Phase Two of

A Preliminary Inventory and Assessment of Health Care Facilities Within Manhattan Community District 3:

Safety-Net Health Care Facilities

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Executive Summary

Safety-net providers are a critical link in the health care infrastructure. While they exist to provide care to those who cannot pay for medical expenses, they are often overlooked and underfunded.

The 2014 New York State Medicaid reform aims to cut costs and improve care, the results of which should also benefit safety-net providers. However, with its implementation having just begun a month ago in April 2015, it is difficult to tell how the long-term effects of this reform will impact the capacity of safety-net providers to care for the predicted increase in Medicaid patients, and therefore patients seeking health care. This report, therefore, focuses on two items: 1) safety-net provider trends in Manhattan Community District 3 (CD 3) and 2) the potential effect of the 2014 Medicaid reform on these safety-net providers.

After compiling a list of safety-net providers in CD 3, the inventory was broken down to investigate which types of services were abundant and which were lacking. Considering both safety-net provider trends and potential ramifications of the 2014 Medicaid reform, five main takeaways emerged:

1) CD 3 is a federally designated health professional shortage area (HPSA) in the fields of primary care, dental care, and mental health.

2) The number of uninsured users at HHC hospitals will not drop enough to compensate for decreasing DSH funding, putting HHC facilities and other safety-net providers in peril.

3) High rates of preventable ED visits are linked with poor access to primary care. The demographic characteristics connected with higher rates of preventable emergency department (ED) visits also reflect the demographic make-up of CD 3

4) While Spanish-speaking services might be readily available to the Hispanic population of CD 3, there is a need to increase the number of Chinese-speaking providers.

5) In terms of public insurance, providers should consider accepting different forms of public health insurance that is meant for the vulnerable populations they aim to help.

Based these findings, this report suggests a handful of action items for Manhattan Community Board 3:

1) Work with existing providers to create more urgent care locations.

2) Work with existing providers to increase awareness of and streamline access to enabling and social services.

3) Lobby for increased city investment into safety-net providers.

4) Integrate the issue of safety-net provider preservation with other issues faced by CD 3.

5) Improve the socio-economic status of CD 3 residents.

Manhattan Community District 3 (CD 3) has the distinct quality of having a population composed of individuals vastly different from one another in race, gender, sexuality, age, education, and income. Ensuring that all types and all kinds of people have access to quality health care is tricky because they all have different needs. Health care providers in CD 3 are challenged with providing a wide range of services to a wide range of people who face a wide range of extenuating life circumstances that may make it hard to stay healthy despite their best intentions and providers' best efforts.

The U.S. Department of Health Resources and Services Administration (HRSA) has identified many cultural, language, and health literacy factors that may inhibit access to health care (U.S. Department of Health Resources and Service Administration (HRSA), 2015). Many of these barriers could be lowered by offering culturally sensitive care, speaking different languages, and providing enabling services to help people understand their health conditions and insurance options. Usually it is a community health organization that provides the enabling services catering to the vulnerable population (Ku, Zur, Jones, Shin, & Rosenbaum, 2014). Since they cater to the vulnerable population, they are considered safety-net providers, and it is these safety-net providers that are at risk of closing due to financial hardships. Inherently, serving the vulnerable population means absorbing some of the costs that the patient cannot cover, causing these important community assets to lose money and eventually close. This is why government subsidy and reimbursement programs are so important to keeping these critical providers open and supporting them in what they already do well, which is caring for those who cannot seek

care through the costly and confusing mainstream medical system.

