BRONX COMMUNITY NEEDS ASSESSMENT
APPENDIX A - MAPS

December16, 2014

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION The New York Academy of Medicine

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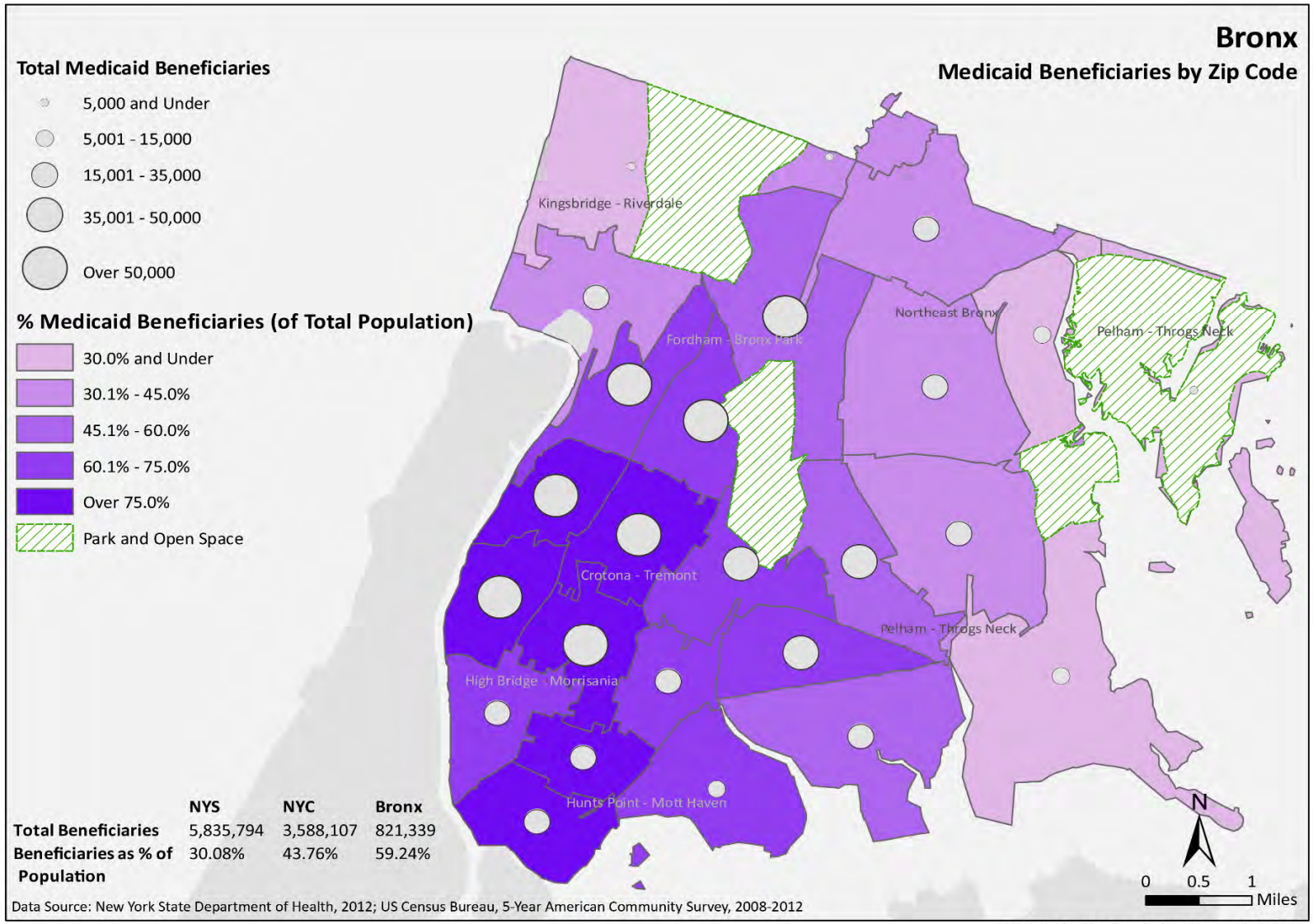
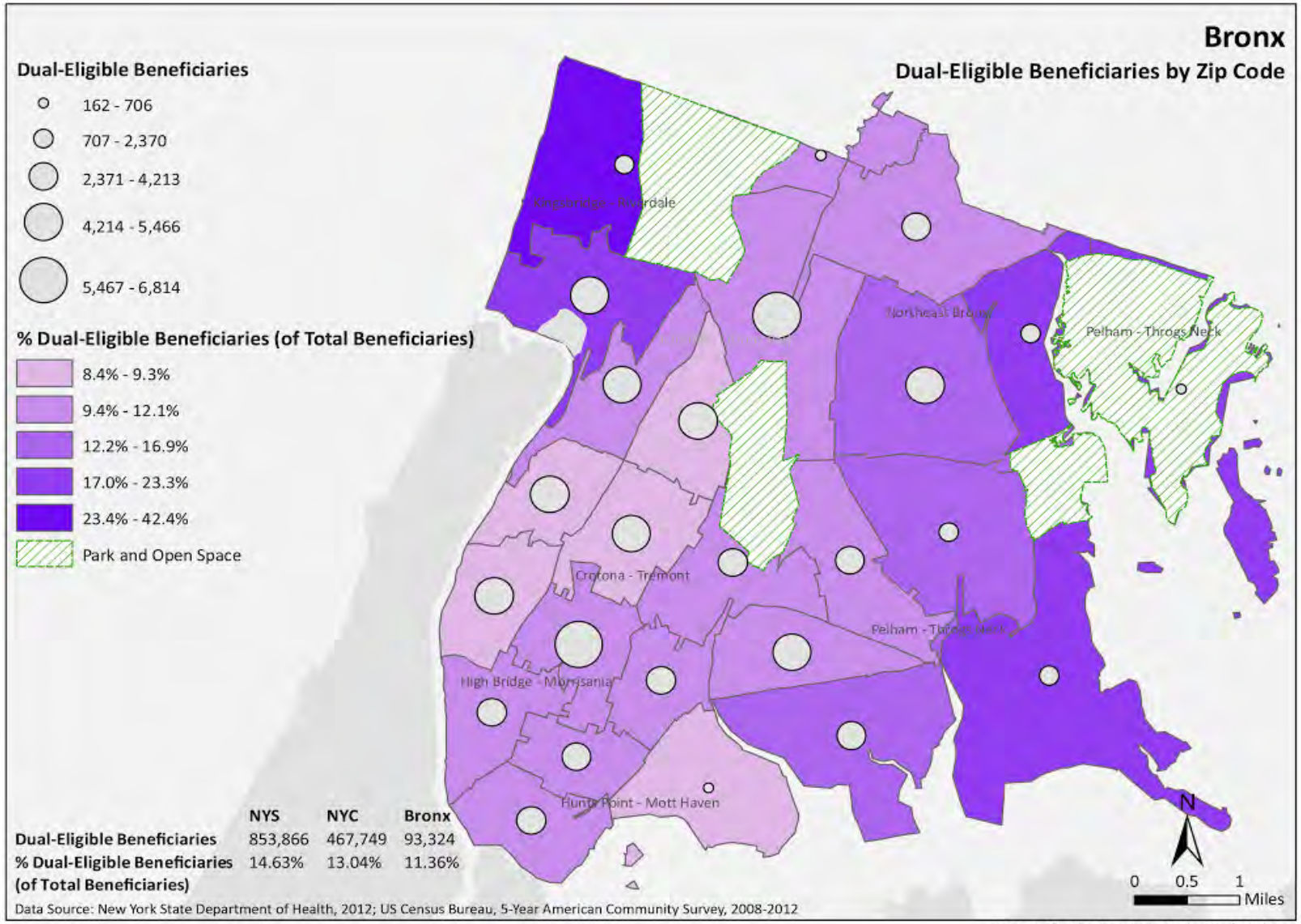
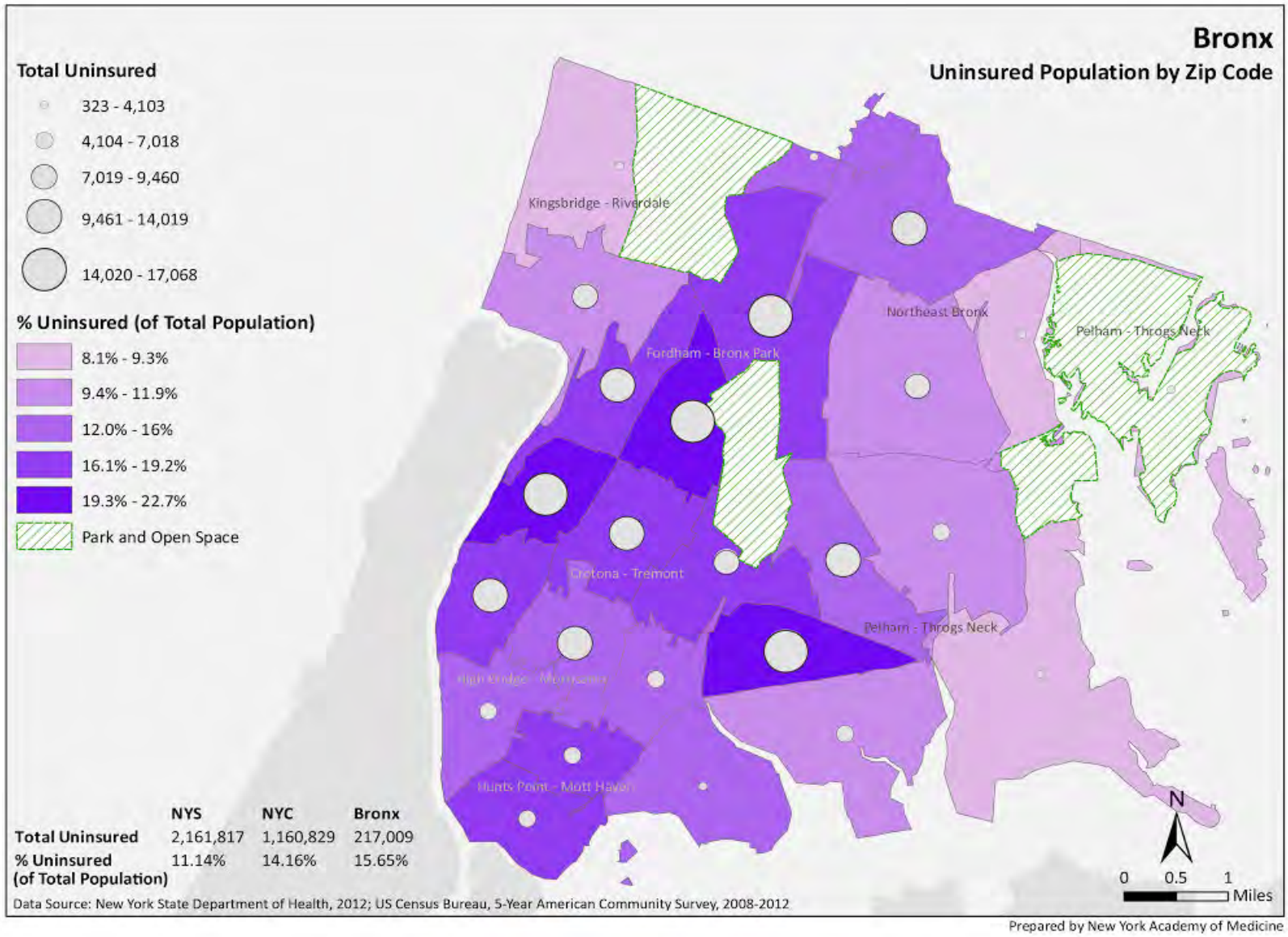


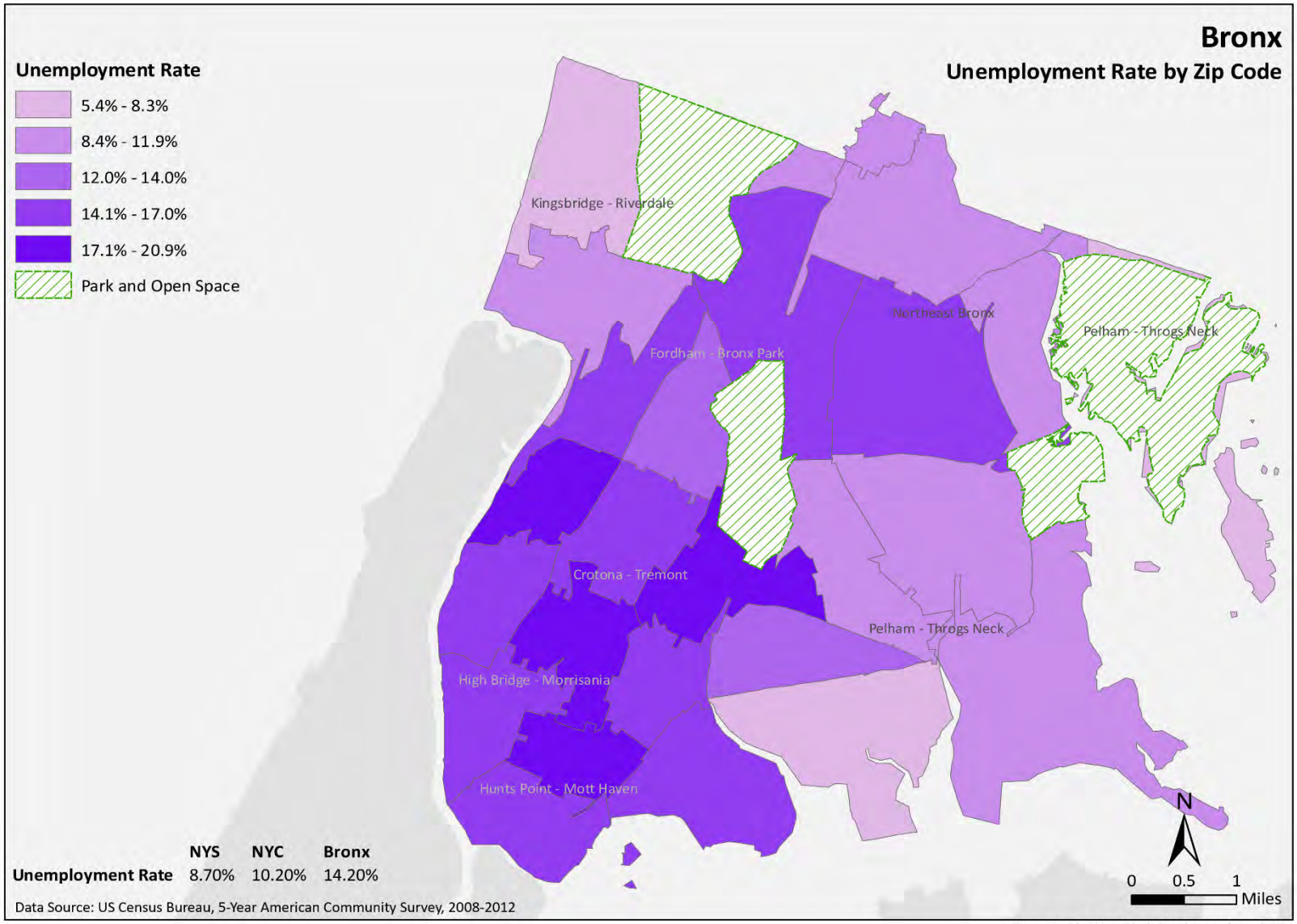
2. Dual-Eligible Beneficiaries by Zip Code



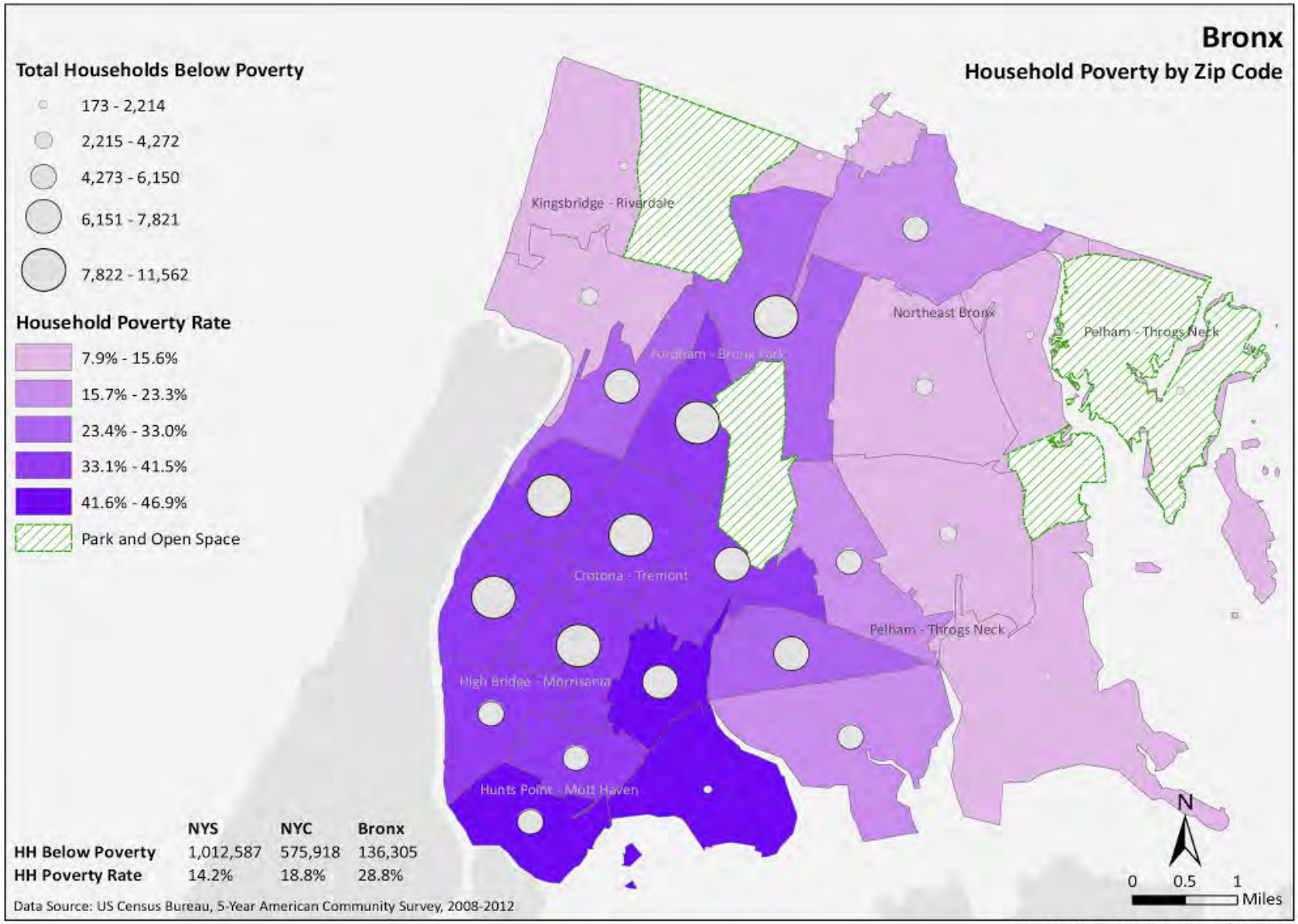
3. Uninsured Population by Zip Code



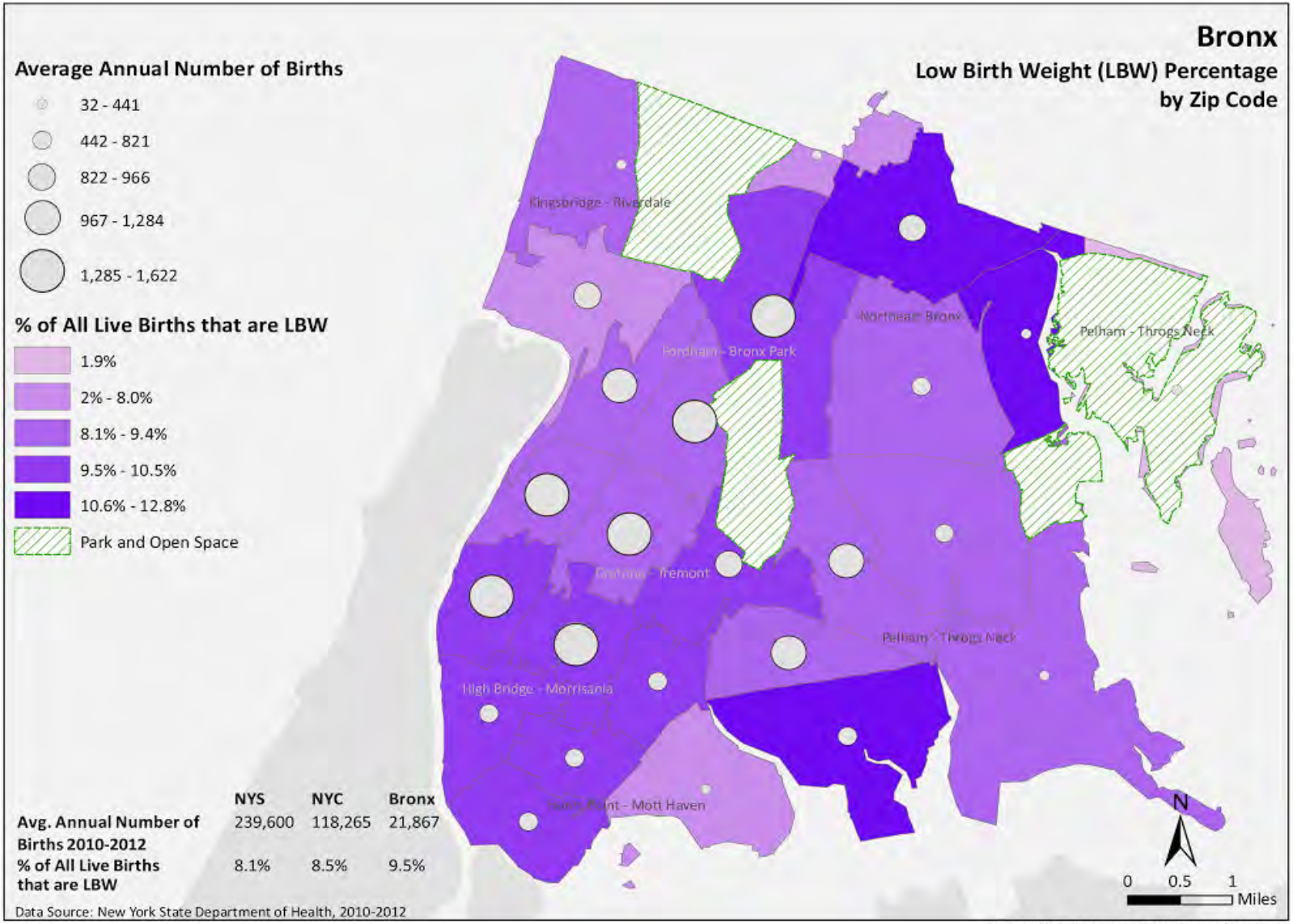
4. Unemployment Rate by Zip Code



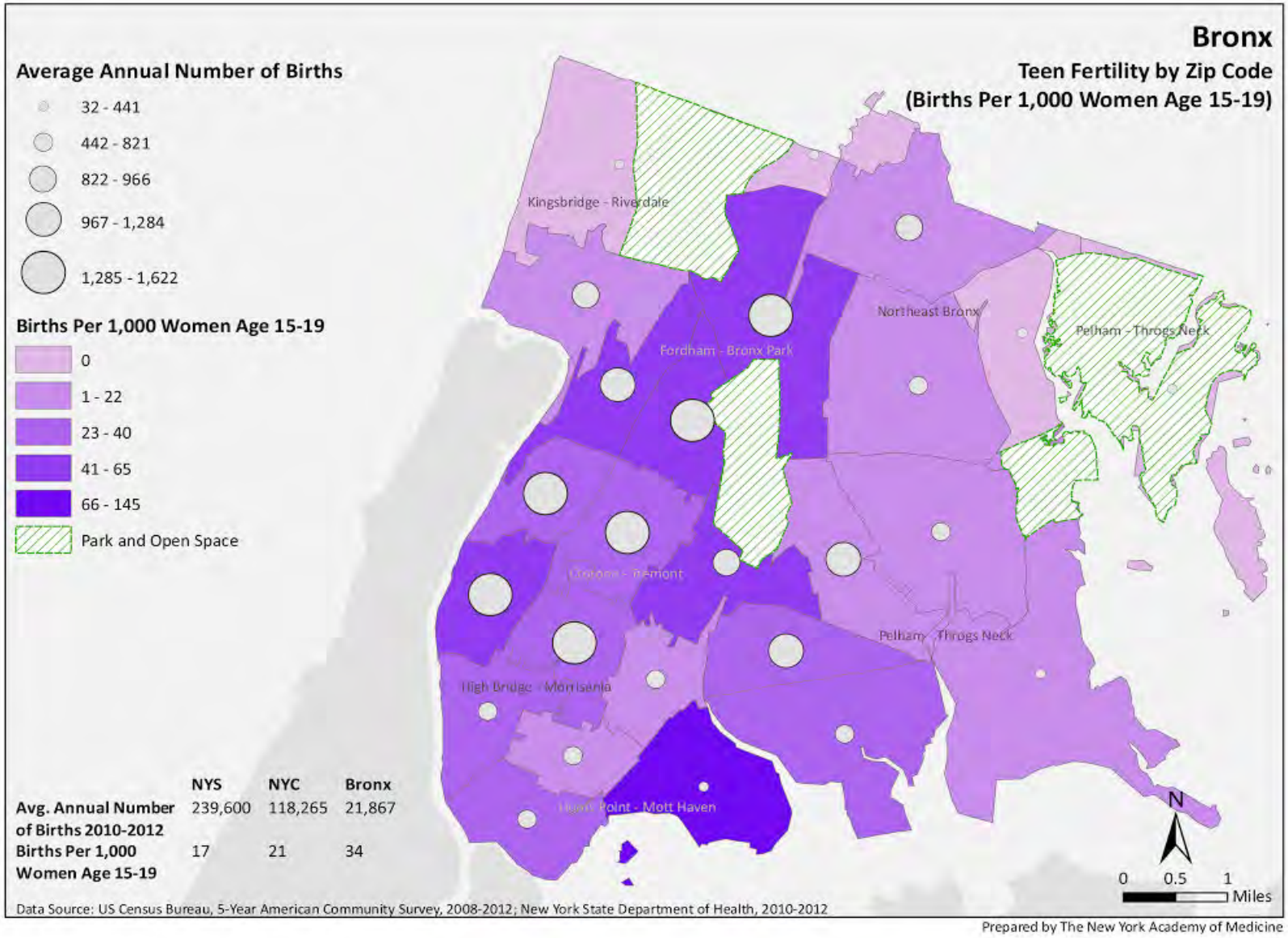
5. Household Poverty by Zip Code



6. Low Birth Weight Percentage by Zip Code

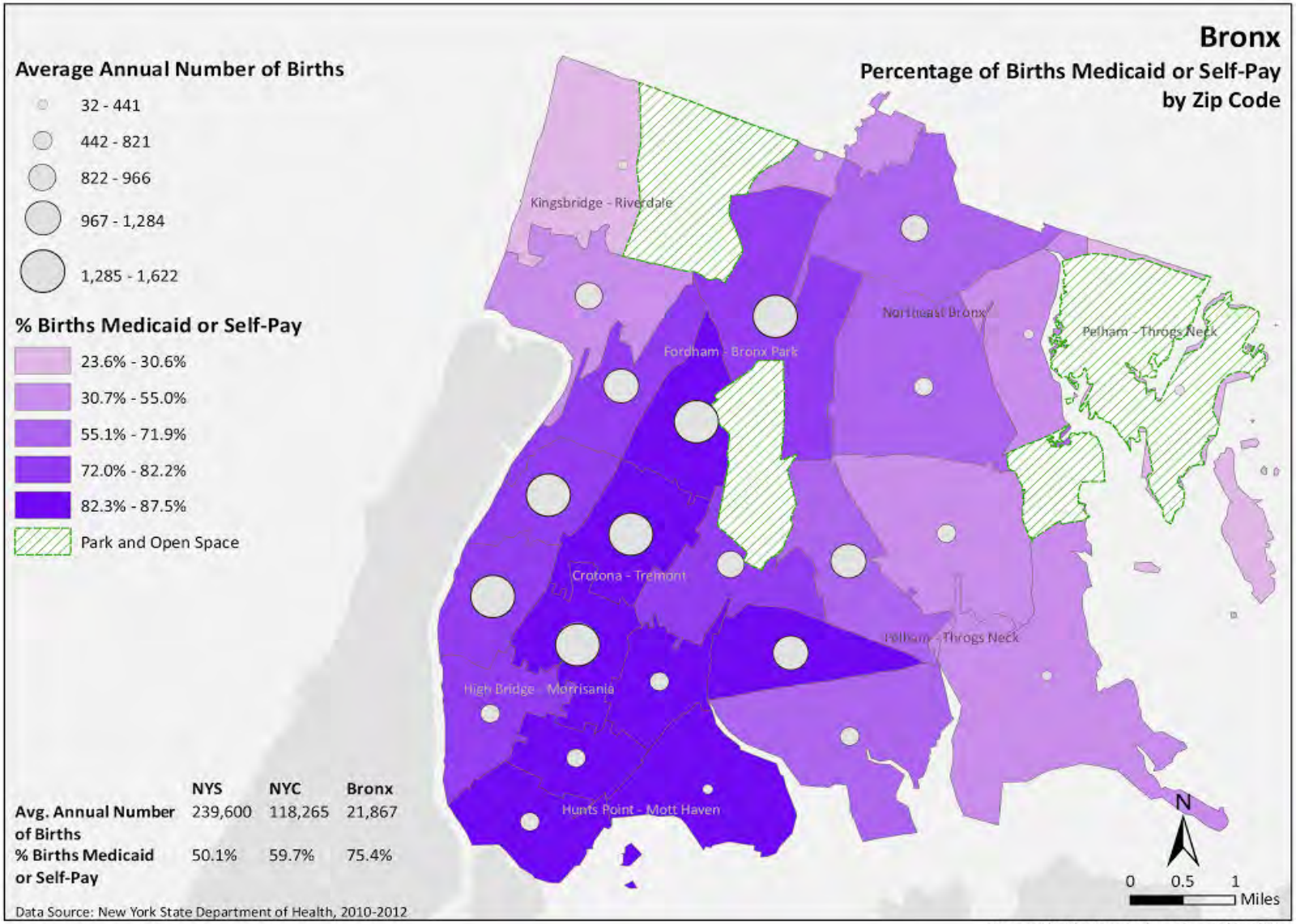


7. Teen Fertility by Zip Code

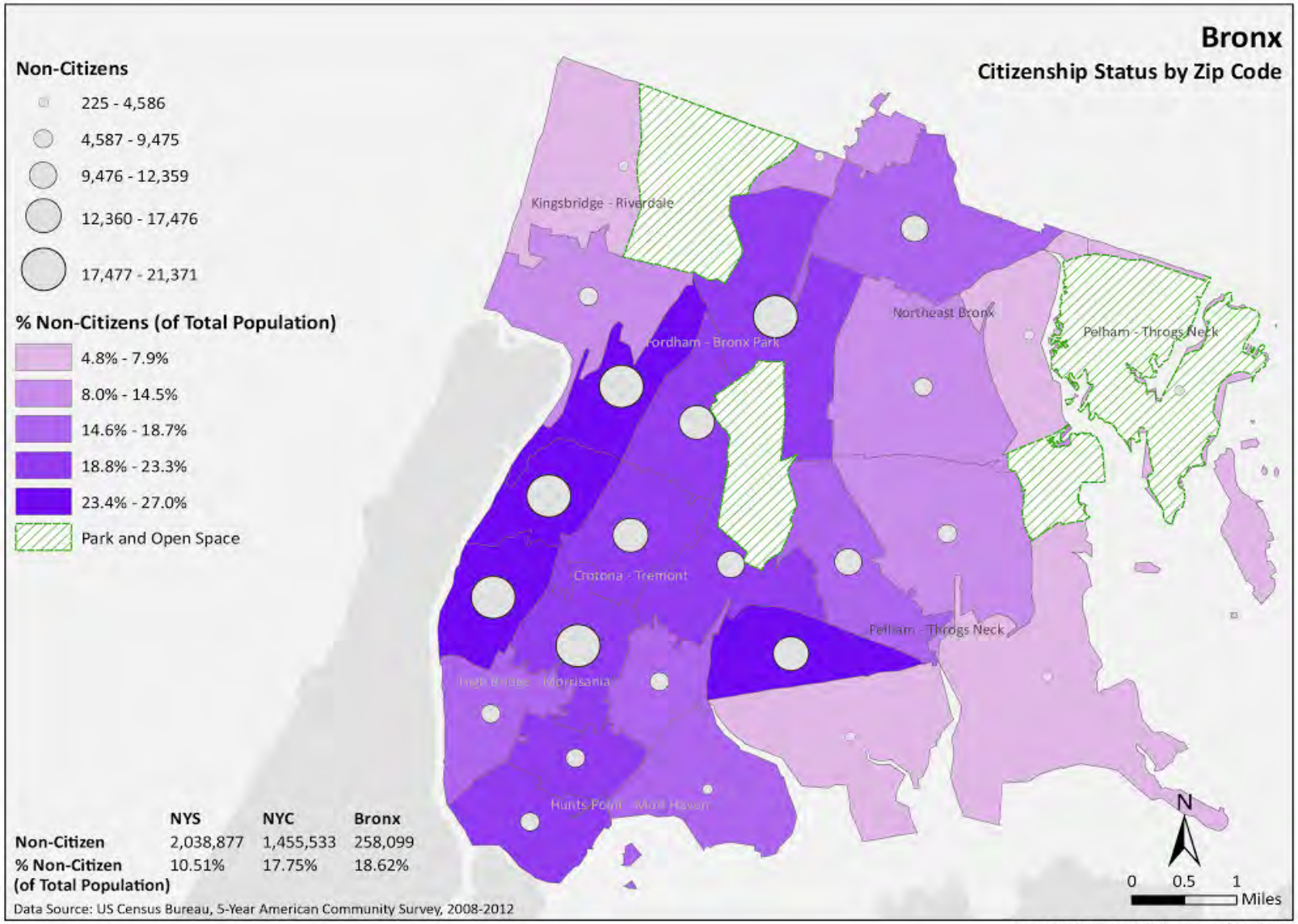


	NYS	NYC	Bronx
Avg. Annual Number of Births 2010-2012	239,600	118,265	21,867
Births Per 1,000 Women Age 15-19	17	21	34

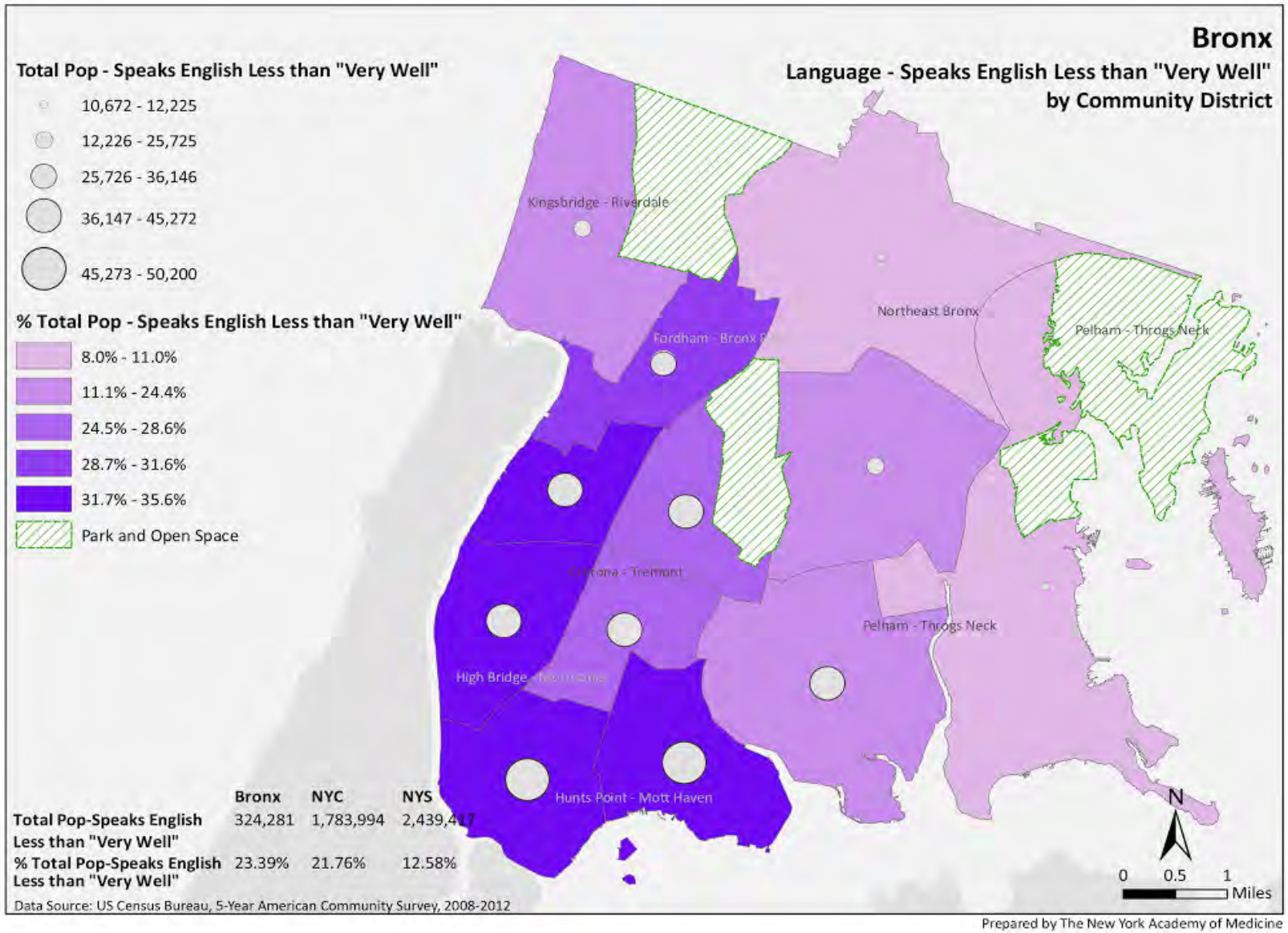
8. Percentage of Births Medicaid or Self-Pay by Zip Code



9. Citizenship Status by Zip Code



10. Language—Speaks English Less than "Very-Well" by Community District



	Bronx	NYC	NYS
Total Pop-Speaks English Less than "Very Well"	324,281	1,783,994	2,439,417
% Total Pop-Speaks English Less than "Very Well"	23.39%	21.76%	12.58%

Data Source: US Census Bureau, 5-Year American Community Survey, 2008-2012

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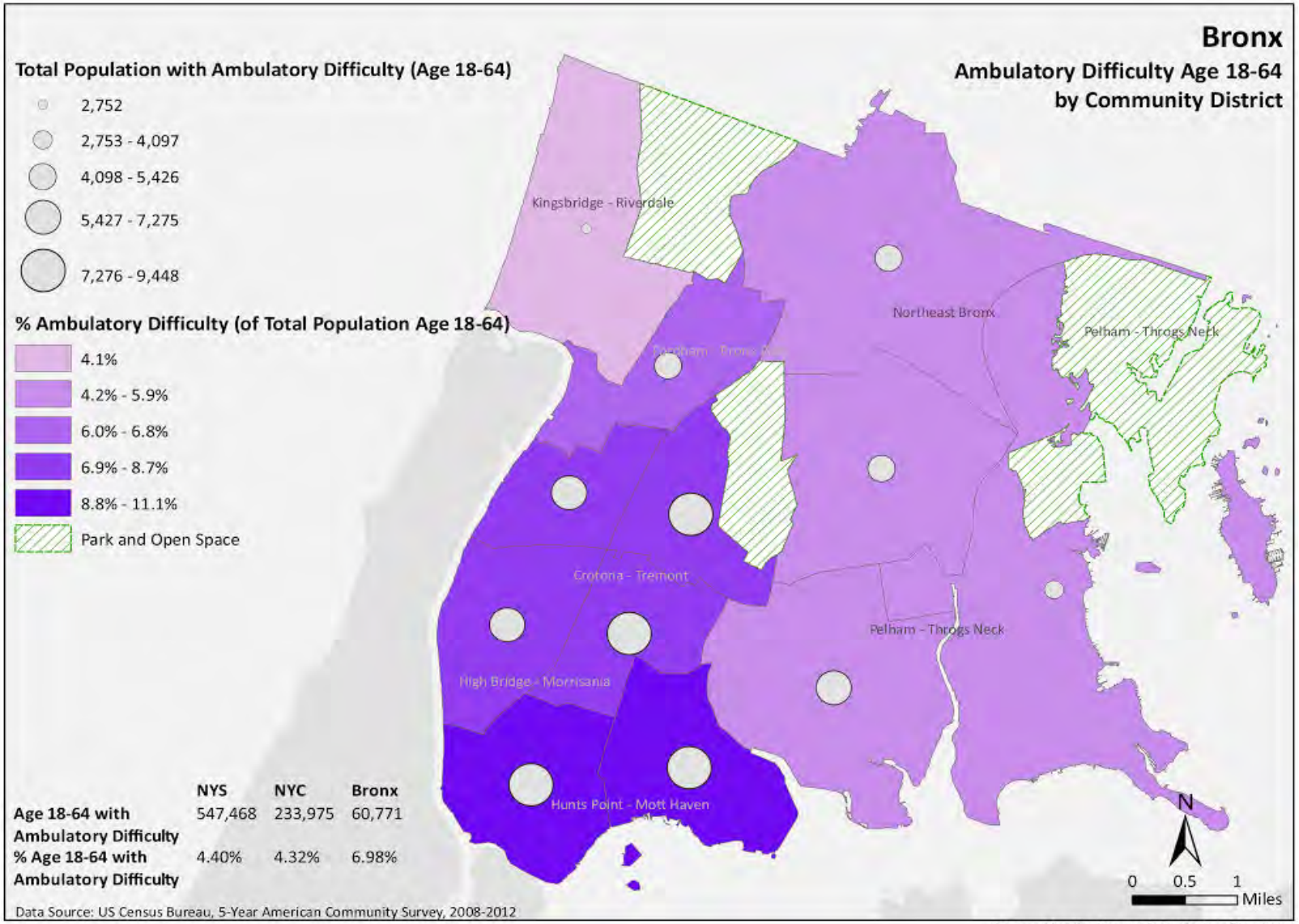
11. Ambulatory Difficulty (Ages 18-64) by Zip Code



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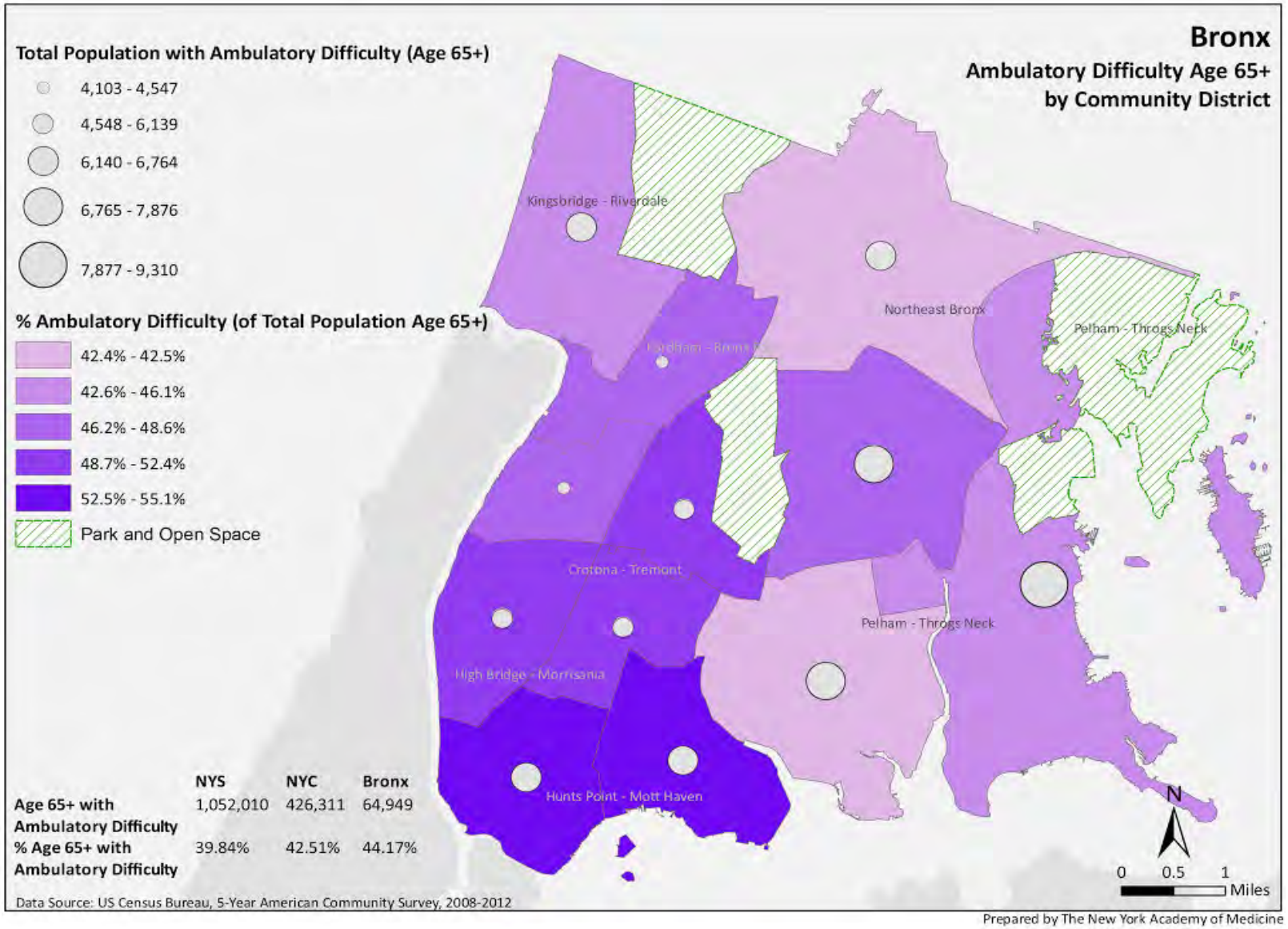

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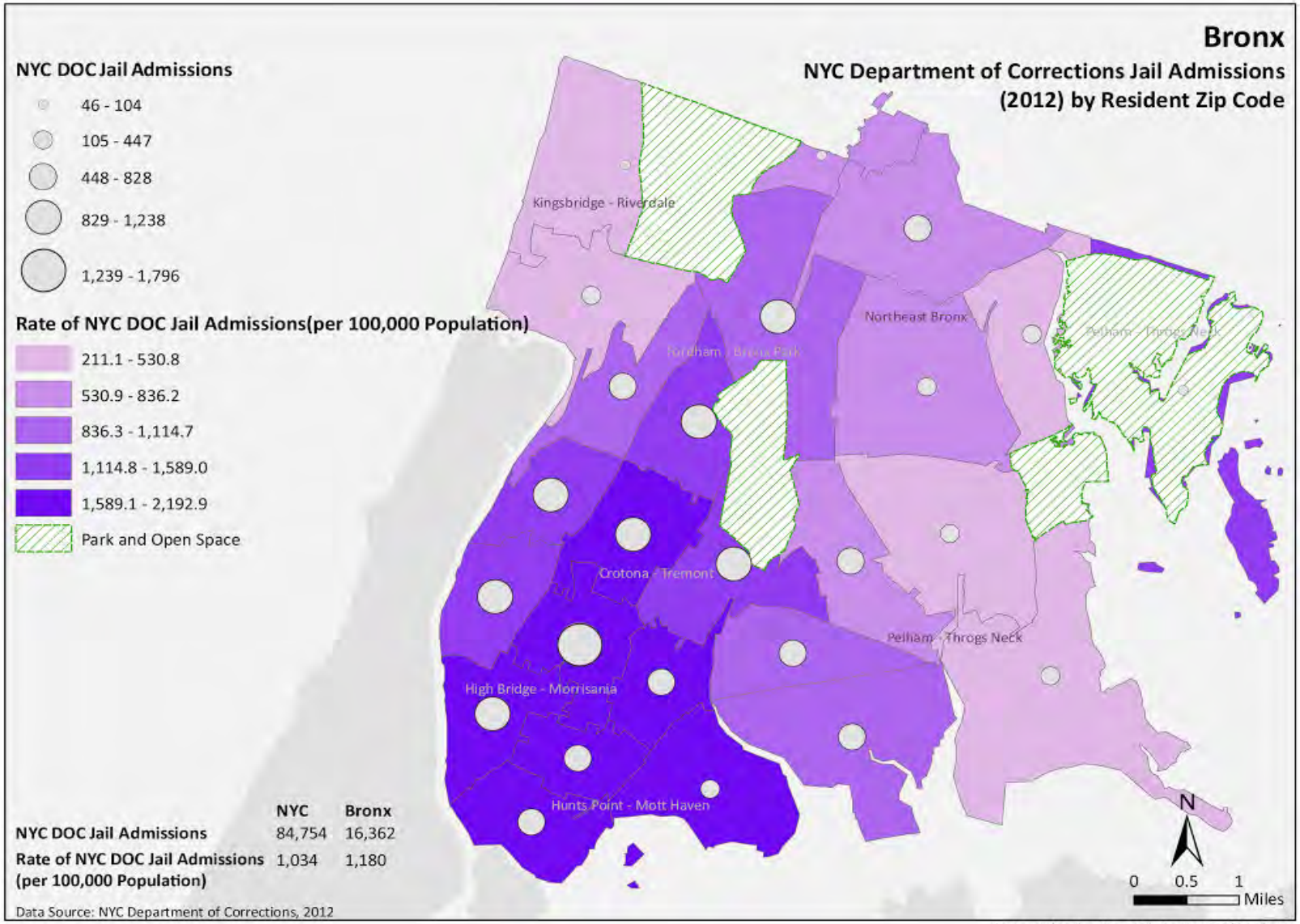
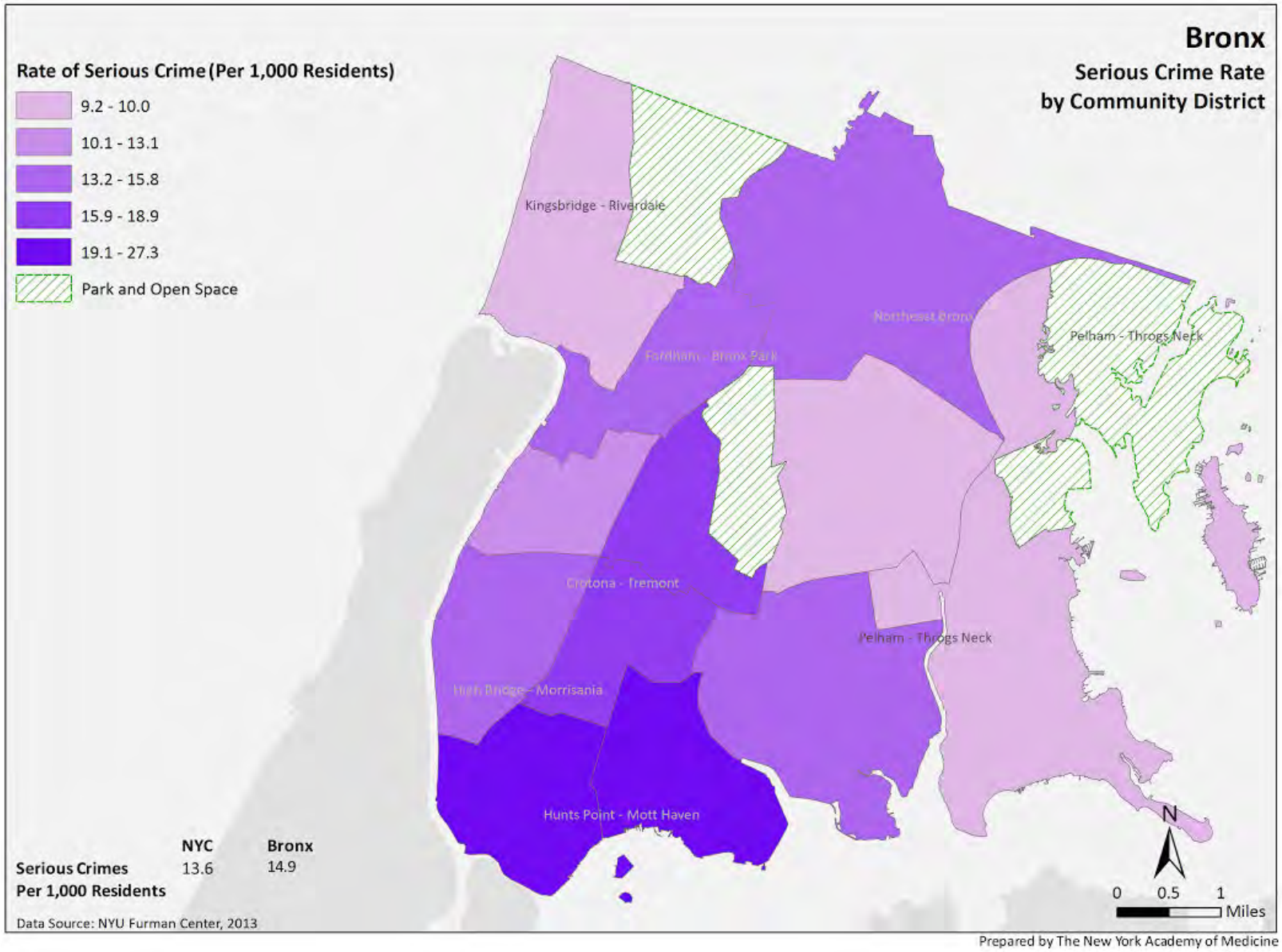


14. Serious Crime Rate by Community District



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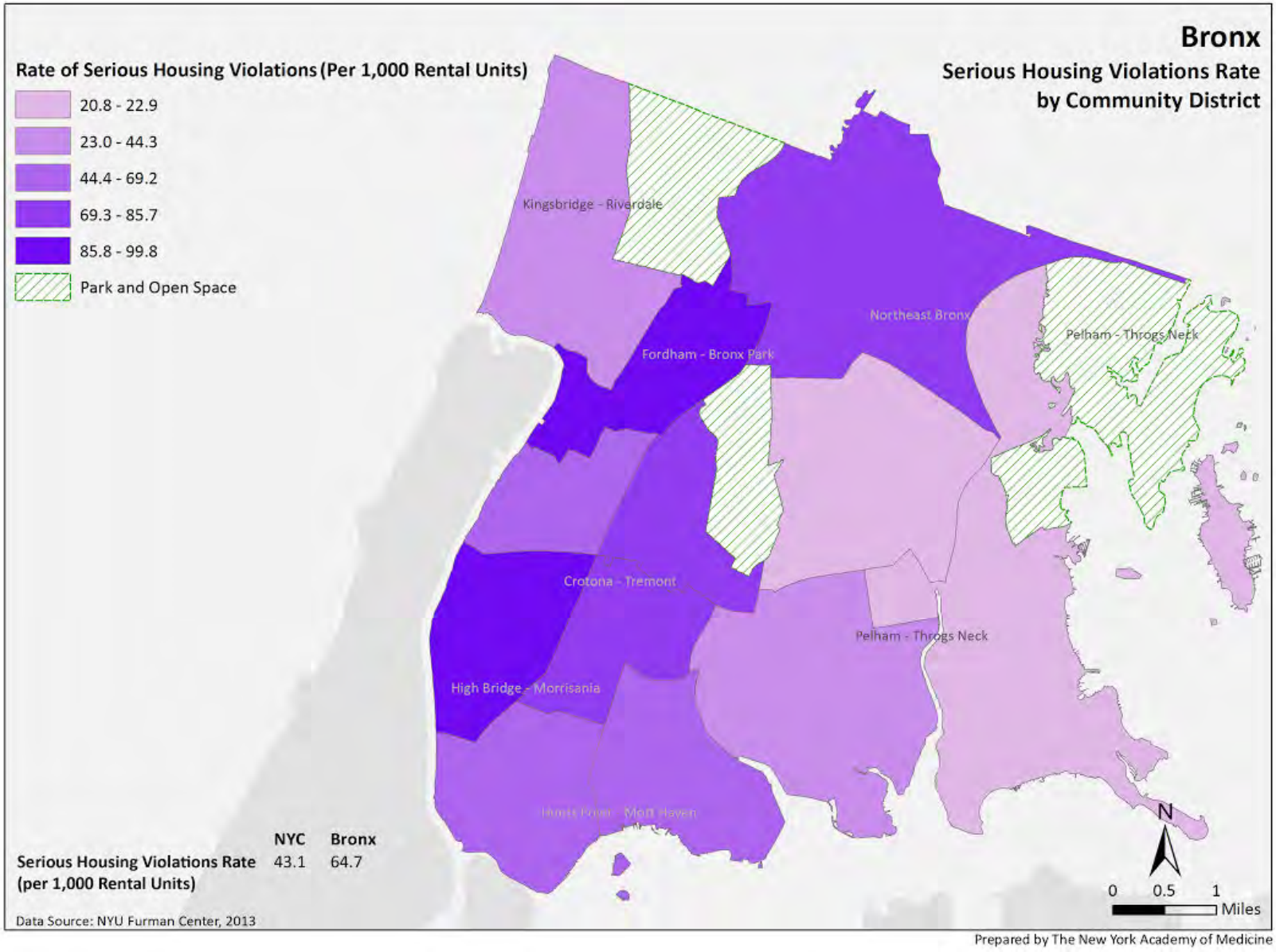
15. Serious Housing Violations by Community District



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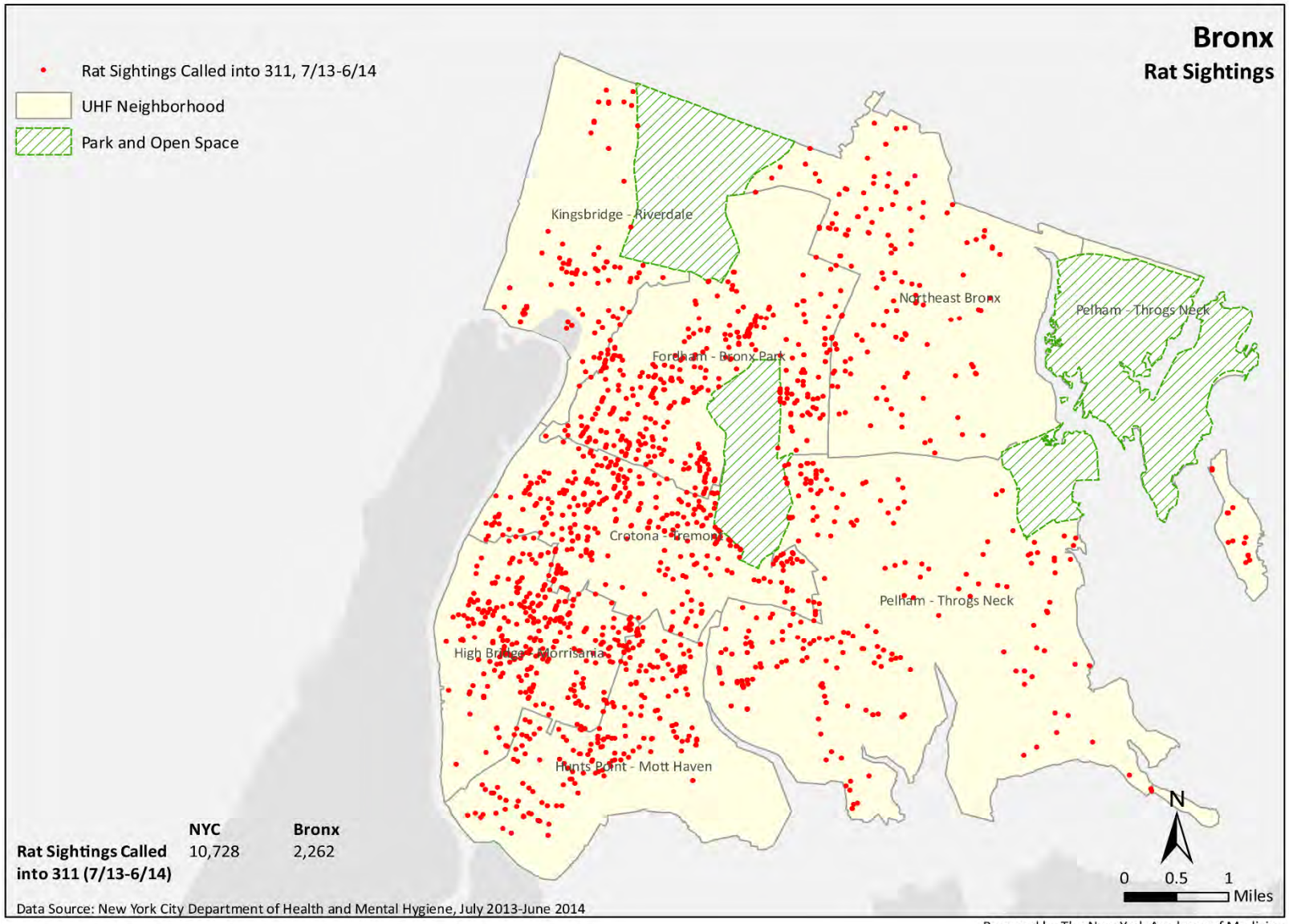

