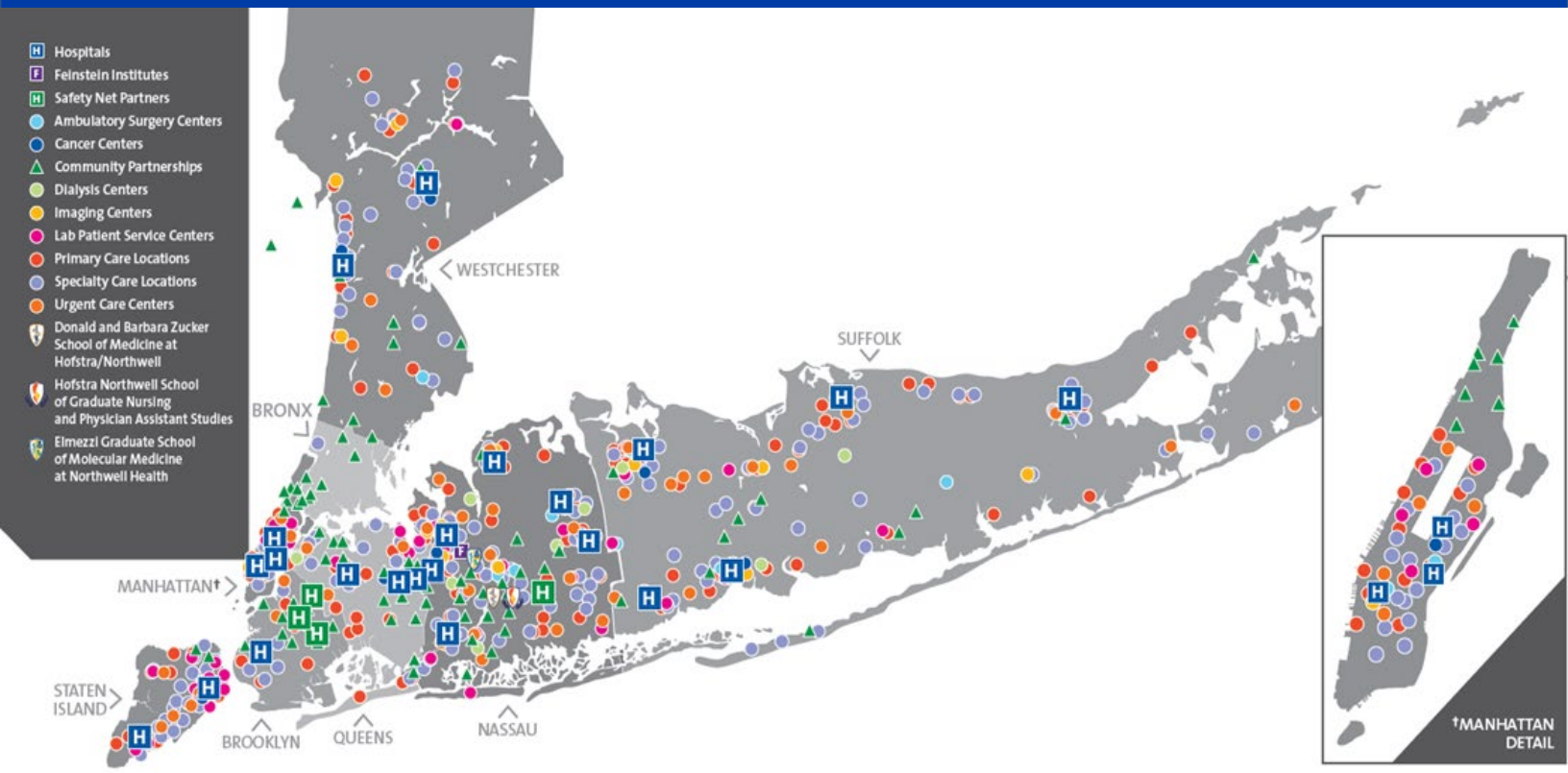
Northwell Health

Community Health Needs Assessment 2022 – 2024

Queens County

Encompasses the following Northwell Health Hospitals:
Cohen's Children Medical Center, LIJ Medical Center, and LIJ Forest Hills



Northwell Health®

About Northwell Health

Northwell Health is New York State's largest healthcare provider that cares for over two million people annually in the New York metropolitan region. Northwell operates 21 hospitals across 13 campuses, 830 outpatient facilities and has more than 16,600 affiliated physicians on its medical staff, 4,200+ of which are members of Northwell's multi-specialty physician's group. Northwell is also home to the Feinstein Institutes for Medical Research, and we train the next generation of medical professionals at the innovative Zucker School of Medicine at Hofstra/Northwell, and the Hofstra Northwell School of Nursing and Physician Assistant Studies.

Northwell has a long-standing commitment to providing exceptional care and investing in our most vulnerable and underrepresented communities. We have developed an extensive network of community partnerships to impact the health and well-being of the diverse communities we serve.

Our goal is to measurably improve health and wellness in the communities we serve and to provide the highest quality of care for all regardless of race, ethnicity, cultural background, language proficiency, literacy, age, gender, gender identity, sexual orientation, religion, disability, geographic location, or socioeconomic status. Northwell's integrated community and population health strategy includes data-driven approaches to screening for and addressing non-medical factors (social determinants of health). In doing so, our purpose is to empower the communities we serve to eliminate disparities and create sustainable change. This work is aligned with the Surgeon General's National Prevention strategy, and we believe is fundamental to delivering the highest quality of care to all.

The following section details the efforts of our needs assessment process for the CHNA 2022-2024 cycle. Northwell conducted both primary and secondary analysis efforts and actively engaged in efforts to listen to our communities, so as to better understand and identify their significant health needs. This report was prepared to better inform our leaders, partners, and stakeholders across the communities we serve on our approach to identify the significant health needs of our communities and alignment with the New York State Prevention Agenda Priority and Focus Areas.

Northwell Health is committed to serving our vulnerable populations to improve our communities and meet the New York State Prevention Agenda Objectives.

Northwell Health Community Health Needs Assessment 2022 - 2024

Methodology and Analysis

The purpose of the CHNA is to understand the significant health needs and priorities of those who live, play and work in the communities we serve. The Northwell Health CHNA Steering Committee began the needs assessment process for the CHNA 2022-2024 cycle in February of 2022. Out process was guided by the framework we adapted from the American Hospital Association's Community Health Improvement, Health Needs Assessment Toolkit.

Our assessment incorporated information through both primary and secondary sources. Primary analysis efforts consisted of a series of focus groups conducted with 80 community leaders across our service area. In partnership with the Greater New York Hospital Association, we also designed and implemented a health survey which was released to our community members, patients, and families through various points of care across our health system.

A secondary analysis was also collected to understand the demographics and health outcomes of each of the counties that make up our service area. The type of data that was collected and analyzed were measures of incidence, prevalence, rates of hospitalizations mortality, trends in health behaviors, the use and access of healthcare resources, and other relevant social determinants of health factor, all of which contributed to the identification of significant health needs of the communities we serve and Northwell's alignment with the NYSDOH Prevention Agenda.

The sources utilized for the secondary analysis of the CHNA are publicly available. A brief list of the resources are as follows:

- NYSDOH Community Health Indicator Reporting System (NYS CHIRS),
- NYSDOH Prevention Agenda (NYSDOHPA)
- NYSDOH Perinatal Data Profile
- NYSDOH Statewide Planning and Research Cooperative System (SPARCS)
- NYSDOH Leading Causes of Death
- CDC/NVSS Life Expectancy Tables
- NYSDOH Cancer Registry
- CDC/ATSDR Social Vulnerability Index (SVI)

- County Health Rankings & Roadmaps
- US Census / American Community Survey
- NY DCJS Criminal Justice Statistics

Throughout the Needs Assessment process, special attention was given to vulnerable communities. This report synthesizes our efforts and our findings that inform the significant health needs we identified and prioritized in alignment with the New York State Prevention Agenda. Our prioritization and related efforts to address these health needs based on the findings in this appendix are documented in other aspects of our CHNA Report, namely the Northwell Health 2022-2024 Community Health Needs Assessment Summary Report, our Northwell Health Community Service Plans for each of our hospitals, and our Northwell Health 2022-2024 Community Health Needs Assessment Implementation Plan.

Northwell CHNA 2022-2024
Primary Analysis

CHNA 2022 – 2024 Focus Group Discussions

In the Spring of 2022, the Northwell CHNA Steering Committee conducted a series of focus group discussions (FGDs) to gain a better understanding of what the most significant health needs are for the service area. A total of six FGDs were conducted with a total of 80 community leaders across our service area. This research was designed to produce primary data to inform the Community Health Needs Assessment (CHNA) process and subsequent implementation plans for each Northwell hospital.

Methodology

The FGDs were conducted following a scripted, semi-structured discussion guide. One FGD was held for five of our six county service area: Queens, Nassau, Suffolk, New York, and Richmond. The FGDs were held both in-person and virtually through the use of a Zoom platform. Each FGD lasted for approximately 90 minutes, and two members of Northwell's CHNA Steering Committee served as the primary facilitators for each FGD. For Westchester County, we convened two in-person "listening tours" at Northern Westchester Hospital. The listening tours were similar to a series of key-informant interviews with community leaders. The questions asked and information gathered about community health needs during the listening tour with community leaders in Westchester County, were similar to those of the FGDs with community leaders in the remaining five counties.

Participants were recruited through snowball sampling. For each FGD, one or two initial 'seed' participants who are community leaders within each county were identified. These participants then identified *additional* participants within their network who are also community leaders in the service area. This part of the sampling process was repeated until the desired range of 9-12 participants per group was achieved for most of the FGDs.

The criteria for participation in the FGD were:

- Age 18 or older
- Identified as a 'community leader' within the county
- Willing to participate in an audio (for in-person sessions) or video (for virtual sessions) recorded focus group discussion.

In order to hear a range of perspectives, the Northwell CHNA Steering Committee strove to include participants from a diverse cross-section of professional and demographic groups. Community participation and input through the FGDs were drawn from all sectors serving our communities. These included:

- Leaders of various community-based organizations
- Leaders from faith-based organizations
- County public health department officials and other public health leaders
- Federally Qualified Health Centers (serving low income and medically underserved populations)
- School-system administrative leadership (i.e.: superintendents)
- Community activists
- Law Enforcement Officials
- Business Leaders

Following a round of introductions, the Northwell CHNA Steering Committee led each discussion with the following open question:

"What do you see as the most pressing health concerns of the communities you serve?"

Each FGD was video- or audio-recorded and transcribed by a professional transcription service for accuracy. The transcript was then uploaded to a web-based data management and analysis software program called Dedoose, to facilitate analysis by the research team.

In order to analyze the transcript and its data systematically, we developed a comprehensive and thematic "codebook" of 54 items. The codes were drawn from the New York State Prevention Agenda Priority Areas followed by a grounded theory approach to generate additional codes based on the discussion itself.

The integrity of the data analysis was ensured in the following ways:

- Use of trained qualitative researchers
- Double-coding of each transcript
- Convening to discuss coding experiences and arrive to consensus of code applications.

To improve coding consistency, two team members blind coded the transcripts without conferring with their partner until their coding process was completed. The coding team for each transcript convened and resolved any discrepancies to produce a final version of the codebook for application and interpretation of the transcript. Consensus was reached by referring back to codebook.

Focus Group Considerations

We conducted one focus group discussion in each county of our service area. Taken together, these discussions revealed numerous thematic convergences across our highly diverse service area. Additionally, participants in each county FGD raised concerns that were heightened for, or specific to, their county. We intentionally recruited participants who worked in various sectors and were socio-demographically diverse. However, the information obtained was necessarily limited by the knowledge and opinion of the participants. Several participants served primarily poor or homeless clients. This may explain, in part, why the negative SDOH affecting poor communities were discussed extensively, including food insecurity, housing insecurity, and lack of transportation. Conducting more focus groups, perhaps with participants from the same neighborhoods, could have produced a broader and more nuanced understanding of the health needs of the diverse communities of Nassau County.

CHNA 2022 – 2024 Focus Group Discussions

Queens County

In the Spring of 2022, the Northwell CHNA Steering Committee conducted a series of focus group discussions (FGDs) to gain a better understanding of what the most significant health needs are for the service area. A total of six FGDs were conducted with a total of 80 community leaders across our service area. This research was designed to produce primary data to inform the Community Health Needs Assessment (CHNA) process and subsequent implementation plans for each Northwell hospital.

Findings

Major keywords identified from participant feedback

Worsening mental health & substance use

The most prominent theme to emerge from the FGDs was the urgent need to address worsening mental health in recent years. Several participants acknowledged that they raised mental health concerns in their communities for several years. However, there was consensus that the stress and social isolation of the COVID-19 pandemic rapidly accelerated these negative mental health trends. The FGD participants were particularly concerned about worsening mental health crises among children and adolescents. Several specified that cases were not being identified early enough, leading to more serious consequences. FGD participants also emphasized that they were seeing acute crises in children at a younger age than they ever had before the pandemic.

The FGDs participants also stressed that current resources within their communities were inadequate to meet the mental health needs of those they serve. Mental health resources were insufficient for not just the youth, but also for other vulnerable populations such as members of immigrant communities and backgrounds with limited English proficiency.

Community leaders also perceived an increased addiction to drugs and alcohol within their communities, largely exacerbated by the pandemic. While the participants identified alcohol and drug use as a problem, they also addressed the stigma of alcohol and substance use as being a factor that reduces access to healthcare resources by community members.

Disruptions to care for chronic conditions

In addition to the harm from COVID-19 itself, participants noted that preventative care and regular vaccinations fell off during the pandemic and have yet to fully rebound. Ongoing relationships with providers were disrupted as a result of the pandemic which disproportionately affected communities of color that have been burdened by chronic illnesses such as diabetes. Disruptions to routine visits to pediatricians, vaccinations, and connections to schools also particularly affected children.

Poverty is a driver of poor health

Participants—several of whom work with low-income clients—named poverty as a fundamental cause for poor health and health inequities. Community leaders drew connections between a constellation of unmet social needs and their negative community health consequences. In particular, they named housing insecurity, food insecurity, financial instability, and lack of transportation as persistent barriers to wellbeing, especially among individuals who struggle to get by on low incomes. All of these adverse social determinants of health were linked to poverty.

Significant need for access to healthy & nutritious food

Participants acknowledged that food insecurity has been widespread and worsening within their communities. With inflation and rising food prices, the demand for food assistance has considerably increased within the service area.

Housing

Lack of adequate housing and homelessness was repeatedly raised as an unmet health related social need within the series of FGDs. The challenges of substandard housing or severe housing problems, such as overcrowding, unaffordability, inadequate basic utilities such as cooking gas for extended periods of time, paired with rising costs, all worsened health conditions.

Transportation

The lack of transportation also came up as a common factor contributing to poor health and worsening access issues. Participants acknowledged that access to health services and healthy & nutritious foods were even more difficult to achieve due to poor public transportation infrastructure. Affordability challenges for car ownership or cab fares, paired with poor public transportation networks made it difficult to find adequate treatment and social services.

Undocumented communities

In addition to challenges faced generally by low-income communities, participants shared that individuals and families who were undocumented had a particularly hard time of obtaining health care and getting other basic needs met. This was largely due to a lack of necessary documentation such as medical insurance cards, work permits, or drivers' licenses. Many undocumented immigrants were also afraid to reach out and ask for health insurance because they were concerned it would affect their ability to remain in the country.

Technological challenges

The COVID-19 pandemic accelerated a trend towards telehealth visits for certain non-urgent care. In theory, conducting visits remotely via telehealth platforms could solve for lack of transportation to visits. However, participants raised concerns that poor digital literacy and lack of technological resources could also contribute to health inequities.

The following section highlights relevant quotations from our participants. The feedback is color-coded to reflect themes identified in alignment with the New York State Prevention Agenda Priority Areas.

Queens County
Focus Group Participant Feedback

"The pandemic actually exposed more than anything the harms that was going on in communities already. We were suffering from poverty, lack of resources, education, and affordable housing. This pandemic has kind of blew the lid because a lot of us who would work in this space, have been working on these issues prior to the pandemic. But what it has exposed is how great inequities are existing in this city particularly in the last two years. And so now the communities must confront it in a more direct way prior to the pandemic."

"I think our health institutions need more resources. I think the staff in our facilities need more training or more supportive services. I don't see enough happening to keep our staff in these hospitals or medical centers. They're jaded and overwhelmed, as well, with the pandemic. We could use more resources for the staff so that they can be effective at their job. This can increase the high demands to address mental health services."

"In Southeast Queens, particularly, we have a high concentration of pre-diabetic cases, individuals dealing with that, especially dealing with lack of quality foods in this areas. Also, we need to put more attention to hypertension in black and brown communities as it is ravaging our communities."

- Promote Well-Being and Prevent Mental and Substance Use Disorders
- Promote Healthy Women, Infants, and Children
- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Prevent Communicable Diseases
- Address Unmet Health Related Social Needs

CHNA 2022 – 2024 Community Health Survey

In collaboration with the Greater New York Hospital Association (GNYHA) and its member hospitals across the New York Metropolitan region, Northwell Health participated in the 2022 Community Health Survey. The purpose of the survey was to learn from members of the community about the health issues that are important to them in order to improve the health services that are available in their neighborhoods.

Methodology

Recruitment

The Community Health Survey was open to community participation between April 11th—June 30th, 2022. Inviting community members to participate in the survey was a collective effort undertaken by GNYHA members. At Northwell, we took a multi-pronged approach to seek participation among community members across our service area:

- **Patient Experience:** We emailed a participation request and the Community Health Survey link to all 48,000+ Northwell patients who completed our Press-Ganey Patient Experience survey from January 1st, 2022 through June 30th 2022.
- **Go Health:** We texted a participation request with the survey link to all 17,000+ patients seen in our network of Go Health urgent care practices during the survey period.
- **Innovare Kiosks:** We created an advertisement requesting participation with a QR code linking to the survey. The advertisement ran several times daily during the survey period on the 33 Innovare advertising and phone-charging kiosks located throughout the health system.
- **CBO Partnerships:** We reached out to over 180 community leaders with whom we partner to request that they distribute the survey to the communities they serve in our service area. They included leaders of community-based organizations, faith-based organizations, schools, and businesses, among others.
- **Community Events:** We distributed quarter-sheet flyers requesting participation with a QR code link to the survey at community events held by the OCPH during the survey period. These events included a health career fair, cancer screenings, food distributions, among others.
- **Website:** We posted a link to the survey on our public-facing Northwell Health website for the duration of the survey period.

Eligibility

Any community member living in our six-county hospital service area age 18 or older was eligible to participate. Respondents were asked to report their zip code on the survey. No personally identifying information (e.g., names, addresses, phone numbers, or email) were collected.

Sampling

The 2022 GNYHA CHNA Survey used a non-probability convenience sample. A web-based survey tool and a paper-based tools were used to collect the survey data. Participants who completed the survey online could use any Internet-enabled device. Surveys were available in the 11 most widely spoken languages in the New York Metropolitan area: English, Spanish, Chinese, Russian, Yiddish, Bengali, Korean, Haitian Creole, Italian, Arabic, and Polish. All data collected were self-reported by respondents.

Analysis

Initial summary data analysis was completed by GNYHA. Northwell conducted sub-analyses at the county level and for certain neighborhoods within our service area, in collaboration with GNYHA, in order to gain finer insight into the needs of our diverse communities.

Survey Considerations

The survey used a non-probability convenience strategy to recruit participants. Anyone who was 18+ years of age and lived within the survey area was eligible to participate. As a result, respondents differed from the general population in certain characteristics.

Among those who provided their demographic data, respondents were older, more female, predominantly white, more highly educated, and wealthier (households that made more than $100,000 last year), than the average for the six-county service area. The survey respondents' demographics should be kept in mind when interpreting these findings.

CHNA 2022 – 2024 Community Health Survey

Survey Findings

The information below reflects the survey findings of all respondents within our six-county service area:

Respondent Demographics

- A total of 11,647 qualified respondents who were ages 18+ and lived within our six-county service area participated in the survey.
- Older individuals made up the majority of respondents. 85% (n=5,423) of respondents who reported their ages were 45 or older. However, 45% (n=5,299) of respondents did not report their age.
- The majority (67%) of respondents who reported their gender were women. 34% of respondents (n=3,943) did not indicate their gender or preferred not to say.
- Most (71%) respondents who reported their race/ethnicity indicated that they were White and non-Hispanic. 34% of respondents (n=3,909) did not indicate their race/ethnicity at all.
- College graduates comprised 67% of the respondents who chose to indicate the highest level of school they had completed.
- 44% (n=2,937) of those who specified their household income in the last year indicated that it was $100,000 or more. 44% of all respondents did not respond to the income question. 47% (n=3,626) of those who indicated their current employment status were retired; 31% (n=2,347) were employed full-time for wages or salary.

The survey asked respondents to consider 21 different health issues and indicate how important each issue was to them on a five-point scale, ranging from 'Not at all' to 'Extremely'. Respondents were also asked to indicate how satisfied they were with the current services in their neighborhood to address each of the 21 health issues. Issues that were above average for respondents in terms of importance, yet below average in terms of respondents' satisfaction with current services to address the issue were designated as "Needs Attention". Based on the survey responses (issues ranked as above average importance but below average satisfaction), the following three conditions were determined to be needing attention for the six-county service area:

1. Violence (including gun violence)
2. Stopping falls among the elderly
3. Mental health/depression

The top 10 most important issues for respondents were as follows:

- Dental care
- Violence (including gun violence)

- Cancer
- COVID-19
- Heart disease
- Access to healthy/nutritious foods
- High blood pressure
- Stopping falls among elderly
- Mental health/depression
- Arthritis/disease of the joints

Respondents were also asked to indicate whether or not in the last 12 months they had experienced any of a series of SDOH-related issues. 49% (n=3,940) of those who answered the question said that their household expenses had increased. 39% (n=3,161) had experienced anxiety or depression. 29% (n=2,362) said that their medical expenses had increased.

Survey Findings for Queens County

The following section details the summary of findings for respondents from Queens County. This is followed by a detailed analysis of responding feedback.

Summary: Survey respondents for Queens County were mainly white and female. Approximately 44% of respondents were 65 years or older, and a quarter of them (26%) had a household income of $100,000 or more. Over half of the respondents had a college degree or higher and almost half of them were retired. Nearly half of the respondents indicated experiencing financial challenges with rising expenses to meet basic needs (i.e.: households, rent/mortgage, medical bills). Survey respondents also reported challenges accessing medical care when needed, largely due to the lack of timely appointments available. The top health concerns identified as being important to respondents but with inadequate resources to address them were related to violence, including gun violence, falls among the elderly, worsening mental health and women's and maternal health care

Demographics

- **Language:** Approximately 14% of survey respondents spoke a primary language at home other than English; The non-English language primarily spoken at home the most among the survey respondents was Spanish
- **Race/Ethnicity:** Survey respondents from this county were mostly White (46%). The proportion of survey respondents that were non-White were Black (19%), Hispanic (18%), AAPI (11%) with 6% as Other.
- **SOGI:** Survey respondents from the county mainly identified as female (68%); 86% of respondents identified as Straight, 3% identified as gay, lesbian or bisexual, and 9% preferred not to say.
- **Age:** Survey respondents skewed toward older age groups with over 44% aged 65 or older, followed by 35% in the 45-65 age range.

