



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

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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.

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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

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“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.

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- ◆ 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

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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.

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LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

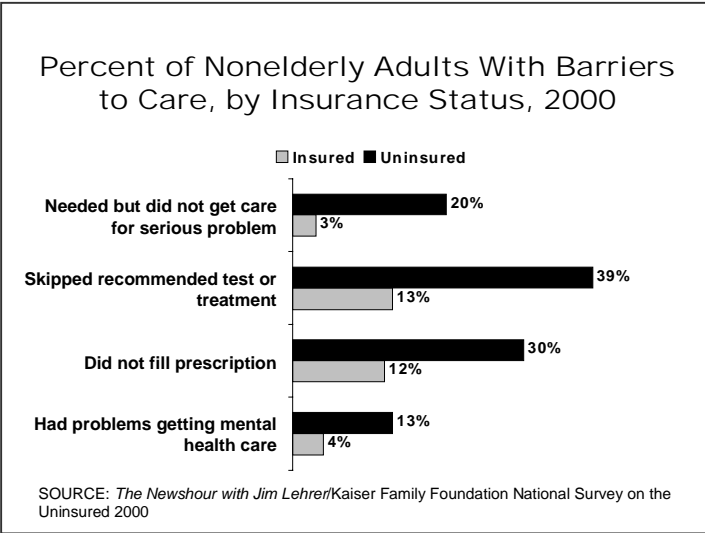
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

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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

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- ◆ 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

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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

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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.

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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.*

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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.

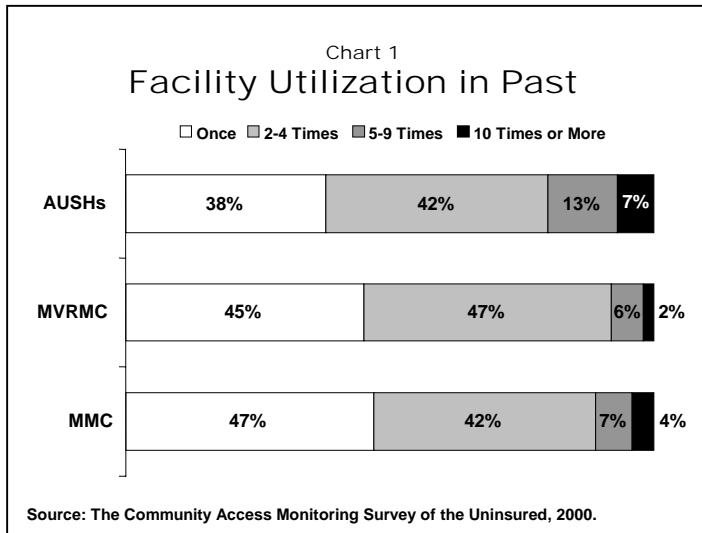
Emergency room use: Two-thirds of the respondents for MVRMC (66%) and MMC (69%) said that they used the emergency room at least once in the past year. The AUSH average, however, was slightly higher (77%).

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)

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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.

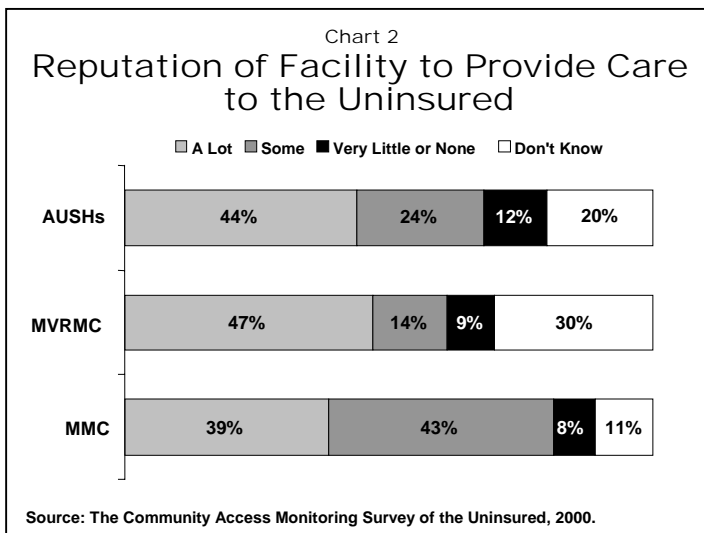
“They help out a lot for those who can’t pay or who seek medical care.”

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

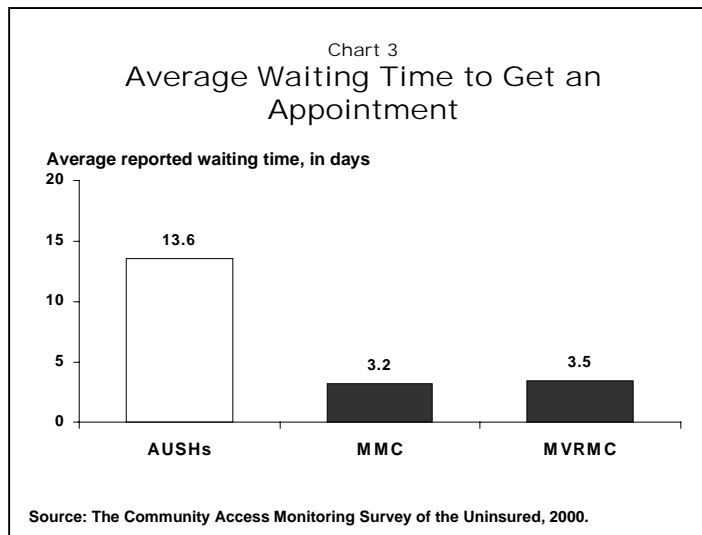
Less than one-fourth of MMC or MVRMC respondents reported problems even sometimes with accessibility factors such as facility hours, waiting time to get an appointment, and convenience to public transportation. However, between 20 and 40 percent of the respondents did report problems related to the facility’s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

respectively). Notably, the average reported travel time for both respondent groups was between 16 and 18 minutes, while the average for AUSHs was 22 minutes.

MVRMC respondents were more likely than for MMC respondents to report that the waiting time to get an appointment was a problem at least sometimes (25% vs. 13%, respectively). However, the average waiting time to get an appointment reported by both respondent groups was 10 days shorter than the average for AUSHs. (Chart 3)



Nearly two of five respondents from each group said that the waiting time to see a provider on the day of an appointment, which averaged 34 minutes, was a problem at least sometimes. However, this was nearly *half* the waiting time reported by respondents for AUSHs (63 minutes).

Between 13 and 15 percent of MMC respondents stated that convenience to public transportation and getting transportation assistance, if needed, were problems at least sometimes, compared with about 4 to 7 percent of MVRMC respondents. Notably, more than two-thirds of the MMC respondents and 90 percent of the MVRMC respondents responded “don’t know” to these questions.



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

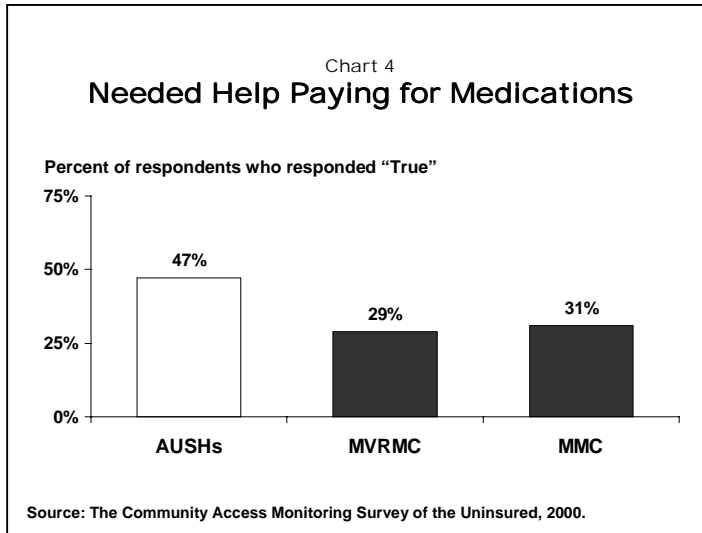
"If you tell them you can't get the medications, they do try to help you and give you samples of meds if available."
MVRMC Respondent

"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)

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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).

