National Association for State Community Services Programs

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A Community-Based Approach to Addressing the Causes and Effects of Poverty:

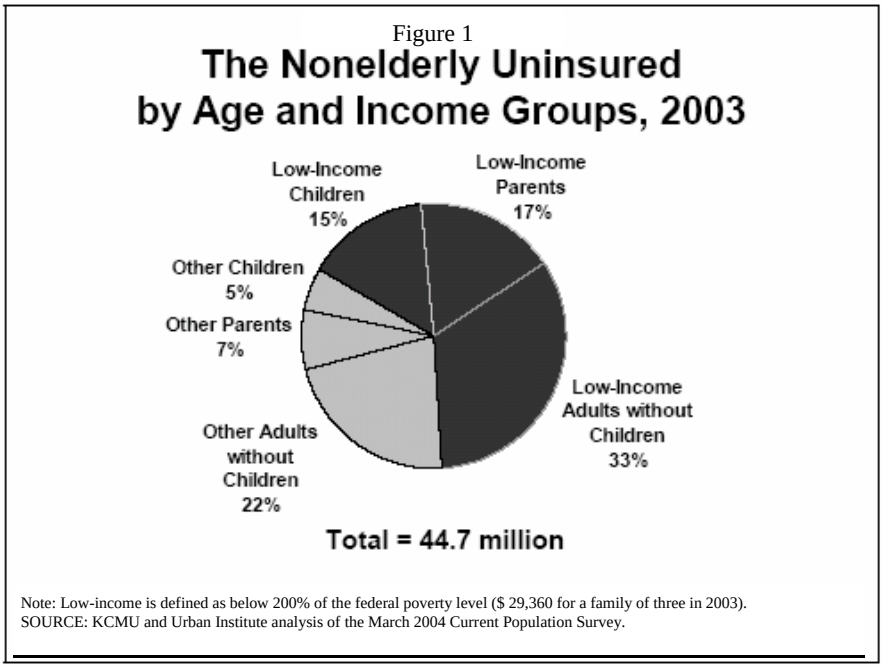
Community Action Agencies Provide Health Care

By Jovita Tolbert

Overview

According to a report by the Kaiser Commission on Medicaid and the Uninsured entitled *The Uninsured and Their Access to Health Care*, due to the economic downturn of 2001, family incomes along with employer sponsored health insurance have declined over the past four years. Consequently, in 2003, an astonishing 44.7 million non-elderly Americans lacked health insurance. Two-thirds of this uninsured population was comprised of low-income families (Figure 1).[1]

Figure 1



Note: Low-income is defined as below 200% of the federal poverty level ($ 29,360 for a family of three in 2003).
SOURCE: KCMU and Urban Institute analysis of the March 2004 Current Population Survey.

Additionally, many low-income individuals and families lack access to a health care facility. In a joint study, performed by the National Association of Health Centers and The George Washington University, it was found that "nearly one thousand poor counties lack a health center, accounting for almost a third of all US counties, and over half of all poor counties." The population within the boundaries of these poor counties averages 20 million people. More than two in five of them (42%) are low-income and more than 3 million of them are completely uninsured.[2]

400 North Capitol Street, NW, Suite 395, Washington, D.C. 20001
Phone: 202.624.5866 Fax: 202.624.8472 Email: nascsp@sso.org
Website: www.nascsp.org

