MANHATTAN COMMUNITY NEEDS ASSESSMENT
APPENDIX A - MAPS

December 16, 2014

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

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APPENDIX A: MAPS OF MANHATTAN

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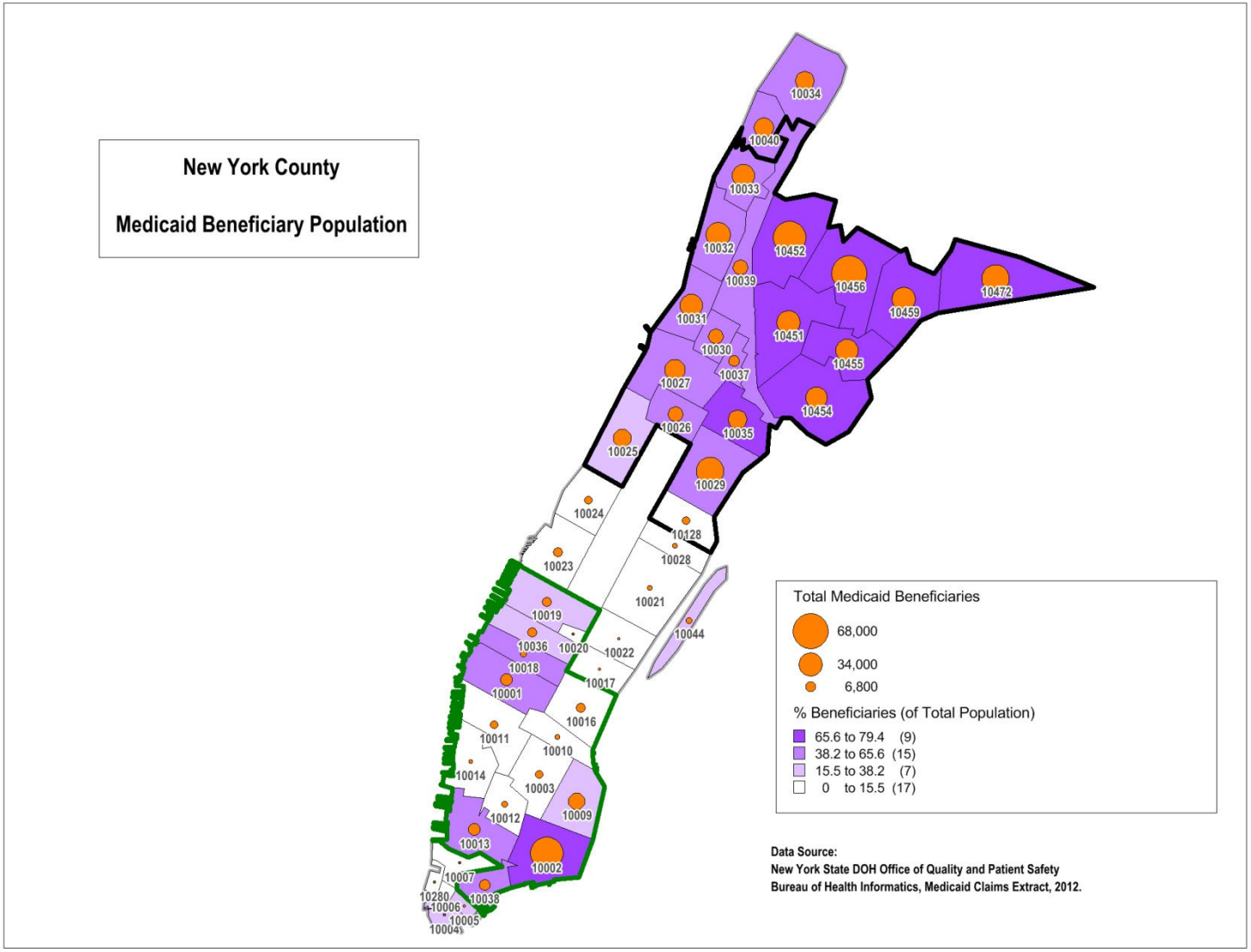
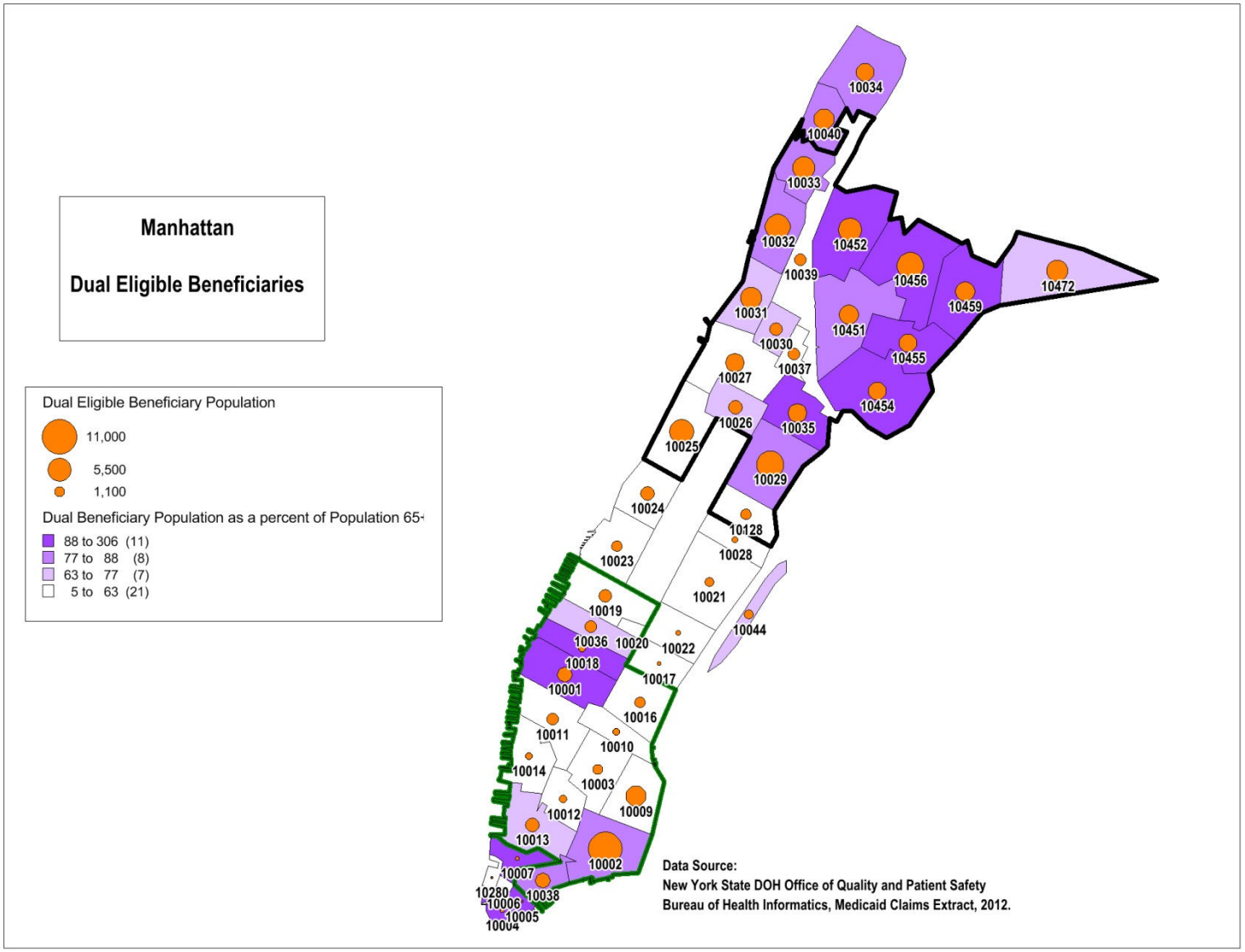
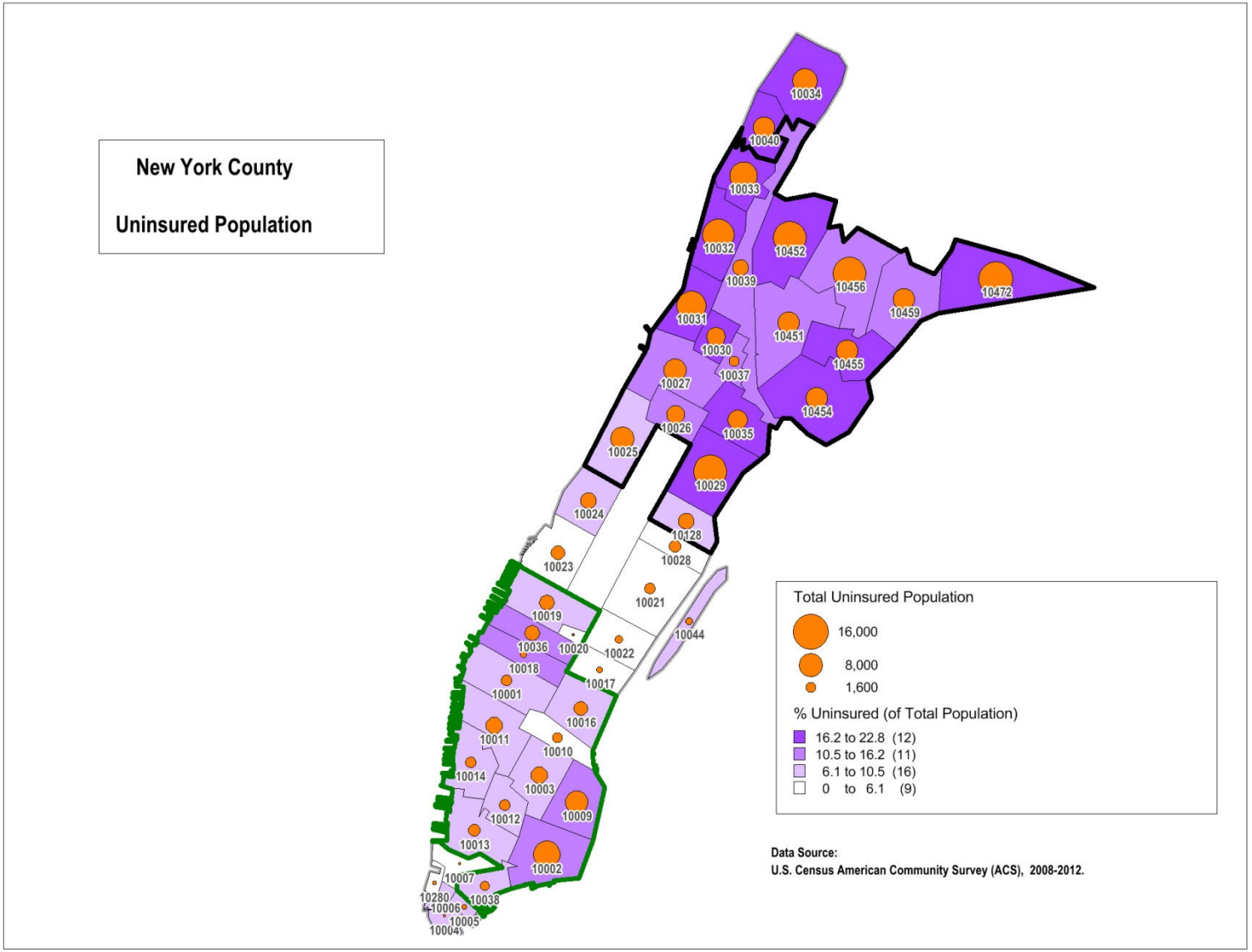
2. Medicaid Beneficiaries by Zip Code



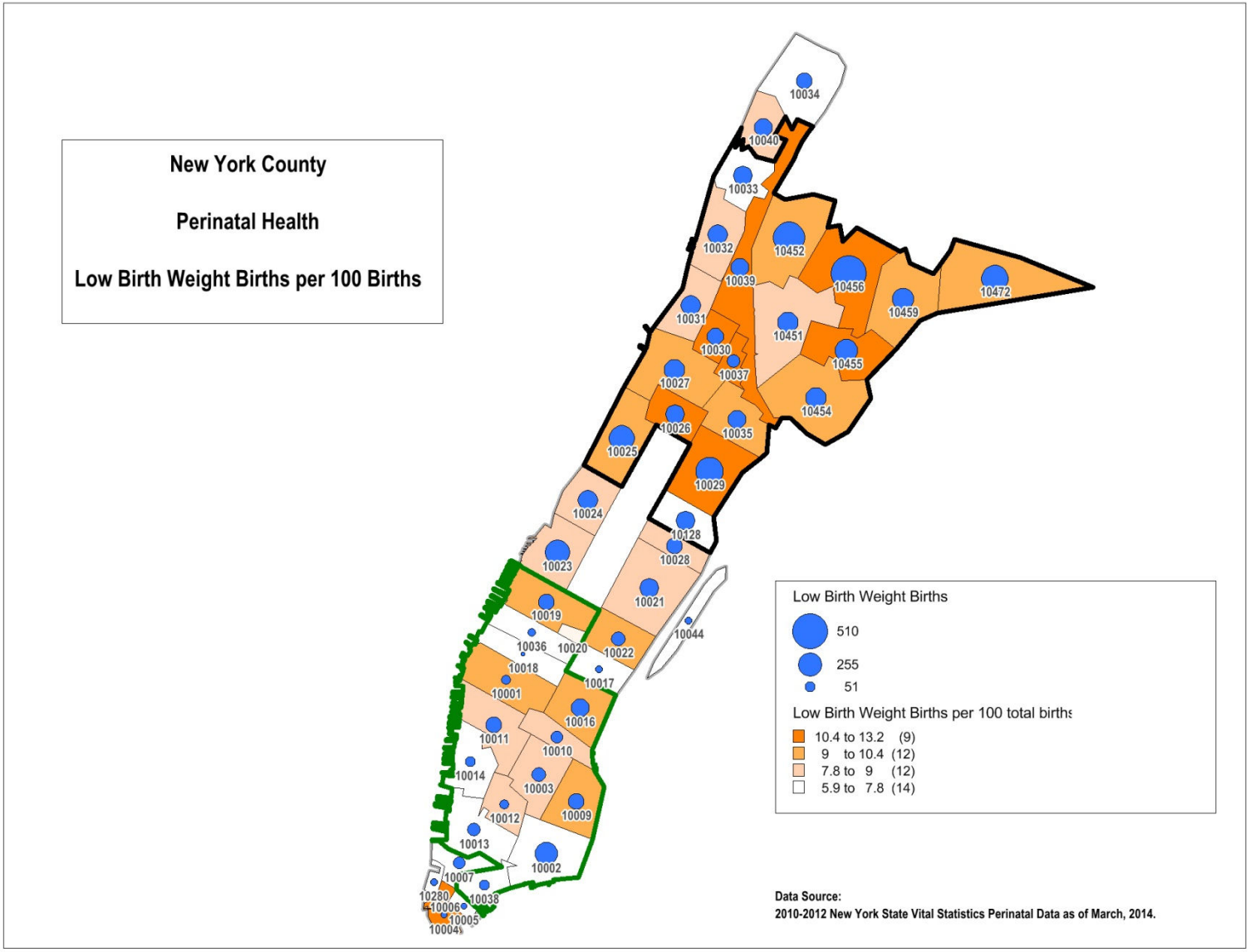
3. Dual-Eligible Beneficiaries by Zip Code



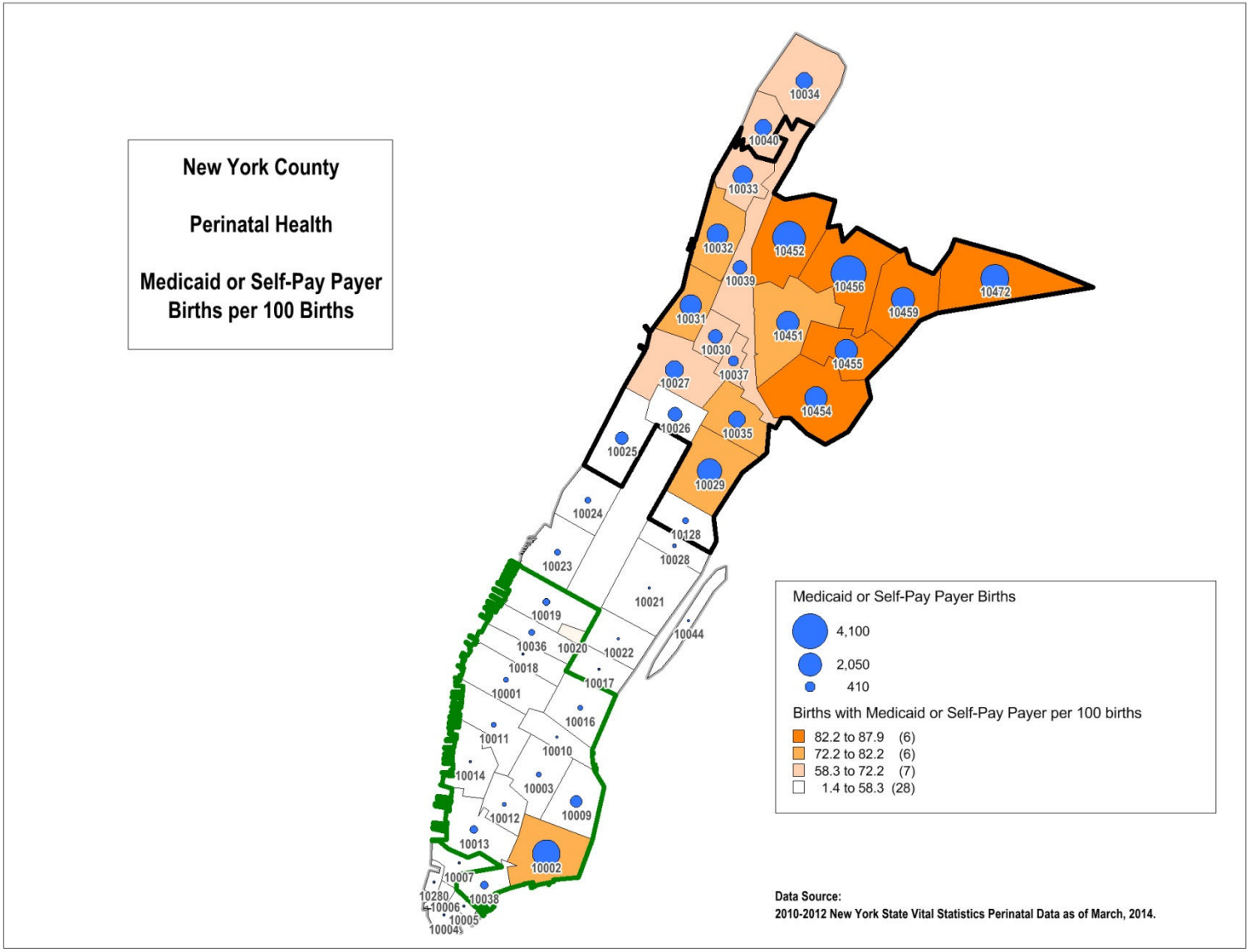
4. Uninsured Population by Zip Code



5. Low Birth Weight Births by Percentage of Births by Zip Code



6. Percentage of Births with Medicaid or Self-Pay Payer by Zip Code



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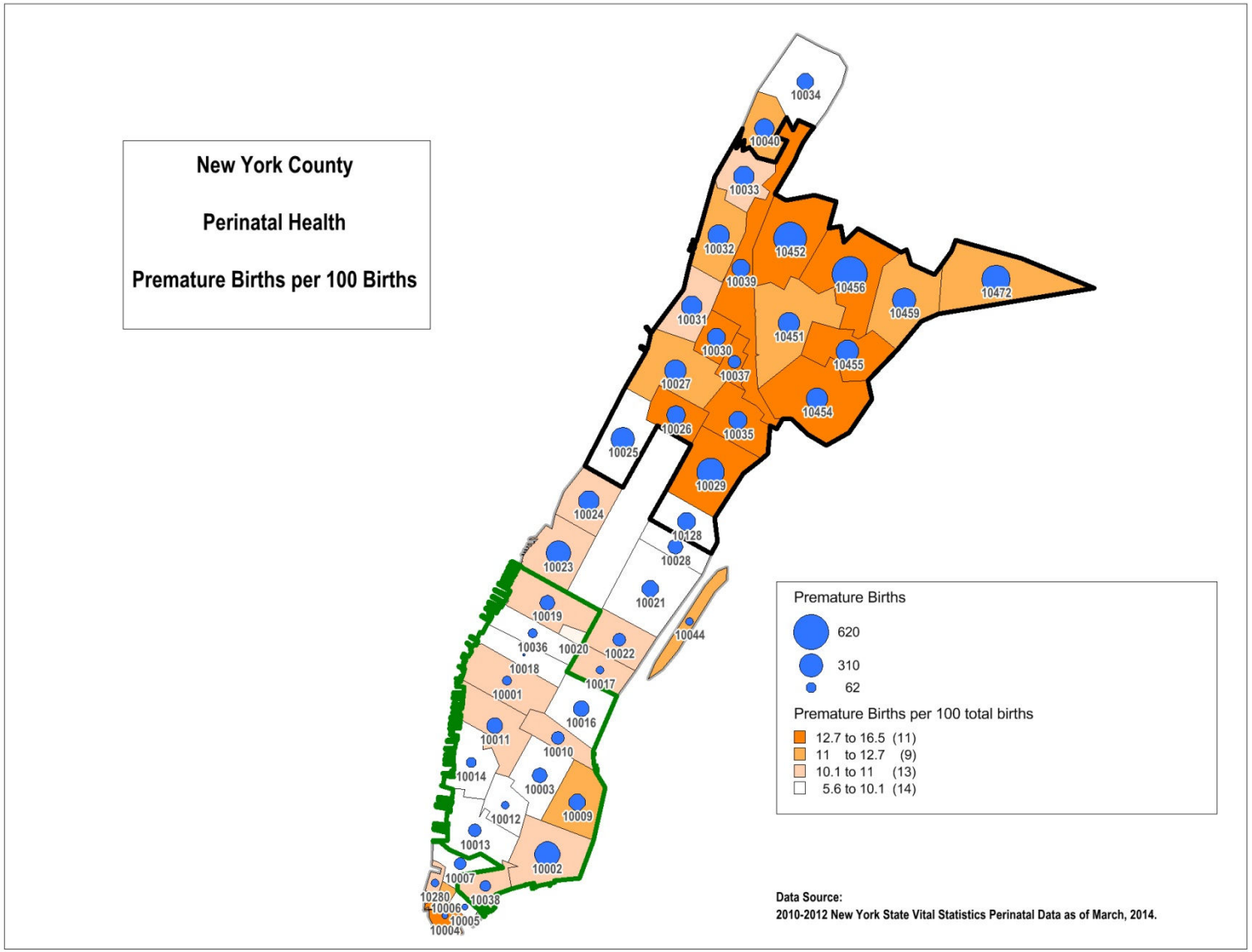
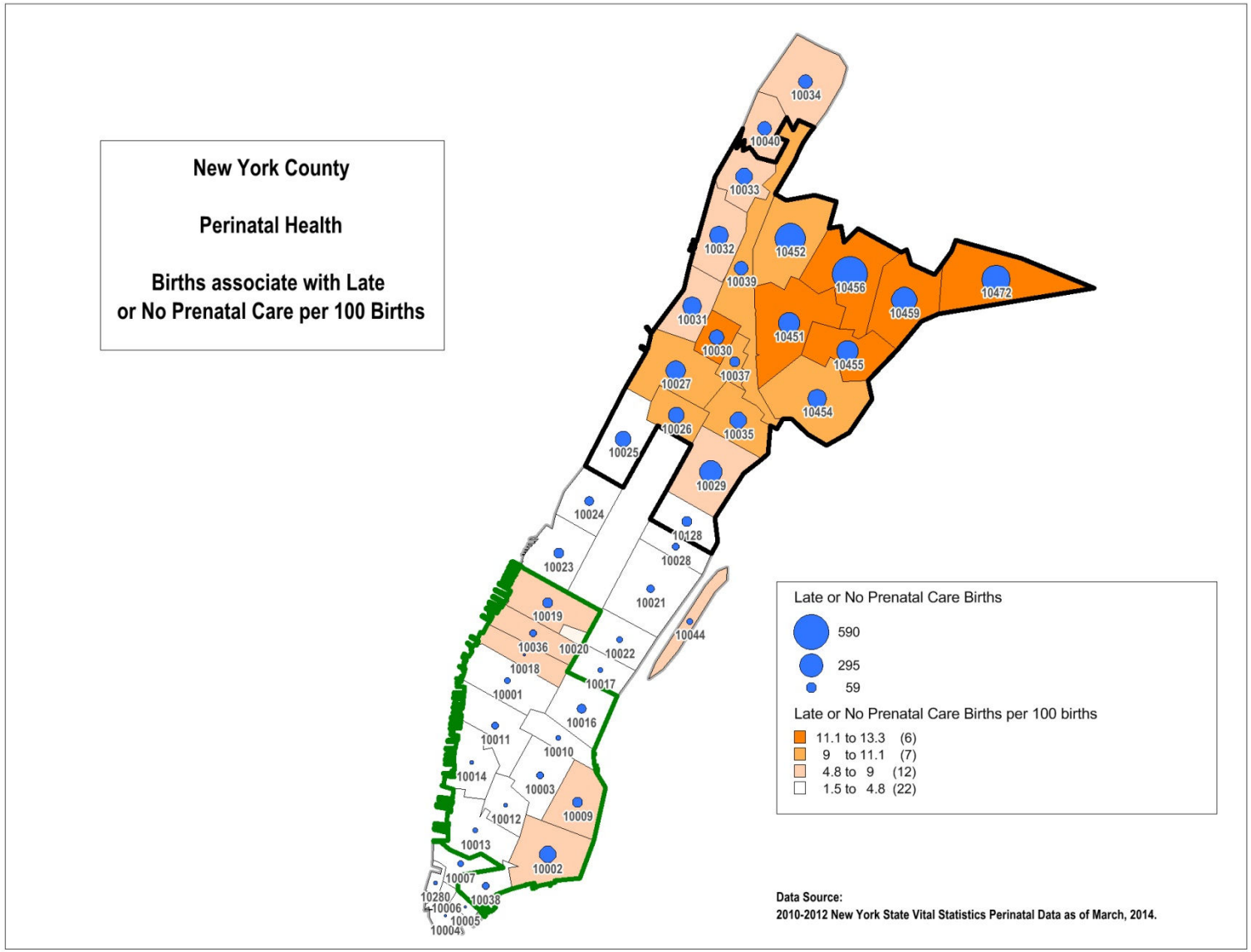


8. Percentage of Births Associated with Late or No Prenatal Care by Zip Code



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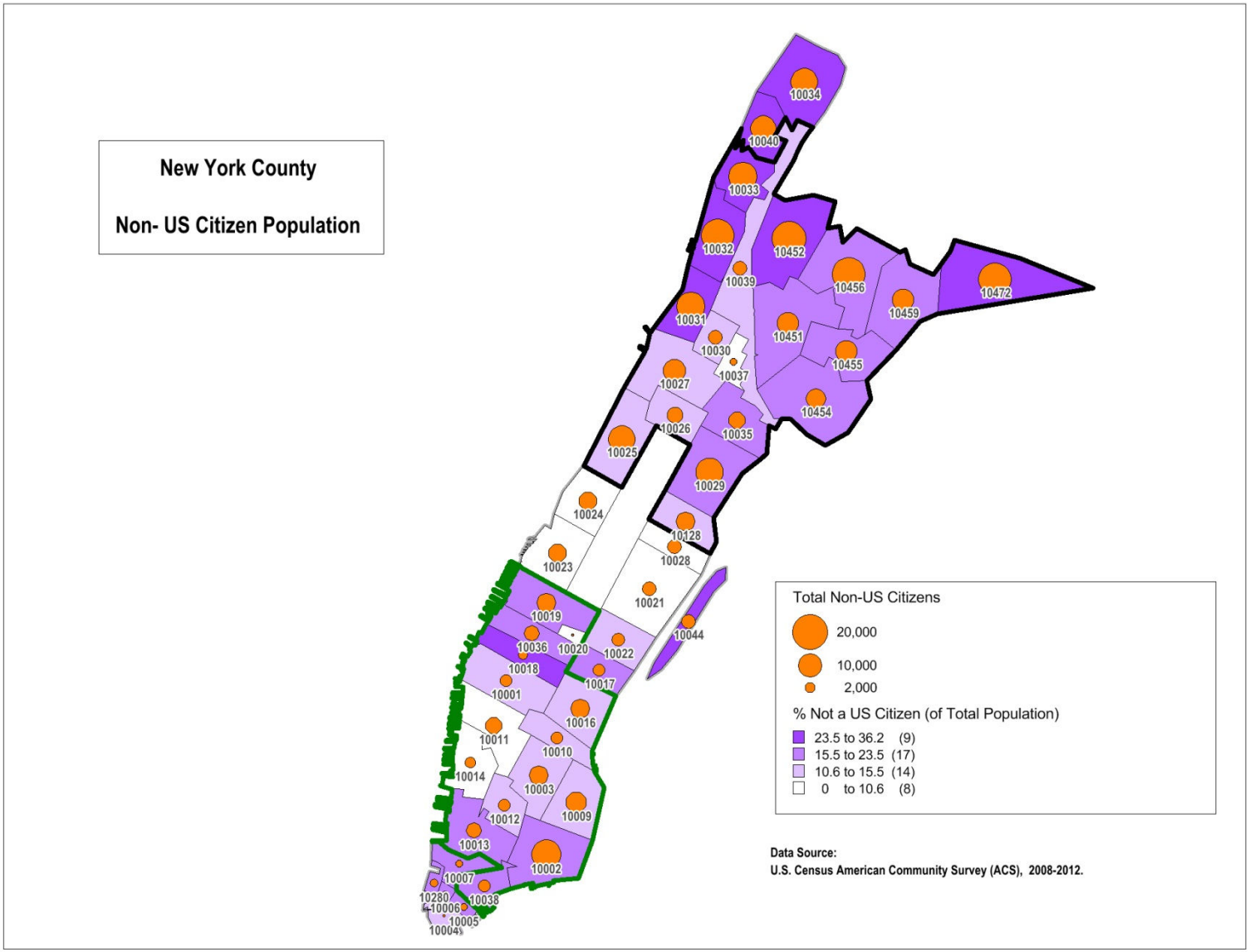
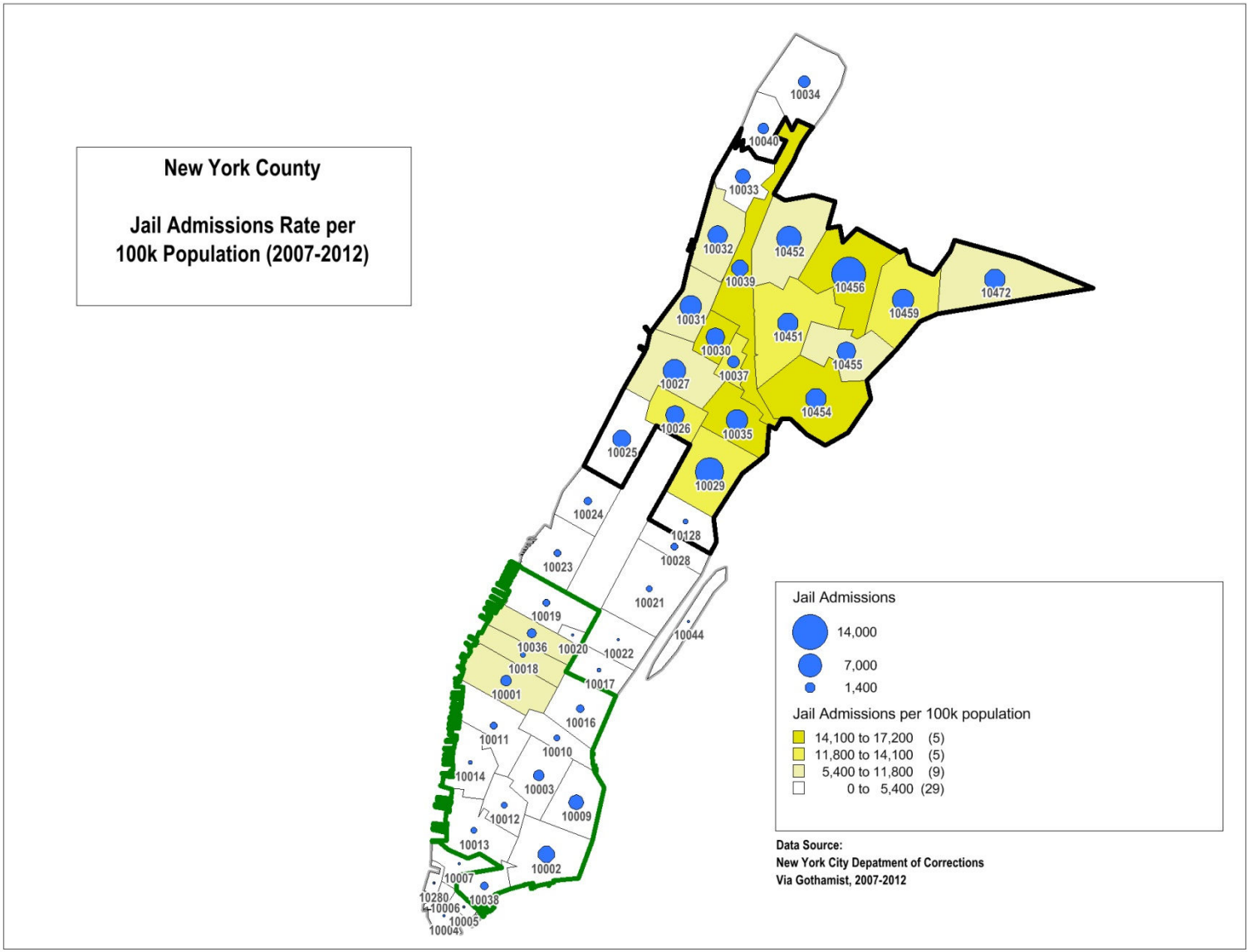
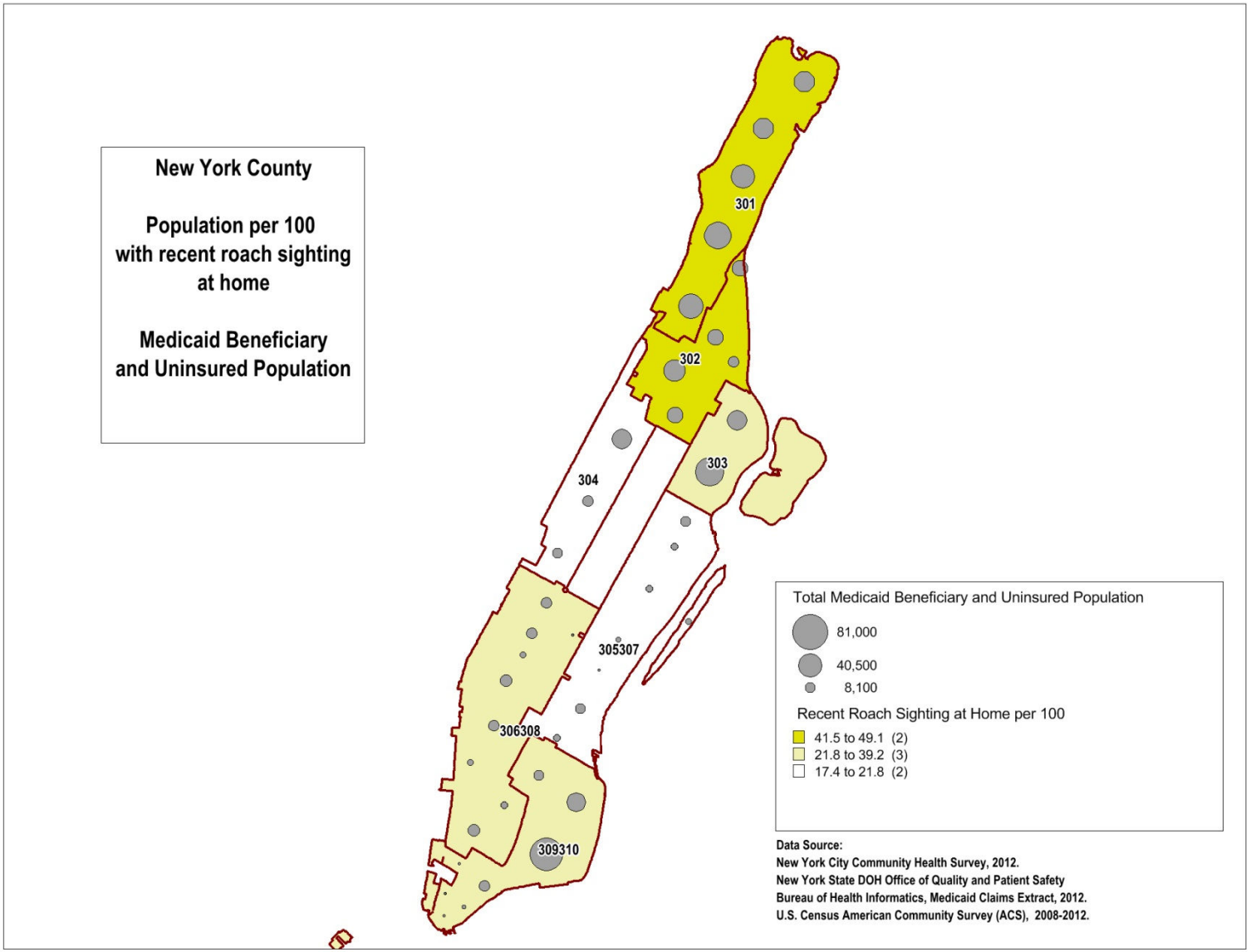


10. NYC Department of Corrections Average Rate Per 100,000 of Jail Admissions by Zip Code



11. Recent Cockroach Sighting at Home (by UHF neighborhood) and Medicaid Beneficiary and Uninsured Population (by Zip Code)



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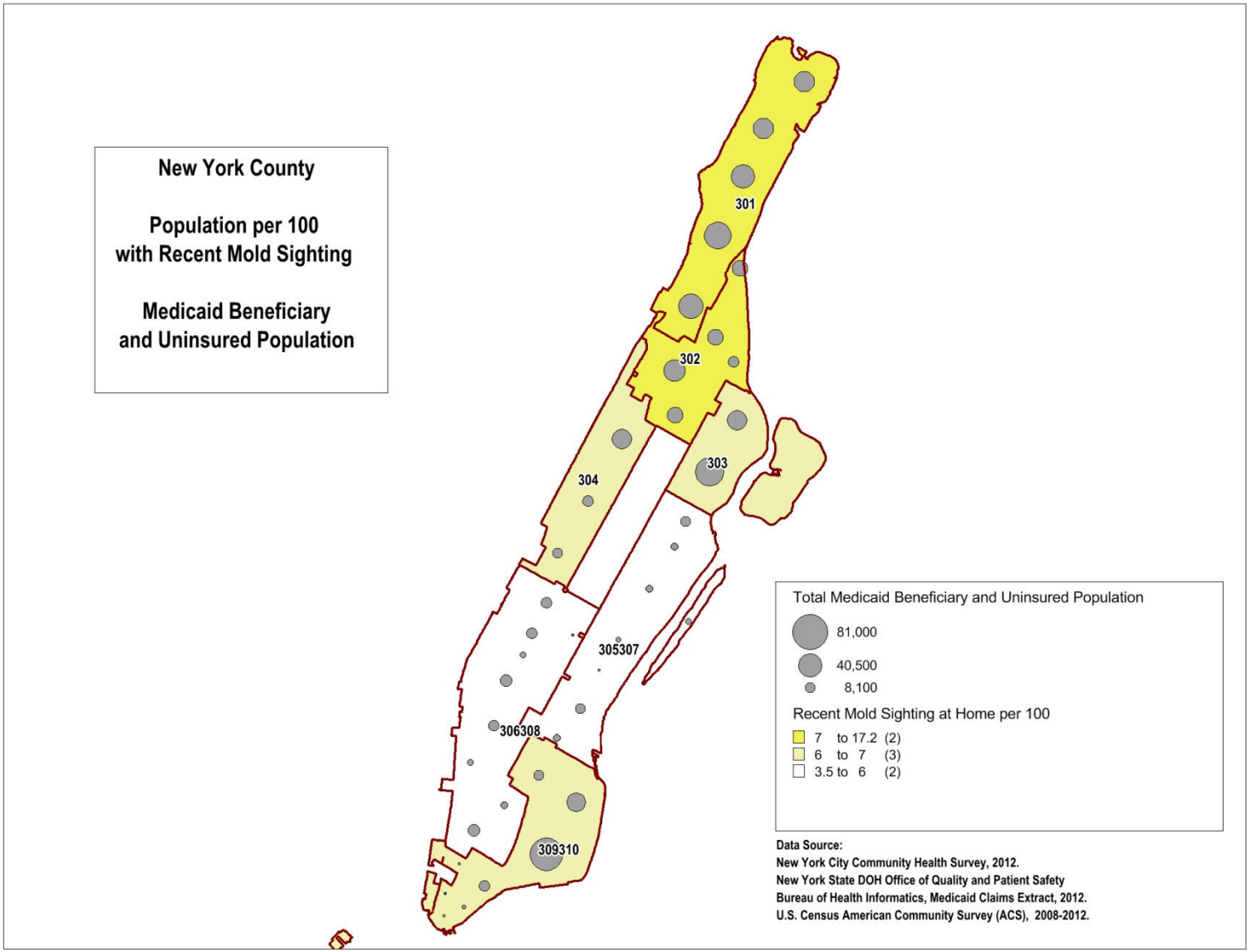
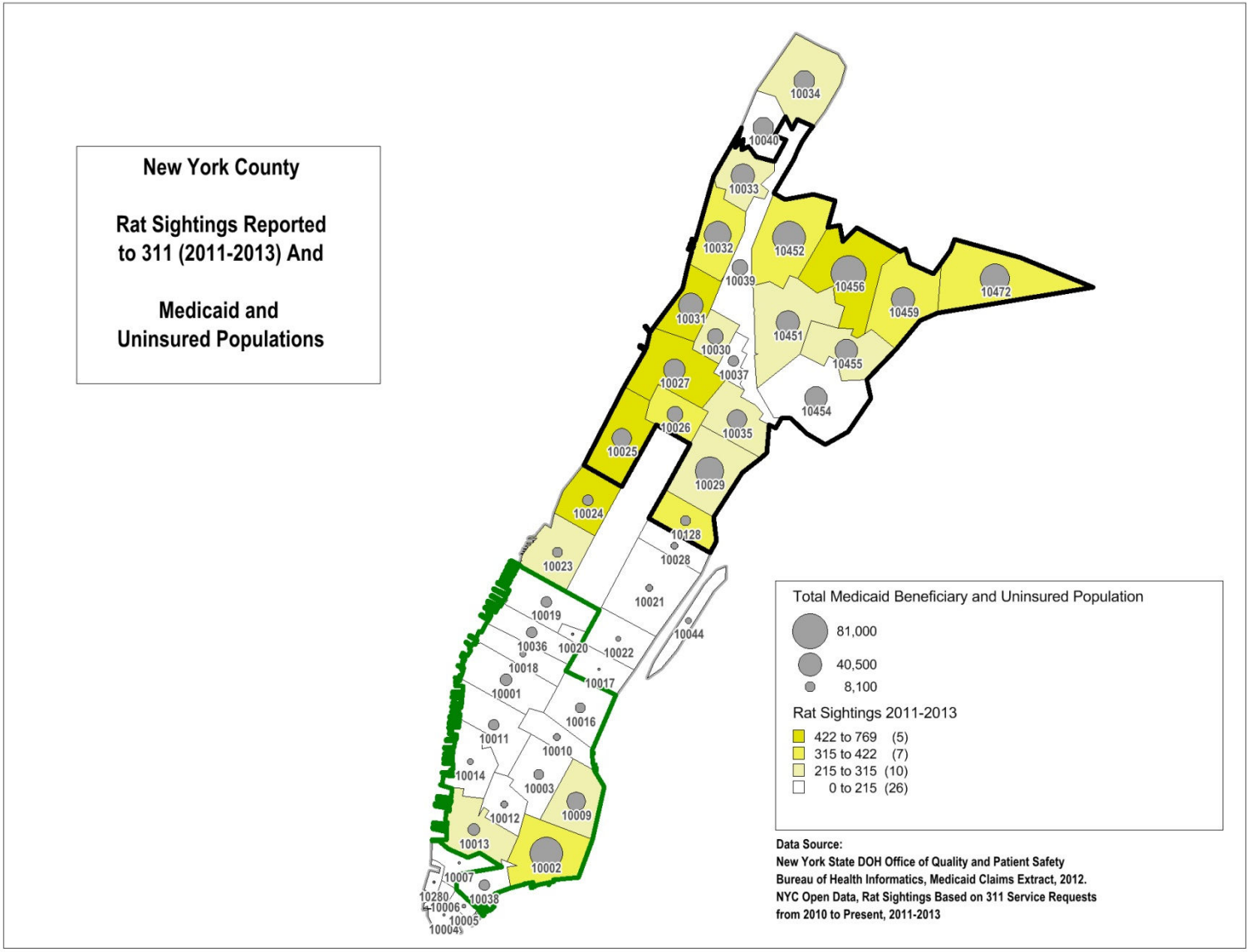


13. Rat Sightings Reported to 311 and Medicaid Beneficiaries and Uninsured Population by Zip Code



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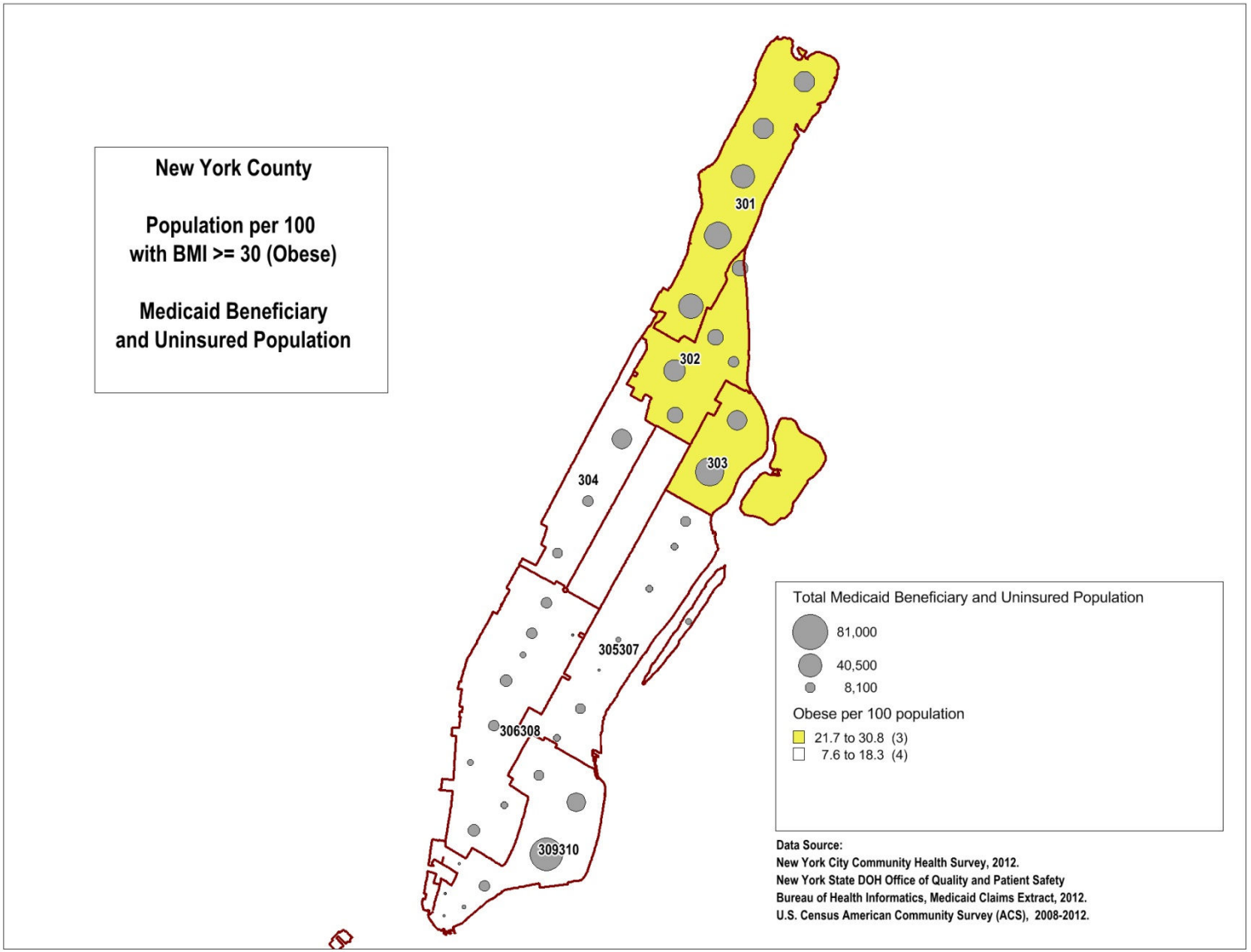
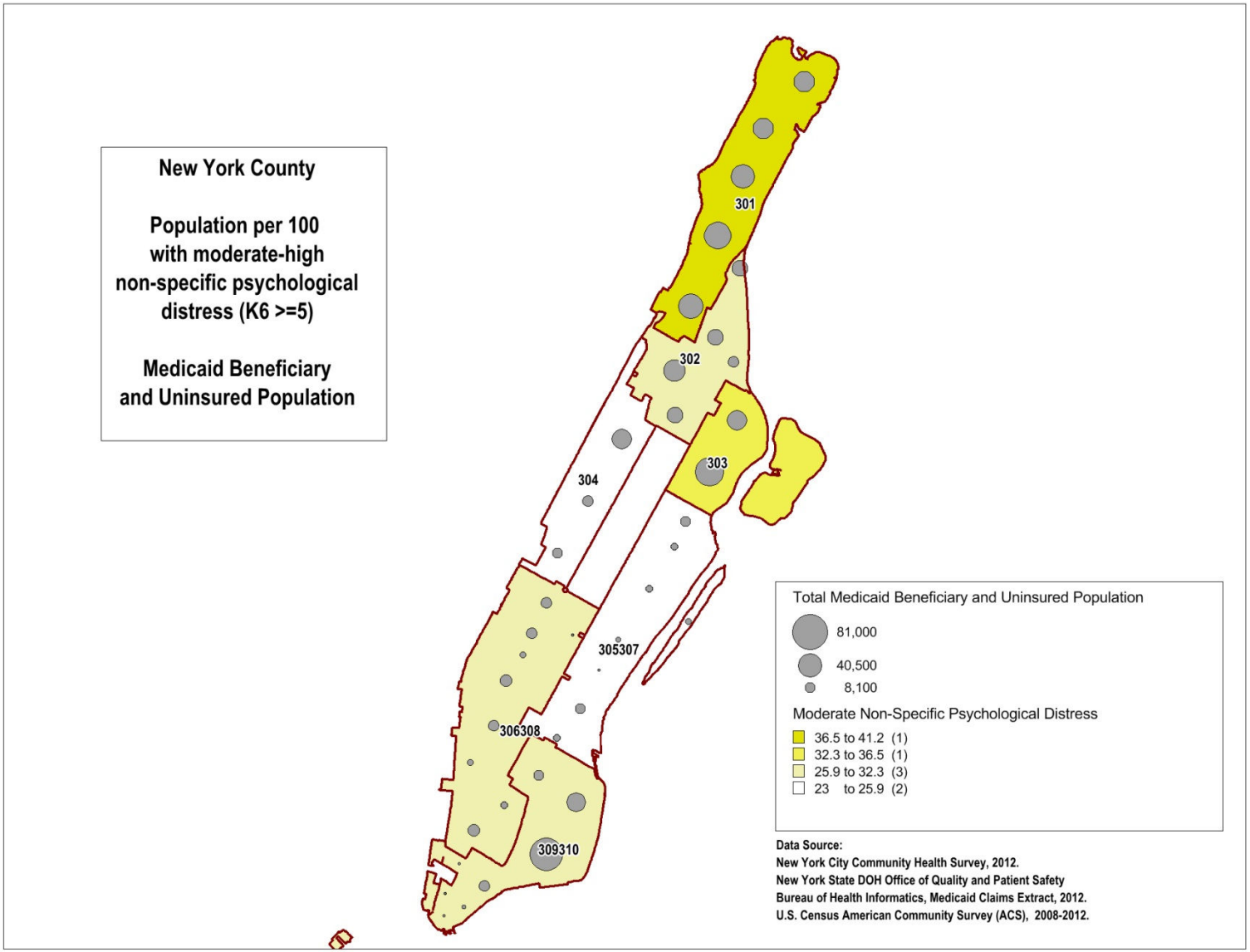
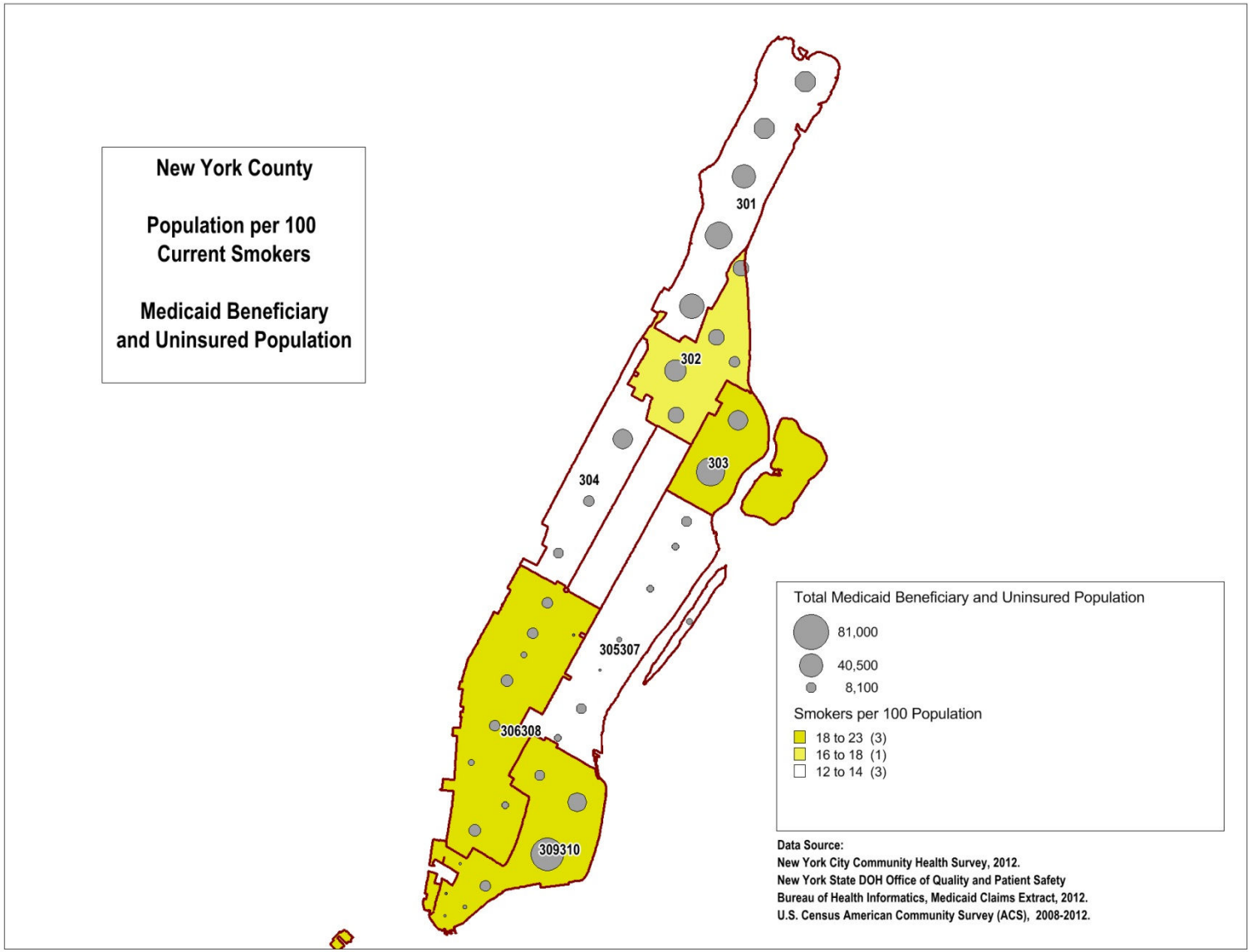


15. Moderate or Higher Level of Psychological Distress Rate (by UHF Neighborhood) and Medicaid Beneficiaries and Uninsured Population



