
The Miami Dade County Immigrant Health Access Task Force

Access to Public Health Trust Services: Success and Challenges

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The Access Project is a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University. It has served as a resource center for local communities working to improve health and healthcare access since 1998. The project receives its funding from a variety of public and private sources.

The mission of The Access Project is to strengthen community action, promote social change, and improve health, especially for those who are most vulnerable. The Access Project conducts community action research in conjunction with local leaders to improve the quality of relevant information needed to change the health system. It seeks to enhance the knowledge and skills of community leaders to strengthen the voice of underserved communities in the public and private policy discussions that directly affect them.

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Community Catalyst is a national advocacy organization that builds consumer and community participation in the shaping of our health system to ensure quality, affordable health care for all. Community Catalyst's work is aimed at strengthening the voice of consumers and communities wherever decisions shaping the future of our health system are being made. Community Catalyst strengthens the capacity of state and local consumer advocacy groups to participate in such discussions. The technical assistance it provides includes policy analysis, legal assistance, strategic planning, and community organizing support. Together we're building a network of organizations dedicated to creating a more just and responsive health system.

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INTRODUCTION

This report documents the efforts of the Immigrant Health Access Task Force in their collaboration to broaden access to services provided with Public Health Trust (PHT) Funds. The PHT receives money from a half-cent sales tax in Miami-Dade County and provides funding to the Jackson Memorial Hospital, the primary public hospital facility in the county. Immigrants and other low-income residents had a difficult time accessing care due to encounter fees and immigration documentation required to obtain free or subsidized care. The Immigrant Health Access Task Force was organized around the effort to address these problems. This report documents Task Force activities and highlights areas in need of continued attention. It is based on interviews with the advocacy group leaders, representatives of the PHT, and discussions with thirteen uninsured residents who accessed or attempted to access this care. The report concludes that efforts to date succeeded in changing certain PHT policies that limited access, yet barriers to care still exist for immigrant and low-income populations. The final section includes a list of wide ranging recommendations for continued Task Force activity.

BACKGROUND

Access to care remains a critical problem in Miami-Dade County. Nearly 25 percent of the non-elderly people (450,000) in the County do not have health insurance.¹ This is compared to 18 percent nationally. Ethnic minorities, including immigrants, make up a disproportionate share of this group. More than 50 percent of the county is ethnically Hispanic and about 30 percent of Hispanics in Miami/Dade are uninsured (compared to 25 percent of blacks, 10 percent of non-Hispanic whites and close to 40 percent of those who identified themselves as “other race or ethnicity.”) The proportion of non-citizens in Miami/Dade is also three times higher than the state as a whole; and “non-citizens are uninsured at twice the rate of citizens.”³

THE IMMIGRANT HEALTH TASK FORCE

The Access Project sponsored a one-day training workshop on immigrants’ access to health care on October 13, 1999. The evaluation of this meeting found that the greatest value to participants was in identifying barriers to obtaining health care services.⁴ Overall, participants rated this meeting highly successful in focusing attention on the critical issues. The forum provided an opportunity to coalesce around specific impediments to care for immigrants in the county. Some members of the taskforce knew of these problems from their work experience, and for others the magnitude became clear after the Access training.

The meeting is widely credited with being a catalyst for the creation of the Immigrant Health Access Task Force. Based upon the need articulated by individuals in attendance, the Human Services Coalition organized approximately 60 volunteer advocates from a host of consumer groups, legal services organizations, and health care clinics/providers to work and address the critical issues they had identified. Yet, advocates were already stretched in terms of issues and resources. The Access Project

provided financial assistance to the Human Services Coalition to provide coordination, and this funding was essential to move this process forward.⁵ Additional meetings were called and the Task Force was formed.⁶ The group keyed in on the difficulties immigrants' face in accessing care and the resources available through the PHT.

