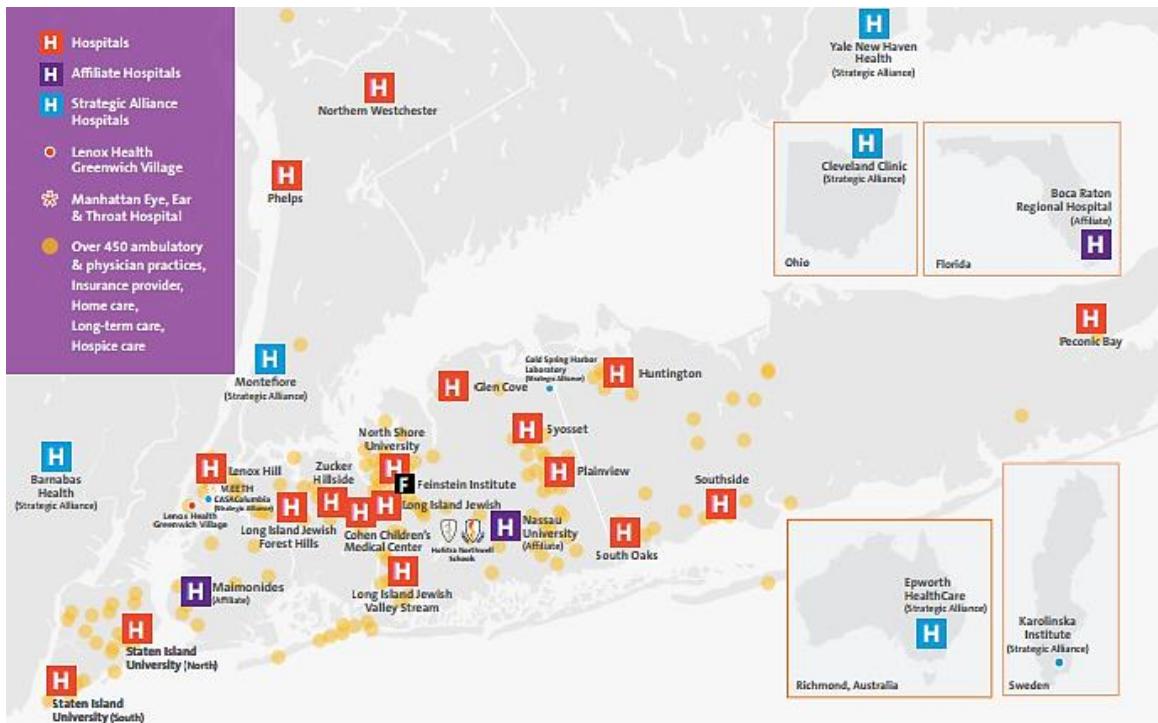


# Northwell Health Community Service Plan 2016-2019

## Queens County Service Area CHNA



# ***Queens County Community Health Needs Assessment***

## **Queens County Health Indicator Status Since 2013 CHNA**

The 2013-2016 Implementation Plan activities have had an impact in improving and meeting New York State Prevention Agenda Objectives that were related to health disparities, chronic disease, obesity and behavioral health as shown below. Since 2013, Northwell Health has delivered over 4000 community health programs and over 65,000 health screenings. Examples of interventions that helped achieved these goals include robust chronic disease and cancer screening programs; implementation of culturally relevant evidence-based chronic disease self-management education; prevention of childhood obesity through school-based projects as well as promotion of policies and practices in support of breastfeeding; creation of community environments that promote and support healthy food and beverage choices and physical activity; elimination of exposure to secondhand smoke and prevention of the initiation of tobacco use by youth, especially among low socioeconomic status (SES) populations and the promotion of tobacco cessation, especially among low SES populations and those with poor mental health; and strengthened infrastructure to promote mental, emotional and behavioral wellbeing. However, the burden of health disparities, chronic disease, obesity and behavioral health issues is still present as demonstrated below by the indicators that have not met the New York State Department of Health (NYSDOH) Prevention Agenda Objectives and/or have worsened indicating the need to continue to address the 2013-2016 priority agenda item and focus areas.

Since the last community health needs assessment the following NYSDOH Prevention Objectives (NYSPA0)<sup>1</sup> have:

### **Improved**

- Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics
- Premature deaths: Ratio of Hispanics to White non-Hispanics
- Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years\*
- Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics
- Percentage of adults (aged 18-64) with health insurance\*
- Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years\*
- Assault-related hospitalization rate per 10,000
- Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics
- Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics
- Assault-related hospitalization: Ratio of low income ZIP codes to non-low income ZIP codes
- Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home
- Asthma emergency department visit rate per 10,000 - Aged 0-4 years\*
- Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years
- Newly diagnosed HIV case rate per 100,000\*
- Difference in rates (Black and White) of newly diagnosed HIV cases\*
- Percentage of preterm births\*
- Premature births: Ratio of Black non-Hispanics to White non-Hispanics

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<sup>1</sup> New York State Department of Health Prevention agenda Dashboard  
[https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?\\_program=%2FEBI%2FPHIG%2Fapps%2Fdashboards%2Fpa\\_dashboard&p=ch&cos=60](https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboards%2Fpa_dashboard&p=ch&cos=60) Assessed November 2016.

Premature births: Ratio of Hispanics to White non-Hispanics  
Premature births: Ratio of Medicaid births to non-Medicaid births  
Percentage of infants exclusively breastfed in the hospital\*  
Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics  
Exclusively breastfed: Ratio of Hispanics to White non-Hispanics  
Maternal mortality rate per 100,000 births  
Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs\*  
Percentage of children aged 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs\*  
Percentage of children aged 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs\*  
Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics  
Percentage of women (aged 18-64) with health insurance\*  
*\*Significant change*

### **No Significant Change**

Percentage of premature deaths (before age 65 years) #  
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years#  
Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years  
Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge  
Percentage of residents served by community water systems with optimally fluoridated water#  
Percentage of adults who are obese#  
Percentage of children and adolescents who are obese#  
Percentage of cigarette smoking among adults#  
Asthma emergency department visit rate per 10,000 population #  
Age-adjusted heart attack hospitalization rate per 10,000  
Percentage of adults with flu immunization - Aged 65+ years  
Difference in rates (Hispanic and White) of newly diagnosed HIV cases  
Gonorrhea case rate per 100,000 women - Aged 15-44 years  
Chlamydia case rate per 100,000 women - Aged 15-44 years  
Primary and secondary syphilis case rate per 100,000 women  
Percentage of children aged 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs#  
Percentage of children (aged under 19 years) with health insurance#  
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years  
Percentage of unintended pregnancy among live births#  
Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic#  
Unintended pregnancy: Ratio of Hispanics to White non-Hispanics#  
Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births#  
Percentage of live births that occur within 24 months of a previous pregnancy  
*# did not meet NYSDOH Prevention Agenda Objective*

### **Worsened**

Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics  
Rate of hospitalizations due to falls per 10,000 - Aged 65+ years\*  
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years

Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births

Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics

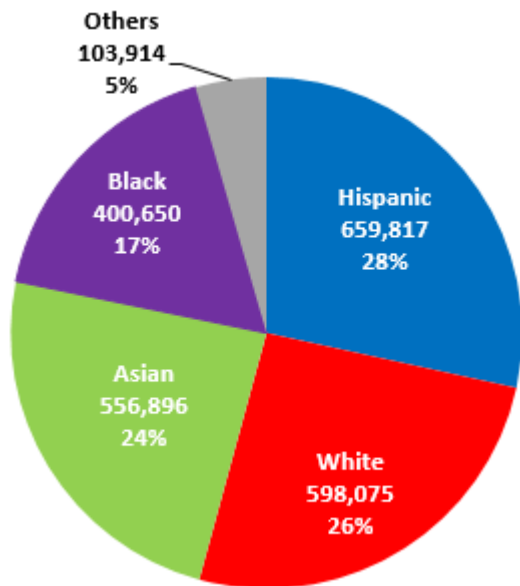
Age-adjusted suicide death rate per 100,000

*\*Significant change*

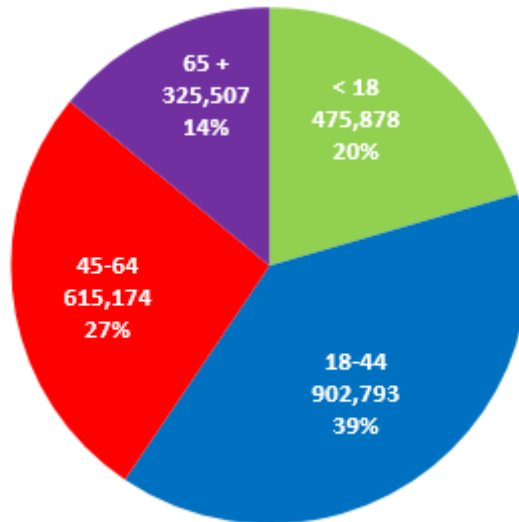
**Demographic Profile**

Our primary service areas in Queens County encompass four hospitals; Long Island Jewish Medical Center; Cohen Children’s Medical Center of New York; The Zucker Hillside Hospital; and Long Island Jewish Forest Hills. Queens County has a population of 2,319,352 that is 52% female and has an age distribution of 20% aged less than 18 years, 39% aged between 18 and 44 years old, 27% aged 45 to 64, and 14% over 65 years of age. Queens County is the most racially diverse county in the United States with a racial distribution that is 26% white, 28% Hispanic, 17% black, and 24% Asian. Approximately 48% of Queens County residents are foreign-born and 57% of residents speak a language other than English at home.

QUEENS COUNTY RACIAL DIVERSITY



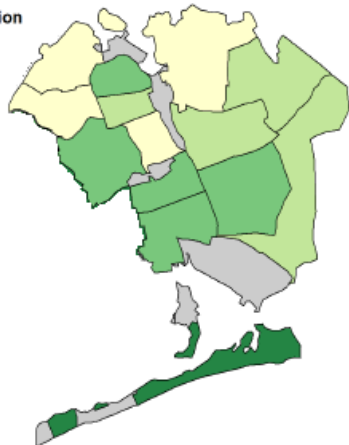
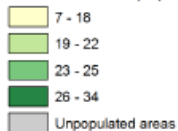
QUEENS COUNTY POPULATION AGE DISTRIBUTION



Source: Truven Market Discovery.v2015.03.26.tpn

**Children (0-17 years)**

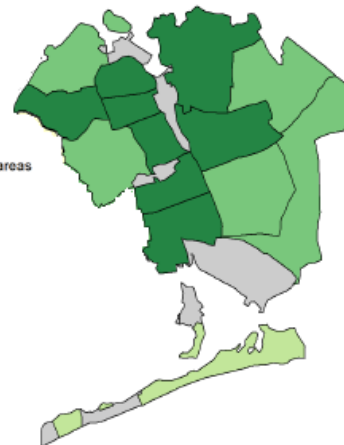
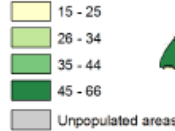
**Percent of total population**



Source: U.S. Census Bureau Population Estimates, 2013

**Foreign Born**

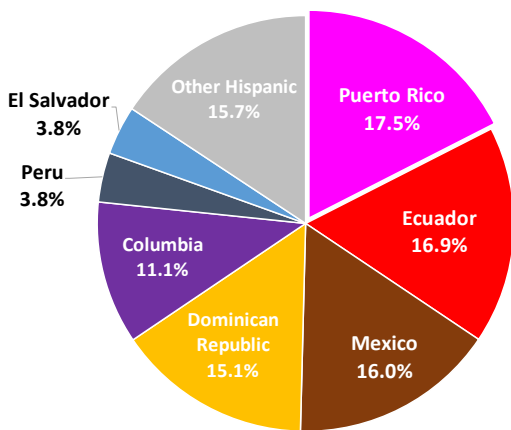
**Percent**



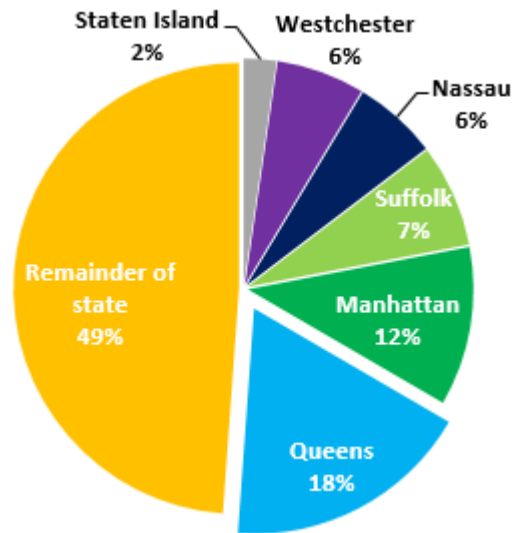
Source: U.S. Census Bureau, American Community Survey, 2011-2013

The Hispanic population is the most largely represented minority in Queens County. Within the Hispanic population, there are several countries of origin represented. Approximately 66% of the Hispanic population is composed of Central American, South American, and Spanish subgroups. Eighteen percent of the Hispanic population is Puerto Rican, while 16% is Mexican. Queens County alone makes up 18% of the State’s Hispanic population. Similarly, Queens County makes up 14% of the State’s black population.

HISPANIC/LATINO SUB-POPULATIONS

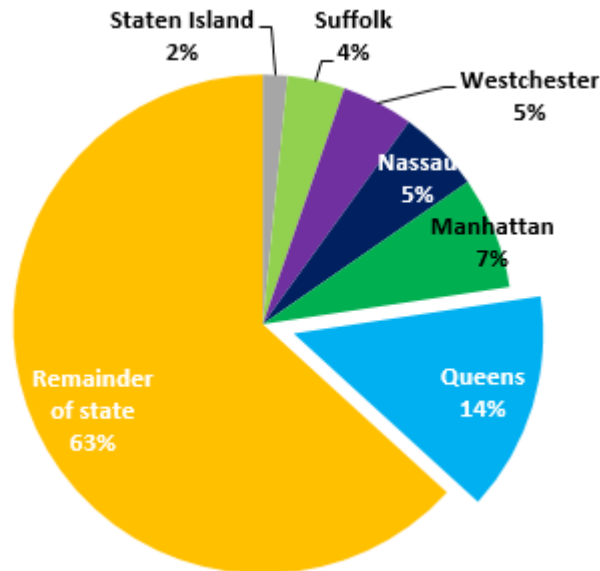


PERCENT OF STATE HISPANIC POPULATION



\*Other is comprised of Central American, South American, and Spanish sub-groups; tpn

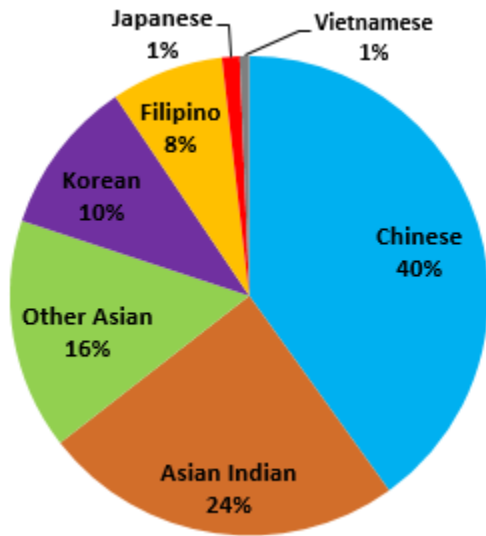
PERCENT OF STATE BLACK POPULATION



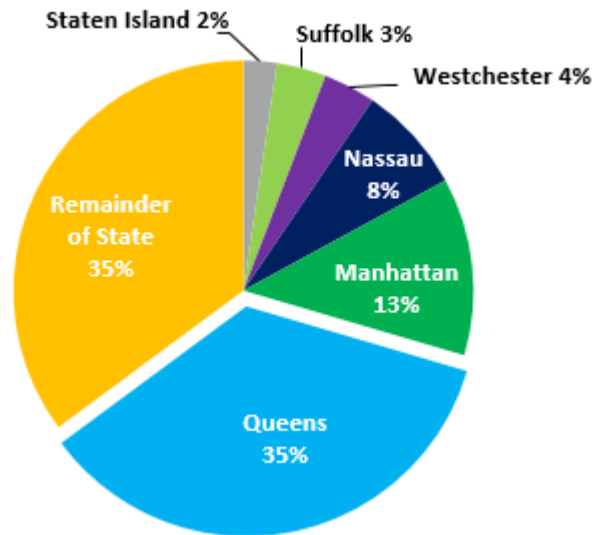
Source: Truven Market Discovery.v2015.03.26, ACS Census 2014; tpn

The Asian population of Queens is the second most largely represented minority, and there are several countries of origin represented in the Asian population of Queens County. The breakdown of Asian subpopulations is as follows: 40% Chinese, 24% Asian Indian, 16% other Asian, 10% Korean, 8% Filipino, 1% Vietnamese, and 1% Japanese. Queens County makes up 35% of the State's Asian population.

ASIAN SUB-POPULATIONS



PERCENT OF STATE ASIAN POPULATION



Source: Truven Market Discovery.v2015.03.26, ACS Census 2014; tpn

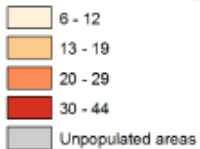
## Social Determinant Analysis

Secondary data on various social determinants of health in Queens County was analyzed to identify factors that may contribute to the health status of the population of Queens County. The results of this analysis are as follows.

