



PRIMARY CARE
DEVELOPMENT
CORPORATION



NYC COUNCIL DISTRICT
PRIMARY CARE PROFILES

COUNCIL DISTRICT 42

PRIMARY CARE PROFILES: NEW YORK CITY COUNCIL DISTRICT

Primary care is the foundation of the health care system and a cornerstone of healthy, thriving communities. Increasing primary care access across New York City (NYC), as in other cities, is critical to creating healthy communities, ensuring health equity, and reducing health care costs. Primary care is often the first point of contact with the health care system and can prevent, identify, and treat illnesses as well as promote wellness. Effective primary care means that providers and services are accessible, comprehensive, continuous, and coordinated.

Inequalities in primary care access and delivery alike are largely driven by economics, including insurance coverage, reimbursement, and poverty. Significant geographic, sociodemographic, and cultural barriers within communities may impact where primary care providers are located. Even in communities where providers are located, accessing and receiving their services may prove difficult.

The Primary Care Development Corporation (PCDC) has identified key measures of primary care access and provides data about each of the 51 New York City Council Districts. The City Council Primary Care Profiles utilize existing data sources to identify primary care facilities and services in NYC and to contrast measurable elements of access to quality primary care across Council Districts (CDs). While these Profiles do not depict actual utilization of primary care services or the health status of Council District residents, it is our hope that these Profiles will help to identify gaps in access, support advocacy for additional primary care services, and inform siting of new primary care facilities.

Primary Care Development Corporation

Founded in 1993 in New York City, PCDC is a nationally recognized nonprofit that catalyzes excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity. In NYC, PCDC has worked with hundreds of primary care organizations in all 51 City Council Districts to expand access to high-quality primary care.

As a Community Development Financial Institution (CDFI), PCDC provides low-interest capital and expertise to build, renovate, and expand community-based health care facilities, supporting providers in delivering quality care to their patients in settings that promote dignity, respect, and wellness. PCDC also provides expert consulting, training, and coaching to help primary care practices adopt patient-centered models, care coordination, and integrated services; improve operations; incorporate coordinated care; leverage health information technology; and boost patient health outcomes.

PCDC works with key policymakers, trade associations, and industry leaders to advance policy initiatives that strengthen, sustain, and expand access to quality primary care. In a rapidly evolving health policy environment, PCDC brings both policy expertise and nearly a quarter-century's experience investing in and strengthening primary care practices in

Contact Information

Primary Care Development Corporation
45 Broadway, Suite 530
New York, NY 10006
Mary M. Ford, MS
mford@pcdc.org
212-437-3900
pcdc.org

The City Council Primary Care Profiles have been made possible through the generous support of the New York City Council and the New York City Department of Health and Mental Hygiene.

WHAT'S INSIDE THE PROFILE

Each Primary Care Profile presents key measures of primary care access for adult residents living in the respective Council District. These measures include the ability to gain entry to the primary care system by having health insurance, to access sites and receive services, and to find providers who meet patient needs and can establish an ongoing relationship.¹ Such qualities are largely dependent on variables including the availability of health care practitioners and facilities that provide primary care, the quality of these services, and whether providers accept a patient's health insurance.

For this initial description of primary care access, PCDC has chosen the following measures:

- Locations of health care facilities providing primary and preventive services
- Health insurance coverage rates
- Primary care sites that are recognized as Patient-Centered Medical Homes
- Population to primary care provider (PCP) ratio
- Providers who accept Medicaid and Medicare

The Profile does not include information on health status or social determinants of health for the Council District residents. Populations with worse health outcomes might require more primary care services to attain adequate access. Health status and outcomes data were not available at the Council District level, however, future profiles may explore methods to include these data to complement provider and facility-based access measures.

CITY COUNCIL DISTRICT 42

The Primary Care Profile for Council District 42 (CD42) shows that adult residents in CD42 have mixed indicators of primary care access compared with those of other Council Districts. In CD42, approximately 14% of persons ages 18–64 are uninsured—better than the citywide average of 17%. However, CD42 ranks 32nd out of 51 Council Districts in population to primary care provider ratio, with 528 residents per PCP. Approximately 83% of PCPs in CD42 accept Medicaid, which is slightly higher than the citywide average, but a lower percentage than the citywide average, 77%, accept Medicare. CD42 has more Federally Qualified Health Centers and Substance Abuse Treatment Program sites than the citywide averages. In addition, CD42 has a greater-than-average proportion of Patient Centered Medical Home-recognized practices.

