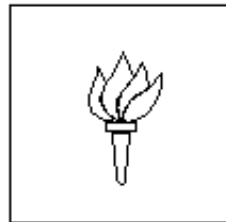


A MODEL FOR ASSESSING ACCESS

Version 4.3A

March 26, 2002



NYU Center for Health and Public Service Research

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access
 - Tend to focus primarily on...
 - Insurance coverage
 - Provider supply
 - Getting care

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access
 - Tend to focus primarily on...
 - Insurance coverage
 - Provider supply
 - Getting care
 - Ignore important dimensions such as...
 - Provider performance
 - Patient perceptions of provider performance
 - Personal behavior
 - Personal circumstances
 - Public health
 - Non-care related factors

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access
 - Tend to focus primarily on...
 - Insurance coverage
 - Provider supply
 - Getting care
 - Ignore important dimensions such as...
 - Provider performance
 - Patient perceptions of provider performance
 - Personal behavior
 - Personal circumstances
 - Public health
 - Non-care related factors
 - Tend to focus on process, rather than outcomes

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access
- Track indicators by categories that are immutable...
 - Race/ethnicity
 - Gender
 - National origin/immigration status

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

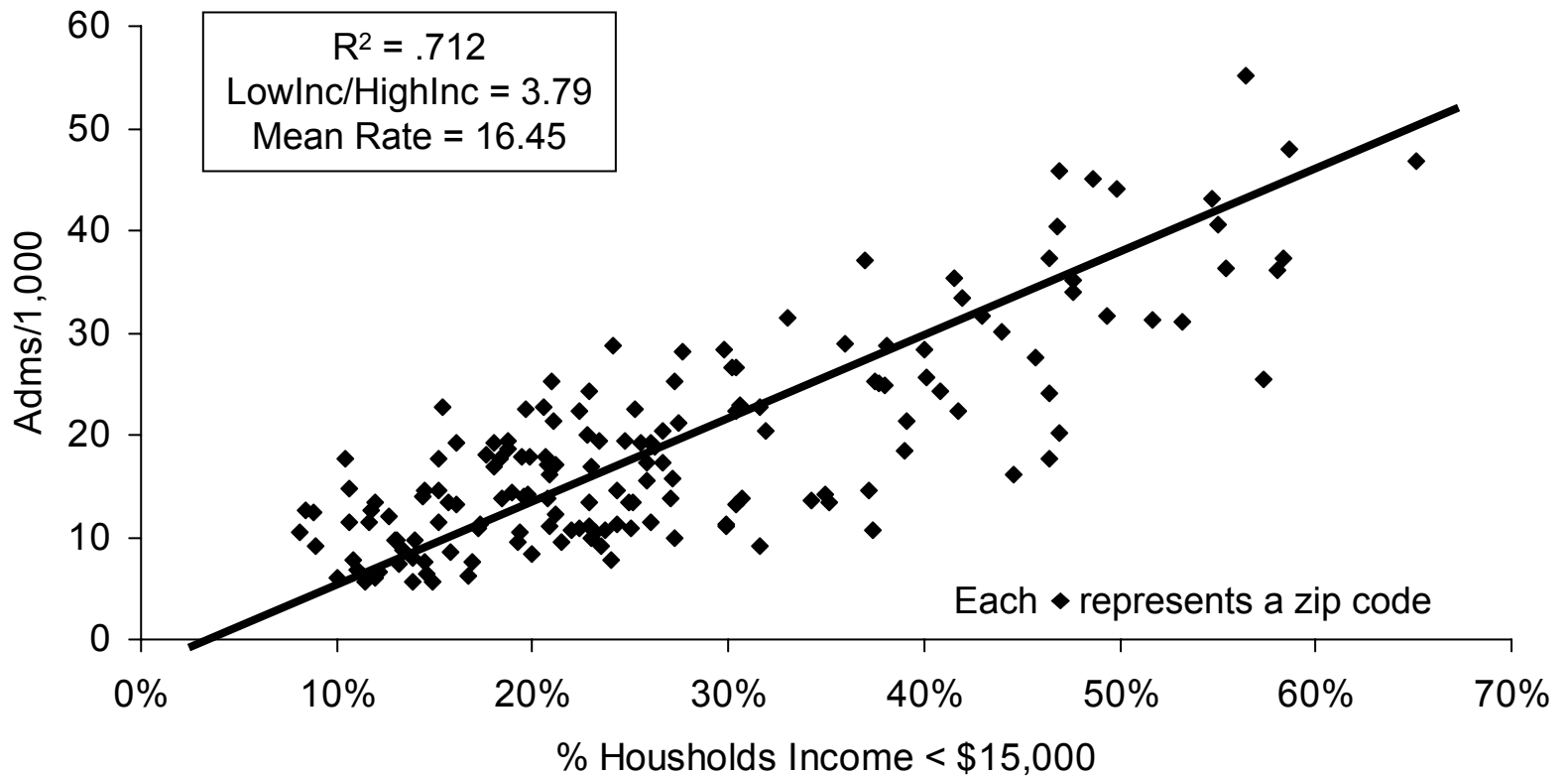
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 - Race/ethnicity
 - Gender
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And stop there...without providing much guidance to policy makers interested in designing interventions

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access
- Track indicators by categories that are immutable and that are not very useful to policy makers designing interventions
- Most indicators of access are probably measuring multiple dimensions of access...
 - Obscuring the cause of the problem
 - Making it difficult for policy makers to design interventions

New York City ACS (Preventable/Avoidable) Admissions/1,000 Age 18-64 - 2000



What are we measuring anyway???

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?
 - More asthma?
 - More diabetes?
 - More heart disease?
 - More acute illness?

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?
- Lack of coverage among low income populations?

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?
- Lack of coverage among low income populations?
- Shortage of primary care capacity?

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?
- Lack of coverage among low income populations?
- Shortage of primary care capacity?
- Differences in care seeking behavior?

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?
- Lack of coverage among low income populations?
- Shortage of primary care capacity?
- Differences in care seeking behavior?
- **Poor performance by safety net providers?**

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?
- Lack of coverage among low income populations?
- Shortage of primary care capacity?
- Differences in care seeking behavior?
- Poor performance by safety net providers?
- Differences in physician practice style?

WHAT ARE WE MEASURING ANYWAY???

- Higher rates of disease among poor/minorities?
- Lack of coverage among low income populations?
- Shortage of primary care capacity?
- Differences in care seeking behavior?
- Poor performance by safety net providers?
- Differences in physician practice style?
- Etc, etc, etc.

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access
- Track indicators by categories that are immutable and that are not very useful to policy makers designing interventions
- Most indicators of access are probably measuring multiple dimensions of access
- Often use terms that mask important aspects of the problem
 - “Cultural factors”
 - “Social factors”

PROBLEMS WITH CURRENT APPROACHES FOR ASSESSING ACCESS

- Lack a clear/comprehensive definition of access
- Track indicators by categories that are immutable and that are not very useful to policy makers designing interventions
- Most indicators of access are probably measuring multiple dimensions of access
- Often use terms that mask important aspects of the problem
- **Fail to take into account...**
 - How components of access interact with each other
 - How access is mediated by other factors
 - Individual patient characteristics
 - Community contextual factors

GOAL FOR A REVISED MODEL FOR ASSESSING ACCESS

- Provide a comprehensive definition of access

GOAL FOR A REVISED MODEL FOR ASSESSING ACCESS

- Provide a comprehensive definition of access
- Provide framework for interpreting measures of access

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- Help identify what is known and not known

GOAL FOR A REVISED MODEL FOR ASSESSING ACCESS

- Provide a comprehensive definition of access
- Provide framework for interpreting measures of access
- Help identify what is known and not known
- Provide guidance to providers and policy makers for initiatives to improve access

A WORKING DEFINITION OF “ACCESS”

“Access” is the ability to obtain information, services, and other resources that promote optimal health

A WORKING DEFINITION OF “ACCESS”

“Access” is the ability to obtain information, services, and other resources that promote optimal health

- Getting them how you need/want them

A WORKING DEFINITION OF “ACCESS”

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- Getting them how you need/want them
- Getting them when you need/want them

A WORKING DEFINITION OF “ACCESS”

“Access” is the ability to obtain information, services, and other resources that promote optimal health

- Getting them how you need/want them
- Getting them when you need/want them
- Eliminating the things that get in the way of that

A FEW OBSERVATIONS ABOUT THIS DEFINITION OF “ACCESS”

“Access” is the ability to obtain information, services, and other resources that promote optimal health

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- This definition goes beyond getting “care”
- This definition does not include an assurance that “optimal health” will be attained

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“Access” is the ability to obtain information, services, and other resources that promote optimal health

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- What’s needed to achieve “access” will differ for the various components that make up “optimal health”

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- “Access” and what’s needed to achieve access are mediated by a broad range of
 - Personal factors
 - Contextual factors

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- “Access” and what’s needed to achieve access are mediated by a broad range of
 - Personal factors
 - Contextual factors
- These personal and contextual mediating factors differ among individuals, population subgroups, and geographic areas

MAKING THIS DEFINITION OF ACCESS USEFUL TO POLICY MAKERS...

“Access is the ability to obtain information, services, and other resources that promote optimal health”

MAKING THIS DEFINITION OF ACCESS USEFUL TO POLICY MAKERS...

“Access is the ability to obtain information, services, and other resources that promote optimal health”

- Getting an understanding of the key components of *optimal health*

MAKING THIS DEFINITION OF ACCESS USEFUL TO POLICY MAKERS...

“Access is the ability to obtain information, services, and other resources that promote optimal health”

- Getting an understanding of the key components of optimal health
- Examining in detail the things that can mediate what's needed to achieve access
 - Personal factors
 - Contextual factors

COMPONENTS OF OPTIMAL HEALTH

COMPONENTS OF OPTIMAL HEALTH

- Genetics

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
 - Water
 - Air
 - Public health/sanitation
 - Etc.

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
 - Nutrition

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
 - Nutrition
 - Exercise

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
 - Nutrition
 - Exercise
 - Health habits
 - Smoking
 - Substance abuse
 - Etc.

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
 - Nutrition
 - Exercise
 - Health habits
 - Smoking
 - Substance abuse
 - Etc.
 - Stress

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
 - Nutrition
 - Exercise
 - Health habits
 - Smoking
 - Substance abuse
 - Etc.
 - Stress
 - Risk taking

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- **Personal health maintenance**

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- **Personal health maintenance**
 - Prevention
 - Check-ups
 - Immunizations
 - Screening
 - Etc.

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- **Personal health maintenance**
 - Prevention
 - Symptom identification

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- **Personal health maintenance**
 - Prevention
 - Symptom identification
 - Condition/symptom self-management

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- **Personal health maintenance**
 - Prevention
 - Symptom identification
 - Condition/symptom self-management
 - Care seeking behavior
 - Decision to seek care
 - Where seek care
 - Continuity/loyalty

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- **Care availability**

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- **Care availability**
 - Resource supply

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- **Care availability**
 - Resource supply
 - “Open-dooriness”

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- **Care availability**
 - Resource supply
 - “Open-dooriness”
 - Acceptability

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- **Provider performance**

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- **Provider performance**
 - Content of care
 - Technical competence
 - Practice style/MD decision making
 - Patient education

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- **Provider performance**
 - Content of care
 - Linkages
 - Diagnostic work-up
 - Specialty referral/feedback
 - Hospital privileges
 - Hospital admission/ED visit notification
 - Community based organizations
 - Etc.

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- **Provider performance**
 - Content of care
 - Linkages
 - Decision support
 - Elicitation of values
 - Assistance in applying to critical decisions/treatment choices

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- **Provider performance**
 - Content of care
 - Linkages
 - Decision support
 - Customer orientation/cultural competence
 - Respect
 - Understanding
 - Language

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- **Provider performance**
 - Content of care
 - Linkages
 - Decision support
 - Customer orientation/cultural competence
 - Customer service
 - Hours of operation
 - Wait times/cycle times/dwell times/etc.
 - Telephone access, etc.

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- **Provider performance**
 - Content of care
 - Linkages
 - Decision support
 - Customer orientation/cultural competence
 - Customer service
 - Array of services

COMPONENTS OF OPTIMAL HEALTH

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 - Administrative/management/MIS support

COMPONENTS OF OPTIMAL HEALTH

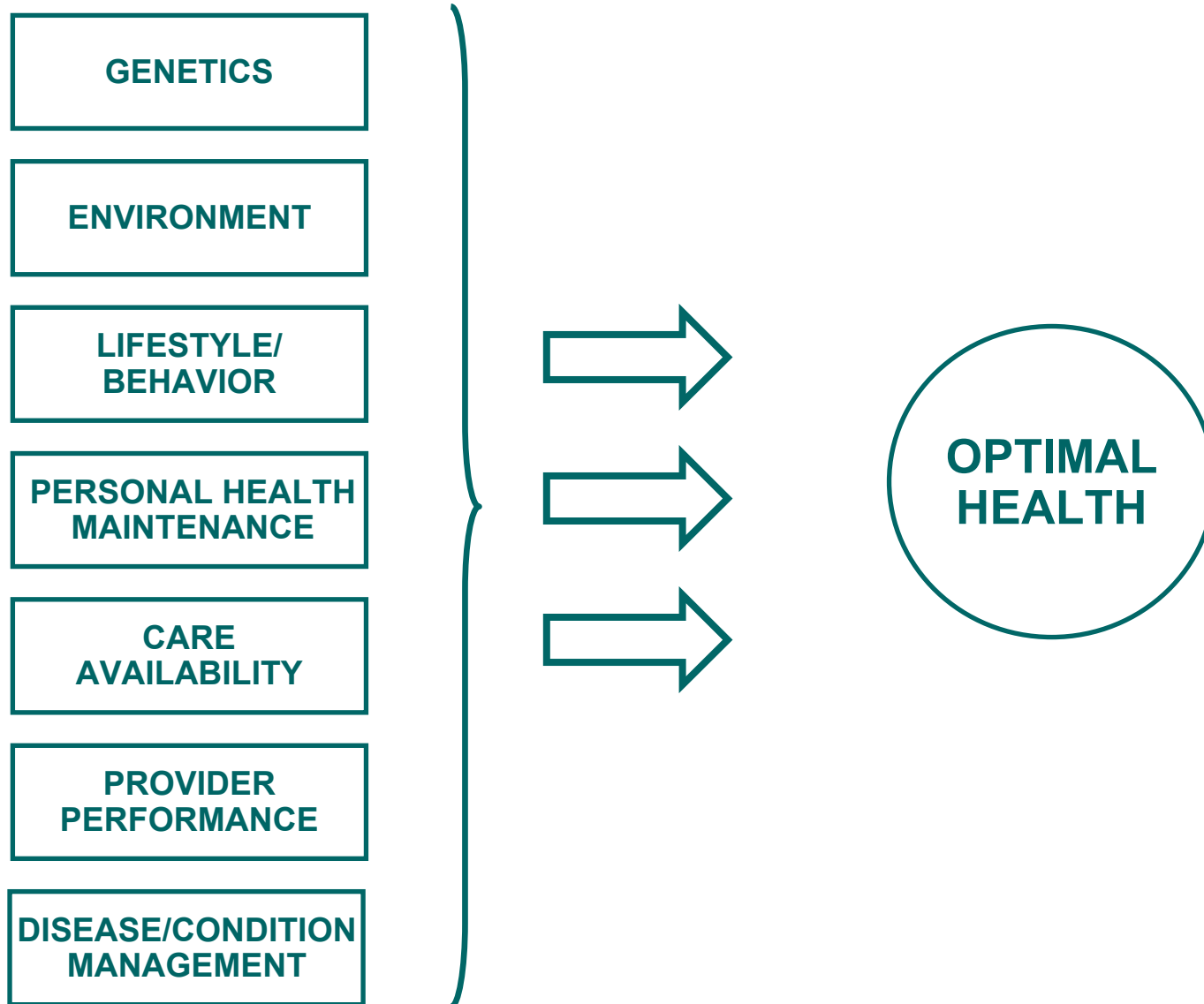
- Genetics
- Environment
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- Personal health maintenance
- Care availability
- Provider performance
- **Personal disease/condition management**

COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
- Lifestyle/behavior
- Personal health maintenance
- Care availability
- Provider performance
- **Personal disease/condition management**
 - Symptom/flare-up identification
 - Condition/symptom self-management
 - Care seeking behavior
 - Compliance/adherence

MODEL FOR ASSESSING ACCESS

COMPONENTS OF OPTIMAL HEALTH



COMPONENTS OF OPTIMAL HEALTH

- Genetics
- Environment
 - Air
 - Water
 - Sanitation/Public health
- Lifestyle/behavior
 - Nutrition
 - Exercise
 - Health habits
 - Smoking
 - Substance abuse
 - Etc.
 - Stress
 - Risk taking
- Personal health maintenance
 - Prevention
 - Check-ups
 - Immunizations
 - Screening
 - Symptom identification
 - Condition/symptom self-management
 - Care seeking behavior
 - Decision to seek care
 - Where seek care
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UNDERSTANDING THE ACCESS PROBLEM

To adequately understand and respond to the access problem, it's necessary to:

- Examine all of these components of optimal health

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- Recognize that these components are mediated by:
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 - Contextual factors

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- Recognize that some of these factors impact individuals, some impact institutions, some impact systems

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To adequately understand and respond to the access problem, it's necessary to:

- Examine all of these components of optimal health
- Recognize that these components are mediated by:
 - Personal factors
 - Contextual factors
- Recognize that some of these factors impact individuals, some impact institutions, some impact systems
- Recognize that this stuff is complex
 - The various components affect each other
 - The personal and contextual factors affecting these components affect:
 - Multiple components, institutions, systems (sometimes differentially)
 - Each other (sometimes differentially)

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
 - Health habits
 - Symptom identification
 - Self management
 - Resource availability
 - System navigation

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system
 - What's there/available
 - Waits, care expectations, etc
 - Respect afforded
 - Communication effectiveness -language
 - Communication effectiveness -listening
 - Cultural sensitivity
 - Expectation of payment

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system
- **Personal characteristics**

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system
- **Personal characteristics**
 - Health beliefs
 - “Self efficacy”
 - Expectations
 - Self advocacy
 - Attitudes towards benefit/risk
 - Motivation
 - Confidence
 - Mental health
 - Stoicism

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system
- Personal characteristics
- **Personal resources**

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system
- Personal characteristics
- **Personal resources**
 - Insurance coverage
 - Economics (income)
 - Skills/education
 - Social capital - personal
 - Social capital - community

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system
- Personal characteristics
- Personal resources
- **Personal circumstances**

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
- Perceptions about the health system
- Personal characteristics
- Personal resources
- **Personal circumstances**
 - Employment
 - Life demands
 - Competing priorities
 - Stress/psychosocial factors

**MANY COMPONENTS OF OPTIMAL HEALTH
ARE MEDIATED BY CONTEXTUAL FACTORS**

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
 - Structure
 - Public/NFP/I-O
 - Teaching/community
 - Service integration
 - Support for vulnerable populations
 - Medicaid/SCHIP/etc. coverage
 - Reimbursement policies
 - Direct support/pools
 - Market competitiveness
 - Regulatory environment
 - MD practice style

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system (services, inspection, regulation)
 - Sanitation
 - Disease prevention
 - Environment
 - Immunization

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment
 - State/local economy
 - Crime rates
 - Housing stock
 - Etc.

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment
- Community organization infrastructure

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment
- Community organization infrastructure
 - Community based institutions
 - CBOs
 - Faith based organizations
 - Public institutions
 - Social services system
 - Education system
 - Transportation system
 - Public-private relationships
 - Leadership

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment
- Community organization infrastructure
- Neighborhood characteristics

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment
- Community organization infrastructure
- Neighborhood characteristics
 - Crime/substance abuse/etc. rates
 - “Collective efficacy”
 - Availability of resources
 - Health system
 - Pharmacies
 - Healthy foods, exercise venues, etc.
 - Community organizations

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment
- Community organization infrastructure
- Neighborhood characteristics
- Civic environment/civil culture

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system characteristics
- Public health system
- Community environment
- Community organization infrastructure
- Neighborhood characteristics
- Civic environment/civil culture
 - Political environment/political will
 - Racial/ethnic/economic segregation/bias
 - Social cohesion within population subgroups
 - Expectations of institutions
 - Willingness/capacity for innovation
 - Willingness/capacity for cooperative action

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

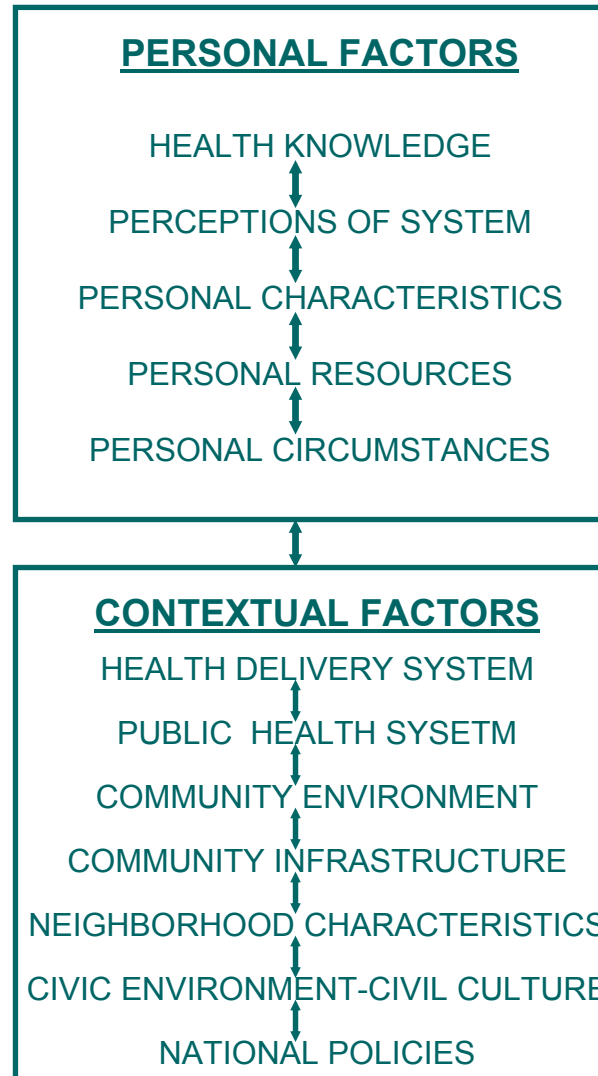
- Health care delivery system characteristics
- Public health system
- Community environment
- Community organization infrastructure
- Neighborhood characteristics
- Civic environment/civil culture
- National policies
 - Medicare
 - Medicaid/SCHIP/etc.
 - Environment

MODEL FOR ASSESSING ACCESS

COMPONENTS OF OPTIMAL HEALTH



MEDIATING FACTORS



MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY PERSONAL FACTORS

- Health knowledge
 - Health habits
 - Symptom identification
 - Self management
 - Resource availability
 - System navigation
- Perception of health system
 - What's there/available
 - Waits, care expectations, etc
 - Respect afforded
 - Communication effectiveness - language
 - Communication effectiveness - listening
 - Cultural sensitivity
 - Expectation of payment
- Personal characteristics
 - Health beliefs
 - “Self-efficacy”
 - Expectations
 - Self advocacy
 - Attitudes towards benefit/risk
 - Motivation
 - Confidence
 - Mental Health
 - Stoicism
- Personal resources
 - Insurance coverage
 - Economics (income)
 - Skills/education
 - Social capital -personal
 - Social capital - community
- Personal circumstances
 - Employment
 - Life demands
 - Competing priorities
 - Stress/psychosocial factors

MANY COMPONENTS OF OPTIMAL HEALTH ARE MEDIATED BY CONTEXTUAL FACTORS

- Health care delivery system
 - Structure
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 - Teaching/community
 - Service integration
 - Support for vulnerable populations
 - Medicaid/SCHIP/etc coverage
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 - Direct support
 - Market competitiveness
 - Regulatory environment
 - MD practice style
- Public health system
 - Sanitation
 - Disease prevention
 - Environment
 - Immunization
- Community environment
 - State/local economy
 - Crime rates
 - Housing stock
 - Etc.
- Community organization infrastructure
 - Community based institutions
 - CBOs
 - Faith based organizations
 - Public institutions
 - Social service system
 - Education system
 - Transportation system
 - Public/private relationships
 - Leadership
- Neighborhood characteristics
 - Crime/substance abuse/etc.
 - “Collective efficacy”
 - Availability of resources
 - Health system
 - Pharmacies
 - Healthy foods, exercise venues, etc
 - Community organizations
- Civic environment/civil culture
 - Political environment/will
 - Racial/ethnic/economic segregation
 - Social cohesion within population subgroups
 - Expectations of institutions
 - Willingness/capacity for innovation
 - Willingness/capacity for cooperative action
- National policies
 - Medicare/Medicaid/SCHIP etc.
 - Environment

MOST “ACCESS” INDICATORS ARE PROBABLY MEASURING DIFFERENT/MULTIPLE DIMENSIONS OF ACCESS

- Different components of optimal health

["Access" is the ability to obtain information, services, and other resources that promote optimal health]

MOST “ACCESS” INDICATORS ARE PROBABLY MEASURING DIFFERENT/MULTIPLE DIMENSIONS OF ACCESS

- Different components of optimal health
- The impact of different/multiple mediating personal factors

[“Access” is the ability to obtain information, services, and other resources that promote optimal health]

MOST “ACCESS” INDICATORS ARE PROBABLY MEASURING DIFFERENT/MULTIPLE DIMENSIONS OF ACCESS

- Different components of optimal health
- The impact of different/multiple mediating personal factors
- The impact of different/multiple mediating contextual factors

[“Access” is the ability to obtain information, services, and other resources that promote optimal health]

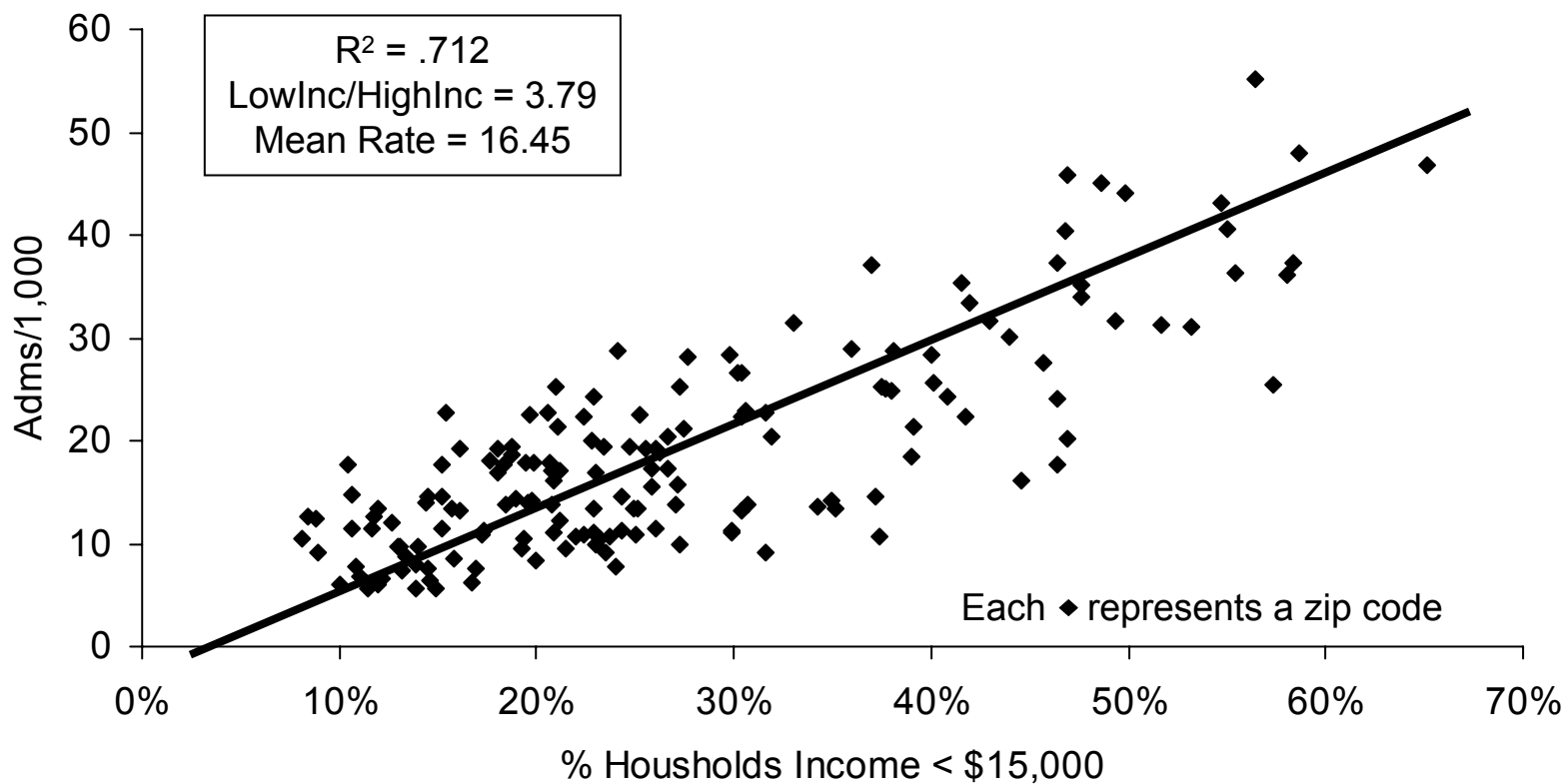
SOME TYPICAL “ACCESS” INDICATORS

- Preventable/avoidable hospitalizations - ambulatory care sensitive (ACS) conditions
- Late or no prenatal care
- Lack of a usual “source of care”
- No primary care visits in the past year
- Delay or inability to obtain needed care
- Use of emergency rooms for primary care

[“Access” is the ability to obtain information, services, and other resources that promote optimal health]

FOR EXAMPLE...