The average household income in Queens is \$74,962 and the per capita income is \$26,580, both below the service area average. The poverty rate in Queens is high at 15.4%. The highest poverty rates are concentrated in the Jackson Heights and Elmhurst and Corona neighborhoods of Queens. In these neighborhoods, residents are on average 20 to 29% below the federal poverty level. Furthermore, it's important to note that most of Queens is at least 13% below the federal poverty level. Despite the poverty rate in Queens being slightly less than the poverty rate in Manhattan, Queens still maintains the lowest average household income and lowest per capita income in Northwell's six-county service area.

### Poverty

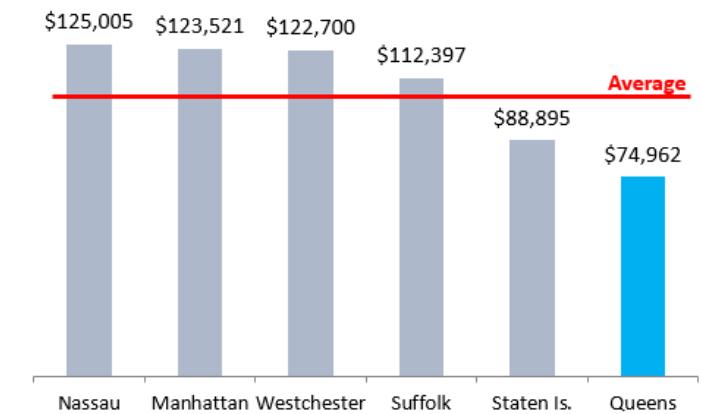
#### Percent below federal poverty level



Source: U.S. Census Bureau, American Community Survey, 2011-2013

## Average Household Income

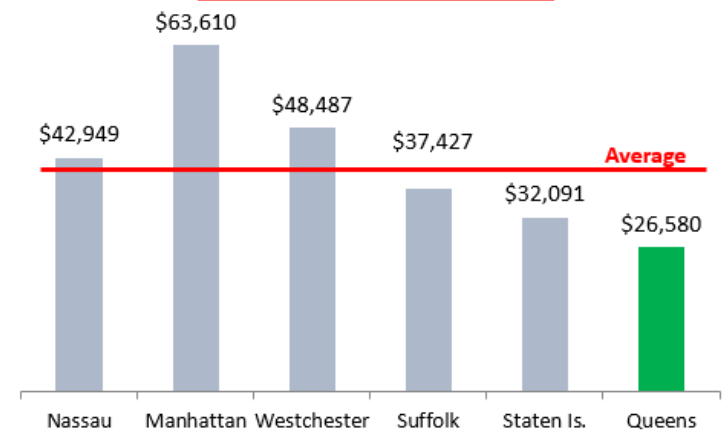
**Service Area Avg. = \$107,913**



Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn

## Per Capita Income

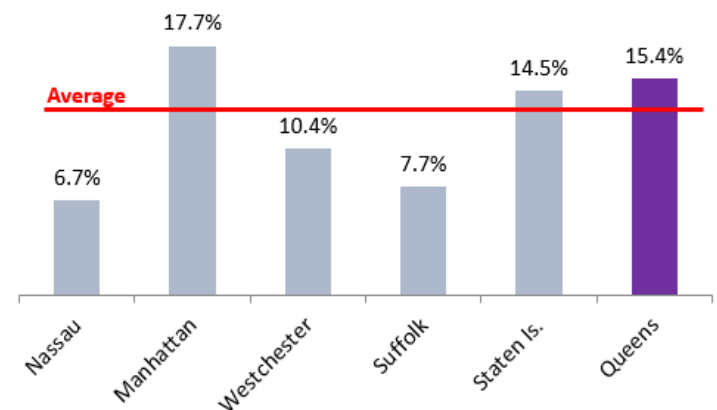
**Service Area Avg. = \$41,857**



Source: Truven 2015 v. 2015.08.04, US Census 2014. Tpn

## Percent Poverty (est.)

**Service Area Avg. = 12.1%**



Source: Truven 2015 v. 2015.08.04, US Census 2014. Tpn

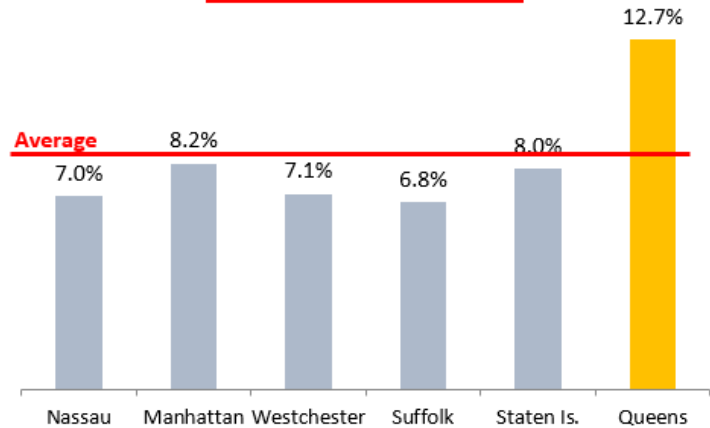


The socioeconomic state of Queens is further represented in its extremely high rates of unemployment. The unemployment rate in Queens is 12.7%, well above the other counties in Northwell's scope. This is also nearly double the New York State unemployment of 6.3%. Unemployment may be as high as 20% in Jamaica and Hollis. Very high unemployment, coupled with poverty and low income makes many areas of Queens considerably more socioeconomically strained.

Poverty and unemployment are not the only socioeconomic determinants of health. Educational attainment has perhaps the strongest correlation to health outcomes. Sixty-eight percent of Queens students graduate from high school, and 62.1% of residents have attended at least some college<sup>2</sup>. In addition, nearly 20% of Queens residents have less than a high school diploma. If we look more closely at Jackson Heights, Elmwood and Corona, we see that between 29 and 45% of residents did not complete high school.

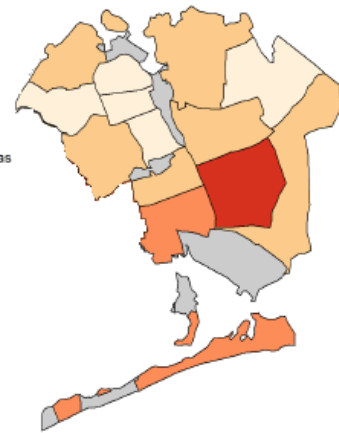
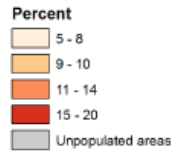
## 2015 Unemployment Rate

**Service Area Avg. = 8.3%**



Source: Truven 2015 v. 2015.08.04, US Census 2014. tpm

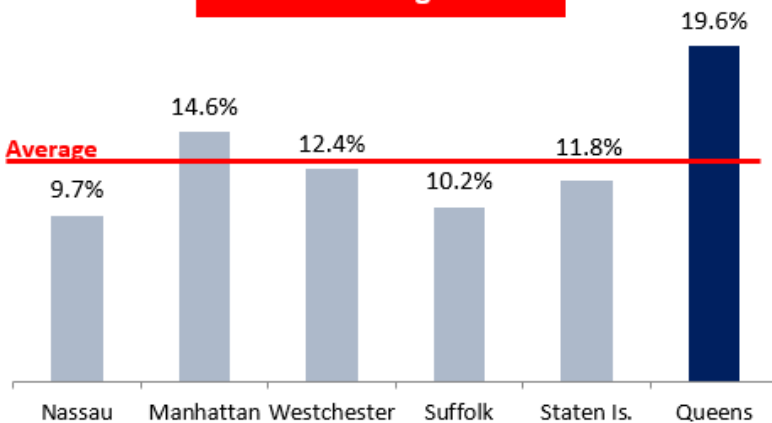
### Unemployment



Source: U.S. Census Bureau, American Community Survey, 2011-2013

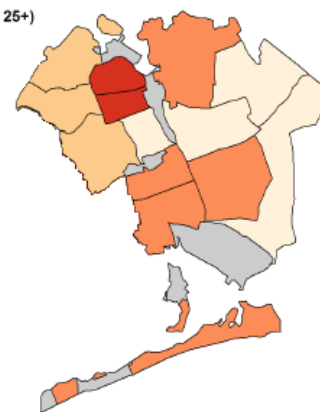
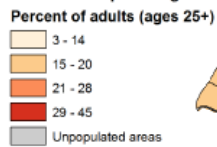
## Less Than High School Diploma

**Service Area Avg. = 13.1%**



Source: Truven 2015 v. 2015.08.04, US Census 2014. tpm

### Did Not Complete High School



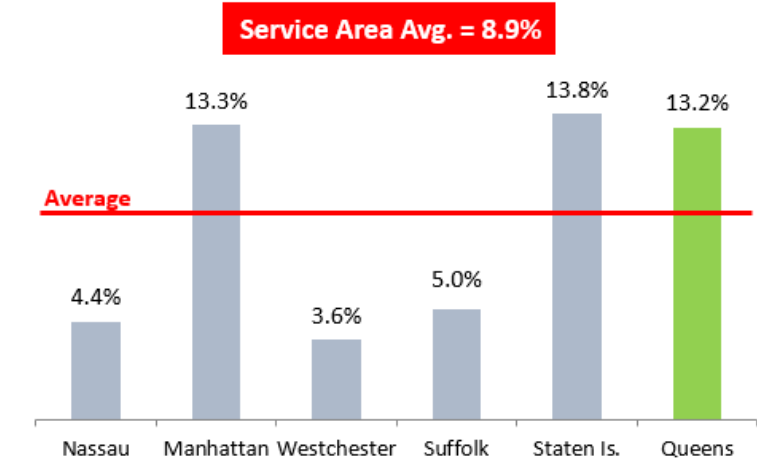
Source: U.S. Census Bureau, American Community Survey, 2011-2013

<sup>2</sup> U.S. Dept of Education, EDFacts 2012-2013

Income and employment greatly impact health in a number of ways, but perhaps the most discernible of those is one's ability to buy food, especially healthful foods. An estimated 13% of the population of Queens experiences food insecurity, with approximately 298,250 food insecure individuals living in Queens<sup>3</sup>. Approximately 13% of Queens residents are receiving food assistance (SNAP). This is well above our service area average of 8.9% and, as shown in the figure to the right, there is a significant divide in food assistance amongst our counties served. Between 13 and 14% of residents of Manhattan, Staten Island, and Queens receive food assistance while just 3 to 5% of Long Island and Westchester residents receive food assistance.

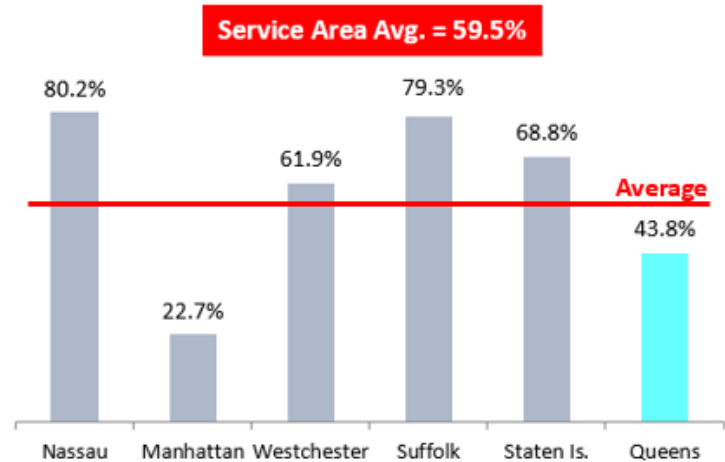
Other contributors to health status include neighborhood safety and housing security. In 2014, the county experienced a violent crime rate of 633 per 100,000 inhabitants, compared to 365 per 100,000 nationally<sup>4</sup>. The percentage of Queens residents experiencing housing insecurity in the last 12 months was approximately 51.6% in 2014 (this figure was generated city-wide, and represents housing insecurity across all five boroughs of New York City)<sup>5</sup> and, according to the American Housing Survey, 9.3% of housing units were overcrowded. The home ownership rate in Queens from 2010-2014 was 43.8%. With such high rates of renter-occupation and overcrowding, it's important to examine rent burden in Queens. The U.S. Census Bureau American Community Survey defines rent burden as the percent of renter households whose gross rent (rent plus utilities) is greater than 30 percent of their monthly pre-tax income. In Queens, we see 58-64% of renter households in Jackson Heights, Elmwood, Corona, Jamaica and Hollis, and Howard Beach experiencing rent burden.

### 2015 Food Assistance (SNAP)



Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn

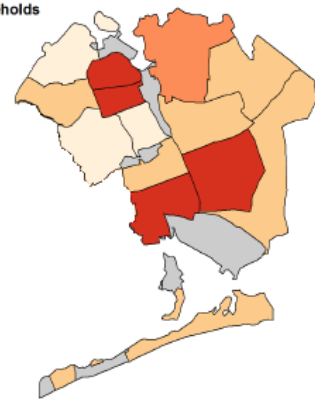
### Home Ownership Rate 2010-2014



Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn

**Rent Burden (>30% of income)**  
 Percent of renter households

- 37 - 49
- 50 - 53
- 54 - 57
- 58 - 64
- Unpopulated areas



Source: U.S. Census Bureau, American Community Survey, 2011-2013

<sup>3</sup> Map the Meal Gap, 2013

<sup>4</sup> FBI Uniform Crime Reporting, 2014

<sup>5</sup> eBRFSS, 2014

Access to exercise and walking suitability are environmental factors that also contribute to health status. Ninety-five percent of residents report having access to exercise opportunities and 90.3% believe their neighborhoods are suitable for walking (this figure was generated city-wide, and represents housing insecurity across all five boroughs of New York City)<sup>6</sup>. One's environment is also shaped by the accessibility of health services in the area. Health services in Queens County, services are not very accessible, when compared to state averages. The population to primary care provider ratio is 1527:1<sup>7</sup>, while the NYS average is 1200:1 and the population to mental health provider ratio is 752:1<sup>8</sup>, on par with the state average. Nineteen percent of the population is uninsured.<sup>9</sup>

Health status is also shaped by an individual's social support network and their individual behaviors. The social association rate is increasingly used as an indicator of social connectedness in the community. The social association rate for Queens County, determined by the number of membership associations per 10,000 residents, was 4.7 in 2013<sup>10</sup>, while the service area and NYS average were roughly 7 in 2013. When it comes to diet and nutrition, only 7% of Queens residents consume the recommended daily intake of fresh fruits and vegetables and 28% of adults report having no leisure time physical activity<sup>11</sup>. Twelve percent of adults in Queens County smoke and 14% report drinking excessively<sup>12</sup>. Sixteen percent of driving deaths in Queens were attributed to alcohol from 2012-2014<sup>13</sup>. In addition, the drug overdose mortality rate in Queens is 7 per 100,000 deaths and, from 2012-2014, Queens County experienced 464 drug overdose deaths<sup>14</sup>.

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<sup>6</sup> eBRFSS, 2014

<sup>7</sup> Area Health Resource File, American Medical Association, 2013

<sup>8</sup> CMS, National Provider Identification File

<sup>9</sup> Dartmouth Atlas of Healthcare, 2013

<sup>10</sup> County Business Patterns, 2013

<sup>11</sup> CDC Diabetes Interactive Atlas, 2012

<sup>12</sup> eBRFSS, 2014

<sup>13</sup> Fatality Analysis Reporting System, 2010-2014

<sup>14</sup> CDC WONDER Mortality Data, 2012-2014

**Primary Data Analysis**

Take Care New York 2020 (TCNY 2020) is the New York City Health Department’s blueprint for giving everyone a healthier life. Its goal is twofold, to improve health, and to make greater strides with groups that have the worst health outcomes, so that New York City becomes a more equitable place for everyone. To begin building partnerships around TCNY 2020, the Health Department held Community Consultations in dozens of neighborhoods across the City during fall and winter of 2015-2016. TCNY spoke with more than 800 New Yorkers about TCNY 2020 goals and local priorities for change. At each Community Consultation held by the Health Department between October 2015 and March 2016, participants were asked to rank the indicators outlined in TCNY 2020 according to order of importance for the local community, where the #1 rank represents the most important indicator. Indicators are grouped into four broad categories: Healthy Childhoods, Create Healthier Neighborhoods, Support Healthy Living and Increase Access to Quality Care. The complete Queens County report can be found in the accompanying appendix.