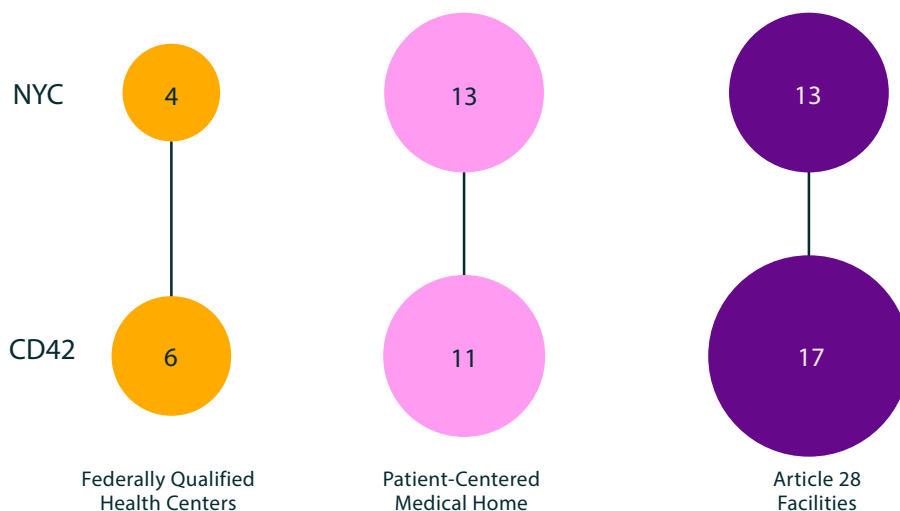
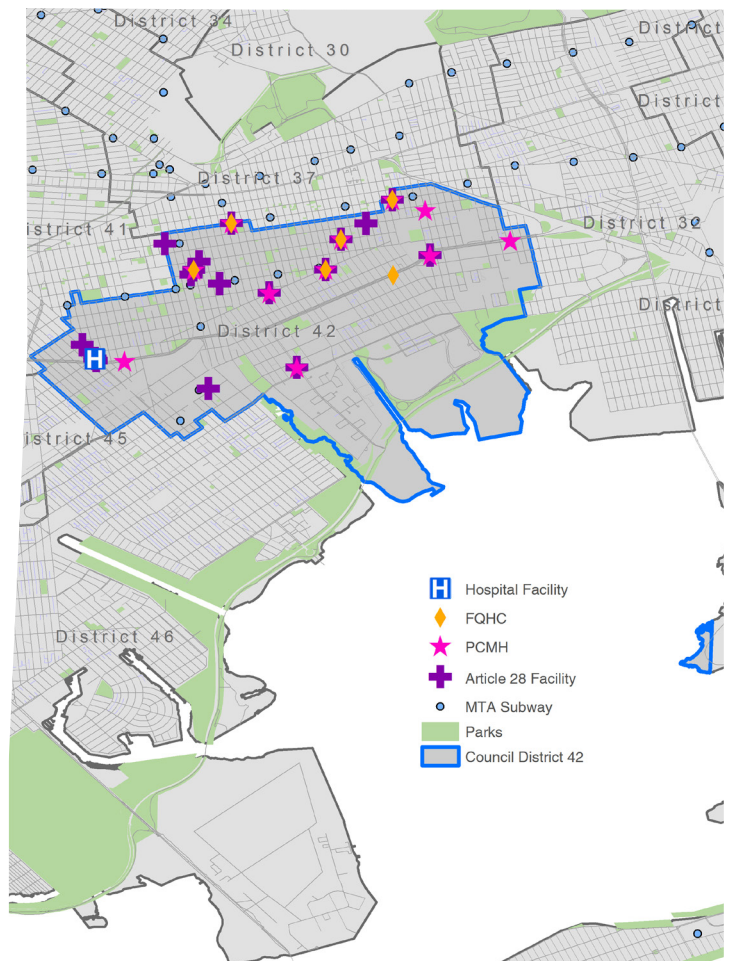
COUNCIL DISTRICT 42: PRIMARY CARE FACILITIES

The locations of key health care facilities in Council District 42 are mapped to capture the distribution of sites that deliver primary care services. This map identifies where services are currently provided and where gaps may exist in the District's primary care coverage.

- **Article 28 facilities** include New York State-licensed hospitals and diagnostic and treatment centers.

- **Federally Qualified Health Centers (FQHCs)** are nationally designated organizations providing primary care and preventive services, regardless of a person's ability to pay, insurance status, or immigration status, and are an important subset of Article 28 facilities in NYC.

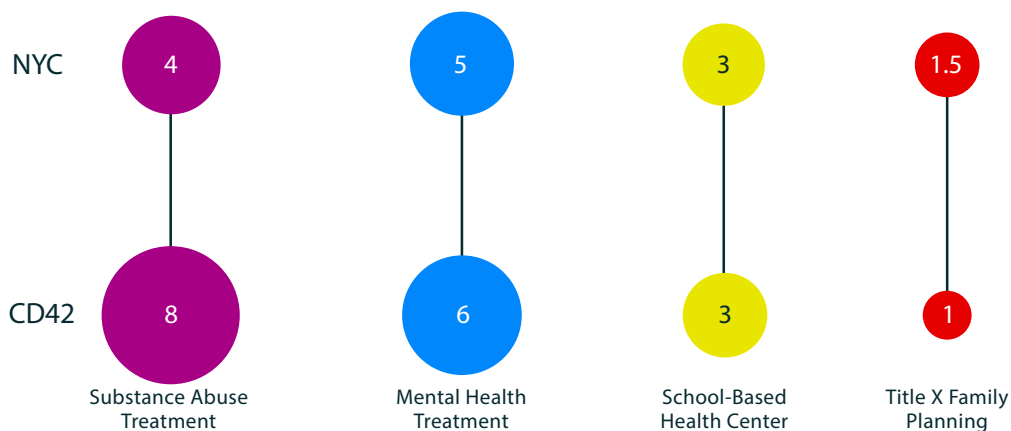
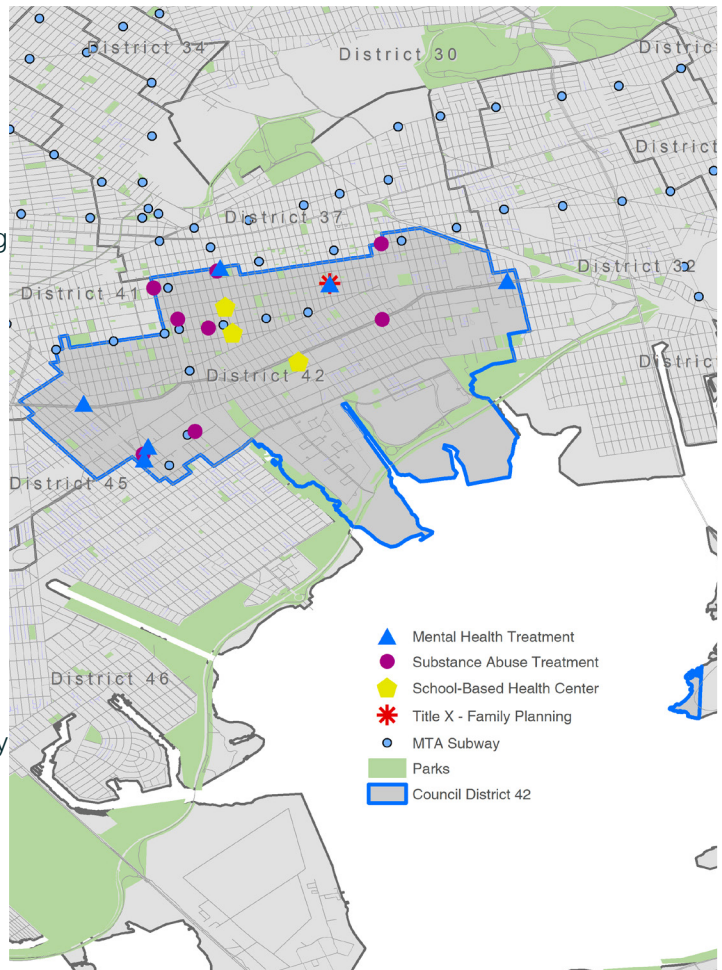
- **Patient-Centered Medical Homes (PCMHs)** are sites recognized by the National Center for Quality Assurance (NCQA) as implementing a primary care delivery model whereby patient treatment is coordinated through their primary care physician to deliver high-quality, comprehensive, and patient-centered care. These may be solo or small group practices, FQHCs, diagnostic and treatment centers, and hospital ambulatory care centers. Note: Primary care practices without PCMH designation are not mapped here.



