



Getting Health Care
When You Are
Uninsured:
*A Survey of Uninsured Patients
at Inova Alexandria Hospital in
Alexandria, Virginia*

AUTHORS:

Dennis Andrulis, Ph.D., MPH

Research Professor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Christina An, MPH, MA

Research Instructor

Department of Preventive Medicine & Community Health

State University of New York, Health Science Center at Brooklyn

Carol Pryor, MPH, M.Ed.

Policy Analyst, The Access Project

*This report was produced in collaboration with the Tenants' and Workers'
Support Committee, Healthy Community Project*

December 2000

The Access Project is a national initiative supported by the Robert Wood Johnson Foundation and the Annie E. Casey Foundation. It works in partnership with the Heller Graduate School for Advanced Studies in Social Welfare at Brandeis University and the Collaborative for Community Health Development. It began its efforts in early 1998. The mission of The Access Project is to improve the health of our nation by assisting local communities in developing and sustaining efforts that improve healthcare access and promote universal coverage, with a focus on people who are without health insurance.

The Access Project
30 Winter Street, Suite 930
Boston, MA 02108
Phone: 617-654-9911 Fax: 617-654-9922
E-mail: info@accessproject.org Web site: www.accessproject.org

The **Tenants' and Workers' Support Committee/Comité de Apoyo de Inquilinos and Trabajadores** (TWSC/CAIT) is a low-income community-based organization in Alexandria, Virginia. First organized in 1986 in response to the mass evictions of 5,000 low-income Latinos and African-Americans from local neighborhoods, the Committee's mission is to develop the collective power of low-income residents, workers, women, and youth, to challenge racism and sexism through direct action and education, and to promote social change, political leadership, and community ownership and control of resources through grassroots organizing in Northern Virginia.

The TWSC/CAIT Comunidad Saludable/Healthy Community Project was created in 1996 to 1) increase access to health care for the uninsured regardless of income or immigration status; 2) mobilize and educate the community around broadly-defined workers', women's, and community health issues, and 3) change public health policy, practices, and expenditures to respond to community-defined health and health promotion goals.

Silvia Portillo, Program Coordinator
Comunidad Saludable/Healthy Community Program
Tenants' and Workers' Support Committee
P.O. Box 2327
Alexandria, VA 22301
Phone: 703-684-5697 Fax: 703-684-5714
Email: silvia.twsc@hotmail.com

This report may be reproduced or quoted with appropriate credit.

•
•
•
•
•
•
•

TABLE OF CONTENTS

Executive Summary 5

Introduction 7

 Community Access Monitoring Survey Project 8

 About This Report 9

Lack of Insurance is Dangerous to Your Health..... 10

 Lack of Insurance and Access to Care10

 Lack of Insurance and Health Outcomes11

 Benefits of Improved Access to Health Care12

 The Health Care Market and Care for the Uninsured.....13

Community Context..... 15

Survey Methodology 17

Survey Findings..... 18

 Respondent Characteristics18

 Use of Health Services18

 Openness to the Uninsured and Satisfaction with Providers19

 Accessibility.....20

 Language Needs.....22

 Obtaining Prescription Medications23

 Concerns Over Payment for Health Care.....24

 Seeking Care in the Future25

Discussion 27

References..... 30

Appendix A: Table of Survey ResultsA-1

**Appendix B: Surveyed Facilities By CAMS Sponsoring
 Organization and By Type** B-1

**Appendix C: Locations of CAMS Sponsoring Organizations
 and State Uninsurance Rates 1997-98** C-1

Appendix D: Survey Instrument..... D-1

Acknowledgements

•
•
•
•
•
•
•
•



EXECUTIVE SUMMARY

The number of uninsured Americans rose significantly over the last decade—according to current estimates, 43 million people are now without health insurance. While it is often assumed that the uninsured can easily obtain health care, much research demonstrates that lack of insurance leads to reduced access to health care and poorer health outcomes. Moreover, recent changes in the healthcare market have exposed healthcare providers to financial pressures that may be limiting their ability to provide care for the uninsured. However, access to care for the uninsured varies greatly across regions and communities.

The Community Access Monitoring Survey (CAMS) project, an initiative of The Access Project, provided support to organizations in 24 communities to survey uninsured patients receiving care at local facilities. The goals of the project were to investigate the effectiveness of local facilities in responding to the needs of the uninsured and to document barriers the uninsured face when seeking care.

This report summarizes national data on the impact of health insurance on access to care and health outcomes, and presents the results of the survey in one community, Alexandria, Virginia. The survey was conducted in the summer of 2000 and gathered information from 221 uninsured patients who obtained health care at Inova Alexandria Hospital in the previous year. The report also compares their experiences with those of uninsured patients surveyed at other CAMS sites across the country who received care at similar facilities.

KEY FINDINGS

Key findings of the survey of uninsured patients who received care at Inova Alexandria Hospital include the following:

- ◆ Most respondents (70 percent) reported that the hospital had been open to them even if they were unable to pay for care. However, only about a fourth said the hospital had a reputation in the community for providing “a lot” of care to the uninsured (28 percent vs. 44 percent of respondents for all urban and suburban hospitals included in CAMS nationwide). Moreover, a similar proportion (23 percent) said the hospital had a reputation for providing “very little or no care” to the uninsured, while the average for all urban and suburban hospitals included in CAMS was 12 percent.

•
•
•
•
•
•
•

- ◆ Of the 65 percent of respondents who reported that they needed help paying their medical bills, 90 percent said that staff “never” offered any assistance, such as reducing or waiving their bills.
- ◆ Of the 48 percent of respondents who reported that they needed help paying for their prescribed medications, nearly nine of ten (89 percent) said that staff “never” asked them if help was needed.
- ◆ Thirty-five percent of respondents said that their past experiences paying for care at the hospital would deter them from seeking care there again, much higher than the 13 percent average for all urban and suburban hospitals in CAMS.
- ◆ One-half of respondents said that they needed interpreter services, and half of these respondents reported that an interpreter was not readily available. Only 28 percent of respondents needing help with interpretations said they noticed signs in the waiting area in Spanish, and only 21 percent said they received written information in Spanish.
- ◆ Nine in ten respondents were satisfied with their interactions with doctors. However, while a majority of respondents were satisfied with their interactions with other staff, rates of dissatisfaction tended to be higher than the averages for all CAMS urban and suburban hospitals. About one in five respondents (21%) reported that they were either dissatisfied or very dissatisfied with the care they received from receptionists and nurses, and 44 percent said they were “dissatisfied” or “very dissatisfied” with the service they received from billing clerks.
- ◆ Forty-four percent of respondents said the waiting time on the day of an appointment was often or always a problem, much higher than the 26 percent average for all urban and suburban hospitals included in CAMS. The average waiting time reported by respondents was almost two hours, 55 minutes longer than the average for all CAMS urban and suburban hospitals.
- ◆ About one-third of respondents said the hospital’s location was often or always a problem.
- ◆ About three-quarters (73 percent) of the respondents said they would use the hospital again if they had health insurance, similar to the CAMS average of 77 percent.

