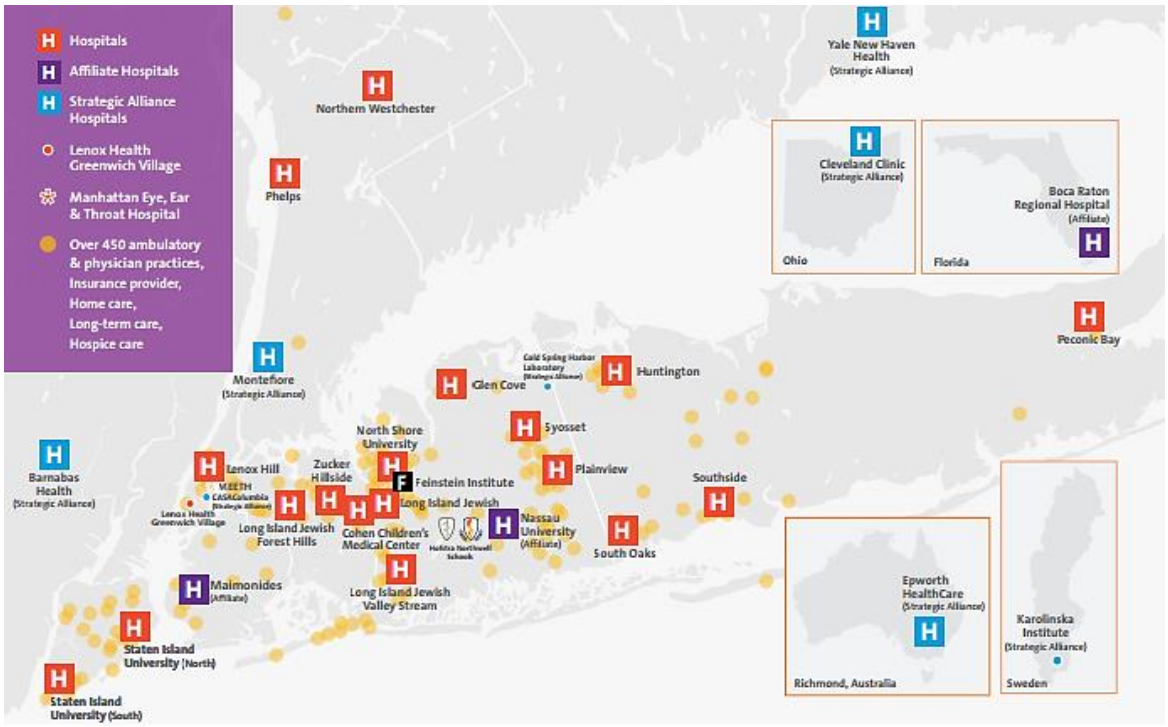
# Northwell Health
# Community Service Plan 2016-2019

# Richmond County Service Area
# CHNA



# Richmond County Community Health Needs Assessment

### *Richmond 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[1] 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 Black non-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: Ratio of Hispanics to White non-Hispanics
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
Gonorrhea case rate per 100,000 women - Aged 15-44 years*
Premature births: Ratio of Medicaid births to non-Medicaid births
Exclusively breastfed: Ratio of Hispanics to White non-Hispanics
Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births
Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics
Percentage of unintended pregnancy among live births*
Percentage of women (aged 18-64) with health insurance*
**Significant change*

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

**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 hospitalizations due to falls per 10,000 - Aged 65+ years#
Rate of hospitalizations due to falls per 10,000 - Aged 65+ 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 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#
Newly diagnosed HIV case rate per 100,000
Difference in rates (Black and White) of newly diagnosed HIV cases
Difference in rates (Hispanic and White) of newly diagnosed HIV cases
Gonorrhea case rate per 100,000 men - Aged 15-44 years
Chlamydia case rate per 100,000 women - Aged 15-44 years
Primary and secondary syphilis case rate per 100,000 men
Primary and secondary syphilis case rate per 100,000 women
Percentage of preterm births#
Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs#
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 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#
Percentage of children (aged under 19 years) with health insurance#
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years#
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**

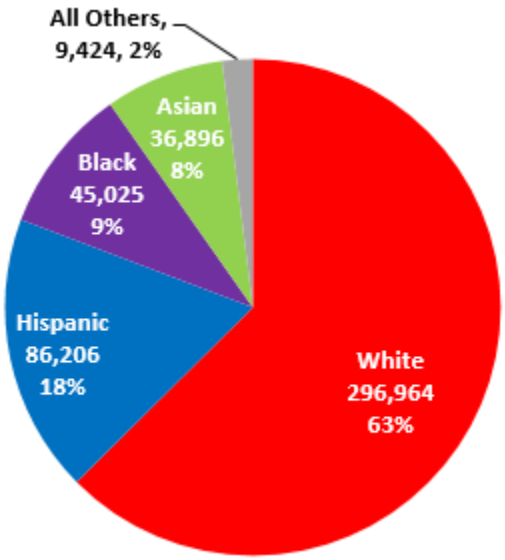
Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics
Assault-related hospitalization rate per 10,000
Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics
Assault-related hospitalization: Ratio of low income ZIP codes to non-low income ZIP codes
Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home

Percentage of adults who are obese*
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years
Premature births: Ratio of Black non-Hispanics to White non-Hispanics
Premature births: Ratio of Hispanics to White non-Hispanics
Percentage of infants exclusively breastfed in the hospital*
Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics
Maternal mortality rate per 100,000 births
Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics
Age-adjusted suicide death rate per 100,000
**Significant change*

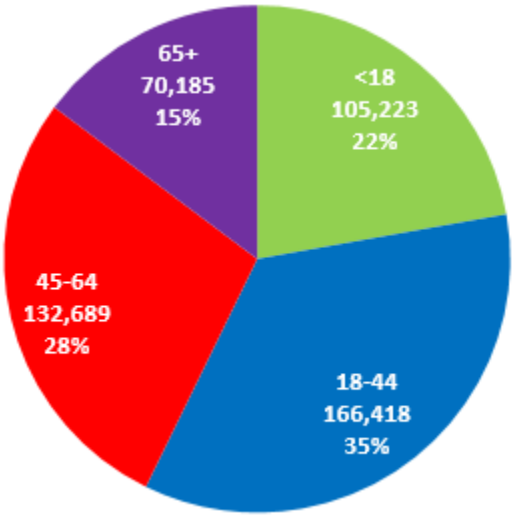
***Demographic Profile***

Our primary service area in Staten Island encompass two hospitals, Staten Island University Hospital, North and Staten Island University Hospital, South. Richmond County has a population of 474,515 that is 52% female and has an age distribution of 22% aged less than 18 years, 35% aged between 18 and 44 years old, 28% aged 45 to 64, and 15% over 65 years of age. The racial distribution of Staten Island is 63% white, 18% Hispanic, 9% black, and 8% Asian. Approximately 22% of Richmond County residents are foreign-born and 31% of residents speak a language other than English at home.

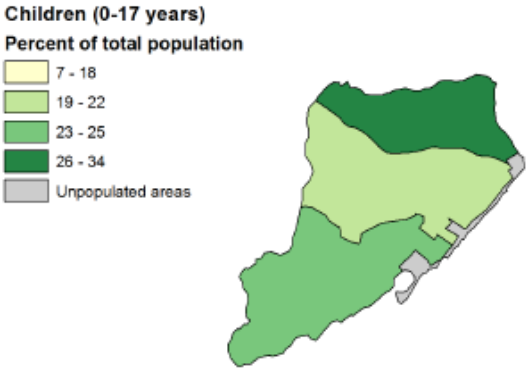
Staten Island Racial Diversity



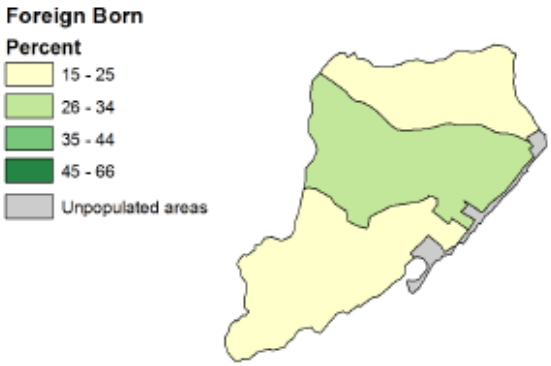

Staten Island Population Age Distribution




Source: Truven Market Discovery.v2015.03.26.tpn



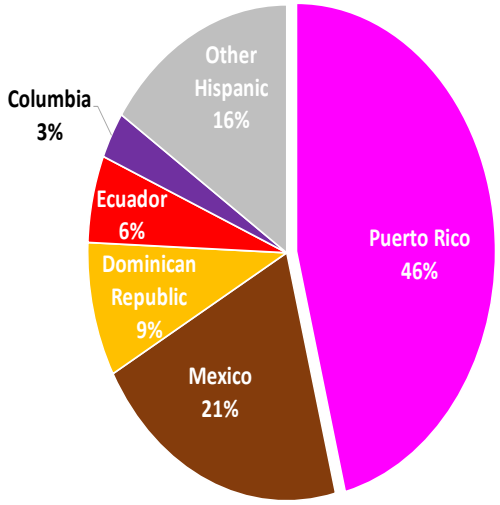

Source: U.S. Census Bureau Population Estimates, 2013



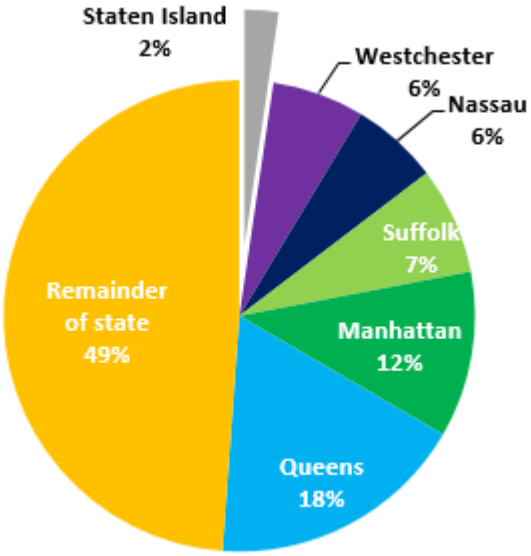

Source: U.S. Census Bureau, American Community Survey, 2011-2013

The Hispanic population is the most largely represented minority in Richmond County. Within the Hispanic population, there are several countries of origin represented. Approximately 46% of the Hispanic population is Puerto Rican and 27% is composed of Central American, South American, and Spanish subgroups. Twenty-one percent of the Hispanic population is Mexican. Staten Island makes up 2% of the State's Hispanic population and 2% of the State's black population.