COUNCIL DISTRICT 42: PRIMARY CARE FACILITIES FOR SPECIFIC POPULATIONS

Additional health care facility types are essential to the provision of comprehensive primary care within a neighborhood. Here, we extend the definition of facilities that may deliver primary care to include those that provide behavioral health care, family planning and women's health services, and children's health care. For many, these health care facilities represent a primary-source-of-care site or where key acute or chronic conditions are managed.²

- **Mental and Behavioral Health Centers** are facilities that provide evidence-based clinical services to treat mental health and behavioral disorders.
- **Substance Abuse Treatment Programs (SATPs)** are community-based sites that treat addiction to drugs or alcohol. These sites may provide individual and group counseling, medical treatment, intensive outpatient treatment, case or care management, recovery support services, and peer supports.³
- **School-Based Health Centers (SBHCs)** are primary care centers located within a public school, often in communities with poor health status and/or with limited access to health care services. These centers provide on-site care to students at the school.
- **Title X Family Planning Programs** are federally-funded sites that provide family planning, contraception, screenings, and related reproductive-health clinical services primarily to low-income women.



HEALTH INSURANCE COVERAGE

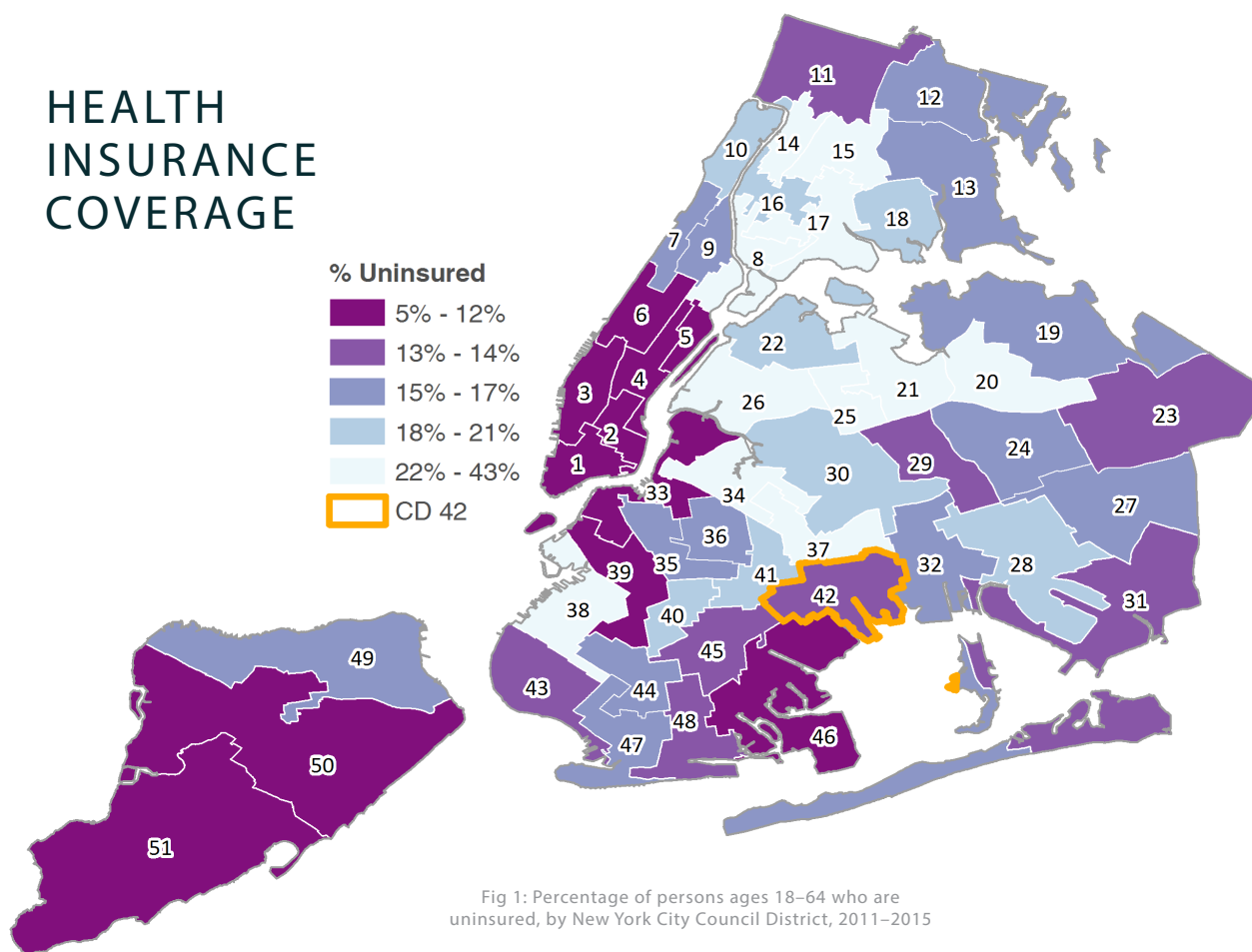


Fig 1: Percentage of persons ages 18–64 who are uninsured, by New York City Council District, 2011–2015

Health insurance coverage is essential to the ability to engage in primary care. Persons who are uninsured are often sicker,⁴ spend a greater proportion of their income on out-of-pocket health care costs, have greater difficulty accessing services,^{5,6} and are more likely to lack a usual source of care than their insured counterparts.⁷

Rates of adults who are uninsured vary across NYC (Figure 1), including approximately 14% of CD42 residents ages 18–64. The uninsured rate

in CD42 is lower than the citywide uninsured rate for this population. Uninsured rates among people ages 0–17 and 65+ in CD42 are also slightly lower (Figure 2).

