Health Care Access, Utilization, and Needs in a Predominantly Latino Immigrant Community in Providence, Rhode Island

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More than 46 million people in the US lack health insurance,[1] as do 140,000 Rhode Islanders (16% of the state's population under age 65).[2] Most of the state's uninsured are low income working adults, and thirty-eight percent are low-income childless adults who are not currently eligible for Medicaid.[3] The number of uninsured individuals has been rising in the region, due to decreases in employer-based coverage.[2] National and regional statistics do not account for individuals who are uninsured because they do not yet have citizenship status and are not eligible for company-associated programs or state health insurance.

State-supported health care (**RIte Care**) has also been eroding. Rhode Island's fiscal woes have led to loss of coverage for low-income children and families. The biggest changes have included i) removing eligibility for children who are undocumented immigrants, ii) removing children who have legal immigrant status but have been in the US for less than five years, iii) increasing the cost of monthly premiums, and iv) reducing parent eligibility. In 2009, reauthorization of the Children's Health Insurance Program allowed states to receive federal matching funds for covering legally present immigrant children, resulting in RI restoring coverage for this group, who had previously been funded entirely with state dollars; the ACA contains a "Maintenance of Effort" requirement that has prevented RI for implementing monthly RIte Care premium increases that were contained in SFY 2012 budget. The revocation and restoration of coverage reflects the fragility of health care coverage in a time of economic down turn and state fiscal challenges. [4] Together, these changes caused at least 1,000 adults and 3,000 children to lose coverage in 2009.[3] In the years before health reform is implemented, it is likely that the number of uninsured in Rhode Island will continue to rise, due to the erosion of RIte Care as well as the ongoing deterioration of employer-sponsored coverage. Furthermore, experts anticipate that health care reform will not eradicate the problem of the uninsured. While the number of uninsured is expected to decrease by 32 million if health reform is implemented, gaps will remain.[5]

Free clinics are one potential solution to health care access problems in the interim before health care reform, and may provide a longer-term solution to those individuals who will still be unable to access care after reform. **Clínica Esperanza/Hope Clinic (CEHC)** was established in 2007 to address the health problems of the uninsured in Rhode Island. Due to the founders' commitment to providing linguistically appropriate, culturally attuned care, CEHC initially established temporary clinics in two church basements, serving a predominantly Latino community derived from the neighborhoods of Olneyville and Washington Park. In order to assess the current status of health care access in the target communities before opening at a new, permanent site (60 Valley Street, Olneyville), CEHC's community health workers (the Navegantes) performed a health care needs assessment survey in the two target communities. In this report, we provide the results of that survey and assess the impact of uninsurance at the community level in Rhode Island.

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Methods

Study setting and population: The health care access survey was performed by CEHC's bilingual community outreach workers in two neighborhoods served by CEHC, Olneyville and Washington Park (Providence, RI). Over the past decade, the Olneyville neighborhood has undergone significant demographic shifts, with a fourfold increase in the non-white population and a fivefold increase in the number of persons whose primary language is not English.[6] 57% of individuals are Hispanic, 41% live below the federal poverty level and nearly one in four families receives public assistance. In nearby Washington Park, similar shifts have occurred. 30% of individuals are Hispanic, nearly 20% are living below the federal poverty level and 12% are receiving public assistance.

Survey design: The needs assessment survey consisted of questions on age, sex, race, ethnicity, country of origin, length of time in the US, primary language, immigration status, insurance status, health care utilization, health status (as determined by length of time since last physical exam), and personal and/or family history of chronic conditions. Surveys were conducted verbally for those who could not read (in English or Spanish) and made available to participants in both English and Spanish.

Data collection: Convenience sampling was performed in the Olneyville and Washington Park neighborhoods over a four month period from March to June 2010. Participants were recruited at church fairs, food distribution points, flea markets, bodegas, barbershops, and on the street in the two survey neighborhoods by bilingual community outreach workers. All surveys were anonymous and participant consent was obtained and recorded. No personal identifiers were included on the data forms. The individual survey forms were compiled in a Microsoft Excel spreadsheet.

