

Oregon Health Care Survey

Six Month Follow-Up

Six months ago, we sent you the first survey in the ongoing Oregon Health Care Study. Now, please help the study continue by telling us about your health and health care experiences in the last six months. Your experiences will be used to help leaders in Oregon improve access to health care in the future. Whether you were able to respond to the last survey or not, it is extremely important for us to hear from you on this survey.

You may choose to answer this survey or not. If you do, all information that would let someone identify you or your family will be kept private. The Office for Oregon Health Policy & Research, Portland State University, and the Center for Outcomes Research & Education will not share your personal information with anyone without your OK. Choosing not to answer this survey will not affect any health benefits you may be receiving.

If you return this survey, you will be entered into a drawing to win \$200.

You may notice a number on this survey. This number is used only to let us know if you returned the survey so we don't have to keep sending you reminders, and to enter you into the drawing to win \$200.

Before you fill out this survey, please read the included letter explaining this research study.

If you have any questions, want to know more about this study, or want to leave the study, please call 1-866-332-9896.

Survey Instructions

1. Answer all the questions by checking the box to the left of the answer.
2. You are sometimes told to skip over questions in this survey. When this happens, you will see an arrow with a note that tells you what question to answer next, like this:

Yes → [GO TO QUESTION 1]
 No

The Oregon Health Care Survey

START HERE ↓

Your Health Coverage

1. Do you **currently** have health insurance through any of the following? *Mark all that apply.*

- Oregon Health Plan (OHP)/Medicaid
- Medicare
- Employer or family member's employer
- A private plan I pay for myself
- Other coverage: _____
- I don't have any insurance now
- I don't know

2. For how many of the **last 6 months** did you have some kind of health insurance?

- No insurance during last 6 months
- 1 Month
- 2 Months
- 3 Months
- 4 Months
- 5 Months
- Insured for all of the last 6 months

Your Health Care

3. Is there a place you usually go to receive medical care?

- Yes
- No → (Go to Question 5)

4. Where do you usually go to receive medical care? *Mark only one.*

- A private doctor's office or clinic
- A public health clinic, community health center, or tribal clinic
- A hospital-based clinic
- A hospital emergency room
- An urgent care clinic
- Some other place not listed here
Where? _____
- I don't have a usual place
- I don't know

5. Do you have one person you think of as your personal doctor or health care provider?

- Yes
- No

6. Was there a time in the **last 6 months** when you needed medical care?

- Yes
- No → (Go to Question 9)

7. If you needed medical care in the **last 6 months**, did you get **all** the care you needed?

- Yes → (Go to Question 9)
- No
- I didn't need care in the last 6 months

8. The **most recent time** you went without needed medical care, what were the main reasons? *Mark all that apply.*

- It cost too much
- I didn't have insurance
- The doctor wouldn't take my insurance
- I owed money to the care provider
- I couldn't get an appointment quickly enough
- The office wasn't open when I could get there
- I didn't have a doctor
- Some other reason: _____
- I don't know

9. Was there a time in the **last 6 months** when you needed prescription medication?


- Yes
- No → (Go to Question 13)



