



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at the Istrouma School-Based
Health Center, Baton Rouge, LA*

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*This report was produced in collaboration with Health Care Centers in
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March 2001

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

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

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Health Care Centers in Schools, Inc. (HCCS) is a not-for-profit community-based organization that runs health centers in the public schools in East Baton Rouge Parish. It is governed by a community board and has a mission to “provide comprehensive, quality health care services to students in the schools we serve. HCCS is committed to community collaboration. HCCS links education with the physical and emotional health care to promote the health, education, and well being of students.” HCCS also helps students understand appropriate use of health care facilities and how to give feedback about quality.

HCCS was started in 1986 with a grant from the Robert Wood Johnson Foundation. By 1997, HCCS was running seven school health centers, and has recently received funding to open an eighth center. The school clinics were originally run by the Department of Pediatrics and later Family Medicine at Louisiana State University Medical School, but have since moved to community-based status, which is more in keeping with HCCS philosophy and facilitates public-private partnerships. The clinics are staffed with a full-time registered nurse, social worker, and community outreach worker during the school year. Physicians and a psychologist provide back-up and weekly visits.

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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 at one facility in Baton Rouge, Louisiana. The survey was conducted in the summer of 2000 and gathered information from 198 uninsured students who obtained health care at the Istrouma School-Based Health Center in the previous year. This health center, which provides free services, was the only school-based facility included in the CAMS project nationwide. The report also compares the experiences of the Istrouma respondents with those of uninsured patients who received care at all urban and suburban health clinics included in the CAMS project nationwide.

KEY FINDINGS

Respondents reported moderate use of Istrouma School-Based Health Center. Slightly more than half said they used the clinic between two and four times in the past year, and another fifth said they used it five to nine times. One-fourth of the respondents said they used the clinic only once, while very few said they used it ten times or more.

Overall, the responses indicated very favorable perceptions of the clinic.

- ◆ More than four out of five said that, in their experience, the clinic was open and accepting even though they could not pay for care.

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- ◆ Most respondents said they were satisfied with the care and services they received from staff, and almost all (94%) said that they were always treated with respect.
- ◆ More than half of the respondents said they were able to make an appointment for the same day, and the average reported waiting time to see a health provider was ten minutes.
- ◆ Nearly all of the respondents (93%) said that the location of the clinic—inside the school—was never a problem for them.
- ◆ Few respondents who received prescriptions had difficulty obtaining their medications, even though two-thirds of them paid for them out-of-pocket.
- ◆ As services at the clinic are free, very few respondents reported that it was difficult to pay for their medical care.
- ◆ Nearly all of the respondents (92%) said they would use the clinic even if they had health insurance.

While few respondents reported problems with the clinic, a small subset did report issues related to access.

- ◆ Although the waiting time to make an appointment was much shorter than the average for AUSCs, it was still seen as a problem at least sometimes by one-quarter of the respondents.
- ◆ Fifteen percent of respondents thought that the hours of operation were a problem at least sometimes.



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 Baton Rouge, Louisiana. The survey was conducted by Health Care Centers in Schools, Inc. in the summer of 2000, and gathered information from uninsured students who received care at Istrouma School-Based Health Center in Baton Rouge in the previous year. Along with providing the results of the survey for this facility, the report compares the results with aggregate responses for 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 Summer 2001.



LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

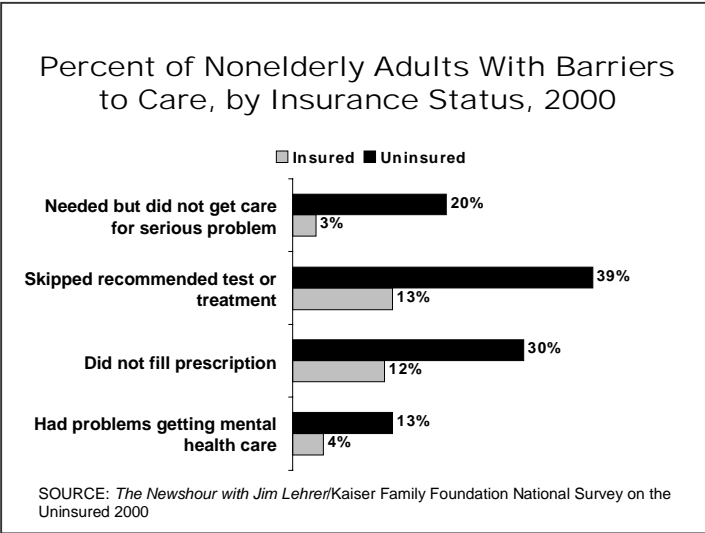
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

