



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at CHRISTUS Jasper Memorial
Hospital in Jasper, Texas*

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*This report was produced in collaboration with The Texas Institute for Health
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November 2000

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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The **Texas Institute for Health Policy Research**, located in Austin, is a non-profit health policy research entity that develops policy options designed to improve the health of Texans and shape health care delivery for tomorrow. The organization uses a three-pronged process to gain broad-based input: grassroots stakeholder opinions, academic research, and shared knowledge with health policy decision-makers. Both the public and private sectors use the Institute's findings to redesign health care delivery and financing systems that will facilitate community-focused care, enhance personal health status, and improve clinical outcomes.

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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 one community, Jasper, Texas. The survey was conducted in the summer of 2000 and gathered information from 166 uninsured patients who obtained health care in the previous year at the CHRISTUS Jasper Memorial Hospital. 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.

While the majority of Jasper respondents were satisfied or very satisfied with the care they received from staff at CHRISTUS Jasper Memorial Hospital, some described difficulties with hospital openness if they were unable to pay for care, and with waiting times to get appointments and to see providers on the day of an appointment. A majority of those who needed help paying for prescribed medications or for their medical care reported that staff offered assistance in working out payment. However, a significant proportion reported that staff “never” offered financial assistance.

- ◆ One-third of Jasper respondents reported that the hospital had been “reluctant” to provide care if they were unable to pay, compared to the one in four average for all rural hospitals included in the CAMS project nationwide. Only one in four respondents reported that Jasper has a reputation in the community for providing “a lot” of care to the uninsured, compared to the national CAMS average of 41 percent.

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- ◆ Nevertheless, 92 percent of Jasper respondents were satisfied with the care they received from doctors, compared with the CAMS average of 81 percent. The same proportion, 92 percent, were satisfied with the service they received from receptionists and admitting clerks.
- ◆ Although Jasper respondents did not report significant problems related to the hospital's hours or location, nearly half (48 percent) found waiting times to get an appointment sometimes or often a problem. This was nearly twice the CAMS average of 26 percent.
- ◆ One in five Jasper respondents found it "very difficult" to pay for their medications. Of those who needed help, 75 percent reported that Jasper staff asked if help was needed at least sometimes. The CAMS average for rural hospitals was 28 percent.
- ◆ One in three respondents found paying for their medical care "very difficult," and more than half said they needed help with payment. Among those who needed help, 78 percent said staff offered to find out if financial assistance was available. The remaining 22 percent reported that staff "never" offered help.

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, in order to assist them in improving access to care for this population.

ABOUT THIS REPORT

This report, along with reviewing some of the research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Jasper, Texas. The survey was conducted by the Texas Institute for Health Policy Research in the summer of 2000, and gathered information from uninsured individuals who received care at CHRISTUS Jasper Memorial Hospital in the previous year. Along with providing the results of the survey for this facility, the report compares the results with aggregate responses at all similar facilities surveyed as part of the CAMS project nationwide. A report presenting the overall findings for all surveyed sites will be released in Spring 2001.



LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

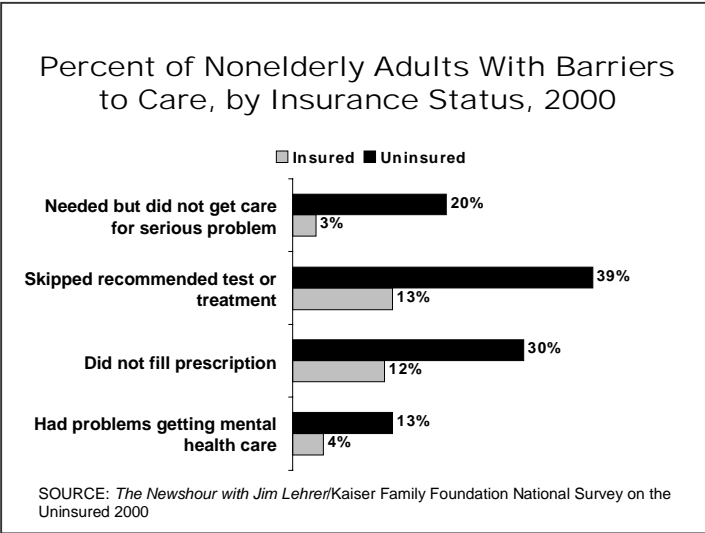
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

LACK OF INSURANCE AND ACCESS TO CARE

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

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

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



LACK OF INSURANCE AND HEALTH OUTCOMES

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

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

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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 Texas Institute for Health Policy Research.

