INSIDE BALTIMORE'S SAFETY NET

WHERE PEOPLE GO FOR HEALTH AND SOCIAL SERVICE NEEDS, WHY, AND WILL THESE RESOURCES BE THERE IN THE FUTURE

Open Society Institute – Baltimore
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OSI Medicine as a Profession - Soros Service Program for Community Health
Executive Summary

Medical students from the Open Society Institute's Program on Medicine as a Profession summer internship recently completed an assessment of Baltimore's safety net organizations and the clients who use them. These groups provide health and social services to the most vulnerable of city residents regardless of their ability to pay. Three separate surveys were conducted: one to clients accessing services at these sites; one to health providers working there; and one to site directors. The preliminary data reveal several disturbing trends regarding the extent of need among clients, the pivotal role these organizations play in their care, and challenges they are facing.

- The majority of individuals served by these agencies have a staggering array of medical, mental health and social support needs. Of those surveyed, almost 8 out of 10 have at least one chronic medical condition and 30% have three or more chronic medical problems. The 3 most commonly reported were HIV/AIDS (38.3%), chronic arthritis (29.0%) and hypertension (27.0%). Almost 50% of the sample reported an active mental health condition and 68.1% were taking prescription medications; one third were taking 3 or more prescribed meds.

- While 24.2% were working and 57.7% were receiving government assistance, 43% were homeless and only 40% rented or owned their residence. The average income earned from work was $1,037 per month ($12,500 annually)

- 25.4% reported receiving at least 3 different services at that safety net site and 70.2% also accessed services at other sites. 43.1% could not identify somewhere else to go if that care was not available and 1 in 4 reported they would be either homeless, actively using drugs or dead if care at that site wasn't available.

- Despite the prevalence of medical and mental health need, only 40.5% of individuals surveyed had health insurance, typically Medicaid coverage. Over half the sample (51.2%) reported having difficulty accessing medical services in the past, with two thirds reporting it was due to financial barriers and lack of health insurance.

- - Among health providers surveyed, 69.2% reported an increase in the numbers of uninsured patients seeking health care and substantial difficulties getting specialized care and procedures for them. Over half felt less confident in being able to get their patients needed health care now compared with 5 years ago.

- Most "safety net" site directors reported a substantial reliance on federal grant support for their operations. When presented with scenarios of 10% and 25% funding reductions, most reported the need to substantially reduce staffing and services. Current funding of federal programs most heavily relied upon by these agencies does not appear at-risk. However, the increase in demand for services among uninsured patients is of particular concern as organizations try to meet this need with limited and potentially shrinking resources.

Introduction

This report presents data from a series of surveys of safety net organizations, clients who access care at these sties, and the providers who work there. The goal of this project was to identify issues and needs facing clients at these sites and the unique role of safety net organizations in meeting these needs. An additional goal was to identify potential challenges to the mission and capacity of this network of providers that is caring for society's most vulnerable and needy individuals.

The surveys were conducted by medical students participating in the Soros Service Program for Community Health. This summer internship, part of the Open Society Institute's Medicine as a Profession initiative, places first year medical students from around the country in community-based organizations for a seven-week internship. The students get to experience first-hand issues facing patients trying to access care in the face of poverty, addiction, abuse, and homelessness. They receive mentoring from a very talented and committed team of community providers and participate in an intensive curriculum that focuses on issues of professionalism facing physicians. The goal is to introduce students early in their education and training to positive examples of empowered communities and providers serving the needs of traditionally disenfranchised patient populations and to introduce the concepts and practice of patient advocacy.

A total of 248 clients were interviewed at 8 community based organizations on specific needs they may have, previous difficulties they have had accessing care and why they go to that particular site. Directors from seven of the eight sites also completed a survey describing funding streams for their site and responding to different financial scenarios where they might experience reductions in their current levels of government grant support. Finally, a total of 17 clinicians who provide medical care to patients at these sites were surveyed regarding issues of access to care and ability to navigate the health system for patients without health insurance.

While the findings presented in this report are compelling and shed light on the scope of need among clients accessing these service sites and issues facing providers, the results should not be over-interpreted. Only clients accessing care at these safety net organizations were interviewed and the conclusions should not be generalized to those persons not able to access care. Likewise, only eight sites were studied. There are many other provider groups in Baltimore that may or may not be experiencing similar issues and needs. Additional work is needed to better determine how representative are the provider site data.

Overview of Safety Net sites and services provided

Eight sites were included in this survey. These sites, where the medical students had also spent their service rotation, provide care to a spectrum of needy population groups here in Baltimore including homeless persons, persons with HIV/AIDS, working poor families, and persons with addictions. They are geographically distributed throughout the city. All sites are independently operated and not affiliated with either an academic health center, hospital or health care system. They were chosen because of their focused mission of providing whole-person care to members of a specific community, regardless of their ability to pay.

