QUEENS COMMUNITY NEEDS ASSESSMENT
APPENDIX A - MAPS

December 16, 2014

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

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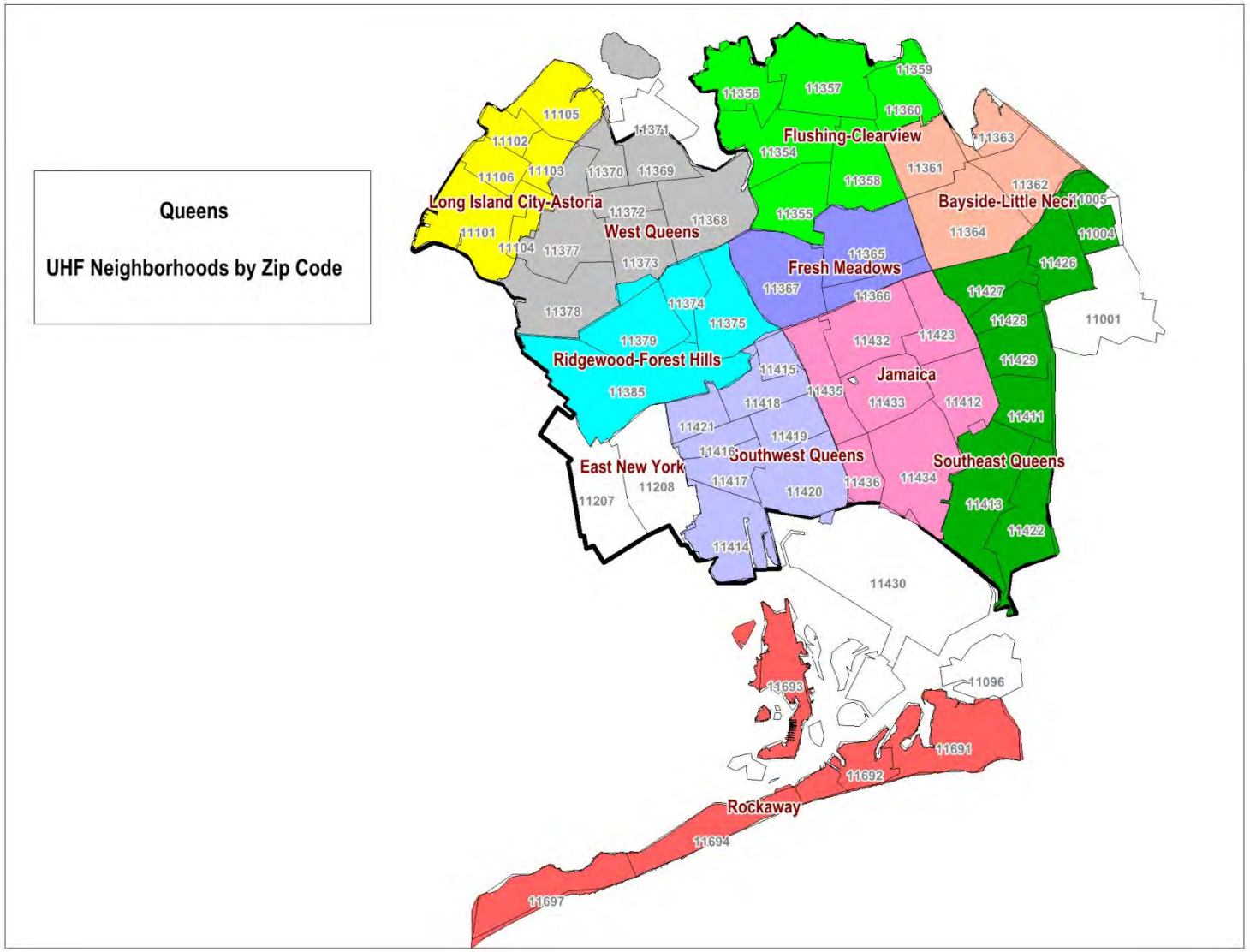

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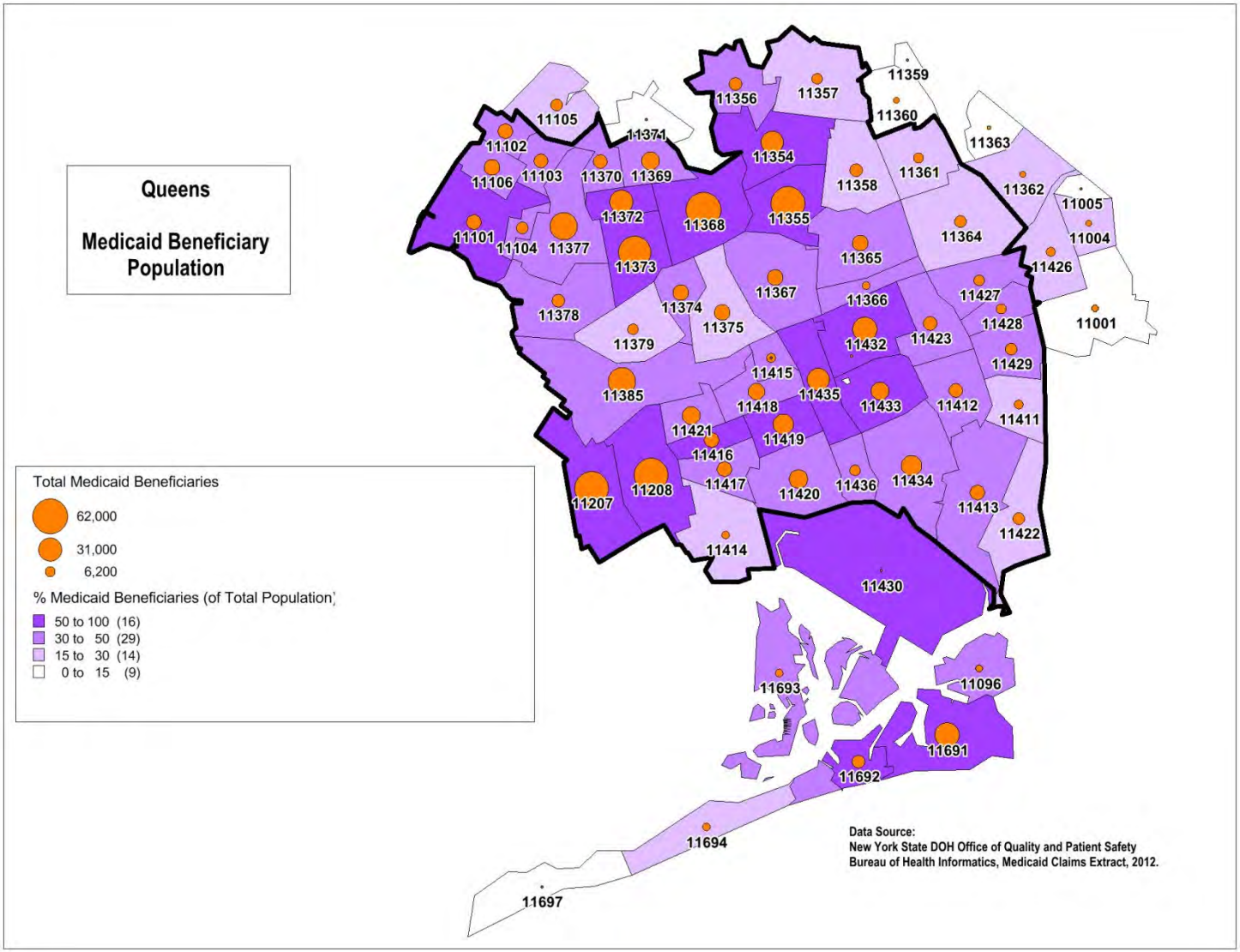

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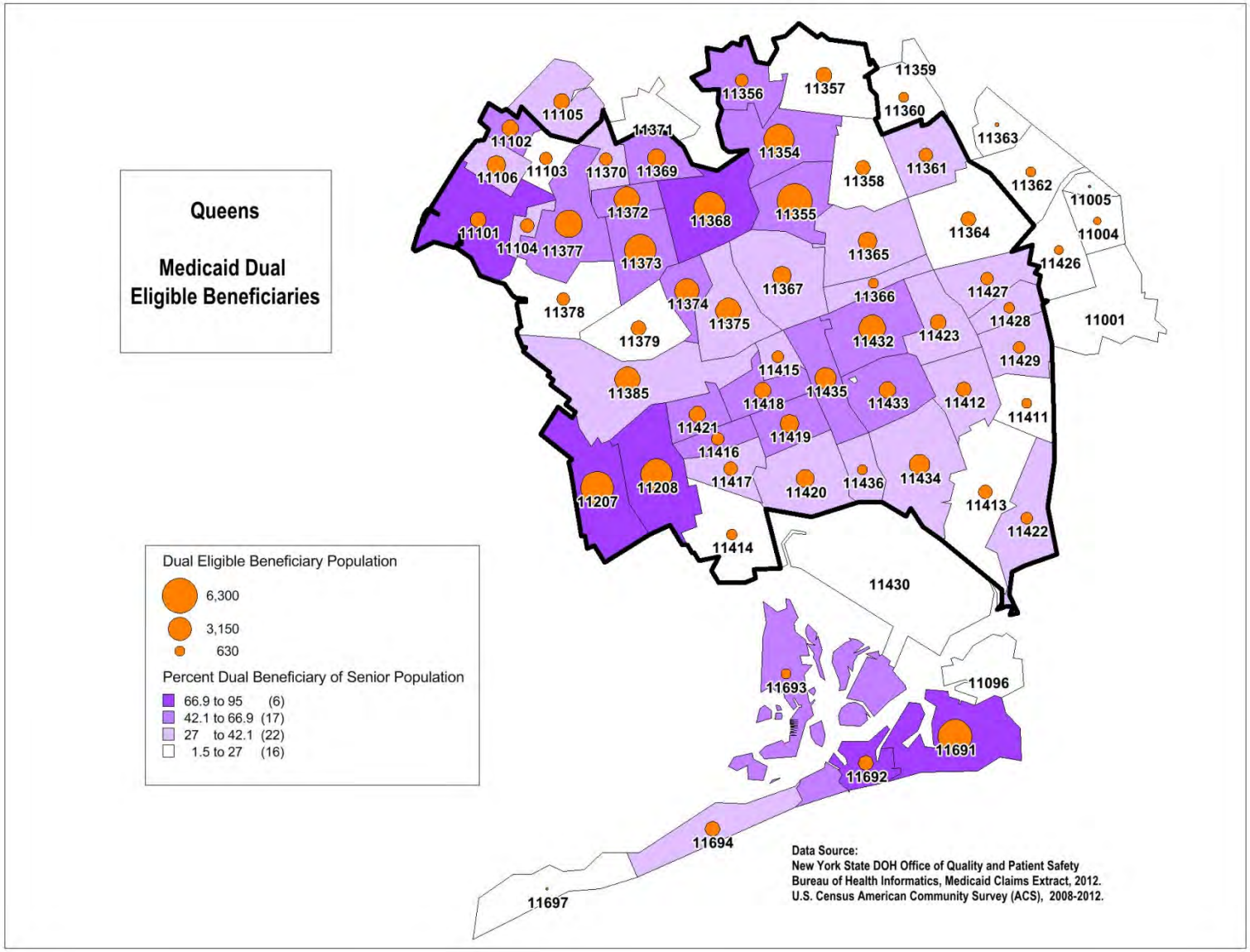

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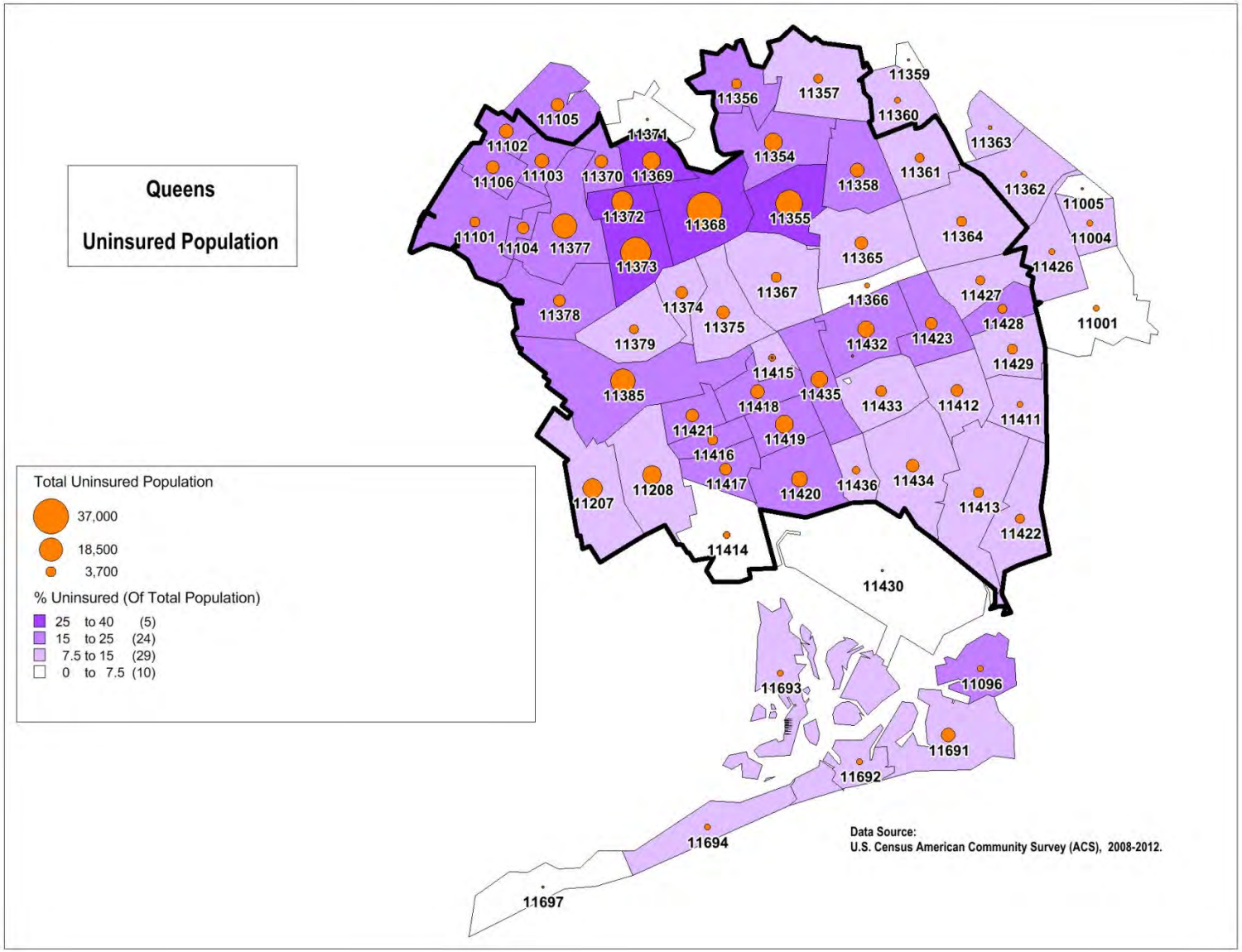

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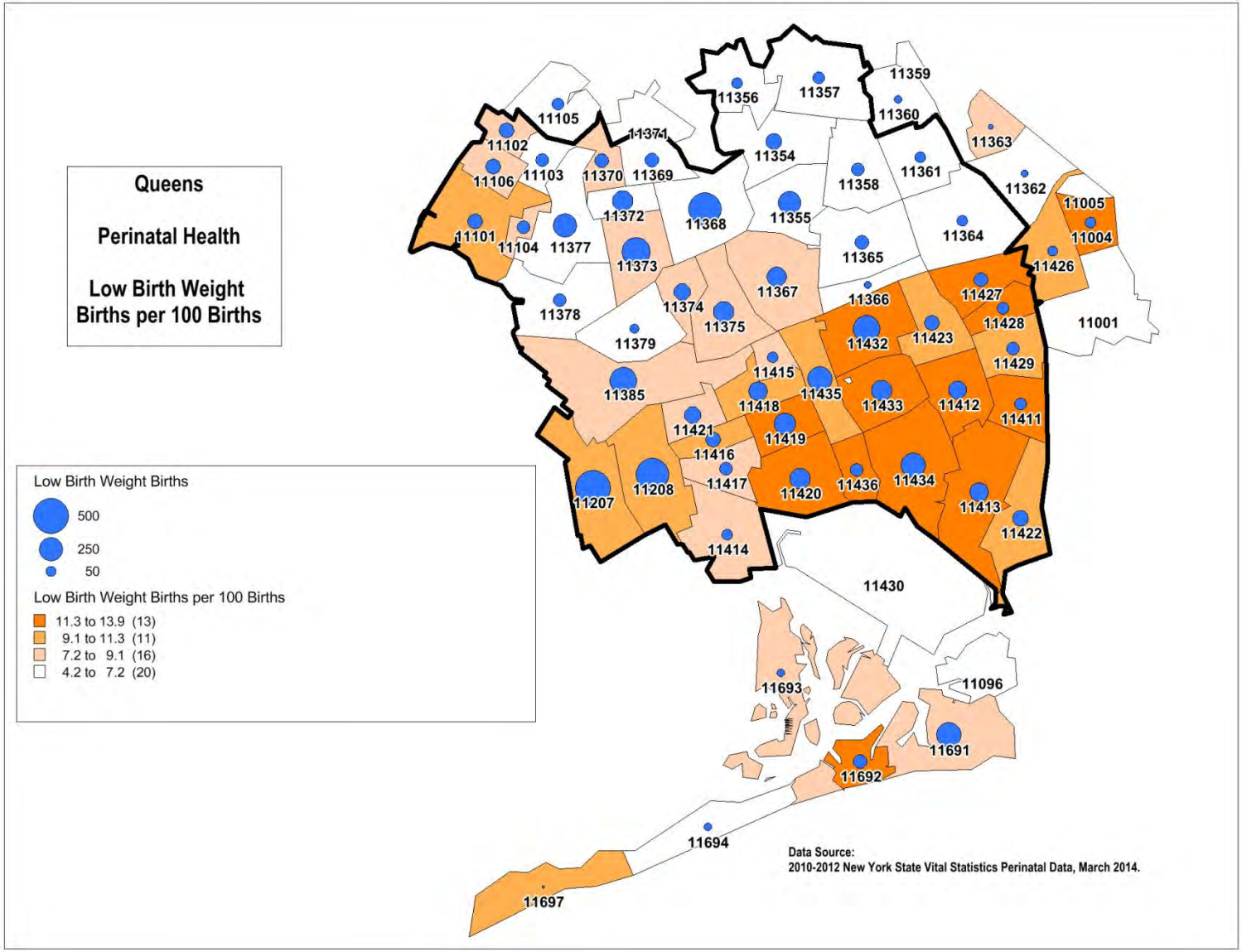

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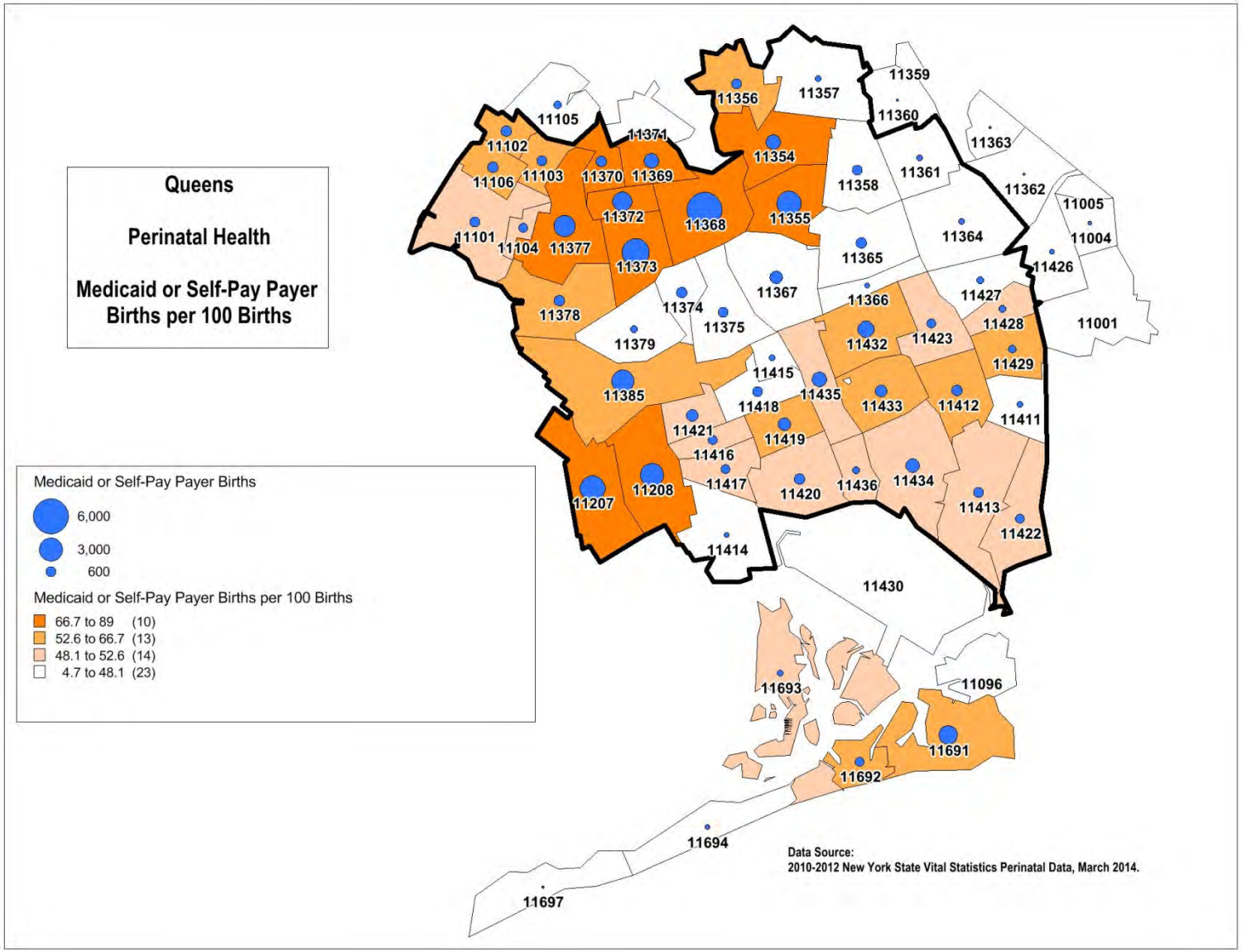

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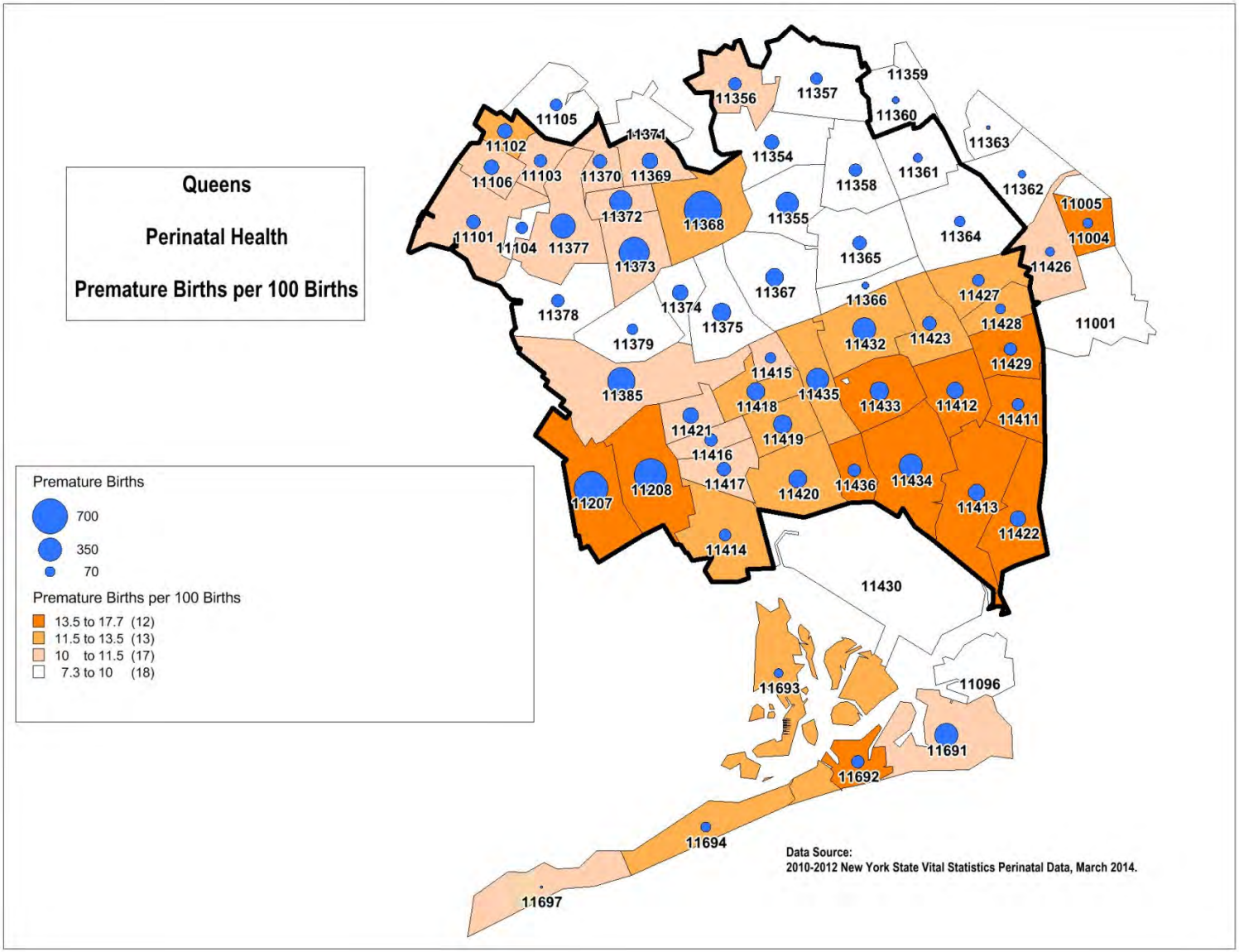

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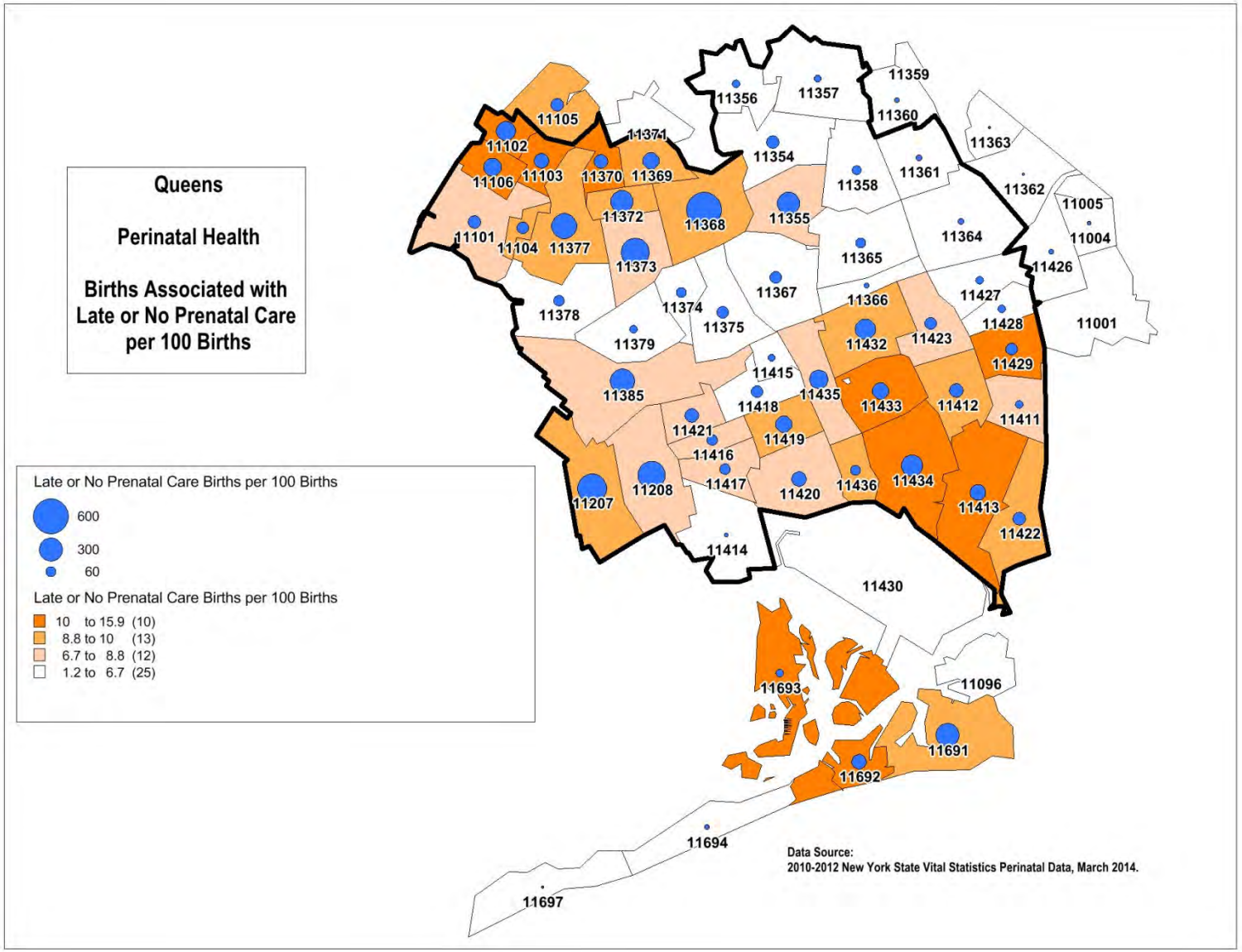

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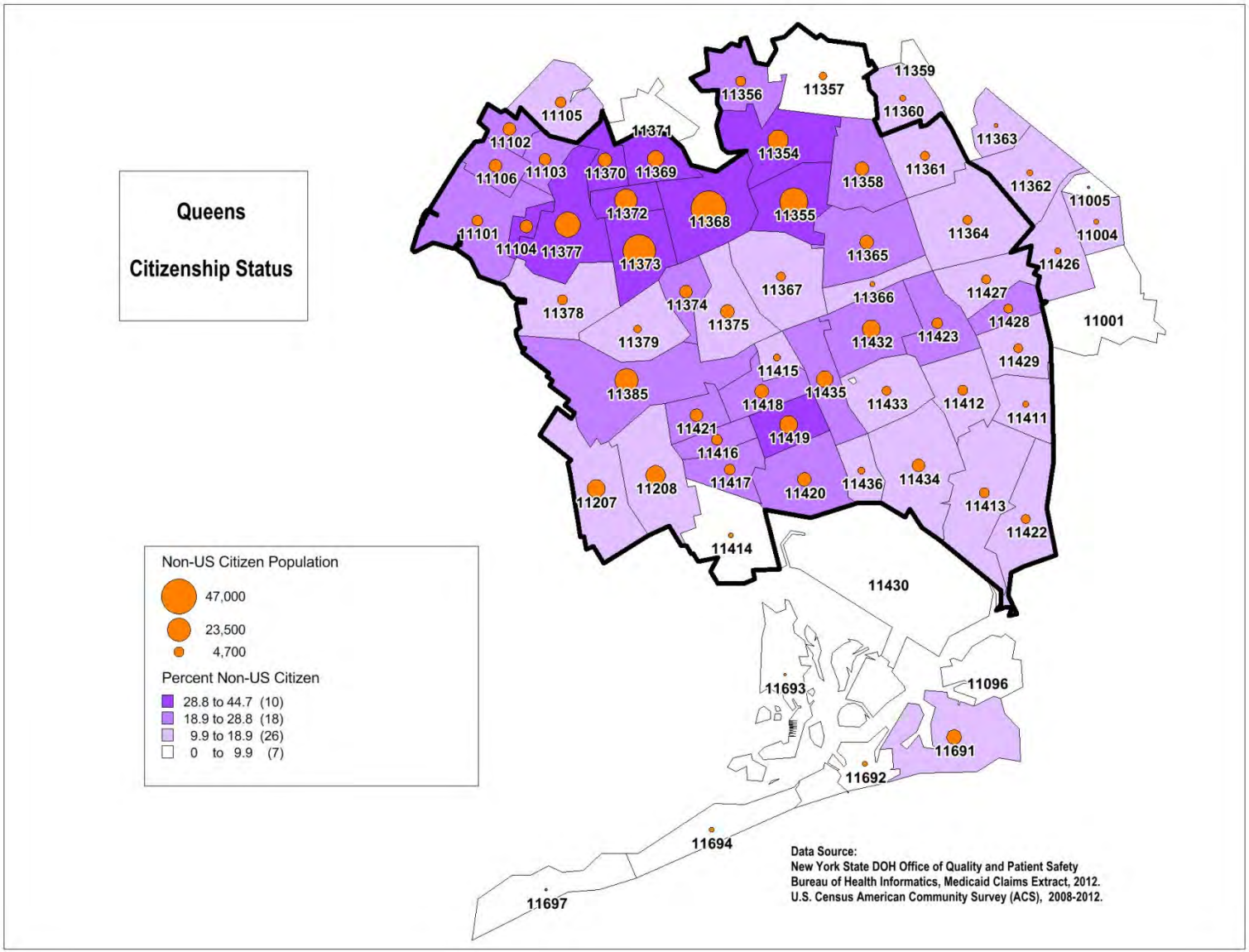

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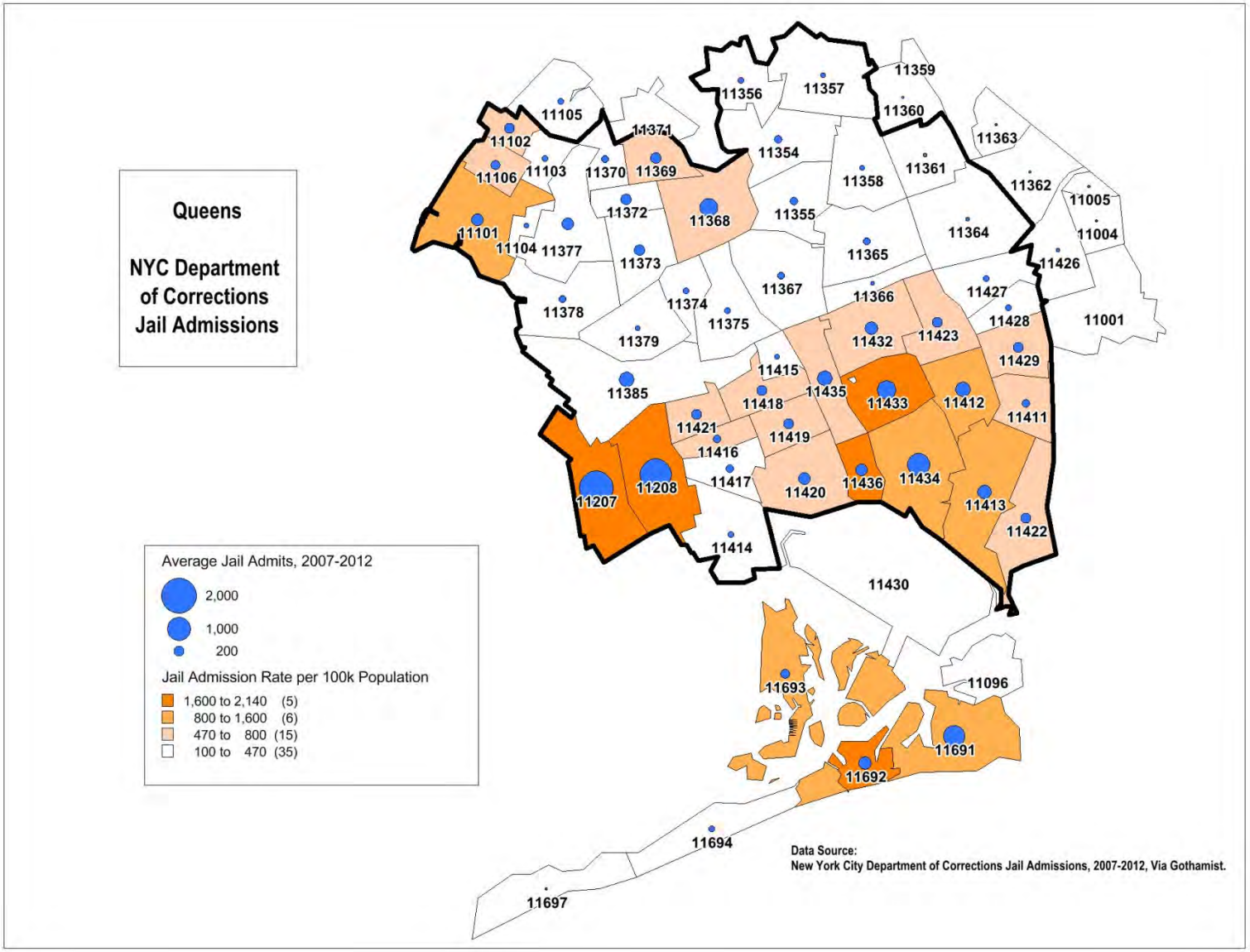

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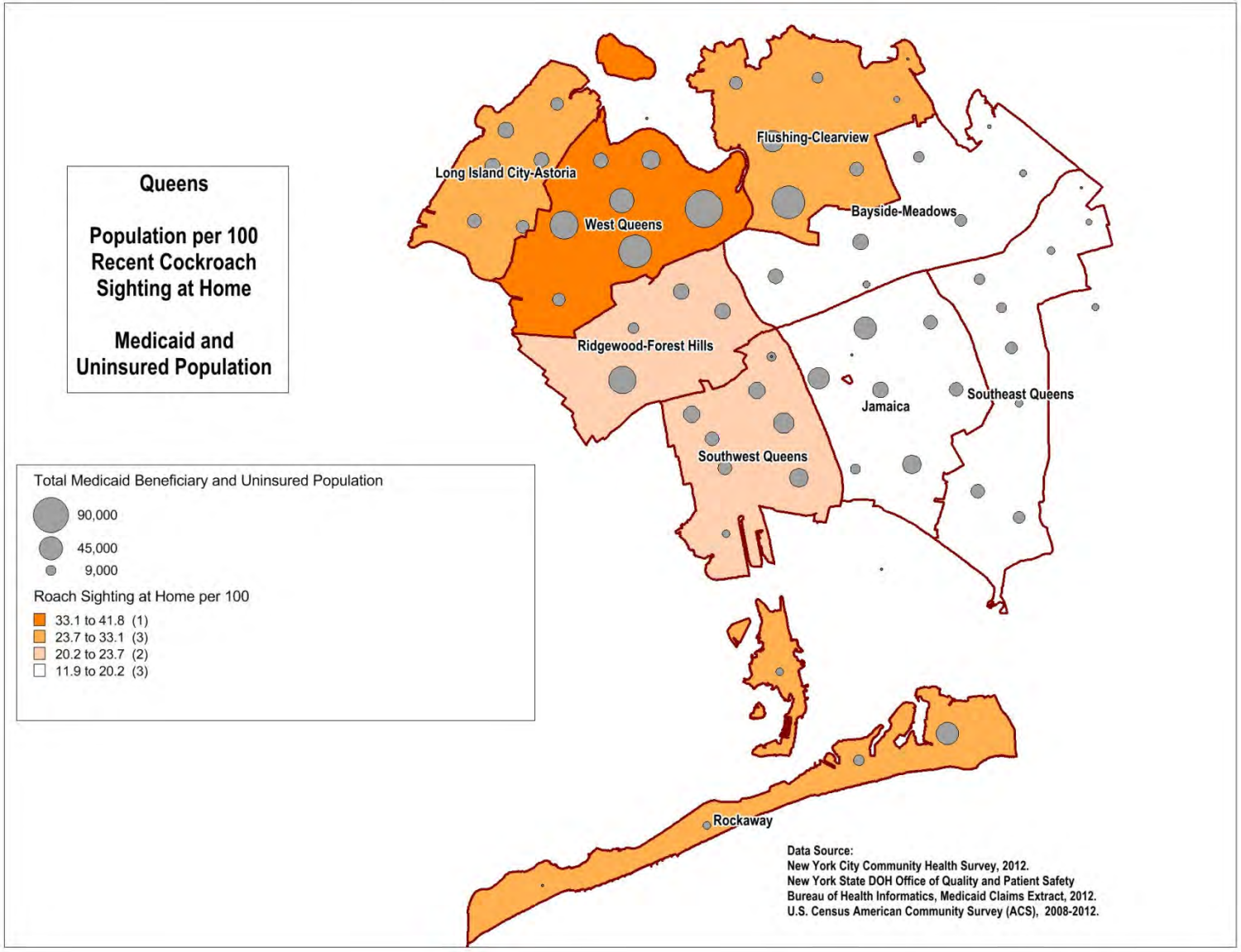

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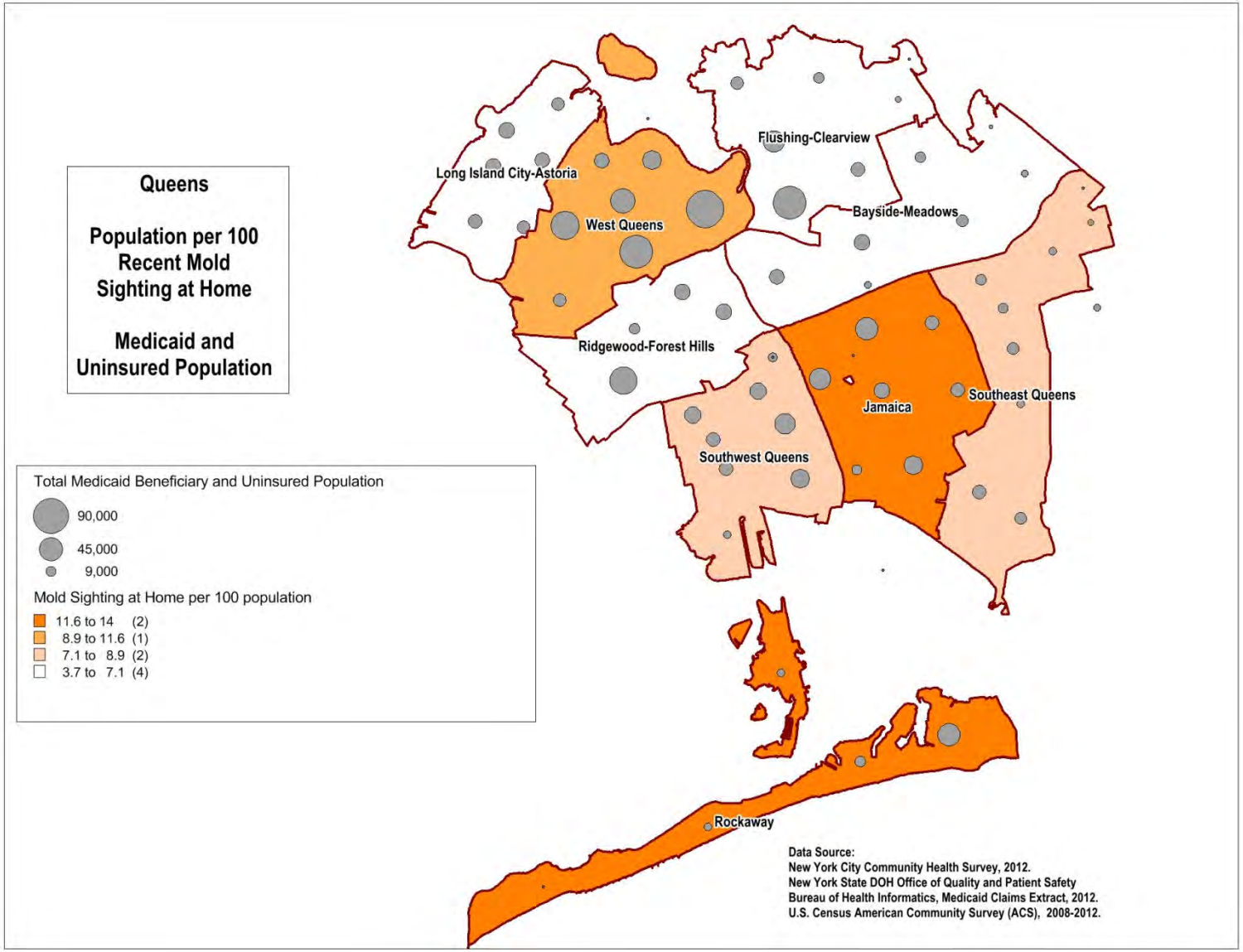

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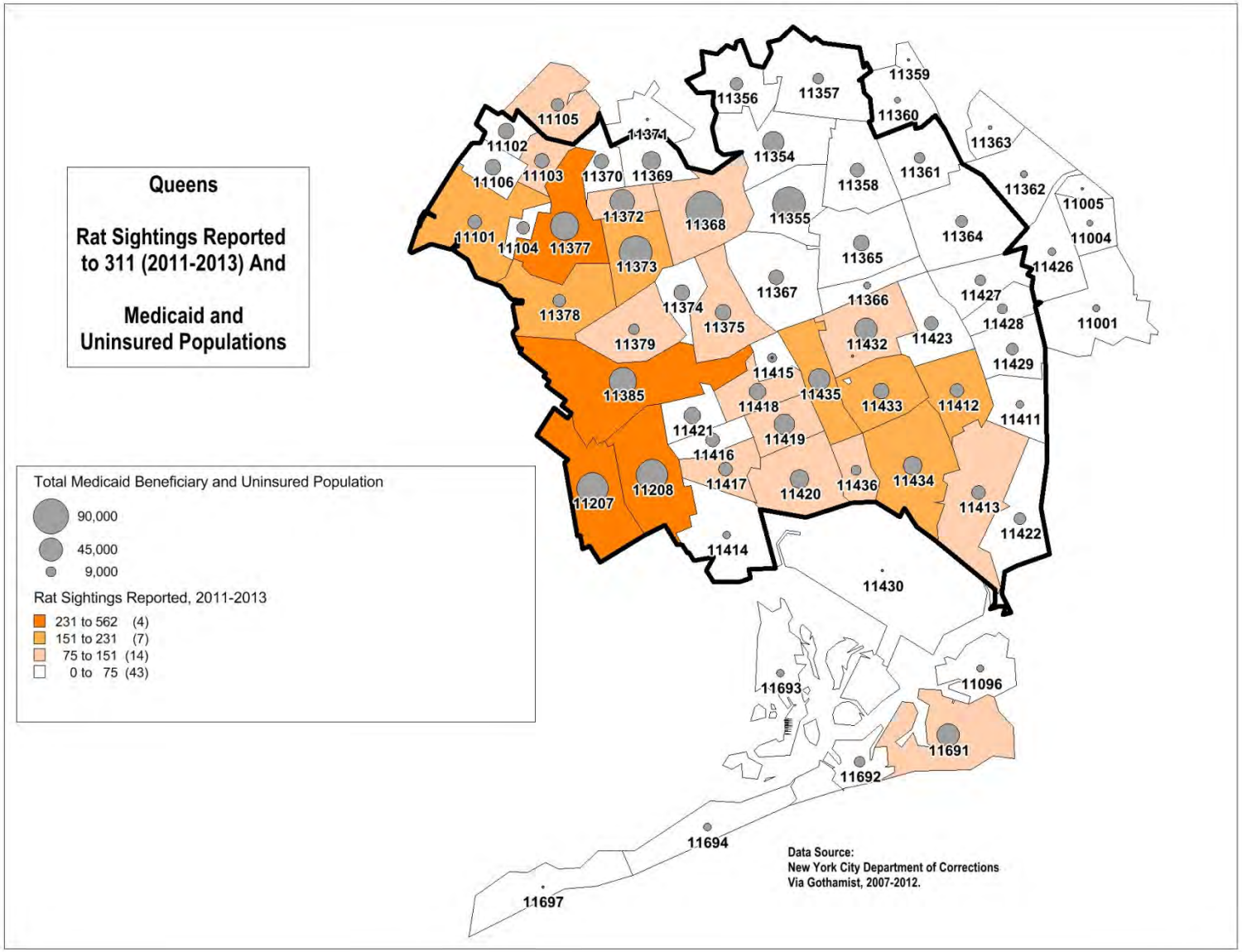

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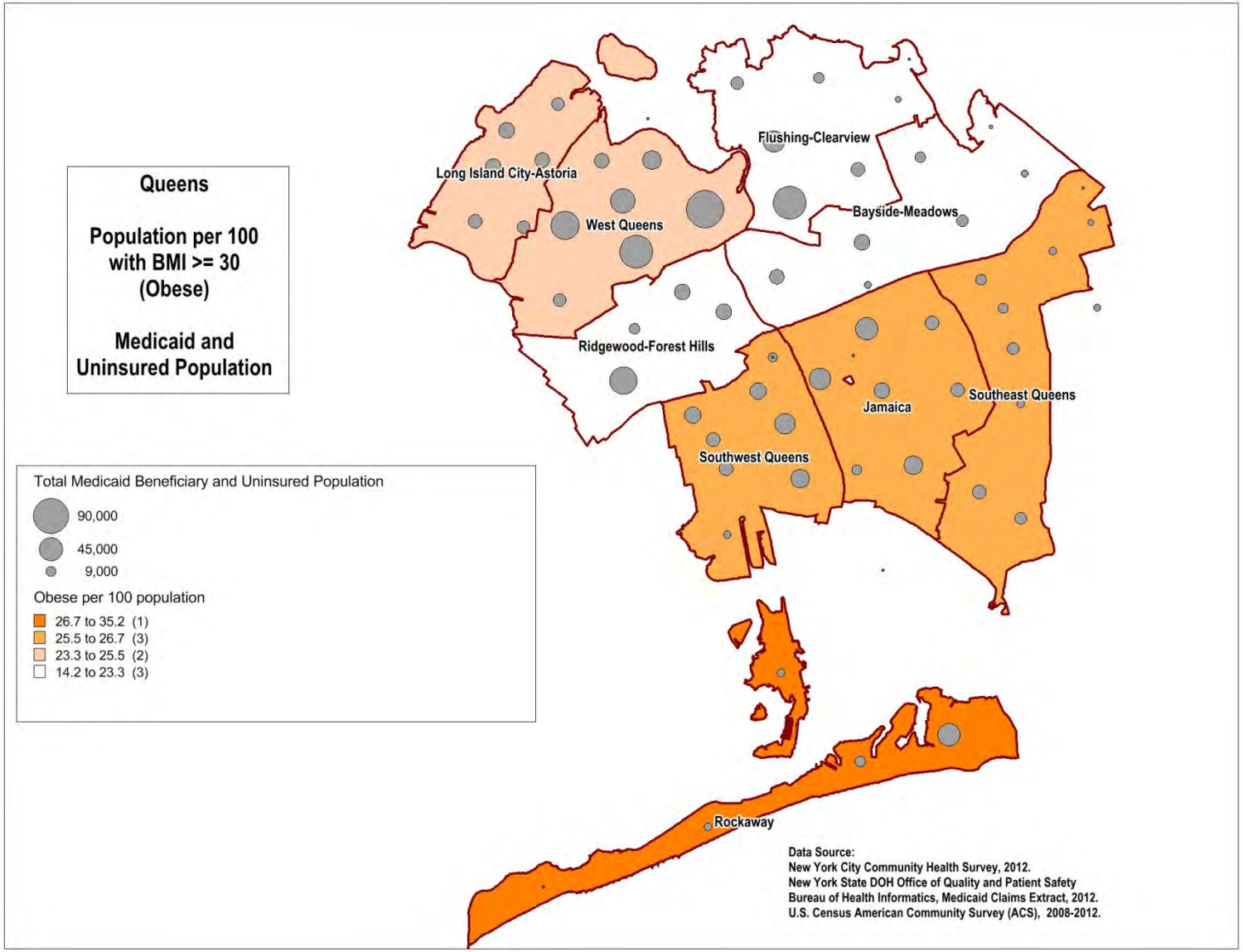

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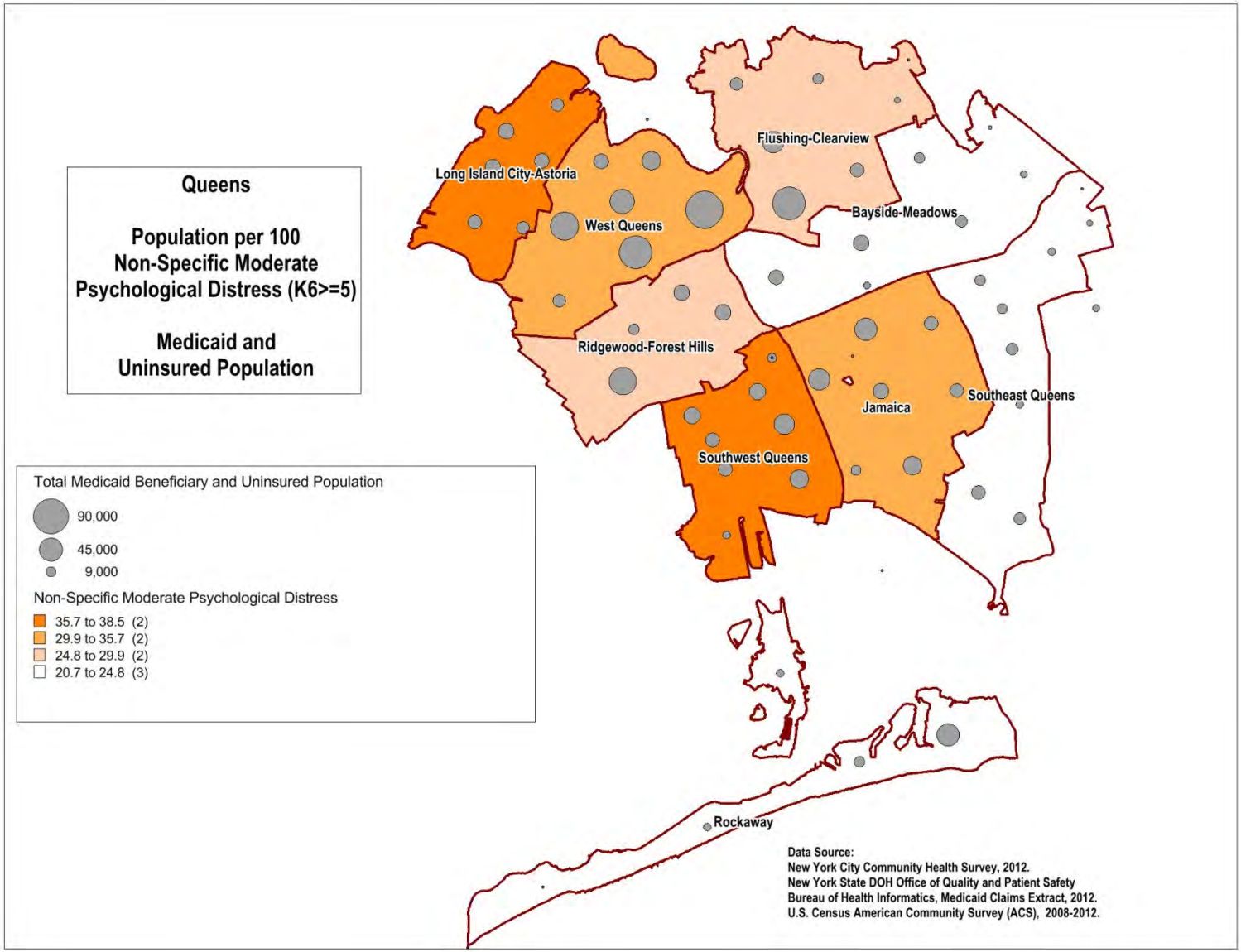