This report therefore seeks to understand the role of safety-net providers in CD 3, especially in light of the Medicaid expansion, as well as to suggest areas of improvement.
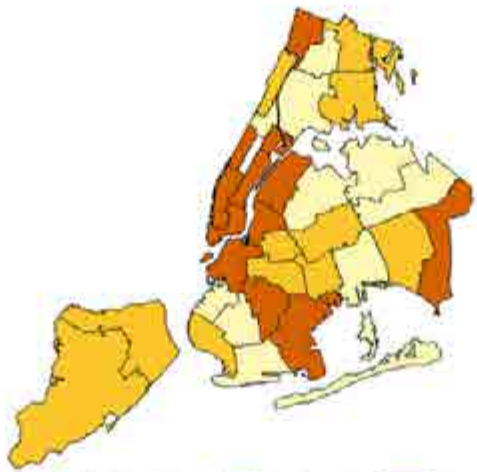
Demographics of CD 3

As concluded in a previous report, "A Preliminary Inventory and Assessment of Health Care Facilities in Manhattan Community Board 3," the demographics of the district can be broken down geographically, depicted in Map 1. In the northwest corner, the

Map 1. Three focus areas from *Preliminary Assessment* Report

demographics are predominately high-income, white, educated, young professionals. Along the eastern border, the demographics are predominantly low-income, Hispanic, with mostly high-school level education. In the southwest corner, the demographics are predominantly very low income

Map 2. Percentage reporting excellent general health by UHF neighborhood (map generated from NYC DOHMH Epiquery: 2013 Community Health Survey)

Percent of Population   7.4-15.2%   15.3-20.6%   21.3-32.8%

Map 4. Percentage reporting good general health by UHF neighborhood (map generated from NYC DOHMH Epiquery: 2013 Community Health Survey)

Percent of Population   20.7-33.2%   33.6-35.6%   35.6-45.5%

Map 3. Percentage reporting very good general health by UHF neighborhood (map generated from NYC DOHMH Epiquery: 2013 Community Health Survey)

Percent of Population   11.5-22.1%   22.7-28.1%   28.3-45.0%

Map 5. Percentage reporting fair or poor general health by UHF neighborhood (map generated from NYC DOHMH Epiquery: 2013 Community Health Survey)

Percent of Population   8.0-19.1%   19.4-23.3%   24.2-30.5%

Asian, with very low-education and English-speaking abilities. The southwest corner of the district is also home to a large elderly population.

According to 2013 New York City Community Health Survey, many people in the district report very good to excellent health (Map 2, 3). Many, although slightly less, also reported being in fair to poor health (Map 5). Very few reported being of good health status (Map 4). This disparity could be tied to many factors, such as income, insurance status, and comfort navigating the health care system, which is also dependent on fluency in English and level of cultural competency of their provider.

Drug rehabilitation, geriatric care, HIV/AIDS care, and mental health services are in high demand, not to mention the need for enabling services to help the uninsured, the non-English speaker, and those who cannot physically go to a health care facility.

Emergency Department Usage

In 2013, over 70 percent of all emergency department admittances in New York State were potentially preventable (Goins & Conroy, 2015). Because of this, problems that show up in emergency department visits likely "reflect the greater health needs of the surrounding community…[with many being] potentially preventable, meaning that access to high-quality, community-based health care can prevent the need for a portion of ED visits" (Weiss, Weir, Stocks, & Blanchard, 2014; Tang, Stein, Hsia, Maselli, & Gonzales, 2010). Using a methodology called the Emergency Department Sensitive Conditions pioneered by NYU Langone's John Billings, a 2008 United Hospital Fund study showed that "neighborhood level ED use variation is highly correlated with safety net payer status (0.73); poverty (0.81); education/not graduating high school (0.73); and fair or poor health status (0.64)" (Gould, 2008). These positively correlated variables indicate that higher levels of ED usage is linked with higher numbers of people with a safety net payer status, higher levels of poverty, higher levels of people not graduating from high school, and higher levels of people in fair or poor health. Many CD 3 residents can be described by some or all of these demographic traits.

Not only does this show the importance of safety-net providers within the district, it also shows its current state of incompetence of the safety-net provider system in providing primary care, as "reliance on the ED means patients lack continuity in their health care" (Billings, Parikh, & Mijanovich, 2000). The researchers concluded that there was "extraordinarily high rates of use for nonemergent conditions and for care that could otherwise be

