



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured
Patients at Two Clinics in
Chicago, Illinois*

AUTHORS:

Dennis Andrulis, Ph.D., MPH

Research Professor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Nanette Goodman, MS

Health Policy Consultant

Christina An, MPH, MA

Research Instructor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Carol Pryor, MPH, M.Ed.

Policy Analyst, The Access Project

This report was produced in collaboration with the Westside Health Authority.

March 2001

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

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

The Access Project
30 Winter Street, Suite 930
Boston, MA 02108
Phone: 617-654-9911 Fax: 617-654-9922
E-mail: info@accessproject.org Web site: www.accessproject.org

The Westside Health Authority (WHA) is a grassroots membership-based organization that seeks to “use the capacity of local people to improve the health and well being of Westside residents and to preserve existing health service institutions.” Founded in 1988 to respond to the closing of St. Anne’s Hospital, the tenth and largest hospital to close in Chicago, the WHA has since initiated a block-by-block, asset-based organizing strategy, networking neighbors with neighbors and with organizations, providers, businesses, schools, and parks. Its member organizations include 50 social service agencies, faith-based organizations, businesses, political entities, educational institutions, hospitals, health clinics, and community-based organizations. WHA’s accomplishments include the purchase of St. Anne’s hospital and use of the facility as a campus for ambulatory care and social services, the prevention of the sale of a community hospital, the creation of health internships for youth interested in health careers, and prevention of the closure of the R.M Gunnar Health Clinic by MacNeal Hospital.

Jacqueline Reed, MA
Executive Director
Westside Health Authority
5437 W. Division Street
Chicago, IL 60651
E-mail: info@healthauthority.org

This report may be reproduced or quoted with appropriate credit.

TABLE OF CONTENTS

Executive Summary.....5

Introduction7

 Community Access Monitoring Survey Project.....8

 About This Report.....9

Lack of Insurance is Dangerous to Your Health.....10

 Lack of Insurance and Access to Care.....10

 Lack of Insurance and Health Outcomes.....11

 Benefits of Improved Access to Health Care.....12

 The Health Care Market and Care for the Uninsured13

Community Context.....15

Survey Methodology17

Survey Findings18

 Respondent Characteristics.....18

 Use of Health Services.....18

 Openness to the Uninsured and Satisfaction with Providers.....19

 Accessibility20

 Obtaining Prescription Medications.....21

 Concerns Over Payment for Health Care22

 Seeking Care in the Future23

Discussion.....25

References27

Appendix A: Table of Survey Results.....A-1

Appendix B: Surveyed Facilities by CAMS Sponsoring Organization and by Type.....B-1

Appendix C: Locations of CAMS Sponsoring Organizations and State Uninsurance Rates 1997-98.....C-1

Appendix D: Survey InstrumentD-1

Acknowledgements

•
•
•
•
•
•
•
•

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 in Chicago, Illinois. The survey was conducted in the summer of 2000 and gathered information from 300 uninsured patients who obtained health care at the Austin Cook County Health Center or at Circle Family Care/R.M Gunnar 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.

The survey responses indicate that on most indicators of access and satisfaction, respondents for Austin Cook County Health Center (Austin) and CFC/Gunnar Clinic (CFC/Gunnar) fared as well as or better than respondents for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide.

- ◆ Ninety-five percent or more of the respondents for both facilities reported that, in their experience, their clinic had been open and accepting to them even if they were unable to pay for their care. In addition, four of five respondents for both clinics reported that their clinic has a reputation for providing a lot of care to the uninsured.
- ◆ The majority of respondents for both clinics (over 96%) rated their interactions with receptionists, nurses, and doctors very highly, and nearly all of the respondents for both clinics (over 95%) stated that staff “always” treated them with respect. Notably, however,

•
•
•
•
•
•
•

one of five Austin respondents (21%) reported dissatisfaction with the care and service they received from pharmacists.

- ◆ The majority of respondents for both facilities reported that they used their clinic more than once in the past year; 22 percent of Austin respondents said they used their clinic ten times or more.
- ◆ Relatively few respondents for either clinic reported that their clinic's hours or location were a problem. In addition, the average reported waiting times to see a provider on the day of an appointment were shorter for both respondent groups than the AUSC average. However, the average reported waiting time to obtain an appointment for Austin respondents was 17 days, much longer than the waiting time reported by either CFC/Gunnar respondents (11 days) or the AUSC average (9 days).
- ◆ Two-thirds or more of the respondents for both clinics who needed to fill prescriptions received their medications free, while 96 percent or more stated that they understood their instructions for using their medications.
- ◆ CFC/Gunnar respondents were much more likely than Austin respondents or the AUSC average to report that paying for their medications and their medical care was "very difficult." In addition, about half of the CFC/Gunnar respondent said that they needed financial assistance to help pay their medical bills, compared with only 17 percent of Austin respondents. However, among Gunnar respondents who said they needed help, over 90 percent reported that staff offered help at least sometimes.
- ◆ Very few respondents for either facility reported that they were in debt to their clinic.
- ◆ Nearly all the respondent for both clinics said that they would use their facility again even if they had health insurance.



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

•
•
•
•
•
•
•
•

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. It is hoped that this information will assist communities in improving access to care for their uninsured residents.

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 in Chicago, Illinois. The survey was conducted by Westside Health Authority in the summer of 2000, and gathered information from 300 uninsured individuals who received care at Austin Cook County Health Center or at Circle Family Care/R.M Gunnar Clinic in the previous year. Along with providing the results of the survey for these facilities, the report compares the results with aggregate responses at all similar facilities surveyed as part of the CAMS project nationwide. A report presenting the overall findings for all surveyed sites will be released in Spring 2001.