INTRODUCTION

In 1998, 44 million people in the United States were uninsured, representing a 38% increase in the number of uninsured since 1987.¹ While this number fell slightly between 1998 and 1999, according to current estimates 43 million people are still without health insurance.² The ability of the uninsured to gain access to health care is thus a major national issue, but it is at the community level that the consequences are most apparent.

Many assume that even when people are uninsured, they are readily able to obtain health care. A 1999 survey of college-educated people in the United States found that 57 percent believed that uninsured people are able to get the care they need from doctors and hospitals, up from 43 percent in 1993.³ However, research has consistently demonstrated that individuals without insurance see health providers less frequently, receive fewer preventive health services, and delay care. As a result, when the uninsured do get care, they often require more expensive care. For example, the uninsured tend to come into the hospital more severely ill, and are hospitalized more frequently for conditions that could have been treated on an ambulatory, and less costly, basis.

Structural changes in the health care environment over the last decade have only increased the barriers to care facing the uninsured. Managed care companies have negotiated aggressively with health care providers to reduce their fees; as a result, providers have fewer financial resources available to subsidize care for the uninsured. At the same time, the number of uninsured has risen, increasing the demand for services, while various direct and indirect public subsidies that in the past helped support care for the uninsured have been eroding. All types of health care providers are affected by these changes, but perhaps the hardest hit are the "safety net" providers—those that, either by legal mandate or explicitly adopted mission, are dedicated to providing health care regardless of patients' ability to pay—as they generally treat the largest number of uninsured patients.

The situation, however, is not uniform across communities. Comparing the provision of care in different metropolitan statistical areas (MSAs), the author of a recent study said, "One of the most striking findings from our analysis...is the tremendous variation in the provision of uncompensated care by MSAs across the country. Our MSA-level analysis indicates that there are pockets in the country where the uninsured have very limited access to hospital care."⁴

•
•
•
•
•
•
•
•

COMMUNITY ACCESS MONITORING SURVEY PROJECT

To gather information about the barriers to care facing the uninsured in particular communities and at particular facilities, The Access Project initiated the Community Access Monitoring Survey (CAMS) project. The CAMS project funded 24 organizations across the country to survey uninsured individuals who received care at key facilities in their communities.

PROJECT GOALS

The goals of the project were to

- ◆ Learn directly from those without health insurance about their experiences and perceptions when obtaining health care
- ◆ Investigate the effectiveness of local facilities in responding to the needs of the uninsured
- ◆ Document barriers to care for the uninsured
- ◆ Use survey data to stimulate dialogue and promote change
- ◆ Put a local face on the problem of the uninsured

THE SURVEY DESIGN

The survey instrument was developed by Dennis Andrulis, Ph.D., Research Professor at SUNY Health Science Center in Brooklyn, NY. It was used to gather information about the experiences of over 10,000 uninsured patients at 58 facilities nationwide, and results were reported for each of the participating communities. The survey asked respondents a range of questions about their experiences when they received care at a particular facility while they were uninsured, such as their perceptions of the facility's willingness to provide care, satisfaction with interactions with staff, waiting times for appointments, ability to obtain needed medications, and difficulties paying for care.

Survey Limitations

The survey was designed to gather data about key providers that care for the uninsured in various communities. It was not intended to provide definitive conclusions, and readers should be aware of the limitations of the methodology.

The survey was based on a convenience rather than a random sample. Respondents were recruited at a variety of local sites, such as homeless shelters, employment offices, and housing projects, sometimes with the intent of collecting information from a particular group or groups, and the number of people who were eligible but refused to participate was not recorded. For these reasons, survey



responses cannot be generalized either to all uninsured people or to all uninsured patients who used a given facility--rather, they reflect the experiences only of those surveyed.

In addition, while all surveyors received uniform training in administration of the survey, it was not possible to evaluate actual implementation at each site. The authors also did not have access to other sources of data, such as medical records, that might have added to or verified individuals' reports, and they were not able to assess environmental factors, such as the volume of uninsured patients treated, operating budget, and staff size, which might have affected a facility's provision of care. Finally, the surveys gathered information only from uninsured individuals who were able to access care at particular facilities; they did not capture either the numbers or the experiences of those who were unable or never tried to access care.

Intended Uses of the Survey

The survey was intended to provide information on a frequently overlooked topic, the actual experiences of the uninsured when they obtain care. Notwithstanding its limitations, the authors expect that the results will be useful to providers, local officials, community representatives, and others in suggesting issues related to the provision of care for the uninsured in their communities that may benefit from further discussion or more rigorous and comprehensive study. It is hoped that this information will assist communities in improving access to care for their uninsured residents.

ABOUT THIS REPORT

This report, along with reviewing some of the research documenting the impact of lack of insurance on healthcare access and on health outcomes, describes the survey results at one CAMS site, Alexandria, Virginia. The survey was conducted by the Healthy Community Project of the Tenants' and Workers' Support Committee in the summer of 2000, and gathered information from uninsured individuals who received care at Inova Alexandria Hospital in the previous year. Along with providing the results of the survey for this facility, the report compares the results with aggregate responses at all similar facilities surveyed as part of the CAMS project nationwide. A report presenting the overall findings for all surveyed sites will be released in Spring 2001.