Additionally, the Health Department and Community Resource Exchange engaged participants in discussions about the health goals of the local community and local assets that can help achieve those goals. Ranking results were calculated using a simple point system in which each ranking is assigned a point value from 1-23, with the indicator ranked 1 receiving 23 points and the indicator ranked 23 receiving 1 point. The indicators that received the most collective points were identified as the top priorities for the participants at the respective event. The top five priorities from each Community Consultation in Queens are as follows:

<b>Consultation</b>	<b>Prioritization Results</b>
<b>Queens Village</b>	Child Care
	Controlled High Blood Pressure
	Obesity
	Physical Activity
	Violence
<b>Astoria</b>	Air Quality
	Homes with no Maintenance Issues
	Obesity
	Unmet Medical Need
	Unmet Mental Health Need
<b>Corona</b>	Air Quality
	Controlled High Blood Pressure
	Obesity
	Physical Activity
	Sugary Drinks
<b>Flushing</b>	Air Quality
	Obesity
	Physical Activity
	Social Cohesion
	Unmet Mental Health Need

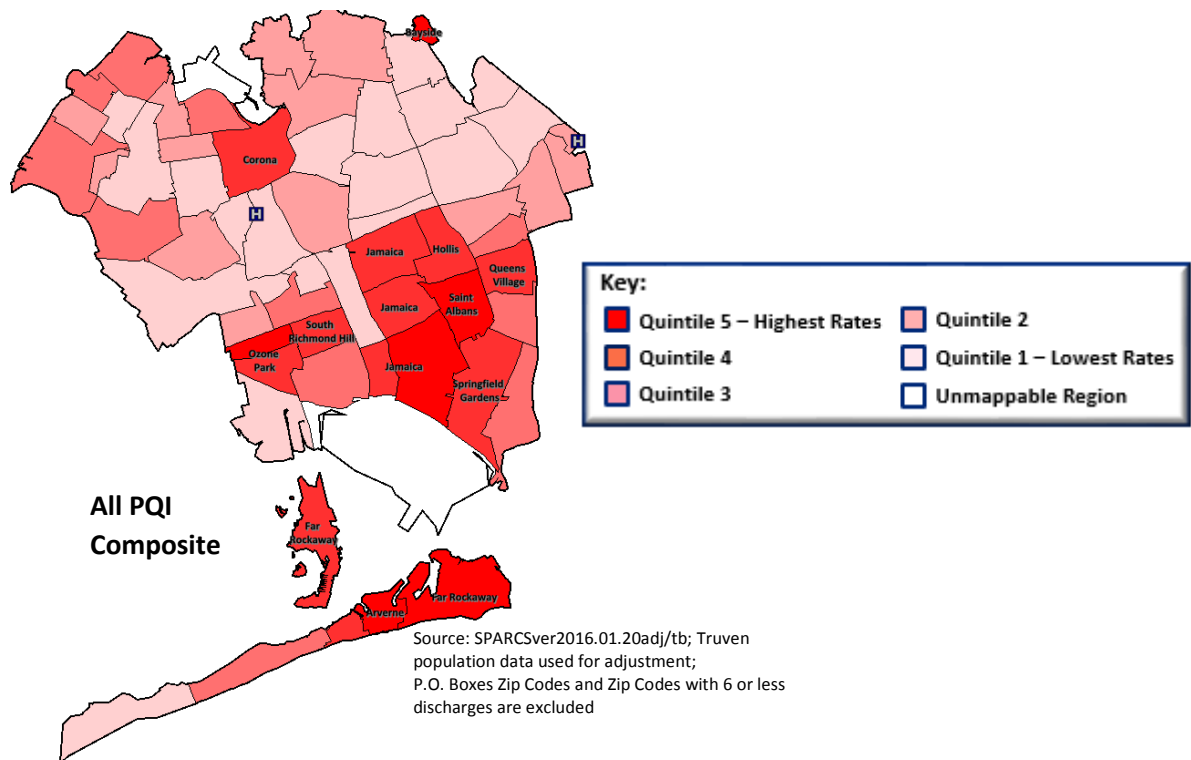
Consultation	Prioritization Results
<b>Jamaica</b>	Binge Drinking
	Child Care
	Controlled High Blood Pressure
	High School Graduation
	Smoking
<b>Far Rockaway</b>	Controlled High Blood Pressure
	High School Graduation
	Unmet Medical Need
	Unmet Mental Health Need
	Violence

## Secondary Data Analysis

As aforementioned, sources of information included SPARCS data (version 2016), NYSDOH Vital Statistics, NYS Cancer Registry and the NYSDOH Surveillance System. Data were age-adjusted (direct standardization of rates) based on 2010 U.S. standard population. A mapping of Prevention Quality Indicators (PQIs) quintiles was also used as part of the data analysis to identify pockets of diminished health in the counties we serve. For PQIs, quintiles are assigned to the data based on their comparative rates of disease per 100,000 population, and these quintiles were used to assess the relative health of different zip codes. The quintiles are arranged 5 to 1 with the 5<sup>th</sup> quintile containing the highest rates of the targeted PQIs and their associated conditions, while quintile 1 contains the lowest rates.

### Prevention Quality Indicator (PQI) Composite

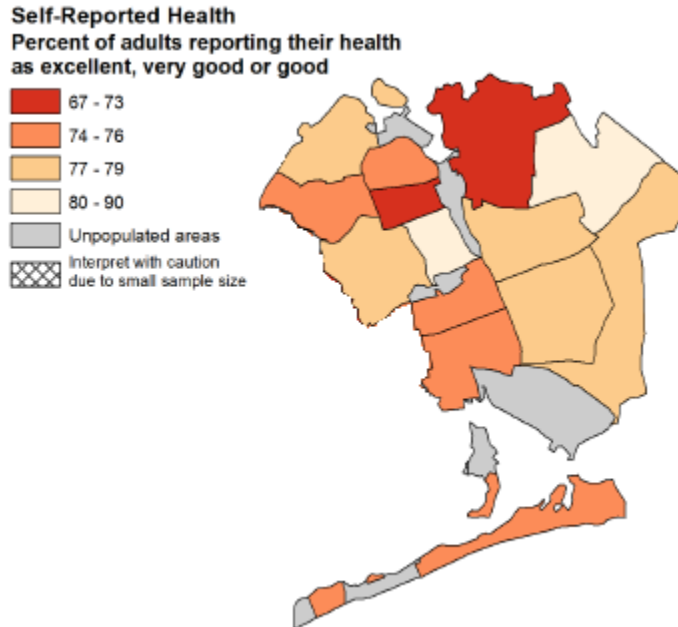
Of Queens County's 61 zip codes, some consistently emerged in PQI quintiles 4 or 5, indicating high rates of disease and poorer health outcomes in those areas. These areas include: Corona, Bayside, Ozone Park, South Richmond Hill, Jamaica, Hollis, St. Albans, Queens Village, Springfield Gardens, Far Rockaway, and Arverne.



### Chronic Disease

To assess chronic disease prevalence in Queens County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). In addition, communities within the county that have higher prevalence rates than the county average have been identified.

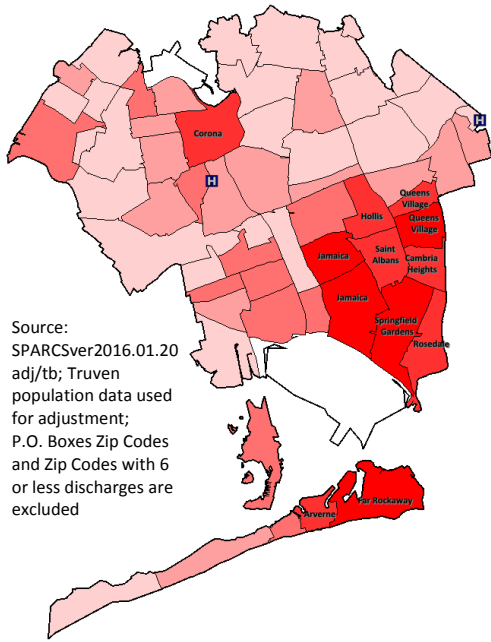
The New York City DOHMH completed a Community Health Survey asking residents to report on their overall health. As the map below indicates, Elmhurst and Corona as well as Flushing and Whitestone exhibit lower percentages of residents that consider their health to be excellent, very good, or good. In these areas, 27-33% of respondents reported their health as less than good.



Source: NYC DOHMH, Community Health Survey, 2011-2013

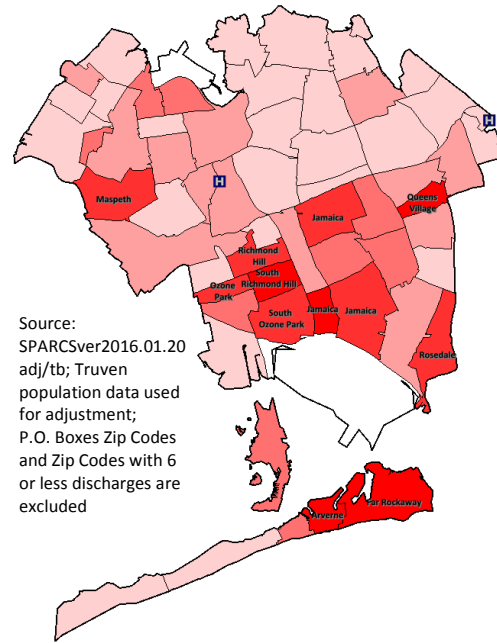
Coronary heart disease hospitalization rates in Queens were above both the NYS average and the NYSPAQ, but congestive heart failure hospitalization rates were below than the NYS average and approaching the NYSPAQ. Cerebrovascular (Stroke) disease mortality was better than the state average and achieved the NYSPAQ. Circulatory PQIs had the highest rates in South Richmond Hill, South Ozone Park, Jamaica, Arverne, Far Rockaway, Springfield Gardens, St. Albans, Hollis, Bayside, and Queens Village.

## Hypertension



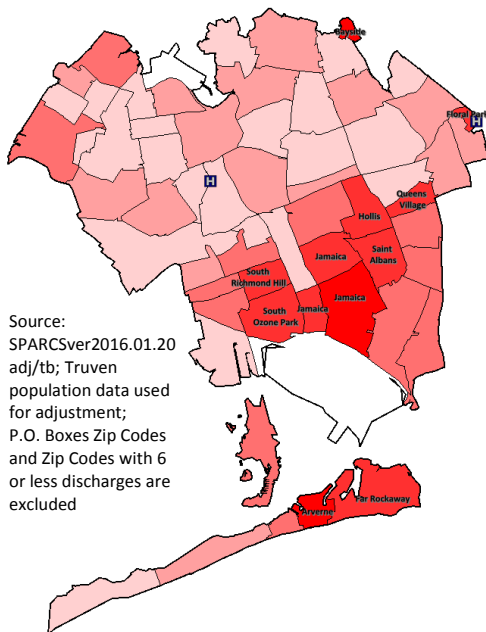
Source:  
SPARCSver2016.01.20  
adj/tb; Truven  
population data used  
for adjustment;  
P.O. Boxes Zip Codes  
and Zip Codes with 6  
or less discharges are  
excluded

## Angina



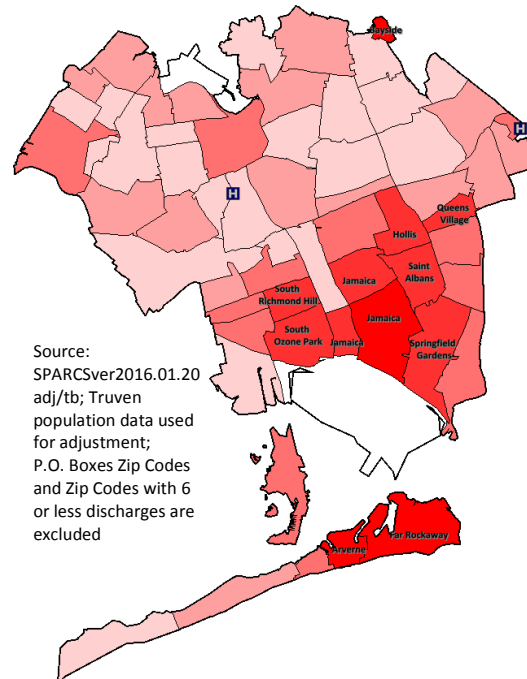
Source:  
SPARCSver2016.01.20  
adj/tb; Truven  
population data used  
for adjustment;  
P.O. Boxes Zip Codes  
and Zip Codes with 6  
or less discharges are  
excluded

## Congestive Heart Failure



Source:  
SPARCSver2016.01.20  
adj/tb; Truven  
population data used  
for adjustment;  
P.O. Boxes Zip Codes  
and Zip Codes with 6  
or less discharges are  
excluded

## Circulatory Composite

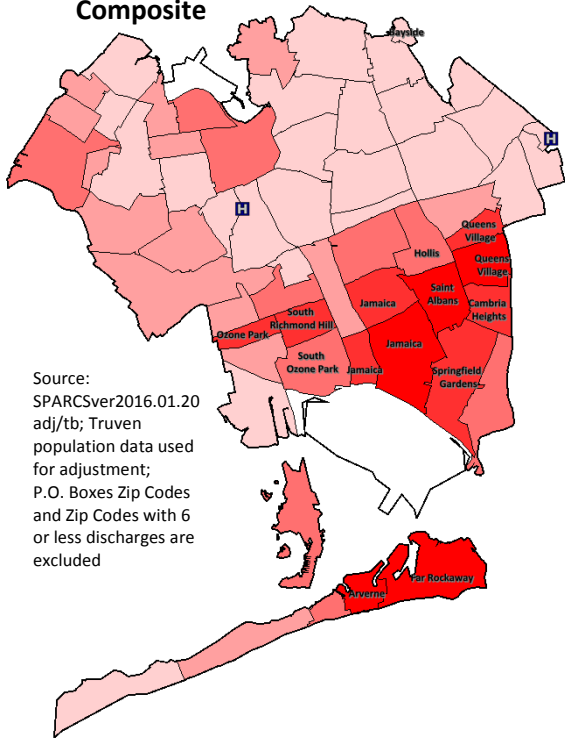


Source:  
SPARCSver2016.01.20  
adj/tb; Truven  
population data used  
for adjustment;  
P.O. Boxes Zip Codes  
and Zip Codes with 6  
or less discharges are  
excluded





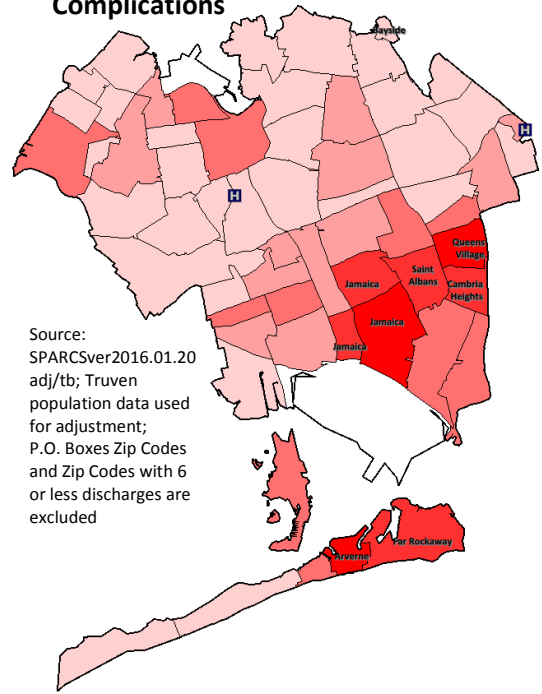
**Diabetes Composite**



Source: SPARCSver2016.01.20 adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

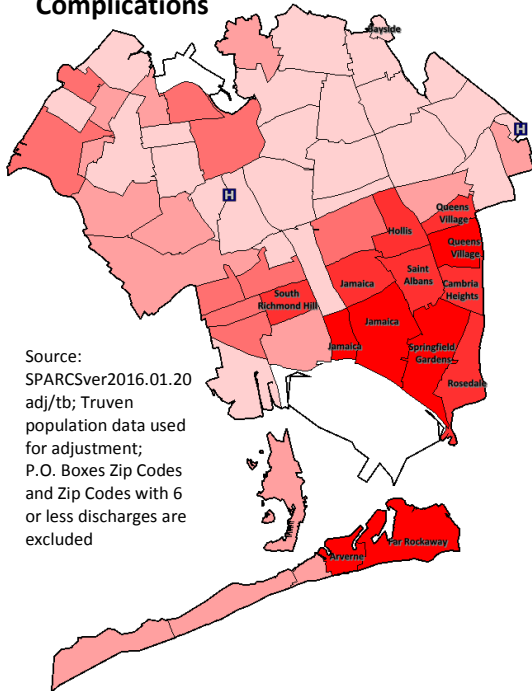
Diabetes prevalence rates in Queens County were 11%, greater than both the NYS average and the NYSPAO of 5.7%. The diabetes short term complication hospitalization rate was better than the NYS average but did not achieve the NYSPAO for both people ages 6-17 and ages 18+ years. Obesity rates for adults (BMI>30) were 20.6%, below the NYS average of 24% but still above the NYSPAO of 15%. Diabetes PQIs had the highest rates in Ozone Park, South Richmond Hill, Jamaica, Arverne, Far Rockaway, Springfield Gardens, St. Albans, Cambria Heights, and Queens Village.