Percent of Population
- <19.8%
- 19.8-24.2%
- >24.2%
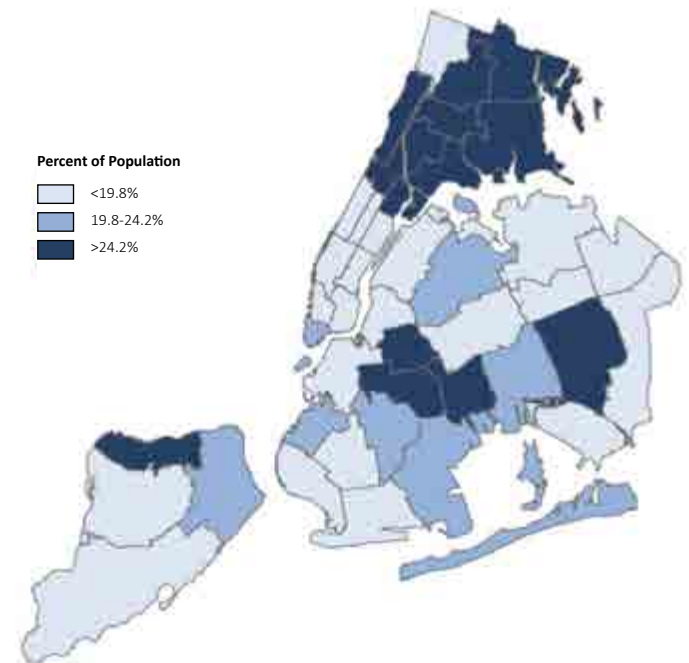
Map 6. Percent of Population with 1 ED Visit by United Hospital Fund Neighborhood, 2008 (map from Raven & Gould, 2012)

provided in a primary care setting – even among those with health insurance coverage…[indicating] that the primary care delivery system is not functioning well for many New Yorkers" (Billings, Parikh, & Mijanovich, 2000).

If many CD 3 residents use a safety-net payer like Medicaid, live in poverty, have not graduated high school, and are in fair or poor health, then, according to the trends found by Gould (2008), analysis should show CD 3 to have a fairly high rate of ED usage. However, in 2008, less than 19.8 percent of the population in the CD 3 area had visited the emergency department (Map 6). In contrast, between 19.8 and 24.2 percent of lower Manhattan's population visited the emergency room (Raven & Gould, 2012).

Although these data might show that CD 3 residents are in good health and use the emergency department less than other neighborhoods with vulnerable populations and therefore have good access to primary care, we must remember who

is more likely to fill out the Community Health Survey and think critically about why ED usage is lower in CD 3 when the demographics might predict otherwise. Perhaps non-English speakers and undocumented immigrants, or even family members of undocumented immigrants, are reluctant to give information to the government, as they have shown to be when signing up for health insurance (Office of the New York City Comptroller Scott M. Stringer, 2015). Furthermore, Goins and Conroy (2015) found that Asians comprise a very low percentage of ED usage in the state at 2.38 percent, while all other races were above 20 percent. As the Asian population in CD 3 makes up more than one third of the total population (New York University Furman Center, 2014), their emergency department usage trends would greatly skew the overall trends in the district, falsely indicating that low ED usage means good primary care access.

MRT, DSRIP, & PPS:
Where Safety-Net Providers Fit In

In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT) to help develop a plan to restructure New York State's Medicaid program. These reforms are predicted to generate $17.1 billion in federal savings. In order to carry out MRT's key initiatives, an amendment was made to the Medicaid 1115 waiver; effectively, this 1115 waiver amendment will allow the state to reinvest $8 billion of the $17.1 billion to into carrying out the MRT action plan (New York State Department of Health, 2015).

The Delivery System Reform Incentive Payment (DSRIP), in short, is a way to implement and distribute the $8 billion to be reinvested into the MRT action plan, which heavily involves safety-net Medicaid providers. Providers that apply and qualify to be a DSRIP safety-net are able to participate and share in the performance payments of a Performing Provider System (PPS). Non DSRIP safety-net providers can also participate and receive a share of the performance payments, however only up to a certain amount (New York State Department of Health, 2014).

