



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

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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

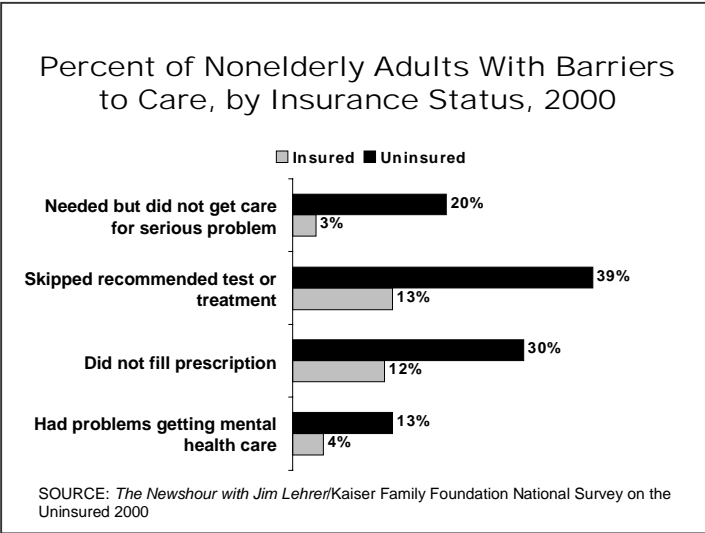
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

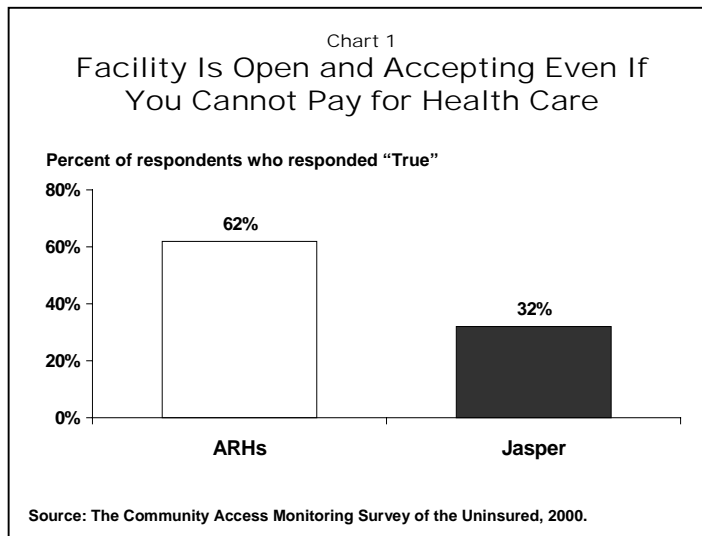
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One-third of the Jasper respondents reported that they sought care to treat a chronic problem such as asthma or diabetes.

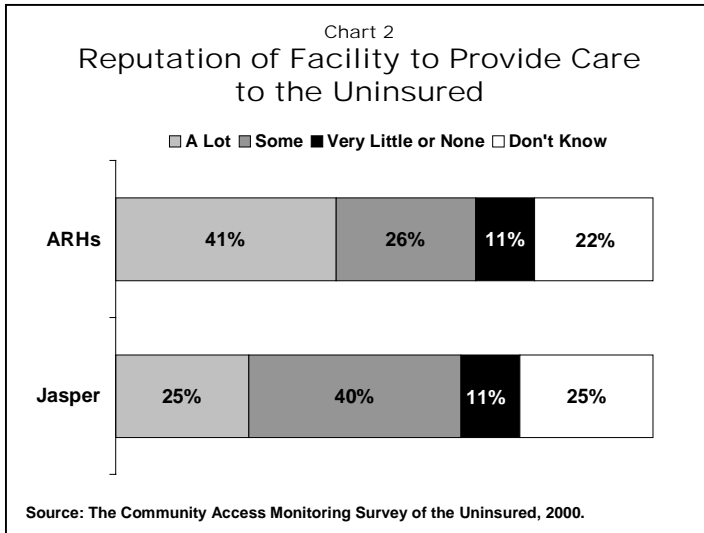
OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

