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Assessing the Early Impacts of OHP2:

A Pilot Study of Federally Qualified Health Centers Impacts in Multnomah and Washington Counties

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EXECUTIVE SUMMARY

In February 2003, the Oregon Health Plan (OHP) underwent a significant redesign of benefits and cost sharing structure. The OHP redesign resulted in two tiers of coverage, OHP Plus and OHP Standard, as well as a premium subsidy program. The OHP Plus benefit package and cost sharing structure is similar to the original OHP and serves the federally mandated Medicaid population. OHP Standard, designed for Oregon's expansion population (adults, 19 to 64, up to 100% of federal poverty level), includes a reduced benefit package, significant co-pays and increased premiums.

The Office for Oregon Health Policy and Research (OHPR) contracted with the Oregon Health Policy Institute (OHPI) to assess the early impacts of these changes on Federally Qualified Health Centers (FQHC) and the patients they serve. This preliminary assessment includes interview data from a convenience sample of FQHC administrators and other key informants in the Portland metropolitan area and survey data from a 320 patients seen at four FQHC clinics located in Washington and Multnomah counties.

These data, in combination with the August 2003 report by Dr. Robert A. Lowe concerning Emergency Department utilization at the Oregon Health & Science University (OHSU) Hospital[*], provide an initial snapshot of changes occurring among safety net provider organizations and their patients in the Portland metropolitan area since the OHP changes were implemented in February.

The information contained in this report is grouped into several topical areas:

- *Administrative and fiscal adaptations* - In response to state policy changes and local economic conditions, clinic administrators have looked for innovative ways to maintain access to prescription drugs, primary care, mental health services, and specialty care for their un- and under-insured patients.
- *Issues related to quality, continuity of care, and informed patient decision making* – particularly those related to chronic disease management and the challenges faced by patients as they attempt to make informed decisions about their care needs based on unclear and often inconsistent information regarding changes in their OHP eligibility and benefits coverage.
- *Reduced access to care* - because of increased administrative burden, a growing number of community providers are retreating from Medicaid, particularly from OHP Standard patients.
- *The face of FQHC patients* - Profiles reflecting the experiences of a convenience sample of FQHC patients in the Portland metro area, including health and insurance status, their self-reported assessment of access to needed health care services and health status.

[*] Dr. Lowe's full report is available at the OHPR website, www.ohppr.state.or.us, in the Oregon Health Research and Evaluation Collaborative (OHREC) section.

SUMMARY FINDINGS

- Clinic administrators report that elimination of mental health and substance abuse coverage for the OHP Standard population has had a significant impact on the primary care delivered in safety net clinics. They report a lack of trained personnel to absorb the increased demand for mental health and related substance abuse services.
- With almost 40,000 people leaving OHP since the implementation of OHP2, safety net clinics report a significant increase in the number of individuals requiring assistance in obtaining prescription medications, which has resulted in a significantly increased administrative burden. Clinics are aggressively attempting to ensure continued access to necessary prescription medications, primarily through pharmacy assistance programs.
- Clinic administrators reported widespread confusion among both providers and patients about changes in OHP coverage and cost sharing. Providers are hesitant to accept new OHP Standard patients because of their uncertain coverage. Conversely, OHP Standard patients are hesitant to seek care because they are uncertain that their coverage remains in force.
- The patients interviewed for this report represent those seen in the four FQHC clinics during a typical week in August. The interviewers were available for day and evening hours to capture information from individuals who work during the day. Only a handful of patients refused to be interviewed.
    - The patients interviewed were largely insured (72%). Of these, 62% had OHP coverage and 14% were covered by Medicare; 73% had been covered for at least one year, while 26% had been covered more than five years
    - The patients interviewed were heavy health care utilizers (41% had more than 5 visits in the previous 6 months) compared to a representative sample of OHP enrollees (22% had more than 5 visits in the previous 6 months) interviewed in 2002 as part of a biennial statewide survey conducted by the Office of Medical Assistance Programs (OMAP)
    - 10% of FQHC patients reported having 4+ visits to an ED during the past 6 months as opposed to 3% in the OHP sample
    - 56% of FQHC patients reported having a physical or medical condition that was expected to last at least 12 months, and 45% reported their health status as fair or poor
    - The majority of patients interviewed (54%) were in the clinic at the time of the interview for a follow-up visit and half reported having the condition that brought them to the clinic for more than 6 months
    - Only 18% of the FQHC patients were employed at the time of the interview and those employed were significantly more likely to be uninsured than those who were unemployed.

INTRODUCTION

The purpose of this pilot study is to provide timely feedback to state policy makers about the early impacts of increased cost sharing and reduced services for OHP Standard clients being felt among a convenience sample of safety clinics. The data contained in the current report were collected from FQHC key informants in June 2003 and among FQHC patients in August 2003.

The Safety Net and Why It Is Important

According to the Oregon Committee on Health Care Safety Net Support[3] "the health care safety net is comprised of a broad range of local, non-profit organizations, government agencies and individual providers who share the common mission of delivering health care to persons who experience barriers to accessing the health care they need. Barriers may include: lack of insurance; inability to pay; geographic isolation; personal, cultural, and/or linguistic needs."

The role that the health care safety net plays in the broader health care system in Oregon is an increasingly critical one as the number of uninsured residents (currently 14%)[†] continues to grow throughout the state. Data from the 2000 Oregon Population Survey (OPS) and supplemented by OMAP revealed that over 700,000 (one-fifth of all Oregonians) were either uninsured or relied on the Medicaid program for their health care coverage. By 2002, this number had expanded to over 860,000 or about one-quarter of all Oregonians.[4]

Safety net clinics have traditionally seen a significant portion of the vulnerable and uninsured populations, both in Oregon and nationally. At the same time, Medicaid provides an important financing stream for most safety net clinics. As a result, we might expect that the early system shocks resulting from eligibility and cost-sharing changes in Medicaid will be most acutely felt by safety net health care providers as the numbers of uninsured grow and OHP shrinks.

The Oregon Health Research and Evaluation Collaborative (OHREC)[5] collectively agreed on the importance of checking in early regarding the strength and 'tension' of the safety net as changes in Medicaid eligibility and benefits are being implemented. The initial strategic direction for OHREC in terms of OHP evaluation has been to focus on examining the impact of Medicaid policy changes as they have begun reverberating within safety net clinics and their companion providers of last resort, hospital emergency departments.

[†]Oregon Population Survey, 2002.

