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# **Baltimore Safety Net Access-to-Care Survey 2004**

**Baltimore REACH  
Community Health Consortium**

and

**Open Society Institute–Baltimore  
Program on Medicine as a Profession**

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**Baltimore REACH**  
**(Research, Education, Advocacy, Community Health)**  
**A Consortium Promoting Social Justice and Community Health in Baltimore**

The Baltimore Community Health Consortium, Baltimore REACH, began in 2000 as an initiative of the Open Society Institute. Recently Baltimore REACH became an independent corporation dedicated to Baltimore and services to the vulnerable populations that reside in the city. REACH represents eight community-based safety net organizations that provide medical and social service assistance to low income Baltimore residents. Baltimore REACH gauges access to care among Baltimore's low-income and indigent residents, identifies barriers to needed medical care and social services, and provides a foundation to bring assistance into the realm of indigent care services.

Baltimore REACH current membership is: Beans and Bread Outreach Center, Chase Brexton Health Services, Franciscan Center, Health Care for the Homeless, Health Education and Resource Organization, Paul's Place, St. Michael's Outreach Center and The Shepherd's Clinic. Baltimore REACH works to provide for the health care needs of the underserved urban poor by building a network of service providers. Additionally REACH sponsors health care professional students to work at the above providers.

Professionals from these agencies have developed placement sites, a mentoring program and have supported the social research projects for summer interns in an effort to bring more professionals into the arena of indigent care. Baltimore REACH has received national recognition with its Baltimore Safety Net Access-to-Health Projects, research conducted to evaluate the barriers to health care as well as the degree of uninsured among the urban poor. The U.S. Department of Health, National Public Radio, Associated Press, the Maryland state delegation and the Journal of General Internal Medicine, among others, have cited the research conducted by Baltimore REACH.

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## **Executive Summary**

For the fourth consecutive year, medical students participating in the Baltimore REACH/OSI-Medicine as a Profession summer internship surveyed Baltimore City residents who were accessing care at eight community clinics and resource centers throughout the city. The sample represents a cross-section of an urban poor population living at or below the federal poverty level and often in the context of significant and substantial physical and mental health disabilities while trying to achieve employment, raise and support a family, and secure safe and affordable housing. This survey provides a glimpse into how they survive day-to-day, the barriers and obstacles to care that they experience, their needs, both met and unmet, and the role being played by the community “safety net”. This year’s survey focuses on what has changed over the past four years for this population: what are their current needs; how are those needs being met; what obstacles remain or have grown; and how is our system of public and privately supported assistance responding to the challenge?

### **Survey Findings**

- The average age of respondents was 45.7 years; 75.8% were African American, 57.7% male, 42.7% were homeless, and the average annual income was \$9,498. Overall, 26.5% were employed in some capacity, 58.7% had at least a 12<sup>th</sup> grade education, and 25.5% were primary caregivers to children in their household.

This year’s sample is notable for very little change in age, gender, race, employment or education levels. Substantially more individuals report living in apartments or homes compared with four years earlier (54.2% vs. 40.3%) and the average annual income is higher than that reported for both 2002 and 2003, but still at or below poverty level for most adults.

- 77.8% of respondents reported having a chronic medical condition and 52.4% reported a chronic mental health condition; 75.2% reported they had been prescribed medication that they are supposed to be currently taking which is up substantially over the past four years. The proportion reporting chronic medical conditions, including hypertension, asthma or other respiratory conditions, and arthritis all increased over the past four years, while the proportion reporting HIV/AIDS and hepatitis has remained constant at approximately 20%.
- This year, 44.1% of respondents reported that they currently were without any form of health insurance. Those with coverage typically were enrolled in medical assistance/Medicaid with very few covered by private health insurance. The proportion without health insurance has consistently gone down over the past four years from 59.5% in 2001 to 44.1% this year. This change has predominantly been due to increased public health insurance enrollment (medical assistance/Medicaid). Slightly over half of all respondents (55.5%) reported they had been without health insurance at some point in the past two years; those experiencing periods uninsured were typically without coverage for long periods. The average time without coverage over the past two years was 19.4 months.
- Individuals continue to report significant hardship and adverse consequences to being without health insurance coverage. Two thirds of respondents (66.7%) reported they had to go to an emergency department instead of a primary care

center while waiting for their medical assistance to be processed; 43.3% reported they had to stop taking a prescribed medication and 41.8% reported they become more ill.

Most concerning is that all levels and types of care were reportedly more difficult to access now compared with four years ago, with the cost of care being the primary impediment. In 2004 40.2% reported difficulty accessing primary care and 39.8% difficulty accessing specialty care, compared with 22.2% and 13.3% respectively in 2001. This difficulty was most pronounced for dental care where now almost 60% of respondents reported they could not get care when needed compared with 28.6% in 2001.