LACK OF INSURANCE AND ACCESS TO CARE

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

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

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



LACK OF INSURANCE AND HEALTH OUTCOMES

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

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

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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 **Health Care Centers in Schools, Inc.**

The first school-based health center in Louisiana, the **Istrouma High School Health Center**, opened in 1987. This center, along with the Westdale Middle School Health Center in Baton Rouge and the Carver High School Health Center in New Orleans, has been a model for the state on how to deliver multi-disciplinary health services to children and adolescents in Louisiana. In the year 2000, communities across Louisiana will operate school-based health centers in forty-nine schools and serve thousands of children and their families. Louisiana is one of the top-ranked states in the school-based health center initiative.

Access to health care remains an overriding issue for adolescents in Louisiana, many of whom are among the state's uninsured and under-insured population. Louisiana ranks 50th among the states in overall indicators of health, and the precursors of many future health problems are detectable in the adolescents treated at the school-based health centers.³¹

The Louisiana Office of Public Health and The Louisiana Assembly on School-Based Health Care have joined forces to promote good health among Louisiana residents. All school-based health centers have instituted risk assessment tools that allow the health care providers in the health centers to educate and prevent some of the behavior that leads to high incidence of disease and premature death in Louisiana.

Health Care Centers in Schools, Inc (HCCS) operates the clinics in public schools. The clinics have 18,300 visits annually, including visits for both mental health and physical health problems. The most common mental health problems seen at HCCS clinics are family stress, academic underachievement, and interpersonal conflict. The major reasons for physical health visits include primary preventive health care, treatment for acute accidents and injuries, and treatment for acute illness. HCCS is a center for active research in the use of the American Medical Association's Guidelines to Adolescent Preventive Services (GAPS). HCCS is also reaching out to the communities that surround these schools to engage neighborhoods in earnest dialogue concerning risk factors that are detected, and to offer community-wide health promotion activities in an effort to reduce student health risks.

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The Department of Family Medicine at Earl K. Long Medical Center (EKL) provides the medical care and back-up for HCCS. EKL is a public hospital, one of nine hospitals operated by the Louisiana State University Health Care Services Division. As a public hospital, EKL serves the state's uninsured population, and has a mission to provide high quality medical care regardless of income and to work cooperatively with other health care programs, providers and groups at the state and community level.

SURVEY METHODOLOGY

The surveys were conducted by three trained surveyors. Prior to conducting the interviews, the surveyors attended a full-day training session in survey administration provided by trainers from the Health Training Innovations Program of The Medical Foundation in Boston, Massachusetts.

All respondents were adolescents who had received services at the Istrouma School-Based Health Center during the previous year while uninsured, and who had been granted parental consent to participate in survey or questionnaire activity. Respondents were screened face-to-face using a prepared face sheet designed to identify eligible participants. Fifty-four initial interviews were conducted through mass interview sessions that took place over a two-day period during six Reserve Officers Training Corps (ROTC) classes, six physical education classes, four home economics classes, and four health classes at Istrouma High School. The remaining survey interviews were conducted in the Istrouma High School library and in respondents' homes.

In addition, Istrouma School-Based Health Center provided the names of 340 students who were uninsured; these students comprised 45 percent of Health Center enrollment. These prospective respondents were contacted by telephone to schedule appointment dates and times for an initial screening. Students who had previously participated through the mass interviews, students whose insurance status had changed, and others who chose not to participate were eliminated. Among these students, survey administrators completed 144 surveys.

In total, 198 surveys were completed. All but ten respondents answered for themselves. Ten respondents answered on behalf of their children; these respondents had received services for themselves and their children at the Istrouma High School Teen Learning-Early Headstart Center.

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, and by Nanette Goodman, an independent health policy consultant.