Jasper County is a rural county in Deep East Texas with a population of 31,778.³¹ It is located about 120 miles northeast of Houston and 70 miles north of Beaumont. Approximately 77% of the county’s residents are white, 20% African American, and 2% Hispanic.³² The percentage of the population that is Hispanic in Jasper County is probably higher, but the U.S. Census has not been able to accurately account for the size of that population as is the trend across Texas and the nation.³³

The economy of the county is based on timber, oil, gas and tourism, industries subject to seasonal and market fluctuations. As a result, the unemployment rate in the county is high; at 12.2%, it is almost triple the state average of 4.6%.³⁴ The median household income is \$19,324, and 20% of the population lives in poverty.³⁵

BARRIERS TO ACCESS TO HEALTH CARE

As Jasper is a rural county, transportation is a major barrier to access to health care. Public transportation is non-existent in Jasper County and only one taxi cab serves the City of Jasper from 8 AM to 5 PM.

Jasper County also experiences difficulties in recruiting and retaining qualified healthcare providers. Jasper has a population-to-health care provider ratio of 1,265:1, compared to 719:1 for the state,³⁶ and is thus designated a Medically Underserved Population.³⁷

A factor that has contributed to the lack of health care providers and services in Jasper is the closure of local health care facilities: Buna Medical Center, a 33-bed hospital, closed in 1987, Kirbyville Mixon Moore Clinic, a 24- bed facility, closed in 1988, and in 1998 Mary Dickerson Hospital closed. In addition, closures in neighboring Newton and Hardin Counties have left those counties with no hospitals.

EXISTING HEALTH CARE FACILITIES

CHRISTUS Jasper Memorial Hospital in Jasper County is an acute care hospital with 81 licensed beds and 48 staffed beds. It also has ten licensed beds for rehabilitation. The Jasper County Hospital District managed the hospital until 1995, when it entered a management agreement with Sisters of Charity Healthcare.³⁸ CHRISTUS Jasper is the only hospital in the tri-county area and, as a result of the closures

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mentioned above, the hospital is experiencing an increase in emergency room visits by the uninsured and indigent from Newton and Hardin Counties. The Balanced Budget Act (BBA) of 1997 reduced reimbursements to Medicaid providers, contributing to the distress and ultimate closure of rural hospitals across the country. BBA had a detrimental effect on the hospitals in the tri-county area and was the primary reason for the series of recent hospital closures.³⁹

The Jasper Newton County Public Health District provides medical services for the uninsured and qualified low-income individuals. In 1999, it saw 4,099 unduplicated patients at its Jasper office⁴⁰. Patients pay a minimal fee based on a sliding scale, and those with incomes below 100 percent of the federal poverty level are not charged for services.

Gulf Coast Health Center in Newton County has a federally funded community health clinic that serves the indigent.

The University of Texas Medical Branch (UTMB) in Galveston treats patients with incomes below 17 percent of the federal poverty level free of charge. Galveston is over two hours' drive from Jasper. Two times a week a shuttle bus takes uninsured patients as well as Medicaid and Medicare patients to the facility.

Approximately 70 patients in Jasper County are enrolled in the county indigent program, which serves individuals below 25 percent of the federal poverty level. Other patients receive some support from UTMB's Demand and Access Management Program office. The patients for UTMB are referred by the hospital, the public health district, and rural health clinics for operative as well as diagnostic services.