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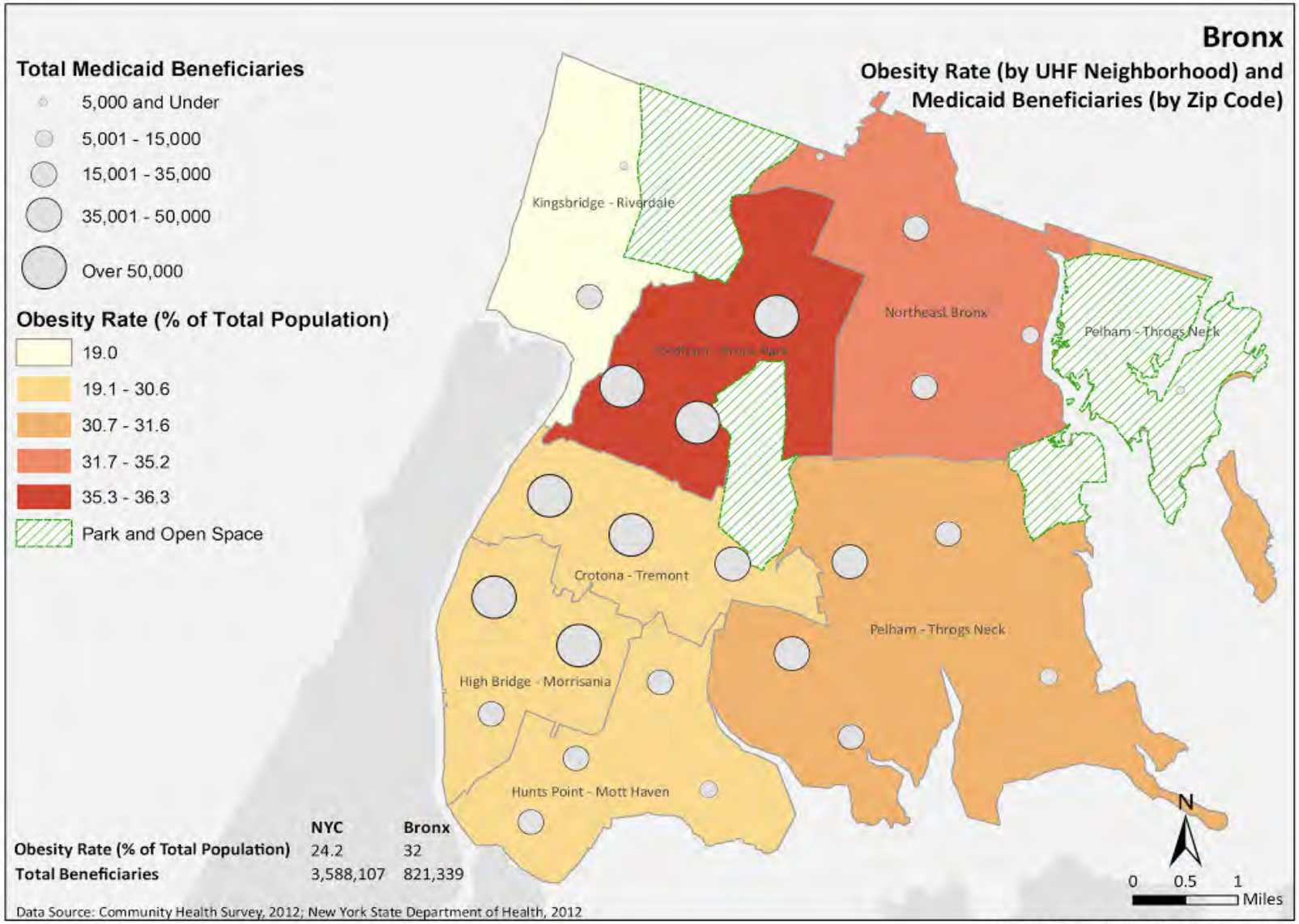
17. Obesity Rate (by UHF Neighborhood) and Medicaid Beneficiaries (by Zip Code)



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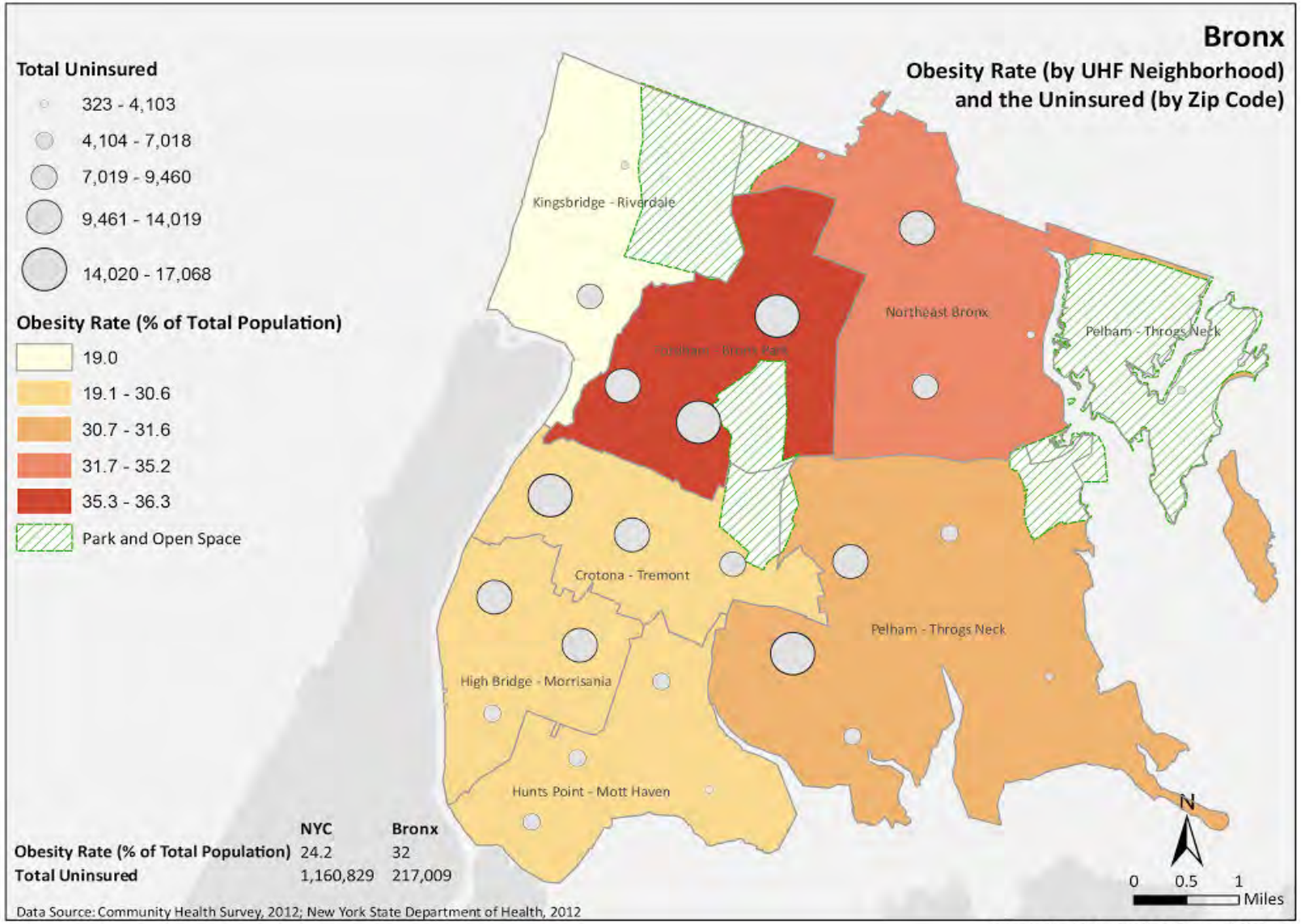

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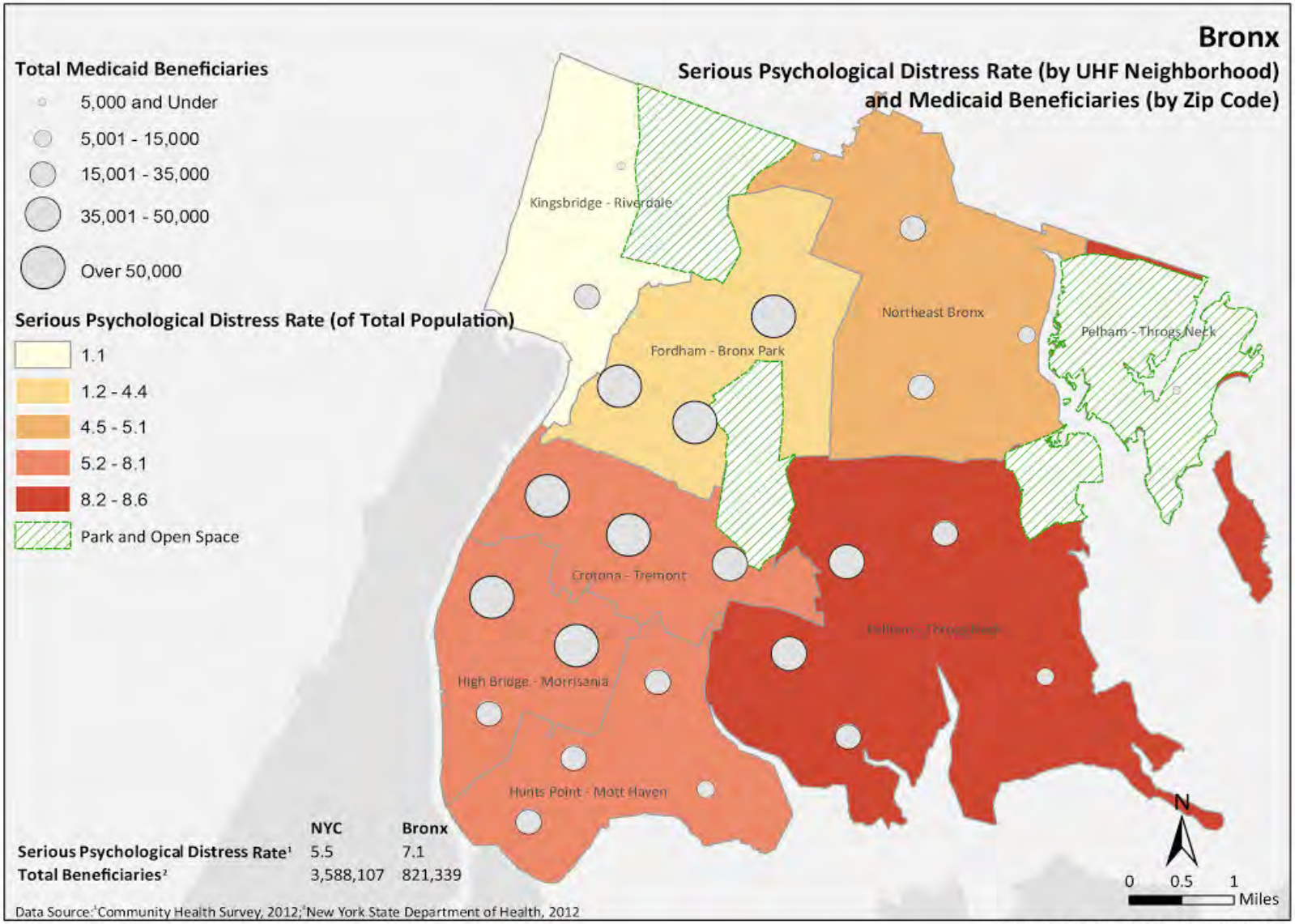
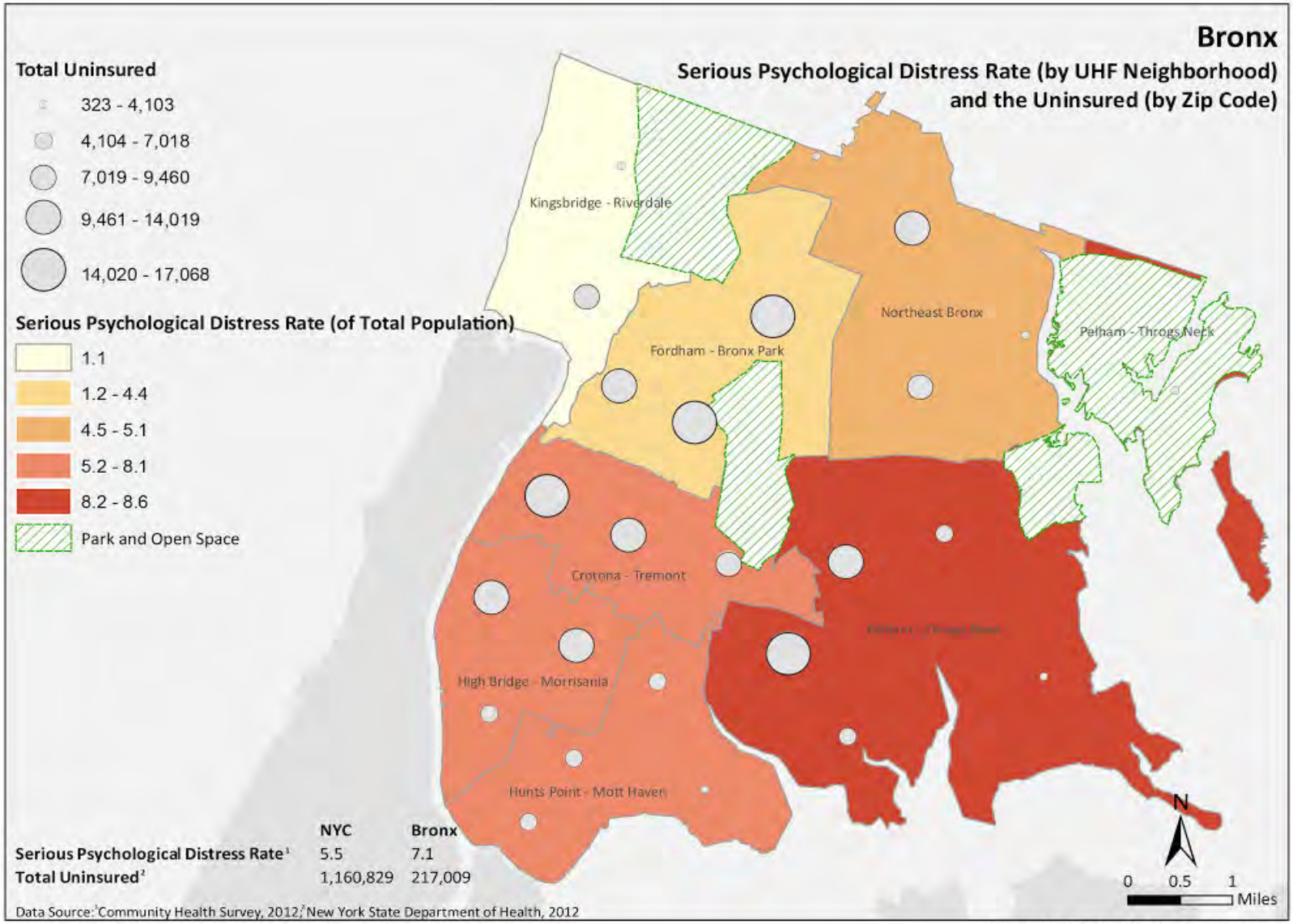
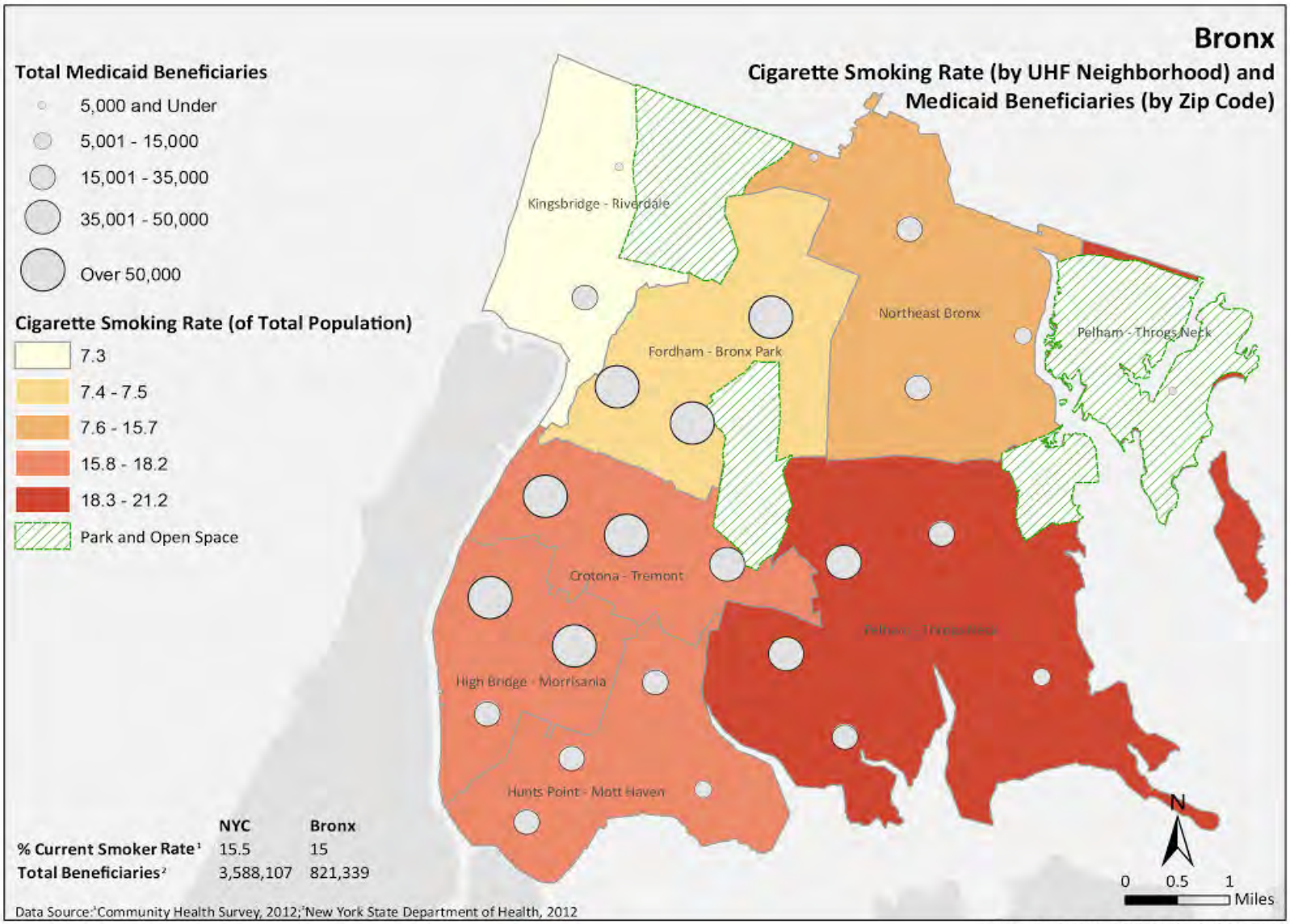


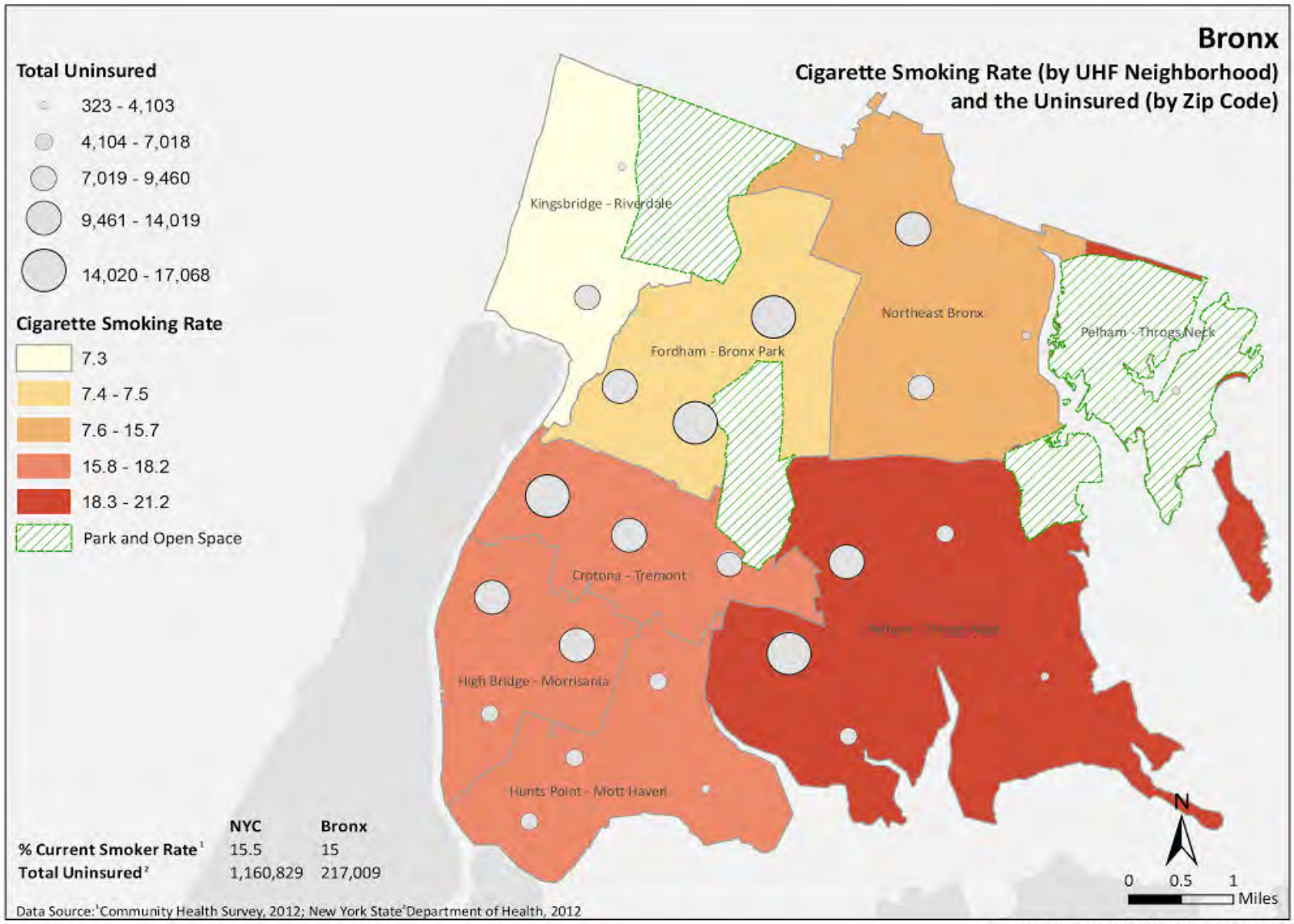
20. Serious Psychological Distress Rate (by UHF Neighborhood) and Uninsured (by Zip Code)



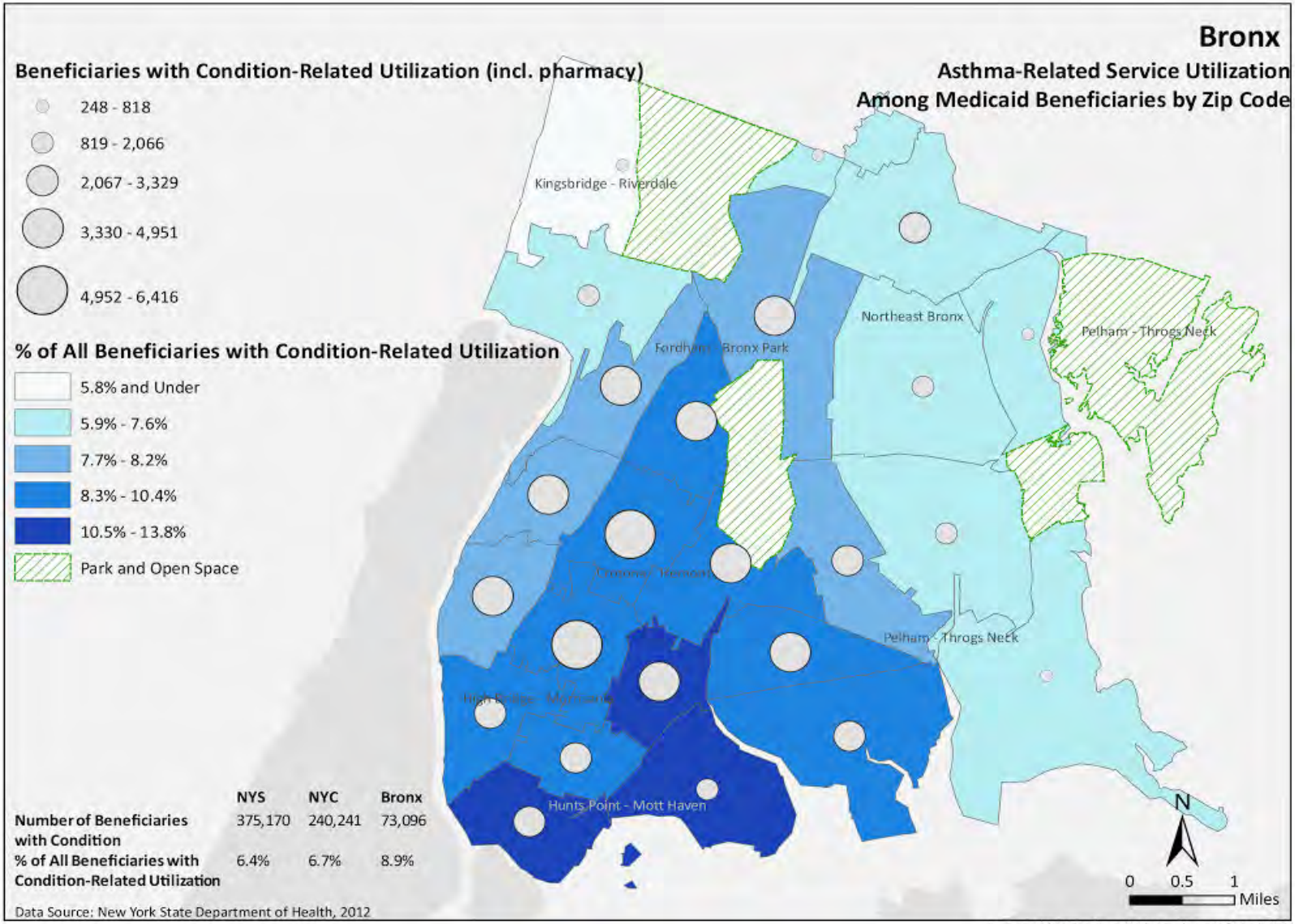
21. Cigarette Smoking Rate (by UHF Neighborhood) and Medicaid Beneficiaries (by Zip Code)



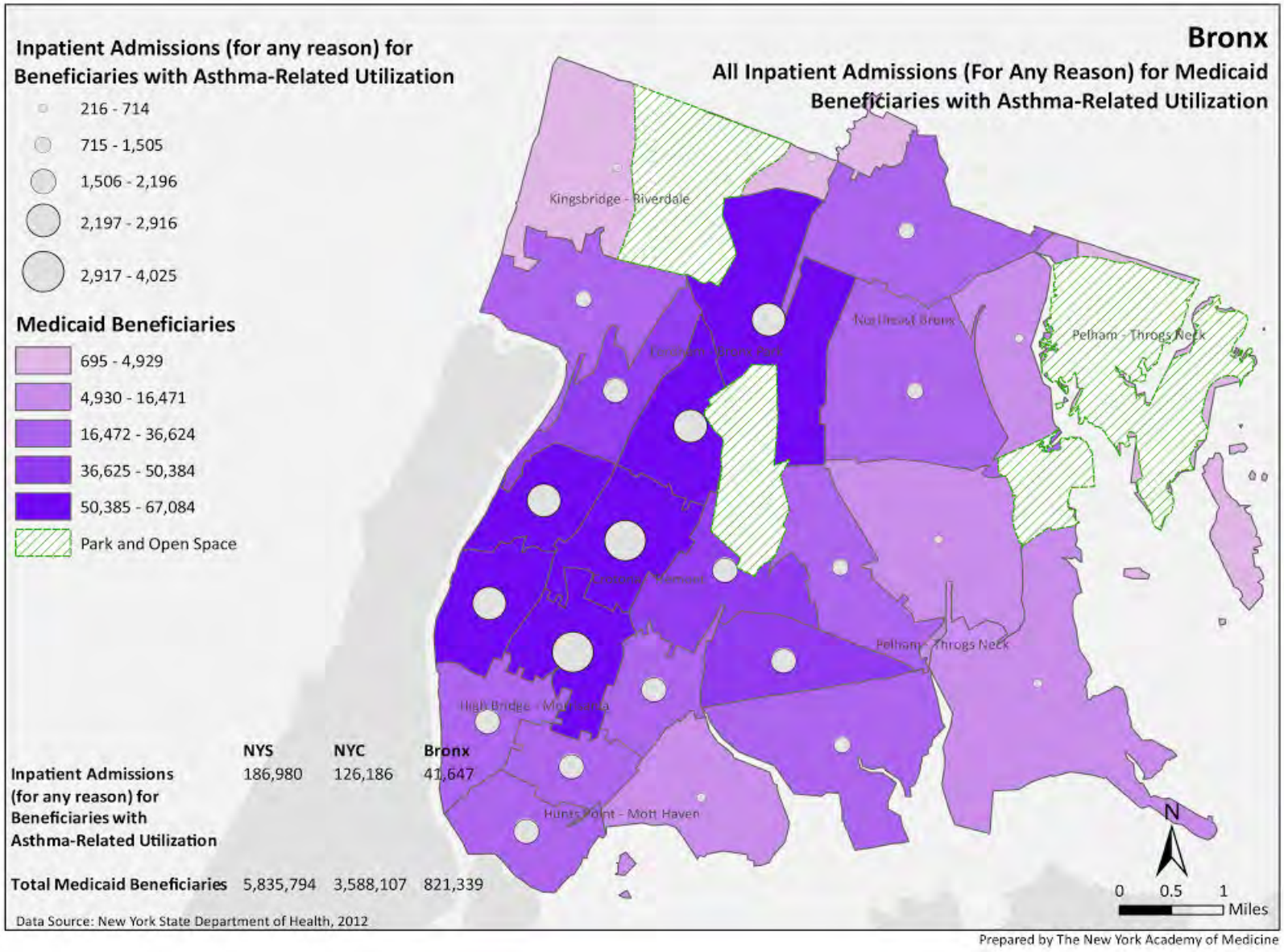
22. Cigarette Smoking Rate (by UHF Neighborhood) and Uninsured (by Zip Code)



23. Asthma-Related Service Utilization Among Medicaid Beneficiaries

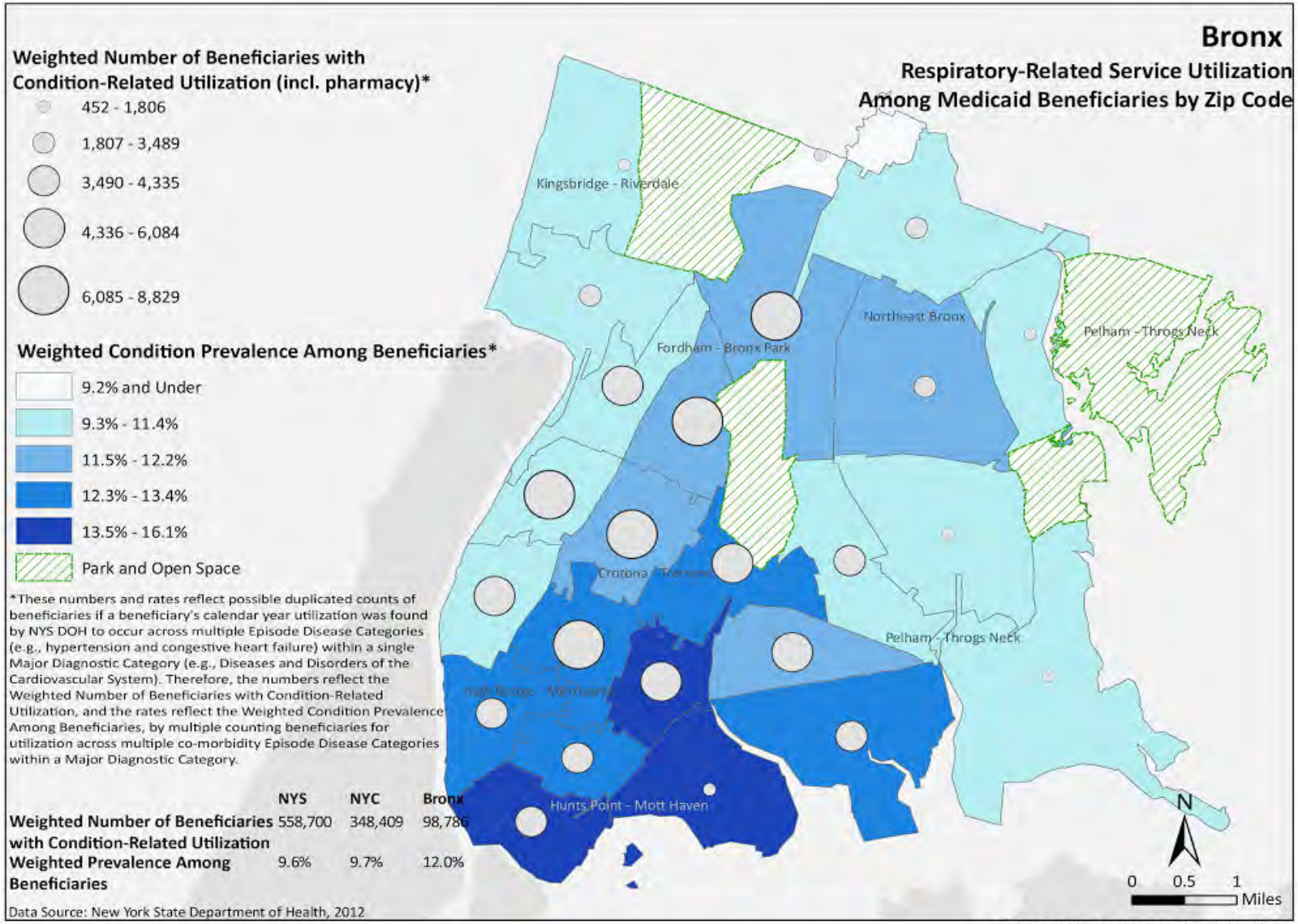


24. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with Asthma-Related Utilization



	NYS	NYC	Bronx
Inpatient Admissions (for any reason) for Beneficiaries with Asthma-Related Utilization	186,980	126,186	41,647
Total Medicaid Beneficiaries	5,835,794	3,588,107	821,339

25. Respiratory-Related Service Utilization Among Medicaid Beneficiaries



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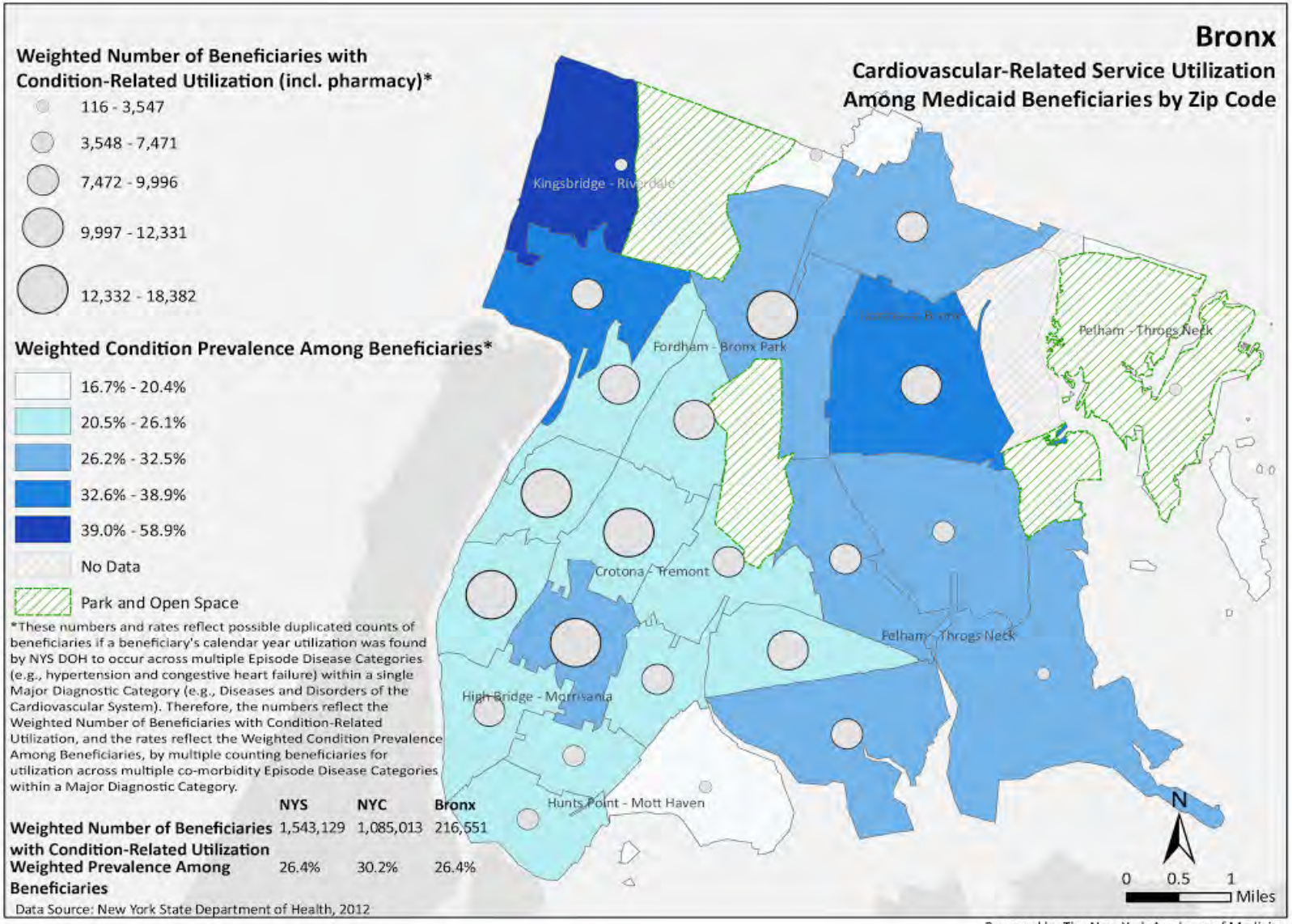
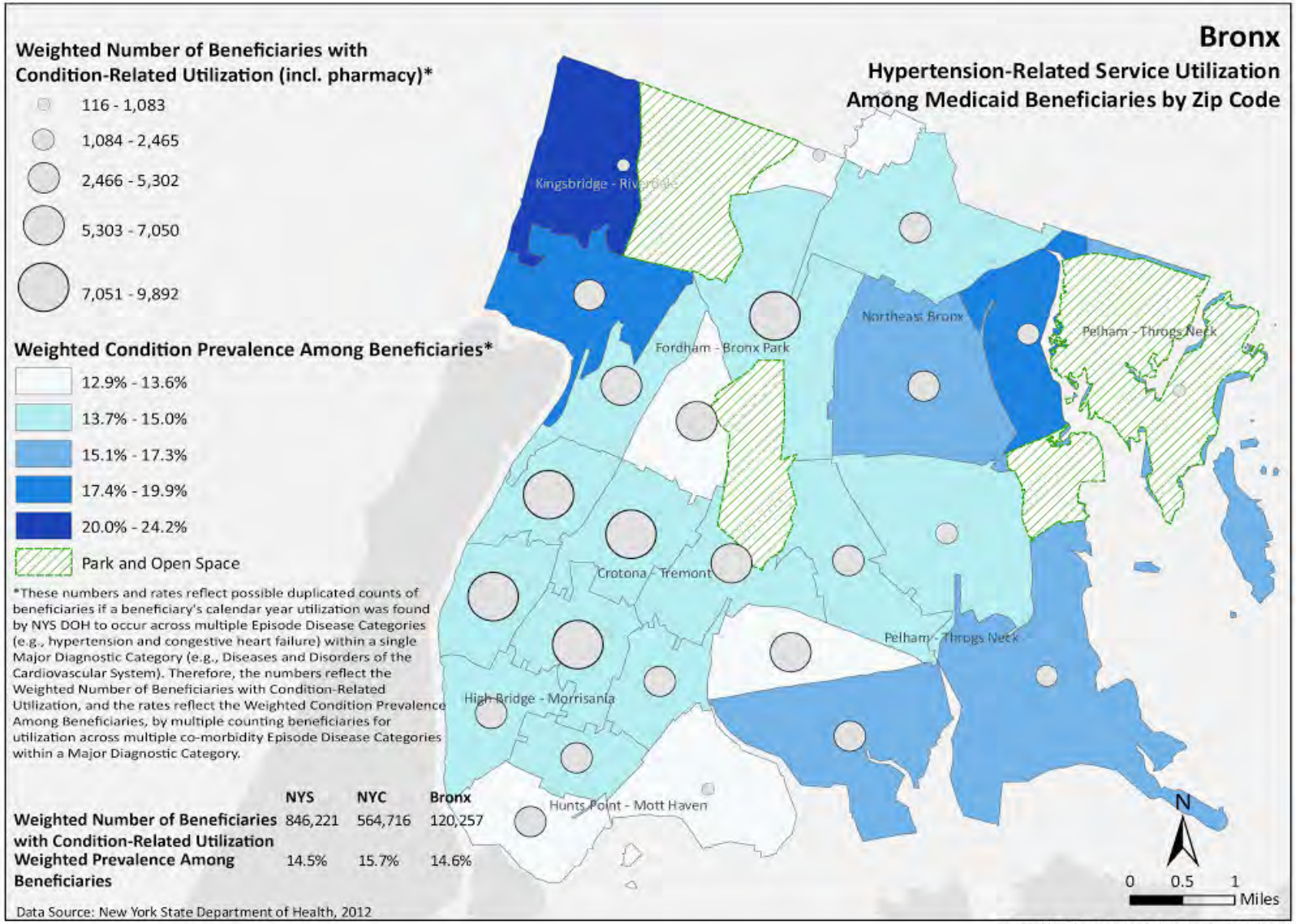
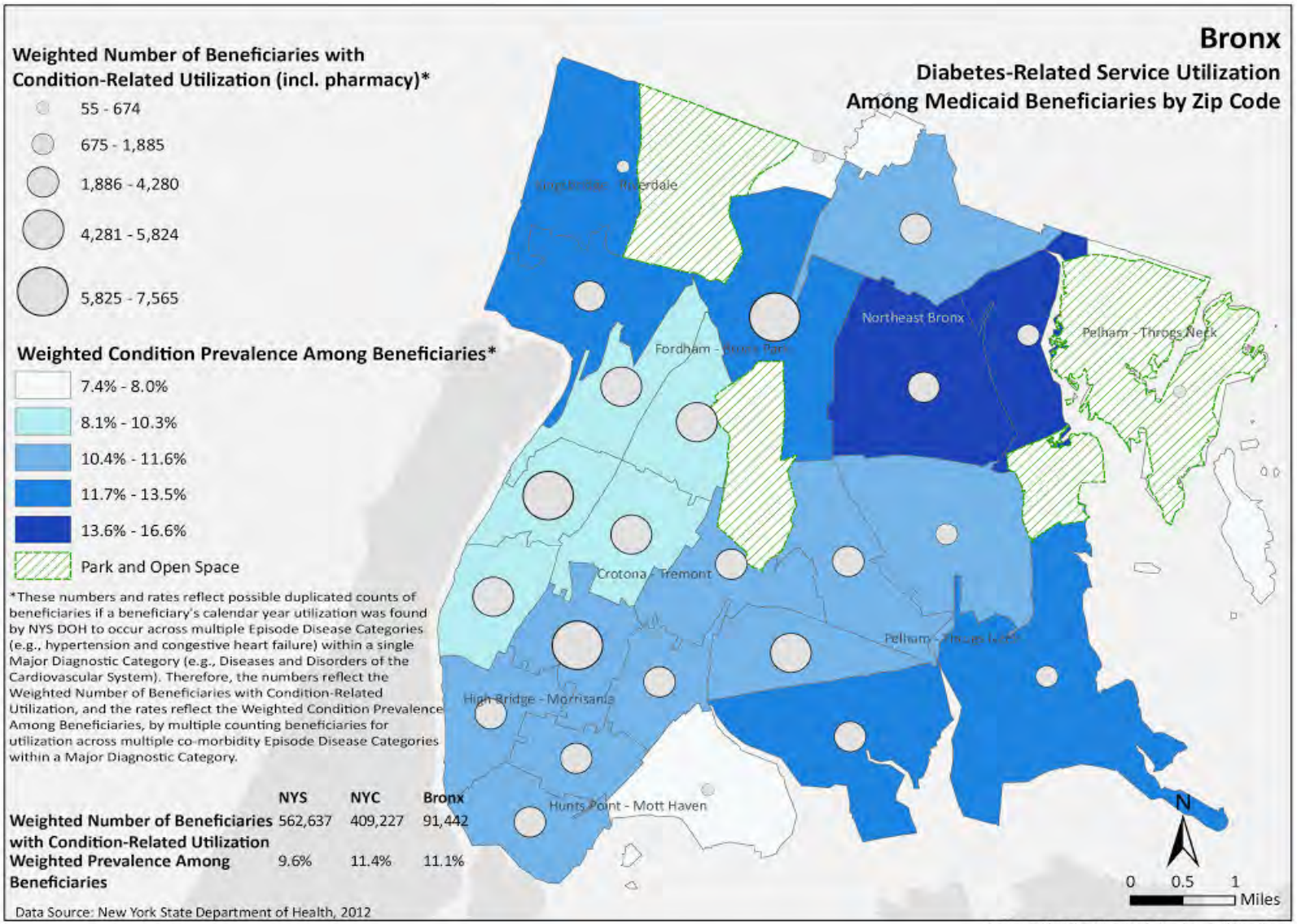


27. Hypertension-Related Service Utilization Among Medicaid Beneficiaries



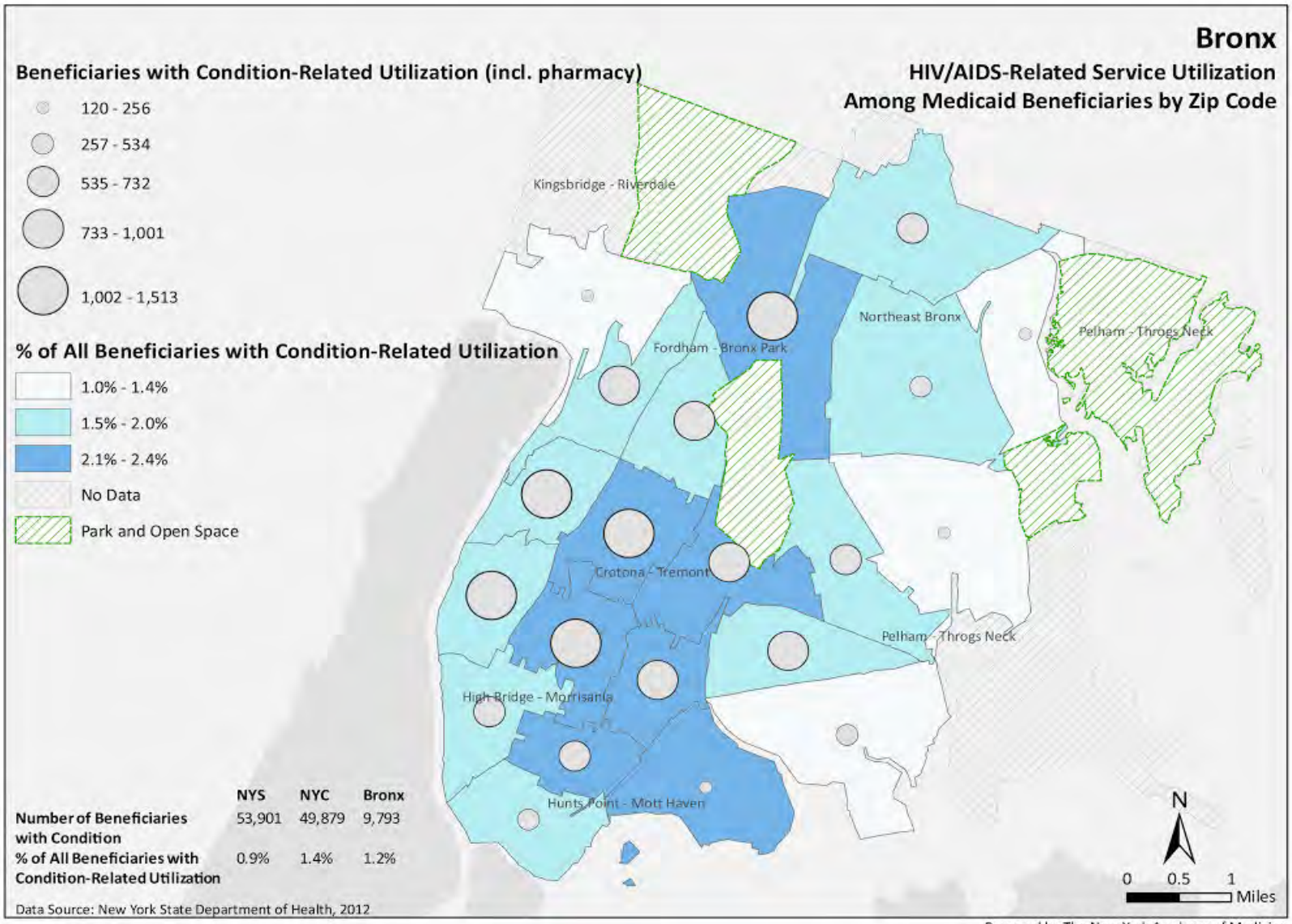
	NYS	NYC	Bronx
Weighted Number of Beneficiaries with Condition-Related Utilization	846,221	564,716	120,257
Weighted Prevalence Among Beneficiaries	14.5%	15.7%	14.6%

28. Diabetes-Related Service Utilization Among Medicaid Beneficiaries



	NYS	NYC	Bronx
Weighted Number of Beneficiaries with Condition-Related Utilization	562,637	409,227	91,442
Weighted Prevalence Among Beneficiaries	9.6%	11.4%	11.1%

29. HIV/AIDS-Related Service Utilization Among Medicaid Beneficiaries



	NYS	NYC	Bronx
Number of Beneficiaries with Condition	53,901	49,879	9,793
% of All Beneficiaries with Condition-Related Utilization	0.9%	1.4%	1.2%

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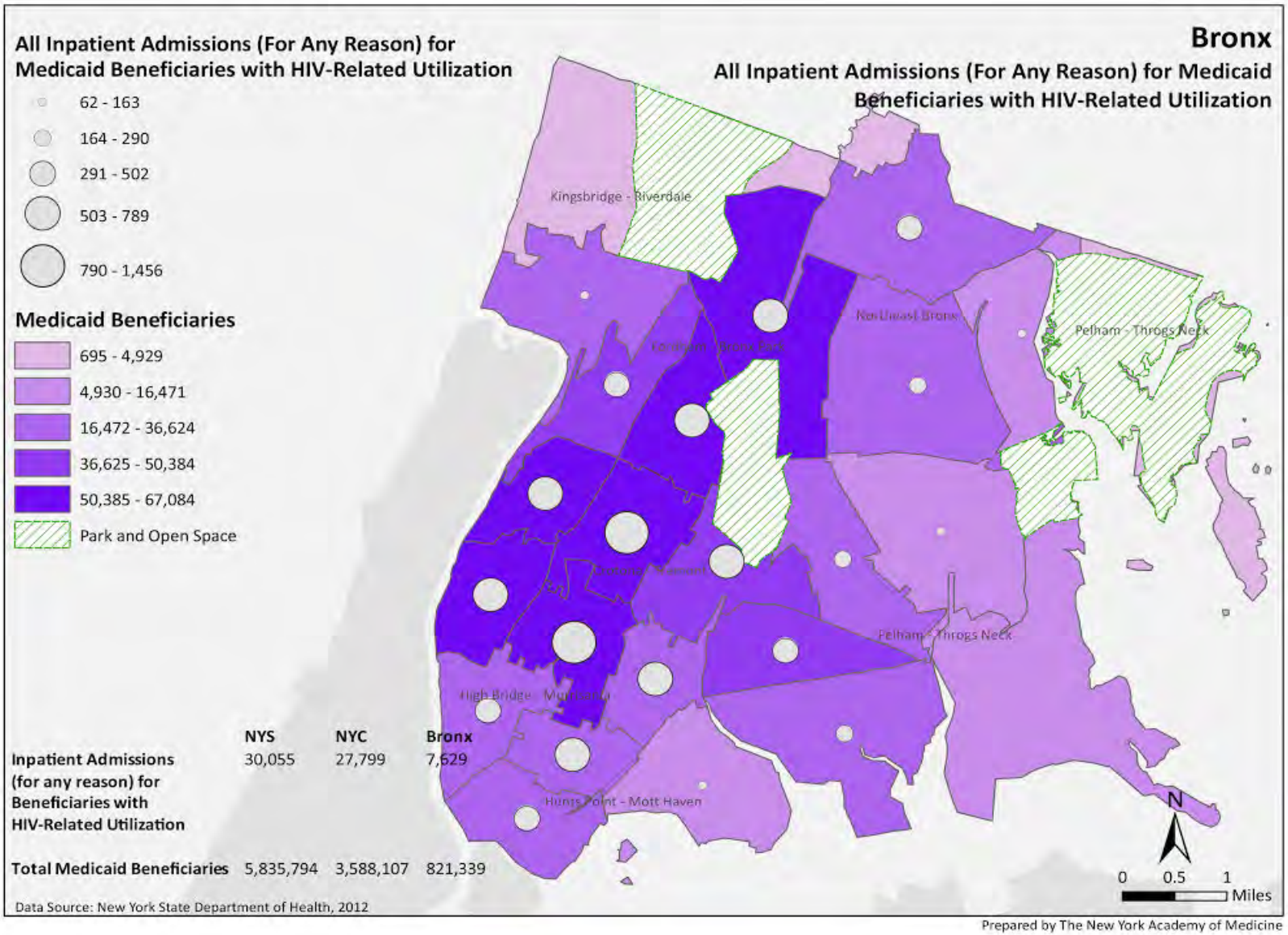
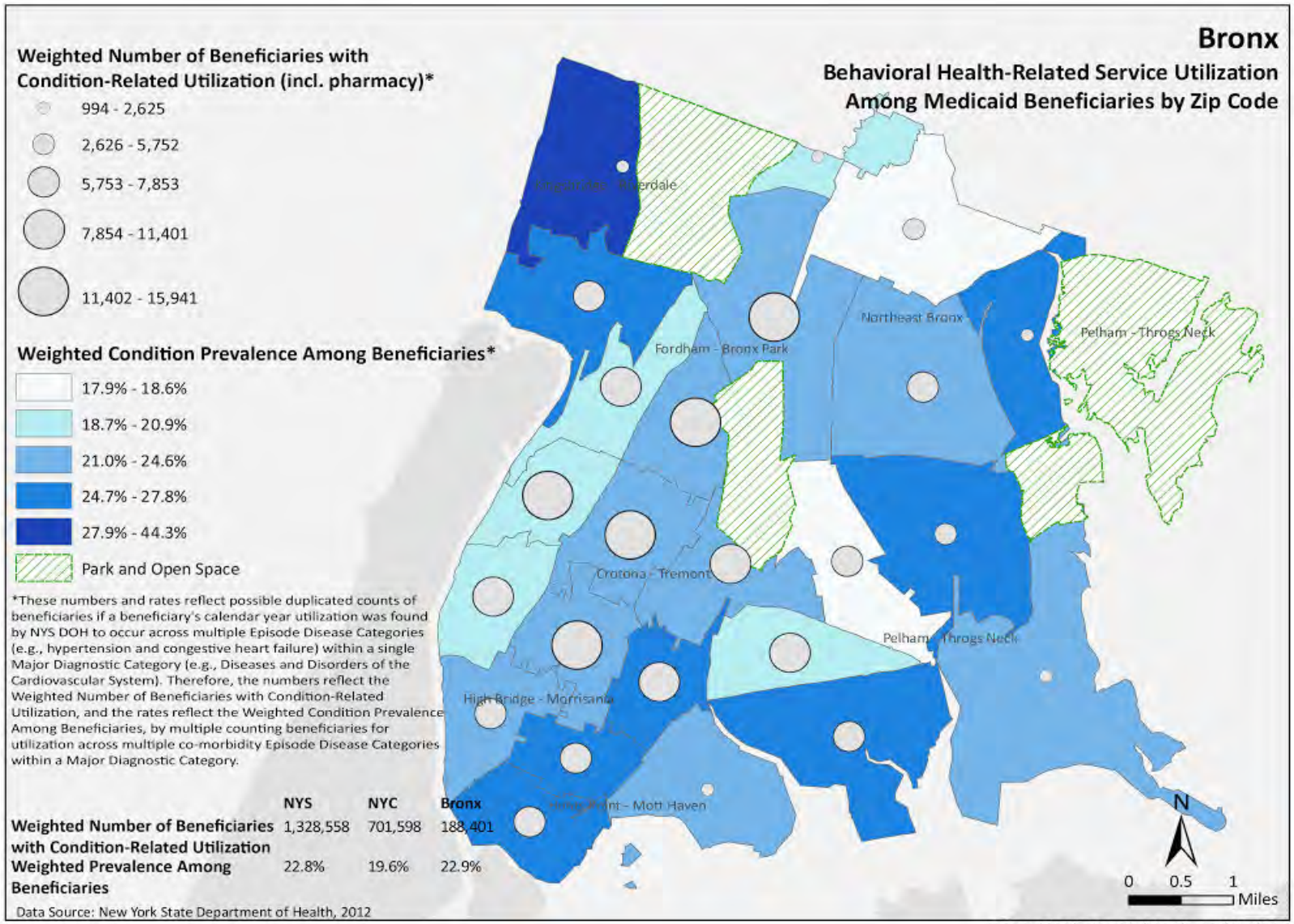
30. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with HIV -Related Utilization



	NYS	NYC	Bronx
Inpatient Admissions (for any reason) for Beneficiaries with HIV-Related Utilization	30,055	27,799	7,629
Total Medicaid Beneficiaries	5,835,794	3,588,107	821,339

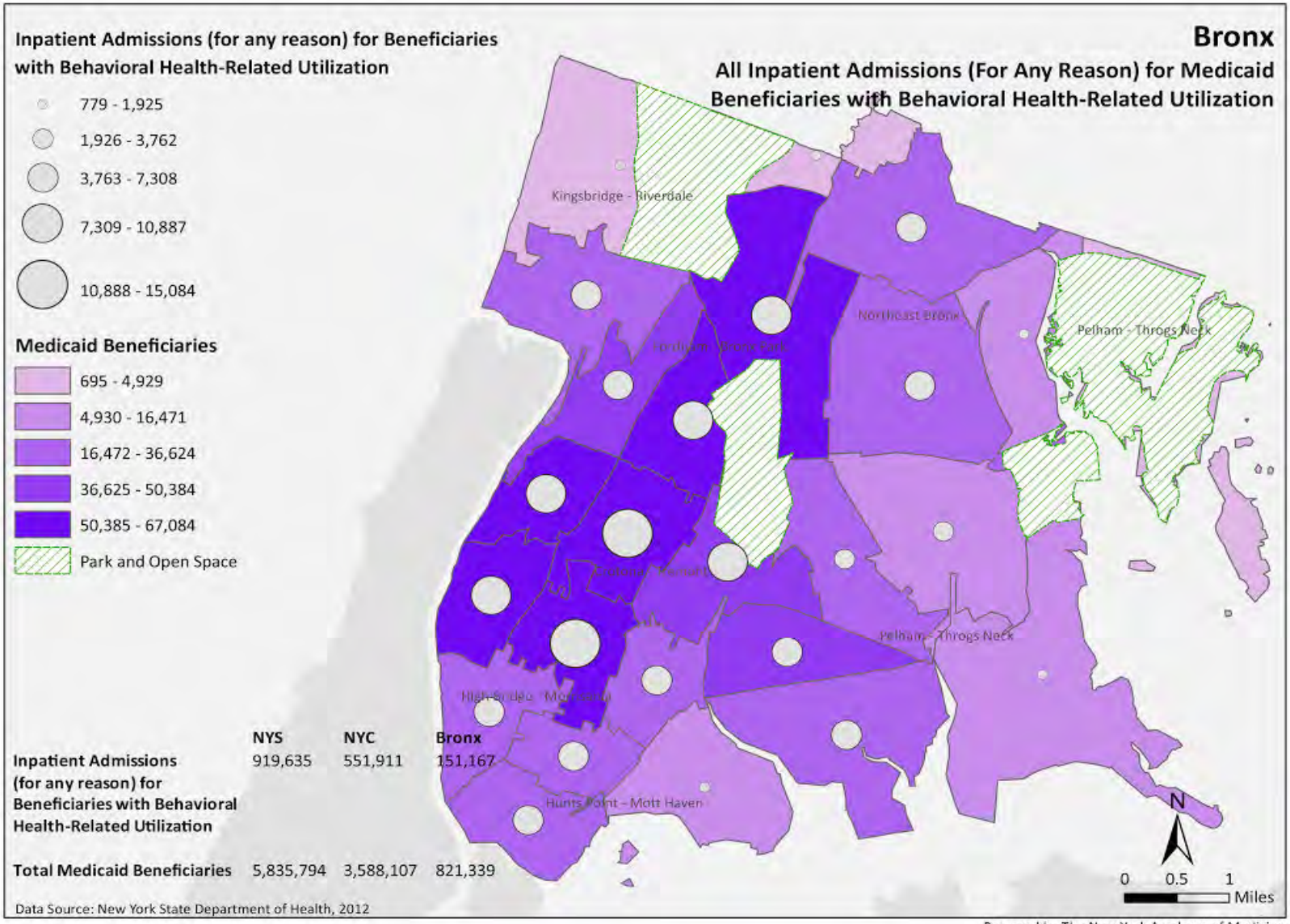
Prepared by The New York Academy of Medicine

31. Behavioral Health-Related Service Utilization Among Medicaid Beneficiaries



	NYS	NYC	Bronx
Weighted Number of Beneficiaries with Condition-Related Utilization	1,328,558	701,598	188,401
Weighted Prevalence Among Beneficiaries	22.8%	19.6%	22.9%

