NewYork-Presbyterian

NewYork-Presbyterian Hospital
Community Health Needs Assessment
2019-2021

February 6, 2020

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Executive Summary

NewYork-Presbyterian

NYP and NYPH

NewYork-Presbyterian Hospital (NYPH) is ranked #1 in New York and #5 in the nation in U.S. News & World Report's "Best Hospitals" survey. NYPH is the nation's only hospital affiliated with two world-class medical schools, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons. Its 47,000 employees and affiliated physicians are dedicated to providing the highest quality, most compassionate care to New Yorkers and patients from across the country and around the world. NYPH provides more than $1 billion in benefits every year to the community. NewYork-Presbyterian Hospital is comprised of seven campuses located mainly within New York City.

NYPH is part of **NewYork-Presbyterian (NYP)**, one of the nation's most comprehensive and integrated academic healthcare delivery systems. Founded nearly 250 years ago with the fundamental belief that every person deserves access to the very best care, NYP now includes NYPH with its seven campuses, the three Regional Hospitals consisting of NewYork-Presbyterian Queens, NewYork-Presbyterian Brooklyn Methodist Hospital, and NewYork-Presbyterian Hudson Valley Hospital, as well as more than 200 primary and specialty care clinics and medical groups, and an array of telemedicine services. NYPH and each of the Regional Hospitals conduct their own community health needs assessment and develop independent community service plans.

NewYork-Presbyterian Hospital CHNA Executive Summary

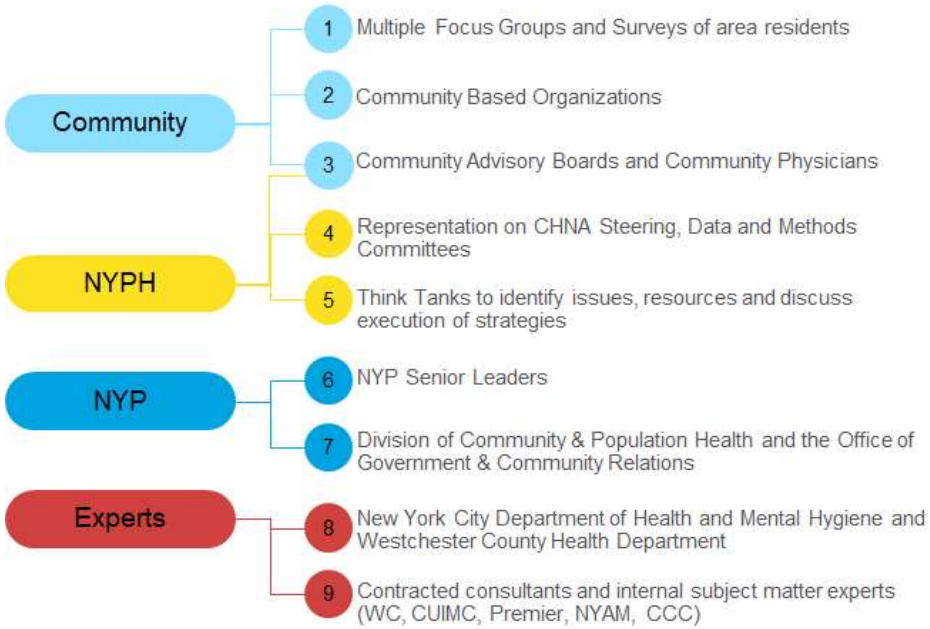
Purpose:

NewYork-Presbyterian (NYP) is deeply committed to the communities residing in the boroughs of New York City, Westchester County, and the surrounding areas. NYP delivers a range of innovative programs and services intended to educate and provide resources to prevent illness, maintain health, and improve the overall well-being of the community.

NewYork-Presbyterian Hospital (NYPH) has completed this Community Health Needs Assessment (CHNA) in order to update its understanding of the needs of local community members and the conditions that influence their well-being, and to assemble a three-year plan to enhance community health in areas identified as high disparity neighborhoods.

Governance and Engagement:

The Division of Community & Population Health and the Office of Government & Community Relations partnered to develop an enterprise-wide CHNA process to promote community awareness and hospital alignment in order to maximize the impact to those who need it most. A Steering Committee comprised of NYP leadership, which included representation from NYPH, and campus leadership was key to providing insight, guidance, and making decisions that impacted the completion of the CHNA.



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NewYork-Presbyterian Hospital CHNA Executive Summary

Process:

NYPH obtained broad community input regarding local health needs including the needs of medically underserved and low-income populations. Data collection included quantitative data for demographics, socioeconomic status, health, and social determinants as well as qualitative data from community questionnaires and focus groups which were analyzed to identify high disparity communities and a prioritization process ensuring integration with the Priority Areas of the 2019-2024 NYS Prevention Agenda. Premier, Inc. was engaged to partner with the NYPH team to complete the CHNA utilizing a transparent and collaborative manner.

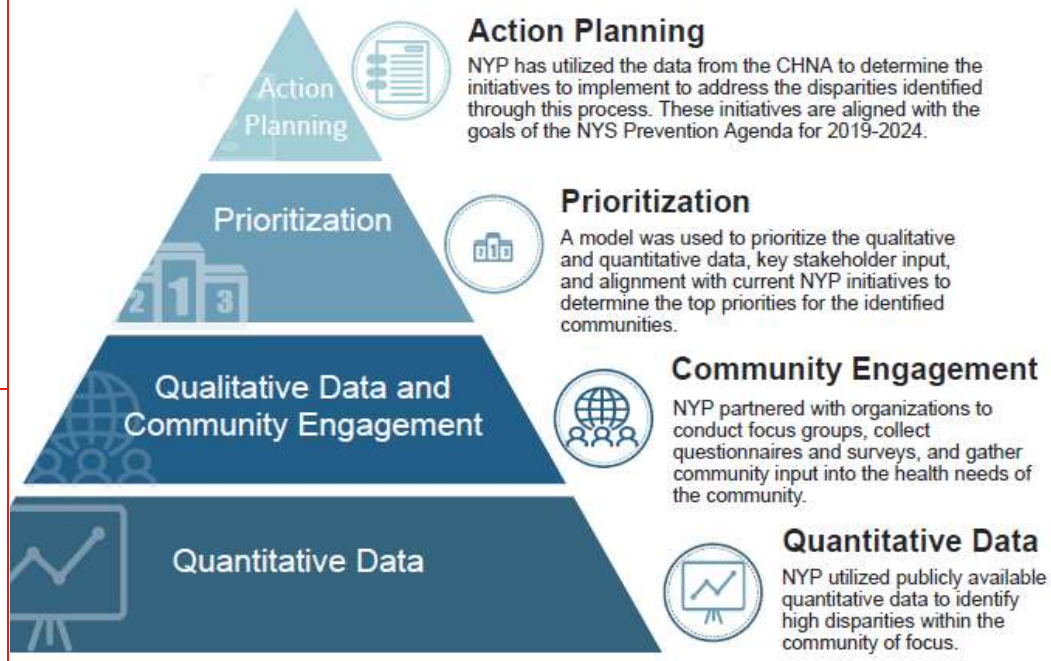
New York Prevention Agenda 2019-2024:

Vision: New York is the Healthiest State for People of all Ages

Priority Areas:

1. Prevent Chronic Diseases
2. Promote a Healthy and Safe Environment
3. Promote Healthy Women, Infants and Children
4. Promote Well-being and Prevent Mental and Substance Use Disorders
5. Prevent Communicable Diseases

2019 – 2021 Community Focus & Planning



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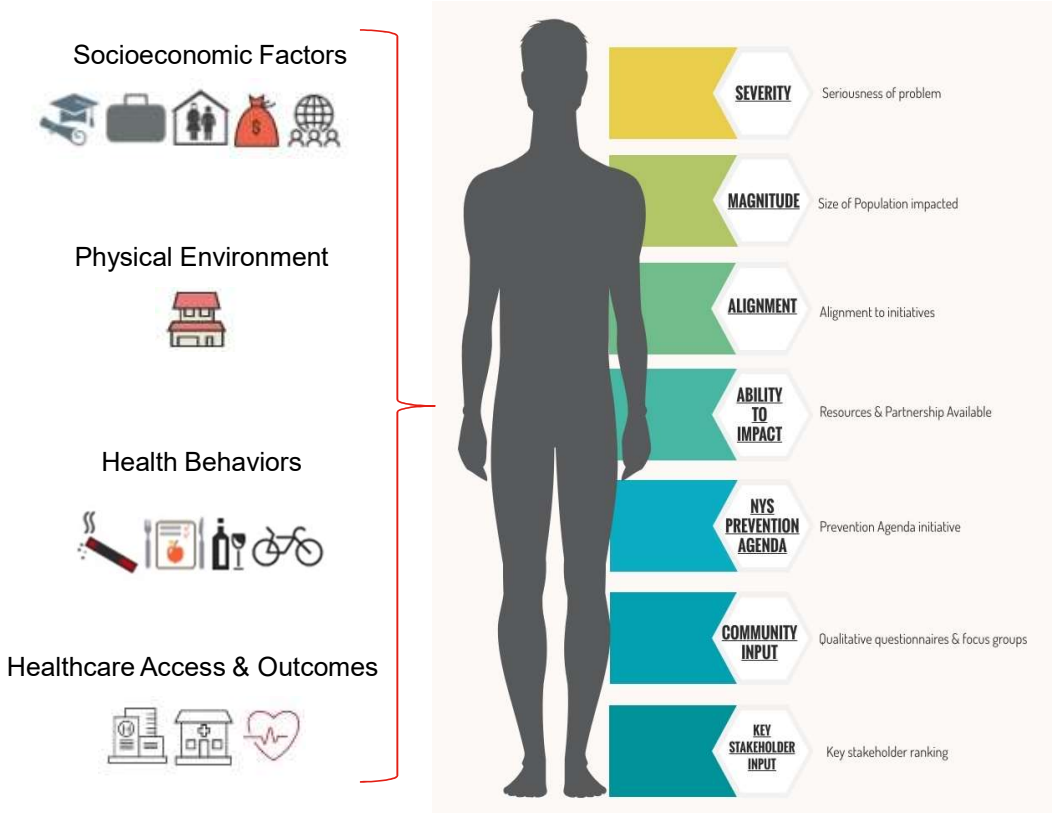
NewYork-Presbyterian Hospital CHNA Executive Summary

Prioritization Method:

Premier, Inc. customized a prioritization model that utilized an approach inclusive of the Hanlon Method technique to quantify and compare indicators and identify significant community needs. The top quartile high disparity neighborhood data sets inclusive of social determinants of health, health outcomes, access, and utilization were analyzed to ensure a dynamic model for NYP. The model also included qualitative data sets to allow the voice of the community to play into the top priorities.

Representatives from NYPH hospitals, NYP, Community Advisory Boards, and clinical and operational leadership participated throughout the process. Community Health Think Tanks provided opportunities for participants to review summaries of quantitative and qualitative data in order to rank the top health issues. This process allowed the team to receive input as well as ensure complete understanding of the process and intent of the CHNA.



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NewYork-Presbyterian Hospital CHNA Executive Summary

Prioritized Indicators:

The prioritization method allowed the NYPH team to narrow a vast amount of quantitative and qualitative data sets and define the highest disparity community and health indicators impacting that community. The top ten (10) indicators include:

1. Binge Drinking
2. Cancer Incidence - Lung
3. Hospitalizations: Drug
4. Cancer Incidence - Prostate
5. Diabetes
6. HIV
7. Physical Activity
8. % of adults taking high blood pressure medication
9. Psychiatry
10. Cancer Incidence - All Sites

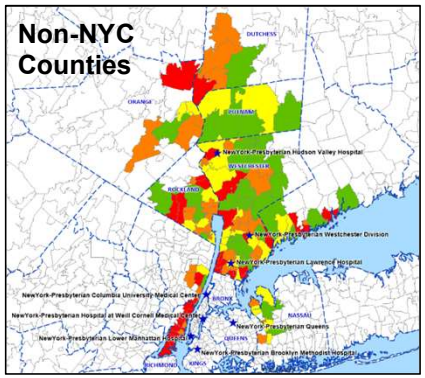
High Disparity Communities:

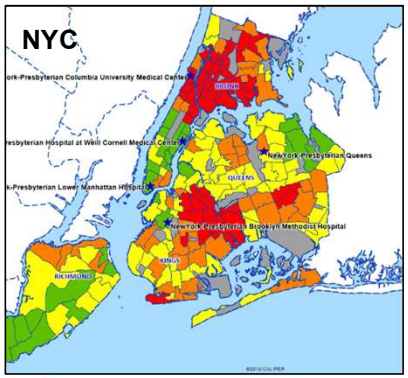
An analysis of community health need and risk of high resource utilization was undertaken. High NYC disparity communities were identified by calculating a need score consisting of a composite of 29 indicators, carefully selected, across five domains: demographics, income, insurance, access to care and New York State Department of Health Prevention Agenda Priorities. For geographies outside NYC, a ZIP code level Community Need Index was utilized.

Details of disparity and neighborhood are included in the complete CHNA.

This analysis will be used within the prioritization model to strategically place initiatives to maximize community impact.

Overall the higher disparity quartiles are illustrated below in red and orange.





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NewYork-Presbyterian Hospital Defined Community at a Glance

POPULATION
11,707,588

HOUSEHOLDS
4,415,637

ETHNICITY
28.7%
Index: 146
Hispanic/Latino

HOME LANGUAGE*
53.6%
Index: 77
Only English

MEDIAN AGE OF HOUSEHOLDER
51
Index: 96

PRESENCE OF CHILDREN*
31.8%
Index: 101

HOUSING TENURE
Own 37.2%
Index: 71
Rent 62.8%
Index: 132

AGE OF HOUSING**
79+ years old
% Comp:**34.7** Index: 113

EDUCATIONAL ATTAINMENT: TOP 2*
23.7%
Index: 90
High School Graduate

22.4%
Index: 112
Bachelor's Degree

EDUCATION: HISPANIC/LATINO
4.7%
Index: 149
Bachelor's degree or higher

HOUSEHOLD INCOME
Median Household Income
$68,944
Index:101

Average Household Income
$109,086
Index:107

POVERTY STATUS
85.8%
Index: 97
At or above poverty

UNEMPLOYMENT RATE
6.8%
Index: 109
Percent of civilian labor force unemployed

METHOD OF TRAVEL TO WORK: TOP 2*
47.9%
Index: 169
Travel to work by **Public Transport**

31.0%
Index: 59
Travel to work by **Driving Alone**

The index is a measure of how similar or different the defined area is from the benchmark.
Benchmark is New York State.

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NewYork-Presbyterian Hospital – A Diverse Geography

The NYPH community is diverse in its geography with the NYC NTAs having a younger, more minority, but economically challenged population. The SDoH concerns are concentrated upon language, safety, food insecurity, high cost of housing and public transportation. Behavioral risk factors such as smoking, drinking and consuming fruits and vegetables vary among the NTAs but are problematic for those in high-disparity neighborhoods.

New York City NTAs

4.8M PEOPLE The high disparity NYC community covers a geography of approximately 4.8M people	**YOUNGER ON AVERAGE** Is slightly younger on average, 11.2% of the population is 65+, compared to NYC, 12.5%	**26.8% DID NOT COMPLETE HIGH SCHOOL** There are more than NYC average of foreign born, non-English speaking, not graduated from high school and unemployed
15.9% UNINSURED Higher percentages of the population without health insurance, 15.9%, than the NYC average, 13.5%	**26.4% LIVING IN POVERTY** A higher percentage of the population is living in poverty, all ages 26.4%, than the NYC average, 20.6%	**85.5% MINORITY POPULATION** Has a much higher minority population at 85.5% (especially Black and Hispanic/Latino) than does the NYC average 67%

At the same time NYPH must also serve a county population that is older, less minority, less economically challenged and more likely to speak only English, but that still has similar SDoH concerns such as food insecurity and cost of living. There is still variance among counties for behavioral risk factors and health status that range from favorable to unfavorable. Complicating access to health care in the five counties can be the fewer number of physical health care locations than are currently available in NYC.

North-NYC Counties

3.4M PEOPLE The five counties cover a geography of approximately 3.4M people	**OLDER ON AVERAGE** Is slightly older, 17.1% of the population is 65+, compared to NYC, 12.5% and NYS 16.3%	**10.7% DID NOT COMPLETE HIGH SCHOOL** There are more than NYS average of persons that speak only English at home and that graduated from high school, but less unemployed
89.5% INSURED Higher percentages of the population have health insurance 89.5%, than the NYS average 87.6%	**6.2% FAMILIES BELOW FEDERAL POVERTY LEVEL** There are less families living in poverty, 6.2%, than the NYS average 11.3%	**41.4% MINORITY POPULATION** Has a lower minority population at 41.4% than does the NYC average 67%, or the NYS average 45.6%

NewYork-Presbyterian Hospital
High Disparity Community Highlights

2019 Health Issue Ranking and Data Highlights for New York City Community

NYSPA / NYPH Issue	Quantitative Highlights	Qualitative Highlights
New York City		
Chronic Disease / Obesity	Higher percent of adult population with obesity, 28.5%, NYC 24.0%; Higher percent of child population with obesity, 22.3%, NYC, 20.0%	Obesity 6th most commonly reported community health issue 35.1%
Healthy Women, Infants, Children	Maternal morbidity crude rate per 10,000 deliveries, 282.3 is worse than NYC 229.6; other selected indicators are also worse	
Well-being and Behavioral Health	Higher alcohol hospitalizations per 100,000 population ages 15-84, 1,169, NYC 995; Higher psychiatric hospitalizations per 100,000 population ages 18+, 859, NYC 774	Alcohol and drug addiction is the 1st most commonly reported community health issue 44.5%; Mental health 4th 38.3%
Prevent Communicable Diseases		
Non-NYC Counties		
Healthy Women, Infants, Children	Lower maternal morbidity per 100,000 live births, 12.6, NYS 18.7; Other selected indicators are also better or average	
Well-being and Behavioral Health	About the same percent of population self-reporting poor mental health, 10.4%, NYS 10.7%	
Chronic Disease / Obesity	Higher percent of adult population with obesity in Duchess, 27.0% and Orange, 29.7%, NYS 25.5%; Higher percent of child population with obesity in Orange, 19.0%, NYS N/A	

Focused Priorities:

The data collection and prioritization allowed NYPH to identify the highest disparity of need within the communities of highest need and to align initiatives and partnerships to focus efforts and maximize the return to the communities they serve. **Mental Health & Substance Abuse, Obesity and Women's Health** were chosen as the top three priorities in order to develop a community service plan. The focus will not preclude NYPH from initiatives not related to the focused priorities but allows NYP to invest in new opportunities of impact.

NewYork-Presbyterian Hospital
Prioritized Communities

Based on the data process of analytics and prioritization, NYPH will target efforts in **Washington Heights and Lower East Side** neighborhoods to allow our teams to invest and concentrate efforts and directly impact a high need community within the three-years of the service plan.

NYPH Data Highlights for Community of Focus

Adult Obesity, Percent of Population Washington Heights North 26.0% ↑ Washington Heights South 26.0% ↑ Lower East Side 10.0% ↓ High Disparity NTAs 28.5% NYC 24.0%	**Percent of preterm births among all live births** Washington Heights North 9.4% ↑ Washington Heights South 8.3% ↓ Lower East Side 9.7% ↑ High Disparity NTAs 10.0% NYC 9.1%	**New diagnoses of HIV per 100,000 population** Washington Heights North 31.4↑ Washington Heights South 31.1↑ Lower East Side 15.2 ↓ High Disparity NTAs 31.2 NYC 24.0	**Self-reported "poor mental health"** Washington Heights North 9.8 ↕ Washington Heights South 9.8 ↕ Lower East Side 9.8 ↓ High Disparity NTAs 10.9 NYC 10.3
Child Obesity, Percent of Population Child Obesity Washington Heights North 24.0% ↑ Washington Heights South 24.0% ↑ Lower East Side 16.0% ↓ High Disparity NTAs 22.3% NYC 20.0%	**Rate of infant deaths (under one year old) per 1,000 live births** Washington Heights North 4.3 ↕ Washington Heights South 4.3 ↕ Lower East Side 3.0 ↓ High Disparity NTAs 5.0 NYC 4.8	**New HCV diagnoses per 100,000 population** Washington Heights North 58.8 ↓ Washington Heights South 60.3 ↓ Lower East Side 64.3 ↓ High Disparity NTAs 65.7 NYC 71.8	**Psychiatry** Washington Heights North 551 ↓ Washington Heights South 873 ↑ Lower East Side 1,051 ↑ High Disparity NTAs 859 NYC 774

↕ indicates about the same as the NYC average

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NewYork-Presbyterian Hospital
Prioritized Communities, continued

NYPH will also target efforts in **Mount Vernon** to allow our teams to invest and concentrate efforts and directly impact a high need community within the three-years of the service plan.

Highlights in Westchester County

Adult Obesity, Percent of Population Westchester County, 17.7% ↓ NYS, 25.5%	**Percent of preterm births among all live births** Westchester County, 1.8% ↑ NYS, 1.7%	**New diagnoses of HIV per 100,000 population** Westchester County, 12.0% ↓ NYS, 17.9%	**Self-reported binge drinking, percent of adults** Westchester County, 20.7% ↑ NYS, 18.3%
Child Obesity, Percent of Population Westchester County, 13.7% NYS, 17.3%	**Rate of infant deaths (under one year old) per 1,000 live births** Westchester County, 4.6% ↕ NYS, 4.8%	**New HCV diagnoses per 100,000 population** Not available	**Self-reported "poor mental health"** Westchester County, 9.1 ↓ NYS, 10.7%

↕ indicates about the same as the NYS average

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Introduction

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Acknowledgements: Westchester County Health Planning Coalition

The Westchester County Health Planning Coalition (WCHPC), inclusive of the Westchester County Department of Health (WCDOH) and the sixteen local Westchester County Hospitals formed in response to the New York State Department of Health's appeal that each county's local health department, hospitals/hospital systems, and other community partners collectively work together to identify and address local health priorities associated with the New York State Prevention Agenda (NYSPA).

We thank this group who collaborated on several elements included within this Community Health Needs Assessment, with the ultimate goal of together advancing the health and wellness of Westchester County residents.

Acknowledgements: Community Members / Organizations

This Community Health Needs Assessment represents the culmination of work completed by multiple individuals and groups during the past year. We would like to thank our NYP leaders, staff, and physicians as well as the community members who provided their input via focus groups and questionnaires. We would especially like to thank the organizations that hosted focus groups for the community members, including:

- Asian Americans for Equality
- Battery Park Seniors
- Brooklyn Pride Center
- Bronxville Senior Citizens, Inc.
- Caribbean Women's Health Association
- Carter Burden Network
- Caring for the Homeless and Hungry of Peekskill
- CAMBA
- Church of the Epiphany
- Columbia University Irving Medical Center
- Community League of the Heights
- Dominican Women's Development Center
- Downtown Health Association
- Eastchester Community Action Partnership
- Elmcor
- Field Library
- Hamilton-Madison House
- Harlem Pride
- Henry Street Settlement
- HOPE Community Services
- Hudson Valley Gateway Chamber of Commerce
- HRH Care Community Health
- Make the Road New York
- Marble Hill Resident Council
- Northern Manhattan Coalition for Immigrant Rights
- NYP Community Leadership Council
- NYP Lower Manhattan Community Advisory Board (CAB)
- Uptown Community Physicians
- NYP Weill Cornell Community Advisory Board (CAB)
- NYP Westchester Behavioral Health Center Community Advisory Board (CAB)
- People's Theatre Project
- Public Health Solutions
- Shorefront Y
- Stanley M. Isaacs Neighborhood Center
- Town of Yorktown New York
- The Korean Community Services of Metropolitan New York Inc.
- The Yorktown Chamber of Commerce
- Upper Manhattan Interfaith Leaders Coalition
- Weill-Cornell Medicine
- Yonkers Police Athletic League

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Acknowledgements: Consultants

We recognize the collaboration of several consultants that contributed to this CHNA in partnership with NYP:

- **Premier, Inc.,** a nationally recognized healthcare consulting organization that specializes in advisory services and identifying community needs for underserved populations;
- **New York Academy of Medicine**, a New York City-based organization that addresses health challenges through innovative approaches to research, evaluation, education, policy leadership, and community engagement; and
- **Citizens' Committee for Children of New York**, a nonprofit and nonpartisan child advocacy organization that educates and mobilizes New Yorkers to make the City a better place for children.

Why a Community Health Needs Assessment?

NewYork-Presbyterian Hospital (NYPH) is ranked #1 in New York and #5 in the nation in U.S. News & World Report's "Best Hospitals" survey. NYPH is the nation's only hospital affiliated with two world-class medical schools, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons. Its 47,000 employees and affiliated physicians are dedicated to providing the highest quality, most compassionate care to New Yorkers and patients from across the country and around the world. NYPH provides more than $1 billion in benefits every year to the community. NewYork-Presbyterian Hospital is comprised of seven campuses located mainly within New York City.

In particular, NYPH is deeply committed to the communities residing in the boroughs of New York City, Westchester County, and the surrounding areas, delivering a range of innovative programs and services intended to educate and provide resources to prevent illness, maintain health, and improve the overall well-being of the community.

NYPH has completed this Community Health Needs Assessment in order to update its understanding of the needs of local community members and the conditions that influence their well-being, and to assemble a plan to enhance community health.

NewYork-Presbyterian Hospital

Weill Cornell Medical Center

Lawrence Hospital

Columbia University Irving Medical Center

Westchester Division

The Allen Hospital

Lower Manhattan Hospital

Morgan Stanley Children's Hospital

NewYork-Presbyterian Hospital (NYPH) is a world-class academic medical center committed to excellence in patient care, research, education and community service. With some approximately 2,600 beds and more than 6,500 affiliated physicians and 20,000 employees, it sees more than 2 million visits annually including more than 310,000 emergency department visits.

NYPH is ranked #1 in New York and #5 in the nation in U.S. News & World Report's "Best Hospitals" survey and repeatedly named to the Honor Roll of "America's Best Hospitals." NYPH is comprised of the following seven campuses in New York City:

- NewYork-Presbyterian/Weill Cornell Medical Center (WCMC)
- NewYork-Presbyterian Morgan Stanley Children's Hospital
- NewYork-Presbyterian Lawrence Hospital
- NewYork-Presbyterian/Columbia University Medical Center (CUMC)
- NewYork-Presbyterian/ Westchester Behavioral Health Center
- NewYork-Presbyterian/The Allen Hospital
- NewYork-Presbyterian/Lower Manhattan Hospital (LMH)

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CHNA Vision Statement

Our Community Health Needs Assessment will be a collaboration between NYP and the communities it serves.

It will identify significant health needs across our regions and align our hospital community benefits to improve community health over time.

Our approach will be systematic in an effort to capture current and unmet need while putting in place a process for ongoing evaluation.

Definition of Health

The definition of health historically referenced only physical health, but the definition for this CHNA is rooted in the knowledge that it is increasingly important to understand the broader components of health and well-being and how it can be impacted as well as improved.

"Health is a holistic combination of physical health (absence of sickness or pain), mental health, and wellness for which there is an individual and a community wide responsibility".

The quotes below reflect views voiced by CHNA focus group participants.

Health is physical and psychological well-being.

To me, health means not being sick and feeling good and having the feeling of enjoying things. That's what health is..

For me, health has changed, quite honestly. You used to think about health, your body, your physical health, but certainly, mental health has become part of it. But, I think for a lot of us, health has become more quality of life, financial health, just different things, housing, a broader perspective.

Your well-being, mentally, physically, spiritually...making sure that you eat correctly and just monitoring your health...making sure that you are okay.

When I hear health, I think about food, I think about work/life balance, and I think about sleep.

Health means to me, being able to be independent. That I can do things on my own, but if I do have a problem, that I have a doctor or a hospital I can go to, you know, to help me.

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CHNA Governance and Collaboration

- NewYork-Presbyterian Hospital engaged in a seven-month, comprehensive, and collaborative development of this Community Health Needs Assessment (CHNA).
- Several existing NYP committees were leveraged and several newly formed to provide both governance and guidance to the process.
- NYP's CHNA Core Committee managed this process, with significant input from hospital leaders, NYP's diverse team of subject matter experts, and contracted consultants.
- In addition, NYP obtained broader community input through facilitation of focus groups and administration of surveys to area residents – detailed later in this study.

NewYork-Presbyterian

CHNA Process

Following the NewYork-Presbyterian approach, NYP Hospital conducted its 2019 CHNA by:

1. Obtaining broad community input regarding local health needs including the needs of medically underserved and low-income populations
2. Collecting and evaluating quantitative data for multiple indicators of demographics, socioeconomic status, health, and social determinants
3. Preparing an analysis resulting in the identification of the high disparity neighborhoods in the NYPH community
4. Completing an analysis and health needs prioritization
5. Ensuring integration with the Priority Areas of the 2019-2024 New York State Prevention Agenda
6. Describing the process and methodologies utilized throughout
7. Making the CHNA results publicly available online

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Defining the NYP Hospital Community

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Defining New York Geographies

This CHNA utilizes information based upon multiple geographical definitions as were publicly available. The below is a description of these various geographies provided by the Citizen's Committee for Children (CCC).

Citizens' Committee for Children OF NEW YORK

Geography	Population Range	Description
Community District (CD)	Between 50,000 to 250,000 residents	There are 59 community districts (CD) in New York City (NYC). Each is assigned to a community board, which were created by local law in 1975 as appointed advisory groups for questions related to land use and zoning, the city budget process, and service delivery. There are 12 CDs in Manhattan, 12 in the Bronx, 18 in Brooklyn, 14 in Queens, and 3 in Staten Island.
Census Tract	Between 3,000 to 4,000 residents	There are 2,168 census tracts in New York City. They are small statistical subdivisions of counties used by the United States Census Bureau (USCB) for analyzing population demographics. Each decade, the USCB updates the boundaries of census tracts and attempts to keep changes to a minimum. The population range reported here is specific to NYC and may be larger for census tracts outside the city.
Neighborhood Tabulation Area (NTA)	Minimum 15,000 residents	There are 190 NTAs in New York City. The NYC Department of City Planning created these boundaries to estimate populations in small areas, which are similar to historical New York City neighborhoods, but not fully reflective due to several constraints. NTAs are aggregations of census tracts from the decennial census and they are subsets of New York City's 55 Public Use Microdata Areas (PUMAs) and congruent with PUMA boundaries. Typically, two or three NTAs fit within one PUMA. NTAs offer greater statistical reliability compared to census tracts, and therefore are a compromise between census tracts and the larger CDs and PUMAs, which provide less granularity but more reliable estimates for census survey data.
ZIP Codes	Not applicable	There are 263 ZIP Codes in NYC. Around 60 are associated with individual buildings and part of a larger ZIP Code in Manhattan. Individual ZIP Codes may cross state, place, county, census tract, and other census boundaries. The USCB created generalized areal representations of ZIP Code service areas called ZIP Code Tabulation Areas (ZCTAs) and provides census estimates for these areas. ZCTAs were introduced with the 2000 Census and in most cases ZCTA Codes and ZIP Codes for an area are the same.

Summary for the Defined NYPH Community

Community Profile Overview

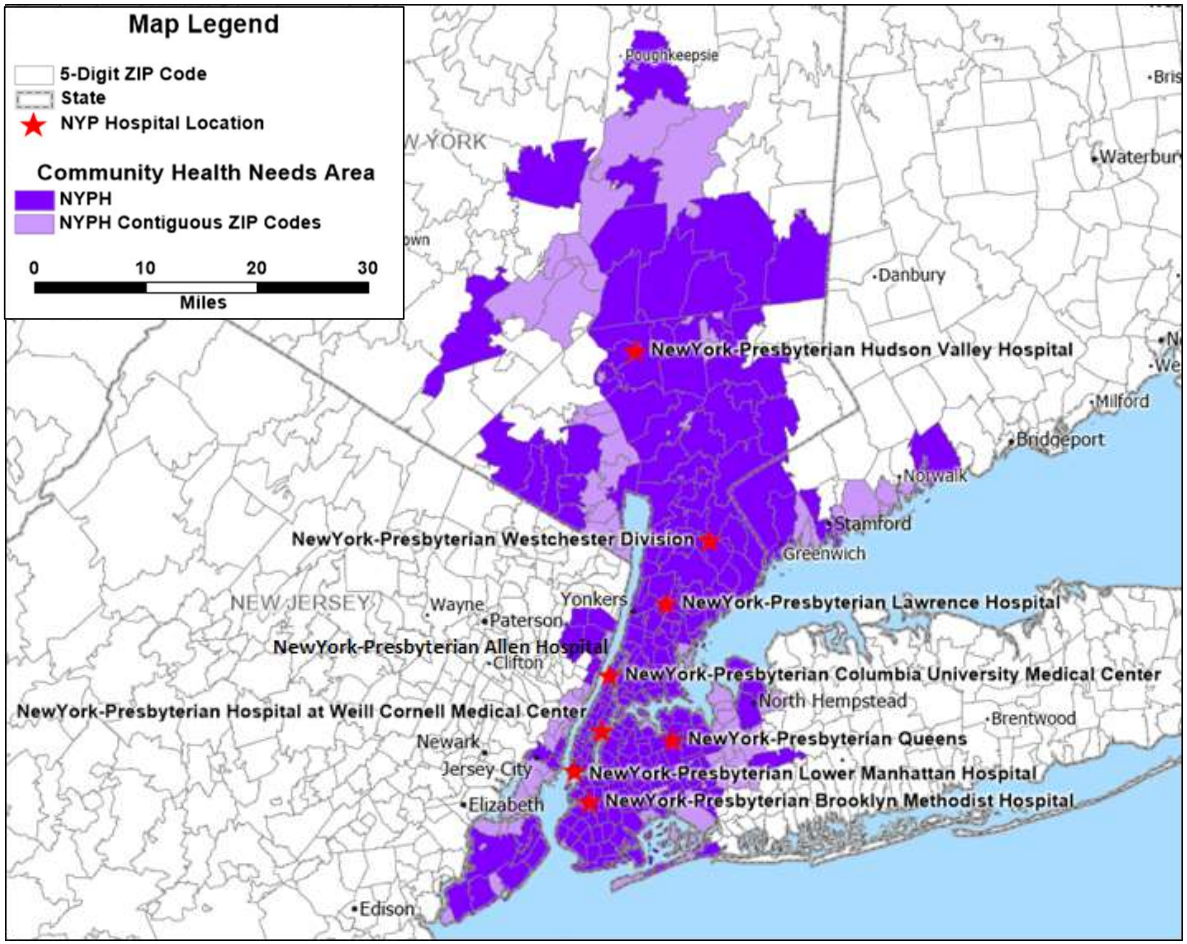
- The community definition for NewYork-Presbyterian Hospital was derived using 80% of ZIP codes from which NYP Hospital's patients originate and adding ZIP codes not among the original patient origin to create continuity in geographical boundaries, **resulting in a total of 380 community ZIP codes mostly within NYC, but also communities in upstate NY.**
- The NewYork-Presbyterian Hospital community covers a geography of **almost 11.7M people and is forecast to grow, 2.6%, between 2019-2024, faster than the state, 1.5%**.
- The community's age cohort profile is similar to that of New York State but **is slightly younger** with only 14.7% of the population aged 65+ compared to 16.3%.
- However, this could be changing as the **growth projected in ages 65+ is higher in the community**, 15.4%, than the state, 14.4%, between 2019-2024.
- In 2019, **the community has a higher non-White population**, 63.8%, than the state 45.6%; **driven by Hispanics, 28.7%, and African Americans, 18.6%.**
- **Future growth is projected among Hispanics, Asian/Hawaiian /Pacific Islanders and Other** populations while the **White population is projected to decline**.
- In 2019, the income distribution for NewYork-Presbyterian Hospital community is similar to the New York State comparison. However, **the community's average household income, $109,086, is higher than the average of New York State**, $101,507.

Summary for the Defined NYPH Community, continued

Community Profile Overview, continued

- The community is **less likely to speak 'only English' at home** than the average for New York State.
- **More of the population lives in family households**,61.3%, than non-family households, 38.7% and **the household size is similar in comparison to New York State** (25.1% are household size 4 or greater compared to 24.0% in New York State).
- **There are 1% more children in the community than the average** for the benchmark of New York State.
- In 2019, this **community had a 10% lower high school and 12% higher Bachelor's degree attainment** than the average for the benchmark of New York State.
- The **unemployment rate is 9% higher than the average for the benchmark of New York State**, with a 1% higher number of white collar workers compared to the benchmark of New York State.
- With an index value of 169**, the population that uses public transport to travel to work is 69% higher than the average for the benchmark of New York State.**

NYPH Community Definition



- The community definition was derived using 80% of ZIP codes from which NYPH's patients originated (Nov. 17- Mar. 2019).
- Hospital based patient data was provided and included inpatient admissions and outpatient visits and ancillary procedures.
- In order to create a contiguous community definition, ZIP codes not among the original patient origin were included to create continuity in geographical boundaries, resulting in a total of 380 ZIP codes.

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NYPH CHNA Defined Communities

Original ZIP Code

- 10516
- 12524
- 12603
- 10512
- 12550
- 10471
- 10705
- 10470
- 10548
- 10511
- 08701
- 10541
- 10589
- 06831
- 06830
- 06902
- 10506
- 10509
- 06880
- 10044
- 11101
- 11106
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NewYork-Presbyterian

Total Population Growth by Age Cohort

NewYork-Presbyterian
NYP Hospital Service Area vs. the State of New York State - Population by Age Cohort
Calendar Years 2019 to 2024

Age Cohort	Census 2010 Number	Census 2010 Percent of Total	Estimated 2019 Number	Estimated 2019 Percent of Total	Projected 2024 Number	Projected 2024 Percent of Total	Percent Change 2010 - 2024	Percent Change 2019 - 2024
NYP Hospital Service Area								
0 - 14	2,042,038	18.5%	2,148,340	18.3%	2,197,804	18.3%	7.6%	2.3%
15 - 44	4,880,721	44.2%	4,925,935	42.1%	4,849,329	40.4%	-0.6%	-1.6%
45 - 64	2,741,026	24.8%	2,913,603	24.9%	2,976,790	24.8%	8.6%	2.2%
65 +	1,378,940	12.5%	1,719,710	14.7%	1,984,935	16.5%	43.9%	15.4%
Total	**11,042,725**	**100.0%**	**11,707,588**	**100.0%**	**12,008,858**	**100.0%**	8.7%	2.6%
Women 15 - 44	2,483,330	22.5%	2,491,211	21.3%	2,437,590	20.3%	-1.8%	-2.2%
Median Age		35.9		37.3		38.7	7.8%	3.8%
New York State								
0 - 14	3,531,233	18.2%	3,458,401	17.4%	3,450,628	17.1%	-2.3%	-0.2%
15 - 44	8,046,567	41.5%	7,971,497	40.1%	7,907,927	39.2%	-1.7%	-0.8%
45 - 64	5,182,359	26.7%	5,223,469	26.2%	5,121,167	25.4%	-1.2%	-2.0%
65 +	2,617,943	13.5%	3,250,309	16.3%	3,716,838	18.4%	42.0%	14.4%
Total	**19,378,102**	**100.0%**	**19,903,676**	**100.0%**	**20,196,560**	**100.0%**	4.2%	1.5%
Women 15 - 44	4,047,947	20.9%	3,985,000	20.0%	3,930,376	19.5%	-2.9%	-1.4%
Median Age		37.8		39.0		40.1	6.1%	2.7%

NYPH_Demographic_SAbyZIP_Revised.xlsx]Pop_Table

Source: Nielsen, Inc.

- The NewYork-Presbyterian Hospital community covers a geography of almost 11.7M people and is forecast to grow faster, 2.6%, than the state, 1.5%, between 2019-2024.
- The age cohort profile is similar to that of New York State but is slightly younger, with only 14.7% of the population aged 65+ compared to 16.3%.
- However, this could be changing as the growth projected between 2019-2024, in ages 65+, is higher in the NYPH community, 15.4%, than the state, 14.4%.

NewYork-Presbyterian

Population by Race & Ethnicity

NewYork-Presbyterian
NYP Hospital Service Area vs. the State of New York State - Ethnic Profile
Calendar Years 2019 to 2024

Ethnicity	Census 2010 Number	Census 2010 Percent of Total	Estimated 2019 Number	Estimated 2019 Percent of Total	Projected 2024 Number	Projected 2024 Percent of Total	Percent Change 2010 - 2024	Percent Change 2019 - 2024
NYP Hospital Service Area								
Hispanics	3,005,474	27.2%	3,356,347	28.7%	3,539,390	29.5%	17.8%	5.5%
Non-Hispanics								
White	4,317,657	39.1%	4,241,012	36.2%	4,159,092	34.6%	-3.7%	-1.9%
African American	2,162,870	19.6%	2,177,942	18.6%	2,164,228	18.0%	0.1%	-0.6%
American Indian/Alaskan/Aleutian	21,083	0.2%	20,982	0.2%	20,713	0.2%	-1.8%	-1.3%
Asian/Hawaiian/Pacific Islander	1,273,836	11.5%	1,586,574	13.6%	1,764,804	14.7%	38.5%	11.2%
Other	261,805	2.4%	324,731	2.8%	360,631	3.0%	37.7%	11.1%
Subtotal	8,037,251	72.8%	8,351,241	71.3%	8,469,468	70.5%	5.4%	1.4%
Total	**11,042,725**	**100.0%**	**11,707,588**	**100.0%**	**12,008,858**	**100.0%**	8.7%	2.6%
New York State								
Hispanics	3,416,922	17.6%	3,897,754	19.6%	4,163,356	20.6%	21.8%	6.8%
Non-Hispanics								
White	11,304,247	58.3%	10,829,785	54.4%	10,574,224	52.4%	-6.5%	-2.4%
African American	2,783,857	14.4%	2,846,150	14.3%	2,864,737	14.2%	2.9%	0.7%
American Indian/Alaskan/Aleutian	53,908	0.3%	54,848	0.3%	55,436	0.3%	2.8%	1.1%
Asian/Hawaiian/Pacific Islander	1,411,514	7.3%	1,775,160	8.9%	1,984,868	9.8%	40.6%	11.8%
Other	407,654	2.1%	499,979	2.5%	553,939	2.7%	35.9%	10.8%
Subtotal	15,961,180	82.4%	16,005,922	80.4%	16,033,204	79.4%	0.5%	0.2%
Total	**19,378,102**	**100.0%**	**19,903,676**	**100.0%**	**20,196,560**	**100.0%**	4.2%	1.5%

NYPH_Demographic_SAbyZIP_Revised.xlsx]Ethnicity_Table

Source: Nielsen, Inc.

- In 2019, the NewYork-Presbyterian Hospital community has a higher non-White population, 63.8%, than the state 45.6%.
- This is driven by Hispanics, 28.7%, and African Americans, 18.6%.
- Future growth is projected for Hispanics, Asian/Hawaiian/Pacific Islanders and Other populations while the White population is projected to decline.

NewYork-Presbyterian

Socioeconomic Profile – Household Income

NewYork-Presbyterian
NYP Hospital Service Area vs. the State of New York State - Socioeconomic Profile
Calendar Years 2019 to 2024

Socioeconomic Indicator	Census 2010	Estimated 2019	Projected 2024	Percent Change 2010 - 2024	Percent Change 2019 - 2024
NYP Hospital Service Area					
Population	11,042,725	11,707,588	12,008,858	8.7%	2.6%
Households	4,002,082	4,415,637	4,537,827	13.4%	2.8%
Median Household Income	$42,710	$68,944	$76,301	78.6%	10.7%
Average Household Income	$64,746	$109,086	$119,771	85.0%	9.8%
Income Distribution					
Under $25,000	31.6%	21.3%	19.4%	-38.6%	-6.3%
$25,000 - $49,999	24.8%	17.9%	16.8%	-32.1%	-3.4%
$50,000 - $99,999	26.8%	24.7%	23.8%	-11.2%	-1.2%
$100,000 +	16.8%	36.1%	40.0%	137.4%	13.9%
	100.0%	100.0%	100.0%		
New York State					
Population	19,378,102	19,903,676	20,196,560	4.2%	1.5%
Households	7,056,878	7,584,043	7,719,346	9.4%	1.8%
Median Household Income	$43,792	$68,067	$74,555	70.2%	9.5%
Average Household Income	$61,489	$101,507	$111,343	81.1%	9.7%
Income Distribution					
Under $25,000	29.5%	19.9%	18.2%	-38.5%	-7.0%
$25,000 - $49,999	26.3%	19.0%	17.8%	-32.1%	-4.3%
$50,000 - $99,999	29.0%	26.7%	25.7%	-11.2%	-2.0%
$100,000 +	15.3%	34.4%	38.3%	151.1%	13.2%

NYPH_Demographic_SAbyZIP_Revised.xlsx]Household_Table

Source: Nielsen, Inc.

- In 2019, the income distribution for the NewYork-Presbyterian Hospital community is similar to the New York State comparison.
- However, the community's average household income, $109,086, is higher than the average of New York State, $101,507.

