



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at Two Facilities in
Somerton and Yuma, Arizona*

AUTHORS:

Dennis Andrulis, Ph.D., MPH

Research Professor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Christina An, MPH, MA

Research Instructor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Carol Pryor, MPH, M.Ed.

Policy Analyst, The Access Project

*This report was produced in collaboration with Puentes de Amistad (Bridges
in Friendship).*

March 2001

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

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

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

Puentes de Amistad (Bridges in Friendship) is a community-based organization that is based in Somerton, Arizona, twelve miles south of the city of Yuma. Puentes de Amistad is one of four offices operated by the Border Health Foundation (BHF), a non-profit organization incorporated in 1984.

The mission of Puentes de Amistad is to build healthy families through health education, cultural awareness, and capacity building strategies in Yuma County, Arizona, San Luis, Arizona, Rio, Colorado, and Sonora, Mexico. Puentes de Amistad facilitates and manages a number of community development and public health projects, the majority of which use trained Lay Health Promoters (Promotores de Salud) and are tailored to meet the needs of migrant and seasonal farm workers. Puentes de Amistad also collaborates with U.S and Mexican government officials and public and private groups to improve the quality of life on both sides of the border.

Emma Torres
Project Manager
Puentes de Amistad/Bridges in Friendship
P.O. Box 646 Somerton, AZ 85350
Phone: 520-627-4280 Fax: 520-627-4277
E-mail: pda1@primenet.com

This report may be reproduced or quoted with appropriate credit.

TABLE OF CONTENTS

Executive Summary 5

Introduction 9

 Community Access Monitoring Survey Project 10

 About This Report 11

Lack of Insurance is Dangerous to Your Health..... 12

 Lack of Insurance and Access to Care 12

 Lack of Insurance and Health Outcomes 13

 Benefits of Improved Access to Health Care 14

 The Health Care Market and Care for the Uninsured..... 15

Community Context..... 17

Survey Methodology 18

Survey Findings..... 19

 Sunset Health Center 19

 Yuma Regional Medical Center 26

Discussion 35

 Sunset Health Center: Key Findings..... 35

 Yuma Regional Medical Center: Key Findings 36

 Conclusion 37

References..... 38

Appendix A: Table of Survey ResultsA-1

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

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

Appendix D: Survey Instrument..... D-1

Acknowledgements

•
•
•
•
•
•
•
•

EXECUTIVE SUMMARY

The number of uninsured Americans rose significantly over the last decade—according to current estimates, 43 million people are now without health insurance. While it is often assumed that the uninsured can easily obtain health care, much research demonstrates that lack of insurance leads to reduced access to health care and poorer health outcomes. Moreover, recent changes in the healthcare market have exposed healthcare providers to financial pressures that may be limiting their ability to provide care for the uninsured. However, access to care for the uninsured varies greatly across regions and communities.

The Community Access Monitoring Survey (CAMS) project, an initiative of The Access Project, provided support to organizations in 24 communities to survey uninsured patients receiving care at local facilities. The goals of the project were to investigate the effectiveness of local facilities in responding to the needs of the uninsured and to document barriers the uninsured face when seeking care.

This report summarizes national data on the impact of health insurance on access to care and health outcomes, and presents the results of the survey in one community, Somerton, Arizona. The survey was conducted in the summer of 2000 and gathered information from 345 uninsured patients who obtained health care at the Sunset Health Center or Yuma Regional Medical Center in the previous year. The report also compares their experiences with those of uninsured patients surveyed at other CAMS sites across the country who received care at similar facilities.

KEY FINDINGS

Findings for Sunset Health Center include the following:

- ◆ Four of five respondents reported that the clinic had been “open and accepting” to them even if they could not pay for their care. In addition, the majority of respondents reported that they were satisfied with the care and service they received from staff. However, Sunset respondents were less likely than the average for All Rural Clinics (ARCs) included in CAMS nationwide to report that the clinic has a reputation in the community for providing “a lot” of care to the uninsured.
- ◆ About half the respondents reported that they needed help with translations. Of these, almost all said interpreters were available, and three-quarters said that their ability was “very good.”

•
•
•
•
•
•
•

- ◆ The average reported time to get an appointment at Sunset was over two weeks, nearly a full week longer than the ARC average.
- ◆ More than 40 percent of Sunset respondents reported that convenience to public transportation and getting transportation assistance when needed had been a problem at least sometimes, figures that were much higher than the averages for ARCs.
- ◆ Sunset respondents were less likely to report that they needed financial assistance to pay for medical care and prescriptions than the averages for ARCs. In addition, about three in ten respondents said they owed the clinic money, while the ARC average was close to 50 percent.

However, among those respondents who received prescriptions, only one-fourth received their medications at no cost, much lower than the ARC average. Among respondents who said they needed help paying their medical bills, two-thirds said they “never” received help, almost three times the ARC average.

- ◆ Ninety-three percent of the respondents said they would use the clinic again if they had health insurance.

Findings for Yuma Regional Medical Center include the following:

- ◆ Yuma respondents were more likely to have used the emergency room, more likely to be admitted as an inpatient, and less likely to have been a clinic patient than the averages for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide.
- ◆ The majority of the respondents reported that they were satisfied with their interactions with staff.
- ◆ Four of five respondents reported that in their experience the hospital had been open and accepting to them even if they could not pay, which was higher than the average for (AUSHs).
- ◆ At the same time, while more than half of the respondents reported that they needed help paying for medical care and one-third that they needed help paying for medications, the majority said they were “never” offered any assistance by staff. More than one-fourth said their past experiences paying bills at the hospital would deter them from seeking care there again, and another third said it would cause them to use a different facility. Furthermore, nearly two-thirds said they were in debt to the hospital, and over 40 percent of these respondents said their indebtedness would discourage them from seeking care there again.



- ◆ With respect to accessibility measures, the average reported time to get an appointment was 8.5 days, nearly a week shorter than the average for AUSHs. However, more than two-fifths of the respondents reported that convenience to public transportation and getting transportation assistance when needed had been a problem at least sometimes, higher than the averages for AUSHs.
- ◆ Half the respondents required assistance with translations. Although more than half of the respondents who needed assistance reported that interpreters were readily available, 43 percent said interpreters were “not very available” or “unavailable.”
- ◆ Nearly all (98%) the respondents said they would use the hospital again if they had health insurance.

•
•
•
•
•
•
•
•



INTRODUCTION

In 1998, 44 million people in the United States were uninsured, representing a 38% increase in the number of uninsured since 1987.¹ While this number fell slightly between 1998 and 1999, according to current estimates 43 million people are still without health insurance.² The ability of the uninsured to gain access to health care is thus a major national issue, but it is at the community level that the consequences are most apparent.

Many assume that even when people are uninsured, they are readily able to obtain health care. A 1999 survey of college-educated people in the United States found that 57 percent believed that uninsured people are able to get the care they need from doctors and hospitals, up from 43 percent in 1993.³ However, research has consistently demonstrated that individuals without insurance see health providers less frequently, receive fewer preventive health services, and delay care. As a result, when the uninsured do get care, they often require more expensive care. For example, the uninsured tend to come into the hospital more severely ill, and are hospitalized more frequently for conditions that could have been treated on an ambulatory, and less costly, basis.

Structural changes in the health care environment over the last decade have only increased the barriers to care facing the uninsured. Managed care companies have negotiated aggressively with health care providers to reduce their fees; as a result, providers have fewer financial resources available to subsidize care for the uninsured. At the same time, the number of uninsured has risen, increasing the demand for services, while various direct and indirect public subsidies that in the past helped support care for the uninsured have been eroding. All types of health care providers are affected by these changes, but perhaps the hardest hit are the "safety net" providers—those that, either by legal mandate or explicitly adopted mission, are dedicated to providing health care regardless of patients' ability to pay—as they generally treat the largest number of uninsured patients.

The situation, however, is not uniform across communities. Comparing the provision of care in different metropolitan statistical areas (MSAs), the author of a recent study said, "One of the most striking findings from our analysis...is the tremendous variation in the provision of uncompensated care by MSAs across the country. Our MSA-level analysis indicates that there are pockets in the country where the uninsured have very limited access to hospital care."⁴

•
•
•
•
•
•
•
•
•
•

COMMUNITY ACCESS MONITORING SURVEY PROJECT

To gather information about the barriers to care facing the uninsured in particular communities and at particular facilities, The Access Project initiated the Community Access Monitoring Survey (CAMS) project. The CAMS project funded 24 organizations across the country to survey uninsured individuals who received care at key facilities in their communities.