METHODS

Key Informant Interviews

Two different sources of information were collected for this study. First, six semi-structured key informant interviews were conducted. Informants were identified through a snowball sampling technique[6] and interviewed for their unique perspective about the local healthcare delivery system in the Portland Metro Area. Informants included clinic administrators, other clinic staff, and one statewide policy expert. The interviews ranged from 20 minutes to one hour in length and were either conducted in person or as a telephone interview. The summary findings were derived from a qualitative content analysis of the information obtained (see Appendix A for Interview Guide).

The interview questions focused on observed changes in clinic policy and practice occurring since February 2003. Informants were queried as to the extent to which they believed these changes had resulted from recent Medicaid policy changes, changing economic conditions, or both. Although the total number of interviews was limited, it does reflect information gleaned from other safety net providers around the state and validates this particular "finger on the pulse" in terms of how clinics are responding to the range of constraints they face while attempting to provide access to primary health and mental health services for their patients. The informants interviewed in Multnomah and Washington counties represented the administrative core of each counties FQHC system of clinics.

Patient Surveys

The second source of data included in this report is 320 in-person patient interviews conducted at four FQHC clinics in Washington and Multnomah Counties. A 33-item questionnaire (see Appendix B) was administered to those patients agreeing to participate. All patients waiting for a primary care appointment during the second and third weeks of August 2003 were eligible to participate in the survey. Each clinic posted an announcement it its waiting room explaining the study and inviting patients to participate. All participants received a $5.00 incentive payment at the end of the interview. Participants were informed of the voluntary and anonymous nature of the survey prior to participating. Interviews were conducted in English, Spanish and Russian.

A total of 320 patients were interviewed. Among the four participating clinics, the distribution of respondents included: 30% from Virginia Garcia Migrant Health Center in Washington County; while the remaining 70 percent represented Multnomah County clinics

- 17% were from North County Clinic, 38% from Westside Clinic, and 13% were from Mid-County Clinic.

KEY INFORMANT FINDINGS

Administrative and Fiscal Adaptations

Key informants within FQHC clinics reported several areas of strategic adaptation, specifically as they have attempted to maintain access for uninsured and underinsured patients in the metro area. These adaptive strategies related specifically to:

- Pharmaceutical assistance
- Primary care services
- Mental health services
- Specialty care referrals
- Reduced access for OHP Standard patients

Access to Prescription Medications

The primary pharmacy concern related to the newly imposed co-payments ($2 for generic and $3 for brand) for prescription medications for the OHP Standard group of enrollees. Enrollees in this group include those with incomes at or below 100% of the federal poverty level who have little-to-no disposable income to pay for their prescriptions; this is particularly significance for individuals with chronic health conditions who are on multiple prescription drug regimens.

Among the informants interviewed in both Multnomah and Washington counties, we heard that clinics were exploring new and creative ways to assure that patients no longer covered by OHP and those with co-payments that couldn't be paid were getting the pharmaceuticals they needed to manage their acute illnesses and chronic health conditions. One informant reported being in the process of expanding available pharmacy assistance programs to assure continued access to needed prescription drugs for the population. It was noted that using these programs require additional staff time and resources, both of which add to the administrative costs of doing business as a safety net provider.

> *"All the pharmaceutical assistance programs are pretty time-intensive, so we've actually got to make an investment in order to make them work. They're not something you can do in your spare time. They take a great deal of time, and so we have put some personnel dollars in the next budget year to assign someone to help clients access pharmaceutical assistance programs."*

"OK, say you're on six medications from six different companies. Each one will have a different form. Sometimes you have to call the company for the form and have the form sent; sometimes you can get it online. Some require one income level, while others require a different income level. They all require that they be provider-initiated and signed, so the provider has to fill out the paperwork. They require different documents from the patients. And plus, most all of them require that patients be citizens, and clearly, that sometimes is an issue for folks. They are all different; they are all very time consuming. They're not meant to be easy."[‡]

This same informant described a significant increase in the use of pharmacy assistance programs and a commensurate increase in the amount of time required of clinicians to secure needed drugs as office administrative staff do not have the clinical knowledge to search out the appropriate drugs from the available pharmacy companies participating in the drug assistance programs.

"*A lot of times the administrative work can be done by a pharmacy tech, while at other times, physicians and nurse practitioners do the paperwork… Nurses also are involved so it's a lot of different people, and it takes a lot of time."*

Another informant described setting up a dispensing pharmacy in his clinic. This new clinic service was made possible by a demonstration grant awarded by the federal Health Resources and Service Administration (HRSA). Although this new pharmacy service has made access to prescription drugs much easier for the clinics' uninsured patients, it has also made it easier for providers to dispense medications at no charge to OHP patients with co-pay obligations for whom they fear prescriptions will not get filled. As a result, the dispensary that was targeted at uninsured patients has also enhanced access to needed prescriptions by OHP Standard patients unable to afford their co-payments. This enhanced access for Medicaid patients comes at the expense of increasing overall access to uninsured patients as less revenue is generated by co-payment collections.

This same informant described the clinic's awareness that it needed to start collecting co-pays from OHP patients as well as more aggressively billing the managed care plans in which its patients are enrolled and the state in the case of fee-for-service patients. It was feared that it will not be possible to sustain the free dispensary service once the initial HRSA grant funds have been expended.

[‡] Italicized sections of this report, unless otherwise noted by the use of quotation marks, are paraphrased from key informant comments.

Access to mental health services and specialty referrals

Mental Health Services- Informants reported a range of pressures experienced by the clinics; especially with regard to their ability to manage the care needed by patients with complex health problems, including both physical and mental health conditions.
In February 2003, the Medically Needy and General Assistance Medicaid programs were eliminated in Oregon and the newly implemented OHP Standard Group lost its coverage for mental health and substance abuse treatment services.[§] Since these cuts were implemented, key informants noted a significant increase in the number of requests for mental health services.

To illustrate the severity of the mental health services problem, a multi-site Washington County safety net clinic employed only a single social worker at the time of the interview. It has been well-documented in the literature that many mental health conditions are managed in primary care settings, but FQHCs report not having the capacity to absorb the increased demand for mental health services brought on by the loss of OHP coverage for the large number of individuals with significant mental health problems who visit their clinics (see OHREC Research Brief, "Projected Impact of Oregon Health Plan Changes: A Combined Data Set Analysis in Lane County").

Specialist Referrals. Two primary issues regarding access to specialist referrals were discussed. The first related to the new policies imposed by OHSU regarding the scheduling of appointments to it specialty clinics.