PUBLIC HEALTH TRUST AND JACKSON MEMORIAL HOSPITAL

In 1991, Florida enacted legislation enabling counties to pass referenda for approval of tax levies to help finance the public health care system. In September 1991, Miami-Dade County voters approved a half-cent sales tax “for the operation, maintenance and administration of Jackson Memorial Hospital to improve health services.”⁷ This funding, administered through the Public Health Trust (PHT), is provided exclusively to Jackson Memorial Hospital. This surtax revenue, \$142 million annually, represents nearly 20 percent of Jackson’s operating expenses.⁸ In addition, Jackson receives a portion of the county’s property tax proceeds (\$80 million). As a non-profit entity, they are also tax exempt. These funds and subsidies are for operations and are not direct reimbursement for the care of individual patients. Jackson receives the same amount of county funding regardless of the total amount of “free care” they provide. This funding is more generally tied to Jackson’s goal of ensuring “that all residents of Miami-Dade County receive a consistent, high standard of care, regardless of their ability to pay.”⁹

There is some ambiguity and considerable controversy over how the tax funds received by PHT are required to be spent. Although the ballot language authorizing the PHT is clear that the money is for the maintenance and operation of Jackson, public opinion polls taken shortly before the vote revealed that voters supported the measure largely because they believed it would cut waiting lists for poor patients.¹⁰ The county contains a number of federally-qualified health centers and other providers of uncompensated care to low-income at risk populations, but these organizations do not have access to tax surcharge funds. In May 2000, the Florida legislature attempted to distribute a portion of the property taxes assigned to the PHT to other health care providers through an amendment to the 1991 surtax statute. The Miami-Dade County Commission declared that the provision violated the county’s Home Rule Charter and refused to implement the amendment.¹¹

THE PROBLEM

The Human Services Coalition convened a series of meetings and the Task Force began its work in January 2000. The group agreed to focus on two PHT practices: (1) charging encounter fees even for those with income below the FPL (\$10 for those designated county residents and \$75 for those not designated county residents); and (2) denial of subsidies to immigrants living in the county based on their inability to prove county residency in a manner specified by the PHT’s.¹⁵ Rosalía Boullón said that her organization, the Hemophilia Foundation of Southern Florida, at times actually paid the \$75 fee for certain clients so that they could receive necessary care.¹⁶ Other advocates affirmed that this barrier significantly discouraged people from seeking care

until it was absolutely necessary. It also discouraged people from returning for necessary follow-up care.

In order to receive free or subsidized care from the Jackson and affiliated institutions a patient must obtain a Jackson ID or PHT CareCard and meet income and county residency standards under the PHT financial classification system. Cards are issued after a financial evaluation, and patients are given a code classification indicating patient responsibility for payment. County residents under 100 percent of the federal poverty level (FPL) are given a JO2 classification and are not billed for hospital services. Residents with family income between 101 and 150 percent of the FPL are given a JO3 status and billed 33 percent of charges. Those between 151 and 300 percent of the FPL are given a JO4 status and are responsible for 66 percent of charges. People whose income and residency are undetermined are given a JO6 status, and are billed 100 percent of charges. Two critical questions are whether people are being correctly classified and whether they are receiving necessary and appropriate health care services regardless of their classification.

Advocates considered paperwork requirements for proving county residency excessive and a significant hurdle to obtaining care. Immigrants were asked for documentation that they were legal residents and for proof of citizenship status in order to qualify for assistance under the PHT. Advocates believed that many immigrants who were county residents and financially qualified under the PHT financial classification system for free or reduced price care were misclassified. Although Jackson did not directly refuse people services, financial barriers and concern about fees and about revealing immigration status discouraged people from seeking care and encouraged them to put off care or to seek alternative sources of care. Advocates sensed that while Jackson was the exclusive recipient of PHT funds, other non-profit facilities including federally-qualified health centers were seeing many of the uninsured.