PROJECT GOALS

The goals of the project were to

- ◆ Learn directly from those without health insurance about their experiences and perceptions when obtaining health care
- ◆ Investigate the effectiveness of local facilities in responding to the needs of the uninsured
- ◆ Document barriers to care for the uninsured
- ◆ Use survey data to stimulate dialogue and promote change
- ◆ Put a local face on the problem of the uninsured

THE SURVEY DESIGN

The survey instrument was developed by Dennis Andrulis, Ph.D., Research Professor at SUNY Health Science Center in Brooklyn, NY. It was used to gather information about the experiences of over 10,000 uninsured patients at 58 facilities nationwide, and results were reported for each of the participating communities. The survey asked respondents a range of questions about their experiences when they received care at a particular facility while they were uninsured, such as their perceptions of the facility's willingness to provide care, satisfaction with interactions with staff, waiting times for appointments, ability to obtain needed medications, and difficulties paying for care.

Survey Limitations

The survey was designed to gather data about key providers that care for the uninsured in various communities. It was not intended to provide definitive conclusions, and readers should be aware of the limitations of the methodology.

The survey was based on a convenience rather than a random sample. Respondents were recruited at a variety of local sites, such as homeless shelters, employment offices, and housing projects, sometimes with the intent of collecting information from a particular group or groups, and the number of people who were eligible but refused to participate was not recorded. For these reasons, survey



responses cannot be generalized either to all uninsured people or to all uninsured patients who used a given facility--rather, they reflect the experiences only of those surveyed.

In addition, while all surveyors received uniform training in administration of the survey, it was not possible to evaluate actual implementation at each site. The authors also did not have access to other sources of data, such as medical records, that might have added to or verified individuals' reports, and they were not able to assess environmental factors, such as the volume of uninsured patients treated, operating budget, and staff size, which might have affected a facility's provision of care. Finally, the surveys gathered information only from uninsured individuals who were able to access care at particular facilities; they did not capture either the numbers or the experiences of those who were unable or never tried to access care.

Intended Uses of the Survey

The survey was intended to provide information on a frequently overlooked topic, the actual experiences of the uninsured when they obtain care. Notwithstanding its limitations, the authors expect that the results will be useful to providers, local officials, community representatives, and others in suggesting issues related to the provision of care for the uninsured in their communities that may benefit from further discussion or more rigorous and comprehensive study, in order to assist them in improving access to care for this population.

ABOUT THIS REPORT

This report, along with reviewing some of the research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Somerton, Arizona. The survey was conducted by Puentes de Amistad (Bridges in Friendship) in the summer of 2000, and gathered information from uninsured individuals who received care at Sunset Health Center or Yuma Regional Medical Center in the previous year. Along with providing the results of the survey for these facilities, the report compares the results with aggregate responses at all similar facilities surveyed as part of the CAMS project nationwide. A report presenting the overall findings for all surveyed sites will be released in Spring 2001.

•
•
•
•
•
•
•

LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

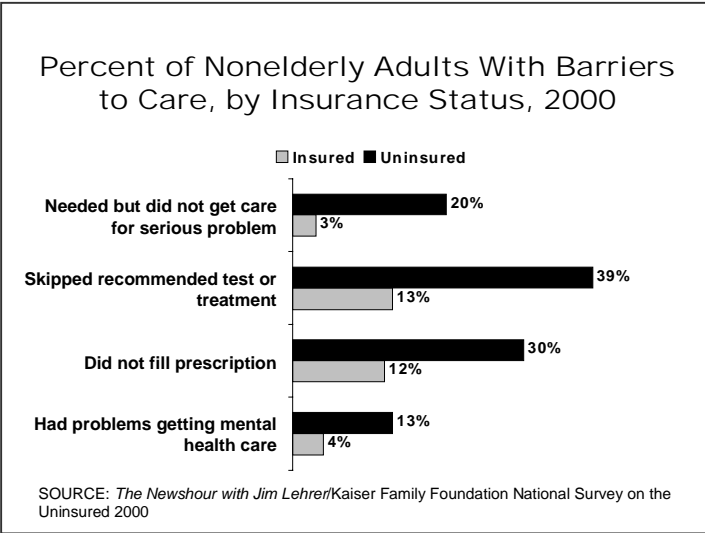
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

LACK OF INSURANCE AND ACCESS TO CARE

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

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

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



LACK OF INSURANCE AND HEALTH OUTCOMES

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

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

•
•
•
•
•
•
•
•

BENEFITS OF IMPROVED ACCESS TO HEALTH CARE

While lack of insurance is a serious barrier to receiving care, making health services available to the uninsured has been shown to lead to significant improvement in the use of critical services and in health status. One recent study found, for example, that uninsured individuals who obtained insurance coverage had better access to care based on indicators such as having a usual source of care, higher satisfaction with providers, and a greater number of physician visits in the previous year.²⁰ Another study in the Seattle area found that having insurance was strongly related to ease of access to care, and was the strongest predictor for having a regular source of care.²¹ When previously uninsured individuals were enrolled in a managed care program, investigators found their use of health care services similar to that of a commercially enrolled group.²²

Increased access to care for individuals infected with HIV represents one of the most recent dramatic instances of improvements in both mortality and morbidity. According to the Centers for Disease Control and Prevention, the first decrease in AIDS-related opportunistic infections occurred in 1997.²³ One of the major reasons cited was increased availability of new anti-retroviral therapies. The proportion of patients using this treatment regimen—for which many rely on public sector support through Medicaid and other programs—increased from 24% to 60% in just one year (1995 to 1996). This dramatic change is one demonstration of how access to critical treatments can make the difference between life and death.

Making health related services available to the uninsured at little or no cost has also led to improved outcomes. For example, the Women, Infants, and Children program, which provides food assistance to low-income children starting with the prenatal period, has helped reduce the prevalence of iron-deficiency anemia in infants and children.²⁴ Similarly, a study in Wisconsin showed that children at an initial preventive health visit who did not have access to the free Early and Periodic Screening, Diagnosis, and Treatment program had a greater number of medical and dental health problems and fewer preventive dental care visits than their contemporaries who had had continual access to the program.²⁵



THE HEALTH CARE MARKET AND CARE FOR THE UNINSURED

Over the last decade, changes in the health care market have significantly affected the provision of care to the uninsured.²⁶ Rising premiums and eroding employer-offered coverage have left increasing numbers of workers, especially low-income workers in small firms, without access to affordable health insurance. The rising numbers of uninsured increase the demand for uncompensated care on "safety net" providers—those that are charged by legal mandate or by mission with providing care to all regardless of ability to pay—as well as on other charity providers.

This increased demand is occurring simultaneously with other market changes that make it more difficult for providers to respond. An increasingly competitive health care environment, increased efforts to contain costs, and the growth of managed care have reduced the financial resources available to providers to subsidize care for the uninsured.

For example, many states have enrolled Medicaid recipients in managed care plans in an effort to reduce costs. These plans generally negotiate with providers for lower fees and also contract with multiple providers to provide services to Medicaid clients in order to obtain the best rates. However, while these changes may help reduce the overall costs of the program, they can have indirect effects on the ability of charity providers to care for the uninsured. Because major charity providers usually treat large numbers of both Medicaid and uninsured patients, they have traditionally depended on Medicaid revenues to help subsidize care for those who are unable to pay. If their Medicaid revenues decline, both because they see fewer Medicaid patients and because they receive lower fees for those they do treat, less money is available to cross-subsidize uncompensated care for the uninsured.

Research studies have in fact found that the penetration of managed care plans in a market and pressure on reimbursements are associated with reduced access to care for the uninsured. They have shown that

- ◆ In general, access to health care for low-income uninsured people is lower in states with high Medicaid managed care penetration, compared to uninsured persons in states with low Medicaid managed care penetration; access to care for low-income uninsured persons is also lower in areas with high uninsurance rates.²⁷
- ◆ Physicians involved with managed care plans and those who practice in areas with high managed care penetration tend to provide less charity care.²⁸

•
•
•
•
•
•
•

- ◆ Between 1988 and 1997, while national hospital costs for uncompensated care remained around 6% of annual operating costs, the ratio of per capita expenses for the uninsured to per capita expenses overall declined by 22%. This change, which was associated with reductions in Medicaid reimbursement rates, indicated that the uninsured were losing ground compared to the insured in the number, level, or quality of services received.²⁹

In this environment, some safety net providers have in fact been forced to close, raising the question, "Where...will the safety net reside for the large number of uninsured in the community who do not qualify for [public] programs?"³⁰

COMMUNITY CONTEXT

Note: Information in this section was provided by Puentes de Amistad (Bridges in Friendship).