Every PPS has a lead provider. CD 3 is included in the Mount Sinai PPS, who is the lead provider for Manhattan, Brooklyn, and Queens. The Mount Sinai PPS includes a total of nearly 6,000 providers, 5,000 of whom are physicians; the remaining 1,000 are a compilation of hospitals, clinics, nursing homes, behavioral health and substance abuse providers, social service organizations, housing providers, and care management programs (Mount Sinai Performing Provider System Website, 2015). Funds are distributed to PPSs based on performance and meeting project goals.

The main purpose of DSRIP is to reduce avoidable hospitalization by 25% in five years (New York State Department of Health, 2014). In order to do this, safety-net providers and communities must work together to bolster the primary health care network in their respective communities through a series of projects and initiatives. Success and good performance in these initiatives leads to additional funding for the PPS and subsequently, the DSRIP safety-net providers involved. Additional funding leads to increased capacity to carry out more projects and continue serving and improving the community in which they are invested.

Funding Cuts

With the prospect of saving billions through DSRIP, and because of the presumption that "with fewer uninsured patients in a reformed system [with policies such as the Affordable Care Act's insurance mandate], there will be fewer uncompensated costs," long-standing funding sources accounting for the uninsured and underinsured, like Disproportionate Share Hospital (DSH) payments, are less needed (AcademyHealth, 2011). Even with the Medicaid expansion, there will be populations that remain uninsured or under-insured, and hospitals will need to treat them without receiving adequate compensation.

Affecting HHC specifically, President Obama's Federal Fiscal Year 2016 budget request will cause "significant Medicare and Medicaid provider cuts totaling $431.3 billion in Medicare cuts over ten years" (Brown, 2015). In the current fee-for-service Medicaid system, reimbursements do not fully cover the costs of care. For example, as HHC

transitions to managed care Medicaid for behavioral health services, their funding situation will become increasingly dire because "the proposed managed care premiums for Behavioral Health are insufficient" (Brown, 2015). The well-being of HHC operations is especially important for the "city's indigent and uninsured population. Of more than one million emergency room visits to HHC hospitals, 78 percent were made by Medicaid recipients or the uninsured" (Citizens Budget Commission, 2012). As HHC has three community health centers and one long term care facility in CD 3, the well-being of HHC can also affect the well-being of CD 3 residents that depend on these facilities.

New York City is also home to the homeless, undocumented immigrants, and non-English speaking migrants, all of whom are less likely to seek routine primary care and will likely end up in an emergency room if their health fails (Institute of Medicine, 2000). This puts unnecessary financial strain on hospitals that are already struggling to make ends meet, especially since "recession-driven reductions in Medicaid reimbursement rates, along with flat Medicare reimbursement, have placed these institutions in increasingly precarious situations...These institutions struggle from day-to-day to maintain basic services, and have no capacity to invest in the infrastructure necessary to implement delivery system reform" (New York State Department of Health, 2012a).

While safety-net providers have historically functioned on limited funds, they have somehow managed to stay open and functional (Institute of Medicine, 2000). More recently, "safety net providers have voiced concerns that with continuing financial pressures in states, efforts to control

Medicaid spending may involve more provider rate cuts" (AcademyHealth, 2011). To accept this status quo is to accept the reality that safety-net providers could easily be pushed into extinction at any time.

Methodology

Definitions

The study area for this project includes the zip codes of CD 3: 10002, 10003, 10009, 10013, 10038. Taking the U.S. Human Resources and Services Administration (HRSA)-defined Primary Care Service Areas into consideration, two additional zip codes are included: 10007 and 10012. Safety-net provider facilities that fall within these zip codes are included in the inventory.

Safety-net providers are an important part of the health care system, and there are many ways to describe what it could or should be to best serve the population. According to the Institute of Medicine, safety-net providers refer to "those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients" (Institute of Medicine, 2000). However, the population that would be associated with being uninsured, a Medicaid user, or more generally, a vulnerable patient, is wide-ranging, and as a result, "the safety net is not uniform, comprehensive, or well-organized as the name might imply" (AcademyHealth, 2011). Thus, for the purposes of categorization and the need to draw hard lines between what is and is not a safety-net provider, this report adopts the definitions used by federal, New York State, and New York City programs to populate the inventory. For example, a state-identified safety net provider's income is comprised of 35% or more from Medicaid.