•
•
•
•
•
•
•

LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

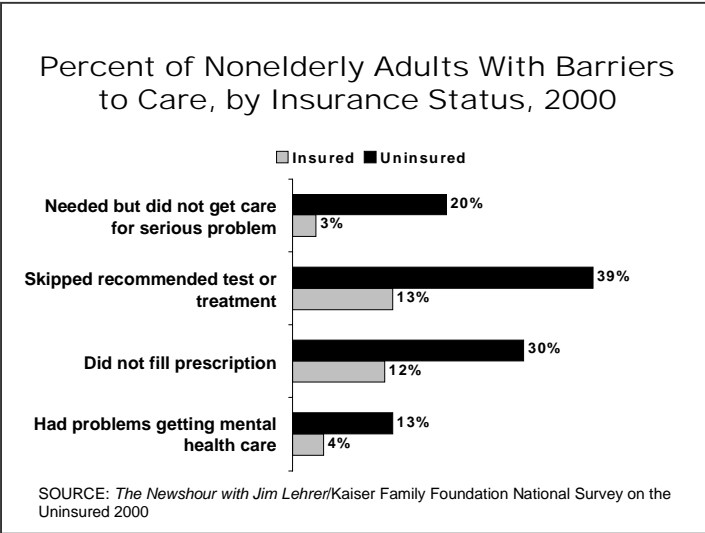
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

LACK OF INSURANCE AND ACCESS TO CARE

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

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

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



LACK OF INSURANCE AND HEALTH OUTCOMES

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

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

•
•
•
•
•
•
•
•

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

•
•
•
•
•
•
•

- ◆ 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 Westside Health Authority.

The Westside Health Authority serves the predominantly African-American and economically distressed Chicago neighborhoods of Austin, East and West Garfield Park, and North Lawndale. The combined population of the three contiguous neighborhoods is approximately 230,000 residents, 87 percent of whom are African-American, 9 percent Latino, and 4 percent White. An estimated 34 percent of residents live below the poverty line, and approximately 27 percent receive Transitional Aid to Needy Families (TANF), greatly exceeding the 13.2 percent rate for the City of Chicago. A little less than half of the residents have a high school diploma. The unemployment rate is approximately 18%, more than twice the seven percent rate for the City of Chicago.³¹

The community's health indicators demonstrate acute and chronic health problems. Residents suffer from disproportionate rates of asthma, heart disease, low-birth weight babies, AIDS, syphilis, gonorrhea, tuberculosis, street violence, violent crimes, domestic violence, and lead poisoning.³²

Twenty-four percent of Westside residents have no health insurance, compared to 16% of residents of the Chicago metropolitan area.³³ It is common for residents to rely on expensive and episodic emergency room care due to lack of primary care facilities, an inability to pay for care, and limited knowledge about preventive health practices. In addition, three hospitals have recently closed on Chicago's West side: St. Anne's Hospital, located in the center of Austin, which employed 400 workers, and Mary Thompson Hospital and Walter Memorial Hospital, located in nearby communities.

For the CAMS project, Westside Health Authority surveyed patients who had received services during the last year while uninsured at any of the following facilities:

The Austin Cook County Health Center is a public satellite clinic of Cook County Hospital. The clinic handles approximately 1,000 visits each month: 60 percent of its patients are uninsured, 35 percent are on Medicare or Medicaid, and 5 percent are privately insured. Fifty percent of the patients are aged 18-65, the majority of whom are between 45-60. In addition, 20 percent are aged 18 years or younger, and 30 percent are over age 65. Cook County Hospital and its clinics

•
•
•
•
•
•
•
•

are funded by county tax dollars and provide both medical care and medications free of charge to indigent patients.

Circle Family Care (CFC) is a private federally qualified health center (FQHC) that serves the North Austin community. CFC has several sites; this project surveyed patients who received services at two of these sites.

The first site, the central parent site, is located at 4909 West Division. This health center handles approximately 1,300 patient visits each month. Twenty-three percent of the patient population is uninsured. Most of the clinic's clients are adults of all ages, many of whom have chronic diseases.³⁴

The second site, Circle Family Care's **R.M. Gunnar Clinic**, is located in South Austin, a high crime, poor area of Austin. The clinic provides 400 patient visits each month: 15 percent of its patients are uninsured, 30 percent are covered by Medicaid, 20 percent are covered by Medicare, and the remaining 55 percent are covered by private insurance.³⁵ The clinic was originally established by MacNeal Hospital, which provided up to \$400,000 annually in subsidies.³⁶ After the sale of MacNeal, the Chicago Department of Health subsidized the clinic's rent to care for patients with sexually-transmitted diseases (STDs) under the auspices of Circle Family Care (CFC). The clinic also provides primary care services.

All of the clinics emphasize preventive health care and have a good community reputation. In 1994-96, Westside Health Authority established relationships with neighborhood clinics, including Austin Cook County Health Center, Circle Family Care, and the R.M. Gunnar Clinic, as part of its involvement in the Opening Doors: Reducing Socio-Cultural Barriers to Health Care project supported by the Robert Wood Johnson Foundation. As part of this project, the clinics worked actively with Westside Health Authority to identify and eliminate or reduce barriers to care.

SURVEY METHODOLOGY

The survey was administered by seven community surveyors, all of whom were community residents and four of whom were unemployed or retired. 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, Massachusetts. In addition, Westside Health Authority provided eight hours of pre and post-training.

