



ACCESS TO PRIMARY CARE IN NEW YORK STATE

A SPECIAL DATA REPORT
DURING THE COVID-19 PANDEMIC

MAY 2022
(UPDATED AUGUST 2022)

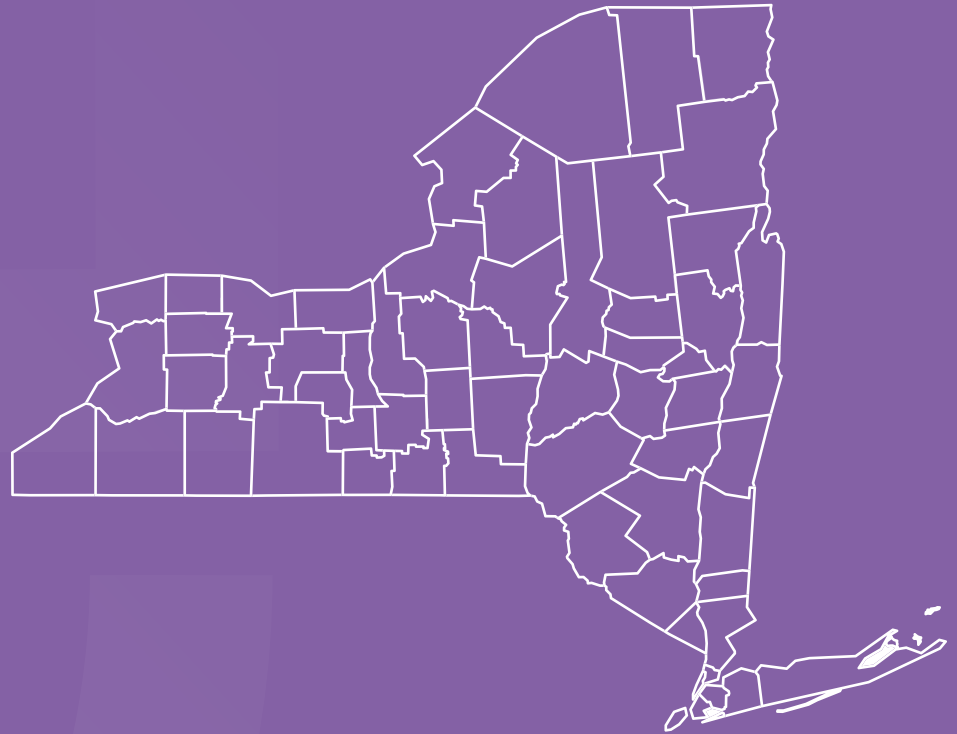
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INTRODUCTION



SECTION 1.0

1.0 INTRODUCTION

Primary care is a cornerstone of vibrant, thriving communities across New York State (NYS) and helps keep families healthy, children ready to learn, and adults able to pursue education and participate in the workforce. Primary care also saves lives, leads to improved individual and community health, and is unequivocally central to health equity.

Regular access to primary care is consistently associated with positive health outcomes and has not only been shown to reduce overall health care costs but is the only part of the health system that has been proven to lengthen lives and reduce inequities at the population level.

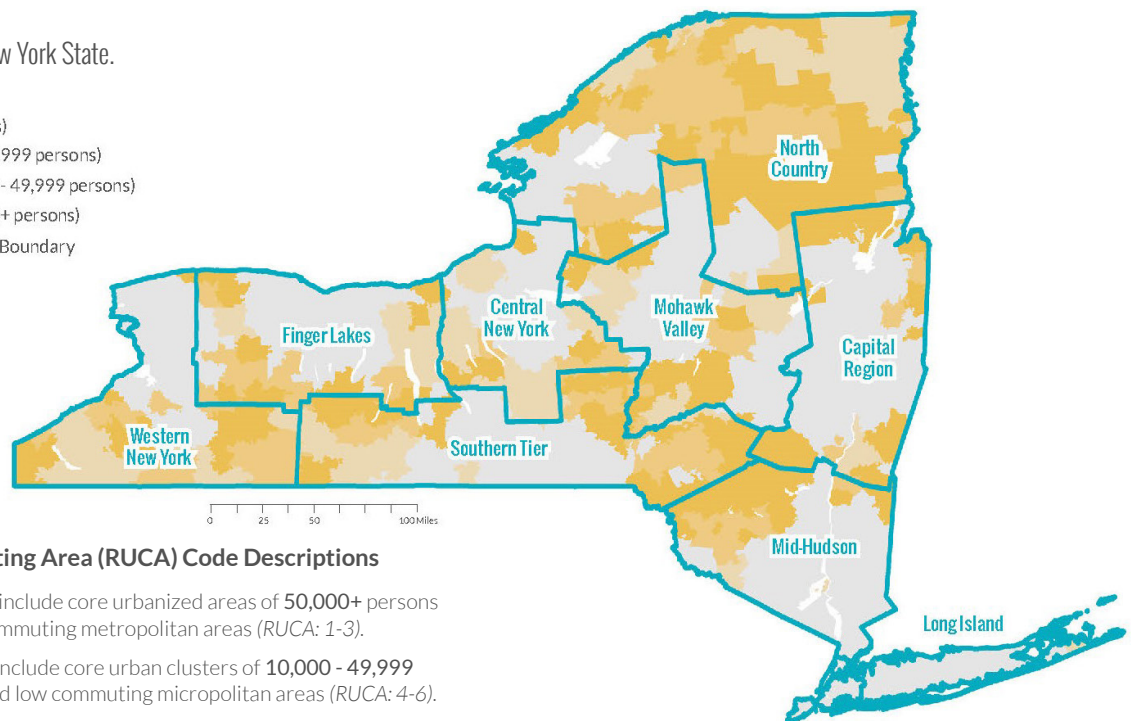
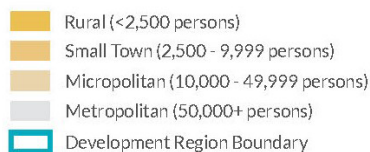
Geographic disparities in primary care access exist across New York, a diverse state – home to both large urban centers and broad swaths of rural

communities, making health care needs and challenges as unique as New York’s populations. In rural communities, access to health care is one of the most urgent health care problems, driven by provider shortages, lack of resources, and threats to financial sustainability for rural practices.