> *They (OHSU) have created many obstacles for the community clinics, including the practice that patients have to call to set up their own appointments. This is a major barrier to securing an appointment for many patients, as there are language and cultural issues that have been mitigated in the past by community clinic staff making referral appointments. This administrative change has turned out to be a significant obstacle to access because previously clinic staff made the calls, having their own translators who assured that appointments got made. OHSU has informed clinic staff that they don't want it done this way any longer.*

> *There appears to be a pushback by OHSU onto the safety net. This is all relatively new, but it's a big problem for us and other safety net clinics in the area.*

Another major issue in specialist referrals is the amount of time it takes to get an appointment. Informants noted that it is not uncommon to experience a 6-month wait for a specialist appointment. Considering the health problems experienced by a large percentage of

[§] With the passage of the 2003-2005 Human Services budget, mental health and chemical dependency services will be full restored for the OHP Standard population, most likely beginning January 1, 2004.

the uninsured as well as OHP patients, this constrained access to specialty care is cause for some concern among clinicians and administrators alike.

Issues Related to Quality, Continuity of Care, and Informed Decision-making

Two issues relating to quality and continuity of care emerged as major concerns among the practitioners and administrators we interviewed. They included:

- Lack of clear and consistent information about the changes in OHP coverage and benefits affecting both clinician and patient behavior; and,
- Inadequate chronic care management, affecting both medication management and follow-up appointments.

Communication gaps regarding information about OHP eligibility and benefits

FQHC key informants reported that there appeared to be a lot of confusion among OHP patients and clinic providers about coverage and benefit issues. Many patients reported limited knowledge about the level and extent of their current coverage, *"there is increased fear about out-of-pocket costs and their (patients) ability to pay for services once accessed."*

It was reported that instead of coming in and receiving a bill for three to five dollars, which most clinics wouldn't send to collections if not paid, many patients are self-selecting not to schedule follow-up visits, and as a result their health outcomes are getting progressively worse. Communication and information gaps are one of the primary reasons for lack of chronic care management as noted by clinic administrators.

It was also reported that many people cannot afford the new co-pays. Informants noted a higher rate of no-shows for clinic appointments, including those patients who don't come back for a follow-up visit because of a fear that they will have to pay a second co-pay or not get a prescription filled because of the co-pay.

Inadequate chronic care management affecting medication management and follow-up appointments

Numerous examples were provided by key informants of patients coming into clinics with substantial fears about their ability to fill needed prescriptions on an on-going basis. Informants described patients making difficult decisions about their medications in terms of whether to discontinue or cut back on doses. Informants also reported difficulty to manage chronic conditions because of loss of medication coverage or restrictions on certain drugs imposed by managed care plan formularies and the OMAP prescription drug legend.

I've actually heard physicians talk about patients coming in and having to sit them down, especially if it's somebody who's been dropped off of OHP, and making the decision with the patient about which medications are the most important. Patients are saying 'I can't afford all of this' so their physicians are put in the position of saying, 'Well, you really can't get off of this one, this one I prefer you don't get off. But if you have to choose between the two, this is the most important.' This is not optimal, that's for sure. Providers are having to go in and help figure this out with their patients. Some people are taking a pill every other day or they're cutting their pills in half. Patients are making all kinds of adaptations. People are very creative.

The following scenario graphically illustrates the problem.

Dr. X had a visit with a patient who was an asthmatic, in acute distress. She had to keep the patient in her office for four hours trying to get him stabilized using a nebulizer. The patient really should've gone to the emergency department but he said, "I'm not going. I've got a bill. I don't want to do it." The physician noted that these patients are not trying to get a free ride – this guy could not breathe and he wasn't going to do what he needed to do, for fear of getting a bill. He didn't even want to get an aerosol pump because he had to pay $3 or $5. The administrative team tried to ease his concerns by saying, "don't worry about it" but his response was, "Well, I don't want a bill! They're sending me bills!" As an administrator, I'm really struggling with it because you have to let people know what they owe. But on the other hand, I don't want people to get so freaked out that they've got this bill hanging over their head, that they'll risk their life. It's really hard for all of us.

This example highlights several of the problems that practitioners and administrators reported with regard to the recent OHP changes. In particular, it highlights the reluctance of patients to fill their prescriptions because they cannot afford the co-payments.

Private and public clinics reluctance to continue accepting OHP Standard patients

A final issue raised by key informants in the area of administrative challenges related to the 'moving target' nature of future policy changes anticipated in the Medicaid program. At the time of the key informant interviews, the legislature was still in session, with many of the February 2003 policy changes being debated in terms of the need to make even deeper cuts in the Medicaid program.

One Multnomah County informant noted that the percentage of *OHP Standard* patients currently being seen in the county was about 28 percent of the county's caseload, while the total Medicaid population was holding at about 55 percent. There was considerable apprehension that this ratio could dramatically change as a result of legislative action.

It was reported that increasingly Multnomah County clinics were controlling the number of *OHP Standard* patients they were accepting as new patients. It was further noted that until the legislature made a final decision about the *OHP Standard* population, the clinics were needing to assess the uncompensated debt exposure they would incur if a sizeable new group of uninsured patients, beyond those currently being served, came into the system. As one informant noted, this would not a viable option from a fiscal bottom-line perspective.

> *OK, tomorrow OHP Standard goes away – the end result is that Multnomah County's patient payer mix goes from 55 percent Medicaid coverage and 45 percent uninsured to the reverse 45 percent Medicaid and 55 percent uninsured.*

At the same time clinic managers are controlling the numbers of new *OHP Standard* patients they see, they are working with their clinicians to encourage existing patients to schedule preventive check-ups and to keep the appointments they have already scheduled because many these patients are not coming in for follow-up appointments. The result is a growing number of empty appointment slots where none existed in the past. This informant was careful to note that his clinic was not dumping *OHP Standard* patients, but rather trying to limit how the number of new *OHP Standard* patients coming into county clinics.

The problem of open slots was described in terms of the newly implemented $5 office visit co-payment assessed on OHP Standard patients. It was believed that many of these patients can't afford the $5 co-pay, or that they are confused about their coverage for visits and services. As one informant noted:

> *"The county is actually experiencing an increase in open appointments for OHP Standard patients because they are choosing not to schedule appointments due to the co-payments. A lot of OHP Standard patients can't afford the $5 co-payment and they are unaware that the county will still see them regardless of their ability to pay. Further, they are generally confused about their level of coverage under the new plan."*

The clinic administrators we interviewed have observed that some private providers in the community have stopped seeing Medicaid patients. The reasons they hear are not only low reimbursement rates, but also the increased administrative costs resulting from the imposition of co-payments for office visits, prescription drugs, and certain procedures. Each of these 'cost-sharing' strategies has increased the administration burden for physicians participating in the OHP.