Results

A total of 138 participants completed the survey. 59 (44%) of participants were US citizens, 34 (25%) were

Table 1: Participant characteristics (n=138)

Participant characteristic	Number (%)
Demographics	
Age (mean years)	37.9
Gender	
Male	74 (54)
Female	57 (41)
Race	
White	5 (4)
Black	10 (7)
Native American	2 (1)
Asian	0
Other	119 (86)
Ethnicity	
Latino	119 (86)
Not Latino	19 (14)
Country of Birth	
Born in U.S.	19 (15)
Born in Rhode Island	12 (9)
Foreign born	97 (76)
Primary Language	
English	40 (25)
Spanish	113 (71)
French	3 (2)
Creole	2 (1)
Other	2 (1)
Immigration status	
U.S. Citizen	59 (44)
Documented Immigrant	34 (25)
Undocumented Immigrant	42 (31)
Insurance status	
Uninsured	122 (92)
Medicaid/RIte Care	0
Medicare	1
Private Insurance	6 (5)

Participant characteristic	Number (%)
Health care utilization	
Emergency department	74 (57)
Community health center	6 (5)
RI Free Clinic	12 (9)
Hospital clinic	7 (5)
Private physician	13 (10)
Other	18 (14)
Time since last physical	
<1 year	40 (29)
>2 years	39 (28)
>5 years	50 (36)
>10 years	6 (4)
Never had physical exam	2 (1)
Personal/family history of condition	
Asthma	34 (25)
Cancer	17 (12)
Diabetes	43 (31)
Heart disease	39 (28)
High cholesterol	47 (34)
Hypertension	61 (44)
Obesity	51 (37)
Dental needs	93 (67)
Vision problems	69 (50)
Depression	47 (34)
Skin problems	39 (28)
Substance abuse	33 (24)
Women's health problems Ever had/used…	37 (69)
Mammogram	8 (16)
Breast self exam	23 (43)
Pap Smear	25 (46)
Oral contraceptives	22 (43)
HIV testing	17 (32)
Men's health problems Ever had/used…	17 (23)
Testicular self exam	5 (7)
Condom use	38 (51)
HIV testing	35 (47)
Unmet immunization needs	58 (42)

documented immigrants and 42 (31%) were undocumented immigrants. 113 (71%) of respondents' primary language was Spanish; 40 (25%) of respondents' primary language was English, additional demographic details are provided in Table 1.

122 (92%) of respondents were uninsured; none reported having Medicaid or RIte Care; one participant had Medicare; six (5%) had private insurance through employers. 74 (57%) reported that they used the emergency department when asked where they obtained health care; 13 (10%) reported that they had a private physician; six (5%) used a community health center; 12 (9%) attended the RI Free Clinic; seven (5%) attended a hospital clinic; 17 (13%) responded "other." 40 (29%) had had a physical exam within the past year; 39 (28%) had gone more than two years since their last physical exam; and 50 (36%) had gone more than five years since their last physical exam.

Participants reported a personal or family history of chronic conditions including asthma 34 (25%); cancer 17 (12%); diabetes 43 (31%); heart disease 39 (28%); high cholesterol 47 (34%); hypertension 61 (44%); obesity 51 (37%). 37 of the 54 women reported women's health problems. Among the 74 men, men's health problems were reported by 17 (23%). Unmet immunization needs were reported by 58 participants (42%). These results are presented in Table 1.

Discussion

This survey provides an important snapshot of health care access, utilization, and needs in the Olneyville and Washington Park neighborhoods of Providence in the months prior to the opening of a new free clinic for the uninsured (CEHC). Convenience sampling has an inherent limitation, namely that the sample may not be representative of the population being studied. The data collection may also have been biased toward Spanish- and English-speaking respondents as the forms and interviews were only in Spanish and English. Moreover, while all surveys were conducted in the Olneyville and Washington Park neighborhoods, there was no verification that respondents actually resided in these neighborhoods. Response bias is also a concern, as there was no verification of responses to survey questions. For example, citizenship documentation was not requested.