For this report, the **Primary Care Development Corporation (PCDC)** explored primary care

access across New York and identified emergent challenges associated with the COVID-19 pandemic. To complement the quantitative data analysis, PCDC conducted interviews with three prominent health care providers who serve rural communities in New York. Herein, PCDC also presents new data on primary care access, vaccination status, and other measures by economic development region.

FIG 1.
Map of Rural Areas in New York State.



Rural-Urban Commuting Area (RUCA) Code Descriptions

- Metropolitan areas include core urbanized areas of 50,000+ persons and high and low commuting metropolitan areas (RUCA: 1-3).
- Micropolitan areas include core urban clusters of 10,000 - 49,999 persons and high and low commuting micropolitan areas (RUCA: 4-6).
- Small towns include urban clusters of 2,500 - 9,999 persons and high and low commuting small towns (RUCA: 7-9).
- Rural areas include clusters of <2,500 persons (RUCA: 10).

EXECUTIVE SUMMARY



SECTION 2.0

2.0 EXECUTIVE SUMMARY

In this report, PCDC explores primary care access and barriers across New York State through the lens of the COVID-19 pandemic. Previous reports in this series have highlighted disparities in accessing health care across NYS, contrasting the different elements of primary care access in micropolitan and metropolitan areas of the state. Through further investigation and analyses, trends of previously published access measures were revisited, as well as recent challenges that magnified existing disparities.

The COVID-19 pandemic led to the intensification of existing access barriers and the emergence of new health care delivery challenges, such as broadband access and vaccine hesitancy, making clear that equitable, upstream investments in primary care in NYS are needed now more than ever.

In this report, PCDC makes available new data by economic development region that describe primary care access, broadband access, and vaccination status indicators.

Key findings:

- + Primary care access varies widely across NYS, and primary care provider availability is directly associated with the number of residents reporting they had a routine visit within the past year.
- + A higher percentage of residents identifying as racial/ethnic minorities associates with a higher percentage of residents reporting they have no usual source of care and delaying or forgoing care due to cost.
- + Broadband access is lower in rural regions of NYS, areas that also have larger Medicaid populations and higher uninsured rates, which may compound access challenges for these patients.
- + A high rate of COVID-19 vaccine hesitancy is associated with indicators of low primary care utilization, including a lower percentage of people with recommended screenings or core preventive services.

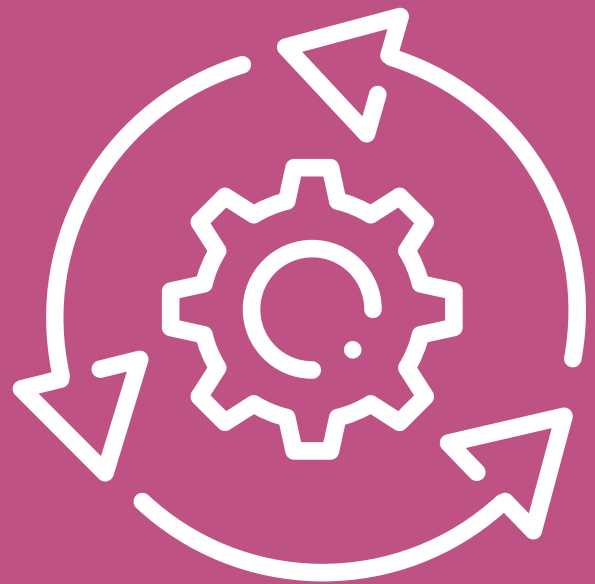
In this report, PCDC offers a series of recommendations to increase access to high-quality primary care for all New Yorkers.

Increase investment in primary care through higher reimbursement rates, incentive payments, and other investments to ensure better access to quality primary care by attracting more providers to practice in primary care, reducing burnout and exits from the workforce, and increasing the ability of providers to integrate care.

Eliminate barriers to care by supporting and investing in expanded access to telehealth.

Expand rural workforce incentives by adding new loan forgiveness, incentives, recruitment, and other workforce expansion programs to bring primary care providers to rural areas in NYS.

THE STATE OF PRIMARY CARE IN NEW YORK: AN UPDATE



SECTION 3.0

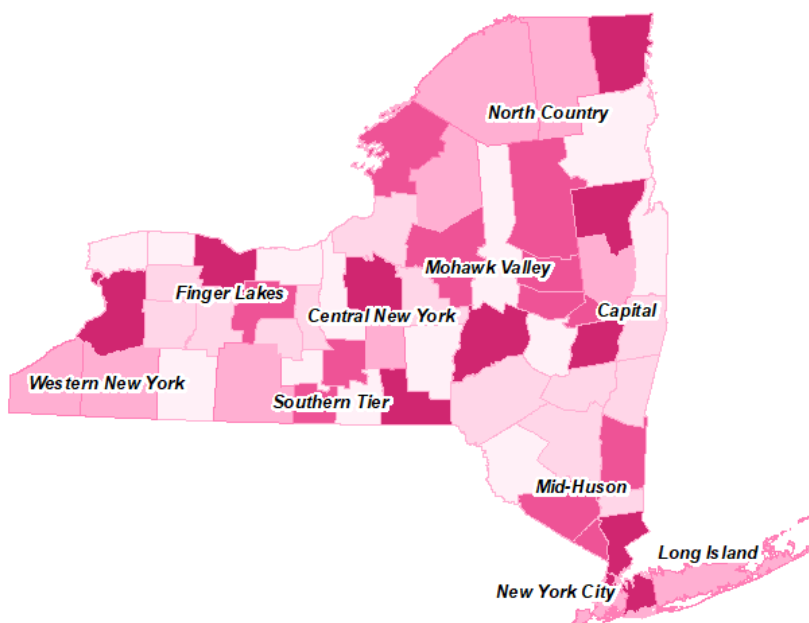
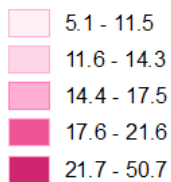
3.0 THE STATE OF PRIMARY CARE IN NEW YORK: AN UPDATE

Regular access to primary care is associated with positive health outcomes, especially when addressing heart disease, the leading cause of death in New York State, and other common chronic conditions such as diabetes and asthma (Shi, 2012).

Primary care is essential to ensure individuals and communities have access to preventive services such as screenings and immunizations and can manage chronic disease and avoid more costly services like emergency department visits (CDC, 2017). Across NYS, access to primary care varies greatly by both geography and population characteristics. In its 2019 report, PCDC found key challenges to primary care access, particularly in non-metro areas of the state (PCDC, 2019).