The documentation required to determine financial status was difficult for many immigrants to satisfy. Employer and landlord documentation had to be notarized. Individuals working for multiple private employers, such as house cleaners, were asked to get a notarized document from each person they worked for. Leases were requested although many low income uninsured individuals applying for assistance do not have a lease.

THE PROCESS

Terry Coble from the Human Services Coalition arranged, organized and facilitated meetings and discussion. Early meetings began as “gripe sessions,” and gave people an opportunity to express and share frustration. This energy was quickly concentrated and directed toward a plan for action.¹⁷ The group was very motivated and focused.¹⁸ The team was described as “dynamite,” with each participant having something unique to offer.¹⁹ Meetings were held on a monthly or more frequent basis. Those most involved communicated frequently by phone and email in between meetings. Task Force members attended a County Commission hearing and PHT meetings. They

corresponded with PHT and Jackson officials and requested policy changes. They provided information to the media regarding problems faced by immigrants and others trying to access services.

Advocates reported that there was initial resistance on the part of the PHT to change anything and a longstanding reluctance to share information. The Task Force used leverage from the threat of submitting a civil rights violation against the hospital and press coverage to help bring the PHT to the negotiating table. PHT officials counter that they were always willing to speak with concerned advocates, and in fact were in the process of making some of the Task Force recommended changes prior to the more formal negotiations.²⁰ Most advocates viewed legal action and media attention as powerful tools to move the PHT towards negotiations.

Under the direction of Miriam Harmatz and Florida Legal Services, and with support from ACLU, the Task Force was prepared to file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services for violations under Title VI of the Civil Rights Act of 1964. The complaint was based on an allegation that Jackson was treating foreign-born county residents differently from U.S. born residents in receiving timely health care and meeting program eligibility.²¹ Several press accounts and discussion on the radio also focused the attentions of the public and Jackson on these issues.²²

Early in the process substantial progress was made in limiting the collection of the \$75 encounter fees (for those not given county residency status). In addition, the PHT decided not to collect the \$10 encounter fees for county residents with income below the federal poverty level. The Chairman of the PHT, Amadeo Lopez-Castro sent a letter to Miriam Harmatz of Florida Legal Services on June 14, 2000 with an attachment stating that Jackson would no longer collect the encounter for patients with income below 100 percent FPL.²³ Chairman Lopez-Castro stated that the Trust was in the process of reviewing and changing this policy prior to meetings with advocates.²⁴

Negotiations, including a series of meetings and document exchanges, took place between October 1999 and November 2001. The PHT requested the documentation of problems with examples of specific patients.²⁵ These were provided primarily by Rosalía Boullón.²⁶ Early negotiations focused on the number and type of documents required to prove residency. At one point in the process, the PHT was requesting that applicants provide three documents to prove residency from a list of six different types of documents; the Task Force was pushing for one, and PHT ultimately agreed on two.²⁷

After five meetings, Jackson agreed to clarify that while they still would ask about immigration status, they would not require immigration documents in order to provide subsidized care.²⁸ Jackson maintained that it was necessary to continue asking about immigration status in order to determine eligibility for a Cuban/Haitian health care program. Jackson agreed that it would make a greater effort to assure patients that this information, if provided, would only be used to determine eligibility for other programs and would not be turned over to any governmental entity. Towards the end of the negotiations, Jackson agreed to prominently post signs in English, Spanish and

Creole stating, "If you do not provide immigration information, access to health care service will not be delayed or denied."²⁹

The Task Force also focused on what kind of financial documentation was required; they suggested that the requirement that letters from landlords and employers be notarized be eliminated. The PHT did not drop this requirement and also refused to allow self-declaration of status so that extremely poor people, including the homeless, could obtain subsidized care.