- Medical debt continues to be a significant issue for a majority of respondents. 53.6% reported having a current medical debt in 2004 which is essentially unchanged from 2003. However, the debt load is now approaching almost \$5,000 per person up from \$3,409 in 2003.

On a positive note, over half (50.4%) of respondents reported receiving discounted or free care from their medical provider in 2004 compared with just 29.7% in 2003. The proportion reporting assistance from family or friends also went up while those reporting they had to stop taking medications or going to a doctor was essentially unchanged at 39.7%.

## **Conclusions and Recommendations**

The face of urban poverty in Baltimore appears to reflect more people living with chronic illnesses and requiring medications compared with four years ago. Clients accessing the urban safety net agencies used in this survey were, for the first time, more likely to be living in an apartment or house instead of being homeless. This suggests that it is getting harder and not easier to be poor and get by in Baltimore.

These data also suggest that financial obstacles to receiving timely and appropriate care continue and grow for the urban poor of Baltimore City despite increased enrollment and access to public health insurance programs. While the provision of free and discounted care has gone up, it has not kept pace with the costs of accessing all forms of health care and the growing gaps in health insurance coverage.

- We need to hold the entire health system accountable to what they charge and how they bill low income and poor residents;
- Efforts to aggressively enroll eligible clients in medical assistance need to continue and to grow; at the same time, efforts to streamline the application process and reduce waiting periods are needed to avoid the undue and needless suffering that is taking place; and,
- We need to view these findings in the context of a bigger picture of urban poverty, the need for a universal living wage, and the increasing need to accommodate disabling and chronic conditions in our society without sentencing the individual to a life of poverty in the process.

## Overview

260 Baltimore residents accessing health care and social services at one of eight community agencies were surveyed this summer as part of the Baltimore REACH/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 and others for their care
- Describe how individuals navigate the health care system and manage medical needs and expenses when without health insurance
- Compare findings with the same survey administered at the same Baltimore sites over the past four years to identify trends in need and capacity

## **Survey Methods**

A face-to-face survey was administered to clients accessing care at eight “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 Baltimore REACH community health consortium and supported by the Open Society Institute Medicine as a Profession initiative for medical students between the first and second years of medical school. This is the fifth and final year of foundation support for this program which has been assumed by the Baltimore REACH consortium. 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

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

Beans and Bread Outreach Center  
*Fells Point*

Health Education and Resource Organization  
*Downtown Baltimore*

Chase Brexton Health Services  
*Mount Vernon/Downtown*

Paul's Place  
*Pigtown/Washington Village*

Franciscan Center  
*Greenmount/East Baltimore*

St. Michael's Outreach Center  
*Upper Fells Point*

Health Care for the Homeless  
*Downtown Baltimore*

The Shepherd's Clinic  
*North Avenue/Downtown*

## Soros Summer Interns

Deepti Agarwal  
*SUNY Stony Brook School of Medicine*

Marc Callender  
*Johns Hopkins University School of Medicine*

Ariel Green  
*Johns Hopkins University School of Medicine*

Paulette Grey  
*Johns Hopkins University School of Medicine*

Stephanie Pope  
*University of Maryland School of Medicine*

Julie Story  
*Johns Hopkins University School of Medicine*

## Survey Respondents: what are their health and social service needs and where do they go for health care?

### Demographics

The average age of respondents was 45.7 years, 75.8% were African American, 57.7% male, 42.7% were homeless, and the average annual income was \$9,498. Overall, 26.5% were employed in some capacity, 58.7% had at least a 12<sup>th</sup> grade education, and 25.5% were primary caregivers to children in their household.

Average age	45.7 years
Race (African American)	75.8%
(white)	17.3%
Gender (male)	57.7%
Current living arrangement: apartment/house	54.2%
homeless	42.7%
< 12 <sup>th</sup> grade education	41.3%
Annual income	\$9,498
Currently employed	26.5%
Reasons for being unemployed	
Poor health (major/most important reason)	54.3%
% with children < 18 (primary caregiver)	25.5%

This year's sample is notable for very little change in age, gender, race, employment or education levels. Substantially more individuals report living in apartments or homes compared with four years earlier (54.2% vs. 40.3%) and the average annual income is higher than that reported for both 2002 and 2003, but still at or below poverty level for most adults.