To be eligible to participate, respondents had to have received care during the previous year while uninsured at Austin Cook County Health Center or at Circle Family Care/R.M Gunnar Clinic. Participants were recruited and the interviews conducted at the health clinics. Staff alerted patients about the project and provided contact information, and surveyors conducted the interviews with eligible individuals willing to participate in private rooms or other private areas. Surveyors worked days, evenings and weekends when the clinics were open. All respondents who qualified and completed the survey received a five dollar cash incentive.

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, and by Nanette Goodman, a health policy consultant.

In total, 300 surveys were completed, 150 for each clinic. Because respondents were not randomly selected, the survey results cannot be generalized to the entire population of uninsured persons or of individuals receiving care at the targeted facilities. *The results reflect the experiences only of those surveyed.*

•
•
•
•
•
•
•

SURVEY FINDINGS

This section describes the survey results for respondents who received care at Austin Cook County Health Center (Austin) or at Circle Family Care/R.M Gunnar Clinic (CFC/Gunnar) while uninsured. It also compares their results with averages for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide. All comparisons are statistically significant unless otherwise indicated (ns = non-significant). See Appendix A for a table of the results for the two Chicago clinics, as well as for the aggregate results for AUSCs 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

Nine of ten respondents for both facilities identified themselves as African-American. Austin respondents tended to be slightly older than CFC/Gunnar respondents.

Respondents varied by age, but only seven percent of each respondent group answered on behalf of a child. Austin respondents tended to be slightly older than either CFC/Gunnar respondents or the average for AUSCs.

About nine of ten respondents for both respondent groups identified themselves as African-American, compared to a 44 percent average for AUSCs.

All respondents took the survey in English.

USE OF HEALTH SERVICES

Respondents for both Austin and CFC/Gunnar were more likely than the AUSC average to have visited their clinic for a chronic condition and to have used it more than once in the past year.

Between 84 and 89 percent of the respondents for both facilities reported that they used their respective clinic more than once in the past year. In fact, one of five (22%) respondents for Austin stated that they had used their clinic *ten* times or more in the past year. This



compared to one in ten (11%) of CFC/Gunnar respondents and 13 percent of respondents for AUSCs.

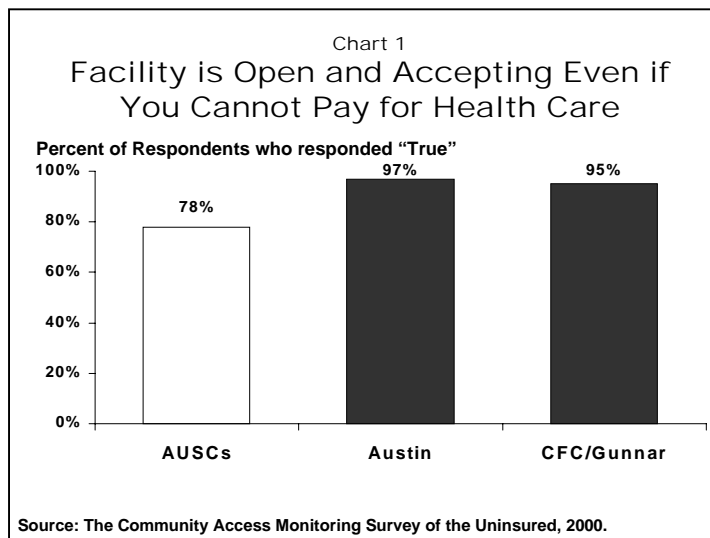
More than half of the respondents for both facilities said that they used their respective facility to treat a chronic problem (Austin 51% and CFC/Gunnar 54%). The average for AUSCs was 38 percent.

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

Most Austin and CDF/Gunnar respondents said their clinic was “open and accepting” even if they were not able to pay for their care, and that it had a reputation for providing “a lot” of care to the uninsured.

The overwhelming majority of both respondent groups—95 percent or more—stated that, in their experience, their clinic had been “open and accepting” even if they were unable to pay for their care. In comparison, the average for AUSCs was 78 percent. (Chart 1)

“They are very nice about people not being able to pay. They treat you anyway.”
CFC/Gunnar Respondent



Respondents were also asked what kind of reputation their facility had in the community for providing care to the uninsured. More than 80 percent of respondents for Austin and CFC/Gunnar reported that their clinic had a reputation for providing “a lot” of care to the uninsured. The average for AUSCs was 62 percent.

Nearly all of the respondents (over 96%) reported that they were either “very satisfied” or “satisfied” with the care and service they received from receptionists, nurses, and doctors.

“[I was] treated with excellent care. The doctor stayed with me even when it was time for him to go.”
Austin Respondent

Less than eight percent of the respondents for both facilities rated their interactions with physician assistants, social workers, or billing

•
•
•
•
•
•
•
•

“The pharmacy gives other patient’s medicine to you. Also if there are a lot of medications, they only give you half and say they are out of the prescriptions. They need attitude adjustment classes.”
Austin Respondent

clerks as unsatisfactory. Notably, however, 21 percent of the Austin respondents said that they were dissatisfied with the care and service they received from pharmacists, while only 3 to 4 percent of respondents for CFC/Gunnar or for AUSCs reported dissatisfaction with pharmacists.

Nearly all respondents for both clinics (95%-96%) stated that they are “always” treated with respect. The average for AUSCs was 84 percent.