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

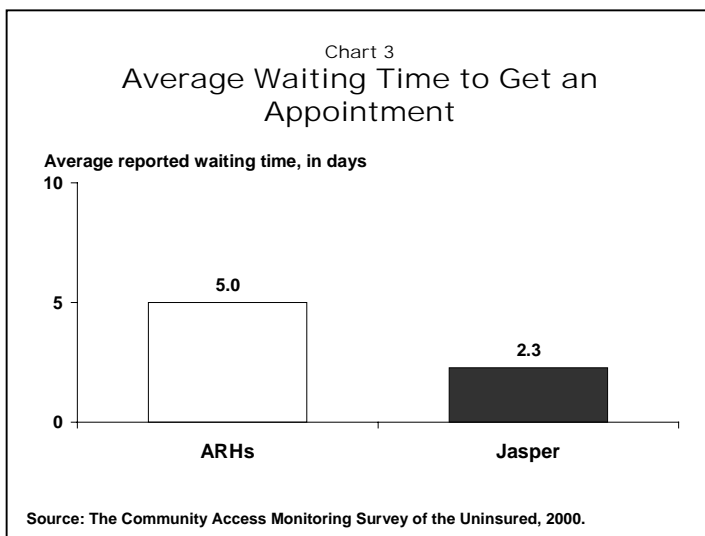
With regard to the facility’s hours and location, Jasper respondents did not have significant difficulty compared with the ARH averages. However, Jasper respondents were more likely to have problems with waiting times than the average.

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

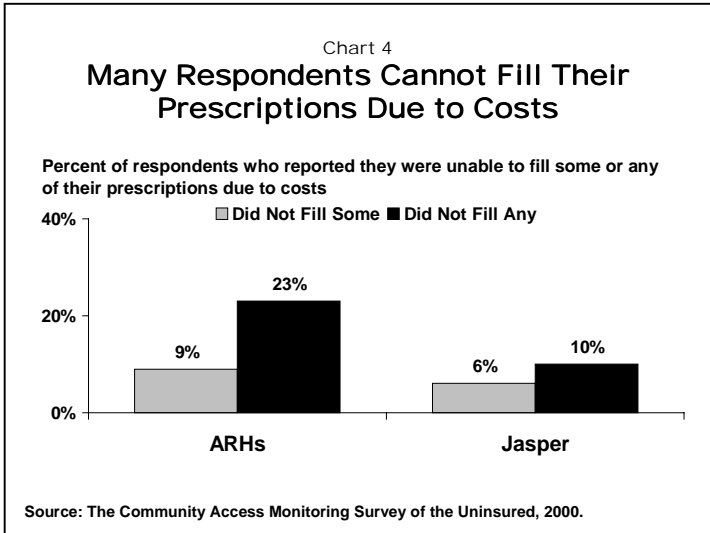
More than half of the Jasper respondents (54%) found the waiting time on the day of an appointment to be a problem at least sometimes (ARH average 37%), and the average reported waiting time for Jasper respondents was in fact longer than the ARH average (43 minutes vs. 36 minutes, respectively).

OBTAINING PRESCRIPTION MEDICATIONS

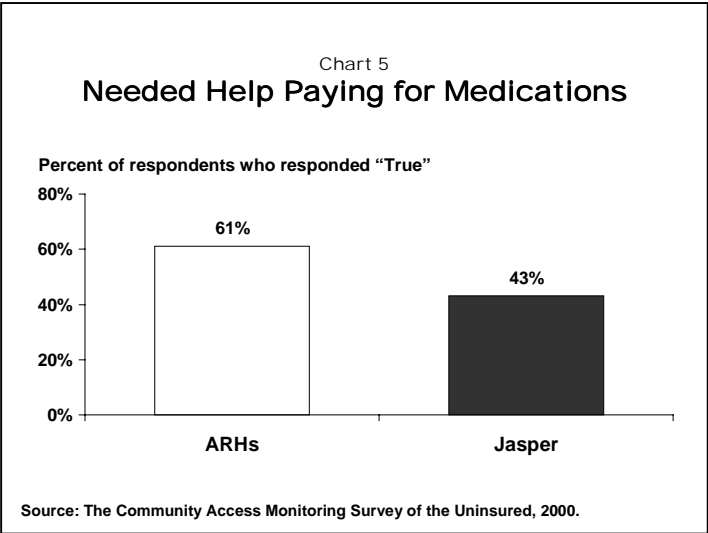
Almost three of four Jasper respondents were prescribed medications. The majority obtained them at a drug store and paid for them out-of-pocket. While 16 percent of respondents did not obtain some or all of their medications due to cost, Jasper respondents were much less likely than the ARH average to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

