Epi Research Report

New York City Department of Health and Mental Hygiene November 2011

Health Care Reform in New York City — Access to Primary Care Before Reform

The Affordable Care Act (ACA) — the nation's recent health care reform law — is expected to expand access to health insurance coverage for more New Yorkers and to emphasize preventive and primary care that has the most potential to save lives and prevent disease. As the ACA is implemented over the next several years, this series will monitor changes in access to primary care.

The leading causes of illness, disability and death in New York City are largely preventable. Clinical encounters with medical staff are important opportunities for health promotion and disease prevention and treatment,[1] yet many New Yorkers face barriers to receiving care, including lack of insurance, or receive inadequate care. Lack of access to quality primary care can result in negative health outcomes and lead to more intensive and expensive clinical care.

In March 2010, President Barack Obama signed health care reform legislation, known as the Affordable Care Act (ACA), which provides for comprehensive health care reform.[2] Many provisions included in the ACA have the potential to change the health care system to better promote health and prevent disease and encourage innovative approaches to delivering and coordinating primary care. Although the provisions described in this report were authorized by the ACA, it is important to note that debate continues at national and state levels regarding funding and implementation. For more information on the specific provisions of the ACA, see references on page 12.

Key Points in this Baseline Report:

- In 2009, 16% of adult New Yorkers were uninsured.
- Certain NYC neighborhoods had a shortage of primary care physicians, high rates of emergency department use for routine care, and high rates of preventable hospitalizations.
- Screening rates for some recommended clinical preventive services were substantially below 100%.

1 *Farley TA, Dalal MA, Mostashari F, Frieden TR. Deaths Preventable in the U.S. by Improvements in Use of Clinical Preventive Services. 2010. Am J Prev Med; 38:600–609.*

2 *Patient Protection and Affordable Care Act, 2010 Available at http://docs.house.gov/energycommerce/ppacacon.pdf; and amendments under the Health Care Education and Reconciliation Act, 2010. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf (collectively referred to as the ACA). Accessed August 10, 2011.*

NYC Health

This report describes primary care in New York City in terms of access, capacity and quality before the ACA, using the most recently available data as a baseline. Follow-up analyses will help the NYC Health Department and its partners assess the impact of the ACA and identify gaps where action may be necessary to improve access to insurance programs, primary care providers and preventive services.

In this Report

This report examines four aspects of adult primary care: access to care, primary care capacity, receipt of clinical preventive services and adverse outcomes from lack of quality primary care. It concludes with a discussion and review of next steps.

Section One: Access to Care

Access to care, including high quality primary care, is critical to a health care system that promotes prevention and management of chronic disease. Insurance status, having a regular provider, usual site of primary care and wait time for appointments are often used to measure access to care.

Insurance Coverage and Regular Care Provider

One million adult New Yorkers (16%) did not have health insurance in 2009 (Table 1). New Yorkers 18 to 24 years of age and Hispanics were more likely to be uninsured (both 27%). Self-employed or unemployed New Yorkers were more than twice as likely as others to lack health

ACA provisions that may affect access to care in New York City

- Requirement for most U.S. citizens and lawfully residing immigrants to have health insurance and requirement of employers with more than 50 employees to offer full time employees coverage or face a penalty in 2014
- Creation of Health Insurance Exchanges in each state for both individuals and small employers to purchase insurance plans, with subsidies of premiums and cost sharing available for all income-eligible individuals starting in 2014. Access to Exchanges limited to U.S. citizens and lawfully-present immigrants
- Expansion of Medicaid eligibility to all individuals under age 65 with incomes of up to 133% of federal poverty level (FPL) by 2014. New York State had already expanded eligibility to a large portion of this population (up to 100% FPL). As under current Medicaid law, undocumented immigrants will be ineligible
- Extension of coverage for young adults up to age 26 through parents' insurance in 2010
- Option for states to enroll Medicaid beneficiaries with chronic conditions into "health homes" in 2010, where a provider or team of providers coordinates services and facilitates access for patients including comprehensive care management, health promotion, home health-related services, and integration of medical and behavioral health services
- Coverage of a yearly wellness visit for Medicare beneficiaries starting in 2011
- Prohibition on most insurance plans from excluding coverage for children starting in 2010 and for adults in 2014. Creation of NY Bridge Plan, New York's federally-subsidized pre-existing condition insurance plan for uninsured residents, available until 2014
- Prohibition on most insurance plans from imposing lifetime dollar limits starting in 2010 and annual dollar limits (in 2014) on essential health benefits
- Direct access to an obstetric and gynecology (ob/gyn) provider for women in some insurance plans starting in 2010

insurance. Those living in households with incomes below 100% of the federal poverty level were approximately ten times more likely to be uninsured than those in households at or above 600% of the poverty level (28% vs. 3%).