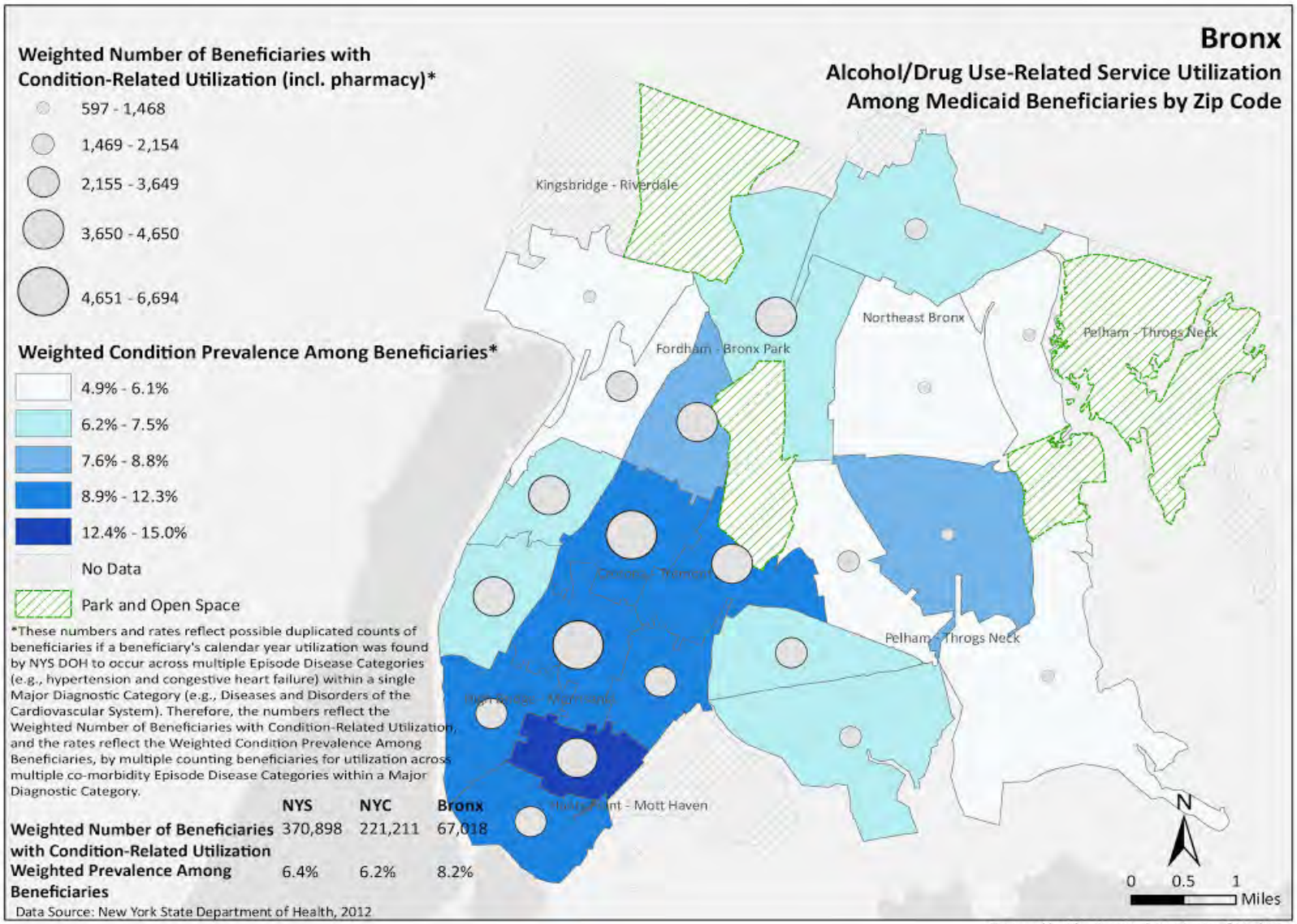
32. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with Behavioral Health-Related Utilization



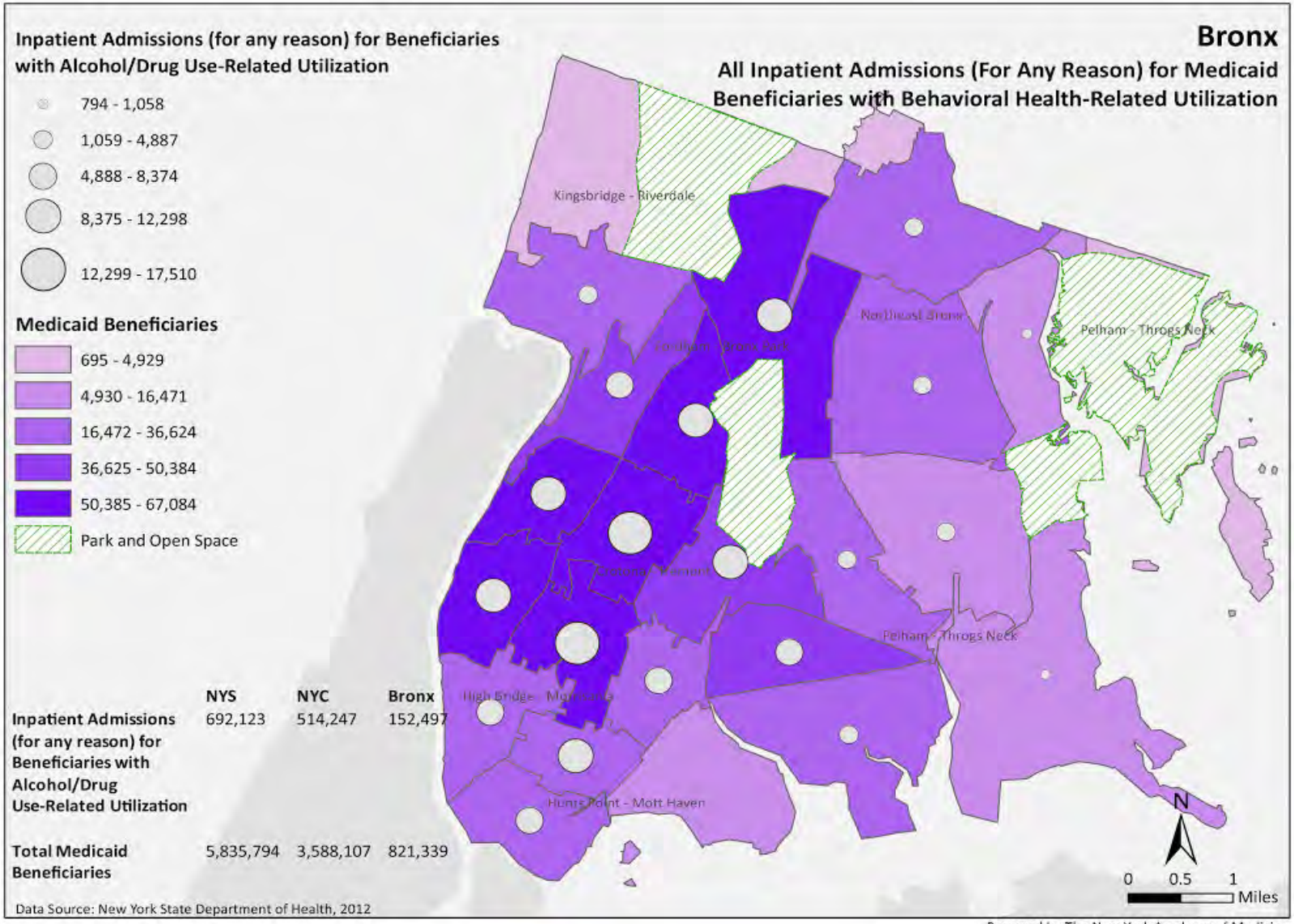
	NYS	NYC	Bronx
Inpatient Admissions (for any reason) for Beneficiaries with Behavioral Health-Related Utilization	919,635	551,911	151,167
Total Medicaid Beneficiaries	5,835,794	3,588,107	821,339

Prepared by The New York Academy of Medicine

33. Alcohol/Drug Use-Related Service Utilization among Medicaid Beneficiaries

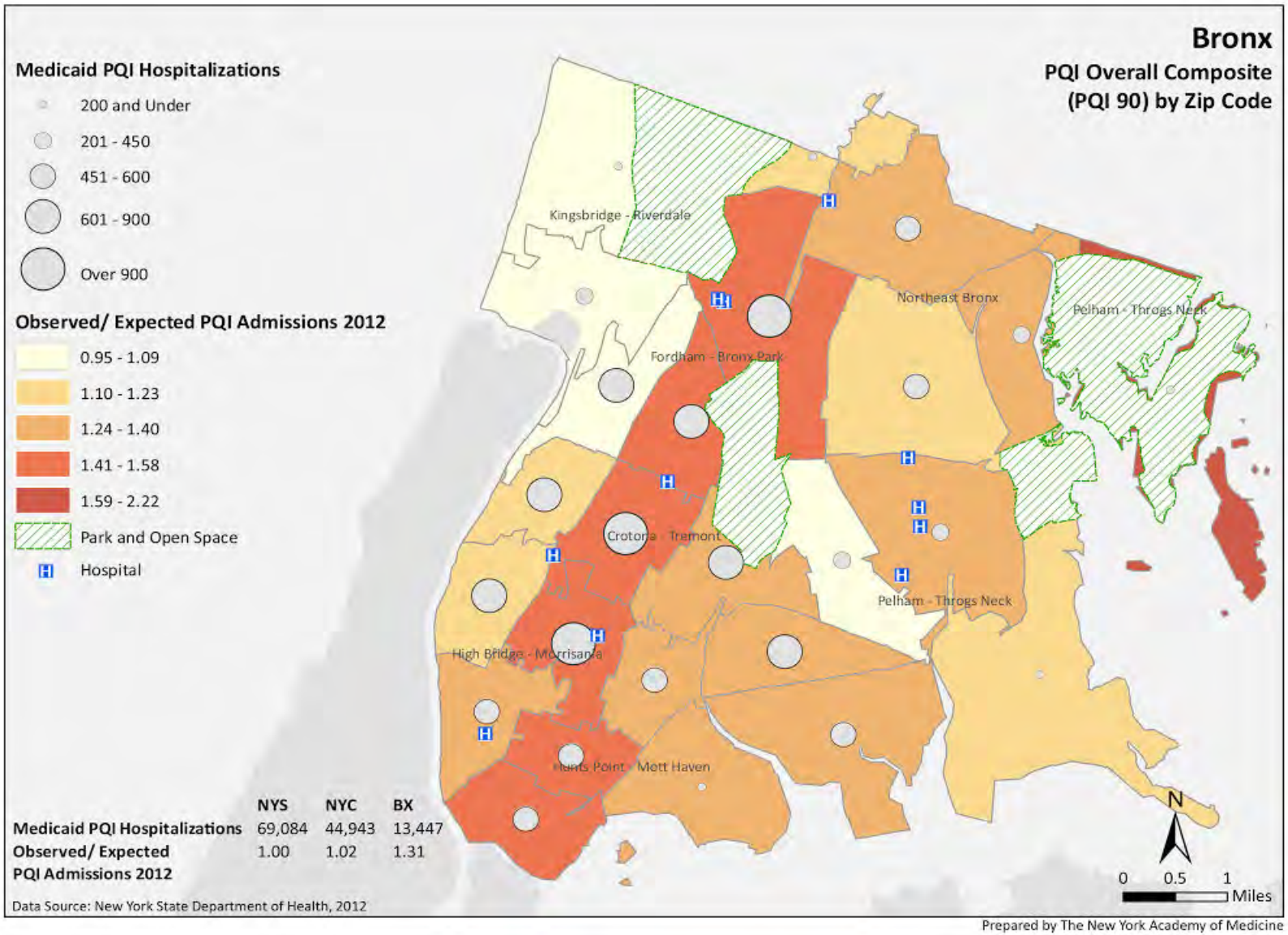


34. All Inpatient Admissions (For Any Reason) for Medicaid Beneficiaries with Alcohol/Drug Use-Related Utilization

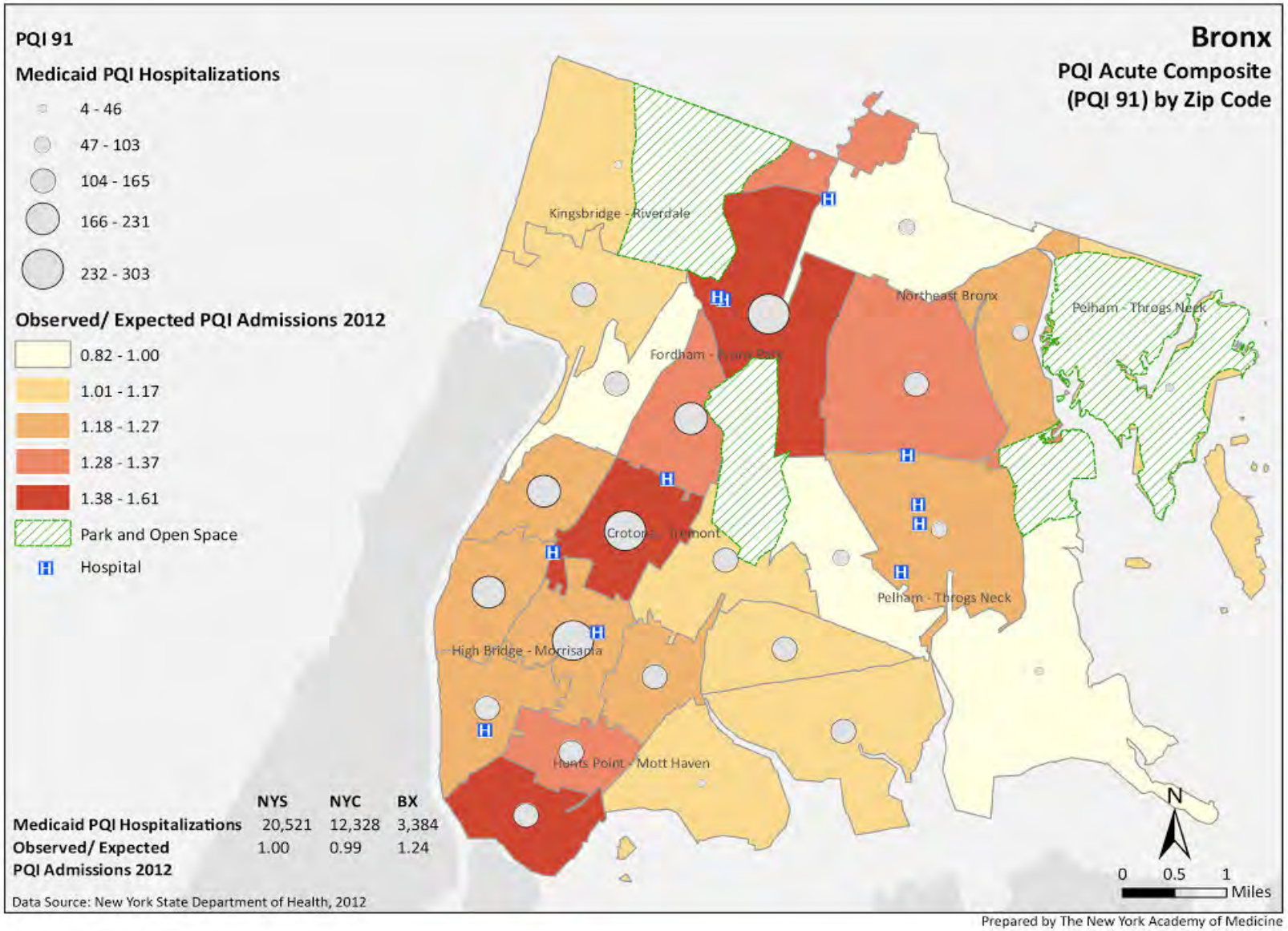


	NYS	NYC	Bronx
Inpatient Admissions (for any reason) for Beneficiaries with Alcohol/Drug Use-Related Utilization	692,123	514,247	152,497
Total Medicaid Beneficiaries	5,835,794	3,588,107	821,339

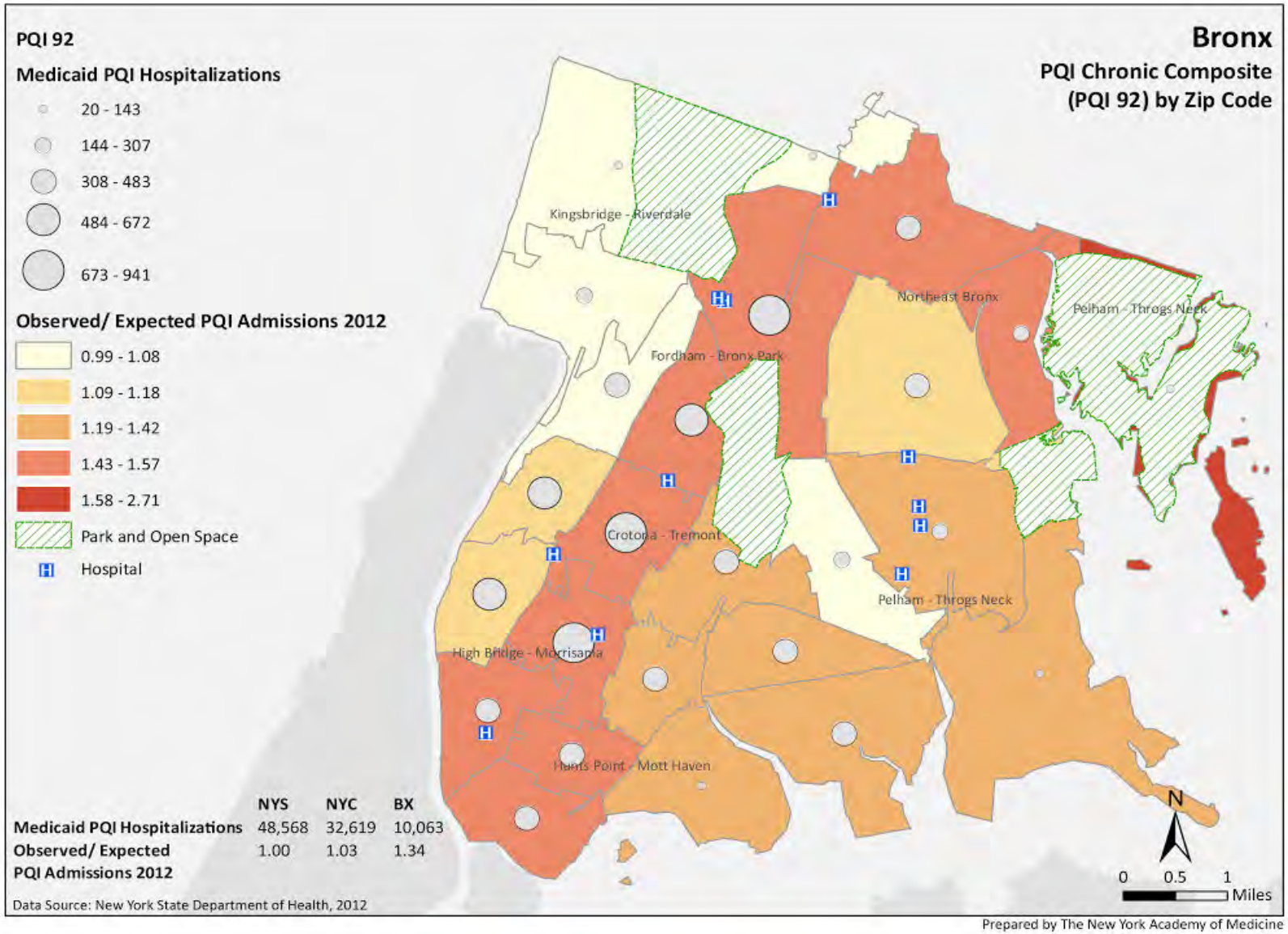
35. PQI Overall Composite (PQI 90) by Zip Code



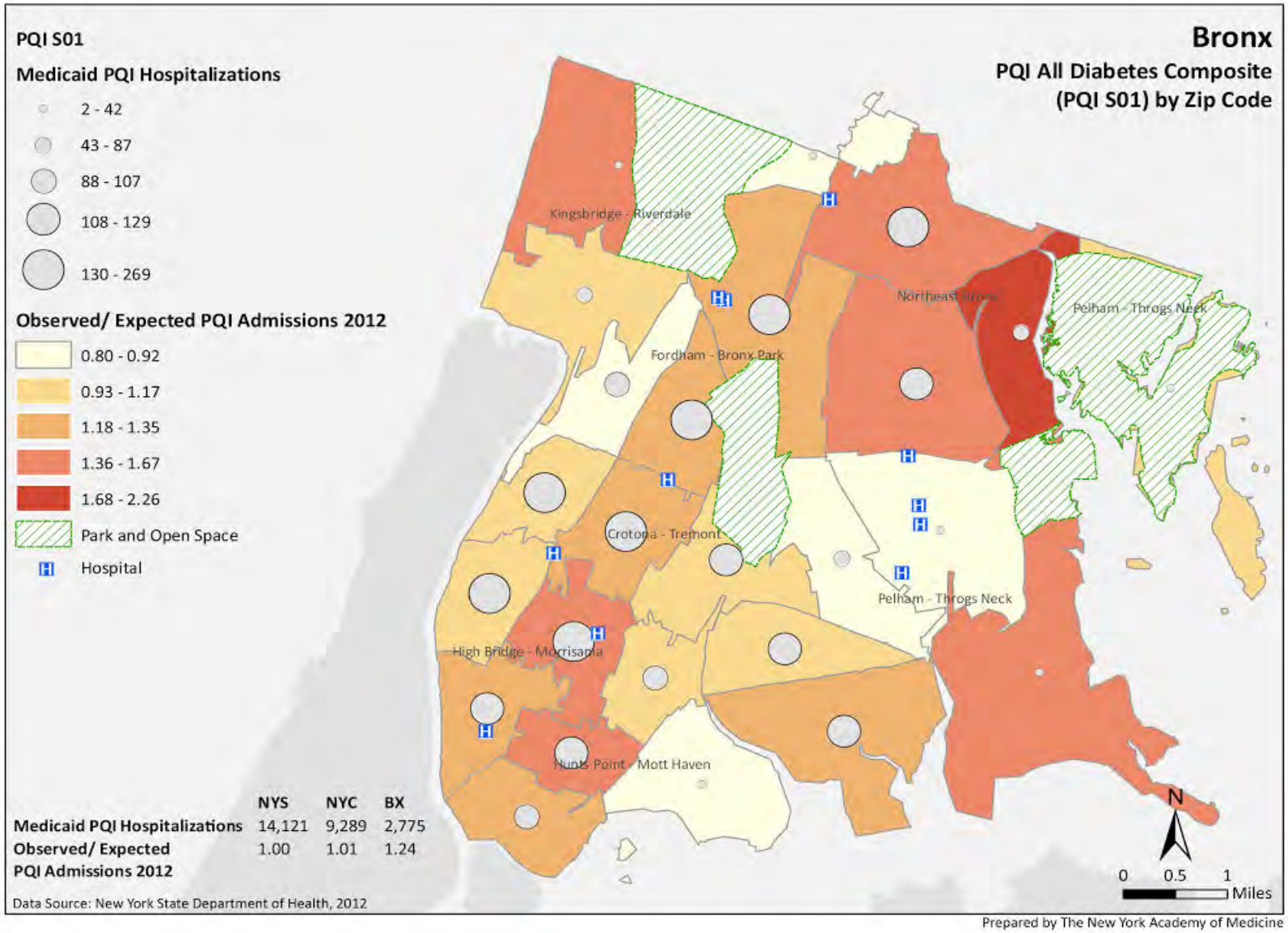
36. PQI Acute Composite (PQI 91) by Zip Code



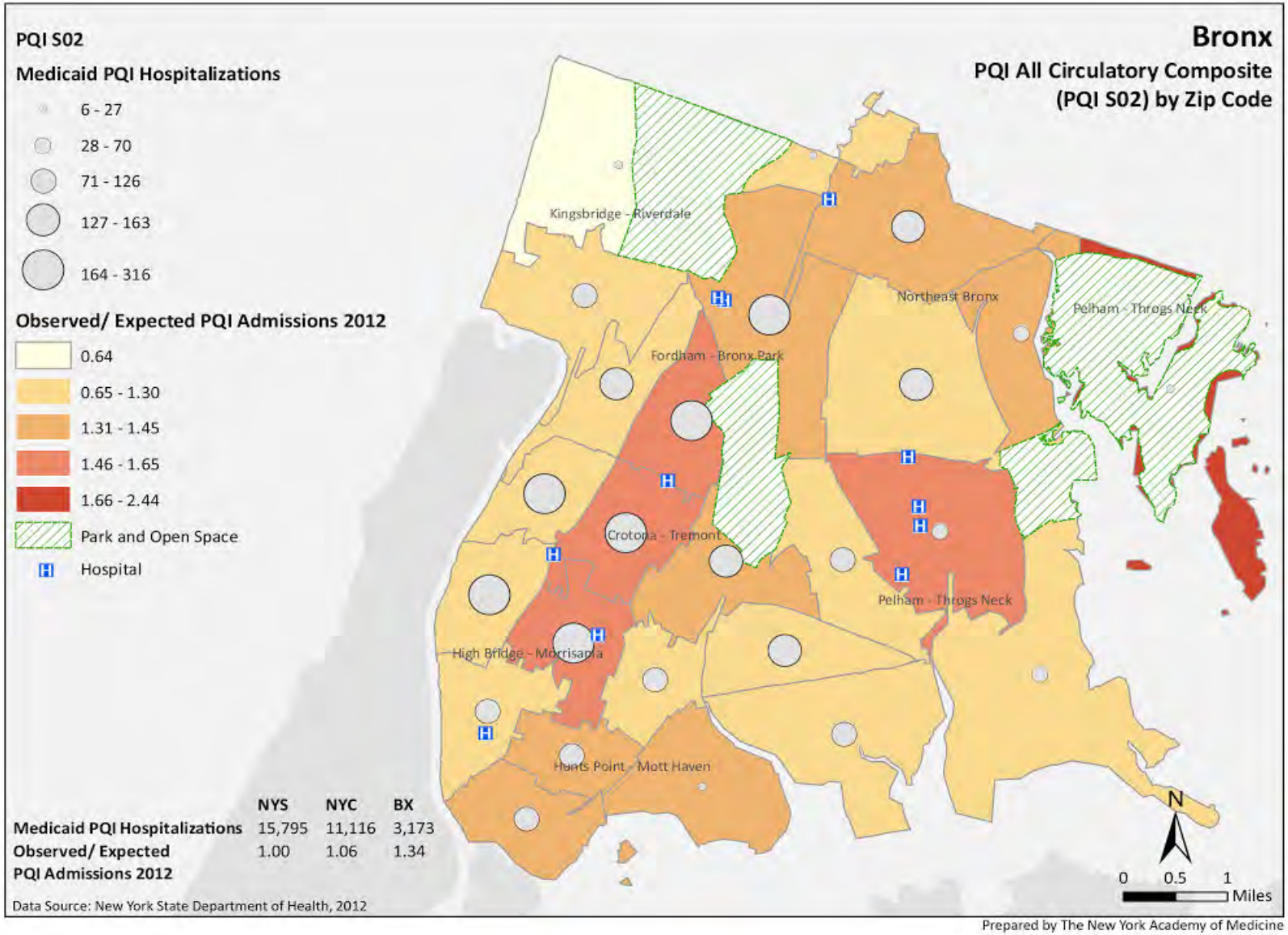
37. PQI Chronic Composite (PQI 92) by Zip Code



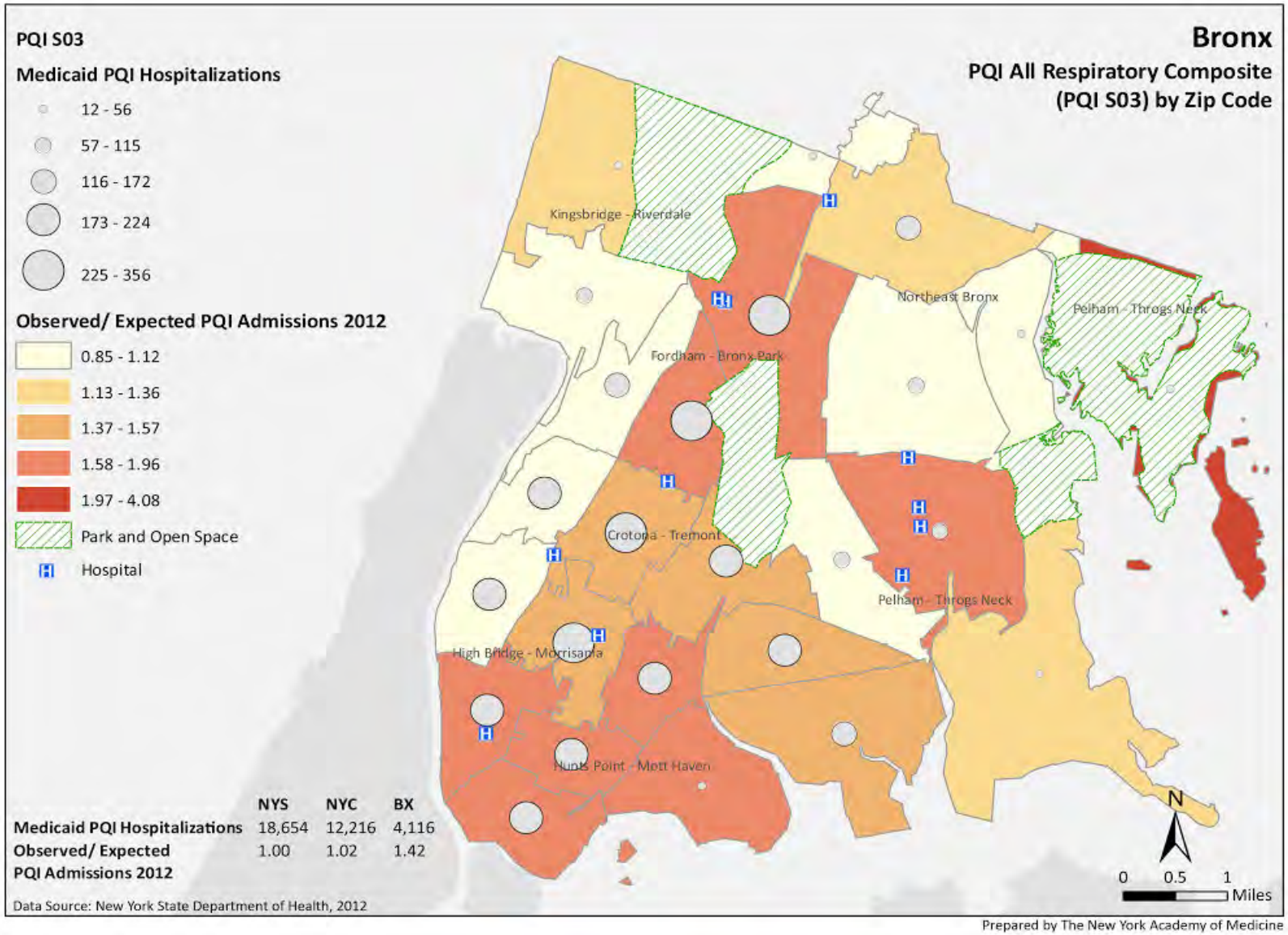
38. PQI All Diabetes Composite (PQI S01) by Zip Code



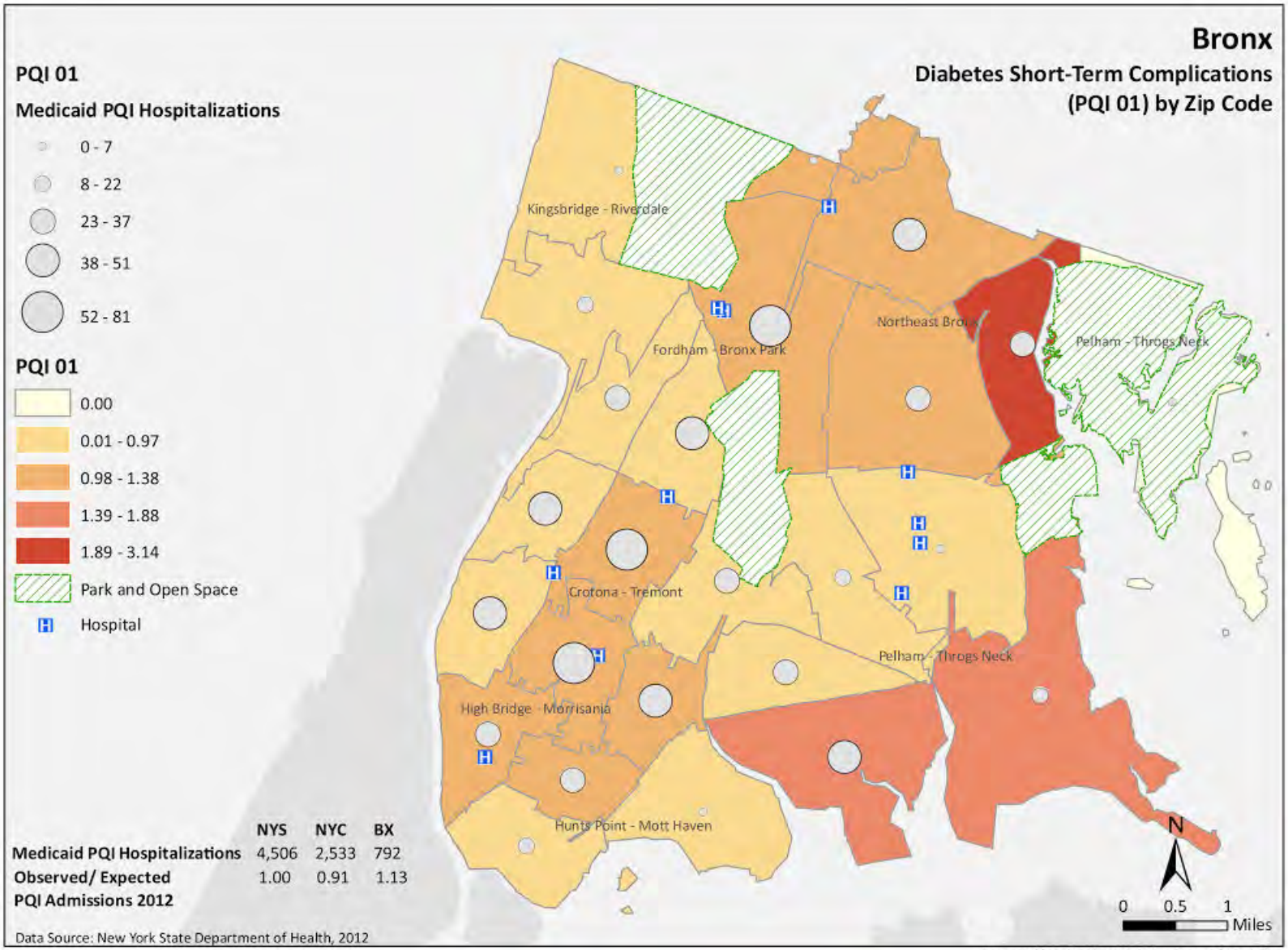
39. PQI All Circulatory Composite (PQI S02) by Zip Code



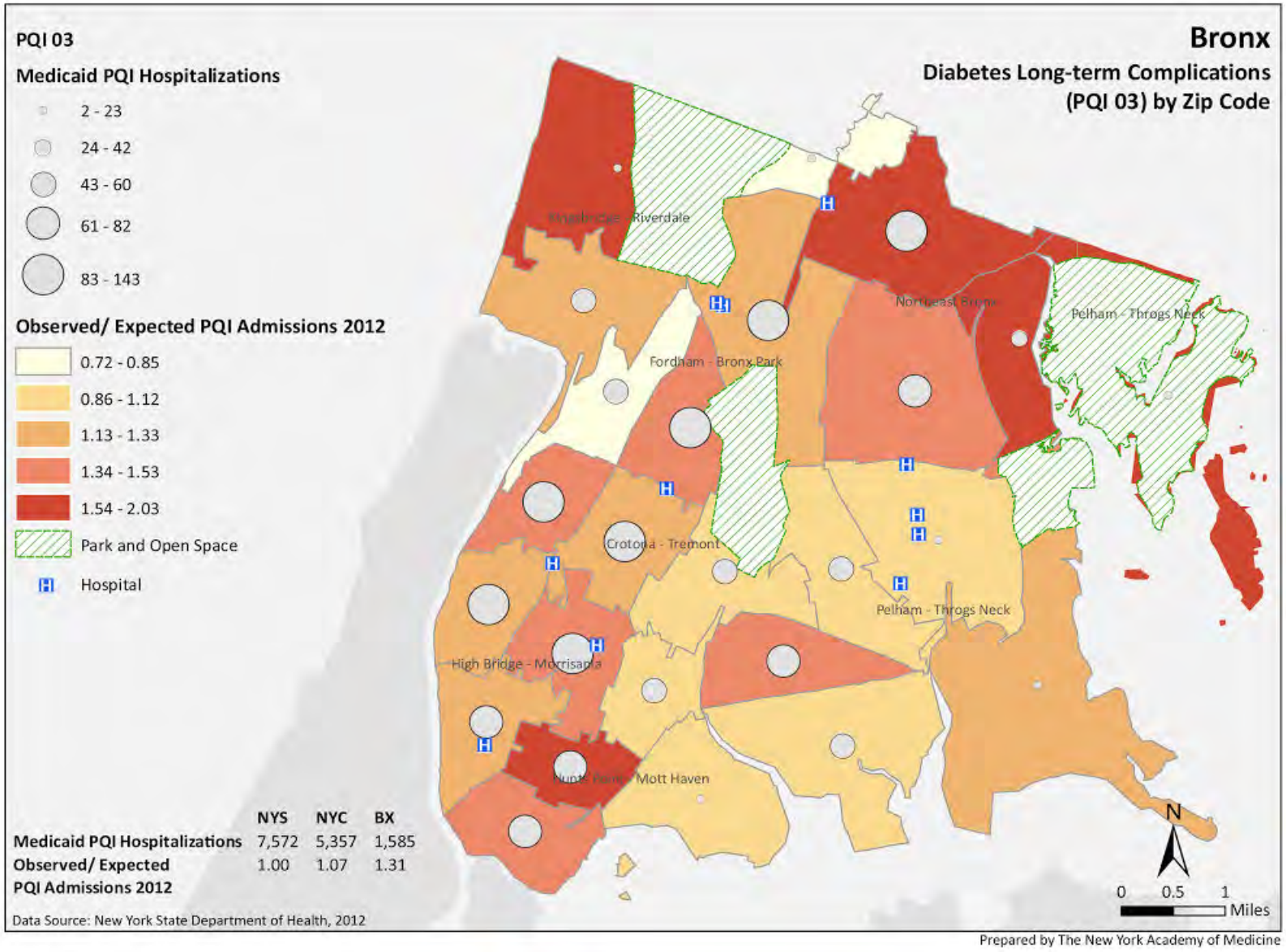
40. PQI All Respiratory Composite (PQI S03) by Zip Code



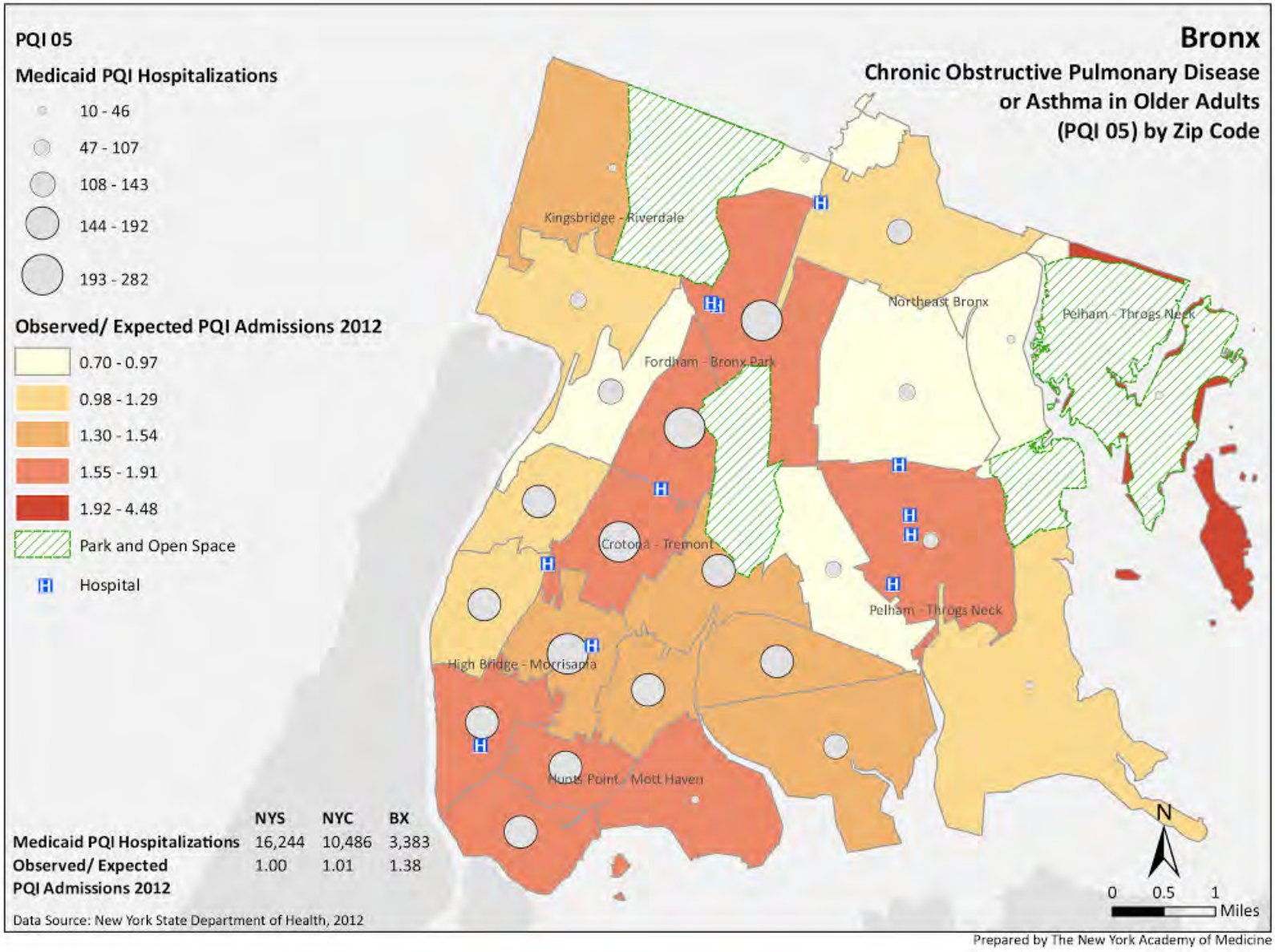
41. Diabetes Short-term Complications (PQI 01) by Zip Code



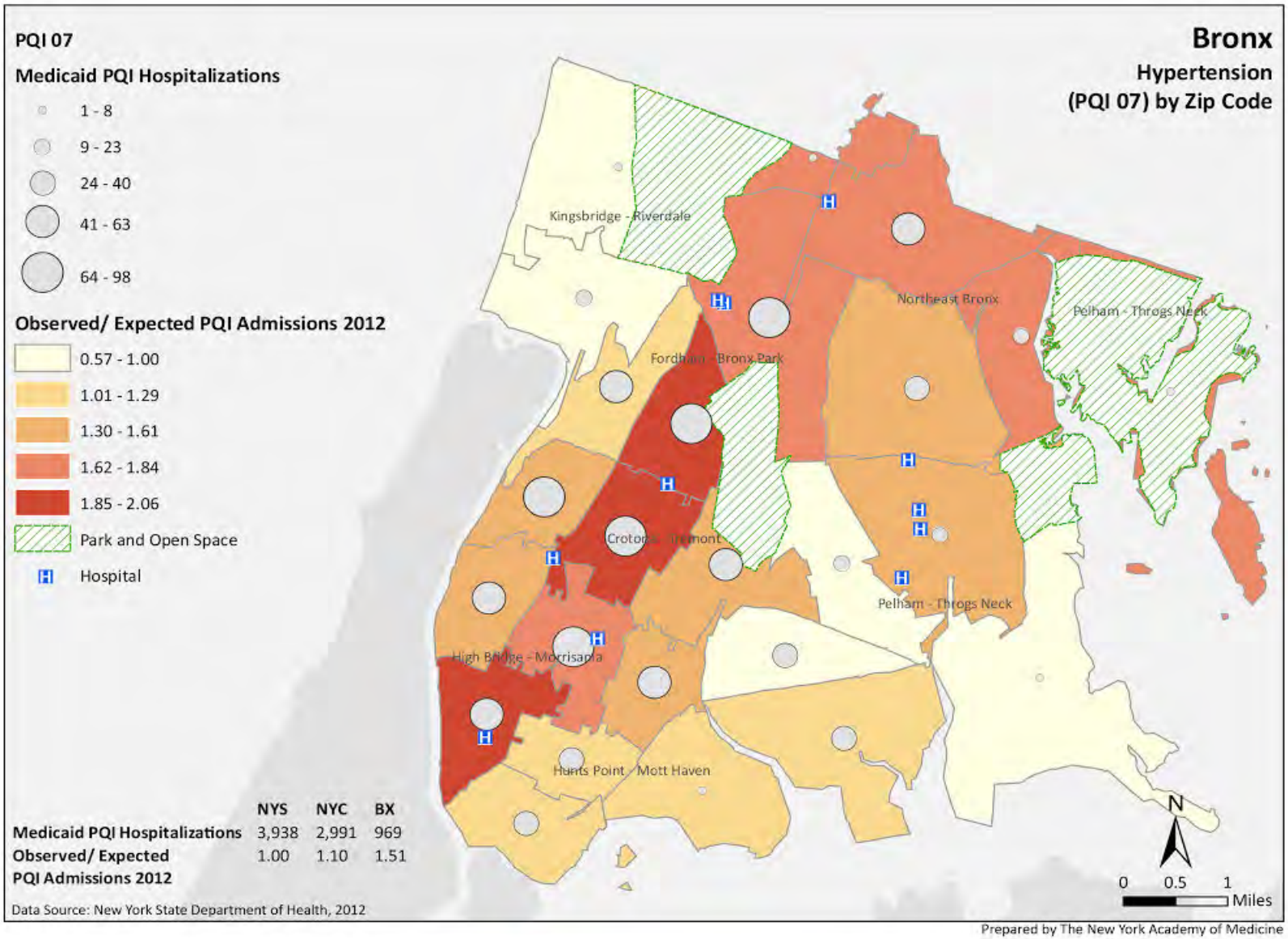
42. Diabetes Long-term Complications (PQI 03) by Zip Code



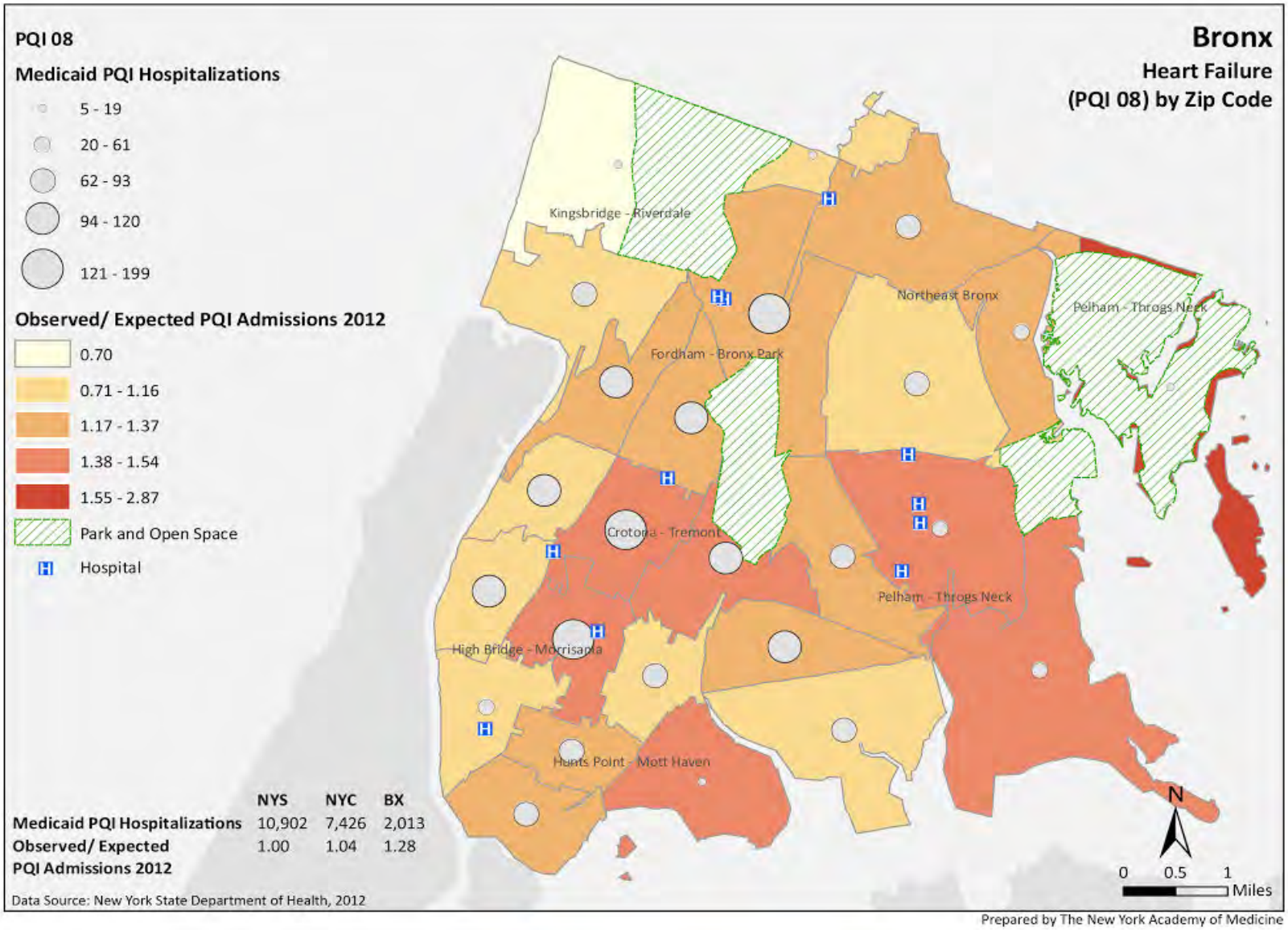
43. Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (PQI 05) by Zip Code



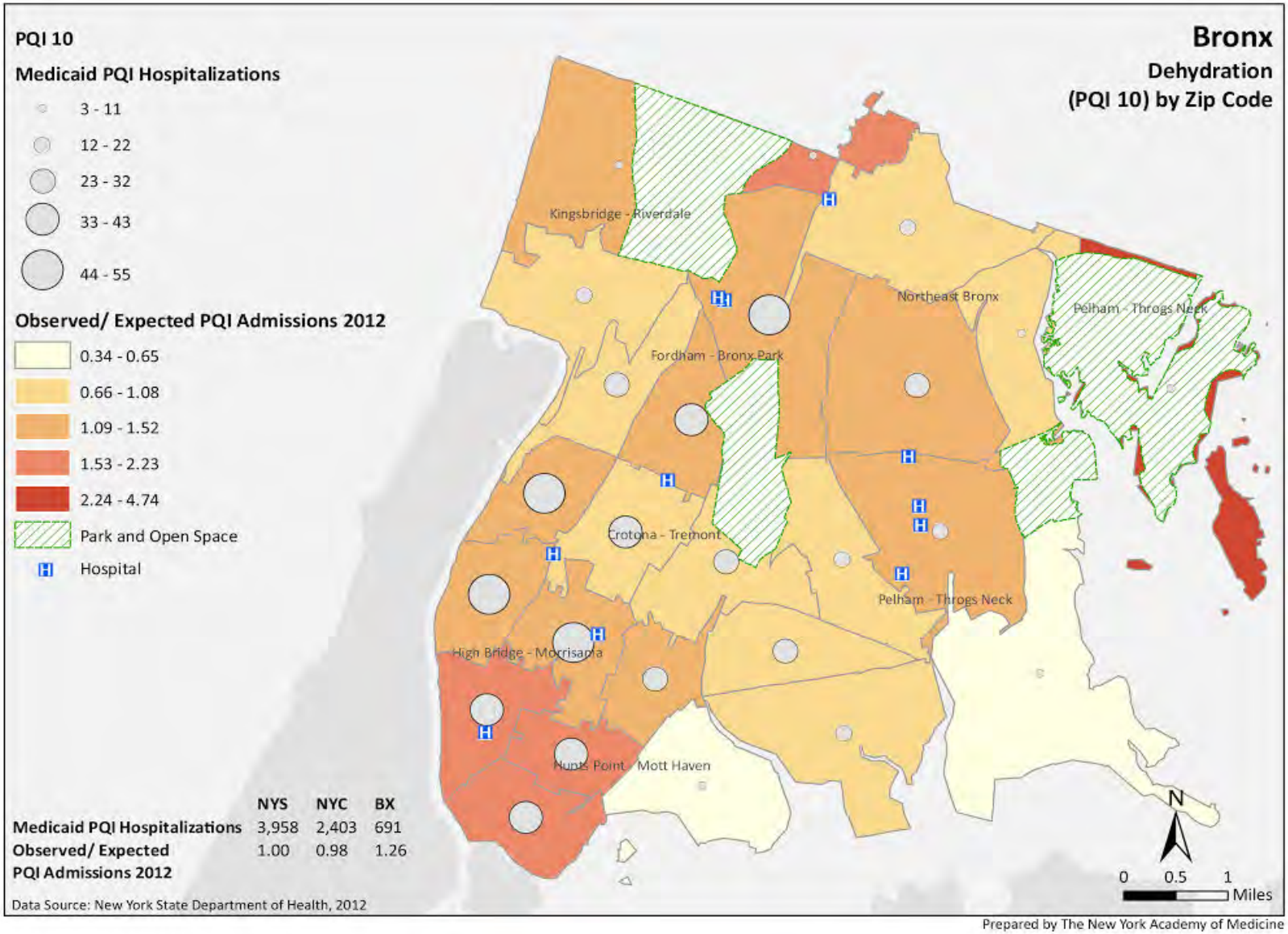
44. Hypertension (PQI 07) by Zip Code



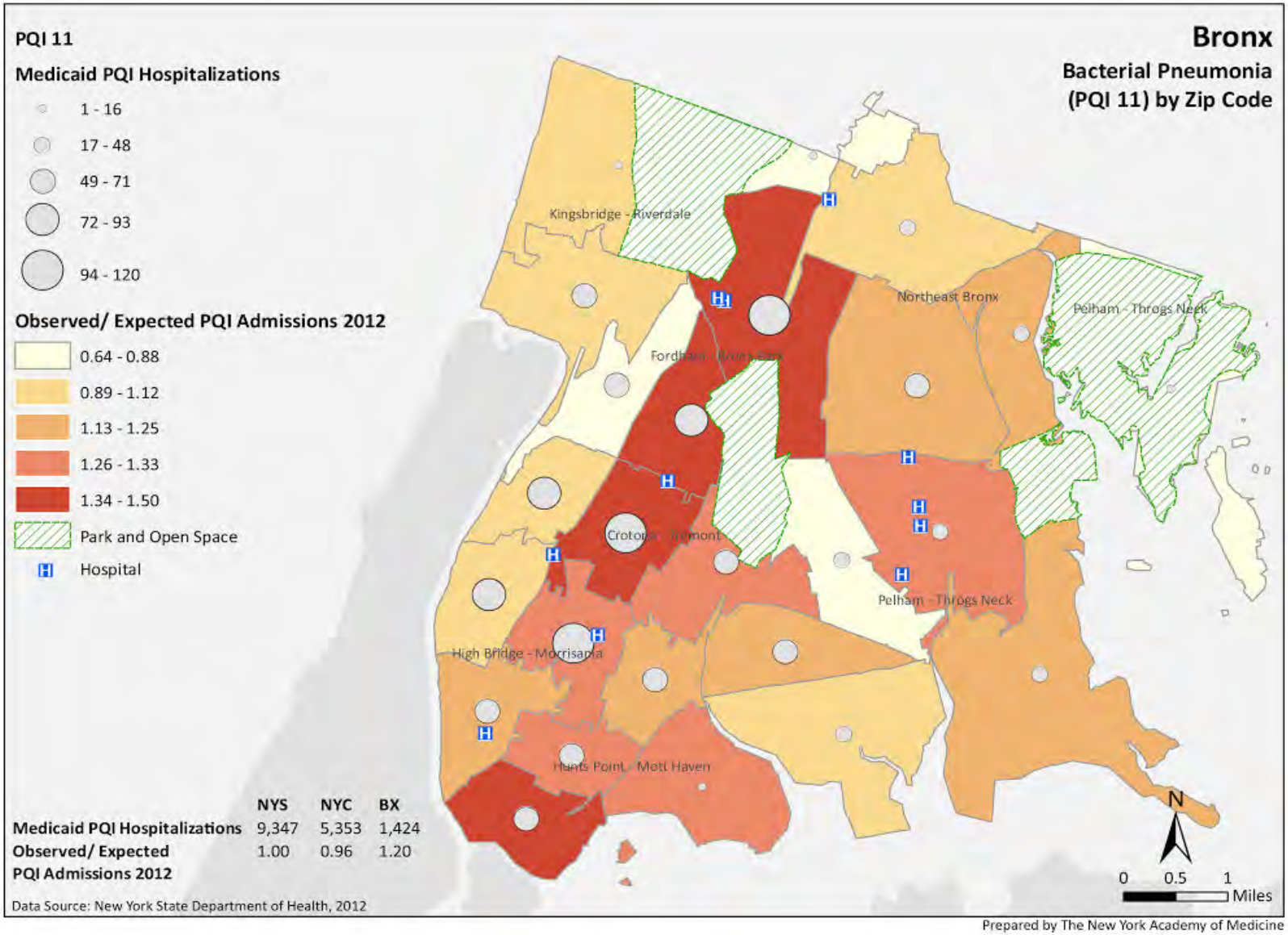
45. Heart Failure (PQI 08) by Zip Code



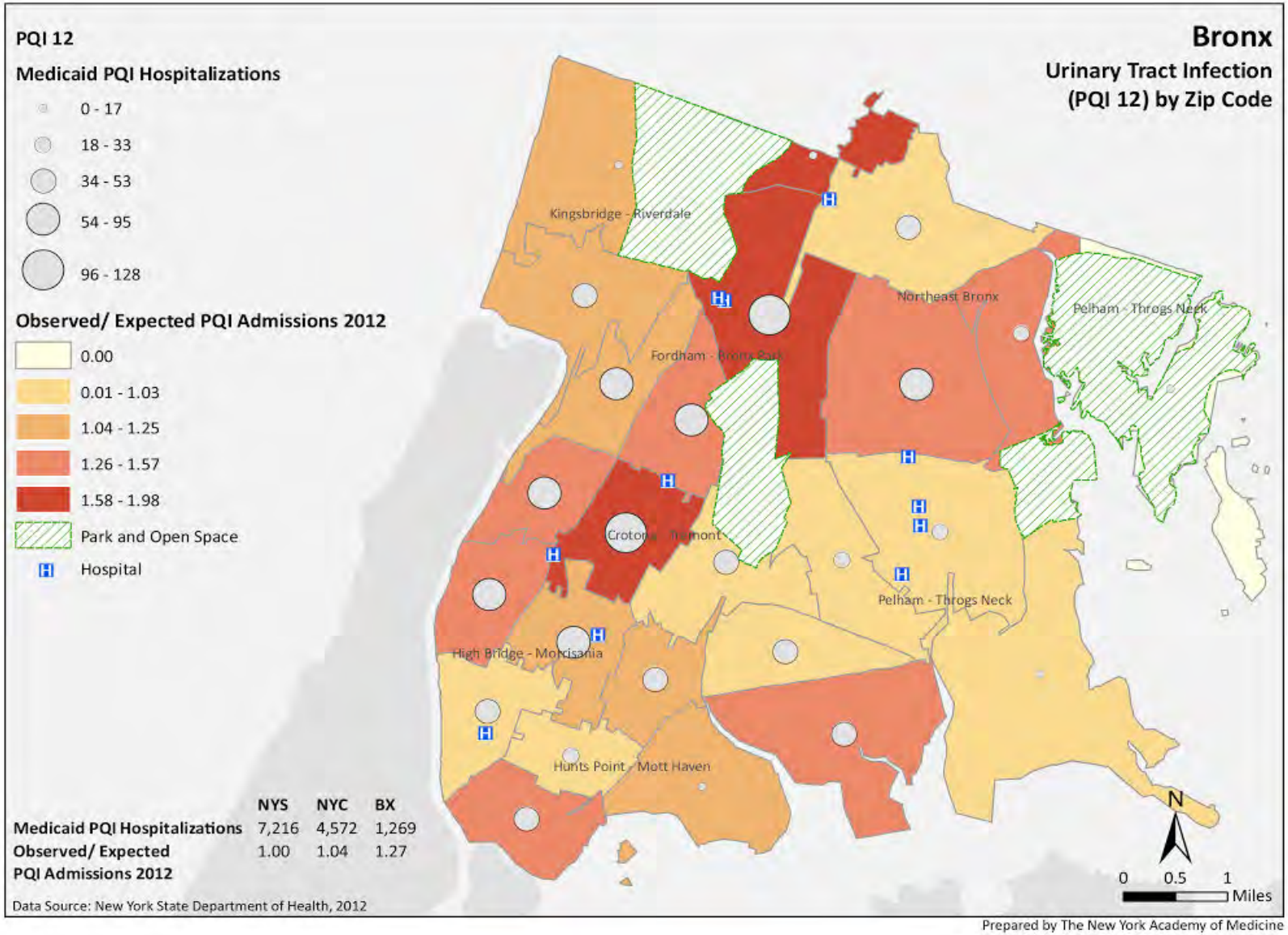
46. Dehydration (PQI 10) by Zip Code



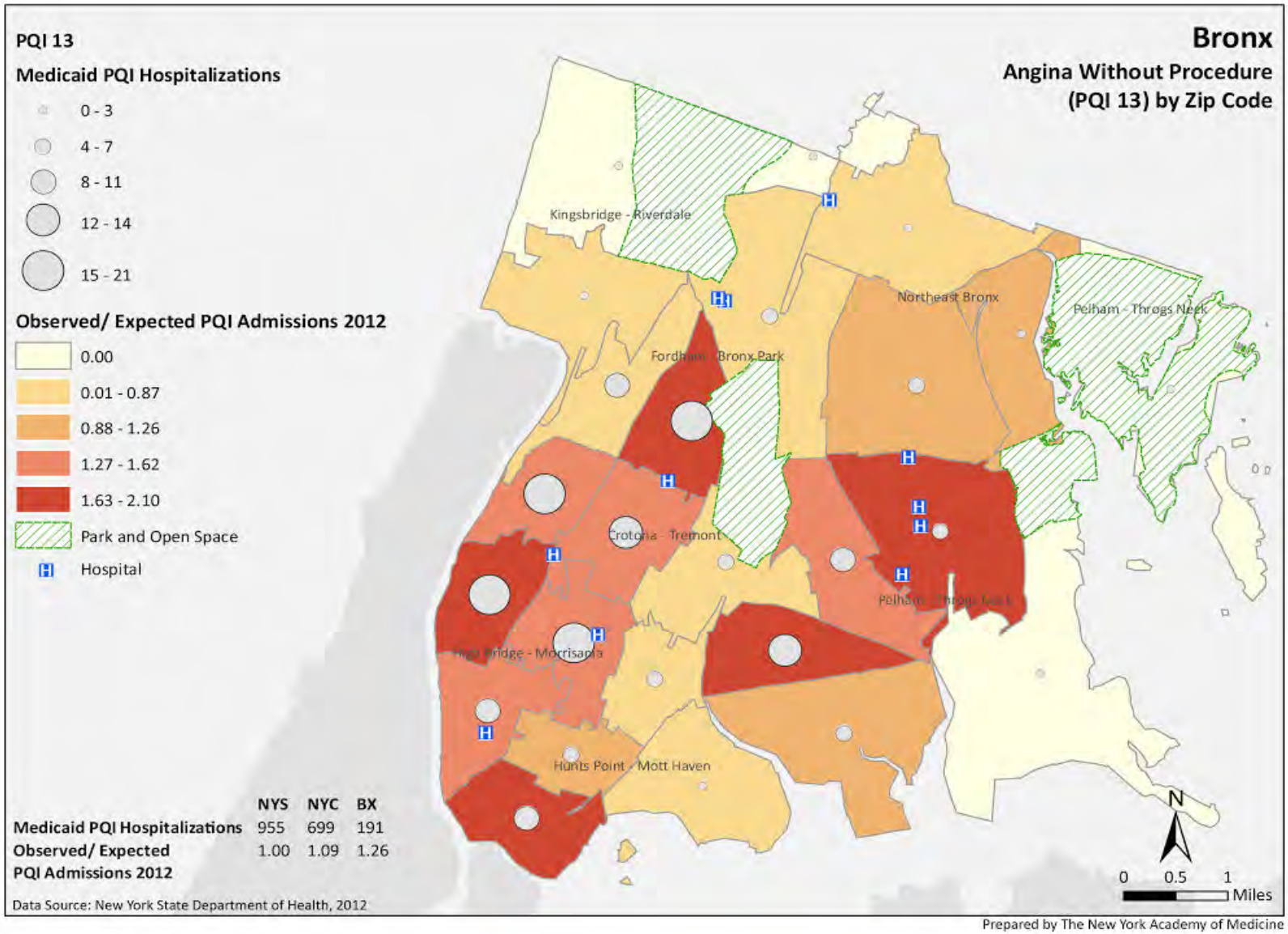
47. Bacterial Pneumonia (PQI 11) by Zip Code



