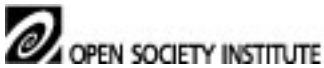

Baltimore Safety Net Access-to-Care Survey 2002

How are people ending up in the Safety Net and how safe are they?

Open Society Institute – Baltimore
Program on Medicine as a Profession
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The Open Society Institute is a private operating and grantmaking foundation founded by philanthropist George Soros and headquartered in New York. OSI promotes the development of open societies around the world through a variety of domestic and international programs that support educational, social, and legal reform and encourages public debate and policy alternatives in complex and often controversial fields. In 1997, OSI opened its first U.S.-based field office in Baltimore specifically dedicated to city-specific issues and needs. The Baltimore office works with a local board to develop and support grantmaking programs that foster debate, empower marginalized groups, and strengthen communities and families. Current areas of interest include: drug addiction treatment, criminal justice, workforce and economic development, access to justice, community fellowships, education and youth development. The Medicine as a Profession program seeks to address the principles of professionalism that promote trust, quality, equity, efficacy, and privacy in the delivery of health care.

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Executive Summary

274 Baltimore residents accessing care at ten community clinics and resource centers in the city were interviewed this summer as part of the Open Society Institute-Baltimore Medicine as a Profession initiative. The intent of the survey was to describe who it is that is accessing care in Baltimore's Safety Net, how well the system works, and how vulnerable this safety net is in our current fiscal environment. Sites included in the survey were: Health Care for the Homeless, HERO, Chase Brexton, Beans and Bread, Franciscan Center, St. Michael's Outreach Center, Mattie B. Uzzle Outreach Center, Tuerk House, New Song Health Center, and Shepherd's Clinic.

Survey Findings:

- The average age of respondents was 44 years; 77.0% were African American, 54.4% male, 50.7% were homeless, and the average annual income was $7,864, well below the poverty level.

- 78.8% of respondents had at least one chronic medical problem and 50.7% reported a chronic mental health condition. Almost 6 out of 10 were supposed to be taking prescribed medications.

- Over half of the respondents reported difficulty in the past accessing health care, including 30.0% for dental care, 15.0% specialty care, 15.0% prescription drugs, and 13.9% for primary care. Not having insurance and not being able to afford it were the most commonly reported reasons for those having difficulty with access.

- 45.9% reported currently owing money for a medical expense, with the average reported debt per person $3,409. 37.5% of those interviewed and 81.0% of those with a medical debt reported having been referred to a collection agency for their medical bills. 52.6% of individuals who currently owe money for their medical care were insured.

- While 30.7% reported they would go elsewhere if that site were not available, 35.3% reported a likely adverse consequence including homelessness, relapse, worsening illness or death if this site were closed. Overall, 19.7% knew of no alternative site, and 14.3% reported they would go to an ER instead.

- Most organizations rely significantly on federal and state programs for anywhere from 50% to 85% of their operating budget. Any drop in funding will likely result in significant reduction in service capacity.

Conclusions

These data suggest that people are falling through the cracks in our current system because of no health insurance or being under-insured, medical debt, and systems of care ill-equipped to address the multiple medical, mental health and social needs associated with urban poverty. The agencies and organizations that do serve them are increasingly strained and overwhelmed by the increasing need among our most poor. Specific recommendations to address these concerns are introduced in this report.

Overview

274 Baltimore residents accessing health care and social services at one of ten community agencies were surveyed this summer as part of the Open Society Institute-Baltimore Medicine as a Profession initiative. The focus of the survey was to identify areas of needs, barriers to care, and past experiences with the health system among those persons relying on the community safety net for care.

Background and Rationale

The community safety net in Baltimore city has evolved over the years to represent a substantial network of service providers caring for individuals and families with complex medical, mental health and social needs, poverty, and subtle and not-so subtle obstacles to care at traditional provider sites. This network includes social service agencies and outreach centers that are often the first point of contact for individuals and families in-need. It also includes community health centers, free clinics, and clinics and programs affiliated with Baltimore-area health systems that provide care to those most vulnerable.

While we typically have a good understanding of what organizations make up this safety net from United Way directories, networking among charitable organizations, and public information and outreach campaigns, we know much less about the clients that access them. Why are they going here as opposed to somewhere else? What are their specific needs and are those needs being met? What are the barriers to care and obstacles that they are experiencing? And how safe are they in this safety net? These questions are relevant for the following reasons:

- The safety net is typically very dependent on public funding and philanthropy to maintain their level of operations. As greater demands are placed on limited or shrinking resources, many sites are vulnerable. We need to know to what extent are sites vulnerable and what are the anticipated consequences of budget shortfalls.

