Baltimore Safety Net Access-to-Care Survey 2003

Navigating the health care system without health insurance: An uphill battle

Community Health Consortium of Baltimore

and

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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The Community Health Consortium of Baltimore

Community Health Consortium of Baltimore is a network of health and social service agencies in Baltimore committed to educating health professional students from around the country to the needs of vulnerable and disenfranchised populations and promoting an articulation of professional values through community service and advocacy.

The Community Health Consortium of Baltimore mission is to provide service-learning experiences for students through a network of community based providers that introduce students to multi-disciplinarian approaches to health care, the social aspects of medicine, and the needs of the underserved urban poor. The CHCB network of service providers represents the disciplines necessary to meet the total needs of the client while fostering collaborations that improve their quality of life. The network supports and facilitates research and advocacy efforts that lead to a community response and successful impact on these issues.

Member organizations:

- **Beans and Bread Outreach Center/Frederick Ozanam House**
- **Chase Brexton Health Services**
- **Franciscan Center**
- **Health Care for the Homeless**
- **Health Education and Resource Organization (HERO)**
- **Mattie B. Uzzle Outreach Center**
- **New Song Health Center/Eden Jobs**
- **Paul's Place**
- **Shepherd's Clinic**
- **St. Michael's Outreach Center**

Executive summary

Baltimore residents accessing care at ten community clinics and social service centers in the city were interviewed during June and July, 2003 as part of the Community Health Consortium of Baltimore/Open Society Institute–Baltimore Medicine as a Profession initiative. The intent of the survey was to describe how low income individuals manage their health care needs, particularly without health insurance.

Survey Findings

- The average age of respondents was 40.6 years; 72.9% were African American, 57.1% male, 52.2% were homeless, and the average annual income was $7,908, well below the poverty level. 32.2% were currently caring for dependent children.

- Overall, 70.1% of respondents reported having a chronic medical condition, 43.1% reported a chronic mental health condition, and 66.6% reported they were currently supposed to be taking a prescribed medication. Of note, 35.4% reported suffering from depression, one in four had hypertension, and 20.2% had HIV/AIDS.

- While 47.1% were currently without health insurance, 82.6% had experienced recently episodes of being uninsured. When asked how they managed medical expenses during periods of time when they did not have health care coverage, 42.7% reported they stopped taking medications or going to the doctor, 29.7% reported their health provider charged less or provided free care and 12.2% reported that family or friends helped with medical costs. Only 12.6% reported that they did not have any medical needs during those episodes without health insurance.

- 32.9% of respondents reported that they had to wait four weeks or less to receive medical assistance once they applied; 36.5% reported waiting one to three months and 24.3% reported waiting times from four months to over one year. While waiting for their medical assistance application to be processed, 43.7% reported they went to an emergency department for care instead of a doctor's office or clinic; 32.1% stopped taking prescribed medications because they could not afford them; and 21.4% became more ill because they could not get care when they needed it.

- Overall, 53.2% of respondents reported they currently owed money for health care they had received. The average medical debt among those owing money was $8,655, which is both more than the average annual income reported in this survey and substantially higher than the 47.2% reporting a medical debt averaging $3,409 in 2002.

- When seeking health care, most reported going to a community clinic (62.0%) where 66.8% reported receiving free or discounted care and 17.9% received no help with their bill. In contrast, 56.4% went to an emergency department for care where 22.6% received free care or discounted care, and 66.1% received no financial counseling or assistance. 38.3% went to hospital-based clinics where 30.7% received free or discounted care and 32.6% reported going to a private physician's office where 32.0% received free or discounted care.

- "Safety net" organizations that provide the bulk of care to this population 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 a 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, gaps in coverage, 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 discussed.

Overview

297 Baltimore residents accessing health care and social services at one of ten community agencies were surveyed this summer as part of the Community Health Consortium of Baltimore/Open Society Institute–Baltimore Medicine as a Profession initiative. The focus of the survey was to identify respondent needs and barriers to care, along with issues associated with accessing care while without health insurance and enrolling in medical assistance.

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. 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 those entities receiving public funding accountable 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
- Describe how individuals without health insurance navigate the health care system and manage medical needs and expenses

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 conducted the survey.