Among insured adults, more than half had primary coverage through their employer or someone else's employer (60%), and about one third through government plans such as Medicaid (19%) and Medicare (16%).

In 2009, 18% of adults – 1.1 million New Yorkers – did not have a regular provider (physician, nurse practitioner or other provider). Uninsured adults were almost five times more likely to report not having a regular provider than insured adults (51% vs. 11%).

Time Since Last Checkup

There is no evidence-based recommendation for how often adults should receive regular medical checkups, i.e., visits not for a specific injury, illness or health condition. However, regular checkups can facilitate the receipt of preventive care services and early detection of chronic disease. Overall, one in 10 (10%) adults had not had a checkup in more than two years.

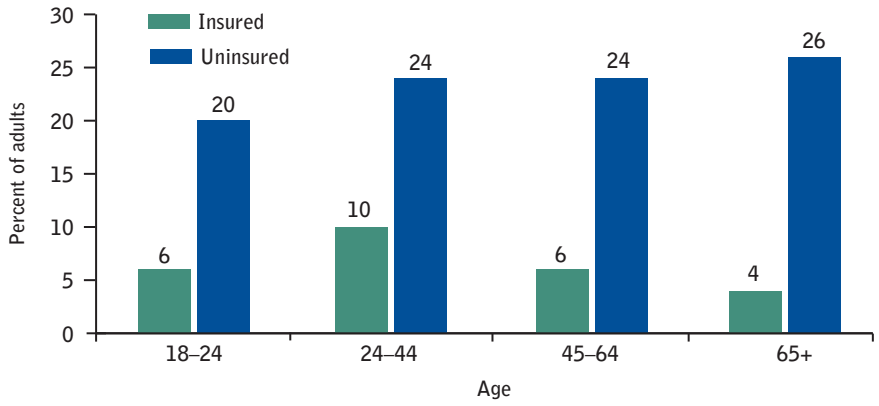
- Depending on age, uninsured adults were three to six times more likely than insured adults not to have had a checkup in the past two years (Figure 1).

Table 1 Adults without insurance, 2009

		Uninsured	
		%	Number of NYC adults
Overall		16	1,000,000
Age Group			
	18-24 years	27	183,000
	25-44 years	21	575,000
	45-64 years	13	215,000
	65+ years	2	23,000
Race/Ethnicity			
	White, non-Hispanic	9	198,000
	Black, non-Hispanic	16	215,000
	Hispanic	27	472,000
	Asian/Pacific Islander	14	91,000
	Other	18	25,000
Employment Status			
	Employed	16	638,000
	For wages	14	480,000
	Self-employed	33	158,000
	Unemployed	34	205,000
	Not in labor force	12	149,000
Nativity			
	US-born	11	392,000
	Foreign-born	23	603,000
Household Income *(% of poverty level)*			
	<100	28	318,000
	100-199	25	247,000
	200-399	15	146,000
	400-599	8	66,000
	>=600	3	38,000

Source: NYC Community Health Survey, 2009.
Percents are age-adjusted.
Insurance estimates may differ from other sources (e.g. Current Population Survey, American Community Survey) due to difference in survey methodologies, including imputation for missing responses, and coverage periods examined.

Figure 1 Adults with no checkup in past two years, 2004



Source: NYC Community Health Survey, 2004.
Percents are not age-adjusted.

- Among those with both health insurance and a regular provider, just 5% reported no regular checkup in the past two years.