Individuals receiving care at UTMB who do not qualify for the county indigent program or who do not have health insurance are often forced to pay before the hospital will perform tests.⁴¹ This had reduced usage of UTMB services among Jasper citizens and as a result the weekly shuttle service was changed from three times a week to two in October, 2000.⁴²

RACE ISSUES AND COMMUNITY WELLNESS

Jasper County experienced a horrendous hate crime on July 7, 1998: the dragging death of James Byrd Jr. This incident happened in a community that on the surface appears to have overcome a history of racism; for example, Jasper now has a black hospital administrator, black mayor and black president of the Council of Governments. After the Byrd incident, the Jasper Ministerial Alliance, already active in



the area, intensified its work. The CEO of CHRISTUS Jasper Memorial Hospital, George N. Miller, Jr., participated in the alliance and helped focus attention on the needs of the medically underserved. Mrs. Willie Brown, a licensed medical social worker, and her husband, Larry Brown, M.D., have organized a monthly Community Wellness Program, as well as preventive medicine sessions at area churches on diabetes and hypertension.

FOCUS GROUPS AND USE OF THE SURVEY

As part of the East Texas Rural Access Program, a Robert Wood Johnson Foundation program to increase access to primary care in medically underserved areas in 8 southern states, the Institute conducted a focus group in Jasper on February 15, 2000. Attendees included the administrator of the hospital, his key community health and outreach staff, and members of the Jasper community. In all, 17 community leaders participated. This initial contact led to further discussions about issues facing the community, and participants expressed a strong desire to develop partnerships with community pastors, educators, healthcare professionals, and legislators to work to improve health outcomes in the area.

The CAMS project surveyed people who received care in the previous year at CHRISTUS Jasper Memorial Hospital while uninsured. It was supported by the CEO of the hospital, George N. Miller, Jr., as well as by Rev. Hardin of the Mt. Olive Baptist Church, who previously served on the state's Indigent Health Care Taskforce and the Jasper Newton Public Health District Administrative Board. The survey was undertaken to provide data, in addition to the focus group results, that will enable the community to continue its dialogue about the future of health care in Jasper and how to improve access to health care for the indigent.

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SURVEY METHODOLOGY

The Institute contracted with five Jasper residents to administer the surveys. All received training in administration of the survey at training sessions hosted by Rev. Hardin. Surveyors identified respondents by going door-to-door in targeted neighborhoods and low-income housing complexes, approaching customers shopping at Wal-Mart, and through referrals from the high school, friends, and family members. CHRISTUS Jasper Memorial Hospital also provided lists of uninsured persons who consented to being surveyed. The surveys were conducted between May 29 and July 10, 2000.

Because respondents were not randomly selected, the survey results cannot be generalized to the entire population of uninsured persons or of uninsured individuals receiving care at CHRISTUS Jasper Memorial Hospital. *The results reflect the experiences only of those surveyed.* Surveys were completed for 166 uninsured patients who received care at the hospital in the previous year.

SURVEY RESULTS

This section describes the survey results for CHRISTUS Jasper Memorial Hospital respondents and compares them with the aggregate results for all rural hospitals (ARHs) included in the CAMS project nationwide. In general, descriptions of categorical differences between Jasper and ARH respondents are statistically significant unless indicated otherwise (ns = non-significant). See Appendix A for a table of the results for all Jasper respondents and the averages for ARHs.

RESPONDENT CHARACTERISTICS

Jasper respondents tended to be young and ethnically diverse.

Jasper respondents were generally younger than the average for ARHs. More than half of the Jasper respondents were 29 years of age or younger, and another 29 percent were between the ages of 30 and 49. In addition, one in five (22%) Jasper respondents answered on behalf of a child, compared to an ARH average of 11 percent.

Jasper respondents were ethnically diverse. One-third (34%) were white, 54 percent identified themselves as African-American, and 7 percent said they were Hispanic. In comparison, the ARH average was 72 percent white and only 19 percent African-American. Notably, all Jasper respondents chose to take the survey in English.

USE OF HEALTH SERVICES

Three of five respondents reported emergency room use and nearly three-fourths—73 percent—used an outpatient clinic at least once in the past year. Respondents were likely to have used the hospital fewer than five times and many sought care to treat a chronic condition.

Sixty-three percent of Jasper respondents reported that they used the emergency room at least once in the past year.

Notably, inpatient use was similar to ARHs (19% vs. 22%, respectively), but outpatient use was significantly higher. Indeed, nearly three of four (73%) Jasper respondents said they sought care in the outpatient clinic at least once in the past year, compared with an average of 54 percent for ARHs.