10. If you needed prescription medications in the **last 6 months**, did you get **all** the medications you needed?
- Yes → (Go to Question 12)
 - No
 - I didn't need medications in the last 6 months
11. The **most recent time** you went without prescription medications you needed, what were the main reasons? *Mark all that apply.*
- They cost too much
 - I didn't have insurance
 - I didn't have a doctor
 - I couldn't get a prescription
 - I couldn't get to the pharmacy
 - Some other reason: _____
 - I don't know
12. How many different prescription medications are you currently taking? _____
13. Was there a time in the **last 6 months** when you needed **dental care**?
- Yes
 - No → (Go to Question 15)
14. If you needed dental care in the **last 6 months**, did you get **all** the care you needed?
- Yes
 - No
 - I didn't need dental care in the last six months
15. In the **last 6 months**, how many times did you go to a doctor's office, clinic, or other health care provider to get care for yourself? *Don't include hospital and emergency room visits or dental care. Your best estimate is fine.*
- None
 - 1 time
 - 2 times
 - 3 or more times (*how many?:*_____)
16. In the **last 6 months**, how many times did you go to an emergency room to get care for yourself? *Your best estimate is fine.*
- None → (Go to Question 18)
 - 1 time
 - 2 times
 - 3 or more times (*how many?:*_____)
17. The **most recent time** you went to the emergency room, what was the reason you went there instead of somewhere else for health care? *Mark all that apply.*
- I needed emergency care
 - I didn't have insurance
 - Doctors' offices/clinics were closed
 - I couldn't get an appointment to see a regular doctor soon enough
 - I didn't have a personal doctor
 - I couldn't afford the copay to see a doctor
 - I needed a prescription drug
 - I didn't know where else to go
 - Some other reason: _____
 - I don't know
 - I haven't gone to the emergency room in the last 6 months
18. In the **last 6 months**, how many different times were you a patient in a hospital at least overnight? *Do not include hospital stays to deliver a baby.*
- None → (Go to Question 20)
 - 1 time
 - 2 times
 - 3 or more times (*how many?:*_____)
19. In the **last 6 months**, how many days did you spend in a hospital? *Include the total number of days for all the times you checked in question 18, above. Your best estimate is fine.*
- Total number of days: _____
20. Overall, how would you rate the **quality** of the medical care you've received in the **last 6 months**?
- Excellent
 - Very Good
 - Good
 - Fair
 - Poor
 - I didn't receive medical care in the last 6 months



Your Health Care Costs

21. In the **last 6 months**, have you paid any out of pocket medical expenses for yourself? (*Out of pocket costs are costs you pay yourself. Do not include dental costs.*)
- Yes
- No → (Go to Question 23)
22. In the **last 6 months**, about how much money did you spend out of pocket on each of the following types of medical care for yourself? *Do not include dental costs. Out of pocket costs are costs you have already paid yourself. Your best estimate is fine.*
- Visits to doctors' offices,
clinics or health centers \$ _____
- Emergency rooms or
overnight hospital care \$ _____
- Prescription medicines
(don't include medicines you
can buy without a prescription) . . . \$ _____
- Other medical care
not covered above \$ _____
23. Do you **currently** owe money to a health care provider, credit card company, or anyone else for medical expenses?
- No
- Yes
-  *If yes, about how much do you owe?* _____
24. In the **last 6 months**, have you had to borrow money, skip paying other bills, or pay other bills late in order to pay health care bills?
- No
- Yes
25. In the **last 6 months**, has a doctor, clinic, or medical service refused to treat you because you owed money to them for past treatment?
- Yes
- No
- I don't know

Your Health

26. Taken all together, how would you say things are these days—would you say that you are very happy, pretty happy, or not too happy?
- Very happy
- Pretty happy
- Not too happy
27. In general, would you say your health is:
- Excellent
- Very Good
- Good
- Fair
- Poor
28. How has your health changed in the **last 6 months**?
- My health has gotten better
- My health is about the same
- My health has gotten worse
29. Thinking about your physical health, which includes physical illness and injury, for how many days during the **past 30 days** was your physical health not good?
- Total number of days (0-30): _____
30. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the **past 30 days** was your mental health not good?
- Total number of days (0-30): _____
31. During the **past 30 days**, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
- Total number of days (0-30): _____
32. Over the **past 2 weeks**, how often have you been bothered by feeling down, depressed, or hopeless?
- Not at all
- Several days
- More than half the days
- Nearly every day



About You

32. Over the **past 2 weeks**, how often have you been bothered by little interest or pleasure in doing things?

- Not at all
- Several days
- More than half the days
- Nearly every day

34. Have you ever been told by a doctor or other health professional that you have any of the following?

	Yes	No
Diabetes or Sugar Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or Chronic Bronchitis (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease, Angina, or Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Depression or Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>

35. In the **last 6 months**, have you **taken medication** for any of the following?

	Yes	No
Diabetes or Sugar Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or Chronic Bronchitis (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease, Angina, or Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Depression or Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>

36. Have you smoked at least 100 cigarettes in your **entire life**?

- Yes
- No → (Go to Question 39)