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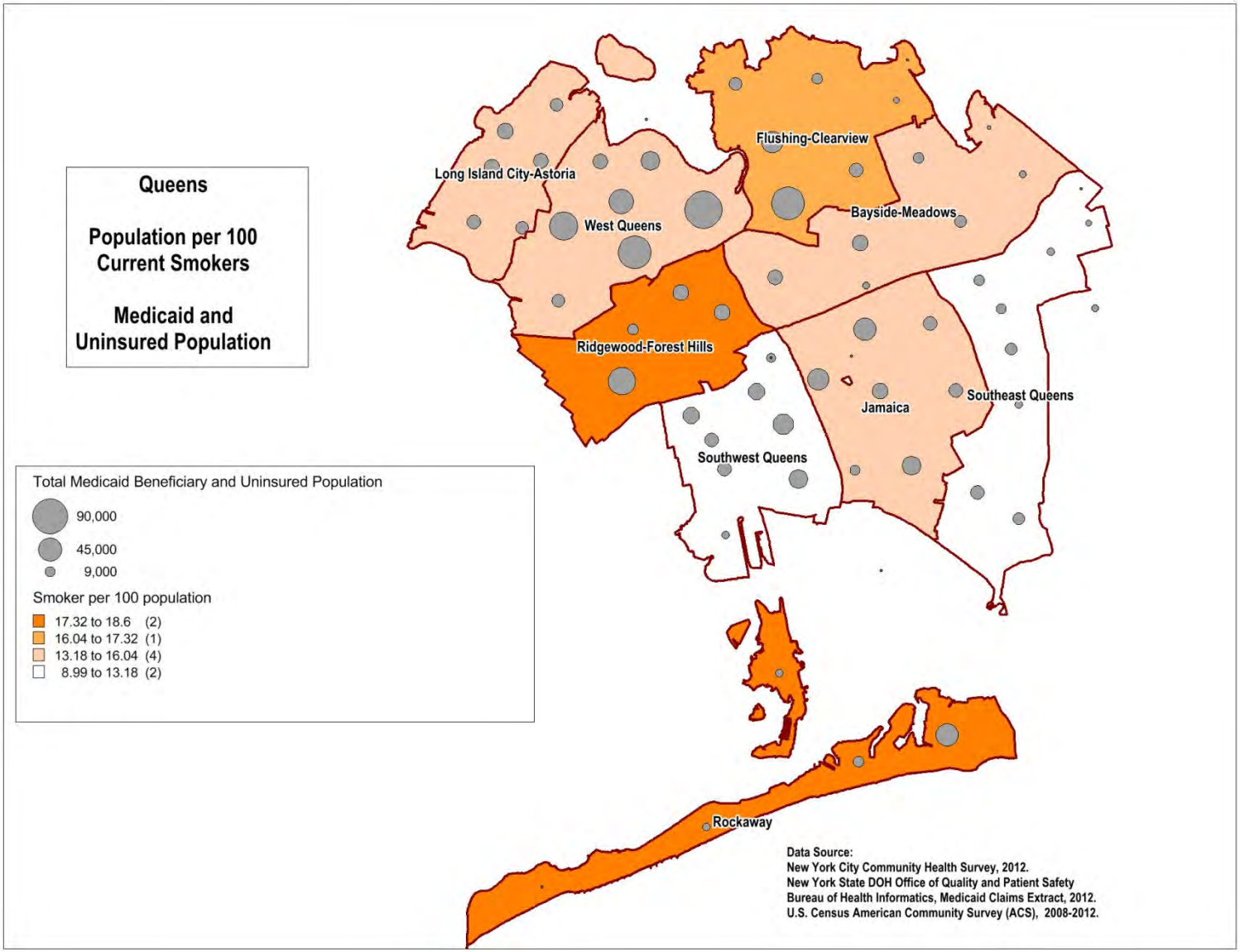

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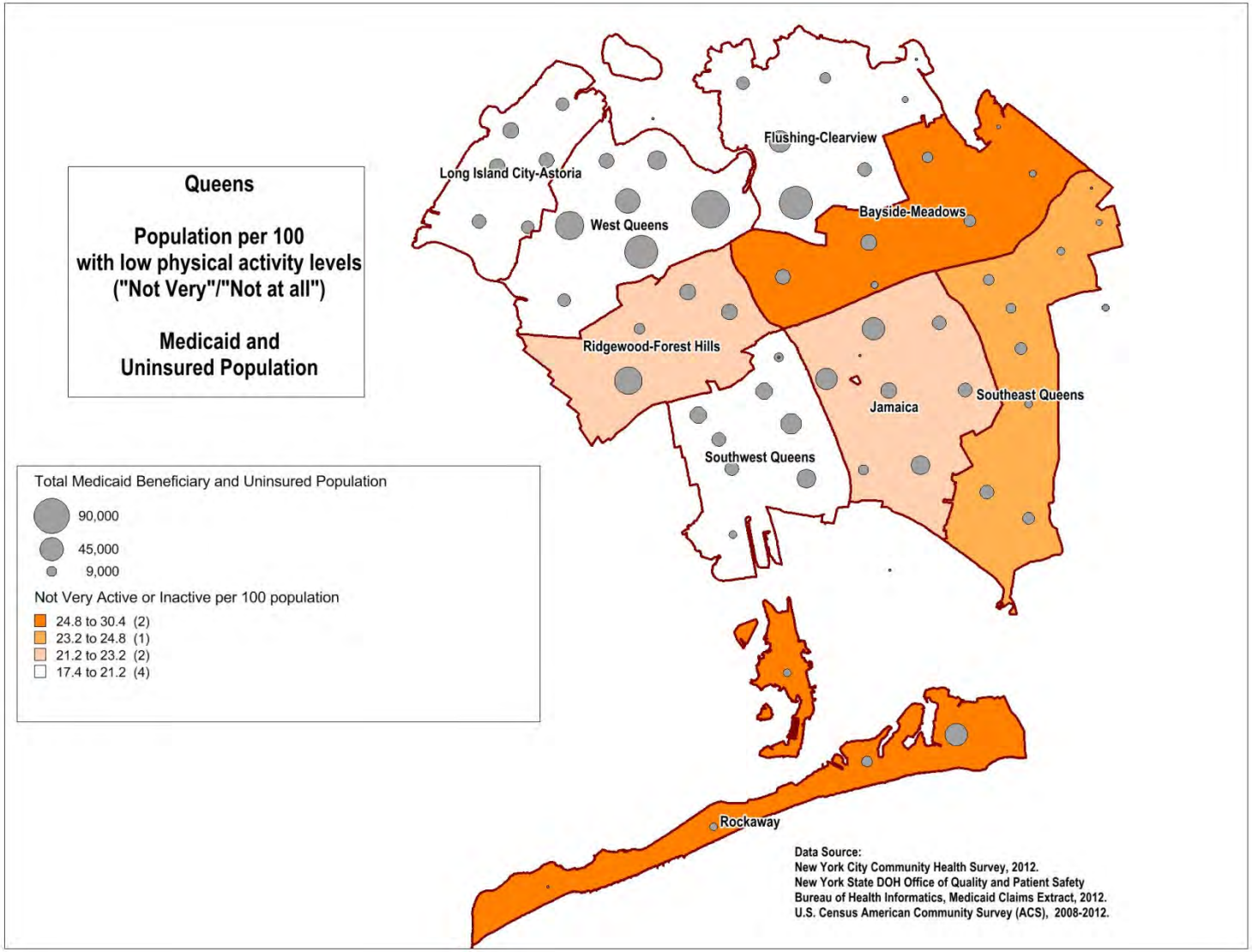

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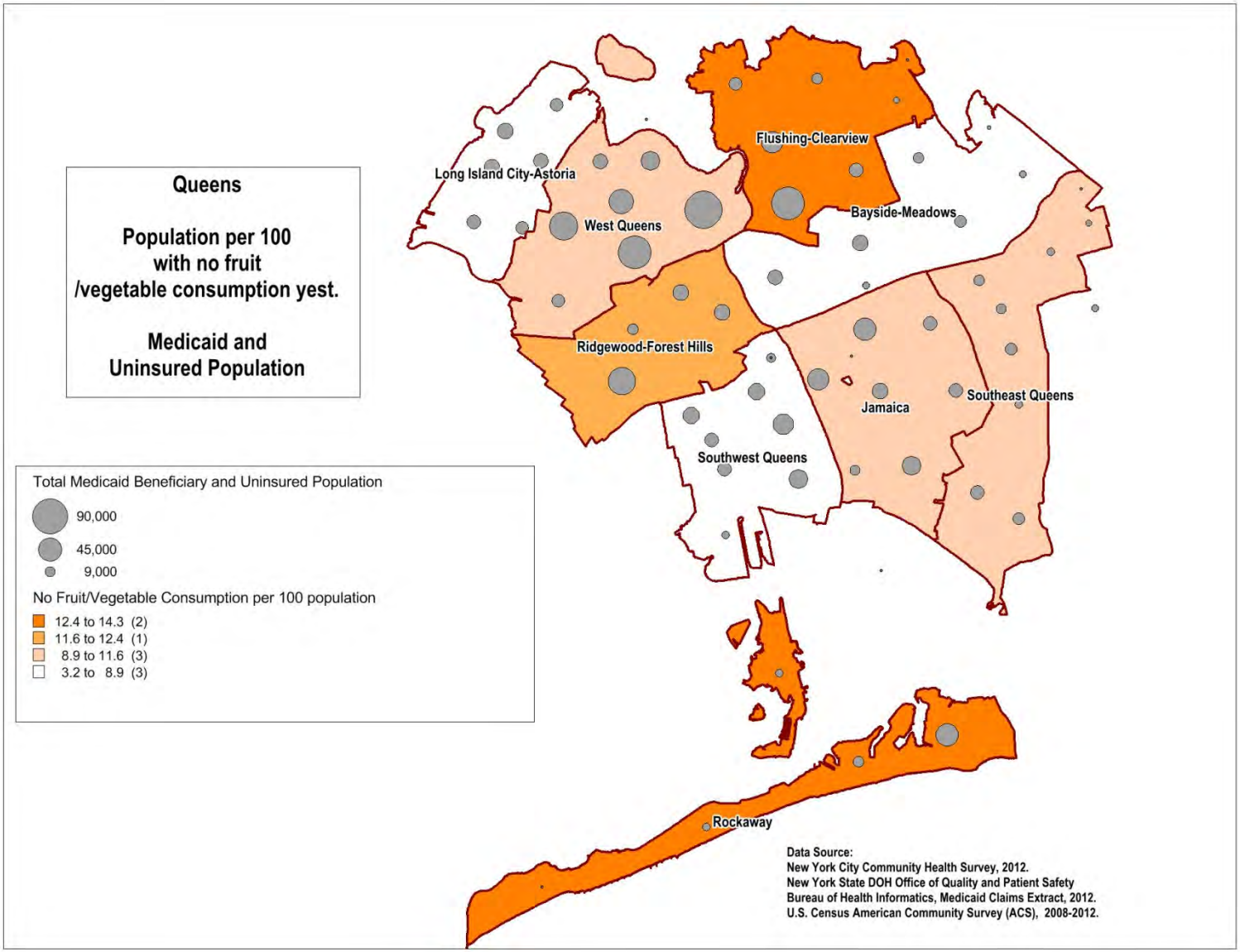

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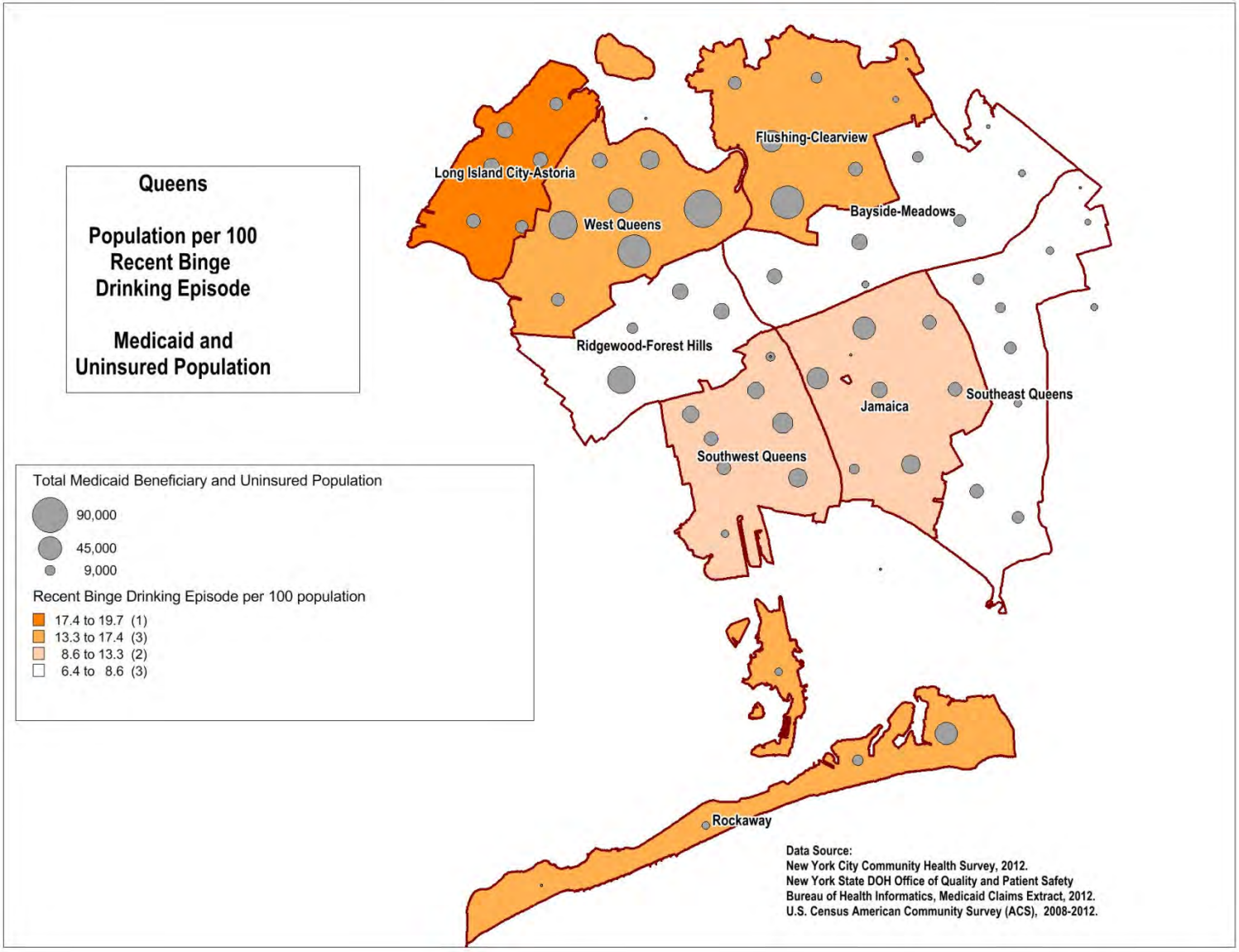

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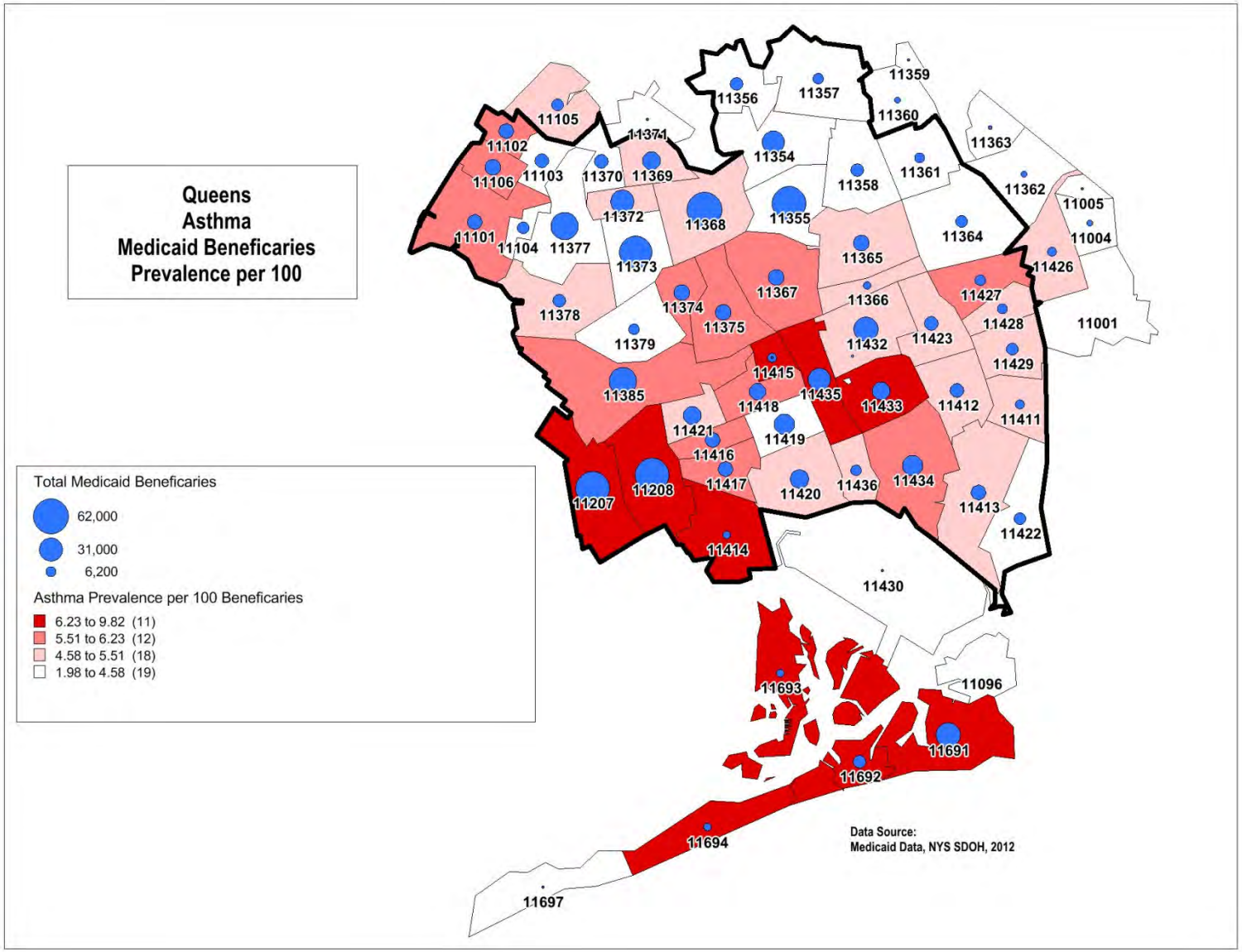

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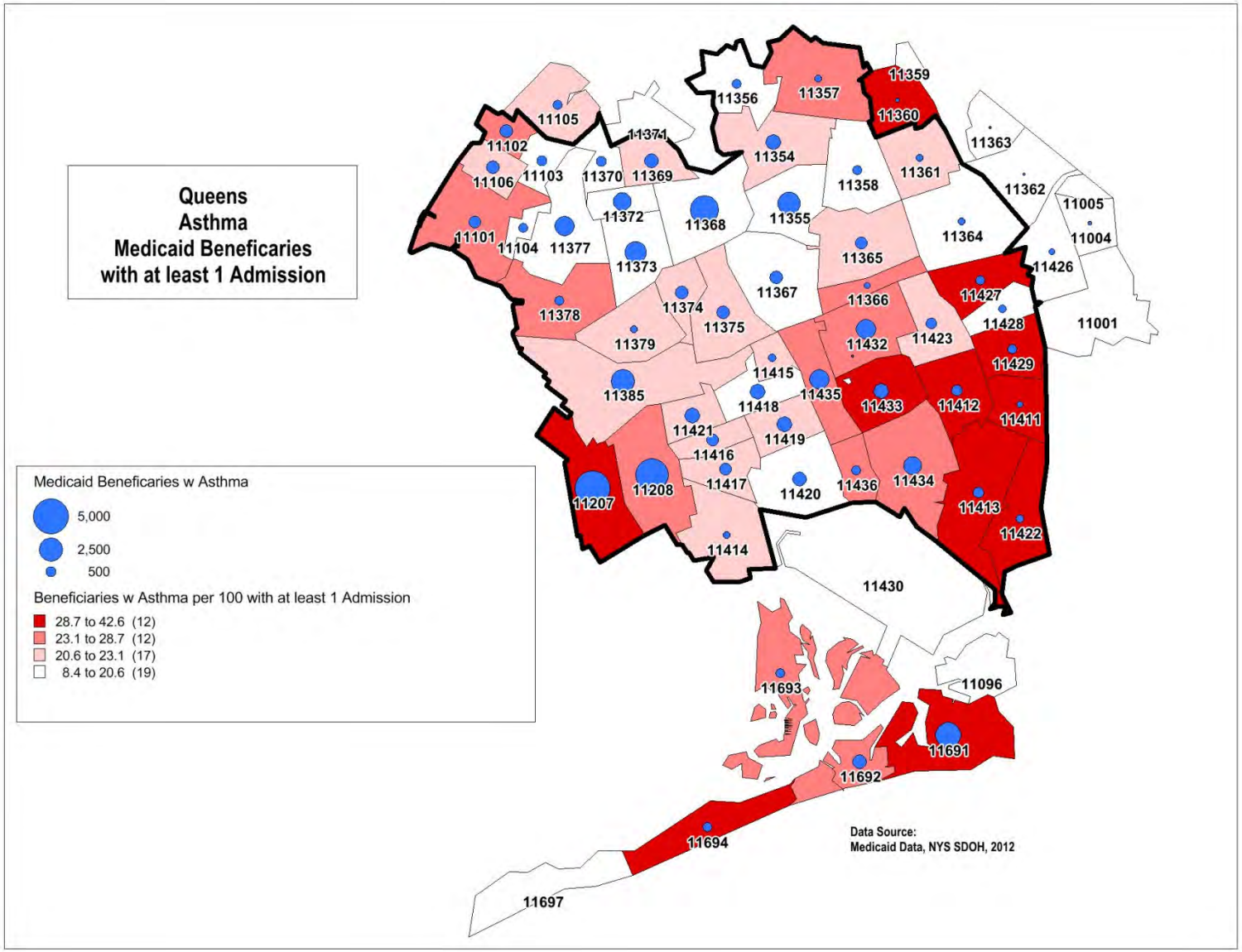

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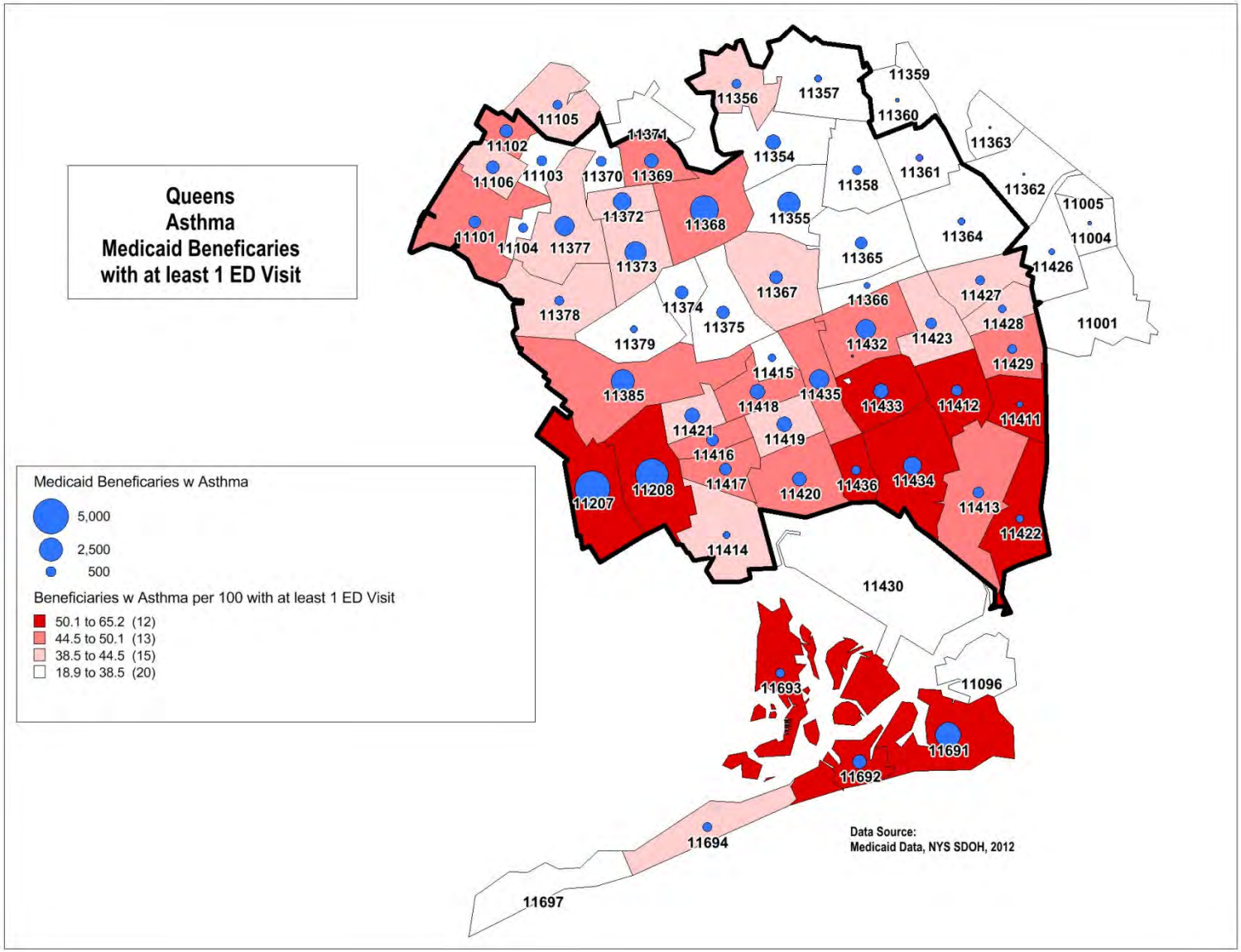

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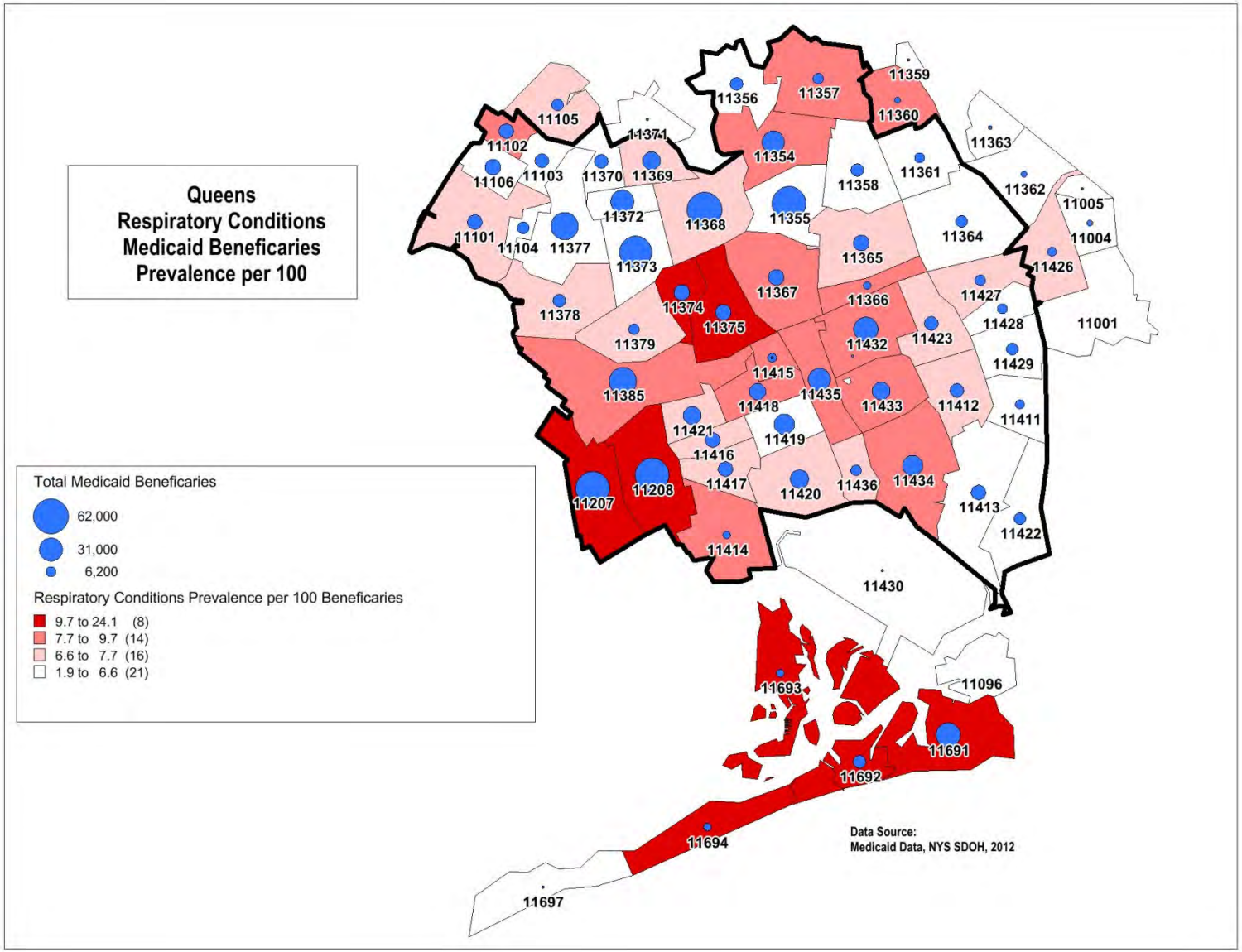

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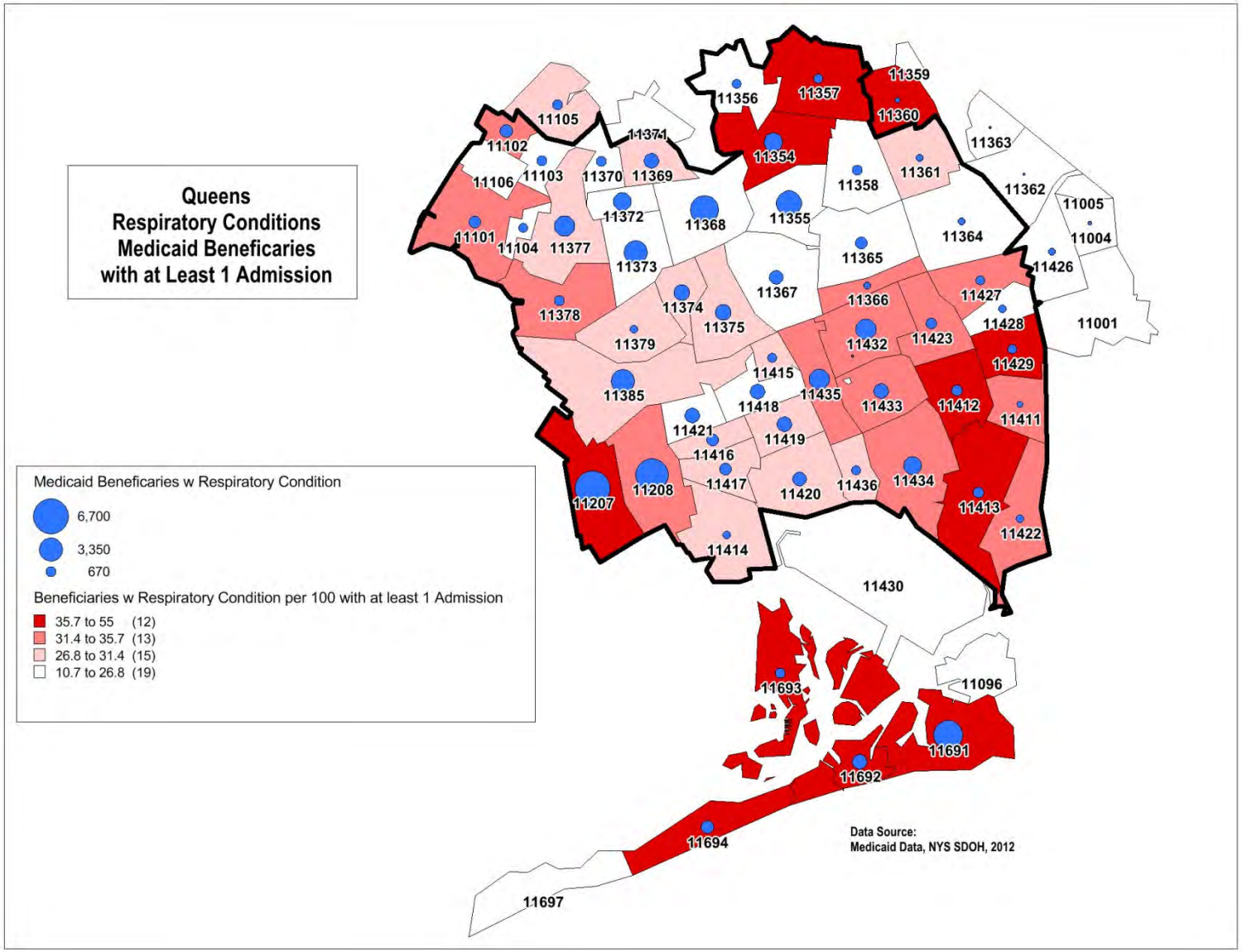

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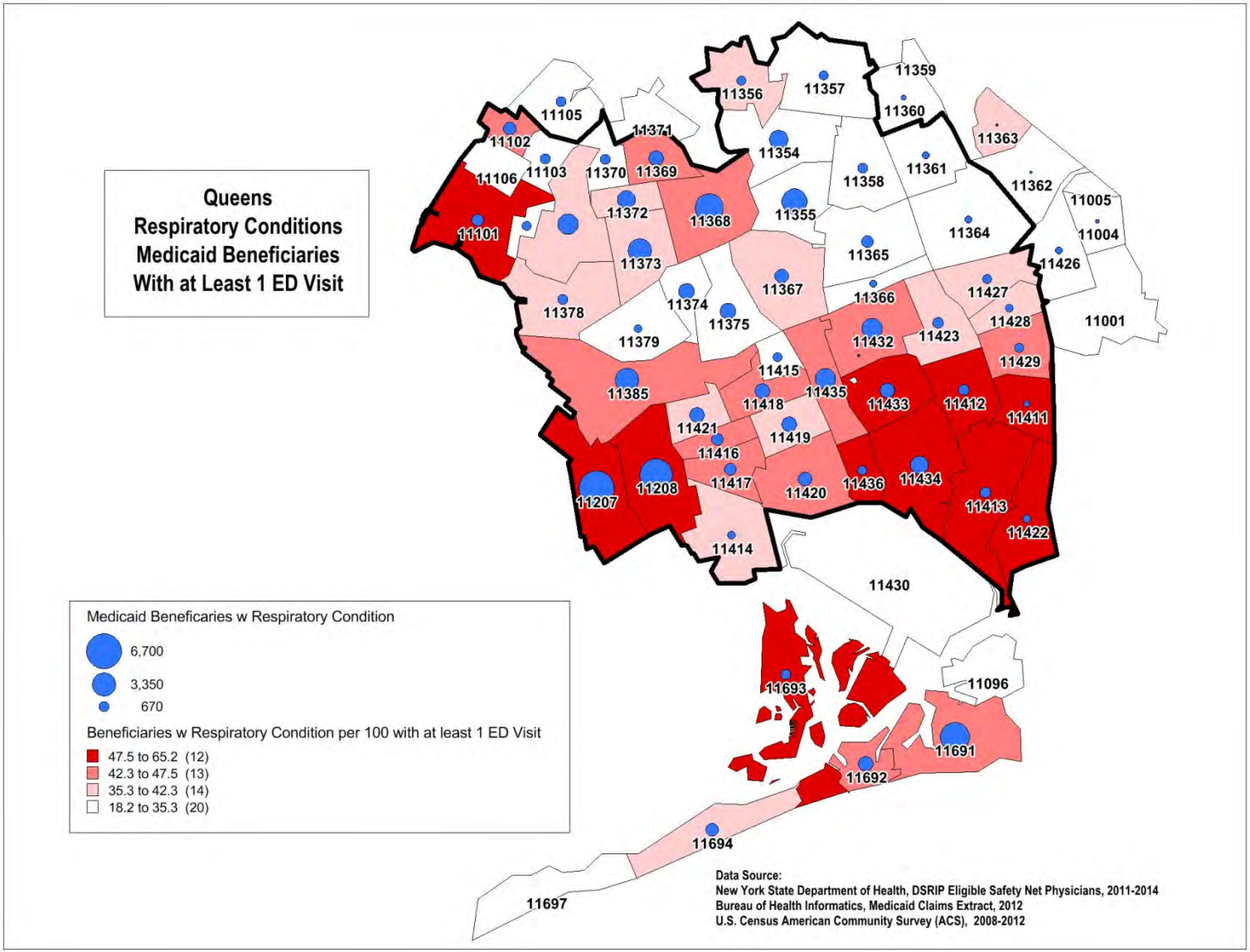

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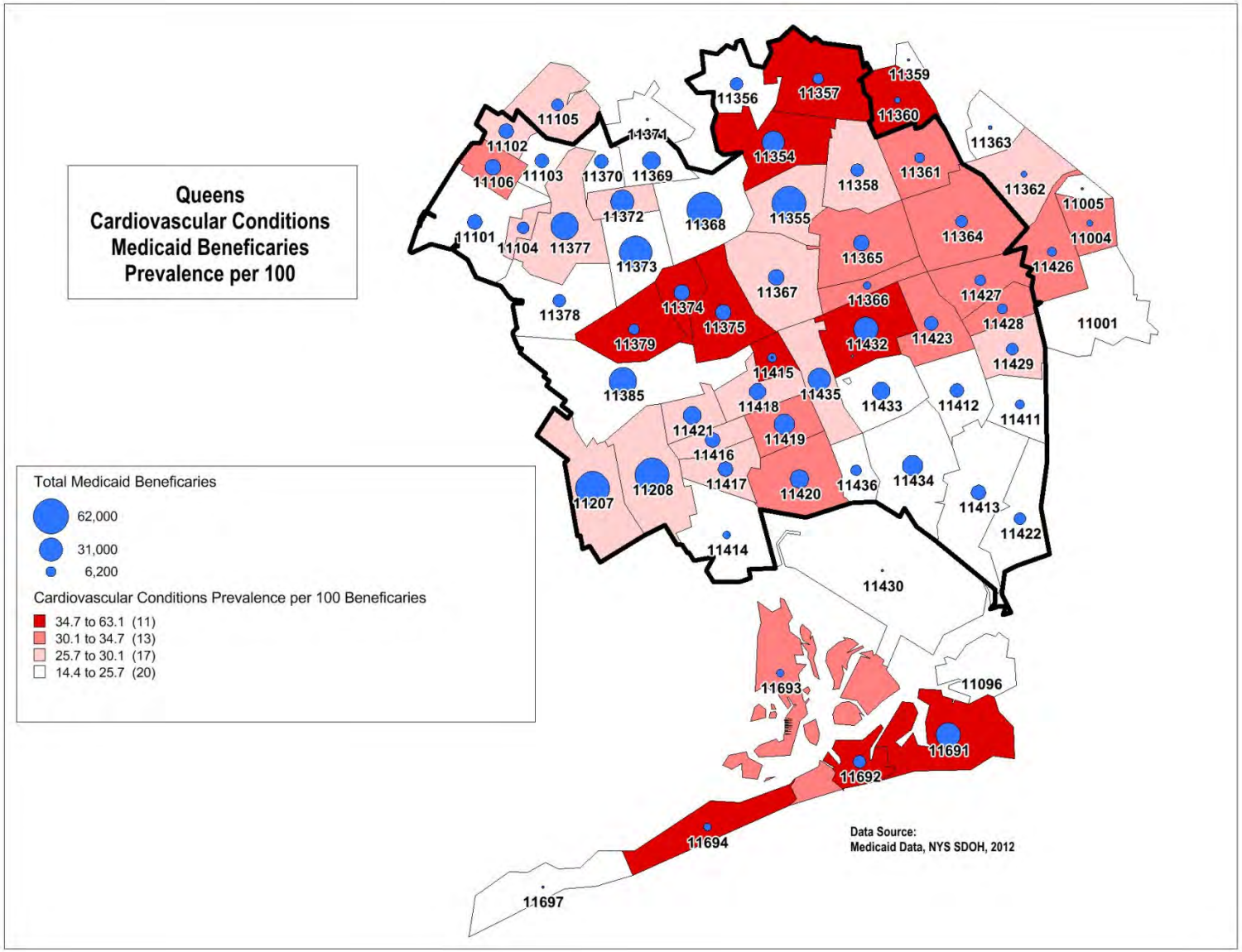

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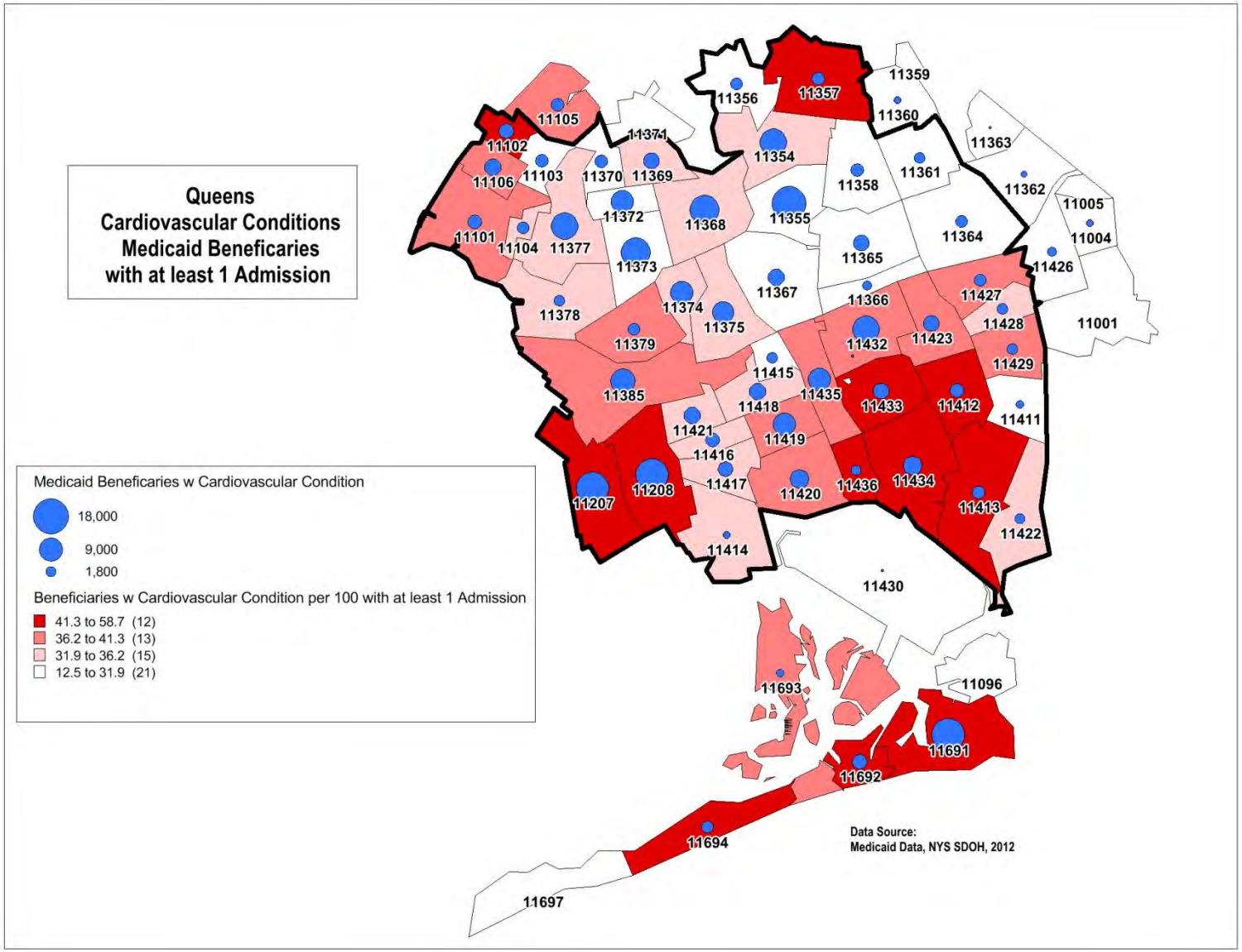

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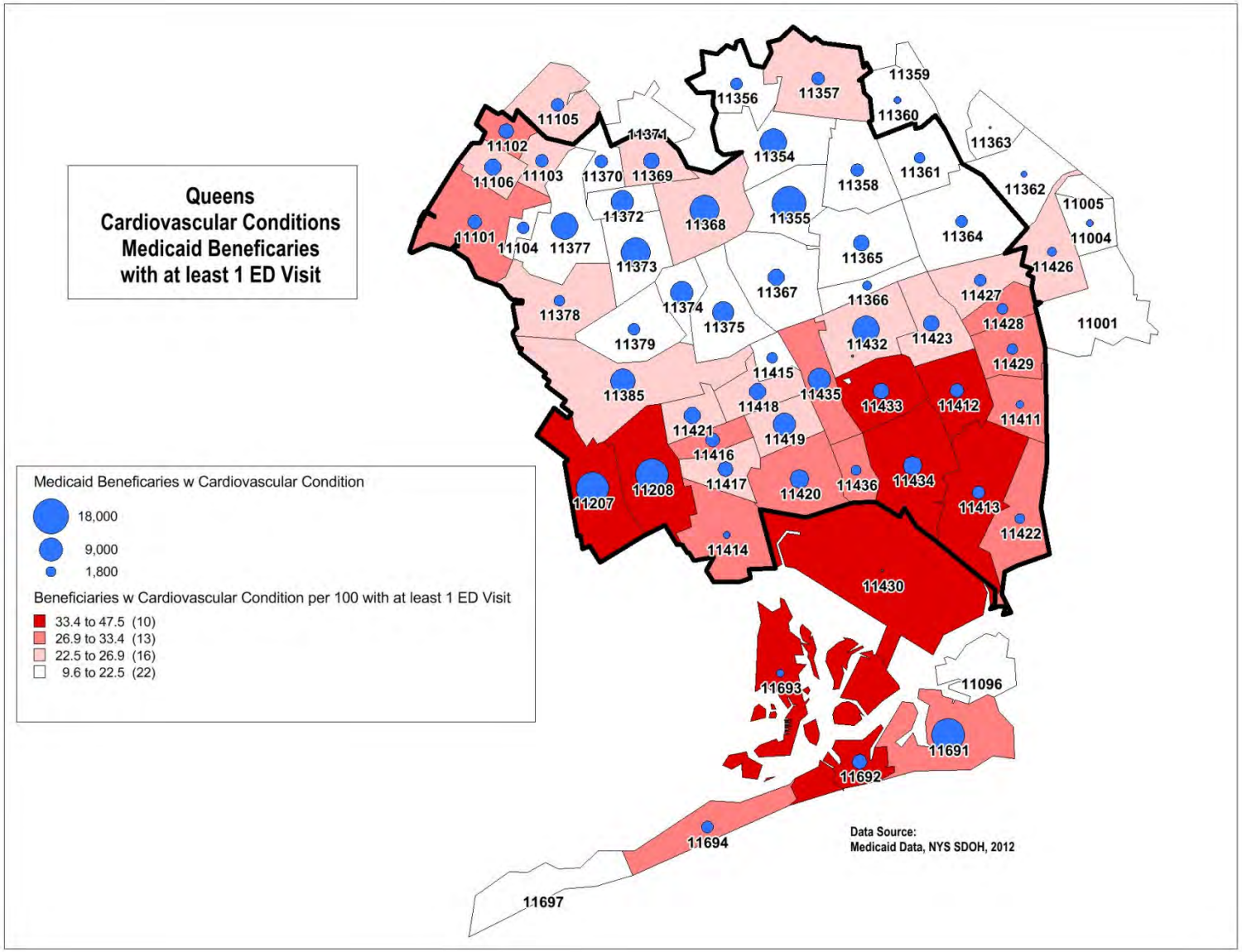

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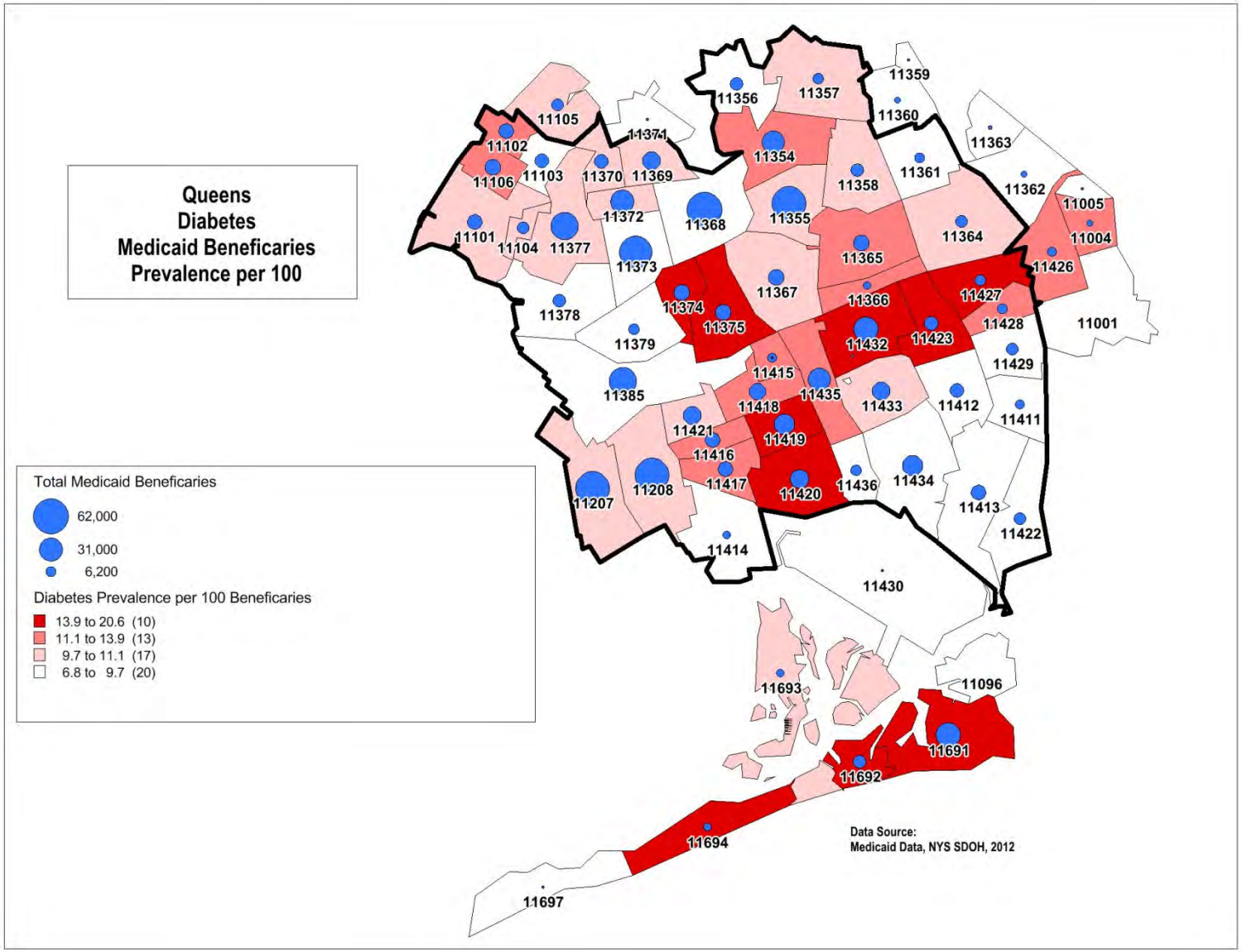

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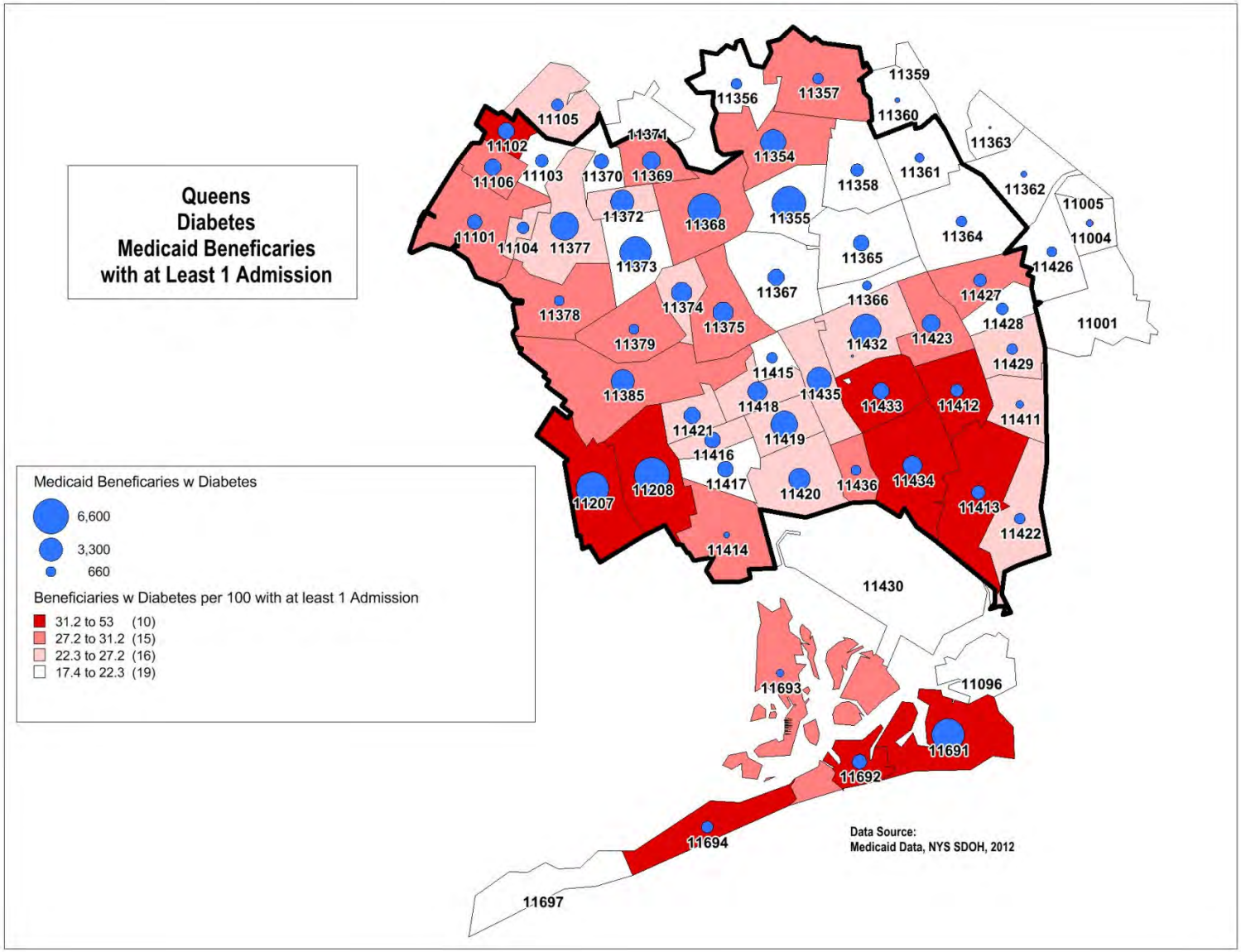