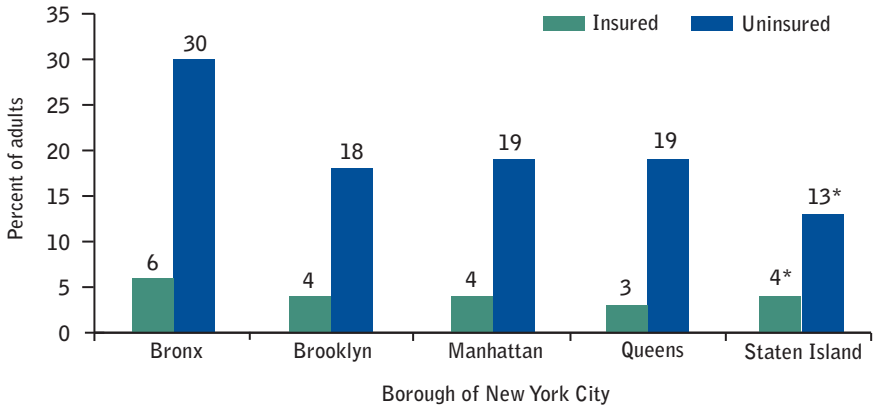
Usual Site of Primary Care

Receiving non-emergency care in an emergency department (ED) is not uncommon and can unnecessarily increase health care costs.[3–5] Furthermore, care provided in an ED may lack continuity, which is critical especially for individuals with chronic illnesses that require regular monitoring. Recommended preventive services also may not be available or offered. Common reasons cited for using the ED for primary care include lack of insurance or primary care provider, preference or dissatisfaction with other sources of care and inability to see a provider during business hours.[6]

In 2004, 7% of adults (422,000 New Yorkers) reported that their usual place of care was an ED.

- ED use as usual site of care was five times more common among uninsured than insured adults (20% vs. 4%), and about four times more common among Medicare and Medicaid recipients than those with private health insurance (10% and 9% vs. 2%).
- Three in 10 (30%) uninsured adults living in the Bronx reported using an ED as their primary source of health care. This was a higher rate than among uninsured adults in Brooklyn, Manhattan or Queens (18%–19%) (Figure 2).

Figure 2 Adults with emergency department as usual site of care, 2004



Source: NYC Community Health Survey, 2004.
Percents are age-adjusted.
** Due to small sample or large relative standard error, estimate should be interpreted with caution.*

Wait Time for an Appointment When Ill or Injured

Another useful measure of access to care is how quickly people can get an appointment for an acute illness. Delays may indicate a short supply of providers, particularly those accepting specific types of insurance.

- Overall, about one third of adults with a regular provider (34%) said they had to wait more than two days the last time they

3 *Weinich RM, Burns RM, and Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Affairs, 2010; 29(9): 1630-1636.*

4 *Billing J, Parikh N, and Mijanovich T. Emergency Department Use: The New York Story. The Commonwealth Fund. November 2010. Available at http://www.commonwealthfund.org/usr_doc/billings_nystory.pdf?section=4039. Accessed June 14, 2011.*

5 *Pitts et al. National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary. Centers for Disease Control and Prevention. National Health Statistics Reports. Number 7, August 2008. Available at http://www.cdc.gov/nchs/data/nhsr/nhsr007.pdf. Accessed June 14, 2011.*

6 *Ragin DF et al. Reasons for Using the Emergency Department: Results of the EMPATH Study. Acad Emerg Med. 2005 Dec;12(12):1158-66. Available at http://onlinelibrary.wiley.com/doi/10.1197/j.aem.2005.06.030/pdf. Accessed June 14, 2011.*

scheduled an appointment for an injury or acute illness.

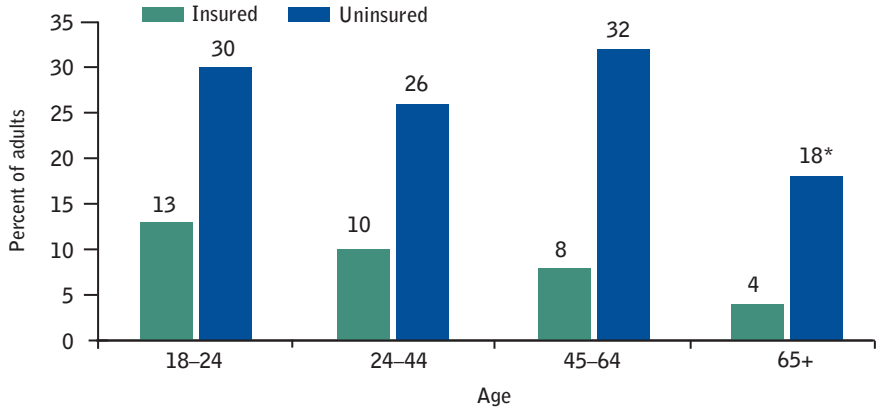
- Waiting more than two days was more common among adults with Medicare coverage (46%) than Medicaid (32%) or private health insurance (34%).

Did Not Get Needed Care

Overall, 12% of adults said they did not get needed care in the past year, including provider visits, tests, procedures, prescription medications and hospitalizations. Reasons why people may not get needed medical care include financial (e.g., lack of funds, inadequate insurance coverage or co-payments) and logistical (e.g., work schedule or transportation).

