



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at Four Facilities in
Nampa and Twin Falls, Idaho*

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
the Idaho Primary Care Association (IPCA)*

February 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

The **Idaho Primary Care Association (IPCA)** is a 501(c)(3) not-for-profit organization incorporated in 1982. IPCA is the statewide membership association for Idaho's Community Health Centers. Its mission is to be a support system and an advocate for safety net providers and a leader in addressing the need for expanded health care access for Idaho's medically underserved communities and populations.

For more information, please contact:

Bill Foxcroft, Executive Director
4948 Kootenai, Suite 205
Boise, Idaho 83705
Phone: (208) 345-2335

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

 Nampa 17

 Twin Falls..... 18

Survey Methodology 20

Survey Findings..... 22

 Mercy Medical Center and Magic Valley Regional
 Medical Center 22

 Terry Reilly Health Services and Family Health Services 31

Discussion 38

References..... 42

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 two communities in Idaho, Nampa and Twin Falls. The survey was conducted in the summer of 2000 and gathered information from 619 uninsured patients who obtained health care at Mercy Medical Center (MMC), Magic Valley Regional Medical Center (MVRMCC), Terry Reilly Health Services (TRHS), or Family Health Services (FHS), 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

MERCY MEDICAL CENTER AND MAGIC VALLEY REGIONAL MEDICAL CENTER

- ◆ Respondents for Mercy Medical Center (MMC) and Magic Valley Regional Medical Center (MVRMC) reported waiting times both to get appointments and to see providers on the day of an appointment that were significantly shorter than the averages for All Urban and Suburban Hospitals (AUSHs) included in the CAMS project nationwide.
- ◆ Both groups of respondents were more likely than the AUSH average to report using their hospital only once in the past year, and less likely to report using it more than five times.
- ◆ Most respondents for both hospitals rated the care and service they received from hospital staff as either “very satisfactory” or

•
•
•
•
•
•
•
•

“satisfactory,” although respondents for MVRMC were somewhat more likely to report that they were “always” treated with respect (78%) than respondents for MMC (63%).

- ◆ A majority of respondents for both hospitals said that their hospital had been open to them even if they couldn’t pay for care. MVRMC respondents were somewhat more likely than MMC respondents to report that their hospital had a reputation for providing “a lot” of care to the uninsured.
- ◆ More MVRMC respondents than MMC respondents said they needed assistance with translations. However, among respondents who needed assistance, MMC respondents were more likely than either MVRMC respondents or the AUSH average to find interpreters readily available.
- ◆ MMC respondents were more likely than MVRMC respondents to report that paying their medical bills was very difficult and that they needed help paying their bills. Among respondents who said they needed help, about half of both groups said that staff never offered to find out if help was available.
- ◆ Of respondents who received prescriptions, about a quarter of each group said they received their medications free, similar to the AUSH average. However, the proportion of respondents saying they paid for their medications out-of-pocket was much higher for MVRMC respondents than for either MMC respondents or the AUSH average.
- ◆ Two-thirds of both respondent groups said they owed money to their facility. MMC respondents were almost twice as likely as MVRMC respondents to report that their debt would deter them from seeking care at their facility in the future.

TERRY REILLY HEALTH SERVICES AND FAMILY HEALTH SERVICES

- ◆ Nearly 90% of respondents for both Terry Reilly Health Services (TRHS) and Family Health Services (FHS) used their clinic two or more times in the past year.
- ◆ FHS respondents were more likely than the average for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide to report that their clinic had been “open and accepting” to them even if they were unable to pay for their care. Responses for TRHS were similar to the AUSC averages.
- ◆ Respondents for both clinics were generally satisfied with their interactions with staff. However, TRHS respondents were somewhat more likely than FHS respondents to report dissatisfaction.

- ◆ FHS respondents reported waiting times both to get an appointment and to see the provider on the day of the appointment that were considerably shorter than the average for AUSCs. The times reported by TRHS respondents were similar to AUSC averages.
- ◆ Although about one-third of each respondent group said they required assistance with translations, FHS respondents were somewhat more likely to report that interpreters were available. However for both groups, over 90 percent of respondents who received assistance said the ability of their interpreters was “very good” or “fair.”
- ◆ FHS respondents were more than three times as likely as TRHS respondents to report that they received prescribed medications for free. However, a higher than average proportion of respondents for both groups reported that they paid for their medications out-of-pocket.
- ◆ About half of the respondents in each group said they needed help paying for their medical care. Sixty-two percent of FHS respondents said that staff always or often offered to find out if assistance was available; this compared to 38 percent of TRHS respondents and an AUSC average of 53 percent.
- ◆ Between 43 and 52 percent of respondents for both clinics said their past experiences paying for care would either make it easier, or would not affect, their likelihood of seeking care at their clinic in the future. However, respondents for both clinics were much more likely to report being in debt to their clinic than the average for AUSCs. Of respondents who were in debt, TRHS respondents were somewhat more likely than FHS respondents to say that the debt would deter them from seeking care at the clinic in the future.
- ◆ Almost all (95%) FHS respondents said they would use the clinic again if they had health insurance. The proportion for TRHS respondents was similar to the AUSC average (79% and 82% respectively).

COMPARISON OF HOSPITALS AND CLINICS

Note: Differences between hospitals and clinics should be interpreted with caution. The points highlighted below are intended to serve only as topics for further discussion and do not imply statistically significant differences.

- ◆ Larger proportions of clinic than hospital respondents reported that they visited their facility more than once in the past year, and that they sought care to treat a chronic problem.

•
•
•
•
•
•
•

- ◆ Clinic respondents were more likely than hospital respondents to say that their facility had been open and accepting to them even if they were unable to pay.
- ◆ Hospital respondents were more likely than clinic respondents to report that paying their medical bills was very difficult, and that they needed help paying their bills. However, larger proportions of clinic respondents said that staff offered to find out if financial assistance was available, at least sometimes, than respondents for hospitals.
- ◆ Hospital respondents were more likely than clinic respondents to report that they owed money to their facility.
- ◆ About four of five respondents or more for both the hospitals and the clinics said that they would use their facility 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. It is hoped that this information will assist communities in improving access to care for their uninsured residents.

ABOUT THIS REPORT

This report, along with reviewing some of the general research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site in Idaho. The survey was conducted by the Idaho Primary Care Association (IPCA) in the summer of 2000, and gathered information from uninsured individuals who received care in the previous year at Terry Reilly Health Services or Mercy Medical Center in Nampa, Idaho, or at Family Health Services or Magic Valley Regional Medical Center in Twin Falls, Idaho. Along with providing the results of the survey for these facilities, the report compares the results with aggregate responses at all similar facilities surveyed as part of the CAMS project nationwide. A report presenting the overall findings for all surveyed sites will be released in Spring 2001.