HISPANIC/LATINO SUB-POPULATIONS

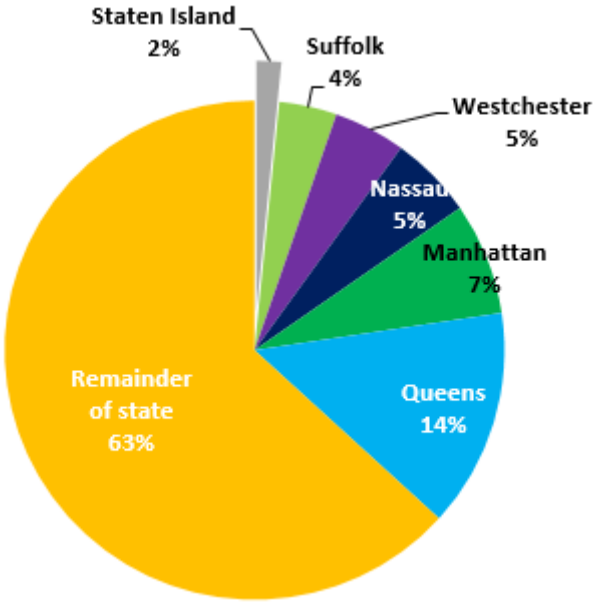



PERCENT OF STATE HISPANIC POPULATION




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

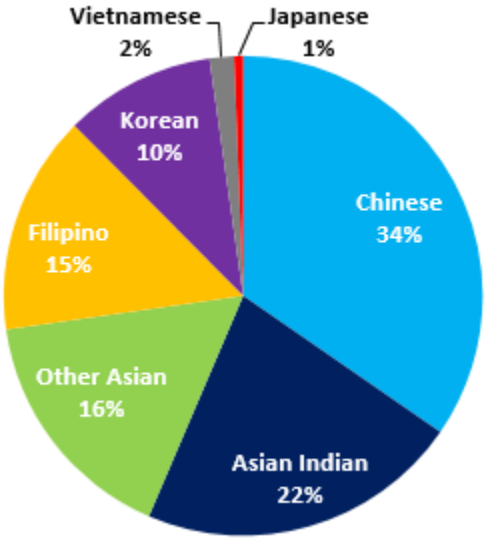
PERCENT OF STATE BLACK POPULATION



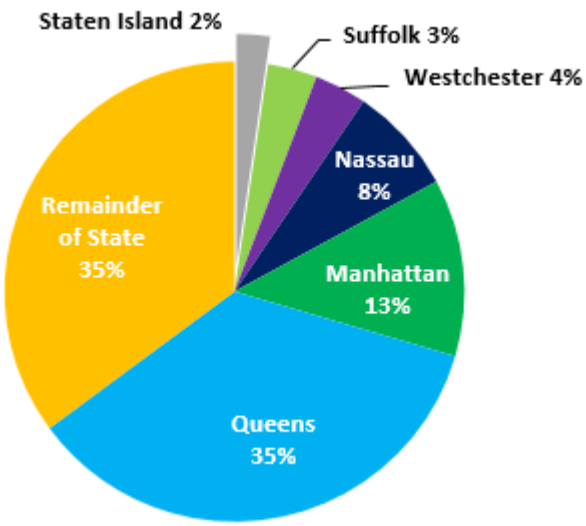

Source: Truven Market Discovery.v2015.03.26, ACS Census 2014; tpn

In addition, there are several countries of origin represented in the Asian population of Staten Island. The breakdown of Asian subpopulations is as follows: 34% Chinese, 22% Asian Indian, 16% other Asian, 15% Filipino, 10% Korean, 2% Vietnamese, and 1% Japanese. Staten Island makes up 2% of the State's Asian population.

ASIAN SUB-POPULATIONS




PERCENT OF STATE ASIAN POPULATION

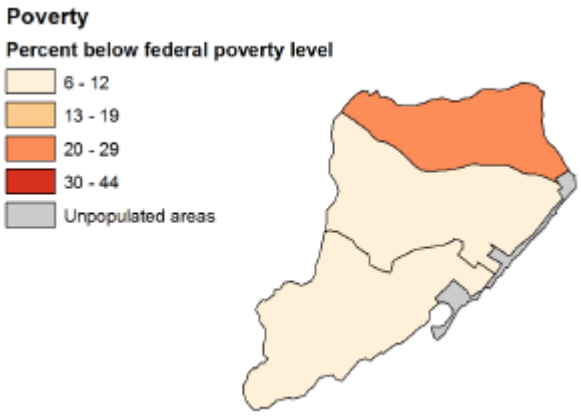



Source: Truven Market Discovery.v2015.03.26, ACS Census 2014; tpn

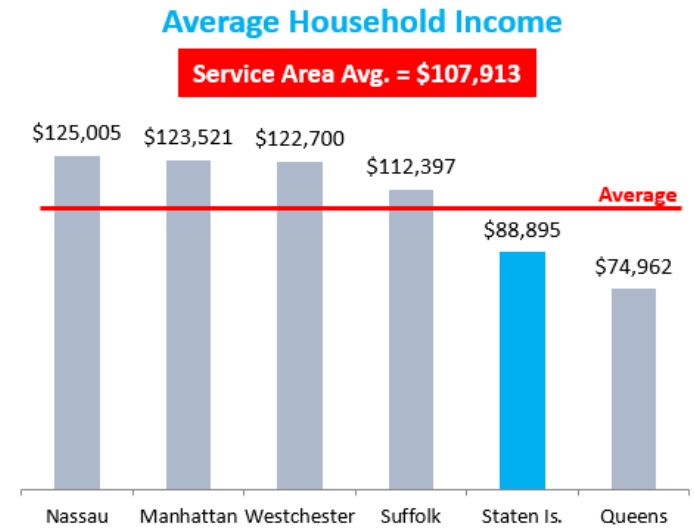
***Social Determinant Analysis***

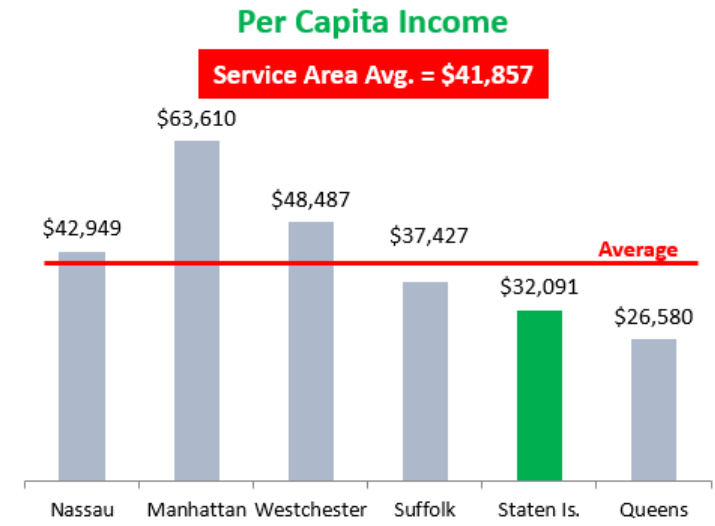
Secondary data on various social determinants of health in Richmond County was analyzed to identify factors that may contribute to the health status of the population of Richmond County. The results of this analysis are as follows.

The average household income in Staten Island is $88,895 while the per capita income is $32,091. Both of these statistics fall below the service area average. The per capita income in Staten Island is slightly below the NYS average, but the average household income is greater than the state average. The poverty rate in Staten Island is high at 14.5%, above the service area average. As depicted in the map below, there are higher rates of poverty in the St. George and Stapleton sections of Staten Island. In these areas, residents may be up to 29% below federal poverty level.

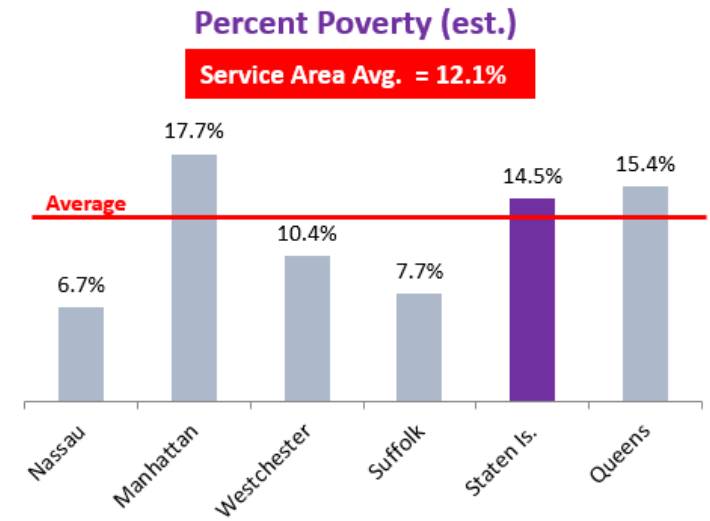



Source: U.S. Census Bureau, American Community Survey, 2011-2013



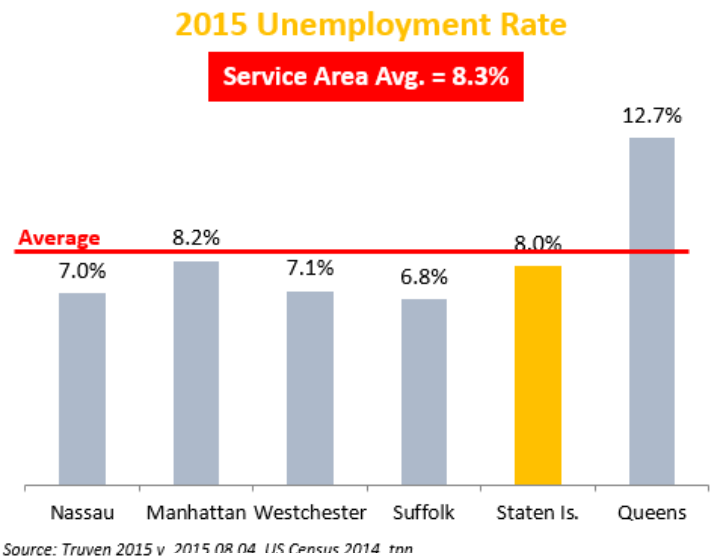

*Source: Truven 2015 v. 2015.08.04, US Census 2014. Tpn*



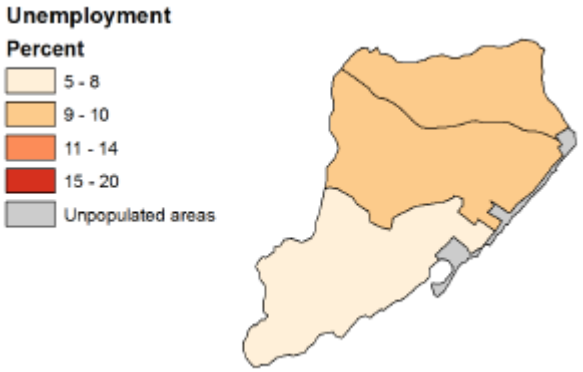

*Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn*

The socioeconomic state of Staten Island is further represented in its rates of unemployment. While the county-wide unemployment rate is 8.0%, just below Northwell's service area average, there are higher unemployment rates in the same impoverished communities mentioned above. One cannot be discussed without the other.

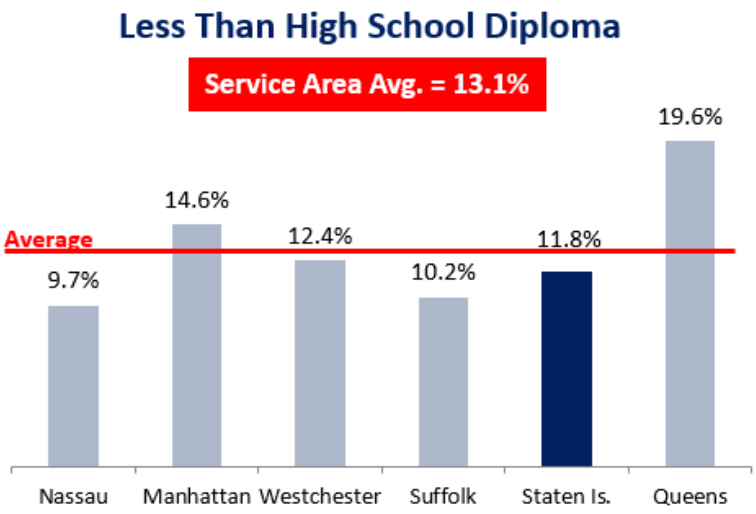
Poverty and unemployment are not the only socioeconomic determinants of health. Educational attainment has perhaps the strongest correlation to health outcomes. In Staten Island, 75% of students graduate from high school, and 67.1% have attended at least some college[2]. In addition, almost 12% of Staten Island residents have less than a high school diploma. If we look more closely at St. George and Stapleton, we see that between 15 and 20% of residents did not complete high school.