NewYork-Presbyterian

Community Demographic Profile

POPULATION

11,707,588

HOUSEHOLDS

4,415,637

ETHNICITY

28.7%

Index: 146

Hispanic/Latino

HISPANIC ORIGIN*

54.6%

Index: 103

Non Cuban/Mexican/Puerto Rican

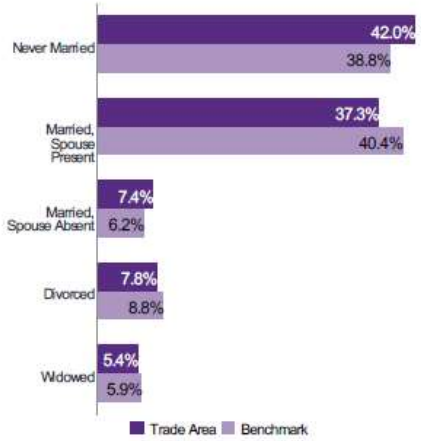
HOME LANGUAGE*

53.6%

Index: 77

Only English

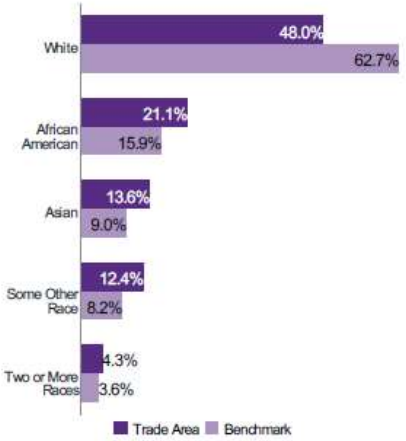
MARITAL STATUS



POPULATION BY AGE

Age	Count	%	Index
0 - 4	746,091	6.4	110
5 - 9	722,356	6.2	107
10 - 14	679,893	5.8	100
15 - 17	406,576	3.5	96
18 - 20	423,406	3.6	89
21 - 24	576,004	4.9	94
25 - 34	1,903,179	16.3	113
35 - 44	1,616,770	13.8	109
45 - 54	1,505,685	12.9	99
55 - 64	1,407,918	12.0	91
65 - 74	993,658	8.5	89
75 - 84	496,569	4.2	92
85+	229,483	2.0	88

POPULATION BY RACE**



Benchmark: New York

*Top variable chosen from percent composition ranking

**Top 5 variables chosen from percent composition ranking

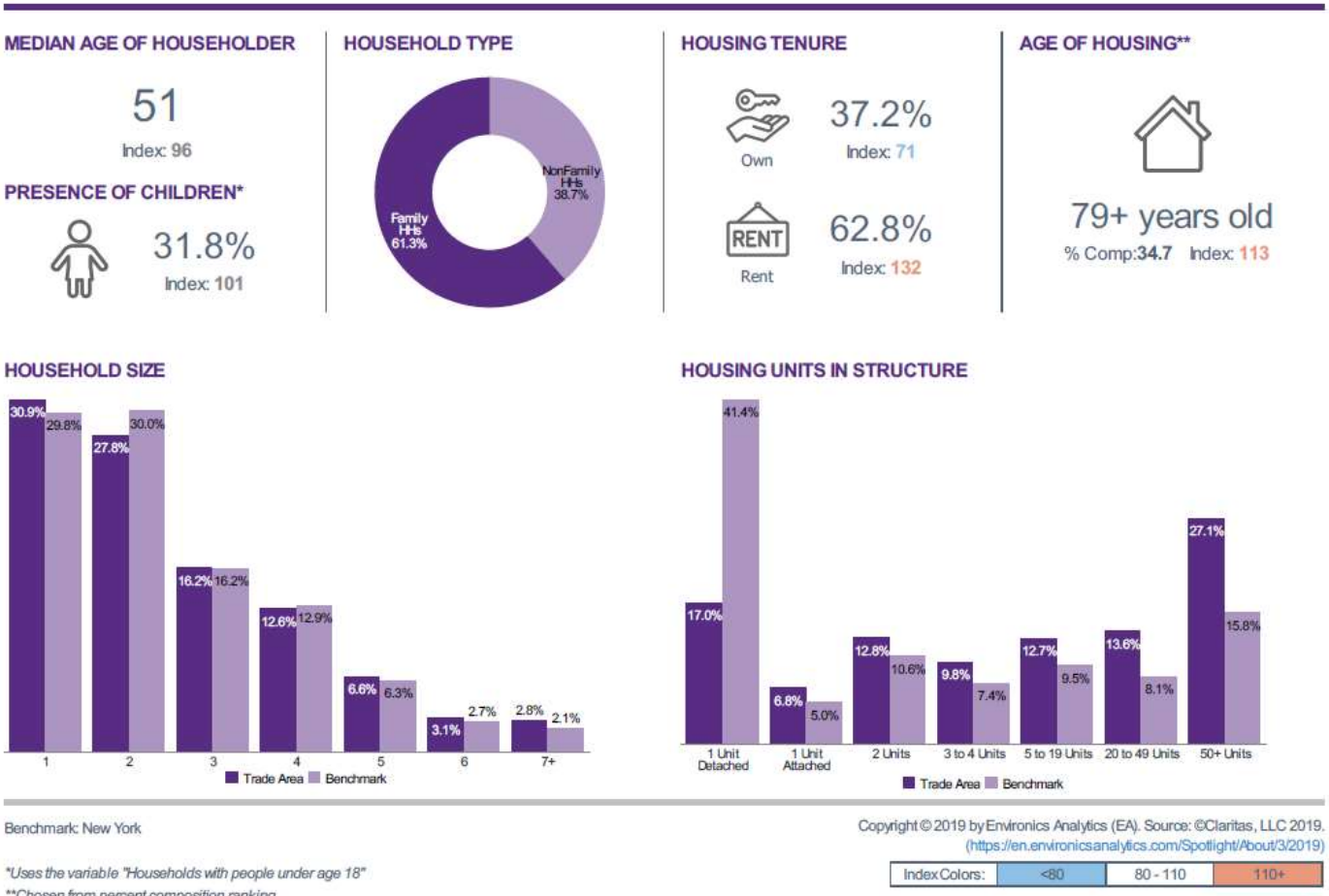
Index Colors: <80 | 80 - 110 | 110+

The index is a measure of how similar or different the defined area is from the benchmark.

- In 2019, this community comprises almost 11.7M people.
- The population that is Hispanic/Latino is 46% higher than the average for the benchmark of New York State.
- The population also is less likely to speak only English at home than the average for the benchmark of New York State.
- There is a higher minority population than the state and there are less married persons than there are never married.

NewYork-Presbyterian

Community Household & Housing



The index is a measure of how similar or different the defined area is from the benchmark.

- This community is younger than the average for the benchmark of New York State; there are 1% more children in the community than the average for the benchmark of New York State.
- More of the population lives in family households, 61.3%, than non-family households, 38.7% and the household size is similar in comparison to New York State (Household size of 4 or greater is 25.1%, NYS 24.0%).
- With an index value of 132, the number of homes rented are 32% higher than the average for the benchmark of New York State and fewer than average own a home.

NewYork-Presbyterian

Community Education & Socio Economic Status

EDUCATIONAL ATTAINMENT: TOP 2*

23.7%
Index: 90
High School Graduate

22.4%
Index: 112
Bachelor's Degree

EDUCATION: HISPANIC/LATINO

4.7%
Index: 149
Bachelor's degree or higher

POVERTY STATUS

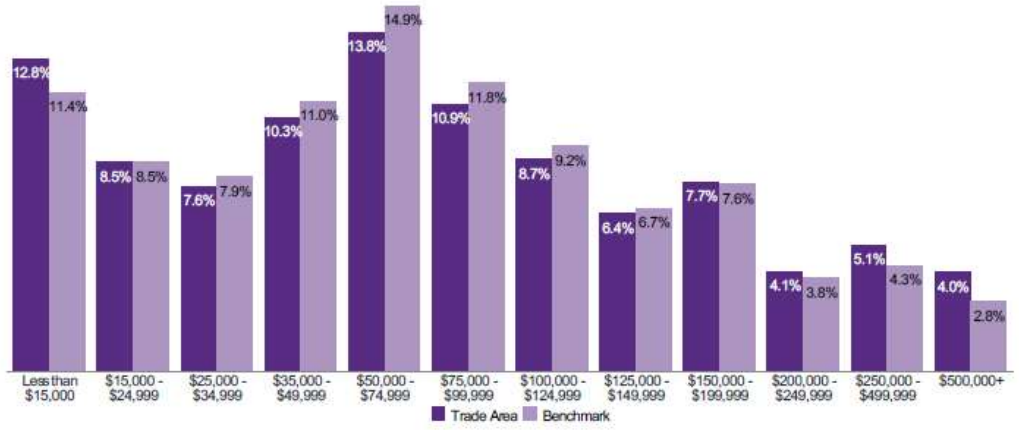
85.8%
Index: 97
At or above poverty

HOUSEHOLD INCOME

Median Household Income
$68,944
Index:101

Average Household Income
$109,086
Index:107

HOUSEHOLD INCOME DISTRIBUTION



Benchmark: New York

*Ranked by percent composition

Index Colors:	<80	80 - 110	110+

The index is a measure of how similar or different the defined area is from the benchmark.

- In 2019, this community had a 10% lower high school and 12% higher Bachelor's Degree attainment than the average for the benchmark of New York State.
- The community's median household income, $68,944 and average household income, $109,086, are higher than the average for the benchmark of New York State.

NewYork-Presbyterian

Community Employment & Occupation

OCCUPATIONAL CLASS*

63.8%
Index: 101

White Collar

UNEMPLOYMENT RATE

6.8%
Index: 109

Percent of civilian labor force unemployed

METHOD OF TRAVEL TO WORK: TOP 2*

47.9%
Index: 169

Travel to work by **Public Transport**

31.0%
Index: 59

Travel to work by **Driving Alone**

OCCUPATION: TOP 10*

Benchmark: New York

*Chosen from percent composition ranking

Index Colors:	<80	80 - 110	110+

The index is a measure of how similar or different the defined area is from the benchmark.

- In 2019, this community's unemployment rate is 9% higher than the average for the benchmark of New York State, with a 1% higher number of white collar workers than the state average.
- With an index value of 169, the population that uses public transport to travel to work is 69% higher than the average for the benchmark of New York State.

NewYork-Presbyterian

AMAZING THINGS ARE HAPPENING HERE

Assessing the Health of the High Disparity NYC Communities

NewYork-Presbyterian

Assessing the NYPH High Disparity Communities Summary

Demographics and Socioeconomic Status

- In the subset of NewYork-Presbyterian Hospital's neighborhoods that have been identified as high disparity there is a total population of 4,798,531, more than half the NYC population, 8,354,889.
- There is variation between NTAs among gender and age cohorts which have implications for health services needed, but **overall the high disparity community is 52.8% female and slightly younger**, 11.2% of the population is 65+, compared to NYC, 12.5%.
- The **NYPH community has a much higher percentage of the population that is minority,** 85.5% (especially Hispanic/Latino and Black) than does the NYC average 67%.
- Overall, there is a **higher percent of 'all ages' living in poverty, 26.4%**, than the NYC average, 20.6%.
- In aggregate, **there are more than the NYC average percentages of residents that are foreign born, non-English speaking, not graduated from high school, unemployed, and single parents.**
- Most of these neighborhoods have a **higher percent of the population that is uninsured,**15.9%, than the NYC average, 13.5%.
- Many of these neighborhoods have a **higher percent of the population enrolled in Medicaid**, 43.7%, than the NYC average, 37.0%.
- Compared to the NYS average, there are **fewer people in the NYPH community living in an Area Median Income (AMI) income band of $200,000,** but there are **more people living in an income band under $15,000.**

Assessing the High Disparity Communities Summary

Social Determinants of Health

- The high cost of housing is a concern, as the percentage of **overcrowded housing and high rent burden is less favorable than the NYC average** and the percentage of residents in public housing, 7.0%, is higher than the NYC average, 4.7%.
- The **number of meals missing annually from food insecure households in these NTAs were estimated at more than 510 million.**
- Among the Social & Environmental Safety indicators assessed, there was **about the same, 103.3, as the NYC average, 101.0, for senior center participation (**number of persons served by Senior Center program per 1,000 population age 65+).
- All but three neighborhoods in the NYPH high disparity community have **longer than NYC average commute times to work.**

Health Status

- There are also **higher than average reports of percentage adult population with obesity** 28.5%, NYC, 20.0%.
- There is **about the same amount of regular physical activity as a percentage of the population** , 71.2%, NYC 73.0%.
- There is **higher than average percent of live births receiving late prenatal care**, 9.3%, NYC, 7.0%, in the community which could be contributing to the **higher than NYC average infant death rates** (under one year old per 1,000 live births)**,** 5.0, NYC 4.4, **and percent of preterm births among all live births, in select neighborhoods,** 10.0%, NYC, 9.1%.
- **NYPH also has a higher than average teen birth rate per 1,000 women ages 15-19 ,** 29.1, NYC 23.7.

Assessing the High Disparity Communities Summary

Health Status, continued

- Overall in the NYPH community, **premature mortality per 100,000 population under age 65 is more favorable, 128.4, in comparison to the NYC average, 193.8.**
- While community adults are self reporting **average 'poor mental health' and 'good to excellent' health**, they are also reporting **less favorable than average access to needed medical care**.
- I**n aggregate, there is an average percentage of the population self-reporting smoking**, 13.9%, NYC 14.0%.
- Community **children are visiting the ER for asthma care at higher rates per 10,000 children ages 5-17,** 285.1, than the NYC average, 223.0.
- Overall, **new diagnoses of HIV per 100,000 population are higher, 31.2,** than NYC 24.0. There is significant variation among NTAs, but Central Harlem South's rate is 69.6.
- New diagnoses of **Hepatitis C per 100,000 population are lower, 65.7**, than the NYC average, 71.8. Belmont's rate is 131.0.
- The **higher than average percentage of chronic conditions are diabetes** (14.2%, NYC 11.0%) and **hypertension** (32.1%, NYC 28%); **cardiovascular related conditions are the same as the average** for NYC 6.6%, **but several NTAs are higher**, 7.6%.
- **Overall, cancer incidence compares about the same or more favorably** than the NYC average.

Assessing the High Disparity Communities Summary

Health Care Service Utilization

- There is a **higher rate of avoidable or preventable hospitalizations in the community**, and several neighborhoods report higher for all categories (all, asthma, diabetes, and hypertension) which indicates a lack of access to ambulatory care for conditions that would otherwise not have required an admission.
- **Other hospitalizations** (psychiatric, alcohol, drugs, stroke, and child asthma) in the community vary by neighborhood, but **are mostly unfavorable** to the NYC average.
- However, while hospitalizations for falls per 100,000 population ages 65+, appear to be more favorable overall, individual NTAs range from 693 to 2,748 in comparison to the NYC average, 1,840.
- There are **higher than NYC average all ED visits per 100,000 population,** 55,878, NYC 46,079.
- The **percentage of preventable ER treat and release visits of all treat and release visits** , is only slightly higher 54.3, than NYC average 52.4. Norwood is 59.8.

Assessing the High Disparity Communities Summary

Neighborhoods with the Highest Disparities

- These neighborhoods' needs vary across indicators but most among Quartile 4 and many in Quartile 3 have significant needs.
- Several NTAs have higher percentages of adult population with obesity, 42% in comparison to NYC 24%, including Melrose South-Mott Haven North, Longwood, Hunts Point, and Mott Haven-Port Morris.
- Two NTAs, Bushwick North and Bushwick South, have the highest area percentage of child population with obesity, 28%, in comparison to NYC 20%.
- Central Harlem South's rate for new diagnoses of HIV per 100,000 population, are among the NTA's highest, 31.2, which is greater than the NYC rate of 24.0.
- Belmont's rate of 131.0 for new diagnoses of Hepatitis C per 100,000 population, is much higher than the NYC average, 71.8.
- Claremont-Bathgate has the highest rate of 4,221, compared to NYC 1,662, for Preventable All Hospitalizations per 100,00 Population for ages 18+.
- Norwood has the highest percentage of preventable ER treat and release visits**,** 59.8, in comparison to NYC average of 52.4.
- The percentage of preventable ER treat and release visits of all treat and release visits, is only slightly higher at 54.3, than NYC average of 52.4.

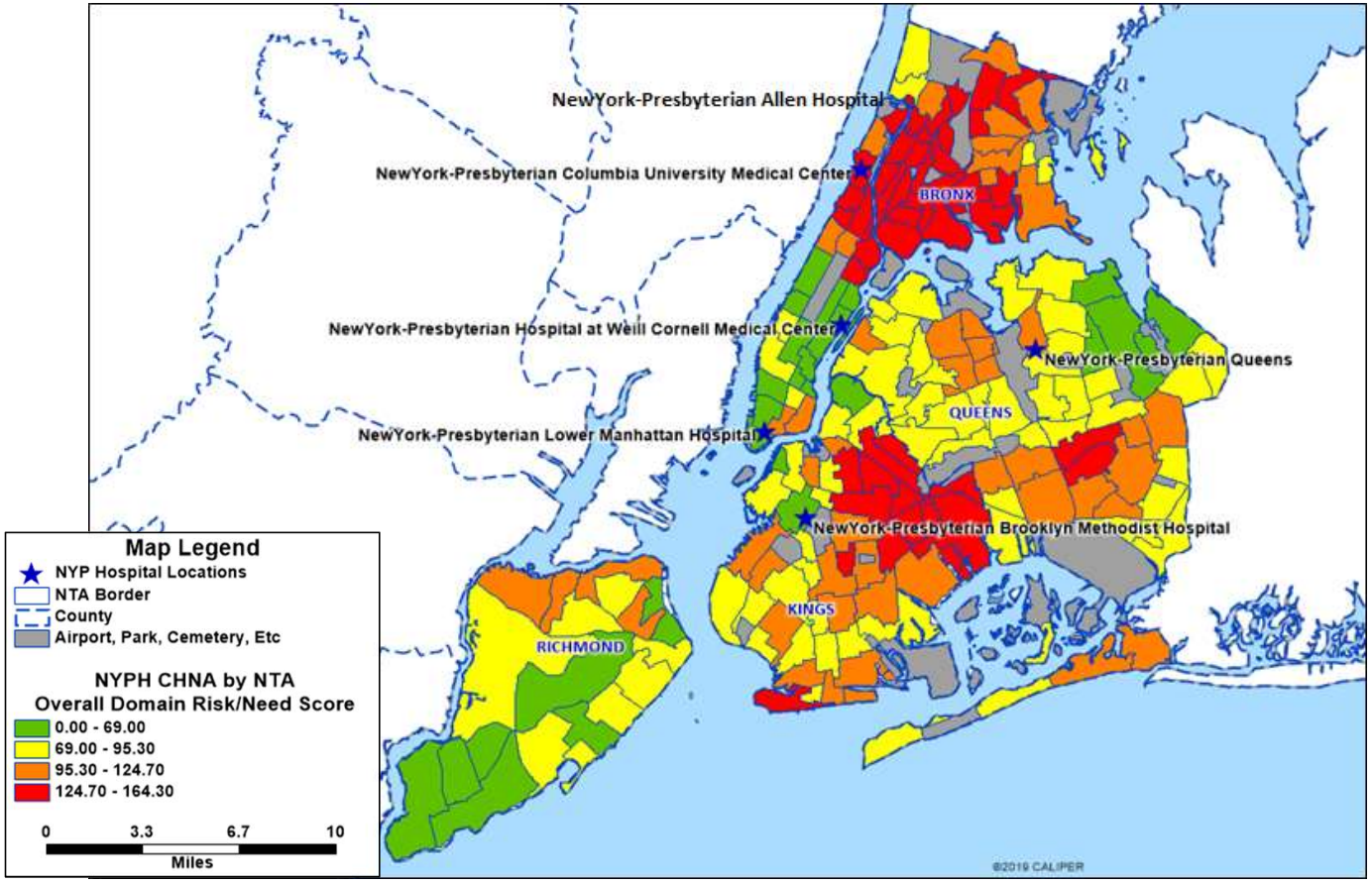
NYPH High Disparity NYC Communities Analysis Method

Objective: The objective is to identify the geographical areas by Neighborhood Tabulation Area (NTA) within NYC for which there is a higher health need and/or a higher risk of required resources.

Method:

- This analysis was adapted from the Citizen's Committee for Children Community Risk Index Report. However, the risk ranking utilized a selection of 29 indicators across five domains (demographics, income, insurance, access to care and the New York State Department of Health Prevention Agenda Priorities) for the broader community of all ages.
- Similar to the CCC analysis:
  - Data for individual indicators are collected by NTA (or cross-walked to NTA).
  - Each indicator's data are standardized using Linear Scaling Technique (LST), which calculates the difference between the value of a given NTA and that of the lowest value NTA, and divides this number by the difference between the highest value NTA and the lowest value NTA.
  - The standardized values are then ranked from low to high with regard to increasing risks to well-being (a higher rank illustrates a higher risk/need).
  - Then indicators are averaged within each domain using equal weighting to produce 5 domain indices.
  - These five domains indices are averaged again using equal weighting to produce an overall domain of risk/need for each NTA.

NYPH Communities of High Disparity Analysis (NYC)



- An analysis of community health need and risk of high resource utilization was undertaken at the Neighborhood Tabulation Area (NTA) geography.
- The need score is a composite of 29 different indicators, carefully selected, across five domains: demographics, income, insurance, access to care and New York State Department of Health Prevention Agenda Priorities.
- The results show where there is more or less need comparatively between NTAs.
- The 380 NYPH ZIP codes were cross-walked to 195 NTAs categorized into four quartiles. Additional analysis was undertaken for the 97 NTAs of higher disparity.

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NYPH Communities of High Disparity Analysis (NYC)
Higher Disparity Quartiles 3 & 4

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
BX17	East Tremont	144	176	158	180	164	164.3	Quartile 4
BX26	Highbridge	138	180	146	176	166	161.1	Quartile 4
BX39	Mott Haven-Port Morris	153	169	132	188	156	159.3	Quartile 4
BX14	East Concourse-Concourse Village	158	169	130	174	161	158.3	Quartile 4
BX36	University Heights-Morris Heights	142	170	145	174	160	158.3	Quartile 4
BX01	Claremont-Bathgate	131	175	129	181	169	157.2	Quartile 4
BX35	Morrisania-Melrose	136	167	130	180	168	156.2	Quartile 4
BK81	Brownsville	129	167	147	181	157	156.1	Quartile 4
BX33	Longwood	143	169	118	186	154	154.1	Quartile 4
BX75	Crotona Park East	121	162	142	180	164	153.6	Quartile 4
BX27	Hunts Point	137	168	116	186	160	153.1	Quartile 4
BX40	Fordham South	133	179	114	174	164	152.8	Quartile 4
BK85	East New York (Pennsylvania Ave)	114	169	144	178	159	152.8	Quartile 4
BX41	Mount Hope	149	147	128	173	165	152.4	Quartile 4
BX34	Melrose South-Mott Haven North	135	168	108	188	161	151.7	Quartile 4
BK82	East New York	131	160	129	163	165	149.8	Quartile 4
BK79	Ocean Hill	125	161	121	180	162	149.5	Quartile 4
BX55	Soundview-Bruckner	149	163	129	151	149	148.2	Quartile 4
BX63	West Concourse	143	143	122	175	156	147.9	Quartile 4
BX05	Bedford Park-Fordham North	136	142	130	167	157	146.5	Quartile 4
BX30	Kingsbridge Heights	137	164	114	166	149	146.3	Quartile 4
BX06	Belmont	125	149	115	179	155	144.4	Quartile 4
MN34	East Harlem North	129	151	104	177	153	143.0	Quartile 4
BK35	Stuyvesant Heights	122	149	133	154	153	142.4	Quartile 4

- Recognizing the variability among domains and individual indicators, the 97 Quartile 3 & 4 neighborhoods were identified to be of comparatively higher disparities which could benefit from focused efforts of health improvement.

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

NYPH Communities of High Disparity Analysis (NYC)
Higher Disparity Quartiles 3 & 4

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
BX08	West Farms-Bronx River	138	163	102	153	153	142.0	Quartile 4
BX44	Williamsbridge-Olinville	134	133	129	157	157	141.9	Quartile 4
MN03	Central Harlem North-Polo Grounds	119	132	134	161	154	140.0	Quartile 4
MN33	East Harlem South	122	137	133	170	133	138.9	Quartile 4
BK21	Seagate-Coney Island	126	150	144	136	134	138.2	Quartile 4
BX43	Norwood	132	124	115	169	149	137.7	Quartile 4
BK78	Bushwick South	133	151	107	151	141	136.6	Quartile 4
BX09	Soundview-Castle Hill-Clason Point-Harding Park	143	136	112	152	140	136.6	Quartile 4
QN61	Jamaica	145	132	130	131	142	136.2	Quartile 4
BK93	Starrett City	105	132	134	163	138	134.2	Quartile 4
BX59	Westchester-Unionport	127	142	128	149	124	133.9	Quartile 4
BK61	Crown Heights North	120	135	110	153	151	133.8	Quartile 4
BK75	Bedford	101	155	112	153	143	133.0	Quartile 4
QN01	South Jamaica	128	124	135	143	135	132.8	Quartile 4
BX07	Bronxdale	126	136	107	148	142	131.7	Quartile 4
MN36	Washington Heights South	154	137	104	116	143	130.9	Quartile 4
BK77	Bushwick North	145	148	88	148	125	130.9	Quartile 4
BK83	Cypress Hills-City Line	128	125	104	156	140	130.7	Quartile 4
BK95	Erasmus	121	99	118	147	167	130.4	Quartile 4
MN04	Hamilton Heights	123	136	119	124	148	129.9	Quartile 4
BX03	Eastchester-Edenwald-Baychester	114	113	118	154	148	129.5	Quartile 4
MN01	Marble Hill-Inwood	139	141	129	113	121	128.6	Quartile 4
BK96	Rugby-Remsen Village	125	114	106	141	146	126.6	Quartile 4
MN06	Manhattanville	116	154	96	122	144	126.5	Quartile 4

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

NYPH Communities of High Disparity Analysis (NYC)
Higher Disparity Quartiles 3 & 4

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
MN28	Lower East Side	137	130	122	110	125	124.7	Quartile 3
BK26	Gravesend	112	140	143	113	117	124.7	Quartile 3
BX28	Van Cortlandt Village	134	118	129	116	125	124.4	Quartile 3
BK60	Prospect Lefferts Gardens-Wingate	120	123	106	131	142	124.3	Quartile 3
BX37	Van Nest-Morris Park-Westchester Square	116	108	109	141	138	122.5	Quartile 3
QN12	Hammels-Arverne-Edgemere	123	122	124	114	126	121.7	Quartile 3
MN27	Chinatown	136	147	125	81	113	120.2	Quartile 3
QN15	Far Rockaway-Bayswater	125	129	108	113	117	118.6	Quartile 3
MN11	Central Harlem South	98	124	73	154	143	118.5	Quartile 3
BX46	Parkchester	115	85	107	139	138	116.8	Quartile 3
SI22	West New Brighton-New Brighton-St. George	101	139	97	119	127	116.7	Quartile 3
BK34	Sunset Park East	144	136	116	76	104	115.4	Quartile 3
QN68	Queensbridge-Ravenswood-Long Island City	93	132	124	98	127	114.8	Quartile 3
QN76	Baisley Park	119	90	110	138	117	114.7	Quartile 3
BX62	Woodlawn-Wakefield	112	84	110	139	127	114.4	Quartile 3
BX31	Allerton-Pelham Gardens	112	99	115	139	107	114.2	Quartile 3
BK91	East Flatbush-Farragut	119	72	100	133	146	113.9	Quartile 3
BK42	Flatbush	122	99	110	109	130	113.8	Quartile 3
BK32	Sunset Park West	130	122	89	105	121	113.4	Quartile 3
BK50	Canarsie	125	93	109	118	120	112.9	Quartile 3
BK63	Crown Heights South	99	91	110	133	127	111.8	Quartile 3
BX49	Pelham Parkway	110	87	117	132	113	111.8	Quartile 3
MN35	Washington Heights North	129	99	102	102	117	109.9	Quartile 3
BK19	Brighton Beach	89	128	125	100	106	109.6	Quartile 3

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

NYPH Communities of High Disparity Analysis (NYC)
Higher Disparity Quartiles 3 & 4

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
QN07	Hollis	103	71	129	129	112	108.7	Quartile 3
QN02	Springfield Gardens North	111	65	124	134	109	108.6	Quartile 3
QN08	St. Albans	117	65	119	131	110	108.4	Quartile 3
QN25	Corona	148	122	83	76	108	107.2	Quartile 3
QN27	East Elmhurst	123	102	110	93	106	106.8	Quartile 3
SI12	Mariner's Harbor-Arlington-Port Ivory-Graniteville	91	123	90	112	113	105.8	Quartile 3
BK72	Williamsburg	86	160	108	78	90	104.6	Quartile 3
BK68	Fort Greene	86	102	106	111	108	102.6	Quartile 3
QN28	Jackson Heights	142	105	104	61	102	102.6	Quartile 3
BK43	Midwood	86	119	100	100	107	102.4	Quartile 3
QN55	South Ozone Park	124	81	113	102	90	101.9	Quartile 3
QN22	Flushing	132	138	119	39	80	101.4	Quartile 3
BK58	Flatlands	115	72	106	109	105	101.2	Quartile 3
BX52	Schuylerville-Throgs Neck-Edgewater Park	111	91	111	110	79	100.3	Quartile 3
QN54	Richmond Hill	125	80	91	105	100	99.9	Quartile 3
QN26	North Corona	150	100	83	67	99	99.7	Quartile 3
BK17	Sheepshead Bay-Gerritsen Beach-Manhattan Beach	106	115	123	69	83	99.1	Quartile 3
BX13	Co-op City	118	65	102	120	88	98.8	Quartile 3
QN53	Woodhaven	121	72	98	108	94	98.4	Quartile 3
SI08	Grymes Hill-Clifton-Fox Hills	88	78	108	96	123	98.3	Quartile 3
QN34	Queens Village	125	62	117	91	94	97.7	Quartile 3
QN29	Elmhurst	147	107	78	48	108	97.7	Quartile 3
BK28	Bensonhurst West	136	101	119	34	92	96.4	Quartile 3
MN09	Morningside Heights	74	108	80	109	109	96.0	Quartile 3
SI28	Port Richmond	75	103	89	101	109	95.4	Quartile 3

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

NYPH Communities of High Disparity Analysis (NYC)
Lower Disparity Quartiles 1 & 2

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
QN71	Old Astoria	91	114	81	88	102	95.3	Quartile 2
BK38	DUMBO-Vinegar Hill-Downtown Brooklyn-Boerum Hill	73	100	89	111	103	95.2	Quartile 2
BK29	Bensonhurst East	123	87	129	32	96	93.5	Quartile 2
QN38	Pomonok-Flushing Heights-Hillcrest	91	117	100	69	90	93.3	Quartile 2
BK41	Kensington-Ocean Parkway	103	124	90	58	91	92.9	Quartile 2
SI45	New Dorp-Midland Beach	74	103	89	85	109	92.0	Quartile 2
BK88	Borough Park	99	133	92	38	91	90.7	Quartile 2
BK90	East Williamsburg	90	110	70	73	103	89.2	Quartile 2
QN56	Ozone Park	95	78	86	101	83	88.4	Quartile 2
QN20	Ridgewood	115	78	88	76	85	88.4	Quartile 2
QN03	Springfield Gardens South-Brookville	91	36	121	95	99	88.4	Quartile 2
QN23	College Point	108	104	112	48	68	88.0	Quartile 2
BX10	Pelham Bay-Country Club-City Island	87	65	115	108	62	87.5	Quartile 2
QN35	Briarwood-Jamaica Hills	103	71	116	64	83	87.4	Quartile 2
BX29	Spuyten Duyvil-Kingsbridge	94	68	88	101	86	87.2	Quartile 2
QN70	Astoria	98	95	80	68	95	87.2	Quartile 2
SI35	New Brighton-Silver Lake	66	60	109	100	102	87.2	Quartile 2
SI54	Great Kills	82	60	109	77	102	86.0	Quartile 2
BK73	North Side-South Side	77	118	74	69	87	85.2	Quartile 2
QN66	Laurelton	101	46	99	90	91	85.0	Quartile 2
BK23	West Brighton	65	96	89	100	70	84.0	Quartile 2
QN60	Kew Gardens	76	63	90	99	86	82.8	Quartile 2
QN52	East Flushing	111	84	114	34	68	82.3	Quartile 2
QN30	Maspeth	95	63	100	73	77	81.3	Quartile 2

- These 97 Quartile 1 & 2 neighborhoods were identified to be of comparatively lesser disparities, but will continue to benefit from the community health improvement efforts offered broadly by NYP Hospital.

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

NYPH Communities of High Disparity Analysis (NYC)
Lower Disparity Quartiles 1 & 2

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
QN51	Murray Hill	116	92	99	34	65	81.3	Quartile 2
QN63	Woodside	109	70	81	51	91	80.5	Quartile 2
BK33	Carroll Gardens-Columbia Street-Red Hook	66	84	77	103	69	79.9	Quartile 2
BK27	Bath Beach	101	80	107	31	78	79.4	Quartile 2
BK30	Dyker Heights	112	75	103	29	77	79.1	Quartile 2
QN10	Breezy Point-Belle Harbor-Rockaway Park-Broad Channel	70	51	92	93	87	78.6	Quartile 2
MN22	East Village	42	90	86	90	85	78.6	Quartile 2
BK45	Georgetown-Marine Park-Bergen Beach-Mill Basin	82	50	92	97	69	78.1	Quartile 2
QN62	Queensboro Hill	97	82	120	30	60	77.8	Quartile 2
BK25	Homecrest	88	89	98	44	69	77.2	Quartile 2
BK69	Clinton Hill	64	58	79	97	86	76.6	Quartile 2
QN05	Rosedale	94	39	76	86	86	76.2	Quartile 2
QN57	Lindenwood-Howard Beach	84	37	92	93	73	75.7	Quartile 2
SI14	Grasmere-Arrochar-Ft. Wadsworth	74	79	92	61	72	75.5	Quartile 2
QN43	Bellerose	88	25	105	79	80	75.4	Quartile 2
SI36	Old Town-Dongan Hills-South Beach	70	83	86	68	71	75.4	Quartile 2
MN15	Clinton	57	64	101	62	90	74.8	Quartile 2
BK64	Prospect Heights	46	51	54	129	94	74.5	Quartile 2
BK46	Ocean Parkway South	65	114	92	38	62	74.1	Quartile 2
QN33	Cambria Heights	101	21	88	78	79	73.3	Quartile 2
BK31	Bay Ridge	99	70	84	32	76	72.1	Quartile 2
QN31	Hunters Point-Sunnyside-West Maspeth	103	67	63	43	79	70.8	Quartile 2
QN50	Elmhurst-Maspeth	109	60	76	30	80	70.8	Quartile 2
BK44	Madison	85	75	83	43	67	70.7	Quartile 2

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

NYPH Communities of High Disparity Analysis (NYC)
Lower Disparity Quartiles 1 & 2

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
QN17	Forest Hills	91	68	97	44	47	69.2	Quartile 2
QN06	Jamaica Estates-Holliswood	83	50	98	51	62	68.8	Quartile 2
QN19	Glendale	93	54	68	70	59	68.7	Quartile 2
BX22	North Riverdale-Fieldston-Riverdale	71	34	78	87	72	68.5	Quartile 2
QN37	Kew Gardens Hills	77	53	88	51	70	67.7	Quartile 2
MN13	Hudson Yards-Chelsea-Flat Iron-Union Square	59	72	67	52	87	67.5	Quartile 2
SI99	park-cemetery-etc-Staten Island6	38	83	86	59	71	67.1	Quartile 2
QN41	Fresh Meadows-Utopia	76	74	77	47	62	67.1	Quartile 2
QN18	Rego Park	88	55	93	41	59	67.1	Quartile 2
QN21	Middle Village	87	42	87	67	50	66.8	Quartile 2
SI05	New Springville-Bloomfield-Travis	83	65	89	55	40	66.4	Quartile 2
BK40	Windsor Terrace	61	68	66	75	61	66.2	Quartile 2
QN72	Steinway	78	43	73	62	71	65.5	Quartile 2
QN49	Whitestone	94	54	94	34	47	64.5	Quartile 2
QN44	Glen Oaks-Floral Park-New Hyde Park	70	27	94	67	54	62.3	Quartile 2
SI07	Westerleigh	56	41	68	80	61	61.3	Quartile 2
SI37	Stapleton-Rosebank	63	35	102	61	44	60.8	Quartile 1
MN12	Upper West Side	77	58	61	42	64	60.2	Quartile 1
BK76	Greenpoint	44	63	75	44	66	58.5	Quartile 1
MN20	Murray Hill-Kips Bay	57	51	57	42	81	57.4	Quartile 1
BK37	Park Slope-Gowanus	60	22	56	83	64	56.7	Quartile 1
SI25	Oakwood-Oakwood Beach	61	35	102	38	44	56.0	Quartile 1
QN48	Auburndale	85	40	101	13	41	56.0	Quartile 1
MN17	Midtown-Midtown South	49	40	63	34	91	55.2	Quartile 1

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

NYPH Communities of High Disparity Analysis (NYC)
Lower Disparity Quartiles 1 & 2

NTA Code	NTA Name	Domain 1, Demographics	Domain 2, Income	Domain 3, Insurance	Domain 4, Access to Care	Domain 5, NYS DOH PA	Overall Domain Risk/Need	Quartile
QN42	Oakland Gardens	81	47	96	17	35	55.1	Quartile 1
QN47	Ft. Totten-Bay Terrace-Clearview	65	54	87	35	30	54.2	Quartile 1
SI24	Todt Hill-Emerson Hill-Heartland Village-Lighthouse Hill	74	37	77	50	31	53.9	Quartile 1
QN46	Bayside-Bayside Hills	93	32	99	14	32	53.6	Quartile 1
MN32	Yorkville	61	46	81	17	39	48.8	Quartile 1
MN14	Lincoln Square	62	46	59	32	43	48.1	Quartile 1
MN31	Lenox Hill-Roosevelt Island	65	41	67	18	46	47.4	Quartile 1
MN24	SoHo-TriBeCa-Civic Center-Little Italy	58	39	60	15	61	46.5	Quartile 1
SI48	Arden Heights	44	51	67	34	34	46.0	Quartile 1
SI32	Rossville-Woodrow	39	51	67	34	34	44.9	Quartile 1
MN21	Gramercy	35	21	76	33	58	44.5	Quartile 1
SI11	Charleston-Richmond Valley-Tottenville	42	46	61	40	27	43.4	Quartile 1
QN45	Douglas Manor-Douglaston-Little Neck	77	27	68	15	29	43.2	Quartile 1
BK09	Brooklyn Heights-Cobble Hill	34	20	56	59	40	41.7	Quartile 1
SI01	Annadale-Huguenot-Prince's Bay-Eltingville	54	20	64	31	32	40.1	Quartile 1
MN50	Stuyvesant Town-Cooper Village	49	21	76	13	36	39.0	Quartile 1
MN25	Battery Park City-Lower Manhattan	36	20	56	23	59	38.6	Quartile 1
MN23	West Village	50	11	55	13	44	34.5	Quartile 1
MN19	Turtle Bay-East Midtown	56	12	55	12	32	33.3	Quartile 1
MN40	Upper East Side-Carnegie Hill	58	9	56	14	27	32.8	Quartile 1
BK99	park-cemetery-etc-Brooklyn	1	1	1	1	1	1.0	Quartile 1
BX99	park-cemetery-etc-Bronx	1	1	1	1	1	1.0	Quartile 1
MN99	park-cemetery-etc-Manhattan	1	1	1	1	1	1.0	Quartile 1
QN98	Airport	1	1	1	1	1	1.0	Quartile 1
QN99	park-cemetery-etc-Queens	1	1	1	1	1	1.0	Quartile 1

Source: Citizen's Committee for Children; Data City of New York; Data2Go; NYC Health Atlas; NYC Mayor Report

- Note that the cross walk from one geography to another (ZIP code to NTA) includes neighborhoods (airport and park-cemetery-etc.) that may otherwise appear to be unpopulated.

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Assessing the High Disparity NYC Communities Overview

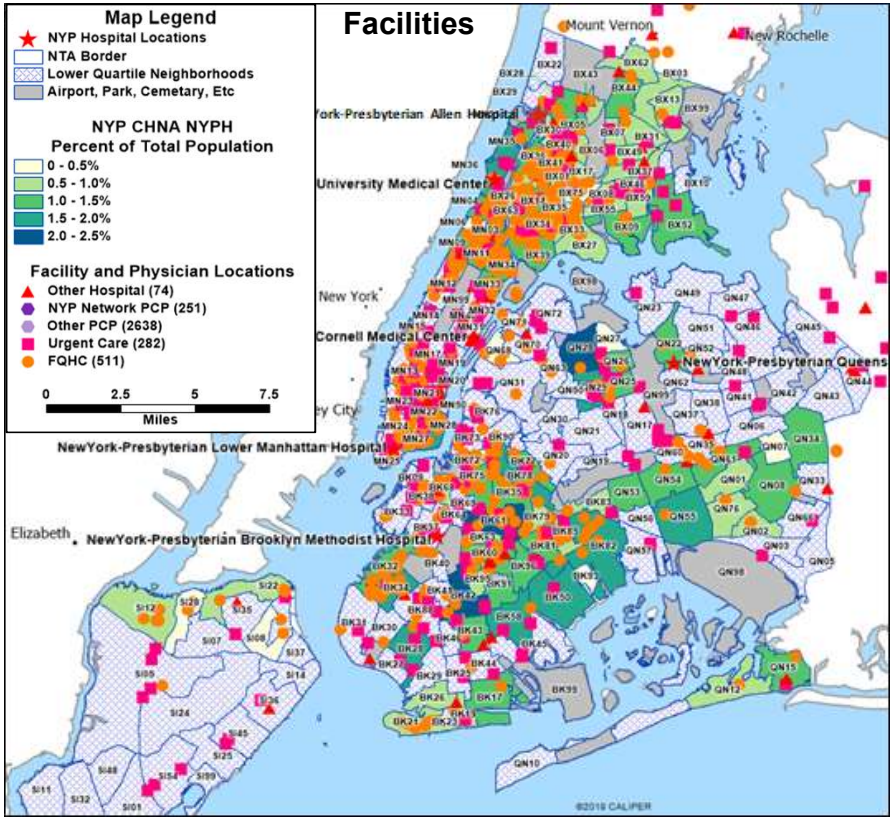
The Neighborhood Tabulation Areas (NTA) identified as Quartiles 3 and 4, for which there is a higher health need and/or a higher risk of required resources, will be evaluated in greater detail.

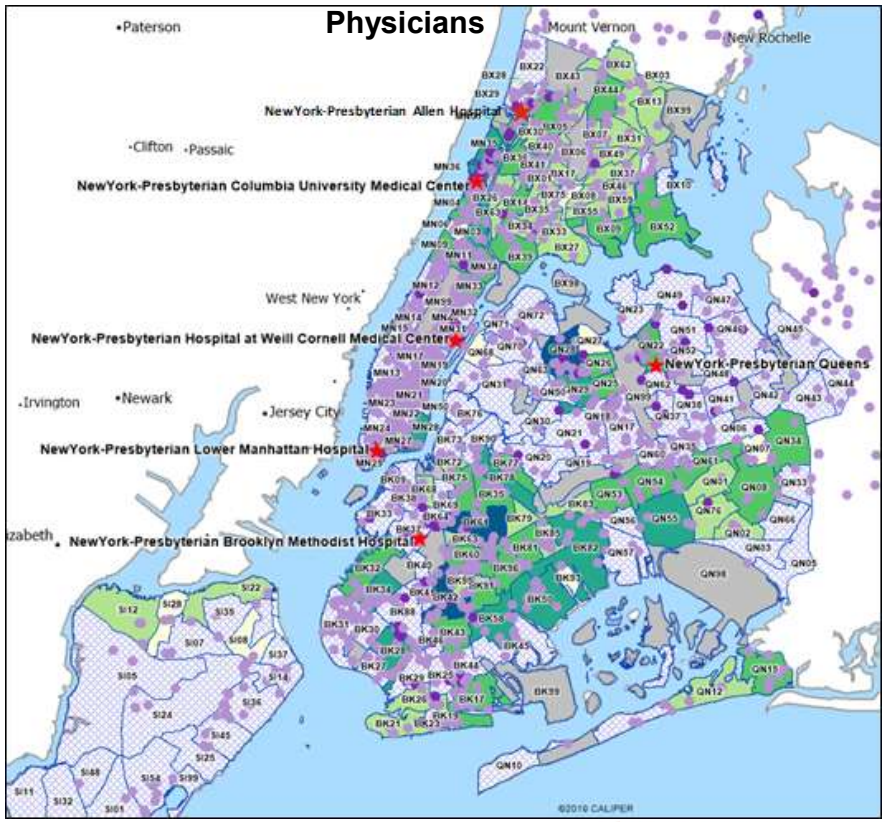
The following indicators have been selected to assess community health needs, to identify health disparities, to utilize in prioritizing the implementation strategies, and to support health intervention planning.

- **Demographics** (population, gender, age cohort, race/ethnicity, foreign born, limited English language, unemployment, disability status, single parent households, etc.)
- **Socioeconomic status** (poverty, Area Median Income (AMI) eligibility for housing financial assistance)
- **Insurance status** (uninsured, Medicaid enrolled)
- **Social Determinants of Health** (housing, food and nutrition, social and safety environment, transportation)
- **Indicators of health** (healthy eating and physical activity, women, infants, and children, well-being & mental health, chronic disease, hospitalizations, and Emergency Department utilization)

Total Population and Key Health Care Providers in the High Disparity NYC Community

- Market saturation of health care providers reflects a composition of Hospitals, NYP network Primary Care providers, non-NYP Primary Care providers, Urgent Care facilities, and Federally Qualified Health Centers (FQHC's) in order to reflect pockets of need to address community access issues.
- Analysis of such saturation or lack of saturation in appropriate providers allows for strategic placement of services to address community needs.