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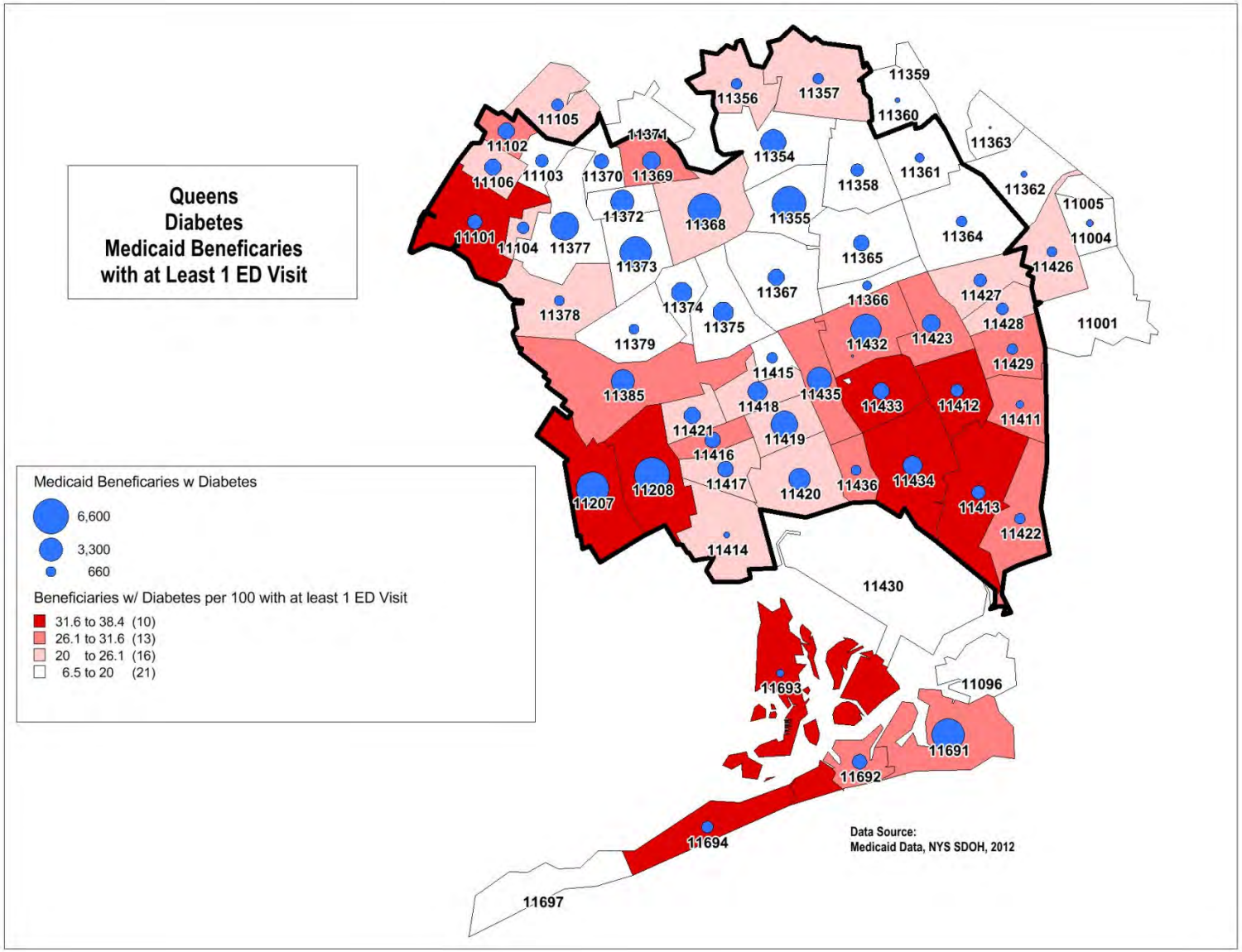

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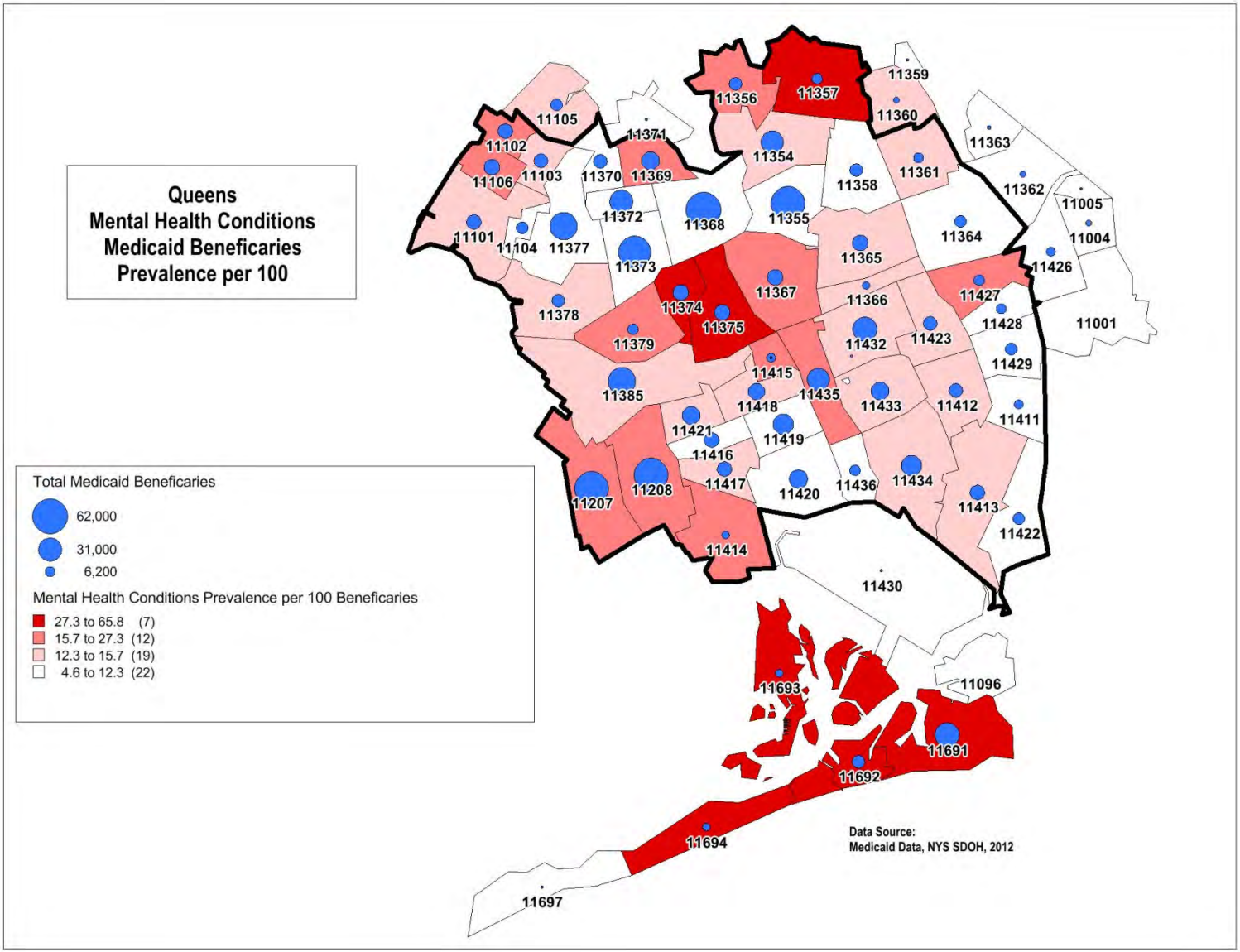

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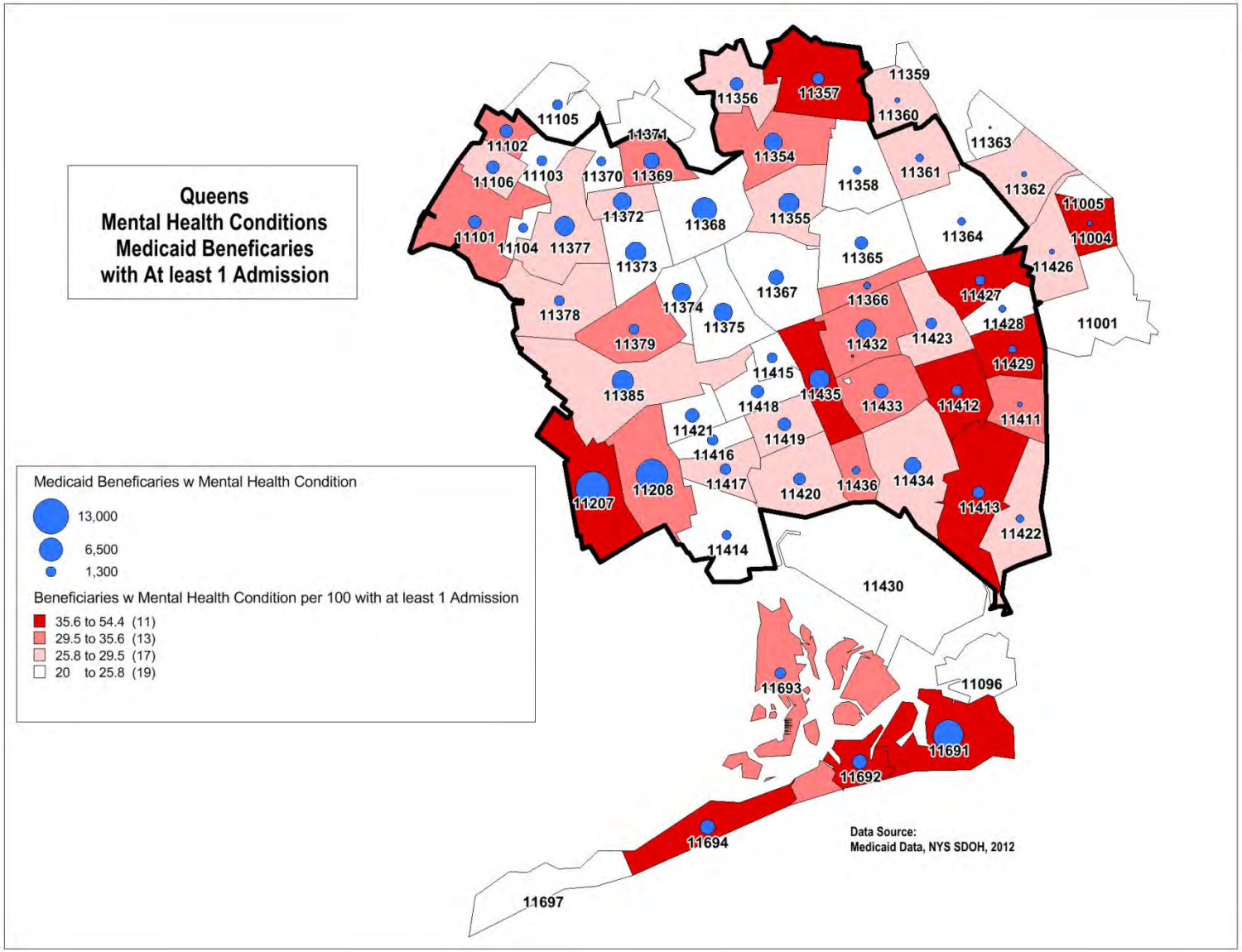

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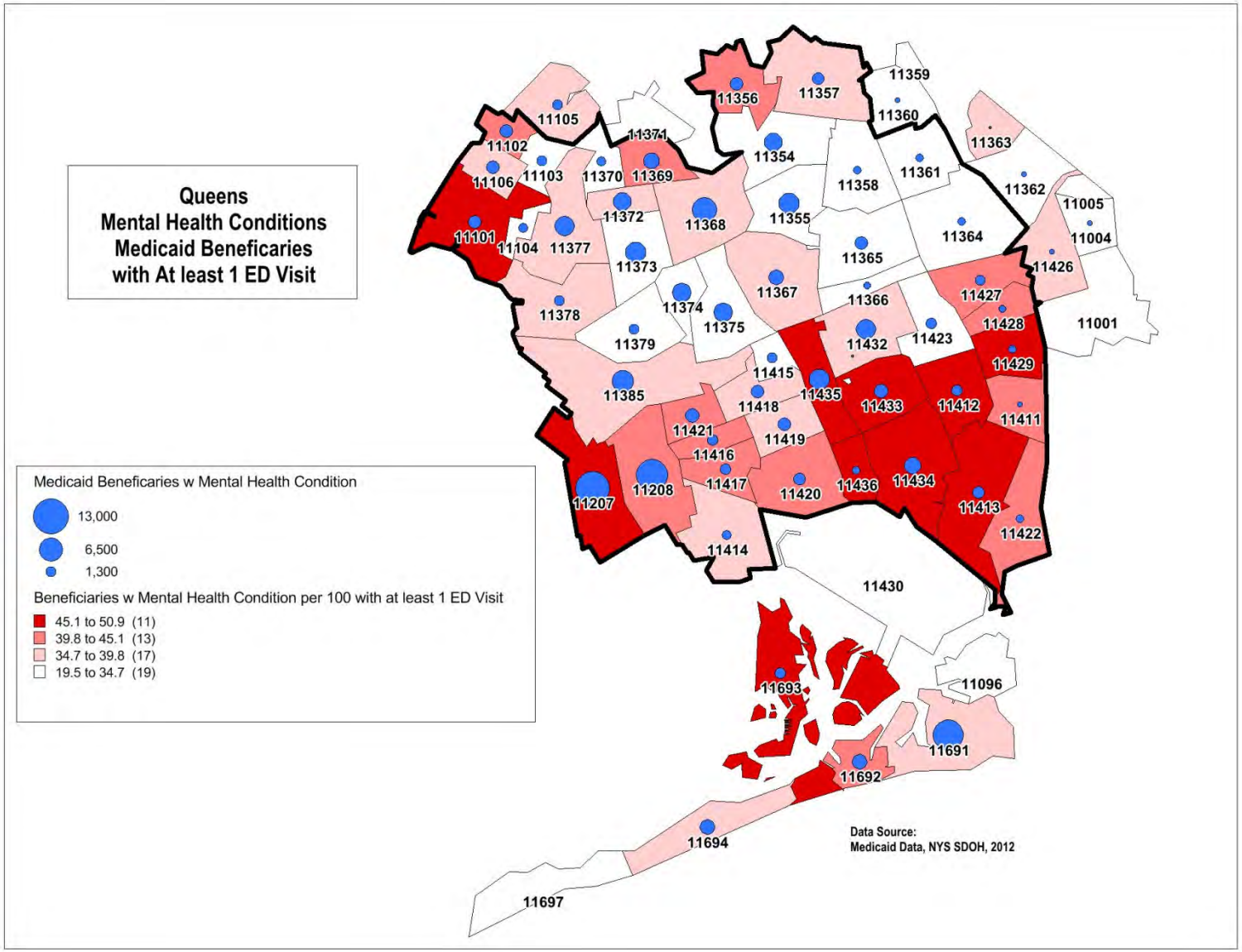

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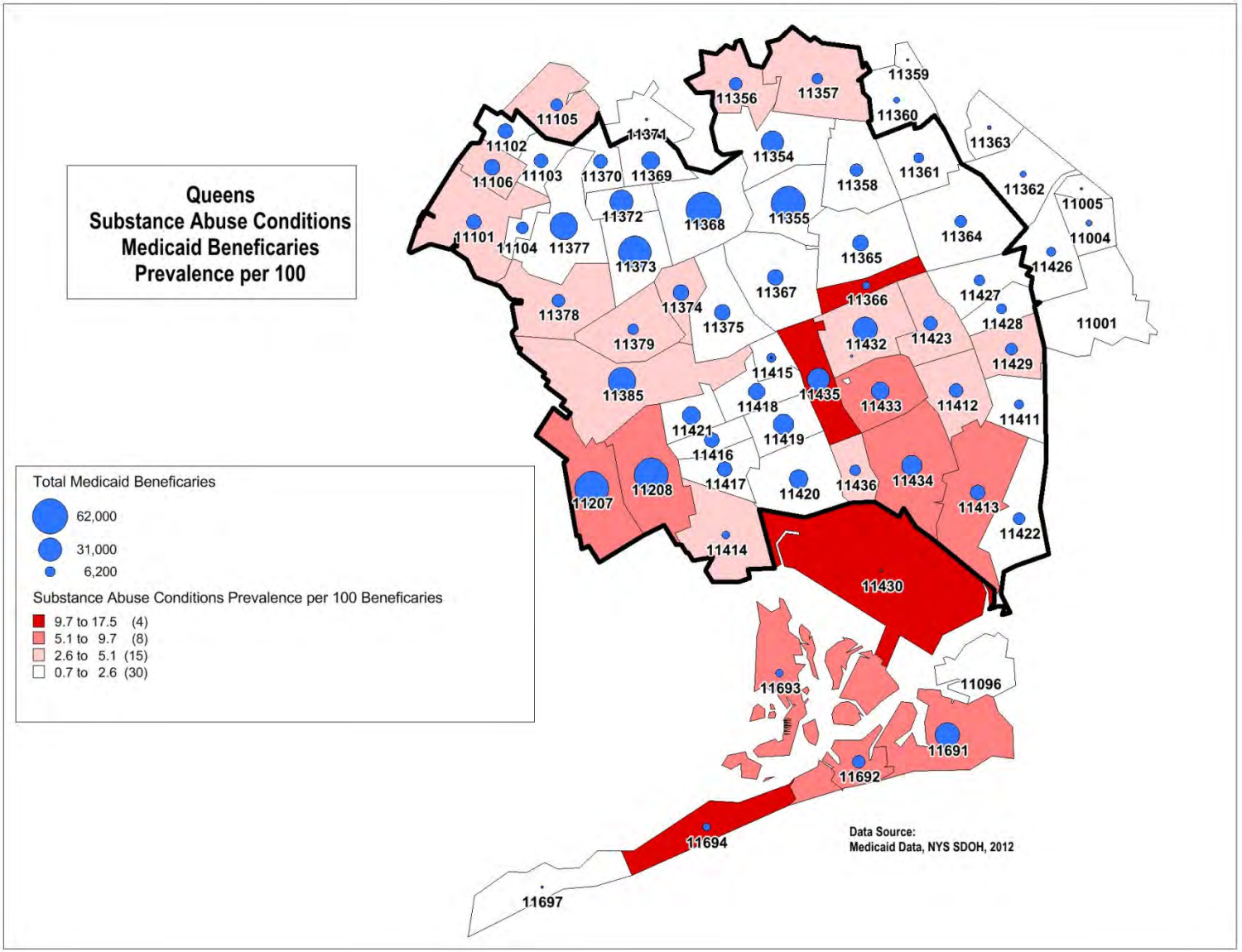

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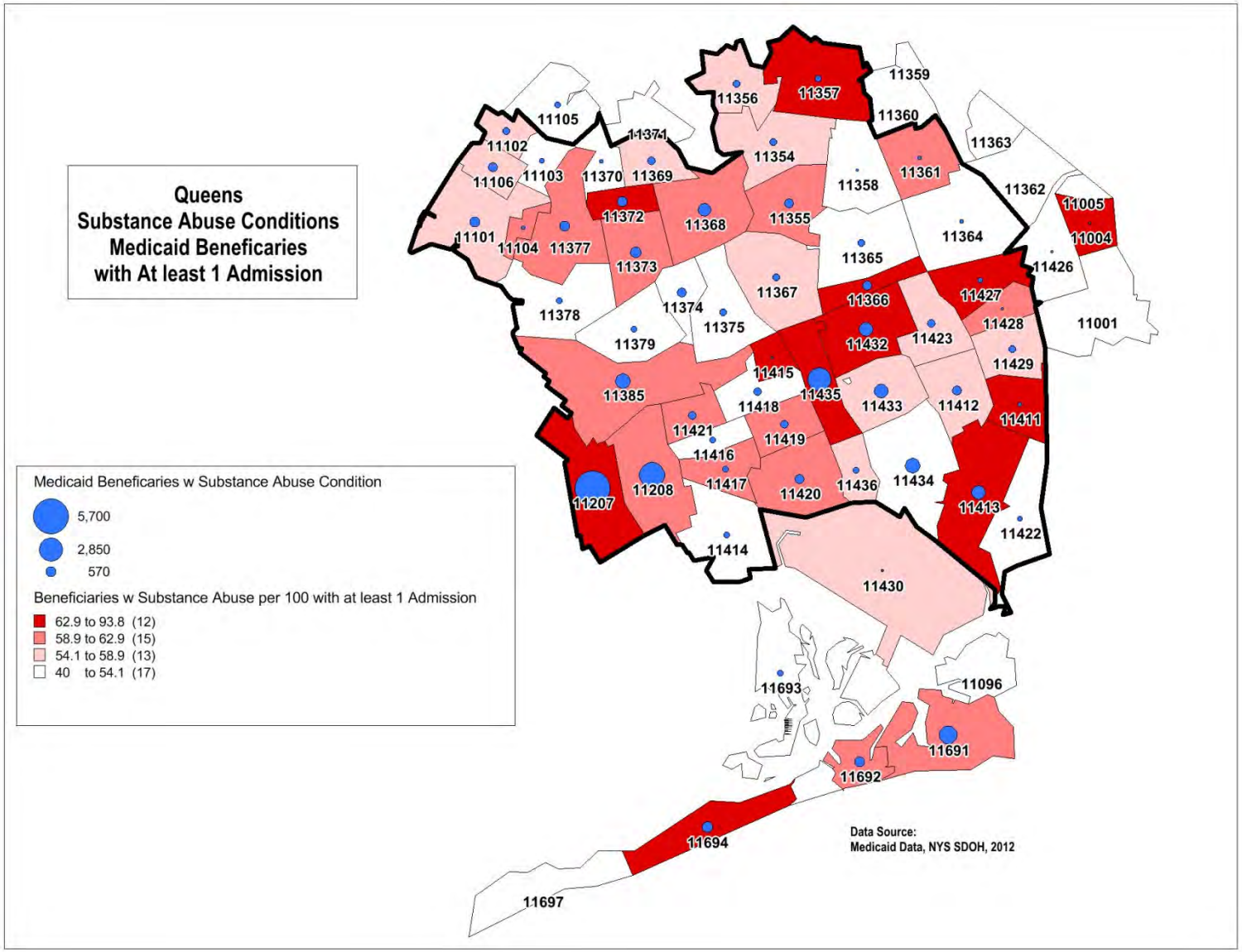

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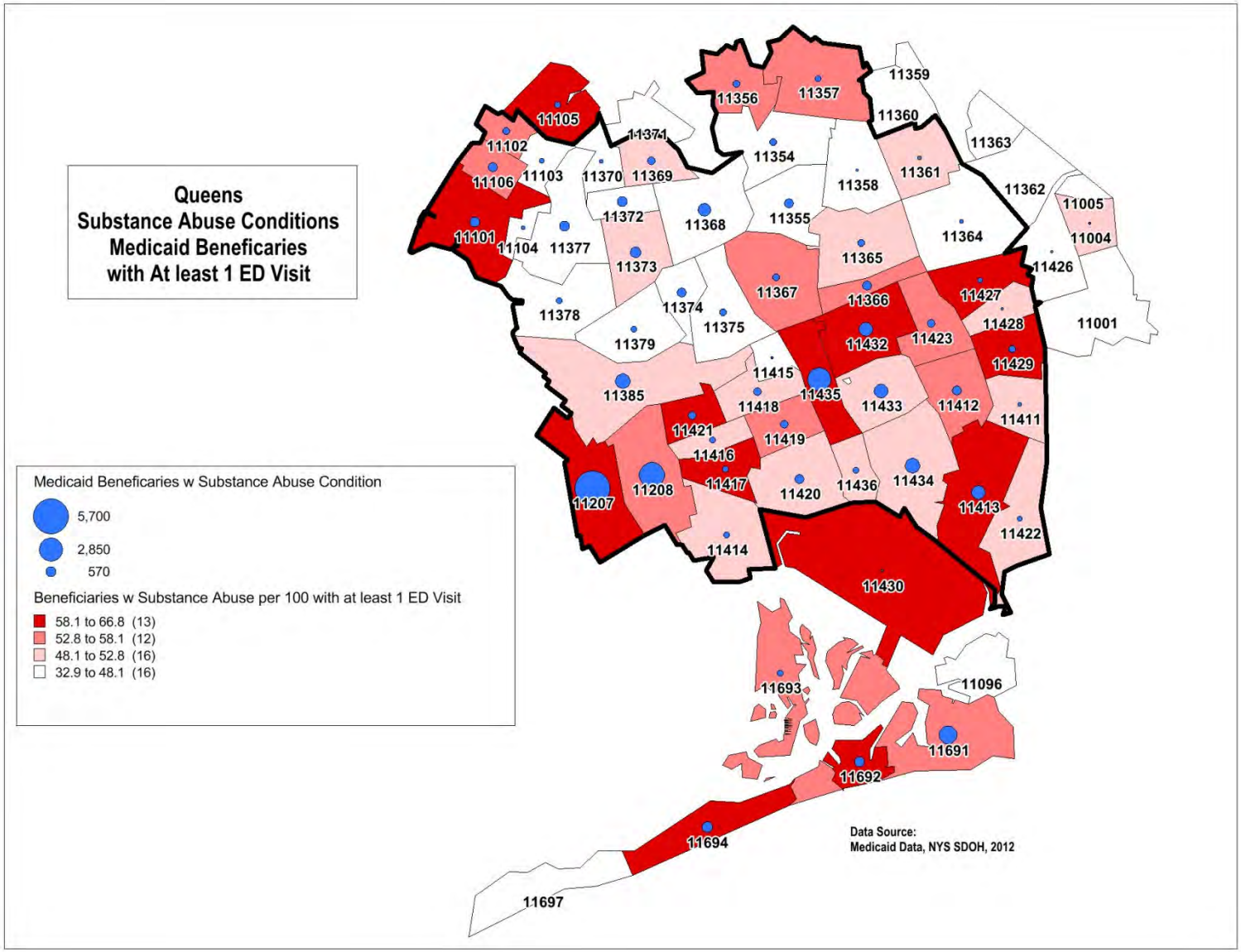

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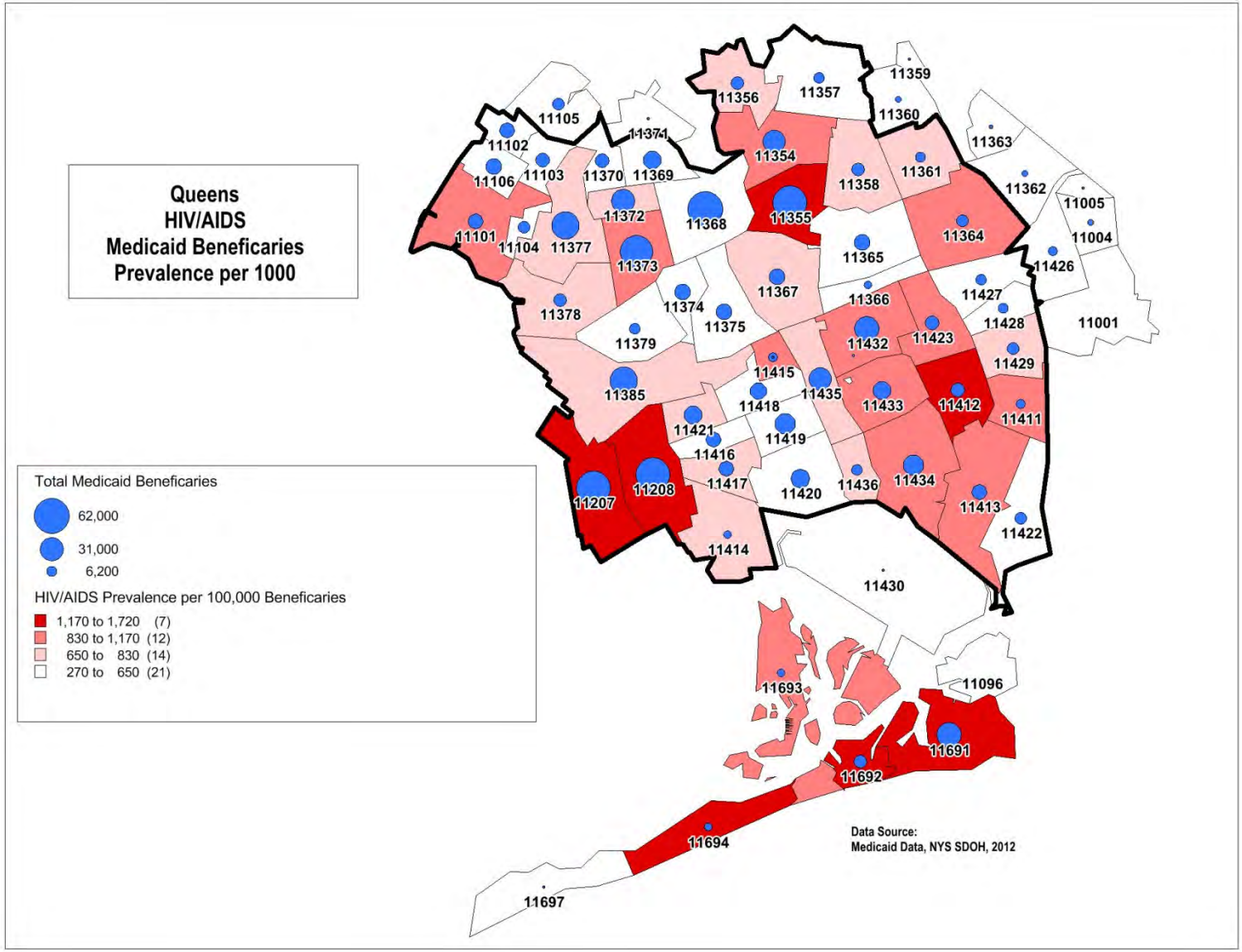

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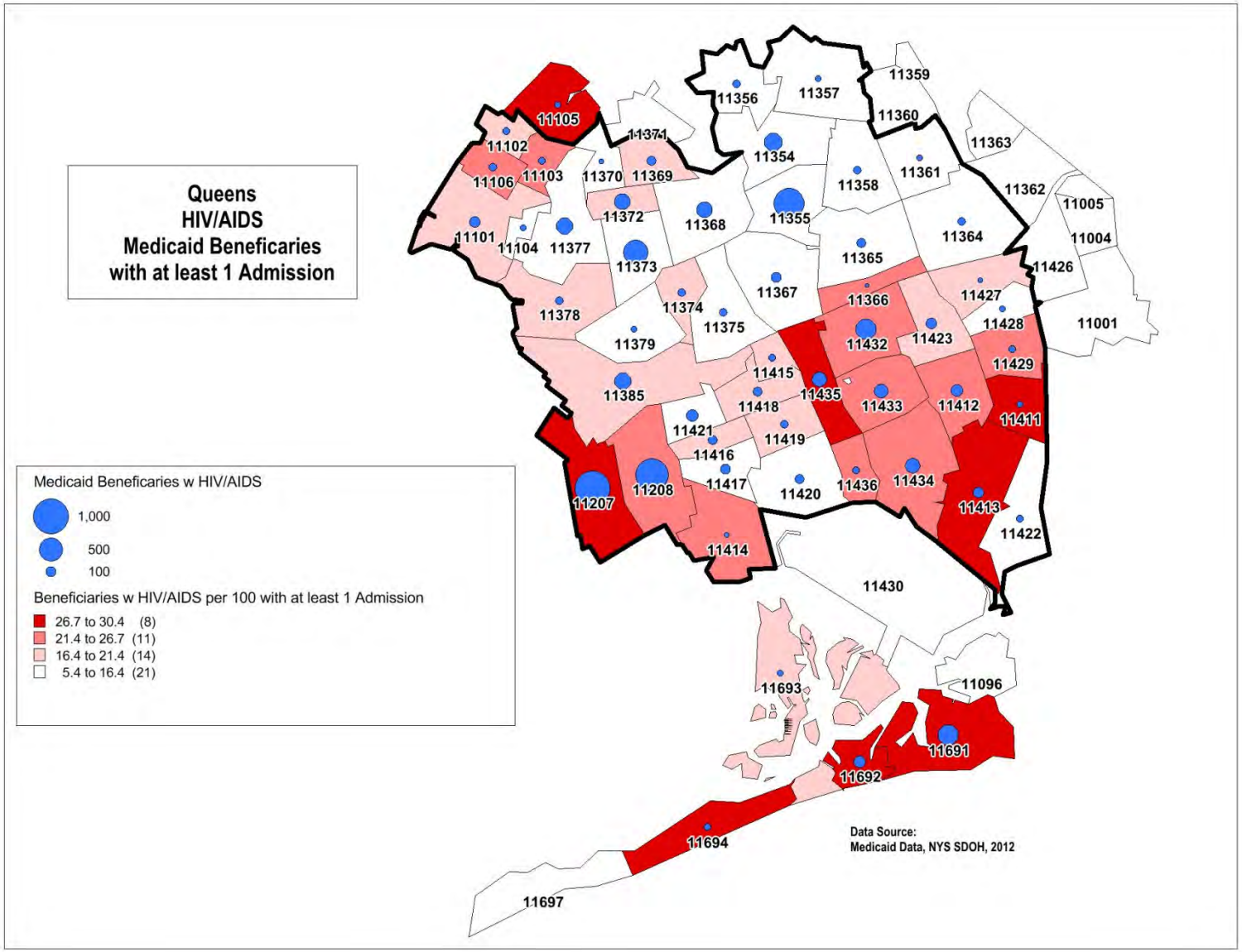

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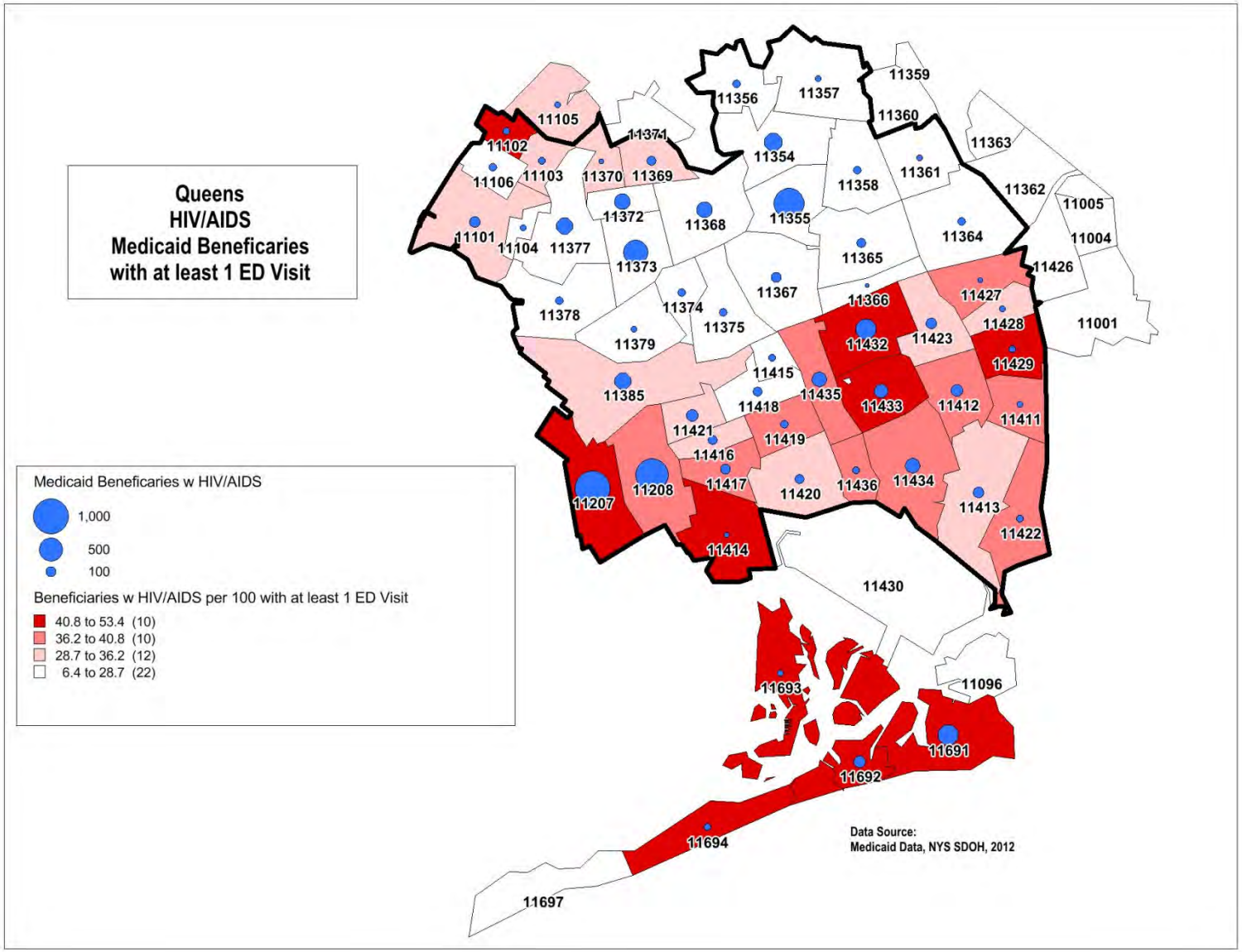

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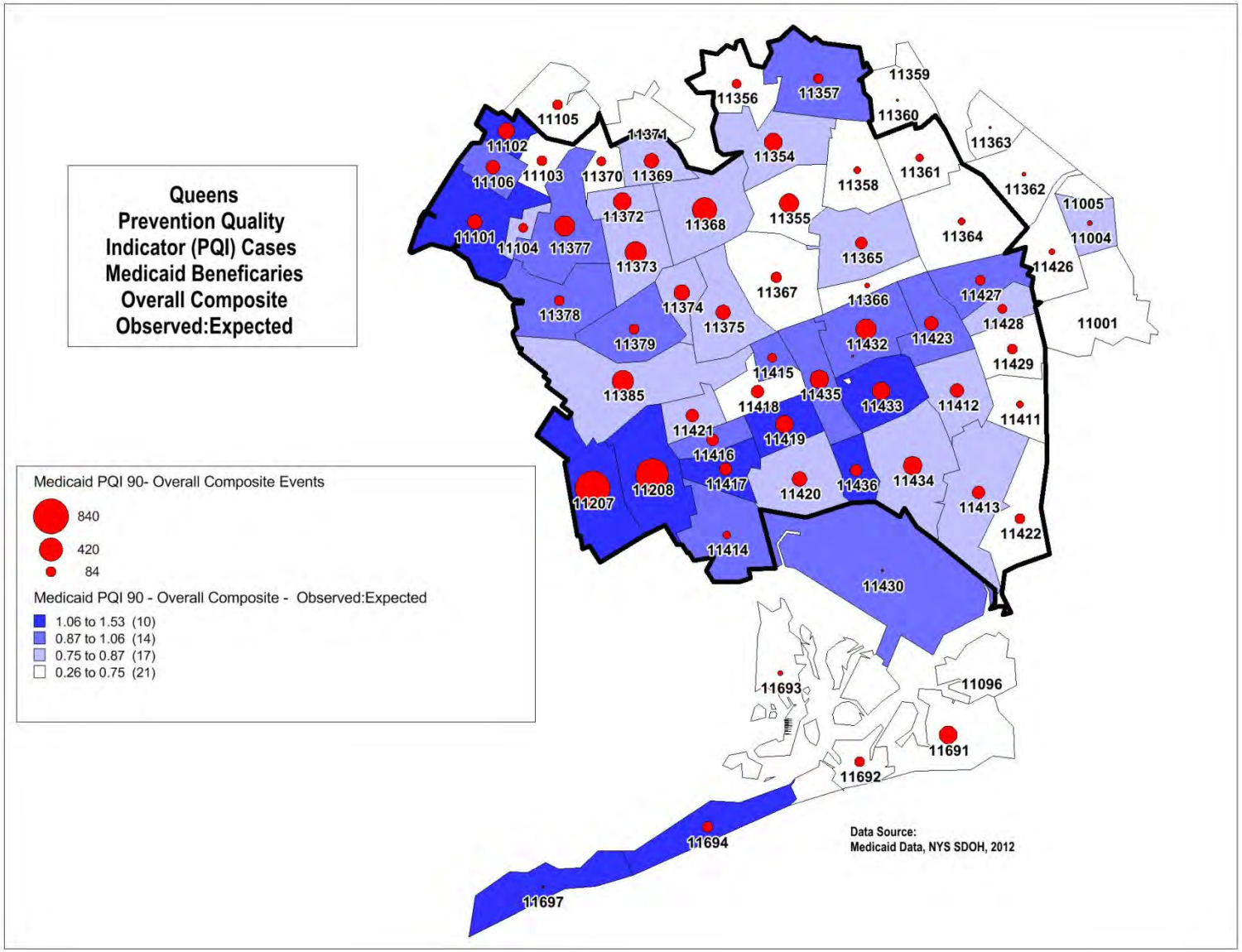

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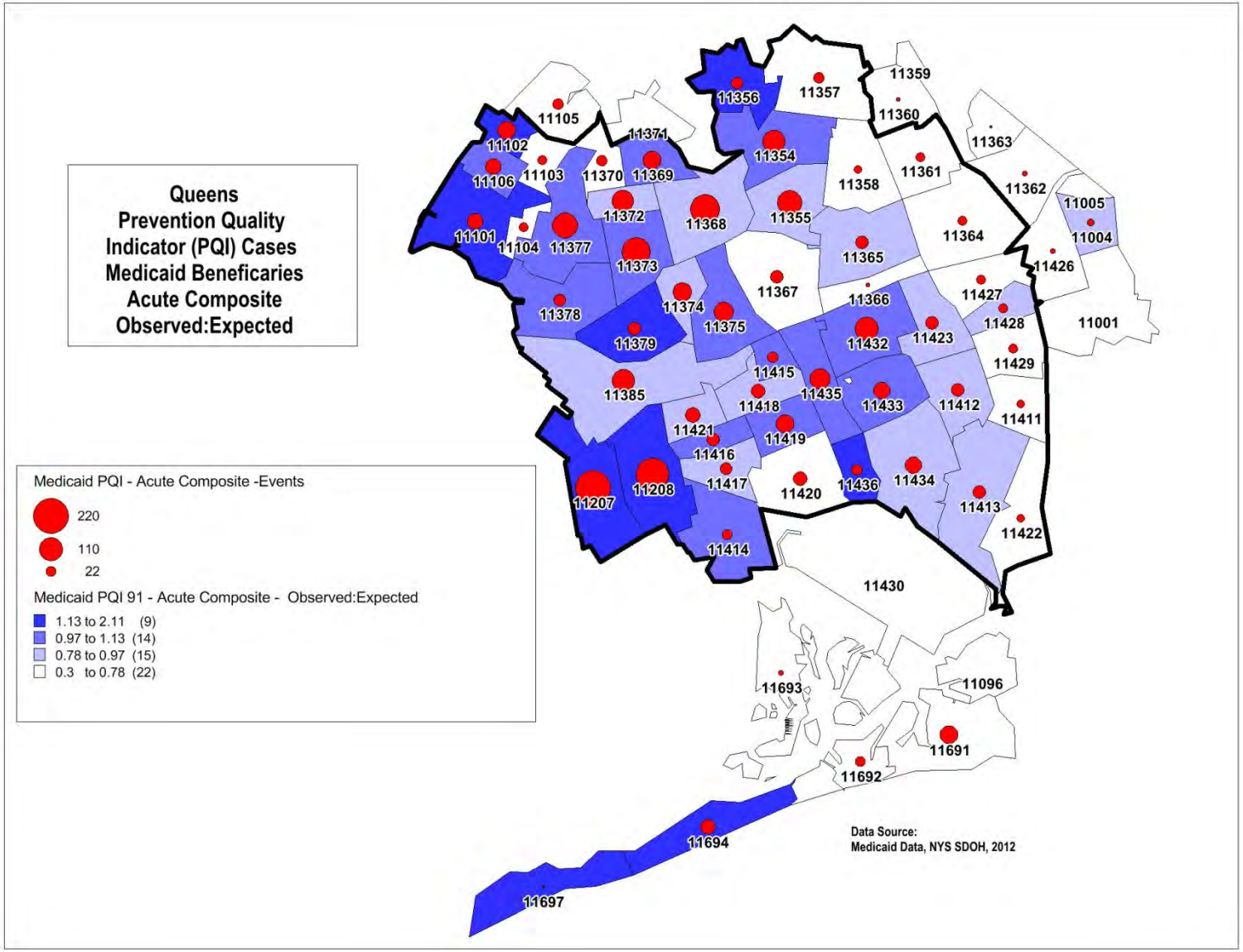

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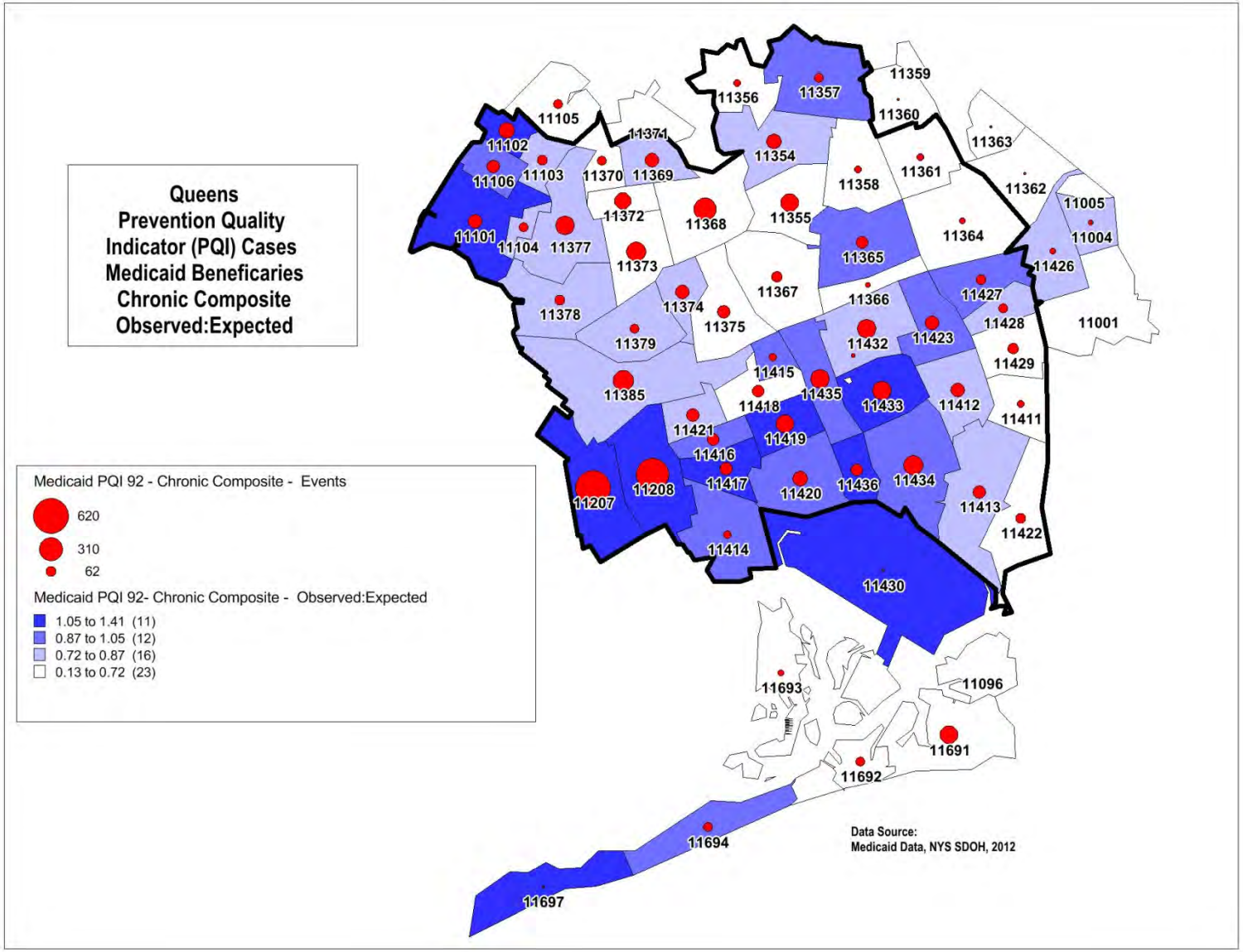

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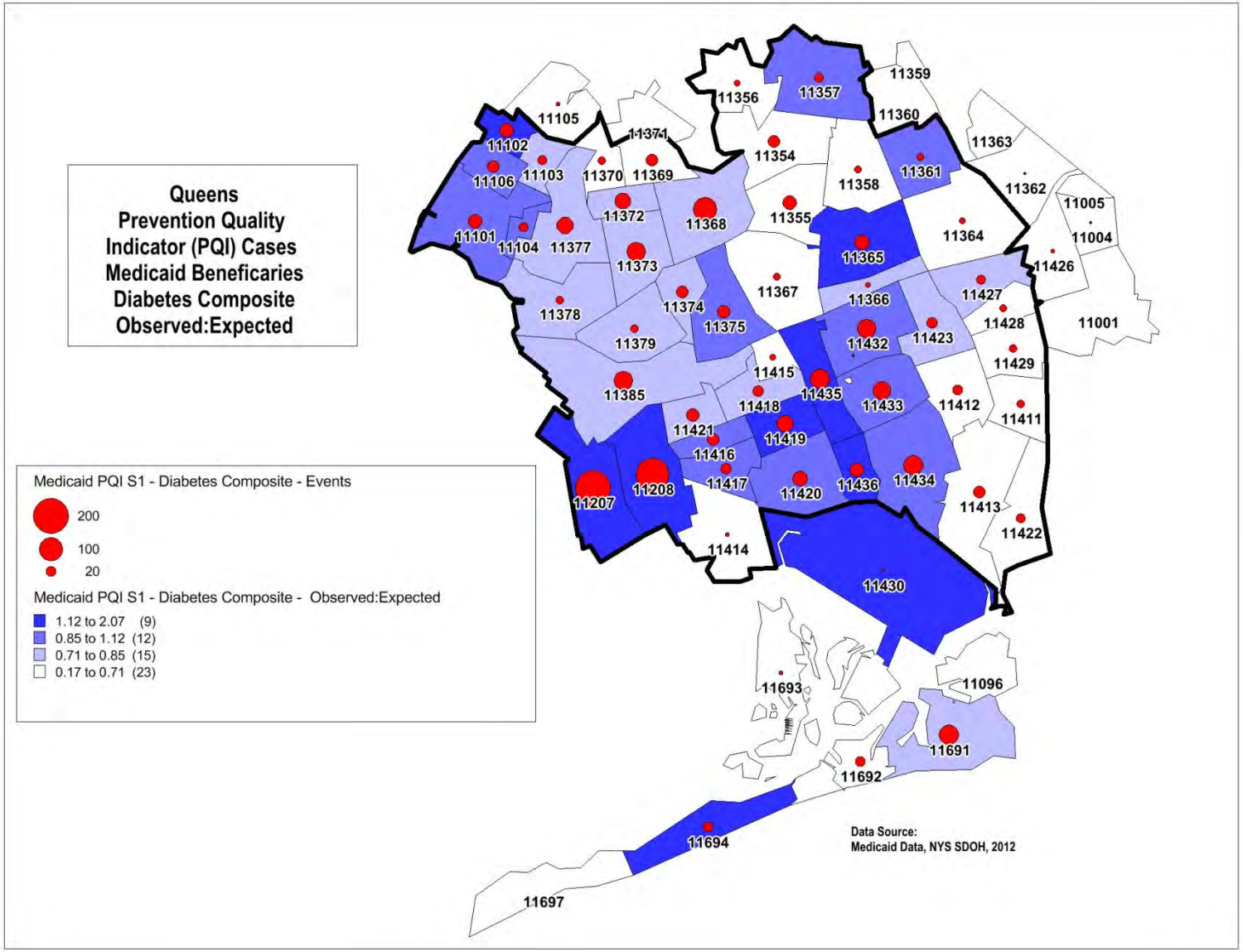

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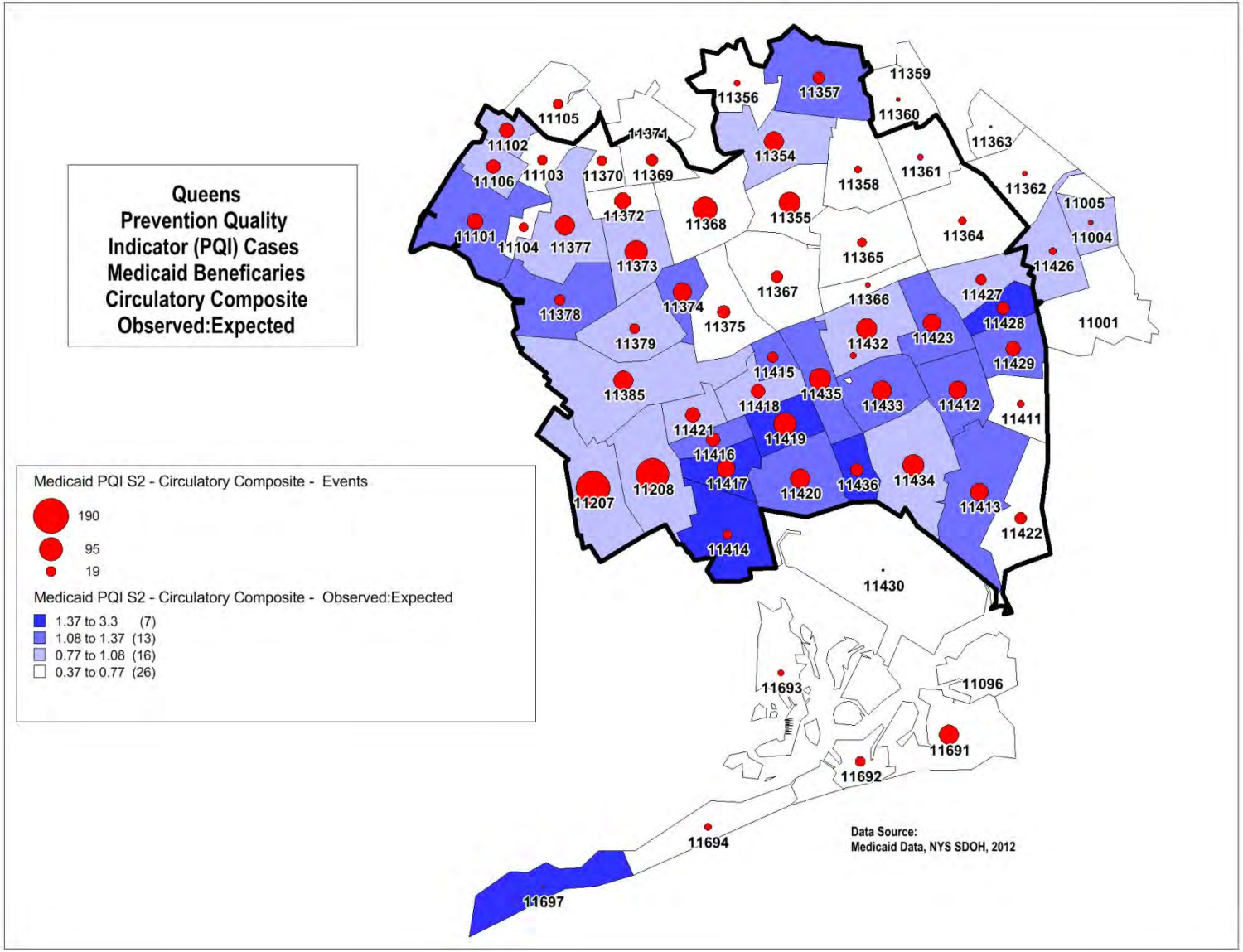

