

**A Look at the Uninsured: A Survey of the Parents of the Caring Program
Participants**

By

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Chaper One

Introduction

Introduction to the Uninsured Population

In the United States, all children are not guaranteed access to health care services, even through publicly funded programs. Melissa Manchester Harrell, is an example of one of many children confronted with problems of accessing health care.

Melissa died because she was born poor and did not have a Medicaid card. She lived less than nine weeks. Mississippi's Medicaid eligibility process took nearly four months between application for and receipt of a Medicaid card. The only proof of Medicaid eligibility Melissa's social worker could offer was a letter, not a Medicaid card or number.

When Melissa ran a temperature, a symptom for concern among newborns, her mother unsuccessfully sought medical help. First, a private physician refused to accept Melissa's letter from her social worker and demanded cash. Then a pharmacist refused to fill a prescription written at a charity clinic without a Medicaid card. Since Melissa's mother could not pay for the prescribed medicine that day, she gave Melissa over the counter medicine to reduce the fever. Melissa's fever continued for two days. She was found dead April 18, 1986 (Whitfill, et.al, 1989:1).

According to the Office of Technology Assessment (1988: 58), lack of insurance exposes family members to a small risk of catastrophic health care expenses beyond the resources of all but the wealthiest of American families.

There are strong correlations between income levels and health insurance status. The presence of financial and non-financial barriers prevent people from obtaining health insurance and accessing health care services.

While many people cannot afford health insurance, they are also not eligible for the existing subsidized programs like Medicaid. In 1995, the barriers resulted in an estimated 37 million uninsured Americans. Approximately 12.2 million are

less than 18 years of age. In addition, there is another 7 million who have insurance coverage for only part of the year (Diekema, 1996: 3).

Due to the presence of the barriers, children from low income families are more likely to experience poor health outcomes than those with higher incomes. For example, (11 percent) of the poor children compared to (4 percent) of the non-poor children are in either fair or poor health. Poor children, especially those in the inner cities and medically underserved areas, are particularly at risk for certain health problems, such as lead poisoning, asthma, and tuberculosis (Rowland, 1993: 2).

Poverty is also associated with inadequate prenatal care and other environmental factors, which leave many children impaired throughout life by conditions that are preventable during youth. Approximately 21 percent of those less than 18 years of age live in families with incomes below the federal poverty level. Surprisingly, most of these children live in families where at least one member is employed (Rowland, 1993: 3).

Unfortunately, children are incapable of paying for their own health care. In order for children to have a fair shot at life's opportunities, they must receive a good healthy start in life. From a moral point of view, the adult members of the United States society have a duty to assure that all children receive at least a basic level of health care.

Purpose of the Study

The purpose of this study is threefold. First, it assesses the Blue Cross Blue Shield of Texas Caring for Children Program (Caring Program). The Caring Program provides access to primary and preventive outpatient health care benefits for eligible Texas children, ages 6 through 18, whose parents earn too much to qualify for Medicaid yet cannot afford private health insurance. Assessment of the Program will be achieved by describing the perceptions of the families participating in the Caring Program.

Secondly, the research describes the make up of the uninsured population, and the problems the uninsured are more likely to incur. Prior to enrollment in the Caring Program, the participants are uninsured. Unfortunately, there may be more than one potential child participant from a family. Yet, the Caring Program can only accommodate enrollment for one child. Consequently, part of the family remains uninsured. Capturing the perceptions of the parents of the participants in the Caring Program will allow for a comparison of how enrollment in the Program has impacted issues confronting the uninsured.

Finally, based on the findings, this study recommends on potential strategies to address the problems. It is hoped that by documenting the perceptions of the Caring Program family participants and the problems the uninsured are more likely to incur, the information in this study may then be employed by programs designed for the uninsured.

Chapter Summaries

Basically, Chapter Two addresses the second research purpose. The Chapter addresses the literature on the make up of the uninsured population, and the issues confronting the uninsured. The literature describes the populations that are uninsured and populations which are vulnerable in becoming uninsured. The literature also describes the historical background, and the present role and impact of Medicaid on the uninsured. In addition, the literature describes the conceptual framework that includes four major categories of issues which are more likely to confront the uninsured. The four categories include: access to care; utilization of health care services; quality of health care services; and health education and communication.

Chapter Three addresses the first research purpose. The Chapter discusses the background and the role of the Caring Program in Texas. This chapter also provides a fifth category of issues as discussed by the Executive Director of the Caring Program. In addition, this chapter identifies other programs like the Caring Program. In addition, this chapter discusses current and future initiatives.

Chapter Four provides a description of the methodology used in the research, specifically the survey research method and its design. The respondents are identified and examined in the methodology chapter. Also, the strengths and weaknesses of survey research are addressed.

Chapter Five analyzes and states the results of the survey. The chapter

focuses on the perspectives of the parents of the Caring Program participants. The survey results determine what impact the Program has on the issues confronting the uninsured. The survey results also identify which of the issues are perceived to be more significant. Finally, Chapter Six concludes this study by offering recommendations, for programs like the Caring Program, to improve access to health care for children. Furthermore, this chapter describes the direction of health insurance for children in the United States.

Chapter Two

Review of Literature

Understanding the Literature

The purpose of this chapter is to review the literature available on American uninsured families with children. More specifically, this chapter describes the make up of the uninsured population, and the problems the uninsured are more likely to incur. This chapter contributes to the overall goal, which is to identify the problems that confront the uninsured. The problems identified in the literature are used as a springboard in the analysis of the uninsured families currently participating in the Blue Cross and Blue Shield Caring for Children Program (Caring Program).

Who Make Up the Uninsured Population

Of the estimated 37 million uninsured Americans, 12.2 million are less than 18 years of age. There is also another 7 million who have insurance coverage for only part of the year. In addition, 21 percent of the uninsured youth live in families with incomes below the federal poverty level. In total, only 45 percent of the population is covered by comprehensive, privately financed health insurance. The rest of the population is either covered by Medicare or Medicaid programs, uninsured, or have very limited insurance (Lundberg, 1996: 7).

Most uninsured children live in families where at least one member is employed (Diekema, 1996: 3). As a matter of fact, approximately 84 percent of uninsured families have at least one working adult. Hence, the general view of the uninsured as non-workers is wrong (Blumberg & Liska, 1996: 4). (See Table 2.1). The large number of uninsured children, may be attributed to the lack of employer health coverage.

Table 2.1: Who Are the Uninsured by Employment Status 1993?	
Full-time/ full-year workers & families	52%
Non-workers & their families	16%
Part-time/ part-year workers & families	32%

Source: Journal American Medical Association 1996: 7 George Lundberg

Demographics

Within the population of uninsured children there are slight disparities by racial and ethnic status. The proportion of white children covered by a health insurance plan, (84 percent), was greater than the proportion of black children covered, (81 percent). For both toddlers, and older children, there was no clear trend in health insurance coverage for white or black children. Within every age, however, the percentage of Hispanic children covered was significantly lower than the figure for non-Hispanic children. In 1988, 83 percent of our nation's children age 17 and below were covered by either a private pay health insurance plan or Medicaid (Bloom, 1990: 1).

Public or Private Coverage

Private insurance is closely tied to employment status (Diekema, 1996: 8). Large employers negotiate with insurance companies for health benefit plans on behalf of their employees. In addition, most large employers qualify for group insurance coverage, but many small employers have too few employees to obtain the more favorably priced group policies (Kaiser, 1994: 4).

According to the National Commission on Children (1991: 135), almost no American family can pay for child health care without public or private/ employer health insurance. As a matter of fact, "the decline of employer health coverage for children has been felt most acutely among children in moderate income, working families and has cut across all racial and ethnic groups" (Rosenbaum, et. al, 1992: 1).

The National Commission on Children also suggest that the need for health care services is greatest among low income families. The increasing cost of medical services, however, has placed care for many significant health problems beyond the means of middle class families. Furthermore, national survey data have led to twin conclusions that most uninsured Americans actually have some connection to employers who are the traditional source of health insurance, and that the family incomes of the majority of uninsured persons, including uninsured workers are low (Farley-Short, 1990: 21). As of 1994, one half of all people with family incomes below \$5,000 and 37% of those with incomes between \$5,000 and \$15,000, lack coverage. As income rises, this

proportion drops. In contrast, only 11% of those with incomes of \$50,000 or more are not covered (Barents Group, 1995: 1). When comparing children most likely to be uninsured, poverty has the strongest association with child health.

Poverty

In 1995, there were approximately 40 million Americans living on the brink of poverty with incomes between 100 and 200 percent of the federal poverty level. The number represents a decrease from the approximate 50 million in 1994 as shown in Table 2.2

Table 2.2: Families Below Poverty in 1994 & 1995				
Characteristic	1995 Number	1994 Number	1995 Percent	1994 Percent
Families	27,501	28,985	12.3	13.1
Children less than 18	13,999	14,610	20.2	21.2
Children less than 6	5,670	5,878	23.7	24.5

Source: U.S. Census Bureau 1995 (Numbers in thousands)

According to the U.S. Census Bureau, in 1995, the black and Hispanic populations were more likely to live in poverty, than the white population. It appears that minorities (blacks and Hispanics) are about three times more likely to live in poverty, since roughly (11 percent) of the white population lives in poverty, while approximately (30 percent) of the minority population (blacks and Hispanics) live in poverty. See Table 2.3.