Note: Data on the uninsured were obtained through the American Community Survey 2011–2015 estimates. With the expansion of Medicaid in New York State under the Affordable Care Act in 2014, as well as the advent of the Essential Health Plan and enrollment in the New York State of Health marketplace, the uninsured rates may have declined. Undocumented people without health insurance may not be represented in this data.

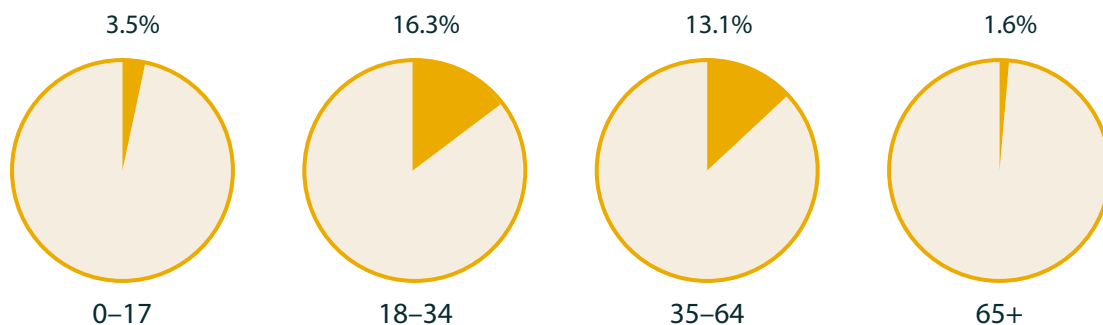
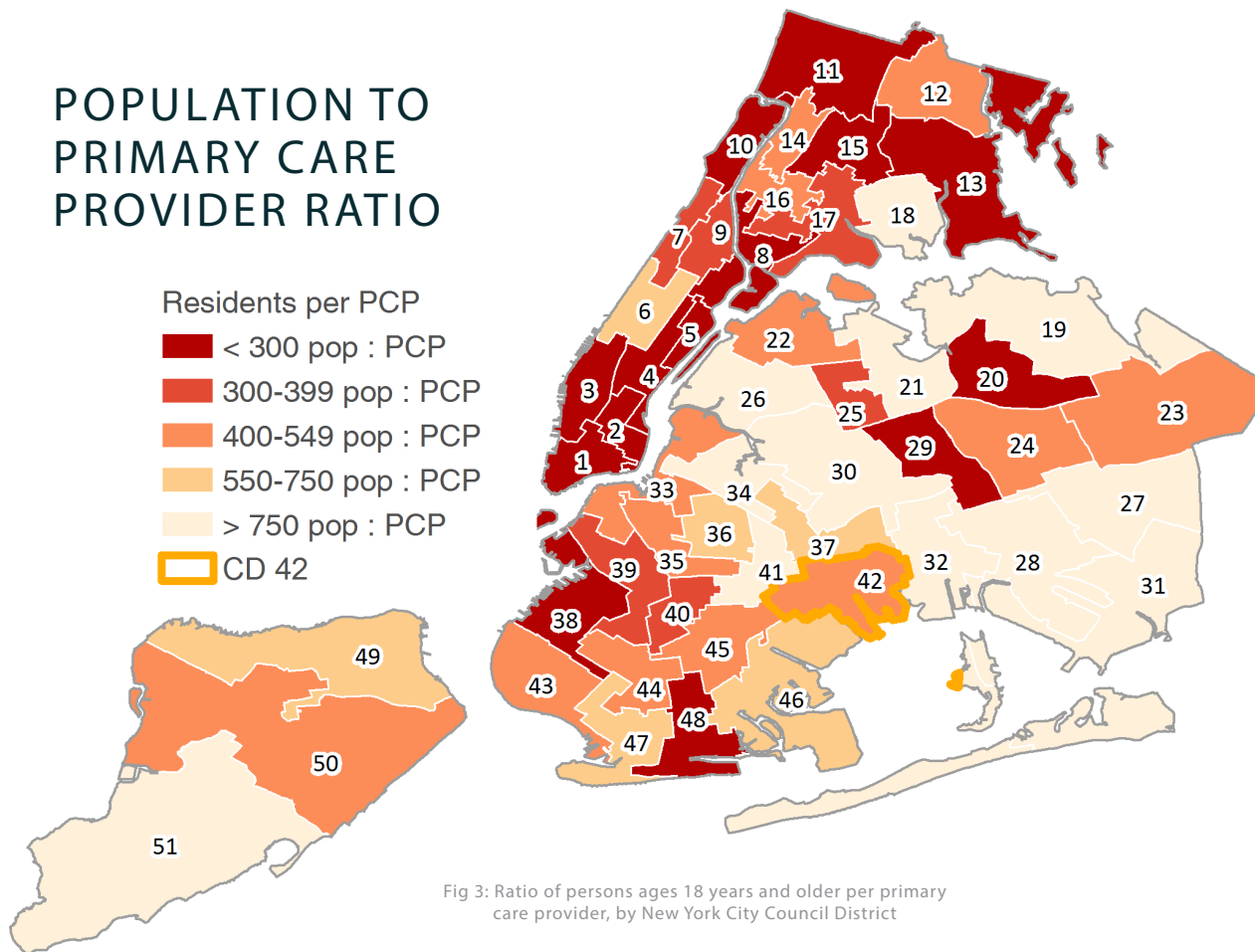


Fig 2: Percentage of uninsured Council District 42 residents, by age group, 2011–2015

POPULATION TO PRIMARY CARE PROVIDER RATIO



Living in close proximity to a primary care provider may promote care continuity, utilization of preventive services, and better management of chronic conditions. Studies identify an association between neighborhood-specific availability of primary care providers and both positive health outcomes and increases in health care service utilization.⁸ Vulnerable persons who live in neighborhoods with fewer primary care providers may have to travel farther or wait longer to be able to access primary care services.⁹

The population to primary care provider ratio represents the number of Council District

residents ages 18+ per PCP. This ratio varies greatly by Council District and borough across NYC, with a citywide average of 811 residents per PCP. CD42 ranks 32nd in population to PCP ratio, with an estimated 528 residents per PCP (Figures 3 and 4).