Oftentimes, enabling services are what draws vulnerable populations to safety-net providers and more specifically, to community health centers. Because these facilities have "a broad range of primary health care as well as dental and mental health services, plus an array of other social and enabling services to meet the complex needs of patients in vulnerable communities," these providers tend to be "a key safety valve to help guarantee access to care, particularly for those with lower incomes" (Ku, Zur, Jones, Shin, & Rosenbaum, 2014). Officially, enabling services are "non-clinical services that do not include direct patient services that enable individuals to access health care and improve health outcomes" (US Health Resources and Services Administration (HRSA), 2014). For this report, enabling services include languages, cultural sensitivities, case management/insurance navigation, and the types of insurances accepted.

Inventory Compilation

This inventory of safety-net providers was created compiling DSRIP safety-net lists, HRSA Federally Qualified Health Centers (FQHC) and Look-Alike lists, New York City Health and Hospital Corporation (HHC) facilities, and New York City Department of Education School-Based Health Centers (SBHC). Listings were also cross-referenced with HealthNow New York Inc. SmartSaver RX PDP's Pharmacy Directory and the Mount Sinai-Beth Israel Listing of Contracted "PAR" Carriers.

Some organizations have multiple service locations. These locations were added to the inventory, provided that the services offered were medical services. In some instances, one provider is on multiple lists. In these cases, the provider is listed once for each sponsor, and therefore is a repeat entry.

The inventory is organized by types of insurance accepted and a variety of enabling services. The languages included were the languages offered by HHC. The medical services included were

roughly based on the services the Mount Sinai PPS Community Needs Assessment chose to poll when asking how "Difficult" or "Very Difficult" it was to access a particular service. Additional services were added to capture services for the aging, LGBTQ, and the teen/young adult populations.

Assumptions, Caveats, and Error

In the data collection process, there was a lot of room for assumption. For instance, if the rhetoric of their mission statement seeks to help minority groups and the photos on their website shows Hispanic and Asian patients, one might assume that this facility offers services in Spanish and an Asian language such as Mandarin Chinese. However, if the provider's website does not explicitly say that they speak these languages at the facility and instead says generally that they offer services in many different languages, it is not accounted for in the inventory. On the other hand, while only explicitly-shown available services are noted in the inventory, something as simple as an attached PDF fact sheet in two languages is sufficient evidence of providing that language and is therefore marked accordingly in the inventory. In general, data collection for this project and report aimed to err on the side of undercounting the actual number of services provided in the district.

From the viewpoint of a potential health care consumer in CD 3, perhaps it would be helpful for providers to list very specifically the languages that their staff can use to communicate, so as to make their wonderful enabling services less ambiguous and more welcoming to wary patients. In a similar vein, another reason why data on available services was assessed in this way, is to reflect the information the lay consumer can find on his or her own. Health care providers can take note and improve their outreach methods and online resources.

In some instances, the address listed in the government listing is the administrative office of the provider and not the address of where services are provided. Additionally, many organizations have multiple service locations. This report assumes that all health care-providing branch locations of qualifying provider organizations will be receiving the funding from the same pool as the listed address. Deciding whether or not to include a branch location also involved some assumption. In some cases, a branch location would provide many wonderful enabling services, but no health care. While enabling services are undoubtedly important for improving health, in general, these were not included. However, sometimes it was explicitly stated that the programs hosted by these branches were funded by the city and/or state departments of health and/or mental health. Due to these funding sources, a handful of branch locations providing only enabling services were also included in the inventory.

Finally, this inventory collects facilities that qualify for government funding programs. Qualifying for these funding sources includes providing for Medicaid patients. However, qualifying is also contingent on applying. Some facilities may not have applied, meaning they are not the list of sponsored facilities and are therefore missing from this inventory.

Analysis is only as good as the data available, and this inventory faces limitations in the accuracy of information provided online. The consequence is that there may be more services and more facilities in the district than is accounted for in the inventory.

This perhaps can be remedied by encouraging health care providers to improve their online and community presence and keep their business and service information up to date and in sufficient detail.