Table 2.3: Persons Below Poverty by Ethnic Background 1994 & 1995				
Persons	1995 Number	1994 Number	1995 Percent	1994 Percent
White	24,423	25,379	11.2	11.7
Black	9,872	10,196	29.3	30.6
Hispanic	8,574	8,416	30.3	30.7

Source: U.S. Census Bureau 1995 (Numbers in thousands)

Poverty is a result of low family income. According to Diane Rowland (1993: 2), decline of the fathers' income, due to unemployment, for children in the bottom half of the income distribution explains part of the poverty rate. Also, many do not have fathers. More than 40% of the nation's poor were children under the age of 18 in 1991. In 1991, 34 percent of the poor children were Black. In 1993, the percentage of poor black children had increased to 47%, 41% Hispanic poor children, and 12% white poor children (Rowland, 1993:2).

Unfortunately, the children from low income families are more likely to experience poor health than those with higher incomes. For example, 11% of the poor children compared to 4% of the non-poor children are in either in fair or poor health (Rowland, 1993: 2). Furthermore, poor children, especially those in the inner cities and medically underserved areas, are particularly at risk for certain health problems, such as lead poisoning, asthma, and tuberculosis (Rowland, 1993: 2). Poverty is also associated with environmental factors that leave many children impaired throughout life by conditions that are preventable during youth (Rowland, 1993: 3). While there is no consensus on the make up of a comprehensive national health care plan, Medicaid serves as an access to

health care for many children, who might otherwise remain uninsured.

Role of Medicaid

Since 1965, Medicaid has been on the frontlines, as a primary means of providing health care benefits to our most needy population (Rowland, 1995: 1). In the United States, however, all children are not guaranteed access to health care services even through publicly funded programs, like Medicaid. While the Medicaid program has been instrumental in providing access to health care for needy children, not all children meet the income standard to receive benefits. "Lack of insurance coverage exposes family members to a small risk of catastrophic health care expenses beyond the resources of all but the wealthiest of American families" (Office of Technology Assessment, 1988: 58).

Medicaid was authorized under Title XIX of the Social Security Act in 1965. It is an open-ended entitlement program that is jointly financed by the federal and state governments. Also, Medicaid's structure is jointly determined by federal and state requirements (Rowland, 1995: 2). The Medicaid structure includes the design and the operation of the program within federal guidelines. In addition, the states determine the population groups and services for which the federal government will match state expenditures.

The states are allowed to make autonomous decisions about whom to cover, what benefits to provide, and what services to pay. Not surprisingly, the scope and cost of the program vary from state to state (Rowland, 1995: 3). In an effort to improve maternal and child health among low income families, Congress

enacted a series of Medicaid improvements. The improvements permit states to extend coverage to all "financially needy" children younger than 18 years of age, with family incomes below the Aid to Families with Dependent Care (AFDC) financial eligibility level, but who do not receive AFDC for non-financial reasons (Whitfill, et. al, 1989: 35).

Medicaid finances care for persons who meet strict state-specific income, asset limits, and those who fall into particular categories. The categories include people receiving cash assistance or low income children and pregnant women (Rowland, 1995: 7). "Over the last 30 years, the program has enabled millions of low income Americans to gain access to needed health services" (Rowland, 1995: 1). It has helped to close gaps in care between the poor and the non-poor, eased financial burdens associated with health care, and provided a safety net for most needy Americans (Rowland, 1995: 2).

For 16 million children, Medicaid is a health insurance program with comprehensive benefits with little or no cost -sharing by the recipients of benefits. "From the perspective of who is served, Medicaid is predominantly a program assisting low income families; from the perspective of how Medicaid dollars are spent, however, Medicaid is a program serving primarily the low income aged and disabled population" (Rowland, 1995: 3). Essentially, adults and children in low income families make up nearly three-fourths of the beneficiaries, but account for only 27% of spending (Rowland, 1995:3).

Simply stated, without Medicaid, millions of poor children would be

uninsured. Medicaid is the largest source of health care financing for the poor (Wiener & Engel, 1991: 29). It is an important source of coverage for children. Without it, the uninsured numbers would increase significantly (Rosenbaum, et. al, 1992: 1). Despite the presence of Medicaid, in 1994, the percentage of children without any health insurance coverage reached its highest level of 14.2% since 1987 (General Accounting Office, 1996: 1). Perhaps the increase, in 1993 and 1994, in the percentage of children covered by Medicaid is due to expansion of eligibility requirements. (See Table 2.4). Medicaid finances care for one in four American children, pays for one-third of the nation's birth, and assists 60% of people living in poverty.

Table 2.4: Health Insurance Status of Children Less Than 18 Years Old 1987 - 1994			
Year	Private Insurance	Medicaid	Uninsured
1994	65.6	22.9	14.2
1993	67.4	23.9	13.7
1992	68.7	22.0	12.7
1991	69.7	20.4	12.7
1990	71.1	18.5	13.0
1989	73.6	15.7	13.3
1988	73.5	15.6	13.1
1987	73.6	15.2	12.9

Source: The Bureau of the Census 1995

Note: Rows may add to more than 100 percent because children with both private insurance and Medicaid will be counted in both categories. In any year, less than 5 percent of the children have other coverage, such as CHAMPUS. Children with coverage other than private insurance or Medicaid and who are insured are not counted in this table.

As the primary source of health care financing for the poor, Medicaid has also demonstrated the importance of insurance in obtaining access to care. Before Medicaid, access to physician and hospital services for the poor lagged considerably behind that of the non-poor. Non-poor is defined as 200% above the federal poverty level (Rowland, 1995: 2). "For most indicators of access to care, the uninsured lag well behind those with Medicaid, while those with Medicaid fare comparably to the privately insured" (Rowland, 1995: 2). Also, despite recent extensions of coverage to poor children, millions of uninsured low income Americans, most notably poor individuals remain beyond the program's reach (Rowland, 1995: 8).

What Problems are the Uninsured More Likely to Incur

Introduction

A review of the literature uncovered a set of issues confronting uninsured families with children. The health care issues are classified within four broad descriptive categories. Although there are four categories identified each category is not exclusive of issues represented in the other categories. The categories are 1) access to care, 2) utilization of health care services, 3) quality of health care services, and 4) health education and communication. Each category contains a number of specific problems which will be discussed.

Overview

According to Diane Rowland (1995: 1), the uninsured are sicker, they are

less likely to get needed care, and have higher mortality rates. Also, the adjusted death rates are 25% higher for the uninsured than for privately insured people with the same health conditions. Furthermore, children born into poverty are less likely to receive health services which could prevent diseases in adult life. Basically, children in poor health endure long term problems that can limit their learning ability. Consequently, poor health also keeps children home from school and prevents optimal learning (Weiner & Engel, 1991: 16).

Karen Donelan and Robert Blendon (1996: 1347) conducted a study based on a national survey in 1995 called the "Voices From a National Survey." Out of the 3993 respondents surveyed, (45 percent) reported a problem getting needed medical care, and (36 percent) reported a problem paying medical bills as shown in Table 2.5. Approximately 19% of the respondents were without insurance at the time of the interview.

Table 2.5: The Percent of Insured & Uninsured Reporting a Problem During 1994		
	Uninsured	Insured
Problem getting needed medical care	45%	11%
Problem paying medical bills	36%	11%
Both problems	28%	4%

Source: Getting Behind the Numbers on Access to Care, Harvard School of Public Health, Kaiser Foundation, National Opinion Research Center, October 22, 1996: 1347

The study demonstrated that there are real consequences associated with the lack of health insurance. For example, the sicker an individual is when they are uninsured, the more likely it is that the individual cannot get medical care.

As a matter of fact, 55 percent of the uninsured people who said they were in poor health reported problems getting medical care. Unfortunately, the study also demonstrated that individuals reporting poor health overall encounter serious problems in obtaining medical care (Donelon & Blendon, 1996: 1348). (See Table 2.6)

Table 2.6: The Percent of Insured & Uninsured Reporting Problems Getting Care by Health Status in 1994		
	Insured	Uninsured
Excellent Health	8%	33%
Good Health	12%	47%
Fair Health	13%	53%
Poor Health	23%	55%

Source: Journal of the American Medical Association 1996:7

Overall, the survey indicated that the uninsured are four times more likely than the insured to report an episode of needing and not getting medical care. Furthermore, the uninsured are three times more likely to have a problem paying medical bills. Both of these problems contribute to child mortality and morbidity (Donelan & Blendon, 1996: 1347).

Barbara Starfield (1982:248) suggests that poor children receive a different kind of care from the non-poor children. Poor children are three times more likely to have no regular source of care. Also, poor children are four times more likely to report a place rather than an individual doctor as their regular source of care. There is even a difference with regard to the places where services are rendered. For example, the poor are more likely to obtain care in a

clinic setting as opposed to a private doctor's office.

Public health experts also suggest that there is evidence that an uninsured status makes a difference in the use of health services and probably health status as well. Compared to persons with private or public insurance, the uninsured are less likely to have a usual source of care. The uninsured use fewer ambulatory and hospital services than insured persons in similar health, and they are more likely to report needing medical help which they were subsequently unable to obtain (Farley-Short, et. al, 1990: 10).

Uninsured children in low income families make fewer visits to the doctor, but their parents often spend as much or more out of pocket for their care than the insured (Farley-Short, et. al, 1990: 10). As a matter of fact, the parents often end up spending more for health care services, due to accidents, sudden illnesses, or potentially preventable illnesses. Hence, unforeseen events account for why the uninsured are twice as likely to be unable to obtain care than the insured (Himmelstein & Woodhandler, 1995: 342). As a result, the uninsured are faced with the inability to obtain or pay for health care services. Basically, a major impediment to improving child health is the fact that many children do not have access to basic health services (Weiner & Engel, 1991: 1).