•
•
•
•
•
•
•

LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

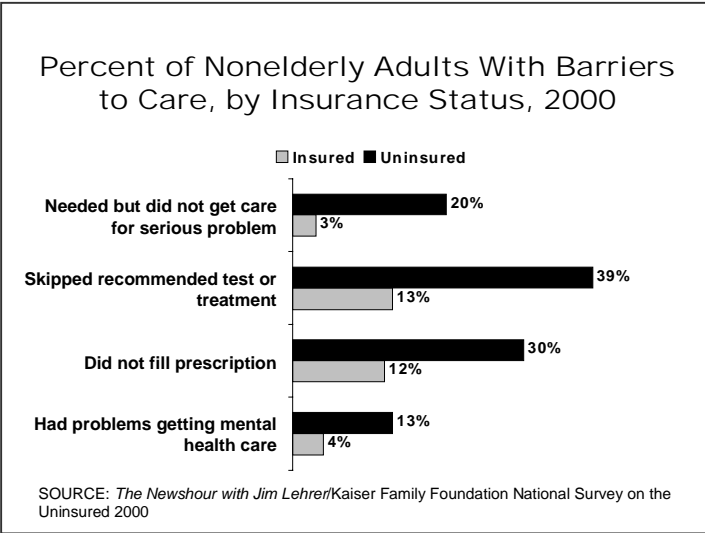
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

LACK OF INSURANCE AND ACCESS TO CARE

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

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

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



LACK OF INSURANCE AND HEALTH OUTCOMES

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

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

•
•
•
•
•
•
•
•

BENEFITS OF IMPROVED ACCESS TO HEALTH CARE

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

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

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



THE HEALTH CARE MARKET AND CARE FOR THE UNINSURED

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

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

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

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

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

•
•
•
•
•
•
•

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

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



COMMUNITY CONTEXT

Note: Information in this section was provided by the Idaho Primary Care Association (IPCA).

The state of Idaho has seen its population increase by more than 20% in the past decade; it now has over 1,250,000 residents, of whom more than 239,000, or 19.2%, lack health insurance.³¹ According to a 1998 New York Times feature story, Idaho's policies are among the worst in the nation in terms of supporting the needs of poor families.³² Its Medicaid program, for example, covers low-income families at only the federal minimum levels, while the Children's Health Insurance Program (CHIP) covers children only in families earning up to 150% of the Federal Poverty Level.³³

Recently, simplification of Idaho's application process for Medicaid and CHIP has led to more than 17,000 children receiving health insurance coverage.³⁴ State dollars, however, have not been used to expand access to health coverage or health care services for uninsured people who are ineligible for Medicaid.

To better understand the needs of the uninsured, the Idaho Primary Care Association (IPCA) surveyed uninsured people in two representative Idaho communities, Nampa, in Canyon County, and Twin Falls, in Twin Falls County. In each community, IPCA surveyed patients who had accessed services while uninsured at one of two health care facilities. In Nampa, the facilities were Mercy Medical Center, a 149-bed hospital, and Terry Reilly Health Services, a Community Health Center (CHC). In Twin Falls, the facilities included Magic Valley Regional Medical Center, a 177-bed hospital, and Family Health Services, a CHC.

Both of the CHCs are funded under Section 330 of the Public Health Services Act to serve the uninsured and underinsured, and all of the participating health care facilities have a mission to provide care for all regardless of the ability to pay. The administrators at all of these facilities agreed to participate in the project and expressed support for using the survey findings to identify opportunities for improving access and care for the uninsured.

NAMPA

Nampa, Idaho is a city of 46,000, which is just over a third of the total population of Canyon County. Located approximately 20 miles from Boise, three of Nampa's top eight employers are food-processing

•
•
•
•
•
•
•
•

plants. These plants are supported by agricultural business in the areas surrounding Nampa.³⁵

According to the Idaho Department of Health and Welfare, in 1998, Canyon County was approximately 17.5% Hispanic. According to Census data, in 1990 Canyon County had slightly less than 21,000 migrant/seasonal farm workers. In addition, approximately 19,495 people were living in poverty and about 49,109 county residents had incomes below 200% of the Federal Poverty Level.³⁶

In Nampa, Mercy Medical Center, a member of the Catholic Health Initiatives health care system, provides inpatient, outpatient, emergency, and behavioral health services. It is the fourth largest employer in Nampa. In 1999, the 149 bed hospital reported 6,043 hospital admissions and 117,311 outpatient visits.³⁷

Terry Reilly Health Services (TRHS), which was established in 1971, serves Canyon County, Ada County, and Owyhee County at four medical clinic sites in Nampa, Boise, Marsing and Homedale. In addition, dental services are provided at a dental clinic in Nampa and a new dental site in Boise.³⁸ In 1999, it had more than 17,500 patients, of whom 55% were uninsured, and over 3,000 were migrant seasonal farm workers. TRHS provides services on a sliding scale; their services include case management and bilingual and translation services.³⁹

TWIN FALLS

Twin Falls is a town of about 34,000 people, which is approximately half of the total population of Twin Falls County. Three of the top eight employers are food-processing companies supported by the agricultural business in the areas surrounding Twin Falls. In 1998, according to the Idaho Department of Health and Welfare, Twin Falls County was approximately 8% Hispanic. According to 1990 Census data, Twin Falls County had just over 8,000 migrant seasonal farm workers. In addition, approximately 8,835 people were living in poverty and about 25,203 residents had incomes below 200% of the Federal Poverty Level.⁴⁰

Magic Valley Regional Medical Center in Twin Falls was established in 1918. Its service area includes eight counties in South Central Idaho and one in Northern Nevada. It is the largest employer in Twin Falls. It provides inpatient, outpatient, emergency, and behavioral health services. In 1999, the hospital reported 6,457 hospital admissions and 92,718 outpatient visits, and the provision of more than \$265,000 in charity care to over 7,465 uninsured patients.⁴¹



Family Health Services (FHS), established in 1982, serves the uninsured and underserved population of the Magic Valley Region. It is the only provider in the area offering services on a sliding scale and, through its clinics in Twin Falls, Buhl, Burley and Jerome, is the sole provider for many isolated farm worker populations.⁴² In 1999, FHS served over 17,000 patients, of whom 55% were uninsured, and more than 3,200 were migrant seasonal farm workers. FHS also provides bilingual and translation services.⁴³

•
•
•
•
•
•
•

SURVEY METHODOLOGY

The surveys were conducted by fifteen surveyors, all of whom attended a full-day training session in survey administration provided by the Health Training Innovations Program of The Medical Foundation in Boston, Massachusetts.

To be eligible to participate in the survey, respondents had to have received health care services at one of the participating facilities in the past 12 months and to have been uninsured at the time they received the services. All surveys were conducted between May 25 and July 17, 2000.