The Task Force wanted notices in brochures and prominently posted to inform patients of the right to appeal their eligibility classification and the name of an agency where people could go for help. The PHT agreed to add language for internal appeal, but refused to provide information on where to seek legal aid. Jackson refused to allow the Task Force to place brochures in the lobby informing people of their right to appeal and where to go for help.³¹ In September 2000 Jackson said that it would conduct staff sensitivity and cultural training to improve and make more consistent the manner in which immigrant patients are treated.³²

According to some advocates, negotiations, which initially led to some success, dragged on for far too long with no forward progress. Once the PHT mooted the legal bases for the Title VI complaint, advocates' leverage was severely diminished. Several stated that Jackson and the PHT unilaterally decided that negotiations were over and they were not going to attend additional meetings. PHT representatives maintain that they are always open to working with advocacy groups. In any case, the Task Force role shifted their focus at this point to monitoring the impact of policy change.

In retrospect, most Task Force members interviewed believed that there was a good strategic mix between a legal- and media-driven approach and a willingness to negotiate with Jackson and the PHT. Some members thought that the legal approach led to some imbalance in the Task Force, with more of the responsibilities and control placed in the hands of the attorneys. They believed that a broader-based taskforce effort could have led to greater success. A few believed that the legal strategy was not pushed hard enough. They had little faith in the PHT and their inseparable relationship with Jackson. They view Jackson as an enormously powerful bureaucracy that would be difficult to change even under the best circumstances.

From the PHT perspective, Chairman Amadeo Lopez-Castro Jr. said that this exchange of ideas was positive and always welcome.³³ In a letter on the subject of encounter fees to Miriam Harmatz, the Chairman wrote that Jackson's traditional practice was not to collect these fees if people could not pay.³⁴ This is an indication that he did not view this issue as a significant barrier to care. A member of the PHT said that advocates were contentious from the beginning, and acted as if the Trust deliberately had done something wrong. This person thought that initially problems came out of the blue, but felt that some of the initial mistrust was overcome and progress was made. Hope was expressed that an ongoing relationship between the advocates and the PHT could be established. It was feared that the PHT would learn of problems only when lawsuits were filed. Trust officials also acknowledged potential

problems with the consistency of intake workers and that this is an area that needs further work.

OUTCOMES

With a singular exception, Task Force members interviewed thought that negotiations achieved some success. This said, it is very hard to determine the total impact of the policy changes, because limited data is available on the number of uninsured who apply for free or subsidized care and how they are classified. Advocates were concerned that Jackson does not share essential financial and eligibility data. Thus, advocates have primarily monitored the impact through reports of current patients and the outcomes of the appeals they have helped file. Some patients have said they have noticed a difference since these policy changes.³⁵ Several patients interviewed said that since the changes, it is easier to have Jackson Care Cards renewed. More, however, reported that they remained initially unaware that they could apply for reduced or no fees under the PHT financial classification system. Treatment from intake workers also seemed to vary significantly.

Patients interviewed mainly dealt with the classification system only after they were billed and sent to collection agencies. Several people said that there are no signs or brochures at Jackson or affiliated clinics letting people know that free or reduced fee care is available, how to apply, and where to get help. Once people do apply there is no information telling them where they might appeal a determination and obtain outside help if they do not agree with their classification.

Some in the immigrant community are still holding back going to Jackson for fear of exposing their immigration status. Members of the Haitian community noted a particular nervousness both with the election of President George W. Bush and the backlash against immigrants felt after the events of September 11. Many of these people are very scared about anything associated with the government.³⁶

Legal aid representatives have noticed significant results from the changes. While they believe that rule changes have helped them to obtain better health care services for their clients, they fear that they are helping only a small portion of those who could use assistance. Interviews with patients confirmed that many found out about legal services only by happenstance. Attorneys at the Florida Immigrant Advocacy Center (FIAC) and Legal Services of Greater Miami, Inc. said that each case of suspected misclassification they brought before Jackson was resolved in favor of the patient. Over four months prior to March 2002, Legal Services of Greater Miami, Inc. investigated between 25 and 30 cases, and in each case the hospital changed the classification to benefit the patient. Jackson data for a four-month period show that of 38 classification appeals, 29 were reclassified for a reversal rate of 76 percent.