An additional measure of primary care access is the ratio of primary care providers to specialists. Studies show that health care systems with higher proportions of PCPs have better health outcomes and lower health care costs.¹⁰ In CD42, 33% of physicians are primary care providers, lower than the citywide average. (Figure 5)

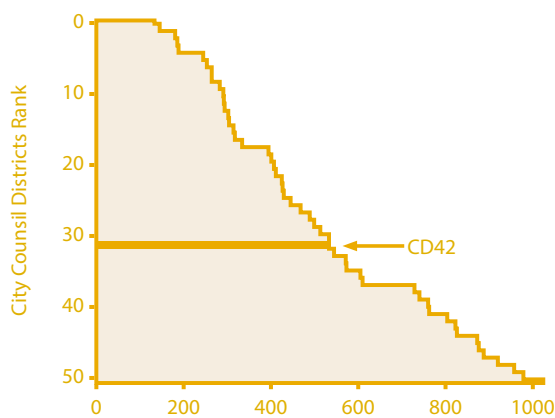


Fig 4: Ranking of the 51 Council Districts by population to primary care provider ratio

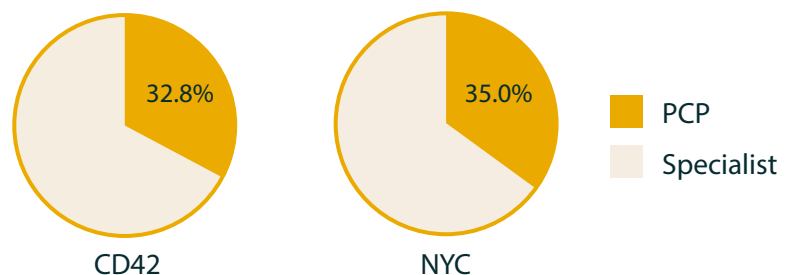


Fig 5: Percent of providers that are primary care providers, Council District 42 vs. New York City

QUALITY OF PRIMARY CARE— THE PATIENT CENTERED MEDICAL HOME

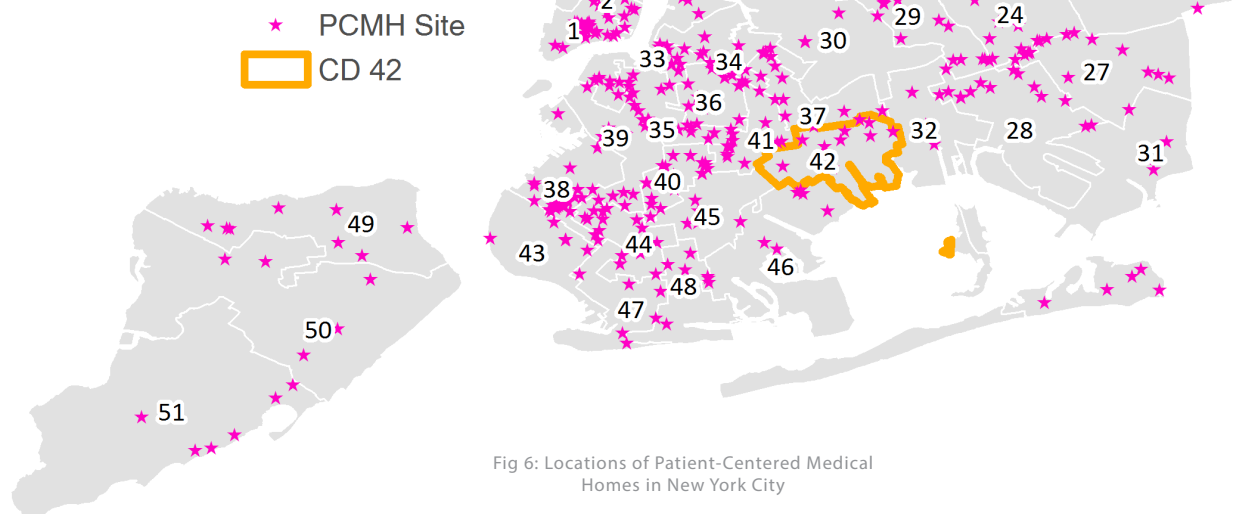


Fig 6: Locations of Patient-Centered Medical Homes in New York City

The Institute of Medicine defines quality health care as care that is “safe, effective, patient-centered, timely, efficient and equitable.”¹¹ High-quality primary care leads to improved patient health outcomes through easy access, care coordination, care management, and a population health approach which supports providers to give the right care at the right time.¹⁰ The Patient-Centered Medical Home (PCMH) is a care model aimed at transforming the delivery of primary care through a commitment to quality improvement and a patient-centered care approach.¹ In the transformation of health care reimbursement and delivery systems to quality over volume, PCMHs and other similar models are a nationally accepted benchmark. In New York State’s

Medicaid program, PCMH-enabled primary care practices receive additional reimbursement, as a component of the New York State “Value Based Payment Roadmap,” with a goal of ensuring that 80% of New York’s primary care providers are providing high-quality, patient-centered care through PCMH recognition.

Research suggests primary care providers who are recognized as Patient-Centered Medical Homes deliver high-quality care, leading to improved patient experience, better health care and outcomes, and lower costs.¹² The Primary Care Profiles use PCMH recognition as a proxy for high-quality primary care (Figure 6). In CD42, approximately 25% of primary care provider sites are recognized as PCMHs, which is greater than the citywide average (Figure 7).