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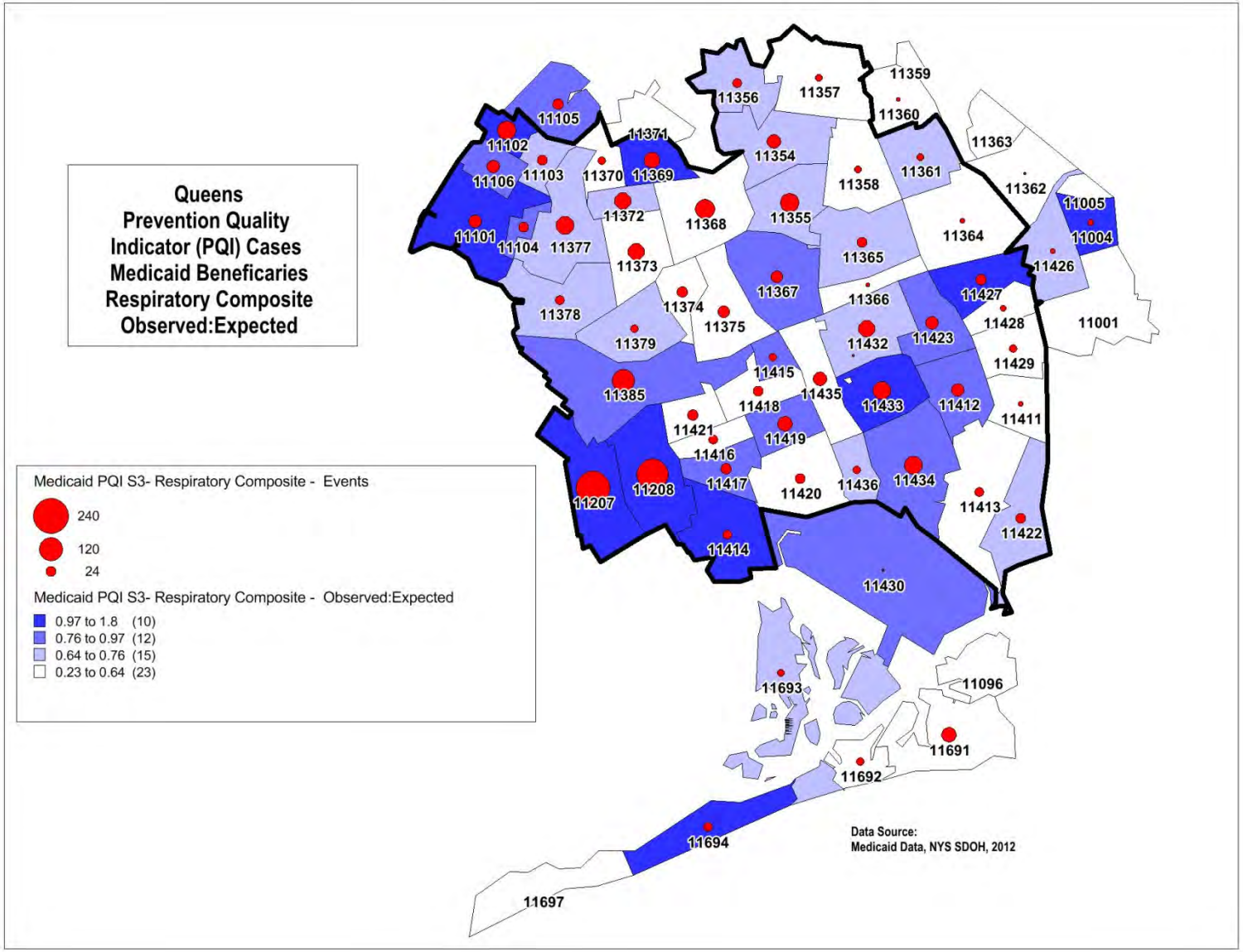

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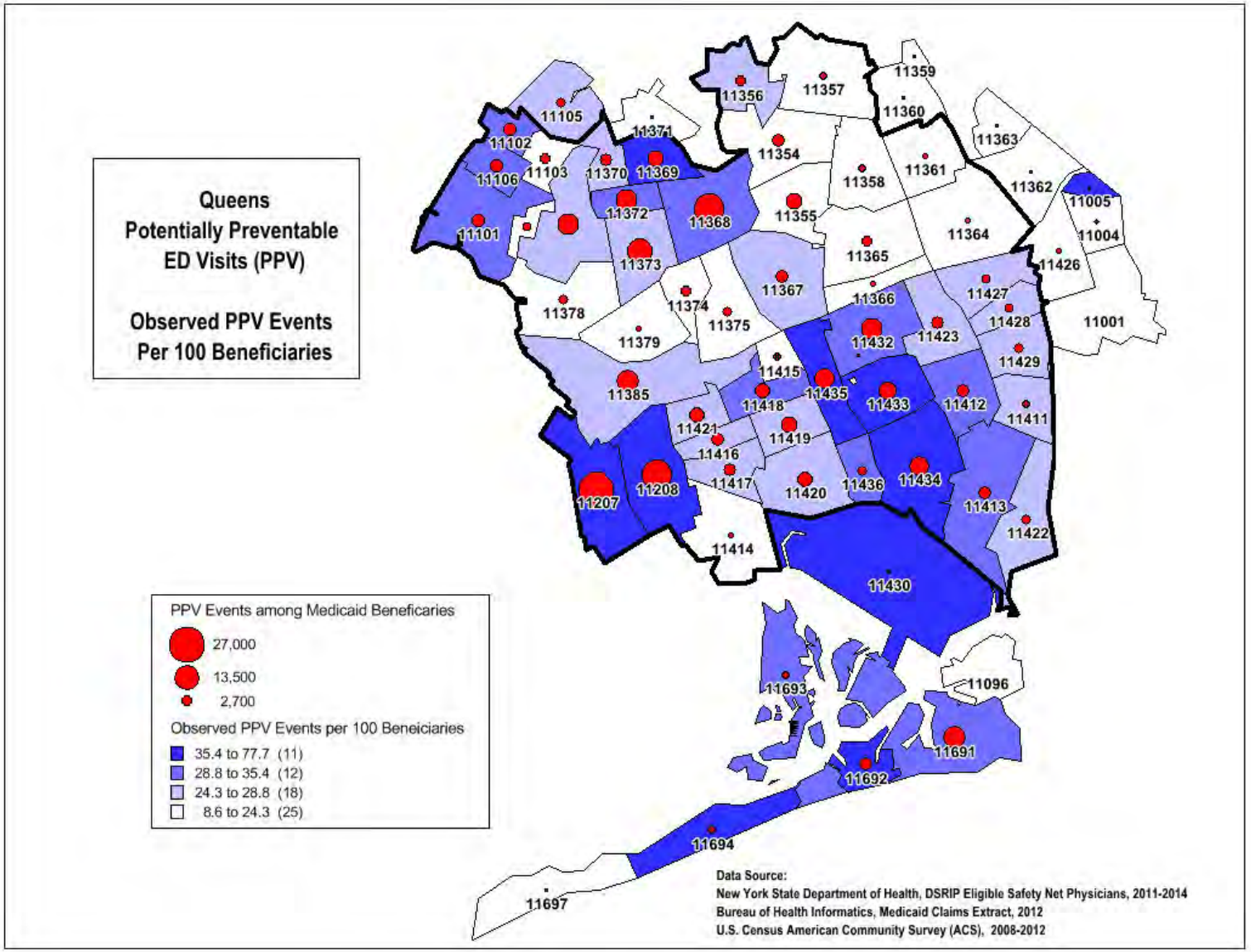

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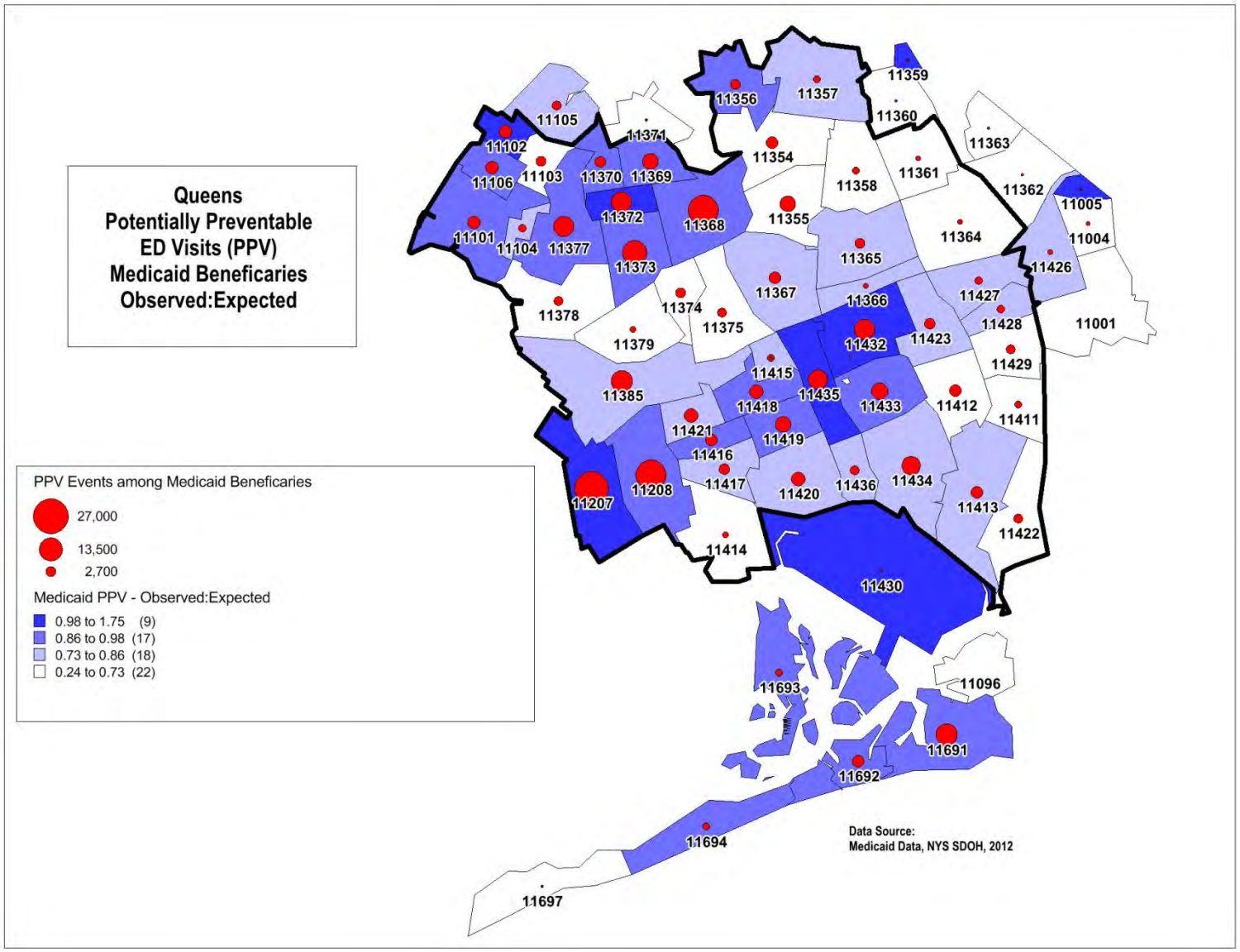

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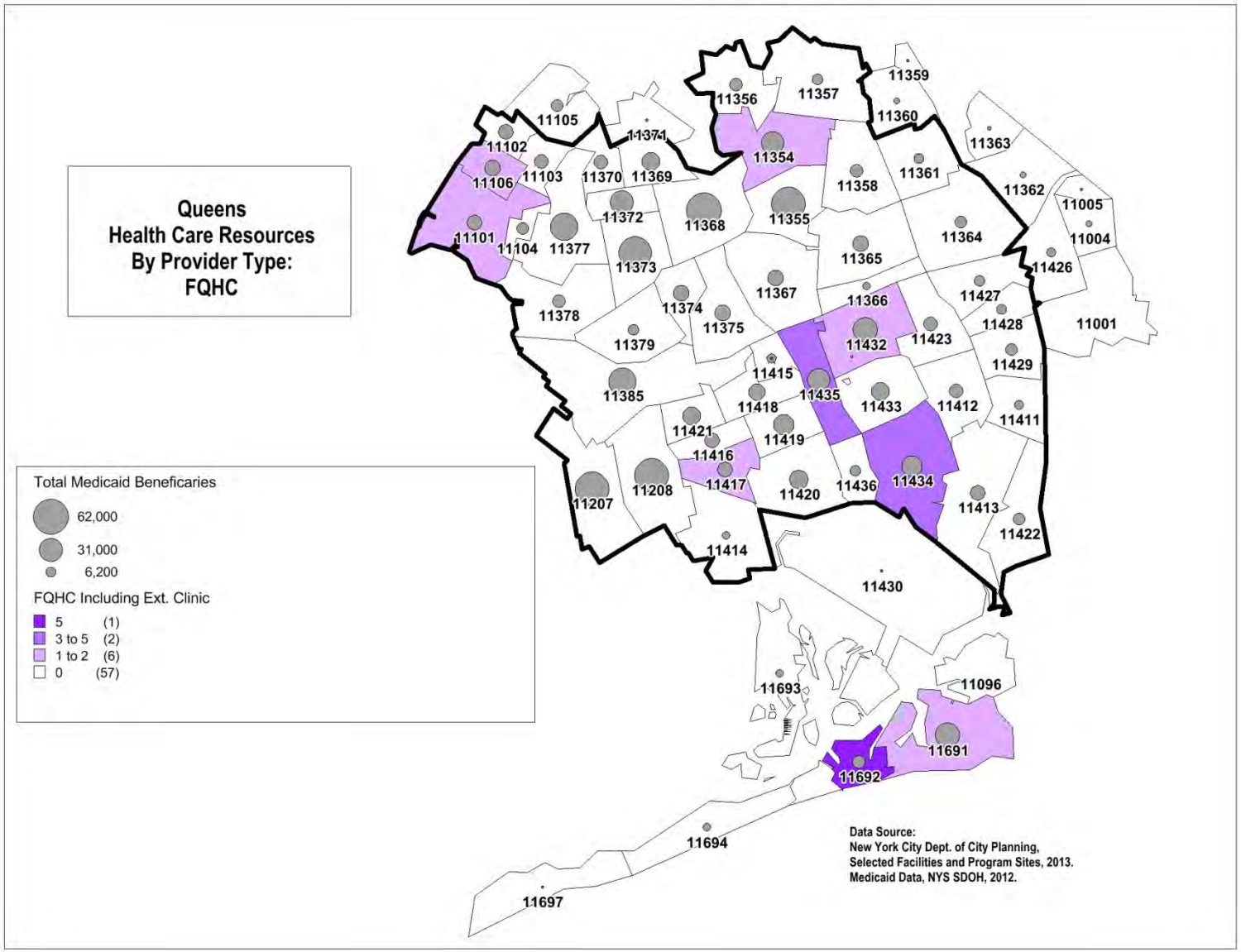

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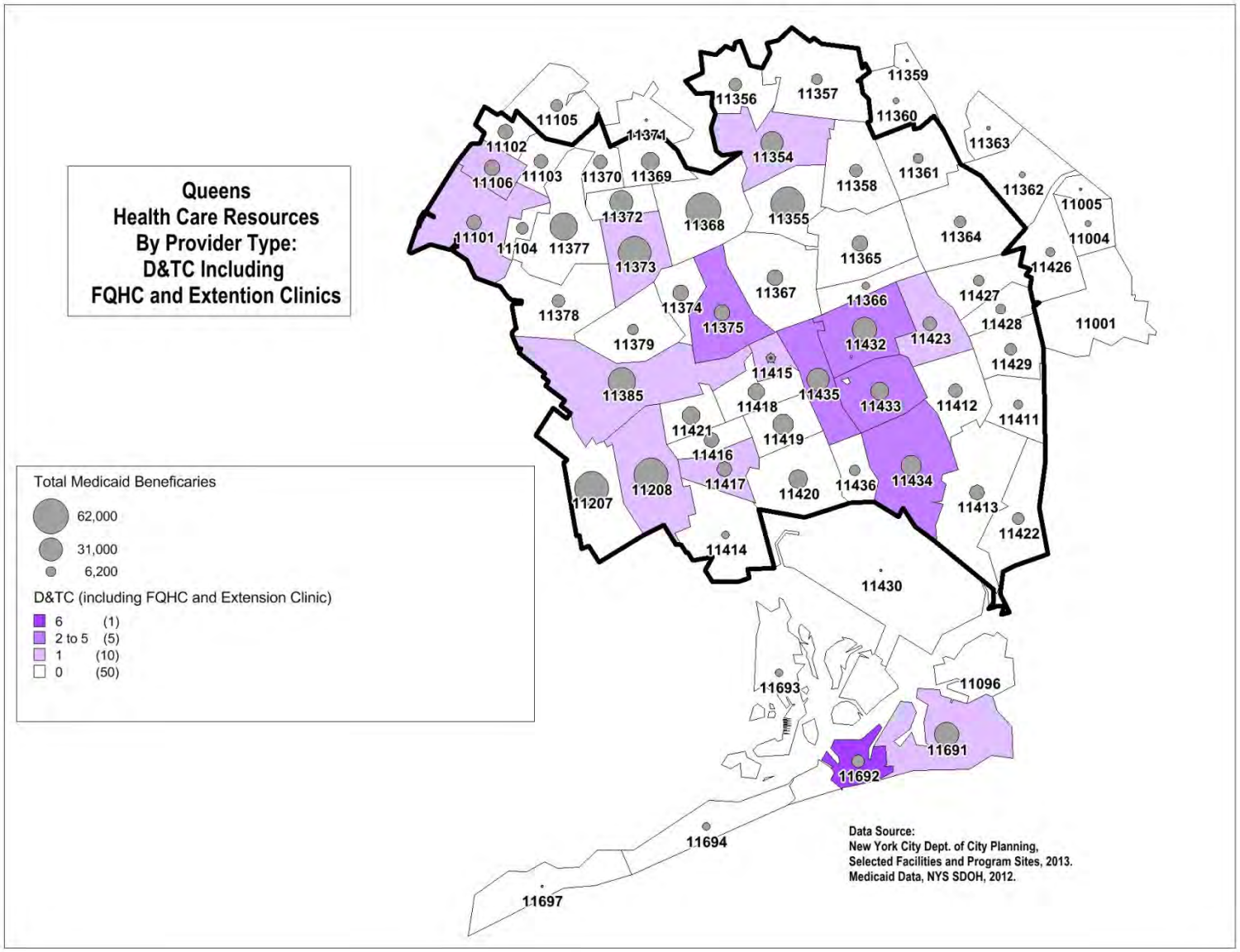

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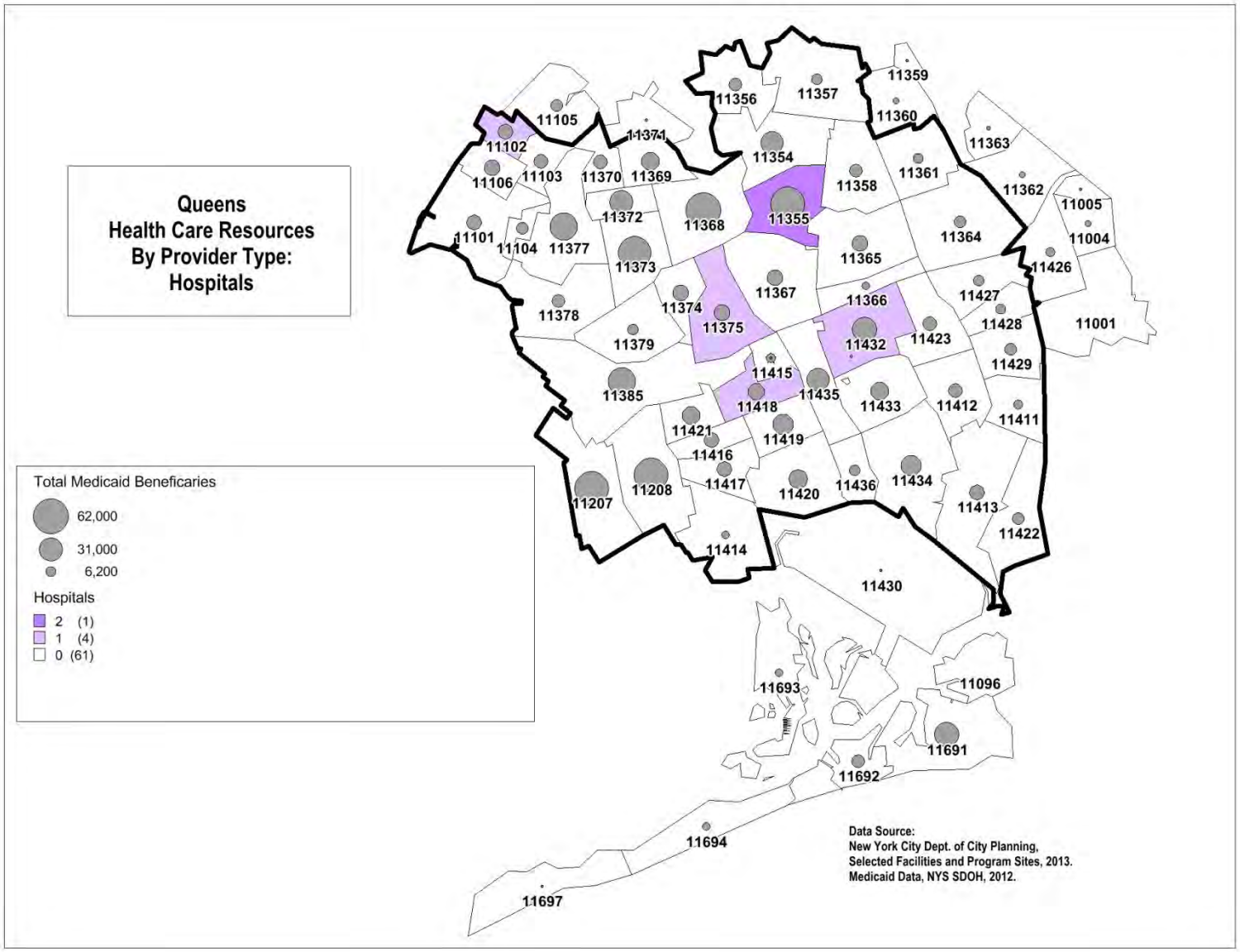

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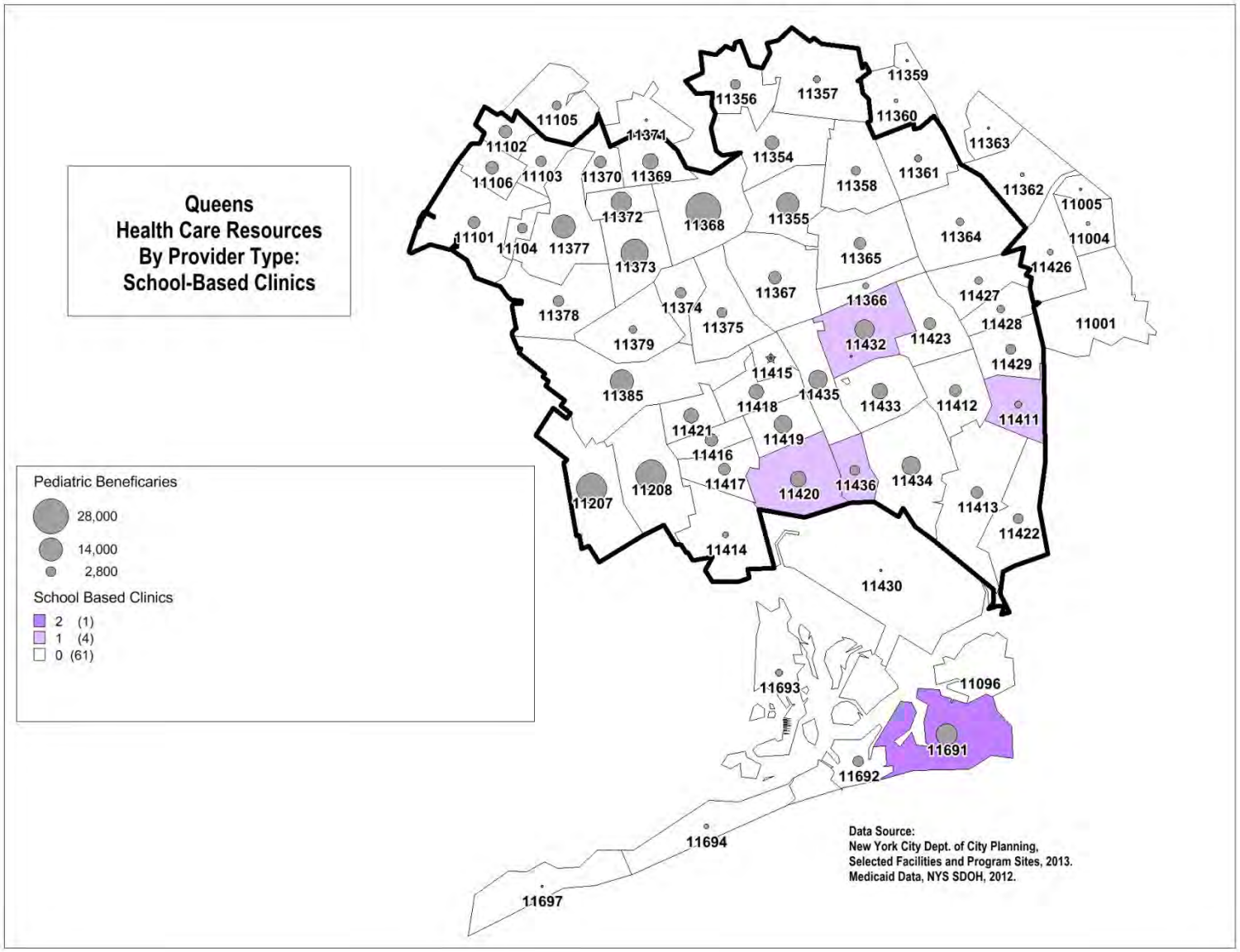
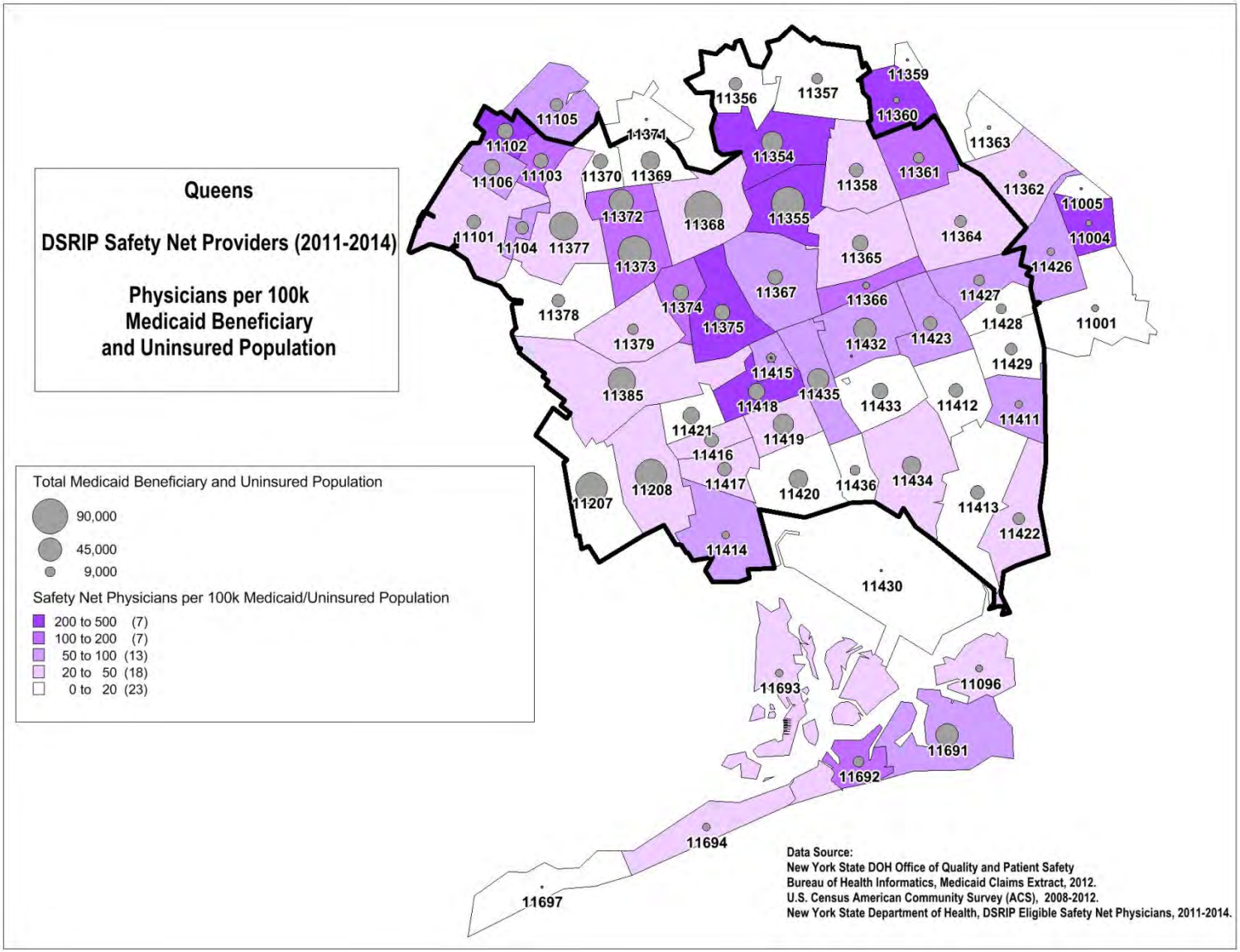
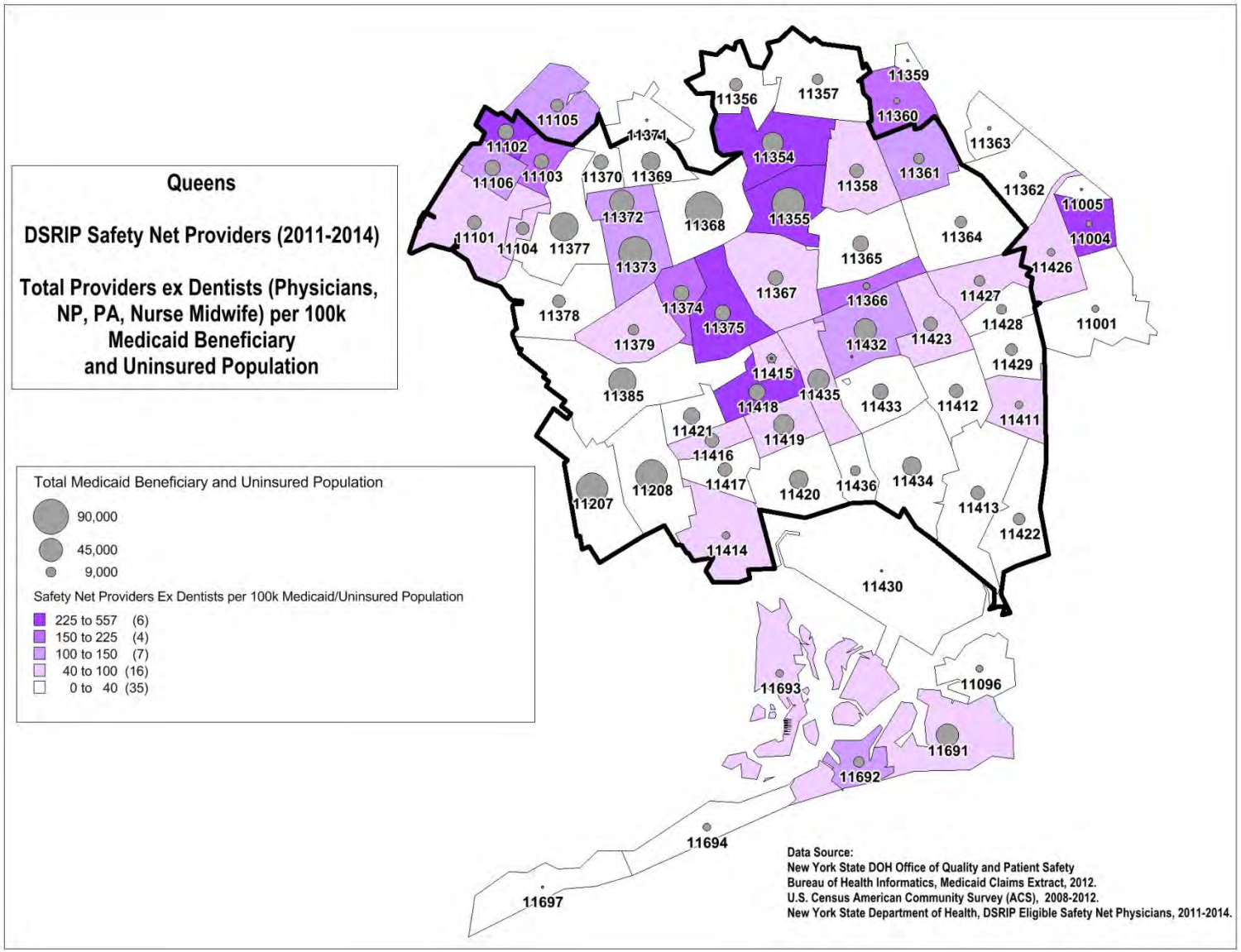


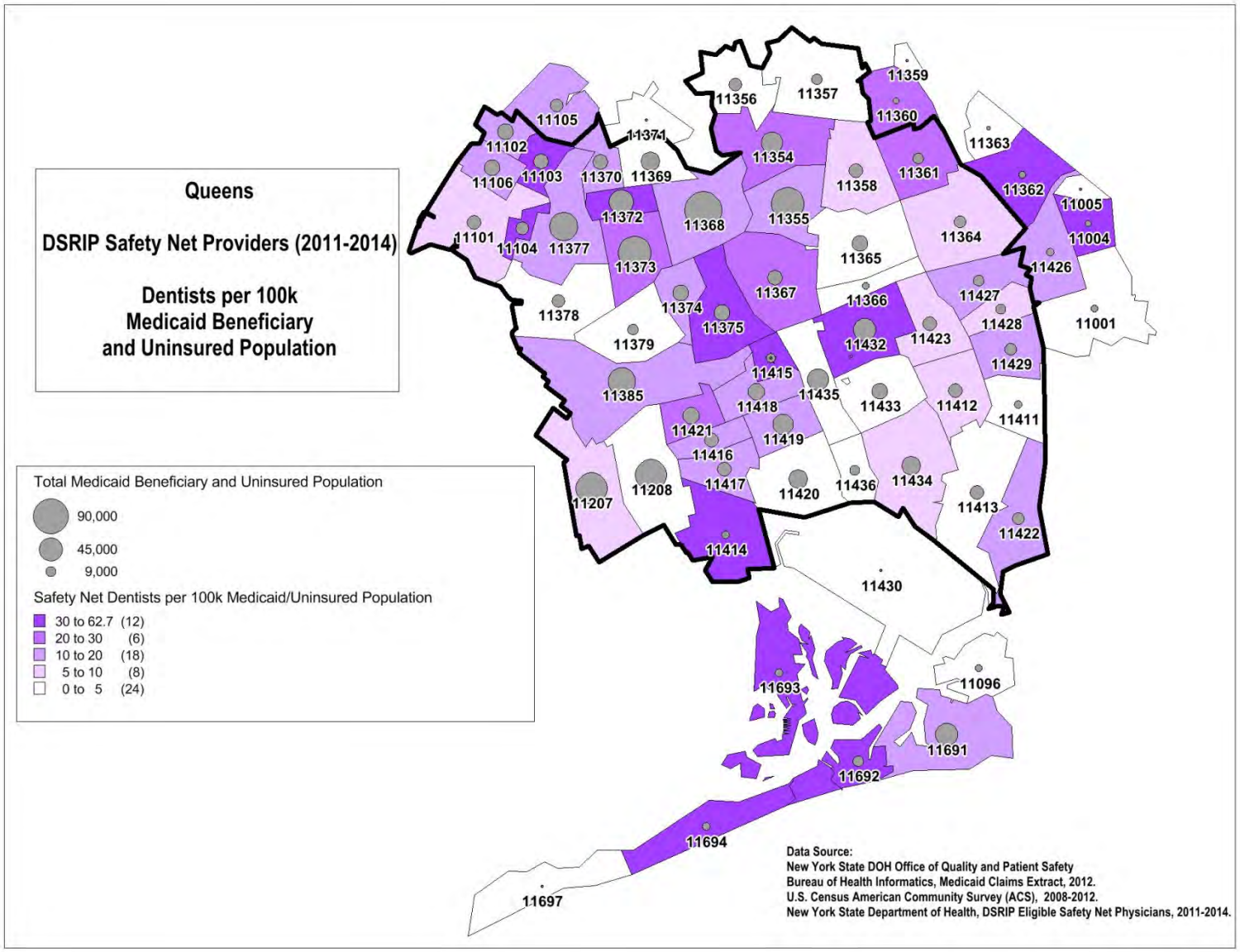
53. Safety Net Physicians per 100,000 Medicaid Beneficiary and Uninsured Population by Zip Code



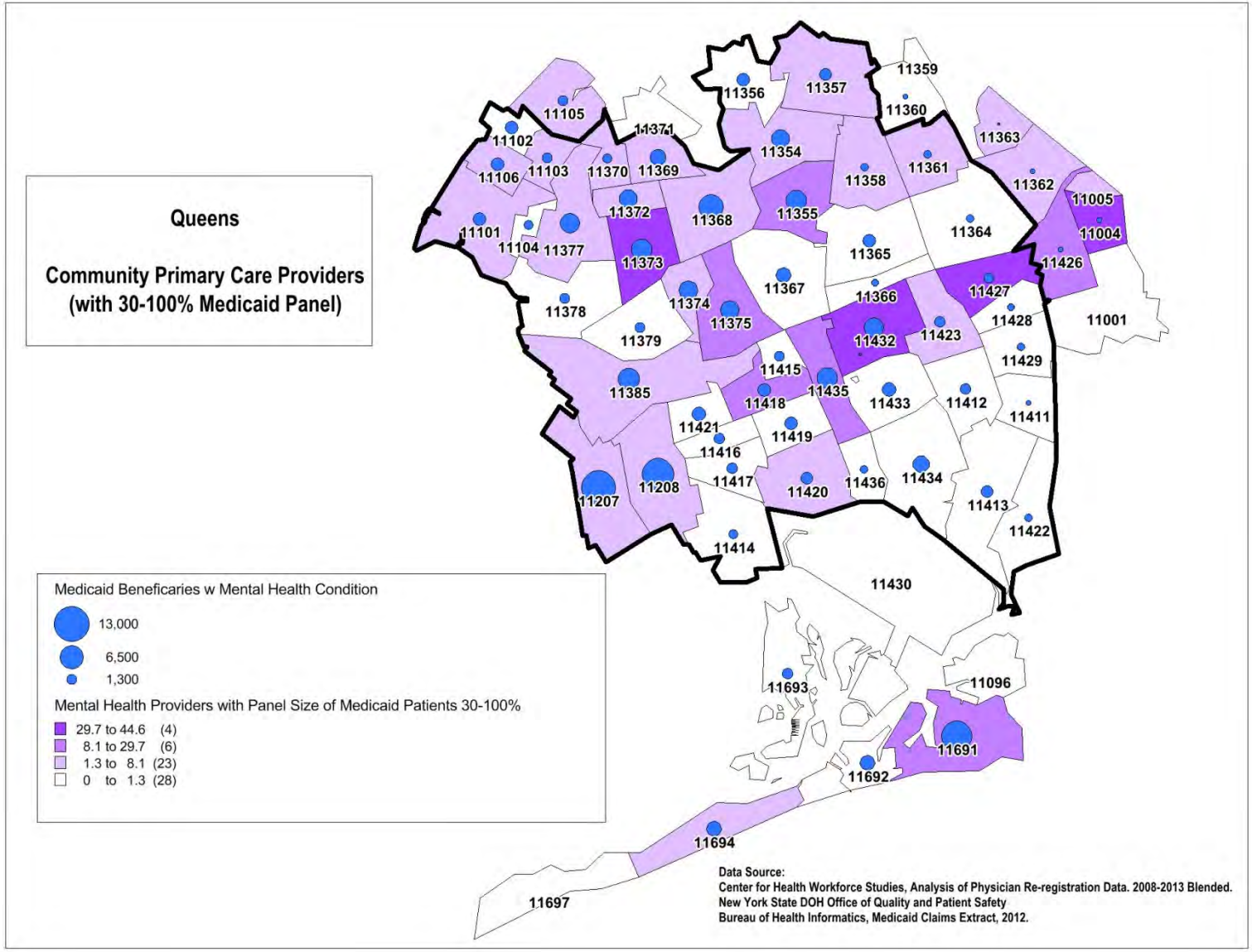
54. Safety Net Providers (Physician, Nurse Practitioner, Physician Assistant and Nurse Midwife) per 100,000 Medicaid Beneficiary and Uninsured Population by Zip Code



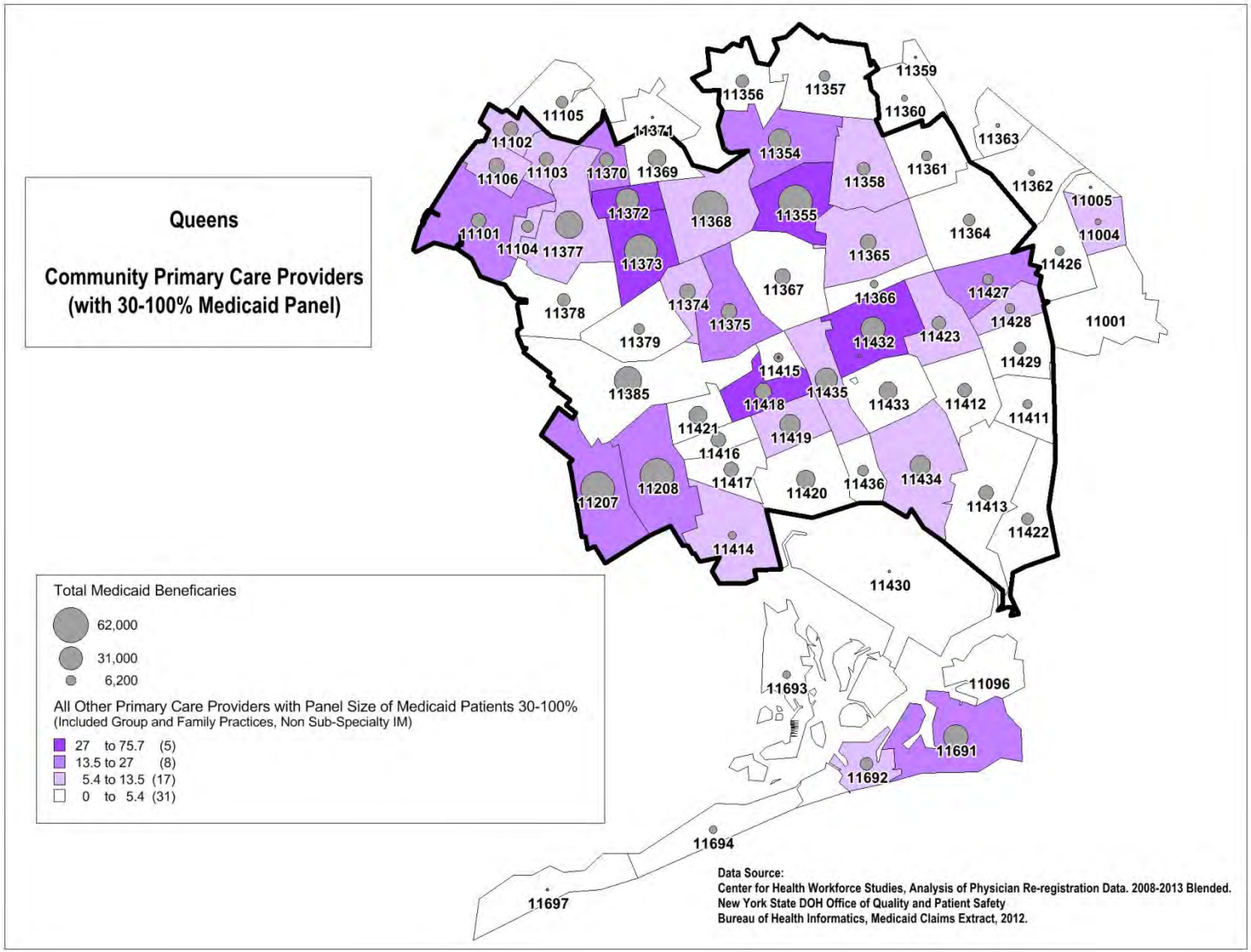
55. Safety Net Dentists per 100,000 and Medicaid Beneficiary and Uninsured Population by Zip Code



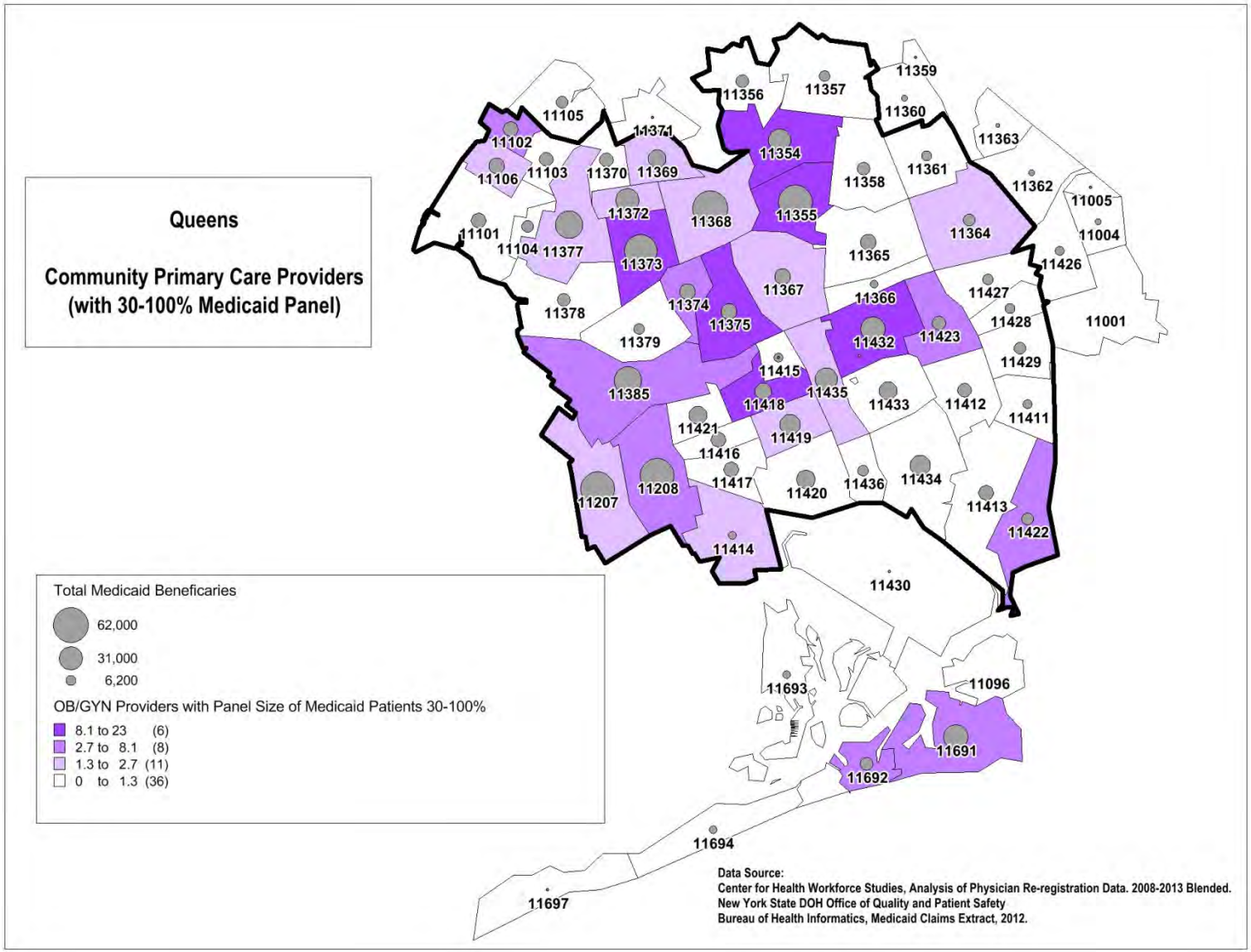
56. Mental Health Physicians reporting 30-100% of panel being Medicaid payer patients and Medicaid population with a Mental Health CRG diagnosis by Zip Code



57. Other Primary Care Physicians (Family Practice, Group Practice, Non-Specialty Internal Medicine) reporting 30-100% of panel being Medicaid payer patients and Medicaid Beneficiaries by Zip Code



58. OB/GYN Physicians reporting 30-100% of panel being Medicaid payer patients and Medicaid Beneficiaries by Zip Code



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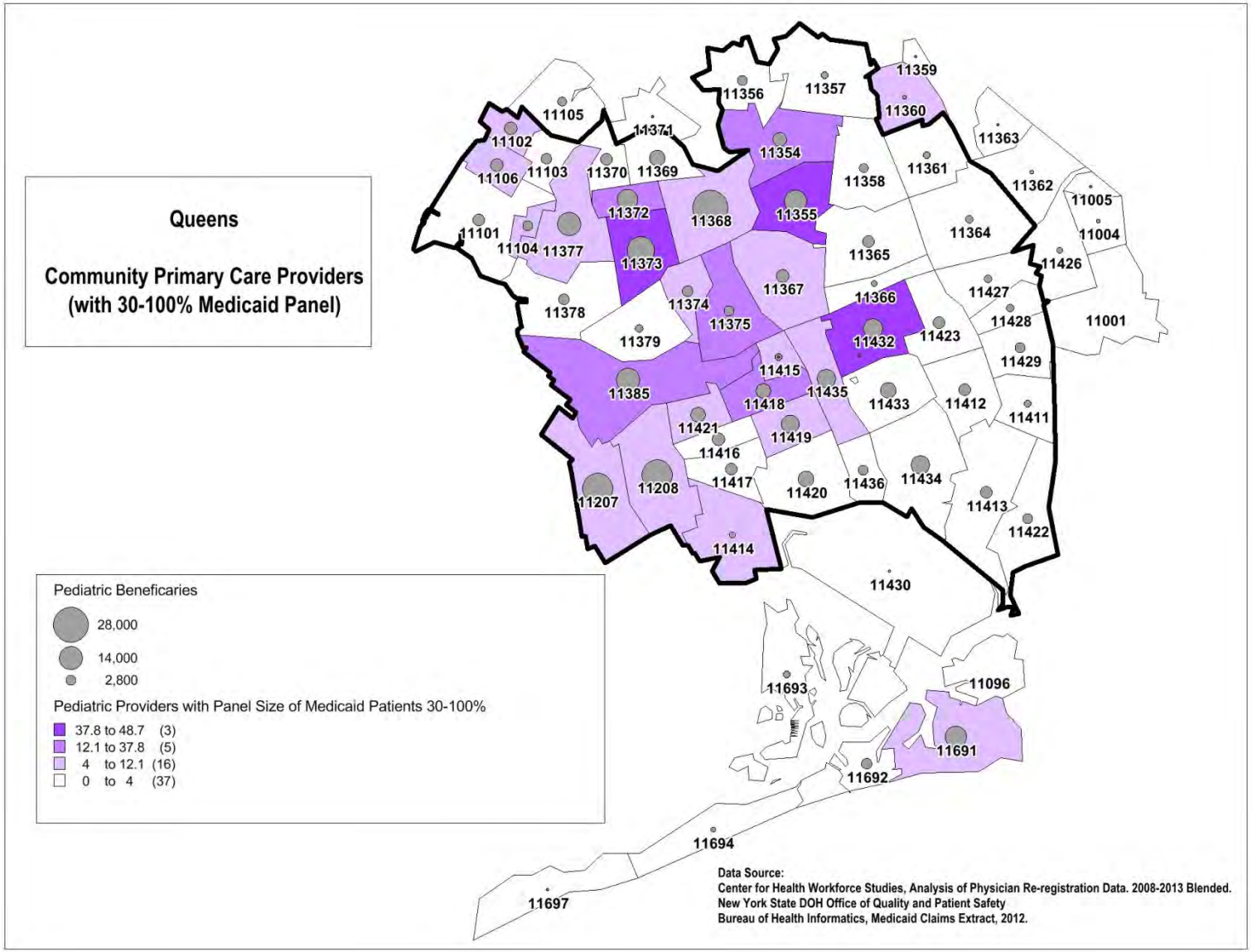
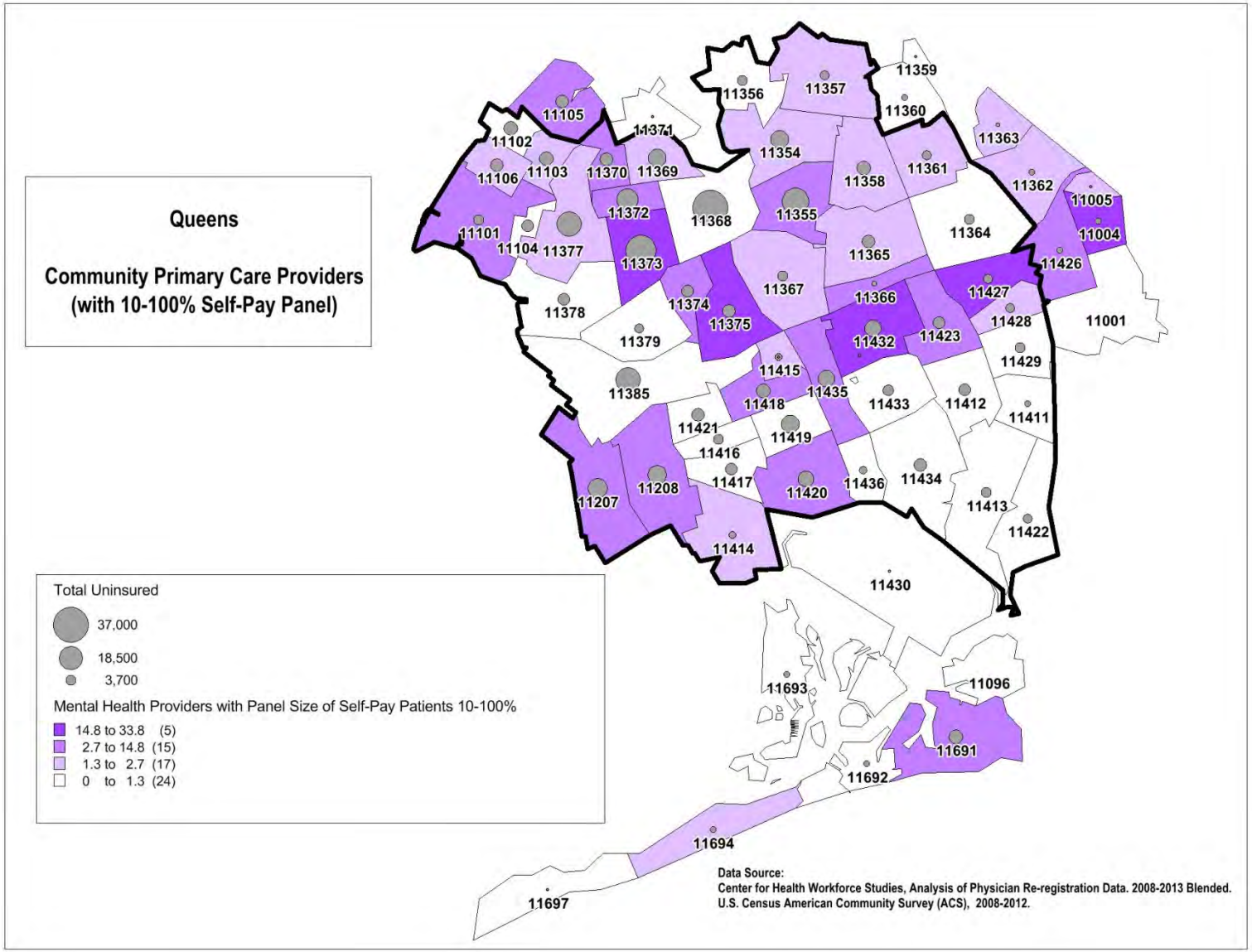