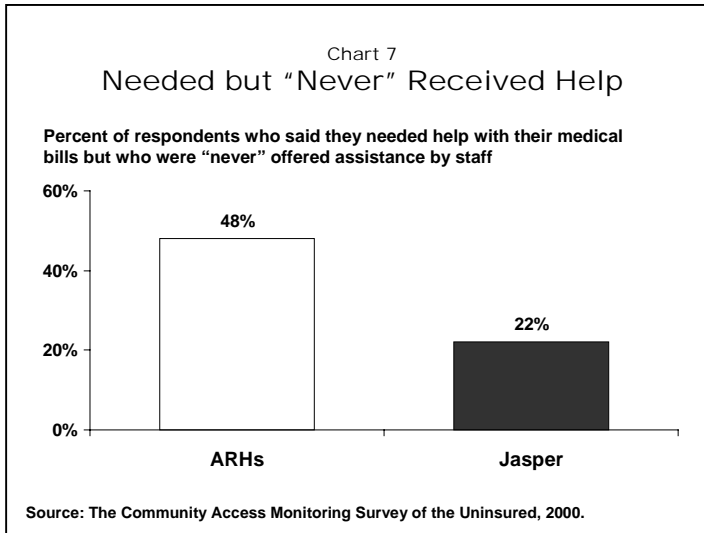
Notably, while lower than the ARH average, several respondents who had medications prescribed did not fill some, and ten percent did not fill *any*, of their prescriptions due to costs. (Chart 4)



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)

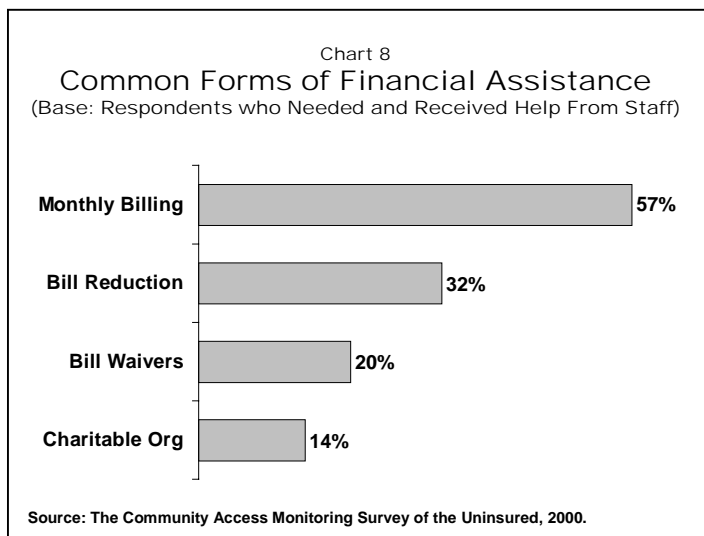


Among those who needed help, Jasper respondents were much more likely to report that staff asked if help was needed at least sometimes than the ARH average (75% vs. 28%, respectively).



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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REFERENCES

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

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

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³¹ Texas State Data Center, *Population Data for 1999 by Age and Race/Ethnicity*, Population projections electronic database for 1999. Based on population growth model 1.0., version of 4/98.

³² *Ibid.*

³³ December 1, 2000 Interview with Edli Collberg, Ph.D., Research Demographer, Texas Health and Human Services Commission

³⁴ *Unemployment Data for 1998 by Age Group*, Texas Workforce Commission, 1999.

³⁵ *Poverty Data for 1999 by Age Group*, Texas Health and Human Services Commission. Research Department.