**Short-term Complications**



Source: SPARCSver2016.01.20 adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Long-term Complications**

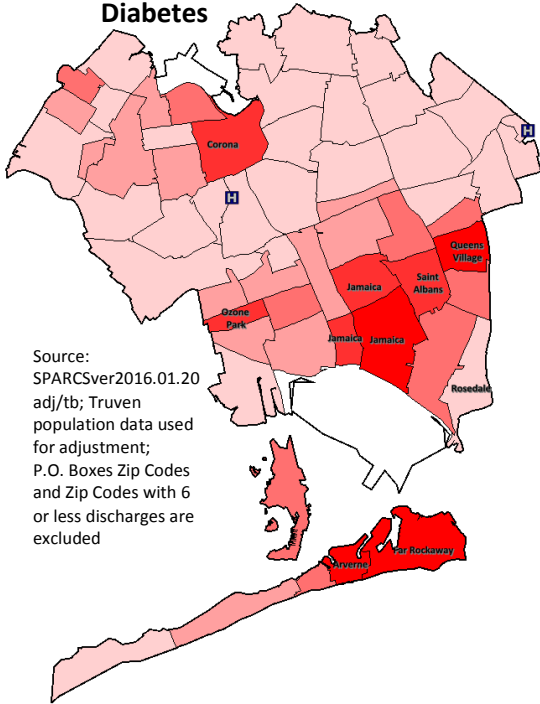


Source: SPARCSver2016.01.20 adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Key:**

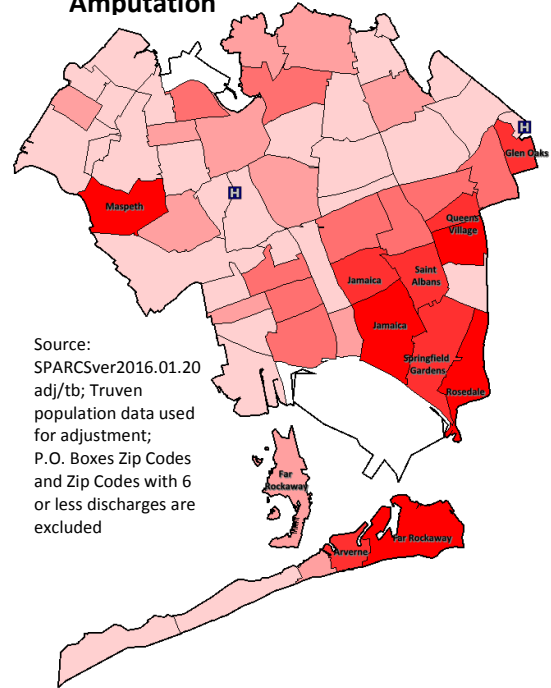
- |   |  |
|---|--|
| <span style="color: red;">■</span> Quintile 5 – Highest Rates | <span style="color: lightpink;">■</span> Quintile 2  |
| <span style="color: orange;">■</span> Quintile 4              | <span style="color: lightblue;">■</span> Quintile 1 – Lowest Rates   |
| <span style="color: pink;">■</span> Quintile 3                | <span style="border: 1px solid black; display: inline-block; width: 10px; height: 10px;"></span> Unmappable Region |

**Uncontrolled Diabetes**



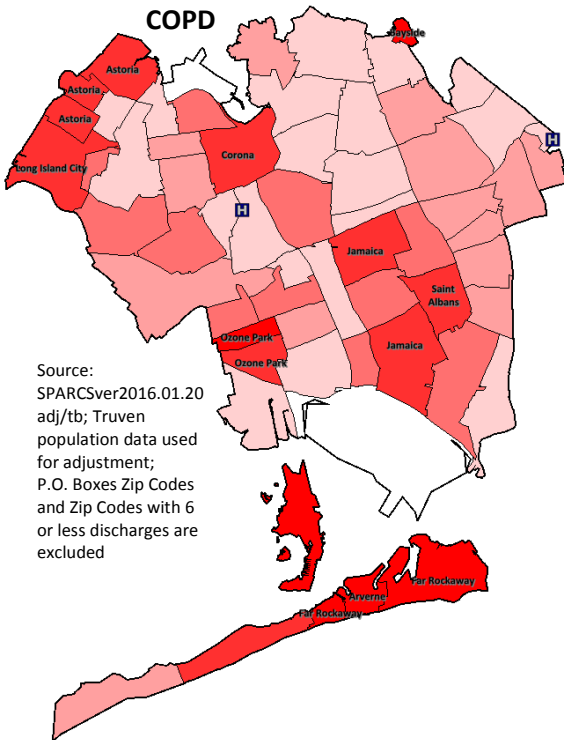
Source: SPARCSver2016.01.20 adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Lower Extremity Amputation**



Source: SPARCSver2016.01.20 adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Rates of COPD**

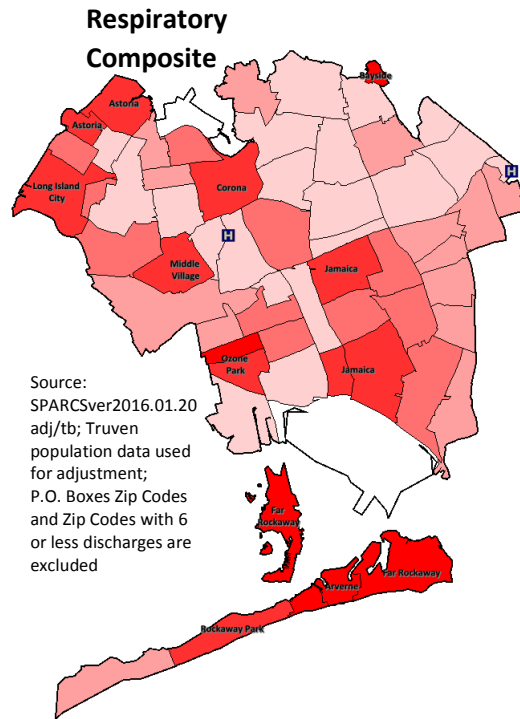
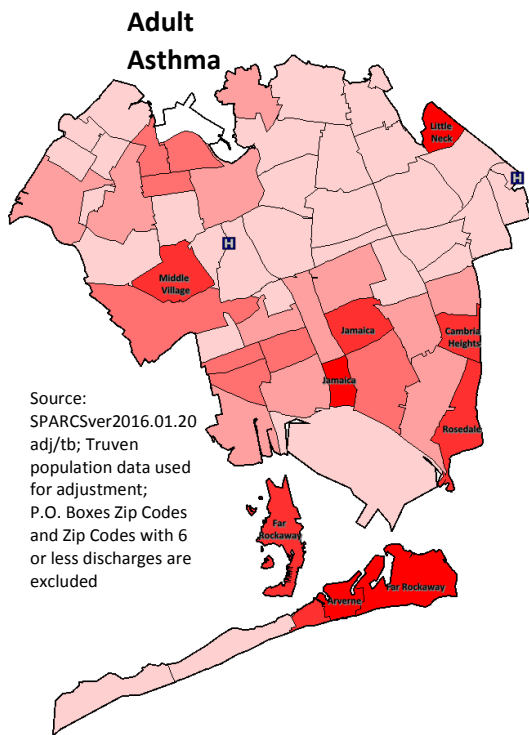


Source: SPARCSver2016.01.20 adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

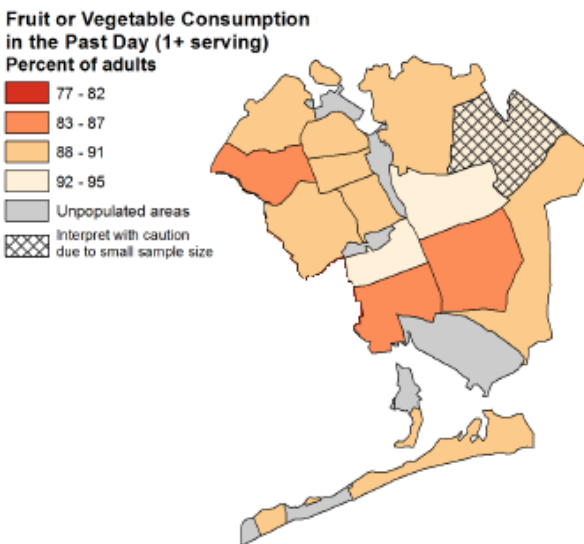
**Key:**

- |   |  |
|---|--|
| <span style="color: red;">■</span> Quintile 5 – Highest Rates | <span style="color: lightpink;">■</span> Quintile 2                |
| <span style="color: orange;">■</span> Quintile 4              | <span style="color: lightblue;">■</span> Quintile 1 – Lowest Rates |
| <span style="color: purple;">■</span> Quintile 3              | <span style="color: white;">■</span> Unmappable Region             |

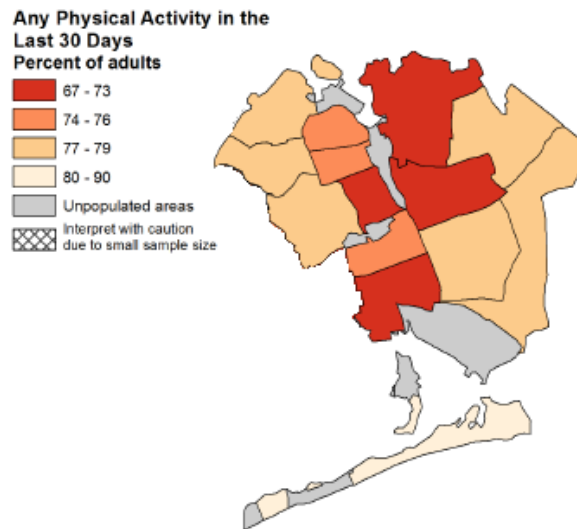
Cigarette smoking rates for adults in Queens County were 15.5%, below the NYS and US averages, but above the NYSPAO of 12%. Chronic Obstructive Pulmonary Disease adult hospitalizations per 10,000 in Queens County were 31.4, below the NYS average of 41.3, and on par with the NYSPAO. Astoria, Long Island City, Ozone Park, Far Rockaway, Arverne, Jamaica, Corona, St. Albans, and Bayside had the highest rates of COPD. Queens County asthma-related hospitalization rates were on par with the NYS averages, but above the NYSPAO. Areas with the highest asthma rates were Little Neck, Middle Village, Jamaica, Cambria Heights, Rosedale, Far Rockaway and Arverne.



Lifestyle data including nutrition and physical activity are major factors in the prevention and management of chronic disease. Approximately 71.9% of Queens County adults report that they are engaged in some type of leisure time physical activity which is below both the NYS rate (73%) and the NYSPAO target of 80%. Seven percent of Queens residents report that they eat 5 or more fruits and vegetables per day. This is far below the NYS average (27%) and below the NYSPAO target (33%).



Source: NYC DOHMH, Community Health Survey, 2011-2013

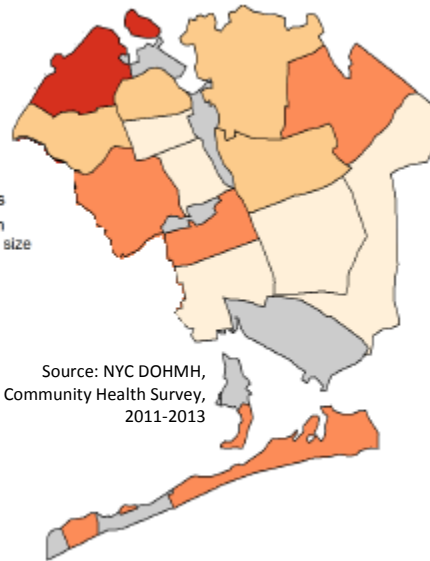
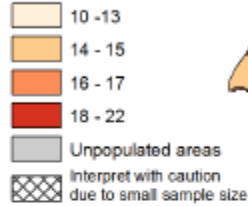


Source: NYC DOHMH, Community Health Survey, 2011-2013

In addition, Queens has relatively high rates of smoking when compared to the rest of New York City. Of the residents surveyed in each district, greater than 18% of respondents were current smokers.

**Current Smokers**

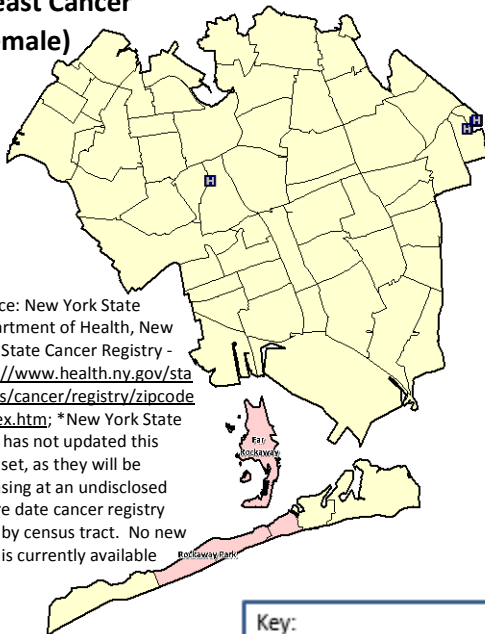
**Percent of adults**



Source: NYC DOHMH, Community Health Survey, 2011-2013

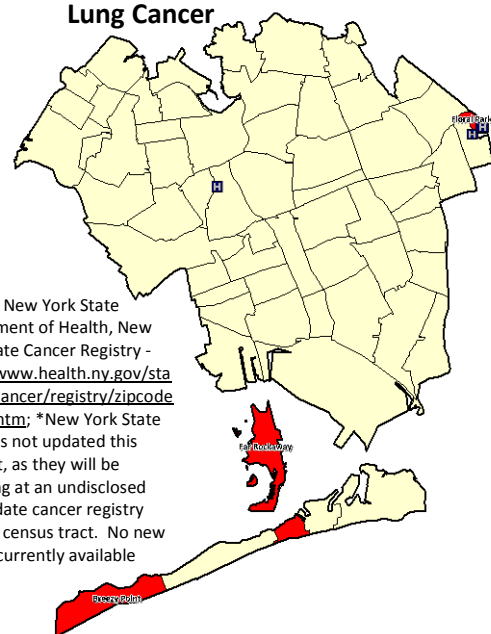
Breast cancer early stage diagnosis rates (60.9%) were lower than the NYS average but cervical cancer early stage diagnosis rates (50%) were greater than the US and NYS averages. Both rates, however, are still below the NYSPA0. The highest female breast cancer rates were located in the communities of Far Rockaway and Rockaway Park. Prostate cancer rates were highest in Springfield Gardens, Rosedale, Cambria Heights, St. Albans, and Jamaica. Lung Cancer incidence for men and women per 100,000 respectively were 60.9 and 39. For both males and females, incidence is below the NYS and US averages, and the NYSPA0.

**Breast Cancer (Female)**

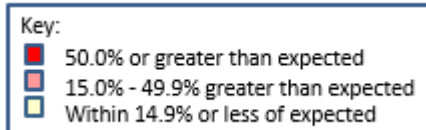


Source: New York State Department of Health, New York State Cancer Registry - <http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm>; \*New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new data is currently available

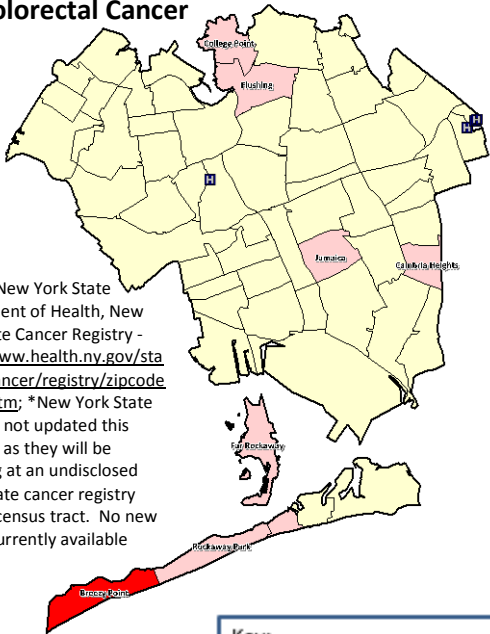
**Lung Cancer**



Source: New York State Department of Health, New York State Cancer Registry - <http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm>; \*New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new data is currently available

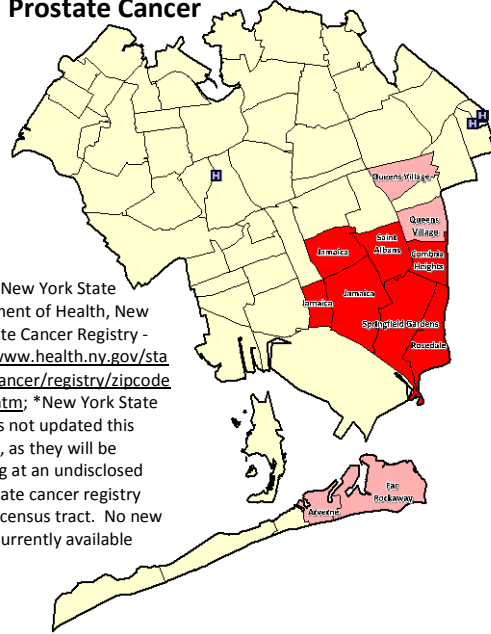


### Colorectal Cancer

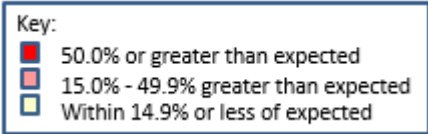


Source: New York State Department of Health, New York State Cancer Registry - <http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm>; \*New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new data is currently available

### Prostate Cancer



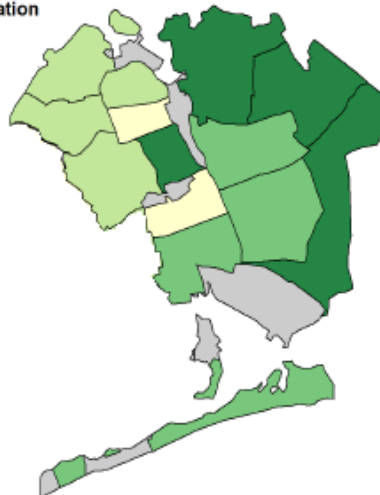
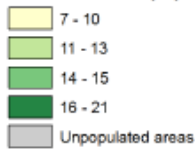
Source: New York State Department of Health, New York State Cancer Registry - <http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm>; \*New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new data is currently available



### Healthy Safe Environment

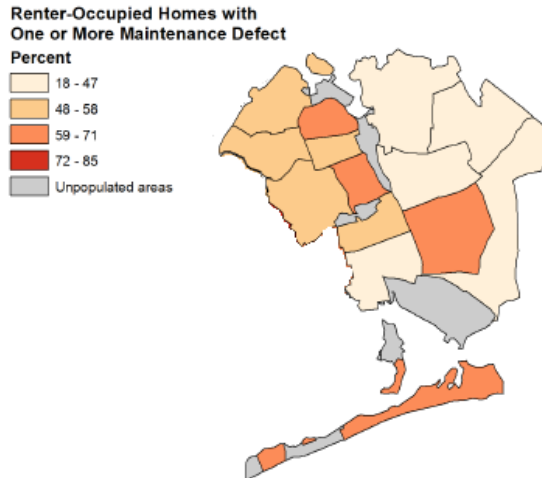
To assess preventable injury prevalence in Queens County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). Fall-related hospitalizations for Queens residents aged 65+ years (per 10,000) were 177, below than the NYS rate of 198 but above the NYSPAO target of 155. The highest rates were present in Astoria, Corona, Flushing, Forest Hills, Bayside, Little Neck, Floral Park, Far Rockaway and Rockaway Park.