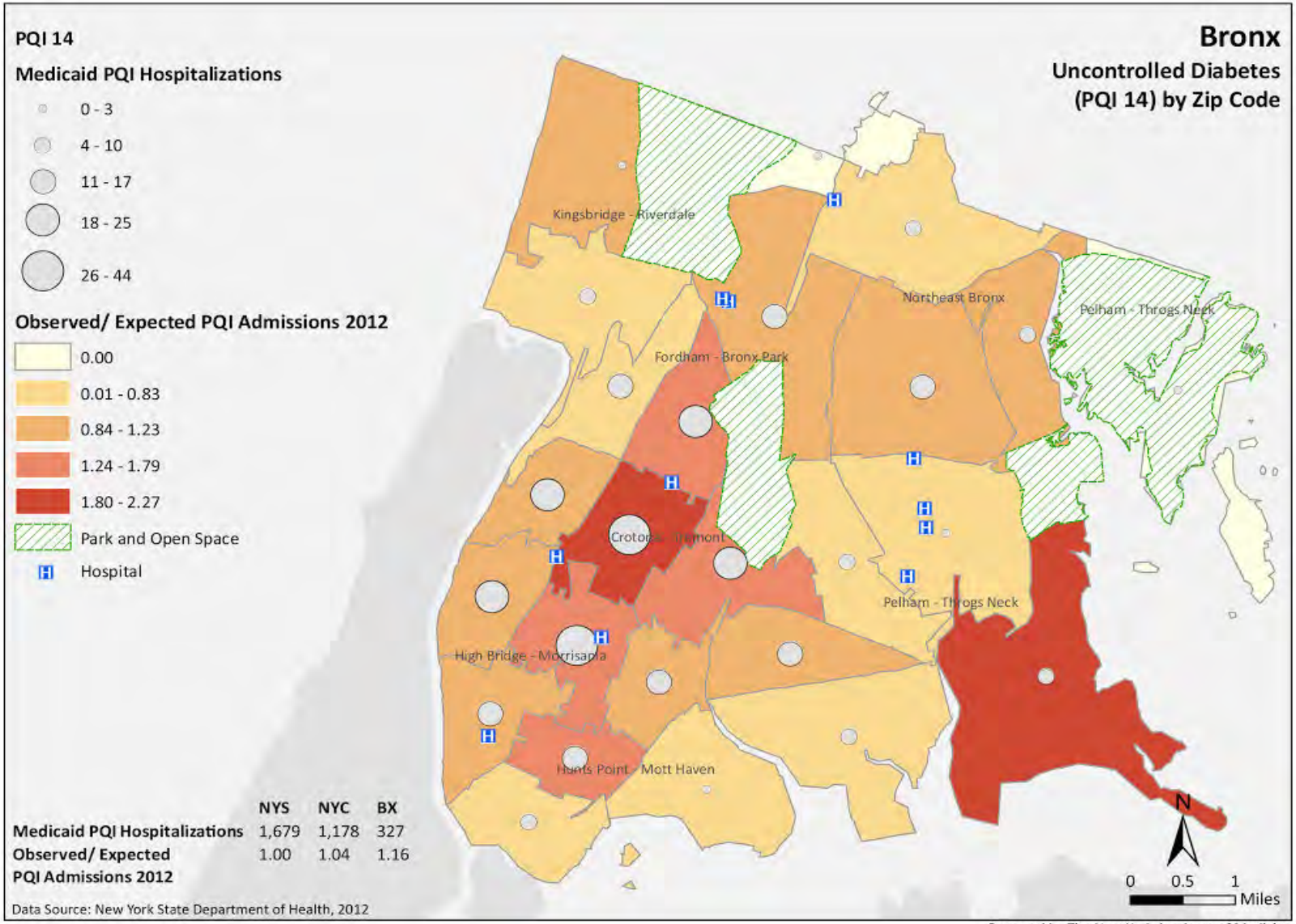
48. Urinary Tract Infection (PQI 12) by Zip Code



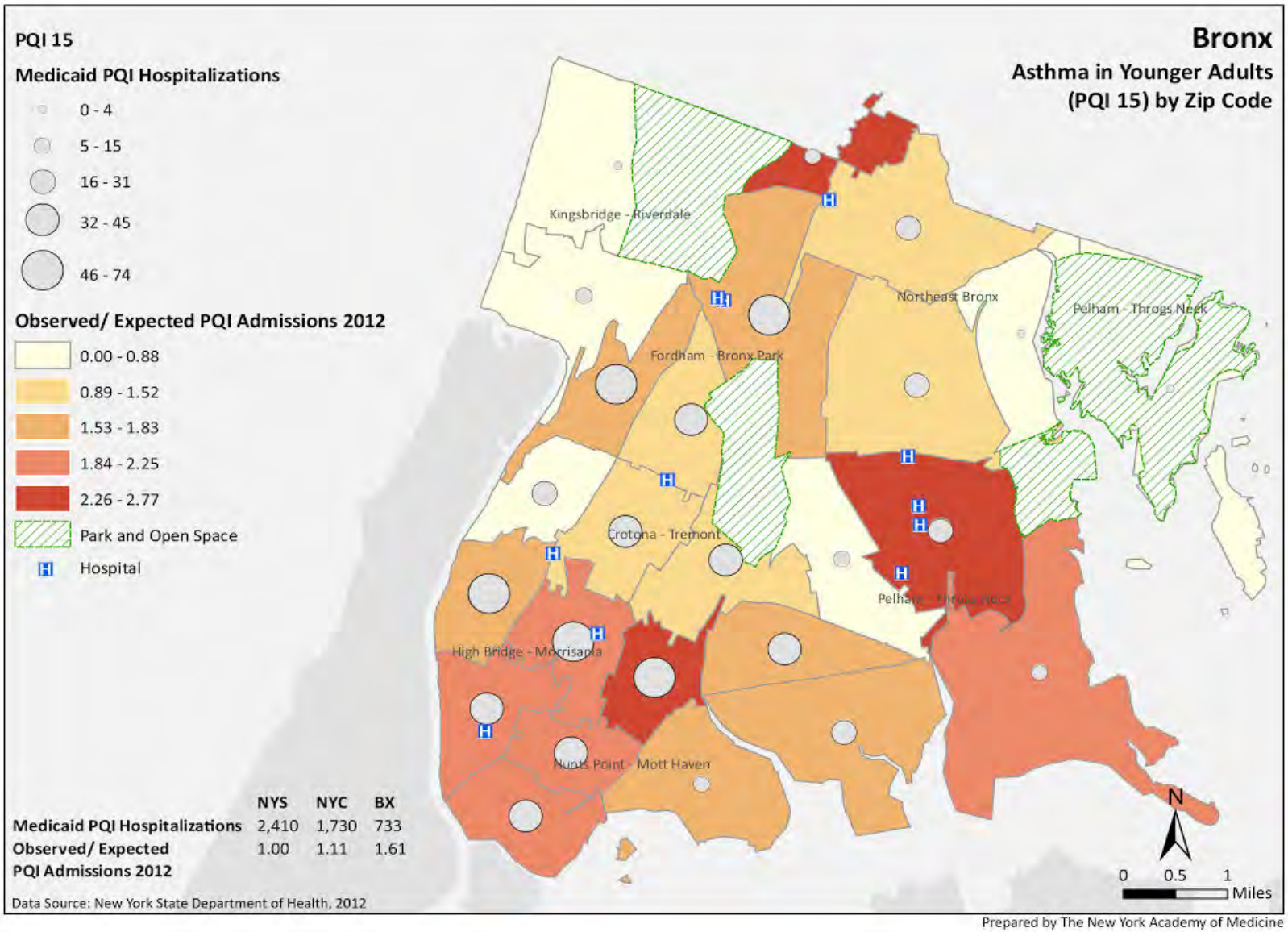
49. Angina Without Procedure (PQI 13) by Zip Code



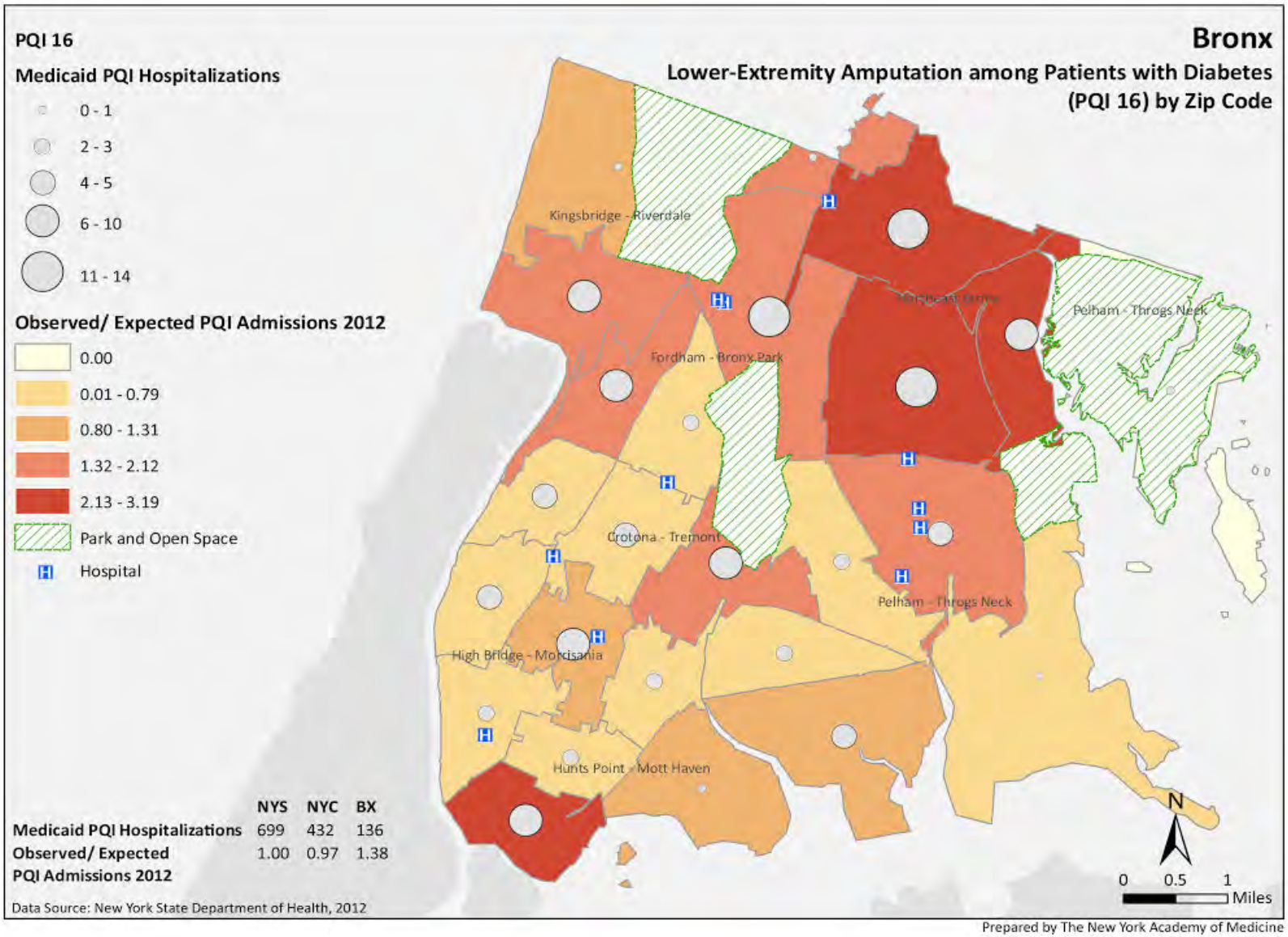
50. Uncontrolled Diabetes (PQI 14) by Zip Code



51. Asthma in Younger Adults (PQI 15) by Zip Code



52. Lower-Extremity Amputation among Patients with Diabetes (PQI 16) by Zip Code



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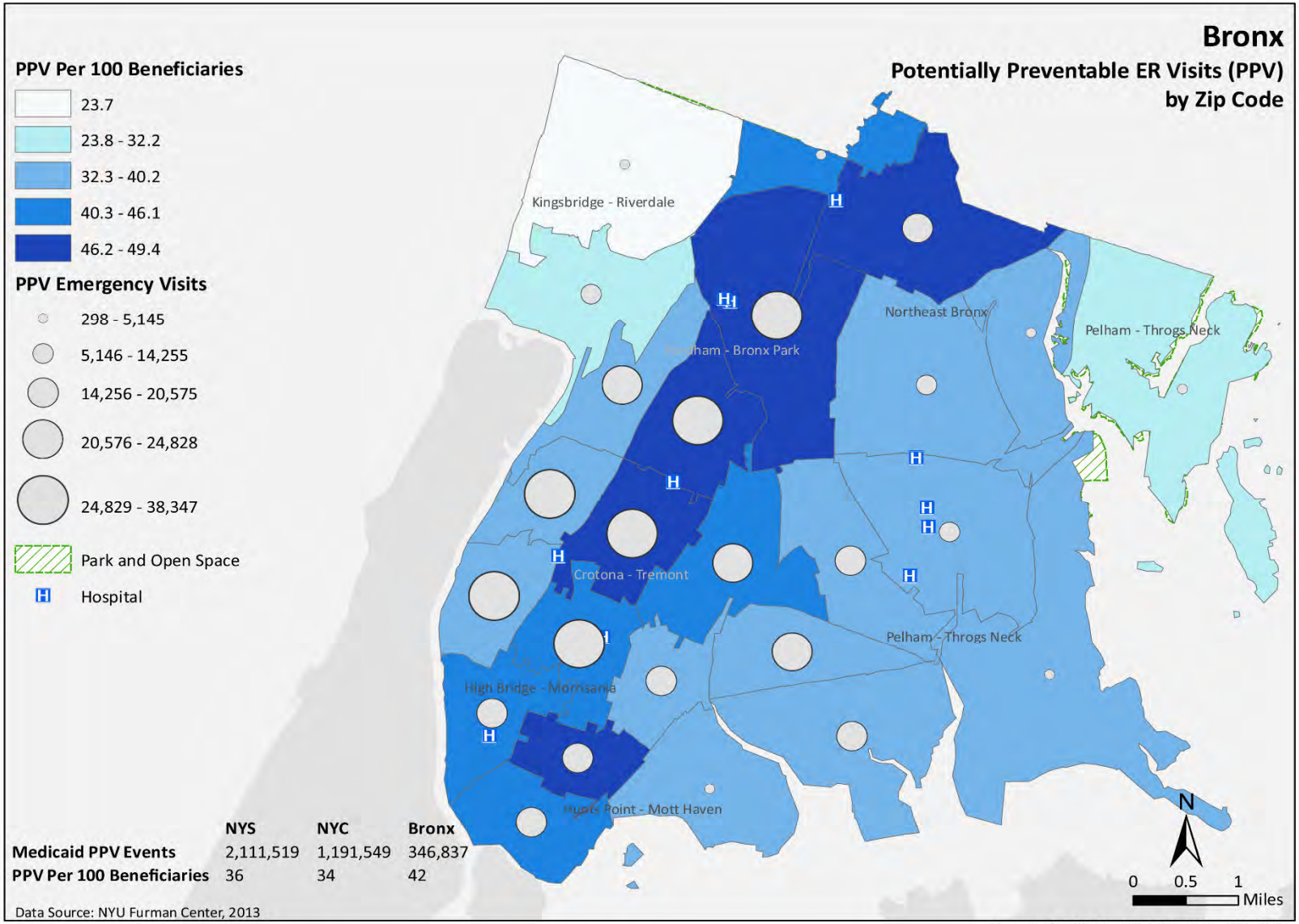
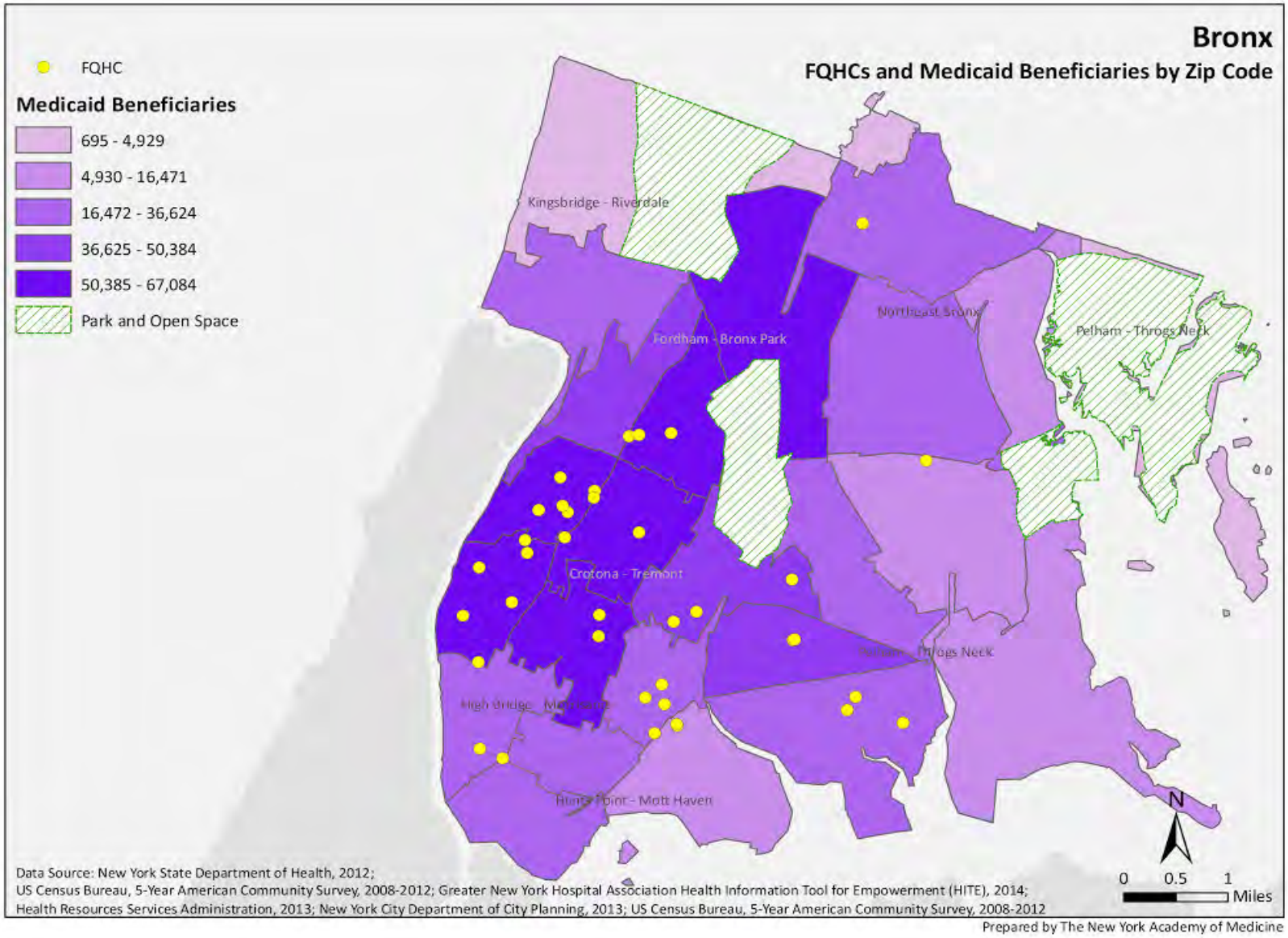
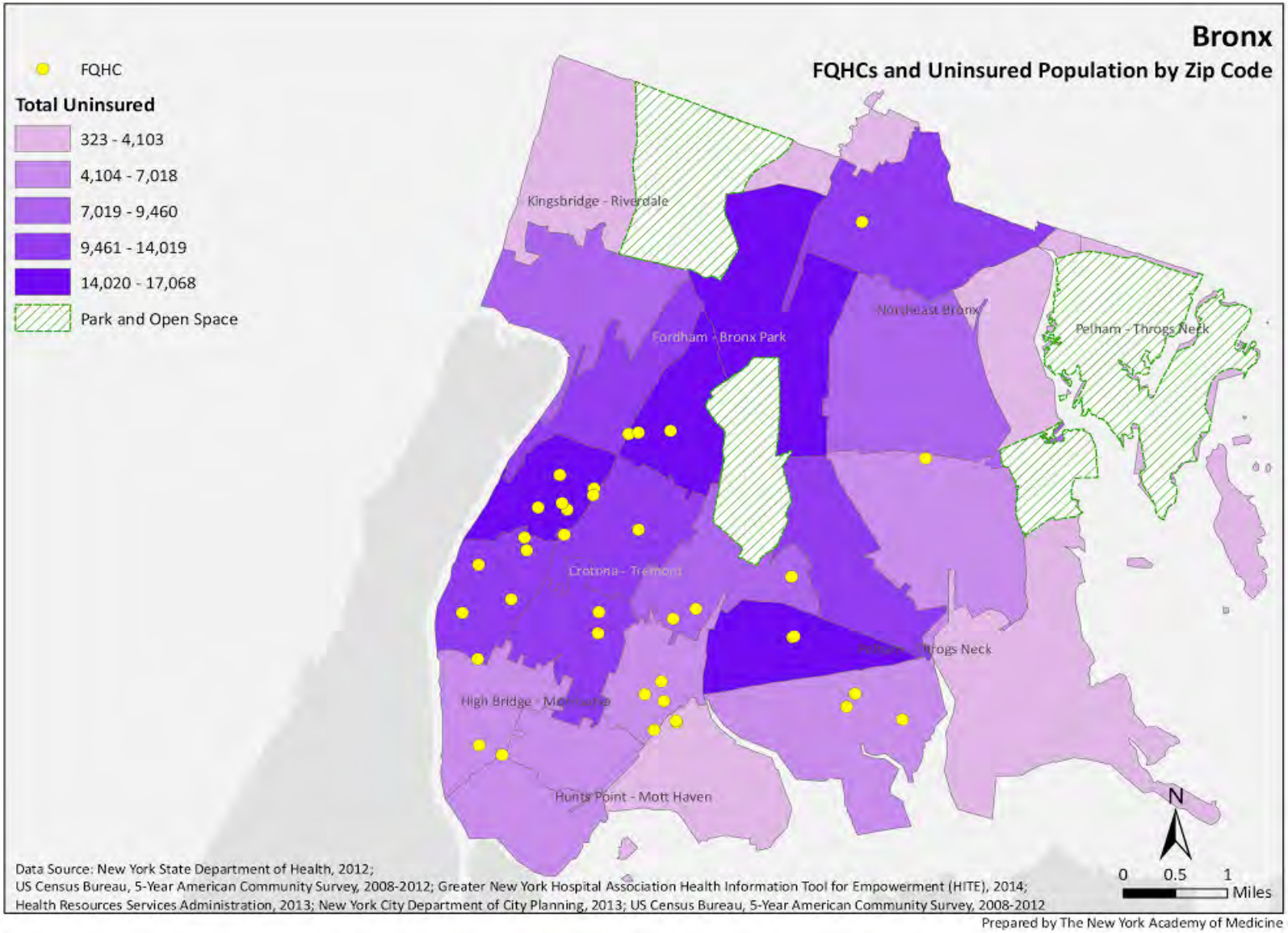


54. FQHCs and Medicaid Beneficiaries by Zip Code



55. FQHCs and Uninsured Population by Zip Code



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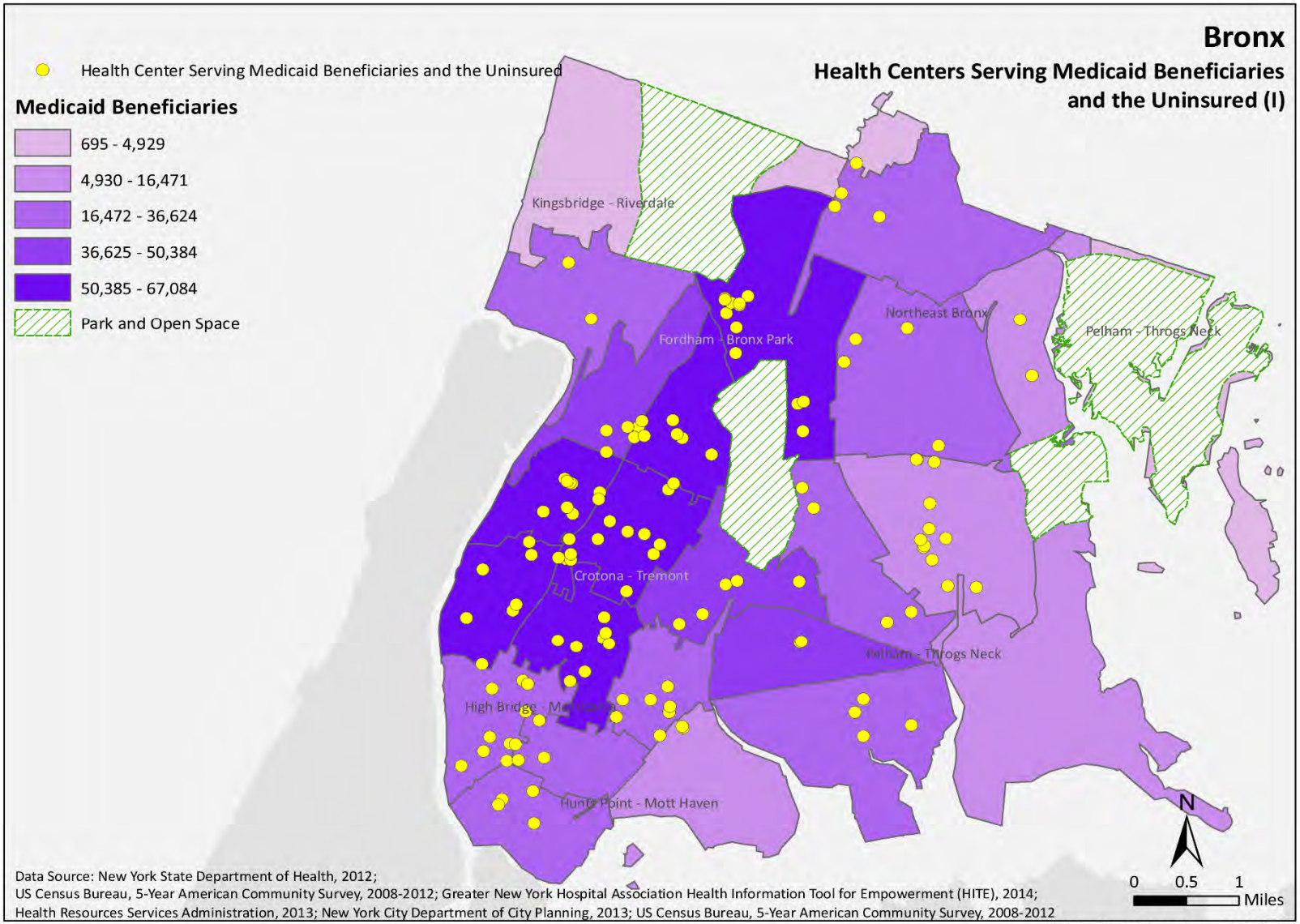
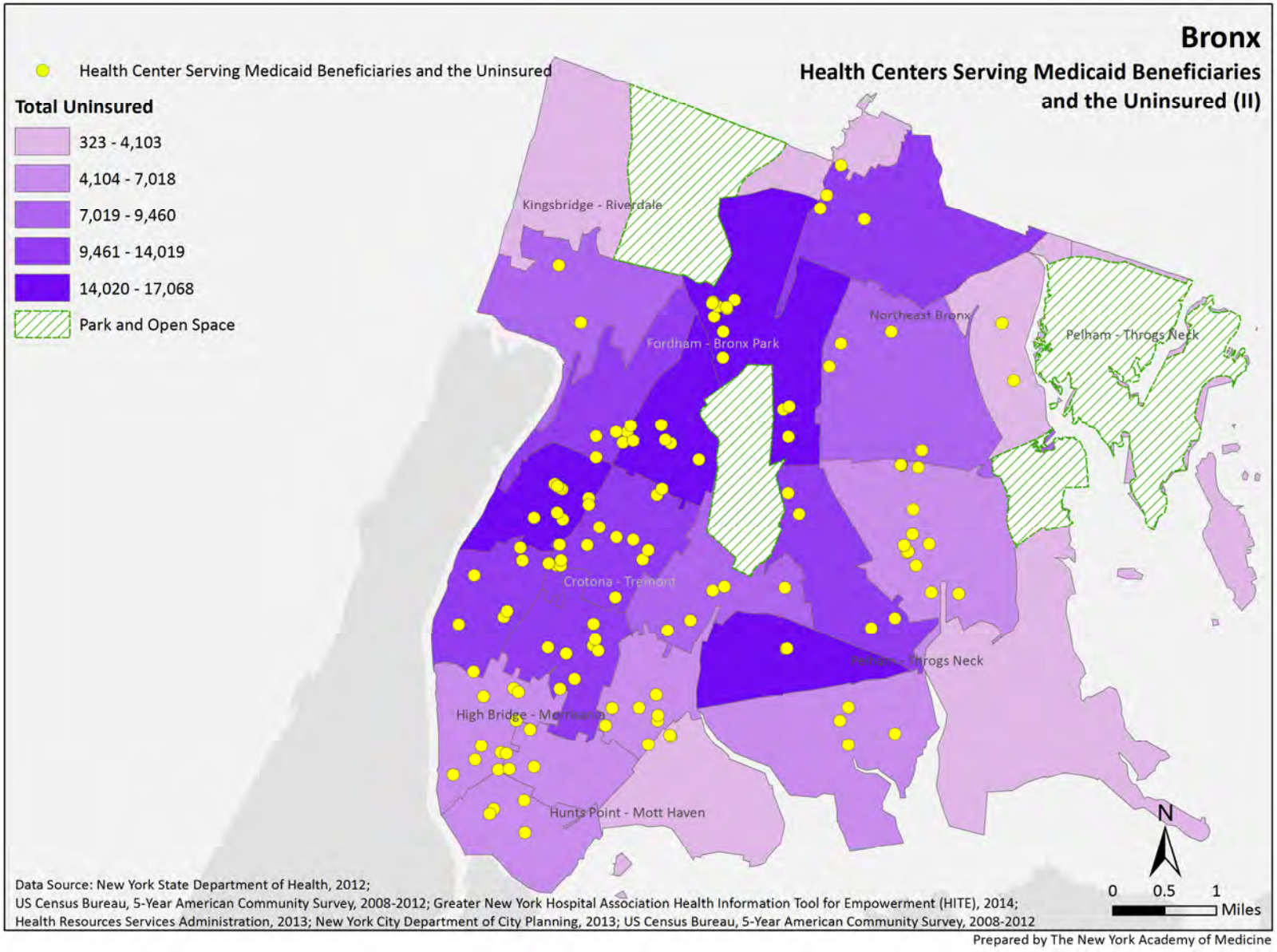


57. Health Centers Serving Medicaid Beneficiaries and the Uninsured (II)



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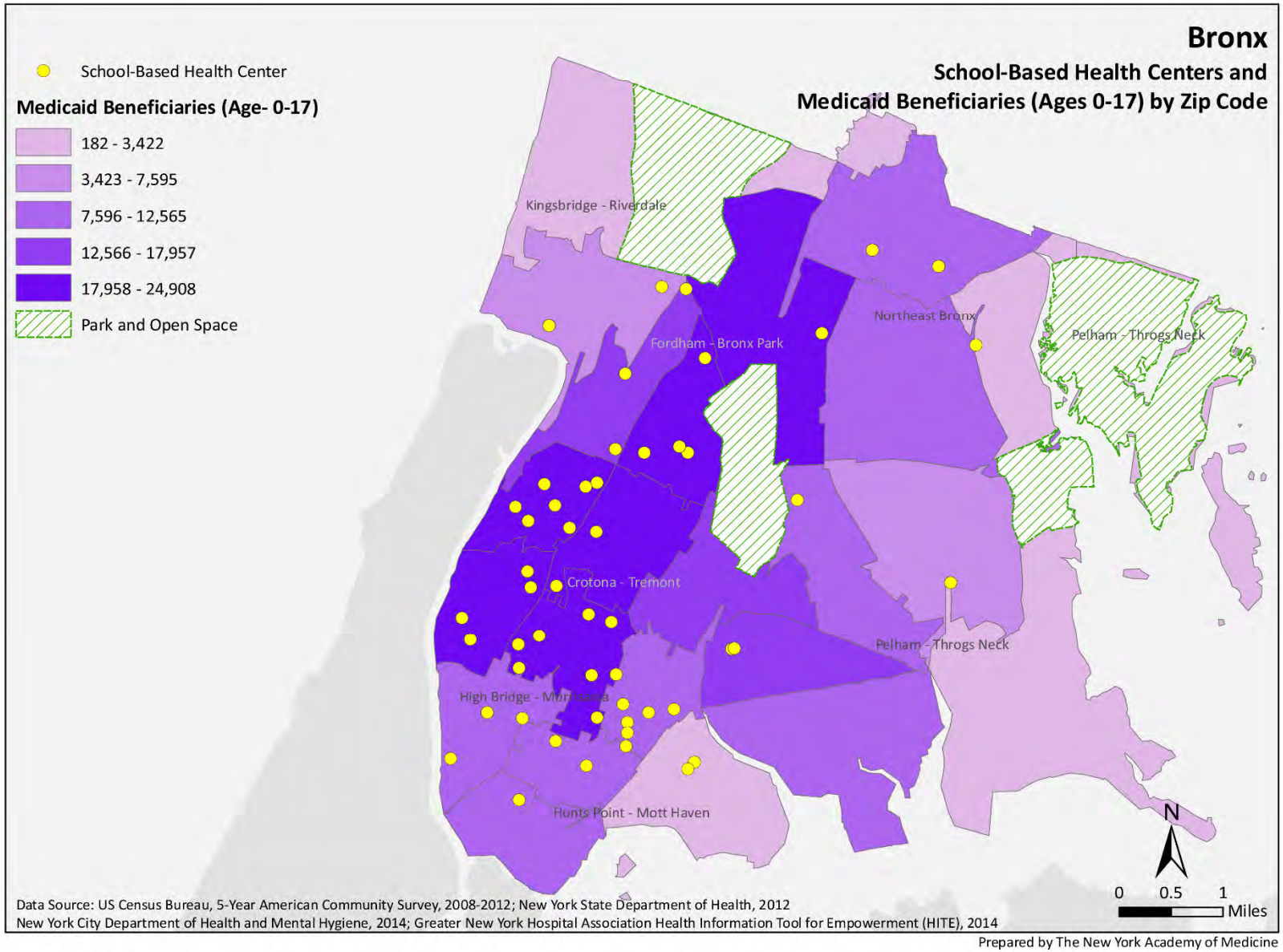

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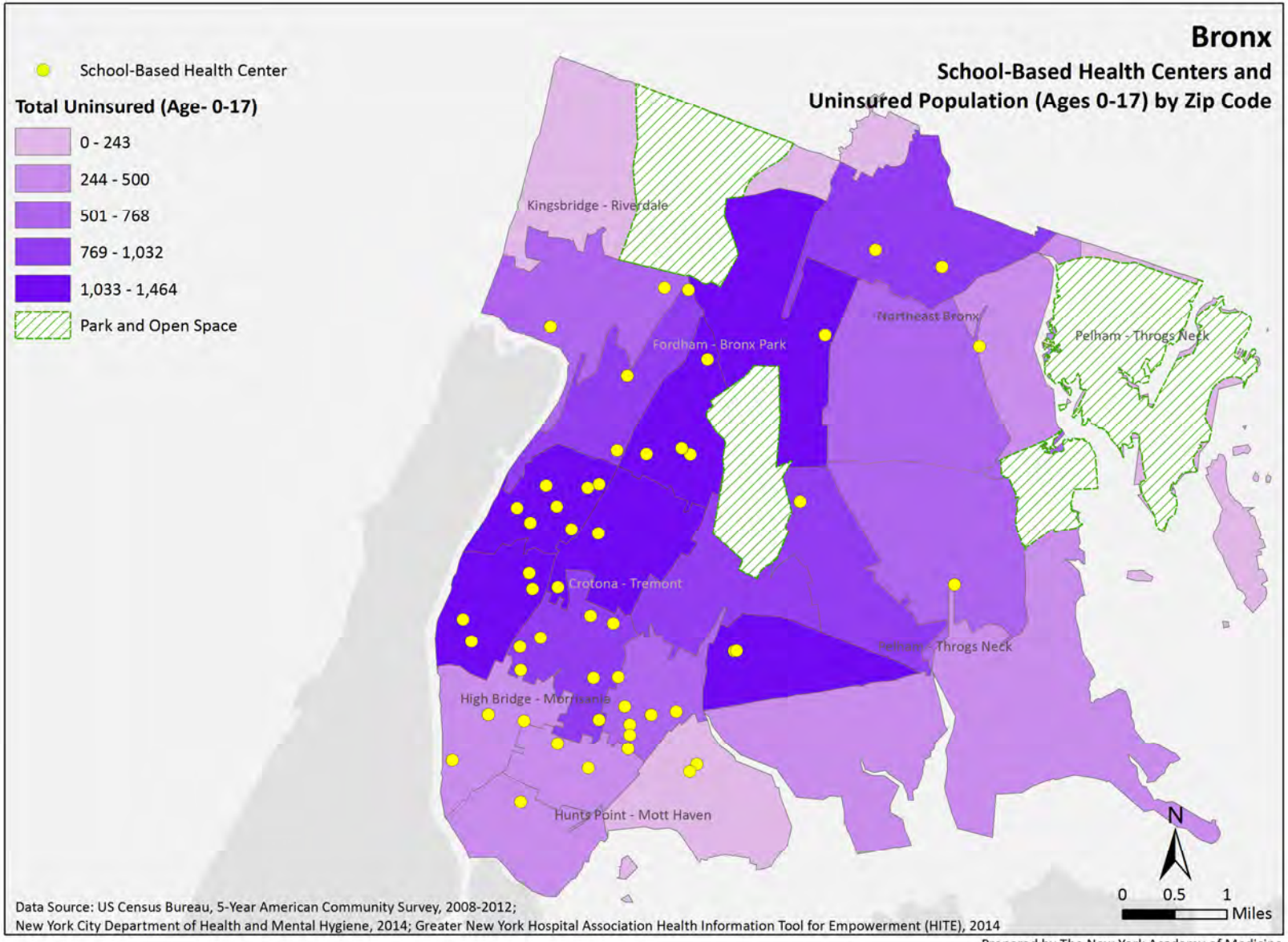

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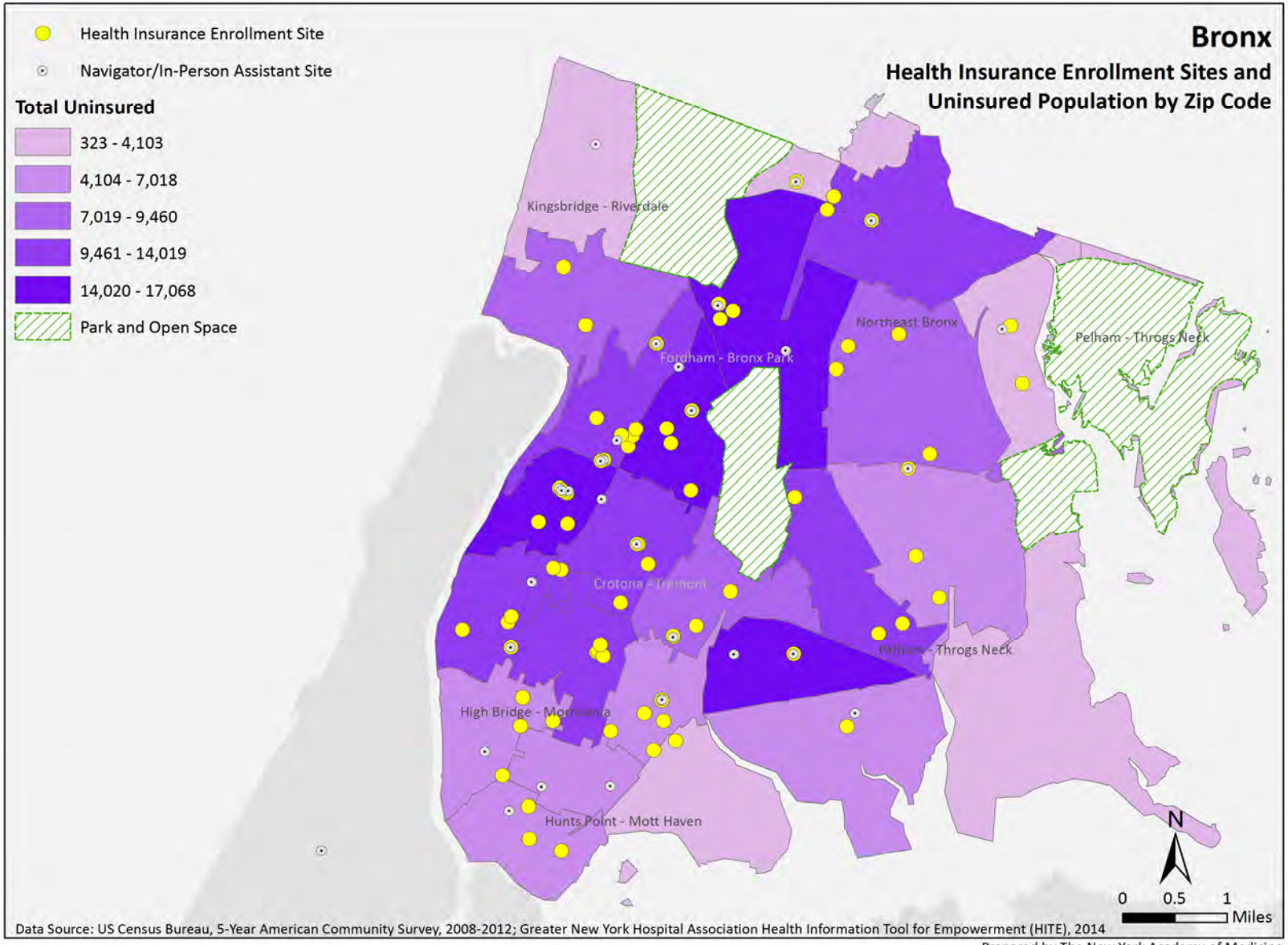

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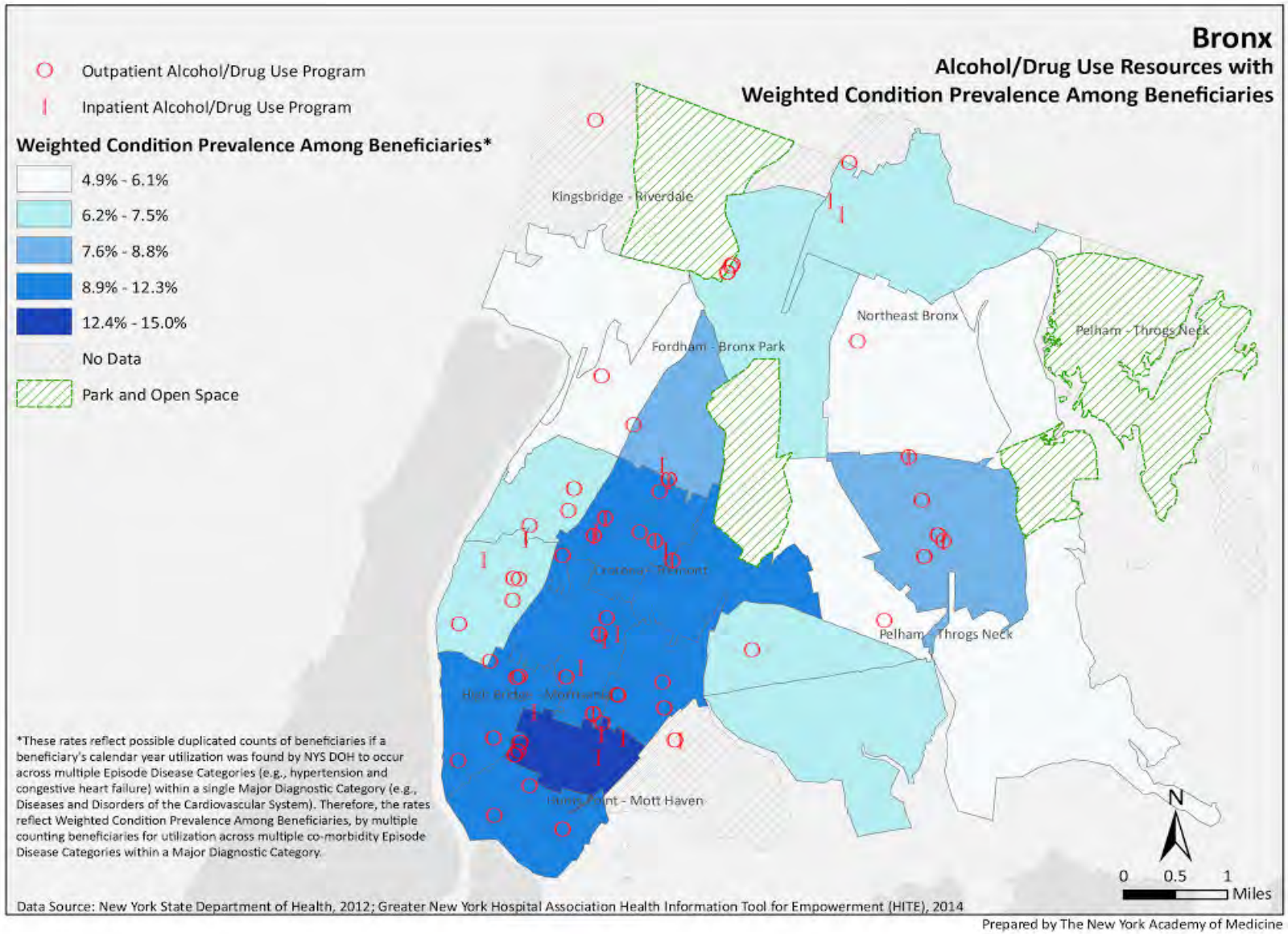

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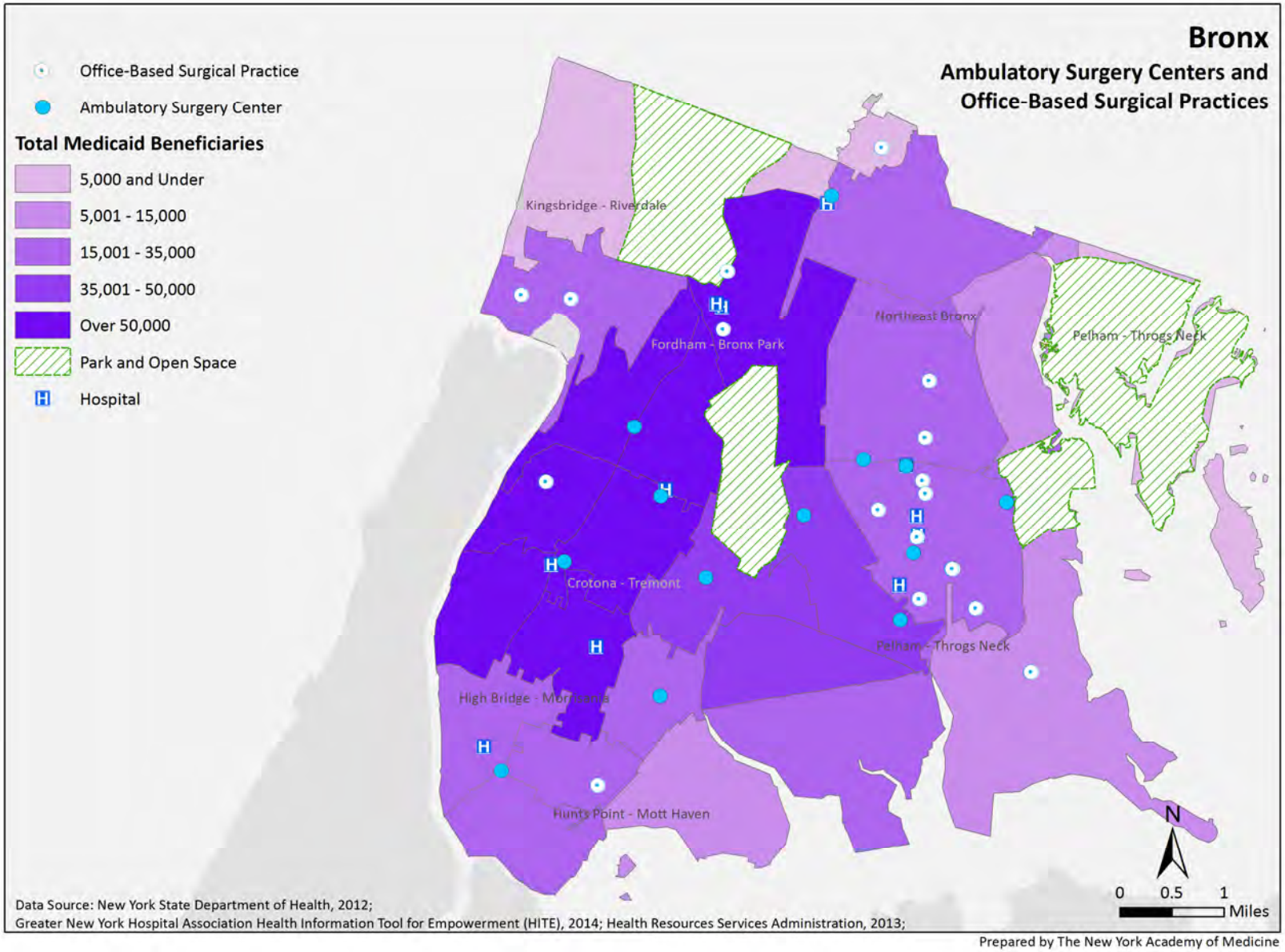

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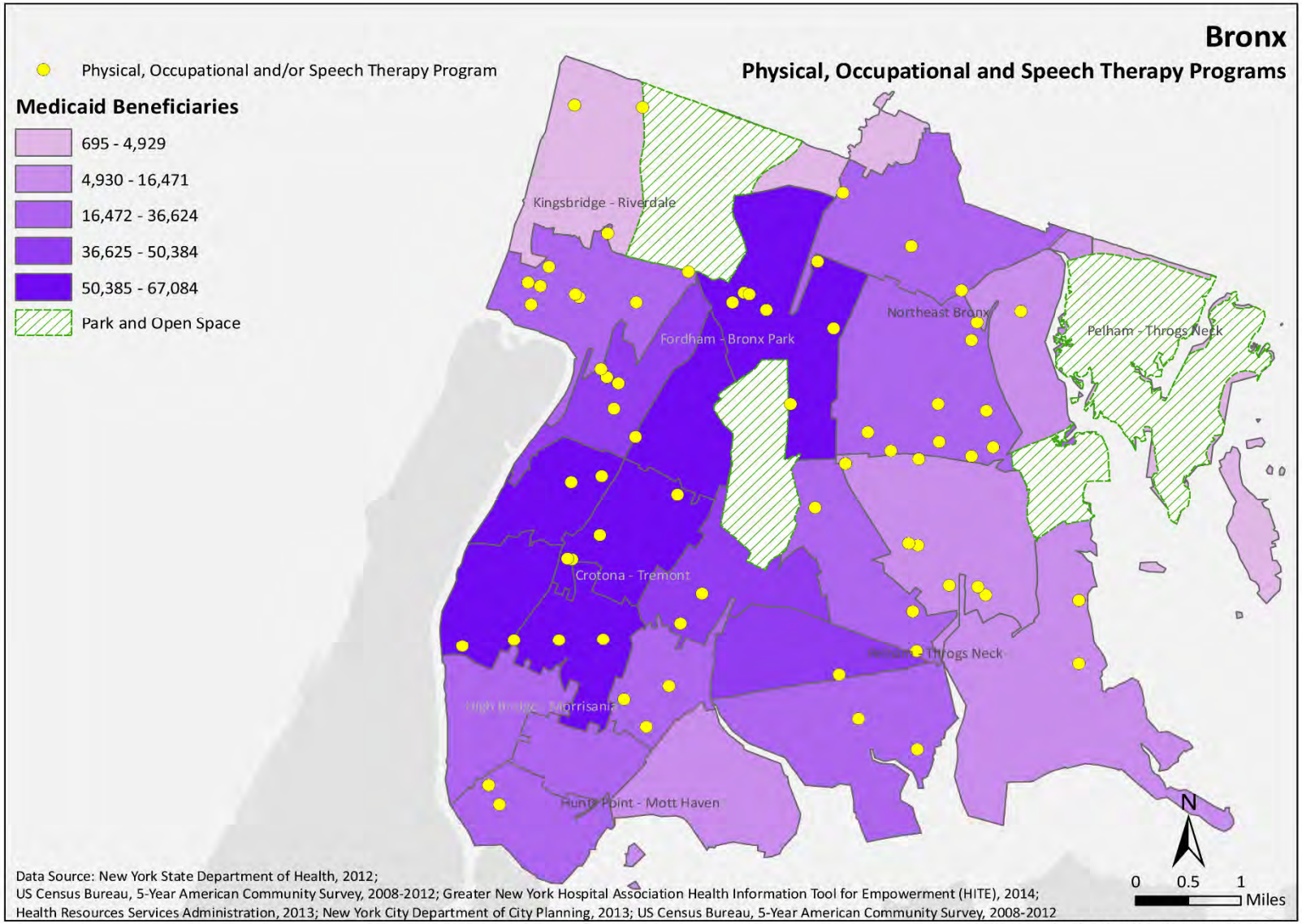
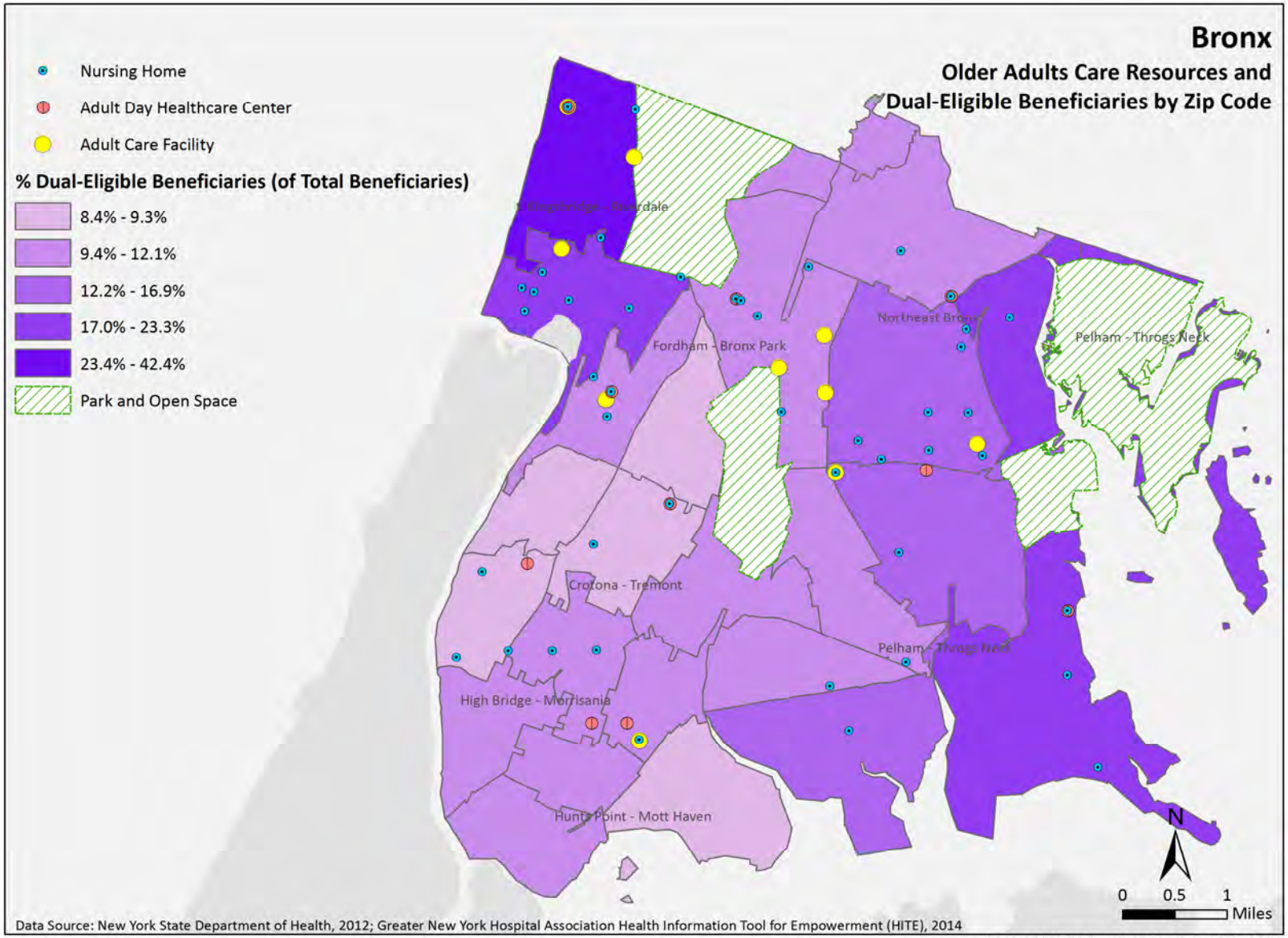
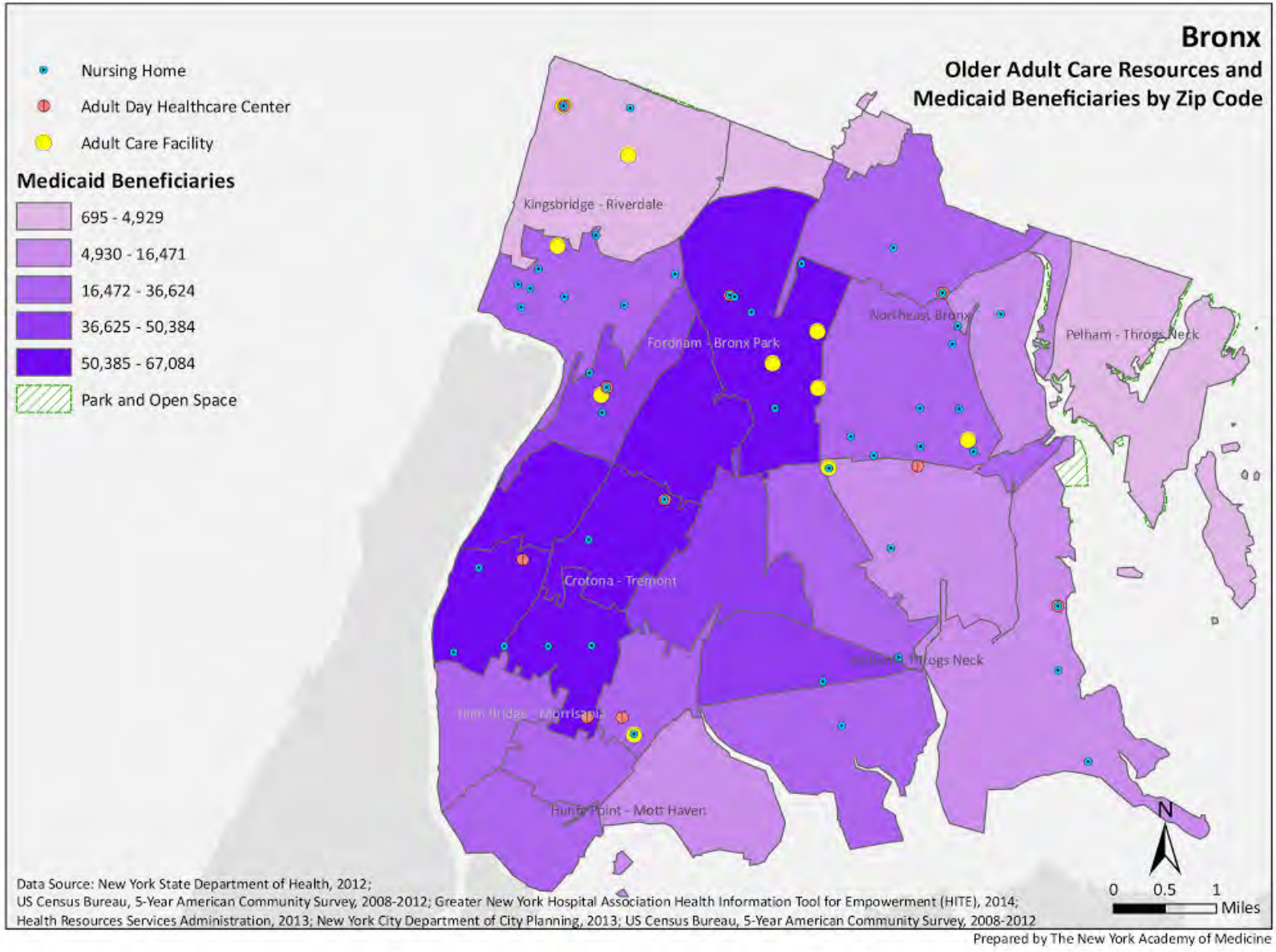