- Uninsured New Yorkers were three times more likely to report not getting needed care than those with health insurance (27% vs. 9%).
- Among insured adults, 18- to 24-year olds were three times more likely to not receive needed care than those age 65 and older (13% vs. 4%) (Figure 3).

Figure 3 Adults who did not get needed medical care in the past 12 months, 2009



Source: NYC Community Health Survey, 2004.
Percents are not age-adjusted.
**Due to small sample or large relative standard error, estimate should be interpreted with caution.*

Section Two: Primary Care Capacity

Indicators in the Access to Care section are influenced by the ability or capacity of the City's health care system to deliver high quality and timely preventive and primary care. One indicator of capacity is the number of primary care physicians (family medicine, general internal medicine and general pediatrics) in relation to the population.

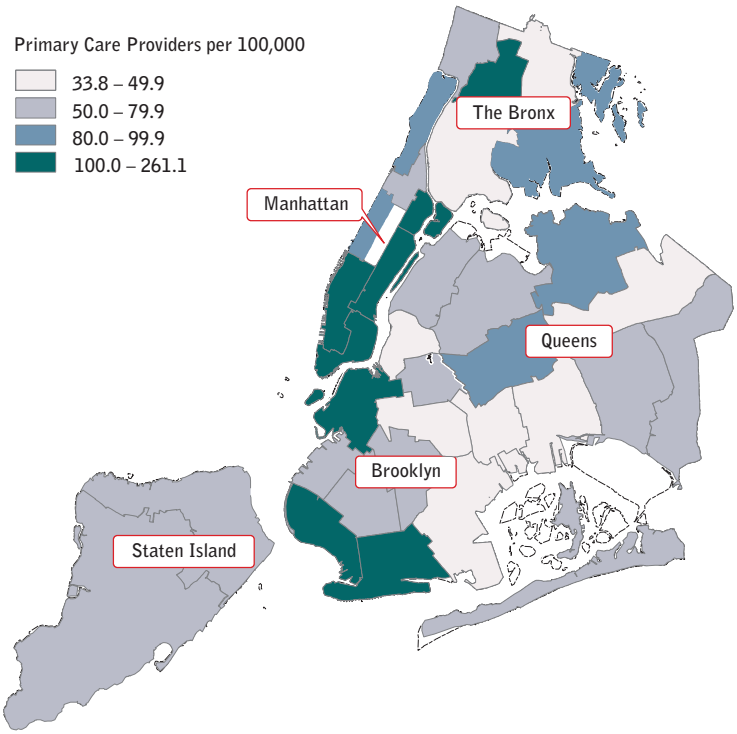
ACA provisions that may affect primary care capacity

- $11 billion to expand community health centers to serve more patients by 2015
- $1.5 billion to expand the National Health Services Corps by 2015
- Increase in Medicare primary care reimbursement through 10% bonus payments to primary care practitioners from 2011 to 2015 and increased parity between Medicaid/Medicare reimbursement levels for primary care for 2013 and 2014
- Grants to states for workforce development, including support for primary care training and capacity building
- Establishment of community health teams, community-based collaborative care networks, and primary care extension centers to support the patient-centered medical home model

According to the U.S. Department of Health and Human Services guidelines, 50 primary care physicians per 100,000 residents is the minimum needed for adequate service.[7]

Citywide, there were 99 full-time equivalent primary care physicians per 100,000 New Yorkers in 2009. However, the geographic distribution of these physicians varied widely, from 261 per 100,000 on the Upper East Side/Gramercy to 34 per 100,000 in the Northeast Bronx. Several neighborhoods in the Bronx, Brooklyn and Queens had fewer than 50 primary care physicians per 100,000 residents (Figure 4).

Figure 4 Full-time equivalent primary care physicians by United Hospital Fund Neighborhood, New York City, 2009



Source: Center for Health Workforce Studies, State University of New York at Albany. New York City Health Department analysis.

Section Three: Receipt of Clinical Preventive Services

Clinical preventive services are services delivered in clinical health care settings with the goal of preventing or treating a health condition or illness; increased use of clinical preventive services can result in a substantial reduction of preventable deaths,[8] especially with regard to services that prevent cardiovascular disease and cancer.

Cancer Screening

In 2009, screening rates for three cancers where screening can prevent illness and death (breast, colon and cervical) were highest for insured adults with a regular provider.