³⁶ *Ibid.*

³⁷ List of MUA's per March 27, 2000, Texas Dept. of Health, Office of Policy & Planning.

³⁸ *The Financial Outlook for Rural Hospitals: Should They Consider Affiliation with Larger Health Systems?* Presentation at Texas Hospital Association Conference and Expo, Dallas, June 16, 2000 by George N. Miller, Jr., CEO/Administrator, CHRISTUS Jasper Memorial Hospital and Charlie Nicholson, Chairman of the Board, Jasper Hospital District.

³⁹ Interview with Frances Simmons, RNC, M.Ed, Assistant Director, Jasper Newton County Public Health District, June 23, 2000. Interviews with George N. Miller, Jr., CEO, CHRISTUS Jasper Memorial Hospital and James Gainey, Director of Physician Integration and Support Services, CHRISTUS Jasper Memorial Hospital, October 25 and October 30, 2000.

⁴⁰ Interview with Frances Simmons, RNC, M.Ed, Assistant Director, Jasper Newton County Public Health District, June 23, 2000.

⁴¹ Interview with Frances Simmons, RNC, M.Ed, Assistant Director, Jasper Newton County Public Health District, June 23, 2000.

⁴² *Ibid.*

APPENDIX A: TABLE OF SURVEY RESULTS

This table presents the results of the Community Access Monitoring Survey of respondents for CHRISTUS Jasper Memorial Hospital. For comparison purposes, it also presents the averages for respondents for all rural hospitals included in the CAMS project nationally.

Asterisks in the *Inter-site p value* column indicate statistically significant differences between CHRISTUS Jasper Memorial Hospital and the average for all rural hospitals, 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 $p < 0.01$. (An explanation of p-values is provided at the end of the table.)

	Jasper, Texas Hospitals		CAMS Sites
	Inter-site p-value	CHRISTUS Jasper Memorial Hospital	All Rural Hospitals
Number of survey respondents		166	1380
		% ^a	% ^a
RESPONDENT CHARACTERISTICS			
Age	**		
Under 18		25	14
18-29 years		27	25
30-39 years		16	23
40-49 years		13	20
50-64 years		16	17
65 or older		3	2
Race/Ethnicity	**		
White		34	72
Black		54	19
Hispanic		7	3
Other ^b			6
Gender			
Male		42	39
Female		58	61
Language in which survey administered	—		
English		100	99
Spanish			
Answered on behalf of child	**	22	11
FACILITY UTILIZATION			
Used hospital emergency room	**	63	77
Admitted to hospital as inpatient	**	19	22
Used outpatient clinic	**	73	54
Use of facility in past year			
Once		44	43
2-4 times		37	43
5-9 times		11	10
10 or more times		8	5

	Jasper, Texas Hospitals		CAMS Sites
	Inter-site p-value	CHRISTUS Jasper Memorial Hospital	All Rural Hospitals
Reason for visit(s)			
Chronic problem or Mixed (chronic and non-chronic):	—	33	34
Other problem (non-chronic)		67	66
PERCEPTION OF FACILITY			
Experience of facility's openness to uninsured			
Open and accepting even if can't pay	**	32	62
Reluctant but accepts you even if can't pay	*	31	24
Offers some care if can't pay	**	18	8
Provides no assistance if can't pay	—	1	1
Don't know		18	7
Opinion of facility's reputation for treating uninsured			
Provides a lot of care for those who can't pay		25	41
Provides some care		40	26
Provides very little or no care		11	11
Don't know		25	22
SATISFACTION WITH PROVIDERS/COURTESY OF STAFF			
Receptionists/Admitting clerks			
	*		
Very satisfactory or satisfactory		92	87
Unsatisfactory or very unsatisfactory		8	8
Don't know		1	4
Nurses			
Very satisfactory or satisfactory		94	92
Unsatisfactory or very unsatisfactory		6	6
Don't know		1	2
Physician assistants			
	**		
Very satisfactory or satisfactory		84	58
Unsatisfactory or very unsatisfactory		3	6
Don't know		13	37
Examining physicians			
	**		
Very satisfactory or satisfactory		92	81
Unsatisfactory or very unsatisfactory		4	12
Don't know		4	7
Social worker			
	**		
Very satisfactory or satisfactory		44	17
Unsatisfactory or very unsatisfactory		3	5
Don't know		53	79
Billing Clerks			
	**		
Very satisfactory or satisfactory		78	53
Unsatisfactory or very unsatisfactory		12	15
Don't know		10	32
Pharmacist			
	**		
Very satisfactory or satisfactory		65	22
Unsatisfactory or very unsatisfactory		2	2
Don't know		33	77
Treated with respect			
Always		64	62
Sometimes		35	33
Never		1	4
Don't know		-	1