Somerton, Arizona is located about twelve miles south of the city of Yuma, which is the seat of Yuma County, and ten miles north of Arizona's western international border with Sonora, Mexico. In 1998, Somerton and the neighboring border community of San Luis, Arizona had a combined population of 17,700.³¹ Approximately 95 percent of the population is Hispanic,³² mainly Mexican-Americans and Mexicans. Many adult residents are migrant and seasonal farm workers. The Somerton area is economically depressed--in 1998, the unemployment rate was close to 50% in Somerton,³³ and over 70% in San Luis.³⁴ In 1996, only 8.8 percent of area residents graduated from high school.³⁵

While it is difficult to gather local data on the number of uninsured, in 1996 birth certificate information indicated that 12% of mothers who gave birth in Yuma County were uninsured.³⁶ In addition, the community is home to populations that are known to have high uninsurance rates: residents not born in the U.S., farm workers, and those who are unemployed or underemployed at least part of the year. In addition, the community is largely Spanish speaking, a group that often faces linguistic barriers to accessing health care.

In order to capture the experiences both of those seeking primary care and those seeking acute care in Yuma County, surveys were conducted at one community health center, Sunset Health Center, and one hospital, Yuma Regional Medical Center.

Sunset Health Center is a federally funded Migrant Health Center located in Somerton, with four satellite clinics in Yuma County. It provides primary care services, including maternal and child, dental, nutrition, and family planning services, as well as a variety of health promotion programs. The clinic serves approximately 1,500 clients who make 51,000 visits a year. The staff is predominantly Hispanic and bilingual.

Yuma Regional Medical Center (YRMC) is a private, non-profit community hospital located in the city of Yuma. YRMC is the only hospital in the county. It has 237 beds and last year had over 62,000 patient encounters. It provides ambulatory care, urgent care, and surgical services. Patients with needs beyond the capacity of YRMC are referred to facilities in Phoenix, Tucson, and San Diego.

•
•
•
•
•
•
•

SURVEY METHODOLOGY

Surveys were conducted by volunteer Lay Health Promoters (Promotores), all of whom were native Spanish speakers. All of the surveyors attended a full-day training session in survey administration, which was conducted by trainers from the Health Training Innovations Program of The Medical Foundation in Boston, Massachusetts. In addition, surveyors received additional training from Puentes de Amistad.

Initially, the surveyors identified respondents by going door-to-door in the Somerton and San Luis communities, as well as in some outlying areas. However, as information about the project spread, many uninsured residents also came to the Puentes de Amistad office to volunteer to be interviewed.

All survey interviews were conducted between May 16 and June 17, 2000. To be eligible to participate, respondents had to have received care during the past year at Sunset Health Center or Yuma Regional Medical Center while they were uninsured. (Health Center patients were eligible to participate if they received care at either the main clinic site in Somerton or at any of the center's satellite clinics.) Almost all respondents were farm workers or their family members. After completing the survey, respondents were given \$10 vouchers to purchase food at local grocery stores.

The Access Project arranged for entry of the data by an independent firm. The data were analyzed by Dennis Andrulis and Christina An of the State University of New York, Health Science Center at Brooklyn.

Surveys were completed for 345 respondents. 170 had received care at Sunset Health Center and 175 at Yuma Regional Medical Center. Because respondents were not randomly selected, the survey results cannot be generalized to the entire population of uninsured persons or of individuals receiving care at the targeted facilities. *The results reflect the experiences only of those surveyed.*

SURVEY FINDINGS

This section describes the survey results for respondents who received care at Sunset Health Center or Yuma Regional Medical Center while uninsured. It also compares their results with averages for all similar facilities included in CAMS nationwide. All comparisons are statistically significant unless otherwise indicated (ns = non-significant). See Appendix A for a table of the results for the Arizona facilities, as well as for the aggregate results for all similar facilities included in CAMS nationwide.

Note: For the purpose of analysis, all facilities included in the CAMS project were grouped by type (hospital or clinic), and by location (urban/suburban or rural.) These designations were determined by the organizations that sponsored the surveying. See Appendix B for a list of all facilities included in the project nationally.

SUNSET HEALTH CENTER

This section presents the results of the survey for Sunset Health Center (Sunset), and compares them with the results for All Rural Clinics (ARCs) included in CAMS.

RESPONDENT CHARACTERISTICS

Nearly all of the Sunset respondents were Hispanic, and all chose to take the survey in Spanish. One-third of the respondents answered on behalf of a child.

Ninety-seven percent of the respondents for Sunset identified themselves as Hispanic. In comparison, the average proportion of Hispanic respondents for ARCs was 53 percent. In addition, *all* the respondents chose to take the survey in Spanish, while the average proportion for ARCs was 32 percent.

Respondents varied in age, but the proportion of respondents younger than 29 years of age was much higher than the average for ARCs (63% vs. 46%, respectively). Indeed, one-third (33%) of the Sunset respondents answered on behalf of a child. In comparison, the average for ARCs was 20 percent.

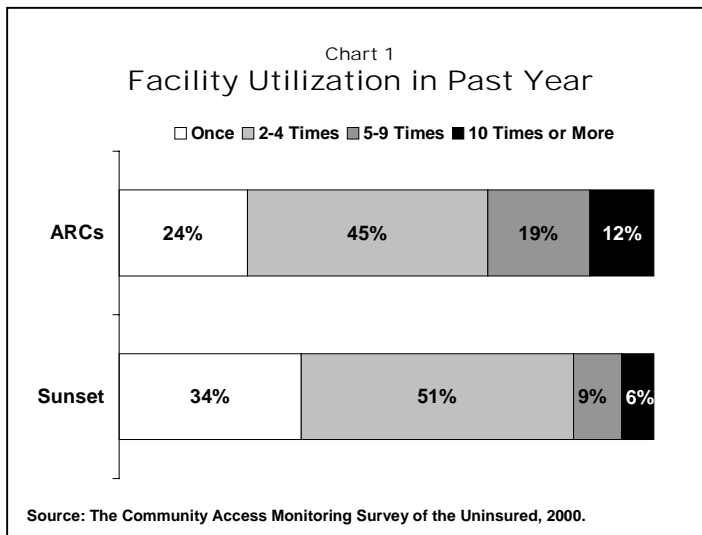
Seventy-one percent of the Sunset respondents were women, a proportion higher than the ARC average of 63 percent.

•
•
•
•
•
•
•
•
•
•

USE OF HEALTH SERVICES

Two of three respondents for Sunset used the facility more than once and one-fifth of the respondents said they sought care to treat a chronic problem.

Two-thirds of the Sunset respondents reported that they used the clinic more than once in the past year, which was less than the average for ARCs. (Chart 1)



One of five (20%) respondents for Sunset reported using the clinic to treat a chronic health problem such as asthma or diabetes. In comparison, the average for ARCs was 34 percent.

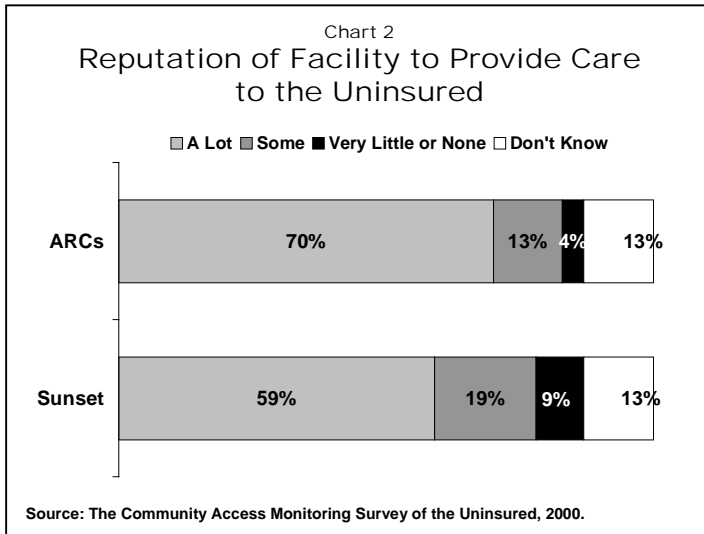
OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

The majority of the respondents said Sunset had been open and accepting to them even if they could not pay for their care, and that it had a positive reputation in the community for providing care to the uninsured. In addition, most respondents reported high levels of satisfaction with staff.

Four of five (79%) respondents for Sunset said that the facility had been “open and accepting” to them even if they were unable to pay, a proportion very similar to the ARC average (81%). Notably, however, five percent of the respondents said that, in their experience, the clinic did not provide them with any care because they were unable to pay.

Fifty-nine percent of Sunset respondents said that the clinic had a reputation in the community for providing “a lot” of care for people who cannot pay, which was slightly below the average for ARCs. However, several respondents thought that the clinic had a reputation

for providing only “some” or “very little or no care” to the uninsured. (Chart 2)



Generally, respondents for Sunset were satisfied with the care and service they received from their providers. For example, 89 percent of respondents stated that they were “very satisfied” or “satisfied” with their interactions with receptionists, 95 percent with nurses, and 87 percent with doctors. However, as many as eight percent of the respondents said that they were unsatisfied with their encounters with staff.

Finally, 93 percent of the respondents said that they were “always” treated with respect by staff.