- **Insurance Coverage:** Survey respondents were primarily insured by Medicare (40%); 37% were commercially insured.
- **Education and Income:** Survey respondents of the county skewed towards highly educated with 54% having a college degree or higher; 26% of the survey respondents had a household income greater than or equal to $100,000.
- **Employment Status:** Nearly half of survey respondents were retired (44%), and 31% of respondents were employed full time; approximately 5% of survey respondents were unemployed at the time they took the survey

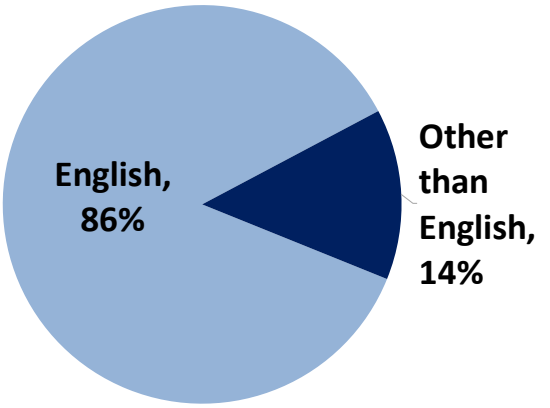
Health Status & Needs Identified:

- **Overall Health of Neighborhood:** Approximately 19% of survey respondents identified the overall health of their neighborhood as very good or excellent.
- **Physical Health:** 26.4% of survey respondents identified their physical health as being 'Fair' or 'Poor'
- **Mental Health:** Over 15% of survey respondents identified their physical health as being 'Fair' or 'Poor'
- **Health-Related Social Needs:** 48.9% of survey respondents indicated they experienced an increase in their household expenses within the last year; 11.5% indicated difficulties in paying their rent or mortgage. Similarly, 27.5% indicated experiencing higher medical expenses in the last year. Additionally, 37.6% respondents indicated experiencing anxiety or depression.
- **COVID-19 Needs:** Half of survey respondents identified the need for at-home COVID-19 tests (54.2%) and access to boosters for COVID-19 (43.3%). Over 40% of survey respondents also identified the need for reliable sources of information on COVID-19.
- **Access to Care:** Approximately 17% of survey respondents in the county indicated they were unable to access medical care in-person when they needed it. The top reason identified was that 'There were no available appointments, or I couldn't get an appointment soon enough'. Additionally, 7% of the respondents indicated they were unable to get medical care virtually (video or phone), the primary reason being 'There were no available appointments, or I couldn't get an appointment'
- **Health Needs Identified:** The three main health needs that survey respondents ranked as having the highest importance but the lowest satisfaction of services within their neighborhood were related to 1) violence (including gun violence), 2) stopping falls among the elderly, 3) mental health and depression and 4) women's and maternal health care.

Queens County

Survey Respondent Demographics
Total Qualified Respondents: 2,209

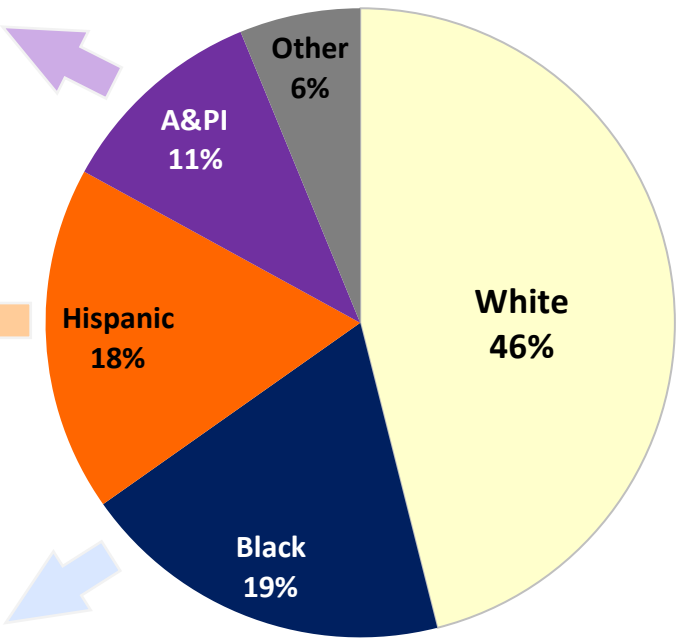
Primary language you speak at home



No response: 724

Primary Language	Respondents #	%
Spanish	99	6.7%
Bengali	15	1.0%
Mandarin	10	0.7%
Haitian Creole	9	0.6%
Cantonese	6	0.4%
Korean	5	0.3%
Arabic	3	0.2%
Yiddish	2	0.1%
Italian	2	0.1%
Russian	1	0.1%
Other	54	3.6%

Race & Ethnicity



No response: 711

Asian Heritage or Ancestry	Respondents #	%
Asian Indian	59	36%
Chinese	56	34%
Filipino	19	12%
Korean	6	4%
Japanese	4	2%
Other	20	12%

No response: 6

Hispanic/LatinX Origin or Ancestry	Respondents #	%
Puerto Rican	83	32%
Dominican	40	15%
Other Central American	30	12%
Ecuadorian	28	11%
Colombian	25	10%
Other South American	21	8%
Mexican	15	6%
Cuban	4	2%
Other	14	5%

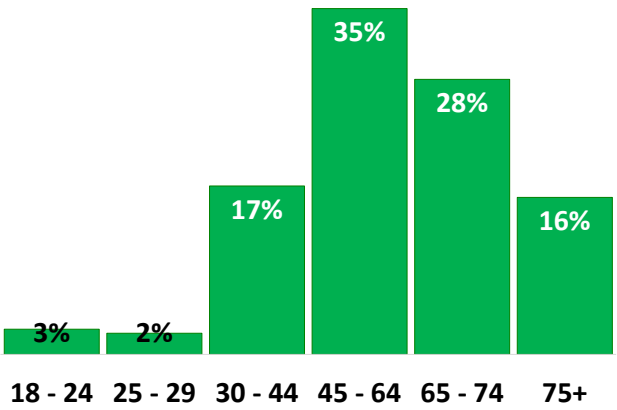
No response: 6

Heritage or Ancestry in addition to being Black	Respondents #	%
African American	170	54%
Caribbean or West Indian	129	41%
A recent immigrant or the child of recent immigrants from Africa	170	36%

Queens County

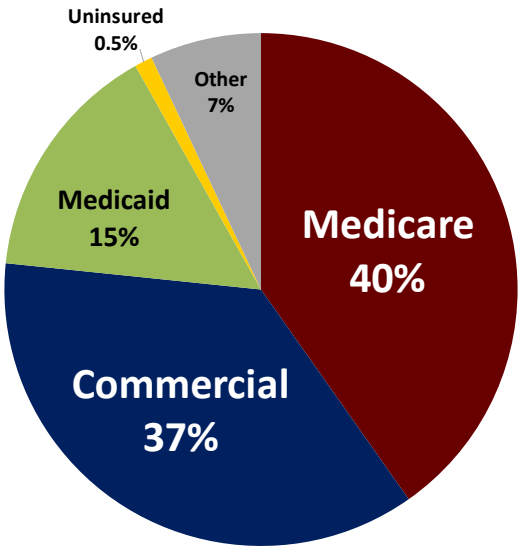
Survey Respondent Demographics
Total Qualified Respondents: 2,209

Age



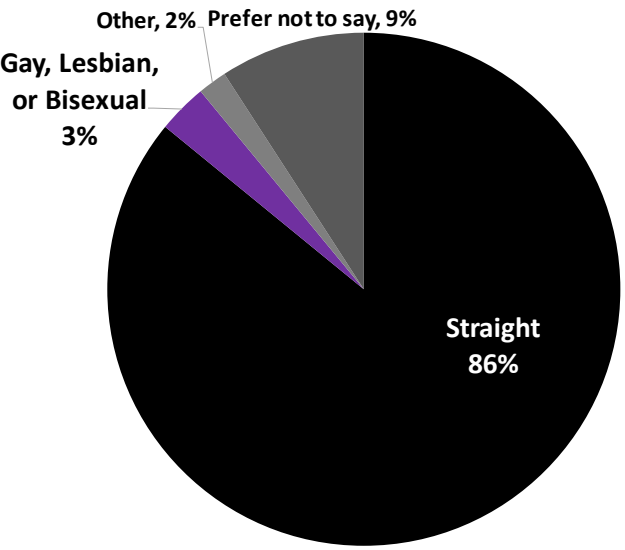
No response: 989

Insurance Coverage



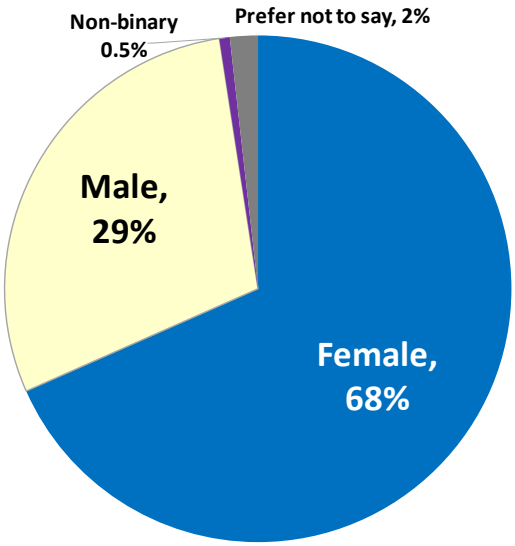
No response: 698

Sexual Orientation



No response: 733

Gender Identity

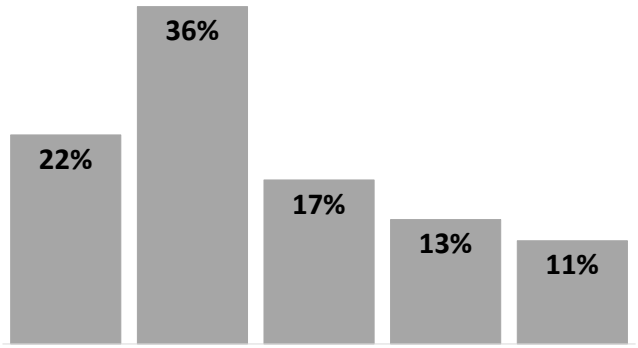


No response: 694

Queens County

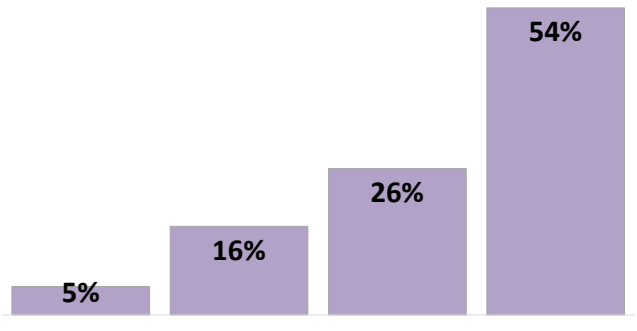
Survey Respondent Demographics
Total Qualified Respondents: 2,209

Housing



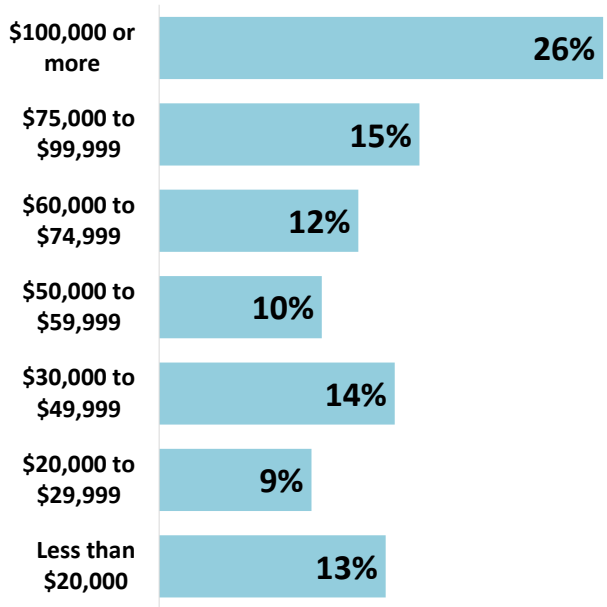
No response: 791

Education



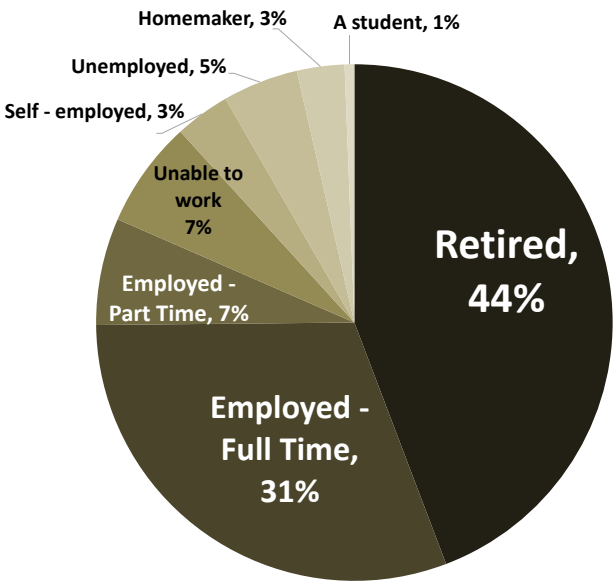
No response: 728

Household Income



No response: 918

Employment Status



No response: 730

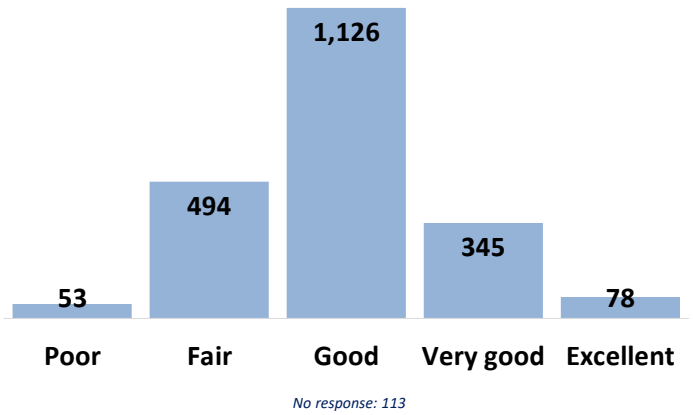
Queens County

Survey Results

Total Qualified Respondents: 2,209

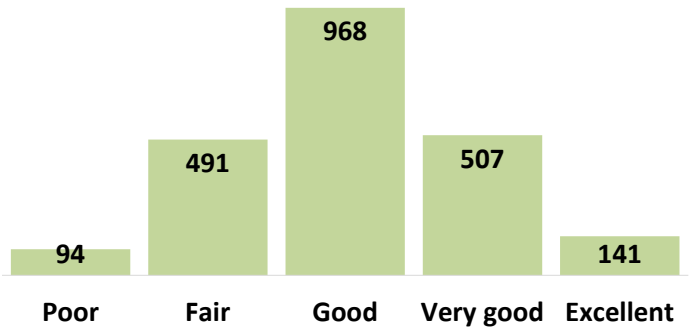
In general, how is your …

…overall health?



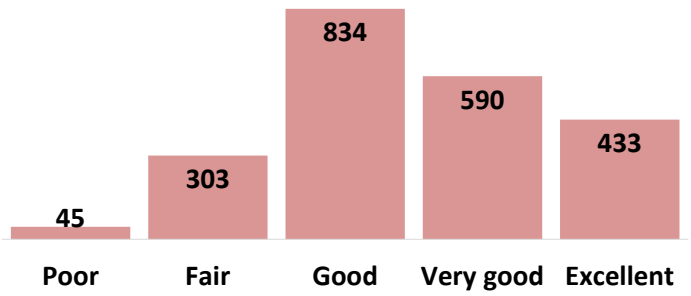
No response: 113

…physical health?



No response: 8

…mental health?



No response: 4

Queens County

Survey Results

Total Qualified Respondents: 2,209

What are your COVID-19 needs?*

Responses	#	%
At-home COVID-19 tests	867	54.2%
Personal protective equipment (e.g., masks, hand sanitizer, face shields, gloves)	722	45.2%
Boosters for COVID-19	693	43.3%
Reliable source(s) of information on COVID-19	653	40.8%
In-person testing for COVID-19 (e.g., doctor's office, pharmacy, mobile van)	642	40.2%
Treatment for COVID-19	535	33.5%
COVID-19 vaccination	447	28.0%

No response: 610

In the last 12 months, have you experienced any of the following?*

Responses	#	%
Increased household expenses	762	48.9%
Anxiety or depression	586	37.6%
Increased medical expenses	397	25.5%
Difficulty paying utilities or other monthly bills	236	15.1%
Difficulty paying your rent/mortgage	180	11.5%
Hunger or skipped meals because you did not have enough money to buy food	83	5.3%
None of the above	446	28.6%

No response: 650

Note: * indicates multi-select questions with non-exclusive responses, therefore percentages may not add up to 100%

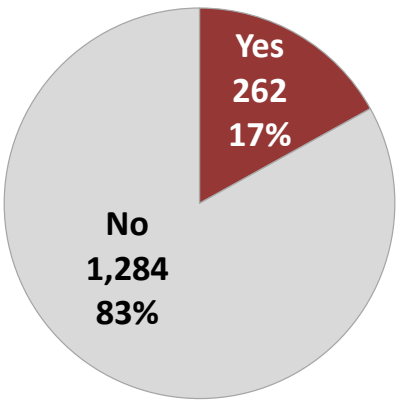
Prepared by the Office of Strategic Planning at Northwell Health/jc

Queens County

Survey Results

Total Qualified Respondents: 2,209

In the last 12 months, was there a time when you needed medical care in-person but did not get it?



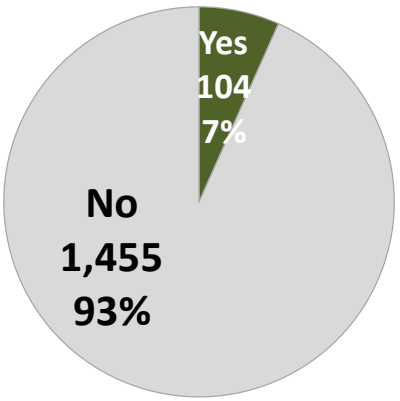
No response: 663

For which of the following reasons could not get medical care in-person the last 12 months?*

Responses	#	%
There were no available appointments, or I couldn't get an appointment soon enough	136	52.5%
I could not get through on the telephone to make the appointment	69	26.6%
Because of COVID-19	67	25.9%
I could not afford the cost of care (e.g., copay, deductible)	41	15.8%
Once I got there the wait was too long to see the doctor	38	14.7%
I did not have transportation	36	13.9%
I did not have health insurance	19	7.3%
I did not have childcare	16	6.2%
Other	47	18.1%
None of the above	23	8.9%

No response: 3

In the last 12 months, was there a time when you needed medical care by video or phone but could not get it?



No response: 650

For which of the following reasons could not get medical care by video or phone in the last 12 months?*

Responses	#	%
There were no available appointments, or I couldn't get an appointment	42	41.6%
I could not get through on the telephone to make the appointment	27	26.7%
I did not know how to see the doctor by video or phone	15	14.9%
I could not afford the cost of care (e.g., copay, deductible)	10	9.9%
I did not have a computer, phone, or other device to use for the visit	9	8.9%
I did not have internet	6	5.9%
I did not have a private place to have my appointment	6	5.9%
I did not have health insurance	3	3.0%
I did not have data or minutes in my phone plan to use for a visit	3	3.0%
Other	15	14.9%
None of the above	12	11.9%

No response: 3

Note: * indicates multi-select questions with non-exclusive responses, therefore percentages may not add up to 100%

Prepared by the Office of Strategic Planning at Northwell Health/jc

Queens County

Survey Results

Importance and Satisfaction Ratings

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	1	4.55	Above Average	21	2.58	Below Average
Stopping falls among elderly	8	4.23	Above Average	13	2.99	Below Average
Mental health/depression	9	4.17	Above Average	18	2.80	Below Average
Women's and maternal health care	12	4.03	Above Average	12	3.05	Below Average
Maintain Efforts						
COVID-19	2	4.40	Above Average	1	3.54	Above Average
Dental care	3	4.39	Above Average	3	3.33	Above Average
Cancer	4	4.37	Above Average	9	3.13	Above Average
Heart disease	5	4.35	Above Average	5	3.29	Above Average
Access to healthy/nutritious foods	6	4.27	Above Average	4	3.33	Above Average
High blood pressure	7	4.27	Above Average	2	3.36	Above Average
Diabetes/elevated sugar in the blood	10	4.08	Above Average	7	3.19	Above Average
Arthritis/disease of the joints	11	4.07	Above Average	11	3.07	Above Average
Relatively Lower Priority						
Obesity in children and adults	15	3.94	Below Average	17	2.81	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	16	3.76	Below Average	20	2.69	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	18	3.55	Below Average	19	2.73	Below Average
Hepatitis C/liver disease	19	3.45	Below Average	14	2.99	Below Average
Sexually Transmitted Infections (STIs)	20	3.30	Below Average	16	2.86	Below Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	21	3.27	Below Average	15	2.94	Below Average
Asthma/breathing problems or lung disease	13	3.95	Below Average	10	3.09	Above Average
Adolescent and child health	14	3.95	Below Average	8	3.17	Above Average
Infant health	17	3.76	Below Average	6	3.21	Above Average

*How important is this issue to you?