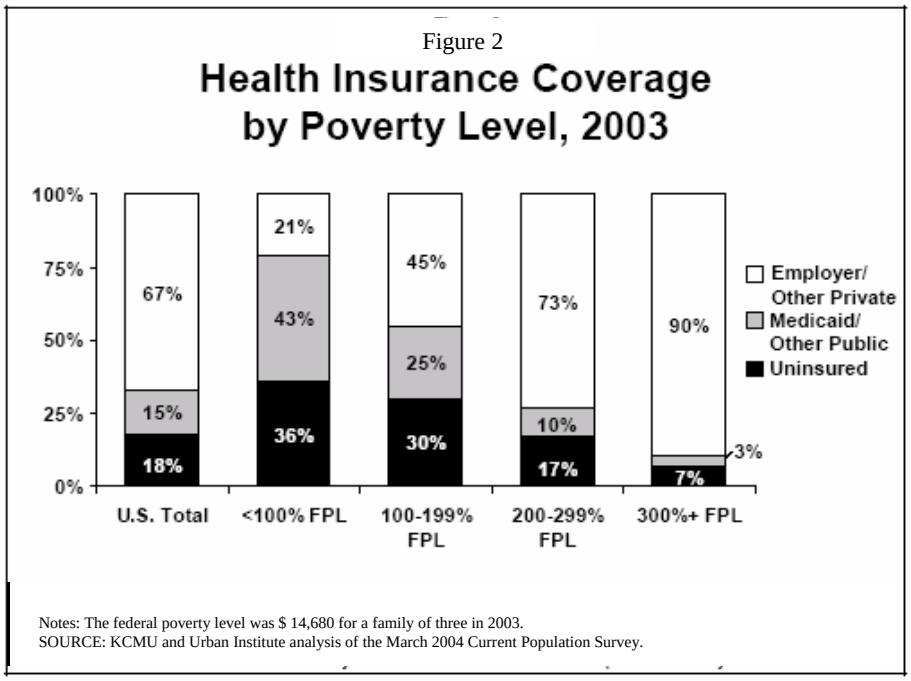
Introduction

Patterns and Causes of Disparities in Health, by David R. Williams, informs us that while medical care plays an important role in health, "better nutrition, sanitation and higher living standards are more important." Therefore, he concludes that, "socioeconomic deprivation and exposure to poor living and working conditions are central determinants of poor health for socially disadvantaged … low-socioeconomic status groups."[3] In their research entitled, *Promoting Population Health and Reducing Disparities*, Bruce G. Link and Jo C. Phelan's findings support Williams' research discovering that while "risk factors change from one period to another, socioeconomic status—which is associated with such risks at any single point in time—remains strongly related to health outcomes even as risk factors change." Link and Phelan further argue that social status is a more fundamental influence on health than risk factors because, regardless the risks, "persons with more resources, information, power, and useful networks are better able to marshal these resources to take advantage of what is known about preventing disease and maintaining health."[4]

Thus, in its report *Low-Income Working Families: Facts and Figures*, the Urban Institute found that despite the significant advances in the health care field, "health problems are more prevalent among low-income working families." In fact, "sixteen percent of full-time workers heading low-income families report fair or poor health, compared with 7 percent of workers in middle-income families." The report then goes on to state that "low-income adults working a moderate amount are even more likely to have health problems, with 25 percent reporting fair or poor health. Low-income families are also more likely than middle-income families to have a child in poor health."[5]

Furthermore, as stated earlier, low-income individuals and families either have unstable health coverage or lack health coverage at all (Figure 2).[6] This is because low-income workers are less

Figure 2



likely to be offered health insurance coverage through their job or their spouse's job and purchasing individual insurance often is not a practical option as they have high premiums or limited benefits.[7] As a result, many low-income individuals must choose between their health care needs and other essential needs such as food and clothing. Also, their unmet health needs often affect their job decisions, financial security, and ultimately, their quest for self-sufficiency. This in turn affects all of society as productivity decreases and disability increases and an increased burden on the health care system arises.[8]

Community Action Agencies Respond

The Community Services Network was born at the enactment of the Economic Opportunity Act (EOA) of 1964. This statute's aim was to eliminate the causes and consequences of poverty in the United States. To accomplish this goal, the Act established Community Action Agencies (CAAs), which are community-based anti-poverty agencies. In 1981, the program evolved to a block grant entitled the Community Services Block Grant (CSBG). The federal Department of Health and Human Services' (DHHS) Office of Community Services (OCS) allocates the CSBG to the states who in turn administer the CSBG to a network of CAAs. These agencies, which are the core of the Community Services Network, work to alleviate poverty on a community level.

Today, the Community Services Network is comprised of nearly 1,100 local, private, non-profit and public agencies that work to alleviate poverty and empower low-income families in communities throughout the United States. Most of these agencies are CAAs created through the EOA of 1964. The balance, included under the Community Services Block Grant, follow similar guidelines for structure and service. CAAs currently serve over 16 million low-income people yearly in 99 percent of the nation's counties.

According to Sec. 676 of the Community Opportunities, Accountability, Training, and Educational Services (COATES) Act of 1998, CSBG funds should be used "(1) to provide assistance to States and local communities, working through a network of community action agencies and other neighborhood-based organizations, for the reduction of poverty, the revitalization of low-income communities, and **the empowerment of low-income families and individuals in rural and urban areas to become fully self-sufficient** (particularly families who are attempting to transition off a State program carried out under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.)); and ''(2) to accomplish the goals described in paragraph (1) through—(C) **the greater use of innovative and effective community-based approaches to attacking the causes and effects of poverty and of community breakdown**."

Therefore, Community Action has developed a variety of innovative strategies to provide low-income individuals and families the quality health care services they need and deserve. Below are several examples of the innovative health services provided by CAAs, and an eligible entity receiving CSBG funds, around the United States.