- Our approach to addressing the needs of those most vulnerable to the ill-effects of poverty has traditionally been categorical and programmatic. While measures of well-being are more readily available for Temporary Aid to Needy Families (TANF) recipients, Medicaid managed care enrollees, or recipients of Head Start programming, we know much less about the greater population of people in poverty who do not neatly fit into one of our designations. We need better, population-defined measures of success and shortcomings in order to be more honest in how we define the health of a community.

- There is a shared responsibility to the needs of our poor and most vulnerable that is increasingly threatened by reduced reimbursement by third party payers, shrinking eligibility requirements, and market-driven demands. We need to hold accountable those entities receiving public funding just as we need to hold government and our publicly elected officials accountable to the needs and demands of those disenfranchised members of society.

Study Goals

The goals of this study were to:

- Identify the health and social needs of those clients accessing care in Safety Net organizations
- Describe barriers to care experienced by this population and reasons why they rely on "safety net" providers for their care
- Define the relative vulnerabilities of community safety net organizations to federal and state funding shortfalls and potential consequences to the individual client, the overall health system in Baltimore, and society at-large.

Survey methods

A face-to-face survey was administered to clients accessing care at ten "safety net" provider sites within the city of Baltimore. All surveys were strictly voluntary and anonymous. Consecutive clients were selected for interview on randomly assigned days. Second year medical student interns in the Soros Service Program for Community Health (OSI's Medicine as a Profession initiative) conducted the survey after extensive training and piloting of the survey.

The survey itself was developed with direct and ongoing input from representatives from the community based organizations participating in the professionalism curriculum and student placements. This group met for six months prior to initiating the survey to pilot test questions and develop the study design. Community mentors at each site supervised the students in the administration of the survey. The survey itself took approximately 20 minutes to complete. The voluntary response rate was greater than 80%.

The Soros Program for Community Health summer internship

The Soros Program for Community Health summer internship is an eight week intensive program sponsored by the Open Society Institute Medicine as a Profession initiative for medical students between the first and second years of medical school. The intent of the program is to provide exposure and experience to the students early in their careers to issues and domains of professionalism facing the medical community. They are introduced to ways to act on their professional mandate through community and patient-centered advocacy and care. In addition to the advocacy project described in this report, the students participated in weekly day-log seminars on professionalism and worked full time at the community organization in a staff context.

Participating Community Organizations

Eleven community organizations and their designate representatives participated in the study and survey design and ten served as survey sites for the study. They included:

Health Care for the Homeless Clinic
Downtown Baltimore

New Song Health Clinic
Sandtown-Winchester

H.E.R.O.
Downtown

Chase Brexton Health Center
Mount Vernon/Downtown

Mattie B. Uzzle Outreach Center
Collington Square/East Baltimore

Franciscan Center
Greenmount/East Baltimore

Tuerk House
West Baltimore

Paul's Place*
Pigtown/Washington Village

Shepherd's Clinic
North Ave./Downtown

Beans & Bread Drop-in Cntr
Fell's Point

St. Michael's Outreach Cntr
Upper Fell's Point

* did not serve as survey site because the majority of clientele were <18 years old

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What are the health and social services needs of clients accessing Baltimore's Safety Net?

Demographics

The average age of respondents to this survey was 44 years. Overall, 77.0% were African American, 54.4% male, and 59.6% were lifetime residents of the city of Baltimore. Of those persons who were not native to the city, most (24.8%) reported moving to Baltimore from out of state as opposed to from an adjoining county or in-state location. The sample was evenly split among those persons living in an apartment or house they owned or rented (49.3%) and those who were homeless at the time of interview (50.7% - unsheltered, doubled-up, living in an emergency shelter or in a half-way house).

Four out of ten respondents did not complete the 12th grade and only 31.9% of those not completing had a Graduation Equivalency Degree (GED). The average annual income was $7,864; 26.6% reported being the primary caregivers for children < 18 years old. Overall, 46.4% reported currently having health insurance coverage, typically medical assistance (62.2%).

Health Care and Social Service Needs

Overall, 78.8% of respondents reported having a chronic medical condition, 50.7% reported a chronic mental health condition, and 58.8% reported they were currently supposed to be taking a prescribed medication. The ten most commonly reported conditions were

Depression	33.9%
Hypertension	31.0%
Chronic arthritis	29.6%
Asthma or other lung conditions	21.2%
Hepatitis B or C	21.2%
HIV/AIDS	18.2%
Diabetes	13.5%
Anxiety disorder	12.8%
Bipolar disorder	10.2%
Heart disease	8.0%

Overall, 38.7% of respondents reported a history of drug or alcohol abuse and were currently in recovery; 14.2% reported active use while 42.7% denied any substance abuse.