> *"The private physicians in the community used to include a certain number of Medicaid patients in their practice as "charity care" knowing that they were going to receive a significantly discounted fee for their services. Now these "charity" patients who come to private physicians offices also have a co-payment obligation, this being the only way they can remain eligible for the Oregon Health Plan. As a result, the docs receive even less. They must pursue the co-pay, and then administer two (possibly three) different payment*

streams for the same service: one from the client who is sent a statement for $3, a second statement is sent to OMAP, and potentially a third to a health plan. In total, all payments, if collected, are significantly less than the standard fee for service billed private pay patients. It's this administrative burden that community physicians in private practice are being asked to assume.

This policy change, which has been calculated to 'save' money for the Oregon Health Plan (i.e., the state) by making sure every service has a co-payment, has shifted a major element of the administrative burden for OHP to health care providers. This is going to be a major disincentive for private practitioners to continue to accept charity care, including Medicaid patients. This situation is yet another reason why community physicians increasingly shun Medicaid clients and will not accept those enrolled in a managed care plan."

PATIENT SURVEY FINDINGS

The Face of FQHC Patients

To supplement the perceptions of FQHC informants about the impact of OHP2, the research queried patients served in Multnomah and Washington county clinics in order to assess impacts at the patient level. This study provides a snapshot in time; therefore the patients agreeing to be interviewed represent a convenience sample of individuals visiting four clinics during a typical week in August. The survey instrument was designed to elicit information about the purpose of the visit on the day interviewed, patients' overall health status, general use of health care services, perceptions about access to care, and health insurance coverage.

Although it is beyond the scope of this initial report to validate the representativeness of the FQHC patients contained in this sample, the sample does represent a group of patients seen in four FQHC clinics during the second and third weeks of August 2003. In order to have some context for the survey results, we present our data against results from a survey of OHP enrollees in 2002 and from the national Consumer Assessment of Health Plans (CAHPS) benchmarking results from Medicaid programs around the country. An analysis of differences in demographics and health status between respondents in the FQHC clinics sampled suggests that there are marked differences between our sample and a representative sample of OHP enrollees surveyed in 2002; further, that clinic location plays a role in patient profiles and the burden of illness found among the patients interviewed in this study (see page 19 for a discussion of clinic location variations).

The following tables present comparative statistics showing the similarities and differences between the FQHC sample, the OMAP 2002 CAHPS, and the national CAHPS benchmarking results from Medicaid programs around the country. The FQHC sample is demographically similar to the 2002 CAHPS sample with several notable exceptions and

where differences exist, they are significant -- particularly in terms of race, ethnicity, and health status.

Table 1: Comparative Demographics

Demographic Characteristic	FQHC Study 2003		OHP[1] 2002		NCBD[2] 2002	
	Child	Adult	Child	Adult	Child	Adult
Gender						
Male	49%	37%	55%	33%	54%	24%
Female	52%	63%	45%	67%	46%	76%
Age						
18-34 years	-	29%	-	26%	-	40%
35-54 years	-	50%	-	39%	-	40%
55-74 years	-	20%	-	25%	-	18%
75+ years	-	1%	-	10%	-	2%
Race						
White	**39%**	**56%**	**87%**	**90%**	66%	62%
African-American	3%	15%	2%	2%	23%	26%
Asian	0%	1%	1%	1%	3%	4%
Native Hawaiian/ Pacific Islander	0%	0%	0%	0%	0%	3%
American Indian/ Alaskan Native	0%	2%	3%	2%	2%	2%
Multi-Racial	17%	4%	6%	4%	6%	4%
Other	41%	22%	NA	NA	NA	NA
Health Status (Child health status reported by adult proxy)						
Excellent	49%	7%	45%	8%	39%	12%
Very Good	23%	14%	32%	19%	33%	20%
Good	14%	24%	18%	29%	21%	30%
Fair	**15%**	**39%**	**5%**	**30%**	**6%**	**26%**
Poor	0%	**16%**	0%	**15%**	1%	**12%**

Bolded numbers indicate significant differences, p<=.05.

[1] Results of Oregon Department of Human Services 2002 Consumer Assessment of Health Plans Survey (CAHPS) of OHP enrollees.

[2] Results of 2002 National Consumer Assessment of Health Plans Survey Benchmarking Database (NCBD)

- Both children and adults in our FQHC study were significantly less likely to be Caucasian than in the 2002 OMAP or the NCBD benchmarking survey.
- Adult participants in the FQHC sample were eight times more likely to be African-American than in the OMAP sample of OHP enrollees
- Children in the FQHC study were three times more likely to be reported as having 'fair' health status than in the OMAP survey

- Adults in the FQHC sample were more likely to report 'fair-to-poor' health status (55%) than those in the 2002 CAHPS survey (45%)

Table 2: Comparative Utilization

Utilization Characteristic	FQHC 2003		OHP 2002		NCBD 2002	
	Child	**Adult**	**Child**	**Adult**	**Child**	**Adult**
Call a doctor's office?						
Yes	**32%**	58%	**63%**	67%	**61%**	60%
No	69%	42%	37%	33%	39%	40%
Illness/Injury that needed care right away?						
Yes	36%	**55%**	36%	**43%**	42%	**43%**
No	64%	45%	64%	57%	58%	57%
Visits to the ED?						
None	**69%**	**56%**	**80%**	**73%**	69%	64%
1-3	28%	35%	19%	24%	29%	32%
4-5	3%	**5%**	1%	**2%**	1%	3%
5+	0%	**5%**	0%	**1%**	1%	1%
Visits to the doctor's office or clinic?						
None	**11%**	**11%**	**27%**	**22%**	18%	21%
1-2	53%	28%	46%	33%	45%	34%
3-4	23%	19%	18%	23%	23%	22%
5-9	11%	**25%**	6%	**15%**	6%	15%
10+	1%	**16%**	2%	**7%**	3%	8%

Bolded numbers indicate significant differences, p<=.05.

From a self-reported utilization perspective, there were several noteworthy differences between the two samples:

- Adults and child proxies in the FQHC sample were less likely to have called a doctor's office for medical care or advice during the past six months than those in the 2002 OMAP survey or the NCBD Benchmarking survey; conversely, adults in the FQHC study were more likely to have called for an urgent care visit

- Adults and child proxies in the FQHC sample were **much less likely** than the OMAP sample to have had no visits to an ED during the past six months

- Adults were **five times more likely** to have had 5 or more visits to the ED during this period

- Adults in the FQHC sample were twice as likely to have more than 5 visits to a doctor's office or clinic as among the OMAP sample

Table 3: Comparative Access Characteristics

Access Characteristic	FQHC Study 2003		OHP 2002
	Child	Adult	Adult
Called doctor's office or clinic – how often did you get help you needed?			
Always	74%	54%	55%
Usually	13%	22%	28%
Sometimes	13%	20%	17%
Never	0%	4%	
How often did you get a regular care appointment as soon as wanted?			
Always	63%	52%	53%
Usually	13%	22%	30%
Sometimes	18%	18%	17%
Never	7%	8%	
Got care for an illness or injury as soon as wanted?			
Always	65%	57%	60%
Usually	15%	20%	20%
Sometimes	19%	18%	19%
Never	0%	5%	

Bolded numbers indicate significant differences, p<=.05.