**How satisfied are you with current services in your neighborhood?

^Rated on a 5-point scale from 1="Not at all" to 5="Extremely"

Northwell CHNA 2022-2024
Secondary Analysis

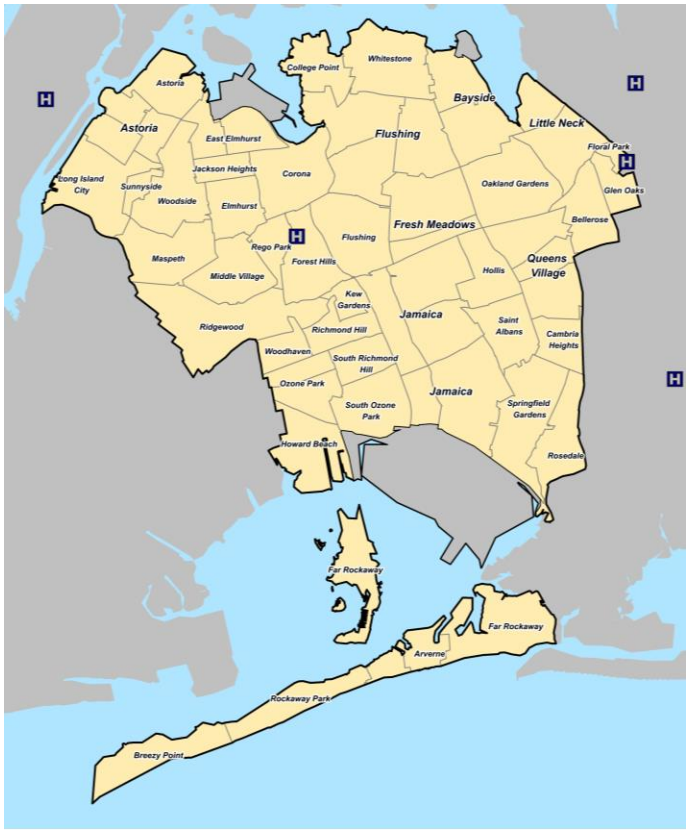
Sociodemographics

Population

Queens	NYS
2,270,976	19,514,849

10 Year Population Change

Queens	NYS
3.3%	**1.5%**



Overall County Health Ranking	Quality of Life Ranking	Length of Life Ranking
12	**40**	**8**

Sociodemographics

Life Expectancy

81.5

years

Birth Rate

11.8

Birth rate per 1,000 population

Mortality Rate

512.7

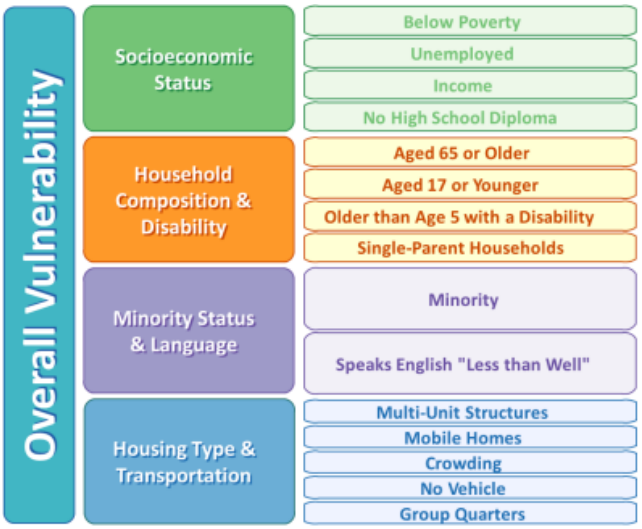
Age-adjusted total mortality rate per 100,000

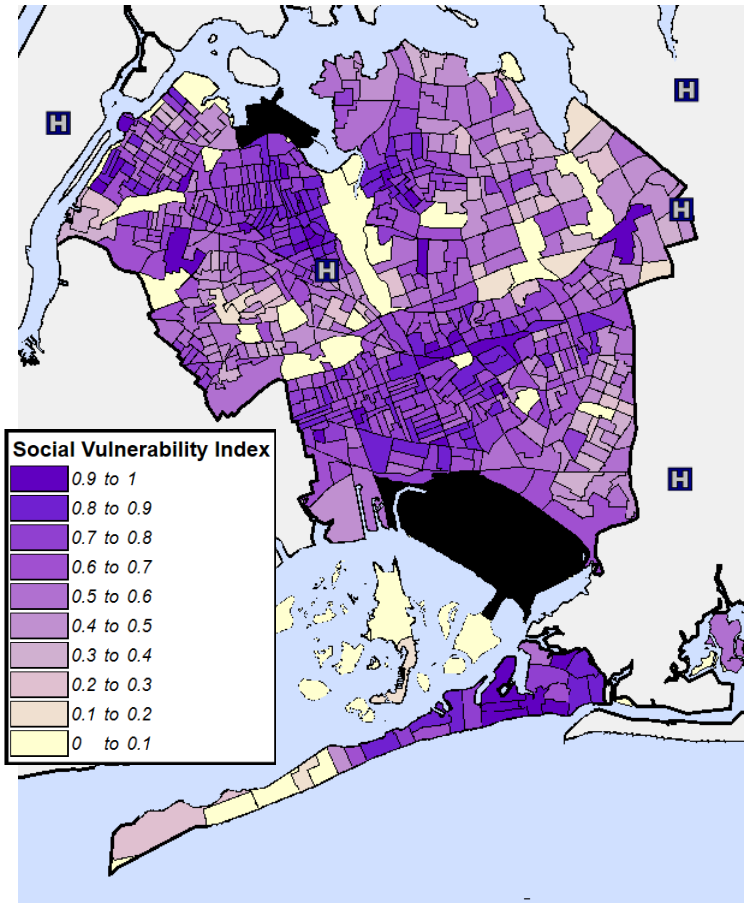
Top Five Leading Causes of Death

	Condition	Incidence *Per 100,000 population*	Case Count
1	Heart Disease	171.3	5,010
2	Cancer	112.9	3,201
3	Unintentional Injury	22.9	577
4	Cerebrovascular Disease	20.2	577
5	CLRD	16.3	462

Sociodemographics

CDC's Social Vulnerability Index



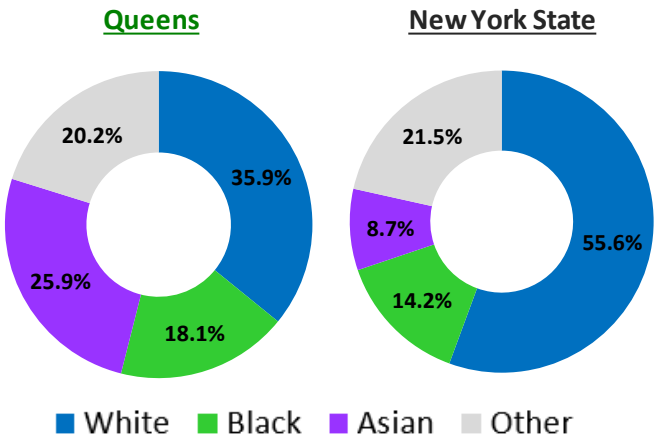


The CDC's purpose in designing the Social Vulnerability Index (SVI) was to provide specific socially and spatially relevant information to help public health officials and local planners, better prepare communities to respond to emergency events such as severe weather, floods, disease outbreaks and chemical exposure.

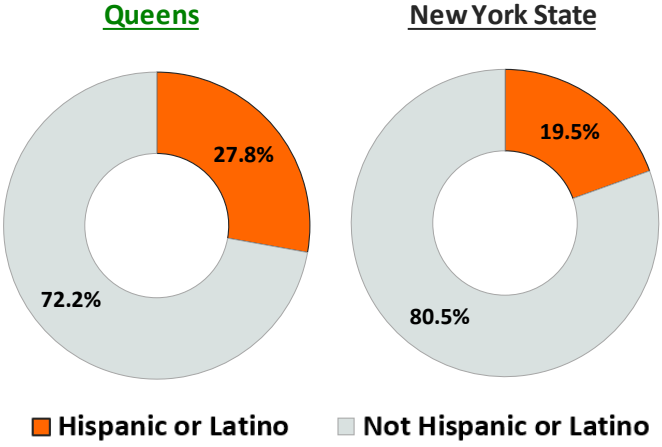
The SVI identifies relative vulnerability of every U.S. Census tract and ranks census tracts on 15 social factors, including unemployment, minority status, and disability. It groups these measures into four related themes, as well as an overall ranking. Centers for Disease Control and Prevention (CDC). Agency for Toxic Substances and Disease Registry (ATSDR). CDC/ATSDR Social Vulnerability Index

Sociodemographics

Race

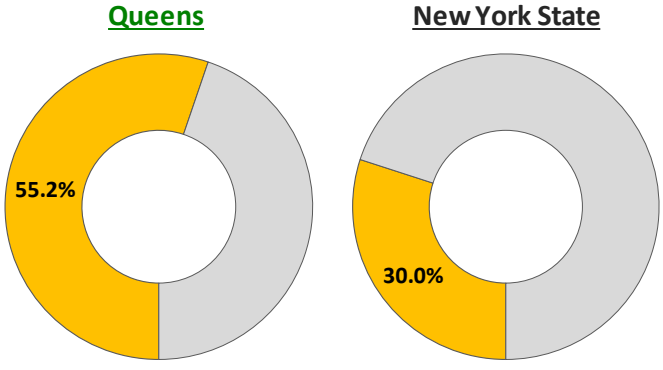


Ethnicity

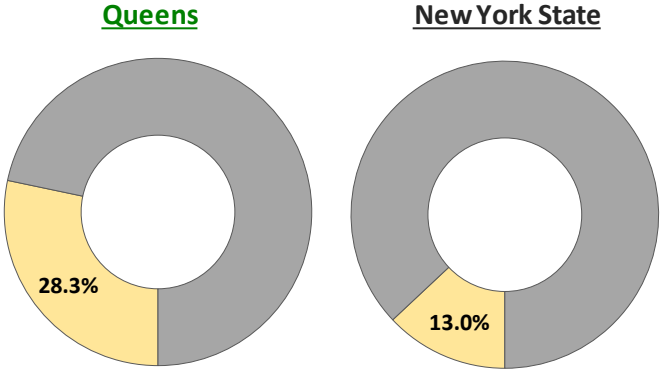


Language

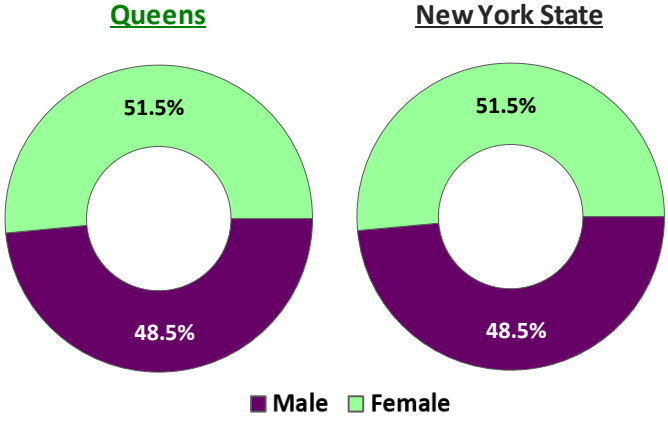
Languages Spoken at Home Other than English



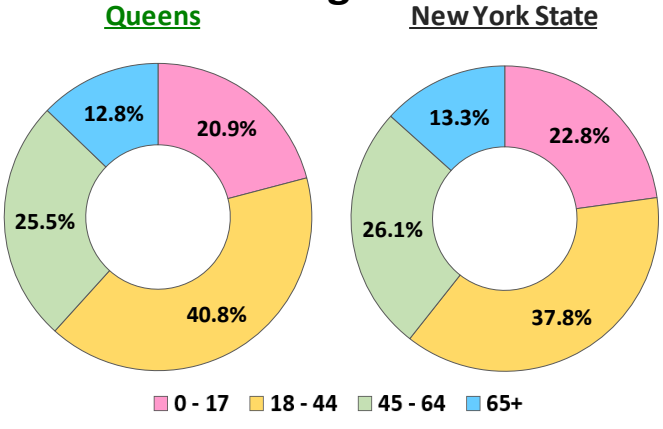
Speaks English less than "very well"



Gender



Age



Sociodemographics

Income

Queens		New York State
$72,975	Annual median household income in US dollars	$72,038

Unemployment

Queens		New York State
3.5%	Percentage of labor force unemployed	4.0%

Veteran Status

Queens		New York State
2.2%	Population that are Veterans	3.9%

Medicaid Insured

Queens		New York State
29.4%	Population receiving Medicaid	25.7%

Disability Status

9.7%	Population with a disability	12.0%

Uninsured

8.9%	Population that are uninsured	5.4%

Foreign Born

46.9%	Population born in a different country	22.4%

Sociodemographics

Education

College Graduates

Queens		New York State
54.5%	Population aged 25 years and older with at least some college	60.8%

Less than High School

18.0%	Population aged 25 years and older with less than a high school degree	13.2%

Poverty

All Poverty

Queens		New York State
11.6%	Population below 100% FPL	13.6%

Childhood Poverty

14.4%	Children aged <18 years below poverty	18.2%

Housing

Rent

Queens		New York State
$1,583	Monthly median gross rent	$1,280

Housing Burden

42.6%	Monthly Housing Costs is equal to or greater than 30% of monthly household income	36.9%

Substandard Housing

31.0%	Households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	23.0%

Transportation

Travel Time

Queens		New York State
44.4	Mean travel time in minutes to work	33.6

Driving Alone

32.4%	Percentage of work population who drove alone (car, truck, and van)	53.0%

Public Transportation

51.1%	Percentage of work population who used public transportation (excluding taxicab)	28.0%

Health Status

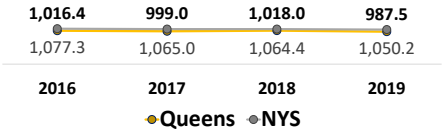
Findings:

- Hospitalizations in the County and New York State (NYS) remained relatively stable between 2016-2019,
- Emergency department visits showed a decrease between 2016 – 2019 with the County having a lower rate than the NYS overall
- The percentage of adults between 18-64 with health insurance has remained stable at above 87% in the County; slightly lower than the State at 92.5%
- Children in the County have health insurance at comparable rates to the State, above 97%
- The percentage of the population that are Medicaid insured in the County and the State has been relatively unchanged
- The percentage of adults with access to a regular healthcare provider have decreased at a faster rate in the County compared to the State

Healthcare Utilization

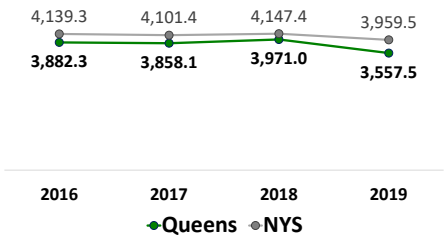
Hospitalizations

Age-adjusted total hospitalization rate per 10,000



ER Visits

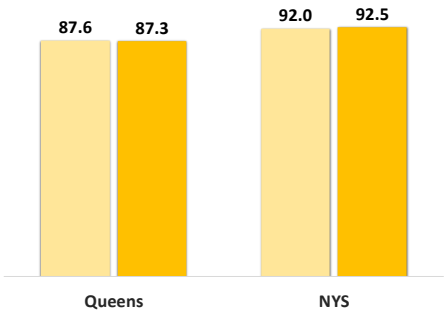
Age-adjusted total emergency department visit rate per 10,000



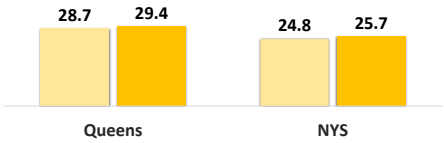
Healthcare Access

Insurance Coverage

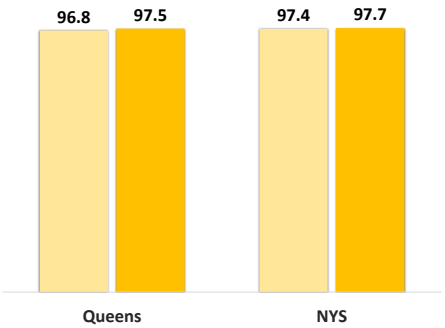
Percentage of adults aged 18-64 years with health insurance



Percentage of population with Medicaid/means-tested public coverage

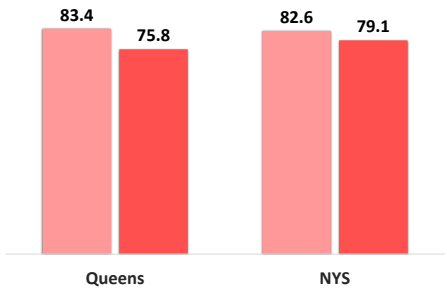


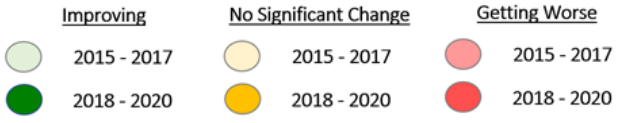
Percentage of children aged <19 years with health insurance



Access to Medical Care

Adults who have a regular health care provider, age-adjusted percentage





Health Status

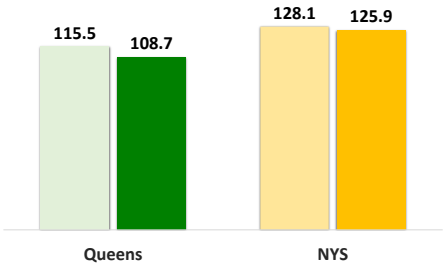
Findings:

- Total preventable hospitalizations improved in the County and slightly improved in the State
- The difference in preventable hospitalization rates for adults between Black and White populations have widened and the State, suggesting ongoing disparities
- The Hispanic-to-White ratio of preventable hospitalizations increased for the County and the State
- The County experienced an improvement in the percentage of total premature deaths
- The disparity in premature deaths between Black and White populations in the County has been stable
- The disparity in premature deaths between Hispanic and White populations in the County have been stable

Preventable Hospitalizations

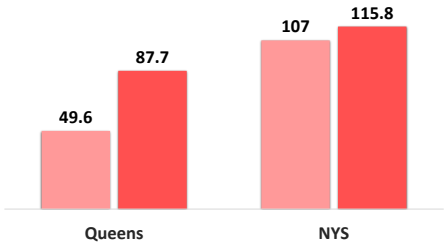
Overall

Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000



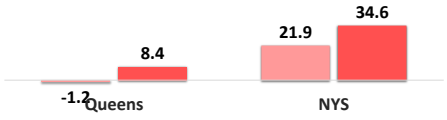
Black to White

Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black non-Hispanics and White non-Hispanics



Hispanic to White

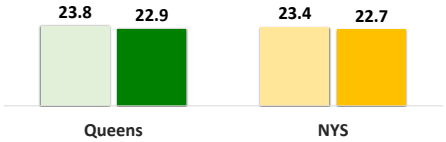
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics



Premature Deaths

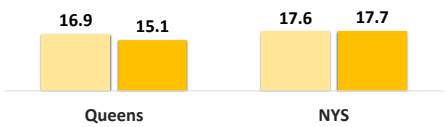
Overall

Percentage of premature deaths (before age 65 years)



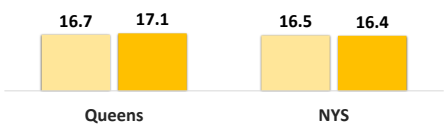
Black to White

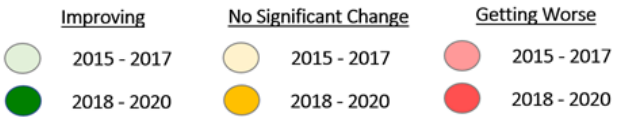
Premature deaths (before age 65 years), difference in percentages between Black non-Hispanics and White non-Hispanics



Hispanic to White

Premature deaths (before age 65 years), difference in percentages between Hispanics and White non-Hispanics





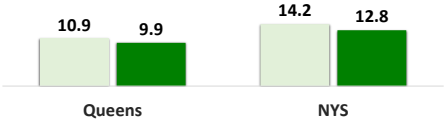
Health Behaviors

Findings:

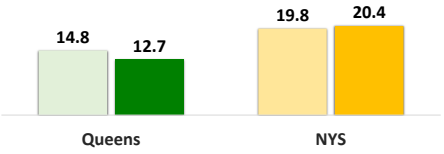
- The overall prevalence of cigarette smoking has improved in both the County and the State
- The percentage of cigarette smoking among the County's low-income adults has improved and is lower compared to the State
- The County's percentage of low-income adults consuming sugar beverages has worsened and is but still lower compared to the State
- The County's percentage of households receiving Food Stamp/SNAP benefits decreased and so did the State's percentage
- The percentage of students eligible for free/reduced price lunch has increased in the County and the State, reaching approximately 72% and 55% respectively

Smoking

Prevalence of cigarette smoking among adults

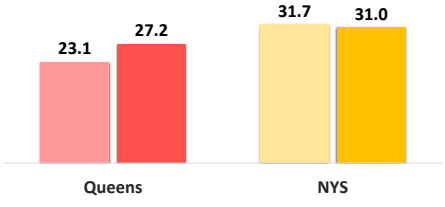


Percentage of cigarette smoking among adults with income less than $25,000

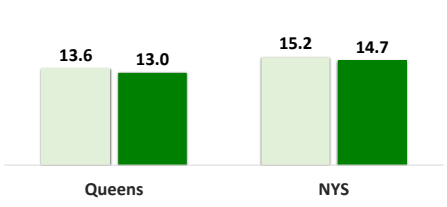


Healthy Eating & Food Security

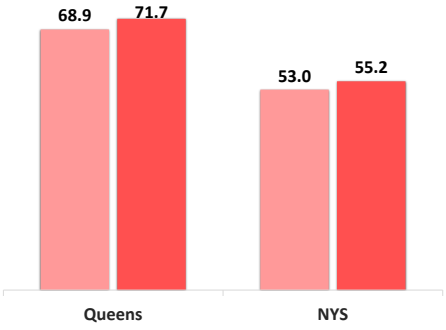
Percentage of adults with an annual household income less than $25,000 who consume one or more sugary drinks per day

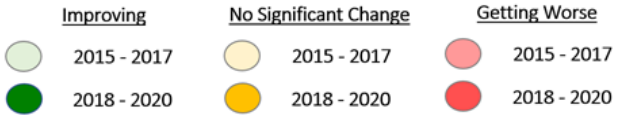


Percentage of households receiving Food Stamp/SNAP benefits in the past 12 months



Percentage of enrolled students eligible for free/reduced priced lunch





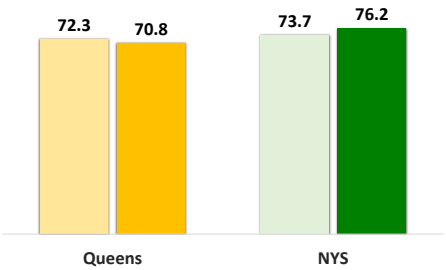
Health Behaviors

Findings:

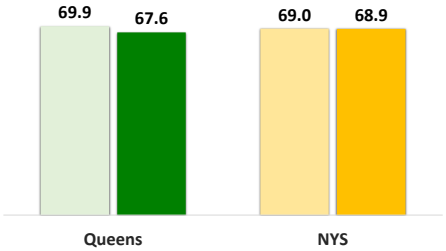
- The rate of adults participating in physical activity for leisure has been stable in the County but improved in the State
- Adults 65 and older improved in their rates of leisure time physical activity in the County compared to the State
- Rates of physical activity also improved for adults with disabilities at the County and State level
- The percentage of children aged 2-4 years old enrolled in WIC and watching TV for 2 hours or less a day noticeably improved

Physical Activity

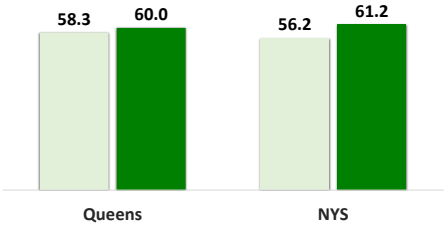
Percentage of adults who participate in leisure-time physical activity



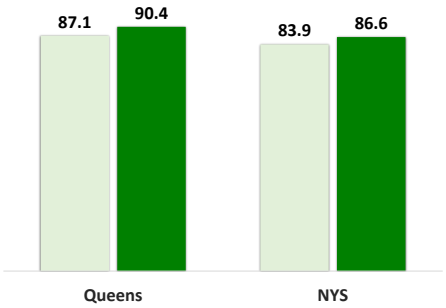
Percentage of adults who participate in leisure-time physical activity, aged 65+ years

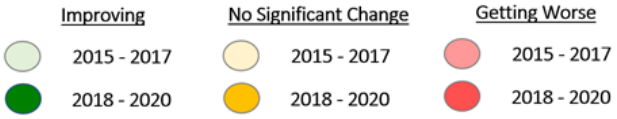


Percentage of adults with disabilities who participate in leisure-time physical activity



Percentage of children (aged 2-4 years) enrolled in WIC watching TV 2 hours or less per day





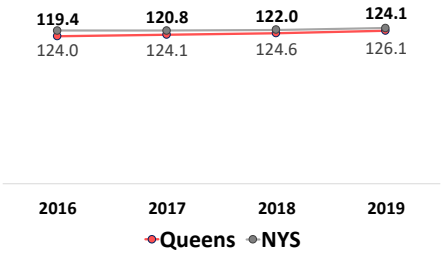
Chronic Conditions

Findings:

- Hospitalization rates for cardiovascular disease have worsened in the County since 2016; the County's mortality rates due to cardiovascular disease are comparable to the State and have shown some improvement
- The County's rate of hospitalizations for coronary heart disease (CHD) have been stable and are similar to the rate statewide
- The County's mortality rate for CHD has improved over the last few years, while the State's mortality rate for CHD stayed stable
- The rate of hospitalizations for cerebrovascular strokes are comparable to the State but have worsened; stroke related mortality rates have experienced worsened in the County but have remained stable statewide