LACK OF INSURANCE IS DANGEROUS TO YOUR HEALTH

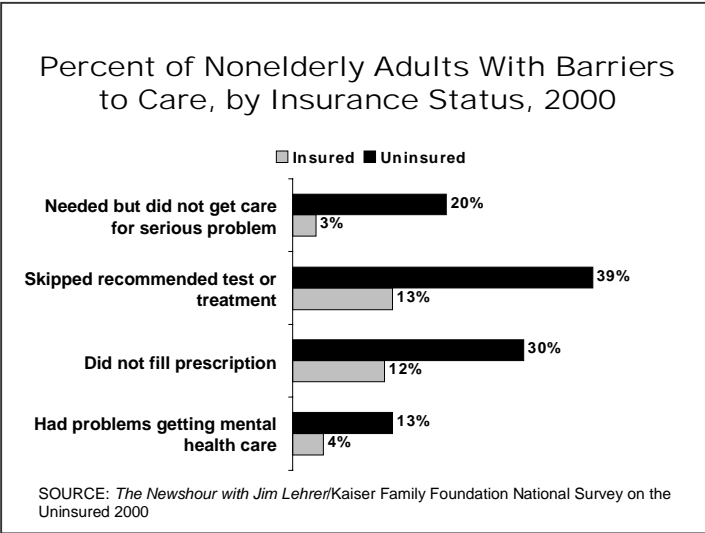
With great consistency, national research has demonstrated that insurance status affects the amount and type of care individuals receive. Lack of health insurance is related to both reduced access to care and to poorer health outcomes. In addition, many of the changes in the health care market over the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

LACK OF INSURANCE AND ACCESS TO CARE

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

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

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



LACK OF INSURANCE AND HEALTH OUTCOMES

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

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

•
•
•
•
•
•
•
•

BENEFITS OF IMPROVED ACCESS TO HEALTH CARE

While lack of insurance is a serious barrier to receiving care, making health services available to the uninsured has been shown to lead to significant improvement in the use of critical services and in health status. One recent study found, for example, that uninsured individuals who obtained insurance coverage had better access to care based on indicators such as having a usual source of care, higher satisfaction with providers, and a greater number of physician visits in the previous year.²⁰ Another study in the Seattle area found that having insurance was strongly related to ease of access to care, and was the strongest predictor for having a regular source of care.²¹ When previously uninsured individuals were enrolled in a managed care program, investigators found their use of health care services similar to that of a commercially enrolled group.²²

Increased access to care for individuals infected with HIV represents one of the most recent dramatic instances of improvements in both mortality and morbidity. According to the Centers for Disease Control and Prevention, the first decrease in AIDS-related opportunistic infections occurred in 1997.²³ One of the major reasons cited was increased availability of new anti-retroviral therapies. The proportion of patients using this treatment regimen—for which many rely on public sector support through Medicaid and other programs—increased from 24% to 60% in just one year (1995 to 1996). This dramatic change is one demonstration of how access to critical treatments can make the difference between life and death.

Making health related services available to the uninsured at little or no cost has also led to improved outcomes. For example, the Women, Infants, and Children program, which provides food assistance to low-income children starting with the prenatal period, has helped reduce the prevalence of iron-deficiency anemia in infants and children.²⁴ Similarly, a study in Wisconsin showed that children at an initial preventive health visit who did not have access to the free Early and Periodic Screening, Diagnosis, and Treatment program had a greater number of medical and dental health problems and fewer preventive dental care visits than their contemporaries who had had continual access to the program.²⁵



THE HEALTH CARE MARKET AND CARE FOR THE UNINSURED

Over the last decade, changes in the health care market have significantly affected the provision of care to the uninsured.²⁶ Rising premiums and eroding employer-offered coverage have left increasing numbers of workers, especially low-income workers in small firms, without access to affordable health insurance. The rising numbers of uninsured increase the demand for uncompensated care on "safety net" providers—those that are charged by legal mandate or by mission with providing care to all regardless of ability to pay—as well as on other charity providers.

This increased demand is occurring simultaneously with other market changes that make it more difficult for providers to respond. An increasingly competitive health care environment, increased efforts to contain costs, and the growth of managed care have reduced the financial resources available to providers to subsidize care for the uninsured.

For example, many states have enrolled Medicaid recipients in managed care plans in an effort to reduce costs. These plans generally negotiate with providers for lower fees and also contract with multiple providers to provide services to Medicaid clients in order to obtain the best rates. However, while these changes may help reduce the overall costs of the program, they can have indirect effects on the ability of charity providers to care for the uninsured. Because major charity providers usually treat large numbers of both Medicaid and uninsured patients, they have traditionally depended on Medicaid revenues to help subsidize care for those who are unable to pay. If their Medicaid revenues decline, both because they see fewer Medicaid patients and because they receive lower fees for those they do treat, less money is available to cross-subsidize uncompensated care for the uninsured.

Research studies have in fact found that the penetration of managed care plans in a market and pressure on reimbursements are associated with reduced access to care for the uninsured. They have shown that

- ◆ In general, access to health care for low-income uninsured people is lower in states with high Medicaid managed care penetration, compared to uninsured persons in states with low Medicaid managed care penetration; access to care for low-income uninsured persons is also lower in areas with high uninsurance rates.²⁷
- ◆ Physicians involved with managed care plans and those who practice in areas with high managed care penetration tend to provide less charity care.²⁸

•
•
•
•
•
•
•

- ◆ Between 1988 and 1997, while national hospital costs for uncompensated care remained around 6% of annual operating costs, the ratio of per capita expenses for the uninsured to per capita expenses overall declined by 22%. This change, which was associated with reductions in Medicaid reimbursement rates, indicated that the uninsured were losing ground compared to the insured in the number, level, or quality of services received.²⁹

In this environment, some safety net providers have in fact been forced to close, raising the question, "Where...will the safety net reside for the large number of uninsured in the community who do not qualify for [public] programs?"³⁰



COMMUNITY CONTEXT

The TWSC has worked primarily in the low-income community of Arlandria-Chirilagua in Alexandria, Virginia, located approximately one mile south of Washington's National Airport. Combined with the adjacent neighborhoods of Arna Valley in Arlington, Virginia and Lynhaven/Hume Springs in Alexandria, the area is home to approximately 15,000 predominantly low-income Latina/os (65%) and African Americans (30%). The median household income in the community is estimated at \$30,500, only 40% of the citywide median of \$77,200.³¹

Alexandria (pop. 120,000) has both the highest concentration of low-income people of color in Northern Virginia and the highest citywide per capita income in the state, making for stark racial and economic divisions.³² Since 1970, Alexandria's nonwhite population has risen from 15% to 40%.³³ Today, three of five children in the city are people of color and one in nine youth are foreign-born. Alexandria has the highest youth poverty rate in Northern Virginia, and is second only to Washington, D.C. in the metropolitan area.³⁴

The Arlandria-Chirilagua community has the highest concentration of Latina/o immigrants in Alexandria and, in the metropolitan Washington, D.C. area, one of the highest concentrations of immigrants from Central America. Latina/o immigrant workers are concentrated in a number of key industries where wages are low and health benefits minimal, including hotels and restaurants, construction, landscaping, cleaning and maintenance, and other predominantly low-wage, service-sector jobs such as dry-cleaning and childcare. Area adults often work more than one full-time job.³⁵