	Jasper, Texas Hospitals		CAMS Sites
	Inter-site p-value	CHRISTUS Jasper Memorial Hospital	All Rural Hospitals
ACCESSIBILITY OF SERVICES			
Hours facility open	—		
Never a problem		87	89
Sometimes a problem		9	6
Often/always a problem		3	2
Don't know		1	3
Hours ER open	—		
Never a problem		89	93
Sometimes a problem		6	3
Often/always a problem		3	2
Don't know		2	3
Location			
Never a problem		80	78
Sometimes a problem		14	16
Often/always a problem		6	5
Don't know		-	1
Waiting time to get appointment	**		
Never a problem		39	35
Sometimes a problem		35	17
Often/always a problem		13	9
Don't know		12	39
Waiting time to see provider on day of appointment	**		
Never a problem		36	43
Sometimes a problem		35	24
Often/always a problem		19	13
Don't know		10	19
Convenient to public transportation	**		
Never a problem		20	9
Sometimes a problem		3	4
Often/always a problem		6	16
Don't know		70	71
Transportation assistance if needed	**		
Never a problem		23	21
Sometimes a problem		7	7
Often/always a problem		3	11
Don't know		68	61
MEDICATIONS			
Medication prescribed		72	72
If yes, how obtained			
Supplied free		18	23
Used a pharmacy card	—	13	3
Used a drug store and paid	**	71	56
Didn't get /couldn't afford		6	9
Got some/couldn't afford all	**	10	23
Other	—	2	3
Medication instructions	—		
Understood instructions		92	95
No instructions given		4	2
Did not understand instructions		3	2
Did not need medicine for home		1	1

	Jasper, Texas Hospitals		CAMS Sites
	Inter-site p-value	CHRISTUS Jasper Memorial Hospital	All Rural Hospitals
Difficulty paying for medications	**		
Very difficult		19	52
Not so difficult		57	19
Easy to pay		8	5
N/A		15	24
Needed help paying for medications	**	43	61
If yes, did staff offer help?	**		
Always		35	15
Often		20	5
Sometimes		20	8
Never		25	71
MEDICAL BILLS			
Difficulty paying for medical care	**		
Very difficult		30	69
Not so difficult		56	22
Easy to pay		14	9
Needed help paying the medical bill? If yes	**	57	80
Did staff offer to find out if financial assistance was available?	**		
Always		41	38
Often		17	5
Sometimes		20	8
Never		22	48
Type of help staff offered <i>(If Always, Often, Sometimes to previous question)</i>			
Pay in monthly installments	**	57	40
Reduce amount of bill	**	32	13
Waive bill		20	22
Find charitable organization to pay		14	18
Other	**	3	28
FUTURE CARE			
Effect of payment experience on seeking future care at facility	*		
Will not seek care at facility		5	9
Will use another facility		7	6
Easier to seek care at facility		11	11
Makes no difference		77	73
Currently owe facility money	**	29	60
If yes, will make not seek care in future		21	29
If had insurance, would use facility in future		91	90
TRAVEL AND WAIT TIMES			
Travel time, mean (minutes)		15.28	16.50
Travel time, median (minutes)		10	13.00
Days to get appointment, mean	**	2.26	5.02
Days to get appointment, median		2	2.00
Waiting time to see provider, mean (minutes)	*	42.59	35.75
Waiting time to see provider, median (minutes)		30	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).