Utah

The Community Action Agencies in Utah convened the state's first statewide summit on eliminating health disparities, involving 260 individuals from a broad cross-section of ethnic communities, policymakers, providers, and state health department officials. Out of this they

were able to launch a successful effort to install and fund a new Center for Multicultural Health (CMH) at the Department of Health. They also formed the Utah Multicultural Health Network, a mechanism for information sharing and networking around statewide efforts to eliminate health disparities. In its first two months of operation, the Utah Multicultural Health Network was able to correct Medicaid policy so that children of undocumented immigrants, who are citizens, now qualify for Medicaid coverage under the standard criteria. Utah CAAs use CSBG funds to support the administration of the programs they provide and as venture capitol to secure additional funding, new partnerships, and to provide self-sufficiency services to their communities.

Connecticut

In 2004, the Community Renewal Team, Inc. (CRT), a CAA which is located in Hartford, Connecticut and provides services to 31 counties in Connecticut, began the operation of a Behavioral Health Services Center after St. Francis Hospital and Medical Center was no longer able to run the intensive day treatment and outpatient program. Although CRT had not previously operated a behavioral health clinic, it quickly developed capacity, and is now a federally qualified community mental health center and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. CRT Behavioral Health Services program serves adults and adolescents with psychiatric conditions, chemical dependencies and dual diagnosis. Services include mental health diagnosis and assessment, medication management, counseling, crisis management, hospital discharge planning, hospital after care, therapy focused on goal settings, community reintegration and effective self expression and wrap around services are available for additional needs. The center is a fee-for-service program, meaning it must pay for expenses out of revenues generated, rather than being funded by a grant or contract. Program services are provided at St. Francis Hospital in Hartford, Connecticut. The program accepts State Administered General Assistance (SAGA), Medicare, Medicaid and Private Insurance. CSBG funds are used to identify, plan for, and leverage additional resources for the BHS program. Specific outcomes include better functioning, improved mental health. If someone has no insurance, the program will work with him or her to find an insurance program for which they qualify.

Hawaii

Kauai Economic Opportunity, Inc. (KEO) is located in Lihue, Hawaii and serves the county of Kauai, which is actually an entire island. In 2004, KEO was granted a contract with Ogilvy, a public relations firm, in conjunction with the federal government to conduct the Medicare Prescription Drug Discount Card and Transitional Assistant Enrollment Programs on the island of Kauai. These programs assisted low-income Medicare beneficiaries with prescription drug discounts and in certain cases gave Medicare beneficiaries up to $1,200 in credit for purchasing prescription drugs. Kauai Economic Opportunity, Inc.'s set a target of providing education and outreach to 600 customers and assistance with enrollment to 2700 customers. KEO's campaign exceeded these goals by reaching a total of 100,519 for education and outreach activities and 3,534 for assistance with enrollment. KEO was also able to enroll over 500 Medicare beneficiaries.

Louisiana

ASSIST Community Action Agency Inc., located in Crowley, Louisiana, serves four counties. Its Pharmaceutical Access Program provides over $1 million worth of free medication from national pharmaceutical companies to the low-income population of areas it serves at no charge. Since the costs of prescription medications are so high, ASSIST Agency, Inc.'s Pharmaceutical Access Program (PAP) was able to make a significant contribution to the available incomes of hundreds of low-income residents in its area. Qualifying customers had more income available to spend on other essentials because they received most of their medications at no charge from national pharmaceutical companies. Moreover, since ASSIST Community Action Agency is not able to reach all of the low-income people in its area, it has established a training program for individuals and/or other agencies so that they can also provide PAP services. This has facilitated the accessibility of affordable health care services to a larger number of low-income people in the communities served by this CAA. CSBG funds are used in the administration of the PAP.

Nebraska

Located in Kearny, Nebraska and serving 27 counties, Community Action Partnership of Mid-Nebraska administers a Child Abuse Resource and Education (CARE) Program. Recently, the agency added Active Parenting Classes to their CARE Program. The CARE program is the only consistent provider of parenting classes within the counties it serves. Agency staff work closely with the County District Courts to make sure their parenting classes reflect community needs. An example is their "Cooperative Parenting and Divorce" class. Before CARE began this program, parents would have to drive at least 74 miles to get a class similar to this. These classes have been very successful, as word of mouth has spread quickly through the courts, Health and Human Services, the SAFE Center, and other local agencies. The word has even spread to locations in five of the larger near by towns and as a result, enrollment continues to grow. CSBG funding is used to purchase materials for CARE parenting classes and the children, ages 1-18 years, who participate. In 2004, Community Action Partnership of Mid-Nebraska's CARE program assisted 1,903 children. CSBG funds used for the CARE Program help to pay the salary for the Child Abuse Resource Director. The Director is in charge of ensuring service to the 27 counties that the Community Action Partnership of Mid-Nebraska serves.