A 1998 occupational health and safety survey conducted by the Healthy Community Project of TWSC, in conjunction with the University of Massachusetts Environmental and Occupational Health Program, found that 81% of adult Latina/os in Arlandria had no form of health insurance. The study, the first such study nationwide of immigrant non-agricultural workers, also found that 80% of respondents had never received information about and had no knowledge of their mandatory worker's compensation coverage. Over 60% of those surveyed paid medical costs out of pocket, including costs resulting from work-related injuries and illnesses.³⁶

A 1999 survey by the Alexandria United Way found that 50% of Latino families citywide had no form of health insurance. Those who said that a member of their household needed, but could not obtain,

•
•
•
•
•
•
•
•

medical services cited lack of information, lack of money, failure to qualify for economic assistance, and language barriers as the greatest impediments to getting medical care.³⁷

Alexandria is served principally by one hospital, Inova Alexandria Hospital. The hospital is part of Inova Health Systems, a non-profit health care corporation. The Arlandria community is also served by the independent, non-profit Arlandria Clinic for Women and Children, which provides family planning, WIC (Special Supplemental Nutrition Program for Women, Infants and Children), and other women's and children's primary care services on a sliding fee scale. However, the community lacks any primary care facility for low-income adults of all ages, which may contribute to high rates of emergency room visits by community residents for illnesses and injuries that could be easily and less expensively treated in a community-based primary care setting.

In 1999, in preparation for a citywide access to health care campaign, the Healthy Community Project began to focus on low-income community concerns about access to and quality of services at Inova Alexandria Hospital. As part of an informal effort to better understand these concerns, the Project conducted interviews and home visits with dozens of community residents. The interviews revealed a number of problems related to access at Inova Alexandria Hospital for the largely uninsured Latina/o population, including high medical debts, lack of information regarding available economic assistance programs, and lack of bilingual personnel and services.

The CAMS project in Alexandria was undertaken to provide additional information about how uninsured Latina/os perceive the care they receive at Inova Alexandria Hospital, in order to help identify possible barriers to care and stimulate discussion about ways to improve access for this population.

Note: Information in this section was provided by the Tenants' and Workers' Support Committee (TWSC).



SURVEY METHODOLOGY

The coordinator of the Healthy Community Project and three paid, part-time survey coordinators worked with 21 volunteer surveyors to conduct the surveying. In the spring of 2000, 15 of the volunteer surveyors participated in a ten-week lay health promoter course sponsored by the Project. In addition, 15 of the surveyors participated in a one-day training session in interviewing techniques and the survey instrument that was coordinated by The Access Project and conducted by trainers from the Health Training Innovations program of The Medical Foundation in Boston.

Twenty-five surveyors conducted 221 surveys in the Arlandria neighborhood of Alexandria, Virginia. To identify respondents, surveyors went door-to-door and visited all 282 apartments of the resident-owned Arlandria-Chirilagua Housing Cooperative (approximately 1,000 residents), all 400 apartments of the Presidential Greens complex (approximately 1,600 residents), 100 apartments of the Glebe Park complex (approximately 400 residents), and an estimated 200 apartments of the Kingsport complex (approximately 800 residents). In total, surveyors visited a total of 1,000 apartments, representing approximately 4,000 residents.

Out of over 600 residents contacted, approximately 225 qualified for the survey, and 221 completed the survey. To be eligible, participants had to respond affirmatively to two questions: 1) Had they received treatment at Inova Alexandria Hospital in the last year? 2) Were they uninsured when they received treatment at the hospital? Nearly all respondents were Latina/o residents, and nearly all of the surveys were conducted in Spanish.

The Access Project arranged for entry of the data by an independent firm. The data were analyzed by Dennis Andrulis and Christina An of the State University of New York, Health Science Center at Brooklyn.

Because respondents were not randomly selected, the survey results cannot be generalized to the entire population of uninsured persons or of individuals receiving care at the targeted facility. *The results reflect the experiences only of those surveyed.*

•
•
•
•
•
•
•

SURVEY FINDINGS

This section describes the survey results for respondents who received care at Inova Alexandria Hospital (Inova) in Alexandria, Virginia while uninsured, and compares them with averages for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide. All comparisons were statistically significant unless otherwise indicated (ns = non-significant). See Appendix A for a table of the results for all Inova respondents and the aggregate results for AUSHs.

Note: For the purpose of analysis, all facilities included in the CAMS project were grouped by type (hospital or clinic), and by location (urban/suburban or rural.) These designations were determined by the organizations that sponsored the surveying. See Appendix B for a list of all facilities included in the project nationally.

RESPONDENT CHARACTERISTICS

Nearly all Inova respondents were Hispanic. Respondents varied in age.

Ninety-eight percent of the respondents identified themselves as Hispanic. In comparison, the average proportion of Hispanics for AUSHs was 37 percent. All respondents took the survey in Spanish.

Respondents varied in age, but one of ten (11%) answered on behalf of a child.

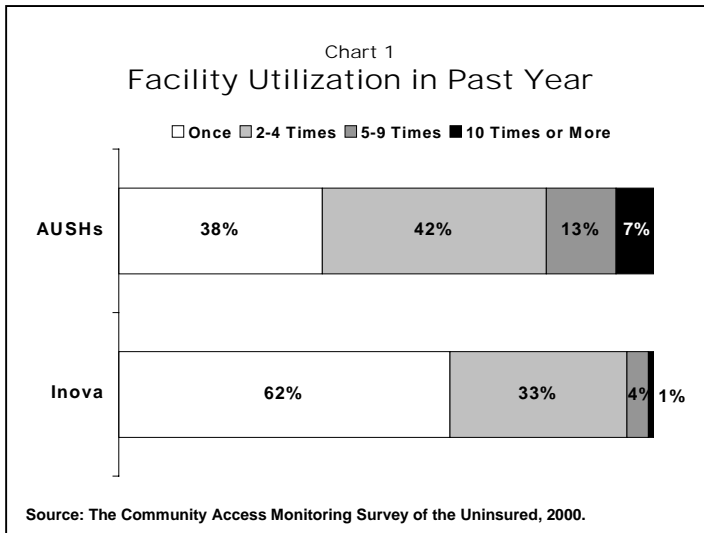
USE OF HEALTH SERVICES

The majority of the respondents said that they used the emergency room at least once in the past year. One-third said they used the hospital more than once.