On measures of access, with only adults to compare, respondents in both groups are generally reporting similar levels of access to care.

4. Demographics of FQHC Patient Respondents

Table 4: Patient Demographic Characteristics

Characteristic	Percentage
Children (0-18) Adults (19-77)	24% 76%
Female	60%
Marital Status of Adults	32% married/living with partner 24% single 21% divorced/separated/widowed
Employment Status	18% employed/self-employed 60% unemployed
Ethnicity	42% Hispanic
Race	52% White 13% African American 35% Other
Insurance status	72% had some type of healthcare insurance (62% of whom were covered by Medicaid)

Burden of Illness

Reported as a group (n=320), patients completing the interview had an exceptionally high burden of chronic health conditions:

- 49% reported having symptoms lasting in excess of 6 months;
- 56% reported a physical or mental condition expected to last at least 12 months;
- 54% were at the clinic for a follow-up visit;
- 18% had had an overnight stay in a hospital during the past 6 months;
- 58% reported that they were currently taking a prescription medication;
- 80% had seen a doctor or other health care provider more than twice in the past six months;
- 45% reported their health status as either 'fair' or 'poor'; and,
- 32% reported that their health status had worsen from the previous year.

Health insurance status did appear to make a difference in the *excellent-to-very good* self-reported health status categories. Of those insured, 35% reported their health status as *excellent* or *very good*; while only 19% of the uninsured report in these categories. These differences diminished in the *fair* to *poor* grouping where 45% of insured and 47% of uninsured had reported poor health status.

Health Care Coverage

- 72% of patients interviewed reported having some form of health care coverage at the time of the interview
- Of those currently covered, 65% had OHP coverage, 14% Medicare coverage, and the remainder a mix of CHAMPUS and private coverage
- Of the uninsured, 37% had been uninsured for more than one year with 48% reporting their most recent coverage as OHP, while 40% reported never having had health insurance coverage.

Table 5: Characteristics of FQHC Patient Sample by Insurance Status

	Insured	Uninsured
Children (ages 0-18 years)	**82%**	**18%**
Adults (ages 19+) (n=248)	**70%**	**30%**
Gender: Female	**70%**	**30%**
Male	**76%**	**24%**
Marital Status:		
Married/living with partner	**35%**	**56%**
Single	35%	22%
Divorced/separated/widowed	30%	22%

	Insured	Uninsured
Employment Status:		
Employed/self-employed	**19%**	**31%**
Unemployed	81%	69%
Ethnicity (Hispanic)	**30%**	**70%**
Race: White	**62%**	**26%**
African American	16%	4%
Other	22%	70%

Bolded numbers indicate significant differences, p<=.05.

Characteristics of insured respondents that differentiate them from uninsured respondents included:

- Insured patients were significantly more likely than the uninsured to report an emergency room visit during the last 6 months
- Insured were significantly more likely than the uninsured to have been a patient in hospital overnight or longer in the last 6 months
- Uninsured patients were significantly more likely to be Hispanic adults
- Uninsured patients were significantly more likely to be employed than insured patients
- As a group, Hispanics (adults and children) were significantly more likely to be uninsured
- Caucasian patients were significantly more likely to be insured than all other races
- Uninsured patients were more likely to schedule an urgent care visit than a non-urgent care visit
- Insured patients were twice as likely to have had a doctor's visit in the last 6 months.

Table 6: Response to question 16

"In the last 6 months (not counting times you went to an emergency room), how many times including today did you (your child) go to a doctor's office or clinic to get care for yourself (your child)?"

	Insured (n=228)	**Uninsured** (n=86)
None	**7.9%**	**18.6%**
1	15.4%	17.4%
2	18.9%	16.3%
3	12.3%	12.8%
4	8.8%	4.7%
5 to 9	21.9%	23.3%
10 or more	**14.9%**	**7%**

Bolded numbers indicate significant differences, p.value(chi-square) = .073.

Health Seeking During the Past 6 Months

- 51% of all respondents reported calling a doctors office during regular office hours in the past six months to get health advice
- Of those patients who called (n=164) during regular office hours, 76% reported 'usually' or 'always' getting the advice they needed
- Of those patients reporting needing health care *right away*, 77% reported getting this needed care 'usually' or 'always'
- Of those needing *routine* care, 75.5% of the insured patients and 71.67% of uninsured patients reported that they "usually" or "always" obtained an appointment as soon as they wanted.

It appears from these data that patients who report needing access to information and/or care are getting the access they need. This stands in relief to the information reported by key informants who reported that access had worsened during the past eight months.

On the issue of prescription drugs, there appears to be much more convergence of opinion between clinic key informants and clinic patients:

- 57% of all patients surveyed reported taking at least one prescription drug, and 87% reported getting their prescriptions filled
- When asked a series of questions about their prescriptions, the following information was provided:
  - 24% went without a needed prescription because of cost
  - 20% skipped doses because of cost
  - 22% delayed filling a prescription because of cost
  - 23% ran out of a prescription and didn't get it refilled because of cost

Site Characteristics

Virginia Garcia Migrant Health Center was the only clinic where more uninsured than insured patients completed the survey -- 55% (n=53) of respondents were *uninsured*. In comparison, 84% of North County Clinic respondents, 84% (n=102) of Westside Clinic respondents, and 89% (n=39) of Midtown Clinic respondents were *insured*.

- Virginia Garcia Health Center was the only clinic of the four participating clinics where the majority of patients (68%) responded having insurance coverage for one year or less, while only 32% had been covered for one-five or more years.
- In the North County Clinic, 15% (n=7) of respondents reported having health insurance for one year or less and 85% (n=41) had insurance coverage for one-five or more years.
- At Westside, 29% (n=29) respondents had health insurance for one year or less and 71% (n=72) had insurance coverage for 1-5+ years.

- At Mid-county, 39% (n=15) respondents had health insurance for one year or less, while 61% (n=23) had health insurance coverage for 1-5+ years.