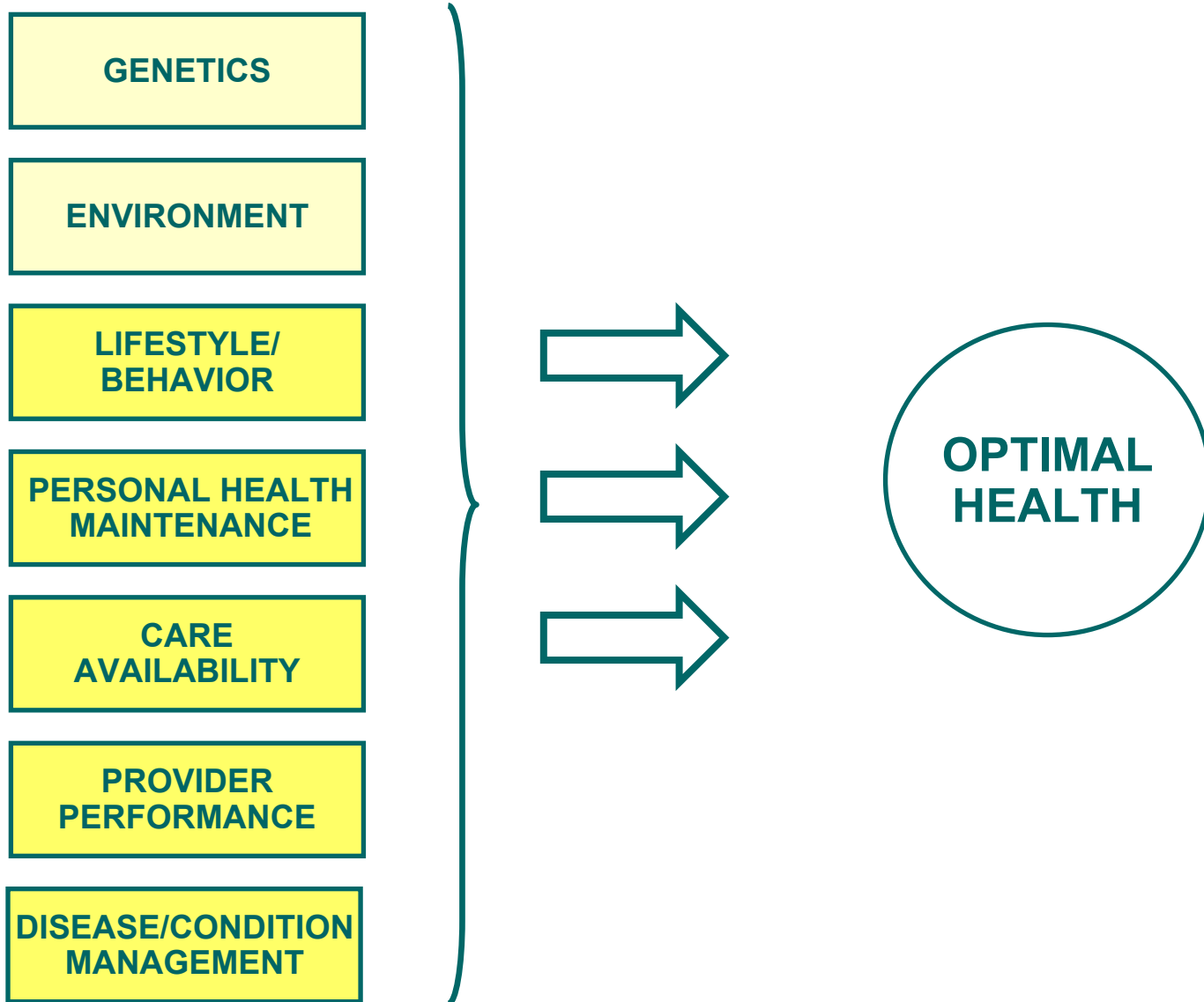
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MODEL FOR ASSESSING ACCESS

COMPONENTS OF OPTIMAL HEALTH

ACS CONDITIONS

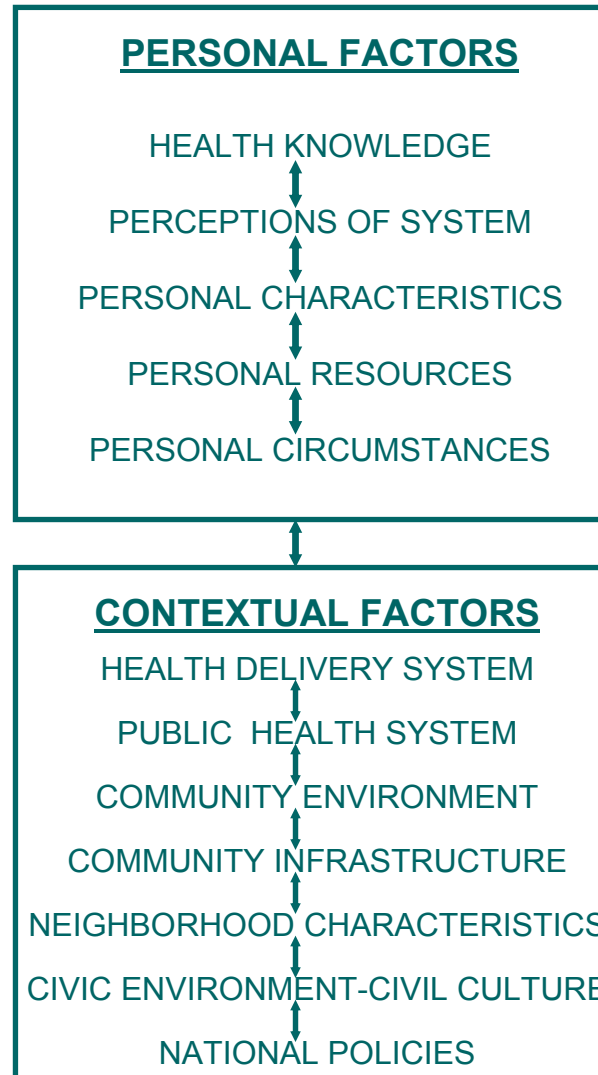


MODEL FOR ASSESSING ACCESS

COMPONENTS OF OPTIMAL HEALTH



MEDIATING FACTORS



ACS CONDITIONS

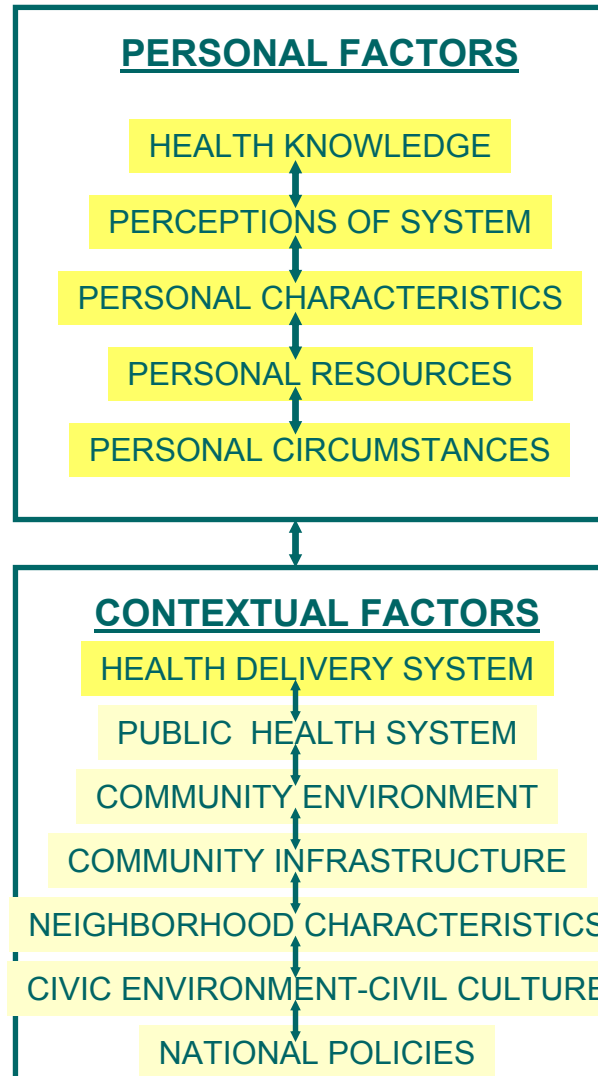


MODEL FOR ASSESSING ACCESS

COMPONENTS OF OPTIMAL HEALTH



MEDIATING FACTORS



ACS CONDITIONS

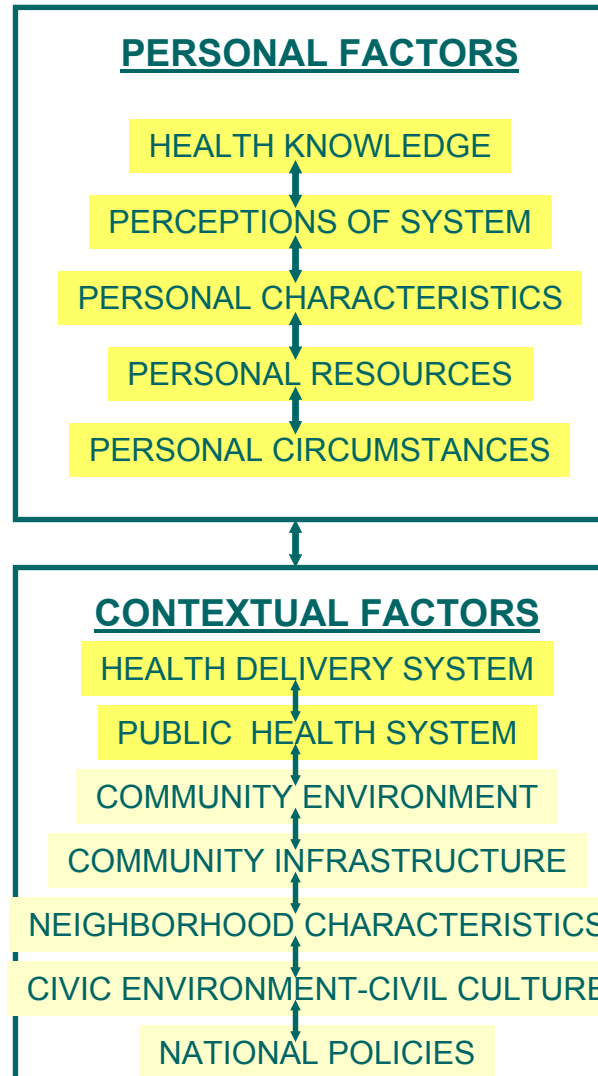


MODEL FOR ASSESSING ACCESS

COMPONENTS OF OPTIMAL HEALTH



MEDIATING FACTORS



LATE OR NO
PRENATAL CARE

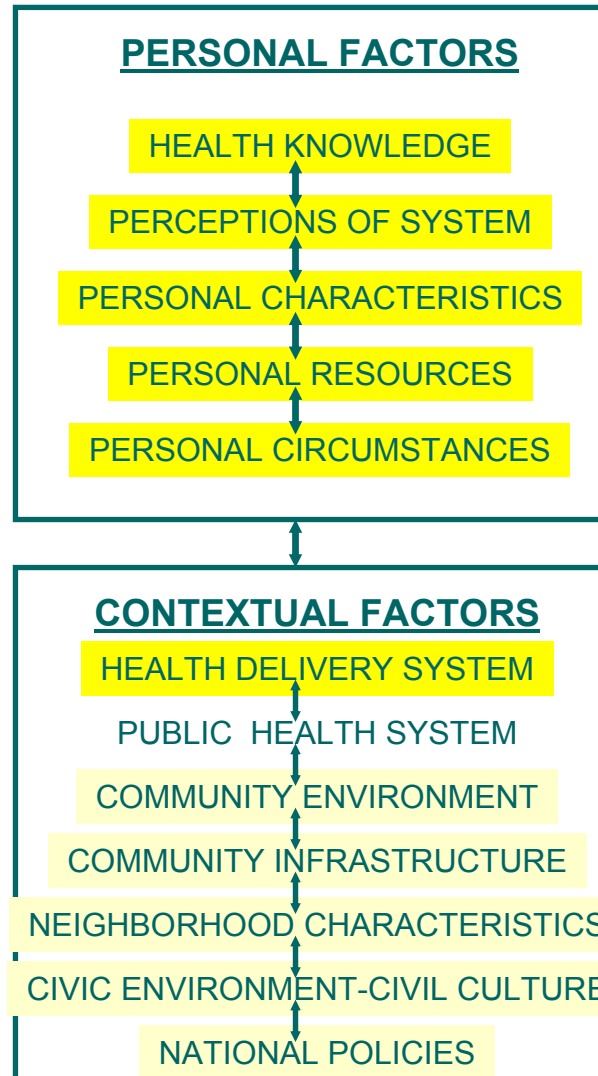


MODEL FOR ASSESSING ACCESS

COMPONENTS OF OPTIMAL HEALTH



MEDIATING FACTORS





NO USUAL SOURCE
OF CARE



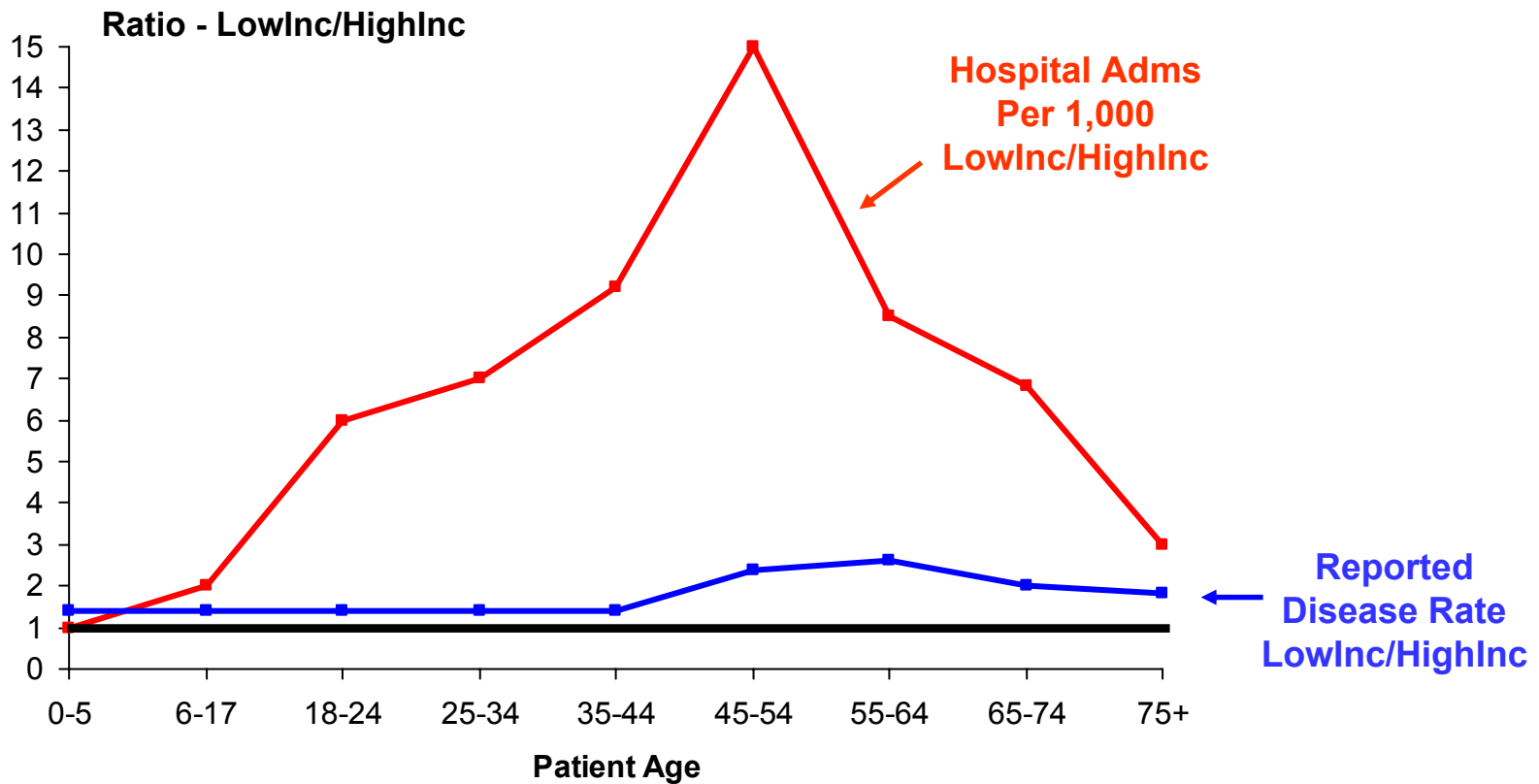
COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Genetics	x			x		
Environment	x			x		
Air	x			x		
Water	x			x		
Sanitation/public health/etc	x			x		
Lifestyle/Behavior	X				X	
Nutrition	x					
Exercise	x					
Health Habits	X			x		
Smoking	X			x		
Substance abuse	X					
Stress	x			x		
Risk taking	x		x	x	X	x

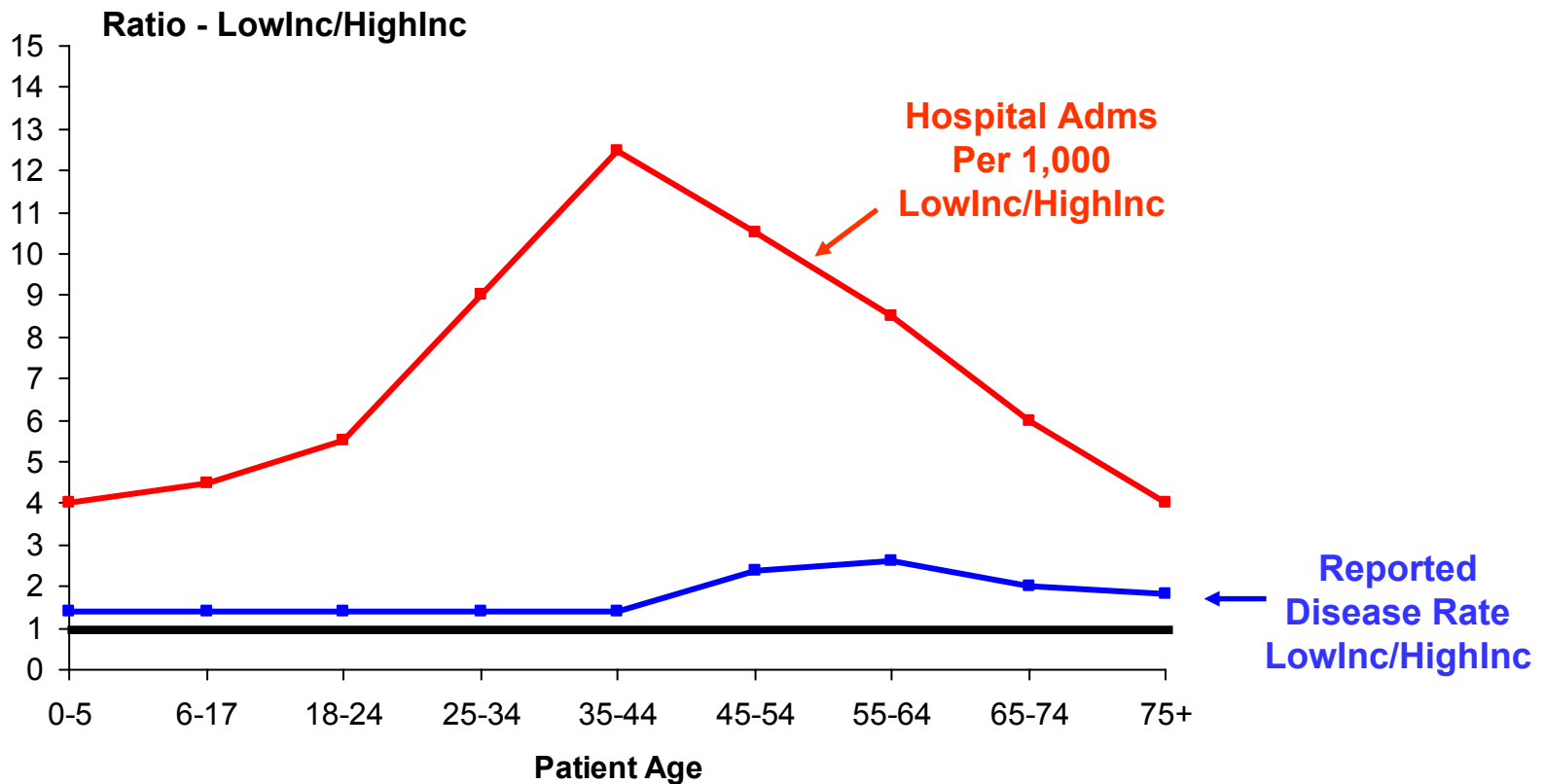
COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
 Genetics	x			x		
Environment	x			x		
Air	x			x		
Water	x			x		
Sanitation/public health/etc	x			x		
Lifestyle/Behavior	X				X	
Nutrition	x					
Exercise	x					
Health Habits	X			x		
Smoking	X			x		
Substance abuse	X					
Stress	x			x		
Risk taking	x		x	x	X	x

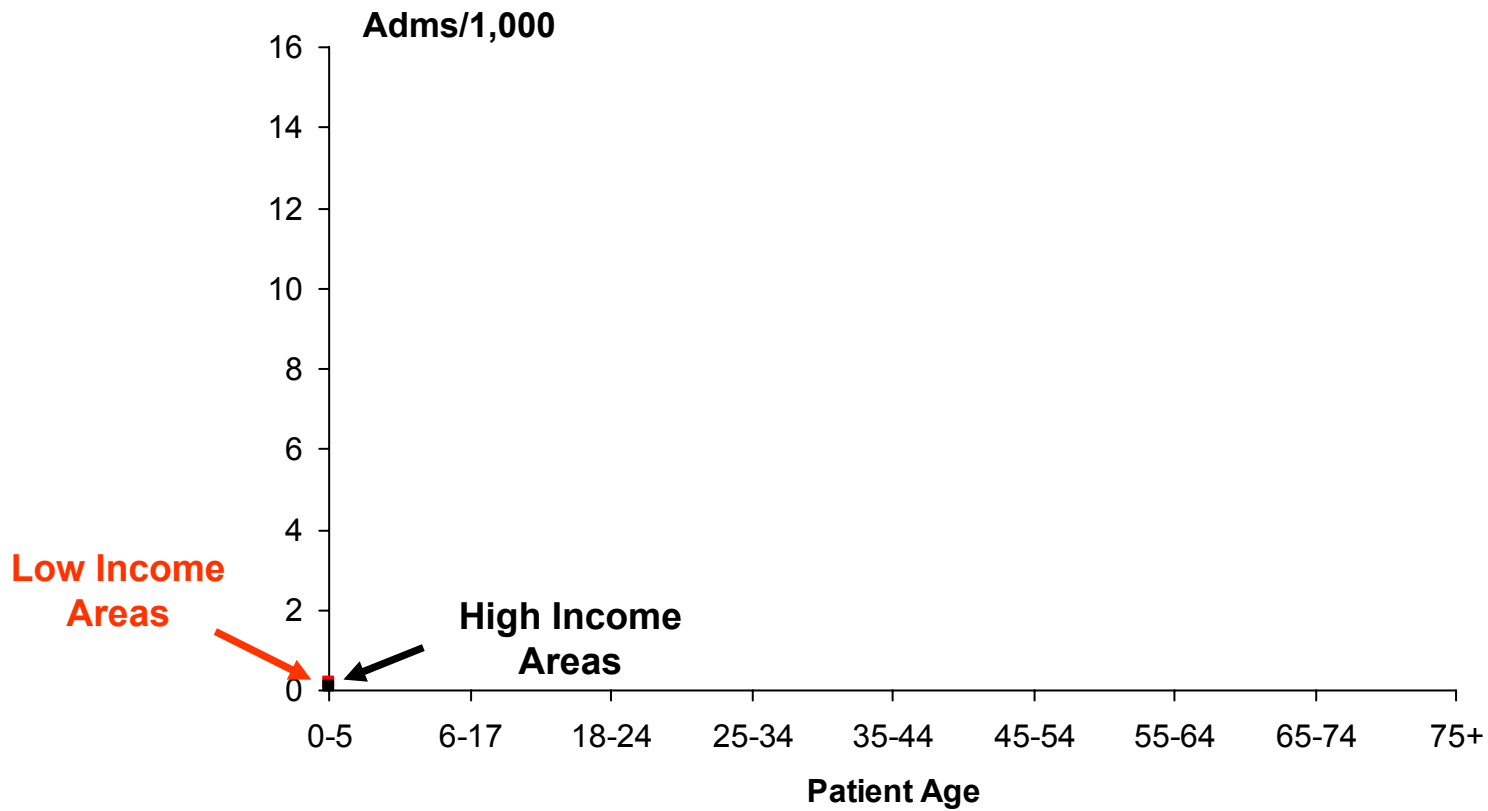
Ratio Low Income to High Income Diabetes Adms/1,000 and Reported Disease By Age – NYC – 1990



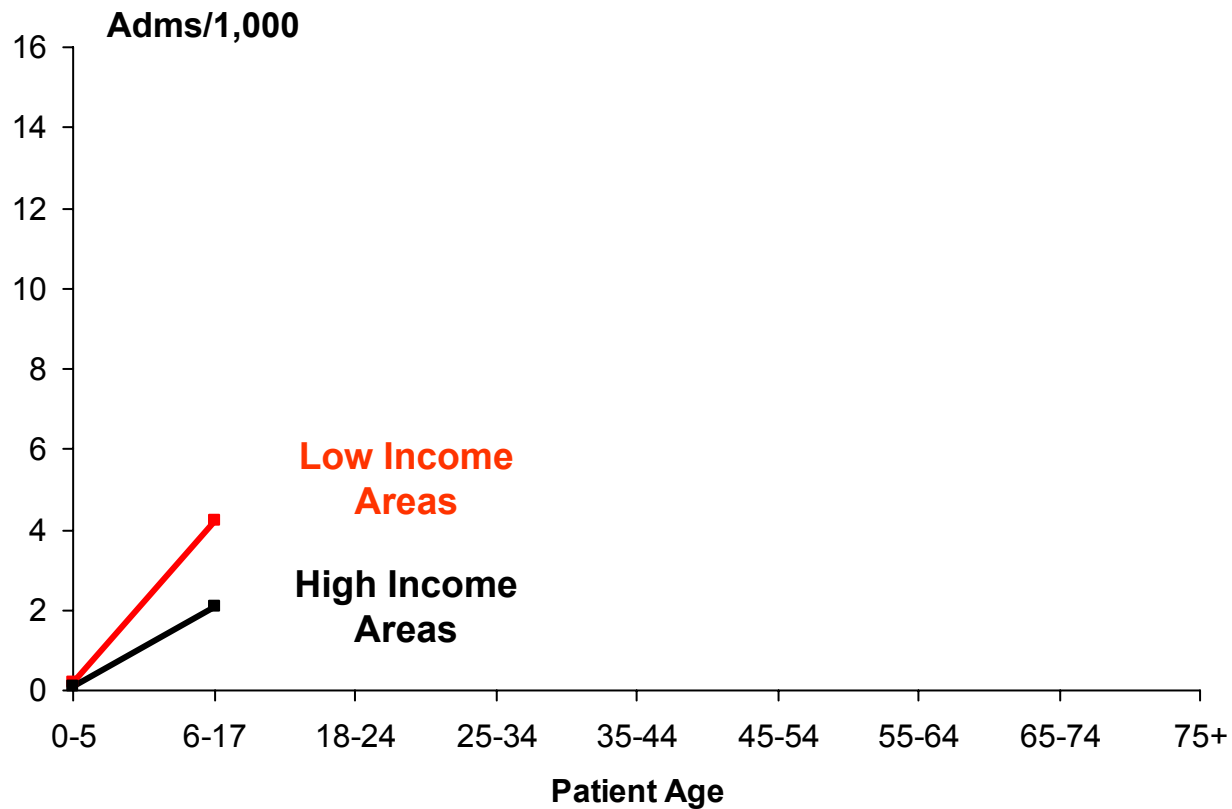
Ratio Low Income to High Income Asthma Adms/1,000 and Reported Disease By Age – NYC – 1990



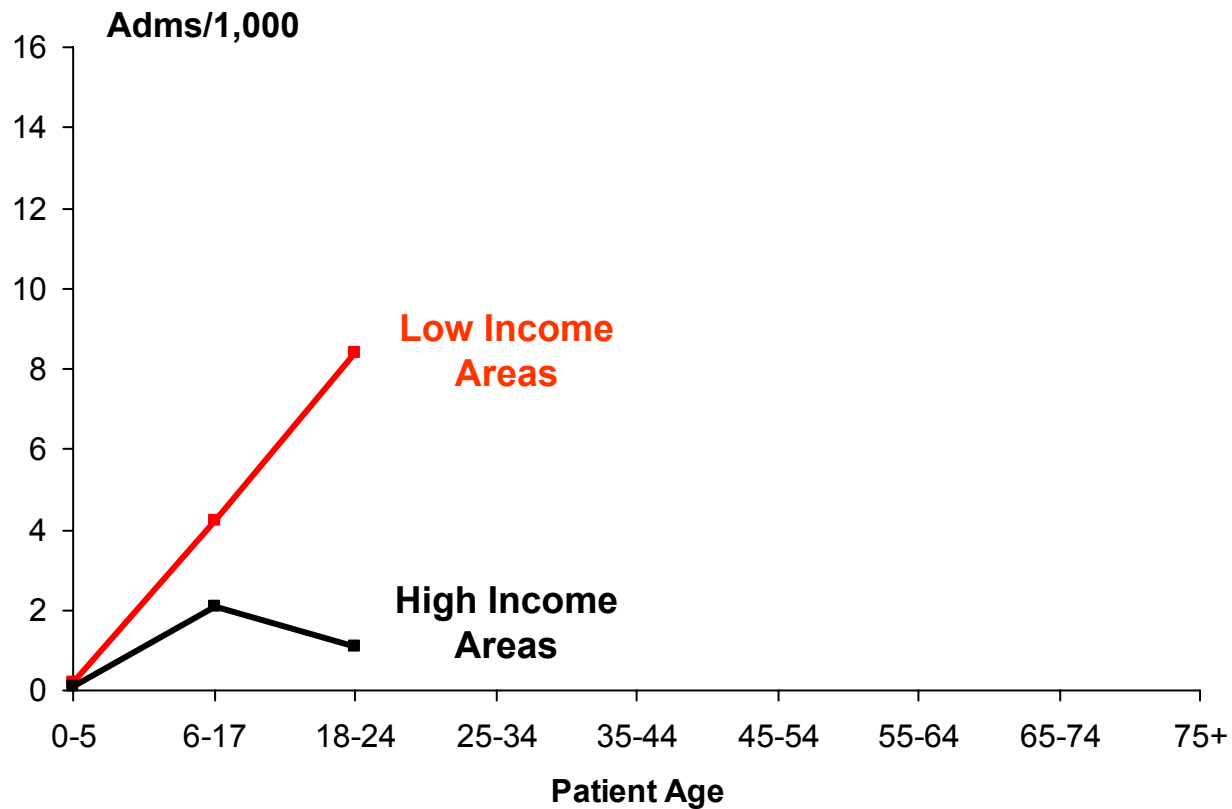
New York City Diabetes Admissions/1,000 By Age – 1990