“Pharmacy is unconcerned and gives you the wrong medication a lot of times. Every time I get a prescription they fill it wrong, and I have to go see administration.”
Austin Respondent

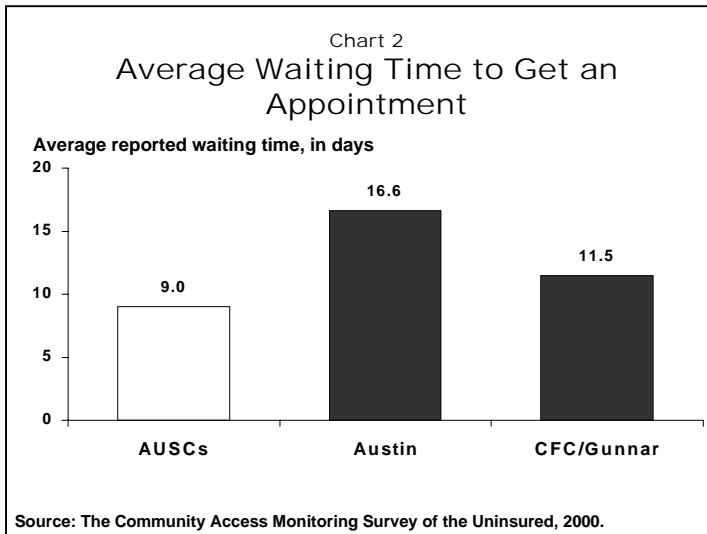
ACCESSIBILITY

Respondents generally reported that Austin and CFC/Gunnar were accessible in terms of hours of operation and location. Austin respondents were more likely than CFC/Gunnar respondents or the AUSC average to report that the waiting time to get an appointment was a problem. Fewer respondents considered the waiting time on the day of the appointment to be a problem.

Thirteen percent of Austin respondents and 19 percent of CFC/Gunnar respondents reported that the hours at the facility were a problem for them at least sometimes. This proportion was smaller than the AUSC average of 24 percent. In addition, over 90 percent of both respondent groups stated that the location of their clinic was “never a problem.”

“It takes some time to schedule appointments, that’s about it.”
Austin Respondent

One-half of the Austin respondents said that the waiting time to get an appointment was a problem at least sometimes. In comparison, the proportion of respondents who reported problems getting an appointment for CFC/Gunnar and AUSCs was smaller (33% and 39%, respectively). The reported waiting times to get an appointment reflected these ratings: the average reported waiting time for Austin respondents was 17 days, compared to 11 days for CFC/Gunnar respondents and 9 days for AUSCs. (Chart 2)



Both Austin and CFC/Gunnar respondents were less likely to report that the waiting time on the day of an appointment was a problem than the average for AUSCs. That is, while 60 percent of Austin respondents and 70 percent of CFC/Gunnar respondents stated that the waiting time on the day of an appointment was “never a problem,” the average for AUSCs was 46 percent. The average reported waiting times were also correspondingly shorter: Austin 37 minutes, CFC/Gunnar 31 minutes, and AUSCs 47 minutes.

When respondents were asked whether convenience to public transportation or assistance with transportation were issues for them, less than ten percent responded that they were problems even sometimes.

OBTAINING PRESCRIPTION MEDICATIONS

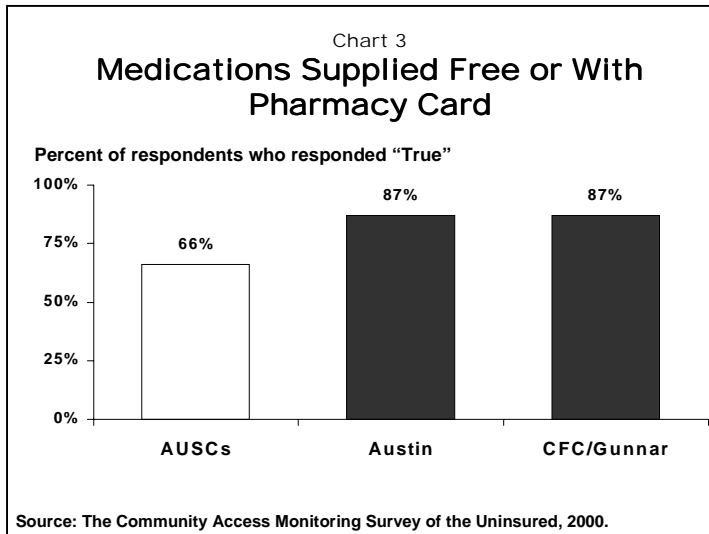
The majority of the respondents for both clinics reported that they had medications prescribed. Among these respondents, two-thirds or more said they received their medications free.

Four of five (81%) respondents for Austin and 69 percent for CFC/Gunnar reported that they received prescriptions for medications. The average for AUSCs was 70 percent.

Among those who received prescriptions, 66 percent of Austin respondents and 81 percent of CFC/Gunnar respondents reported that they received their medications free. The average for AUSCs was 56 percent. In addition, 21 percent of Austin respondents and 6 percent of CFC/Gunnar respondents said they used a pharmacy card. (Chart 3)

“It’s free, you just go to Cook County Hospital and pick it up.”
Austin Respondent

•
•
•
•
•
•
•
•



Nearly all of the respondents for both facilities (96% or more) said that they understood the instructions for using their medications.