Participants were identified through flyers distributed at grocery stores, parks, laundry facilities, and community gatherings; a mailing to 50 non-profit organizations; and referrals from participants who had themselves taken the survey. The interviews occurred in a variety of settings, including food bank distribution sites, job service offices, shelters for women and children, senior centers, recreational facilities, churches, migrant labor camps, and low-income housing projects. Surveyors received \$15 for each completed survey, while participants who completed the survey received a \$10 gift certificate to a local grocery store.

Respondents were more likely to be Hispanic than their proportion in the overall population of the counties. IPCA was particularly interested in capturing the perceptions of Hispanics, because they traditionally have higher rates of uninsurance than the general population, and because the facilities included in the survey provide a significant amount of care to Hispanics. One way in which IPCA was able to identify Hispanic respondents was through its use primarily of Hispanic surveyors, most of whom were women who spoke Spanish as their first language.

Six hundred and nineteen surveys were completed in all, and included 150 individuals who received care at Mercy Medical Center, 151 who received care at Terry Reilly Health Services, 150 who received care at Magic Valley Regional Medical Center, and 168 who received care at Family Health Services.

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.

•
•
•
•
•
•
•

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 Mercy Medical Center, Magic Valley Regional Medical Center, Terry Reilly Health Services, or Family Health Services while uninsured. It also compares these results with averages for all similar facilities included in the CAMS project nationwide. All comparisons are statistically significant unless otherwise indicated (ns = non-significant). See Appendix A for a table of the results for these facilities, as well as for the aggregate results for all similar facilities included in CAMS.

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

MERCY MEDICAL CENTER AND MAGIC VALLEY REGIONAL MEDICAL CENTER

This section presents the results for the two hospitals included in the study, Mercy Medical Center (MMC) and Magic Valley Regional Medical Center (MVRMC). It also compares their results with the averages for all urban and suburban hospitals (AUSHs) included in the CAMS project nationwide.

RESPONDENT CHARACTERISTICS

Most MMC and MVRMC respondents were Hispanic or white. More than one-fourth of the respondents for each hospital chose to take the survey in Spanish.

Nearly one-half (49%) of the MMC respondents and 77 percent of the MVRMC respondents identified themselves as Hispanic. In comparison, the average proportion of Hispanic respondents for AUSHs was 37 percent. In addition, 37 percent of MMC respondents and 20 percent of MVRMC respondents identified themselves as white, while the average for AUSHs was 11 percent.

More than one-fourth of the respondents for both facilities chose to take the survey in Spanish (MMC 26% and MVRMC 29%), similar to the AUSH average of 28 percent.



Respondents varied in age, but MVRMC respondents were more likely than MMC respondents or the average for AUSHs to have answered on behalf of a child (23% vs. 13% and 15%, respectively).

USE OF HEALTH SERVICES

Two of three respondents for both facilities reported that they used the emergency room at least once in the past year, while one-third stated that they used an outpatient clinic. In addition, more than half of the MMC and MVRMC respondents used their facilities more than once in the past year.

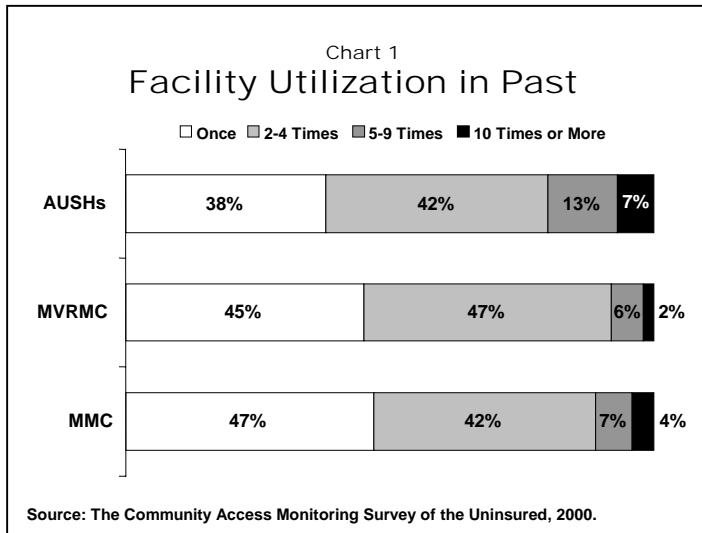
Emergency room use: Two-thirds of the respondents for MVRMC (66%) and MMC (69%) said that they used the emergency room at least once in the past year. The AUSH average, however, was slightly higher (77%).

Outpatient clinic use: One of three respondents for both MMC (33%) and MVRMC (34%) reported using the outpatient clinic in the past year, lower than the average for AUSHs (45%).

Inpatient hospital use: MMC and MVRMC respondents were slightly more likely to report that they had been admitted to the hospital in the past year than the average for AUSHs (40% and 41% vs. 32%, respectively).

Frequency of use: More than half of the MMC and MVRMC respondents reported that they used their respective facility more than once in the past year. However, the proportion of MMC and MVRMC respondents who used their facility only once in the past year was higher than the AUSH average, while the proportion who used their facility five or more times in the past year was lower than the average. (Chart 1)

•
•
•
•
•
•
•
•



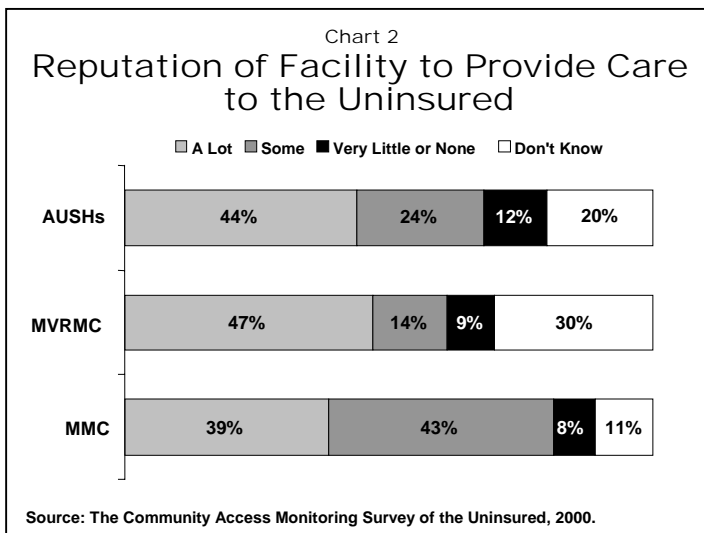
OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

The majority of respondents for MMC and MVRMC stated that their facility had been open and accepting to them even if they were unable to pay for their care. However, MVRMC respondents were more likely than MMC respondents to report that their hospital had a reputation in the community for providing care to the uninsured. The majority of respondents for both facilities reported that they were satisfied with the care and service that they received from hospital staff.