Despite these concerns, information obtained from this sample suggests that access to health care in the neighborhoods is limited. 92% of respondents reported that they were uninsured, suggesting a critical need for access to health care in the Olneyville and Washington Park neighborhoods (Figure 1). Health insurance, or lack thereof, is an important social determinant of health. Uninsurance has been associated with mortality, even after adjusting for age, sex, race, income, education, smoking and drinking.[7] Furthermore, the uninsured are more likely to suffer from uncontrolled chronic health conditions such as diabetes and hypertension.[8]

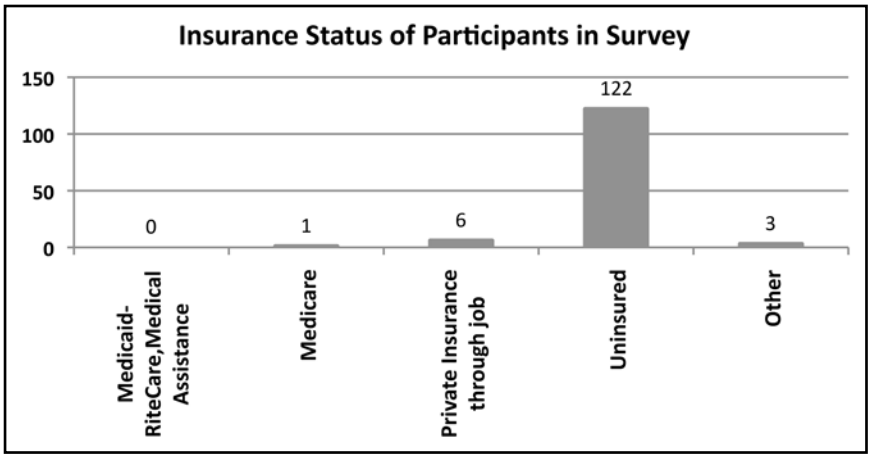

Figure 1. Insurance Status of Participants

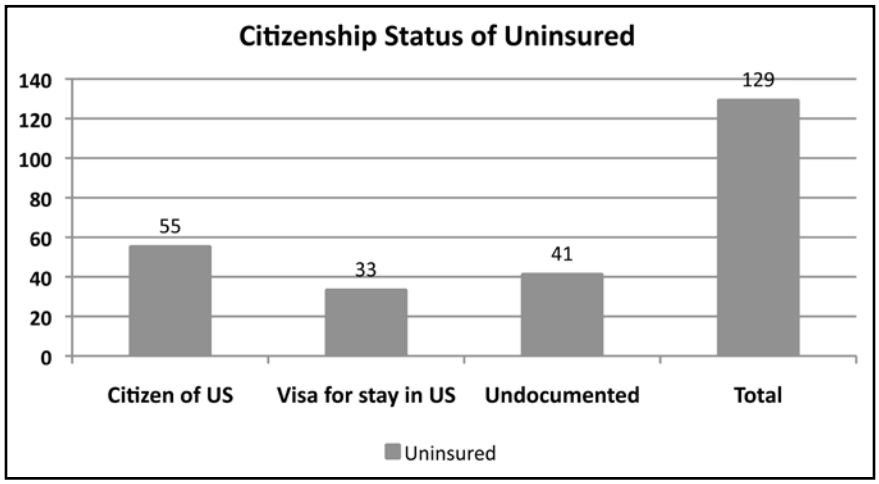

Figure 2. Citizenship Status of Uninsured Survey Participants

Lack of engagement with the health care system may contribute to poor health. According to a 2009 analysis of NHIS data,[9] 56% of uninsured adults report no consistent source of care (compared with 10% of those with private insurance), 26% went without care due to cost (vs. 4% with private insurance), and 27% could not afford medications (vs. 6% with private insurance). In our study, two thirds of individuals had gone more than two years since their last physical exam; four out of ten had gone more than five years since their last physical exam. The high prevalence of chronic health care conditions suggests that there is a high level of unmet need for health care screening and intervention in the two neighborhoods.

It has been demonstrated that previously uninsured adults who became insured after acquiring Medicare coverage showed significant improvements in health.[10] This is due to increased emphasis on prevention, decreased delay in seeking care, and better management of chronic medical conditions.[11] Participation in preventive health care was low; two-fifths of respondents had self-reported unmet immunization needs; only 25 (46%) of the women surveyed had ever had a Pap smear and eight (16%) had ever had a mammogram.