Two of five (39%) respondents for CFC/Gunnar and 11 percent for Austin reported that paying for their medications was "very difficult." The average for AUSCs was 27 percent. In addition, one of five respondents for Austin (22%) and 43 percent for CFC/Gunnar reported that they needed help paying for their medications. The average for AUSCs was 36 percent. Among the respondents who needed financial assistance, 25 percent of Austin respondents and 13 percent of CFC/Gunnar respondents said that staff "never" offered any help. Ten percent of CFC/Gunnar respondents and 7 percent of Austin respondents said they were unable to get some of their medications due to cost.

CONCERNS OVER PAYMENT FOR HEALTH CARE

Austin respondents were more likely than the AUSC average to report that paying for their medical care was "easy," while CFC Gunnar respondents were more likely to report that it was "very difficult" to pay for medical care. However, among those who said they needed help to pay for their care, Gunnar respondents were more likely to report that staff "always" offered help.

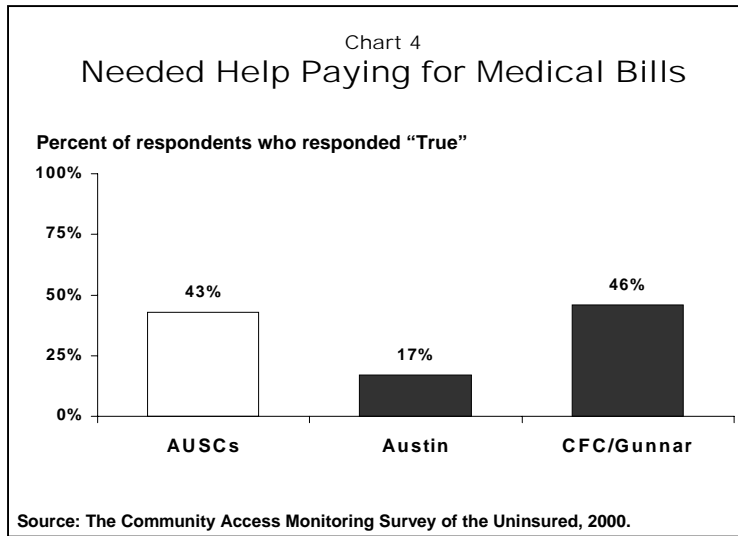
CFC/Gunnar respondents were much more likely than either Austin respondents or the average for AUSCs to report that paying for their medical care was "very" difficult (49% vs. 17% and 33%, respectively). Three-fourths (75%) of Austin respondents reported that it was "easy

"Medical care is free."
Austin Respondent



to pay” for medical care, compared to 40 percent of CFC/Gunnar respondents and 34 percent of all AUSC respondents.

About half of the CFC/Gunnar respondents (46%) stated that they needed financial assistance to pay for their medical bills. In comparison, only 17 percent of Austin respondents reported that they needed help, while the average for AUSCs was 43 percent. (Chart 4)



Among the Gunnar respondents who needed financial assistance, the majority (over 90%) reported that staff offered help at least sometimes, compared to about two-thirds of both Austin respondents and respondents for all AUSCs. Of the respondents who received help, waiving the bill was the most common form of assistance (Austin 53%, CFC/Gunnar 40%, AUSC average 26%).

“They do work with a sliding scale. I don’t think they could be any fairer than that.”
CFC/Gunnar Respondent

SEEKING CARE IN THE FUTURE

Two-thirds of the respondents for both clinics reported that their past experiences paying for care would make it easier to seek care at their clinic in the future. In addition almost all respondents said they would use the facility even if they had health insurance

Respondents were asked how their past experiences paying bills at their clinic would affect their likelihood of seeking care there in the future. Two-thirds of the respondents for both facilities stated that their past experiences would make it easier for them to seek care. The average for AUSCs was 53 percent.

“I just hope they stay here, because they are good for the community. There are no other free clinics in the community.”
Austin Respondent

•
•
•
•
•
•
•

Very few respondents (Austin 3% and CFC/Gunnar 6%) reported that they owed money to their clinic. These proportions were much lower than the AUSC average of 20 percent.

"I've been coming here for five years. I won't go anywhere else."
CFC/Gunnar respondent

The overwhelming majority of respondents for both clinics—Austin 97 percent and CFC/Gunnar 98 percent—stated that they would use their clinic again even if they had health insurance. The average for AUSCs was 82 percent.

DISCUSSION

The survey responses indicate that on most indicators of access and satisfaction, respondents for Austin Cook County Health Center (Austin) and CFC/Gunnar Clinic (CFC/Gunnar) fared as well as or better than respondents for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide. The two notable exceptions were that CFC/Gunnar respondents were more likely than either Austin respondents or the average for AUSCs to report difficulty paying for their medical care and prescriptions, while Austin respondents reported a longer average time to get an appointment than either CFC/Gunnar respondents or the AUSC average.

COMMON STRENGTHS

- ◆ Ninety-five percent or more of the respondents for both facilities reported that, in their experience, their clinic had been open and accepting to them even if they were unable to pay for their care. In addition, four of five respondents for both clinics reported that their clinic has a reputation for providing a lot of care to the uninsured.
- ◆ The majority of respondents for both clinics (over 96%) rated their interactions with receptionists, nurses, and doctors very highly. Nearly all of the respondents for both clinics (over 95%) stated that staff “always” treated them with respect.
- ◆ Relatively few respondents for either clinic reported that their clinic’s hours or location were a problem. In addition, the average reported waiting times to see a provider on the day of an appointment were shorter for both respondent groups than the AUSC average.
- ◆ Two-thirds or more of the respondents for both clinics who needed to fill prescriptions received their medications free, while 96 percent or more stated that they understood their instructions for using medication.
- ◆ Very few respondents reported that they were in debt to their clinic.
- ◆ Nearly all the respondent for both clinics said that they would use their facility again even if they had health insurance.

