CSHP News

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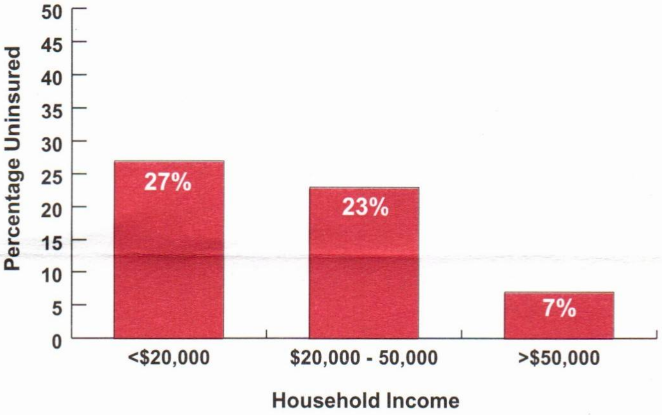
The Institute for Health, Health Care Policy, and Aging Research

Understanding the Uninsured: Findings from the New Jersey Family Health Survey

In 2001 and early 2002, CSHP conducted the New Jersey Family Health Survey (NJFHS) to arm policymakers with timely information about the health and health care of New Jersey residents. The NJFHS was funded by The Robert Wood Johnson Foundation. Although more detailed analysis will be available in the future, the findings reported here provide an overview of the characteristics of the uninsured population and reveal who in the state is most at risk for becoming uninsured. Since most elderly residents have coverage through Medicare, the analysis is restricted to residents under the age of 65.

According to the NJFHS, approximately 1.08 million residents, or 15% of the non-elderly population, were uninsured in 2001-2002. Not surprisingly, lack of insurance is strongly related to household income. However, while residents of households with annual income less than $20,000 are the most likely to be uninsured (Figure 1a), the majority of the uninsured

Figure 1a: Risk of Uninsurance by Household Income



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CSHP Promotes Long-Term Care System Changes: The Community Living Exchange Collaborative

In September 2001, the Centers for Medicare and Medicaid Services (CMS) awarded a grant to Rutgers Center for State Health Policy (CSHP) as part of the "Systems Changes for Community Living" initiative. CSHP has been using these resources to provide technical assistance to recipients of Real Choices Systems Change grants, which promote the development of community-based services for people with disabilities and long-term illnesses.

Through a cooperative effort, dubbed The Community Living Exchange Collaborative, CSHP staff and their

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New Jersey Family Health Survey

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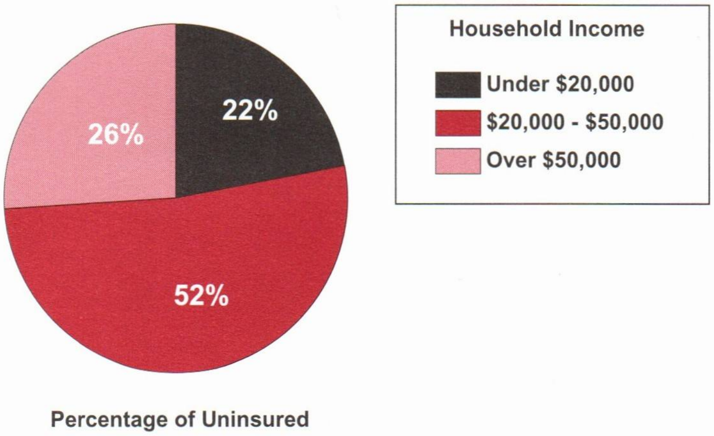
come from households with higher annual incomes (Figure 1b). Specifically, more than half (52%) of the state's uninsured residents live in households with incomes between $20,000 and $50,000. In part, these numbers reflect the fact that residents below this income category are eligible for a greater number of public insurance programs. Although residents from households with annual income exceeding $50,000 are the least likely to be uninsured, it is noteworthy that approximately one-fourth (26%) of the uninsured come from these households. This finding reflects the large number of state residents who fall into this category of household income.