60. Mental Health Physicians reporting 10-100% of panel being Self-Pay payer patients and Uninsured population by Zip Code



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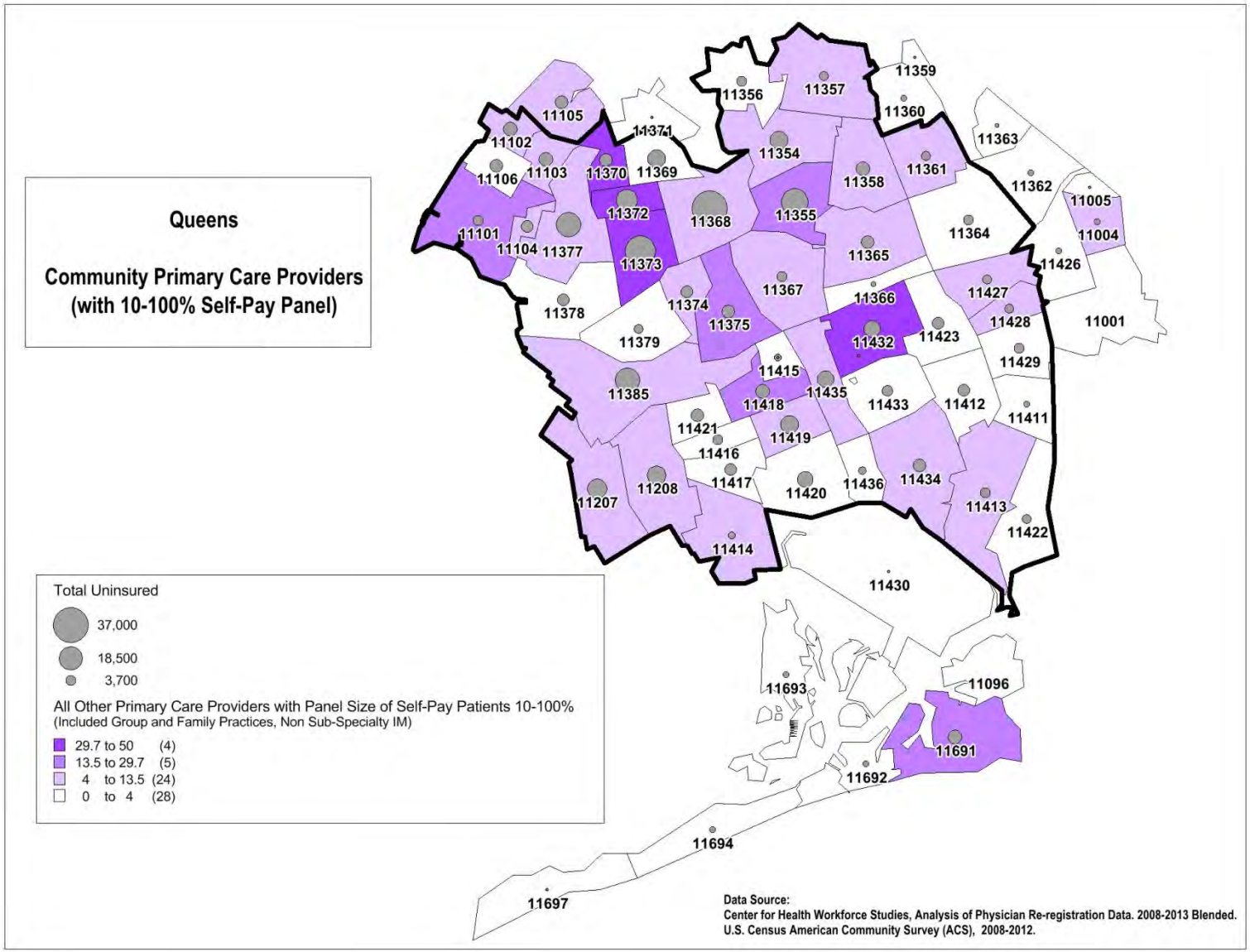
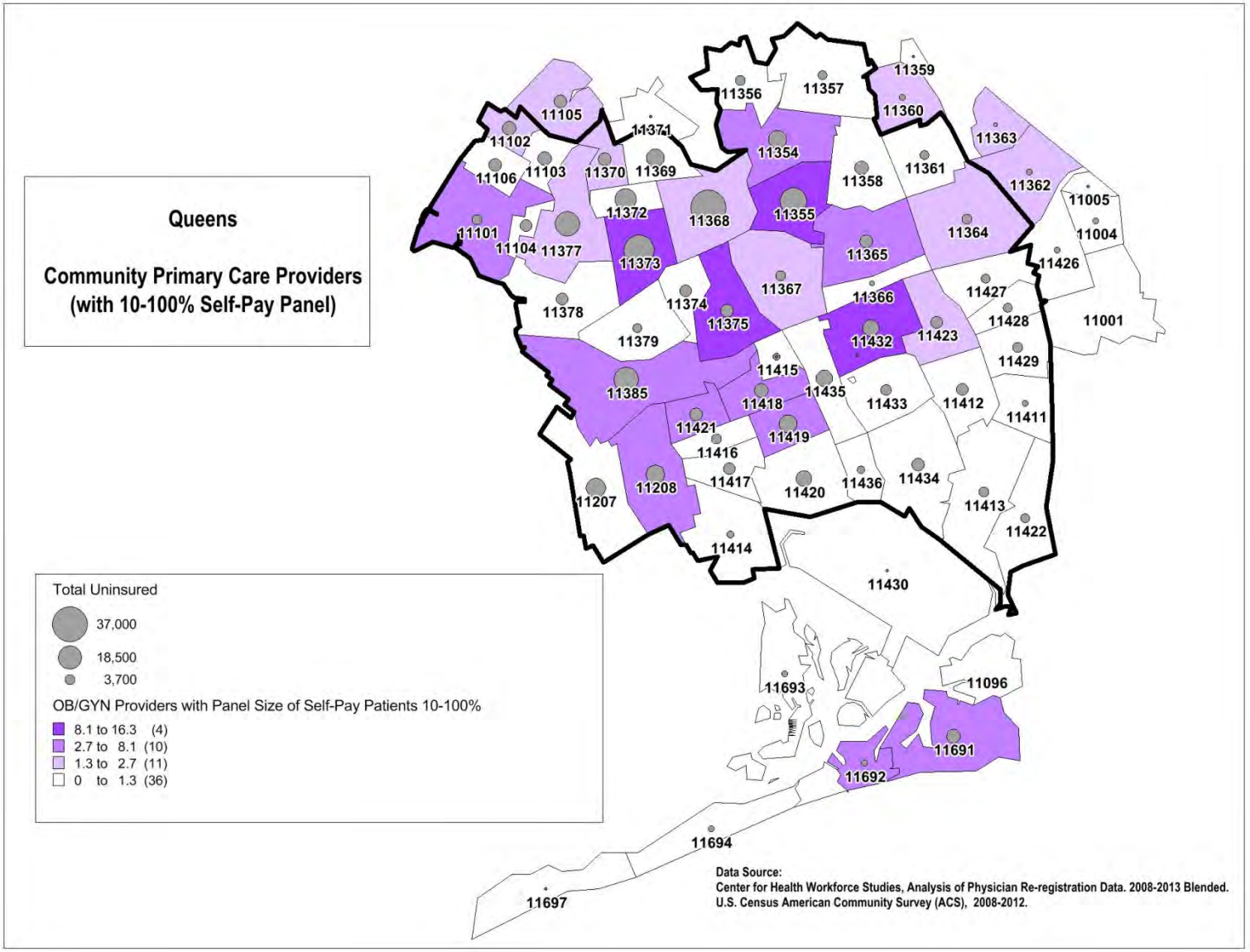
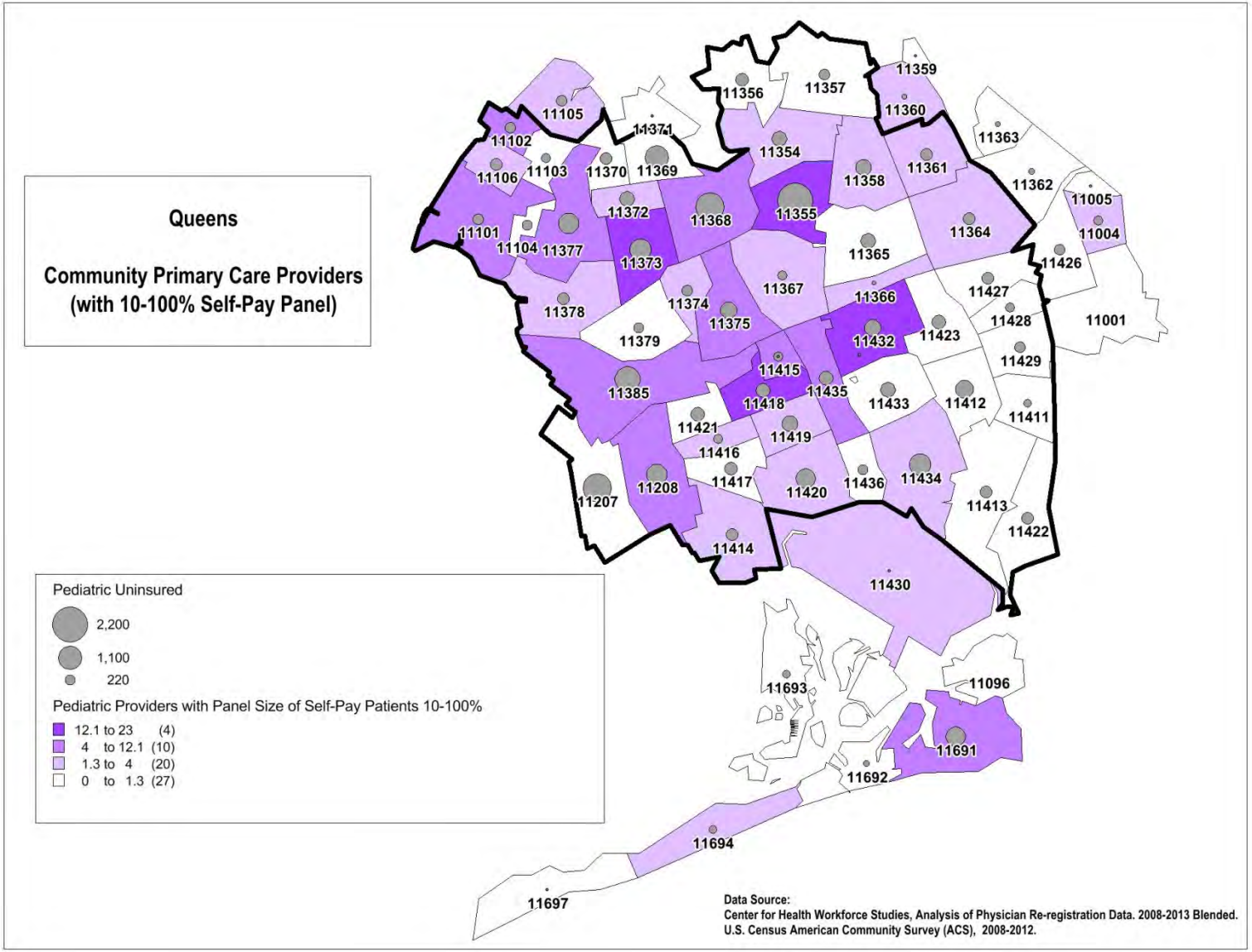


62. OB/GYN Physicians reporting 10-100% of panel being Self-Pay payer patients and Uninsured Population by Zip Code



63. Pediatric Physicians reporting 10-100% of panel being Self-Pay payer patients and Pediatric Uninsured Population by Zip Code



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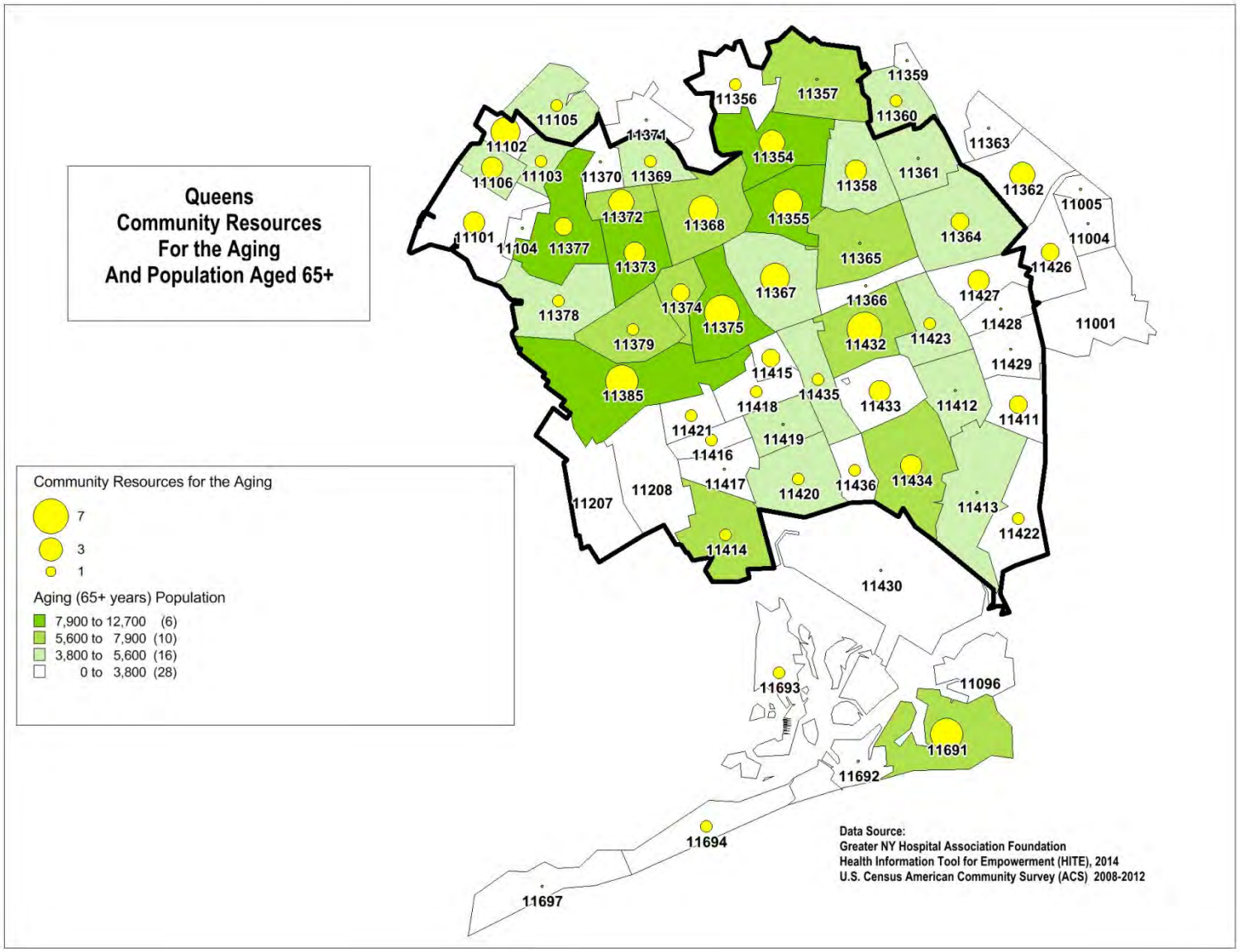

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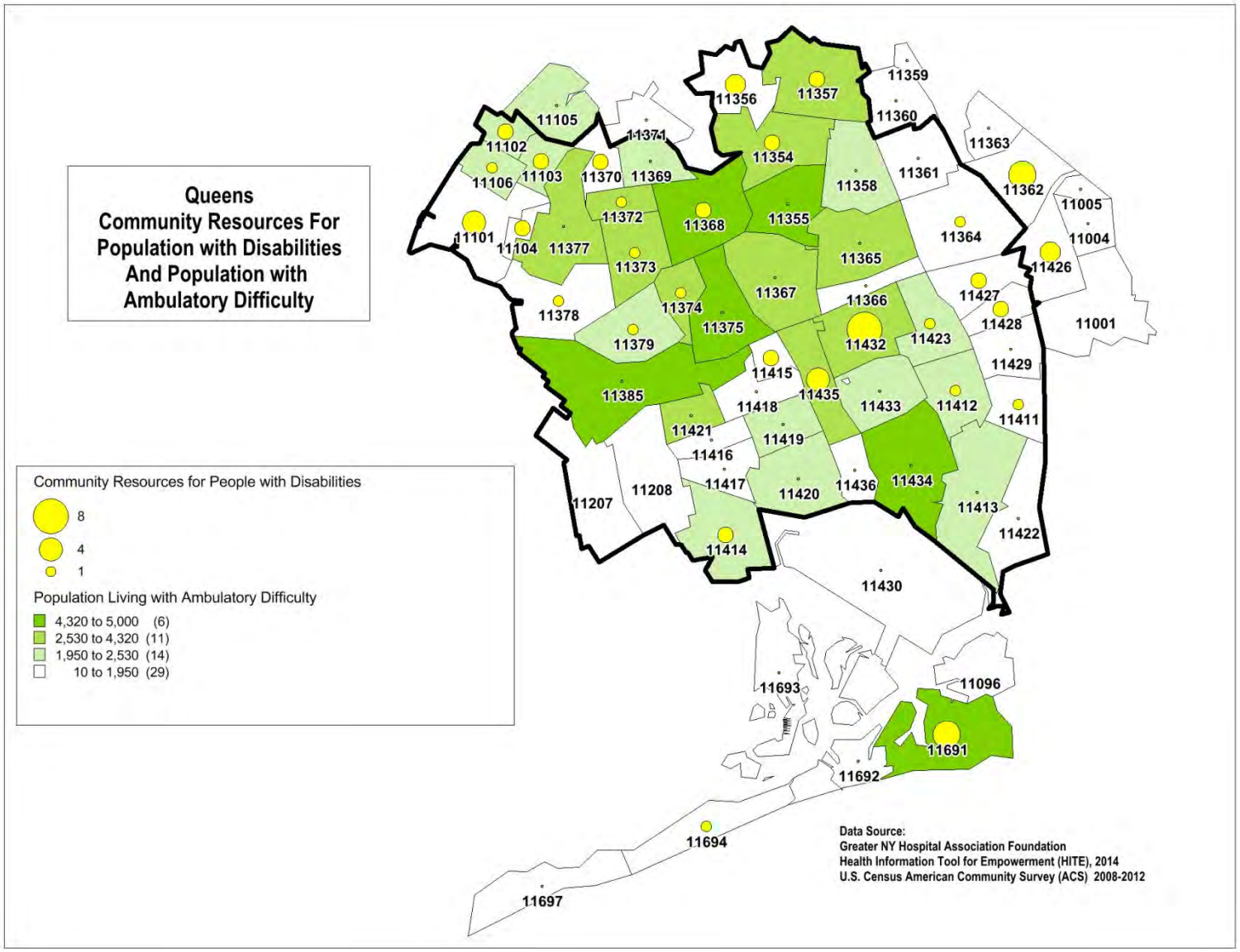

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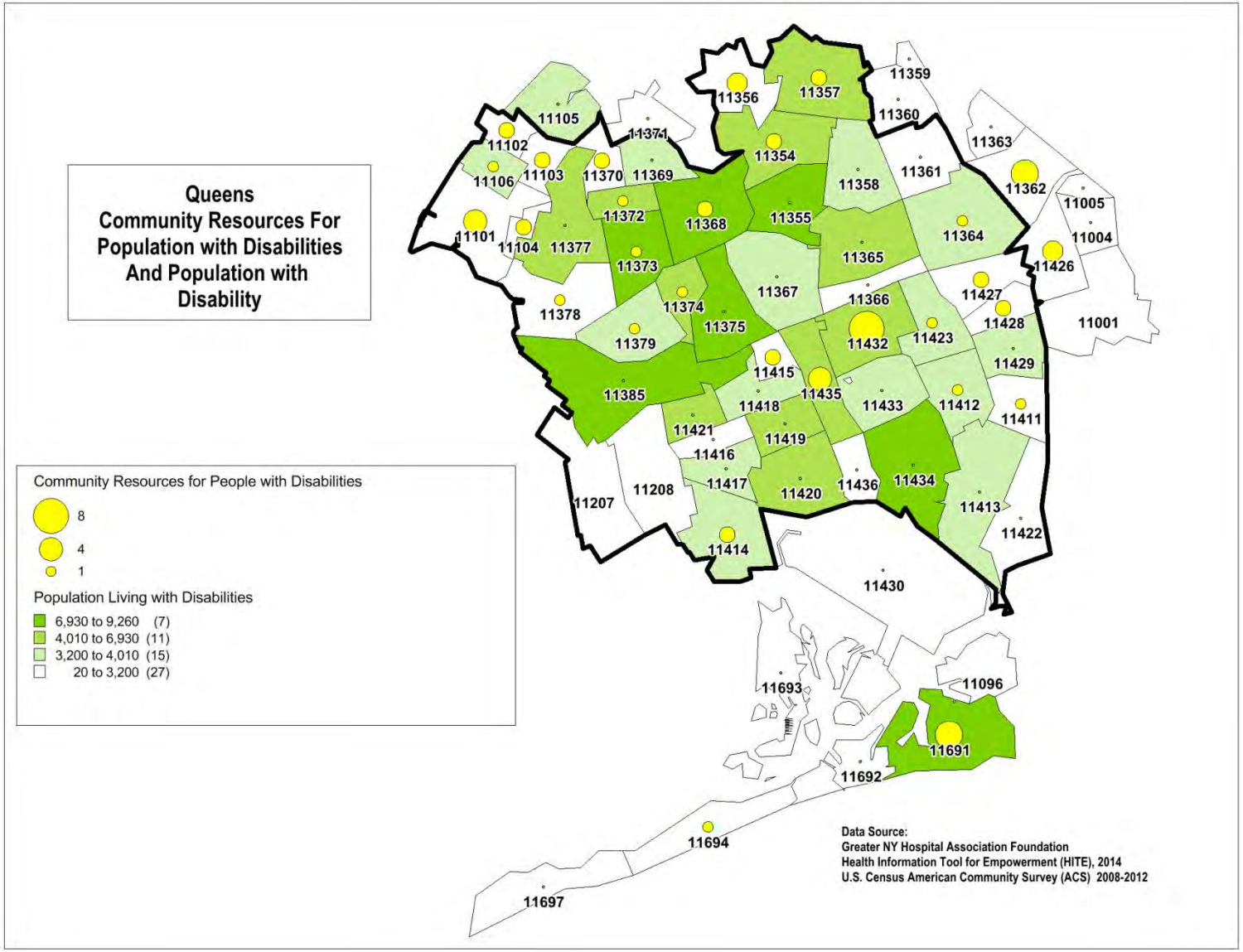

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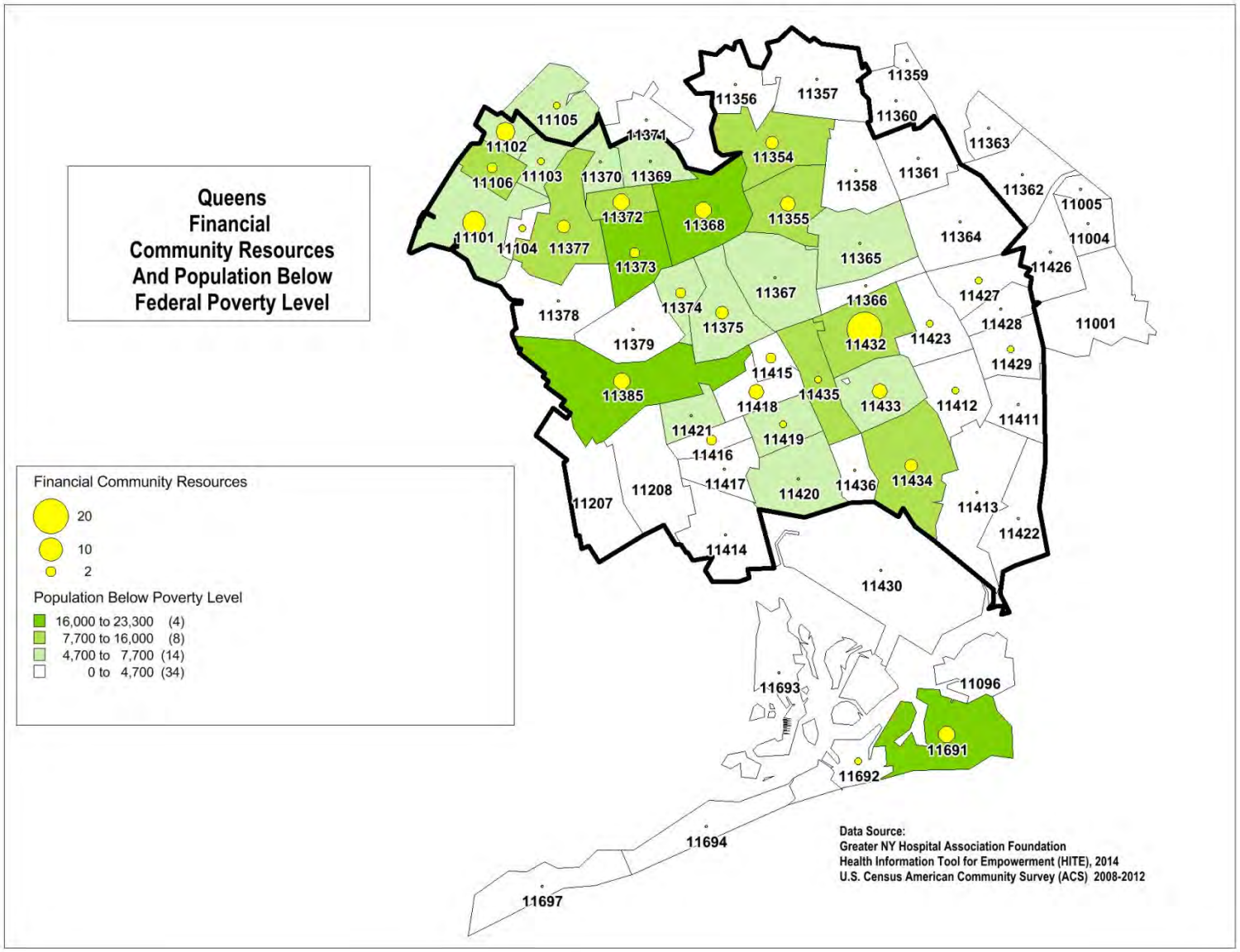

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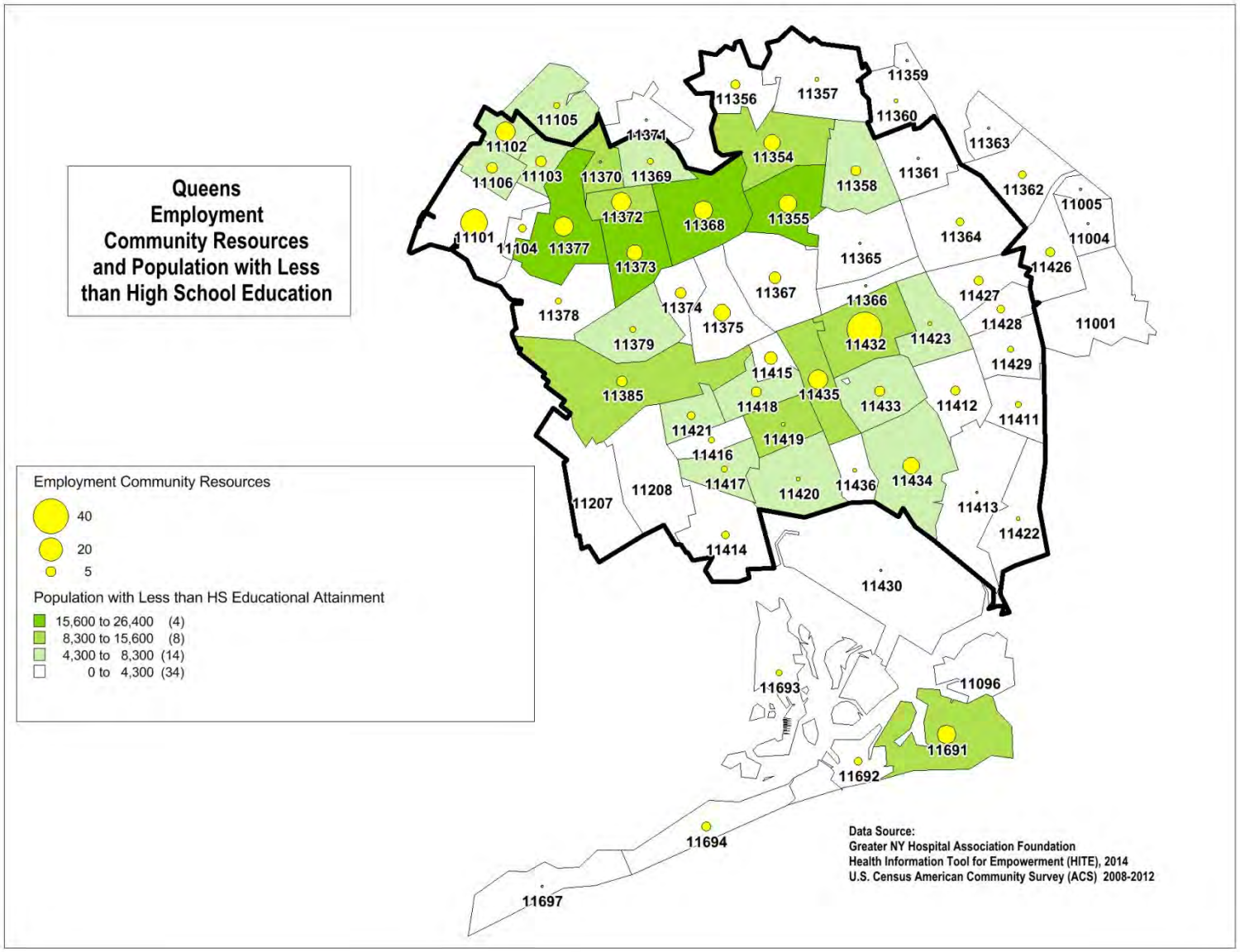

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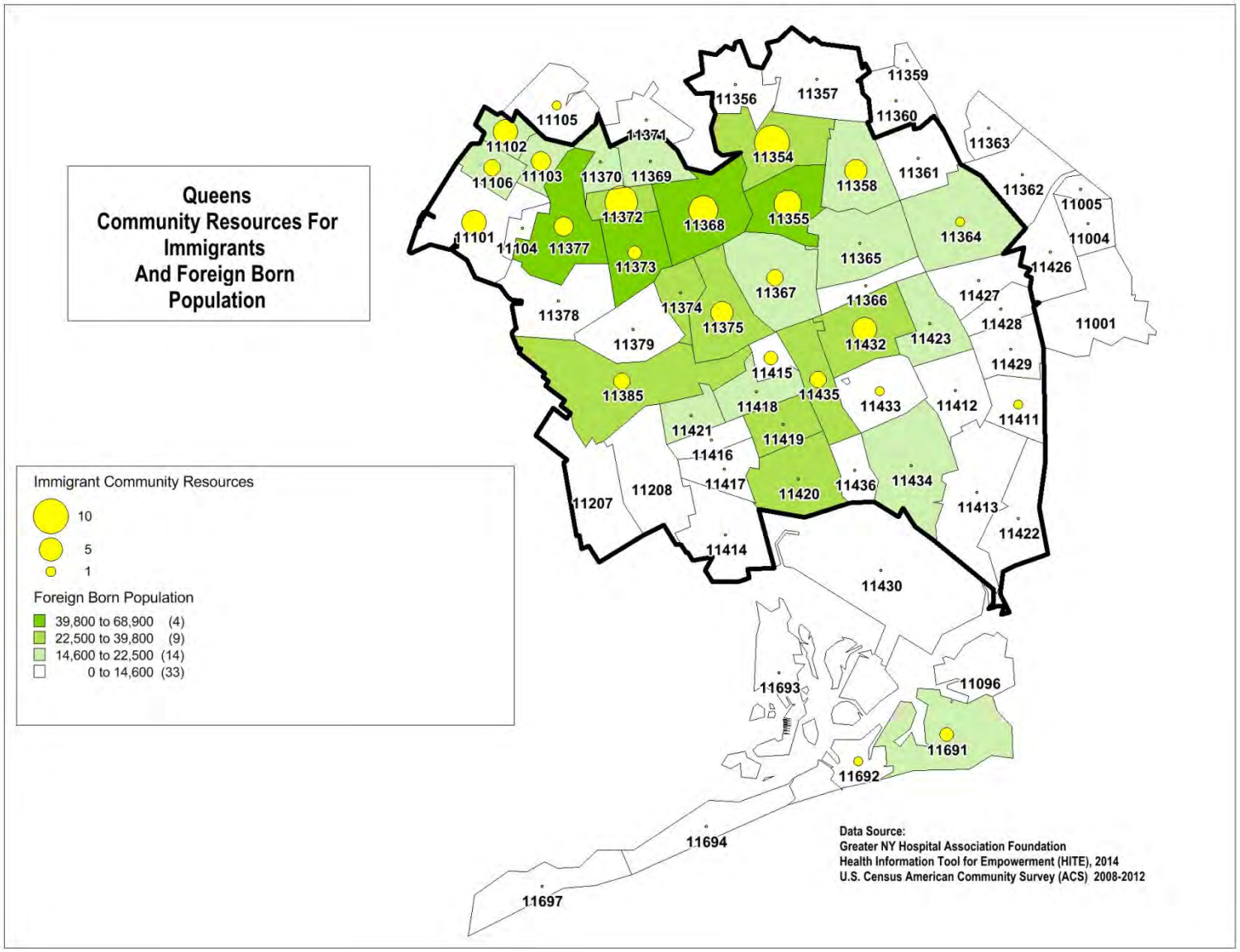

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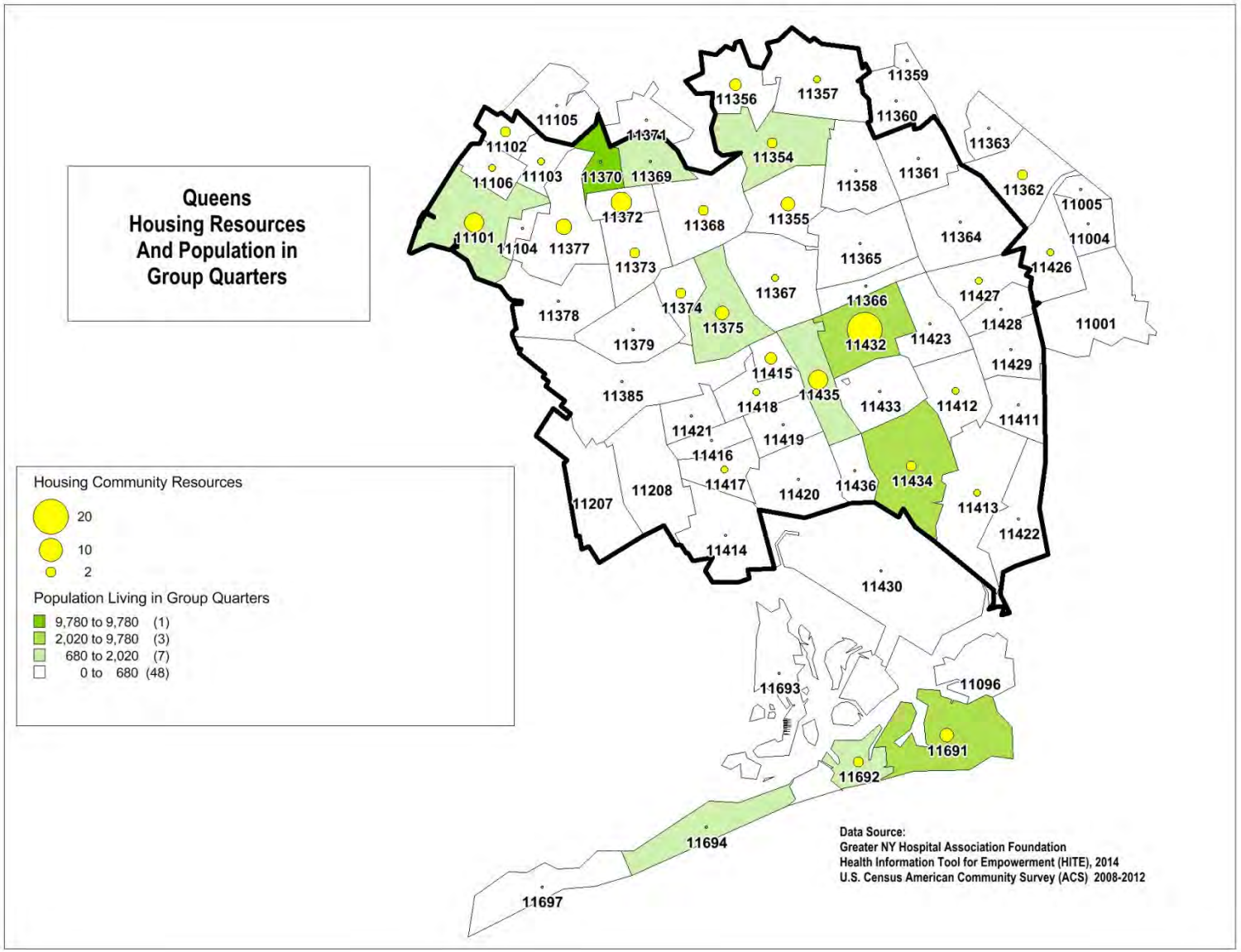

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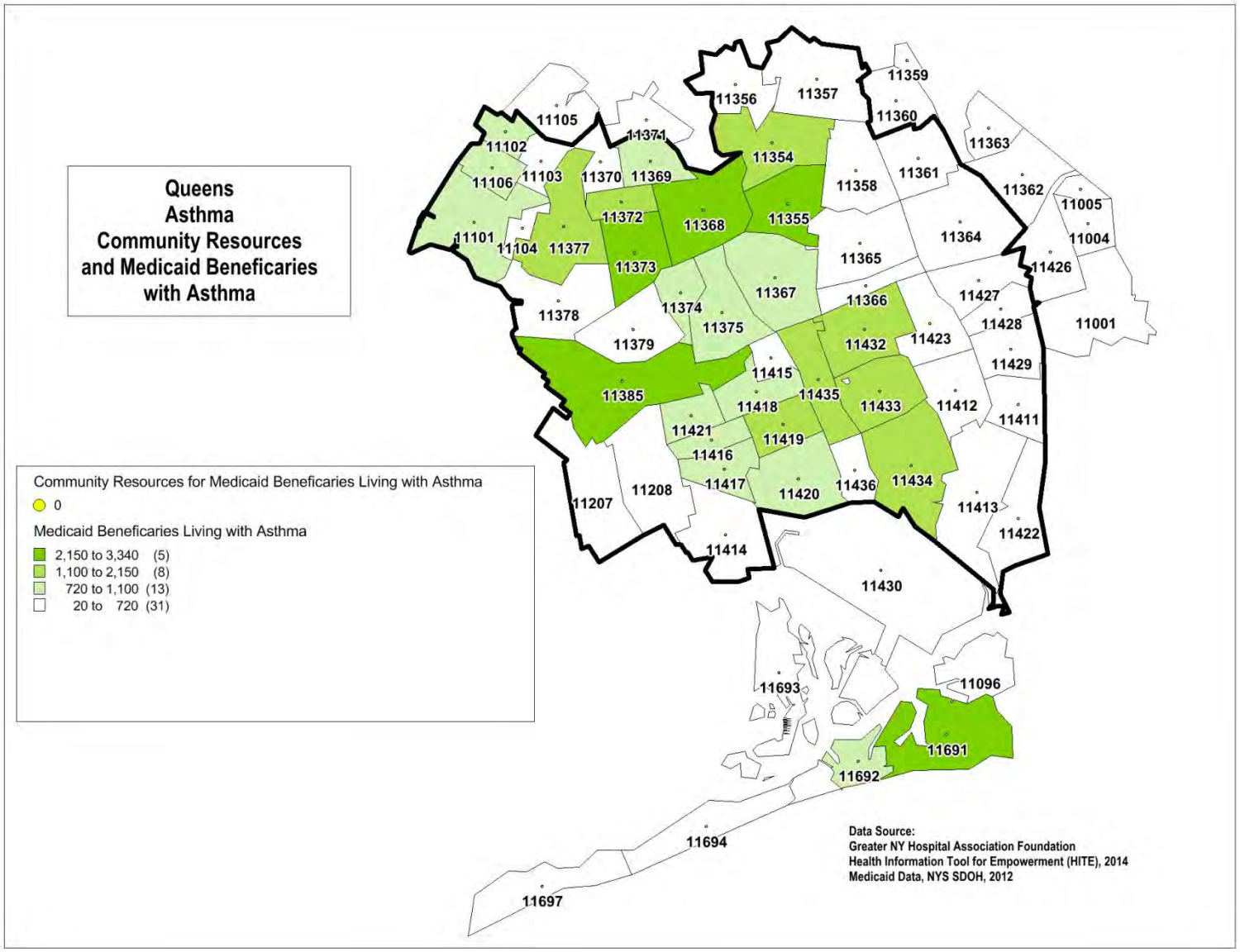

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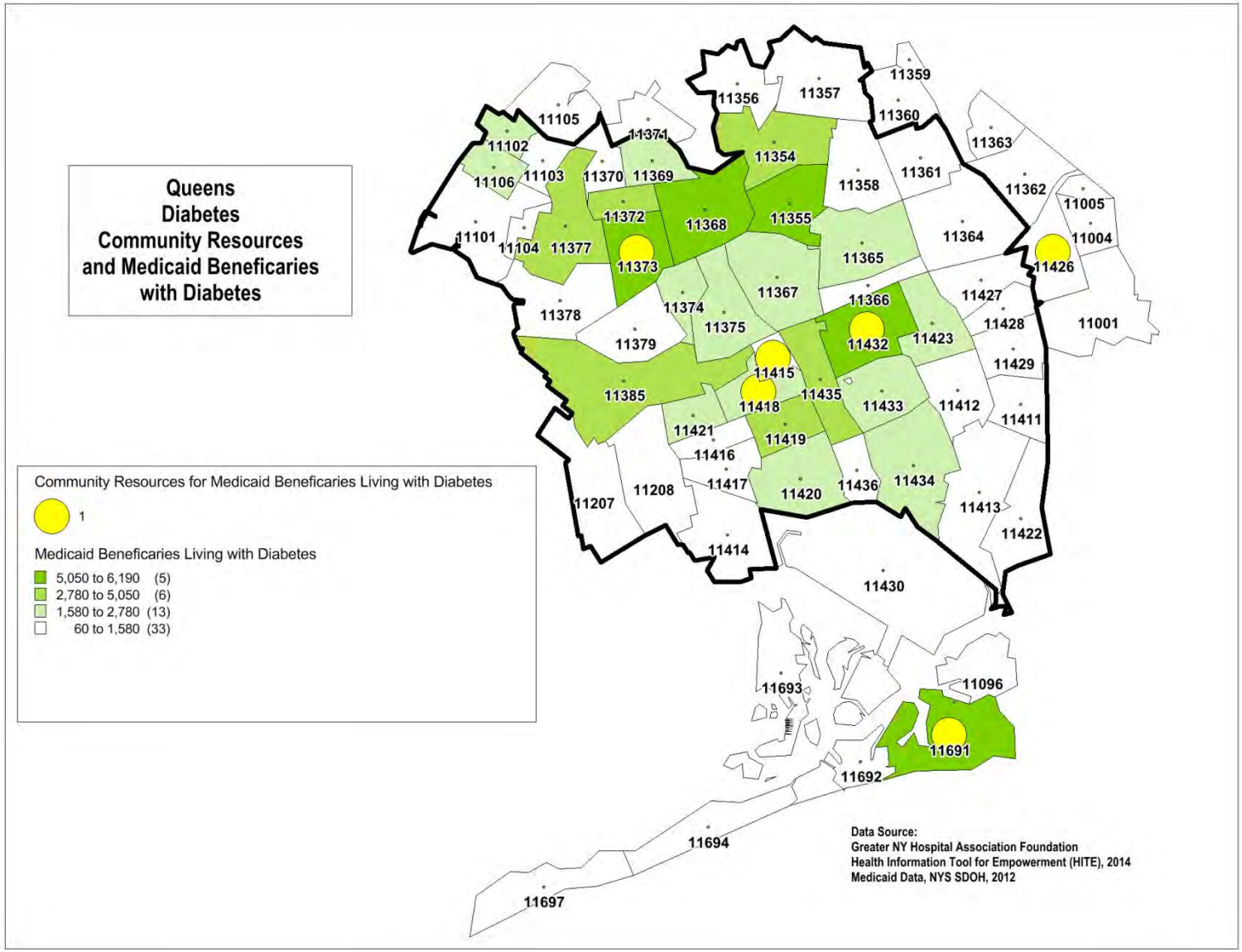

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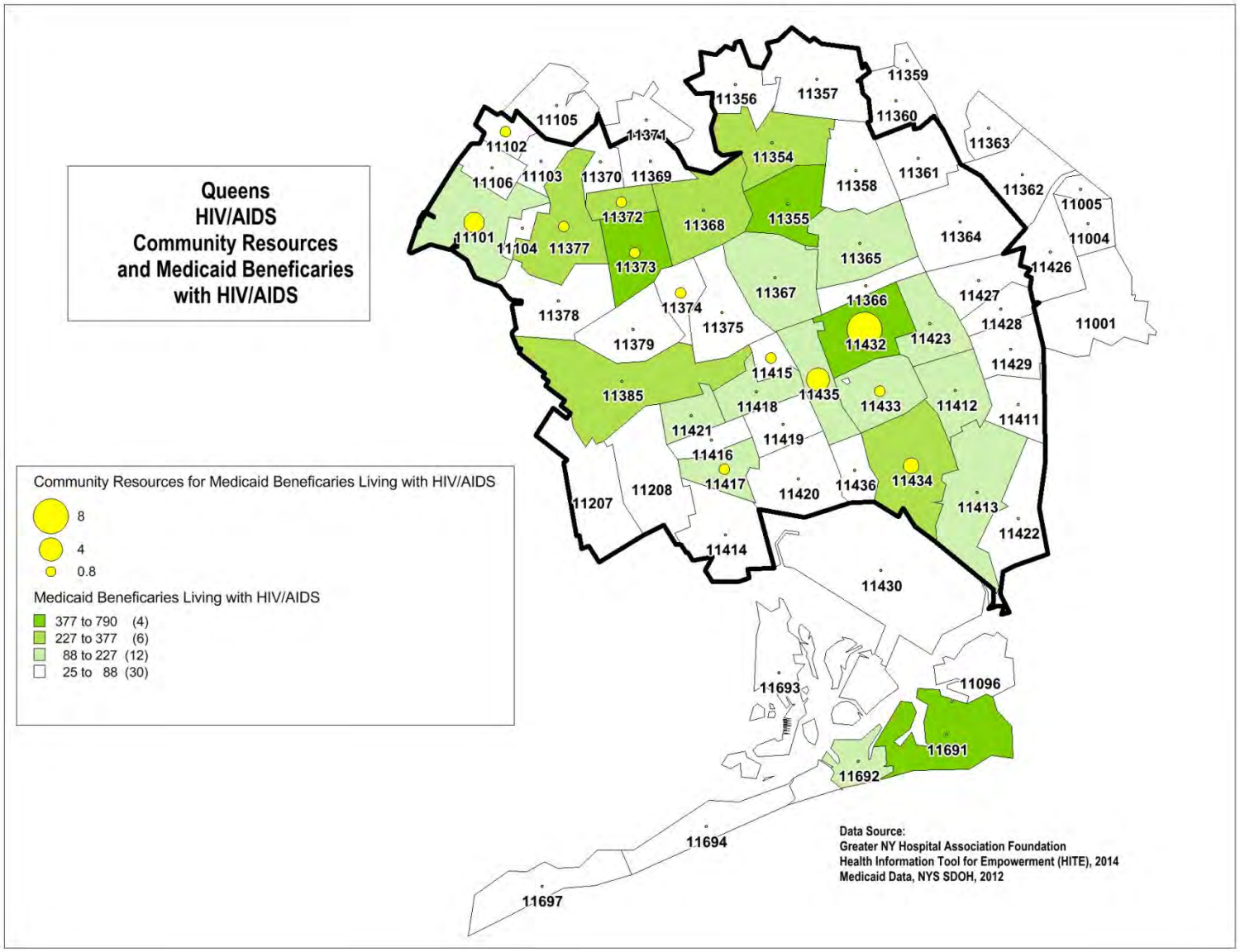

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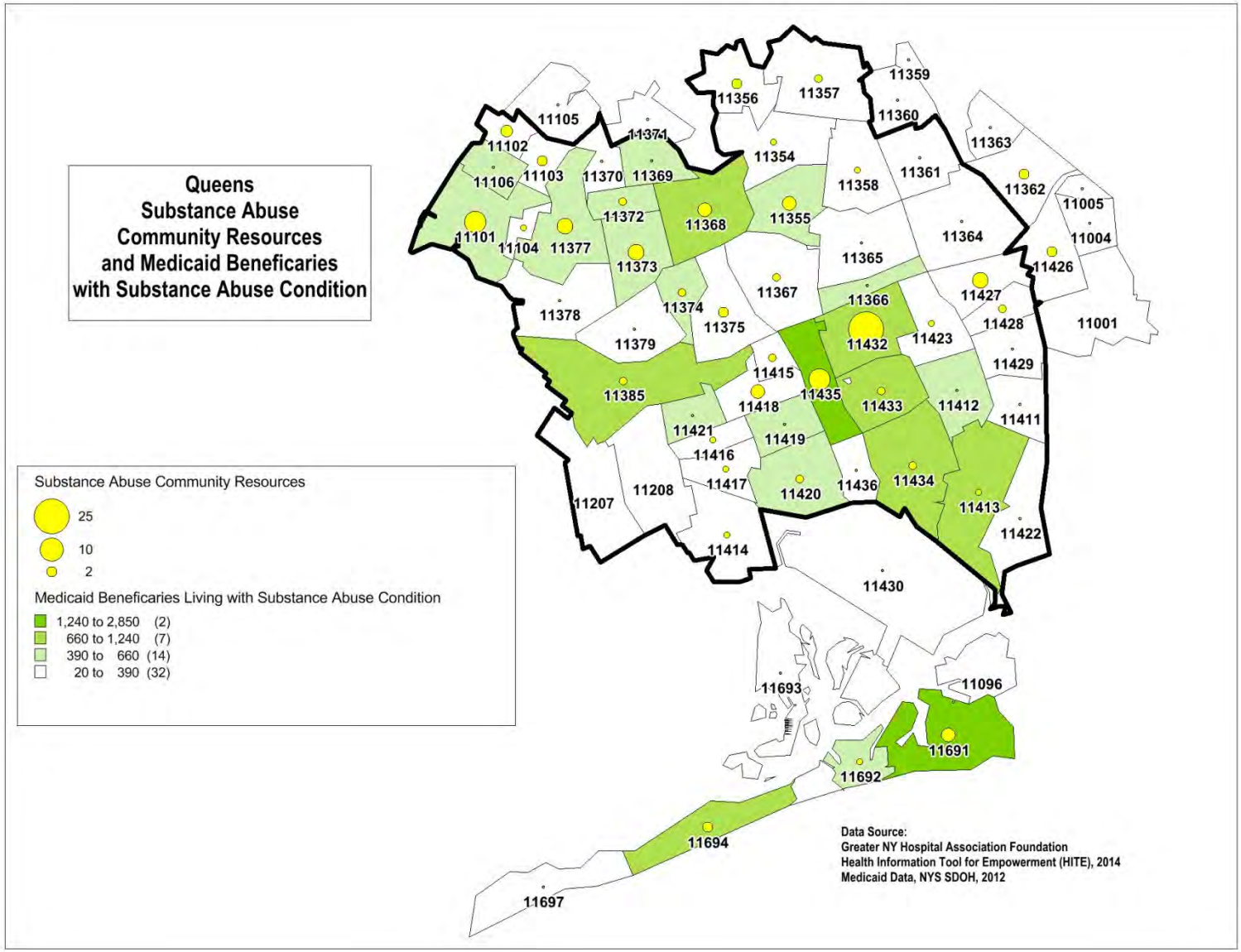

QUEENS COMMUNITY NEEDS ASSESSMENT
APPENDIX B - TABLES

December 16, 2014

New York City Health and Hospitals Corporation

Contents

SECTION A: TABLES WITHIN QUEENS CNA

Table 1. Queens Hospitals

Hospital Name	Hospital Type	Certified Beds	Occupancy Rate	Safety Net Payer Mix (Medicaid and Self-Pay)
Elmhurst Hospital	HHC	545	84%	66%
Queens Hospital	HHC	261	90%	67%
Flushing Hospital	Voluntary	293	84%	53%
Jamaica Hospital	Voluntary	424	75%	53%
Mt. Sinai Queens	Voluntary	192	82%	31%
Forest Hills Hospital	Voluntary	302	63%	30%
NY Queens Hospital	Voluntary	519	92%	32%
St. John's Episcopal	Voluntary	224	93%	49%
L.I. Jewish	Voluntary	983	80%	33%

Source: Hospital Institutional Cost Report 2012

Table 2. Queens Service Area Clinics (includes FQHCs, D&TCs, Hospital Based, and their Extension Sites), Medicaid Beneficiaries, and Uninsured Populations by Neighborhood

	Clinics	Medicaid Beneficiaries	Uninsured	Safety Net (Sum Medicaid and Uninsured)	Ratio of Clinics to Safety Net Population
West Queens	13	229,864	122,803	352,667	10.6
Bayside-Little Neck	1	15,741	7,311	23,052	13.7
Flushing-Clearview	7	114,149	48,068	162,217	14.6
Southwest Queens	7	118,100	46,120	164,220	15.2
Southeast Queens	3	50,703	19,418	70,121	15.4
Ridgewood-Forest Hills	9	76,645	35,403	112,048	25.4
Long Island City-Astoria	11	62,149	30,486	92,635	36.1
Fresh Meadows	6	34,868	11,065	45,933	54.2
Jamaica	32	134,200	44,132	178,332	72.5
East New York	20	117,543	26,339	143,882	75.9
Queens Service Area Total	109	953,962	391,145	1,345,107	27.9

Source: NYS Department of Health 2012

Table 3: 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, and is based on primary specialty. 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 4: 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 5: Early Intervention Program Providers

	Brooklyn	Bronx	Manhattan	Queens	Staten Island	NYC Total (Unique)
Number of Providers	71	65	65	72	50	97
Services:						
Service Coordination	39	39	39	42	27	56
Screening	34	35	34	36	29	48
Evaluation	49	49	48	53	36	69
Psychological Services	7	5	7	11	7	16
Family Education	32	21	26	31	21	41
Family Counseling	14	13	13	14	9	20
Speech Therapy	34	29	30	37	24	45
Occupational Therapy	35	30	30	37	21	48
Physical Therapy	36	30	31	37	22	49

Source: New York City Department of Health and Mental Hygiene Directory of New York City Early Intervention Providers, available at http://www.health.ny.gov/community/infants_children/early_intervention/, Accessed December 8, 2014.

Table 6: Eating Disorder Providers by Borough

	Brooklyn	Manhattan	Queens	Staten Island	Grand Total
Number of Providers	5	101	2	1	109

Source: National Eating Disorder Association (NEDA) Directory of Facilities and Treatment Providers, available at http://www.nationaleatingdisorders.org/find-treatment, Accessed December 5, 2014.