“They help out a lot for those who can’t pay or who seek medical care.”
MMC Respondent

“They have never refused services. They have always taken care of me.”
MVRMC Respondent

About three of five respondents for both MMC (63%) and MVRMC (60%) reported that, in their experience, their hospital had been “open and accepting” to them even if they were unable to pay for their care. These proportions were similar to the 61 percent average for AUSHs. Nearly one-half of the MVRMC respondents and 39 percent of the MMC respondents stated that their hospitals had a reputation in the community for providing “a lot” of care to the uninsured. In addition, about two of five MMC respondents stated that the facility had a reputation for providing “some” care. Notably, 30 percent of MVRMC respondents said they did not know the reputation of the facility. (Chart 2)



The majority of MMC and MVRMC respondents rated the care and service they received from hospital staff as either “very satisfactory” or “satisfactory.” For example, more than 90 percent of the respondents said that they were satisfied with the services they received from doctors and nurses. In addition, no more than 13 percent of the respondents said that they were “unsatisfied” or “very unsatisfied” with the care they received from any category of staff.

“Every time I’ve gone there I have been treated really well.”
MVRMC Respondent

“Good doctors. Sliding discount. I like the evening clinic.”
MMC Respondent

About four of five (78%) MVRMC respondents reported that they were “always” treated with respect, slightly larger than the proportion either for MMC respondents (63%) or the average for AUSHs (61%) (ns).

ACCESSIBILITY

Less than one-fourth of MMC or MVRMC respondents reported problems even sometimes with accessibility factors such as facility hours, waiting time to get an appointment, and convenience to public transportation. However, between 20 and 40 percent of the respondents did report problems related to the facility’s location and waiting times on the day of an appointment.

Few respondents for either MMC (5%) or MVRMC (9%) reported that the facility’s hours were a problem for them even sometimes. The AUSH average was similar—11 percent.

MVRMC respondents were less likely than either MMC respondents or the average for AUSHs to report that the location of the facility was a problem for them even sometimes (19% vs. 28% and 29%,



LANGUAGE NEEDS

About two of five MVRMC respondents said they needed help with translations. More than half of these respondents, however, said they did not find an interpreter readily available.

Two of five (39%) MVRMC respondents said they needed assistance with translations, compared with 24 percent of MMC respondents. These figures were slightly higher than the average for AUSHs (17%).

Among those who needed help, MVRMC respondents were more likely than MMC respondents to say that interpreters were unavailable or not very available (60% vs. 41%). In addition, 65% of MVRMC respondents who did get help rated the quality of interpreters as fair or poor, higher than the proportion for MMC respondents (53%) or the AUSH average (53%). Less than half of the respondents for either facility said they noticed signs in the waiting area in their language. Slightly more than half said they were provided with written information in their language (ns).

"I always have my son with me to interpret what the doctor says."
MVRMC Respondent

"I had my daughter with me, who translated the information for me."
MMC Respondent

"The cleaning lady was the interpreter."
MVRMC Respondent

OBTAINING PRESCRIPTION MEDICATIONS

The majority of respondents for both facilities reported that they received prescriptions for medications. MMC and MVRMC respondents were less likely to report that paying for their medications was very difficult or that they needed help paying for their medications than the average for AUSHs.

Two of three (68%) MVRMC respondents and 57 percent of MMC respondents said they had medications prescribed. About one of four respondents who had medications prescribed received their medications free. The majority—84 percent of MVRMC respondents and 56 percent of MMC respondents—said they paid out-of-pocket at a pharmacy. However, 8 percent of MMC respondents and 4% of MVRMC respondents reported that they were unable to fill any of their prescriptions due to cost (ns).

"They always gave me samples if I couldn't pay."
MMC Respondent

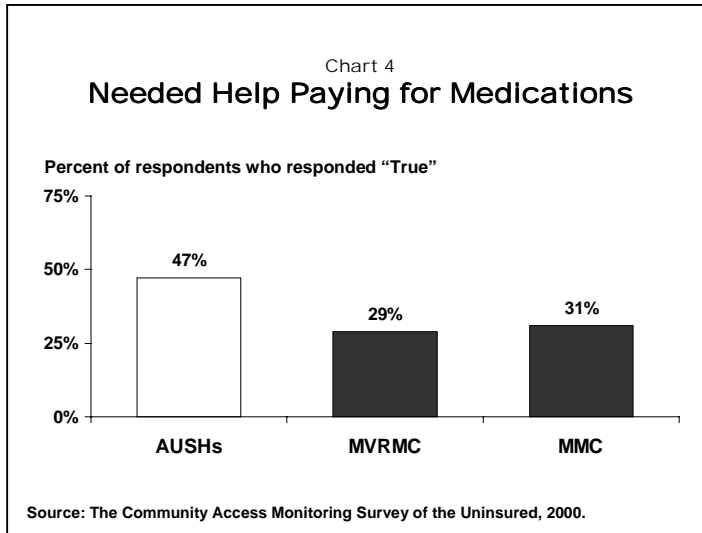
"If you tell them you can't get the medications, they do try to help you and give you samples of meds if available."
MVRMC Respondent

"I bought one, but the other two I didn't buy because they were too expensive."
MMC Respondent

"I can't pay my other bills because I have to buy the medicines."
MVRMC Respondent

MMC respondents were slightly more likely than MVRMC respondents to report that paying for their medications was "very difficult" (29% vs. 22%, respectively). The average for AUSHs was higher—40 percent. About three of ten respondents for both MMC and MVRMC reported that they needed help paying for their medications, while the average for AUSHs was much higher (47%). (Chart 4)

•
•
•
•
•
•
•
•



Among those who said they needed help, 68 percent of MMC respondents and 63 percent of MVRMC respondents said that staff “never” offered to find out if help was available (ns).

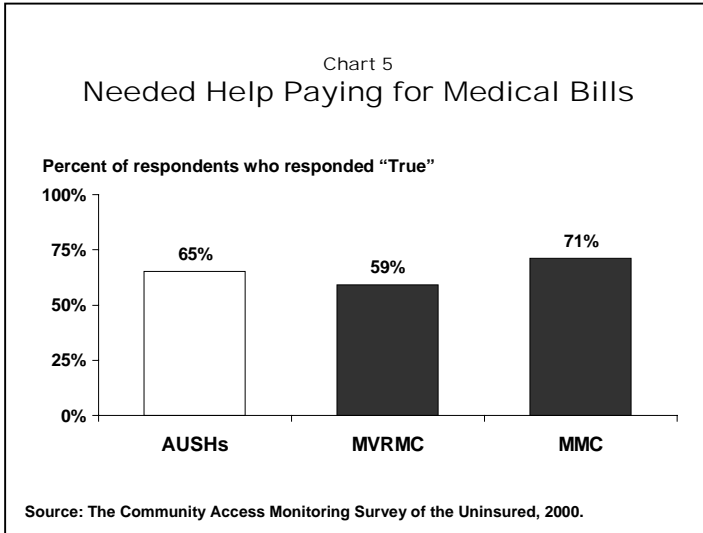
Notably, nearly all respondents for MMC and MVRMC—96 percent—said they understood their medication instructions.

