2015

Charm City Clinic 2015 Annual Report

Increasing health care access, improving lives

Charm City Clinic, Inc. is a 501(c)(3) non-profit organization founded by students and community leaders in East Baltimore.

Board of Directors
Charm City Clinic
1/1/2016

Who we are

Charm City Clinic, Inc. is a 501(c)(3) non-profit organization founded and operated by Baltimore medical, undergraduate, and graduate students in collaboration with community leaders in East Baltimore. Our goal is to reduce health inequities by helping East Baltimore residents to obtain and maintain access to high quality health care and other social services.

Charm City Clinic has served over 3500 individuals by providing them free preventative screenings for hypertension and diabetes and health insurance counseling. We provide longitudinal care to every patient who walks into our clinic and do everything that we can to improve their health and health care.

Mission Statement

PROVIDING SERVICES *TO*, *IN*, AND *FOR* THE COMMUNITY

Charm City Clinic's chief goal is to provide increased access to healthcare ***TO*** underserved residents of East Baltimore. CCC operates on the belief that there is something unsophisticatedly wrong about the poor health East Baltimore residents experience particularly since their neighborhood houses some of the nation's premier infrastructure.

Additionally, CCC recognizes that it operates ***IN*** a rich ecosystem of community activism and health care. Thus, it is essential to work with patients, community organizations, health systems and their programs to connect patients with affordable and sustainable quality care outside our clinic should they need it. Working this way also insures that our efforts will synergize with others in the community instead of duplicate them.

In addition to providing a valuable service to the underserved community, CCC also provides a place ***FOR*** community volunteers and local medical, nursing, public health, dental, and undergraduate students to develop themselves as conscientious and compassionate individuals. Each volunteer, whether they be a student or a physician, must recognize that patients are our most valuable teachers. It is absolutely essential to the healing process that genuine relationships are built with patients and thus priority will be given to developing cultural sensitivity and cross-cultural communication skills in each volunteer.

The services we provide our patients

To date, we have seen a total of approximately 3500 patients, in East Baltimore in receiving basic health care, and we are continuing to expand our program. Our services have included over 19,000 client interactions, ranging from telephone calls to clinic visits to home visits.

Screening and Counseling

Charm City Clinic's Preventative Health Program is devoted to screening for and identifying chronic conditions early and providing longitudinal care. We currently run a program that screens clients for hypertension, diabetes, and vision problems. In the future, we will expand services to include cholesterol panels as well.

This past year, we added behavioral counseling with motivational interviewing into the services that our screeners offer. This allows our clients to have access to support for their personal health goals, such as losing weight, changing their diet, quitting smoking, or abstaining from other drug or alcohol use. In the future, we hope to expand this program to enhance the continuity of the counseling.

We rely on the help of volunteers and volunteer physicians to conduct screening and health education. Patients found to have abnormal screening results are provided with counseling on ways to help prevent progression of chronic conditions. In addition, patients who receive screenings at the Charm City Clinic will be referred through the Clinic's Health Resource Center to be directed to appropriate longitudinal care.

Health Resource Center

We provide longitudinal care to every patient who walks into our clinic and do everything that we can to improve their health and health care. We work with each patient to identify health insurance programs offered by the State of Maryland and other entities and to assist in the process of enrolling and receiving care. Our clinic is open every Saturday from 12 to 5 PM and Tuesday from 6 to 9 PM.

Longitudinal Follow-up Care

We work with each client well beyond the initial meeting with the intent of finding long-term solutions to their problems accessing healthcare. During this initial visit, we work with every new client to create a plan for continued care that outlines immediate and long-term goals for our work together. Health Resource Center staff members then begin the follow up process in the few days immediately following the initial visit.