16. Cigarette Smoking Rate (by UHF Neighborhood) and Medicaid Beneficiaries and Uninsured Population (by Zip Code)



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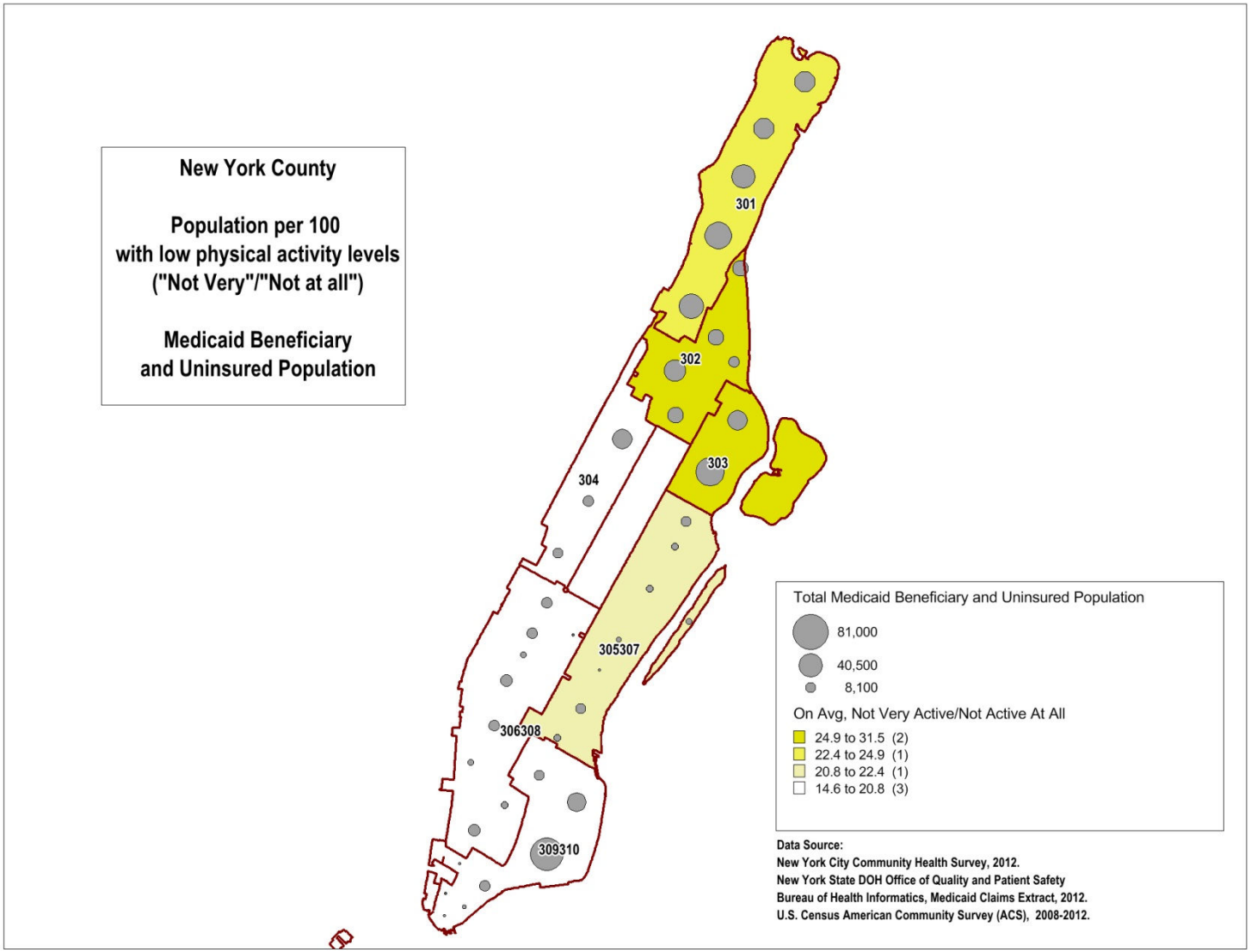
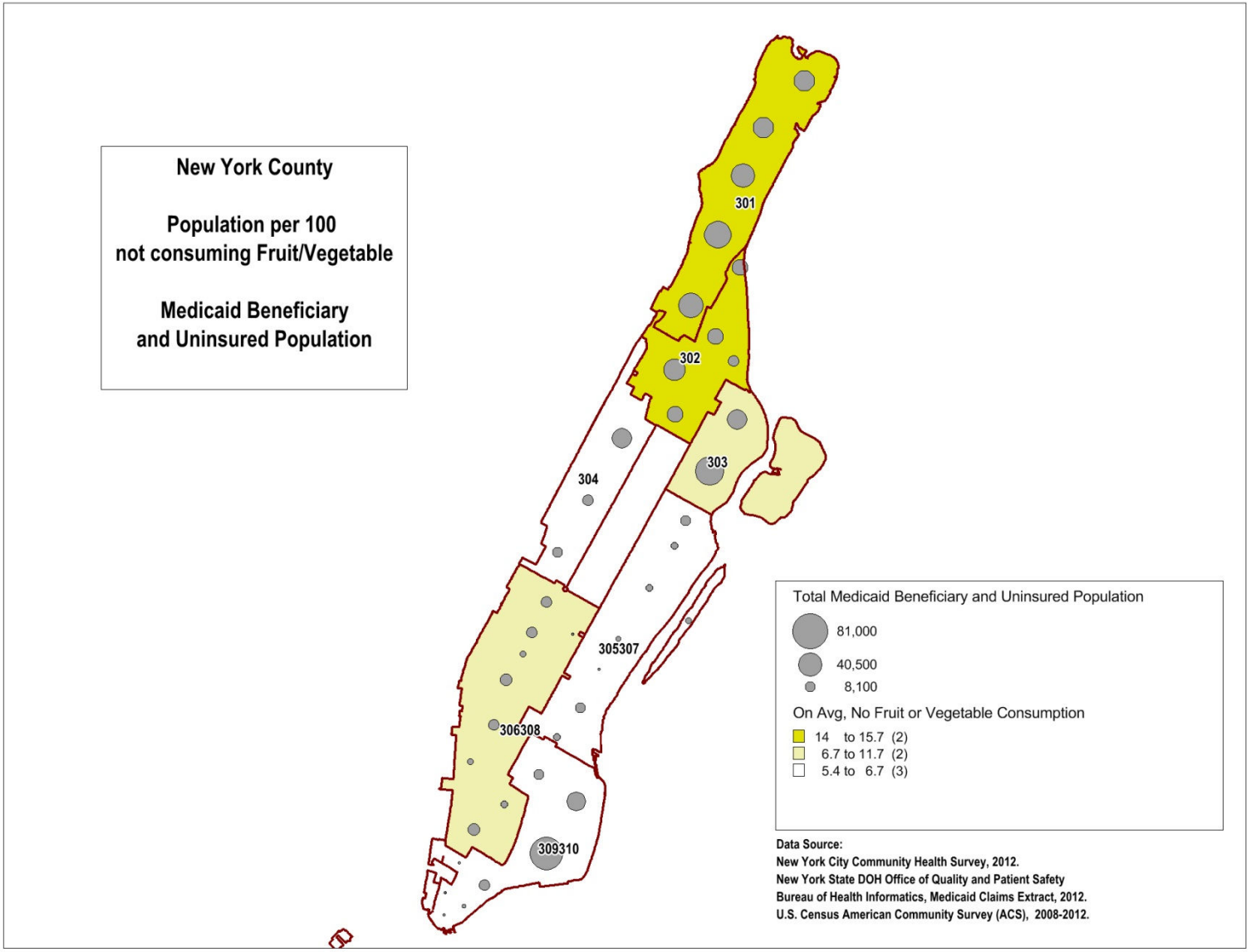
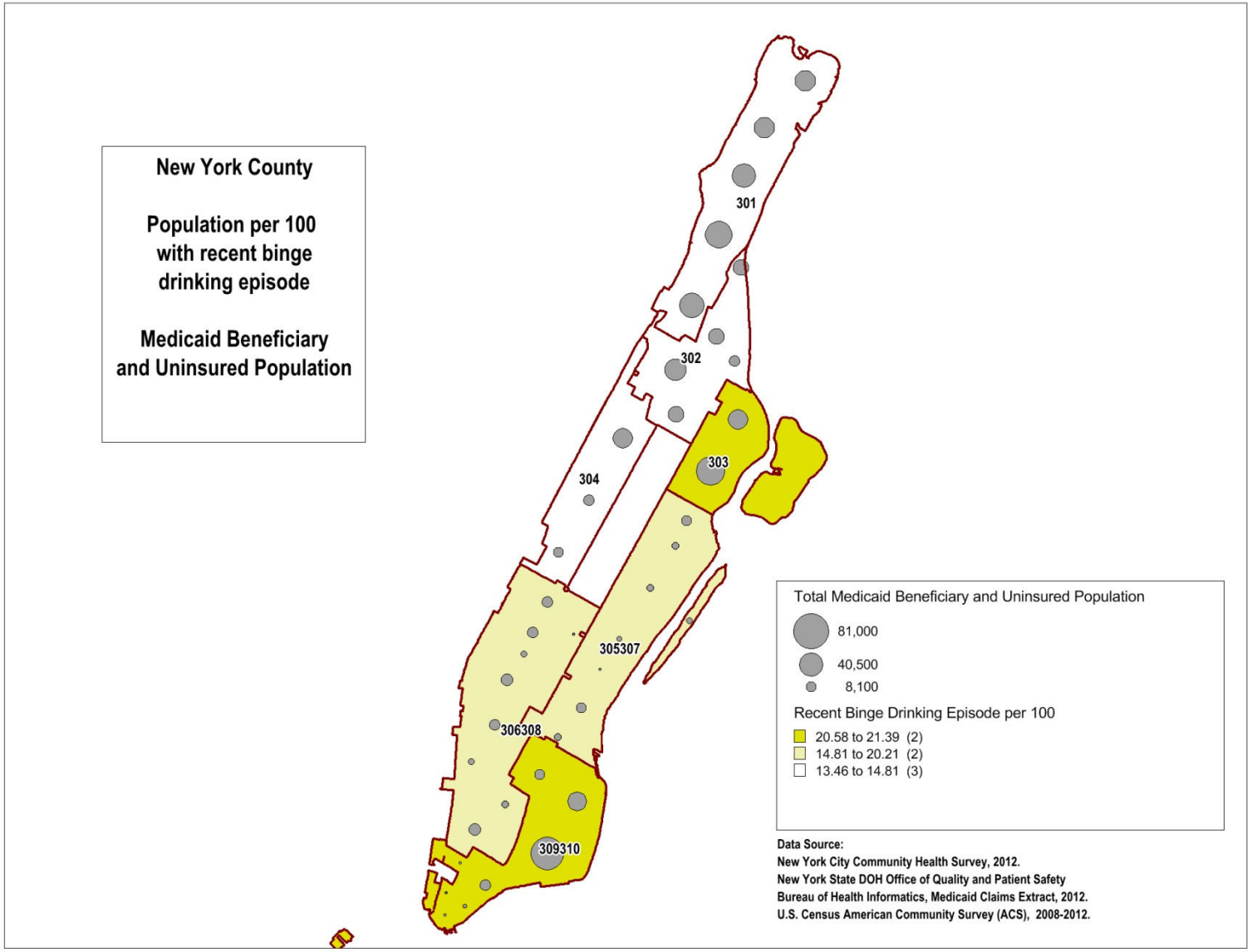


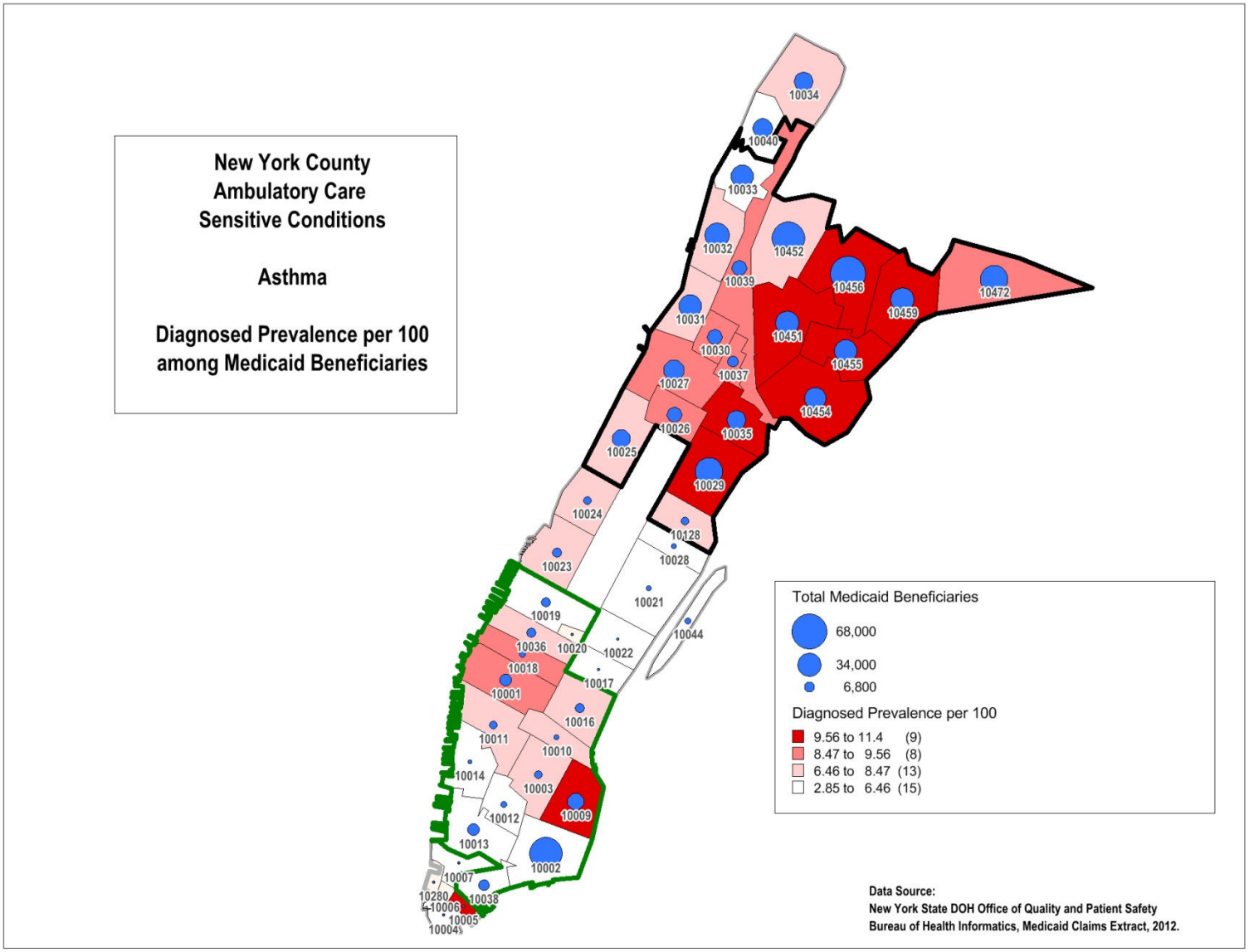
18. No Fruit/Vegetable Consumption Yesterday (by UHF Neighborhood) and Medicaid Beneficiaries and Uninsured Population



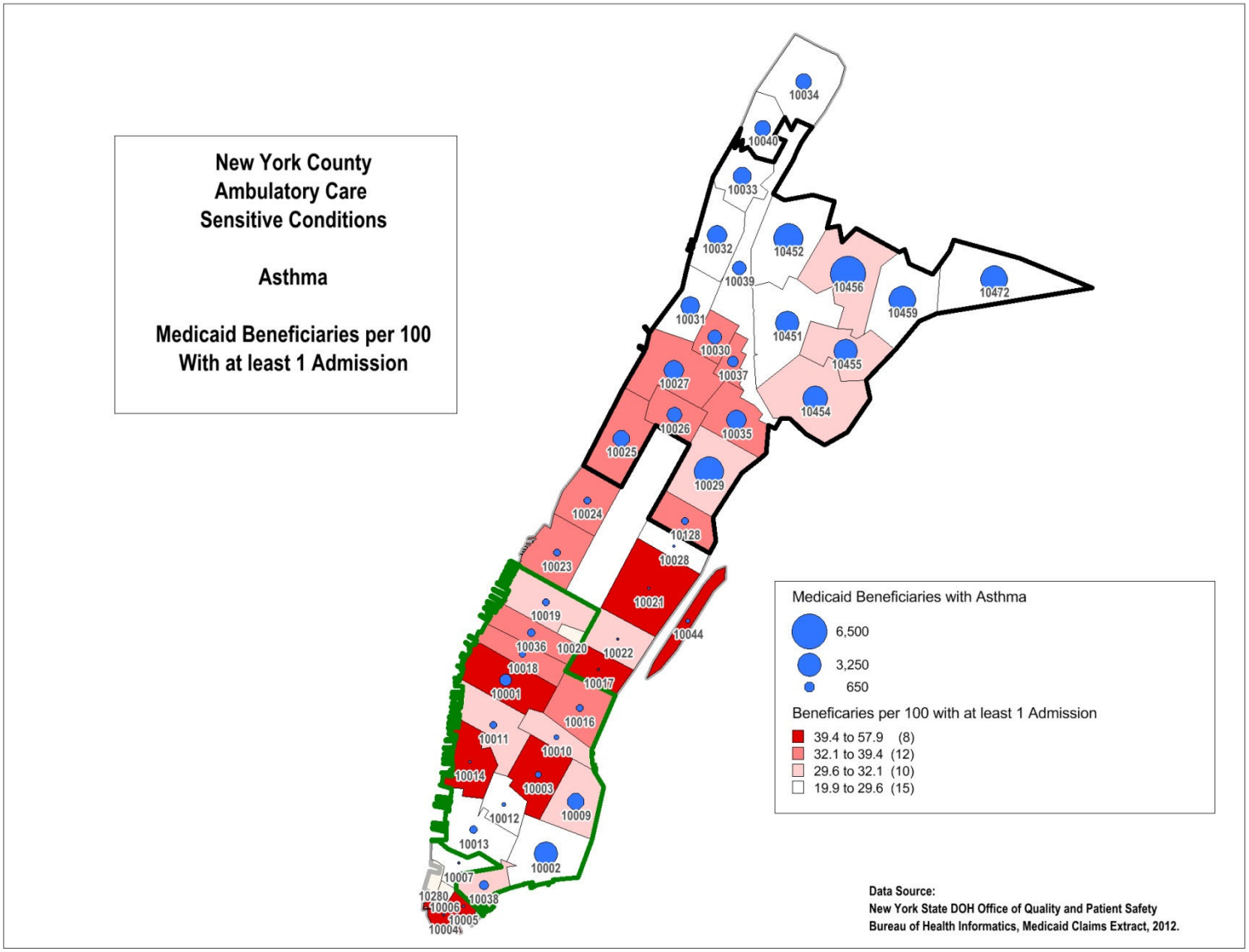
19. Recent Binge Drinking Episode Rate (by UHF Neighborhood) and Medicaid Beneficiaries and Uninsured Population (by Zip Code)



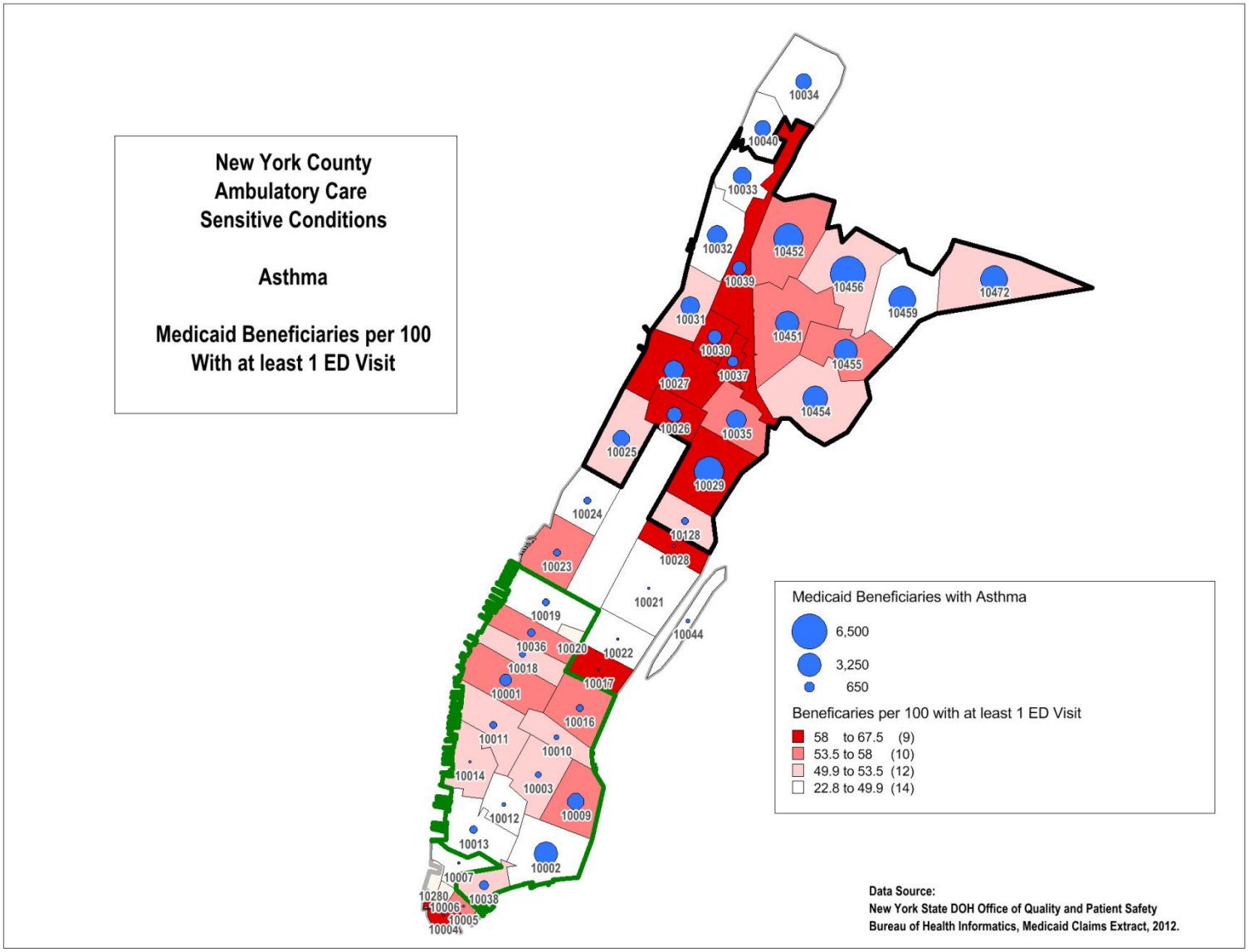
20. Asthma Prevalence Among Medicaid Beneficiaries (by Zip Code)



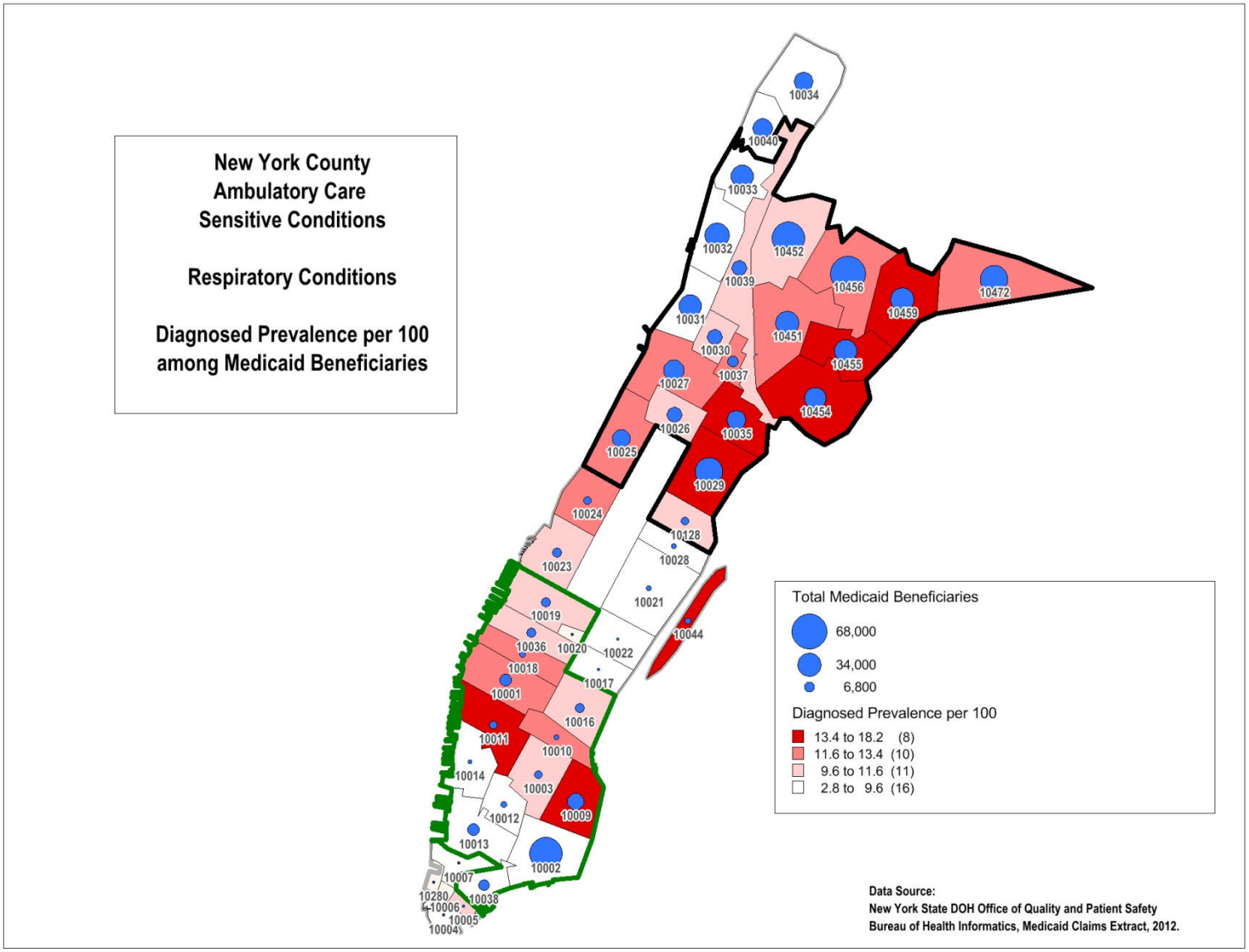
21. Percentage among Medicaid Beneficiaries with Asthma with any inpatient admission (by Zip Code)



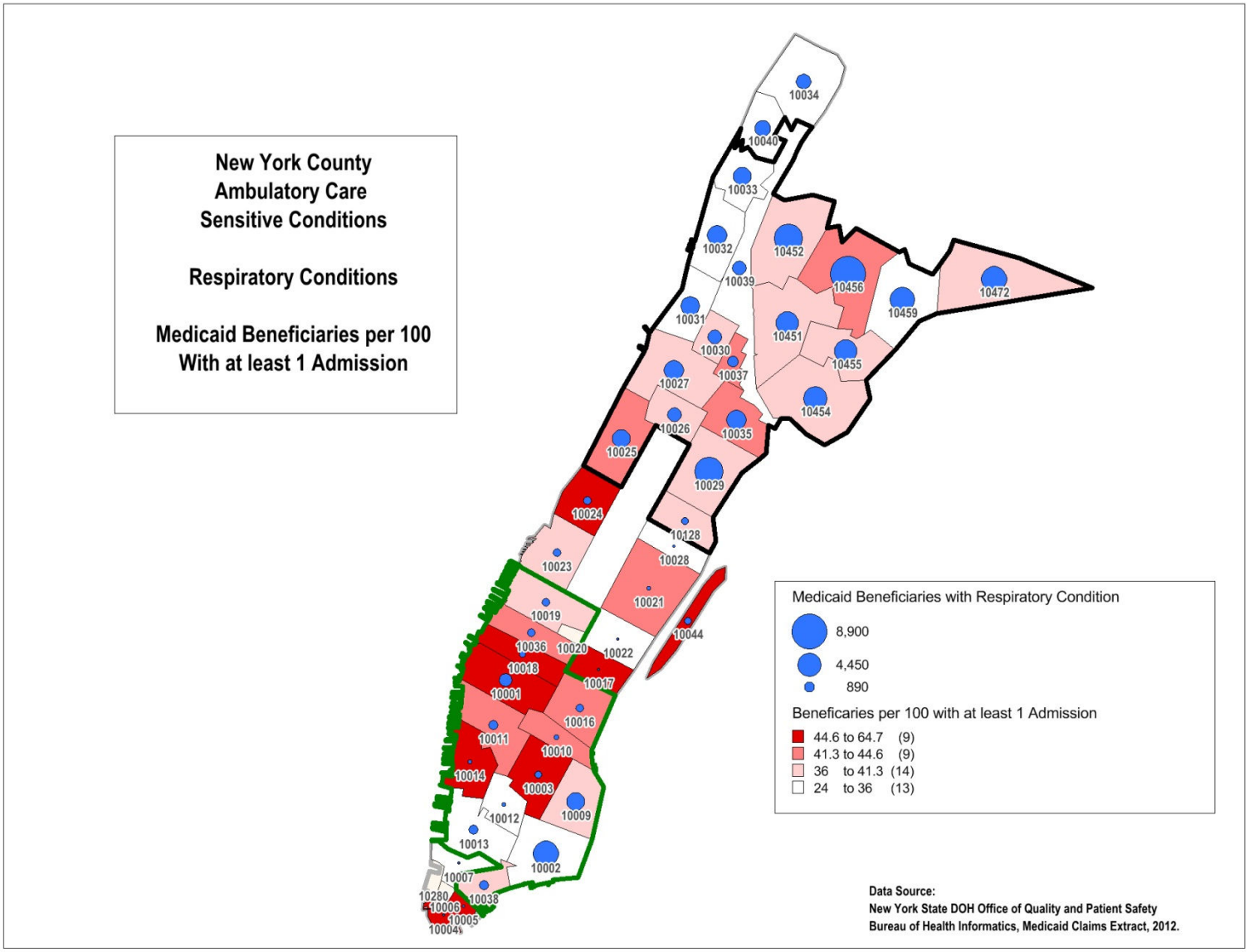
22. Percentage among Medicaid Beneficiaries with Asthma with any emergency department visit (by Zip Code)



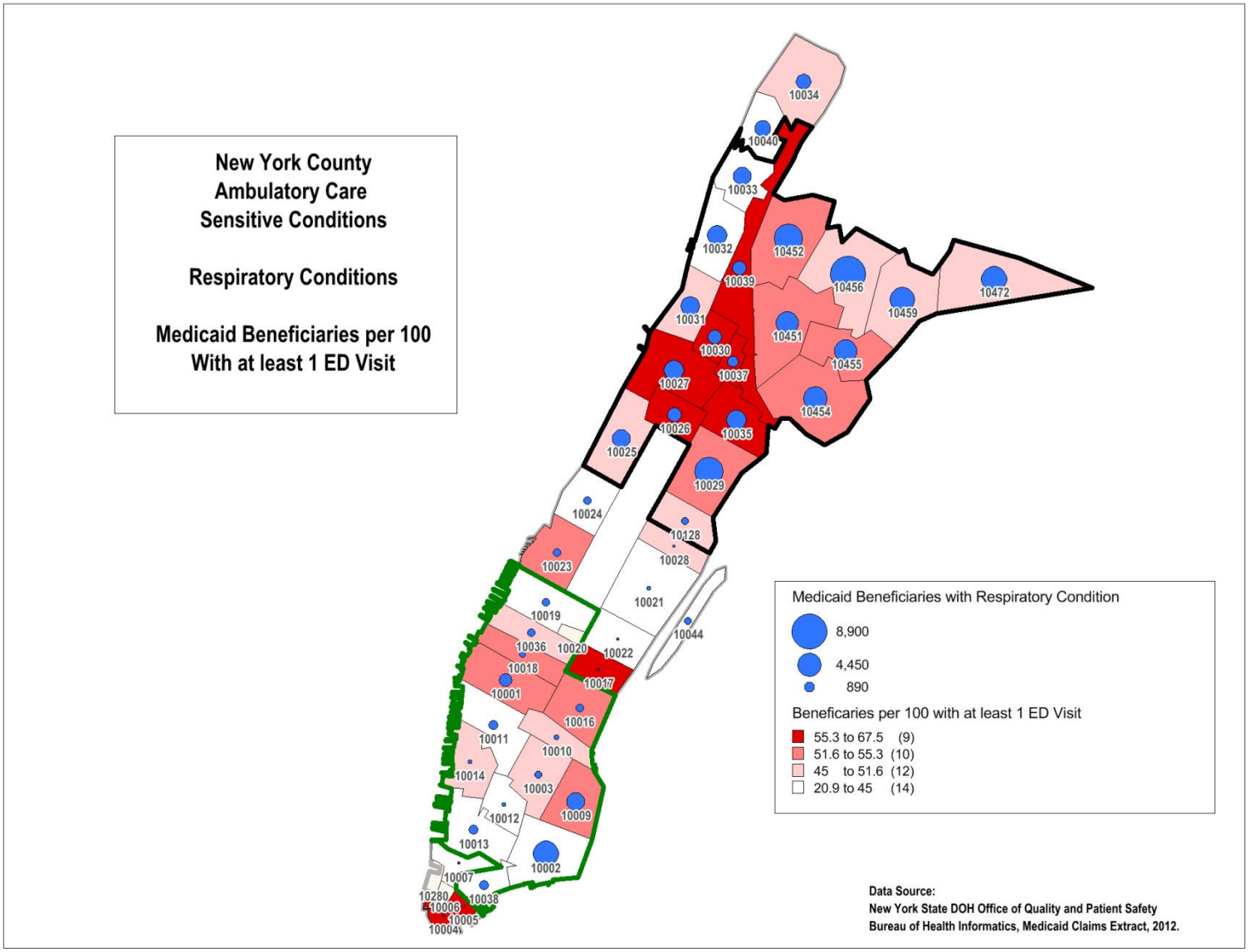
23. Respiratory Clinical Risk Group (CRG) Diagnosis Prevalence Among Medicaid Beneficiaries (by Zip Code)



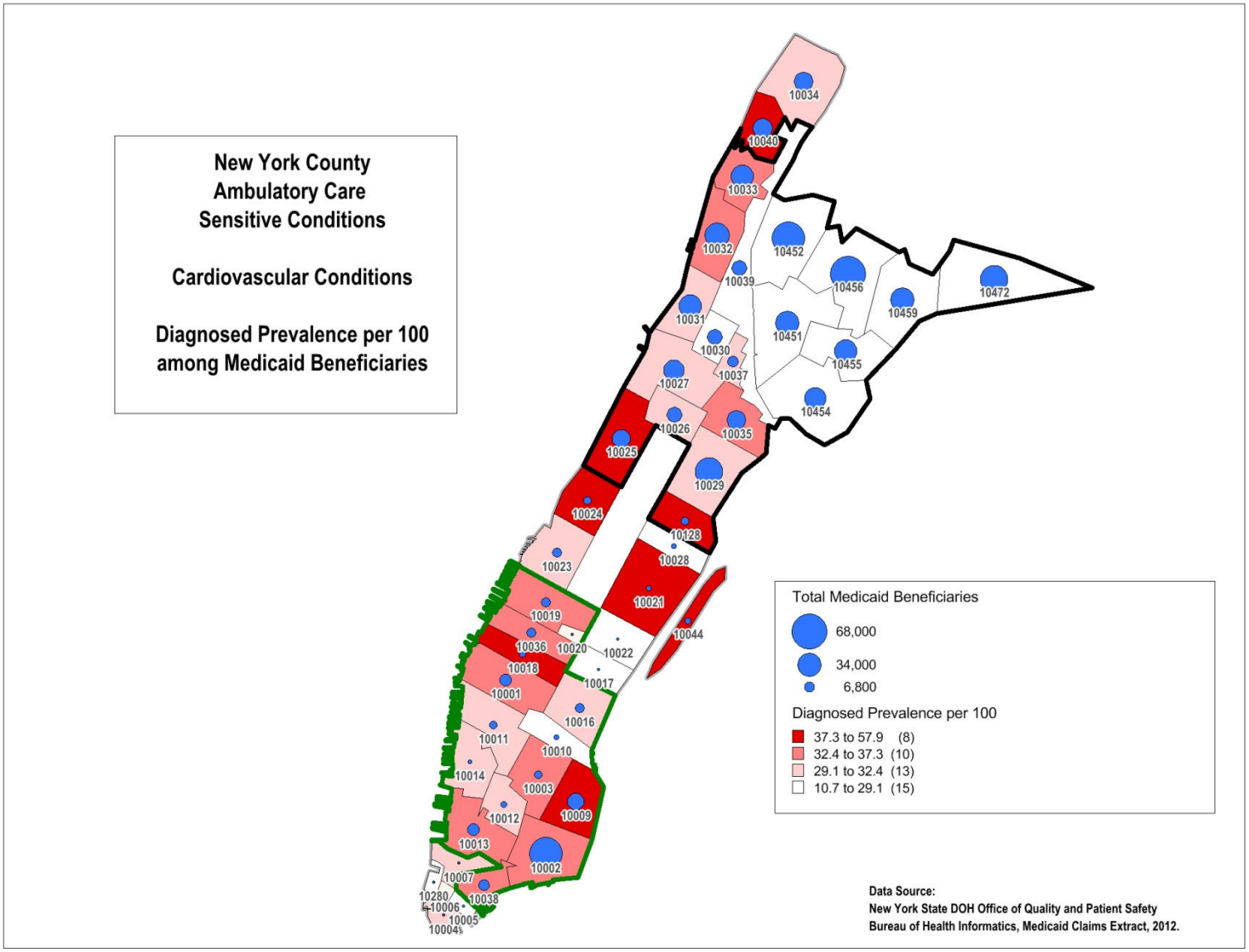
24. Percentage among Medicaid Beneficiaries with Respiratory CRG Diagnosis with any inpatient admission (by Zip Code)



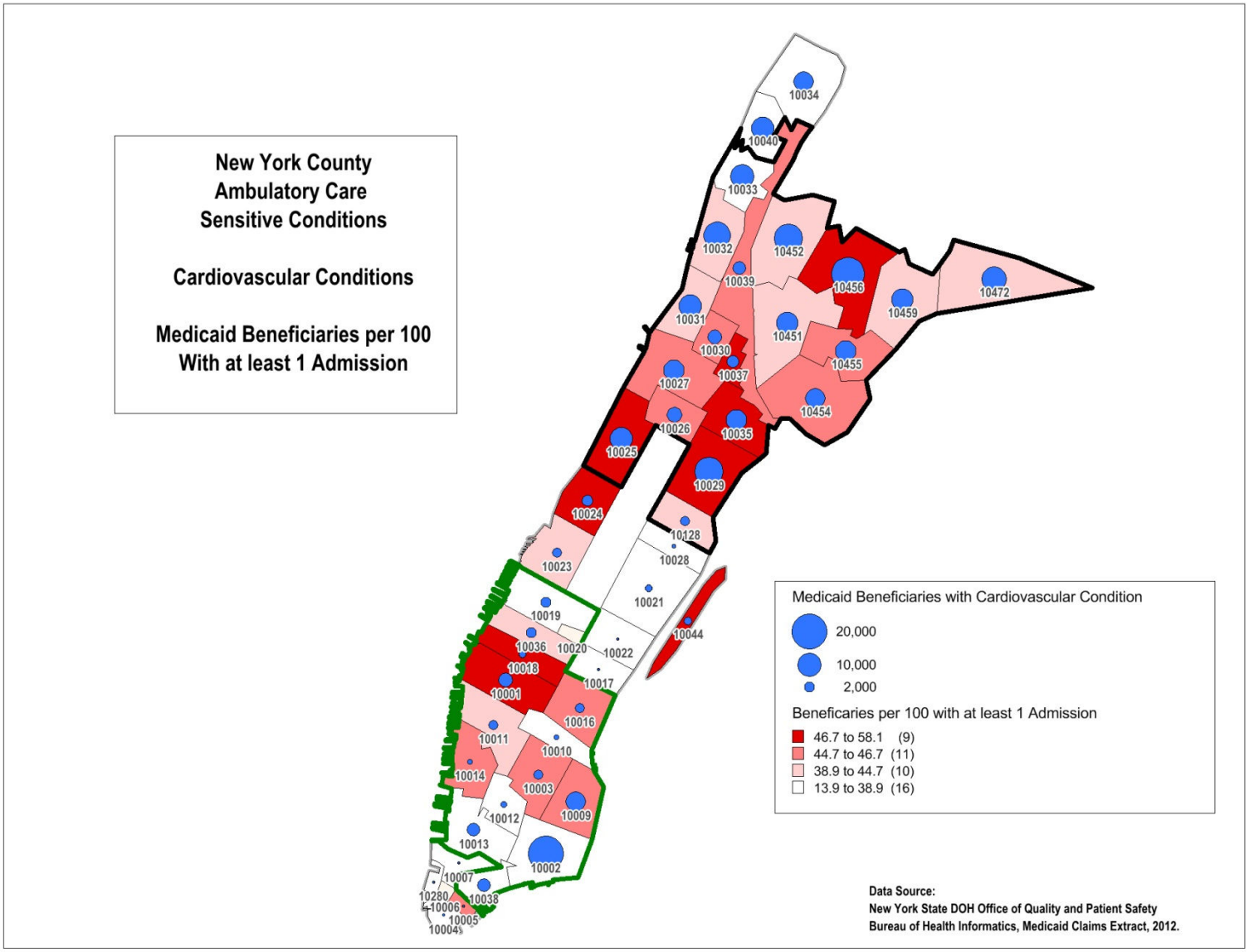
25. Percentage among Medicaid Beneficiaries with Respiratory CRG Diagnosis with any emergency department visit (by Zip Code)



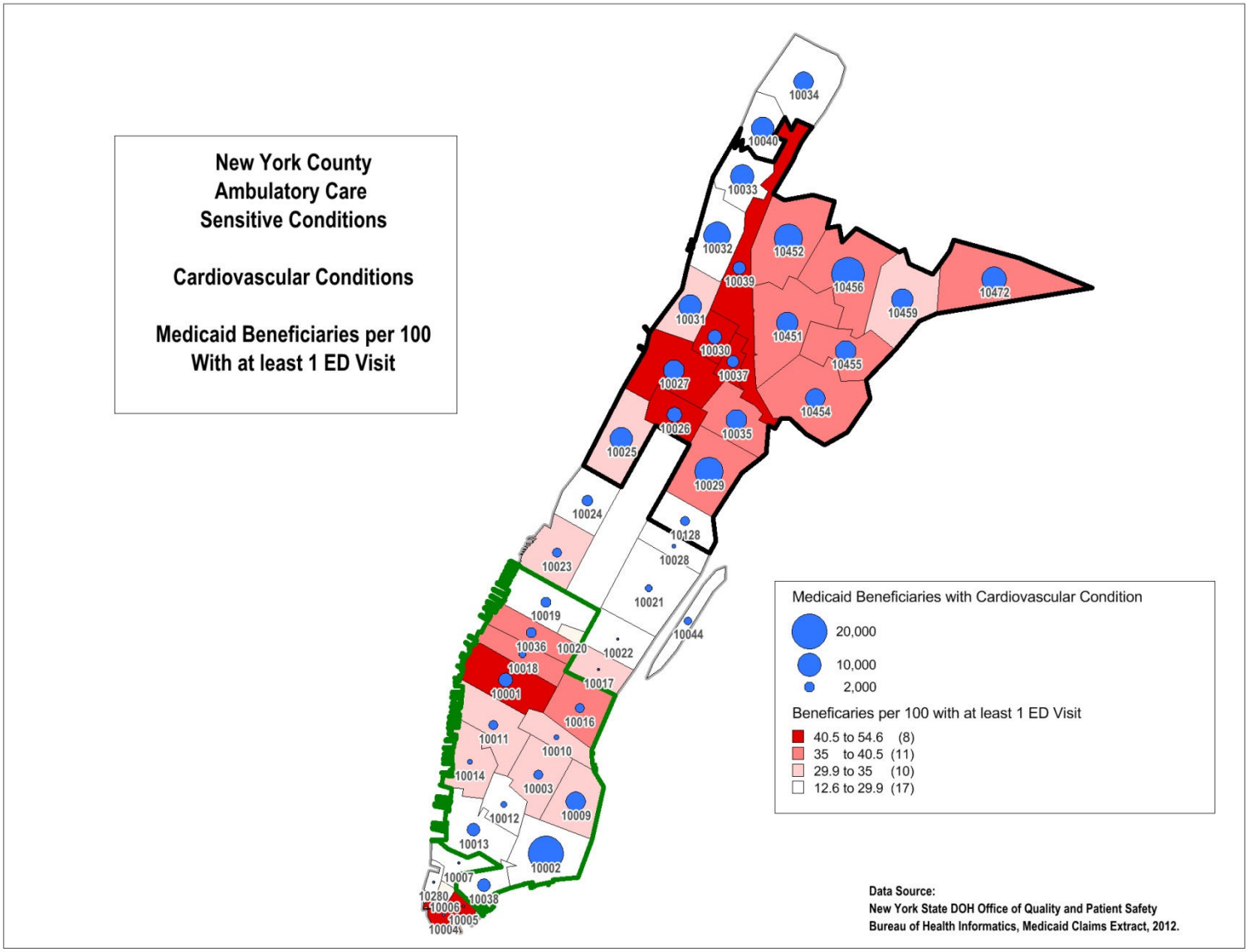
26. Cardiovascular CRG Diagnosis Prevalence Prevalence Among Medicaid Beneficiaries (by Zip Code)



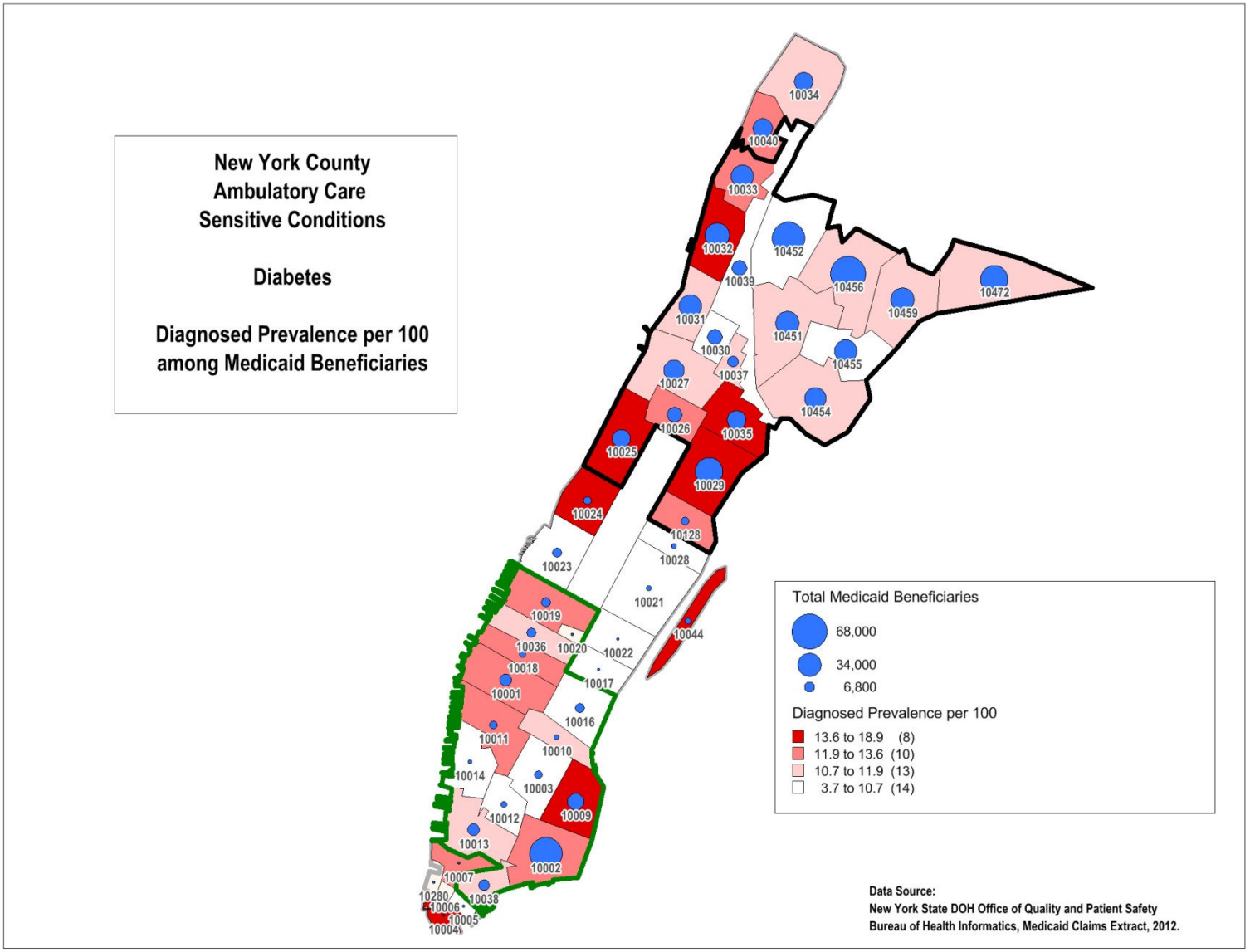
27. Percentage among Medicaid Beneficiaries with Cardiovascular CRG diagnosis with any inpatient admission (by Zip Code)



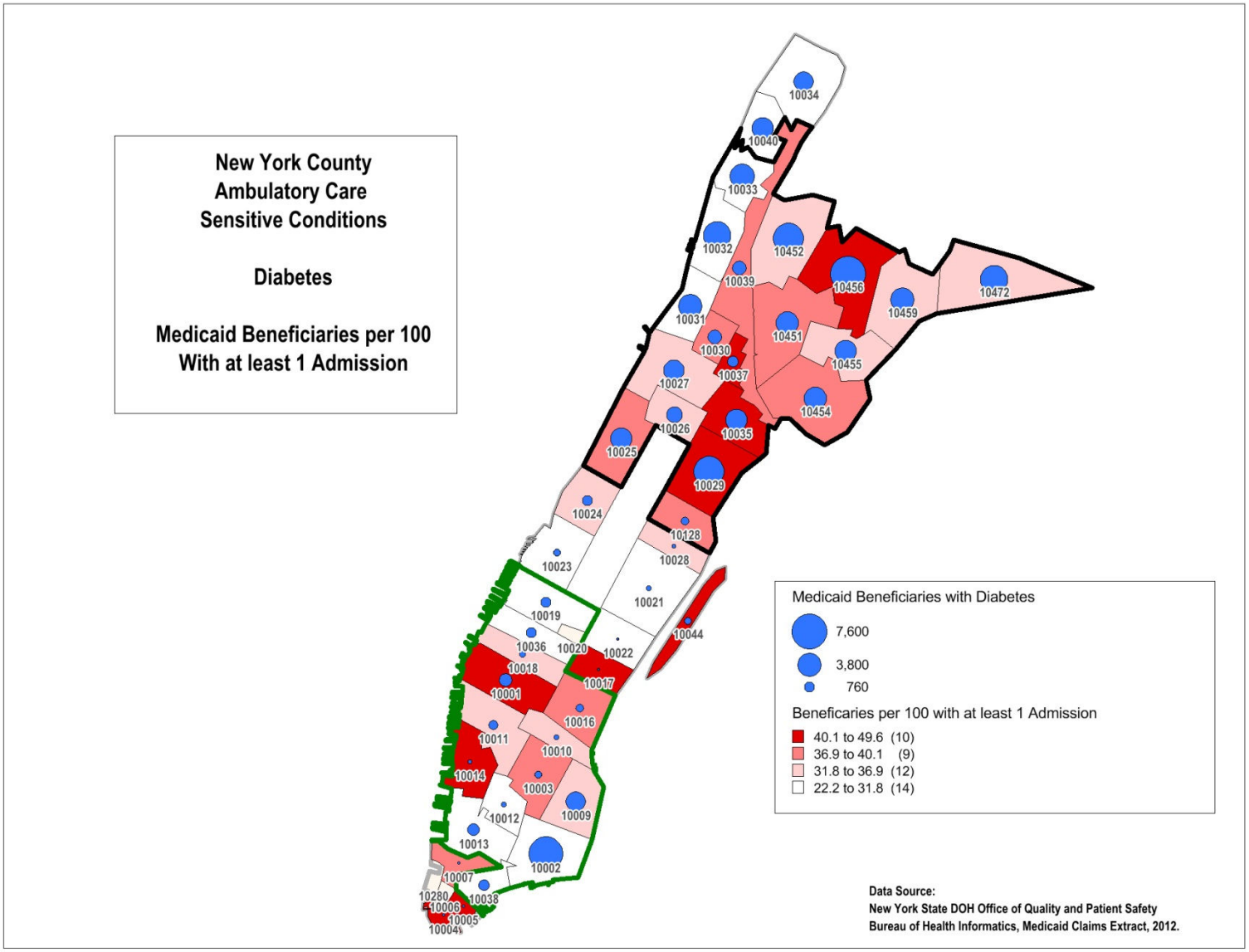
28. Percentage among Medicaid Beneficiaries with Cardiovascular CRG diagnosis with any emergency department visit (by Zip Code)



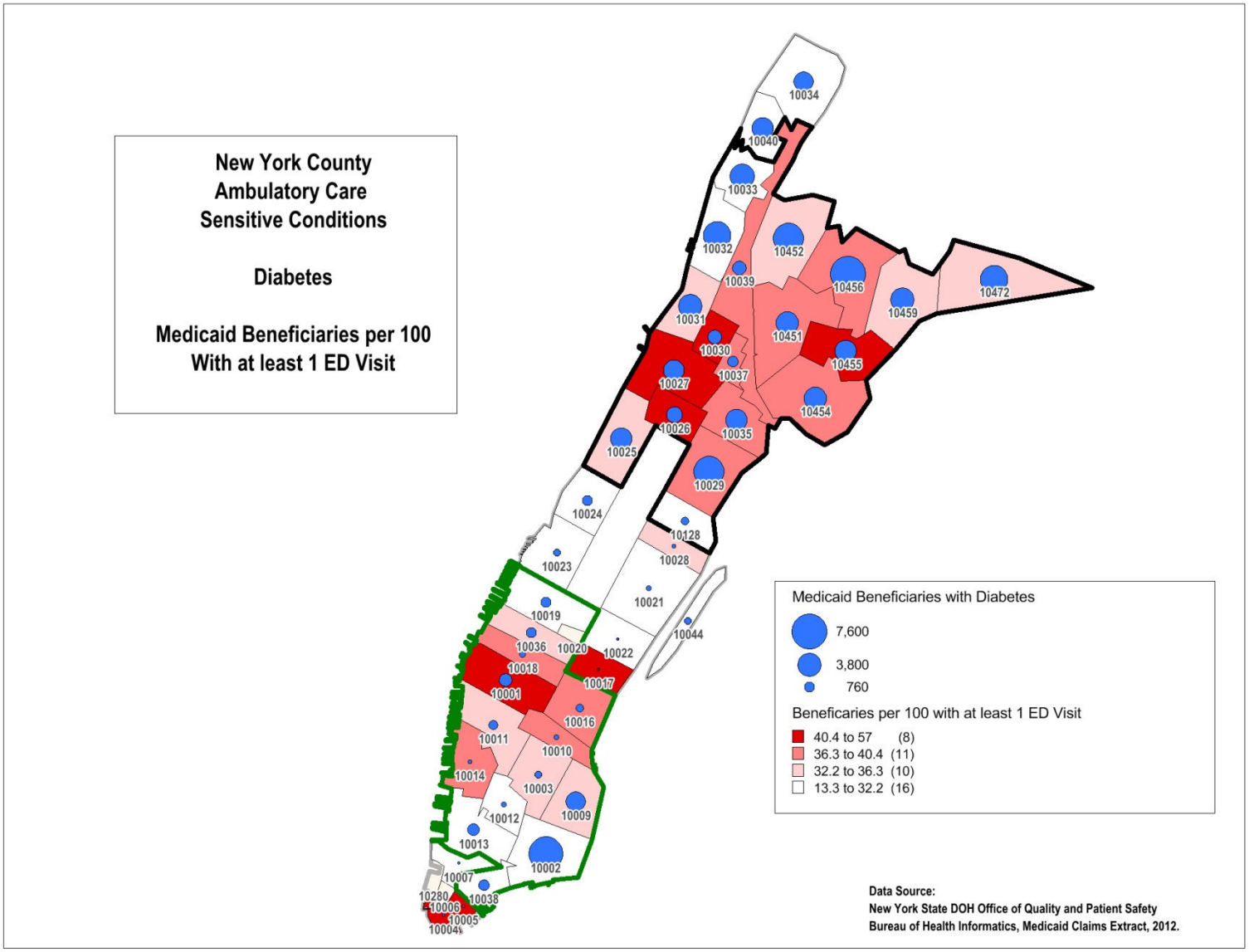
29. Diabetes CRG diagnosis Prevalence Among Medicaid Beneficiaries (by Zip Code)



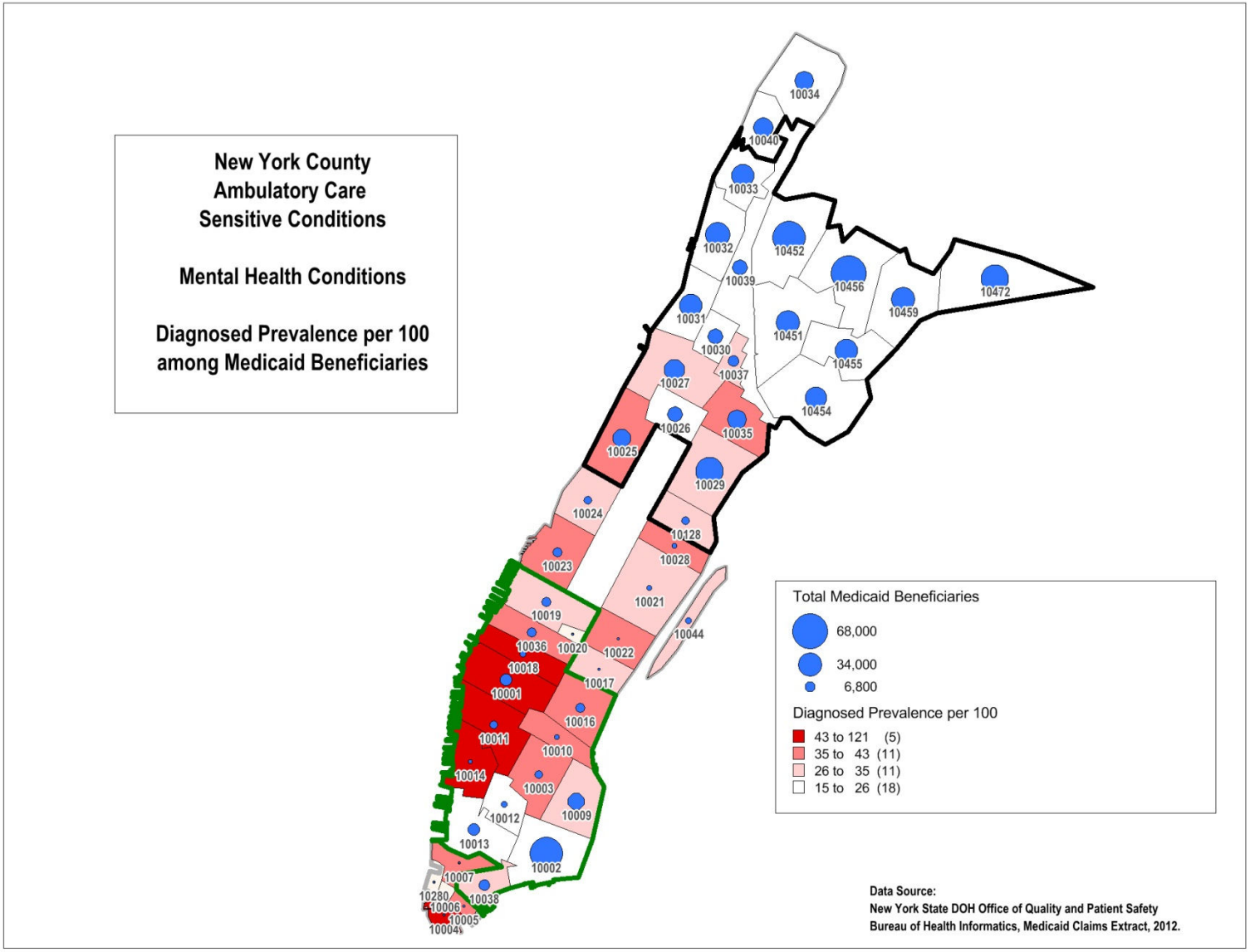
30. Percentage among Medicaid Beneficiaries with Diabetes CRG diagnosis with any inpatient admission (by Zip Code)