It seems clear that if financially eligible people are taken by an attorney or advocate and guided through the system, they have a high rate of obtaining a JO2 classification, or no-bill, status. The question becomes, "how many people do not seek this guidance or

know it is available?” Information from Jackson indicates that they look at the rate of reversal numbers positively.³⁸ They view it as an indication that most problems are taken care of satisfactorily. Advocates believe that the cases they help bring to the attention of Jackson may be just the tip of the iceberg, and that such high reversal rates indicate that the system is not working effectively. They conclude that more people would benefit from legal advocacy regarding their classification. However, there is a risk that with current resources, this would overburden a legal service system already stretched for resources.

There are strong indications that workers at Jackson are inconsistent in intake practices. As a result of Task Force efforts Jackson did conduct additional training of their intake workers but did not allow advocates to monitor this training.³⁹ Nevertheless, advocates believe, and conversations with patients indicate, that intake workers vary widely with regards to congeniality, helpfulness, and understanding of the financial classifications system. A number of patients told us that they have received dismissive and/or rude treatment from administrative staff.

Limited data is available on who is applying for free or subsidized care and who is being accepted or denied access and why. From our discussions with advocates and the patients we spoke with, it seems that many people are receiving Jackson health cards with a JO6 classification. Although our sample of patients was admittedly small, most had JO6 classifications and advocates shared a widespread perception that this classification is common. This means that their status is undetermined, they will be billed 100 percent of charges, and may be subject to a \$75 encounter fee.

In a Jackson/PHT meeting on September 28, 2001 it was disclosed that between May and August of 2001 there were a total of 38,182 outpatient registrations. The PHT reported that just 1,404 or 3.67 percent of these were classified PO1 “full pay/self pay.”⁴⁰ These data may be misleading and imply that everyone else is getting some sort of subsidy. From advocate and patients interviews there was consistent concern that many people receive JO6 status, which means that their status is underdetermined. These people are treated similarly to “full pay/self pay.” They are billed 100 percent of charges and may be charged an encounter fee, but do receive a discount on prescription drugs.

ADDITIONAL PROBLEMS

Interviews with patients and advocates shed light on access problems in addition to those that were the focus of the Task Forces earlier efforts. It was widely reported that it takes four or more hours to apply for a Jackson Care Card (which is necessary to obtain care), many months to schedule tests, non-emergency surgery, and follow-up primary care appointments. All the people interviewed were asked how long it took them to apply for their cards. The shortest amount of time reported was two hours but most said four or more, and these were people that by and large had scheduled appointments. One interview with an attorney present took four hours.⁴¹ In addition, sometimes it takes several months to schedule an interview.

The Jackson patients we interviewed spoke of the difficulty in obtaining certain documentation. One woman worked as a maid for a number of employers and found it impossible to get letters that were notarized from each of them. A woman described how she could not be treated without proof that she was pregnant and this had to be obtained from a clinic in a different location. She said that similar circumstances happened with two people she knew, and one woman was 6 months along and visibly pregnant. It was reported that homeless people are, at times, required to show a lease, and that migrant workers must have a notarized letter from the employer.⁴²

Many of the people we interviewed spoke of the long time it took them to obtain care. Some were still waiting for tests, test results, and/or non-emergency surgery or treatment. One woman presented at 10:00 AM with severe migraines and was not seen until 10:00 PM. An elderly gentleman presented at 9:00 PM with high blood pressure and was not seen until 3:00 AM. A mother brought her two children in for scheduled vaccinations at 6:30 AM and was not seen until 4:00 PM. A father with a small child is out of work because of hernia. He gets treated when it is an emergency, but Jackson has not scheduled surgery despite his chronic pain. The majority of patients interviewed believed that people with insurance obtain more timely care, and are generally treated with more respect.