Because respondents were not randomly selected, the survey results cannot be generalized to the entire population of uninsured persons or of individuals receiving care at the targeted facilities. *The results reflect the experiences only of those surveyed.*



SURVEY FINDINGS

This section describes the survey results for respondents who received care at Istrouma School-Based Health Center while uninsured and compares them with averages for All Urban and Suburban Clinics (AUSCs) 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 Istrouma School-Based Health Center, as well as for the aggregate results for AUSCs.

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.

RESPONDENT CHARACTERISTICS

Istrouma School-Based Health Center (SBHC) respondents were predominantly under age 18. Nearly all were African-American and two-thirds were female.

Most of the respondents (85%) were 18 years of age or younger. Fifteen percent reported that they were between 18 and 29 years of age. In comparison, the average proportion of respondents who were younger than 29 for AUSCs was 43 percent. Four percent of the Istrouma SBHC respondents answered on behalf of their child.

Nearly all—94 percent—of the respondents identified themselves as African American. Five percent of the respondents were white and one percent said they were of Hispanic origin.

Similar to AUSCs, two thirds of the respondents were female. All the respondents chose to take the survey in English.

USE OF HEALTH SERVICES

Istrouma SBHC respondents were less likely to have visited the clinic more than 10 times in the past year and less likely to have a chronic condition than the average for AUSCs.

Slightly more than half (55%) of the Istrouma SBHC respondents said that they used the clinic between two and four times in the past year. Another one-fifth (21%) of the respondents said they used the facility five or more times. Very few used it ten or more times. About one of



six respondents (16%) said that they sought care to treat a chronic problem, lower than the average for AUSCs (38%).

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

Most respondents reported that the clinic had been open and accepting to them even though they were not able to pay, and most felt that they were treated with respect.

Eighty-three percent of respondents for Istrouma SBHC said that in their experience, the clinic had been open and accepting to them even if they were unable to pay for their care. The average for AUSCs was similar: 78 percent (ns).

Two of five respondents (44%) reported that the clinic had a reputation in the community for providing “a lot” of care to those who cannot pay. In addition, 14 percent of the respondents said that the facility has a reputation for providing “some care,” but 42 percent responded that they did not know the reputation.

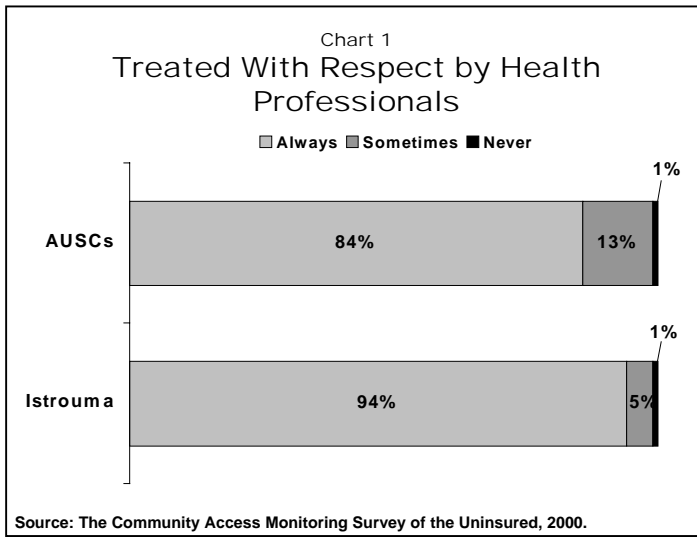
Most respondents reported that they were either “very satisfied” or “satisfied” with the care and service they received from providers. Very few respondents said they were dissatisfied with their interactions with any category of staff.

When respondents were asked if they were treated with respect by the clinic staff, 94 percent responded that they were “always” treated with respect; this compared to an average of 83 percent for AUSCs. (Chart 1)

“I like the way they treat the students when they go there.”
Istrouma SBHC Respondent

“At first I did not like anyone in the clinic. I was mad every time they wanted to see me, but they helped me see that they were trying to help me.”
Istrouma SBHC Respondent.

“I’m glad they were able to treat my baby. It helped me to stay at school so I can graduate”
Istrouma SBHC Respondent



ACCESSIBILITY

Most respondents reported that Istrouma SBHC was very accessible in terms of hours, location and waiting times.