The sites included:

Health Care for the Homeless - downtown

Beans and Bread – East Baltimore

Paul's Place – West Baltimore/Pigtown

HERO - downtown

Chase Brexton – downtown/Mt. Vernon

New Song Ministries – West Baltimore/Sandtown/Winchester

Shepherd's Clinic – North Avenue

Mattie B. Uzzle Outreach Center – East Baltimore/Collington Square

Total # of clients served/yr*: 21,839
Encounters/yr: 115,257

Range of client volumes: 1,200-9,000 per site

Number of staff at sites:	Paid	Volunteer	Total Staff
Range:	4-93	2-111	8-125

Top 5 services provided at sites

1) 1) Medical care – 4/8 sites
2) 2) Mental health/substance abuse – 4/8 sites
3) 3) Case management – 5/8 sites
4) 4) Food - 4/8 sites
5) 5) Housing assistance – 4/8 sites

*client volumes do not include Mattie B. Uzzle data

Demographics of populations served at those sites

A total of 248 persons were surveyed in a face-to-face interview conducted by the medical students working at that site. The survey itself lasted approximately 15 to 20 minutes in most cases and participation was strictly voluntary with no compensation provided. Survey questions consisted of both multiple choice and open-ended questions.

Average age:	40.2 years			
African American:	83.5%			
Male:	65.7%			
Education:				
< 12th grade:	46.0%			
< 12th grade w/ GED	22.0%			
Income:				
Work:	24.2%			
Ave. monthly income:		$1,037 ($12,500 annualized)		
Gov't assistance:	57.7%			
SSDI:		25.4%		
TEHMA:		20.6%		
Food stamps		24.2%		
Social Security		7.7%		
Housing status:				
Homeless:	42.3%			
Rent/own:	40.3%			
Transitional hsng:	17.3%			
Previous residence:				
Outside Balt. city		41.9%		
Proportion without health insurance:		59.5%		
Chronic medical conditions:				
≥ 1	78.2%			
≥ 3	29.5%			
Top 4 conditions:		HIV		38.3%
		Hypertension		27.0%
		Chronic hepatitis		23.8%
		Arthritis		29.0%
Mental health conditions:				
≥ 1:	47.6%			
≥ 3:	9.7%			
Currently on prescribed medication:				
≥ 1:	68.1%			
≥ 3:	35.9%			

These findings demonstrate both the scope and severity of need among respondents as well as their generally destitute status, compounding their medical and mental health conditions. It is concerning that despite this profile, 60% did not have health insurance.

Services received at Safety Net sites

Clients were asked about what services they were accessing at that site, why they were going there for care, and what would happen to them if care at that site were not available. They were also asked about other sites they accessed, for what services and whether they knew of alternatives to that site for the care they were receiving there.

Number of services received at that site:

≥ 3:	25.4%
Medical	50.4%
Mental health	15.3%
Addiction tx	25.0%
Social work	23.8%
Food	25.0%
Housing assist.	13.3%
Legal	3.2%

Top three reasons for accessing care at that site:

Staff-related reasons/humanistic qualities of provider site
Convenient location
Referral from other site of care

Proportion currently accessing additional sites for other service needs:

70.2%

Expected outcome if that site were not available

Go elsewhere	35.5%
Become homeless	
Actively using drugs	
Go untreated	24.9%
Dead	

Proportion not knowing alternative sites for care or services currently being received

43.1%

These data are notable for the number and scope of services accessed at these sites. The mission and focus of the provider site, collectively captured in reference to "humanistic qualities" appears to contribute to the niche role they play for clients. Also important to note is how these sites are portrayed as part of a network of access points for clients that included both "traditional" and "safety net" provider. It is concerning that almost half could not identify an alternative to that safety net site and 1 in 4 identified a devastating outcome if services there were not available.

Previous difficulties accessing care

Clients were asked to identify any past difficulties they had in accessing a spectrum of health services, including primary care, specialty care, dental care, mental health and addiction treatment services, and obtaining prescription medications. They were also asked, in an open-ended question format, what was the reason for not being able to access that service.

Proportion reporting difficulty receiving health services in the past:	51.2%

Proportion reporting difficulty accessing specific health services in the past

Primary care:	22.2%
Specialty care:	13.3%
Mental health care:	6.9%
Drug and Alcohol tx:	7.7%
Dental care:	28.6%
Prescription drugs:	18.5%

Principal reason: No Health insurance/cost:	63.8%

It is very disconcerting that over half the sample reported past difficulties accessing care, particularly in light of the scope and severity of need. It is also important to note that the spectrum of health service venues where access was limited extends across specialty areas, disciplines, and includes both health care and prescription medications. What was noticed uniformly across all service areas was how the lack of health insurance and the high cost of care were the primary obstacles to care for almost 2 of every 3 respondents.

Provider survey responses

A total of 17 primary care providers working at the safety net sites were surveyed on how they are able to access care for patients with no health insurance. They were presented with a hypothetical case of a 53 year-old woman with signs and symptoms worrisome for a serious medical condition that requires a more extensive diagnostic work-up. The woman has no health insurance and works in a low-paying service sector position that precludes her from qualifying for public assistance. The providers were asked how would they proceed with her work-up, would the work-up be different if she had health insurance, how did they typically access specialty services, how common was this scenario and were they seeing more or fewer cases like this in their practice. Finally, they were asked about their confidence in being able to get patients like this one, the care they need and what effect that has on their professional satisfaction.