37. Do you **now** smoke cigarettes every day, some days, or not at all?

- Every day
- Some days
- Not at all → (Go to Question 39)

38. On average, how many cigarettes do you now smoke **a day**? _____

39. Are you male or female?

- Male Female

40. What is the **YEAR** of your birth? _____

41. Are you currently employed or self employed?
Mark only one.

- Yes, employed
- Yes, self-employed
- Not currently employed
- Retired

42. About how many hours per week, on average, do you work at your current job(s)?

- Less than 20 hours per week
- 20-29 hours per week
- 30 or more hours per week
- I don't currently work

43. What was your gross household income (before taxes and deductions are taken out) for last year (2008)? *Please include any cash assistance or unemployment you may have received. Your best estimate is fine.*

- | | |
|---|---|
| <input type="checkbox"/> \$0 | <input type="checkbox"/> \$25,001 to \$27,500 |
| <input type="checkbox"/> \$1 to \$2,500 | <input type="checkbox"/> \$27,501 to \$30,000 |
| <input type="checkbox"/> \$2,501 to \$5,000 | <input type="checkbox"/> \$30,001 to \$32,500 |
| <input type="checkbox"/> \$5,001 to \$7,500 | <input type="checkbox"/> \$32,501 to \$35,000 |
| <input type="checkbox"/> \$7,501 to \$10,000 | <input type="checkbox"/> \$35,001 to \$37,500 |
| <input type="checkbox"/> \$10,001 to \$12,500 | <input type="checkbox"/> \$37,501 to \$40,000 |
| <input type="checkbox"/> \$12,501 to \$15,000 | <input type="checkbox"/> \$40,001 to \$42,500 |
| <input type="checkbox"/> \$15,001 to \$17,500 | <input type="checkbox"/> \$42,501 to \$45,000 |
| <input type="checkbox"/> \$17,501 to \$20,000 | <input type="checkbox"/> \$45,001 to \$47,500 |
| <input type="checkbox"/> \$20,001 to \$22,500 | <input type="checkbox"/> \$47,501 to \$50,000 |
| <input type="checkbox"/> \$22,501 to \$25,000 | <input type="checkbox"/> \$50,001 or more |

44. Would you describe yourself as Spanish, Hispanic, or Latino?

- Yes
- No



45. How would you describe your race?

Mark all that apply.

- White
- Black or African-American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Other: _____

46. What is the highest level of education you have completed?

- Less than high school
- High school diploma or GED
- Vocational training or 2-year degree
- A 4-year college degree or more

47. What is your current living arrangement?

Mark all that apply.

- Live alone
- Live with partner or spouse
- Live with parents
- Live with other relatives (including children)
- Live with friends or roommates
- Other: _____

48. How many family members, including yourself, counting adults and children, are living in your home? (For example, if you live alone, you should write "1".)

Size of Household: _____

49. Of the family members living in your house, how many are under 19?

Number under 19: _____

50. Thinking about the family members in your house under 19 years of age, how many are currently covered by some kind of health insurance?

- All family members under 19 are covered by health insurance of some kind
- Some family members under 19 are insured, some are not
- None of the family members under 19 are insured

Contact Information

Thank you for participating! This study will continue for 3 years, and we would like to contact you again in six months. It is important for us to have a way to reach you if you move during that time.

Please tell us three people who **do not** live with you and would know how to reach you if you moved. Good contacts are people like your mother, a sister or brother, or a good friend.

This information will NOT be shared, and will be used by us ONLY if we are unable to find you, and ONLY for the sole purpose of continuing this study.

Name: _____

Relationship: _____

Address: _____
Street Apartment #

_____ City State Zip

Home Phone: _____

Cell or Message Number: _____

Name: _____

Relationship: _____

Address: _____
Street Apartment #

_____ City State Zip

Home Phone: _____

Cell or Message Number: _____

Name: _____

Relationship: _____

Address: _____
Street Apartment #

_____ City State Zip

Home Phone: _____

Cell or Message Number: _____

When you have finished your survey, please place it in the postage-paid envelope and drop it in the mail. Thank you for your time!