Both transitional and illegal immigration status are risk factors for being uninsured. Documented immigrants must be in the US for five years before they may enroll in Medicaid.[12] Undocumented immigrants are prohibited from receiving subsidies under health care reform and from enrolling in Medicaid.[13] 56% of participants in the survey reported that they were recent (legal) immigrants, and 31% reported that they were undocumented immigrants (Figure 2). Free clinics provide an important source of health care for immigrants living in the US—almost 40% of patients seeking care in US free clinics are immigrants.[14]

86% of the survey participants reported that they were Latino; most of these individuals were also immigrants. Latinos have the lowest insurance rates in the United States.[15,16] In addition to legal and financial barriers, Latino immigrants also face the challenge of receiving culturally competent care from providers: communication problems and language barriers have been identified as key issues.[16] CEHC was established with the aim of providing culturally attuned, linguistically appropriate care; the survey indicates that the need for such health care exists in Olneyville and Washington Park.

Emergency departments, community health centers, and free clinics currently comprise the safety net for patients without health insurance.[11] 57% of the participants in the survey reported using the emergency department as their primary source of care; all of these individuals were uninsured (Figure 3). Less than 10% of participants used the **RI Free Clinic (RIFC)** as their source of care. RIFC was the only free clinic in Rhode Island offering continuity of care at the time the survey was conducted. Having a consistent source of primary care has been correlated with decreased emergency department utilization, decreased delay in seeking treatment, increased use of preventive services,[11] and better health outcomes.[17]

Free clinics are an important part of the ambulatory safety net. There are over 1,100 free clinics in the US, providing care to an estimated 1.8 million patients.[14] Free clinics provide care to patients who might otherwise delay care or seek more expensive care in emergency departments. In a recent national survey of free clinic patients, it was found that nearly one in four patients would not otherwise seek care if their free clinic did not exist, mostly due to cost; 23% would use the emergency department.[18] Small-scale savings attributed to each free clinic may add up to millions of dollars saved nationwide.[19] If the average cost of an emergency room visit for an uninsured individual in the US is an estimated

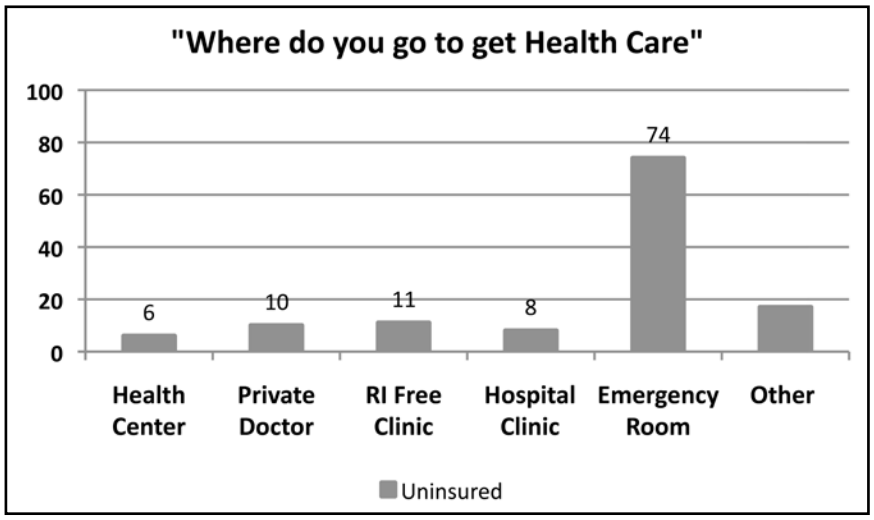

Figure 3. Source of Care of Uninsured Survey Participants

986 dollars, and 23% of the 1.8 million patients getting care at a free clinic would use the emergency department if the clinic did not exist, then the annual savings attributable to free clinics would be over 400 million dollars.[20]

Conclusions

Lack of health insurance continues to be a problem as health care reforms begin to be implemented, contributing to poor health outcomes at the national, regional, state, local, and individual level. While the macroeconomic impact of uninsurance can be measured in terms of lost income, decreased productivity, and increased federal, regional and state health care costs, the impact at the individual level can be quite serious. Individuals who do not have health insurance but are affected by chronic health conditions can experience increased morbidity and shortened life spans due to lack of preventive and maintenance health care interventions.

In Rhode Island, access to free care is currently provided at two free clinics—Rhode Island Free Clinic and Clínica Esperanza/Hope Clinic—in addition to a network of community health centers and hospital clinics. At the time of this survey, CEHC was operating in church basements and not able to provide continuity of care; subsequently CEHC opened its doors at a permanent Olneyville site. Currently, more than 250 uninsured patients who have chronic health care problems are followed at the clinic; free laboratory tests are negotiated with the local hospitals. The Navegantes assist patients with the process of obtaining free care at the local hospitals if more extensive evaluations (radiologic, invasive) are required.