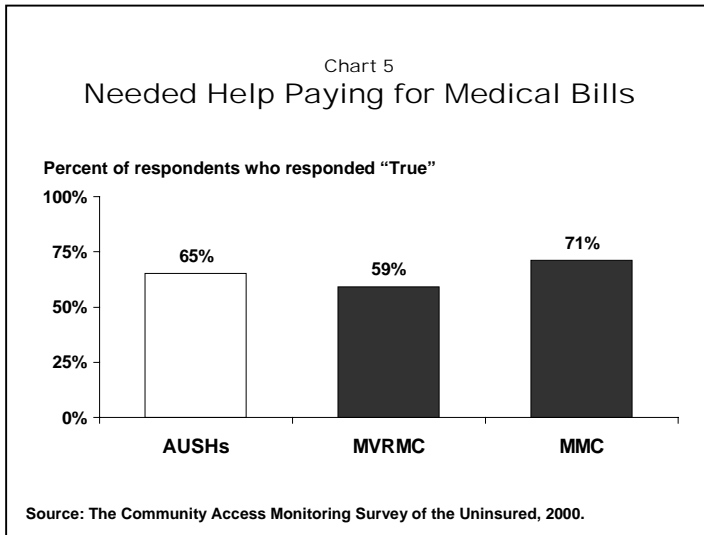
Notably, nearly all respondents for MMC and MVRMC—96 percent—said they understood their medication instructions.

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

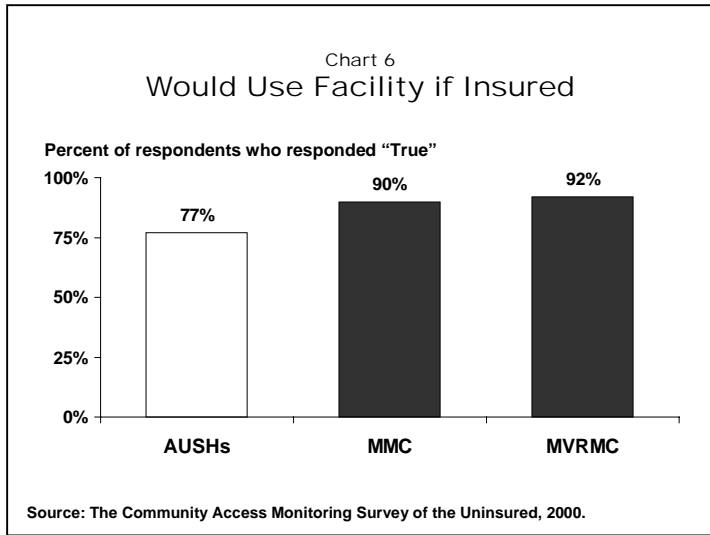
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Two of three (66%) respondents for both hospitals said they had owed money to the hospital. MMC respondents were nearly twice as likely to say that this debt would deter them from seeking care at the facility in the future (38% vs. 20%, respectively).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

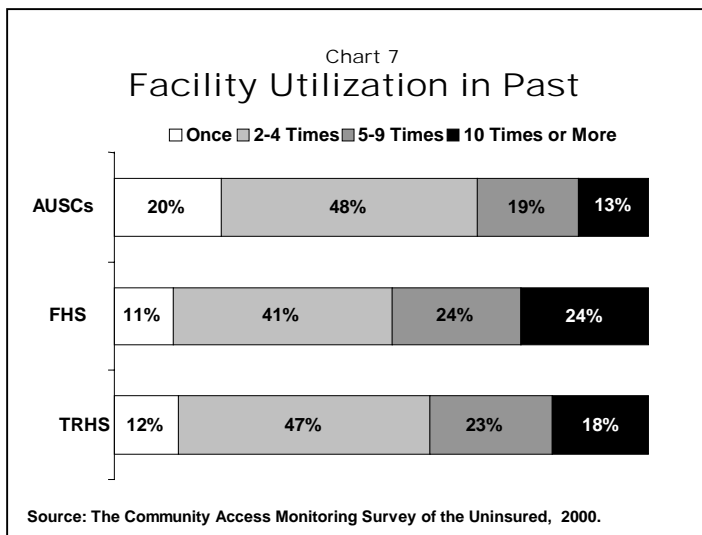
About two of three respondents for TRHS (64%) and FHS (69%) identified themselves as Hispanic, much higher than the average proportion of Hispanics for AUSCs (26%). About one-fourth of the respondents for both facilities said that they were white. More than one-fourth of the TRHS (29%) and FHS (26%)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

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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



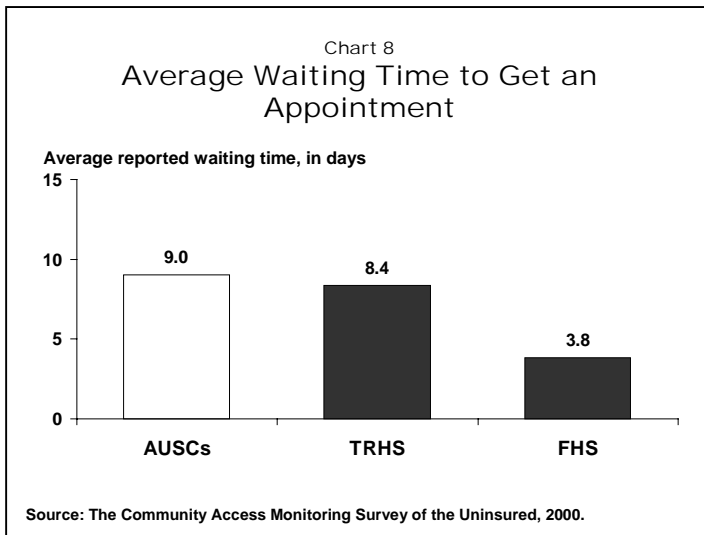
respondents reported they were “very satisfied” or “satisfied” with the care and service they received from nurses, compared with 90 percent of TRHS respondents. In addition, very few FHS respondents (8 percent or less) reported that they were dissatisfied with their interactions with any category of 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

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less than half the time reported by respondents for TRHS or the average for AUSCs (47 minutes for both).

LANGUAGE NEEDS

About one-third of both TRHS and FHS respondents said that they needed assistance with interpretation during their health care encounter. Among those who needed help, most reported that interpreters were available and that their ability was very good.

One of three respondents for both TRHS (31%) and FHS (33%) said that they required help with interpretation, while the average for AUSCs was much lower—13 percent. Among respondents who needed interpreter services, 84 percent of TRHS and 91 percent of FHS respondents said an interpreter was either “very available” or “available.” In addition, over 90% of both groups found their interpreter’s ability to be “very good” or “fair”.

FHS respondents were much more likely than TRHS respondents to say they saw signs in their language posted in the waiting areas (91% vs. 62%, respectively). However, TRHS respondents were more likely than FHS respondents to say they were provided with written information in their language (90% vs. 69%, respectively).