FIG 2.
Map of Primary Care Providers per 10,000 Residents, New York State.

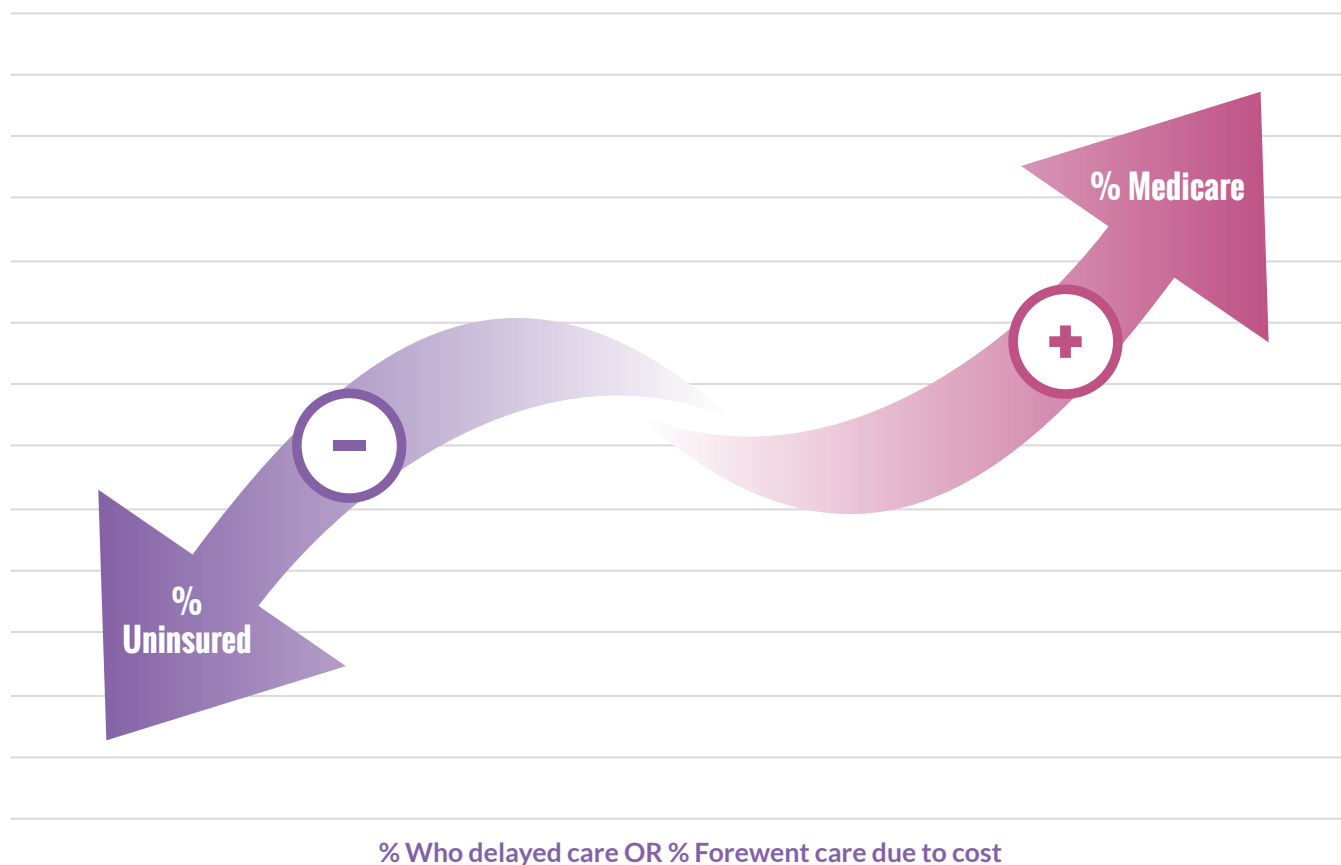
PCPs per 10,000 residents



Provider availability impacts primary care utilization, and racial/ethnic disparities exist.

Primary care provider (PCP) availability varies significantly across New York. [Figure 2] A greater number of PCPs per 10,000 residents is positively associated with the percentage of residents reporting they visited a doctor for a routine checkup within the last year. A higher percentage of residents identifying as racial/ethnic minorities is associated with more residents reporting they have no usual source of care and that they delayed or forwent care due to cost.

FIG 3.
Insurance and Primary Care Utilization



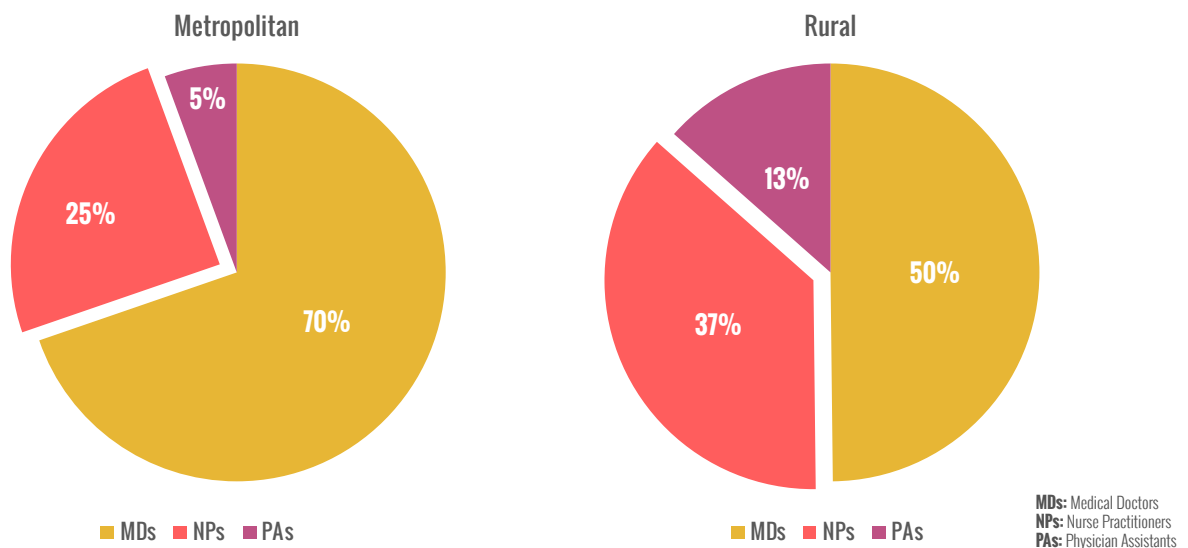
Primary care access is directly correlated with health insurance coverage

Primary care utilization across NYS is affected by populations' insured status. For example, in areas where there are higher rates of uninsured, fewer people report having a visit with a doctor for a routine checkup in the last year [Table 1], an association supported by previous research (Kravet et al., 2008). Areas with a larger uninsured population are also more likely to have more residents reporting no usual source of care and having to delay or forgo care due to costs (Garfield et al., 2019).