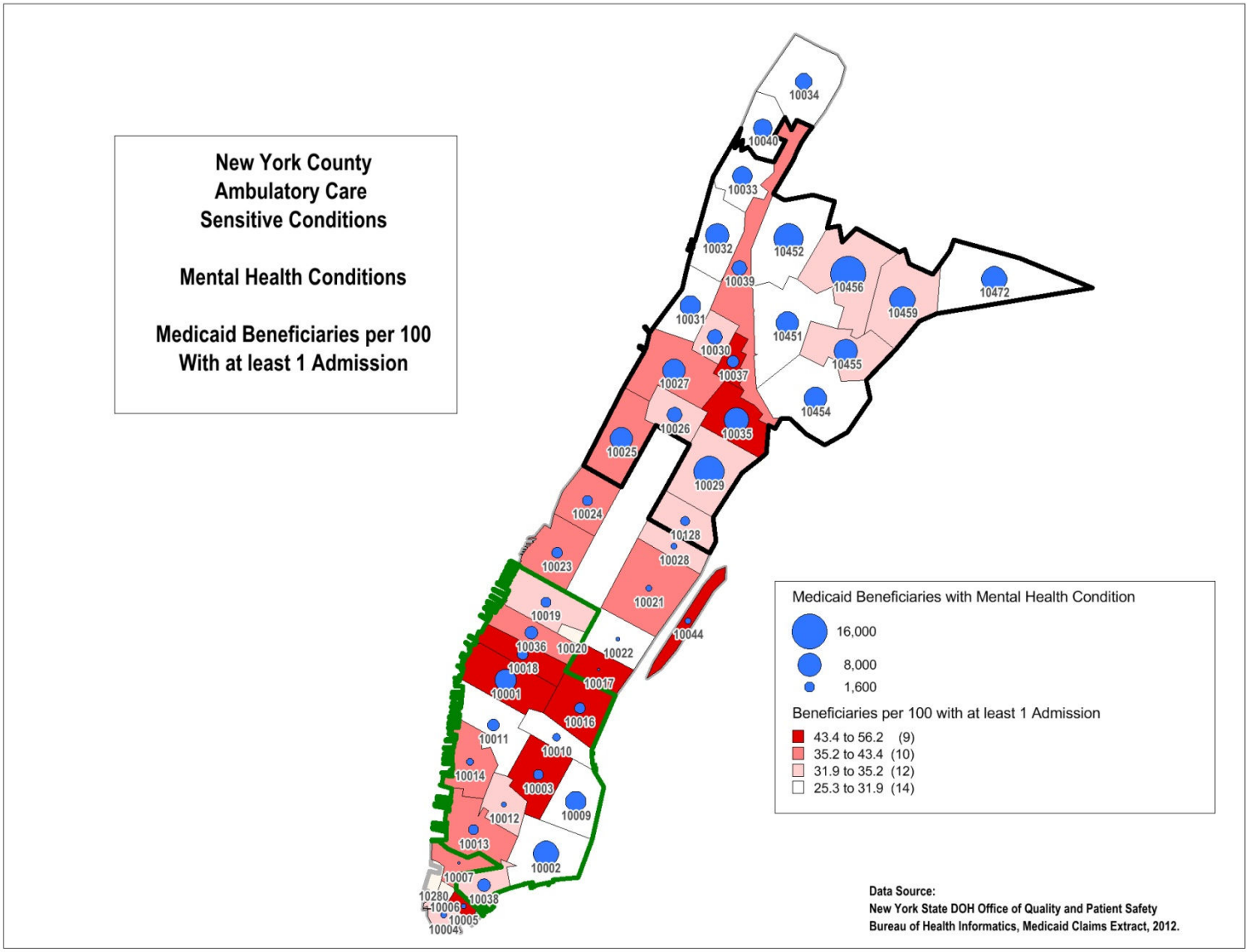
31. Percentage among Medicaid Beneficiaries with Diabetes CRG diagnosis with any emergency department visit (by Zip Code)



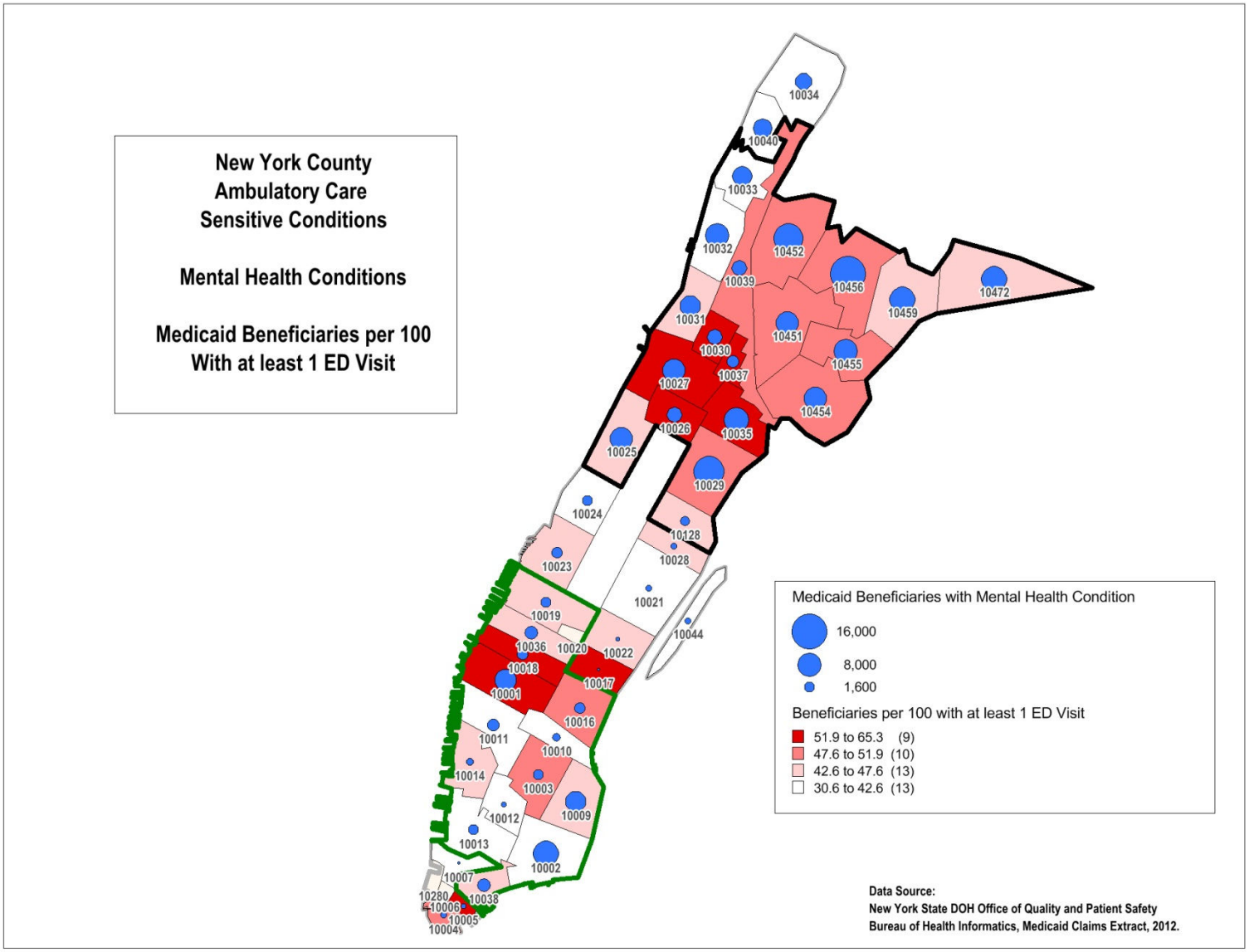
32. Mental Health CRG diagnosis Prevalence Among Medicaid Beneficiaries (by Zip Code)



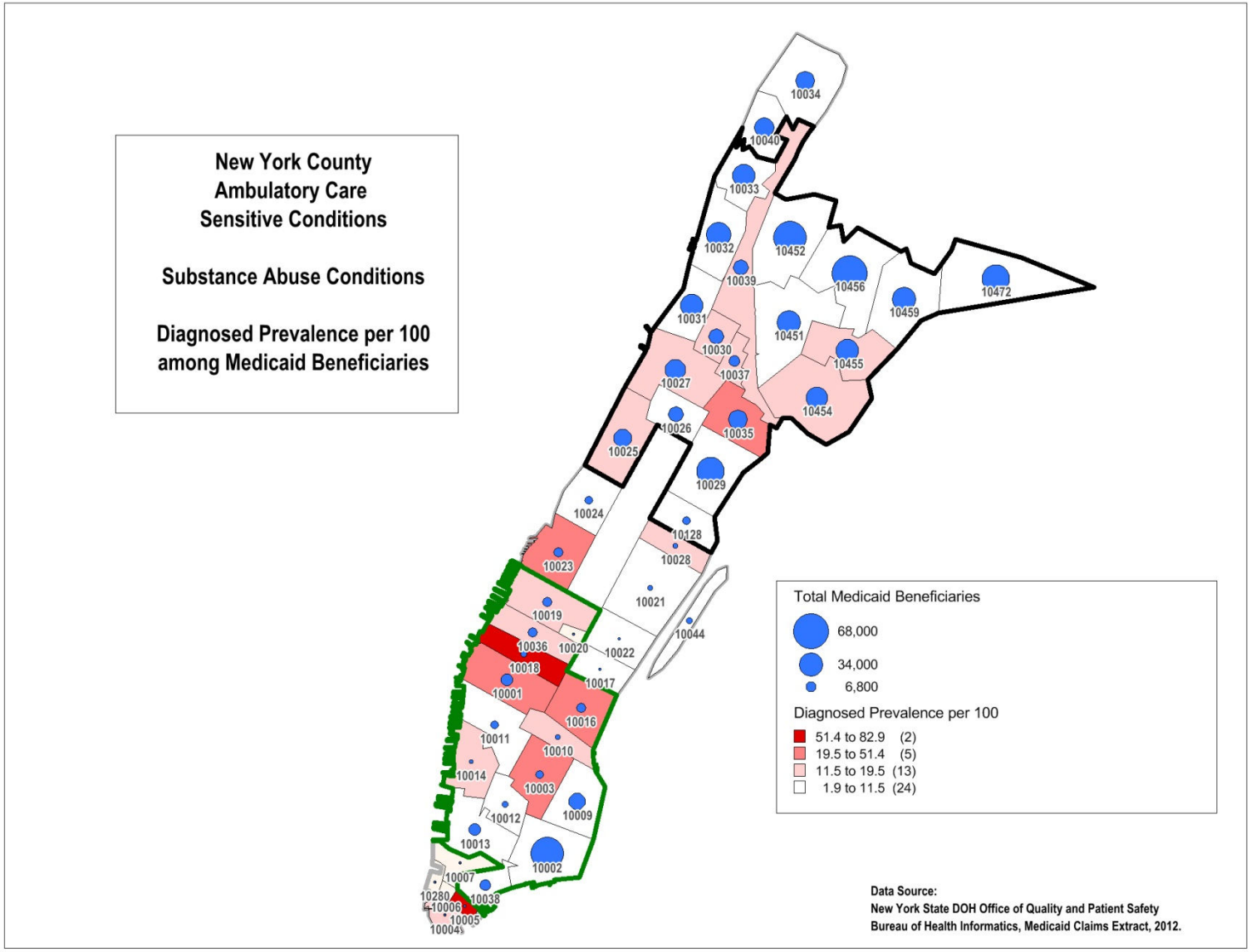
33. Percentage among Medicaid Beneficiaries with Mental Health CRG diagnosis with any inpatient admission (by Zip Code)



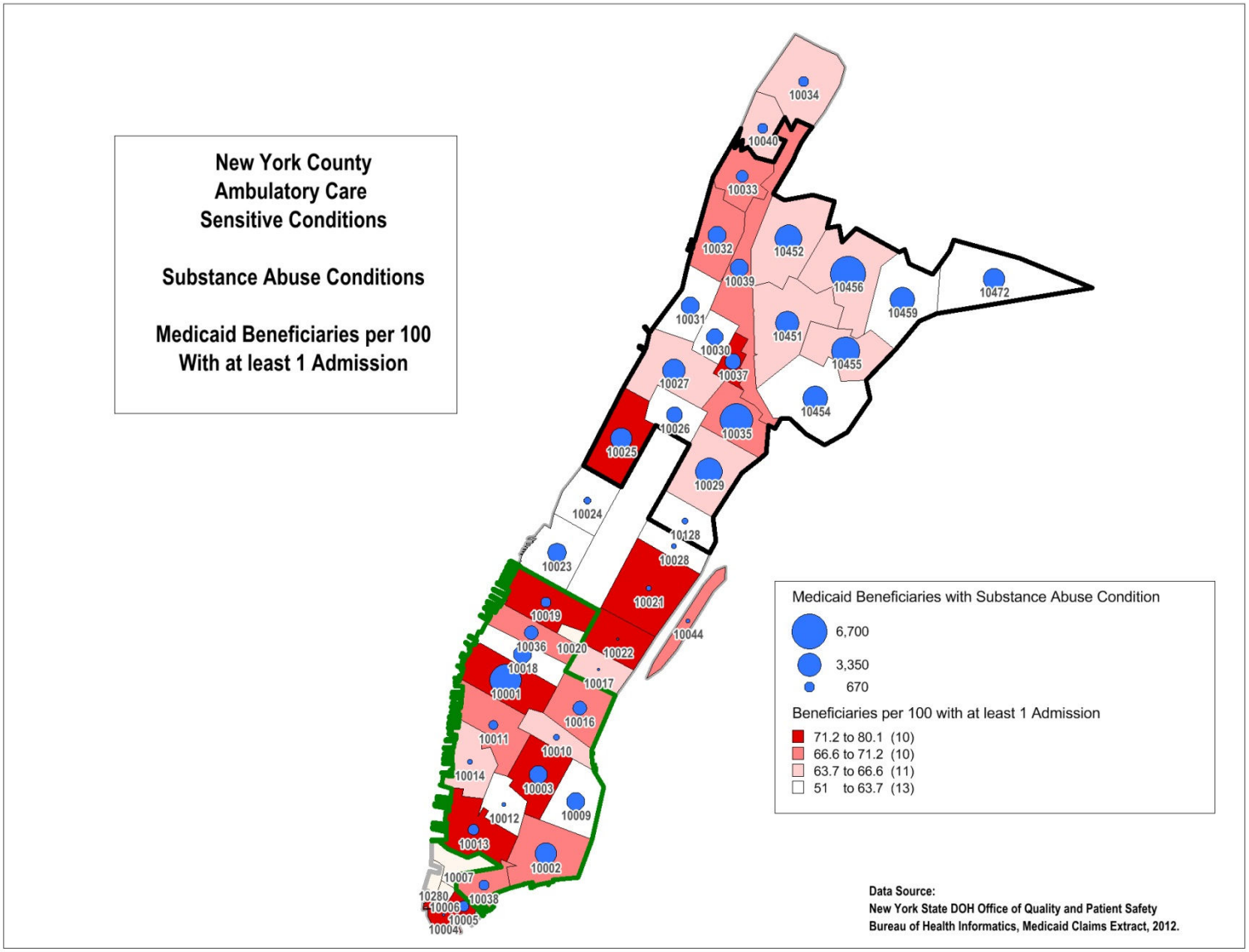
34. Percentage among Medicaid Beneficiaries with Mental Health CRG diagnosis with any emergency department visit (by Zip Code)



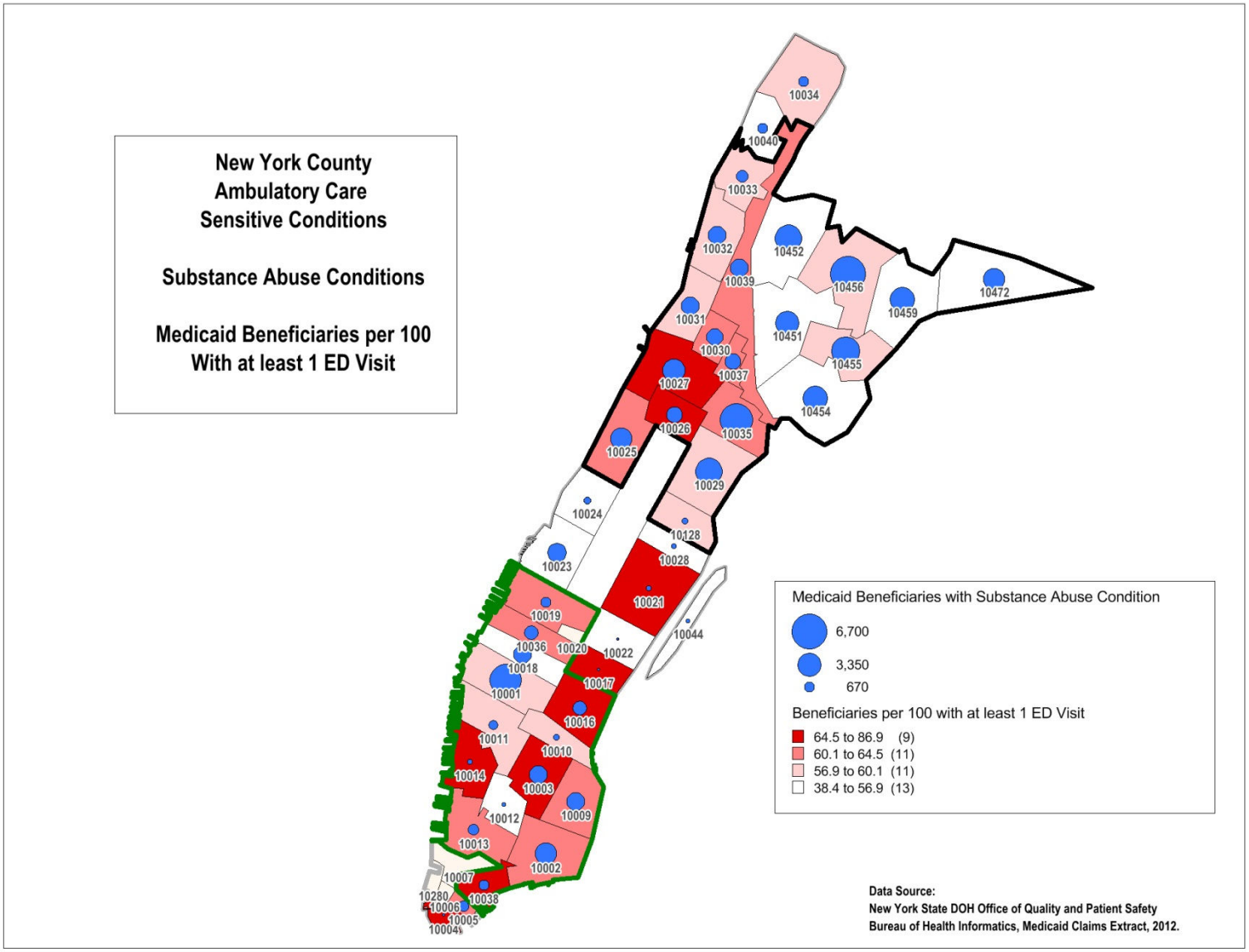
35. Subtance Abuse CRG diagnosis Prevalence Among Medicaid Beneficiaries (by Zip Code)



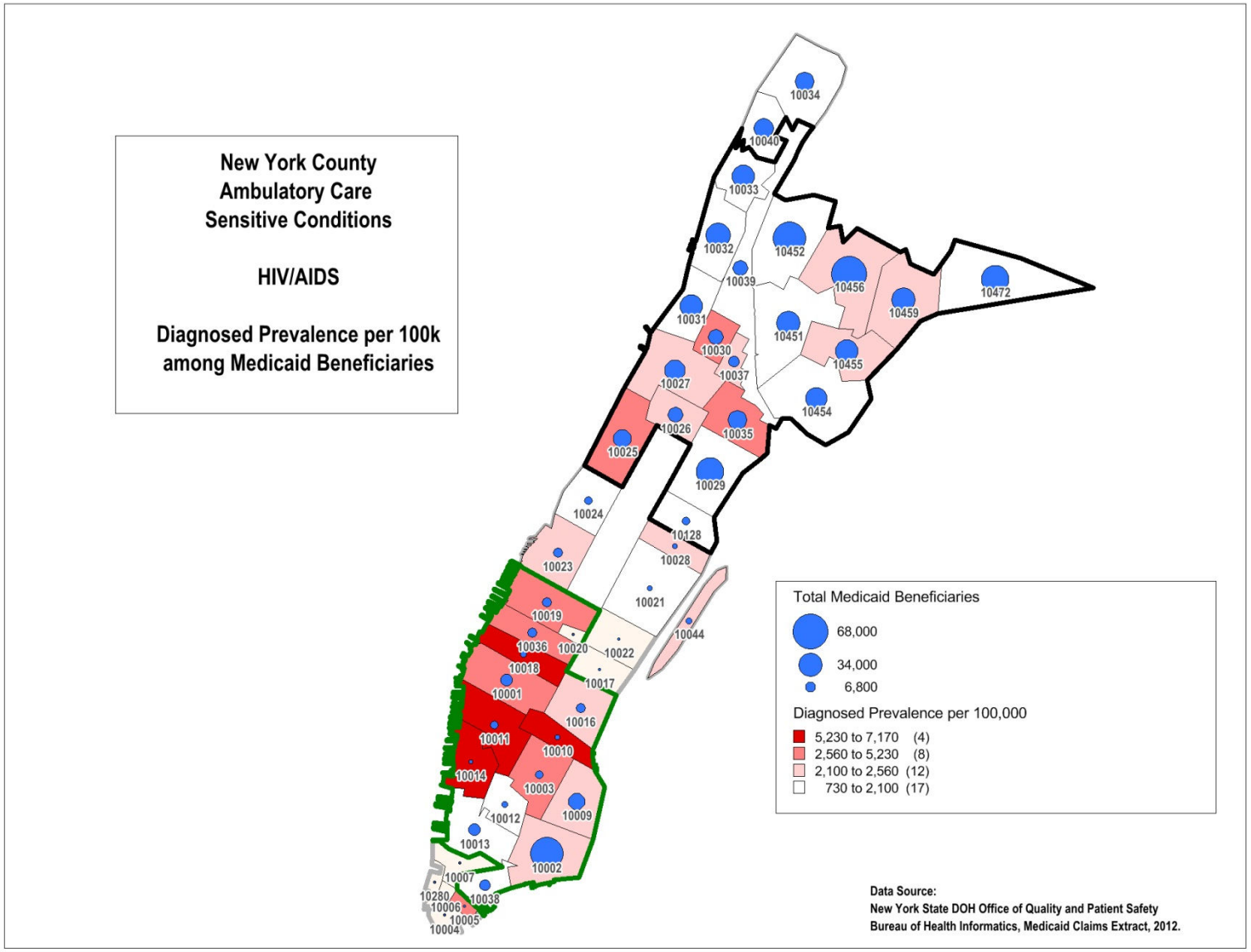
36. Percentage among Medicaid Beneficiaries with Subtance Abuse CRG diagnosis with any inpatient admission (by Zip Code)



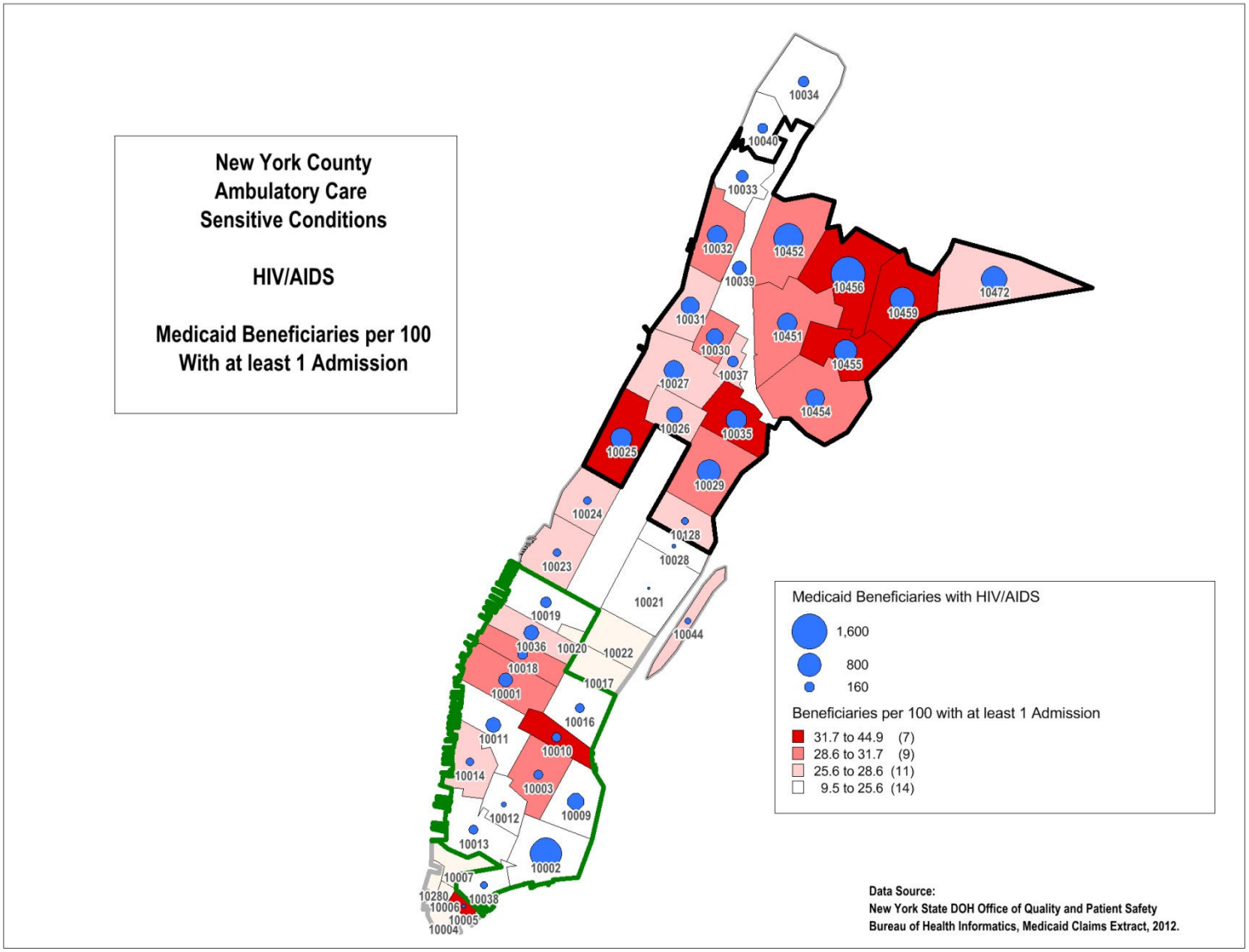
37. Percentage among Medicaid Beneficiaries with Subtance Abuse CRG diagnosis with any emergency department visit (by Zip Code)



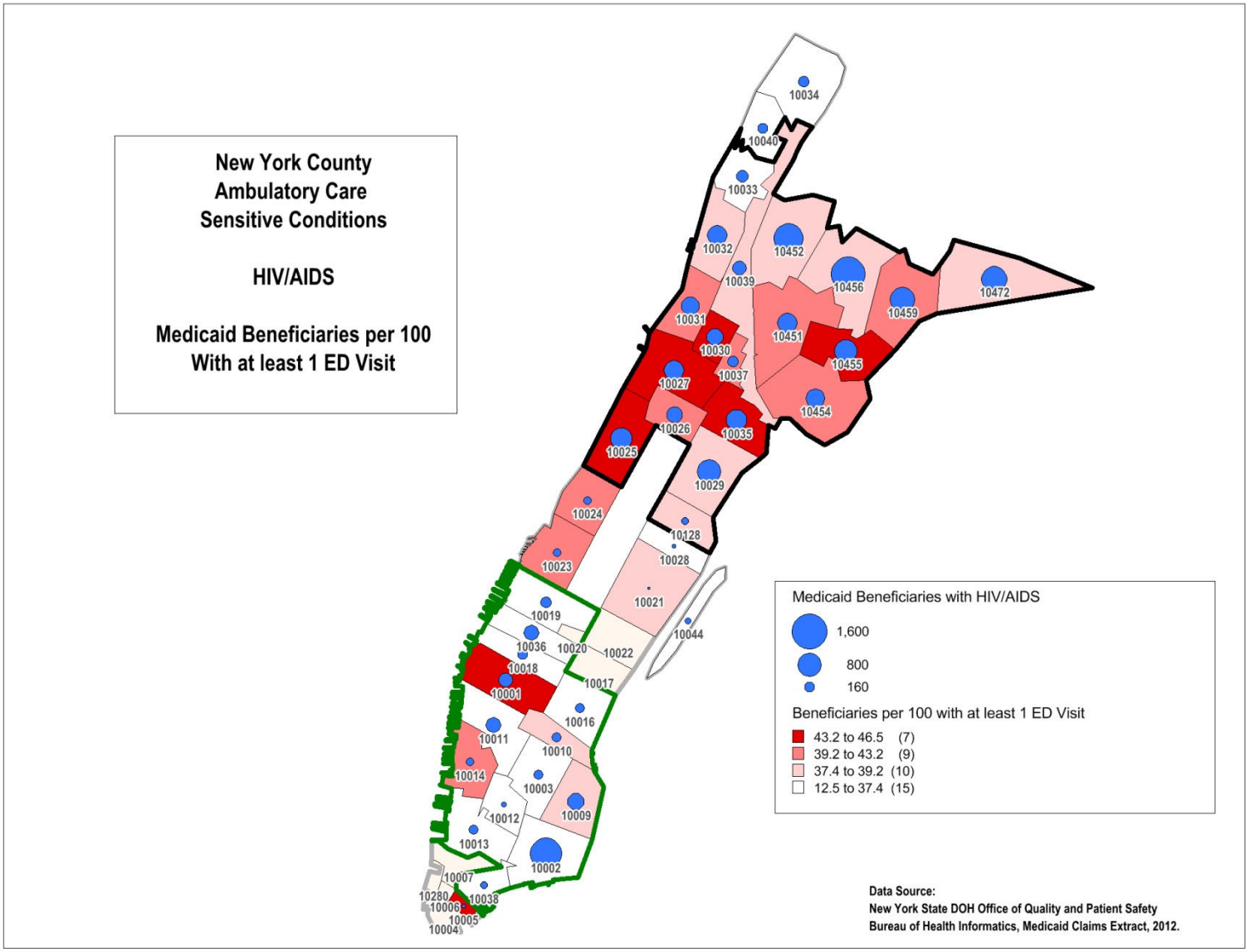
38. HIV Diagnosis Prevalence Among Medicaid Beneficiaries (by Zip Code)



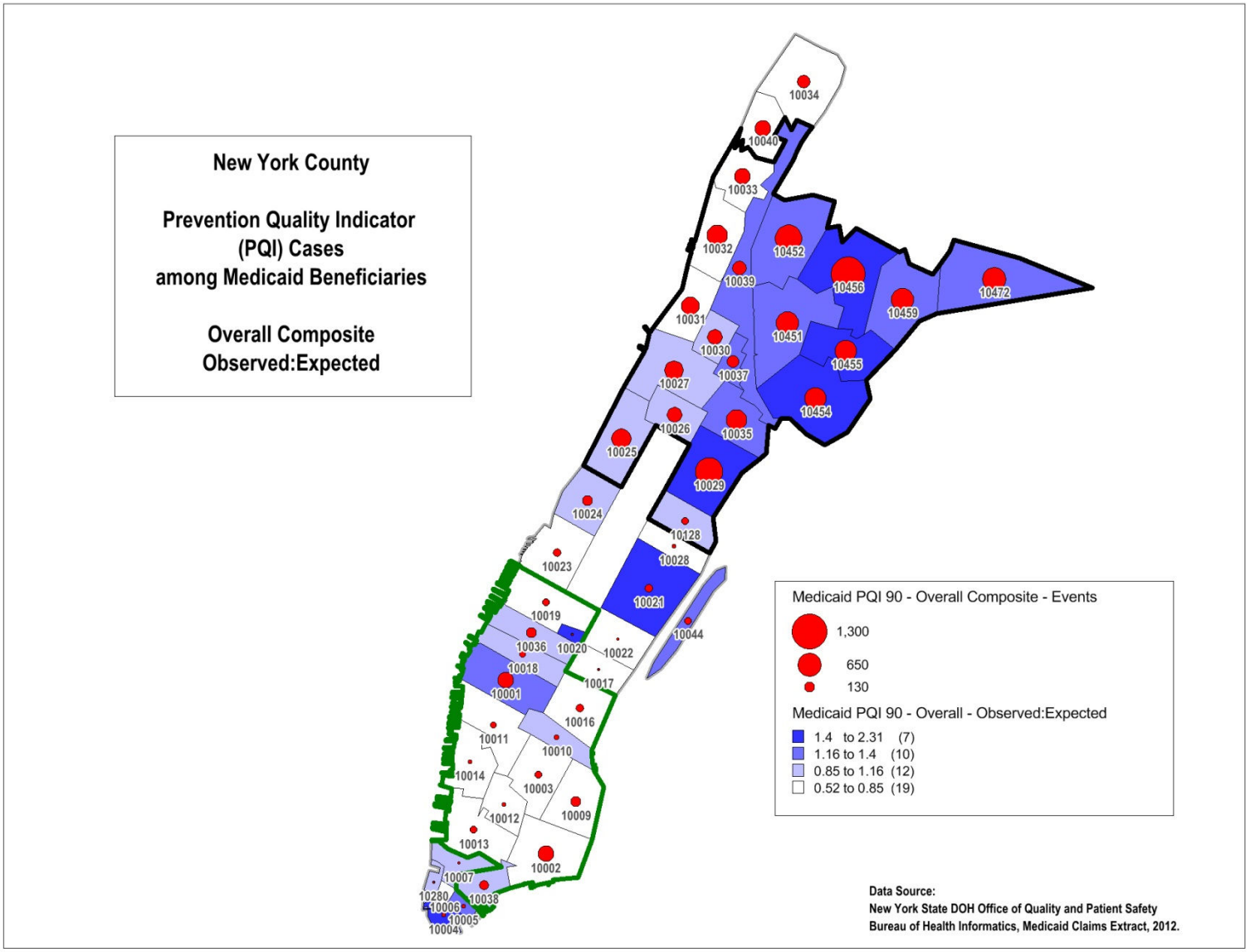
39. Percentage among Medicaid Beneficiaries with HIV Diagnosis with any inpatient admission (by Zip Code)



40. Percentage among Medicaid Beneficiaries with HIV Diagnosis with any emergency department visit (by Zip Code)



41. PQI Overall Composite Cases (PQI 90) by Zip Code



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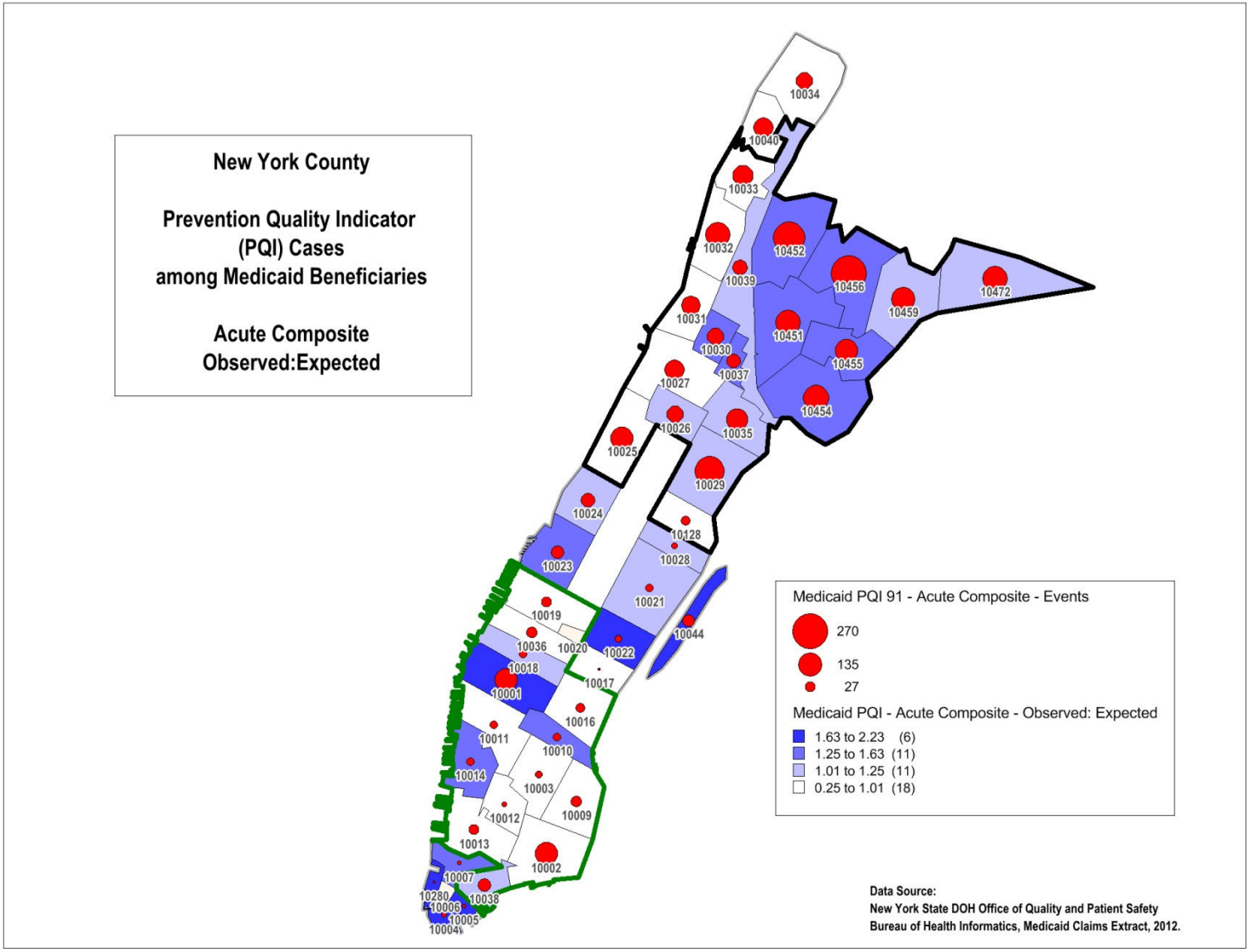
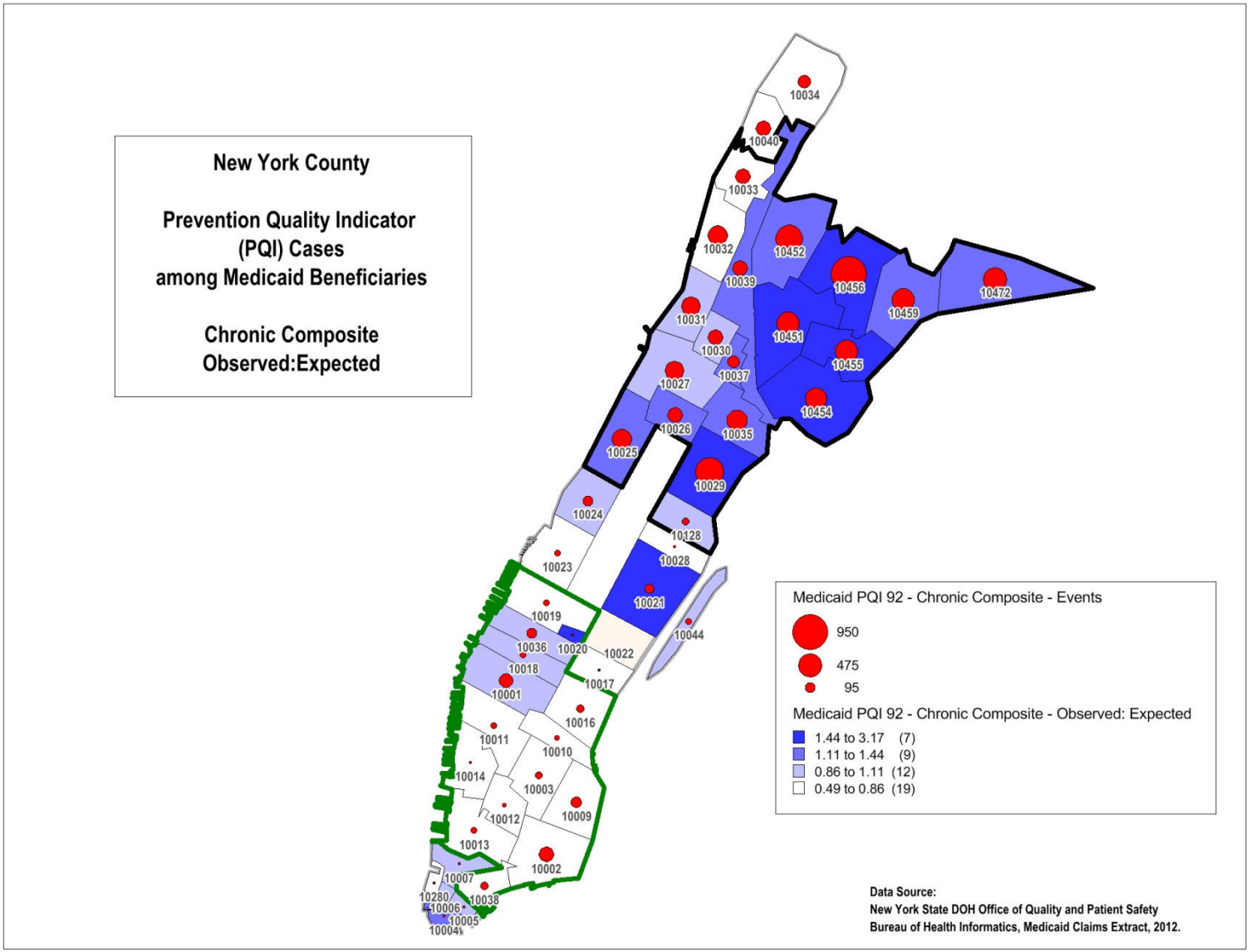


43. PQI Chronic Composite Cases (PQI 92) by Zip Code



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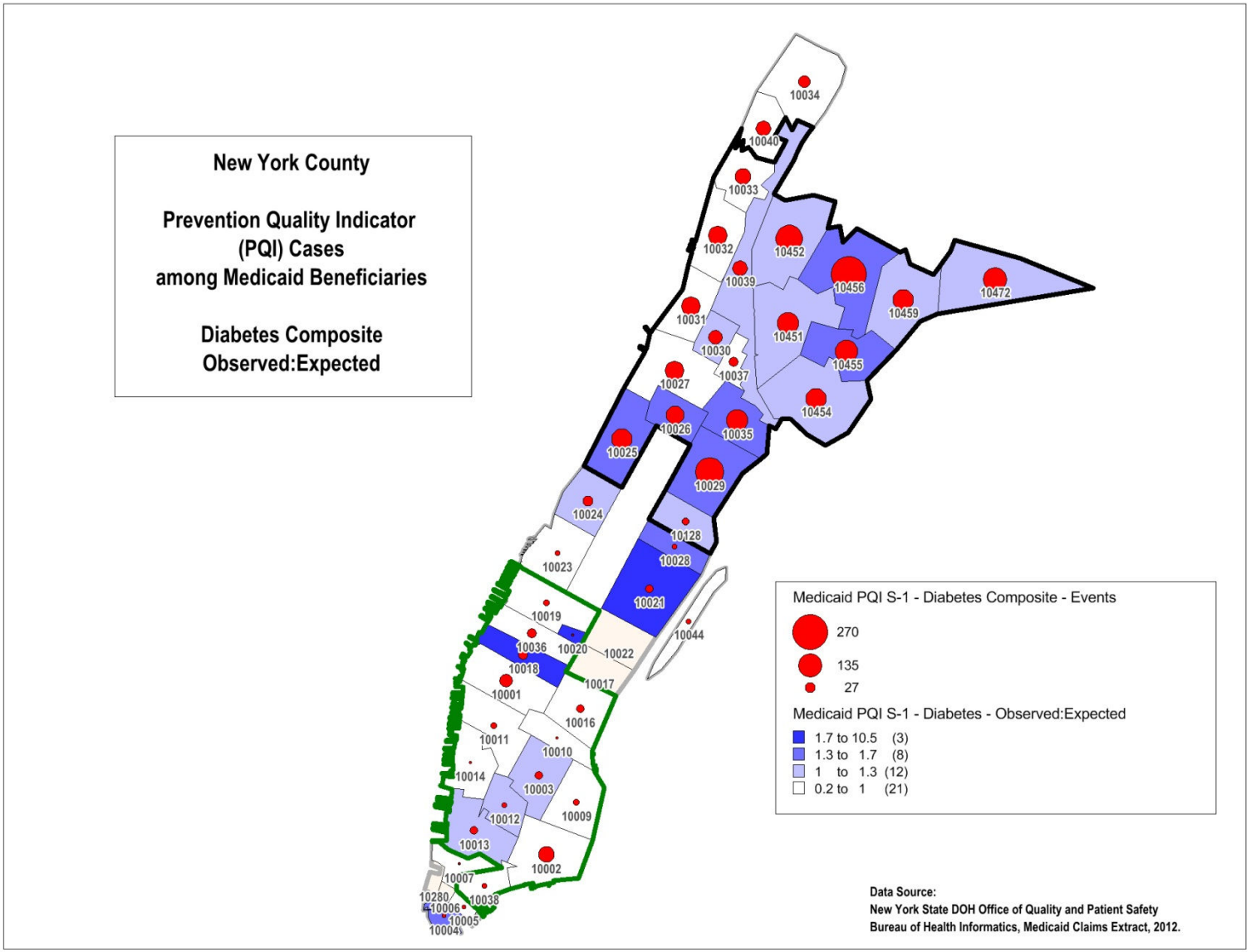

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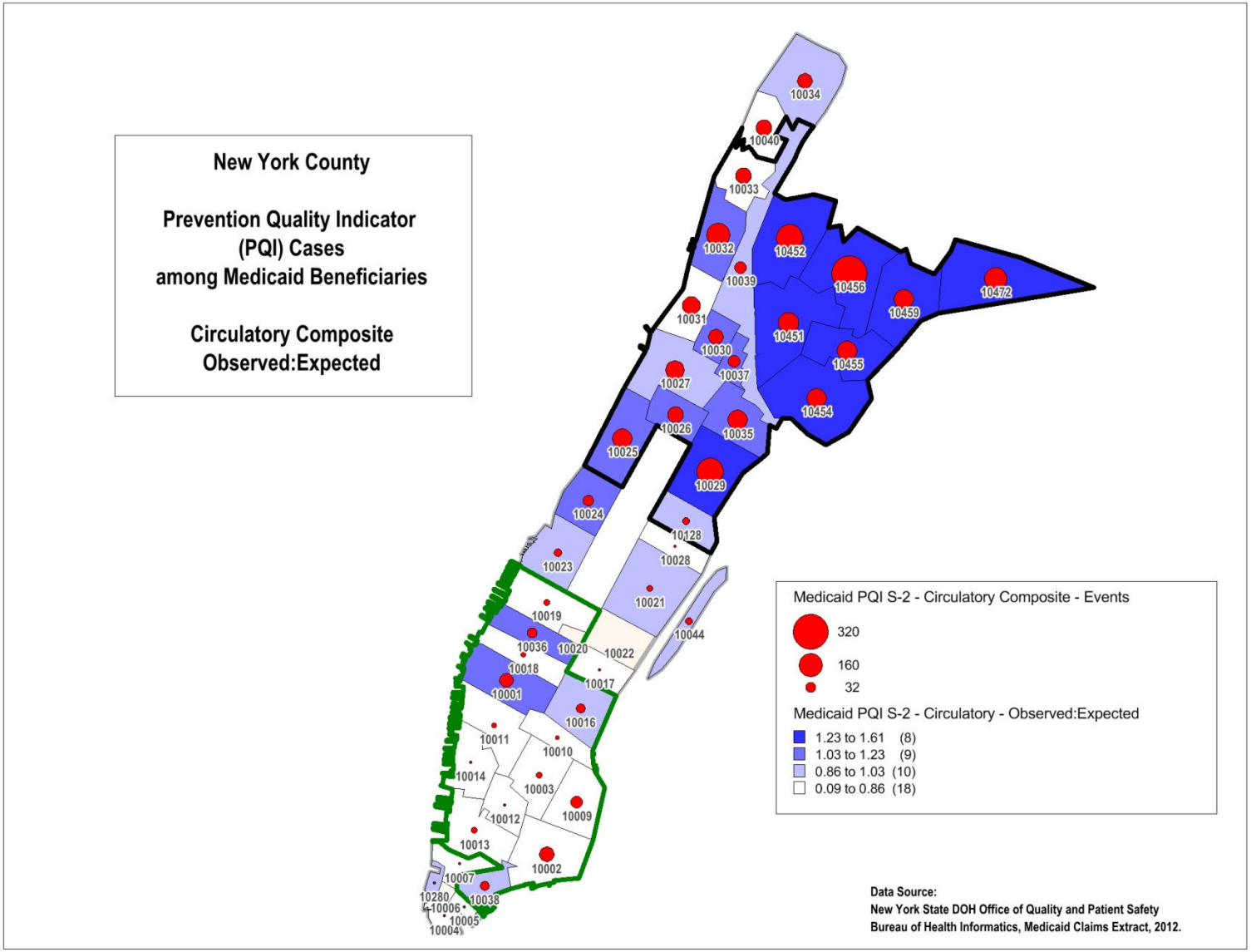

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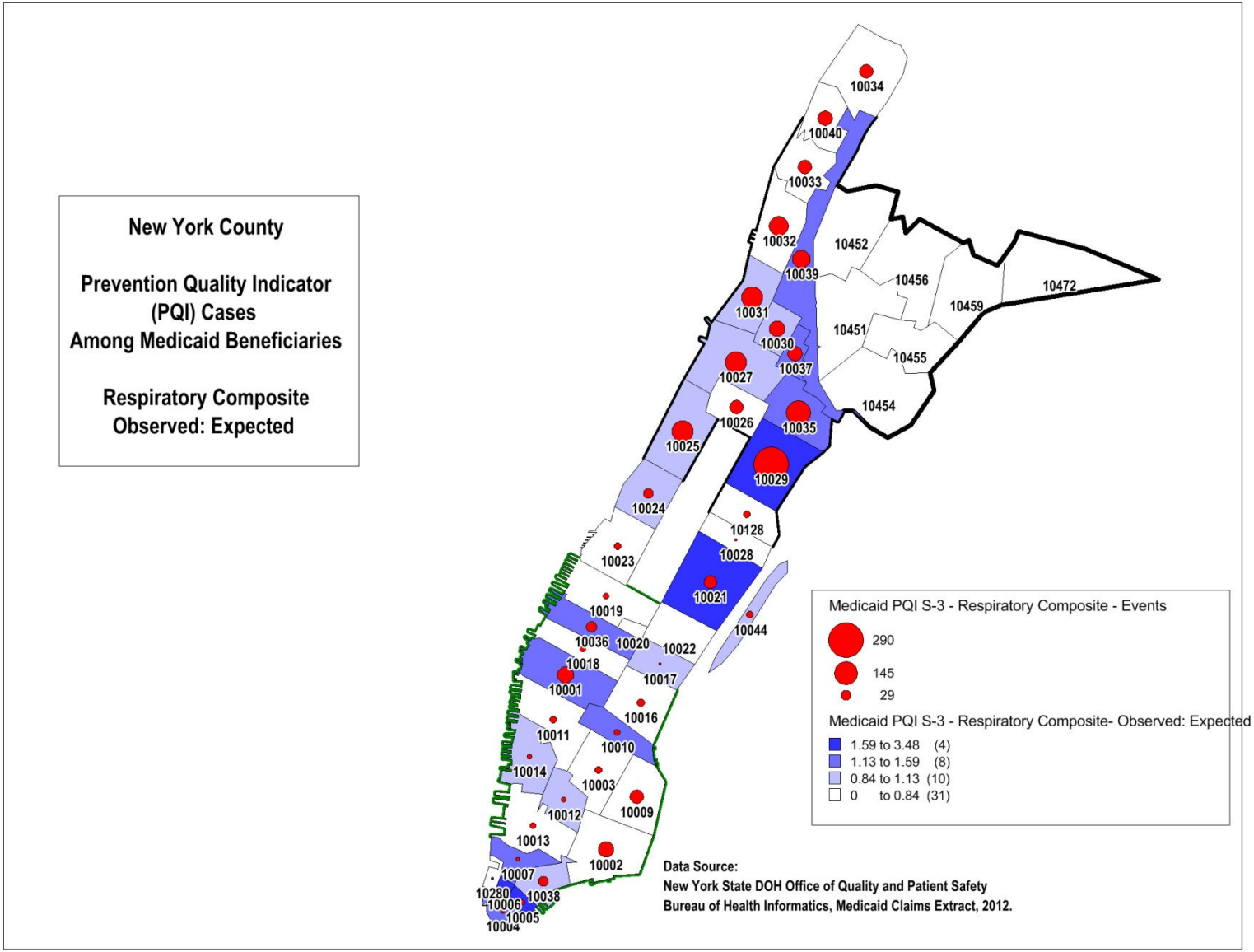

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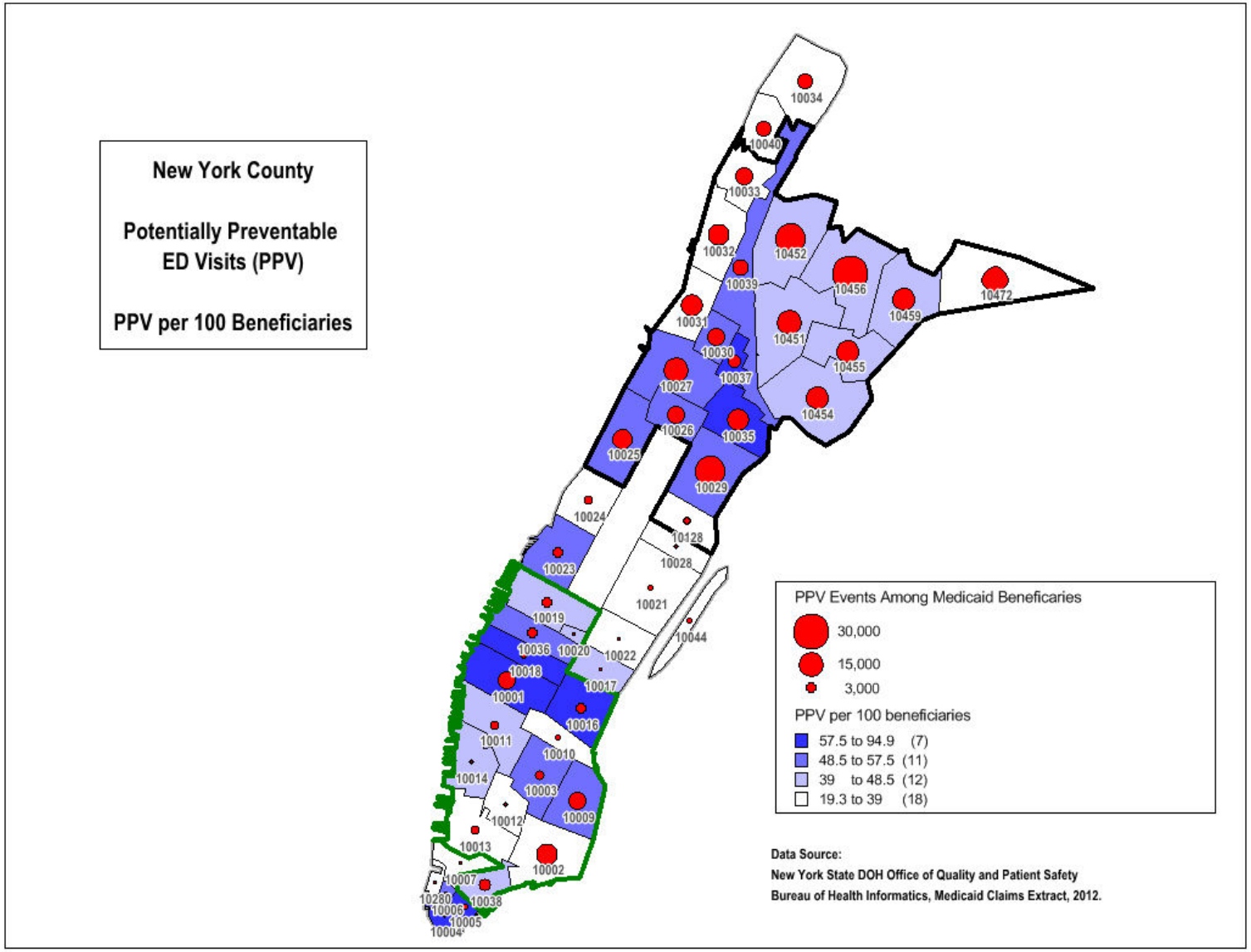

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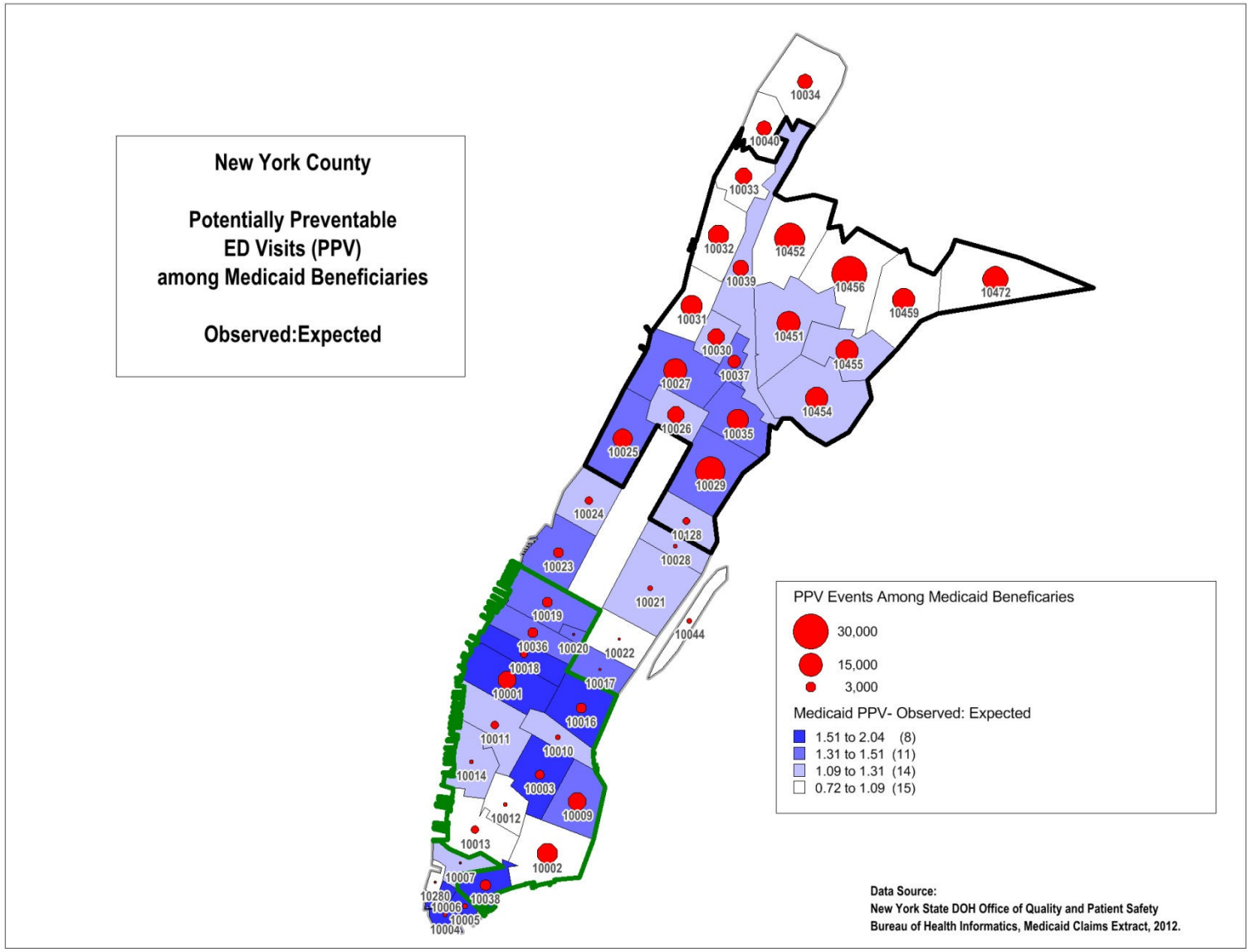