“They had magazines and posters in Spanish.”
TRHS Respondent

OBTAINING PRESCRIPTION MEDICATIONS

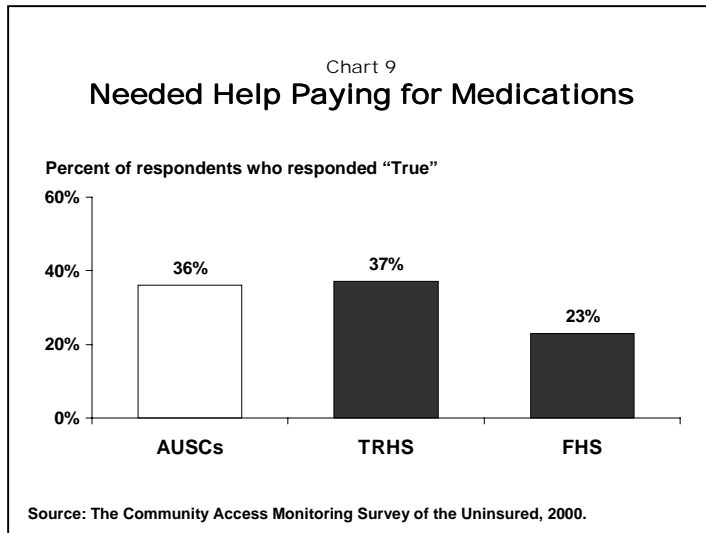
The majority of both TRHS and FHS respondents said they received prescriptions for medications. Over 70 percent of FHS respondents who received prescriptions got their medications free, much higher than the proportion of TRHS respondents. About one-fifth or more of the respondents for both clinics reported that paying for their medications was very difficult and that they needed help paying for them.

More than three-fourths of the respondents for both clinics said they had received prescriptions for medications (81% of TRHS respondents and 76% of FHS respondents). Among those who needed medications, 71 percent of FHS respondents received them free, compared with only 21 percent of TRHS respondents. The AUSC average was 56 percent. In addition, 71 percent of TRHS respondents and 83 percent of FHS respondents said they had to use a drug store and paid for their medications out-of-pocket. These proportions were much higher than the AUSC average of 34 percent. Nine percent of TRHS respondents and six percent of FHS respondents said they did not fill any of their prescriptions due to cost (ns).

“Some medications cost more than others. And sometimes I have to wait to afford the medicines I really need.”
TRHS Respondent

“The medications were expensive. But since I needed them I found a way to pay for them. I just didn’t pay another bill that I owed so that I could get the meds.”
FHS 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)



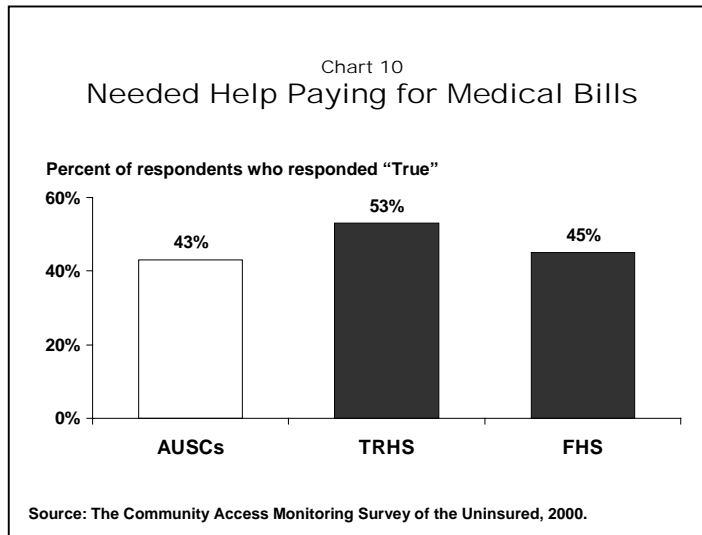
However, among those respondents who needed help, over half (51%) of TRHS respondents and 44 percent of FHS respondents said staff "never" asked them if help was needed (ns).

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)

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"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

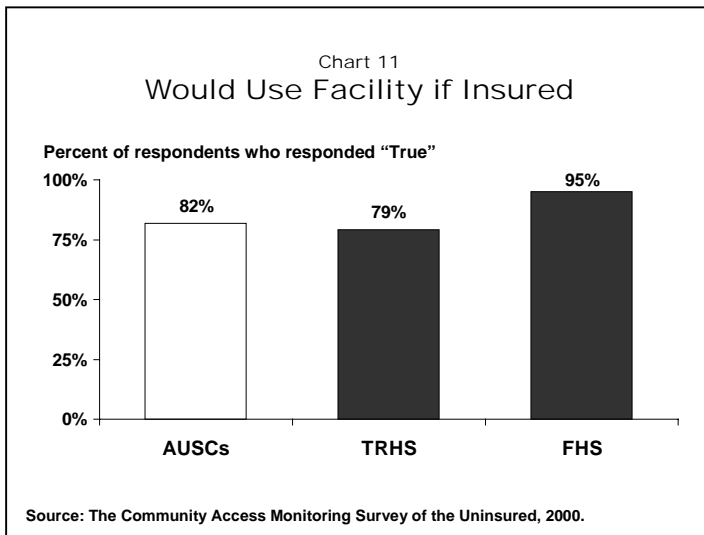


(50%) of TRHS and 44 percent of FHS respondents said that they had unpaid bills, while the average for AUSCs was 20 percent. A slightly larger proportion of TRHS respondents than FHS respondents said the debt would discourage them from seeking care at the facility again (27 vs. 15%, respectively, (ns)).

"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

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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.

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APPENDIX A: TABLE OF SURVEY RESULTS

The following sections include tables with the results of the surveys for the hospitals and clinics included in the CAMS project in Nampa and Twin Falls, Idaho. For comparison purposes, it also presents results of surveys of patients at all similar facilities that were included in the CAMS project nationally.

Asterisks in the *Intra-site p value* column indicate statistically significant differences between Idaho facilities, although the statistical chi-square test does not specify which of those differences were significant. A single asterisk (*) indicates $p < 0.05$. Two asterisks (**) indicate $p < 0.01$. (The legend and an explanation of p-values are provided on page A-10.)

The letters in the *Inter-site p-value* column indicate statistically significant differences between one or more of the Idaho facilities and the average for all similar facilities included in the national CAMS project. The letters in the column indicate which of the Idaho facilities significantly differed from the overall average. The letter corresponding to each facility appears under its name in the column headings. (For example, in the first table B refers to Mercy Medical Center.)

IDAHO HOSPITALS

This table presents the results of the surveys of patients at the two hospitals included in the CAMS project in Idaho, Mercy Medical Center and Magic Valley Regional Medical Center. For comparison purposes, it also presents results of surveys of patients at all urban and suburban hospitals that were included in the CAMS project nationally.