Primary care access also varies for people with public insurance coverage as residents of areas with a greater proportion of Medicaid patients are more likely to report delaying or forgoing care due to cost and not having a usual source of care [Table 1]. For people covered by Medicare, the opposite is true; a larger proportion of Medicare patients is associated with fewer residents reporting delaying or forgoing care due to cost and not having a usual source of care (Seo et. al, 2019).

FIG 4.

Primary Care Provider Type by Profession Type and Rural-Urban Commuting Area (RUCA) Category, New York State



Multiple factors impact rural PCP workforce

Primary care providers in rural NYS communities provided insights into key areas that impact the availability and sustainability of the rural primary care workforce. Dr. John Rugge at Hudson Headwaters in the Adirondacks Region and Mary Zelazny at Finger Lakes Community Health Center both recognized the challenges faced at health centers of identifying and retaining providers in rural areas of the State, citing the following as key challenges to the rural workforce.

- + **Providers accept insurance plans at different rates across the state.**
 - + There are geographic differences in the availability of providers who accept Medicaid vs. Medicare and previous findings suggest that providers are less likely to accept new patients who are covered by Medicaid than those with Medicare or private insurance (MACPAC, 2021). This is likely due to lower reimbursement rates for Medicaid.
- + **Reimbursement rates differ by region and provider profession types.**
 - + In NYS, NPs are reimbursed 85% of the physicians' rates for Medicare, but for Medicaid, they get 100% of the physician reimbursement rate.
 - + Upstate and downstate Medicaid reimbursement rates differ with upstate providers receiving a lower rate.
- + **There are fewer primary care providers in rural areas [Figure 2]**
 - + In rural areas of NYS there are larger proportions of NPs and PAs providing primary care than in metropolitan areas, which highlights the importance of these profession types in shortage areas. [Figure 4]
 - + Existing funding mechanisms and medical school loan forgiveness programs may be used to recruit more PCPs to rural areas, particularly for NPs to practice in rural NYS.

NEW ACCESS ISSUES EMERGE: BROADBAND ACCESS



SECTION 4.0

4.0 NEW ACCESS CHALLENGES EMERGE: BROADBAND ACCESS

In March 2020, the swift onset of the COVID-19 pandemic forced the large majority of New Yorkers into quarantine or isolation and work from home settings. As many health centers made quick changes to move health service delivery to virtual visits, a new barrier to access to health care emerged for many: broadband access.

“

For so many patients we've had to say, 'Please drive to your local town center and then call us up on your iPhone so that we can have a clinical visit.'"

- DR. JOHN RUGGE
Hudson Headwaters
Health Network

Challenges with broadband access for accessing telehealth services are not new and have been documented nationally: 43% of households with an annual income of \$30,000 or less are estimated to not have at-home broadband. This digital divide well preceded the COVID-19 pandemic. However, the pandemic's quick and nearly universal transition to virtual visits made broadband access a core component of health care access (Horrigan, 2021).

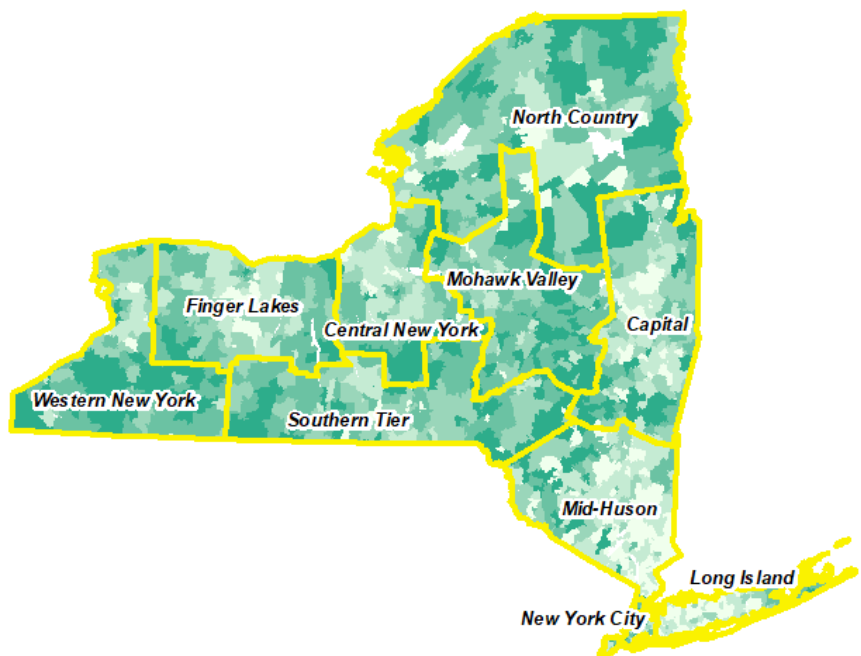
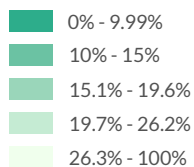