We anticipate that opening CEHC will have a significant impact on access to care for the uninsured in Rhode Island. However, unmet needs will remain, as the number of patients needing access to care far exceeds the case load that two free clinics can currently provide. Increased support for staff at the clinic (such as funding for volunteer coordinators) and increasing the number of volunteer health care providers at both clinic locations will leverage available health care expertise to make preventive health care accessible and decrease morbidity associated with chronic health conditions for one of the most vulnerable sectors of the Rhode Island community.

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References

1. Cohen RA, Martinez ME, Ward BW. Health insurance coverage: early release of estimates from the National Health Interview Survey, 2009. Centers for Disease Control and Prevention. June 2010.
2. Chollet D, Ballou J, Barrett A, and Bell T. Study of Rhode Island's Uninsured: current costs and future options. Mathematica Policy Research, Inc. March 2010.
3. Rhode Island Department of Health. An analysis of Rhode Island's uninsured: trends, demographics, and regional and national comparisons. September 2007.October 1, 2010. http://www.dbr.state.ri.us/documents/divisions/healthinsurance/070910%20Final%20Uninsured%20Report.pdf
4. Hayward, Jane A. Rhode Island Annual Medicaid Report. Executive Office of Health and Human Services. December 2006. October 1, 2010. http://www.dhs.state.ri.us/dhs/whatnew/RIMedicaidExpRpt2006.pdf.
5. Kaiser Permanente Foundation. Cost estimate for pending health care legislation. March 2010. October 1, 2010. https://www.kaiserpermanente.org/
6. Providence Neighborhood Profiles: Olneyville. City of Providence 2010."October 1, 2010. http://www.providenceri.com/Neighborhoods/olney.html.
7. Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. Health insurance and mortality in US adults. *Am J Public Health*. 2009 Dec;99(12):2289-95.
8. Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured U.S. adults. *Health Aff (Millwood)*. 2009 Nov-Dec;28(6):w1151.
9. Kaiser Family Foundation. The uninsured and the difference health insurance makes. September 2010. October 1, 2010. http://www.kff.org/uninsured/upload/1420-12.pdf.
10. McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. *JAMA*. 2007 Dec 26;298(24):2886-94.
11. Shi L, Stevens GD, Politzer RM. Access to care for U.S. health center patients and patients nationally: how do the most vulnerable populations fare? *Med Care*. 2007 Mar;45(3):206-13.
12. Nandi A, Loue S, Galea S. Expanding the universe of universal coverage: the population health argument for increasing coverage for immigrants. *J Immigr Minor Health*. 2009 Dec;11(6):433-6.
13. Passel J, Cohn D. A portrait of unauthorized immigrants in the United States. Pew Hispanic Center. April 2009.
14. Darnell JS. Free clinics in the United States: a nationwide survey. *Arch Intern Med*. 2010 Jun 14;170(11):946-53.
15. Fuentes-Afflick E, Hessol NA. Immigration status and use of health services among Latina women in the San Francisco Bay Area. *J Womens Health (Larchmt)*. 2009 Aug;18(8):1275-80.
16. Perez D, Ang A, Vega WA. Effects of Health Insurance on Perceived Quality of Care Among Latinos in the United States. *J Gen Intern Med.* 2009 November; 24(Suppl 3): 555–560.
17. Retchin SM, Garland SL, Anum EA. The transfer of uninsured patients from academic to community primary care settings. *Am J Manag Care*. 2009 Apr;15(4):245-52.
18. Gertz AM, Frank S, Blixen CE. A Survey of Patients and Providers at Free Clinics Across the United States. *J Community Health*. 2010 Jun 8.
19. Crump WJ, Fricker RS, Crump AM, James TE. Outcomes and cost savings of free clinic care. *J KY Med Assoc*. 2006 Aug;104(8):340-3.
20. United States, 2007 Facility And SBD Expenses Agency for Healthcare Research and Quality, U.S. Dept. of Health and Human Services 2007. (Table 6: Emergency Room Services-Median and Mean Expenses per Person With Expense and Distribution of Expenses by Source of Payment).

Disclosure of Financial Interest

The authors and or spouses/significant others have no financial interests to disclose.

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