64. Older Adults Care Resources and Dual-Eligible Beneficiaries by Zip Code



65. Older Adult Care Resources and Medicaid Beneficiaries by Zip Code



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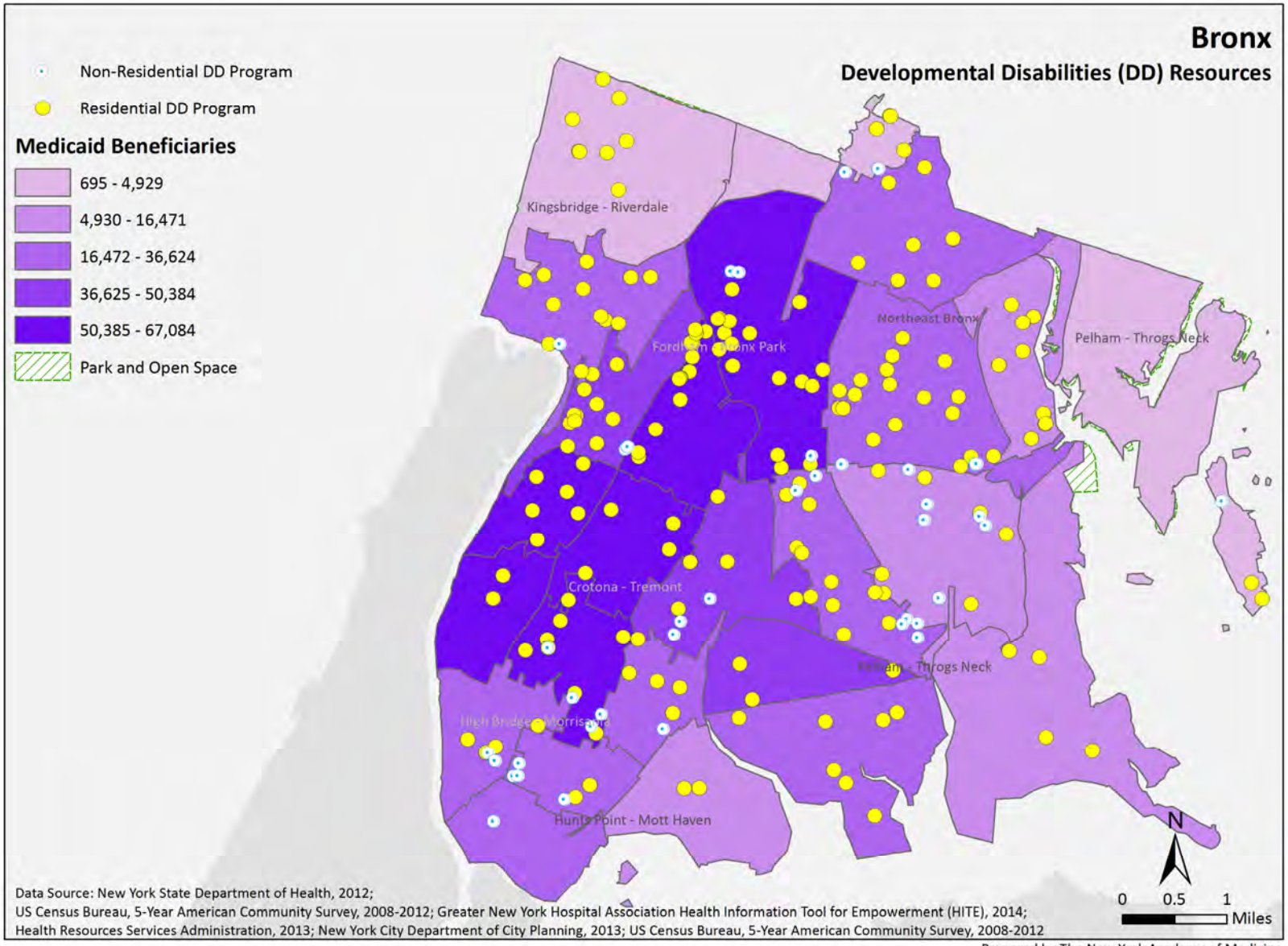
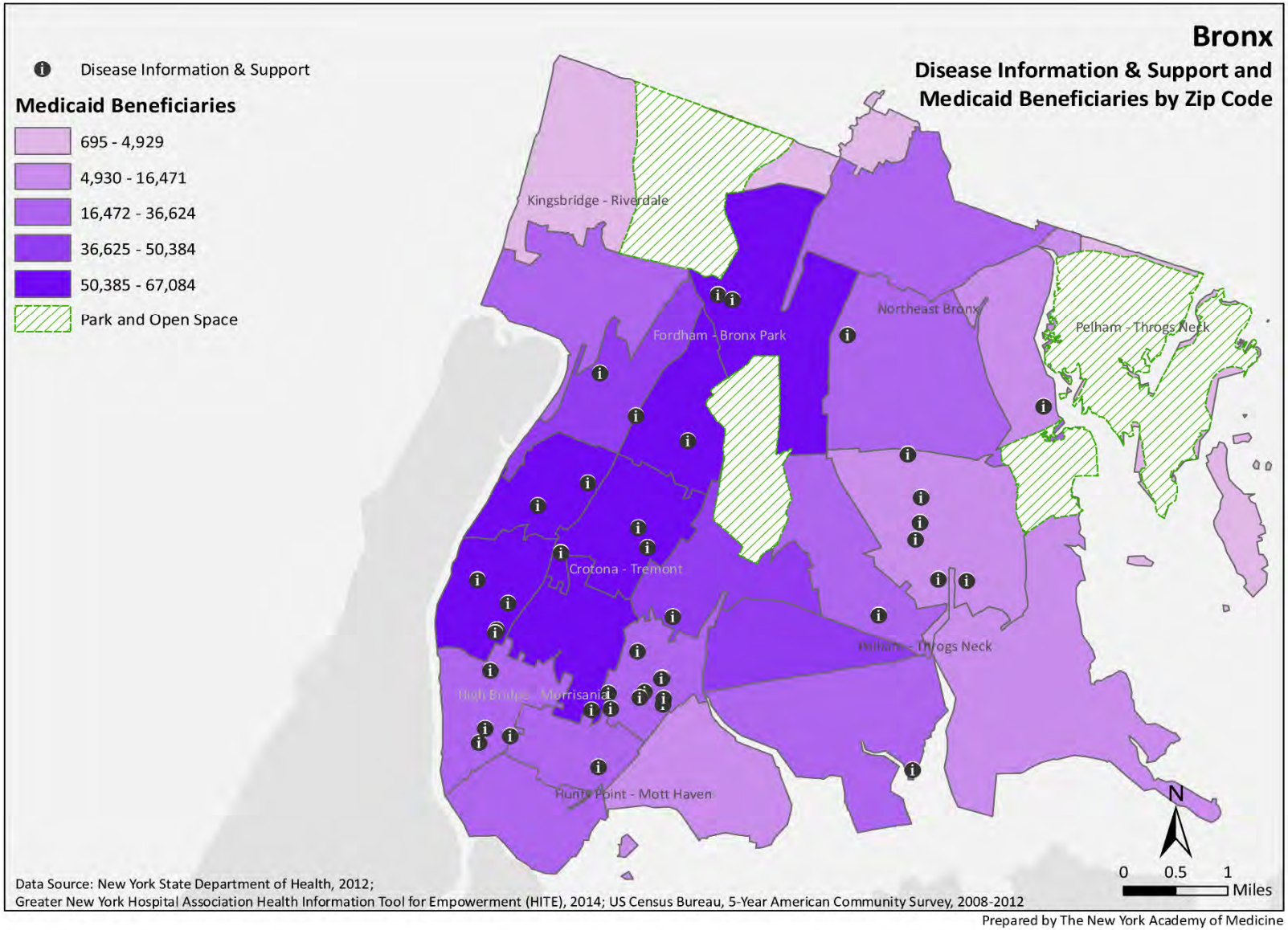


67. Disease Information and Support and Medicaid Beneficiaries by Zip Code



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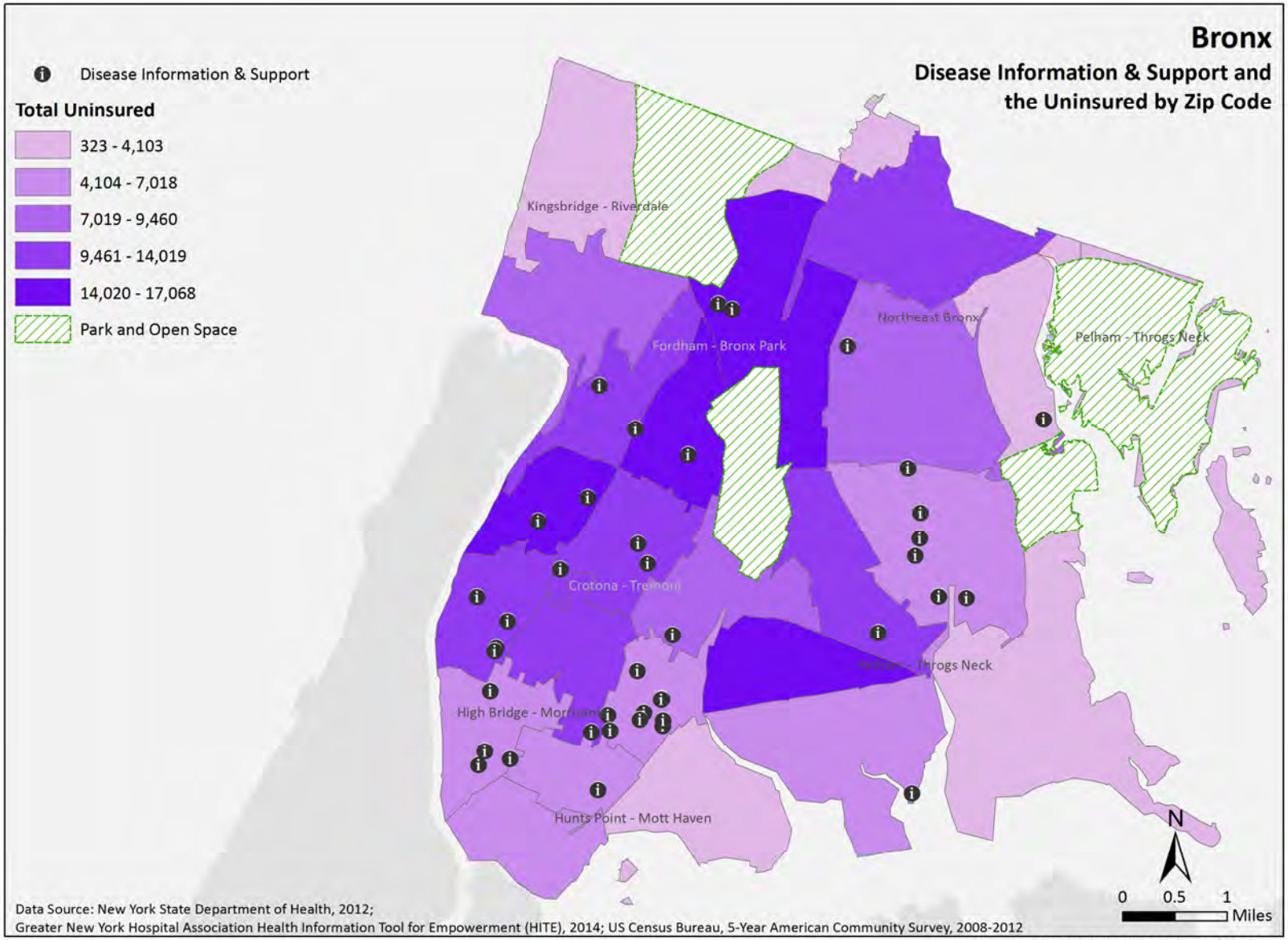

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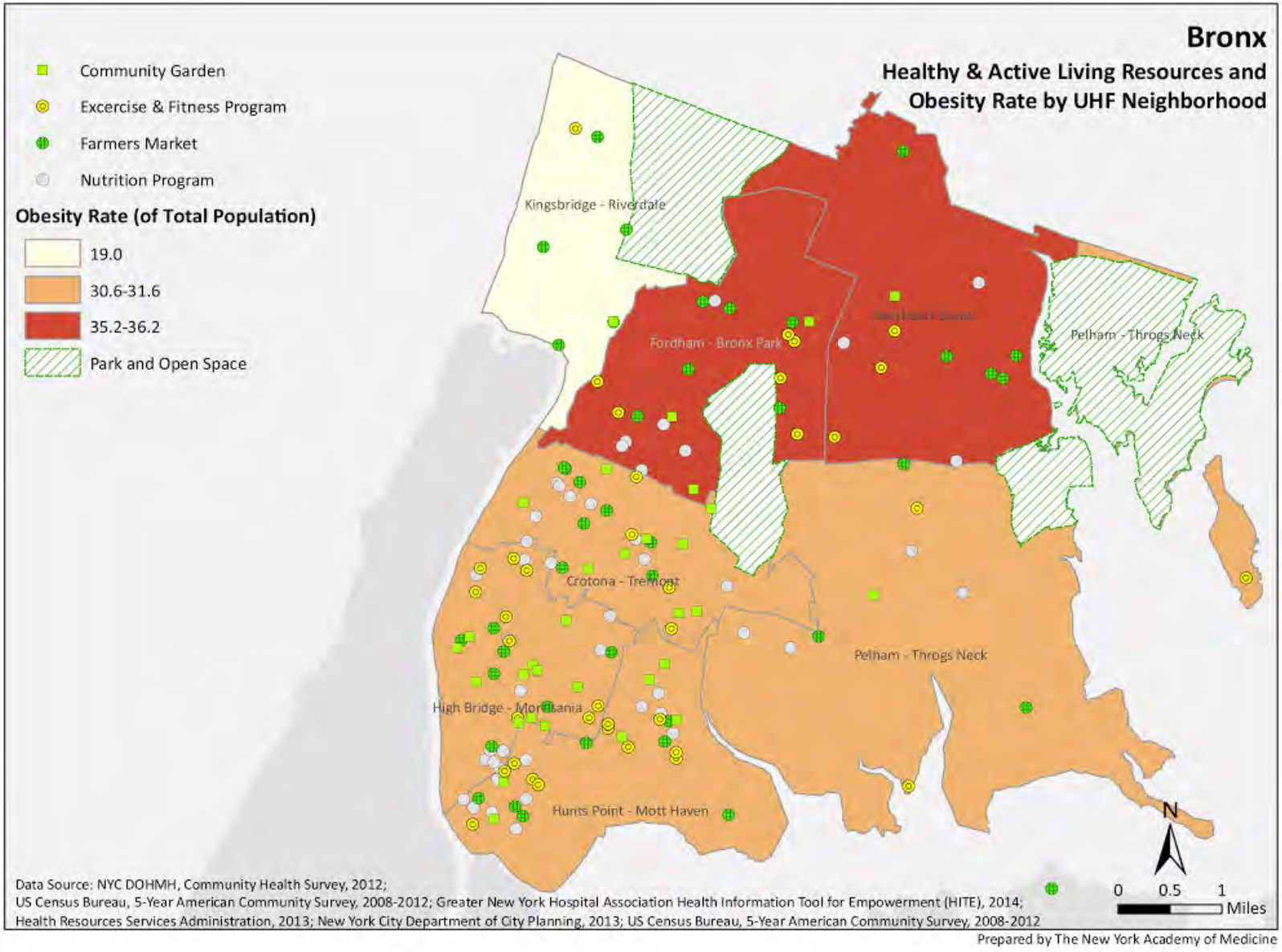

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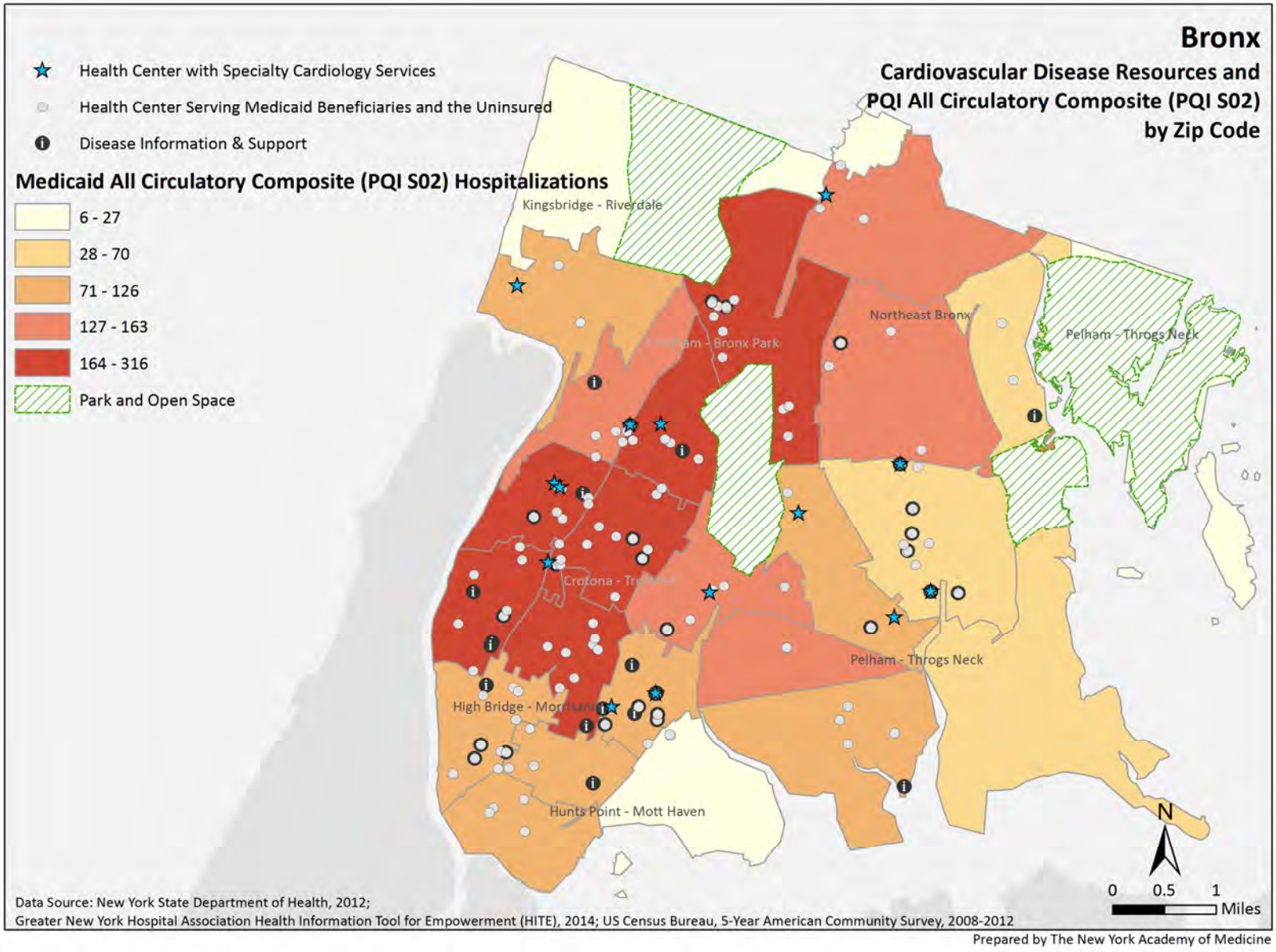

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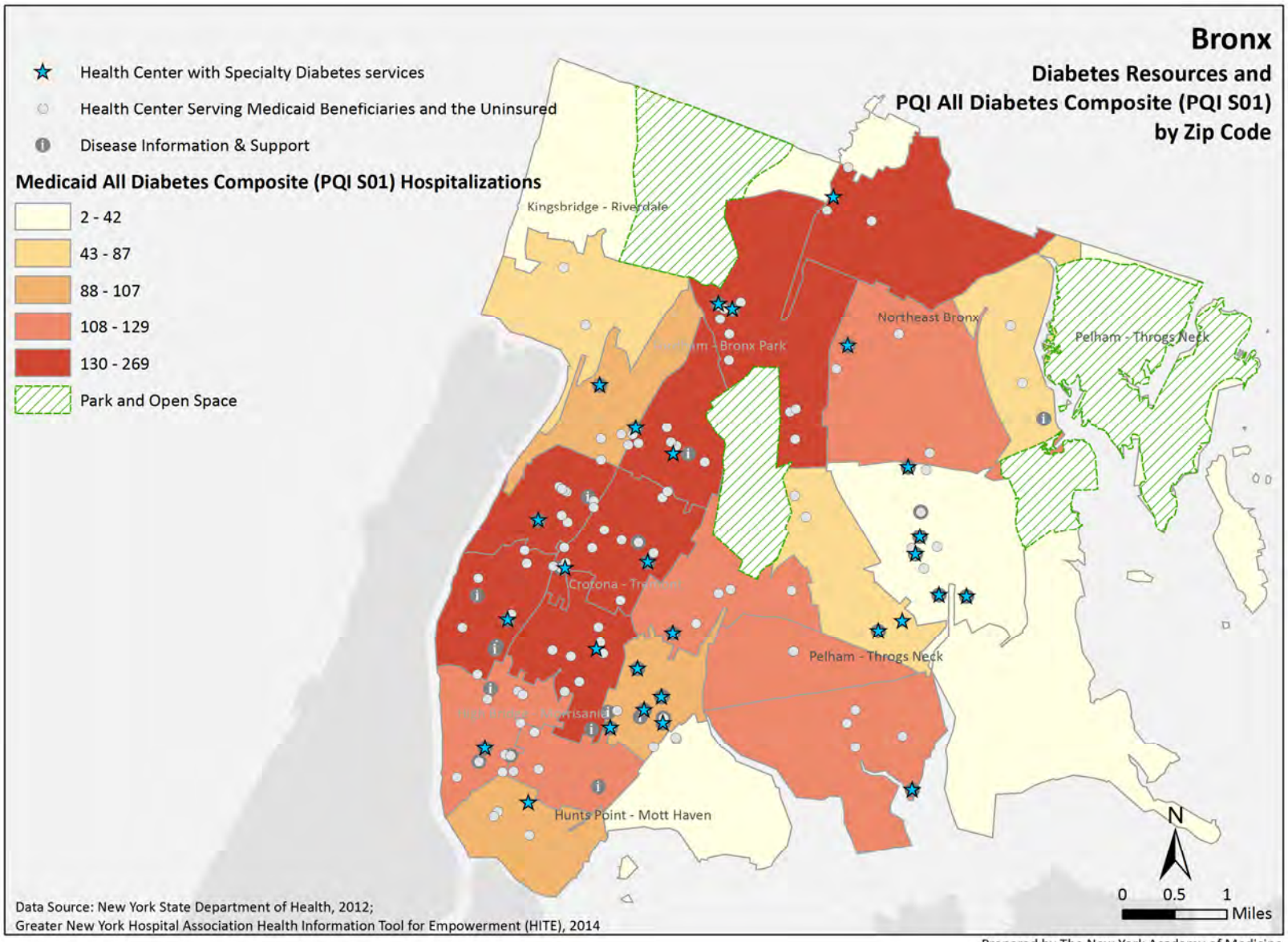

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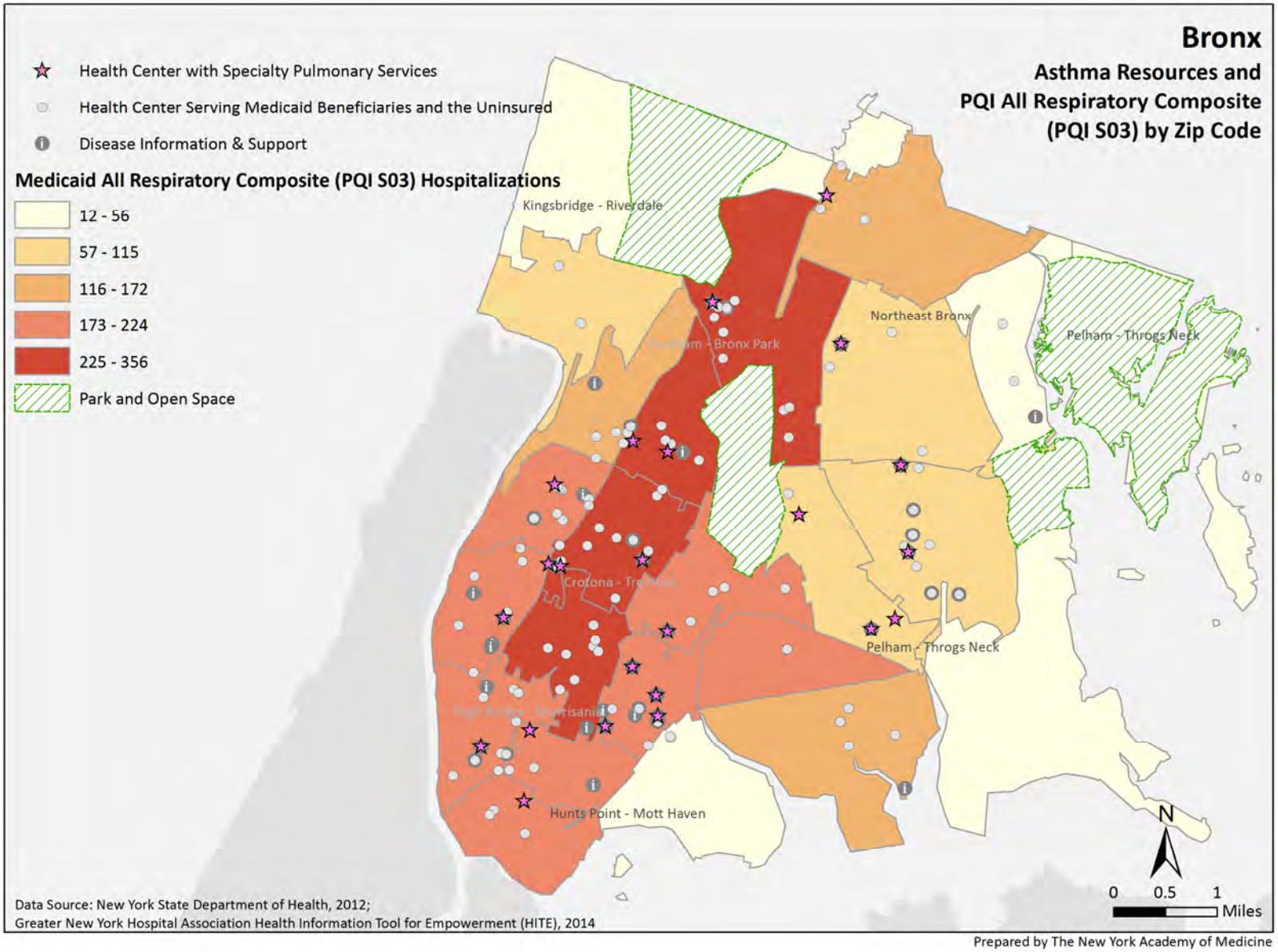

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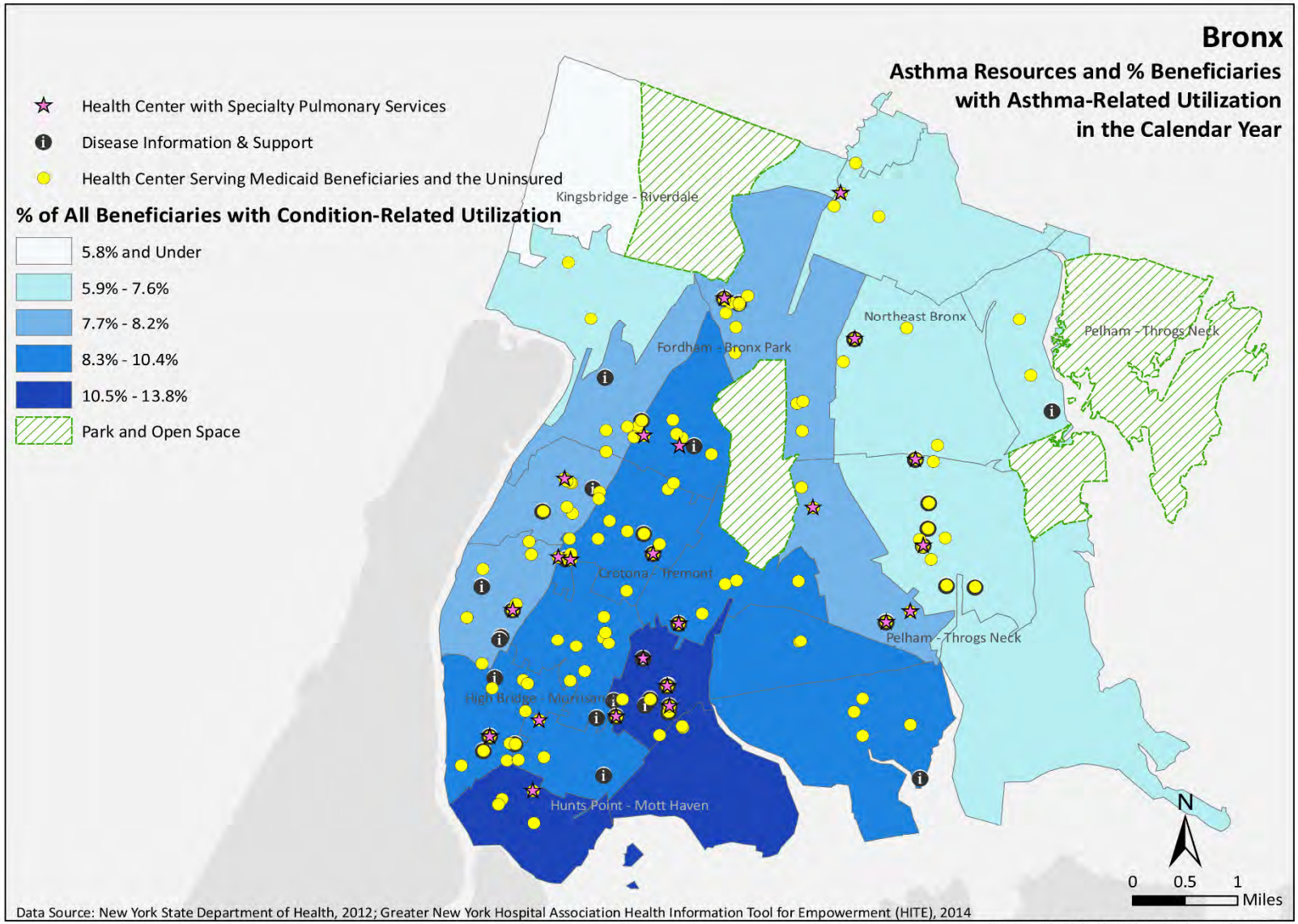

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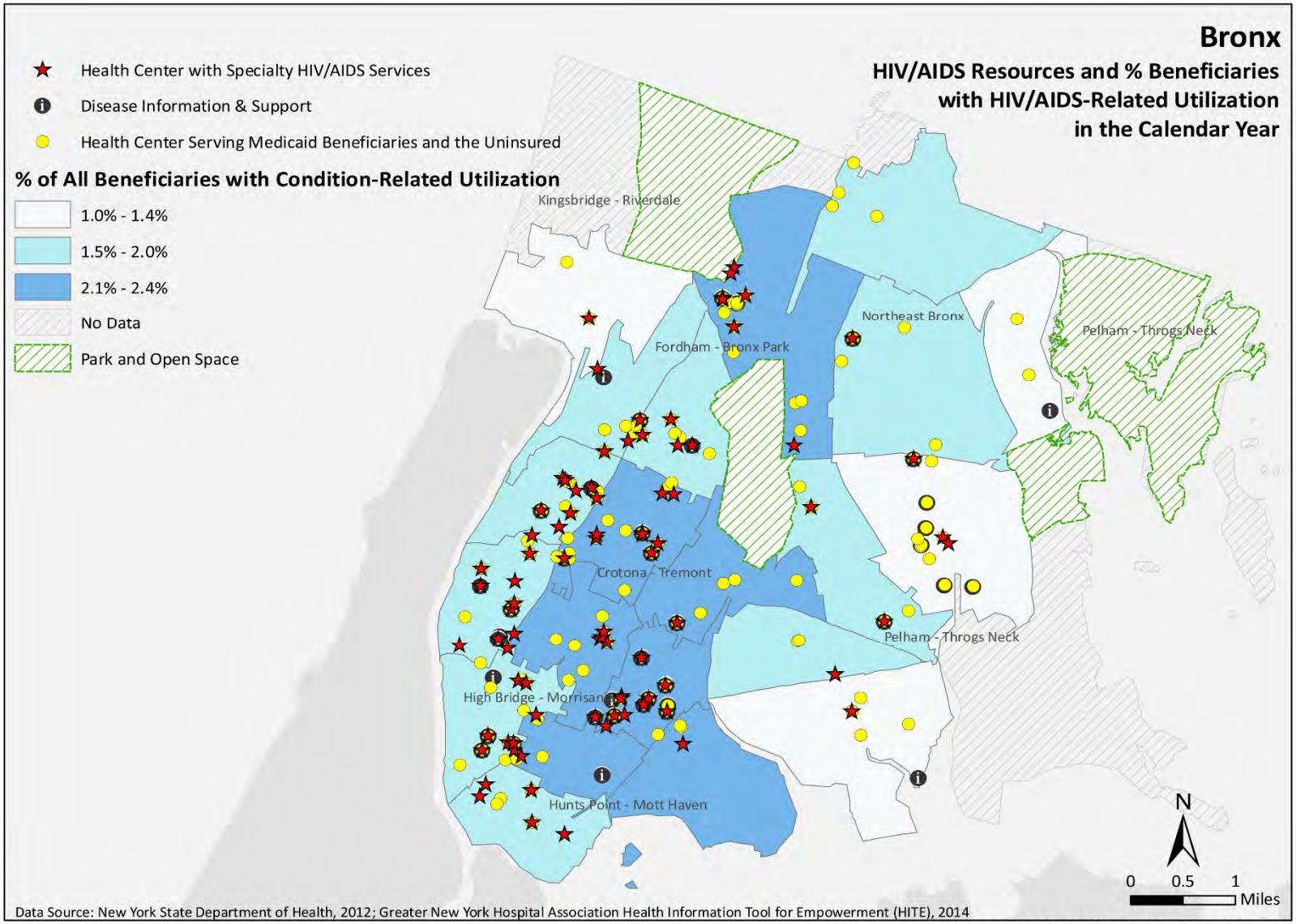
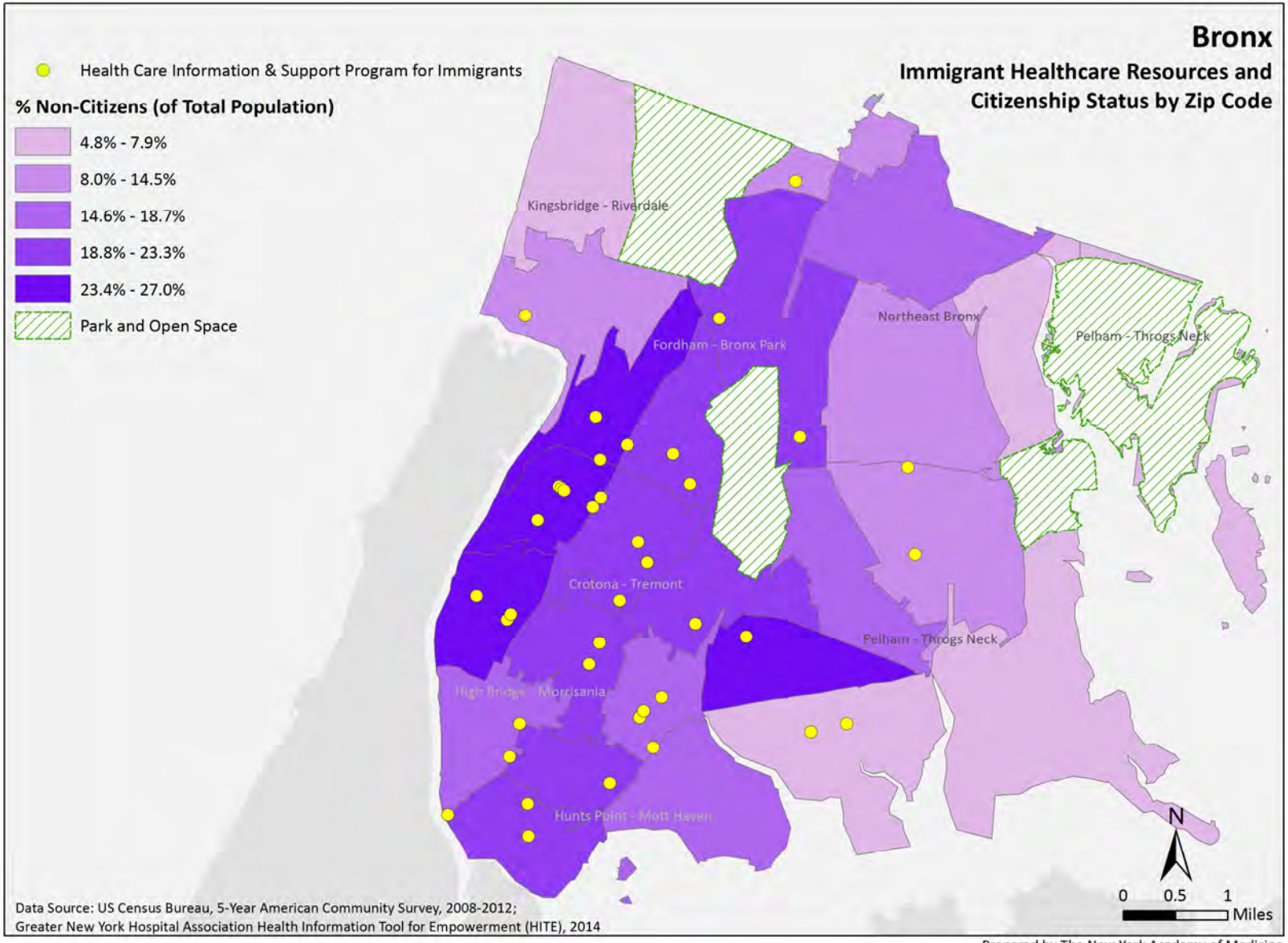
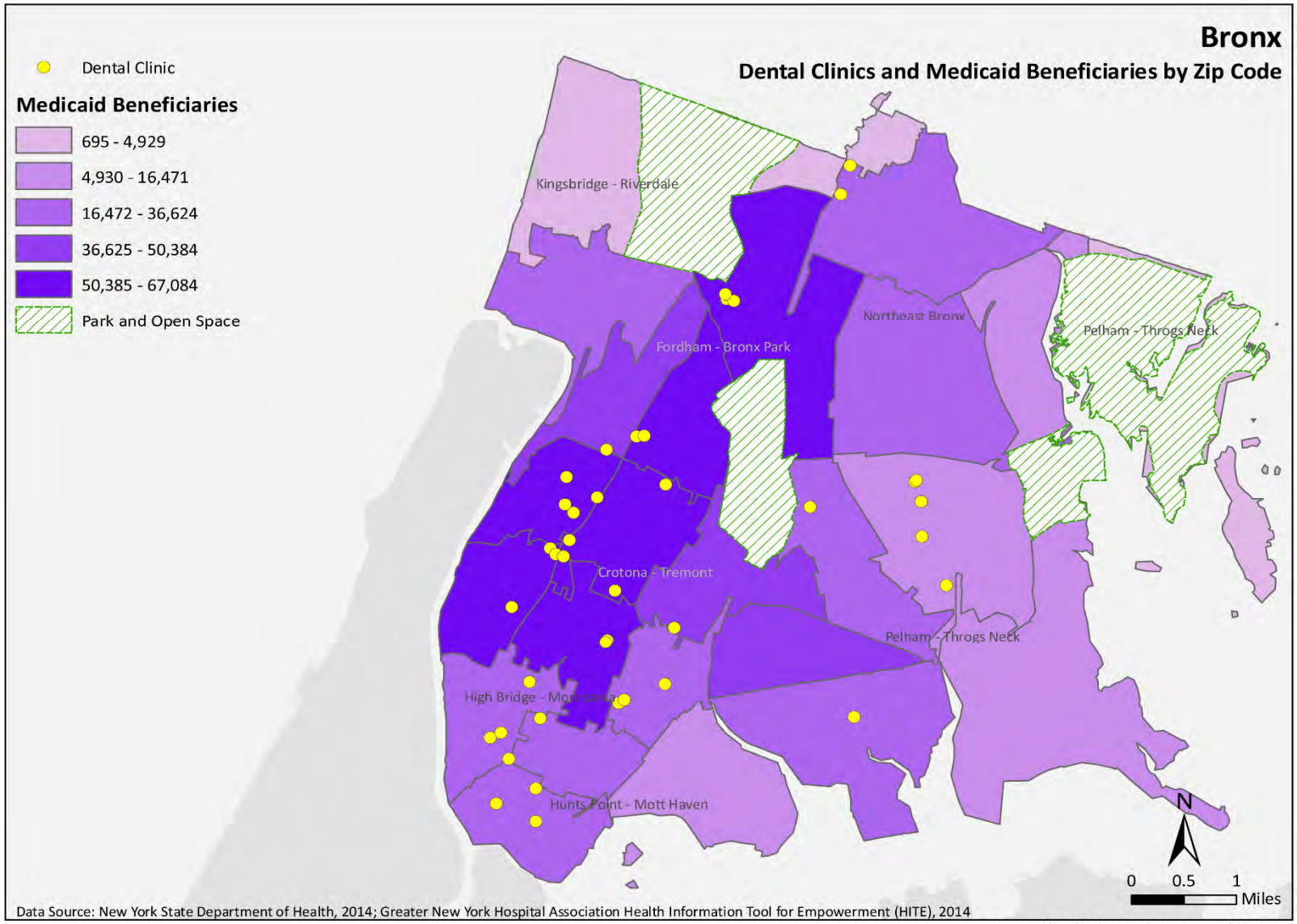


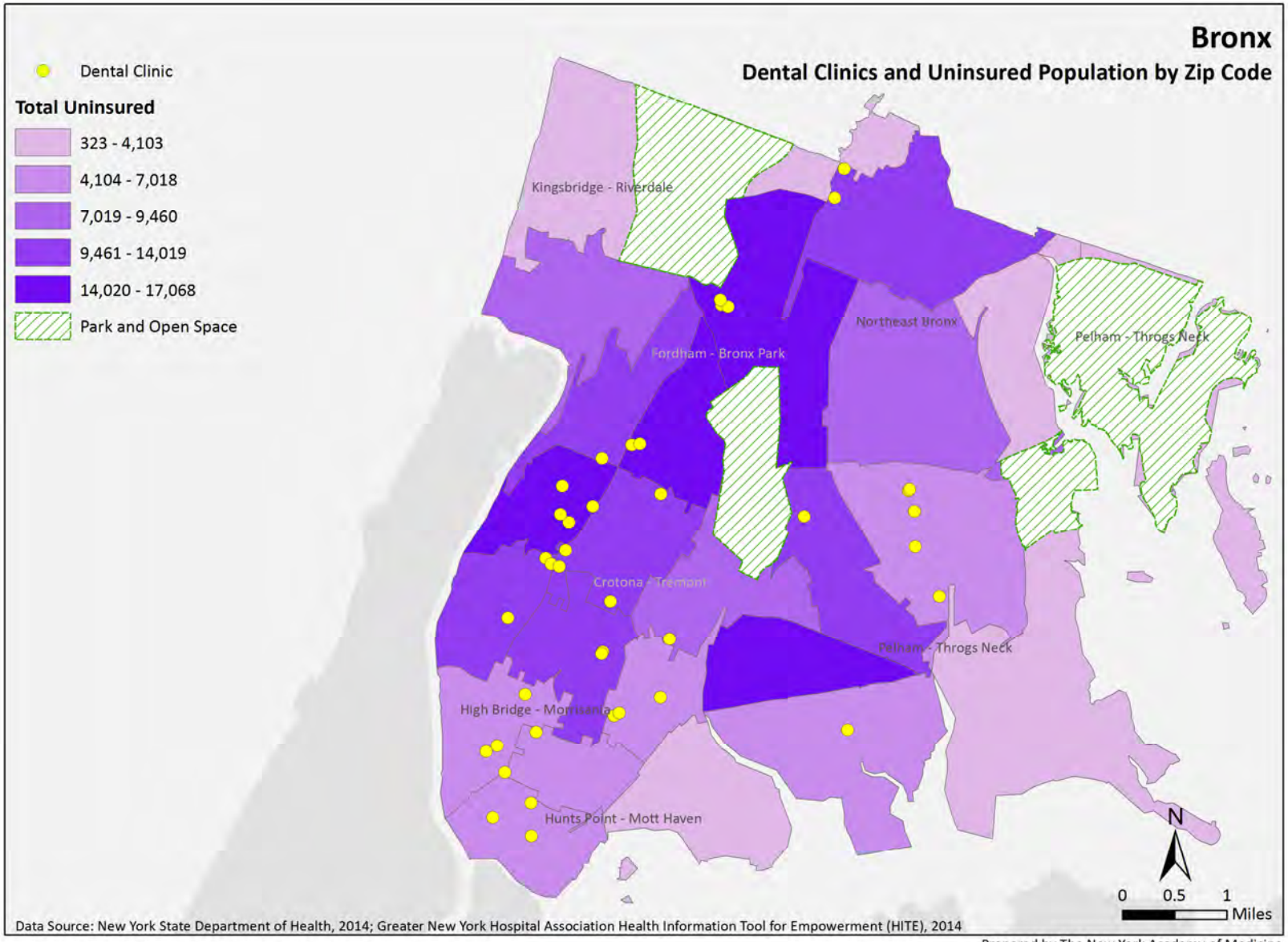
75. Immigrant Healthcare Resources and Citizenship Status by Zip Code



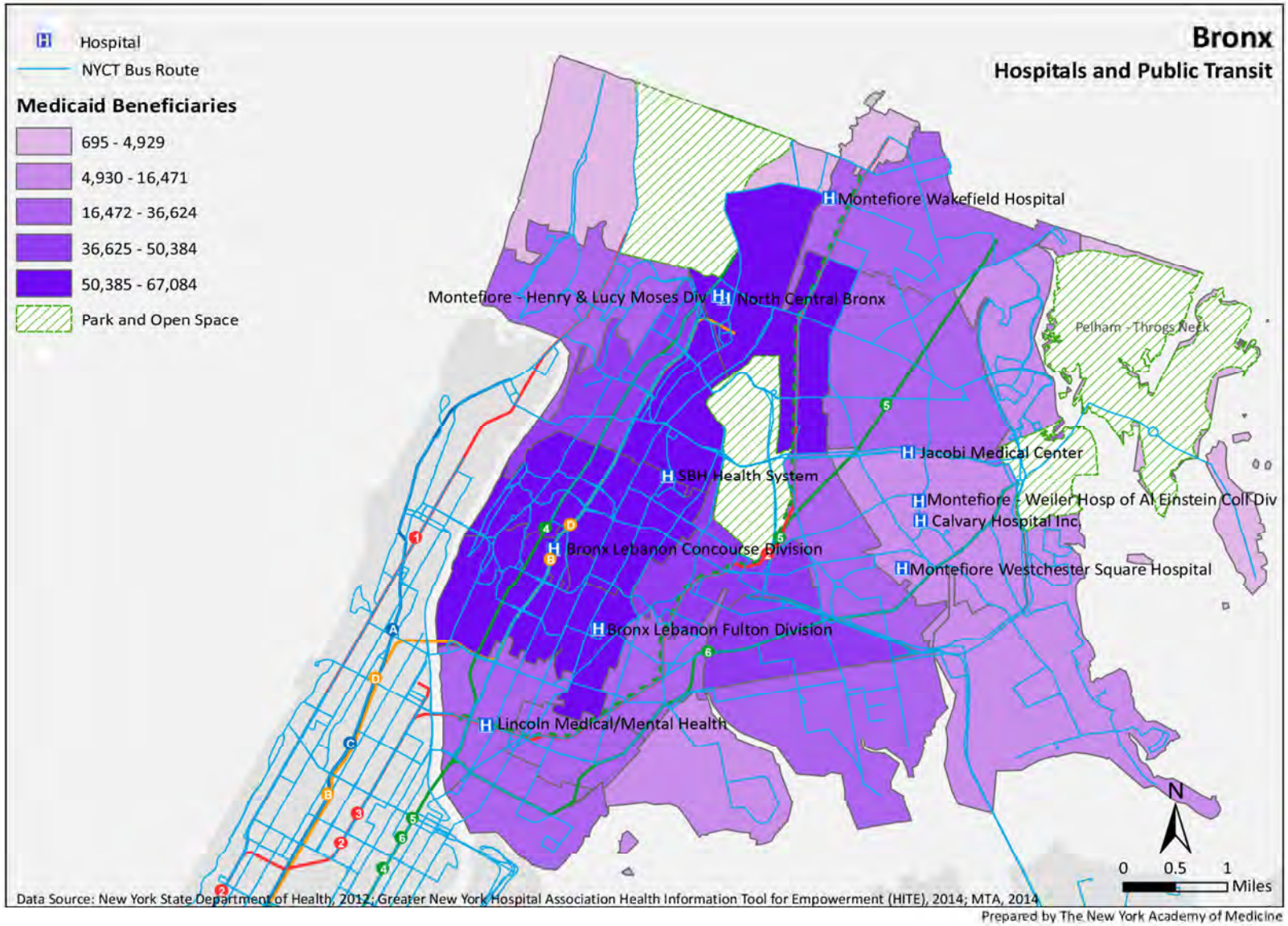
76. Dental Clinics and Medicaid Beneficiaries by Zip Code



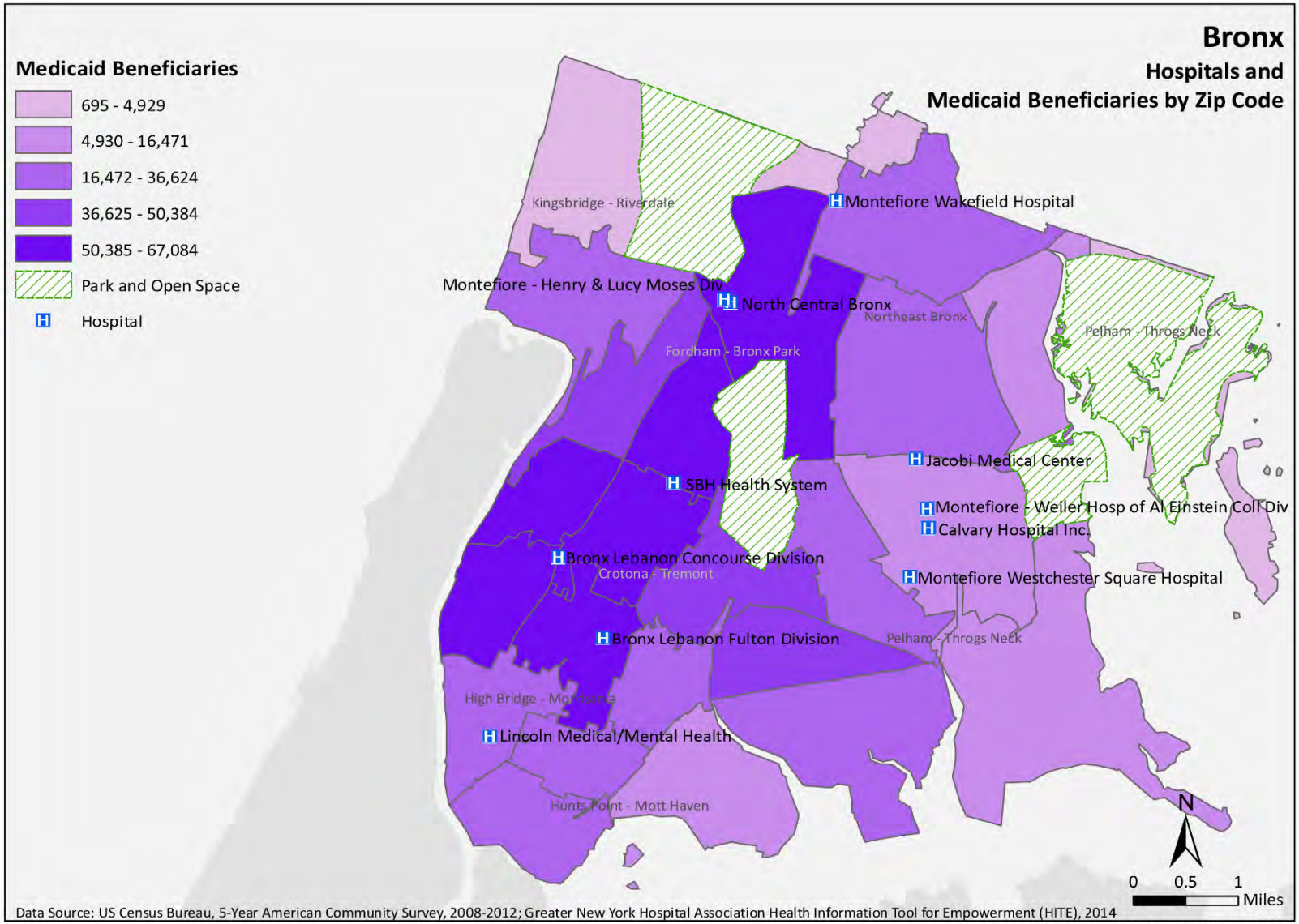
77. Dental Clinics and Uninsured Population by Zip Code



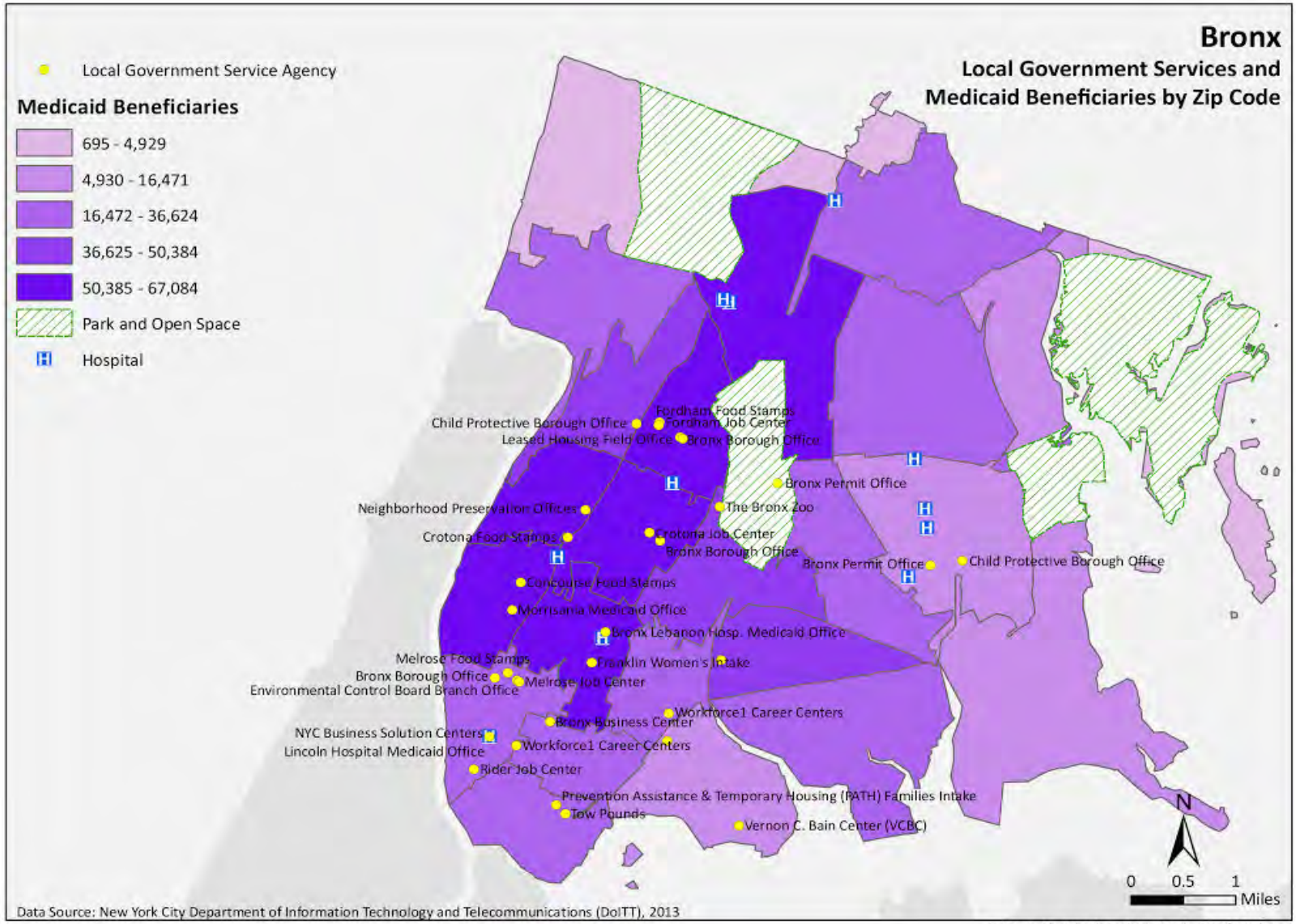
78. Hospitals and Public Transit



79. Hospitals and Medicaid Beneficiaries by Zip Code



80. Local Governmental Services and Medicaid Beneficiaries by Zip Code



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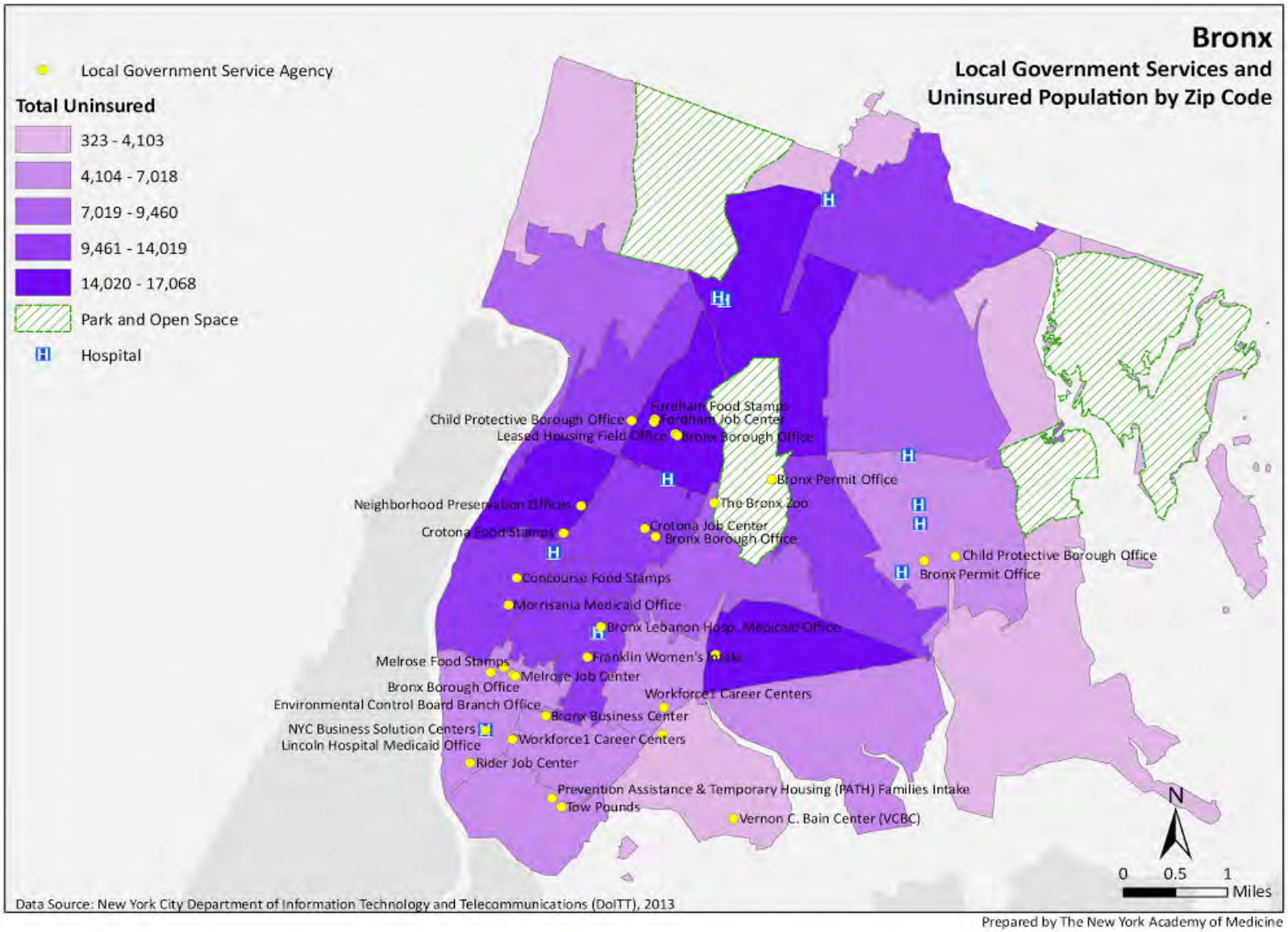