CONCERNS OVER PAYMENT FOR HEALTH CARE

The majority of respondents, and particularly those for MMC, said that paying for their medical care was very difficult and that they needed help paying their bill. About one-half of the respondents who needed help said they received some form of assistance.

Seven of ten MMC respondents (71%) and 58 percent of MVRMC respondents reported that paying their medical bill was “very difficult” (ns), and that they needed help paying the bill. (Chart 5)

“It’s good they let us pay whenever we can, because we can’t afford to pay what regular doctors charge.”
MMC Respondent



Of those respondents who said they needed help, MVRMC respondents were a little more likely to say they received some form of assistance, at least sometimes, than MMC respondents (55% vs. 45%, respectively), while about half said staff “never” offered to find out if help was available (MVRMC 46%, MMC 56%). MVRMC respondents were much more likely to be offered a monthly payment plan than either MMC respondents or the AUSH average (85% vs. 52% and 52%, respectively). In addition, one-fourth of MMC respondents and 13 percent of MVRMC respondents had their bill reduced, and 42 percent of MMC respondents were directed to a charitable organization for help.

“They did not offer me any help. I had to save up to pay the account.”

MVRMC Respondent

“They give you very little time to pay.”

MVRMC Respondent

“They let me make monthly payments.”

MMC Respondent

SEEKING CARE IN THE FUTURE

The overwhelming majority of respondents for both facilities said they would use their hospital again if they were insured. Two of three reported that they have unpaid bills at their hospital. Among these respondents, between 20 and 40 percent said the debt would deter them from seeking care at their facility in the future.

Eight percent of MMC respondents and 13 percent of MVRMC respondents said that their experience paying medical bills in the past would deter them from seeking care at their facility in the future. Twelve percent of MMC respondents and 3 percent of MVRMC respondents said because of their experiences paying bills, they would use a different facility. However, between 69 and 77 percent of the respondents said their past experiences paying bills would not affect whether they sought care at their facility again.

“I have no choice. It’s the only hospital there is.”

MVRMC Respondent

“I feel embarrassed going there because I owe money.”

MVRMC Respondent

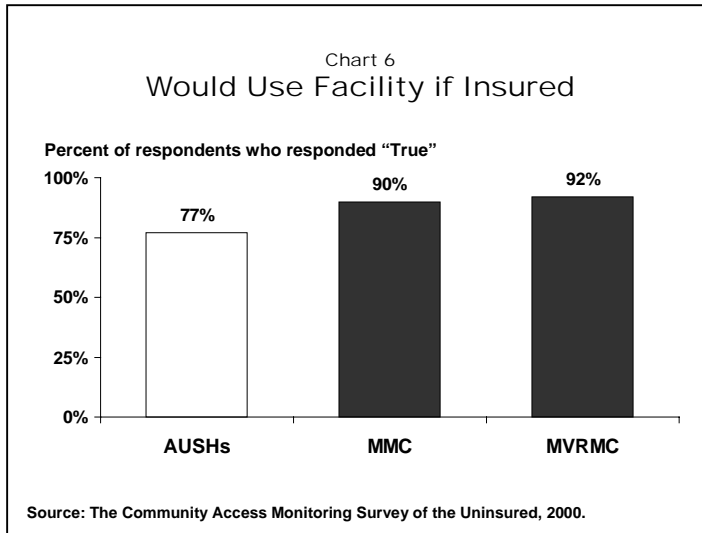
•
•
•
•
•
•
•
•
•
•

Two of three (66%) respondents for both hospitals said they had owed money to the hospital. MMC respondents were nearly twice as likely to say that this debt would deter them from seeking care at the facility in the future (38% vs. 20%, respectively). The average for AUSHs was 28 percent.

"I have been going there for years and I wouldn't change."
MMC Respondent

"I enjoy going to my doctor there and I don't want to change doctors."
MMC respondent

An overwhelming majority of the respondents for both hospitals—90 percent or more—said they would use the facility again if they had health insurance. (Chart 6)





TERRY REILLY HEALTH SERVICES AND FAMILY HEALTH SERVICES

This section presents the results for the two clinics included in the study, Terry Reilly Health Services (TRHS) and Family Health Services (FHS). It also compares their results with the averages for all urban and suburban clinics (AUSCs) included in the CAMS project nationwide.

RESPONDENT CHARACTERISTICS

Respondents varied in age. Two of three respondents for both clinics were Hispanic, and about a quarter of the respondents chose to take the survey in Spanish.

Respondents varied in age, but FHS respondents tended to be younger than TRHS respondents. Specifically, more than one-half (56%) of FHS respondents were 29 years of age or younger, compared with 40 percent of TRHS respondents.

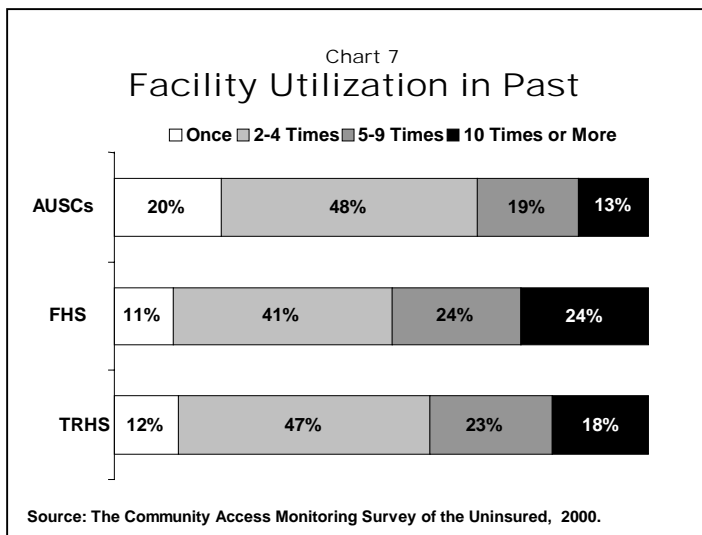
About two of three respondents for TRHS (64%) and FHS (69%) identified themselves as Hispanic, much higher than the average proportion of Hispanics for AUSCs (26%). About one-fourth of the respondents for both facilities said that they were white. More than one-fourth of the TRHS (29%) and FHS (26%) respondents chose to take the survey in Spanish.