We have two primary aims when following up with clients:

1. **We recognize that each client's case is different and presents its own kinds of complications**. More often than not, it will take more than a single visit to our Health Resource Center to solve these kinds of problems. Moving from this recognition, we work with clients when it is convenient for them and take the time to work together toward addressing the problems that block or complicate their efforts to manage their health

2. **We aim toward long-term continuity with each client in order to build partnerships to solve problems related to healthcare access before they become crises.** For this crucial reason, we follow up with our clients regardless of whether their case demands that immediate action be taken. We aspire to get to know our clients well enough that our follow-up activities contribute to building a community-based network of support for addressing healthcare access problems.

We adapt our approach to our clients' different needs and living situations and make use a combination of phone calls, meetings at our Health Resource Center and throughout the neighborhood, and actions on clients' behalf to move toward meeting their needs.

By the numbers

The need in East Baltimore is great

	East Baltimore	Maryland
Median Household Income	$29,382	$70,545
Percentage below poverty line	29%	8.1%
Percentage below 50% of poverty line	14.3%	3.7%

In 2006, the Baltimore City Task Force on Emergency Room Crowding found that Maryland had the second-highest emergency room wait time in the US; lack of insurance and the inability to get a timely appointment with a primary care doctor were listed as major contributors. The task force recommended expanding access to primary health care (1). Another recent study reported a shortage of 150,000 primary care visits in Baltimore City (2), and the 2016 University of Wisconsin's County Health Rankings support this conclusion. Although Baltimore City has the fourth best (1051:1) primary care provider ratio in Maryland, Baltimore City ranks 20th in preventable hospital visits and 24th in health outcomes (out of 24 counties). Howard County, by contrast, has the lowest percentages of uninsured residents (8%) and ranks second highest for health outcomes (3). Expanding access to health care will help improve these outcomes.

In East Baltimore, poor access to health care has been shown to correlate with higher rates of hospitalization for chronic conditions such as asthma, hypertension, chronic obstructive pulmonary disease, congestive heart failure, and diabetes (6). According to the 2011 Neighborhood Health Profiles maintained by the Baltimore City Department of Health, the area immediately surrounding Charm City Clinic falls short of Baltimore City averages in a number of important healthcare-related metrics. Greenmount East, Madison/East End and Perkins/Middle East all rank at 40th or below out of 55 statistical neighborhoods in both average life expectancy and percentage of avertable deaths. Madison/East End had the second highest percentage of avertable deaths. Furthermore, cardiovascular disease is the leading cause of death in many Middle East Baltimore neighborhoods, including Greenmount East, Madison/East End, and Perkins/Middle East. These numbers are noticeably poorer than the averages from across Baltimore City (7-9).

150,000	Shortage of primary care visits in Baltimore City
58%	Percentage of East Baltimore residents who **lack health insurance**

94%	Percentage of East Baltimore residents who are African-American
32%	Percentage of East Baltimore residents who are under the age of 18
47%	Percentage of East Baltimore residents unemployed

There are tangible ways we can improve the situation

Existing data suggests that many families who are eligible for certain forms of government assistance do not take advantage of them either because:

- they lack information about how to apply,
- have difficulty navigating the complex web of medical resources and agencies

In a survey of East Baltimore residents, 95% thought that help with obtaining health insurance or with enrollment into cash assistance or other benefit programs would be helpful to them or someone they know.

Milestone and Accomplishments: Overview

Motivational interviewing added to health screening services.
In 2015, medical student volunteers at Charm City Clinic identified a need to provide in-depth counseling to clients regarding chronic health issues including smoking, addiction, nutrition, hypertension, and diabetes. Although these health issues were previously evident, and health screening volunteers were encouraged to discuss strategies for improvement with clients, there did not exist a structured system for providing and tracking counseling services. The clinical team of the auxiliary board provided training to health screening volunteers on the concepts and practice of motivational interview, and a field to track motivational interviewing was incorporated into our electronic medical records system to facilitate follow-up regarding the important issues.

