Good Afternoon Chairperson Rivera and all Council Members present. My name is Dr. Tara A. Cortes and I am Executive Director for The Hartford Institute for Geriatric Nursing (HIGN), the geriatric arm of the New York University (NYU) Rory Meyers College of Nursing. Thank you for the opportunity to testify today and share my expertise on the topic of healthcare service delivery and outcomes among urban populations.

Access to affordable, quality and timely health care contributes to efficient and effective health care. Improved access to good primary care can contribute to the prevention of chronic diseases, better management of existing chronic diseases and earlier detection of health issues. Offering people access to affordable, even free, primary care eliminates the concern of economic insecurity. There are several reasons that are barriers to accessible healthcare.

27.5M people in the United States or 8.5% of the population went without health insurance in 2018. That is an increase of 1.9M people from the previous year. This is usually considered the first barrier to receiving quality healthcare. Others do not access health services because of language barriers, insensitivity to cultural differences, high cost deductibles or immigration status. These people most often receive their primary care in the city’s emergency rooms where they go when they have a health issue. This inappropriate use of the healthcare system is not only costly, but also does not provide people with the care needed to decrease the incidence or mitigate the impact of chronic disease. It results in poorer health outcomes, lower quality of life and higher mortality rates.

Access to quality clinical care is not the only determinant of better health outcomes. The County Health Rankings developed by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation look at multiple factors that contribute to the health and health equity of a community. These factors, known as determinants of health, have shown that clinical care, including access to and quality of that care, only contributes 20% to length of life and quality of life in a community. Social economic factors which are characterized by where people are born, grow, live, work and age and defined by education, employment and income contribute 40%. Health behaviors defined by activity, nutrition, smoking and sexual health contribute 30% and the physical environment - air and water quality and housing - contributes 10%. In New York in 2019, the Bronx is ranked #62 in health outcomes, the lowest in the entire state. New York is #5, Queens is #8, Kings is #17 and Richmond is #28.

From the Affordable Care Act, a model of primary care emerged which requires providers to integrate social supports into their care. This model, the Patient-Centered Medical Home, has
become the model for primary care services across most of the New York City Federally Qualified Health Centers (FQHCs) and H+H practices. This designation by the federal government creates a higher level of reimbursement and gives provider incentives for addressing patients’ socio-economic needs, which account for 40% of the influence on health outcomes.

Health behaviors which account for 30% of the influence on health outcomes are actions individuals take to affect their health. They include actions such as eating well, being physically active and avoiding actions which increase the risk of disease such as smoking, excessive alcohol intake and risky sexual behavior. For example, poor nutrition and lack of exercise are associated with a higher risk of cardiovascular disease, type 2 diabetes and obesity. Tobacco use is associated with cardiovascular disease, cancer and poor pregnancy outcomes. Excessive alcohol is associated with injuries, certain cancers and liver disease.

To improve health outcomes and reduce the high cost of disease treatment there must be a multifaceted approach. Increased access to primary care is one way, and using the medical home model for care makes the assessment and intervention of socio-economic factors part of the primary care paradigm. It must be noted that not everyone has the means and resources to make healthy decisions. Since health behaviors account for 30% of health outcomes, they must be addressed.

The Hartford Institute for Geriatric Nursing at NYU Meyers College of Nursing has implemented an initiative in the Bronx in partnership with RAIN and JASA to increase health literacy and impact health outcomes for older adults in the Bronx. Using community-based volunteers to ensure cultural competency, we have educated almost 200 volunteers who have held nearly 300 classes and educate nearly 5000 older adults on such topics as exercise, nutrition, stress management, sexuality, oral health, opioid uses and misuse, and management of chronic diseases – asthma, heart disease, and dementia. When surveyed between one and 3 months after completing the education 79% of the seniors say they have changed their behavior and 75% say the feel their health has improved. One participant said “I finally know how to talk to my doctor about my asthma symptoms.”

In summary, improving population health requires more than just addressing health care cost and access. Risk behaviors such as poor food choices or sedentary lifestyles, and social/economic/physical conditions such as food insecurity and housing, whose combined impact on health outcomes exceeds that of clinical care by 4:1, also need to be addressed.

Thank you for the opportunity to testify. We welcome any additional questions the Committees may have. (Please contact Konstantine Tettonis, NYU Government Affairs, kt1249@nyu.edu)