Provider demographics:

Avg. age: 49 years
Gender: 52.9 % male
Work setting: Free clinic
Triage center
Neighborhood HC
Avg.: # years out of training: 14.4 years
Specialty area:

Internal Medicine:	23.6%
Family Practice	29.4%
Nurse Practitioner:	29.4%
Specialist:	23.5%

Proportion who anticipated the medical work-up would be different if this patient had insurance (either faster or using different tests/procedures):
70.6%

Rated ability to obtain specialty referrals for patients like this:
5.1/10 in relative difficulty (10=most difficult)

Rated ability to obtain diagnostic studies for patients like this:
4.7/10 in relative difficulty (10=most difficult)

Proportion reporting that this type of presentation is becoming increasingly more common over the past 5 years:

69.2%

Proportion reporting less confidence in their ability to get appropriate care to this type of patient compared with 5 years ago:

53.3%

Rating of overall professional satisfaction

7.3/10 (10=extremely satisfying)

These findings were very concerning for several reasons. First, they highlight the inequities in care for people with insurance as opposed to people without insurance. Second, while the providers expressed some degree of confidence in their ability to get this woman the necessary tests, access to a specialist, and a relatively high degree of professional satisfaction, they also reported disturbing trends. The vast majority of providers reported increasing numbers of patients fitting this profile that are seeking care at their sites over the past five years. The majority also reported less confidence now than compared with five years ago in their ability to navigate the system and get the necessary tests and treatment for her.

Many of the providers cited internal, grant-generated funds to pay for some of the specialized services required by this type of patient. Whether grant dollars will be able to keep up with demand, particularly given the increased numbers of working poor and uninsured persons needing health care, is a key policy question.

Funding support for Safety Net provider sites

Seven of the eight site directors completed surveys regarding funding sources for their organization, staffing needs, and projected outcomes if funding were reduced. Given the shifting focus and proposed changes to many federal programs within HRSA and the CDC, this question has particular relevance when trying to determine what effect if any federal funding changes will have at the local level.

Percent of annual support coming from city/state/federal grants:

Range: 0%-75%

3 sites: 0-10% government grant funding
1 site: 20% government grant funding
1 site: 50% government grant funding
2 sites: 75% government grant funding

Federal Funding sources:	*2002 Funding Requests* Projections	% Change
HOPWA (HUD)	$277 million	7.8% increase
Emergency shelter funding (HUD)	$1.123 billion	no change
Ryan White funding	$1.81 billion	no change
Health Care for the Homeless	$111.8 million	11.8% increase
CDC	$3.96 million	4.0% decrease
-HIV/AIDS Prevention	$1.07 million	2.3% increase
SAMHSA	$2.96 billion	3.4% increase
Bureau of Primary Health Care	$1.45 billion	9.5% increase
-Health Centers	$1.29 billion	10.6% increase
FEMA	$140 million	no change

Projected outcomes if funding cuts occur

No change in federal grant amounts:…….No change in services or staffing
10% reduction in federal grants…….20% staff reduction
10-50% reduction in client services
25% reduction in federal grants……25% -50% staff reductions
10-66% service reduction

These findings are notable for two significant reasons. First, the majority of sites rely heavily on government grants for core and vital services. More importantly, at least for the next fiscal year, key programs that support these core activities do not appear to be slated for cutbacks in the proposed 2002 budget requests. The caveat to this is that with demand increasing within the populations being served, will there be adequate resources to meet increased demand, particularly in future fiscal years when there is no budget surplus and greater political demands on limited resources? Second, is it appropriate to be relying on grant support to cover the costs associated with caring for this population as opposed to expanded Medicaid coverage, enrollment, and reimbursement?

Conclusions

The data presented in this report represent a snapshot of the needs of our city's most vulnerable populations and how those needs are being met. The findings here are unique in that they take three different perspectives on this issue: from the client, the provider, and the site director. Several unifying themes emerge from this study:

- The service needs of the people accessing safety net sites are immense, cover a spectrum of health and social service issues, and very dependent on the capacity of these sites to provide care.

- The services provided by these safety net organizations represent an alternative to the barriers to care experienced by over half of those individuals surveyed. It is far too easy to fall through the cracks in our current system of care.

- The lack of health insurance, despite what appears to be large numbers of potentially eligible persons, is a common denominator in the barriers and obstacles clients encounter in accessing health services.

- Safety net sites are playing a crucial role in coordinating the spectrum of service needs and personalizing the care being received by vulnerable and traditionally disenfranchised persons. The status of their clients is fragile at best.

- These organizations rely heavily on government grant support for the services they provide. By this analysis, this funding appears safe at this juncture. However, as need increases it will be critical to ensure that financial support not be compromised. Whether alternative or more stable funding streams need to be explored is an issue for future policy debate.

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