- Among adults age 50 and older, 69% of those with both insurance and a regular provider reported having a colonoscopy in the past 10 years, compared with 49% of those with insurance but no regular provider and only 44% of uninsured adults.
- Women age 40 and older who had health insurance and a regular provider were more likely to have had a mammogram in the past two years (81%), compared to insured women without a

7 *U.S. Department of Health and Human Services Health Resources and Services Administration. Shortage designation: HPSAs, MUAs and MUPs. Available at http://bhpr.hrsa.gov/shortage. Accessed February 10, 2011.*

8 *Farley et al. Deaths preventable in the U.S. by improvements in use of clinical preventive services. Am J Prev Med. 2010 Jun; 38(6):600-9.*

ACA provisions that may affect clinical preventive services

- Elimination of co-payments and deductibles for recommended preventive care under Medicare and creation of personalized prevention plans for Medicare beneficiaries in 2011
- Required coverage of recommended preventive care and immunizations recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention without cost-sharing in many private plans starting in 2010; no cost-sharing for specified preventive care services for women starting in 2012
- Increased federal financial assistance for states that prohibit cost-sharing for recommended preventive care and immunizations under Medicaid starting in 2013
- Support of comparative effectiveness research to compare the clinical effectiveness of medical treatments starting in 2010

regular provider (71%) and uninsured women (64%).

Flu Vaccination

Every year influenza sickens thousands of New Yorkers, and more than 2,000 New Yorkers die annually from influenza and pneumonia.[9] Flu vaccination can prevent people from getting sick from the flu and is now recommended for everyone over 6 months of age.

- In 2009, 30% of adult New Yorkers (18 years and older) reported receiving a flu vaccine. Rates were higher among adults age 50 to 64 (35%) and 65 and older (53%) – target groups under previous recommendations.
- New Yorkers with insurance and a regular provider were more likely to receive a flu vaccine (33%) than those with insurance but no regular provider (24%) or those without insurance (18%).

Cardiovascular Disease Prevention

Early detection and control of high blood pressure and high cholesterol can reduce the burden of heart disease and mortality. Cardiovascular disease, which includes heart disease and stroke, is the leading cause of death in New York City and a major cause of disability. Screening for high blood pressure and high cholesterol are important components of a regular checkup at the doctor's office and are among the most commonly received preventive services (Table 2). Quitting smoking can also decrease the risk of heart disease (and other diseases, such as cancer and chronic obstructive pulmonary disease).

Table 2 Clinical Preventive Services among adult New Yorkers

	Overall (%)
Blood pressure screening in the past two years (2006)	95%
Currently on blood pressure medication, among those ever told to take medication (2009)	58%
Cholesterol screening in the past five years (2007)	82%
Currently on cholesterol medication among those ever told they had high cholesterol (2008)	38%
Use of prescription cessation medication in the past year among current smokers (2009)	6%

Source: NYC Community Health Survey.
Percents are age-adjusted.

9 *Baker T, McVeigh K, Zucker J. Influenza and Pneumococcal Vaccination in among New York City Adults. NYC Vital Signs 2010, 9(7); 1-4. Available at: http://www.nyc.gov/html/doh/downloads/pdf/survey/survey-2010-influenza-vaccination.pdf. Accessed February 4, 2011.*

Receipt of Clinical Preventive Services: What We Know From the Primary Care Information Project (PCIP)

The 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, in conjunction with the ACA, established Medicare and Medicaid meaningful use incentive programs. These programs will provide additional payments to eligible professionals and hospitals as they implement certified electronic health record (EHR) technology and demonstrate meaningful use, such as documenting patient information electronically, applying clinical decision alerts and prescribing medications electronically.

About three quarters (76%) of patients in PCIP practices had their body mass index (BMI) calculated in the past year. Other preventive services such as cholesterol screening in the past five years and depression screening in the past year were less frequent, 32% and 22%, respectively (Table 3).

Among PCIP practices (see box on this page), there were some differences in receipt of services by practice setting:

- Only about one third (36%) of patients with diabetes in small practices (10 providers or fewer) received A1C (to measure diabetes control) testing in the past six months compared with two thirds (66%) of those seen in community health centers.
- Patients seen in community health centers were more likely to be screened for depression in the past 12 months (34%) than those seen in small practice settings (18%).

What is the Primary Care Information Project (PCIP)?