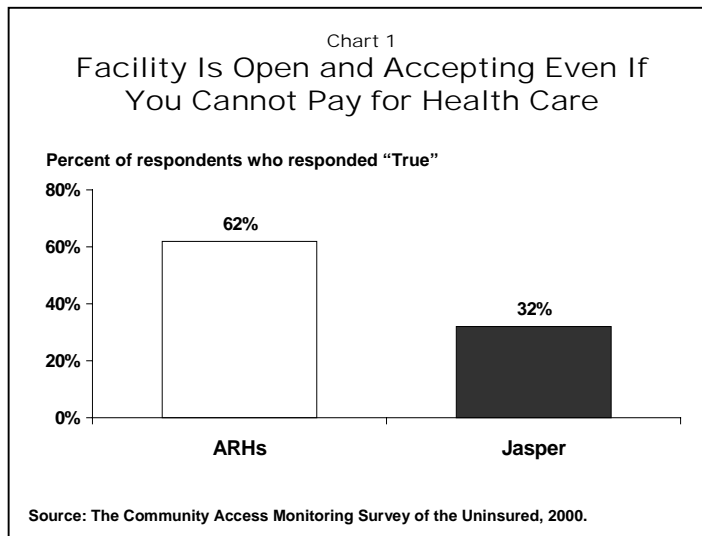
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One-third of the Jasper respondents reported that they sought care to treat a chronic problem such as asthma or diabetes.

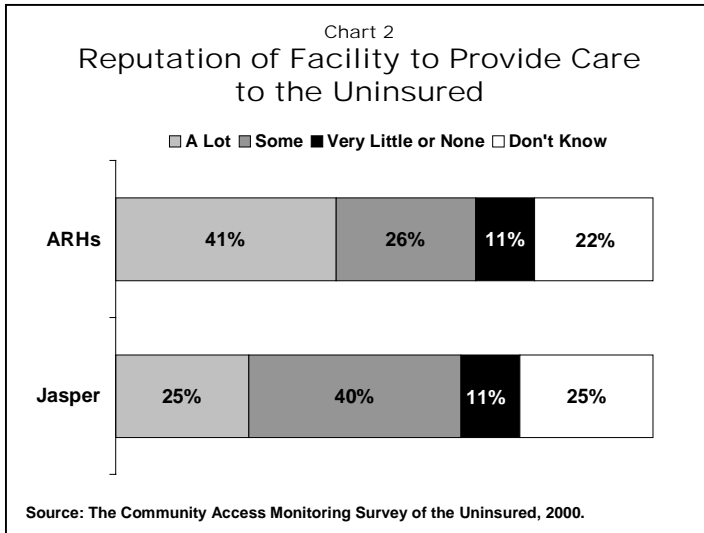
OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

Jasper respondents were not likely to report that the hospital had been open and accepting to them if they couldn't pay, or that the hospital had a reputation in the community for providing care to the uninsured. Nevertheless, Jasper respondents were likely to have been satisfied with the care and service they received from Jasper staff.

Respondents for Jasper were more likely than the average for ARHs to report that, in their experience, the hospital had been "reluctant" to provide care if they were unable to pay (31% vs. 24%, respectively). Only one-third of Jasper respondents found the hospital "open and accepting" even if they could not pay. (Chart 1)



Only one in four Jasper respondents said that the hospital had a reputation in the community for providing "a lot" of care to the uninsured, compared with an average of 41 percent for ARHs. However, Jasper respondents were more likely to report that the hospital had a reputation for providing *some* care to the uninsured than the ARH average. (Chart 2)



At the same time, the overwhelming majority of respondents were either very satisfied or satisfied with the care and service they received from Jasper staff. For example, 92 percent of respondents were satisfied with the care they received from doctors, compared with an average of 81 percent for ARHs, and 92 percent were satisfied with the service of receptionists and admitting clerks, compared with an ARH average of 87 percent. Indeed, on every measure of satisfaction with staff, Jasper respondents were more likely to be satisfied than respondents for ARHs.