	Idaho Hospitals			CAMS Sites	
	Intra-site p-value	Mercy Medical Center -B-	Magic Valley Regional Med. Center -D-	All Urban Hospitals	Inter-site p-value
Number of survey respondents		150	150	4522	
		% ^a	% ^a	% ^a	
RESPONDENT CHARACTERISTICS					
Age					D
Under 18		18	24	17	
18-29 years		34	32	27	
30-39 years		26	23	25	
40-49 years		11	9	19	
50-64 years		12	8	11	
65 or older		1	4	1	
Race/Ethnicity	—				B,D
White		37	20	11	
Black		1		46	
Hispanic		49	77	37	
Other ^b		13	3	7	
Gender					
Male		34	43	40	
Female		66	57	60	

	Idaho Hospitals			CAMS Sites	
	Intra-site p-value	Mercy Medical Center -B-	Magic Valley Regional Med. Center -D-	All Urban Hospitals	Inter- site p-value
Language in which survey administered					
English		74	71	72	
Spanish		26	29	28	
Answered on behalf of child	*	13	23	15	D
FACILITY UTILIZATION					
Used hospital emergency room		69	66	77	B,D
Admitted to hospital as inpatient		40	41	32	B,D
Used outpatient clinic		33	34	45	B,D
Use of facility in past year	—				B,D
Once		45	47	38	
2-4 times		47	42	42	
5-9 times		6	7	13	
10 or more times		2	4	7	
Reason for visit(s)					B
Chronic problem or Mixed (chronic and non-chronic)	—	18	27	32	
Other problem (non-chronic)		82	73	68	
PERCEPTION OF FACILITY					
Experience of facility's openness to uninsured					
Open and accepting even if can't pay		63	60	61	
Reluctant but accepts you even if can't pay		23	23	19	
Offers some care if can't pay	**	18	6	12	B,D
Provides no assistance if can't pay	—	1	1	3	
Don't know	**	3	15	9	B,D
Opinion of facility's reputation for treating uninsured	**				B,D
Provides a lot of care for those who can't pay		39	47	44	
Provides some care		43	14	24	
Provides very little or no care		8	9	12	
Don't know		11	30	20	
SATISFACTION WITH PROVIDERS					
Receptionists/Admitting clerks	—				D
Very satisfactory or satisfactory		91	94	84	
Unsatisfactory or very unsatisfactory		8	6	14	
Don't know		1	1	2	
Nurses					D
Very satisfactory or satisfactory		94	97	88	
Unsatisfactory or very unsatisfactory		6	3	11	
Don't know				1	
Physician assistants	—				B,D
Very satisfactory or satisfactory		61	30	78	
Unsatisfactory or very unsatisfactory		4	1	9	
Don't know		36	68	14	
Examining physicians	**				D
Very satisfactory or satisfactory		90	92	90	
Unsatisfactory or very unsatisfactory		9		8	
Don't know		2	8	2	

	Idaho Hospitals			CAMS Sites	
	Intra-site p-value	Mercy Medical Center -B-	Magic Valley Regional Med. Center -D-	All Urban Hospitals	Inter- site p-value
Social worker	—				B,D
Very satisfactory or satisfactory		24	13	36	
Unsatisfactory or very unsatisfactory		2		10	
Don't know		73	87	54	
Billing Clerks					B,D
Very satisfactory or satisfactory		62	59	49	
Unsatisfactory or very unsatisfactory		12	13	18	
Don't know		27	29	33	
Pharmacist	—				B,D
Very satisfactory or satisfactory		31	18	37	
Unsatisfactory or very unsatisfactory		3	1	6	
Don't know		65	81	57	
Treated with respect	—				D
Always		63	78	61	
Sometimes		33	19	32	
Never		3	1	4	
Don't know		1	2	3	
ACCESSIBILITY OF SERVICES					
Hours facility open	—				D
Never a problem		91	79	85	
Sometimes a problem		3	8	9	
Often/always a problem		2	1	2	
Don't know		4	13	5	
Hours ER open	—				D
Never a problem		87	71	84	
Sometimes a problem		1	1	6	
Often/always a problem		1		2	
Don't know		11	29	8	
Location	—				D
Never a problem		71	81	69	
Sometimes a problem		20	15	21	
Often/always a problem		8	4	8	
Don't know		1	1	2	
Waiting time to get appointment	**				B,D
Never a problem		20	15	23	
Sometimes a problem		7	21	20	
Often/always a problem		6	4	16	
Don't know		66	61	40	
Waiting time to see provider on day of appointment	**				B,D
Never a problem		40	30	26	
Sometimes a problem		23	30	26	
Often/always a problem		16	8	26	
Don't know		21	33	22	
Convenient to public transportation	**				B,D
Never a problem		17	6	43	
Sometimes a problem		9	1	10	
Often/always a problem		6	3	13	
Don't know		68	90	35	

	Idaho Hospitals			CAMS Sites	
	Intra-site p-value	Mercy Medical Center -B-	Magic Valley Regional Med. Center -D-	All Urban Hospitals	Inter-site p-value
Transportation assistance if needed	—				B,D
Never a problem		17	4	22	
Sometimes a problem		5	1	6	
Often/always a problem		8	6	13	
Don't know		70	90	59	
LANGUAGE NEEDS					
Needed help with translations If yes	**	24	39	17	B,D
Availability of interpreter	*				D
Very available		19	14	21	
Available		41	25	24	
Not very available		25	14	30	
Unavailable		16	46	25	
Ability of interpreter					D
Very good		47	35	46	
Fair		32	37	39	
Poor		21	28	14	
Signs in waiting area in your language		37	48	46	
Written information in your language		52	63	42	
MEDICATIONS					
Medication prescribed		57	68	74	B
If yes, how obtained					
Supplied free		25	24	20	
Used a pharmacy card	—	2	1	8	D
Used a drug store and paid	**	56	84	57	D
Didn't get /couldn't afford	—	8	4	8	
Got some/couldn't afford all	—	7	1	9	D
Other	*	13	4	6	
Medication instructions	—				
Understood instructions		96	96	92	
No instructions given		2	1	3	
Did not understand instructions			3	4	
Did not need medicine for home		1		1	
Difficulty paying for medications	**				B,D
Very difficult		29	22	40	
Not so difficult		22	39	32	
Easy to pay		4	14	10	
N/A		44	26	18	
Needed help paying for medications If yes, did staff offer help?	—	31	29	47	B,D
Always		9	11	16	
Often		9	6	7	
Sometimes		14	20	13	
Never		68	63	64	

	Idaho Hospitals			CAMS Sites	
	Intra-site p-value	Mercy Medical Center -B-	Magic Valley Regional Med. Center -D-	All Urban Hospitals	Inter-site p-value
MEDICAL BILLS					
Difficulty paying for medical care					B
Very difficult		71	58	61	
Not so difficult		24	34	30	
Easy to pay		5	7	10	
Needed help paying medical bill? If yes	*	71	59	65	B
Did staff offer to find out if financial assistance was available?	*				
Always		18	24	19	
Often		11	14	6	
Sometimes		16	17	19	
Never		56	46	56	
Type of help staff offered (If Always, Often, Sometimes to previous question)					
Pay in monthly installments	**	52	85	52	D
Reduce amount of bill		25	13	13	B
Waive bill	—	2		8	
Find charitable organization to pay	**	42	6	22	B,D
Other		17	17	20	
FUTURE CARE					
Effect of payment experience on seeking future care at facility					
Will not seek care at facility		8	13	13	B
Will use another facility	**	12	3	10	D
Easier to seek care at facility		7	5	17	B,D
Makes no difference		69	77	60	B,D
Currently owe facility money		66	66	61	
If yes, will make not seek care in future	**	38	20	28	B
If had insurance, would use facility in future		90	92	77	B,D
TRAVEL AND WAIT TIMES					
Travel time, mean (minutes)		18.24	16.48	21.55	B,D
Travel time, median (minutes)		15.00	15.00	18.00	
Days to get appointment, mean		3.24	3.46	13.55	B,D
Days to get appointment, median		1.00	2.00	7.00	
Waiting time to see provider, mean (minutes)		33.78	33.90	63.24	B,D
Waiting time to see provider, median (minutes)		20.00	30.00	45.00	

IDAHO CLINICS

This table presents the results of the surveys of patients at the two clinics included in the CAMS project in Idaho, Terry Reilly Health Services and Family Health Services. For comparison purposes, it also presents results of surveys of patients at all urban and suburban clinics that were included in the CAMS project nationally.