USE OF HEALTH SERVICES

Nearly nine of ten respondents for both facilities reported that they used their clinic more than once in the past year.

The overwhelming majority of the respondents—88 percent of TRHS respondents and 89 percent of FHS respondents—reported that they used their clinic two or more times in the past year. (Chart 7)

•
•
•
•
•
•
•
•



Nearly two of five respondents for both facilities (37% of TRHS respondents and 45% of FHS respondents) said that they sought care to treat a chronic health problem such as diabetes. The AUSC average was 38 percent.

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

FHS respondents were more likely than TRHS respondents to report that their clinic had been open and accepting to them even if they were unable to pay for care, and that it had a positive reputation in the community for providing care to the uninsured. The majority of the respondents for both facilities reported that they were satisfied with the care and service they received from staff.

“They see a lot of people in the community. I think they are the only ones that will see you even if you don’t have any money.”

FHS Respondent

A large proportion of FHS respondents (87%) reported that, in their experience, the clinic had been “open and accepting” to them even if they were unable to pay. In comparison, the proportion of TRHS respondents was 71 percent, and the average for AUSCs was 78 percent.

“This is the only place I can go without any insurance and I don’t have to pay the whole amount at once.”

TRHS Respondent

Three-fourths (76%) of the FHS respondents said their clinic has a reputation in the community for providing “a lot” of care to those who cannot pay. This compared with 60 percent of TRHS respondents and an AUSC average of 62 percent.

Respondents for both groups were generally satisfied with their interactions with staff, although FHS respondents were somewhat more likely to report being satisfied with their interactions with nurses and physicians. For example, nearly all (99%) FHS



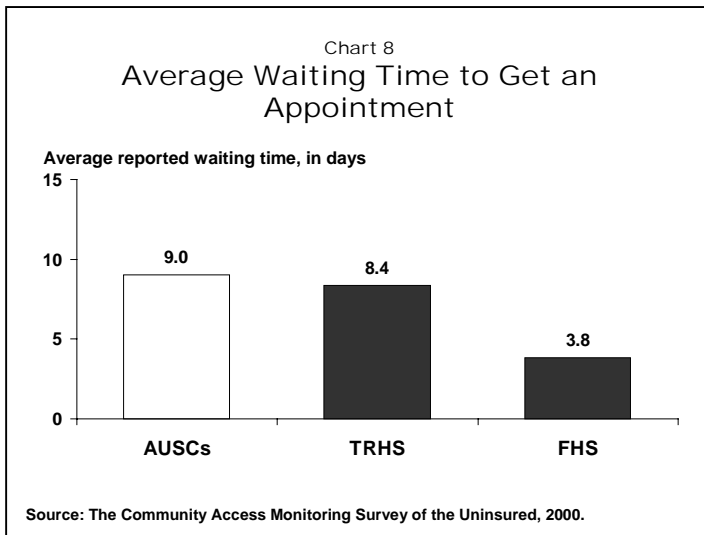
respondents reported they were “very satisfied” or “satisfied” with the care and service they received from nurses, compared with 90 percent of TRHS respondents. In addition, very few FHS respondents (8 percent or less) reported that they were dissatisfied with their interactions with any category of staff. However, more than ten percent of TRHS respondents said they were dissatisfied with the care and service they received from nurses, receptionists, billing clerks, and pharmacists.

ACCESSIBILITY

One-fifth or more of the respondents for both facilities reported that they had problems at least sometimes with the facility’s location, the waiting time to get an appointment, and the waiting time to see a provider on the day of an appointment.

TRHS respondents were twice as likely as FHS respondents to report that the facility hours were a problem (30% vs. 15%, respectively).

Close to half of the respondents for both TRHS (48%) and FHS (46%) reported that the waiting time to get an appointment was a problem for them at least sometimes. However, the average reported waiting time for FHS respondents was about four days less than the average for either TRHS respondents or for AUSCs. (Chart 8)

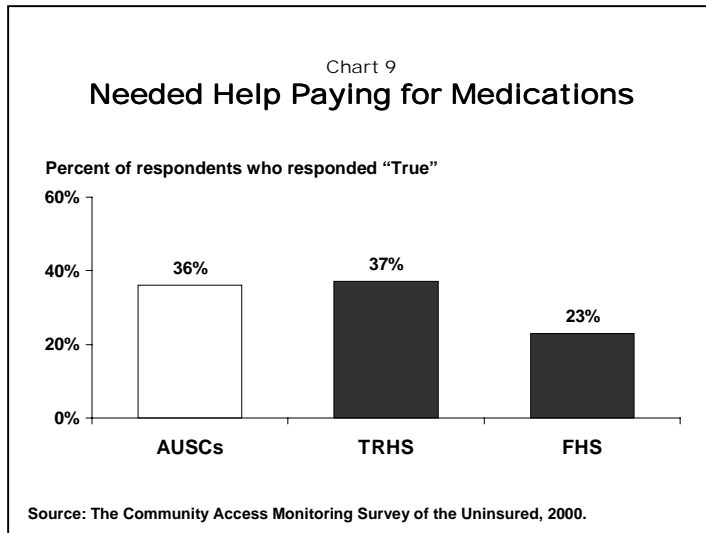


“All were very friendly. It just took too long to get in. Too much waiting.”
FHS Respondent

TRHS respondents were more likely than FHS respondents to report that the waiting time to see a provider on the day of an appointment was a problem at least sometimes (69% vs. 50%, respectively). The average reported waiting time for FHS respondents was 21 minutes,

“Sometimes you are called in 5-10 minutes after you get there and then there are times you wait forever.”
TRHS Respondent

Many TRHS (27%) and FHS (19%) respondents reported that they had difficulty paying for their medications (ns). TRHS respondents were more likely than FHS respondents to report that they needed help paying for their medications (37% vs. 23%, respectively). (Chart 9)



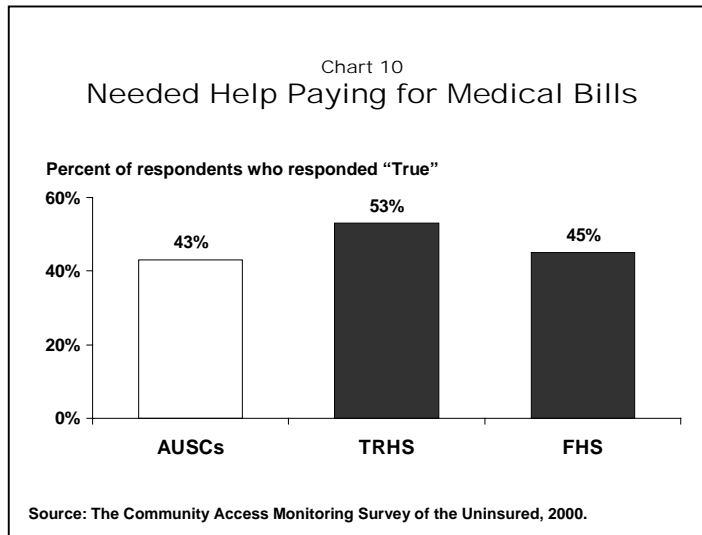
However, among those respondents who needed help, over half (51%) of TRHS respondents and 44 percent of FHS respondents said staff "never" asked them if help was needed (ns).