Safety-net providers are operating with diminishing financial viability. Their future depends on the government's decision to increase funding to support the growing demand, especially as efforts to cut health costs by targeting emergency department (ED) waste and promoting primary care kick in. In a sentence, "New York's fragile health care safety net must be modernized and primary care access must be expanded in order to prepare for new enrollees" (New York State Department of Health, 2012).

Facility and Services Breakdown

A breakdown of the inventory (Table 1) shows the need for more urgent care facilities to ease the burden on emergency departments and more Asian language-speaking services to serve a major portion of the CD 3 community. **Currently, there are many more Spanish-speaking facilities than Asian language-speaking facilities, while population-wise, there are more Asians than Hispanics in the district.** Due to the way races are aggregated in population data, it would require a more nuanced analysis of Asian languages spoken in CD 3 to know which dialects and languages to focus on.

Navigating the health care landscape is daunting for anyone, and indeed, Mount Sinai's Community Needs Assessment (2014) as lead provider of their PPS finds that "regardless of provider type, the leading cause behind challenges to accessing care was reported as a difficulty navigating the system and a lack of awareness of available resources for the patients. An exception was in the case of mental health services, for which respondents noted the difficulty here was due primarily to a lack of capacity." Enabling and social services seem to be available in most settings, and there are many

Table 1. List of inventory findings*

- 66 of 183 (36.0 percent) facilities offer primary health care services.
- 92 of 183 (50.3 percent) facilities offer mental health services.
- 49 of 183 (26.8 percent) facilities offer both primary care and mental health services.
- 20 of 183 (10.9 percent) facilities provide LGBTQ sensitive care to youth/teens/young adults. 17 of these (9.3 percent of total) also provide insurance/benefits navigation services.
- 45 of 183 (24.6 percent) facilities provide geriatric care. 18 of 45 (9.8 percent of total) specialize in people with disabilities. 12 of 18 (6.6 percent of total) offer mental health services. 10 of 12 (5.5 percent of total) provide primary care.
- 53 of 183 (29.0 percent) facilities offer substance abuse services. 27 of these (14.8 percent of total) also offer HIV/AIDS services. 8 of these (4.4 percent of total) will accept ADAP.
- 61 of 183 (33.3 percent) facilities offer pediatric/early childhood services. 11 of these (6.0 percent of total) accept Child Health Plus/CHIP.
- 27 of 183 (14.8 percent) facilities offer prenatal/ob-gyn services for women. Of these, 6 facilities (3.3 percent of total) accept PCAP.
- 74 of 183 (40.4 percent) facilities offer services in Spanish. Of these, 41 (22.4 percent of total) provide primary health care.
- 60 of 183 (32.8 percent) facilities offer services in Chinese. Of these, 27 (14.8 percent of total) provide primary health care.

*Please use these percentages only as rough estimates due to duplications in entries.

helpful public insurances offered by New York State for more specific health care needs.

However, sometimes facilities might offer a type of specialty care, but do not accept the respective public insurance. For example, facilities offering HIV/AIDS treatment do not always accept the AIDS Drug Assistance Program (ADAP). Further research is needed to determine what the gap is between Medicaid coverage and the coverage provided by other types of New York State insurances, and whether or not this is a gap that a lot of people are falling through. On a positive note, mental health services seem to be very pervasive and effective throughout the district. This is perhaps why 76.4 percent of the CD 3 area (more accurately, of UHF District 309/310) of adults with serious psychological distress have received counseling or taken a prescription medication for a mental health problem (NYC DOHMH, 2013).

Additionally, a search of CVS, Walgreens, Duane Reade, and Rite Aid walk-in clinic locations in NYC show that none of these chain retail stores have clinic locations in CD 3. Only three facilities – Ryan-NENA Community Health Center, Charles B. Wang Community Health Center, and the New York Eye and Ear Infirmary of Mount Sinai – advertised that they offered urgent care services. Inviting these retail stores to open walk-in clinics in their CD 3 locations might ease the burden on emergency departments.

This analysis is based on pre-Medicaid reform conditions. It is difficult to determine what the effect of the Medicaid expansion and DSRIP reform will be, but since the PPS indicators are perhaps dependent on existing health facility structures and hospital networks, it may depend on additional ingenuity to improve health care access for this very special area of Manhattan.