Table 7: Potentially Avoidable ER Visits, Admissions, and Re-Admissions, 2012

Measure Name	NYS	NYC	Queens	QSA
Potentially Avoidable Emergency Room Visits per 100 Medicaid beneficiaries	36	34	27	28
PQI Suite – Composite of All Measures: Adult, per 100,000 Medicaid Beneficiaries	1,784	1,822	1,482	1,579
Acute Conditions Composite (PQI 91), per 100,000 Medicaid Beneficiaries	530	525	474	503
Chronic Conditions Composite (PQI 92), per 100,000 Medicaid Beneficiaries	1,254	1,295	1,008	1,078
PDI Suite – Composite of All Measures: Pediatric, per 100,000 Recipients	323	383	235	245
Acute Conditions Composite (PDI 91), per 100,000 Medicaid Beneficiaries	75	87	79	77
Chronic Conditions Composite (PDI 92), per 100,000 Medicaid Beneficiaries	248	296	154	166

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH. Rates are risk-adjusted expected (controlling for race/ethnicity, gender, age and case mix)

Table 8: Total Population by Gender and Insurance Status

	Total Population	Uninsured			Medicaid			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%
Queens	2,233,483	17.6%	56.8%	43.2%	25.4%	44.9%	55.1%	57.0%	47.4%	52.6%

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 Distribution for Uninsured Population

	Total	Under 5	5 - 9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over
NYC	100%	1.5%	1.5%	2.0%	4.9%	14.6%	16.5%	13.3%	10.7%	9.3%	8.1%	6.7%	5.4%	3.9%	0.8%	0.3%	0.2%	0.1%	0.1%
NYC	100%	9.9%				55.1%				33.5%					1.5%				
Queens	100%	1.3%	1.3%	1.8%	4.5%	13.4%	15.5%	13.3%	11.0%	10.4%	8.6%	7.4%	5.7%	4.1%	0.9%	0.2%	0.2%	0.2%	0.1%
Queens	100%	8.9%				53.2%				36.3%					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: Age Distribution for Medicaid Beneficiaries

	Total	Under 5	5 - 9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over
NYC	100%	11.4%	10.1%	9.7%	9.3%	7.1%	5.4%	4.9%	4.7%	5.2%	5.6%	5.1%	4.5%	4.0%	3.2%	3.0%	2.5%	2.2%	2.3%
NYC	100%	40.4%				22.1%				24.4%					13.1%				
Queens	100%	16.6%	14.9%	14.2%	13.1%	9.5%	7.0%	6.7%	7.1%	7.8%	8.2%	7.5%	6.6%	5.6%	4.7%	4.2%	3.4%	3.0%	3.6%
Queens	100%	58.9%				30.2%				35.8%					18.9%				

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

Table 11: Age Distribution for Population with Other Insurance

	Total	Under 5	5 - 9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 and over
NYC	100%	5.1%	4.5%	4.7%	5.2%	6.4%	8.9%	8.5%	7.5%	7.5%	7.3%	7.3%	6.7%	5.9%	4.7%	3.4%	2.6%	1.9%	1.8%
NYC	100%	19.5%				31.4%				34.6%					14.5%				
Queens	100%	5.0%	4.6%	4.8%	5.1%	5.6%	7.6%	7.8%	7.2%	7.4%	7.7%	7.8%	7.2%	6.1%	5.0%	3.8%	3.0%	2.3%	2.2%
Queens	100%	19.5%				28.1%				36.1%					16.3%				

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

Table 12. Educational Attainment for Population with No Health Insurance

Region	No Health Insurance Coverage			
	% Less than HS diploma	% HS diploma or equivalent	% Some college/ Associate's	% Bachelor's degree or higher
New York City	30%	29%	20%	21%
Queens	28%	30%	21%	21%

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

Table 13. Educational Attainment for Population With Medicaid/Low Income Medical Assistance

Region	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%
Queens	35%	30%	20%	15%

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 Other Insurance

Region	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%
Queens	13%	26%	24%	37%

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

Table 15 - Percentage of Renter Households with 1.5 Occupants per room or more

	Percent of Renter Households with 1.5 Occupants or More per Room				
Region	**2005**	**2006**	**2007**	**2008**	**2009**
New York City	3.01	3.41	3.17	4.67	4.04
Queens	3.70	4.10	3.83	5.69	4.42
Astoria	3.68	2.85	3.53	3.10	2.96
Bayside/Little Neck	2.17	2.76	0.89	2.06	0.42
Elmhurst/Corona	7.09	8.13	7.45	13.19	10.74
Flushing/Whitestone	3.98	3.98	4.11	4.78	4.25
Hillcrest/Fresh Meadows	2.24	3.46	6.50	3.77	2.21
Jackson Heights	8.57	7.20	9.33	12.52	9.68
Jamaica	5.15	4.13	3.70	5.15	3.81
Middle Village/Ridgewood	1.30	1.10	1.04	1.97	3.76
Ozone Park/Woodhaven	3.26	2.39	2.66	2.93	3.29
Queens Village	0.36	1.38	1.25	0.99	1.85
Rego Park/Forest Hills	2.45	2.74	0.98	2.25	3.77
Rockaways	2.55	6.04	1.04	9.80	2.17
South Ozone Park/Howard Beach	0.94	1.59	2.31	3.46	0.56
Sunnyside/Woodside	2.15	6.66	4.35	8.28	6.13
East New York/Starrett City	0.86	2.30	0.81	6.26	4.64

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

Table 16 - Serious Housing Violations by Community District, 2008

Community District	**Serious Housing Violations per 1,000 Rental Units**
New York City	53.79
QN01: Astoria	11.10
QN02: Woodside/Sunnyside	21.25
QN03: Jackson Heights	33.60
QN04: Elmhurst/Corona	16.09
QN05: Ridgewood/Maspeth	22.78
QN06: Rego Park/Forest Hills	7.68
QN07: Flushing/Whitestone	11.79
QN08: Hillcrest/Fresh Meadows	11.57
QN09: Kew Gardens/Woodhaven	26.45
QN10: South Ozone Park/Howard Beach	33.61
QN11: Bayside/Little Neck	5.95
QN12: Jamaica/Hollis	51.34
BK05: East New York/Starrett City	101.10

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

Table 17: Service Availability as Reported by Survey Respondents

	(N=605)
Accessible transportation	86.9%
Affordable housing	34.1%
Dental services	71.2%
Healthy food	76.2%
Home health care	66.4%
Job training	38.4%
Medical specialists	72.4%
Mental health services	54.6%
Pediatric and adolescent services	73.4%
Places to exercise, walk, and play	79.1%
Primary care medicine	79.8%
Social services	67.3%
Substance abuse services	39.1%
Vision services	69.4%

*Percentage reflects participants who responded very available or available

Source: CNA Survey. 2014.

Table 18. Nativity By Insurance Status By PUMA Neighborhood

Region	No Health Insurance Coverage		Population with Medicaid/Low Income Medical Assistance		Other Insurance	
	% Foreign Born	% Native	% Foreign Born	% Native	% Foreign Born	% Native
New York City	62%	38%	35%	65%	32%	68%
Queens	72%	28%	45%	55%	41%	59%
Astoria & Long Island City	60%	40%	42%	58%	37%	63%
Jackson Heights & North Corona	87%	13%	48%	52%	57%	43%
Flushing, Murray Hill & Whitestone	81%	19%	60%	40%	44%	56%

Region	No Health Insurance Coverage		Population with Medicaid/Low Income Medical Assistance		Other Insurance	
	% Foreign Born	% Native	% Foreign Born	% Native	% Foreign Born	% Native
Bayside, Douglaston & Little Neck	67%	33%	50%	50%	37%	63%
Queens Village, Cambria Heights & Rosedale	58%	42%	35%	65%	40%	60%
Briarwood, Fresh Meadows & Hillcrest	71%	29%	47%	53%	42%	58%
Elmhurst & South Corona	86%	14%	53%	47%	62%	38%
Forest Hills & Rego Park	68%	32%	58%	42%	46%	54%
Sunnyside & Woodside	77%	23%	56%	44%	50%	50%
Ridgewood, Glendale & Middle Village	60%	40%	34%	66%	31%	69%
Richmond Hill & Woodhaven	73%	27%	47%	53%	45%	55%
Jamaica, Hollis & St. Albans	63%	37%	35%	65%	39%	61%
Howard Beach & Ozone Park	68%	32%	49%	51%	39%	61%
Far Rockaway, Breezy Point & Broad Channel	52%	48%	23%	77%	23%	77%
East New York & Starrett City	58%	42%	27%	73%	32%	68%

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

Table 19: Limited English Proficiency by Insurance Status

	No Health Insurance	Medicaid	Other Insurance
NYC	40%	29%	14%
Queens	47%	31%	18%

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

Table 20: Language Spoken at Home by Insurance Status

Uninsured					Medicaid Beneficiaries				
	NYC		Queens			NYC		Queens	
	Total	Percent	Total	Percent		Total	Percent	Total	Percent
Spanish	299,759	64%	104,469	57%	Spanish	355,732	52%	63,550	36%
Chinese	36,616	8%	13,958	8%	Chinese	67,666	10%	19,737	11%
Korean	17,497	4%	11,793	6%	Russian	48,401	7%	4,773	3%
Mandarin	15,807	3%	6,376	3%	Cantonese	30,822	5%		
Russian	12,272	3%	1,182	1%	Bengali	24,008	4%	10,928	6%
Polish	7,923	2%	1,978	1%	Mandarin	21,487	3%	5,843	3%
French Creole	7,811	2%	1,067	1%	Yiddish	18,246	3%		
Bengali	7,219	2%			French Creole	16,225	2%	2,139	1%
Cantonese	7,137	2%			Korean	10,998	2%	6,293	4%
Arabic	5,771	1%			Arabic	10,446	2%		
French	5,256	1%			Urdu	8,764	1%		

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

Table 21. Top Places of Birth Among Foreign Born With No Health Insurance

PUMA Name	No Health Insurance Coverage												
	Total	Mexico	Dominican Republic	China	Ecuador	Jamaica	Guyana	Korea	Trinidad & Tobago	Colombia	India	El Salvador	Bangladesh
New York City	**724,452**	**131,000**	**74,765**	**60,385**	**56,982**	**32,639**	**25,737**	**23,941**	**20,659**	**17,511**	**15,482**	**13,230**	**11,487**
Queens	**284,315**	**39,103**	**10,360**	**27,947**	**34,350**	**7,831**	**15,958**	**18,254**	**6,788**	**14,331**	**12,911**	**7,242**	**7,450**
Astoria & Long Island City	19,874	4,655	578	586	2,285	16	310	942	7	660	328	297	571
Jackson Heights & North Corona	47,885	15,763	2,662	1,213	13,357	168	132	378	164	3,668	1,660	1,162	990
Flushing, Murray Hill & Whitestone	38,540	1,103	342	16,093	988	16	193	8,727	-	1,721	1,160	1,751	370
Bayside, Douglaston & Little Neck	9,640	280	96	1,400	384	-	1	4,206	-	89	189	215	-
Queens Village, Cambria Heights &	13,933	106	179	124	434	2,866	2,011	63	660	283	1,875	177	368
Briarwood, Fresh Meadows & Hillcrest	13,713	602	539	1,495	264	88	1,040	1,061	391	500	932	208	967
Elmhurst & South Corona	32,748	8,529	1,310	3,076	6,817	82	52	692	59	3,087	887	312	535
Forest Hills & Rego Park	8,478	102	16	770	164	14	16	444	24	595	882	13	60
Sunnyside & Woodside	22,335	3,009	374	1,508	2,833	30	108	1,595	-	1,661	971	80	1,037
Ridgewood, Glendale & Middle Village	16,911	1,579	1,116	824	3,569	-	130	41	79	650	146	279	105
Richmond Hill & Woodhaven	18,379	1,491	1,290	491	1,758	93	2,777	14	1,094	868	2,533	252	643
Jamaica, Hollis & St. Albans	20,839	684	723	267	934	3,687	3,793	7	1,542	407	344	1,082	1,469
Howard Beach & Ozone Park	14,438	1,107	869	12	473	363	4,888	84	2,559	112	977	490	324
Far Rockaway, Breezy Point & Broad Channel	6,602	93	266	88	90	408	507	-	209	30	27	924	11

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

Table 22. Top Places of Birth Among Foreign Born with Medicaid/Low Income Medical Assistance

PUMA Name	Population with Medicaid/Low Income Medical Assistance														
	Total	Dominican Republic	China	Jamaica	Mexico	Ecuador	Guyana	Haiti	Bangladesh	Trinidad & Tobago	Colombia	India	Korea	Pakistan	Philippines
New York	**1,280,549**	**223,746**	**152,43**	**62,456**	**54,940**	**54,338**	**54,137**	**41,369**	**40,962**	**32,125**	**29,990**	**28,705**	**24,217**	**21,156**	**16,828**
Queens	**416,706**	**27,182**	**53,61**	**15,234**	**15,64**	**27,733**	**30,35**	**9,553**	**24,542**	**9,919**	**22,062**	**20,72**	**17,843**	**9,220**	**9,131**
Astoria & Long Island	26,032	1,851	923	137	1,711	2,257	256	19	1,702	88	1,508	907	703	779	307
Jackson Heights &	45,300	6,558	3,424	344	5,142	7,925	438	294	2,840	178	5,566	1,633	397	1,648	456
Flushing, Murray Hill	58,597	1,328	24,14 6	288	742	934	155	171	709	105	2,484	2,253	8,370	744	619
Bayside, Douglaston & Little Neck	17,147	171	4,221	-	197	116	8	40	28	192	519	493	4,440	298	34
Queens Village, Cambria Heights &	25,775	502	348	5,312	84	479	2,328	4,376	674	1,102	407	4,126	92	629	712
Briarwood, Fresh Meadows & Hillcrest	28,020	1,000	4,053	292	401	600	943	653	3,707	506	1,063	2,152	1,376	1,391	1,327
Elmhurst & South Corona	37,869	3,724	6,791	146	3,045	5,128	303	350	2,484	259	3,287	1,431	674	494	1,529
Forest Hills & Rego Park	17,837	80	2,061	65	194	453	185	47	560	46	980	1,095	195	27	353
Sunnyside & Woodside	29,683	825	3,401	46	1,585	2,304	32	115	4,146	58	2,057	1,383	1,336	605	1,514
Ridgewood, Glendale & Middle	22,304	2,335	1,658	34	623	2,460	60	15	16	136	919	331	101	242	571
Richmond Hill &	32,992	3,652	1,524	51	867	2,551	6,713	146	2,717	1,214	2,019	2,954	71	1,344	770

PUMA Name	Population with Medicaid/Low Income Medical Assistance														
	Total	Dominican Republic	China	Jamaica	Mexico	Ecuador	Guyana	Haiti	Bangladesh	Trinidad & Tobago	Colombia	India	Korea	Pakistan	Philippines
Jamaica, Hollis & St. Albans	38,282	2,088	362	7,392	386	1,242	7,533	2,745	3,579	2,714	699	591	53	285	540
Howard Beach & Ozone Park	24,597	1,629	372	260	572	1,096	10,586	196	1,241	2,884	461	1,222	2	734	215
Far Rockaway, Breezy Point & Broad Channel	12,271	1,439	333	867	96	188	812	386	139	437	93	158	33	-	184

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

Table 23: 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 24: Leading Causes of Death, Queens, 2012

Rank		Total Reported	Percent of Total%
	QUEENS		
1	Diseases of Heart	4,192	34.4%
2	Malignant Neoplasms	2,963	24.3%
3	Influenza (Flu) and Pneumonia	534	4.4%
4	Cerebrovascular Disease	449	3.7%
5	Diabetes Mellitus	399	3.3%
6	Chronic Lower Respiratory Diseases	389	3.2%
7	Accidents Except Drug Poisoning	236	1.9%
8	Essential Hypertension and Renal Diseases	203	1.7%
9	Alzheimer's Disease	161	1.3%
10	Intentional Self-Harm	143	1.2%
	All Other Causes	2,515	20.6%
	Total	12,184	100%

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

Table 25: 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 26: 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 27: 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 28: 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 the 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
Drowning	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 29. 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 30. 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%

	NYC		Manhattan		Bronx		Brooklyn		Queens	
	2010	2013	2010	2013	2010	2013	2010	2013	2010	2013
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%

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

Table 31. ED visits by top 20 primary diagnoses, 2010 and 2013

	NYC		Manhattan		Bronx		Brooklyn		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%
Complic. 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 32 - Potentially Preventable ER Visits (PPV)

	NYS	NYC	Queens	Queens service area
Observed/Risk-Adjusted Expected Rate ratio	1.00	0.94	0.85	0.87

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

Table 33 - Potentially Preventable ED Visits (PPV), Medicaid Beneficiaries, UHF Neighborhood, 2012

UHF Neighborhood	PPV Observed Events	Observed Rate per 100 Beneficiaries	Risk-Adjusted Expected Rate per 100 Beneficiaries	Observed/ Risk Adjusted Expected Rate Ratio
East New York	47,135	39.96	35.48	1.13
*Rockaway	18,535	35.27	32.69	1.08
Southeast Queens	15,473	27.38	26.26	1.04
Jamaica	45,601	33.92	33.77	1.00
Long Island City/Astoria	21,041	29.28	32.01	0.91
Ridgewood/Forest Hills	17,730	23.12	25.31	0.91
West Queens	68,268	29.69	33.74	0.88
Southwest Queens	32,531	26.85	30.95	0.87
Fresh Meadows	7,591	21.77	29.29	0.74
Bayside/Little Neck	2,236	11.22	18.77	0.60
Flushing/Clearview	17,334	14.83	25.46	0.58

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

Table 34: Potentially Preventable Readmissions, Queens Hospitals

Facility Name	At Risk Admissions	Observed PPR Chains	Observed PPR Rate	Risk Adjusted Expected PPR Chains	Risk-Adjusted Expected PPR Rate	Observed/ Risk Adjusted Expected Ratio
St. John's Episcopal	341	31	9.09	21	6.07	1.50
Queens Hospital	6,690	469	7.01	475	7.09	0.99
Elmhurst Hospital	12,830	733	5.71	873	6.80	0.84
Jamaica Hospital	9,797	571	5.83	695	7.10	0.82
Flushing Hospital	7,532	422	5.6	564	7.49	0.75
NY Queens Hospital	11,157	443	3.97	687	6.16	0.64
Forest Hills Hospital	5,233	235	4.49	367	7.01	0.64

Facility Name	At Risk Admissions	Observed PPR Chains	Observed PPR Rate	Risk Adjusted Expected PPR Chains	Risk-Adjusted Expected PPR Rate	Observed/ Risk Adjusted Expected Ratio
Total Queens Hospitals	53,580	2,904	5.42	3,694	6.89	0.79
New York City Total	345,073	23,981	6.95	24,823	7.19	0.97
New York State Total	604,308	40,687	6.73	N/A	N/A	N/A

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

Table 35: 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
Queens service area				
Respiratory	7.5%	30.6%	41.6%	2,155
CVD/Circulatory	28.4%	35.7%	24.9%	2,341
Diabetes	11.2%	26.5%	24.2%	1,856
Mental Health	14.2%	29.1%	39.0%	n/a
Substance Abuse	3.3%	61.2%	55.0%	n/a

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

Table 36 - Potentially Avoidable Hospitalizations (Composite PQI), 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 37: Hospitalizations for Major PQI Composite Indicators by Neighborhood, 2012

	PQI 90 Overall Composite		PQI 91 Acute Composite		PQI 92 Chronic Composite	
	PQI Admissions	Risk-Adjusted Expected Rate	PQI Admissions	Risk-Adjusted Expected Rate	PQI Admissions	Risk-Adjusted Expected Rate
QSA	9,204	1,579	2,852	503	6,352	1,078
Queens	8,316	1,482	2,641	474	5,675	1,008
NYC	44,913	1,822	12,328	525	32,619	1,295
NYS	69,084	1,784	20,521	530	48,568	1,254
Queens service area Neighborhoods:						
East New York	1,578	1,957	422	629	1,156	1,339
LIC /Astoria	793	1,714	237	502	556	1,212
Jamaica	1,573	1,699	417	509	1,156	1,191
Southwest Queens	1,155	1,678	331	492	824	1,186
Ridgewood / Forest Hills	814	1,521	294	498	520	1,015
West Queens	1,744	1,423	650	527	1,094	895
Flushing/Clearview	773	1,320	296	450	477	860
Southeast Queens	573	1,296	141	371	432	923
Fresh Meadows	257	1,280	78	359	179	923
*Rockaway	472	1,079	143	350	329	732
Bayside/Little Neck	121	1,027	46	333	75	687

**Outside of Queens service area.*

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

Table 38 - Hospitalizations for Chronic PQI Composite Indicators by Neighborhood, 2012

	PQI S01 Diabetes Composite		PQI S02 Circulatory Composite		PQI S03 Respiratory Composite	
	Observed PQI Admissions	Risk-Adjusted Expected Rate	Observed PQI Admissions	Risk-Adjusted Expected Rate	Observed PQI Admissions	Risk-Adjusted Expected Rate
QSA	1,856	317	2,341	388	2,155	431
Queens	1,612	292	2,171	372	1,892	425
NYC	9,289	370	11,116	432	12,216	493
NYS	14,121	365	15,795	408	18,654	482
Queens service area Neighborhoods						
East New York	381	414	346	411	429	512
Jamaica	356	357	445	436	355	391
Fresh Meadows	64	351	50	243	65	337
LIC /Astoria	145	321	174	382	237	509
Southwest Queens	224	321	370	537	230	330
Ridgewood/Forest Hills	142	297	188	368	190	352
West Queens	326	272	378	310	390	313
*Rockaway	118	269	107	226	104	238
Bayside/Little Neck	21	222	31	243	23	220

	PQI S01 Diabetes Composite		PQI S02 Circulatory Composite		PQI S03 Respiratory Composite	
	Observed PQI Admissions	Risk-Adjusted Expected Rate	Observed PQI Admissions	Risk-Adjusted Expected Rate	Observed PQI Admissions	Risk-Adjusted Expected Rate
Southeast Queens	105	220	208	416	119	274
Flushing/Clearview	104	208	201	316	172	326

**Outside of Queens service area.*

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

Table 39 - Hospital Utilization among Medicaid Beneficiaries with Asthma by UHF Neighborhood, 2012

	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	Average # of Admissions	% with at least 1 ED Visit	Average # of ED Visits
NYS	375,170	6.43	26.8	1.86	50.3	2.79
NYC	240,241	6.70	27.6	1.90	48.3	2.63
Queens	47,526	5.19	22.4	1.77	43.0	2.40
Queens service area	51,118	5.36	23.0	1.77	44.8	2.42
Neighborhoods						
Long Island City/Astoria	4,215	5.33	23.29	1.82	42.64	2.42
West Queens	15,193	4.63	18.20	1.60	42.73	2.33
Flushing/Clearview	8,003	4.03	19.44	1.78	31.13	2.37
Bayside/Little Neck	952	3.32	19.21	1.61	27.53	1.91
Ridgewood/Forest Hills	7,060	5.73	22.36	1.64	37.20	2.10
Fresh Meadows	2,713	5.18	20.81	1.90	36.91	2.35
Southwest Queens	8,733	5.34	20.75	1.64	43.70	2.15
Jamaica	10,759	5.78	25.64	1.84	50.68	2.52
Southeast Queens	3,511	4.76	27.47	1.82	46.08	2.64
*Rockaway	8,148	8.63	29.76	2.04	50.78	2.71
East New York	12,412	7.88	28.89	1.90	55.88	2.65

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

Table 40 - Hospital Utilization among Medicaid Beneficiaries with Cardiovascular Conditions by UHF Neighborhood

	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	Average # of Admissions	% with at least 1 ED Visit	Average # of ED Visits
NYS	1,543,129	26.44	40.00	1.97	31.28	2.57
NYC	1,085,013	30.24	40.44	2.03	28.09	2.37
Queens	271,388	29.63	35.55	1.89	23.89	2.10
QUEENS SERVICE AREA	270,776	28.38	35.68	1.92	24.88	2.16
UHF Neighborhoods:						
*Rockaway	23,924	45.43	47.75	2.10	30.06	2.50
Ridgewood/Forest Hills	27,747	36.20	35.47	1.70	20.16	1.86
Flushing/Clearview	37,374	32.02	29.01	1.78	16.65	2.00
Fresh Meadows	10,718	30.74	28.73	1.74	19.91	2.02
Bayside/Little Neck	5,924	29.74	24.71	1.57	13.23	1.53
Southwest Queens	35,914	29.66	35.50	1.85	25.90	1.94
Jamaica	38,841	28.94	41.21	2.03	30.73	2.20
Long Island City/Astoria	20,511	28.55	37.52	1.94	26.68	2.29
Southeast Queens	15,411	27.69	37.41	2.13	28.71	2.63
East New York	31,027	26.40	44.83	2.19	36.36	2.65
West Queens	54,707	23.80	32.08	1.79	21.34	1.82

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

Table 41 - Hospital Utilization among Medicaid Beneficiaries with Diabetes by Neighborhood, 2012

	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	Average # of Admissions	% with at least 1 ED Visit	Average # of ED Visits
NYS	562,637	9.64	32.52	1.89	31.23	2.43
NYC	409,227	11.41	32.27	1.93	28.55	2.25
Queens	105,074	11.47	26.52	1.80	23.17	1.97
Queens service area	106,517	11.17	26.46	1.83	24.23	2.00
Neighborhoods:						
Long Island City/Astoria	7,959	11.08	27.18	1.86	25.88	1.98
West Queens	22,717	9.88	24.90	1.67	20.58	1.72
Flushing/Clearview	12,964	11.11	21.37	1.67	15.78	1.85
Bayside/Little Neck	1,795	9.01	20.95	1.55	13.76	1.51
Ridgewood/Forest Hills	9,134	11.92	27.74	1.64	19.74	1.78
Fresh Meadows	3,902	11.19	21.19	1.80	18.55	2.13

	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	Average # of Admissions	% with at least 1 ED Visit	Average # of ED Visits
Southwest Queens	15,534	12.83	23.59	1.70	23.92	1.86
Jamaica	16,526	12.31	28.87	1.92	29.64	2.03
Southeast Queens	6,003	10.79	25.54	2.06	27.14	2.33
*Rockaway	8,424	16.00	41.99	2.01	29.76	2.48
East New York	12,580	10.70	35.41	2.10	35.66	2.39

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

Table 42 - Hospital Utilization among Medicaid Beneficiaries with Mental Health Condition

	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	Average # of Admissions	% with at least 1 ED Visit	Average # of ED Visits
NYS	997,306	17.09	41.21	2.24	60.98	3.19
NYC	702,585	19.58	32.34	2.43	42.33	2.98
Queens	133,250	14.55	30.20	2.17	37.60	2.74
QUEENS SERVICE AREA	135,746	14.23	29.14	2.26	39.03	2.83
UHF Neighborhoods:						
Long Island City/Astoria	10,432	14.52	27.91	1.99	39.48	2.51
West Queens	26,313	11.45	26.32	1.96	36.24	2.27
Flushing/Clearview	14,390	12.33	29.94	2.05	32.74	2.95
Bayside/Little Neck	2,400	12.05	24.88	2.05	27.17	2.22
Ridgewood/Forest Hills	15,446	20.15	25.09	1.87	29.96	2.36
Fresh Meadows	5,652	16.21	24.63	2.34	34.16	2.94
Southwest Queens	14,752	12.18	25.31	2.06	38.63	2.53
Jamaica	19,784	14.74	32.71	2.40	44.21	3.02
Southeast Queens	6,509	11.69	37.18	2.89	46.31	3.64
*Rockaway	17,488	33.21	43.37	2.26	40.19	3.02
East New York	22,969	19.54	33.58	2.72	47.60	3.33

**Outside of Queens service area. Source: New York State Department of Health Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012.'*

Table 43 - Mental Health Readmissions within 30 Days among Medicaid Fee for Service Beneficiaries

Region	All Ages

	# of Discharges	# of Readmissions in <= 30 Days to Any Region	Rate of Readmission in <= 30 Days to Any Region	# of Readmissions in <= 30 Days to the Same Region	Rate of Readmission in <= 30 days to the Same Region
Queens	4,008	1,004	25.0%	904	22.6%
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					
Elmhurst Hospital	969	215	22.2%	201	20.7%
Flushing Hospital	168	67	39.9%	62	36.9%
Holliswood Hospital (closed 2013)	491	93	18.9%	69	14.1%
Jamaica Hospital	300	53	17.7%	51	17.0%
Long Island Jewish Med. Center	974	220	22.6%	190	19.5%
Queens Hospital	626	154	24.6%	141	22.5%
St John's Episcopal Hospital	397	191	48.1%	182	45.8%

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

Table 44: 7, 30, and 60 Day Mental Health Outpatient Service Follow-up, Adult Medicaid Fee for Service

Event	Queens	New York City	New York State
7 day MH Follow-Up (MH Only)	34.6%	31.1%	34.8%
7 day MH Follow-Up (MH and SUD)	37.1%	35.9%	39.1%
30 Day MH Follow-Up (MH Only)	46.4%	42.6%	46.9%
30 Day MH Follow-Up (MH and SUD)	49.2%	48.0%	52.1%
30 Day MH Engagement (2 or More OP)	38.7%	32.6%	36.1%
60 Day MH Engagement (4 or More OP)	33%	26.5%	29.5%

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

Table 45: 30 Day Mental Health Outpatient Service Follow-up, Adult Medicaid Fee for Service

Outpatient Service within 30 Days	Discharges	Outpatient Service, 30 days
Queens	4,915	46.4%
New York City	16,629	42.6%
Statewide	29,661	46.9%
Hospital		
Elmhurst Hospital Center	755	43.0%
Flushing Hospital Medical Center	158	44.9%
Holliswood Hospital	1	100.0%
Jamaica Hospital Medical Center	265	52.5%
Long Island Jewish Medical Center	778	47.7%
Queens Hospital	512	44.3%
St John's Episcopal Hospital	298	50.7%

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

Table 46: Medication Fill Rates post Mental Health Discharge, Medicaid Fee for Service

Event	Queens	New York City	New York State
30 Day MH Rx Fill (1st Psychotropic Rx)	62.6%	57.6%	63.9%
100 Day MH Rx Fill (Refill Psychotropic Rx)	89.7%	86.5%	88.2%
30 Day MH Rx Fill, w/ Psychosis (1st Antipsychotic Rx)	56.7%	54.3%	59.6%
100 Day MH Rx Fill, w/ Psychosis (Refill Antipsychotic Rx)	85.7%	83.0%	84.4%
30 Day MH Rx Fill, w/ Mood Disorder (1st Mood Stabilizer	51.3%	47.0%	55.8%
100 Day MH Rx Fill, w/ Mood Disorder (Refill Mood Stabilizer	85.5%	83.1%	84.8%

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

Table 47: Hospital Utilization among Medicaid Beneficiaries with Substance Use CRG Diagnosis by UHF Neighborhood

	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	Average # of Admissions	% with at least 1 ED Visit	Average # of ED Visits
NYS	370,898	6.36	59.56	3.13	59.86	4.18
NYC	222,198	6.19	65.03	3.58	58.37	4.34
Queens	26,264	2.87	60.23	3.24	54.04	3.92
QUEENS SERVICE AREA	31,425	3.29	61.21	3.37	55.02	4.19
UHF Neighborhoods:						
East New York	8,911	7.58	64.31	3.76	59.35	4.89
*Rockaway	3,386	6.43	62.76	3.44	58.33	4.25
Jamaica	7,468	5.56	59.75	3.19	56.55	3.85
Southeast Queens	2,045	3.67	68.36	3.61	62.00	4.86
Fresh Meadows	1,115	3.20	71.12	5.71	53.27	4.09

	Beneficiaries with Condition	Diagnosed Prevalence (Per 100)	% with at least 1 Admission	Average # of Admissions	% with at least 1 ED Visit	Average # of ED Visits
Ridgewood/Forest Hills	2,294	2.99	53.36	2.70	46.21	3.49
Long Island City/Astoria	1,909	2.66	56.10	3.25	56.63	3.61
Southwest Queens	2,488	2.05	57.60	2.67	53.82	3.61
West Queens	3,664	1.59	60.02	2.85	47.71	3.47
Flushing/Clearview	1,617	1.39	59.43	2.86	47.62	4.57
Bayside/Little Neck	250	1.25	54.40	2.90	47.60	2.74

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

Table 48: Substance Use Disorder: Readmissions and Post Discharge Care, Medicaid Fee For Service

	New York City			New York State		
	Discharges	Events	%	Discharges	Events	%
Readmissions						
SUD Readmissions (immediate next service) within 30 Days to Any Region	29,304	12,519	42.9%	49,010	16,116	32.9%
SUD Readmissions (immediate next service) within 45 Days to Any Region	29,304	14,134	48.2%	49,010	18,340	37.4%
14 Day Post Discharge Care Outpatient Follow Up						
Percentage of SUD Detox/Rehab Discharges Followed by a Lower Level SUD Service or MH Outpatient Treatment within 14 Days	23,264	7,023	30.2%	41,490	15,210	36.7%
Percentage of SUD Detox or Rehabilitation Discharges Followed by Two or More Lower Level SUD Services within 14 Days of Discharge	20,170	3,557	17.6%	8,198	36,197	22.6%
30 Day Post Discharge Care Outpatient Follow Up						
Percentage of SUD Detox/Rehab Discharges Followed by a Lower Level SUD Service or MH Outpatient Treatment within 30 Days	23,264	7,576	32.6%	41,490	16,798	40.5%
Percentage of SUD Detox or Rehabilitation Discharges Followed by Two or More Lower Level SUD Services within 30 Days of Discharge	20,170	4,085	20.3%	9,553	36,197	26.4%
Post Discharge Care Medication Filled						
Percentage of SUD Detox or Rehabilitation Discharges where a Prescription for an Anti-Addiction/Mood Stabilizer/Antidepressant Medication was Filled within 30 Days	23,435	4,657	19.9%	43,601	10,902	25.0%
Percentage of SUD Detox or Rehabilitation Discharges where a Prescription for an Anti-Addiction/ Mood Stabilizer/Antidepressant Medication was Filled within 100 Days	4,675	3,743	80.1%	10,758	8,583	79.8%

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

Table 49: 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**
Queens	**22.6**	**0.7**	**12.3**	**2,235,260**
Bayside/Little Neck	8.0*	0.2	0.0*	87,972
Flushing/Clearview	6.9	0.3	16.7	259,767
Fresh Meadows	8.3*	0.3	17.2*	96,831
Jamaica	36.3	1.0	14.9	289,314
Long Island City/Astoria	29.3	1.0	8.2	204,715
Ridgewood/Forest Hills	13.8	0.4	10.6	245,746
*Rockaway	23.5	0.8	24.9	114,978
Southeast Queens	16.4	0.6	11.6	189,171
Southwest Queens	16.1	0.6	14.6	266,265
West Queens	35.8	1.0	10.7	480,501
East New York Brooklyn	46.8	1.5	18.6	187,855

**Outside of Queens service area. 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 Semiannual Report. October 2012

Table 50: 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 51 - 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%

*Source: 2013 Health Plan Comparison in New York State, New York State Department of Health. * Data is for 2011.*

Table 52 - 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%

*Source: 2013 Health Plan Comparison in New York State," New York State Department of Health. * Data is from 2011*

Table 53 - Access and Quality Measures for Children and Adolescents, New York State, 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

*Source: 2013 Health Plan Comparison in New York State, New York State Department of Health. *Data is from 2011*

Table 54 - Domain 3 Metrics, Behavioral Health

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
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%	 49%
Diabetes Monitoring for People with Diabetes and Schizophrenia (aged 18-64 years)*	68%	70%	66%
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%	 62%
Follow-up after hospitalization for Mental Illness: Within 7 Days Within 30 Days*	 65% 55%	 51%	 50%
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%	71%
Initiation of Alcohol and Other Drug Dependence Treatment*	78%	78%	74%
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 55 - Domain 3: Behavioral Health Metrics at uhf neighborhood level

Neighborhood/Region	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Antidepressant Medication Management-Effective Acute Phase Treatment	Diabetes Monitoring for People With Diabetes and Schizophrenia	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Follow-up After Hospitalization for Mental Illness within 30 Days	Follow-Up Care for Children Prescribed ADHD Medication-Initiation Phase	Initiation of Alcohol and Other Drug Dependence Treatment
Bayside/Little Neck	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	77.89
Flushing/Clearview	76.11	50.67	60.00	79.53	59.20	72.73	75.39
Fresh Meadows	64.29	51.32	N/A- Small Sample Size	87.06	66.07	N/A- Small Sample Size	72.12
Jamaica	59.75	42.57	76.47	80.07	46.78	58.77	76.78
Long Island City/Astoria	63.43	48.48	N/A- Small Sample Size	73.74	50.00	70.97	74.45
Ridgewood/Forest Hills	69.86	54.55	N/A- Small Sample Size	78.13	49.49	62.16	74.91
*Rockaway	80.90	42.31	42.25	84.31	50.31	67.61	74.70
Southeast Queens	64.52	51.35	62.86	75.45	30.60	N/A- Small Sample Size	71.96
Southwest Queens	66.83	50.69	N/A- Small Sample Size	83.69	58.47	56.60	74.04
West Queens	73.55	47.57	76.43	80.43	59.06	63.98	71.97
NYS	**63.18**	**48.87**	**68.48**	**78.83**	**55.19**	**56.54**	**78.05**

**Outside of Queens service area. Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH*

Table 56 - Select Medicaid Managed Care Clinical Improvement Measures: Mental Health

Select Medicaid Managed Care (MMC) Clinical Improvement Measures, 2012	NYS	NYC	Queens
Antidepressant Medication Management:			
Effective Continuation Phase Treatment	37%		
Effective Acute Phase Treatment*	50%	47%	49%
Follow-up care for Children Prescribed ADHD Medications:		[No known	[No known
Initiation Phase*	57%	public	public
Continuous Phase	63%	source]	source]
Follow-up after hospitalization for Mental Illness:		[No known	[No known
Within 7 Days	65%	public	public
Within 30 Days*	79%	source]	source]

*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 57 - Domain 3 Metrics, Diabetes Mellitus

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
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%	85%
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):		[See source	[See source
Lipids Controlled (<100 mg/dL)	47%	note]	note]
Monitoring Diabetes - Lipid Profile[a]	87%		
Medical Assistance with Smoking Cessation[b]	[See source note]	5.8% (4.3-7.8)	4.6% (2.5-8.3)
Flu Shots for Adults Ages 50 – 64[b]	[See source note]	43% (40.0-45.9)	43% (37.4-48.8)
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]		

*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*

[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 58. Domain 3: Diabetes Metrics at UHF Neighborhood Level

Neighborhood/Region	Comprehensive Diabetes Care HbA1C testing
Bayside/Little Neck	87.94
Flushing/Clearview	88.01
Fresh Meadows	86.83
Jamaica	84.87
Long Island City/Astoria	84.01
Ridgewood/Forest Hills	84.55
Rockaway	72.59
Southeast Queens	82.04
Southwest Queens	85.48
West Queens	87.34
NYS	80.28

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH

Table 59. Domain 3 Metrics, Cardiovascular Disease

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
Cholesterol Management for Patients with CV Conditions[a]	[No known public source]	35.9% (33.3-38.7)	33.1% (28.9-37.5)
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)	4.6% (2.5-8.3)
Flu Shots for Adults Ages 50 – 64[a]	[No known public source]	43% (40 – 45.9)	43% (37.4-48.8)
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]

Source:
[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 60. Select Clinical Improvement Measures, Asthma

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
Asthma Medication Ratio			
Medical Management for People with Asthma:			
50% Covered (Ages 5-11)	48%		
50% Covered(Ages 12-18)	49%		
50% Covered(Ages 19-50)	63%		
50% Covered (Ages 51-64)	77%		
50% Covered (Ages 5-64)	57%		
75% Covered (Ages 5-11)	25%		
75% Covered(Ages 12-18)	25%		
75% Covered(Ages 19-50)	38%		
75% Covered (Ages 51-64)	53%		
75% Covered (Ages 5-64)	34%		

Source: 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 61. Select Clinical Improvement Measures, HIV/AIDS

Select Clinical Improvement Measures	NYS	NYC	Queens
HIV/AIDS Comprehensive Care : Engaged in Care[a]	89%	89%	88%
HIV/AIDS Comprehensive Care : Viral Load Monitoring[a]	66%	67%	66%
HIV/AIDS Comprehensive Care : Syphilis Screening[a]	68%	71%	68%
Cervical Cancer Screening[a]	67%	69%	71%
Chlamydia Screening, Women Ages 16-24[a]	66%	70%	69%
Medical Assistance with Smoking Cessation[b]	[See source note]	5.8% (4.3-7.8)	4.6% (2.5-8.3)
Viral Load Suppression [c]	62.2%	61.2%	59%

[a] *Healthcare Effectiveness Data & Information Set (HEDIS), Medicaid Recipients, 2012, as presented by the New York State Department of Health, Office of Health Systems Management.*
[b] *Source: HIV Ambulatory Care Performance, 2011*
[c] *2011 eHIVQUAL Submissions from NYS HIV Ambulatory Care Programs. Reports updated October 21, 2013*

Table 62. Domain 3: HIV/AIDS Metrics at UHF Neighborhood Level

Neighborhood/Region	Cervical Cancer Screening	Chlamydia Screening in Women	Comprehensive Care for People Living with HIV/AIDS: Engaged in Care	Comprehensive Care for People Living with HIV/AIDS: Syphilis screening	Comprehensive Care for People Living with HIV/AIDS: Viral Load Monitoring
Bayside/Little Neck	67.51	65.89	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size
Flushing/Clearview	75.27	68.47	94.87	62.16	48.72
Fresh Meadows	71.94	61.55	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size
Jamaica	69.63	66.27	87.39	71.32	69.04
Long Island City/Astoria	64.58	70.90	89.21	71.85	77.70
Ridgewood/Forest Hills	68.76	70.96	90.24	74.53	67.07
Rockaway	66.08	63.02	87.79	65.71	57.14
Southeast Queens	67.66	67.46	82.56	62.77	57.95
Southwest Queens	70.01	66.78	90.43	70.00	70.81
West Queens	72.60	73.80	89.40	66.12	67.51
NYS	66.80	65.58	89.34	69.27	66.44

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH

Table 63. Select Clinical Measures, Perinatal Care

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
PQI # 9 Low Birth Weight[a]	8.2%	8.6%	8.1%
Prenatal and Postpartum Care—Timeliness and Postpartum Visits:			
% mothers received postpartum checkup[b]	90.1%	89.2%	
% mothers received prenatal care - start 1st to 3rd month[a]	71.8%	70.4%	70.3%
% mothers received prenatal care - start 4th to 6th month[a]	20%	21.5%	21.0%
% mothers received prenatal care - start 7th to 9th month[a]	4.8%	6.2%	6.5%
% late or no prenatal[a]	3.4%	2.0%	2.2%
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%	87%
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%		

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
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 64. Domain 3: Perinatal Care Metrics At UHF Neighborhood Level

Neighborhood/Region	Cervical Cancer Screening	Chlamydia Screening in Women	Comprehensive Care for People Living with HIV/AIDS: Engaged in Care	Comprehensive Care for People Living with HIV/AIDS: Syphilis screening	Comprehensive Care for People Living with HIV/AIDS: Viral Load Monitoring
Bayside/Little Neck	67.51	65.89	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size
Flushing/Clearview	75.27	68.47	94.87	62.16	48.72
Fresh Meadows	71.94	61.55	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size
Jamaica	69.63	66.27	87.39	71.32	69.04
Long Island City/Astoria	64.58	70.90	89.21	71.85	77.70
Ridgewood/Forest Hills	68.76	70.96	90.24	74.53	67.07
Rockaway	66.08	63.02	87.79	65.71	57.14
Southeast Queens	67.66	67.46	82.56	62.77	57.95
Southwest Queens	70.01	66.78	90.43	70.00	70.81
West Queens	72.60	73.80	89.40	66.12	67.51
NYS	66.80	65.58	89.34	69.27	66.44

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH

Table 65. Select Clinical Improvement Measures, Renal Care

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
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)*

Table 66. Domain 3: Other Clinical Improvement Process Metrics

Neighborhood/Region	Breast Cancer Screening	Colorectal Cancer Screening
Bayside/Little Neck	69.03	63.21
Flushing/Clearview	75.12	69.71
Fresh Meadows	70.89	59.88
Jamaica	64.14	44.73
Long Island	66.25	47.05
Ridgewood/Forest	65.26	51.05
Rockaway	57.09	41.44
Southeast Queens	64.50	46.13
Southwest Queens	70.61	48.53
West Queens	74.31	59.14
NYS	63.40	49.31

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH

Table 67 - Risk Factors by Select Queens Neighborhoods

	Obesity (BMI≥30)	Binge Drink (within past 30 days)	Lack of or low Physical Activity (within past 30 days)	Current Smoker
NYC	24.1%	19.7%	22.2%	15.6%
Long Island City-Astoria	23.8%	22.6%	17.7%	16.0%
West Queens	23.6%	23.6%	24.6%	16.0%
Flushing-Clearview	17.6%	18.2%	29.8%	16.3%
Bayside/Little Neck/Fresh Meadows	14.2%	7.5%	21.8%	13.2%
Ridgewood-Forest Hills	17.0%	13.5%	27.3%	17.3%
Southwest Queens	25.5%	21.7%	21.9%	17.3%
Jamaica	26.7%	13.0%	20.7%	11.9%
Southeast Queens	25.8%	13.9%	21.8%	9.0%
East New York/New Lots	37.0%	18.4%	25.6%	10.1%

Source: NYC Dept. of Health and Mental Hygiene, NYC Community Health Survey, 2012. Values are not adjusted for age. Values in red font should be interpreted with caution. Value's relative standard error (a measure of estimate precision) is greater than 30% or the sample size less than 50 or the 95% confidence interval half width is greater than ten, make the estimate potentially unreliable.

Table 68 – Environmental Risk Factors in Select Queens Neighborhoods

	NYC	Queens	Flushing - Clearview	Jamaica	Long Island City Astoria	Southeast Queens	Southwest Queens	West Queens
Indoor Air Quality								
Homes with cockroaches (2011)	24%	19.7%	16.7%	20.4%	22.2%	7.9%	18%	27.9%
Adults reporting second-hand smoke at home (2011)	4.9%	5%	n/a	2.6%	4.9%	5.7%	n/a	4.7%
Adults reporting mold in the home (2012)	9.5%	8.6%	5.4%	11.6%	6.9%	8.9%	8.6%	10.8%
Adults reporting mice in the home (2012)	15.5%	12.6%	10.9%	16%	12.2%	9.9%	14.8%	16.3%
Home Safety and Maintenance								
Homes with cracks or holes (2011)	15.7%	9.4%	4.6%	9.6%	15.6%	6.7%	7.3%	11.8%
Homes with leaks (2011)	20.6%	15.2%	8.6%	18.3%	16.5%	13.5%	12.3%	18.7%
Households rating neighborhood structures good or excellent (2011)	75.2%	81.9%	88.9%	67.4%	83.7%	86.4%	81.7%	78.7%

Sources: New York Community Health Survey (CHS), New York City Housing and Vacancy Survey (HVS), 2011, 2012.

SECTION B – TABLES NOT IN QUEENS CNA

Table 69 - Correlation Matrix of Clinical Risk Group Conditions Among the Health Home Population

Chronic Episode Diagnostic Categories
Health Home Eligibles Adults 21+ Years
With a Predictive Risk Score 75% or Higher (n=27,752)

Percent of Adult Recipients with Co-Occurring Condition

Condition	Total	Severe Mental Illness	Mental Illness	Substance Abuse	Hypertension	Hyperlipidemia	Diabetes	Asthma	Congestive Heart Failure	Angina & Ischemic Heart Disease	HIV	Obesity	Osteoarthritis	COPD & Bronchiectasis	Epilepsy	CVD	Kidney Disease
Severe Mental Illness	43.5	100.0	74.7	77.2	33.8	28.1	23.2	34.1	6.8	8.5	9.6	14.8	23.2	13.9	20.1	31.9	10.9
Mental Illness	46.2	70.4	100.0	70.9	42.0	33.7	28.0	35.8	11.0	12.6	8.7	16.9	29.9	17.8	19.4	41.0	16.4
Substance Abuse	54.4	61.9	60.3	100.0	35.4	25.9	21.4	32.8	7.5	9.4	11.2	10.7	23.1	14.5	16.4	34.4	11.2
Hypertension	37.6	39.1	51.6	51.1	100.0	47.4	41.4	30.7	28.2	22.1	5.6	17.8	29.3	22.6	13.9	62.2	30.8
Hyperlipidemia	29.8	41.0	52.2	47.1	59.8	100.0	54.9	37.7	27.8	33.4	5.6	23.6	30.9	25.1	15.0	70.4	31.5
Diabetes	27.8	36.3	46.5	41.8	56.0	58.8	100.0	35.4	25.7	25.3	5.4	24.3	28.1	22.8	13.2	64.9	34.3
Asthma	28.3	52.4	58.5	62.9	40.8	39.7	34.8	100.0	15.3	17.4	12.3	22.0	34.3	33.0	16.7	47.7	18.4
Congestive Heart Failure	13.4	22.1	37.9	30.6	79.5	61.9	53.5	32.3	100.0	41.2	4.1	21.1	26.1	33.9	8.9	100.0	50.3
Angina & Ischemic HD	12.2	30.5	47.8	41.8	68.2	81.5	57.6	40.3	45.1	100.0	4.6	24.1	33.8	31.5	11.7	100.0	41.9
HIV	8.3	50.2	48.4	73.5	25.2	20.0	18.1	41.9	6.7	6.8	100.0	4.9	26.6	16.4	13.2	31.1	17.9
Obesity	12.7	50.5	61.4	45.8	52.6	55.4	53.1	49.0	22.2	23.1	3.2	100.0	39.3	25.7	16.5	60.1	27.2
Osteoarthritis	22.1	45.7	62.7	56.8	49.9	41.8	35.5	44.0	15.8	18.7	10.0	22.7	100.0	25.5	15.1	52.0	24.9
COPD & Bronchiectasis	15.5	38.8	53.0	50.6	54.7	48.1	40.7	60.1	29.2	24.8	8.7	21.0	36.1	100.0	14.0	67.2	27.0
Epilepsy	13.5	65.1	66.6	66.3	38.8	33.2	27.2	35.1	8.9	10.6	8.1	15.6	24.8	16.2	100.0	41.1	16.3
CVD	41.9	33.2	45.3	44.6	55.9	50.2	43.1	32.3	32.0	29.2	6.2	18.3	27.4	25.0	13.2	100.0	35.4
Kidney Disease	18.8	25.2	40.4	32.4	61.5	49.9	50.6	27.6	35.8	27.2	7.9	18.3	29.1	22.3	11.7	78.6	100.0
Total	**100.0**	**43.5**	**46.2**	**54.4**	**37.6**	**29.8**	**27.8**	**28.3**	**13.4**	**12.2**	**8.3**	**12.7**	**22.1**	**15.5**	**13.5**	**41.9**	**18.8**

Note: Diagnosis History During Period of July 1, 2010 through June 30, 2011.