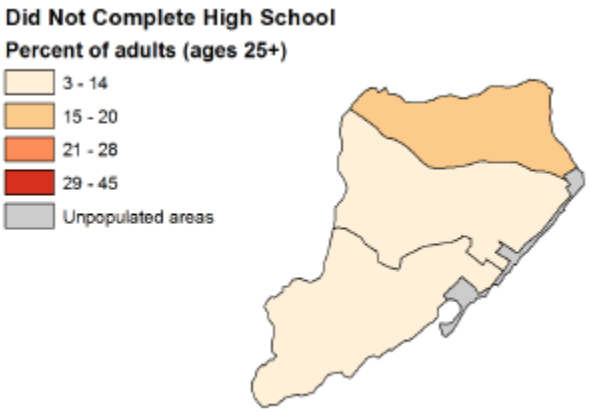

Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn




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



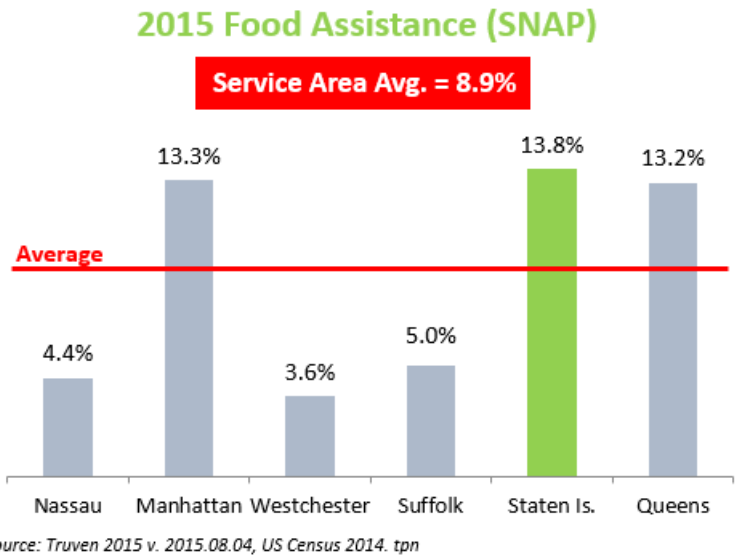

Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn




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

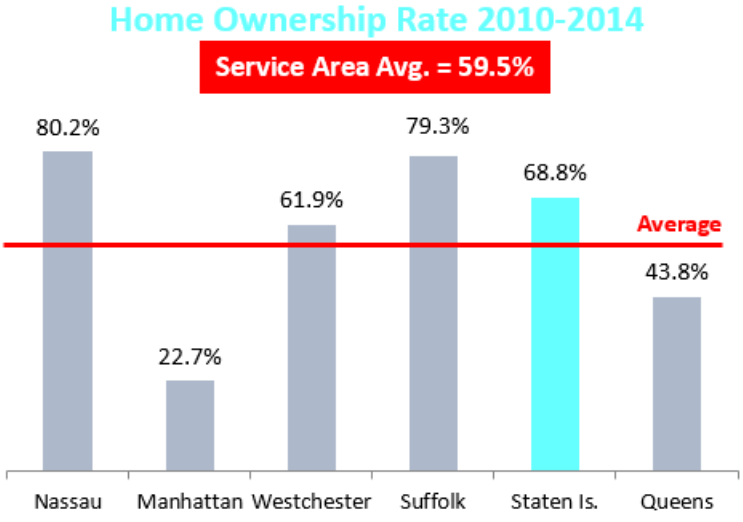
[2] U.S. Dept of Education, EDFacts 2012-2013

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 11% of the population of Staten Island experiences food insecurity, with approximately 48,380 food insecure individuals living in Staten Island[3]. Approximately 14% of Staten Island 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.



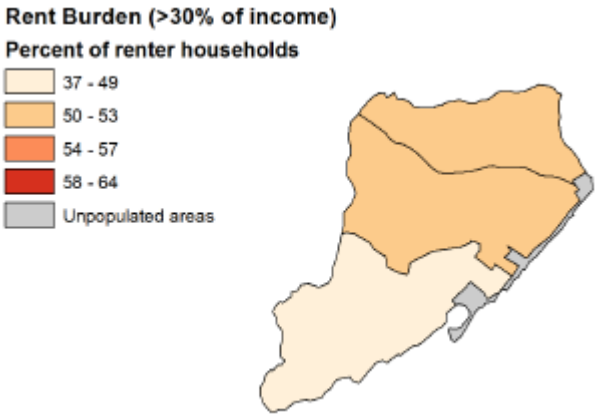
*Source: Truven 2015 v. 2015.08.04, US Census 2014. tpn*

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[4]. The percentage of Staten Island 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)[5] and, according to the American Housing Survey, 3.7% of housing units were overcrowded.



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

The home ownership rate in Staten Island from 2010-2014 was 68.8%. Even with higher rates of home ownership, it's important to examine rent burden in Staten Island. 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 Staten Island, we see 50-53% of renter households in most of the north/northeast portion of the island, with the remainder of Staten Island experiencing rent burden 37-49% of the time.



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

[3] Map the Meal Gap, 2013
[4] FBI Uniform Crime Reporting, 2014
[5] eBRFSS, 2014

Access to exercise and walking suitability are environmental factors that also contribute to health status. Ninety-nine percent of Staten Island 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 walking suitability across all five boroughs of New York City)[6]. One's environment is also shaped by the accessibility of health services in the area. Health services in Staten Island are relatively accessible when compared to New York State averages. The population to primary care provider ratio is 1043:1[7], while the NYS average is 1200:1, but the population to mental health provider ratio is 515:1[8], greater than the state average of 420:1. Ten percent of the population is uninsured.[9]

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 Richmond County, determined by the number of membership associations per 10,000 residents, was 4.1 in 2013[10]. This is much lower than the service area average of 7 and state average of 7.9. When it comes to diet and nutrition, only 10% of Staten Island residents consume the recommended daily intake of fresh fruits and vegetables and 31% of adults report having no leisure time physical activity[11]. Fifteen percent of adults in Staten Island smoke and 17% report drinking excessively[12]. Twenty percent of driving deaths in Staten Island were attributed to alcohol from 2012-2014[13]. In addition, the drug overdose mortality rate in Richmond is 18 per 100,000 deaths and, from 2012-2014, Richmond experienced 248 drug overdose deaths[14].

[6] eBRFSS, 2014
[7] Area Health Resource File, American Medical Association, 2013
[8] CMS, National Provider Identification File
[9] Dartmouth Atlas of Healthcare, 2013
[10] County Business Patterns, 2013
[11] CDC Diabetes Interactive Atlas, 2012
[12] eBRFSS, 2014
[13] Fatality Analysis Reporting System, 2010-2014
[14] 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 Richmond County TCNY Report can be found in 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 Staten Island are as follows:

| Consultation | Prioritization Results |
|---|---|
| **Mariners Harbor** | Air Quality |
| | Controlled High Blood Pressure |
| | Smoking |
| | Unmet Mental Health Need |
| | Violence |
| **St. George Library Center** | Air Quality |
| | Obesity |
| | Physical Activity |
| | Smoking |
| | Unmet Mental Health Need |
| **New Dorp** | Air Quality |
| | Drug Overdose Deaths |
| | Obesity |
| | Physical Activity |
| | Smoking |

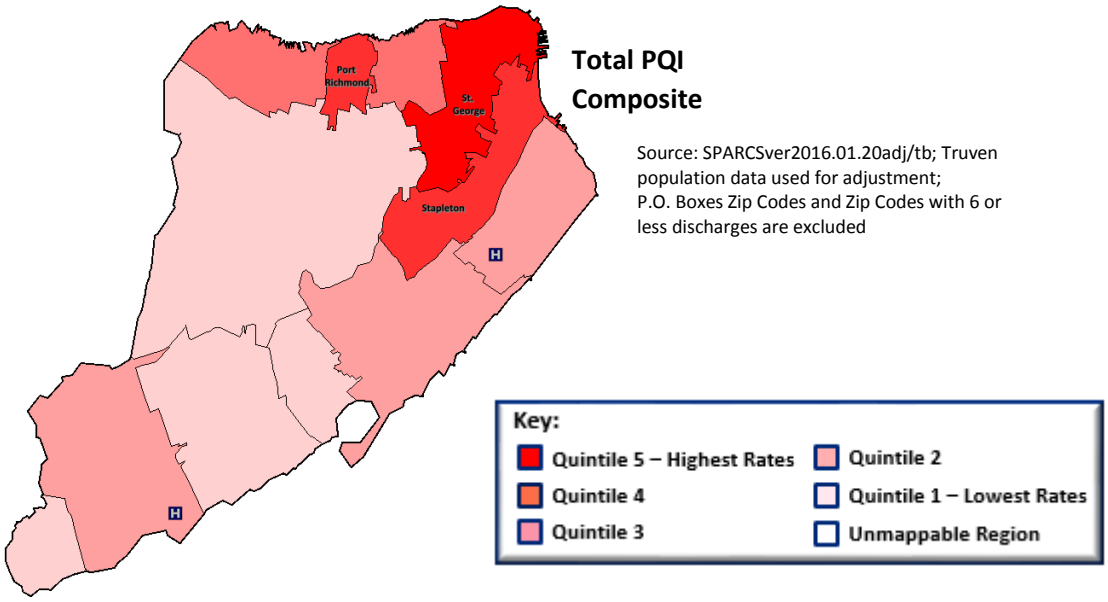
***Secondary Data Analysis***

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 we use these quintiles to assess the relative health of different zip codes. The quintiles are arranged 5 to 1 with the 5th quintile containing the highest rates of the targeted PQIs and their associated conditions, while quintile 1 contains the lowest rates.

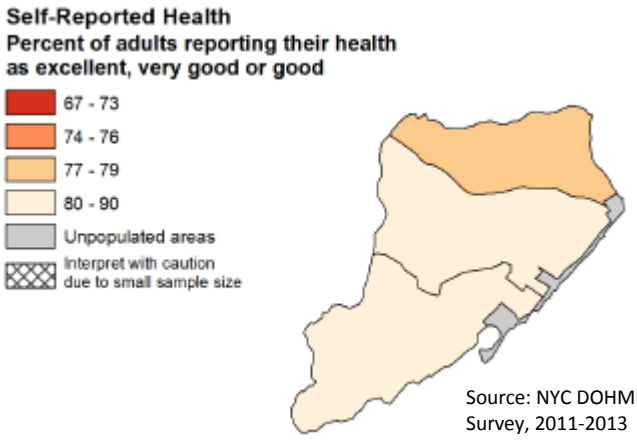
*Prevention Quality Indicator (PQI) Composite*

Of Staten Island's 12 zip codes, a few consistently emerged in PQI quintiles 4 or 5, indicating high rates of disease and poorer health outcomes in those areas. These areas include Port Richmond, St. George, and Stapleton.




*Chronic Disease*

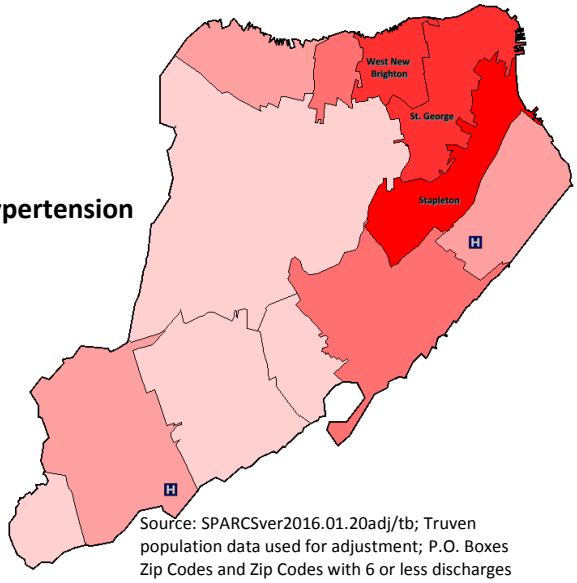
To assess chronic disease prevalence in Richmond County, the county prevalence is compared to New York State (NYS) and national prevalence and in relation to the 2013-2017 NYS Prevention Agenda Objectives (NYSPAO). In addition, communities within the county that have higher prevalence rates than the county average have been identified. Self- reported health status by Richmond residents indicate that most of the respondents perceived their health good to excellent; however, the percentage dropped in Northern Staten Island.