The survey itself was developed with direct and ongoing input from the Community Health Consortium of Baltimore board of directors. 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 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-long seminars on professionalism and worked full time at the community organization in a staff context.

Participating community organizations

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

Beans & Bread Outreach Center
Fells Point

Chase Brexton Health Services
Mount Vernon/Downtown

Franciscan Center
Greenmount/East Baltimore

Health Care for the Homeless
Downtown Baltimore

Health Education and Resource Organization (H.E.R.O.)
Downtown Baltimore

Mattie B. Uzzle Outreach Center
Collington Square/East Baltimore

New Song Health Center/Eden Jobs
Sandtown-Winchester

Paul's Place
Pigtown/Washington Village

Shepherd's Clinic
North Ave./Downtown

St. Michael's Outreach Center
Upper Fells Point

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Survey respondents: who are they and what are their health and social service needs?

Demographics

The average age of respondents in this survey was 40.6 years. Overall, 72.3 % were African American, 57.9% male, 52.2% reported being homeless at the time of the survey and 42.3% had less than a 12th grade education. A total of 24.6% of respondents were currently working, and of those working; 38.9% worked fulltime, 34.7% worked in temporary or odd jobs and 26.4% were in part-time employment. The average annual income among the 67% of respondents who reporting having one, was $7,914 per year, well below the poverty level for a single adult. Overall, 32.2% reported they were currently caring for dependent children.

Health Care and Social Service Needs

Overall, 70.1% of respondents reported having a chronic medical condition, 43.1% reported a chronic mental health condition, and 66.6% reported they were currently prescribed medication. The ten most commonly reported conditions were:

Depression	35.4%
Hypertension	25.6%
Hepatitis B or C	22.9%
Chronic arthritis	22.6%
Asthma or other lung conditions	21.6%
HIV/AIDS	20.2%
Anxiety disorder	17.8%
Bipolar disorder	11.8%
Diabetes	8.1%
Heart disease	7.0%

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

Housing assistance	57.9%
Food assistance	51.5%
Financial assistance with outstanding bills	46.1%
Transportation assistance	44.8%
Education or literacy programs	34.7%

Who has health insurance, what did they have to go through to get it, and what happens when they are without coverage?

Managing medical expenses without insurance

Over half (52.9%) reported that they currently had health insurance, typically Medical assistance coverage, and 45.7% reported receiving pharmacy assistance for their prescription drug needs. However, 82.6% of respondents also reported that they had experienced recent episodes of being uninsured. When asked how they managed medical expenses during periods of time when they did not have health care coverage, 42.7% reported they stopped taking medications or going to the doctor. 29.7% reported that their health provider charged less or provided free care and 12.2% reported that

family or friends helped with medical costs. Only 12.6% reported that they did not have any medical needs during those episodes without health insurance.

Delays in applying for medical assistance

While 32.9% of respondents reported that they had to wait four weeks or less to receive medical assistance once they applied, 36.5% reported waiting one to three months and 24.3% reported waiting times four months to over one year. Of note, only 7.8% of respondents reported seeking legal assistance to get benefit coverage. While waiting for their medical assistance application to be processed, 43.7% reported they went to an emergency department for care instead of a doctor's office or clinic, 32.1% reported they stopped taking prescribed medications because they could not afford them, and 21.4% reported becoming more ill because they could not get care when they needed it.

Financial accommodations by health care providers

When they did seek health care, most reported going to a community clinic (62.0%) where 66.8% reported receiving free or discounted care, while 17.9% reported receiving no assistance with their bill. Only one person (0.5%) reported they could not get an appointment or be seen because of no money or insurance. In contrast, 56.4% reported going to an emergency department for care where only 22.6% reported receiving free or discounted care, 66.1% reported receiving no help with their medical bill, and 4% reported they could not get seen because of no money or insurance. Hospital-based clinics were the next most commonly reported site accessed by 38.3% of respondents. Here, 30.7% reported receiving free or discounted care while 36.0% reported receiving no help with their bill and 2.6% reported they tried but could not get an appointment because of no money or insurance. Finally, 32.6% reported accessing a private physician's office where 32.0% received free or discounted care, 47.4% received no assistance with their bill and 10.3% tried but were unable to get an appointment because of no money or insurance.

