One Size Doesn't Fit All: The Need for Local Approaches to Improve Neighborhood Health

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NYS HEALTH FOUNDATION

Introduction

Many communities across the country suffer from poor health outcomes related to obesity, heart disease, asthma, and other chronic conditions. These issues are exacerbated for socio-economically disadvantaged populations, who face additional barriers to a healthy lifestyle such as limited access to health care providers, healthy foods, or safe places to be physically active. In response, initiatives have been launched by various stakeholders—including federal, state, and local governments, as well as foundations—to help build healthier communities, focusing on those most in need. These efforts are largely organized through grant-based programs.

In this brief, we take an in-depth look at the communities that are part of the New York State Health Foundation's Building Healthy Communities initiative. The program seeks to improve neighborhood health by (1) expanding access to and demand for nutritious foods and (2) expanding access to safe places where residents can be more physically active. The Foundation's place-making model builds on similar efforts that have been conducted across the country. For example, the CDC's Healthy Communities Program supported efforts in more than 300 communities across the country involving local, state, and national partnerships to prevent chronic diseases and reduce health gaps.[1]

The six Building Healthy Communities neighborhoods are spread throughout New York State: Clinton County; Brownsville, Brooklyn; East Harlem, Manhattan; Near Westside, Syracuse; North End, Niagara Falls; and Two Bridges, on the Lower East Side of Manhattan. For more information on the goals and efforts within these communities to date, visit the New York State Health Foundation website.[2]

In this brief, we examine characteristics of these communities, including demographic as well as health status and health care utilization attributes. We focus our analysis on the Medicaid population within these communities. Medicaid enrollees are low-income and traditionally suffer poorer health outcomes than higher-income populations. Hence, focusing on Medicaid beneficiaries can offer a better understanding of the most vulnerable within the communities, who also stand to benefit the most from initiatives such as Building Healthy Communities. We find that while there are some core commonalities, there is much more diversity across these communities. This diversity calls for a resident-led and community-driven strategy to address the health needs of the neighborhoods.

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[1] Source: Center for Disease Control, "Healthy Communities Program (2008-2012)," https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/index.htm, accessed March 2018.

[2] https://nyshealthfoundation.org/what-we-fund/building-healthy-communities/.

Commonality in the 6 Communities

A core commonality across the communities is a lack of economic security. **Exhibit 1** displays the median income, percentage of the population living below the federal poverty level, and the percent unemployment for each of the six communities. We also show New York City (NYC) data to provide context for the data from Brownsville, Two Bridges, and East Harlem. New York State data are displayed to provide similar context for the upstate communities of Niagara Falls, Near Westside, and Clinton County.

The economic indicators for the downstate and upstate communities are generally substantially worse off relative to their NYC and State benchmarks. In the case of the Near Westside of Syracuse, more than half of the residents have incomes below the federal poverty level, more than three times the statewide rate. Correspondingly, unemployment in the Near Westside is almost double the State rate.

EXHIBIT 1. **Income, Poverty, and Unemployment across the Communities, 2012–2016**

NEIGHBORHOOD	EAST HARLEM	BROWNSVILLE	TWO BRIDGES	NYC	CLINTON COUNTY	NORTH END, NIAGARA FALLS	NEAR WESTSIDE, SYRACUSE	NEW YORK STATE
Median Household Income	$31,628	$24,504	$22,732	$55,191	$50,502	$38,575	$17,218	$60,741
% of Residents Below Federal Poverty Level	33.8%	39.9%	34.9%	20.3%	16.1%	39.0%	52.8%	15.5%
Unemployment	10.6%	15.3%	11.8%	8.6%	6.6%	12.9%	14.3%	7.5%

Source: American Community Survey 2016 5-Year Estimates.[3]