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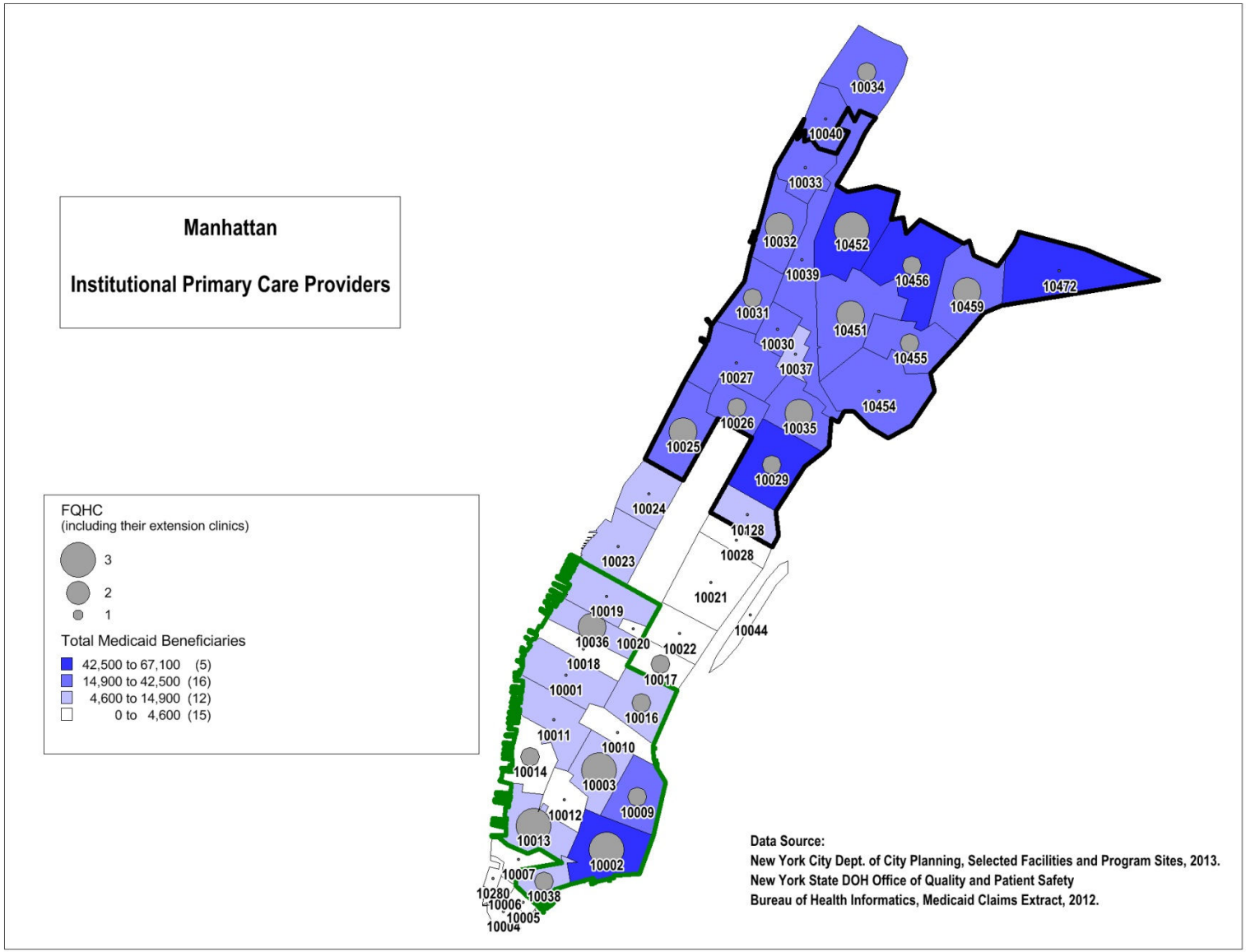

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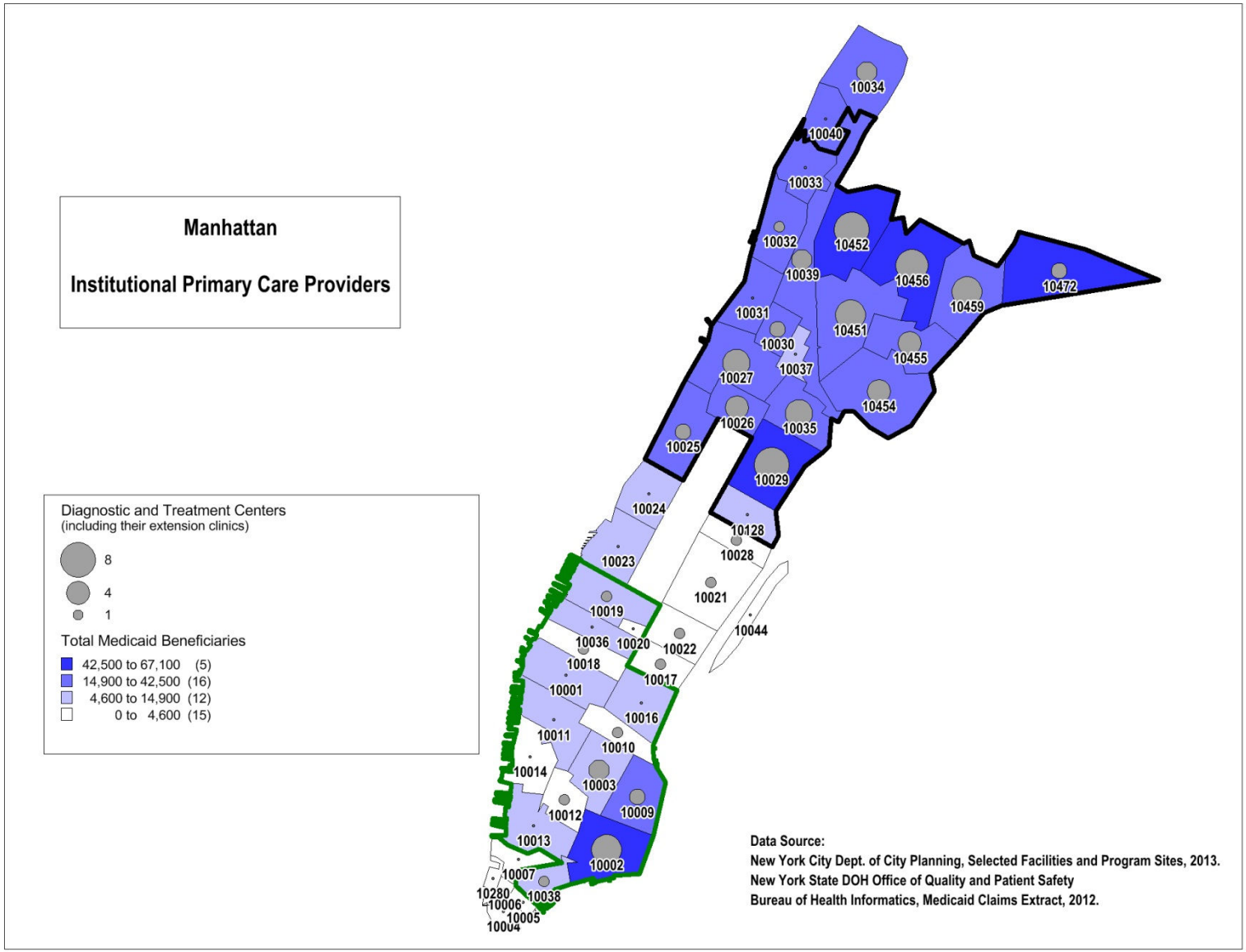

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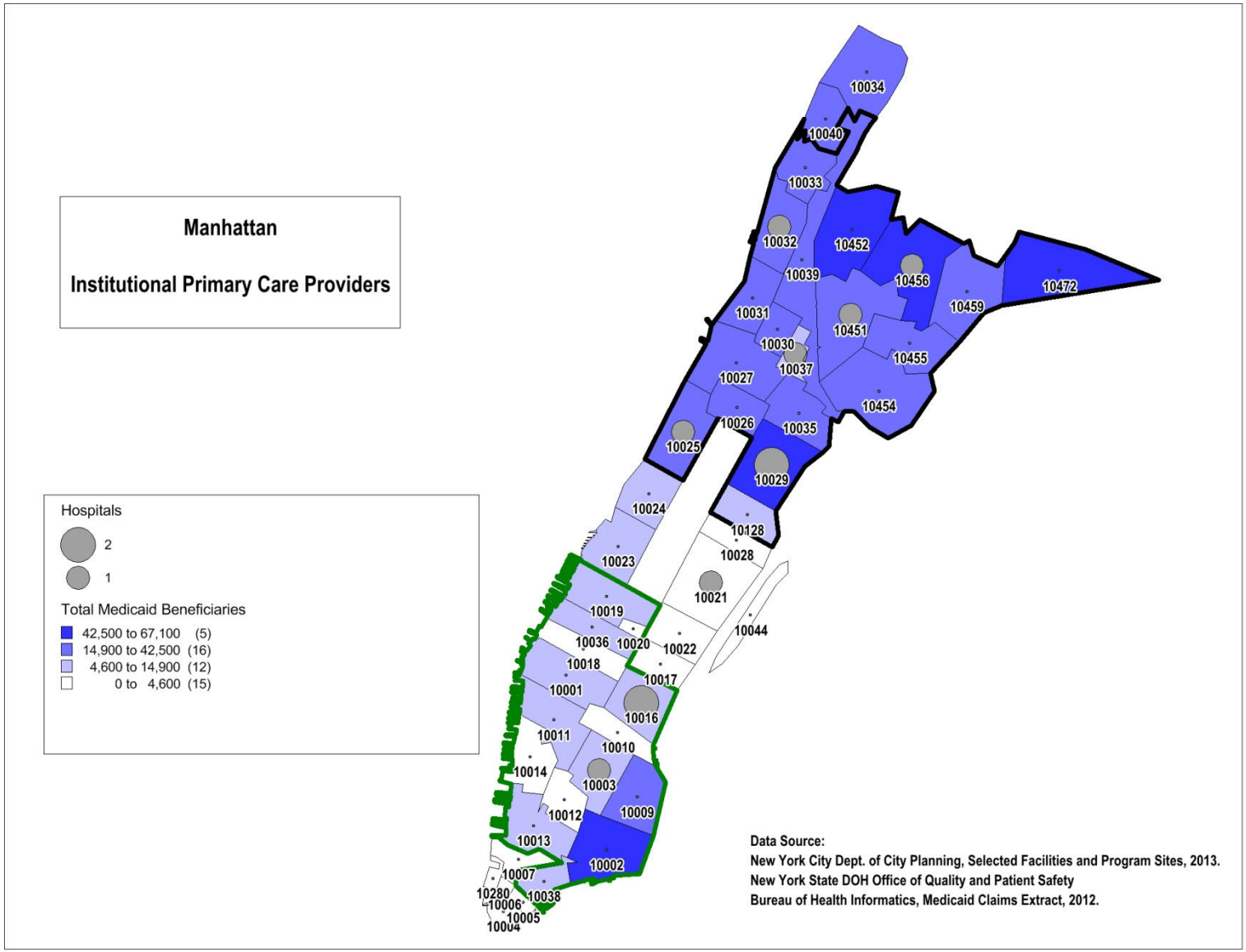

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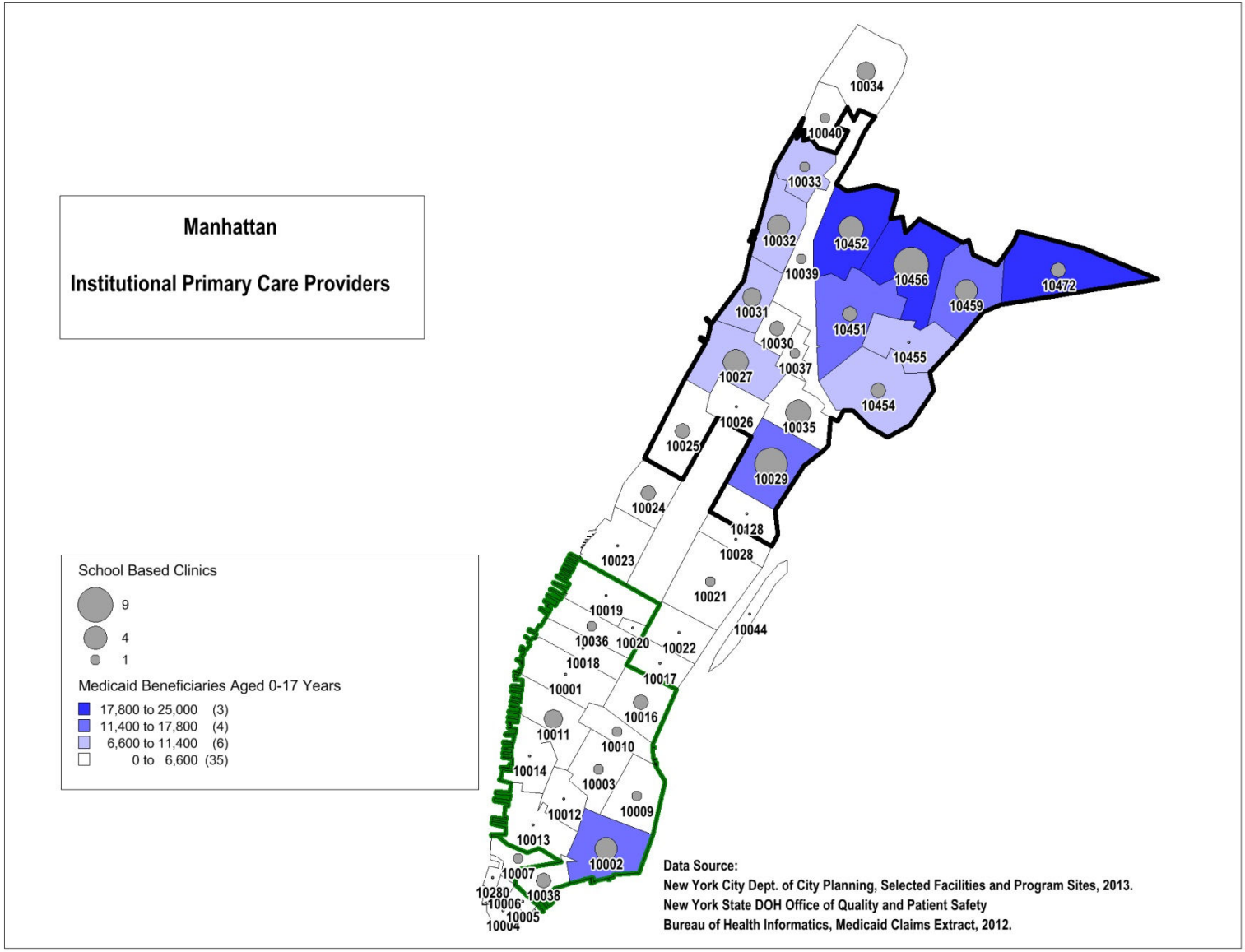

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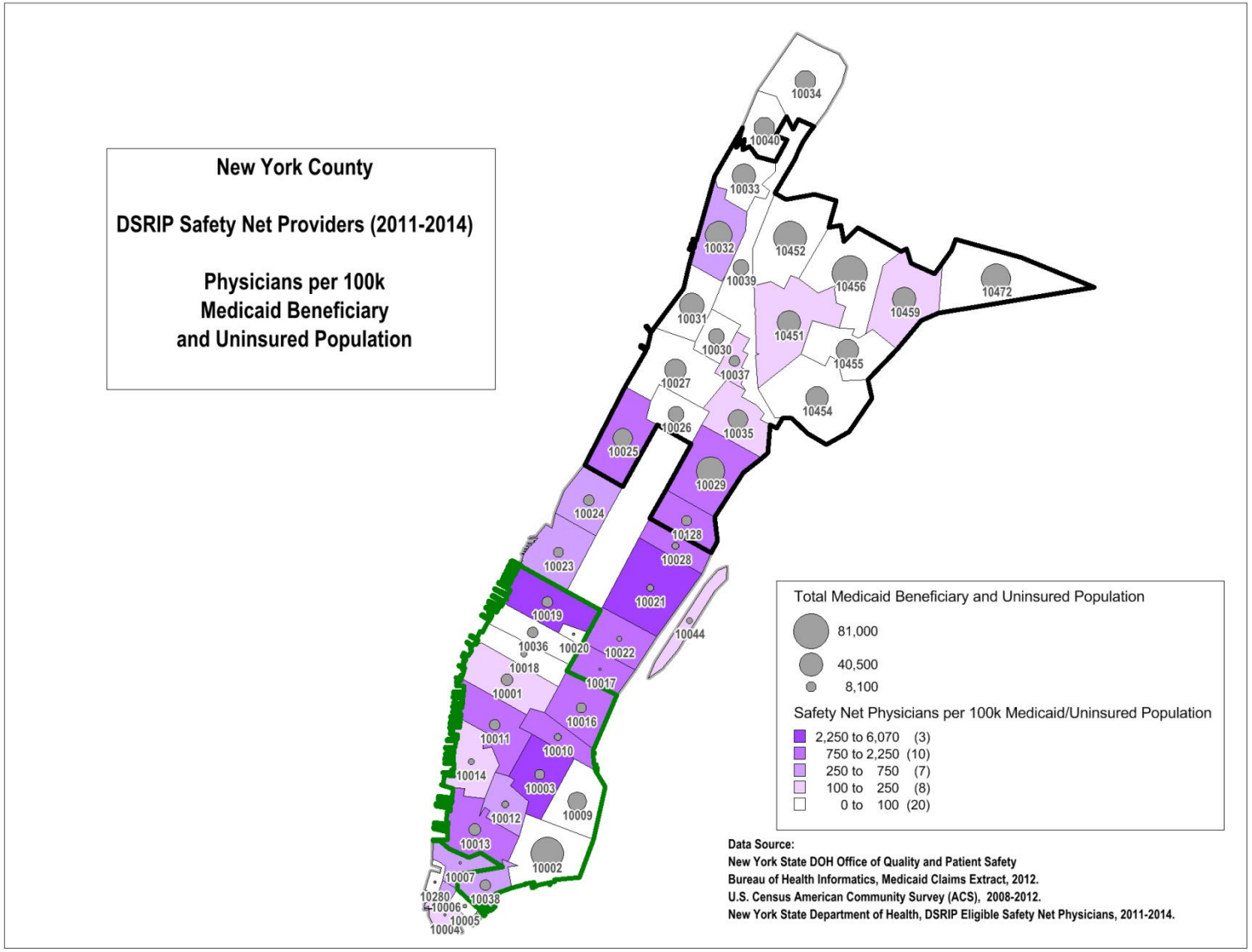

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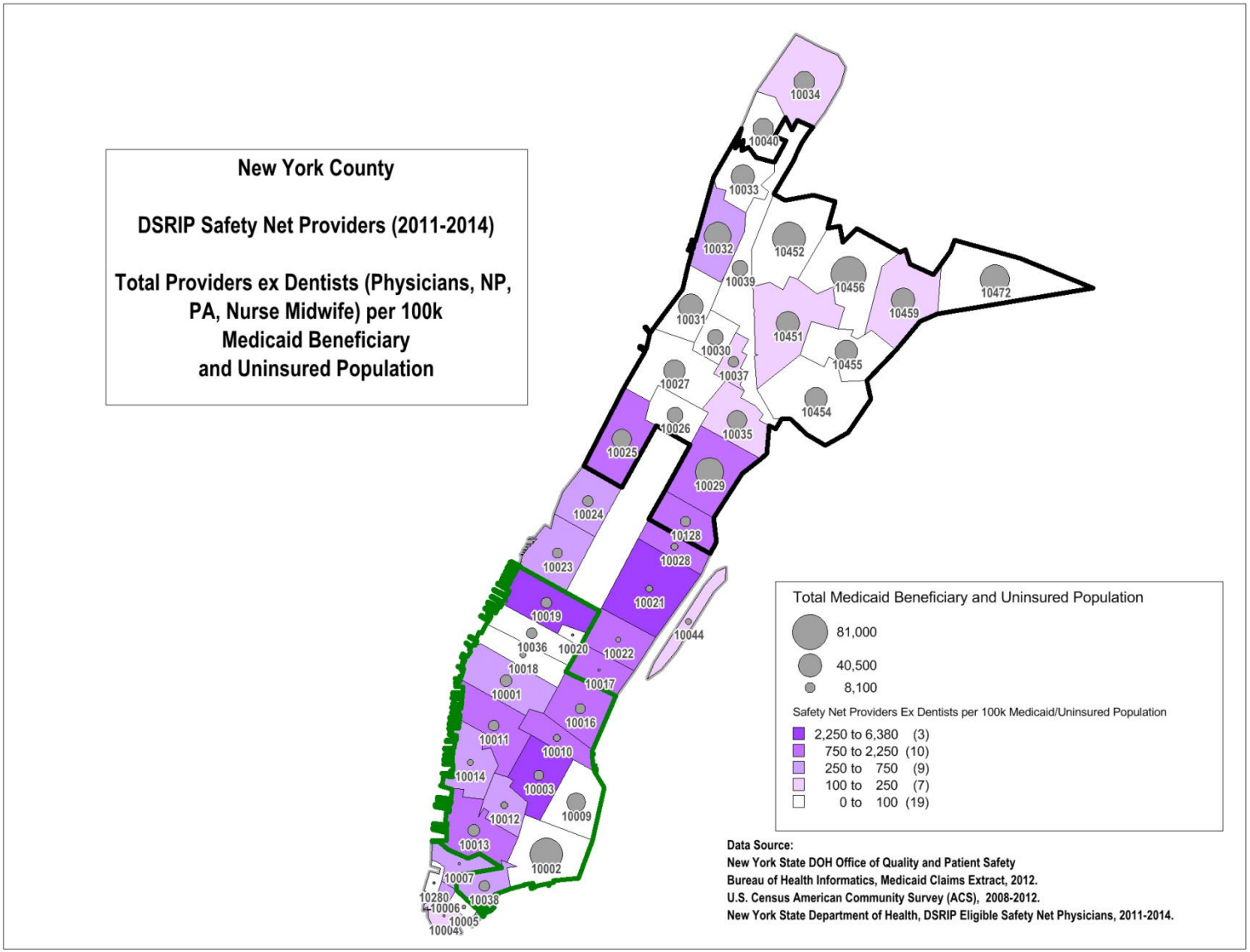

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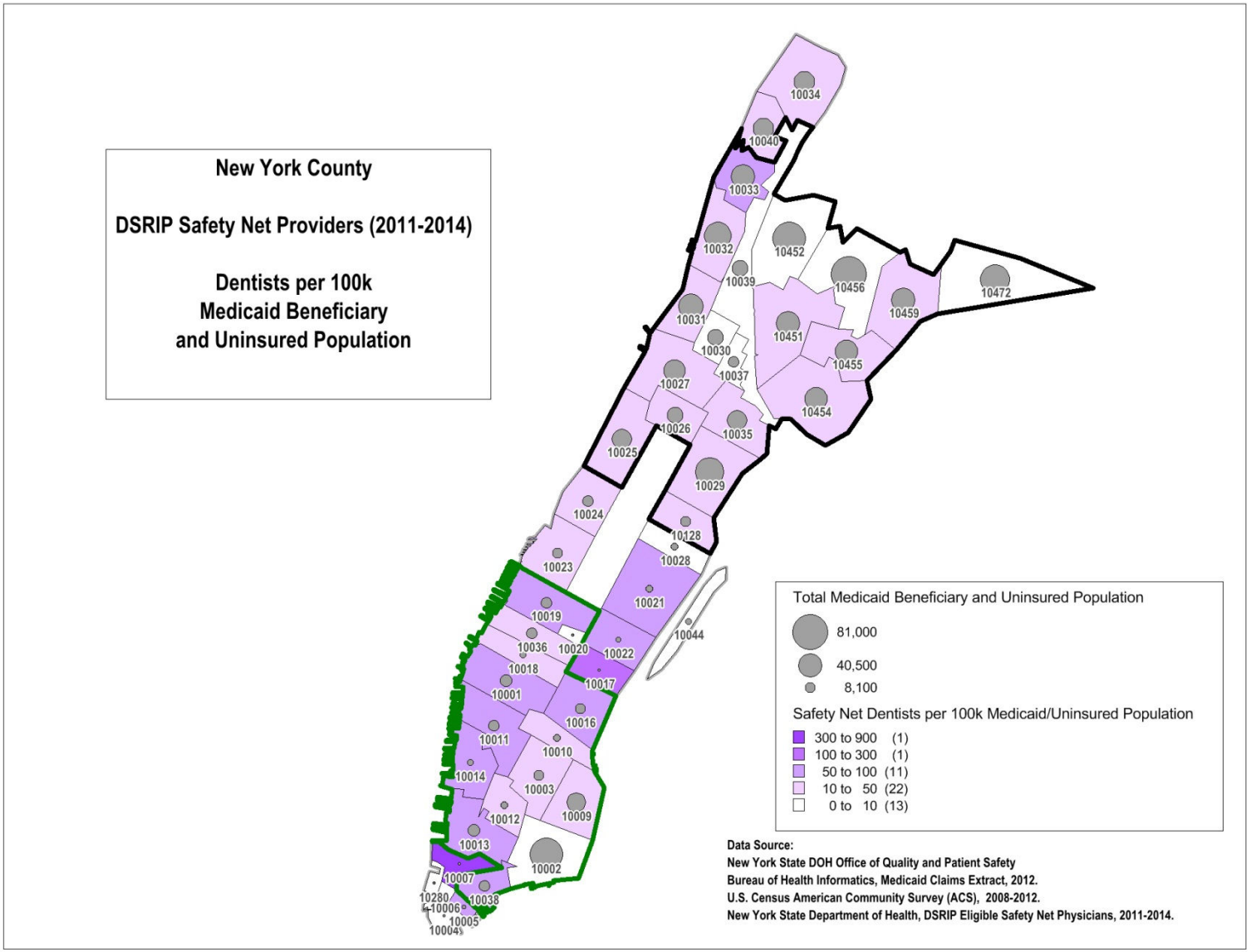

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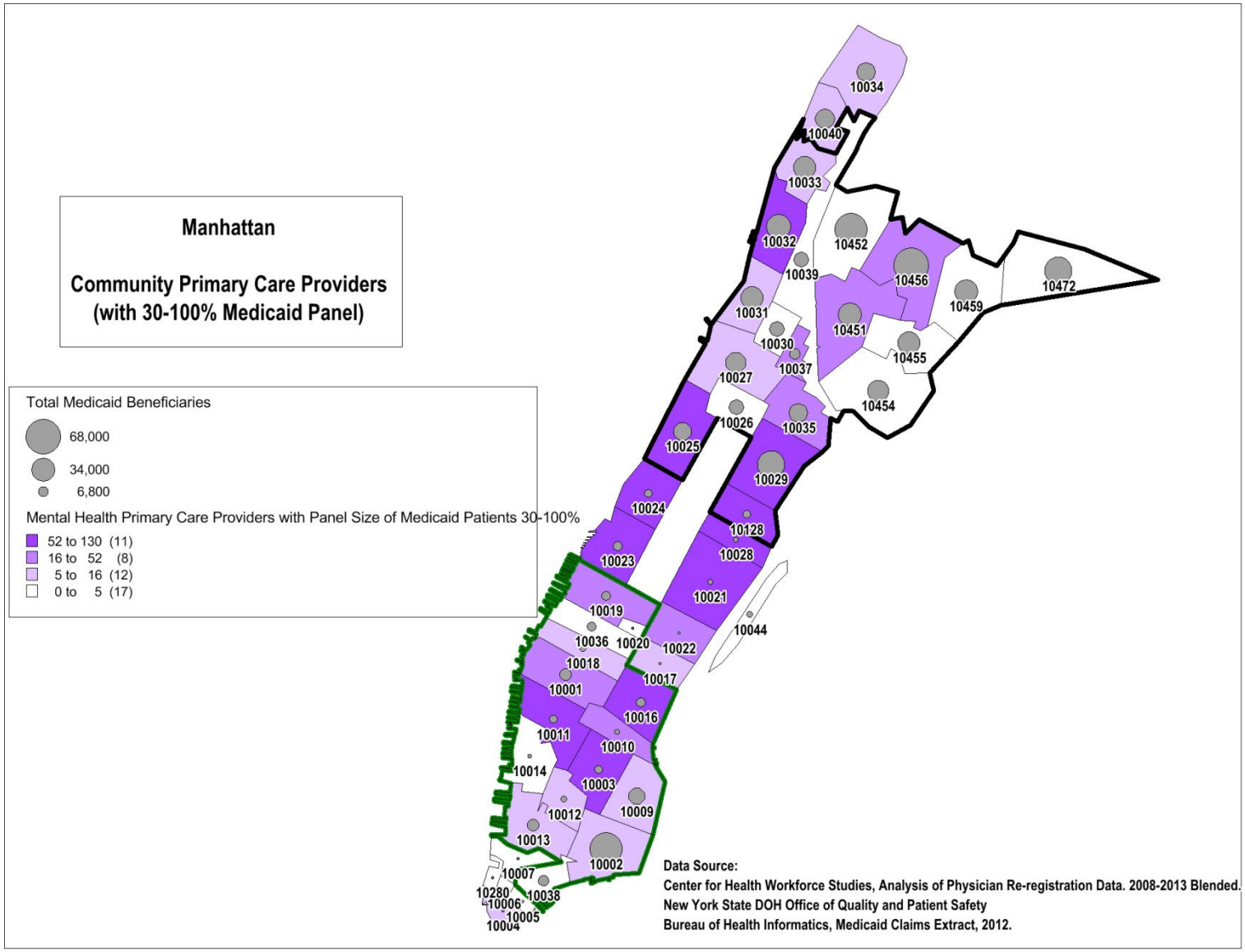

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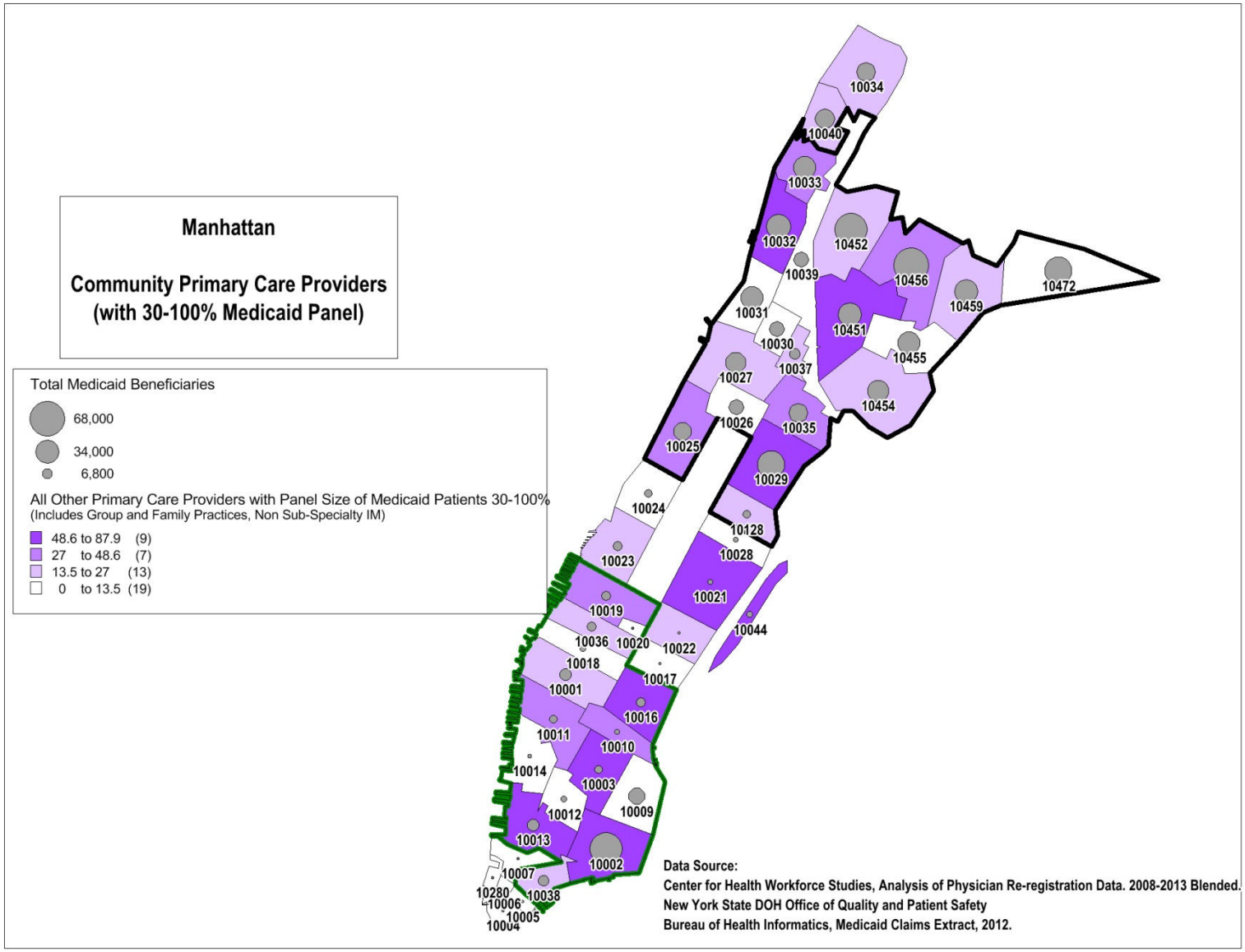

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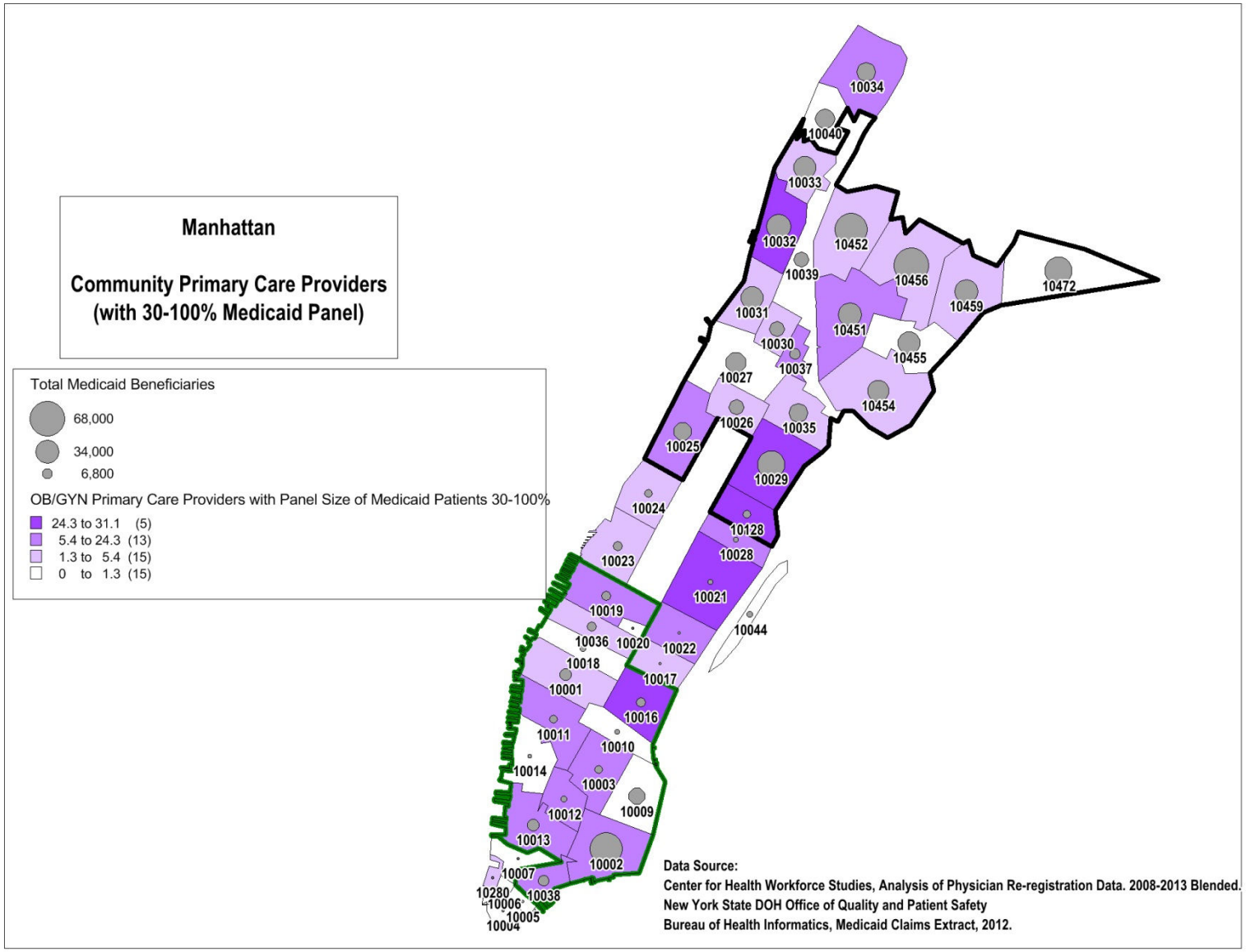

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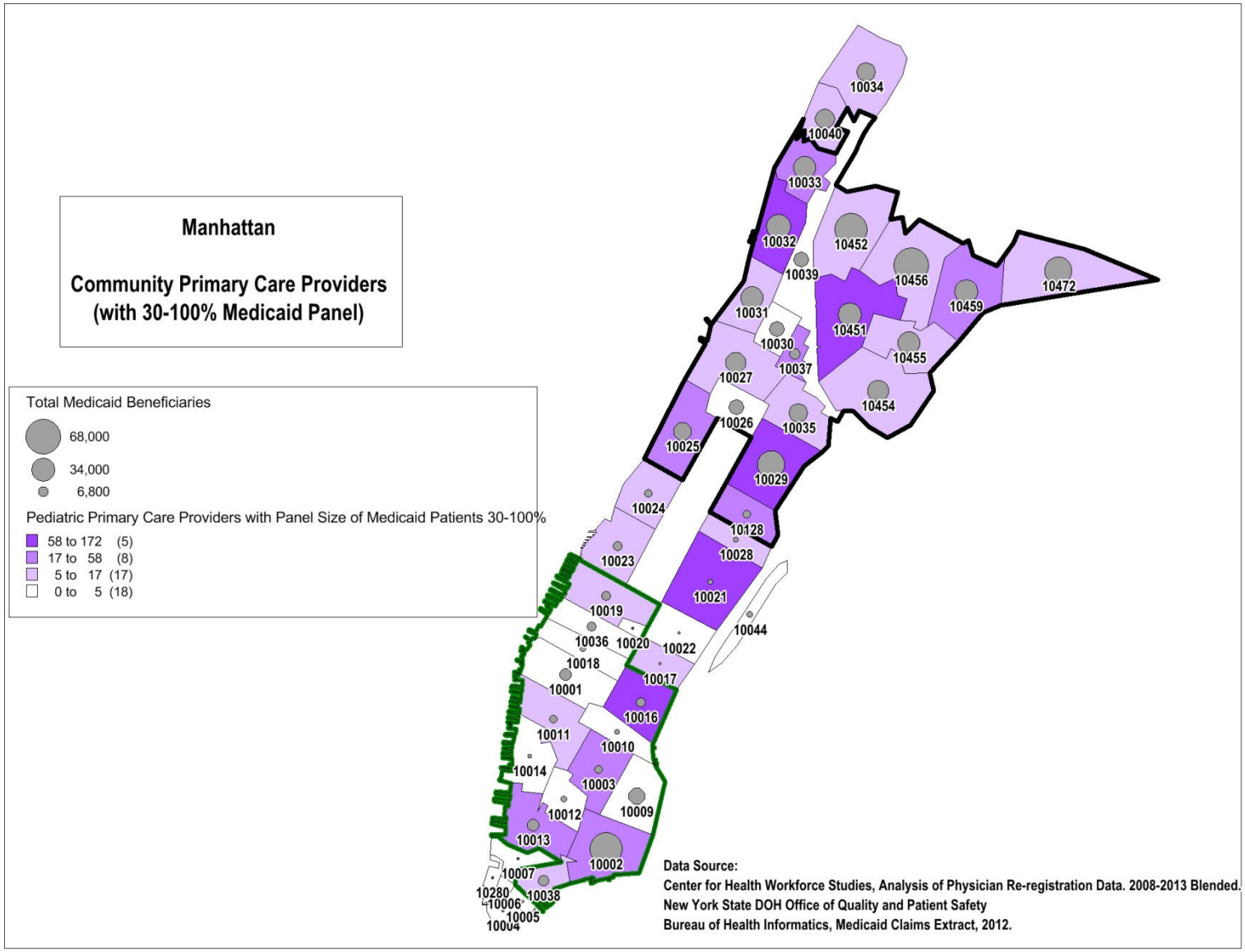

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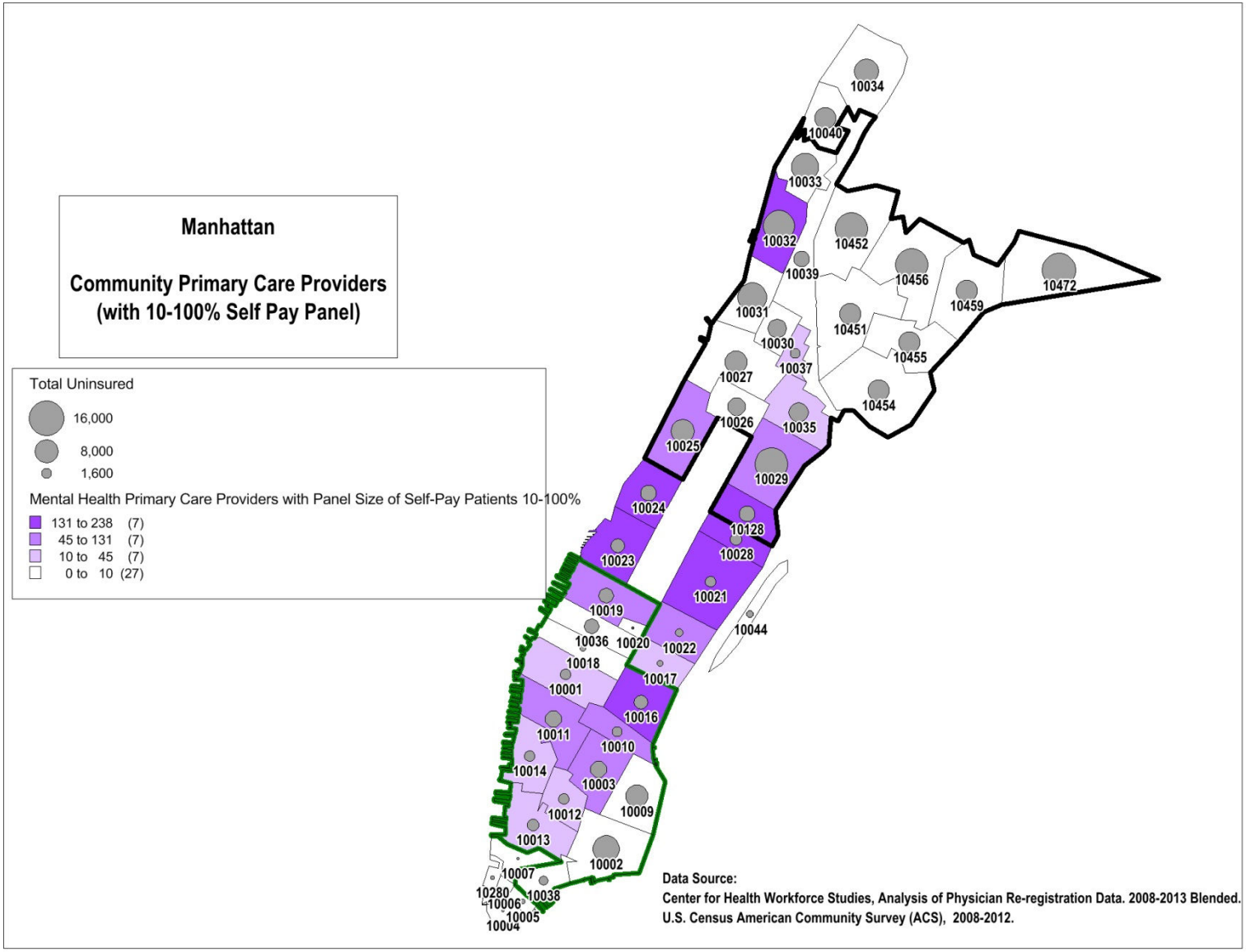

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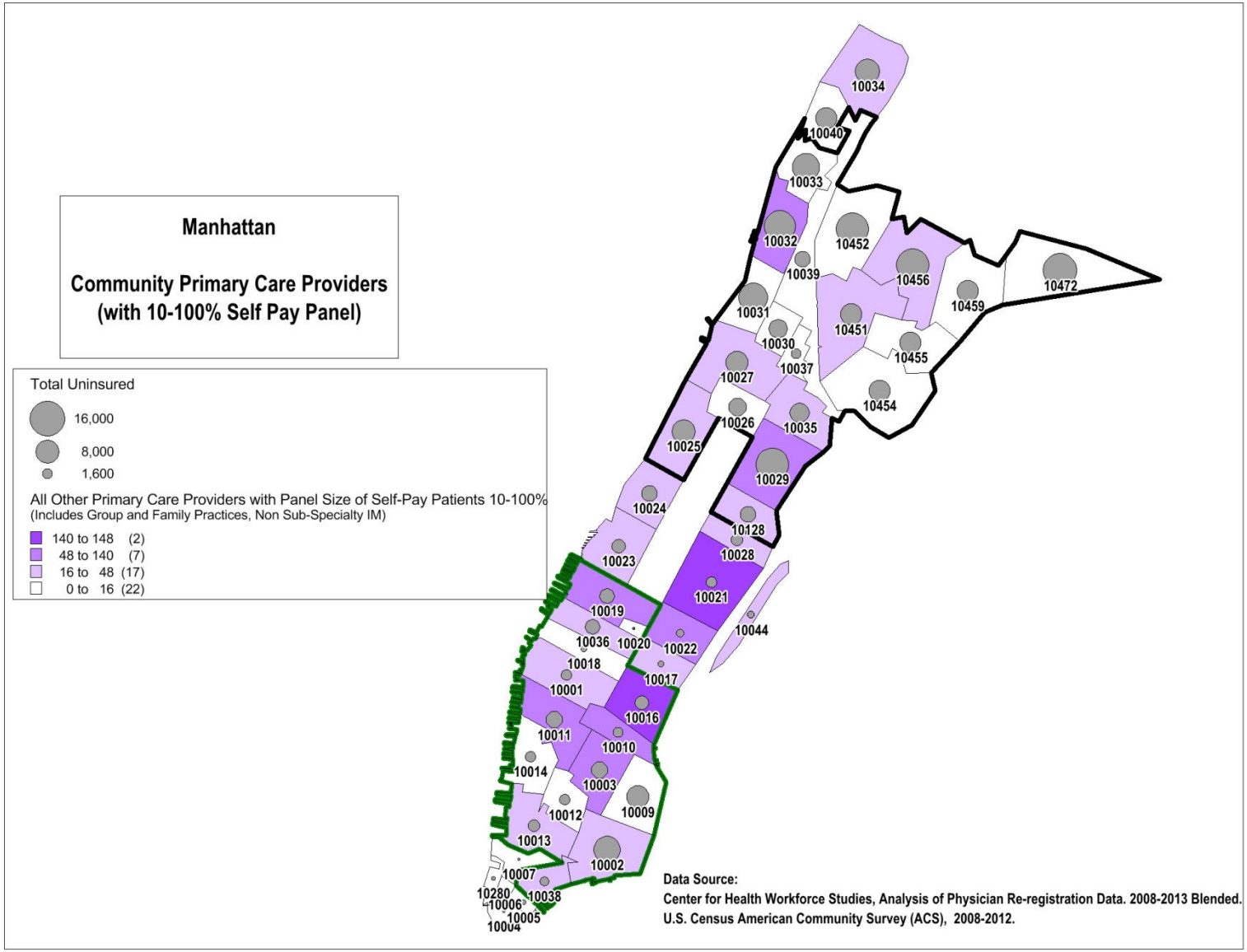

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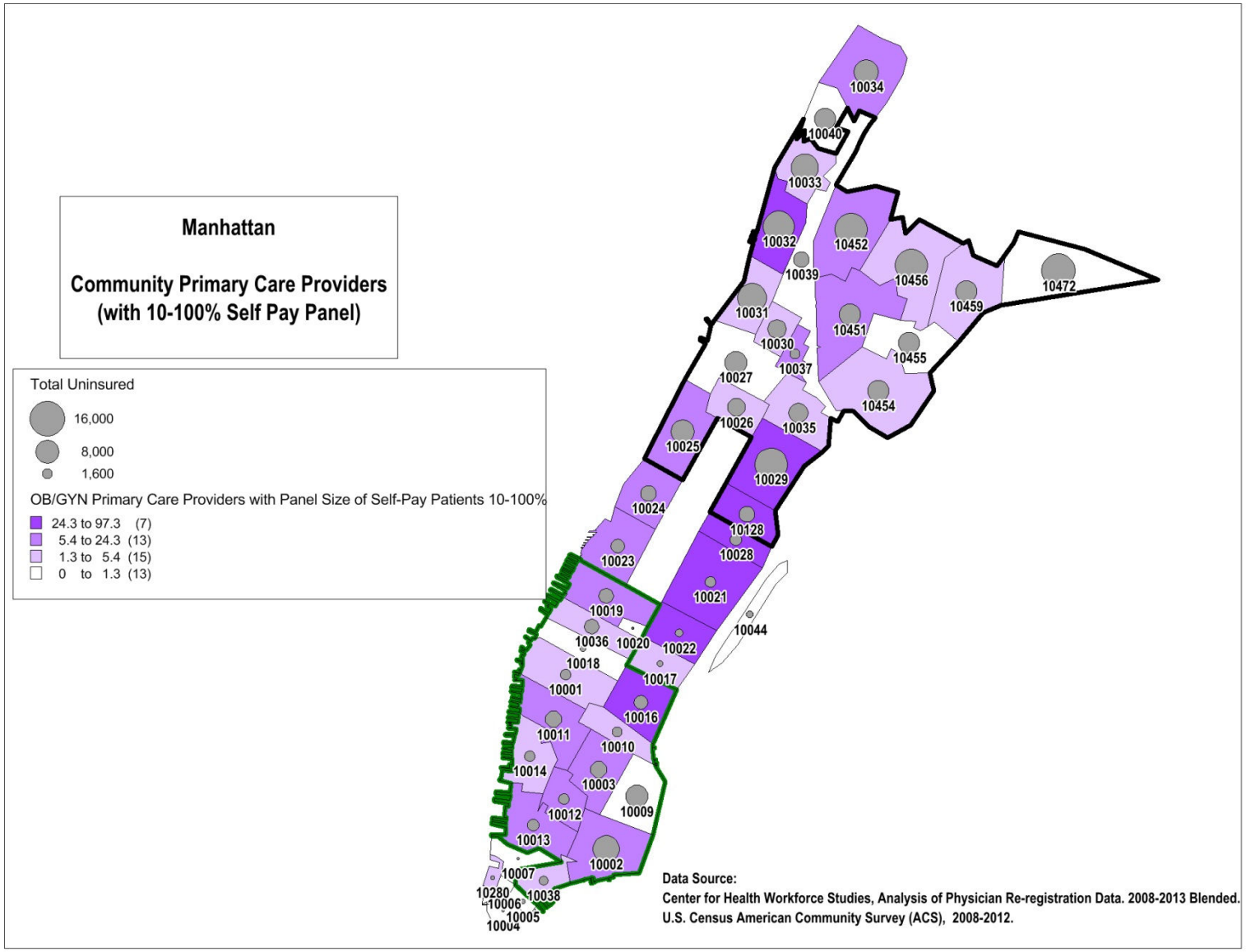

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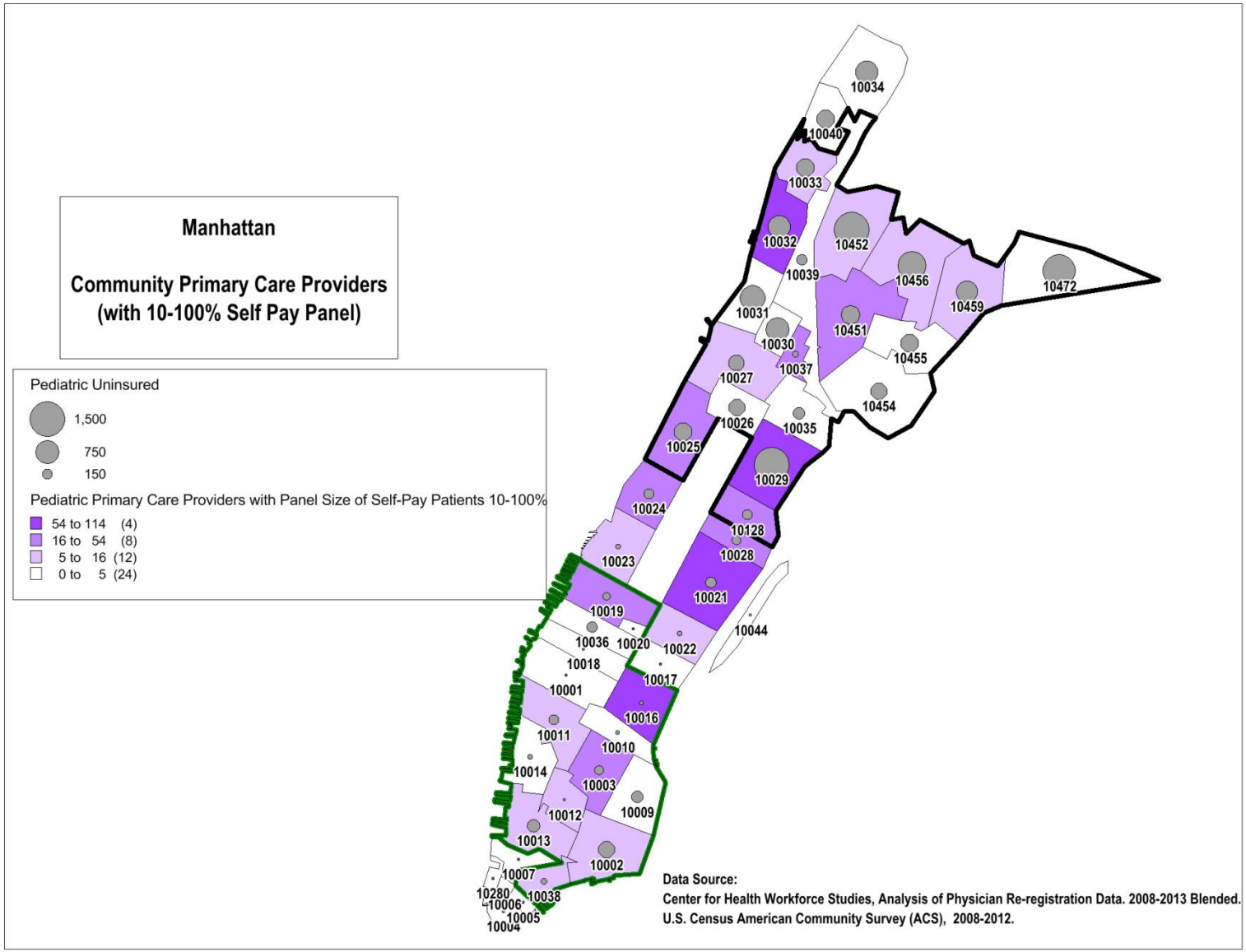

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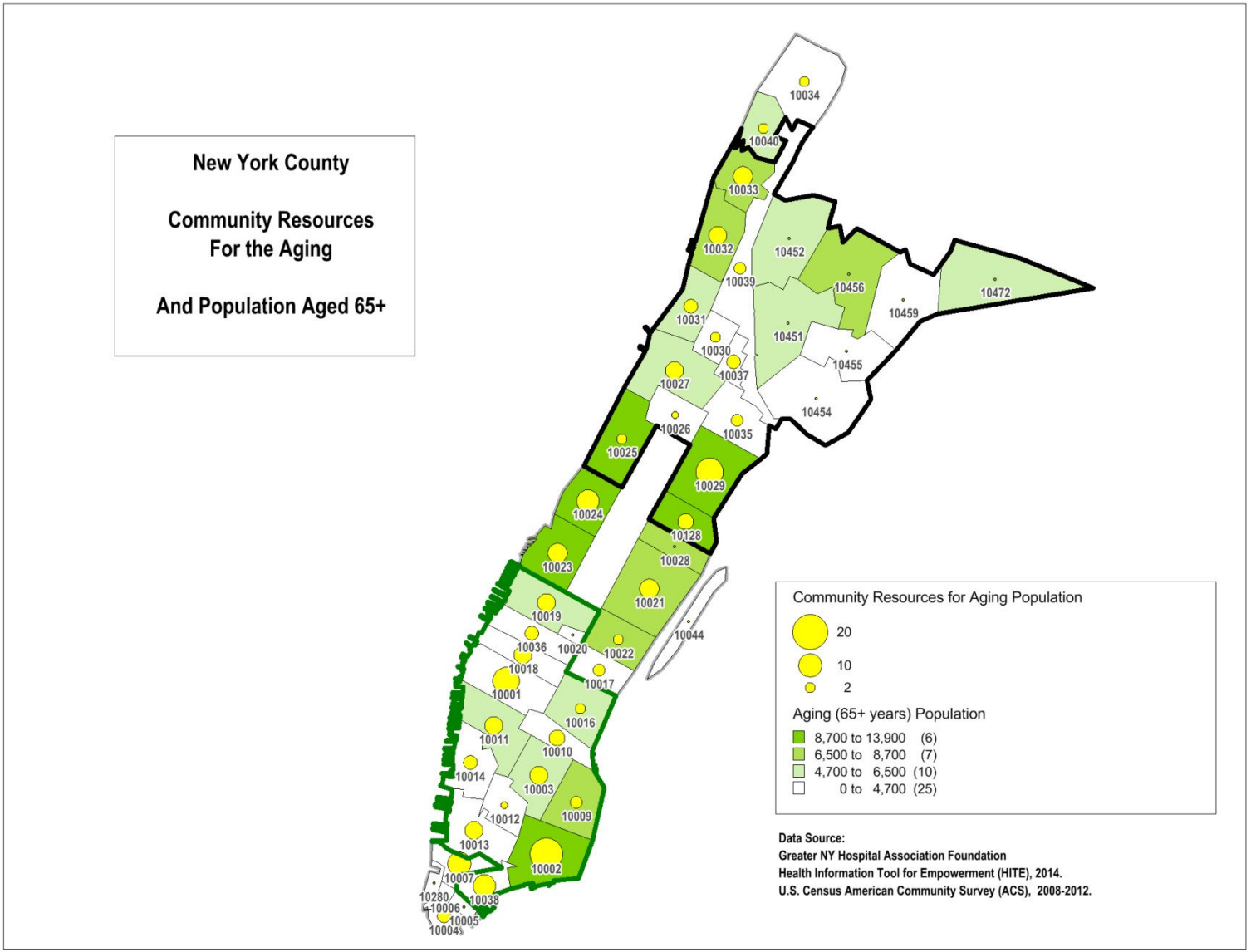