### Older adults (65+ years) Percent of total population



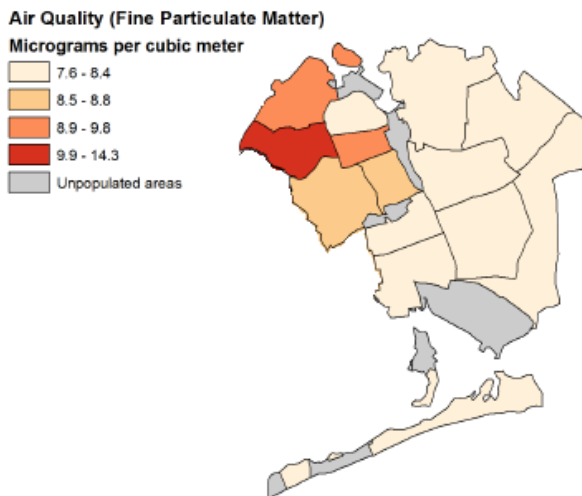
Source: U.S. Census Bureau Population Estimates, 2013

There are also several environmental factors that contribute to safety and safe living conditions. The NYC Department of Health mapped the percentage of renter-occupied homes that have one or more maintenance defects. Maintenance defects included water leaks, cracks and holes, inadequate heating, presence of mice or rats, toilet breakdowns or peeling paint. As shown in the map below, some neighborhoods in Queens report as much as 59-71% of homes with one or more maintenance defects.



Source: NYC Housing and Vacancy Survey, 2011

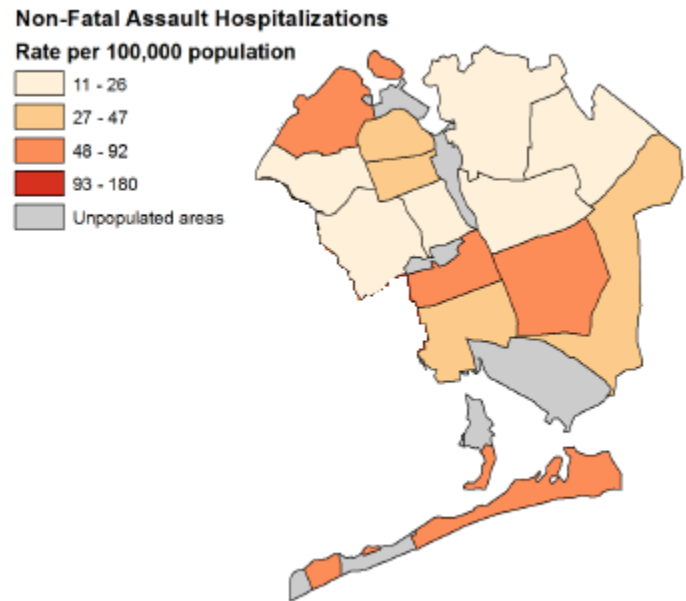
Air quality also plays a prominent role in health status, especially when it comes to respiratory outcomes like childhood or adult asthma. According to NYC DOH Community Health Profiles, Queens falls for the most part in the lowest quartile with 7.6-8.4 micrograms of fine particulate matter per cubic meter in most neighborhoods. However the northwest region of Queens reports much poorer air quality with as much as 14.3 micrograms per cubic meter in Ridgewood.



Source: NYC DOHMH, Community Air Survey, 2013

Finally, neighborhood safety also plays an important role in one's ability to achieve and maintain good health. The rate of non-fatal assault hospitalizations in a neighborhood speaks to

its relative safety and whether or not residents may feel comfortable walking, biking, or otherwise exercising outside. The Rockaway neighborhoods as well as Jamaica, Hollis, Kew Gardens and Woodhaven have relatively high rates of non-fatal assault hospitalizations, with 48-92 hospitalizations per 100,000.



Source: New York State Department of Health, Statewide Planning and Research Cooperative System, 2011-2013

Below is a table outlining NYS Department of Health Injury Data for Queens from 2011-2013, color-coded by whether or not the metric was significantly better than, significantly worse than, or comparable to the NYS average. Queens is, for the most part, significantly better than NYS when it comes to injury statistics, with the exception of certain age groups for falls.

### Queens County Injury Data

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	County Ranking Group
<b>Falls hospitalization rate per 10,000</b>					
Crude	24,174	35.5	39.4	Yes	2nd
Age-adjusted	24,174	32.9	34.7	Yes	2nd
<b>Aged less than 10 years</b>	<b>791</b>	<b>9.9</b>	<b>8.9</b>	<b>Yes</b>	<b>4th</b>
Aged 10-14 years	227	6.2	6.1	No	3rd
<b>Aged 15-24 years</b>	<b>556</b>	<b>6.4</b>	<b>5.7</b>	<b>Yes</b>	<b>4th</b>
Aged 25-64 years	6,683	17.2	18.4	Yes	2nd
Aged 65-74 years	3,383	70	75.2	Yes	2nd
Aged 75-84 years	5,768	204.5	220.3	Yes	2nd
Aged 85 years and older	6,766	505.3	560.2	Yes	2nd
<b>Poisoning hospitalization rate per 10,000</b>					
Crude	5,131	7.5	11.1	Yes	1st
Age-adjusted	5,131	7.2	10.7	Yes	1st
<b>Motor vehicle mortality rate per 100,000</b>					
Crude	273	4	6.3	Yes	1st
Age-adjusted	273	3.8	6	Yes	1st
<b>Non-motor vehicle mortality rate per 100,000</b>					
Crude	996	14.6	21.4	Yes	1st
Age-adjusted	996	13.5	19.5	Yes	1st
<b>Traumatic brain injury hospitalization rate per 10,000</b>					
Crude	6,407	9.4	10	Yes	4th
Age-adjusted	6,407	8.9	9.4	Yes	4th
<b>Alcohol related motor vehicle injuries and deaths per 100,000</b>					
Alcohol related motor vehicle injuries and deaths per 100,000	1313	19.3	33.3	Yes	1st
Alcohol related motor vehicle injuries and deaths per 100,000	1313	19.3	33.3	Yes	1st

<b>Key*:</b>	
<span style="display: inline-block; width: 15px; height: 15px; background-color: #90EE90; border: 1px solid black;"></span> Significantly Better than NYS Average	<span style="display: inline-block; width: 15px; height: 15px; background-color: #FFFF00; border: 1px solid black;"></span> No Significant Difference from NYS Average
<span style="display: inline-block; width: 15px; height: 15px; background-color: #FF0000; border: 1px solid black;"></span> Significantly Worse than NYS Average	

\*Where significance was not available, better, the same or worse than the New York State Average;

Source: [http://www.health.ny.gov/statistics/chac/chai/docs/inj\\_61.htm](http://www.health.ny.gov/statistics/chac/chai/docs/inj_61.htm); The county ranking groups: 1 - most favorable to 4 - least favorable. These county ranking groups are categorized based on the quartile distribution of all county rates



### Healthy Women, Infants, and Children

To assess the prevalence conditions related to the health of women, infants and children in Queens County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). The percent of women receiving first trimester prenatal care is slightly less than the NYS average at 72% but well below the NYSPAO (90%). However, the percentage of low birthweight births in Queens County (8.2%) is equal to both the NYS and US averages but is above the NYSPAO (5%). Women receiving late or no prenatal care were 7.7% for the county but the communities of Arverne, Jamaica, and Astoria had significantly increased rates. Low birth weight rates were also elevated in these communities. Pregnant women enrolled in WIC had gestational diabetes at a rate of 6.6% versus a NYS rate of 5.5%. The percent of obese children (ages 2-4 years) enrolled in WIC was 15.5% versus a NYS rate of 13%. Breastfeeding rates of mothers in the WIC program (45.2%) were significantly better than the state average (38%).

Below is a table outlining NYS Department of Health Birth-related Statistics for Queens from 2011-2013, color-coded by whether or not the metric was significantly better than, significantly worse than, or comparable to the NYS average.

Queens County Birth-related Statistics

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	County Ranking
<b>Percentage of births</b>					
% of births to women aged 25 years and older without a high school education	12,411	17.1	14.1	Yes	4th
% of births to out-of-wedlock mothers	36,069	39.7	40.9	Yes	2nd
% of births that were multiple births	2,976	3.3	3.9	Yes	1st
% of births with early (1st trimester) prenatal care	64,340	71.5	73.1	Yes	3rd
% of births with late (3rd trimester) or no prenatal care	6,927	7.7	5.6	Yes	4th
% of births with adequate prenatal care (Kotelchuck)	60,904	68.6	69.1	Yes	3rd
<b>WIC indicators</b>					
% of pregnant women in WIC with early (1st trimester) prenatal care (2009-2011)	43,269	88.7	86.5	Yes	2nd
% of pregnant women in WIC with gestational diabetes (2009-2011)	3,117	6.6	5.5	Yes	3rd
% of pregnant women in WIC with hypertension during pregnancy (2009-2011)	2,400	5.1	7.1	Yes	1st
% of WIC mothers breastfeeding at least 6 months (2010-2012)	8,003	45.2	38.2	Yes	1st
% of infants fed any breast milk in delivery hospital	68,804	86.1	83.1	Yes	1st
% of infants fed exclusively breast milk in delivery hospital	20,619	25.8	40.7	Yes	4th
% of births delivered by cesarean section	31,452	34.6	34.1	Yes	3rd
<b>Mortality rate per 1,000 live births</b>					
Infant (less than 1 year)	410	4.5	5	No	2nd
Neonatal (less than 28 days)	291	3.2	3.4	No	2nd
Post-neonatal (1 month to 1 year)	119	1.3	1.5	No	2nd
Fetal death (20 weeks gestation or more)	677	7.4	6.6	Yes	4th
Perinatal (20 weeks gestation to less than 28 days of life)	968	10.6	10	No	4th
Perinatal (28 weeks gestation to less than 7 days of life)	487	5.3	5.4	No	2nd
Maternal mortality rate per 100,000 live births +	19	20.9	20	No	3rd
<b>Low birthweight indicators</b>					
% very low birthweight (less than 1.5kg) births	1,166	1.3	1.4	Yes	2nd
% very low birthweight (less than 1.5kg) singleton births	891	1	1.1	No	3rd
<b>Newborn drug-related diagnosis rate per 10,000 newborn discharges</b>					
Newborn drug-related diagnosis rate per 10,000 newborn discharges	550	61.4	95	Yes	1st

**Key\*:**

- Significantly Better than NYS Average
- No Significant Difference from NYS Average
- Significantly Worse than NYS Average

\*Where significance was not available, better, the same or worse than the New York State Average;  
 Source: [http://www.health.ny.gov/statistics/chac/chai/docs/mih\\_61.htm](http://www.health.ny.gov/statistics/chac/chai/docs/mih_61.htm); The county ranking groups: 1 - most favorable to 4 - least favorable. These county ranking groups are categorized based on the quartile distribution of all county rates

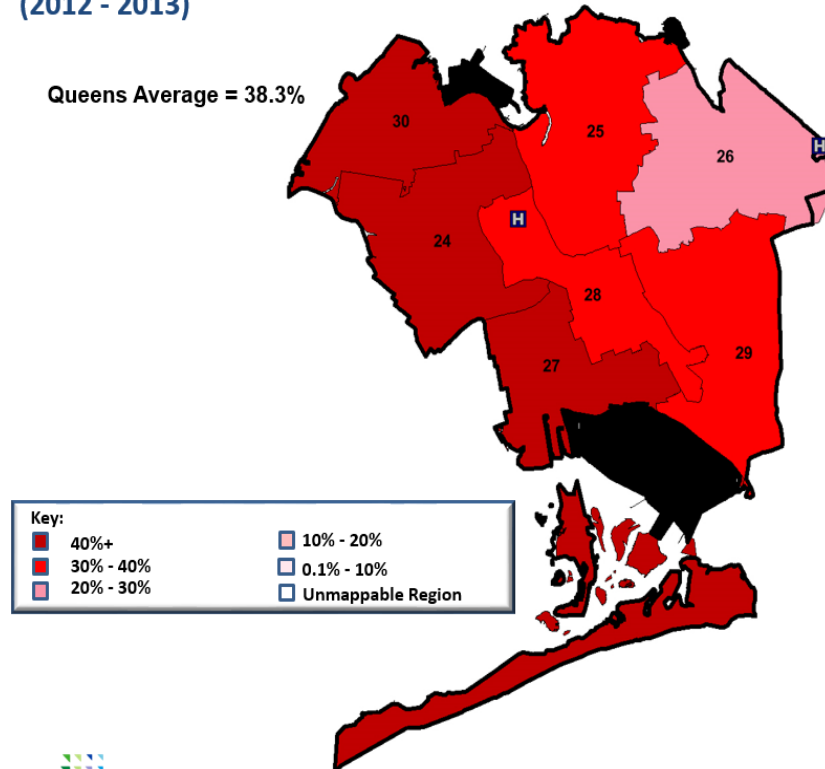
## Pediatric Obesity

Many chronic conditions have their roots in pediatric obesity. Diabetes, cardiovascular disease, cancer, orthopedic conditions, pulmonary disease and gastrointestinal disease are co-morbidities of obesity. Currently, Type 2 Diabetes is the most common form of diabetes diagnosed in adolescents. The NYSDOH has required school districts to measure and report body mass index, a measure of obesity using a person's height and weight, in order to identify overweight and obesity in the school aged children and adolescents. The following maps identify the prevalence of overweight and obesity in geographic areas based on school districts. The school districts with over 40% of children and adolescents classified as overweight or obese are:

**Queens School Districts with 40% of Students Classified as Overweight or Obese: 24, 27, 30**

**Queens School Districts with 30% of Students Classified as Overweight or Obese: 25, 28, 29**

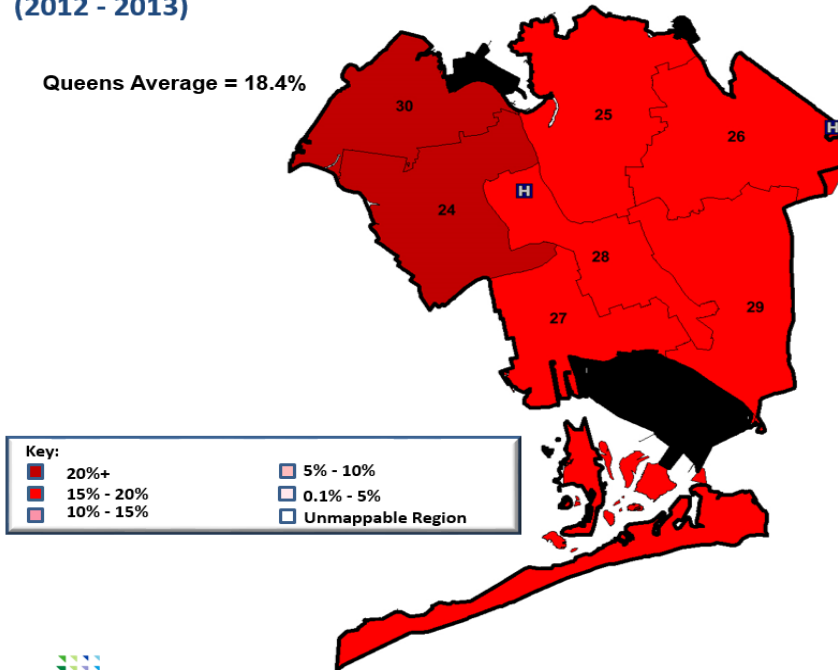
### School District Overweight/Obese Percentages (K – 8<sup>th</sup> Grade) (2012 - 2013)



Source: NYC public school body mass index (BMI) data, collected through the NYC FITNESSGRAM body composition assessments for Administrative School Districts 1-32, Grades K-8; Excludes Charter, Special Ed and Continuing Ed Schools

## School District Overweight Percentages (K – 8<sup>th</sup> Grade) (2012 - 2013)

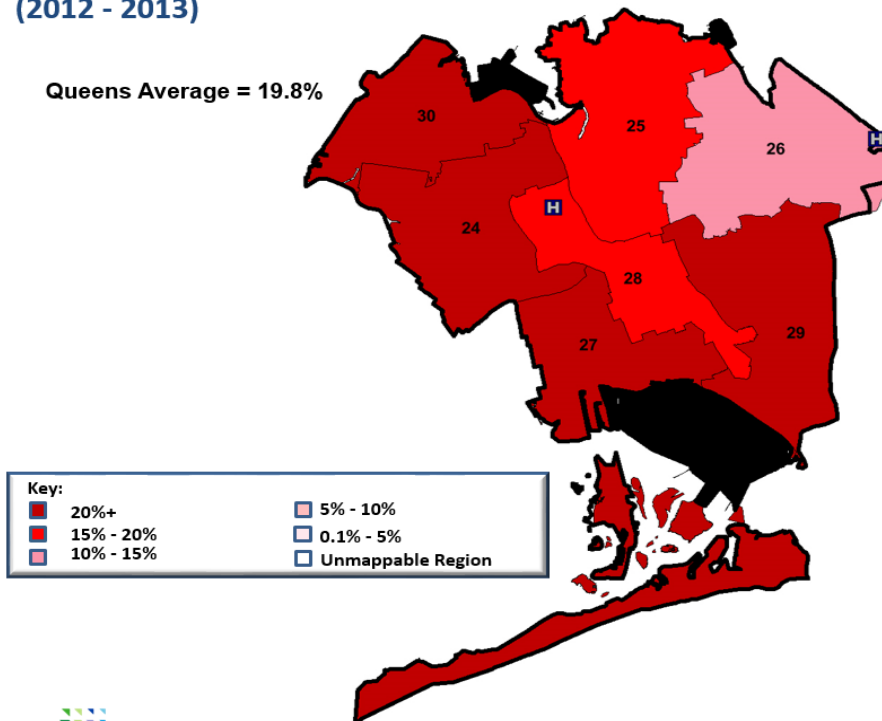
Queens Average = 18.4%



Source: NYC public school body mass index (BMI) data, collected through the NYC FITNESSGRAM body composition assessments for Administrative School Districts 1-32, Grades K-8; Excludes Charter, Special Ed and Continuing Ed Schools