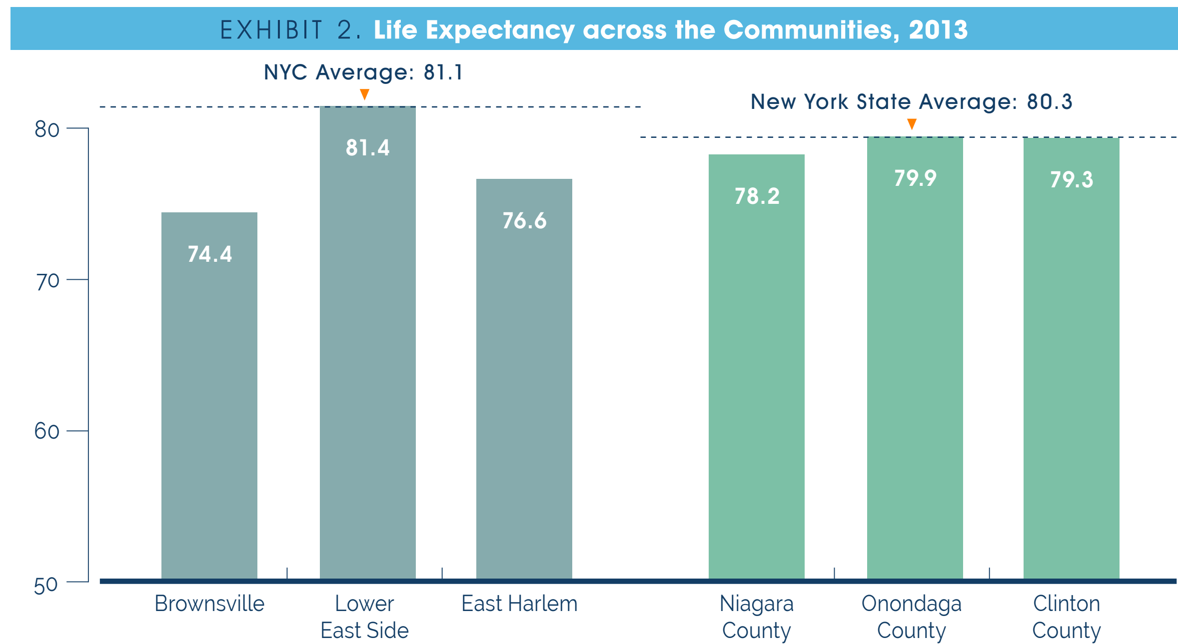
More than one-third of residents have incomes below the federal poverty level in each of the NYC communities and two of the upstate communities. All but one of the communities has an unemployment rate in the double-digits. Also, median household income is more than $20,000 less than the NYC and State benchmarks in all but one of the communities. These extreme levels of poverty and unemployment reflect decades of neglect and disinvestment in the communities. Although Clinton County looks in better economic shape relative to the other five communities, it is still worse off relative to most of New York State.

[3] U.S. Census Bureau, American Community Survey, Table DP03, 2012-2016. Note: Two Bridges data is a weighted average of New York County census tracts 6, 8, and 25. North End, Niagara Falls data is a weighted average of Niagara County census tracts 201 and 202. Near Westside, Syracuse data is a weighted average of Onondaga County census tracts 30, 39, and 40. Brownsville data is from the Brownsville Neighborhood Tabulation Area (BK81). East Harlem data is from the East Harlem PUMA Community District (Manhattan Community District 11).

Commonality in the 6 Communities (continued)

People with low incomes can face obstacles to healthy foods and physical activity. Lower socioeconomic status is also a risk factor for many serious health conditions, such as diabetes and cardiac problems. We see this reflected in the relatively low levels of life expectancy across each of the six communities (**Exhibit 2**).

EXHIBIT 2. **Life Expectancy across the Communities, 2013**



Source: NYC DOHMH Bureau of Vital Statistics,[4] Institute for Health Metrics & Evaluation.[5]

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[4] NYC Department of Health and Mental Hygiene, Summary of Vital Statistics (2013). https://www1.nyc.gov/assets/doh/downloads/pdf/vs/2014sum.pdf

[5] University of Washington, Institute for Health Metrics and Evaluation (2013). https://vizhub.healthdata.org/subnational/usa. Data is not available at the community level for North End, Niagara Falls or Near Westside, Syracuse; hence, county-level data is used for those communities.

