Title X – America's National Family Planning Program.

⁴⁰ *Contraception Counts, op cit*.

⁴¹ S. Brown and L. Eisenberg, eds, *The Best Intentions: Unintended Pregnancy and Well-Being of Children and Families*, Division of Health Promotion and Disease Prevention, Institute of Medicine, 1995.

⁴² Texas Department of Health, Family Planning Division, Austin, 1998.

APPENDIX A: TABLE OF SURVEY RESULTS

This table presents the results of the surveys of patients at Planned Parenthood of Houston, in Houston, TX. For comparison purposes, it also presents results of surveys of patients at all urban and suburban clinics included in the CAMS project nationally.

Asterisks in the *Inter-site p value* column indicate statistically significant differences between the Planned Parenthood of Houston Clinic and the average for all urban and suburban clinics included in CAMS, although the statistical chi-square test does not specify which of those differences were significant. 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.)

	Houston Clinic	CAMS Sites
	Inter-site p-value	All Urban and Suburban Clinics
Number of survey respondents	198	3363
	% ^a	% ^a
RESPONDENT CHARACTERISTICS		
Age	**	
Under 18		16
18-29 years		27
30-39 years		23
40-49 years		18
50-64 years		14
65 or older		1
Race/Ethnicity	**	
White		22
Black		44
Hispanic		26
Other ^b		8
Gender	**	
Male		32
Female		68
Language in which survey administered	**	
English		84
Spanish		16
Answered on behalf of child		10
FACILITY UTILIZATION		
Use of facility in past year	**	
Once		20
2-4 times		48
5-9 times		19
10 or more times		13
Reason for visit(s)	**	
Chronic problem or Mixed (chronic and non-chronic)		38
Other problem (non-chronic)		62

	Houston Clinic		CAMS Sites
	Inter-site p-value	Planned Parenthood of Houston	All Urban and Suburban Clinics
PERCEPTION OF FACILITY			
Experience of facility's openness to uninsured			
Open and accepting even if can't pay	**	52	78
Reluctant but accepts you even if can't pay		5	7
Offers some care if can't pay		10	8
Provides no assistance if can't pay	—	1	2
Don't know	**	34	8
Opinion of facility's reputation for treating uninsured			
Provides a lot of care for those who can't pay		50	62
Provides some care		15	16
Provides very little or no care		2	4
Don't know		34	19
SATISFACTION WITH PROVIDERS/COURTESY OF STAFF			
Receptionists/ Admitting clerks			
Very satisfactory or satisfactory		96	93
Unsatisfactory or very unsatisfactory		3	7
Don't know		1	
Nurses			
Very satisfactory or satisfactory		97	96
Unsatisfactory or very unsatisfactory		2	4
Don't know		1	1
Physician assistants			
Very satisfactory or satisfactory	**	2	78
Unsatisfactory or very unsatisfactory		1	3
Don't know		99	19
Examining physicians			
Very satisfactory or satisfactory		90	91
Unsatisfactory or very unsatisfactory		3	3
Don't know		7	6
Social worker			
Very satisfactory or satisfactory	**	24	42
Unsatisfactory or very unsatisfactory		2	4
Don't know		75	54
Billing Clerks			
Very satisfactory or satisfactory	**	79	50
Unsatisfactory or very unsatisfactory		3	7
Don't know		19	43
Pharmacist			
Very satisfactory or satisfactory	**	1	40
Unsatisfactory or very unsatisfactory		1	4
Don't know		99	56
Treated with respect			
Always	*	92	84
Sometimes		7	13
Never		1	1
Don't know		1	3

	Houston Clinic		CAMS Sites
	Inter-site p-value	Planned Parenthood of Houston	All Urban and Suburban Clinics
ACCESSIBILITY OF SERVICES			
Hours facility open			
Never a problem		72	74
Sometimes a problem		22	20
Often/always a problem		4	4
Don't know		3	2
Location **			
Never a problem		69	79
Sometimes a problem		22	16
Often/always a problem		8	5
Don't know		1	
Waiting time to get appointment *			
Never a problem		57	53
Sometimes a problem		29	27
Often/always a problem		11	12
Don't know		3	8
Waiting time to see provider on day of appointment			
Never a problem		46	46
Sometimes a problem		31	34
Often/always a problem		22	17
Don't know		2	4
Convenient to public transportation **			
Never a problem		18	43
Sometimes a problem		3	6
Often/always a problem		1	4
Don't know		79	47
Transportation assistance if needed **			
Never a problem		7	22
Sometimes a problem		2	5
Often/always a problem		-	4
Don't know		91	69
MEDICATIONS			
Medication prescribed		73	70
If yes, how obtained			
Supplied free		53	56
Used a pharmacy card	**	-	10
Used a drug store and paid	**	7	34
Didn't get/couldn't afford	*	1	4
Got some/couldn't afford all	*	1	6
Other	**	44	7
Medication instructions —			
Understood instructions		94	96
No instructions given		1	1
Did not understand instructions		-	1
Did not need medicine for home		5	1