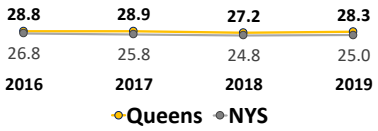
Cardiovascular Disease

Age-adjusted cardiovascular disease hospitalization rate per 10,000



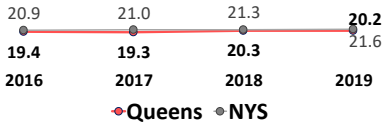
Coronary Heart Disease (CHD)

Age-adjusted coronary heart disease hospitalization rate per 10,000

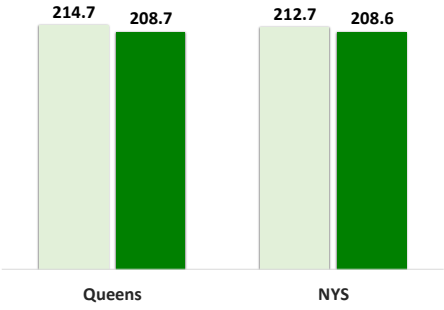


Stroke

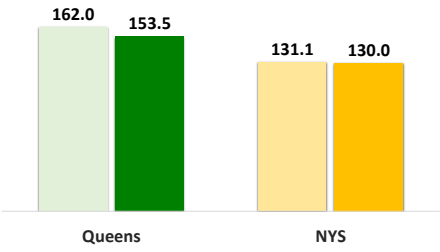
Age-adjusted cerebrovascular disease (stroke) hospitalization rate per 10,000



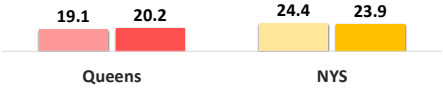
Age-adjusted cardiovascular disease mortality rate per 100,000

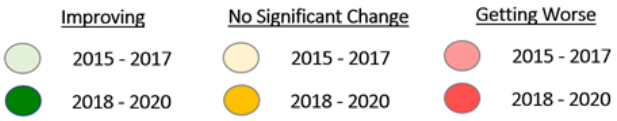


Age-adjusted coronary heart disease mortality rate per 100,000



Age-adjusted cerebrovascular disease (stroke) mortality rate per 100,000





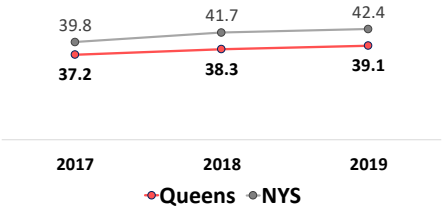
Chronic Conditions

Findings:

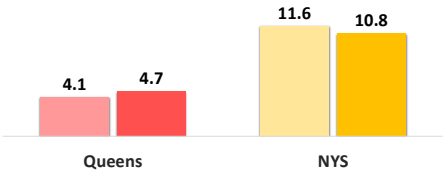
- The County's rate of preventable heart failure inpatient admissions is lower than the State but has increased since 2017
- Compared to the State, the County's mortality rate from congestive heart failure is lower, but has increased (from 4.1 to 4.7)
- Preventable Quality Indicators (PQI) for heart failure admission rates were highest in the southeastern portion of the County

Heart Failure

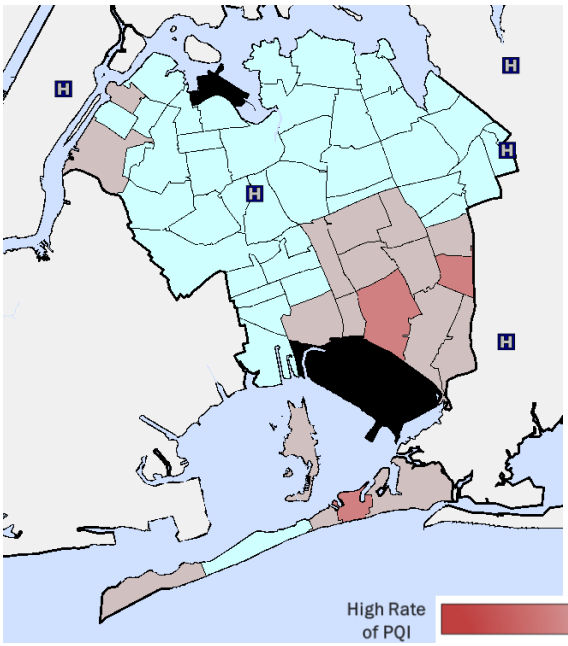
Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older



Age-adjusted congestive heart failure mortality rate per 100,000



PQI 08 Heart Failure Admission Rate

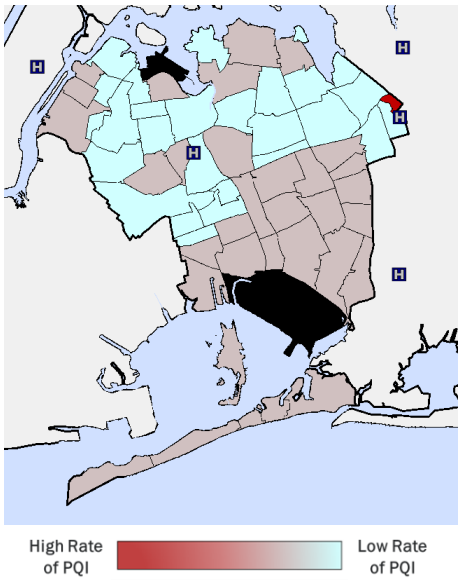


Chronic Conditions

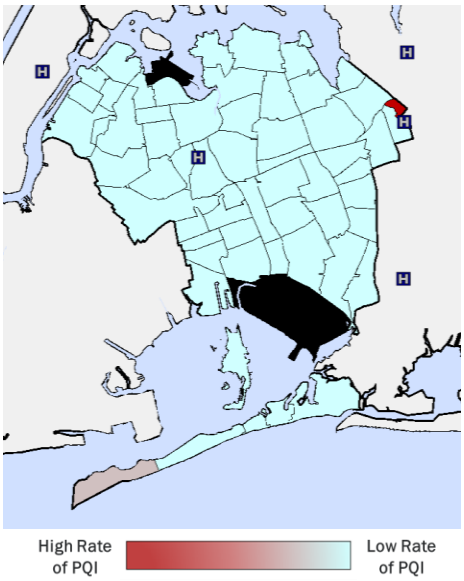
Findings:

- The overall rate of preventable admissions were higher in the southeastern section of the County
- Admissions for PQI 91 were relatively low in the County
- The percentage of adults with chronic conditions who took a course or class to learn how to manage their condition, decreased in the County, while State rates were lower yet remained stable
- Preventable admissions for chronic conditions were highest in the southeastern portion of the County

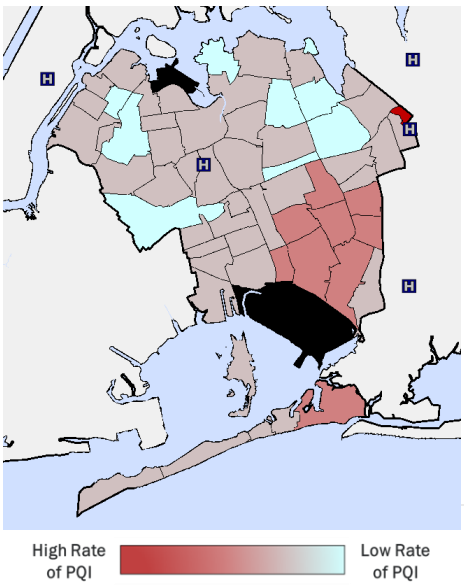
PQI 90: Overall Composite of Admissions



PQI 91: Acute Care Composite of Admissions

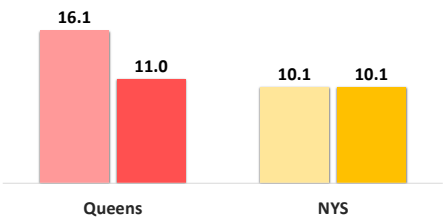


PQI 92: Chronic Composite of Admissions



Chronic Conditions

Percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition



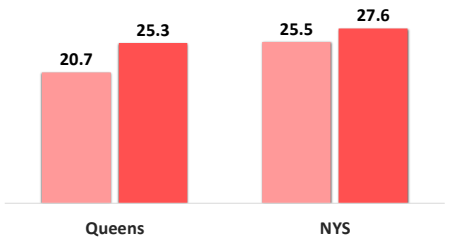
Chronic Conditions

Findings:

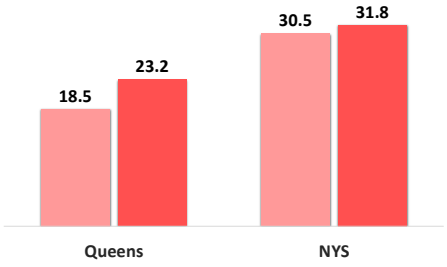
- The adult obesity rate for the County has trended in the same direction as the State and has worsened; the County's obesity rate is still lower than the State's obesity rate
- The percentage of the County's low-income adults with obesity has also worsened but is currently lower than the rate statewide
- Obesity trends among children and adolescents have been relatively stable in both the County and the State; the County has a higher rate of childhood obesity than the state (20.4% vs 17.2%)
- The percentage of children (aged 2-4) in the WIC program who are obese has decreased in the County, slightly less than the State percentage (13.1% vs 13.8%)

Obesity

Percentage of adults with obesity

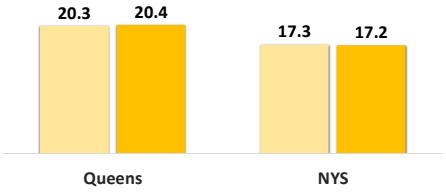


Percentage of adults with an annual household income less than $25,000 with obesity

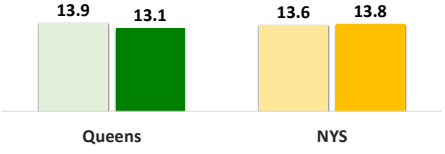


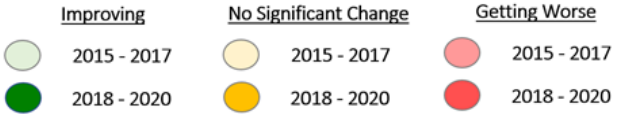
Childhood Obesity

Percentage of children and adolescents with obesity



Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC





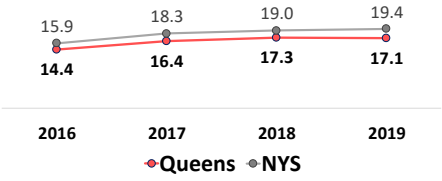
Chronic Conditions

Findings:

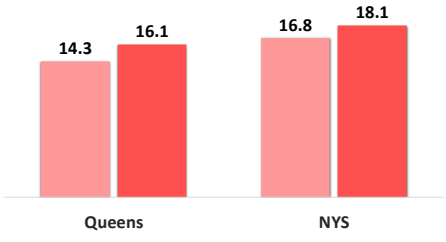
- The County has a lower rate of hospitalization due to diabetes compared to the State, but rates have increased since 2016 (from 14.4% to 17.1%)
- Diabetes related mortality rates have worsened both county- and state-wide, however, the County has a comparably lower rate (16.1% v 18.1%)
- There has been a decline in the County's adult (ages 45+) population who tested for high blood sugar or diabetes in the last 3 years
- PQI - 93 diabetes composite inpatient admission rates are highest in the southeastern sections of the County

Diabetes

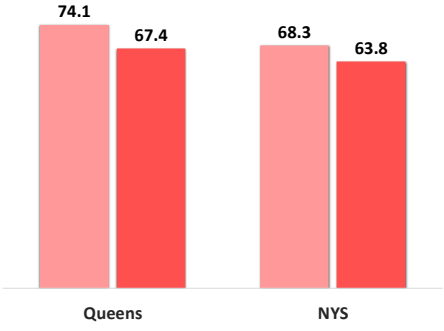
Age-adjusted diabetes hospitalization rate per 10,000 (primary diagnosis)

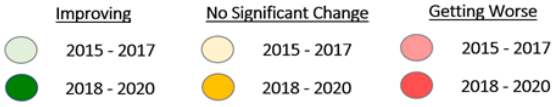


Age-adjusted diabetes mortality rate per 100,000

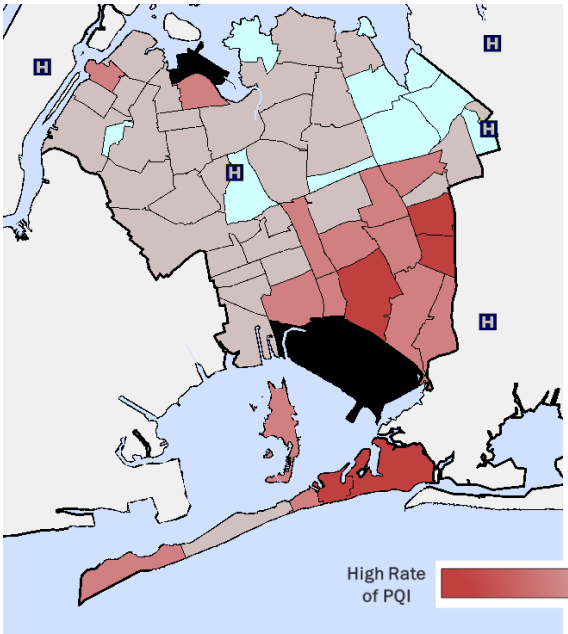


Percentage of adults who had a test for high blood sugar or diabetes within the past three years, aged 45+ years





PQI 93 Diabetes Composite Admission Rate



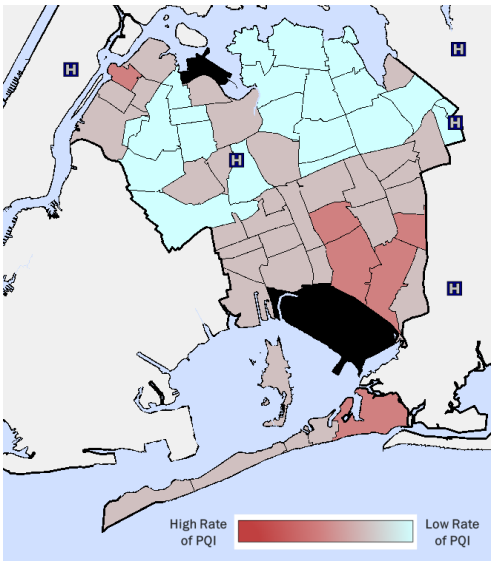
Chronic Conditions: Diabetes

Findings:

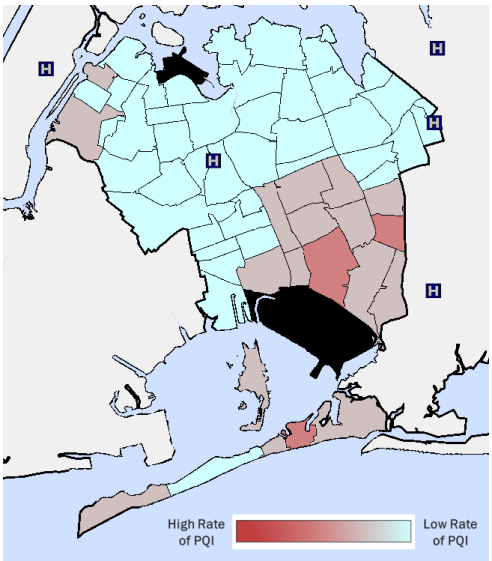
- Preventable hospitalizations for short term complications from diabetes steadily increased in both the County and the State since 2016
- PQIs 01 and 03, preventable inpatient admissions for both short- and long-term complications due to diabetes are highest in the southeastern portions of the County

Diabetes Complications

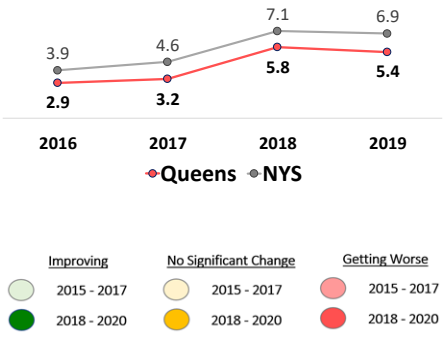
PQI 03: Diabetes Long-Term Complication Admission Rate



PQI 01 Diabetes Short-Term Complication Admission Rate



Potentially preventable diabetes short-term complications hospitalization rate per 10,000 - Aged 18 years and older



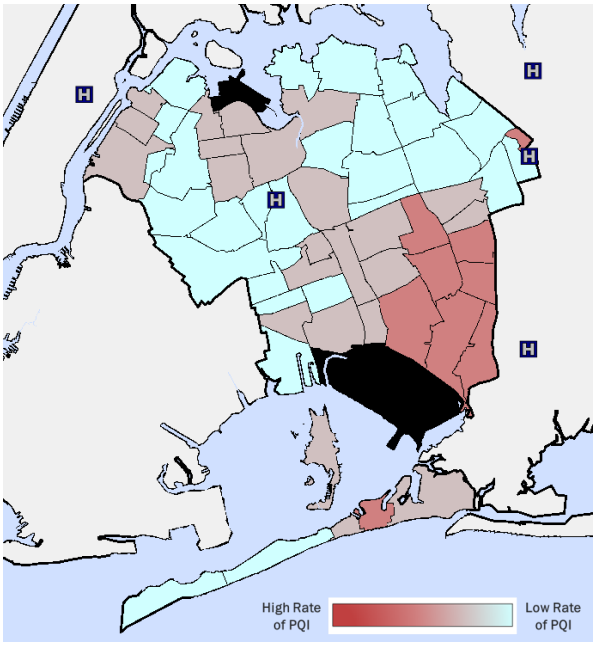
Chronic Conditions

Findings:

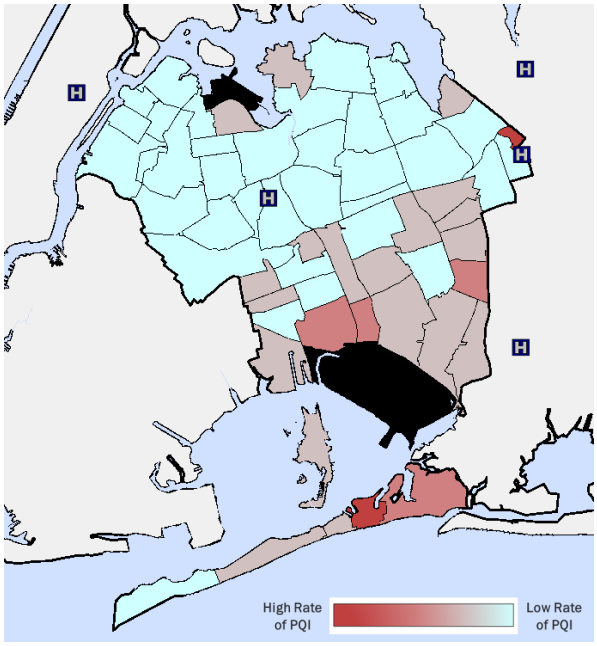
- PQI 14 - uncontrolled diabetes admission rates are concentrated in the southeastern sections of the County
- PQI 16 - lower-extremity amputation among patients with diabetes rates are highest on the southern part of the County

Diabetes Complications

PQI 14 Uncontrolled Diabetes Admission Rate



PQI 16 Lower-Extremity Amputation among Patients with Diabetes Rate



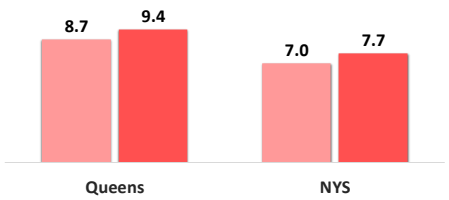
Chronic Conditions

Findings:

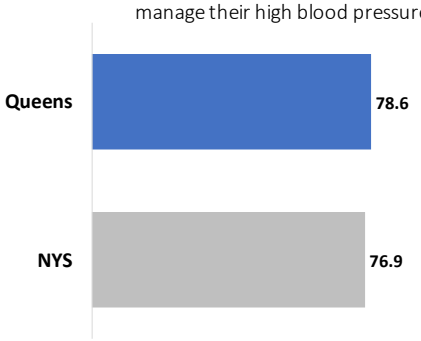
- Preventable hospitalization rates for adults with hypertension has worsened in both the County and the State, with relatively higher rates in the County (9.4% vs 7.7%)
- At 78.6%, the County has more adults with hypertension taking medicine to manage their high blood pressure than the State at 76.9%
- PQI 07 – Hypertension admission rates are highest in the southeastern portion of the County

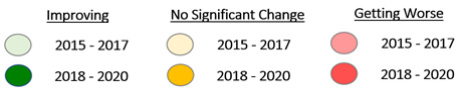
Hypertension

Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older

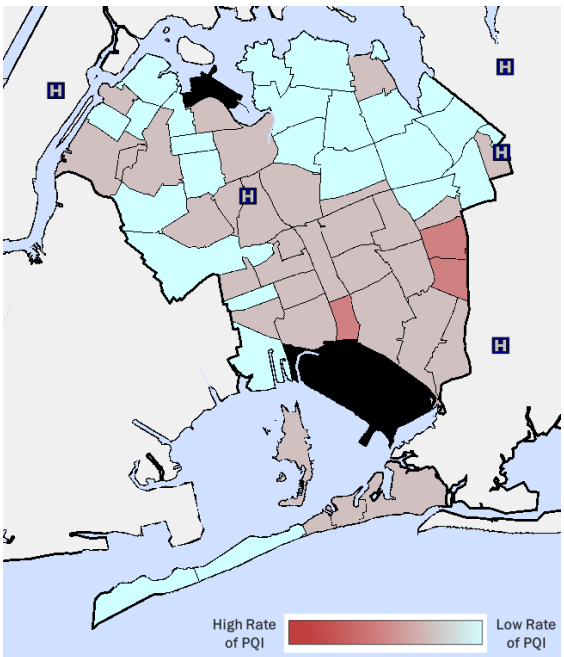


Percentage of adults with hypertension who are currently taking medicine to manage their high blood pressure





PQI 07 Hypertension Admission Rate



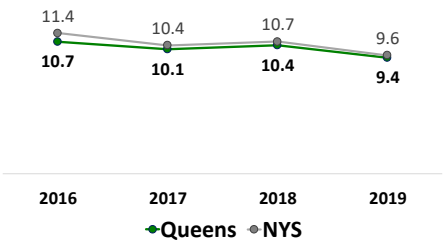
Chronic Conditions

Findings:

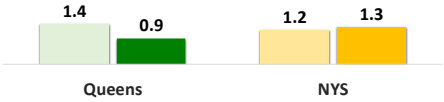
- The age-adjusted rates of hospitalizations and mortality from asthma is lower in the County as compared to the State
- Asthma hospitalization for adults 65+ in the County has gone down but has been higher than the State overall
- The County's asthma related mortality rates showed an improvement in its trend and dropped lower than the State rate

Asthma

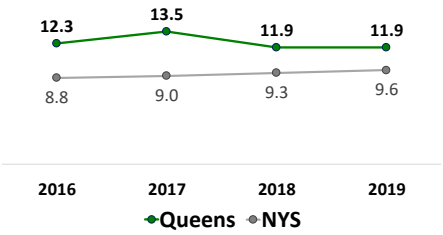
Age-adjusted asthma hospitalization rate per 10,000