Diversity in the 6 Communities

While all of the 6 Building Healthy Communities neighborhoods exhibit characteristics that make residents vulnerable to health risks, there is also a great deal of diversity across the communities on important characteristics relevant to the Foundation's efforts.

Geography

The six communities reflect the range and diversity of New York State itself—both upstate and downstate and urban and rural regions (**Exhibit 3**).

Five of the communities are urban, and one is rural. The urban community areas are smaller and more densely populated. Clinton County's large and sparsely populated area contributes to

EXHIBIT 3. **Location of Each of the 6 Communities**

Clinton County

North End, Niagara Falls

Near Westside, Syracuse

East Harlem

Two Bridges

Brownsville

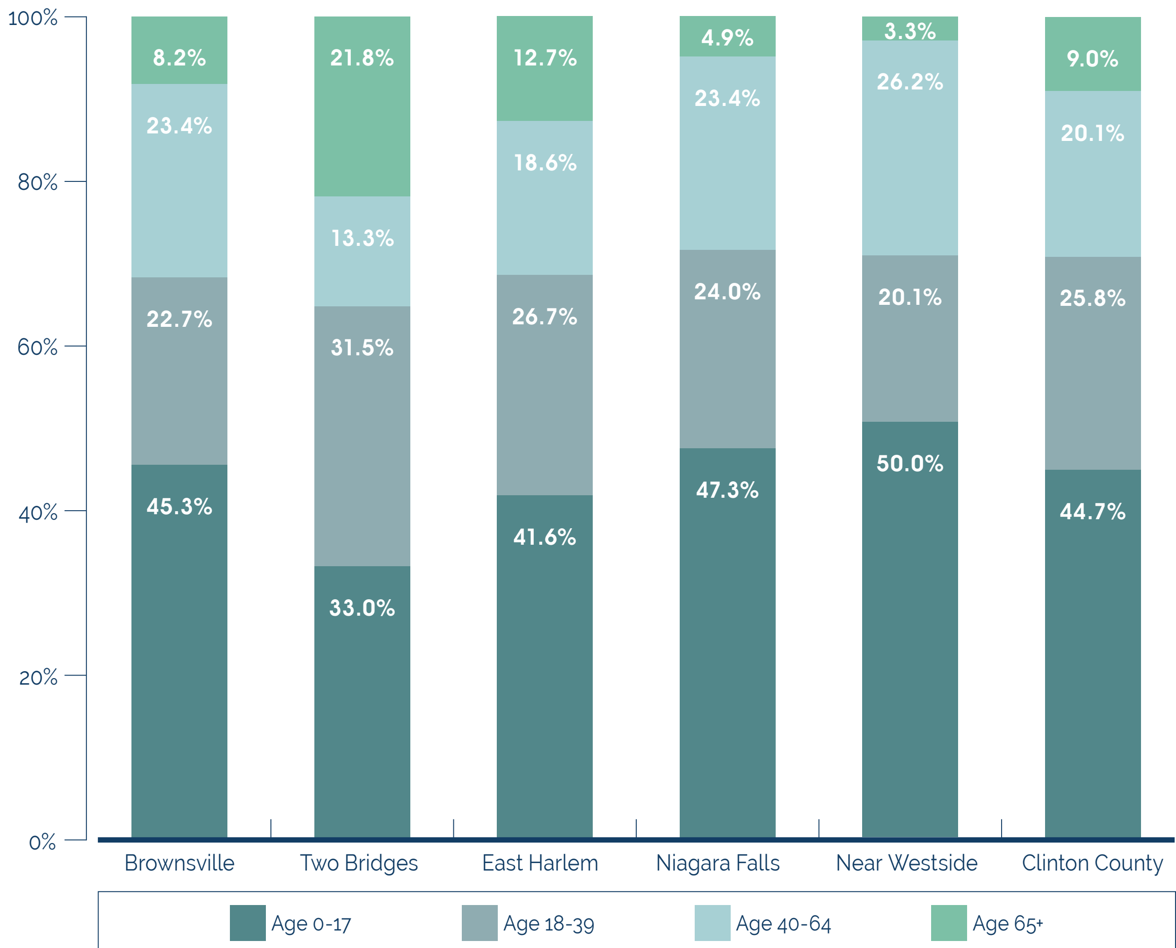
Diversity in the 6 Communities (continued)