FIG 5.
Map of Broadband Access by ZCTA, New York State

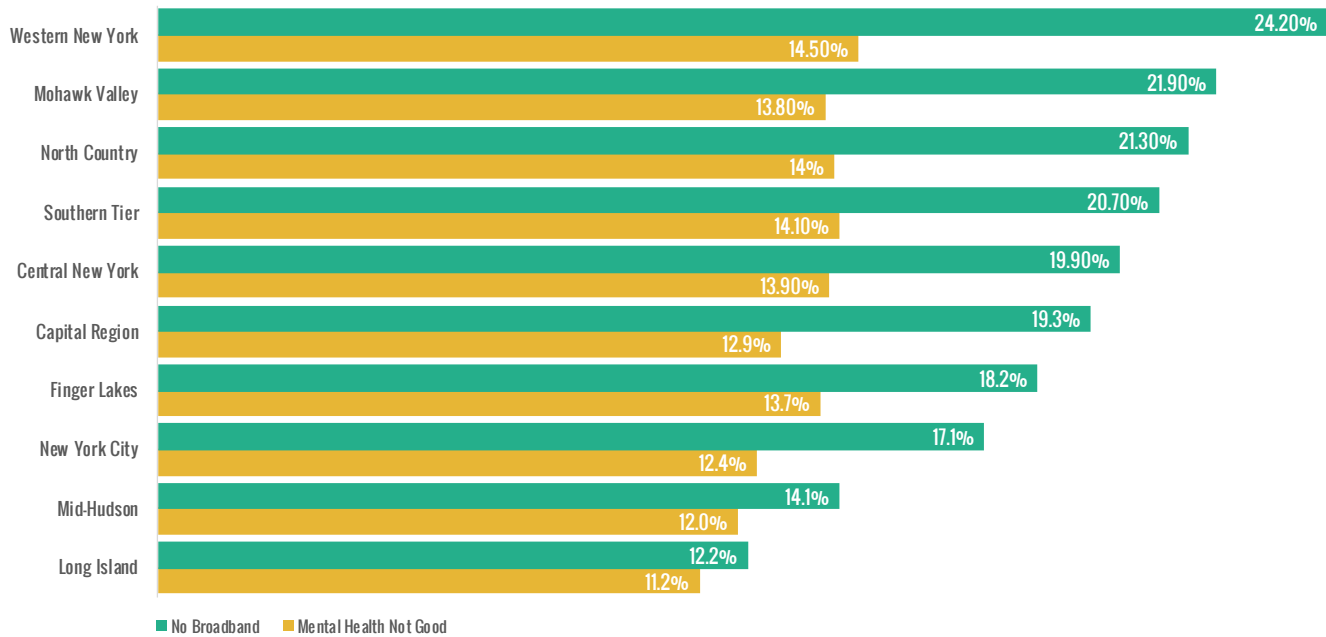
%No Broadband



Yellow outline: Economic Development Regions

FIG 6.

Broadband Access and Self-Reported Poor Mental Health by Economic Development Region, New York State



Broadband access overlaps with key measures of access to care

Across NYS, areas with poor broadband access simultaneously experienced other access barriers. Broadband access is lower in more rural areas across the state. [Figure 5] There is also lower broadband access in areas with lower percentages of people receiving core preventive services, including screenings for cervical, colorectal, and breast cancers [Figure 6, Table 1]. Similarly, there are larger percentages of the population reporting poor mental health in low broadband areas, which emphasizes the importance of being able to deliver behavioral health services.

Broadband access associated with patterns of insurance

Areas with lower broadband access also have larger Medicaid populations and higher uninsured rates, which may compound access challenges for these patients, particularly finding PCPs who will accept new Medicaid patients or are willing to see patients who are unable to pay. [Table 1] Of note, the opposite association is true for Medicare, where high rates are associated with higher percentages of broadband.

“

It is critical to meaningfully invest in telehealth. The return on investment is huge as so many patients rely on it for their health care and mental health needs.”

– MARY ZELAZNY
Finger Lakes
Community Health

Broadband access will become increasingly important as hybrid visit types become the ‘new normal’ of providing health care services (Fishbane and Tomer, 2019). This is an important advancement for patients in provider shortage areas—or areas that do not have affordable providers who accept their insurance—who would otherwise have to drive long distances to get affordable care or be forced to forgo care altogether (Aron et. al, 2021).

Community Health Provider Insights

Providers in rural areas of NYS have long been aware of the need to provide telehealth services for patients unable to physically present at locations and the additional challenge broadband access plays.

“On the outpatient side, people in our community couldn’t go to clinics for long stretches of time due to the pandemic. We had minimal staffing for emergency visits, but for everything else, we were entirely reliant on telehealth to meet our patients’ needs.”

– ROBERT ROSS
St. Joseph’s Addiction Treatment & Recovery Centers

The cost of sustaining telehealth is an issue community providers are acutely aware of, and one that some providers believe the State can play a role in. Robert Ross, CEO of St Joseph’s Treatment Center in the Saranac Lake region, has championed the idea of creating a new rural reimbursement category for State Medicaid. Additionally, Mr. Ross believes that translating waivers from the pandemic into legislation as soon as possible will ensure profitability of telehealth.

“The state waivers were invaluable for telehealth because it wasn’t possible to pass brand new legislation fast enough, but we don’t want to rely on waivers going forward. We need to have actual changes to the regulations so we have the structure to sustain telehealth.”

– ROBERT ROSS
St. Joseph’s Addiction Treatment & Recovery Centers

NEW ACCESS ISSUES EMERGE: VACCINE HESITANCY



SECTION 5.0

5.0 NEW ACCESS CHALLENGES EMERGE: VACCINE HESITANCY

The COVID-19 pandemic has created multiple health care challenges beyond managing the effects of the virus itself. One prominent issue has been vaccine hesitancy, which impacts COVID-19 infection rates, disparities in health outcomes related to the virus, and longer-term outcomes like life expectancy across populations (Ratzan et. al, 2021).

As of August 2021, the majority of hospitalizations and deaths attributable to COVID-19 are among the unvaccinated (Lo et al., 2022). Areas with higher rates of unvaccinated New Yorkers may indicate areas where additional stress may be placed on health care systems and where worse outcomes may be expected (New York State Department of Health, 2022).