Implications

Health care improvement indicators from the Medicaid expansion will not be known for at least a few years (Amy Shah, personal correspondence, 2015), combined with the at-best murky future of federal funding levels (Ku, Zur, Jones, Shin, & Rosenbaum, 2014) but more-likely decline of federal funding (Brown, 2015), make it difficult to predict how recent policy changes will impact safety net facilities' capacity to handle an increase in Medicaid patients. As parts of CD 3 already have primary care physician shortages (Lager, Green, Kim, & Zahn, 2006), it seems that a decrease in federal funding sources like DSH payments may have dire consequences for the population that depends on the facilities who stay open because of these reimbursements.

There are many reasons why health care accessibility in CD 3 should be of concern. **First**, **CD 3 is a federally designated health professional shortage area (HPSA) in the fields of primary care, dental care, and mental health**; 16 out of 30 CD 3 census tracts are federally designated medically underserved areas (MUA) (HRSA, 2014b).

Second, the Affordable Care Act (ACA) predicts that decreasing the number of uninsured people through increasing enrollment will allow for funding cuts to reimbursement programs, namely the Disproportionate Share Hospital (DSH) payments (American Hospital Association (AHA), 2015). However, this may not be the case for New York City. **New York City's Health and Hospital Corporation (HHC) predicts that the number of uninsured users at HHC hospitals will not drop enough to compensate for decreasing DSH funding, putting HHC facilities and other safety-net providers in peril (Office of the New York City Comptroller Scott M. Stringer, 2015; Ku, Zur, Jones, Shin, & Rosenbaum, 2014).**

Third, high rates of preventable ED visits are linked with poor access to primary care (Billings, Parikh, & Mijanovich, 2000; Weiss, Wier, Stocks, & Blanchard, 2014). The demographic characteristics connected with higher rates of preventable emergency department (ED) visits also reflect the demographic make-up of CD 3 (Gould, Woujas, & Raven, 2008); this supports the finding that CD 3 is known to have medical professional shortages in health care (HRSA, 2014b). While some studies show that CD 3 ED usage is relatively low (Raven & Gould, 2012) and the Community Health Survey shows relatively high percentages of people reporting good to excellent health (New York City Department of Health and Mental Hygiene (NYC DOHMH), 2013), **it is necessary to keep in mind that there may be a large population not being captured in these studies and surveys, due to a substantial immigrant as well as undocumented immigrant presence in the district (NYS DOH, 2012).**

Fourth, **results from this report's analysis suggest that while Spanish-speaking services might be readily available to the Hispanic population of CD 3, there is a need to increase the number of Chinese-speaking providers.** Furthermore, the Charles B. Wang Community Health Center states that 89 percent of their patients would be served better in a language other than English (Shao-Chee Sim, personal communication, February 10, 2015), suggesting difficulty in reaching these populations with culturally or linguistically insensitive public health campaigns.

Fifth, **in terms of public insurance, perhaps it would be wise for providers to consider accepting different forms of public health insurance that is meant for the vulnerable populations they aim to help.** For example, 27 percent of safety-net providers offer both substance abuse and HIV/AIDS care services; only a third of these providers (or 4.4 percent of the total number of safety-net providers) will also accept reimbursement from the AIDS Drug Assistance Program (ADAP) to compliment these specialized services. Gaps in target population and appropriate insurance coverage for these populations should also be addressed when addressing health care access.

DSRIP and the MRT's overall goals are aimed to improve all of these issues. However, to deal with these complicated issues, the relationships between safety-net primary care providers, primary care

access, funding, and reform are closely knit together. The success of one component depends on the success of others. **Safety-net providers must have sufficient funding to provide adequate primary care access. Policy reform must be appropriate to allow safety-net providers the leverage and space to innovate new solutions for health care access.**

Taking all into consideration, this report offers a handful of action items:

1) **Work with existing providers to create more urgent care locations.**

2) **Work with existing providers to increase awareness of and streamline access to enabling and social services.** Under New York State Public Health Law and the ACA, "patients will be provided guidance in applying for public insurance programs (Qualified Health Plans), Government or Hospital Financial Assistance programs based on financial need and eligibility for such" (Mount Sinai, 2015). Additionally, it might be helpful to recruit someone on the community board to be an expert in social services resources in the district. Finally, encouraging providers to make services more readily apparent on their website and to do community outreach about their services might make navigating the health care system less daunting.