different health-related problems, such as difficulty in accessing care, while also providing more recreational and outdoor space. All five urban areas have city parks, but the number and size of these spaces vary. East Harlem contains Randall's Island, a large outdoor recreational facility, and Niagara Falls is home to Hyde Park, the largest city park in New York State outside of New York City. However, smaller communities like Two Bridges are without large, expansive parks.

Demographics

Exhibit 4 displays age group distributions in each of the six neighborhoods, focusing on the Medicaid population. There is notable variation in age groups. For example, Two Bridges has a substantially larger elderly Medicaid population (i.e., population aged 65 and above)

EXHIBIT 4. **Distribution of Medicaid Population by Age across the Communities**



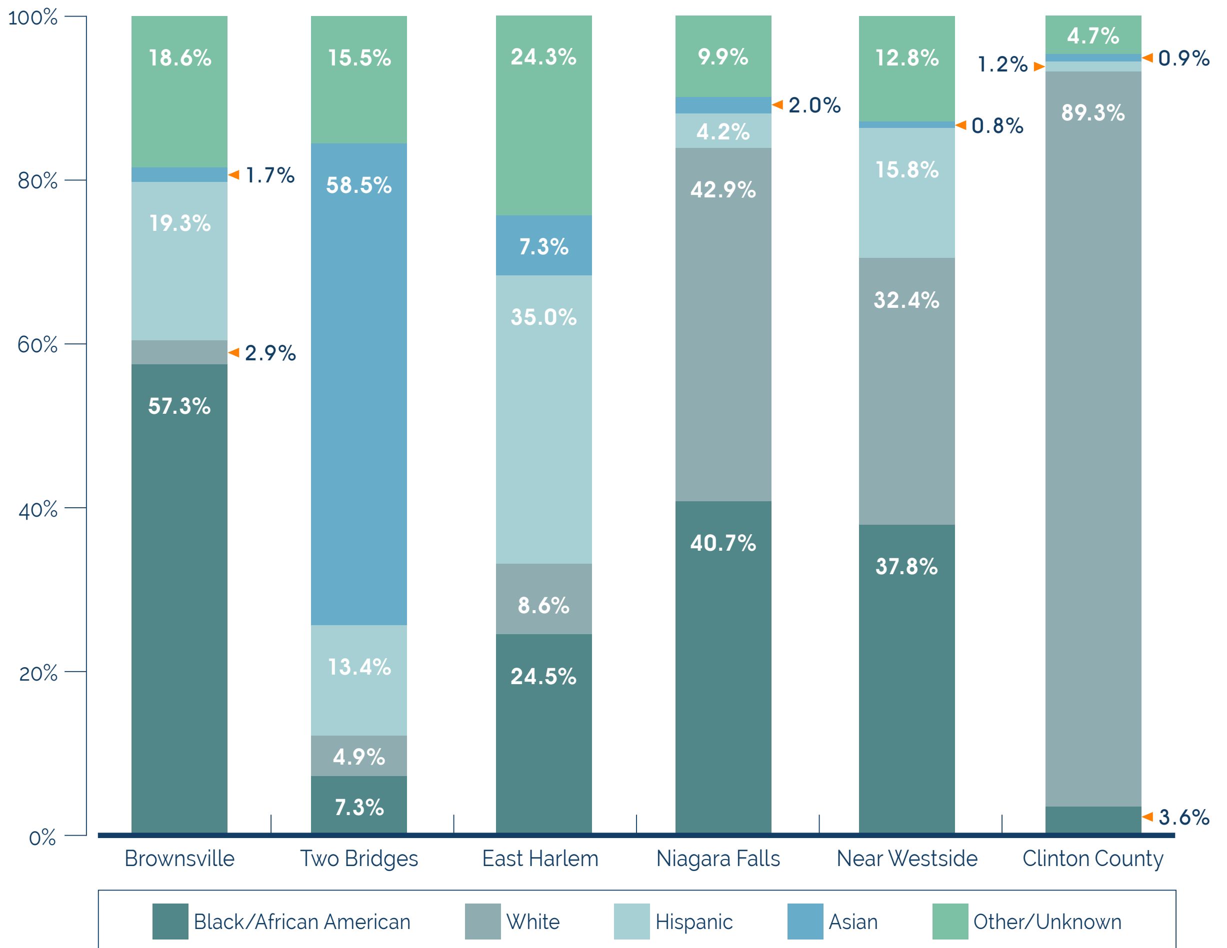
Source: Profile of Medicaid recipients on December 2016 by the New York University Health Evaluation and Analytics Lab (HEAL).