FIG 7.a
New Yorkers Reporting COVID-19 Vaccine Hesitancy by County

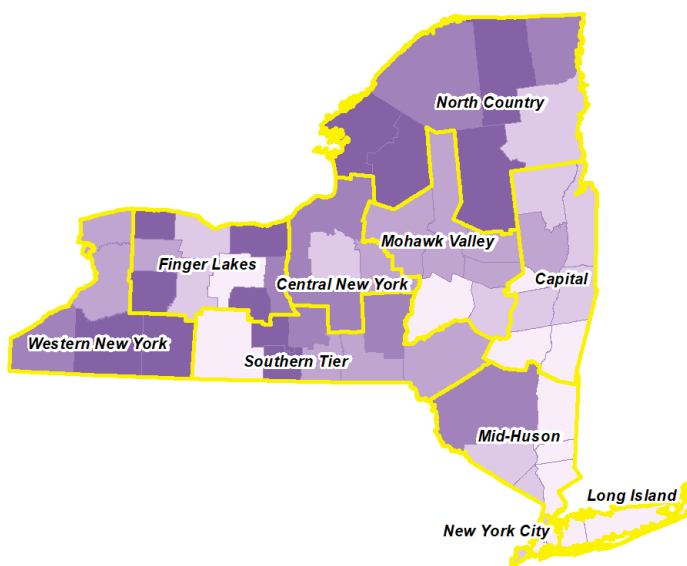
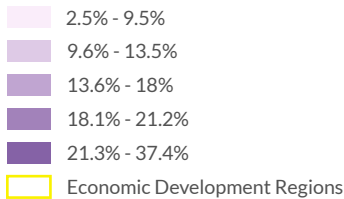
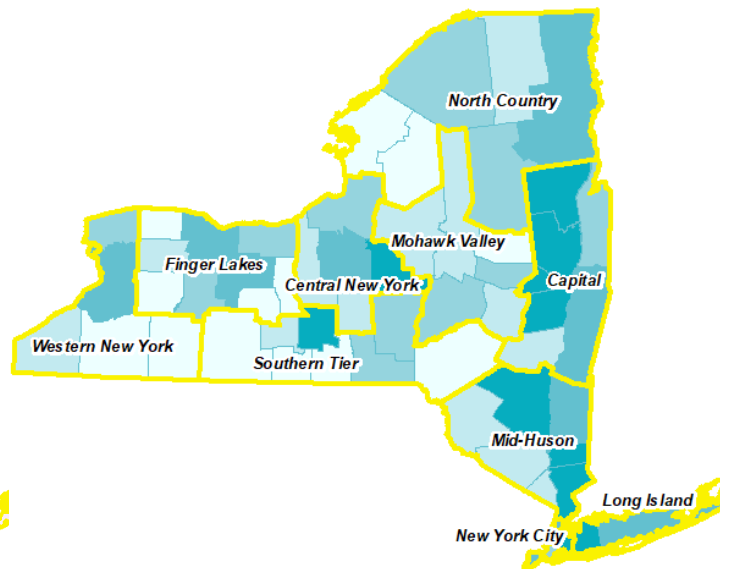
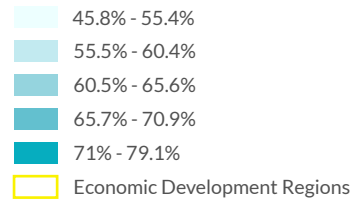


FIG 7.b
New Yorkers Receiving at Least One COVID-19 Vaccination Dose by County



Vaccine hesitancy is higher in communities with lower primary care utilization.

The reported percentages of people reporting vaccine hesitancy as of October 2021 vary across NYS. [Figure 7a] Rates of COVID-19 vaccine hesitancy are associated with indicators of lower primary care utilization, suggesting there may be broader differences in health-seeking behaviors across communities. Higher percentages of reported vaccine hesitancy are associated with a lower percentage of people receiving screenings or core preventive services. [Table 1] Greater hesitancy was also associated with areas with higher proportions of Medicaid and low-income populations.

Counties with more vaccine hesitancy also have larger percentages of the population reporting poor mental health. Closing gaps in vaccination uptake will be important for recovering from the pandemic and ensuring communities are not further burdened by COVID-19 and its impacts on physical and mental health.

Racial and ethnic disparities in vaccination are persistent across New York.

In NYS, there are racial/ethnic disparities in COVID-19 case and mortality rates as well as in vaccination rates, especially for those under 65 (Murthy et. al, 2021). Our findings show that racial/ethnic disparities in vaccination exist across regions of NYS. At the county level, vaccine hesitancy is greater in communities that have a larger percentage of white residents and are lower in communities with a larger population of non-white residents. [Table 1] These findings are supported by research showing that while Black and white individuals reported comparable rates of vaccine hesitancy at the onset of the COVID-19 pandemic, Black individuals more quickly overcame this hesitancy than white individuals (Padamsee, 2022). The gaps in COVID-19 vaccination rates by race, at present, are hypothesized to reflect access barriers rather than vaccine hesitancy (Sparks, 2022).

Community Health Provider Insights

Insights from providers point to differences between health center patients and members of the surrounding community who do not visit the health centers. In the Finger Lakes region, Mary Zelazny, CEO of Finger Lakes Community Health, reports that most patients at their health center have received a vaccination but that anecdotal evidence indicates many people are not getting vaccinated in the broader community.

Additionally, vaccine hesitancy presented a new problem for health centers when vaccine mandates led to resignations of health center staff.

“

We pushed very hard for our staff to get vaccinated without using a mandate, because we saw the mandate as a double-edged sword. Some of the bigger institutions and hospitals are losing scores of people because of the refusal to get vaccinated, and we didn't want to go that route.”

– BOB ROSS
Finger Lakes Community Health

“

We don't have a high vaccination rate; there's a huge divide in rural New York state. I think I lost more staff — 13 people — because of the vaccine mandate than from anything else.

– MARY ZELAZNY
Finger Lakes Community Health

POLICY RECOMMENDATIONS



SECTION 6.0

Eliminate Barriers to Care

Increased uptake of telehealth modalities by providers due to the COVID-19 pandemic, made possible in part by increased reimbursement rates and regulatory flexibility under emergency policies, enabling new care access points.

Moving forward, policymakers should continue to support expanded access to telehealth, including through parity in reimbursement rates.



Recommendation: While expansion of access to telehealth during the pandemic meant better access in rural communities, policymakers should continue to invest in broadband access in rural communities to allow everyone to have full access to telehealth.

Expand Rural Workforce Incentives

Policymakers in New York State have already begun to turn their attention to expanding the health care workforce through incentives, bonuses, and tuition reimbursement programs; those programs are even more critical in rural areas.

Policymakers at the state and federal levels should consider earmarking funding for rural areas and adding new loan forgiveness, incentives, recruitment, and other workforce expansion programs to bring primary care providers to rural areas in NYS.



Recommendation: Medical schools should be encouraged to promote rural residency programs and to partner with rural providers.

Invest in Primary Care to Increase Access, Reducing Vaccine Hesitance

Increasing investment in primary care, through increased reimbursement rates, incentive payments, and other sources of funding, can ensure better access to quality primary care by attracting more providers to practice in primary care, reducing burnout and exits from the workforce, and increasing the ability of providers to integrate care.

Specifically, concentrating on increasing payment for primary care may result in more individuals having a long-term primary care provider, building trust with that provider, and ultimately choosing to get vaccinated. Medicaid reimbursement rates specifically should be a significant priority.