•
•
•
•
•
•
•
•
•
•

CIRCLE FAMILY CARE/R.M. GUNNAR: OTHER HIGHLIGHTS

- ◆ CFC/Gunnar respondents were much more likely than Austin respondents or the AUSC average to report that paying for their medications and their medical bills was “very difficult.” In addition, about half of the CFC/Gunnar respondent said that they needed financial assistance to help pay for their medical bills, compared with only 17 percent of Austin respondents. This finding is not surprising, given Austin’s provision of free care and medications to indigent patients. However, among Gunnar respondents who said they needed help, over 90 percent reported that staff offered help at least sometimes.

AUSTIN COOK COUNTY HEALTH CENTER: OTHER HIGHLIGHTS

- ◆ Twenty-two percent of Austin respondents reported that they used the clinic ten times or more in the past year.
- ◆ Although ratings of satisfaction with interactions with staff were generally very high, one of five Austin respondents (21%) reported dissatisfaction with the care and service they received from pharmacists.
- ◆ The average reported waiting time to obtain an appointment for Austin respondents was 17 days, much longer than the waiting time reported by either CFC/Gunnar respondents (11 days) or the AUSC average (9 days).
- ◆ Austin respondents were much more likely than the AUSC average to report that paying for their medical care was “easy.” This finding presumably reflects Cook County’s policy of providing free care and medications to indigent patients.

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*.

•
•
•
•
•
•
•
•

-
- 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, 1990.



³² City of Chicago, Department of Public Health, *Epidemiology Report 1994-96*.

³³ R. Seifert and K. Sokol, *The Uninsured in Illinois and Chicago: Close to 2 Million Face Barriers to Health Care*, The Access Project, Boston, 1999.

³⁴ Len Sharber, CEO, Circle Family Care, March 1, 2000.

³⁵ Dr. Peter Mayock, Co-Medical Director, R.M. Gunnar Clinic, February 28, 2000.

³⁶ *Ibid.*

APPENDIX A: TABLE OF SURVEY RESULTS

This table presents the results of the surveys of patients at Austin Cook County Health Center and Circle Family Care/R.M. Gunnar Clinic, two urban health centers included in the CAMS project in Chicago, Illinois. For comparison purposes, it also presents results of surveys of patients at all urban and suburban clinics that were included in the CAMS project nationally.

Asterisks in the *Intra-site p value* column indicate statistically significant differences between the Chicago clinics, 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 after the table.)

The letters in the *Inter-site p-value* column indicate statistically significant differences between one or more of the Chicago clinics and the average for all urban and suburban clinics included in the national CAMS project. The letters in the column indicate which of the Chicago clinics significantly differed from the overall average. The letter corresponding to each clinic appears under its name in the column headings. (For example, A refers to Austin Cook County Health Center.)

	Chicago Clinics			CAMS Sites	
	Intra-site p-value	Austin Cook County HC -A-	CFC/Gunnar Clinic -B-	All Urban & Suburban Clinics	Inter-site p-value
Number of survey respondents		150	150	3363	
		% ^a	% ^a	% ^a	
RESPONDENT CHARACTERISTICS					
Age					A
Under 18		9	14	16	
18-29 years		19	24	27	
30-39 years		23	24	23	
40-49 years		23	20	18	
50-64 years		23	16	14	
65 or older		2	2	1	
Race/Ethnicity					A,B
White		3	5	22	
Black		89	87	44	
Hispanic		5	3	26	
Other ^b		3	5	8	
Gender					
Male		35	33	32	
Female		65	67	68	
Language in which survey administered					A,B
English		100	100	84	
Spanish				16	
Answered on behalf of child		7	7	10	

	Chicago Clinics			CAMS Sites	
	Intra-site p-value	Austin Cook County HC -A-	CFC/Gunnar Clinic -B-	All Urban & Suburban Clinics	Inter-site p-value
FACILITY UTILIZATION					
Use of facility in past year					A,B
Once		11	15	20	
2-4 times		39	39	48	
5-9 times		28	34	19	
10 or more times		22	11	13	
Reason for visit(s)					A,B
Chronic problem or Mixed (chronic and non-chronic)		51	54	38	
Other problem (non-chronic)		49	46	62	
PERCEPTION OF FACILITY					
Experience of facility's openness to uninsured					
Open and accepting even if can't pay	—	97	95	78	A,B
Reluctant but accepts you even if can't pay	—	3	1	7	A,B
Offers some care if can't pay	—	1	2	8	A,B
Provides no assistance if can't pay		-	-	2	
Don't know	—	1	3	8	A,B
Opinion of facility's reputation for treating uninsured					
Provides a lot of care for those who can't pay		83	81	62	
Provides some care		3	5	16	
Provides very little or no care		-	1	4	
Don't know		14	14	19	
SATISFACTION WITH PROVIDERS/COURTESY OF STAFF					
Receptionists/Admitting clerks					
	—				
Very satisfactory or satisfactory		97	97	93	
Unsatisfactory or very unsatisfactory		3	3	7	
Don't know		-	-		
Nurses					
	—				
Very satisfactory or satisfactory		98	99	96	
Unsatisfactory or very unsatisfactory		2		4	
Don't know			1	1	
Physician assistants					
	*				
Very satisfactory or satisfactory		72	84	78	A
Unsatisfactory or very unsatisfactory		1		3	
Don't know		27	17	19	
Examining physicians					
	—				
Very satisfactory or satisfactory		99	98	91	A,B
Unsatisfactory or very unsatisfactory		1		3	
Don't know		1	2	6	
Social worker					
	**				
Very satisfactory or satisfactory		22	44	42	A
Unsatisfactory or very unsatisfactory		6	7	4	
Don't know		72	49	54	
Billing Clerks					
	**				A,B
Very satisfactory or satisfactory		13	38	50	
Unsatisfactory or very unsatisfactory		6	5	7	
Don't know		81	57	43	