Diversity in the 6 Communities (continued)

relative to any of the other neighborhoods, nearly twice as large proportionally as the neighborhood with the next largest elderly population (East Harlem).

The six neighborhoods also exhibit substantial variation in the racial and ethnic distribution of their Medicaid populations (**Exhibit 5**). The NYC neighborhoods tend to be majority minority, with Blacks/African Americans being the majority in Brownsville. Asians and Hispanics are the majority in Two Bridges and East Harlem, respectively. In contrast, the upstate neighborhoods have a much larger proportion of white Medicaid recipients, with Clinton County being nearly 90% white.

EXHIBIT 5. **Distribution of Medicaid Population by Race/Ethnicity across the Communities**



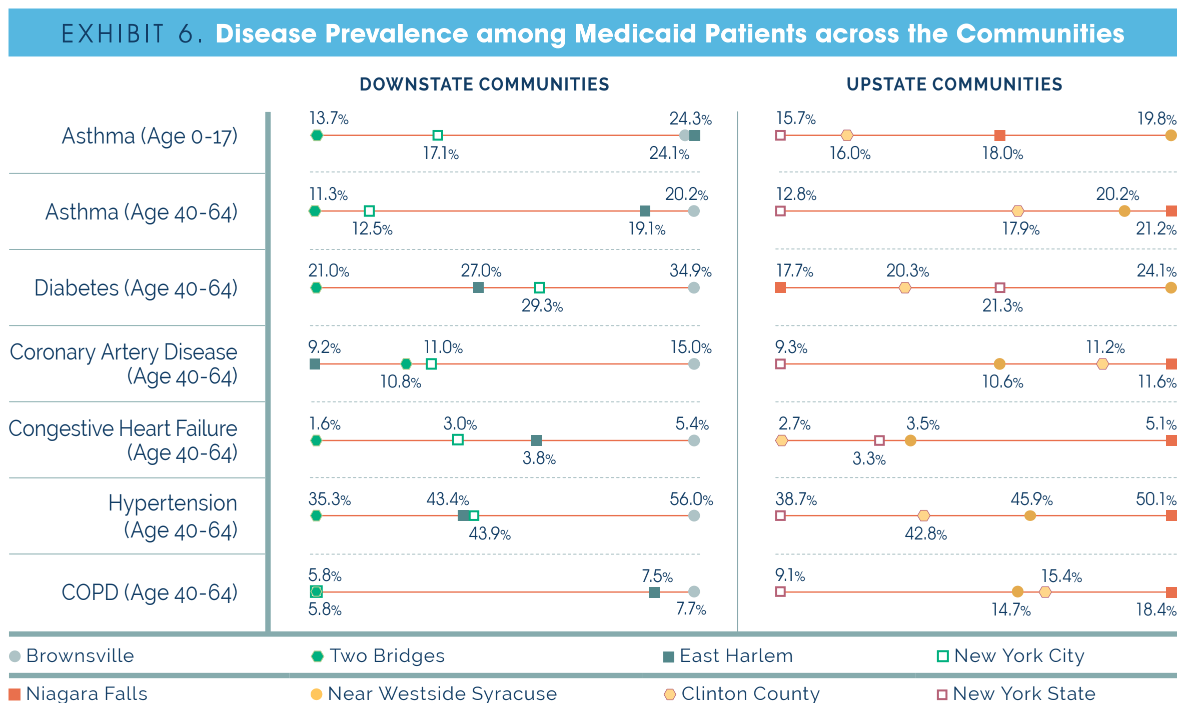
Source: Profile of Medicaid recipients on December 2016 by the New York University Health Evaluation and Analytics Lab (HEAL).