Emergency room use. Three-fourths (75%) of the respondents reported that they used the emergency room at least once in the past year, which was similar to the average for AUSHs (77%).

Outpatient clinic use. Inova respondents reported slightly lower use of the hospitals' outpatient clinic (39%) than the AUSH average (45%).

Frequency of use. Inova respondents were much more likely than the average for AUSHs to report that they used the facility only once in the past year. Notably, only five percent used the facility five or more times compared with the AUSH average of 20 percent. (Chart 1)



One-third of Inova respondents said they went to the facility to treat a chronic problem. This figure was nearly identical to the average for AUSHs (32%).

OPENNESS TO THE UNINSURED AND SATISFACTION WITH PROVIDERS

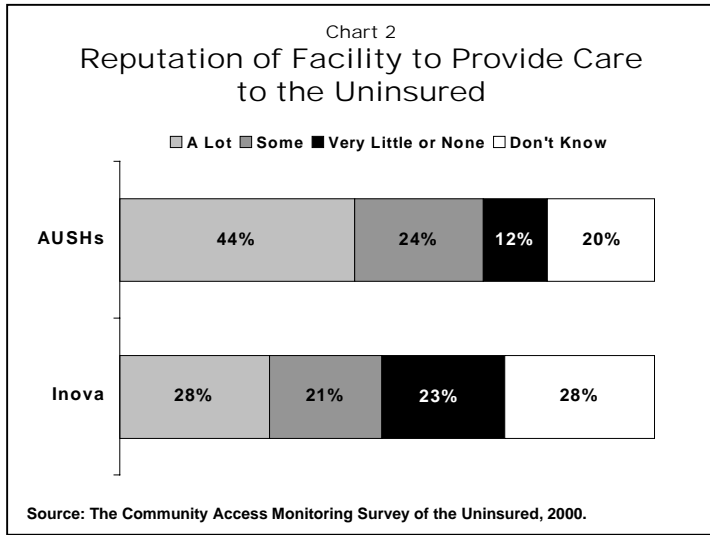
Most of the Inova respondents said the facility had been open and accepting to them even if they were unable to pay, but about one-fourth of the respondents said Inova had a reputation for providing very little or no care to the uninsured. In addition, although most of the respondents reported that they were satisfied with their interactions with staff, one of six or more stated that they were dissatisfied.

The majority of the Inova respondents—70 percent—stated that, in their experience, the hospital had been “open and accepting” to them even if they were unable to pay for their care. This proportion was slightly larger than the AUSH average of 61 percent. In addition, about one of five (19%) respondents reported that the facility accepted them reluctantly because they were unable to pay, a proportion identical to the AUSH average.

“The lady from the finance department didn’t believe me when I said I was single. She was intimidating me, asking me all the time if I was lying. She didn’t believe me.”
Inova Respondent

More than one-fourth (28%) of the Inova respondents reported that the hospital has a reputation in the community for providing “a lot” of care to the uninsured, a proportion smaller than the AUSH average (44%). Notably, Inova respondents were twice as likely as the average for AUSHs to report that the facility had a reputation for providing “very little or no care” to the uninsured. (Chart 2)

•
•
•
•
•
•
•
•



Nine of ten (90%) respondents were satisfied with the care and service they received from their doctors, the same proportion as for AUSHs. In addition, more than two-thirds of the respondents stated that they were “very satisfied” or “satisfied” with the care and service they received from receptionists, nurses, and physician assistants. These proportions were slightly smaller than the averages for AUSHs.

However, about one of five (21%) reported that they were either “unsatisfied” or “very unsatisfied” with the care they received from receptionists and nurses. In comparison, the averages for AUSHs were 14 and 11 percent, respectively. Dissatisfaction ratings for billing clerks were particularly high, with 44 percent of the respondents reporting that they were dissatisfied with the service they received. By comparison, the average for AUSHs was 18 percent.

ACCESSIBILITY

Most of the respondents reported that they had problems at least sometimes related to accessibility measures such as location, waiting time, and convenience to public transportation.

More than one-half (53%) of the respondents stated that the location of the facility was a problem for them at least sometimes. This proportion was much higher than the average for AUSHs (29%).

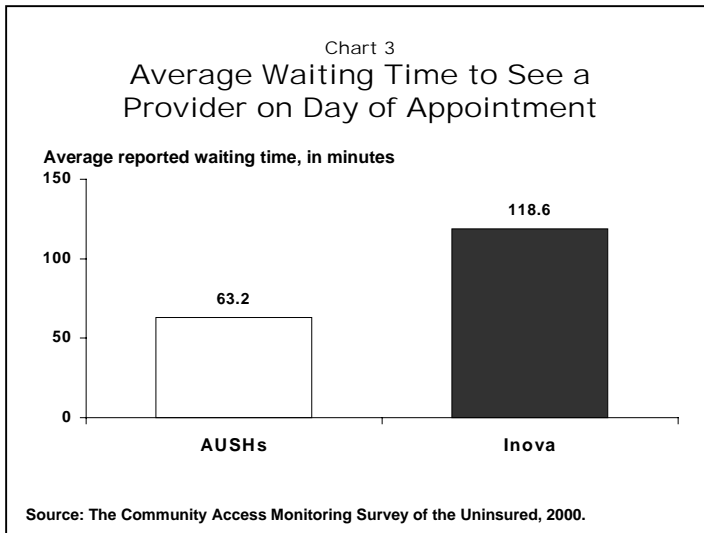
Inova respondents were twice as likely as the average for AUSHs to report that the waiting time to get an appointment was “often” or “always” a problem for them (37% vs. 16%). Notably, however, the average reported waiting time for an appointment was nine days.



This was five days shorter than the average for AUSHs, which was nearly 14 days.