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

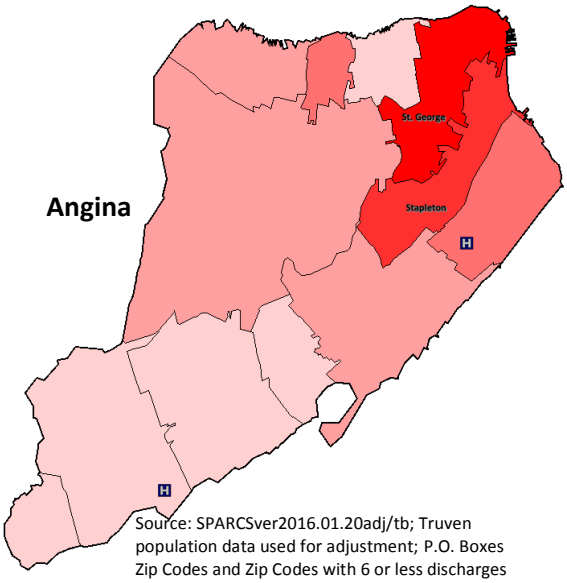
Coronary heart disease hospitalization rates in Staten Island were above both the NYS average and the NYSPAO, but congestive heart failure hospitalization rates were below than the NYS average and the NYSPAO. Cerebrovascular (Stroke) disease mortality was significantly better than the state average and the NYSPAO. Circulatory PQIs had the highest rates in Port Richmond, St. George, and Stapleton.

**Hypertension**



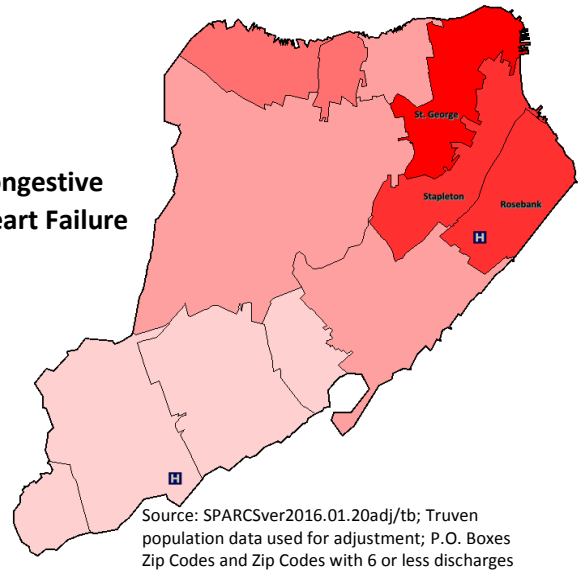

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Angina**



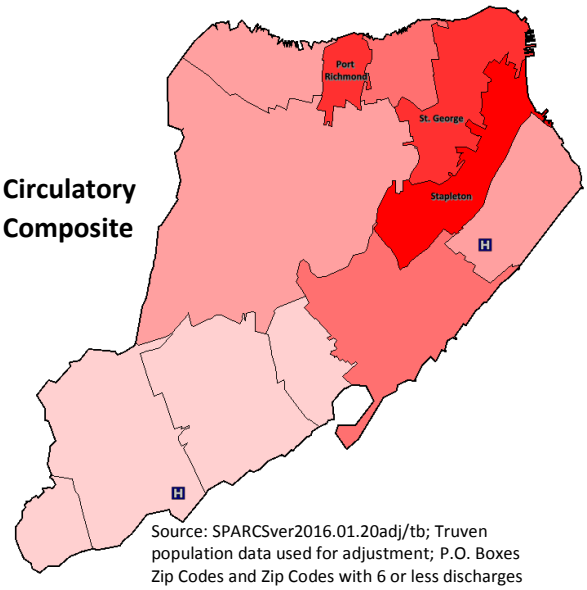

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Congestive Heart Failure**




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

**Circulatory Composite**



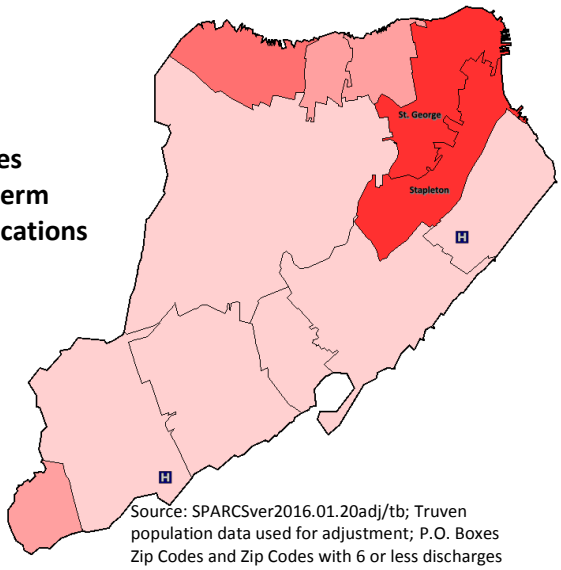

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Key:**

- Quintile 5 – Highest Rates
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 – Lowest Rates
- Unmappable Region

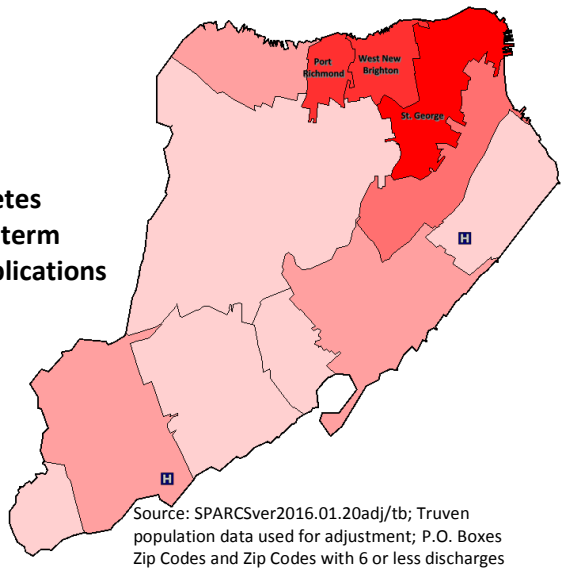
Diabetes prevalence rates in Staten Island were 8.5%, lower than the NYS average but still greater than the NYSPAO of 5.7%. The diabetes short term complication hospitalization rate was better than the NYS average but did not achieve the NYSPAO for both people ages 6-17 and ages 18+ years. Obesity rates for adults (BMI>30) were 26.6%, above both the NYS average of 24% and the NYSPAO of 15%. Diabetes PQIs had the highest rates in St. George and Stapleton.

**Diabetes Short-term Complications**



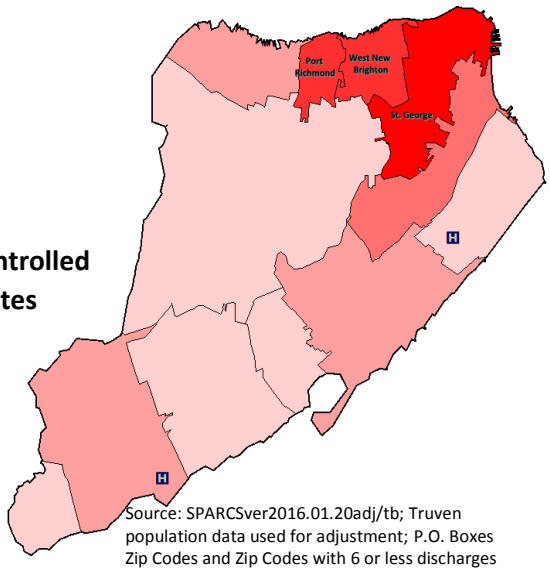

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Diabetes Long-term Complications**



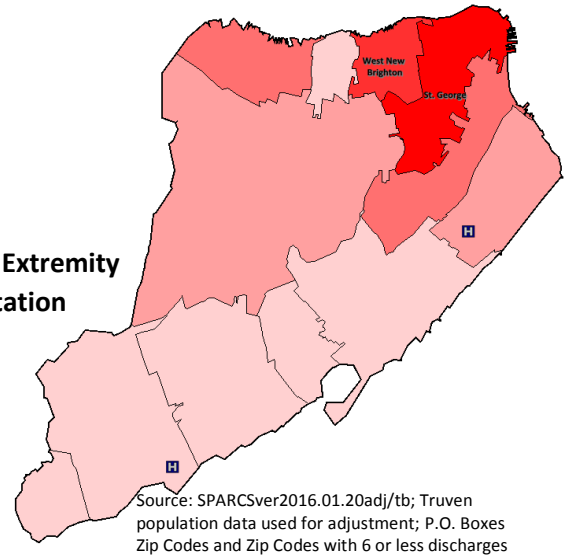

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Uncontrolled Diabetes**



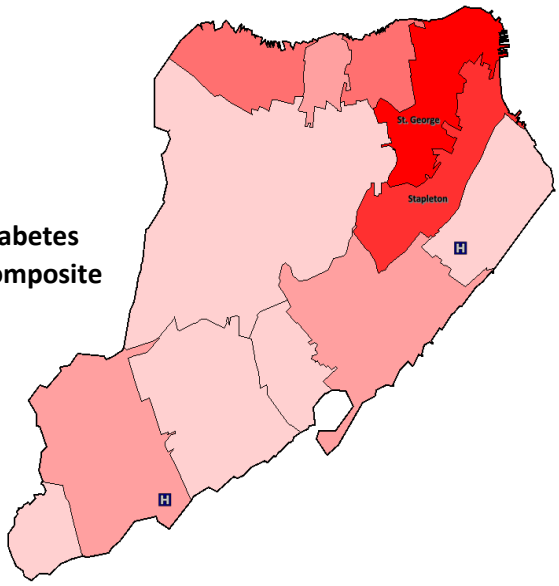

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Lower Extremity Amputation**




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

**Diabetes Composite**



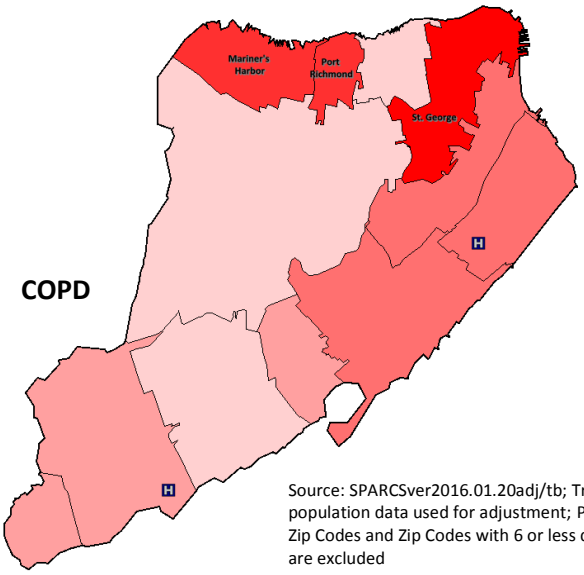

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Key:**

- Quintile 5 – Highest Rates
- Quintile 4
- Quintile 3
- Quintile 2
- Quintile 1 – Lowest Rates
- Unmappable Region

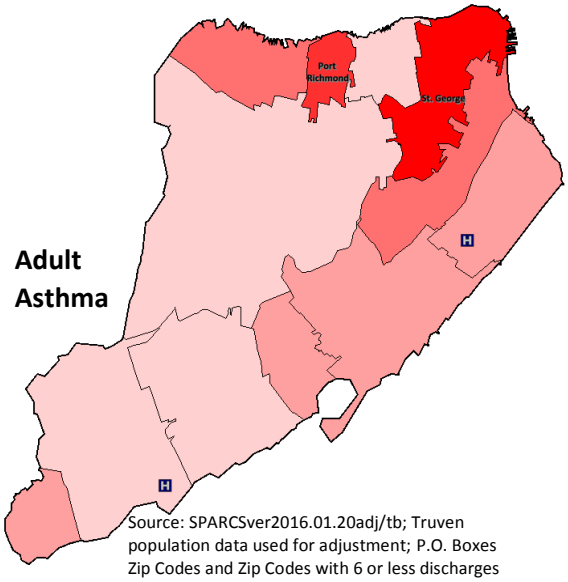
Chronic Obstructive Pulmonary Disease adult hospitalizations per 10,000 in Richmond County were 44.5, above the NYS average of 41.3, and the NYSPAO. Mariner's Harbor, Port Richmond, and St. George had the highest rates of COPD. Richmond County asthma-related hospitalization rates were on par with the NYS averages, but above the NYSPAO. Port Richmond and St. George had the highest asthma rates.