	Chicago Clinics			CAMS Sites	
	Intra-site p-value	Austin Cook County HC -A-	CFC/Gunnar Clinic -B-	All Urban & Suburban Clinics	Inter-site p-value
Pharmacist					A
Very satisfactory or satisfactory		35	45	40	
Unsatisfactory or very unsatisfactory		21	3	4	
Don't know		45	52	56	
Treated with respect	—				
Always		95	96	84	
Sometimes		5	3	13	
Never				1	
Don't know			1	3	
ACCESSIBILITY OF SERVICES					
Hours facility open	—				A
Never a problem		87	80	74	
Sometimes a problem		11	17	20	
Often/always a problem		2	2	4	
Don't know		1	1	2	
Location	—				A,B
Never a problem		93	91	79	
Sometimes a problem		7	7	16	
Often/always a problem		1	1	5	
Don't know					
Waiting time to get appointment	—				A,B
Never a problem		49	66	53	
Sometimes a problem		39	26	27	
Often/always a problem		11	7	12	
Don't know		1	1	8	
Waiting time to see provider on day of appointment	—				A,B
Never a problem		60	70	46	
Sometimes a problem		28	25	34	
Often/always a problem		12	5	17	
Don't know		1		4	
Convenient to public transportation	—				A,B
Never a problem		81	88	43	
Sometimes a problem		5	6	6	
Often/always a problem		3	1	4	
Don't know		11	5	47	
Transportation assistance if needed	—				A,B
Never a problem		14	11	22	
Sometimes a problem		1	1	5	
Often/always a problem		3	1	4	
Don't know		82	86	69	
MEDICATIONS					
Medication prescribed	*	81	69	70	A,B
If yes, how obtained					
Supplied free	*	66	81	56	A,B
Used a pharmacy card	**	21	6	10	A
Used a drug store and paid	—	3	6	34	A,B
Didn't get /couldn't afford	—	3	4	4	
Got some/couldn't afford all	—	7	10	6	
Other	—	3	3	7	

	Chicago Clinics			CAMS Sites	
	Intra-site p-value	Austin Cook County HC -A-	CFC/Gunnar Clinic -B-	All Urban & Suburban Clinics	Inter-site p-value
Medication instructions					
Understood instructions	—	99	96	96	
No instructions given			2	1	
Did not understand instructions				1	
Did not need medicine for home		1	2	1	
Difficulty paying for medications	**				A,B
Very difficult		11	39	27	
Not so difficult		6	7	23	
Easy to pay		13	9	15	
N/A		70	46	36	
Needed help paying for medications	**	22	43	36	A
If yes, did staff offer help?	—				B
Always		63	71	42	
Often		3	5	10	
Sometimes		9	11	14	
Never		25	13	34	
MEDICAL BILLS					
Difficulty paying for medical care	**				A,B
Very difficult		17	49	33	
Not so difficult		8	11	34	
Easy to pay		75	40	34	
Needed help paying the medical bill? If yes	**	17	46	43	
Did staff offer to find out if financial assistance was available?	—				B
Always		44	75	41	
Often		8	6	12	
Sometimes		16	9	14	
Never		32	10	24	
Type of help staff offered <i>(If Always, Often, Sometimes to previous question)</i>					
Pay in monthly installments	—	6	7	41	A,B
Reduce amount of bill	—	12	11	35	A,B
Waive bill		53	40	26	B
Find charitable organization to pay		29	50	28	B
Other		0	0	11	B
FUTURE CARE					
Effect of payment experience on seeking future care at facility					
Will not seek care at facility	—	1	5	4	
Will use another facility	—	-	1	3	
Easier to seek care at facility		66	65	53	A,B
Makes no difference	*	27	16	39	A,B
Currently owe facility money		3	6	20	A,B
If yes, will make not seek care in future	—	-	33	23	
If had insurance, would use facility in future	—	97	98	82	A,B

	Chicago Clinics			CAMS Sites	
	Intra-site p-value	Austin Cook County HC -A-	CFC/Gunnar Clinic -B-	All Urban & Suburban Clinics	Inter-site p-value
TRAVEL AND WAIT TIMES					
Travel time, mean (minutes)	**	15.76	19.38	19.10	A
Travel time, median (minutes)		15	16.5	15.00	
Days to get appointment, mean	*	16.61	11.49	8.98	A
Days to get appointment, median		10	7	3.00	
Waiting time to see provider, mean (minutes)		36.75	31.22	47.47	A,B
Waiting time to see provider, median (minutes)		30	30	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).
- A,B $p < 0.05$ for overall chi-square test between facility and all urban clinics for each characteristic listed. Letter denotes facility (as indicated in column heading). Blank cells in the Inter-site p value column indicate that either no significant difference existed or that the cell size was insufficient.