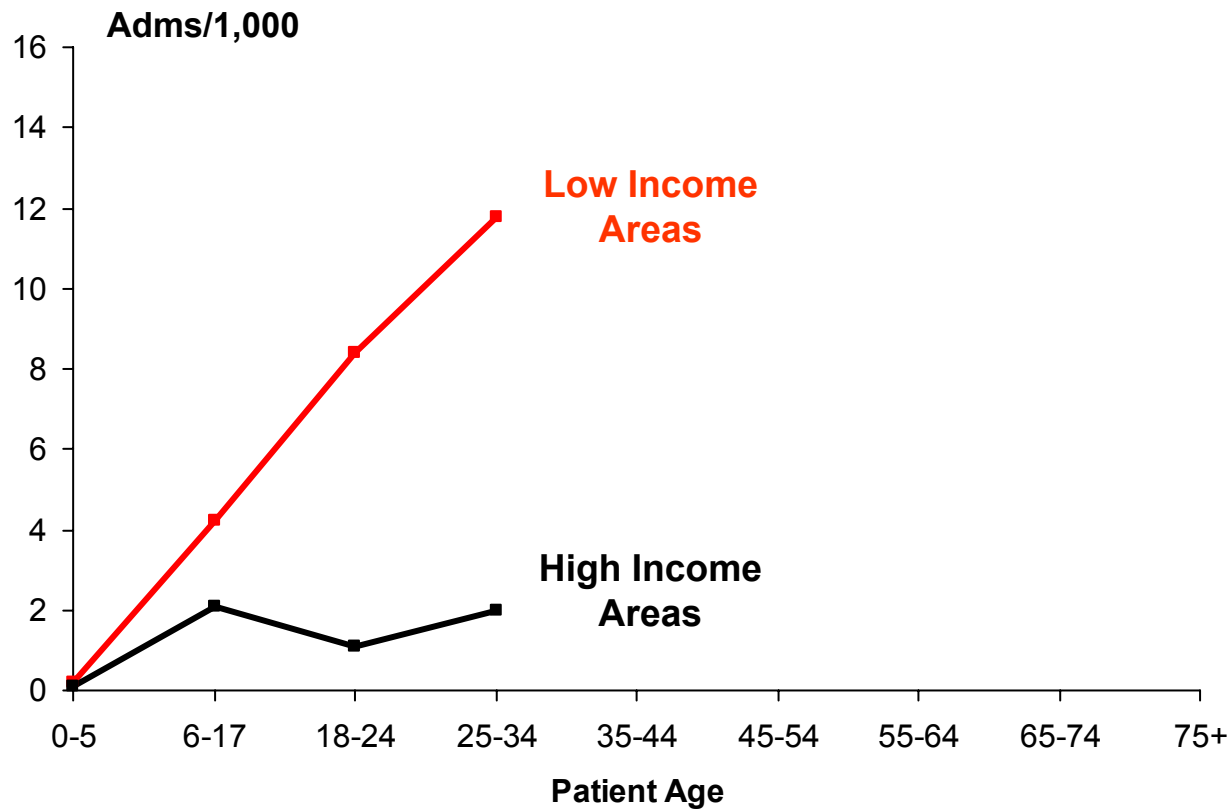
New York City Diabetes Admissions/1,000 By Age – 1990



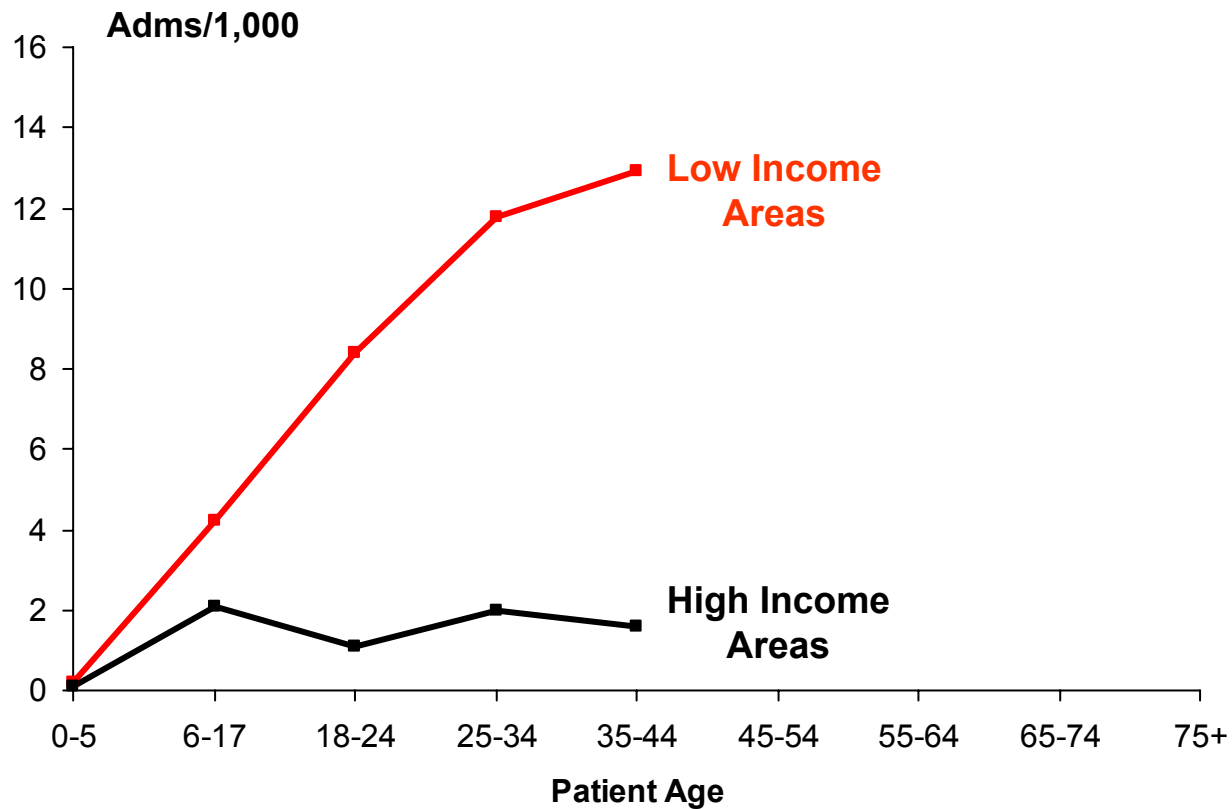
New York City Diabetes Admissions/1,000 By Age – 1990



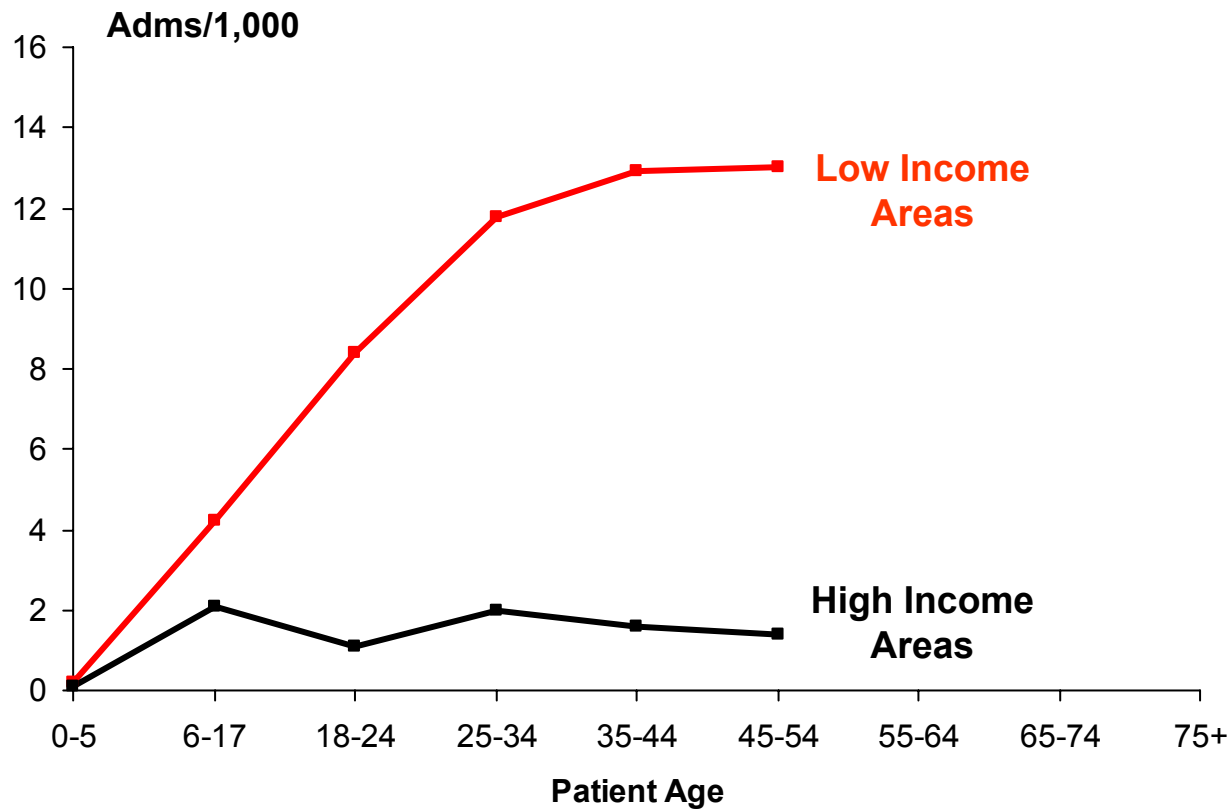
New York City Diabetes Admissions/1,000 By Age – 1990



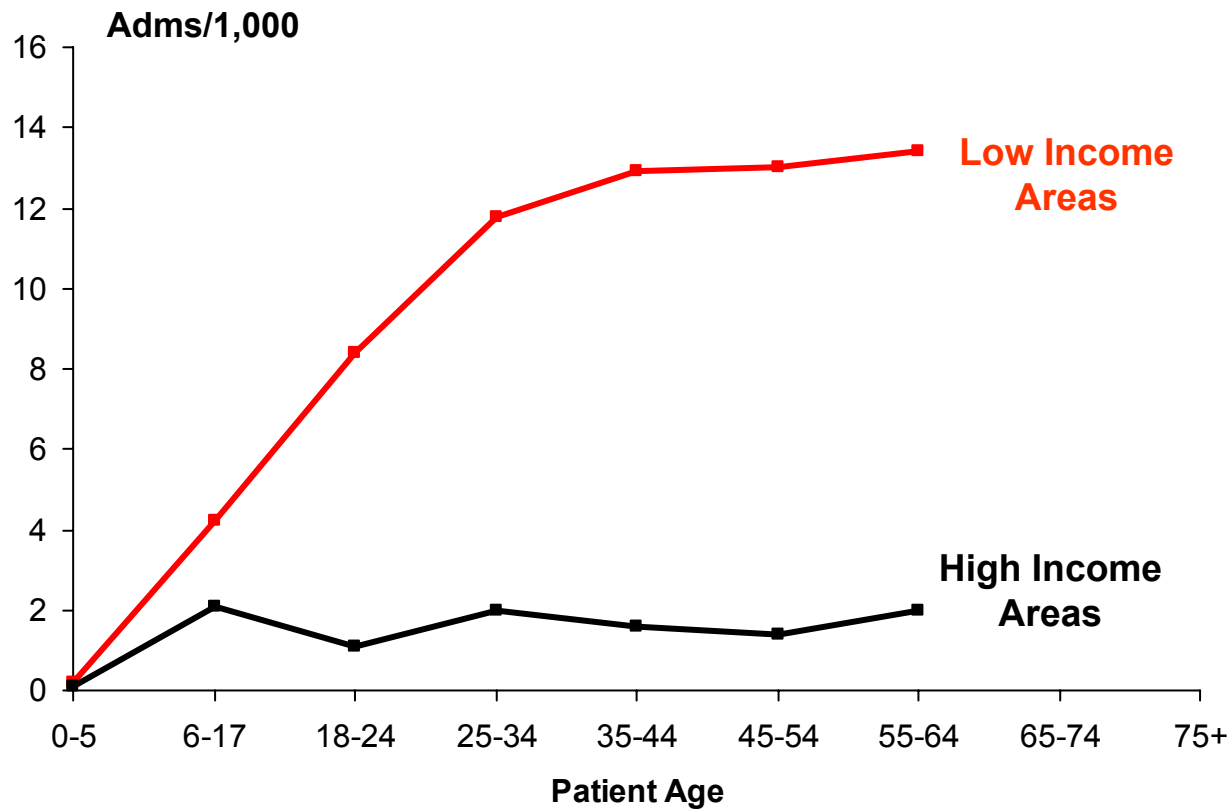
New York City Diabetes Admissions/1,000 By Age – 1990



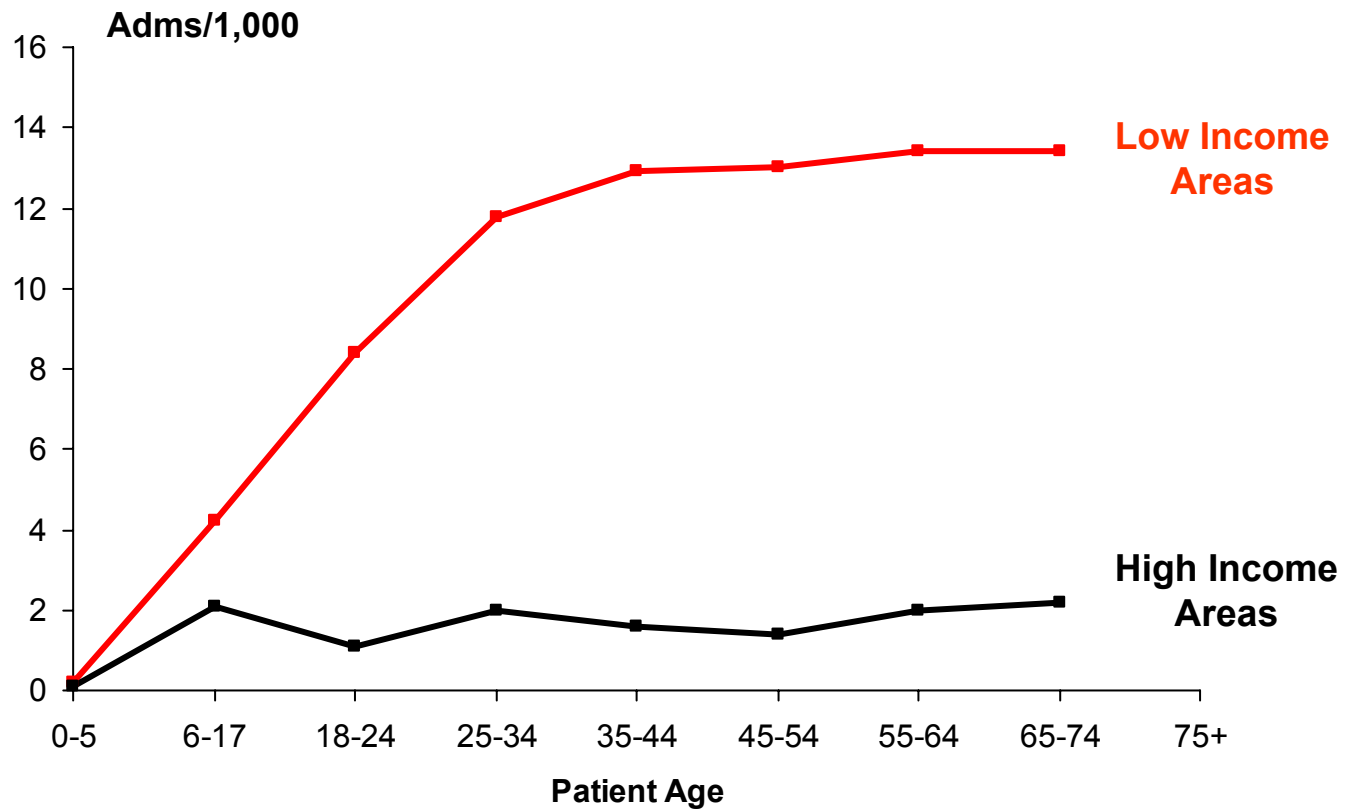
New York City Diabetes Admissions/1,000 By Age – 1990



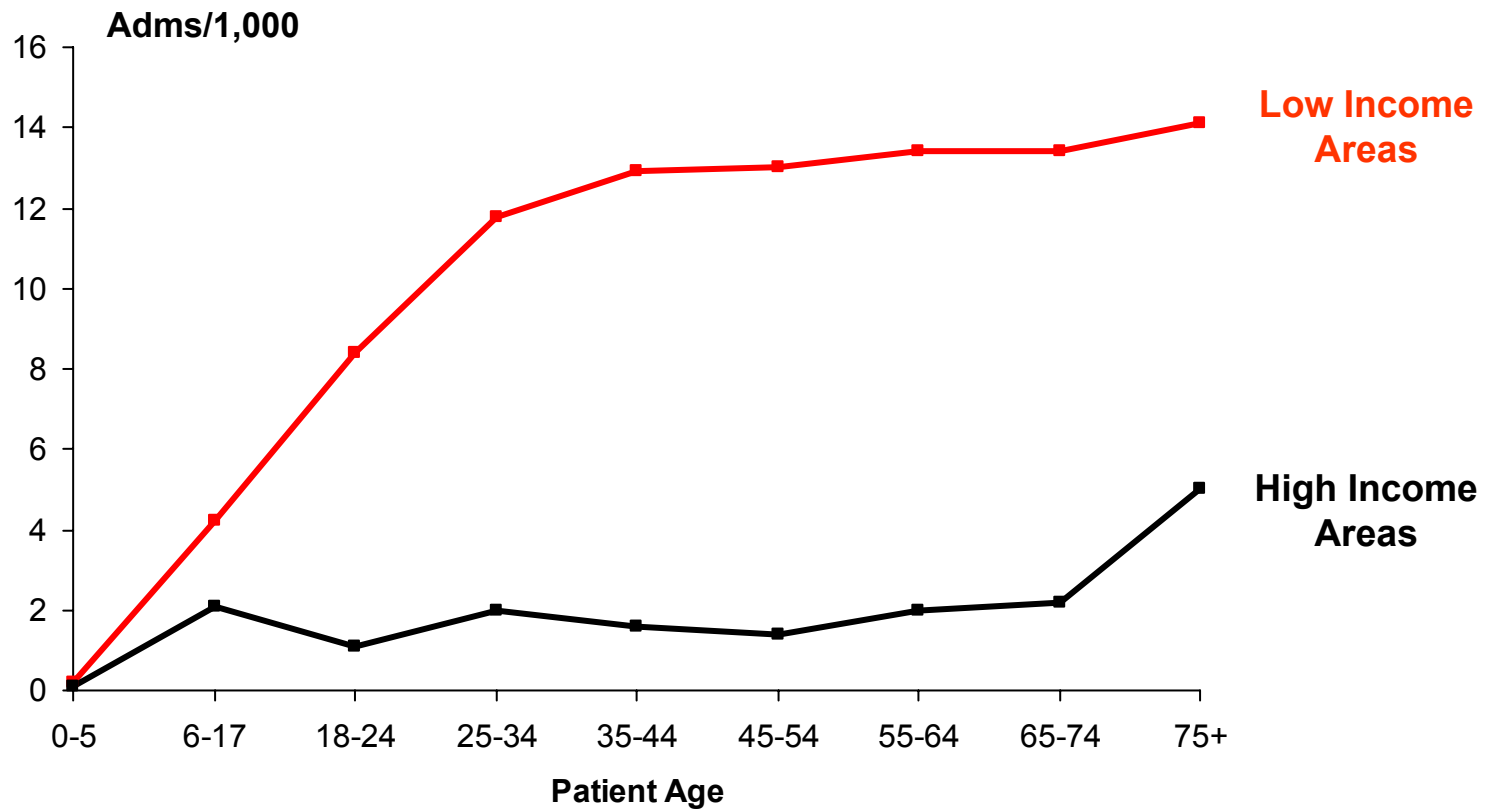
New York City Diabetes Admissions/1,000 By Age – 1990



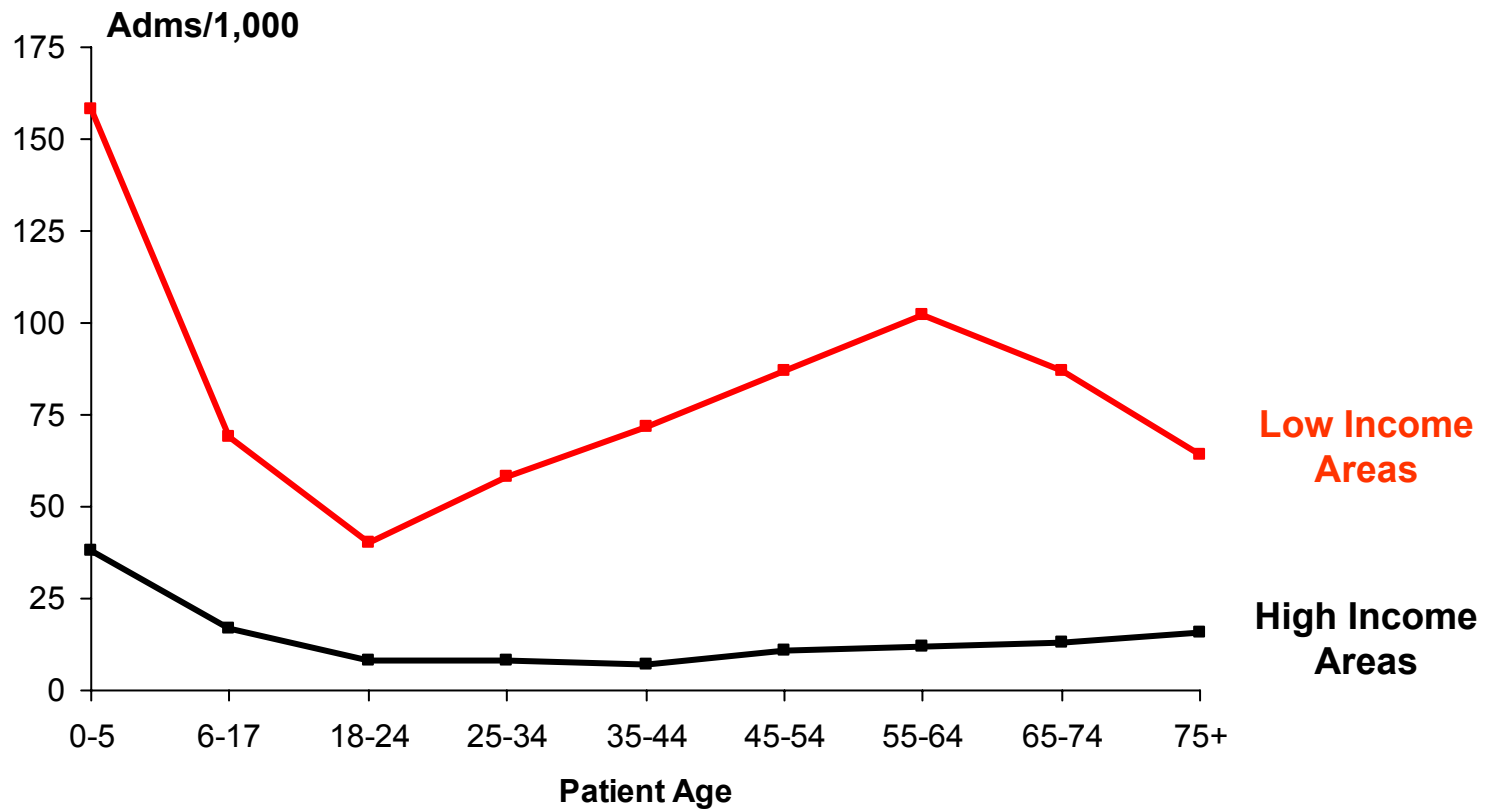
New York City Diabetes Admissions/1,000 By Age – 1990



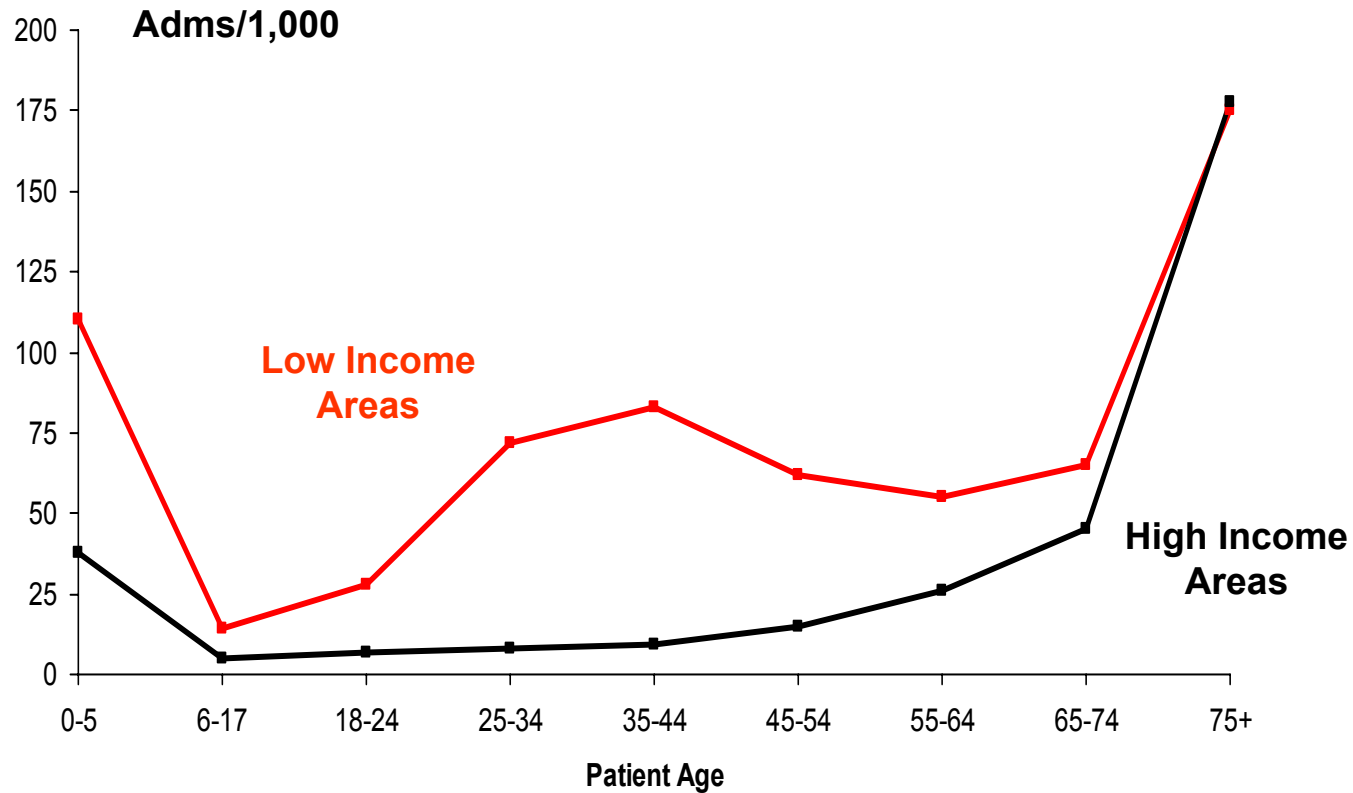
New York City Diabetes Admissions/1,000 By Age – 1990



New York City Asthma Admissions/1,000 By Age – 1990



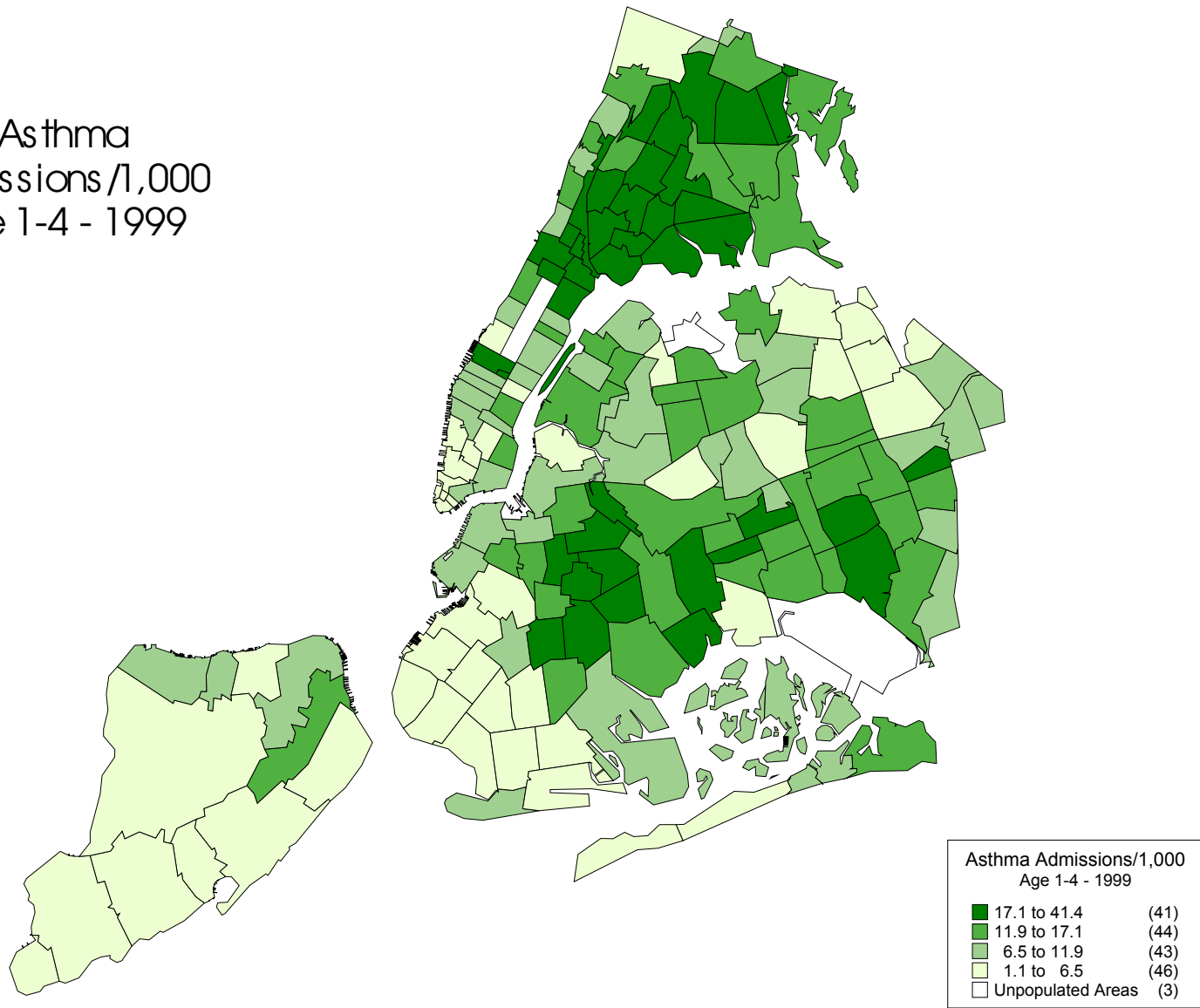
New York City Pneumonia Admissions/1,000 By Age – 1990