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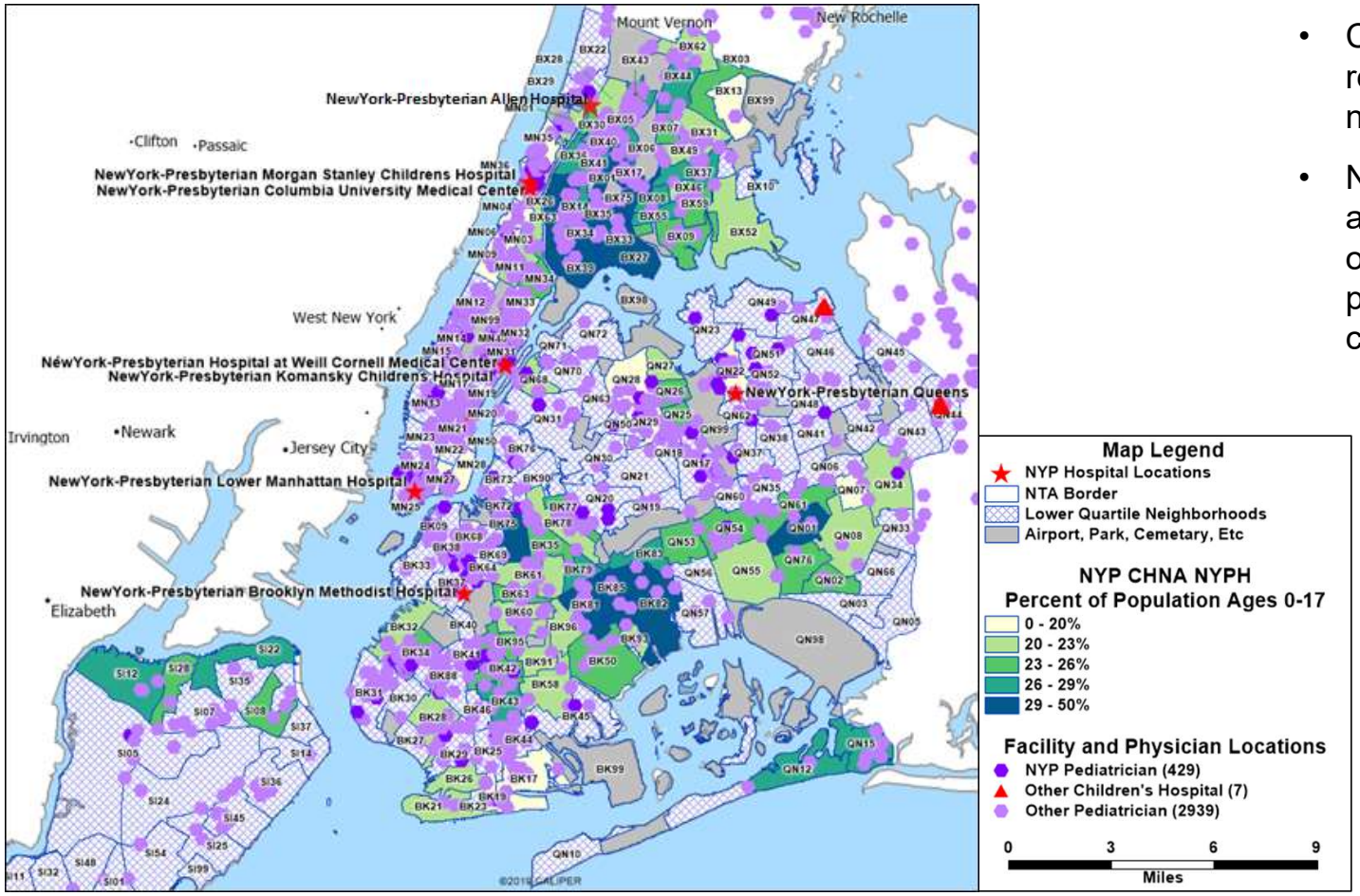
Pediatric Population and Key Health Care Providers in the High Disparity NYC Community



- Community assets are outlined to reflect potential pockets of community need specific pediatric populations.
- NYP and non-NYP pediatric practices are identified to allow for identification of gaps as well as potential partnership arenas to impact the community at large.

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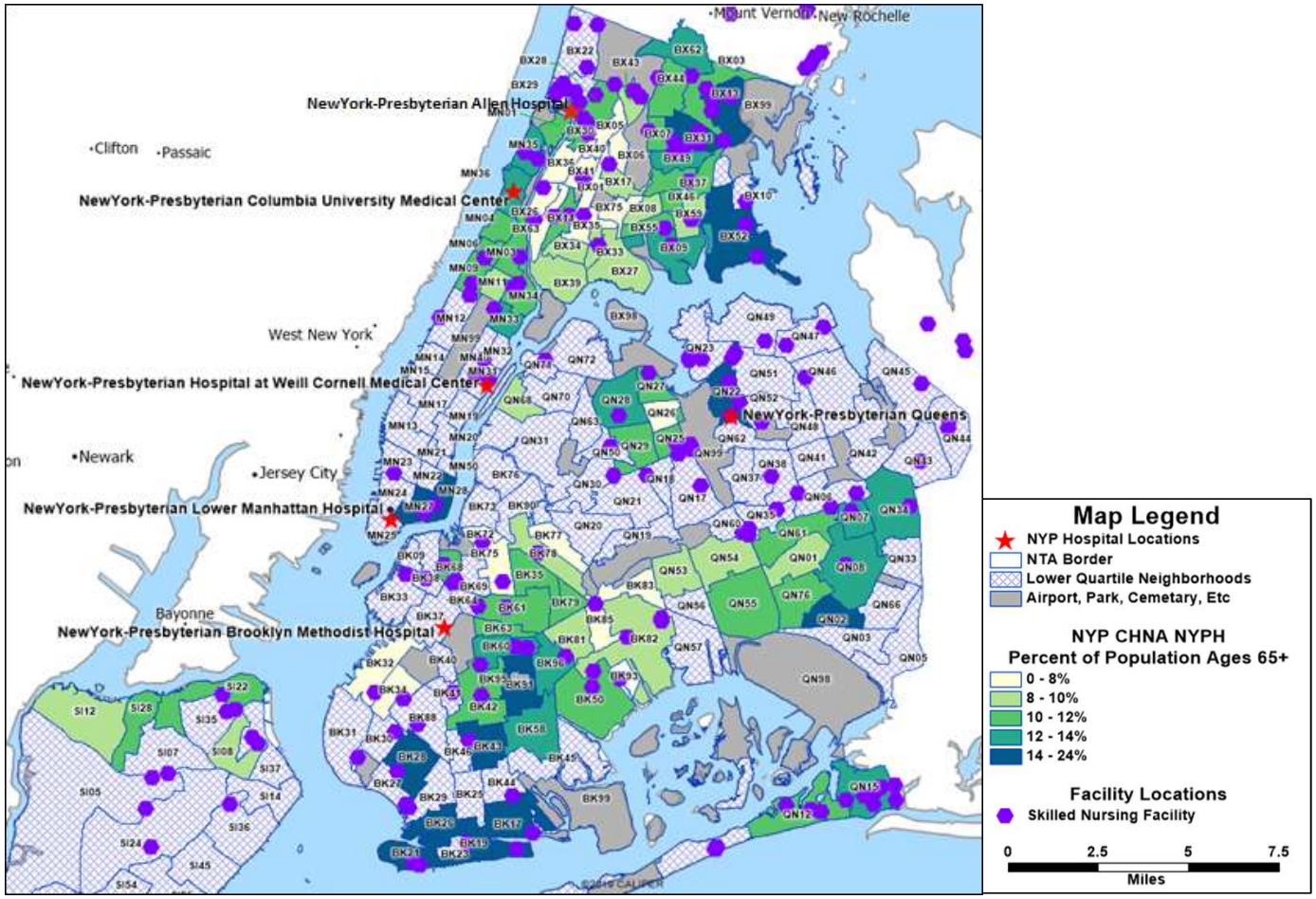
Senior Population and SNFs in the High Disparity NYC Community



- Skilled Nursing Facilities are identified on the map to reflect potential access issues for concentrated senior populations.
- Communities have dispersed providers and SNF's targeting senior populations suggesting areas for focused strategies to impact long-term care and post-acute activity.

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Population Profile of the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Population (Total #)	Percent of female population	Percent of male population	Percent of population ages 0-17	Percent of population ages 18-24	Percent of population ages 25-44	Percent of population ages 45-64	Percent of population ages 65+
East Tremont	43,878	53.4%	46.6%	31.1%	12.4%	27.4%	20.2%	8.8%
Highbridge	38,793	52.7%	47.3%	32.0%	11.7%	27.8%	21.1%	7.4%
Mott Haven-Port Morris	54,487	52.4%	47.6%	31.2%	12.9%	28.4%	19.2%	8.4%
East Concourse-Concourse Village	64,821	53.0%	47.0%	27.0%	12.7%	26.4%	23.0%	10.8%
University Heights-Morris Heights	52,773	54.6%	45.4%	26.9%	13.0%	28.2%	24.4%	7.4%
Claremont-Bathgate	33,205	56.3%	43.7%	33.1%	13.2%	25.7%	20.1%	7.9%
Morrisania-Melrose	39,894	53.7%	46.3%	30.1%	11.5%	27.7%	22.5%	7.9%
Brownsville	61,161	59.2%	40.8%	30.8%	11.5%	27.8%	20.5%	9.4%
Longwood	27,438	52.0%	48.0%	29.8%	12.0%	29.0%	20.9%	8.3%
Crotona Park East	20,756	54.6%	45.4%	31.0%	11.3%	27.0%	22.9%	7.6%
Hunts Point	26,780	51.9%	48.1%	29.2%	13.5%	29.9%	18.6%	9.0%
Fordham South	26,690	55.2%	44.8%	31.9%	12.5%	29.0%	19.7%	6.8%
East New York (Pennsylvania Ave)	30,594	55.2%	44.8%	31.8%	11.5%	27.1%	22.5%	7.2%
Mount Hope	52,999	52.4%	47.6%	28.2%	12.4%	28.2%	24.4%	6.8%
Melrose South-Mott Haven North	40,426	56.1%	43.9%	31.7%	11.8%	28.3%	19.3%	8.9%
East New York	91,139	55.5%	44.5%	29.0%	11.8%	26.6%	23.1%	9.5%
Ocean Hill	32,427	55.6%	44.4%	27.0%	10.6%	28.2%	23.4%	10.9%
Soundview-Bruckner	36,966	51.3%	48.7%	27.4%	11.5%	27.8%	22.6%	10.8%
West Concourse	37,852	52.5%	47.5%	29.0%	11.0%	27.9%	24.7%	7.5%
Bedford Park-Fordham North	53,362	51.5%	48.5%	25.8%	12.0%	30.8%	23.7%	7.8%
Kingsbridge Heights	30,088	53.9%	46.1%	23.7%	11.5%	31.5%	23.0%	10.4%
Belmont	27,395	54.0%	46.0%	27.4%	23.0%	26.9%	15.8%	6.7%
East Harlem North	60,405	54.5%	45.5%	24.6%	12.1%	30.4%	21.4%	11.4%
Stuyvesant Heights	66,124	54.6%	45.4%	23.9%	10.8%	31.0%	23.7%	10.5%
NYPH High Disparity Community	4,798,531	52.8%	47.2%	23.8%	11.2%	29.7%	24.1%	11.2%
New York City	8,354,889	52.4%	47.6%	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	8,354,890	51.4%	48.6%	21.0%	9.3%	27.1%	26.3%	16.3%

Source: NYC Health Data Atlas

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- Age and gender composition help inform an understanding of the community and health service planning.
- In the subset of NewYork-Presbyterian Hospital's neighborhoods that have been identified as high disparity there is a total population of 4,798,531.
- 52.8% of the community is female and 47.2% is male, about the same as the NYC average.
- The population is slightly younger, 11.2% of the population is 65+, compared to NYC, 12.5%.

NewYork-Presbyterian

Population Profile of the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Population (Total #)	Percent of female population	Percent of male population	Percent of population ages 0-17	Percent of population ages 18-24	Percent of population ages 25-44	Percent of population ages 45-64	Percent of population ages 65+
West Farms-Bronx River	36,844	↓ 50.8%	49.2%	↑ 26.7%	10.2%	30.3%	23.7%	↓ 9.0%
Williamsbridge-Olinville	61,934	↑ 54.7%	45.3%	↑ 26.3%	11.8%	26.2%	24.6%	↓ 11.1%
Central Harlem North-Polo Grounds	81,355	↑ 53.9%	46.1%	↑ 21.5%	11.3%	33.1%	24.0%	↓ 10.1%
East Harlem South	58,618	↑ 52.9%	47.1%	↓ 18.7%	12.4%	32.3%	23.7%	↑ 12.9%
Seagate-Coney Island	29,229	↑ 53.1%	46.9%	↑ 22.5%	12.2%	21.2%	24.9%	↑ 19.3%
Norwood	41,804	↑ 53.6%	46.4%	↑ 28.0%	11.1%	31.3%	20.2%	↓ 9.4%
Bushwick South	75,202	↓ 52.2%	47.8%	↑ 22.6%	13.1%	34.5%	20.5%	↓ 9.2%
Soundview-Castle Hill-Clason Point-Ha	55,256	↑ 55.4%	44.6%	↑ 23.5%	11.5%	26.0%	25.5%	↑ 13.4%
Jamaica	54,198	↓ 50.7%	49.3%	↑ 24.0%	9.4%	31.7%	23.6%	↓ 11.3%
Starrett City	12,854	↑ 59.2%	40.8%	↓ 20.2%	9.1%	23.5%	22.8%	↑ 24.4%
Westchester-Unionport	27,952	↑ 52.6%	47.4%	↑ 25.5%	11.8%	29.9%	23.3%	↓ 9.4%
Crown Heights North	103,735	↑ 55.3%	44.7%	↑ 22.4%	10.5%	33.6%	22.5%	↓ 10.9%
Bedford	71,706	↓ 51.7%	48.3%	↑ 30.0%	11.9%	32.3%	18.2%	↓ 7.5%
South Jamaica	44,116	↓ 52.2%	47.8%	↑ 30.7%	12.5%	26.0%	21.7%	↓ 9.1%
Bronxdale	35,587	↓ 50.2%	49.8%	↑ 23.8%	10.5%	29.8%	24.5%	↓ 11.4%
Washington Heights South	89,251	↓ 50.1%	49.9%	↓ 17.4%	12.4%	34.1%	24.0%	↓ 12.1%
Bushwick North	63,458	↓ 49.6%	50.4%	↑ 24.2%	15.2%	36.7%	18.3%	↓ 5.5%
Cypress Hills-City Line	47,199	↓ 52.2%	47.8%	↑ 27.9%	12.4%	29.3%	23.2%	↓ 7.3%
Erasmus	28,357	↑ 54.9%	45.1%	↑ 24.3%	9.6%	29.2%	25.1%	↓ 11.7%
Hamilton Heights	51,644	↓ 51.8%	48.2%	↓ 19.5%	11.4%	35.6%	23.1%	↓ 10.4%
Eastchester-Edenwald-Baychester	35,367	↑ 56.0%	44.0%	↑ 25.7%	11.7%	24.8%	26.2%	↓ 11.4%
Marble Hill-Inwood	51,422	↓ 52.2%	47.8%	↓ 20.9%	10.3%	32.0%	26.6%	↓ 10.2%
Rugby-Remsen Village	55,669	↑ 55.9%	44.1%	↑ 22.5%	10.1%	26.3%	27.3%	↑ 13.9%
Manhattanville	23,155	↑ 52.5%	47.5%	↓ 19.1%	14.2%	33.1%	22.1%	↓ 11.5%
NYPH High Disparity Community	4,798,531	↑ 52.8%	47.2%	↑ 23.8%	11.2%	29.7%	24.1%	↓ 11.2%
New York City	8,354,889	52.4%	47.6%	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	8,354,890	51.4%	48.6%	21.0%	9.3%	27.1%	26.3%	16.3%

Source: NYC Health Data Atlas

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- NTA Quartile 4 continued

NewYork-Presbyterian

Population Profile of the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Population (Total #)	Percent of female population	Percent of male population	Percent of population ages 0-17	Percent of population ages 18-24	Percent of population ages 25-44	Percent of population ages 45-64	Percent of population ages 65+
Lower East Side	74,835	↑ 54.1%	45.9%	↓ 16.4%	9.0%	30.0%	27.4%	↑ 17.2%
Gravesend	28,944	↑ 55.0%	45.0%	↓ 21.1%	8.3%	25.8%	24.2%	↑ 20.6%
Van Cortlandt Village	49,787	↑ 52.5%	47.5%	↑ 22.7%	12.6%	28.4%	25.8%	↓ 10.7%
Prospect Lefferts Gardens-Wingate	69,695	↑ 55.6%	44.4%	↑ 22.0%	9.9%	30.2%	24.3%	↑ 13.7%
Van Nest-Morris Park-Westchester Sq	30,617	↓ 50.8%	49.2%	↑ 27.7%	9.6%	29.2%	23.4%	↓ 10.1%
Hammels-Arverne-Edgemere	36,226	↑ 53.6%	46.4%	↑ 28.8%	9.9%	25.1%	24.7%	↓ 11.4%
Chinatown	45,091	↓ 48.4%	51.6%	↓ 13.9%	8.7%	35.5%	26.3%	↑ 15.5%
Far Rockaway-Bayswater	52,266	↑ 53.3%	46.7%	↑ 28.4%	10.5%	24.8%	22.7%	↑ 13.4%
Central Harlem South	48,596	↑ 54.4%	45.6%	↓ 20.7%	10.6%	34.6%	25.0%	↓ 9.1%
Parkchester	29,368	↑ 52.8%	47.2%	↑ 22.0%	8.5%	30.1%	28.3%	↓ 11.1%
West New Brighton-New Brighton-St.	32,841	↓ 50.7%	49.3%	↑ 28.1%	10.5%	27.3%	24.1%	↓ 10.0%
Sunset Park East	72,622	↓ 49.3%	50.7%	↑ 25.8%	10.3%	33.7%	22.3%	↓ 7.9%
Queensbridge-Ravenswood-Long Islar	18,393	↑ 52.7%	47.3%	↑ 22.2%	12.2%	32.1%	24.5%	↓ 8.9%
Baisley Park	37,155	↑ 53.8%	46.2%	↑ 24.7%	11.0%	27.9%	25.5%	↓ 10.9%
Woodlawn-Wakefield	44,266	↑ 53.0%	47.0%	↑ 22.5%	10.0%	28.4%	26.3%	↑ 12.8%
Allerton-Pelham Gardens	33,848	↓ 52.3%	47.7%	↑ 21.6%	8.9%	26.0%	26.0%	↑ 17.4%
East Flatbush-Farragut	51,723	↑ 56.3%	43.7%	↓ 20.8%	9.8%	27.8%	26.9%	↑ 14.6%
Flatbush	106,012	↑ 54.6%	45.4%	↑ 23.6%	10.3%	31.3%	24.4%	↓ 10.4%
Sunset Park West	56,422	↓ 46.9%	53.1%	↑ 22.8%	11.2%	38.0%	20.3%	↓ 7.6%
Canarsie	87,511	↑ 54.7%	45.3%	↑ 23.2%	11.1%	26.6%	28.5%	↓ 10.5%
Crown Heights South	41,128	↑ 52.8%	47.2%	↑ 24.5%	13.4%	28.2%	23.2%	↓ 10.8%
Pelham Parkway	29,911	↑ 53.5%	46.5%	↑ 22.1%	8.2%	33.0%	22.9%	↑ 13.7%
Washington Heights North	73,704	↓ 49.8%	50.2%	↓ 16.9%	12.5%	31.9%	25.6%	↑ 13.0%
Brighton Beach	33,146	↑ 53.1%	46.9%	↓ 17.6%	7.4%	24.5%	28.4%	↑ 22.1%
Hollis	21,294	↑ 54.0%	46.0%	↓ 19.0%	11.5%	26.2%	30.1%	↑ 13.1%
NYPH High Disparity Community	4,798,531	↑ 52.8%	47.2%	↑ 23.8%	11.2%	29.7%	24.1%	↓ 11.2%
New York City	8,354,889	52.4%	47.6%	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	8,354,890	51.4%	48.6%	21.0%	9.3%	27.1%	26.3%	16.3%

- NTA Quartile 3

Source: NYC Health Data Atlas

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NewYork-Presbyterian

Population Profile of the High Disparity NYC Communities

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Springfield Gardens North	27,396	↑ 59.3%	40.7%	↑ 23.3%	9.5%	26.8%	26.0%	↑ 14.4%
St. Albans	53,797	↑ 54.7%	45.3%	↑ 22.7%	10.2%	25.9%	28.3%	↑ 12.8%
Corona	57,150	↓ 48.3%	51.7%	↑ 24.6%	10.1%	33.0%	22.0%	↓ 10.4%
East Elmhurst	22,716	↓ 47.4%	52.6%	↑ 21.6%	11.1%	34.2%	22.8%	↓ 10.3%
Mariner's Harbor-Arlington-Port Ivory-	30,042	↑ 53.1%	46.9%	↑ 27.0%	11.3%	27.5%	25.9%	↓ 8.3%
Williamsburg	32,094	↓ 49.0%	51.0%	↑ 46.9%	10.5%	19.6%	15.4%	↓ 7.6%
Fort Greene	28,721	↑ 54.3%	45.7%	↓ 18.0%	11.4%	37.9%	20.7%	↓ 11.9%
Jackson Heights	105,083	↓ 49.8%	50.2%	↓ 19.0%	9.7%	31.9%	26.5%	↑ 12.8%
Midwood	52,519	↓ 51.2%	48.8%	↑ 26.1%	10.3%	24.7%	24.6%	↑ 14.2%
South Ozone Park	83,286	↓ 51.5%	48.5%	↑ 21.9%	11.2%	28.4%	27.9%	↓ 10.5%
Flushing	70,193	↑ 53.3%	46.7%	↓ 14.8%	8.5%	29.5%	30.6%	↑ 16.6%
Flatlands	72,864	↑ 53.6%	46.4%	↑ 22.3%	11.3%	25.6%	28.5%	→ 12.5%
Schuylerville-Throgs Neck-Edgewater	49,311	↓ 51.4%	48.6%	↑ 21.9%	11.5%	26.6%	25.0%	↑ 15.2%
Richmond Hill	64,049	↓ 51.0%	49.0%	↑ 23.4%	11.2%	29.9%	26.5%	↓ 9.0%
North Corona	53,290	↓ 44.3%	55.7%	↑ 25.3%	11.5%	40.9%	16.6%	↓ 5.6%
Sheepshead Bay-Gerritsen Beach-Man	63,459	↑ 53.6%	46.4%	↓ 19.1%	7.4%	25.3%	29.7%	↑ 18.6%
Co-op City	47,442	↑ 55.4%	44.6%	↓ 16.9%	9.3%	22.0%	30.6%	↑ 21.2%
Woodhaven	61,278	↓ 50.9%	49.1%	↑ 24.7%	11.2%	30.0%	25.3%	↓ 8.7%
Grymes Hill-Clifton-Fox Hills	22,484	↑ 55.9%	44.1%	↑ 25.3%	16.4%	27.1%	21.3%	↓ 9.9%
Queens Village	56,705	→ 52.4%	47.6%	↓ 20.4%	10.0%	27.9%	28.9%	↑ 12.8%
Elmhurst	87,373	↓ 48.0%	52.0%	↓ 19.5%	9.4%	35.9%	24.5%	↓ 10.8%
Bensonhurst West	90,834	↓ 51.3%	48.7%	↓ 21.0%	8.6%	29.6%	26.0%	↑ 14.8%
Morningside Heights	55,450	↑ 55.1%	44.9%	↓ 11.8%	26.2%	30.4%	20.3%	↓ 11.3%
Port Richmond	19,229	↓ 50.9%	49.1%	↑ 24.7%	9.9%	28.9%	25.6%	↓ 10.9%
NYPH High Disparity Community	4,798,531	↑ 52.8%	47.2%	↑ 23.8%	11.2%	29.7%	24.1%	↓ 11.2%
New York City	8,354,889	52.4%	47.6%	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	8,354,890	51.4%	48.6%	21.0%	9.3%	27.1%	26.3%	16.3%

Source: NYC Health Data Atlas

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- NTA Quartile 3 continued

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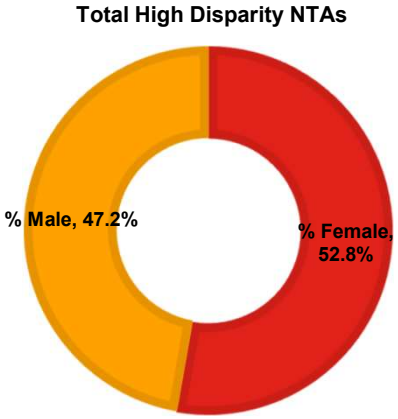
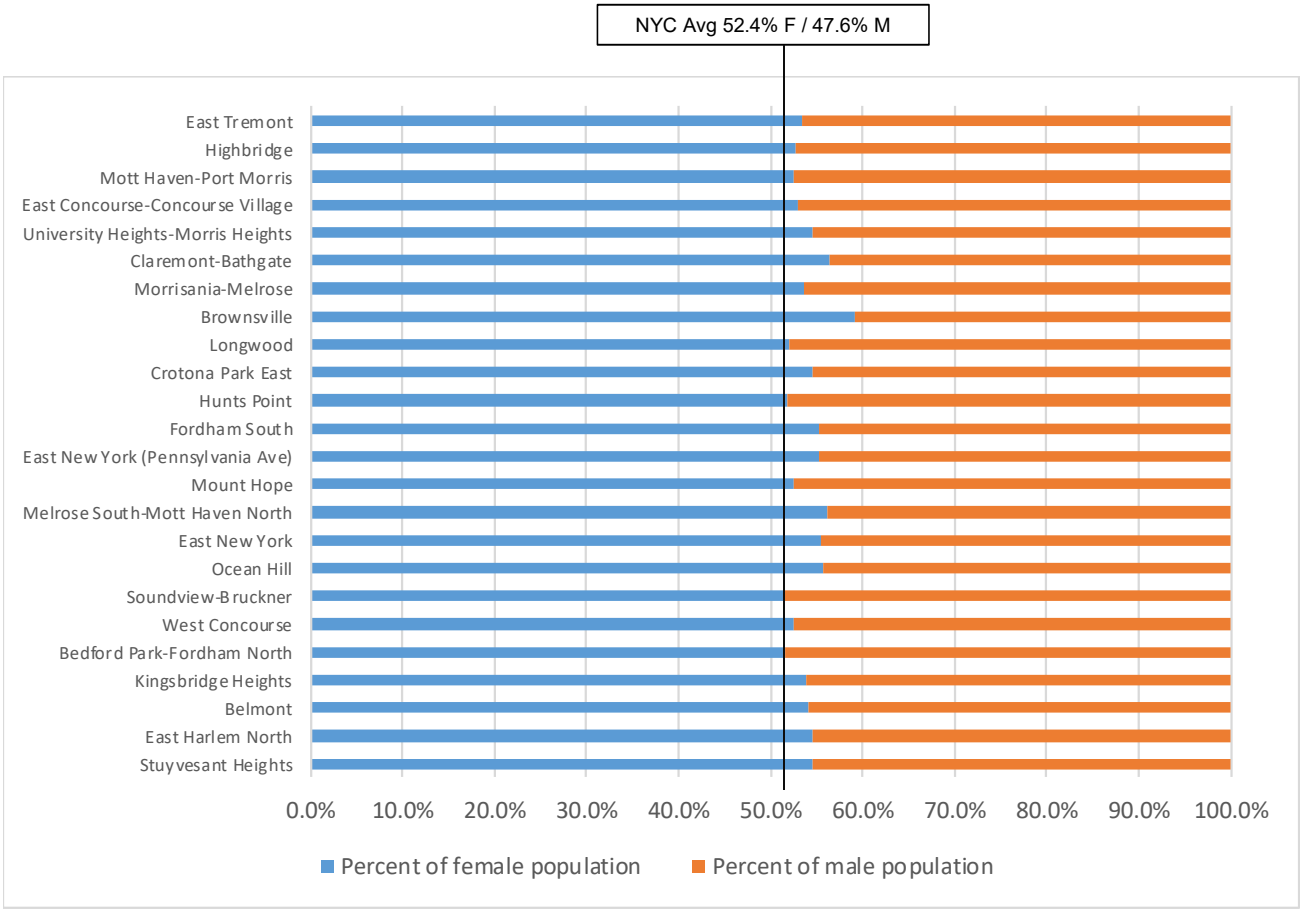
Population by Gender, High Disparity NYC Communities



	% Female	% Male
NYPH High Disparity Community	52.8%	47.2%
New York City	52.4%	47.6%
New York State	51.4%	48.6%

Source: NYC Health Data Atlas

- 52.8% of the community is female and 47.2% is male, about the same as the NYC average.
- There are several neighborhoods with a higher female % than NYC average, particularly Springfield Gardens North 59.3%, Starrett City 59.2%, and Brownsville 59.2%.



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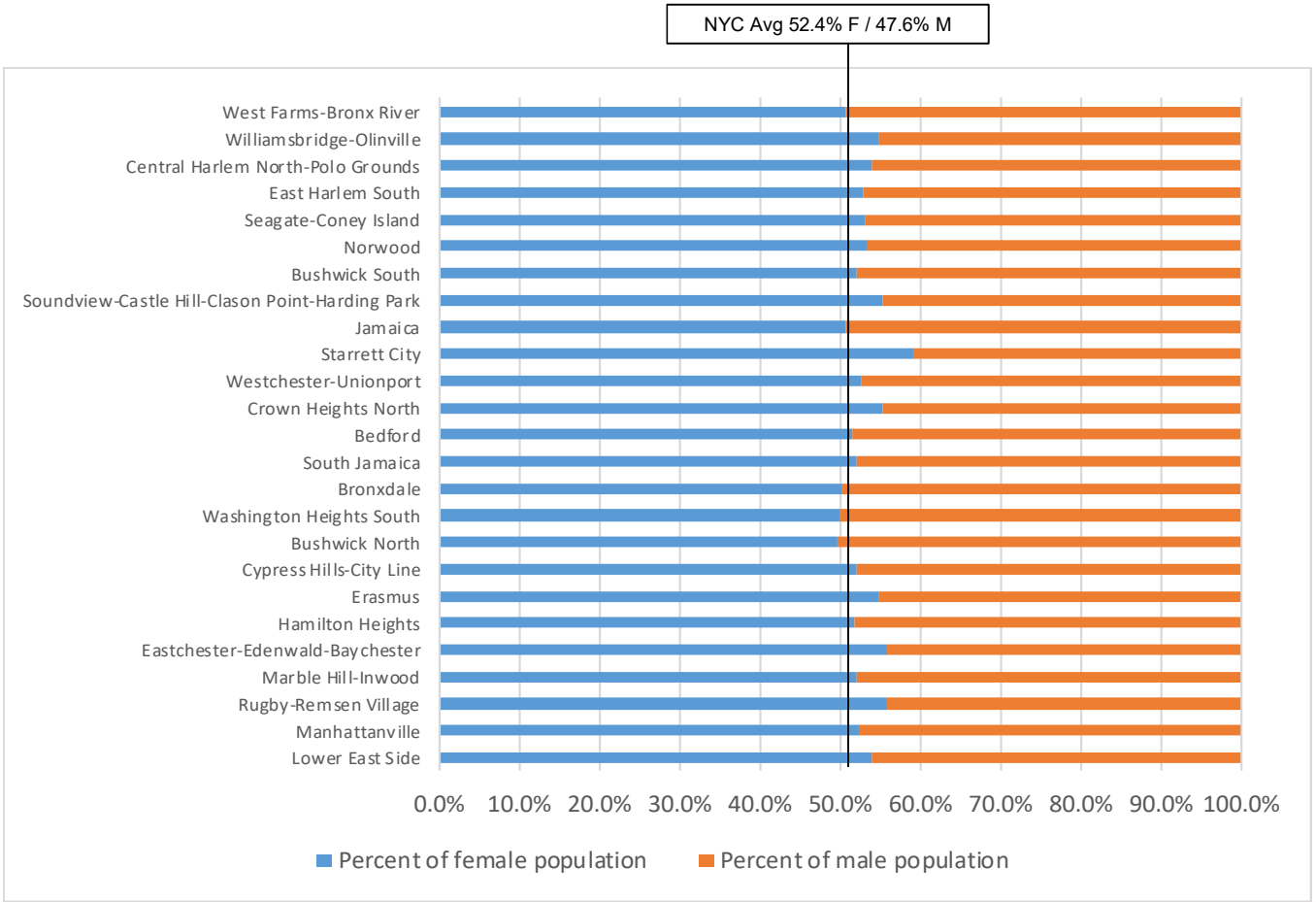
Population by Gender, High Disparity NYC Communities, continued

- NTA Quartile 4 continued



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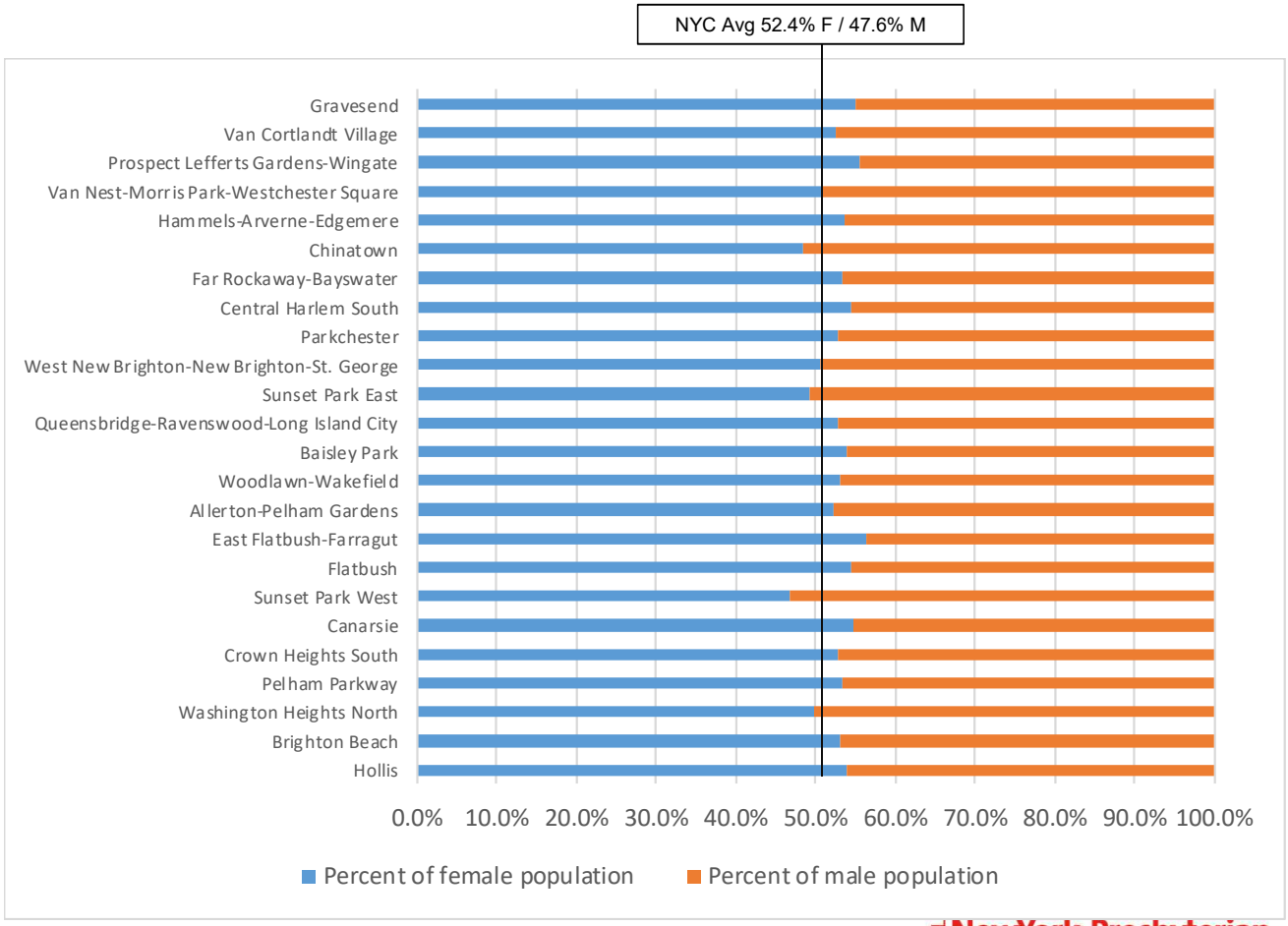
Population by Gender, High Disparity NYC Communities, continued

- NTA Quartile 3



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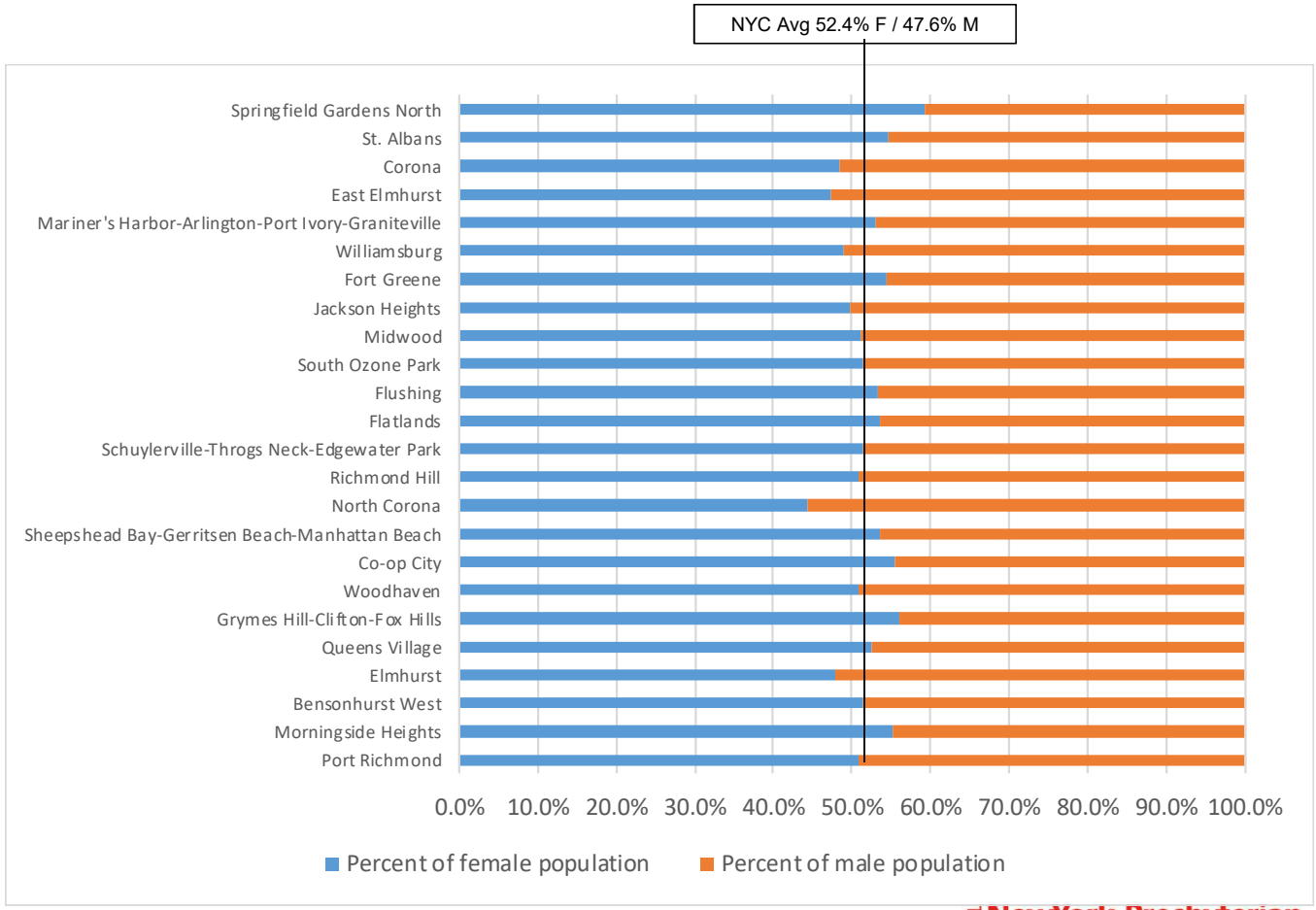
Population by Gender, High Disparity NYC Communities, continued

- NTA Quartile 3 continued



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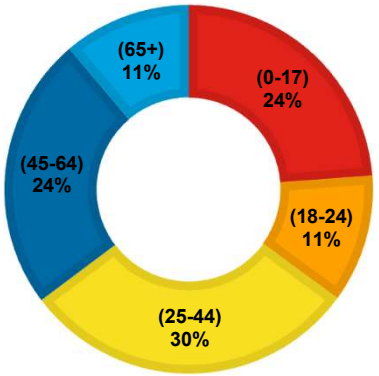
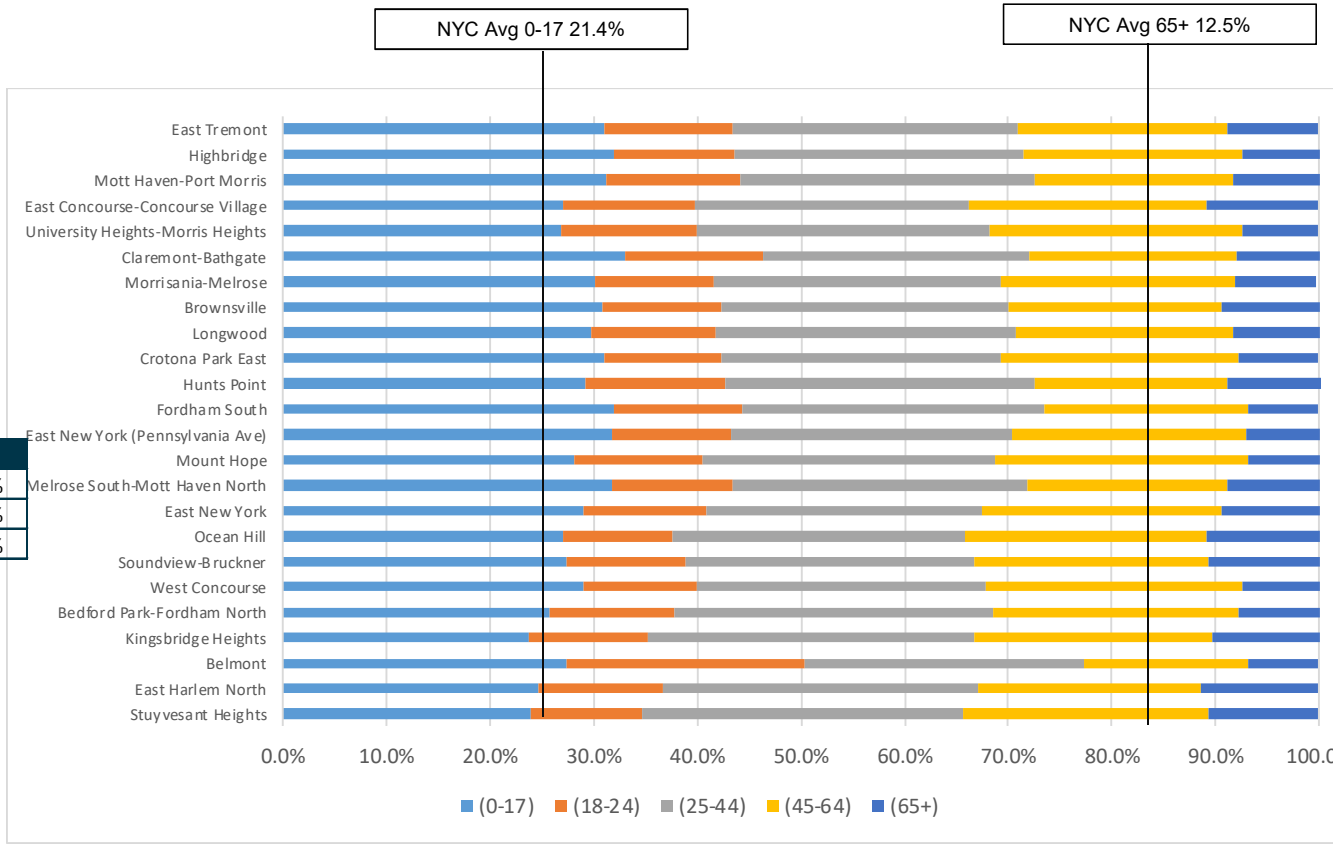
Population by Age Cohort, High Disparity NYC Communities



	(0-17)	(18-24)	(25-44)	(45-64)	(65+)
NYPH High Disparity Community	23.8%	11.2%	29.7%	24.1%	11.2%
New York City	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	21.0%	9.3%	27.1%	26.3%	16.3%

Source: NYC Health Data Atlas



- The population is slightly younger when compared to NYC, in particular Williamsburg 46.9%.
- There are more seniors than NYC average in several NTAs, but among the highest is Starrett City 24.4%, Brighton Beach 22.1% and Co-op City 21.2%.