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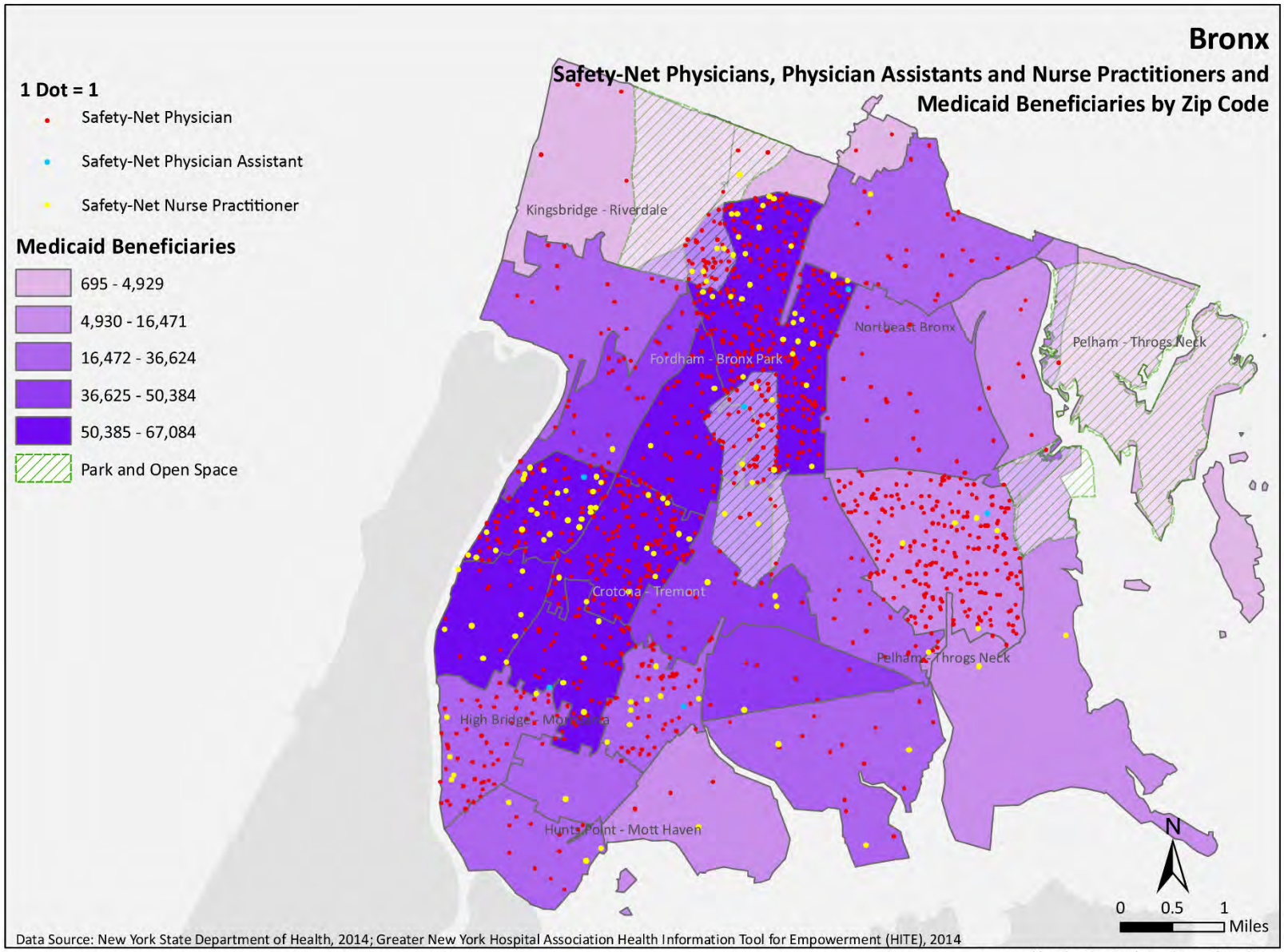
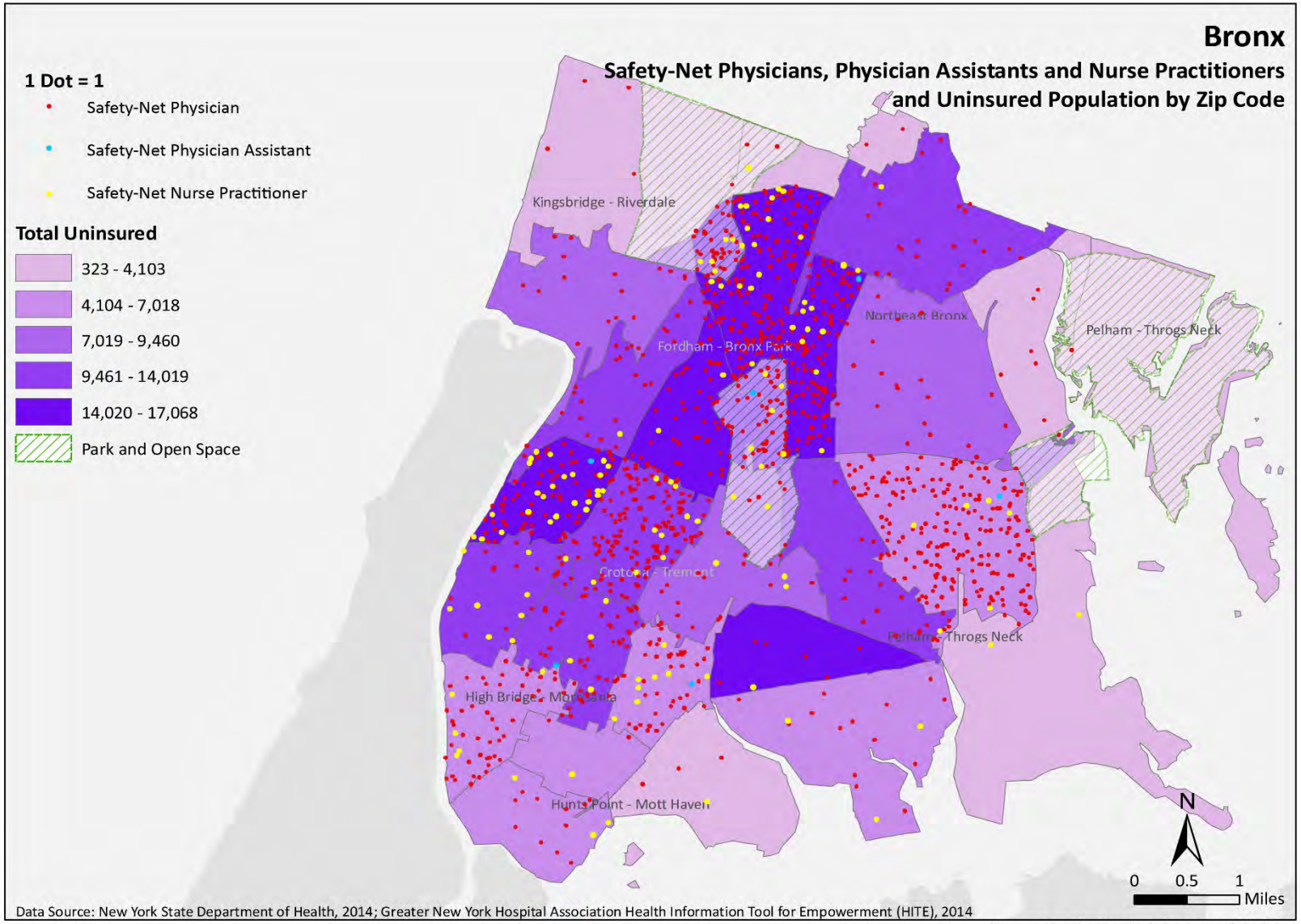
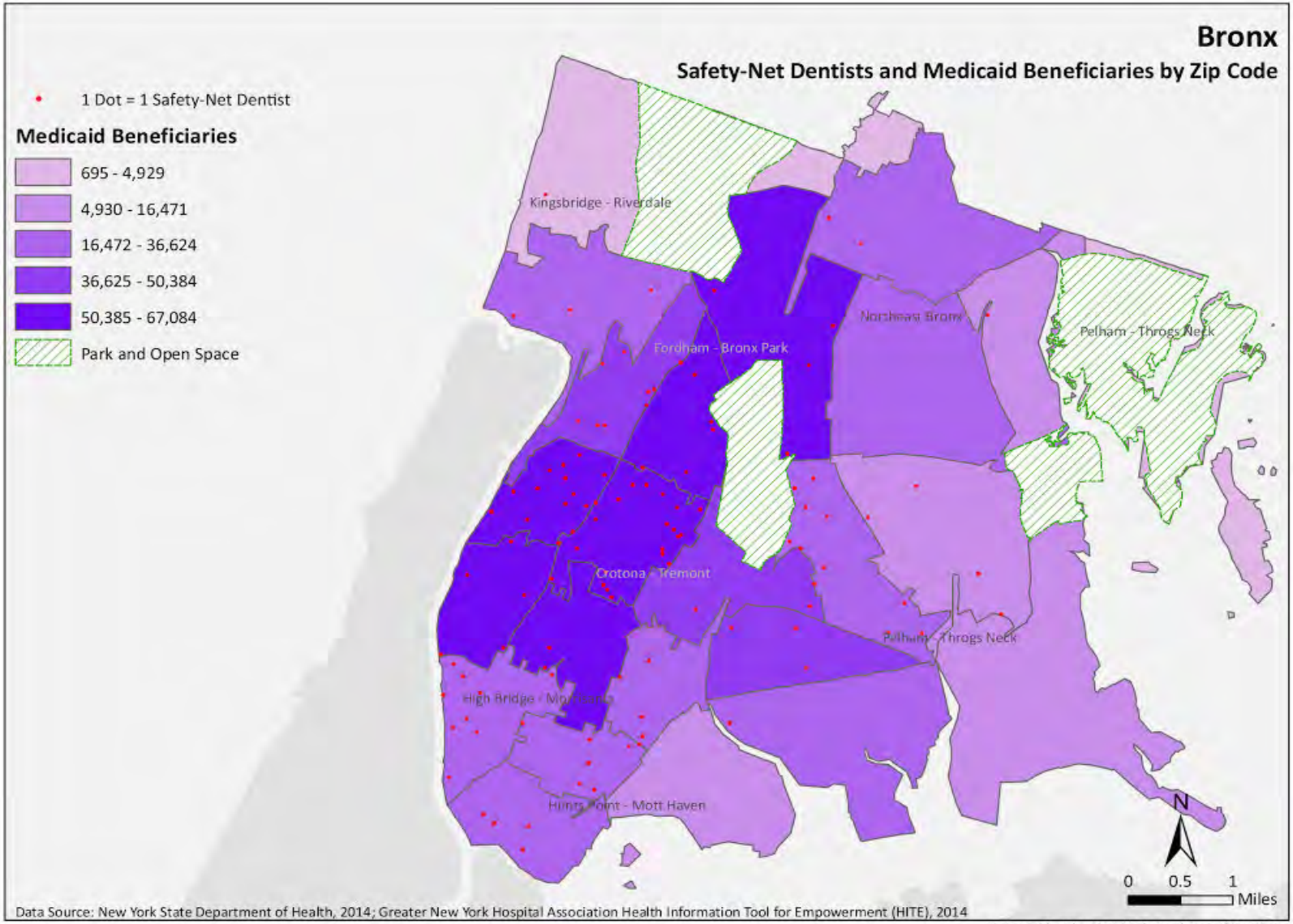
82. Safety-Net Physicians, Physician Assistants, Nurse Practitioners and Medicaid Beneficiaries by Zip Code



83. Safety-Net Physicians, Physician Assistants, Nurse Practitioners and Uninsured Population by Zip Code



84. Safety-Net Dentists and Medicaid Beneficiaries by Zip Code



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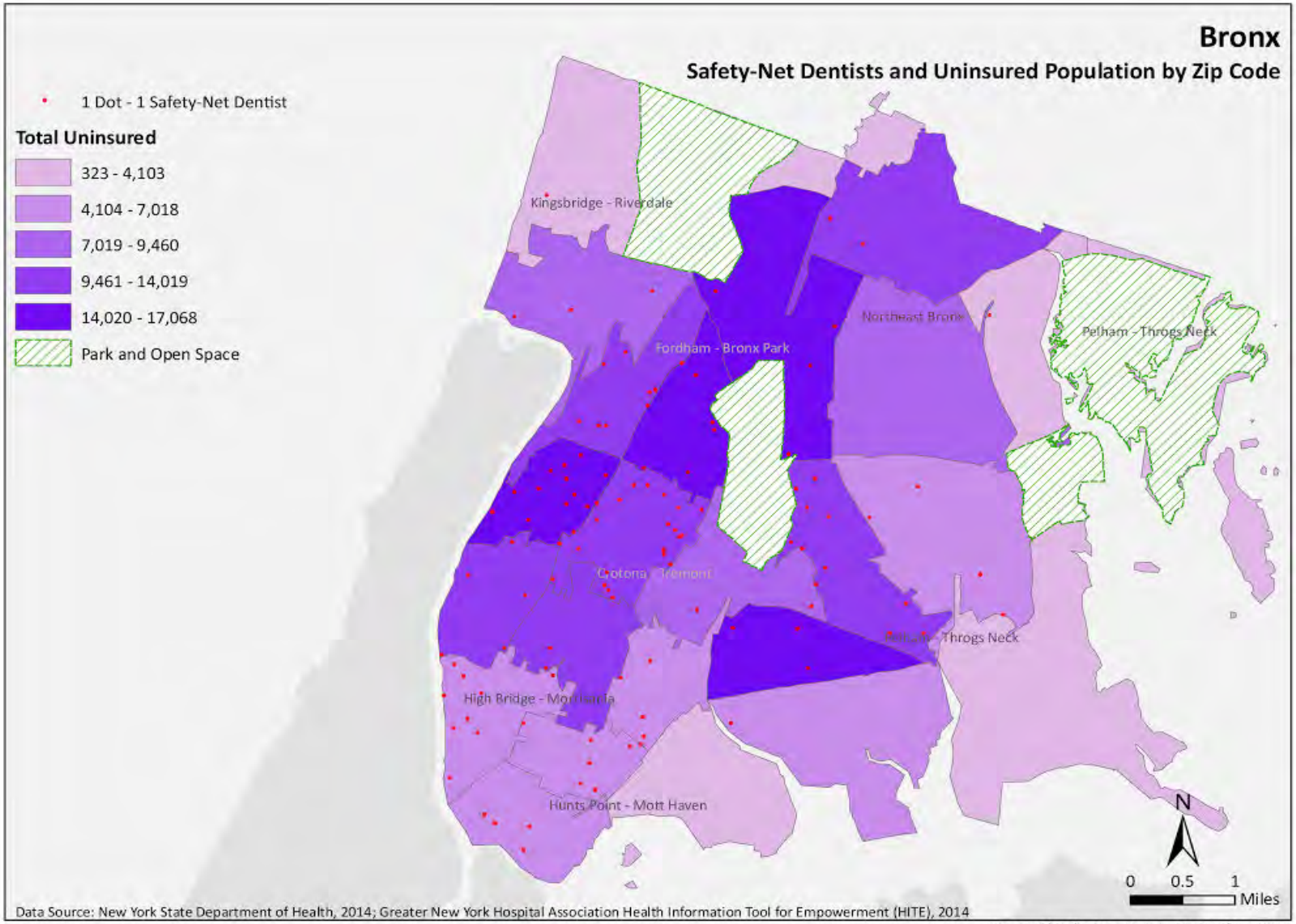

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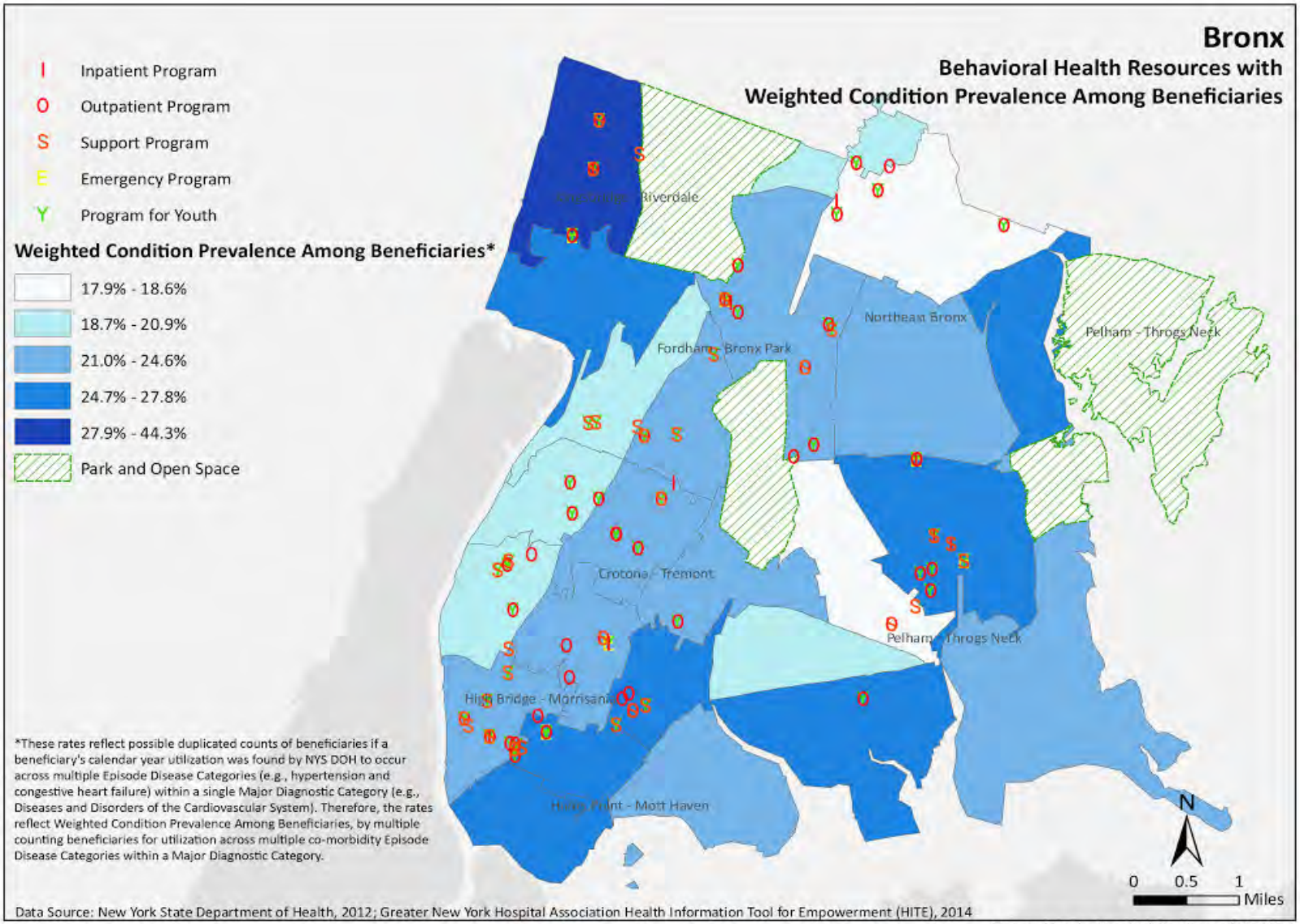
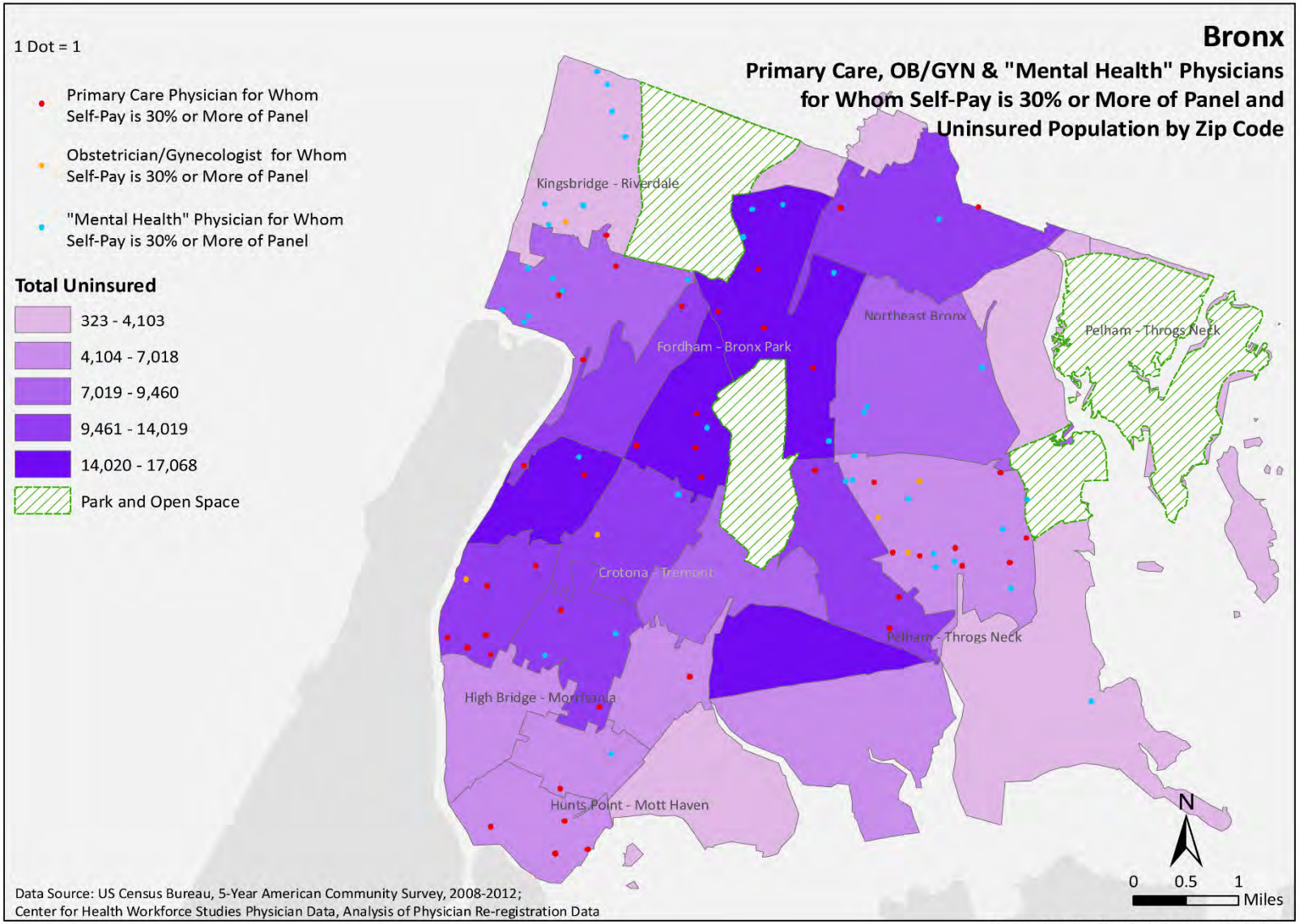


87. Primary Care, OB/GYN and "Mental Health" Physicians for Whom Self-Pay is 30% or More of Panel by Zip Code



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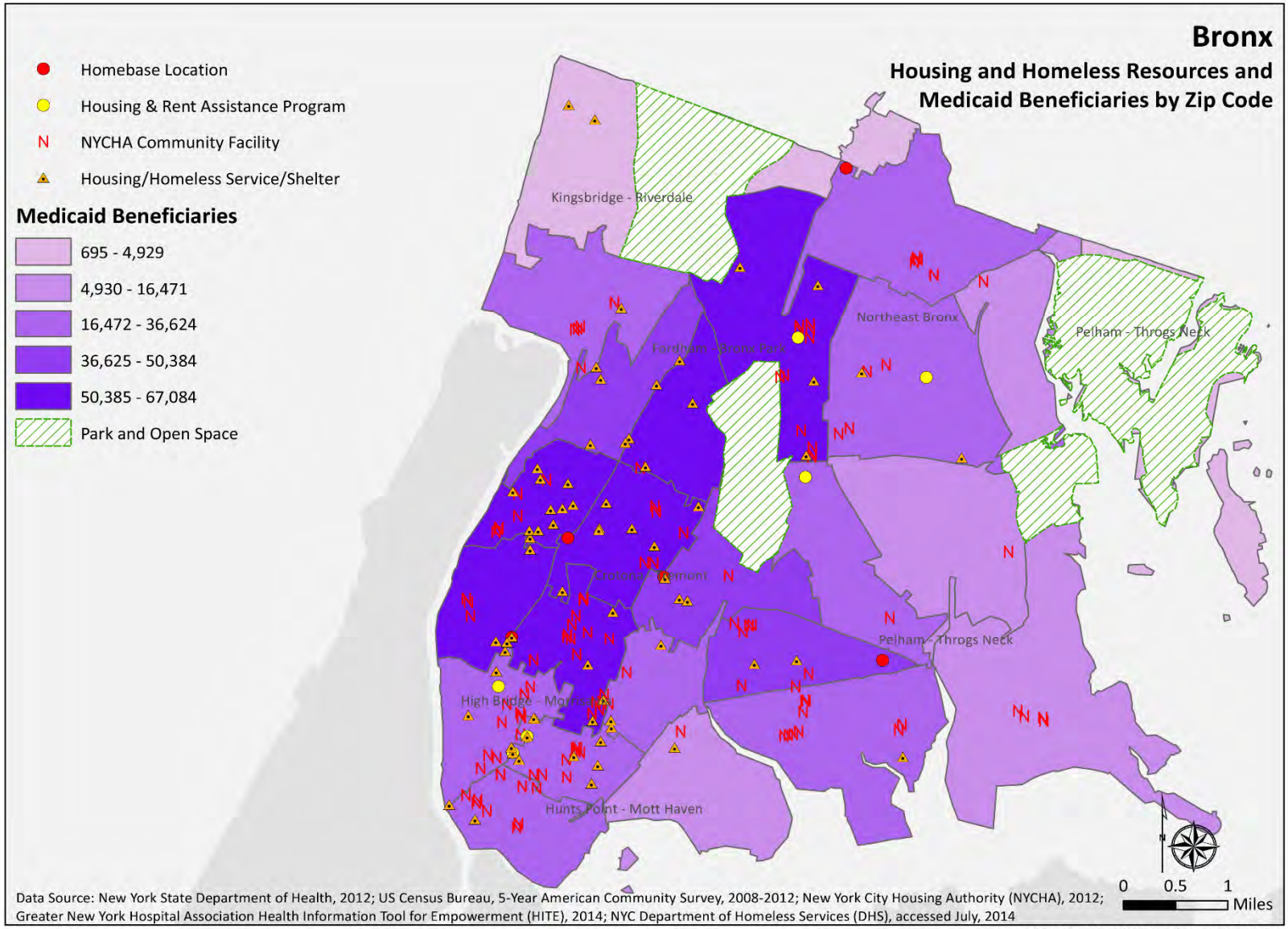

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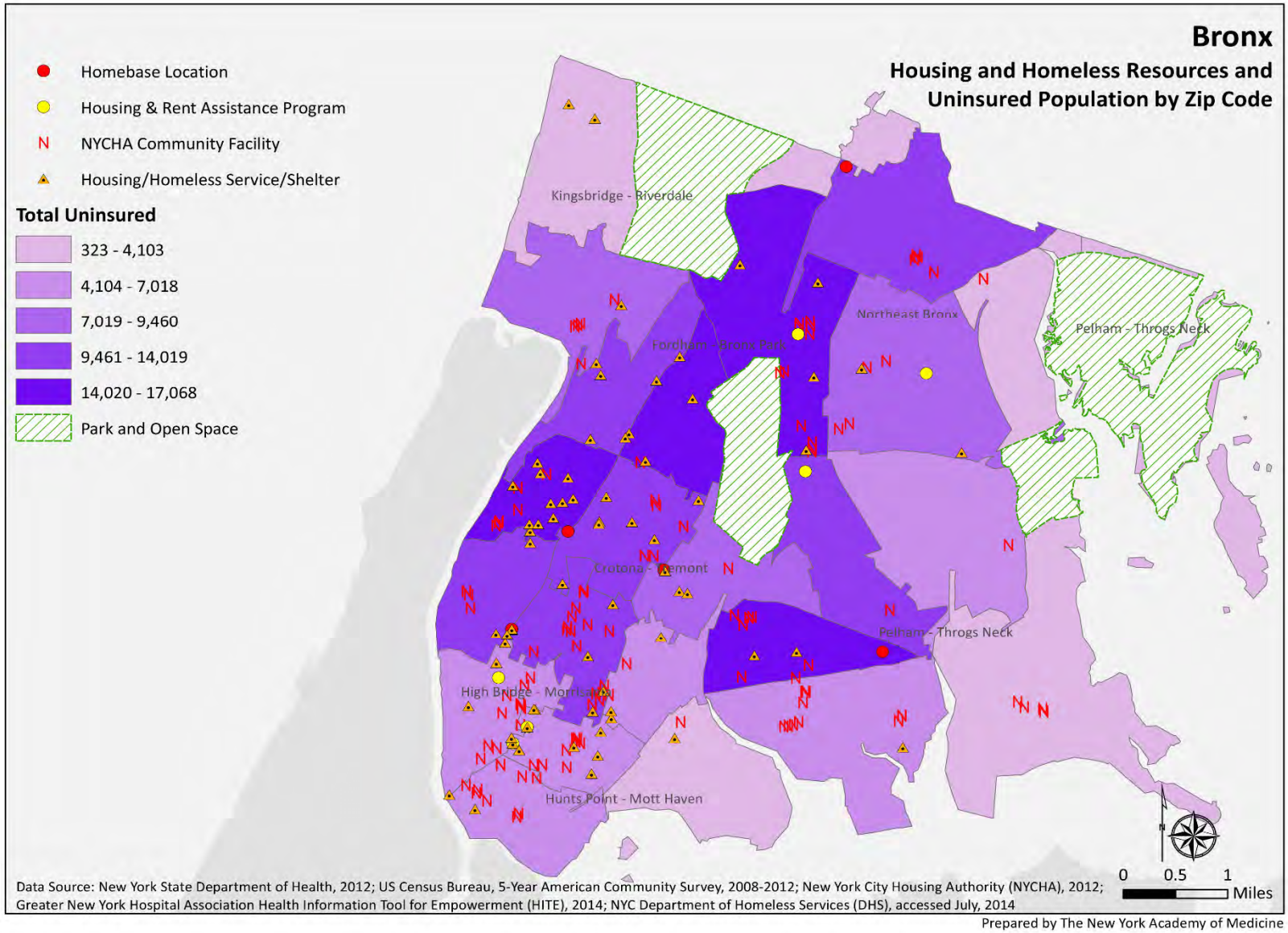
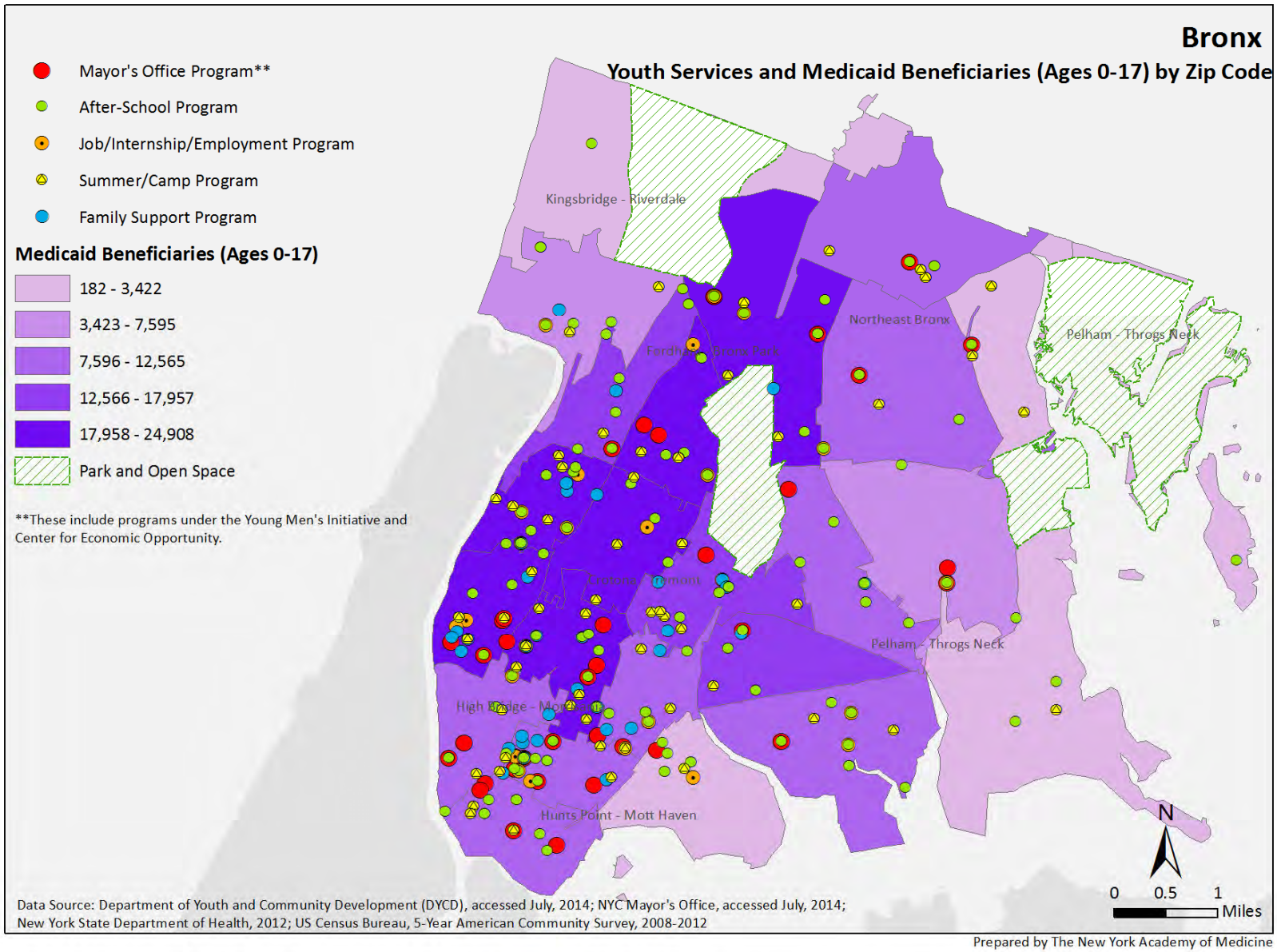


90. Youth Services and Medicaid Beneficiaries (Ages 0-17) by Zip Code



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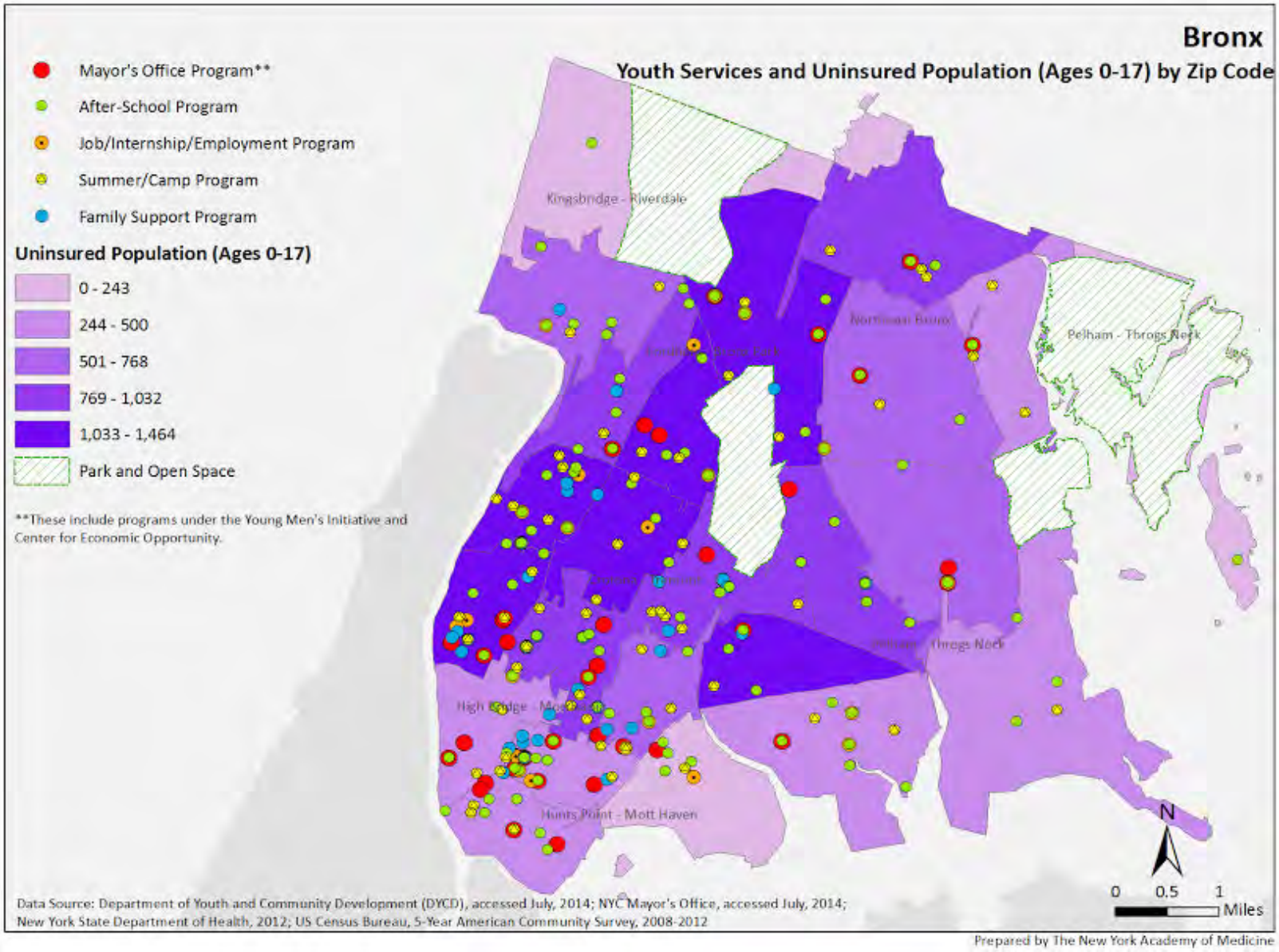
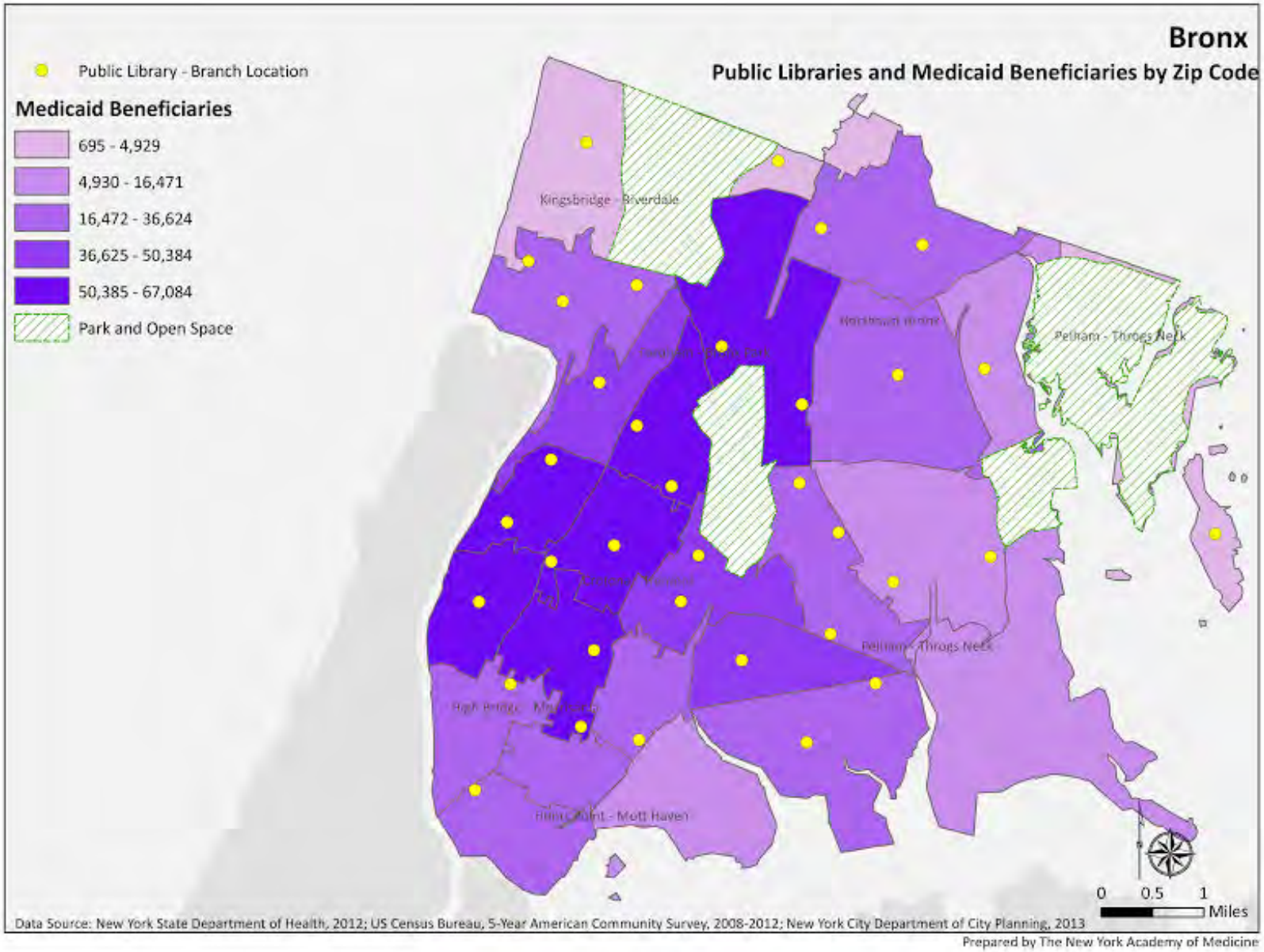
91. Youth Services and Uninsured Population (Ages 0-17) by Zip Code



92. Public Libraries and Medicaid Beneficiaries by Zip Code



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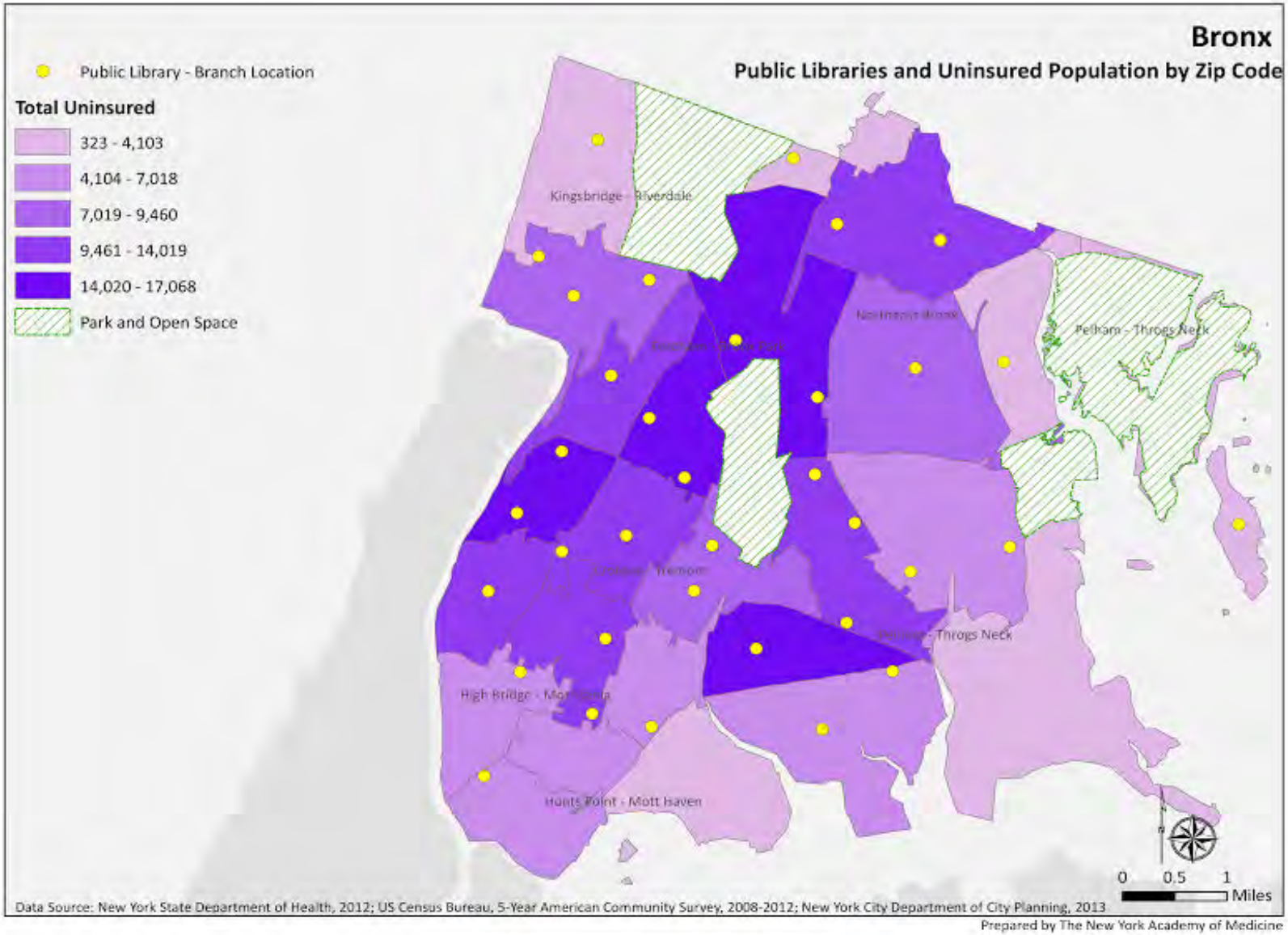

BRONX COMMUNITY NEEDS ASSESSMENT
APPENDIX B - TABLES

December 16, 2014

Original Version Prepared by The New York Academy of Medicine

Final Version Amended by New York City Health and Hospitals Corporation for Submission

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SECTION A: TABLES WITHIN THE BRONX CNA

Table 1 - 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 2 - 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 3 - 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 4 - 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 5 - Total Population by Age Group with No Health Insurance Coverage

	No Health Insurance Coverage																		
Region	**Total**	**< 5**	**5 to 9**	**10 to 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
		9.9				55.1				33.5					1.5				
Bronx (%)	100	2.0	2.0	2.6	5.7	15.6	16.2	12.8	11.0	8.9	8.3	6.2	4.7	2.8	0.5	0.2	0.1	0.1	0.1
		12.3				55.7				30.9					1.1				

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

Table 6 - Total Population by Age Group with Medicaid/Low Income Medical Assistance

	Population with Medicaid/Low Income Medical Assistance																		
Region	**Total**	**< 5**	**5 to 9**	**10 to 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
		40.4				22.1				24.4					13.1				
Bronx (%)	100	12.1	11.1	10.6	10.4	7.2	5.2	4.9	4.6	5.5	5.5	5.0	4.1	3.5	2.9	2.4	2.0	1.6	1.4
		44.2				21.9				23.6					10.3				

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

Table 7 - Total Population by Age Group with Other Insurance

	Other Insurance																		
Region	**Total**	**< 5**	**5 to 9**	**10 to 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
		19.5				31.4				34.6					14.5				
Bronx (%)	100	5.1	5.0	5.6	6.7	6.4	6.7	6.9	6.8	7.7	8.1	7.7	6.9	5.7	4.7	3.6	2.6	1.8	1.9
		22.5				26.9				36					14.6				

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

Table 8 - Nativity by Insurance Status

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%
Bronx	58%	42%	28%	72%	30%	70%

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

Table 9 - 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
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
Bronx	131,665	35,802	32,721	10,767	5,985	4,850	4,309	2,593	2,319	2,297	2,137
Riverdale, Fieldston & Kingsbridge	7,743	989	2,735	180	142	290	131	38	124	98	-
Wakefield, Williamsbridge & Woodlawn	12,287	845	840	6,500	88	458	11	313	-	341	181
Co-op City, Pelham Bay & Schuylerville	3,681	253	686	570	306	261	55	-	-	158	-
Pelham Parkway, Morris Park & Laconia	12,205	3,707	1,006	1,137	364	239	393	63	249	237	182
Belmont, Crotona Park East & East Tremont	13,353	3,850	3,304	446	398	773	620	450	612	177	411
Bedford Park, Fordham North & Norwood	15,787	5,434	4,530	340	964	412	745	54	387	228	-
Morris Heights, Fordham South & Mount Hope	17,700	4,473	7,085	469	723	831	655	648	248	98	368
Concourse, Highbridge & Mount Eden	15,790	3,967	6,099	321	346	1,078	267	515	267	91	652
Castle Hill, Clason Point & Parkchester	16,912	5,465	3,145	646	2,058	367	155	245	175	781	198
Hunts Point, Longwood & Melrose	16,207	6,819	3,291	158	596	141	1,277	267	257	88	145

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

Table 10 - 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	Jamaica	Mexico	Ecuador	Ghana	Bangladesh	Honduras	Guyana	Albania	Nigeria
New York City	1,280,549	223,746	62,456	54,940	54,338	9,474	40,962	13,617	54,137	6,605	7,721
Bronx	222,960	96,328	18,517	12,646	9,611	7,756	6,603	6,167	6,126	2,807	2,547
Riverdale, Fieldston & Kingsbridge	14,336	7,028	311	544	326	398	17	49	243	155	204
Wakefield, Williamsbridge & Woodlawn	20,984	2,354	8,718	626	253	752	187	135	1,460	32	914
Co-op City, Pelham Bay & Schuylerville	8,107	1,090	1,365	181	285	155	86	196	290	169	215
Pelham Parkway, Morris Park & Laconia	18,662	3,441	2,965	1,290	372	399	999	310	561	1,512	71
Belmont, Crotona Park East & East Tremont	25,053	13,125	679	1,299	1,036	694	11	1,255	352	230	326
Bedford Park, Fordham North & Norwood	26,328	13,163	1,107	1,274	1,198	477	1,585	180	639	322	103
Morris Heights, Fordham South & Mount Hope	30,304	19,276	880	1,523	1,217	1,412	104	720	465	152	66
Concourse, Highbridge & Mount Eden	30,233	17,932	694	1,734	917	1,569	520	560	343	-	261
Castle Hill, Clason Point & Parkchester	24,893	7,487	1,367	1,731	1,991	841	3,034	623	1,679	235	271
Hunts Point, Longwood & Melrose	24,060	11,432	431	2,444	2,016	1,059	60	2,139	94	-	116

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

Table 11 - Limited English Proficiency by Insurance Status

Region	% Low English Proficiency		
	No Health Insurance Coverage	Population with	Other Insurance
New York City	40%	29%	14%
Bronx	41%	26%	14%

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%
Bronx	39%	30%	20%	11%

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%
Bronx	47%	26%	20%	7%

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 Populations 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%
Bronx	18%	26%	28%	27%

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

Table 15 - 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 16 - Leading Causes of Death, Bronx, 2012

Rank		Total Reported	Percent of Total
1	Diseases of Heart	2,650	30.6%
2	Malignant Neoplasms	2,028	23.4%
3	Influenza (Flu) and Pneumonia	405	4.7%
4	Diabetes Mellitus	321	3.7%
5	Chronic Lower Respiratory Diseases	281	3.2%
6	Cerebrovascular Disease	242	2.8%
7	Use of or poisoning by psychoactive substance	192	2.2%
8	Human Immunodeficiency Virus Disease	173	2.0%
9	Essential Hypertension and Renal Diseases	165	1.9%
10	Accidents Except Drug Poisoning	156	1.8%
	All Other Causes	2,036	23.5%
	Total	8,649	100%

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

Table 17 - 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 18 - 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 19 - Leading Causes of Death, NYC, 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 20 - 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
Drownings	15	582	14	522	1	60
Falls	110	2,015	92	1,807	18	208
Poisonings	659	14,340	496	11,047	163	3,293
Suicide	433	10,020	306	7,010	127	3,010
Homicide and Legal Intervention	400	14,196	341	12,356	59	1,840
All Other Causes	2,324	39,249	1,357	22,315	967	16,934

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

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

Table 21 - 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 22 - Inpatient Discharges by top 20 primary diagnoses, 2010 and 2013

	NYC		Manhattan		Bronx		Brooklyn		Queens	
	2010	2013	2010	2013	2010	2013	2010	2013	2010	2013
Complications Pregnancy	11%	11%	11%	10%	11%	11%	13%	13%	12%	13%
Newborns	10%	10%	10%	10%	9%	9%	11%	12%	11%	12%
Heart Disease	9%	8%	8%	8%	7%	7%	9%	8%	9%	8%
Digestive Disease	8%	8%	7%	8%	8%	8%	8%	8%	9%	8%
Respiratory Disease	7%	7%	7%	7%	9%	10%	7%	7%	7%	7%
Psychoses	5%	5%	7%	7%	5%	6%	5%	5%	5%	5%
Symptoms And Signs	6%	5%	6%	5%	7%	6%	6%	5%	7%	5%
Infectious/ Parasitic Dis	4%	5%	3%	4%	5%	5%	4%	4%	4%	4%
Musculoskeletal Dis	4%	5%	4%	4%	3%	3%	3%	3%	3%	3%
Malignant Neoplasms	4%	4%	4%	4%	3%	3%	3%	3%	4%	3%
Endo/Nutr/ Metab Dis	4%	4%	4%	4%	5%	5%	4%	4%	3%	4%
Other Injury	4%	4%	4%	4%	3%	3%	3%	3%	3%	3%
Urinary Disease	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%
Other Circulatory Dis	2%	2%	3%	3%	3%	3%	2%	2%	2%	2%
Nervous System Dis	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Other Supplementary	2%	2%	2%	2%	1%	1%	2%	2%	2%	2%
Alcohol/Drug	3%	2%	4%	3%	3%	2%	2%	2%	1%	2%
Fractures	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Skin Disease	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Cerebrovascular Disease	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
All Other Diagnoses	7%	7%	6%	6%	7%	7%	7%	7%	6%	7%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total	**1,160,535**	**1,075,159**	**199,603**	**185,181**	**223,597**	**208,937**	**353,202**	**325,700**	**210,057**	**189,945**

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

Table 23 - Potentially Avoidable Inpatient Discharges (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 24 - 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%
Compl. Pregnancy	4%	4%	4%	3%	4%	5%	6%	6%	4%	4%
Other Supplementary	4%	4%	4%	4%	5%	5%	4%	3%	4%	3%
Open Wounds	4%	4%	4%	4%	3%	3%	4%	4%	4%	4%
Skin Disease	4%	4%	4%	4%	4%	4%	4%	4%	4%	3%
Alcohol/Drug	3%	3%	3%	4%	2%	2%	3%	3%	2%	2%
Urinary Disease	2%	3%	3%	3%	2%	2%	3%	3%	3%	3%
Ear Disease	3%	2%	2%	2%	3%	3%	2%	2%	3%	2%
Fractures	2%	2%	2%	2%	1%	1%	2%	2%	2%	2%
Female Reproductive	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Other Mental Dis.	2%	2%	2%	2%	2%	2%	1%	2%	1%	2%
Psychoses	1%	2%	2%	2%	1%	2%	1%	2%	1%	2%
Eye Disease	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Other Circulatory Dis.	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%
Nervous System Dis.	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
All Other diagnoses	4%	4%	4%	4%	4%	4%	4%	4%	4%	4%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

Table 25 - 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**
Bronx	**47.9**	**1.7**	**18.6**	**1,382,480**
Crotona/Tremont	50.0	2.3	19.8	206,116
Fordham/Bronx Park	47.9	1.7	17.9	252,655
High Bridge/Morrisania	69.8	2.4	21.5	207,631
Hunts Point/Mott Haven	71.7	2.4	20.3	136,591
Kingsbridge /Riverdale	22.0	0.6	8.3*	90,892
Northeast Bronx	38.3	1.0	15.1	190,668
Pelham/Throgs Neck	34.2	1.3	16.2	297,927

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 26 - 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 27 - Selected Patients' Satisfaction Ratings for Adult Services-Statewide Averages By Payer

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

** Data is for 2011*

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

Table 28 - Selected Quality of Care Measures for Adults – Statewide Averages by payer

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

** Data is from 2011*

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

Table 29 - Access and Quality Measures for Children and Adolescents, Statewide Average by Payer

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

**Data is from 2011*

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

Table 30 - Risk Factors by Select Bronx 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%
Kingsbridge and Riverdale	18.4%	16.9%	22.4%	6.4%
The Northeast Bronx	26.6%	18.3%	20.2%	16.3%
Fordham/Bronx Park	37.3%	21.5%	16.9%	8.4%
Pelham/Throgs Neck	32.8%	14.7 %	26.0%	22.3%
The South Bronx	30.1%	20.6%	27.2%	17.3%

Values are not adjusted for age.

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

Table 31 - Environmental Risk Factors in Selected Neighborhoods in the Bronx

	NYC	Bronx	Crotona-Tremont	Fordham - Bronx Pk	Highbridge-Morrisania	Hunts Point-Mott Haven	Kingsbridge-Riverdale	Northeast Bronx	Pelham-Throgs Neck
Indoor Air Quality									
Homes with cockroaches (2011)	24%	37.7%	44.9%	38.8%	48.9%	47.9%	32.8%	23.5%	29.6%
Adults reporting second-hand smoke at home (2011)	4.9%	6.7%	9.4%	6.6%	9.4%	9.4%	1.5%	n/a	7.1%
Adults reporting mold in the home (2012)	9.5%	12.9%	11.8%	18.7%	11.8%	11.8%	9.5%	8.9%	14.4%
Adults reporting mice in the home (2012)	15.5%	23.4%	30.9%	30.2%	30.9%	30.9%	15.2%	15.8%	13.6%
Home Safety and Maintenance									
Homes with cracks or holes (2011)	15.7%	24.7%	29%	26.1%	29.3%	33%	19.5%	18.2%	20%
Homes with leaks (2011)	20.6%	28.1%	30.3%	31.6%	29.3%	30.6%	27.4%	22.3%	26%
Households rating neighborhood structures good or excellent (2011)	75.2%	58.8%	43.3%	58.6%	50.6%	48.7%	74.3%	70.8%	66.2%

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

SECTION B: OTHER TABLES

Table 32 - Top 10 Leading Causes of Death in 2012 by Age Group, NYC

Rank	Causes of Mortality	# Rep.	%	Causes of Mortality	# Rep.	%	Causes of Mortality	# Rep.	%	Causes of Mortality	# Rep.	%
	Less than 1			**1-14 Years**			**15-24 Years**			**25-34 Years**		
1	Congenital Malformations, Deformations, and Chromosomal Abnormalities	125	21%	Malignant Neoplasms	39	18%	Assault	139	25%	Use of or poisoning by psychoactive substance	147	27%
2	Short Gestation/Low Birth Weight	119	20%	Accidents Except Drug Poisoning	31	14%	Accidents Except Drug Poisoning	85	15%	Assault	131	24%
3	Cardiovascular Disorders in the Perinatal Period	75	13%	Congenital Malformations, Deformations, and Chromosomal Abnormalities	26	12%	Intentional Self-Harm	65	12%	Malignant Neoplasms	125	23%
4	External Causes	55	9%	Assault	19	9%	Malignant Neoplasms	51	9%	Accidents Except Drug Poisoning	100	18%
5	Newborn Affected by Complications of Placenta	22	4%	Chronic Lower Respiratory Diseases	13	6%	Use of or poisoning by psychoactive substance	48	9%	Intentional Self-Harm	94	17%
6	Respiratory Distress of New Born	15	3%	Diseases of Heart	12	6%	Diseases of Heart	19	3%	Diseases of Heart	62	11%
7	Bacterial Sepsis of Newborn	10	2%	Intentional Self-Harm	6	3%	Congenital Malformations, Deformations, and Chromosomal Abnormalities	16	3%	Human Immunodeficiency Virus Disease	34	6%
8	Other Respiratory Conditions in Perinatal Period	10	2%	Cerebrovascular Disease	5	2%	Chronic Lower Respiratory Diseases	15	3%	Diabetes Mellitus	17	3%
9	Necrotizing Entercolitis of Newborn	9	2%	Influenza (Flu) and Pneumonia	5	2%	Human Immunodeficiency Virus Disease	11	2%	Pregnancy, Childbirth and the Puerperium	16	3%
10	Neonatal Hemorrhage	9	2%	Insitu or Benign / Uncertain Neoplasms	4	2%	Legal Intervention	7	1%	Congenital Malformations, Deformations, and Chromosomal Abnormalities	13	2%
	All other causes	134	23%	All other causes	57	26%	All other causes	98	18%	All other causes	196	35%
			100%			100%			100%			100%

Rank	Causes of Mortality	# Rep.	%	Causes of Mortality	# Rep.	%	Causes of Mortality	# Rep.	%	Causes of Mortality	# Rep.	%
	35-44 Years			**45-54 Years**			**55-64 Years**			**65-74 Years**		
1	Malignant Neoplasms	342	22%	Malignant Neoplasms	1,234	30%	Malignant Neoplasms	2,604	36%	Malignant Neoplasms	3,340	38%
2	Diseases of Heart	209	13%	Diseases of Heart	807	20%	Diseases of Heart	1,753	24%	Diseases of Heart	2,551	29%
3	Use Of Or Poisoning By Psychoactive Substance	170	11%	Use Of Or Poisoning By Psychoactive Substance	275	7%	Diabetes Mellitus	288	4%	Diabetes Mellitus	382	4%
4	Accidents Except Drug Poisoning	94	6%	Human Immunodeficiency Virus Disease	217	5%	Chronic Liver Disease and Cirrhosis	185	3%	Chronic Lower Respiratory Diseases	332	4%
5	Human Immunodeficiency Virus Disease	90	6%	Diabetes Mellitus	143	4%	Viral Hepatitis	183	3%	Influenza (Flu) and Pneumonia	297	3%
6	Intentional Self-Harm	83	5%	Accidents Except Drug Poisoning	127	3%	Influenza (Flu) and Pneumonia	177	2%	Cerebrovascular Disease	248	3%
7	Assault	59	4%	Intentional Self-Harm	125	3%	Cerebrovascular Disease	173	2%	Essential Hypertension and Renal Diseases	170	2%
8	Diabetes Mellitus	46	3%	Chronic Liver Disease and Cirrhosis	118	3%	Chronic Lower Respiratory Diseases	169	2%	Accidents Except Drug Poisoning	118	1%
9	Chronic Liver Disease and Cirrhosis	45	3%	Cerebrovascular Disease	116	3%	Human Immunodeficiency Virus Disease	169	2%	Chronic Liver Disease and Cirrhosis	113	1%
10	Cerebrovascular Disease	38	2%	Mental and Behavioral Disorders due to Use of Alcohol	87	2%	Use Of Or Poisoning By Psychoactive Substance	148	2%	Nephritis, Nephrotic Syndrome and Nephrisis	86	1%
	All other causes	382	25%	All other causes	811	20%	All other causes	1,361	19%	All other causes	1,238	14%
			100%			100%			100%			100%

Rank	Causes of Mortality	# Rep.	%	Causes of Mortality	# Rep.	%
	75-84 Years			85+ Years		
1	Diseases of Heart	4,108	34%	Diseases of Heart	7,202	44%
2	Malignant Neoplasms	3,424	28%	Malignant Neoplasms	2,240	14%
3	Influenza (Flu) and Pneumonia	604	5%	Influenza (Flu) and Pneumonia	1,052	6%
4	Chronic Lower Respiratory Diseases	511	4%	Cerebrovascular Disease	620	4%
5	Diabetes Mellitus	487	4%	Chronic Lower Respiratory Diseases	522	3%
6	Cerebrovascular Disease	429	4%	Alzheimer's Disease	489	3%
7	Essential Hypertension and Renal Diseases	238	2%	Diabetes Mellitus	448	3%
8	Accidents Except Drug Poisoning	153	1%	Essential Hypertension and Renal Diseases	394	2%
9	Alzheimer's Disease	153	1%	Accidents Except Drug Poisoning	171	1%
10	Nephritis, Nephrotic Syndrome and Nephrisis	120	1%	Nephritis, Nephrotic Syndrome and Nephrisis	154	1%
	All other causes	1,850	15%	All other causes	3,003	18%
			100%			100%

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

Table 35. Federally Qualified Health Centers (FQHCs) in the Bronx

Facility Name	Address	Zip Code
Access Community Health Center	1500 Pelham Pkwy S	10461
Bella Vista Community Health Center	882-886 Hunts Point Ave	10474
Bronxcare - Fulton Family Practice Center	1276 Fulton Avenue	10456
Bronxcare - Mid Bronx Desperados Family Practice Center	1690 Bryant Avenue	10460
Bronxcare - Ogden Family Medical & Dental Center	1067 Ogden Avenue	10451
Bronxcare - Poe Medical And Dental Center	2432 Grand Concourse	10458
Bronxcare - Tiffany Medical & Pediatric Practice	853 Tiffany Street	10459
Bronxcare At Third Avenue	2739-45 Third Avenue	10451
Bronxcare Dental	1770 Grand Concourse	10453
Burnside Medical Center	165 E Burnside Ave	10453
Community Healthcare Network - Bronx Health Center	975 Westchester Avenue	10459
Community Healthcare Network (CHN) - Tremont Health Center	4215 Third Avenue	10457
Comprehensive Community Development Co	731 White Plains Rd	10473-2631
Delaney Sisters Health Center	2727-33 White Plains Rd	10467
Diallo Medical Center	1760 Westchester Ave	10472
Help/Psi Bronx Health Center	1543 Inwood Ave	10452
HELP/PSI Harm Reduction Health Center At Citiwide	226 E 144th St	10451
Highbridge Clinic	1381 Dr Martin L King Jr Blvd	10452
Institute For Family Health - Mt. Hope Family Practice	130 West Tremont Avenue	10453
Institute For Family Health - Stevenson Family Health Center	731 White Plains Road	10473
Institute For Family Health - Urban Horizons Family Health Center	50 East 168th Street	10452
Institute For Family Health - Walton Family Health Center And Center For Counseling	1894 Walton Avenue	10453
Inwood Clinic	1543 Inwood Ave	10452
Jessica Guzman Medical Center	616 Castle Hill Ave	10473
Martin Luther King Jr Health Center	3674 3rd Ave	10456
Morris Heights Health Center - Burnside	85 West Burnside Avenue	10453
Peninsula Community Health Center	1967 Turnbull Ave Ste 2	10473
River Avenue Health Center	880 River Ave Ste 4	10452
St Lawrence Community Health Center	1764-1766 Lawrence Ave	10472
Starhill Clinic	1600 Macombs Rd	10452-2016
Susan's Place (Care For The Homeless)	1921 Jerome Avenue	10453
Union Community Health Center - Grand Concourse	2021 Grand Concourse	10453
Union Community Health Center - Main Facility	260 East 188th Street	10458
Union Community Health Center, Inc	1 Fordham Plz	10458-5871
Urban Health Plan - Adolescent Health And Wellness Center/Club TIA	960 Southern Boulevard	10459
Urban Health Plan - Bella Vista Health Center	890 Hunts Point Boulevard	10474
Urban Health Plan - El Nuevo San Juan Health Center	1065 Southern Boulevard	10459
Urban Health Plan - Plaza Del Castillo Health Center	1515 Southern Boulevard	10460
Urban Health Plan - St. Lawrence Community Health Center	1764 Westchester Avenue	10472

Source: HRSA, 2014; NYC Dept. of City Planning, 2013; GNYHA HITE Data, 2014; NYS DOH, 2014.