**COPD**



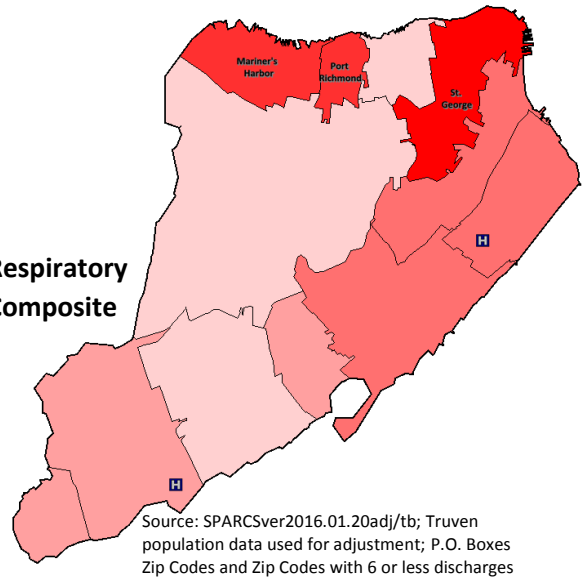

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

**Adult Asthma**

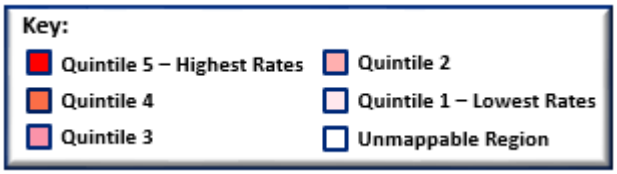



Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded

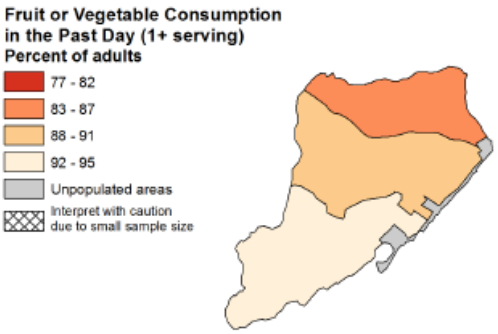
**Respiratory Composite**



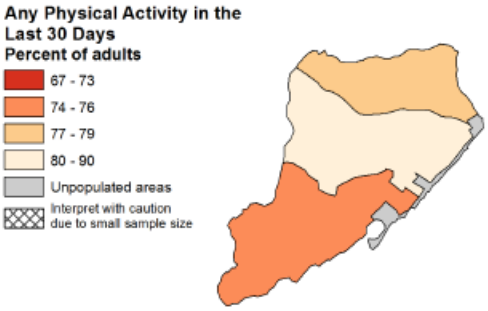

Source: SPARCSver2016.01.20adj/tb; Truven population data used for adjustment; P.O. Boxes Zip Codes and Zip Codes with 6 or less discharges are excluded




Lifestyle data including nutrition and physical activity are major factors in the prevention and management of chronic disease. Approximately 70.2% of Staten Island 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%. Only ten percent of Staten Island 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%).

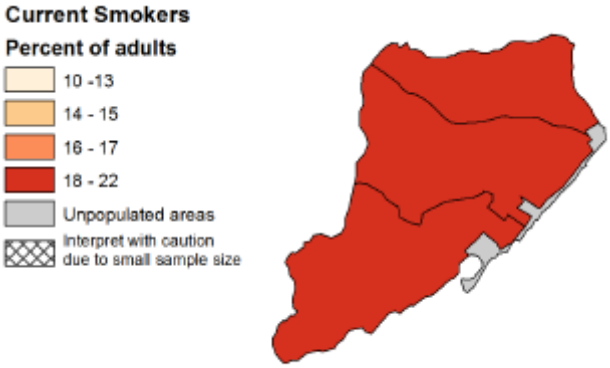



Source: NYC DOHMH, Community Health Survey, 2011-2013




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

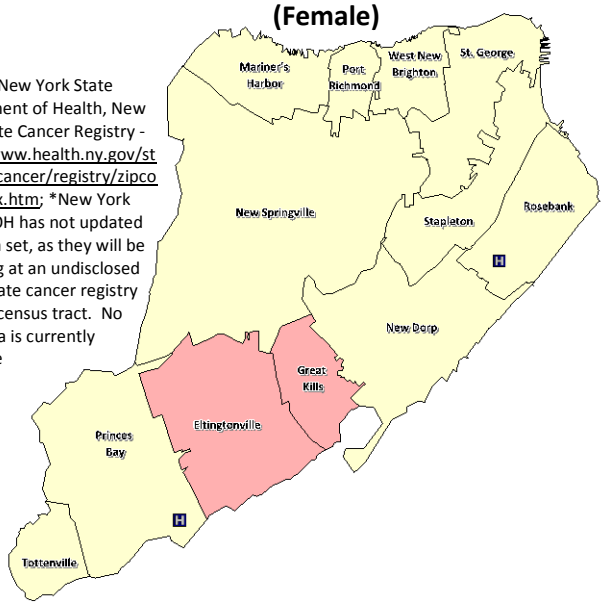
In addition, Staten Island has relatively high rates of smoking when compared to the rest of New York City. Of the residents surveyed in each district, greater than 18% of respondents were current smokers.




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

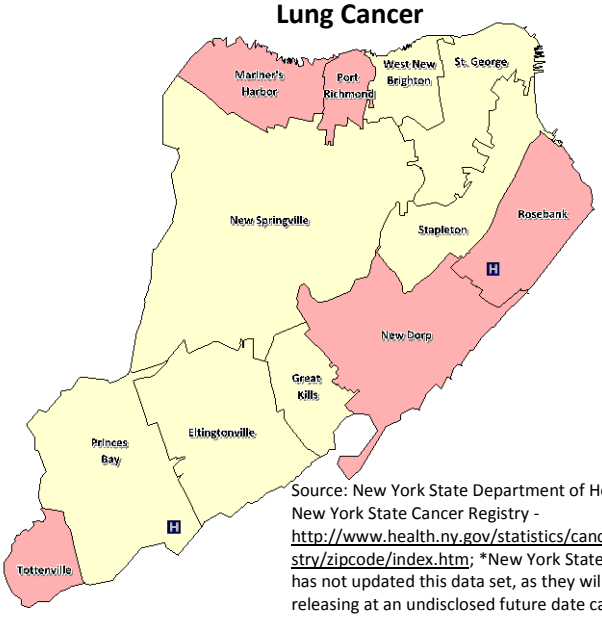
Breast cancer early stage diagnosis rates (65.4%) and cervical cancer early stage diagnosis rates (49.4%) were both greater than the US and NYS averages. Both rates, however, are still below the NYSPAO. The highest female breast cancer rates were located in the communities of Eltington and Great Kills. Prostate cancer rates were highest in Mariner's Harbor. Lung Cancer incidence for men and women per 100,000 respectively were 79.6 and 57.3. For both males and females, incidence is greater than the NYS and US averages, and the NYSPAO.

## Breast Cancer (Female)



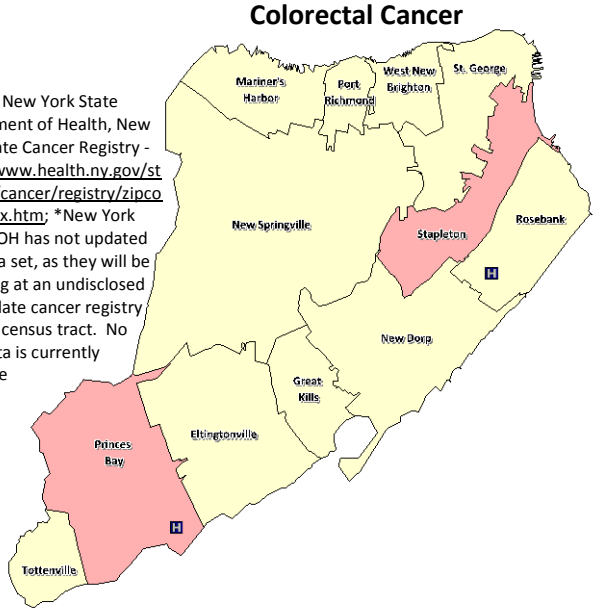

Source: New York State Department of Health, New York State Cancer Registry - http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm; *New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new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

## Lung Cancer



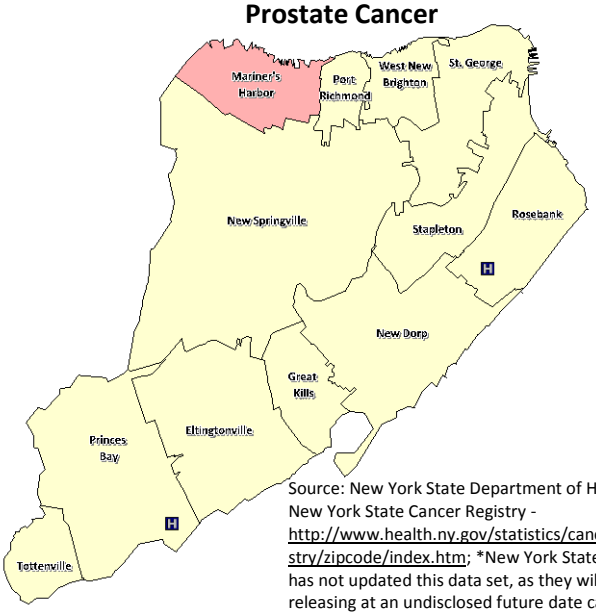

Source: New York State Department of Health, New York State Cancer Registry - http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm; *New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new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



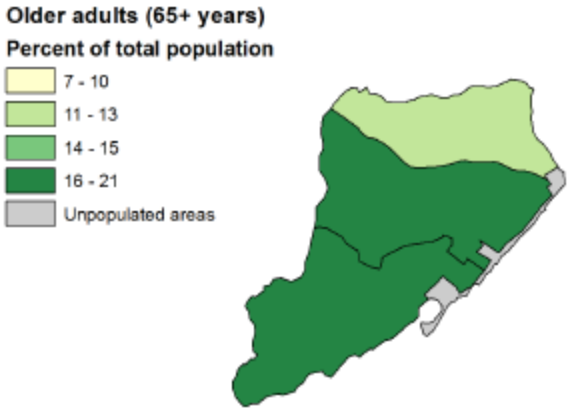

Source: New York State Department of Health, New York State Cancer Registry - http://www.health.ny.gov/statistics/cancer/registry/zipcode/index.htm; *New York State DOH has not updated this data set, as they will be releasing at an undisclosed future date cancer registry data by census tract. No new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

**Key:**

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

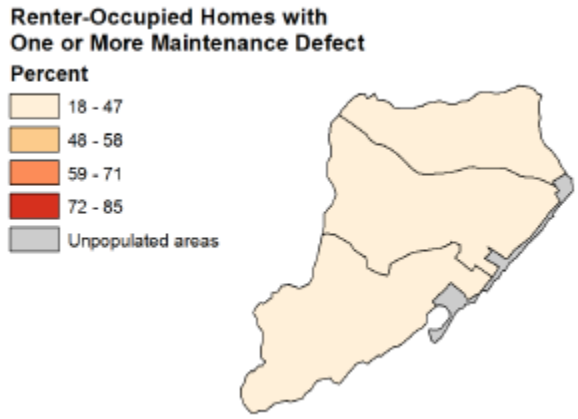
*Healthy Safe Environment*

To assess preventable injury prevalence in Richmond 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 Staten Island residents aged 65+ years (per 10,000) were 193.2, below than the NYS rate of 198 but above the NYSPAO target of 155. The highest rates were present in St. George, Stapleton, and Rosebank. The areas of Staten Island in which the greatest percentages of adults over 65 years of age are pictured in dark green below. The highest percentages of older adults in Staten Island live in South Beach and Willowbrook as well as Tottenville and Great Kills.