	Houston Clinic		CAMS Sites
	Inter-site p-value	Planned Parenthood of Houston	All Urban and Suburban Clinics
Difficulty paying for medications			
	**		
Very difficult		5	27
Not so difficult		33	23
Easy to pay		21	15
N/A		41	36
Needed help paying for medications	**	20	36
If yes, did staff offer help?			
	*		
Always		32	42
Often		5	10
Sometimes		5	14
Never		57	34
MEDICAL BILLS			
Difficulty paying for medical care			
	**		
Very difficult		11	33
Not so difficult		53	34
Easy to pay		35	34
Needed help paying the medical bill? If yes	**	33	43
Did staff offer to find out if financial assistance was available?			
Always		41	41
Often		8	12
Sometimes		10	14
Never		41	34
Type of help staff offered <i>(If Always, Often, Sometimes to previous question)</i>			
Pay in monthly installments	**	5	41
Reduce amount of bill	**	66	35
Waive bill	**	3	26
Find charitable organization to pay	**		28
Other	—	32	11
FUTURE CARE			
Effect of payment experience on seeking future care at facility			
Will not seek care at facility		4	4
Will use another facility		3	3
Easier to seek care at facility		59	53
Makes no difference	*	30	39
Currently owe facility money	**	3	20
If yes, will make not seek care in future	—	20	23
If had insurance, would use facility in future		85	82
TRAVEL AND WAIT TIMES			
Travel time, mean (minutes)	*	21.58	19.10
Travel time, median (minutes)		17.00	15.00
Days to get appointment, mean	**	6.06	8.98
Days to get appointment, median		5.00	3.00
Waiting time to see provider, mean (minutes)		54.70	47.47
Waiting time to see provider, median (minutes)		30.00	30.00

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

CAMS SPONSORING ORGANIZATION	SURVEYED FACILITIES
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

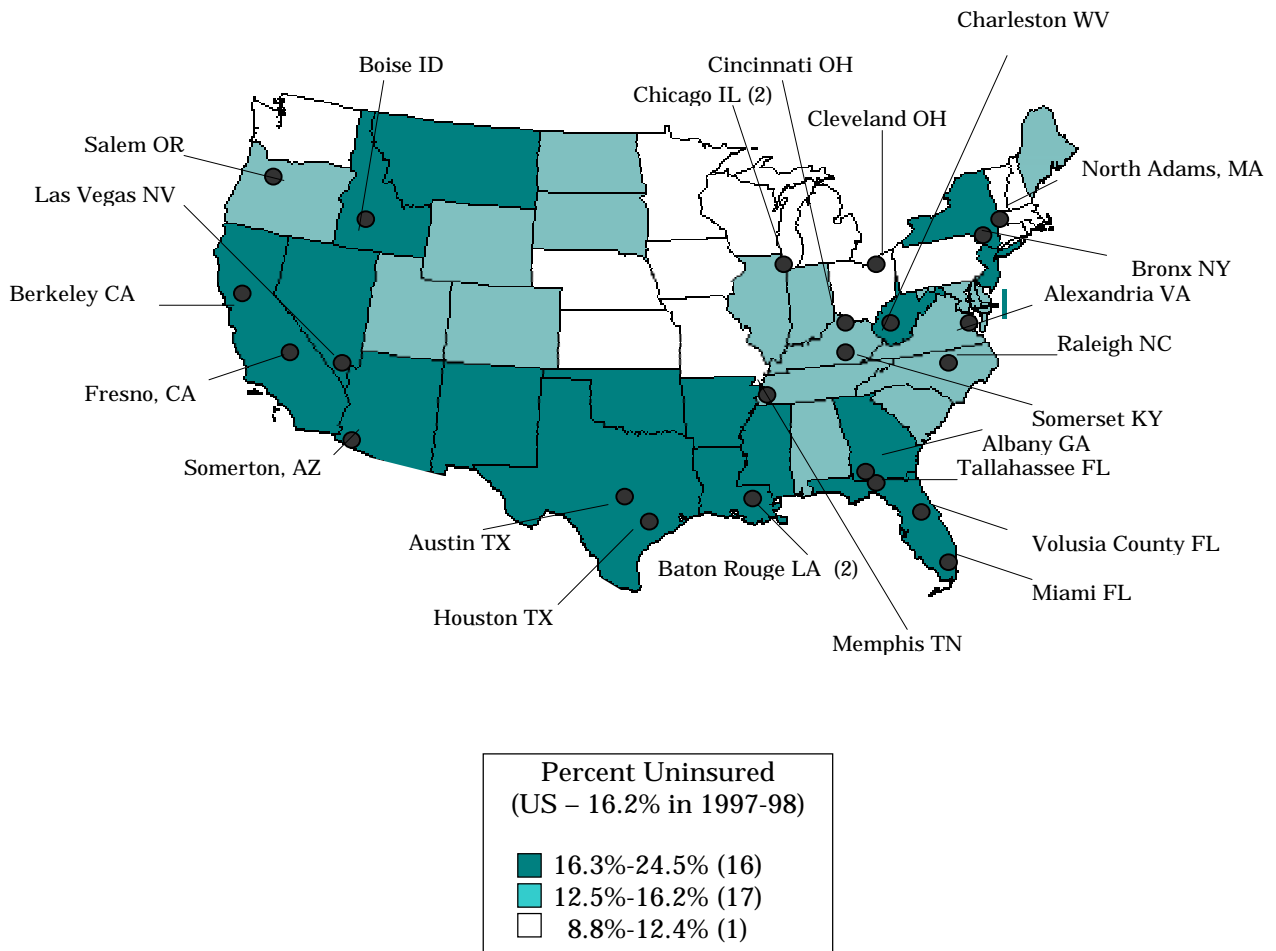
SURVEYED FACILITIES BY TYPE

<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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