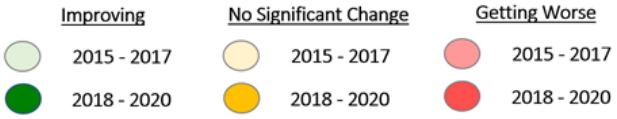


Age-adjusted asthma mortality rate per 100,000



Asthma hospitalization rate per 10,000 - Aged 65 years or older



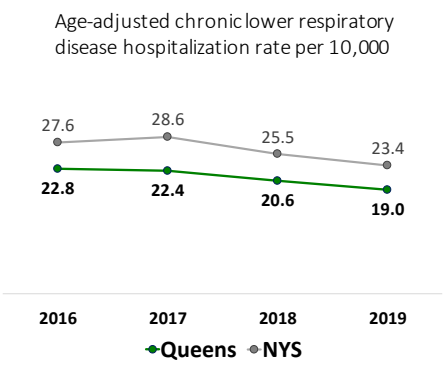


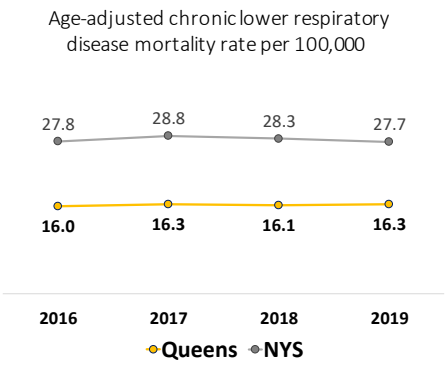
Chronic Conditions

Findings:

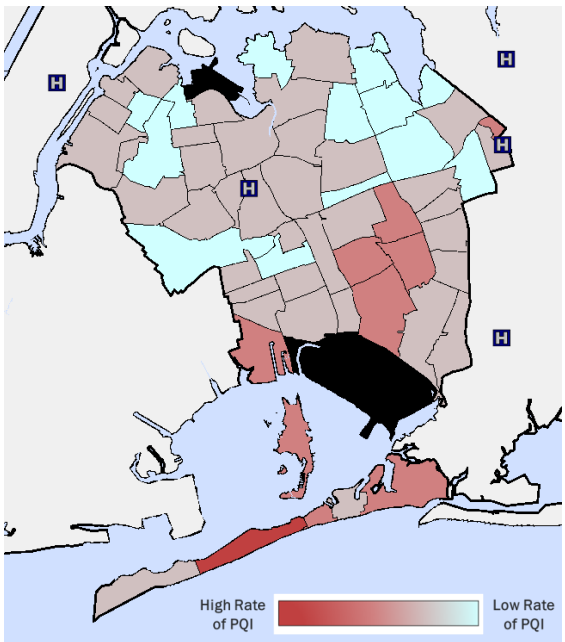
- Since 2016, hospitalization rates for chronic lower respiratory disease have decreased in the County and the State
- Mortality rates per 100,000 from chronic lower respiratory disease have remained stable
- PQI 05 - Chronic Obstructive Pulmonary Disease (COPD) or asthma in older adults admission rates are high all over the County but particularly concentrated in the southeastern section

Chronic Lower Respiratory Disease





PQI 05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate



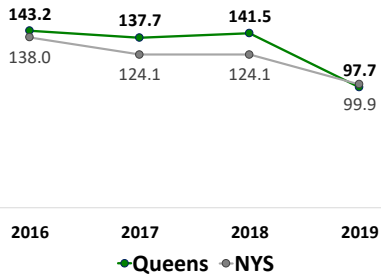
Chronic Conditions

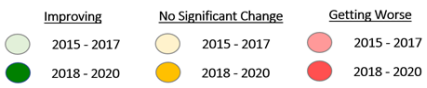
Findings:

- Emergency department visit rates for asthma among the youth aged 0-17 declined significantly from 2016-2019 in the County and NYS.
- PQI 15 - asthma in younger adults admission rates are concentrated in the southeastern portion of the County
- Hospitalization rates for pneumonia and the flu among those age 65 and older decreased in both the County and the State
- PQI 11 - community acquired pneumonia admission rates were low and not strongly observed in the County

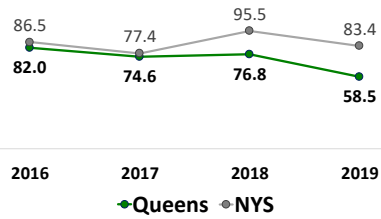
Youth Asthma & Pneumonia

Asthma emergency department visits, rate per 10,000, aged 0-17 years

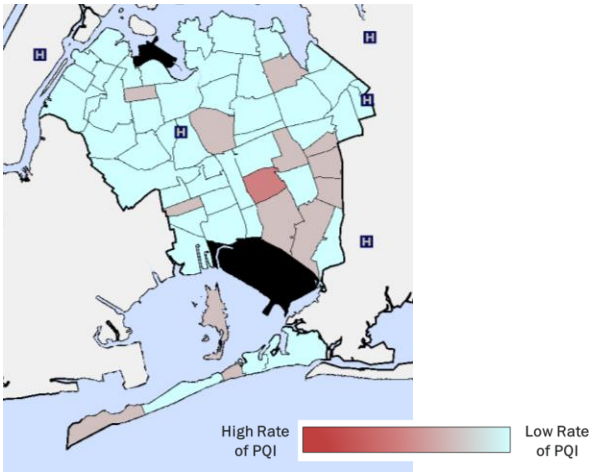




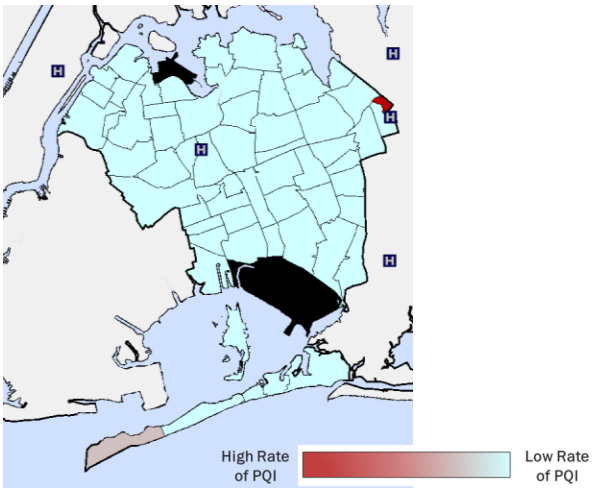
Pneumonia/flu hospitalization rate per 10,000 - Aged 65 years and older



PQI 15 Asthma in Younger Adults Admission Rate



PQI 11 Community Acquired Pneumonia Admission Rate

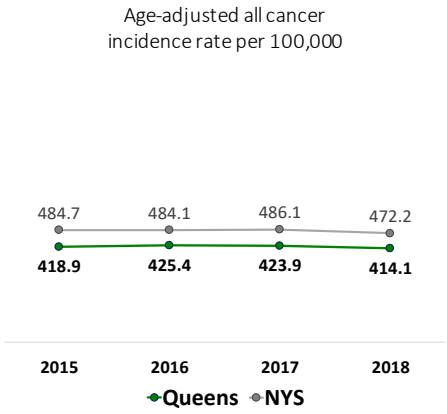


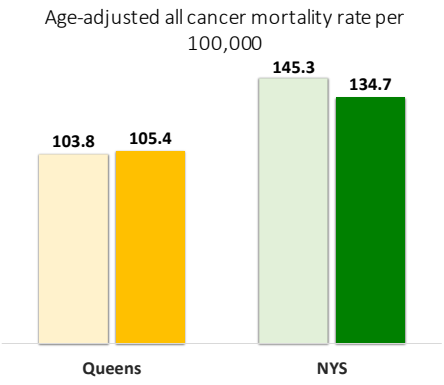
Chronic Conditions

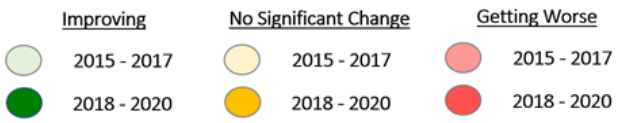
Findings:

- The age-adjusted incidence rate for all cancer was lower in the County than the State; the trend in the rate since 2015 has improved
- The age-adjusted mortality rate for all cancer was stable for the County but improved for the State

Cancer







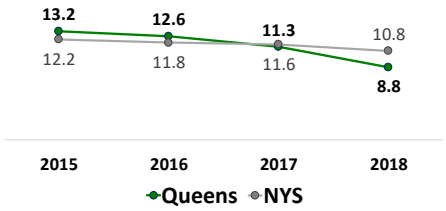
Chronic Conditions

Findings:

- The age-adjusted incidence rate for ovarian cancer was decreased for the County at a faster rate than the State
- The age-adjusted mortality rate from ovarian cancer worsened in the County but improved statewide
- The age-adjusted incidence rate for cervix uteri cancer improved in County and the State since 2015
- The age-adjusted mortality rate for cervix uteri cancer declined in the County and the State

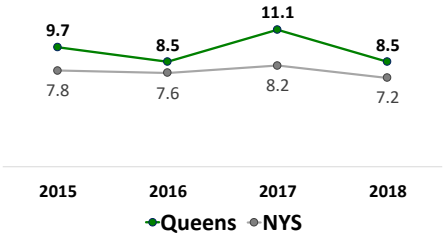
Ovarian Cancer

Age-adjusted ovarian cancer incidence rate per 100,000

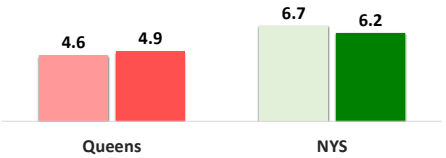


Cervix Uteri Cancer

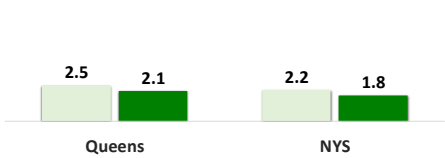
Age-adjusted cervix uteri cancer incidence rate per 100,000

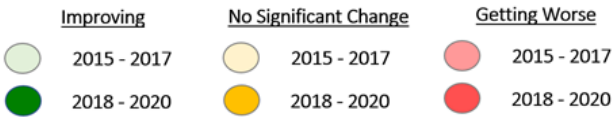


Age-adjusted ovarian cancer mortality rate per 100,000



Age-adjusted cervix uteri cancer mortality rate per 100,000





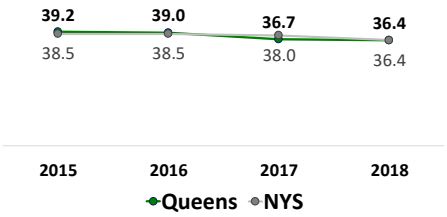
Chronic Conditions

Findings:

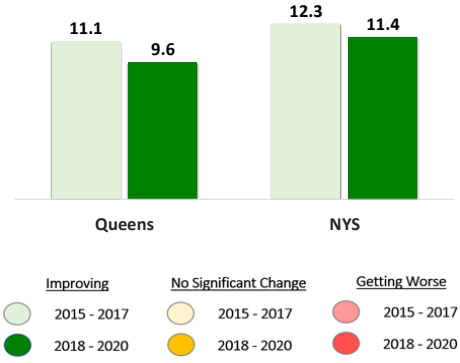
- The County had an age-adjusted colon and rectum cancer incidence rate similar to the State
- The age-adjusted mortality rate from colon and rectum cancer decreased for the County and the State
- The percentage of adults aged 50-64 receiving a colorectal cancer screening remained flat in the County, but improved in the State
- There were higher than expected rates of observed colorectal cancer cases throughout the County

Colorectal Cancer

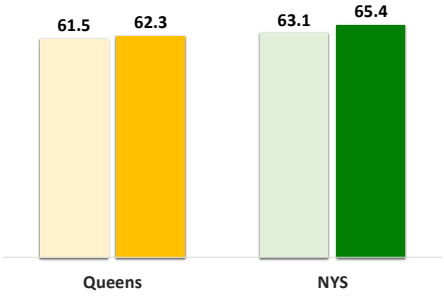
Age-adjusted colon and rectum cancer incidence rate per 100,000

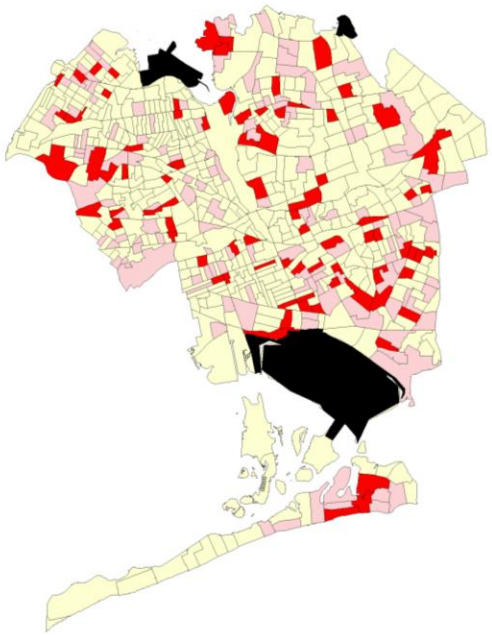


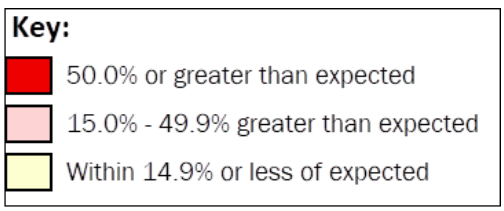
Age-adjusted colon and rectum cancer mortality rate per 100,000



Percentage of adults who receive a colorectal cancer screening based on the most recent guidelines, aged 50-64 years







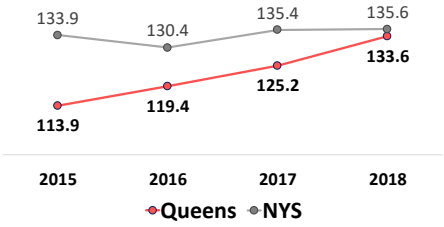
Chronic Conditions

Findings:

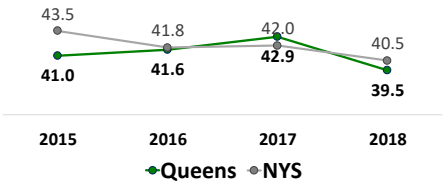
- The County's age-adjusted incidence rates for female breast worsened since 2015
- The age-adjusted late-stage female breast cancer rates slightly improved in the County and the State
- The age-adjusted female breast cancer mortality rate increased in the County but decreased in the State
- Greater than expected cases of breast cancer were clustered in the eastern and western parts of the County

Breast Cancer

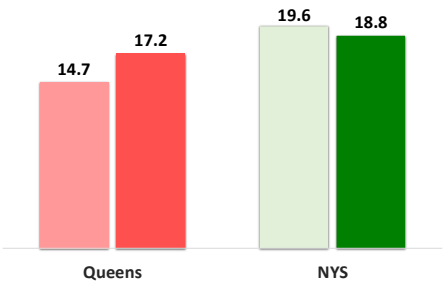
Age-adjusted female breast cancer incidence rate per 100,000

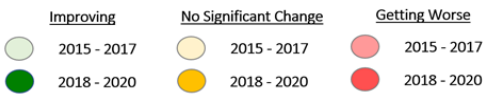


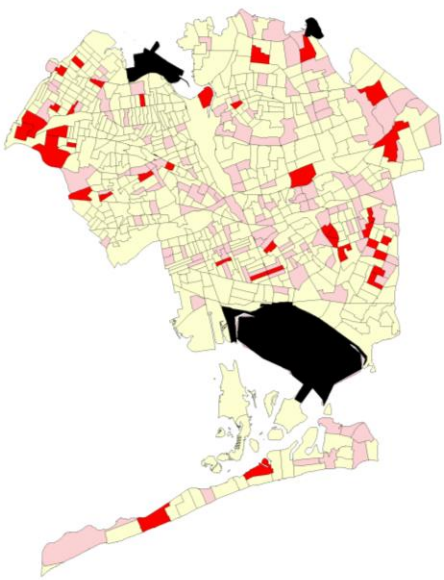
Age-adjusted female breast cancer late stage incidence rate per 100,000



Age-adjusted female breast cancer mortality rate per 100,000







Key:

- 50.0% or greater than expected
- 15.0% - 49.9% greater than expected
- Within 14.9% or less of expected

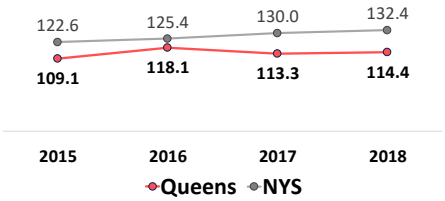
Chronic Conditions

Findings:

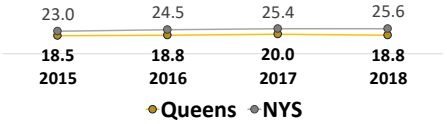
- Between 2015 to 2019,the age-adjusted incidence rate for prostate cancer and late-stage prostate cancer remained lower than the State rates, but showed slight increases
- The age-adjusted mortality rate for prostate cancer worsened in the County, while improving in the State
- The southeastern part of the County observed greater than expected cases of prostate cancer cases

Prostate Cancer

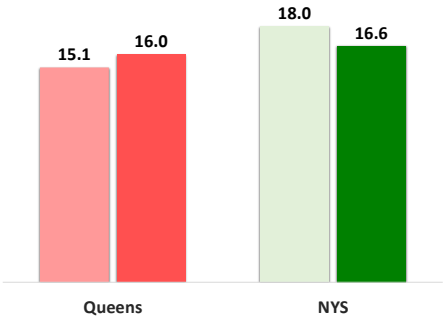
Age-adjusted prostate cancer incidence rate per 100,000

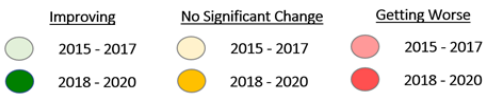


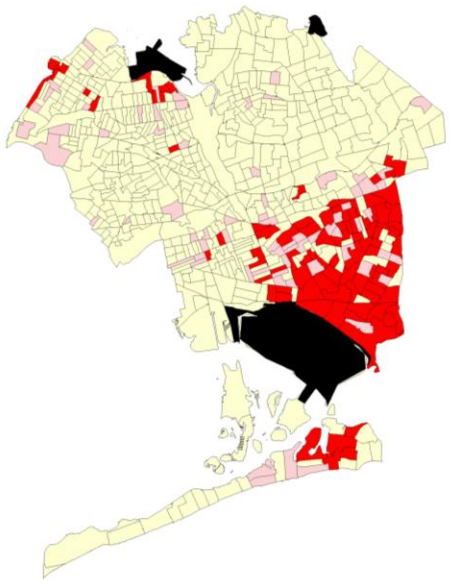
Age-adjusted prostate cancer late stage incidence rate per 100,000



Age-adjusted prostate cancer mortality rate per 100,000







Key:

- 50.0% or greater than expected
- 15.0% - 49.9% greater than expected
- Within 14.9% or less of expected

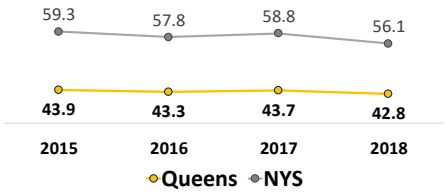
Chronic Conditions

Findings:

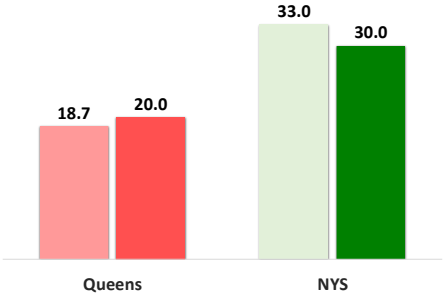
- The age-adjusted incidence rate for lung and bronchus cancer has been lower in the County as compared to the State and the incidence has remained stable
- The age-adjusted lung and bronchus cancer mortality rates increased for the County but decreased for the State
- Greater than expected rates of lung cancer were observed in clusters throughout the County

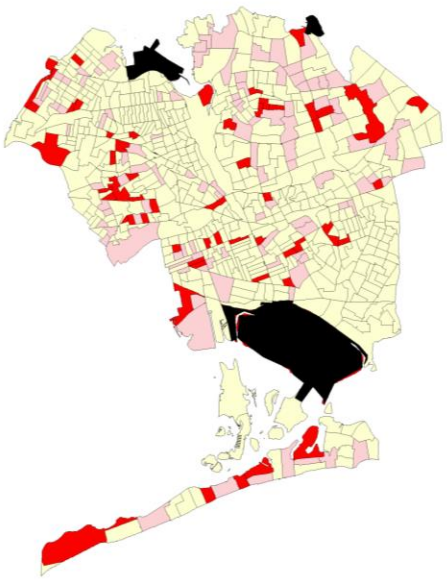
Lung Cancer

Age-adjusted lung and bronchus cancer incidence rate per 100,000



Age-adjusted lung and bronchus cancer mortality rate per 100,000





Key:

- 50.0% or greater than expected
- 15.0% - 49.9% greater than expected
- Within 14.9% or less of expected

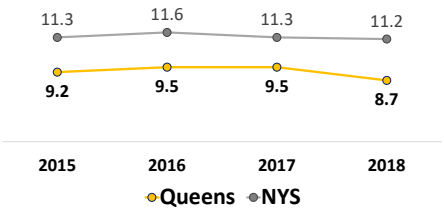
Chronic Conditions

Findings:

- The age-adjusted incidence and mortality rates for oral cavity and pharynx cancer remained stable for both the County and the State
- The rate of outpatient visits for dental caries among children 3-5 years old has improved and has been significantly lower than the State
- The age-adjusted melanoma mortality rate remained flat for the County and the State.