Access to Care

Access to health care is defined as "those dimensions which describe the potential and actual entry of a given population group to a health care delivery

system" (Mentnech, 1995: 1). According to the National Commission on Children (1991: 133), any organized health care system should guarantee access to health care for all children. Without access to health care, many children will experience problems that can severely compromise their long term health and development. Public health experts interested in children's health concerns have worried that typical national health insurance plans would not simply ignore, but would negatively affect children's health care. "Children's health concerns include: access; distribution of providers; and quality of care" (Marmor, 1977: 153).

Previous analyses have shown that, for persons with Medicaid or some other form of health insurance, barriers to care have been substantially reduced. Hence, access to health care may be accomplished through insurance plans that are designed to guarantee access and adequate coverage for important medical needs of children. Further, out of pocket expenditures should not discourage the use of effective health care for children. A large number of the low income populations, however, remain uninsured and continue to experience problems with access to medical care (Howell, 1988: 508).

Unfortunately, there is a relationship between low income and access to care. According to Douglas Diekema (1996: 3), the relationship between both low income and access to care along with lack of insurance has also been demonstrated. This includes the fact that children who live in poverty and lack insurance are more likely to suffer poor health outcomes. For instance, infant

death rates for blacks are twice those for white children. "A major impediment to reducing infant mortality and improving maternal and child health in the United States is the fact that many children and pregnant women do not have access to basic health care services" (Weiner & Engel, 1991:1). Basically, lack of insurance among the poor often compromises access to care (Rowland, 1993: 2).

Cost or lack of insurance accounted for a major reason why people could not or did not obtain care. Cost is a major barrier to care for both the insured and the uninsured. Other barriers to care include inhospitable, inconvenient, inaccessible services or the lack of resources to seek care. Those with a limited family income do not recognize family income as an essential component of health. Rather, the income is viewed by the families as a resource needed to provide nutrition, clothing, safe shelter, and then maybe needed medical care (Whitfill, et. al, 1989: 33).

The literature does not suggest that health insurance guarantees access to health care. There are non-financial barriers that discourage many insured patients, and coverage often has gaps that make care unaffordable (Himmelstein & Woodhandler, 1995: 341). It is, however, suggested that health insurance is a major component to obtaining care. Health insurance is a component of assuring access to health care for all Americans. Without health insurance, it is difficult to obtain timely and appropriate treatment and preventive primary care. "Having insurance coverage is highly dependent on whether and where you or a

family member of your family works or whether you are aged or poor enough to qualify for public assistance for health coverage" (Rowland, 1993: 4).

Furthermore, the literature does not suggest that the uninsured have no access to health care (Weiner & Engel, 1991: 5). Many of the uninsured pay out of pocket for health care services. The uninsured also access care through delivery systems like community health clinics and charity care. The programs, however, are not designed without shortcomings.

In addition to cost and lack of insurance, other non-financial barriers to access exist, that may preclude a child receiving care. The barriers include transportation, provider availability, and education. Transportation is a barrier because the children must rely on the adult to transport them to care. Also, some parents must rely on public transportation, that may be nonexistent. Also, provider availability is a barrier because of the shortage of providers in rural areas of a state. Finally, education is a barrier, because of the lack of knowledge of available health care services (House Committee on Public Health, 1996: 73).

Utilization of Health Care Services

According to Barbara Starfield (1982: 243) utilization of health care services is defined as "the patients use of existing health care delivery systems." Utilization appears to be related to insurance coverage and the availability of

financial resources, rather than the actual need of obtaining care.¹ Diane Rowland (1993: 6) stated that “Americans without insurance are more likely to forego or postpone care than those with insurance.” Rowland also found that 34% of the uninsured reported going without care in the past year, and 71% reported post-poning needed care.

Furthermore, the poor were less likely than the non-poor to have had physician contact for preventive or medical services in the past year, with 35% having no physician contact (Rowland, 1993: 8). In the 1987 the National Medical Care Utilization and Expenditure Survey (NMCUES), an individual’s relationship with the health care system was measured by three variables: (1) whether or not the individual had a regular source of care, (2) whether or not the individual had a regular doctor, and (3) the type of site of care that the individual used (Lambrew, et. al, 1996: 141). The findings of the survey indicated that persons with a regular doctor had better access to primary care than those with a regular site of care, but no doctor. In 1980, NMCUES also found that individuals without any health insurance coverage were less likely to have a usual source of care (25 percent) and had the lowest rate of physician visits. As a result, the uninsured may be more likely to receive care from multiple sources (Howell, 1988: 513).

The character of health care services are different when they come from

¹ The term “utilization indicators” is utilized as a performance measure regarding the quality or appropriateness of service upon patient encounter.

disjoint sources. For example, as a patient moves from one health care delivery to another, each delivery system often has a different focus. Yet the patient's expectation or focus usually remains unchanged. Perhaps the tension between an inconsistent health care environment and the stable needs and expectations of patients often lead to less than satisfied patients and less than adequate care. For example, children are less likely to receive recommended preventive care when attending hospital clinics, than children in prepaid group and private practices (Starfield, 1982: 248). Primary and preventive care services can, in addition to medical services, provide a wide range of social services that address language, educational, environmental, and other issues that could possibly impede patients' ability to obtain health care services (Weiner & Engel, 1991: 47).

According to Starfield (1982: 248), there is little information about the overall quality of care provided by the different sources of care. Unfortunately, uninsured children are more likely to receive care from different health delivery systems, than children served by prepaid and private groups. The different sources of health care delivery systems include doctor's office, outpatient hospital clinics, and Community Health Clinics (CHCs). Essentially, lack of insurance not only reduces utilization of health care services, but also limits the choice of health care providers. Many of the uninsured eventually turn to community health centers, hospital outpatient services, and emergency rooms for care (Rowland, 1993: 8). Consequently, the use of multiple providers of

health care can and does result in a loss of emphasis on preventive care (Starfield, 1982: 248).

Quality of Health Care Services

When seeking health care services, patients expect to receive quality service, regardless of whether one is insured or uninsured. Insurance coverage for and health care services received by our nation's children vary greatly among racial, ethnic, and socioeconomic groups. Although family income and enrollment in a health insurance plan are important factors in the decision to make a routine doctor's visit, quality of care is assumed by the patient (Bloom, 1990: 3).

According to the Institute of Medicine, there are five utilization indicators² that health systems can use to determine quality and effectiveness of services. The indicators include:

- (1) successful birth outcomes;
 - (2) reducing the incidence of vaccine preventable childhood diseases;
 - (3) early detection and diagnosis of treatable diseases;
 - (4) reducing the effects of chronic disease and prolonging life; and
 - (5) reducing morbidity and pain through timely and appropriate treatment
- (Lambrew, et al., 1996: 139).

² Utilization indicators as defined by the Institute of Medicine are employed to define or determine an appropriate source of health care.

The Institute of Medicine further states that the indicators may be measured by outcomes such as 1) the receipt of any childhood immunizations for children 1 to 2 years inclusively; 2) the receipt of a clinical breast and Papanicolaou (Pap) examination in the last 3 years for women 18 years and older and prenatal care; 3) actual use of physician services by those in poor health to prolong life; and hospitalization for ambulatory care conditions for those under the age 65.

Compared to hospital outpatient clinics and office-based physicians, Community Health Clinics (CHCs)³ deliver comparably, and possibly higher, quality of care for Medicaid beneficiaries (O'Malley & Forrest, 1996: 160). Children without health insurance were over twice as likely to use clinic care than children with insurance coverage (32% versus 13%). Community Health Clinics including community, neighborhood, and family health centers, are recognized as a crucial component in providing primary care to children (O'Malley & Forrest, 1996: 159). Community Health Clinics promote the use of preventive and primary care and reduces reliance on emergency rooms and hospital clinics (O'Malley & Forrest, 1996: 160). Promoting preventive and primary care may reduce health care costs.

³ Community Health Clinics were established in the mid-1960s to provide comprehensive, high quality primary health care services in rural and medically underserved areas.

Cost

There is suggestive evidence that CHCs are more cost efficient than hospital outpatient departments. For example, in 1988, Medicaid recipients using CHCs had significantly lower annual health care costs than a similar control population that utilized hospitals and private physicians. Furthermore, in 1988, primary care in CHCs demonstrated lower per capita costs when compared to the national average for a comparable package of health care services.

Demographics

In 1988, children using CHCs were more likely to be members of minority groups, to live below poverty level, to have mothers with less than 12 years of education, and to have mothers who were not married . Also in 1988, approximately half of all children in CHCs lived in the Southern region of the U.S. compared to all children in the U.S. Furthermore, a large portion of children using CHCs were either uninsured or had Medicaid (52 percent), or they had private insurance (48 percent) (O'Malley & Forrest, 1996: 160).

Overall, the utilization indicators can serve as a reference tool for patients as they determine an appropriate source of health care. Until recently, however, there has not been a comprehensive education program available for individuals to use to determine quality and appropriate sources of care. Rather, what has been available are separate educational programs. For the most part, educational programs for social issues have been provided separate from the

health programs (McManus & Dunbar, 1995: 1).

Health Education and Its Communication

When health education programs and communication are inadequate they may hamper a program's ability to ensure access to care. Education and communication problems include lack of outreach to potentially eligible people, complicated enrollment procedures, and low physician participation (Weiner & Engel, 1991: 23). According to the Texas House Committee on Public Health (1996: 73), as programs are developed to meet childrens' health care needs, the potential recipients of health care benefits should have knowledge of program existence. The awareness of programs is often promoted through the use of media, community leaders, churches, and doctors' offices.