“The staff was very nice and they treated me with kindness and respect.”
Jasper Respondent

ACCESSIBILITY

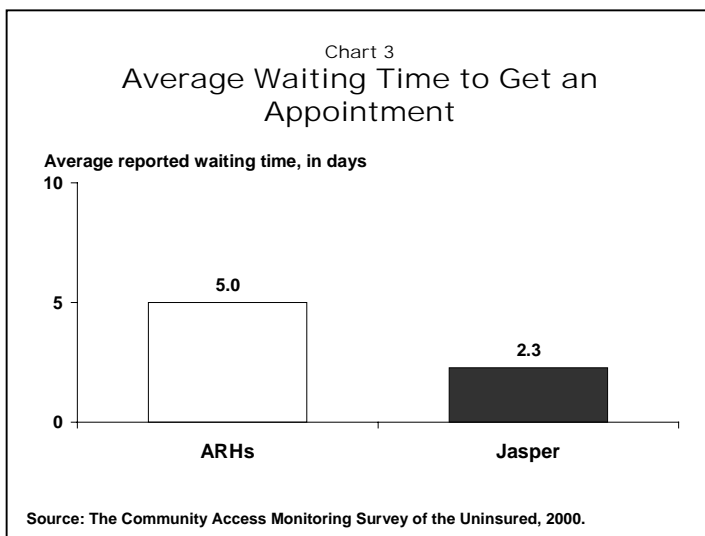
With regard to the facility’s hours and location, Jasper respondents did not have significant difficulty compared with the ARH averages. However, Jasper respondents were more likely to have problems with waiting times than the average.

The proportion of respondents for Jasper and the average for ARHs that found facility hours (12% and 8%, respectively), emergency room hours (9% and 5%, respectively), and facility location (16% and 21%, respectively) a problem at least sometimes were nearly identical. The great majority of respondents did not report problems related to these factors.

However, the proportion of Jasper respondents reporting that waiting times were a problem was nearly twice as high as the ARH average. Specifically, 48 percent of Jasper respondents said the waiting time to get an appointment was a problem at least sometimes compared with 26 percent of respondents for ARHs. In fact, however, the average

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reported number of days to get an appointment was less for Jasper respondents than for ARHs. (Chart 3)



“The services at Jasper are great. You have to understand before you go in that you are going to have to wait.”
Jasper Respondent

“They were very slow at first, they took their time.”
Jasper Respondent

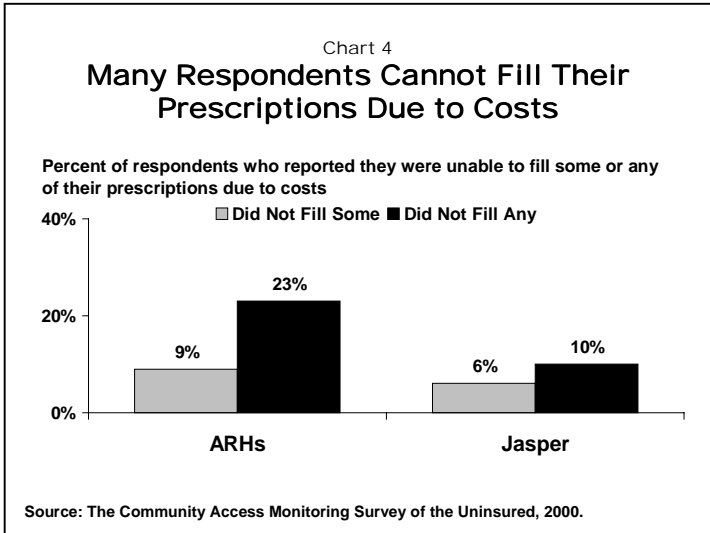
More than half of the Jasper respondents (54%) found the waiting time on the day of an appointment to be a problem at least sometimes (ARH average 37%), and the average reported waiting time for Jasper respondents was in fact longer than the ARH average (43 minutes vs. 36 minutes, respectively).