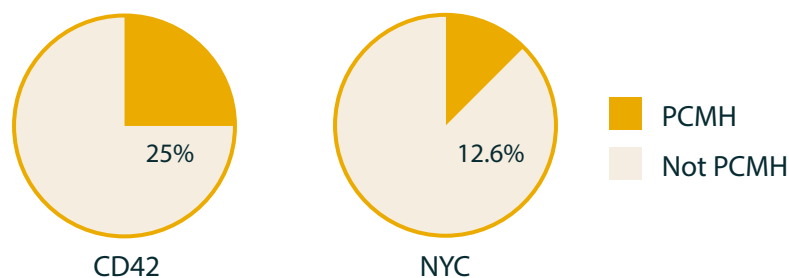
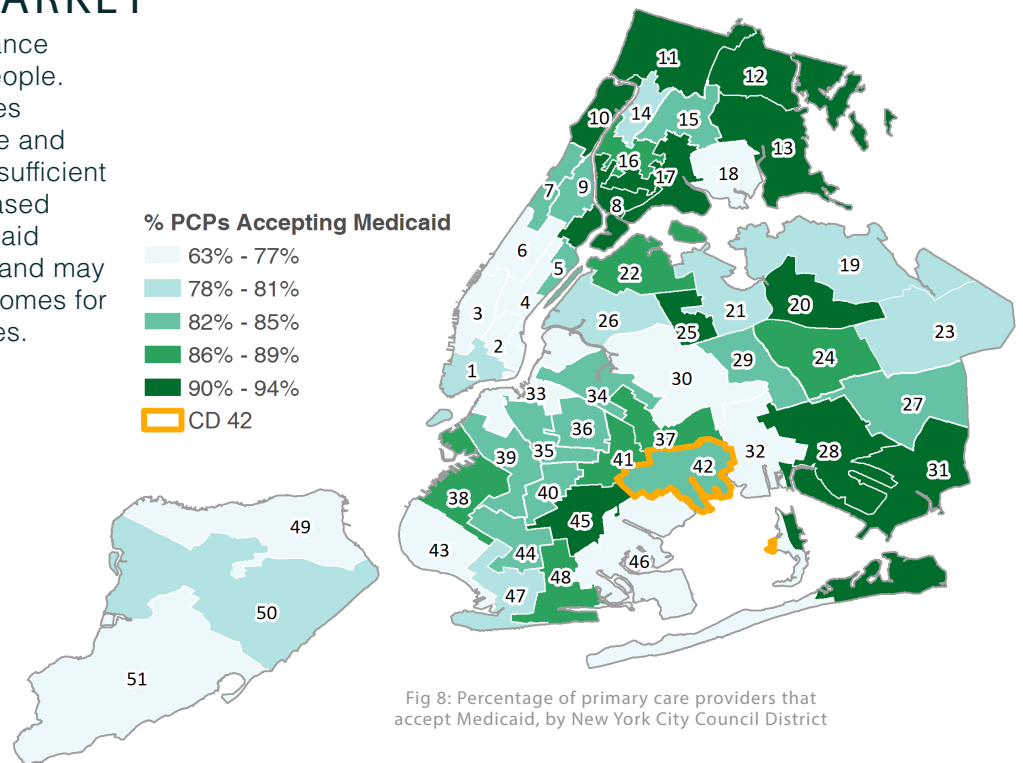


Fig 7: Percent of primary care sites that are recognized as Patient Centered Medical Homes, Council District 42 vs. New York City

MEDICAID: PUBLIC INSURANCE MARKET

Medicaid is a public insurance program for low-income people. For low-income communities with large Medicaid-eligible and covered populations, an insufficient supply of neighborhood-based providers accepting Medicaid presents a barrier to care, and may result in poorer health outcomes for individuals and communities.



The percentage of primary care providers who accept Medicaid varies by Council District (Figure 8), and the pattern is distinct from that of people living below 100% of the Federal Poverty Level (Figure 9). In CD42, 84% of primary care providers accept Medicaid, which is greater than the citywide average of 81% (Figure 10).

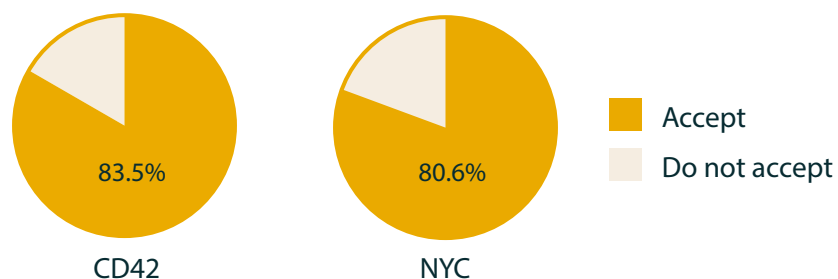
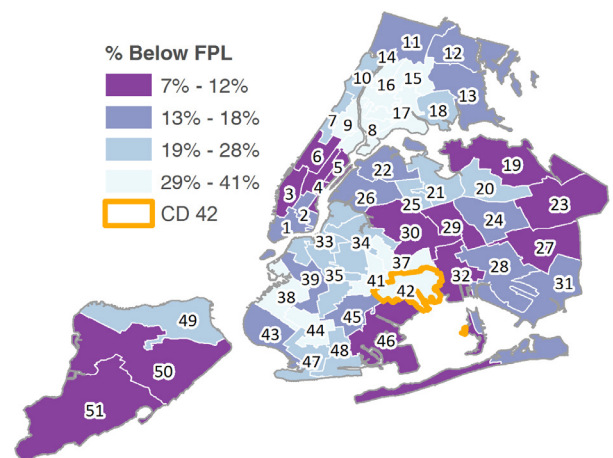


Fig 10: Percentage of primary care providers that accept Medicaid, Council District 42 vs. New York City

MEDICARE: PUBLIC INSURANCE MARKET

The Medicare-eligible population, including people who are ages 65+ and certain younger persons with disabilities, is growing annually, particularly with the aging of the Baby Boomer generation. Primary care is particularly important for Medicare beneficiaries, as older adults are more likely to be living with and managing multiple chronic conditions.¹³ Neighborhood-based primary care services are essential for older adults, as greater mobility issues are experienced by the Medicare population. Accessing a primary care provider is an increasing challenge for many individuals on Medicare; some providers do not accept new Medicare patients and others are opting out of Medicare altogether.