Furthermore, a lack of knowledge of available health care services may create an artificial barrier. For instance, families may be unaware that they are eligible for various programs, especially given the complexity and variability of eligibility rules. In January of 1991, about one half of the states had shortened their Medicaid application forms. Often, the families, who, due to the complexity of the forms, have been inappropriately excluded from coverage, are unaware that the process has been simplified (Weiner & Engel, 1991: 24). As a result, they are effectively denied access to Medicaid. To remedy this problem, the House Committee on Public Health (1996: 73), strongly recommends a strong,

media-enhanced educational program, as a part of any expanded insurance coverage program.

Education is a key element of patient care. An essential element of education is preventive and primary care. When patients are educated on the nature and benefits of preventive and primary care, they are better able to recognize a health problem. Recognition of a problem enables early treatment which is both better for the patient (less time with pain aggravation) and insurance companies (cost). Further, an educated patient is a smarter consumer. The patient is better able to assess the benefits of potential health insurance programs.

If one can assume that families have the knowledge of primary and preventive care needs, families may want to identify a health care delivery systems that is designed to provide preventive services. For example, according to George Silver (1978: 58), hospitals should be avoided by families seeking preventive care. Hospitals are not designed to provide medical or health education to patients. Individual physician practices, however, are more desirable preventive settings. Preventive settings, such as a physician's practice may educate families in ways of preventive thinking. Preventive thinking, by families, includes planning for immunizations, annual physicals, and efforts required to avoid health problems.

In Arizona, there is a program, "Breaking the Cycle," sponsored by the Arizona Department of Health Service. The program emphasizes prevention,

early detection of problems, and health promotion for the disadvantaged populations less than 21 years of age (Arizona Department of Health, 1995: 8).

E.M. Backett (1984: 60) studied how to develop a method for health education and communication. Backett suggests that when developing methods for health communication and education, such as prevention programs and early detection programs, the program administrator should consider the characteristics of the neighborhoods, districts or regions, for which they will be targeting. Characteristic information may include the following:

- Age and sex distribution;
- Mortality by age and sex;
- Local cultural patterns, occupations, and religious customs;
- Attitudes about health, disease and death;
- Environmental risk factors;
- Local community organizations including women and youth groups;
- Local health services available, and use of health care personnel and their qualifications;
- How health problems of mothers and children are currently handled.

McManus (1995: 4) also suggested that “health professionals need to take more time to listen and address parent’s concern.” Information should be tailored to the educational needs and cultural backgrounds of individual families, and outreach should be an integral feature of the programs.

Some examples of educational initiatives for consideration include:

- Team approaches to preventive and primary care
- Developmental and behavioral risk assessments
- Home visiting services
- Health education and counseling programs
- Health education materials
- Telephone advice lines

- Parenting support groups

Another program, the Florida Healthy Kids Corporation, uses a variety of outreach, publicity and marketing activities including radio and television advertisements, brochures, flyers and presentations to reach the target population (House Committee on Public Health, 1996: 64).

Conceptual Framework

This research is descriptive in nature. Loosely defined descriptive categories will serve as the conceptual framework, as illustrated in Table 2.7. There has not been a great deal of recent statistics provided in the literature regarding who is insured, and the issues the uninsured are more likely to incur. The literature, however has been consistent on the type of issues confronting the uninsured. What emerged from the literature was four categories of issues confronting the uninsured. A fifth category also emerged as a result of interviewing the Executive Director of the Caring Program.

Table 2.7: The Conceptual Framework
Concept
I. Access to Care (General)
Financial barriers
Non-financial barriers
II. Utilization of health services (General)
Emergency vs. primary care
Postponing health care
III. Quality health care services (General)
Preventive care
IV. Health education and communication (General)
Outreach Programs or methods
Enrollment procedures
Provider participation
V. Other

Conclusion

Unfortunately, there is a lack of consensus when it comes to determining how to ensure that all children have access to health care. There is also lack of agreement on what type of care is essential. Furthermore, there is lack of agreement on the financial aspect, that is, who should pay. Meanwhile, as various levels of government work to meet all other financial and political obligations, there are a growing number of children who remain untreated because of cost, access, and education. Melissa Manchester Harrell's story is not an isolated situation. Melissa represents one of many children.

On the contrary, as efforts continue to develop a national comprehensive health insurance plan, there are programs, in addition to Medicaid, designed to provide access to preventive and primary health care services. As the programs evolve, they may enhance the strategies employed to reach the target population.

In the next chapter, the Blue Cross and Blue Shield Caring for Children Program (Caring Program) will be discussed. The Caring Program is a private non-profit organization designed to provide access to preventive health care for children. The chapter will describe the history and the benefits of the program. In addition, the chapter will describe other program initiatives, similar to those of the Caring Program. This chapter will also address a fifth category of issues as discussed by the Executive Director of the Caring Program. Finally, this chapter will discuss current and future initiatives of the Caring Program.

Chapter Three

Setting

Programs for Uninsured Children

Children and parents are currently faced with a complicated array of public programs providing health and social services. Most of these programs cover only fragments of care. "The children served are limited by type of service provided, age group, financial status, medical diagnosis, nutritional need, or usually some combination of these factors" (House Committee on Public Health, 1996: 71).

Texas & Florida Healthy Kids Corporation

The Texas House on Public Health Committee has recommended that the Texas Legislature develop a "Texas Healthy Kid Corporation." The corporation would serve as a non-profit corporation, created under the Texas Non-Profit Corporation Act to administer a statewide children's health insurance program through qualified insurers. The purpose of the corporation would focus on accessing comprehensive health insurance for all uninsured children up to age 18, in Texas (House Committee on Public Health, 1996: 63).

The recommended Texas Healthy Kids Corporation is modeled after the Florida Healthy Kids Corporation. The Florida Legislature responded to the problem of uninsured children by creating the corporation in 1992. The non-profit corporation provides insurance for children, using the local school system as an enrollment base to create a group of participants. Florida Healthy Kids

was charged with developing standards for preventive health services, providers, and comprehensive insurance benefits appropriate for children (House Committee on Public Health, 1996: 63). In creating the benefit package, the Florida Healthy Kid Corporation focused on what children need in order to learn. With that focus in mind, the benefits available included the following: 1) vision and hearing care including hearing aids and glasses; 2) preventive and primary care (immunizations); and 3) prescription drugs and hospitalization (House Committee on Public Health, 1996: 65).

The Texas House Committee on Public Health suggest that ideally the Texas Healthy Kids Corporation should use the existing private health care delivery systems. Private health care delivery systems, such as insurance companies or Health Maintenance Organizations (HMOs), would provide care in the same manner as they do for private customers. Like the Florida Healthy Kids, the Texas program would use the public school systems as one of the dissemination points for information on this affordable private insurance program for uninsured children (House Committee on Public Health, 1996: 66).

Texas currently has a pilot health insurance program, sponsored by the Texas Department of Health, for children up to age thirteen (13) with family incomes up to (133 percent) of the federal poverty level, and who are ineligible for Medicaid. The pilot is a result of Texas House Bill 997, passed by the 74th Legislature in 1995. The pilot site is Farias Elementary School in Laredo, Texas. Enrollment for the program began on November 1, 1996. The pilot was

implemented by a for profit HMO. The benefits of the program are illustrated in Table 3.1.

Table 3.1: Texas Pilot Health Insurance Benefits
Primary and specialty physician services
Inpatient hospital
Outpatient care (including diagnostic tests and surgery)
Emergency room visits
Prescription drugs
Mental health treatment
Ambulance services
Durable medical equipment
Emergency dental services
Transplants (if approved by second opinion)

Source: Texas House Committee on Public Health 1996

Texas Caring for Children Program

The Caring for Children Foundation of Texas, Inc., is a non-profit corporation. The foundation, better known as the Caring Program, provides access to primary and preventive outpatient benefits for eligible Texas children, ages 6 through 18, whose parents earn too much to qualify for Medicaid yet cannot afford private health insurance. The Texas Department of Health estimates there are more than 260,000 Texas children who fall into this Medicaid gap (Caring Program Information Sheet, 1996:1).

History of the Caring Program

The original Caring Program was developed in 1985 by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. Currently, 25 Caring Programs have been established by Blue Cross and Blue Shield Plans, and more than 160,000 children have benefited. The Texas Caring Program started enrolling eligible children on January 1, 1992. It served 311 children in the first year. More than 4,100 Texas children from 90 counties have been helped through the Caring Program. The cost for sponsoring a child is \$456 per year or \$38 per month (Caring Program Information, 1996: 1).

Caring Benefits

Children are sponsored financially by the private sector donations. No government funds are required, no taxes needed. Parents of eligible children pay nothing to have their children enrolled in the Caring Program, other than \$5 co-payments for prescription drugs. To meet the needs of eligible children, the following services, illustrated in Table 3.2, are covered annually. The Caring Program presently continues to enroll as many children as possible.

Table 3.2: Texas Caring for Children Program Benefits
12 doctor's visits, sick or well care
Outpatient emergency room care
Prescription drugs with a \$5 co-pay
Outpatient surgery
Outpatient diagnostic tests
Routine immunizations

Source: Caring for Children Program Executive Director Interview March 1997

Current and Future Caring Program Initiatives

Currently, the Caring Program is focused on reinforcing preventive care and health education. One avenue for achieving this goal is giving priority for re-enrollment to children currently participating in the Caring Program. Giving priority for re-enrollment to current participants allows for more time to change the philosophy or culture of the families, regarding access to health care. Based on the experiences of the Caring Program, the Executive Director of the Caring Program believes that it takes more than more year to change or to impact the philosophy and culture of the parents of the participants.