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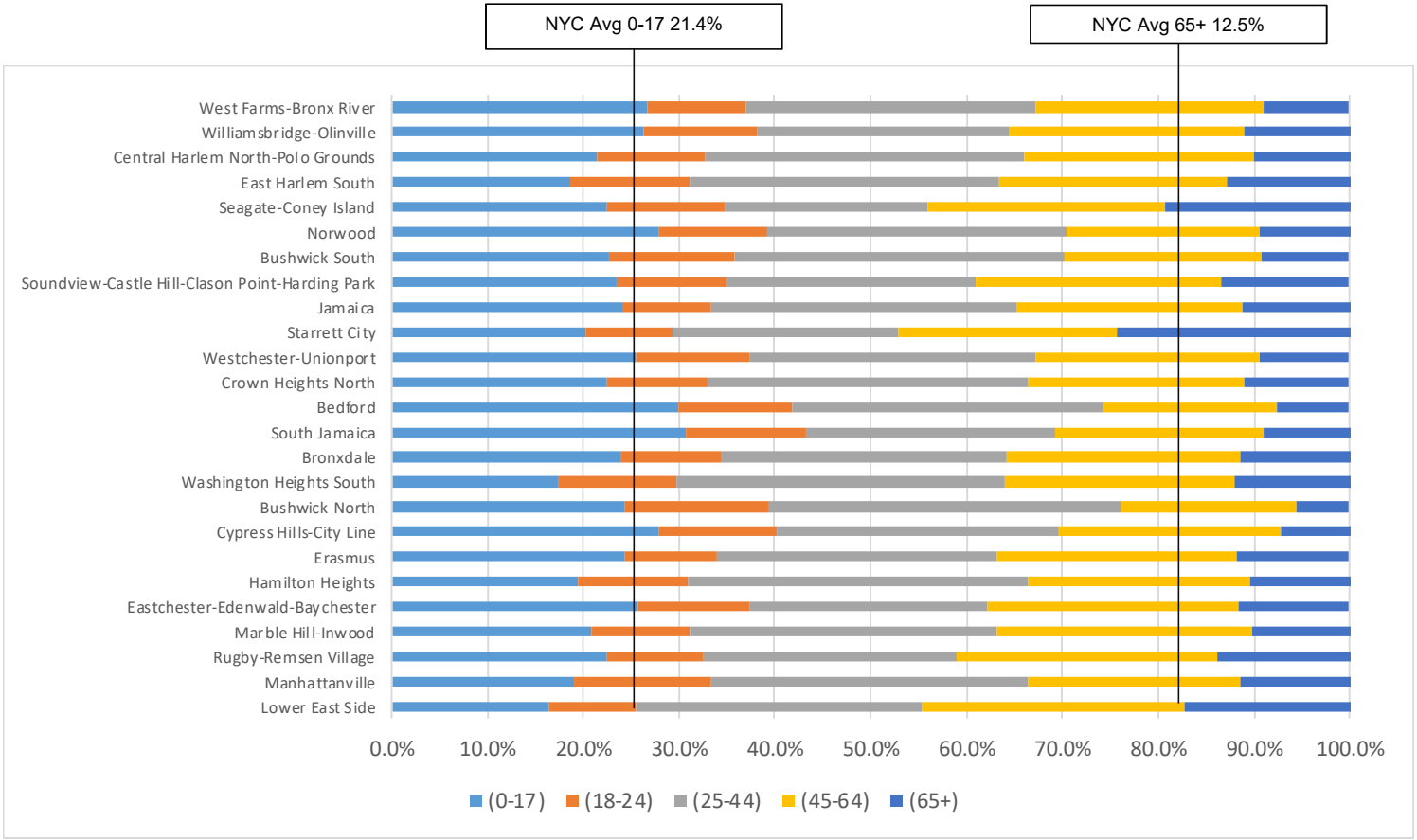
Population by Age Cohort, High Disparity NYC Communities, continued

- NTA Quartile 4 continued



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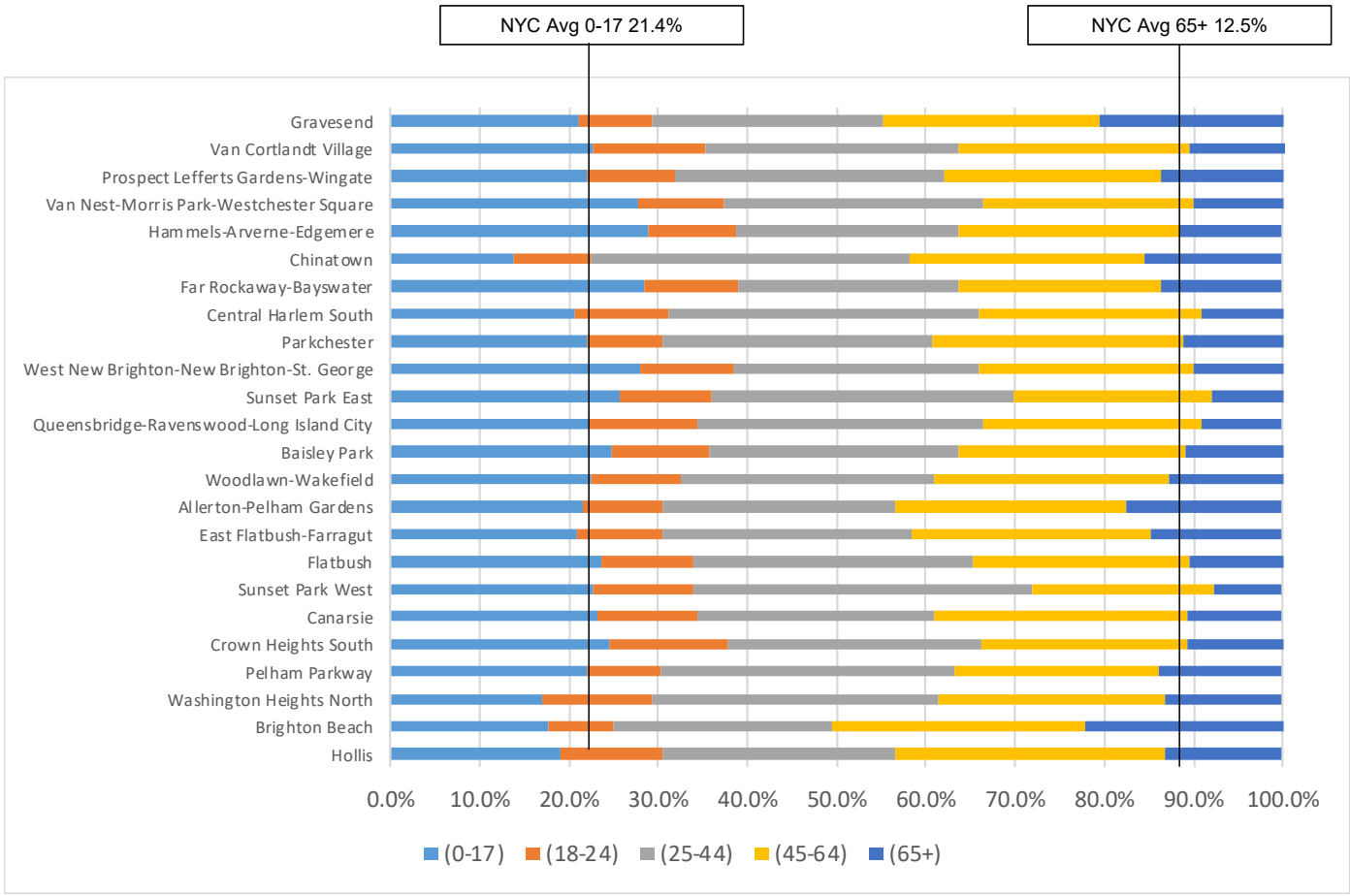
Population by Age Cohort, High Disparity NYC Communities, continued

- NTA Quartile 3



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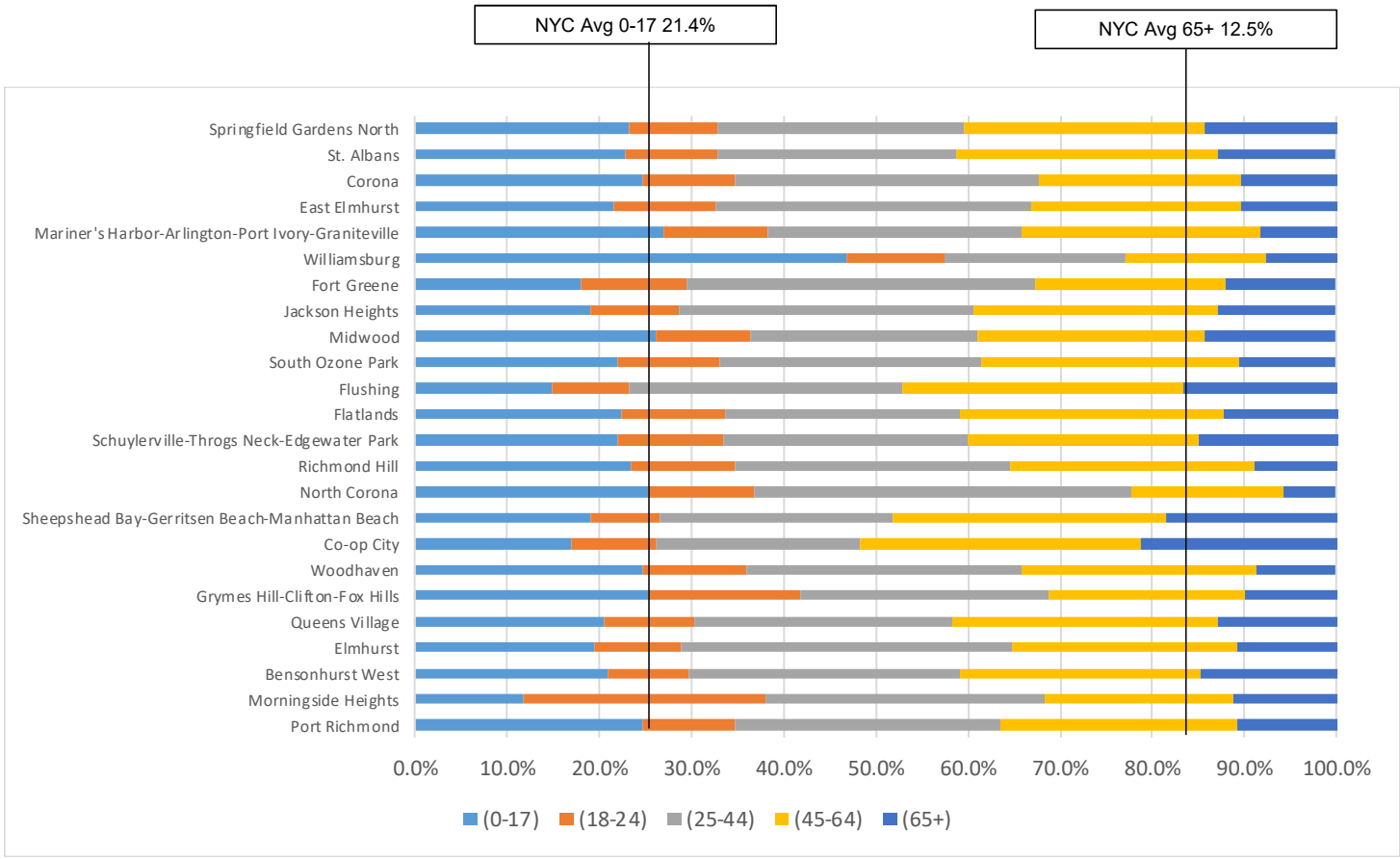
Population by Age Cohort, High Disparity NYC Communities, continued

- NTA Quartile 3 continued



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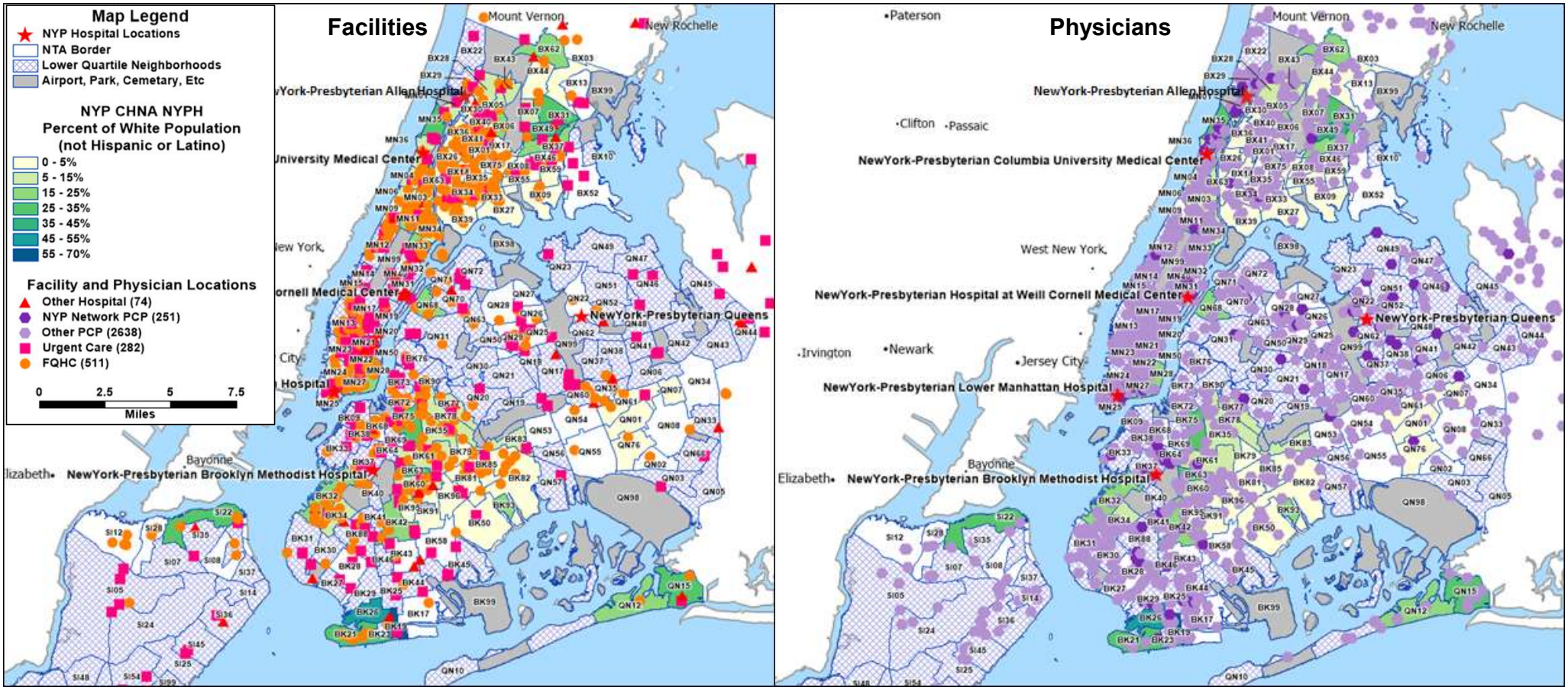
Population by Race / Ethnicity – White and Key Health Care Providers in the High Disparity Communities



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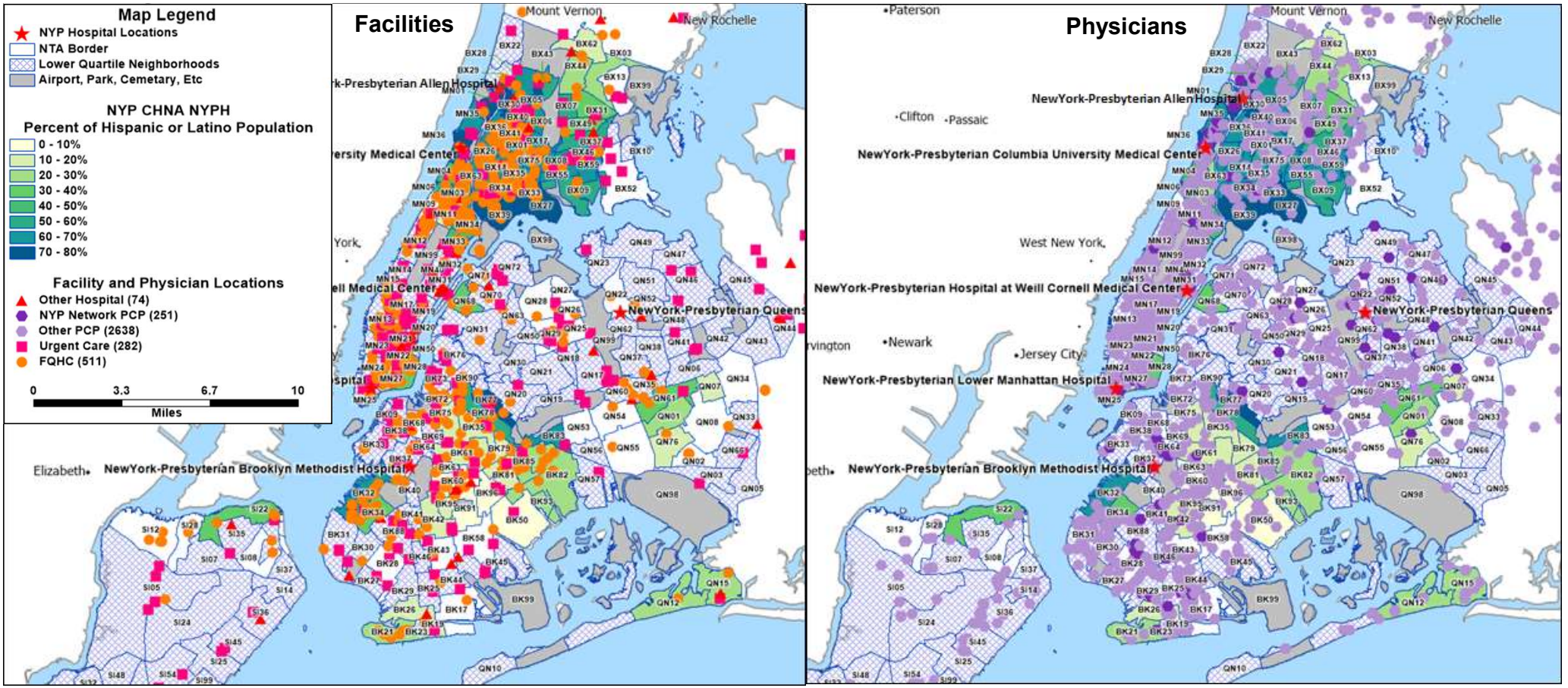
Population by Race / Ethnicity – Hispanic/Latino and Key Health Care Providers in the High Disparity Communities



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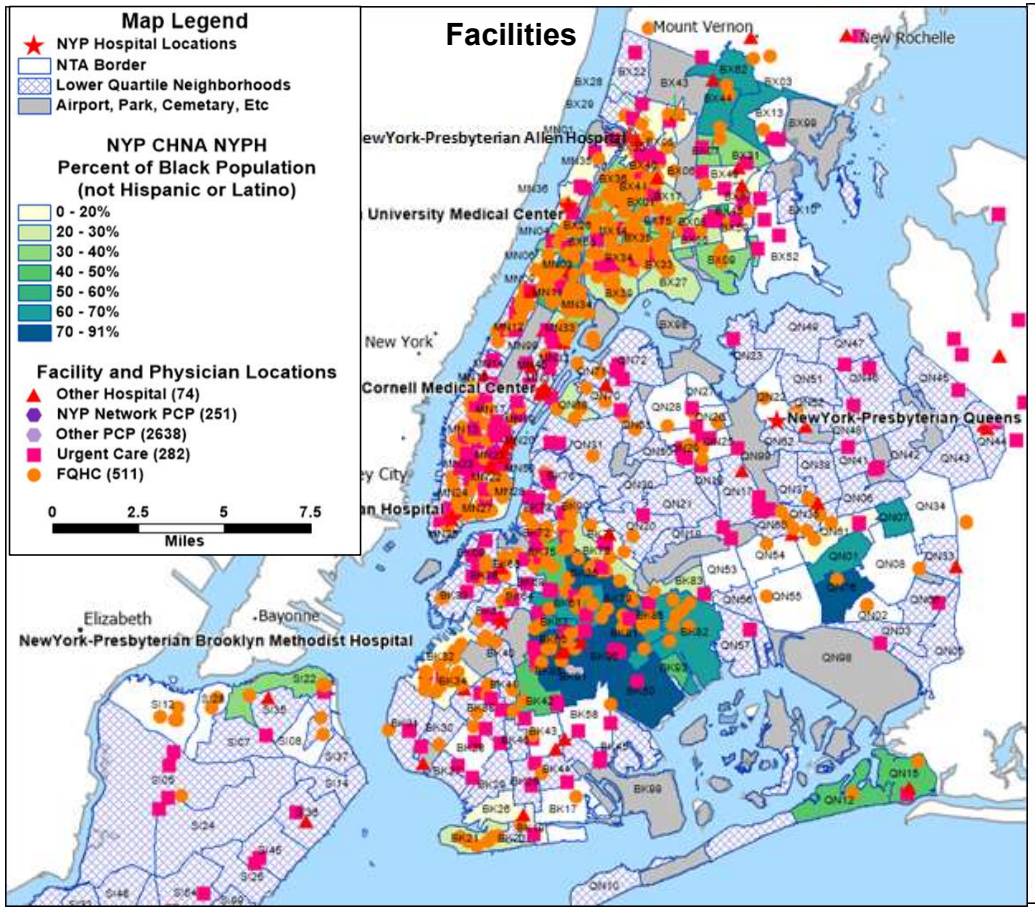
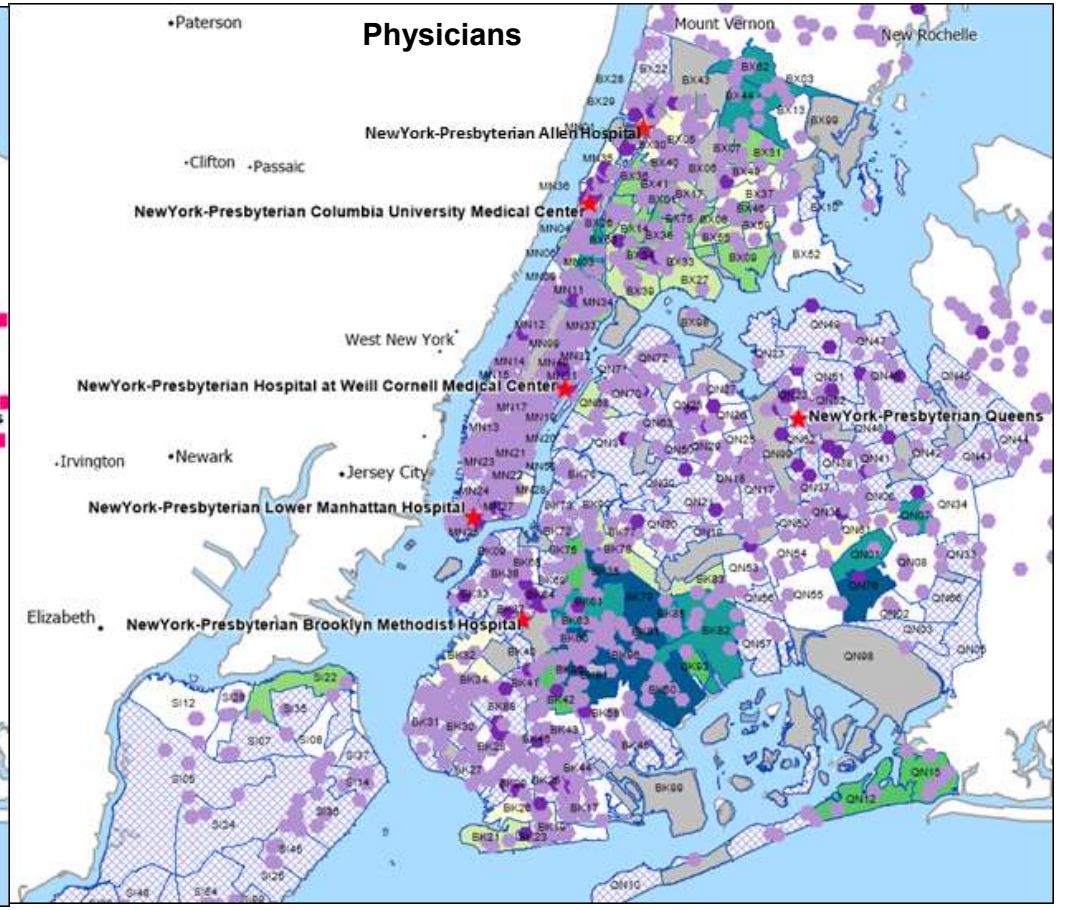
Population by Race / Ethnicity – Black and Key Health Care Providers in the High Disparity Communities





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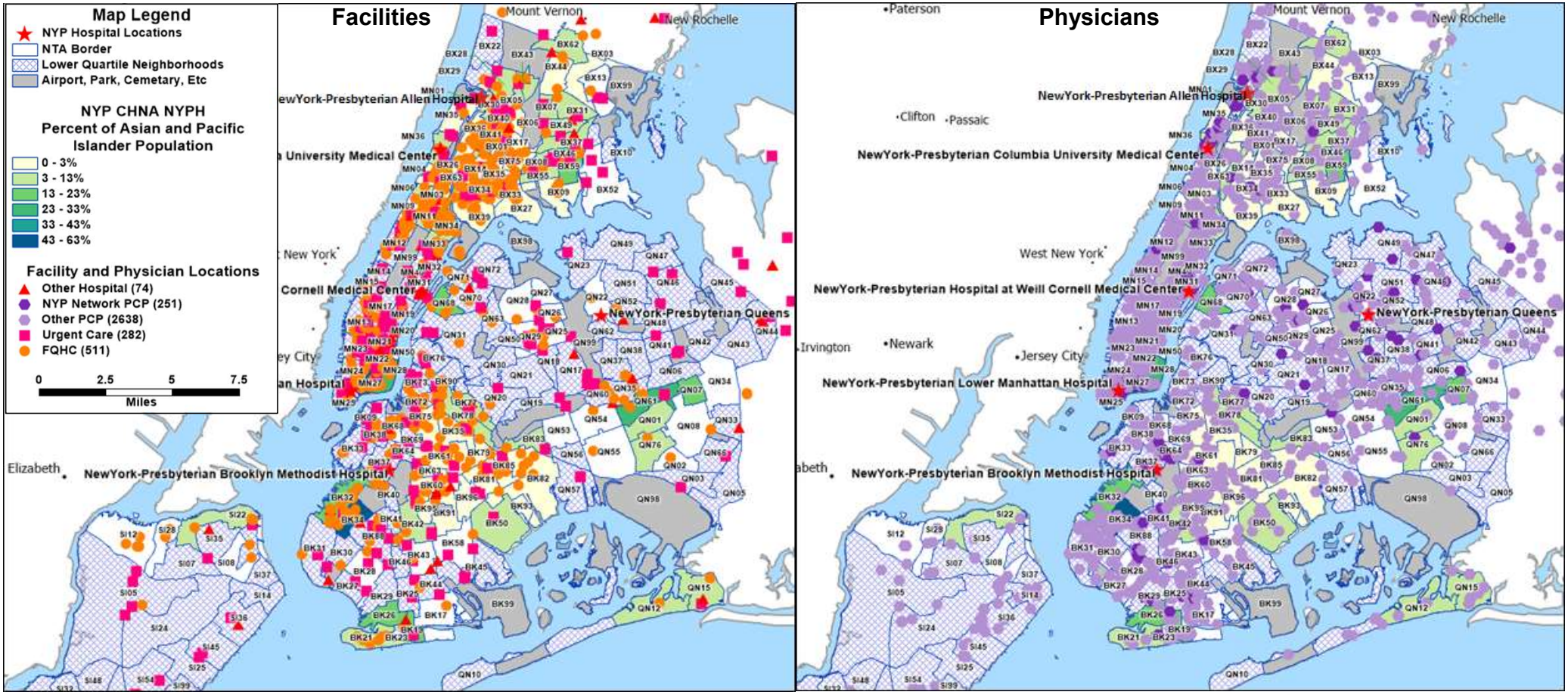
Population by Race / Ethnicity – Asian/ Pacific Islander and Key Health Care Providers in the High Disparity Communities



NewYork-Presbyterian

Race / Ethnicity Profile of the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Percent of Hispanic or Latino population (any race)	Percent of White population (not Hispanic or Latino)	Percent of Black population (not Hispanic or Latino)	Percent of Asian and Pacific Islander population	Percent of all other race population
East Tremont	69.5%	1.6%	26.9%	1.0%	1.0%
Highbridge	65.0%	1.5%	32.5%	0.4%	0.6%
Mott Haven-Port Morris	71.9%	1.3%	25.3%	0.8%	0.7%
East Concourse-Concourse Village	61.3%	1.4%	34.2%	1.3%	1.8%
University Heights-Morris Heights	65.4%	1.3%	30.0%	1.7%	1.7%
Claremont-Bathgate	55.4%	1.0%	42.4%	0.0%	1.2%
Morrisania-Melrose	61.0%	1.3%	35.5%	0.5%	1.7%
Brownsville	18.7%	0.9%	78.2%	0.9%	1.2%
Longwood	74.5%	1.3%	22.6%	1.0%	0.6%
Crotona Park East	67.3%	1.0%	30.0%	0.7%	1.0%
Hunts Point	74.0%	1.0%	23.3%	0.4%	1.3%
Fordham South	70.8%	1.5%	26.1%	0.8%	0.7%
East New York (Pennsylvania Ave)	28.1%	1.7%	69.1%	0.7%	0.5%
Mount Hope	69.3%	1.6%	26.3%	1.2%	1.6%
Melrose South-Mott Haven North	64.5%	2.0%	31.5%	0.6%	1.4%
East New York	27.0%	1.8%	67.8%	2.1%	1.4%
Ocean Hill	16.9%	2.2%	78.2%	1.7%	1.1%
Soundview-Bruckner	62.2%	2.1%	24.0%	7.1%	4.6%
West Concourse	69.1%	1.2%	24.4%	3.0%	2.1%
Bedford Park-Fordham North	71.7%	7.0%	15.7%	4.2%	1.4%
Kingsbridge Heights	71.9%	2.6%	19.1%	5.1%	1.4%
Belmont	60.3%	21.1%	15.1%	1.7%	1.8%
East Harlem North	49.7%	8.3%	35.3%	4.5%	2.2%
Stuyvesant Heights	19.5%	5.8%	70.9%	2.3%	1.4%
NYPH High Disparity Community	38.0%	14.5%	34.2%	10.5%	2.9%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: NYC Health Data Atlas

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- Race/ethnicity composition can also help inform an understanding of the community and health service needs as well as potential cultural norms to consider in outreach and care delivery.
- Overall, the NYPH community has a much higher minority population at 85.5% than does the NYC average 67%.
- Hispanic/Latinos comprise 38.0% of the population, Blacks 34.2% and Asian/Pacific Islanders, 10.5%.
- Three NTAs have less than 1% White population (majority Black) - South Jamaica, Brownsville and Baisley Park.

NewYork-Presbyterian

Race / Ethnicity Profile of the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of Hispanic or Latino population (any race)	Percent of White population (not Hispanic or Latino)	Percent of Black population (not Hispanic or Latino)	Percent of Asian and Pacific Islander population	Percent of all other race population
West Farms-Bronx River	66.2%	2.3%	24.6%	4.4%	2.5%
Williamsbridge-Olinville	24.8%	2.5%	68.8%	1.3%	2.6%
Central Harlem North-Polo Grounds	23.8%	7.9%	62.3%	2.9%	3.0%
East Harlem South	42.8%	19.5%	24.9%	10.5%	2.4%
Seagate-Coney Island	24.9%	32.0%	29.8%	11.6%	1.8%
Norwood	57.6%	11.2%	17.4%	11.4%	2.3%
Bushwick South	59.0%	11.6%	25.0%	3.0%	1.4%
Soundview-Castle Hill-Clason Point-Ha	58.1%	1.7%	36.6%	1.9%	1.8%
Jamaica	36.9%	3.8%	18.6%	30.2%	10.6%
Starrett City	21.8%	24.8%	49.1%	2.8%	1.5%
Westchester-Unionport	62.2%	4.8%	15.7%	14.0%	3.3%
Crown Heights North	12.1%	12.8%	69.9%	2.7%	2.4%
Bedford	19.3%	30.6%	45.4%	2.7%	2.0%
South Jamaica	24.9%	0.5%	61.7%	6.1%	6.8%
Bronxdale	51.3%	11.9%	30.4%	4.6%	2.0%
Washington Heights South	72.0%	11.9%	11.1%	3.0%	2.1%
Bushwick North	71.7%	12.1%	9.5%	6.0%	0.8%
Cypress Hills-City Line	60.4%	5.0%	25.9%	6.4%	2.4%
Erasmus	11.0%	1.4%	84.2%	1.6%	1.8%
Hamilton Heights	48.0%	14.2%	31.8%	2.1%	3.9%
Eastchester-Edenwald-Baychester	24.2%	3.6%	68.8%	1.8%	1.7%
Marble Hill-Inwood	76.0%	13.8%	7.1%	1.5%	1.5%
Rugby-Remsen Village	5.6%	1.3%	90.6%	0.9%	1.6%
Manhattanville	56.7%	9.7%	28.0%	3.1%	2.5%
NYPH High Disparity Community	38.0%	14.5%	34.2%	10.5%	2.9%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

- NTA Quartile 4 continued

Source: NYC Health Data Atlas

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

NewYork-Presbyterian

Race / Ethnicity Profile of the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of Hispanic or Latino population (any race)	Percent of White population (not Hispanic or Latino)	Percent of Black population (not Hispanic or Latino)	Percent of Asian and Pacific Islander population	Percent of all other race population
Lower East Side	39.3%	22.5%	9.4%	25.4%	3.3%
Gravesend	13.9%	52.5%	9.1%	22.9%	1.6%
Van Cortlandt Village	65.2%	9.7%	19.6%	3.5%	2.0%
Prospect Lefferts Gardens-Wingate	9.6%	11.7%	74.2%	2.2%	2.3%
Van Nest-Morris Park-Westchester Squ	55.6%	24.0%	10.1%	8.5%	1.8%
Hammels-Arverne-Edgemere	25.1%	17.6%	49.7%	4.1%	3.5%
Chinatown	13.6%	16.7%	4.1%	61.8%	3.8%
Far Rockaway-Bayswater	27.8%	25.2%	42.0%	3.0%	2.1%
Central Harlem South	19.7%	18.7%	54.9%	4.2%	2.6%
Parkchester	35.4%	2.5%	47.1%	12.7%	2.3%
West New Brighton-New Brighton-St. G	31.5%	25.1%	35.4%	3.8%	4.1%
Sunset Park East	33.6%	11.8%	1.4%	51.6%	1.6%
Queensbridge-Ravenswood-Long Islan	39.1%	16.6%	23.7%	17.6%	2.9%
Baisley Park	13.1%	0.9%	72.7%	5.0%	8.3%
Woodlawn-Wakefield	18.0%	16.3%	60.1%	3.4%	2.1%
Allerton-Pelham Gardens	31.4%	26.0%	31.3%	8.5%	2.8%
East Flatbush-Farragut	5.8%	1.8%	89.1%	1.5%	1.7%
Flatbush	17.7%	22.2%	47.5%	9.8%	2.8%
Sunset Park West	64.1%	17.2%	3.3%	13.8%	1.4%
Canarsie	7.9%	4.9%	82.5%	3.0%	1.7%
Crown Heights South	8.2%	26.4%	62.5%	1.2%	1.5%
Pelham Parkway	38.5%	37.0%	11.9%	11.3%	1.3%
Washington Heights North	65.7%	25.3%	4.9%	2.6%	1.5%
Brighton Beach	12.4%	68.7%	1.3%	15.2%	2.3%
Hollis	10.5%	2.5%	63.9%	15.7%	7.5%
NYPH High Disparity Community	38.0%	14.5%	34.2%	10.5%	2.9%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: NYC Health Data Atlas

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- NTA Quartile 3

Race / Ethnicity Profile of the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of Hispanic or Latino population (any race)	Percent of White population (not Hispanic or Latino)	Percent of Black population (not Hispanic or Latino)	Percent of Asian and Pacific Islander population	Percent of all other race population
Springfield Gardens North	12.2%	1.2%	84.3%	1.3%	0.8%
St. Albans	7.0%	1.0%	88.1%	1.7%	2.2%
Corona	59.6%	8.3%	17.6%	13.7%	0.8%
East Elmhurst	62.4%	4.9%	24.4%	6.9%	1.4%
Mariner's Harbor-Arlington-Port Ivory-(	36.9%	23.4%	29.4%	8.7%	1.5%
Williamsburg	11.0%	85.4%	3.1%	0.1%	0.5%
Fort Greene	21.5%	28.2%	37.8%	8.8%	3.6%
Jackson Heights	55.3%	16.1%	1.8%	24.0%	2.8%
Midwood	7.5%	76.1%	4.4%	10.6%	1.4%
South Ozone Park	20.8%	5.9%	22.9%	24.0%	26.5%
Flushing	15.1%	8.9%	3.8%	68.8%	3.5%
Flatlands	7.9%	16.5%	70.3%	3.7%	1.6%
Schuylerville-Throgs Neck-Edgewater F	41.5%	43.3%	8.8%	3.7%	2.8%
Richmond Hill	35.0%	11.1%	8.5%	30.8%	14.5%
North Corona	86.9%	1.0%	4.2%	7.2%	0.7%
Sheepshead Bay-Gerritsen Beach-Manh	7.1%	69.7%	6.8%	15.4%	1.0%
Co-op City	30.2%	8.0%	58.9%	0.7%	2.2%
Woodhaven	53.1%	15.2%	4.8%	23.9%	3.0%
Grymes Hill-Clifton-Fox Hills	28.8%	27.7%	29.4%	10.8%	3.2%
Queens Village	17.6%	6.2%	49.3%	17.0%	10.0%
Elmhurst	44.3%	6.3%	1.4%	45.9%	2.1%
Bensonhurst West	15.1%	44.9%	0.7%	38.1%	1.2%
Morningside Heights	22.1%	47.7%	11.5%	15.2%	3.5%
Port Richmond	31.3%	43.2%	17.4%	5.3%	2.9%
NYPH High Disparity Community	38.0%	14.5%	34.2%	10.5%	2.9%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: NYC Health Data Atlas

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- NTA Quartile 3 continued

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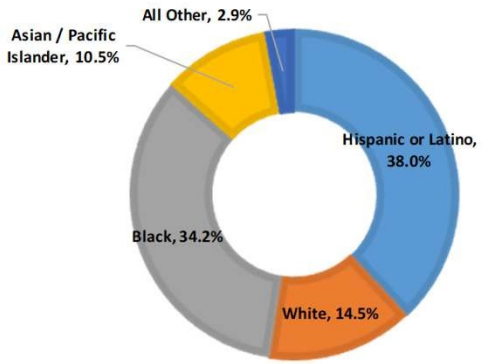
Population by Race / Ethnicity, High Disparity NYC Communities

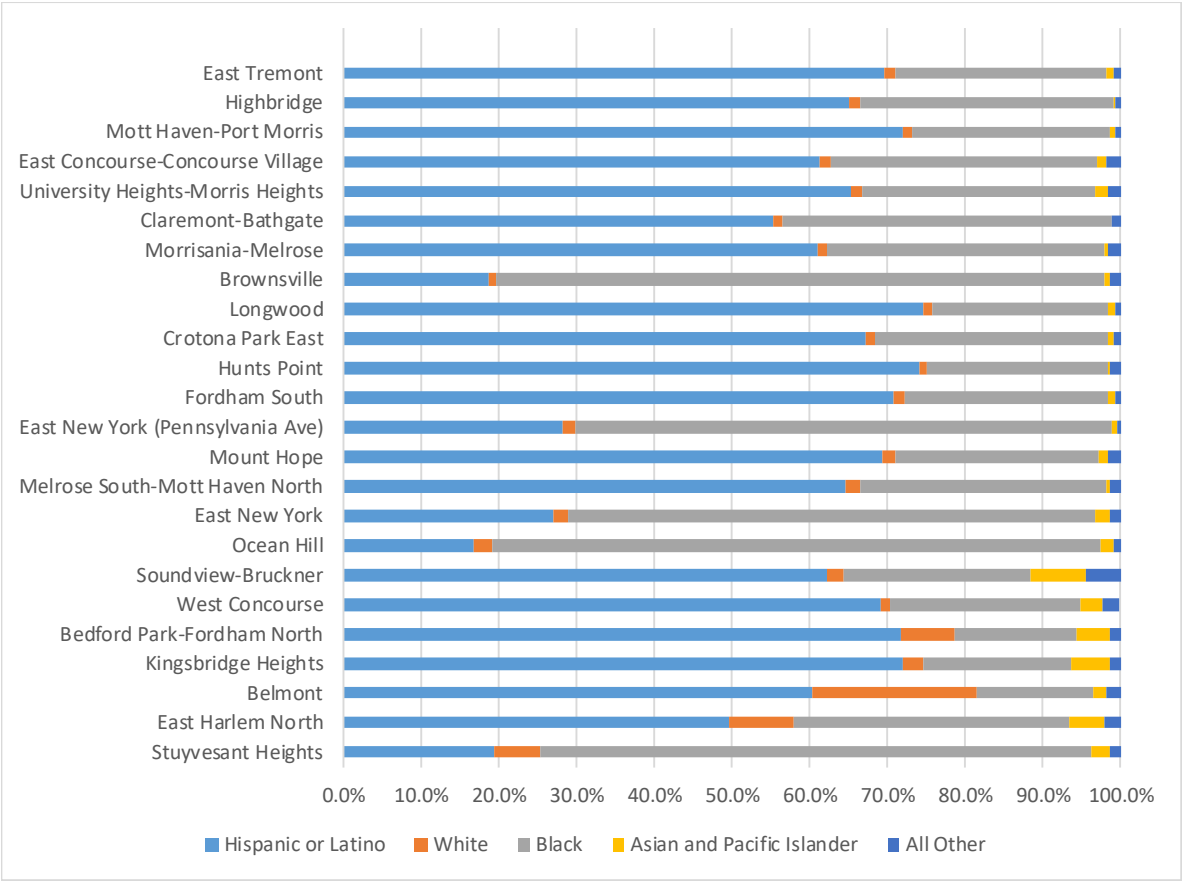
Total Disparity NTAs



	Hispanic or Latino	White	Black	Asian / Pacific Islander	All Other
NYPH High Disparity Community	38.0%	14.5%	34.2%	10.5%	2.9%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: NYC Health Data Atlas

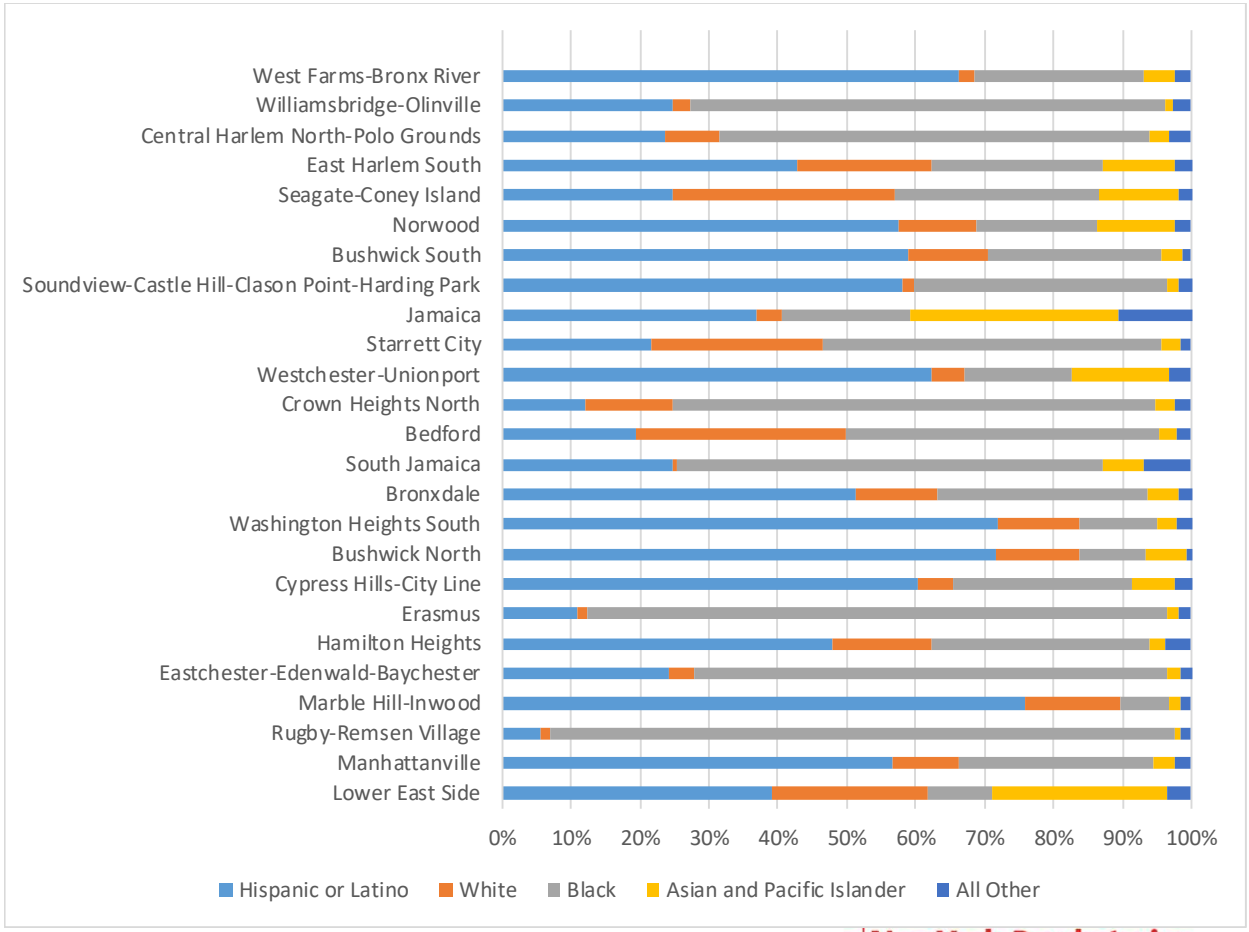
- North Corona, 86.9%, has a Hispanic/Latino population higher than 80%.
- Rugby-Remsen Village, East Flatbush-Farragut, St. Albans, Springfield Gardens North, Erasmus, and Canarsie all have Black populations higher than 80%.
- Flushing, Chinatown, and Sunset Park East each have Asian/Pacific Islander populations higher than 50%.