The Health Department's Primary Care Information Project (PCIP), the nation's largest electronic health records (EHR) extension project, supports the adoption and use of EHRs among primary care providers in New York City's underserved communities (http://www.nyc.gov/html/doh/html/pcip/pcip.shtml). Data in this report are from this subset of New Yorkers who seek care from a PCIP provider and do not represent access patterns among all New Yorkers. EHRs have the potential to transform the way population health data are collected; the Health Department can now gather de-identified data from participating PCIP practices. PCIP receives aggregate, monthly transmissions of quality measure scores directly from providers' EHRs. These data are not shared with third parties.

In conjunction with the passage of the ACA, the Health Department received federal stimulus funding to establish the Regional Extension Center for New York City (NYC REACH), administered through PCIP. NYC REACH aims to help over 4,500 providers achieve meaningful use of an EHR to improve health outcomes.* Over time, as more providers adopt an EHR, these data will become increasingly representative of all New York City primary care practices.

Key benefits of these data are that they do not rely on patient self-report of health care services, and are faster and less costly than some other methods of data collection, such as chart reviews or retrospective surveys. Additionally, PCIP data are available in real-time, increasing the potential to act on the information in a timely manner. These new data sources complement existing, population-based data sources, like the New York City Community Health Survey and New York State's SPARCS database.

** NYC REACH Overview. Meaningful Use. Available at http://www.nycreach.org/site/use. Accessed March 4, 2011*

Table 3 Receipt of clinical preventive services in 2009: a snapshot from PCIP

Health Indicator	% of Patients
A1C testing in the past six months among those with diabetes mellitus	43
A1C well-controlled (defined as last A1C < 7%)	25
Body Mass Index calculated in the past two years using measured height and weight	76
Blood pressure control among those with hypertension**	59
Cholesterol screening† in the past five years	32
Cholesterol control^	54
Depression screening in past year	22
Smoking status assessed in the past year	48
Smoking cessation counseling or medication in the past year among smokers	20

** Hypertension is defined as blood pressure > 140/90, and adequate control is last blood pressure reading <140/90.

† HDL and total cholesterol measured in men 35 and older and women 45 and older.

^ Total cholesterol <240 (with no LDL measurement available or LDL<160).

Results may differ from the Community Health Survey due to the different ways data were collected. With PCIP data, for example, cholesterol tests must be ordered by the physician and results received and recorded from a laboratory. Also, these data represent only a subset of New Yorkers who receive primary care at PCIP practices, while the CHS provides population-based, self-reported data on all New Yorkers.

Section Four: Adverse outcomes from lack of quality primary care

Access to primary care is critically important, but access is not sufficient if services are not high quality and focused on prevention. According to the Institute of Medicine, quality health care should be safe, effective, patient centered, timely, efficient and equitable.[10] Quality primary care – one aspect of comprehensive health care – can often prevent adverse health outcomes. Late cancer diagnosis and preventable hospitalizations are two indicators often used to measure the appropriateness and timeliness of outpatient primary care.

Cancer Diagnoses at Late Stages

While preventive screenings are an important first step in identifying and treating cancers, stage of diagnosis and subsequent treatment also have an impact on health outcomes. Early diagnosis of cancer (before it has spread to other parts of the body) greatly increases chances of survival and decreases morbidity. Substantial variation exists by neighborhood in the percent of late-stage cancer diagnosis. Six in 10 colorectal cancers in men (58%) and women (60%) citywide were diagnosed late (outside the organ of origin at diagnosis), but neighborhood rates vary substantially; more than two-thirds of colorectal cancers in men were diagnosed late in Lower Manhattan (67%) and in East Harlem (68%), compared with only half in Kingsbridge-Riverdale (50%).

Four in 10 (40%) cases of breast cancers among women citywide and 54% of cervical cancers were diagnosed late. Less than one third of breast cancers among women on the Upper East Side were late-stage (32%), compared with more than half in

10 *Institute on Medicine. Crossing the Quality Chasm: The IOM Health Care Quality Initiative. Available at http://www.iom.edu/Global/News%20Announcements/Crossing-the-Quality-Chasm-The-IOM-Health-Care-Quality-Initiative.aspx. Accessed February 11, 2011.*