Please note that, in some cases, only the main address for the FQHC was available via these sources, though an FQHC may have multiple sites.

Table 36 - Urgent Care Centers in the Bronx

Urgent Care Center Name	Address	Zip Code
Montefiore Medical Center - Wakefield Ambulatory Care Center	4234 Bronx Boulevard	10466
Montefiore Medical Group - Bronx East	2300 Westchester Avenue	10462
Montefiore Medical Group - Grand Concourse Site	2532 Grand Concourse	10458
Morris Heights Health Center - Burnside	85 West Burnside Avenue	10453
Urban Health Plan - Adolescent Health and Wellness Center/Club TIA	960 Southern Boulevard	10459
MedCare Plus	1643 Westchester Ave	10472
ProHEALTH Urgent Care	1049 Morris Park Ave	10461
Riverdale Urgent Care	5665 Riverdale Ave	10471
Throggs Neck Walk-In Medical Care	3231 East Tremont Ave	10461
Urgent Care of Eastchester Road	2304 Eastchester Rd	10469

Source: American Academy of Urgent Care Medicine (AAUCM) & City MD websites; GNYHA HITE Data, 2014.

Table 37 Managed Care Organizations that service Bronx (and other counties)

Plan	Total New York City Enrollment, 2012	Plan Type
HealthFirst PHSP, Inc.	455,627	PHSP
MetroPlus Health Plan, Inc.	373,072	PHSP
New York State Catholic Health Plan, Inc.	338,708	(Fidelis Care) PHSP
AMERIGROUP New York,LLC	335,116	PHSP
UnitedHealthcare of New York, Inc.	198,234	HMO
Affinity Health Plan, Inc.	169,489	PHSP
Neighborhood Health Providers, Inc.	165,848	PHSP
Health Insurance Plan of Greater New York	164,798	HIP (Emblem Health) HMO
WellCare of New York, Inc.	55,195	PHSP
Total	**2,256,087**	

Source: United Hospital Fund, "Medicaid Managed Care Enrollment by Region," 2012

Table 38 Nursing Homes in the Bronx

Nursing Home Name	Address	Zip Code
Bainbridge Nursing & Rehabilitation Center	3518 Bainbridge Avenue	10467
Bay Park Center for Nursing and Rehabilitation, LLC	801 Co-Op City Blvd	10475
Beth Abraham Health Services	612 Allerton Avenue	10467
Bronx Center for Rehabilitation & Health Care	1010 Underhill Ave	10472
Bronx Lebanon Special Care Center	1265 Fulton Avenue	10456
Bronx Park Rehabilitation & Nursing Center	3845 Carpenter Ave	10467
Casa Promesa	308 East 175 Street	10457
Concourse Rehabilitation and Nursing Center, Inc	1072 Grand Concourse	10456
Daughters of Jacob Nursing Home Company Inc	1160 Teller Ave	10456
East Haven Nursing & Rehabilitation Center	2323-27 Eastchester Road	10469
Eastchester Rehabilitation and Health Care Center	2700 Eastchester Road	10469
Fieldston Lodge Care Center	666 Kappock Street	10463
Gold Crest Care Center	2316 Bruner Avenue	10469
Grand Manor Nursing & Rehabilitation Center	700 White Plains Road	10473
Hebrew Home for the Aged at Riverdale	5901 Palisade Avenue	10471
Help/psi, Inc.	1401 University Avenue	10452
Highbridge-Woodycrest Center Inc	936 Woodycrest Avenue	10452
Hudson Pointe at Riverdale Center for Nursing &	3220 Henry Hudson	10463
Jeanne Jugan Residence	2999 Schurz Avenue	10465
Jewish Home Lifecare, Harry & Jeanette Weinberg	100 West Kingsbridge Road	10468
Kings Harbor Multicare Center	2000 E Gunhill Road	10469
Kingsbridge Heights Rehabilitation and Care Center	3400 Cannon Place	10463
Laconia Nursing Home	1050 East 230th Street	10466
Manhattanville Health Care Center	311 W 231st Street	10463
Methodist Home for Nursing and Rehabilitation	4499 Manhattan College	10471
Morningside House Nursing Home Company Inc	1000 Pelham Parkway	10461
Morris Park Nursing Home	1235 Pelham Parkway	10469
Mosholu Parkway Nursing & Rehabilitation Center	3356 Perry Avenue	10467
Palisade Nursing Home Company Inc	5901 Palisade Avenue	10471
Park Gardens Rehabilitation & Nursing Center LLC	6585 Broadway	10471
Pelham Parkway Nursing Care and Rehabilitation	2401 Laconia Ave	10469
Providence Rest, Inc.	3304 Waterbury Avenue	10465
Rebekah Rehab and Extended Care Center	1072 Havemeyer Avenue	10462
Regeis Care Center	3200 Baychester Ave	10475
Riverdale Nursing Home	641 West 230th St	10463
Schervier Nursing Care Center	2975 Independence Ave	10463
Split Rock Rehabilitation and Health Care Center	3525 Baychester Ave	10466
St Barnabas Rehabilitation & Continuing Care Center	2175 Quarry Rd	10457
St Patricks Home	66 Van Cortlandt Park	10463
St Vincent Depaul Residence	900 Intervale Avenue	10459
Terrace Health Care Center	2678 Kingsbridge Terrace	10463

Nursing Home Name	Address	Zip Code
Throgs Neck Extended Care Facility	707 Throgs Neck	10465
University Nursing Home	2505 Grand Ave	10468
Wayne Center for Nursing & Rehabilitation	3530 Wayne Avenue	10467
Williamsbridge Manor Nursing Home	1540 Tomlinson Avenue	10461
Workmen's Circle Multicare Center	3155 Grace Avenue	10469

Source: NYS DOH Nursing Home Profiles, 2014

Table 39 Behavioral Health Residential Treatment Capacity and Utilization in the Bronx

	Residential Treatment				Assertive Community Treatment (ACT)
	Congregate Treatment	Apartment Treatment	Support Programs	Supported Housing	
# of Beds or Slots	470	280	630	2,904	531
Beds or Slots /10,000 Adult Population	4.5	2.7	6.1	3.4	NA
% Occupancy Rate	84.8%	91.8%	95.5%	88.2%	98%
Median LOS (days)	296	448	749	1,340	NA
% LOS >2 years	23.5%	30.0%	53.2%	69.0%	NA

Source: OMH, 2011. Note that the data are for all payer categories, not only Medicaid.

Table 40 - NYS DOH Designated Safety Net Pharmacies Serving the Bronx

Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
030818	Family Pharmacy Solutions, Inc.	20,346	20,346	100.00%	By Appeal
29738	STAR PHARMA INC DBA STARHILL PHARMACY	60,240	60,240	100.00%	By Appeal
17330	EJEROME PHARMACY INC	56,000	60,400	92.72%	By Definition
020988	Mt. Carmel Pharmacy, Inc.	204,969	226,226	90.60%	By Appeal
24530	Stand Pharmacy, Inc.	42,173	55,000	76.68%	By Appeal
29963	LAURUS CORP	19,600	26,900	72.86%	By Definition
18453	NVR PHARMACY INC	23,229	33,185	70.00%	By Definition
30215	VSAS PROPERTIES LLC	6,997	10,025	69.80%	By Definition
29615	DDMH PHARMACY INC	35,000	52,000	67.31%	By Definition
18997	UPGRADE PHARMACY INC	25,191	37,813	66.62%	By Definition
30565	NEO PHARMACY INC	17,000	27,000	62.96%	By Definition
24771	75 BURNSIDE DRUG AND SURGICAL INC	52,529	83,504	62.91%	By Definition
24632	PROSPECT AVE PHARMACY	32,915	52,327	62.90%	By Definition
25605	WASHINGTON PHARMACY	35,847	63,775	56.21%	By Definition
24709	PARKCHESTER NATURAL HEALTH CENTER INC	6,500	11,600	56.03%	By Definition
29986	MY PHARMACY INC	2,932	5,274	55.59%	By Definition
28758	PHARMART DRUGS INC	29,500	53,075	55.58%	By Definition
25837	SEM AND SAM	34,355	61,864	55.53%	By Definition
15469	Pilgrim	73,633	132,942	55.39%	By Appeal

Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
	Pharmacy, Inc.				
28752	ROCKAWAY FAMILY PHARMACY CORP	46,913	84,743	55.36%	By Definition
29530	872 HPA DRUG CORP	19,460	35,220	55.25%	By Definition
28262	POLSAK CORPORATION	17,971	32,692	54.97%	By Definition
028058	Hispaniola Pharmaceutical Group, Inc.	43,021	80,919	53.17%	By Appeal
26372	JAFFRI ENTERPRISES	15,581	29,535	52.75%	By Definition
27296	904 PROSPECT PHARMACY INC	38,864	73,753	52.69%	By Definition
17811	WHITE PLAINS RD PHARMACY INC	23,682	44,978	52.65%	By Definition
24634	WORLD PHARMACY INC	1,647	3,146	52.35%	By Definition
17697	YNFK DRUG INC	8,434	16,128	52.29%	By Definition
26401	GCC PHARMACY CORP	31,185	60,120	51.87%	By Definition
26434	UNITED PHARMACY LLC	29,000	56,000	51.79%	By Definition
30123	TOTALCARE PHARMACY MANAGEMENT INC	10,139	19,644	51.61%	By Definition
16055	RB WILLIAMSON INC	60,667	118,000	51.41%	By Definition
30439	SCRIPTRX INC	29,722	57,886	51.35%	By Definition
28981	LEROYS PHARMACY CORP	19,125	37,288	51.29%	By Definition
26868	MERCEDES DRUG CORP	13,963	27,600	50.59%	By Definition
28814	SPECIALTY CARE PHARMACY INC	12,882	25,552	50.41%	By Definition
31173	RHESAK CORP	27,612	55,084	50.13%	By Definition
16178	Sedgwick Pharmacy, Inc.	44,010	87,962	50.03%	By Appeal
24699	NY DRUGS INC	104,364	208,727	50.00%	By Definition

Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
26892	DRUG RITE II PHARMACY CORP	38,500	77,010	49.99%	By Definition
29326	BRONX CHEMISTS CORP	46,426	100,123	46.37%	By Definition
25499	BCP PHARMACY INC	39,518	85,344	46.30%	By Definition
24414	VENKATESWARA PHARMACY INC	31,300	68,330	45.81%	By Definition
17412	MELBOURNE CHEMISTS INC	42,645	93,289	45.71%	By Definition
23055	EAST TREMONT PHARMACY INC	31,823	70,064	45.42%	By Definition
26305	FRIENDLY PHARMACY INC	15,644	34,516	45.32%	By Definition
011440	Bronx Prescription Center South, Inc.	46,127	102,093	45.18%	By Appeal
25587	MANVIHAR PHARMACY INC	19,008	42,133	45.11%	By Definition
26988	MEGA PHARMACY LLC	20,400	45,511	44.82%	By Definition
28595	FAMILY DRUG STORE CORP	11,531	25,812	44.67%	By Definition
29917	BLONDELL RX CORP	7,046	15,957	44.16%	By Definition
24775	NAYOSHA PHARMACY	25,128	57,036	44.06%	By Definition
28951	MAR DRUG CORP	20,078	46,126	43.53%	By Definition
26825	BRUCKNER PLAZA PHARMACY INC	19,200	44,173	43.47%	By Definition
27162	PSK RX INC	16,805	38,782	43.33%	By Definition
18886	FIRO INC	18,904	43,678	43.28%	By Definition
26098	CAREMARK SRX INC	32,415	74,898	43.28%	By Definition
18005	K AND G PHARMACY INC	17,517	40,550	43.20%	By Definition
23572	TEJ PHARMACY INC	15,555	36,056	43.14%	By Definition
27195	DRUGS R US PHARMACY	18,512	42,982	43.07%	By Definition

Pharmacy License Number	Pharmacy Name	Number of NY Medicaid Prescriptions (Sum)	Total Number of Prescriptions (Sum)	Percent Medicaid Prescriptions (Overall >= 35%)	Methodology
25190	ARKAYEM LLC	15,226	35,369	43.05%	By Definition
26707	FELICITY PHARMACY	32,000	76,000	42.11%	By Definition
29894	TRUPTISUDHIR PHARMACY CORP	14,979	36,131	41.46%	By Definition
24368	CONCOURSE DRUGS INC	20,221	48,942	41.32%	By Definition
30382	RXMASTERS INC	3,751	9,162	40.94%	By Definition
26691	BARRETTO PHARMACY INC	6,026	14,922	40.38%	By Definition
18771	WILLEN PHARMACY INC	3,482	8,631	40.34%	By Definition
29543	AMBAR PHARMACY INC	10,433	26,887	38.80%	By Definition
26513	LOUIS PHARMACY INC	18,446	48,953	37.68%	By Definition
29593	PARKARE PHARMACY INC	5,212	14,045	37.11%	By Definition
30621	ARYA PHARMACY CORP	7,914	21,843	36.23%	By Definition
168	AMATO PHARMACY INC	16,371	45,256	36.17%	By Definition
24192	WEBSTER DRUGS INC	37,000	104,000	35.58%	By Definition

Source: NYS DOH, 2014

Table 41 - Domain 2.a Metrics

Measure Name	Data Year	NYS	NYC	Bronx
Potentially Avoidable Emergency Room Visits: ED Visits for Ambulatory Sensitive Conditions, Potentially Preventable Visits (PPV), per 100 Recipients**	2012	36	34	38
Potentially Avoidable Readmissions, by hospital location, 2012**	2012	40,687	24,388	6,825
PQI Suite – Composite of All Measures: Adult, per 100,000 Recipients	2012	1,848	1,885	2,459
Acute Conditions Composite (PQI 91)***	2012	555	547	706
Chronic Conditions Composite (PQI 92)***	2012	1,294	1,336	1,749
PDI Suite – Composite of All Measures: Pediatric, per 100,000 Recipients	2012	323	381	507
Acute Conditions Composite (PDI 91)	2012	75	87	84
Chronic Conditions Composite (PDI 92)	2012	248	294	422
Getting Care Quickly				
Q4. Usually or always got care right away as soon as you needed[a]	2013	81.1%	76%	
Q7. Usually or always got an appt. for check-up or routine care as soon as you needed[a]	2013	74.8%	68.9%	
Getting Needed Care				
Q19. Usually or always got care, tests or treatment you thought you needed[a]	2013	81.4%	76.9%	
Q39. Usually or always got an appointment to see a specialist as soon as you needed[a]	2013	75.1%	71.4%	
Usual Source of Care				
Q8. Never went to doctor's office or clinic in last 6 months[a]	2013	23.9%	24.4%	

[No known public source]

Measure Name	Data Year	NYS	NYC	Bronx
Q8. Went to doctor's office or clinic 1-3 times in last 6 months[a]	2013	52.5%	53.7%	
Q26. Have a personal doctor[a]	2013	85.5%	84.1%	
Patient Loyalty				
Q35. Got care from a doctor or other health provider other than personal doctor[a]	2013	57.9%	52.7%	
Access/Availability of Care				
Adult Access to Preventive/Ambulatory Care (20-44)[b]	2012	95%	[No known public source]	[No known public source]
Adult Access to Preventive/Ambulatory Care (45-64) [b]	2012	96%	[No known public source]	
Adult Access to Preventive/Ambulatory Care (65+) [b]	2012	97%	[No known public source]	
Annual Dental Visit (Ages 19-21) [b]	2012	44%	[See source note]	
Annual Dental Visit (Ages 2-18) [b]	2012	57%	[See source note]	
Children's Access to PCPs/Ambulatory Care (12-24 months)[b]	2012	97%	[No known public source]	
Children's Access to PCPs/Ambulatory Care (25 mos-6 years) [b]	2012	93%	[No known public source]	
Children's Access to PCPs/Ambulatory Care (7-11 years) [b]	2012	96%	[No known public	

Measure Name	Data Year	NYS	NYC	Bronx
			source]	
Children's Access to PCPs/Ambulatory Care (12-19 years) [b]	2012	93%	[No known public source]	
Use of Services				
Well-Child Visits & Preventive Care Visits in the First 15 Months of Life (5+ visits) [b]	2012	83%	[See source note]	[No known public source]
Well-Child & Preventive Care Visits in the 3rd, 4th, 5th & 6th Year [b]	2012	82%		
Adolescent Well-Care Visits [b]	2012	59%		

Sources:

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

[a] NYS DOH, 2014 "Medicaid Managed Care Program CAHPS 5.0 Adult Medicaid Survey, Continuous Quality Improvement Report," available at: http://www.health.ny.gov/health_care/managed_care/medicaid_satisfaction_report_2013/

As per NYS DOH Attachment J, CAHPS measures were requested for the following areas: getting care quickly, getting needed care, access to information after hours, wait time, usual source of care and patient loyalty. Questions 4, 7, 8, 19, 26, 35 and 39 of the CAHPS 5.0 survey seem to most closely align to these requests.

[b] NYS DOH, "2013 Statewide Executive Summary of Managed Care in New York State," available at: http://www.health.ny.gov/health_care/managed_care/qarrfull/qarr_2013/docs/executive_summary.pdf

***NYAM analysis of Potentially Preventable Readmissions data by hospital, New York State Department of Health . Data is available for this measure by health plan at the following link: http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2013/statewide/medicaid/*

**** See Appendix B. Table 52 for all PQI and composites. For example, the Adult Acute Conditions Composite (PQI 91) is comprised of Adult Dehydration (PQI 10), Adult Bacterial Pneumonia (PQI 11), and Adult Urinary Tract Infection (PQI 12).*

Data is not yet available from the New York State Department of Health for the other Domain 2 metrics relating to Provider Reimbursement, System Integration, Primary Care, and Medicaid Spending for Projects Defined Population on a PMPM Basis.

Table 42 - Domain 2.b Metrics

Measure Name	NYS	NYC	Bronx
Summary of HCAHPS Survey Results, October 2012 to September 2013 Discharges			
Patients who reported that their nurses "Always" communicated well	75%	[No known public source]	[No known public source]
Patients who reported that their doctors "Always" communicated well	77%		
Patients who reported that they "Always" received help as soon as they wanted	61%		

Measure Name	NYS	NYC	Bronx
Patients who reported that their pain was "Always" well controlled	67%		
Patients who reported that staff "Always" explained about medicines before giving it to them	59%		
Patients who reported that their room and bathroom were "Always" clean	69%		
Patients who reported that the area around their room was "Always" quiet at night	51%		
Patients who reported that YES, they were given information about what to do during their recovery at home	83%		
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	63%		
Patients who reported YES, they would definitely recommend the hospital	65%		

Source: Hospital Consumer Assessment of healthcare Providers and Systems. Centers for Medicare & Medicaid Services. (July, 2014). Summary of HCAHPS Survey Results. Baltimore, MD. *http://www.hcahpsonline.org*

Table 43. Total Population, by Gender

Total Population, by Gender	NYS	NYC	Bronx
Total Population	**19,398,125**	**8,199,221**	**1,386,364**
Male	9,391,875	3,897,434	650,728
Female	10,006,250	4,301,787	735,636

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

Table 44 - Total Population, by Age

Age	NYS	NYC	Bronx
Child (0-17)	4,316,920	1,774,909	369,168
All Adults (18+)	15,081,205	6,424,312	1,017,196
Older Adults (65+)	2,640,634	1,002,872	147,030

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

Table 45 - Total Population, by Race/Ethnicity

Race/Ethnicity	NYS (A)	NYC (B)	Bronx (C)	% of Bronx Total Population (D)	Bronx as a % of that race or ethnicity in NYC (C/B)	Bronx as a % of that race or ethnicity in NYS (C/A)
White	12,808,268	3,646,181	312,055	22.5%	8.6%	2.4%
Black or African American	3,037,255	2,059,279	481,739	34.7%	23.4%	15.9%
American Indian and Alaska Native	69,500	30,743	7,196	0.5%	23.4%	10.4%
Asian	1,445,539	1,053,649	49,489	3.6%	4.7%	3.4%
Native Hawaiian and other Pacific Islander	6,477	3,866	308	0.0%	8.0%	4.8%
Other race	1,557,020	1,169,421	488,156	35.2%	41.7%	31.4%
2 or more races	474,066	236,082	47,421	3.4%	20.1%	10.0%
Total of Race Categories Above	**19,398,125**	**8,199,221**	**1,386,364**	**100.0%**	**16.9%**	**7.1%**
Hispanic or Latino (of any race)	**3,425,845**	**2,343,458**	**741,954**	**53.5%**	**31.7%**	**21.7%**
Mexican	447,323	308,952	70,786	**5.1%**	22.9%	15.8%
Puerto Rican	1,117,995	761,655	311,547	**22.5%**	40.9%	27.9%
Cuban	72,378	40,426	7,913	**0.6%**	19.6%	10.9%
Other Hispanic or Latino	1,788,149	1,232,425	351,708	**25.4%**	28.5%	19.7%

NYC Black/African American as % of Total NYC Population: 25.1%
NYC Hispanic/Latino Population as % of Total NYC Population: 28.6%
NYS Black/African American as % of Total NYS Population: 15.7%
NYS Hispanic/Latino Population as % of Total NYS Population: 17.7%
Source: US Census American Community Survey, 5-year table, 2008-2012.

Table 46 - Income

Income	NYS	NYC	Bronx
% HH Below Poverty	14%	19%	29%
Median HH income (USD)	57,683	51,865	34,300

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

Table 47 - Educational Attainment

Educational Attainment	NYS	NYC	Bronx
% age 25+ High School+	85%	79%	69%
% age 25+ Bachelor's degree+	33%	34%	18%

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

Table 48 - Unemployment

Unemployed	NYS	NYC	Bronx
% Unemployed	8.7%	10.2%	14.2%

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

Table 49 - Immigration and Citizenship Status

Immigration and Citizenship Status	NYS	NYC	Bronx
Migrated from abroad < 1 yr ago	148,931	93,367	14,421
Not a US citizen	2,038,877	1,455,533	258,099
% Not a US citizen	10.5%	17.8%	18.6%

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

Table 50 - Language

Language	NYS	NYC	Bronx
Total - Speak English less than "very well"	2,439,417	1,783,994	324,281
% Total - Speak English less than "very well"	12.6%	21.8%	23.4%
Spanish -Speak English less than "very well"	1,230,302	889,091	267,764

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

Table 51 - Languages Spoken at Home

Language	Total Speakers	% of Total Pop.
Speak only English	553,446	43.2%
Spanish or Spanish Creole	594,250	46.4%
African languages	37,854	3.0%
French (incl. Patois, Cajun)	12,439	1.0%
Other Indic languages (i.e., other than Hindi, Urdu, Gujarati)	12,373	1.0%
Other Indo-European languages	11,250	0.9%
Italian	10,104	0.8%
Chinese	6,970	0.5%
French Creole	4,600	0.4%
Tagalog	4,329	0.3%
Arabic	4,206	0.3%
Russian	3,312	0.3%
Vietnamese	2,961	0.2%
Urdu	2,446	0.2%
Korean	2,412	0.2%
Greek	2,143	0.2%

Language	Total Speakers	% of Total Pop.
Other Asian languages	1,995	0.2%
Serbo-Croatian	1,463	0.1%
German	1,420	0.1%
Other Slavic languages	1,226	0.1%
Hindi	1,172	0.1%
Polish	1,090	0.1%
Mon-Khmer, Cambodian	1,005	0.1%
Japanese	734	0.1%

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

Table 52 - Household Type

Household Type	NYS	NYC	Bronx
Total Households	7,130,896	3,063,393	473,281
Family Households	4,646,324	1,843,819	310,803
Family Households - Married couple	3,224,971	1,103,512	126,677
Family Households - Male Householder no wife	351,847	170,979	35,203
Family Households - Female Householder no husband	1,069,506	569,328	148,923
Non-family Households	2,584,572	1,219,574	162,478
Non-family Households - Living alone	2,119,199	996,487	141,774
% of Total Households - Living Alone	30%	33%	30%
Non-family Households - Not living alone	465,373	223,087	20,704

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

Table 53 - Incarceration

Incarceration	NYS	NYC	Bronx
NYC DOC Jail admissions (2012)	NA	84,754	16,362
NYC DOC Jail admissions rate per 100,000 Population (2012)	NA	1,034	1,180
NYS Prison admissions (2008)[a]	21,141	9,640	2,848

[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 54 - Medicaid Beneficiaries

	NYS	NYC	Bronx
Total Population	**19,398,125**	**8,199,221**	**1,386,364**
Total Medicaid Beneficiaries	5,835,794	3,588,107	821,339
Medicaid Beneficiaries / Total Population	30.1%	43.8%	59.2%
Bronx Medicaid pop. / NYC Medicaid pop.			22.9%
Bronx Medicaid pop. / NYS Medicaid pop.			14.1%

Source: NYS DOH, 2012

Table 55 - Uninsured Population by Age

Uninsured	NYS	NYC	Bronx
Total Uninsured	2,161,817	1,160,829	217,009
Uninsured / Total Population	11.1%	14.2%	15.7%
Bronx Uninsured / NYC Uninsured			18.6%
Bronx Uninsured / NYS Uninsured			10.0%
Older Adult 65+ Uninsured	26,086	17,769	2,874
% Older Adult 65+ Uninsured	1.0%	1.8%	2.0%
Child 0-17 Uninsured	197,779	80,534	17,757
% Child 0-17 Uninsured	4.5%	4.5%	4.8%
Adult 18+ Uninsured	1,964,038	1,080,295	199,252
% Adult 18+ Uninsured	13.0%	16.8%	19.6%

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

Table 56 - Uninsured and Foreign Born

Country/Region of Origin	Number Uninsured in the Bronx	Percent of the Total Foreign Born Uninsured Population in the Bronx
Latin America	86,572	65.8%
Caribbean	16,070	12.2%
Africa	13,699	10.4%
Balkans and eastern Europe	3,349	2.5%
South Asia	2,766	2.1%
Sub-Total of Above Groups	**122,456**	**93.0%**
Other Countries	9,209	7.0%
Total Foreign Born Uninsured in the Bronx	**131,665**	**100.0%**

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

Table 57 - Dual Eligible Beneficiaries

	NYS	NYC	Bronx
Total Older Adult 65+ Population	2,640,634	1,002,872	147,030
Dual Eligible Beneficiaries	853,866	467,749	93,324
Dual Eligible/ Older Adult 65+ pop.	32.3%	46.6%	63.5%
Bronx Duals/ NYC Duals			20.0%
Bronx Duals/ NYS Duals			10.9%

Source: NYS DOH, 2012

Table 58 - Insurance Status

Insurance Status	NYS	NYC	Bronx
Child 0-17 Beneficiaries	1,979,039	1,180,983	298,329
Total Child 0-17 Population	4,316,920	1,774,909	369,168
Child 0-17 Beneficiaries/Pop	45.8%	66.5%	80.8%
Adult 18+ Beneficiaries	3,856,755	2,407,124	523,010
Total Adult 18+ Population	15,081,205	6,424,312	1,017,196
Adult 18+ Beneficiaries/Pop	25.6%	37.5%	51.4%

Source: NYS DOH, 2012

Table 59 - Disability and Difficulty Status

Disability /Difficulty	NYS	NYC	Bronx
% Disabled HH member	22.5%	21.2%	29.1%
Impairments, by Age:			
Hearing			
age 0-17 with Hearing Difficulty	22,395	8,324	2,172
% age 0-17 with Hearing Difficulty	0.5%	0.5%	0.6%
age 18-64 with Hearing Difficulty	182,116	60,231	14,705
% age 18-64 with Hearing Difficulty	1.5%	1.1%	1.7%
age 65+ with Hearing Difficulty	310,580	105,560	15,164
% age 65+ with Hearing Difficulty	11.8%	10.5%	10.3%
Vision			
age 0-17 with Vision Difficulty	23,724	10,606	3,208
% age 0-17 with Vision Difficulty	0.5%	0.6%	0.9%
age 18-64 with Vision Difficulty	166,396	79,038	19,538
% age 18-64 with Vision Difficulty	1.3%	1.5%	2.2%

Disability /Difficulty	NYS	NYC	Bronx
age 65+ with Vision Difficulty	168,818	82,840	14,900
% age 65+ with Vision Difficulty	6.4%	8.3%	10.1%
Cognitive			
age 0-17 with Cognitive Difficulty	112,555	36,208	13,236
% age 0-17 with Cognitive Difficulty	2.6%	2.0%	3.6%
age 18-64 with Cognitive Difficulty	413,409	165,152	47,532
% age 18-64 with Cognitive Difficulty	3.3%	3.0%	5.5%
age 65+ with Cognitive Difficulty	844,970	337,659	48,999
% age 65+ with Cognitive Difficulty	32.0%	33.7%	33.3%
Ambulatory			
age 0-17 with Ambulatory Difficulty	20,920	9,268	2,788
% age 0-17 with Ambulatory Difficulty	0.5%	0.5%	0.8%
age 18-64 with Ambulatory Difficulty	547,468	233,975	60,771
% age 18-64 with Ambulatory Difficulty	4.4%	4.3%	7.0%
age 65+ with Ambulatory Difficulty	1,052,010	426,311	64,949
% age 65+ with Ambulatory Difficulty	39.8%	42.5%	44.2%

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

Table 60 - Self-Reported Health Status by Neighborhood

Neighborhood	% Self-Report Fair or Poor Health Status	Absolute #
New York City	**21.3**	**1,318,000**
Bronx	**24.0**	**231,000**
Kingsbridge/Riverdale	12.0	9,000
Northeast Bronx	14.7	23,000
Fordham/Bronx Park	21.8	35,000
Pelham/Throgs Neck	25.6	53,000
The South Bronx	29.2	97,000

Source: NYC DOHMH Community Health Survey, 2012

Table 62 - Medicaid Beneficiary Behavioral Health Utilization of Care, Bronx Providers

Medicaid Beneficiary Utilization through Bronx County Providers			
Service type	**Individuals**	**Medicaid Paid ($)**	**Expenditure Rate ($/Individual)**
Inpatient	3,602	$82,985,990	$23,039
Outpatient Mental Health Clinic	20,225	$34,739,429	$1,718
Residential	547	$11,466,603	$20,963
Assertive Community Treatment (ACT)	643	$6,157,004	$9,575
Targeted Case Management	856	$3,294,941	$3,849
Continuing Day Treatment	772	$3,584,256	$4,643
Prepaid Mental Health Plan Recovery Services	461	$5,908,821	$12,817
Comprehensive Psychiatric Emergency Program	1,468	$846,041	$576
Partial Hospitalization	132	$350,699	$2,657
Intensive Psychiatric Rehab	0	$0	$0

Source: NYS OMH, 2012

Table 63 - Bronx Hospital Behavioral Health Readmissions within 30 Days

	Hospital Name	Discharges	Readmitted Within 30 Days	
			# Readmissions	Percent
Adults (age 18 +)				
General Hospital	Bronx-Lebanon Hospital Center	1806	350	19.4%
General Hospital	Montefiore Medical Center	803	102	12.7%
General Hospital	NYC-HHC Jacobi Medical Center	1148	198	17.2%
General Hospital	NYC-HHC Lincoln Medical & Mental Health Ctr.	490	95	19.4%
General Hospital	NYC-HHC North Central Bronx Hospital	707	119	16.8%
General Hospital	St. Barnabas Hospital	951	246	25.9%
State Psychiatric	Bronx Psychiatric Center	336	38	11.3%
ADULT TOTAL		**6241**	**1148**	**18.4%**
Children (age 0 -17)				
General Hospital	Bronx-Lebanon Hospital Center	391	52	13.30%
General Hospital	NYC-HHC Lincoln Medical & Mental Health Ctr.	16	0	0%
State Psychiatric	Bronx Children's Psychiatric Center	61	2	3.30%
CHILDREN TOTAL		**468**	**54**	**11.5%**
ADULT AND CHILDREN TOTAL		**6709**	**1202**	**17.9%**

Source: NYS OMH, 2012.

Table 64 - Chronic Medical Condition Co-Morbidity of Behavioral Health Clients, by Age Group

		Age		
Chronic Medical Condition	**Total Clients**	**Below 18**	**18-64**	**65+**
Total Clients Served	16,942	3,268	12,364	1,308
No Chronic Medical Condition	6,668	2,451	4,054	163
At Least One Chronic Medical Condition	9,215	658	7,467	1,089
Unknown if Chronic Medical Condition is Present	1,059	159	843	56
% of Clients Served with at least One Chronic Medical Condition	54.4%	20.1%	60.4%	83.3%

Source: NYS OMH, Patient Characteristic Survey (PCS), 2013.

Table 65 - Binge Drinking by Neighborhood

Neighborhood	% Binge Drink	Absolute #
New York City	**19.6**	**1,224,000**
Bronx	**18.5**	**189,000**
Kingsbridge/Riverdale	18.8	11,000
Northeast Bronx	18.5	26,000
Fordham/Bronx Park	19.4	38,000
Pelham/Throgs Neck	17.2	30,000
The South Bronx	18.8	74,000

Source: NYC DOHMH Community Health Survey, 2012

Table 66 - Chronic Hepatitis C

Location	Reported Cases	Crude Rate (per 100,000)	Age-Adjusted Rate (per 100,000)*
NYC	7,582	90.9	85.5
Bronx	1,787	126.9	not available

**adjusted to the Year 2000 Standard Population Source: New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - [Communicable Disease Surveillance Data]. [9/10/14].* http://nyc.gov/health/epiquery

Table 67 - Gonorrhea Rate by Neighborhood

Neighborhood	Gonorrhea Rate per 100,000	Absolute #
New York City	**130.3**	**10,898**
Bronx	**218.5**	**3,029**
Kingsbridge	71.8	62
Northeast Bronx	230.2	434
Fordham	173.1	449
Pelham	155.2	462
Crotona	311.3	661
Morrisania	244.1	503
Mott Haven	275	375
Bronx- neighborhood unknown	*n/a*	*83*

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 68 - Chlamydia Rate, by Neighborhood

Neighborhood	Chlamydia Rate per 100,000	Absolute #
New York City	**697.7**	**58,353**
Bronx	**1,238.80**	**17,176**
Kingsbridge	453	391
Northeast Bronx	1,179.80	2,224
Fordham	1060	2,750
Pelham	1,009.10	3,003
Crotona	1,653.80	3,511
Morrisania	1,406.50	2,898
Mott Haven	1,423.60	1,941
Bronx- neighborhood unknown	*n/a*	*458*

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 69 - All PQI Indicators, 2012

				PQI Observed / Expected ratio		
PQI Indicator	**# of Medicaid PQI Hospitalizations, Bronx**	**# of Medicaid PQI Hospitalizations, NYC**	**# of Medicaid PQI Hospitalizations, NYS**	**Bronx**	**NYC**	**NYS**
Adult Overall Conditions Composite (PQI 90)	13,447	44,943	69,084	1.31	1.02	1.00
Adult Chronic Conditions Composite (PQI 92)	10,063	32,619	48,568	1.34	1.03	1.00
Adult All Diabetes Composite (PQI S01)	2,775	9,289	14,121	1.24	1.01	1.00
Adult Diabetes Short-term Complications (PQI 01)	792	2,533	4,506	1.13	0.91	1.00
Adult Diabetes Long Term Complications (PQI 03)	1,585	5,357	7,572	1.31	1.07	1.00
Adult Uncontrolled Diabetes (PQI 14)	327	1,178	1,679	1.16	1.04	1.00
Lower Extremity Amputation among Adults with Diabetes (PQI 16)	136	432	699	1.38	0.97	1.00
Adult All Circulatory Conditions Composite (PQI S02)	3,173	11,116	15,795	1.34	1.06	1.00
Adult Hypertension (PQI 07)	969	2,991	3,938	1.51	1.10	1.00
Adult Heart Failure (PQI 08)	2,013	7,426	10,902	1.28	1.04	1.00
Adult Angina Without Procedure (PQI 13)	191	699	955	1.26	1.09	1.00

				PQI Observed / Expected ratio		
PQI Indicator	**# of Medicaid PQI Hospitalizations, Bronx**	**# of Medicaid PQI Hospitalizations, NYC**	**# of Medicaid PQI Hospitalizations, NYS**	**Bronx**	**NYC**	**NYS**
All Adult Respiratory Conditions Composite (PQI S03)	4,116	12,216	18,653	1.42	1.02	1.00
COPD and Asthma in Older Adults (PQI 05)	3,383	10,486	16,244	1.38	1.01	1.00
Asthma in Younger Adults (PQI 15)	733	1,730	2,410	1.61	1.11	1.00
Adult Acute Conditions Composite (PQI 91)	3,384	12,328	20,521	1.24	0.99	1.00
Adult Dehydration (PQI 10)	691	2,403	3,958	1.26	0.98	1.00
Adult Bacterial Pneumonia (PQI 11)	1,424	5,353	9,347	1.20	0.96	1.00
Adult Urinary Tract Infection (PQI 12)	1,269	4,572	7,216	1.27	1.04	1.00
Pediatric Overall Conditions Composite (PDI 90): ages 6-17 years	1,151	2,909	3,774	1.58	1.19	1.00
Pediatric Chronic Conditions Composite (PDI 92): ages 6-17 years	958	2,255	2,903	1.69	1.19	1.00
Pediatric Asthma (PDI 14): ages 2-17 years	1,865	4,282	5,384	1.80	1.73	1.00
Pediatric Diabetes Short-term	74			1.16	1.04	1.00

				PQI Observed / Expected ratio		
PQI Indicator	**# of Medicaid PQI Hospitalizations, Bronx**	**# of Medicaid PQI Hospitalizations, NYC**	**# of Medicaid PQI Hospitalizations, NYS**	**Bronx**	**NYC**	**NYS**
Complications (PDI 15): ages 6-17 years		234	380			
Pediatric Acute Conditions Composite (PDI 91): 6 - 17 years	193	654	871	1.17	1.16	1.00
Pediatric Gastroenteritis (PDI 16): ages 3 months - 17 years	558	1,758	2,333	1.31	1.18	1.00
Pediatric UTI (PDI 18): ages 3 months - 17 years	134	602	929	0.80	1.04	1.00

Source: 2012, New York State Department of Health

Table 70 - Potentially Preventable Readmission data for Bronx Hospitals

Facility Name	At Risk Admissions	Observed PPR Chains	Observed / Expected PPR	Observed PPR Rate	Expected PPR Rate	Expected PPR Chains
BRONX LEB HSP CTR CNCRSE DIV*	15,869	1,443	1.14	9.09	7.95	1,262
CALVARY HOSPITAL	61	7	2.54	11.48	4.52	3
JACOBI MEDICAL CENTER	10,172	694	1.03	6.82	6.65	676
LINCOLN MEDICAL/MENTAL HLTH	13,130	855	1.07	6.51	6.1	801
MONTEFIORE MEDICAL CENTER	32,086	2,381	1.11	7.42	6.67	2,140
NORTH CENTRAL BRONX HOSPITAL	4,551	311	1.10	6.83	6.19	282
ST BARNABAS HOSPITAL	10,287	1,134	1.26	11.02	8.76	901
BRONX HOSPITALS TOTAL	**86,156**	**6,825**	**1.13**			**6,065**

Source: New York State Department of Health, 2012

*PPR is not available from DOH for Bronx Lebanon Fulton Division, which offers behavioral health related services.

Table 71 - Domain 3 Metrics, Behavioral Health

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
PPV (for persons with BH diagnosis)	[No known public source]	[No known public source]	[No known public source]
Antidepressant Medication Management (Effective Acute Phase Treatment)*	50%	47%	46%
Diabetes Monitoring for People with Diabetes and Schizophrenia (aged 18-64 years)*	68%	70%	71%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (aged 18-64 years) Using Antipsychotic Medication*	79%	80%	83%
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%	64%
Follow-up after hospitalization for Mental Illness within 30 Days*	55%	51%	56%
Screening for Clinical Depression and follow-up			
Adherence to Antipsychotic Medications (at least 80% of	64%	63%	59%

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
treatment time) for People with Schizophrenia (aged 19-64 yrs)*			
Initiation of Alcohol and Other Drug Dependence Treatment*	78%	78%	82%
PPR for SNF patients	[No known public source]	[No known public source]	[No known public source]
Percent of Long Stay Residents who have Depressive Symptoms**	12.23%	[No known public source]	[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*
*** Nursing Home Quality Initiative 2012 (this source does not provide data at the city or county level).*

Table 72 - Domain 3 Metrics, Cardiovascular Disease

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
PQI # 7 Hypertension, # of Discharges, 2012	3,938	2,991	969
PQI #13 Angina Without Procedure, # of Discharges, 2012	955	699	191
Cholesterol Management for Patients with CV Conditions[a]	[No known public source]	35.9% (33.3-38.7)	38.3% (30.6-46.7)
Controlling High Blood Pressure (Provider responsible for medical record reporting)[a,b]	63%*	67.0% (63.3-70.5)	[No known public source]
Aspirin Discussion and Use [b] Discussion of Aspirin Risks and Benefits(HMO/PPO) Aspirin Use(HMO/PPO)	 49%/43% 39%/39%	[No known public source]	[No known public source]
Medical Assistance with Smoking Cessation[a]	[No known public source]	5.8% (4.3-7.8)	5.1% (2.4-10.8)
Flu Shots for Adults Ages 50 – 64[a]	[No known public source]	51.6% (49.4 - 53.7)	56.5% (50.7 - 62.1)
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse	[No known public source]	[No known public source]	[No known public source]

Sources: 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 73 - Domain 3.b. Metrics, Cardiovascular Disease

Adult Hospitalizations, 2012	NYS	NYC	Bronx
Angina Without Procedure (PQI 13)	955	699	191
Hypertension (PQI 07)	3,938	2,991	969
All Circulatory Conditions (PQI 07, PQI 08)	15,795	11,116	3,173
Adult Heart Failure (PQI 08)	10,902	7,426	2,013

Source: NYS DOH, 2012 data

Table 74 - Domain 3 Metrics: Diabetes Mellitus

Potentially Avoidable Hospitalizations, 2012	NYS	NYC	Bronx
Diabetes Long Term Complications (PQI 03)	7,572	5,357	1,585
All Diabetes Composite (PQI 01, PQI 03, PQI 16)	14,121	9,289	2,775
Adult Diabetes Short-term Complications (PQI 01)	4,506	2,533	792
Adult Uncontrolled Diabetes (PQI 14)	1,679	1,178	327
Lower Extremity Amputation among Adults with Diabetes (PQI 16)	699	432	136
Pediatric Diabetes Short-term Complications (PDI 15)	380	234	74

Source: NYS DOH, 2012 data

Table 75 - Select Clinical Improvement Measures, Diabetes

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
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%	80%
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)[a]	33%	[See source note]	[See source note]
Comprehensive diabetes care - LDL-c control (<100mg/dL): Lipids Controlled (<100 mg/dL) Monitoring Diabetes - Lipid Profile[a]	 47% 87%	[See source note]	[See source note]
Medical Assistance with Smoking Cessation[b]	[See source note]	5.8% (4.3-7.8)	5.1% (2.4-10.8)
Flu Shots for Adults Ages 50 – 64b	[See source note]	43% (40.0-45.9)	51.5% (43.8-59.1)
Health Literacy Items (includes understanding of instructions to manage chronic condition, ability to carry out the instructions and instruction about when to return to the doctor if condition gets worse)	[No known public source]	[No known public source]	[No known public source]

Sources:

** 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 75 - Domain 3 Metrics, Asthma

Potentially Avoidable Hospitalizations, 2012	NYS	NYC	Bronx
All Adult Respiratory Conditions Composite (PQI 05, PQI 15)	18,653	12,216	4,116
Asthma in Younger Adults (PQI 15)	2,410	1,730	733
COPD and Asthma in Older Adults (PQI 05)	16,244	10,486	3,383
Pediatric Asthma (PDI 14)	5,384	4,282	1,865

Source: NYS DOH, 2012 data

Table 76 - Select Clinical Improvement Measures, Asthma

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
Asthma Medication Ratio	[See Source Note]	[See Source Note]	[See Source Note]
Medical Management for People with Asthma:			
50% Covered (Ages 5-11)	48%	[See Source Note]	[See Source Note]
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 77. Select Clinical Measures, Perinatal Care

Select Clinical Improvement Measures, 2012			
Measure	**NYS**	**NYC**	**Bronx**
Prenatal and Postpartum Care—Timeliness and Postpartum Visits:[a, b]			
% mothers received postpartum checkup	90.1%	89.2%	
% mothers received prenatal care - start 1st to 3rd month	71.8%	70.4%	60.3%
% mothers received prenatal care - start 4th to 6th month	27.9%	30.5%	44.8%
% mothers received prenatal care - start 7th to 9th month	23.9%	28.7%	37.0%
% late or no prenatal (Note: zip code level avl.)	5.4%	6.9%	10.2%
Frequency of Ongoing Prenatal Care:[c]			
Frequency of Ongoing Prenatal Care 61-80%	12%	[See source note]	[See source note]
Frequency of Ongoing Prenatal Care 41-60%	6%		
Frequency of Ongoing Prenatal Care 21-40%	4%		
Frequency of Ongoing Prenatal Care <21%	8%		
Percentage of Children Who Had Five (5) or More Well Care Visits in the first 15 months*	85%	83%	83%
Childhood Immunization Status:[c]			
Childhood immunization (0lmmz)	1%		
Childhood immunization-3 or more IPVs	93%		
Childhood immunization-2 or 3 rotavirus	69%		

Select Clinical Improvement Measures, 2012			
Measure	**NYS**	**NYC**	**Bronx**
Childhood immunization-4 or more pneumococcals	81%	[See source note]	[See source note]
Childhood immunization-2 or more HepA	37%		
Childhood Immunization-2 or more influenza	57%		
Childhood Immunization-Varicella	91%		
Childhood Immunization-MMR	93%		
Childhood Immunization-4 or more DTPs	83%		
Childhood Immunization-3 or more HepB	92%		
Childhood Immunization-3 or more Hibs	93%		
Childhood Immunization Status (Combo 3: 4-3-1-3-3-1-4)	74%		
Lead Screening in Children[c]	89%	[See source note]	[See source note]

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 78 - Select Clinical Improvement Measures, Palliative Care

Select Clinical Improvement Measures	NYS	NYC	Bronx
Risk-Adjusted percentage of members who remained stable or demonstrated improvement in pain	[No known public source]	[No known public source]	[No known public source]
Risk-Adjusted percentage of members who had severe or more intense daily pain	[No known public source]	[No known public source]	[No known public source]
Risk-adjusted percentage of members whose pain was not controlled.	[No known public source]	[No known public source]	[No known public source]
Advanced Directives – Talked about Appointing for Health Decisions	[No known public source]	[No known public source]	[No known public source]
Depressive feelings - percentage of members who experienced some depression feeling	[No known public source]	[No known public source]	[No known public source]

Source: Not applicable

Table 79 - Select Clinical Improvement Measures, Renal Care

Select Clinical Improvement Measures, 2012	NYS	NYC	Bronx
Comprehensive Diabetes screening (HbA1c, lipid profile, dilated eye exam, nephropathy)[a]	51%	[See Source Note]	[See Source Note]
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)[a]	47% 87%	[See Source Note]	[See Source Note]
Annual Monitoring for Patients on Persistent Medications – ACE/ARB[b]	92%	[See Source Note]	[See Source Note]

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 80 - Domain 4 Metrics: Premature Death, Preventable Hospitalizations, Insurance and Health Care Provider Status

Measure	Data year(s)	NYS	NYC	Bronx
Percentage of premature death (before age 65 years)[a]	2012	23.9	27.6	33.9
Ratio of Black non-Hispanics to White non-Hispanics [a]	2010-2012	2.04	2.1	2.52
Ratio of Hispanics to White non-Hispanics [a]	2010-2012	2.03	2.04	2.43
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years [b]	2012	135.6	158.5	238.5
Ratio of Black non-Hispanics to White non-Hispanics [b]	2010-2012	2.06	2.27	1.76
Ratio of Hispanics to White non-Hispanics [b]	2010-2012	1.51	1.58	1.4
Percentage of adults with health insurance - Aged 18-64 years [c]	2012	89.1	86.2	85.1
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years [d]	2012	81.5	81.7	78.7

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] *SPARCS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.*

[c] *US Census Bureau, American Community Survey, 2012*

[d] *State data retrieved from the 2012 Behavioral Risk Factor Surveillance System as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard; city and county data retrieved from the 2012 NYC Community Health Survey*

Table 81 - Domain 4 Metrics: Promote Mental Health and Prevent Substance Abuse

Measure	Data Year(s)	NYS	NYC	Bronx
Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month [a]	2008-2009	10.2	9.2	9.1
Age-adjusted percentage of adult binge drinking during the past month [b]	2012	17.7	19.6	18.5
Age-adjusted suicide death rate per 100,000 [c]	2010-2012	7.8	5.7	5.4

Sources:

[a] *2008-2009 BRFSS and Expanded BRFSS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.*
[b] *State data retrieved from the 2012 Behavioral Risk Factor Surveillance System as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard; city and county data retrieved from the 2012 NYC Community Health Survey.*
[c] *Vital Statistics data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.*

Table 82 - Domain 4 Metrics: Prevent Chronic Diseases

Measure	Data Year(s)	NYS	NYC	Bronx
Percentage of adults who are obese [a]	2008-2009, 2012	23.6	24.2	32
Percentage of children and adolescents (K-8th grades) who are obese [b]	2010-2011	17.6 (excludes NYC)	21.7	23.5
Percentage of cigarette smoking among adults [a]	2012	16.2	15.6	15.8
Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years [c]	2008-2009, 2012	61.5	68.5	70.7
Asthma emergency department visit rate per 10,000 [d]	2012	88.6	139.6	260.2
Asthma emergency department visit rate per 10,000 - Aged 0-4 years [d]	2012	225.1	348.4	642.5
Age-adjusted heart attack hospitalization rate per 10,000 [d]	2012	15.1	13.5	14.6
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years [d]	2010-2012	3	3.4	5
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years [d]	2010-2012	6.1	7	12

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] *State data excludes NYC and was obtained from the 2010-12 Student Weight Status Category Reporting System as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard (includes children in grades K-12). City and county-level data obtained from "FitnessGram" (2010-2011) as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard (includes children in grades K-8).*
[c] *State data obtained from the 2012 BRFSS and reports the "Percentage of adults who received colorectal cancer screening according to most recent guidelines." Those complying with recent guidelines included individuals who used a blood stool test at home in the past year; and/or, sigmoidoscopy in the past 5 years and blood stool test in the past 3 years; and/or, had a colonoscopy in the past 10 years. However, the 2012 NYC Community Health Survey only reports the percentage of respondents who received a "colon cancer screening in last 10 years."*
[d] *SPARCS data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard.*

Table 83 - Domain 4 Metrics: Prevent HIV/STDs

Measure	Data Year(s)	NYS	NYC	Bronx
Newly diagnosed HIV case rate per 100,000 [a]	2010-2012	18.3	33.5	43.1
Difference in rates (Black and White) of new HIV diagnoses [a]	2010-2012	46.7	49.1	54.2
Difference in rates (Hispanic and White) of new HIV diagnoses [a]	2010-2012	24.2	21.6	23.8
Gonorrhea case rate per 100,000 women - Aged 15-44 years [b]	2012	235.8	283.1	513.6
Gonorrhea case rate per 100,000 men - Aged 15-44 years [b]	2012	284.1	444.9	584.7
Chlamydia case rate per 100,000 women - Aged 15-44 years [b]	2012	1,625.1	2,047.6	3,508.2
Primary and secondary syphilis case rate per 100,000 males [b]	2012	12.4	24.3	25.8
Primary and secondary syphilis case rate per 100,000 females [b]	2012	0.5	0.7	0.9

Sources:
[a] *Bureau of HIV/AIDS Epidemiology data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard*
[b] *NYS STD Surveillance System data as reported on the NYS Prevention Agenda 2013-2017 State and County Dashboard*

Table 84 - Domain 4 Metrics: Promote Healthy Women, Infants, and Children

	Measure	Data Year(s)	NYS	NYC	Bronx
41	Percentage of preterm births	2012	10.8	10.8	12.2
42	*Ratio of Black non-Hispanics to White non-Hispanics*	2010-2012	1.62	1.8	1.41
43	*Ratio of Hispanics to White non-Hispanics*	2010-2012	1.25	1.39	1.21

Source: Vital Statistics data as reported on the NYS Prevention Agenda 201

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

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

December 16, 2014

Prepared by The New York Academy of Medicine

BRONX COMMUNITY NEEDS ASSESSMENT
OCTOBER 2014

EXECUTIVE 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 (NYS). 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 Bronx 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 PPSs, 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 622 surveys of community residents, 22 focus groups and 23 interviews with Bronx residents, providers, and other stakeholders. The protocol was developed in collaboration with selected PPSs in the Bronx, Brooklyn, Queens, and Manhattan and was implemented in partnership with the PPSs as well as a number of Community Based Organizations (CBOs).

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

Bronx community members and other stakeholders are clearly interested in partnering with hospitals and health care providers 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 themes in the Bronx are persistent poverty, environmental hazards, and systemic neglect. Focus group and interview participants articulated specific barriers to good health and good health care, many of which were related to poverty and its consequences, including long work hours, unstable housing, unsafe neighborhoods 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 appropriate use of health care services, 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.

BRONX COMMUNITY NEEDS ASSESSMENT
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 (NYS). 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 Bronx PPS's CNAs, 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 findings and has been developed as an attachment to the full CNA. The primary data component was intended to provide more in-depth information to the PPSs, which may be useful for DSRIP project planning, as well as planning and implementation of programs and services outside of DSRIP.

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 Bronx residents, providers, and other stakeholders (see appendix for data collection instruments). The protocol was developed in collaboration with selected PPSs in the Bronx, Brooklyn, Queens, 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, as well as their causes and impact; 2) data on populations (e.g., particular immigrant groups) and issues (e.g., links between food access and health) that might be obscured in population-based data sets; 3) significant detail on issues identified; and 4) recommended approaches to address reported 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 (see appendix for listing), which were identified with assistance from the PPS's, and represented a range of populations (e.g., older adults, immigrants) 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*:* 622 surveys were completed by Bronx 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 where we wanted to ensure sufficient representation, including Hunts Point, Mott Haven, High Bridge, Tremont, Fordham Road, and Soundview. Surveys were self-administered or administered by NYAM staff or staff or volunteers from community organizations (as described above), 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-three key informant interviews were conducted, including 29 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: Twenty-two focus groups were conducted for the Bronx Community Needs Assessment, involving over 240 participants. Most of the focus groups were with community members, recruited by collaborating CBOs. Populations targeted included, but were not limited to, older adults; Latino, African, and southeast Asian immigrant populations, individuals with behavioral health issues, and individuals living in public housing. Community member interest in the focus groups was high, with some groups including up to 30 individuals. In addition to the resident groups, we conducted a small number of focus groups with community leaders, including hospital advisory board members. These groups were coordinated by collaborating PPS's. Most focus group participants were female (62.8%), Black/African American or Latino (46.1% and 39.2%, respectively), and on Medicaid (57.6%); 10.8% were uninsured. The mean age of respondents was 49.6, with a standard deviation of 15.7.

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 Bronx 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.

Survey respondents (N=622 individuals) came from all Bronx neighborhoods. Sociodemographic characteristics included: 58.9% female, 54.6% Black/African American, 35.1% Latino, 10.6% Asian, 39.2% foreign born, 11.3% limited English proficiency, 78.6% living below the poverty line,

Table 1: Demographic characteristics of survey participants

Characteristic	(N=622)
Age (Mean, SD)	45.9 (17.9)
18-20	4.0%
21-44	44.4%
45-64	31.5%
65-74	10.5%
75-84	5.0%
85 and older	1.6%
Unknown	3.1%
Gender	
Female	58.9%
Male	40.7%
Transgender	0.5%
Sexual Orientation	
Heterosexual	92.6%
LGBTQI	7.5%
High school graduate or higher	77.7%
Hispanic	35.1%
Race	
White	9.3%
Black or African American	54.6%
Asian	10.6%
American Indian or Alaskan Native	1.2%
Native Hawaiian or other Pacific Islander	0.5%
Other/mixed/unknown	23.9%
Limited English proficiency	11.3%
Foreign born	39.2%
Below poverty level	78.6%
Health insurance	
Medicaid	52.7%
Medicare	21.6%
Private/commercial	17.1%
VA/Other/More than one	17.3%
None	10.8%

52.7% on Medicaid, 21.6% on Medicare, and 10.8% uninsured. The mean age of respondents was 45.9, with a standard deviation of 17.9. (see appendix for survey results by neighborhood)

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 hospital 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)

Despite the disincentive, 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

Communities of Color: The Bronx has the highest proportion of non-white residents in the city, with very significant numbers of Black/African American residents (including US-born and immigrant populations coming from Caribbean nations and increasingly from Africa), as well as Latinos. Among the borough's Latino population, Puerto Ricans predominate, though an increasing number of immigrants are from the Dominican Republic and Central America. There is also a growing South and Southeast Asian population, though small in comparison to other immigrant groups. Common immigrant-related themes from interviews with key informants and focus group discussions included some combination of:

- Gaps in language access across the spectrum of services;
- Difficulties meeting basic needs, leading to extended work hours and emotional stresses;
- Prioritization of work over health;
- Lack of sufficient information on health and health services;
- Minimal knowledge, interest, and engagement in prevention services;
- 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.

The concerns of other immigrant populations are magnified among the undocumented. Access to most services is limited, and the fear of deportation results in lower utilization of services that are available, including health services. Providers report that people who are undocumented want to avoid providing information about themselves, and avoid "the system" to the greatest extent possible.

CNA participants were consistent in their reports of very long work hours among multiple foreign born groups. Descriptions of 12 - 16 hours days, six or seven days a week were not uncommon, with people working multiple jobs (often under hazardous conditions) because pay is low. Such long work hours impact health and access to health care services:

The guy working 2 jobs, one in the morning, the other at night, he doesn't have time to take are of his health, and then it's too late. You don't have time for yourself. (focus group participant)

Concerns about language access obviously suggest concrete requirements with respect to knowledge and skills. Although many CNA participants described significant capacity among some Bronx providers for Spanish, there were complaints about use of telephonic services when a bilingual provider was not available. There was also some concern regarding training and skills of dual role interpreters (i.e., bilingual staff who are asked to interpret on an *ad hoc* basis), as well as gaps in services for groups newer to the Bronx, including Africans, South Asians, and Southeast Asians.

> *So we have heard of [Asian] folks that are living up in the Bronx, perhaps because that's where they got placed in NYCHA housing, but all of their services are in Brooklyn. So they go to the grocery in Brooklyn. Their friends are there. Their doctors are there. So that's a tremendous amount of time to be able to travel to get culturally-competent, language-accessible programs and services. So then that's a real big challenge that we're seeing across a lot of communities, in the Asian-American community* (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 (including HIV and mental health issues), difficulties navigating the health insurance and care system, low prioritization of preventive care services, and fear of medical bills and deportation.

> *It's a cultural issue. Where we come from greatly impacts our behaviors, and it's clear, in Africa, health is not a priority. It's a fact. The fact that health isn't a priority and the financial difficulties, they go together, this combination is devastating for us. I have a certain level of education, but I swear, as long as I'm not caput, I won't go to the hospital.* (focus group participant)

Poverty: Given the DSRIP and CNA focus on low-income populations, the significance of poverty and its implications is unsurprising.

> *John Jones who lives in the South Bronx goes to work and is breaking his neck trying to earn a living. He's not going to worry about being screened.* (focus group participant)

However, poverty in the Bronx was unquestionably more pervasive and seen as more intractable as compared to other parts of New York City (NYC)—and its consequences for health and well-being more pronounced.

> *I think it's less about [health care] access and more about all of the other things that are hindering access: poverty, chaotic drug use, unstable housing, hunger. So that's why we*

spent so much time attacking those issues, so they can get stabilized, so then they can think about medical care. So, I think what's lacking is more commitment of resources to really addressing homelessness and hunger and those things that once they're stabilized, access becomes much, much easier. (key informant, CBO)

There could be as many as 17 people living [in a two bedroom apartment]. I mean, literally three bunk beds in the living room, two bunks in - you know, in each bedroom, you know. And people working and living in shifts, people working at day where people who can work at night can sleep. It's just unreal. And the reality of what's happening throughout the Bronx. (key informant, CBO)

It's just stunning to me the amount of hunger. We call our congregate food program an emergency food program, but the fact is even with food stamps, we've still got a lot of people coming to the program because food stamps aren't enough. (key informant, community based organization)

Multiple key informants cited the County Health Rankings, with the Bronx again ranking 62 out of 62 NYS counties.