OBTAINING PRESCRIPTION MEDICATIONS

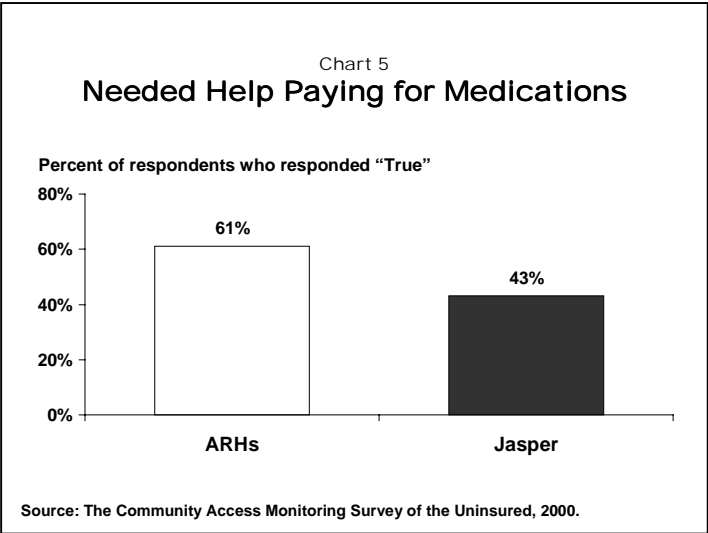
Almost three of four Jasper respondents were prescribed medications. The majority obtained them at a drug store and paid for them out-of-pocket. While 16 percent of respondents did not obtain some or all of their medications due to cost, Jasper respondents were much less likely than the ARH average to report that they needed assistance paying for their medications.

The majority—72 percent—of respondents for Jasper reported that they received prescriptions for medications. This was identical to the average for ARHs. Of the respondents who received prescriptions, most (71%) filled them at a pharmacy and paid for the drugs out-of-pocket (ARH average 56%).

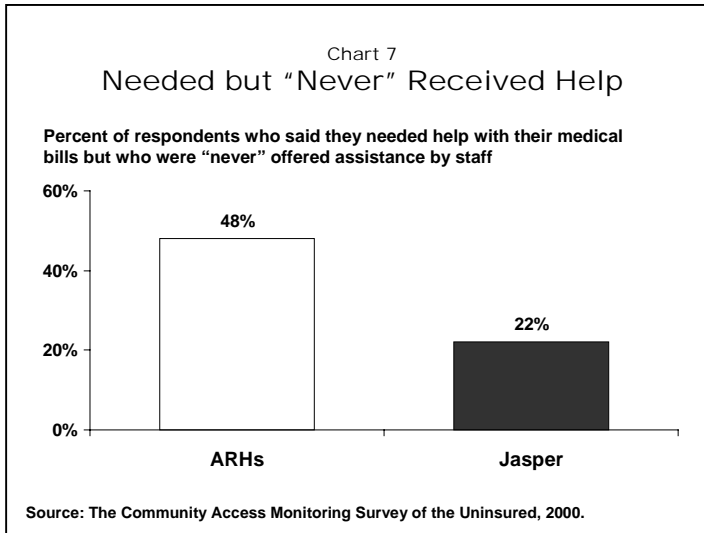
Notably, while lower than the ARH average, several respondents who had medications prescribed did not fill some, and ten percent did not fill *any*, of their prescriptions due to costs. (Chart 4)



In spite of this, Jasper respondents were less likely to report both having difficulty paying for their medications and needing help paying for them than respondents for ARHs. One in five (19%) Jasper respondents found it “very difficult” to pay for their medications, compared with more than half of the respondents for ARHs (52%). Almost two in five (43%) reported needing assistance paying their medications, compared with 61 percent of respondents for ARHs. (Chart 5)

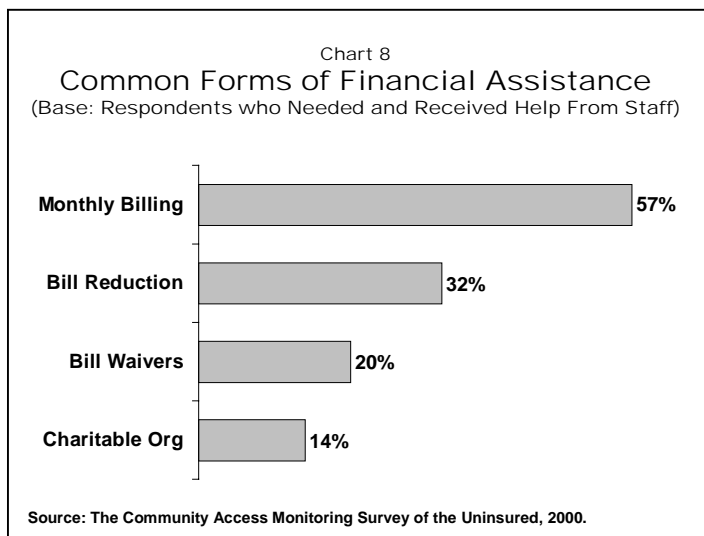


Among those who needed help, Jasper respondents were much more likely to report that staff asked if help was needed at least sometimes than the ARH average (75% vs. 28%, respectively).