	2001	2002	2003	2004
Age	40.2 years	44.0 years	40.6 years	45.7 years
Race (African American)	83.5%	77.0%	72.3%	75.8%
Gender (male)	65.7%	54.4%	57.9%	57.7%
Education (< 12 <sup>th</sup> grade)	46.0%	40.0%	42.3%	41.3%
Employed	24.2%		24.6%	26.5%
Average annual income	\$12,500	\$7,864	\$7,914	\$9,498
Live in apartment/house	40.3%	49.3%	47.8%	54.2%

### Health Care and Social Service Needs

77.8% of respondents reported having a chronic medical condition and 52.4% reported a chronic mental health condition; 75.2% reported they had been prescribed medication that they are supposed to be currently taking which is up substantially over the past four years. The proportion reporting chronic medical conditions, including hypertension, asthma or other respiratory conditions, and arthritis all increased over the past four

years, while the proportion reporting HIV/AIDS and hepatitis has remained constant at approximately 20%.

% with a chronic medical problem	77.8%
Top five conditions	
Hypertension	37.5%
Musculoskeletal problem	35.2%
Asthma/Chronic respiratory condition	24.5%
Hepatitis B/C	19.9%
HIV/AIDS	19.2%
% with a chronic mental health problem	52.4%
Top three conditions	
Depression	40.6%
Anxiety disorder	34.3%
Bipolar disorder	26.3%
% currently prescribed medication	75.2%
% unable to afford medications	16.0%
Current needs (top five)	
Housing assistance	62.4%
Food assistance	57.5%
Financial assistance with outstanding bills	49.8%
Transportation assistance	46.0%
Social support	34.1%

	2001	2002	2003	2004
Chronic medical condition	78.2%	78.8%	70.1%	77.8%
HTN	27.0%	31.0%	25.6%	37.5%
Respiratory		21.2%	21.6%	24.5%
Musculoskeletal	29.0%	29.6%	22.6%	35.2%
Hepatitis	23.8%	21.2%	22.6%	19.9%
HIV	38.3%	18.2%	20.2%	19.2%
Mental health condition	47.6%	50.7%	43.1%	52.4%
% with prescribed medications	68.1%	58.8%	66.6%	75.2%

### **Managing Medical Expenses without Insurance**

This year, 44.1% of respondents reported that they currently were without any form of health insurance. Those with coverage typically were enrolled in medical assistance/Medicaid with very few covered by private health insurance. The proportion without health insurance has consistently gone down over the past four years from 59.5% in 2001 to 44.1% this year. This change has predominantly been due to increased public health insurance enrollment (medical assistance/Medicaid). Slightly over half of all respondents (55.5%) reported they had been without health insurance at some point in the past two years; those experiencing periods uninsured were typically without coverage for long periods. The average time without coverage over the past two years was 19.4 months.

% currently with no health insurance	44.1%
% uninsured during past 2 years	55.5%
# months uninsured in past 2 years (average)	19.4 months

	2001	2002	2003	2004
% with no health insurance	59.5%	53.6%	47.1%	44.1%

Individuals continue to report significant hardship and adverse consequences to being without health insurance coverage. Two thirds of respondents (66.7%) reported they had to go to an emergency department instead of a primary care center while waiting for their medical assistance to be processed; 43.3% reported they had to stop taking a prescribed medication and 41.8% reported they become more ill.

While waiting to get enrolled in medical assistance	
Became more ill	41.8%
Had to go to an ER instead of a doctor's office	66.7%
Did not take prescribed meds/couldn't afford	43.3%

On a positive note, over half (50.4%) of respondents reported receiving discounted or free care from their medical provider in 2004 compared with just 29.7% in 2003. The proportion reporting assistance from family or friends also went up while those reporting they had to stop taking medications or going to a doctor was essentially unchanged at 39.7%.

During periods of time without health insurance, how did you manage medical expenses:	
Family/friends helped out	26.2%
Church/charitable group helped out	14.2%
Received free/discounted care from provider	50.4%
Stopped taking medications or going to MD	39.7%
No medical needs	25.5%

### **Difficulty Access Health Care Services in Baltimore**

Most concerning is that all levels and types of care were reportedly more difficult to access now compared with four years ago, with the cost of care being the primary impediment. In 2004 40.2% reported difficulty accessing primary care and 39.8% difficulty accessing specialty care, compared with 22.2% and 13.3% respectively in 2001. This difficulty was most pronounced for dental care where now almost 60% of respondents reported they could not get care when needed compared with 28.6% in 2001.