ACCESSIBILITY

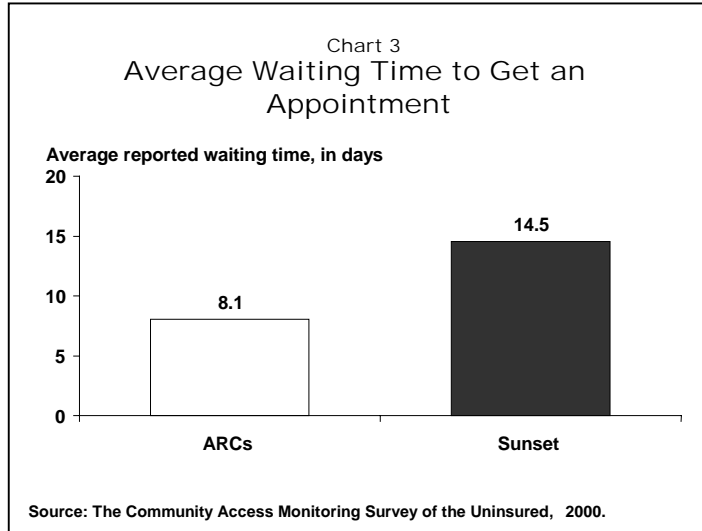
More than two of five respondents for Sunset said that waiting times and convenience to public transportation were problems for them at least sometimes.

Sunset respondents were two times more likely than the average for ARCs to report that they had problems with the clinic’s hours at least sometimes (29% vs. 15%, respectively). In addition, one of six (17%) respondents stated that the location of the clinic was a problem for them at least sometimes.

Waiting time to get an appointment was likely to be an issue for most Sunset respondents. Fully 54 percent of Sunset respondents stated that the waiting time to get an appointment was a problem at least sometimes, which was much higher than the ARC average (34%).

“If you are not a patient of the clinic and you are new it takes a long time before giving you an appointment.”
Sunset Respondent

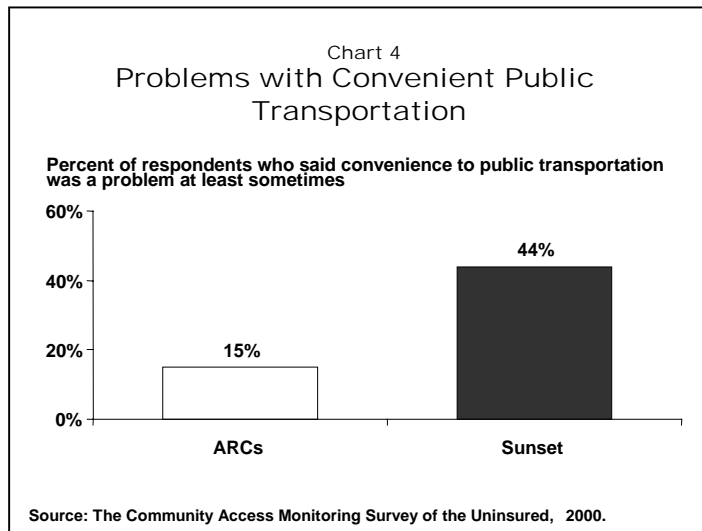
Indeed, the average reported waiting time for Sunset respondents was more than 6 days longer than the average for ARCs. (Chart 3)



Sunset respondents were just as likely to find the waiting time to see a provider on the day of an appointment a problem at least sometimes as respondents for ARCs (49% vs. 44%). However, the average reported waiting time for Sunset respondents was 20 minutes shorter than for respondents for ARCs (34 minutes vs. 55 minutes).

“There is no public transportation and I had to pay thirty dollars for the taxi.”
Sunset Respondent

Sunset respondents were three times more likely than the average for ARCs to report that they had problems with convenience to public transportation at least sometimes. (Chart 4)





Respondents were also asked whether transportation assistance if needed was a problem for them. Forty-one percent of the Sunset respondents said it had been a problem for them at least sometimes, which was much higher than the average for ARCs (15%).

“Sometimes I do not have a ride and the clinic is far. I can’t go walking and there is no public transportation and no help for any type of transportation.”
Sunset Respondent

LANGUAGE

One-half of the Sunset respondents said that they needed help with translations. Of those respondents who needed help, most reported that an interpreter was readily available and that the interpreter’s ability was very good.

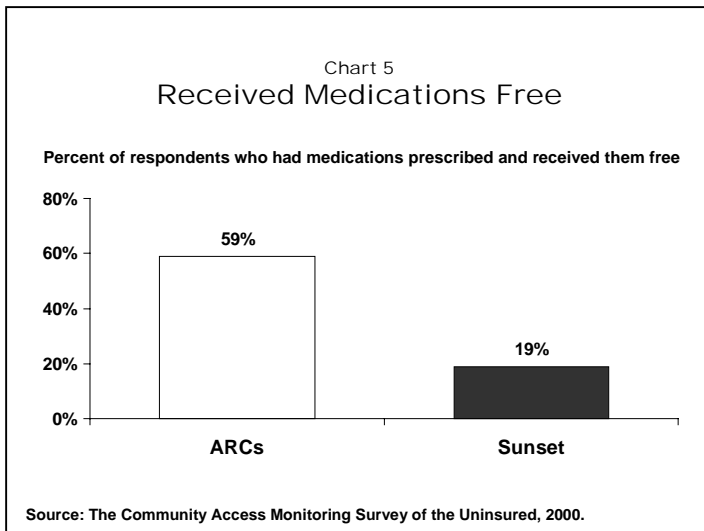
Half (46%) of the respondents reported that they needed help with translations. Of the respondents who needed help, 72 percent said that interpreters were “very available” and another 23 percent said they were “available.” In addition, most stated that the ability of the interpreters at Sunset was either “very good” (76%) or “fair” (18%).

OBTAINING PRESCRIPTION MEDICATIONS

Sunset respondents were less likely than the ARC average to report that paying for their medications was very difficult or that they needed help paying their bills.

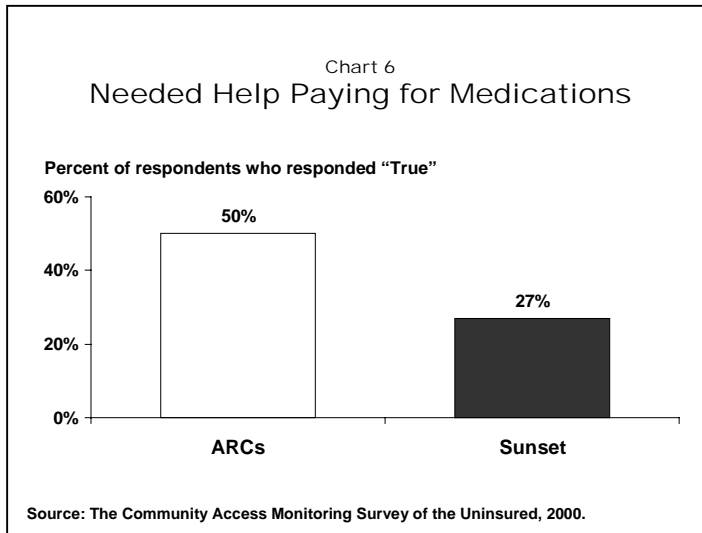
Three of five (64%) Sunset respondents reported that they had medications prescribed, less than the ARC average (80%).

Of those respondents who received prescriptions, the majority—60 percent—had to pay for their medications out-of-pocket at a drug store, while the proportion who said they received their medications free was lower than the 59 percent average for ARCs. (Chart 5)



•
•
•
•
•
•
•
•

Respondents for Sunset were *less* likely to report that paying for their medications was “very difficult” than the average for ARCs (26% vs. 43%, respectively). Twenty-seven percent of Sunset respondents said they needed help paying for their medications, a proportion that was also much smaller than the average for ARCs. (Chart 6)



“I didn’t buy it [medications], it was expensive.”
Sunset Respondent

“Sometimes we don’t have money for medicines so we go to Mexico.”
Sunset Respondent

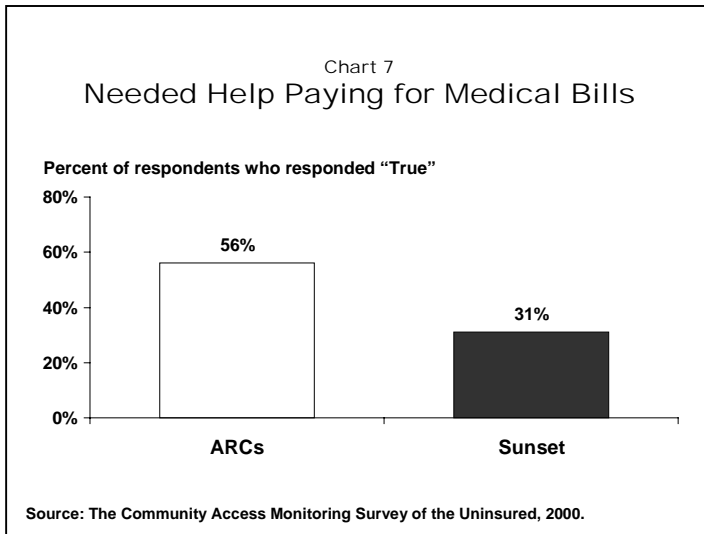
However, among the respondents who needed help, 74 percent reported that staff “never” asked if they needed financial assistance, and seven percent of the respondents reported that they did not get some of their medications due to cost.