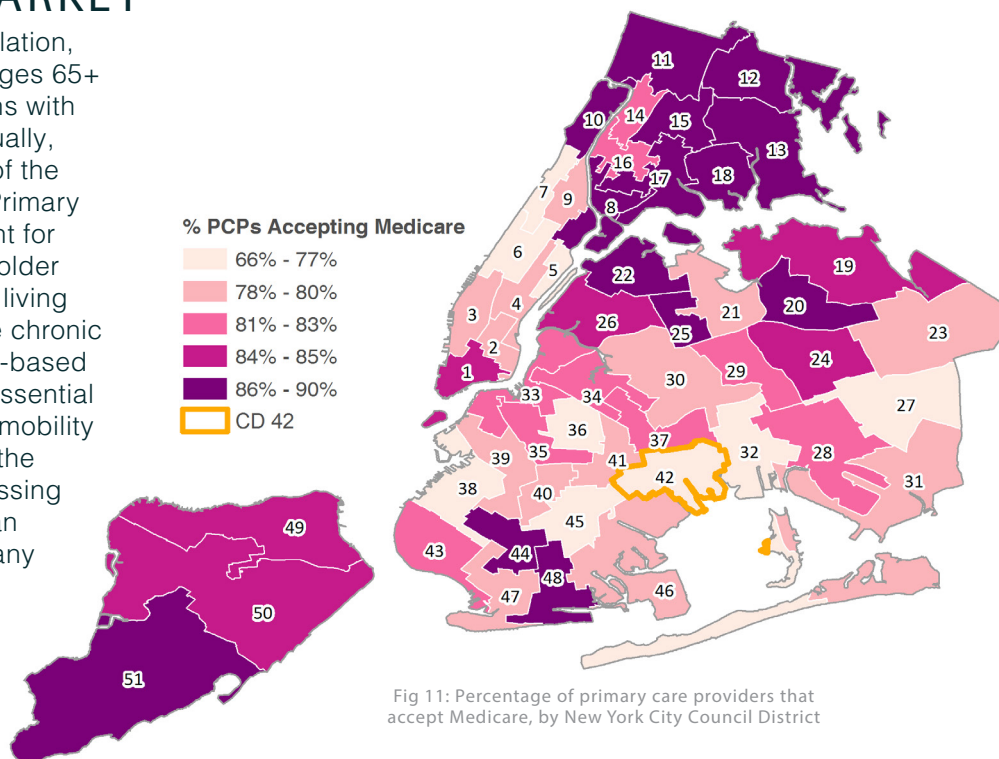


Fig 11: Percentage of primary care providers that accept Medicare, by New York City Council District

The percentage of primary care providers who accept Medicare varies by Council District (Figure 11), with 77% of providers in CD42 accepting Medicare (Figure 13). This percentage is lower than the citywide average of 84%. The pattern of the proportion of primary care providers who accept Medicare is similar to that of the proportion of residents ages 65+, by Council District (Figure 12)..

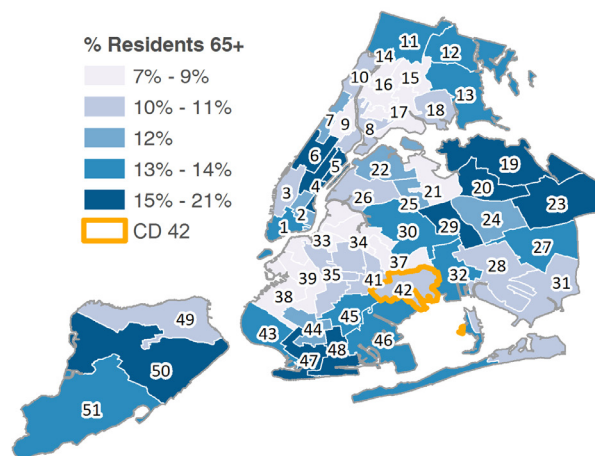


Fig 12: Percentage of persons ages 65 years or older, by New York City Council District

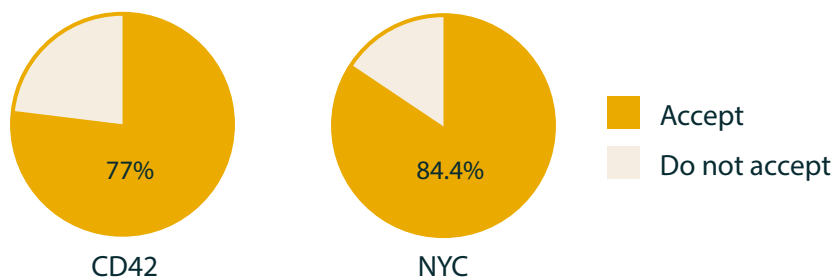


Fig 13: Percent of primary care providers that accept Medicare, Council District 42 vs. New York City

APPROACHES AND ACTIVITIES TO IMPROVE PRIMARY CARE ACCESS

Promoting quality primary care access among all individuals across NYC is critical to ensuring health equity, creating healthy communities, and reducing health care costs. This profile may serve to inform health care planning and future siting of health care facilities. The findings also support advocacy for additional services to encourage equitable access to primary care.

To address **low rates of health insurance coverage** in a district, stakeholders can:

- Advocate for adequate funding of public health insurance programs
- Educate constituents about health insurance programs that might be available to them
- Communicate the importance of and benefits from adequate health insurance to constituents

For districts with **insufficient numbers of primary care providers** for their residents, stakeholders can help to increase the number of local PCPs providing services by:

- Advocating for more primary care services to be located in the CD
- Advocating for additional funding targeted at programs to encourage medical students to train in primary care and preventive specialties

For districts with a) high poverty and **low rates of Medicaid coverage**, or b) large proportions of senior citizens and **low rates of Medicare coverage**, stakeholders can take several steps to ensure adequate access to services for residents by:

- Supporting the location of additional Medicaid and Medicare providers in the CD, particularly FQHCs and other safety net providers
- Working with providers to help them develop effective, efficient, and financially viable practices that accept public health insurance

In order to increase the **number of practices recognized as PCMHs** in their District, thus enhancing the quality of primary care services provided to constituents, stakeholders can:

- Provide needed resources, including technical assistance, to enable practices of all types and sizes to apply to become PCMH-recognized
- Advocate with insurers to provide additional value-based reimbursement for PCMH-recognized practices

PRIMARY CARE PROVIDER DEFINITION

Primary Care Provider, in this profile, is defined as a physician (MD or DO) with primary specialty of Internal Medicine, General Medicine, or Family Medicine.