	Idaho Clinics			CAMS Sites	
	Intra-site p-value	Terry Reilly Health Services -A-	Family Health Services -C-	All Urban & Suburban Clinics	Inter-site p-value
Number of survey respondents		151	168	3363	
		% ^a	% ^a	% ^a	
RESPONDENT CHARACTERISTICS					
Age	**				A,C
Under 18		14	27	16	
18-29 years		26	29	27	
30-39 years		34	19	23	
40-49 years		14	11	18	
50-64 years		12	11	14	
65 or older			2	1	
Race/Ethnicity	—				A,C
White		27	26	22	
Black		1	2	44	
Hispanic		64	69	26	
Other ^b		8	4	8	
Gender					
Male		31	31	32	
Female		69	69	68	
Language in which survey administered					A,C
English		72	74	84	
Spanish		29	26	16	
Answered on behalf of child		17	19	10	A,C
FACILITY UTILIZATION					
Used outpatient clinic	*	30	37	55	A,C
Use of facility in past year					C
Once		12	11	20	
2-4 times		47	41	48	
5-9 times		23	24	19	
10 or more times		18	24	13	
Reason for visit(s)					C
Chronic problem or Mixed (chronic and non-chronic)	—	37	45	38	
Other problem (non-chronic)		63	55	62	
PERCEPTION OF FACILITY					
Experience of facility's openness to uninsured					
Open and accepting even if can't pay	**	71	87	78	A,C
Reluctant but accepts you even if can't pay	**	17	5	7	A
Offers some care if can't pay	*	15	6	8	A
Provides no assistance if can't pay	—	3	1	2	
Don't know		3	8	8	A

	Idaho Clinics			CAMS Sites	
	Intra-site p-value	Terry Reilly Health Services -A-	Family Health Services -C-	All Urban & Suburban Clinics	Inter- site p-value
Opinion of facility's reputation for treating uninsured	**				A,C
Provides a lot of care for those who can't pay		60	76	62	
Provides some care		23	7	16	
Provides very little or no care		7		4	
Don't know		10	17	19	
SATISFACTION WITH PROVIDERS/COURTESY OF STAFF					
Receptionists/Admitting clerks	—				A
Very satisfactory or satisfactory		83	93	93	
Unsatisfactory or very unsatisfactory		17	7	7	
Don't know		1			
Nurses	**				A
Very satisfactory or satisfactory		89	99	96	
Unsatisfactory or very unsatisfactory		11	2	4	
Don't know				1	
Physician assistants	**				A,C
Very satisfactory or satisfactory		72	63	78	
Unsatisfactory or very unsatisfactory		6	2	3	
Don't know		22	36	19	
Examining physicians	**				A
Very satisfactory or satisfactory		86	93	91	
Unsatisfactory or very unsatisfactory		8		3	
Don't know		5	8	6	
Social worker	—				C
Very satisfactory or satisfactory		34	38	42	
Unsatisfactory or very unsatisfactory		5		4	
Don't know		62	63	54	
Billing Clerks	**				A,C
Very satisfactory or satisfactory		73	62	50	
Unsatisfactory or very unsatisfactory		14	5	7	
Don't know		13	33	43	
Pharmacist	**				A,C
Very satisfactory or satisfactory		68	7	40	
Unsatisfactory or very unsatisfactory		14	2	4	
Don't know		19	92	56	
Treated with respect	—				
Always		71	89	84	
Sometimes		23	10	13	
Never		3		1	
Don't know		2	1	3	
ACCESSIBILITY OF SERVICES					
Hours facility open	**				A
Never a problem		60	83	74	
Sometimes a problem		26	13	20	
Often/always a problem		4	2	4	
Don't know		10	3		

	Idaho Clinics			CAMS Sites	
	Intra-site p-value	Terry Reilly Health Services -A-	Family Health Services -C-	All Urban & Suburban Clinics	Inter- site p-value
Location	—				A
Never a problem		73	80	79	
Sometimes a problem		19	15	16	
Often/always a problem		8	5	5	
Don't know			1		
Waiting time to get appointment	—				A,C
Never a problem		40	50	53	
Sometimes a problem		39	38	27	
Often/always a problem		9	8	12	
Don't know		10	4		
Waiting time to see provider on day of appointment	—				A,C
Never a problem		32	48	46	
Sometimes a problem		38	41	34	
Often/always a problem		31	9	17	
Don't know		1	1	4	
Convenient to public transportation	—				A,C
Never a problem		11	1	43	
Sometimes a problem		4		6	
Often/always a problem		4	3	4	
Don't know		81	96	47	
Transportation assistance if needed	*				A,C
Never a problem		7	1	22	
Sometimes a problem		5	3	5	
Often/always a problem		6	3	4	
Don't know		82	92	69	
LANGUAGE NEEDS					
Needed help with translations		31	33	13	A,C
If yes					
Availability of interpreter	—				C
Very available		51	80	57	
Available		33	11	26	
Not very available		9	6	12	
Unavailable		7	4	5	
Ability of interpreter	—				C
Very good		60	82	66	
Fair		31	11	28	
Poor		9	7	6	
Signs in waiting area in your language	**	62	91	73	C
Written information in your language	*	90	69	78	
MEDICATIONS					
Medication prescribed		81	76	70	A
If yes, how obtained					
Supplied free	**	21	71	56	A,C
Used a pharmacy card	—	1	2	10	A,C
Used a drug store and paid	*	71	83	34	A,C
Didn't get /couldn't afford		9	6	4	A

	Idaho Clinics			CAMS Sites	
	Intra-site p-value	Terry Reilly Health Services -A-	Family Health Services -C-	All Urban & Suburban Clinics	Inter-site p-value
Got some/couldn't afford all	**	9	2	6	C
Other	—	7	2	7	C
Medication instructions	—				
Understood instructions		95	98	96	
No instructions given		2		1	
Did not understand instructions		3	1	1	
Did not need medicine for home			1	1	
Difficulty paying for medications					A,C
Very difficult		27	19	27	
Not so difficult		45	46	23	
Easy to pay		14	10	15	
N/A		15	25	36	
Needed help paying for medications	**	37	23	36	C
If yes, did staff offer help?					A
Always		13	28	42	
Often		17	17	10	
Sometimes		19	11	14	
Never		51	44	34	
MEDICAL BILLS					
Difficulty paying for medical care					A,C
Very difficult		37	29	33	
Not so difficult		43	51	34	
Easy to pay		20	20	34	
Needed help paying the medical bill? If yes		53	45	43	A
Did staff offer to find out if financial assistance was available?	**				A,C
Always		14	33	41	
Often		24	29	12	
Sometimes		23	8	14	
Never		39	29	34	
Type of help staff offered (If Always, Often, Sometimes to previous question)					
Pay in monthly installments	**	49	85	41	C
Reduce amount of bill		67	77	35	A,C
Waive bill	—	4		26	A,C
Find charitable organization to pay		25	11	28	C
Other	—	8	8	11	
FUTURE CARE					
Effect of payment experience on seeking future care at facility					
Will not seek care at facility	—	4	2	4	
Will use another facility	**	9		3	C
Easier to seek care at facility		43	52	53	A
Makes no difference		46	49	39	C
Currently owe facility money		50	44	20	A,C
If yes, will make not seek care in future		27	15	23	
If had insurance, would use facility in future	**	79	95	82	C

	Idaho Clinics		CAMS Sites		
	Intra-site p-value	Terry Reilly Health Services -A-	Family Health Services -C-	All Urban & Suburban Clinics	Inter-site p-value
TRAVEL AND WAIT TIMES					
Travel time, mean (minutes)		17.34	18.65	19.10	
Travel time, median (minutes)		15.00	15.00	15.00	
Days to get appointment, mean	**	8.38	3.83	8.98	C
Days to get appointment, median		5.00	2.00	3.00	
Waiting time to see provider, mean (minutes)	**	47.58	21.07	47.47	C
Waiting time to see provider, median (minutes)		30.00	15.00	30.00	

LEGEND

- a Persons with missing values were excluded from analysis.
- b “Other” includes Asian/Pacific Islander, Native American, and “mixed.”
- * $p < 0.05$ for overall chi-square test among facilities for each characteristic listed.
- ** $p < 0.01$ for overall chi-square test among facilities for each characteristic listed.
- The cell size was insufficient to conduct an overall chi-square test (more than 20 percent of the cells have expected counts less than five).
- A,B $p < 0.05$ for overall chi-square test between facility and all urban/suburban clinics for each characteristic listed. Letter denotes facility (as indicated in column heading). Blank cells in the Inter-site p value column indicate that either no significant difference existed or that the cell size was insufficient.