The participating families continue to think in terms of crisis intervention. Even with the presence of health benefits, there remains a fear of utilizing the benefits. Somehow there is satisfaction, with some families, gained from just knowing the benefits exist. The satisfaction and fear are a result of economic and cultural challenges. Hence, the longer the child is in the program, the more likely the parents will understand the philosophies of primary and preventive

care.

With regards to the future, the Director would like to continue with efforts to raise money to expand enrollment opportunities for many uninsured Texas children. The methods for raising money include soliciting grants from various foundations, charities and participation in events across the State of Texas.

The Director also would like to develop partnerships with restaurant chains, as another avenue for emphasizing the importance of preventive care. For example, upon receiving an annual well check examination, the child would be rewarded with a certificate for a free happy meal. The Director recognizes that there are probably more uninsured children than the Program can cover, but the Program will continue to provide a service that is well appreciated by the families they do cover. The next chapter, Chapter Four, will address the methodology of this study, specifically the survey method and its design.

Chapter Four

Research Methodology

Methodology

In this chapter, the methodology and perceptions used to describe the attitudes of the parents of the Caring Program participants is presented. The categories are used to address the research questions developed in the literature review. These categories and the literature form the basis of the survey instrument designed to determine the parental attitudes and perceptions

Survey Research

The general purpose of survey research is to measure individuals' attitudes and perceptions. Survey research allows the researcher to draw conclusions about the general population from a relatively small sample (Babbie, 1995: 257). According to Babbie (1995: 257), survey research is best in collecting original data for describing a population to observe directly.

The flexibility of a survey allows for many questions on a given topic. Also, surveys allow for development of operational definitions from actual observations. Furthermore, surveys contain standardized questions, which yields a higher degree of reliability and generalizability (Babbie, 1995: 273). Survey research, however, has weaknesses as well as strengths.

Due to the standardization of questions, researchers may produce results that are somewhat artificial. Another survey research weakness is the lack of

conditions in which a researcher can examine the respondents' answers. Finally, survey research is weak on validity and strong on reliability. The structure of the survey places a strain on the validity. Standardization of questions, however, aids in eliminating unreliability (Babbie, 1995: 274). Overall, survey research is appropriate because the research purpose is in part to measure the perceptions of the parents of the Caring Program participants.

Several drafts of the survey were submitted to the Executive Director of the Caring Program for review and comments. Mailing surveys, a survey technique, was used in order to assess perceptions of the parents of the Caring Program participants. The surveys were mailed on February 3, 1997, from the Caring Program, located in Dallas Texas, to 476 parents of the Caring participants. The respondents were asked to return the survey by February 14, 1997. The survey, a cover letter from the Executive Director of the Caring Program, and a pre-addressed, postage paid return envelope were included in each envelope.

There were two final versions of the survey, an English version, and a Spanish version. The final version of the survey contained 20 questions. The parents are asked to share their perceptions based on the four categories identified in the literature review. The fifth category represents issues addressed by the Executive Director of the Caring Program. The survey was organized according to the five broad descriptive categories representing major issues confronting the uninsured population as illustrated in Table 4.1.

Response Rate

The survey was sent to 476 parents of the Caring Program participants. The parents returned 161 surveys for a response rate of thirty-four percent. The number of responses received was satisfactory for the purposes of this study. Also, the return date for completed surveys was only two weeks, due to the time frame of this study.

Test Instrument

The survey instrument consisted of 20 questions divided into five broad descriptive categories. (See Appendix A for a copy of the survey instrument) The categories included access to care, utilization of health care services, quality of health care services, health communication and education, and other issues identified by the executive director of the Caring Program. Specific issues within each category were addressed. There was one question at the end of the survey, that was designed to elicit additional comments regarding the Caring Program from the parents. In addition, the survey was designed to elicit responses from the parents concerning the issues confronting the uninsured, and how the issues have been impacted by the Caring Program.

The first descriptive category included questions that addressed the issues involving access to care. Specifically, the questions addressed financial and non-financial barriers. The second category included questions that addressed the issues involving utilization of health care services, such as use of emergency room care versus use of primary care. The third category included

questions that addressed the issues involving quality of health care services, like preventive care. In the next category, the questions addressed issues involving health education and education, such as enrollment procedures and outreach programs. The last category included questions involving issues identified by the executive director of the Caring Program. The survey statements are directly linked to the descriptive categories as illustrated in Table 4.1 below.

Table 4.1: Operationalizing the Conceptual Framework	
Concept	Questionnaire Item(s)
I. Access to Care (General)	
Financial barriers	Questionnaire item 15
Non-financial barriers	Questionnaire items 7 and 8
II. Utilization of health services (General)	
Emergency vs. primary care	Questionnaire items 12, and 13
Postponing health care	Questionnaire item 6
III. Quality health care services (General)	Questionnaire items 1 and 2
Preventive care	Questionnaire items 3, 4, and 5
IV. Health education and communication (General)	
Outreach Programs or methods	Questionnaire items 17
Enrollment procedures	Questionnaire items 10 and 11
Provider participation	Questionnaire item 9
V. Other	Questionnaire items 14, 16, 18, 19, and 20

Measurement

The variables were measured using a Likert scale for questions 1 through 11, with the respondents answering either “strongly agree,” “agree,” “disagree,” “strongly disagree,” or “undecided.” The answers will be coded 5 , 4, 3, 2, and 1 respectively.

When computing the mean, any figure greater than 3, indicates that the respondent agreed with that statement on the questionnaire. A mean less than

3, indicates that respondent disagreed with that statement on the questionnaire. Questions 12 through 19 included multiple choice responses. The answers were coded 0 through 6, with "0" representing no response; "1" representing the first choice; and "6" representing the last choice.

Statistics

Simple descriptive statistics were employed to quantify the results of the survey. According to Babbie (1995: 440), "some descriptive statistics summarize the distribution of attribute on a single variable, others summarize the association between the variables." Each statement was analyzed, and the frequency, percentage, and the mean of the responses were calculated for each statement. The calculation of the mean helps to determine the overall perception and significance of each statement.

The next chapter, Chapter Five, discusses the results of the survey. All issues from the five broad descriptive categories are reviewed. Also, the results of the survey are analyzed and stated.

Chapter Five

Results

Results

This chapter discusses the results of the survey received from the parents of the Caring Program participants. The five major categories, access to care, utilization of health services, quality of health services, health education and communication, and issues identified by the executive director of the Caring Program, provide a framework to assess the results. The survey results focus on the perceptions of the parents of the Caring Program participants regarding the impact the program has had on the issues confronting the uninsured. In addition, the most significant issues are identified and discussed.

Survey Results and Analysis

As mentioned earlier, the survey is divided into five sections, with the fifth section representing issues identified by the executive director of the Caring Program. Each section in this chapter details the responses with both qualitative and quantitative data, specifically the mean for each survey statement and the percentages of responses to the survey statements. The survey also requested information regarding geographic location and ethnic background as illustrated in Tables 5.1 and 5.2 below. The majority of the Caring Program participants reside in Houston, Dallas/Fort Worth, and El Paso, which is representative of the responses received.

Table 5.1: Frequency of Response by Geographic Location (N=161)	
East Texas	22%
North Texas	30%
South Texas	3%
West Texas	14%
Central Texas	24%
No Response	7%

Table 5.2: Percent of Distribution by Ethnic Background (N=161)	
Indian	2%
Black	17%
Hispanic	47%
White	32%
Asian	1%
Other	1%

Perceptions of Access to Care

The first category of questions focuses of the perceptions of the parents of the Caring Program participants regarding access to health care. Specifically, the respondents were asked to provide their perceptions on access to care in terms of financial and non-financial barriers. In general, when commenting on the non-financial barriers, parents did not perceive provider accessibility as a

significant issue. The respondents did, however, feel there is a significant issue when commenting on financial issues. There were 58 percent of the parents who felt direct cost, including taking off from work, as a barrier to scheduling a routine checkup for their child or children. Table 5.3 details the mean rating of the responses for Questions 7, 8, and 15.

Table 5.3: Perceptions of Access to Care		
<u>Financial Barriers</u> Which problem is most likely to prevent you from scheduling a doctor's appointment for a routine checkup for your child or children?	<u>Ranking of Top 3</u>	<u>Percent Distribution (N=161)</u>
• Cost to me	1	39%
• No family doctor		11%
• Getting off from work	2	19%
• Transportation		9%
• Other	3	17%
• No Response		5%
<u>Non-Financial Barriers</u>		
• The doctor or staff are available to answer questions.	4.39	
• The doctor's wait time is usually 0-20 minutes.	3.86	

Perceptions of Utilization of Health Care Services

The second category of questions focuses on the perceptions of the parents regarding utilization of health care services. Specifically, the questions focused on the use of emergency room services versus primary care services, both prior and during enrollment with the Caring Program. The mean rating for use of the emergency room prior to enrollment was 1.19. As a participant of the Caring Program, however, the meaning rating decreased to 0.76. See Table 5.4.

The results of the survey suggest that utilization of the emergency room, after enrollment, was significantly decreased; $t = +2.86$, $p < .002$. This category also included a question that captured where the parent was more likely to seek out health care services for their child or children. An overwhelming majority of the respondents (91 percent) indicated that they are more likely to seek care in a doctor's office as opposed to an emergency room setting. Based on the response, this evidence suggests that the Caring Program has lowered the use of health care services in the emergency room.