ACA provisions that may affect the quality of primary care

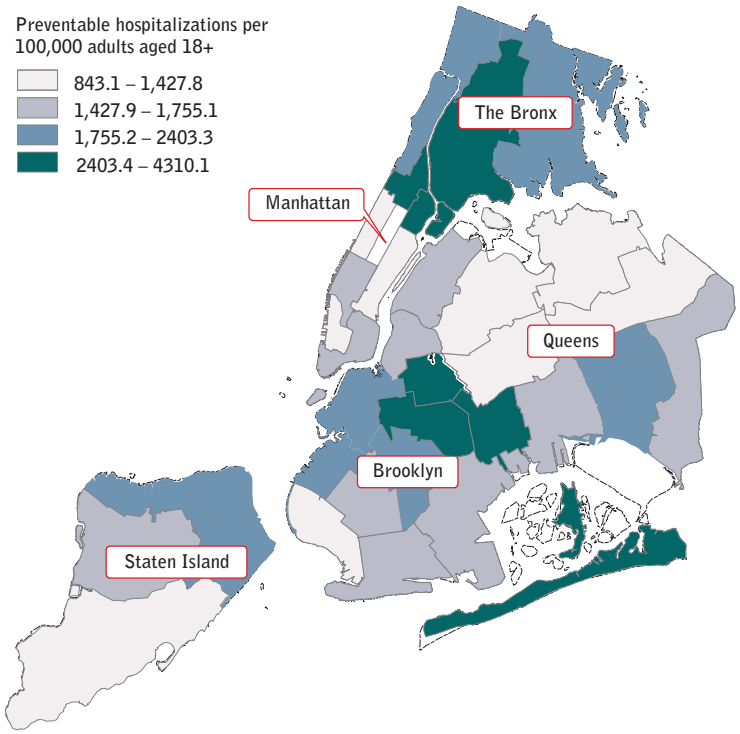
- Creation of Essential Benefits Package that provides a comprehensive set of services and requirement that it be offered by all qualified health plans starting in 2014
- Accountable Care Organizations (ACOs) will allow providers to organize and be accountable for the quality, cost and overall care of Medicare beneficiaries assigned to their ACO. Those ACOs that meet specified quality performance standards will be eligible to receive a share of cost savings starting in 2012
- Establishment of the National Prevention, Health Promotion and Public Health Council and the Prevention and Public Health Fund to coordinate and expand funding for federal prevention and public health programs starting in 2010
- Establishment of Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency in 2011
- Development of a national quality improvement strategy that sets priorities to improve the delivery of health care services, patient health outcomes and population health by 2011
- Establishment of the Medicaid Quality Measurement Program to test and develop health quality measures for Medicaid eligible adults starting in 2010
- Requirement of federally funded or supported programs to collect data and conduct analyses to promote increased understanding of health disparities starting in 2012

Williamsburg-Bushwick (51%) and Flatbush (52%). For more information about racial/ethnic disparities in cancer screening and mortality, see the NYC Health Department's Cancer Disparities report.[11]

Preventable Hospitalizations

The federal Agency for Healthcare Research and Quality (AHRQ) has developed guidelines to identify certain chronic conditions (e.g., diabetes) and acute conditions (e.g., urinary tract infections) for which quality outpatient care could prevent hospitalization. Although these hospitalizations may be necessary, many could have been avoided.[12] Since hospitalizations are typically more costly than outpatient services, they represent an area for potential cost savings.

Figure 5 **Adult inpatient hospitalizations that could have been prevented with good primary care, by United Hospital Fund Neighborhood, New York City, 2006**



Data are age-adjusted to the US 2000 Standard Population.
Source: Statewide Planning Research Cooperative System (SPARCS), 2006. New York City Health Department analysis.

11 *New York City Department of Health and Mental Hygiene. Health Disparities in New York City. Available at http://www.nyc.gov/html/doh/html/episrv/disparities.shtml. Accessed March 14, 2011.*

12 *Kruzikas DT, Jiang HJ, Remus D, et al. Preventable Hospitalizations: A Window Into Primary and Preventive Care, 2000. HCUP Fact Book No. 5. AHRQ Publication No. 04-0056, September 2004. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/data/hcup/factbk5/.*

Citywide, there were 119,777 preventable hospitalizations among adults ages 18 years or older in 2006 (an age-adjusted rate of 1,958 per 100,000 adults), with congestive heart failure (26,848 hospitalizations) the leading cause. The total estimated charges associated with these hospitalizations were $3.2 billion – an average of $25,000 per hospitalization.

Rates of preventable hospitalizations were highest in the Bronx neighborhoods of Hunts Point–Mott Haven (4,310 per 100,000 residents), Highbridge–Morrisania (4,213 per 100,000 residents) and Crotona–Tremont (4,007 per 100,000 residents) (Figure 5). Manhattan's Greenwich Village–Soho had the lowest rate (843 per 100,000).