Public concerns have also focused on access for uninsured individuals in the southern and western portions of Miami/Dade, which are at a greater distance from JMH and affiliated health centers. Uninsured and Medicaid patients travel farther for care, including emergency care, than privately insured patients in these areas. JMH is the hospital they most frequently travel to, according to a RAND report.⁴³ The authors surmise that “the centralized system approach taken by the Public Health Trust with JMH as its hub results in most uninsured and Medicaid patients going to that hospital. The persistent need for some patients to travel outside their areas of residence for emergency care suggests that the local hospitals are not meeting the needs of the uninsured in their areas.”⁴⁴ In 2001, Jackson opened a 199-bed facility, Jackson South Community Hospital, which may serve to alleviate some of the need in this part of the county.

A physician from a community health center said that he does not send his Medicaid patients to Jackson, and that they receive more patient-friendly services and continuity of care at other facilities. Uninsured patients of limited means must go to Jackson. The same physician confirmed difficulties and delays in scheduling diagnostics and non-emergency care. The doctor added that when patients go to Jackson facilities they usually see a different provider each visit and the hospital does not do a good job of sharing and updating patient files with clinics or primary care physicians.

CONTINUING TASK FORCE ACTIVITIES

The Task Force worked most intensively from January 2000 through March 2001 to achieve policy changes in the PHT registration and financial assistance process, as

described in detail above. From March 2001 to the present, Task Force members have monitored the effect of the changes. The legal advocates were able to track the complaints around issues brought to their attention. The community advocates continued to collect stories and anecdotal information. When necessary, advocates made referrals to the appropriate legal assistance organization in order to resolve individual complaints.

In addition, the Task Force met several times during this period to discuss their observations and concerns regarding implementation of the PHT policies and related issues of immigrant health access. Task Force members found the increased communication between Task Force members constructive and many expressed an interest in resuming joint advocacy activities. In April 2002, the Task Force renamed itself the Immigrant or Uninsured Health Care Access Task Force, or I.O.U. Health Care Access, in recognition that uninsured non-immigrants also experience significant, and in many cases parallel, health access problems.

NEXT STEPS

The members of the Task Force we interviewed made a series of recommendations that are listed below. Many of these issues can be addressed whether the group decides to use a more collaborative approach, a more confrontational approach, a strategy that attempts to expand the access by opening up public health trust to other safety net providers, or a combination of these strategies. Some recommendations are geared more towards one of these approaches.

Suggestions focus both on substantive issues and on the process and tasks needed to support the Task Force's ongoing advocacy on access issues.

- Continue advocacy related to PHT intake and financial classification.
- Advocate for more consistency in how immigrants and indigent people are treated by intake workers.
- Push for greater information and accountability in how Jackson spends public money.
- Obtain more information regarding the number of people who seek a PHT financial classification and how each is classified. If a large number are considered "undetermined" (JO6), it is essential to know why, and remove unnecessary barriers.
- Seek more information on additional issues surrounding access. Request statistics on waiting times to apply for financial classification, on the time it takes to be seen by a health care professional, and on the length of time it takes to get an appointment for primary, specialty care, and non-emergency care. It will be important to note variation in waiting times by insurance status across a spectrum of procedures.

- Advocate for more funding for patient advocacy. Organizations like Abriendo Puertas and the Haitian-American Youth of Tomorrow could partner with the Public Health Trust to help to insure that immigrants are properly classified. These types of organizations have the community contacts Jackson needs to insure that it is fulfilling its public mission. The suggestion was made to have one advocate per clinic simply to help people through the paperwork. (Jackson has made some efforts to work with these groups in doing community outreach.)

Legal advocates already assist qualified individuals with reclassification, but expanded resources would increase their capacity to inform the community of this service and handle the larger number of patients who might come forth.