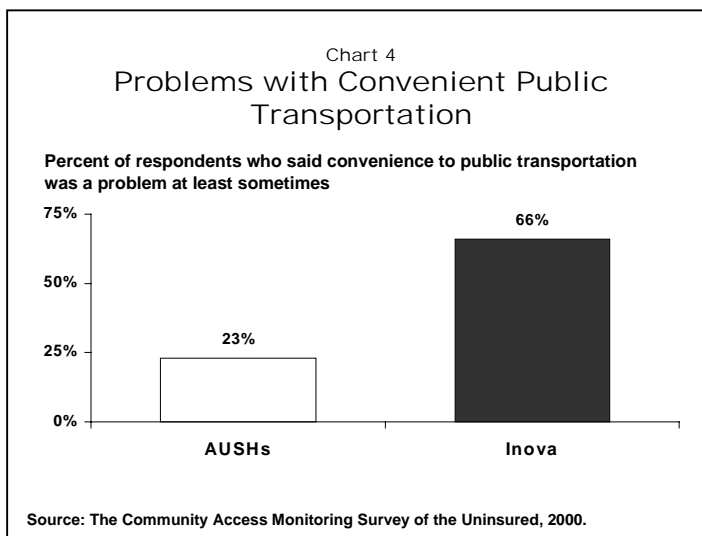
Inova respondents were much more likely to report that the waiting time on the day of the appointment was “often” or “always” a problem (44%) than the average for AUSHs (26%). Indeed, the average reported waiting time was 55 minutes *longer* than the average for AUSHs. (Chart 3)

“I was very upset because they didn’t do anything. They sent me to a clinic and for that they had me waiting for four hours.”
Inova Respondent



More than one-half (56%) of the Inova respondents said that assistance with transportation, when needed, was a problem for them at least sometimes. This proportion was three times higher than the average for AUSHs (19%). In addition, Inova respondents were three times as likely as the AUSH average to report that convenience to public transportation was a problem at least sometimes. (Chart 4)

•
•
•
•
•
•
•
•
•
•



LANGUAGE NEEDS

One-half of the respondents reported that they needed the assistance of an interpreter. Among these respondents, about half said that an interpreter was not readily available.

One-half of the respondents said that they needed interpreter services. This proportion was three times higher than the average for AUSHs. (Chart 5)

“The receptionist told me to speak English or to find someone who does.”

Inova Respondent

“There are some people who speak a little bit of Spanish.”

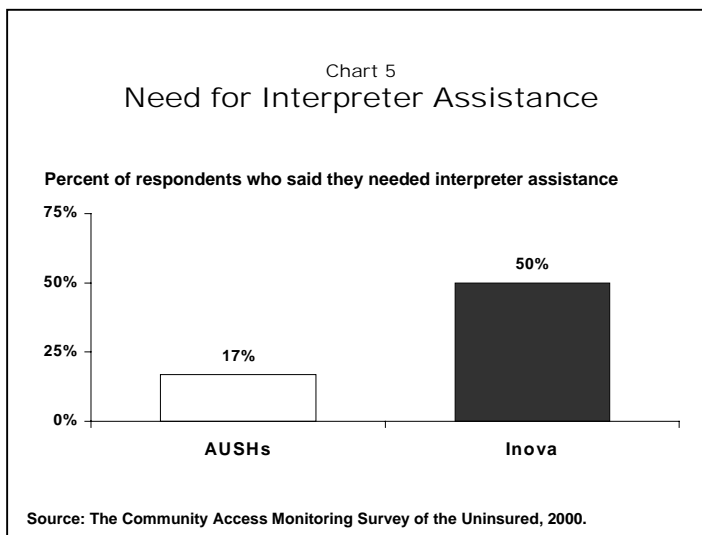
Inova Respondent

“I went with my cousin and she helped me because neither the doctor nor the nurse knew Spanish.”

Inova Respondent

“They didn’t ask me anything. Maybe because I don’t speak English.”

Inova Respondent



Among those who needed help, 51 percent reported that an interpreter was not readily available.

Among the respondents who reported that they needed help with interpretation, only 28 percent said that they noticed signs in the



waiting area in Spanish and 21 percent said they were given written information in Spanish. In comparison, more than two of five respondents for AUSHs who needed assistance said they noticed signs (46%) and were given written information (42%) in their language.

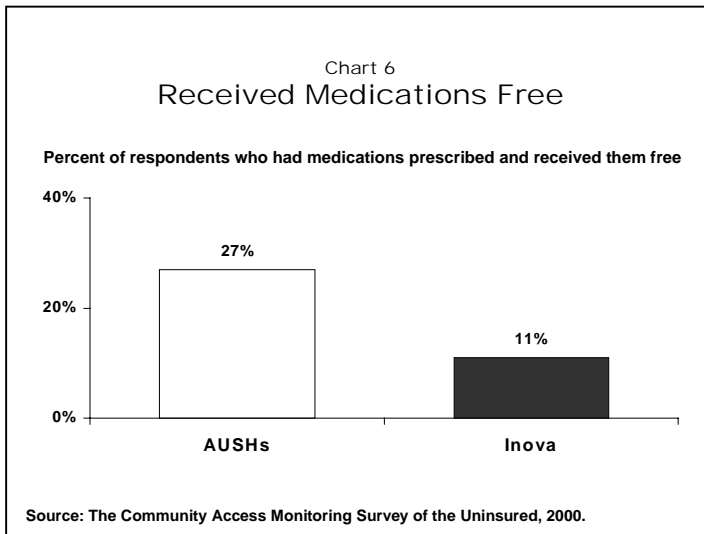
OBTAINING PRESCRIPTION MEDICATIONS

More than two of five respondents stated that paying for their medications was very difficult and that they needed financial assistance to pay for them. However, respondents were much more likely than the AUSH average to report that staff never offered to find out if financial assistance was available. Few respondents reported that they received their medications free.

Three of four (77%) respondents reported that they had medications prescribed. Seventy-three percent of the respondents who received prescriptions stated that they obtained their medications at a drug store and paid out-of-pocket. This figure was much higher than the average for AUSHs (57%). In addition, Inova respondents were less than half as likely as the average for AUSHs to report that they were given their medications free. (Chart 6)

“If you don’t have any money how can you buy them.”
Inova Respondent

“The nurse helped me quickly. She just gave me the prescriptions and left.”
Inova Respondent



Two of five (43%) Inova respondents reported that paying for their medications was “very difficult,” nearly the same as the average for AUSHs (40%). They were also just as likely as the average for AUSHs to need help paying for their medications (48% vs. 47%, respectively).

“I would not have been able to buy them, because I need to pay for other stuff.”
Inova Respondent

Among the respondents who needed financial assistance, nearly nine of ten (89%) reported that staff “never” asked them if help was needed. In comparison, the AUSH average was 64 percent.