Discussion

As the provisions of the ACA are implemented over the next several years, the NYC Health Department and its partners will use this series of Research Briefs as one way to assess the impact of reform – by tracking health insurance coverage and receipt of primary care services and highlighting trends related to access, capacity and outcomes.

The ACA will support and help advance the Health Department's ongoing efforts to emphasize prevention and to ensure that all New Yorkers have access to high-quality health care, including evidence-based clinical interventions that reduce disability and save lives. However, successful implementation may not be easy given the scope of the provisions, the complexity of the health care system and ongoing debate over funding.

Some people may continue to face barriers to receiving quality care despite expanded coverage options and increased primary care capacity. As noted throughout this report, having both insurance and a regular provider is associated with better access to care, but some New Yorkers have a limited connection to the health care system and may not access care despite being insured. In addition, some New Yorkers, including undocumented immigrants, will not be eligible for insurance programs established under the ACA. It will be critical to monitor barriers to care, the capacity of the health care system to meet increased demand for primary care, as well as persistent or emergent health disparities. The Health Department will work with local, state and federal partners to identify and address challenges.

Technical Notes

Data Sources: Most of the data presented on the health of New Yorkers are from the Health Department's Community Health Survey 2004-2009, an annual, representative survey of 10,000 adults aged 18 and older from all five boroughs of New York City. Statewide Planning and Research Cooperative System (SPARCS) hospitalization data are based on administrative claims, which provide retrospective data on all discharges from hospitals including patient level data on diagnoses, treatments and services. Data presented are from the August 2007 update file. Primary Care Information Project (PCIP) data are derived from aggregated and de-identified patient data generated by PCIP providers, who work primarily with underserved populations (practices with at least 10% Medicaid and uninsured patients). Late-stage cancer diagnoses are calculated from data from the New York State Cancer Registry: http://www.health.state.ny.us/statistics/cancer/registry/table3/tb3neighborhood.htm. Physician supply data are from the Center for Health Workforce Studies (http://chws.albany.edu/). Supply is measured in terms of full-time equivalent physicians to allow comparability across neighborhoods.

Summary of Key Indicators

	%	Number of NYC adults
Access to care (CHS data*)		
Uninsured (2009)	16	1,000,000
No regular care provider (2009)	18	1,123,000
Emergency department as usual source of care (2004)	7	422,000
Waited two or more days for acute medical appointment with regular provider (2004)	34	1,420,000
Clinical preventive services (CHS data*)		
Colonoscopy in past 10 years (2009, adults 50+)	66	1,386,000
Mammogram in past two years (2009, women 40+)	79	1,451,000
Pap test in past three years (2009, women)	82	2,638,000
Cholesterol screening in past five years (2007)	82	4,856,000
Clinical preventive services received (2009, PCIP data)†		
A1C testing in the past six months among those with diabetes mellitus	43	N/A
Body Mass Index calculated in the past two years using measured height and weight	76	N/A
Blood pressure control among those with hypertension**	59	N/A
Depression screening in past year	22	N/A
Smoking status assessed in the past year	48	N/A
Cancer diagnoses at late stages (2004-2008 average, New York State Cancer Registry data)§	**% of cases**	**Average number of late stage cases**
Colorectal cancer, males	58	993
Colorectal cancer, females	60	1,096
Breast cancer, females	40	1,976
Cervical cancer, females	54	220
Adult preventable hospitalizations (2006, SPARCS data)	**Rate per 100,000 adults**	**Hospitalizations**
	1,958	119,777

* *CHS data are age-adjusted.*
** *Hypertension is defined as blood pressure >140/90, and adequate control is last blood pressure reading <140/90.*
§ *Among tumors with known stage. Public Use Data from 2004 to 2008, New York State Cancer Registry, New York State Department of Health, data as of November 2010. New York State Public Access Cancer Epidemiology Data.*
† *Percentages apply to subset of NYC adults covered by PCIP practices.*

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Division of Health Care Access and Improvement: Amanda Parsons, MD, MBA, **Deputy Commissioner**

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Appendix tables are available online at http://nyc.gov/html/doh/downloads/pdf/epi/epireport-access1-appendix.pdf

Health Care Reform Resources:
Federal government website: http://www.healthcare.gov/
Federal health care reform in New York State: http://www.healthcarereform.ny.gov/
Kaiser Family Health Foundation: http://healthreform.kff.org/
Commonwealth Fund Health Care Reform Resource Center: http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx
New York City government website, NYC Health Insurance Link: http://www.nyc.gov/hilink