Figure 1b: Household Income Distribution Among the Uninsured



Lack of insurance is also related to general health status as reported by survey respondents. Twenty-five percent of those who report their health as fair or poor lack health insurance, compared to 20% of those who report good health, and 11% of those who report excellent or very good health (Figure 2a). However, since most residents of the state are not in fair or poor health, poor health is not the dominant characteristic among the uninsured. In fact, approximately one-half (47%) of the uninsured describe their health as very good or excellent (Figure 2b).

Figure 2a: Risk of Uninsurance by General Health

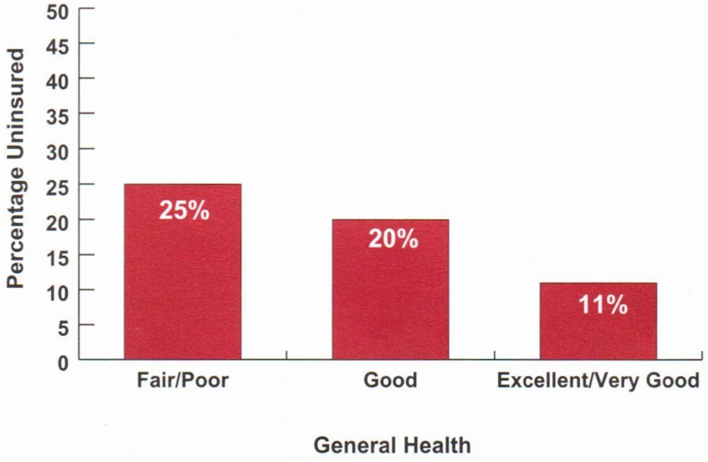
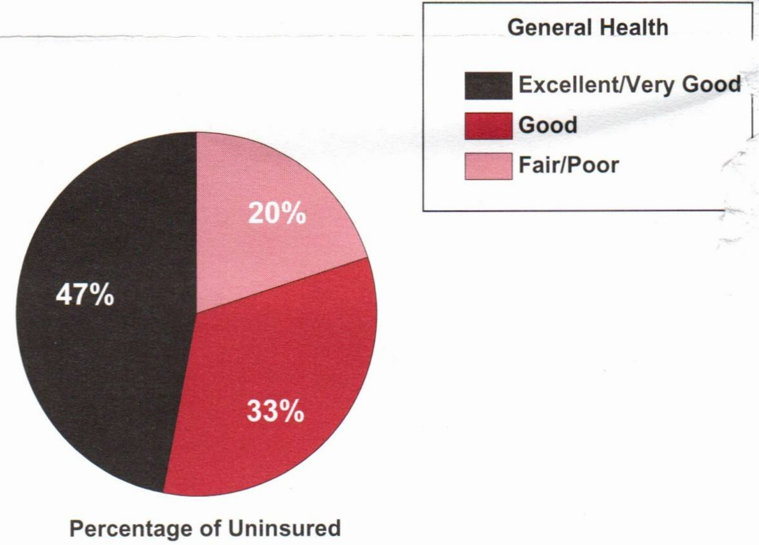


Figure 2b: General Health Distribution Among the Uninsured



Insurance status varies considerably by race and ethnicity. Only 10% of white non-Hispanic residents are uninsured compared to 34% of Hispanics, 17% of blacks, and 17% who classify themselves as members of other race/ethnicity categories (Figure 3a). Nevertheless, since white non-Hispanics make up the majority of residents in NJ, they also account for the largest share (40%) of the uninsured population, followed very closely by Hispanics at 36% (Figure 3b).

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CSHP Pilot Study Focuses on Health Disparites

Collecting information on patient race and ethnicity can provide important clues about health disparities. It can shed light on where disparities exist in a given region, enable comparisons among population segments, and identify which segments are disproportionately affected.