	<u>Mean Rating</u>	<u>Percent Distribution</u> (N=161)
<u>Emergency vs. Primary Care</u> <ul style="list-style-type: none"> In the year prior to your child or children's enrollment in the Caring Program how many times did your child or children visit the emergency room? While participating in the Caring Program, how many times have your child or children been to the emergency room? 	1.19 0.76	
<u>Post-poning health care</u> <ul style="list-style-type: none"> While participating in the Caring Program, I have been more likely to obtain medical services in the doctor's office, rather than the emergency room. 		91%(strongly agree or agree)

Perceptions of Quality Health Care Services

The third category of questions focused on continuity or type of care the children receive from the health care provider. The emphasis in this category is preventive care or annual well examinations. Almost all of the parents (94 percent) agree that they usually understand the course of treatment for their child. Also, close to 9 out of the 10 parents (88 percent) agreed that the child's health condition usually improves after a visit with a doctor.

On the other hand, when asked whether the children had been encouraged to have annual well check examination, only 57 percent of the parents agreed they had been encouraged to have an annual examination, while 35 percent indicated that they had not been encouraged by their health care provider. Furthermore, as participants of the Caring Program, only 53 percent of the parents responding agreed that their child had received an annual well check examination, while 37 percent indicated that their child had not received an annual examination. Based on the responses in the access to care category, cost may serve as the reason for the children not receiving an annual examination. Almost 60 percent of the parents indicated that cost impact their decision to take a child to the doctor. See Table 5.5.

Table 5.5: Perceptions of Quality of Care		
	<u>Mean Rating</u>	<u>Frequency Rating</u> (N=161)
<u>General</u> <ul style="list-style-type: none"> The doctor's course of treatment for my child or children is easy to understand. My child or children's health condition has improved. 	4.40 4.18	94% agree 88% agree
<u>Preventive Care</u> <ul style="list-style-type: none"> The doctor has made suggestions on my child or children maintaining good health. I have been encouraged by the doctor to have an annual well check for my child or children (a visit not related to an illness or injury). While participating in the Caring Program, my child or children has received an annual well check examination (a visit not related to an illness or injury). 	4.12 3.66 3.53	84% agree 57% agree 35% disagree 53% agree 37% disagree

Perceptions of Health Education and Communication

The fourth category of questions focused on issues involving outreach methods, enrollment procedures, and provider participation. Specifically, the questions elicited perceptions regarding how the parents found out about the Caring Program, perceptions regarding understanding program benefits and provider participation.

Finally, almost all respondents (98 percent) agreed that the enrollment procedures for the Caring Program are easy to understand. In addition, 96

percent of the responding parents agreed that the benefits for the Program are easy to understand. The parents also indicated, in the other category selection, various methods in which they learned of the Caring Program. The various methods include television, radio, newspaper, friends, Texas Department of Human Services, and the Texas Department of Health. There was no surprise in finding that 40 percent of the parents learned of the Caring Program through the Medicaid Office, considering that potential enrollees must complete the Medicaid application process, prior to enrolling in the Caring Program. Also, 91 percent of the responding parents agreed that the location of the participating provider is convenient. See Table 5.6.

Table 5.6: Perceptions of Health Education & Communication		
	<u>Mean Rating</u>	<u>Percent Distribution</u> (N=161)
<u>Enrollment Procedures</u> <ul style="list-style-type: none"> The Caring Program enrollment procedures are easy to understand. The benefits of the Caring Program are easy to understand. 	4.51 4.46	98% agree 92% agree
<u>Provider Participation</u> <ul style="list-style-type: none"> The location of the doctor's office is convenient. 	4.34	91% agree
<u>Outreach Programs or Methods</u> <ul style="list-style-type: none"> How did you find out about the Caring Program? <ul style="list-style-type: none"> -Church -School -Medicaid Office -Community Leader -Doctor's Office -Other 		2% 6% 40% 9% 10% 32%

Perceptions of Other Issues

The fifth category consisted of questions that were not specifically addressed in the review of literature. The questions involved the number of times parents seek medical advice, the number of school days missed, specific preventive care examinations, and insurance status prior to enrolling in the Caring Program.

The question involving the number of times parents seek medical advice was designed to capture how the parent utilizes services. The objective is to

determine whether the Caring Program participants, are they more likely to seek preventive medical advice. Fifty-one percent of the responding parents indicated that they have contacted the doctor at least 1 to 3 times. Twenty-five percent responded that they never contact the doctor for medical advice. The 25 percent may be a result of the parents who are not accustomed to having a doctor available for medical advice. See Table 5.7. Perhaps this group may also continue to rely on emergency room services. This category also addressed the issue of school days missed as a result of a sick child.

The relationship between the level of education and a child's health status warrants a separate study. However, the questions were designed to find the number of days missed prior to enrollment in the Caring Program, and days missed while participating in the Program. In the year prior to enrollment in the Caring Program, the mean rating for missed school days is 4.97. During enrollment in the Program, however, the mean rating for missed school days is 3.09 as illustrated in Table 5.7. The results of the survey suggest that the number of school days missed during enrollment has significantly decreased; $t = +3.63$, $p < .0001$.

The third category addressed preventive care issues, but this category involves specific types of examinations received while participating in the Caring Program. The specific examinations include eye examinations, hearing tests, immunizations, and regular check ups. Seventy-two percent of the responding parents indicated that their child or children had not received an eye

examination. The large percentage may be due to the fact that eye examinations are not a covered benefit with the Caring Program. Immunizations are, however, a covered benefit, yet only 41 percent responded that their child or children had been immunized. Fifty-one percent responded that their child had not been immunized while participating in the program. The large percentage of those not immunized during enrollment may be a result of the participating age group of 6 to 18. On the other hand, 53 percent responded that their child or children had received a regular check up.

Finally in this category, is a question which focuses on the participants health insurance status prior to enrollment in the Caring Program. There is also a statement of request for additional comments regarding the Program. Based on the surveys, it was found that 76 percent of the responding parents had no insurance coverage prior to the Caring Program. Twenty percent of the parents had Medicaid.

Table 5.7: Perceptions of Other Issues		
	Mean Rating	Percent Distribution (N=161)
<ul style="list-style-type: none"> While participating in the Caring Program, about how many times have you called your Caring Program doctor for medical advice or to decide whether your child or children needed to see the doctor? <ul style="list-style-type: none"> -Never -1 to 3 times -4 to 7 times -8 or more times -No response 	1.93	25% 51% 16% 4% 4%
<ul style="list-style-type: none"> In the year prior to your child or children's enrollment in the Caring Program, how many days did your child miss school? How many days of school has your child or children missed since being enrolled in the Caring Program? 	4.97 3.09	
<ul style="list-style-type: none"> While participating in the Caring Program has your child or children had an: <ul style="list-style-type: none"> -Eye examination -Hearing test -Immunization -Regular check up 		22% yes 17% yes 41% yes 53% yes
<ul style="list-style-type: none"> Prior to enrolling in the Caring Program, what insurance plan covered your children? <ul style="list-style-type: none"> -No insurance coverage -Private insurance/ employer -Medicaid -Other 		76% 2% 20% 1%

Overall, the parents of the Caring Program participants are generally

satisfied with the issues represented in the survey. However, as the executive director mentioned, more emphasis is required on preventive and primary care versus emergency room care. A gap continues to remain with regards to receipt of annual well check examinations, including immunizations. There remains an opportunity for improvement with regards to removing the financial barriers perceived by the parents.

Summary of Findings

According to the survey data, the Caring Program has had a positive impact on how and when parents access health care services for their child or children.

See Table 5.8.

Table 5.8: Summary of the Findings

Key Categories:	Perceptions/ Attitudes:
I. Access to Care	Basically, the results indicate that the non-financial barriers are not a significant problem. Fifty-eight percent, however, responded that cost impacted their decision to seek health care services for their child or children
II. Utilization of Health Care Services	The Caring Program has had a significant impact on participant use of emergency room services. Also, an overwhelming majority of the parents responded that they are more likely to seek care in a doctor's office as opposed to the emergency room.
III. Quality Health Care Services	Unfortunately, there remains a problem of understanding and communicating the importance of an annual well check examination.
IV. Health Education and Communication	Basically, the enrollment procedures and the benefits of the Caring Program are easy to understand. Over 40% of the respondents learned of the Caring Program from the local Medicaid Office.
V. Other Issues	The Caring Program has had a significant impact on the number of missed school days of the children currently participating in the program. Close to 80% of the respondents indicated that their child or children had no insurance prior to enrollment in the Caring Program.

Chapter Six

Research Conclusion

Recommendations to Enhance Programs Designed for the Uninsured

The issues confronting the uninsured are issues that require reconciliation from the American society as a whole. Debra Lipson (1994: 8) suggest that there are several elements that are necessary for reconciliation. The elements include: 1) political consensus; 2) public and interest group support; 3) dedicated finance resources; and 4) strong management capabilities in the public sector. All of these elements are critical to sustaining or implementing program strategies. The goals of most programs is to identify methods for providing comprehensive preventive care services.

Several health care experts have written about methods or strategies that can be used for providing comprehensive preventive care services. Most of the strategies discussed are recommended based on proven success in various pilot programs across the United States. Particularly, as a result of a study conducted by the Association of Maternal and Child Health program, several recommendations were made to improve parent education regarding primary and preventive care. The key which connected the recommendations was the idea of "one stop shopping" (McManus & Dunbar, 1995: 4).

Many programs have been implemented with the goal of providing children with access to primary and preventive services. Most programs, however, have encountered problems that exist among the uninsured, such as

economic and cultural issues. The idea of one stop shopping does not suggest ignoring or going around the issues. One stop shopping supports confronting the issues utilizing the following approaches:

- Health care, parenting, and other related services
- Staff training that focuses on patient centered care
- Parent involvement in design, implementation, and evaluation of health programs
- Health professionals taking more time to listen and address parent concerns
- Information tailored to the educational needs and cultural backgrounds of individual families (McManus & Dunbar, 1995: 4).