The Bronx Health County rankings came out again a week or two ago, and that's what I brought up is we were 62 out of 62 again. (key informant, CBO)

Of survey respondents in the Bronx, 78.6% were living below the federal poverty line; in the South Bronx neighborhoods of Hunts Point-Mott Haven, High Bridge-Morrisania, and Crotona-Tremont, respondents below poverty were 87.8%, 85.9%, and 79.2, respectively. Borough-wide, 19.1% of respondents reported that they were unemployed; the comparable figures from respondents from the South Bronx were 17.0% in Hunts Point-Mott Haven, 30.3% in High Bridge-Morrisania, and 23.1% in Crotona-Tremont. Sixty-four percent (64.0%) of all respondents stated that they worried about not having enough to eat, with the percentage in Crotona-Tremont reaching 70.0% and in High Bridge-Morrisania, 66.4%.

Community members and key informants clearly connected common health conditions to the causes and repercussions of poverty, including income insecurity, lack of jobs, insufficient or hazardous housing, and unhealthy neighborhoods. They also associated poverty—and its diminished life chances and daily struggles— with depression, and likewise depression with substance abuse (including—and in some cases, especially—alcohol and tobacco). CNA participants reported concerns about jobs, housing, access to government benefits programs, and the safety of their streets. Particularly in the South Bronx, school quality is reported to be poor and dropout rates are high, impacting future opportunities for individuals as well as the strength of the community.

There are areas of the South Bronx where 7% of the adults have a college degree. That means 93 percent of adults do not have a college degree. That is like a staggering educational segregation. You know, I don't remember off the top of my head what Manhattan is like, but it's like 40 or 50 percent of adults have a college degree. So, the young people who are growing up in these areas, the odds that they meet a grown-up from their neighborhood who has a college degree is exceedingly low… If you're talking about young men in the South Bronx, I don't have the data exactly current—but it's got to be less than 50 percent [graduate from high school]. So that means the high schools are mostly creating dropouts and not successful high school graduates, and that has a huge health impact and the long-term employment impact and all of those things…You know, the school system can try as hard as it can, but it's very ill-equipped to deal with and under-resourced to deal with all the myriad of issues that young people present in high school. (key informant, government)

A dramatic indicator of poverty with obvious health implications is food insecurity, which was described as a challenge by multiple respondents in focus groups and interviews and—as mentioned above—by 64.0% of respondents in the borough-wide survey. Focus group participants and key informants described the trade-offs made in the interest of food security.

It's cheaper to eat rice and chicken. So finances have a lot to say also with food choices, because if you have a large family and you want, you know, the food to go longer or further with the number of people in the household, what is it you're buying? Is it more expensive to buy oranges, grapes, strawberries and watermelon than it is to have other items that may not be as nutritious? (Key informant, community based organization)

I would say that poverty is the main concern because people are finding it - number one, they're unemployed or they're underemployed or they're working places where they cannot get health insurance and now with the new law, they must have health insurance. So they - like I said, if - when people have to decide between having health insurance and having food in their stomach, they'd rather eat (key informant, CBO)

Environmental Conditions: Residents and service providers in the Bronx describe numerous environmental challenges, including:

- Outdoor environmental toxins coming from multiple congested highways, as well as facilities for waste transfer, waste processing, and power generation
- Indoor environmental toxins, such as pest infestation and mold, resulting from poor maintenance in public and other low income housing
- Food "deserts" (lack of healthy food) and food "swamps" (excess of unhealthy food)

- Challenging social conditions resulting from concentrated poverty and a seemingly disproportionate placement of particular services (e.g., homeless shelters, methadone clinics) in particular neighborhoods, resulting in perceived declines in safety and quality of life for community members
- Lack of affordable housing

Among survey participants, close to half (47.5%) identified affordable housing as "not very available" or "not available at all." Housing, and other environmental conditions—though in many ways dramatically improved compared to decades when the Bronx was best known for arson, violent crime and drugs—are seen to reflect decades of neglect by government, service providers, and landlords. Focus group participants and key informants are concerned that the area remains neglected, and that opportunities for change go nowhere:

> *We won a million dollars for our housing authority to upgrade our parks for the children. This was last year. They won the money but went back to another meeting and I asked them well, "Where did the money go? We won the money; you came here, and you told us that we won the money. Where is it? And what's going to happen?" We had some very damaged sidewalks in our community.* (focus group participant)

> *We try. We try to put new buildings, new everything in the community, but there's always somebody trying to drag it back down, so it's hard…The crime, the drugs... We try to fix it, and there's always something bad happening. We get no service, police, or whatever it is. We are ignored. Even health issues in that community, like I said, in that community, I know about 50 people that have cancer; don't smoke, don't do none of that. But they have cancer, and it's the community, because we're surrounded by the garbage, okay. We're surrounded by Con Edison.* (focus group participant)

> *Housing big, big need. You have individuals that are complaining that landlords are converting their buildings into shelter-like settings and offering tenants that have been there for several years $5,000, $6,000 to move out so that they can convert that building and secure city funding and reimbursement for that type of client profile or tenant profile (key informant, CBO)*

However, the legacy of activism in the Bronx, particularly around housing, was described as a strength of community:

> *The South Bronx has a pretty vibrant history of having pushed back against the bad mortgage practices and done a lot of community organizing around unfair practices and pushing for affordable housing. And I don't think the affordable housing situation is solved, but it's a lot better than it was, and there's a lot more attention put into*

affordable housing. So that's like a rich recent history that I think a lot of community-based organizations were forged during that time period, and then they came to take on health because that's sort of, you know, housing, health education, as far as kind of primitive needs that we all want. (key informant, government)

PHYSICAL HEALTH ISSUES

Overview: The five most common physical health concerns reported by survey respondents were diabetes (53.6%), drug and alcohol abuse (47.2%), high blood pressure (39.8%), asthma (38.5%), and obesity (34.5%). When asked about the health education needs of the community, the top issues were diabetes (51.5%), nutrition (43.3%), HIV and sexually transmitted infections (40.0%), and exercise and physical activity (38.2%). Cancer and cancer prevention tied with substance abuse (both 36.3%). As one service provider in the community commented:

Table 2: Health concerns

	(N=621)
Adolescent health	10.0%
Asthma	38.5%
Arrest and incarcertation	17.7%
Cancer	31.7%
Diabetes	53.6%
Disability	20.9%
Drug and alcohol abuse	47.2%
Family planning/birth control	12.2%
Hepatitis	7.4%
Heart disease	22.4%
High blood pressure	39.8%
HIV	25.8%
Maternal and child health	7.3%
Mental health (e.g. depressin, suicide)	19.5%
Obesity	34.5%
Pollution (e.g. air quality, garbage)	11.0%
Sexual transmitted infections	17.7%
Stroke	12.1%
Teen pregnancy	20.8%
Tobacco use	17.9%
Violence or injury	17.1%
Other	4.7%

You know, it's sad to see … the health conditions of the individuals that I'm seeing in the Bronx. I'm looking at obesity, I'm looking at smoking, I'm looking at and hearing as well of diabetes, hypertension. You know, we have a senior population that's also in poverty mode as well, so that's a challenge. (key informant, health provider)

Diabetes, Nutrition and Physical Activity: Overall, a little over half (56.7%) of survey respondents reported that healthy foods were available or very available in their community, and comparison across Bronx neighborhoods demonstrated the disparities between neighborhoods (see appendix for neighborhood breakout). Community members and key informants draw clear linkages between diabetes, obesity, lack of exercise, and food access. They noted the relatively high cost of healthy food choices and the travel required to purchase fresh fruit and vegetables. They also described the challenges of changing dietary behavior in general—and of losing

weight, in particular—despite obvious negative health consequences. Cultural preferences for fried and certain high caloric foods were acknowledged.

> *The biggest issue we confront is obesity and diabetes. Again, that's a function of what I just spoke about - people not getting out, kids not playing in the street, so a lack of physical activity, lack of safe places for people to interact and be together and add to that the lack of access to healthy food. That is a bad combination to try to make improvements in obesity rates and diabetes.* (key informant, FQHC)

> *The South Bronx: number one, it's a healthy food desert. I think it's getting better because of concerted efforts by a lot of people, businesses and funders and City Harvest and Food Bank have done remarkable work on that. But I think for the most part, if you walked into a bodega you wouldn't find a piece of fruit or a vegetable, and if you did, it would be like a plantain. Everything is canned. We've got people who are obese who are starving because they're eating empty calories. Chips and fried chicken and fried this and fried that. And so I think that's diet and a sedentary lifestyle and lack of access to fresh foods is a huge driver of the poor health of the Bronx, and the South Bronx in particular.* (key informant, community based organization)

> *My son lives with me, and he will go on a diet and eat vegetables and a bit of meat. But my husband, who's the fattest in the household doesn't let us because he's insatiable. He can spend all day in the kitchen. He doesn't like going on a diet because he doesn't understand why he should go hungry. We've tried but then he goes out and buys himself something.* (focus group participant)

> *You're selling stuff on the street there from seven o'clock to seven o'clock at night. You can't take a two hour break because you're gonna lose a client. Right? So then all that time you don't seem to eat anything, because you don't want to miss a dollar. You've got a bill to pay. You have to work six days in a week to get maybe less than $300.00. If you don't come to work, you don't get paid that day …. So then when you finish at night not only are you exhausted physically and mentally, but you need to eat. And guess what we do. We walk into the restaurant and get a whole plate of food. (focus group participant)*

Access to healthy foods differed according to neighborhood, with apparently better access in particular northern Bronx communities.

> *Relatively, in [Pelham Parkway], we have very good stores with plentiful vegetables or fruits. But we live in a donut. We're in the eye of that storm. Around us, we have other communities that are virtually food deserts.* (focus group participant)

I find myself going to Whole Foods a lot. So the milk you are talking about, you can get it for like a gallon or half a gallon, you can get it for like $5.49 when you pay for one. But I got to go out the area for it. But you pay car fare to go there. It's not like I can walk to the corner store and get it, or go to my local supermarkets and get it. (focus group participant)

Some providers and community members perceive a sense of resignation to the convergence of circumstances and conditions that produce disproportionately poor health outcomes in the Bronx.

In the Bronx, so many people have diabetes. The South Bronx has the highest rate for amputations as a direct result of diabetes. So a lot of people just think of it as a chronic disease and like everybody's living with diabetes. So they're not afraid of it, you know. They kinda think, "My grandmother had it and my mother had it, so I'll get it too at some point." (key informant, CBO)

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

Table 3: Health Status

	(N=622)
Perceived health status	
Excellent/very good/good	73.7%
Fair/Poor	26.3%
Body mass index (Mean, SD)	28.0 (6.0)
Underweight	2.7%
Normal	30.5%
Overweight	34.8%
Obese	32.1%
Health issues faced	
Asthma	20.4%
Cancer	6.3%
Chronic pain	19.9%
Depression or anxiety	21.5%
Diabetes	16.0%
Drug or alcohol abuse	9.1%
Heart disease	9.4%
Hepatitis C	4.0%
High blood pressure	27.3%
High cholesterol	19.3%
HIV	4.3%
Mobility impairment	7.6%
Osteoporosis	7.1%

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)

Asthma: Key informants and focus group participants attribute high rates of asthma in the South Bronx to environmental conditions. These include congested truck traffic on multiple highways and private and public facilities that spew toxic chemicals into the air. Apartment buildings with low-income tenants tend to be poorly maintained and are frequently infested with insects, rodents, and mold. CNA participants recognized that melioration of poor environmental conditions cannot be the responsibility of individuals; rather systems and policy change are required.

> *It's very mind-boggling the statistics on asthma in the Bronx. And, it's mainly related to the built environment ... we call it the asthma alley because if you know the city well, you know, 87 Highway, you have the Cross Bronx, then you have 95, so there's a triangle in the South Bronx, and the number of trucks… the traffic 24/7 is jam-packed. And the inner roads, all the pollution, particulate matter, you know, all those things fairly contribute a lot. And, of course, with the environment of the housing units, you have the mold and the cockroaches, and rodents…We give care to people who come in walking through the door, we don't even do a history of them first. We just treat them in the asthma room, and then we discharge them … They go back home and they have the same triggers and they get worse.* (key informant, provider).
>
> *People who live in the Bronx are concerned about the amount of trucks, because of all the highways we have and particularly around the Hunts Point area where trucks are idled over there a lot because of dropping off or picking up stuff. And asthma is extremely high. The Bronx has one of the highest asthma rates in New York. And, so they're concerned about the environment, the pollution that's going around … some of the housing … is riddled with roaches, you know, and mice and they're concerned because, again, roaches also affect people's asthma.* (key informant, CBO).
>
> *In my neighborhood they have a lot of chemical incinerators. …. We had to do a petition to get rid of the hazardous waste on Bruckner Boulevard, because when they was incinerating needles and surgical stuff, all sorts of hazardous stuff they were burning in our area, and it caused a lot of people to have asthma. So we had to get a petition.* (focus group participant)
>
> *[Asthma] is a health indicator that needs to be changed, right? And the community will tell you that, but then you need to bring in government. It's not enough to have health partners and the community. But if we are serious about impacting the health outcomes of communities, why couldn't we bring government in, you know to say, "Are there things that can be done with moving the roads or whatever?" Anyway, what I'm just saying is*

that the onus cannot just be put on community. Government has a role, a role to play in these things, too. (key informant, multiservice organization)

HIV: HIV was not among the highest concerns of the survey respondents (25.8% listed HIV). However, 40.0% of respondents stated that more health education is needed on HIV and other sexually transmitted infections. According to key informants in the field, transmission of HIV among injecting drug users in the Bronx has dropped dramatically, although hepatitis C remains a concern, since it is more easily transmitted.

In '95 … the new infection rate among injection drug users was 54%, so literally one out of every two people had HIV or AIDS. Now it's under 4%. We've got very few new infections. We have a lot – we see a prevalence around hepatitis C, because it's so much more communicable, with the cotton and other stuff. (key informant, CBO)

There was a recognition among those in the HIV service world (as providers or consumers) that funding has shifted away from HIV care, that medical management—rather than addressing psychosocial issues—is considered paramount, and that HIV is increasingly seen as a manageable chronic condition. There was variability in attitudes regarding this shift.

We still have the state ADAP program that covers immigrants, the undocumented and uninsured. So the system of care for HIV is well-built. What's peeling away are some of the supportive services that keep people in care or bring them to care in the first place. I think substance use treatment services and mental health services have blossomed finally…. Community-based programs that used to provide supportive services for HIV … have been pared down, and there's more of a funder focus on medical [unclear] HIV care, putting more funding in the hospital setting for case management, HIV case management. (key informant, CBO)

I've noticed that a lot of HIV has become a controlled infection, and they don't look at it as serious as it was. We are losing a lot of funding and we're losing a lot of our specialty clinics that were there to help specifically people that are HIV. Now their clinics have opened up to the general public, and we've lost a lot of that, which I think is disgusting. Even though HIV has become a manageable disease, it is still as serious as it was in the '80s. (Focus group participant)

I could click off six organizations that probably shouldn't even exist right now, because they're more concerned with their funding than about really meeting the needs of who they're serving. They're giving away a syringe while people's toes are falling off from diabetes and not asking about the diabetes…. That was the shift. That was the light bulb for me. We were doing syringe exchange and [not] worrying about people's diabetes or

psychiatric conditions and that's what they were dying from. It's immoral, it's wrong to just focus on one thing, because that's what you're funded to do. (key informant, CBO)

Violence: Only 17.1% of survey respondents rated violence as significant health concern, and publicly available data suggest that crime has declined in the Bronx, as it has declined in other parts of NYC. However, 30.7% of respondents indicated that more education was needed on violence and 35.8% reported that education was needed on domestic violence. Focus group participants and key informants described violence as prevalent in particular neighborhoods and in public housing, with repercussions for those directly and directly involved. Domestic violence was also alluded to and was linked to the stresses of poverty and drug use.

There's a high portion of youth against youth. It's turf issues. It's, "I live over here and you live over there," or whatever it is…even though older people are not targeted, they're definitely impacted by the safety that they feel about the community. (Key informant, CBO)

The amount of gun violence that's gone on and the amount of people and kids that are shot just by stray bullets or intentional bullets … It's related to drugs, but it's also just related to gang violence, in general, you know... But the guns, the amount of guns that are just so accessible to our community is alarming. (Key informant, CBO)

I think safety is a big component that sometimes people don't think about with social determinants. Safety from violence, that your kids are going to be okay, that you can go to the park and you are going to be safe and that your kids are going to be okay playing outside. … When I grew up in the Bronx, I was just let out into the street and I played. I don't think that happens in too many places, not just in the Bronx, but also all over. (Key informant, FQHC)

Concentrated poverty, you've got a neighborhood [in the South Bronx that] has a poverty rate of about 46%. The Bronx in general is about 26%, which is still ridiculous, but that area has that concentrated poverty because of all the NYCHA housing projects. And so when you get that kind of concentrated poverty and then the violence, sexual violence, domestic violence, street violence, gang violence, drug violence, it's a perfect storm for breeding ground for spreading illness, disease, lots of psychiatric issues and lots of drugs. (Key informant, CBO)

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. Immigrant groups coming from

war-torn countries may also perpetuate the violence they experienced. Focusing on immigrants from Southeast Asia, a key informant explained:

> *There are these young men in his community that the image that they have always seen when they were growing up was the way that their fathers would treat their mothers, right? And then they realized later on when they were kind of able to unpack it and get treatment was really, when you come from communities who have been just so devastated by war and by trauma, that what was happening to the fathers and their uncles is that a lot of times they didn't get treatment. They were totally traumatized, and they were taking it out on the mothers. So that's how – so these young men were growing up thinking, well, that's how you treat women*. (key informant, CBO)

BEHAVIORAL HEALTH ISSUES

Mental Health: Depression, anxiety, and other mental health issues are important to large parts of the community in the Bronx: 19.5% of survey respondents rated mental health as an area of concern, 21.5% reported depression or anxiety as issues they have personally faced, and 32.4% reported that mental health education is needed in the borough. Just 53.3% of respondents reported that the mental health services are "available" or "very available" in their community. Problems related to mental health were commonly attributed to the myriad of stresses faced by lower income residents.

> *What we see is depression, anxiety, some personality adjustment disorders. Those kinds of diagnoses that are part of the environment as well. People are smart, and they look around at their surroundings- what is there to hope for?* (Key informant, FQHC)

> *We have extremes of problems, mental health is an issue because of the complex environment they live in, the poor support. So we see a lot of depression, a lot of anxiety, and that leads to an impact on their own health. Adherence to medications, adherence to follow-up, you know, family getting separated because of that. … that's a problem in terms of - it goes across all demographics… There's no political motivation to address an issue. It's sort of like an accepted norm for the community. "Oh, Bronx, you know, it should have these elements." I feel that way after seeing this for many years. Because if we can address many other issues so, so aggressively, why is this not being addressed, I'm not so sure. So the mental health, drug use complicates medical health, medical issues a lot. A lot.* (Key informant, provider)

For low-income immigrants, stresses were exacerbated by issues of assimilation, as well as poorer access to care, due to insurance and language barriers.

> *You've got to be somebody, somebody who [was] a doctor or military for years. You come into this country and become a cashier. If you are not mentally prepared for this, this is not really a culture shock. But this is a big shock …But sometime people don't want to talk about it. People are keeping this to themselves, but at some point you'll see they'll start talking by themselves, and start doing some things.* (immigrant focus group participant)

Failure to address mental health issues was common across groups, with broad health implications.

> *Men, in general, shun medical attention – be it mental or physical. We're not examining ourselves as much. We're not seeking help to talk to a peer. When we're depressed, we internalize. When we're angry, we express ourselves and that transforms into violence.* (Focus group participant)

> *Like counseling for a lot of people in this community because we have a lot of broken families, which is single mothers, and single fathers, too. And that's why a lot of our youth have the tendency to don't continue in school, and get into drugs. And also men, you know, and women are getting into drugs. So I think that we should have more services – programs, services that they could allot for counseling regarding help about how to deal with divorce, how to deal with a parent leaving, things like that.* (focus group participant)

Substance abuse (including tobacco, alcohol, and illicit drugs): Substance abuse was the second most commonly cited health concern by survey respondents (47.2%); many (36.2%) also noted the need for education on the topic. As noted throughout this report, substance abuse was linked to many other issues related to health and well-being, including depression, violence, domestic violence, infectious disease, and inappropriate use of health care services.

> *There is high substance use. You know, heroin has come back to the Bronx very strong. Crack and cocaine never left the Bronx. It's still here. Marijuana is, you know, everywhere... I think it's probably more and more due to poverty than anything else. Poor people, you know, are so stressed out with just having a roof over their heads, having food on their plates, being able to get their child in school. And, you know, there's just so many challenges for people - for poor people to have to deal with. People being homeless. The domestic violence is just unbelievable… Many people, you know, use substances so they cannot face the reality of their lives. So they smoke crack or take heroin because it's easier not to feel the reality.* (Key informant, CBO)

Obviously drug abuse is still a big problem. Alcoholism is a huge problem, and we see a lot of admissions, a lot of patients with some sort of drug abuse or alcohol misuse (key informant, provider)

CNA participants recognized the relationship between community characteristics and substance use issues, citing both the presence of drug treatment programs that draw active users and commercial establishments that sell alcohol and cigarettes.

That building on 147th at the end of the Betances North, there's like three methadone clinics around there. And we did hear a lot from the residents that that was a big concern. (key informant, CBO)

I think our businesses in our communities play an important role. We can impact what they do or not. Outside the mouth of Co-op City, there's a Sunoco gas station. In big letters the advertisement is "lotto, beer, cigars." Big signs to get—that's a negative impact on the community. And it's not about cigars. They know that these young folk use the cigar wrappings to wrap marijuana. (focus group participant)

Focus group respondents also indicated that substance abuse can affect diverse populations. Individuals who rely on prescription medicines were described as facing increasing risk of addiction.

We're also hearing about the increase of prescription abuse with the seniors, and, you know, people are living longer and, with that said, you have a lot of chronic diseases, not a lot of pain management. So that's also another concern that we want to be able to try and address and that's why I would love to have a substance abuse program in order to meet those needs of the seniors that are experiencing that, let alone the stigma associated with that as well … (Focus group participant)

ACCESS TO RESOURCES AND SERVICES

Medical Services: Almost 76% of survey respondents reported that primary care was available or very available, 81.8%% reported that they had a primary care provider or personal doctor, and 85.5% reported that there is a place they "usually for health care, when it is not an emergency." Just under half of respondents (49.5%) went to a primary care doctor's office, 18.0% went to a hospital outpatient clinic, 14.3% went to a community/family health center, and 6.4% went to a specialist doctor's office. The overwhelming majority (85.5%) percent reported that the place they usually go is in the Bronx; 11.2% reported that it is Manhattan. Eighty-one percent reported that had a routine check-up in the last 12 months.

A relatively high number of respondents (45.7%) reported that they had been to an emergency room in the last year, and approximately one quarter (24.7%) of reported that they did not obtain healthcare when it was needed. Of these, 44.6% reported that they were not insured, 22.1% that the cost of co-pays was too high, 11.0% that they could not get a timely appointment. 8.4% were concerned with the quality of care, and 6.5% did not have transportation and had other responsibilities (same proportion for each).

Independent of the actual number of health care resources described in the sections below, a strong theme that emerged from the key informant interviews and focus groups was the perception that there was an insufficient access to the high quality providers on a timely basis, including outside of regular office hours (i.e., nights and weekends). A key informant working in the South Bronx explained:

Because it's the Bronx. You know how hard it is to get [organizations] to come up here to do anything? And generally they don't get providers… The services in a lot of the outer boroughs are not at the level of quality that they should be. I'm saying that as a Bronx-based provider. (key informant, community based organization)

Table 4: Service availability

	(N=622)
Accessible transportation	90.0%
Affordable housing	47.5%
Dental services	71.5%
Healthy food	56.7%
Home health care	62.0%
Job training	34.3%
Medical specialists	59.3%
Mental health services	53.3%
Pediatric and adolescent services	64.5%
Places to exercise, walk, and play	70.6%
Primary care medicine	75.8%
Social services	63.5%
Substance abuse services	51.9%
Vision services	65.8%

*Percentage reflects participants who responded very available or available

Community members also complained about poor access to what they perceived as quality care:

When you go to a hospital for an emergency they give you a form to fill out. You sit down, and an hour later they call you. And they give you an appointment for three months to now. Three months to now, you could be dead. And when you go in three months, some of them spend 5 minutes with you. Some of them even have the nerve to have a clock. And you're not feeling well. And then you have to fill out a long sheet about why you're here. So I don't bother to go. I get my herbs. Holistic doctors is what I believe in because these doctors know nothing … They don't care nothing about you. Everything is money. If I can help it I don't even bother going. (focus group participant)

The doctor I have, she has on my thing, 15 minutes. She knows she can't tell me something in five minutes. Fifteen minutes and she has to examine me. I go and I open my

mouth for them because that's all they're doing. They think I'm crazy. (focus group participant)

Approximately sixty percent reported that medical specialists are available/very available, although there was significant variability in responses according to neighborhood (e.g., 53% in Hunts Point-Mott Haven as opposed to 72% in the Northeast Bronx). 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)

Sometimes now they're having programs for like younger kids that are not using it and sometimes you know, you might be older, needing of help, but you can't get it because there isn't a lot of help for the older. (focus group participant)

Behavioral Health Services: Survey respondents reported that behavioral health services are less available than other types of care: only 53.3% reported that mental health services were available/very available; 51.9% of Bronx survey respondents reported substance abuse services as available or very available. Barriers to behavioral health services include low reimbursement and provider shortages, including outside regular business hours.

The way reimbursement is being structured, it's straining programs and there are many programs right now that are trying to survive within the new payment structure. So there is a concern that, you know, they could do more, but because of constrictions within their budget, they're limited in the number of visits and services that they're able to provide, even on extended hours. And then when you look at, you know, who can truly benefit, right, from mental health services, you also have a working population, and if you're not open later in the evening or on the weekends, then that excludes another group. By the same token, I've been involved with another mental health clinic and the staff expressed grave concerns regarding extended hours during the winter because it gets dark so early and safety. (key informant, CBO)

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)

> *When you grew up without this and you're a certain age, it's hard to accept getting the help. So I think that's part of the problem also. So even if it's open to you, if you weren't brought up to believe that you can go to someone else for help or therapy, it was never a part of our culture.* (focus group participant)

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 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 which does not make you go through that. 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-two percent of survey respondents felt that dental services are available or very available in their community:

My center facility has the WIC program and dentists and the doctors there will always refer you to specialists. (key informant, CBO)

I don't have dental insurance. I could be a little better with my dental health. I need dental work. I can't afford it. I've had a good experience with dental care at Jacobi. Thumbs up for Jacobi dental care, which is more accessible than lots of dental care. (focus group participant)

However, just 58% reported having been to the dentist in the prior 12 months. A common barrier to dental care was cost: When a focus facilitator asked, "What about dental care—do people go to the dentist each year?" responses included:

- *Nope.*
- *I don't.*
- *I don't need to, unless I break something. (Laughs - has dentures)*
- *These co-pays are ridiculous.*
- *I pay $40 every time.*
- *I pay $40, and I pay $190-something a month for the coverage.*
- *Too expensive. Just for a cleaning.*

Insurance: Focus group participants, in response to a question regarding what should change in health care, commonly 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.

> *Sometimes [they] simply can't afford them 'cause not everybody's eligible for Medicaid, you know. And then there is this group of individuals that fall in between Medicaid and private health insurance. Unfortunately, that group is much larger than any of us would like to see.* (Key informant, CBO)

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. For example:

> *I have hypertension and when I moved here from the DR [Dominican Republic] I didn't have insurance, and so I had to ask people to bring my hypertension pills from the Dominican Republic. One time, there wasn't anyone coming and so I ran out and I felt terrible. My daughter's father didn't want to take me to the doctor because he didn't want to pay, so I had to drink some water with sugar and salt and wait it out. He didn't bring me to the doctor for fear of the bill. Now I have health insurance and I get my pills here.* (community member, focus group participant)

> *So, Medicaid, if you look at Medicaid, it's a complete inverse of private insurance, lots of kids, almost no adults, lots of old people, all disabled people. Private insurance, not a lot of kids, lots of working adults, all these other folks. So, you get all these uninsured people, they get hit by a bus, they get AIDS, they get cancer, their addiction goes untreated, they immediately fall into Medicaid because they don't have insurance that's sustaining them and then they end up in one of the more catastrophic levels of Medicaid because Medicaid differentiates patients based on their needs based on their diagnosis and the DSRIP as much about that.* (Key informant, CBO provider)

Supportive Services: 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.

There was a concern that medical providers have insufficient information regarding supportive services and the benefits they offer. A hospital based physician commented:

> *Because physicians like us, we have absolutely zero knowledge of community resources, and there are plenty of community resources. (key informant, health provider)*

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)

> *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)

Particularly for immigrant communities, CHWs—whether they be health educators, navigators, or advocates—helped to ameliorate the pervasive language and cultural barriers:

I don't care where you come from, but it has to be people seeing people [in the hospital] who look like them, that are like them, who speak like them and who feel like this people are – have my interests on my – their mind. … Seriously, you need to have a program where you have people who look like me [West African], who will be there to pass along information to the people is critical. (focus group participant)

CHWs were reported to be particularly valuable and effective in ensuring that hospital discharge plans are effectively implemented, as discharge planning was seen as generally problematic:

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

This silo specialization in medicine is a problem for everybody, but it's a particular problem for the geriatric population with, you know, 12 medications and four presenting conditions. And so that anything that can happen to not just coordinate but actually integrate care across specialties so that when you do need the interaction of the medical institution for it to deal with a whole person as a whole person, not by its individually, coded and billed body parts would be really important. Anything that could happen along those lines would help everybody, but it would particularly help our guys…All our social workers can tell you stories and we could say personally, you know, the orthopedist comes in and says, well you know, "Mrs. Smith, yeah, your hip will be great," but Mrs. Smith has dementia and Mrs. Smith is not going to recover in a great way. You know, he's solely looking at one body part. And he's not thinking what the rehab

is going to be like… and the disorientation. And the family is left standing like, "Are you kidding, what are you talking about?"(key informant, multiservice organization)

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 in care coordination on the part of medical providers was also 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 electronic health records were described as challenging 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. It was emphasized the education has to be comprehensive and ongoing in order to affect behavior change.

> *You have to continue to be out there every so often asking, like, 'What's going on? Who are you? You know, where you from? What do you practice?'" And that's the way it is. Education, health education has to be dynamic. It has to be ongoing. You have to constantly remind people about, "If you're gonna have sex with multiple partners, you should really use a condom."* (key informant, CBO)

> *It's been proven if we can have health educators dedicated to an individual to work with them, to see them on a regular basis, people tend to respond more, you know. So the one-on-one care works. It does.* (key informant, CBO)

> *We're gonna have to pull our forces together and unitedly, you know, present ongoing seminars, town hall meetings, presentations about various health topics, you know. We need to remind people that diabetes is directly - there's a serious, serious correlation between obesity and diabetes, you know. We need to just keep plugging that in.* (key informant, CBO)

Topics for education of the broader public included immigrant rights, sexual health, health literacy, tobacco cessation, and nutrition, as well as access and appropriate use of health care services, such as preventive health care and screening, mental health care, and emergency care.

I feel that the ER should explain to the people that if their problem is not that serious if it's not serious, because the emergency [department] is for the emergency. It's for right now. It's not because I got a common cold … that's your primary care doctor. They really need to emphasize what the ER is for and really let these people know that they need to start turning them away if it's not an emergency. (focus group participant)

Information related to general awareness and to behavior change were both considered important. Health fairs, faith based programing, and school based programming were all seen as important venues for the dissemination of information—and for health screening. School-based programming recommendations incorporated both a return to a more basic comprehensive curriculum (e.g., offering recess), as well as enhanced offerings.

We know what works. What works is being in the schools, providing quality sexual reproductive health education and not just a one-time going in there but a series of programs with the same health educator and then having the health educator based in the school building as a continual consistent presence for those kids to be able to know that they can go and talk to somebody about that … having that health educator be able to link kids who are on the verge of sexual activity with medical family planning services to help prevent pregnancy. With mental health services, to deal with issues that might lead them to having early sexual initiation or deal with whatever's going on in their house but I think the other part of that is making sure that their medical providers are giving kids private times starting at around age 11 to be able to discuss those sensitive issues without the parent present and those are the things that work … (key informant, CBO)

I believe our people need education. Schools need to get back to exercise. If our children don't have the exercise and things to make them busy, our children will not do too much and they won't help the family education themselves. Taking exercise out of the school, the gyms, and various different things is bad. (focus group participant)

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)

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

  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] (key informant, health advocacy)

  I know of this one person who was afraid that she had cancer of some type, and she had an appointment that was three months away. She said after a week she was going bonkers, went to the ER, says, "Let them test me here, let them run the x-rays and all that," and that's what she did. And she got information before the three month period. She said, "I could be dead by then." (Key informant, CBO)

- Wait times on the day of a visit

  The wait [in the ER] is better than you gotta wait for clinic….when I go to clinic, I have a one o'clock appointment, this is my thing with them: if I got a one o'clock appointment, why, "Here it is two o'clock, three o'clock, you're calling, and I'm still here?" You ain't gonna see everybody at one o'clock, don't have me sit there for five or six hours. Are you kidding me? I tell them, "I'm leaving, because now I've got to go get something to eat, because now my sugar went down, and go back upstairs and wait, and sit on that hard chair, with no cushion. Are you kidding me?" Here it is six, seven o'clock at night, here I am coming home from a one o'clock appointment. Are you kidding me? Then they wonder why I don't come. (focus group participant)

- Short visits that did not allow for health needs to be appropriately addressed. Community members feel that providers do what is expedient rather than what represents the highest quality of care. Related to brief visits are poor communication skills.

  Where I go, you would think that they do not like seeing patients. Instead of feeling comfortable, you feel bad. Then you wait for so long only to be seen for 5 minutes. (focus group participant)

  I've already had cancer. I've got cancer again. I told the doctor: "I want the other breast removed." They looked at me like I had just grown another head. And she never answered me, and she never told me if it was a good idea or a bad idea. And I'm still waiting for an answer and it's been over a year. No respect. (focus group participant)

- Multiple and complicated referral pathways, that result in significant inconvenience and expense for patients. Furthermore, the possible need for multiple visits (e.g., for tests) discourages timely use of services.

  When you go [to the health center], you always got to get a referral for this, for that, and the third. So you are going to end up in a two fare zone. To get to that referral, because they never conduct it on site. They could say, 'Okay you have a problem with your left eye. Here is a referral to go 40 blocks away, and that's where you have to go, and you come back here for your results. But then I might give you a referral to go to the GYN that is 50 blocks away," and so forth and so on. So either way you look at it, you are getting on the train, while they are right around the corner. (focus group participant)

- 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—or confirmation that needed supports are in place. 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 payment concerns. Or, in contrast, ED patients that have a primary care provider will be referred to a hospital clinic for follow-up care.

  Patients that are going hungry and they don't even ask the question – is there enough food in the home or do you need a referral to a food pantry or Meals on Wheels program? And then, you know, if they're going through their treatment and there are all these other medications and you don't have food, it upsets everything and it contributes to another visit to the hospital (key informant, community based organization)

  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, the foreign born and older adults

  When people with disabilities go to seek care, someone sees them in terms of their diagnosis. "Oh, you are the person with MS. You are the person with the [traumatic brain injury]. You are the person with cerebral palsy." And so you are not seen as the person who is sexually active and needs advice about that. Or who may be drinking excessively. Or who may be drugging and self-medicating. You are not seen as the person who needs vaccinations. You are not seen as the person who needs advice about smoking cessation. After all, your quality of life must be so poor that at least I could allow you smoking. So I'm not going to bother to give you smoking messages because I'm assuming that if I were you, I would feel so bad about myself. So there's also a mythology about people with disabilities, that we are all depressed as well. So why bother to counsel you about any of these other things? (key informant, health advocacy)

  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)

<u>SPECIFIC POPULATIONS</u>

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, and transgender (LGBT); 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, absence of sign language interpreters, poor transit services) and providers that are insensitive to both their capabilities and their limitations. These access barriers—and their implications— were described by CNA participants.

> *I have access-a-ride. Access-a-ride doesn't take me anywhere in the Bronx. It goes to Queens, Brooklyn and Staten Island. But I cannot use it here in the Bronx. Now the last time I called them for them to take me to [Manhattan], I went over to Fifth Avenue to the hospital. She told me "You can take this bus, and it will take you to Manhattan, and that bus will drop you off." And then I said, "so what do I do now? I have difficulty walking." And where they were gonna drop me off would have been at least two blocks and that hospital I was going to I know for a fact, two blocks is like four. I'm gonna have to walk. And I couldn't walk so I said "I have to walk there. What do you suggest I do?" "Uh, well uh ma'am." I said "You can't help me. Thank you very much."* (focus group participant)

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. As explained by a key informant in the field:

> *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…

LGBT: The LGBT population has 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 affects 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 issues 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., 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.* (key informant, government)

Bridging connections directly from jails/prisons to community based organizations and providers upon re-entry was recommended, so as 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.* (key informant, government)

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. (key informant, government)*

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.

[Homeless] 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. (key informant, government)

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.

The [supportive housing] staff is there for relapse. So, "You stop taking your meds," it's that staff that's going to know. Maybe it might be a neighbor who notices first, and it's reported to the case manager who comes up and has a relationship, and it's like, "Is everything okay? Do we need to put you in the hospital for a week?" But making sure that the main goal is housing stability, right? So doing everything they can so the person doesn't lose their apartment. Which would happen, or probably did happen in their past life, particularly with mental illness or substance abuse. You decompensate and there's nobody there to help you before you lose your apartment. So you end up in the shelter, the jail, the psych unit, before you can get back (key informant, health advocacy)

DISCUSSION

Bronx community members and other stakeholders are clearly interested in partnering with hospitals and health care providers 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 themes in the Bronx are persistent poverty, environmental hazards, and systemic neglect. Focus group and interview participants articulated specific barriers to good health and good health care, many of which were related to poverty and its consequences, including long work hours, unstable housing, unsafe neighborhoods 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 appropriate use of health care services, 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=622)

UHF Neighborhood	UHF code	Zipcode	Frequency	%
Kingsbridge and Riverdale	101	10463, 10471	6	1.0%
Co-op City, Eastchester, Wakefield, Williamsbridge, and Woodlawn	102	10466, 10469, 10470, 10475	88	14.2%
Bedford Park, Belmont, Kingsbridge Heights, Norwood, and University Height	103	10458, 10467, 10468	105	16.9%
Castle Hill, City Island, Country Club, Morris Park, Parkchester, Pelham Bay, Soundview, and Throgs Neck	104	10461, 10462, 10464, 10465, 10472, 10473	77	12.4%
Bathgate, Bronx Park South, Crotona, Morris Heights, Mt. Hope, and Tremont	105	10453, 10457, 10460	105	16.9%
Highbridge and Morrisania	106	10451, 10452, 10456	134	21.5%
Hunts Point and Mott Haven	107	10454, 10455, 10459, 10474	107	17.2%
			622	100%

Table 2: Demographic characteristics

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=622)
Age (Mean, SD)	47.3 (18.1)	62.1 (18.8)	47.9 (18.2)	40.8 (14.3)	39.0 (15.9)	45.9 (16.1)	41.6 (15.0)	45.9 (17.9)
18-20	0.0%	0.0%	2.9%	3.9%	6.7%	5.2%	4.7%	4.0%
21-44	50.0%	18.2%	43.8%	58.4%	55.2%	41.8%	48.6%	44.4%
45-64	33.3%	21.6%	26.7%	29.9%	25.7%	42.5%	37.4%	31.5%
65-74	16.7%	25.0%	15.2%	6.5%	6.7%	7.5%	3.7%	10.5%
75-84	0.0%	21.6%	7.6%	0.0%	1.9%	0.0%	1.9%	5.0%
85 and older	0.0%	6.8%	1.0%	0.0%	0.0%	2.2%	0.0%	1.6%
Unknown	0.0%	6.8%	2.9%	1.3%	3.8%	0.8%	3.7%	3.1%
Gender								
Female	50.0%	75.6%	63.8%	56.6%	49.0%	52.6%	59.8%	58.9%
Male	50.0%	24.4%	35.2%	43.4%	49.0%	47.4%	40.2%	40.7%
Transgender	0.0%	0.0%	1.0%	0.0%	2.0%	0.0%	0.0%	0.5%
Sexual Orientation								
Heterosexual	100.0%	94.4%	92.5%	92.8%	90.8%	91.3%	93.8%	92.6%
LGBTQI	0.0%	5.6%	7.5%	7.3%	9.2%	8.7%	6.2%	7.5%
High school graduate or higher	66.7%	86.3%	81.0%	79.2%	74.3%	76.2%	72.5%	77.7%
Hispanic	40.0%	21.4%	24.0%	40.5%	29.8%	40.8%	50.5%	35.1%
Race								
White	20.0%	25.3%	6.8%	15.3%	2.9%	3.9%	6.9%	9.3%
Black or African American	40.0%	56.6%	41.8%	40.3%	64.7%	61.7%	57.4%	54.6%
Asian	20.0%	3.6%	33.0%	15.3%	10.8%	1.6%	1.0%	10.6%
American Indian or Alaskan Native	0.0%	2.4%	1.0%	1.4%	1.0%	0.8%	1.0%	1.2%
Native Hawaiian or other Pacific Islander	0.0%	0.0%	0.0%	1.4%	1.0%	0.0%	1.0%	0.5%
Other	0.0%	4.8%	12.6%	11.1%	13.7%	25.8%	21.8%	15.8%
Mixed	20.0%	1.2%	1.9%	5.6%	2.0%	3.1%	1.0%	2.5%
Unknown	0.0%	6.0%	2.9%	9.7%	3.9%	3.1%	9.9%	5.6%
Unemployed	50.0%	9.4%	8.7%	19.7%	23.1%	30.3%	17.0%	19.1%
Always/sometimes worry about not having enough money to pay for food or housing	83.3%	44.2%	65.7%	69.3%	70.0%	66.4%	63.5%	64.0%
Living below a federal poverty level	100.0%	50.0%	83.8%	75.4%	79.2%	85.9%	87.8%	78.6%

Table 3: Language

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=622)
Primary langauge spoken at home								
English	50.0%	80.7%	61.5%	71.1%	77.9%	86.1%	72.9%	75.2%
Spanish	33.3%	19.3%	11.5%	21.1%	17.3%	24.0%	28.0%	20.5%
Arabic	0.0%	0.0%	1.0%	2.6%	1.0%	1.6%	0.0%	1.0%
Chinese (Mandarin, Cantonese, or other)	0.0%	0.0%	0.0%	2.6%	0.0%	0.0%	0.0%	0.3%
French	0.0%	0.0%	1.9%	2.6%	1.0%	0.8%	3.7%	1.6%
Haitian/French Creole	0.0%	1.1%	1.0%	0.0%	0.0%	0.8%	0.0%	0.5%
Hindi	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.2%
Italian	0.0%	0.0%	0.0%	4.0%	0.0%	0.8%	0.0%	0.7%
Korean	0.0%	1.1%	1.0%	0.0%	0.0%	0.0%	0.0%	0.3%
Russian	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.0%	0.2%
Urdu	0.0%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.2%
Yiddish	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	16.7%	0.0%	27.9%	14.5%	10.6%	1.6%	1.9%	9.1%
Multiple language	0.0%	2.3%	6.8%	14.5%	6.7%	13.3%	6.5%	8.3%
English proficiency	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Very well/well	83.3%	95.2%	84.6%	87.7%	93.1%	89.4%	83.5%	88.7%
Not well/not at all	16.7%	4.8%	15.4%	12.3%	6.9%	10.6%	16.5%	11.3%
Ever not get healthcare because of language or translation	0.0%	0.0%	0.0%	5.9%	0.0%	0.0%	0.0%	0.7%
Foreign born	50.0%	32.9%	55.3%	41.6%	45.5%	29.3%	32.7%	39.2%

* only those who indicated ever not getting healthcare when needed

Table 4: Health-related characteristics

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=622)
Perceived health status								
Excellent/very good/good	83.3%	77.1%	76.8%	82.7%	75.0%	66.9%	68.3%	73.7%
Fair/Poor	16.7%	22.9%	23.2%	17.3%	25.0%	33.1%	31.7%	26.3%
Body mass index (Mean, SD)*	27.2 (4.0)	27.6 (6.5)	27.3 (5.7)	27.4 (5.0)	28.2 (6.8)	28.6 (5.9)	28.5 (5.7)	28.0 (6.0)
Underweight	0.0%	2.7%	2.2%	2.9%	4.2%	2.4%	2.1%	2.7%
Normal	50.0%	37.3%	35.9%	27.9%	32.6%	24.4%	26.6%	30.5%
Overweight	25.0%	30.7%	33.7%	41.2%	28.4%	37.8%	37.2%	34.8%
Obese	25.0%	29.3%	28.3%	27.9%	34.7%	35.4%	34.0%	32.1%
Have health insurance								
Medicaid	83.3%	30.7%	48.6%	48.1%	57.1%	63.9%	57.9%	52.7%
Medicare	16.7%	43.2%	30.5%	11.7%	15.2%	15.0%	16.8%	21.6%
Private/commercial	0.0%	22.7%	19.1%	20.8%	14.3%	15.0%	14.0%	17.1%
VA	0.0%	1.1%	1.0%	0.0%	1.9%	0.0%	1.9%	1.0%
Other	16.7%	4.6%	7.6%	6.5%	3.8%	9.0%	5.6%	6.4%
More than one insurance	33.3%	9.2%	17.1%	4.1%	4.8%	11.5%	9.3%	9.9%
Uninsured	16.7%	5.8%	11.4%	12.3%	14.3%	6.9%	14.0%	10.8%

***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

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=622)
Have a primary care provider/personal doctor	100.0%	88.4%	73.5%	86.3%	76.8%	82.6%	83.8%	81.8%
Have a usual place to go for non-emergency health services	100.0%	90.6%	85.3%	83.3%	78.6%	86.4%	87.6%	85.5%
Use complimentary or alternative treatments or remedies	0.0%	16.4%	28.3%	28.2%	25.3%	19.4%	17.5%	22.0%
In the past 12 months:								
Have last routine check-up	100.0%	84.0%	75.3%	72.3%	81.1%	89.2%	78.0%	81.0%
Have been to a dentist	83.3%	60.2%	55.0%	58.9%	64.1%	55.7%	53.8%	58.0%
Have gone to a hospital emergency room at least once	50.0%	39.5%	36.3%	33.3%	53.5%	55.0%	48.5%	45.7%
Need healthcare but didn't get it	33.3%	18.7%	27.2%	23.3%	28.7%	27.5%	26.2%	25.8%

Table 5: Place for non-emergency healthcare services*

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=517)
Type of place								
Primary care doctor's office	83.3%	76.6%	39.1%	61.7%	45.7%	41.2%	40.2%	49.5%
Specialist doctor's office	0.0%	15.6%	8.1%	8.3%	6.2%	3.5%	0.0%	6.4%
Community/family health center	16.7%	7.8%	14.9%	15.0%	24.7%	8.8%	16.3%	14.3%
Hospital-based clinic	0.0%	11.7%	24.1%	8.3%	12.4%	24.6%	21.7%	18.0%
Private clinic	0.0%	1.3%	6.9%	5.0%	3.7%	16.7%	6.5%	7.4%
Emergency room	0.0%	3.9%	6.9%	5.0%	11.1%	7.0%	4.4%	6.4%
Urgent care	0.0%	2.6%	3.5%	1.7%	1.2%	0.9%	0.0%	1.6%
Pharmacy	0.0%	1.3%	5.8%	5.0%	6.2%	0.9%	1.1%	3.1%
Drug treatment center	0.0%	0.0%	0.0%	0.0%	0.0%	2.6%	2.2%	1.0%
Mental health center	0.0%	0.0%	0.0%	0.0%	2.5%	0.0%	0.0%	0.4%
Alternative care (e.g. herbalist, acupuncturist)	0.0%	1.3%	2.3%	0.0%	1.2%	0.0%	0.0%	0.8%
Other	0.0%	0.0%	0.0%	1.7%	2.5%	1.8%	3.3%	1.6%
Location								
Bronx	66.7%	94.5%	82.8%	78.3%	88.8%	86.6%	82.6%	85.5%
Brooklyn	0.0%	1.4%	0.0%	0.0%	0.0%	3.6%	1.1%	1.2%
Manhattan	33.3%	2.7%	12.6%	18.3%	11.3%	7.1%	15.2%	11.2%
Queens	0.0%	0.0%	2.3%	1.7%	0.0%	0.9%	1.1%	1.0%
Staten Island	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Outside of New York City	0.0%	1.4%	2.3%	1.7%	0.0%	1.8%	0.0%	1.2%

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

Table 6: Barrier to gettig healthcare*

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=154)
Not insured	100.0%	21.4%	39.3%	29.4%	51.7%	47.2%	39.3%	41.6%
Cost of copays	50.0%	7.1%	32.1%	11.8%	17.2%	22.2%	28.6%	22.1%
Concerns about quality of care	0.0%	7.1%	14.3%	0.0%	10.3%	11.1%	3.6%	8.4%
Did not know where to go	0.0%	7.1%	0.0%	0.0%	3.5%	5.6%	0.0%	2.6%
Had other responsibilities (e.g. work, family)	0.0%	0.0%	7.1%	5.9%	10.3%	5.6%	7.1%	6.5%
Could not get an appointment soon or at the right time	0.0%	7.1%	17.9%	5.9%	13.8%	5.6%	14.3%	11.0%
Did not have transportation	0.0%	14.3%	7.1%	0.0%	10.3%	8.3%	0.0%	6.5%
Concerns about language or translation issues	0.0%	0.0%	0.0%	5.9%	0.0%	0.0%	0.0%	0.7%
Other	0.0%	0.0%	0.0%	5.9%	3.5%	0.0%	3.6%	2.0%

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

Table 7: Reason for ER use*

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=270)
Did not have insurance	0.0%	12.5%	10.8%	13.0%	7.6%	18.1%	12.0%	12.6%
Did not have transportation to a doctor's office or clinic	0.0%	3.1%	8.1%	4.4%	3.8%	2.8%	0.0%	3.3%
Get most care at ER	0.0%	9.4%	10.8%	21.7%	13.2%	8.3%	22.0%	13.3%
Problem too serious for a doctor's office or clinic	33.3%	34.4%	43.2%	30.4%	34.0%	44.4%	32.0%	37.4%
Doctor's office or clinic was not opened	33.3%	25.0%	10.8%	4.4%	17.0%	25.0%	16.0%	18.2%
Other	0.0%	6.3%	10.8%	17.4%	15.1%	4.2%	10.0%	9.6%

*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

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=621)
Adolescent health	16.7%	8.1%	10.5%	10.4%	8.6%	6.0%	16.8%	10.0%
Asthma	66.7%	44.8%	36.2%	29.9%	33.3%	35.8%	48.6%	38.5%
Arrest and incarcertation	16.7%	12.6%	13.3%	18.2%	17.1%	22.4%	20.6%	17.7%
Cancer	16.7%	46.0%	36.2%	36.4%	30.5%	21.6%	27.1%	31.7%
Diabetes	50.0%	65.5%	58.1%	58.4%	43.8%	47.0%	54.2%	53.6%
Disability	16.7%	34.5%	23.8%	26.0%	14.3%	14.9%	17.8%	20.9%
Drug and alcohol abuse	33.3%	31.0%	46.7%	58.4%	47.6%	48.5%	51.4%	47.2%
Family planning/birth control	33.3%	8.1%	12.4%	10.4%	16.2%	12.7%	11.2%	12.2%
Hepatitis	16.7%	4.6%	4.8%	6.5%	10.5%	9.0%	7.5%	7.4%
Heart disease	50.0%	35.6%	28.6%	26.0%	21.0%	14.2%	13.1%	22.4%
High blood pressure	50.0%	65.5%	53.3%	40.3%	29.5%	28.4%	29.0%	39.8%
HIV	33.3%	13.8%	19.1%	22.1%	39.1%	26.1%	30.8%	25.8%
Maternal and child health	16.7%	9.2%	6.7%	7.8%	8.6%	5.2%	6.5%	7.3%
Mental health (e.g. depressin, suicide)	16.7%	19.5%	19.1%	29.9%	23.8%	13.4%	15.9%	19.5%
Obesity	16.7%	41.4%	34.3%	42.9%	28.6%	30.6%	34.6%	34.5%
Pollution (e.g. air quality, garbage)	16.7%	12.6%	13.3%	10.4%	9.5%	11.9%	7.5%	11.0%
Sexual transmitted infections	16.7%	11.5%	13.3%	13.0%	30.5%	13.4%	23.4%	17.7%
Stroke	16.7%	24.1%	18.1%	11.7%	11.4%	6.7%	3.7%	12.1%
Teen pregnancy	33.3%	16.1%	20.0%	19.5%	28.6%	15.7%	24.3%	20.8%
Tobacco use	50.0%	17.2%	21.9%	23.4%	20.0%	11.2%	15.0%	17.9%
Violence or injury	16.7%	11.5%	19.1%	27.3%	20.0%	12.7%	15.0%	17.1%
Other	16.7%	2.3%	4.8%	0.0%	4.8%	8.2%	4.7%	4.7%

Table 9: Health issues faced

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=622)
Asthma	16.7%	19.3%	15.5%	21.3%	27.2%	15.9%	24.8%	20.4%
Cancer	0.0%	8.4%	6.8%	6.7%	4.9%	5.3%	6.7%	6.3%
Chronic pain	16.7%	24.1%	17.5%	20.0%	18.5%	18.2%	22.9%	19.9%
Depression or anxiety	16.7%	7.2%	15.7%	20.0%	21.4%	28.8%	30.5%	21.5%
Diabetes	16.7%	21.7%	15.5%	12.0%	7.8%	19.9%	18.1%	16.0%
Drug or alcohol abuse	0.0%	6.0%	2.9%	4.1%	10.7%	13.7%	14.3%	9.1%
Heart disease	16.7%	8.4%	8.7%	9.3%	8.7%	12.1%	7.6%	9.4%
Hepatitis C	0.0%	1.2%	3.9%	1.3%	2.9%	6.8%	5.7%	4.0%
High blood pressure	33.3%	35.4%	33.0%	20.0%	19.4%	29.8%	24.8%	27.3%
High cholesterol	16.7%	23.2%	24.3%	22.7%	8.7%	16.8%	22.9%	19.3%
HIV	0.0%	3.6%	3.9%	6.7%	3.9%	6.1%	1.9%	4.3%
Mobility impairment	0.0%	4.8%	2.9%	8.1%	10.7%	10.7%	7.6%	7.6%
Osteoporosis	0.0%	10.8%	7.8%	5.4%	5.8%	7.6%	5.7%	7.1%

Table 10: Service availability

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=622)
Accessible transportation	100.0%	90.2%	94.0%	93.1%	83.7%	89.0%	90.3%	90.0%
Affordable housing	0.0%	63.5%	40.9%	45.1%	43.2%	43.8%	55.0%	47.5%
Dental services	80.0%	72.9%	75.5%	69.1%	67.7%	70.3%	72.9%	71.5%
Healthy food	83.3%	60.9%	61.3%	55.1%	54.2%	53.5%	55.5%	56.7%
Home health care	75.0%	69.8%	56.6%	59.7%	62.6%	58.6%	65.9%	62.0%
Job training	20.0%	32.7%	26.3%	27.1%	29.7%	42.2%	42.1%	34.3%
Medical specialists	80.0%	71.6%	55.1%	63.1%	60.4%	56.3%	53.3%	59.3%
Mental health services	60.0%	50.9%	48.2%	48.2%	51.1%	57.9%	58.4%	53.3%
Pediatric and adolescent services	80.0%	65.4%	65.9%	71.7%	55.1%	65.0%	65.6%	64.5%
Places to exercise, walk, and play	100.0%	75.3%	75.5%	78.9%	49.5%	73.6%	70.9%	70.6%
Primary care medicine	100.0%	82.5%	76.3%	81.5%	61.3%	77.0%	78.6%	75.8%
Social services	66.7%	70.3%	66.3%	53.2%	55.3%	69.6%	63.0%	63.5%
Substance abuse services	60.0%	40.8%	44.3%	49.1%	47.6%	67.2%	49.4%	51.9%
Vision services	80.0%	73.1%	58.8%	66.7%	62.9%	71.5%	60.5%	65.8%

*Percentage reflects participants who responded very available or available

Table 11: Health education needed in the community

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=612)
Cancer/cancer prevention	33.3%	44.2%	45.1%	41.3%	35.6%	27.3%	29.9%	36.3%
Diabetes	33.3%	64.0%	55.9%	60.0%	48.1%	42.4%	46.7%	51.5%
Domestic violence	50.0%	26.7%	29.4%	40.0%	42.3%	33.3%	42.1%	35.8%
Exercise/physical activity	33.3%	46.5%	53.9%	42.7%	43.3%	22.7%	28.0%	38.2%
Family planning	50.0%	24.4%	32.4%	30.7%	34.6%	32.6%	38.3%	32.7%
Heart disease	33.3%	44.2%	33.3%	25.3%	20.2%	18.2%	19.6%	26.0%
HIV/sexual transmitted diseases	33.3%	22.1%	39.2%	42.7%	58.7%	34.9%	42.1%	40.0%
Maternal and child health	33.3%	11.6%	20.6%	29.3%	21.2%	10.6%	19.6%	18.3%
Mental health	16.7%	32.6%	29.4%	36.0%	43.3%	27.3%	29.0%	32.4%
Nutrition	50.0%	51.2%	46.1%	45.3%	45.2%	34.1%	42.1%	43.3%
Substance abuse	16.7%	29.1%	24.5%	36.0%	41.4%	40.2%	44.9%	36.3%
Sickle cell anemia	0.0%	14.0%	8.8%	9.3%	7.7%	8.3%	5.6%	8.7%
Vaccinations	16.7%	17.4%	14.7%	13.3%	15.4%	9.9%	11.2%	13.4%
Violenece	16.7%	23.3%	26.5%	33.3%	35.6%	29.6%	36.5%	30.7%
Other	16.7%	3.5%	7.8%	4.0%	6.7%	18.9%	11.2%	9.6%

Table 12: Source of health information

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=616)
Doctor or health care provider	83.3%	62.8%	59.1%	52.0%	48.5%	65.7%	50.5%	57.1%
Family or friends	33.3%	12.8%	27.6%	27.3%	39.8%	21.6%	28.6%	26.5%
Books	33.3%	25.6%	18.1%	23.4%	20.4%	14.2%	19.1%	19.6%
Television or radio	66.7%	15.1%	18.1%	23.4%	24.3%	14.9%	11.4%	18.0%
Newspaper or magazines	33.3%	12.8%	12.4%	13.0%	6.8%	6.7%	2.9%	8.9%
Ethnic media (e.g. ethnic newspaper, TV, radio)	33.3%	8.1%	15.2%	22.1%	14.6%	6.7%	7.6%	12.0%
Internet	33.3%	16.3%	23.8%	33.8%	32.0%	23.1%	27.6%	26.0%
Library	33.3%	4.7%	5.7%	9.1%	6.8%	1.5%	2.9%	5.0%
Community-based organization	16.7%	22.1%	21.9%	6.5%	14.6%	8.2%	10.5%	13.8%
	0.0%	8.1%	14.3%	14.3%	9.7%	8.2%	2.9%	9.3%
Faith-based organization (e.g. church, temple, synogogue, mosque)								
School	16.7%	1.2%	5.7%	9.1%	8.7%	3.7%	6.7%	5.8%
Health insurance plan	33.3%	15.1%	12.4%	15.6%	6.8%	6.0%	5.7%	9.9%
Health department	0.0%	1.2%	2.9%	5.2%	8.7%	4.5%	6.7%	4.9%
Health fairs	16.7%	14.0%	7.6%	13.0%	5.8%	1.5%	9.5%	8.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	1.5%	0.0%	0.3%

Table 13: Use of technology

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=610)
Email	66.7%	52.5%	50.0%	57.9%	54.4%	46.3%	52.3%	51.8%
Internet	83.3%	48.8%	50.0%	54.0%	53.4%	46.3%	50.5%	50.5%
Smart phone (e.g. iPhone, Galaxy)	50.0%	38.8%	51.0%	50.0%	65.1%	53.7%	59.8%	53.8%
Text messaging	83.3%	35.0%	43.3%	43.4%	61.2%	53.7%	45.8%	48.4%
Twitter	33.3%	2.5%	5.8%	13.2%	8.7%	8.2%	13.1%	8.9%
Facebook	83.3%	20.0%	26.0%	36.8%	32.0%	40.3%	33.6%	32.6%

Table 14: Civic engagement

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=611)
Community center	33.3%	37.2%	24.8%	16.0%	16.5%	11.4%	20.2%	20.5%
Library	50.0%	27.9%	27.6%	29.3%	28.2%	31.1%	34.6%	30.1%
	50.0%	22.1%	43.8%	32.0%	33.0%	34.1%	27.9%	32.7%
Faith-based organization (e.g. church, temple, synogogue, mosque)								
Neighborhood association	16.7%	11.6%	2.9%	4.0%	6.8%	6.8%	16.4%	8.2%
Gym or recreational center	33.3%	11.6%	20.0%	26.7%	28.2%	19.7%	21.2%	21.3%
Political club	16.7%	3.5%	1.0%	1.3%	2.9%	0.8%	0.0%	1.6%
Senior center	16.7%	45.4%	16.2%	9.3%	1.0%	3.8%	2.9%	12.0%
School	16.7%	11.6%	18.1%	16.0%	13.6%	9.9%	13.5%	13.6%
Sport league	16.7%	0.0%	2.9%	4.0%	1.9%	2.3%	3.9%	2.6%
Other community organization	0.0%	8.1%	8.6%	6.7%	9.7%	6.8%	14.4%	9.0%

Table 15: Use of complementary or alternative treatments/remedies

	Kingsbridge Riverdale	Northeast Bronx	Fordham Bronx Park	Pelham Throgs Neck	Crotona Tremont	High Bridge Morrisania	Hunts Point Mott Haven	Bronx (N=599)
Acupunture	0.0%	5.1%	7.8%	6.7%	4.0%	7.7%	4.8%	6.0%
Chiropractic care	0.0%	2.5%	3.9%	2.7%	0.0%	3.1%	4.8%	2.8%
Herbal medicine	0.0%	5.1%	13.6%	12.0%	13.9%	8.5%	8.6%	10.2%
Homeopathy	0.0%	1.3%	1.9%	1.3%	1.0%	1.5%	1.0%	1.3%
Remedies from a botanica	0.0%	3.8%	3.9%	1.3%	5.9%	1.5%	0.0%	2.7%
Other	0.0%	2.5%	7.8%	8.0%	3.0%	0.0%	2.9%	3.7%