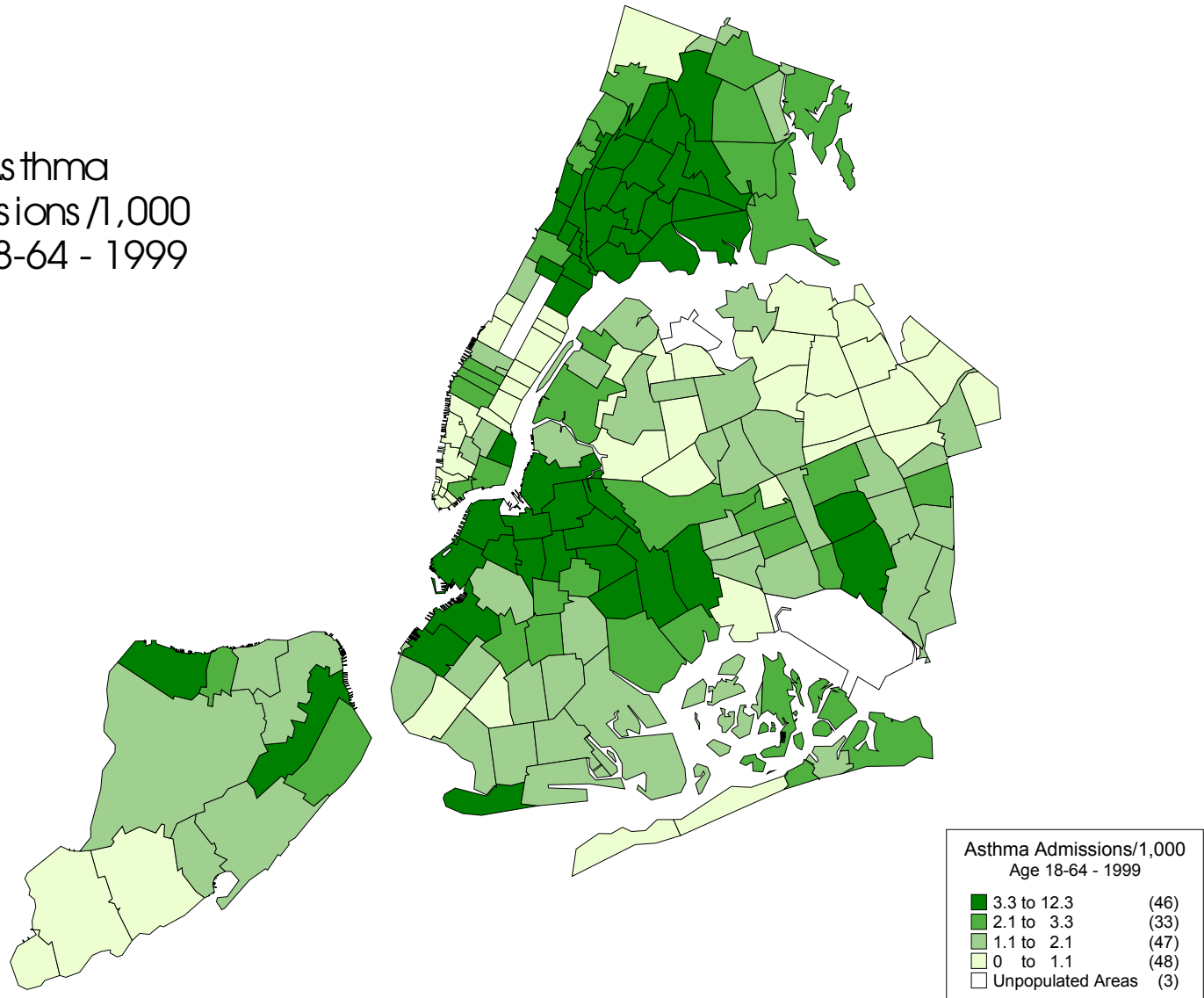
COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Genetics	x			x		
Environment	x			x		
Air	x			x		
Water	x			x		
Sanitation/public health/etc	x			x		
Lifestyle/Behavior	X				X	
Nutrition	x					
Exercise	x					
Health Habits	X			x		
Smoking	X			x		
Substance abuse	X					
Stress	x			x		
Risk taking	x		x	x	X	x

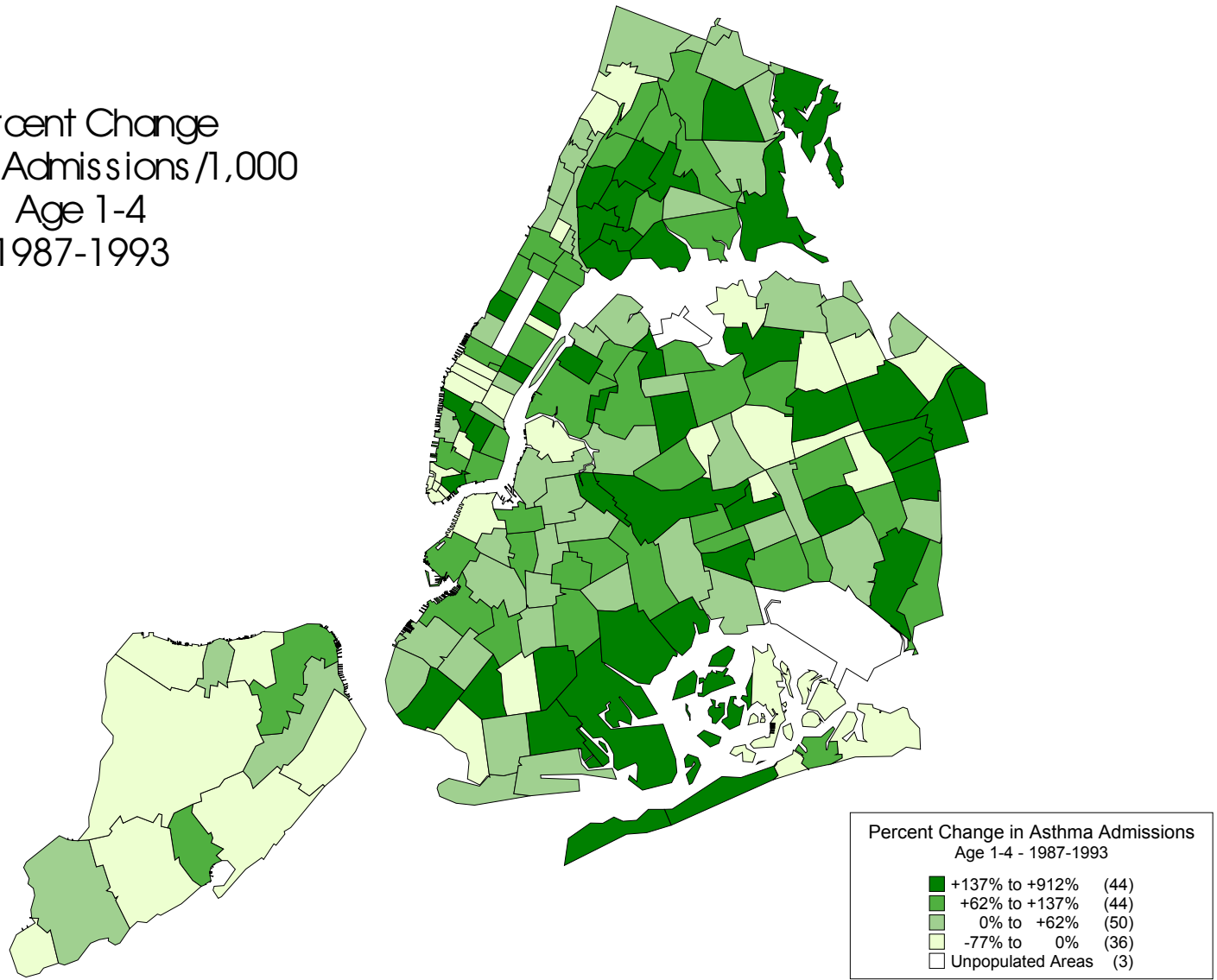
Asthma
Admissions/1,000
Age 1-4 - 1999



Asthma
Admissions/1,000
Age 18-64 - 1999



Percent Change
Asthma Admissions /1,000
Age 1-4
1987-1993

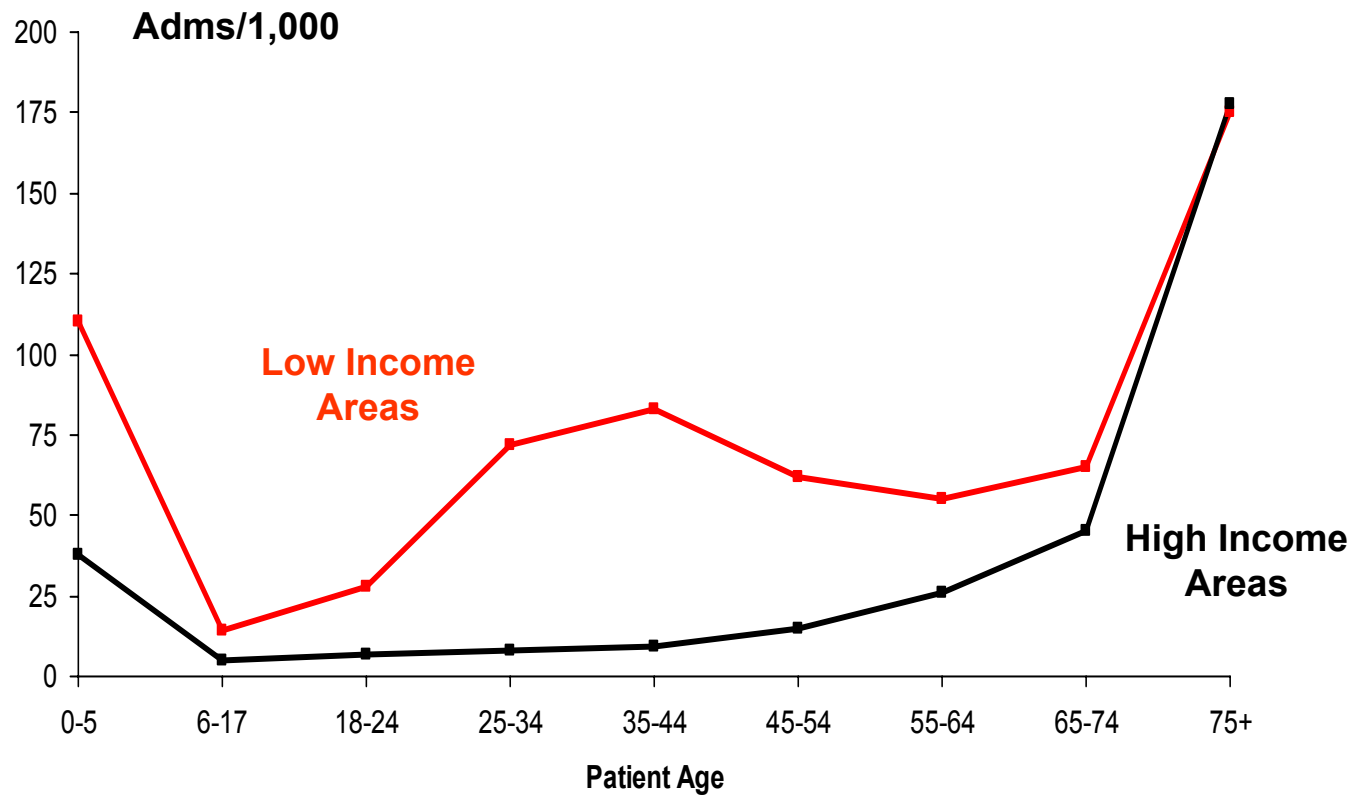


COMPONENTS OF OPTIMAL HEALTH

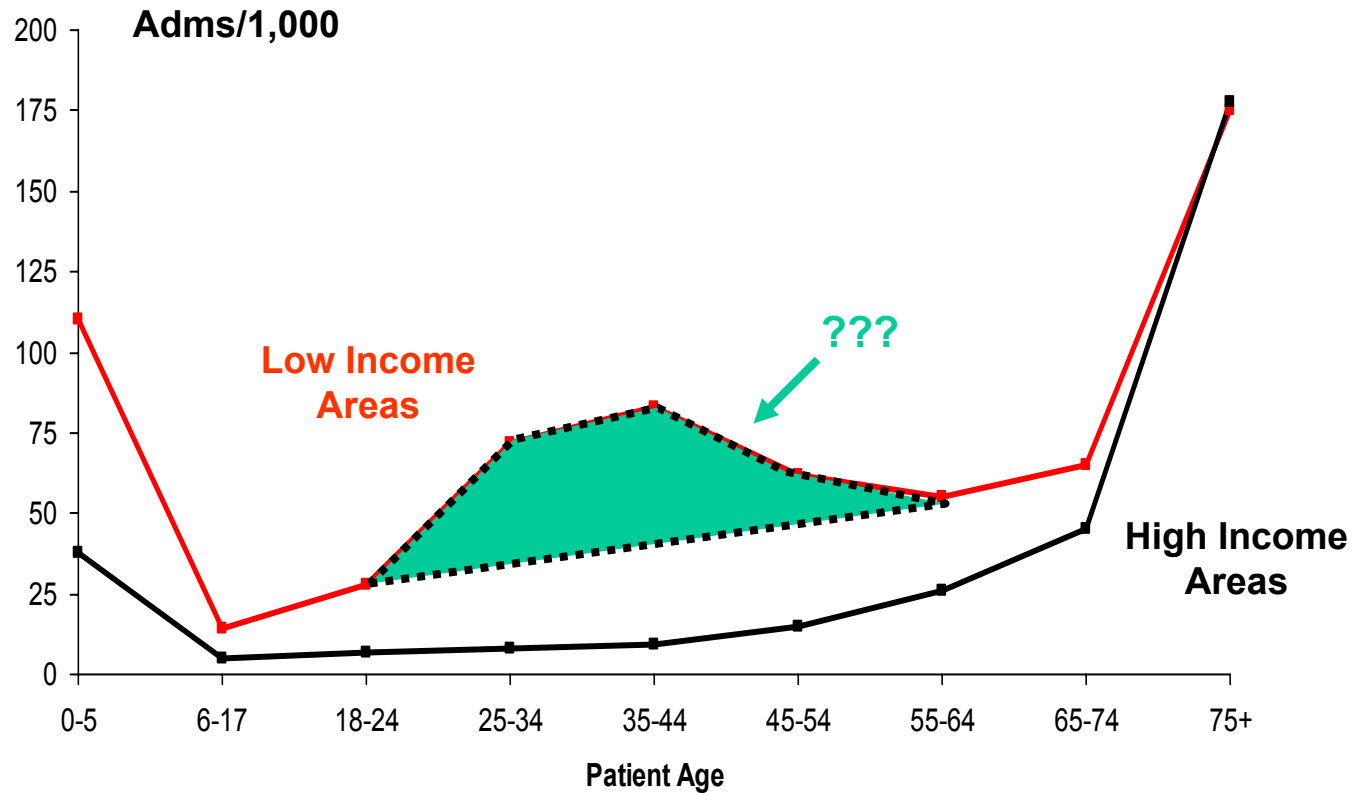
	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Genetics	x			x		
Environment	x			x		
Air	x			x		
Water	x			x		
Sanitation/public health/etc	x			x		
Lifestyle/Behavior	X				X	
Nutrition	x					
Exercise	x					
Health Habits	X			x		
Smoking	X			x		
Substance abuse	X					
Stress	x			x		
Risk taking	x		x	x	X	x



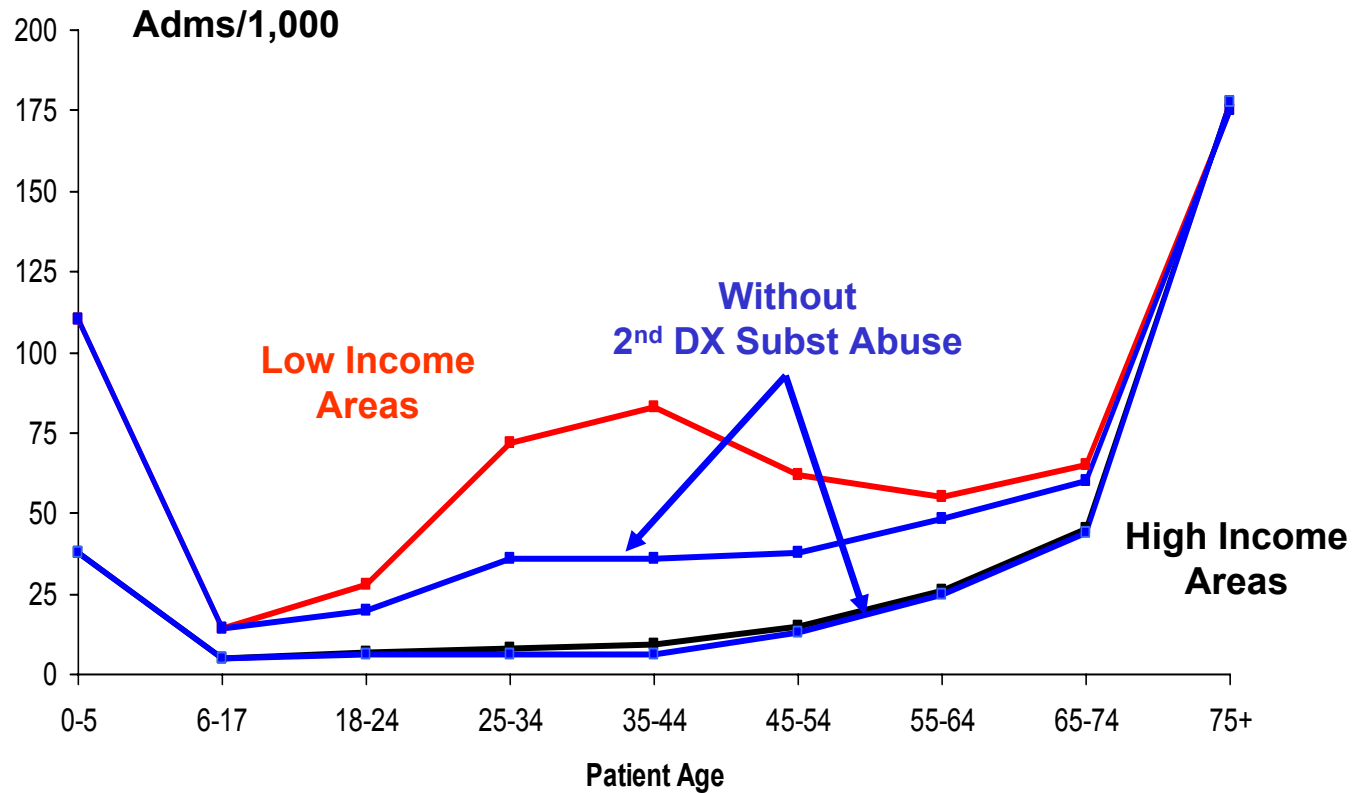
New York City Pneumonia Admissions/1,000 By Age – 1990



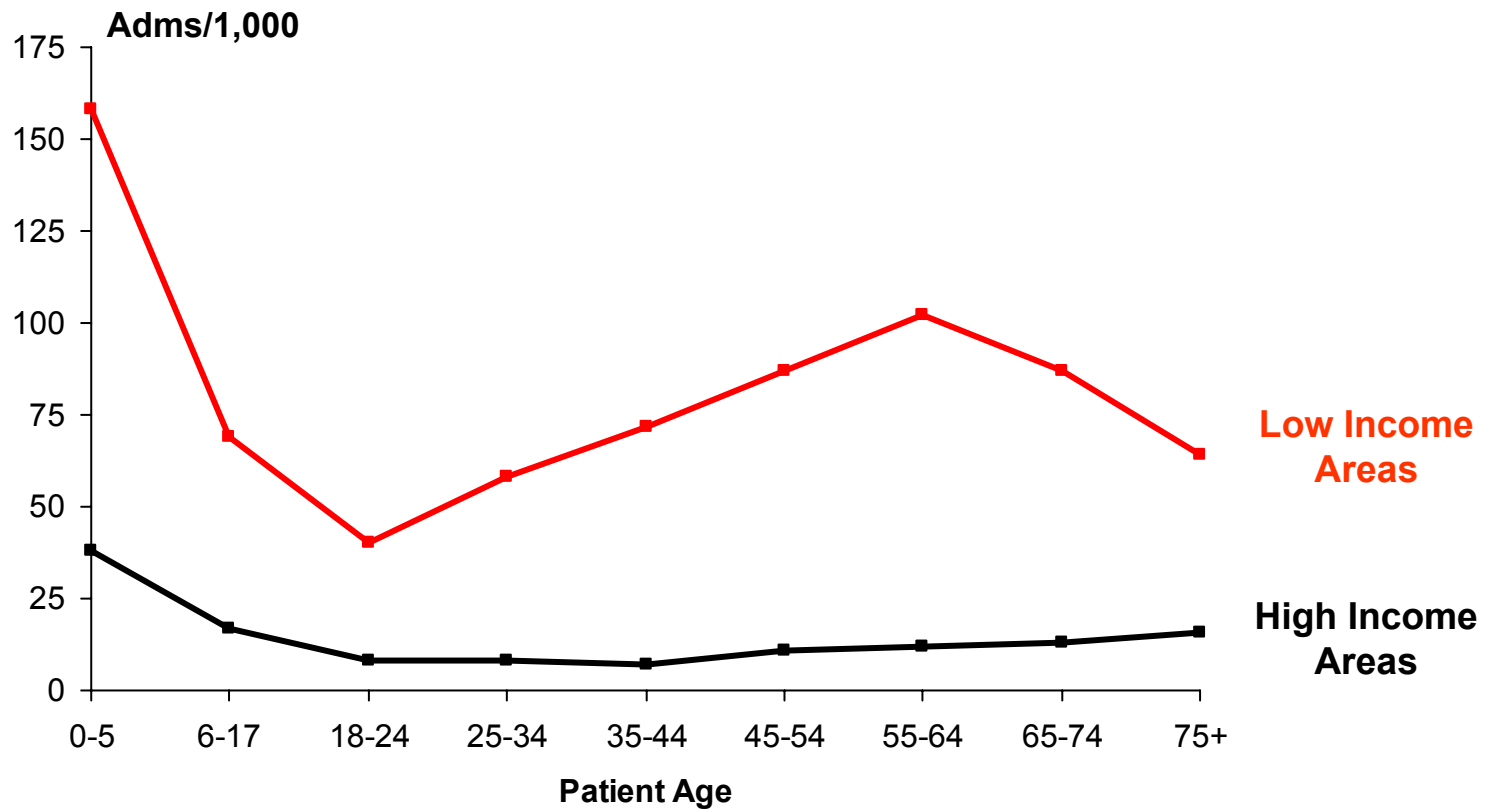
New York City Pneumonia Admissions/1,000 By Age – 1990



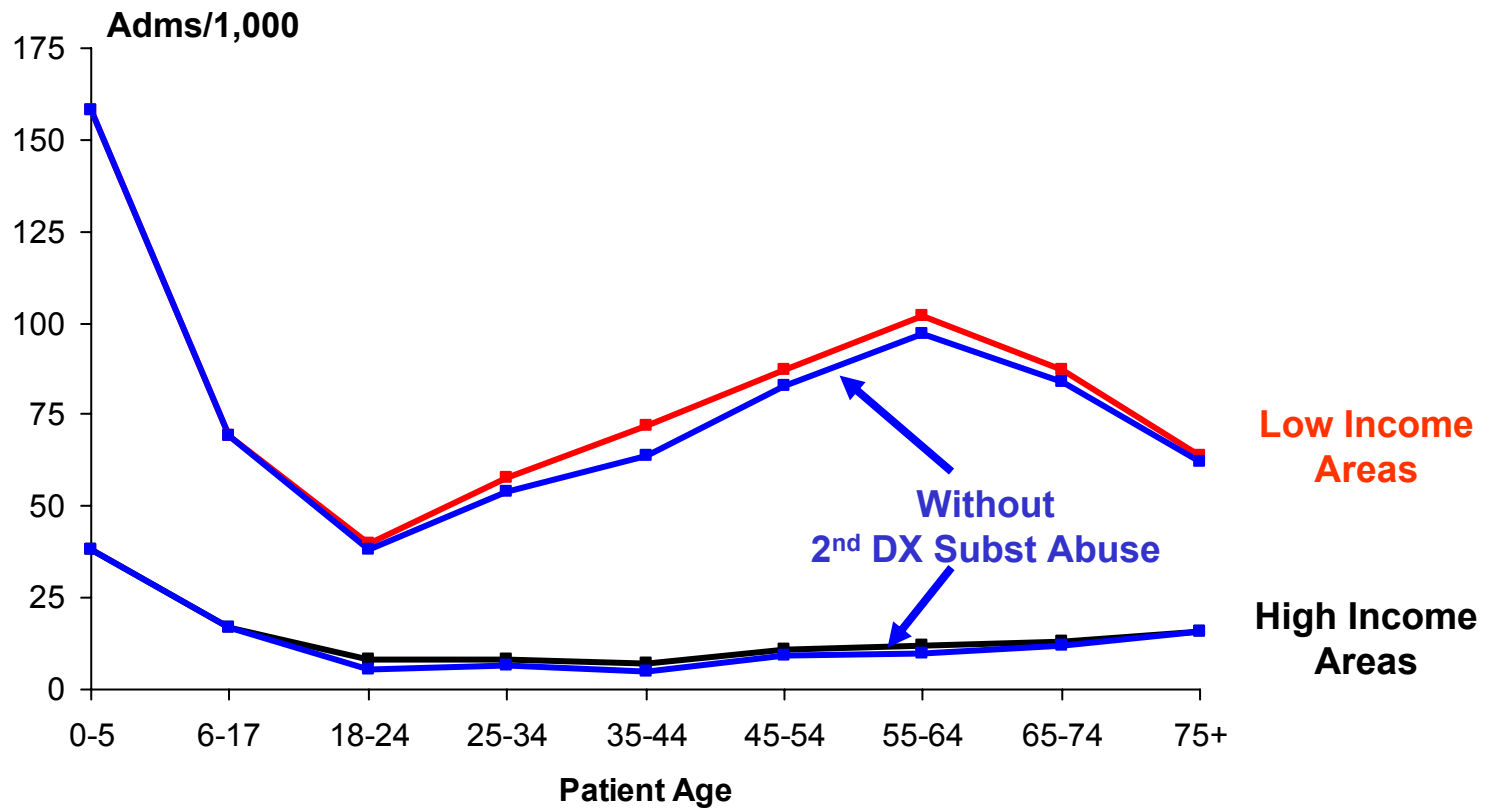
New York City Pneumonia Admissions/1,000 By Age – 1990



New York City Asthma Admissions/1,000 By Age – 1990



New York City Asthma Admissions/1,000 By Age – 1990



COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Personal Health Maintenance	X				X	
Prevention		X	x	x		X
Check-ups			x	x		
Immunizations			x	x		
Screening			x	x		
Symptom identification	X	X		x	X	X
Condition/symptom self-management	X			x	X	X
Care seeking behavior	X	X	X	x	X	X
Decision to seek care	X	X	X	x	X	X
Site of care	x	x	X	x		X
Continuity	x	X	X			X
Loyalty	x	X	X			X
Care Availability	X	X	X	X	X	X
Resource supply	x	X	X	X	X	X
Beds	x					
Practitioners	x	X	X	X	X	X
Open-doorness	X	X	X	X	X	X
Acceptability	X	X	X	X	X	X



**Ambulatory Care Sensitive (ACS)
Hospital Admissions/1,000**
By MMC Payor Class (W/o Excluded/Exempted)
Medicaid – NYC - 1999

	ADC/HR Females 6Mo-14Yrs	ADC/HR Males 6Mo-20Yrs	SSI Adults 21-64Yrs
Hospital OPD/Satellite	43.6	37.5	89.5
Freestanding Clinic	17.6	16.3	37.0
Private/Group MD	16.8	28.5	75.0
Shoppers	84.9	66.9	220.5
Occasional Users	10.9	15.1	38.8
0 PC Visit Patients	7.0	6.9	8.1
Total – All Patients	20.6	23.6	54.8

COMPONENTS OF OPTIMAL HEALTH

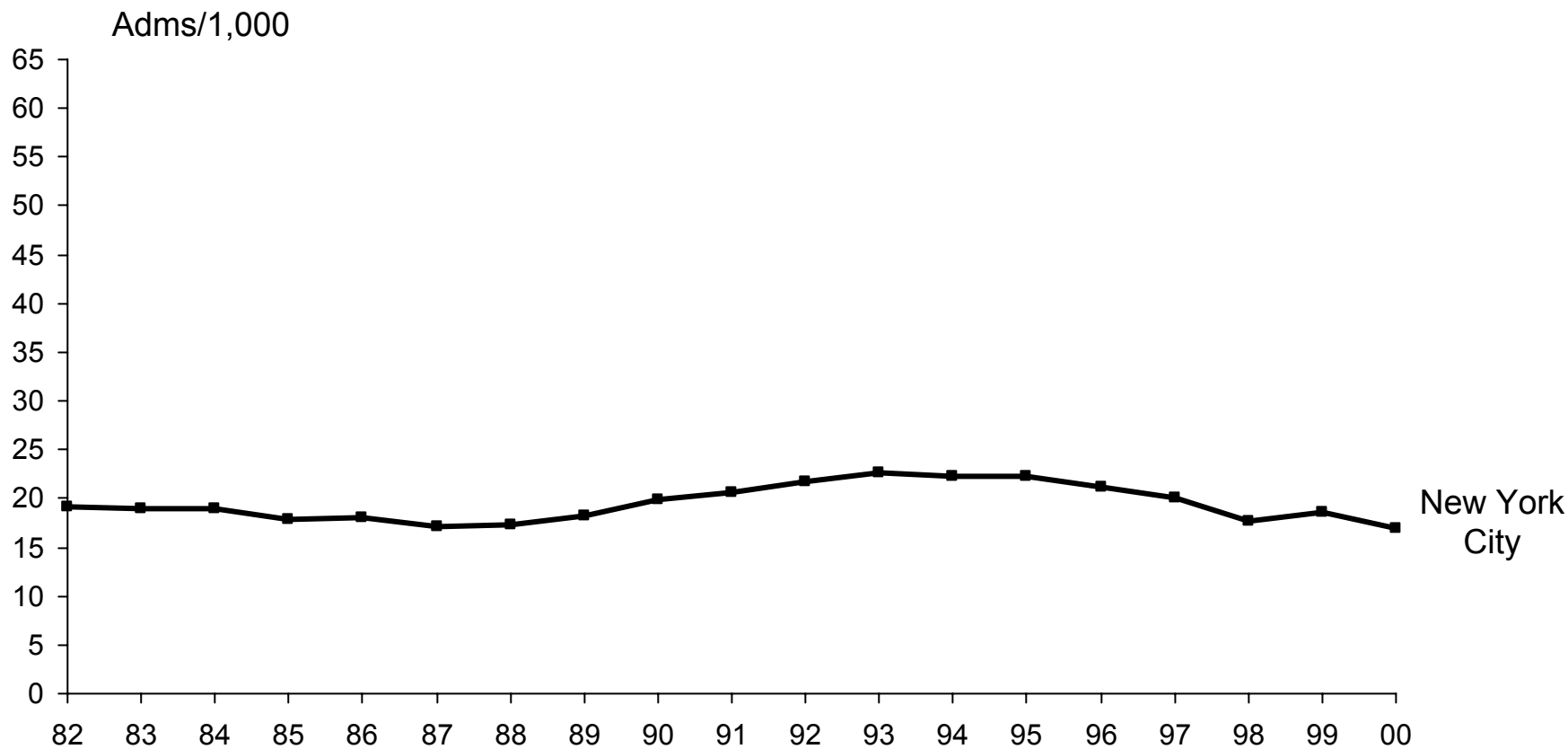
	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Personal Health Maintenance	X				X	
Prevention		X	x	x		X
Check-ups			x	x		
Immunizations			x	x		
Screening			x	x		
Symptom identification	X	X		x	X	X
Condition/symptom self-management	X			x	X	X
Care seeking behavior	X	X	X	x	X	X
Decision to seek care	X	X	X	x	X	X
Site of care	x	x	X	x		X
Continuity	x	X	X			X
Loyalty	x	X	X			X
Care Availability	X	X	X	X	X	X
Resource supply	x	X	X	X	X	X
Beds	x					
Practitioners	x	X	X	X	X	X
Open-doorness	X	X	X	X	X	X
Acceptability	X	X	X	X	X	X