Table 7: Demographic Profile of Respondents by Clinic Location

CLINIC	Virginia Garcia	North County	Westside	Mid-County
Children (ages 0-18)	24%	16%	9%	34%
Adults (ages 19+)	76%	84%	91%	66%
Gender				
%Female	63%	68%	48%	76%
Marital Status:				
Married/Partner	58%	48%	25%	61%
Single	21%	29%	40%	22%
Divorced/Widowed/Separated	21%	23%	35%	17%
Employment Status:				
Employed	31%	23%	16.5%	31%
Unemployed	69%	77%	83.5%	69%
Ethnicity:				
Hispanic	73%	37%	24%	29%
Non Hispanic	27%	63%	76%	71%
Race:				
White	22%	60%	68%	62%
African American	2%	14%	20%	10%
Other	76%	26%	12%	28%
Reason for Visit:				
Follow-up Appointment	51%	63%	61%	31%
Preventive Care	23%	19%	12%	36%
Urgent Care	17%	8%	22%	9%
Non-urgent care	9%	10%	5%	24%
Insurance status:				
Insured	44%	84%	84%	89%
Uninsured	56%	16%	16 %	11%

LIMITATIONS OF THE DATA

The primary source of bias in this sample is the non-random nature of sample selection. As noted earlier, the patients who participated in the study were a convenience sample, that is, they were selected based on availability at the time the interviews were conducted. The percentage of patients with health insurance coverage is high for an FQHC population, thus the sample should look more like the OHP population although it is different along a number of dimensions, particularly race and ethnicity.

DISCUSSION OF FINDINGS

Key informants reported a concern that OHP Standard patients were less likely to keep follow-up appointments since the changes in OHP coverage in February 2003 because of misunderstandings about coverage and co-payment obligations. Patient survey data do not appear to validate this concern. The majority of patients interviewed were scheduling and keeping follow-up appointments, regardless of insurance status, type of insurance coverage, or clinic location. It could well be that the patients interviewed are a unique subset of the larger OHP population and thus reflect a source of bias that differentiates this sample from the greater OHP and uninsured populations.

While 320 patients is a small sample of the population seen in the four clinic sites, it is a sample of patients with high levels of need as evidenced by their utilization of health care services, and yet both insured and uninsured patients reported being generally satisfied with their ability to get a clinic appointment when needed.

A major concern of clinic informants had to do with prescription drug coverage as a result of changing OHP policies for the Standard population. The spill-over impact of changing rules and co-payments were reported to be affecting clinics' ability to continue to provide drugs to their uninsured patients because of the increased demand for free medications among the Standard group. The survey data confirm that approximately one-quarter of patients who were prescribed medications were not getting prescriptions filled, skipping doses, delaying getting prescriptions filled, or not getting refills because of the costs involved.

Finally, there is much concern about emergency rooms getting overloaded with uninsured patients or those patients with non-emergent conditions. Both Dr. Lowe's data and those reported here would suggest that OHP coverage does not necessarily serve as a buffer against visiting an emergency department for non-emergent reasons. Our data suggests that insured patients were as likely to visit the emergency room as those without health insurance coverage. This finding suggests that further study into the causes of ED visits is warranted.

END NOTES

[1] *Federally Qualified Community Health Centers* (FQHCs) provide comprehensive primary health care for adults, children and families living in rural and urban areas that have demonstrated financial, geographic, or cultural barriers to care. In addition to primary care, FQHCs provide enabling services such as transportation and translation services as well as preventive health care, mental health services, and dental services. FQHCs are public or private nonprofit corporations. They are governed by a consumer-majority board of directors, and thus are representative of the communities they serve. FQHCs receive grants from the federal Health Services and Resources Administration (HRSA) as well as third-party reimbursement from private insurance, Medicare and Medicaid and on a fee-for-service basis from uninsured patients according to their ability to pay.

[3] The *Committee on Health Care Safety Net Support* was convened in 2002 to advocate for safety net providers to receive more resources and support in the 2002 budgetary process by speaking with one voice in the legislative arena and at other venues in the community. Committee members include FQHCs, Indian/tribal clinics, school-based health centers, public health departments, and community-sponsored clinics.

[4] The *2002 Oregon Population Survey*, conducted in July 2002, found that 14% (472,000) of all Oregonians were uninsured at that time. Oregon Medical Assistance Programs data for the same month show 388,976 Oregonians participating in the Medicaid program statewide.

[5] The *Oregon Health and Evaluation Collaborative* (OHREC) is a statewide organization that includes health services researchers from Oregon's distinguished universities, state and county agencies, representatives of managed care organizations, hospital systems, mental health and substance abuse advocates and a variety of other stakeholders.

[6] A method of identifying informants where initial contacts are asked to identify appropriate individuals to be interviewed based on their particular expertise and experience with the issue being studied.

APPENDIX A

Assessing the Early Impacts of OHP2:
A Pilot Study of FQHC Impacts in Multnomah and Washington Counties

Key Informant Questions – Clinic Administrators

Clinic Impact of OHP Policy Changes

1) What changes, if any, in clinic administration and/or fiscal policies have you instituted in response to the February 2003 policy changes in OHP eligibility and benefits?
2) Have you experienced a change in the mix of patients who visit your clinic since February 2003? If so, how would you describe this change? (PROBE: Issues around changes in number of children as parents drop off of OHP? Change in substance abuse/chemical dependency/mental health diagnoses?
3) Are there further clinic changes you anticipate will be made as a result of the new OHP policies expected to be implemented in July 2003?
4) Based on your experience at [X] Clinic, what do you believe to be the biggest gaps in health care in your community as a result of recent OHP changes?
5) What do you consider to be the most viable solutions available to you in meeting your clinic's budgetary and staffing resource needs as a result of recent and proposed changes in the OHP?
6) Changes in clinic staffing?

Capacity Issues

7) Are you aware of any clinic closures in your community as a result of recent changes in the OHP? Are you aware of any anticipated clinic closures in the near future in your community? What types of clinics would these be [PROBE: behavioral health, dental clinic, safety net clinics]?
8) Has your clinic changed its hours of operation as a result of recent changes in the OHP?
9) Has your clinic expanded or decreased any services as a result of recent changes in the OHP?
10) Have your clinic providers changed their prescribing practices in response to the recent changes in OHP? Has the clinic set in place any pharmacy assistance programs in response to the recent changes in OHP? (Particularly in response to the increased co-payments certain patients must now pay for prescription drugs). [Clackamas County changed their formulary to match more closely to OHP to avoid being a sole source for some meds. Have other counties, clinics made the same kind of changes?] Ask about changes in the clinic formulary?