For instance, race and ethnicity data enable researchers to locate greater instances of heart disease and related cardiac procedures, obesity, or diabetes. From this information, strides can be made toward providing care to disenfranchised groups and closing gaps in access to care. However, to accomplish these goals, information from health care intake workers must be properly collected and documented when patients seek treatment.

To that end, CSHP recently conducted a small pilot study to assess the level and accuracy of data collection occurring within local New Jersey health care facilities. The study was commissioned by the New Jersey Office of Minority and Multicultural Health in the New Jersey Department of Health and Senior Services (NJDHSS). Through interviews in local clinics, hospitals, and health departments, CSHP researchers were able to develop a baseline sketch of the current methods of collection and use of race- and ethnicity-related data in Middlesex County.

The study found that policies and processes for data collection differ among health care providers, and that these differences make it challenging to develop a standardized method of collecting race and ethnicity data at the local level.

Officials at all three types of health care facilities studied realize the importance of recruiting intake workers who share similar ethnic and cultural backgrounds with patient populations. However, small organizations, operating with small staffs and limited budgets, rely heavily on "health ambassadors" and volunteers. These volunteers function as translators and cultural brokers, assisting the departments in identifying and meeting the needs of minority populations. Hospitals, however, tend to rely on intake workers of varying race and ethnicity and data collection guidelines that many view as vague and confusing.

The study found that while Hispanic workers at local health departments and clinics are able to provide translation services and culturally competent communication, problems emerge due to the volume of patients seeking care, inconsistent training of volunteers, and lack of a standardized process to guide data collection. Similar frustrations were shared by trained hospital intake workers who complained about the isolation of registration workers, as well as the frequency and brevity of each intake encounter. Oftentimes, it is unclear to these workers why data must be collected, creating the perception that this very challenging activity is largely useless. This environment creates the opportunity for misclassification and undercounting.

The CSHP researchers also noted that staff members in all locations struggle with the collection of race- and ethnicity-related data because they feel uncomfortable assigning or determining someone's race. This situation is due largely to culturally-specific reasons within the Hispanic community, but is also experienced by non-Hispanic workers who are concerned about offending clients. Most individuals reported the use of visual assessment, that is, using appearance, last name, and language spoken in order to "guess" race or ethnicity. Many intake workers are also likely to use categories of race and nationality interchangeably.

The pilot study showed that to address these problems and insure more accurate and consistent race and ethnicity data collection, all staff should be trained to follow culturally-sensitive data collection procedures. Trainers must also be equipped to clearly explain the link between accurate data collection and the potential reduction of racial disparities.

This study inolved a series of 37 interviews that took place in clinics, hospitals, and public health departments. In addition to interviews, the CSHP research team analyzed all data collection forms used in each health care setting. Complete results from this study are available in the report "Pilot Study of County Data Resources" by Sabrina M. Chase, M.A., and Denise Davis, Dr.P.H., M.P.A., available at www.cshp.rutgers.edu.

NJ Family Health Survey

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Figure 3a: Risk of Uninsurance by Race/Ethnicity