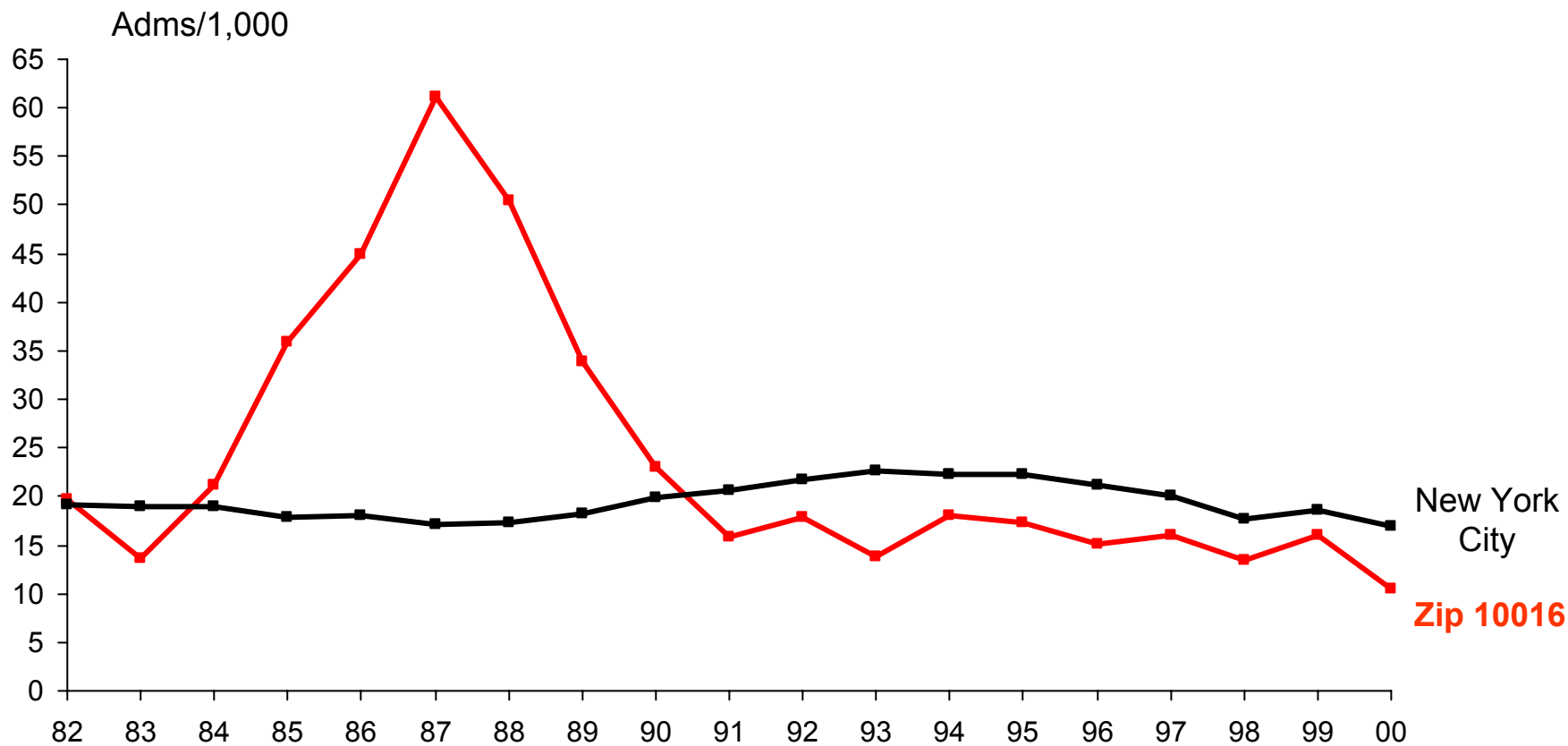
New York City Survey of Hospitalized ACS Patients Age 18-64 - 1993

	Wash Heights	Central Harlem	East Harlem	North East Queens
Area Characteristics				
ACS Adms/1,000 – Age 18-64	24.0	46.2	55.7	9.4
PCP Supply/100,000	67.6	71.7	87.8	57.1
Survey Patient Characteristics				
% < Poverty Level	65.6%	62.1%	64.3%	24.6%
% Medicaid	68.2%	67.1%	64.8%	24.6%
% Uninsured	15.3%	18.9%	13.7%	10.9%
% Non-US Birth	38.4%	9.3%	34.4%	22.3%
% Speak mostly non-English at home	47.1%	6.7%	21.2%	10.3%
% Poor health	39.5%	49.1%	44.5%	18.6%

New York City ACS (Preventable/Avoidable) Admissions/1,000 Age 0-17 – 1982-2000



New York City ACS (Preventable/Avoidable) Admissions/1,000 Age 0-17 – 1982-2000



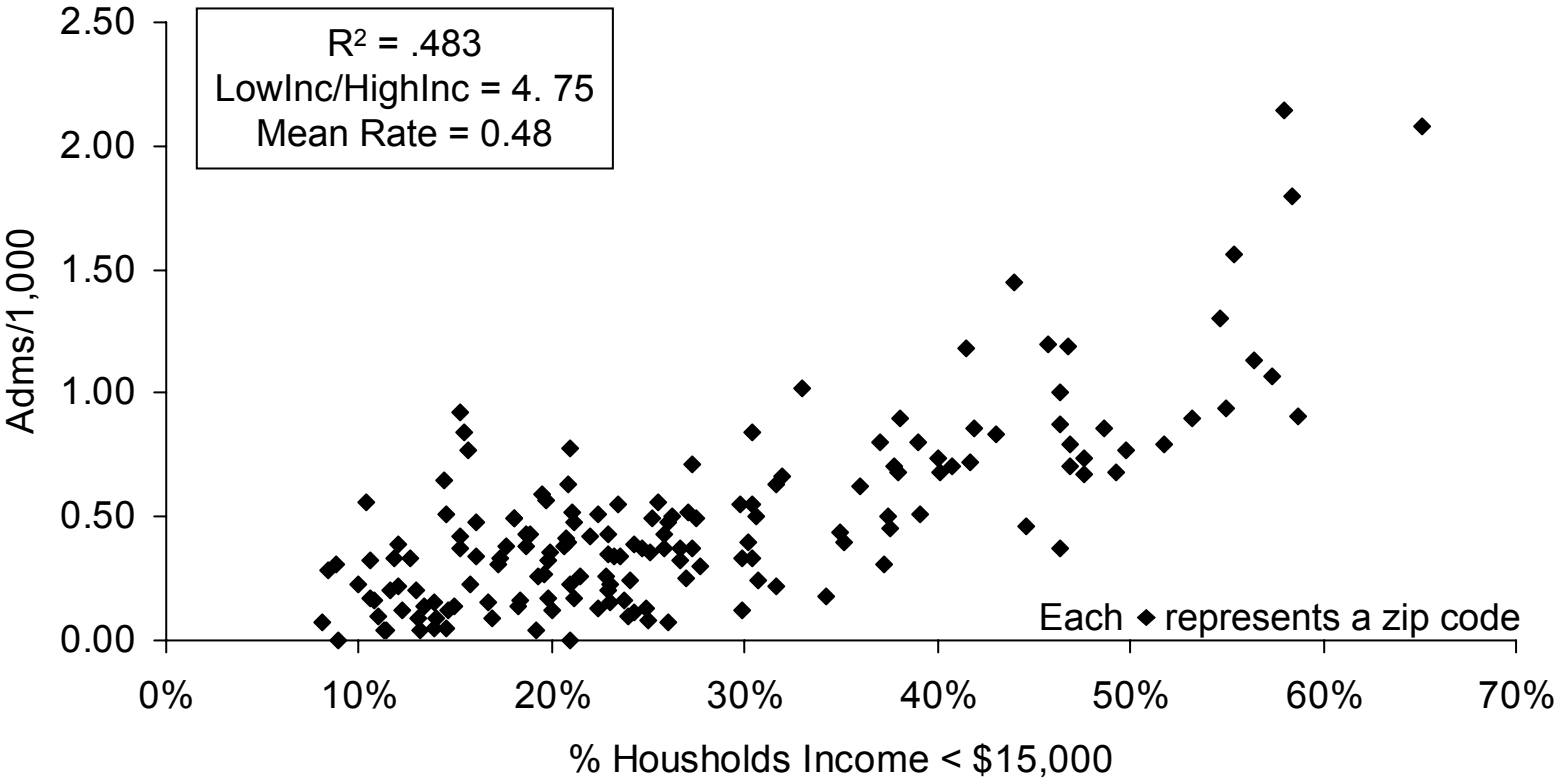
COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Provider Performance	X		X	X	X	X
Content of care	X					
Technical competence	X					
Practice style/MD decision making	x					
Patient education	X		X	X	X	X
Linkages	x		x			X
Diagnostic work-up						X
Specialty referral						X
Hospital privileges	x					
Hospital admission/ED visit notification	x					X
Community based organizations	x					
Decision support						
Elicitation of values						
Assistance in applying to critical decisions/treatment choices						
Customer orientation/cultural competence	X	X	X	X	X	X
Respect	X	X	X	X	X	X
Understanding	X	X	X	X	X	X
Language	X	X	X	X	X	X
Communication	X	X	X	X	X	X
Customer service	X	X	X	X	X	X
Hours of operation	X	x	X	X	X	X
Wait times/cycle times/dwell times/etc	X	x	X	X	X	X
Telephone access	X	x	X	X	X	X
Array of services	x		X			X
Administrative/management/MIS support	x					

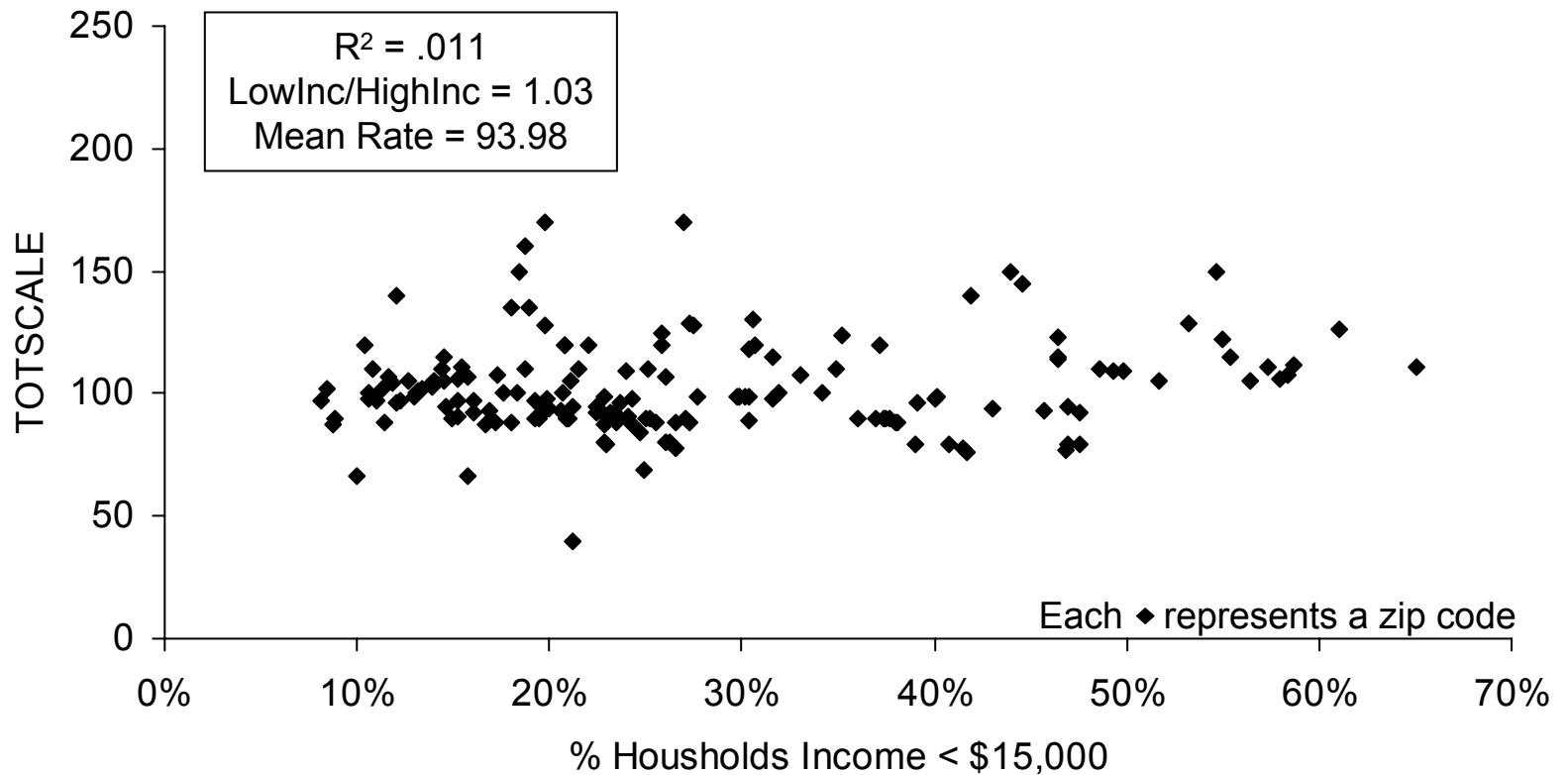
COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Provider Performance	X		X	X	X	X
Content of care	X					
Technical competence	X					
Practice style/MD decision making	x					
Patient education	X		X	X	X	X
Linkages	x		x			X
Diagnostic work-up						X
Specialty referral						X
Hospital privileges	x					
Hospital admission/ED visit notification	x					X
Community based organizations	x					
Decision support						
Elicitation of values						
Assistance in applying to critical decisions/treatment choices						
Customer orientation/cultural competence	X	X	X	X	X	X
Respect	X	X	X	X	X	X
Understanding	X	X	X	X	X	X
Language	X	X	X	X	X	X
Communication	X	X	X	X	X	X
Customer service	X	X	X	X	X	X
Hours of operation	X	x	X	X	X	X
Wait times/cycle times/dwell times/etc	X	x	X	X	X	X
Telephone access	X	x	X	X	X	X
Array of services	x		X			X
Administrative/management/MIS support	x					

New York City Diabetes Admissions/1,000 Age 0-64 - 1988



New York City “TOTSCALE” Severity Rating Age 0-64 - 1988



COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Provider Performance	X		X	X	X	X
Content of care	X					
Technical competence	X					
Practice style/MD decision making	x					
Patient education	X		X	X	X	X
Linkages	x		x			X
Diagnostic work-up						X
Specialty referral						X
Hospital privileges	x					
Hospital admission/ED visit notification	x					X
Community based organizations	x					
Decision support						
Elicitation of values						
Assistance in applying to critical decisions/treatment choices						
Customer orientation/cultural competence	X	X	X	X	X	X
Respect	X	X	X	X	X	X
Understanding	X	X	X	X	X	X
Language	X	X	X	X	X	X
Communication	X	X	X	X	X	X
Customer service	X	X	X	X	X	X
Hours of operation	X	x	X	X	X	X
Wait times/cycle times/dwell times/etc	X	x	X	X	X	X
Telephone access	X	x	X	X	X	X
Array of services	x		X			X
Administrative/management/MIS support	x					

Performance Measures Medicaid ADC/HR - NYC - 1997

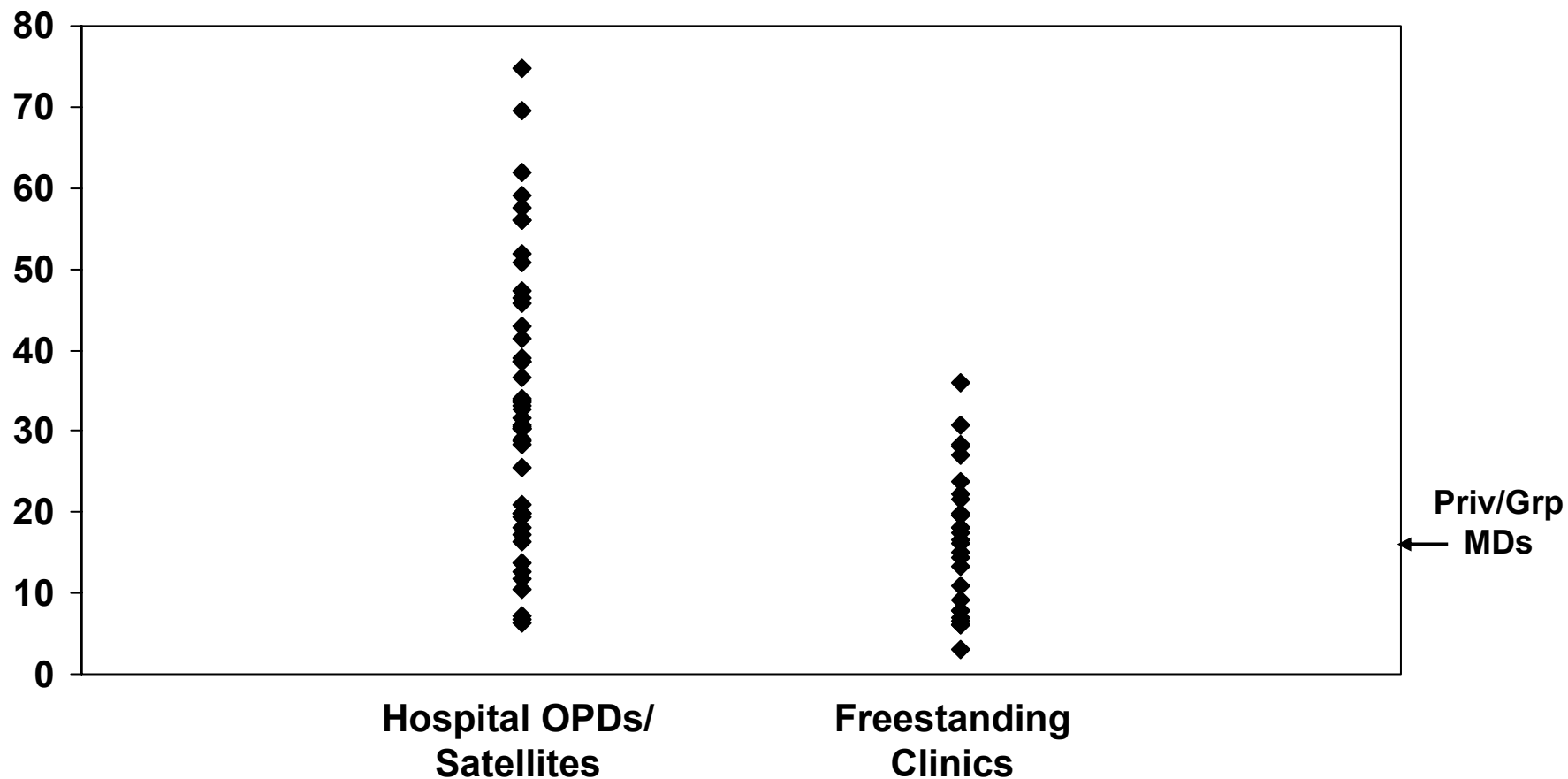
	% of All Patients
<hr/>	
<u>Children 0-17</u>	
No follow-up visit within 30 days of hosp discharge	34.5%
No follow-up visit within 30 days of ED visit	52.0%
No ambulatory visit within 30 days of birth	50.3%
No ambulatory visit within 60 days of birth	30.8%
ED visit during 12 months following birth	51.2%
<u>Adults 18-64</u>	
No follow-up visit within 30 days of hosp discharge	49.6%
No follow-up visit with 30 days of ED visit	52.3%
ED Visit during pregnancy	51.2%

**Ambulatory Care Sensitive (ACS)
Hospital Admissions/1,000**
By MMC Payor Class (W/o Excluded/Exempted)
Medicaid – NYC - 1999

	ADC/HR Females 6Mo-14Yrs	ADC/HR Males 6Mo-20Yrs	SSI Adults 21-64Yrs
Hospital OPD/Satellite	43.6	37.5	89.5
Freestanding Clinic	17.6	16.3	37.0
Private/Group MD	16.8	28.5	75.0
Shoppers	84.9	66.9	220.5
Occasional Users	10.9	15.1	38.8
0 PC Visit Patients	7.0	6.9	8.1
Total – All Patients	20.6	23.6	54.8

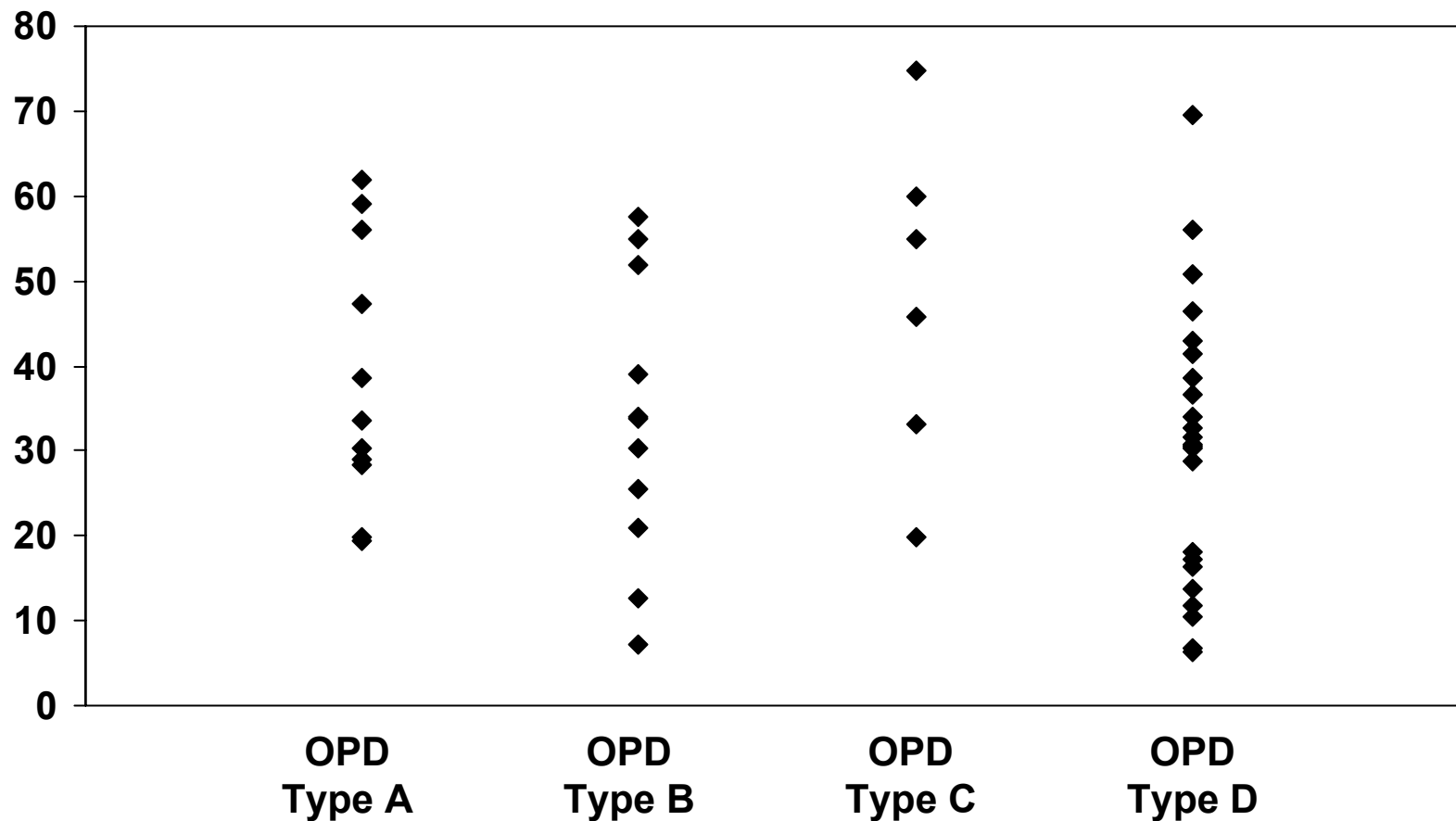
Ambulatory Care Sensitive (ACS) Conditions Hospital Admissions/1,000

ADC/HR Females Age 6mos-14Yrs (W/o Excluded/Exempted)
Medicaid - NYC - 1999



Ambulatory Care Sensitive (ACS) Conditions Hospital Admissions/1,000

ADC/HR Females Age 6mos-14Yrs (W/o Excluded/Exempted)
Medicaid - NYC - 1999



ACS Admissions/1,000 – Severity Adjustment Analysis
Rates, Ratio to Average, and Observed/Expected
 By MMC Payor Class (W/o Excluded/Exempted)
 Medicaid – NYC - 1999

	Adms Per 1,000	Ratio To Average	Charleson Obs/ Exp	ACG Obs/ Exp	Kronick Obs/ Exp
Hospital OPD/Satellite	43.6	2.15	1.90	1.58	1.87
Freestanding D&TC	17.6	0.87	0.76	0.73	0.79
Private/Group MD	16.8	0.83	0.76	0.78	0.84
Shoppers	84.9	4.19	3.48	1.96	3.59
Occasional Users	10.9	0.54	0.74	1.19	0.61
0 PC Visit Patients	7.0	0.35	0.65	3.19	0.46
Total – All Patients	20.6	1.00	1.00	1.00	1.00

COMPONENTS OF OPTIMAL HEALTH

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Personal Disease/Condition Management	X	X		X	X	X
Symptom/flare-up identification	X			X	X	X
Condition/symptom self-management	X			X	X	X
Care seeking behavior	X	X		X	X	X
Compliance/adherence	X	x		X		

PERSONAL MEDIATING FACTORS

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Health Knowledge	X	X		X	X	X
Health habits	X	X		X	X	X
Symptom identification	X	X		X	X	X
Self management	X	X		X	X	X
Resource availability	X	X		X	X	X
System navigation	X	X		X	X	X
Perception of Health System	X	X	X	X	X	X
What's there/available	X	X	X	X	X	X
Waits, care expectations, etc	X	X	X	X	X	X
Respect afforded	X	X	X	X	X	X
Communication effectiveness-language	X	X	X	X	X	X
Communication effectiveness-listening	X	X	X	X	X	X
Cultural sensitivity	X	X	X	X	X	X
Expectation of payment	X	X	X	X	X	X

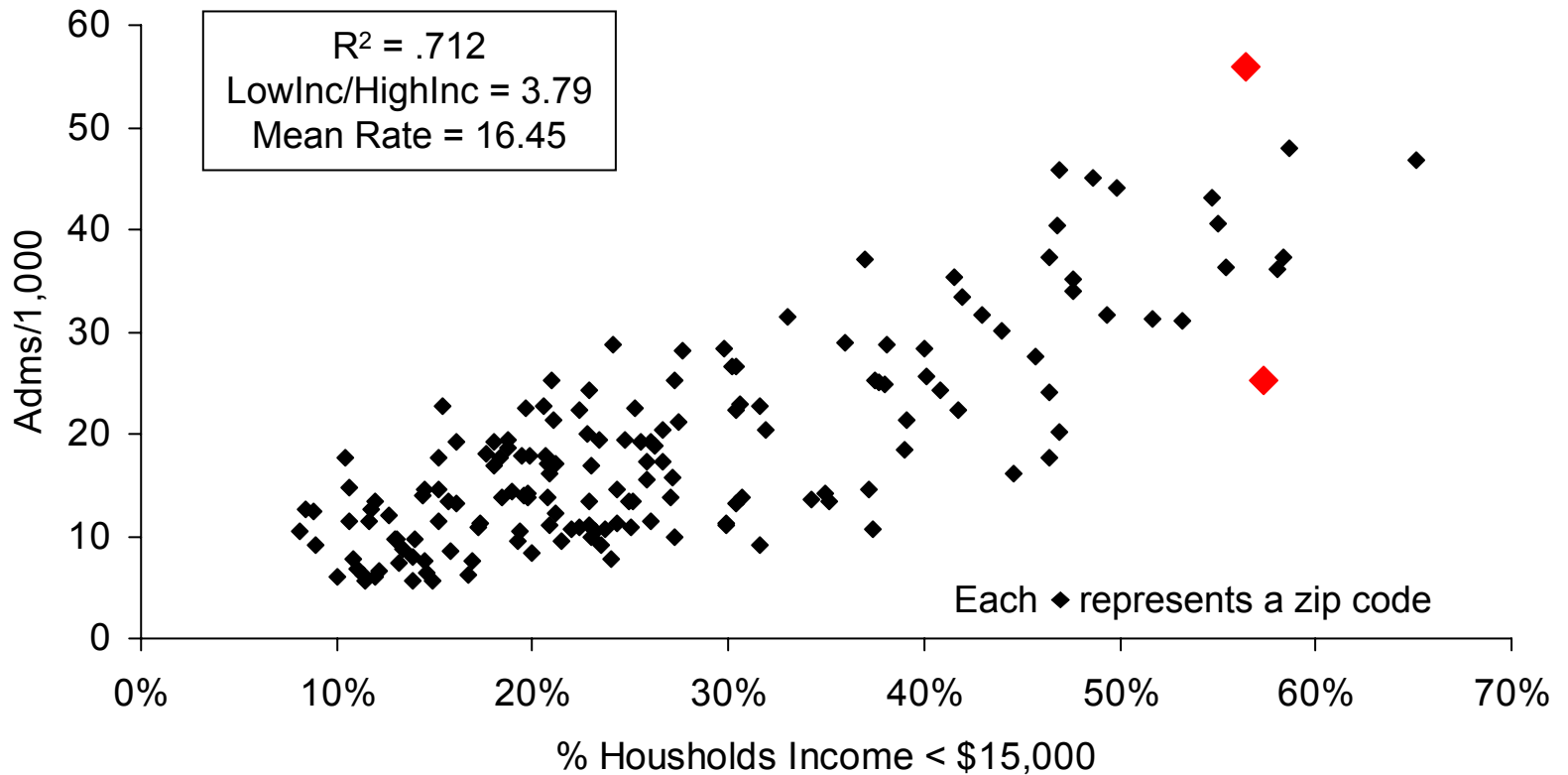
PERSONAL MEDIATING FACTORS

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Personal characteristics	X	X	X	X	X	X
Health beliefs	X	X	X	X	X	X
"Self-efficacy"	X	X	X	X	X	X
Expectations	X	X	X	X	X	X
Self-advocacy	x	x	X	x	X	X
Attitudes towards benefit/risk	X	X	X	X	X	X
Motivation	X	X	X	X	X	X
Confidence	X	X	x	X	x	x
Mental health	X	X	x	X	X	X
Stoicism	X			X	X	X