Recommendation: Given the efficacy of FQHCs in meeting the needs of patients with a range of insurance providers as well as those who are uninsured, policymakers should incentivize the construction of new FQHCs in rural areas that currently do not have facilities.

DATA RESOURCES



SECTION 7.0

7.1 DATA TABLES

Table 1. Economic Development Region

		Capital Region	Central New York	Finger Lakes	Long Island	Mid-Hudson	Mohawk Valley	New York City	North Country	Southern Tier	Western New York
Primary Care Access	PCPs per 10,000	16.0	19.3	18.2	16.2	14.9	18.4	18.2	15.6	15.8	17.2
	Routine Checkup	80.7%	79.9%	79.8%	81.0%	79.9%	80.5%	80.5%	80.2%	79.6%	81.7%
	Delayed Care	9.8%	10.6%	10.2%	9.3%	11.1%	11.2%	12.4%	9.7%	10.2%	10.5%
	Colon Screen	67.5%	67.5%	66.3%	65.9%	66.2%	66.9%	63.2%	67.3%	65.7%	64.6%
	Cervical Screen	86.6%	86.2%	85.5%	88.8%	86.6%	86.3%	84.4%	85.5%	85.0%	85.7%
	Core Services	27.9%	28.4%	26.4%	29.5%	26.2%	26.0%	22.7%	26.8%	26.0%	23.3%
	Mhealth Not Good	12.9%	13.9%	13.7%	11.2%	12.0%	13.8%	12.4%	14.0%	14.1%	14.5%
Health Insurance	Uninsured	3.1%	3.7%	4.2%	4.6%	4.0%	4.0%	5.5%	5.2%	4.2%	5.1%
	Medicaid	17.5%	19.6%	19.5%	11.0%	15.8%	21.2%	20.6%	21.7%	22.4%	21.1%
	Medicare	79.4%	76.0%	75.9%	84.4%	80.1%	74.8%	62.8%	73.1%	73.4%	73.9%
Sociodemographic	Race/Ethnic Minority	10.1%	8.9%	12.4%	27.7%	25.3%	6.4%	62.9%	7.0%	7.1%	12.7%
	White	92.0%	92.5%	90.2%	81.0%	81.9%	95.2%	47.1%	94.0%	94.5%	88.9%
	Low Income	25.1%	29.1%	27.8%	14.5%	21.5%	29.9%	31.3%	32.1%	32.3%	33.8%
Broadband Access	No Broadband	19.3%	19.9%	18.2%	12.2%	14.1%	21.9%	17.1%	21.3%	20.7%	24.2%
COVID-19 Vaccine	Fully Vaccinated	68.8%	64.2%	59.8%	75.0%	65.9%	59.3%	72.2%	60.3%	58.0%	57.4%
	Vaccine Hesitant	13.2%	16.3%	17.1%	8.0%	11.6%	18.9%	10.2%	15.9%	19.4%	20.0%
	Black Vaccinated	61.1%	56.9%	45.1%	74.6%	65.1%	54.1%	75.0%	33.8%	61.1%	58.5%
	White Vaccinated	79.1%	75.8%	70.4%	82.3%	71.7%	67.1%	62.8%	75.9%	66.9%	66.5%

7.2 DATA SOURCES AND DEFINITIONS

Measure Definitions

Rural - Urban Classification :

- + Metropolitan areas include core urbanized areas of **50,000+** persons and high and low commuting metropolitan areas
- + Micropolitan areas include core urban clusters of **10,000 - 49,999** persons and high and low commuting micropolitan areas
- + Small towns include urban clusters of **2,500 - 9,999** persons and high and low commuting small towns
- + Rural areas include clusters of **<2,500** persons

Note on Primary Care Access Measures :

Each of the primary care measures presented in the report serves to compare access at the Zip Code Tabulation Area (ZCTA), economic development region, or county level in New York State. These comparisons do not establish a threshold for adequate access for the measures.

Primary Care Providers:

Mean ratio of primary care providers per 10,000 persons ages 18 years and older, in New York State, 2021

- + Number of PCPs with a practice location in the ZCTA multiplied by **10,000**, and then divided by the population of persons **18 years of age** and older residing in a ZCTA
- + PCPs with multiple practice locations in one ZCTA were counted once within the ZCTA

Demographics and Health Status:

Mean percent of persons identified as a racial or ethnic minority, New York State, 2015-2019

- + Number of persons **ages 18** and older in the ZCTA who identify as a racial or ethnic minority divided by the total number of persons **ages 18 and older** residing in the ZCTA

Mean percent of persons identified as White, in New York State, 2015-2019

- + Number of persons **ages 18** in and up the ZCTA who identify as white divided by the total number of persons **ages 18** and up residing in the ZCTA

Mean percent of households that are low income (at or below 200% FPL), by Economic Development Region in New York State, 2015-2019

- + Number of households in the ZCTA that are low income (living at or below 200% FPL), divided by the total number of households residing in the ZCTA

Health Care Insurance and Access :

Mean percent of persons ages 18–64 who are uninsured in New York State, 2020

- + Number of persons **ages 18-64** in the ZCTA with no insurance divided by the total number of persons **ages 18-64** residing in the ZCTA

Mean percent of persons who delayed or did not seek out care due to high cost, in New York State, 2017

- + Number of persons **ages 18** and older in the ZCTA who delayed or did not seek out care due to high cost divided by the total number of persons **ages 18** and older residing in the ZCTA
- + Mean percent of persons **aged 18** and up who do not have a usual source of primary care, in New York State, 2017
- + Number of persons **ages 18 and up** in the ZCTA who do not have a usual source of primary care divided by the total number of persons **ages 18 and up** residing in the ZCTA

Preventive Care Utilization and Health Status :

Mean percent of persons aged 18 and up who had a routine checkup in the past year, in New York State, 2020

- + Number of persons ages 18 and older in the ZCTA who have had a routine checkup in the past year divided by the total number of persons ages 18 and older residing in the ZCTA

Mean percent of male adults aged 65 and up who are up to date on their core set of clinical preventative services, by Economic Development Region in New York State, 2020

- + Number of male-identified persons aged 65 and older in the ZCTA who are up to date on their core set of clinical preventative services divided by the total number of persons aged 65 and older residing in the ZCTA, averaged by Economic Development Region

Mean percent of persons aged 18 and up who have had a colon cancer screening, in New York State, 2020