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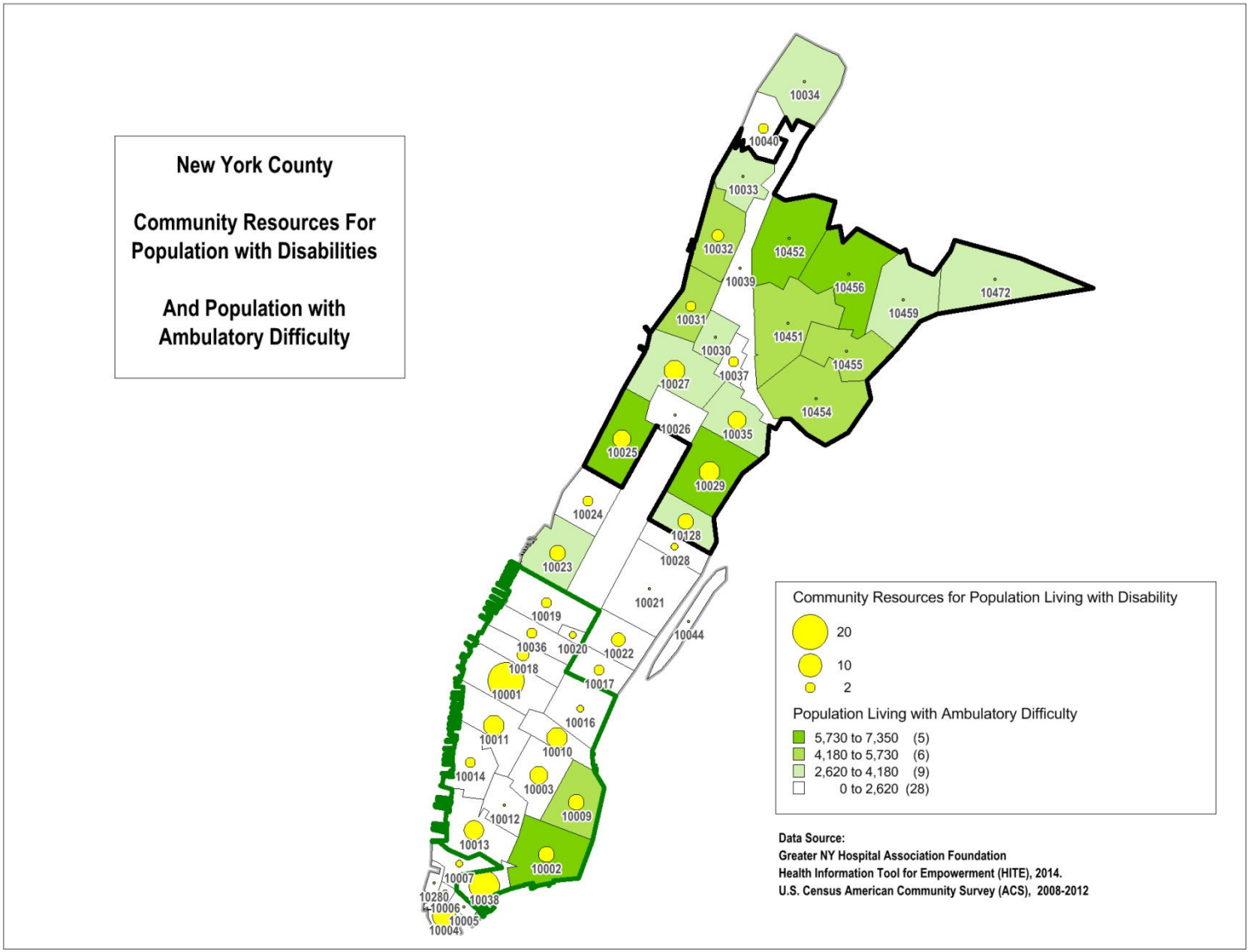

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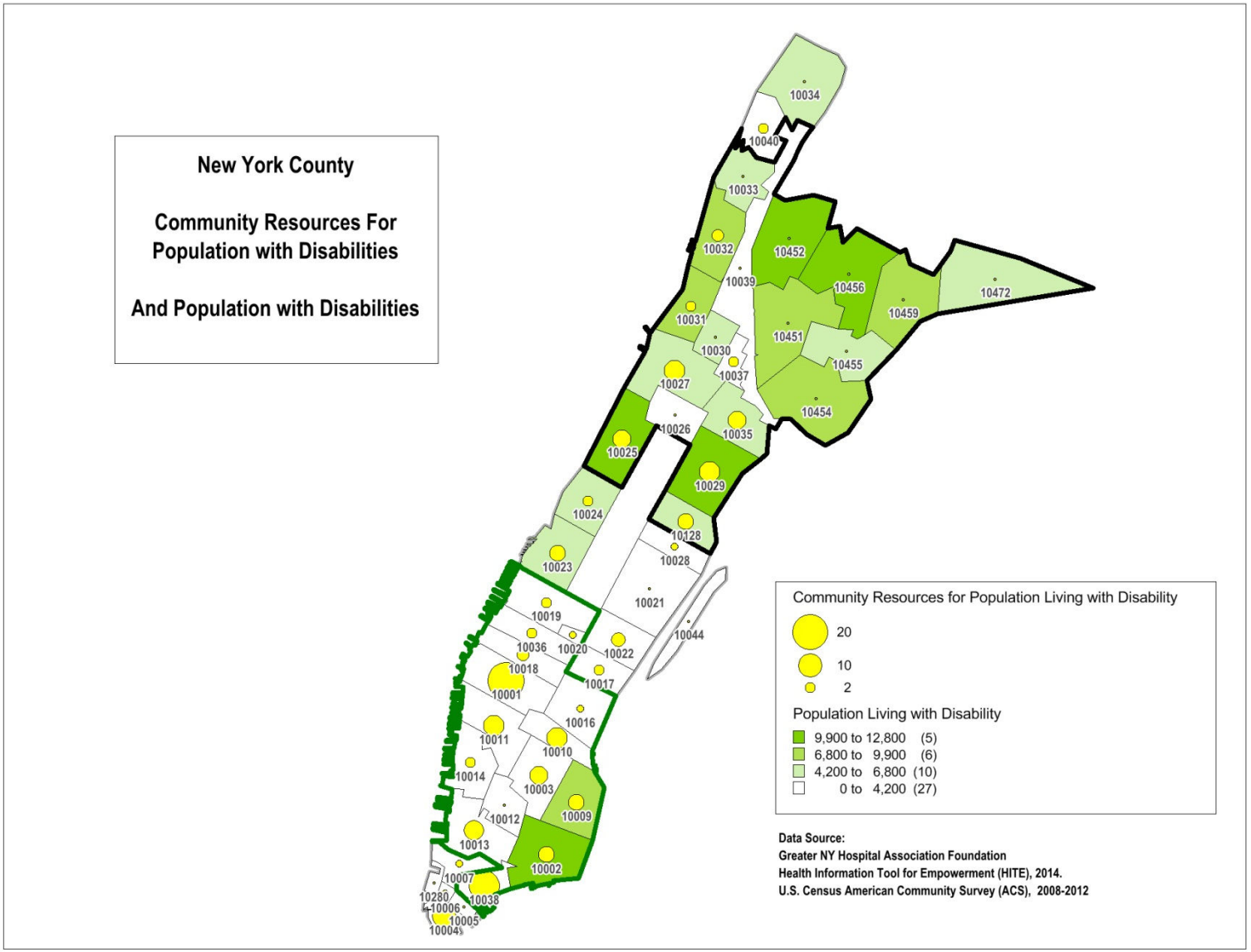

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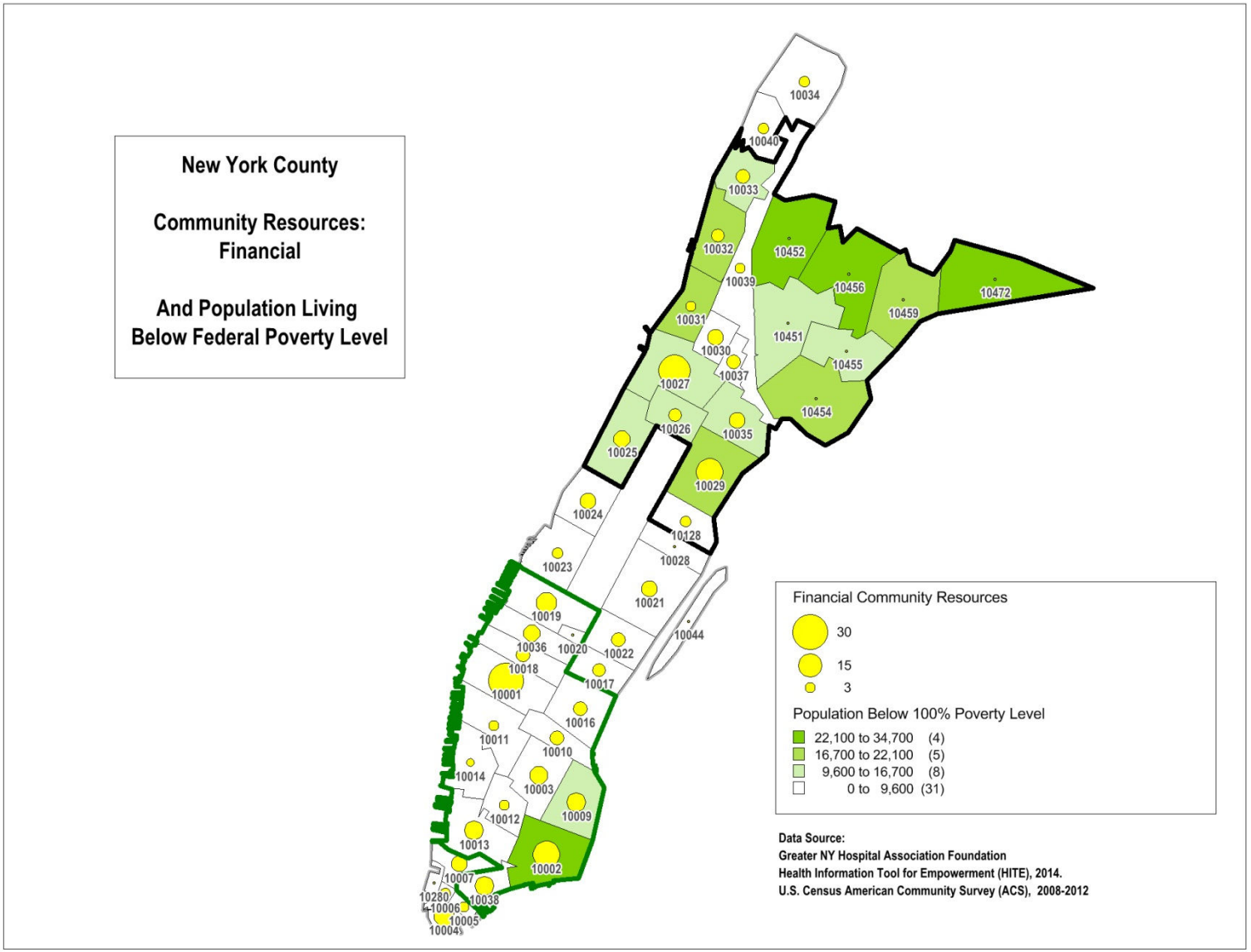

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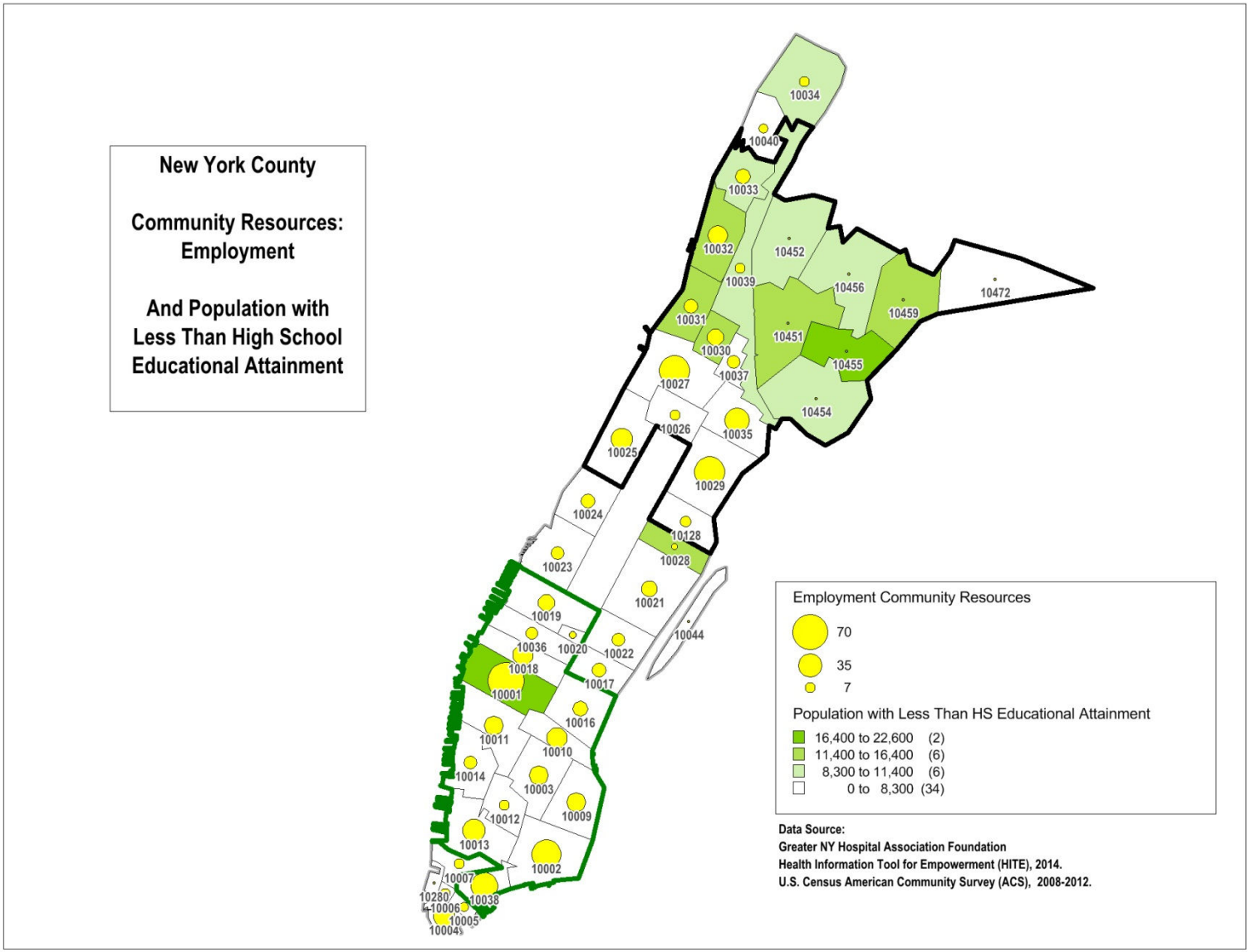

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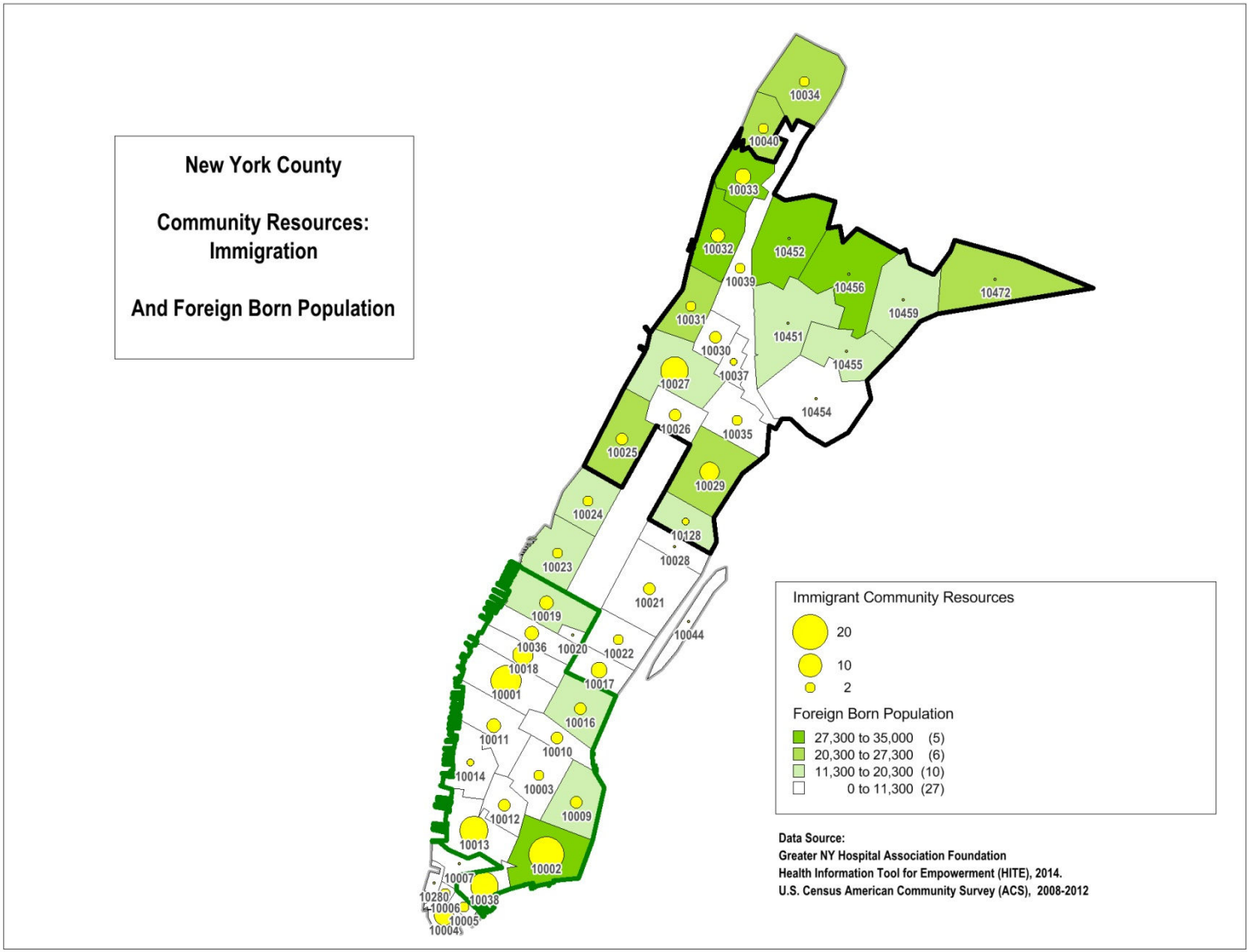

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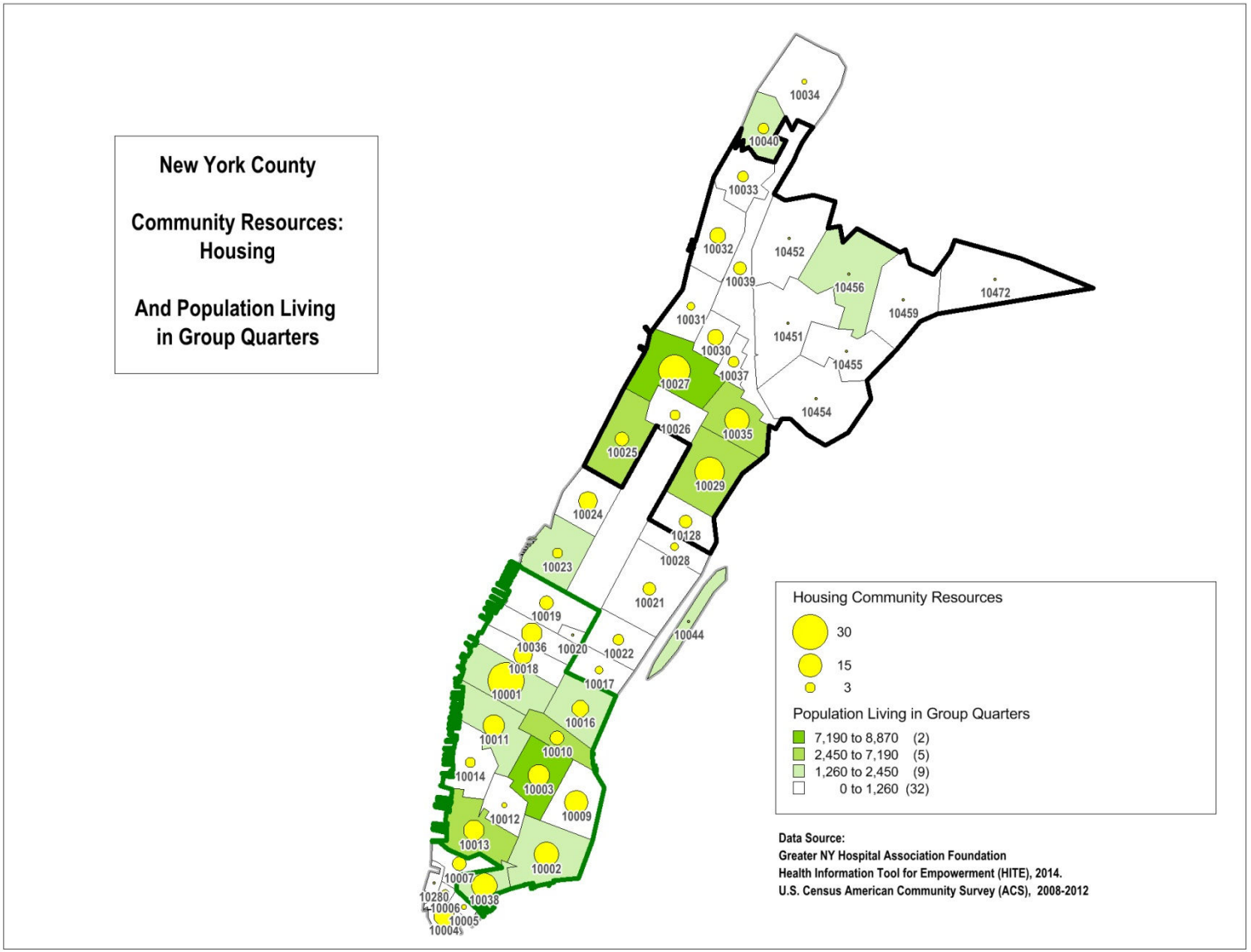

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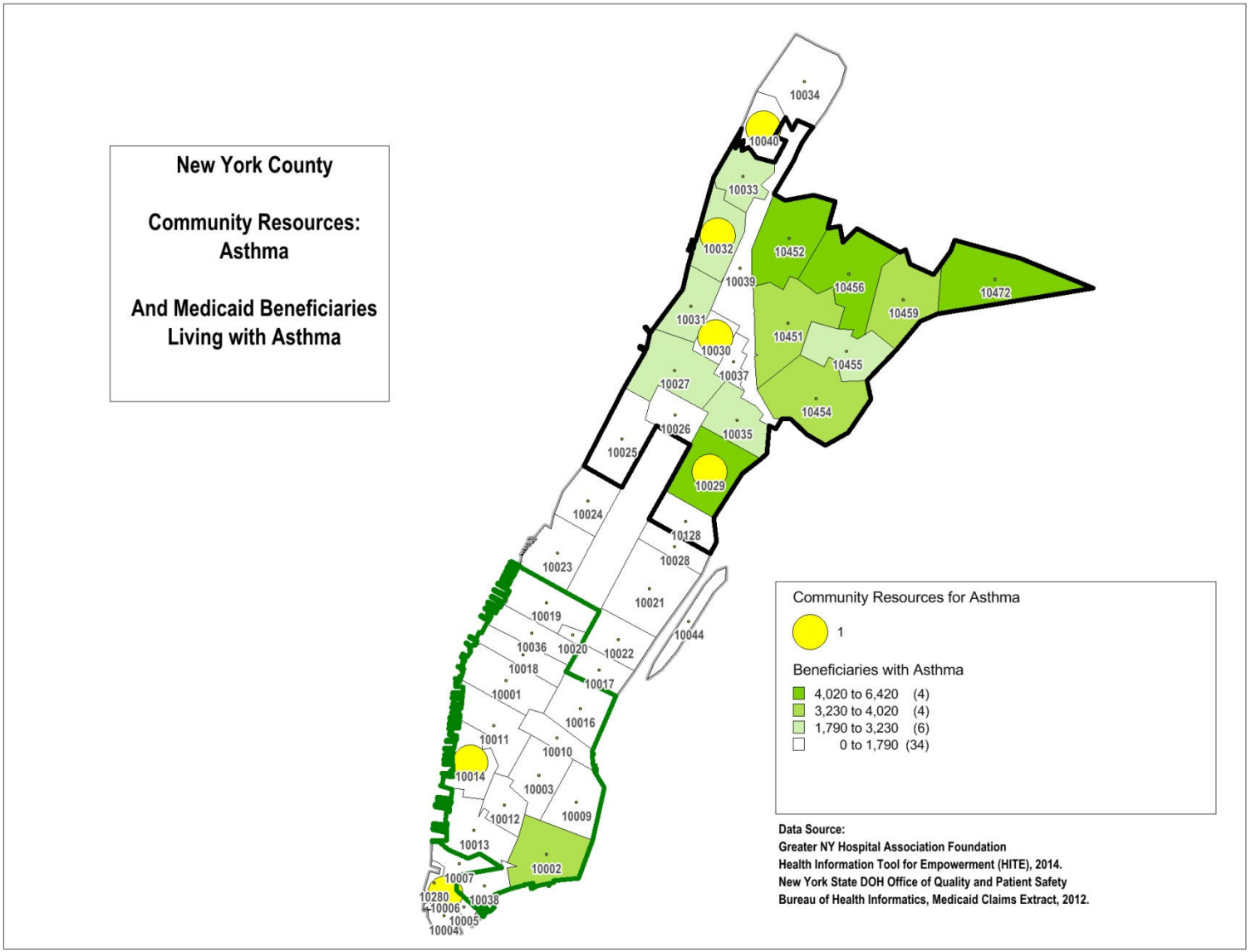

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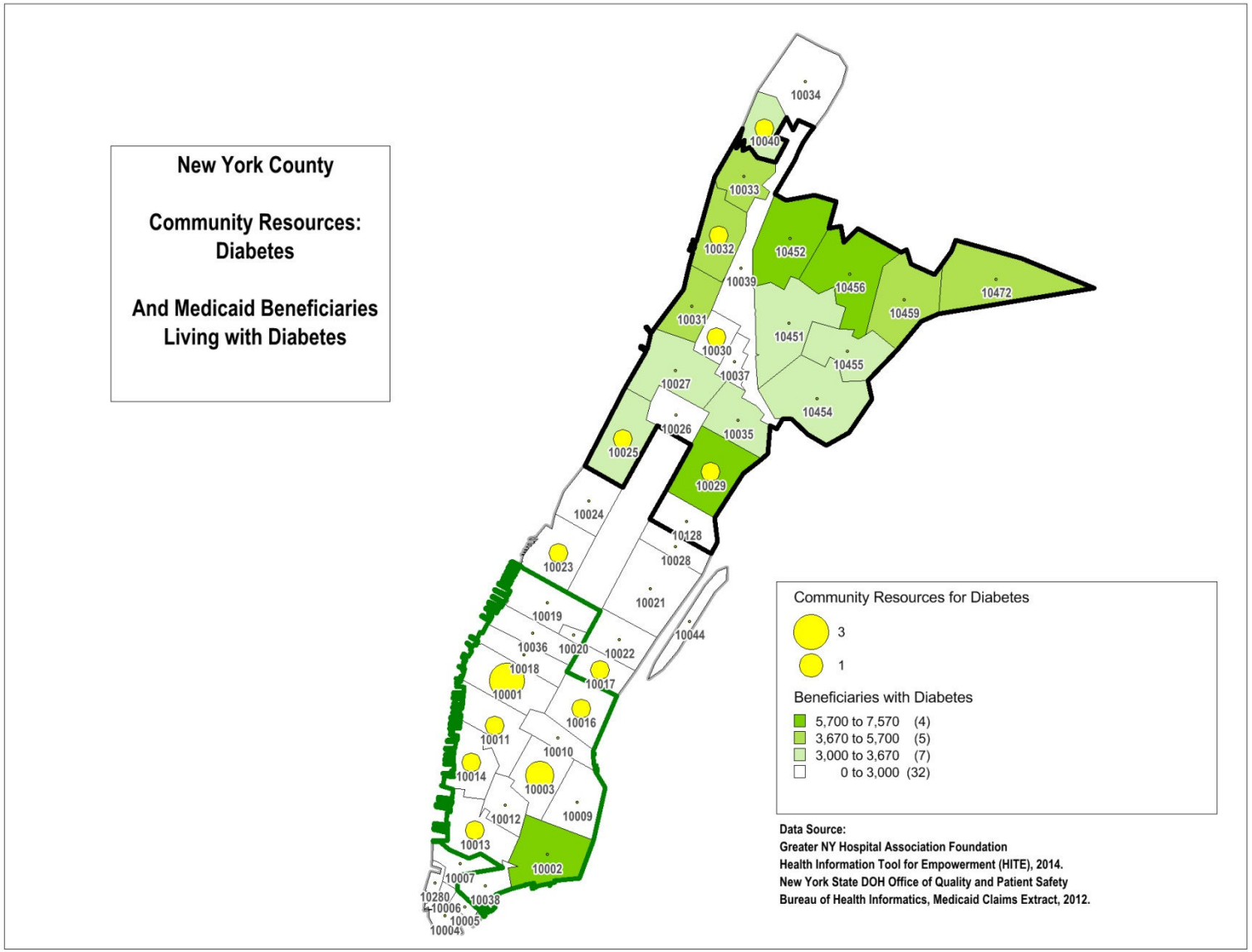

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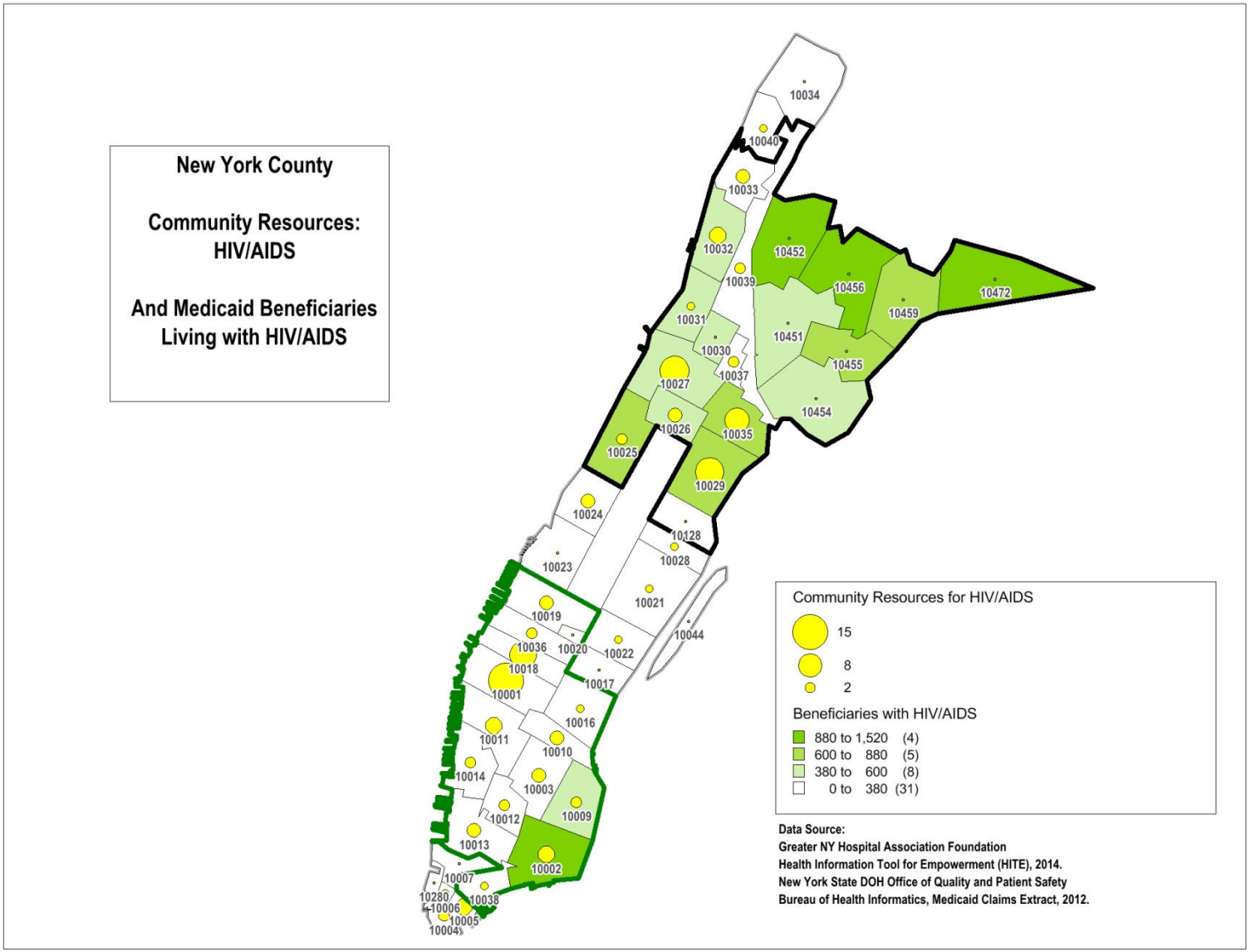

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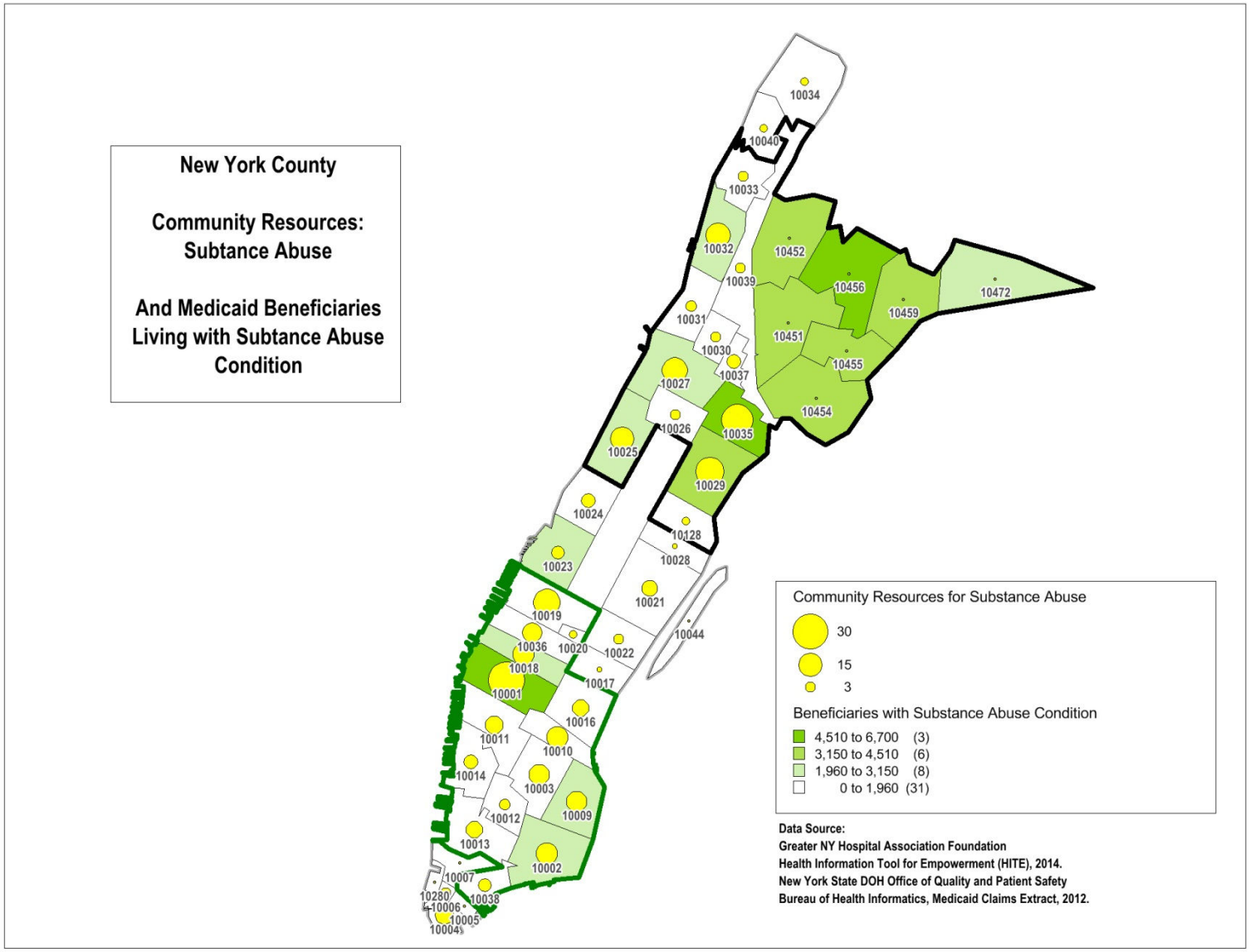

MANHATTAN COMMUNITY NEEDS ASSESSMENT APPENDIX B - TABLES

December 16, 2014

New York City Health and Hospitals Corporation

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Section A: Tables within Manhattan CNA

Table 1: Manhattan Hospitals located in the Service Area

Hospital Name	Hospital Type	Certified Beds	Occupancy Rate	Safety Net Payer Mix (Medicaid+SP)
Upper Manhattan Service Area				
Harlem Hospital	HHC	286	65%	68%
Metropolitan Hospital	HHC	356	65%	74%
Lincoln Hospital	HHC	347	71%	68%
St. Luke's - Roosevelt	Voluntary	1,028	65%	33%
Mount Sinai Hospital	Voluntary	1,107	78%	26%
NewYork-Presbyterian Hospital	Voluntary	2,292	83%	28%
Bronx Lebanon Hospital	Voluntary	587	78%	71%
Lower Manhattan Service Area				
Bellevue Hospital	HHC	912	74%	63%
Beth Israel Hospital	Voluntary	856	75%	39%
Lower Manhattan Hospital	Voluntary	180	63%	40%
NYU Langone Medical Center	Voluntary	987	49%	13%
Other Manhattan Hospitals				
Lenox Hill Hospital	Voluntary	653	58%	14%
Specialty Hospitals				
Memorial	Specialty			
Hospital For Special Surgery	Specialty			
New York Eye And Ear Infirmary	Specialty			

Source: New York State Department of Health: HCRA Provider List, October 2014.

Table 2: Number of Primary care Physicians with Significant Self-Pay and Medicaid Panel

	Pediatrics	OB/GYN	All other PCP	Sum
Upper Manhattan Service Area				
Physicians Self-pay≥10%	320	147	343	810
Physicians Medicaid≥30%	543	120	478	1,141
Total Physicians (does not sum)	778	274	871	1,923
Lower Manhattan Service Area				
Physicians Self-pay≥10%	181	131	573	885
Physicians Medicaid≥30%	218	89	443	750
Total Physicians (does not sum)	377	330	1,204	1,911

Source: Center for Health Workforce Studies, Analysis of Physician Re-registration Data. 2008-2013 Blended.

Table 3: Institutional Primary Care Providers by Service Area

	FQHC (incl. Ext. Clinics)	D&TC (incl. Ext. Clinics)	Hospital Based Ext. Clinics
Upper Manhattan service area	18	83	43
Lower Manhattan service area	15	30	57
Manhattan Borough	26	79	103

Source: HRSA: FQHC and FQHC Look-alike Site Directory, November 2014.

Table 4: Specialty Physicians by Borough

	Bronx	Brooklyn	**Manhattan**	Queens
Cardio Pulmonary	326	493	1044	361
Endocrine / Diabetes	70	71	223	56
Ear, Nose, Throat	57	67	190	73
Eye	110	196	531	206
Infectious Disease	95	74	199	49
Nephrology	102	112	204	67
Oncology	103	120	325	103

Source and notes: New York State Dept. of Health Provider Network Data System (PNDS). 2014. Specialty physicians are defined as having a Specialist designation, Provider Type of MD or DO. Specialty and service code are as follows: Cardiopulmonary (62, 928, 68, 929, 151, 940, 157, 942, 243, 650, 651, 652, 653, 925 and 927); Endocrine/Diabetes (63, 516, 902, 156, 903, 944, 961); Ear Nose and Throat (120, 121, 935); Eye (100, 958, 101, 919); Infectious Disease (66, 966186, 980, 249, 308, 303, 430-432); Nephrology (67, 954, 154, 941); Oncology (241, 242, 244, 245, 933, 934).

Table 5 : Medical Specialists by Borough

	Bronx	Brooklyn	**Manhattan**	Queens
Acupuncturist	4	16	36	24
Audiologist	23	46	71	26
Chiropractor	59	101	104	121
Occupational Therapist	51	114	67	43
Physical Therapist	370	539	231	306
Speech-Language Pathologist	25	142	100	49
Optometrist	100	215	325	214
Durable Medical Equipment Supplier	36	117	59	67
Hospital and Clinic Based Labs	14	20	47	10

Source and notes: New York State Dept. of Health Provider Network Data System (PNDS). 2014. Based on Provider Type codes. Duplicates within were deleted only if within same specialty. Hospital and Clinic Based Laboratories NYSDOH HCRA providers, as of 9/01/2014. http://www.health.ny.gov/regulations/hcra/provider.htm

Table 6: Potentially Avoidable ER Visits and Readmissions

Measure Name	NYS	NYC	Manhattan	Lower Manhattan Service Area (LMSA)	Upper Manhattan Service Area (UMSA)	Total Admissions, Manhattan
Potentially Avoidable Emergency Room Visits per 100 Recipients	36	33	42	38	44	203,340
Potentially Avoidable Readmissions	1.00	0.94	1.17	1.31	1.11	

Source: HHC analysis of Potentially Preventable Readmissions data by hospital, New York State Department of Health, 2012

Table 7: Total Population by Insurance Status

	Total Population	No health insurance		Medicaid/low income medical assistance	
		Total	%	Total	%
New York City	8,199,221	1,160,829	14.2	3,588,107	43.8
Manhattan	1,596,735	172,790	10.8	485,833	30.4
Upper Manhattan Service Area (includes 295,276 from Bronx)	1,011,230	159,401	15.8	562,215	55.6
Lower Manhattan Service Area	546,292	48,701	8.9	146,505	26.8

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012.

Table 8: Total Population by Gender and Insurance Status

	Total Population	No Health Insurance Coverage			Population with Medicaid/Low Income Medical Assistance			Other Insurance		
		%	% Male	%Female	%	% Male	%Female	%	% Male	%Female
New York City	8,198,393	14.4%	57.2%	42.8%	29.3%	44.0%	56.0%	56.3%	46.9%	53.1%
Manhattan	1,593,807	11.0%	55.7%	44.3%	20.9%	43.2%	56.8%	68.1%	46.9%	53.1%

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012.

Table 9: Age by Insurance Status

	Total	Ages 0-19	Ages 20-39	Ages 40-64	Ages 65 and older
Medicaid/low income medical assistance	100%	31.1%	20.8%	29.9%	18.2%
No health insurance	100%	8.9%	56.8%	32.8%	1.6%

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012.

Table 10: Race/Ethnicity with No Health Insurance

	% White	% Black	% Asian	% Other/ Multi-Racial	% Hispanic
NYC	18.2%	21.8%	15.7%	2.5%	41.8%
Manhattan	26.2%	15.7%	13.1%	2.5%	42.5%

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012.

Table 11: Race/Ethnicity With Medicaid and Other Low Income Medical Support

	% White	% Black	% Asian	% Other/ Multi-Racial	% Hispanic
NYC	17.6%	25.7%	13.7%	2.3%	40.8%
Manhattan	11.1%	22.8%	10.7%	2.1%	53.3%

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012.

Table 12: Percent of Specific Disabilities in Persons Age 65 Or Older In Service Areas

	% Hearing difficulty	% ambulatory difficulty	% Cognitive difficulty	% Vision difficulty
Upper Manhattan	9.0	32.3	11.7	8.8
Bronx portion	10.8	40.2	16.4	13.6
Lower Manhattan	11.0	25.4	11.0	7.3

Source: US Census American Community Survey (ACS), 2008-2012

Table 13: Educational Attainment for Population with No Health Insurance

	% Less than HS diploma	% HS diploma or equivalent	% Some college/ Associate's	% Bachelor's degree or higher
New York City	30%	29%	20%	21%
Manhattan	24%	19%	21%	36%

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012

Table 14: Educational Attainment for Population with Medicaid/Low Income Medical Assistance

	% Less than HS diploma	% HS diploma or equivalent	% Some college/ Associate's	% Bachelor's degree or higher
New York City	40%	29%	19%	12%
Manhattan	42%	26%	18%	14%

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012

Table 15: Educational Attainment for Populations with Other Insurance

	% Less than HS diploma	% HS diploma or equivalent	% Some college/ Associate's	% Bachelor's degree or higher
New York City	11%	22%	22%	45%
Manhattan	6%	9%	13%	72%

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012

Table 16: Severe Crowding Rate by Neighborhood 2005-2009

	Severe Crowding Rate - Percentage of Renter Households with 1.5 Occupants per Room or More (Severe Crowding), by PUMA, Census ACS				
Region	**2005**	**2006**	**2007**	**2008**	**2009**
New York City	3.01	3.41	3.17	4.67	4.04
Manhattan	2.14	3.01	2.44	3.16	2.83
Central Harlem	2.34	2.87	2.30	2.71	3.13
Chelsea/Clinton/Midtown	1.58	2.25	2.10	2.37	3.55
East Harlem	1.95	6.06	3.95	3.72	4.78
Greenwich Village/Financial District	1.23	3.83	2.46	3.75	1.78
Lower East Side/Chinatown	2.89	4.33	4.81	4.24	3.58
Morningside Heights/Hamilton Heights	1.57	2.69	1.59	3.61	2.85
Stuyvesant Town/Turtle Bay	1.83	2.59	1.46	3.37	2.44
Upper East Side	0.72	1.85	1.52	2.20	1.91
Upper West Side	1.89	2.01	2.07	2.66	1.43
South Bronx					
Mott Haven/Hunts Point	3.15	3.44	3.54	4.97	3.80
Morrisania/Belmont	3.31	2.65	2.89	2.70	2.74
Highbridge/South Concourse	6.03	5.02	5.63	5.05	6.39

Source: The Furman Center New York City Neighborhood Information, 2005-2009

Table 17: Serious Housing Violations per 1000 Rental Units by Neighborhood, 2008

Serious Housing Violations by Community District, 2008	Rate/1000 Rental Units
New York City	53.79
MN01: Financial District	1.45
MN02: Greenwich Village/Soho	15.02
MN03: Lower East Side/Chinatown	14.35
MN04: Clinton/Chelsea	12.73
MN05: Midtown	6.00
MN06: Stuyvesant Town/Turtle Bay	4.07
MN07: Upper West Side	11.44
MN08: Upper East Side	8.68
MN09: Morningside Heights/Hamilton	103.87
MN10: Central Harlem	43.53
MN11: East Harlem	25.31
MN12: Washington Heights/Inwood	120.73
BX01: Mott Haven/Melrose	68.57
BX03: Morrisania/Crotona	97.68
BX04: Highbridge/Concourse	146.35

Source: The Furman Center New York City Neighborhood Information, 2008

Table 18: Top Places of Birth Among Foreign Born With No Health Insurance

PUMA Name	Total	Mexico	Dominican Republic	China	Ecuador	Jamaica	Korea
New York City	724,452	131,000	74,765	60,385	56,982	32,639	23,941
Manhattan	84,642	15,272	20,571	7,705	4,846	1,209	2,951
Washington Heights, Inwood & Marble Hill	26,963	6,450	13,619	275	1,716	34	155
Hamilton Heights, Manhattanville & West Harlem	9,956	2,101	2,906	324	1,167	397	474
Central Harlem	6,896	396	1,170	84	542	452	74
East Harlem	9,856	5,090	999	515	603	54	159
Upper East Side	4,260	200	402	250	-	20	435
Upper West Side & West Side	4,856	316	325	236	284	54	390
Chelsea, Clinton & Midtown Business District	5,036	269	379	382	230	53	516
Murray Hill, Gramercy & Stuyvesant Town	3,448	313	89	423	95	-	385
Chinatown & Lower East Side	9,689	137	667	4,520	209	138	-
Battery Park City, Greenwich Village & Soho	3,682	-	15	696	-	7	363

Source: US Census American Community Survey-Public Use Microdata Sample (PUMS), New York City Department of City Planning, Population Division, 2008-2012.

Table 19: Jail and Prison Admissions by Area 2007-2009[a]

	NYS	NYC	Manhattan	Lower Manhattan	Upper Manhattan
NYC DOC Jail admissions (2007-2012), Average	94,951	71,929	13,710	3,014	17,181
NYC DOC Jail admissions rate per 100,000 Population (2007-2012), Average	489	877	859	552	1,699
NYS Prison admissions (2008)[a]	21,141	9,640	2,393	22	93

Source: NYC Department of Corrections, 2012, as cited in http://gothamist.com/2013/05/01/these_interactive_charts_show_you_w.php and http://www.justiceatlas.org/.

[a]The most recent data available for NYS prison admissions is from 2008; it is likely that more recent figures would be significantly lower.

Table 20: Leading Causes of Death, NYC, 2012

Rank		Total Reported	Percent of Total
1	Diseases of Heart	16,730	31.9%
2	Malignant Neoplasms	13,399	25.5%
3	Influenza (Flu) and Pneumonia	2,244	4.3%
4	Diabetes Mellitus	1,813	3.5%
5	Chronic Lower Respiratory Diseases	1,651	3.1%
6	Cerebrovascular Disease	1,646	3.1%
7	Accidents Except Drug Poisoning	1,032	2.0%
8	Essential Hypertension and Renal Diseases	980	1.9%
9	Use of or Poisoning By Psychoactive Substance	812	1.5%
10	Alzheimer's Disease	696	1.3%
	All Other Causes	11,452	21.8%
	Total	52,455	100%

Source: The New York City Department of Health and Mental Hygiene, Vital Statistics, 2012, accessed December 1, 2014.

Table 21: Leading Causes of Death, Manhattan, 2012

Rank		Total Reported	Percent of Total
1	Diseases of Heart	2,674	28.9%
2	Malignant Neoplasms	2,409	26.1%
3	Influenza (Flu) and Pneumonia	353	3.8%
4	Chronic Lower Respiratory Diseases	320	3.5%
5	Cerebrovascular Disease	307	3.3%
6	Diabetes Mellitus	265	2.9%
7	Essential Hypertension and Renal Diseases	206	2.2%
8	Alzheimer's Disease	200	2.2%
9	Accidents Except Drug Poisoning	159	1.7%
10	Use of or Poisoning By Psychoactive Substance	149	1.6%
	All Other Causes	2,196	23.8%
	Total	9,238	100%

Source: The New York City Department of Health and Mental Hygiene, Vital Statistics, 2012, accessed December 1, 2014.

Table 22: Leading Causes of Death by Sex, NYC, 2012

Rank	Causes of Mortality	Total Reported	%	Causes of Mortality	Total Reported	%
	Males			**Females**		
1	Diseases of Heart	7,954	31%	Diseases of Heart	8,776	33%
2	Malignant Neoplasms	6,578	26%	Malignant Neoplasms	6,821	25%
3	Influenza (Flu) and Pneumonia	1,078	4%	Influenza (Flu) and Pneumonia	1,166	4%
4	Diabetes Mellitus	883	3%	Cerebrovascular Disease	975	4%
5	Chronic Lower Respiratory Diseases	734	3%	Diabetes Mellitus	930	3%
6	Accidents Except Drug Poisoning	699	3%	Chronic Lower Respiratory Diseases	917	3%
7	Cerebrovascular Disease	671	3%	Essential Hypertension and Renal Diseases	562	2%
8	Use of or Poisoning By Psychoactive Substance	592	2%	Alzheimer's Disease	488	2%
9	Essential Hypertension and Renal Diseases	418	2%	Accidents Except Drug Poisoning	333	1%
10	Human Immunodeficiency Virus Disease	402	2%	Septicemia	242	1%
	All other causes	5,658	22%	All other causes	5,578	21%
			100%			100%

Source: The New York City Department of Health and Mental Hygiene, Vital Statistics, 2012, accessed December 1, 2014.

Table 23: Leading Causes of Death by Race, NYC, 2012

Rank	Causes of Mortality	Total	%	Causes of Mortality	Total	%	Causes of Mortality	Total	%	Causes of Mortality	Total	%
	Hispanic			**White, Non-Hispanic**			**Black, Non-Hispanic**			**Asian and Pacific Islander**		
1	Diseases of Heart	2,514	27%	Diseases of Heart	8,875	36%	Diseases of Heart	4,209	30%	Malignant Neoplasms	1,086	32%
2	Malignant Neoplasms	2,251	24%	Malignant Neoplasms	6,440	26%	Malignant Neoplasms	3,475	25%	Diseases of Heart	872	25%
3	Influenza (Flu) and Pneumonia	414	4%	Influenza (Flu) and Pneumonia	1,117	4%	Diabetes Mellitus	717	5%	Cerebrovascular Disease	172	5%
4	Diabetes Mellitus	394	4%	Chronic Lower Respiratory Diseases	859	3%	Influenza (Flu) and Pneumonia	537	4%	Influenza (Flu) and Pneumonia	150	4%
5	Cerebrovascular Disease	298	3%	Cerebrovascular Disease	701	3%	Cerebrovascular Disease	441	3%	Diabetes Mellitus	133	4%
6	Chronic Lower Respiratory Diseases	290	3%	Diabetes Mellitus	532	2%	Chronic Lower Respiratory Diseases	388	3%	Chronic Lower Respiratory Diseases	94	3%
7	Accidents Except Drug Poisoning	251	3%	Accidents Except Drug Poisoning	463	2%	Human Immunodeficiency Virus Disease	359	3%	Accidents Except Drug Poisoning	90	3%
8	Use Of Or Poisoning By Psychoactive Substance	222	2%	Use Of Or Poisoning By Psychoactive Substance	363	1%	Essential Hypertension and Renal Diseases	357	3%	Essential Hypertension and Renal Diseases	78	2%
9	Chronic Liver Disease and Cirrhosis	197	2%	Essential Hypertension and Renal Diseases	352	1%	Assault	261	2%	Intentional Self-Harm	75	2%
10	Essential Hypertension and Renal Diseases	182	2%	Alzheimer's Disease	337	1%	Accidents Except Drug Poisoning	209	2%	Nephritis, Nephrotic Syndrome and Nephrisis	39	1%
	All other causes	2,407	26%	All other causes	4,865	20%	All other causes	2,911	21%	All other causes	657	19%

Source: The New York City Department of Health and Mental Hygiene, Vital Statistics, 2012, accessed December 1, 2014

Table 24: Leading Causes of Death, New York City, 2002, 2007, 2012

Rank	Causes of Mortality	Deaths	%	Causes of Mortality	Deaths	%	Causes of Mortality	Deaths	%
	2002			**2007**			**2012**		
1	Diseases of Heart	24,504	41%	Diseases of Heart	21,424	40%	Diseases of Heart	16,730	32%
2	Malignant Neoplasms	13,731	23%	Malignant Neoplasms	13,234	24%	Malignant Neoplasms	13,399	26%
3	Influenza (Flu) and Pneumonia	2,508	4%	Influenza (Flu) and Pneumonia	2,245	4%	Influenza (Flu) and Pneumonia	2,244	4%
4	Cerebrovascular Disease	1,853	3%	Cerebrovascular Disease	1,563	3%	Diabetes Mellitus	1,813	3%
5	Human Immunodeficiency Virus Disease	1,713	3%	Diabetes Mellitus	1,559	3%	Chronic Lower Respiratory Diseases	1,651	3%
6	Diabetes Mellitus	1,704	3%	Chronic Lower Respiratory Diseases	1,427	3%	Cerebrovascular Disease	1,646	3%
7	Chronic Lower Respiratory Diseases	1,700	3%	Human Immunodeficiency Virus Disease	1,113	2%	Accidents Except Drug Poisoning	1,032	2%
8	Accidents Except Drug Poisoning	1,176	2%	Accidents Except Drug Poisoning	1,027	2%	Essential Hypertension and Renal Diseases	980	2%
9	Use of or Poisoning by Psychoactive Substance	904	2%	Use of or Poisoning by Psychoactive Substance	848	2%	Use of or Poisoning by Psychoactive Substance	812	2%
10	Essential Hypertension and Renal Diseases	723	1%	Essential Hypertension and Renal Diseases	791	1%	Alzheimer's Disease	696	1%
	All other causes	9,135	15%	All other causes	8,842	16%	All other causes	11,452	22%
			100%			100%			100%

Source: The New York City Department of Health and Mental Hygiene, Vital Statistics, 2012, accessed December 1, 2014

Table 25: Leading Causes of Premature Death (<65) and Years of Life Lost (YLL), New York City - 2012

Cause of Death	Total		Male		Female	
	Deaths	YLL	Deaths	YLL	Deaths	YLL
Total	14,047	224,047	8,559	139,257	5,488	84,790
Acquired Immune Deficiency Syndrome (AIDS)	499	8,111	326	5,090	173	3,021
Malignant Neoplasms	3,993	43,370	1,959	20,341	2,034	23,029
Buccal Cavity and Pharynx	86	1,035	60	687	26	348
Digestive Organs and Peritoneum	1,226	11,921	756	7,271	470	4,650
Respiratory System	844	7,263	487	4,027	357	3,236
Trachea, Bronchus and Lung	786	6,609	447	3,610	339	2,999
Breast	448	5,694	1	9	447	5,685
Genital Organs	409	4,338	81	685	328	3,653
Urinary Organs	124	1,270	91	871	33	399
Other and Unspecified Sites	514	6,791	278	3,552	236	3,239
Lymphatic and Hematopoietic Tissues	342	5,058	205	3,239	137	1,819
Diabetes Mellitus	476	5,182	306	3,458	170	1,724
Diseases of the Circulatory System	3,386	36,272	2,256	24,359	1,130	11,913
Diseases of the Heart	2,718	27,754	1,854	19,363	864	8,391
Hypertension with Heart Disease	586	6,552	378	4,320	208	2,232
Acute Myocardial Infarction	338	3,066	242	2,322	96	744
Other Ischemic Heart Diseases+	1,493	13,254	1,061	9,791	432	3,463
Other Diseases of the Heart	301	4,882	173	2,930	128	1,952
Hypertension with or without Renal Disease	169	1,782	98	1,039	71	743
Cerebrovascular Disease	355	4,701	211	2,683	144	2,018
Other Diseases of the Circulatory System	144	2,035	93	1,274	51	761
Pneumonia	278	3,366	165	2,021	113	1,345
Chronic Lower Respiratory Disease (CLRD)	278	3,719	156	2,179	122	1,540
Cirrhosis of Liver	328	3,920	230	2,764	98	1,156
Congenital Anomalies	198	9,589	110	5,049	88	4,540
Certain Conditions Originating in Perinatal Period	302	19,581	170	11,048	132	8,533
Accidents (Total)	1,152	27,472	877	21,267	275	6,205
Motor Vehicle	222	6,497	163	4,809	59	1,688
Drownings	15	582	14	522	1	60
Falls	110	2,015	92	1,807	18	208
Poisonings	659	14,340	496	11,047	163	3,293
Suicide	433	10,020	306	7,010	127	3,010
Homicide and Legal Intervention	400	14,196	341	12,356	59	1,840
All Other Causes	2,324	39,249	1,357	22,315	967	16,934

Premature death is defined a death before age 65. Years of Life Lost (YLL) is calculated by subtracting the age of death from age 65.

Source: The New York State Department of Health, Vital Statistics, 2012, accessed December 2, 2014

Table 26: Ten Leading Causes of Death by Medicaid Status, New York State, 2012

	Non-Medicaid		Medicaid*	
Rank	Underlying Cause of Death	Deaths	Underlying Cause of Death	Deaths
1	Diseases of the Heart	25,887	Diseases of the Heart	17,350
2	Malignant Neoplasms	24,753	Malignant Neoplasms	10,845
3	Chronic Lower Respiratory Disease	4,211	Chronic Lower Respiratory Disease	2,775
4	Cerebrovascular Disease	3,666	Cerebrovascular Disease	2,357
5	Accidents	3,457	Pneumonia	2,168
6	Pneumonia	2,157	Accidents	1,959
7	Septicemia	1,331	Alzheimer's	1,423
8	Nephritis, Nephrotic Syndrome, &Nephrosis	1,311	Septicemia	977
9	Alzheimer's	1,200	Hypertension	947
10	Suicide	1,196	Nephritis, Nephrotic Syndrome, & Nephrosis	873

*Determined on the basis of Medicaid enrollment sometime during the year of death. Differences in causes of mortality between Medicaid and non-Medicaid decedents may be due, in part, to differences in age, sex, or race/ethnicity.