- Advocate for training of Jackson Clinical staff so they can help people obtain proper classification. If they see someone of obviously limited means and a JO6 classification, they should refer them to information on reclassification.
- Organize a public and provider education campaign about what financial assistance is available and how to obtain assistance or to appeal an eligibility determination.

INFLUENCE COUNTY-LEVEL POLICY

- Push for broader access expansions. Expand efforts to assist immigrants and the indigent by convincing the PHT to draft a county-wide plan for primary care that includes a wider range of providers.
- Foster a movement for broader access to trust money, making it available to multiple sources including other traditional safety net providers.

INFLUENCE STATE-LEVEL POLICY

- Work as a group and possibly with the hospital system to enact state legislation reinstating immigrant Medicaid benefits.
- Consider legislative action reducing hospital flexibility and directly tying the provision of public funds and subsidies to indigent patient care.

BUILD THE TASK FORCE

- Hold additional conferences on health and access problems for an even wider group of advocates. Broaden the coalition in order to exert more leverage.
- Unify the group around several clearly defined issues and present a united front to PHT/Jackson. This would entail having two or three leaders present the group's views in order to minimize inconsistent or contradictory representations.
- Secure funding for activities selected as priorities and for Task Force coordination.

¹ Carol Pryor. (2000). "Lives at Risk: Nearly Half Million Without Health Insurance in Miami-Dade County," The Access Project, Boston, Massachusetts, September. (This report can be found at www.accessproject.org)

² Pryor.

³ Pryor. P. 6.

⁴ *Health Access for Immigrants: Obstacles and Opportunities*. (1999) Evaluation Preliminary Report, Feedback from the November 10, 1999 Miami meeting. The Access Project, Boston, MA.

⁵ Miriam Harmatz. Personal Interview, February 20, 2002.

⁶ Memorandum from Terry Coble, Human Resources Coalition, and Riché Zamor, Access Project to Interested Persons. (November 4, 1999). This memo included a list of issues identified at the October 13, 1999 Access training and set up the first meeting of the taskforce.

⁷ Language on referendum ballot, as cited in Jackson C, Derose KP, Chiesa JR, Escarce JJ. (2002). "Hospital Care for the Uninsured in Miami-Dade County: Hospital Finance and Patient Travel Patterns," RAND MR-1522-CH. Available at: <http://www.rand.org/publications/MR/MR1522/>

⁸ Ibid. page 48.

⁹ This quote was taken from the Jackson Memorial website. (2002). <http://um-jmh.org/JHS/Jackson.html>

¹⁰ Petchel J. (1991). "Poll: 70 Percent of Voters back JMH Tax," as cited in Jackson. et al. (2002) P. 7.

¹¹ Ibid.

¹² *Health Access for Immigrants: Obstacles and Opportunities*. (1999) Evaluation Preliminary Report, Feedback from the November 10, 1999 Miami meeting. The Access Project, Boston, MA.

¹³ Miriam Harmatz. Personal Interview, February 20, 2002.

¹⁴ Memorandum from Terry Coble, Human Resources Coalition, and Rich Zamor, Access Project to Interested Persons. (November 4, 1999). This memo included a list of issues identified at the October 13, 1999 Access training and set up the first meeting of the taskforce.

¹⁵ Immigrant Health Access Report, Access to Public Health Services, October 1999 – November 2001. Human Service Coalition, 2002.

¹⁶ Rosalía Boullón. Personal Interview, February 20, 2002.

¹⁷ Terry Coble. Personal Interview, January 28, 2002.

¹⁸ Tom Zamorano. Personal Interview, February 3, 2002.

¹⁹ Carline Paul (Teacher Carline). Personal Interview, January 30, 2002.

²⁰ Amadeo Lopez Castro Jr. Personal Interview, February 12, 2002.