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

CAMS SPONSORING ORGANIZATION	SURVEYED FACILITIES
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

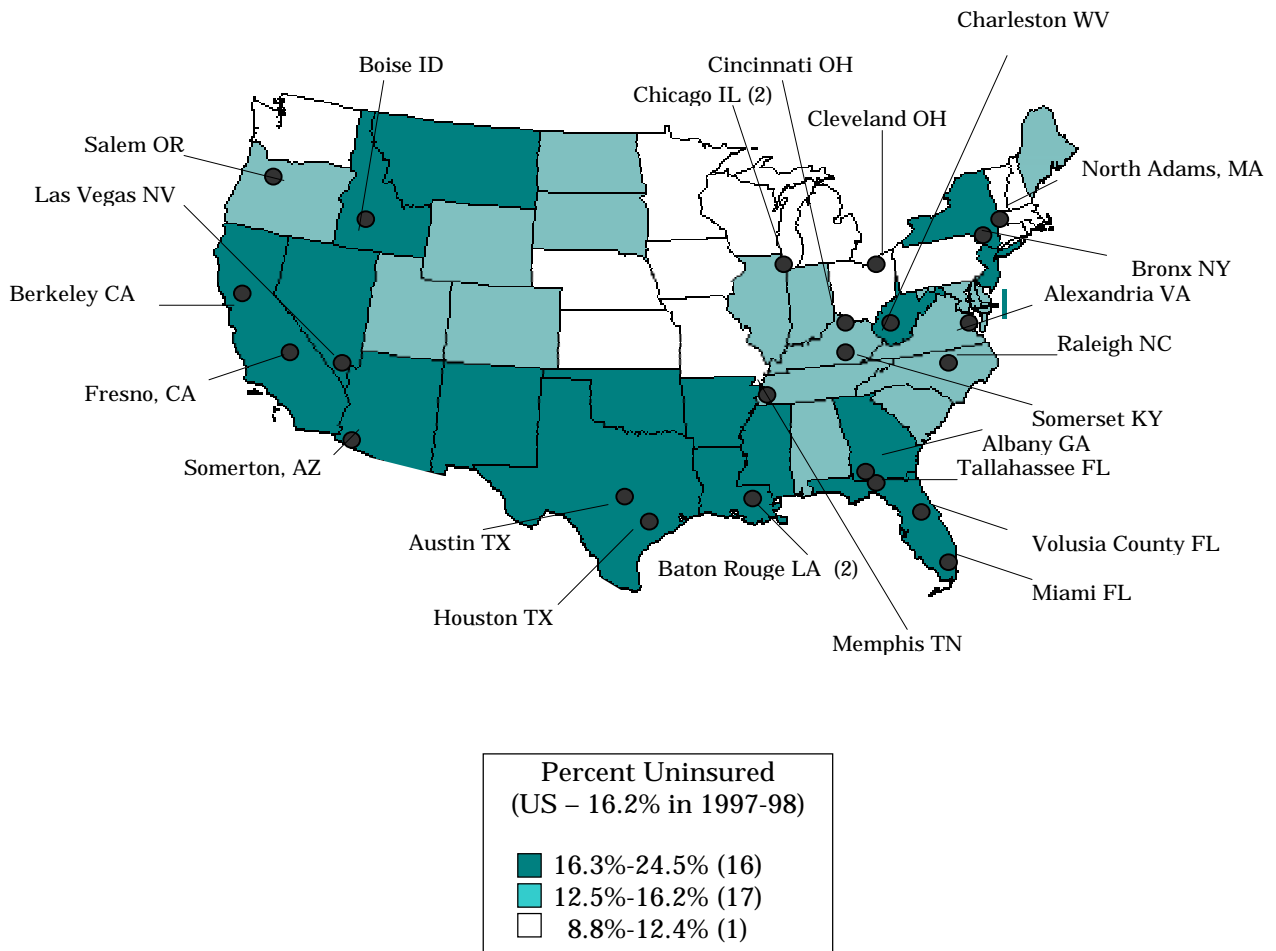
SURVEYED FACILITIES BY TYPE

<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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