“I owe a lot and the bills keep coming.”
Inova Respondent

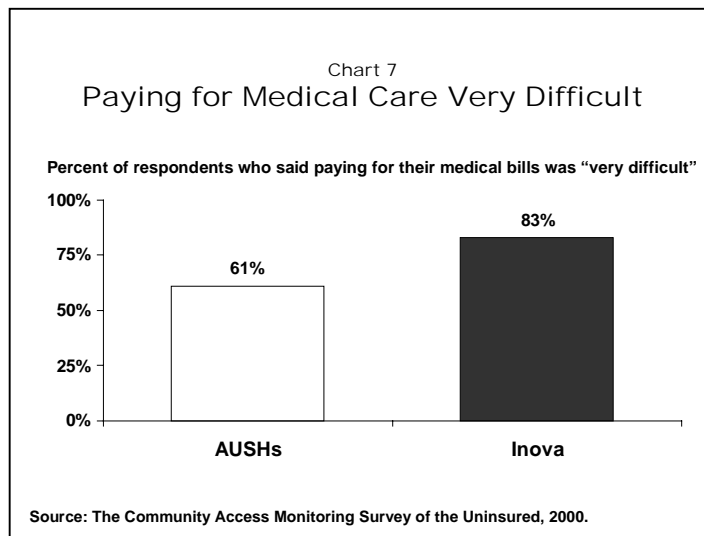
•
•
•
•
•
•
•
•

The proportion of respondents who understood the instructions for using their medications was high: 82 percent. However, 13 percent of Inova respondents reported that they did not understand their medication instructions. In comparison, the average for AUSHs was four percent.

CONCERNS OVER PAYMENT FOR HEALTH CARE

The majority of Inova respondents stated that paying for their medical bills was very difficult and that they needed help paying for them. However, nearly all the respondents who needed help stated that staff never offered to find out if assistance was available.

Inova respondents were more likely to report that paying their medical bills was “very difficult” than respondents for AUSHs. (Chart 7)



Sixty-five percent of the respondents stated that they needed help paying their medical bills, the same as the average for AUSHs.

Among the Inova respondents who needed help with their medical bills, 90 percent stated that they were “never” offered any assistance, such as by reducing or waiving their bills. In comparison, the AUSH average was much lower. (Chart 8)

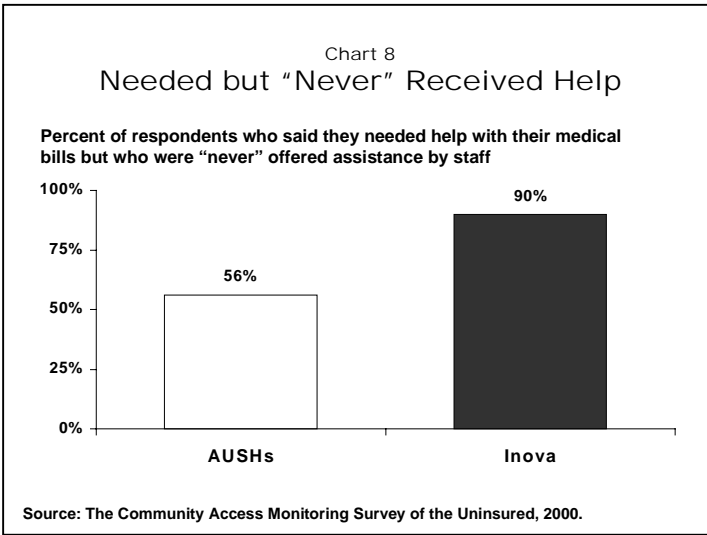
“It is difficult to pay, that is why I try to stay away from the hospital.”
Inova Respondent

“For the operation I had to bring in some paper and \$700 and make an appointment, but someone there told me that if I didn’t bring in the \$700 not to bother coming in.”
Inova Respondent

“They just sent me the bill and they told me that I could pay monthly.”
Inova Respondent

“They did not provide any information about receiving any form of assistance.”
Inova Respondent

“I owe over \$20,000 to the hospital, and as I wasn’t paying the bills, they would call me at home. They asked me to pay \$500 a month, but I can’t. I have four children.”
Inova Respondent



SEEKING CARE IN THE FUTURE

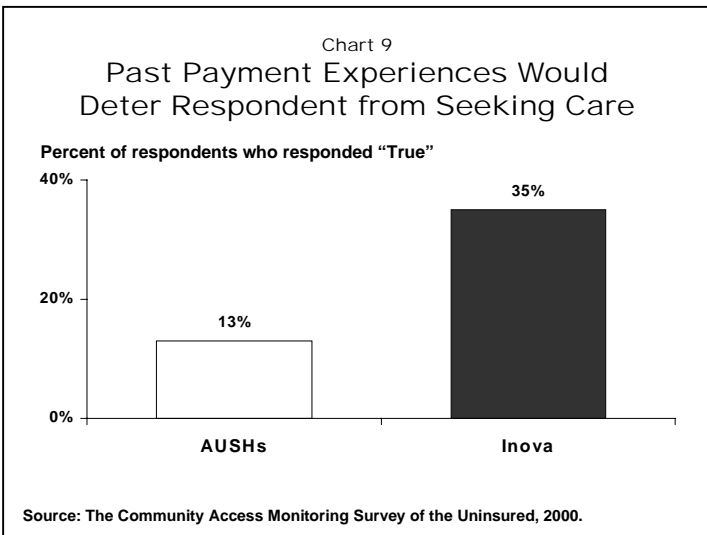
One-third of the Inova respondents reported that their past experiences paying their bills would deter them from seeking care at the hospital again, and nearly two-fifths said they owed money to the hospital. The majority of the respondents said that they would use the facility again if they had health insurance.

When respondents were asked how their past experiences paying for care at their hospital would affect their likelihood of seeking care there in the future, about one-third said that they would not seek care again. The average for AUSHs was much lower. (Chart 9)

"I don't want to return because the cost is high. I would if they lower the cost."
Inova Respondent

"I am scared to go because it's so expensive."
Inova Respondent

"It would depend on how the hospital is. If they offered a plan I would return."
Inova Respondent



•
•
•
•
•
•
•

About two of five (37%) respondents for Inova reported that they were in debt to the facility, lower than the AUSH average (61%). However, among those who had unpaid bills, 41 percent said the debt would deter them from seeking care at the hospital again, a figure comparatively larger than the average for AUSHs (23%).

About three-quarters (73%) of the respondents said they would use the facility again if they had health insurance, similar to the average for AUSHs (77%).

DISCUSSION

This section discusses some of the perceived strengths of Inova Alexandria Hospital (Inova) suggested by the survey results. In addition, it highlights issues that might warrant further discussion.

STRENGTHS

A slightly larger proportion of Inova respondents said that, in their experience, the facility had been open and accepting to them even if they could not pay than the average for All Urban and Suburban Hospitals (AUSHs) included in CAMS nationwide.