Source: MJ Sharp, LD Schoen, T Wang, TA Melnik. Leading causes of death, New York State, 2012. New York State Department of Health, Office of Quality and Patient Safety, Bureau of Vital Statistics.

Table 27: Hospital Admissions – Medicaid and Dual-Eligible Beneficiaries, 2012

	NYS	NYC	Manhattan	LMSA	UMSA
Dual beneficiaries admitted at least once	149,622	89,093	16,860	5,359	14,936
Total dual-eligible admissions	207,893	125,358	23,565	7,586	21,050
Non-dual beneficiaries admitted at least once	515,821	315,132	41,628	11,948	53,961
Total non-dual admissions	746,996	468,005	72,647	23,679	86,352
Total beneficiaries admitted	665,443	404,225	58,488	17,307	68,897
Total admissions	954,889	593,363	96,212	31,265	107,402
% beneficiaries admitted	11%	11%	12%	11.8%	12.3%

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 28: Inpatient Discharges by top 20 primary diagnoses, 2010 and 2013

	NYC		Manhattan		Bronx		Brooklyn		Queens	
	2010	2013	2010	2013	2010	2013	2010	2013	2010	2013
Complications Pregnancy	11%	11%	11%	10%	11%	11%	13%	13%	12%	13%
Newborns	10%	10%	10%	10%	9%	9%	11%	12%	11%	12%
Heart Disease	9%	8%	8%	8%	7%	7%	9%	8%	9%	8%
Digestive Disease	8%	8%	7%	8%	8%	8%	8%	8%	9%	8%
Respiratory Disease	7%	7%	7%	7%	9%	10%	7%	7%	7%	7%
Psychoses	5%	5%	7%	7%	5%	6%	5%	5%	5%	5%
Symptoms And Signs	6%	5%	6%	5%	7%	6%	6%	5%	7%	5%
Infectious/Parasitic Dis	4%	5%	3%	4%	5%	5%	4%	4%	4%	4%
Musculoskeletal Dis	4%	5%	4%	4%	3%	3%	3%	3%	3%	3%
Malignant Neoplasms	4%	4%	4%	4%	3%	3%	3%	3%	4%	3%
Endo/Nutr/Metab Dis	4%	4%	4%	4%	5%	5%	4%	4%	3%	4%
Other Injury	4%	4%	4%	4%	3%	3%	3%	3%	3%	3%
Urinary Disease	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
Other Circulatory Dis	2%	2%	3%	3%	3%	3%	2%	2%	2%	2%
Nervous System Dis	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Other Supplementary	2%	2%	2%	2%	1%	1%	2%	2%	2%	2%
Alcohol/Drug	3%	2%	4%	3%	3%	2%	2%	2%	1%	2%
Fractures	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Skin Disease	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Cerebrovascular Disease	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
All Other Diagnoses	7%	7%	6%	6%	7%	7%	7%	7%	6%	7%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total	**1,160,53**	**1,075,15**	**199,603**	**185,181**	**223,597**	**208,937**	**353,202**	**325,700**	**210,057**	**189,945**

Source: New York Statewide Planning and Research Cooperative System (SPARCS), 2010 and 2013.

Table 29: ED visits by top 20 primary diagnoses, 2010 and 2013

	NYC	NYC	Manhattan	Manhattan	Bronx	Bronx	Brooklyn	Brooklyn	Queens	Queens
	2010	2013	2010	2013	2010	2013	2010	2013	2010	2013
Symptoms And Signs	21%	20%	20%	23%	27%	19%	18%	17%	19%	23%
Respiratory Disease	11%	11%	11%	9%	10%	13%	12%	12%	11%	10%
Other Injury	11%	11%	11%	10%	10%	10%	12%	12%	13%	12%
Musculoskeletal Dis.	8%	9%	9%	9%	9%	9%	8%	9%	7%	8%
Digestive Disease	6%	6%	5%	5%	5%	5%	6%	6%	7%	6%
Infectious/Parasitic Dis	5%	5%	5%	4%	4%	6%	4%	4%	6%	4%
Compl. Pregnancy	4%	4%	4%	3%	4%	5%	6%	6%	4%	4%
Other Supplementary	4%	4%	4%	4%	5%	5%	4%	3%	4%	3%
Open Wounds	4%	4%	4%	4%	3%	3%	4%	4%	4%	4%
Skin Disease	4%	4%	4%	4%	4%	4%	4%	4%	4%	3%
Alcohol/Drug	3%	3%	3%	4%	2%	2%	3%	3%	2%	2%
Urinary Disease	2%	3%	3%	3%	2%	2%	3%	3%	3%	3%
Ear Disease	3%	2%	2%	2%	3%	3%	2%	2%	3%	2%
Fractures	2%	2%	2%	2%	1%	1%	2%	2%	2%	2%
Female Reproductive	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Other Mental Dis.	2%	2%	2%	2%	2%	2%	1%	2%	1%	2%
Psychoses	1%	2%	2%	2%	1%	2%	1%	2%	1%	2%
Eye Disease	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Other Circulatory Dis.	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%
Nervous System Dis.	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
All Other diagnoses	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: New York Statewide Planning and Research Cooperative System (SPARCS), 2010 and 2013.

Table 30: ED visits - Medicaid and Dual-Eligibles, 2012

	NYS	NYC	Manhattan	LMSA	UMSA
Dual Beneficiaries who used the ED at least once	138,965	67,499	15527	4,854	13,660
Total Dual Beneficiaries' ED visits	276,130	117,640	29320	9,733	24,607
Total Non-Dual Beneficiaries who used the ED at least once	1,324,449	773,479	110,705	24,202	153,623
Total Non-Dual Beneficiaries ED visits	2,607,918	1,470,587	236,845	58,815	306,441
Total Beneficiaries who used the ED	1,463,414	840,978	126,232	29,056	167,283
Total ED visits by both groups	2,884,048	1,588,227	266,165	68,548	331,048
% Beneficiaries with ED visit	25%	23%	26.0%	19.8%	29.8%
ED Visits per Beneficiaries with at least one visit	1.97	1.89	2.11	2.36	1.98

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 31: Potentially Preventable ED visits (PPVs) by Service Area, Borough, City and State, 2012

			Risk-Adjusted Expected Rate Ratios*	
Area	**Observed PPV Events**	**Risk- Adjusted Expected Rate per 100**	**to NYC**	**to NYS**
Lower MH SA	**55,217**	**47.26**	**1.40**	**1.31**
Upper MH SA	**249,414**	**39.93**	**1.18**	**1.11**
Manhattan (MH)	**203,340**	**42.12**	**1.25**	**1.17**
NYC	**1,191,549**	**33.78**	**1.00**	**0.94**
NYS	**2,111,519**	**36.08**	**1.00**	**1.00**

* Risk-Adjusted Rate accounts for demographic (age,gender, race/ethnicity) and case mix (statewide PPV rate) factors. Rate ratio less than 1 signifies outperformance by area, relative to NYC/NYS after controlling for these factors.

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 32: Potentially Preventable Admissions for Manhattan Hospitals, 2012

Facility Name	**At Risk Admissions**	**Observed PPR Chains**	**Observed / Risk Adjusted Expected PPR**	**Observed PPR Rate**	**Risk-Adjusted Expected PPR Rate**	**Risk Adjusted Expected PPR Chains**
Bellevue Hospital Center	10,626	1,171	1.27	11.02	8.68	923
Beth Israel Medical Center	191	6	1.45	3.14	2.17	4
Coler Goldwater Specialty Hospital (HHC)	82	4	1.14	4.88	4.29	4
Harlem Hospital (HHC)	6,411	624	1.21	9.73	8.04	516
Hospital For Special Surgery	405	3	0.51	0.74	1.44	6
Lenox Hill Hospital	3,702	293	0.96	7.91	8.23	305
Metropolitan Hospital	7,684	686	1.13	8.93	7.88	605
Mount Sinai Hospital	17,206	1,253	1.01	7.28	7.22	1,242
N Y Eye And Ear Infirmary	221	6	0.39	2.71	7.01	16
New York Presbyterian	30,552	1,752	0.92	5.73	6.22	1,900
NYU Hospital For Joint Diseases	392	11	0.56	2.81	4.99	20
NYU Hospitals Center	2,989	193	1.01	6.46	6.37	191
Manhattan Hospitals Total	80,461	6,002	1.03	7.46	7.24	5,824
New York City Total	345,073	23,981	0.97	6.95	7.19	24,823
New York State Total	604,308	40,687		6.73		

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 33: Chronic Diseases Prevalence and Potentially Avoidable Utilization

	Prevalence Medicaid Beneficiaries	Percent w/ Hospitalization	Percent w/ ED Visit	Observed PQI Hospitalizations per 100,000 Beneficiaries
NYS				
Respiratory	9.6%	35.3%	47.3%	486
CVD/Circulatory	26.4%	40.0%	31.3%	412
Diabetes	9.6%	32.5%	31.2%	368
Mental Health	22.8%	30.9%	45.8%	n/a
Substance Abuse	6.4%	59.6%	59.9%	n/a
NYC				
Respiratory	9.7%	35.3%	47.3%	507
CVD/Circulatory	30.2%	40.4%	28.1%	461
Diabetes	11.4%	32.3%	28.6%	388
Mental Health	19.5%	32.3%	42.3%	n/a
Substance Abuse	6.2%	65.0%	58.4%	n/a
Manhattan				
Respiratory	10.8	38.2	48.7	550
CVD/Circulatory	33.5	41.6	31.5	486
Diabetes	12.5	33.5	31.8	411
Mental Health	26.8	35.1	46.5	n/a
Substance Abuse	11.2	68.1	60.8	n/a

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 34: Total Potentially Avoidable Hospitalizations (Composite PQI 90), 2009 and 2012

		Bronx		Brooklyn		Manhattan		Queens	
		2009	2012	2009	2012	2009	2012	2009	2012
Overall (PQI 90)	Observed Rate Per 100,000	2,982	2,482	1,991	1,731	**1,547**	**1,360**	1,453	1,318
	Expected Rate Per 100,000	2,048	1,796	2,002	1,633	**1,615**	**1,398**	1,874	1,641
	Observed/Expected	1.46	1.38	0.99	1.06	**0.96**	**0.97**	0.78	0.80
Diabetes (PQI S01)	Observed Rate Per 100,000	553	495	387	347	**246**	**230**	243	225
	Expected Rate Per 100,000	369	336	337	289	**250**	**227**	296	272
	Observed/Expected	1.50	1.47	1.15	1.20	**0.99**	**1.01**	0.82	0.83
Respiratory Conditions (PQI S03)	Observed Rate Per 100,000	831	701	442	393	**357**	**304**	289	269
	Expected Rate Per 100,000	493	437	458	378	**365**	**319**	426	374
	Observed/Expected	1.69	1.60	0.96	1.04	**0.98**	**0.95**	0.68	0.72
Circulatory Conditions (PQI S02)	Observed Rate Per 100,000	825	653	611	503	**425**	**350**	427	386
	Expected Rate Per 100,000	590	499	590	464	**456**	**380**	543	462
	Observed/Expected	1.40	1.31	1.04	1.08	**0.93**	**0.92**	0.79	0.83

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012

Table 35: Acute Conditions PQI Risk-adjusted Expected Hospitalization Rates and Rate Ratios, 2012*

			Risk-Adjusted Expected Rate Ratios	
Area	**Observed Cases**	**Risk-Adjusted Expected Rate/100k**	**to NYC**	**to NYS**
Lower MH SA	**572**	**481**	**0.91**	**0.91**
Upper MH SA	**2,313**	**592**	**1.13**	**1.12**
Manhattan (MH)	**2,140**	**527**	**1.00**	**0.99**
NYC	**12,328**	**525**	**1.00**	**0.99**
NYS	**20,521**	**530**	**1.00**	**1.00**
* Risk-Adjusted Rate accounts for demographic (age,gender, race/ethnicity) and case mix (statewide rate for specific PQI) factors. Rate ratio less than 1 signifies outperformance by area, relative to NYC/NYS after controlling for these factors.				

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 36: Chronic Conditions PQI Risk-Adjusted Expected Hospitalization Rates and Rate Ratios, 2012

			Risk-Adjusted Expected Rate Ratios	
Area	**Observed Cases**	**Risk-Adjusted Expected Rate/100k**	**to NYC**	**to NYS**
Lower MH SA	**1,048**	**887**	**0.68**	**0.71**
Upper MH SA	**7,081**	**1,536**	**1.19**	**1.22**
Manhattan (MH)	**5,236**	**1,191**	**0.92**	**0.95**
NYC	**32,619**	**1,295**	**1.00**	**1.03**
NYS	**48,568**	**1,254**	**1.00**	**1.00**
* Risk-Adjusted Rate accounts for demographic (age,gender, race/ethnicity) and case mix (statewide rate for specific PQI) factors. Rate ratio less than 1 signifies outperformance by area, relative to NYC/NYS after controlling for these factors.				

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 37: Respiratory Related Prevalence and Hospitalization Utilization

	NYS	**NYC**	**Manhattan**	**Lower Manhattan SA**	**Upper Manhattan SA UMSA**
Beneficiaries with Condition	558,700	348,955	70,576	14,838	68,204
Diagnosed Prevalence (Per 100)	9.57	9.73	10.79	10.13	12.13
% with at least one Admission	35.28	36.00	38.18	38.31	37.80
% with at least one ED Visit	47.29	44.93	48.73	42.92	52.13
Average # of Admissions	1.98	2.06	2.23	2.47	2.15
Average # of ED Visits	2.86	2.69	3.10	3.55	2.79

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 38: Respiratory Conditions Related Prevalence and Utilization, Medicaid Beneficiaries, 2012

Area	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	% with at least 1 ED Visit	Average # of Admissions	Average # of ED Visits
LMSA	9,803	6.69	31.43	46.42	2.39	3.41
UMSA	50,874	9.05	29.69	53.81	1.95	2.69
Manhattan	47,526	7.55	30.20	52.03	2.09	2.98
NYC	240,241	6.70	27.57	48.34	1.90	2.63
NYS	275,170	6.43	26.78	50.26	1.86	2.79
Rate Ratio						
LM/NYC		1.00	1.14	0.96	1.25	1.29
LM/NYS		1.04	1.17	0.92	1.28	1.22
UM/NYC		1.35	1.08	1.11	1.02	1.02
UM/NYS		1.41	1.11	1.07	1.05	0.97
MANHATTAN/NYC		1.13	1.10	1.08	1.10	1.13
MANHATTAN/NYS		1.18	1.13	1.04	1.12	1.07
NYC/NYS		1.04	1.03	0.96	1.02	0.94

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 39: Respiratory Conditions PQI Risk-Adjusted Expected Hospitalization Rates (PQI S03), 2012

			Risk-Adjusted Expected Rate Ratios	
Area	**Observed Cases**	**Risk-Adjusted Expected Rate/100k**	**to NYC**	**to NYS**
Lower MH SA	**417**	**371**	**0.75**	**0.77**
Upper MH SA	**2,862**	**628**	**1.27**	**1.30**
Manhattan (MH)	**1,991**	**466**	**0.94**	**0.97**
NYC	**12,216**	**493**	**1.00**	**1.02**
NYS	**18,654**	**482**	**1.00**	**1.00**

* Risk-Adjusted Rate accounts for demographic (age,gender, race/ethnicity) and case mix (statewide rate for specific PQI) factors. Rate ratio less than 1 signifies outperformance by area, relative to NYC/NYS after controlling for these factors.

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 40: Observed and Risk-Adjusted Asthma Related Hospitalizations, 2012

			Risk-Adjusted Expected Rate Ratios	
Area	Observed Cases	Risk- Adjusted Expected Rate/100k	to NYC	to NYS
Pediatric Asthma (PDI 14)				
Lower MH SA	51	239	0.61	0.75
Upper MH SA	1,213	566	1.45	1.77
Manhattan (MH)	490	407	1.04	1.27
NYC	4,282	391	1.00	1.22
NYS	5,384	321	1.00	1.00
Young Adult Asthma Ages 18-39 (PQI 15)				
Lower MH SA	30	92	0.62	0.68
Upper MH SA	515	225	1.51	1.67
Manhattan (MH)	262	164	1.10	1.21
NYC	1,730	149	1.00	1.11
NYS	2,410	135	1.00	1.00
COPD and Asthma Ages 40 and Above (PQI 055)				
Lower MH SA	387	606	0.77	0.78
Upper MH SA	2,347	968	1.23	1.24
Manhattan (MH)	1,729	731	0.93	0.94
NYC	10,486	788	1.00	1.01
NYS	16,244	779	1.00	1.00

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012

Table 41: Cardiovascular Conditions Related Prevalence and Utilization, Medicaid Beneficiaries, 2012

Area	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	% with at least 1 ED Visit	Average # of Admissions	Average # of ED Visits
LMSA	50,978	34.79	37.05	26.11	2.25	3.06
UMSA	160,194	28.49	44.56	36.39	2.22	2.54
Manhattan	271,388	33.55	41.59	31.51	2.12	2.70
NYC	1,085,013	30.24	40.44	28.09	2.03	2.37
NYS	1,543,129	26.44	40.00	31.28	1.97	2.57
Rate Ratio						
LM/NYC		1.15	0.92	0.93	1.11	1.29
LM/NYS		1.32	0.93	0.83	1.14	1.19
UM/NYC		0.94	1.10	1.30	1.09	1.07
UM/NYS		1.08	1.11	1.16	1.13	0.99
Manhattan/NYC		1.11	1.03	1.12	1.05	1.14
Manhattan /NYS		1.27	1.04	1.01	1.08	1.05
NYC/NYS		1.14	1.01	0.90	1.03	0.92

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012

Table 42: Observed and Risk-Adjusted Circulatory Related Hospitalizations (PQI SO2), 2012

			Risk-Adjusted Expected Rate Ratios	
Area	**Observed Cases**	**Risk- Adjusted Expected Rate/100k**	**to NYC**	**to NYS**
Lower MH SA	340	262	0.61	0.64
Upper MH SA	2,247	489	1.13	1.20
Manhattan (MH)	1,759	379	0.88	0.93
NYC	11,116	432	1.00	1.06
NYS	15,795	408	1.00	1.00

Rate ratio less than 1 signifies outperformance by area, relative to NYC/NYS after controlling for these factors.

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012.

Table 43: Hypertension Related Prevalence and Utilization, Medicaid Beneficiaries, 2012

	NYS	**NYC**	**Manhattan**	**LMSA**	**UMSA**
Beneficiaries with Condition	846,221	564,716	148,171	26,793	88,258
Diagnosed Prevalence (Per 100)	14.50	15.74	18.07	18.28	15.70
% With at Least one Admission	23.11	22.02	23.39	22.04	24.72
% With at Least One ED Visit	30.24	26.41	29.63	24.44	34.20
Average # of Admissions	1.79	1.83	1.95	2.14	1.95
Average # of ED Visits	2.39	2.15	2.42	2.81	2.27

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012

Table 44: Observed and Risk-Adjusted Hypertension Related Hospitalizations (PQI 07), 2012

			Risk-Adjusted Expected Rate Ratios	
Area	**Observed Cases**	**Risk- Adjusted Expected Rate/100k**	**to NYC**	**to NYS**
Lower MH SA	96	75	0.67	0.74
Upper MH SA	646	130	1.16	1.27
Manhattan (MH)	475	99	0.89	0.98
NYC	2,991	112	1.00	1.10
NYS	3,938	102	1.00	1.00

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012

Table 45: Diabetes Related Prevalence and Utilization, Medicaid Beneficiaries, 2012

	NYS	NYC	Manhattan	LMSA	UMSA
Beneficiaries with Condition	562,637	409,227	105,074	17,746	66,088
Diagnosed Prevalence (Per 100)	9.64	11.41	12.48	12.11	11.75
% With at Least One Admission	32.52	32.27	33.51	29.90	36.35
% With at Least One ED Visit	31.23	28.55	31.80	27.13	36.12
Average Admissions	1.89	1.93	1.98	2.01	2.06
Average ED Visits	2.43	2.25	2.56	2.78	2.43

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012.

Table 46: Observed and Risk-Adjusted Diabetes Related Hospitalizations (PQI S01), 2012

			Risk-Adjusted Expected Rate Ratios	
Area	**Observed Cases**	**Risk-Adjusted Expected Rate/100k**	**to NYC**	**to NYS**
Lower MH SA	291	258	0.70	0.71
Upper MH SA	1,972	420	1.14	1.15
Manhattan (MH)	1,486	348	0.94	0.95
NYC	9,289	370	1.00	1.01
NYS	14,121	365	1.00	1.00

* Risk-Adjusted Rate accounts for demographic (age,gender, race/ethnicity) and case mix (statewide rate for specific PQI) factors. Rate ratio less than 1 signifies outperformance by area, relative to NYC/NYS after controlling for these factors.

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 47: Mental Health Related Prevalence and Utilization, Medicaid Beneficiaries, 2012

Area	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	% with at least 1 ED Visit	Average # of Admissions	Average # of ED Visits
LMSA	42,466	28.98	36.85	45.90	3.13	3.83
UMSA	136,998	24.37	33.29	48.61	2.64	3.02
Manhattan	133,250	26.77	35.05	46.52	2.79	3.37
NYC	702,585	19.58	32.34	42.33	2.43	2.98
NYS	997,306	17.09	41.21	60.98	2.24	3.19
Rate Ratio						
LM/NYC		1.48	1.14	1.08	1.29	1.28
LM/NYS		1.70	0.89	0.75	1.40	1.20
UM/NYC		1.24	1.03	1.15	1.08	1.01
UM/NYS		1.43	0.81	0.80	1.18	0.95
MANHATTAN /NYC		1.37	1.08	1.10	1.14	1.13
MANHATTAN/NYS		1.57	0.85	0.76	1.25	1.06
NYC/NYS		1.15	0.78	0.69	1.09	0.94
<1: Outperforms NYC/NYS; >1 Needs Improvement						

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics Medicaid Claims Extract, 2012

Table 48: Average Numbers of Admissions, Medicaid Beneficiaries with a Mental Health Condition

	NYS	NYC	Manhattan	LMSA	UMSA
Average # of Admissions	2.24	2.43	2.79	3.13	2.64
Average # of ED Visits	3.19	2.98	3.37	3.83	3.02

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 49: Mental Health Readmissions Within 30 Days, Medicaid Fee For Service, 2012

Region	All Ages				
	Discharges	Readmissions within 30 Days to Any Region	Rate of Readmission within 30 Days to Any Region	Readmissions in <= 30 Days to the Same Region	Rate of Readmission within 30 days to the Same Region
Manhattan	6,040	1,392	23.0%	1,283	21.2%
New York City	21,653	5,047	23.3%	4,672	21.6%
Statewide	**41,814**	**8,754**	**20.9%**	**7,953**	**19.0%**
Hospitals					
Bellevue Hospital Center	1535	383	25.0%	364	23.7%
Beth Israel Medical Center	624	122	19.6%	115	18.4%
Harlem Hospital Center	702	188	26.8%	179	25.5%
Lenox Hill Hospital	106	32	30.2%	29	27.4%
Metropolitan Hospital Center	1173	303	25.8%	284	24.2%
Mount Sinai Hospital	810	145	17.9%	128	15.8%
NY Hospital	513	103	20.1%	82	16.0%
NYU Hospitals Center	47	14	29.8%	12	25.5%
St Lukes Roosevelt Hospital Center	530	102	19.2%	90	17.0%

Source: NYS Office of Mental Health, DSRIP Dashboard; Behavioral Health Organization Performance Metrics, 2012.

Table 50: Medication Fill post Mental Health Discharge, Medicaid Fee For Service, 2012

Event	Manhattan	New York City	New York State
30 Day MH Rx Fill (1st Psychotropic Rx)	51.0%	57.6%	63.9%
100 Day MH Rx Fill (Refill Psychotropic Rx)	85.6%	86.5%	88.2%
30 Day MH Rx Fill, w/ Psychosis (1st Antipsychotic Rx)	45.6%	54.3%	59.6%
100 Day MH Rx Fill, w/ Psychosis (Refill Antipsychotic Rx)	80.1%	83.0%	84.4%
30 Day MH Rx Fill, w/ Mood Disorder (1st Mood Stabilizer Rx)	43.4%	47.0%	55.8%
100 Day MH Rx Fill, w/ Mood Disorder (Refill Mood Stabilizer Rx)	82.5%	83.1%	84.8%

Source: NYS Office of Mental Health, DSRIP Dashboard; Behavioral Health Organization Performance Metrics, 2012.

Table 51: Substance Abuse Prevalence and Utilization, Medicaid Beneficiaries, 2012

Area	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	% with at least 1 ED Visit	Average # of Admissions	Average # of ED Visits
LMSA	21,158	14.44	70.85	61.09	4.44	5.57
UMSA	56,799	10.10	65.46	59.24	3.76	4.22
Manhattan	26,264	11.17	68.12	60.84	4.04	4.94
NYC	222,198	6.19	65.03	58.37	3.58	4.34
NYS	370,898	6.36	59.56	59.86	3.13	4.18
Rate Ratio						
LM/NYC		2.33	1.09	1.05	1.24	1.28
LM/NYS		2.27	1.19	1.02	1.42	1.33
UM/NYC		1.63	1.01	1.01	1.05	0.97
UM/NYS		1.59	1.10	0.99	1.20	1.01
MANHATTAN/NYC		1.80	1.05	1.04	1.13	1.14
MANHATTAN/NYS		1.76	1.14	1.02	1.29	1.18
NYC/NYS		0.97	1.09	0.98	1.14	1.04
<1: Outperforms NYC/NYS; >1 Needs Improvement						

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 52: Hospital Utilization among Medicaid Beneficiaries with a Substance Abuse Condition, 2012

	NYS	NYC	Manhattan	LMSA	UMSA
Average # of Admissions	3.13	3.58	4.04	4.44	3.76
Average # of ED Visits	4.18	4.34	4.94	5.57	4.22

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 53: Rates of HIV diagnoses, People With HIV/AIDS (PWHA), and deaths among PWHA by United Hospital Fund (UHF) neighborhood, New York City, 2011

UHF Neighborhood	HIV Diagnoses per 100,000 Population	Reported PWHA as Percent of Population	Age-Adjusted Death Rate per 1,000 PWHA	Population from 2010 Census
NYC Total	**41.6**	**1.4**	**14.7**	**8,175,133**
Manhattan	**54.9**	**2.2**	**12.5**	**1,577,279**
Central Harlem Morningside Heights	92.8	2.9	16.4	162,652
Chelsea Clinton	126.3	4.5	10.0	144,896
East Harlem	76.4	2.9	24.8	109,972
Gramercy Park Murray Hill	40.1	1.7	8.8	134,520
Greenwich Village SoHo	46.6	2.7	5.9	83,749
Lower Manhattan	22.6	1.0	6.3*	53,159
Union Square Lower East Side	45.3	1.7	12.6	198,781
Upper East Side	15.8	0.7	8.6	220,962
Upper West Side	30.9	1.5	11.9	220,080
Washington Heights Inwood	56.3	1.7	14.4	248,508

*Rates based on numerators ≤10 are marked with an asterisk(*) and should be interpreted with caution.

Source: New York City Department of Health and Mental Hygiene HIV Epidemiology and Field Services Programs

UHF Neighborhood	HIV Diagnoses per 100,000 Population	Reported PWHA as Percent of Population	Age-Adjusted Death Rate per 1,000 PWHA	Population from 2010 Census

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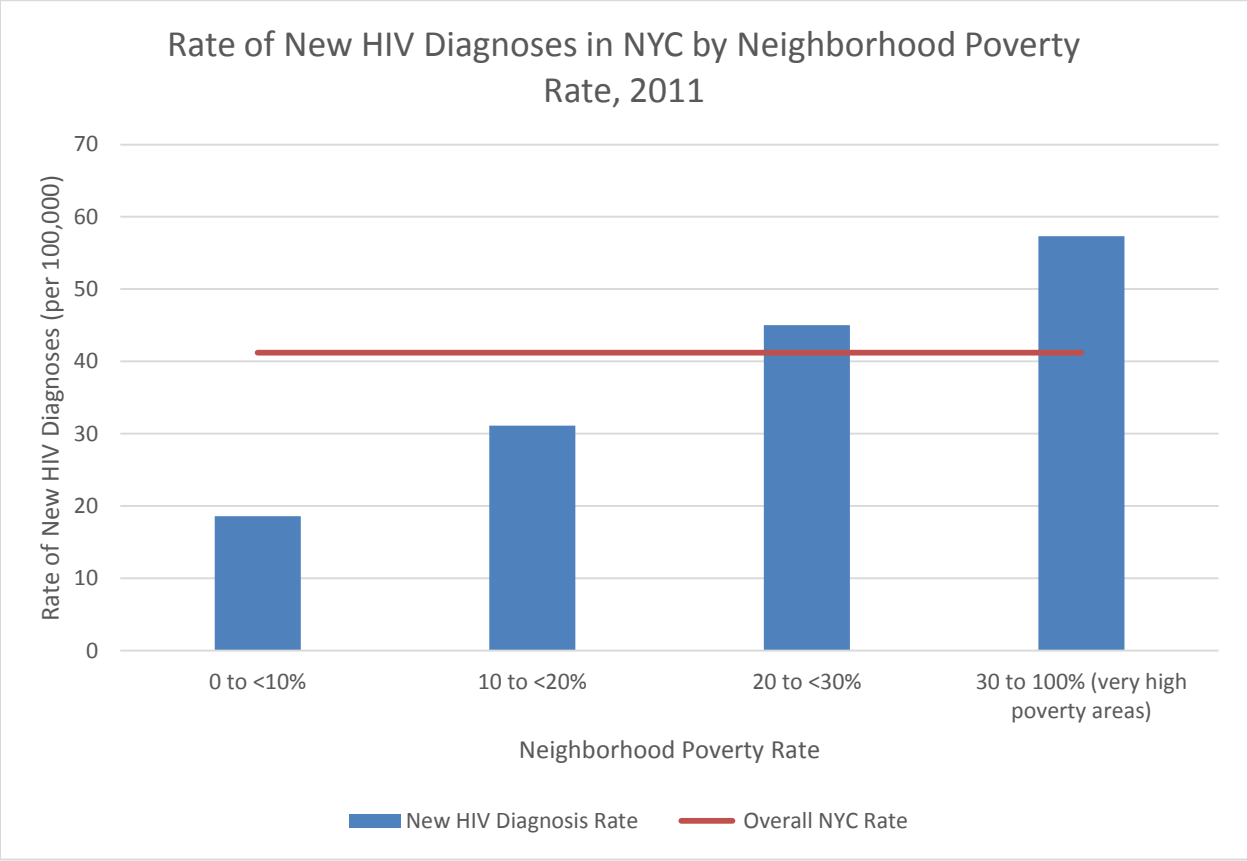
Table 54: Rate of New HIV Diagnoses in NYC by Neighborhood Poverty Rate, 2011



Source: The New York City Department of Health and Mental Hygiene, Epiquery: NYC Interactive Health Data System-[HIV/AIDS Surveillance Data, 2009]. [1 August 2014] http://nyc.gov/health/epiquery

Table 55: Medicaid beneficiaries with HIV/AIDS-Prevalence, at least 1 admission and ED visit by Service Area, 2012

Area	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	% with at least 1 ED Visit	Average # of Admissions	Average # of ED Visits
LMSA	3,972	2710.56	22.18	29.38	2.34	2.75
UMSA	11,494	2044.41	30.82	40.83	2.42	2.51
Manhattan	6,984	2062.03	25.92	35.72	2.36	2.71
NYC	49,984	1393.05	25.12	35.44	2.22	2.43
NYS	53,901	923.63	25.33	36.43	2.20	2.49
Rate Ratio						
LM/NYC		1.95	0.88	0.83	1.05	1.13
LM/NYS		2.93	0.88	0.81	1.06	1.10
UM/NYC		1.47	1.23	1.15	1.09	1.03
UM/NYS		2.21	1.22	1.12	1.10	1.01
MANHATTAN/NYC		1.48	1.03	1.01	1.06	1.11
MANHATTAN/NYS		2.23	1.02	0.98	1.07	1.09
NYC/NYS		1.51	0.99	0.97	1.01	0.98
<1: Outperforms NYC/NYS; >1 Needs Improvement						

Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.

Table 56: HIV/AIDS Diagnoses and Deaths and Persons Diagnosed with HIV/AIDS, NYC, 2012

	HIV diagnoses			AIDS diagnoses	PLWHA as of 12/31/2012	Deaths
	Total	Without AIDS	Concurrent with AIDS diagnosis			
Total	3,141	2,529	612	1,889	114,926	1,578
Male	2,494	2,018	476	1,392	82,426	1,085
Female	647	511	136	497	32,500	493
Race/Ethnicity						
Black	1,394	1,091	303	987	51,154	829
Hispanic	1,019	830	189	586	37,290	509
White	611	517	94	262	23,715	211
Asian/Pacific Islander	107	83	24	49	2,047	22
Native American	3	1	2	5	251	5
Multiracial	7	7	0	0	70	2
Unknown	0	0	0	0	399	0
Age group (years)						
0-12	6	6	0	1	192	2
13-19	141	135	6	32	1,081	1
20-29	1,073	959	114	360	8,907	45
30-39	762	630	132	424	16,515	109
40-49	643	455	188	536	35,004	369
50-59	360	249	111	378	35,540	596
60+	156	95	61	158	17,687	456
Borough of residence						
Bronx	584	465	119	452	26,613	477
Brooklyn	860	675	185	548	28,544	499
Manhattan	808	656	152	418	31,067	328
Queens	501	396	105	271	17,071	143
Staten Island	44	40	4	38	2,228	45
Outside NYC	324	277	47	132	9,196	62
Unknown	20	20	0	30	207	24
Area-based poverty level						
Low (<10% below FPL)	259	211	48	132	12,237	101
Medium (10 to <20% below FPL)	883	701	182	522	31,544	361
High (20 to <30% below FPL)	862	688	174	509	29,292	441
Very high (>30% below FPL)	773	618	155	552	30,969	588
not available	364	311	53	174	10,884	87
Transmission risk						
Men who have sex with men	1,719	1,447	272	755	41,641	283
Injection drug use history	139	110	29	171	19,529	577
Heterosexual	616	462	154	455	22,767	309
Perinatal	6	6	0	27	2,496	15
Other	0	0	0	1	226	0
Unknown	661	504	157	480	28,267	394

Source: New York City Department of Health and Mental Hygiene. HIV Surveillance Annual Report, 2012

Table 57: Chlamydia Incidence Rate, by Neighborhood

Neighborhood	Chlamydia Rate per 100,000	Absolute Totals
New York City	697.7	58,353
Manhattan	646.5	10,521
Washington Heights	899.1	2335
Central Harlem	1419.1	2028
East Harlem	1152.5	1231
Upper West Side	258.6	634
Upper East Side	120.6	298
Chelsea	672.5	947
Gramercy Park	263.4	360
Greenwich Village	587.3	554
Union Square	459.5	996
Lower Manhattan	489.7	182
Manhattan- neighborhood unknown	n/a	956

Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [STD Surveillance Data, 2009]. [1 August 2014]. http://nyc.gov/health/epiquery

Table 58: Gonorrhea Incidence Rate, by Neighborhood

Neighborhood	Gonorrhea Rate per 100,000	Absolute totals
New York City	**130.3**	**10,898**
Manhattan	**144.8**	**2,356**
Washington Heights	131.7	342
Central Harlem	347.1	496
East Harlem	244.4	261
Upper West Side	71.8	176
Upper East Side	31.2	77
Chelsea	261.3	368
Gramercy Park	66.6	91
Greenwich Village	135.7	128
Union Square	103.8	225
Lower Manhattan	96.9	36
Manhattan- neighborhood unknown	n/a	156

Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [STD Surveillance Data, 2009]. [1 August 2014]. http://nyc.gov/health/epiquery

Table 59: Selected Patients' Satisfaction Ratings for Adult Services-Statewide Averages By Payer

	Commercial HMO	Commercial PPO	Medicaid Managed Care*
Satisfaction with Provider Communication	94%	95%	87%
Satisfaction with Personal Doctor	83%	84%	73%
Satisfaction with Specialist	83%	83%	69%
Received Needed Care	87%	87%	75%
Got Care Quickly	87%	86%	76%

** Data is for 2011.*

Source: 2013 Health Plan Comparison in New York State, New York State Department of Health.

Table 60: Selected Quality of Care Measures for Adults – Statewide Averages by payer

	Commercial HMO		Commercial PPO		Medicaid Managed Care*	
Controlling High Blood Pressure	59%		57%		63%	
Poor HbA1c Control in Diabetics* (Lower is better)	27%		42%		33%	
Use of Appropriate Medications for People with Asthma	89%		90%		82%	
Behavioral Health: Follow-up after Hospitalization for Mental Illness	64%	78%	58%	71%	65%	79%

** Data is from 2011.*

Source: 2013 Health Plan Comparison in New York State," New York State Department of Health.

Table 61:Access and Quality Measures for Children and Adolescents, Statewide Average by Payer

	Commercial HMO	Commercial PPO	Medicaid Managed Care*
Well-Child and Preventive Care Visits in the First 15 Months*	91	90	83
Well-Child and Preventive Care Visits Years 3-6*	84	79	82
Adolescent Well-Care Visits*	61	53	59
Appropriate Treatment—no antibiotic--for Upper Respiratory Infection	89	89	93

**Data is from 2011*

Source: 2013 Health Plan Comparison in New York State, New York State Department of Health.

Table 62: Behavioral Health

Select Clinical Improvement Measures, 2012	**NYS**	**NYC**	**Manhattan**
PPV (for persons with BH diagnosis)	[No known public source]	[No known public source]	[No known public source]
Antidepressant Medication Management: Effective Continuation Phase Treatment Effective Acute Phase Treatment*	 37% 50%	 47%	 48%
Diabetes Monitoring for People with Diabetes and Schizophrenia (aged 18-64 years)*	68%	70%	73%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (aged 18-64 years) Using Antipsychotic Medication*	79%	80%	80%
Cardiovascular Monitoring for People with CVD and Schizophrenia.	[No known public source]	[No known public source]	[No known public source]
Follow-up care for Children Prescribed ADHD Medications: Initiation Phase* Continuous Phase	 56% 63%	 64%	 67%
Follow-up after hospitalization for Mental Illness: Within 7 Days Within 30 Days*	 65% 55%	 51%	 48%
Screening for Clinical Depression and follow-up			
Adherence to Antipsychotic Medications (at least 80% of treatment time) for People with Schizophrenia (aged 19-64 yrs.)*	64%	63%	61%
Initiation of Alcohol and Other Drug Dependence Treatment*	78%	78%	79%
Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm in Nursing Homes (BIPNH) project:			
PPR for SNF patients	[No known public source]		
Percent of Long Stay Residents who have Depressive Symptoms**	12.23%	[See source note]	[See source note]

Sources: *Health care Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management
** Source: Nursing Home Quality Initiative 2012 (this source does not provide data at the city or county level).

Table 63: Domain 3 Metrics, Cardiovascular Disease

Select Clinical Improvement Measures, 2012	NYS	NYC	Manhattan
Cholesterol Management for Patients with CV Conditions[a]	[No known public source]	35.9% (33.3-38.7)	32.5% (26.8-38.7)
Controlling High Blood Pressure (Provider responsible for medical record reporting)[a,b]	63%*	67.0% (63.3-70.5)	[No known public source]
Aspirin Discussion and Use [b] Discussion of Aspirin Risks and Benefits(HMO/PPO) Aspirin Use(HMO/PPO)	49%/43% 39%/39%	[No known public source]	[No known public source]
Medical Assistance with Smoking Cessation[a]	[No known public source]	5.8% (4.3-7.8)	8.8% (5.1-14.9)
Flu Shots for Adults Ages 50 – 64[a]	[No known public source]	43% (40 – 45.9)	39% (33.4-45)
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse	[No known public source]	[No known public source]	[No known public source]

Sources:
[a] *NYC DOHMH Community Health Survey, 2012 (Note: this source provides information only that the city and county level)*
[b] *QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)*
[c] *QARR 2011(Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)*

Table 64: Domain 3 Metrics, Diabetes Mellitus

Select Clinical Improvement Measures, 2012	NYS	NYC	Manhattan
Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy) [a]	51%	[See source note]	[See source note]
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing*	80%	82%	82%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) [a]	33%	[See source note]	[See source note]
Comprehensive diabetes care - LDL-c control (<100mg/dL): Lipids Controlled (<100 mg/dL) Monitoring Diabetes - Lipid Profile[a]	47% 87%	[See source note]	[See source note]
Medical Assistance with Smoking Cessation[b]	[See source note]	5.8% (4.3-7.8)	8.8% (5.1-14.9)
Flu Shots for Adults Ages 50 – 64[b]	[See source note]	43% (40.0-45.9)	39% (33.4-45)
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	[No known public source]	[No known public source]	[No known public source]

Sources: * Health care Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management
[a] QARR, 2011 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

[b] NYC DOHMH Community Health Survey, 2012 (NYC DOHMH Community Health Survey, 2012 (Note: this source provides information only that the city and county level)

Table 65: Risk Factors by Select Manhattan Neighborhoods

	Obesity (BMI≥30)	Binge Drink (within past 30 days)	Lack of or low Physical Activity (within past 30 days)	Current or Past Smoker
NYC	24.1%	13.4%	21.6%	15.6%
UM: Washington Heights	21.7%	13.5%	22.4%	13.0%
UM: Central Harlem	30.8%	14.1%	24.9%	16.1%
UM: East Harlem	25.8%	21.4%	31.5%	18.6%
UM: Upper West Side	18.3%	14.8%	15.2%	12.6%
LM: Chelsea/Village	7.6%	20.2%	14.7%	18.4%
LM: Union Sq./Lower Manhattan	7.8%	20.6%	20.8%	22.8%

Values are not adjusted for age.

Source: NYC Dept. of Health and Mental Hygiene, NYC Community Health Survey, 2012.

Table 66: Current Smokers, Percent by Neighborhood

Neighborhood	% Current Smoker*	Absolute #
New York City	**15.6**	**981,000**
Manhattan	**15.6**	**202,000**
Washington Heights	13.0	25,000
Central Harlem	16.1	18,000
East Harlem	18.6	13,000
Upper West Side	12.6	23,000
Upper East Side-Gramercy	12.8	38,000
Chelsea-Village	18.4	37,000
Union Square-Lower Manhattan	22.8	46,000

Source: New York City Department of Health and Mental Hygiene. NYC Community Health Survey, 2012.

Section B: Tables Not Cited in Manhattan CNA

Table 67: Risk Factors by Insurance Status, NYC

	Current or Past Smoker	Overweight	Obese	Healthy diet
Medicaid	19.0%	34.9%	30.2%	39.6%
Uninsured	17.9%	33.6%	24.0%	32.3%

Source: NYC Dept. of Health and Mental Hygiene, NYC Community Health Survey, 2012, age adjusted.

Table 68: Managed Care Organizations

Plan	Total New York City Enrollment, 2012	Plan Type
HealthFirst PHSP, Inc.	457,055	PHSP
MetroPlus Health Plan, Inc.	378,067	PHSP
Amerigroup, Inc.	337,758	PHSP
New York State Catholic Health Plan, Inc.	283,847	(Fidelis Care) PHSP
UnitedHealthcare of New York, Inc.	198,809	HMO
Affinity Health Plan, Inc.	150,914	PHSP
Neighborhood Health Providers, Inc.	167,245	PHSP
Health Insurance Plan of Greater New York	157,530	HIP (Emblem Health) HMO
WellCare of New York, Inc.	52,534	PHSP
Total	2,200,890	

Source: New York State Department of Health Division of Managed Care, "2012 Monthly Medicaid Managed Care Enrollment," 2012.

Table 69: Domain 2.a Metrics. Implementation of Care Coordination and Transitional Care Programs

Measure Name	NYS	NYC	Manhattan	Lower Manhattan Service Area (LMSA)	Upper Manhattan Service Area (UMSA)
Potentially Avoidable Emergency Room Visits: ED Visits for Ambulatory Sensitive Conditions, Potentially Preventable Visits (PPV), per 100 Recipients	36	33	42	38	44
Potentially Avoidable Readmissions, by hospital location, 2012*	40,687	24,388	6,002		

*Source: *HHC analysis of Potentially Preventable Readmissions data by hospital, New York State Department of Health*

Table 70: Domain 2.b Metrics

Measure Name	NYS	NYC	Manhattan
H-CAHPS – Care Transition Metrics	36	34	

Table 71: Household Type

Household Type	NYS	NYC	Manhattan
Total Households	7,130,896	3,063,393	738,131
Family Households	4,646,324	1,843,819	302,793
Family Households - Married couple	3,224,971	1,103,512	192,290
Family Households - Male Householder no spouse	351,847	170,979	23,776
Family Households - Female Householder no spouse	1,069,506	569,328	86,727
Non-family Households	2,584,572	1,219,574	435,338
Non-family Households - Living alone	2,119,199	996,487	352,802
% of Total Households - Living Alone	30%	33%	47.8%
Non-family Households - Not living alone	465,373	223,087	82,536

Source: US Census American Community Survey, 5-year table, 2008-2012.

Table 72: Incarceration

Incarceration	NYS	NYC	Manhattan	LMSA	UMSA
NYC DOC Jail admissions (2007-2012), Average	94,951	71,929	13,710	3,014	17,181
NYC DOC Jail admissions rate per 100,000 Population (2007-2012), Average	489	877	859	552	1,699
NYS Prison admissions (2008)[a]	21,141	9,640	2,393	22	93

[a]The most recent data available for NYS prison admissions is from 2008; it is likely that more recent figures would be significantly lower.

Source: NYC Department of Corrections, 2012, as cited in http://gothamist.com/2013/05/01/these_interactive_charts_show_you_w.php and http://www.justiceatlas.org/

Table 73: Moderate - Serious Psychological Distress by Neighborhood

Neighborhood	Serious Psychological Distress*	Absolute #
New York City	31.9	2,010,000
Manhattan	29	378,000
Washington Heights	41.18	81,000
Central Harlem	27.99	32,000
East Harlem	36.45	26,000
Upper West Side	23.82	43,000
Upper East Side-Gramercy	23.03	71,000
Chelsea-Village	25.92	52,000
Union Square-Lower Manhattan	32.26	66,000

Source: New York City Department of Health and Mental Hygiene. NYC Community Health Survey, 2012.

Table 74: Select Medicaid Managed Care Clinical Improvement Measures: Mental Health

Select Medicaid Managed Care (MMC) Clinical Improvement Measures, 2012	NYS	NYC	Manhattan
Antidepressant Medication Management:			
Effective Continuation Phase Treatment	37%		
Effective Acute Phase Treatment*	50%	47%	48%
Follow-up care for Children Prescribed ADHD Medications:		[No known public source]	[No known public source]
Initiation Phase*	57%		
Continuous Phase	63%		
Follow-up after hospitalization for Mental Illness:		[No known public source]	[No known public source]
Within 7 Days	65%		
Within 30 Days*	79%		

Sources:
**Healthcare Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management*
QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

Table 75: Mental Health Outpatient Service within Thirty Days of Discharge from a Mental Health Inpatient Episode By adults, Medicaid Fee For Service, 2012

Region	Discharges	Outpatient Service, 30 days	% Outpatient Service, 30 days
Manhattan	4,915	1,686	34.3%
New York City	16,629	7,083	42.6%
Statewide	29,661	13,919	46.9%
Hospital			
Bellevue Hospital Center	1,199	281	23.4%
Beth Israel Medical Center	587	248	42.2%
Gracie Square General Hospital	11	2	18.2%
Harlem Hospital Center	534	241	45.1%
Lenox Hill Hospital	104	38	36.5%
Metropolitan Hospital Center	1,031	317	30.7%
Mount Sinai Hospital	507	224	44.2%
NY Hospital	436	155	35.6%
NYU Hospitals Center	41	14	34.1%
St Luke's Roosevelt Hospital Center	465	166	35.7%

Source: Office of Mental Health, 2012.

Table 76: Mental Health Outpatient Service Follow-up and Continuity of Care post Mental Health Discharge By Adults, Medicaid Fee For Service, 2012

Event	Manhattan	New York City	New York State
7 day MH Follow-Up (MH Only)	25.5%	31.1%	34.8%
7 day MH Follow-Up (MH and SUD)	31.4%	35.9%	39.1%
30 Day MH Follow-Up (MH Only)	34.3%	42.6%	46.9%
30 Day MH Follow-Up (MH and SUD)	41.1%	48.0%	52.1%
30 Day MH Engagement (2 or More OP)	23.8%	32.6%	36.1%
60 Day MH Engagement (4 or More OP)	18.2%	26.5%	29.5%

Source: Office of Mental Health, 2012.

Table 77: Population Health Indicators: Cardiovascular Health

Population Health Indicator	NYS	NYC	Manhattan
Cardiovascular disease mortality rate per 100,000			
Crude	281.2	256.4	224.5
Age-adjusted	242.3	249.3	203.1
Premature death (aged 35-64 years)	100	107.8	81.3
Pretransport mortality	144.2	126.7	126.8
Cardiovascular disease hospitalization rate per 10,000			
Crude	178.2	176.9	150.9
Age-adjusted	159.9	173.6	140.2
Disease of the heart mortality rate per 100,000			
Crude	230.9	218.4	182.8
Age-adjusted	198.6	212.2	165.1
Premature death (aged 35-64 years)	81.2	86.9	63.8
Pretransport mortality	124.7	117.1	114.4
Disease of the heart hospitalization rate per 10,000			
Crude	120.6	117.3	97.3
Age-adjusted	107.9	114.9	90.2
Coronary heart disease mortality rate per 100,000			
Crude	186.5	200	160.6
Age-adjusted	160.4	194.4	145.1
Premature death (aged 35-64 years)	66.5	77.4	54.8
Pretransport mortality	104	111	105.5
Coronary heart disease hospitalization rate per 10,000			
Crude	48.3	49.5	36
Age-adjusted	43	48.2	33.4
Congestive heart failure mortality rate per 100,000			
Crude	13.3	4.6	6
Age-adjusted	11.2	4.4	5.3
Premature death (aged 35-64 years)	1.5	0.9	0.6
Pretransport mortality	7.2	2.2	3.5
Congestive heart failure hospitalization rate per 10,000			
Crude	31.2	31	25.7
Age-adjusted	27.6	30.5	23.7
Cerebrovascular disease (stroke) mortality rate per 100,000			

Population Health Indicator	NYS	NYC	Manhattan
Crude	31	19.7	22
Age-adjusted	26.9	19.3	20.2
Premature death (aged 35-64 years)	10.7	10.9	7.8
Pretransport mortality	11.3	3.8	5.1
Cerebrovascular disease (stroke) hospitalization rate per 10,000			
Crude	27.9	25.2	21.9
Age-adjusted	24.9	24.7	20.3
			8.2
Hypertension hospitalization rate per 10,000 (aged 18 years and older)	7.9	11.3	N/A
Age-adjusted % of adults ever told they have high blood pressure (2008-2009)	25.7	28.8	N/A

Source: Cardiovascular Disease Indicators, Manhattan County, from County Health Assessment Indicators, 2009-2011 data http://www.health.ny.gov/statistics/chac/chai/docs/chr_58.htm

Table 78: Population Health Indicators: Sexually Transmitted Diseases

Population Health Indicator	NYS	NYC	Manhattan
HIV case rate per 100,000			
Crude	20	37.3	54.3
Age-adjusted	20	35.9	49.3
AIDS case rate per 100,000			
Crude	15.2	28.9	36.8
Age-adjusted	15.2	28.3	34.5
AIDS mortality rate per 100,000			
Crude	5.1	9.8	11.3
Age-adjusted	4.7	9.4	10.5
Early syphilis case rate per 100,000	12.4	25.7	49.8
Gonorrhea case rate per 100,000			
All ages	95.8	151.8	179.7
Aged 15-19 years	362	620.2	659.7
Chlamydia case rate per 100,000 males			
All ages	323	508.7	583.1
Aged 15-19 years	1,077.10	1,829.00	1,947.90
Aged 20-24 years	1,484.30	2,121.00	2,129.60
Chlamydia case rate per 100,000 females			
All ages	674	973.9	822.4
Aged 15-19 years	3,773.90	5,913.40	6,247.10
Aged 20-24 years	3,344.70	4,308.90	3,183.90
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	3.5	4.8	3.2

Source: Manhattan County: County Health Assessment Indicators, 2009 – 2011 data, http://www.health.ny.gov/statistics/chac/chai/docs/sti_58.htm

Table 79: Obesity Rate by Neighborhood

Neighborhood	% Obese*	Absolute #
New York City	24.1	1,495,000
Manhattan	14.5	185,000
Washington Heights	21.7	42,000
Central Harlem	30.8	33,000
East Harlem	25.8	18,000
Upper West Side	18.3	33,000
Upper East Side-Gramercy	8.9	26,000
Chelsea-Village	7.6	15,000
Union Square-Lower Manhattan	7.8	16,000

Source: New York City Department of Health and Mental Hygiene. NYC Community Health Survey, 2012.

Table 80. Percentage of People who Reported No Fruit of Vegetable Consumption (Yesterday), by Neighborhood

Neighborhood	% No Fruit/Vegetable Consumption*	Absolute #
New York City	12.5	772,000
Manhattan	8.4	107,000
Washington Heights	14.7	27,000
Central Harlem	14.0	17,000
East Harlem	15.6	8,000
Upper West Side	11.7	10,000
Upper East Side-Gramercy	5.7	20,000
Chelsea-Village	6.7	14,000
Union Square-Lower Manhattan	7.0	11,000

Source: New York City Department of Health and Mental Hygiene. NYC Community Health Survey, 2012.

Table 81: Current Smokers, Percent by Neighborhood

Neighborhood	% Current Smoker*	Absolute #
New York City	15.6	981,000
Manhattan	15.6	202,000
Washington Heights	13.0	25,000
Central Harlem	16.1	18,000
East Harlem	18.6	13,000
Upper West Side	12.6	23,000
Upper East Side-Gramercy	12.8	38,000
Chelsea-Village	18.4	37,000
Union Square-Lower Manhattan	22.8	46,000

Source: New York City Department of Health and Mental Hygiene. NYC Community Health Survey, 2012.

Table 82: Domain 3 Metrics, Behavioral Health

Select Clinical Improvement Measures, 2012	NYS	NYC	Manhattan
PPV (for persons with BH diagnosis)	[No known public source]	[No known public source]	[No known public source]
Antidepressant Medication Management: Effective Continuation Phase Treatment Effective Acute Phase Treatment*	 37% 50%	 47%	 48%
Diabetes Monitoring for People with Diabetes and Schizophrenia (aged 18-64 years)*	68%	70%	73%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (aged 18-64 years) Using Antipsychotic Medication*	79%	80%	80%
Cardiovascular Monitoring for People with CVD and Schizophrenia.	[No known public source]	[No known public source]	[No known public source]
Follow-up care for Children Prescribed ADHD Medications: Initiation Phase* Continuous Phase	 56% 63%	 64%	 67%
Follow-up after hospitalization for Mental Illness: Within 7 Days Within 30 Days*	 65% 55%	 51%	 48%
Screening for Clinical Depression and follow-up			
Adherence to Antipsychotic Medications (at least 80% of treatment time) for People with Schizophrenia (aged 19-64 yrs)*	64%	63%	61%
Initiation of Alcohol and Other Drug Dependence Treatment*	78%	78%	79%
Additional behavioral health measures for provider systems implementing the Behavioral Interventions Paradigm in Nursing Homes (BIPNH) project:			
PPR for SNF patients	[No known public source]		
Percent of Long Stay Residents who have Depressive Symptoms**	12.23%	[See source note]	[See source note]

Sources:
**Healthcare Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management*
*** Source: Nursing Home Quality Initiative 2012 (this source does not provide data at the city or county level).*

Table 83: Select Clinical Measures, Perinatal Care

Select Clinical Improvement Measures, 2012	NYS	NYC	Manhattan
PQI # 9 Low Birth Weight[a]	8.2%	8.6%	8.8%
Prenatal and Postpartum Care—Timeliness and Postpartum Visits:			
% mothers received postpartum checkup[b]	90.1%	89.2%	73.6%
% mothers received prenatal care - start 1st to 3rd month[a]	71.8%	70.4%	20%
% mothers received prenatal care - start 4th to 6th month[a]	20%	21.5%	4.4%
% mothers received prenatal care - start 7th to 9th month[a]	4.8%	6.2%	2.0%
% late or no prenatal[a]	3.4%	2.0%	__
Frequency of Ongoing Prenatal Care:			
Frequency of Ongoing Prenatal Care 61-80%[c]	12%		
Frequency of Ongoing Prenatal Care 41-60%[c]	6%		
Frequency of Ongoing Prenatal Care 21-40%[c]	4%		
Frequency of Ongoing Prenatal Care <21%[c]	8%		
Percentage of Children Who Had Five (5) or More Well Care Visits in the first 15 months[c]	85%	83%	82%
Childhood Immunization Status:[d]			
Childhood immunization (0lmmz)[d]	1%		
Childhood immunization-3 or more IPVsd	93%		
Childhood immunization-2 or 3 rotavirus[d]	69%		
Childhood immunization-4 or more pneumococcals[d]	81%		
Childhood immunization-2 or more HepA[d]	37%		
Childhood Immunization-2 or more influenza[d]	57%		
Childhood Immunization-Varicella[d]	91%		
Childhood Immunization-MMR[d]	93%		
Childhood Immunization-4 or more DTPs[d]	83%		
Childhood Immunization-3 or more HepB[d]	92%		
Childhood Immunization-3 or more Hibs[d]	93%		
Childhood Immunization Status (Combo 3: 4-3-1-3-3-1-4)[d]	74%		
Lead Screening in Children[d]	89%		

Sources:
[a] *NY State Vital Statistics, 2012*
[b] *PRAMS 2011 (postpartum metrics)*
[c] *QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)*
[d] *QARR, 2011 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)*

Table 84: Select Clinical Improvement Measures, Renal Care

Select Clinical Improvement Measures, 2012	NYS
Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy)[a]	51%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)[a]	33%
Comprehensive diabetes care - LDL-c control (<100mg/dL)[a]	47% 87%
Annual Monitoring for Patients on Persistent Medications – ACE/ARB[b]	92%

Sources:
[a] QARR, 2011 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)
[b]QARR, 2012 (Note: this source reports data by health plan. Due to the fact that many health plans operate throughout the state, it is not possible to report metrics from this data set at the city or county level)

COMMUNITY NEEDS ASSESSMENT APPENDIX C – Primary Data Collection Instruments and Information

December 16, 2014

Instruments Prepared by The New York Academy of Medicine

ID : _____ **Date: _____**

New York City Health Provider Partnership: Community Needs Assessment
Community Survey

The New York Academy of Medicine and Tripp Umbach are conducting this 15-20 minute survey on behalf of HHC as part of a community needs assessment. The community needs assessment is being done for New York City health care providers. The information that you provide is important to help providers better serve their communities.

The survey is voluntary and confidential. You do not have to complete the survey, and you can skip questions you do not want to answer. Your name will not be written on the survey, and we will not be able to connect your answers to you personally.

In appreciation of your time and effort, you will receive a $10 MetroCard for completing this survey.

First, some background questions.

1. Where do you live?

☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens

[If Bronx, Brooklyn, Manhattan, or Queens - Continue to Question 2]

☐ Staten Island ☐ Outside of New York City

[If Staten Island, or outside of NYC - Thank you for your time. Unfortunately you are not eligible for the survey.]