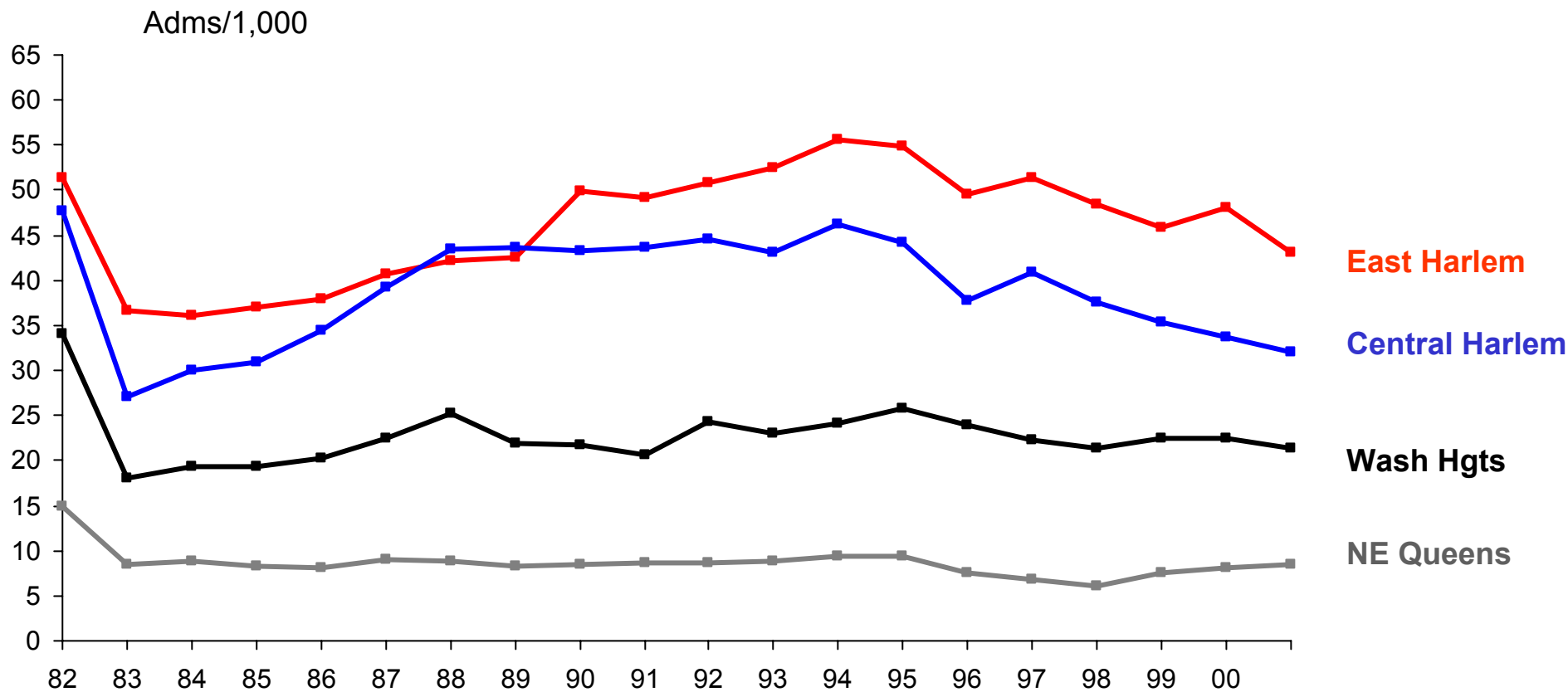
PERSONAL MEDIATING FACTORS

	ACS Adms	Late/No Prenatal Care	No Usual Source of Care	No PC Visit In Past Year	Unable To Get Needed Care-Delay	ED Use for Primary Care
Personal Resources	X	X	X	X	X	X
Insurance coverage	X	X	X	X	X	X
Economics (income)	X	X	X	X	X	X
Skills/education	X	X	X	X	X	X
Social capital - personal	X	X	X	X	X	X
Social capital - community	X	X	X	X	X	X
Personal Circumstances	X	X	X	X	X	X
Employment	X	X	x	X	X	X
Life demands	X	X	X	X	X	X
Competing priorities	X	X	X	X	X	X
Stress/psycho-social factors	X	X	x	X	X	X

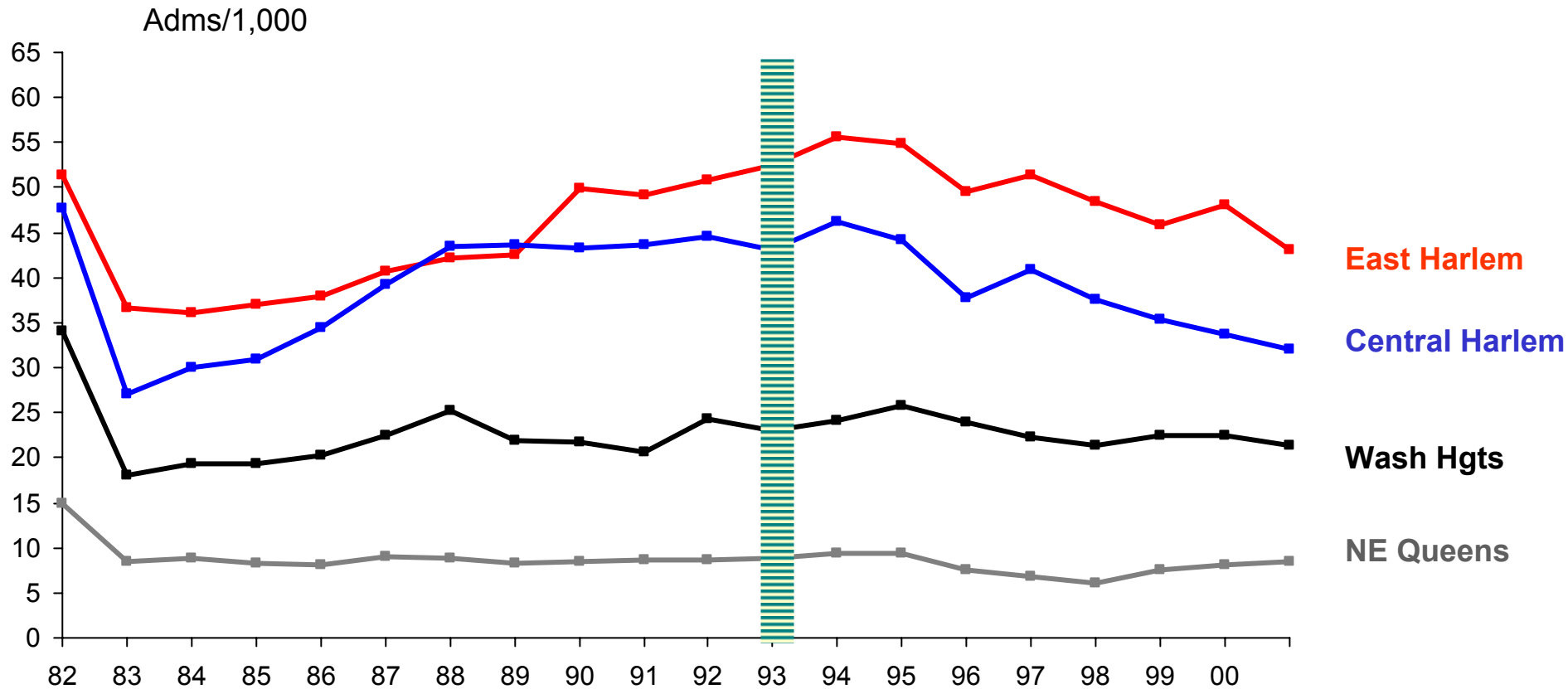
New York City ACS (Preventable/Avoidable) Admissions/1,000 Age 18-64 - 2000



New York City ACS (Preventable/Avoidable) Admissions/1,000 Age 18-64 – 1982-2000



New York City ACS (Preventable/Avoidable) Admissions/1,000 Age 18-64 – 1982-2000



New York City Survey of Hospitalized ACS Patients Age 18-64 - 1993

	Wash Heights	Central Harlem	East Harlem	North East Queens
Area Characteristics				
ACS Adms/1,000 – Age 18-64	24.0	46.2	55.7	9.4
PCP Supply/100,000	67.6	71.7	87.8	57.1
Survey Patient Characteristics				
% < Poverty Level	65.6%	62.1%	64.3%	24.6%
% Medicaid	68.2%	67.1%	64.8%	24.6%
% Uninsured	15.3%	18.9%	13.7%	10.9%
% Non-US Birth	38.4%	9.3%	34.4%	22.3%
% Speak mostly non-English at home	47.1%	6.7%	21.2%	10.3%
% Poor health	39.5%	49.1%	44.5%	18.6%

New York City Survey of Hospitalized ACS Patients Age 18-64 - 1993

	Wash Heights	Central Harlem	East Harlem	North East Queens
Characteristics of Primary Care				
No usual source of care	31.6%	40.3%	39.8%	15.6%
Usual source is clinic/OPD	30.8%	46.8%	41.7%	23.4%
Usual source is private/group MD	31.2%	12.9%	17.0%	58.4%
Consider one person in charge of care	44.7%	32.4%	38.0%	70.1%
Telephone access	10.7%	7.3%	13.9%	35.1%

New York City Survey of Hospitalized ACS Patients Age 18-64 - 1993

	Wash Heights	Central Harlem	East Harlem	North East Queens
Contact Prior to ACS Admission				
No health system contact	68.2%	62.7%	51.9%	39.0%
ED visit only	10.2%	21.3%	21.0%	9.6%
Physician visit and ED visit	6.4%	6.2%	14.4%	7.4%
Physician visit only	15.3%	9.8%	12.7%	44.1%

New York City Survey of Hospitalized ACS Patients Age 18-64 - 1993

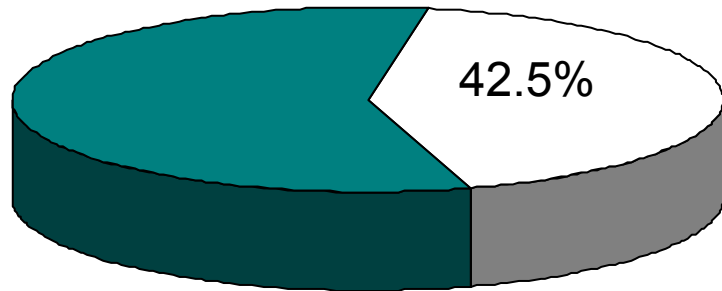
	Wash Heights	Central Harlem	East Harlem	North East Queens
Barriers to Care Prior to Admission				
Reported barrier of any type	48.7%	66.5%	74.8%	44.2%
Care not available when needed it	3.8%	8.4%	6.0%	4.4%
Costs too much	6.9%	6.2%	10.4%	9.5%
Wait too long for appointment	3.1%	11.5%	16.5%	5.1%
Too busy with other things	7.5%	16.7%	18.1%	4.4%
Wasn't up to going	7.5%	23.8%	15.9%	6.6%
Too nervous afraid	5.6%	13.2%	17.6%	5.1%

New York City Survey of Hospitalized ACS Patients Low Income Patients - 1993

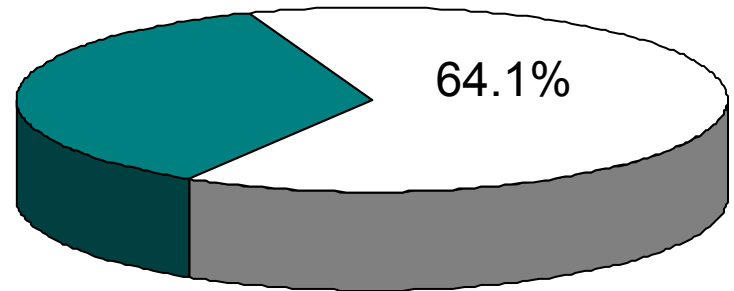
	Children Age 0-17	Adults Age 18-64
Survey Patient Characteristics		
No usual source of care	9.3%	36.8%
One person in charge of care	74.0%	38.0%
Telephone access	24.0%	10.9%
Reported Barriers to Access		
Barrier of any type	29.8%	65.7%
Problems with childcare	32.8%	14.3%
Wait too long for appointment	20.3%	20.4%
Too busy with other things	8.1%	27.2%
Wasn't up to going	5.1%	36.1%
Too nervous afraid	10.2%	33.8%

Hospitalized Asthma Patients New York City 1992

CONFIDENCE IN ABILITY TO MANAGE CARE AT HOME



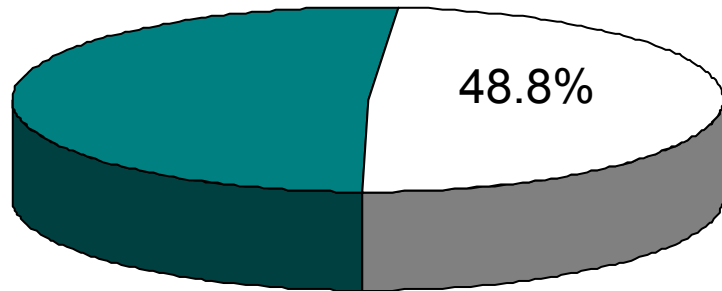
Patients <100% Poverty



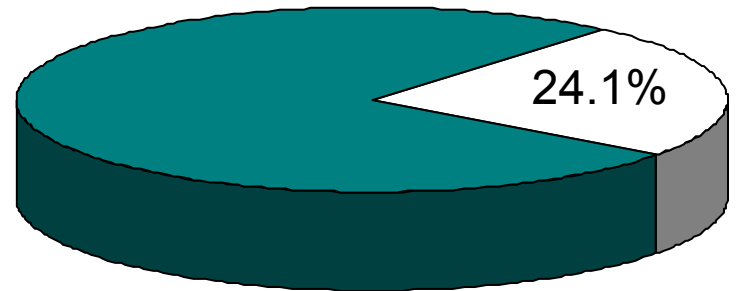
Patients >300% Poverty

Hospitalized Asthma Patients New York City 1992

SELF-MANAGEMENT TRAINING: % “NOT MUCH” or “NONE”

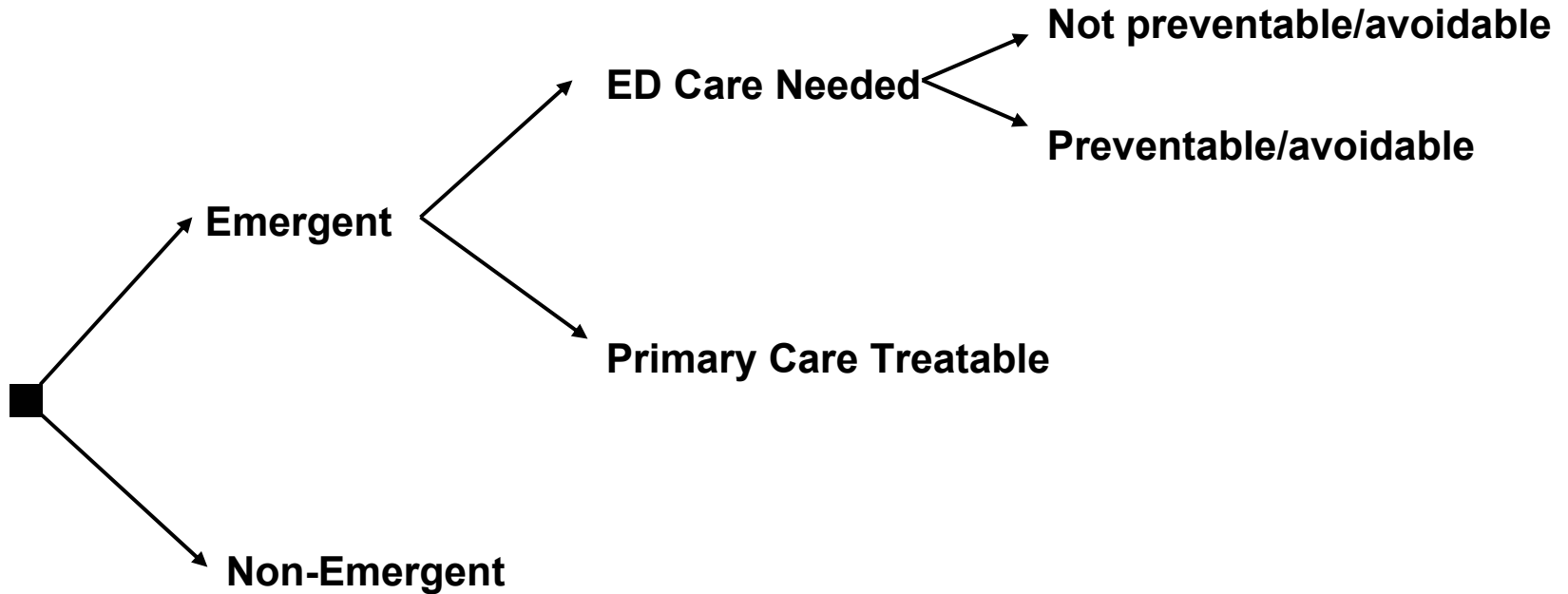


Patients <100% Poverty

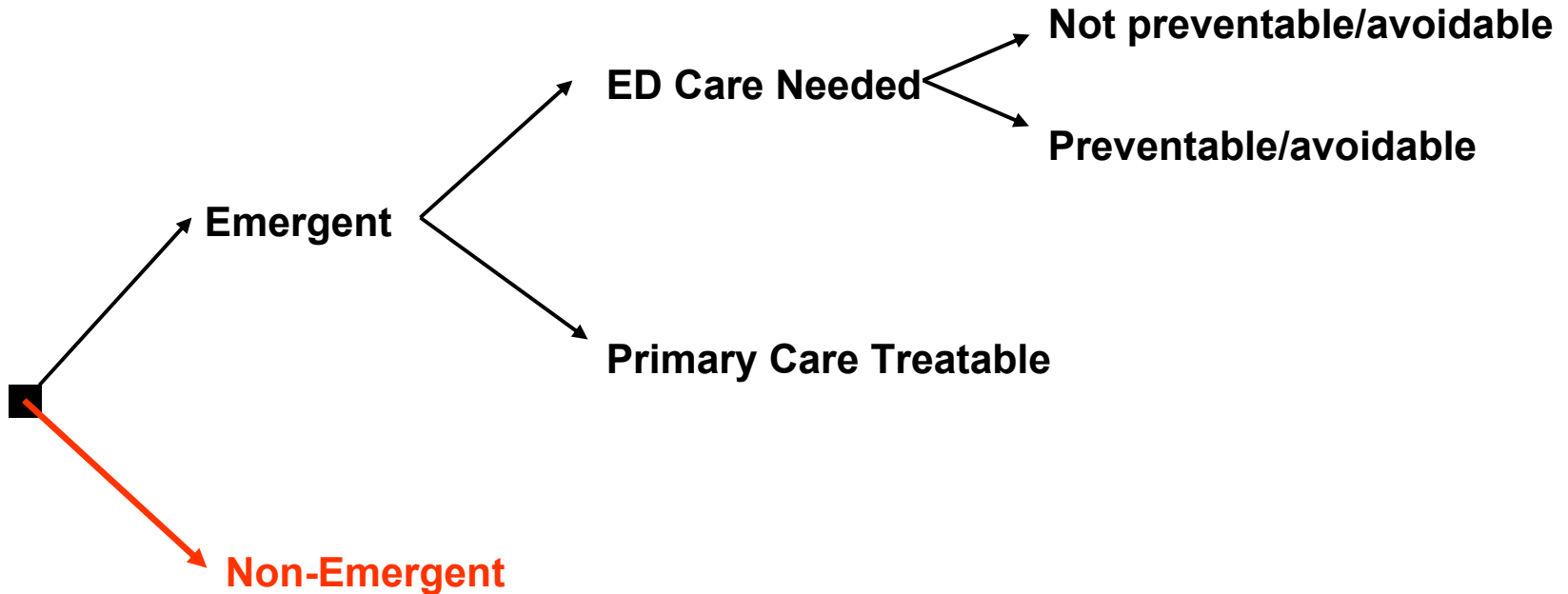


Patients >300% Poverty

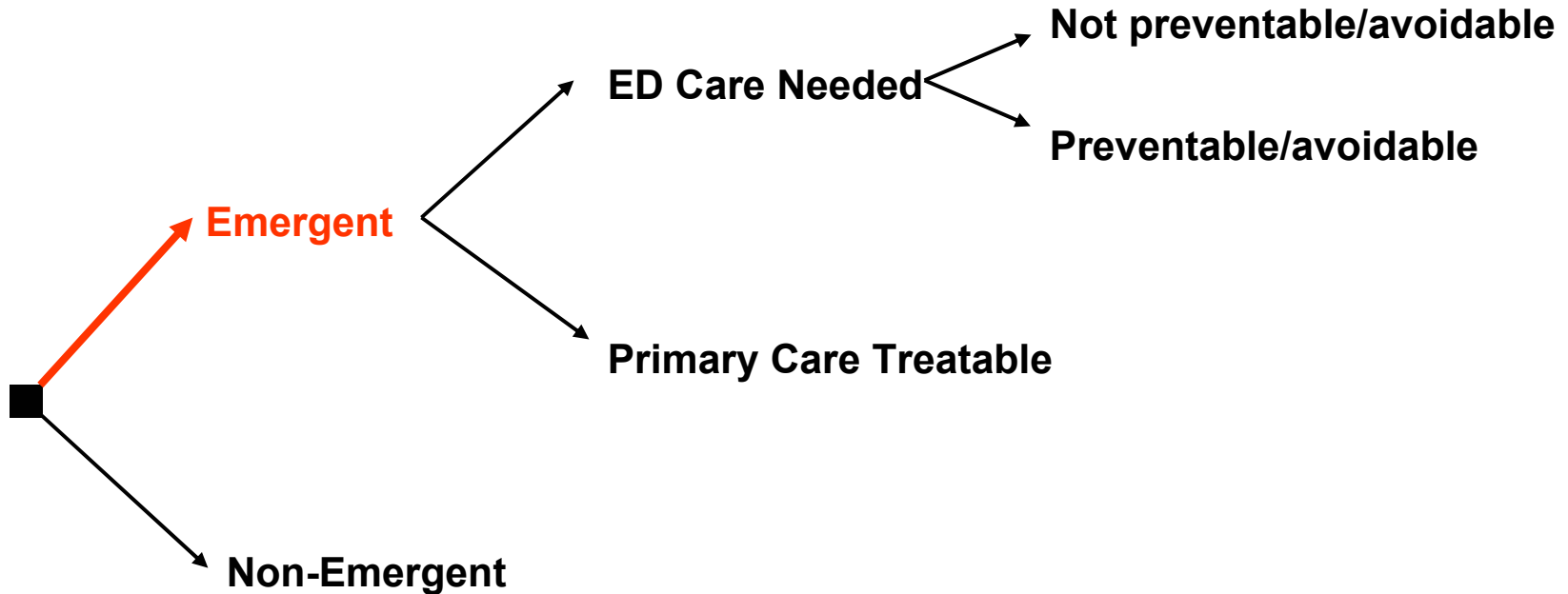
EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



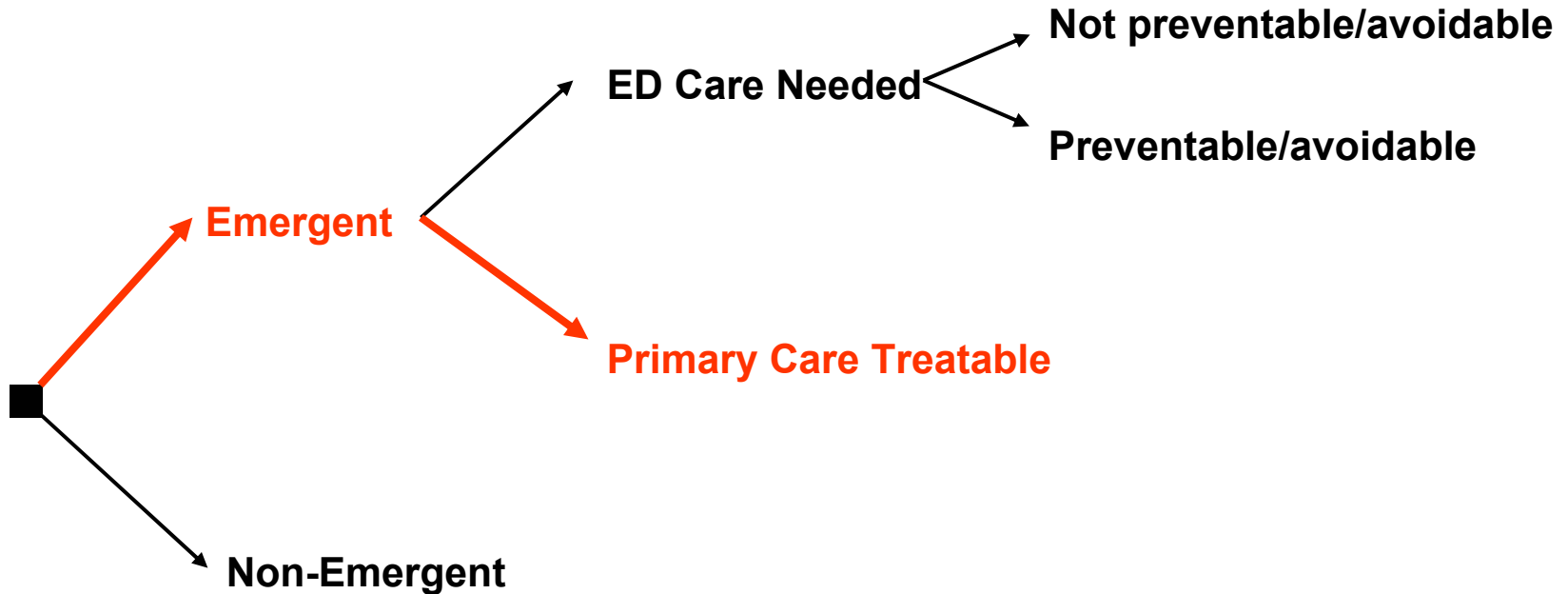
EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



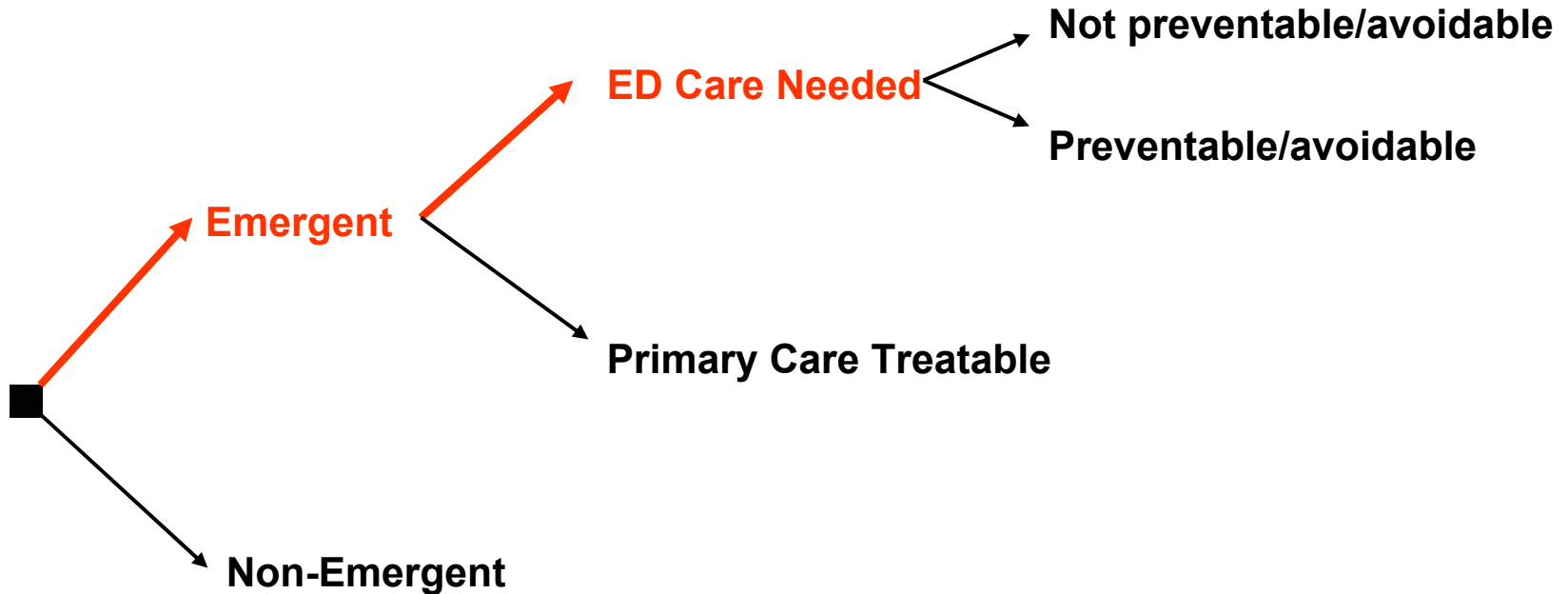
EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