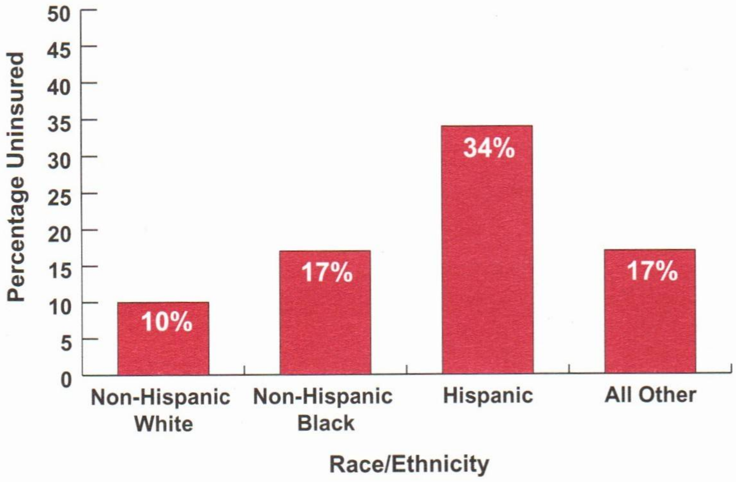
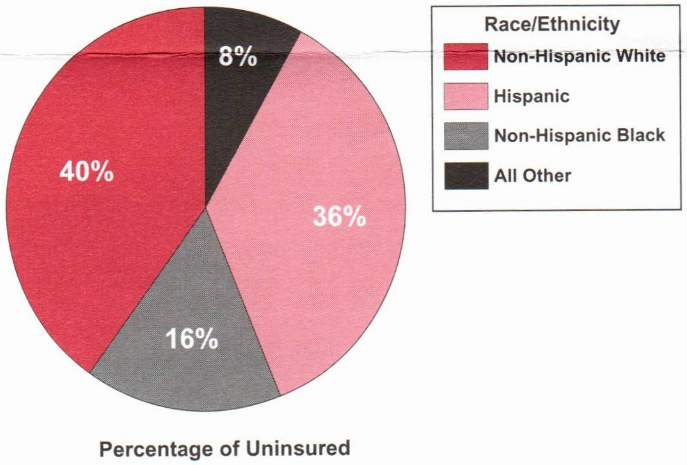


Figure 3b: Race/Ethnicity Distribution Among the Uninsured



Finally, age plays a role in the lack of health insurance. Adults ages 19-45 are the most likely to be uninsured (Figure 4a) and account for the majority (60%) of the uninsured population (Figure 4b). This pattern may reflect the fact that, compared to older residents, this group has lower demand for insurance, and, compared to children, this group is less likely to qualify for public coverage and private dependent coverage.

Clearly, certain population groups face greater risks of being uninsured than others. Nevertheless, New Jersey's overall uninsured population exhibits considerable diversity in health and demographic characteristics. These preliminary findings underscore the difficulty in targeting coverage expansions to meet the dual goals of providing relief to the neediest populations while significantly reducing the total number of uninsured.

Figure 4a: Risk of Uninsurance by Age

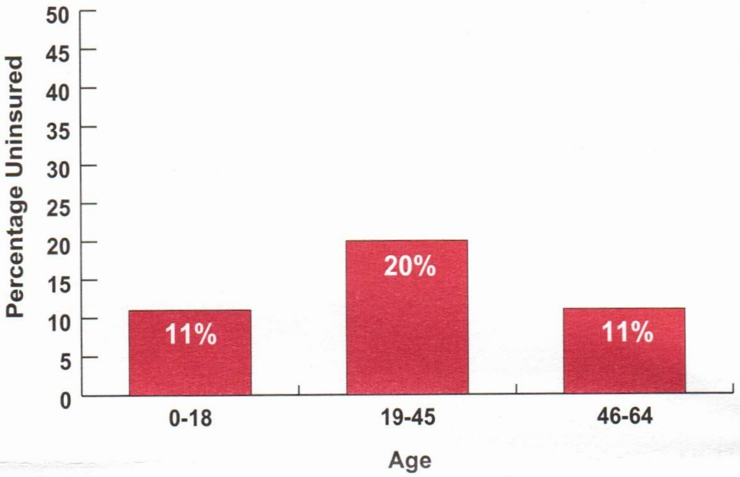
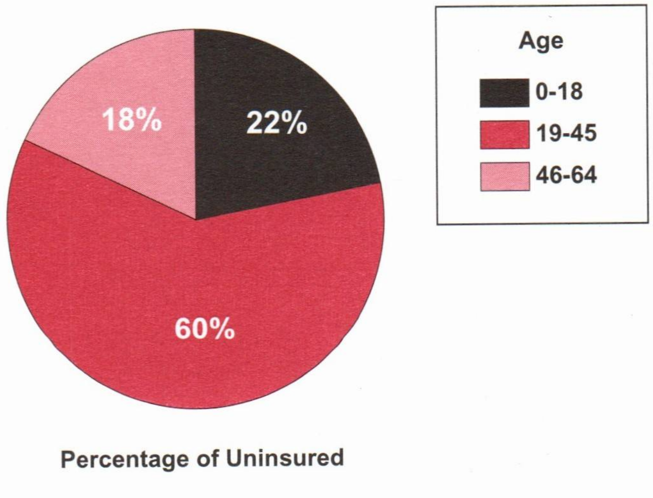