METHODS

Percent of persons ages 18–64 who are uninsured, by New York City Council District, 2011–2015

- Number of persons ages 18-64 in the Council District (CD) with no insurance divided by the total number of persons ages 18-64 residing in the CD.

Ratio of persons ages 18 years and older per primary care provider, by New York City Council District

- Number of persons 18 years of age and older residing in a CD divided by the total number PCPs with a practice location in the CD. PCPs with multiple practice locations in one CD were counted once within the CD.

Percent of primary care sites that are recognized as Patient-Centered Medical Homes, Council District 42 vs. New York City

- Number of PCP sites identified as PCMH-recognized divided by the total number of PCP sites in CD42.

Percent of primary care providers that accept Medicaid, by New York City Council District

- Number of PCPs in the CD that accept Medicaid divided by the total number of PCPs in the CD.

Percent of residents living below the Federal Poverty Level, by New York City Council District

- Number of persons in the CD with an income below the Federal Poverty Level (FPL) divided by the total number of individuals residing in the CD.

Percent of primary care providers that accept Medicare, by New York City Council District

- Number of PCPs in the CD that accept Medicare divided by the total number of PCPs in the CD.

Percent of residents ages 65 years or older, by New York City Council District

- Number of persons 65 years of age and older residing in a CD divided by the total number of individuals residing in the CD.

Note: Each of the primary care measures presented in the profile serve to compare percentages across NYC Council Districts. These comparisons do not establish a threshold for adequate access for the measures.

FUTURE DIRECTION

To complement the primary care access metrics presented in the 2017 profiles, future iterations of the Primary Care Profiles project may include additional population-level characteristics. At present, the profiles do not capture social determinants of health or health outcomes, which are key factors that influence primary care need and access.

Provider Data Sources

- 1.SK&A Information Services Inc. (2017). Office Based Physicians Database. Received: 9 March 2017
- 2.State of New York (2016). Managed Care Individual Provider Network Data System (PNDS): September 30, 2016. Retrieved from: <https://www.healthdata.gov/dataset/managed-care-individual-provider-network-data-september-30-2016>, 9 March 2017
- 3.Centers for Medicare and Medicaid Services (2017). National Plan & Provider Enumeration System (NPDES). Retrieved from: http://download.cms.gov/nppes/NPI_Files.html, April 2017

Facilities Data Sources

- 1.State of New York (2016). Health Facility General Information Database. Retrieved from: <https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r>, 18 January 2017.
- 2.Human Resources Service Administration (HRSA) (2016). HRSA Geospatial Database – Restricted to Federally Qualified Health Centers (FQHCs). Retrieved from: PolicyMap (<https://www.policymap.com>), 2 March 2017.
- 3.National Center for Quality Assurance (NCQA) (2017). NCQA Patient Centered Medical Home (PCMH) recognized practices database. Retrieved: 19 April 2017.
- 4.New York City Department of Education (2016). School based health centers (SBHCs) database. Retrieved: 27 October 2016.
- 5.Substance Abuse and Mental Health Services Administration (SAMHSA) (2016). Substance Abuse Treatment Facilities. Retrieved from: PolicyMap (<https://www.policymap.com>), 10 April 2017.
- 6.Substance Abuse and Mental Health Services Administration (SAMHSA) (2016). Mental Health Treatment Facilities. Retrieved from: PolicyMap (<https://www.policymap.com>), 10 April 2017.
- 7.Office of Population Affairs (2017). Title X Family Planning Database. Retrieved from: <https://www.opa-fpclinicdb.com/>, 24 April 2017.

References

- 1.National Committee for Quality Assurance. "Patient Centered Medical Home Recognition" available online at <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh>
- 2.Health Resources and Services Administration. "School-Based Health Centers." available online at <https://www.hrsa.gov/ourstories/schoolhealthcenters/>
- 3.Substance Abuse and Mental Health Services Administration. 2016. "Treatment for Substance Use Disorders." available online at <https://www.samhsa.gov/treatment/substance-use-disorders>
- 4.Wilpern, Andrew. Et al. 2009. "Health Insurance and Mortality in US Adults." American Journal of Public Health. 12:2289-2295
- 5.Institute of Medicine Committee on the Consequences of Uninsurance. 2003. "Hidden Costs, Values Lost: Uninsurance in America." National Academies Press. 3:38-59
- 6.Cook, Nakela. Et al. 2007. "Access to Specialty Care and Medical Services in Community Health Centers." Health Affairs. 26:1459-1468
- 7.Pleis, JR. Et al. 2007. "Summary Health Statistics for U.S. Adults: National Health Interview Survey, 2006," Vital Health Statistics. 235:1-153
- 8.Kruk, M. et al.2010. "The contribution of primary care to health systems in low and middle income countries: A critical review of major primary care initiatives." Social Science & Medicine. 70:904-911
- 9.Brown, Elizabeth. Et al. 2016. "Racial Disparities In Geographic Access To Primary Care In Philadelphia." Health Affairs. 35:1374-1381
- 10.Bissonnette, Laura. Et al. 2012. "Neighbourhoods and potential access to health care: The role of spatial and aspatial factors." Health and Place. 18:841-853
- 11.National Committee for Quality Assurance. "The Essential Guide to Health Care Quality" available online at http://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf.
- 12.National Committee for Quality Assurance. "Latest Evidence: Benefits of the Patient-Centered Medical Home" available online at <http://www.ncqa.org/programs/recognition/practices/pcmh-evidence>
- 13.Centers for Disease Control and Prevention. "Multiple Chronic Conditions." available online at <https://www.cdc.gov/chronicdisease/about/multiple-chronic.htm>