2. What is your ZIP code? _____ 3. What neighborhood do you live in? _____

4. How old are you? _____ years

[If younger than 18 years old: Thank you for your time. Unfortunately you are not eligible for the survey.]

Next, some questions about health issues in your community.

5. What do you think are the biggest health concerns in your community? (Check up to five.)

☐ Adolescent health
☐ Asthma
☐ Arrests and incarceration
☐ Cancer
☐ Diabetes
☐ Disability
☐ Drug and alcohol use
☐ Family planning/birth control
☐ Hepatitis
☐ Heart disease
☐ High blood pressure
☐ HIV
☐ Maternal and child health
☐ Mental health (e.g., depression, suicide)
☐ Obesity
☐ Pollution (e.g., air quality, garbage)
☐ Sexually transmitted infections
☐ Stroke
☐ Teen pregnancy
☐ Tobacco use
☐ Violence or injury
☐ Other, specify: _____
☐ Don't know

6. What kind of health education or programs are **needed** in your community? (Check all that apply.)

☐ Cancer/cancer prevention
☐ Diabetes
☐ Domestic violence
☐ Exercise/physical activity
☐ Family planning
☐ Heart disease
☐ HIV/sexually transmitted diseases
☐ Maternal and child health
☐ Mental health
☐ Nutrition
☐ Substance abuse
☐ Sickle cell anemia
☐ Vaccinations
☐ Violence
☐ Other, specify: _____
☐ Don't know

7. To what extent is each of the following available in your community?

	Very available	Available	Not very available	Not available at all	Don't know
a. Accessible transportation	☐	☐	☐	☐	☐
b. Affordable housing	☐	☐	☐	☐	☐
c. Dental services	☐	☐	☐	☐	☐
d. Healthy foods	☐	☐	☐	☐	☐
e. Home health care	☐	☐	☐	☐	☐
f. Job training	☐	☐	☐	☐	☐
g. Medical specialists	☐	☐	☐	☐	☐
h. Mental health services	☐	☐	☐	☐	☐
i. Pediatric and adolescent services	☐	☐	☐	☐	☐
j. Places to exercise, walk and play	☐	☐	☐	☐	☐
k. Primary care medicine	☐	☐	☐	☐	☐
l. Social services	☐	☐	☐	☐	☐
m. Substance abuse services	☐	☐	☐	☐	☐
n. Vision services	☐	☐	☐	☐	☐

The next questions are about your health and health care use.

8. In general, would you say that your health is:
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

9. Which of the following health concerns do you face? *[If yes to any condition]* Do you feel that your condition is under control?

	No	Yes	*[If yes] Is it under control?*	Prefer not to answer
a. Asthma	☐	☐	☐	☐
b. Cancer	☐	☐	☐	☐
c. Chronic pain	☐	☐	☐	☐
d. Depression or anxiety	☐	☐	☐	☐
e. Diabetes	☐	☐	☐	☐
f. Drug or alcohol abuse	☐	☐	☐	☐
g. Heart disease	☐	☐	☐	☐
h. Hepatitis C	☐	☐	☐	☐
i. High blood pressure	☐	☐	☐	☐
j. High cholesterol	☐	☐	☐	☐
k. HIV	☐	☐	☐	☐
l. Mobility impairment	☐	☐		☐
m. Osteoporosis	☐	☐	☐	☐

10. What is your current weight in pounds? _____ pounds ☐ Don't know ☐ Prefer not to answer

11. What is your current height? _____ feet, _____ inches ☐ Don't know ☐ Prefer not to answer

12. Do you currently have health insurance? (Check all that apply.)
☐ Yes, Medicaid ☐ Yes, Medicare ☐ Yes, Private/commercial ☐ Yes, VA
☐ Yes, other, specify: _____ ☐ No ☐ Don't know

13. Do you have a primary care provider or personal doctor?
☐ Yes ☐ No ☐ Don't know ☐ Prefer not to answer

14. Is there a specific place you **usually** go for health care, when it is not an emergency (e.g., for a fever or rash)?
☐ Yes *[Continue to Question 15]* ☐ No *[Skip to Question 17]* ☐ Prefer not to answer *[Skip to Question 17]*

15. What kind of place is it?

- ☐ Primary care doctor's office
- ☐ Specialist doctor's office
- ☐ Community/family health center
- ☐ Hospital-based clinic
- ☐ Private clinic
- ☐ Emergency room
- ☐ Urgent care
- ☐ Pharmacy
- ☐ Drug treatment center
- ☐ Mental health center
- ☐ Alternative care (e.g., herbalist, acupuncturist)
- ☐ Other, specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

16. Where is it located?

- ☐ Bronx
- ☐ Brooklyn
- ☐ Manhattan
- ☐ Queens
- ☐ Staten Island
- ☐ Outside of New York City
- ☐ Prefer not to answer

17. Do you use any complementary or alternative treatments or remedies? (Check all that apply.)

- ☐ Yes, acupuncture
- ☐ Yes, homeopathy
- ☐ No
- ☐ Yes, chiropractic care
- ☐ Yes, remedies from a botánica
- ☐ Prefer not to answer
- ☐ Yes, herbal remedies
- ☐ Yes, other, specify: _____

18. When was your last routine checkup (when you were not sick)?

- ☐ Within the past year
- ☐ Over two years ago
- ☐ Prefer not to answer
- ☐ Over one year ago, but within the past two years
- ☐ Never had a routine physical exam
- ☐ Don't know

19. Have you been to the dentist in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

20. Was there a time in the past 12 months when you needed health care or health services but did not get it?

- ☐ Yes *[Continue to Question 21]*
- ☐ No *[Skip to Question 22]*
- ☐ Prefer not to answer *[Skip to Question 22]*

21. Why didn't you get the health care you needed? (Check all that apply.)

- ☐ Not insured
- ☐ Cost of co-pays
- ☐ Concerned about quality of care
- ☐ Didn't know where to go
- ☐ Had other responsibilities (e.g., work, family)
- ☐ Didn't have transportation
- ☐ Couldn't get an appointment soon or at the right time
- ☐ Concerned about language or translation issues
- ☐ Other, specify: _____
- ☐ Don't know
- ☐ Prefer not to answer

22. During the past 12 months, how many times have you gone to a hospital emergency room about your own health?

- ☐ None (skip to 24)
- ☐ One time
- ☐ Two or more times
- ☐ Don't know
- ☐ Prefer not to answer

23. Why did you go to the emergency room in the last year? (Check all that apply.)

- ☐ Didn't have insurance
- ☐ Didn't have transportation to doctor's office or clinic
- ☐ Get most care at emergency room
- ☐ Don't know
- ☐ Problem too serious for a doctor's office or clinic
- ☐ Doctor's office or clinic wasn't open
- ☐ Other, specify: _____
- ☐ Prefer not to answer

24. Do you ever worry you won't have enough money to pay for food or housing?

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Don't know
- ☐ Prefer not to answer

25. Where do you get most of your health information? (Check all that apply.)

- ☐ Books
- ☐ Doctor or health care provider
- ☐ Community based organization
- ☐ Ethnic media (e.g., ethnic newspaper, TV, radio)
- ☐ Faith-based organization (e.g., church, temple, mosque)
- ☐ Family or friends
- ☐ Health insurance plan
- ☐ Health department
- ☐ Health fairs
- ☐ Internet
- ☐ Library
- ☐ Newspapers or magazines
- ☐ School
- ☐ Television or radio
- ☐ Other, specify: _____
- ☐ Don't know *[Only if none of the above are selected]*
- ☐ Prefer not to answer

26. Which of the following do you currently use? (Check all that apply.)
☐ Email ☐ Smart phone (e.g., iPhone or Galaxy) ☐ Twitter
☐ Internet ☐ Text messaging ☐ Facebook
☐ None ☐ Prefer not to answer

27. Do you visit or attend events at any of the following organization at least once per month?
☐ Community center organization ☐ Gym or recreational center ☐ Other community
☐ Library ☐ Political club ☐ School
☐ Faith-based organization (e.g., church, temple, synagogue, mosque) ☐ Senior center ☐ Sports league
☐ None ☐ Prefer not to answer
☐ Neighborhood association (e.g., tenant or block association, precinct council)

Last, we'd like to get some background information.

28. Are you…
☐ Female ☐ Male ☐ Transgender ☐ Prefer not to answer

29. Do you consider yourself…
☐ Heterosexual or straight ☐ Homosexual, gay, or lesbian ☐ Bisexual
☐ Other ☐ Don't know ☐ Prefer not to answer

30. Do you consider yourself to be Hispanic or Latino?
☐ Yes ☐ No ☐ Prefer not to answer

31. What is your race? (Check all that apply.)
☐ White ☐ Native Hawaiian or other Pacific Islander
☐ Black or African American ☐ Other, specify: _____
☐ Asian, specify: _____ ☐ Prefer not to answer
☐ American Indian or Alaskan Native

32. What ethnic group do you identify with, if any? _____

33. Were you born outside of the U.S.?
☐ Yes ☐ No ☐ Prefer not to answer

34. What is the primary language you speak at home?
☐ English ☐ Haitian/French Creole ☐ Urdu
☐ Spanish ☐ Hindi ☐ Yiddish
☐ Arabic ☐ Italian ☐ Other, specify: _____
☐ Chinese (Mandarin, Cantonese, or other) ☐ Korean ☐ Prefer not to answer
☐ French ☐ Russian

35. Do you prefer to get health care in a language other than English?
☐ Yes ☐ No ☐ No preference ☐ Prefer not to answer

36. How well do you speak English?
☐ Very well ☐ Well ☐ Not well ☐ Not at all ☐ Prefer not to answer

37. What is your highest level of education completed? (Check one)
☐ Did not attend high school ☐ Some high school, but did not graduate
☐ High school graduate or GED ☐ Technical or vocational training

- ☐ Some college but no degree
- ☐ Two year degree (i.e., Associate's Degree)
- ☐ Bachelor's Degree
- ☐ Master's Degree or above
- ☐ Prefer not to answer

38. What is your current employment status?
    - ☐ Employed full-time
    - ☐ Employed part-time
    - ☐ Homemaker
    - ☐ Student
    - ☐ Retired
    - ☐ Unemployed
    - ☐ Unable to work
    - ☐ Prefer not to answer

39. What is your total annual household income?
    - ☐ Less than $10,000
    - ☐ $50,000 to $59, 999
    - ☐ $150,000 or more
    - ☐ $10,000 to $19,999
    - ☐ $60,000 to $69, 999
    - ☐ Don't know
    - ☐ $20,000 to $29, 999
    - ☐ $70,000 to $79, 999
    - ☐ Prefer not to answer
    - ☐ $30,000 to $39, 999
    - ☐ $80,000 to $99, 999
    - ☐ $40,000 to $49, 999
    - ☐ $100,000 to $149, 999

40. How many people are part of your household, including yourself, children and adults? _____

Thank you for helping us to better understand the needs of people in your community!

Community Needs Assessment
Key Informant Interview Guide

We first wanted to find out about you, your general experience and your role within the community here.

1) Can you tell me a little about your background, including how long you have lived/worked in this community?

2) Can you talk a little about your position as [community leader/role]?
   a) How long have you been doing that?
   b) How did you come to take on this role?

3) In what ways is your work—or your organization—involved with health issues or health care services?

Next I wanted to ask your perception of the community and communities here.

4) I'm very interested in hearing you describe your community – can you tell me about it?
   a) What are the strengths and weaknesses?
   b) What are the priorities and concerns?
   c) What challenges do you think are most common among your community members?

I'd like to talk about health and health care now.

5) From your perspective, what are the most significant health issues in your community?
   a) Why do you feel those are particularly significant?
   b) To what extent are services available and accessible to prevent and manage these issues?
   c) Are there any factors that make it difficult for people to manage these issues? (e.g., lack of insurance, housing, transportation, language, poverty)

6) What are the most significant behavioral health issues (including mental health, substance abuse, domestic violence) in your community and who do they affect (e.g. a particular age group or gender)?
   a) What are the services available to help people with behavioral health issues—such as medical and social services, as well as faith- and – community-based services?
   b) Can you describe the access issues—both what limits access and what promotes access?

7) To what extent is health care easily accessible to members of your community?
   a) How accessible is preventive care? Primary care? Specialty care?
   b) Are there any significant gaps?
   c) What specifically makes it easy—or difficult—to get health care here?
   d) Are there organizations that are particularly accessible – or that help in facilitating access to other organizations (e.g., outreach and referral programs)?
   e) Do you have any concerns about the quality of available services?

8) Where are people in your community most likely to go for health care? Why?
   a) What are the qualities that are most important to people in your community when they are choosing healthcare?

9) What do you consider to be the most prevalent social service needs in the community?
   a) Are there organizations that help people address these needs? Which organizations?
   b) How effectively are social service needs addressed?

As you know, there is more to good health than just health care. Next, I'd like to talk to you about the neighborhood and the community and their impact on health.

10) In what ways do you feel this neighborhood promotes or discourages good health? (For example, is there healthy food available here, places for physical activity, does it seem safe, etc.)
   a) To what extent do people take advantage of those opportunities (what are the barriers/facilitators)?
   b) How might organizations facilitate access to these resources (e.g., parks, farmers markets, etc.)?
   c) What is needed to make the neighborhood a healthier place to live?

11) What role might health care providers have in making this neighborhood a healthier place to live? (e.g., health education, programs that give people "healthy" skills, easier access to preventive and disease management services)
   a) Would people in the community be interested in these activities?
   b) What would be the best way to engage people in these activities (e.g., where to hold them, what organizations to partner with, how to publicize)?

12) What role might community, faith, civic and other organizations have in making this neighborhood a healthier place to live?

13) Thinking about the community again, and their culture and habits, to what extent and in what ways does your community and culture promote (or discourage) good health?
   a) Is maintaining good health (e.g. eating right, exercising, maintaining a good weight) important in your community? Can you describe in what ways it is or is not important?
   b) What might motivate people in your community to be more concerned about health and to access health-related services?

14) If you were able to transform the health care system to better meet the needs of community members, what would you do?

I want to thank you again for taking the time to talk to us. Just a few final questions:

15) Can you name a few other individuals or organizations that you would recommend we talk to in order to get a fuller picture of the health needs of this community?

16) We also want to talk to groups of residents—to conduct some focus groups (group interviews with about 8-10 people)—so we can gather information and recommendations directly from them. Do you have suggestions about organizations (including your own) that might be appropriate for hosting such conversations?
   a) In general, what are the characteristics of the community members that would participate?

17) Is there anything else you would like us to know?

18) Do you have any questions?

Thank you!

Community Needs Assessment
Resident Focus Group Guide

Thank you for taking the time to meet with us today. We want to talk to you about health issues and health care services in your community. This focus group is part of a community needs assessment, a study to find out about health-related needs of residents. We will use information from this focus group and discussions with other community groups to identify ways that providers can better serve communities. The study is being conducted by The New York Academy of Medicine in collaboration with a large group of health care providers.

I want to remind you that everything you say will be kept confidential. In our reports, no one will be able to connect you with the comments you made. You do not have to be part of the focus group and you do not have to answer any question you do not want to answer. I also want to mention some guidelines for discussion. Information shared during this focus group should be treated as confidential by everyone present today. However, we can't control what people say later, so if you are worried that something you say might be repeated later, you need not say it. Also, it's okay to ask each other questions. We expect people to disagree, as long as we are all respectful. The facilitators will lead the discussion to make sure that all topics are covered and everyone has an equal opportunity to speak.

---

19) To start, can a few of you tell us a little about your involvement with *[the host organization]*, including what kind of services or activities you are involved in?

20) We'd next like to hear a little about you, including how long you have lived in this community and what you do.

As you know, we're particularly interested in health and health care here. We'd first like to ask a little about behaviors that might affect health.

21) Can you talk a little about the food that you and your family generally eat?
    a) Do you feel it's healthy?
    b) Do you and your family think about whether food is healthy or not?
    c) Where do you usually get your food? How easy is it to eat and serve healthy food?
    d) What might make it easier to eat healthy?
    e) Do you think others in your community think about how healthy their food is? (explain)

22) We're also interested in exercise, including walking, sports (like soccer and basketball) and other kinds of physical activity.
    a) Do people here (in your community) exercise?
    b) *[If yes]* What do they do and how often?
    c) *[If no]* Why not?
    d) What might encourage people to exercise more?

Switching more specifically to health.

23) What do you think are the greatest health issues for people here? (e.g., particularly common illnesses or problems)
    a) Do you know why these health issues are so significant here? (e.g., age of the population, diet, lifestyle, pollution, other environmental factors)
    b) How well are people able to control or manage these issues?

24) Are there any particular mental health issues for people here, including depression, anxiety, trauma, or stress?
    a) Why do you think these issues are significant here?
    b) Are there adequate organizations in the community to help people cope with these issues?
    c) Are there gaps?

25) *[If appropriate condition mentioned]* We've heard that *[x condition, as determined from key informant interviews or other focus groups]* is particularly common in this community. Do you think it is a problem here?
    a) *[If yes]* Why do you think *[x condition]* is so common?

26) Overall, what might make it easier or more difficult to be healthy?

27) What could organizations in this neighborhood, including *[x organization]*, health care providers, or the government, do to help people here stay healthy? [*If silence, use these prompts]* Here are some thoughts:
    a) More health education (for whom, on what?)
    b) More programs that strengthen people's skills with respect to "healthy" choices (e.g., healthy cooking classes, exercise classes)
    c) Easier access to services that may help prevent disease, such as vaccinations or cancer screenings.
    d) Easier access to services that help people manage illnesses (e.g., education, supports)

28) Would people in the community be interested in these activities and services?
    a) What would be the best way to get people to attend? (e.g., where to hold them, what organizations to partner with, how to publicize)

Now I'd like to talk about health care.

29) Do people here (and family members) go to the doctor each year to get checked, *[for women]* including seeing a gynecologist?
    a) For those that don't, why not?

30) How about dental care – do people go to the dentist each year to get checked?
    a) If not, why not?

31) When you are sick and feel you need to see a doctor, do you always go?
    a) For those that don't, why not?
    b) How about family members, do they see doctors when they are sick?
    c) What are some of the things you do when you don't see a doctor for illness?

32) Where do people go for doctor's visits (like checkups and relatively minor illnesses)?
   a) How did you choose that place?
   b) How do you like it – what's good and bad about it?

33) Do people see complimentary or alternative medicine providers, such as herbalists, botánicas or acupuncturists?
   a) What kind of providers do you see?
   b) How do you decide when to see a complimentary provider and when to see a mainstream provider?

34) Do people ever go to the emergency room instead of an office or clinic-based doctor?
   a) Do you ever go when it's not a real emergency (i.e., a condition that could be treated in your provider's office)? If so, why do you go to the emergency room?
   b) What do you think providers can do to get people into the doctor's office and out of the emergency room?

35) Do you generally get health care in *[Brooklyn, the Bronx, or Queens]*?
   a) What services do you use here?
   b) What services do you go to other boroughs for?
   c) How do you decide where to receive care? (e.g., referrals, input from friends)

36) Who do people – people here in this group or people in the community – talk to if they are feeling sad or anxious and need help with that?
   a) Doctors? Religious leaders? Community organizations? Others?
   b) Are people willing to seek help for these kinds of issues?
   c) What might help people to use these kinds of services more for these types of issues?

37) Where do people go if they need help with issues such as benefits, insurance, immigration, or receiving other supportive services?
   a) What needs are the most common in the community?
   b) Are people able to get help with these issues?

38) Overall, do you feel that health care (of different types) is easy for you and your family members or friends to get?
   a) What specifically makes it easy—or difficult—to get health care in this community?
   b) Are there organizations that are helpful? (i.e. for providing services or providing connections to other organizations)
   c) Is cost of services an issue?
   d) Is insurance an issue?
   e) Is language – or provider sensitivity an issue?

39) If you could change the way healthcare is provided in your community, what would you do? What would it look like?

40) Do you have any other comments about health or health care here – anything we haven't discussed?

Community Needs Assessment
CBOs and Local Organizations Participating in the CNA

Bronx

Bronx - Primary Data Collection (Focus Groups and/or Surveys):

African Diaspora and Festival Parade
BOOM! Health
Center for Independence of the Disabled, New York
Friends of Saint Mary's Park
Health and Hospitals Corporation
Highbridge Gardens Houses
Local Initiatives Support Corporation
Mekong
Morris Heights Health Center
Regional Aid for Interim Needs (RAIN)
Services & Advocacy for GLBT Elders (SAGE)
Soundview Houses
Violence Intervention Program

Bronx Key Informant Interviews:[1]

- **African Services Committee**
  Kim Nichols, Co-Executive Director

- **AHRC**
  Melvin Gertner, Board member

- **BOOM! Health**
  Robert Cordero, President and Chief Program Officer

- **Bronx District Public Health Office**
  Jane Bedell, Assistant Commissioner and Medical Director

- **Bronx Health Link**
  Barbara Hart, Executive Director

- **Callen Lorde**
  Jay Laudato, Executive Director

- **Center for Independence of the Disabled, New York**

[1] There is some repetition in the list of key informants by borough, as some interviewees addressed City-wide issues, and data obtained were used in more than one CNA.

Susan Dooha, Executive Director

- **Children's Aid Society**
  Lisa Handwerker, Medical Director
  Maria Astudilla, Deputy Director, Health and Wellness Division

- **Coalition for Asian American Families and Children (CACF)**
  Noilyn Abesamis-Mendoza, Health Policy Director

- **Commission on the Public Health System**
  Anthony Feliciano, Director
  Judy Wessler, Former Director

- **Community Service Society**
  Elisabeth Benjamin, Vice President of Health Initiatives

- **Corporation for Supportive Housing**
  Kristin Miller, Director

- **Jewish American Serving the Aging (JASA)**
  Kathryn Haslanger, CEO
  Amy Chalfy, Director of Programs

- **Lincoln Medical Center**
  Balavenkatesh Kanna, Director of Research of Lincoln Medical and Mental Health Center

- **LISC NYC**
  Jessica Guilfoy, Deputy Director
  Anabelle Rondon, Community Development Associate

- **NADAP**
  John Darin, President & CEO
  Joy Demos, Assistant Director of Care Coordination

- **New York Immigration Coalition**
  Jackie Vimo, Director of Health Advocacy
  Claudia Calhoon, Health Advocacy Senior Specialist

- **New York Lawyers for the Public Interest**
  Shena Elrington, Former Director of the Health Justice Program

- **NYC Department of Homeless Services**
  Dova Marder, Medical Director

- **NYCDOH/Rikers Island**

Alison Jordan, Executive Director, NYCDOHMH, Correctional Health Services' Transitional Health Care Coordination

- **NYCHA**
  Andrea Bachrach Mata, Senior Manager for Community Health Initiatives

- **RAIN**
  Anderson Torres, CEO

- **Services & Advocacy for GLBT Elders (SAGE)**
  Catherine Thurston, Senior Director for Programs

- **Urban Health Plan**
  Paloma Hernandez, Executive Director

Brooklyn

Brooklyn - Primary Data Collection (Focus Groups and/or Surveys):

Arab Family Support Center
Arthur Ashe Institute for Urban Health
Brookdale Healthy Families
Brooklyn Health Provider Partnership
Brownsville Multiservice Family Health Center
CAMBA
Caribbean Women's Health Association
Center for Independence of the Disabled, New York
Chinese American Planning Council
Diana Jones Senior Center
El Puente
Health and Hospitals Corporation
Jewish Association Serving the Aging (JASA)
Make the Road NY
NADAP
New Dimensions in Care
Red Hook Initiative
Ridgewood Bushwick Senior Citizens Council
Services & Advocacy for GLBT Elders (SAGE)
Youth Congress of Bangladeshi Americans

Brooklyn - Key Informant Interviews:

- **AHRC**
  Melvin Gertner, Board member

- **Arab American Family Support Center**
  Maha Attieh, Health Program Manager

- **Arthur Ashe Institute for Urban Health**
  Humberto R. Brown, Director of Health Disparities Initiative & New Constituency Development

- **Brooklyn District Public Health Office**
  Aletha Maybank, Assistant Commissioner, New York City Dept. of Health and Mental Hygiene

- **Brooklyn Perinatal Network**
  Ngozi Moses, Executive Director

- **Brownsville Multiservice Family Health Center**
  Nathalie Georges, Community Follow-up Health Homes Care Management Director

- **Callen Lorde**
  Jay Laudato, Executive Director

- **CAMBA**
  Kevin Muir, Vice President, Health Homes/Care Management

- **Caribbean Women's Health Association**
  Cheryl Hall, Executive Director

- **Center for Independence of the Disabled, New York**
  Susan Dooha, Executive Director

- **Charles B. Wang Community Health Center**
  Nuna Kim, Medical Director

- **Children's Aid Society**
  Lisa Handwerker, Medical Director
  Maria Astudilla, Deputy Director, Health and Wellness Division

- **Coalition for Asian American Families and Children (CACF)**
  Noilyn Abesamis-Mendoza, Health Policy Director

- **Commission on the Public Health System**
  Anthony Feliciano, Director
  Judy Wessler, Former Director

- **CommuniLife**
  Rosa Gil, President and CEO

- **Community Service Society**
  Elisabeth Benjamin, Vice President of Health Initiatives

- **Corporation for Supportive Housing**
  Kristin Miller, Director

- **Crown Heights Community Mediation Center**
  Allen James, Program Manager, S.O.S. Crown Heights

- **Haitian American United for Progress**
  Elsie St. Louis Accilien, Executive Director

- **Jewish American Serving the Aging (JASA)**
  Kathryn Haslanger, CEO
  Amy Chalfy, Director of Programs

- **Make the Road**
  Theo Oshiro, Deputy Director

- **NADAP**
  John Darin, President & CEO
  Joy Demos, Assistant Director of Care Coordination

- **New York Immigration Coalition**
  Jackie Vimo, Director of Health Advocacy
  Claudia Calhoon, Health Advocacy Senior Specialist

- **New York Lawyers for the Public Interest**
  Shena Elrington, Former Director of the Health Justice Program

- **NYC Department of Homeless Services**
  Dova Marder, Medical Director

- **NYCDOH/Rikers Island**
  Alison Jordan, Executive Director, NYCDOHMH Correctional Health Services' Transitional Health Care Coordination

- **Ridgewood Bushwick Senior Citizens Council**
  James Cameron, CEO
  Sandy Christian, Asst. Exec. Director - Senior & Care Management
  Maria Viera, Deputy Housing Director of Social Services

- **Services & Advocacy for GLBT Elders (SAGE)**
  Catherine Thurston, Senior Director for Programs

Queens

Queens - Primary Data Collection (Focus Groups and/or Surveys):

Adhikaar
Center for Independence of the Disabled in New York
Charles B. Wang Community Health Center
Chhaya Community Development Corporation
Health and Hospitals Corporation
Korean American Family Service Center
Korean Community Services
Make the Road NY
Queens Community House
Queens PPS
Queens Pride House
Self Help Community Services
Services & Advocacy for GLBT Elders (SAGE)
South Asian Council for Social Services
Services Now for Adult Persons (SNAP)
Youth Congress of Bangladeshi Americans

Queens – Key Informant Interviews:

- **AHRC**
  Melvin Gertner, Board member

- **Callen Lorde**
  Jay Laudato, Executive Director

- **Center for Independence of the Disabled, New York**
  Susan Dooha, Executive Director

- **Charles B. Wang Community Health Center**
  Nuna Kim, Medical Director

- **Children's Aid Society**
  Lisa Handwerker, Medical Director
  Maria Astudilla, Deputy Director, Health and Wellness Division

- **Child Center of New York**
  Traci Donnelly, CEO

- **Coalition for Asian American Families and Children (CACF)**
  Noilyn Abesamis-Mendoza, Health Policy Director

- **Commission on the Public Health System**
  Anthony Feliciano, Director
  Judy Wessler, Former Director

- **CommuniLife**
  Rosa Gil, President and CEO

- **Community Service Society**
  Elisabeth Benjamin, Vice President of Health Initiatives

- **Corporation for Supportive Housing**
  Kristin Miller, Director

- **Haitian American United for Progress**
  Elsie St. Louis Accilien, Executive Director

Jamaica Hospital Center
Jogesh Syalee, Director, School Health

- **Jewish American Serving the Aging (JASA)**
  Kathryn Haslanger, CEO
  Amy Chalfy, Director of Programs

- **Make the Road**
  Theo Oshiro, Deputy Director

- **NADAP**
  John Darin, President & CEO
  Joy Demos, Assistant Director of Care Coordination

- **New York Immigration Coalition**
  Jackie Vimo, Director of Health Advocacy
  Claudia Calhoon, Health Advocacy Senior Specialist

- **New York Lawyers for the Public Interest**
  Shena Elrington, Former Director of the Health Justice Program

- **NYC Department of Homeless Services**
  Dova Marder, Medical Director

- **NYCDOH/Rikers Island**
  Alison Jordan, Executive Director, NYCDOHMH Correctional Health Services' Transitional Health Care Coordination

- **Services & Advocacy for GLBT Elders (SAGE)**
  Catherine Thurston, Senior Director for Programs

- **South Asian Council for Social Services**
  Sudha Acharya, Executive Director

Manhattan

Manhattan: Primary Data Collection (Focus Groups and/or Surveys)

Addicts Rehabilitation Center Fund, Inc.
ALBOR
Fortune Society
Gay Men's Health Crisis
Hamilton-Madison House
Harlem United
Henry Street Settlement
Independence Care
Postgraduate Center for Mental Health-Care Coordination
Ryan-NENA Community Health Center
William F. Ryan Community Health Center
East Harlem Council for Human Services
NYCHA Johnson House
The Door
CAMBA - Urban Peace Academy RAPP
Callen-Lorde Community Health Center
Central Harlem Senior Citizens' Centers, Inc.
Hamilton-Madison House: City Hall Senior Center
Hamilton-Madison House: Knickerbocker Village Senior Center
Hamilton-Madison House: Smith Senior Service NORC
Iris House
The Lesbian, Gay, Bisexual & Transgender Community Center

Manhattan: Key Informant Interviews

- **African Services Committee**
  Kim Nichols, Co-Executive Director

- **Coalition for Asian-American Children and Families**
  Noilyn Abesamis-Mendoza, Health Policy Director

- **Corporation for Supportive Housing**
  Kristin Miller, Director

- **East and Central Harlem District Public Health Office**
  Roger Hayes, Assistant Commissioner, New York City Department of Health and Mental Hygiene

- **Isabella Geriatric Center**
  Mark Kater, President and CEO

- **Little Sisters of Assumption Family Health Service**
  Ray Lopez, Director of Environmental Health

- **NADAP**
  John Darin, President and CEO
  Joy Demos, Assistant Director of Care Coordination

- **New York Lawyers for the Public Interest- Health Justice Program**
  Shena Elrington, Former Director of the Health Justice Program

MANHATTAN COMMUNITY NEEDS ASSESSMENT APPENDIX D - REPORT OF THE PRIMARY DATA COMPONENT

December 16, 2014

Prepared by Tripp Umbach in collaboration with The New York Academy of Medicine

MANHATTAN COMMUNITY NEEDS ASSESSMENT:
REPORT OF THE PRIMARY DATA COMPONENT
OCTOBER 2014

INTRODUCTION

The goal of the Delivery System Reform Incentive Payment (DSRIP) program is to promote community-level collaborations and focus on system reform in order to reduce avoidable inpatient admissions and emergency room visits by 25% over five years for the Medicaid and uninsured populations in New York State. To inform the health system transformation that is required under the DSRIP program, emerging Performing Provider Systems (PPS's) must submit a comprehensive Community Needs Assessment (CNA) with their Project Plan applications. The Manhattan PPS's CNA, conducted from July through September, included primary and secondary data analysis and had the following aims:

- To describe health care and community resources;
- To describe the communities served by the PPSs;
- To identify the main health and health service challenges facing the community; and
- To summarize the assets, resources, and needs for proposed DSRIP projects.

This report describes the primary data methodology and analysis and has been developed as an appendix to the full CNA, and to provide more in-depth information to the PPS's, which may be useful for DSRIP project planning, as well as planning and implementation of programs and services outside of the DSRIP program.

METHODS

PROTOCOL DESIGN

Tripp Umbach and The Center for Evaluation and Applied Research (CEAR) at The New York Academy of Medicine (NYAM) conducted the primary data portion of the CNA, which included surveys of community residents, and focus groups and interviews with Manhattan residents, providers, and other stakeholders (see appendix for data collection instruments). The protocol was developed in collaboration with selected PPS's in Manhattan, Brooklyn, the Bronx, and Queens and was approved by the HHC Institutional Review Board (IRB).

The primary data component was designed to address anticipated gaps in the secondary data, including: 1) community member and stakeholder perspectives on health issues, including their causes and impact; 2) data on populations (e.g., particular immigrant groups) and issues (e.g., links between incarceration and health) that might be obscured in population-based data sets; 3) significant detail on issues identified; and 4) recommended approaches to address identified

problems. Overarching questions for the primary data component, which—consistent with DSRIP—focused on Medicaid and other low-income populations, as well as the uninsured, included:

- To what extent are community and environmental conditions conducive to health promotion and disease prevention?
- What are the primary health concerns and health needs of residents, overall and according to neighborhood and socio-demographic characteristics?
- What are the health related programming and services available to community residents, what organizations are providing the services, and what are the service gaps?
- Are there differences in access, use and perceptions of health related programming and services according to neighborhood and according to ethnic, racial, and language groups?
- In what ways can health promotion and health care needs be better addressed, overall and for distinct populations?

DATA COLLECTION

Community Engagement: Consistent with DSRIP CNA guidance, Tripp Umbach conducted primary data collection in collaboration with numerous community organizations, which were identified in collaboration with PPS representatives, and represented a range of populations (e.g., older adults, immigrant populations, etc.) and neighborhoods. As described below, community organizations assisted in recruitment for and administration of focus groups and surveys. All organizations assisting with survey administration or focus group facilitation were provided with written guidelines including information on data collection and the general research protocol, the voluntary nature of research, and confidentiality. Organizations also participated in an in-person or phone training on data collection conducted by Tripp Umbach staff. Community organizations partnering in the research received an agency honorarium consistent with their level of responsibility.

As described in a subsequent section, community members and stakeholders were largely responsive to the request to participate in the CNA and they appreciated DSRIP aims and the opportunity to have their opinions heard.

Data Collection Activities: As noted above, the primary data component involved three distinct methodologies:

- Resident Surveys*:* 943 surveys were completed by residents of either Manhattan, Brooklyn, the Bronx, and Queens, ages 18 and older. Of all the surveys collected for the Manhattan CNA, 632 were from Manhattan residents. Survey questions focused on basic demographics, health concerns (individual and community-wide), health care utilization, barriers to care, and use

of community and other services. Survey respondents were identified and recruited by local organizations, including community based organizations, senior centers, social service, and health providers. Surveys were self-administered or administered by staff or volunteers at community organizations, who were trained and supported in survey administration by Tripp Umbach staff and consultants. The surveys were translated into 4 languages: Chinese (simplified and traditional), French, and Spanish. Participants received a Metrocard valued at $5 for completing the survey.

- Key Informant Interviews: Eight key informant interviews which included 10 individuals each were conducted. Key informants were selected with input from the PPS. A portion had population specific expertise, including particular immigrant groups, older adults, children and adolescents. Others had expertise in specific issues, including supportive housing, care coordination, and homelessness. All key informant interviews were conducted by NYAM staff using a pre-written interview guide. All key informants were asked about perceptions of health issues in the community, barriers and facilitators to good health, health care and other service needs, and recommendations for services and activities that may benefit the local population. Follow-up questions, asked on *ad hoc* basis, probed more deeply into the specific areas of expertise of key informants. The interview guide was designed for a discussion lasting 60 minutes; in fact, interviews ranged from 45 to 120+ minutes. All key informant interviews were audiotaped and professionally transcribed to ensure an accurate record and to allow for verbatim quotations. (See Appendix C for the list of Key Informants by name, position, and organization.)
- Focus Groups: Seventeen focus groups were conducted for the Manhattan Community Needs Assessment, involving over 150 participants. All of the focus groups were with community members, recruited by collaborating CBOs. Populations targeted included, but were not limited to, older adults, Asian and Latino populations, LGBTQ, and individuals with disabilities. The mean age of focus group participants was 45; 60% were female; 44% were Black, 9% Asian, and 46% Latino; 56% were on Medicaid and 21% were uninsured; 23% reported speaking a language other than English at home.

  Focus groups lasted approximately 90 minutes and were conducted using a semi-structured guide, with questions that included, but were not limited to: perceptions of health issues in the community, access to resources that might promote health (e.g., fresh fruit and vegetables, gyms), use of health services, access to medical and behavioral health care, domestic violence, and recommendations for change. Follow-up questions were asked on *ad hoc* basis, based on responses heard. Focus groups were conducted by Tripp Umbach staff members and consultants retained by Tripp Umbach, each of whom was trained in the established protocol. Many of the resident focus groups were co-facilitated by representatives of CBOs that were also trained on the focus group protocol. Focus groups in languages other than English and Spanish were conducted solely by trained community partners. Participants received a $25 honorarium, in appreciation of their time and insights. All focus groups were

audio recorded, so that transcriptions and/or detailed reports could be developed for each, and to allow for verbatim quotations.

DATA MANAGEMENT AND ANALYSIS

Surveys: Survey data were entered using SPSS, data analysis software. They were analyzed according to standard statistical methods, using SPSS. Means and proportions were generated, overall and by Upper and Lower Manhattan. Although the survey sample cannot be considered representative of the catchment areas in a statistical sense, and gaps are unavoidable, the organizational outreach facilitated engagement of a targeted yet diverse population, including individuals connected and unconnected to services.

Survey respondents came from all Manhattan neighborhoods; socio-demographic characteristics included: 54% female, 38% Black/African American, 29% Latino, 27% Asian, 45% foreign born, 27% limited English proficient, 40% on Medicaid and 4% uninsured. The mean age of respondents was 55, with a standard deviation of 16.5 (see Table 1).

Interviews and Focus Groups: Transcripts and focus group reports were maintained and analyzed in NVivo, a software package for qualitative research. Data were coded according to pre-identified themes

Table 1: Demographic characteristics	**Manhattan Only**
Characteristic	**(N = 621)**
Age (Mean, SD)	54.98 (16.5)
18-20	0.6%
21-44	23.3%
45-64	43.5%
65-74	15.0%
75-84	9.0%
85 and older	3.2%
Missing	5.4%
Gender	
Female	53.8%
Male	44.2%
Transgender	1.5%
Prefer not to Answer	0.5%
Sexual Orientation	
Heterosexual	78.3%
LGBTQI	11.5%
Other/Don't Know/Prefer not to Answer	10.2%
High school graduate or higher	68.8%
Hispanic	28.6%
Race	**(N=553)**
White	19.0%
Black or African American	37.6%
Asian	27.1%
American Indian or Alaska Native	1.1%
Native Hawaiian or othe Pacific Islander	0.4%
Other/mixed	14.8%
Limited English proficient	26.8%
Foreign born	44.5%
Health Insurance	
Medicaid	39.9%
Medicare	14.4%
Private/commercial	9.2%
VA/Other/More than one	31.9%
None	4.4%
Don't Know	0.2%

relevant to health, community needs, and DSRIP, as well as themes emerging from the data themselves. Analysts utilized standard qualitative techniques, involving repeated reviews of the data and consultation between multiple members of the research team. Analyses focused on 1) common perceptions regarding issues, populations, recommendations, etc., 2) the unique knowledge and expertise of particular individuals or groups and 3) explanatory information that facilitated interpretation of primary and secondary source data.

FINDINGS

POPULATION DESCRIPTION

Poverty: Given the DSRIP and CNA focus on low income populations, the significance of poverty and its implications is unsurprising. As noted above, 55% of survey respondents earn less than $20,000 a year and 15% were unable to work or unemployed (25.9%). Overall, 76% of survey respondents report that they worried about not having enough to eat (see Exhibit 1 for detailed data tables).

Although the health related implications of poverty may vary by population, common themes were evident: poverty was described as directly affecting health; affecting prioritization (or de-prioritization) of health behaviors; and as affecting access to health related resources, including nutritious food, stable and well-maintained housing, health care coverage, and medical services.

Discussions focused on the relationship between:

- Access to basic necessities: Key Informants and focus group populations discussed the relationship between the choices residents must make about food, clothing, housing, etc. based on the amount of money they have available.
- Poor health outcomes: Key informants and focus group populations discussed that often lower income populations have poorer health outcomes and a higher prevalence of chronic health conditions and disease due to an inability to afford the treatment and/or lifestyle needed.
- Access to income: Key informants and focus group populations discussed the access residents have to income (i.e., homelessness, incarceration, physical disability, etc.) having an impact on physical and behavioral health outcomes.
- Immigrant residents that have ties and responsibilities to loved ones in other countries may send resources out of the home, which limits resources for this population.

Foreign Born: Large foreign born populations in Manhattan include Chinese (from different countries and provinces), Latinos, and a growing—and increasingly diverse—West African population. Although there are many overlaps, each of these communities has needs related to culture, language, education, and economics, which may impact on health and healthcare use. In addition, the strengths of these and other immigrant communities were emphasized, which may

include close family ties, strong work ethics, and healthy eating habits relative to American born populations.

Concerns about language access obviously suggest concrete requirements with respect to knowledge and skills. CNA participants discussed the role that language plays in seeking healthcare services for residents that have limited English proficiency. When residents discussed language barriers what they often relayed was a disjointed experience when they seek health services. Key informants talked about the role that language barriers play in the comfort level of residents to seek treatment for physical and/or mental ailments, as well as the barrier to effective service provision when language barriers were present:

> *The only thing I can think of, like we've had language barrier problems, but the thing about the Health Home system is that it's such a huge conglomerate that all I have to do if I have a client who's, "I only want to speak to someone in Creole, my native tongue." Actually, we do have two Creole-speaking staff members, but as an example, if I called the Heath Home and said, "This is what I have, I need services," they get back to me within a day with this is your new care management agency, this is their information, this is their counselor, this is where they go. (Key informant, home health)*

> *So one of the studies that we found was we had interviewed clients among our social service agencies just to find out what are some of their primary issues. Language access came up over and over again. So in certain communities, I think about some of our smallest South Asian communities, if they need specialty care, like for the Nepali speaking community, they probably would have a really hard time finding somebody who spoke their language, a cardiologist, for example. They oftentimes would have to rely on family members that could interpret for them or community-based organizations that would have to go with them to their appointments or their treatments. (Key informant, Asian social services)*

Residents described the experiences they have had related to poor translation services in healthcare settings and the way it made them feel. Often times an experience of poor translation services colored the experience residents had and their opinion of healthcare providers.

> *I'm helping a lady from the community who was diagnosed with cancer and has been operated on. She receives her healthcare from Bellevue. One day, I went with her to Bellevue and they had no one on their staff that spoke Spanish. So the doctor got a secretary on the phone who was able to translate and the secretary from over the phone told the lady that the chances of her survival were 1 in 100. They had a secretary tell her that over the phone. I thought that was horrible and insensitive and so that was the icing on the cake. (Participant from a focus group conducted with Latino(a) residents)*

> *Language barrier is also a big concern, because when you speak to them in Spanish then they speak to you in English and they continue, making you feel ignorant. (Participant from a focus group conducted with residents who have limited English proficiency)*

PHYSICAL HEALTH ISSUES

Overview: Survey respondents felt that the most common physical health concerns in their community were drug and alcohol abuse (50%), diabetes (46%), high blood pressure (39%), HIV (33%), and mental health (32%) (see Table 2). Similarly, the most common areas where they reported additional health information was needed were mental health (49%), substance abuse (48%), and diabetes (47%). Community members clearly recognize that obesity was linked to diabetes and heart disease and talked about the need for healthy eating and physical activity.

Smoking: Smoking was discussed in 10 focus groups, with discussions about the impact of cigarette and marijuana smoking. Manhattan residents identified with the negative impact that smoking had on the respiratory health of smokers and non-smokers alike, including children:

> *Everywhere you go you see people of all ages smoking cigarettes, no matter what age group from 12 to 90, everybody's smoking cigarettes and that has to raise some real serious concerns. (Participant from a focus group conducted with residents that have a history of substance abuse)*

> *Asthma is also a major issue. Just the other day I was in the park and there were people smoking cigarettes, they have no respect. Second hand smoke also affects our children. (Participant from a focus group conducted with residents that have limited English proficiency)*

Table 2: Health Concerns	
Adolescent health	8.70%
Asthma	29.10%
Arrests and incarceration	19.70%
Cancer	25.90%
Diabetes	50.60%
Disability	18.90%
Drug and alcohol use	49.30%
Family planning / Birth control	9.50%
Hepatitis	11.30%
Heart Disease	23.10%
High Blood Pressure	43.10%
HIV	28.50%
Maternal and child health	6.20%
Mental health (e.g., depression, suicide)	33.20%
Obesity	31.00%
Pollution (e.g., air quality, garbage)	16.90%
Sexually transmitted infections	20.00%
Stroke	10.00%
Teen pregnancy	13.00%
Tobacco use	30.80%
Violence or injury	21.80%
Other	4.30%

Obesity, nutrition and physical exercise:

Discussions among CNA participants often focused on obesity; particularly as it relates to poverty and the resources to maintain a healthy weight. CNA participants discussed the reality that the resources necessary for health eating (e.g., stores, time to prepare food, money, etc.) were often scarce and unhealthy foods often readily available in lower SES neighborhoods. Participants felt that limited education related to healthy nutrition which also plays a role in the obesity seen in the community.

So, it's about having enough leisure time and flexibility to engage in activities, exercise or yoga or meditation or mental health counseling or cooking. Cooking a healthy meal, or shopping for healthy food, there has to be that leisure time, but also they have to be a routine that builds up and that takes a while. Especially for new immigrants. I don't see the healthcare setting as being the prime impetus for moving healthy lifestyle change. (Key informant, African services)

McDonald's offers these dollar meals. They offer these very cheap meals, so that's very hard to compete with. If you've got four kids and you've got four bucks in your pocket, that's where you're going to go. So I think the poverty issues, the cost issues are still a big issue in this community, no matter what our messaging is. (Key informant, public health)

McDonald's, soda and the advertisement, such as 3 burgers if you buy this then you get this for free, the portion like the soda and fries. So look for how to mess yourself up. The nutritional program here, helped me out a lot, I educated myself. My son loves soda, but now I bought a water filter in where I use it and give him water constantly rather than juices and soda. I educated myself. (Participant from a focus group conducted with residents with limited English proficiency)

I also agree on part of what he said, however what we have to see is that our supermarkets around here take brands like Crasdale which doesn't provide good options on healthy foods and that is what they put on our shelves and it is more affordable, so that is what we are going to buy. Conversely in the other markets they do provide healthy foods but they are more expensive. (Participant from a focus group conducted with Latino(a) residents)

Yeah, but they flood the neighborhood with a lot of liquor stores and have a lot of unhealthy things. All your grocery stores have all these sugary things, all these sugary drinks. They don't have natural things or organic stuff here. (Participant from a focus group conducted with residents living in NYCHA Housing)

When you live in the mental health assisted place and near shelter, you're above everything like fast food places…burger king and pizza places. (Participant from a focus group conducted with residents diagnosed with mental health and medical health comorbidities)

CNA participants also discussed the lack of physical exercise in the community and public schools due to a lack of accessible recreational space, legal liabilities, safety concerns, and time.

So it turns out, we had about a quarter of the kids we figure in this neighborhood go to some afterschool program. East and Central. Some major providers like Union Settlement, RBI, SCAN, etc., Children's Zone, obviously, Children's Aid, and then we try to get a sense of what's going on there. So there was a survey and we found that generally a lot of activities like you'd suspect, but one of the issues was the problem of

regularly scheduling physical activity. It seems like a lot of these afterschool programs that are kind of stuck in classrooms. (Key informant, public health)

Culture and traditional diets were often central to discussions about healthy nutrition related to obesity.

There's many community members who feel in their mind they're transient here and they haven't exactly connected with their communities. And then on top of that they're living in neighborhoods that are very different from the country that they're coming from. For example, there's a plaza where everybody can gather and that isn't necessarily the case in many neighborhoods. They don't even have green space. And then in terms of – I think about farmers' markets, too. Oftentimes I've heard things from our community partners like, "It would be great for our community members to go there." And it's not even a cost issue but a lot of the fruits and vegetables that they sell are things that we don't cook with. Yes, so figuring out how to integrate that. And then the other piece which I felt was interesting, too, was we looked at the food options that are quote "culturally specific" to our communities. They're not the healthiest options, either. (Key informant, Asian community)

Sincerely as Latinos we are usually eating foods that are not so good for us. We eat a lot of rice, pork and of course fried foods. (Participant from a focus group conducted with Latino(a) residents)

Access to healthy foods was described as sufficient in most neighborhoods (the average rating being 2.16 on a scale of 1 to 4), although affordability was most often discussed in relationship to healthy foods:

So, vegetables, and grains, and things of that nature are very important to me. But being on a fixed income, and depending on the neighborhood that you live in, that can be very costly. And the way things are at this time, the more you get, the cost of living increases in your benefits, the more they decrease your food-stamps. By the time you end up getting what you're going to get, and you get let's say $147, that's all for the whole month. By the time you buy some vegetables one time, and some milk, and some bread, and some eggs, the whole $147 is gone. And then, if you live in a building where, let's say, I can only go by my own, by what I go through, if you live in a place where your income is almost, not much, but almost exceeds your expenses, almost exceeds your income, then you're not really able to afford the nutritious things that you need to eat. Then you buy carbs, which are cheap, and that's not good when you're diabetic. (Participant from a focus group conducted with residents living with a physical disability)

Yes those are some of the problems as well. Also around here it is a lot more expensive to buy vegetables than buying a big sack of rice. Right now there is a supermarket on the corner of the senior living center and I don't know how these old folk on a limited income

can afford to eat healthier because the prices will bankrupt them. (Participant from a focus group conducted with Latino(a) residents)

Even where healthy food was available, some CNA participants reported that purchase of unhealthy choices was common.

Because a lot of people go to these fast food restaurants, you go to Chinese food, you go to someplace convenient. A lot of these people need to take care of themselves and eat properly and have the right nutrition within their system. If you're not eating right, it's going to affect your body and you're going to end up having to have illnesses, some type of problem. Then you got to end up going to the hospital. (Participant from a focus group conducted with residents living with HIV/AIDS)

More than one-third of survey respondents reported being in fair or poor health. The most commonly reported health issues were high blood pressure (44%), depression and anxiety (41%) and chronic pain (39%) (see Table 3).

Table3: Health Status	
	(N=632)
Perceived health status	
Excellent/very good/good	64.6%
Fair/Poor	35.4%
Body mass index (Mean)	
	26.8%
Health issues faced	
Asthma	23.4%
Cancer	7.6%
Chronic pain	38.5%
Depression or anxiety	40.9%
Diabetes	24.8%
Drug & alcohol abuse	19.6%
Heart disease	12.2%
Hepatitis C	9.6%
High blood pressure	43.7%
High cholesterol	34.7%
HIV	17.4%
Mobility impairment	19.4%
Osteoporosis	21.2%

The ability to manage health conditions was impacted by a number of factors, including broader environmental conditions (e.g., indoor and/or outdoor pollution in the case of asthma), knowledge, attitudes, disease management skills, conflicting priorities, depression, and poverty. Culture and traditional choices were discussed as a barrier of successful behavior change. Additionally, it was noted that stores that sell healthy produce often do not offer a variety of ethnic food options.

Asthma: One of the most discussed topics among CNA participants was asthma and other respiratory conditions. CNA participants connected asthma with poor housing conditions, and environmental factors (i.e., rats, roaches, mold, second hand smoke, etc.), which are found most often in lower SES communities.

One is sort of these kids who have really bad symptoms often and there are a lot of them in Harlem and a lot of them live in NYCHA. NYCHA's a big issue for our families. The

repairs, the slowness, just the general deterioration over the years. There have been a lot of articles written on that recently,– a consequence of that is that kids are exposed to more triggers, I would say; 50% of our kids live in the projects, so there's that. (Key informant, public health)

But with the asthma, that's also in reference with children, unfortunately, it's very high in Harlem because of the rat, the roaches and bad living conditions. (Participant from a focus group conducted with residents living with a physical disability)

Asthmas is also a major issue. Just the other day I was in the park and there were people smoking cigarettes, they have no respect. Second hand smoke also affects our children. (Participant from a focus group conducted with residents that have limited English proficiency)

CNA participants discussed the positive effects of care coordination and education (i.e., effective ways to employ medications and healthy activities) in residents' ability to effectively manage respiratory conditions like asthma.

Once a parent can understand her child's asthma and how medication plays a role and triggers play a role, she's pretty good at managing that…So that just in terms of getting people more a sense of their own power to manage their lives, the more we can do with that, the better. (Key informant, public health)

Diabetes: Residents often discussed that it can be difficult to manage diabetes due to homelessness, income, and education. Homelessness was cited as a barrier to controlling diabetes in many ways. Residents discussed the food at homeless shelters not being diabetic friendly and the lack of stability making it difficult to develop routines necessary for management of diabetes. Residents often discussed the cost of medications, testing equipment and diabetic friendly foods being more than they could afford. Residents also discussed eating habits as they are shaped by mental health status and cultural practices and the relationship to effectively managing diabetes. Additionally, residents discussed the need for care management in diabetes due to medication regimens and nutritional changes required to manage the disease.

You can't get the proper food. I live in a shelter. I don't eat their food at all, so mine's really up and down, up and down. It's not a good environment for me…Because you can't take all the insulin because of the food. (Participant from a focus group conducted with residents diagnosed with diabetes)

My children's mother was turned diabetic through alcohol abuse. And, medication induced. There's some of the medications we take who are HIV positive, that they're always monitoring your sugar because they're sugar-based. (Participant from a focus group conducted with residents living with HIV/AIDS)

So I now go to the Roberto Clemente Center, which is a very good center for mental health. That's where I found out about how diabetics shouldn't take Seroquels. They shouldn't prescribe Seroquels to diabetics because number one, it raises your sugar. It makes you eat. You sleep and you eat. You sleep and you eat. You understand? \ I'm not

even prescribed Seroquels anymore. (Participant from a focus group conducted with residents diagnosed with diabetes)

HIV/AIDS: When HIV/AIDS was discussed among key informants and focus groups, they discussed the stigma associated with the disease, the avoidance of testing due to a fear of diagnosis, and the unhygienic conditions found in some of the common areas of supportive housing. Key Informants discussed the shift in funding strategies away from outreach and supportive services.

> *So the system of care for HIV is well-built. What's peeling away are some of the supportive services that keep people in care or bring them to care in the first place. With the community-based programs that used to provide supportive services for HIV Africa Care have been pared down, and there's more of a funder focus on medical HIV care, putting more funding in the hospital setting for case management, HIV case management. And, I think that 70 AIDS service organizations in New York City have closed or merged with another organization since 2009. (Key informant, African services)*

> *It's common areas not being taken care of. I'm scared for my health. And that's why I'm trying to stress to get out of this place. Because my health is important today. And I'm not trying to pick up something I didn't come in here with. And I know, being the person that I am, being HIV positive going on 31 years; I have to be around a clean environment because I don't need to get another disease, on top of what I have there. (Participant from a focus group conducted with residents having experienced domestic violence)*

> *Before I got into housing in Harlem United, they had me living in one of those SROs and it was so unhealthy. Because the bathrooms, they weren't clean. The roaches, the way we were eating, the kitchen privileges. Being HIV, I can't be around all that stuff. I got sick while I was in there. (Participant from a focus group conducted with residents living with HIV/AIDS)*

One focus group discussed the desire of youth to become infected with HIV in order to secure affordable housing.

> *In my community there's a lot of young gay kids coming up and they think that having unprotected sex is cute. They think it's cute because they want to get the virus so they can get HASA or get an apartment. But that's just not the solution. (Participant from a focus group conducted with residents having experienced domestic violence)*

Additionally, CNA participants felt there is a persisting lack of education and understanding related to HIV in their communities, which often leads to poor decision making and the spread of the virus.

> *Well, in the gay community some guys still believe that you can't get STDs if you are on top and some people think that unless you're gay you can't get HIV or AIDS because there's no intercourse. Such as two females think they can't get it because there isn't*

intercourse. (Participant from a focus group conducted with residents from the LGBTQ community)

But when I stop people, and I say, "Oh how are you doing? We got a health fair over here, a lot of good information and my company, I work for Harlem United. What we're doing over here, is we're doing free HIV testing…So many people say, nah, I'm OK, I'm OK. I ask them, "Have never been tested." "No." "But you OK. How many girlfriends?" One guy told me, "I only mess with two girls, so I know I'm OK." You know? People are ignorant to the facts. (Participant from a focus group conducted with residents living with HIV/AIDS)

The general consensus among CNA participants is that HIV/AIDS patients have a great deal of resources.

People living with HIV disease or living with AIDS diagnosis have pretty good access to the help and support if they need it in New York City. (Key informant, African services)

BEHAVIORAL HEALTH ISSUES

Mental Health: Behavioral health issues were seen as common in all populations. Thirty-three percent of survey respondents reported that mental health issues were a main concern in their community; 41% report personally facing depression or anxiety.

Residents recognized the lack of stability mental health patients often face as they cycle through hospitals, prisons and homelessness. Additionally, residents discussed the public safety issues related to the decompensation of residents with serious mental illnesses who are not managed consistently. Typical comments include:

Sometimes these people are mental, and they need help, and they need to be institutionalized…A lot of our institutions put out all these people out on the street and then they send them back to go and get medication every day. But these people are not able to do that. They put them out in the street. They put them in housing, they put them in all these places. They're not able to take care of themselves…They need supervisor, but the hospitals don't want to keep them because it costs too much to keep them in the hospital. So they put them on the street and they going around doing all kinds of crazy things. Then what happens? They get arrested, they put them in the jail. They don't get no help from the jail. Then they end up back in the street. Some of them don't want to live in shelters because the shelters are bad. They get victimized in the shelters. (Participant from a focus group conducted with residents living in NYCHA Housing)

Alcohol and Other Drugs: CNA participants discussed the prevalence of substance abuse in their communities. CNA participants recognized that substance abuse and homelessness are heavily correlated and coupled with poor health outcomes. Residents with a history of substance abuse explained that they did not often seek medical care while using:

I don't think I'm going to do that neither. When I was using, I didn't think about going to a doctor. That drug was my doctor. If my tooth hurts, I go smoke some crack. (Participant from a focus group conducted with residents that have a history of substance abuse)

I found out after I wasn't using, everything breaks down then. You find out everything that's wrong with you all at one time. I'm blessed, I only had two medicals and it is a part of fear but I find myself pushing even harder after using, smoking behind people, being around different places, clean places, messy places, things of that nature so always follow up once my mind is clear to make sure that things are coping steady. (Participant from a focus group conducted with residents that have a history of substance abuse)

[A doctor] we were on a panel with her a while ago, and she opened by talking about how she had started a double shift on a Saturday morning, and discharged a guy who was homeless. He came into the emergency department inebriated, had fallen. They kind of fixed him up. She discharged him. That night he came back and had smashed his face and was inebriated. And as she was ordering the expensive tests to see if he had facial fractures, and the plastic surgeon, and everybody had come in, she knew that she would kind of repair this thing. But that he was just going to be back. And until we got housing for him, she was just doing Band-Aids. And I think that's where there's huge opportunity to really make very positive impacts for these individuals if we can find them a place to live. (Key informant, public health)

Residents discussed the prevalence of co-occurrence of mental health and substance abuse and the need for co-location of substance abuse and mental health services

If you go there for psych and you also have an alcohol problem, you've got depression but they say it's either depression or psych. It usually goes hand in hand. You have multiple things that are coming into play like you're saying, you're depressed and you turn to alcohol or you turn to drugs to recover rather than going and getting the help that you really need. (Participant from a focus group conducted with residents without continuous care)

I was in the hospital for 14 days, psych, New York Presbyterian. When I came out of there, I had told them about the alcohol but I was there for 14 days and I was fine but they wanted to put me in one of those rehabs and my health plan wouldn't cover it. They said: "how could she relapse if she's been in the hospital for 14 days". When I came out the cab dropped me off right at my building he gave me $10 and I went out and bought me a bottle. (Participant from a focus group conducted with residents without continuous care)

ACCESS TO RESOURCES AND SERVICES

Resources for Good Health: As noted above, survey respondents in most neighborhoods reported that healthy foods were available or very available. Places to walk, exercise and play were also reported to be available in most neighborhoods (average score of 2.02 on a scale of 1 to 4). In contrast, respondents were less likely to report that affordable housing was available or very available (average score of 2.66 on a scale of 1 to 4). (see Table 4). Consistent with this survey result, CNA participants recognized the relationship between housing stability and health outcomes by often discussing the notable higher rate of mental illness among homeless, the high use of healthcare resources by chronic homeless persons and the high recidivism rates in the medical health and behavioral health industries of persons without stable housing due to the inability to fully implement medical recommendations and lack of oversight/ case management. Key informants and focus group participants both discussed the impact of housing on physical health. Discussions focused on the relationship between:

- Housing conditions on asthma and other chronic health conditions: Key Informants and focus groups discussed the inflammatory impact that poor housing conditions (i.e., lead paint, rats, mold, roaches, bed bugs, etc.) have on chronic health conditions (e.g., asthma).
- Housing stability: Key Informants discussed the positive impact that stable housing can have on reducing the use of health care resources (i.e., ED use) among chronically homeless populations; particularly those residents with mental health or substance abuse issues.
- Homelessness: Key informants and focus groups discussed the negative impact homelessness has on residents related to victimization, street violence, lack of hygiene, access to proper nutrition to manage chronic health issues (i.e., diabetes), etc.
- Communal Housing: Focus groups discussed the poor hygiene found in communal housing (i.e., SROs) and the impact on individuals including persons with existing health conditions (i.e., persons diagnosed with HIV).
- Location: focus groups discussed the location of housing for at-risk populations often being located around unhealthy options with limited access to healthy options (i.e., fast food restaurants, liquor stores, violence, etc.).