SO WHAT IS A P-VALUE?

Statistics based on samples are always subject to “sampling error,” that is, there is most likely some difference between the value that a sample yields and the *true* value in the population that the sample represents. Statistics are often given with a range (for example, “plus or minus 3%”) for this reason. Because of sampling error, two numbers based on samples, which appear to be different, may not actually be different; their ranges might overlap.

The p-value is a statistical measure to determine if there is a true, significant difference between compared numbers. The value of $p < 0.05$, which is a standard accepted level of significance, says that the likelihood is small - 5% or less - that the comparison between two sample statistics is *not* the same as the population comparison. The difference is said to be “statistically significant.” The lower the p-value (e.g., $p < 0.01$), the more likely that the differences are significant.

APPENDIX B: SURVEYED FACILITIES BY CAMS SPONSORING ORGANIZATION AND BY TYPE

SURVEYED FACILITIES BY CAMS SPONSORING ORGANIZATION

<i>CAMS SPONSORING ORGANIZATION</i>	<i>SURVEYED FACILITIES</i>
Puentes de Amistad/ Bridges in Friendship Somerton, Arizona	Sunset Health Center Yuma Regional Medical Center
Central CA Legal Services Fresno, California	Community Hospital Poverello House/Holy Cross Center for Women Sequoia Health Foundation Clinics United Health Centers-Mendota United Health Centers-Parlier University Medical Center
LifeLong Medical Care Berkeley, California	Berkeley Primary Care Access Clinic The LifeLong Clinic West Berkeley Family Practice
The Volusia County Access Project Volusia County, Florida	Halifax Keech Health Center Halifax Medical Center Memorial Hospital-West Volusia Volusia County Health Department Clinic, DeLand
Human Services Coalition of Dade County, Inc. Miami, Florida	Jefferson Reaves, Jr. Health Center Dr. Rafael A. Peñalver Clinic
Capital Medical Society Foundation, Inc. Tallahassee, Florida	Bond Community Health Center Leon County Health Department Neighborhood Health Services Tallahassee Memorial Healthcare Emergency Room The We Care Network of the Capital Medical Society Foundation
Southwest Georgia Community Health Institute Albany, Georgia	Albany Area Primary Health Care Palmyra Medical Center Phoebe Putney Memorial Hospital's Emergency Center Southwest Georgia Regional Medical Center
Idaho Primary Care Association Boise, Idaho	Family Health Services Magic Valley Regional Medical Center Mercy Medical Center Terry Reilly Health Services
Campaign for Better Health Care Chicago, Illinois	Mile Square Health Center
Westside Health Authority Chicago, Illinois	Austin Cook County Health Center Circle Family Care/R.M. Gunnar Clinic
Lake Cumberland District Health Department Somerset, Kentucky	Clinton County Hospital Russell County Hospital Wayne County Hospital

Department of Family Medicine, Louisiana State University Healthcare Services Division Baton Rouge, Louisiana	Earl K. Long Medical Center
Health Care Centers in Schools, Inc. Baton Rouge, Louisiana	Istrouma School-Based Health Center
Northern Berkshire Community Coalition North Adams, Massachusetts	North Adams Regional Hospital
Progressive Leadership Alliance of Nevada (PLAN) Las Vegas, Nevada	Sunrise Hospital and Medical Center University Medical Center
The Northwest Bronx Community & Clergy Coalition Commission on the Public's Health System in New York City Bronx, New York	North Central Bronx Hospital
North Carolina Fair Share Raleigh, North Carolina	Wake Medical Center
Universal Health Care Action Network of Ohio (UHCAN) Cleveland, Ohio	Cleveland Clinic Huron Hospital MetroHealth Hospital University Hospital
Legal Aid Society of Greater Cincinnati Cincinnati, Ohio	University Hospital
Project Equality/Oregon Health Access Project Lincoln County, Oregon	Pacific Communities Hospital North Lincoln Hospital
Latino Memphis Conexion Memphis, Tennessee	The Memphis Regional Medical Center
Planned Parenthood of Houston and Southeast Texas, Inc. Houston, Texas	Fannin Family Planning Clinic
Texas Institute for Health Policy Research Austin, Texas	CHRISTUS Jasper Memorial Hospital
Tenants' and Workers' Support Committee Alexandria, Virginia	INOVA Alexandria Hospital
West Virginia Community Voices Partnership Charleston, West Virginia	Boone Memorial Hospital Cabin Creek Health Center Clay County Primary Care West Virginia Health Right, Inc. WOMENCARE