Among social services, the five most frequently cited needs were:

Food assistance	48.9%
Housing assistance	47.1%
Transportation assistance	37.2%
Information on available social services	30.3%
Case management	29.9%

What are the barriers experienced by this population and why do they rely on the Safety Net for their care?

Over half of all respondents reported difficulty receiving health care in the past. For the overwhelming majority, lack of health insurance and the cost of medical care was the reason. The breakdown of unavailable health services was:

Dental care	30.0%
Specialty medical care	15.0%
Prescribed medications	15.0%
Primary care	13.9%
Mental health/substance abuse care	10.2%

Overall, 45.9% of respondents reported they currently owed money for health care they had received. The average medical debt was $3,409, slightly less than half the annual average income of the sample. Additionally, 37.5% of the sample and 81.0% of those with an active medical debt reported being referred to a collection agency for their medical bills. Of note, 52.6% of those individuals who currently owe money for their medical care had health insurance coverage.

One in three people in this survey reported that either being referred to a collection agency or currently owing money for medical care affected the way they sought future health care, either by:

- delaying seeing a health provider or getting medical attention when they felt they needed to,
- not going to the same provider where the debt is owed,
- not having a source for usual care, or
- now only going to an emergency department for health care.

Of note, 70.1% of respondent reported their usual source of care to be a community clinic or health center compared with 15.4% identifying an outpatient clinic at a local hospital. 10.0% went to an emergency department only for their usual care.

The top three reasons cited by most people in this survey for why they accessed care at a “safety net” site were: ***The way the staff treats them***; ***Convenient location or hours of operation***; and ***Affordability.*** When asked what would happen were that site not available, 30.7% of respondents reported they would go elsewhere for the care they were receiving. However,

- 35.3% reported likely adverse consequences including homelessness, becoming much more ill, relapsing to drug or alcohol use again, or death;
- 19.7% reported they didn’t know of any alternatives to that site for the care they were receiving;
- 14.3% reported they would go to an emergency department for care instead.

How vulnerable is our Safety Net?

The sites participating in this project averaged 8,675 client visits per year and typically provided multiple services including: primary care, case management, mental health care, triage services, pharmacy assistance and direct service, food and clothing, and client advocacy. Most organizations relied significantly on federal or state programs for anywhere from 50% to 85% of their overall funding. Those organizations not reliant on government funding instead met their operating budget predominantly through foundation grants with private donations making up the difference.

Federal and state programs most often identified were:

- Medical assistance reimbursement
- Steward McKinney Act grant support
- HUD funding (HOPWA program)
- Ryan White HIV funds
- HRSA/SAMSHA grant support
- HRSA/Bureau of Primary Care
- CDC funding
- Maryland AIDS Drug Assistance Program
- FEMA
- Maryland Emergency Food Assistance Program

When asked what effect a drop in federal or state funding would have on their program and operations, most organizations reported minimal staffing cuts unless they experienced a 25% or more funding cut. This typically reflected their large dependence on volunteers for much of the work at each site. However, invariably any funding cut was expected to result in a proportionate decrease in the number of clients served, especially if the funding was at the Medical Assistance or federal level.

> "It is frustrating to realize that everyone thinks our services are needed and everyone admires the quality of our services, yet the funds are not available to sustain it. To get funding from multiple sources is challenging because each source has different priorities and wants your organization to 'act' differently. We have focused on service but that is not what 'counts.'"
>
> - Medical director of one of the surveyed community organizations

Limitations

Given the design of this survey, there are several limitations that need to be considered when interpreting the results. First, the survey was a cross-sectional assessment of individuals at only one point in time. We are unable to definitively report on what happens to the individuals over any period of time without serially conducting reassessments. Second, the survey relies on respondents' accurate reporting of medical needs, medical debt, health seeking behavior, and other answers with no means of verifying any of their responses. We have tried to minimize the potential for misrepresentation by keeping the questionnaire anonymous and without any self-implicating questions. We purposely did not attempt to link responses to specific events or to any health care settings. However, we do feel this is an important next step, particularly if accompanied by the opportunity and capacity to address implications of any future findings. Third, the sample is concentrated in health and social service settings that are specifically targeted to people of limited financial means. We cannot extend these findings to all people in poverty whether they have a medical need or not, nor can we extend the findings to all people in the health system, regardless of their economic means. Finally, in attempting to link the consequences of having medical debt and being referred to a collection agency to health-seeking behavior, it is possible that these forces are also keeping individuals out of all care setting including those at safety net sites. Therefore, the potential for both under-reporting and over-reporting biases need to be considered.