The idea of providing health care services, parenting and other services within the same facility, would alleviate the problem of fragmenting services. In addition to the health care services, the parental development includes self-care, strength recognition, family planning, and other parenting skills (McManus & Dunbar, 1995: 5).

Educating health care professionals suggests that the primary care provider and staff are ready to provide anticipatory guidance and support to families with children. Guidance and support is provided to enrich the content of the pediatric visits. Also during the visit, the health care staff will respond to questions the parents may have regarding their child's health status. In addition the staff will focus on quality of the family relationship.

In order to tailor information for a family, McManus (1995: 6) suggests using home visits, health education, and counseling programs as methods for assessing educational needs and cultural backgrounds. Home visiting services

basically serve to combat stress and offer support to families. "Some of the topics addressed during home visits include parent-child interaction, parental support and stress, problem solving, and increasing social support ."

The Caring Program has made significant strides in their endeavor to provide access to preventive and primary care services. The Program, however, may want to review the opportunity to provide educational programs on how and when to access preventive services. In other words, based on the results of the survey, the parents are clear on what benefits are available with the Caring Program. Some parents, however, continue to have a problem in understanding how the use of preventive care impacts the child's overall health status.

Suggestions for Future Research

The following are suggestions by the researcher that would further enhance this study if it were replicated. A simultaneous analysis of two programs designed for uninsured children. Also, specific demographic information regarding educational levels, language preference, and cultural backgrounds of the program participants would add significantly to the study. Furthermore, in order to strengthen the methodology of the study, t-statistics should be employed when comparing the means of the two programs selected for analysis.

Conclusion

Overall, the responding parents of the Caring Program participants are pleased with the fact that they have access to health care through the Caring

Program. Most parents expressed thanks and relief for benefits that might not otherwise exist. These same parents, however, remain reluctant to use the benefits, perhaps out of fear that they may lose the benefits. Again, there is satisfaction shared by the parents from just knowing the benefits exist. This state of mind may hinder the overall goal of providing access to primary and preventive care. On the other hand, if continued emphasis on preventive care, along with implementation of relevant recommended strategies are employed, then this program and other like programs may overcome this roadblock.

Bibliography

- Arizona Department of Health Services. "Breaking the Cycle." Arizona Health Information System, 1995.
- Backett, E.M., A.M. Davies & A. Petros-Barvazian. "The Risk Approach in Health Care with Special Reference to Maternal & Child Health, including Family Planning." Public Health Papers No. 76, World Health Organization, 1984.
- Barents Group, LLC KPMG, "Analysis of Texas Health Care Expenditures 1994 - 2000." The Henry J. Kaiser Family Foundation, 1995.
- Bloom MPA, Barbara. "Health Insurance and Medical Care: Health of Our Nation's Children, U.S." Advanced Data from Vital & Health Statistics of the National Center for Health Statistics No. 188 October 1, 1990.
- Blumberg, Linda J. & David W. Liska. "The Uninsured in the United States: A Status Report." The Urban Institute. April 1996.
- Currie, Janet, & Jonathan Gruber. "Health Insurance Eligibility, Utilization of Medical Care, and Child Health." Working Paper No. 5052. National Bureau of Economic Research Inc. Publication, Cambridge, Ma. March 1995.
- Diekema M.D. MPH, Douglas S. "Children First: The Need to Reform Financing of Health Care Services for Children." Journal of Health Care for the Poor and Underserved. Vol. 7, No. 1 1996.
- Donelan ScD, Karen & Robert J. Blendon Scd. "Whatever Happened to the Health Insurance Crisis in the United States? Voices from a National Survey." Journal of the American Medical Association. Vol 276, No. 16 October 23, 1996.
- Farley-Short Ph.D, Pamela, Llewellyn J. Cornelius Ph. D, & Donald E. Goldstone, M.D., MPH. "Health Insurance of Minorities in the United States." Journal of HealthCare for the Poor and Underserved. Vol. 1, No. 1 1990.
- Himmelstein M.D., David U., & Steffie Woodhandler, M.D. MPH. "Care Denied: US Residents Who Are Unable to Obtain Needed Medical Services." American Journal of Public Health. Vol. 85, No. 3 March 1995.

- House Committee on Public Health Texas House of Representatives.
 "Improving Access to Health Care for Children." A Report to the House
 of Representatives 74th Texas Legislature. 1996.
- Howell, Embry M. MSPH. Low-Income Persons' Access to Health Care:
 NMCUES Medicaid Data Public Health Reports Vol. 103, No. 5.
 September - October 1988.
- Lambrew, Jeanne, Ph.D., Gordon H. DeFrieze, Ph.D., Timothy S. Carey, M.D.,
 Thomas Ricketts, Ph.D., & Andrea K. Biddle, Ph.D. "The Effects of
 Having a Regular Doctor on Access to Primary Care." Journal of
 Medical Care. February 1996 Vol. 34 No. 2.
- Lipson, Debra J. "Keeping the Promise? Achieving Universal Health Coverage
 in Six States." Innovations in State Health Reform. The Henry J. Kaiser
 Family Foundation. September 1994.
- Lundberg M.D., George D. "A Portrait of the Uninsured." Journal of the
 American Medical Association. October 1996. Vol. 276, No. 16.
- Marmor, Theodore R. "Children and National Health Insurance." Developing a
 Better Health Care System for Children. Harvard Child Health Project.
 Vol. 3 Ballinger Publishing Co. Cambridge, Ma. 1977.
- McManus, Margaret A. & Jennifer. "Innovative Approaches for the Delivery and
 Financing of Parent Education Programs in Health Care Settings."
 McManus Health Policy, Inc. September 1995.
- Mentnech, Renee MS. "Overview on Access to Health Services for Vulnerable
 Populations." Health Care Financing Review. Winter 1995 Vol. 17, No.
 2.
- Montgomery, MA, Laura E., John L. Kiely Ph.D. & Gregory Pappas, M.D. Ph.D.
 "The Effects of Poverty, Race, and Family Structure on US Children's
 Health: Data form the NHIS, 1978 through 1980 and 1989 through 1991."
American Journal of Public Health. Vol. 86, No. 10 October 1996.
- O'Malley, M.D. MPH, Ann S. & Christopher B. Forrest, M.D., Ph.D. "Ambulatory
 Services to Children in Community Health Clinics." Journal of Community
 Health The Publication for Health Promotion and Disease Prevention.
 Vol. 21, No. 3 June 1996.

Patrick, Donald L., Ph.D., MSPH, Carolyn W. Madden Ph.D., Paula Diehr, Ph.D., Diane P. Martin, Ph.D., Allen Cheadle, Ph.D. & Susan M. Skillman, MS. "Health Status and Use of Services Among Families With and Without Health Insurance." Journal of Medical Care. October 1992, Vol. 30, No. 10.

Rosenbaum, Sara, Dan Hughes, Phyllis Harris, & Joseph Liu. "Special Report: Children and Health Insurance." Children's Defense Fund; George Washington University Center for Health Policy Research January 1992.

Rowland Sc.D., Diane. Testimony on Meeting the Health Needs of the Low-Income Population in Health Reform. Hearing Before the Subcommittee on Health and the Environment Committee on Energy and Commerce. November 1993.

Rowland Sc.D., Diane. Medicaid: Challenges and the Choices in Health Care for the Poor. Hearing Before the Committee on Commerce. Hearing on Perspectives on the Medicaid Program. August 1995.

Silver M.D., George A. Child Health: America's Future. Aspen Systems Corp. Germantown, Maryland 1978.

Starfield, Barbara. "Family Income, Ill Health, and Medical Care of US Children." Journal of Public Health Policy. September 1982.

Sultz DDS, MPH, Harry. "Health Policy: If you Don't Know Where You Are Going, Any Road Will Take You." American Journal of Public Health. Vol. 81, No. 4 April 1991.

The National Commission on Children. "Beyond Rhetoric A New American Agenda for Children & Families." Final Report of the National Commission on Children. Library of Congress 1991.

U.S. Census Bureau, Population Data, 1995

U.S. Congress, Office of Technology Assessment. Healthy Children: Investing in the Future. OTA-H-345 Washington D.C.: US Govt. Office, February 1988.

Whitfill, Aileen, Joseph Liv, & Kay Johnson. The Health of America's Southern Children Maternal & Child Health Data Book. Children's Defense Fund 1989.

Wiener, Joshua M., & Jeannie Engel. Improving Access to Health Services for Children and Pregnant Women. The Brookings Institution, Washington, DC 1991.

Appendix A

The Caring Program would like to take this opportunity to extend our appreciation for your time to complete the following questions. Our goal is to provide access to primary and preventive health care needs through the Caring Program benefits. This survey is one of many tools used to ensure that the goals of this program are in fact being met. Your response to the following questions will enable the Caring Program to assess your satisfaction with the program. Also, your response will allow the Caring Program to evaluate areas that may or may not require additional efforts in meeting our goals.