Unmet health care needs/Cost of care kept you from receiving that type of care	
Primary care	40.2%
% for whom cost was primary obstacle	52.4%
Specialty medical care	39.8%
% for whom cost was primary obstacle	60.6%
Dental care	58.2%

% for whom cost was primary obstacle Mental health treatment	73.0%
% for whom cost was primary obstacle Substance abuse treatment	29.9%
% for whom cost was primary obstacle Prescription medications	51.3%
% for whom cost was primary obstacle	26.8%
	48.6%
	41.0%
	68.2%

	2001	2002	2003	2004
% with difficulty accessing:				
Primary care	22.2%	13.9%	27.6%	40.2%
Specialty care	13.3%	15.0%	22.9%	39.8%
MH care	6.9%	10.2%	17.2%	29.9%
SA tx	7.7%			26.8%
Dental care	28.6%	30.0%	40.7%	58.2%
Rx drugs	18.5%	15.0%	29.3%	41.0%

### **Medical Debt**

Medical debt continues to be a significant issue for a majority of respondents. 53.6% reported having a current medical debt in 2004 which is essentially unchanged from 2002. However, the debt load is now approaching almost \$5,000 per person up from \$3,409 in 2003.

% with a current medical debt	53.6%
Average debt load per person	\$4,621
Reported debt range	\$10 - \$56,000

	2001	2002	2003	2004
% with medical debt		45.9%	53.2%	53.6%
Ave medical debt		\$3,409	\$8,655	\$4,621

### **What Has Changed in the Past Four Years?**

Compared with four years ago, how would you compare your health:	
Better	30.0%
About the same	35.6%
Worse	34.4%
Compared with four years ago, how would you describe your ability to get health care when you needed it	
Better	31.8%
About the same	48.2%
Worse	20.0%

## 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. 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.

Finally, the inter-year comparisons are subject to several potential biases that also limit its interpretation. As we are comparing cross-sectional anonymous surveys, we cannot control for the influx or efflux of clients at a particular site. Nor can we comment on longitudinal changes that may have occurred for individual clients over time. While the inter-year comparisons are limited to questions that have stayed constant over time, inter-observer bias within each cohort of student interviewers may have affected our findings. Also, some sites included in earlier surveys were not included in the 2004 survey. Specifically, Mattie B. Uzzle and New Song were not included in this year's survey. However, the consistency in core population demographics between years suggests that this bias may be minimal.

## Conclusions

This year's survey of urban poor adults accessing safety net sites in Baltimore City identifies both encouraging and discouraging indicators by which to measure our city's capacity to care for its most needy. These findings likely reflect the combination of both how well or poorly the system for caring for the poor is operating as well as external forces defining poverty and avenues out of it.

The face of urban poverty in Baltimore appears to reflect more people living with chronic illnesses and requiring medications compared with four years ago. Clients accessing the urban safety net agencies used in this survey were, for the first time, more likely to be living in an apartment or house instead of being homeless. This suggests that it is getting harder, not easier, to be poor and to get by in Baltimore. Placing these findings in the context of broader economic indicators, the wage scales that are typically available to low-skilled workers, and the paucity of benefits typically associated with these jobs is important. These data likely also reflect the successes being achieved by safety net providers in securing more stable housing to homeless and near homeless adults and families.

While it is very encouraging to see the proportion of individuals with publicly financed health insurance increase over the past four years, the data also show that this alone is not enough to ensure access to timely and affordable health care. Financial obstacles to receiving timely and appropriate care continue and grow for the urban poor of Baltimore City and are reflected in increasing proportions reporting they cannot gain access to primary care, specialty care, mental health and substance abuse treatment, and prescription drugs. The growing gap is most apparent for dental care where almost 60% of respondents reported obstacles to timely access. While the provision of free and discounted care has gone up, it has not kept pace with the costs of accessing all forms of health care and the growing gaps in health insurance coverage.

## Recommendations

Based on these findings, we make the following recommendations:

- We need to hold the entire health system accountable to what they charge and how they bill low income and poor residents. Non-profit status and not paying taxes need to mean something in this city and should be reflected in proactive policies towards care to the poor un- and underinsured;
- Efforts to aggressively enroll eligible clients in medical assistance need to continue and to grow; at the same time, efforts to streamline the application process and reduce waiting periods are needed to avoid the undue and needless suffering that is taking place; and,
- We need to view these findings in the context of a bigger picture of urban poverty, the need for a universal living wage, and the increasing need to accommodate disabling and chronic conditions in our society without sentencing the individual to a life of poverty in the process.

## Acknowledgements

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## Appendix

The following is a list of Baltimore REACH Publications:

*The Baltimore Safety Net Access to Care Survey: years 2001; 2002; 2003; 2004*  
Reprints available at [www.soros.org](http://www.soros.org)

*The Urban Healthy Net - Can It Keep People Healthy and Out of the Hospital.*  
"Journal of Urban Health": Bulletin of the New York Academy of Medicine, 2004; Vol. 81, No. 2: 179-190

*Medical Debt and Aggressive Debt Restitution Practices: Predatory Billing Among the Urban Poor.* "Journal of General Internal Medicine", 2004; Vol. 19: 772-778