Referral Patterns

11) Please describe the referral process generally used by your clinicians when a specialist referral is needed? Have these staff members noticed changes in the availability of specialist appointments since February 2003?
12) Does someone on the clinic staff track whether patients keep their referral appointments? (Specialists offices call and report no shows. Are #'s of those calls increasing
13) Have you seen an increase, decrease, or no change in the number of new patients seen at your clinic since February 2003? Likewise, have you seen a change in your registered patient population since February 2003?
14) Has there been a change in the length of time it takes to schedule a routine, non-urgent visit with a primary care provider in your clinic since February 2003?
15) Have you had to refer out to other clinics because your clinic is full? Where are patients generally referred to when a suitable appointment time cannot be scheduled? Has this referral source changed since February 2003? Ask if there's an increase in triage nurse calls?
16) Among the range of health care services your patients are most in need of, for example, dental care, mental health care, prescription drugs, and specialist referrals, which among these are the most resource constrained as a result of recent and proposed changes in the OHP? What was most constrained **before** changes and what is most constrained **after** changes? Has it changed?

Financial Viability

17) Have you experienced any changes in the level of bad debt your clinic has absorbed (?) since the February 2003 OHP policy changes?
18) Has your clinic changed its patient payment policies since the February 2003 policy changes in OHP?
19) Do you anticipate further patient payment policy changes in response to the anticipated OHP policy changes in July 2003?
20) How has you third-party payer mix changed, if at all, since implementation of the February 2003 OHP policy changes?
21) Have you experienced an increase in the number of totally uninsured patients since February 2003? If so, would you describe this increase as significant or not significant?
22) Are there any other changes you have witnessed in patient care access and/or stressors on the local health care delivery system since February 2003 that we haven't discussed? Please describe these changes.

THANK YOU FOR PARTICIPATING IN THIS INTERVIEW, THE INFORMATION IS VERY IMPORTANT TO THE POLICY MAKING DELIBERATIONS CURRENTLY UNDERWAY IN SALEM.

APPENDIX B

Assessing the Early Impacts of OHP2:
A Pilot Study of FQHC Impacts in Multnomah and Washington Counties

Patient Survey

1. How long have you *(has your child)* had the symptoms that brought you here today? **[DO NOT READ RESPONSES. PROBE TO FIT.]**
   - [1] ❑ 1 to 2 days
   - [2] ❑ 3 to 6 days
   - [3] ❑ 1 to 4 weeks
   - [4] ❑ 1 to 6 months
   - [5] ❑ More than 6 months

2. Which of the following best describes the reason for your *(your child's)* visit to this clinic today? **[READ LIST. MARK ONLY ONE.]**
   - [1] ❑ It is a non-urgent care visit for a minor illness, such as a sore throat or earache
   - [2] ❑ It a preventive care visit; for example, for an annual check-up, immunizations, mammogram, or prostate exam
   - [3] ❑ It an urgent care visit for a serious illness or injury that requires immediate medical attention
   - [4] ❑ It a follow-up appointment from a previous visit to this clinic

3. Before coming to this clinic today, did you try to get advice or medical care for this problem? **[READ LIST. MARK ONLY ONE RESPONSE.]**
   - [1] ❑ No, you did not seek advice or medical care for this problem prior to today's visit.
   - [2] ❑ Yes, you got treatment advice from a family member, friend, or neighbor.
   - [3] ❑ Yes, you sought medical care from a different clinic or hospital.

READ: I am going to read you a list of reasons why people have told us that they come to this clinic. Please let me know whether any of these are a reason why you came here today. Some of the statements seem similar, but we would like to understand your reasons for coming to this clinic so please answer all that apply to you. [CHECK ALL THAT APPLY]

4. You came to this clinic today because:

[1]❑ This is the clinic where you usually come for treatments.
[2]❑ This clinic is the closest one to your home.
[3]❑ This clinic is on/near a bus route.
[4]❑ This was the earliest appointment you could get.
[5]❑ You come here when you can't get an appointment at your regular clinic.
[6]❑ You can get evening and weekend appointments at this clinic.
[7]❑ This clinic accepts your *(your child's)* OHP card.
[8]❑ This clinic is more affordable than your other clinic.
[9]❑ This clinic will see you *(your child)* even though you do not currently have health insurance.
[10]❑ You were *(your child was)* refused care at the clinic you usually go to. Explain_____
[11]❑ This clinic is more affordable than the clinic you usually go to.
[12]❑ Are there other reasons why you have come to this clinic that we have not mentioned? **IF YES**, Please explain:
_____

READ: Now I'm going to ask you some questions about your *(your child's)* health insurance.

5. Do you *[your child]* currently have health insurance from any source, including coverage provided by the government such as Medicare or the Oregon Health Plan?

[1]❑ Yes ➔ **GO TO Q9**
[2]❑ No

6. About how long has it been since you have *[your child has]* had health insurance coverage? **[DO NOT READ RESPONSES. PROBE TO FIT]**

[1]❑ Less than 6 months
[2]❑ Less than 1 year
[3]❑ 1-3 years
[4]❑ 3-5 years
[5]❑ 5 years or more
[6]❑ Don't know
[7]❑ You've *[your child has]* never had health insurance. ➔ **Go TO Q12**

7. What was your *[child's]* most recent health insurance coverage? **[DO NOT READ RESPONSES. PROBE TO FIT]**

   [1]❑ Provided by your employer or a family member's employer ➔ **GO TO Q12**
   [2]❑ Paid for by you or a family member as an individual(s) ➔ **GO TO Q12**
   [3]❑ Oregon Health Plan (Medicaid) ➔ **GO TO Q8**
   [4]❑ Medicare ➔ **GO TO Q12**
   [5]❑ TriCare/Champus or ChampVA ➔ **GO TO Q12**
   [6]❑ Other_____ ➔ **GO TO Q12**

8. What is the main reason you are *(your child is)* no longer covered by the Oregon Health Plan (Medicaid)? **[READ LIST. MARK ONLY ONE ➔ GO TO Q12 AFTER COMPLETING.]**

   [1]❑ You have too much income to qualify
   [2]❑ You have too many assets. For example, too much in savings to qualify
   [3]❑ You could not afford the monthly premium
   [4]❑ You didn't reapply in time to become eligible
   [5]❑ There was too much paperwork involved
   [6]❑ Other, specify_____
   [7]❑ Don't know

9. What is the source of your *(your child's) current* health insurance coverage? **[DO NOT READ. PROBE TO FIT. MARK ALL THAT APPLY.]**

   [1]❑ Your employer or a family member's employer
   [2]❑ Health insurance you or a family member purchased as an individual
   [3]❑ The Oregon Health Plan (Medicaid/OMAP).
   [4]❑ Medicare
   [5]❑ TriCare/Champus or ChampVA
   [6]❑ Other (specify)_____
   [7]❑ Don't know

10. How long have you *(your child)* had this current health insurance? **[DO NOT READ. PROBE TO FIT.]**

[1]❑ Less than 6 months
[2]❑ Less than one year
[3]❑ 1-3 years
[4]❑ 3-5 years
[5]❑ Five years or more
[6]❑ Don't know

11. Does your *(your child's)* health insurance require that you make a co-payment for office visits? [**PROBE**: A co-payment is a fee made at the time of your visit even when you have health insurance]

[1]❑ Yes

11a. **IF YES**, How much is the co-payment for an office visit? $_____
❑ Don't know

[2]❑ No
[3]❑ Don't know

READ: Now I am going to ask you about your health care in the last 6 months

READ: We are interested in better understanding the health care needs of the patients who visit this clinic. The following questions are about your needs for health care services during the past six months.