NewYork-Presbyterian

Population by Race / Ethnicity, High Disparity NYC Communities, continued

- NTA Quartile 4 continued



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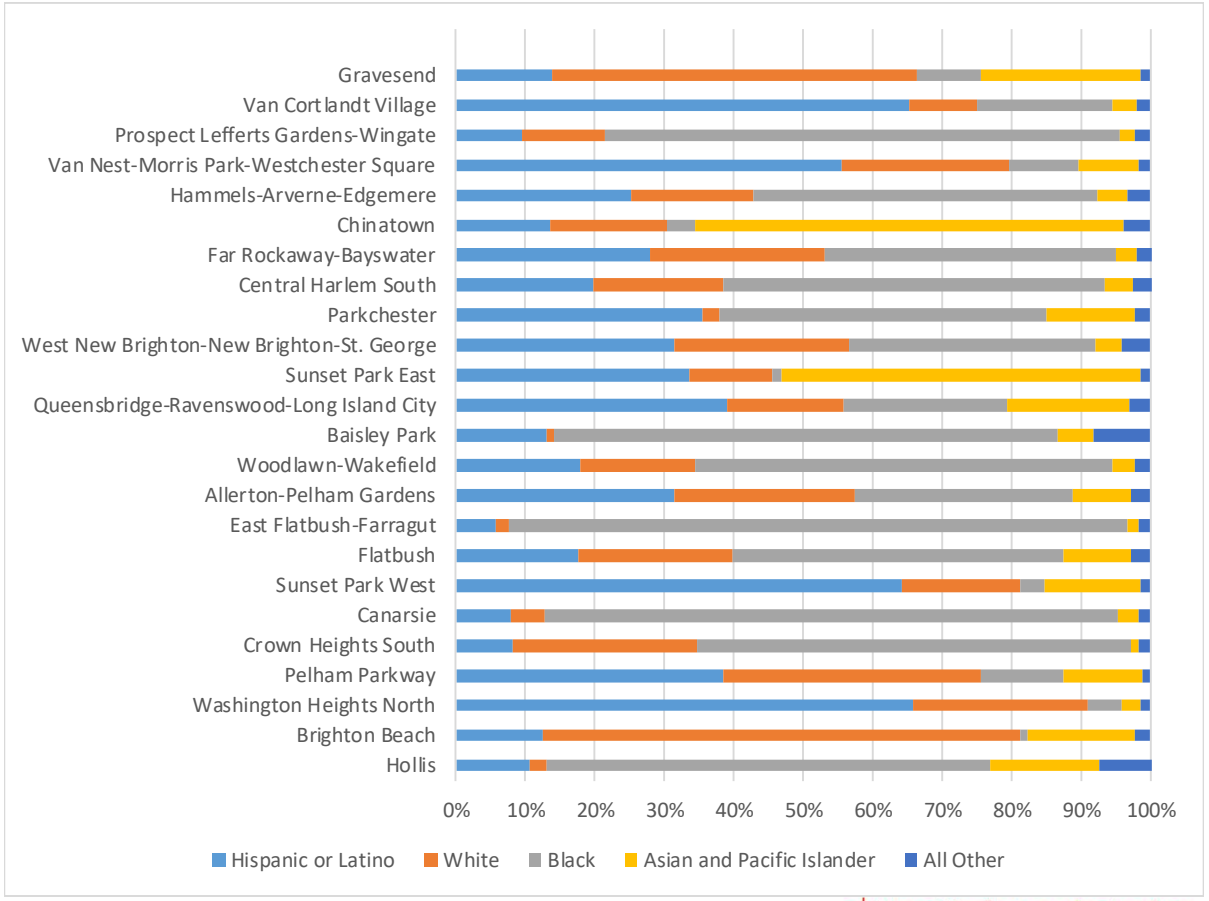
Population by Race / Ethnicity, High Disparity NYC Communities, continued

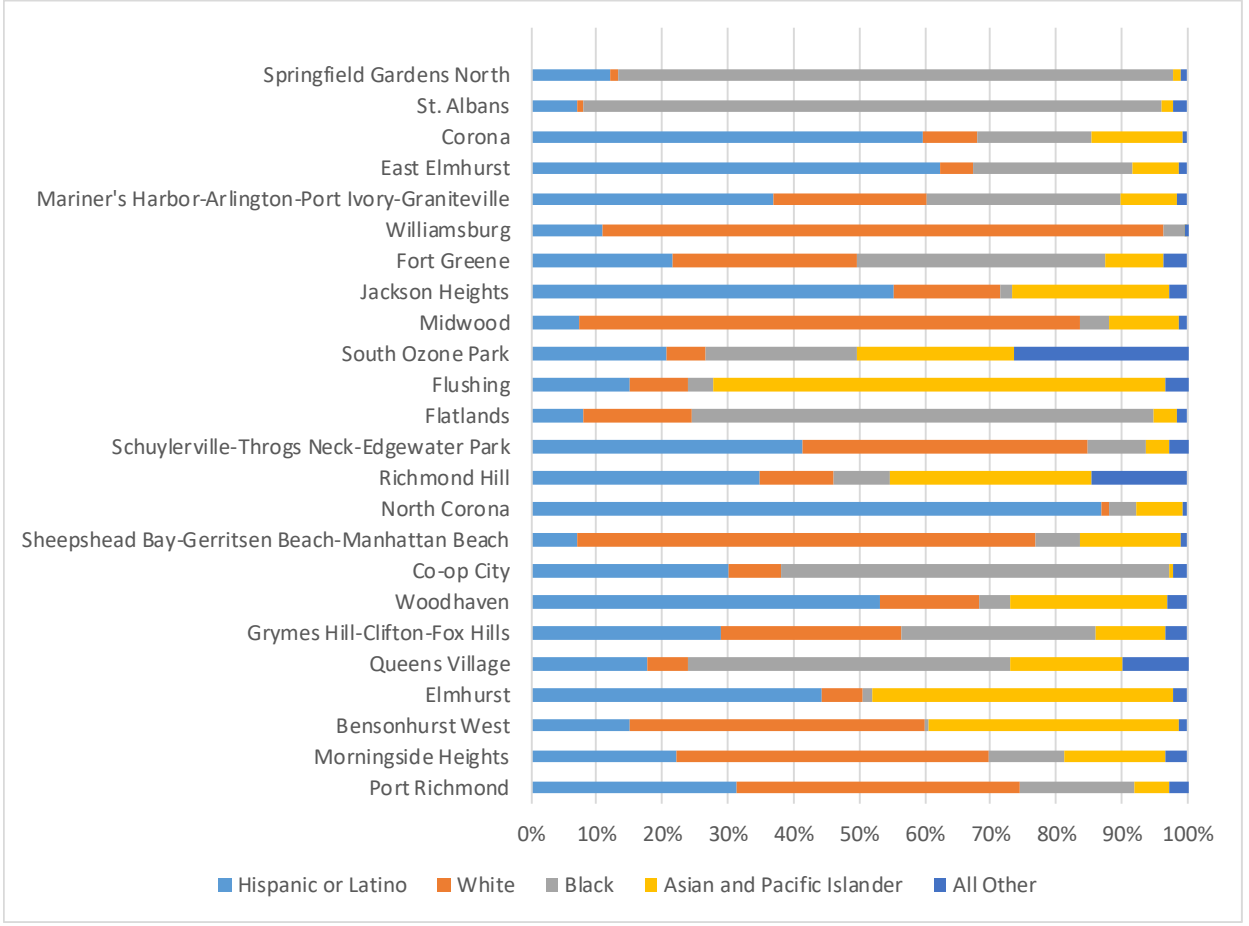
- NTA Quartile 3



NewYork-Presbyterian

Population by Race / Ethnicity, High Disparity NYC Communities, continued

- NTA Quartile 3 continued



NewYork-Presbyterian

Poverty & Health Insurance in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	% of population all ages living below FPL	% of population ages 0-17 living below FPL	% of population ages 65+ living below FPL	Percent of population without health insurance	Percent of ages 0-17 without health insurance	Percent of population enrolled in Medicaid
East Tremont	45.3%	56.8%	41.5%	16.6%	3.7%	62.0%
Highbridge	43.0%	50.5%	45.9%	17.4%	3.8%	60.0%
Mott Haven-Port Morris	46.4%	59.8%	38.7%	16.0%	4.2%	55.2%
East Concourse-Concourse Village	35.9%	48.2%	30.6%	16.0%	4.2%	55.2%
University Heights-Morris Heights	41.5%	52.9%	35.1%	17.4%	3.8%	60.0%
Claremont-Bathgate	50.6%	63.8%	50.8%	14.2%	3.7%	60.0%
Morrisania-Melrose	36.2%	44.2%	29.8%	16.0%	4.2%	55.2%
Brownsville	40.0%	54.0%	31.2%	11.0%	3.6%	51.4%
Longwood	38.5%	46.1%	40.8%	16.1%	1.7%	61.0%
Crotona Park East	44.7%	58.5%	39.5%	14.2%	3.7%	60.0%
Hunts Point	42.7%	49.3%	45.2%	16.1%	1.7%	61.0%
Fordham South	47.4%	62.6%	37.9%	20.2%	2.8%	66.9%
East New York (Pennsylvania Ave)	39.4%	56.7%	27.2%	11.0%	3.6%	51.4%
Mount Hope	38.8%	51.4%	31.0%	17.4%	3.8%	60.0%
Melrose South-Mott Haven North	40.8%	53.1%	42.9%	16.0%	4.2%	55.2%
East New York	33.2%	42.2%	30.7%	11.0%	3.6%	51.4%
Ocean Hill	30.0%	41.8%	26.2%	11.0%	3.6%	51.4%
Soundview-Bruckner	35.5%	49.4%	27.8%	21.1%	5.6%	53.8%
West Concourse	36.6%	47.8%	31.8%	16.0%	4.2%	55.2%
Bedford Park-Fordham North	33.5%	44.6%	35.8%	17.8%	4.4%	56.3%
Kingsbridge Heights	32.5%	46.5%	31.6%	20.2%	2.8%	66.9%
Belmont	46.1%	55.7%	42.1%	16.6%	3.7%	62.0%
East Harlem North	37.1%	48.9%	41.7%	15.3%	3.0%	50.2%
Stuyvesant Heights	28.9%	41.4%	28.2%	11.0%	1.9%	52.0%
NYPH High Disparity Community	26.4%	35.3%	25.2%	15.9%	4.2%	43.7%
New York City	20.6%	29.7%	18.6%	13.5%	4.0%	37.0%
New York State	N/A	N/A	N/A	0.0%	0.0%	0.0%

Source: NYC Health Data Atlas

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- Economic factors and insurance are the larger predictors of health outcomes, and also strongly influence health behavior.
- Overall, the NYPH community has a higher percent of its population living in poverty, all ages 26.4%, than the NYC average, 20.6%.
- In aggregate, these neighborhoods have a higher percent of uninsured,15.9%, than the NYC average, 13.5%.
- There is also a higher Medicaid enrollment, 43.7%, than the NYC average, 37.0%.

Poverty & Health Insurance in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	% of population all ages living below FPL	% of population ages 0-17 living below FPL	% of population ages 65+ living below FPL	Percent of population without health insurance	Percent of ages 0-17 without health insurance	Percent of population enrolled in Medicaid
West Farms-Bronx River	34.8%	50.4%	25.8%	15.3%	6.9%	62.4%
Williamsbridge-Olinville	23.9%	33.6%	17.8%	13.8%	3.9%	43.5%
Central Harlem North-Polo Grounds	30.2%	39.0%	26.9%	16.9%	4.0%	42.4%
East Harlem South	26.9%	38.4%	26.1%	15.3%	3.0%	50.2%
Seagate-Coney Island	37.1%	43.1%	47.6%	14.0%	4.2%	48.9%
Norwood	29.4%	38.1%	21.9%	17.8%	4.4%	56.3%
Bushwick South	27.8%	38.5%	35.2%	11.0%	1.9%	52.0%
Soundview-Castle Hill-Clason Point-Ha	27.6%	38.8%	20.7%	13.2%	6.1%	30.6%
Jamaica	24.5%	33.5%	23.5%	12.6%	5.5%	24.7%
Starrett City	32.0%	32.4%	45.4%	11.0%	3.6%	51.4%
Westchester-Unionport	22.8%	31.4%	22.1%	16.1%	3.9%	39.6%
Crown Heights North	29.1%	38.5%	30.4%	12.5%	5.0%	54.4%
Bedford	34.3%	49.5%	29.3%	12.5%	3.5%	21.5%
South Jamaica	19.8%	26.4%	21.5%	15.2%	5.5%	39.2%
Bronxdale	25.8%	37.5%	29.0%	18.4%	3.6%	46.5%
Washington Heights South	27.5%	35.0%	27.1%	18.2%	7.8%	38.4%
Bushwick North	31.0%	43.8%	31.9%	11.0%	1.9%	52.0%
Cypress Hills-City Line	30.2%	39.6%	26.4%	11.0%	3.6%	51.4%
Erasmus	23.0%	30.6%	19.8%	15.4%	4.6%	34.5%
Hamilton Heights	28.8%	40.0%	32.5%	18.2%	7.8%	38.4%
Eastchester-Edenwald-Baychester	18.0%	26.9%	15.6%	6.7%	4.9%	19.4%
Marble Hill-Inwood	26.9%	37.1%	30.8%	17.1%	5.3%	40.9%
Rugby-Remsen Village	18.6%	23.5%	16.7%	15.4%	4.6%	34.5%
Manhattanville	33.1%	50.4%	34.9%	16.9%	4.0%	42.4%
NYPH High Disparity Community	26.4%	35.3%	25.2%	15.9%	4.2%	43.7%
New York City	20.6%	29.7%	18.6%	13.5%	4.0%	37.0%
New York State	N/A	N/A	N/A	0.0%	0.0%	0.0%

- NTA Quartile 4 continued

Source: NYC Health Data Atlas

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

NewYork-Presbyterian

Poverty & Health Insurance in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	% of population all ages living below FPL	% of population ages 0-17 living below FPL	% of population ages 65+ living below FPL	Percent of population without health insurance	Percent of ages 0-17 without health insurance	Percent of population enrolled in Medicaid
Lower East Side	28.2%	35.7%	33.4%	10.0%	3.5%	47.3%
Gravesend	23.7%	35.5%	23.4%	14.0%	4.2%	48.9%
Van Cortlandt Village	26.2%	38.6%	21.1%	8.0%	3.3%	22.5%
Prospect Lefferts Gardens-Wingate	23.4%	32.6%	21.8%	15.4%	4.6%	34.5%
Van Nest-Morris Park-Westchester Sq	24.6%	33.9%	18.2%	15.3%	6.9%	62.4%
Hammels-Arverne-Edgemere	26.0%	40.8%	16.5%	13.5%	3.8%	42.8%
Chinatown	29.0%	42.5%	35.6%	10.0%	3.5%	47.3%
Far Rockaway-Bayswater	23.2%	28.8%	30.9%	13.5%	3.8%	42.8%
Central Harlem South	27.3%	34.3%	32.8%	10.9%	1.7%	31.3%
Parkchester	17.0%	18.9%	18.0%	13.2%	6.1%	30.6%
West New Brighton-New Brighton-St.	27.7%	41.6%	18.6%	11.2%	2.3%	41.6%
Sunset Park East	34.7%	46.2%	35.2%	16.3%	4.8%	40.6%
Queensbridge-Ravenswood-Long Islar	34.0%	43.4%	41.3%	21.6%	4.4%	27.0%
Baisley Park	14.9%	21.9%	7.9%	15.2%	5.5%	39.2%
Woodlawn-Wakefield	15.5%	23.8%	12.6%	13.8%	3.9%	43.5%
Allerton-Pelham Gardens	12.9%	18.0%	9.6%	9.1%	3.6%	27.7%
East Flatbush-Farragut	12.4%	17.4%	12.5%	15.4%	4.6%	34.5%
Flatbush	20.6%	27.5%	23.2%	16.3%	4.8%	40.6%
Sunset Park West	28.0%	39.4%	29.4%	24.3%	3.9%	41.6%
Canarsie	15.2%	22.0%	17.7%	11.0%	3.6%	51.4%
Crown Heights South	21.2%	25.9%	15.0%	15.4%	4.6%	34.5%
Pelham Parkway	17.3%	25.7%	16.4%	16.1%	3.9%	39.6%
Washington Heights North	20.0%	27.6%	22.2%	13.4%	3.1%	36.2%
Brighton Beach	28.1%	30.6%	44.7%	7.2%	3.9%	36.0%
Hollis	11.6%	15.9%	9.1%	12.6%	5.5%	24.7%
NYPH High Disparity Community	26.4%	35.3%	25.2%	15.9%	4.2%	43.7%
New York City	20.6%	29.7%	18.6%	13.5%	4.0%	37.0%
New York State	N/A	N/A	N/A	0.0%	0.0%	0.0%

- NTA Quartile 3

Source: NYC Health Data Atlas

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

Poverty & Health Insurance in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	% of population all ages living below FPL	% of population ages 0-17 living below FPL	% of population ages 65+ living below FPL	Percent of population without health insurance	Percent of ages 0-17 without health insurance	Percent of population enrolled in Medicaid
Springfield Gardens North	12.9%	21.6%	15.4%	12.6%	5.5%	24.7%
St. Albans	9.3%	12.7%	8.9%	10.5%	4.8%	19.8%
Corona	23.9%	35.0%	23.7%	41.5%	4.8%	49.1%
East Elmhurst	20.6%	26.6%	13.5%	41.5%	4.8%	49.1%
Mariner's Harbor-Arlington-Port Ivory-	21.1%	28.2%	14.4%	11.3%	2.6%	39.8%
Williamsburg	56.5%	64.1%	35.5%	12.5%	3.5%	21.5%
Fort Greene	24.1%	39.9%	20.2%	8.3%	1.7%	30.1%
Jackson Heights	18.4%	24.5%	18.5%	41.5%	4.8%	49.1%
Midwood	23.3%	29.4%	28.5%	16.3%	4.8%	40.6%
South Ozone Park	14.1%	20.6%	12.4%	12.9%	2.0%	34.0%
Flushing	23.6%	26.9%	24.5%	21.6%	9.2%	39.5%
Flatlands	11.4%	17.5%	8.6%	15.4%	4.6%	34.5%
Schuylerville-Throgs Neck-Edgewater	16.0%	28.7%	12.4%	17.4%	3.8%	60.0%
Richmond Hill	16.2%	20.5%	14.3%	9.7%	3.9%	25.4%
North Corona	25.2%	36.3%	14.0%	41.5%	4.8%	49.1%
Sheepshead Bay-Gerritsen Beach-Man	16.6%	21.9%	21.5%	10.1%	2.6%	39.4%
Co-op City	10.1%	13.9%	10.0%	9.1%	3.6%	27.7%
Woodhaven	15.6%	22.3%	11.8%	11.0%	3.6%	51.4%
Grymes Hill-Clifton-Fox Hills	20.9%	27.4%	27.0%	11.2%	2.3%	41.6%
Queens Village	10.8%	18.2%	7.7%	10.5%	4.8%	19.8%
Elmhurst	20.5%	26.3%	18.9%	41.5%	4.8%	49.1%
Bensonhurst West	19.3%	27.2%	19.6%	14.0%	4.2%	48.9%
Morningside Heights	24.2%	15.7%	20.3%	7.4%	3.3%	17.6%
Port Richmond	23.2%	33.8%	18.0%	12.1%	4.6%	32.2%
NYPH High Disparity Community	26.4%	35.3%	25.2%	15.9%	4.2%	43.7%
New York City	20.6%	29.7%	18.6%	13.5%	4.0%	37.0%
New York State	N/A	N/A	N/A	0.0%	0.0%	0.0%

- NTA Quartile 3 continued

Source: NYC Health Data Atlas

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

Other Risk Indicators in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Percent of population born outside the U.S. or U.S. territories	Percent of population age 5+ report speaking English "less than very well"	Percent Adults Age 25+ Not Completed High School	% of poulation ages 16+ unemployed	% of population reported disabled	% of households, single mother with children	% of households, single father with children
East Tremont	30.7%	27.1%	40.9%	23.3%	14.1%	31.4%	5.2%
Highbridge	37.4%	32.3%	35.9%	18.4%	16.7%	27.1%	4.4%
Mott Haven-Port Morris	27.5%	36.1%	42.9%	14.8%	17.7%	29.2%	4.6%
East Concourse-Concourse Village	37.8%	33.4%	38.9%	15.3%	14.3%	19.9%	5.9%
University Heights-Morris Heights	38.1%	33.3%	31.8%	19.6%	15.9%	23.8%	4.5%
Claremont-Bathgate	26.3%	26.0%	39.9%	21.7%	15.8%	35.3%	2.7%
Morrisania-Melrose	32.0%	29.9%	37.4%	15.8%	13.8%	26.4%	3.6%
Brownsville	27.7%	8.2%	27.2%	15.1%	11.6%	32.6%	3.0%
Longwood	31.9%	36.0%	43.7%	12.7%	14.8%	28.6%	6.2%
Crotona Park East	34.2%	24.9%	37.8%	18.4%	11.4%	30.6%	3.1%
Hunts Point	28.2%	33.8%	41.4%	18.3%	14.9%	28.9%	3.9%
Fordham South	40.8%	36.5%	41.5%	17.4%	13.5%	32.1%	3.4%
East New York (Pennsylvania Ave)	34.7%	9.3%	29.2%	16.3%	9.8%	31.4%	3.4%
Mount Hope	45.0%	37.2%	35.5%	18.0%	14.1%	27.3%	5.3%
Melrose South-Mott Haven North	30.2%	32.3%	41.5%	16.1%	15.4%	30.6%	2.6%
East New York	29.2%	9.9%	22.1%	13.9%	10.3%	25.9%	3.9%
Ocean Hill	29.6%	9.1%	26.8%	13.1%	12.1%	22.7%	5.2%
Soundview-Bruckner	42.5%	34.7%	41.2%	13.5%	10.0%	23.6%	5.4%
West Concourse	47.1%	39.9%	37.0%	15.2%	15.2%	27.3%	4.5%
Bedford Park-Fordham North	40.5%	34.5%	34.1%	16.2%	12.5%	22.9%	3.1%
Kingsbridge Heights	43.7%	33.9%	32.5%	16.2%	12.3%	20.1%	5.0%
Belmont	32.5%	30.0%	39.1%	12.0%	13.2%	24.7%	5.5%
East Harlem North	24.0%	21.2%	29.2%	11.3%	15.2%	20.6%	2.1%
Stuyvesant Heights	20.6%	8.9%	24.0%	17.0%	11.3%	17.8%	3.5%
NYPH High Disparity Community	40.4%	26.3%	26.8%	12.8%	11.4%	16.9%	3.7%
New York City	37.1%	23.2%	19.9%	10.3%	10.3%	9.6%	2.3%
New York State	N/A	N/A	13.8%	36.9%	4.9%	12.0%	3.2%

Source: NYC Health Data Atlas, Data2Go.NYC

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- While none of these are conclusive determinants alone, these are other predictors of health outcome to consider - foreign born, the non-English speaking, those not graduating from high school, the unemployed, the disabled and single parents.
- Overall, the NYPH community has a larger than NYC average across all these indicators - residents that are foreign born, non-English speaking, not graduated from high school, unemployed, disabled and single parents.

Other Risk Indicators in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of population born outside the U.S. or U.S. territories	Percent of population age 5+ report speaking English "less than very well"	Percent Adults Age 25+ Not Completed High School	% of poulation ages 16+ unemployed	% of population reported disabled	% of households, single mother with children	% of households, single father with children
West Farms-Bronx River	37.9%	31.8%	38.3%	14.2%	12.3%	23.8%	4.6%
Williamsbridge-Olinville	39.1%	10.1%	22.6%	18.5%	13.3%	22.7%	4.7%
Central Harlem North-Polo Grounds	22.3%	11.6%	21.4%	17.1%	15.3%	18.2%	2.5%
East Harlem South	28.1%	20.4%	24.0%	12.2%	11.9%	14.5%	2.4%
Seagate-Coney Island	34.4%	32.3%	28.6%	20.0%	22.1%	15.7%	2.3%
Norwood	42.4%	34.2%	27.7%	14.3%	13.2%	19.7%	4.4%
Bushwick South	30.2%	24.9%	34.2%	15.0%	10.2%	19.0%	3.0%
Soundview-Castle Hill-Clason Point-Ha	21.9%	19.9%	25.9%	11.9%	16.0%	23.9%	3.8%
Jamaica	62.5%	38.2%	32.4%	13.7%	10.7%	10.6%	5.2%
Starrett City	30.9%	21.9%	20.5%	15.6%	24.0%	21.6%	1.0%
Westchester-Unionport	33.2%	25.6%	27.6%	16.3%	10.5%	20.6%	6.1%
Crown Heights North	32.5%	8.8%	20.9%	12.7%	10.0%	19.0%	3.0%
Bedford	19.3%	15.8%	22.5%	13.2%	10.2%	15.6%	1.7%
South Jamaica	32.5%	9.8%	22.3%	19.8%	9.2%	25.3%	5.3%
Bronxdale	38.0%	26.6%	27.0%	14.6%	16.9%	21.2%	2.8%
Washington Heights South	48.5%	41.8%	34.0%	14.4%	13.0%	14.3%	4.7%
Bushwick North	42.8%	43.4%	45.9%	13.3%	6.5%	17.6%	8.2%
Cypress Hills-City Line	46.1%	24.0%	28.5%	8.6%	6.6%	19.6%	5.0%
Erasmus	54.5%	12.6%	19.2%	14.3%	6.9%	19.5%	4.5%
Hamilton Heights	35.5%	25.0%	26.3%	12.0%	12.4%	15.9%	3.0%
Eastchester-Edenwald-Baychester	36.4%	8.6%	19.6%	14.4%	12.5%	21.1%	3.5%
Marble Hill-Inwood	48.0%	39.9%	29.8%	16.5%	10.8%	15.8%	4.8%
Rugby-Remsen Village	50.8%	5.4%	17.6%	11.4%	9.5%	20.2%	3.1%
Manhattanville	39.1%	29.5%	33.5%	9.1%	12.6%	18.8%	2.0%
NYPH High Disparity Community	40.4%	26.3%	26.8%	12.8%	11.4%	16.9%	3.7%
New York City	37.1%	23.2%	19.9%	10.3%	10.3%	9.6%	2.3%
New York State	N/A	N/A	13.8%	36.9%	4.9%	12.0%	3.2%

Source: NYC Health Data Atlas, Data2Go.NYC

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- NTA Quartile 4 continued

NewYork-Presbyterian

Other Risk Indicators in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of population born outside the U.S. or U.S. territories	Percent of population age 5+ report speaking English "less than very well"	Percent Adults Age 25+ Not Completed High School	% of poulation ages 16+ unemployed	% of population reported disabled	% of households, single mother with children	% of households, single father with children
Lower East Side	31.6%	30.9%	30.9%	11.2%	18.2%	12.1%	2.0%
Gravesend	47.0%	41.7%	23.9%	11.9%	15.0%	9.5%	1.5%
Van Cortlandt Village	40.2%	29.1%	27.5%	16.3%	10.6%	20.1%	3.7%
Prospect Lefferts Gardens-Wingate	45.4%	10.8%	18.2%	15.1%	9.0%	16.8%	2.2%
Van Nest-Morris Park-Westchester Squ	31.0%	23.5%	25.5%	14.4%	11.2%	16.2%	5.0%
Hammels-Arverne-Edgemere	26.8%	13.4%	25.5%	14.7%	16.7%	25.6%	4.5%
Chinatown	53.8%	46.1%	38.7%	9.1%	11.1%	6.5%	2.7%
Far Rockaway-Bayswater	34.4%	19.5%	29.1%	10.2%	15.8%	16.0%	2.7%
Central Harlem South	23.5%	11.5%	16.8%	8.1%	10.3%	13.2%	2.8%
Parkchester	28.7%	14.8%	18.9%	13.3%	10.7%	13.6%	4.7%
West New Brighton-New Brighton-St.	22.2%	11.9%	16.4%	9.9%	11.1%	17.1%	4.0%
Sunset Park East	58.4%	60.7%	53.5%	11.1%	8.5%	11.8%	5.2%
Queensbridge-Ravenswood-Long Islar	38.0%	28.8%	28.4%	15.6%	10.9%	15.1%	1.6%
Baisley Park	35.8%	7.9%	16.8%	12.2%	11.5%	18.1%	5.3%
Woodlawn-Wakefield	42.2%	7.1%	16.4%	13.4%	10.1%	15.9%	4.6%
Allerton-Pelham Gardens	34.9%	14.4%	21.7%	14.1%	13.1%	14.0%	2.2%
East Flatbush-Farragut	53.6%	9.7%	12.5%	10.2%	7.6%	16.3%	3.3%
Flatbush	47.6%	27.2%	20.3%	10.6%	8.9%	13.4%	2.8%
Sunset Park West	45.0%	44.5%	38.2%	10.1%	8.5%	10.8%	3.9%
Canarsie	46.7%	14.1%	16.3%	9.7%	9.0%	16.9%	3.7%
Crown Heights South	35.9%	10.9%	16.1%	16.4%	7.5%	11.9%	3.4%
Pelham Parkway	35.4%	24.9%	21.5%	10.6%	10.9%	9.5%	3.3%
Washington Heights North	46.6%	34.8%	25.8%	12.9%	9.5%	12.8%	2.1%
Brighton Beach	69.5%	58.8%	12.1%	7.9%	20.0%	3.5%	1.1%
Hollis	46.1%	9.7%	16.9%	15.1%	11.7%	12.1%	3.9%
NYPH High Disparity Community	40.4%	26.3%	26.8%	12.8%	11.4%	16.9%	3.7%
New York City	37.1%	23.2%	19.9%	10.3%	10.3%	9.6%	2.3%
New York State	N/A	N/A	13.8%	36.9%	4.9%	12.0%	3.2%

Source: NYC Health Data Atlas, Data2Go.NYC

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- NTA Quartile 3

NewYork-Presbyterian

Other Risk Indicators in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of population born outside the U.S. or U.S. territories	Percent of population age 5+ report speaking English "less than very well"	Percent Adults Age 25+ Not Completed High School	% of poulation ages 16+ unemployed	% of population reported disabled	% of households, single mother with children	% of households, single father with children
Springfield Gardens North	24.9%	4.9%	14.8%	12.8%	14.7%	16.8%	4.2%
St. Albans	35.8%	5.6%	12.6%	13.6%	10.0%	17.4%	3.9%
Corona	56.6%	44.7%	33.8%	7.5%	10.4%	14.4%	7.6%
East Elmhurst	55.1%	36.1%	25.0%	9.1%	7.6%	13.7%	5.3%
Mariner's Harbor-Arlington-Port Ivory-	25.2%	12.3%	17.3%	8.6%	9.5%	17.0%	2.5%
Williamsburg	11.7%	33.4%	30.5%	5.8%	7.2%	4.7%	2.8%
Fort Greene	21.9%	11.9%	18.1%	13.3%	9.6%	13.4%	1.3%
Jackson Heights	62.0%	44.1%	23.6%	9.4%	7.7%	8.5%	4.3%
Midwood	39.1%	31.2%	13.9%	9.1%	10.9%	4.5%	1.1%
South Ozone Park	56.5%	11.3%	25.4%	11.6%	9.2%	9.6%	4.2%
Flushing	71.3%	63.0%	26.2%	8.3%	9.5%	6.4%	1.1%
Flatlands	43.6%	16.2%	13.6%	10.3%	7.7%	15.1%	2.6%
Schuylerville-Throgs Neck-Edgewater	16.4%	11.7%	18.0%	9.9%	12.2%	13.1%	2.9%
Richmond Hill	56.9%	24.3%	26.3%	10.2%	9.2%	9.8%	4.5%
North Corona	66.6%	61.4%	46.6%	6.0%	7.7%	14.2%	12.0%
Sheepshead Bay-Gerritsen Beach-Man	46.5%	31.5%	12.6%	10.6%	14.0%	6.3%	2.0%
Co-op City	26.1%	10.4%	16.0%	12.4%	15.5%	14.1%	2.3%
Woodhaven	47.0%	28.4%	23.5%	11.7%	10.5%	11.9%	4.1%
Grymes Hill-Clifton-Fox Hills	28.2%	14.0%	19.0%	11.0%	8.0%	18.2%	2.1%
Queens Village	51.1%	17.4%	17.1%	13.0%	9.6%	12.2%	4.0%
Elmhurst	69.4%	57.7%	30.6%	6.2%	7.4%	7.8%	4.6%
Bensonhurst West	55.4%	48.8%	29.6%	10.6%	10.3%	5.7%	3.0%
Morningside Heights	30.1%	12.5%	11.7%	7.3%	9.3%	5.0%	0.9%
Port Richmond	23.7%	14.0%	13.8%	6.4%	10.3%	11.9%	2.1%
NYPH High Disparity Community	40.4%	26.3%	26.8%	12.8%	11.4%	16.9%	3.7%
New York City	37.1%	23.2%	19.9%	10.3%	10.3%	9.6%	2.3%
New York State	N/A	N/A	13.8%	36.9%	4.9%	12.0%	3.2%

Source: NYC Health Data Atlas, Data2Go.NYC

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- NTA Quartile 3 continued

NewYork-Presbyterian

Percent of People Living within Select Income Bands (% AMI) in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	% of People Living within Income Band $200,000 or more	% of People Living within Income Band $100,000 to $199,999	% of People Living within Income Band $75,000 to $99,999	% of People Living within Income Band $50,000 to $74,999	% of People Living within Income Band $35,000 to $49,999	% of People Living within Income Band $25,000 to $34,999	% of People Living within Income Band $15,000 to $24,999	% of People Living within Income Band Under $15,000
East Tremont	0.9%	5.3%	6.9%	15.2%	11.7%	11.2%	17.0%	31.8%
Highbridge	0.7%	6.7%	4.8%	14.6%	17.8%	11.8%	15.7%	27.8%
Mott Haven-Port Morris	0.5%	5.1%	6.7%	10.5%	11.3%	10.8%	17.6%	37.5%
East Concourse-Concourse Village	0.7%	6.7%	4.8%	14.6%	17.8%	11.8%	15.7%	27.8%
University Heights-Morris Heights	0.7%	6.5%	7.8%	12.7%	15.0%	11.9%	14.9%	30.5%
Claremont-Bathgate	0.9%	5.3%	6.9%	15.2%	11.7%	11.2%	17.0%	31.8%
Morrisania-Melrose	0.9%	5.3%	6.9%	15.2%	11.7%	11.2%	17.0%	31.8%
Brownsville	1.5%	7.4%	7.0%	11.2%	9.7%	8.5%	9.7%	45.0%
Longwood	0.5%	5.1%	6.7%	10.5%	11.3%	10.8%	17.6%	37.5%
Crotona Park East	0.9%	5.3%	6.9%	15.2%	11.7%	11.2%	17.0%	31.8%
Hunts Point	0.5%	5.1%	6.7%	10.5%	11.3%	10.8%	17.6%	37.5%
Fordham South	0.7%	6.5%	7.8%	12.7%	15.0%	11.9%	14.9%	30.5%
East New York (Pennsylvania Ave)	1.5%	7.4%	7.0%	11.2%	9.7%	8.5%	9.7%	45.0%
Mount Hope	0.7%	6.5%	7.8%	12.7%	15.0%	11.9%	14.9%	30.5%
Melrose South-Mott Haven North	0.5%	5.1%	6.7%	10.5%	11.3%	10.8%	17.6%	37.5%
East New York	3.0%	10.9%	9.5%	15.6%	12.8%	11.2%	12.3%	24.8%
Ocean Hill	1.5%	7.4%	7.0%	11.2%	9.7%	8.5%	9.7%	45.0%
Soundview-Bruckner	1.8%	14.9%	7.7%	18.4%	13.2%	10.2%	12.7%	21.1%
West Concourse	0.7%	6.7%	4.8%	14.6%	17.8%	11.8%	15.7%	27.8%
Bedford Park-Fordham North	1.2%	7.3%	11.1%	18.7%	12.0%	11.4%	14.0%	24.3%
Kingsbridge Heights	1.2%	7.3%	11.1%	18.7%	12.0%	11.4%	14.0%	24.3%
Belmont	0.9%	5.3%	6.9%	15.2%	11.7%	11.2%	17.0%	31.8%
East Harlem North	4.9%	10.4%	9.3%	15.8%	10.6%	8.8%	12.6%	27.6%
Stuyvesant Heights	8.2%	18.3%	10.3%	14.6%	10.8%	8.9%	11.9%	16.9%
NYPH High Disparity Community	5.0%	17.3%	10.9%	15.9%	12.2%	9.0%	10.7%	19.0%
New York City	10.3%	21.2%	10.9%	14.7%	10.4%	7.8%	9.2%	15.4%
New York State	11.0%	23.5%	11.8%	14.9%	11.0%	7.9%	8.5%	11.4%

Source: Citizens Committee for Children

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- The Area Median Income (AMI) is the midpoint of a region's income distribution – half of families in a region earn more than the median and half earn less than the median.
- For housing policy, U.S. Department of Housing and Urban Development (HUD) sets income thresholds relative to the AMI to identify persons eligible for housing assistance.
- The 2019 AMI for the NYC region is $96,100 for a three-person family (100% AMI).
- Compared to the NYC average, there are fewer, 5.0%, in the NYPH community living in an income band of $200,000, and there are more, 19.0%, living in an income band under $15,000.

NewYork-Presbyterian

Percent of People Living within Select Income Bands (% AMI) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	% of People Living within Income Band $200,000 or more	% of People Living within Income Band $100,000 to $199,999	% of People Living within Income Band $75,000 to $99,999	% of People Living within Income Band $50,000 to $74,999	% of People Living within Income Band $35,000 to $49,999	% of People Living within Income Band $25,000 to $34,999	% of People Living within Income Band $15,000 to $24,999	% of People Living within Income Band Under $15,000
West Farms-Bronx River	1.8%	14.9%	7.7%	18.4%	13.2%	10.2%	12.7%	21.1%
Williamsbridge-Olinville	4.7%	18.8%	14.6%	19.5%	11.4%	8.8%	9.5%	12.7%
Central Harlem North-Polo Grounds	7.7%	19.9%	8.3%	13.7%	10.6%	7.0%	10.1%	22.7%
East Harlem South	4.9%	10.4%	9.3%	15.8%	10.6%	8.8%	12.6%	27.6%
Seagate-Coney Island	4.4%	14.5%	8.0%	13.1%	11.2%	8.0%	12.6%	28.2%
Norwood	1.2%	7.3%	11.1%	18.7%	12.0%	11.4%	14.0%	24.3%
Bushwick South	6.2%	18.7%	10.1%	15.4%	11.6%	8.3%	10.4%	19.2%
Soundview-Castle Hill-Clason Point-Ha	1.8%	14.9%	7.7%	18.4%	13.2%	10.2%	12.7%	21.1%
Jamaica	5.0%	23.8%	12.4%	18.8%	12.5%	7.3%	9.4%	10.8%
Starrett City	3.0%	10.9%	9.5%	15.6%	12.8%	11.2%	12.3%	24.8%
Westchester-Unionport	1.8%	14.9%	7.7%	18.4%	13.2%	10.2%	12.7%	21.1%
Crown Heights North	8.7%	23.2%	9.5%	13.7%	12.0%	6.6%	7.0%	19.3%
Bedford	8.2%	18.3%	10.3%	14.6%	10.8%	8.9%	11.9%	16.9%
South Jamaica	5.0%	23.8%	12.4%	18.8%	12.5%	7.3%	9.4%	10.8%
Bronxdale	2.8%	18.3%	10.0%	18.1%	14.0%	10.7%	10.1%	16.1%
Washington Heights South	4.1%	20.3%	13.1%	17.1%	11.5%	9.7%	8.3%	15.9%
Bushwick North	6.2%	18.7%	10.1%	15.4%	11.6%	8.3%	10.4%	19.2%
Cypress Hills-City Line	3.0%	10.9%	9.5%	15.6%	12.8%	11.2%	12.3%	24.8%
Erasmus	3.1%	16.9%	13.7%	15.4%	16.1%	7.9%	10.6%	16.4%
Hamilton Heights	10.9%	16.7%	8.7%	13.8%	11.0%	7.2%	11.6%	20.0%
Eastchester-Edenwald-Baychester	4.7%	18.8%	14.6%	19.5%	11.4%	8.8%	9.5%	12.7%
Marble Hill-Inwood	4.1%	20.3%	13.1%	17.1%	11.5%	9.7%	8.3%	15.9%
Rugby-Remsen Village	3.1%	16.9%	13.7%	15.4%	16.1%	7.9%	10.6%	16.4%
Manhattanville	10.9%	16.7%	8.7%	13.8%	11.0%	7.2%	11.6%	20.0%
NYPH High Disparity Community	5.0%	17.3%	10.9%	15.9%	12.2%	9.0%	10.7%	19.0%
New York City	10.3%	21.2%	10.9%	14.7%	10.4%	7.8%	9.2%	15.4%
New York State	11.0%	23.5%	11.8%	14.9%	11.0%	7.9%	8.5%	11.4%

- NTA Quartile 4

Source: Citizens Committee for Children

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

NewYork-Presbyterian

Percent of People Living within Select Income Bands (% AMI) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	% of People Living within Income Band $200,000 or more	% of People Living within Income Band $100,000 to $199,999	% of People Living within Income Band $75,000 to $99,999	% of People Living within Income Band $50,000 to $74,999	% of People Living within Income Band $35,000 to $49,999	% of People Living within Income Band $25,000 to $34,999	% of People Living within Income Band $15,000 to $24,999	% of People Living within Income Band Under $15,000
Lower East Side	8.7%	16.7%	6.8%	12.7%	8.4%	10.0%	10.9%	25.9%
Gravesend	4.4%	14.5%	8.0%	13.1%	11.2%	8.0%	12.6%	28.2%
Van Cortlandt Village	7.4%	22.0%	10.6%	14.9%	12.7%	10.0%	10.8%	11.8%
Prospect Lefferts Gardens-Wingate	5.1%	15.6%	13.2%	17.1%	14.0%	6.8%	11.1%	17.1%
Van Nest-Morris Park-Westchester Squ	2.8%	18.3%	10.0%	18.1%	14.0%	10.7%	10.1%	16.1%
Hammels-Arverne-Edgemere	5.6%	19.6%	10.3%	17.9%	13.2%	8.4%	8.3%	16.7%
Chinatown	8.7%	16.7%	6.8%	12.7%	8.4%	10.0%	10.9%	25.9%
Far Rockaway-Bayswater	5.6%	19.6%	10.3%	17.9%	13.2%	8.4%	8.3%	16.7%
Central Harlem South	7.7%	19.9%	8.3%	13.7%	10.6%	7.0%	10.1%	22.7%
Parkchester	1.8%	14.9%	7.7%	18.4%	13.2%	10.2%	12.7%	21.1%
West New Brighton-New Brighton-St. C	8.6%	24.1%	10.5%	13.9%	10.1%	5.3%	7.8%	19.7%
Sunset Park East	9.6%	18.9%	13.0%	13.8%	10.9%	10.0%	9.4%	14.4%
Queensbridge-Ravenswood-Long Islan	6.1%	26.1%	13.7%	15.2%	11.4%	7.9%	9.5%	10.2%
Baisley Park	5.0%	23.8%	12.4%	18.8%	12.5%	7.3%	9.4%	10.8%
Woodlawn-Wakefield	4.7%	18.8%	14.6%	19.5%	11.4%	8.8%	9.5%	12.7%
Allerton-Pelham Gardens	2.8%	18.3%	10.0%	18.1%	14.0%	10.7%	10.1%	16.1%
East Flatbush-Farragut	3.1%	16.9%	13.7%	15.4%	16.1%	7.9%	10.6%	16.4%
Flatbush	6.8%	18.8%	10.5%	19.3%	11.9%	7.9%	6.9%	18.0%
Sunset Park West	9.6%	18.9%	13.0%	13.8%	10.9%	10.0%	9.4%	14.4%
Canarsie	6.8%	28.7%	16.4%	14.7%	10.3%	7.4%	7.9%	7.9%
Crown Heights South	5.1%	15.6%	13.2%	17.1%	14.0%	6.8%	11.1%	17.1%
Pelham Parkway	2.8%	18.3%	10.0%	18.1%	14.0%	10.7%	10.1%	16.1%
Washington Heights North	4.1%	20.3%	13.1%	17.1%	11.5%	9.7%	8.3%	15.9%
Brighton Beach	4.4%	14.5%	8.0%	13.1%	11.2%	8.0%	12.6%	28.2%
Hollis	5.0%	23.8%	12.4%	18.8%	12.5%	7.3%	9.4%	10.8%
NYPH High Disparity Community	5.0%	17.3%	10.9%	15.9%	12.2%	9.0%	10.7%	19.0%
New York City	10.3%	21.2%	10.9%	14.7%	10.4%	7.8%	9.2%	15.4%
New York State	11.0%	23.5%	11.8%	14.9%	11.0%	7.9%	8.5%	11.4%

Source: Citizens Committee for Children

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- NTA Quartile 3

NewYork-Presbyterian

Percent of People Living within Select Income Bands (% AMI) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	% of People Living within Income Band $200,000 or more	% of People Living within Income Band $100,000 to $199,999	% of People Living within Income Band $75,000 to $99,999	% of People Living within Income Band $50,000 to $74,999	% of People Living within Income Band $35,000 to $49,999	% of People Living within Income Band $25,000 to $34,999	% of People Living within Income Band $15,000 to $24,999	% of People Living within Income Band Under $15,000
Springfield Gardens North	5.0%	23.8%	12.4%	18.8%	12.5%	7.3%	9.4%	10.8%
St. Albans	5.0%	23.8%	12.4%	18.8%	12.5%	7.3%	9.4%	10.8%
Corona	3.1%	17.5%	13.5%	19.1%	16.1%	10.5%	11.1%	9.2%
East Elmhurst	4.4%	18.4%	13.8%	19.7%	16.7%	9.9%	7.4%	9.8%
Mariner's Harbor-Arlington-Port Ivory-(	8.6%	24.1%	10.5%	13.9%	10.1%	5.3%	7.8%	19.7%
Williamsburg	16.9%	23.3%	10.5%	11.6%	8.8%	4.8%	8.5%	15.5%
Fort Greene	19.2%	28.3%	12.3%	10.7%	6.4%	6.8%	6.3%	10.1%
Jackson Heights	4.4%	18.4%	13.8%	19.7%	16.7%	9.9%	7.4%	9.8%
Midwood	6.8%	18.8%	10.5%	19.3%	11.9%	7.9%	6.9%	18.0%
South Ozone Park	6.6%	27.4%	15.4%	15.8%	10.2%	9.6%	7.1%	8.0%
Flushing	5.3%	18.2%	11.4%	16.4%	12.1%	9.2%	13.1%	14.3%
Flatlands	6.8%	28.7%	16.4%	14.7%	10.3%	7.4%	7.9%	7.9%
Schuylerville-Throgs Neck-Edgewater F	4.0%	22.3%	15.0%	15.8%	11.0%	8.1%	9.7%	14.0%
Richmond Hill	5.8%	23.9%	16.8%	19.8%	10.4%	8.2%	6.5%	8.6%
North Corona	4.4%	18.4%	13.8%	19.7%	16.7%	9.9%	7.4%	9.8%
Sheepshead Bay-Gerritsen Beach-Manl	7.8%	26.3%	9.1%	14.8%	10.7%	8.3%	8.7%	14.3%
Co-op City	4.0%	22.3%	15.0%	15.8%	11.0%	8.1%	9.7%	14.0%
Woodhaven	5.8%	23.9%	16.8%	19.8%	10.4%	8.2%	6.5%	8.6%
Grymes Hill-Clifton-Fox Hills	8.6%	24.1%	10.5%	13.9%	10.1%	5.3%	7.8%	19.7%
Queens Village	7.9%	33.2%	15.9%	13.8%	8.5%	6.8%	5.7%	8.2%
Elmhurst	3.1%	17.5%	13.5%	19.1%	16.1%	10.5%	11.1%	9.2%
Bensonhurst West	5.8%	19.8%	11.7%	16.3%	12.9%	10.3%	11.4%	11.8%
Morningside Heights	10.9%	16.7%	8.7%	13.8%	11.0%	7.2%	11.6%	20.0%
Port Richmond	8.6%	24.1%	10.5%	13.9%	10.1%	5.3%	7.8%	19.7%
NYPH High Disparity Community	5.0%	17.3%	10.9%	15.9%	12.2%	9.0%	10.7%	19.0%
New York City	10.3%	21.2%	10.9%	14.7%	10.4%	7.8%	9.2%	15.4%
New York State	11.0%	23.5%	11.8%	14.9%	11.0%	7.9%	8.5%	11.4%

Source: Citizens Committee for Children

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- NTA Quartile 3 continued

NewYork-Presbyterian

Overcrowded Housing, Rent Burden and Maintenance Defects in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Percentage of occupied housing units with more than one occupant per room	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 30% of monthly pre-tax income	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 50% of monthly pre-tax income	Percentage of renter-occupied homes without maintenance defects
East Tremont	12.6%	66.9%	40.5%	27.0%
Highbridge	14.8%	66.4%	40.2%	19.0%
Mott Haven-Port Morris	13.5%	58.4%	30.0%	24.0%
East Concourse-Concourse Village	16.7%	64.2%	39.7%	19.0%
University Heights-Morris Heights	12.3%	63.1%	35.7%	18.0%
Claremont-Bathgate	16.3%	58.9%	31.7%	27.0%
Morrisania-Melrose	15.7%	60.0%	35.4%	27.0%
Brownsville	8.0%	57.8%	32.5%	29.0%
Longwood	13.6%	62.6%	36.5%	24.0%
Crotona Park East	14.7%	63.9%	31.8%	27.0%
Hunts Point	13.0%	65.6%	34.9%	24.0%
Fordham South	19.7%	69.7%	47.1%	18.0%
East New York (Pennsylvania Ave)	9.2%	63.1%	38.2%	29.0%
Mount Hope	18.7%	69.3%	44.9%	18.0%
Melrose South-Mott Haven North	11.4%	59.3%	30.0%	24.0%
East New York	13.6%	57.1%	33.8%	38.0%
Ocean Hill	9.2%	63.4%	37.6%	29.0%
Soundview-Bruckner	16.3%	60.3%	36.3%	41.0%
West Concourse	19.3%	64.7%	40.5%	19.0%
Bedford Park-Fordham North	16.8%	65.3%	40.1%	29.0%
Kingsbridge Heights	12.0%	69.7%	40.3%	29.0%
Belmont	15.1%	71.1%	44.5%	27.0%
East Harlem North	9.7%	52.3%	24.7%	42.0%
Stuyvesant Heights	6.7%	57.1%	32.2%	40.0%
NYPH High Disparity Community	12.1%	58.4%	33.3%	40.3%
New York City	8.9%	54.2%	29.8%	44.0%
New York State	N/A	39.2%	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- The high cost of housing is a significant concern for residents in New York.
- Overall in the NYPH community, the percentage of overcrowded housing, 12.1%, NYC, 8.9%, and rent burden greater than 50% of income 33.3%, is higher than New York City averages of 29.8%.
- The percentage of renter-occupied homes <u>without</u> maintenance defects, 40.3% is less favorable (lower) than New York City, 44.0%.