CONCERNS OVER PAYMENT FOR HEALTH CARE

More than one-third of Sunset respondents stated that paying their medical bills was very difficult and that they needed financial help to pay them. Among the respondents who needed financial help, 65 percent said they never received any assistance.

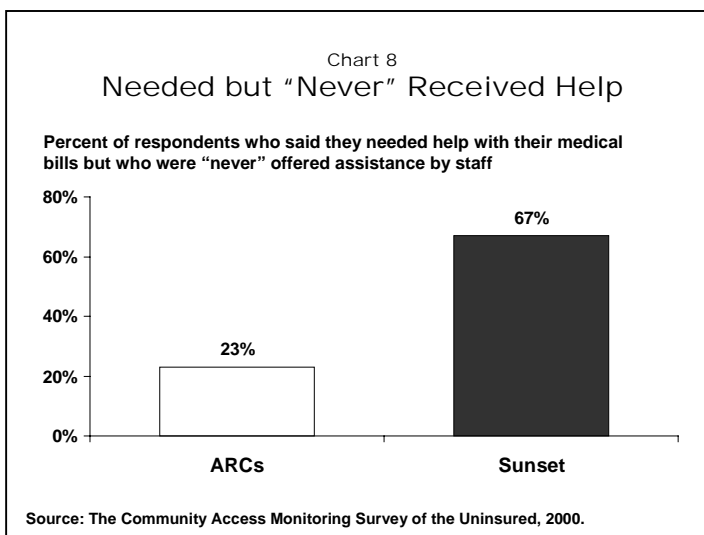
Two of five Sunset respondents (40%) said that paying their medical bills was “very difficult” compared with 45 percent of respondents for ARCs.

In addition, about one-third of the Sunset respondents reported that they needed help to pay their medical bills, a much lower proportion than the ARC average. (Chart 7)



Among the respondents who needed help, one-third (32%) of the respondents said staff offered them assistance at least sometimes. However, 67 percent of the respondents said they were "never" offered any assistance. (Chart 8)

"They did not offer me anything."
Sunset Respondent



For those respondents who received help, the most common form of assistance offered was a monthly billing plan (47%). Notably, only 16 percent of these respondents were offered reductions in fees, a proportion much lower than the average for ARCs (53%).

•
•
•
•
•
•
•

SEEKING CARE IN THE FUTURE

Several respondents said that their past experiences paying bills would deter them from seeking care at the clinic or would make them use a different facility in the future. About three of ten respondents owed money to the facility. Nevertheless, the majority of the respondents said they would use the facility again if they had health insurance.

When respondents were asked how their previous experiences paying bills at the clinic would affect their future care, most respondents (54%) said it would make seeking care at the clinic easier in the future, and another 20 percent said it would make no difference. However, eight percent of the respondents said they would not seek care at the clinic again because of their payment experiences and another 11 percent reported that they would use a different facility. Both figures were higher than the averages for ARCs.

“I am ashamed to take my kids to the physician because I think they know I owe thirty-five dollars.”

Sunset Respondent

Three of ten (29%) respondents for Sunset reported that they owe money to the clinic. However, this is proportionally smaller than the ARC average (48%). Fifteen percent of Sunset respondents who owed money said that the debt would deter them from seeking care again at the clinic.

An overwhelming majority—93 percent—of the respondents stated that they would use the clinic again even if they had health insurance.

YUMA REGIONAL MEDICAL CENTER

This section presents the results of the survey for Yuma Regional Medical Center (Yuma), and compares them with the results for All Urban and Suburban Hospitals (AUSHs) included in CAMS.

RESPONDENT CHARACTERISTICS

Yuma respondents varied in age. Nearly all respondents were Hispanic.

Respondents varied in age, but 29 percent answered on behalf of a child.

Ninety-six percent of the Yuma respondents identified themselves as Hispanic. In comparison, the average proportion of Hispanics for AUSHs was 37 percent. All of the respondents chose to take the survey in Spanish.

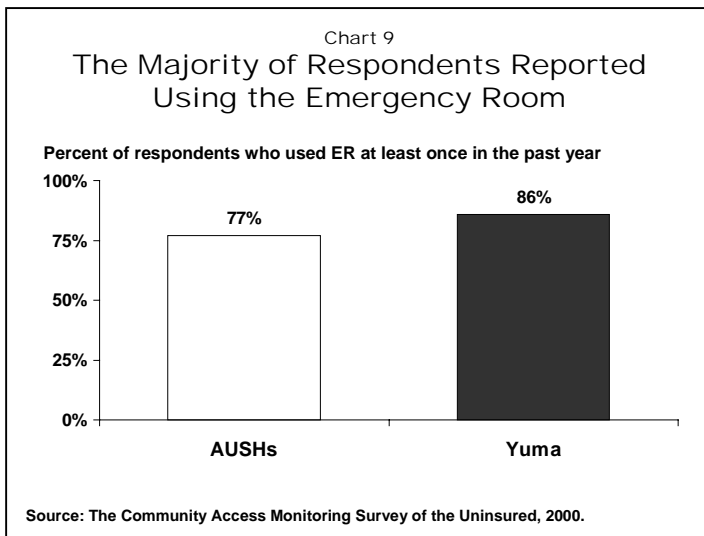


USE OF HEALTH SERVICES

Most Yuma respondents used the emergency room at least once in the past year, and about half used the hospital only once. Yuma respondents were less likely to have sought care for a chronic problem than the average for AUSHs.

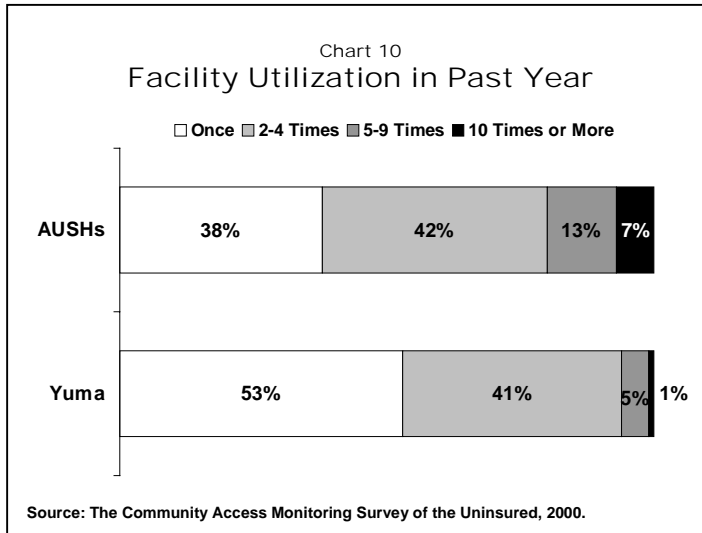
"It is difficult because I am an agricultural worker and the pay is low."
Yuma Respondent

Overall, the vast majority (86%) of Yuma respondents reported that they used the emergency room at least once in the past year, a figure higher than the average for AUSHs. (Chart 9)



In addition, Yuma respondents were *more* likely than the average for AUSHs to have been a hospital inpatient (54% vs. 32%, respectively) and *less* likely to have been a clinic outpatient (37% vs. 45%, respectively).

A little over half of the Yuma respondents used the hospital only once in the past year, while 47 percent of the respondents used it more than once. This was much lower than the average proportion using the facility more than once in the past year for AUSHs. (Chart 10)

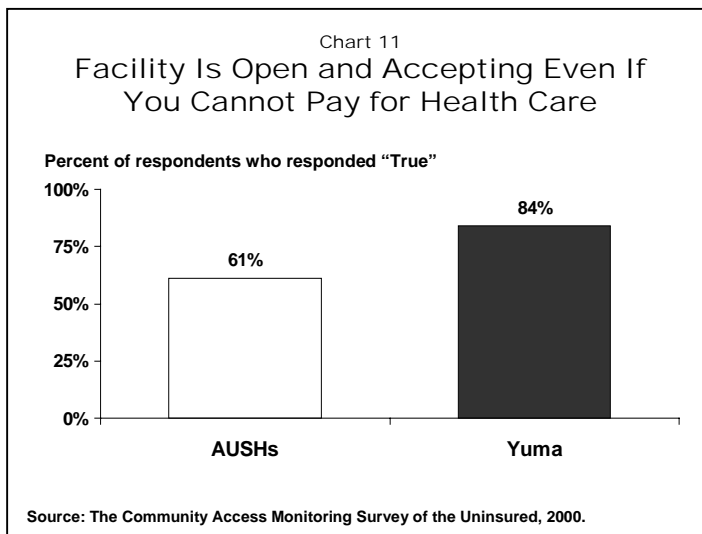


About one of five (22%) respondents for Yuma reported that they sought care to treat a chronic health problem compared with one-third (32%) of respondents for AUSHs.