Diversity in the 6 Communities (continued)

Health Status

Exhibit 6 displays the prevalence of various chronic diseases within the Medicaid population for each of the six communities. The rates are based on diagnoses available on Medicaid claims data for all enrollees in the neighborhoods.[6] The data shows that substantial portions of the Medicaid populations within the six neighborhoods suffer from chronic conditions including asthma, diabetes, and various heart diseases. These trends are generally similar for all age groups, although we focus the data on the older adults (those aged 40 to 64) as they have a relatively high prevalence of chronic conditions. We show rates of asthma for children aged 0 to 17 as well, given that asthma also has a relatively high prevalence among the younger population.

EXHIBIT 6. **Disease Prevalence among Medicaid Patients across the Communities**



Source: Profile of Medicaid recipients based on 2014 through 2016 diagnostic history conducted by the New York University Health Evaluation and Analytics Lab (HEAL). "New York State" data excludes "New York City" data in calculations. All data is for Medicaid patients age 40-64 unless otherwise noted.

While the prevalence of diseases are generally higher for the Building Healthy Communities neighborhoods relative to overall NYC and New York State levels, the rates vary considerably by community. For example, Brownsville tends to have substantially higher rates for all conditions relative to the other communities and to New York City in general. Of the upstate communities, Niagara Falls tends to have the highest prevalence of chronic conditions.

[6] In this case, the statewide rates exclude NYC data from their calculations.

Diversity in the 6 Communities (continued)

Two Bridges has lower rates of many chronic conditions than NYC as a whole. However, the Medicaid population has higher concentrations of certain illnesses, such as hyperlipidemia, than the other NYC neighborhoods.

As shown in **Exhibits 7** and **8**, Medicaid enrollees in most of the six communities are more likely to have a chronic condition, and to have more chronic conditions, than the average Medicaid population citywide or statewide. Medicaid enrollees in Brownsville and Niagara Falls also have the highest average numbers of chronic medical conditions relative to the other Building Healthy Communities neighborhoods (3.2 and 2.8, respectively).[7] This data is for Medicaid enrollees ages 40 to 64 in those communities.

EXHIBIT 7. **Average Number of Chronic Medical Conditions among Medicaid Enrollees Ages 40-64**