Data collection for development of new services. We continued to collect in-house data on the blood pressures of clients during clinic visits. Only 19% of blood pressures taken fell within the normotensive range, whereas 24% of patients screened had either Stage 2 hypertension or hypertensive emergency requiring immediate attention. In addition to emphasizing the importance of longitudinal primary care and the necessity of the services that Charm City Clinic currently offers, these data provide motivation for new services. Based on the prevalence of severe hypertension in our clients, we have applied to a grant to implement direct patient assistance for hypertensive clients to support the costs of prescription copays, medical visit copays, and requirements for

transportation to medical appointments made through the services of Charm City Clinic and the Men and Families Center. These services will be implemented in the coming year.

Quality improvement initiatives. Our AmeriCorps staff members redeveloped our classification system for urgencies and emergencies to better triage patient follow-up as well as developing a Baltimore City resource distribution map that which has facilitated our community outreach efforts.

Increased client flow and demand for services. Charm City Clinic provided services to 696 unique clients in 2015, of whom 211 were enrolled in Medicaid. In addition, our longitudinal case management model allowing us to address clients' needs beyond that of health insurance. We continued to provide two fully operative clinic days per week (Tuesday from 6pm to 9pm and Saturday from 12pm to 5pm) with preventative health screening services in addition to the usual case management services.

Partnerships and expansion of services. Charm City Clinic partnered with Priority Partners on November 17th, 2015. Since then, Priority Partners has referred 37 clients to us for redetermination. Of the 14 clients appointment, and we were able to re-enroll 11 (80%) of those clients into Medicaid. Our case managers are following up with three clients still in the renewal process to overcome their barriers to redetermination, and to ensure that any needs beyond health insurance are addressed. We continue to receive referrals from Priority Partners and offer our longitudinal case management approach to ensure these clients obtain the benefits they deserve. In addition, of the 211 clients enrolled in Medicaid in 2015, 49 chose Priority Partners as their preferred

Increased staffing. In 2015, we entered an exciting partnership with Towson University's Department of Health Science, which offers a Community Health Internship as a capstone experience. In 2016, an intern from Towson University will work full-time at Charm City Clinic for a full semester, supporting development of community health plans and leading projects to promote the awareness of Charm City Clinic in the community. Our volunteer staff increased from 80 volunteers at the end of 2014 to over 130 volunteers at the end of 2015. Our full-time staff continues to include four members hired through the Americorps program: two of whom were hired through Public Allies, one through the Americorps VISTA, and one through Volunteer Maryland.

Increased client volume and expansion of clinical services. From June 2014 to June 2015, as we carried out our role in the community as an assister site for the Affordable Care Act expansion, our week-to-week client volume more than tripled, and our unique client population grew nearly 50%, from approximately 2,500 in June 2014 to approximately 3,500 in June 2015. In order to respond to this increased demand for our services, our clinic successfully doubled our availability for walk-in clinical services. In addition to our traditional Saturday clinic day, we have now also offered services on Tuesday evenings for over a year. Each of these clinic days is staffed with a volunteer

physician, medical students, and case managers. By offering services during non-traditional hours, we believe we have significantly expanded our accessibility.

Volunteers and Staffing

During weekly walk-in hours each Saturday from 11:30am - 5pm, Charm City Clinic is fully staffed with an average of 6 Health Resource Center (HRC) Volunteers, 4 medical students who conduct preventive health screenings, a clinic manager, the full time Program Director, and a board-certified physician volunteer. Case managers spend substantial time outside of clinic walk-in hours following up with their clients.

Volunteer Highlights

There has been an increasing number of our clients who were Spanish speakers. To better serve our clients, we have begun recruiting volunteers who are fluent in Spanish. We have also increased the number of volunteers this year reaching over 130 volunteer screeners and case managers. With the increase of volunteers, there had been an increase in the quality of service for our clients as well.

In addition to volunteers, we are currently working with four AmeriCorps members. These contributors are facilitated through the Public Allies (2 members), Vista (1 member), and Volunteer Maryland (1 member) program).

Executive Director: The Executive Director helps manage facilities, conducts strategic planning concerning funding and grant writing, and oversees the full-time staff members, who were hired through the Americorps program.

Americorps: Our staff includes our full-time staff members through the Americorps program: two of whom were hired through Public Allies, one through the Americorps VISTA, and one through Volunteer Maryland.