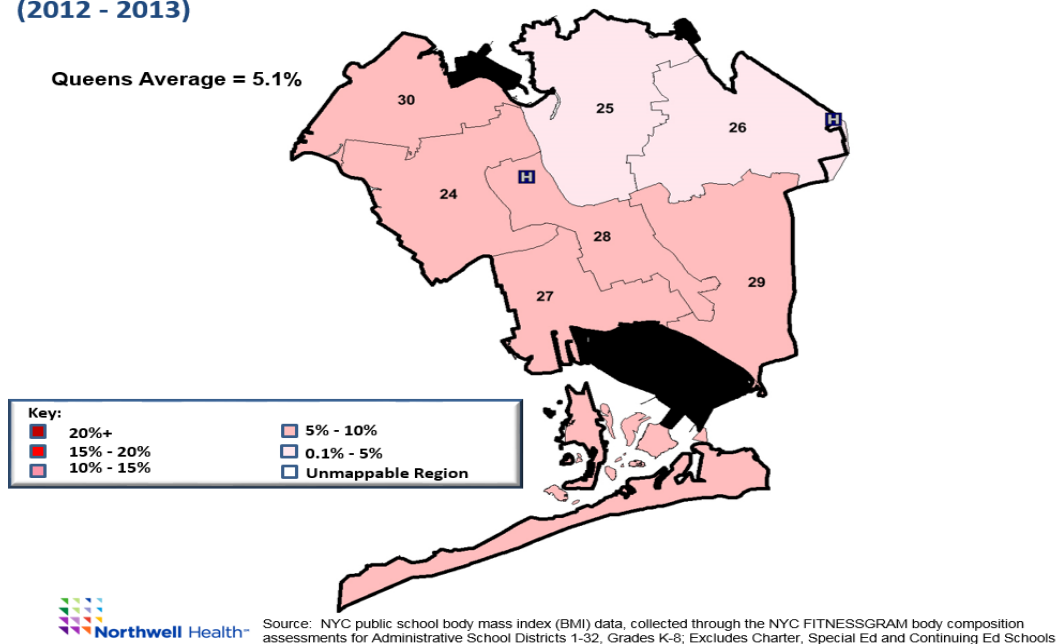
## School District Obese Percentages (K – 8<sup>th</sup> Grade) (2012 - 2013)

Queens Average = 19.8%



Source: NYC public school body mass index (BMI) data, collected through the NYC FITNESSGRAM body composition assessments for Administrative School Districts 1-32, Grades K-8; Excludes Charter, Special Ed and Continuing Ed Schools

## School District Severely Obese Percentages (K – 8<sup>th</sup> Grade) (2012 - 2013)



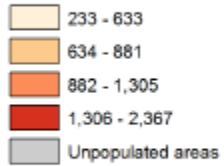
### *Mental Health and Substance Abuse*

To assess the prevalence of mental health disorders and substance abuse in Queens County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). Although the suicide rate (per 100,000) for Queens County was 5.2, lower than the NYS rate (7.5), it was still slightly above the NYSPAO of 4.8. The percent of Queens County adults reporting 14 or more days with poor mental health in the last month was 7.2% compared to NYS (11%) and below the NYSPAO of 7.8%. PQI data for mental health emergency department visits showed increased rates in the following communities: Far Rockaway and Rockaway Park, Arverne, Jamaica, Queens Village, and Bayside. Queens County's rate of binge drinking is 11.5%, below NYS (19%) and the NYSPAO of 13.4%. Drug-related Queens County hospitalization rates (per 10,000) were 14.5, below the NYS average and well below the NYSPAO (26). PQI data for substance abuse emergency department visits showed increased rates in the following communities: Far Rockaway and Rockaway Park, Arverne, Jamaica, Bayside, Richmond Hill and South Richmond Hill, Elmhurst, Astoria, and Long Island City. New York opioid and heroin death rates were higher than any other state and rose by 2000% from heroin and 200% from opioids. Queens County heroin and opioid death rates were 2.0 and 2.5 percent respectively.<sup>15</sup>

<sup>15</sup> Prescription Opioid Abuse and Heroin Addiction in New York State. Report from Office of NYS Comptroller. (June 2016) [https://www.osc.state.ny.us/press/releases/june16/heroin\\_and\\_opioids.pdf](https://www.osc.state.ny.us/press/releases/june16/heroin_and_opioids.pdf)

### Alcohol-Related Hospitalizations

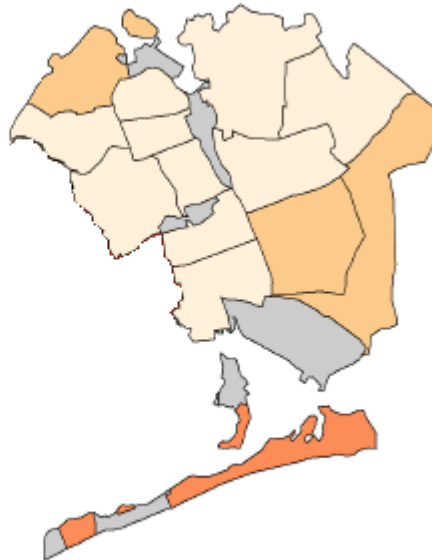
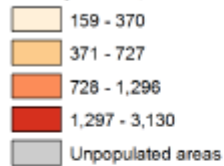
Rate per 100,000 adults



Source: New York State Department of Health, Statewide Planning and Research Cooperative System, 2011-2013

### Drug-Related Hospitalizations

Rate per 100,000 adults



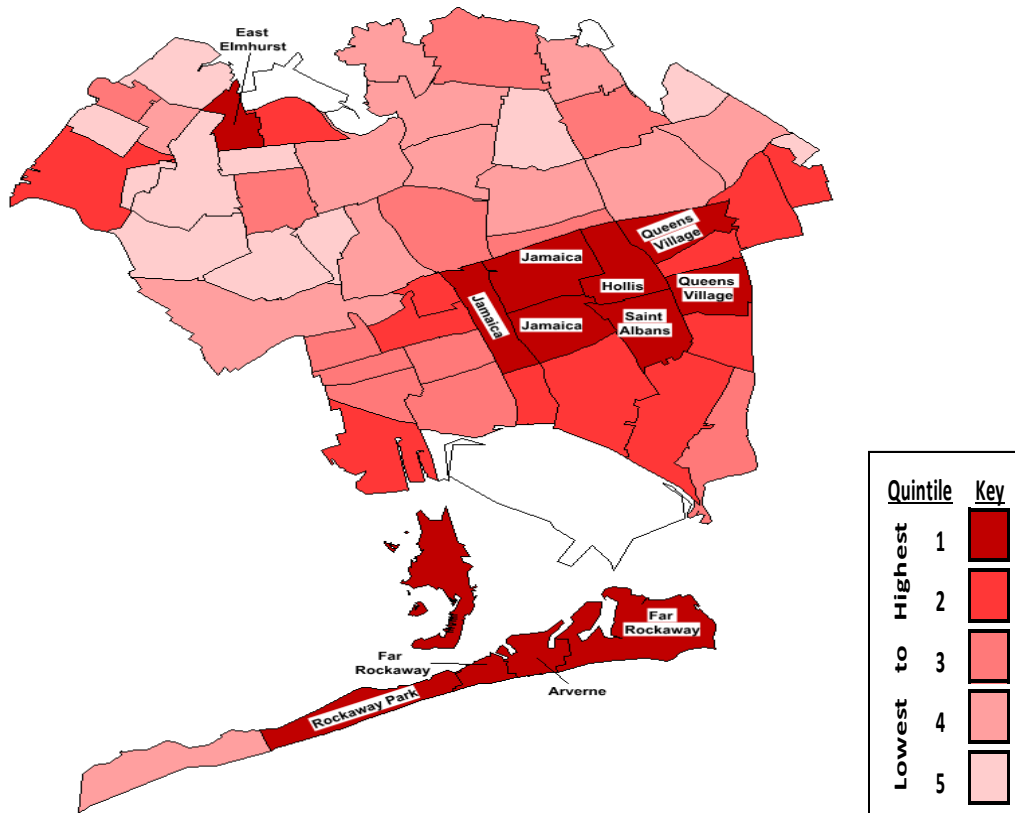
Source: New York State Department of Health, Statewide Planning and Research Cooperative System, 2011-2013

This data was also supported by the analysis of serious mental illness in Queens. The calculation of serious mental illness rates first required establishing a definition of all behavioral health diagnoses that qualify as a Serious Mental Illness (SMI). After review of scholarly and regulatory research, it was determined that the definition most relevant and applicable was New York State's Office of Mental Health's (OMH) DSM4-R/ICD-9 diagnoses codes for Serious Mental Illness, a criteria used to determine eligibility for Health Home services for Medicaid

recipients. CMS General Equivalency Mappings (GEMs) were applied to crosswalk all ICD-9 diagnoses codes to find their ICD-10 equivalents. The updated definition was then applied to NYS DOH Statewide Planning and Research Cooperative Systems, (SPARCS) claims based data source. The definition was used to analyze all inpatient admissions within Northwell Health's service area counties, with a principle diagnoses code defined as an SMI for the full years of 2014-2015. The data was stratified by patient origin (county and zip code), gender and age-group. Adjusted rates were calculated after stratifying both inpatient volumes and US census based population estimates (sourced from Truven Health Analytics) by patient origin (county and zip), gender, and age-group. An average county-level rate was calculated and used as a benchmark comparison when analyzing at the zip-code level. The adjusted rates per zip-code, per county, were then ranked into quintiles, and visualized using MapInfo, a geo-spatial software program. While the analysis is indicative of a density of patients and cases, and can add value in future planning and community health initiatives, it is not without its limitations. The primary limitation of the analysis is that it is far from comprehensive, restricted to just claims-based data looking at inpatient admissions based on a principle diagnoses of SMI. However, its value is in its ability to provide a relational understanding in terms of neighborhoods and communities with the highest rates of SMI.

The county rate of Serious Mental Illness (SMI) in Queens was 371.5 per 100,000 population. The highest rates of SMI were found in the Southeast Queens and Jamaica. Zip code 11427, in Queens Village, had the highest rate in all of Queens, with a total of 1,231 per 100,000 population. Other areas exhibiting high rates include: East Elmhurst, Hollis, Jamaica and Saint Albans.

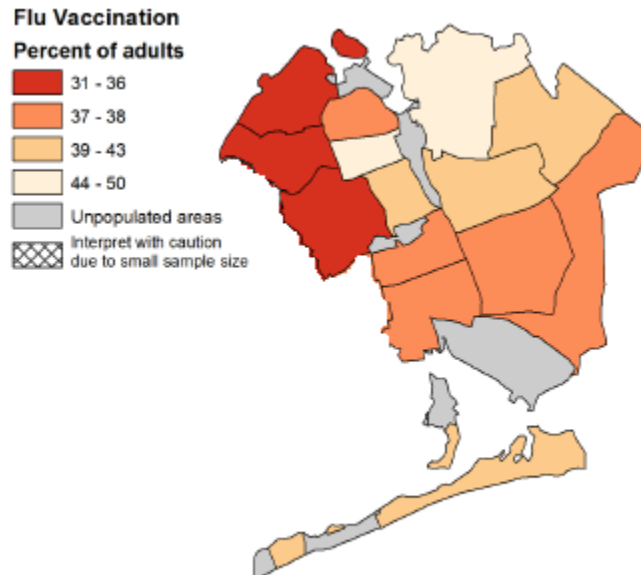
### Queens County Serious Mental Illness (SMI) Rates



*HIV, STDs, Vaccine-Preventable Diseases & Health Care-Associated Infections*

To assess the prevalence of HIV, STDs, Vaccine-Preventable Diseases & Health Care-Associated Infections in Queens County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). Queens flu immunization rates are 60% below the NYS average and the NYSPAO of 72% and 70% respectively. The map shows the areas in western Queens with the lowest rates of flu vaccination.

Queens County's newly diagnosed HIV case rate (per 100,000) was 26, well above the NYS rate (19) and NYSPAO (23). The Queens County Gonorrhea case rate (per 100,000) was 82, lower than NYS (94) but well above NYSPAO (19). The tuberculosis case rate (per 100,000) for Queens County was 12, well above both NYS (4.9) and NYSPAO (1). Queens County case rates for chlamydia for both men and women were also above the NYS rate.



Source: NYC DOHMH, Community Health Survey, 2011-2013

Below is a table outlining HIV/AIDS and STD Rates for Queens County, compared to NYS averages. The indicators are color-coded by whether Queens is significantly better than, significantly worse than, or comparable to the state. Queens is significantly worse than or comparable to NYS on most indicators, with the exception of AIDS mortality and all-age gonorrhea case rates.

HIV/AIDS and STD Rates for Queens County

Indicator	3 Year Total	County Rate	NYS Rate	Sig.Dif.	County Ranking Group
<b>HIV case rate per 100,000</b>					
Crude	1,541	22.6	19.1	Yes	4th
Age-adjusted	1,541	21.3	19.1	Yes	4th
<b>AIDS case rate per 100,000</b>					
Crude	914	13.4	12.2	Yes	4th
Age-adjusted	914	12.7	12.2	No	4th
<b>AIDS mortality rate per 100,000</b>					
Crude	204	3	4	Yes	4th
Age-adjusted	204	2.7	3.7	Yes	4th
<b>Early syphilis case rate per 100,000</b>					
Early syphilis case rate per 100,000	1,098	16.1	14.4	Yes	4th
<b>Gonorrhea case rate per 100,000</b>					
All ages	6670	97.8	107.7	Yes	4th
Aged 15-19 years	1,417	367.8	368.1	No	4th
<b>Chlamydia case rate per 100,000 males</b>					
All ages	12,707	384.2	336	Yes	4th
Aged 15-19 years	2,869	1450.2	1029.1	Yes	4th
Aged 20-24 years	3,984	1620.5	1492.7	Yes	4th
<b>Chlamydia case rate per 100,000 females</b>					
All ages	24,095	686.7	672.3	Yes	4th
Aged 15-19 years	7,062	3767.8	3595.5	Yes	4th
Aged 20-24 years	8,166	3,378.30	3,432.20	No	4th
<b>% of sexually active young women aged 16-24 with at least one Chlamydia test in Medicaid program (2013)</b>					
Medicaid program (2013)	15,768	74.1	72.2	Yes	1st
<b>Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)</b>					
Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)	427	2.9	3	No	4th

Key\*:

- Significantly Better than NYS Average
- No Significant Difference from NYS Average
- Significantly Worse than NYS Average

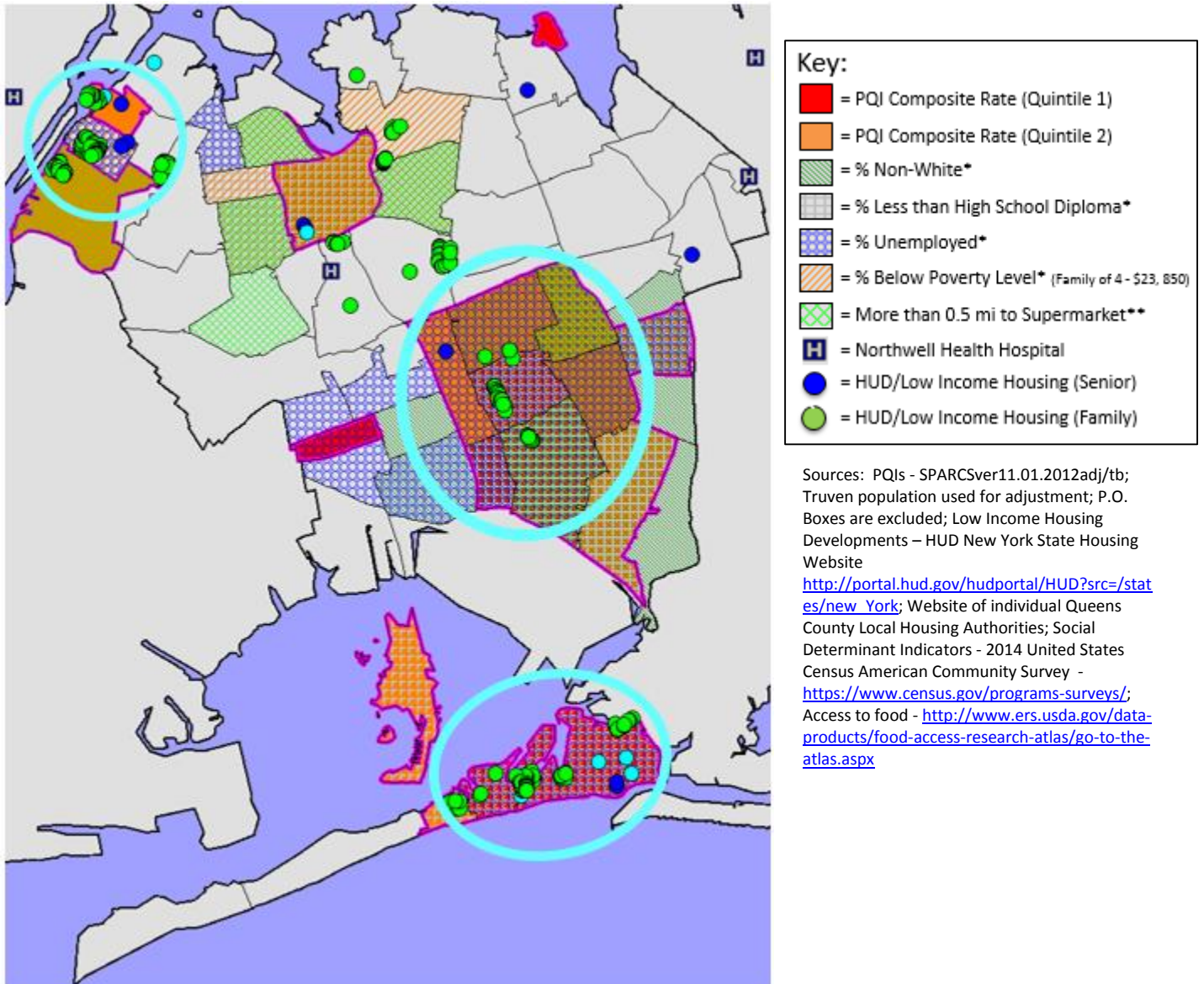
\*Where significance was not available, better, the same or worse than the New York State Average;