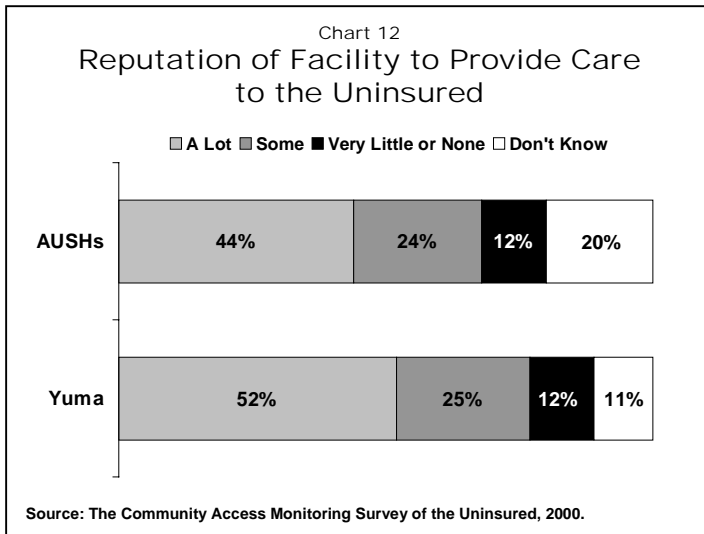
OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

Most of the respondents said the facility had been open and accepting to them and that it had a positive reputation in the community for providing care to the uninsured. In addition, the majority of the respondents were satisfied with the care they received from staff.

More than four-fifths of the respondents for Yuma reported that the facility had been “open and accepting” to them even if they were unable to pay for their care. This was higher than the average for AUSHs. (Chart 11)



About one-half (52%) of the Yuma respondents stated that the hospital had a reputation in the community for providing “a lot” of care to the uninsured and an additional 25 percent said Yuma had a reputation for providing “some” care to those who cannot pay. These proportions were higher than the averages for AUSHs. (Chart 12)



Overall, between 87% and 90% of the Yuma respondents said they were “very satisfied” or “satisfied” with the care they received from their nurses, physician assistants, and doctors. However, about one of five (18%) respondents for Yuma reported that they were dissatisfied with the care and service they received from billing clerks.

Four of five (81%) Yuma respondents reported that they were “always” treated with respect by hospital staff, a higher proportion than the average for AUSHs (61%).

ACCESSIBILITY

Many Yuma respondents reported problems related to accessibility indicators such as location, convenience of public transportation, and waiting time to see a provider.

Over 90 percent of the Yuma respondents said the hospital’s hours, including the emergency room’s hours, were “never a problem” for them.

Location, however, was an issue for nearly two-fifths of the respondents. Thirty-seven percent of Yuma respondents reported that the location of the hospital was a problem for them at least sometimes, while the average for AUSHs was 29 percent. However, the average

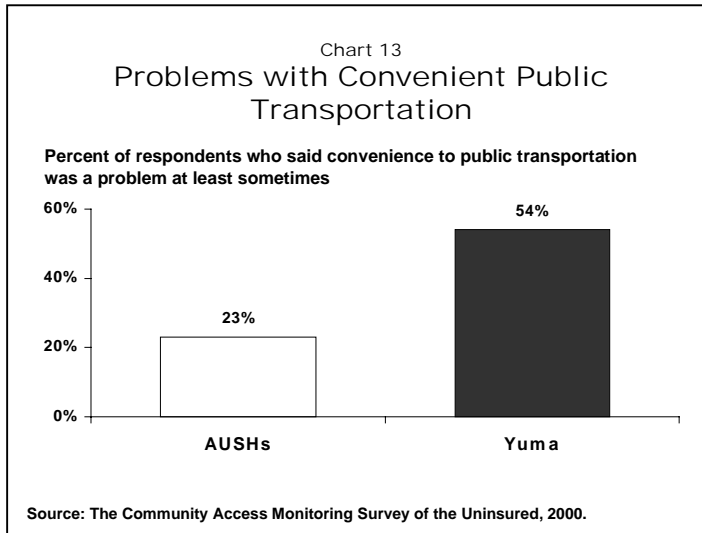
•
•
•
•
•
•
•

reported travel time was 23 minutes, only one minute longer than the average for AUSHs.

“Sometimes the transportation is bad, because I don’t drive and when my husband is not around I can’t go because the ambulance is very expensive.”
Yuma Respondent

When respondents were asked whether convenience to public transportation was an issue, more than half of the respondents said it was a problem at least sometimes. In comparison, the average for AUSHs was 23 percent. (Chart 13)

“I have a lot of problems because I don’t have any transportation and when we need to go to the emergency room it is difficult. There is no public transportation.”
Yuma Respondent



“They should have a program for people that have no transportation.”
Yuma Respondent

Moreover, Yuma respondents were more than twice as likely to report that they had problems at least sometimes getting assistance with transportation as respondents for AUSHs (42% vs. 19%, respectively).

Yuma respondents were less likely than the average for AUSHs to report that the waiting time to get an appointment was a problem at least sometimes (22% vs. 36%, respectively). Indeed, the average reported waiting time to get an appointment was 8.5 days compared with an average of nearly two weeks for AUSHs.

In addition, nearly three of five (59%) respondents for Yuma said the waiting time to see a provider on the day of the appointment was a problem (AUSH average was 52%). Yet, the average reported waiting time for Yuma respondents was about 10 minutes less than the average for AUSHs (53 minutes vs. 63 minutes, respectively).

LANGUAGE

About half of the Yuma respondents said that they needed help with translations. Most of these respondents reported that interpreters were available and that their ability was very good.

Nearly half (47%) of the Yuma respondents reported that they needed help with translations.

Compared with the average for AUSHs, Yuma respondents were more likely to report that an interpreter was “very available” or “available” (45% vs. 57%, respectively). Notably, however, 43 percent reported that an interpreter was “not very available” or “unavailable.” When asked about the ability of their interpreters, most (58%) Yuma respondents said they were “very good”.

Yuma respondents were also more likely to report that the waiting area had signs in their language and that they were provided with written information in their language than the average for AUSHs.

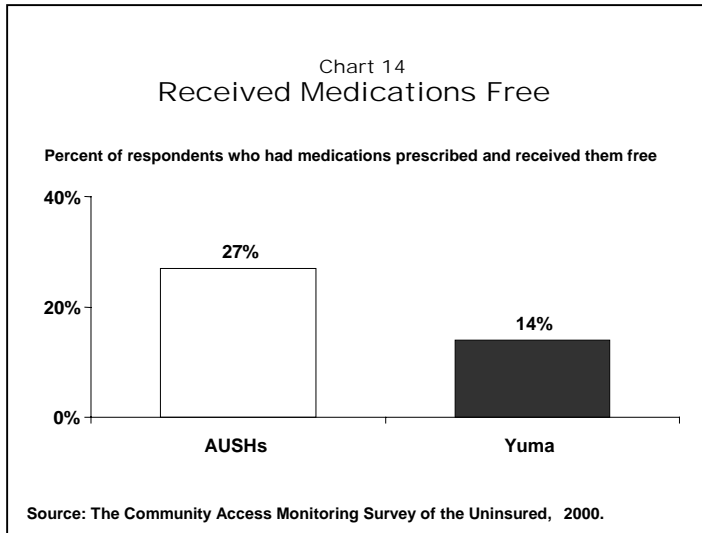
OBTAINING PRESCRIPTION MEDICATIONS

About three of ten respondents said paying for their medications was very difficult and that they needed help paying for them. These respondents were less likely to receive their medications free than the average for AUSHs.

About three-fourths (72%) of Yuma respondents reported that they had medications prescribed, which was the same as the average for AUSHs.

The great majority—79 percent—of respondents who received prescriptions filled them at a pharmacy and paid out-of-pocket. The average for AUSHs was much lower (57%). One of seven (14%) respondents who needed medications reported that they received them at no cost; this proportion was half that for AUSHs. (Chart 14)

•
•
•
•
•
•
•
•



Notably, nearly all (98%) of the Yuma respondents stated that they understood their medication instructions.