CONCERNS OVER PAYMENT FOR HEALTH CARE

About three of ten or more of the respondents for both clinics said that paying their medical bills was very difficult, and nearly half said they needed help paying their bills.

Thirty seven percent of TRHS respondents and 29 percent of FHS respondents (ns) said that paying for medical care was "very difficult," which was similar to the AUSC average (33%). About one-half of the respondents in each group said they needed help paying their medical bill (ns). (Chart 10)

•
•
•
•
•
•
•
•



"They told me to pay and if not it would go to a collection agency."
TRHS Respondent

"They just billed me and threatened to turn me over to collections."
FHS Respondent

"They offered me help on a sliding fee scale."
TRHS Respondent

"They worked with me on a payment plan."
FHS Respondent

"No other place will take me."
TRHS Respondent

"We had to claim bankruptcy."
FHS Respondent

However, two of five (39%) TRHS respondents and nearly one-third (29%) of FHS respondents said that staff "never" offered to find out if financial assistance was available for them.

Among those who received help, the most common forms of assistance offered by staff were monthly billing plans and a reduction in their bills. In fact, 85 percent of FHS respondents were offered monthly billing plans; this compared with 49 percent of TRHS respondents who were offered billing plans. For both respondent groups, over two-thirds of those who received help said they were offered reductions in their bills. This was much higher than the AUSC average of 35 percent. Few respondents in either group reported that their bills were waived; the AUSC average was 26%.

SEEKING CARE IN THE FUTURE

A greater proportion of respondents for both FHS and TRHS said they owed money to their clinic than the average for AUSCs. Almost all of the FHS respondents, and a large proportion of TRHS respondents, said they would use the clinic again even if they had health insurance.

Most respondents for both clinics reported that their past payment experiences would either make it "easier to seek care" at their clinic again or would "make no difference" in their likelihood of seeking care. However, about one of ten (9%) TRHS respondents said that they would use another facility and an additional four percent said they would not seek care at TRHS again.

Respondents for both clinics were much more likely to report that they were in debt to their facility than respondents for AUSCs. One-half

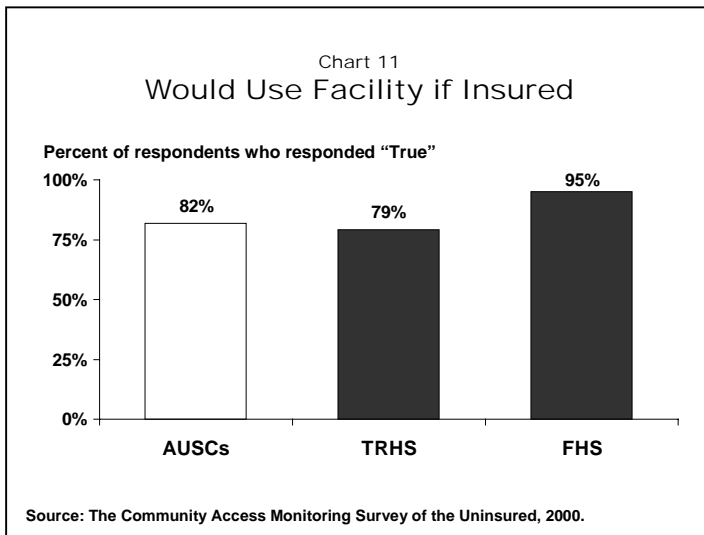


(50%) of TRHS and 44 percent of FHS respondents said that they had unpaid bills, while the average for AUSCs was 20 percent. A slightly larger proportion of TRHS respondents than FHS respondents said the debt would discourage them from seeking care at the facility again (27 vs. 15%, respectively, (ns)).

"I don't go because I owe."
TRHS Respondent

"I don't want to get into more debt unless it is an emergency."
FHS Respondent

Fully 95 percent of FHS respondents said they would use their clinic again if they were insured, compared to 79 percent of TRHS respondents and 82 percent of respondents for AUSCs. (Chart 11)



"I like the clinic; I would use it with insurance more often."
FHS Respondent

•
•
•
•
•
•
•

DISCUSSION

This section summarizes the results of the surveys for the hospitals and clinics included in the CAMS project in Idaho. It suggests some of the perceived strengths of the facilities, as well as issues that might warrant further discussion.

MERCY MEDICAL CENTER AND MAGIC VALLEY REGIONAL MEDICAL CENTER

- ◆ Respondents for Mercy Medical Center (MMC) and Magic Valley Regional Medical Center (MVRMC) reported waiting times both to get appointments and to see providers on the day of an appointment that were significantly shorter than the averages for All Urban and Suburban Hospitals (AUSHs) included in the CAMS project nationwide.
- ◆ The proportion of respondents for both hospitals who used their hospital only once in the past year was higher than the average for AUSHs, while the proportion who used their hospital more than five times in the past year was lower than the AUSH average.
- ◆ Most respondents for both hospitals rated the care and service they received from hospital staff as either “very satisfactory” or “satisfactory,” although respondents for MVRMC were somewhat more likely to report that they were “always” treated with respect (78%) than respondents for MMC (63%).
- ◆ A majority of respondents for both hospitals said that their hospital had been open to them even if they couldn’t pay for care. Respondents for MVRMC were somewhat more likely than MMC respondents to report that their hospital had a reputation for providing “a lot” of care to the uninsured. However, a high proportion of MVRMC respondents—30 percent—said they didn’t know what the hospital’s reputation was for providing such care.
- ◆ Two of five (39%) MVRMC respondents said they needed assistance with translations, compared to one-fourth (24%) of MMC respondents. However, among respondents who needed assistance, MMC respondents were more likely than either MVRMC respondents or the AUSH average to find interpreters readily available.
- ◆ MMC respondents were more likely than MVRMC respondents to report that paying their medical bills was very difficult and that they needed help paying their bills. Among respondents who said they needed help, about half of both groups said that staff never offered to find out if help was available. Among those who

received help, MVRMC respondents were more likely than MMC respondents to be offered a monthly payment plan, while MMC respondents were more likely than MVRMC respondents to be referred to a charitable organization.