Source: New York State Department of Health [https://www.health.ny.gov/statistics/chac/chai/docs/sti\\_61.htm](https://www.health.ny.gov/statistics/chac/chai/docs/sti_61.htm); The county ranking groups: 1 - most favorable to 4 - least favorable. These county ranking groups are categorized based on the quartile distribution of all county rates



### Queens County Summary of Findings

Finally, PQI and social determinant data were overlaid to identify areas of greatest need in Queens County. We mapped areas of Queens County that fall into Quintiles 4 & 5 of the PQI Composite Rate. Then we began to overlay characteristics that provide some indication of health outcomes such as percent Non-White, percent Less than High School Diploma, percent Unemployed, and percent Below Poverty Level. In addition, areas where less than 70% were located within 0.5 mi to a supermarket, which classifies an urban area as food insecure were highlighted. Ultimately, there was substantial overlap between social determinants of health, a lack of easy access to food, and poor health outcomes. This overlap was most apparent in Jamaica, Far Rockaway, Arverne, and Astoria (these areas are circled on the map below).



In both our primary and secondary data analyses, major trends emerged regarding chronic disease, particularly obesity and the health behaviors associated with obesity, as well as mental health and substance abuse and access to healthcare. In our primary data analysis, both individual community members and community-based organizations expressed concerns about obesity and weight loss, and advocated for improving access to healthy foods and recreation. In addition, survey respondents and summit participants expressed concern about the growing need for increased mental health and substance abuse services. We saw the impacts of substance abuse, including drugs, alcohol, and tobacco, in our secondary data analysis as well. Finally, much of the conversation in our primary data analyses was centered on access and disparities in access.

Therefore, as a result of the 2016 primary and secondary data analysis the following health priorities, which are also impacted by identified social determinants of health such as poverty, unemployment, lack of housing, education and healthy food access which are present in specific in Queens County, emerged as pressing community health issues in the Northwell Health Queens County Service area:

- Chronic disease, especially in at risk and diverse communities
- Obesity
- Decreased consumption of and access to healthy foods
- Decreased physical activity and access to safe recreational areas
- Mental health and substance abuse
- Access to healthcare
- Healthy indoor and outdoor air
- Language and cultural sensitivity

# APPENDIX

## **Greater New York Hospital Association Community Health Needs Assessment Planning Committee**

Bronx-Lebanon Hospital Center Health Care System\*  
Flushing Hospital Medical Center  
Hospital for Special Surgery  
Jamaica Hospital Medical Center  
Memorial Hospital for Cancer and Allied Diseases  
Montefiore Health System\*  
The Mount Sinai Health System\*  
New York Hospital Queens  
NYC Health + Hospitals  
New York-Presbyterian Hospital\*  
NYU Langone Medical Center\*  
Northwell Health\*  
Richmond University Medical Center  
St. John's Episcopal Hospital  
The Rockefeller University Hospital

\*Health systems that represent multiple hospital facilities in NYC

### **Meeting Dates**

1/15/16

2/4/16

4/22/16



**TCNY 2020 Community  
Priorities and related  
DOHMH services in  
Queens**

August 31, 2016



NEW YORK CITY DEPARTMENT OF  
HEALTH AND MENTAL HYGIENE

Mary T. Bassett, MD, MPH

*Commissioner*

Oxiris Barbot, M.D.  
First Deputy Commissioner  
[obarbot@health.nyc.gov](mailto:obarbot@health.nyc.gov)

August 31, 2016

Gotham Center  
42-09 28<sup>th</sup> Street  
CN-28c, WS 8-46  
Queens, NY 11101-4132  
347.396.4005 tel

Dear hospital partner,

Conversations we had with hospitals across the city over the last several months confirm our agreement that partnering in health planning can maximize our collective impact to improve the health of New Yorkers. We identified two opportunities for collaboration that I want to highlight:

1. Bi-directional sharing of community health improvement interventions and services, and
2. Meaningfully utilizing the results of the Take Care New York 2020 Community Consultations to guide the CSP and CHNA planning process.

You have committed to meaningfully incorporate the community's voice in your health planning activities by including in your CSP and/or CHNA activities that address at least one of the Top 5 TCNY 2020 Borough Priorities identified through TCNY 2020 Community Consultations.

The attached document reflects the results of the consultations in your borough, the methodology we followed in the consultations, and a select list of DOHMH activities that address the issues that the communities prioritized.

Additionally, you will find information about TCNY 2020 grantees in your borough. These CBO's will engage in a structured community-based planning process during the fall of 2016 to further prioritize TCNY 2020 areas for action. I strongly encourage you to attend and/or support their planning activities and, in 2017, consider aligning resources to enable the execution of those plans.

Asia Young [ayoung6@health.nyc.gov](mailto:ayoung6@health.nyc.gov) will be your contact person to coordinate any support, and we ask that you please also be sure to send her the final CSP and CHNA that you submit to the State.

Together we can maximize our impact on NYC health outcomes and reduce gaps in longstanding health inequities. We look forward to partnering with you in the health planning process in 2016 and years to come.

Sincerely,

Oxiris Barbot, M.D.  
First Deputy Commissioner

This document is provided to support Community Health Needs Assessment (CHNA) and Community Service Plan (CSP) efforts of hospitals who committed to including at least one of the “Top 5 TCNY Borough Community Priorities” into their 2016 CHNA Implementation Plans and CSPs. The package is for exclusive use of the hospitals that receive it directly from NYC DOHMH. If you have any questions, please contact Asia Young at [ayoung6@health.nyc.gov](mailto:ayoung6@health.nyc.gov).

# TCNY 2020 Community Priorities and related DOHMH services in Queens

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## 1 Background

Take Care New York 2020 (TCNY 2020) is the City’s blueprint for giving our residents a chance to live a healthier life. Its goal is twofold – to improve the health of every community and to make greater strides with groups that have the worst health outcomes, so that our city becomes a more equitable place for everyone.

Achieving TCNY 2020 goals require the collective action of diverse communities and stakeholders; so we asked New Yorkers “What matters most to your community?” The New York City Department of Health and Mental Hygiene (DOHMH) held community consultations across the five boroughs and released an online survey during fall and winter of 2015-2016. During this process, we compiled feedback from over 1,000 New Yorkers and identified the Top 5 community concerns citywide, by borough, and by community district. Now that we have heard the voice of the community on their health priorities, the next step is to meaningfully include it in health planning to address those needs. This package is provided to support CHNA and CSP efforts of hospitals who have committed to include at least one of the “Top 5 TCNY Borough Community Priorities” into their Implementation Plans.

## 2 Queens Community Health Profiles

The [New York City Community Health Profiles](#) (CHPs) capture the health of 59 community districts across the city. They provide the most comprehensive report of neighborhood health data ever produced by looking beyond traditional measures of health. This enables us to define a broader picture of neighborhood health that can serve as a critical resource towards improving the health of our city.

For health planning purposes, you can use CHPs in at least two ways:

1. Gaining a more granular understanding of the health outcomes and needs of your community
2. Using it to target and tailor programs and services to the community districts and populations with the highest risk or prevalence of a condition, so you can improve overall population health metrics while decreasing disparity gaps.

Most of the CHP information can be further analyzed and compared by querying our interactive NYC Health Database – [EpiQuery](#) – which compiles several public databases and produces maps, trend data, and gives you the opportunity to stratify variables online.

See below the list of individual Queens CHPs:

- Long Island City and Astoria ([PDF](#))
- Woodside and Sunnyside ([PDF](#))
- Jackson Heights ([PDF](#))
- Elmhurst and Corona ([PDF](#))
- Ridgewood and Maspeth ([PDF](#))
- Rego Park and Forest Hills ([PDF](#))
- Flushing and Whitestone ([PDF](#))
- Hillcrest and Fresh Meadows ([PDF](#))
- Kew Gardens and Woodhaven ([PDF](#))
- South Ozone Park and Howard Beach ([PDF](#))
- Jamaica and Hollis ([PDF](#))
- Queens Village ([PDF](#))
- Rockaway and Broad Channel ([PDF](#))

For a comparative table of Community Districts, including information on avoidable hospitalizations, psychiatric hospitalizations, percentage of the population with chronic conditions, and demographics, refer to the recently released joint report of the PHIP, UHF, and DOHMH: [“A Strategy for Expanding and Improving the Impact of the Medical Home Across New York City”](#) (Data table is on Appendix D, Page 35-39). The report includes recommendations for hospitals on how to align preventive activities with the TCNY 2020 community consultations in a way that supports primary care practice transformation.

### 3 TCNY 2020 Community Health Priorities

#### 3.1 Queens Borough Priorities and crosswalk with DSRIP projects

Below is the combined data of the top 5 health indicators from the Queens consultations and the online survey completed by the borough’s residents:

Indicator	Description	City-wide TCNY 2020 baseline and goal	Priority Population	Priority Population baseline + goal	Potential DSRIP Project Alignment
Air Quality	Difference in the level of outdoor air pollution between neighborhood with highest and lowest level	Baseline - 6.65 µg/m3 Goal – 6.1 µg/m3	NYC in comparison with all other major cities	A <a href="#">OneNYC</a> goal is to achieve the best air-quality ranking among major cities by 2030	Advocate for clean air policies that support the outcomes of 3.d.ii – Expansion of asthma home-based self-management program
Controlled High Blood Pressure	%e of adult patients with controlled blood pressure	Baseline – 67% Goal – 76% (13% increase)	Black	Baseline – 62% Goal – 74% (19% increase)	3.b.i - Cardiovascular Health: Million Hearts Campaign
Obesity	% of adults who are obese	Baseline – 25% Goal – 23% (7% decrease)	Very-high poverty neighborhoods	Baseline – 31% Goal – 25% (20% decrease)	3.b.i - Cardiovascular Health: Implementation of Million Hearts Campaign  3.c.ii. – Implementation of evidence-based strategies in community to address chronic disease
Physical Activity	% of public high school students who met physical activity recommendations	Baseline – 19% Goal – 22% (15% increase)	Asian-Pacific Islander	Baseline – 14% Goal – 18% (30% increase)	3.b.i - Cardiovascular Health: Million Hearts Campaign  3.c.ii. – Evidence-based strategies in community (for chronic disease)
Unmet Mental Health Need	% of adults with serious psychological distress who did not get needed mental health treatment	Baseline – 22% Goal – 20% (9% decrease)	Very high poverty neighborhoods	Baseline – 30% Goal – 22% (26% decrease)	3.a.i - Integration of primary care and behavioral health services

### 3.2 Queens Community District Priorities

Community Districts included in this list are only those that had at least 10 votes in the ranking of their priorities. Due to the small sample size for this level of detail, additional community consultation activity is recommended if you plan to include more robust information on the stated health priorities of these neighborhoods.

Community	Prioritization Results
<b>Astoria (CD 1)</b> <i>(Including Long Island City, Astoria, Astoria Heights, Queensbridge, Dutch Kills, Long Island City, Ravenswood and Steinway)</i>	1. Air Quality 2. Obesity 3. Unmet Medical Need 4. Child Care 5. Smoking
<b>Jackson Heights (CD 3)</b> <i>(Including East Elmhurst, Jackson Heights and North Corona)</i>	1. Physical Activity 2. Air Quality 3. Controlled High Blood Pressure 4. Sugary Drinks 5. Obesity
<b>Corona (CD 4)</b> <i>(Including Elmhurst, Corona, Corona Heights, and Lefrak City)</i>	1. Controlled High Blood Pressure 2. Physical Activity 3. Unmet Mental Health Need 4. Unmet Medical Need 5. Air Quality
<b>Rego Park and Forest Hills (CD 6)</b> <i>(Including Forest Hills, Forest Hills Gardens and Rego Park)</i>	1. Air Quality 2. Obesity 3. Unmet Mental Health Need 4. Violence 5. Unmet Medical Need
<b>Flushing (CD 7 )</b> <i>(Including Auburndale, Flushing, Bay Terrace, College Point, East Flushing, Queensboro Hill and Whitestone)</i>	1. Air Quality 2. Physical Activity 3. Child Care 4. Obesity 5. Unmet Medical Need
<b>Jamaica (CD 12)</b> <i>(Including Hollis, Jamaica, Jamaica Center, North Springfield Gardens, Rochdale, South Jamaica and St. Albans)</i>	1. High School Graduation 2. Drug Overdose Deaths 3. Controlled High Blood Pressure 4. Binge Drinking 5. Smoking
<b>Queens Village (CD 13)</b> <i>(Including Bellerose, Cambria Heights, Glen Oaks, Laurelton, Queens Village, Rosedale and Springfield Gardens)</i>	1. Controlled High Blood Pressure 2. Physical Activity 3. Air Quality 4. Obesity 5. Child Care
<b>Far Rockaway (CD 14 )</b> <i>(Including Arverne, Bayswater, Belle Harbor, Breezy Point, Broad Channel, Edgemere and Rockaway)</i>	1. Controlled High Blood Pressure 2. High School Graduation 3. Unmet Medical Need 4. Unmet Mental Health Need 5. Violence

### 3.2.1 TCNY 2020 Community-Based Planning Grantees

The Health Department and the Fund for Public Health in New York awarded \$400,000 in grants to eight community-based organizations in neighborhoods across the city as part of Take Care New York (TCNY) 2020, the agency's blueprint for creating healthier communities. Building on extensive input that the DOHMH received through 28 community consultations in fall 2015- spring 2016 the community-based TCNY Planning Partners will each receive \$50,000 to lead the development of collaborative plans to address local health priorities, such as obesity, smoking, high school graduation, among others. The TCNY Planning Partners will help achieve health equity goals set out in TCNY 2020 by working with diverse community members, including hospitals, to: make a collective decision about which TCNY 2020 objective to focus local attention on; (2) map assets and opportunities to effect change, and (3) develop a plan of action. By participating in the action planning process led by our TCNY Planning Partners, hospitals can help create sustainable solutions for the root causes of poor health outcomes. All stakeholders, including hospitals, are encouraged to consider aligning resources to implement the collaborative plan.

In Queens, the two organizations that received funding are:

- **Public Health Solutions** (serving the Jamaica neighborhood), which implements innovative, cost effective, and population based community health programs, conducts research on public health issues, and provides services to other nonprofit organizations to address public health challenges.
- **The Rockaway Waterfront Alliance** (serving the Far Rockaway neighborhood), which is dedicated to empowering residents of underserved communities in the Rockaways to play a role in the determination of their neighborhoods.

## 3.3 Methodology

### 3.3.1 Community Consultation Site Selection

In order to make the Community Consultations accessible to as many New Yorkers as possible, DOHMH staff with expertise in policy, communications, community engagement and intergovernmental affairs collaboratively selected Consultation sites based on the following criteria:

- Location within, or proximity to, neighborhoods with high rates of poor health outcomes
- Accessibility by subway or, in the case of outer neighborhoods, by other common modes of transportation
- Availability of a free or inexpensive venue meeting the following requirements
  - Neutral and welcoming space
  - Open during evening and/or weekend hours
  - Layout accommodating to small group discussions
  - AV equipment

### 3.3.2 Community Consultation Outreach

The Community Consultation results aim to inform the development of strategies to improve population health outcomes through a focus on closing health equity gaps. This is why DOHMH prioritized outreach

efforts to lay community members living in neighborhoods with high rates of poor health outcomes. We did this by using internal communication channels and leveraging outreach support from sister agencies, healthcare organizations, nonprofit organizations, city officials (elected and non-elected), and faith-based leaders. We provided grants to 11 community organizations to support our outreach efforts.