Auxiliary Board Teams: To maintain and manage the clinic, CCC has an Auxiliary Board with three main teams to provide support for our clients and staffs, as well as seeking potential funding sources for the clinic.

- **Clinical Team:** Coordinates the health care screening portion of the clinic by organizing volunteers, physicians and ensuring that documentation and clinic flow is effective and efficient.

- **Finance Team:** Manages all organizational finances, submits grants, and executes fundraising events.

- **Quality Improvement and Data Team:** Reviews the active clinic caseload on a weekly basis to ensure high quality care and coordination for clients with the most urgent medical need and complex social barriers. Also creates resources to improve the flow of the clinic

Financial Overview 2015

Revenue	**May 2014 - December 2015**
Fundraising Events	$2,184
Grants	$156,111
Contributions/Donations	$27,567
Income Total	**$186,961**

Expenses	**May 2014 - December 2015**
Salary/Staff	$99,392
Client Services	$47,596
Administrative Costs (cleaning, insurance, travel)	$6,030
Equipment/Supplies	$12,250
Utilities	$15,735

Miscellaneous	$8,106
Training	$4,846
Expenses Total	**$194,314**

Revenue Highlights

Grants:

Baltimore General Dispensary Foundation: $5,000

Health Care Access Maryland: $71,000

Jacob and Hilda Blaustein Foundation: $25,000

Johns Hopkins Alumni Fund: $1,000

Johns Hopkins Neighborhood Fund: $15,000

Johns Hopkins Urban Health Institute: $4,000

Kaiser Permanente: $10,000

Leonard and Helen R. Stulman Charitable Foundation: $25,000

Fundraising events:

Amazon Associates Program and Amazon Smile: $2,000

Charm City Happy Hour Mad River: $400

Medical Student Senate Fundraiser: $120

Ottobar Fundraiser: $500

Silent Auction: $115

Donations:

Associated Jewish Charities: $15,000

Engle Family Foundation: $500

Iggies: $200

Just Give: $150

Microsoft: $1,100

O'Melveny & Myers: $300

United Way: $3,500

United Way of Central Maryland: $1,700

Families and Individuals: $3,300

Expenditure Highlights

Client Assistance.
Throughout 2014 and 2015, we were able to provide over $47,000 in direct financial assistance to clients of Charm City Clinic. This assistant contributed towards obtaining identification documentation, medical visit and prescription copays, and transportation to medical visits arranged through Charm City Clinic.

Staffing and Support.
Charm City Clinic continues its staffing support alongside services and outreach provided. Salary for six staff including AmeriCorps members totaled approximately $57,000 in 2015.

Future Directions

Health Resource Counseling Teams

Starting in 2016, we will be implementing the Health Resource Counsellors Team System whereby each counsellor will be grouped in a team of 4 - 6. Each team will be working with the same clients, and each member will be paired up to counsel and do long term follow-ups with their clients

together. Each team will be led by a team leader, who will be responsible for volunteer support and accountability. Team leaders are also responsible for quality assurance - ensuring that chart notes and client interactions are of high quality and adhere to CCC's missions.

Longitudinal Client Pathways

Charm City Clinic has successfully developed and implemented two separate specialized training and curriculum programs, one for our health resource center and the other for our preventative health screening program. Each program works synergistically but somewhat individually. Clients who participate in our preventative health screening program are screened first, and any urgent and emergent health needs are identified. The client is then transferred to a case management team, who are briefed on the client's screening results and health-related priorities. The case management team follows the client longitudinally to ensure these needs are met.