Number of persons ages 18 and up in the ZCTA who have had a colon cancer screening divided by the total number of persons ages 18 and up residing in the ZCTA

Mean percent of persons aged 18 and up who reported that their mental health had not been good for 14 or more days in the past 30 days, in New York State, 2020

- + Number of persons ages 18 and up in the ZCTA who reported that their mental health had not been well in the past 30 days

Broadband Access :

Mean percent of households with no broadband access, in New York State, 2015-2019

- + Number of households in the ZCTA with no broadband access divided by the total number of households in the ZCTA, averaged by Economic Development Region

COVID-19 Vaccination :

Mean percent of persons aged 18 and up who reported hesitancy about the COVID-19 vaccination, in New York State, 2021

- + Number of persons ages **18 and older** in the ZCTA who are hesitant about receiving the COVID-19 vaccination divided by the total number of persons ages **18 and older** residing in the ZCTA, averaged by Economic Development Region

Mean percent of persons aged 5 and up who received both doses of the COVID-19 Vaccine, by County in New York State, 2022

- + Number of persons **ages 5 and older** in the ZCTA who received both doses of the COVID-19 vaccine divided by the total number of persons ages 5 and older residing in the ZCTA, averaged by County Level

Mean percent of persons identified as Black, aged 15 and up, who received at least one dose of the COVID-19 Vaccine, by Economic Development Region in New York State, 2022

- + Number of persons identified as Black, **ages 15 and older**, in the ZCTA who received at least one dose of the COVID-19 vaccine divided by the total number of persons identified as Black, ages 15 and older, residing in the ZCTA, averaged by Economic Development Region

Mean percent of persons identified as White, aged 15 and up, who received at least one dose of the COVID-19 Vaccine, by Economic Development Region in New York State, 2022

- + Number of persons identified as White, **ages 15 and older**, in the ZCTA who received at least one dose of the COVID-19 vaccine divided by the total number of persons identified as White, ages 15 and older, residing in the ZCTA, averaged by Economic Development Region

DATA SOURCES by figure number

Figure 1. Map of Rural Areas in New York State

- WWAMI Rural Health Research Center, 2004
- New York State Civil Boundaries, New York State GIS Data, 2018
- New York State Streets, New York State GIS Data, 2019

Figure 2. Map of Primary Care Providers per 10,000 residents, New York State

- IQVIA, 2020
- PLACES ZIP Code Tabulation Area (ZCTA) Data, CDC, 2020

Figure 3. Insurance and Primary Care Utilization

- Uniform Data System (UDS) Mapper, 2021
- Uniform Data System (UDS) Mapper, 2021

Figure 4. Primary Care Provider Type by Profession Type and Rural-Urban Commuting Area (RUCA) Category, New York State

- IQVIA, 2020

Figure 5. Map of Broadband Access by ZCTA, New York State

- Uniform Data System (UDS) Mapper, 2021

Figure 6. Broadband Access and Self-Reported Poor Mental Health by Economic Development Region, New York State

- Uniform Data System (UDS) Mapper, 2021
- PLACES ZIP Code Tabulation Area (ZCTA) Data, CDC, 2020

Figure 7.a New Yorkers Reporting COVID-19 Vaccine Hesitancy by County

- COVID-19 Vaccine Hesitancy in the US by County and ZIP Code, Institute for Health Metrics and Evaluation (IHME), COVID Collaborative, October 2021

Figure 7.b New Yorkers Receiving at Least One COVID-19 Vaccination Dose by County

- New York State Vaccination Progress by County, NYS Department of Health, March 2022.

7.3 INTERVIEWEE PROFILES



Dr. John Rugge is the founding CEO and now Executive Chairman of Hudson Headwaters Health Network (HHHN). Through opening the first health center in Chestertown in 1974 and growing the nonprofit HHHN system to 17 community health centers, Dr. Rugge has had ample experiences to share about improving access to primary care for rural New Yorkers. Collectively, these FQHCs provide “safety net” primary care for over 1,000 patients per day across 5,600 square miles of the Adirondack North Country and Glen Falls region, a predominantly rural, medically underserved area. HHHN strives to provide the best health care, and access to that care, for everyone in its community.

www.hhhn.org



Mary Zelazny is the CEO of Finger Lakes Community Health (FLCH) and has worked with this organization since its founding in 1989. Ms. Zelazny shared the many successes and challenges in providing primary care for agricultural workers, one of the high need rural populations in the region, and detailed the ongoing expansion of the FQHC system from its first location in Sodus, New York, to several other access points across the region: Penn Yan, Bath, Dundee, Geneva, Newark, Ovid, and Port Byron. In addition to advocating for the health of surrounding communities, FLCH offers affordable, coordinated, team-based care to ensure that all patients are comfortable throughout the health care process, and that all their health needs are met.

localcommunityhealth.com



Robert Ross is the CEO of St. Joseph's Addiction Treatment and Recovery Centers, now in its 48th year and based in Saranac Lake, New York. Mr. Ross and his team shared their extensive experiences providing comprehensive care for residents across many areas in New York State, including Malone, Elizabethtown, Schenectady, Ticonderoga, Lake Placid, Saranac Lake, Keeseville, Poughkeepsie, and Massena. While focused primarily on addiction treatment and recovery, St. Joseph's integrates its inpatient, outpatient, and residential services with behavioral health, primary care, and supportive housing to improve care continuity for its clients and improve their chances of a sustained recovery. Today, St. Joseph's upholds the mission of the organization's original founders, the Franciscan Friars of the Atonement, while working to heal individuals, restore families, and strengthen communities.

www.stjoestreatment.org

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PRIMARY
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**ABOUT
US**



SECTION 8.0

About Primary Care Development Corporation



PCDC IS A NATIONALLY RECOGNIZED NONPROFIT ORGANIZATION THAT CATALYZES EXCELLENCE IN PRIMARY CARE THROUGH STRATEGIC COMMUNITY INVESTMENT, CAPACITY BUILDING, AND POLICY INITIATIVES TO ACHIEVE HEALTH EQUITY.

IN NEW YORK STATE, PCDC HAS WORKED WITH HUNDREDS OF PRIMARY CARE ORGANIZATIONS TO EXPAND ACCESS TO HIGH QUALITY 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 policy makers, trade associations, primary care practices, 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 a quarter century's experience investing in and strengthening primary care practices in New York.

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