However, the study design is very well suited given the focus on identifying the needs of those persons accessing care at safety net organizations. These findings point to the importance of having community-based data available to inform policy decision making and accurately assess the effectiveness of our current care systems.

Conclusions

The findings from this study raise more questions than it provides answers. What is apparent from these data are that people are falling through the cracks in our current system because of no health insurance or from being under-insured, from being in medical debt, and because of a disjointed system of care that is ill-equipped to respond to the ravages of urban poverty. The agencies and organizations that do serve the people in our survey are increasingly strained and overwhelmed by the growing demand among our most poor.

The data collected identify several areas of concern that need to be addressed before we can forge a civic agenda where truly no one is left behind. Without addressing these issues, we will have, in essence, sentenced a segment of our society to an underclass status that will take many more generations of initiatives and efforts to pull ourselves out from.

First: Urban poverty is associated with poor health. Almost 80% of our sample had a chronic medical condition and over half a chronic mental health condition; many had more than one condition and all required ongoing treatment and medication to control. For economic empowerment to cut across socio-economic lines, we need to ensure access to timely and affordable health care so that individuals can get good jobs and keep them.

Second: We cannot have competing systems of parallel health care where one system feeds into the other through predatory billing practices, including accumulated medical debt and the use of collection agencies. Our goal should be to get individuals out of emergency departments for primary care, make preventive care and early treatment available to those who most need it, and not make health care (and health) only available to the highest bidder. There is a shared responsibility to our poor that requires a shared accountability.

Third: The system of care that has emerged for those most destitute and in need is far less secure than we might like to think. In the past three years we have already lost two inner-city community hospitals to closure (Church Home and Liberty Hospital). With the looming state deficit jeopardizing our Medicaid program and the war on terrorism threatening many domestic funding priorities, we are likely to see the effects in the availability of care and services to our most poor. Unfortunately this also just propagates a vicious cycle of increasing shifts of care back to emergency departments and deferring treatment until the care needs require expensive inpatient hospitalizations.

While these observations may be nothing new, there is a greater sense of urgency to address them. Much of the progress we have made in the past ten years of economic prosperity along with urban revitalization both completed and planned for Baltimore are tenuous at best and threatened by any deterioration in neighborhood conditions. Furthermore, our capacity to respond systematically and consistently has eroded dramatically with provisions within welfare reform legislation, restrictions on legal immigrants accessing services, and proposed cuts in federal and state funding. To respond requires a rethinking of “business-as-usual” in the allocation of resources, the expectations of our providers, and the accountability assigned to organizations and individuals.

Recommendations

Based on these findings, we make the following recommendations:

(1) Mandate a systematic, comprehensive, and ongoing monitoring of the health and well-being of our most poor.

Most measures of how well we address the needs of our most poor are programmatic and operations-driven, reflecting how well specific programs serve the needs of those enrolled. Instead, we need to be looking at communities and the people who live there to identify not only those that are able to navigate the system but also those falling through the cracks.

(2) Hold health systems and health providers to a higher level of accountability in the care of indigent patients.

Unfortunately we cannot assume that having a "medical home" necessarily means adequate access to affordable health care and that the individual is not being forced into personal bankruptcy by their medical bills. Additionally, sending a homeless person with no income to a collection agency for a medical debt doesn't appear to do anything other than stigmatize any future attempts to get health care. Specifically

- **There should be a state-mandated means test for referring clients to collection agencies for their medical debt.**
- **There should be rate caps in what uninsured patients can be charged for care, comparable to the rates paid by insurance companies and/or Medicaid**

(3) Support a proactive city, state, and federal government agenda for ensuring adequate and timely access to health care for all.

There is a responsibility by our elected official and government to the health and well-being of all our citizenry that cannot be held hostage to political whim or jettisoned into the private sector. Ensuring adequate and affordable access to health care may require expanding eligibility for Medical Assistance and reducing the processing time to get enrolled, using municipal and state purchasing power to negotiate lower costs for prescription drugs and medical care for uninsured persons, and developing programs that truly make it easier for employers to offer health insurance to their low-and mid-wage employees. All avenues need to be explored and pursued.

(4) Secure/expand federal and state funding currently being relied upon by our safety net of providers.

We cannot afford to let this system of necessity "whither on the vine" while we re-sort national and state priorities. Funding the safety net is needed even more now than ever and cannot and should not be held hostage to other agendas.

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