Source: Health Homes: Improving Health Outcomes for Women of Reproductive Age, Public Health Committee of the Public Health and Health Planning Council, as provided by SDOH, 2014

Table 70. Percentage of Renter Households Considered Severe Crowding

	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**
Queens	**3.70**	**4.10**	**3.83**	**5.69**	**4.42**
Astoria	3.68	2.85	3.53	3.10	2.96
Bayside/Little Neck	2.17	2.76	0.89	2.06	0.42
Elmhurst/Corona	7.09	8.13	7.45	13.19	10.74
Flushing/Whitestone	3.98	3.98	4.11	4.78	4.25
Hillcrest/Fresh Meadows	2.24	3.46	6.50	3.77	2.21

	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
Jackson Heights	8.57	7.20	9.33	12.52	9.68
Jamaica	5.15	4.13	3.70	5.15	3.81
Middle Village/Ridgewood	1.30	1.10	1.04	1.97	3.76
Ozone Park/Woodhaven	3.26	2.39	2.66	2.93	3.29
Queens Village	0.36	1.38	1.25	0.99	1.85
Rego Park/Forest Hills	2.45	2.74	0.98	2.25	3.77
Rockaways	2.55	6.04	1.04	9.80	2.17
South Ozone Park/Howard Beach	0.94	1.59	2.31	3.46	0.56
Sunnyside/Woodside	2.15	6.66	4.35	8.28	6.13
East New York/Starrett City	0.86	2.30	0.81	6.26	4.64

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

Table 71. Serious Housing Violations by Community District

Serious Housing Violations by Community District, 2008	Rate/1000 Rental Units
New York City	53.79
QN01: Astoria	11.10
QN02: Woodside/Sunnyside	21.25
QN03: Jackson Heights	33.60
QN04: Elmhurst/Corona	16.09
QN05: Ridgewood/Maspeth	22.78
QN06: Rego Park/Forest Hills	7.68
QN07: Flushing/Whitestone	11.79

QN08: Hillcrest/Fresh Meadows	11.57
QN09: Kew Gardens/Woodhaven	26.45
QN10: South Ozone Park/Howard Beach	33.61
QN11: Bayside/Little Neck	5.95
QN12: Jamaica/Hollis	51.34
BK05: East New York/Starrett City	101.10

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

Table 72. Domain 2.a Metrics. Implementation of Care Coordination and Transitional Care Programs

Measure Name	**NYS**	**NYC**	**Queens**	**QSA**
Potentially Avoidable Emergency Room Visits: ED Visits for Ambulatory Sensitive Conditions, Potentially Preventable Visits (PPV), per 100 Recipients, 2012	36 2,111,519	34 1,191,549	27 247,384	28 270,336
Potentially Avoidable Readmissions, by hospital location, 2012*	40,687	24,388	2,873	
PQI Suite – Composite of All Measures: Adult, per 100,000 Recipients, 2012	1,784	1,822	1,482	1,579
Acute Conditions Composite (PQI 91)	*530*	*525*	*474*	*503*
Chronic Conditions Composite (PQI 92)	*1,254*	*1,295*	*1,008*	*1,078*
PDI Suite – Composite of All Measures: Pediatric, per 100,000 Recipients,2012	323	383	235	245
Acute Conditions Composite (PDI 91)	*75*	*87*	*79*	*77*
Chronic Conditions Composite (PDI 92)	*248*	*296*	*154*	*166*

Data Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH. Rates are risk-adjusted expected (controlling for race/ethnicity,

gender, age and case mix)

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

Table 73. Domain 3 Metrics, Behavioral Health

Select Clinical Improvement Measures, 2012	**NYS**	**NYC**	**Queens**
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	37%		
Effective Acute Phase Treatment*	50%	47%	49%
Diabetes Monitoring for People with Diabetes and Schizophrenia (aged 18-64 years)*	68%	70%	66%
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*	56%	64%	62%
Continuous Phase	63%		
Follow-up after hospitalization for Mental Illness:			
Within 7 Days	65%		
Within 30 Days*	55%	51%	50%
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%	71%
Initiation of Alcohol and Other Drug Dependence Treatment*	78%	78%	74%

Select Clinical Improvement Measures, 2012	NYS	NYC	Queens
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 74. Domain 3: Behavioral Health Metrics at UHF neighborhood level

Neighborhood/Region	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Antidepressant Medication Management-Effective Acute Phase Treatment	Diabetes Monitoring for People With Diabetes and Schizophrenia	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Follow-up After Hospitalization for Mental Illness within 30 Days	Follow-Up Care for Children Prescribed ADHD Medication-Initiation Phase	Initiation of Alcohol and Other Drug Dependence Treatment
Bayside/Little Neck	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	N/A- Small Sample Size	77.89
Flushing/Clearview	76.11	50.67	60.00	79.53	59.20	72.73	75.39
Fresh Meadows	64.29	51.32	N/A- Small Sample Size	87.06	66.07	N/A- Small Sample Size	72.12
Jamaica	59.75	42.57	76.47	80.07	46.78	58.77	76.78
Long Island City/Astoria	63.43	48.48	N/A- Small Sample Size	73.74	50.00	70.97	74.45
Ridgewood/Forest Hills	69.86	54.55	N/A- Small Sample Size	78.13	49.49	62.16	74.91
Rockaway	80.90	42.31	42.25	84.31	50.31	67.61	74.70
Southeast Queens	64.52	51.35	62.86	75.45	30.60	N/A- Small Sample Size	71.96
Southwest Queens	66.83	50.69	N/A- Small Sample Size	83.69	58.47	56.60	74.04
West Queens	73.55	47.57	76.43	80.43	59.06	63.98	71.97
NYS	**63.18**	**48.87**	**68.48**	**78.83**	**55.19**	**56.54**	**78.05**

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH

Table 76. Select Medicaid Managed Care Clinical Improvement Measures: Mental Health

Select Medicaid Managed Care (MMC) Clinical Improvement Measures, 2012	NYS	NYC	Queens
Antidepressant Medication Management:			
Effective Continuation Phase Treatment	37%		
Effective Acute Phase Treatment*	50%	47%	49%
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 77. 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 78. Household Type

Household Type	NYS	NYC	Queens
Total Households	7,130,896	3,063,393	776,311
Family Households	4,646,324	1,843,819	525,813
Family Households - Married couple	3,224,971	1,103,512	348,463
Family Households - Male Householder no spouse	351,847	170,979	51,753
Family Households - Female Householder no spouse	1,069,506	569,328	125,597
Non-family Households	2,584,572	1,219,574	250,498
Non-family Households - Living alone	2,119,199	996,487	203,488
% of Total Households - Living Alone	30%	33%	26.2%
Non-family Households - Not living alone	465,373	223,087	47,010

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

Table 79. Insurance Status

Insurance Status	NYS	NYC	Queens	QSA
Total Medicaid (MA) Beneficiaries	5,835,794	3,588,107	915,815	953,962
Total Population	19,398,125	8,199,221	2,235,008	2,166,613
Total Uninsured	2,161,817	1,160,829	390,647	391,145
% Total Uninsured	11%	14%	17.5%	18.1%
MA Beneficiaries, % of Population	30%	44%	41.0%	44.0%
Dual Eligible Beneficiaries	853,866	467,749	109,085	106,060
Older Adult 65+ Population	2,640,634	1,002,872	279,471	259,040
Non Dual Beneficiaries	4,981,928	3,120,358	806,730	847,902
Older Adult 65+ Uninsured	26,086	17,769	6,488	6,805
Older Adult 65+ % Uninsured	1%	1.8%	1.7%	1.7%
Dual Eligible Benefic/ 65+ Pop	32%	47%	39.0%	40.9%
Child 0-17 Beneficiaries	1,979,039	1,180,983	288,970	307,518

Insurance Status	NYS	NYC	Queens	QSA
Total Child 0-17 Population	4,316,920	1,774,909	462,002	464,230
Child 0-17 Uninsured	197,779	80,534	25,028	25,156
% Child 0-17 Uninsured	4.6%	4.5%	5.4%	5.4%
Child 0-17 Beneficiaries/Pop	46%	67%	62.5%	66.2%
Adult 18+ Beneficiaries	3,856,755	2,407,124	517,760	540,384
Total Adult 18+ Population	15,081,205	6,424,312	1,478,520	1,443,343
Adult 18+ Uninsured	1,964,038	1,080,295	359,131	359,184
% Adult 18+ Uninsured	13%	17%	24.3%	24.9%
Adult 18+ Beneficiaries/Pop	26%	37%	35.0%	37.4%

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

Table 80. Incarceration

Incarceration	NYS	NYC	Queens	QSA
NYC DOC Jail admissions (2007-2012), Average	94,951	71,929	11,687	13,465
NYC DOC Jail admissions rate per 100,000 Population (2007-2012), Average	489	877	523	621
NYS Prison admissions (2008)[a]	21,141	9,640	44	41

[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 81. Mental Health Readmissions Within 30/90 Days By Adults, Medicaid Fee For Service, 2012

Region	All Ages				
	# of Discharges	# of Readmissions in <= 30 Days to Any Region	Rate of Readmission in <= 30 Days to Any Region	# of Readmissions in <= 90 Days to Any Region	Rate of Readmission in <= 90 Days to Any Region
Queens	3,016	829	27.5%	1,226	39.6%
New York City	18,300	4,440	24.3%	6,777	36.1%
Statewide	32,242	7,212	22.4%	11,152	33.6%
Hospitals					
Elmhurst Hospital Center	797	193	24.2%	306	36.9%
Flushing Hospital Medical Center	164	66	40.2%	82	49.4%
Holliswood Hospital	1	0	0.0%	0	0.0%
Jamaica Hospital Medical Center	281	51	18.1%	80	27.8%
Long Island Jewish Medical Center	807	195	24.2%	325	39.3%
Queens Hospital	580	139	24.0%	212	35.6%
St Johns Episcopal Hospital	386	185	47.9%	221	56.7%

OMH, 2012

Table 82. Admissions Visits – Medicaid and Dual-Eligible Beneficiaries

Admissions – Medicaid and Dual-Eligibles	NYS	NYC	Queens	QSA
Dual Beneficiaries Admitted	149,622	89,093	19,326	18,339
Total Dual Admissions	207,893	125,358	26,832	25,335
Non Dual Beneficiaries Admitted	515,821	315,132	73,179	77,741
Total Non-Dual Admissions	746,996	468,005	100,780	107,581
Total Beneficiaries Admitted	665,443	404,225	92,505	96,080
Total Admissions	954,889	593,363	127,612	132,916
% Beneficiaries Admitted	11%	11%	10.1%	10.1%
Admissions per Beneficiary	0.16	0.17	0.14	0.14

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH

Table 83. ER Visits – Medicaid and Dual-Eligibles

ER Visits – Medicaid and Dual-Eligibles	NYS	NYC	Queens	QSA
Dual Beneficiaries ER	138,965	67,499	13,274	13,319
Dual Beneficiaries ER Visits	276,130	117,640	22,075	22,138
Non Dual Beneficiaries ER	1,324,449	773,479	177,128	191,894
Non Dual Beneficiaries ER Visits	2,607,918	1,470,587	314,951	343,610
Total Beneficiaries ER	1,463,414	840,978	190,402	205,213
Total ER Visits	2,884,048	1,588,227	337,026	365,748
% Beneficiaries with ER	25%	23%	20.8%	21.5%
ER Visits per Benefic. w/ ER visit	1.97	1.89	1.77	1.78

Source: Medicaid 2012 data, from Office of Quality and Patient Safety, 2014. Created by Office of Health Systems Management, NYSDOH

Table 84. Population Health Indicators: Cardiovascular Health

Population Health Indicator	NYS	NYC	Queens
Cardiovascular disease mortality rate per 100,000			
Crude	281.2	256.4	268.8
Age-adjusted	242.3	249.3	242.9
Premature death (aged 35-64 years)	100	107.8	95.2
Pretransport mortality	144.2	126.7	130.7
Cardiovascular disease hospitalization rate per 10,000			
Crude	178.2	176.9	171.2
Age-adjusted	159.9	173.6	158.5
Disease of the heart mortality rate per 100,000			
Crude	230.9	218.4	232.3
Age-adjusted	198.6	212.2	209.7
Premature death (aged 35-64 years)	81.2	86.9	78.5
Pretransport mortality	124.7	117.1	121.1
Disease of the heart hospitalization rate per 10,000			
Crude	120.6	117.3	117.4
Age-adjusted	107.9	114.9	108.5
Coronary heart disease mortality rate per 100,000			

Population Health Indicator	NYS	NYC	Queens
Crude	186.5	200	213.9
Age-adjusted	160.4	194.4	192.9
Premature death (aged 35-64 years)	66.5	77.4	71.1
Pretransport mortality	104	111	114.1
Coronary heart disease hospitalization rate per 10,000			
Crude	48.3	49.5	52.4
Age-adjusted	43	48.2	48.1
Congestive heart failure mortality rate per 100,000			
Crude	13.3	4.6	5.1
Age-adjusted	11.2	4.4	4.5
Premature death (aged 35-64 years)	1.5	0.9	0.8
Pretransport mortality	7.2	2.2	2.4
Congestive heart failure hospitalization rate per 10,000			
Crude	31.2	31	27.9
Age-adjusted	27.6	30.5	25.8
Cerebrovascular disease (stroke) mortality rate per 100,000			
Crude	31	19.7	20.3
Age-adjusted	26.9	19.3	18.6
Premature death (aged 35-64 years)	10.7	10.9	9.8
Pretransport mortality	11.3	3.8	4.4
Cerebrovascular disease (stroke) hospitalization rate per 10,000			
Crude	27.9	25.2	24.9
Age-adjusted	24.9	24.7	23.1
Hypertension hospitalization rate per 10,000 (aged 18 years and older)	7.9	11.3	9
Age-adjusted % of adults ever told they have high blood pressure (2008-2009)	25.7	28.8	29.7

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

Table 85. Population Health Indicators: Sexually Transmitted Diseases

Population Health Indicator	NYS	NYC	Queens
HIV case rate per 100,000			
Crude	20	37.3	24.4
Age-adjusted	20	35.9	23.4
AIDS case rate per 100,000			
Crude	15.2	28.9	17.3
Age-adjusted	15.2	28.3	16.6
AIDS mortality rate per 100,000			
Crude	5.1	9.8	3.9
Age-adjusted	4.7	9.4	3.7
Early syphilis case rate per 100,000	12.4	25.7	13.7
Gonorrhea case rate per 100,000			
All ages	95.8	151.8	91.2
Aged 15-19 years	362	620.2	388.5
Chlamydia case rate per 100,000 males			
All ages	323	508.7	364.5
Aged 15-19 years	1,077.10	1,829.00	1,536.70
Aged 20-24 years	1,484.30	2,121.00	1,653.70
Chlamydia case rate per 100,000 females			
All ages	674	973.9	666.2
Aged 15-19 years	3,773.90	5,913.40	3,754.50
Aged 20-24 years	3,344.70	4,308.90	3,348.50
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	3.5	4.8	3.1

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

Table 86. Fertility and Infant Mortality

Fertility and Infant Mortality	NYS	NYC	Queens	QSA
Births in past year per 1000 women age 15-50	50	52	38	
Births in past year per 1000 women age 15-19	17	21	15	
Births in past year per 1000 women age 20-34	84	76	41	
Births in past year per 1000 women age 35-50	30	33	39	
Births % Medicaid or self-pay	50%	60%	56.6%	59.4%
Births % Late or No prenatal care	5.5%	7%	7.5%	7.7%
Births % Low Birth Weight	8.1%	8.5%	8.1%	8.3%
Infant Mortality per 1000	4.8	4.4	4.45	4.62

Table 87. Population Health Indicators: Overweight/Obesity/Healthy Eating/Exercise

Population Health Indicator	NYS	NYC	Queens
% of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25-less than 30)	26.6	26.7	27.3
% of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)	24.2	21.4	18
% obese (95th percentile or higher) children in WIC (aged 2-4 years)	14.4	13.8	15.5
% of children in WIC viewing TV 2 hours or less per day (aged 2-4 years) (2009-2011)	79.1	77.9	85.8
% of WIC mothers breastfeeding at least 6 months (2009-2011)	38.3	46.2	46.1
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2008-2009)	59.3	57.9	56.4
Age-adjusted % of adults obese (BMI 30 or higher) (2008-2009)	23.1	22.6	20.6
Age-adjusted % of adults who participated in leisure time physical activity in last 30 days (2008-2009)	76.3	72.7	71.9
Age-adjusted % of adults eating 5 or more fruits or vegetables per day (2008-2009)	27.1	9.4	6.8
Age-adjusted % of adults with physician diagnosed diabetes (2008-2009)	9	9.7	11
			N/A
Age-adjusted mortality rate per 100,000	**658.1**	**604**	
Cardiovascular disease mortality (2009-2011)	242.3	249.3	242.9

Population Health Indicator	NYS	NYC	Queens
Cerebrovascular disease (stroke) mortality (2009-2011)	26.9	19.3	18.6
Diabetes mortality (2009-2011)	17	20.1	15.8
Age-adjusted hospitalization rate per 10,000	**1,230.4**	**1,340.4**	
Cardiovascular disease hospitalizations (2009-2011)	159.9	173.6	158.5
Cerebrovascular disease (stroke) hospitalizations (2009-2011)	24.9	24.7	23.1
Diabetes hospitalizations (primary diagnosis) (2009-2011)	18.8	25.6	18.6

Source: Queens County: County Health Assessment Indicators, 2010 – 2012 data
http://www.health.ny.gov/statistics/chac/chai/docs/obs_60.htm

Table 88. Tobacco Usage and Cessation

Measure	NYS	NYC	Queens
Percentage of cigarette smoking among adults[a]	16.2	15.6	14.9
Medical Assistance with Smoking Cessation[b]	[No known public source]	5.8% (4.3-7.8)	4.6% (2.5-8.3)
Age-adjusted % of adults living in homes where smoking is prohibited (2008-2009)[c]	80.9	79.6	79.2

Sources:
[a] State data obtained from 2012 Behavioral Risk Factor Surveillance System (BRFSS) as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard. City and county data retrieved from: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [Community Health Survey 2012]. [1 August 2014]. http://nyc.gov/health/epiquery
[b] NYC DOHMH Community Health Survey, 2012 (Note: this source provides information only that the city and county level)
[c]Source: County Health Assessment Indicators, http://www.health.ny.gov/statistics/chac/chai/docs/sub_58.htm
Source: NYC DOHMH Community Health Survey, 2012

Table 89. Chlamydia Incidence Rate, by Neighborhood

Neighborhood	Chlamydia Rate per 100,000	Absolute #
New York City	**697.7**	**58,353**
Queens	**466.5**	**10,757**
Astoria	319.8	712
West Queens	517.2	2646
Flushing	168.7	466
Bayside	123.5	111
Forest Hills	209.1	496
Fresh Meadows	219.6	208
Southwest Queens	375.4	1033
Jamaica	890	2573
Southeast Queens	688.6	1375
Rockaway	685	751
Queens- neighborhood unknown	n/a	386

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 90. Gonorrhea Incidence Rate, by Neighborhood

Neighborhood	Gonorrhea Rate per 100,000	Absolute #
New York City	**130.3**	**10,898**
Queens	**78.4**	**1,808**
Astoria	159	71.4
West Queens	300	58.6
Flushing	52	18.8
Bayside	6	6.7
Forest Hills	68	28.7
Fresh Meadows	24	25.3
Southwest Queens	155	56.3
Jamaica	583	201.7
Southeast Queens	260	130.2
Rockaway	139	126.8
Queens- neighborhood unknown	n/a	62

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 91. HIV Diagnosis Rate, 2011, by Neighborhood

Neighborhood	HIV Rate per 100,000	Absolute #
New York City	**41.2**	**3,404**
Queens total	**22.4**	**505**
Long Island City - Astoria	34.9	60
West Queens	6.9	172
Flushing - Clearview	8	18
Bayside - Little Neck	13.9	7
Ridgewood - Forest Hills	8.2	34
Fresh Meadows	16.1	8
Southwest Queenss	36.1	43
Jamaica	15.8	105
Southeast Queens	23.5	31
Rockaway	34.9	27

Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [HIV/AIDS Surveillance Data, 2011]. [1 August 2014]. http://nyc.gov/health/epiquery

Table 92. Moderate - Serious Psychological Distress by Neighborhood

Neighborhood	Moderate-Serious Psychological Distress*	Absolute #
New York City	**31.9**	**2,010,000**
Queens	**30**	**525,000**
LIC, Astoria	35.73	60,000
West Queens	33.07	117,000
Flushing	26.16	53,000
Bayside Little Neck-Fresh Meadows	22.05	32,000
Ridgewood	26.89	52,000
SouthWest Queens	38.48	78,000
Jamaica	29.92	65,000
SouthEast Queens	20.77	32,000
Rockaway	24.76	19,000

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

Table 93. Moderate - Serious Psychological Distress by Selected Characteristics

		Low Risk NSPD			Moderate NSPD			Serious NSPD		
Variable	**Level**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**
Insurance Status	**Private (Includes Employer sponsored, Medicare, VA, Tricare)**	65.1	74.0	2,773,510	49.5	21.7	813,758	47.9	4.3	161,303
	Medicaid	17.2	58.7	732,926	25.5	33.6	419,889	28.6	7.7	96,196
	Uninsured	17.7	60.7	756,418	24.9	32.9	409,807	23.5	6.3	79,035
Received counseling or meds for mental health problem IN LAST 30 DAYS	**Yes**	3.2	27.3	139,075	14.5	47.4	241,178	37.2	25.3	129,018
	No	96.8	71.7	4,148,820	85.5	24.5	1,420,106	62.8	3.8	217,765
Received counseling or meds for mental health problem IN LAST 12 MONTHS	**Yes**	4.5	30.4	193,593	16.9	44.0	280,476	46.9	25.6	162,870
	No	95.5	72.4	4,092,314	83.1	24.4	1,376,701	53.1	3.3	184,328
Ever told had bipolar disorder, mania, psychosis, schizophrenia, or schizoaffective disorder	**Yes**	0.7	18.1	28,429	4.0	41.7	65,468	18.6	40.2	63,247
	No	99.3	69.5	4,249,292	96.0	26.0	1,587,134	81.4	4.5	277,242
Nativity	**US born**	52.0	69.7	2,221,143	48.7	25.2	804,458	46.1	5.0	160,466
	Foreign born	48.0	66.4	2,053,326	51.4	27.5	849,106	53.9	6.1	187,787
Employment status	**Employed**	61.2	71.7	2,616,879	53.8	24.5	893,202	41.0	3.8	140,170
	Unemployed	8.0	53.7	342,360	14.5	37.8	241,227	15.8	8.5	54,124
	Not in labor force	30.8	66.2	1,319,476	31.6	26.3	524,622	43.2	7.4	147,890
Household poverty level	**<200%**	41.4	60.7	1,669,905	53.6	31.5	867,938	62.7	7.8	215,341
	200-399%	15.6	71.3	630,467	13.9	25.4	224,899	8.5	3.3	29,142

		Low Risk NSPD			Moderate NSPD			Serious NSPD		
Variable	**Level**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**
	400+%	33.2	76.6	1,338,416	22.5	20.8	363,824	13.2	2.6	45,260
	Don't know	9.7	64.5	391,770	10.0	26.6	161,424	15.7	8.9	53,938
Binge Drinking: During the past 30 days, had 5 or more drinks on one occasion?	**Yes**	12.2	62.3	522,941	15.5	30.4	255,237	18.0	7.4	61,864
	No	87.8	69.2	3,747,969	84.5	25.6	1,387,019	82.0	5.2	281,708
Heavy alcohol drinking (all adults)	**Yes**	4.9	56.8	206,850	7.1	31.9	116,101	12.0	11.3	41,331
	No	95.1	69.0	4,042,704	92.9	25.9	1,516,970	88.0	5.2	302,835
Smoking status	**Never**	68.5	71.2	2,923,208	62.6	25.3	1,036,982	42.1	3.5	145,561
	Current	11.9	51.7	506,575	21.0	35.5	348,095	36.4	12.8	125,968
	Former	19.6	70.8	835,356	16.3	22.9	270,646	21.5	6.3	74,223
Borough of residence	**Bronx**	14.3	61.8	613,673	18.5	31.0	307,723	20.3	7.1	70,836
	Brooklyn	29.7	67.1	1,275,508	30.7	26.8	509,516	32.9	6.0	114,490
	Manhattan	21.5	71.0	924,776	18.8	24.0	312,927	18.6	5.0	64,816
	Queens	28.7	70.2	1,234,372	26.7	25.2	443,855	23.2	4.6	80,699
	Staten Island	5.8	70.3	248,835	5.3	24.8	87,651	5.0	5.0	17,534

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

Table 94. Obesity Rate by Neighborhood

Neighborhood	% Obese*	Absolute #
New York City	**24.1**	**1,495,000**
Queens	**22.2**	**385,065**
LIC, Astoria	23.8	39,000
West Queens	23.3	80,000
Flushing	17.2	35,000
Bayside Little Neck-Fresh Meadows	14.2	21,000
Ridgewood	17.0	32,000
SouthWest Queens	25.5	51,000
Jamaica	26.7	56,000
SouthEast Queens	25.8	39,000
Rockaway	35.2	27,000
East New York	37.0	48,000

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

Table 95. Percentage of People who Reported Binge Drinking (Last 30 Days), by Neighborhood

Neighborhood	% Binge Drink*	Absolute #
New York City	**19.6**	**1,225,000**
Queens	**18.0**	**310,000**
LIC, Astoria	22.6	37,000
West Queens	23.6	82,000
Flushing	18.2	37,000
Bayside Little Neck-Fresh Meadows	7.5	11,000
Ridgewood	13.5	25,000
SouthWest Queens	21.7	44,000
Jamaica	13.0	28,000
SouthEast Queens	13.9	21,000
Rockaway	15.2	12,000
East New York	18.4	24,000

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

Table 96. 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**
Queens	**9.8**	**169,000**
LIC, Astoria	7.7	13,000
West Queens	10.2	35,000
Flushing	12.4	25,000
Bayside Little Neck-Fresh Meadows	3.3	5,000
Ridgewood	12.2	23,000
SouthWest Queens	8.5	17,000
Jamaica	11.6	25,000
SouthEast Queens	8.9	13,000
Rockaway	14.2	11,000
East New York	23.0	29,000

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

Table 97. Percentage of People who Reported Inactive Physical Activity, on Average (Per Week), by Neighborhood

Neighborhood	% Inactive*	Absolute #
New York City	**21.6**	**1,322,000**
Queens	**22.3**	**410,000**
LIC, Astoria	19.0	31,000
West Queens	21.2	71,000
Flushing	21.2	42,000
Bayside Little Neck-Fresh Meadows	30.4	42,000
Ridgewood	23.2	44,000
SouthWest Queens	17.5	35,000
Jamaica	21.7	46,000
SouthEast Queens	23.4	35,000
Rockaway	24.8	19,000
East New York	18.3	23,465

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

Table 98. Current Smokers, Percent by Neighborhood

Neighborhood	% Current Smoker*	Absolute #
New York City	**15.6**	**981,000**
Queens	**14.9**	**261,000**
LIC, Astoria	16.0	27,000
West Queens	15.9	56,000
Flushing	16.3	33,000
Bayside Little Neck-Fresh Meadows	13.2	19,000
Ridgewood	17.3	33,000
SouthWest Queens	11.9	24,000
Jamaica	13.8	30,000
SouthEast Queens	9.0	14,000
Rockaway	18.6	14,000
East New York	16.7	21,165

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

Table 99. Tobacco Usage and Selected Characteristics

		Current Smoker			Former Smoker			Never Smoker		
Variable	**Level**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**
Insurance Status	**Private (Includes Employer sponsored, Medicare, VA, Tricare)**	52.1	13.5	503,539	73.7	23.3	865,999	57.8	63.2	2,348,005
	Medicaid	24.4	19.0	236,390	12.0	11.4	141,147	21.3	69.6	864,989
	Uninsured	23.5	18.3	227,056	14.2	13.5	167,129	20.9	68.3	847,989
Have one or more personal care providers?	**Yes**	75.4	14.5	738,168	86.6	20.1	1,021,059	81.5	65.4	3,324,119
	No	24.6	20.9	240,846	13.4	13.7	157,483	18.5	65.4	754,190
Nativity	**US born**	60.2	18.7	590,339	62.0	23.2	731,677	45.0	58.1	1,834,756
	Foreign born	39.8	12.7	390,299	38.0	14.6	448,396	55.0	72.8	2,240,219
Employment status	**Employed**	60.7	16.3	590,444	56.9	18.5	669,959	57.9	65.2	2,365,593
	Unemployed	13.2	20.4	128,985	6.9	12.9	81,648	10.3	66.7	422,844
	Not in labor force	26.1	12.8	254,056	36.2	21.5	425,691	31.8	65.7	1,300,734
Age group in years	**18 - 24**	10.3	12.5	100,566	3.3	4.8	39,030	16.3	82.7	65,513

		Current Smoker			Former Smoker			Never Smoker		
Variable	**Level**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**
	25 - 44	49.5	19.2	485,281	29.5	13.8	347,566	41.3	67.0	1,688,328
	45 - 64	32.2	16.0	315,881	41.0	24.6	483,987	28.6	59.4	1,168,360
	65+	8.0	8.2	78,372	26.2	32.4	309,576	13.9	59.5	568,944
Household poverty level	**<200%**	50.8	17.4	477,866	37.0	14.8	404,664	47.3	67.8	1,857,669
	200-399%	12.3	13.1	115,765	14.7	18.2	160,650	15.4	68.6	604,653
	400+%	29.6	16.0	278,203	42.9	27.1	469,754	25.1	56.9	985,554
	Don't know	7.2	11.3	68,054	5.4	9.8	58,948	12.1	78.9	475,619
Binge Drinking: During the past 30 days, had 5 or more drinks on one occasion?	**Yes**	26.3	30.8	253,957	17.1	24.0	198,165	9.1	45.1	371,918
	No	73.7	13.2	711,152	82.9	17.9	962,987	90.9	69.0	3,720,478
Heavy alcohol drinking (all adults)	**Yes**	11.8	32.4	113,060	8.0	26.7	93,196	3.5	40.9	142,471
	No	88.2	14.5	844,353	92.0	18.3	1,069,327	96.5	67.2	3,925,932
Ever been told you have diabetes?	**Yes**	8.8	13.0	85,934	14.6	25.9	171,676	9.9	61.2	405,547

		Current Smoker			Former Smoker			Never Smoker		
Variable	**Level**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**
	No	91.2	16.0	893,135	85.4	18.0	1,005,921	90.1	66.0	3,689,938
Ever told by a doctor, nurse or other hlth prof you have hypertension?	**Yes**	28.1	16.0	275,254	37.4	25.7	440,577	24.5	58.3	1,001,805
	No	71.9	15.6	705,384	62.6	16.2	736,185	75.5	68.2	3,089,764
Ever told by doctor, nurse, other hlth prof you have high cholesterol	**Yes**	27.7	14.9	268,824	39.5	25.7	463,052	26.2	59.3	1,067,230
	No	72.3	15.9	701,500	60.5	16.1	710,560	73.8	68.0	3,003,364
Ever told by doctor, nurse or other hlth prof that you had asthma?	**Yes**	16.2	20.2	159,008	12.8	19.1	150,647	11.7	60.7	478,031
	No	83.8	15.0	821,436	87.2	18.7	1,024,686	88.3	66.2	3,622,541
Borough of residence	**Bronx**	15.9	15.8	155,852	12.2	14.7	144,218	16.6	69.5	683,565
	Brooklyn	31.0	16.1	303,667	27.4	17.1	323,625	30.7	66.8	1,259,779
	Manhattan	20.6	15.6	201,636	23.5	21.4	276,900	19.8	63.0	813,543
	Queens	26.6	14.9		29.2	19.6		28.0	65.5	1,148,313

		Current Smoker			Former Smoker			Never Smoker		
Variable	**Level**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**	**Col. %**	**Row %**	**Weighted Population**
				261,316			344,386			
	Staten Island	5.9	16.6	58,166	7.7	26.0	91,096	4.9	57.3	200,551

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

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

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

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

☐ Within the past year ☐ Over one year ago, but within the past two years
☐ Over two years ago ☐ Never had a routine physical exam
☐ Prefer not to answer ☐ 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 ☐ Concerned about quality of care ☐ Had other responsibilities (e.g., work, family)
☐ Cost of co-pays ☐ Didn't know where to go ☐ 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 ☐ Problem too serious for a doctor's office or clinic
☐ Didn't have transportation to doctor's office or clinic ☐ Doctor's office or clinic wasn't open
☐ Get most care at emergency room ☐ Other, specify: _____
☐ Don't know ☐ 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 ☐ Family or friends ☐ School
☐ Doctor or health care provider ☐ Health insurance plan ☐ Television or radio
☐ Community based organization ☐ Health department ☐ Other, specify: _____
☐ Ethnic media (e.g., ethnic newspaper, TV, radio) ☐ Health fairs ☐ Don't know *[Only if none of the above are selected]*
☐ Internet
☐ Faith-based organization (e.g., church, temple, mosque) ☐ Library ☐ Prefer not to answer
☐ Newspapers or magazines

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

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

December 16, 2014

Prepared by The New York Academy of Medicine

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

SUMMARY

BACKGROUND

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 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 (PPSs) must submit a comprehensive Community Needs Assessment (CNA) with their Project Plan applications. The Queens PPS's CNA included primary and secondary data analysis. This report describes the primary data methodology and analysis and has been developed as an attachment 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

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 605 surveys of community residents, and 18 focus groups and 22 interviews with Queens residents, providers, and other stakeholders. The protocol was developed in collaboration with selected PPS's in Queens, Brooklyn, the Bronx, and Manhattan and was implemented in partnership with the PPS's as well we a number of Community Based Organizations.

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?

FINDINGS

Queens community members and other stakeholders are clearly interested in partnering with hospitals and being part of solutions that promote good health and reduced hospitalizations. Many are wary, fearing that hospitals will not fully engage with the community going forward, as most lack experience doing so and the financial incentives of health system re-engineering are unclear. The predominant theme in Queens is seemingly "diversity," given the large numbers of foreign born – as well as a sizable African American population in particular neighborhoods. This diversity brings with it strengths, as well as multiple challenges regarding language, culture, and economics. Focus group and interview participants articulated specific barriers to good health and good health care, many of which were related to poverty and it's consequences, including long work hours, unstable housing, and the need to prioritize expenditures—even among basic needs. For specific groups, including the disabled, LGBTQ, 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 community health workers, care coordinators—particularly for difficult to manage medical conditions and high risk populations—and navigators. Health education, addressing (for example) prevention, screening, disease management, insurance, and the normalizing 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.

QUEENS 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 Queens 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 attachment 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

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 Queens residents, providers, and other stakeholders (see appendix for data collection instruments). The protocol was developed in collaboration with selected PPS's in Queens, Brooklyn, the Bronx, and Manhattan and was approved by the NYAM 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, NYAM 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) 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 NYAM 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. Although several expressed concern that their input and recommendations would not ultimately be used in the selection and planning of DSRIP projects, they appreciated the ultimate 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*:* 605 surveys were completed by Queens residents, ages 18 and older. 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, and through NYAM initiated street outreach in targeted neighborhoods—consistent with PPS service areas—where we wanted to ensure sufficient representation, including Jamaica, Flushing, Woodside and Corona. Surveys were self-administered or administered by NYAM staff or staff or volunteers at community organizations, who were trained and supported in survey administration by NYAM staff and consultants. The surveys were translated into 10 languages: Arabic, Bangla, Chinese (simplified and traditional), Haitian Creole, French, Hindi, Korean, Polish, Russian and Spanish. Participants received a Metrocard valued at $10 for completing the survey.

- Key Informant Interviews: Twenty-two key informant interviews were conducted, including 27 individuals. Key informants were selected with input from the PPS's. 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, corrections, 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 for the list of Key Informants by name, position, and organization.)
- Focus Groups: Eighteen focus groups were conducted for the Queens Community Needs Assessment, involving over 200 participants. Most 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 immigrant populations, LGBTQ, and individuals with disabilities. The mean age of survey participants was 53; 56% were female; 12% were Black, 41% Asian, and 25% Latino; 47% were on Medicaid and 14% were uninsured; 43% reported speaking a language other than English at home. In addition to the resident groups, we conducted a small number of focus groups with community leaders, as well as providers, including behavioral health providers, care coordinators, and physicians, so as to ensure that the perspective of key stakeholders was incorporated into the findings. These groups were coordinated by collaborating PPS's.

  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 CEAR staff members and consultants retained by CEAR, 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 Qualtrics, a web-based survey platform. They were analyzed according to standard statistical methods, using SAS. Means and proportions were generated, overall and by neighborhood. Although the survey sample cannot be considered representative of the catchment areas in a statistical sense, and gaps are unavoidable, the combination of street and organizational outreach facilitated engagement of a targeted yet diverse population, including both individuals connected and unconnected to services.

Table 1: Demographic characteristics

Characteristic	(n = 605)
Age (Mean, SD)	50.2 (19.8)
18-20	3.6%
21-44	39.3%
45-64	29.1%
65-74	11.7%
75-84	10.3%
85 and older	4.1%
Unknown	1.8%
Gender	
Female	64.0%
Male	35.7%
Transgender	0.3%
Sexual Orientation	
Heterosexual	94.4%
LGBTQI	5.7%
High school graduate or higher	80.5%
Hispanic	19.5%
Race (N=584)	
White	20.2%
Black or African American	10.8%
Asian	53.9%
American Indian or Alaskan Native	1.0%
Native Hawaiian or other Pacific Islander	0.2%
Other/mixed/unknown	13.9%
Limited English proficient	38.6%
Foreign born	71.7%
Health Insurance	
Medicaid	43.0%
Medicare	25.6%
Private/commercial	16.1%
VA/Other/More than one	17.8%
None	19.3%

Survey respondents came from all Queens neighborhoods; socio-demographic characteristics included: 64% female, 11% Black/African American, 20% Latino, 54% Asian (primarily Chinese, South Asian, and Korean), 72% foreign born, 39% limited English proficient, 70% living below the poverty line,

43% on Medicaid and 19% uninsured. The mean age of respondents was 50.2, with a standard deviation of 19.8 (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 relevant to health, community needs, and DSRIP, as well as themes emerging from the data themselves (see Appendix for code list). 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

IMPORTANCE OF COMMUNITY ENGAGEMENT

As noted above, key informants and focus group participants largely welcomed engagement in the community needs assessment and appreciated the opportunity to provide input that might be used for the re-engineering of health care in NYS. They were enthusiastic about the basic DSRIP aim of shifting health-related efforts from inpatient services to the community, where the focus can be on prevention and health maintenance. As described in some detail within this report, CNA participants had numerous ideas regarding health promotion, disease management, and improved health systems. However, a number of respondents expressed skepticism and concern that suggestions from the community—and recommendations in the interest of community based organizations—would be ignored by the hospitals that are applying for DSRIP funds, in part because the DSRIP goals are seemingly contrary to their financial interests and inconsistent with usual practice.

> *The hospitals don't like doing things outside of the hospitals… They always try to do it themselves and do it…acting as if they're going to incorporate the community, the nonprofit organizations, community-based organizations and so on. But they find any way possible to not include them and to do it within their own structure. They're challenged with having to change … in a way that's going to hurt them [i.e., reducing readmissions and revenue], and then they're also told that they're forced to integrate the community and community providers and they're not used to doing that. So there's a lot of fanfare … but in reality it it's not in their best interest to do either one of the two things, integrate the community and community providers, community service providers, or to reduce their inpatient hospitalizations by 25%. (key informant, multiservice organization)*

The importance of alignment with community-based recommendations and the need for solutions that address the social determinants of health were emphasized. For example:

> *My greatest fear is that hospital will get the money from DSRIP and they will define what to do. As opposed to going outside the door, getting people and saying, "Listen, what do you think that we could do to really minimize this problem"... You really have to seriously listen to [community] and then they really have to be partners. You know, you just cannot use the community for something and then discard. (key informant, CBO)*

> *We may not like every aspect of the waiver, but it is much better than past waivers. But there's still concerns, legitimate concerns that include how things are going to be done in terms of engaging communities. ... you can write it all in the document and say all you want, but we're talking about, historically, hospitals not knowing how to do it. (key informant, health advocacy)*

> *The [PPS's] really, I think, often naturally gravitate towards the medical solutions. And what we try to say is, "Yes, but without housing you're never going to achieve that." And when you go talk to the frontline staff, whether they're in your emergency department, your social work department, your nurses, they're going to tell you that this guy needs housing. We were on a panel a while ago, and [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. (key informant, health advocacy)*

There were also concerns regarding the mismatch between, on the one hand, an emphasis on prevention and community engagement, and on the other, clinical and utilization measures that may not reflect the highest priorities of the community. For example, addressing obesity, particularly among children, is unlikely to impact hospitalizations and ER use in the short term.

> *I think that's a real challenge, because when we're looking at things like DSRIP, we're looking at preventing hospitalizations, ... Children who are obese don't get hospitalized. They get hospitalized and they use higher cost services when they become adults but then all this money is gonna be gone. So you know, so nobody's looking at doing something that you need 15 years to have an impact on. Everybody's looking at something that you can have an impact on today or tomorrow. (key informant, provider)*

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, 70% of survey respondents were living below the federal poverty line; in Jamaica, 78% of respondents were living below the poverty line and 62% report that in the last year they sometimes worried about not having enough to eat. Overall, 53% of survey respondents report that they worried about not having enough to eat (see Appendix for detailed data tables).

Although the health related implications of poverty may vary by population, common themes were evident: poverty was describing 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:

> *Most of us parents are constantly working, and many times we don't have the time to commit to cooking a healthy meal every night – and so, we resort to fast food. (focus group participant)*

> *We also have identified that there's food insecurity because of lack of available funds to maybe buy the groceries that they need. So people are making those decisions every day about, "Well, what can I buy, what can I afford with my limited amount of income for this month?" And oftentimes nutrition suffers in that mix, because they'll get their medication instead of buying the food. And sometimes we found they won't get their medication either. (key informant, CBO)*

The behavioral implications of living in poverty were clear to focus group participants and to key informants that worked closely with community members. There was frustration that many health care providers appeared to lack a similar level of understanding.

> *I'm just gonna reflect on a conversation I had with a father who was there with this 12-year-old son who was already showing signs of pre-diabetes and he just, he looked at me and he says, "You, there is no way you are ever going to understand my life." I said "You're absolutely right. I can hear what you're telling me but I don't understand how hard it is for you to have food in your house, and how hard it is for you to get your child to eat the right things and exercise which is the only way that's gonna prevent him from getting diabetes as this point." But I think that what he expressed is his frustration that the general medical community could not understand the problems of people living in poverty when their children have health problems. (key informant, provider)*

Foreign Born: Among the most consistent themes across data collection activities was the concentration of foreign born in Queens, and the seemingly unprecedented diversity of many of the target neighborhoods, particularly Elmhurst, Corona, Jackson Heights, and Flushing. Seventy-two percent of survey respondents were foreign born. Large foreign born populations in Queens include Chinese (from different countries and provinces), Koreans, Latinos (from Puerto Rico, Ecuador, Colombia, Dominican Republic, and elsewhere), and a growing—and increasingly diverse—South Asian population, including groups from India, Pakistan, Bangladesh, and Nepal. 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. Common themes from key informants and focus groups representing diverse population groups included some combination of:

- Significance of language access across the spectrum of services;
- Difficulties meeting basic needs, leading to extended work hours and emotional stresses;
- Prioritization of work, children and education over health;
- Lack of sufficient information on health and health services;
- Minimal knowledge, interest, and engagement in prevention services;
- Low utilization of health care services, relative to other populations;
- Cultural issues, including greater stigmatization of particular health conditions;
- Relatively high rates of non-insurance, due to multiple factors including ineligibility; and
- Fear of medical bills, medical debt, and deportation.

> *In the Borough of Queens, one of the biggest barriers to healthcare is the ethnic diversity that exists here. So it's not even just about language. Language, of course, is a barrier, but more easily addressed than cultural barriers. And in some cultures, seeking out healthcare is just not something that they do. They're not comfortable with it, especially if a person has a questionable immigration status. They're extremely hesitant... So a lot of times what happens is that the emergency room becomes a primary care provider, because they don't have preventive care. They're not keeping up with regular routine visits, they're not monitoring their status. (key informant, CBO)*

Concerns about language access obviously suggest concrete requirements with respect to knowledge and skills. Although many CNA participants described significant capacity among Queens providers, there was some concern regarding training, skills, and credentials of dual role interpreters (i.e., bilingual staff who are asked to interpret on an *ad hoc* basis) and gaps in services remain, particularly for smaller language and ethnic groups, and for particular services, including mental health care and specialist services:

The main issue [in the Nepali community] is language …. Our family member shouldn't have to explain medical conditions to us unless they are also medical practitioners, because even an educated and good English speaker may not understand medical terms, and so they aren't able to interpret what is going on. (focus group participant)

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. (key informant, health advocacy)

CNA participants were consistent in their reports of very long work hours among multiple foreign born groups. Descriptions of 16 hours days, six or seven days a week were not uncommon. Small business owners felt the need to keep shops open for extended hours, taxi drivers report 12 hour shifts without a break, and laborers work multiple jobs because pay is low. Key informants and focus group participants reported that some workers are supporting large families in the US, while also sending funds to relatives in their home country. Such long work hours impact health and access to health care services

Small business that include the liquor stores to laundromats to deli stores. They're the most common ones [Koreans] have. So, because you are small business owner or worker who work at those small businesses, your working hours are much longer, because they are open at 7:00 up to like 10:00-ish. And you barely get to have a day off. And then a lot of workers also work in restaurant field so that's also long, labor intensive work. (key informant, CBO)

We see people [in the Latino community] who have very low paying jobs. But as long as they're able to have their children in school, as long as they're able to maybe send them to a community college – really the vision and the longer term goal is about their children, and their children having better futures… I don't like frame it as it's their concern and that it's their fault, but they're so concerned about jobs that other things kind of fall to the wayside. So health is a key part of that really. (key informant, CBO)

Independent of work and language access issues, key informants and focus group participants described cultural, attitudinal, perceptual and knowledge-based barriers to care among the foreign born, including greater stigmatization of particular health conditions, difficulties navigating the health insurance and care system, low prioritization of preventive care services, and fear of medical bills and deportation if they engage with any part of "the system."

[Arab] women if they have breast cancer, they try to hide it as much as they can, because they don't want the community to know that their girls might get it. They might inherit it

from the mother. Nobody will marry their daughters, so all these problems, they feel like they don't let anyone in the community – even though confidentiality is a very big issue for us and very important for us, but they feel very protective of themselves. They don't want anybody to know about health issues and health problems. (key informant, CBO)

Fear of medical bills and deportation was greatest among the undocumented but affected other immigrant groups, as well.

You also have insurance literacy and like, "What does a co-pay mean?" And some of the complexity of some of the plans, the way they're designed, you have co-payments and then you have co-insurance which is distinct. And then on top of that you have your premiums. And so, that's – we say this all the time, but that type of stuff is confusing to all of us, so how [immigrants] are able to navigate that moving forward and use their insurance, is huge. (key informant, health advocacy)

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, CBO)

Those are some of the most prevalent cases we get. Where people say, "I have this bill. I don't know how I could ever pay this bill." Often, even though in many cases we will help resolve the bill through the financial assistance policy, the person never wants to go back to the hospital again because that happened… Any hospital…. Often they'll have gone for like one appointment, and they get like a $7,000 bill. It just doesn't make sense to them. So it's just scary, right? So it does feel like hospitals don't really get the impact that a scary bill can have to their patient's desire to ever come back to the hospital. (key informant, CBO)

It was reported that immigrants that regularly returned to their home country used medical services there. It was also reported that immigrants received prescription medicines from their home country, as the costs of medicine were generally much lower outside the US.

PHYSICAL HEALTH ISSUES

Overview: Survey respondents felt that the most common physical health concerns in their community were diabetes (53%), high blood pressure (46%), cancer (36%), obesity (33%), and heart disease (33%) (see Table 2). Similarly, the most common areas where they reported additional health information was needed were diabetes (53%), exercise and physical activity (47%), and cancer/cancer prevention (40%). Community members clearly recognize that obesity was linked to diabetes and heart disease and talked about the need for healthy eating and physical activity. For some, change was described as challenging:

I am more familiar with the right ways of nutrition and I am trying to get used to it as much as I can. (focus group participant)

Others report that they—and other community members—are making efforts to exercise and to eat well, so as to remain healthy.

I used to think, 'if I don't eat rice, I'm not eating' but now I don't eat rice, and I am still alive. (Focus group participant)

Seniors are aware of exercise. In my neighborhood there are two groups along the parkway for seniors to do exercise: Tai Chi. In my neighborhood, residents walk in their walkers around the houses. Here in Flushing, in the park, a lot of people are doing activities. Seniors are more aware than before. (Focus group participant)

People are getting more health conscious, joining a gym… Not where we ought to be, but as [the Haitian] community we've definitely made some progress in the direction that we should have in obesity and child obesity—a little better, understanding it and making some kind of life change. (key informant, CBO)

Table 2: Health Concerns

	Queens (N=599)
Adolescent health	8.0%
Asthma	19.4%
Arrest and incarcertation	6.3%
Cancer	36.0%
Diabetes	52.8%
Disability	11.7%
Drug and alcohol abuse	25.5%
Family planning/birth control	6.0%
Hepatitis	7.4%
Heart disease	32.7%
High blood pressure	45.6%
HIV	10.5%
Maternal and child health	9.5%
Mental health (e.g. depression, suicide)	23.2%
Obesity	33.3%
Pollution (e.g. air quality, garbage)	13.5%
Sexual transmitted infections	7.5%
Stroke	11.2%
Teen pregnancy	9.4%
Tobacco use	24.4%
Violence or injury	12.4%
Other	3.0%

Just over one-quarter of survey respondents reported being in fair or poor health. The most commonly reported health issues were high blood pressure and high cholesterol (both approximately 28%) and chronic pain (19%). Fifteen percent reported having diabetes (see Table 3). There appeared to be some variability in health and health concerns according to

population. According to one key informant working with older adults, reported that African Americans had more illnesses at a younger age, compared to other populations, possibly due to historically poor access to health care services in minority communities. Survey respondents in Jamaica were more likely to report that HIV was a health concern (26.4%, compared to 11% for the full sample) and more likely to report having asthma (19% compared to 11% for the full sample). Overweight and obesity rates were highest in Jamaica and in the Western Queens UHF neighborhood (Corono, Elmhurst, Jackson Heights, etc.) —53% in each, compared to 44% for the full sample (see Appendix). The Asian population appeared to have better dietary behavior (more vegetables, although commonly fried) and greater levels of physical activity (e.g., walking, yoga, tai chi) than other populations. However, smoking rates were reported to be high, particularly among Asian men.

Table 3: Health Status

	(N=605)
Perceived health status	
Excellent/very good/good	72.6%
Fair/Poor	27.4%
Body mass index (Mean, SD)*	25.2 (5.2)
Underweight	4.7%
Normal	51.0%
Overweight	29.5%
Obese	14.8%
Health Issues Faced	
Asthma	10.5%
Cancer	4.5%
Chronic pain	19.4%
Depression or anxiety	16.9%
Diabetes	15.3%
Drug or alcohol abuse	2.6%
Heart disease	12.9%
Hepatitis C	1.9%
High blood pressure	28.3%
High cholesterol	27.7%
HIV	1.9%
Mobility impairment	10.3%
Osteoporosis	13.9%

I think Asians and Koreans in general, especially men, there are many smokers. Just in our populations, so smoking is another issue. If you actually walk on Main Street [in Flushing], there are a lot of people smoking. (key informant, CBO)

Access to healthy foods was described as sufficient in most neighborhoods (76% of survey respondents reported that healthy food was available or very available), although limitations were described in Jamaica. (63% reported healthy food was available or very available). According to one Jamaica based provider: *We preach to our patients and they go home and they don't have much in the way of good options (key informant, health care provider).* Even where healthy food was available, some CNA participants reported that purchase of unhealthy choices was common.

> *I live in Elmhurst. Generally, most of the supermarkets are Asian, we have a Stop and Shop and generally the food is very healthy.… And we have choices, so we are not, even when we go to the Corona Park and Rego Park, that area, when we go to the*

supermarket we have choices still. The food is generally healthy. The meat and the fish and the vegetables, we have options. (focus group participant)

I shop at the Trade Fair on Astoria Boulevard on 99th street. You can see the shopping carts filled with a lot of junk food. (focus group participant)

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. Although the implications of these factors on health and disease management are described throughout this report, additional comments illustrating these factors include:

[In the South Asian community] they don't consider high blood pressure or diabetes. It doesn't show. They don't feel anything unless it is very very acute, so they don't think it needs to be [addressed]…. Like, "Oh, it's okay." They don't feel it, so to them it's okay. And you probably remember, a kind of fatalistic attitude. So it's the good deeds that you have done, you can take a few, it's all there, it's all karma, it's all something. It's like, if you need to go you need to go, that sort of thing. That's there, right? And it's a coping strategy as well. (key informant, CBO)

So their medications in the early part of the year, they can keep up with. And then toward the latter part of the year, they have difficulty and sometimes have to make that decision whether to fill the prescription or fill their shopping cart. Or they start taking their medication every other day. You know, they find very creative ways of making it last. (key informant, CBO)

There are people who are very fragilely or inappropriately housed. Like a 65-year-old man with extreme diabetes, who is living in the 4th-floor walkup in his daughter's overcrowded apartment, sleeping on the couch. That man is not going to have good health outcomes. He's stressed. He's not getting out. Can't get a good meal. (key informant, health advocacy)

BEHAVIORAL HEALTH ISSUES

Mental Health: Behavioral health issues were seen as common in all populations. Twenty-three percent of survey respondents reported that mental health issues were a main concern in their community; 17% report personally facing depression or anxiety. For immigrant groups, depression and isolation were reported to result from the pressures of migration and assimilation, long work hours, and social isolation. Typical comments include:

I think there's just a lot of trauma about what [Latino immigrants have] left, and then the process of trying to integrate here. And to some extent, a good amount of isolation.

When you're working so much, you don't really have as much time to seek out other things that are not hard work. So we've seen that as kind of crisis moments where people come in and they're like, "I can't take this anymore." (key informant, CBO)

From day one in the United States there is mental pressure. There is depression and frustration because my experiences, qualification and education from [Bangladesh] are not compatible with the demands here. There is no job satisfaction. We aspire to do well in this country, but the realization of not being able to is frustrating. (focus group participant)

The Chinese population is depressed because they came from their home to a new environment. Maybe they felt they had a good life back then, but here it's a different situation. And the language barrier makes it so they don't have as many friends to talk to. (focus group participant)

Depression was also cited as relatively common in older adults, with implications for physical health and disease self-management.

And also one of the issues on the physical side that is connected with isolation is poor nutrition. A person oftentimes when they're alone has no incentive to cook or to eat. And we find that many of the [older adult] clients that [we see] are nutritionally compromised. (key informant, CBO)

When people entering old age stop working. Work is very important, because it distracts you, physically and mentally. If you don't have work, you fall little by little into depression. (focus group participant)

Alcohol and Other Drugs: Substance abuse, particularly alcohol, was described as problematic for individuals and for health care delivery. There were suggestions that alcohol issues were particularly pronounced among foreign born populations.

I grew up in New York in my 20s and we drank hard and we partied, but I feel like the new immigrants are not acclimated to the amount of alcohol that's available and the way we drink. I don't know the answer to this. But I see on Roosevelt Avenue people crazy drunk like I've never seen before, so those people are not being reached [in AA]. Maybe different languages in this neighborhood are not being reached and represented (focus group participant)

Emergency department staff reported that caring for patients with alcohol issues was difficult and put a strain on ED resources. Comments from a focus group of emergency department providers include:

> *We see a pretty large group of patients with alcohol related issues. And so those patients are very regular here and very difficult, despite trying to get interventions for them, whether it be psychiatric interventions or substance abuse interventions. It's extremely difficult to get them connected and to get them to stay in any kind of program. So we can see them more than once a day, and it wouldn't be surprising….And I'll also say there are some private hospitals in the area that the expectation is the patients are going to come here. We're an HHC hospital. This is an intoxicated patient. You bring them to the city hospital.*

> *Once we admit a patient with intoxication, we treat and release, they go back and drink… We can give names of places [for treatment], but many patients do not follow… They go out, drink and come back.*

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 (76%). Residents of Jamaica were least likely to report that healthy foods were available (63%). Places to walk, exercise and play were also reported to be available in most neighborhoods (79%). In contrast, just 34% of respondents reported that affordable housing was available or very available (see Table 4). Consistent with this survey result, multiple key informants described crowded and instable living conditions, with implications for health and well-being:

> *Because of increase in rent, more families are moving in together, even with strangers. Children are exposed to all kinds of things as a result. Toxic stress. You go to school with all the stress, and the little things just make you explode. (key informant, provider)*

> *The other issue is they're staying with friends and relatives and cousins, they move a lot. So they have different homes and different parents or families, and children move so much that that also causes the same destruction in whatever set up that they've got ... The phones change every other day, the phones change, because they don't have the money to pay the bills, and now you're stuck with, "How do you reach this guardian?" You have a child who's sick and you need to get hold of mom or dad, and it's very hard to reach them (key informant, provider)*

There's a lot of housing issues and things that [the Asian community doesn't] really want people to know about. We room together in like a two, three bedroom, you know, three or four families living together, these kinds of things. (key informant, provider)

Medical services: Approximately one quarter of 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" (41% of the subsample), "could not get an appointment soon or at the right time" (17%), and "cost of copays" (13%). They did, however, report relatively good access to most types of medical care. Approximately 80% of survey respondents reported that primary care was available or very available, 77% reported that they had a primary care provider or personal doctor, and 76% reported that had a routine check-up in the last 12 months. However, acess obviously varies according to individual characteristics:

Table 4: Service Availability

	(N=605)
Accessible transportation	86.9%
Affordable housing	34.1%
Dental services	71.2%
Healthy food	76.2%
Home health care	66.4%
Job training	38.4%
Medical specialists	72.4%
Mental health services	54.6%
Pediatric and adolescent services	73.4%
Places to exercise, walk, and play	79.1%
Primary care medicine	79.8%
Social services	67.3%
Substance abuse services	39.1%
Vision services	69.4%

*Percentage reflects participants who responded very available or available

I would say the majority of immigrants that we hear about go to HHC. I think that some go to FQHC's. A lot of people though pay out of pocket to go see their own providers. That's actually fairly common. (key informant, health advocacy)

Seventy-three percent of survey respondents reported that pediatric and adolescent services were available/very available. Seventy-two percent reported that medical specialists are available/very available, although there was significant variability in responses according to neighborhood (e.g., 57% in northwest Queens, compared to 85% in north Queens). Several key informants and focus groups participants reported on relatively poor access to specialist services.

There's still a ton of people in the community that we've served that have chronic illnesses that are the result of a whole bunch of different factors that primary and preventative care are just not going to be able to address. And so there's a gap in primary care providers' ability to find specialists who are accepting Medicaid or different kinds of insurance. (key informant, health advocacy)

Behavioral Health Services: Survey respondents reported that behavioral health services are less available than other types of care: 55% reported that mental health services were available/very available (range: 30% in northwest Queens, 79% in central Queens) and 39% reported that substance abuse services were available/very available. Mental health services for children and adolescents were described as particularly limited, as well as culturally and linguistically competent services. As described by a key informant working with the Latino community:

> *People going through really crappy situations on a day-to-day basis that wears them down over time. And then, people come to us and they're just like, "Where can I go? Who can I see?" And really what they need is not to be admitted to a long-term thing. They need to have someone to be able to talk to. And, you know, the folks that don't have insurance – there's just nothing for them, right? I guess one thing is the language issue. There aren't a ton of good psychologists or psychiatrists or social workers – maybe some more social workers -- but psychologists or psychiatrists that speak Spanish and can do talk therapy in Spanish. And then the cost thing, you know. Most good providers do not take insurance at all, let alone Medicaid, so that's been huge. It's been a big challenge for us to figure out, as an organization. (key informant, CBO)*

In the words of one primary care provider, *"We often throw our hands up because it is so difficult to find [adolescent mental health] providers."* According to some providers, services that are available might also be unknown to community organizations and residents—or they might be unaware of processes for accessing them. In addition, behavioral health issues generally carry greater stigma than other health concerns, which tends to limit use of services. Key informants and focus group participants both reported that many affected individuals and families try to address problems internally—or not at all. A key informant emphasized the disparities in perceptions of behavioral health across NYC.

> *In New York, if you're white having a therapist is a badge of honor, if you're black it's stigmatized. (key informant, CBO)*

According to key informants that are themselves providers, regulatory issues promote fragmentation of services.