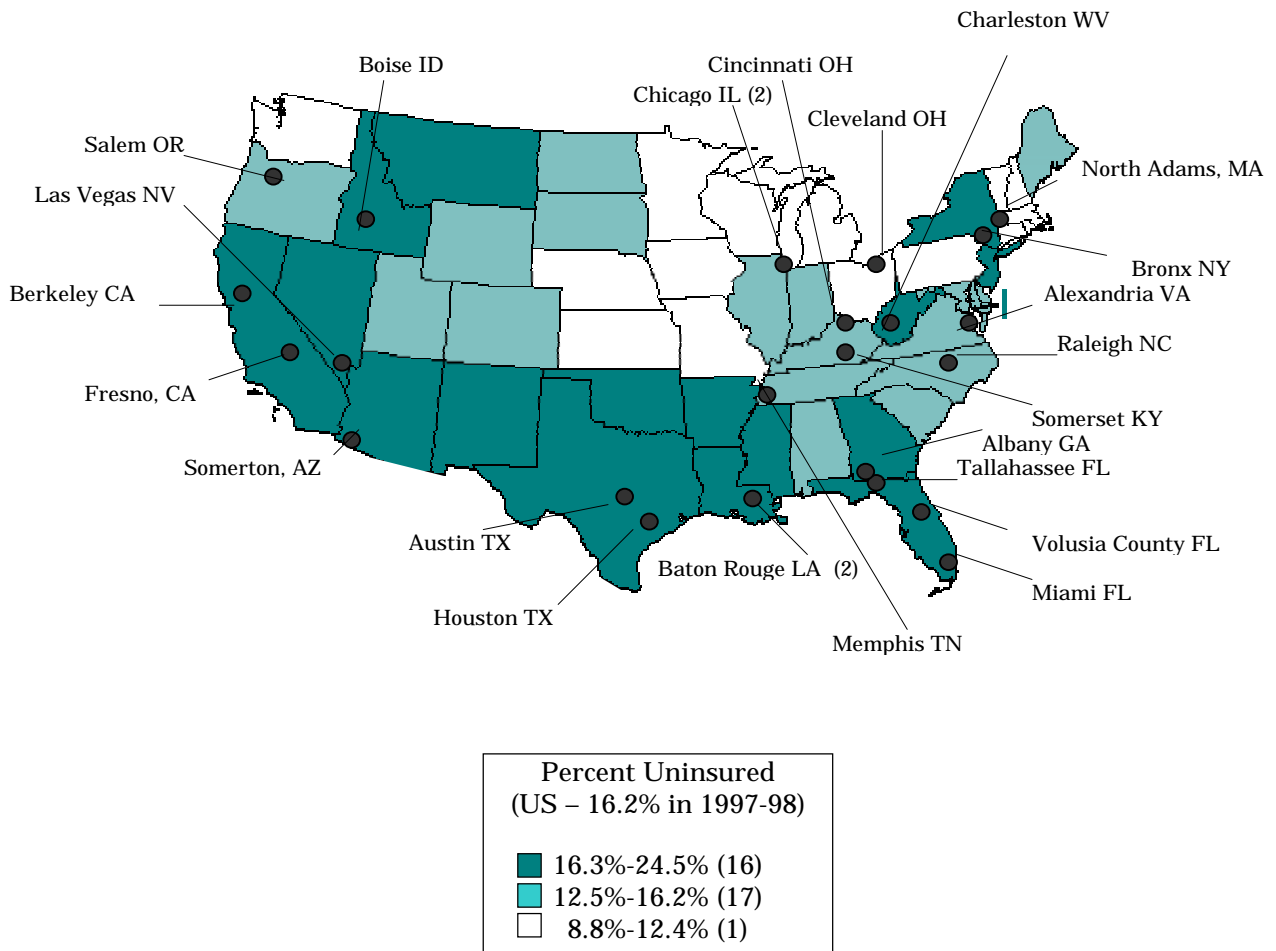
SURVEYED FACILITIES BY TYPE

<i>FACILITIES BY TYPE</i>	<i>LOCATION</i>
Urban/Suburban Hospitals	
Yuma Regional Medical Center	Yuma, AZ
Community Hospital	Fresno, CA
University Medical Center	Fresno County, CA
Halifax Medical Center	Halifax, FL
Tallahassee Memorial Healthcare Emergency Room	Tallahassee, FL
Memorial Hospital	West Volusia County, FL
Palmyra Medical Center	Albany, GA
Phoebe Putney Memorial Hospital's Emergency Center	Albany, GA
Mercy Medical Center	Nampa, ID
Magic Valley Regional Medical Center	Twin Falls, ID
Earl K. Long Medical Center	Baton Rouge, LA
Sunrise Hospital and Medical Center	Las Vegas, NV
University Medical Center	Las Vegas, NV
North Central Bronx Hospital	The Bronx, NY
Wake Medical Center	Raleigh, NC
University Hospital	Cincinnati, OH
Cleveland Clinic	Cleveland, OH
Huron Hospital	Cleveland, OH
Metrohealth Hospital	Cleveland, OH
University Hospital	Cleveland, OH
The Memphis Regional Medical Center	Memphis, TN
INOVA Alexandria Hospital	Alexandria, VA
Rural Hospitals	
Southwest Georgia Regional Medical Center	Cuthbert, GA
Clinton County Hospital	Albany, KY
Wayne County Hospital	Monticello, KY
Russell County Hospital	Russell Springs, KY
North Adams Regional Hospital	North Adams, MA
North Lincoln Hospital	Lincoln City, OR
Pacific Communities Hospital	Newport, OR
CHRISTUS Jasper Memorial Hospital	Jasper County, TX
Boone Memorial Hospital	Madison, WV
Urban/Suburban Clinics	
Berkeley Primary Care Access Clinic	Berkeley, CA
The Lifelong Clinic	Berkeley, CA
West Berkeley Family Practice	Berkeley, CA
Poverello House/Holy Cross Center for Women	Fresno, CA
Sequoia Health Foundation Clinics	Fresno County, CA
Volusia County Health Department Clinic	Deland, FL

Halifax Health Center	Halifax, FL
Bond Community Health Center	Leon County, FL
Leon County Health Department	Leon County, FL
Neighborhood Health Services	Leon County, FL
Dr. Rafael A. Peñalver Clinic	Miami-Dade County, FL
Jefferson Reaves, Jr. Health Center	Miami-Dade County, FL
Terry Reilly Health Services	Boise, ID
Family Health Services	Magic Valley Region, ID
Austin Cook County Health Center	Chicago, IL
Mile Square Health Center	Chicago, IL
Circle Family Care/R.M. Gunnar Clinic	Chicago, IL
Istrouma School-Based Health Center	Baton Rouge, LA
Fannin Family Planning Clinic	Houston, TX
West Virginia Health Right, Inc.	Charleston, WV
WomenCare	Scott Depot, WV
Rural Clinics	
Sunset Health Center	Somerton, AZ
United Health Centers - Mendota	Mendota, CA
United Health Centers - Parlier	Parlier, CA
Albany Area Primary Health Care	Dougherty, Lee, Terrell, and Baker, Calhoun Counties, GA
Clay Primary Care	Clay, WV
Other (Provider Network)	
The We Care Network	Leon County, FL

APPENDIX C: LOCATIONS OF CAMS SPONSORING ORGANIZATIONS AND STATE UNINSURANCE RATES 1997-98

The map below shows the locations of all of the organizations conducting Community Access Monitoring Surveys. It also indicates percentages without health insurance in each state for 1997-98.



APPENDIX D: SURVEY INSTRUMENT

Record time interview begins _____

[If the respondent is answering on behalf of his or her child, mark this box and change the wording in all of the following questions from *you* to *your child*.]

“First, I have a few background questions about your experience at (facility name)

_____:

I. BACKGROUND / DEMOGRAPHICS

1. How many times did you use (facility name) _____ in the past year?

- Once
- 2 - 4 times
- 5 - 9 times
- 10 or more times

Comments: _____

2. Why did you go there? (for what medical problem(s))

3. Did you visit this facility for a problem that bothers you frequently and that you often need care for, or for some other problem?

- For a problem that bothers you frequently like asthma, diabetes or arthritis
Please specify: _____
- Some other problem
- A mix of both

Comments: _____

4a. Did you use the hospital emergency room?

- Yes
- No
- Not applicable

4b. Were you admitted?

- Yes
- No
- Not applicable

4c. Did you visit a clinic as an outpatient?

- Yes
- No
- Not applicable

“Now I would like to ask you a few background questions”

5. Age:

Are you:

- Under 18
- 18-29
- 30-39
- 40-49
- 50-64
- 65 and over

6. Gender:

- Male
- Female

7. Ethnicity/Cultural Heritage:

Do you identify yourself as:

- African American/Black
- Asian/Pacific Islander
- Caucasian
- Hispanic/Latino
- Native American
- Mixed
- Other (Please Specify) _____

8. What is your zip code? _ _ _ _ _

“The next questions are more about (facility name) _____.”

II. PROVIDER HISTORY TOWARD CARING FOR THE UNINSURED

1. In your experience, how open has (facility name) _____ been in offering services to you if you can't pay for medical care? (Choose all that apply)

- Open and accepting even if you can't pay for health care
- Reluctant but accepts you even if you can't pay for health care
- Offers some care if you can't pay
- Provides no care if you can't pay
- Do not know

Comments: _____

2. In your opinion, what is the reputation of (facility name) _____ in providing treatment to people who can't pay for medical care in your community?