3) **Lobby for increased city investment into safety-net providers**, especially in light of predicted decreases in federal funding.

4) **Integrate the issue of safety-net provider preservation with other issues faced by CD 3.** Gentrification and increasing property values not only affects low-income residents, it also affects small and local businesses. Community-based health organizations are so effective precisely because

they are based locally. Additionally, they operate with financial risk because they serve vulnerable populations. Thus, lobbying for zoning and land use policies that are local business friendly and are effective in keeping rent low, may give key community health organizations the extra financial cushion they need to keep serving the community. Educating property owners about the benefits of local business may also help them actively look for and foster the small businesses and organizations that make a community healthy and vibrant.

5) Finally, **improve the socio-economic status of CD 3 residents.** Safety-net providers face people living in poverty every day. Many organizations in the district already provide job training, standardized test tutoring, and re-entry programs to help people become and stay independent. Supporting and bolstering the efforts of these non-medical organizations will also increase the capacity of safety-net users to carry some of the financial burden currently being pushed onto safety-net providers. The Institute of Medicine (2000) aptly writes in their book America's Safety-Net: Intact But Endangered, "the level of local support received by safety net providers depends in no small degree on the political will of the community, its attitudes toward vulnerable populations, and its attitudes toward the providers who serve them."

Terms & Resources

	Term	Definition	Resource
Geographic Areas	HPSA	Health professional shortage area	http://hpsafind.hrsa.gov/
	MUA	Medically underserved areas	http://muafind.hrsa.gov/
	CD 3	Manhattan Community District 3	
	CB 3	Manhattan Community Board 3	
Agencies	AHA	American Hospital Association	http://www.aha.org/
	HRSA	U.S. Health and Services Administration	www.hrsa.gov
	HHC	New York City Health and Hospital Corporation	http://www.nyc.gov/html/hhc/html/home/home.shtml
Policies	MRT	Medicaid Redesign Team	https://www.health.ny.gov/health_care/medicaid/redesign/
	ACA	Affordable Care Act, also known as 'Obamacare'	http://www.hhs.gov/healthcare/rights/
	DSH	Disproportionate Share Hospital payments	http://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/medicaid-disproportionate-share-hospital-dsh-payments.html
	DSRIP	Delivery System Reform Incentive Payment Program	https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/
	PPS	Performing Provider System	Mt Sinai PPS website: http://mountsinaipps.org
Insurances	EPIC	Elderly Pharmaceutical Insurance Coverage	https://www.health.ny.gov/health_care/epic/
	CHIP	Children's Health Insurance Program	https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/
	ADAP	AIDS Drug Assistance Program	https://www.health.ny.gov/diseases/aids/general/resources/adap/eligibility.htm
	PCAP	Prenatal Care Assistance Program	https://www.health.ny.gov/community/pregnancy/health_care/prenatal/helpful_links.htm

General	ED	Emergency Department	http://www.cdc.gov/nchs/fastats/emergency-department.htm
	HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome	https://www.aids.gov/hiv-aids-basics/
	LGBTQ	the population identifying as lesbian, gay, bisexual, transgender, queer	http://www.cdc.gov/lgbthealth/
	SBHC	School-Based Health Centers	http://schools.nyc.gov/Offices/Health/SBHC/SBHC.htm
	SBHMC	School-Based Mental Health Centers	http://schools.nyc.gov/Offices/Health/SBHC/MentalHealth.htm
	FQHC	Federally qualified health centers	Find a health care center: http://findahealthcenter.hrsa.gov/Search_HCC.aspx
	FQHC-LKL	Federally qualified health centers look-alike	Find a health care center: http://findahealthcenter.hrsa.gov/Search_HCC.aspx

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