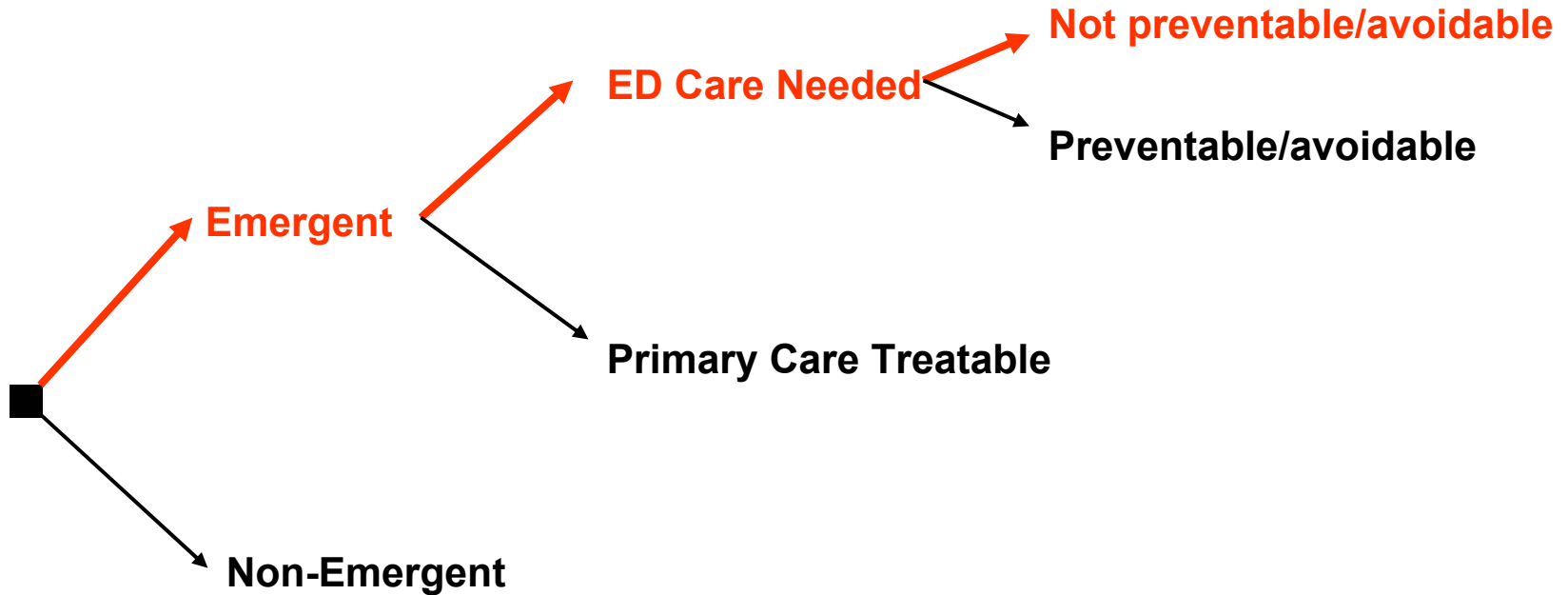
EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



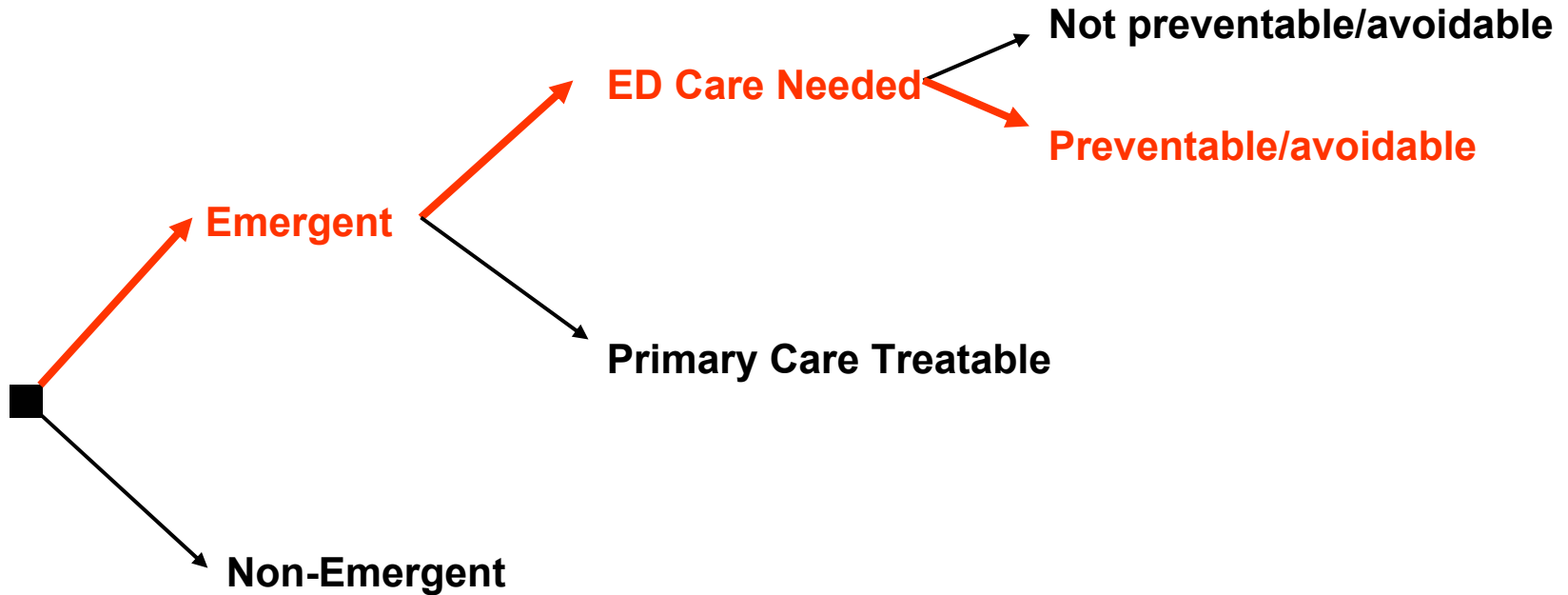
EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



STEPS IN DEVELOPMENT OF ED CLASSIFICATION ALGORITHM

- **Step 1**: 6,000 full ED records analyzed and abstracted
- **Step 2**: Records classified as emergent or non-emergent based on:
 - Patient's initial complaint
 - Vitals signs/history (from triage)
- **Step 3**: Records classified as to optimal setting of care (primary care treatable vs ED care needed)
 - Resources consumed in ED
 - Diagnosis (e.g., "chest pain")

STEPS IN DEVELOPMENT OF ED CLASSIFICATION ALGORITHM

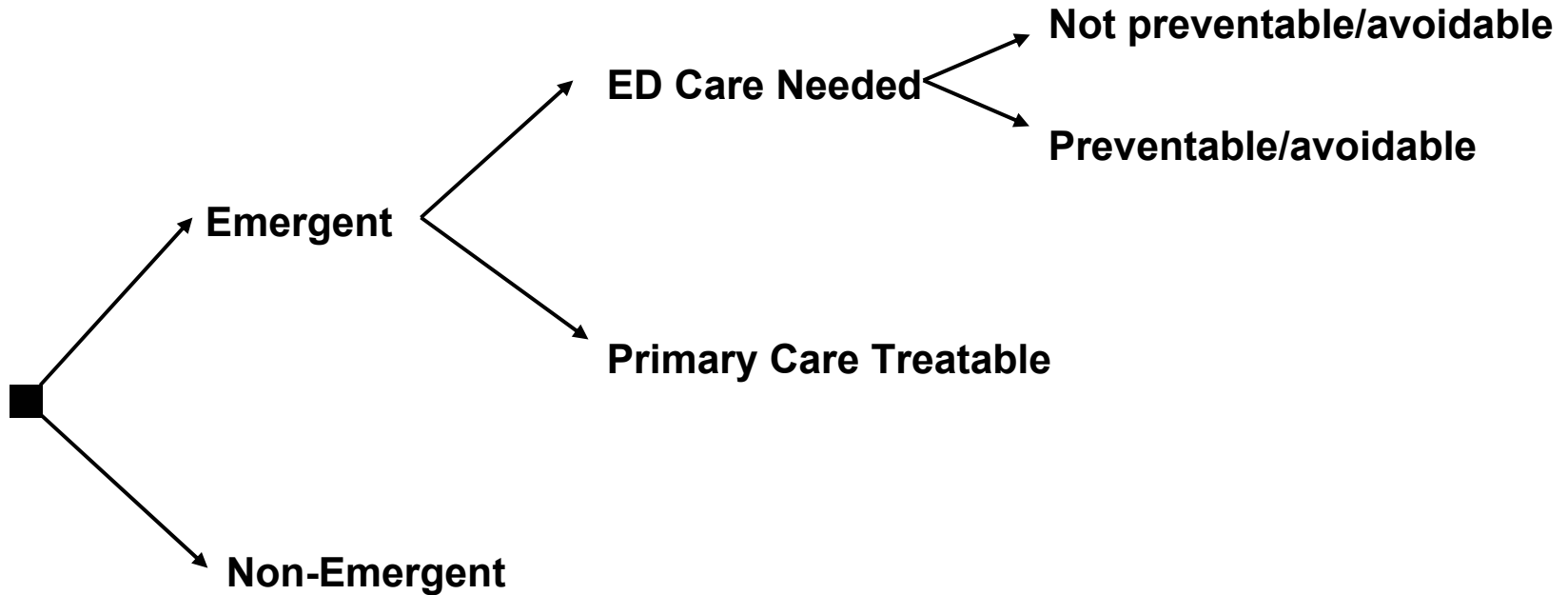
- **Step 4**: Records classified as to visit was potentially “preventable/avoidable” based on:
 - Use of ACS (ambulatory care sensitive) condition algorithm
- **Step 5**: Records mapped to ED **discharge** diagnosis
- **Step 6**: Each discharge diagnosis given a percentage weighting from total sample as:
 - Non-emergent
 - Emergent - Primary care treatable
 - Emergent - ED care needed

AN EXAMPLE...

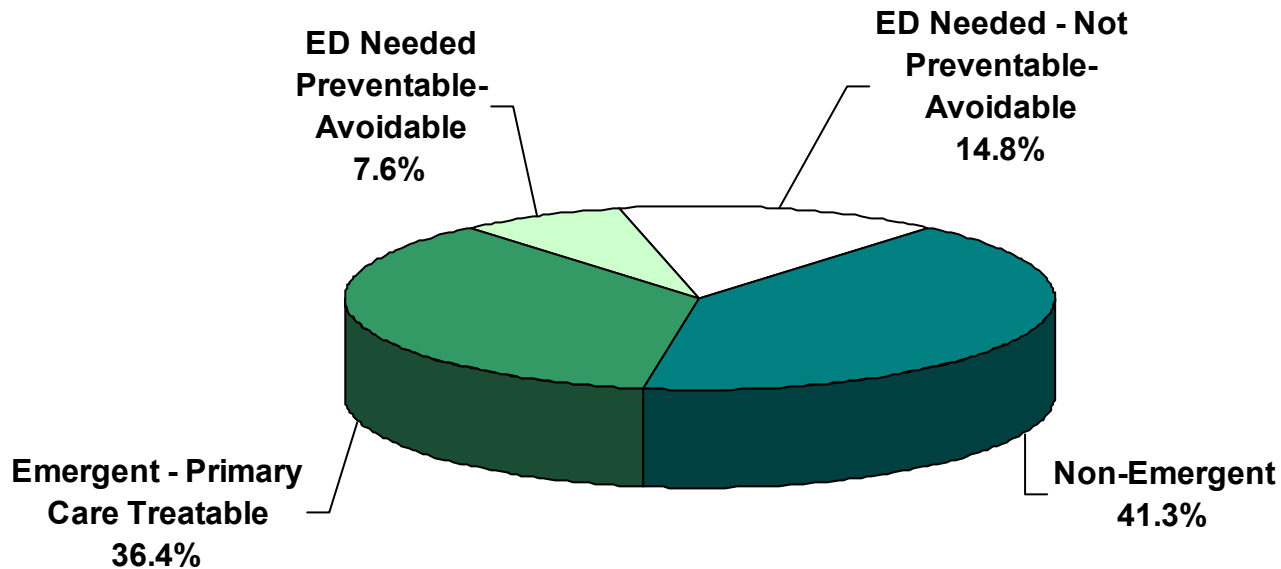
465.9 - Acute upper respiratory infection

- 48.1% Non-emergent
- 38.6% Emergent - Primary care treatable
- 13.3% Emergent - ED care needed

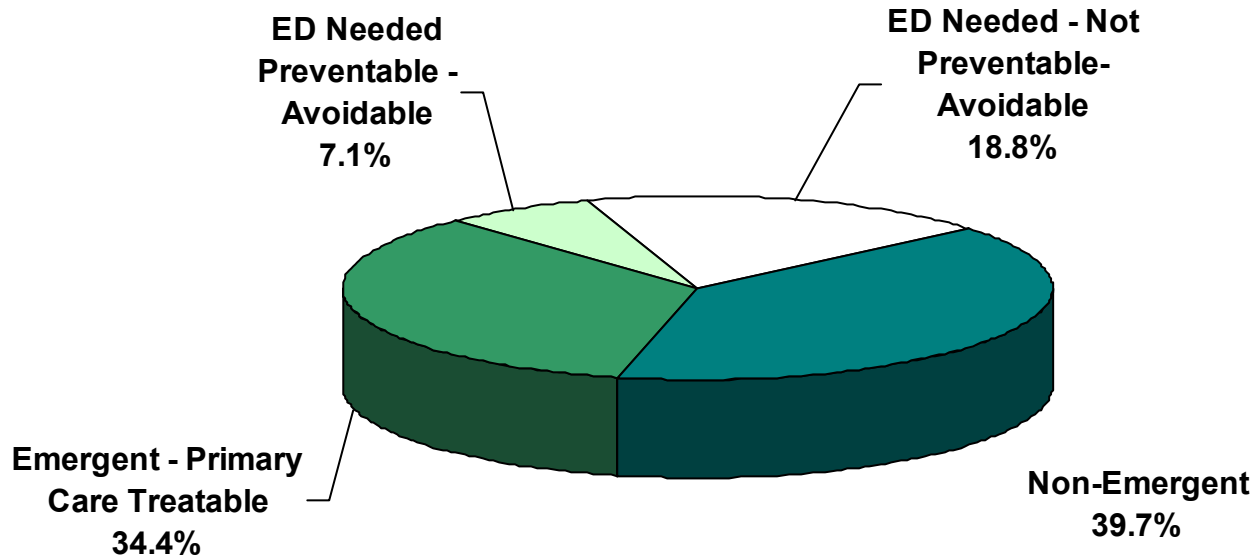
EMERGENCY DEPARTMENT CLASSIFICATION PROCESS



New York City ED Utilization Profile Children Age 0-17 - 1998



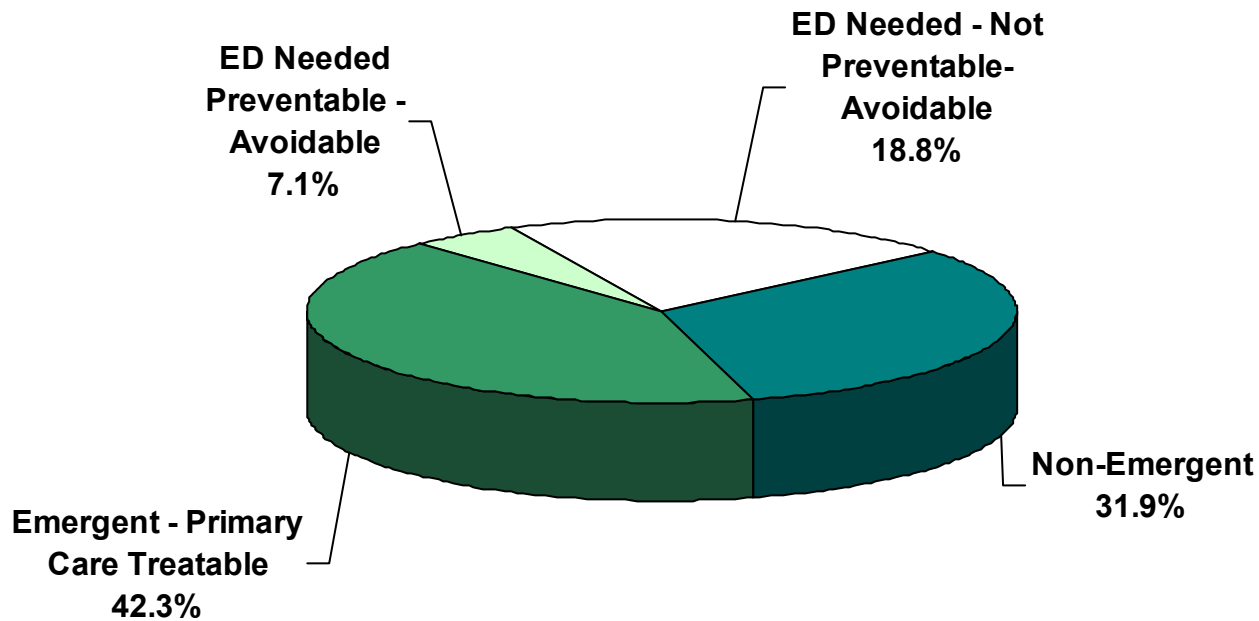
New York City ED Utilization Profile Adults Age 18-64 - 1998



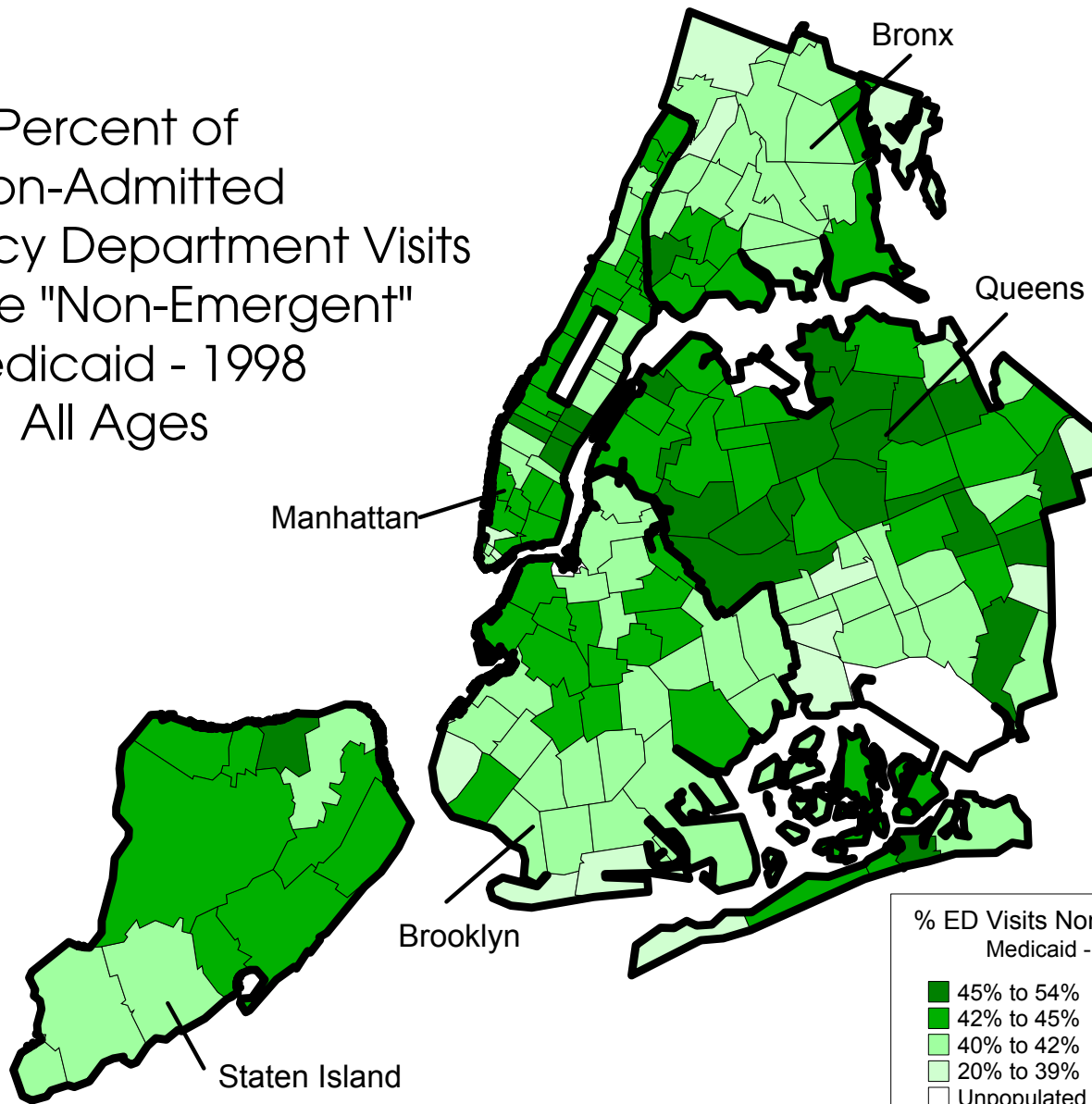
SOUTH CAROLINA

ED Utilization Profile

Adults Age 18-64 - 1997

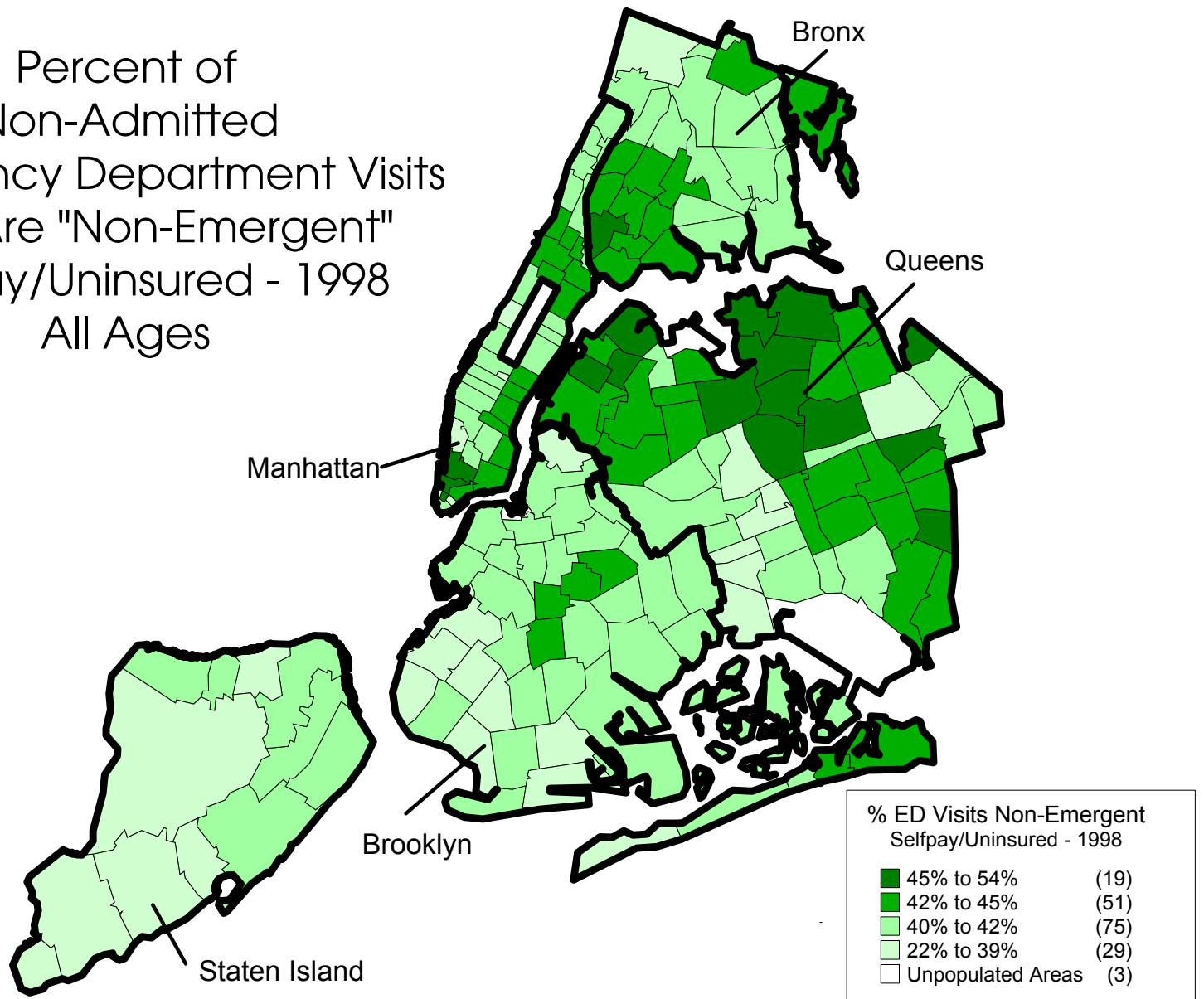


Percent of
Non-Admitted
Emergency Department Visits
That Are "Non-Emergent"
Medicaid - 1998
All Ages

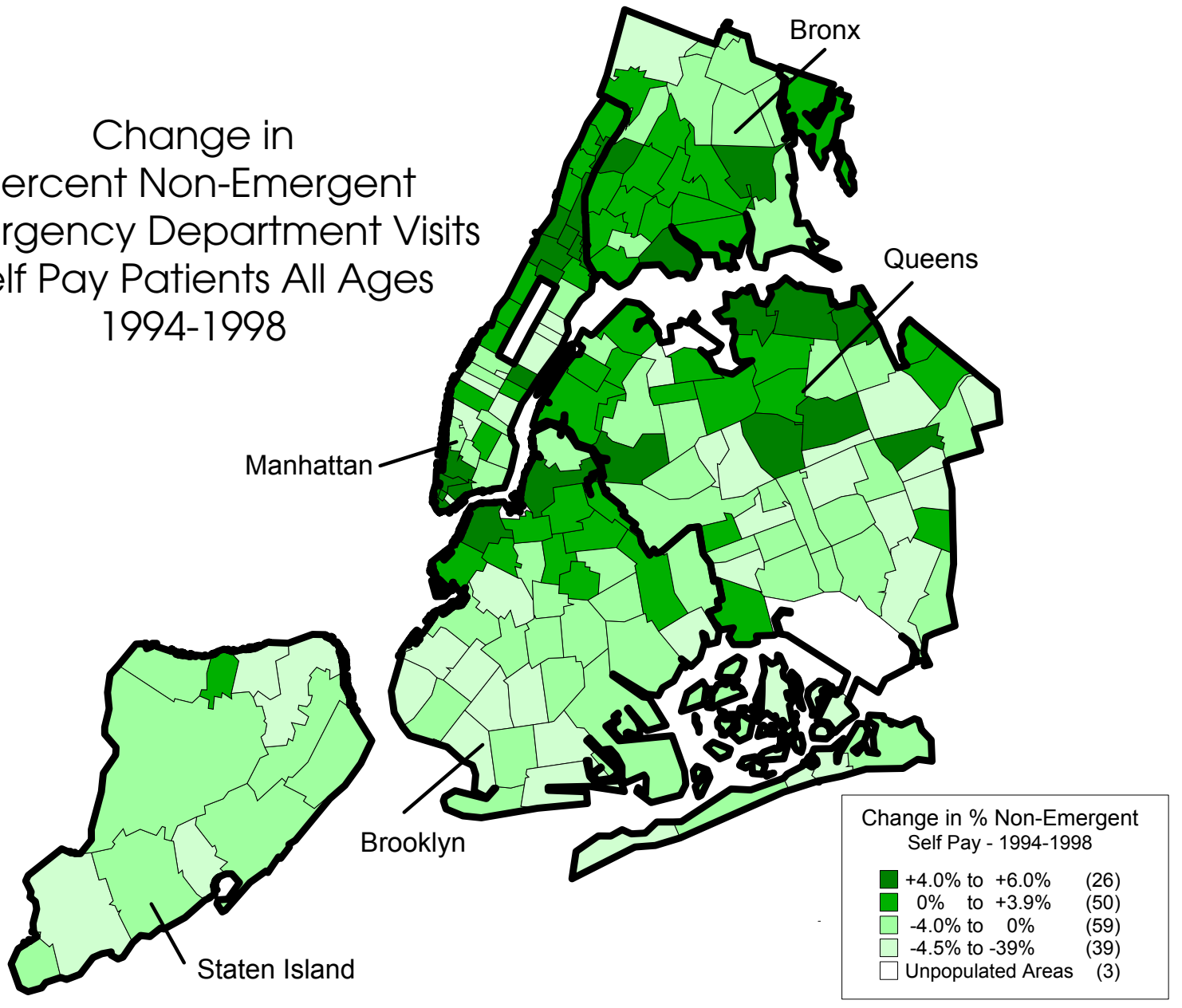


% ED Visits Non-Emergent Medicaid - 1998	
45% to 54%	(28)
42% to 45%	(67)
40% to 42%	(64)
20% to 39%	(15)
Unpopulated Areas	(3)

Percent of
Non-Admitted
Emergency Department Visits
That Are "Non-Emergent"
Selfpay/Uninsured - 1998
All Ages



Change in Percent Non-Emergent Emergency Department Visits Self Pay Patients All Ages 1994-1998



MORE FINDINGS: SOME COMPARISONS

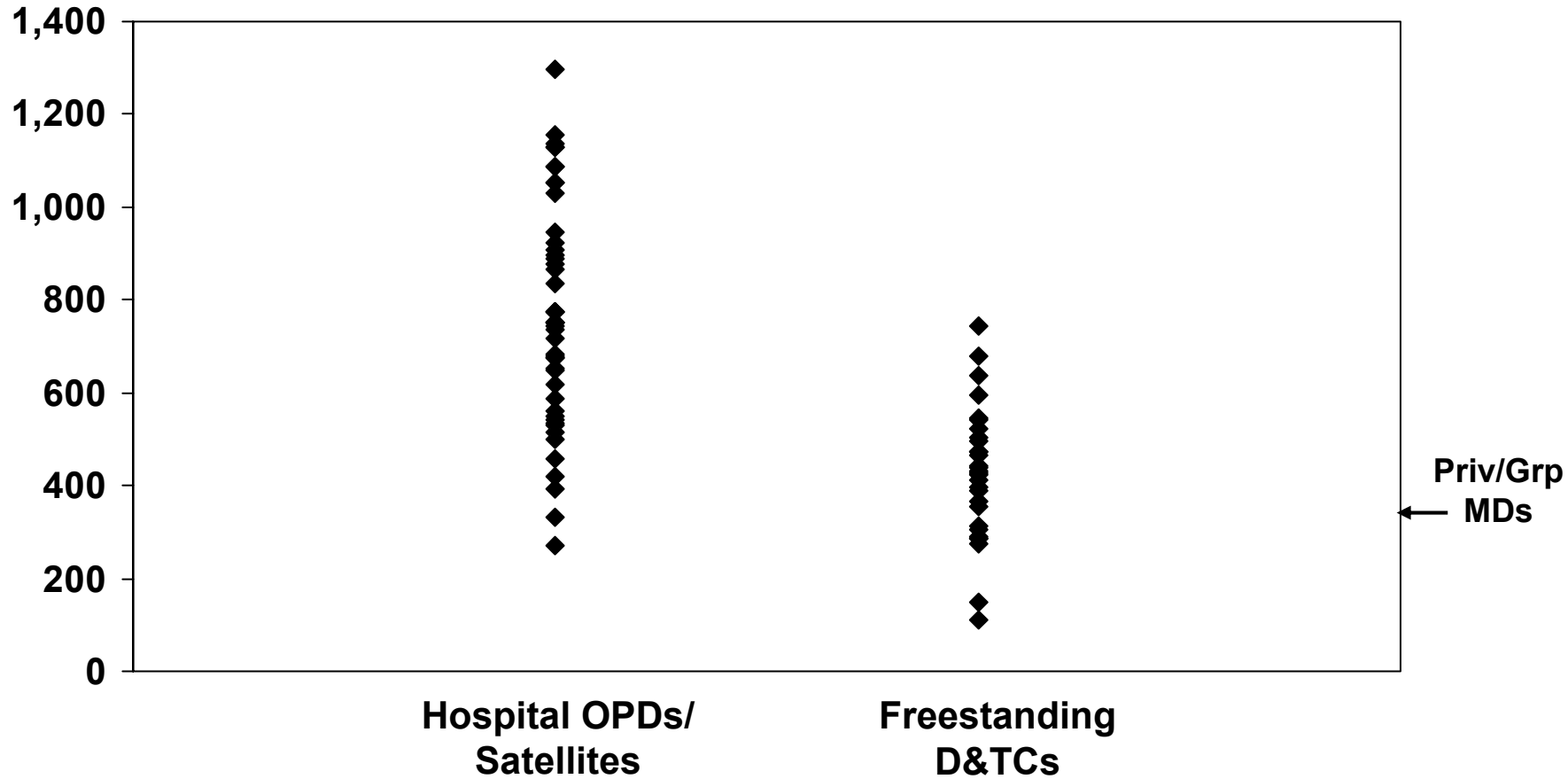
- Things are worse among Medicaid patients (higher % of non-emergent and primary care treatable ED use)
- Things are better for commercially insured patients
- Uninsured patients are about in the middle
 - Possible impact of access barriers
 - Potential costs may mediate utilization behavior