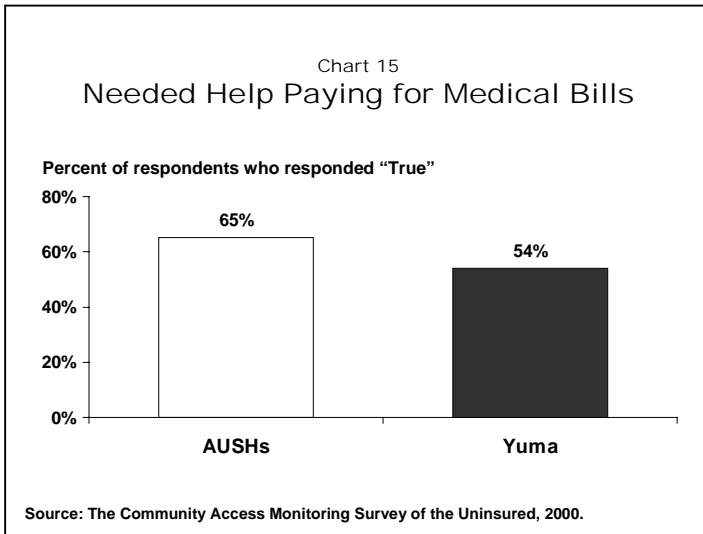
A little more than one-fourth (27%) of the respondents reported that paying for medications was very difficult for them. In comparison, the average for AUSHs was 40 percent.

One-third (34%) of the Yuma respondents reported that they needed help paying for their medications. Yet, 91 percent of these respondents stated that staff “never” asked them if they needed financial assistance.

CONCERNS OVER PAYMENT FOR HEALTH CARE

More than half of the Yuma respondents said that paying their medical bills was very difficult and that they needed help paying for them.

Nearly seven of ten (68%) Yuma respondents reported that paying their medical bill was “very difficult.” The average for AUSHs was slightly lower (61%). Fifty-four percent reported that they needed help paying their medical bill, a proportion somewhat smaller than the average for AUSHs (65%). (Chart 15)



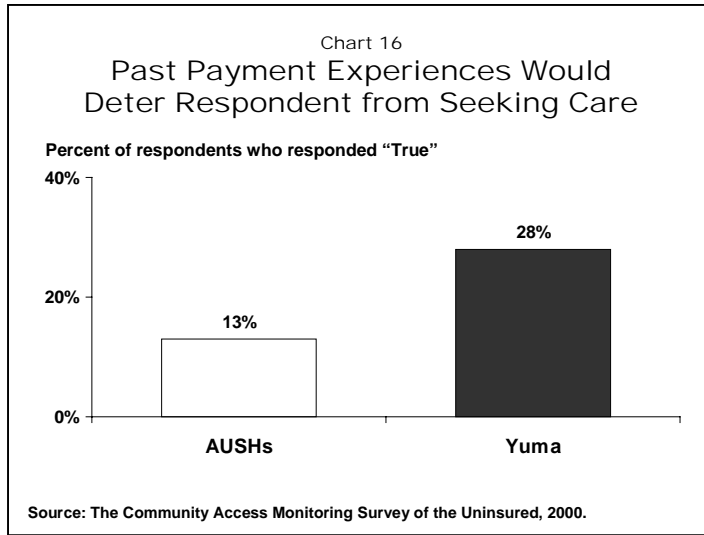
Among the Yuma respondents who said they needed help, more than half (54%) reported that they were “never” offered assistance by staff.

Among the Yuma respondents who received help, the form of assistance received most frequently was a monthly billing plan (61%), followed by referral to charitable organizations (23%), and reductions in the bills (14%). Only two percent of the respondents stated the facility waived their bill.

SEEKING CARE IN THE FUTURE

More than one-fourth of the Yuma respondents said their past experiences paying bills at the hospital would deter them from seeking care there again, and another third said that they would use a different facility. Furthermore, nearly two-thirds of the respondents were in debt to the facility, and of these respondents more than two out of five said the debt would discourage them from seeking care there in the future. Nearly all respondents said they would use the facility again if they had health insurance.

More than one-fourth of the Yuma respondents reported that their previous experiences paying bills at the hospital would deter them from seeking care there again, a proportion much higher than the 13 percent average for AUSHs. (Chart 16)



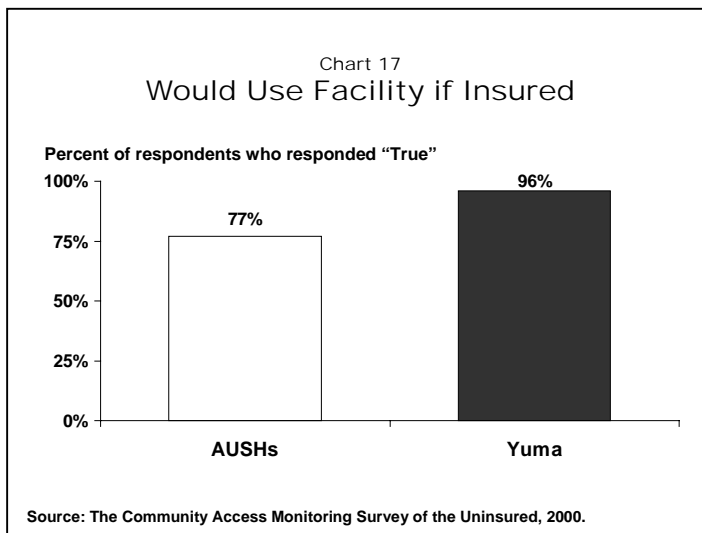
In addition, Yuma respondents were three times more likely than the average for AUSHs to report that their past experiences paying bills would make them use a different facility (31% vs. 10%, respectively).

"I'd rather not go there because I owe, and I am scared of another debt."
Yuma Respondent

Sixty-three percent of Yuma respondents reported that they were in debt to the hospital, similar to the average for AUSHs. However, of those respondents who were in debt, two of five (44%) said the debt would discourage them from seeking care at the hospital again, a proportion much higher than the AUSH average (28%).

"I don't know when I will be finished paying and I'm not going to charge more to my account."
Yuma Respondent

An overwhelming majority of respondents—96 percent—reported that they would use the hospital if they had health insurance. (Chart 17)



DISCUSSION

This section discusses some of the perceived strengths, as well as issues that might warrant further consideration, suggested by the survey results for Sunset Health Center and Yuma Medical Center.

SUNSET HEALTH CENTER: KEY FINDINGS

Strengths of Sunset Health Center suggested by the survey results include the following:

- ◆ Four of five Sunset respondents reported that the clinic had been “open and accepting” to them even if they could not pay for their care.
- ◆ The majority of respondents reported that they were satisfied with the care and service they received from staff.
- ◆ About half of the respondents reported that they needed help with translations. Almost all of these respondents said interpreters were available, and most said that their ability was “very good.”
- ◆ Respondents were less likely to report difficulty paying for medical care and prescriptions than the averages for ARCs. In addition, about three in ten respondents said they owed the clinic money, while the ARC average was close to 50 percent.
- ◆ Ninety-three percent of the respondents said they would use the clinic again if they had health insurance.

The following survey results suggest issues that might warrant further consideration:

- ◆ Sunset respondents were less likely than the ARC average to report that the clinic has a reputation in the community for providing “a lot” of care to the uninsured.
- ◆ The average reported time to get an appointment at Sunset was over two weeks, nearly a full week longer than the average for ARCs.
- ◆ More than 40 percent of Sunset respondents reported that convenience to public transportation and getting transportation assistance when needed had been a problem at least sometimes, figures that were much higher than the averages for ARCs.
- ◆ Among those respondents who received prescriptions for medications, only one-fourth received the medications at no cost. The average for ARCs was three times higher.

•
•
•
•
•
•
•

- ◆ Among respondents who said they needed help paying their medical bills, two-thirds said they “never” received help, almost three times the ARC average.

YUMA REGIONAL MEDICAL CENTER: KEY FINDINGS

Strengths of Yuma Regional Medical Center suggested by the survey results include the following:

- ◆ Four of five respondents reported that in their experience the hospital had been open and accepting to them even if they could not pay. In comparison, the average for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide was 61 percent.
- ◆ About half of Yuma respondents reported that the hospital has a reputation in the community for providing “a lot” of care, slightly higher than the AUSH average.
- ◆ The majority of the respondents reported that they were satisfied with their interactions with staff.
- ◆ The average reported time to get an appointment was 8.5 days, nearly a week shorter than the average for AUSHs.
- ◆ Nearly all (98%) the respondents said they would use the hospital again if they had health insurance.