Figure 4b: Age Distribution Among the Uninsured



CSHP Collaborates on Healthier New Brunswick 2010 Initiative

According to the New Jersey Family Health Survey (See "Understanding the Uninsured" on Page 1), approximately 15% of non-elderly New Jersey residents lacked health insurance coverage in 2001-2002. Although this statistic is below the national estimate of non-insured citizens (roughly 18%), the number of uninsured in New Jersey, as in most states across the country, is rising. Further complicating the situation in New Jersey is the substantial undercounting of Hispanic immigrants living below the poverty level.

In recent years, New Jersey has attempted to address issues of access to care and health coverage through the introduction of market reforms and coverage initiatives. The state has helped to make insurance more affordable by expanding Medicaid eligibility and providing new coverage for low-income children and their parents. However, to date, these state programs have not gone far enough in addressing the problem, which is particularly acute in the city of New Brunswick.

Thus, CSHP, in collaboration with the Robert Wood Johnson Medical School and representatives of the community, is helping to establish a baseline description of the health and health care of New Brunswick residents by conducting a community health assessment. This assessment has several phases including gathering and synthesizing findings from prior health studies, conducting key informant interviews and focus groups, and designing and fielding a community health survey of area residents. The assessment is funded through New Brunswick Tomorrow with a grant from Johnson & Johnson.

The focus groups and key informant interviews, conducted between August 2001 and January 2002, identified the critical health issues: access to care or barriers to utilization; the challenges of providing health services to a diverse population including large numbers of immigrants; specific health conditions that are prevalent, serious, or inadequately addressed; inadequate health education and outreach; and fragmentation in the health care system. Inadequate access to health care is complicated since it encompasses a broad array of issues, including lack of insurance and under-insurance, obstacles to care for undocumented aliens, linguistic and cultural barriers, provider adequacy, and transportation.

The researchers also uncovered health concerns that are prevalent among specific demographic groups. For example, the elderly cite the need for affordable prescription drugs and access to specialty care, while younger populations are more concerned with access to primary and preventive care.

It is also interesting to note that many respondents framed their concerns in terms of underlying social issues and health system characteristics rather than specific health conditions. Diabetes, other nutrition problems, and mental health issues, including depression and substance abuse, were specifically identified as concerns by participants in the focus groups and key informant interviews.

Key informant interviews included officials from the public sector — leaders from health, social service, and faith–based organizations; and representatives from organizations that provide funding and other forms of assistance in the city. Initial participants were identified by the study's community-based advisory group. Additional participants were recruited through word-of-mouth. Twenty-five in-person interviews were conducted. Twelve focus groups were assembled, each comprised of a population that had been identified as important by the advisory group or through the key informant interviews. Discussions concentrated on the city's major problems, including residents' health and health care needs, underutilized health services, and possible strategies for health improvement.

The next phase of the study will involve a population-based survey. The project team expects that translating its findings to concrete solutions will be challenging, given the city's and state's limited resources, the wide variety of issues, and the fact that so many problems are rooted in social and health system structures that extend beyond city borders. However, the team's guiding principle in addressing these challenges is to produce data that are as timely and useful as possible for the community's ongoing deliberation and planning.