In addition, nine of ten Inova respondents were satisfied with the care they received from doctors at the hospital.

ISSUES FOR FURTHER CONSIDERATION

Use of Facility. Three-fourths of the respondents reported that they used the emergency room at least once in the past year. This proportion, although similar to the AUSH average, suggests heavy emergency room use.

Openness to the Uninsured. Although about one-fourth (28%) of Inova respondents said the facility had a reputation in the community for providing “a lot” of care, a similar proportion (23%) reported that it had a reputation for providing “very little or no care.”

Paying for Medical Care. More than four of five respondents (83%) for Inova reported that paying their medical bills was “very difficult” for them, while the average for AUSHs was 61 percent. In addition, two-thirds of the respondents (65%) said that they needed help paying their bills. Among these respondents, 90 percent said staff “never” offered help.

Obtaining Medications. More than two of five respondents (43%) reported that paying for their medications was “very difficult” for them, and nearly half said that they needed help to pay for them. Among the respondents who said they needed help paying for their prescriptions, nine of ten reported that staff “never” offered to find out if assistance was available.

Thirteen percent of the respondents stated that they did not understand their medication instructions. This proportion was much higher than the average for AUSHs (4%).

•
•
•
•
•
•
•
•

Language Assistance. One-half of the respondents stated that they needed interpreter assistance during a health care encounter. This figure, however, may underestimate the need for interpreter services, as the survey did not ask whether respondents brought interpreters with them. In fact, many respondents commented that they brought interpreters with them because they thought the hospital would not have one available.

Among those respondents who said they needed interpreter services, 51 percent said that an interpreter was not readily available. Furthermore, the proportion of respondents who stated that they noticed signs in the waiting room or were provided with written materials in their language was much lower than the AUSH average.

Satisfaction with Staff. Inova respondents were slightly less likely to report being satisfied with their interactions with staff than the average for AUSHs. Furthermore, for several categories of staff, the proportion of respondents saying they were either “unsatisfied” or “very unsatisfied” was nearly twice the AUSH averages. Notably, 44 percent said they were dissatisfied with their interactions with billing clerks, two and a half times the AUSH average.

Accessibility Measures. According to respondents, the average waiting time to see a provider was nearly an hour longer than the average for AUSHs. In addition, convenience to public transportation was likely to be an issue. More than two-fifths of the respondents reported that convenience to public transportation and getting transportation assistance when needed was often or always a problem.

Seeking Care in the Future: More than one-third (35%) of the Inova respondents said their past experiences paying for care would make them not seek care at the facility again, higher than the average for AUSHs (13%). Moreover, about two of five respondents (39%) who owed money to the hospital said that the debt would deter them from seeking care there again. However, the majority of the respondents (73%) said they would use the hospital again if they had health insurance.



CONCLUSION

This report provides information on a topic that has not often been investigated, the experiences of the uninsured when they access health care at their local health facilities. Given the large numbers of uninsured in our country, it is a topic of increasing importance.

Because the survey was not based on a random sample, the results are more suggestive than definitive. Notwithstanding its limitations, however, the authors expect that the results will be useful in suggesting issues and questions that would benefit from further discussion and investigation as communities attempt to ensure and improve access to care for their uninsured residents.



REFERENCES

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

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

•
•
•
•
•
•
•
•

³¹ Good Jobs First, *Alexandria Hospitality: Promoting Responsible Development*, October 1999. This report was prepared for the Tenants' and Workers' Support Committee. Estimates are based on 1997 Virginia State and Washington, D.C. MSA Occupational Employment and Wage Estimates and a 1999 survey of Arlandria Latinos by the Tenants' and Workers' Support Committee.

³² *1998 Data Book*, Northern Virginia Planning District Commission, Annandale, Virginia.

³³ *Ibid.*

³⁴ *1999 Needs Assessment of the Hispanic Community in Alexandria*, Alexandria United Way, Alexandria, Virginia, p. 10.

³⁵ G. Pransky, J Thackeray, and TWSC Healthy Community Project, *Work-related injury and illness in a non-agricultural immigrant population: a pilot study and overview*, 1998.

³⁶ Alexandria United Way, *op. cit.*, pp. 7-10.



ACKNOWLEDGEMENTS

The **Healthy Community Project** of the **Tenants' and Workers Support Committee** would like to acknowledge the community health promoters and volunteers who participated in the CAMS project in Alexandria and helped make it a success.

Alejandra Cruz, Alicia Flores, Amalia Quiñones, Amalia Ruiz, Blanca Rivera, Nicolasa Trejo, Mario Aguilar, Marina Mendoza, Mauricio Espinoza, Mauricio Hernández, Ruth Dinzey, Ximena Valenzuela, and Zoila Aguilar completed the 10-week course on community health promotion, access, and disease prevention, and also administered many of the Community Access Monitoring Surveys. Other volunteers who conducted surveys included Jose Solis, Carlos Zurita, Vivian Zurita, Susana Espinoza, Marcelo Espinoza, and Milton Solis. In addition, Alicia Ruiz, Mario Aguilar, and Nabuconodosor Espinoza acted as paid survey coordinators.

Special thanks to Silvia Portillo who, as TWSC Healthy Community Project Coordinator, acted as overall coordinator for this project.

The Access Project would especially like to thank the authors, Dennis Andrulis, Christina An, and Carol Pryor for their dedication in creating not only this report, but the reports for all twenty-four sites participating in the CAMS project nationwide.

The Community Access Monitoring Survey project was one that involved our *entire* staff, and we would like to thank all of them for the tremendous amount of time and effort they contributed to making the project a success. Special thanks are due to the following people:

- ◆ Bill Lottero, the Site Coordinator, who worked directly with Tenants' and Workers' Support Committee to help plan the project, and who provided consultation throughout the project's duration.
- ◆ Nicole St. Clair, who assisted in the writing of the report
- ◆ Bill Hewett and Meg Baker, who provided invaluable administrative support in the production of the report
- ◆ Nancy Kohn, who, as The Access Project CAMS coordinator, attended to the myriad of details necessary to keep the project on track

In addition, we want to express our appreciation to our colleagues at Community Catalyst Inc., whose participation in the project was essential to its success.

•
•
•
•
•
•
•
•

We are also grateful to the committed team of trainers from The Medical Foundation's Health Training Innovations program. Laurie Jo Wallace, Moacir (Mo) Barbosa, and Jorge Armesto developed a standard curriculum and conducted interactive one-day training sessions at each site, in a very short period of time, to ensure consistent administration of the survey.