Overcrowded Housing, Rent Burden and Maintenance Defects in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of occupied housing units with more than one occupant per room	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 30% of monthly pre-tax income	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 50% of monthly pre-tax income	Percentage of renter-occupied homes without maintenance defects
West Farms-Bronx River	14.4%	63.0%	37.7%	41.0%
Williamsbridge-Olinville	9.8%	65.9%	39.9%	42.0%
Central Harlem North-Polo Grounds	6.3%	51.7%	27.8%	37.0%
East Harlem South	7.7%	50.8%	25.1%	42.0%
Seagate-Coney Island	6.2%	57.4%	25.8%	44.0%
Norwood	17.2%	62.7%	36.5%	29.0%
Bushwick South	12.3%	58.2%	31.3%	40.0%
Soundview-Castle Hill-Clason Point-Ha	6.8%	49.8%	26.8%	41.0%
Jamaica	21.0%	67.6%	39.5%	54.0%
Starrett City	5.7%	50.9%	20.3%	38.0%
Westchester-Unionport	12.1%	61.4%	39.2%	41.0%
Crown Heights North	7.3%	56.3%	30.7%	23.0%
Bedford	11.9%	58.5%	31.9%	40.0%
South Jamaica	11.2%	55.1%	34.2%	54.0%
Bronxdale	10.9%	53.0%	27.7%	47.0%
Washington Heights South	13.5%	58.0%	33.9%	33.0%
Bushwick North	18.6%	59.5%	34.7%	40.0%
Cypress Hills-City Line	23.2%	65.0%	35.9%	38.0%
Erasmus	12.7%	59.9%	34.1%	26.0%
Hamilton Heights	8.8%	54.5%	32.7%	37.0%
Eastchester-Edenwald-Baychester	7.3%	54.7%	26.8%	42.0%
Marble Hill-Inwood	14.8%	51.3%	30.1%	33.0%
Rugby-Remsen Village	8.7%	61.4%	36.1%	26.0%
Manhattanville	9.0%	62.4%	33.9%	37.0%
NYPH High Disparity Community	12.1%	58.4%	33.3%	40.3%
New York City	8.9%	54.2%	29.8%	44.0%
New York State	N/A	39.2%	N/A	N/A

- NTA Quartile 4 continued

Source: NYC Health Data Atlas; NYC Community Health Profiles

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

NewYork-Presbyterian

Overcrowded Housing, Rent Burden and Maintenance Defects in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of occupied housing units with more than one occupant per room	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 30% of monthly pre-tax income	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 50% of monthly pre-tax income	Percentage of renter-occupied homes without maintenance defects
Lower East Side	5.5%	47.5%	19.6%	36.0%
Gravesend	9.0%	58.5%	30.5%	44.0%
Van Cortlandt Village	14.8%	59.2%	33.6%	39.0%
Prospect Lefferts Gardens-Wingate	11.6%	58.9%	32.6%	38.0%
Van Nest-Morris Park-Westchester Sq	11.6%	60.5%	36.6%	47.0%
Hammels-Arverne-Edgemere	6.3%	48.8%	26.4%	44.0%
Chinatown	13.9%	54.4%	30.5%	36.0%
Far Rockaway-Bayswater	11.8%	57.5%	31.4%	44.0%
Central Harlem South	5.6%	48.6%	24.2%	37.0%
Parkchester	8.4%	51.7%	28.9%	41.0%
West New Brighton-New Brighton-St.	7.8%	58.0%	38.6%	59.0%
Sunset Park East	26.5%	64.5%	37.6%	49.0%
Queensbridge-Ravenswood-Long Islan	8.4%	50.5%	24.1%	46.0%
Baisley Park	8.0%	59.7%	31.3%	54.0%
Woodlawn-Wakefield	5.9%	57.5%	33.4%	42.0%
Allerton-Pelham Gardens	6.5%	50.8%	29.9%	47.0%
East Flatbush-Farragut	7.7%	55.9%	31.9%	26.0%
Flatbush	15.6%	58.0%	31.1%	40.0%
Sunset Park West	20.3%	59.2%	33.9%	49.0%
Canarsie	11.2%	52.6%	26.9%	31.0%
Crown Heights South	11.2%	58.3%	34.8%	38.0%
Pelham Parkway	9.4%	56.3%	30.6%	47.0%
Washington Heights North	12.3%	52.0%	30.8%	33.0%
Brighton Beach	12.9%	63.0%	37.9%	44.0%
Hollis	8.1%	62.7%	36.1%	54.0%
NYPH High Disparity Community	12.1%	58.4%	33.3%	40.3%
New York City	8.9%	54.2%	29.8%	44.0%
New York State	N/A	39.2%	N/A	N/A

- NTA Quartile 3

Source: NYC Health Data Atlas; NYC Community Health Profiles

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

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Overcrowded Housing, Rent Burden and Maintenance Defects in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of occupied housing units with more than one occupant per room	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 30% of monthly pre-tax income	Rent burden, i.e. rent plus electricity and heating fuel costs is greater than 50% of monthly pre-tax income	Percentage of renter-occupied homes without maintenance defects
Springfield Gardens North	5.4%	50.7%	26.2%	54.0%
St. Albans	6.2%	58.4%	35.3%	54.0%
Corona	20.4%	63.2%	36.7%	53.0%
East Elmhurst	15.7%	62.0%	37.8%	52.0%
Mariner's Harbor-Arlington-Port Ivory-	7.8%	56.3%	42.8%	59.0%
Williamsburg	25.3%	66.7%	43.6%	50.0%
Fort Greene	4.6%	43.1%	19.0%	29.0%
Jackson Heights	14.3%	62.5%	36.2%	52.0%
Midwood	10.1%	61.9%	39.7%	40.0%
South Ozone Park	9.6%	67.6%	42.9%	59.0%
Flushing	15.8%	64.2%	39.9%	55.0%
Flatlands	8.7%	52.4%	27.3%	31.0%
Schuylerville-Throgs Neck-Edgewater	3.1%	48.8%	26.6%	50.0%
Richmond Hill	11.5%	56.0%	33.8%	62.0%
North Corona	34.7%	61.8%	32.8%	52.0%
Sheepshead Bay-Gerritsen Beach-Man	5.4%	54.3%	31.0%	50.0%
Co-op City	4.5%	43.4%	21.8%	50.0%
Woodhaven	10.0%	55.9%	30.8%	62.0%
Grymes Hill-Clifton-Fox Hills	7.6%	49.7%	24.0%	59.0%
Queens Village	6.1%	65.8%	38.0%	61.0%
Elmhurst	21.4%	61.3%	35.3%	53.0%
Bensonhurst West	13.3%	57.9%	33.2%	62.0%
Morningside Heights	4.0%	48.4%	28.1%	37.0%
Port Richmond	5.4%	63.6%	45.2%	59.0%
NYPH High Disparity Community	12.1%	58.4%	33.3%	40.3%
New York City	8.9%	54.2%	29.8%	44.0%
New York State	N/A	39.2%	N/A	N/A

- NTA Quartile 3 continued

Source: NYC Health Data Atlas; NYC Community Health Profiles

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Public Housing, Foreclosures and Families in Shelters in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Percent of Residents Living in Public Housing Excl. Sec. 8	Housing Code violations	Housing Code complaints	Evictions	County Foreclosure Rate 2018	Percent of Families with Children in Shelter
East Tremont	3.8%	9,938	9,114	531	0.4%	14.5%
Highbridge	5.7%	7,242	10,056	720	0.4%	10.4%
Mott Haven-Port Morris	32.3%	5,454	4,682	421	0.4%	13.5%
East Concourse-Concourse Village	4.2%	13,986	4,682	720	0.4%	10.4%
University Heights-Morris Heights	4.9%	8,580	10,056	741	0.4%	10.8%
Claremont-Bathgate	36.1%	3,762	8,009	531	0.4%	14.5%
Morrisania-Melrose	14.9%	6,903	4,682	531	0.4%	14.5%
Brownsville	29.7%	7,431	5,225	377	0.6%	8.8%
Longwood	4.7%	4,386	3,290	421	0.4%	13.5%
Crotona Park East	4.3%	3,125	4,619	531	0.4%	14.5%
Hunts Point	4.6%	5,050	3,290	421	0.4%	13.5%
Fordham South	3.3%	6,773	9,569	741	0.4%	10.8%
East New York (Pennsylvania Ave)	7.4%	6,364	5,225	377	0.6%	8.8%
Mount Hope	0.0%	14,391	10,056	741	0.4%	10.8%
Melrose South-Mott Haven North	24.5%	4,109	4,682	421	0.4%	13.5%
East New York	14.8%	11,482	5,225	783	0.6%	10.3%
Ocean Hill	7.0%	6,259	5,225	377	0.6%	8.8%
Soundview-Bruckner	10.3%	5,942	5,103	666	0.4%	7.4%
West Concourse	0.0%	8,136	4,682	720	0.4%	10.4%
Bedford Park-Fordham North	0.0%	11,160	10,342	740	0.4%	7.3%
Kingsbridge Heights	1.5%	5,396	9,569	740	0.4%	7.3%
Belmont	0.0%	5,582	9,114	531	0.4%	14.5%
East Harlem North	31.9%	7,756	4,093	338	0.1%	6.3%
Stuyvesant Heights	10.2%	10,123	3,856	384	0.6%	8.5%
NYPH High Disparity Community	7.0%	513,682	402,503	41,958	0.5%	5.1%
New York City	4.7%	N/A	N/A	N/A	0.4%	3.8%
New York State	N/A	N/A	N/A	N/A	0.6%	N/A

Source: NYC Health Data Atlas; Data City of New York; Association for Neighborhood & Housing Development; Office of the New York State Comptroller and Citizen's Committee for Children

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Indicates neighborhood statistic is within five percent of the NYC statistic

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- Housing insecurity can lead to poor health outcomes, especially for children.
- The high cost of housing is a concern, as the percentage of residents in public housing, 7.0%, is higher than the NYC average, 4.7%.
- The rest of these statistics illustrate raw volumes for indicators such as housing code violations & complaints, evictions, foreclosures and families with children in shelters.
- Neighborhoods with the highest evictions (783 each) are East New York, Starrett City, and Cypress Hills-City Line.

Public Housing, Foreclosures and Families in Shelters in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of Residents Living in Public Housing Excl. Sec. 8	Housing Code violations	Housing Code complaints	Evictions	County Foreclosure Rate 2018	Percent of Families with Children in Shelter
West Farms-Bronx River	9.0%	5,172	6,515	666	0.4%	7.4%
Williamsbridge-Olinville	2.4%	10,951	4,121	685	0.4%	8.7%
Central Harlem North-Polo Grounds	18.1%	13,258	4,150	442	0.1%	5.7%
East Harlem South	25.2%	5,037	4,093	338	0.1%	6.3%
Seagate-Coney Island	30.7%	2,037	2,942	185	0.6%	2.1%
Norwood	0.0%	6,652	10,342	740	0.4%	7.3%
Bushwick South	11.9%	8,159	3,856	207	0.6%	4.1%
Soundview-Castle Hill-Clason Point-Ha	21.1%	1,971	5,959	666	0.4%	7.4%
Jamaica	1.1%	2,830	551	669	0.6%	5.4%
Starrett City	4.8%	280	5,225	783	0.6%	10.3%
Westchester-Unionport	0.5%	2,307	2,557	666	0.4%	7.4%
Crown Heights North	9.0%	20,783	6,188	318	0.6%	3.7%
Bedford	16.3%	8,841	1,140	384	0.6%	8.5%
South Jamaica	5.4%	2,301	830	669	0.6%	5.4%
Bronxdale	12.9%	4,503	10,384	393	0.4%	4.3%
Washington Heights South	1.8%	16,204	8,389	467	0.1%	2.4%
Bushwick North	0.9%	11,180	3,856	207	0.6%	4.1%
Cypress Hills-City Line	0.0%	4,630	5,225	783	0.6%	10.3%
Erasmus	0.0%	8,069	5,552	628	0.6%	5.4%
Hamilton Heights	0.9%	12,390	3,091	222	0.1%	3.2%
Eastchester-Edenwald-Baychester	15.9%	1,809	85	685	0.4%	8.7%
Marble Hill-Inwood	8.6%	9,120	4,921	467	0.1%	2.4%
Rugby-Remsen Village	0.5%	10,294	5,552	628	0.6%	5.4%
Manhattanville	11.7%	5,932	4,150	222	0.1%	3.2%
NYPH High Disparity Community	7.0%	513,682	402,503	41,958	0.5%	5.1%
New York City	4.7%	N/A	N/A	N/A	0.4%	3.8%
New York State	N/A	N/A	N/A	N/A	0.6%	N/A

Source: NYC Health Data Atlas; Data City of New York; Association for Neighborhood & Housing Development; Office of the New York State Comptroller and Citizen's Committee for Children

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- NTA Quartile 4 continued

Public Housing, Foreclosures and Families in Shelters in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percent of Residents Living in Public Housing Excl. Sec. 8	Housing Code violations	Housing Code complaints	Evictions	County Foreclosure Rate 2018	Percent of Families with Children in Shelter
Lower East Side	32.9%	2,708	2,988	193	0.1%	2.1%
Gravesend	12.0%	605	2,942	185	0.6%	2.1%
Van Cortlandt Village	1.5%	6,420	4,815	279	0.4%	1.9%
Prospect Lefferts Gardens-Wingate	0.5%	14,128	5,552	295	0.6%	2.9%
Van Nest-Morris Park-Westchester Squ	0.0%	2,258	6,515	393	0.4%	4.3%
Hammels-Arverne-Edgemere	23.2%	2,552	2,541	402	0.6%	4.7%
Chinatown	12.7%	3,879	2,988	193	0.1%	2.1%
Far Rockaway-Bayswater	2.8%	3,549	2,541	402	0.6%	4.7%
Central Harlem South	7.9%	6,896	2,514	442	0.1%	5.7%
Parkchester	0.0%	1,137	5,959	666	0.4%	7.4%
West New Brighton-New Brighton-St.	10.0%	2,276	1,261	421	0.5%	3.3%
Sunset Park East	0.0%	4,442	2,691	87	0.6%	1.2%
Queensbridge-Ravenswood-Long Islar	46.6%	712	761	187	0.6%	1.8%
Baisley Park	2.6%	1,262	1,122	669	0.6%	5.4%
Woodlawn-Wakefield	0.0%	3,659	4,121	685	0.4%	8.7%
Allerton-Pelham Gardens	6.1%	692	1,929	393	0.4%	4.3%
East Flatbush-Farragut	0.0%	4,895	5,552	628	0.6%	5.4%
Flatbush	0.0%	18,542	3,041	413	0.6%	2.0%
Sunset Park West	0.0%	4,563	2,244	87	0.6%	1.2%
Canarsie	6.9%	3,200	5,225	378	0.6%	2.7%
Crown Heights South	0.0%	6,885	5,552	295	0.6%	2.9%
Pelham Parkway	0.0%	2,207	2,557	393	0.4%	4.3%
Washington Heights North	0.0%	10,307	6,076	467	0.1%	2.4%
Brighton Beach	0.0%	3,062	3,674	185	0.6%	2.1%
Hollis	0.0%	737	551	669	0.6%	5.4%
NYPH High Disparity Community	7.0%	513,682	402,503	41,958	0.5%	5.1%
New York City	4.7%	N/A	N/A	N/A	0.4%	3.8%
New York State	N/A	N/A	N/A	N/A	0.6%	N/A

Source: NYC Health Data Atlas; Data City of New York; Association for Neighborhood & Housing Development; Office of the New York State Comptroller and Citizen's Committee for Children

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 3

Public housing, Foreclosures and Families in shelters in the High Disparity NYC Communities continued

NYC Neighborhood Tabulation Area	Percent of Residents Living in Public Housing Excl. Sec. 8	Housing Code violations	Housing Code complaints	Evictions	County Foreclosure Rate 2018	Percent of Families with Children in Shelter
Springfield Gardens North	0.0%	443	599	669	0.6%	5.4%
St. Albans	0.0%	1,456	145	669	0.6%	5.4%
Corona	0.0%	2,229	2,164	258	0.6%	1.5%
East Elmhurst	0.0%	840	2,164	185	0.6%	1.3%
Mariner's Harbor-Arlington-Port Ivory-	5.3%	1,767	569	421	0.5%	3.3%
Williamsburg	8.6%	1,440	1,140	135	0.6%	1.8%
Fort Greene	23.1%	1,637	987	138	0.6%	1.6%
Jackson Heights	0.0%	3,191	2,164	185	0.6%	1.3%
Midwood	0.0%	4,293	3,041	413	0.6%	2.0%
South Ozone Park	0.0%	1,901	470	165	0.6%	1.6%
Flushing	2.6%	2,089	1,041	264	0.6%	0.3%
Flatlands	3.5%	2,707	5,552	378	0.6%	2.7%
Schuylerville-Throgs Neck-Edgewater	7.5%	1,242	10,056	213	0.4%	2.7%
Richmond Hill	0.0%	2,000	987	212	0.6%	1.5%
North Corona	0.0%	2,354	2,164	185	0.6%	1.3%
Sheepshead Bay-Gerritsen Beach-Man	7.6%	1,980	2,609	213	0.6%	0.6%
Co-op City	2.9%	923	1,929	213	0.4%	2.7%
Woodhaven	0.0%	1,637	4,457	212	0.6%	1.5%
Grymes Hill-Clifton-Fox Hills	0.0%	1,398	1,261	421	0.5%	3.3%
Queens Village	0.0%	1,102	145	292	0.6%	2.2%
Elmhurst	0.0%	2,849	2,164	258	0.6%	1.5%
Bensonhurst West	0.0%	4,591	1,975	185	0.6%	0.5%
Morningside Heights	8.1%	3,388	4,499	222	0.1%	3.2%
Port Richmond	0.0%	612	389	421	0.5%	3.3%
NYPH High Disparity Community	7.0%	513,682	402,503	41,958	0.5%	5.1%
New York City	4.7%	N/A	N/A	N/A	0.4%	3.8%
New York State	N/A	N/A	N/A	N/A	0.6%	N/A

Source: NYC Health Data Atlas; Data City of New York; Association for Neighborhood & Housing Development; Office of the New York State Comptroller and Citizen's Committee for Children

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 3 continued

Food & Nutrition in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	SNAP Benefits (% Households)	# of Meals Needed per Year for Food Security (Meal Gap)	Food Desert
East Tremont	55.4%	6,700,229	N
Highbridge	55.7%	5,126,873	N
Mott Haven-Port Morris	54.0%	5,637,546	N
East Concourse-Concourse Village	45.1%	5,126,873	N
University Heights-Morris Heights	51.6%	5,105,643	N
Claremont-Bathgate	61.3%	6,700,229	N
Morrisania-Melrose	49.8%	6,700,229	N
Brownsville	45.2%	6,890,757	N
Longwood	53.6%	5,637,546	N
Crotona Park East	55.4%	6,700,229	N
Hunts Point	54.5%	5,637,546	Y
Fordham South	51.1%	5,105,643	N
East New York (Pennsylvania Ave)	38.2%	6,890,757	N
Mount Hope	48.6%	5,105,643	N
Melrose South-Mott Haven North	56.1%	5,637,546	N
East New York	29.8%	6,373,047	N
Ocean Hill	35.5%	6,890,757	N
Soundview-Bruckner	41.7%	5,667,139	N
West Concourse	49.2%	5,126,873	N
Bedford Park-Fordham North	47.2%	3,808,397	N
Kingsbridge Heights	42.0%	3,808,397	N
Belmont	47.7%	6,700,229	N
East Harlem North	32.3%	4,548,222	N
Stuyvesant Heights	33.5%	6,831,068	N
NYPH High Disparity Community	30.3%	510,256,159	N/A
New York City	7.5%	241,956,200	N/A
New York State	N/A	N/A	N/A

Source: NYC Health Data Atlas; Data2GoNYC; U.S. Department of Agriculture

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- Food insecurity affects millions of people in America and has a direct and long-lasting impact on health and well-being outcomes.
- The Supplemental Nutrition Assistance Program (SNAP) is the largest federal nutrition assistance program, providing benefits to eligible low-income individuals and families; The percentage receiving SNAP benefits, 30.3%, is much higher than the NYC average, 7.5%.
- Meal Gap is the number of meals missing annually from food insecure households; there are large numbers estimated for a number of NTAs.
- U.S. Department of Agriculture defines food deserts as geographical areas lacking fresh fruit, vegetables, and other healthful whole foods, largely due to an absence of grocery stores, farmers' markets, and healthy food providers in impoverished areas.
- Two NTAs are defined as a food desert - Hunts Point and Hammels-Arverne-Edgemere.

Food & Nutrition in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	SNAP Benefits (% Households)	# of Meals Needed per Year for Food Security (Meal Gap)	Food Desert
West Farms-Bronx River	42.0%	5,667,139	N
Williamsbridge-Olinville	30.8%	5,850,169	N
Central Harlem North-Polo Grounds	28.7%	6,300,973	N
East Harlem South	27.3%	4,548,222	N
Seagate-Coney Island	49.1%	3,798,001	N
Norwood	37.8%	3,808,397	N
Bushwick South	38.4%	4,269,443	N
Soundview-Castle Hill-Clason Point-Ha	34.5%	5,667,139	N
Jamaica	27.1%	9,464,831	N
Starrett City	36.0%	6,373,047	N
Westchester-Unionport	29.1%	5,667,139	N
Crown Heights North	29.1%	5,898,863	N
Bedford	36.2%	6,831,068	N
South Jamaica	33.3%	9,464,831	N
Bronxdale	38.3%	3,532,469	N
Washington Heights South	40.0%	5,565,856	N
Bushwick North	35.3%	4,269,443	N
Cypress Hills-City Line	23.5%	6,373,047	N
Erasmus	30.7%	6,616,561	N
Hamilton Heights	31.9%	4,465,450	N
Eastchester-Edenwald-Baychester	26.0%	5,850,169	N
Marble Hill-Inwood	37.4%	5,565,856	N
Rugby-Remsen Village	20.9%	6,616,561	N
Manhattanville	29.6%	4,465,450	N
NYPH High Disparity Community	30.3%	510,256,159	N/A
New York City	7.5%	241,956,200	N/A
New York State	N/A	N/A	N/A

Source: NYC Health Data Atlas; Data2GoNYC; U.S. Department of Agriculture

Illustrates neighborhood statistic is larger than the NYC statistic

Illustrates neighborhood statistic is equal to the NYC statistic

Ilustrates neighborhood statistic is smaller than the NYC statistic

- NTA Quartile 4 continued

Food & Nutrition in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	SNAP Benefits (% Households)	# of Meals Needed per Year for Food Security (Meal Gap)	Food Desert
Lower East Side	35.5%	5,066,241	N
Gravesend	29.3%	3,798,001	N
Van Cortlandt Village	32.3%	2,448,908	N
Prospect Lefferts Gardens-Wingate	24.3%	5,857,514	N
Van Nest-Morris Park-Westchester Squ	25.8%	3,532,469	N
Hammels-Arverne-Edgemere	33.3%	3,963,909	Y
Chinatown	26.1%	5,066,241	N
Far Rockaway-Bayswater	37.1%	3,963,909	N
Central Harlem South	18.1%	6,300,973	N
Parkchester	21.4%	5,667,139	N
West New Brighton-New Brighton-St. G	28.5%	4,256,215	N
Sunset Park East	34.5%	3,830,870	N
Queensbridge-Ravenswood-Long Islan	33.4%	4,755,505	N
Baisley Park	22.9%	9,464,831	N
Woodlawn-Wakefield	17.2%	5,850,169	N
Allerton-Pelham Gardens	16.6%	3,532,469	N
East Flatbush-Farragut	17.6%	6,616,561	N
Flatbush	27.5%	5,873,204	N
Sunset Park West	28.9%	3,830,870	N
Canarsie	16.8%	7,243,599	N
Crown Heights South	24.4%	5,857,514	N
Pelham Parkway	19.8%	3,532,469	N
Washington Heights North	29.7%	5,565,856	N
Brighton Beach	33.8%	3,798,001	N
Hollis	19.5%	9,464,831	N
NYPH High Disparity Community	30.3%	510,256,159	N/A
New York City	7.5%	241,956,200	N/A
New York State	N/A	N/A	N/A

Source: NYC Health Data Atlas; Data2GoNYC; U.S. Department of Agriculture

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- NTA Quartile 3

Food & Nutrition in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	SNAP Benefits (% Households)	# of Meals Needed per Year for Food Security (Meal Gap)	Food Desert
Springfield Gardens North	15.0%	9,464,831	N
St. Albans	16.6%	9,464,831	N
Corona	28.6%	2,851,549	N
East Elmhurst	15.9%	2,715,853	N
Mariner's Harbor-Arlington-Port Ivory-(	24.2%	4,256,215	N
Williamsburg	51.8%	4,230,546	N
Fort Greene	21.9%	3,995,959	N
Jackson Heights	15.2%	2,715,853	N
Midwood	23.1%	5,873,204	N
South Ozone Park	17.9%	2,924,411	N
Flushing	17.5%	5,543,537	N
Flatlands	16.8%	7,243,599	N
Schuylerville-Throgs Neck-Edgewater P	15.6%	2,890,426	N
Richmond Hill	18.3%	2,810,093	N
North Corona	30.7%	2,715,853	N
Sheepshead Bay-Gerritsen Beach-Manh	17.1%	3,865,084	N
Co-op City	13.8%	2,890,426	N
Woodhaven	20.3%	2,810,093	N
Grymes Hill-Clifton-Fox Hills	21.5%	4,256,215	N
Queens Village	14.5%	5,682,579	N
Elmhurst	16.2%	2,851,549	N
Bensonhurst West	21.2%	4,955,978	N
Morningside Heights	10.0%	4,465,450	N
Port Richmond	21.4%	4,256,215	N
NYPH High Disparity Community	30.3%	510,256,159	N/A
New York City	7.5%	241,956,200	N/A
New York State	N/A	N/A	N/A

Source: NYC Health Data Atlas; Data2GoNYC; U.S. Department of Agriculture

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- NTA Quartile 3 continued

Social & Environmental Safety in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Air Quality (Annual Avg. MCG per Cubic Meter of Fine Particle Matter)	Percent of Households with a Person Age 65+ Living Alone	Number of Persons Served by Senior Center Program per 1,000 Population Age 60+	Assault Hospitalization per 100,000 Population, Age Adjusted Rate	Felony Crime Complaints per 100,000 Population, Crude Rate	Total Number of Arrests of 16 & 17 Year Olds (Borough)
East Tremont	7.8	10.9%	102.0	181.7	27.9	2,950
Highbridge	8.3	8.1%	98.0	138.9	19.6	2,950
Mott Haven-Port Morris	8.6	11.6%	92.0	197.4	34.0	2,950
East Concourse-Concourse Village	8.3	12.6%	109.0	131.4	23.4	2,950
University Heights-Morris Heights	8.3	6.9%	116.0	136.7	18.0	2,950
Claremont-Bathgate	7.8	8.0%	98.0	197.1	25.7	2,950
Morrisania-Melrose	7.8	8.3%	120.0	151.1	24.3	2,950
Brownsville	8.0	10.6%	132.0	158.6	40.0	3,375
Longwood	8.6	9.6%	102.0	133.6	33.9	2,950
Crotona Park East	7.8	9.1%	126.0	166.1	27.6	2,950
Hunts Point	8.6	12.8%	135.0	193.4	49.4	2,950
Fordham South	8.3	5.7%	85.0	140.8	28.8	2,950
East New York (Pennsylvania Ave)	8.0	6.2%	55.0	147.3	42.5	3,375
Mount Hope	8.3	6.7%	120.0	136.6	22.8	2,950
Melrose South-Mott Haven North	8.6	11.8%	168.0	185.0	29.7	2,950
East New York	7.7	7.3%	63.0	134.6	39.9	3,375
Ocean Hill	8.0	11.1%	53.0	170.8	46.7	3,375
Soundview-Bruckner	7.6	9.5%	57.0	126.9	25.9	2,950
West Concourse	8.3	7.7%	113.0	113.4	28.6	2,950
Bedford Park-Fordham North	7.8	8.3%	58.0	126.5	29.6	2,950
Kingsbridge Heights	7.8	9.3%	51.0	85.4	22.4	2,950
Belmont	7.8	9.0%	101.0	120.6	26.7	2,950
East Harlem North	8.2	14.2%	185.0	138.9	33.5	2,440
Stuyvesant Heights	8.1	10.8%	71.0	142.0	35.5	3,375
NYPH High Disparity Community	7.7	9.6%	103.3	81.3	22.2	2,845
New York City	7.5	10.5%	101.0	61.6	20.3	11,678
New York State	N/A	N/A	N/A	3.8	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

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- The physical environment (pollution, access to safe streets & parks, etc.) also plays a key role in health and well-being. Long term health factors have also evolved to include social and familial support resources.
- There is a lot of variation in air quality among neighborhoods, but most of the Quartile 4 NTAs are worse than the NYC average.
- Compared to the NYC averages there are fewer seniors living alone and about the same Senior Center participation.
- Assault hospitalizations and felony complaints are higher among many of these neighborhoods. Mott Haven-Port Morris and Ocean Hill fare worse than average on all of these indicators.

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Social & Environmental Safety in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Air Quality (Annual Avg. MCG per Cubic Meter of Fine Particle Matter)	Percent of Households with a Person Age 65+ Living Alone	Number of Persons Served by Senior Center Program per 1,000 Population Age 60+	Assault Hospitalization per 100,000 Population, Age Adjusted Rate	Felony Crime Complaints per 100,000 Population, Crude Rate	Total Number of Arrests of 16 & 17 Year Olds (Borough)
West Farms-Bronx River	7.6	10.3%	105.0	104.8	21.2	2,950
Williamsbridge-Olinville	7.5	9.7%	69.0	94.9	20.9	2,950
Central Harlem North-Polo Grounds	7.9	12.1%	143.0	131.9	24.1	2,440
East Harlem South	8.2	14.3%	203.0	91.7	23.0	2,440
Seagate-Coney Island	6.7	19.1%	256.0	99.7	32.2	3,375
Norwood	7.8	6.9%	52.0	101.2	23.0	2,950
Bushwick South	8.1	9.3%	144.0	96.1	30.2	3,375
Soundview-Castle Hill-Clason Point-Ha	7.6	10.4%	88.0	114.7	19.9	2,950
Jamaica	7.0	7.5%	78.0	70.5	35.3	2,358
Starrett City	7.7	24.2%	263.0	73.6	14.8	3,375
Westchester-Unionport	7.6	7.6%	61.0	78.1	19.1	2,950
Crown Heights North	8.0	11.0%	77.0	106.0	36.1	3,375
Bedford	8.1	7.9%	79.0	75.3	29.4	3,375
South Jamaica	7.0	11.0%	84.0	91.3	26.2	2,358
Bronxdale	7.4	11.2%	140.0	83.3	16.9	2,950
Washington Heights South	7.8	10.9%	187.0	51.1	15.6	2,440
Bushwick North	8.1	4.2%	196.0	43.2	22.1	3,375
Cypress Hills-City Line	7.7	5.5%	101.0	71.2	27.9	3,375
Erasmus	7.8	9.1%	32.0	105.6	34.7	3,375
Hamilton Heights	8.0	10.4%	122.0	70.2	20.3	2,440
Eastchester-Edenwald-Baychester	7.5	8.0%	79.0	90.9	16.9	2,950
Marble Hill-Inwood	7.8	9.8%	155.0	42.3	16.5	2,440
Rugby-Remsen Village	7.8	7.8%	34.0	85.2	24.1	3,375
Manhattanville	8.0	12.0%	110.0	86.5	27.3	2,440
NYPH High Disparity Community	7.7	9.6%	103.3	81.3	22.2	2,845
New York City	7.5	10.5%	101.0	61.6	20.3	11,678
New York State	N/A	N/A	N/A	3.8	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

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- NTA Quartile 4 continued

Social & Environmental Safety in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Air Quality (Annual Avg. MCG per Cubic Meter of Fine Particle Matter)	Percent of Households with a Person Age 65+ Living Alone	Number of Persons Served by Senior Center Program per 1,000 Population Age 60+	Assault Hospitalization per 100,000 Population, Age Adjusted Rate	Felony Crime Complaints per 100,000 Population, Crude Rate	Total Number of Arrests of 16 & 17 Year Olds (Borough)
Lower East Side	8.9	12.6%	220.0	60.5	17.6	2,440
Gravesend	6.7	17.2%	90.0	40.0	17.0	3,375
Van Cortlandt Village	7.5	8.7%	73.0	67.9	14.2	2,950
Prospect Lefferts Gardens-Wingate	7.8	9.6%	40.0	90.9	24.5	3,375
Van Nest-Morris Park-Westchester Squ	7.4	8.1%	40.0	65.7	20.3	2,950
Hammels-Arverne-Edgemere	6.0	9.1%	61.0	112.0	28.2	2,358
Chinatown	8.9	12.2%	232.0	53.3	23.7	2,440
Far Rockaway-Bayswater	6.0	11.4%	126.0	70.0	20.3	2,358
Central Harlem South	7.9	9.9%	139.0	73.0	30.1	2,440
Parkchester	7.6	9.5%	88.0	63.5	14.0	2,950
West New Brighton-New Brighton-St. G	7.1	9.9%	130.0	154.6	22.3	552
Sunset Park East	8.5	6.5%	114.0	31.2	13.3	3,375
Queensbridge-Ravenswood-Long Islan	7.8	10.0%	274.0	83.2	32.9	2,358
Baisley Park	7.0	7.6%	59.0	80.3	27.6	2,358
Woodlawn-Wakefield	7.5	9.7%	45.0	57.9	18.0	2,950
Allerton-Pelham Gardens	7.4	9.6%	45.0	67.1	11.7	2,950
East Flatbush-Farragut	7.8	8.6%	36.0	65.4	23.1	3,375
Flatbush	7.5	8.8%	58.0	45.1	17.5	3,375
Sunset Park West	8.5	5.9%	154.0	49.2	16.4	3,375
Canarsie	7.1	5.6%	60.0	54.6	20.5	3,375
Crown Heights South	7.8	9.3%	43.0	55.0	20.5	3,375
Pelham Parkway	7.4	11.4%	70.0	40.4	13.8	2,950
Washington Heights North	7.8	9.6%	174.0	32.6	12.8	2,440
Brighton Beach	6.7	21.7%	147.0	30.6	16.1	3,375
Hollis	7.0	4.8%	33.0	55.5	17.5	2,358
Port Richmond	7.1	10.5%	70.0	96.9	21.2	552
NYPH High Disparity Community	7.7	9.6%	103.3	81.3	22.2	2,845
New York City	7.5	10.5%	101.0	61.6	20.3	11,678
New York State	N/A	N/A	N/A	3.8	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

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- NTA Quartile 3

Social & Environmental Safety in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Air Quality (Annual Avg. MCG per Cubic Meter of Fine Particle Matter)	Percent of Households with a Person Age 65+ Living Alone	Number of Persons Served by Senior Center Program per 1,000 Population Age 60+	Assault Hospitalization per 100,000 Population, Age Adjusted Rate	Felony Crime Complaints per 100,000 Population, Crude Rate	Total Number of Arrests of 16 & 17 Year Olds (Borough)
Springfield Gardens North	7.0	16.4%	147.0	39.3	21.8	2,358
St. Albans	7.0	7.9%	57.0	68.7	22.0	2,358
Corona	7.7	8.9%	100.0	51.2	10.6	2,358
East Elmhurst	7.3	7.5%	89.0	30.0	18.8	2,358
Mariner's Harbor-Arlington-Port Ivory-(	7.1	8.1%	50.0	86.5	16.9	552
Williamsburg	9.6	11.5%	160.0	21.2	8.5	3,375
Fort Greene	8.8	8.5%	73.0	69.8	38.4	3,375
Jackson Heights	7.3	10.5%	118.0	30.8	16.0	2,358
Midwood	7.5	13.6%	111.0	19.7	11.1	3,375
South Ozone Park	6.8	5.1%	28.0	36.1	19.0	2,358
Flushing	7.3	12.8%	185.0	26.4	16.2	2,358
Flatlands	7.1	7.6%	65.0	43.3	16.4	3,375
Schuylerville-Throgs Neck-Edgewater P	7.5	11.2%	66.0	49.5	10.0	2,950
Richmond Hill	7.3	3.5%	37.0	49.6	17.5	2,358
North Corona	7.3	4.6%	98.0	51.1	17.9	2,358
Sheepshead Bay-Gerritsen Beach-Manh	6.8	15.1%	119.0	30.3	16.5	3,375
Co-op City	7.5	16.9%	110.0	52.7	12.6	2,950
Woodhaven	7.3	5.6%	73.0	44.7	13.9	2,358
Grymes Hill-Clifton-Fox Hills	7.1	8.0%	68.0	114.9	11.7	552
Queens Village	6.5	5.0%	42.0	49.4	15.1	2,358
Elmhurst	7.7	7.8%	144.0	33.6	13.7	2,358
Bensonhurst West	7.0	10.6%	85.0	27.7	10.4	3,375
Morningside Heights	8.0	12.0%	114.0	25.8	15.0	2,440
Port Richmond	7.1	10.5%	70.0	96.9	21.2	552
NYPH High Disparity Community	7.7	9.6%	103.3	81.3	22.2	2,845
New York City	7.5	10.5%	101.0	61.6	20.3	11,678
New York State	N/A	N/A	N/A	3.8	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

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- NTA Quartile 3 continued

Transportation in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Workers who commute by any form of transportation over 60 minutes each way.
East Tremont	39.7
Highbridge	39.5
Mott Haven-Port Morris	46.1
East Concourse-Concourse Village	39.4
University Heights-Morris Heights	58.3
Claremont-Bathgate	47.2
Morrisania-Melrose	45.8
Brownsville	55.2
Longwood	37.5
Crotona Park East	41.1
Hunts Point	41.9
Fordham South	38.1
East New York (Pennsylvania Ave)	59.2
Mount Hope	38.0
Melrose South-Mott Haven North	39.5
East New York	48.9
Ocean Hill	41.9
Soundview-Bruckner	52.9
West Concourse	41.8
Bedford Park-Fordham North	46.0
Kingsbridge Heights	46.5
Belmont	35.9
East Harlem North	35.0
Stuyvesant Heights	38.1
NYPH High Disparity Community	n/a
New York City	27.0
New York State	36.0

Source: Data2GoNYC

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- According to multiple studies, New York City has the longest commute time via car and public transit among large cities across the U.S.
- All neighborhoods in the NYPH community have longer than NYC average commute times to work, with the exception of Sunset Park East, Williamsburg and Morningside Heights.