**Sometimes primary data can add help
in understanding administrative data...**

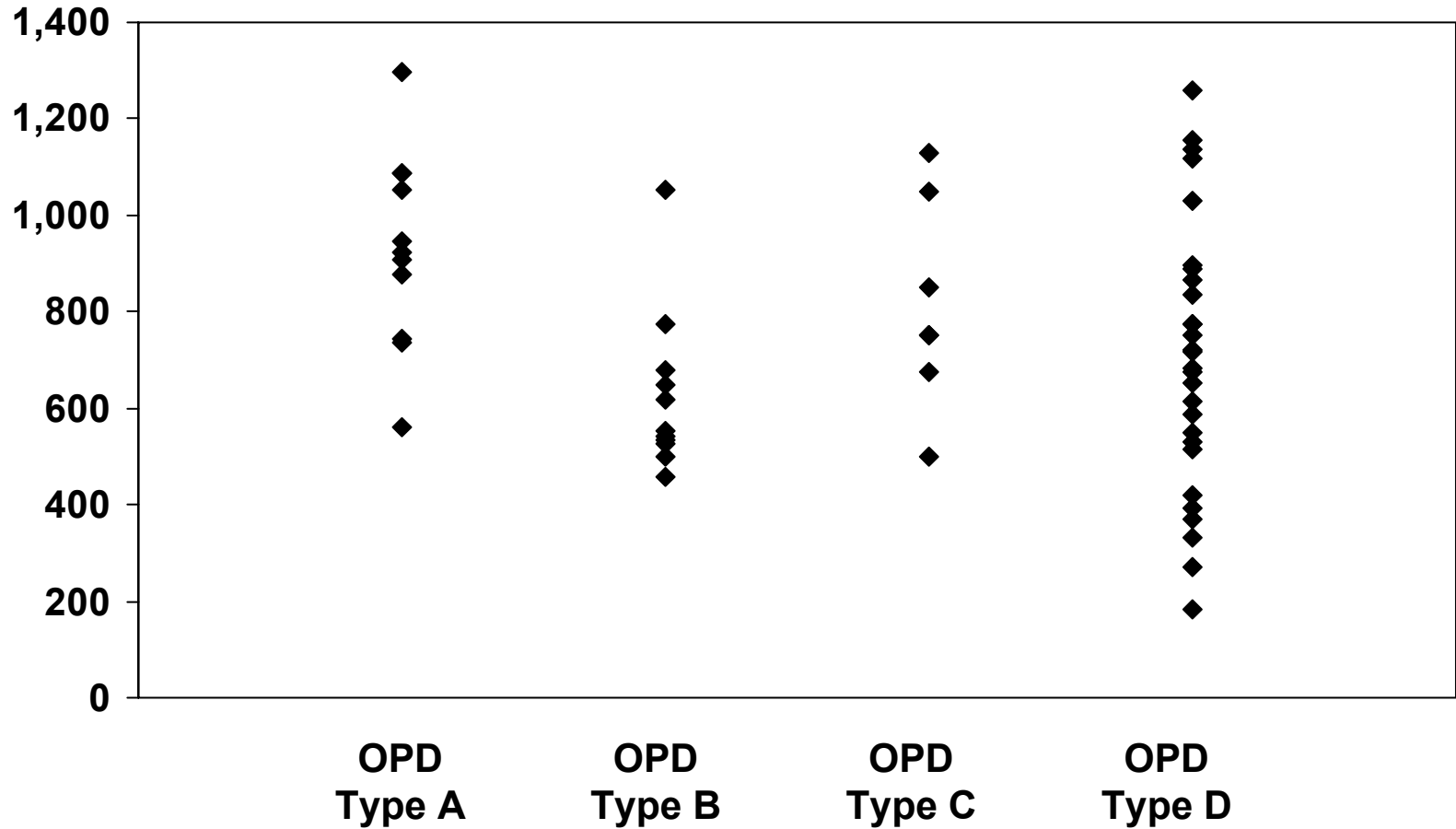
**Non-Emergent - Emergent/Primary Care Treatable
Emergency Department Use Rates/1,000**
By MMC Payor Class (W/o Excluded/Exempted)
Medicaid 1993-1997

	ADC/HR Females 6Mo-14Yrs	ADC/HR Males 6Mo-20Yrs	ADC Adults 21-64Yrs
Hospital OPD/Satellite	709.9	734.2	525.4
Freestanding D&TC	435.8	441.1	372.3
Private/Group MD	330.6	353.8	306.4
Shoppers	467.4	507.0	502.6
Occasional Users	242.8	243.5	294.4
0 PC Visit Patients	140.1	137.3	164.2
Total – All Patients	421.6	444.3	397.6

**Non-Emergent - Emergent/Primary Care Treatable
Emergency Department Use Rates/1,000**
ADC/HR Females Age 6mos-14Yrs (W/o Excluded/Exempted)
Medicaid NYC - 1993-1997



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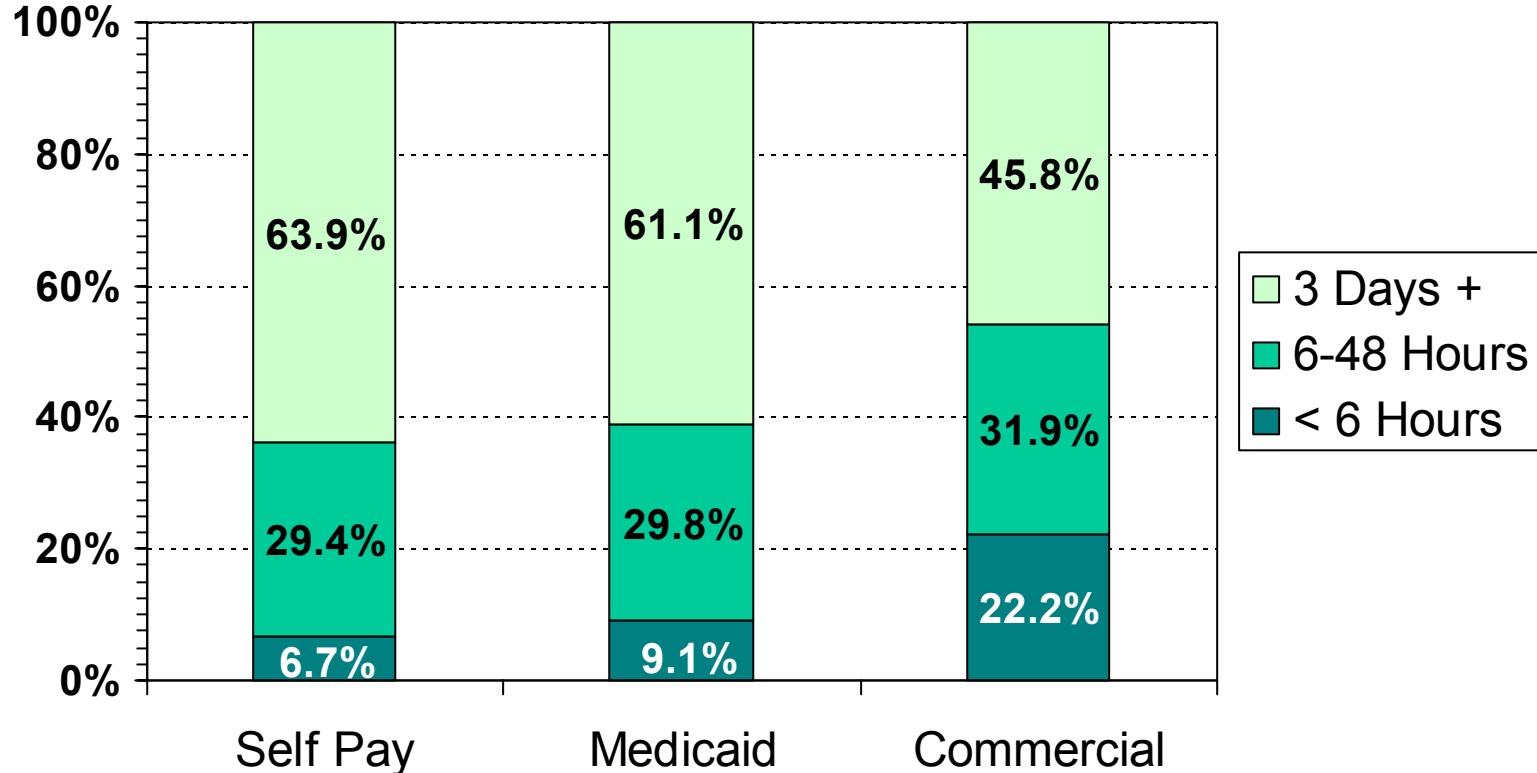


NOT TOO SURPRISINGLY...

- Most patients wait a considerable amount of time before heading to the ED

Source: NYU/UHF survey of ED patients in 4 Bronx hospitals - 1999

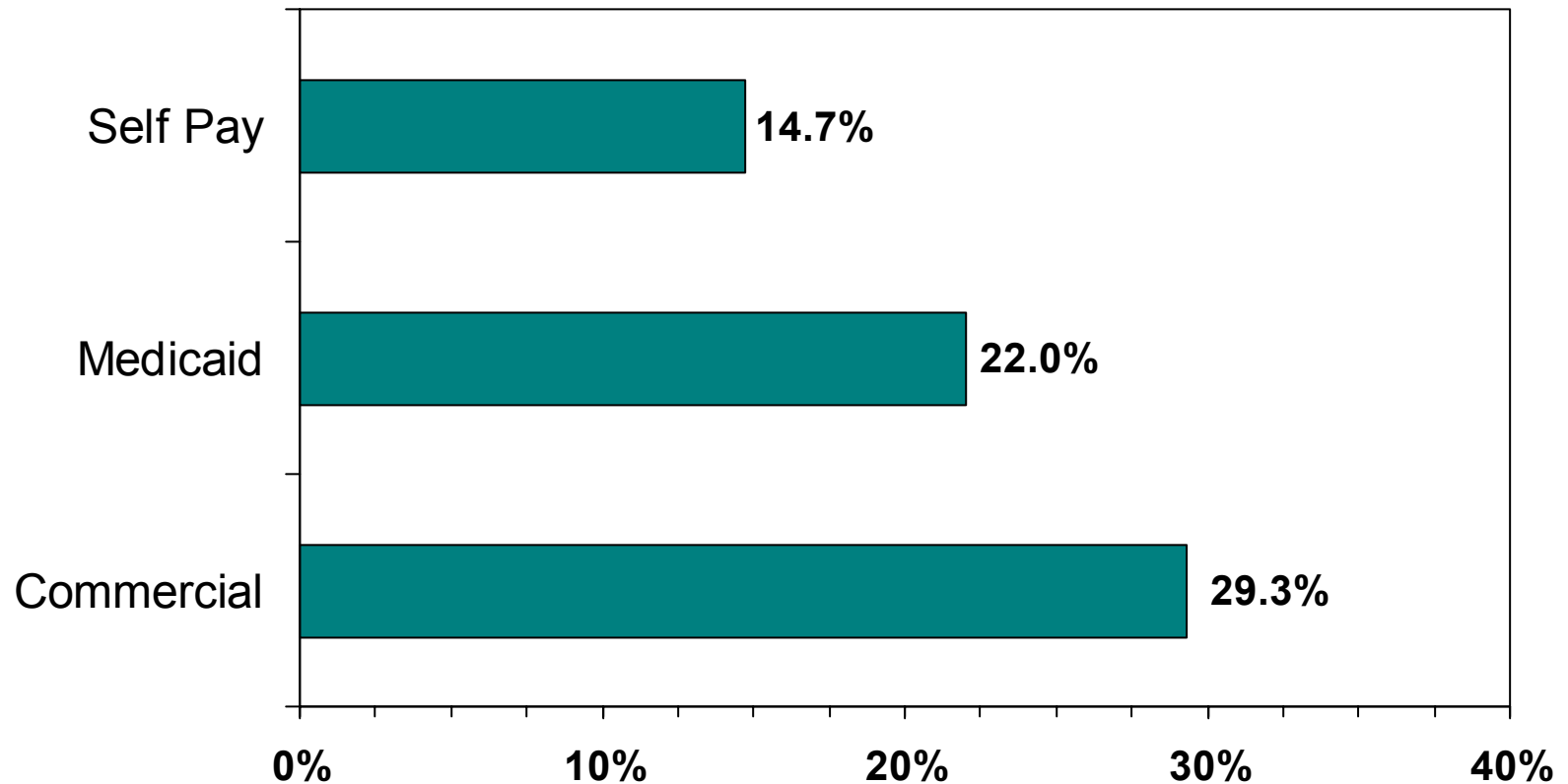
DURATION OF ILLNESS/CONDITION PRIOR TO ED VISIT



NOT TOO SURPRISINGLY...

- Most patients wait a considerable amount of time before heading to the ED
- But they are unlikely to have contacted the health care delivery system before the visit

PERCENT WITH MD CONTACT PRIOR TO ED VISIT

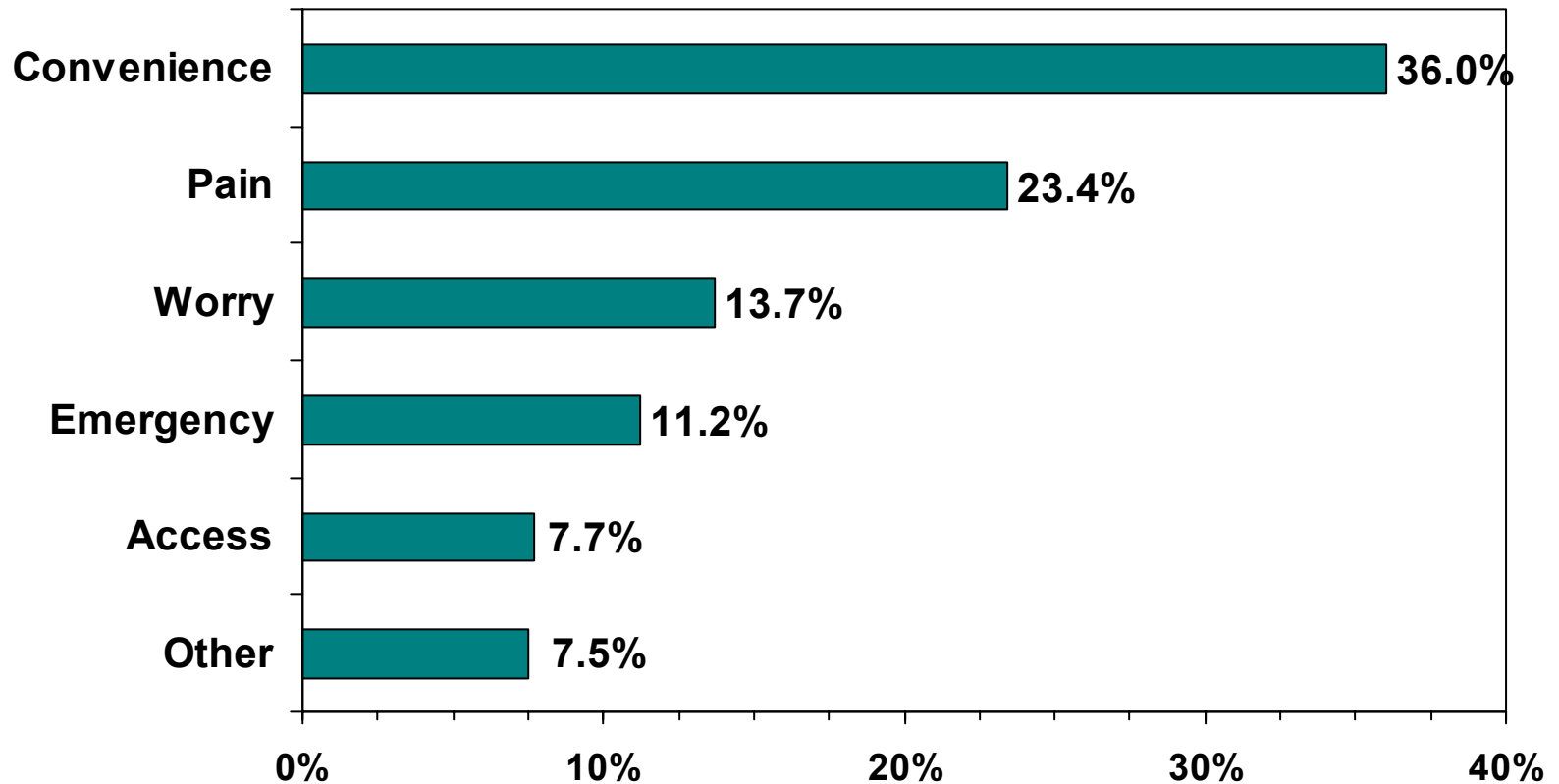


Source: NYU/UHF survey of ED patients in 4 Bronx hospitals - 1999

NOT TOO SURPRISINGLY...

- Most patients wait a considerable amount of time before heading to the ED
- But they are unlikely to have contacted the health care delivery system before the visit
- **Convenience is the leading reason for ED use**

MAIN REASON FOR CHOICE OF ED OVER OTHER SITES OF CARE

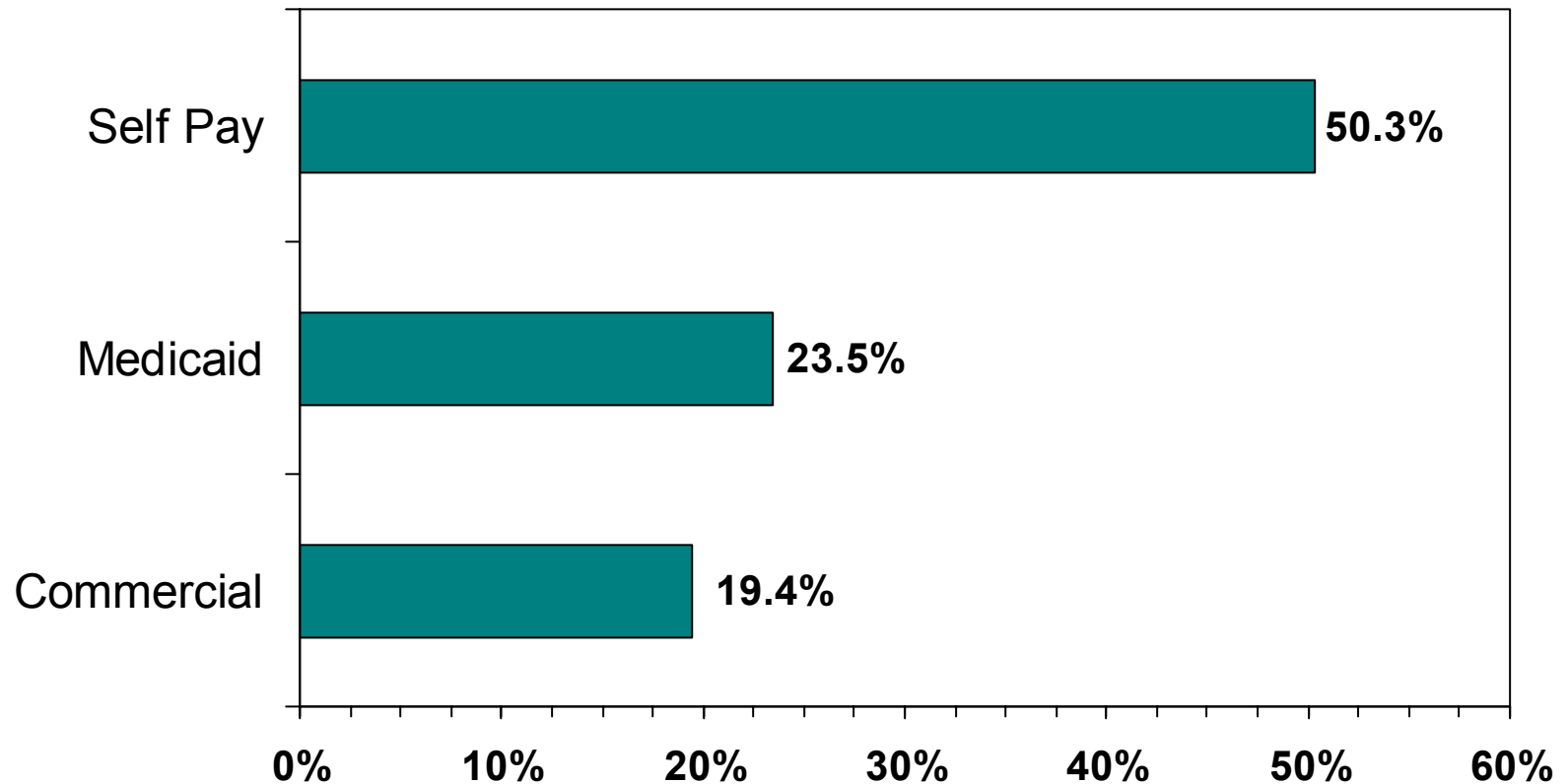


Source: NYU/UHF survey of ED patients in 4 Bronx hospitals - 1999

NOT TOO SURPRISINGLY...

- Most patients wait a considerable amount of time before heading to the ED
- But they are unlikely to have contacted the health care delivery system before the visit
- Convenience is the leading reason for ED use
- **Many are not well-connected to the health system**

PERCENT WITH NO USUAL SOURCE OF CARE

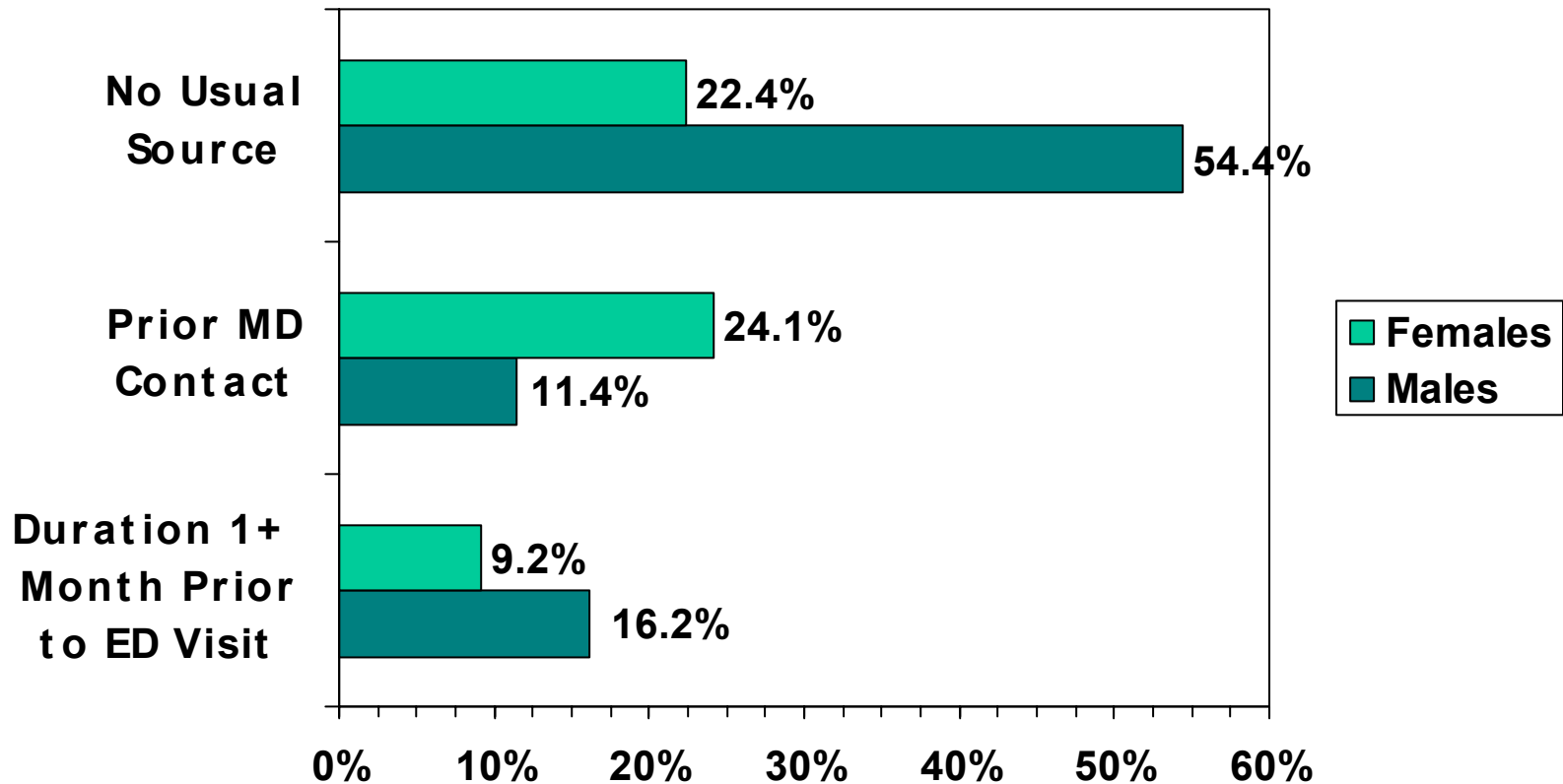


Source: NYU/UHF survey of ED patients in 4 Bronx hospitals - 1999

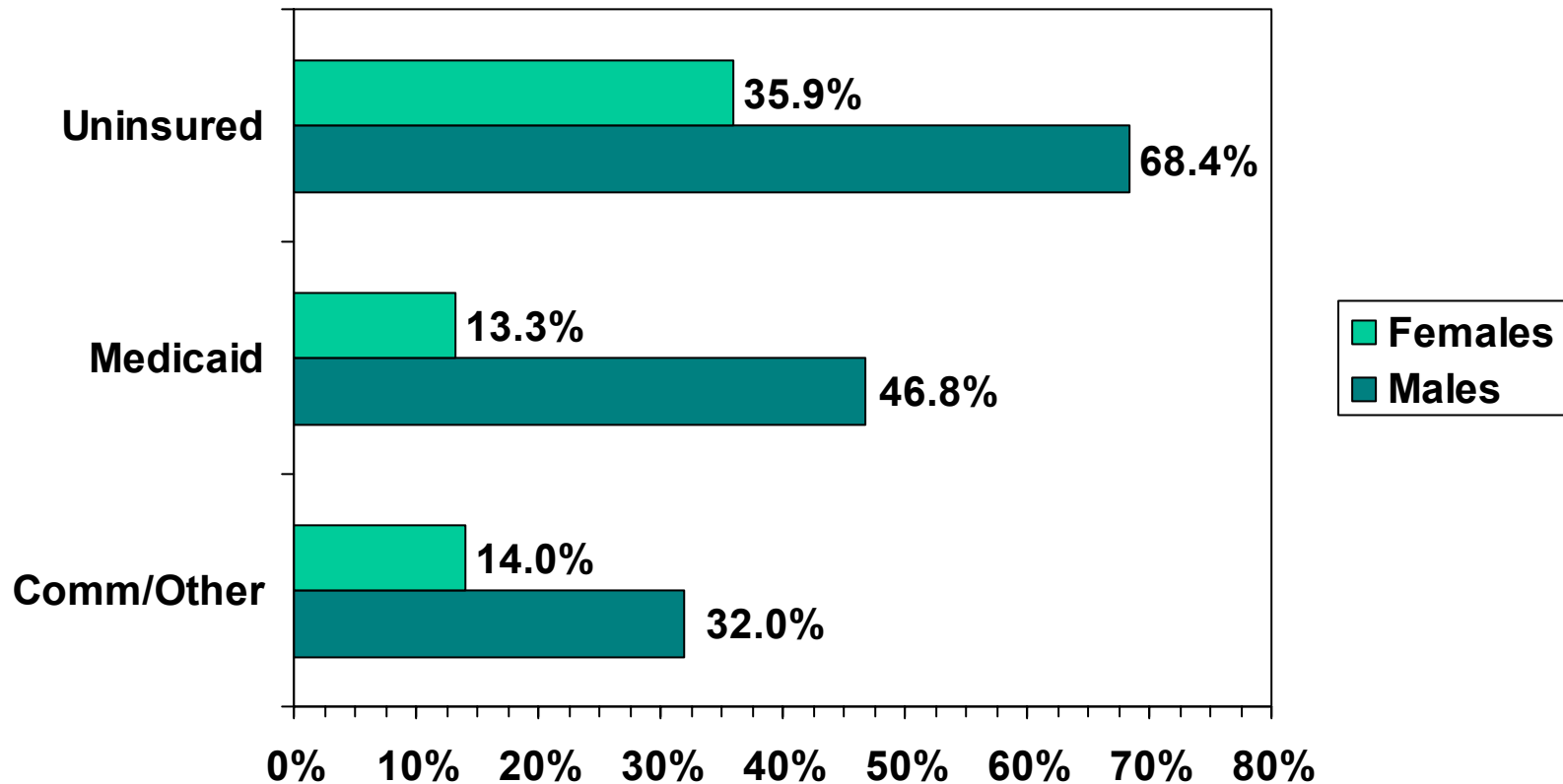
NOT TOO SURPRISINGLY...

- Most patients wait a considerable amount of time before heading to the ED
- But they are unlikely to have contacted the health care delivery system before the visit
- Convenience is the leading reason for ED use
- Many are not well-connected to the health system
- **Men are basically idiots**

ED USE PATTERNS BY GENDER



NO USUAL SOURCE BY GENDER AND INSURANCE STATUS



OK - Enough already...

WHAT NEEDS TO BE DONE...

- Understand what we know
 - Apply rigorous “evidenced-based” standards to access research
 - Synthesize what we know

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- **Stop documenting the problem and start helping identify...**
 - Specific causal factors for problems
 - Specific factors that contribute to better outcomes

WHAT NEEDS TO BE DONE...

- Understand what we know
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- Understand what we don’t know
 - Fit it in a comprehensive definition of access/optimal health
- Stop documenting the problem and start helping identify...
 - Specific causal factors for problems
 - Specific factors that contribute to better outcomes
- **Fill in the important gaps...**
 - What patients want
 - How patients make decisions
 - Operations improvement (management matters)
 - Help patient self-management