The most common forms of assistance Jasper respondents received were paying in monthly installments, followed by reductions in the bill and waiving the bill. (Chart 8)

"Made a small down-payment and paid each week."
Jasper Respondent



"They worked with me on my bill and made it easy to pay."
Jasper Respondent

SEEKING CARE IN THE FUTURE

Jasper respondents were half as likely to owe money to the hospital as respondents for ARHs, but over one in five who owed money said the debt would deter them from seeking care at the facility again. More than 90 percent of the respondents said they would use the hospital again if they were insured.

While 5 percent of Jasper respondents said that their past experiences paying bills at the hospital would make them not seek care there in

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"I would not go anywhere else."
Jasper Respondent

the future, and 7 percent said it would cause them to use another facility, 11 percent reported that their experiences made it easier to seek care. Most, however, said their payment experiences would not affect whether they would seek care at the hospital in the future (77%).

"Because I owe money, I am reluctant to go to Jasper. I am embarrassed by my old bill. The office staff makes you feel uncomfortable about the bill. So I pray I never have a dire emergency, because I'll go to Lufkin for anything else."
Jasper Respondent

Jasper respondents were half as likely to owe money to the hospital as respondents for ARHs (29% vs. 60%, respectively). Of those who owed money, 21 percent reported that this debt would deter them from seeking care at Jasper in the future.

Finally, the vast majority of respondents—91 percent—said they would use the hospital again even if they had insurance.

DISCUSSION

This section discusses some of the perceived strengths and issues for further discussion suggested by the survey results for Jasper.

STRENGTHS

- The vast majority of Jasper respondents were either satisfied or very satisfied with the care and service they received from staff.
- Jasper respondents were only half as likely as respondents for ARHs to owe money to the hospital.
- The overwhelming majority of respondents said they would use the hospital again even if they were insured.

Although the respondents for Jasper were ethnically diverse, analysis of the survey results by race/ethnicity did not reveal any significant differences among racial and ethnic groups.

ISSUES FOR FURTHER CONSIDERATION

- Although the proportion of Jasper respondents who used the emergency room at least once in the past year was lower than the average for ARHs, emergency department use was still high.
- Only three of ten respondents reported that in their experience the hospital had been open and accepting to them even if they could not pay for their care. Similarly, only one-quarter of the respondents said that Jasper Memorial had a reputation in the community for providing a lot of care to the uninsured.
- Nearly half of the respondents found waiting times both to get an appointment and to see a provider on the day of the appointment a problem at least sometimes.
- One-fifth of the respondents reported that paying for their medications was very difficult. The same proportion also stated that debts to the hospital would discourage them from seeking care there in the future. Many respondents—three in ten—found their medical bills very difficult to pay, and one in five said they were *never* offered any assistance by staff.

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ACKNOWLEDGEMENTS

The **Texas Institute for Health Policy Research** thanks Willie Brown and Theronda R. Levias, who helped coordinate the CAMS project in Jasper, and Jason R. Dunn, Theronda R. Levias, Kimberly Fogle, Andria Brown, and Charles Land, Jr., who conducted the surveys.

It is also grateful for the support of George N. Miller, Jr., CEO, CHRISTUS Jasper Memorial Hospital; Rev. Hardin of Mt. Olive Baptist Church; Frances Simmons of the Jasper-Newton County Public Health District; and Dreka Strickland, minority health coordinator for the Texas Department of Health, Public Health Regions 4 & 5 North.

The Access Project would especially like to thank the authors, Dennis Andrulis, Christina An, and Carol Pryor for their dedication and energy 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:

- ◆ Nicole St. Clair, 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, who provided overall coordination of the project 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. Debbie Katz, the Site Coordinator, worked directly with the Texas Institute for Health Policy Research to help plan the project, and provided extensive consultation throughout the project's duration.

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.