- Press announcements and print media
  - At the launch of the Community Consultations, DOHMH targeted press outreach at large-circulation newspapers in order to raise overall awareness of the process
  - Once the Consultations were ongoing, DOHMH targeted additional press outreach at local outlets, community calendars and blogs serving the neighborhoods where Consultations were being held
  - DOHMH did an additional press release at the launch of Online Voting
- Social media
  - DOHMH promoted each Consultation and Online Voting on our website, and partners promoted select Consultations on their own websites
  - DOHMH created a Facebook event page for each Consultation, with some pages created in more than one language
  - DOHMH and partners additionally promoted each Consultation and Online Voting through twitter and Facebook posts
  - DOHMH paid for sponsored social media promotion targeting social media users based on their location
- Dissemination of print materials (flyers, posters, postcards)
  - Print materials in multiple languages were hung and disseminated in the venues hosting the Consultations and nearby public spaces
  - Print materials were directly handed out to community members by staff and partners who canvassed the neighborhoods near the Consultations
- Word-of-mouth
  - DOHMH staff and partners spoke directly with local organizations (churches, businesses, schools, housing developments, arts organizations) and residents through street outreach conducted in the days before each Consultation
  - DOHMH and partners promoted the Consultations by making announcements at local events, such as church services, school meetings, etc.
  - DOHMH and partners sent out emails about the Consultations and Online Voting to lists of additional partners and lay community members

### **3.3.3 Consultation participants**

Community consultation outreach targeted participation of lay community members, with special emphasis on those who live in impoverished neighborhoods and are at high risk of poor health. We used a combined model of in-person consultations and online consultation. We received input from 1033 New Yorkers - 22% of them lived in Queens.

City-wide, 27% of participants identified as Black, 27% identified as Hispanic, and 14% identified as Asian. The vast majority (83%) of participants spoke English, 9% of participants spoke Spanish only, and 3% of participants spoke Chinese only. 59% of respondents were women.

### 3.3.4 Analysis of input

Residents were asked to select their community district of residence (in the paper ballot at Community Consultations, or in the online survey) and rank a list of indicators provided by DOHMH in order of importance (where 1 = most important). DOHMH analyzed the results using a simple point system, in which each ranking was assigned a point value from 1-23 (with the indicator ranked 1 receiving 23 points, and the indicator ranked 23 receiving 1 point). The indicators that received the most points from all participants' rankings were identified as top priorities.

Preliminary data published earlier in 2016 identified the top priorities of a given Consultation, by collectively analyzing all of the ballots completed and collected at that in-person Consultation.

The final results by community district, borough, and city priorities presented above combine the prioritization done at the in-person consultations and the online survey. In order to identify the top priorities of a given borough, DOHMH collectively analyzed all ballots (in-person and online) on which participants had noted a community district of residence located within that borough.

## 4 Select DOHMH Services in Line with the Top 5 Queens Priorities

Below is a select list of city government-led initiatives that are contributing to achieving our TCNY 2020 goals. If you would like more information about any of these services, please email Asia Young at [ayoung6@health.nyc.gov](mailto:ayoung6@health.nyc.gov) and she will connect you to the right program lead.

### 4.1 Air Quality

- **[New York City Community Air Survey \(NYCCAS\)](#)** – This is the largest ongoing street-level urban air monitoring program of any U.S. city. It is conducted by NYC DOHMH and provides data for designing policy, evaluating trends, and characterizing air pollution exposure. NYC DOHMH routinely produces reports on neighborhood air quality.
- **Healthy Homes Program (HHP)** - The mission of the Department of Health & Mental Hygiene (DOHMH)'s Healthy Homes Program (HHP), formerly the Lead Poisoning Prevention Program, is to reduce environmental hazards in the home associated with disease and injury. HHP has a special focus on children's homes and aims to prevent childhood lead poisoning and reduce asthma triggers in the homes of children. Here are trainings that we provide:
  - **The ABCs of Environmental Home Health Hazards Training:** This is a four hour interactive training for professionals working with children and families. The training topics include: Lead Poisoning Prevention, Consumer Product Safety, Facts about Mold, How to Control Pests Safely, Poison Prevention/Medicine Safety, Fire Safety and Environmental Data Portal.
  - **Creating Healthy Homes for Older Adults Training:** This is a four-hour interactive training focusing on how to assess a home for common hazards that can cause injury, poisoning, heat illness and other dangers for older adults. Topics will include: Falls Prevention, Medicine Safety, Extreme Heat, Consumer Product Safety, Mosquito Bite Prevention and Environmental Data Portal.
  - **Integrated Pest Management (IPM) Training-** This is a one to four hour training on integrated pest management (such as rats, cockroaches, mice and bed bugs) to building

owners, property managers, maintenance staff, architects, general contractors, and tenants. One of our IPM trainings is our training for Two Shades of Green (TSG). TSG is a partnership between Local Initiatives Support Corporation (LISC NYC), NYC Department of Health and Mental Hygiene (DOHMH), NYC Department of Housing Preservation and Development (HPD), and NYC Smoke Free. TSG focuses on water and energy conservation, along with IPM, Green Cleaning, Smoke-Free, Active Design in LISC affiliated buildings. HHP provides technical assistance for implementation.

- **HHP Support for Delivery System Reform Incentive Payment (DSRIP) Asthma-Related Activities:** HHP's DSRIP activities include training for home visiting staff on identifying asthma triggers and other home health hazards in the home and effective remediation practices, technical assistance on accessing IPM services.
- **Technical Assistance:**  
**Integrated Pest Management (IPM) Technical Assistance-** HHP offers technical assistance to building owners, property managers, maintenance staff, architects and general contractors on implementing a building wide IPM program and opportunities during new construction and rehabilitation. HHP has developed an [IPM Toolkit](#) for building owners and staff.

#### 4.2 *Controlled High Blood Pressure*

- **Join the BEAT** – A grant funded initiative that is focused on select neighborhoods (including Southeast Queens) with high rates of obesity, uncontrolled diabetes, hypertension, hospitalizations, and deaths from cardiovascular causes. Strategies to address these health inequities include: enhancing environmental strategies to promote, support, and reinforce healthy behaviors; building support for healthy lifestyles; improving health system interventions to improve the quality of health care delivery to populations with the highest hypertension and prediabetes disparities; and linking community and clinical strategies to support heart disease, stroke, and diabetes preventions efforts.
- **[Keep on Track](#)** – A community-based blood pressure monitoring program that provides free training and materials to faith and community-based organizations for regular blood pressure monitoring and counseling.
- **Partnering with pharmacists** –DOHMH seeks to improve the quality of health care delivery by engaging 17 community pharmacies in activities that will drive the prevention and control of high blood pressure. We will provide technical assistance and quality improvement support to: increase awareness of the impact of high blood pressure; promote evidence based strategies that increase the rate of blood pressure control; and increase the demand for pharmacist-directed care.
- **Healthy lifestyle programs** -- DOHMH also runs or supports a variety of [healthy eating](#) and [physical activity programs](#), both of which can help patients control their blood pressure.

#### 4.3 *Obesity*

- **Media campaigns** – Our three most recent campaigns promoted making healthy choices when [grabbing a snack](#), [drinking tap water](#), and the importance of family support when [making and sustaining healthy lifestyle changes](#).
- **[Eat Well, Play Hard in Child Care Settings](#)** – Through this program, registered dietitians from the Health Department visit child care settings that serve low-income families and provide a series



of lessons on the importance of good nutrition and physical activity for children aged 3 to 4 years and their caregivers. The program is implemented in approximately 100 centers per year and over 50,000 children, parents, and staff have been reached at more than 500 child care centers to date.

- [National Diabetes Prevention Program \(NDPP\)](#) – This is an evidence-based intervention prevention program designed to help participants lose weight and attempt to prevent/delay the onset of Type 2 Diabetes. DOHMH provides NDPP coaches’ trainings, in addition to providing technical assistance to external organizations to sustain programmatic delivery.
- [Quality and Technical Assistance Center \(QTAC\)](#) – This is a national online registration and data management portal. DOHMH provides technical assistance to external organizations to sustain programmatic delivery. Through QTAC, providers in clinical settings can refer and enroll patients into a variety of wellness programs. Benefits of using QTAC include:
  - Directly registering patients for programs in real time
  - Enabling clinical providers to directly register patients in classes from a variety of providers at various locations
  - Receiving automated feedback regarding a patient’s attendance, physical activity, and weight loss if the patient attends a workshop

QTAC includes referrals to NDPP services to help prevent diabetes, but also to self-management programs such as:

- Diabetes Self-Management Program (DSMP) – This program provides participants with the tools and knowledge to help manage their diabetes. Discussions focus on topics, such as medication adherence, exercising, and nutrition.
  - Chronic Disease Self-Management Program (CDSMP) – This is a self-management program for people with chronic health conditions. Discussions focus on topics, such as medication adherence, exercising, and nutrition.
- Designing a Strong and Health New York City (DASH-NYC) Workgroup released their plan entitled [“Interventions for Healthy Eating and Active Urban Living: A Guide for Community Health”](#) for hospitals and community organizations looking to improve their investment in population health. This guide outlines concrete approaches to promote healthy eating and active living in NYC neighborhoods by:
    - Increasing access to healthy, affordable food,
    - Decreasing access to unhealthy foods and beverages, and
    - Improving opportunities for physical activity and exercise

#### 4.3.1 Healthy Eating Programs

In addition to our efforts to address obesity, we have nutrition initiatives that increase access to healthy food.

- [Health Bucks](#) – Health Bucks are \$2 coupons redeemable for fresh fruits and vegetables at all New York City farmers’ markets. SNAP recipients can receive one \$2 Health Buck for every \$5 spent in SNAP benefits at all NYC farmers’ markets that accept electronic benefits transfer (EBT) cards. Starting this year, Health Bucks will be available year-round to customers using their SNAP benefits at farmers’ markets. Nearly 400 community-based organizations serving low income New Yorkers also distribute Health Bucks through health and nutrition education programming.



Over the last 10 years, low-income New Yorkers have used Health Bucks to purchase more than \$2.5 million worth of fresh produce from New York City farmers' markets and more than 90% of market customers using EBT reported that they bought more fruits and vegetables because of the incentive. Health Bucks may also be purchased by healthcare providers for use as part of a fruit and vegetable prescription program or to support health-related programming. If you would like to purchase Health Bucks for your organization, click [here](#). For more information on how to donate to the Health Bucks Program, click [here](#). See the poster with Queens-specific information [here](#) and additional information [here](#).

- **[Food Retail Expansion to Support Health \(FRESH\)](#)** – FRESH encourages the development and retention of convenient, accessible stores that provide fresh produce. It offers zoning incentives that provide additional floor area in mixed buildings, reduce the amount of required parking for food stores, and permit larger grocery stores as-of-right in light manufacturing districts.
- **[Shop Healthy](#)** – NYC DOHMH helps shops make changes in their stores to promote healthier items, increase the stock of healthier drinks and snacks, and increase the visibility of fresh produce.
- **[Green Carts](#)** – We created the Green Cart licensing program to offer fresh fruits and vegetables in NYC neighborhoods that have limited access to healthy foods. We are also providing free wireless EBT terminals to be used by SNAP recipients. See locations [here](#).
- **[Farmers' markets](#)** – We are working with them to provide free, bilingual food-based activities for adults and children at select farmers markets. See list of farmers' markets locations [here](#). All farmers' markets that accept Supplemental Nutrition Assistance Program (SNAP) benefits will give one \$2 Health Buck coupon to each customer for every \$5 spent using Electronic Benefits Transfer (EBT).
  - The Stellar Farmers' Market program aims to increase low-income New Yorkers' fruit and vegetable consumption through free nutrition workshops and cooking demonstrations at select farmers' markets across the city, reaching about 30,000 participants annually.
  - The Farmers' Markets for Kids program offers free bilingual food-based education workshops for children and their caregivers at select neighborhood farmers' markets in NYC. Last year, over 8,000 participants, including 5,300 children and 2,800 adult caregivers, attended the workshops.

#### 4.4 *Physical Activity*

- **Active Design Schools Initiative** – The New York City Department of Health and Mental Hygiene (DOHMH) promotes healthy physical environments in NYC Department of Education (DOE) public schools through monetary awards, trainings and technical assistance to optimize active spaces. Since 2015, this initiative has supported over 45 small-scale built environment enhancements in schools that are featured in the [Active Design Toolkit for Schools](#). These strategies aim to increase physical activity among students, and help reduce obesity, diabetes and related chronic diseases over the long term, while providing immediate cognitive benefits like improved mood, increased on-task classroom behavior and improved academic performance.
- **Active Design in Early Childhood Settings** – The New York City Department of Health and Mental Hygiene (DOHMH) promotes healthy physical environments in early childhood centers

through monetary awards, trainings and technical assistance to optimize active spaces. Since 2015, this initiative has supported 37 early childhood centers in low income neighborhoods throughout the five boroughs to implement built environment enhancements that increase access to physical activity and active play. In November 2016, the *Active Design for Early Childhood Settings Playbook* will be published which includes practical and easy to implement ideas for enhancing existing indoor and outdoor spaces to increase active play as well as provide tips on promoting unstructured play and opportunities for outdoor learning.

- **Shape Up** – Shape Up NYC is a free, drop-in fitness program provided by NYC Parks in partnership Empire BlueCross BlueShield Foundation and NYC Service. No membership or pre-registration is required to participate, and classes range from yoga, to dance, to self-defense. NYC DOHMH was a founding member of the Shape Up program and partnered with NYC Parks to reach more New Yorkers through translation of marketing materials into Spanish, Chinese, and Russian and to identify new locations for Shape Up classes. Shape Up NYC is located at various locations throughout the city including Parks’ Recreation Centers, public libraries, community centers, hospitals and clinics and is always looking for new sites so more New Yorkers have access to this fitness program.

#### 4.5 Unmet Mental Health Need

The DOHMH services listed below are part of the [ThriveNYC](#) city-wide, mayoral campaign to raise awareness among New Yorkers about the prevalence and treatment of mental health issues.

- **Roadmap Website** – NYC DOHMH launched a website that includes:
  - Information on what mental health looks like
  - Easy-to-read guidance on how to get help for common mental health conditions
  - Roadmap animation
  - Information on how to support the roadmap
  - A mechanism for providing feedback
- **Mental Health Program Finder** – allows New Yorkers to easily find mental health and substance abuse services. The finder allows users to conduct a search that factors in four variables:
  - Age
  - Types of payment accepted
  - Type of service
  - Optional demographic data (e.g., LGBT, veteran)
- **Health and Recovery Plans (HARPs)** – Adults who enrolled in Medicaid and are 21 years or older with Serious Mental Illness (SMI) and Substance Abuse Disorder (SUD) diagnoses who have serious behavioral health issues are eligible to enroll in HARP. Benefits of HARPS include:
  - Managing the Medicaid services for people who need them
  - Managing an enhanced benefit package of Home and Community-Based Services (HCBS)
  - Providing enhanced care management for members to help them coordinate all physical health, behavioral health and non-Medicaid support needs.
- **NYC Support** – This is an upcoming crisis and support line that will be 24/7/365 and accessed via phone, text, and the web for New Yorkers to connect with mental health and substance use services. NYC Support will provide suicide prevention, peer support, referrals, assistance making appointments, counseling and follow-up with New Yorkers until they connect to care. NYC Support will be available in English, Spanish, Cantonese, and Mandarin. This service will replace

the currently existing 1-800-LIFENET which will continue to operate 24/7 until NYC Support is announced and online.

- **Mental Health Service Corps** – The Service Corps is an innovative program that will hire, train and place early career Social Workers and Clinical Psychologists in substance abuse programs, mental health clinics, and primary care practices in high-need communities throughout the city for 3 years of service. When fully operational after 3 years, close to 400 mental health clinicians will be working at any given time across NYC to increase accessibility of mental health services.
- **Mental Health Services in Additional High-Need Schools** – Starting in fall 2016, the City will assess the mental health service needs at additional public schools that have a disproportionate share of suspensions.
- **School Mental Health Consultants** - The City will hire 100 School Mental Health Consultants (SMHCs) who will provide mental health consultation and technical assistance to schools citywide. The Consultants will create School Mental Health Plans with school teams. Based on needs identified as part of the plans, Consultants will create referral pathways and linkages to community based organizations.
- **Behavioral Health in Schools Project (DSRIP):** DOHMH is assisting in the identification of schools with high need for behavioral health services for the Behavioral Health Schools Project led by a group of four PPSs that will fund services in up to 100 middle and high schools in Brooklyn, the Bronx, Manhattan and Queens. The project started in Brooklyn and Bronx in 2016 and will be scaled up in subsequent phases. The goals are to strengthen mental health and substance use literacy in schools, help schools develop behavioral health crisis response plans and resources, and link schools to hospitals and other community-based service providers.
- **Regional Planning Consortium (RPC)** – RPC brings together a variety of stakeholders including Medicaid managed care organizations (MCOs), behavioral health providers, DSRIP PPS behavioral health leads, Health Homes, city agencies, and consumers to monitor, discuss, and explore potential solutions to problems and issues inherent to the Behavioral Health transition into Medicaid managed care.
- **Police Crisis Intervention Team Training** – NYC DOHMH and NYPD are partnering to oversee a four-day training program to help police officers identify behaviors and symptoms of mental illness and substance misuse and learn techniques for engaging people in respectful, non-stigmatizing interactions that de-escalate crisis situations.
- **Mental Health First Aid Training** – The Department of Health and Mental Hygiene (DOHMH) is offering training for individuals and groups on Mental Health First Aid, a groundbreaking public education program that teaches the skills needed to identify, understand, and respond to signs of mental health and substance use challenges or crises. [ThriveNYC](#) and DOHMH aims to train 250,000 New Yorkers over the next five years. **Enroll your staff and partners today!**

## 5 Additional Information

To support your CSP/CHNA needs, we have attached additional resources that may be of use:

- List of [school-based mental health clinics](#)
- List of [school-based health centers](#)
- List of [NYC DOHMH clinics](#)