> *Depending upon the level of what people talk about, behavioral health can be done within the Article 28. We have psychiatrists who work within the [article] 28 and psychiatry can be in health clinics. They're really there to really confirm and confer. It's called a consultation liaison model and you know, you're really, the rule of thumb and it's hard to get answers out of Medicaid about how many times we can be seen. It's like a maximum of three times. So if someone needs more than just a simple SSRI, you know, you see that the psychiatrist. The psychiatrist may say you know what, "I really think you*

should go into [article] 31" … It's not that it's a bad thing, you know but it's just another step … We do offer short term therapy in our 28 … We have very limited slots and because of licensure, it has to be secondary to a medical issue because again, the Medicaid rules are very clear. (key informant, CBO)

A number of providers suggested that there is even poorer integration within behavioral health services themselves than between physical and behavioral health. Behavioral health services are reported to be highly regulated by multiple agencies: Office for People with Developmental Disabilities (OPWDD), Office for Alcoholism and Substance Abuse Services (OASAS), and Office of Mental Health (OMH) with patient care being restricted according to the funding and regulatory agency—despite the frequency of co-occurring disorders. Thus, a mental health provider might be limited in the severity of illness that can be treated, the age of the patient, and other factors.

Historically, your systems like OMH and OASAS, up until very recently, they really worked in silos. So, if you came into a mental health clinic and in your intake appointment, you said, "You know, I smoke pot a couple times a week," a red flag would go up. You talk to your supervisor and they say, "They have to go to substance abuse." So until those doors really become integrated, I mean really become integrated in treatment and acceptance and a model of care, we're going to continue to run into these types of challenges because it's very fragmented. (key informant, multiservice organization)

Dental Care: Seventy-one percent of survey respondents felt that dental services are available or very available in their community; 58% reported having been to the dentist in the prior 12 months. Although 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.

I became a citizen but whenever I go to Korea, I'll do my dental care there, because here it's so expensive. (key informant, CBO)

You go to the doctor for one problem and they tell you 2, 3 more problems. You have a cavity they tell you to get a root canal. (focus group participant)

Two health care providers described poor oral health *("horrible teeth")* among children.

Insurance: Focus group participants, in response to a question regarding what should change in health care, overwhelming cited insurance, including its expense, complications, and the limitations it places on choice. Limitations on choice were particularly problematic for

individuals with special needs, including individuals with disabilities and limited English proficient individuals. A key informant explained:

> *So if you signed up for a plan and that doctor that takes care of your community isn't on that plan then there's not a whole lot you can do. And the other issue is you might be signed up for a provider who says he accepts this plan and then halfway through the year you're locked into the plan, [even] if the provider drops it…They do not have any commitment and so that's been – there's no accountability on the provider side in terms of staying in it. And this is particularly important for immigrants … when you talk about languages of lesser infusion, where there are not that many providers that speak those languages or have the cultural competence. (key informant, health advocacy)*

Lack of insurance was, not surprisingly, a more common problem in immigrant communities, due to limitations on immigrant eligibility for public insurance programs, as well as more limited access to employer-sponsored care (due to restricted job opportunities). However, community members and key informants also report that income restrictions for Medicaid are unrealistically low, and self-purchased coverage is felt to be too expensive for low- income populations, given the difficulties of paying for basic necessities like food and housing in NYC. Many low income, previously uninsured, community members had been receiving free or very low cost services at FQHC's or HHC facilities; insurance is perceived to be expensive in comparison.

Lack of insurance coverage resulted in neglect of primary care, preventive services, and dentistry; limited access to prescription medications; and use of emergency care for non-urgent issues. Many focus group participants commented that they do not receive care without insurance coverage. For example:

> *I was a diabetic. I had to fight [it alone] for 10 years, because I had no insurance and no place to support me. Even I didn't report my disease to my wife and children. I decided to cure it by myself. The problem is that the middle-income and middle age groups in society do not usually benefit from government-controlled health insurance programs like Medicaid and Medicare. (focus group participant)*

<u>Supportive Services</u>

For populations that have difficulty accessing health care services, whether because of unfamiliarity with the system, age, language, or other factors, supportive services, including transit, health education, navigation, case management, can make a critical difference. For example:

> *We have transportation services that allow many seniors access to the centers, because otherwise they'd have no other way of getting here. We provide transportation to medical*

appointments. And not only do we provide the transportation, but we … launched an escort program. So in addition to providing the actual transportation, we now will assist by providing a companion to travel with the senior, because what we were finding was that both in physical frailty as well as cognitive frailty, seniors needed more assistance because they often became disoriented or needed that help in navigating through the holes … and even in medical buildings, you know, it's very difficult. And even though you may have been there before, sometimes it looks different. (key informant, CBO)

Community Health Workers: Several CNA participants described the significance of community health workers (CHWs), and the multiple roles they played (or could play) in promoting health and appropriate health care use, particularly with respect to complicated components of the health care system, including health insurance and hospitals. From the perspective of CNA participants, training and employment of CHWs not only benefited patients and clients but also provided important training and employment opportunities for community members.

A great model is the community health worker model. This cooperative idea is training, hiring people from the community to improve people's health. Who's better than someone who's next to you? And maybe not always, because of privacy and other issues. But if he looks like you, and he has family who comes from [the same place], they get trained in a way to do it. It would be great to have more community health workers around everywhere. (key informant, health advocacy)

There's some work to be done on the pre, coming into the hospital … making sure that all the doctors have been pre-certified and pre-cleared, making sure that people did or did not drink or understood exactly all the instructions they needed to follow before coming into the hospital. Making sure that they know where to go when they go to the hospital, so it's not so scary and daunting and maybe so scary and so daunting that perhaps someone doesn't show up, because it just sounds a little too overwhelming. (key informant, health advocacy)

Particularly for immigrant communities, CHWs—whether they be health educators, navigators, or advocates—helped to ameliorate the pervasive language and cultural barriers. A key informant working with the Latino community commented:

They are people that come from the community, that speak the language, and that are trained up on how to navigate this hospital, or how to navigate the health insurance system, etc. And so, when you plug in that person as part of the team of people that takes care of someone, and then it just makes a world of difference. So the [patient] isn't confused as to where in the hospital he's supposed to go. They ask their navigator how the primary care department is relating to the specialized care department, and there's communication happening. You know, there's advocacy being done on language

resources, on financial aspects… So I don't think it's the magical solution, but having someone that can help guide you through that and make it less of a scary process is huge. (key informant, CBO)

CHWs were reported to be particularly valuable and effective in ensuring that hospital discharge plans are effectively implemented:

We see a lot of people that – when they emerge, when they leave the hospital, and they come to us, and we say, "All right, what's the plan?" And people often say, "I'm not sure." "All right, when is your next appointment?" And they say, "I don't know." So we have to just call [the hospital] and ask, "When is this person's [appointment]?" So they've been discharged, and they're supposed to understand this stuff, but the people just don't know… We try to find out what the next steps are. And then, often people get prescriptions, and … people don't understand why. If you don't understand why you're taking this thing, you're less likely to keep taking it. So people stop. They get sick again. (key informant, CBO)

I think one of the things we do miserably in New York City … is horrible discharge planning, horrible, horrible. And if there were these advanced primary care workers or at least community health workers, I think one of the main things I would really have them do is think about discharge planning. If [DSRIP] money is going through hospitals, I would really, No. 1, think about discharge planning and how to make that really real and follow-up calls and texts and whatever for all these folks. And making sure that there's really a system, and that the community health worker or advanced primary care worker gets a copy of that discharge plan and follows up with the patient. (key informant, health advocacy)

Care Coordination/Case Management: 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, assistance with accessing entitlement and supportive services, and monitoring the stability and engagement of clients.

Children with asthma and other chronic illnesses need care managers, who my suggestion would be that there is some communication from the emergency room to the primary care provider, who then reaches out to the care manager to follow up with that parent on whether or not they were, or using the medication as prescribed, whether they filled the prescription, whether they had the medication. Whether they're using the

medication as prescribed during a home visit to make sure that's indeed the case and ensuring that there is a follow up within one week at the pediatrician's office.

Care coordination was seen as valuable in part because of excessive fragmentation within the healthcare system, though developing care coordination programs did not diminish the need for improved integration of care.

I think [DISRP is] exciting for a lot of people for different reasons, but we're excited about it because we think that it's an opportunity to potentially change some of [this]. The system doesn't support us…. And when I say "us," I mean me as a representative of the client. The client themselves, it doesn't support them. And that's a problem, and we shouldn't have to be working double time, and we shouldn't have to have another system of people who we pay to coordinate care, because the system is so fragmented. You do need coordinated care and creating that resource is valuable, but this has to get unfragmented, too. (key informant, CBO)

Unfortunately, funds for care coordination are limited and salaries for the positions are relatively low. Low salaries make hiring difficult and may necessitate selection of candidates that are under-qualified, particularly considering the expectations of the job, which include work with challenging populations, familiarity with multiple psychosocial and health issues—and the services available to address them, as well as the logistic and administrative aspects of the position, including use of multiple electronic health records.

We have to find people that are from the managed care world, that are from the hospital world. We have to find professionals that understand those worlds and they also have to be database professionals, they have to be able to navigate Navitar, they have to be able to navigate Dashboard, they have to be able to input information into these databases, and into our own database, and to be able to do it many times offsite. You're stuck between a rock and hard place, because people with enough skills and training to work with such a high acuity, in most cases, group of clients. But then also they'll have, like the background is more like data entry… You want them to come in with some of the skills, 50% of the skills, I mean, maybe we have to teach them the other 50%. Maybe they come in with substance abuse skills but they don't know mental health and they don't diabetes and primary healthcare concerns, or maybe it's the other way around. It feels like [it's too much to ask of a person], but you have to make it work. (key informant multiservice agency).

Lack of trust or engagement (or possibly time) in care coordination on the part of medical providers also was considered to limit the potential effectiveness of care coordination models.

What's missing is … saying to individual providers that this is important, and you need to be responsive, and you need to talk to people, and you need to interact with care coordinators. One of the biggest problems and flaws in the system is that in all of our contracts… we're required to go to providers, individual PCP's and psychiatrists, and get information from them both about their care that they're providing to our client or their patient or the lab work that's been done, tests, reports, anything that they're doing with our patient. We need to get access to that information so that we can help to provide better care and to guide that person along in the care that they're getting. So if they get prescribed a specific medication, we can say, "Are you taking that medication? Where are you at with it? Have you filled the prescription?" Those kind of things. The problem is, on the provider's side, they don't get paid. No one's telling them – no one's saying to them from the funder level … "You must communicate with these people."… so the providers ignore us. (key informant, multiservice organization)

Finally, a consistent electronic health record was described as a challenge for agencies offering care coordination services, as they had to utilize multiple systems.

The State's not equipped to be able to mandate [a consistent electronic health record]. So everybody is left on their own to be able to design their own or to pick and choose an on-the-shelf or off-the-shelf package. And that's been what's causing the mess. So then not only do you have that, but you also don't have the communication between Health Homes to talk about a client, where a client is… being able to get some kind of a text message or an email saying a client is in an emergency room or a hospital. …that should be really enhanced where we have much more access to the client's status, where that client is, when the client is in crisis, so that we can intervene and help the client. (key informant, Multiservice agency)

Health Education: Health education was a common theme in interviews and focus groups, incorporating both education of the broader public and individual level education regarding management of complex health conditions.

All the hospitals, for example, that saw these kids and saw a lot of admissions hired instructors, asthma care instructors, patient care instructors, who would meet regularly with the asthmatics after the physicians saw them. "Are you taking your meds? What are you taking? What do you do when you do this?" …. So that was patient educators I guess is what they called them, and it worked beautifully for all those diseases. (key informant, provider)

Topics for education of the broader public included insurance, nutrition, screening, preventive health care, and mental health care. Information related to general awareness and related to

behavior change were both considered important. Health fairs, school based programming, and faith based programing were all seen as important venues for the dissemination of information—and for health screening. For example:

> *I would love to see lots of programs in schools to target children. We have millions of people in our schools, in public schools, in private schools. Can we target the children and their parents with workshops? Education materials for them to give it to go home with every child. We'll be targeting millions of people. Public school is a big door for us, open wide for us to reach out to the children and their families, to educate them about preventive services. (key informant, CBO)*

> *Teach them how to shop, read labels, especially they need to know what they're eating. Eat small portions. Eat lots of fruits and vegetables. What has sugar; what doesn't have sugar? (key informant, CBO)*

> *Some of the communities that we know of—they do a lot of their health education at faith-based organizations. Faith-based organizations have access to space, for example, so many of them I know will open up their space. Groups can rent it out. They'll have exercise classes or dance classes. So I think they play a huge role. And this idea around shared use agreements, I think would be really fantastic to look at. And then civic – I mean civic associations, too, I mean they reach a certain community that might not necessarily be going for social services. So, definitely ways to integrate them. And then they're trusted in their community. They're leaders there, so if you can convince those members or leaders to partner with you on these projects, I think it would be a win-win. (key informant, health advocacy)*

> *Mental health services and behavioral health are supposed to be treated as equally important. And so, insurers cannot decline to provide coverage [for mental health services]. And so, but the way that that's – the degree to which that is sort of implemented and I think communicated – education is really important to lots of communities. (key informant, health advocacy)*

> *I feel that young [Arab] adults… they are the ones who are going to reach out to their parents and grandparents to educate them about what's going on, about health disparities like breast cancer. It works out for the girls, they want to talk to their mother and grandma, "Did you do your mammogram? Do you know about breast cancer?" Because of the stigma in our community about breast cancer, they don't like to do mammograms. The women are very protective, like, "I'm not going to show my breast to anyone." … Some of them they never did mammogram in their lifetime. (key informant, CBO)*

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.

- Wait times for appointments. For certain specialty services, including dieticians, wait times are reported to be as long as a year.

  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 [to the ER]

- Wait times on the day of a visit and in the ER

  They give you an appointment at 10:00 am and you leave at 5:00 pm (Focus group participant)

- Short visits that did not allow for health needs to be appropriately addressed. Community members felt that providers do what is expedient rather than what represents the highest quality of care, and ER physicians report that primary care providers refer their difficult cases to the ER, since their allotted time per visit is so brief.

  We try to encourage people to ask questions, and get as much information as possible. And often people feel like the reality is really that they have five minutes with the doctor. (Key informant, CBO)

- Multiple and complicated referral pathways, that result in significant inconvenience and expense for patients. Limitations on subspecialty services in Queens mean that patients may be referred to hospitals in other boroughs. Furthermore, the possible need for multiple visits (e.g., for tests) discourages timely use of services.

- Poor discharge planning after emergency department visits and inpatient stays. Patients are discharged without a clear understanding of their discharge plan, including medication use and follow-up visits. In addition, follow-up appointments are not necessarily consistent or logical. For example, patients discharged after hospital stays will be referred to other institutions due to financial incentives (or disincentives). Or, in contrast, ED patients that they a primary care provider will be referred to a hospital clinic for follow-up care.

  Kids walk into the emergency room with a Medicaid card that says that they have Health First, and they get prescribed the medicine in the emergency room, and then they get

scheduled with a follow-up appointment at that hospital's clinic even though their pediatrician is on the card. Does that make sense? No. (Key informant, provider)

If I'm hospitalized at Hospital X, and I have an outpatient service – the expectation … is that: You've had them on your inpatient service for two weeks. Have this institutional transference and pop them into your outpatient service – whether it be psych or medical. It's not happening [for homeless patients]. They're being sent to walk-in clinics. If it's a voluntary hospital, we're not seeing them take ownership. Sometimes they're sent to an HHC hospital…. The hospitals – and I say this not only about our psychiatrically ill populations but even about our family shelters: They have no clue, for the most part, as to where these homeless people are landing, what services are in the shelters, what connection they have to medical services, what they're able and not able to do. You can't give a single adult or a street homeless person an appointment for a colonoscopy three weeks from now. You can't. If you think that somebody needs a colonoscopy – you have to do it while you have them inpatient. (Key informant, provider

- Lack of knowledge, sensitivity, and competency regarding diverse populations, and populations with special health needs.

  Community members have reported back that doctors and health care professionals in general talk about certain illnesses, like diabetes, hypertension, heart [disease] – a lot of these things are inevitable, right? Or kind of like, "Okay, you have hypertension, here's your medication," as opposed to actually there are things that you can do, lifestyle changes that you can make. I remember we had a really well-known pastor at an organization we're working with in the Bronx, and he said that he didn't know that if you had diabetes, it didn't mean that you had to have a limb amputated, which is pretty nuts, right? That because you have diabetes it does not mean that you have to lose limbs. I think, for whatever reason, providers may feel like when they're talking with certain populations that it's not worth it to talk about what else you can do to address your needs that's not medication or that's not amputation. And there may be some cultural biases that are – there are culture biases, I think, that are built into that way of talking to the patient (key informant, health advocacy)

SPECIFIC POPULATIONS

Low income, uninsured, and immigrant populations, as described above, face a number 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, as well as individuals that are lesbian, gay, transgender, and queer (LGBTQ); criminal justice involved, homeless, or victims or survivors of domestic violence. 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 delay 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.

> *A requirement, for example, that you come to an appointment timely, or if you miss an appointment three times, you can be dis-enrolled from a program or a provider, [is discriminatory]. If you use Access-a-Ride, for example, it is almost impossible to know when you will arrive at a location on a consistent basis. The service is simply of such poor quality that if … you need door-to-door transportation, you need flexibility in appointment scheduling.*

> *In the health setting, practitioners are often listed – clinics are often listed as being wheelchair accessible in managed care program directories. But in fact, according to a survey by the Community Service Society, it was found that these practitioners have steps at their front entrance. The providers don't even know what accessibility means. And so they list themselves as accessible, but when you go to their site or you call them on the phone, they'll say, "Oh yes, we have a few [steps] at our entrance, but that's no big deal."*

> *They don't have exam tables that will lower so that you can transfer from a wheelchair. Or they don't provide ASL interpreters, either in person or by video phone or other system. …. They don't give you longer times for your appointment if it's going to take you a long time to dress and undress…*

LGBTQ: The LGBT population have both typical and particular health concerns. Utilization of health care services—even the ER—is reported to be less than needed, due to lack of sensitivity on the part of providers. Although the lack of sensitivity is particularly pronounced with respect to transgender patients, it effects lesbian, gay and bisexual individuals as well.

> *So there are health disparities that we know exist among LGBT older people. And part of this has to do with the fact that they're so much less likely to reach out for help and so much less likely to get screening. So there's a higher rate of breast and gynecological cancers among lesbian women. There are higher rates of rectal cancer and prostate cancer among gay and bisexually identified men. (key informant, CBO)*

They're not willing to be forthcoming with their providers, they withhold information from their providers, they're real reluctant particularly with transgender folks to engage in health care on so many levels and we could talk for hours about trans people like getting disrobed, what room do you go into, what's your name on the form, why doesn't this match your insurance card, why do you have breasts and a penis, can I touch this? (key informant, health care organization)

But even when I was in the hospital with my mother. I went there with no makeup. I clearly have boobs, have my long hair. I looked weird, and no one gave me the respect or anything. When I used to open my mouth before, I got attention and I got whatever I needed. Now it's like, "You're a freak, go away."(focus group participant)

Isolation and perceived stigma lead to mental health concerns in the LGBT population.

I think for many LGBT people they're separate from other minority groups, the isolation from levels of support starts at a very young age and it's within the family and within the local community and so there is a lot of effective issues that people experience just from an early age onward. I wouldn't say that the prevalence of psychiatric diagnosis is greater but there is a substantial amount of the affective issues of mood anxiety, depression and with those in particular for anxiety and depression, substances play a very key role in modulating mood. (key informant, health care organization)

Criminal Justice Involved: Working with individuals that have been involved in the criminal justice system requires nonjudgmental staff that are familiar with the practical (e.g., Medicaid deactivations of Medicaid, parole regulations), medical, and psychosocial issues faced, including the limited economic options and high rates of trauma and mental illness. According to a key informant that works in correctional health, this population is comprised of:

The sickest people in the city, who are the most socioeconomically disadvantaged, the most stigmatized and the least likely to access care in a way that would be, exclusive of using the emergency room and that sort of thing.

I think, honestly, with the, state emptying the psychiatric facilities, which nobody liked, but I'm not sure that jail is a better alternative. And right now we're talking about 40% of [the Rikers] population are mentally ill. And about 60 to 80% have some kind of behavioral health issue. And then we're talking about, you know, folks with chronic health conditions and the population in jails is aging, so now we've got diabetes and heart disease at much higher rates.

A key informant knowledgeable in this field recommends bridging connections directly from jails/prisons to community based organizations and providers upon re-entry, to avoid emergency department use post-release:

> *[There are] increased rates of hospitalization and emergency department visits post release. We've shown both those things. So anything that we do to try to systematically reduce hospitalizations would definitely benefit from partnering with local jails to help facilitate what I call warm transitions to primary care for medical and to behavioral health treatment, including drug treatment, substance use treatment so that we can avoid people coming to the emergency room 'cause that's what they're gonna do if they don't have - if they don't have a plan. I think it's kind of a no-brainer.*

Aggressive policing in Queens related to carrying condoms was reported by a key informant and in an unrelated focus group:

> *The police around here take the fact that you're carrying a condom, if you're a transgender person, as proof that you're a prostitute and will arrest you. So that's, to say the least, exactly the wrong message. They've actually harassed me, as well, for giving condoms to transgender individuals on the street, accusing me of encouraging prostitution. I have to show them my ID, the letter from the Department of Health that shows my job, and they're like, "It's three in the morning. Why are you out here propositioning them?" And I'm like, "Look, here's my bag. I work for the center. I'm not encouraging them to do anything, I just want them to be safe." (focus group participant, CBO)*

> *One good example is this whole access to condoms thing where right now the police can use someone having condoms as evidence of prostitution. So, we've seen that people, particularly in Queens, are stopped, searched, they have condoms, they get arrested… the access to condoms has a direct health component. Because we see people that are like, "I'm not going to carry condoms. I'm not going to use condoms anymore because they're evidence." (key informant, CBO)*

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. Although many are people that have come into the system due to particular interpersonal or economic difficulties, others have behavioral health issues that make it difficult to remain housed, and which may be, in turn, further exacerbated by homelessness. According to a key informant that works with the homeless:

A lot of clients have very significant mental illness; very significant substance use – largely, alcohol, but … a lot of opioids. … Our clients are not different than the highest poverty clients.

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.

Our clients use EMS all the time for things that – if one were confident that they had a medical home – they would be calling. A child has a 102 degree fever – this is not a newborn. We would call our pediatrician and ask what to do. But, they are not calling pediatricians…. I think, often feel disconnected. Maybe they've been placed in a borough that is not their home borough, and they're not connected to the doctor who was across the street.

Recommendations for improved coordination of care, more efficient use of services, and improved health focus on targeted outreach and care coordination involving multiple hospital staff persons, including social workers in the emergency department and on the inpatient service. In addition, key informants in multiple fields emphasized the importance of supportive housing for high need homeless populations.

Domestic Violence: Domestic violence—with wives, older adults and children as potential victims— was a topic that resonated with several interviewees and focus group participants as a significant community concern that has received inadequate attention. Of Queens survey respondents, 28% reported that health education or programs on domestic violence are needed in their community; the proportion was 44% in Jamaica. Domestic violence obviously can result in both physical health (e.g., injury) and mental health issues, including anxiety and depression. Although not necessarily more prevalent, domestic violence issues were particularly relevant in immigrant communities, due to possibly different standards in their home country as compared to the US, stigma, lack of linguistically and culturally appropriate resources, and fear of deportation—particularly in mixed immigration status families.

They came to U.S. legally with their husband, but because of abuse, and sometimes, oftentimes abusers use their immigration status as a tool to control their partner, so they ended up being undocumented, so it's much harder for then get a job. They ended up working under the table, a lot of labor trafficking issues there too by the employer. (key informant, CBO)

DISCUSSION

Queens community members and other stakeholders are clearly interested in partnering with hospitals and being part of solutions that promote good health and reduced hospitalizations. Many are wary, fearing that hospitals will not fully engage with the community going forward, as most lack experience doing so and the financial incentives of health system re-engineering are unclear. The predominant theme in Queens is seemingly "diversity," given the large numbers of foreign born – as well as a sizable African American population in particular neighborhoods. This diversity brings with it strengths, as well as multiple challenges regarding language, culture, and economics. Focus group and interview participants articulated specific barriers to good health and good health care, many of which were related to poverty and it's consequences, including long work hours, unstable housing, and the need to prioritize expenditures—even among basic needs. For specific groups, including the disabled, LGBTQ, 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 community health workers, care coordinators—particularly for difficult to manage medical conditions and high risk populations—and navigators. Health education, addressing (for example) prevention, screening, disease management, insurance, and the normalizing 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	Alternate Name (for attached tables)	Frequency	%
Long Island City, Astoria, Sunnyside	401	11101, 11102, 11103, 11104, 11105, 11106	Northwest Queens	35	5.8%
Corona, Elmhurst, Jackson Heights, Maspeth, Woodside	402	11368, 11369, 11370, 11372, 11373, 11377, 11378	West Queens	217	35.9%
Bay Terrace, Clearview, College Point, Flushing, Whitestone	403	11354, 11355, 11356, 11357, 11358, 11359, 11360	North Queens	169	27.9%
Bayside, Douglaston, Little Neck, Oakland Gardens	404	11361, 11362, 11363, 11364	West Central Queens	30	5.0%
Forest Hills, Glendale, Middle Village, Rego Park, Ridgewood	405	11374, 11375, 11379, 11385	Central Queens	29	4.8%
Fresh Meadows, Hillcrest, Kew Garden Hills	406	11365, 11366, 11367	Northeast Queens	24	4.0%
Kew Gardens, Ozone Park, Richmond Hill, Woodhaven	407	11414, 11415, 11416, 11417, 11418, 11419, 11420, 11421	Southwest Queens	15	2.5%
Jamaica	408	11412, 11423, 11432, 11433, 11434, 11435, 11436	Jamaica	55	9.1%
Cambria Heights, Glen Oaks, Laurelton, Queens Village, Rosedale	409	11004, 11005, 11411, 11413, 11422, 11426, 11427, 11428, 11429	Southeast Queens	24	4.0%
Rockaways	410	11691, 11692, 11693, 11694, 11695, 11697	Rockaways	7	1.2%
				605	100%

* Only included responses with zipcode

Table 2: Demographic characteristics

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=605)
Age (Mean, SD)	43.7 (17.4)	45.8 (18.0)	59.9 (19.4)	58.8 (19.6)	46.9 (19.2)	53.3 (18.5)	32.6 (11.1)	40.0 (14.1)	59.7 (22.2)	37.4 (20.9)	50.2 (19.8)
18-20	5.7%	1.4%	2.4%	0.0%	3.5%	4.2%	6.7%	9.1%	8.3%	42.9%	3.6%
21-44	57.1%	49.8%	20.1%	23.3%	44.8%	33.3%	66.7%	56.4%	20.8%	28.6%	39.3%
45-64	17.1%	30.9%	30.2%	36.7%	34.5%	37.5%	20.0%	27.3%	12.5%	14.3%	29.1%
65-74	11.4%	7.8%	17.2%	13.3%	6.9%	8.3%	0.0%	7.3%	33.3%	14.3%	11.7%
75-84	5.7%	5.1%	20.1%	16.7%	10.3%	8.3%	0.0%	0.0%	20.8%	0.0%	10.3%
85 and older	0.0%	3.2%	7.1%	10.0%	0.0%	8.3%	0.0%	0.0%	4.2%	0.0%	4.1%
Unknown	2.9%	1.8%	3.0%	0.0%	0.0%	0.0%	6.7%	0.0%	0.0%	0.0%	1.8%
Gender											
Female	68.6%	62.4%	73.1%	55.2%	89.3%	54.2%	53.3%	36.5%	70.8%	42.9%	64.0%
Male	31.4%	37.1%	27.0%	41.4%	10.7%	45.8%	46.7%	63.5%	29.2%	57.1%	35.7%
Transgender	0.0%	0.5%	0.0%	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Sexual Orientation											
Heterosexual	87.0%	93.6%	95.8%	100.0%	91.3%	100.0%	100.0%	91.8%	100.0%	60.0%	94.4%
LGBTQI	13.0%	6.4%	4.2%	0.0%	8.7%	0.0%	0.0%	8.2%	0.0%	40.0%	5.7%
High school graduate or higher	90.6%	73.0%	84.8%	86.2%	85.2%	77.3%	92.9%	85.7%	81.8%	57.1%	80.5%
Hispanic	15.2%	35.0%	4.4%	7.7%	40.7%	8.7%	20.0%	7.7%	25.0%	0.0%	19.5%
Race (N=584)											
White	14.7%	21.0%	24.0%	28.6%	28.6%	12.5%	6.7%	3.8%	30.4%	14.3%	20.2%
Black or African American	5.9%	5.4%	2.4%	3.6%	0.0%	8.3%	33.3%	50.9%	21.7%	85.7%	10.8%
Asian	52.9%	49.8%	68.9%	64.3%	42.9%	66.7%	53.3%	32.1%	39.1%	0.0%	53.9%
American Indian or Alaskan Native	2.9%	1.5%	0.0%	0.0%	3.6%	0.0%	0.0%	1.9%	0.0%	0.0%	1.0%
Native Hawaiian or other Pacific Islander	0.0%	0.0%	0.0%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Other	17.7%	15.6%	2.4%	0.0%	14.3%	4.2%	6.7%	5.7%	8.7%	0.0%	9.1%
Mixed	2.9%	2.0%	0.6%	0.0%	3.6%	4.2%	0.0%	0.0%	0.0%	0.0%	1.4%
Unknown	2.9%	4.9%	1.8%	0.0%	7.1%	4.2%	0.0%	5.7%	0.0%	0.0%	3.4%
Unemployed	8.6%	17.1%	7.2%	10.0%	10.7%	16.7%	0.0%	34.0%	12.5%	0.0%	13.8%
Always/sometimes worry about not having	54.6%	61.7%	40.4%	42.9%	60.0%	39.1%	75.0%	61.5%	45.5%	66.7%	53.2%
Living below a federal poverty level	76.2%	68.0%	69.6%	60.0%	50.0%	75.0%	66.7%	78.1%	76.9%	100.0%	69.8%

Table 3: Language

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=594)
Primary langauge spoken at home											
English	35.3%	35.1%	30.1%	36.7%	46.4%	25.0%	40.0%	66.7%	40.9%	100.0%	37.9%
Spanish	14.7%	31.3%	1.8%	6.7%	32.1%	8.3%	13.3%	3.7%	27.3%	0.0%	16.5%
Arabic	14.7%	1.9%	0.0%	0.0%	0.0%	4.2%	0.0%	1.9%	0.0%	14.3%	2.0%
Chinese (Mandarin, Cantonese, or other)	2.9%	4.7%	32.5%	20.0%	10.7%	25.0%	6.7%	1.9%	4.6%	0.0%	13.9%
French	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	14.3%	0.3%
Haitian/French Creole	0.0%	0.0%	0.0%	3.3%	0.0%	0.0%	6.7%	0.0%	4.6%	0.0%	0.5%
Hindi	2.9%	1.9%	3.0%	0.0%	3.6%	4.2%	0.0%	0.0%	4.6%	0.0%	2.2%
Italian	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Korean	17.7%	2.8%	26.5%	40.0%	14.3%	29.2%	0.0%	0.0%	4.6%	0.0%	13.5%
Russian	0.0%	0.0%	5.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%
Urdu	0.0%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	1.9%	4.6%	0.0%	0.5%
Yiddish	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	32.4%	34.1%	9.6%	0.0%	7.1%	12.5%	40.0%	25.9%	22.7%	0.0%	21.9%
Multiple language	20.6%	12.2%	9.0%	6.7%	12.3%	13.0%	6.7%	1.9%	4.6%	14.3%	10.3%
English proficiency											
Very well/well	69.7%	56.2%	50.6%	60.0%	67.9%	68.2%	80.0%	90.6%	69.6%	100.0%	61.4%
Not well/not at all	30.3%	43.8%	49.4%	40.0%	32.1%	31.8%	20.0%	9.4%	30.4%	0.0%	38.6%
Ever not get healthcare because of language or	0.0%	1.9%	17.1%	0.0%	0.0%	0.0%	0.0%	7.7%	25.0%	0.0%	6.5%
Foreign born	67.7%	76.4%	74.4%	65.5%	75.0%	75.0%	46.7%	59.6%	68.2%	42.9%	71.7%

* only those who indicated ever not getting healthcare when needed

Table 4: Health-related characteristics

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=605)
Perceived health status											
Excellent/very good/good	82.4%	74.0%	65.6%	71.4%	82.1%	69.6%	66.7%	82.4%	66.7%	85.7%	72.6%
Fair/Poor	17.6%	26.0%	34.4%	28.6%	17.9%	30.4%	33.3%	17.7%	33.3%	14.3%	27.4%
Body mass index (Mean, SD)*	24.8 (6.7)	25.9 (5.2)	24.1 (4.3)	24.7 (4.8)	24.9 (5.1)	25.7 (4.7)	25.3 (6.0)	26.3 (5.3)	26.1 (6.2)	25.8 (9.4)	25.2 (5.2)
Underweight	3.5%	4.4%	7.3%	0.0%	5.0%	5.3%	0.0%	2.0%	0.0%	16.7%	4.7%
Normal	65.5%	42.3%	58.0%	63.2%	50.0%	47.4%	71.4%	44.9%	50.0%	50.0%	51.0%
Overweight	17.2%	36.3%	24.7%	21.1%	30.0%	31.6%	21.4%	32.7%	27.8%	16.7%	29.5%
Obese	13.8%	17.0%	10.0%	15.8%	15.0%	15.8%	7.1%	20.4%	22.2%	16.7%	14.8%
Have health insurance											
Medicaid	45.7%	39.4%	44.6%	31.0%	37.9%	50.0%	60.0%	58.2%	25.0%	57.1%	43.0%
Medicare	25.7%	15.3%	43.5%	37.9%	13.8%	12.5%	0.0%	10.9%	54.2%	28.6%	25.6%
Private/commercial	17.1%	13.4%	14.3%	34.5%	24.1%	25.0%	20.0%	9.1%	29.2%	0.0%	16.1%
VA	0.0%	0.0%	0.0%	0.0%	3.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Other	11.4%	6.5%	6.6%	6.9%	3.5%	4.2%	0.0%	7.3%	8.3%	0.0%	6.5%
More than one insurance	14.3%	4.7%	22.3%	13.8%	10.3%	4.2%	0.0%	3.6%	16.7%	0.0%	11.1%
Uninsured	14.3%	29.6%	12.1%	6.9%	27.6%	12.5%	14.3%	18.2%	4.2%	14.3%	19.3%

***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

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=605)
Have a primary care provider/personal doctor	77.4%	71.8%	83.5%	85.7%	69.9%	72.7%	73.3%	67.9%	91.3%	83.3%	76.5%
Have a usual place to go for non-emergency health services	72.7%	75.6%	81.1%	90.0%	65.4%	82.6%	64.3%	73.6%	82.6%	83.3%	77.5%
Use complimentary or alternative treatments or remedies	26.5%	21.7%	39.1%	48.2%	25.9%	31.6%	38.5%	28.3%	31.6%	0.0%	30.1%
In the past 12 months:											
Had routine check-up	67.9%	74.9%	75.8%	79.3%	78.6%	63.6%	80.0%	85.7%	73.9%	100.0%	76.0%
Have been to a dentist	62.5%	51.2%	62.8%	72.4%	75.9%	50.0%	64.3%	50.0%	58.3%	83.3%	58.1%
Have gone to a hospital emergency room at least once	26.7%	31.1%	18.5%	27.6%	17.2%	29.2%	20.0%	43.9%	31.8%	40.0%	27.5%
Need healthcare but didn't get it	15.2%	26.7%	21.5%	26.7%	29.6%	30.4%	14.3%	24.5%	19.1%	33.3%	24.1%

Table 5: Place for non-emergency healthcare services*

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=450)
Type of place											
Primary care doctor's office	62.5%	67.7%	57.9%	74.1%	58.8%	47.4%	77.8%	74.4%	68.4%	40.0%	64.2%
Specialist doctor's office	12.5%	8.9%	15.8%	7.4%	11.8%	15.8%	11.1%	5.1%	26.3%	40.0%	12.2%
Community/family health center	0.0%	3.2%	8.3%	0.0%	5.9%	5.3%	0.0%	2.6%	5.3%	0.0%	4.4%
Hospital-based clinic	8.3%	12.0%	0.8%	3.7%	5.9%	15.8%	11.1%	7.7%	0.0%	0.0%	6.9%
Private clinic	12.5%	9.5%	16.5%	11.1%	23.5%	10.5%	0.0%	2.6%	10.5%	0.0%	11.6%
Emergency room	4.2%	4.4%	5.3%	7.4%	5.9%	0.0%	0.0%	7.7%	0.0%	0.0%	4.7%
Urgent care	4.2%	3.2%	3.0%	3.7%	11.8%	10.5%	0.0%	0.0%	5.3%	0.0%	3.6%
Pharmacy	4.2%	5.1%	3.8%	3.7%	5.9%	5.3%	0.0%	0.0%	5.3%	0.0%	4.0%
Drug treatment center	0.0%	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Mental health center	4.2%	1.3%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%
Alternative care (e.g. herbalist, acupuncturist)	4.2%	0.6%	0.8%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%
Other	0.0%	0.6%	0.0%	3.7%	5.9%	0.0%	0.0%	2.6%	0.0%	0.0%	0.9%
Location											
Bronx	8.3%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%
Brooklyn	0.0%	0.6%	0.0%	3.7%	17.7%	0.0%	0.0%	7.7%	15.8%	20.0%	2.7%
Manhattan	8.3%	8.3%	6.0%	3.7%	11.8%	0.0%	22.2%	5.1%	5.3%	0.0%	6.9%
Queens	83.3%	89.8%	90.2%	88.9%	70.6%	94.7%	77.8%	84.6%	63.2%	80.0%	87.1%
Staten Island	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
Outside of New York City	0.0%	0.6%	3.0%	3.7%	0.0%	5.3%	0.0%	2.6%	15.8%	0.0%	2.5%

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

Table 6: Barrier to gettig healthcare*

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=138)
Not insured	20.0%	50.0%	31.4%	50.0%	50.0%	14.3%	0.0%	61.5%	0.0%	0.0%	40.6%
Cost of copays	0.0%	20.4%	8.6%	12.5%	0.0%	0.0%	0.0%	7.7%	25.0%	50.0%	13.0%
Concerns about quality of care	0.0%	9.3%	8.6%	0.0%	0.0%	0.0%	0.0%	7.7%	0.0%	0.0%	6.5%
Did not know where to go	0.0%	5.6%	2.9%	0.0%	0.0%	14.3%	0.0%	7.7%	0.0%	0.0%	4.4%
Had other responsibilities (e.g. work, family)	20.0%	14.8%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	25.0%	0.0%	8.0%
Could not get an appointment soon or at the right time	40.0%	11.1%	17.1%	50.0%	12.5%	14.3%	100.0%	7.7%	0.0%	0.0%	16.7%
Did not have transportation	0.0%	1.9%	2.9%	0.0%	0.0%	14.3%	0.0%	7.7%	50.0%	0.0%	4.4%
Concerns about language or translation issues	0.0%	1.9%	17.1%	0.0%	0.0%	0.0%	0.0%	7.7%	25.0%	0.0%	6.5%
Other	20.0%	14.8%	11.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.4%

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

Table 7: Reason for ER use*

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=158)
Did not have insurance	0.0%	23.1%	6.7%	12.5%	0.0%	14.3%	66.7%	17.4%	14.3%	50.0%	17.1%
Did not have transportation to a doctor's office or clinic	0.0%	4.6%	0.0%	12.5%	0.0%	0.0%	0.0%	4.4%	0.0%	50.0%	3.8%
Get most care at ER	12.5%	10.8%	26.7%	12.5%	20.0%	14.3%	0.0%	13.0%	14.3%	0.0%	14.6%
Problem too serious for a doctor's office or clinic	50.0%	33.9%	33.3%	62.5%	20.0%	14.3%	33.3%	26.1%	28.6%	50.0%	33.5%
Doctor's office or clinic was not opened	12.5%	13.9%	16.7%	37.5%	20.0%	28.6%	0.0%	8.7%	28.6%	0.0%	15.8%
Other	0.0%	12.3%	6.7%	0.0%	0.0%	28.6%	0.0%	13.0%	0.0%	0.0%	9.5%

*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

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=599)
Adolescent health	2.9%	10.7%	6.0%	6.7%	6.9%	8.3%	20.0%	5.7%	8.7%	0.0%	8.0%
Asthma	25.7%	21.9%	16.1%	16.7%	27.6%	20.8%	13.3%	13.2%	21.7%	14.3%	19.4%
Arrest and incarcertation	11.4%	5.6%	6.0%	3.3%	13.8%	0.0%	6.7%	5.7%	4.4%	28.6%	6.3%
Cancer	45.7%	40.0%	38.7%	30.0%	34.5%	25.0%	26.7%	24.5%	43.5%	0.0%	36.0%
Diabetes	60.0%	53.0%	53.6%	43.3%	55.2%	58.3%	40.0%	45.3%	73.9%	14.3%	52.8%
Disability	2.9%	10.2%	12.5%	13.3%	24.1%	4.2%	6.7%	15.1%	21.7%	0.0%	11.7%
Drug and alcohol abuse	37.1%	31.2%	15.5%	6.7%	31.0%	25.0%	6.7%	39.6%	26.1%	28.6%	25.5%
Family planning/birth control	0.0%	9.8%	1.8%	0.0%	3.5%	8.3%	13.3%	7.6%	13.0%	0.0%	6.0%
Hepatitis	17.1%	4.2%	10.7%	10.0%	0.0%	8.3%	13.3%	3.8%	8.7%	0.0%	7.4%
Heart disease	31.4%	28.8%	41.7%	33.3%	34.5%	41.7%	33.3%	15.1%	43.5%	0.0%	32.7%
High blood pressure	45.7%	42.3%	51.2%	43.3%	41.4%	54.2%	53.3%	32.1%	65.2%	28.6%	45.6%
HIV	14.3%	12.6%	4.2%	3.3%	6.9%	12.5%	6.7%	26.4%	8.7%	14.3%	10.5%
Maternal and child health	20.0%	11.2%	7.1%	0.0%	3.5%	8.3%	33.3%	7.6%	8.7%	0.0%	9.5%
Mental health (e.g. depressin, suicid	25.7%	22.8%	26.2%	33.3%	24.1%	12.5%	26.7%	22.6%	4.4%	0.0%	23.2%
Obesity	25.7%	37.2%	32.1%	40.0%	34.5%	45.8%	20.0%	22.6%	39.1%	14.3%	33.3%
Pollution (e.g. air quality, garbage)	31.4%	9.3%	19.1%	13.3%	13.8%	16.7%	0.0%	3.8%	8.7%	28.6%	13.5%
Sexual transmitted infections	11.4%	11.6%	2.4%	0.0%	0.0%	0.0%	13.3%	15.1%	4.4%	14.3%	7.5%
Stroke	14.3%	9.8%	14.9%	10.0%	3.5%	20.8%	0.0%	7.6%	13.0%	0.0%	11.2%
Teen pregnancy	11.4%	16.3%	0.6%	3.3%	13.8%	8.3%	0.0%	15.1%	0.0%	14.3%	9.4%
Tobacco use	42.9%	17.2%	29.8%	26.7%	24.1%	41.7%	6.7%	22.6%	21.7%	14.3%	24.4%
Violence or injury	14.3%	14.0%	11.9%	10.0%	13.8%	16.7%	0.0%	11.3%	4.4%	14.3%	12.4%
Other	0.0%	4.7%	2.4%	3.3%	0.0%	0.0%	0.0%	5.7%	0.0%	0.0%	3.0%

Table 9: Health issues faced

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=605)
Asthma	11.4%	10.1%	6.8%	14.8%	14.8%	4.2%	6.7%	19.2%	13.6%	28.6%	10.5%
Cancer	11.4%	2.9%	6.7%	3.7%	0.0%	4.2%	6.7%	1.9%	4.4%	0.0%	4.5%
Chronic pain	14.3%	13.5%	31.7%	32.1%	7.4%	20.8%	13.3%	11.5%	17.4%	0.0%	19.4%
Depression or anxiety	20.0%	16.4%	20.1%	18.5%	0.0%	12.5%	40.0%	11.5%	17.4%	0.0%	16.9%
Diabetes	22.9%	11.6%	16.5%	21.4%	7.4%	20.8%	20.0%	17.3%	21.7%	0.0%	15.3%
Drug or alcohol abuse	5.7%	2.9%	0.6%	0.0%	0.0%	4.2%	6.7%	5.8%	4.4%	0.0%	2.6%
Heart disease	5.7%	10.2%	21.2%	11.1%	3.7%	12.5%	13.3%	3.9%	21.7%	14.3%	12.9%
Hepatitis C	2.9%	1.5%	2.5%	0.0%	0.0%	0.0%	6.7%	3.9%	0.0%	0.0%	1.9%
High blood pressure	11.4%	24.2%	34.4%	40.7%	14.8%	45.8%	13.3%	26.9%	43.5%	28.6%	28.3%
High cholesterol	17.1%	26.7%	33.3%	22.2%	33.3%	37.5%	6.7%	19.2%	34.8%	28.6%	27.7%
HIV	5.7%	1.5%	2.5%	0.0%	0.0%	0.0%	6.7%	1.9%	0.0%	0.0%	1.9%
Mobility impairment	8.6%	8.2%	15.2%	18.5%	7.7%	4.2%	20.0%	3.9%	8.7%	0.0%	10.3%
Osteoporosis	17.1%	7.8%	27.2%	18.5%	7.7%	12.5%	6.7%	1.9%	8.7%	0.0%	13.9%

Table 10: Service availability

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=605)
Accessible transportation	100.0%	89.2%	87.8%	69.2%	92.0%	63.6%	71.4%	88.0%	87.5%	80.0%	86.9%
Affordable housing	29.0%	36.7%	36.2%	13.0%	26.1%	21.1%	26.7%	36.0%	52.4%	25.0%	34.1%
Dental services	67.7%	68.2%	78.7%	69.2%	90.5%	50.0%	46.2%	72.3%	66.7%	66.7%	71.2%
Healthy food	75.0%	73.7%	80.5%	76.0%	91.3%	75.0%	83.3%	62.5%	81.8%	75.0%	76.2%
Home health care	46.2%	57.0%	87.9%	58.3%	80.0%	42.1%	58.3%	66.7%	63.2%	66.7%	66.4%
Job training	39.3%	37.8%	54.4%	5.9%	47.1%	31.6%	15.4%	32.6%	23.5%	25.0%	38.4%
Medical specialists	56.7%	66.9%	85.3%	76.0%	85.7%	50.0%	54.6%	68.1%	76.2%	33.0%	72.4%
Mental health services	30.0%	53.9%	62.0%	45.8%	78.6%	38.9%	54.6%	58.7%	64.7%	0.0%	54.6%
Pediatric and adolescent services	63.0%	73.7%	84.3%	57.9%	73.7%	58.8%	64.3%	75.0%	70.6%	0.0%	73.4%
Places to exercise, walk, and play	78.2%	72.6%	84.2%	74.1%	81.8%	85.7%	76.9%	83.0%	89.5%	75.0%	79.1%
Primary care medicine	84.0%	78.4%	87.2%	68.0%	90.0%	44.4%	83.3%	77.1%	76.2%	75.0%	79.8%
Social services	51.9%	60.0%	85.6%	56.6%	62.5%	65.0%	41.7%	60.5%	68.4%	50.0%	67.3%
Substance abuse services	26.1%	40.4%	39.4%	22.2%	33.3%	20.0%	57.6%	54.8%	50.0%	0.0%	39.1%
Vision services	70.4%	62.9%	85.5%	56.5%	68.8%	31.8%	72.7%	76.7%	66.7%	50.0%	69.4%

*Percentage reflects participants who responded very available or available

Table 11: Health education needed in the community

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=596)
Cancer/cancer prevention	62.9%	39.9%	42.8%	40.0%	44.8%	20.8%	33.3%	29.1%	50.0%	0.0%	40.3%
Diabetes	68.6%	49.3%	57.2%	36.7%	62.1%	45.8%	40.0%	45.5%	77.3%	14.3%	52.5%
Domestic violence	37.1%	31.0%	21.1%	3.3%	27.6%	29.2%	40.0%	43.6%	18.2%	14.3%	27.7%
Exercise/physical activity	60.0%	43.7%	47.0%	56.7%	44.8%	62.5%	40.0%	47.3%	36.4%	0.0%	46.5%
Family planning	31.4%	23.9%	6.0%	0.0%	13.8%	8.3%	20.0%	36.4%	0.0%	42.9%	17.5%
Heart disease	28.6%	29.6%	43.4%	26.7%	48.3%	45.8%	26.7%	18.2%	45.5%	0.0%	33.9%
HIV/sexual transmitted disea	22.9%	27.2%	10.2%	10.0%	24.1%	16.7%	20.0%	40.0%	22.7%	14.3%	21.5%
Maternal and child health	17.1%	16.4%	8.4%	0.0%	13.8%	4.2%	26.7%	21.8%	13.6%	0.0%	13.3%
Mental health	28.6%	36.6%	47.0%	46.7%	27.6%	33.3%	20.0%	32.7%	27.3%	14.3%	37.6%
Nutrition	42.9%	44.1%	41.0%	26.7%	41.4%	45.8%	40.0%	30.9%	31.8%	0.0%	39.9%
Substance abuse	42.9%	21.1%	16.3%	16.7%	34.5%	25.0%	20.0%	27.3%	18.2%	28.6%	22.2%
Sickle cell anemia	2.9%	3.8%	2.4%	0.0%	13.8%	4.2%	0.0%	10.9%	0.0%	0.0%	4.0%
Vaccinations	22.9%	15.0%	22.3%	16.7%	24.1%	37.5%	6.7%	20.0%	9.1%	0.0%	18.8%
Violence	20.0%	17.8%	10.2%	10.0%	41.4%	12.5%	0.0%	34.6%	9.1%	42.9%	17.5%
Other	5.7%	3.8%	4.2%	6.7%	6.9%	12.5%	6.7%	7.3%	0.0%	0.0%	4.9%

Table 12: Source of health information

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=597)
Doctor or health care provider	41.2%	45.8%	39.9%	40.0%	44.8%	47.8%	46.7%	40.4%	65.2%	42.9%	43.9%
Family or friends	44.1%	38.0%	41.1%	56.7%	31.0%	34.8%	46.7%	23.1%	34.8%	28.6%	38.4%
Books	20.6%	15.3%	20.2%	30.0%	20.7%	17.4%	6.7%	25.0%	17.4%	42.9%	19.1%
Television or radio	32.4%	20.8%	29.8%	30.0%	17.2%	21.7%	6.7%	15.4%	13.1%	0.0%	23.0%
Newspaper or magazines	17.7%	13.0%	30.4%	23.3%	17.2%	34.8%	0.0%	11.5%	0.0%	14.3%	18.8%
Ethnic media (e.g. ethnic newspaper, TV, radio)	26.5%	14.4%	35.7%	20.0%	10.3%	21.7%	13.3%	9.6%	8.7%	28.6%	20.9%
Internet	47.1%	36.6%	20.8%	26.7%	34.5%	47.8%	40.0%	26.9%	13.0%	14.3%	30.7%
Library	5.9%	4.6%	10.1%	6.7%	6.9%	13.0%	0.0%	7.7%	8.7%	14.3%	7.2%
Community-based organization	5.9%	21.8%	19.1%	23.3%	10.3%	13.0%	0.0%	11.5%	4.4%	0.0%	16.9%
Faith-based organization (e.g. church, temple, synogogue, mosque)	11.8%	4.2%	8.3%	0.0%	6.9%	4.4%	6.7%	1.9%	8.7%	0.0%	5.7%
School	2.9%	5.6%	3.6%	3.3%	3.5%	0.0%	6.7%	3.9%	4.4%	14.3%	4.4%
Health insurance plan	11.8%	13.9%	14.3%	30.0%	3.5%	4.4%	0.0%	3.9%	4.4%	0.0%	12.1%
Health department	17.7%	3.2%	6.6%	6.7%	0.0%	0.0%	0.0%	3.9%	0.0%	0.0%	3.9%
Health fairs	8.8%	5.1%	6.0%	13.3%	6.9%	4.4%	0.0%	5.8%	13.0%	0.0%	6.2%
Other	0.0%	0.9%	1.8%	6.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.2%

Table 13: Use of technology

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=596)
Email	54.3%	44.7%	44.1%	71.4%	51.7%	58.3%	80.0%	71.7%	39.2%	16.7%	50.0%
Internet	62.9%	51.2%	46.4%	53.6%	55.2%	62.5%	60.0%	60.4%	52.2%	66.7%	52.5%
Smart phone (e.g. iPhone, Galaxy)	54.3%	47.9%	40.5%	57.1%	41.4%	50.0%	60.0%	58.5%	56.5%	33.3%	47.8%
Text messaging	45.7%	37.2%	30.4%	39.3%	41.4%	41.7%	60.0%	60.4%	43.5%	16.7%	38.9%
Twitter	0.0%	7.4%	6.0%	3.6%	3.5%	8.3%	20.0%	3.8%	4.4%	0.0%	6.0%
Facebook	40.0%	34.5%	17.9%	32.1%	34.5%	20.8%	60.0%	43.4%	30.4%	0.0%	30.4%

Table 14: Civic engagement

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=594)
Community center	25.7%	24.4%	23.5%	36.7%	13.8%	25.0%	15.4%	18.9%	25.0%	14.3%	23.6%
Library	28.6%	26.8%	38.0%	36.7%	37.9%	41.7%	30.8%	50.9%	29.2%	0.0%	33.7%
Faith-based organization (e.g. church, temple, synogogue, mosque)	20.0%	32.4%	32.5%	36.7%	24.1%	25.0%	38.5%	30.2%	37.5%	0.0%	31.0%
Neighborhood association	2.9%	4.2%	5.4%	6.7%	3.5%	0.0%	0.0%	7.6%	8.3%	0.0%	4.7%
Gym or recreational center	11.4%	15.0%	10.2%	20.0%	13.8%	8.3%	15.4%	22.6%	33.3%	0.0%	14.7%
Political club	0.0%	2.4%	1.8%	6.7%	0.0%	0.0%	0.0%	3.8%	0.0%	0.0%	2.0%
Senior center	20.0%	11.7%	37.4%	36.7%	17.2%	16.7%	0.0%	5.7%	50.0%	14.3%	21.9%
School	5.7%	13.6%	4.8%	0.0%	10.3%	12.5%	30.8%	11.3%	16.7%	0.0%	9.9%
Sport league	0.0%	3.8%	0.0%	0.0%	3.5%	8.3%	0.0%	1.9%	8.3%	0.0%	2.4%
Other community organization	8.6%	8.5%	7.8%	13.3%	3.5%	4.2%	0.0%	1.9%	0.0%	0.0%	6.9%

Table 15: Use of complementary or alternative treatments/remedies

	Northwest Queens	West Queens	North Queens	West Central Queens	Central Queens	Northeast Queens	Southwest Queens	Jamaica	Southeast Queens	Rockaways	Queens (N=582)
Acupunture	588.0%	2.9%	17.8%	10.7%	6.9%	9.5%	0.0%	3.9%	435.0%	0.0%	8.3%
Chiropractic care	8.8%	2.9%	7.1%	7.1%	0.0%	4.8%	0.0%	2.0%	0.0%	0.0%	4.3%
Herbal medicine	8.8%	9.2%	14.8%	17.9%	10.3%	4.8%	26.7%	5.9%	21.7%	0.0%	11.7%
Homeopathy	0.0%	2.4%	1.8%	10.7%	0.0%	9.5%	6.7%	9.8%	0.0%	0.0%	3.3%
Remedies from a botanica	5.9%	3.4%	5.3%	7.1%	10.3%	4.8%	0.0%	0.0%	0.0%	0.0%	4.1%
Other	0.0%	2.9%	2.4%	7.1%	0.0%	4.8%	0.0%	5.9%	4.4%	0.0%	2.9%