Transportation in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Workers who commute by any form of transportation over 60 minutes each way.
West Farms-Bronx River	42.5
Williamsbridge-Olinville	48.0
Central Harlem North-Polo Grounds	34.9
East Harlem South	33.3
Seagate-Coney Island	43.2
Norwood	46.0
Bushwick South	30.5
Soundview-Castle Hill-Clason Point-Harding Park	43.6
Jamaica	50.5
Starrett City	48.9
Westchester-Unionport	40.1
Crown Heights North	39.7
Bedford	40.0
South Jamaica	45.3
Bronxdale	37.9
Washington Heights South	43.5
Bushwick North	43.2
Cypress Hills-City Line	40.0
Erasmus	46.4
Hamilton Heights	39.0
Eastchester-Edenwald-Baychester	44.2
Marble Hill-Inwood	42.8
Rugby-Remsen Village	42.9
Manhattanville	34.4
NYPH High Disparity Community	n/a
New York City	27.0
New York State	36.0

Source: Data2GoNYC

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- NTA Quartile 4 continued

Transportation in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Workers who commute by any form of transportation over 60 minutes each way.
Lower East Side	32.2
Gravesend	39.4
Van Cortlandt Village	45.6
Prospect Lefferts Gardens-Wingate	42.2
Van Nest-Morris Park-Westchester Square	48.9
Hammels-Arverne-Edgemere	45.3
Chinatown	33.5
Far Rockaway-Bayswater	44.9
Central Harlem South	36.0
Parkchester	47.6
West New Brighton-New Brighton-St. George	47.3
Sunset Park East	0.0
Queensbridge-Ravenswood-Long Island City	41.7
Baisley Park	48.4
Woodlawn-Wakefield	42.3
Allerton-Pelham Gardens	32.4
East Flatbush-Farragut	41.3
Flatbush	33.5
Sunset Park West	38.3
Canarsie	45.4
Crown Heights South	42.1
Pelham Parkway	44.6
Washington Heights North	37.4
Brighton Beach	48.1
Hollis	41.6
NYPH High Disparity Community	n/a
New York City	27.0
New York State	36.0

Source: Data2GoNYC

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- NTA Quartile 3

Transportation in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Workers who commute by any form of transportation over 60 minutes each way.
Springfield Gardens North	44.7
St. Albans	57.0
Corona	44.6
East Elmhurst	44.9
Mariner's Harbor-Arlington-Port Ivory-Graniteville	41.4
Williamsburg	25.6
Fort Greene	43.2
Jackson Heights	36.3
Midwood	39.8
South Ozone Park	50.2
Flushing	43.8
Flatlands	37.9
Schuylerville-Throgs Neck-Edgewater Park	37.8
Richmond Hill	50.8
North Corona	40.9
Sheepshead Bay-Gerritsen Beach-Manhattan Beach	49.4
Co-op City	41.2
Woodhaven	42.9
Grymes Hill-Clifton-Fox Hills	48.8
Queens Village	40.8
Elmhurst	37.8
Bensonhurst West	41.1
Morningside Heights	27.4
Port Richmond	39.0
NYPH High Disparity Community	n/a
New York City	27.0
New York State	36.0

Source: Data2GoNYC

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- NTA Quartile 3 continued

Health Status Indicators: Healthy Eating & Physical Activity in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Percentage of adults who ate in 24 hrs, 1+ serving fruit/veg	Percentage of adults who drink >1 sweetened beverages daily	Percentage of adults reporting obesity	Percentage of public school children (K to 8) with obesity	Percentage of adults w/ physical activity in last 30 days
East Tremont	81.0%	34.0%	36.0%	24.0%	68.0%
Highbridge	83.0%	34.0%	34.0%	23.0%	65.0%
Mott Haven-Port Morris	82.0%	29.0%	42.0%	24.0%	65.0%
East Concourse-Concourse Village	83.0%	34.0%	34.0%	23.0%	65.0%
University Heights-Morris Heights	78.0%	33.0%	34.0%	24.0%	67.0%
Claremont-Bathgate	81.0%	34.0%	36.0%	24.0%	68.0%
Morrisania-Melrose	81.0%	34.0%	36.0%	24.0%	68.0%
Brownsville	80.0%	35.0%	41.0%	23.0%	74.0%
Longwood	82.0%	29.0%	42.0%	24.0%	65.0%
Crotona Park East	81.0%	34.0%	36.0%	24.0%	68.0%
Hunts Point	82.0%	29.0%	42.0%	24.0%	65.0%
Fordham South	78.0%	33.0%	34.0%	24.0%	67.0%
East New York (Pennsylvania Ave)	80.0%	35.0%	41.0%	23.0%	74.0%
Mount Hope	78.0%	33.0%	34.0%	24.0%	67.0%
Melrose South-Mott Haven North	82.0%	29.0%	42.0%	24.0%	65.0%
East New York	76.0%	31.0%	35.0%	25.0%	70.0%
Ocean Hill	80.0%	35.0%	41.0%	23.0%	74.0%
Soundview-Bruckner	83.0%	39.0%	32.0%	25.0%	73.0%
West Concourse	83.0%	34.0%	34.0%	23.0%	65.0%
Bedford Park-Fordham North	84.0%	29.0%	33.0%	25.0%	68.0%
Kingsbridge Heights	84.0%	29.0%	33.0%	25.0%	68.0%
Belmont	81.0%	34.0%	36.0%	24.0%	68.0%
East Harlem North	84.0%	29.0%	28.0%	23.0%	68.0%
Stuyvesant Heights	84.0%	29.0%	29.0%	22.0%	70.0%
NYPH High Disparity Community	84.4%	27.4%	28.5%	22.3%	71.2%
New York City	87.0%	23.0%	24.0%	20.0%	73.0%
New York State	N/A	24.7%	N/A	0.0%	74.0%

Source: NYC Community Health Profiles

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

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Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- Behaviors related to healthy eating and physical activity, though challenging to change, can directly contribute to improved health outcomes and fewer chronic illnesses.
- Overall in the NYPH community, adults are reporting eating at least one serving of fruits and vegetables on par with the NYC average. However, residents are drinking more than one sugary beverage per day at percentages higher than the NYC average.
- There are also higher than average reports of obesity in adults, 28.5%, worse compared to NYC, 24.0%, and in children, 22.3%, also worse than NYC, 20.0%.
- There is about the same amount of physical activity, 71.2%, as the NYC average, 73.0%.
- Multiple NTAs fare poorly on all these indicators.

Health Status Indicators: Healthy Eating & Physical Activity in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of adults who ate in 24 hrs, 1+ serving fruit/veg	Percentage of adults who drink >1 sweetened beverages daily	Percentage of adults reporting obesity	Percentage of public school children (K to 8) with obesity	Percentage of adults w/ physical activity in last 30 days
West Farms-Bronx River	83.0%	39.0%	32.0%	25.0%	73.0%
Williamsbridge-Olinville	88.0%	29.0%	30.0%	24.0%	71.0%
Central Harlem North-Polo Grounds	84.0%	29.0%	34.0%	21.0%	73.0%
East Harlem South	84.0%	29.0%	28.0%	23.0%	68.0%
Seagate-Coney Island	91.0%	21.0%	28.0%	18.0%	71.0%
Norwood	84.0%	29.0%	33.0%	25.0%	68.0%
Bushwick South	82.0%	23.0%	26.0%	28.0%	75.0%
Soundview-Castle Hill-Clason Point-Ha	83.0%	39.0%	32.0%	25.0%	73.0%
Jamaica	86.0%	30.0%	30.0%	23.0%	69.0%
Starrett City	76.0%	31.0%	35.0%	25.0%	70.0%
Westchester-Unionport	83.0%	39.0%	32.0%	25.0%	73.0%
Crown Heights North	84.0%	21.0%	26.0%	19.0%	74.0%
Bedford	84.0%	29.0%	29.0%	22.0%	70.0%
South Jamaica	86.0%	30.0%	30.0%	23.0%	69.0%
Bronxdale	83.0%	29.0%	32.0%	23.0%	74.0%
Washington Heights South	81.0%	23.0%	26.0%	24.0%	77.0%
Bushwick North	82.0%	23.0%	26.0%	28.0%	75.0%
Cypress Hills-City Line	76.0%	31.0%	35.0%	25.0%	70.0%
Erasmus	80.0%	32.0%	34.0%	22.0%	73.0%
Hamilton Heights	88.0%	29.0%	21.0%	25.0%	76.0%
Eastchester-Edenwald-Baychester	88.0%	29.0%	30.0%	24.0%	71.0%
Marble Hill-Inwood	81.0%	23.0%	26.0%	24.0%	77.0%
Rugby-Remsen Village	80.0%	32.0%	34.0%	22.0%	73.0%
Manhattanville	88.0%	29.0%	21.0%	25.0%	76.0%
NYPH High Disparity Community	84.4%	27.4%	28.5%	22.3%	71.2%
New York City	87.0%	23.0%	24.0%	20.0%	73.0%
New York State	N/A	24.7%	N/A	0.0%	74.0%

Source: NYC Community Health Profiles

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- NTA Quartile 4 continued

NewYork-Presbyterian

Health Status Indicators: Healthy Eating & Physical Activity in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of adults who ate in 24 hrs, 1+ serving fruit/veg	Percentage of adults who drink >1 sweetened beverages daily	Percentage of adults reporting obesity	Percentage of public school children (K to 8) with obesity	Percentage of adults w/ physical activity in last 30 days
Lower East Side	88.0%	16.0%	10.0%	16.0%	77.0%
Gravesend	91.0%	21.0%	28.0%	18.0%	71.0%
Van Cortlandt Village	86.0%	20.0%	24.0%	21.0%	72.0%
Prospect Lefferts Gardens-Wingate	81.0%	32.0%	32.0%	19.0%	77.0%
Van Nest-Morris Park-Westchester Squ	83.0%	29.0%	32.0%	23.0%	74.0%
Hammels-Arverne-Edgemere	89.0%	24.0%	32.0%	23.0%	72.0%
Chinatown	88.0%	16.0%	10.0%	16.0%	77.0%
Far Rockaway-Bayswater	89.0%	24.0%	32.0%	23.0%	72.0%
Central Harlem South	84.0%	29.0%	34.0%	21.0%	73.0%
Parkchester	83.0%	39.0%	32.0%	25.0%	73.0%
West New Brighton-New Brighton-St. G	87.0%	27.0%	24.0%	21.0%	73.0%
Sunset Park East	87.0%	24.0%	24.0%	18.0%	68.0%
Queensbridge-Ravenswood-Long Islan	89.0%	24.0%	19.0%	22.0%	73.0%
Baisley Park	86.0%	30.0%	30.0%	23.0%	69.0%
Woodlawn-Wakefield	88.0%	29.0%	30.0%	24.0%	71.0%
Allerton-Pelham Gardens	83.0%	29.0%	32.0%	23.0%	74.0%
East Flatbush-Farragut	80.0%	32.0%	34.0%	22.0%	73.0%
Flatbush	80.0%	26.0%	28.0%	21.0%	69.0%
Sunset Park West	87.0%	24.0%	24.0%	18.0%	68.0%
Canarsie	85.0%	23.0%	30.0%	21.0%	80.0%
Crown Heights South	81.0%	32.0%	32.0%	19.0%	77.0%
Pelham Parkway	83.0%	29.0%	32.0%	23.0%	74.0%
Washington Heights North	81.0%	23.0%	26.0%	24.0%	77.0%
Brighton Beach	91.0%	21.0%	28.0%	18.0%	71.0%
Hollis	86.0%	30.0%	30.0%	23.0%	69.0%
NYPH High Disparity Community	84.4%	27.4%	28.5%	22.3%	71.2%
New York City	87.0%	23.0%	24.0%	20.0%	73.0%
New York State	N/A	24.7%	N/A	0.0%	74.0%

Source: NYC Community Health Profiles

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- NTA Quartile 3

Health Status Indicators: Healthy Eating & Physical Activity in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of adults who ate in 24 hrs, 1+ serving fruit/veg	Percentage of adults who drink >1 sweetened beverages daily	Percentage of adults reporting obesity	Percentage of public school children (K to 8) with obesity	Percentage of adults w/ physical activity in last 30 days
Springfield Gardens North	86.0%	30.0%	30.0%	23.0%	69.0%
St. Albans	86.0%	30.0%	30.0%	23.0%	69.0%
Corona	88.0%	20.0%	23.0%	24.0%	69.0%
East Elmhurst	86.0%	25.0%	20.0%	26.0%	72.0%
Mariner's Harbor-Arlington-Port Ivory-(	87.0%	27.0%	24.0%	21.0%	73.0%
Williamsburg	91.0%	18.0%	23.0%	23.0%	66.0%
Fort Greene	88.0%	20.0%	24.0%	14.0%	76.0%
Jackson Heights	86.0%	25.0%	20.0%	26.0%	72.0%
Midwood	80.0%	26.0%	28.0%	21.0%	69.0%
South Ozone Park	83.0%	30.0%	27.0%	21.0%	69.0%
Flushing	95.0%	16.0%	13.0%	15.0%	69.0%
Flatlands	85.0%	23.0%	30.0%	21.0%	80.0%
Schuylerville-Throgs Neck-Edgewater F	87.0%	35.0%	24.0%	23.0%	75.0%
Richmond Hill	86.0%	24.0%	23.0%	22.0%	67.0%
North Corona	86.0%	25.0%	20.0%	26.0%	72.0%
Sheepshead Bay-Gerritsen Beach-Manh	93.0%	21.0%	26.0%	17.0%	67.0%
Co-op City	87.0%	35.0%	24.0%	23.0%	75.0%
Woodhaven	86.0%	24.0%	23.0%	22.0%	67.0%
Grymes Hill-Clifton-Fox Hills	87.0%	27.0%	24.0%	21.0%	73.0%
Queens Village	86.0%	28.0%	27.0%	20.0%	68.0%
Elmhurst	88.0%	20.0%	23.0%	24.0%	69.0%
Bensonhurst West	90.0%	17.0%	21.0%	14.0%	65.0%
Morningside Heights	88.0%	29.0%	21.0%	25.0%	76.0%
Port Richmond	87.0%	27.0%	24.0%	21.0%	73.0%
NYPH High Disparity Community	84.4%	27.4%	28.5%	22.3%	71.2%
New York City	87.0%	23.0%	24.0%	20.0%	73.0%
New York State	N/A	24.7%	N/A	0.0%	74.0%

Source: NYC Community Health Profiles

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

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- NTA Quartile 3 continued

NewYork-Presbyterian

Health Status Indicators: Women, Infants, & Children in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Crude rate of severe maternal morbidity (SMM) per 10,000 deliveries	Rate of infant deaths (under one year old) per 1,000 live births	Percent of live births receiving late prenatal care	Percent of preterm births among all live births	Rate of Teen Births (per 1,000 women ages 15 to 19)
East Tremont	284.1	6.4	11.5%	11.0%	44.6
Highbridge	307.3	3.8	11.9%	9.5%	34.6
Mott Haven-Port Morris	313.4	5.1	10.1%	10.2%	43.6
East Concourse-Concourse Village	309.7	3.8	11.7%	9.5%	35.6
University Heights-Morris Heights	273.2	5.4	11.2%	9.9%	38.7
Claremont-Bathgate	332.3	6.4	13.0%	11.2%	35.3
Morrisania-Melrose	335.8	6.4	12.8%	9.8%	48.3
Brownsville	506.0	4.9	9.9%	15.0%	36.3
Longwood	301.5	5.1	13.7%	9.0%	54.9
Crotona Park East	292.8	6.4	12.7%	11.5%	33.8
Hunts Point	291.6	5.1	13.3%	9.7%	43.1
Fordham South	248.0	5.4	12.2%	9.8%	64.2
East New York (Pennsylvania Ave)	442.7	4.9	11.5%	13.0%	34.6
Mount Hope	275.4	5.4	12.0%	9.6%	38.4
Melrose South-Mott Haven North	344.1	5.1	11.9%	9.3%	44.0
East New York	454.6	6.2	9.8%	12.6%	33.2
Ocean Hill	494.3	4.9	11.4%	14.0%	38.8
Soundview-Bruckner	312.2	6.0	12.5%	9.8%	34.9
West Concourse	304.0	3.8	10.6%	10.6%	42.9
Bedford Park-Fordham North	290.4	3.6	10.4%	9.1%	45.4
Kingsbridge Heights	248.3	3.6	10.4%	8.9%	47.8
Belmont	306.5	6.4	10.0%	9.8%	24.1
East Harlem North	257.5	5.9	9.8%	11.1%	36.2
Stuyvesant Heights	481.0	5.7	9.5%	12.6%	38.2
NYPH High Disparity Community	282.3	5.0	9.3%	10.0%	29.1
New York City	229.6	4.4	7.0%	9.1%	23.7
New York State	N/A	4.8	5.6%	1.7%	17.8

Source: NYC Health Data Atlas; NYC Community Health Profiles

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- The health status of infancy can impact long term health and the lack of early prenatal care can result in very costly neonatal and/or pediatric care needs.
- The rate of severe maternal morbidity, 282.3 is worse than NYC 229.6.
- There is a higher percentage of live births receiving late prenatal care, 9.3%, compared to NYC 7.0%, which could be contributing to the higher than NYC average rate of infant deaths, 5.0, compared to NYC, 4.4, and preterm births, 10.0%, compared to NYC, 9.1%.
- NTAs particularly impacted are East Flatbush-Farragut, Brownsville, Ocean Hill, and Erasmus.
- A variety of neighborhoods also have a higher than average teen birth rate- North Corona 68.9%, Fordham South 64.2%, and Longwood 54.9%. NYC rate is 23.7%

NewYork-Presbyterian

Health Status Indicators: Women, Infants, & Children in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Crude rate of severe maternal morbidity (SMM) per 10,000 deliveries	Rate of infant deaths (under one year old) per 1,000 live births	Percent of live births receiving late prenatal care	Percent of preterm births among all live births	Rate of Teen Births (per 1,000 women ages 15 to 19)
West Farms-Bronx River	317.2	6.0	13.3%	9.8%	43.6
Williamsbridge-Olinville	307.4	7.7	14.9%	9.3%	32.5
Central Harlem North-Polo Grounds	245.1	7.2	11.7%	11.3%	31.7
East Harlem South	249.9	5.9	7.4%	11.0%	26.0
Seagate-Coney Island	364.3	5.6	8.4%	12.7%	44.3
Norwood	270.5	3.6	9.6%	8.8%	32.0
Bushwick South	331.0	3.8	7.8%	9.6%	42.2
Soundview-Castle Hill-Clason Point-Ha	334.2	6.0	13.3%	11.7%	36.8
Jamaica	345.7	6.2	10.6%	9.7%	30.6
Starrett City	332.8	6.2	6.0%	11.5%	35.5
Westchester-Unionport	216.9	6.0	11.8%	9.5%	27.5
Crown Heights North	372.5	5.4	8.9%	11.5%	32.5
Bedford	235.5	5.7	5.3%	8.0%	36.3
South Jamaica	334.9	6.2	11.4%	11.9%	22.4
Bronxdale	282.7	8.1	12.3%	10.6%	41.5
Washington Heights South	199.0	4.3	7.6%	8.3%	33.6
Bushwick North	320.3	3.8	7.2%	8.7%	33.0
Cypress Hills-City Line	286.6	6.2	8.6%	9.4%	31.6
Erasmus	532.3	7.1	14.5%	13.9%	29.3
Hamilton Heights	262.4	4.5	9.5%	8.9%	34.8
Eastchester-Edenwald-Baychester	386.4	7.7	14.3%	12.1%	22.6
Marble Hill-Inwood	192.6	4.3	7.0%	7.9%	22.5
Rugby-Remsen Village	434.4	7.1	12.5%	12.9%	20.4
Manhattanville	235.9	4.5	8.5%	11.2%	44.9
NYPH High Disparity Community	282.3	5.0	9.3%	10.0%	29.1
New York City	229.6	4.4	7.0%	9.1%	23.7
New York State	N/A	4.8	5.6%	1.7%	17.8

Source: NYC Health Data Atlas; NYC Community Health Profiles

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- NTA Quartile 4 continued

Health Status Indicators: Women, Infants, & Children in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Crude rate of severe maternal morbidity (SMM) per 10,000 deliveries	Rate of infant deaths (under one year old) per 1,000 live births	Percent of live births receiving late prenatal care	Percent of preterm births among all live births	Rate of Teen Births (per 1,000 women ages 15 to 19)
Lower East Side	162.7	3.0	5.5%	9.7%	21.9
Gravesend	217.9	5.6	5.5%	8.9%	15.5
Van Cortlandt Village	253.2	4.4	9.1%	9.2%	34.0
Prospect Lefferts Gardens-Wingate	370.9	3.5	10.3%	11.0%	23.3
Van Nest-Morris Park-Westchester Squ	384.4	8.1	10.1%	10.0%	31.0
Hammels-Arverne-Edgemere	290.5	6.3	14.3%	10.9%	35.1
Chinatown	104.8	3.0	4.2%	6.0%	14.4
Far Rockaway-Bayswater	159.7	6.3	10.4%	9.9%	28.8
Central Harlem South	177.6	7.2	9.7%	10.1%	25.3
Parkchester	375.8	6.0	10.3%	9.9%	23.1
West New Brighton-New Brighton-St. G	210.0	6.9	4.9%	10.3%	44.7
Sunset Park East	149.6	2.0	3.1%	6.2%	29.4
Queensbridge-Ravenswood-Long Islan	263.8	4.3	13.5%	10.2%	33.1
Baisley Park	314.8	6.2	11.3%	12.2%	24.4
Woodlawn-Wakefield	296.4	7.7	14.9%	9.9%	22.1
Allerton-Pelham Gardens	292.7	8.1	12.1%	10.0%	16.5
East Flatbush-Farragut	519.1	7.1	12.9%	15.1%	17.1
Flatbush	305.2	4.1	8.3%	10.5%	25.4
Sunset Park West	217.0	2.0	4.3%	8.4%	38.9
Canarsie	445.8	4.3	11.3%	13.6%	18.6
Crown Heights South	234.6	3.5	6.4%	8.1%	17.3
Pelham Parkway	268.3	8.1	9.0%	8.1%	16.9
Washington Heights North	169.2	4.3	5.8%	9.4%	29.8
Brighton Beach	203.1	5.6	8.8%	9.9%	23.6
Hollis	301.2	6.2	12.8%	12.2%	15.2
NYPH High Disparity Community	282.3	5.0	9.3%	10.0%	29.1
New York City	229.6	4.4	7.0%	9.1%	23.7
New York State	N/A	4.8	5.6%	1.7%	17.8

Source: NYC Health Data Atlas; NYC Community Health Profiles

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- NTA Quartile 3

Health Status Indicators: Women, Infants, & Children in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Crude rate of severe maternal morbidity (SMM) per 10,000 deliveries	Rate of infant deaths (under one year old) per 1,000 live births	Percent of live births receiving late prenatal care	Percent of preterm births among all live births	Rate of Teen Births (per 1,000 women ages 15 to 19)
Springfield Gardens North	358.0	6.2	12.0%	10.7%	18.0
St. Albans	275.7	6.2	9.5%	11.7%	19.7
Corona	188.8	3.7	8.3%	8.2%	37.4
East Elmhurst	266.5	4.2	10.5%	7.2%	47.1
Mariner's Harbor-Arlington-Port Ivory-(	238.3	6.9	4.3%	10.6%	29.1
Williamsburg	79.1	2.4	2.2%	4.5%	17.8
Fort Greene	236.7	2.8	3.2%	10.2%	21.0
Jackson Heights	216.8	4.2	9.2%	7.4%	23.6
Midwood	143.7	4.1	4.5%	6.4%	10.1
South Ozone Park	258.7	4.8	9.9%	10.8%	19.9
Flushing	131.9	2.6	8.6%	5.9%	9.7
Flatlands	395.4	4.3	9.9%	11.9%	13.7
Schuylerville-Throgs Neck-Edgewater P	304.2	4.3	10.5%	11.6%	13.7
Richmond Hill	253.7	4.1	8.0%	9.9%	19.0
North Corona	207.5	4.2	9.4%	7.4%	68.9
Sheepshead Bay-Gerritsen Beach-Manl	204.3	2.9	7.0%	8.6%	14.4
Co-op City	325.3	4.3	12.5%	12.7%	13.1
Woodhaven	244.1	4.1	7.0%	8.4%	24.3
Grymes Hill-Clifton-Fox Hills	206.8	6.9	4.2%	8.5%	14.6
Queens Village	261.0	5.7	8.7%	11.1%	11.6
Elmhurst	229.6	3.7	8.4%	7.2%	31.8
Bensonhurst West	139.1	3.7	4.6%	7.2%	13.4
Morningside Heights	133.9	4.5	7.0%	7.8%	4.3
Port Richmond	170.7	6.9	3.2%	12.1%	36.1
NYPH High Disparity Community	282.3	5.0	9.3%	10.0%	29.1
New York City	229.6	4.4	7.0%	9.1%	23.7
New York State	N/A	4.8	5.6%	1.7%	17.8

Source: NYC Health Data Atlas; NYC Community Health Profiles

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- NTA Quartile 3 continued

Health Status Indicators: Well-Being & Mental Health in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Percentage of deaths that could have been averted (based on top 5 NTAs)	Premature Mortality, per 100,000 population under ages 65	Percentage of adults self-report health as good-excellent	Percentage of adults not getting needed medical care	Percentage of adults self-reporting poor mental health [1]	Percentage of adults self-reporting binge drinking
East Tremont	50.0%	316.0	69.0%	15.0%	13.7%	13.0%
Highbridge	41.0%	267.9	72.0%	10.0%	13.7%	12.0%
Mott Haven-Port Morris	45.0%	292.2	72.0%	10.0%	13.7%	18.0%
East Concourse-Concourse Village	41.0%	242.1	72.0%	10.0%	13.7%	12.0%
University Heights-Morris Heights	40.0%	221.8	67.0%	16.0%	13.7%	14.0%
Claremont-Bathgate	50.0%	345.7	69.0%	15.0%	13.7%	13.0%
Morrisania-Melrose	50.0%	271.0	69.0%	15.0%	13.7%	13.0%
Brownsville	54.0%	335.4	79.0%	14.0%	10.5%	14.0%
Longwood	45.0%	247.5	72.0%	10.0%	13.7%	18.0%
Crotona Park East	50.0%	242.5	69.0%	15.0%	13.7%	13.0%
Hunts Point	45.0%	231.0	72.0%	10.0%	13.7%	18.0%
Fordham South	40.0%	246.4	67.0%	16.0%	13.7%	14.0%
East New York (Pennsylvania Ave)	54.0%	253.9	79.0%	14.0%	10.5%	14.0%
Mount Hope	40.0%	220.2	67.0%	16.0%	13.7%	14.0%
Melrose South-Mott Haven North	45.0%	280.6	72.0%	10.0%	13.7%	18.0%
East New York	41.0%	282.6	70.0%	14.0%	10.5%	14.0%
Ocean Hill	54.0%	291.9	79.0%	14.0%	10.5%	14.0%
Soundview-Bruckner	35.0%	212.6	72.0%	13.0%	13.7%	16.0%
West Concourse	41.0%	206.5	72.0%	10.0%	13.7%	12.0%
Bedford Park-Fordham North	39.0%	196.9	67.0%	11.0%	13.7%	12.0%
Kingsbridge Heights	39.0%	227.7	67.0%	11.0%	13.7%	12.0%
Belmont	50.0%	290.6	69.0%	15.0%	13.7%	13.0%
East Harlem North	42.0%	295.5	76.0%	14.0%	9.8%	18.0%
Stuyvesant Heights	46.0%	275.7	76.0%	14.0%	10.5%	21.0%
NYPH High Disparity Community	29.4%	189.2	75.0%	11.2%	10.9%	15.3%
New York City	N/A	193.8	78.0%	10.0%	10.3%	17.0%
New York State	N/A	40.1	4.0%	11.5%	10.7%	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; [1] County-Level Behavioral Risk Factor Surveillance System

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- Key indicators for the health of a community include mortality rates and self-reported physical and mental health status as well as general access to needed medical care.
- Overall in the NYPH community, premature mortality is approximately the same, 189.2, as NYC 193.8.
- Community adults are self reporting average percentages of “good-excellent health”, 75.0%, but higher percentages of “poor mental health”, 10.9%.
- Self-reported binge drinking,15.3% is lower than the NYC average, 17.0%, but may be underreported.
- An estimated 11.2% are self-reporting not getting needed medical care in the last year; NYC average is 10.0%.

Health Status Indicators: Well-Being & Mental Health in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of deaths that could have been averted (based on top 5 NTAs)	Premature Mortality, per 100,000 population under ages 65	Percentage of adults self-report health as good-excellent	Percentage of adults not getting needed medical care	Percentage of adults self-reporting poor mental health [1]	Percentage of adults self-reporting binge drinking
West Farms-Bronx River	35.0%	191.9	72.0%	13.0%	13.7%	16.0%
Williamsbridge-Olinville	27.0%	194.8	78.0%	10.0%	13.7%	15.0%
Central Harlem North-Polo Grounds	50.0%	258.1	79.0%	10.0%	9.8%	17.0%
East Harlem South	42.0%	237.7	76.0%	14.0%	9.8%	18.0%
Seagate-Coney Island	30.0%	328.4	70.0%	11.0%	10.5%	11.0%
Norwood	39.0%	232.8	67.0%	11.0%	13.7%	12.0%
Bushwick South	33.0%	228.0	71.0%	13.0%	10.5%	20.0%
Soundview-Castle Hill-Clason Point-Ha	35.0%	202.9	72.0%	13.0%	13.7%	16.0%
Jamaica	29.0%	145.0	82.0%	13.0%	8.5%	10.0%
Starrett City	41.0%	288.7	70.0%	14.0%	10.5%	14.0%
Westchester-Unionport	35.0%	186.9	72.0%	13.0%	13.7%	16.0%
Crown Heights North	36.0%	244.4	84.0%	14.0%	10.5%	20.0%
Bedford	46.0%	244.8	76.0%	14.0%	10.5%	21.0%
South Jamaica	29.0%	203.8	82.0%	13.0%	8.5%	10.0%
Bronxdale	32.0%	203.7	80.0%	12.0%	13.7%	10.0%
Washington Heights South	12.0%	128.6	68.0%	17.0%	9.8%	24.0%
Bushwick North	33.0%	149.2	71.0%	13.0%	10.5%	20.0%
Cypress Hills-City Line	41.0%	180.6	70.0%	14.0%	10.5%	14.0%
Erasmus	23.0%	194.1	83.0%	9.0%	10.5%	12.0%
Hamilton Heights	25.0%	174.4	83.0%	10.0%	9.8%	21.0%
Eastchester-Edenwald-Baychester	27.0%	181.7	78.0%	10.0%	13.7%	15.0%
Marble Hill-Inwood	12.0%	107.2	68.0%	17.0%	9.8%	24.0%
Rugby-Remsen Village	23.0%	177.5	83.0%	9.0%	10.5%	12.0%
Manhattanville	25.0%	196.3	83.0%	10.0%	9.8%	21.0%
NYPH High Disparity Community	29.4%	189.2	75.0%	11.2%	10.9%	15.3%
New York City	N/A	193.8	78.0%	10.0%	10.3%	17.0%
New York State	N/A	40.1	4.0%	11.5%	10.7%	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; [1] County-Level Behavioral Risk Factor Surveillance System

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- NTA Quartile 4 continued

Health Status Indicators: Well-Being & Mental Health in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of deaths that could have been averted (based on top 5 NTAs)	Premature Mortality, per 100,000 population under ages 65	Percentage of adults self-report health as good-excellent	Percentage of adults not getting needed medical care	Percentage of adults self-reporting poor mental health [1]	Percentage of adults self-reporting binge drinking
Lower East Side	18.0%	193.0	70.0%	8.0%	9.8%	23.0%
Gravesend	30.0%	170.9	70.0%	11.0%	10.5%	11.0%
Van Cortlandt Village	31.0%	164.5	83.0%	12.0%	13.7%	21.0%
Prospect Lefferts Gardens-Wingate	25.0%	190.7	78.0%	10.0%	10.5%	14.0%
Van Nest-Morris Park-Westchester Squ	32.0%	181.3	80.0%	12.0%	13.7%	10.0%
Hammels-Arverne-Edgemere	47.0%	299.9	75.0%	10.0%	8.5%	14.0%
Chinatown	18.0%	151.4	70.0%	8.0%	9.8%	23.0%
Far Rockaway-Bayswater	47.0%	234.4	75.0%	10.0%	8.5%	14.0%
Central Harlem South	50.0%	198.7	79.0%	10.0%	9.8%	17.0%
Parkchester	35.0%	174.2	72.0%	13.0%	13.7%	16.0%
West New Brighton-New Brighton-St. G	36.0%	267.4	77.0%	10.0%	10.7%	14.0%
Sunset Park East	18.0%	118.8	74.0%	4.0%	10.5%	12.0%
Queensbridge-Ravenswood-Long Islan	13.0%	221.5	79.0%	10.0%	8.5%	25.0%
Baisley Park	29.0%	165.9	82.0%	13.0%	8.5%	10.0%
Woodlawn-Wakefield	27.0%	153.6	78.0%	10.0%	13.7%	15.0%
Allerton-Pelham Gardens	32.0%	159.0	80.0%	12.0%	13.7%	10.0%
East Flatbush-Farragut	23.0%	163.1	83.0%	9.0%	10.5%	12.0%
Flatbush	22.0%	176.0	77.0%	9.0%	10.5%	13.0%
Sunset Park West	18.0%	131.2	74.0%	4.0%	10.5%	12.0%
Canarsie	24.0%	159.7	89.0%	8.0%	10.5%	13.0%
Crown Heights South	25.0%	186.9	78.0%	10.0%	10.5%	14.0%
Pelham Parkway	32.0%	148.7	80.0%	12.0%	13.7%	10.0%
Washington Heights North	12.0%	97.0	68.0%	17.0%	9.8%	24.0%
Brighton Beach	30.0%	177.9	70.0%	11.0%	10.5%	11.0%
Hollis	29.0%	149.8	82.0%	13.0%	8.5%	10.0%
NYPH High Disparity Community	29.4%	189.2	75.0%	11.2%	10.9%	15.3%
New York City	N/A	193.8	78.0%	10.0%	10.3%	17.0%
New York State	N/A	40.1	4.0%	11.5%	10.7%	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; [1] County-Level Behavioral Risk Factor Surveillance System

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- NTA Quartile 3

Health Status Indicators: Well-Being & Mental Health in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of deaths that could have been averted (based on top 5 NTAs)	Premature Mortality, per 100,000 population under ages 65	Percentage of adults self-report health as good-excellent	Percentage of adults not getting needed medical care	Percentage of adults self-reporting poor mental health [1]	Percentage of adults self-reporting binge drinking
Springfield Gardens North	29.0%	177.3	82.0%	13.0%	8.5%	10.0%
St. Albans	29.0%	147.9	82.0%	13.0%	8.5%	10.0%
Corona	^	118.6	68.0%	9.0%	8.5%	14.0%
East Elmhurst	4.0%	144.0	72.0%	11.0%	8.5%	15.0%
Mariner's Harbor-Arlington-Port Ivory-(	36.0%	186.7	77.0%	10.0%	10.7%	14.0%
Williamsburg	23.0%	140.5	79.0%	17.0%	10.5%	19.0%
Fort Greene	28.0%	221.7	86.0%	12.0%	10.5%	25.0%
Jackson Heights	4.0%	102.8	72.0%	11.0%	8.5%	15.0%
Midwood	22.0%	129.8	77.0%	9.0%	10.5%	13.0%
South Ozone Park	26.0%	127.9	77.0%	7.0%	8.5%	16.0%
Flushing	10.0%	108.8	71.0%	8.0%	8.5%	12.0%
Flatlands	24.0%	121.2	89.0%	8.0%	10.5%	13.0%
Schuylerville-Throgs Neck-Edgewater F	27.0%	166.9	77.0%	12.0%	13.7%	14.0%
Richmond Hill	20.0%	132.0	78.0%	7.0%	8.5%	16.0%
North Corona	4.0%	99.9	72.0%	11.0%	8.5%	15.0%
Sheepshead Bay-Gerritsen Beach-Manl	17.0%	167.3	70.0%	9.0%	10.5%	12.0%
Co-op City	27.0%	171.4	77.0%	12.0%	13.7%	14.0%
Woodhaven	20.0%	126.2	78.0%	7.0%	10.5%	16.0%
Grymes Hill-Clifton-Fox Hills	36.0%	189.9	77.0%	10.0%	10.7%	14.0%
Queens Village	17.0%	110.4	74.0%	11.0%	8.5%	16.0%
Elmhurst	^	88.9	68.0%	9.0%	8.5%	14.0%
Bensonhurst West	14.0%	134.6	65.0%	6.0%	10.5%	9.0%
Morningside Heights	25.0%	118.1	83.0%	10.0%	9.8%	21.0%
Port Richmond	36.0%	233.3	77.0%	10.0%	10.7%	14.0%
NYPH High Disparity Community	29.4%	189.2	75.0%	11.2%	10.9%	15.3%
New York City	N/A	193.8	78.0%	10.0%	10.3%	17.0%
New York State	N/A	40.1	4.0%	11.5%	10.7%	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; [1] County-Level Behavioral Risk Factor Surveillance System

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- NTA Quartile 3 continued

Health Status Indicators: Chronic Disease in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Rate of ED visits for asthma per 10,000 children ages 5 to 17	Percentage of adults with diabetes	Percentage of adults with hypertension	Percentage of adults reporting current smoking	Rate of new HIV diagnoses per 100,000 people	Rate of new Hepatitis C diagnoses per 100,000 people
East Tremont	442.0	22.0%	32.0%	16.0%	51.3	131.0
Highbridge	420.0	17.0%	42.0%	15.0%	39.8	78.3
Mott Haven-Port Morris	647.0	20.0%	38.0%	15.0%	43.7	81.3
East Concourse-Concourse Village	420.0	17.0%	42.0%	15.0%	39.8	78.3
University Heights-Morris Heights	405.0	16.0%	37.0%	16.0%	49.2	88.1
Claremont-Bathgate	442.0	22.0%	32.0%	16.0%	51.3	131.0
Morrisania-Melrose	442.0	22.0%	32.0%	16.0%	51.3	131.0
Brownsville	475.0	13.0%	33.0%	17.0%	67.4	92.3
Longwood	647.0	20.0%	38.0%	15.0%	43.7	81.3
Crotona Park East	442.0	22.0%	32.0%	16.0%	51.3	131.0
Hunts Point	647.0	20.0%	38.0%	15.0%	43.7	81.3
Fordham South	405.0	16.0%	37.0%	16.0%	49.2	88.1
East New York (Pennsylvania Ave)	475.0	13.0%	33.0%	17.0%	67.4	92.3
Mount Hope	405.0	16.0%	37.0%	16.0%	49.2	88.1
Melrose South-Mott Haven North	647.0	20.0%	38.0%	15.0%	43.7	81.3
East New York	315.0	14.0%	34.0%	13.0%	38.1	78.9
Ocean Hill	475.0	13.0%	33.0%	17.0%	67.4	92.3
Soundview-Bruckner	349.0	16.0%	34.0%	18.0%	33.1	65.7
West Concourse	420.0	17.0%	42.0%	15.0%	39.8	78.3
Bedford Park-Fordham North	451.0	19.0%	35.0%	12.0%	32.4	63.4
Kingsbridge Heights	451.0	19.0%	35.0%	12.0%	32.4	63.4
Belmont	442.0	22.0%	32.0%	16.0%	51.3	131.0
East Harlem North	580.0	17.0%	34.0%	18.0%	49.9	129.5
Stuyvesant Heights	375.0	13.0%	34.0%	19.0%	55.1	82.0
NYPH High Disparity Community	285.1	14.2%	32.1%	13.9%	31.2	65.7
New York City	223.0	11.0%	28.0%	14.0%	24.0	71.8
New York State	N/A	9.5%	28.9%	14.5%	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

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- Behaviors like smoking can lead to chronic diseases, which are both costly and resource intensive to manage; prevention is a better alternative.
- Community children are visiting the ER for asthma care at rates higher, 285.1, than NYC, 223.0.
- Varying among NTAs, in aggregate there is about the same percentages of smoking, 13.9%, as NYC 14.0%.
- New diagnoses of HIV and Hepatitis C are both very high in certain neighborhoods (East Tremont, Claremont-Bathgate, Morrisania-Melrose, Crotona Park East, and Belmont); HIV is even higher in Central Harlem North-Polo Grounds, Central Harlem South, Brownsville, East New York (Pennsylvania Ave), and Ocean Hill.
- There are higher percentages of diabetes and hypertension, which is a trend nationally.

Health Status Indicators: Chronic Disease in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Rate of ED visits for asthma per 10,000 children ages 5 to 17	Percentage of adults with diabetes	Percentage of adults with hypertension	Percentage of adults reporting current smoking	Rate of new HIV diagnoses per 100,000 people	Rate of new Hepatitis C diagnoses per 100,000 people
West Farms-Bronx River	349.0	16.0%	34.0%	18.0%	33.1	65.7
Williamsbridge-Olinville	369.0	14.0%	39.0%	11.0%	34.5	51.1
Central Harlem North-Polo Grounds	545.0	12.0%	35.0%	10.0%	69.6	99.7
East Harlem South	580.0	17.0%	34.0%	18.0%	49.9	129.5
Seagate-Coney Island	147.0	15.0%	31.0%	19.0%	16.9	115.5
Norwood	451.0	19.0%	35.0%	12.0%	32.4	63.4
Bushwick South	290.0	13.0%	26.0%	17.0%	37.4	57.8
Soundview-Castle Hill-Clason Point-Ha	349.0	16.0%	34.0%	18.0%	33.1	65.7
Jamaica	202.0	16.0%	37.0%	8.0%	20.6	67.8
Starrett City	315.0	14.0%	34.0%	13.0%	38.1	78.9
Westchester-Unionport	349.0	16.0%	34.0%	18.0%	33.1	65.7
Crown Heights North	342.0	13.0%	33.0%	18.0%	44.3	91.6
Bedford	375.0	13.0%	34.0%	19.0%	55.1	82.0
South Jamaica	202.0	16.0%	37.0%	8.0%	20.6	67.8
Bronxdale	325.0	14.0%	31.0%	15.0%	18.1	85.2
Washington Heights South	226.0	13.0%	28.0%	13.0%	31.1	60.3
Bushwick North	290.0	13.0%	26.0%	17.0%	37.4	57.8
Cypress Hills-City Line	315.0	14.0%	34.0%	13.0%	38.1	78.9
Erasmus	343.0	15.0%	36.0%	8.0%	35.6	66.6
Hamilton Heights	333.0	10.0%	29.0%	17.0%	34.1	50.3
Eastchester-Edenwald-Baychester	369.0	14.0%	39.0%	11.0%	34.5	51.1
Marble Hill-Inwood	226.0	13.0%	28.0%	13.0%	31.1	60.3
Rugby-Remsen Village	343.0	15.0%	36.0%	8.0%	35.6	66.6
Manhattanville	333.0	10.0%	29.0%	17.0%	34.1	50.3
NYPH High Disparity Community	285.1	14.2%	32.1%	13.9%	31.2	65.7
New York City	223.0	11.0%	28.0%	14.0%	24.0	71.8
New York State	N/A	9.5%	28.9%	14.5%	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

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- NTA Quartile 4 continued

Health Status Indicators: Chronic Disease in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Rate of ED visits for asthma per 10,000 children ages 5 to 17	Percentage of adults with diabetes	Percentage of adults with hypertension	Percentage of adults reporting current smoking	Rate of new HIV diagnoses per 100,000 people	Rate of new Hepatitis C diagnoses per 100,000 people
Lower East Side	297.0	11.0%	22.0%	20.0%	15.2	64.3
Gravesend	147.0	15.0%	31.0%	19.0%	16.9	115.5
Van Cortlandt Village	218.0	12.0%	28.0%	10.0%	18.5	56.4
Prospect Lefferts Gardens-Wingate	260.0	15.0%	37.0%	8.0%	31.4	58.8
Van Nest-Morris Park-Westchester Squ	325.0	14.0%	31.0%	15.0%	18.1	85.2
Hammels-Arverne-Edgemere	168.0	15.0%	34.0%	16.0%	14.9	68.2
Chinatown	297.0	11.0%	22.0%	20.0%	15.2	64.3
Far Rockaway-Bayswater	168.0	15.0%	34.0%	16.0%	14.9	68.2
Central Harlem South	545.0	12.0%	35.0%	10.0%	69.6	99.7
Parkchester	349.0	16.0%	34.0%	18.0%	33.1	65.7
West New Brighton-New Brighton-St. G	157.0	9.0%	26.0%	16.0%	22.0	65.0
Sunset Park East	104.0	11.0%	27.0%	12.0%	14.3	48.2
Queensbridge-Ravenswood-Long Islan	145.0	11.0%	23.0%	19.0%	29.0	30.0
Baisley Park	202.0	16.0%	37.0%	8.0%	20.6	67.8
Woodlawn-Wakefield	369.0	14.0%	39.0%	11.0%	34.5	51.1
Allerton-Pelham Gardens	325.0	14.0%	31.0%	15.0%	18.1	85.2
East Flatbush-Farragut	343.0	15.0%	36.0%	8.0%	35.6	66.6
Flatbush	113.0	13.0%	31.0%	10.0%	23.0	81.6
Sunset Park West	104.0	11.0%	27.0%	12.0%	14.3	48.2
Canarsie	154.0	14.0%	37.0%	10.0%	17.9	50.2
Crown Heights South	260.0	15.0%	37.0%	8.0%	31.4	58.8
Pelham Parkway	325.0	14.0%	31.0%	15.0%	18.1	85.2
Washington Heights North	226.0	13.0%	28.0%	13.0%	31.1	60.3
Brighton Beach	147.0	15.0%	31.0%	19.0%	16.9	115.5
Hollis	202.0	16.0%	37.0%	8.0%	20.6	67.8
NYPH High Disparity Community	285.1	14.2%	32.1%	13.9%	31.2	65.7
New York City	223.0	11.0%	28.0%	14.0%	24.0	71.8
New York State	N/A	9.5%	28.9%	14.5%	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 3

NewYork-Presbyterian

Health Status Indicators: Chronic Disease in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Rate of ED visits for asthma per 10,000 children ages 5 to 17	Percentage of adults with diabetes	Percentage of adults with hypertension	Percentage of adults reporting current smoking	Rate of new HIV diagnoses per 100,000 people	Rate of new Hepatitis C diagnoses per 100,000 people
Springfield Gardens North	202.0	16.0%	37.0%	8.0%	20.6	67.8
St. Albans	202.0	16.0%	37.0%	8.0%	20.6	67.8
Corona	158.0	14.0%	27.0%	15.0%	25.0	33.5
East Elmhurst	162.0	13.0%	29.0%	13.0%	32.3	36.7
Mariner's Harbor-Arlington-Port Ivory-(	157.0	9.0%	26.0%	16.0%	22.0	65.0
Williamsburg	136.0	11.0%	25.0%	17.0%	12.0	45.2
Fort Greene	249.0	6.0%	25.0%	11.0%	16.2	66.6
Jackson Heights	162.0	13.0%	29.0%	13.0%	32.3	36.7
Midwood	113.0	13.0%	31.0%	10.0%	23.0	81.6
South Ozone Park	111.0	19.0%	34.0%	12.0%	15.1	44.6
Flushing	77.0	8.0%	22.0%	13.0%	8.4	50.2
Flatlands	154.0	14.0%	37.0%	10.0%	17.9	50.2
Schuylerville-Throgs Neck-Edgewater P	240.0	13.0%	37.0%	14.0%	15.6	46.8
Richmond Hill	133.0	14.0%	22.0%	11.0%	17.5	51.9
North Corona	162.0	13.0%	29.0%	13.0%	32.3	36.7
Sheepshead Bay-Gerritsen Beach-Manl	42.0	9.0%	25.0%	17.0%	4.0	79.3
Co-op City	240.0	13.0%	37.0%	14.0%	15.6	46.8
Woodhaven	133.0	14.0%	22.0%	11.0%	17.5	51.9
Grymes Hill-Clifton-Fox Hills	157.0	9.0%	26.0%	16.0%	22.0	65.0
Queens Village	115.0	14.0%	37.0%	12.0%	15.0	40.8
Elmhurst	158.0	14.0%	27.0%	15.0%	25.0	33.5
Bensonhurst West	32.0	12.0%	26.0%	16.0%	5.4	65.4
Morningside Heights	333.0	10.0%	29.0%	17.0%	34.1	50.3
Port Richmond	157.0	9.0%	26.0%	16.0%	22.0	65.0
NYPH High Disparity Community	285.1	14.2%	32.1%	13.9%	31.2	65.7
New York City	223.0	11.0%	28.0%	14.0%	24.0	71.8
New York State	N/A	9.5%	28.9%	14.5%	N/A	N/A

Source: NYC Health Data Atlas; NYC Community Health Profiles; Citizens Committee for Children

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- NTA Quartile 3 continued

Health Status Indicators: Chronic Disease (County BRFSS) in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Percentage of adults with arthritis	Percentage of adults with CV (heart attack, coronary heart disease, or stroke)	Percentage of adults with COPD	Percentage of adults taking medication for high blood pressure
East Tremont	20.4%	6.7%	4.2%	63.2
Highbridge	20.4%	6.7%	4.2%	63.2
Mott Haven-Port Morris	20.4%	6.7%	4.2%	63.2
East Concourse-Concourse Village	20.4%	6.7%	4.2%	63.2
University Heights-Morris Heights	20.4%	6.7%	4.2%	63.2
Claremont-Bathgate	20.4%	6.7%	4.2%	63.2
Morrisania-Melrose	20.4%	6.7%	4.2%	63.2
Brownsville	19.5%	6.2%	3.8%	57.4
Longwood	20.4%	6.7%	4.2%	63.2
Crotona Park East	20.4%	6.7%	4.2%	63.2
Hunts Point	20.4%	6.7%	4.2%	63.2
Fordham South	20.4%	6.7%	4.2%	63.2
East New York (Pennsylvania Ave)	19.5%	6.2%	3.8%	57.4
Mount Hope	20.4%	6.7%	4.2%	63.2
Melrose South-Mott Haven North	20.4%	6.7%	4.2%	63.2
East New York	19.5%	6.2%	3.8%	57.4
Ocean Hill	19.5%	6.2%	3.8%	57.4
Soundview-Bruckner	20.4%	6.7%	4.2%	63.2
West Concourse	20.4%	6.7%	4.2%	63.2
Bedford Park-Fordham North	20.4%	6.7%	4.2%	63.2
Kingsbridge Heights	20.4%	6.7%	4.2%	63.2
Belmont	20.4%	6.7%	4.2%	63.2
East Harlem North	15.0%	6.4%	3.4%	51.0
Stuyvesant Heights	19.5%	6.2%	3.8%	57.4
NYPH High Disparity Community	18.9%	6.6%	3.8%	59.4
New York City	18.5%	6.6%	3.7%	54.7
New York State	21.8%	7.0%	4.9%	55.6

Source: County-Level Behavioral Risk Factor Surveillance System

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- In comparison with NYC average, the counties of the five boroughs have about the same percentages of arthritis, cardiovascular (CV) disease, and COPD (chronic obstructive pulmonary disease).
- However, high blood pressure percentages, 59.4, are higher than the NYC average 54.7.