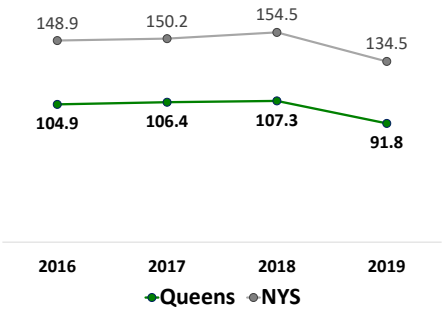
Oral Cancer

Age-adjusted oral cavity and pharynx cancer incidence rate per 100,000



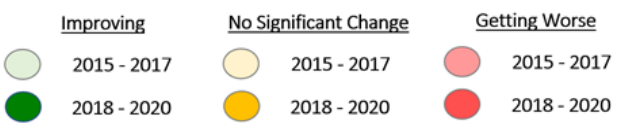
Age-adjusted oral cavity and pharynx cancer mortality rate per 100,000

Caries outpatient visit rate per 10,000 - Aged 3-5 years



Melanoma

Age-adjusted melanoma cancer mortality rate per 100,000

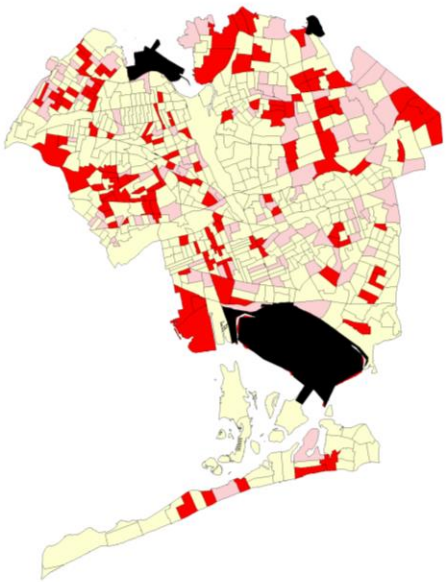


Chronic Conditions

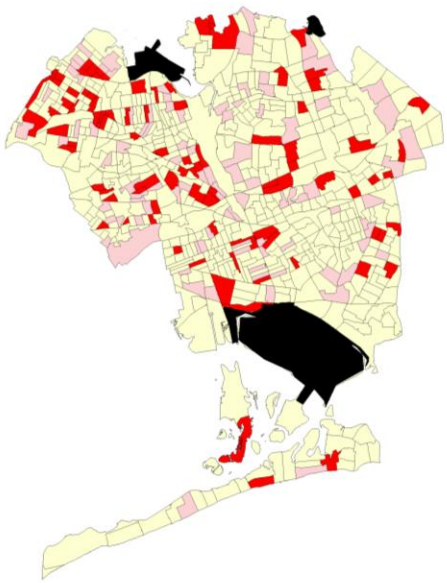
Findings:

- The northeastern and northwestern portions of the County experienced greater than expected rates of urinary cancer cases
- The rate of greater than expected non-Hodgkin's Lymphoma cases were spread throughout the County

Urinary Cancer



Non-Hodgkin's Lymphoma



Key:

- 50.0% or greater than expected
- 15.0% - 49.9% greater than expected
- Within 14.9% or less of expected

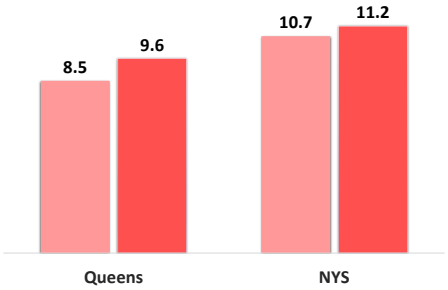
Well-Being, Mental Health & Substance Use Disorders

Findings:

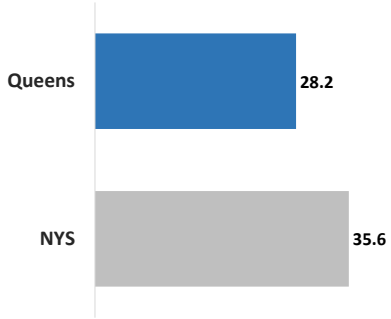
- The age-adjusted percentage of County residents who experienced mental distress during the past month, increased for both the County and the State
- The County has had a lower rate of adults reporting adverse childhood experiences compared to the State (28.2% vs 35.6%)
- Age-adjusted suicide rates have worsened in the County but were stable in the State
- Age-adjusted suicide rates for youths aged between 15-19 years old have noticeably worsened in the County and the State.

Mental Distress

Frequent mental distress during the past month among adults, age-adjusted percentage

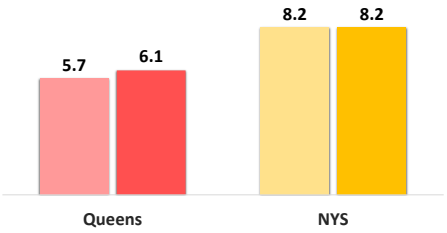


Percentage of adults who have experienced two or more adverse childhood experiences (ACEs)

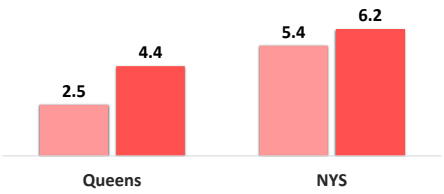


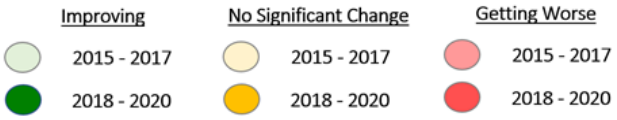
Suicides

Suicide mortality, age-adjusted rate per 100,000 population



Suicide mortality among youth, rate per 100,000, aged 15-19 years





Insert quote on mental health from Suffolk County focus group if avail. If not avail – drop a stat on child hood mental health

Well-Being, Mental Health & Substance Use Disorders

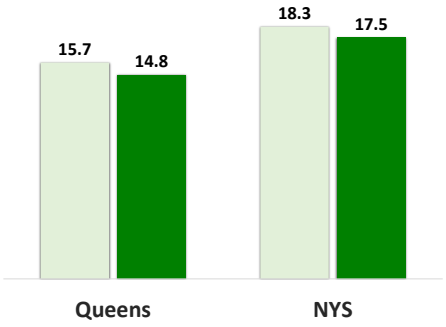
Findings:

- The age-adjusted percentage of binge drinking, reported in the past month decreased in the County and the State overall
- The rate of alcohol related motor vehicle injuries have has increased in the County but has remained lower than the rate stat ewide
- The age-adjusted opioid overdose death rate got worse since 2015, for both the County and the State; County rates have consisten tly been lower than the State
- The rate of opioid overdose ED visits has been stable in the County but the State has seen improvement; the County rate is st ill significantly lower than the rate statewide (22.9 vs 53.1 per 100,000 population)
- The age-adjusted opioid analgesic prescription rates declined for both the County and the State
- The rate of buprenorphine prescriptions have remained slightly improved in the County but are considerably lower than the rat e statewide

Substance Abuse

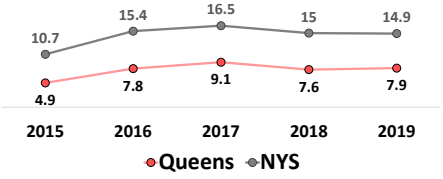
Binge Drinking

Binge drinking during the past month among adults, age-adjusted percentage



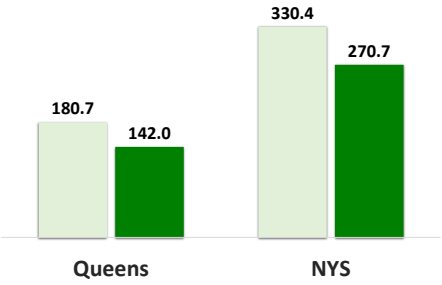
Opioid Overdose Deaths

Overdose deaths involving any opioids, age-adjusted rate per 100,000 population



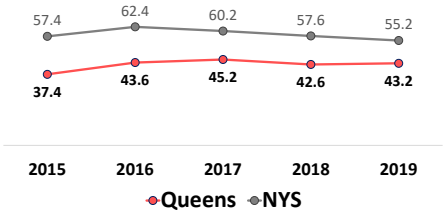
Prescribed Opioid Use

Opioid analgesic prescription, age-adjusted rate per 1,000 population



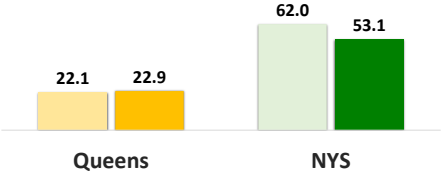
Drunk Driving

Alcohol related motor vehicle injuries and deaths per 100,000



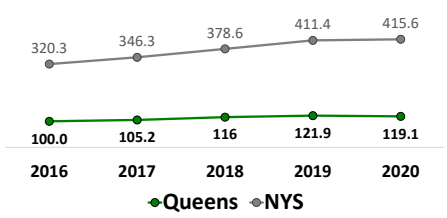
Opioid Overdose ED Visits

ED visits (incl outpatients & admitted patients) involving any opioid overdose, age-adjusted rate per 100,000 population



Buprenorphine Use

Patients who received at least one buprenorphine prescription for opioid use disorder, age-adjusted rate per 100,000 population



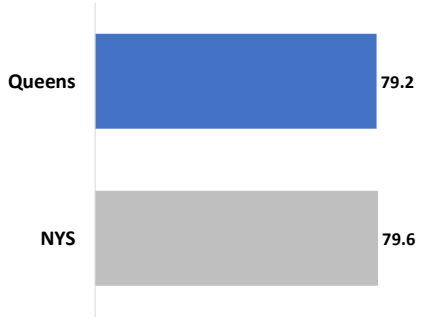
Healthy Women, Infants, & Children

Findings:

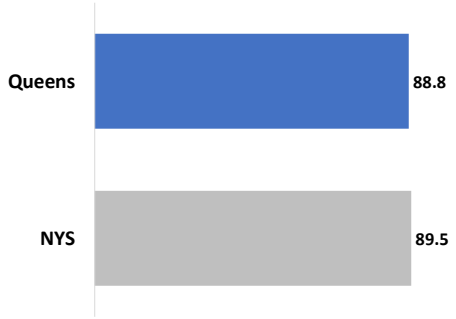
- The County and NYS percentages of women aged 18-44 and 45+ receiving a preventive medical visit were similar and ranged from 79%to 89%
- In the County, 28.2% of women aged 18-44 reported talking with a health care provider about ways to prepare for a healthy pregnancy as compared to only 35.3% in NYS.
- The percentage of births with adequate prenatal care are 77.5% and 76% for the County and the State, respectively.

Preventive Care

Percentage of women with a preventive medical visit in the past year, aged 18-44 years

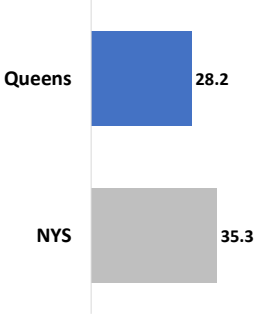


Percentage of women with a preventive medical visit in the past year, aged 45+ years

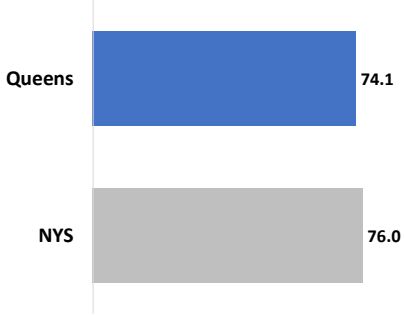


Prenatal Care

Percentage of women who report ever talking with a health care provider about ways to prepare for a healthy pregnancy, aged 18-44 years



Percentage of births with adequate prenatal care



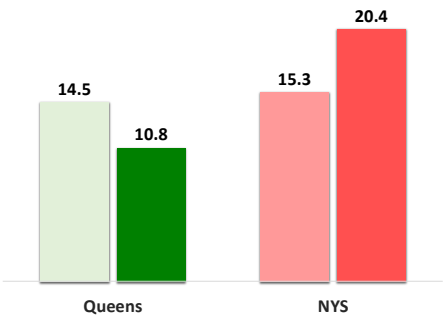
Healthy Women, Infants, & Children

Findings:

- The maternal mortality rate decreased in the County from 14.5 to 10.8 per 100,000 live births, while the State rate increased from 15.3 to 20.4 live births
- The percentage of births to women aged 25+ without a high school education declined in the County and the State
- The percentage of premature births remained relatively stable in the State but slightly increased in the County
- The County had a percentage of cesarean section births similar to the State (34.3%% vs 33.2%), however the trends have improved (from 35.6% to 34.3%)

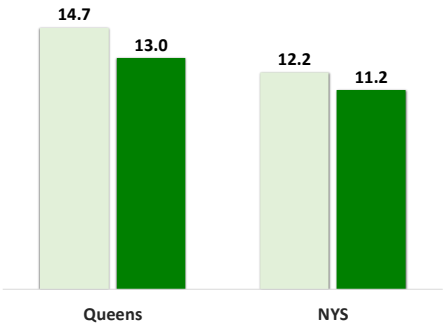
Maternal Mortality

Maternal mortality rate per 100,000 live births



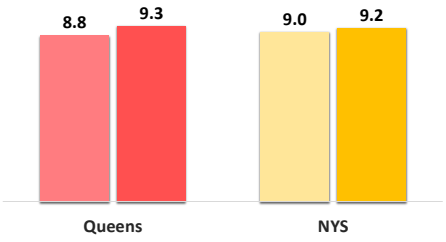
Maternity & Education

Percentage of births to women aged 25 years and older without a high school education

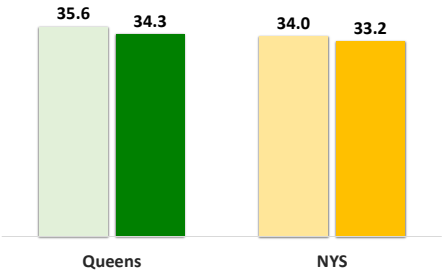


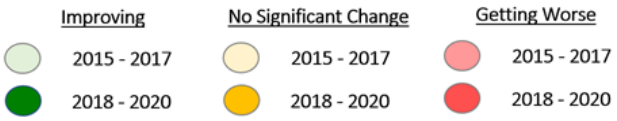
Complicated Births

Percentage of premature births with <37 weeks gestation



Percentage of births delivered by cesarean section





Healthy Women, Infants, & Children

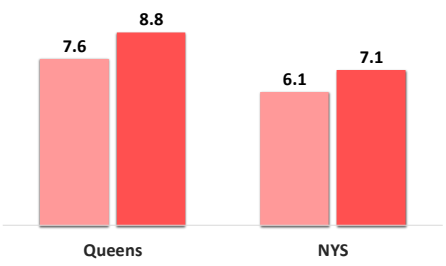
Findings:

- The percentage of pregnant women in WIC who have gestational diabetes rose in the County and the State
- The percentage of pregnant women in WIC with hypertension worsened in both the County and the State;
- The percentage of pregnant women in WIC with 1st trimester prenatal care improved in both the County and the State
- The percentage of women in WIC who were pre-pregnancy underweight remained stable for the County and the State
- Compared to the State, the County had a higher percent of women in WIC who were pre-pregnancy overweight but a lower percent of women in WIC who were pre-pregnancy obese

Pregnancy, Poverty & Comorbidities

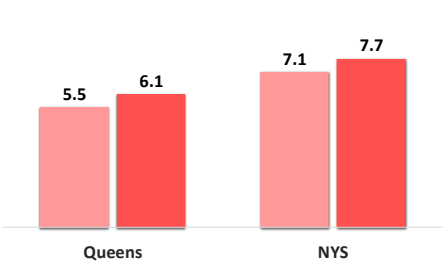
Gestational Diabetes

Percentage of pregnant women in WIC with gestational diabetes



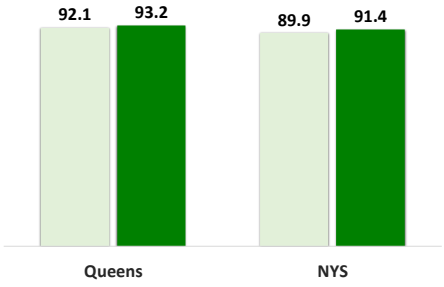
Hypertension

Percentage of pregnant women in WIC with hypertension during pregnancy



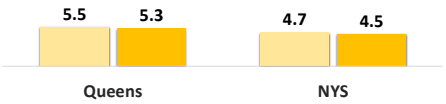
1° Trimester Prenatal Care

Percentage of pregnant women in WIC with early (1st trimester) prenatal care



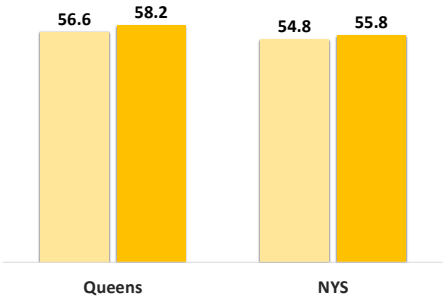
Underweight

Percentage of pregnant women in WIC who were pre-pregnancy underweight (BMI less than 18.5)



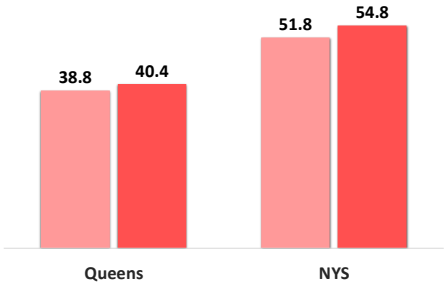
Overweight

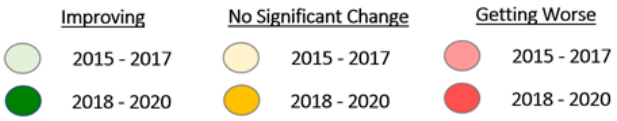
Percentage of pregnant women in WIC who were pre-pregnancy overweight but not obese (BMI 25 to less than 30)



Obesity

Percentage of pregnant women in WIC who were pre-pregnancy obese (BMI 30 or higher)





Healthy Women, Infants, & Children

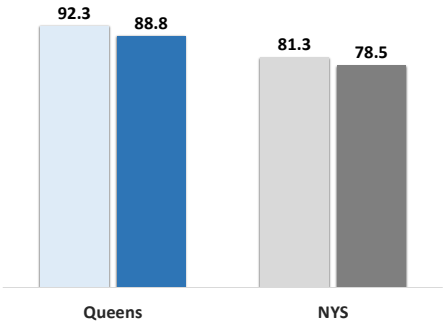
Findings:

- The pregnancy rate is higher in the County than in the State; both have experienced slight declines
- The percentage of geriatric pregnancies, defined as births to women aged 35 years or older, wasslightly higher in the County than in the State
- Teen pregnancy rates improved for both County and State but the County has a slightly higher rate per 1,000 females from 15-19 years old (26.4 vs 23.0 respectively)
- The percentage of births to teens slightly changed in the County which has been less than the rates statewide

Pregnancy Rates

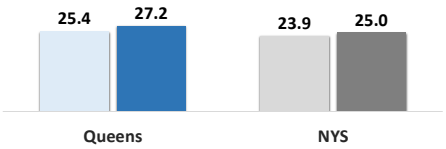
All Pregnancies

Pregnancy rate per 1,000 (all pregnancies/female population aged 15-44 years)



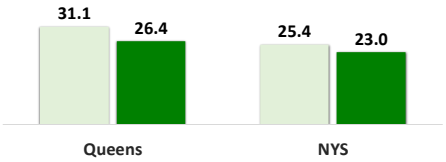
Geriatric Pregnancies

Percentage of births to women aged 35 years and older

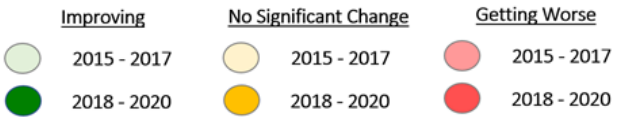


Teen Pregnancy Rates

Teen pregnancy rate per 1,000 females aged 15-19 years



Percentage of births to teens - Aged 15-19 years



Healthy Women, Infants, & Children

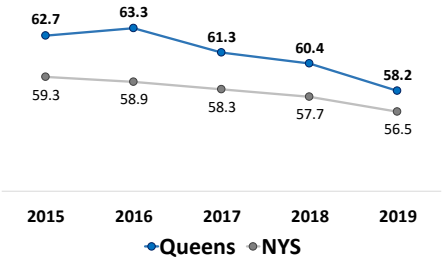
Findings:

- The fertility rate declined steadily among women aged 15-44 in the County and the State
- The teen fertility rate declined slightly in both the County and State.
- The abortion ratio in the County slightly increased in the County compared to the State which had a slight decrease

Fertility Rates

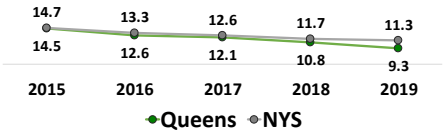
All Fertility Rates

Fertility rate per 1,000 females - Aged 15-44 years



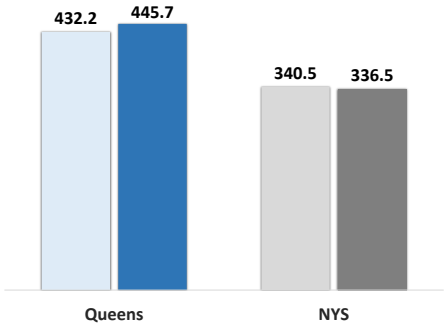
Teen Fertility Rates

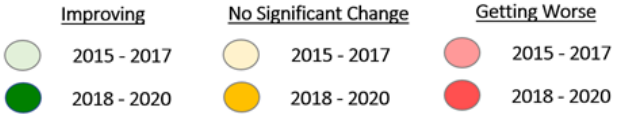
Teen fertility rate per 1,000 (births to mothers aged 15-19 years/female population aged 15-19 years)



Abortions

Abortion ratio (induced abortions per 1,000 live births) - All ages





Healthy Women, Infants, & Children

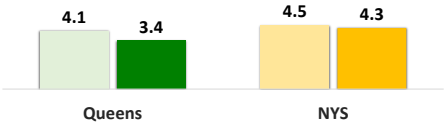
Findings:

- The infant mortality rate per 1,000 live births (<1 year) has noticeably improved in the County while remaining flat for the State
- The percentage of low birthweight singleton births (<2.5 kg) increased since 2015 for both the State and the County
- The crude rate of newborns with any diagnosis relating to maternal drug use remained flat in the County but showed improvements in the State overall; County rates considerably lower than the rates statewide

Infants

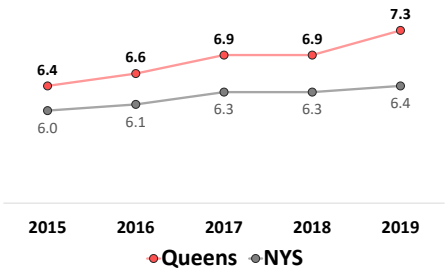
Mortality Rate

Mortality rate per 1,000 live births - Infant (<1 year)



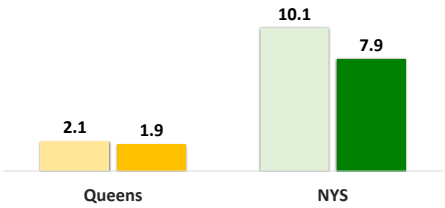
Low Birthweight

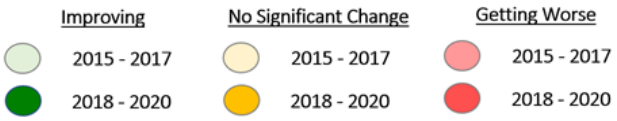
Percentage low birthweight (<2.5kg) singleton births



Newborn Withdrawals

Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges





Healthy Women, Infants, & Children

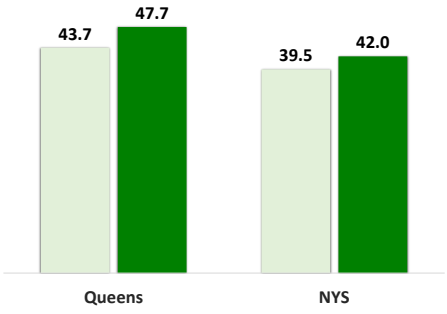
Findings:

- The percentage of 6-month-old infants enrolled in WIC who were breastfed improved for both the County and the State
- The percentage of infants who were supplemented with formula in the hospital noticeably decreased in the County but remained stable in the
- The percentage of infants exclusively breastfed in the hospital slightly improved in the County but remained flat in the State
- The percentage of Black non-Hispanic infants exclusively breastfed remained mostly flat in the County and the State
- The percentage of Hispanic infants exclusively breastfed improved in the County

Breastfeeding

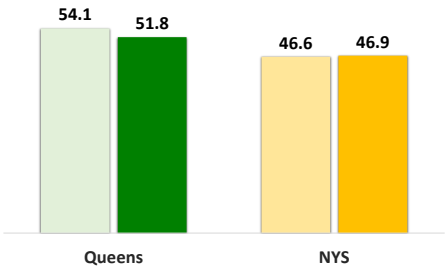
At 6 Months

Percentage of infants enrolled in WIC who are breastfed at 6 months among all WIC infants



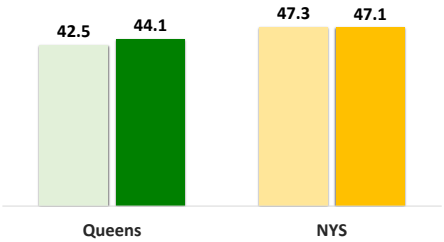
Formula Supplementation

Percentage of infants supplemented with formula in the hospital among breastfed infants



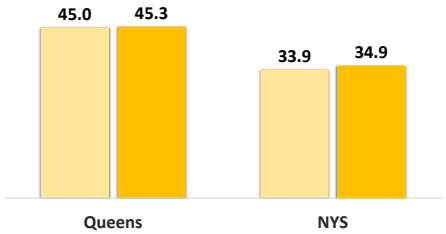
All Infants

Percentage of infants who are exclusively breastfed in the hospital among all infants



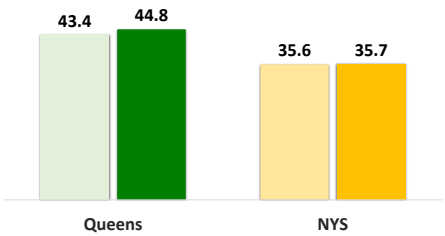
Black Infants

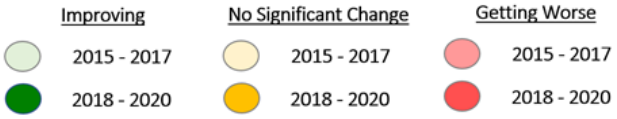
Percentage of infants who are exclusively breastfed in the hospital among Black non-Hispanic infants



Hispanic Infants

Percentage of infants who are exclusively breastfed in the hospital among Hispanic infants





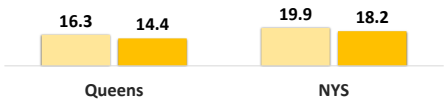
Healthy Women, Infants, & Children

Findings:

- The percentage of children in poverty remained relatively flat for both County and State; the County has a lower rate of childho od poverty compared to the State
- Roughly 55% of children aged 3 to 4 in the County and the State are enrolled in early education
- Over 97% of children below the age of 19 have health insurance coverage on the County and State-levels.