Medical services: Approximately one in five respondents reported that there was a time in the last year when they needed healthcare but didn't get it. The most commonly noted reasons for that were "not insured" (26% of the subsample), and "could not get an appointment soon or at the right time" (23%). While survey respondents reported relatively good access to most types of medical care; residents from Lower Manhattan were more likely to report primary care was available. Approximately 83% of survey respondents reported that they had a primary care provider or personal doctor, and 84% reported that had a routine check-up in the last 12 months.

Table4: Health Status (Mean 1-4; 1=Very available, 4=Not available at all)	
	(N=632)
Accessible transportation	1.69
Affordable housing	2.66
Dental services	2.13
Healthy foods	2.23
Home health care	2.13
Job training	2.65
Medical specialists	2.2
Mental health services	2.3
Pediatric and adolescent services	2.18
Places to exercise, walk and play	2.02
Primary care medicine	2
Social services	2.15
Substance abuse services	2.34
Vision services	2.22

Respondents discussed a sense of apathy among residents in communities with a high concentration of poor health outcomes (e.g., penetrating trauma, cancer, heart disease). As described by community residents, when their neighbors suffer from chronic, long-term, and/or poor health outcomes, they begin to believe that they have no power/control in their own health outcomes. This leads to an increase in high-risk behaviors (i.e., substance abuse, high-risk sexual behaviors, etc.).

> *But like I said, it's where the individual comes. I, by experience and I know some people that said, "Oh, no matter what I eat, I going to die." If I eat this or that, don't matter we know we going to die, but if you want to live another day, be conscious. (Participant from a focus group conducted with residents living in NYCHA Housing)*

Focus group participants discussed the cost of healthcare treatment being a barrier to seeking care in both the ED and primary care. Additionally, participants cited the lack of transparency in billing practices as a cause for not seeking healthcare. Also discussed were unaffordable co-pays for outpatient treatment at some mental health providers.

Emergency Department Services: Forty-one percent of survey respondents had been to the ED at least once in the past year and 11% of respondents report receiving their primary care at the ED. Often focus group participants expressed a resistance to visiting the ED due to cost; however, there were participants that discussed having to seek treatment at the ED due to a lack of insurance:

If you're sick, really sick, you need to go and they can't turn you away. They know this. I don't have insurance yet, I tend to go to the emergency room and they can give me pain medication, they can give me a needle in the back but when you look at it, I don't have money for insurance but now you tell me I'm getting into this big hole, debt from going to get care. (Participant from a focus group conducted with residents without continuous healthcare)

There is a factor that hinders people's overall health. I work and have a good health insurance, however I have friends that need to visit health facilities but don't go because they have no health insurance or any way to cover it out of pocket. So they don't get medical attention and there conditions worsen…But by law no one can be rejected from the hospital….Yes, but then they make you wait or tell you to come in weeks later. (Multiple participants from a focus group conducted with Latino(a) residents)

A key informant related to geriatric care explained their perspective of preventable hospitalizations related to patients that have been discharged from the hospital before they were able to be sustained in a less intensive setting:

I would say, I'm going to give them the benefit of the doubt and say 7 out of 10 times, if my folks are saying, "They got here too soon. They had to go back," they're probably right. If somebody goes back right away within one or two days, that's a cause for concern in that hospital relationship. If someone goes back after two weeks, then you just have to start asking questions about, "Well, what's going on here, and is the event really so acute in nature that we can't handle it?" (Key informant, geriatric care)

Behavioral Health Services: Study participants discussed the need for care coordination, medication management and cultural sensitivity among behavioral health providers. Additional participants discussed the limited capacity and effectiveness of many behavioral health services available in Manhattan.

CNA participants often discussed the lack of consistent behavioral health services and a lack of capacity at institutions that are often filled, causing residents to have to wait to receive services. Additionally, high turnover rates among mental health professionals were identified as a key cause for disruption of consistent care, and was identified as a possible cause for non-adherence to medication. One focus group participant discussed the loss of his psychiatrist and lengthy process in securing a new provider due to a lack of insurance. A process that had caused him to run out of his mental health medication and begin to decompensate:

From my experience, I have been to depression real bad. But for me, it's Department of Corrections. I've been in the system all my life, 28 years. Come out here, nothing out here for me. Get real depressed. Right now I'm a little depressed because I just moved in a new place. The psychiatrist at my other spot, she moved back to Canada, then I don't have a psychiatrist. Then the list here is a two month list. I went back to see, I went to my

parole case manager. They trying to see if they can up the appointment because I'm going through it. Because right now, I'm outside at nighttime, I don't even want to go back in my apartment sometime. I feel comfortable in the street. So, when I'm taking medication, I feel comfortable, not feel comfortable, I feel alive. Since I'm not taking them, I feel like…. (Participant from a focus group conducted with residents living with HIV)

The availability of culturally sensitive care can impact the leverage communities have in managing issues like suicide, substance abuse, etc. One key informant shared that there are issues in the Asian-American community that are not culturally appropriate to discuss:

So, Asian-American young women have the highest rate of suicidal ideation among all racial ethnic groups. And we find something similar, not just with the young people, but senior – Asian-American women who are seniors as well…So we definitely know that that's a big issue. And even among our – we have a young people's program here. And one of the first projects that they wanted to work on was the need for mental health services at their schools, particularly among counselors who are knowledgeable about their communities. And so it is a big issue. And I think there's a lot of stigma across the board of getting services. Some things that we hear are even the parents who understand that there are young people that could really benefit from getting treatment and services, it's like let's just keep it in the family. We'll go ahead and we'll find a place and just don't let anyone else know. Because I think for a lot of them, they just come from cultures where it's not okay to talk about that. Or it's either a reflection on the parents, right? Or it's maybe you did something in a previous life or they're crazy, right? But I definitely see it more among immigrants – even immigrants who have been here for 30, 40 years, are still like, just keep it within the family. I think substance abuse is something that is definitely not talked about. But in the work that I've done, alcoholism in certain communities is definitely something that people just don't want to acknowledge. In the Filipino community, for example, it's called shabu, but it's equivalent to crystal meth. That's definitely – and Asians around addiction, as well as gambling addiction. Domestic violence, definitely, and family violence. (Key informant, Asian social services)

Dental Care: Survey respondents felt that dental services are available or very available in their community (average rating of 2.13 on a scale of 1-very available to 4 not available at all); 59% reported having been to the dentist in the prior 12 months. Focus group participants with good coverage reported using dental services consistently, a number of participants described dissatisfaction with services, commonly due to the high cost, lack of coverage and/or a lack of experienced providers offering dental care to lower-income populations.

I went to the dentist. That my insurance led me to, you gonna go over here and they're going to go over there, because they're paying. And they said it to me just like that. (Participant from a focus group conducted with residents having experienced domestic violence)

Insurance: Manhattan residents discussed frequent experiences of confusion (e.g., which providers accepts which insurances?); they describe as a constant shift in insurance provision that is difficult to keep up with. Residents also discussed the different levels of care provided to residents based on the type of insurances they have. Often residents discussed the experience level, bedside manner and quality of provider care being lower for Medicaid Beneficiaries than it is for residents with other types of insurance:

I think the other barrier is people feel very strongly – and this came out of the needs assessment too – that when they have different – and this came out in the focus groups – when they had different kinds of insurance, they definitely felt a difference in how they were received by the frontline staff, by the health care provider. So if you didn't have insurance, you had Medicaid, you had a certain kind of Medicaid, you were treated a certain way. And this is from people who had different kinds of insurance in their lives, or family members who had private health insurance and when they had Medicaid they felt a difference in the interactions. (Key Informant, Healthcare advocate)

You go to an emergency room, they're going to analyze what your insurance is first before they serve you. It isn't like you can go in there and come out after. They're going to see if they can get their money first on the temperature of how they're going to treat you. (Participant from a focus group conducted with residents living with HIV)

I don't know what the reason is, but I think it's the lack of; it's got to be a lack of communication, first and foremost. Then being a minority with state insurance, not private insurance because there's a difference and it came up in my face when I went to the dentist. That my insurance led me to, you gonna go over here and they're going to go over there, because they're paying. And they said it to me just like that. I felt some kind of way. Okay, but I know where I'm at and I know why I chose to be where I am at, but the fact that my insurance, it's not where it's at I need to go over here. So I'm being treated by the interns. Whereas you're getting treated by a doctor that has skills. Okay, so you got the ones that have to be taught how to treat it and then you got the ones that are experts on how to treat it. (Participant from a focus group conducted with residents having experienced domestic violence)

While residents experience many barriers to care; CNA participants discussed the barriers posed by the cost of care and lack of insurance coverage. One key informant shared the results of a study conducted with Asian social service clients where language and cost of care were the top two barriers to seeking health services:

Language access came up over and over again. But the bigger issue was actually the cost of services, which I thought was really interesting because it was much higher than

language access needs. And so oftentimes they would forego getting any care, getting screenings, or even if they were deathly ill, they will totally wait until the end, and even with people who had insurance, because they were afraid of the cost of care. (Key informant, Asian social services)

Respondents suggest that there is a lack of quality providers accepting Medicaid, specifically for specialty care.

And so there's a gap in primary care providers' ability to find specialists who are accepting Medicaid or different kinds of insurance. And so that continues to be an issue and one that doesn't get talked about. I think dental care is big. That's something that we saw in the health needs assessment that we did as well, that people are very concerned about that. Behavioral health therapy is also big. (Key informant, health advocate)

Supportive Services

CNA participants, key informants and Manhattan resident groups alike, recognized the benefits of care coordination as well as the poor health outcomes when care coordination is absent. CNA participants discussed the need for medication management, provider consistency and provider engagement in both mental health and primary care settings. The discussions often focused on the successful management of mental and physical illnesses, including chronic illness, when providers were engaged, provided follow-up and medication evaluations.

A group of diabetic residents with unstable diabetes discussed the success of a program helping them control their historically uncontrolled diabetes due to the engaging nature of the coordinator and the accessibility of services:

[Our coordinator] helps me a lot. When I talk to [the coordinator] out of his office, I feel good after I talk to [the coordinator]. He makes me feel there is somebody in my corner, there is somebody that cares. I'm getting choked up for real right now. But seriously, he really does. I feel good when I leave his office. I know I can call him up because he tells me, "--, if you need to talk, call me up." … I did so well that I no longer qualified for his program…that should tell you how important it is to have something like this…Because it's like a one-on-one thing. He's one-on-one and has connections. He knows the nutritionist and, "You know what? I got this information about this nutritionist." Or he knows about particular places you may go, and can look it up. [The coordinator], he even takes information that you have to bring to him, and he involves himself with it and helps you with that and lets you know what you need to know so you can talk to your endocrinologist…It's good having someone that knows exactly what his position is, is what it does for us, .he helps you out. He helps you manage the care, and he gives you information that you really need. If you don't have any type of connections or anything like that, he can help direct you to whatever other services are out there…Yeah, oh, he's

good. He is good. (Multiple participants from a focus group conducted with residents diagnosed with diabetes)

The same group, who when asked how this program was different from other programs they had experienced in the past, said:

[Other programs] Not caring at all…The most important, right? They don't care…Not giving you the materials that you're supposed to read up on about diabetes. You're just being diagnosed with it. I'm just speaking for me. You're just being diagnosed with it. Like I said, I've been diagnosed in emergency room, and I never knew nothing about it. When I went to that clinic over there, they really didn't, like [the coordinator], like I've only been to [the coordinator] twice, right? He gave me more information about being diabetic and what we're supposed to do and the material papers and stuff like that to read up on. (Multiple participants from a focus group conducted with residents diagnosed with diabetes)

One resident discussed her experience with a provider that completed a comprehensive medication evaluation to find that she was taking medications that she no longer required, which were negatively impacting her health:

I don't know about anybody else but with me I have quite a few things. I take like six pills a day , everything that y'all can think of but I was going to three hospitals and all those hospitals giving me the same medications. I take six pills a day. I moved from one hospital to another and they checked my heart out. Cost 3,800 dollars. The $800 I have to pay now so the 3,000 my plan paid. My new doctor, he took me and he examined me. One pill was for the heart, which was no good. He said in less than 30 days I could be dead. One pill was for cancer. Co-payment was $140 payment for all three pills. He tell me put it on the table, he said. And another one, he said was for kidney and when he mentioned that, I put all the medications on the table. He said if you take either one of these pills, he said your family might be burying you. He said because how long. I said I took those pills for six years. Six years… I only take 3 pills now…I feel good. (Participant from a focus group conducted with residents living in NYCHA Housing)

<u>Care Coordination/Case Management</u>: Across populations and conditions, care coordinator and case management models were described as highly effective approaches for improving health and reducing health care use. Multiple key informants cited research studies that demonstrated positive outcomes during implementation of care coordination programs. Responsibilities of care coordinators included linkage and serving as liaison to multiple providers, health education, assisting with accessing entitlement and supportive services, and monitoring the stability and engagement of clients.

Key informants talked about the need for continuity of care in more transient populations in order to manage chronic illnesses, as well as the relationship between insurance type and the level of care continuity provided in some facilities:

> *I think what I found in research I've done on my own in previous jobs, it's continuity of care is what needs to be…is the biggest thing that will inspire better outcomes…I think it's the nature of certain diagnoses that it's, yes, harder to sustain kind of stability or housing or all the pieces that, if those are in place, then you can stabilize care. (Key informant, home health)*

> *Yes. I think depending on where people are getting seen there is a whole question around continuity of care that comes up as well. So, I don't know if this is strictly related to insurance, but for some of the teaching hospitals where you have residents rotating in and out, it's those residents they're seeing more likely, which I think is the case between uninsured or Medicaid patients, it becomes an issue with. (Key Informant, Healthcare advocate)*

Residents often discussed the turnover rates among providers of both physical health and mental health services. Discussions focused on the resident's lack of trust and comfort in engaging with new providers once they have lost previous providers. Residents also focused on the confusion that consistently rotating providers can cause, particularly for seniors and mentally ill patients. Additionally, residents discussed the lack of continuity of care resulting from changing providers.

> *Group Discussion (Multiple speakers): They do change the doctors on you a lot. All the time. You have a doctor sometimes for month or two months, until you go again. They change you to somebody else and they'll change you to a different plan, too…It's confusing to some people, especially elderly people who don't understand, who are used to having one doctor. Then when they come back, then they have somebody else telling them something else. You don't feel comfortable because you are used to the doctor that you had for so many years. (Multiple participants from a focus group conducted with residents living in NYCHA Housing)*

> *Group Discussion (Multiple speakers): Yeah, there's groups that are available, there's also individual counsel, the only issue with individual counsel is sometimes you get someone who is a resident, or in training… And then, next year someone else, and then next year is someone else… when you are doing something personal like that and talking to somebody in a meeting, you need somebody who is there all the time to build a relationship with and trust…Yes, to be comfortable with…No continuity of care.*

(Multiple participants from a focus group conducted with residents living with a physical disability)

Every time you get a new doctor it is like starting all over again. I had a therapist for almost four years. He told me a week before he was leaving. I don't even want to go to a therapist now. (Participant from a focus group conducted with residents diagnosed with mental health and medical health comorbidities)

Quality of Care

Several concerns related to quality of care were repeatedly raised in focus groups and key informant interviews. Each of these were reported to contribute to delays in care, neglect of care, poor adherence to medical recommendations, and poor health outcomes.

While many of the participants in the CNA discussed having access to care there were discussions around the length of time it takes to secure an appointment with primary care providers. Participants made the link between the amount of advance notice one must have to secure an appointment at the doctor (e.g., four months), which often leads residents to seek treatment in the ED due to the urgency of their medical condition.

It's still very common sense but sometimes it feels like that message is not getting across to providers who maybe they're … or the hours are at a time when it's really inconvenient for people. Or people say it's not rational to go to the emergency room for care, but when we talk to people, they would say things like, "Well, I tried to make an appointment with my doctor, and it's like four months in advance." What rational person is going to wait four months rather than go. So there just seems to be very common sense things that people are experiencing but we're not hearing people vocalizing it and saying this is not how I access care, this is not the optimal way or this is a barrier. The challenge I think is hard if you're stuck in the institutional setting where you're looking at it like, "What are good hours for my doctor to be working" kind of thing. There's that disconnect. I think things like that. (Key informant, Health advocate)

We should push for walk-in rooms where if you wake up with a problem, you can go to the walk-in room and not have to either call to make an appointment and wait several weeks or go to the emergency room. People should not only have the option of an emergency room or wait a few weeks for a doctor to see them. If there were more walk in rooms where people can get their care from, we would keep a healthier community and people would not have to be compelled to go to the emergency room. We would have better health results at a lesser cost. (Participant from a focus group conducted with Latino(a) residents)

Another problem was the wait to see a physician is very, very long. (Participant from a focus group conducted with residents living with HIV)

Doctors give you appointments too late. (Participant from a focus group conducted with residents with limited English proficiency)

Focus group participants discussed their experiences when visiting the emergency department:

I've gone to the hospital ER before, Metropolitan. I had what I thought was a cold. I went there two weeks in a row, and they kept on saying it was a cold. And I said, "You do additional tests." They would not do it. They just sent me back out. I went to a different hospital, Bellevue, and I had pneumonia. It was just really crazy that some hospitals won't do additional tests to figure out the issues just because you've been there multiple times. (Participant from a focus group conducted with residents living with HIV)

Manhattan residents discussed the need for sensitivity among providers and staff in health care settings to effectively treat clients. Often discussions focused on the lack of sensitivity in healthcare settings, which often lead patients to resist necessary care:

Group discussion (multiple speakers): This is what I see. They'll read your information and still call you on what they see in front of them. There was a representative there, read my stuff, read it loud over the speaker and he still ends up addressing me as sir. And that was a first. I've never had that before. They're not gender sensitive. They're not friendly enough. (Multiple participants from a focus group conducted with residents living with HIV)

And then the other piece is when you look at specialty care, say around mental health, for example, if an individual wants to go to someone who's culturally competent, we don't have a lot of Asian-Americans who are going into fields like mental health or behavioral health issues. Those that specialize in substance abuse. So oftentimes it's like you got them through the door and now what's going to happen? (Key informant, Asian social services)

There are few culturally competent and linguistically competent mental health services available to the African community, so we started a small mental health counseling program initially for HIV clients, but we've expanded it to clients with any kind of trauma. (Key informant, African services)

SPECIFIC POPULATIONS

Low income, uninsured, and immigrant populations, as described above, face a number of multiple barriers to optimal health and health care use. However, within these populations, there are a number of groups for which the barriers are exacerbated. These include individuals with disabilities, criminal justice involved, homeless, and young adults transitioning out of foster care. A number of these groups are also high users of expensive medical services due to a combination of greater medical need and barriers to community based services.

Individuals with Disabilities: Individuals with physical and/or cognitive disabilities are disproportionately low income, unemployed, and have a high number of co-morbidities,

including obesity, hypertension, and cardiovascular disease. Despite a high need for services, they reportedly delayed care because of poor accommodation (e.g., absence of ramps, sign language interpreters) and providers that are insensitive to both their capabilities and their limitations. These access barriers—and their implications— were described by CNA participants. Unfortunately, barriers are considered more significant in community as compared to hospital settings so may become more pronounced as—consistent with the goals of DSRIP—services move into the community.

> *I was very sick at one point very, very sick and that lady was there every day. Now when you go to the hospital, they don't get paid. The home attendants don't get paid, and I was there for three weeks. (Participant from a focus group conducted with residents living with a physical disability)*

> *Unfortunately, my issue with mental health is being a person in a wheelchair, a lot of times, these people, instead of looking at, and I'm sorry for saying these people, because now I'm doing what they do to me, but they freaking look at me like my concerns are not valid. (Participant from a focus group conducted with residents living with a physical disability)*

Criminal Justice Involved: CNA participants discussed the impact incarceration has on physical and mental health as well as socioeconomic status. Focus groups discussed the poor quality and limited capacity of medical and mental health services in prison.

> *I don't think New York City does enough to treat the mentally ill. Right now, like, my husband, mentally ill and he also has substance abuse problems. It's very hard on us, you know? Also, I don't think those who work in certain occupations, such as corrections, are trained properly. Because, to deal with the mentally ... Because my cousin, he's a schizophrenic. He beat a guy up one night. He was wandering the streets and he beat some guy up, and he had went to Riker's Island and instead of them helping him, they put him in a cell and he end up getting the crap beaten out of him. (Participant from a focus group conducted with residents living with HIV/AIDS)*

> *I also want to go with the jail system. I was incarcerated before in Riker's Island, I've never been upstate. They help you in no kind of way. You go in and you're coming out worse than you went in. You sit in the receiving room which is where you do your doctor, 2 days. 2 days in order to get into a cell or into a dorm to get into your bed. 2 days. I learnt my lesson. I'm never going to jail again in my life but I want to say too that it just goes across the board, they're building more jails everyday but the hospitals are shutting down. (Participant from a focus group conducted with residents that have a history of substance abuse)*

Participants discussed the lack of support services available for previously incarcerated individuals post-release particularly transitional housing, employment, and mental health.

> *The assistance you need. They don't have the assistance you need… To keep you out [of prison]. To help you transition to being free. I had to look for all that myself. They didn't assist me in any way. (Participant from a focus group conducted with residents living with HIV/AIDS)*

> *That's what they did. They started out on the Step program. They have you thinking okay when you come out they're going to get you an apartment and then they don't. (Participant from a focus group conducted with residents diagnosed with mental health and medical health comorbidities)*

Homeless Population: The NYC Department of Homeless Services houses approximately 55,000 people per night through its shelter system; there are an estimated 3,000 people living on the street in NYC. The homeless population includes single adults and families with and without children. CNA participants recognized the relationship between housing stability and health/behavioral health outcomes by often discussing the notable higher rate of mental illness among homeless, the high use of healthcare resources by chronic homeless persons and the high recidivism rates in the medical health and behavioral health industries of persons without stable housing due to the inability to fully implement medical recommendations and lack of oversight/ case management. Key informants and focus group participants both discussed the impact of housing on physical health. Discussions focused on the relationship between:

- Housing stability: Key Informants discussed the positive impact that stable housing can have on reducing the use of health care resources (i.e., ED use) among chronically homeless populations; particularly those residents with mental health or substance abuse issues.
- Homelessness: Key informants and focus group populations discussed the negative impact homelessness has on residents related to victimization, street violence, lack of hygiene, access to proper nutrition to manage chronic health issues (i.e., diabetes), etc.
- Communal Housing: Focus group populations discussed the poor hygiene found in communal housing (i.e., SROs) and the impact on individuals including persons with existing health conditions (i.e., persons diagnosed with HIV).
- Location: Focus group populations discussed the location of housing for at-risk populations often being located around unhealthy options with limited access to healthy options (i.e., fast food restaurants, liquor stores, violence, etc.).

Homeless individuals are reported to be frequent users of emergency services, not only because of health conditions but because of the instability in their lives.

[A doctor] opened by talking about how she had started a double shift on a Saturday morning, and discharged a guy who was homeless. He came into the emergency department inebriated, had fallen. They kind of fixed him up. She discharged him. That night he came back and had smashed his face and was inebriated. And as she was ordering the expensive tests to see if he had facial fractures, and the plastic surgeon, and everybody had come in, she knew that she would kind of repair this thing. But that he was just going to be back. And until we got housing for him, she was just doing Band-Aids. And I think that's where there's huge opportunity to really make very positive impacts for these individuals if we can find them a place to live. (Key informant, supportive housing)

Young Adults Transitioning Out of Foster Care: In New York, foster children are able to remain a ward of the state until they are 21. There are professionals in place to guide this transitional process. However, focus group participants told stories of overworked professionals and delayed or missed opportunities in preparing to transition to self-sustainable adult living (i.e., drivers licenses, housing, employment training, etc.). As a result, these young adults often go through a series of transitions with little to no support or guidance:

A lot of kids are not even educated. That's the problem. These kids are not educated. It's a lot of foster kids that's growing up with not even the right proper training and the right home care and the right wisdom to even get through life or even know what it is. So, it's about education. (Participant from a focus group conducted with young adults 18+ transitioning out of foster care)

There's a chance that I might be more at risk because of my social environment. I'm 21. I'm already on one extension. My social worker, last time I saw her, she said she was going on vacation and then will see me when she came back. I don't know if she filled out the paper work for the extension or not. (Participant from a focus group conducted with young adults 18+ transitioning out of foster care)

My social worker, I don't know … She went on vacation and told me she will see me when she gets back. I don't know if she quit, got fired, or just decided I'm not coming back. All of a sudden, come to my agency, she doesn't work there no more. My new social worker, something that, she was giving me stuff to fill out like if you need care, how to get it. Some paperwork that you have to fill out to get insurance after you leave care, stuff like that. It's crazy because she asked me, "Did she give this stuff to you?" I'm like, "No." She said she was supposed to give this stuff to you when you were 19. She never gave me this stuff. I was like, "No, she never did." this is the reason why there might be a chance why I might be homeless, because right now, they're trying to push for me to get a second

extension, at least until November. They're trying right now. My social worker, I already know that when you're in foster care, by the time you're at least 18-19 years old, that's when they usually start putting in the process. I am 21! (Participant from a focus group conducted with young adults 18+ transitioning out of foster care)

DISCUSSION

Manhattan community members and other stakeholders are clearly interested in partnering with hospitals and being part of solutions that promote good health and reduced hospitalizations. Focus group and interview participants articulated specific barriers to good health and good health care, many of which were related to poverty and its consequences, including unstable housing, and the need to prioritize expenditures—even among basic needs. For specific groups, including the disabled, young adults transitioning out of foster care, criminal justice involved, and the homeless, health-related barriers were compounded, due to both attitudinal and practical considerations.

Focus group and interview participants also articulated potential "fixes," such as increased ease of access for medical visits (e.g., reduced wait time, reduced insurance restrictions, increased integrated care); improved provider sensitivity; and a range of supportive services, including care coordinators—particularly for difficult to manage medical conditions and high risk populations. Health education, addressing (for example) prevention, screening, disease management, insurance, and increased capacity for the treatment of mental health issues, was considered essential at the individual and the community level, to ensure that the population has the knowledge and skills necessary for independent action that promotes their own good health.

Table 1: Distribution of Responses (N=605)*

UHF Neighborhood	UHF code	Zipcode	Frequency	%
Washington Hgts/Inwood	301	10031, 10032, 10033, 10034, 10040	49	7.2%
Central Harlem/Morningside Hgt	302	10026, 10027, 10030, 10037, 10039	160	23.6%
East Harlem	303	10029, 10035	99	14.6%
Upper West Side	304	10023, 10024, 10025	27	4.0%
Upper East Side	305	10021, 10028, 10044, 10128	8	1.2%
Chelsea/Clinton	306	10001, 10011, 10018, 10019, 10020, 10036	54	8.0%
Gramercy Park/Murray Hill	307	10010, 10016, 10017, 10022	10	1.5%
Greenwich Village/Soho	308	10012, 10013, 10014	24	3.5%
Union Sq./Lower Eastside	309	10002, 10003, 10009	188	27.8%
Lower Manhattan	310	10004, 10005, 10006, 10007, 10038, 10280	58	8.6%
			677	100.0%

* Only included responses with zipcode

Table 2: Demographic characteristics

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan
Age (Mean, SD) (N=677)	45.3 (15.3)	52.9 (14)	48.3 (12.7)	55.6 (14.6)	44.8 (21.4)	51.8 (14.2)	63.7 (11.4)	51.9 (16.6)	56.5 (17.4)	71.8 (13.5)	54.4 (16.4)
18-20	4.1%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	0.0%	0.0%	1.7%	0.6%
21-44	36.7%	21.3%	34.3%	14.8%	50.0%	27.8%	0.0%	29.2%	25.0%	5.2%	24.5%
45-64	42.9%	55.6%	55.6%	63.0%	0.0%	48.1%	50.0%	33.3%	38.3%	10.3%	44.2%
65-74	10.2%	5.0%	4.0%	7.4%	37.5%	7.4%	40.0%	25.0%	19.1%	39.7%	14.0%
75-84	0.0%	5.6%	3.0%	14.8%	0.0%	3.7%	0.0%	0.0%	13.3%	27.6%	8.7%
85 and older	0.0%	1.3%	2.0%	0.0%	0.0%	1.9%	10.0%	4.2%	3.2%	13.8%	3.1%
Unknown	6.1%	11.3%	1.0%	0.0%	0.0%	11.1%	0.0%	8.3%	1.1%	1.7%	4.9%
Gender (N=667)											
Female	39.6%	49.0%	40.8%	51.9%	12.5%	45.3%	77.8%	50.0%	58.1%	80.7%	52.2%
Male	52.1%	50.3%	58.2%	44.4%	87.5%	50.9%	22.2%	37.5%	40.9%	19.3%	45.7%
Transgender	6.3%	0.6%	0.0%	0.0%	0.0%	1.9%	0.0%	8.3%	1.1%	0.0%	1.3%
Unknown	2.1%	0.0%	1.0%	3.7%	0.0%	1.9%	0.0%	4.2%	0.0%	0.0%	0.7%
Sexual Orientation (N=643)											
Heterosexual	75.0%	78.4%	83.2%	74.1%	87.5%	57.7%	57.1%	65.2%	81.8%	87.0%	78.1%
LGBTQI	20.8%	17.0%	11.6%	14.8%	12.5%	28.8%	28.6%	13.0%	6.8%	9.3%	13.8%
Unknown	4.2%	4.6%	5.3%	11.1%	0.0%	13.5%	14.3%	21.7%	11.4%	3.7%	8.1%
High school graduate or higher (N=649)	91.5%	79.9%	84.9%	81.5%	75.0%	80.8%	90.0%	81.8%	59.6%	48.3%	73.3%
Hispanic (N=646)	33.3%	25.8%	23.2%	15.4%	25.0%	28.0%	12.5%	17.4%	37.7%	35.2%	29.4%
Race (N=630)											
White	28.9%	14.6%	6.7%	14.8%	50.0%	32.0%	44.4%	20.8%	16.0%	22.8%	18.1%
Black or African American	46.7%	62.9%	65.6%	48.1%	12.5%	24.0%	33.3%	4.2%	8.9%	12.3%	36.0%
American Indian or Alaskan Native	0.0%	2.0%	4.4%	3.7%	0.0%	0.0%	0.0%	0.0%	3.0%	0.0%	2.1%
Asian	2.2%	2.6%	4.4%	11.1%	12.5%	18.0%	22.2%	45.8%	49.1%	59.6%	24.1%
Native Hawaiian or other Pacific Islander	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.3%
Other	15.6%	14.6%	12.2%	7.4%	25.0%	18.0%	0.0%	16.7%	17.8%	0.0%	13.8%
Unknown	6.7%	2.6%	6.7%	14.8%	0.0%	8.0%	0.0%	12.5%	4.7%	5.3%	5.6%
Unemployed (N=659)	29.2%	41.3%	41.5%	19.2%	12.5%	37.0%	20.0%	13.0%	13.1%	3.4%	26.4%
Always/sometimes worry about not having enough money to pay for food or housing (N=677)	67.3%	68.8%	62.6%	51.9%	50.0%	75.9%	60.0%	66.7%	61.7%	50.0%	63.7%

Table 3: Language

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan
Primary langauge spoken at home (N=660)											
English	83.3%	89.5%	89.5%	81.5%	75.0%	74.1%	70.0%	50.0%	36.1%	22.4%	64.8%
Spanish	8.3%	7.2%	4.2%	7.4%	12.5%	9.3%	10.0%	8.3%	17.5%	29.3%	12.0%
Arabic	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.2%	0.5%	0.0%	0.3%
Chinese (Mandarin, Cantonese, or other)	2.1%	2.6%	2.1%	7.4%	12.5%	14.8%	20.0%	33.3%	44.8%	44.8%	20.6%
French	0.0%	0.0%	0.0%	0.0%	0.0%	1.9%	0.0%	0.0%	0.0%	0.0%	0.2%
Haitian/French Creole	4.2%	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%
Hindi	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Italian	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Korean	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Russian	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Urdu	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Yiddish	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	1.1%	0.0%	0.5%
Other	0.0%	0.7%	1.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.4%	0.6%
Unknown	2.1%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	4.2%	0.0%	0.0%	0.5%
English proficiency (N=677)											
Very well/well	93.8%	91.4%	96.8%	85.2%	100.0%	84.9%	70.0%	75.0%	48.1%	40.4%	74.2%
Not well/not at all	6.3%	8.6%	2.1%	14.8%	0.0%	15.1%	30.0%	20.8%	48.6%	59.6%	24.5%
Unknown	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	0.0%	4.2%	3.3%	0.0%	1.2%
Foreign born (N=677)	27.1%	35.9%	22.7%	48.1%	25.0%	34.0%	33.3%	34.8%	61.4%	68.4%	43.4%

* only those who indicated ever not getting healthcare when needed

Table 4: Health-related characteristics

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan
Perceived health status (N=636)											
Excellent/very good/good	83.0%	72.7%	78.0%	66.7%	75.0%	72.5%	33.3%	62.5%	58.8%	32.7%	65.9%
Fair/Poor	17.0%	27.3%	22.0%	33.3%	25.0%	27.5%	66.7%	37.5%	41.2%	67.3%	34.1%
Body mass index (Mean, SD)* (N=562)	26.3 (5.6)	26.6 (5.8)	28.6 (7.2)	28.3 (6.1)	25.2 (5.2)	27.6 (5.4)	28.7 (8.3)	24.1 (4.1)	25.9 (5.7)	26.1 (5.8)	25.2 (5.2)
Underweight	0.0%	5.8%	1.3%	0.0%	0.0%	0.0%	0.0%	5.3%	2.5%	3.8%	2.8%
Normal	44.1%	33.6%	26.6%	34.8%	57.1%	34.1%	55.6%	57.9%	51.6%	45.3%	40.9%
Overweight	38.2%	39.4%	40.5%	26.1%	28.6%	43.2%	22.2%	26.3%	29.9%	32.1%	35.1%
Obese	17.6%	21.2%	31.6%	39.1%	14.3%	22.7%	22.2%	10.5%	15.9%	18.9%	21.2%
Have health insurance (N=677)											
Medicaid	34.7%	44.4%	46.5%	18.5%	25.0%	42.6%	10.0%	41.7%	34.0%	8.6%	36.0%
Medicare	16.3%	16.9%	11.1%	11.1%	25.0%	5.6%	0.0%	8.3%	9.6%	27.6%	13.3%
Dual Eligible	10.2%	15.0%	13.1%	29.6%	25.0%	16.7%	60.0%	12.5%	14.9%	41.4%	18.0%
Private/commercial	14.3%	4.4%	5.1%	14.8%	12.5%	7.4%	10.0%	16.7%	11.7%	3.4%	8.4%
VA	0.0%	0.0%	1.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Other	2.0%	1.3%	5.1%	3.7%	0.0%	1.9%	10.0%	4.2%	3.7%	0.0%	2.8%
More than one insurance	4.1%	6.9%	3.0%	7.4%	0.0%	3.7%	10.0%	8.3%	12.2%	13.8%	8.0%
Uninsured	18.4%	11.3%	15.2%	11.1%	12.5%	22.2%	0.0%	8.3%	13.8%	5.2%	13.1%

***BMI categories** less than 18.5 : underweight; 18.5 to 24.9 : normal; 25.0 to 29.9 : overweight; 30.0 or higher : obese

Table 4: Healthcare utilization

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Have a primary care provider/personal doctor	69.4%	86.9%	71.7%	81.5%	100.0%	83.3%	80.0%	75.0%	78.7%	82.8%	79.9%
Have a usual place to go for non-emergency health services	75.5%	76.9%	62.6%	81.5%	75.0%	74.1%	80.0%	83.3%	75.0%	77.6%	74.4%
Use complimentary or alternative treatments or remedies	26.5%	38.1%	36.4%	37.0%	37.5%	44.4%	50.0%	45.8%	49.5%	34.5%	40.8%
In the past 12 months:											
Had routine check-up	73.5%	80.6%	78.8%	81.5%	87.5%	75.9%	80.0%	70.8%	85.1%	87.9%	81.1%
Have been to a dentist	55.1%	60.0%	54.5%	44.4%	62.5%	68.5%	80.0%	62.5%	55.3%	63.8%	58.3%
Have gone to a hospital emergency room at least once	18.4%	25.6%	18.2%	18.5%	12.5%	22.2%	10.0%	8.3%	19.7%	15.5%	19.9%
Need healthcare but didn't get it	24.5%	21.9%	22.2%	14.8%	0.0%	25.9%	10.0%	29.2%	19.7%	5.2%	19.9%

Table 5: Place for non-emergency healthcare services*

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=578)
Type of place											
Primary care doctor's office	52.5%	56.8%	44.9%	48.0%	42.9%	31.3%	50.0%	57.9%	45.3%	64.7%	49.7%
Specialist doctor's office	5.0%	3.6%	1.3%	4.0%	0.0%	2.1%	10.0%	5.3%	3.7%	7.8%	3.8%
Community/family health center	22.5%	10.1%	17.9%	28.0%	28.6%	27.1%	40.0%	21.1%	14.3%	3.9%	15.9%
Hospital-based clinic	12.5%	20.9%	19.2%	8.0%	0.0%	18.8%	0.0%	10.5%	11.2%	9.8%	14.7%
Private clinic	0.0%	4.3%	5.1%	0.0%	14.3%	12.5%	0.0%	5.3%	15.5%	11.8%	8.5%
Emergency room	2.5%	1.4%	5.1%	4.0%	14.3%	2.1%	0.0%	0.0%	3.1%	0.0%	2.6%
Urgent care	0.0%	0.0%	1.3%	4.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.5%
Pharmacy	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Drug treatment center	0.0%	0.0%	3.8%	4.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.9%
Mental health center	0.0%	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	0.0%	1.2%	0.0%	0.5%
Alternative care (e.g. herbalist, acupuncturist)	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	0.3%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%	0.3%
Unknown	2.5%	2.2%	1.3%	0.0%	0.0%	4.2%	0.0%	0.0%	2.5%	2.0%	2.1%
Location											
Bronx	9.8%	9.7%	9.1%	4.2%	0.0%	6.4%	0.0%	0.0%	1.2%	0.0%	5.3%
Brooklyn	0.0%	2.8%	2.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	1.2%
Manhattan	90.2%	83.4%	84.4%	91.7%	100.0%	91.5%	100.0%	100.0%	96.4%	94.2%	90.7%
Queens	0.0%	2.8%	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	0.6%	0.0%	1.0%
Staten Island	0.0%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Outside of New York City	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%	5.8%	1.0%
Unknown	0.0%	0.7%	2.6%	0.0%	0.0%	2.1%	0.0%	0.0%	0.0%	0.0%	0.7%

*only for those who indicated that they have a specific place they usually go for non-emergency services.

Table 6: Barrier to getting healthcare*

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=135)
Not insured	33.3%	10.3%	41.7%	50.0%		19.0%		33.3%	22.9%	0.0%	23.6%
Cost of copays	8.3%	15.4%	4.2%	25.0%		9.5%		11.1%	14.3%	25.0%	12.2%
Concerns about quality of care	8.3%	2.6%	4.2%	0.0%		4.8%		11.1%	5.7%	25.0%	5.4%
Did not know where to go	0.0%	5.1%	0.0%	0.0%		4.8%		0.0%	8.6%	0.0%	4.1%
Had other responsibilities (e.g. work, family)	16.7%	7.7%	8.3%	0.0%		4.8%		11.1%	2.9%	0.0%	6.8%
Could not get an appointment soon or at the right time	8.3%	28.2%	20.8%	0.0%		19.0%		11.1%	14.3%	25.0%	18.9%
Did not have transportation	0.0%	10.3%	4.2%	0.0%		14.3%		0.0%	5.7%	25.0%	7.4%
Concerns about language or translation issues	8.3%	5.1%	4.2%	25.0%		9.5%		0.0%	17.1%	0.0%	8.8%
Other	16.7%	15.4%	12.5%	0.0%		14.3%		22.2%	8.6%	0.0%	12.8%

*only for those who indicated that they ever not get healthcare when needed in the past 12 months.

Table 7: Reason for ER use*

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=266)
Did not have insurance	5.9%	1.3%	20.0%	33.3%	0.0%	13.0%	0.0%	0.0%	13.6%	0.0%	9.2%
Did not have transportation to a doctor's office or clinic	0.0%	2.6%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%	0.0%	1.6%
Get most care at ER	5.9%	13.2%	17.5%	33.3%	0.0%	8.7%	0.0%	0.0%	10.2%	22.2%	12.8%
Problem too serious for a doctor's office or clinic	17.6%	28.9%	30.0%	16.7%	50.0%	34.8%	40.0%	25.0%	35.6%	55.6%	32.4%
Doctor's office or clinic was not opened	41.2%	30.3%	15.0%	16.7%	0.0%	17.4%	20.0%	25.0%	27.1%	16.7%	24.8%
Other	29.4%	23.7%	15.0%	0.0%	50.0%	26.1%	40.0%	50.0%	11.9%	5.6%	19.2%

*only for those who indicated that they went to the ER at least once in the past 12 months

Table 8: Health concern in the community

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Adolescent health	8.2%	8.8%	10.1%	11.1%	0.0%	13.0%	0.0%	4.2%	9.6%	5.2%	8.9%
Asthma	16.3%	38.8%	33.3%	40.7%	25.0%	14.8%	20.0%	16.7%	26.6%	25.9%	28.8%
Arrest and incarcertation	24.5%	30.0%	33.3%	18.5%	12.5%	9.3%	10.0%	0.0%	11.7%	3.4%	19.1%
Cancer	10.2%	26.9%	29.3%	29.6%	0.0%	14.8%	30.0%	20.8%	25.0%	44.8%	25.7%
Diabetes	34.7%	51.3%	51.5%	51.9%	62.5%	24.1%	30.0%	37.5%	53.2%	62.1%	48.7%
Disability	10.2%	23.8%	17.2%	18.5%	37.5%	18.5%	50.0%	12.5%	17.6%	13.8%	18.8%
Drug and alcohol abuse	61.2%	60.6%	72.7%	51.9%	25.0%	53.7%	30.0%	25.0%	36.2%	20.7%	49.2%
Family planning/birth control	12.2%	13.1%	17.2%	7.4%	0.0%	3.7%	0.0%	4.2%	6.9%	0.0%	9.2%
Hepatitis	6.1%	16.3%	16.2%	14.8%	0.0%	9.3%	10.0%	4.2%	9.6%	1.7%	11.1%
Heart disease	10.2%	16.9%	13.1%	25.9%	0.0%	13.0%	10.0%	16.7%	33.0%	46.6%	22.6%
Hypertension (High blood pressure)	32.7%	41.3%	35.4%	40.7%	25.0%	33.3%	10.0%	20.8%	46.3%	69.0%	41.5%
HIV	28.6%	41.9%	43.4%	22.2%	0.0%	42.6%	20.0%	8.3%	14.4%	5.2%	27.6%
Maternal and child health	10.2%	8.8%	5.1%	7.4%	0.0%	3.7%	0.0%	12.5%	5.9%	3.4%	6.5%
Mental health (e.g. depression, suicide)	38.8%	31.9%	26.3%	44.4%	50.0%	40.7%	40.0%	45.8%	32.4%	24.1%	33.1%
Obesity	28.6%	26.9%	34.3%	29.6%	62.5%	25.9%	10.0%	29.2%	33.0%	34.5%	30.7%
Pollution (e.g. air quality, garbage)	16.3%	9.4%	17.2%	7.4%	0.0%	25.9%	20.0%	37.5%	18.6%	15.5%	16.4%
Sexual transmitted infections	18.4%	25.6%	24.2%	14.8%	0.0%	35.2%	10.0%	16.7%	12.8%	6.9%	19.2%
Stroke	4.1%	10.0%	7.1%	3.7%	0.0%	14.8%	0.0%	8.3%	11.7%	15.5%	9.9%
Teen pregnancy	18.4%	14.4%	21.2%	11.1%	25.0%	13.0%	0.0%	0.0%	12.2%	3.4%	13.3%
Tobacco use	18.4%	14.4%	21.2%	11.1%	25.0%	13.0%	0.0%	0.0%	12.2%	3.4%	13.3%
Violence or injury	18.4%	23.8%	33.3%	14.8%	12.5%	16.7%	10.0%	4.2%	20.7%	15.5%	21.3%
Other	0.0%	2.5%	4.0%	0.0%	0.0%	13.0%	0.0%	16.7%	3.7%	3.4%	4.1%

Table 9: Health issues faced

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Asthma	14.3%	25.6%	25.3%	18.5%	12.5%	18.5%	20.0%	29.2%	16.0%	10.3%	19.8%
Cancer	6.1%	7.5%	8.1%	7.4%	0.0%	3.7%	10.0%	8.3%	2.1%	8.6%	5.8%
Chronic pain	18.4%	26.3%	25.3%	14.8%	37.5%	35.2%	60.0%	16.7%	36.2%	48.3%	30.7%
Depression or anxiety	42.9%	33.1%	28.3%	37.0%	37.5%	38.9%	50.0%	33.3%	30.9%	29.3%	33.1%
Diabetes	20.4%	21.3%	18.2%	18.5%	37.5%	16.7%	10.0%	20.8%	17.0%	31.0%	19.9%
Drug or alcohol abuse	16.3%	23.8%	33.3%	14.8%	25.0%	14.8%	10.0%	4.2%	6.9%	0.0%	16.0%
Heart disease	12.2%	7.5%	6.1%	11.1%	12.5%	5.6%	10.0%	8.3%	11.2%	20.7%	9.9%
Hepatitis C	8.2%	15.0%	7.1%	7.4%	0.0%	7.4%	0.0%	4.2%	4.3%	3.4%	7.7%
High blood pressure	30.6%	39.4%	28.3%	37.0%	25.0%	31.5%	40.0%	8.3%	37.2%	69.0%	37.1%
High cholesterol	28.6%	23.8%	20.2%	29.6%	37.5%	25.9%	10.0%	33.3%	32.4%	41.4%	28.2%
HIV	24.5%	27.5%	13.1%	14.8%	12.5%	22.2%	20.0%	4.2%	1.6%	3.4%	13.9%
Mobility impairment	12.2%	12.5%	15.2%	3.7%	25.0%	22.2%	50.0%	4.2%	14.4%	17.2%	14.6%
Osteoporosis	14.3%	10.6%	10.1%	11.1%	25.0%	13.0%	10.0%	12.5%	21.3%	34.5%	16.2%

Table 10: Service availability

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Accessible transportation	75.5%	81.3%	75.8%	81.5%	87.5%	77.8%	80.0%	83.3%	70.2%	63.8%	75.3%
Affordable housing	0.0%	15.0%	8.1%	7.4%	25.0%	9.3%	20.0%	0.0%	9.6%	5.2%	9.5%
Dental services	59.2%	57.5%	62.6%	70.4%	25.0%	55.6%	70.0%	62.5%	66.5%	70.7%	62.3%
Healthy food	55.1%	51.9%	36.4%	66.7%	75.0%	63.0%	70.0%	75.0%	64.9%	69.0%	57.8%
Home health care	46.9%	53.1%	43.4%	55.6%	75.0%	48.1%	60.0%	50.0%	66.5%	65.5%	56.0%
Job training	20.4%	33.1%	34.3%	11.1%	37.5%	33.3%	10.0%	25.0%	34.6%	19.0%	30.1%
Medical specialists	63.3%	48.8%	43.4%	51.9%	62.5%	59.3%	80.0%	58.3%	62.8%	63.8%	56.1%
Mental health services	55.1%	52.5%	40.4%	48.1%	62.5%	42.6%	80.0%	37.5%	47.3%	27.6%	46.4%
Pediatric and adolescent services	57.1%	50.6%	48.5%	55.6%	37.5%	42.6%	50.0%	45.8%	55.3%	46.6%	51.0%
Places to exercise, walk, and play	61.2%	60.0%	57.6%	77.8%	100.0%	59.3%	70.0%	66.7%	73.4%	58.6%	64.8%
Primary care medicine	63.3%	65.0%	59.6%	70.4%	62.5%	66.7%	70.0%	62.5%	72.3%	67.2%	66.6%
Social services	57.1%	60.6%	45.5%	44.4%	37.5%	59.3%	20.0%	54.2%	69.7%	53.4%	58.2%
Substance abuse services	32.7%	55.6%	53.5%	40.7%	37.5%	40.7%	40.0%	20.8%	32.4%	5.2%	39.4%
Vision services	51.0%	57.5%	52.5%	51.9%	37.5%	57.4%	80.0%	50.0%	51.1%	44.8%	53.0%

*Percentage reflects participants who responded very available or available

Table 11: Health education needed in the community

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Cancer/cancer prevention	20.4%	35.6%	44.4%	40.7%	12.5%	29.6%	40.0%	25.0%	27.7%	37.9%	32.9%
Diabetes	44.9%	55.6%	45.5%	48.1%	12.5%	37.0%	30.0%	45.8%	50.5%	51.7%	48.6%
Domestic violence	32.7%	36.3%	45.5%	29.6%	25.0%	29.6%	10.0%	25.0%	30.3%	29.3%	33.4%
Exercise/physical activity	44.9%	40.0%	46.5%	51.9%	75.0%	44.4%	10.0%	50.0%	43.6%	44.8%	43.9%
Family planning	30.6%	28.1%	43.4%	14.8%	37.5%	25.9%	0.0%	8.3%	25.0%	10.3%	26.4%
Heart disease	30.6%	25.0%	23.2%	44.4%	12.5%	20.4%	30.0%	33.3%	35.1%	36.2%	29.5%
HIV/sexual transmitted diseases	49.0%	58.8%	59.6%	40.7%	0.0%	38.9%	10.0%	20.8%	23.9%	5.2%	38.8%
Maternal and child health	20.4%	15.6%	21.2%	14.8%	0.0%	13.0%	0.0%	4.2%	13.3%	12.1%	14.8%
Mental health	46.9%	56.3%	47.5%	63.0%	75.0%	55.6%	40.0%	45.8%	42.6%	44.8%	49.3%
Nutrition	46.9%	45.6%	38.4%	51.9%	50.0%	53.7%	30.0%	29.2%	44.7%	39.7%	44.0%
Substance abuse	59.2%	50.6%	60.6%	59.3%	37.5%	53.7%	20.0%	33.3%	34.6%	31.0%	45.9%
Sickle cell anemia	8.2%	11.3%	11.1%	11.1%	0.0%	3.7%	0.0%	8.3%	2.7%	0.0%	6.6%
Vaccinations	16.3%	16.3%	16.2%	14.8%	12.5%	11.1%	10.0%	20.8%	16.0%	6.9%	14.9%
Violence	34.7%	36.3%	59.6%	51.9%	25.0%	20.4%	0.0%	29.2%	28.7%	19.0%	34.4%
Other	4.1%	6.9%	7.1%	7.4%	0.0%	11.1%	0.0%	4.2%	3.2%	3.4%	5.5%

Table 12: Source of health information

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Doctor or health care provider	53.1%	56.9%	58.6%	59.3%	62.5%	51.9%	70.0%	54.2%	54.3%	48.3%	55.2%
Family or friends	30.6%	11.9%	31.3%	44.4%	37.5%	25.9%	10.0%	37.5%	29.8%	20.7%	25.4%
Books	32.7%	21.9%	17.2%	14.8%	12.5%	22.2%	40.0%	29.2%	18.1%	20.7%	21.0%
Television or radio	32.7%	19.4%	21.2%	25.9%	0.0%	22.2%	30.0%	45.8%	22.3%	20.7%	22.9%
Newspaper or magazines	28.6%	12.5%	12.1%	14.8%	12.5%	22.2%	30.0%	29.2%	15.4%	10.3%	16.0%
Ethnic media (e.g. ethnic newspaper, TV, radio)	16.3%	11.3%	16.2%	11.1%	12.5%	18.5%	0.0%	29.2%	17.6%	37.9%	17.4%
Internet	44.9%	20.0%	24.2%	33.3%	37.5%	40.7%	50.0%	58.3%	19.7%	8.6%	25.6%
Library	16.3%	6.9%	5.1%	3.7%	12.5%	14.8%	20.0%	25.0%	4.8%	1.7%	7.7%
Community-based organization	22.4%	23.1%	25.3%	14.8%	50.0%	31.5%	20.0%	8.3%	22.3%	22.4%	23.2%
Faith-based organization (e.g. church, temple, synogogue, mosque)	12.2%	6.9%	6.1%	0.0%	12.5%	0.0%	0.0%	20.8%	1.1%	6.9%	5.2%
School	8.2%	4.4%	5.1%	3.7%	12.5%	3.7%	10.0%	12.5%	3.2%	3.4%	4.7%
Health insurance plan	16.3%	14.4%	11.1%	11.1%	0.0%	9.3%	20.0%	20.8%	14.4%	12.1%	13.4%
Health department	10.2%	5.0%	8.1%	7.4%	12.5%	3.7%	0.0%	0.0%	3.2%	3.4%	5.0%
Health fairs	8.2%	6.9%	14.1%	11.1%	0.0%	9.3%	10.0%	12.5%	6.4%	1.7%	8.0%
Other	4.1%	5.6%	2.0%	0.0%	0.0%	3.7%	0.0%	4.2%	1.1%	0.0%	2.7%

Table 13: Use of technology

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Email	63.3%	37.5%	42.4%	48.1%	50.0%	59.3%	60.0%	75.0%	31.4%	15.5%	40.5%
Internet	67.3%	40.6%	42.4%	59.3%	50.0%	57.4%	50.0%	75.0%	31.4%	20.7%	42.1%
Smart phone (e.g. iPhone, Galaxy)	53.1%	41.3%	47.5%	37.0%	25.0%	46.3%	30.0%	50.0%	39.4%	12.1%	40.2%
Text messaging	57.1%	36.9%	43.4%	55.6%	50.0%	48.1%	40.0%	41.7%	28.2%	8.6%	36.5%
Twitter	14.3%	0.6%	6.1%	3.7%	0.0%	3.7%	20.0%	4.2%	4.3%	3.4%	4.4%
Facebook	36.7%	20.0%	30.3%	40.7%	0.0%	25.9%	30.0%	25.0%	18.6%	10.3%	22.9%
None	14.3%	21.9%	23.2%	18.5%	25.0%	20.4%	20.0%	12.5%	35.6%	62.1%	28.2%

Table 14: Civic engagement

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Community center	26.5%	33.8%	21.2%	14.8%	50.0%	29.6%	30.0%	29.2%	23.9%	34.5%	27.6%
Library	30.6%	35.0%	15.2%	25.9%	37.5%	27.8%	30.0%	41.7%	22.3%	17.2%	26.0%
Faith-based organization (e.g. church, temple, synogogue, mosque)	32.7%	32.5%	30.3%	63.0%	12.5%	29.6%	40.0%	20.8%	19.7%	27.6%	28.7%
Neighborhood association	10.2%	11.3%	6.1%	18.5%	0.0%	7.4%	0.0%	8.3%	8.5%	5.2%	8.7%
Gym or recreational center	28.6%	16.3%	14.1%	25.9%	0.0%	24.1%	20.0%	29.2%	14.4%	6.9%	16.8%
Political club	6.1%	2.5%	4.0%	3.7%	0.0%	3.7%	10.0%	0.0%	2.1%	0.0%	2.8%
Senior center	12.2%	23.1%	8.1%	11.1%	0.0%	13.0%	40.0%	29.2%	25.0%	81.0%	24.5%
School	6.1%	5.0%	5.1%	3.7%	12.5%	1.9%	20.0%	12.5%	3.7%	3.4%	4.9%
Sport league	0.0%	3.8%	6.1%	0.0%	0.0%	3.7%	0.0%	0.0%	1.6%	3.4%	2.8%
Other community organization	14.3%	15.0%	14.1%	11.1%	37.5%	13.0%	20.0%	8.3%	7.4%	3.4%	11.5%
None	12.2%	15.0%	29.3%	14.8%	37.5%	20.4%	10.0%	12.5%	19.7%	5.2%	17.9%

Table 15: Use of complementary or alternative treatments/remedies

	Washington Hgts/ Inwood	Central Harlem/ Morningside Hgt	East Harlem	Upper West Side	Upper East Side	Chelsea/Clinton	Gramercy Park/ Murray Hill	Greenwich Village/ Soho	Union Sq./ Lower Eastside	Lower Manhattan	Manhattan (N=677)
Acupunture	8.2%	10.0%	8.1%	11.1%	0.0%	11.1%	20.0%	12.5%	16.5%	10.3%	11.7%
Chiropractic care	4.1%	4.4%	5.1%	3.7%	0.0%	7.4%	0.0%	4.2%	1.1%	3.4%	3.5%
Herbal medicine	12.2%	8.8%	10.1%	11.1%	12.5%	20.4%	0.0%	12.5%	21.3%	13.8%	14.2%
Homeopathy	4.1%	2.5%	2.0%	7.4%	12.5%	7.4%	10.0%	8.3%	3.2%	3.4%	3.8%
Remedies from a botanica	2.0%	3.1%	3.0%	0.0%	0.0%	0.0%	0.0%	12.5%	1.6%	0.0%	2.2%
Other	0.0%	2.5%	2.0%	3.7%	0.0%	5.6%	0.0%	4.2%	2.1%	0.0%	2.2%
None	73.5%	61.9%	63.6%	63.0%	62.5%	55.6%	50.0%	54.2%	50.5%	65.5%	59.2%
Unknown	6.1%	6.9%	9.1%	7.4%	12.5%	11.1%	0.0%	4.2%	5.3%	5.2%	6.8%