The following survey results suggest issues that might warrant further consideration:

- ◆ Yuma respondents were more likely to have used the emergency room, more likely to be admitted as an inpatient, and less likely to have been a clinic patient than the averages for AUSHs.
- ◆ More than two-fifths of the respondents reported that convenience to public transportation and getting transportation assistance when needed had been a problem at least sometimes, much higher than the averages for AUSHs.
- ◆ Although more than half of the respondents reported that they needed financial assistance to pay for medical care and one-third that they needed help paying for medications, the majority said they were “never” offered any assistance by staff. Moreover, Yuma respondents were more likely to pay for medications out of pocket and less likely to receive them free than the averages for AUSHs. In addition, about one of five respondents said they were dissatisfied with the service they received from billing clerks.



- ◆ More than one-fourth of the respondents said their past experiences paying bills at the hospital would deter them from seeking care there again, and another third said that they would use a different facility. Furthermore, nearly two-thirds of the respondents were in debt to the hospital, and over 40 percent of these respondents said their indebtedness would discourage them from seeking care at the hospital again.
- ◆ Half the respondents required assistance with translations. Although more than half of the respondents who needed assistance reported that interpreters were readily available, 43 percent said interpreters were “not very available” or “unavailable.”

CONCLUSION

This report provides information on a topic that has not often been investigated, the experiences of the uninsured when they access health care at their local health facilities. Given the large numbers of uninsured in our country, it is a topic of increasing importance.

Because the survey was not based on a random sample, the results are more suggestive than definitive. Notwithstanding its limitations, however, the authors expect that the results will be useful in suggesting issues and questions that would benefit from further discussion and investigation as communities attempt to ensure and improve access to care for their uninsured residents.

•
•
•
•
•
•
•
•

REFERENCES

- ¹ Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, *America's Health Care Safety Net: Intact but Endangered*, Institute of Medicine, National Academy Press, Washington D.C., 2000.
- ² U.S. Census Bureau, *Health Insurance Historical Tables*, Washington D.C., 2000.
- ³ Harvard/Robert Wood Johnson Foundation Report on Public Attitudes Towards Access to Health, 1999, cited in "RWJF Steps Up Insurance Coverage Initiatives," *Advances: The Robert Wood Johnson Foundation Quarterly Newsletter*, 1 (2000): 2.
- ⁴ G. Melnick, cited in "Hospitals' Uncompensated Care Expenses Not Keeping Pace with Per Capita Spending," *Health Care Financing & Organization News & Progress*, The Alpha Center, Washington D.C., March 2000: 6.
- ⁵ K. Donelan, R. Blendon, J. Benson, R. Leitman, and H. Taylor, "All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations," *Health Affairs* (Millwood), 15 (1996): 254-265.
- ⁶ Health Desk, *National Survey on the Uninsured, 2000*, Newshour with Jim Lehrer/Kaiser Family Foundation, Menlo Park, April 2000.
- ⁷ B. Spillman, "The Impact of Being Uninsured on Utilization of Basic Health Care Services," *Inquiry*, 29 (1992): 457-466.
- ⁸ D.D. McAlpine and D. Mechanic, "Utilization of Specialty Mental Health Care Among Persons with Severe Mental Illness: The Roles of Demographics, Need, Insurance, and Risk," *Health Serv Res*, 35(1 Pt 2) (2000): 277-92.
- ⁹ P.W. Newacheck, C. Brindis, C.U. Cart, K. Marchi, and C.E. Irwin, "Adolescent Health Insurance Coverage: Recent Changes and Access to Care," *Pediatrics*, 104 (1999): 195-202.
- ¹⁰ H. Burstein, S. Lipsitz, and T. Brennan, "Socioeconomic Status and Risk for Substandard Medical Care," *JAMA*, 268 (1992): 2383-2387.
- ¹¹ J. Weissman, and A. Epstein, "Case Mix and Resource Utilization by Uninsured Hospital Patients in the Boston Metropolitan Area," *JAMA*, 261 (1989): 3572-3576.
- ¹² Kaiser Commission on Medicaid and the Uninsured, *Uninsured Facts*, The Henry J. Kaiser Family Foundation, May 2000.
- ¹³ National Academy on Aging, "One in Four: Child Poverty in America," *The Public Policy and Aging Report*, 1997, 8.
- ¹⁴ Kaiser Family Foundation, *The Uninsured and Their Access to Health Care*, May 2000.
- ¹⁵ Kaiser Commission on Medicaid and the Uninsured, *op cit*.

-
- ¹⁶ J. Hadley, E. Steinberg, and J. Feder, "Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use, and Outcome," *JAMA*, 265 (1991): 374-379.
- ¹⁷ J.M. Ferrante, E.C. Gonzalez, R.G. Roetzheim, N. Pal, L. Woodward, "Clinical and Demographic Predictors of Late-Stage Cervical Cancer," *Arch Fam Med* 9(5): (2000): 439-45.
- ¹⁸ J. Ayanian, B. Kohler, T. Abe, and A. Epstein, "The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer," *New England Journal of Medicine*, 329: (1993): 326-331.
- ¹⁹ P. Franks, C. Clancy, and M. Gold, "Health Insurance and Mortality: Evidence from a National Cohort," *JAMA*, 270 (1993): 737-741.
- ²⁰ J.D. Kasper, T.A. Giovannini, and C. Hoffman, "Gaining and Losing Health Insurance: Strengthening the Evidence for Effects on Access to Care and Health Outcomes," *Med Care Res Rev*, 57(3): (2000): 298-318; discussion 319-25.
- ²¹ B. Saver and N. Peterfreund, "Insurance, Income and Access to Ambulatory Care in King County, Washington," *American Journal of Public Health*, 83 (1993): 1583-1588.
- ²² H. Bograd, D. Ritzwoller, N. Calonge, K. Shields, and M. Hanrahan, "Extending Health Maintenance Organizations to the Uninsured: A Controlled Measure of Health Care Utilization," *JAMA*, 277 (1997): 1067-1072.
- ²³ "Update: Trends in AIDS Incidence—United States, 1996," *Morbidity and Mortality Weekly Report*, 46 (1997): 861-867.
- ²⁴ B.L. Devaney, M.R. Ellwood, and J.M. Love, "Programs that Mitigate the Effects of Poverty on Children," *Future Child*, 7(2): (1997) 88-112.
- ²⁵ B.R. Clarridge, B.J. Larson, and K.M. Newman, "Reaching Children of the Uninsured and Underinsured in Two Rural Wisconsin Counties: Findings from a Pilot Project," *Journal of Rural Health*, 9(1): (1993), 40-49.
- ²⁶ See for example Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers, *op cit*.
- ²⁷ P. Cunningham, "Pressures on Safety Net Access: The Level of Managed Care Penetration and Uninsurance Rate in a Community," *Health Services Research*, 34 (1998): 255-270.
- ²⁸ P. Cunningham, et al, "Managed Care and Physicians' Provision of Charity Care," *JAMA*, 281 (1997): 1087-1092.
- ²⁹ G. Melnick, *op cit*.
- ³⁰ D. Andrulis and M. Gusmano, *Public-Private Community Initiative and Partnership in Designing and Financing Health Care for the Uninsured*, New York Academy of Medicine, 2000.
- ³¹ Arizona Department of Commerce Communications Division, *Profile: Yuma County, Arizona*, Phoenix, 1999.

•
•
•
•
•
•
•
•

³² Bureau of Health Systems Development, *Somerton Primary Care Area (PCA): Statistical Profile*, Arizona Department of Health Services, 2000.

³³ Arizona Department of Commerce Communications Division, *Community Profile: Somerton*, Phoenix, 1999.

³⁴ Arizona Department of Commerce Communications Division, *Community Profile: San Luis*, Phoenix, 1999.

³⁵ S. Kunz, K. Driesen, and M.F. Baum, *Health Services: Arizona Border Community Health Indicators*, Border Health Foundation, January, 1998.

³⁶ *Ibid.*

ACKNOWLEDGEMENTS

Puentes de Amistad would like to thank the many people who were involved in the CAMS project. This project would not have been successful without the enthusiasm of the Promotores/Surveyors, the dedication and attention to detail of the Puentes de Amistad staff, and the assistance of Border Health Foundation personnel. Special thanks also go to the staff at The Access Project who provided guidance and acted as mentors throughout the surveying process.

The promotores/surveyors were lay health educators who included parents, housewives, heads of households, and other hard working and positive individuals with a helping spirit and progressive attitude. They completed the surveys in spite of demanding deadlines, temperatures as high as 115 degrees, dogs, and poor transportation. Their success depended on their flexibility, patience, and attitude of respect toward everyone with whom they worked.

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

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

- ◆ Bill Lottero, the Site Coordinator, who worked directly with Puentes de Amistad to help plan the project, and who provided consultation throughout the project's duration.
- ◆ Bill Hewett and Meg Baker, who provided invaluable administrative support in the production of the report
- ◆ Nancy Kohn, who provided overall coordination of the project and attended to the myriad of details necessary to keep it on track

In addition, we want to express our appreciation to our colleagues at Community Catalyst Inc., whose participation in the project was essential to its success.

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