CSHP Fields New Jersey State Physician Census

Early Findings Show Limited use of Internet in Patient Care

Working collaboratively with the New Jersey Commission on Physician Workforce and the New Jersey Board of Medical Examiners (NJBME), CSHP recently completed a confidential survey of licensed physicians in the state. The survey was funded by The Robert Wood Johnson Foundation. The findings will inform the development of policy and program initiatives to improve the distribution of physicians throughout New Jersey.

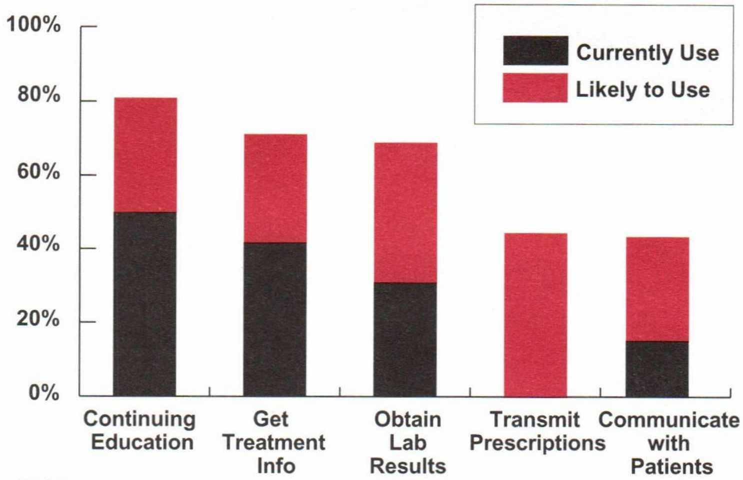
Modeled on successful surveys conducted in other states, the New Jersey State Physician Census was designed to provide a better understanding of the number and characteristics of physicians practicing in the state, where their practices are located, and which areas of the state may be underserved. Topics included medical specialties and training, experiences with managed care, practice arrangements, patient demographics, sources of insurance coverage, and physician use of information technology in patient care.

More than 8,100 of New Jersey's licensed physicians participated in the Census, which began in June and ran through the fall of 2002. A questionnaire with an endorsement letter from the NJBME was mailed to 30,639 physicians licensed in the State of New Jersey and five surrounding states (CT, DE, MD, NY, and PA). Physicians were given the option of completing the survey on a scannable form or online. In addition, e-mail broadcasts announcing the study and offering a link to the web survey were sent to approximately 4,000 physicians. These e-mail announcements were forwarded to physicians by third parties, including the Medical Society of New Jersey and the University of Medicine and Dentistry of New Jersey.

A random sub-sample of about 1,300 physicians was selected for additional follow up. Non-responders to the initial mailing in this "high-intensity follow-up" sample received a second mailing and telephone follow-up. The response rate in the high-intensity sample was 57%. A comparison of responses in the high-intensity sample to the full set of over 8,100 responses shows that the full sample fairly represents the racial/ethnic and gender profile of the state's physician workforce, but it under-represents some groups, including older physicians, internists, and those in solo, private office-based practices. Future analyses of the findings by Rutgers will correct for these factors.

Analysis of the Census data is currently underway at CSHP. Findings from the Census will be presented as part of the Center's new "Facts and Findings" series. However, preliminary analysis is revealing new and interesting information. For example, Figure 1 shows that physicians are most likely to use the Internet to keep up on developments in their fields (to access Continuing Medical Education or information about specific treatments), but doctors use the Internet less frequently in the care of individual patients (to get lab results or communicate with patients). It should be noted that, at the time the Census was fielded, state regulations did not permit physicians to transmit prescriptions drug orders via the Internet. However, electronic prescription entry has been touted as one way to help reduce medical errors.

Figure 1: New Jersey Physician Use of Internet in Patient Care



Notes:
Based on 4,908 physicians with patient care practices in New Jersey, exludes medical residents in training.
*The Census did not ask about current use for transmitting prescriptions

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Community Living Exchange

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technical assistance partners at Independent Research Utilization (ILRU) in Texas, have been providing technical assistance to 48 states, 3 territories, and 101 grantees.