Unmet health care needs

When asked whether they had any health-related needs that they were unable to obtain, dental care was most commonly cited (40.7%), followed by prescription medication (29.3%), primary medical care (27.6%), specialty medical care (22.9%), and mental health treatment (17.2%).

Medical debt

Overall, 53.2% of respondents reported they currently owed money for health care they had received. The average medical debt among those owing money was $8,655, which is higher than the average annual income reported in this survey. It is also notable that the percentage of respondents reporting a medical debt increased from the 47.2% reporting debt in 2002 with the debt load substantially higher than last year's average of $3,409.

What role are "Safety Net" community organizations playing in providing care to these individuals?

The most commonly reported reasons for accessing the "safety net" site where the interview took place were:

61.6% - Convenient time and location for the services
50.8% - Because of the way the staff treats them
47.5% - Affordability
47.2% - For a unique service provided at that site

The most commonly reported services being received at the "safety net" interview sites were:

Medical care	46.8%
Food assistance	41.1%
Case management	33.0%
Housing assistance	23.6%
Mental health care	20.2%

When asked how easy it would be to find another place if this site were not available, only 16.7% reported it would be very easy, compared with 24.0% who reported it to be somewhat easy and 58.3% reporting it as not at all easy.

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 the lack of health insurance, from being in medical debt, and because of a disjointed system of care that is ill-equipped to respond to the multiple medical and social service needs of this population. 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 from which to extract ourselves. The summary findings from this survey can be broadly grouped into three conclusions and recommendations:

We need to strengthen the urban Safety Net that cares for those most vulnerable and at risk

Urban poverty is associated with poor health and these data demonstrate how difficult it is for low income people living in Baltimore to access health care. Those sites that have developed a civic mission to care for these individuals need to be supported. Additionally, the urban safety net in Baltimore is not limited to a handful of clinics, faith-based institutions, and community organizations. A collective and coordinated effort that engages our area hospitals and health systems is needed. 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.

People need health insurance

These data demonstrate just how difficult it is to get care when you do not have health insurance coverage. Most distressing, it also documents the consequences of being ill without health insurance. These are costs that are borne not only by the person who is ill but also by society at-large. We see this in absenteeism and lost productivity at the workplace, increased health care costs because of the medical debts that cannot be re-paid, and a reliance on emergency departments because there is no where else to go when sick and without money. 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.

We need to invest in the potential of all Marylanders

Almost one third of those interviewed were taking care of children whose future potential is closely tied to their parents' ability to be healthy, employed, and productive. The most commonly reported need was housing assistance, followed by food assistance and help with bills. Poverty casts a long shadow, propagates within an underclass, and will not go away by itself. These data describe the consequences when someone drops out of high school, experiences an addiction, is unable to find anything more than odd jobs or part time employment and cannot get adequate health care. We need to view these health statistics as a barometer of social need and invest in family supports, workforce development, and economic security of our most vulnerable.

While these observations are not new, there is a greater sense of urgency to address them. Much of the progress made during years of economic prosperity along with completed and planned urban revitalization for Baltimore are tenuous at best and threatened by any deterioration in neighborhood conditions. Furthermore, our capacity to respond to growing needs has eroded dramatically with 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) We need health care coverage for all Marylanders.

Efforts to expand health care coverage and insurance to all Marylanders need to be aggressively pursued. Poor health has both a personal and societal cost as well as a ripple effect that goes unchecked and has generational effects. It is critical that we move beyond liberal or conservative politics and rhetoric and assume common sense policies that can address this growing crisis. 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. This is not a time to be cutting support to these critically needed programs and initiatives.

(2) We need to hold all health systems and health providers accountable to the care of indigent and low income 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. Greater access to financial counseling and assistance at emergency departments, hospital-based clinics, and physician offices needs to occur. Expanded ombudsmen services and city-mandated oversight of how these services are made available is needed.

(3) We need to secure and expand federal and state funding currently being relied upon by our safety net of providers.

Those sites that do provide care to largely uninsured and indigent populations need to supported by local, state and federal programs to ensure a viable "safety net" that reflects the spectrum of need in this population. 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 it cannot and should not be held hostage to other agendas.

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. 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 specific 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.

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

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