I reside in:

- ☐ East Texas (Houston or Beaumont and surrounding areas)
- ☐ North Texas (Dallas-Fort Worth and surrounding areas)
- ☐ South Texas (McAllen or Harlingen and surrounding areas)
- ☐ West Texas (Lubbock or Amarillo and surrounding areas)
- ☐ Central Texas (Austin or San Antonio and surrounding areas)

My ethnic background:

- ☐ American Indian or Alaskan native
- ☐ Black
- ☐ Hispanic
- ☐ White
- ☐ Asian
- ☐ Other

		Strongly Agree	Agree	Disagree	Strongly Disagree	Undecided
1.	The doctor's course of treatment for my child or children is easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	My child or children's health condition has improved.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	The doctor has made suggestions on my child or children maintaining good health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	I have been encouraged by the doctor to have an annual well check for my child or children (a visit not related to an illness or injury).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	While participating in the Caring Program, my child or children has received an annual well check examination (a visit not related to an illness or injury).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	While participating in the Caring Program, I have been more likely to obtain medical services in the doctor's office, rather than the emergency room.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	The doctor or staff are available to answer questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	The doctor's wait time is usually 0-20 minutes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	The location of doctor's office is convenient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	The Caring Program enrollment procedures are easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	The benefits of the Caring Program are easy to understand.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix A

12. In the year prior to your child or children's enrollment in the Caring Program how many times did your child or child visit the emergency room? _____
13. While participating in the Caring Program, how many times have your child or children been to the emergency room _____
14. While participating in the Caring Program, about how many times have you called your Caring Program doctor for medical advice or to decide whether you child or children needed to see the doctor?
☐ Never ☐ 1 to 3 times ☐ 4 to 7 times ☐ 8 or more times
15. Which problem is most likely to prevent you from scheduling a doctor's appointment for a routine checkup for your child or children? ☐ Cost to me ☐ No family doctor ☐ Getting off from work
☐ Transportation ☐ Other _____
16. In the year prior to your child or children's enrollment in the Caring Program, how many days did your child miss school? _____ How many days of school has your child or children missed since being enrolled in the Caring Program? _____
17. How did you find out about the Caring Program?
☐ Church ☐ School ☐ Medicaid office ☐ Community leader ☐ Doctor's office
☐ Other _____
18. While participating in the Caring Program has your child or children had an...
Eye examination ☐ Yes ☐ No
Hearing test ☐ Yes ☐ No
Immunization ☐ Yes ☐ No
Regular checkup ☐ Yes ☐ No
19. Prior to enrolling in the Caring Program, what insurance plan covered you children?
☐ No insurance coverage
☐ Private insurance through an employer or purchased directly from an insurance company
☐ Medicaid
☐ Other _____
20. Please provide any additional comments regarding your experience or benefits of the Caring Program.

Appendix A

El programa "Caring" desea agradecerle por su tiempo y atención para completar la siguiente información. Nuestra meta es asegurar necesidades básicas de salud preventiva a través de los beneficios del programa "Caring". Esta encuesta es una de muchas formas usadas para asegurarnos de que nuestro objetivo está siendo alcanzado. Su participación al completar la siguiente información nos permitirá evaluar su satisfacción con el programa. Al mismo tiempo, nos permitirá evaluar áreas que requieren o no esfuerzos adicionales para lograr nuestro propósito.

Residencia:

- ☐ Este de Texas (Houston o Beaumont y sus alrededores)
☐ Norte de Texas (Dallas Fort Worth y sus alrededores)
☐ Sur de Texas (McAllen o Harlingen y sus alrededores)
☐ Oeste de Texas (Lubbock o Amarillo y sus alrededores)
☐ Centro de Texas (Austin o San Antonio y sus alrededores)

Procedencia étnica:

- ☐ Indios Americanos o Nativos de Alaska ☐ Moreno ☐ Hispano
☐ Blanco ☐ Asiáticos ☐ Otro

	Totalmente Positivo	Positivo	Negativo	Totalmente Negativo	Indeciso
1. La prescripción médica para el tratamiento de mi(s) hijo(s) es comprensible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. El restablecimiento de mi(s) hijo(s) a mejorado.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. El médico ha indicado la forma de cómo conservar a mi(s) hijo(s) saludable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. El médico me ha recomendado un examen general anual para mi(s) hijo(s) (una visita no causada por enfermedades o lesiones).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Durante el período de cobertura por el programa "Caring", mi(s) hijo(s) han recibido un examen general anual (una visita no causada por enfermedades o lesiones).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Durante el período de cobertura por el programa "Caring", es preferible el servicio en la clínica médica antes que ir al servicio de emergencia.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Los médicos o el personal están dispuestos a contestar preguntas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. En la clínica médica el tiempo de espera es de 0 - 20 minutos.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. La clínica médica está ubicada en un lugar conveniente.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix A

- | | Totalmente
Positivo | Positivo | Negativo | Totalmente
Negativo | Indeciso |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 10. El procedimiento de registro al programa "Caring" es comprensible. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Los beneficios del programa "Caring" son comprensibles. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Antes de inscribir a su(s) hijo(s) en el programa "Caring", cuantas veces uso el servicio de emergencia? _____ | | | | | |
| 13. Durante el período de cobertura por el programa "Caring", cuantas veces ha usado el servicio de emergencia? _____ | | | | | |
| 14. Durante el período de cobertura por el programa "Caring", cuantas veces ha llamado al doctor para que le de un consejo médico o para decidir si su(s) hijo(s) necesita que lo lleve al médico?
<input type="checkbox"/> Nunca <input type="checkbox"/> 1 a 3 veces <input type="checkbox"/> 4 a 7 veces <input type="checkbox"/> 8 o más veces | | | | | |
| 15. Qué problema le impide a usted no poder hacer una cita con el médico para poder llevar a su(s) hijo(s) a un examen rutinario? <input type="checkbox"/> Costo para mi <input type="checkbox"/> No tener médico familiar <input type="checkbox"/> Transportación
<input type="checkbox"/> Tomar tiempo de mi trabajo <input type="checkbox"/> Otro _____ | | | | | |
| 16. Antes de inscribir a su(s) hijo(s) en el programa "Caring", cuantos días faltó su(s) hijo(s) a la escuela? _____ Durante el período de cobertura por el programa "Caring", cuantos días a faltado a la escuela? _____ | | | | | |
| 17. Cómo se enteró del programa "Caring"?
<input type="checkbox"/> Iglesia <input type="checkbox"/> Escuela <input type="checkbox"/> Oficina de Medicaid <input type="checkbox"/> Líder en la comunidad <input type="checkbox"/> Clínica médica
<input type="checkbox"/> Otro _____ | | | | | |
| 18. Durante el período de cobertura por el programa "Caring" su(s) hijo(s) ha tenido un...
Exámen de ojos <input type="checkbox"/> Sí <input type="checkbox"/> No
Exámen de oído <input type="checkbox"/> Sí <input type="checkbox"/> No
Vacunas <input type="checkbox"/> Sí <input type="checkbox"/> No
Exámen rutinario <input type="checkbox"/> Sí <input type="checkbox"/> No | | | | | |
| 19. Antes de inscribir a su(s) hijo(s) en el programa "Caring", que plan de seguro tenía?
<input type="checkbox"/> No tenía seguro
<input type="checkbox"/> Seguro privado por medio del trabajo o comprado directamente de una compañía de seguros
<input type="checkbox"/> Medicaid
<input type="checkbox"/> Otro | | | | | |
| 20. Por favor provea cualquier comentario en cuanto a su experiencia o beneficios del programa "Caring". | | | | | |



Caring for Children

Foundation of Texas, Inc.

February 3, 1996

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Craig Jeffery
Executive Director

Dear Parents,

I need your opinion!

The Caring Program staff, the employees of Blue Cross and Blue Shield of Texas, Inc., the doctors, hospitals, and pharmacists involved in the Caring Program work hard to provide your enrolled child or children with quality, convenient, easy to understand health care. We need your opinion on how we're doing.

Accompanying this letter is a survey which should take you only a few minutes to complete. **Your response is important to us.** Your answers will help us know how well we are doing, and what areas of the Caring Program need to be improved. The survey is in English and Spanish.

Filling out or declining to fill out this survey will not affect your child/children's current or future enrollment in the Caring Program. This survey is completely voluntary and your responses will be kept confidential. If you decide to fill out the survey, please mail it by February 14.

Also, the return envelope is an old fundraising envelope. We are using it only because it has a postage-paid mark which means you will not need to put a stamp on it. **This is not a fundraising request from me to you...so please do not send any money.**

Thank you for your consideration and cooperation. Should you have any questions regarding this letter or survey, please call our office at 1-800-258-KIDS or if you live in the Dallas area call (972)766-7964.

Sincerely yours,

Craig Jeffery
Executive Director

Febrero 3, 1997

Estimados Padres,

Necesito su opinión!

El personal del programa "Caring", los empleados de Blue Cross y Blue Shield de Texas, Inc., los médicos, hospitales, y farmacéuticos que estan envueltos en el programa "Caring" trabajan arduamente para proveer ha su(s) hijo(s) con atención médica que es de calidad, conveniente y comprensible. Necesitamos su opinion para aseguramos como estamos sirviendole.

Acompañando esta carta hay una encuesta qué le llevara unos minutos para completar. **Su contestación es importante para nosotros.** Sus respuestas nos ayudaran para saber como le estamos sirviendo, y evaluar áreas del programa "Caring" que requieren mejoría. La encuesta esta en Ingles y en Español.

Si llena o rehusa de llenar esta encuesta no afectara su presente o su futura elegibilidad en el programa "Caring". Esta encuesta es algo completamente voluntario y sus respuestas seran confidenciales. Si decide llenar la encuesta, por favor mandela por correo antes del día 14 de febrero.

Asimismo, el sobre de retomo es un sobre viejo de recaudación de fondos. Nosotros lo estamos usando porque tiene la marca de estampilla pagada que quiere decir que usted no le tendra que poner una estampilla. **Esta no es una petición para recaudar fondos...a si que por favor no mande dinero.**

Gracias por su consideración y cooperación. Si desea hacer cualquier pregunta tocante a esta carta o la encuesta, por favor llame a nuestra oficina al 1-800-258-KIDS o si vive en el área de Dallas llame al (972) 766-7964.

Atentamente,


Craig Jeffery
Executive Director