To reach such a diverse group of grantees, The Exchange has organized and facilitated forums and conferences that convene grantee teams and provide information on key issues. For example, in November 2002 the Exchange held a Regional Housing Forum in Washington, D.C. that brought together teams from six states and the District of Columbia for two days of training, strategic planning, and interactive discussions to advance affordable and accessible housing opportunities for persons with disabilities. Over 60 individuals from state and local housing agencies, independent living centers, and disability-related service agencies participated in this forum. A 200-page resource manual, featuring state-specific data and analyses of housing resources and related funding for persons with disabilities, was prepared for all participants.

Beginning in June 2002, the CSHP Exchange began hosting National Audio Conferences on key issues. The first call focused on nursing facility transition. More than 40 participants including 34 grantees joined the call, which featured Mary Clarkson from CMS and Steve Eiken from Medstat. The second National Audio Conference took place in September 2002 and focused on Consumer Direction – Cash and Counseling demonstrations and the Independence Plus waivers and templates. The call involved more than 49 participants including 42 grantees, and featured speakers Kevin Mahoney of Boston College, William Ditto of the NJ Division of Disabilities, and Suzanne Crisp of CMS. The third call, with 27 grantees, took place in October 2002 and was entitled "Long-Term Care Workforce: What Are States Doing?" Speakers included Susan Harmuth of the North Carolina Department of Health and Human Services, Steve Edelstein of the Paraprofessional Healthcare Institute, Robyn I. Stone of the Institute for the Future of Aging Services, and Dale Laninga of the Pennsylvania Intra-Governmental Council on Long-Term Care.

As part of the National Academy for State Health Policy's (NASHP) annual health policy conference last August, the CSHP Exchange organized a pre-conference convening session with grantees to discuss Nursing Facility Transition. These programs facilitate the movement of nursing facility residents into the community setting of their choice.

This spring, in April 2003, nine grantees visited Washington State to learn more about that state's extensive experience transitioning individuals from nursing facilities. Participants visited state policy and program field staff as well as several nursing facilities. A second site visit is planned for this fall.

To promote web-based "single point of entry" projects, grantees from Hawaii have been participating on a weekly team call to discuss their efforts. Many states are interested in offering a single Internet access point that provides information on programs and contact numbers. The Hawaii team has developed a portal, or "one stop shopping" access point, that has been particularly successful in handling online confidentiality issues, determining eligibility, managing activities of service providers, and offering information on using the Internet to access services. As a result of these discussions, a working group was formed for states that are interested in making their existing sites more accessible or in implementing web-based single point of entry projects.

The Community Living Exchange Collaborative will continue to work with grantees and other stakeholders on systems changes related to transition and housing issues for the disabled and those with long-term illnesses through September 2005. For more information on the Rutgers Exchange, please contact Winifred Quinn at 732-932-3105 x236.

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Rutgers Center for State Health Policy informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation. *CSHP News* provides details on the Center's latest projects, findings and other activities, and features discussion of emerging state health policy issues. This newsletter was made possible through a major grant from The Robert Wood Johnson Foundation and funding from Rutgers, The State University of New Jersey.

We welcome your comments and suggestions.

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New Jersey State Physician Census

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Not surprisingly, physicians who are younger and those with more patients in HMOs or other managed care plans report the greatest current or anticipated use of Internet-related technologies in their practices. Rates of current or anticipated use of the information technologies are comparatively high among the primary care specialties, but they are notably lower among physicians practicing psychiatry, pathology, and anesthesiology. Perhaps concerns about confidentiality or the impersonal nature of electronic communication make psychiatrists less interested in these technologies. The nature of the work of pathologists and anesthesiology may make the value of these technologies less readily apparent to these specialists. Such findings offer policymakers important intelligence on where to target efforts that encourage greater use of the Internet by physicians.

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