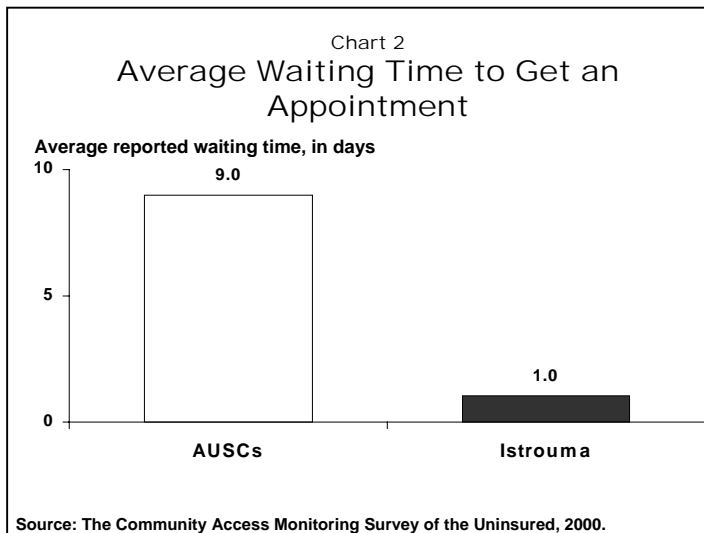
Four of five respondents (82%) reported that the clinic's hours were "never a problem" for them, while 15 percent said the hours were a problem at least sometimes. In comparison, an average of 24 percent of respondents for AUSCs reported that the hours were a problem at least sometimes.

"The clinic is across from the attendance office, so sometimes it makes you wonder who sees you going in the clinic, but they don't tell your business so its okay."

Istrouma SBHC Respondent

The vast majority of Istrouma SBHC respondents (93%) said the location of the clinic was "never a problem," while the average for AUSCs was 79 percent.

The average reported waiting time to get an appointment was one day, and more than half the respondent said they were able to make an appointment for the same day. This was in sharp contrast to AUSCs, where respondents reported an average of nine days to get an appointment. (Chart 2) However, the proportion of Istrouma SBHC respondents who said that the waiting time was a problem at least sometimes was only slightly smaller than the average for AUSCs (29% vs. 39%).



Istrouma SBHC respondents were much less likely than the average for AUSCs to report that the waiting time to see a provider on the day of the appointment was a problem even sometimes (19% vs. 51%). Istrouma SBHC respondents reported waiting an average of ten minutes, compared with an average of 47 minutes for AUSCs.



OBTAINING PRESCRIPTION MEDICATIONS

Relatively few Istrouma SBHC respondents had medications prescribed, and most of these respondents reported that obtaining their medications was not a problem for them. Most said they filled them at a drug store and paid out-of-pocket, and few reported difficulty in paying for medications.

One of five (19%) respondents for Istrouma SBHC reported that they had medications prescribed, compared with 70 percent for AUSCs.

Among the Istrouma SBHC respondents who received prescriptions, about one-third received at least some of their medications free, while more than two-thirds said that they went to a drug store and paid out-of-pocket. Four respondents were unable to obtain some or all of their medications because of cost.

Most reported that paying for medications was either “easy” or “not so difficult.”

“I wasn't given a prescription for my ring worms, but they wrote a note for me to give to my mother to get the over-the-counter medicine that they suggested”.
Istrouma SBHC Respondent

“They gave me a prescription I could afford.”
Istrouma SBHC Respondent

CONCERNS OVER PAYMENT FOR HEALTH CARE

Because the clinic does not charge for services, few respondents reported difficulty paying for care.

About two of three (63%) respondents for Istrouma SBHC said paying for their medical bills was “not so difficult” and 37 percent said it was “easy to pay.” Only one percent of the respondents reported that their medical bills were “very difficult” to pay, while the average for AUSCs was 33 percent.

“I did not pay anything, it was a free service.”
Istrouma SBHC Respondent

SEEKING CARE IN THE FUTURE

Most Istrouma SBHC respondents said they would use the clinic even if they had insurance.

When Istrouma SBHC respondents were asked how their past experience paying for care would affect whether they chose to use the clinic again, 78 percent of the respondents reported that it would make no difference and 31 percent reported that it would make it easier to seek care. No respondents said that they would not seek care again or use a different facility as a result of their past payment experiences.