12. In the last 6 months, did you call a doctor's office or clinic during regular office hours to get help or advice for yourself *(your child)*?

[1]❑ Yes
[2]❑ No ➔ **Go to Q14**

13. In the last 6 months, when you called during regular office hours, how often did you get the help or advice you needed *(for your child)*?

[1]❑ Never
[2]❑ Sometimes
[3]❑ Usually
[4]❑ Always

14. In the last 6 months, did you *(your child)* have an illness, injury, or condition that <u>needed care right away</u> in a clinic, emergency room, or doctor's office?

[1]❑ Yes
[2]❑ No ➔ **Go to Q16**

15. In the last 6 months, when you *(your child)* <u>needed care right away</u> for an illness, injury, or condition, how often did you get care as soon as you wanted?

[1]❑ Never
[2]❑ Sometimes
[3]❑ Usually
[4]❑ Always

16. In the last 6 months (not counting times you went to an emergency room), how many times including today did you *(your child)* go to a <u>doctor's office or clinic</u> to get care for yourself *(your child)*?

[1]❑ None ➔ **Go to Q18**
[2]❑ 1
[3]❑ 2
[4]❑ 3
[5]❑ 4
[6]❑ 5 to 9
[7]❑ 10 or more

17. In the last 6 months, not counting times you needed health care right away, how often did you *(your child)* get an appointment for health care as soon as you wanted?

[1]❑ Never
[2]❑ Sometimes
[3]❑ Usually
[4]❑ Always

18. In the last 6 months, how many times did you go *(take your child)* to an <u>emergency room</u> to get care for yourself *(your child)*?

[1]❑ None
[2]❑ 1
[3]❑ 2
[4]❑ 3
[5]❑ 4
[6]❑ 5 to 9
[7]❑ 10 or more

19. *Are you* (your child) *currently taking or supposed to be taking any prescription drugs?*

[1]❑ Yes
[2]❑ No ➔ **Go to Q21**
[3]❑ Don't know

20. *Are you filling all of the prescriptions your doctor or health care provider has prescribed for you* (your child)*?*

[1]❑ Yes
[2]❑ No
[3]❑ Don't know

21. In the past 6 months, have any of these things happened to you *(your child0*? Please tell me "Yes" or "No" as I read each item. **[MARK ALL THAT APPLY]**

	Yes	No
a. You *(your child)* had to go without filling a prescription because of cost.	[1]❑	[2]❑
b. You *(your child)* took less or skipped doses of a prescription because of cost.	[1]❑	[2]❑
c. You delayed filling a prescription *(for your child)* because of cost.	[1]❑	[2]❑
d. You ran out of prescription medicines *(for your child)* and was not able to get a refill because of cost.	[1]❑	[2]❑
NOW I AM GOING TO ASK ABOUT HEALTH CARE COSTS IN GENERAL. In the past 6 months, has either of these things happened to you?		
e. You cut down on food in order to pay bills related to your *(your child's)* health care.	[1]❑	[2]❑
f. You skipped paying other bills or paid bills late to pay for the cost of your *(your child's)* health care.	[1]❑	[2]❑

22. **In the last 6 months, have you *(has your child)* been a patient in a hospital overnight or longer?**
[DO NOT INCLUDE PREGNANCY]

[1]❑ Yes
[2]❑ No

23. Do you *(does your child)* now have any physical or medical conditions that have lasted or are expected to last for at least 12 months?

[1]❑ Yes
[2]❑ No ➔ **GO TO Q25**

24. In the last 6 months, have you *(has your child)* seen a doctor or other health provider more than twice for any of these conditions?

[1]❑ Yes
[2]❑ No

25. In general, how would you rate your *(your child's)* overall health now? **[READ LIST]**

[1]❑ Excellent
[2]❑ Very good
[3]❑ Good
[4]❑ Fair
[5]❑ Poor

26. Compared to one year ago, how would you rate your *(your child's)* health in general now? **[READ LIST. MARK ONLY ONE.]**

[1]❑ Much better than one year ago
[2]❑ Somewhat better
[3]❑ About the same as one year ago
[4]❑ Somewhat worse than one year ago
[5]❑ Much worse than one year ago

READ: Now I'm going to ask you a few questions about you *[your child]*.

27. ***Gender* (of patient)** *[DO NOT ASK. MARK ACCORDING TO OBSERVATION.]*

[1]❑ Male
[2]❑ Female

28. How old are you *(is your child)*? _____

Are you: **[READ LIST. MARK DOES NOT APPLY IF CHILD.]**

[1]❑ Currently married
[2]❑ Living with a partner
[3]❑ Single
[4]❑ Divorced
[5]❑ Widowed
[6]❑ Separated
[7]❑ Does not apply (child).

29. Are you currently employed, self-employed or not employed? **[MARK DOES NOT APPLY IF CHILD.]**

- [1] ❑ Employed
- [2] ❑ Self-employed
- [3] ❑ Not employed
- [4] ❑ Does not apply (child).

30. Would you describe yourself *(your child)* as either Spanish, Hispanic or Latino/a?

- [1] ❑ Yes
- [2] ❑ No

31. How would you describe your *(your child's)* race? **[DO NOT READ. MARK ALL THAT APPLY.]**

- [1] ❑ White
- [2] ❑ Black or African-American
- [3] ❑ American Indian or Alaska Native
- [4] ❑ Asian
- [5] ❑ Native Hawaiian or other Pacific Islander
- [6] ❑ Mixed race
- [7] ❑ Other, not listed

32. What is your (your child's) zip code?_____

That's the end of the interview, Thank you for giving us some of your time today.

Date: _____
(mm/dd/yyyy)

Time: _____AM/PM (Circle one}

Clinic site: _____

Interviewer initials: _____