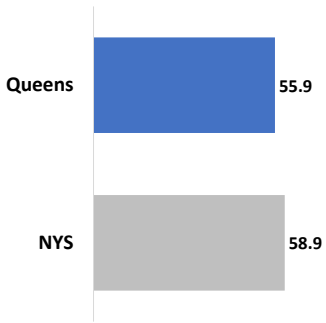
Childhood Poverty

Percentage of children aged <18 years below poverty



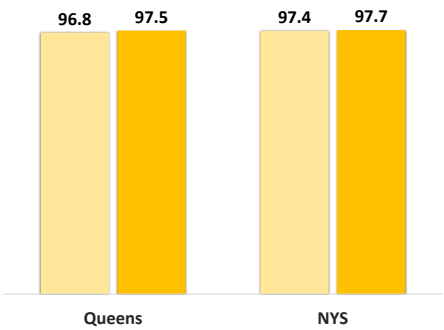
Early Education

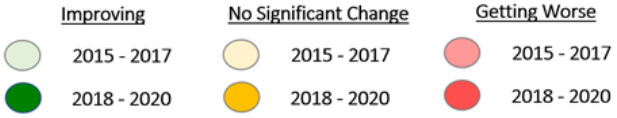
Percentage of children aged 3 to 4 years old who enrolled in schools among population aged 3 to 4 years old



Childhood Insurance Coverage

Percentage of children aged <19 years with health insurance





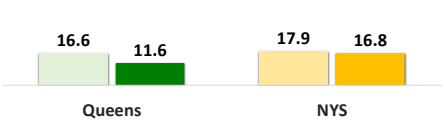
Healthy Women, Infants, & Children

Findings:

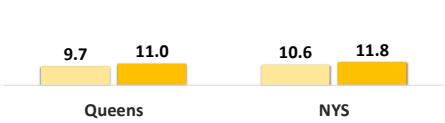
- The mortality rate for children aged 1-4 declined in the County but remained flat in the State
- The mortality rate for children aged 5-14 remained flat in the County and the State
- The mortality rate for youth aged 15-19 increased in the County but decreased in the State
- The trend in teenage suicides has noticeably worsened in the County (going from 2.5 to 4.4) and the State (5.4 to 6.2)

Pediatric Deaths

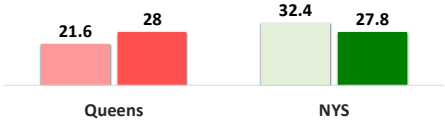
Mortality rate per 100,000 - Aged 1-4 years



Mortality rate per 100,000 - Aged 5-14 years

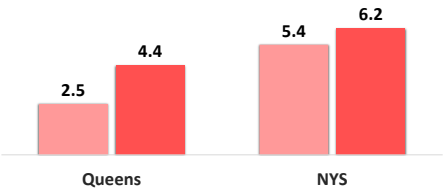


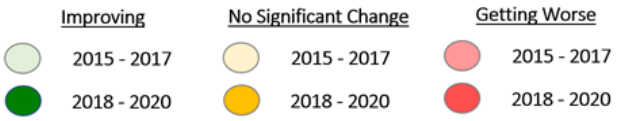
Mortality rate per 100,000 - Aged 15-19 years



Youth Suicide

Suicide mortality among youth, rate per 100,000, aged 15-19 years





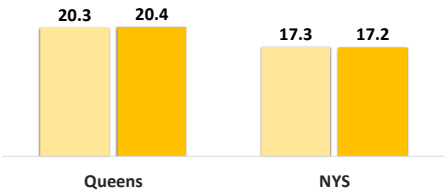
Healthy Women, Infants, & Children

Findings:

- The percentage of children and adolescents with obesity remained flat for both the County and the State
- The percentage of obese children aged 2-4 in WIC slightly decreased in the county but remained relatively flat in the State
- Rates of asthma related ED visits for youth aged 0-17 steadily declined in the County and the State
- The rate of outpatient visits for dental caries among children 3-5 years old has improved and has been consistently lower than the State

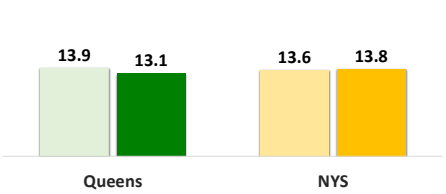
Childhood Obesity

Percentage of children and adolescents with obesity



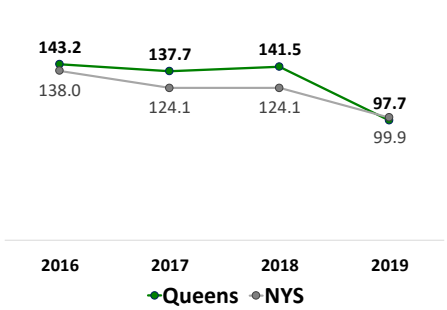
Childhood Obesity & Poverty

Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC



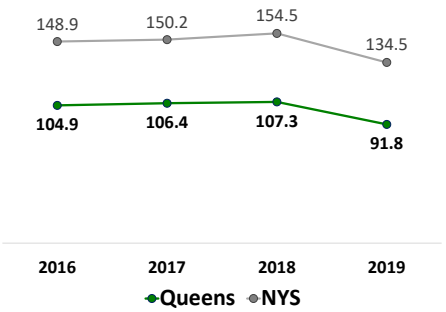
Youth Asthma

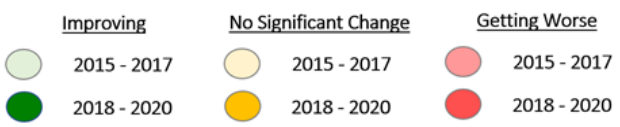
Asthma emergency department visits, rate per 10,000, aged 0-17 years



Pediatric Oral Health

Caries outpatient visit rate per 10,000 - Aged 3-5 years





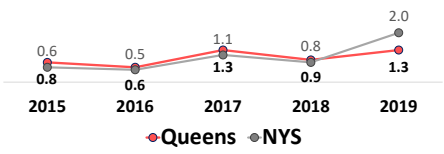
Communicable Diseases

Findings:

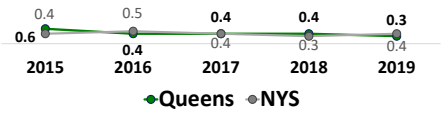
- Incidence rates per 100,000 population for hepatitis A have been low, but worsened since 2015, in both the County and the State
- Incidence rates per 100,000 population for acute hepatitis B have been low, but slightly improved since 2015, in the County
- Rates of chronic hepatitis C cases per 100,000 population improved for both the County and the State
- Age-adjusted rates of sexually transmitted diseases per 100,000 population, such as chlamydia, gonorrhea, and early syphilis allsteadily increased since 2015, for both the County and the State
- Age-adjusted rates per 100,000 population for newly diagnosed HIV cases decreased for the County and the State; County rates were consistently higher
- Age-adjusted mortality rates per 100,000 population for AIDS decreased for the County and the State
- Incidence rates for tuberculosis remained relatively flat for the County and the State since 2015

Hepatitis

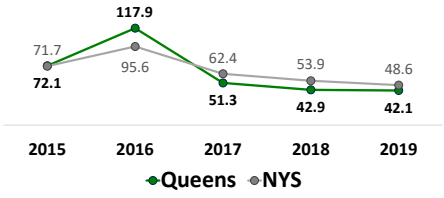
Hepatitis A incidence per 100,000



Acute hepatitis B incidence per 100,000

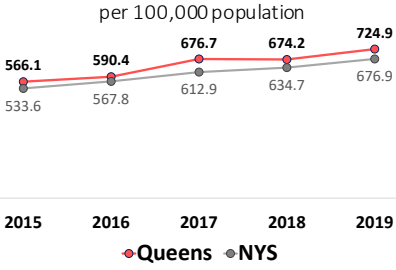


Chronic Hepatitis C cases per 100,000

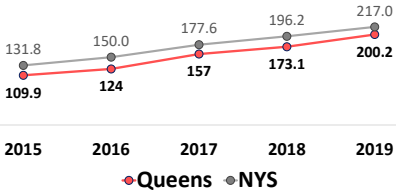


STIs

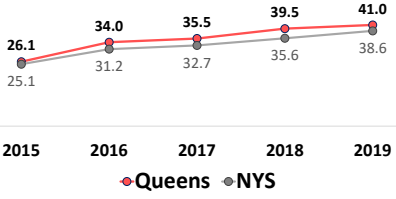
Chlamydia diagnoses, age-adjusted rate per 100,000 population



Gonorrhea diagnoses, age-adjusted rate per 100,000 population

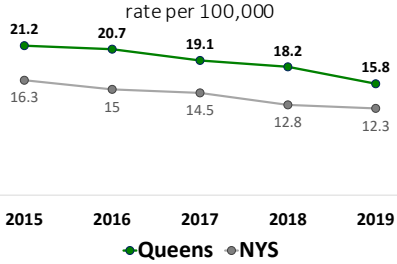


Early syphilis diagnoses, age-adjusted rate per 100,000 population

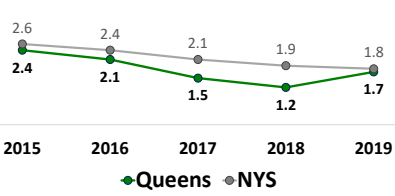


HIV / AIDS

Age-adjusted newly diagnosed HIV case rate per 100,000

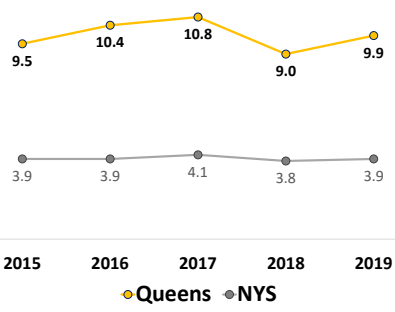


Age-adjusted AIDS mortality rate per 100,000



Tuberculosis

Tuberculosis incidence per 100,000



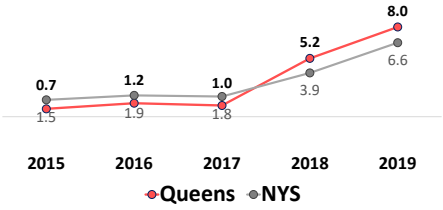
Communicable Diseases

Findings:

- The County's incidence rates got worse for diseases such as E. coli, haemophilus influenza, salmonella and shigella
- The County's incidence rates remained mostly flat for meningococcus
- The County's incidence rate improved for conditions such as pertussis and mumps

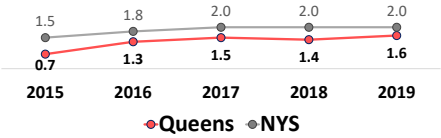
E. coli

E. coli Shiga Toxin incidence per 100,000



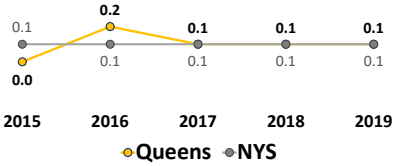
Haemophilus Influenza

Haemophilus influenza incidence per 100,000



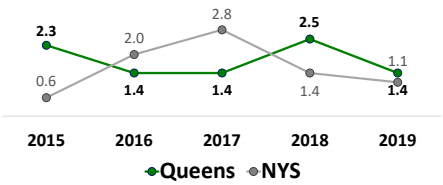
Meningococcus

Meningococcal incidence per 100,000



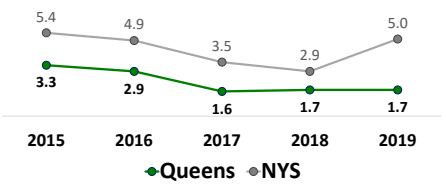
Mumps

Mumps incidence per 100,000



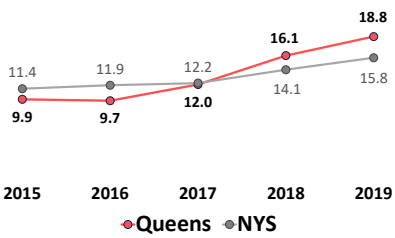
Pertussis

Pertussis incidence per 100,000



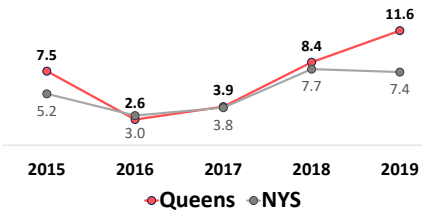
Salmonella

Salmonella incidence per 100,000



Shigella

Shigella incidence per 100,000



Interpersonal Violence & Safety

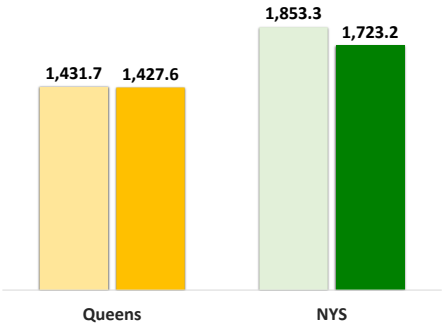
Findings:

- The index crime rate remained relatively flat for the County and below the rate statewide; Statewide rates saw a noticeable decrease
- Violent crime rates slightly increased in the County but remained relatively the same in the state overall
- Homicides in the County relatively lower but increased over time to be on par with statewide rates

Crime

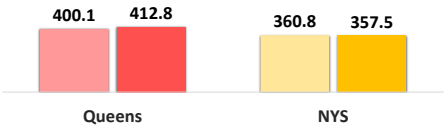
All Crime

Index crime rate per 100,000



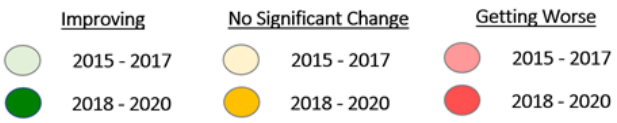
Violent Crime

Violent crime rate per 100,000



Homicides

Age-adjusted homicide mortality rate per 100,000



Interpersonal Violence & Safety

Findings:

- The age-adjusted hospitalization rate for all assaults is the same in the County as it is in the State; trends for both State and County remained flat
- Firearm assault-related hospitalizations are very similar between the County and the State and remained flat
- The rate of assault-related hospitalizations ratio between Black and White persons improved for both the County and the State
- The rate of assault-related hospitalizations ratio between Hispanic and White persons improved for the County while remaining flat for the State

Assaults

All Assaults

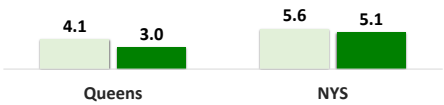
Age-adjusted assault hospitalization rate per 10,000

Firearm Assaults

Firearm assault-related hospitalizations, rate per 10,000 population

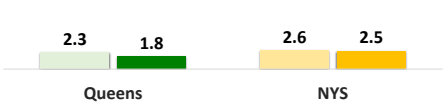
Assaults: Black/White

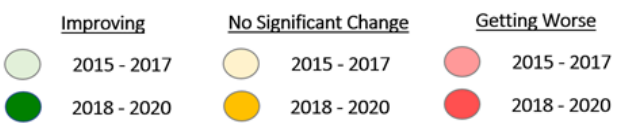
Assault-related hospitalizations, ratio of rates between Black non-Hispanics and White non-Hispanics



Assaults: Hispanic/White

Assault-related hospitalizations, ratio of rates between Hispanics and White non-Hispanics





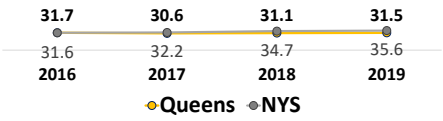
Interpersonal Violence & Safety

Findings:

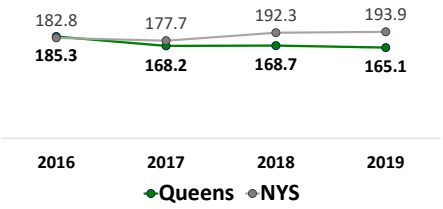
- The age-adjusted hospitalization rate from falls were similar for the County and the State; Hospitalizations for adults over 65+ years old decreased in the County while slightly increasing in the State
- Work-related hospitalizations per 100,000 employed persons increased since 2016 with lower rates in the County compared to the State
- The ratio of work-related ED visits between black and white individuals was similar between the County and the State

Falls

Age-adjusted falls hospitalization rate per 10,000



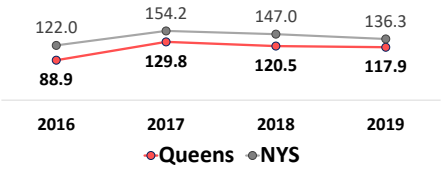
Hospitalizations due to falls among adults, rate per 10,000 population, aged 65+ years



Work-Related Injuries

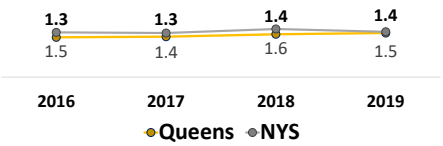
All Hospitalizations

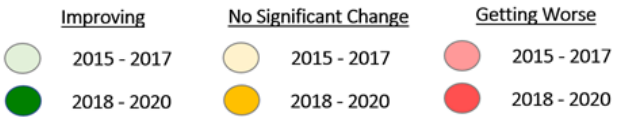
Work-related hospitalizations per 100,000 employed persons aged 16 years and older



ED Visits among Minorities

Work-related emergency department (ED) visits, ratio of rates between Black non-Hispanics and White non-Hispanics





Interpersonal Violence & Safety

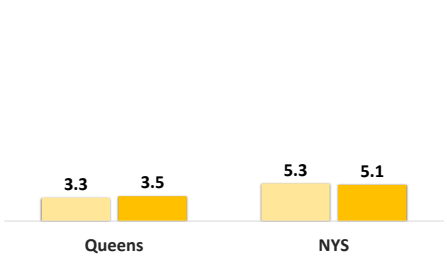
Findings:

- The County had a lower rate of motor vehicle injury and mortality per 100,000 compared to the State; the trends remained flat for both
- Alcohol related motor vehicle injuries and deaths declined in the County and the State
- The rate of crash-related pedestrian fatalities did not have a noticeable change in the County or the State

Vehicle Injuries & Deaths

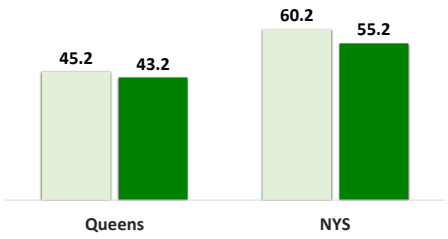
Fatal Accidents

Age-adjusted motor vehicle injury mortality rate per 100,000



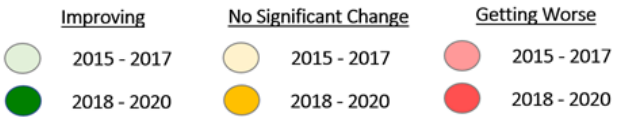
Drunk Driving – Injuries & Deaths

Alcohol related motor vehicle injuries and deaths per 100,000



Pedestrian Deaths

Crash-related pedestrian fatalities, rate per 100,000 population



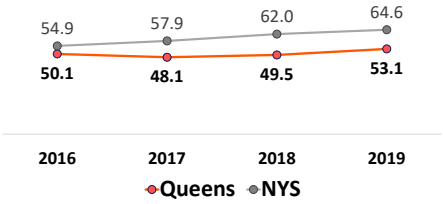
Interpersonal Violence & Safety

Findings:

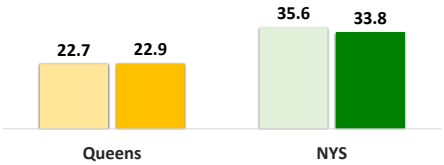
- Since 2016, the age-adjusted hospitalizations for unintentional injuries steadily increased in both the County and the State
- The age-adjusted mortality rates for unintentional injuries have improved for the State, however the County rates are lower and remained relatively flat
- The County hospitalization rate for poisonings worsened, while rates for self-inflicted injuries were flat; both sets of County rates were relatively lower than the rates statewide
- Age-adjusted rate for traumatic brain injury hospitalizations was stable in the County and the State

Unintentional Injuries

Age-adjusted unintentional injury hospitalization rate per 10,000



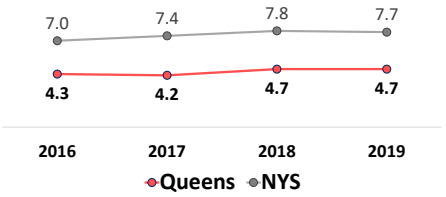
Age-adjusted unintentional injury mortality rate per 100,000



Other Injuries

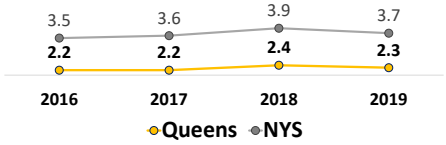
Poisonings

Age-adjusted poisoning hospitalization rate per 10,000



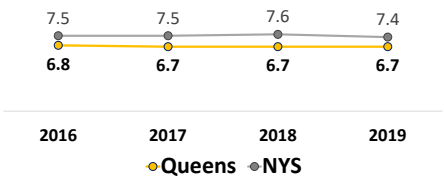
Self-Inflicted Injuries

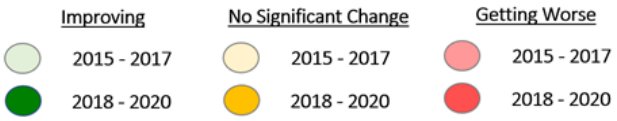
Age-adjusted self-inflicted injury hospitalization rate per 10,000



Traumatic Brain Injuries

Age-adjusted traumatic brain injury hospitalization rate per 10,000





SOUTHEAST JAMAICA

A working-class and middle-class neighborhood located south of downtown Jamaica in the borough of Queens in New York City. Southeast Jamaica is part of Queens Community District 12. Southeast Jamaica has a racial diversity index of .60. The poverty rate in Southeast Jamaica is 10.0%.