“It's really nice having someone to talk to when you really need it and not days later. By then, you can figure stuff out for yourself either in a good or bad way.”
Istrouma SBHC Respondent

Nine of ten (92%) respondents for Istrouma SBHC said that they would use the clinic again if they had health insurance. In comparison, the average for AUSCs was 82 percent.

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DISCUSSION

Overall, the responses of the students who used Istrouma School-Based Health Center indicated very favorable perceptions of the clinic.

- ◆ More than four out of five respondents said that, in their experience, the clinic was open and accepting even though they could not pay for their care.
- ◆ Most respondents said they were satisfied with the care and services they received from staff, and almost all of the respondents (94%) said that they were always treated with respect.
- ◆ The average waiting times reported by respondents both to get an appointment and to see a provider on the day of the appointment were substantially shorter than the average for AUSCs.
- ◆ Nearly all of the respondents (93%) said that the location of the clinic—inside the school—was never a problem for them.
- ◆ Few respondents who received prescriptions had difficulty obtaining their medications, even though two-thirds of them paid for them out-of-pocket.
- ◆ As services at the clinic are free, very few respondents reported that it was difficult to pay for their medical care.
- ◆ Nearly all respondents (92%) said they would use the clinic even if they had health insurance.

While few respondents reported problems with the clinic, a small subset did report issues related to access.

- ◆ Although the waiting time to make an appointment was much shorter than the average for AUSCs, it was still seen as a problem at least sometimes by one-quarter of the respondents.
- ◆ Fifteen percent of respondents thought that the hours of operation were a problem at least sometimes.

In addition, while 44 percent of the students said that the clinic had a reputation in the community for providing “a lot of care” to those who cannot pay, and 14 percent said it had a reputation for providing “some care,” 42 percent said that they “didn’t know” the clinic’s reputation in the community.

Respondents reported moderate use of the clinic. Slightly more than half said they had used it between two and four times in the past year, and another fifth said they used it five to nine times. One-fourth of



the respondents said they used the clinic only once, while very few said they used it ten times or more.

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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ACKNOWLEDGEMENTS

Friends of Health Care Centers in Schools would like to thank:

- ◆ The Health Care Centers in Schools Board of Directors for its continued support,
- ◆ Sue Catchings, Executive Director of Health Care Centers in Schools,
- ◆ Holley Galland MD, Medical Director of Health Care Centers in Schools, for her vision and drive,
- ◆ Mary Mikell of Friends of Health Care Centers in Schools,
- ◆ Terry Rew, Executive Director, Literacy Works, for teaching us that working with the community is always difficult and time-consuming, and always rewarding,
- ◆ The Women's Hospital of Baton Rouge for the excellent preparations of the facility and food during the training of the survey administrators,
- ◆ Elisha Jackson, Principal, Istrouma High School, who has the courage to say yes and the strength to continue to keep what's best for the students of Istrouma at the forefront of his vision,
- ◆ The parents of survey participants at Istrouma High School, and
- ◆ The students of Istrouma High School, who have always challenged us in unimaginable ways and who support us in times of trouble. Their support gives us the courage to continue our work every day.

Friends of Health Care Centers in Schools is especially indebted to the vigilant, dedicated, and persistent Survey Project team:

- ◆ Geraldine F. Brewer, Survey Coordinator and Administrator, is Operations Administrator of Health Care Centers in Schools with 12 years experience in coordinating students' access to comprehensive health care, conducting interviews, and advocating for adolescents. She has a Bachelors of Arts Degree in Sociology.
- ◆ Venisha Judson, Survey Administrator, is a Community Outreach Worker of Health Care Centers in Schools. She has three years of experience in coordinating students' access to comprehensive health care and conducting interviews.
- ◆ Kennetra Montgomery, Survey Administrator, is a sophomore at Southern University in Baton Rouge, majoring in biology. She has experience in telemarketing.

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

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

- ◆ Bill Lottero, the Site Coordinator, who worked directly with Health Care Centers in Schools, Inc. to help plan the project, and who provided consultation throughout the project's duration.
- ◆ Lynn Bannon, who assisted in the writing of the report
- ◆ Bill Hewett and Meg Baker, who provided invaluable administrative support in the production of the report
- ◆ Nancy Kohn, The Access Project CAMS coordinator, who assisted in the writing of this report and attended to the myriad of details necessary to keep the project on track

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

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