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

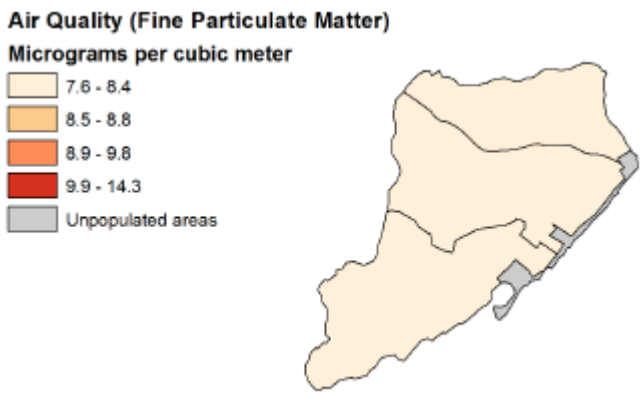
There are also several environmental factors that contribute to safety and safe living conditions. The NYC Department of Health mapped the percentage of renter-occupied homes that have one or more maintenance defects. Maintenance defects included water leaks, cracks and holes, inadequate heating, presence of mice or rats, toilet breakdowns or peeling paint. As shown in the map below, of the residents surveyed in Staten Island, 18-47% of homes report one or more maintenance defects.




Source: NYC Housing and Vacancy Survey, 2011

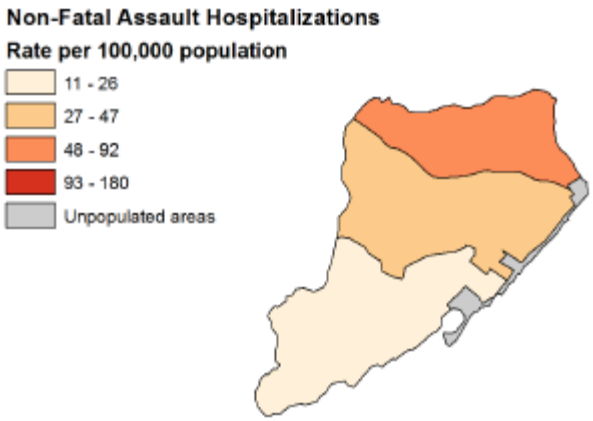
Air quality also plays a prominent role in health status, especially when it comes to respiratory outcomes like childhood or adult asthma. According to NYC DOH Community Health

Profiles, Staten Island falls in the lowest quartile with 7.6-8.4 micrograms of fine particulate matter per cubic meter in most neighborhoods.




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 St. George and Stapleton neighborhoods 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 Staten Island from 2011-2013, color-coded by whether or not the metric was significantly better than, significantly worse than, or comparable to the NYS average.

NYS Department of Health Injury Data for Staten Island

| Indicator | 3 Year Total | County Rate | NYS Rate | Sig.Dif. | County Ranking Group |
|---|---|---|---|---|---|
| Falls hospitalization rate per 10,000 | | | | | |
| Crude | 6,466 | 45.7 | 39.4 | Yes | 4th |
| Age-adjusted | 6,466 | 43 | 34.7 | Yes | 4th |
| Aged less than 10 years | 239 | 13.8 | 8.9 | Yes | 4th |
| Aged 10-14 years | 80 | 8.8 | 6.1 | Yes | 4th |
| Aged 15-24 years | 141 | 7.4 | 5.7 | Yes | 4th |
| Aged 25-64 years | 1,805 | 23.5 | 18.4 | Yes | 4th |
| Aged 65-74 years | 980 | 89.2 | 75.2 | Yes | 4th |
| Aged 75-84 years | 1,584 | 277 | 220.3 | Yes | 4th |
| Aged 85 years and older | 1,637 | 647.6 | 560.2 | Yes | 4th |
| Poisoning hospitalization rate per 10,000 | | | | | |
| Crude | 2,056 | 14.5 | 11.1 | Yes | 4th |
| Age-adjusted | 2,056 | 14.2 | 10.7 | Yes | 4th |
| Motor vehicle mortality rate per 100,000 | | | | | |
| Crude | 52 | 3.7 | 6.3 | Yes | 1st |
| Age-adjusted | 52 | 3.6 | 6 | Yes | 1st |
| Non-motor vehicle mortality rate per 100,000 | | | | | |
| Crude | 381 | 26.9 | 21.4 | Yes | 3rd |
| Age-adjusted | 381 | 26 | 19.5 | Yes | 4th |
| Traumatic brain injury hospitalization rate per 10,000 | | | | | |
| Crude | 2,399 | 17 | 10 | Yes | 4th |
| Age-adjusted | 2,399 | 16.7 | 9.4 | Yes | 4th |
| Alcohol related motor vehicle injuries and deaths per 100,000 | | | | | |
| Alcohol related motor vehicle injuries and deaths per 100,000 | 382 | 27 | 33.3 | 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/inj_28.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 Richmond 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 greater than the NYS average at 81.7% but below the NYSPAO (90%). However, the percentage of low birth weight births in Richmond County (8.4%) is on par with both the NYS and US averages but is above the NYSPAO (5%). Women receiving late or no prenatal care is just 2.8% for the county but the communities of Mariner's Harbor, St. George, and Stapleton 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 5% versus a NYS rate of 5.5%. The percent of obese children (ages 2-4 years) enrolled in WIC was 17.7% versus a NYS rate of 13%. Breastfeeding rates of mothers in the WIC program (36.6%) were similar to the state average (38%).

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

NYS Department of Health Birth-related Statistics for Staten Island

| Indicator | 3 Year Total | County Rate | NYS Rate | Sig.Dif. | County Ranking Group |
|---|---|---|---|---|---|
| **Percentage of births** | | | | | |
| % of births to women aged 25 years and older without a high school education | 1,346 | 10.2 | 14.1 | Yes | 3rd |
| % of births to out-of-wedlock mothers | 5,676 | 35.2 | 40.9 | Yes | 1st |
| **% of births that were multiple births** | **765** | **4.7** | **3.9** | **Yes** | **4th** |
| % of births with early (1st trimester) prenatal care | 13,559 | 84.2 | 73.1 | Yes | 1st |
| % of births with late (3rd trimester) or no prenatal care | 445 | 2.8 | 5.6 | Yes | 1st |
| % of births with adequate prenatal care (Kotelchuck) | 12,525 | 78 | 69.1 | Yes | 1st |
| **WIC indicators** | | | | | |
| % of pregnant women in WIC with early (1st trimester) prenatal care (2009-2011) | 5,442 | 85.8 | 86.5 | No | 3rd |
| % of pregnant women in WIC with gestational diabetes (2009-2011) | 315 | 5 | 5.5 | No | 2nd |
| % of pregnant women in WIC with hypertension during pregnancy (2009-2011) | 373 | 5.9 | 7.1 | Yes | 1st |
| % of WIC mothers breastfeeding at least 6 months (2010-2012) | 774 | 36.6 | 38.2 | No | 1st |
| **% of infants fed any breast milk in delivery hospital** | **10,848** | **75.6** | **83.1** | **Yes** | **3rd** |
| **% of infants fed exclusively breast milk in delivery hospital** | **4,777** | **33.3** | **40.7** | **Yes** | **4th** |
| **% of births delivered by cesarean section** | **6,057** | **37.6** | **34.1** | **Yes** | **4th** |
| **Mortality rate per 1,000 live births** | | | | | |
| Infant (less than 1 year) | 77 | 4.8 | 5 | No | 2nd |
| Neonatal (less than 28 days) | 50 | 3.1 | 3.4 | No | 2nd |
| Post-neonatal (1 month to 1 year) | 27 | 1.7 | 1.5 | No | 2nd |
| **Fetal death (20 weeks gestation or more)** | **150** | **9.2** | **6.6** | **Yes** | **4th** |
| **Perinatal (20 weeks gestation to less than 28 days of life)** | **200** | **12.3** | **10** | **Yes** | **4th** |
| Perinatal (28 weeks gestation to less than 7 days of life) | 101 | 6.2 | 5.4 | No | 3rd |
| Maternal mortality rate per 100,000 live births + | 2 | 12.4* | 20 | No | 3rd |
| **Low birthweight indicators** | | | | | |
| % very low birthweight (less than 1.5 kg) births | 206 | 1.3 | 1.4 | No | 2nd |
| % very low birthweight (less than 1.5kg) singleton births | 127 | 0.8 | 1.1 | Yes | 2nd |
| Newborn drug-related diagnosis rate per 10,000 newborn discharges | | | | | |
| Newborn drug-related diagnosis rate per 10,000 newborn discharges | 91 | 58.1 | 95 | Yes | 1st |

Key*:
Significantly Better than NYS Average
No Significant Difference from NYS Average
Significantly Worse than NYS Average

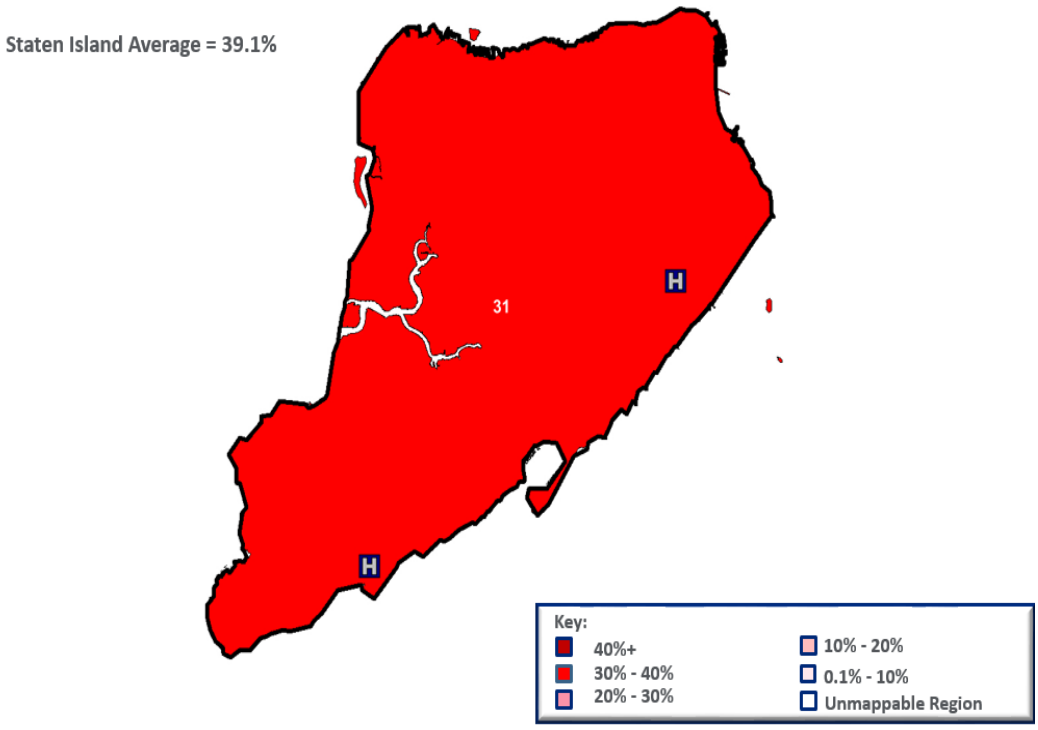
*Where significance was not available, better, the same or worse than the New York State Average;
Source: http://www.health.ny.gov/statistics/chac/chai/docs/inj_28.htm; The county ranking groups: 1 - most favorable to 4 - least favorable. These county ranking groups are categorized based on the quartile 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:

**Richmond County School Districts with 30% of Students Classified as Overweight or Obese: 31**

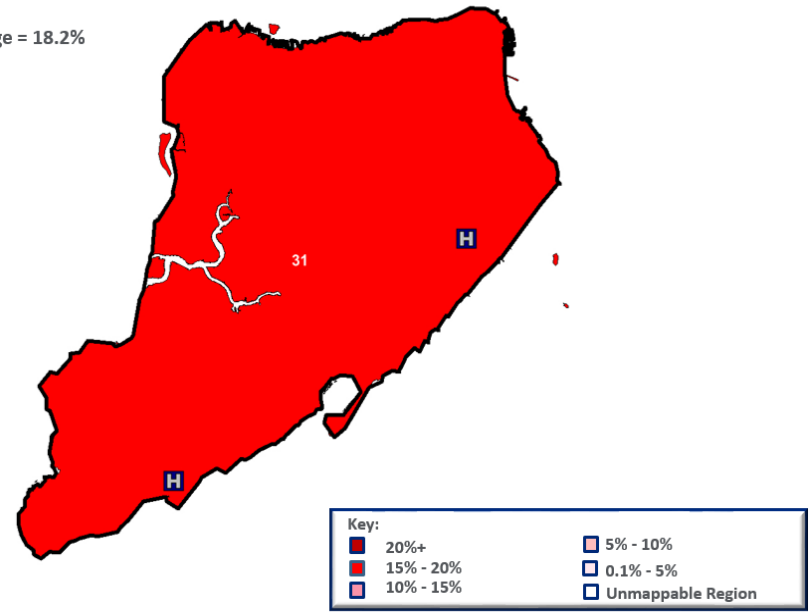
## School District Overweight/Obese Percentages (K – 8th Grade) (2012 - 2013)