District of Columbia

The Spanish Catholic Center (SCC), a nonprofit social service agency of the Archdiocese of Washington in Washington, D.C., assists low-income, uninsured, limited English proficient immigrants in the areas of health, education, employment, immigration and social needs. Since its founding in 1967, the SCC has helped newly arrived immigrants, predominantly Hispanic/ Latinos, in the process of adaptation in the United States. Low-income and minority populations bear a disproportionate burden of dental disease and have a greater than average difficulty in accessing dental care services. These vulnerable populations experience significantly greater levels of untreated tooth decay and tooth loss. The SCC's Dental Care Education & Access Program seeks to improve awareness of and access to good oral health screenings on adults and children by preparing and disseminating culturally appropriate education materials,

both written and through the SCC's radio program. In FY-04, the dental clinic provided 7,300 services during 5,600 patient visits. Volunteers in the Dental Clinic included some 36 dentists, 7 dental hygienists, 13 dental and medical assistants and other health professionals who worked closely with full-time staff. All of the SCC's full-time staff in the medical and dental clinics are bilingual, making the SCC's clinics uniquely positioned to provide culturally and linguistically competent medical and dental care for the community residents who would have no other recourse for assistance. Since 1975, the dental program of SCC has improved the oral health care of low-income, minority populations, particularly the Latino population of Washington, D.C. This is accomplished by decreasing dental disease and improving knowledge of oral health through a program sensitive to the social, cultural, economic and other environmental factors which affect the immigrant community's oral health. CSBG funds totaling $35,714 partially support funding for several full-time positions.

Conclusion

Notably, CAAs work in conjunction with their community members and other community stakeholders to identify the needs of low-income individuals in the communities they serve. Once they identify the needs, they find innovative ways to provide the services needed. As noted in the *Community Services Network: Community Services Block Grant in Action* report which provides a look at data collected from the national CSBG Information Systems Survey, in 2004, CAAs worked with over 3 million low-income individuals who were uninsured and over 1.1 million low-income individuals who were disabled. Identifying the need for health related services, they spent over $24 million, almost 5 percent of their annual expenditures, to provide health care for their customers.

In fact, according to the *Annual Report of Performance Outcomes from the Community Services Block Grant Program*, in forty-three states, 314,114 accessible and affordable health care services/ facilities for low-income people were created or saved from elimination and in forty-one states, emergency medical care was provided to 84,686 households. Also, because of efforts of CAAs, 274,918 low-income infants and children in forty-five states obtained age-appropriate immunizations, medical, and dental care. For FY 2004, state and local agencies receiving CSBG funding set the performance target of providing immunization, medical, and dental care to 268,204 low-income individuals and families. They surpassed this target achieving 102.4 percent of their goal.

Recognizing the significant lack of access to health care coverage and primary health care services for low-income individuals as a cause and effect of poverty as well as a barrier to self-sufficiency, CAAs across the United States will continue to dedicate their efforts and resources to ensuring low-income individuals and families receive access to quality health care.

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[8] Kaiser Commission on Key Facts. "Medicaid and the Uninsured." The Henry J. Kaiser Family Foundation. Nov 2004, Online. <*http://www.kff.org/uninsured/loader.cfm?url=/commonspot/securitygetfile.cfm&PageID=49531*>

Agency Contact Information

Department of Community & Economic Development
Jonathan Hardy
Utah State Community Services Office, Director
(801) 538-8650
jhardy@utah.gov

Community Renewal Team, Inc.
Paul C. Puzzo
Executive Director
(860) 560-5601
paulp@crtct.org

Kauai Economic Opportunity Inc.
MaBel Ferreiro-Fujiuchi
Chief Executive Officer
(808) 245-4077
keo@keoinc.org

ASSIST Agency, Inc.
Sharon Clement
Executive Director
(337) 783-7550
assist@kaplantel.net

Community Action Partnership of Mid-Nebraska
Karen K. Lueck
Executive Director
(308) 865-5675
kklueck@mnca.net

The Spanish Catholic Center
Father Mario Dorsonville
Executive Director
(202) 939-2437

National Association for State Community Services Programs

400 North Capitol Street, NW, Suite 395, Washington, D.C. 20001
Phone: 202.624.5866 Fax: 202.624.8472 Email: nascsp@sso.org
Website: www.nascsp.org