We believe that our staff, our volunteers, and our clients would benefit from tighter collaboration between our case management and screening teams. We will be working towards raising fund for the "Longitudinal Client Pathways" program. The core value of the program is to improve the experience of staff, our volunteers, and our clients through tighter interprofessional collaboration and learning. In order to address the obstacles listed above, we hope to hire an additional full-time case manager through the Public Allies Maryland AmeriCorps program, through the University of Maryland School of Social Work. This staff member would be devoted to following a select group of clients with complex medical and social needs. This staff member's efforts would be supplemented by regular interaction with medical students who have also received case management training. This staff member would also leverage the "Neighborhood Navigators" outreach worker program. Direct follow-up efforts with the client would be carried out by our full-time Public Ally in collaboration with the outreach workers and our dually trained medical students. The students would regularly review these cases to help ensure that decisions related to follow-up efforts are supported by clinical insight as well as case management skill. By creating this environment of reciprocal knowledge-sharing, we hope to improve outcomes for high risk clients, while also creating a unique educational experience for both our medical student volunteers and our staff.

Direct patient assistance

Starting in 2014, we dramatically expanded assistance to our clients in three critical domains: (1) barriers related to identification documents, including state -issued photo IDs and birth

certificates; (2) costs for medications and co-pays for visits; and (3) costs for transportation to health care and social service appointments. This direct assistance benefitted more than 1,000 unique clients.

The overall capacity for this kind of support is severely deficient within the health and human services safety net in Baltimore, which exposes a profound contradiction and injustice in the organization of the care delivery system – especially in one of our nation's wealthiest states and amid a dense network of health and human services resources. It is often simple things, such as IDs, copays and transportation, which pose the most proximate barriers to accessing critical health care services. Unfortunately, due to recent statewide budget cuts, we have been forced to dramatically (but hopefully temporarily) scale back our direct patient assistance programs, beginning in August 2015. CCC has initiated new grant and fundraising efforts to restore and potentially expand our organization's ability to provide these types of assistance.

Expand neighborhood outreach and involvement

Neighborhood residents have played an integral role in project planning and client-finding throughout our organizational history. We seek to formalize their involvement in clinic activities to increase resource coordination knowledge among residents of low-income residential blocks. We aim to train, support, and provide incentives to at least 6 neighborhood "community health organizer" block captains during each year of funding. These individuals will be selected from our clients and low-income neighbors and will work specifically with their neighbors on and around their blocks and participate in case funding, monitoring needs, and follow-up. Our aim is to strengthen these individuals' capacity to support and supplement the relationships and informal care giving networks already in place in their neighborhoods. They will be the first point of contact helping ensuring that their neighbors can access needed resources as needs emerge in their everyday lives.

Data collection

As previously described, we are continuing to record blood pressures, and our data have motivated plans for new services for hypertensive clients that will be implemented in the upcoming year. We also plan to collect data and compile descriptive statistics for heart rate, respiratory rate, BMI and blood glucose to assess the severity and prevalence of cardiovascular disease and diabetes in our client population. We expect that these measurements will improve our current practices and inform the development of new initiatives that best serve the specific needs our clients.

Continued funding for Americorps volunteer through Public Allies Maryland.
We seek to use this funding to hire a full-time Americorps volunteer through Public Allies Maryland, a non-profit entity, for a second year. The efforts of the full-time volunteer will allow us to continue to expand our services.

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Acknowledgement

Charm City Clinic would like to thank the following groups and individuals for their contributions.

The board members of Charm City Clinic
Men and Families Center
Johns Hopkins School of Medicine
Leonard and Helen R. Stulman Foundation
Urban Health Institute
Sisters Together and Reaching
Sight Savers
Americorps

Public Allies
Civic Works
Baltimore General Dispensary Foundation
Dr. Leonard Feldman
Dr. Stuwart Ray
Dr. Khalil Ghanem
Dr. Jonathan Zenilman
Mr. Paul Gaddis
Mrs. Deborah Gaddis
Mr. Richard Rogers
Mrs. Lori Kaufman-Rogers
Ms. Pamela Bass-Bookey
Mr. Carl Streed, Jr.
Ms. Tiffany Saavedra
Mr. Bahir El-Diwany

MORE IMPORTANTLY

We would like to thank all of our volunteers for dedicating their time and effort to help improve the healthcare of the people in East Baltimore community. Without your support, we would not be where we are today.