Northwell Health™ 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 – 8th Grade)
## (2012 - 2013)

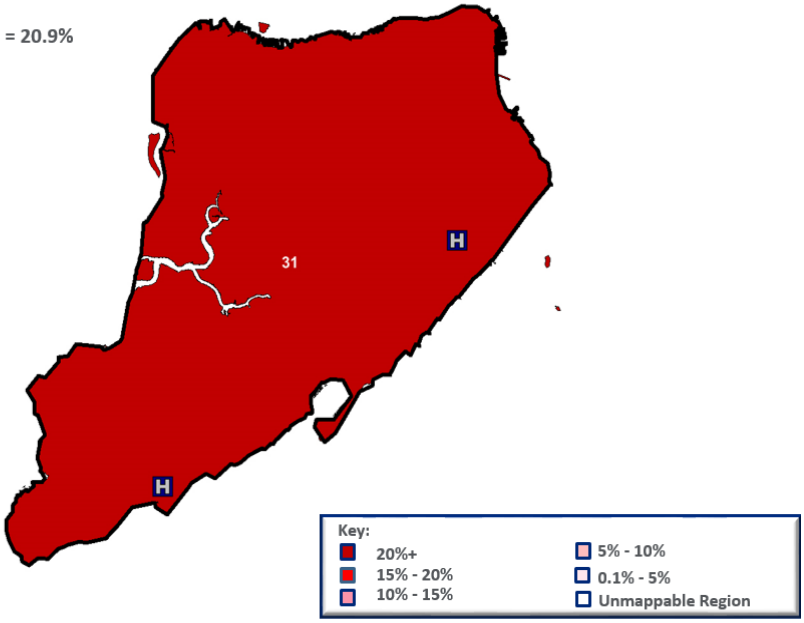
Staten Island Average = 18.2%




Northwell Health™ 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

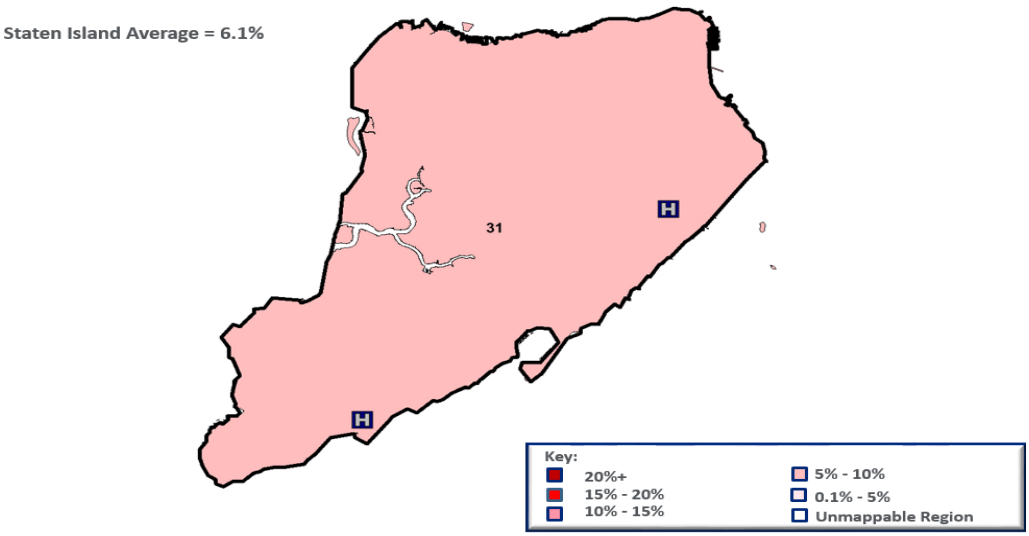
# School District Obese Percentages (K – 8th Grade)
## (2012 - 2013)

Staten Island Average = 20.9%




Northwell Health™ 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 – 8th Grade)
**(2012 - 2013)**

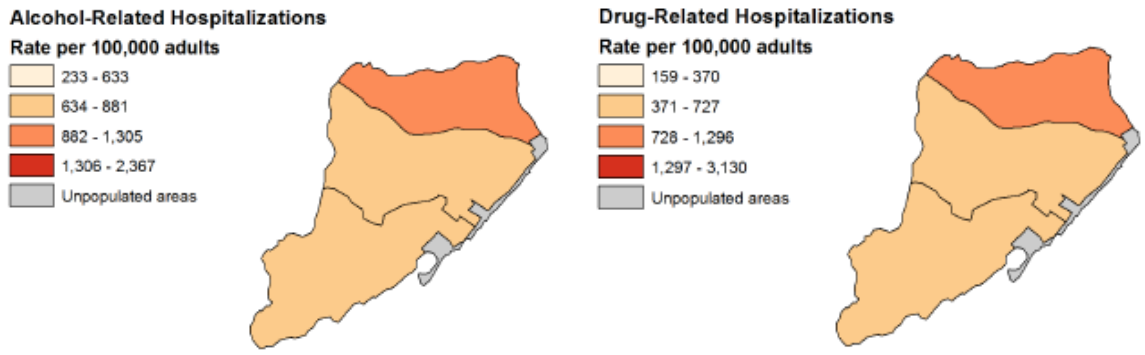



Northwell Health™ Source: NYC public school body mass index (BMI) data, collected through the NYC FITNESSGRAM body composition assessments for Administrative School Districts 1-32, Grades K-8; Excludes Charter, Special Ed and Continuing Ed Schools

*Mental Health and Substance Abuse*

To assess the prevalence of mental health disorders and substance abuse in Richmond 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 Richmond County was 4.9, lower than the NYS rate (7.5), it was on par with the NYSPAO of 4.8. The percent of Staten Island adults reporting 14 or more days with poor mental health in the last month was 6.3% compared to NYS (11%) and below the NYSPAO of 7.8%. PQI data for mental health emergency department visits showed increased rates in West New Brighton and Rosebank. Richmond County's rate of binge drinking is 14.4%, below NYS (19%) and just above the NYSPAO of 13.4%. Drug-related Richmond County hospitalizations (per 10,000) were 43.9, well above the NYS average and the NYSPAO (26%). PQI data for substance abuse emergency department visits showed increased rates in West New Brighton and St. George. New York opioid and heroin death rates were higher than any other state and rose by 2000% from heroin and 200% from opioids. Richmond County heroin and opioid death rates were 6.8 and 9.6 percent respectively.[15] Richmond had some of the highest death rates in the state.

[15] 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

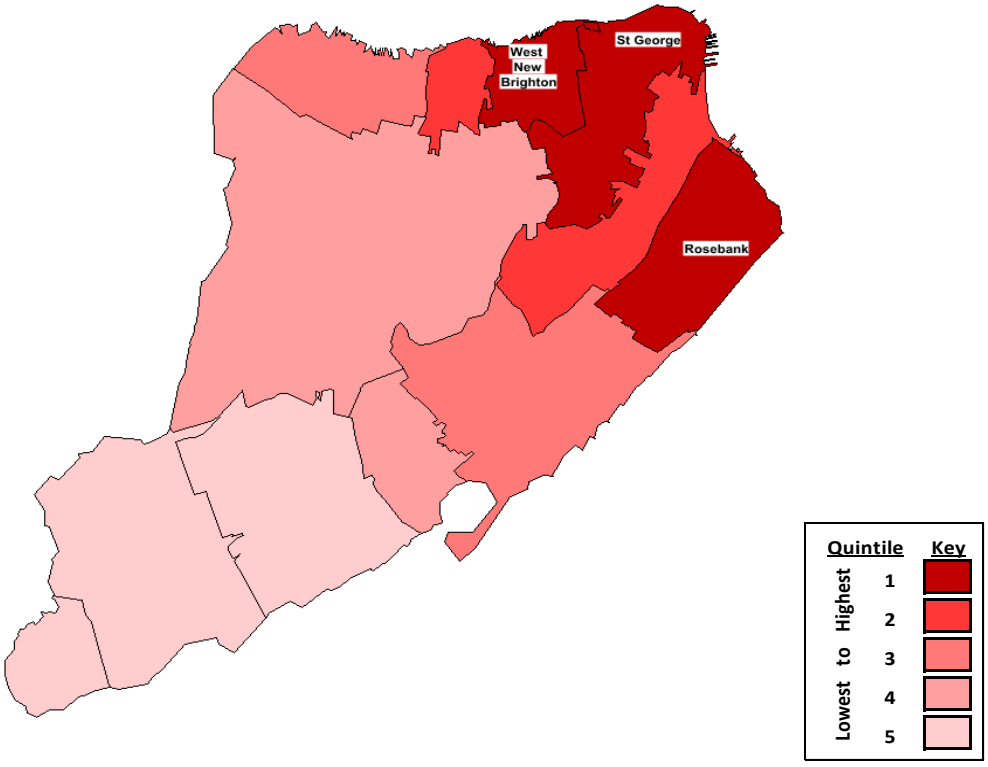



Source: New York State Department of Health, Statewide Planning and Research Cooperative System, 2011-2013

This data was also supported by the analysis of serious mental illness in Richmond. 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.

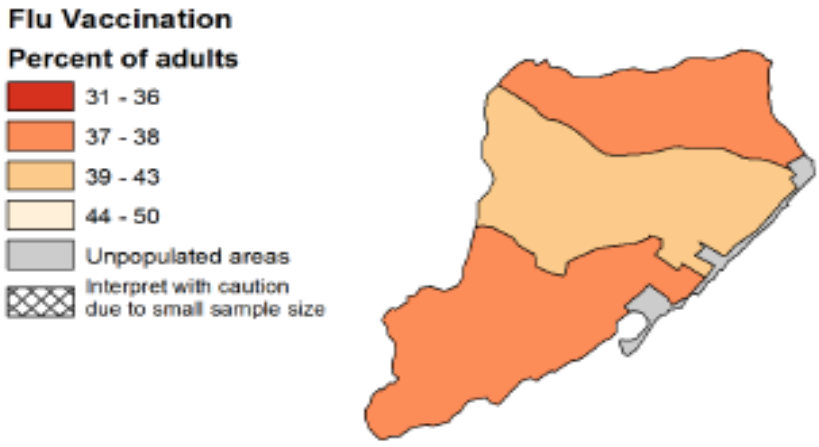
The county rate of Serious Mental Illness (SMI) in Richmond was 512.5 per 100,000 population. The highest rates of SMI were found in the St. George, Stapleton and Rosebank communities. Zip code 10301, St. George, had the highest rate in all of Staten Island, with a total of 907.8 per 100,000 population.

Richmond 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 Richmond 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 Flu immunization rates of Richmond was 67% below the NYS average (72%) and the NYSPAO (70%). Richmond County's newly diagnosed HIV case rate (per 100,000) was 12.1, well below the NYS rate (19) and NYSPAO (23). The Richmond County Gonorrhea case rate (per 100,000) was 43.3, well below the NYS average (94) but well above NYSPAO (19). The tuberculosis case rate (per 100,000) for Richmond County was 3.7, below the NYS average (4.9) but greater than the NYSPAO of 1. Richmond County case rates for chlamydia for both men and women were below the NYS rate but, in this population, the chlamydia case rate for females is almost 3x as high as the rate for males.