²¹ Letter from Miriam Harmatz to Mr. Arthur Hertz, Immediate Past President Public Health Trust Board, March 23, 2000. RE: Encounter Fees at Dade County Public Health Clinics and Eligibility Requirements for Treatment of Foreign Born County Residents.

²² Liz Balmaseda. (Thursday, October 12, 2000). Commentary, *Miami Herald*, "Blatant Bias at Public Hospital," Liz Balmaseda, (Monday, January 22, 2001). *Miami Herald* "Health Trust's distracting issue," Candice Ventra, (Thursday, June 15, 2000) "Health trust gets commission ill will over treatment of needy at Jackson." *Miami Today*. Several radio shows by Teacher Carline focused on this topic, personal interview (2002).

²³ Letter from Amadeo Lopez Castro Jr., Chairman Public Health Trust, to Ms. Miriam Harmatz, Florida Legal Services, June 14, 2000.

²⁴ Amadeo Lopez-Castro Jr. Personal Interview, February 12, 2002.

²⁵ One advocate objected to the use of the word "negotiations." This person did not think that negotiations took place because in his/her view the PHT convened all meetings at their offices, dictated meeting time, how many people could be present, and "generally rejected our suggestions out of hand." Other advocates did see these as negotiations, although discussions were not always on their terms or to their satisfaction.

²⁶ For a specific example see: Liz Balmaseda. (Thursday, October 12, 2000). Commentary, *Miami Herald*, "Blatant Bias at Public Hospital"

²⁷ Proof of county residency requires two of the following items: Florida drivers license, or state ID; Mortgage, lease, or rent receipt; water, electric, phone or other utility bill; police identification; vehicle registration; proof of child enrollment in a County public school.

²⁸ This information was provided in several interviews and mentioned by Liz Balmaseda, (Monday, January 22, 2001). *Miami Herald* "Health Trust's distracting issue"

²⁹ E-mail Memorandum from Miriam Harmatz to Select Taskforce Members, Subject: PHT Response (Friday, March 9, 2000).

³⁰ Proof of county residency requires two of the following items: Florida drivers license, or state ID; Mortgage, lease, or rent receipt; water, electric, phone or other utility bill; police identification; vehicle registration; proof of child enrollment in a County public school.

³¹ Rosalía Boullón. Personal Interview, February 20, 2002.

³² Jacqueline Charles (Friday, September 1, 2000). Hospital staff to get training on immigrants, *Miami Herald*.

³³ Amadeo Lopez Castro Jr. Personal Interview, Comments on the review of a first draft, May 16, 2002.

³⁴ Letter from Amadeo Lopez Castro, Chairman Public Health Trust, to Ms. Miriam Harmatz, Florida Legal Services, June 14, 2000.

³⁵ Most of the positive comments came when interviewing patients of Jackson at Abriendo Puertas (January 29, 2002)

³⁶ Carline Paul (Teacher Carline). Personal Interview, January 30, 2002.

³⁷ Jackson/PHT overheads that were part of a September 28, 2001 meeting of the Program Planning and Primary Care Committee of the PHT, Jackson Memorial Hospital, West Wing Board Room, 8:00 AM.

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³⁹ Rosalía Boullón, Personal Interview, February 20, 2002.

⁴⁰ Jackson/PHT overheads that were part of a September 28, 2001 meeting of the Program Planning and Primary Care Committee of the PHT, Jackson Memorial Hospital, West Wing Board Room, 8:00 AM.

⁴¹ Troy Elder, Personal Interview, Legal Services of Greater Miami, Inc. February 14, 2002.

⁴² Rosalía Boullón, Personal Interview, February 20, 2002.

⁴³ Jackson C, Derose KP, Chiesa JR, Escarce JJ. (2002). "Hospital Care for the Uninsured in Miami-Dade County: Hospital Finance and Patient Travel Patterns," RAND MR-1522-CH. Page xiv-xv; Available at: <http://www.rand.org/publications/MR/MR1522/>

⁴⁴ Ibid. page 49.