COMMUNITY ASSETS

Food Pantries: Beacon Community Center at Richard S. Grossley Campus JHS 8, Bethel Gospel Tabernacle, Community Church of Christ Soup Kitchen, Greater Allen AME Cathedral, Harding Ford Vision, St. Benedict the Moor Catholic Church

Northwell Community Partners: Greater Springfield Community Chruch

Northwell Community Programs: Northwell Community Scholars (planned 2023), Wellness on Wheels

Parks: Baisley Pond Park, Dr. Charles R. Drew Park

School District(s): NYC Department of Education

Transportation: Long Island Rail Road, MTA Bus, MTA Subway

POPULATION

Southeast Jamaica	Queens
156,461	2,270,976

LIFE EXPECTANCY

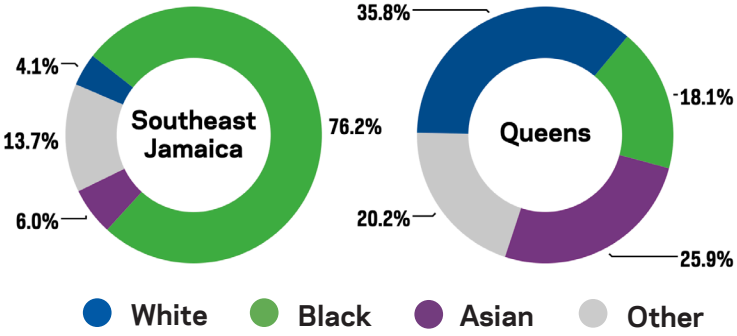
Southeast Jamaica	Queens
79.2	81.5

COVID-19 VACCINATION

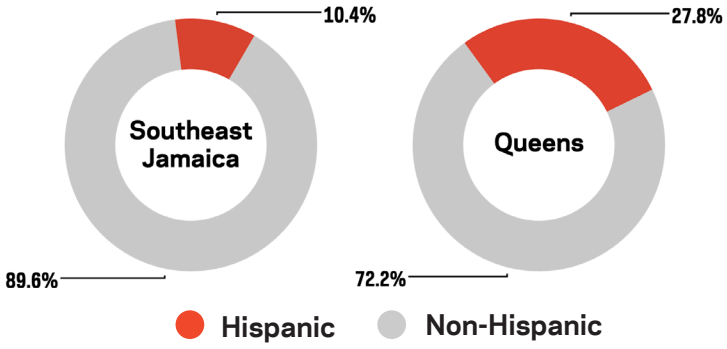
People with completed vaccine series

Southeast Jamaica	Queens
77.4%	87.0%

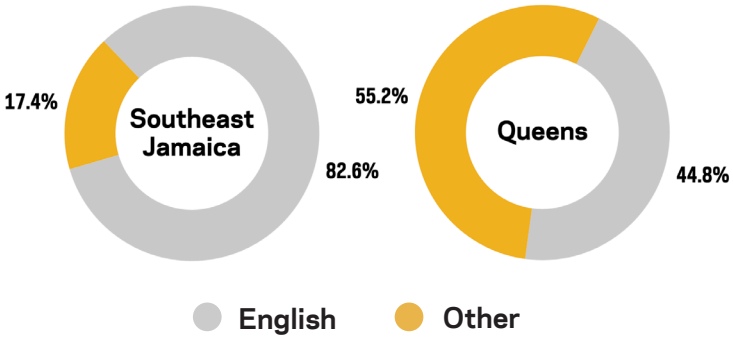
RACE



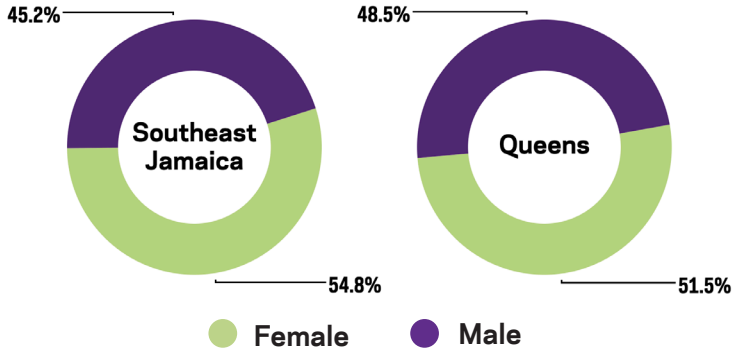
ETHNICITY

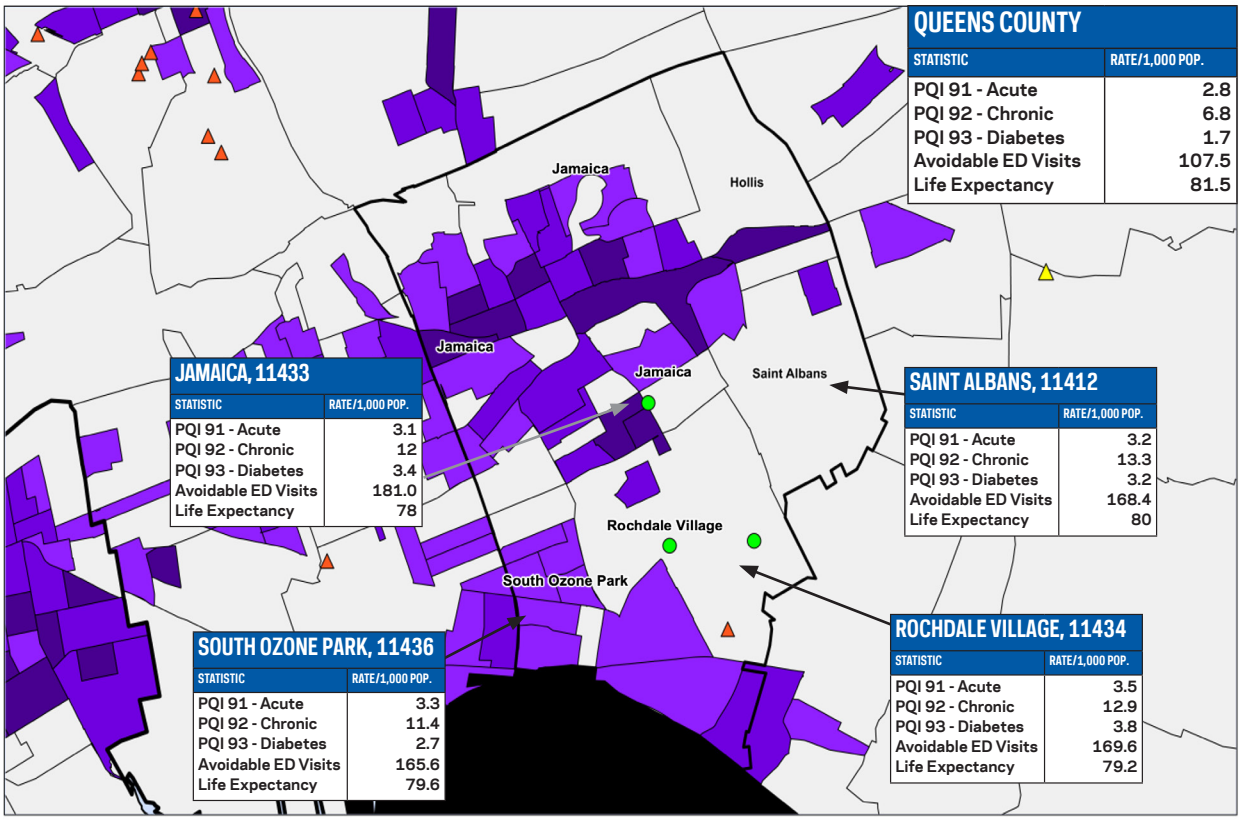


LANGUAGES SPOKEN AT HOME OTHER THAN ENGLISH



GENDER





QUEENS COUNTY

STATISTIC	RATE/1,000 POP.
PQI 91 - Acute	2.8
PQI 92 - Chronic	6.8
PQI 93 - Diabetes	1.7
Avoidable ED Visits	107.5
Life Expectancy	81.5

JAMAICA, 11433

STATISTIC	RATE/1,000 POP.
PQI 91 - Acute	3.1
PQI 92 - Chronic	12
PQI 93 - Diabetes	3.4
Avoidable ED Visits	181.0
Life Expectancy	78

SAINT ALBANS, 11412

STATISTIC	RATE/1,000 POP.
PQI 91 - Acute	3.2
PQI 92 - Chronic	13.3
PQI 93 - Diabetes	3.2
Avoidable ED Visits	168.4
Life Expectancy	80

SOUTH OZONE PARK, 11436

STATISTIC	RATE/1,000 POP.
PQI 91 - Acute	3.3
PQI 92 - Chronic	11.4
PQI 93 - Diabetes	2.7
Avoidable ED Visits	165.6
Life Expectancy	79.6

ROCHDALE VILLAGE, 11434

STATISTIC	RATE/1,000 POP.
PQI 91 - Acute	3.5
PQI 92 - Chronic	12.9
PQI 93 - Diabetes	3.8
Avoidable ED Visits	169.6
Life Expectancy	79.2

- High SVI Score
- CPN - HUB
- CPN - SPOKE
- Faith Based – COVID & Flu

Source: NYSDOH SPARCS/mc
Current faith-based centers include permanent sites; Other faith-based centers were provided by Community Relations; Avoidable ED Visits defined by NYU Algorithm; Prepared by the Office of Strategic Planning

Southeast Jamaica **10.0%** — **POVERTY** *Below 100% Federal poverty* — Queens **11.6%**

Southeast Jamaica **5.0%** — **UNEMPLOYMENT RATE** — Queens **3.8%**

Southeast Jamaica **46.1%** — **HOUSING BURDEN** *Monthly housing cost (i.e.: rent/mortgage as a percentage of household income in the last 12 months* — Queens **44.0%**

Southeast Jamaica **26.1%** — **TRANSPORTATION** *Households with no vehicles available* — Queens **36.9%**

Southeast Jamaica **14.8%** — **EDUCATION** *Less than high school diploma* — Queens **17.4%**

Southeast Jamaica **11.3%** — **PRENATAL CARE** *Late or no prenatal care* — Queens **6.9%**

2022 GNYHA CHNA SURVEY COLLABORATIVE

CHNA SURVEY COLLABORATIVE OVERVIEW

In early 2022, GNYHA offered member hospitals and health systems the opportunity to participate in the GNYHA Community Health Needs Assessment (CHNA) Survey Collaborative. The collaborative supported participating members' primary data collection efforts to meet the requirements of the Federal CHNA and the New York State Community Service Plan (CSP) by gathering information on community health needs and engaging with community members. While not a required element of a CHNA, surveys can be a part of a hospital's CHNA and CSP along with other community engagement efforts and secondary data such as surveillance data from public health departments. The collaborative complemented longstanding GNYHA efforts to support members throughout their CHNA and CSP development and implementation process.

A diverse group of GNYHA member hospitals participated in the 2022 collaborative, including community and safety net hospitals, small health systems, and large academic medical centers. GNYHA developed a health needs assessment survey with member input, made the survey available in 11 languages on paper and online, collected the data and analyzed the results, and created custom reports for each participating hospital. The members recruited participants from their communities to respond to the survey, and more than 17,600 community members responded.

COLLABORATIVE SURVEY DESIGN

The CHNA collaborative survey is an abbreviated version of the 2022 GNYHA Model Community Health Needs Assessment Survey. GNYHA members provided input in multiple stages through a collaborative and iterative process. GNYHA developed the survey using best practice approaches in survey design and needs assessment. The survey used validated questions from existing surveys such as the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (CDC BRFSS) and the New York City Department of Health and Mental Hygiene's Community Health Survey (NYC CHS). GNYHA sought to minimize respondent burden by keeping the survey length to a minimum.

Community members could complete the survey online in a format compatible with mobile devices. The members also received copies of the survey in 11 languages (English and the top 10 languages spoken among non-English speakers as designated by New York State), which participants could print and use for data collection. Before the collaborative began, participating hospitals gave GNYHA a list of the counties or zip codes where the hospital would field the survey. GNYHA attributed respondents who lived in a hospital's survey service area to that hospital. Hospitals recruited members of their community to participate in the survey and entered data from paper surveys online. Each hospital received a report with data from respondents who live in that service area.

COLLABORATIVE SURVEY RESULTS

Approximately 17,600 community members responded to the survey, and about 70% completed the entire survey. Community members qualified for the survey if they were age 18 and above and lived within any of the geographic areas identified by the members as their hospital's service area.

During the survey fielding period, GNYHA held member forums in which the members shared best practices and challenges in recruiting community members for the survey. GNYHA produced biweekly geographic and demographic reports summarizing the responses in their service area, which allowed hospitals to adjust their dissemination strategy.

Following the survey's close, GNYHA provided each participant with a report that summarized the survey responses and respondent demographics, and a spreadsheet with the processed respondent-level data for their service area, allowing for participating hospitals to conduct additional analyses. GNYHA also provided technical assistance to each hospital to interpret their results and identify areas of need, and created custom reports as requested by members.

2022 Community Health Survey

We want to improve the health services we offer to people who live in your neighborhood. The information you give us will be used to improve health services for people like yourself.

Completing the survey is voluntary. We will keep your answers private. If you are not comfortable answering a question, leave it blank.

We value your input. Thank you very much for your help.

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1 **Are you 18 years of age or older?**

- ○ Yes
- ○ No → Thank you very much, but we are only asking this survey of people who are ages 18 and older.

2 **We want people from all different neighborhoods to take part in this survey. Please tell us the zip code where you live so we can identify your neighborhood.**

Zip code: _____

IF YOU PROVIDED A ZIP CODE, PLEASE GO TO PAGE 3. YOU DO NOT NEED TO ANSWER THESE QUESTIONS.

3 **Do you live in New York City?**

- ○ Yes
- ○ No → Skip to 5

4 **If you live in New York City, please select the borough where you live:**

- ○ The Bronx → Go on to page 3
- ○ Brooklyn → Go on to page 3
- ○ Manhattan → Go on to page 3
- ○ Queens → Go on to page 3
- ○ Staten Island → Go on to page 3

5 **If you do not live in New York City, please tell us the county where you live:**

- ○ Albany County
- ○ Allegany County
- ○ Broome County
- ○ Cattaraugus County
- ○ Cayuga County
- ○ Chautauqua County
- ○ Chemung County
- ○ Chenango County
- ○ Clinton County
- ○ Columbia County
- ○ Cortland County
- ○ Delaware County
- ○ Dutchess County
- ○ Erie County
- ○ Essex County
- ○ Franklin County
- ○ Fulton County
- ○ Genesee County
- ○ Greene County
- ○ Hamilton County
- ○ Herkimer County
- ○ Jefferson County
- ○ Lewis County
- ○ Livingston County
- ○ Madison County
- ○ Monroe County
- ○ Montgomery County
- ○ Nassau County
- ○ Niagara County
- ○ Oneida County
- ○ Onondaga County
- ○ Ontario County
- ○ Orange County
- ○ Orleans County
- ○ Oswego County
- ○ Otsego County
- ○ Putnam County
- ○ Rensselaer County
- ○ Rockland County
- ○ Saratoga County
- ○ Schenectady County
- ○ Schoharie County
- ○ Schuyler County
- ○ Seneca County
- ○ St. Lawrence County
- ○ Steuben County
- ○ Suffolk County
- ○ Sullivan County
- ○ Tioga County
- ○ Tompkins County
- ○ Ulster County
- ○ Warren County
- ○ Washington County
- ○ Wayne County
- ○ Westchester County
- ○ Wyoming County
- ○ Yates County

- ○ Other_____

6 **In general, how is the overall health of the people of your neighborhood?**

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

7 **In general, how is your physical health?**

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

8 **In general, how is your mental health?**

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

9 **For each of the following, please tell us: How important is each of the following to you and how satisfied are you with the current services in your neighborhood to address each health issue?**

	How important is this issue to you?						How satisfied are you with current services?					
	Don't know	Not at all	A little	Somewhat	Very	Extremely	Don't know	Not at all	A little	Somewhat	Very	Extremely
1 Access to healthy/nutritious foods	○	○	○	○	○	○	○	○	○	○	○	○
2 Adolescent and child health	○	○	○	○	○	○	○	○	○	○	○	○
3 Arthritis/disease of the joints	○	○	○	○	○	○	○	○	○	○	○	○
4 Asthma/breathing problems or lung disease	○	○	○	○	○	○	○	○	○	○	○	○
5 Cancer	○	○	○	○	○	○	○	○	○	○	○	○
6 Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah	○	○	○	○	○	○	○	○	○	○	○	○
7 COVID-19	○	○	○	○	○	○	○	○	○	○	○	○
8 Dental care	○	○	○	○	○	○	○	○	○	○	○	○
9 Diabetes/elevated sugar in the blood	○	○	○	○	○	○	○	○	○	○	○	○
10 Heart disease	○	○	○	○	○	○	○	○	○	○	○	○
11 Hepatitis C/liver disease	○	○	○	○	○	○	○	○	○	○	○	○
12 High blood pressure	○	○	○	○	○	○	○	○	○	○	○	○
13 HIV/AIDS (Acquired Immune Deficiency Syndrome)	○	○	○	○	○	○	○	○	○	○	○	○
14 Infant health	○	○	○	○	○	○	○	○	○	○	○	○
15 Mental health/depression	○	○	○	○	○	○	○	○	○	○	○	○
16 Obesity in children and adults	○	○	○	○	○	○	○	○	○	○	○	○
17 Sexually Transmitted Infections (STIs)	○	○	○	○	○	○	○	○	○	○	○	○
18 Stopping falls among elderly	○	○	○	○	○	○	○	○	○	○	○	○
19 Substance use disorder/drug addiction (including alcohol use disorder)	○	○	○	○	○	○	○	○	○	○	○	○
20 Violence (including gun violence)	○	○	○	○	○	○	○	○	○	○	○	○
21 Women's and maternal health care	○	○	○	○	○	○	○	○	○	○	○	○

10 **What are your COVID-19 needs?** (Select all that apply)

- ☐ At-home COVID-19 tests
- ☐ Boosters for COVID-19
- ☐ In-person testing for COVID-19 (e.g., doctor's office, pharmacy, mobile van)
- ☐ Personal protective equipment (e.g., masks, hand sanitizer, face shields, gloves)
- ☐ Treatment for COVID-19
- ☐ Reliable source(s) of information on COVID-19
- ☐ COVID-19 vaccination

11 **In the last 12 months, was there a time when you needed medical care in-person but did not get it for any reason?**

- ○ Yes
- ○ No → Skip to 13

12 **For which of the following reasons could you not get medical care in-person the last 12 months?** (Select all that apply)

- ☐ I could not afford the cost of care (e.g., copay, deductible)
- ☐ I did not have health insurance
- ☐ There were no available appointments, or I couldn't get an appointment soon enough
- ☐ I could not get through on the telephone to make the appointment
- ☐ Once I got there the wait was too long to see the doctor
- ☐ I did not have transportation
- ☐ I did not have childcare
- ☐ Because of COVID-19
- ☐ Other
- ☐ None of the above

13 **In the last 12 months, was there a time when you needed medical care by video or phone but could not get it for any reason?**

- ○ Yes
- ○ No → Skip to 15

14 **For which of the following reasons could you not get medical care by video or phone in the last 12 months?** (Select all that apply)

- ☐ I could not afford the cost of care (e.g., copay, deductible)
- ☐ I did not have health insurance
- ☐ There were no available appointments, or I couldn't get an appointment soon enough
- ☐ I could not get through on the telephone to make the appointment
- ☐ I did not have a computer, phone, or other device to use for the visit
- ☐ I did not know how to see the doctor by video or phone
- ☐ I did not have internet
- ☐ I did not have data or minutes in my phone plan to use for a visit
- ☐ I did not have a private place to have my appointment
- ☐ Other
- ☐ None of the above

15 **In the last 12 months, have you experienced any of the following?** (Select all that apply)

- ○ Anxiety or depression
- ○ Difficulty paying your rent/mortgage
- ○ Difficulty paying utilities or other monthly bills
- ○ Increased household expenses
- ○ Increased medical expenses
- ○ Hunger or skipped meals because you did not have enough money to buy food
- ○ None of these

16 **What type of health insurance do you use to pay for your doctor or hospital bills? Is it insurance through:**

- ○ A plan purchased through an employer or union (including plans purchased through another person's employer)
- ○ A plan that you or another family member buys on your own
- ○ Medicare
- ○ Medicaid or other state program
- ○ TRICARE (formerly CHAMPUS), VA, or Military
- ○ Alaska Native, Indian Health Service, Tribal Health Services
- ○ Some other source
- ○ I do not have any kind of health insurance coverage

17 **What is your age?**

_____

18 **Are you…**

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Another gender
- ○ Prefer not to say

19 **Do you describe yourself as…**

- ○ Lesbian or Gay
- ○ Straight, that is not Gay
- ○ Bisexual
- ○ Other
- ○ Prefer not to say

20 **Are you Hispanic or Latino/Latina/Latinx?**

- ○ No
- ○ Yes → Answer 21

21 **Which group best represents your Hispanic or Latino/Latina/Latinx origin or ancestry?**

- ○ Puerto Rican
- ○ Dominican
- ○ Mexican
- ○ Ecuadorian
- ○ Colombian
- ○ Cuban
- ○ Other Central American
- ○ Other South American
- ○ Other

22 **Which one or more of the following would you say is your race?** (Select all that apply)

- ☐ White
- ☐ Black or Black American → Answer 23

  23 **Some people in addition to being Black, have a certain heritage or ancestry. Do you identify with any of these?** (Select all that apply)

  - ☐ African American
  - ☐ Caribbean or West Indian
  - ☐ A recent immigrant or the child of recent immigrants from Africa
  - ☐ Other
- ☐ Asian → Answer 24

  24 **Please tell me which group best represents your Asian heritage or ancestry?**

  - ☐ Chinese
  - ☐ Asian Indian
  - ☐ Filipino
  - ☐ Korean
  - ☐ Japanese
  - ☐ Vietnamese
  - ☐ Other
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian, Native, First Nations, Indigenous Peoples of the Americas, or Alaska Native
- ☐ Other

25 **What is the highest grade or year of school that you have completed?**

- ○ Grades 8 (Elementary) or less
- ○ Grades 9 through 11 (Some High School)
- ○ Grade 12 or GED (High School Graduate)
- ○ Some college or technical school
- ○ College graduate or more

26 **Including yourself, how many people usually live or stay in your home or apartment?**

_____ person(s)

27 **What is the primary language you speak at home?**

- ○ English
- ○ Spanish
- ○ Mandarin
- ○ Cantonese
- ○ Russian
- ○ Yiddish
- ○ Bengali
- ○ Korean
- ○ Haitian Creole
- ○ Italian
- ○ Arabic
- ○ Other

28 **What is your current employment status? Select the category that best describes you.**

- ○ Employed full-time for wages or salary
- ○ Employed part-time for wages or salary
- ○ Self-employed
- ○ Out of work for 1 year or more
- ○ Out of work for less than 1 year
- ○ A homemaker
- ○ A student
- ○ Retired
- ○ Unable to work

29 **What is your household's annual household income from all sources, before taxes, in the last year?** By household income we mean the combined income from everyone living in the household including even roommates or those on disability income.

- ○ Less than $20,000
- ○ $20,000 to $29,999
- ○ $30,000 to $49,999
- ○ $50,000 to $59,999
- ○ $60,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 or more

This is the end of the survey. Thank you very much for your help.