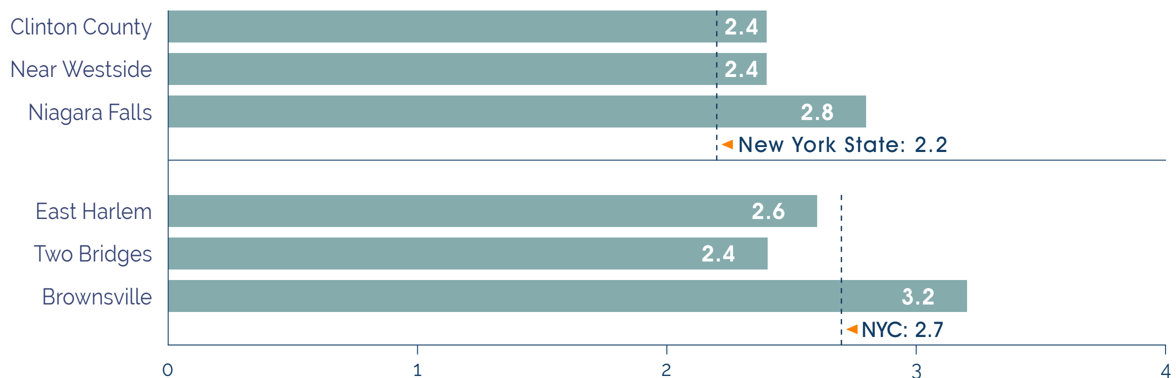
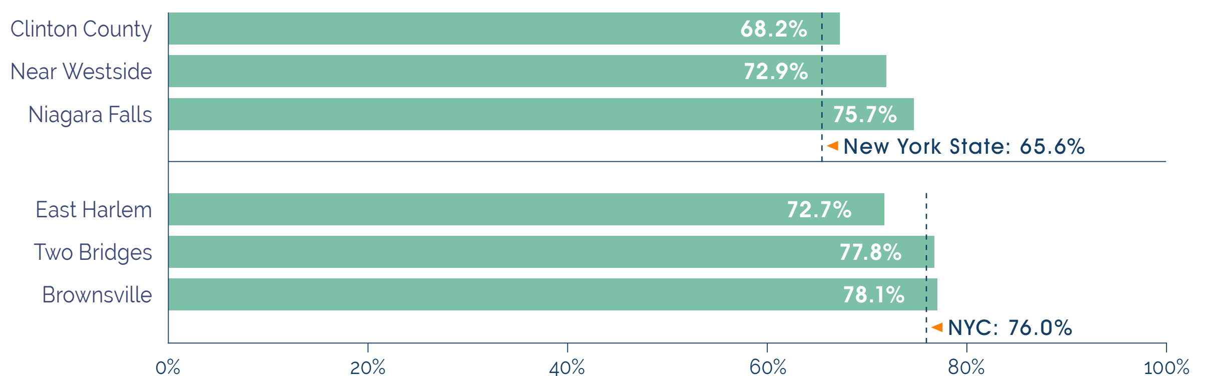


EXHIBIT 8. **Percent of Medicaid Enrollees Ages 40-64 with One or More Chronic Medical Condition**



Source: Profile of Medicaid recipients based on 2014 through 2016 diagnostic history conducted by the New York University Health Evaluation and Analytics Lab (HEAL). "New York State" data excludes "NYC" data in calculations. All data is for Medicaid patients ages 40-64.

[7] The chronic medical conditions counted include: coronary artery disease, congestive heart failure, other arrhythmias, other cardiovascular disease, other vascular disease, hypertension, hyperlipidemia, cerebral vascular disease, chronic obstructive pulmonary disease (COPD), asthma, diabetes, other endocrine diseases, liver disease, and renal failure.

Diversity in the 6 Communities (continued)

Health Care Utilization

There are also substantial differences in how residents of the six neighborhoods use health care (**Exhibit 9**). For example, Medicaid enrollees in the neighborhoods outside of NYC tend to have substantially higher rates of emergency department visits relative to those in the City.

The variation in disease prevalence and utilization is also reflected in the variation in per-enrollee Medicaid expenditures across the neighborhoods (**Exhibit 10**). There is a more than 40% difference in Medicaid expenditures per enrollee (amounting to more than $1,900) between the NYC neighborhoods with the lowest (Two Bridges) and highest (Brownsville) amounts.