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

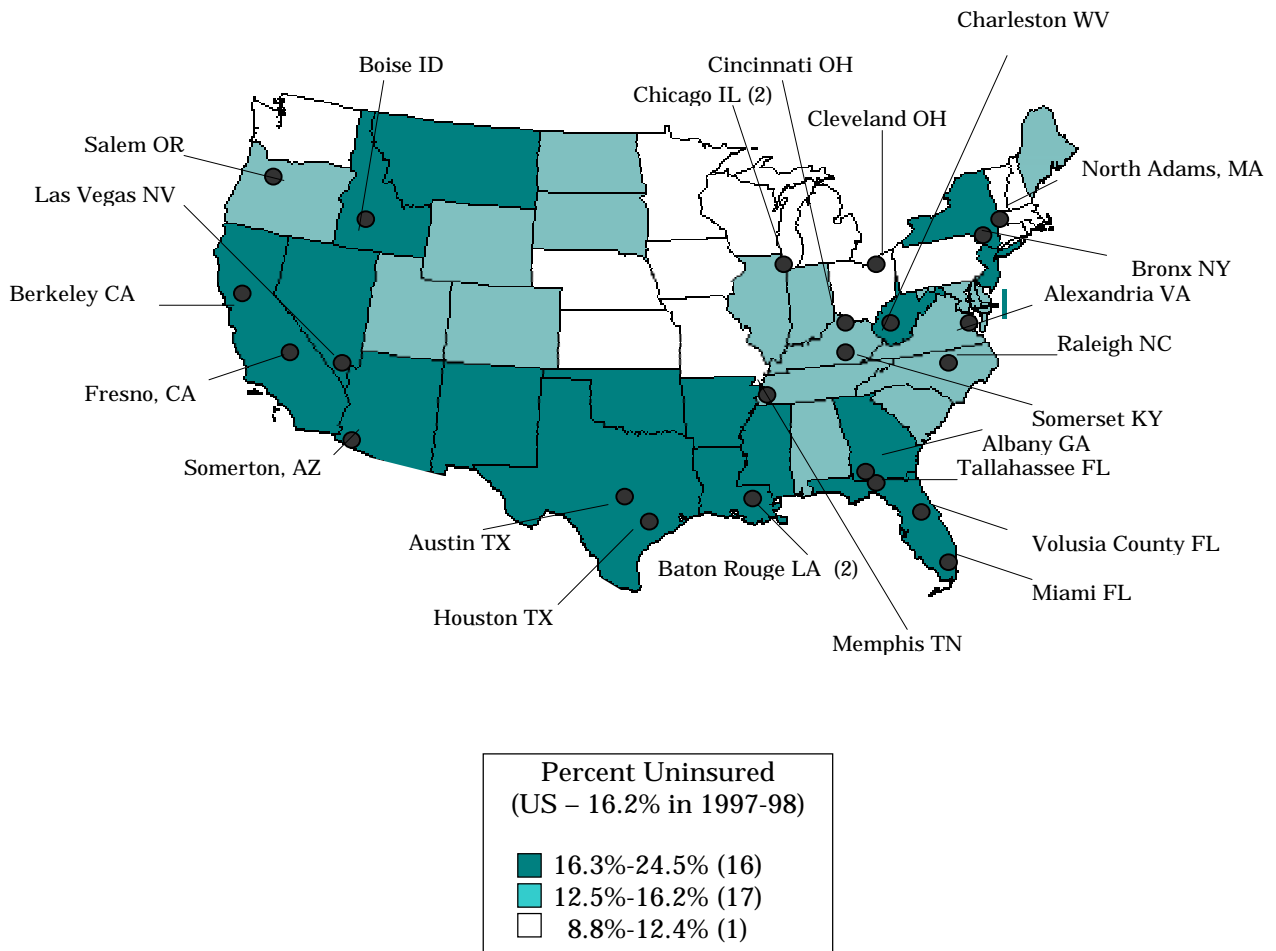
SURVEYED FACILITIES BY TYPE

<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: _____

ACKNOWLEDGEMENTS

The Access Project at Westside Health Authority wishes to thank the following individuals:

- ◆ The Access Project Coordinator: Verda Hester, MA
- ◆ The Access Project Participating Site: Westside Health Authority
- ◆ The Access Project Consultant: Dr. Claire Kohrman
- ◆ Austin Cook County Health Facility Administrators: Darrell Jackson and Dr. Greg Vachon
- ◆ Circle Family Care/R.M. Gunnar Administrators: Len Sharber, Dr. Sue Erlenborn, and Dr. Peter Mayock
- ◆ The Access Project Surveyors: Adell Young, Lisa Young, Sharon Clay, Bonita Love, Marsha Johnson, Bonnie Bell, Bessie Wilson

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

The Community Access Monitoring Survey project was one that involved our *entire* staff, and we would like to thank all of them for the tremendous amount of time and effort they contributed to making the project a success. Special thanks are due to the following people:

- ◆ Nicole St. Clair, who assisted in writing the report
- ◆ Bill Hewett and Meg Baker, who provided invaluable administrative support in the production of the report
- ◆ Nancy Kohn, The Access Project CAMS coordinator, who attended to the myriad of details necessary to keep the project on track

In addition, we want to express our appreciation to our colleagues at Community Catalyst Inc., whose participation in the project was essential to its success. In particular, we want to thank Jacquie Anderson, the Site Coordinator, who worked directly with Westside Health Authority to plan the project, and who provided consultation throughout the project's duration.

We are also grateful to the committed team of trainers from The Medical Foundation's Health Training Innovations program. Laurie Jo Wallace, Moacir (Mo) Barbosa, and Jorge Armesto developed a standard curriculum and conducted interactive one-day training sessions at each site, in a very short period of time, to ensure consistent administration of the survey.