- Provides a lot of care in the community for people who can't pay
- Provides some care for people who can't pay
- Provides very little or no care for people who can't pay
- Do not know

Comments: _____

“The next questions ask about the staff at (facility name)

3. In your experience, were the following staff courteous to you when medical care was needed:

Please rate the courtesy and helpfulness overall for (facility name) _____ on a scale from: 1 (Very Satisfactory), 2 (Satisfactory), 3 (Unsatisfactory), 4 (Very Unsatisfactory) or 5 (Don't Know/Not Applicable)

Repeat choices for each question

	<i>Very Satisfactory</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>	<i>Very Unsatisfactory</i>	<i>Don't Know/Not Applicable</i>
	1	2	3	4	DK/NA
a) Receptionists/ admitting clerks	1	2	3	4	DK/NA
b) Nurses	1	2	3	4	DK/NA
c) Physician's assistants	1	2	3	4	DK/NA
d) Examining physicians	1	2	3	4	DK/NA
e) Social workers	1	2	3	4	DK/NA
f) Billing clerks	1	2	3	4	DK/NA
g) Pharmacy staff	1	2	3	4	DK/NA
h) Others _____	1	2	3	4	DK/NA

4. Are there any special comments you want to make about the way you were treated in the Emergency Room, in any of the clinics, or as an in-patient at (facility name)

_____?

Now I would like to ask you about how easy it was for you to get the services you needed at (facility name) _____ when you were uninsured and trying to get medical care?"

III. ACCESS TO HEALTH SERVICES

1. Please rate the accessibility of services at (facility name) _____ on a scale from: 1 (Never a Problem), 2 (Sometimes a Problem), 3 (Often a Problem), 4 (Always a Problem) or 5 (Don't Know/Not Applicable)

Repeat choices for each question

	<i>Never a Problem</i>	<i>Sometimes a Problem</i>	<i>Often a Problem</i>	<i>Always a Problem</i>	<i>Don't Know/Not Applicable</i>
	1	2	3	4	DK/NA
a) How about the hours that (facility name) _____ is open?	1	2	3	4	DK/NA
b) How about the hours that the hospital emergency department is open?	1	2	3	4	DK/NA
c) How about the convenience of location? How long does it take for you to get there? Time: _____ (in minutes)	1	2	3	4	DK/NA
d) How about the waiting time to get an appointment with a health care provider? Time: _____ (in days)	1	2	3	4	DK/NA
e) How about the waiting time to see the health care provider on the day of your appointment? Time: _____ (in minutes)	1	2	3	4	DK/NA
f) How about getting an interpreter if you need one?	1	2	3	4	DK/NA
g) How about the convenience to public transportation lines?	1	2	3	4	DK/NA
h) How about transportation assistance if needed?	1	2	3	4	DK/NA

Comments: _____

“The next questions are about medications.”

2a. Was medicine prescribed during any of your visits when you were uninsured?

- Yes
- No *(if no, skip to question 4)*

2b. If medication was prescribed, did you get it? (Choose all that apply)

- Yes, supplied free by the staff
- Yes, used a pharmacy card
- Yes, went to pharmacy or drug store and paid
- No, did not get the medication because I could not afford it
- Some, did not get all my medications because I could not afford them
- Other _____

Comments:

3. If you needed medicine to take at home, how well did you understand the instructions on how to take the medicine?

- Yes, I understood the instructions
- No instructions were given
- I did not understand the instructions
- I did not need medicine for home

Comments:

4. Is there anything else you would like to say about how you were treated, or how easy it was for you to get services or medications at (facility name) _____?

“The next questions relate to language and culture issues at (facility name) _____.”

IV. LANGUAGE AND CULTURE NEEDS

Note: *If the interviewee is fluent in English please check “No” in Question 1 and go to Question 6a*

1. When you were treated at (facility name) _____ in the past year was help with translation needed because you spoke little or no English?

- Yes *(If yes, please answer the following questions.)*
- No *(If no, then please go to Question 6a)*

Comments: _____

2. If you did need help, how available was an interpreter to assist? (Choose one only)

- Very available*—the *doctor* or *nurse* spoke my language and was there for treatment
- Available*— an *interpreter* was there when I was treated
- Not very available*—the wait for someone who spoke my language was a long time
- Unavailable*—someone with me (a friend or family member) had to translate

Comments: _____

3. How good was the health care professional who spoke your language in talking to and understanding your problem? (Choose one only)

- Very good*—the health care person and I understood each other
- Fair*—the health care person and I mostly understood each other, but there was some difficulty in translating questions and in understanding the answers
- Poor*—the health care person and I for the most part could not understand each other

Comments: _____

4. Does (facility name) _____ have any signs in your language in the admitting area or waiting room?

- Yes
- No

Comments: _____

5. Did (facility name) _____ offer you information written in your language to assist in medical care?

- Yes
- No

Comments: _____

6a. Did you feel that the health care professionals treated you with respect?

- Always
- Sometimes
- Never
- Does not apply/Don't Know

Comments: _____

6b. Did the health care professionals who treated you ask you whether you are using traditional methods of healing, like herbs, acupuncture, other?

- Always
- Sometimes
- Never
- Does not apply/Don't Know

Comments: _____

7. Is there anything else you would like to say about language or culture issues at (facility name) _____?

“Finally, I would like to ask you some questions about payment of medical bills.”

V. PAYMENT FOR MEDICAL CARE

1. How difficult was it for you to pay for the cost of medical care at (facility name) _____? (Choose one only)

- Very difficult to pay for medical care
- Not so difficult to pay for medical care
- Easy to pay for medical care

Comments: _____

2. Did you need help in paying the medical bill?

- Yes -- *If yes, go to 2a*
- No -- *If no, go to 3*

2a. If yes, did the staff at (facility name) _____ ask if help was needed?

- Always
- Often
- Sometimes
- Never

Comments: _____

3. Did the staff at (facility name) _____ offer to help you find out if any financial assistance was available?

- Always
- Often
- Sometimes
- Never - *If never, go to 4*

Comments: _____

3a. When they did offer, what kind of financial assistance did they offer? (Choose all that apply)

- Pay some amount every month
- Reduce the amount that had to be paid
- Waived bill altogether
- Help find a charitable organization that would help pay the medical bill (please specify)_____
- Other (please describe)_____

Comments: _____

4. How difficult was it for you to pay for the cost of your medications? (Choose one only)

- Very difficult to pay for medications
- Not so difficult to pay for medications
- Easy to pay for medications
- Not applicable

Comments: _____

5. Did you need help in paying for your medication?

- Yes -- *If yes, go to 5a*
- No -- *If no, go to 6*

5a. If yes, did the staff at (facility name) _____ ask if help was needed?

- Always
- Often
- Sometimes
- Never

Comments: _____

**6. How will the amount of money and the way you had to pay for medical care at (facility name) _____ affect your choosing to seek care there in the future?
(Choose all that apply) (Read the following options to the interviewee)**

- The cost for medical care will make you not seek care at (facility name) _____
- The cost for medical care at (facility name) _____ will make you use another medical care facility
- The cost for medical care will make it easier to seek care at (facility name) _____
- It will not make a difference

Comments: _____

7. Do you currently have unpaid bills or debt owed to (facility name) _____?

- Yes (If yes, go to 7a)
- No (If no, go to 8)

Comments: _____

7a. Would these unpaid bills or debt make you not seek care there in the future?

- Yes
- No

Comments: _____

8. If you had insurance that paid for your medical care, would you use (facility name) _____ in the future?

- Yes
- No

Comments: _____

9. Are there any other comments you would like to make about payment of medical bills or about (facility name) _____ in general?

“Thank you very much for taking the time to complete this survey.”

Time Completed: _____

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