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

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

Richmond County HIV/AIDS and STD Rates

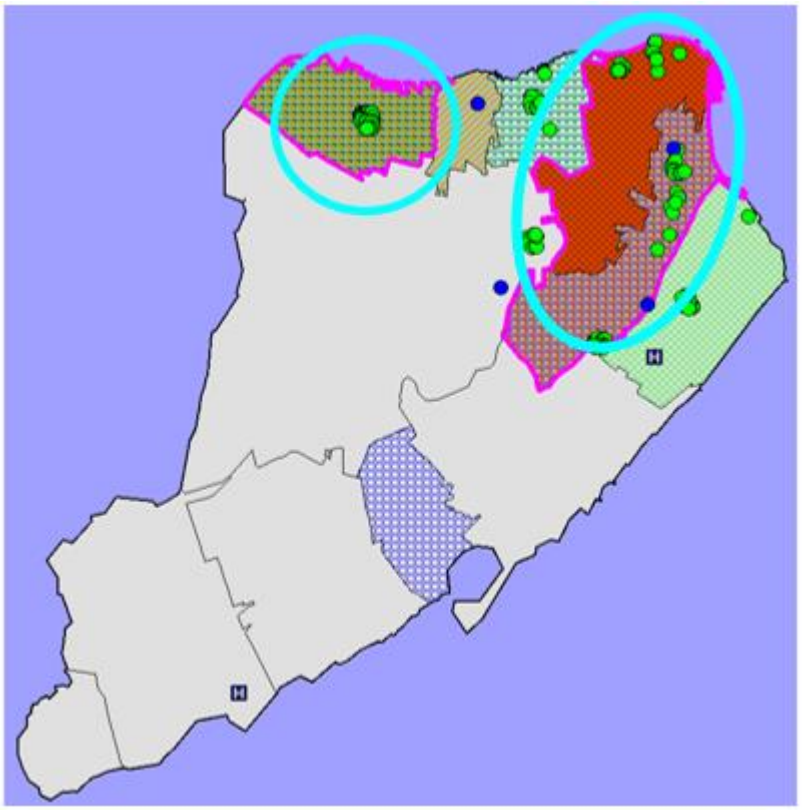
| Indicator | 3 Year Total | County Rate | NYS Rate | Sig.Dif. | County Ranking Group |
|---|---|---|---|---|---|
| **HIV case rate per 100,000** | | | | | |
| Crude | 129 | 9.1 | 19.1 | Yes | 4th |
| Age-adjusted | 129 | 9.5 | 19.1 | Yes | 4th |
| **AIDS case rate per 100,000** | | | | | |
| Crude | 108 | 7.6 | 12.2 | Yes | 4th |
| Age-adjusted | 108 | 7.6 | 12.2 | Yes | 4th |
| **AIDS mortality rate per 100,000** | | | | | |
| **Crude** | **77** | **5.4** | **4** | **Yes** | **4th** |
| **Age-adjusted** | **77** | **4.9** | **3.7** | **Yes** | **4th** |
| **Early syphilis case rate per 100,000** | | | | | |
| Early syphilis case rate per 100,000 | 63 | 4.5 | 14.4 | Yes | 4th |
| **Gonorrhea case rate per 100,000** | | | | | |
| All ages | 984 | 69.6 | 107.7 | Yes | 4th |
| Aged 15-19 years | 277 | 300.2 | 368.1 | Yes | 4th |
| **Chlamydia case rate per 100,000 males** | | | | | |
| All ages | 1,196 | 174.7 | 336 | Yes | 3rd |
| Aged 15-19 years | 247 | 520.5 | 1,029.10 | Yes | 3rd |
| Aged 20-24 years | 459 | 918.3 | 1,492.70 | Yes | 3rd |
| **Chlamydia case rate per 100,000 females** | | | | | |
| All ages | 3,379 | 463.4 | 672.3 | Yes | 3rd |
| Aged 15-19 years | 1,175 | 2,621.60 | 3,595.50 | Yes | 3rd |
| Aged 20-24 years | 1,231 | 2,529.50 | 3,432.20 | Yes | 2nd |
| % of sexually active young women aged 16-24 with at least one Chlamydia test in Medicaid program (2013) | 2,024 | 70.9 | 72.2 | No | 1st |
| **Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years)** | | | | | |
| Pelvic inflammatory disease (PID) hospitalization rate per 10,000 females (aged 15-44 years) | 74 | 2.6 | 3 | No | 3rd |

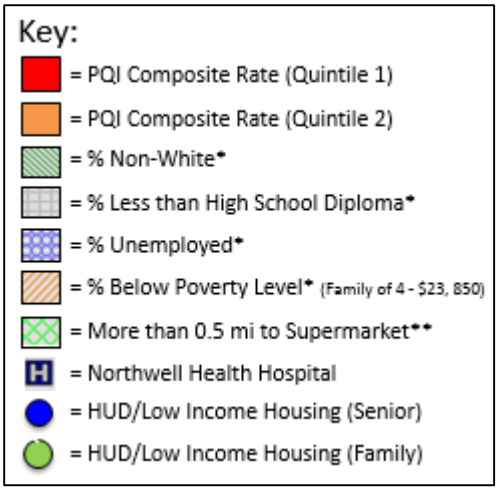
Key*:
- Significantly Better than NYS Average
- No Significant Difference from NYS Average
- Significantly Worse than NYS Average

*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/ini_28.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

***Richmond County Summary of Findings***

Finally, PQI and social determinant data were overlaid to identify areas of greatest need in Richmond County. Areas of Richmond County that fall into Quintiles 4 & 5 of the PQI Composite Rate were mapped. 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 Mariner's Harbor, St. George, and Stapleton (these areas are circled on the map below).






Sources: PQIs - SPARCSver11.01.2012adj/tb; Truven population used for adjustment; P.O. Boxes are excluded; Low Income Housing Developments – HUD New York State Housing Website http://portal.hud.gov/hudportal/HUD?src=/states/new_York; Website of individual Richmond County Local Housing Authorities; Social Determinant Indicators - 2014 United States Census American Community Survey - https://www.census.gov/programs-surveys/; Access to food - http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx

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 primary and secondary data analysis the following health priorities emerged as pressing community health issues:

- 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

# 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 Staten Island

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

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

August 31, 2016

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 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

# TCNY 2020 Community Priorities and related DOHMH services in Staten Island

## Contents

# 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 heard the voice of the community, the next step is to meaningfully include it in health planning. This package is provided to support CHNA and CSP efforts of hospitals who committed to including at least one of the "Top 5 TCNY Borough Community Priorities" into their Implementation Plans.

# 2 Staten Island 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 large scope programs to the community districts and populations with highest risk or prevalence of a condition, so you can move the needle 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 Staten Island CHPs:

- St. George and Stapleton (PDF)
- South Beach and Willowbrook (PDF)
- Tottenville and Great Kills (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 Staten Island Borough Priorities and Crosswalk with DSRIP projects*

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

| Indicator | Description | City-wide TCNY 2020 baseline and goal | Priority Population | City-wide TCNY 2020 Priority Population baseline and goal | Potential DSRIP Project Alignment |
|---|---|---|---|---|---|
| Obesity | % of adults who are obese | Baseline – 25%<br>Goal – 23%<br>(7% decrease) | Very high-poverty neighborhoods | Baseline – 31%<br>Goal – 25%<br>(20% decrease) | 3.b.i -Cardiovascular Health: Implementation of Million Hearts Campaign<br><br>3.c.ii. – Implementation of evidence-based strategies in community to address chronic disease |
| Air Quality | Difference in the level of outdoor air pollution between neighborhood with highest and lowest level | Baseline - 6.65 µg/m3<br>Goal – 6.1 µg/m3 | A OneNYC 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 |
| Smoking | % of adults who smoke | Baseline – 14%<br>Goal – 12%<br>(10% decrease) | High school graduates | Baseline - 18%<br>Goal – 14%<br>(20% decrease) | 4.b.i –Promote Tobacco use cessation, especially among low SES populations and those with poor mental health |
| Unmet Mental Health Need | % of adults with serious psychological distress who did not get needed mental health treatment | Baseline – 22%<br>Goal – 20%<br>(9% decrease) | Very high and high-poverty neighborhoods | Baseline – 30%<br>Goal – 22%<br>(26% decrease) | 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure across Systems |
| Drug Overdose Deaths | Rate of unintentional or accidental overdose deaths involving any drug | Baseline – 11.6 (per 100,000)<br>Goal – 11.0 (per 100,000) | Very high-poverty neighborhoods | Baseline – 15.9 (per 100,000)<br>Goal – 14.3 (per 100,000) | 3.a.iv-Development of Withdrawal Management capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs |

## *3.2 Staten Island 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 |
|---|---|
| **St. George and Stapleton (CD 1)** *(Including Grymes Hill, Mariner's Harbor, Port Richmond, Stapleton, St. George, West Brighton and Westerleigh)* | 1. Obesity |
| | 2. Smoking |
| | 3. Unmet Mental Health Need |
| | 4. Air Quality |
| | 5. Unmet Medical Need |
| | |
| **South Beach and Willowbrook (CD 2)** *(Including Bloomfield, Midland Beach, New Springville, South Beach, Todt Hill, Travis-Chelsea and Willowbrook)* | 1. Smoking |
| | 2. Air Quality |
| | 3. Obesity |
| | 4. Drug Overdose Deaths |
| | 5. Physical Activity |
| | |
| **Tottenville and Great Kills (CD 3)** *(Including Annadale, Eltingville, Great Kills, Huguenot, Oakwood, Rossville and Tottenville)* | 1. Drug Overdose Deaths |
| | 2. Air Quality |
| | 3. Obesity |
| | 4. Unmet Mental Health Need |
| | 5. Physical Activity |

### 3.2.1 TCNY 2020 Community-Based Planning Grantees

The NYC Department of Health and Mental Hygiene 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 and 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: 1) 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 Staten Island, the two organizations that received funding are:

- **Staten Island Partnership for Community Wellness** (serving the Stapleton neighborhood), which promotes wellness and improves the health of the Staten Island community through collaboration and a multidisciplinary approach.

- **Project Hospitality** (serving the Mariner's Harbor neighborhood), which advocates for those in need by establishing a comprehensive continuum of care that begins with the provision of food, clothing, and shelter and extends to other services that include health care, mental health, alcohol and substance abuse treatment, HIV care, education, vocational training, legal assistance, and transitional and permanent housing.

## *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 - 9% of them lived in Staten Island.

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 and borough 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 Staten Island 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 and she will connect you to the right program lead.

## *4.1 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

### 4.1.1 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 Staten Island-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.

### 4.1.2 Physical Activity Programs

- **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.

## *4.2 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.

## *4.3 Smoking*

- **NYC Quits -** Tools and resources on how to quit smoking and cope with withdrawal are available on nyc.gov, by searching NYC Quits, or by following this link to access a cessation guide. New Yorkers can also use the "Text NYC Quits" texting service, which provides smokers and recent quitters with real-time, around-the-clock advice, support, tips and encouragement. To sign up, text "NYCQUITS" to 877-877. Using these services can make smokers twice as likely to successfully quit smoking.
  - DOHMH also has a site locator where you can find a program to quit smoking near you.
- **Public Health Detailing Tobacco Quit Kit** – This kit contains many materials, including clinical tools, provider resources, and patient education materials developed by DOHMH to aid providers in helping patients quit smoking.
- **Smoke-free Housing** – DOHMH assembled a Smoke-Free Housing Kit for landlords and property managing agents that describes the benefits of adopting a smoke-free policy for a residential building and provides recommended steps for developing and implementing a smoke-free policy.

## *4.4 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 Performing Provider Systems (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**!

### *4.5 Drug Overdose Deaths*

- **Opioid Overdose Responder Training** – This training program can help registered Opioid Overdose Prevention Programs (OOPPS) and health care providers train potential responders in overdose prevention.
- **Naloxone and Overdose Prevention in Pharmacies** – DOHMH issued a non-patient specific prescription (also called a "standing order"), which authorizes licensed pharmacists practicing in NYC to dispense naloxone under the Dispensing Protocol. A pre-recorded training webinar for pharmacists is available for CE credit here.
- **Staten Island Adolescent Program** - DOHMH is supporting a new adolescent treatment program on Staten Island that will provider medication assisted therapy including buprenorphine as well as other evidence based therapy modalities. This program will also include an outreach component that will provide skill building, life coaching and mentoring to at risk youth.

## 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