EXHIBIT 9. **Annual Emergency Department Visits per 1,000 Enrollees among Medicaid Enrollees across the Communities**

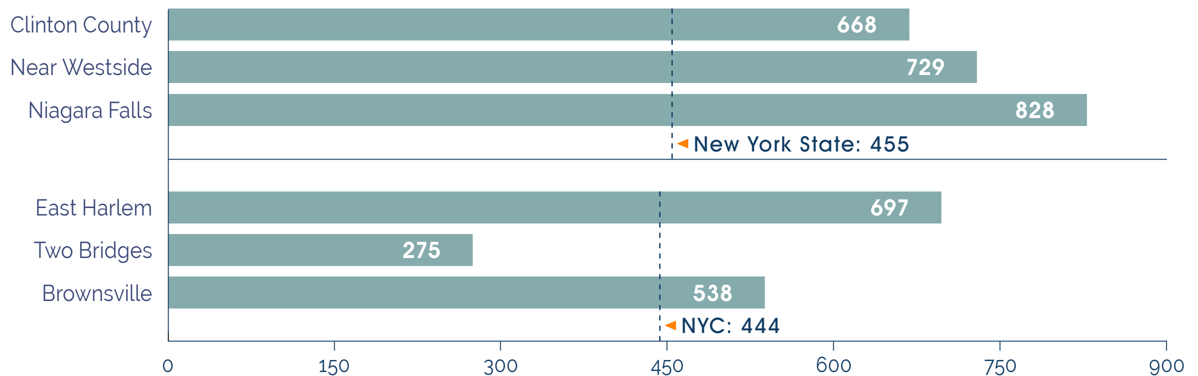
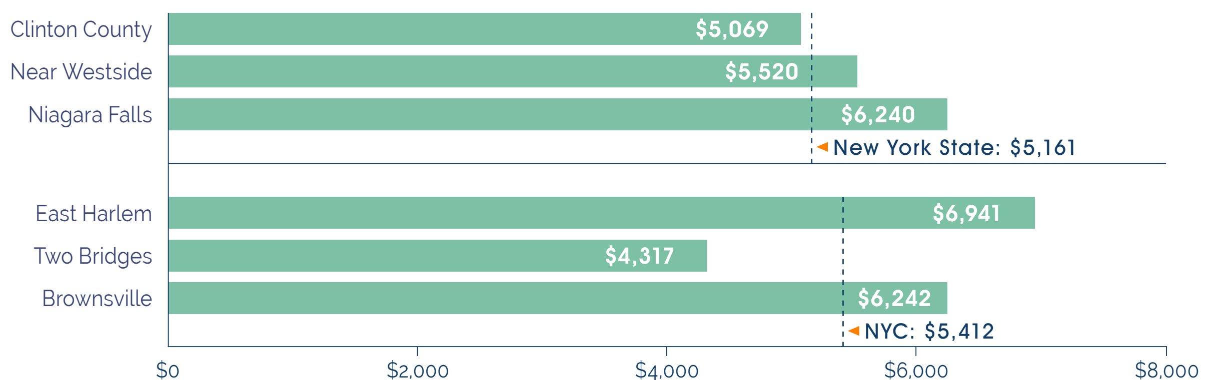


EXHIBIT 10. **Annual Average Total Expenditures among Medicaid Enrollees across the Communities**



Source: Utilization and Expenditures based on 2016 data analyzed by the New York University Health Evaluation and Analytics Lab (HEAL). "New York State" data excludes "NYC" data in calculations. Expenditures and utilization rates annualized based on the number of months patients were on Medicaid during the year.

Conclusion

Though the six Building Healthy Communities neighborhoods differ in terms of demographics and health issues, they all include a substantial number of residents who are vulnerable to poor health outcomes and who can benefit from specialized programming and interventions.

As we take a closer look at the Medicaid population within each of the six communities, we see substantial diversity. These differences lend credence to the notion that there is no "one size fits all" approach to helping to improve the health of communities with health disparities linked to disadvantaged socioeconomic status. To be optimally effective, initiatives aimed at improving neighborhood health should reflect and respond to the specific characteristics and needs of the communities.

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