- ◆ Both MMC and MVRMC respondents were less likely to report that paying for their medications was very difficult and that they needed help paying for them than the AUSH average. About a quarter of each group said their medications were supplied free, similar to the AUSH average, while the proportion of respondents saying they paid for their medications out-of-pocket was much higher for MVRMC than for either MMC or the AUSH average. Several MMC (8%) and MVRMC (4%) respondents reported that they were unable to fill any of their prescriptions due to costs.
- ◆ Two-thirds of both respondent groups said they owed money to their facility. MMC respondents were almost twice as likely as MVRMC respondents to report that their debt would deter them from seeking care at their facility in the future (38% vs. 20%, respectively).

TERRY REILLY HEALTH SERVICES AND FAMILY HEALTH SERVICES

- ◆ Nearly 90% of respondents for both Terry Reilly Health Services (TRHS) and Family Health Services (FHS) used their clinic two or more times in the past year.
- ◆ FHS respondents were more likely than TRHS respondents to report both that their clinic had been “open and accepting” to them even if they were unable to pay for their care, and that their clinic had a reputation in the community for providing “a lot” of care for the uninsured. Responses for TRHS were similar to the averages for All Urban and Suburban Clinics (AUSCs) included in the CAMS project nationwide.
- ◆ Respondents for both clinics were generally satisfied with their interactions with staff—for example, 99 percent of FHS respondents and 89 percent of TRHS respondents said they were satisfied or very satisfied with their interactions with nurses. However, TRHS respondents were more likely than FHS respondents to report dissatisfaction. For example, 11 percent of TRHS respondents said they were dissatisfied with their interactions with nurses, compared to 2 percent of FHS respondents.
- ◆ FHS respondents reported waiting times both to get an appointment and to see the provider on the day of the appointment that were considerably shorter than the average for AUSCs. The

•
•
•
•
•
•
•

times reported by TRHS respondents were similar to AUSC averages.

- ◆ Although about one-third of each respondent group said they required assistance with translations, FHS respondents were somewhat more likely to report that interpreters were readily available. However for both groups, over 90 percent of respondents who received assistance said the ability of their interpreters was “very good” or “fair.”
- ◆ FHS respondents were more than three times as likely as TRHS respondents to report that they received prescribed medications for free. However, a higher than average proportion of respondents for both groups reported that they paid for their medications out-of-pocket. In addition, among respondents who said they needed help paying for medications, more than 4 of 10 respondents in both groups said that staff never asked if help was needed.
- ◆ About half of the respondents in each group said they needed help paying for their medical care. Sixty-two percent FHS respondents said that staff always or often offered to find out if assistance was available; this compared to 38 percent of TRHS respondents and an AUSC average of 53 percent.
- ◆ Between 43 and 52 percent of respondents for both clinics said their past experiences paying for care would either make it easier, or would not affect, their likelihood of seeking care at their clinic in the future. However, respondents for both clinics were much more likely to report being in debt to their clinic than the average for AUSCs. Of respondents who were in debt, TRHS respondents were somewhat more likely than FHS respondents to say that the debt would deter them from seeking care at the clinic in the future.
- ◆ Almost all (95%) FHS respondents said they would use the clinic again if they had health insurance. The proportion for TRHS respondents was similar to the AUSC average (79% and 82% respectively).

HOSPITALS AND CLINICS

This section compares responses for the hospitals included in CAMS in Idaho with responses for the clinics included in the project. However, these differences should be interpreted with caution, especially given the survey limitations and possible unknown differences among the respondent groups. The points highlighted below are intended to serve only as topics for further discussion and do not imply statistically significant differences.



- ◆ Larger proportions of clinic respondents than hospital respondents reported that they visited their facility more than once in the past year, and that they sought care to treat a chronic problem.
- ◆ Clinic respondents were more likely than hospital respondents to say that their facility had been open and accepting to them even if they were unable to pay.
- ◆ Hospital respondents were more likely than clinic respondents to report that paying their medical bills was very difficult, and that they needed help paying their bills. However, larger proportions of clinic respondents said that staff offered to find out if financial assistance was available, at least sometimes, than respondents for hospitals.
- ◆ Hospital respondents were more likely than clinic respondents to report that they owed money to their facility.
- ◆ About four of five respondents or more for both the hospitals and the clinics said that they would use their facility again if they had health insurance.

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 United States Census Bureau, U.S. Department of Commerce, www.census.gov, September 2000.

•
•
•
•
•
•
•
•

³² T. Egan, "As Idaho Booms, Prisons Fill and Spending On Poor Lags," *New York Times*, April 16, 1998.

³³ State of Idaho Medicaid Program Administrative Rules, www.state.id.us.

³⁴ *Monthly CHIP Update: Idaho Success Story, Total CHIP Children*, Idaho Department of Health and Welfare, June 2000.

³⁵ *Population Information*, Nampa Idaho Chamber of Commerce, www.nampa.com/html/population.html, September 2000.

³⁶ *Idaho's Health*, Center for Vital Statistics and Health Policy, Idaho Department of Health and Welfare, April 1999.

³⁷ Personal Communication, Sr. Maura Clark, Mercy Medical Center, August 2000.

³⁸ Community Health Center Grant Application to Bureau of Primary Health Care for Terry Reilly Health Services, November 1999

³⁹ Bureau of Primary Health Care, *1999 Uniform Data Set for Terry Reilly Health Services*.

⁴⁰ *Idaho's Health, op.cit.*

⁴¹ Personal Communication, Pat Wilkerson, Magic Valley Regional Medical Center, August 2000.

⁴² Community Health Center Grant Application to Bureau of Primary Health Care for Family Health Services, September 1999

⁴³ Bureau of Primary Health Care, *1999 Uniform Data Set for Family Health Services*.

ACKNOWLEDGEMENTS

The **Idaho Primary Care Association** would like to thank the administrations of Mercy Medical Center, Magic Valley Regional Medical Center, Terry Reilly Health Services, and Family Health Services for agreeing to participate in this study and use the findings to improve access to health care for Idaho's uninsured and underserved populations.

IPCA would also like to acknowledge the efforts of the surveyor team, who spent many hours finding and surveying individuals in order to complete this project. Special thanks go to Diana Ring, Nampa survey coordinator; Carla Sanchez Benitez, Twin Falls survey coordinator and lead surveyor; and to the other members of the excellent surveyor team, for their dedication to completing this project. The surveyors were Beronica Salazar, Elvira Elias, Diana Perez, Juanita Silva, Maxine Gonzalez, Veronica Arrieta, Margarita Sanchez, Frances Castillo, Mario Ramos, Vickie Horner, Sarah LaPlante, and Jennifer Nye.

The Access Project consultants, Nancy Kohn and Kim Schellenberger, deserve special thanks for supporting this effort.

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

We also want to thank our colleagues at Community Catalyst Inc., and particularly Kim Shellenberger, 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.