Health Status Indicators: Chronic Disease (County BRFSS) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of adults with arthritis	Percentage of adults with CV (heart attack, coronary heart disease, or stroke)	Percentage of adults with COPD	Percentage of adults taking medication for high blood pressure
West Farms-Bronx River	20.4%	6.7%	4.2%	63.2
Williamsbridge-Olinville	20.4%	6.7%	4.2%	63.2
Central Harlem North-Polo Grounds	15.0%	6.4%	3.4%	51.0
East Harlem South	15.0%	6.4%	3.4%	51.0
Seagate-Coney Island	19.5%	6.2%	3.8%	57.4
Norwood	20.4%	6.7%	4.2%	63.2
Bushwick South	19.5%	6.2%	3.8%	57.4
Soundview-Castle Hill-Clason Point-Ha	20.4%	6.7%	4.2%	63.2
Jamaica	18.1%	7.6%	3.5%	64.3
Starrett City	19.5%	6.2%	3.8%	57.4
Westchester-Unionport	20.4%	6.7%	4.2%	63.2
Crown Heights North	19.5%	6.2%	3.8%	57.4
Bedford	19.5%	6.2%	3.8%	57.4
South Jamaica	18.1%	7.6%	3.5%	64.3
Bronxdale	20.4%	6.7%	4.2%	63.2
Washington Heights South	15.0%	6.4%	3.4%	51.0
Bushwick North	19.5%	6.2%	3.8%	57.4
Cypress Hills-City Line	19.5%	6.2%	3.8%	57.4
Erasmus	19.5%	6.2%	3.8%	57.4
Hamilton Heights	15.0%	6.4%	3.4%	51.0
Eastchester-Edenwald-Baychester	20.4%	6.7%	4.2%	63.2
Marble Hill-Inwood	15.0%	6.4%	3.4%	51.0
Rugby-Remsen Village	19.5%	6.2%	3.8%	57.4
Manhattanville	15.0%	6.4%	3.4%	51.0
NYPH High Disparity Community	18.9%	6.6%	3.8%	59.4
New York City	18.5%	6.6%	3.7%	54.7
New York State	21.8%	7.0%	4.9%	55.6

Source: County-Level Behavioral Risk Factor Surveillance System

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- NTA Quartile 4 continued

Health Status Indicators: Chronic Disease (County BRFSS) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of adults with arthritis	Percentage of adults with CV (heart attack, coronary heart disease, or stroke)	Percentage of adults with COPD	Percentage of adults taking medication for high blood pressure
Lower East Side	15.0%	6.4%	3.4%	51.0
Gravesend	19.5%	6.2%	3.8%	57.4
Van Cortlandt Village	20.4%	6.7%	4.2%	63.2
Prospect Lefferts Gardens-Wingate	19.5%	6.2%	3.8%	57.4
Van Nest-Morris Park-Westchester Squ	20.4%	6.7%	4.2%	63.2
Hammels-Arverne-Edgemere	18.1%	7.6%	3.5%	64.3
Chinatown	15.0%	6.4%	3.4%	51.0
Far Rockaway-Bayswater	18.1%	7.6%	3.5%	64.3
Central Harlem South	15.0%	6.4%	3.4%	51.0
Parkchester	20.4%	6.7%	4.2%	63.2
West New Brighton-New Brighton-St. G	22.4%	5.8%	4.7%	56.0
Sunset Park East	19.5%	6.2%	3.8%	57.4
Queensbridge-Ravenswood-Long Islan	18.1%	7.6%	3.5%	64.3
Baisley Park	18.1%	7.6%	3.5%	64.3
Woodlawn-Wakefield	20.4%	6.7%	4.2%	63.2
Allerton-Pelham Gardens	20.4%	6.7%	4.2%	63.2
East Flatbush-Farragut	19.5%	6.2%	3.8%	57.4
Flatbush	19.5%	6.2%	3.8%	57.4
Sunset Park West	19.5%	6.2%	3.8%	57.4
Canarsie	19.5%	6.2%	3.8%	57.4
Crown Heights South	19.5%	6.2%	3.8%	57.4
Pelham Parkway	20.4%	6.7%	4.2%	63.2
Washington Heights North	15.0%	6.4%	3.4%	51.0
Brighton Beach	19.5%	6.2%	3.8%	57.4
Hollis	18.1%	7.6%	3.5%	64.3
NYPH High Disparity Community	18.9%	6.6%	3.8%	59.4
New York City	18.5%	6.6%	3.7%	54.7
New York State	21.8%	7.0%	4.9%	55.6

Source: County-Level Behavioral Risk Factor Surveillance System

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- NTA Quartile 3

Health Status Indicators: Chronic Disease (County BRFSS) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Percentage of adults with arthritis	Percentage of adults with CV (heart attack, coronary heart disease, or stroke)	Percentage of adults with COPD	Percentage of adults taking medication for high blood pressure
Springfield Gardens North	18.1%	7.6%	3.5%	64.3
St. Albans	18.1%	7.6%	3.5%	64.3
Corona	18.1%	7.6%	3.5%	64.3
East Elmhurst	18.1%	7.6%	3.5%	64.3
Mariner's Harbor-Arlington-Port Ivory-(	22.4%	5.8%	4.7%	56.0
Williamsburg	19.5%	6.2%	3.8%	57.4
Fort Greene	19.5%	6.2%	3.8%	57.4
Jackson Heights	18.1%	7.6%	3.5%	64.3
Midwood	19.5%	6.2%	3.8%	57.4
South Ozone Park	18.1%	7.6%	3.5%	64.3
Flushing	18.1%	7.6%	3.5%	64.3
Flatlands	19.5%	6.2%	3.8%	57.4
Schuylerville-Throgs Neck-Edgewater F	20.4%	6.7%	4.2%	63.2
Richmond Hill	18.1%	7.6%	3.5%	64.3
North Corona	18.1%	7.6%	3.5%	64.3
Sheepshead Bay-Gerritsen Beach-Manl	19.5%	6.2%	3.8%	57.4
Co-op City	20.4%	6.7%	4.2%	63.2
Woodhaven	19.5%	6.2%	3.8%	57.4
Grymes Hill-Clifton-Fox Hills	22.4%	5.8%	4.7%	56.0
Queens Village	18.1%	7.6%	3.5%	64.3
Elmhurst	18.1%	7.6%	3.5%	64.3
Bensonhurst West	19.5%	6.2%	3.8%	57.4
Morningside Heights	15.0%	6.4%	3.4%	51.0
Port Richmond	22.4%	5.8%	4.7%	56.0
NYPH High Disparity Community	18.9%	6.6%	3.8%	59.4
New York City	18.5%	6.6%	3.7%	54.7
New York State	21.8%	7.0%	4.9%	55.6

Source: County-Level Behavioral Risk Factor Surveillance System

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Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 3 continued

Health Status Indicators: Cancer (County) in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Cancer Incidence - All Sites	Cancer Incidence - Breast	Cancer Incidence - Colon and Rectum	Cancer Incidence - Lung	Cancer Incidence - Prostate
East Tremont	444.6	110.1	39.7	46.2	147.8
Highbridge	444.6	110.1	39.7	46.2	147.8
Mott Haven-Port Morris	444.6	110.1	39.7	46.2	147.8
East Concourse-Concourse Village	444.6	110.1	39.7	46.2	147.8
University Heights-Morris Heights	444.6	110.1	39.7	46.2	147.8
Claremont-Bathgate	444.6	110.1	39.7	46.2	147.8
Morrisania-Melrose	444.6	110.1	39.7	46.2	147.8
Brownsville	442.0	117.1	40.4	46.7	126.4
Longwood	444.6	110.1	39.7	46.2	147.8
Crotona Park East	444.6	110.1	39.7	46.2	147.8
Hunts Point	444.6	110.1	39.7	46.2	147.8
Fordham South	444.6	110.1	39.7	46.2	147.8
East New York (Pennsylvania Ave)	442.0	117.1	40.4	46.7	126.4
Mount Hope	444.6	110.1	39.7	46.2	147.8
Melrose South-Mott Haven North	444.6	110.1	39.7	46.2	147.8
East New York	442.0	117.1	40.4	46.7	126.4
Ocean Hill	442.0	117.1	40.4	46.7	126.4
Soundview-Bruckner	444.6	110.1	39.7	46.2	147.8
West Concourse	444.6	110.1	39.7	46.2	147.8
Bedford Park-Fordham North	444.6	110.1	39.7	46.2	147.8
Kingsbridge Heights	444.6	110.1	39.7	46.2	147.8
Belmont	444.6	110.1	39.7	46.2	147.8
East Harlem North	449.1	136.8	34.5	47.2	122.8
Stuyvesant Heights	442.0	117.1	40.4	46.7	126.4
NYPH High Disparity Community	441.3	117.8	39.1	46.4	130.0
New York City	477.7	131.3	39.8	60.2	131.7
New York State	482.9	130.7	38.9	58.9	125.0

Source: State Cancer Profiles

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Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- The diagnosis of cancer has a tremendous impact on the physical, mental and economic well-being of an individual and their families.
- There is certain to be variation in neighborhoods, but these data were publicly available at the county level.
- In comparison with NYC, these counties' residents have equal or lower incidence of these cancers.

Health Status Indicators: Cancer (County) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Cancer Incidence - All Sites	Cancer Incidence - Breast	Cancer Incidence - Colon and Rectum	Cancer Incidence - Lung	Cancer Incidence - Prostate
West Farms-Bronx River	444.6	110.1	39.7	46.2	147.8
Williamsbridge-Olinville	444.6	110.1	39.7	46.2	147.8
Central Harlem North-Polo Grounds	449.1	136.8	34.5	47.2	122.8
East Harlem South	449.1	136.8	34.5	47.2	122.8
Seagate-Coney Island	442.0	117.1	40.4	46.7	126.4
Norwood	444.6	110.1	39.7	46.2	147.8
Bushwick South	442.0	117.1	40.4	46.7	126.4
Soundview-Castle Hill-Clason Point-Ha	444.6	110.1	39.7	46.2	147.8
Jamaica	420.6	113.8	39.3	43.6	118.2
Starrett City	442.0	117.1	40.4	46.7	126.4
Westchester-Unionport	444.6	110.1	39.7	46.2	147.8
Crown Heights North	442.0	117.1	40.4	46.7	126.4
Bedford	442.0	117.1	40.4	46.7	126.4
South Jamaica	420.6	113.8	39.3	43.6	118.2
Bronxdale	444.6	110.1	39.7	46.2	147.8
Washington Heights South	449.1	136.8	34.5	47.2	122.8
Bushwick North	442.0	117.1	40.4	46.7	126.4
Cypress Hills-City Line	442.0	117.1	40.4	46.7	126.4
Erasmus	442.0	117.1	40.4	46.7	126.4
Hamilton Heights	449.1	136.8	34.5	47.2	122.8
Eastchester-Edenwald-Baychester	444.6	110.1	39.7	46.2	147.8
Marble Hill-Inwood	449.1	136.8	34.5	47.2	122.8
Rugby-Remsen Village	442.0	117.1	40.4	46.7	126.4
Manhattanville	449.1	136.8	34.5	47.2	122.8
NYPH High Disparity Community	441.3	117.8	39.1	46.4	130.0
New York City	477.7	131.3	39.8	60.2	131.7
New York State	482.9	130.7	38.9	58.9	125.0

Source: State Cancer Profiles

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- NTA Quartile 4 continued

Health Status Indicators: Cancer (County) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Cancer Incidence - All Sites	Cancer Incidence - Breast	Cancer Incidence - Colon and Rectum	Cancer Incidence - Lung	Cancer Incidence - Prostate
Lower East Side	449.1	136.8	34.5	47.2	122.8
Gravesend	442.0	117.1	40.4	46.7	126.4
Van Cortlandt Village	444.6	110.1	39.7	46.2	147.8
Prospect Lefferts Gardens-Wingate	442.0	117.1	40.4	46.7	126.4
Van Nest-Morris Park-Westchester Squ	444.6	110.1	39.7	46.2	147.8
Hammels-Arverne-Edgemere	420.6	113.8	39.3	43.6	118.2
Chinatown	449.1	136.8	34.5	47.2	122.8
Far Rockaway-Bayswater	420.6	113.8	39.3	43.6	118.2
Central Harlem South	449.1	136.8	34.5	47.2	122.8
Parkchester	444.6	110.1	39.7	46.2	147.8
West New Brighton-New Brighton-St. G	521.8	134.9	41.3	64.7	121.9
Sunset Park East	442.0	117.1	40.4	46.7	126.4
Queensbridge-Ravenswood-Long Islan	420.6	113.8	39.3	43.6	118.2
Baisley Park	420.6	113.8	39.3	43.6	118.2
Woodlawn-Wakefield	444.6	110.1	39.7	46.2	147.8
Allerton-Pelham Gardens	444.6	110.1	39.7	46.2	147.8
East Flatbush-Farragut	442.0	117.1	40.4	46.7	126.4
Flatbush	442.0	117.1	40.4	46.7	126.4
Sunset Park West	442.0	117.1	40.4	46.7	126.4
Canarsie	442.0	117.1	40.4	46.7	126.4
Crown Heights South	442.0	117.1	40.4	46.7	126.4
Pelham Parkway	444.6	110.1	39.7	46.2	147.8
Washington Heights North	449.1	136.8	34.5	47.2	122.8
Brighton Beach	442.0	117.1	40.4	46.7	126.4
Hollis	420.6	113.8	39.3	43.6	118.2
NYPH High Disparity Community	441.3	117.8	39.1	46.4	130.0
New York City	477.7	131.3	39.8	60.2	131.7
New York State	482.9	130.7	38.9	58.9	125.0

Source: State Cancer Profiles

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- NTA Quartile 3

Health Status Indicators: Cancer (County) in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Cancer Incidence - All Sites	Cancer Incidence - Breast	Cancer Incidence - Colon and Rectum	Cancer Incidence - Lung	Cancer Incidence - Prostate
Springfield Gardens North	420.6	113.8	39.3	43.6	118.2
St. Albans	420.6	113.8	39.3	43.6	118.2
Corona	420.6	113.8	39.3	43.6	118.2
East Elmhurst	420.6	113.8	39.3	43.6	118.2
Mariner's Harbor-Arlington-Port Ivory-(	521.8	134.9	41.3	64.7	121.9
Williamsburg	442.0	117.1	40.4	46.7	126.4
Fort Greene	442.0	117.1	40.4	46.7	126.4
Jackson Heights	420.6	113.8	39.3	43.6	118.2
Midwood	442.0	117.1	40.4	46.7	126.4
South Ozone Park	420.6	113.8	39.3	43.6	118.2
Flushing	420.6	113.8	39.3	43.6	118.2
Flatlands	442.0	117.1	40.4	46.7	126.4
Schuylerville-Throgs Neck-Edgewater F	444.6	110.1	39.7	46.2	147.8
Richmond Hill	420.6	113.8	39.3	43.6	118.2
North Corona	420.6	113.8	39.3	43.6	118.2
Sheepshead Bay-Gerritsen Beach-Manl	442.0	117.1	40.4	46.7	126.4
Co-op City	444.6	110.1	39.7	46.2	147.8
Woodhaven	442.0	117.1	40.4	46.7	126.4
Grymes Hill-Clifton-Fox Hills	521.8	134.9	41.3	64.7	121.9
Queens Village	420.6	113.8	39.3	43.6	118.2
Elmhurst	420.6	113.8	39.3	43.6	118.2
Bensonhurst West	442.0	117.1	40.4	46.7	126.4
Morningside Heights	449.1	136.8	34.5	47.2	122.8
Port Richmond	521.8	134.9	41.3	64.7	121.9
NYPH High Disparity Community	441.3	117.8	39.1	46.4	130.0
New York City	477.7	131.3	39.8	60.2	131.7
New York State	482.9	130.7	38.9	58.9	125.0

Source: State Cancer Profiles

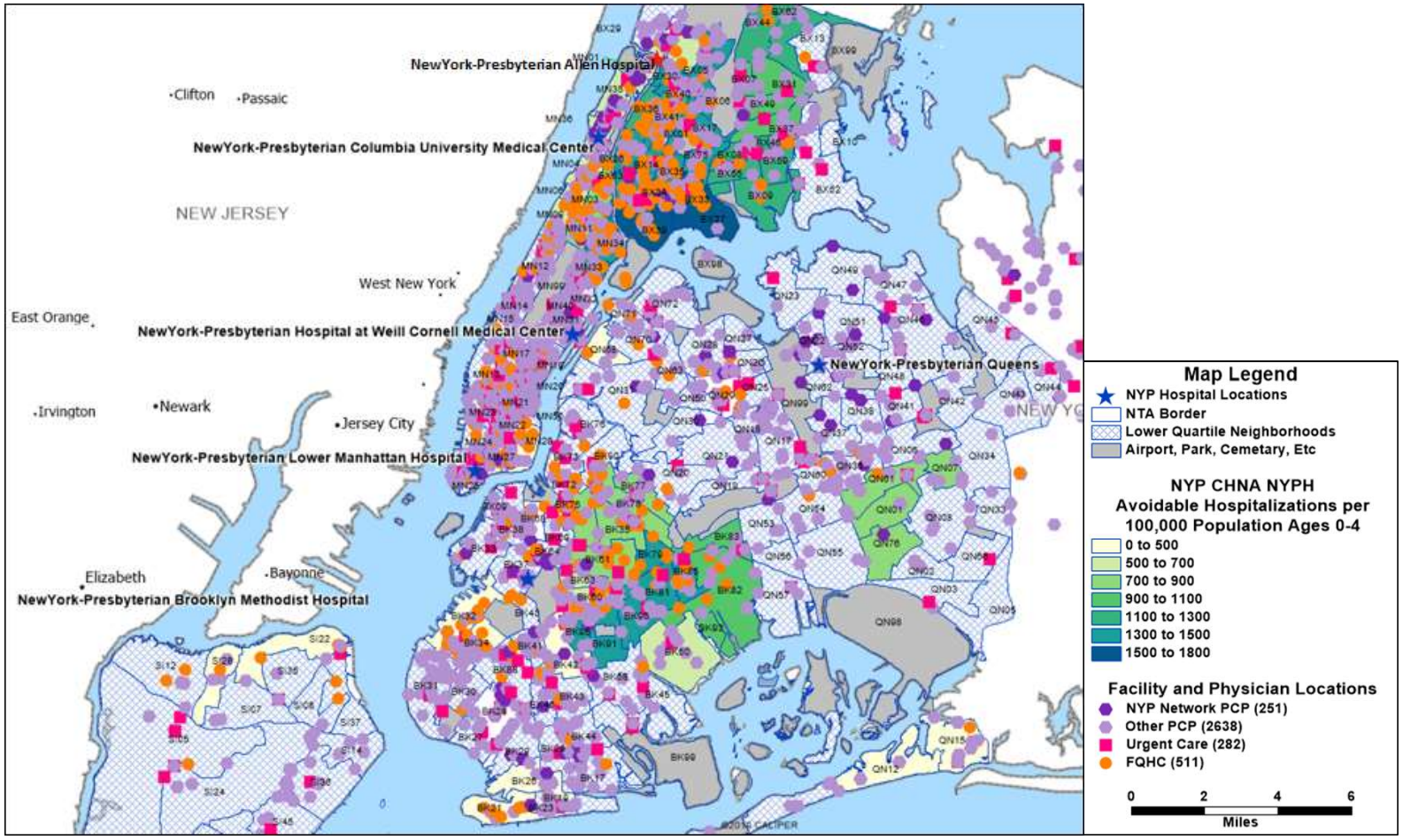
Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 3 continued

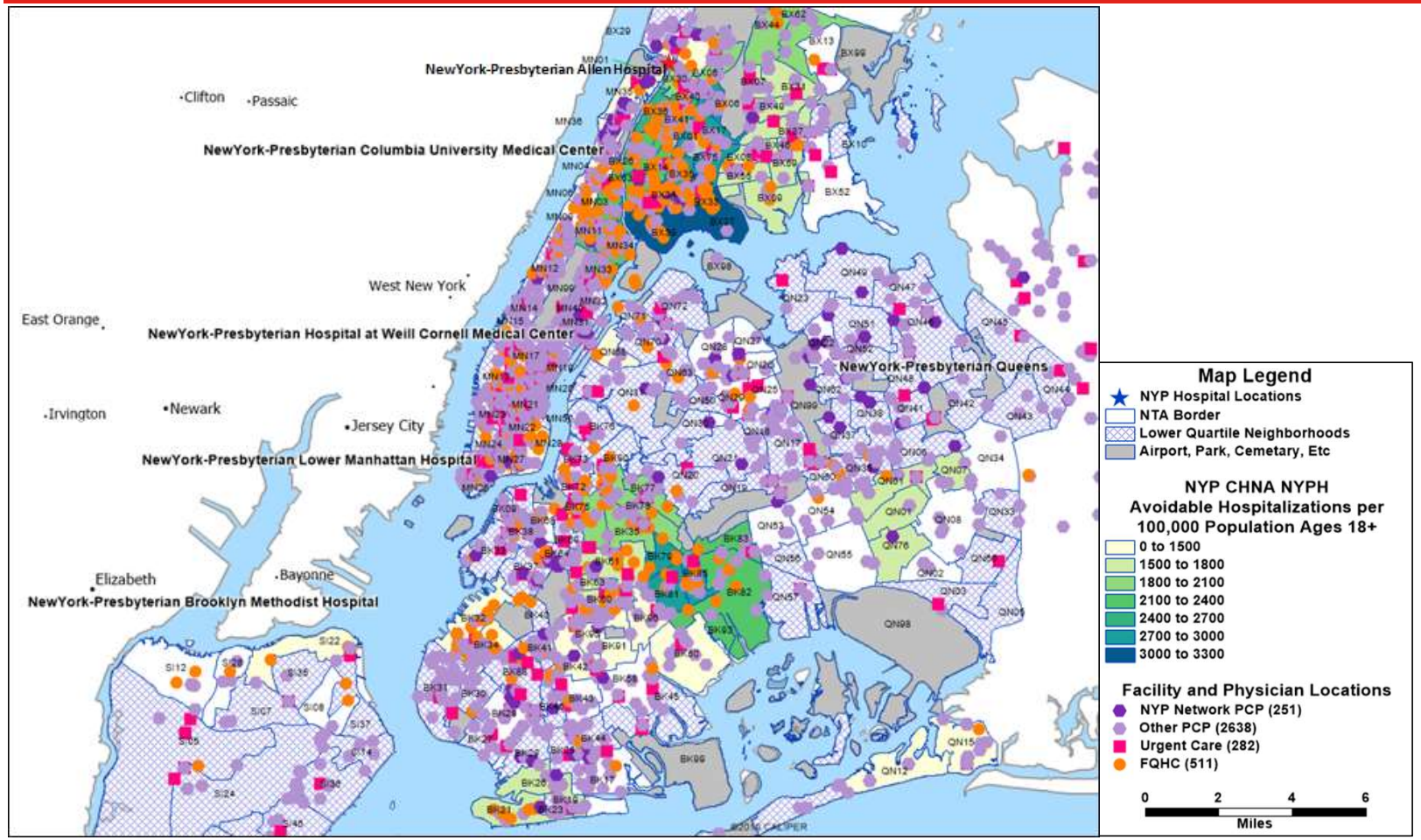
Avoidable Hospitalizations for Ages 0-17 and Key Health Providers in the High Disparity NYC Communities



- Avoidable or preventable hospitalizations indicate a lack of access to ambulatory care for conditions that would otherwise not have required an admission.
- While the percentage of uninsured children is typically lower than uninsured adults other factors such as lack of time, money, transportation and plain fear can delay care.

NewYork-Presbyterian

Avoidable Hospitalizations for Ages 18+ and Key Health Providers in the High Disparity NYC Communities



- Avoidable or preventable hospitalizations indicate a lack of access to ambulatory care for conditions that would otherwise not have required an admission.
- The presence of a provider in the high disparity communities does not necessarily equate to access and many seek delayed care in the Emergency Room with a resulting admission.

NewYork-Presbyterian

Health Care Service Utilization: Avoidable/Preventable Hospitalizations in the High Disparity NYC Communities

	Hospitalizations					
NYC Neighborhood Tabulation Area	Avoidable, per 100,00 Population Ages 18+ (PQI)	Avoidable, per 100,000 Population Ages 0-4 (PDI)	Preventable All per 100,00 Population Ages 18+	Preventable Asthma per 100,00 Population Ages 18+	Preventable Diabetes per 100,00 Population Ages 18+	Preventable Hypertension per 100,00 Population Ages 18+
East Tremont	2,957	1,348	3,831	769	767	322
Highbridge	2,307	1,356	3,135	548	473	251
Mott Haven-Port Morris	3,138	1,760	4,176	853	798	236
East Concourse-Concourse Village	2,307	1,356	2,835	504	574	202
University Heights-Morris Heights	2,573	1,297	3,209	476	586	280
Claremont-Bathgate	2,957	1,348	4,221	853	786	288
Morrisania-Melrose	2,957	1,348	3,524	671	599	287
Brownsville	2,755	1,358	3,277	610	730	160
Longwood	3,138	1,760	3,505	799	660	204
Crotona Park East	2,957	1,348	3,517	695	598	250
Hunts Point	3,138	1,760	3,492	776	665	212
Fordham South	2,573	1,297	3,256	512	699	303
East New York (Pennsylvania Ave)	2,755	1,358	3,065	551	627	145
Mount Hope	2,573	1,297	3,192	591	579	291
Melrose South-Mott Haven North	3,138	1,760	3,973	802	736	175
East New York	2,245	981	2,864	462	646	136
Ocean Hill	2,755	1,358	3,169	556	722	156
Soundview-Bruckner	1,631	1,230	2,061	454	428	108
West Concourse	2,307	1,356	3,005	563	480	257
Bedford Park-Fordham North	2,099	1,353	2,619	589	505	172
Kingsbridge Heights	2,099	1,353	2,589	411	520	169
Belmont	2,957	1,348	3,467	717	692	284
East Harlem North	2,262	1,374	3,113	592	605	182
Stuyvesant Heights	2,068	863	2,571	532	512	134
NYPH High Disparity Community	1,671	831	2,121	341	408	131
New York City	1,033	623	1,662	233	294	96
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas; PQI = Prevention Quality Indicator and PDI = Pediatric Quality Indicator

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

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- Avoidable or preventable hospitalizations indicate a lack of access to ambulatory care for conditions that would otherwise not have required an admission.
- Preventable Quality Indicator (PQI) is an adult measure and Pediatric Quality Indicator (PDI) is a child measure.
- These higher rates of preventable admissions are in aggregate and across many of the Quartile 4 neighborhoods.
- Mott Haven-Port Morris, Hunts Point, Longwood, and Melrose South-Mott Haven North have the highest PQI rates, 3,138 and PDI rates, 1,760.

Health Care Service Utilization: Avoidable/Preventable Hospitalizations in the High Disparity Communities, continued

	Hospitalizations					
NYC Neighborhood Tabulation Area	Avoidable, per 100,00 Population Ages 18+ (PQI)	Avoidable, per 100,000 Population Ages 0-4 (PDI)	Preventable All per 100,00 Population Ages 18+	Preventable Asthma per 100,00 Population Ages 18+	Preventable Diabetes per 100,00 Population Ages 18+	Preventable Hypertension per 100,00 Population Ages 18+
West Farms-Bronx River	1,631	1,230	2,183	429	383	121
Williamsbridge-Olinville	1,891	1,142	2,582	623	536	170
Central Harlem North-Polo Grounds	2,240	886	2,898	501	503	230
East Harlem South	2,262	1,374	2,455	490	524	144
Seagate-Coney Island	1,524	423	3,159	588	638	199
Norwood	2,099	1,353	2,761	505	544	136
Bushwick South	1,897	747	2,688	560	510	125
Soundview-Castle Hill-Clason Point-Ha	1,631	1,230	2,114	466	431	112
Jamaica	1,602	809	1,728	196	326	91
Starrett City	2,245	981	2,818	411	461	140
Westchester-Unionport	1,631	1,230	1,987	367	316	96
Crown Heights North	1,786	856	2,640	411	546	162
Bedford	2,068	863	2,479	372	472	145
South Jamaica	1,602	809	2,526	293	500	183
Bronxdale	1,613	951	2,251	451	423	126
Washington Heights South	1,339	587	1,761	206	328	125
Bushwick North	1,897	747	2,381	473	429	98
Cypress Hills-City Line	2,245	981	2,172	329	432	117
Erasmus	1,439	1,308	2,033	296	455	118
Hamilton Heights	1,345	654	1,905	268	337	118
Eastchester-Edenwald-Baychester	1,891	1,142	2,159	399	468	130
Marble Hill-Inwood	1,339	587	1,641	259	300	103
Rugby-Remsen Village	1,439	1,308	1,758	265	403	108
Manhattanville	1,345	654	1,773	293	357	113
NYPH High Disparity Community	1,671	831	2,121	341	408	131
New York City	1,033	623	1,662	233	294	96
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas; PQI = Prevention Quality Indicator and PDI = Pediatric Quality Indicator

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- NTA Quartile 4 continued

NewYork-Presbyterian

Health Care Service Utilization: Avoidable/Preventable Hospitalizations in the High Disparity Communities, continued

	Hospitalizations					
NYC Neighborhood Tabulation Area	Avoidable, per 100,00 Population Ages 18+ (PQI)	Avoidable, per 100,000 Population Ages 0-4 (PDI)	Preventable All per 100,00 Population Ages 18+	Preventable Asthma per 100,00 Population Ages 18+	Preventable Diabetes per 100,00 Population Ages 18+	Preventable Hypertension per 100,00 Population Ages 18+
Lower East Side	1,207	411	2,056	385	325	102
Gravesend	1,524	423	1,600	263	245	92
Van Cortlandt Village	1,250	590	2,020	303	321	144
Prospect Lefferts Gardens-Wingate	1,515	675	1,891	237	431	113
Van Nest-Morris Park-Westchester Squ	1,613	951	1,815	385	319	98
Hammels-Arverne-Edgemere	1,345	403	2,022	286	503	116
Chinatown	1,207	411	1,182	153	156	38
Far Rockaway-Bayswater	1,345	403	2,005	229	457	119
Central Harlem South	2,240	886	2,222	341	452	145
Parkchester	1,631	1,230	1,608	253	368	88
West New Brighton-New Brighton-St.	1,308	407	2,691	386	632	169
Sunset Park East	1,230	390	1,195	158	196	57
Queensbridge-Ravenswood-Long Islan	1,180	221	2,700	550	472	138
Baisley Park	1,602	809	2,031	214	479	132
Woodlawn-Wakefield	1,891	1,142	1,535	272	278	131
Allerton-Pelham Gardens	1,613	951	1,746	213	354	72
East Flatbush-Farragut	1,439	1,308	1,514	213	368	105
Flatbush	1,307	447	1,706	212	327	109
Sunset Park West	1,230	390	2,154	392	368	120
Canarsie	1,342	590	1,761	209	410	102
Crown Heights South	1,515	675	1,974	277	368	118
Pelham Parkway	1,613	951	1,538	253	264	79
Washington Heights North	1,339	587	1,341	140	248	106
Brighton Beach	1,524	423	1,234	102	171	104
Hollis	1,602	809	1,628	169	291	123
NYPH High Disparity Community	1,671	831	2,121	341	408	131
New York City	1,033	623	1,662	233	294	96
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas; PQI = Prevention Quality Indicator and PDI = Pediatric Quality Indicator

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- NTA Quartile 3

Health Care Service Utilization: Avoidable/Preventable Hospitalizations in the High Disparity Communities, continued

	Hospitalizations					
NYC Neighborhood Tabulation Area	Avoidable, per 100,00 Population Ages 18+ (PQI)	Avoidable, per 100,000 Population Ages 0-4 (PDI)	Preventable All per 100,00 Population Ages 18+	Preventable Asthma per 100,00 Population Ages 18+	Preventable Diabetes per 100,00 Population Ages 18+	Preventable Hypertension per 100,00 Population Ages 18+
Springfield Gardens North	1,602	809	1,802	188	415	144
St. Albans	1,602	809	1,700	163	355	126
Corona	892	286	1,690	219	296	114
East Elmhurst	869	425	1,773	215	319	66
Mariner's Harbor-Arlington-Port Ivory-(	1,308	407	2,084	353	449	142
Williamsburg	1,131	172	1,770	148	251	34
Fort Greene	1,338	297	2,597	408	496	93
Jackson Heights	869	425	1,000	100	146	56
Midwood	1,307	447	1,447	116	219	77
South Ozone Park	1,181	656	1,455	141	274	93
Flushing	708	356	1,013	90	122	51
Flatlands	1,342	590	1,465	196	300	101
Schuylerville-Throgs Neck-Edgewater P	1,185	1,023	1,386	199	241	54
Richmond Hill	1,183	816	1,422	168	258	72
North Corona	869	425	1,143	121	231	103
Sheepshead Bay-Gerritsen Beach-Manh	990	156	1,631	161	213	91
Co-op City	1,185	1,023	1,634	195	430	89
Woodhaven	1,183	816	1,505	149	277	57
Grymes Hill-Clifton-Fox Hills	1,308	407	1,448	234	316	177
Queens Village	1,084	655	1,352	102	272	129
Elmhurst	892	286	1,044	114	168	67
Bensonhurst West	740	204	1,021	77	145	45
Morningside Heights	1,345	654	1,430	197	261	67
Port Richmond	1,308	407	1,628	248	317	102
NYPH High Disparity Community	1,671	831	2,121	341	408	131
New York City	1,033	623	1,662	233	294	96
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas; PQI = Prevention Quality Indicator and PDI = Pediatric Quality Indicator

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- NTA Quartile 3 continued

Health Care Service Utilization: Other Hospitalizations in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Hospitalizations: Alcohol per 100,00 Population Ages 15-84	Child Asthma 10,000 Children Ages 5-14	Drug per 100,000 Population Ages 15-84	Falls per 100,000 Population Ages 65+	Psychiatric per 100,000 Population Ages 18+	Stroke per 100,000 Population Ages 18+
East Tremont	2,535	103	3,004	2,748	1,574	526
Highbridge	1,934	46	2,729	1,408	1,337	449
Mott Haven-Port Morris	2,589	119	2,544	2,080	1,005	390
East Concourse-Concourse Village	1,856	52	1,977	1,439	952	456
University Heights-Morris Heights	1,835	69	2,408	1,259	1,305	434
Claremont-Bathgate	2,747	109	3,994	1,771	1,452	461
Morrisania-Melrose	2,163	91	2,884	1,462	1,587	401
Brownsville	1,640	67	1,900	1,012	1,165	536
Longwood	2,309	89	2,554	1,789	1,137	296
Crotona Park East	2,358	56	2,794	1,710	1,824	633
Hunts Point	2,338	102	2,847	1,585	1,198	406
Fordham South	2,024	54	2,689	825	1,216	419
East New York (Pennsylvania Ave)	1,828	51	2,189	1,060	1,830	421
Mount Hope	1,881	70	2,224	1,478	998	417
Melrose South-Mott Haven North	2,309	81	3,033	1,636	1,238	432
East New York	1,494	59	1,384	1,135	1,211	519
Ocean Hill	2,873	64	3,691	861	2,862	420
Soundview-Bruckner	1,317	78	1,543	1,338	531	291
West Concourse	1,534	68	1,774	1,319	692	428
Bedford Park-Fordham North	1,769	102	1,773	1,640	866	327
Kingsbridge Heights	1,398	58	1,339	2,549	805	367
Belmont	2,027	73	2,434	1,965	1,038	428
East Harlem North	1,824	57	2,370	1,805	1,834	435
Stuyvesant Heights	1,488	65	1,801	693	1,078	398
NYPH High Disparity Community	1,169	47	1,157	1,514	859	360
New York City	955	37	882	1,840	774	318
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas

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- Overall, other hospitalizations in the community vary by neighborhood, but with the exception of 'hospitalizations for falls', are worse than the NYC average.
- Several neighborhoods have higher than average hospitalizations across all these indicators; East Tremont, Mott Haven-Port Morris, Belmont, East Harlem South, Seagate Coney Island, West New Brighton-New Brighton-St. George, and Queensbridge-Ravenswood-Long Island City.

Health Care Service Utilization: Other Hospitalizations in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Hospitalizations: Alcohol per 100,00 Population Ages 15-84	Child Asthma 10,000 Children Ages 5-14	Drug per 100,000 Population Ages 15-84	Falls per 100,000 Population Ages 65+	Psychiatric per 100,000 Population Ages 18+	Stroke per 100,000 Population Ages 18+
West Farms-Bronx River	1,481	80	1,587	1,277	777	272
Williamsbridge-Olinville	1,424	96	1,649	1,491	838	367
Central Harlem North-Polo Grounds	1,584	76	2,052	1,450	1,078	418
East Harlem South	1,439	103	1,610	1,962	1,154	351
Seagate-Coney Island	1,663	40	1,845	2,354	1,676	493
Norwood	1,894	85	1,810	1,723	1,017	311
Bushwick South	1,257	66	1,370	1,306	998	387
Soundview-Castle Hill-Clason Point-Harding Park	1,227	86	1,329	1,312	680	281
Jamaica	1,166	21	686	1,202	844	384
Starrett City	953	28	628	2,321	856	430
Westchester-Unionport	1,167	55	939	2,048	548	255
Crown Heights North	1,527	79	1,932	1,186	1,417	416
Bedford	1,245	39	1,207	933	795	438
South Jamaica	1,047	35	911	1,221	927	480
Bronxdale	1,481	100	1,396	1,817	812	380
Washington Heights South	1,183	37	962	1,293	873	324
Bushwick North	1,072	63	818	1,465	423	412
Cypress Hills-City Line	989	33	651	1,200	597	357
Erasmus	927	76	1,019	742	1,174	520
Hamilton Heights	1,123	40	1,523	954	886	309
Eastchester-Edenwald-Baychester	1,085	86	1,261	1,165	837	329
Marble Hill-Inwood	964	39	734	1,302	585	282
Rugby-Remsen Village	793	62	885	954	820	427
Manhattanville	1,146	62	1,223	924	1,039	315
NYPH High Disparity Community	1,169	47	1,157	1,514	859	360
New York City	955	37	882	1,840	774	318
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas

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- NTA Quartile 4 continued

Health Care Service Utilization: Other Hospitalizations in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Hospitalizations: Alcohol per 100,00 Population Ages 15-84	Child Asthma 10,000 Children Ages 5-14	Drug per 100,000 Population Ages 15-84	Falls per 100,000 Population Ages 65+	Psychiatric per 100,000 Population Ages 18+	Stroke per 100,000 Population Ages 18+
Lower East Side	1,150	41	1,241	1,913	1,051	256
Gravesend	881	15	777	1,367	550	269
Van Cortlandt Village	1,194	59	1,087	1,879	716	260
Prospect Lefferts Gardens-Wingate	1,265	50	1,191	1,026	1,295	407
Van Nest-Morris Park-Westchester Square	1,355	42	1,332	2,101	1,464	301
Hammels-Arverne-Edgemere	964	30	754	1,312	1,424	348
Chinatown	730	11	574	2,144	457	351
Far Rockaway-Bayswater	805	28	606	2,016	1,340	409
Central Harlem South	1,148	43	1,572	1,112	943	365
Parkchester	975	63	948	1,320	647	315
West New Brighton-New Brighton-St. George	1,556	41	1,377	2,264	1,378	414
Sunset Park East	639	10	274	1,301	483	314
Queensbridge-Ravenswood-Long Island City	1,545	50	1,090	2,043	820	433
Baisley Park	862	32	719	971	689	456
Woodlawn-Wakefield	879	49	877	1,435	582	331
Allerton-Pelham Gardens	958	36	714	2,172	534	318
East Flatbush-Farragut	730	51	716	720	759	408
Flatbush	716	39	605	1,465	682	388
Sunset Park West	1,108	19	664	2,333	573	365
Canarsie	519	36	494	1,265	647	386
Crown Heights South	740	31	793	1,146	699	437
Pelham Parkway	994	55	763	1,921	595	240
Washington Heights North	679	25	581	1,689	551	290
Brighton Beach	742	0	444	1,754	588	323
Hollis	752	72	425	1,053	803	451
NYPH High Disparity Community	1,169	47	1,157	1,514	859	360
New York City	955	37	882	1,840	774	318
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas

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- NTA Quartile 3

Health Care Service Utilization: Other Hospitalizations in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Alcohol per 100,00 Population Ages 15-84	Child Asthma 10,000 Children Ages 5-14	Hospitalizations Drug per 100,000 Population Ages 15-84	Falls per 100,000 Population Ages 65+	Psychiatric per 100,000 Population Ages 18+	Stroke per 100,000 Population Ages 18+
Springfield Gardens North	466	25	458	1,282	533	432
St. Albans	566	27	528	1,028	703	372
Corona	838	19	355	1,781	600	351
East Elmhurst	812	24	497	1,805	637	385
Mariner's Harbor-Arlington-Port Ivory-Graniteville	1,036	35	917	1,986	676	370
Williamsburg	690	6	424	2,000	502	275
Fort Greene	1,442	37	1,132	1,477	914	389
Jackson Heights	680	18	274	1,672	424	212
Midwood	583	0	417	2,596	603	263
South Ozone Park	816	20	298	1,207	445	345
Flushing	366	13	166	1,983	552	296
Flatlands	376	32	387	1,285	417	311
Schuylerville-Throgs Neck-Edgewater Park	815	35	695	1,977	458	238
Richmond Hill	870	28	356	1,413	561	328
North Corona	831	25	238	1,127	328	224
Sheepshead Bay-Gerritsen Beach-Manhattan Beach	562	11	551	2,632	581	300
Co-op City	833	50	578	1,704	511	258
Woodhaven	566	27	270	1,606	447	307
Grymes Hill-Clifton-Fox Hills	926	26	860	1,426	743	366
Queens Village	558	41	340	1,180	550	397
Elmhurst	856	16	377	1,554	779	223
Bensonhurst West	419	6	235	1,701	456	239
Morningside Heights	920	40	804	1,806	683	267
Port Richmond	918	33	888	2,044	816	285
NYPH High Disparity Community	1,169	47	1,157	1,514	859	360
New York City	955	37	882	1,840	774	318
New York State	N/A	N/A	N/A	N/A	N/A	N/A

Source: NYC Health Data Atlas

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- NTA Quartile 3 continued

Health Care Service Utilization: ER in the High Disparity NYC Communities

NYC Neighborhood Tabulation Area	Emergency Dept: All Visits per 100,000 Population, Crude Rate	Emergency Dept: Treat and Release Visits, per 100,000 Population, Crude Rate	Emergency Dept: Visits Resulting in Inpatient Stays, per 100,000 Population, Crude Rate	Emergency Dept: % of Preventable Treat and Release Visits of All T&R Visits
East Tremont	83,554	69,860	13,695	55.5%
Highbridge	74,534	63,231	11,304	56.3%
Mott Haven-Port Morris	93,415	79,799	13,616	58.5%
East Concourse-Concourse Village	74,558	62,981	11,577	57.4%
University Heights-Morris Heights	74,424	62,693	11,731	55.7%
Claremont-Bathgate	91,170	77,618	13,552	57.8%
Morrisania-Melrose	78,914	66,251	12,664	55.6%
Brownsville	81,799	70,638	11,161	56.5%
Longwood	78,256	65,920	12,337	55.9%
Crotona Park East	73,184	60,007	13,177	55.0%
Hunts Point	72,229	60,004	12,226	53.5%
Fordham South	79,543	68,078	11,465	57.4%
East New York (Pennsylvania Ave)	75,247	64,650	10,597	53.7%
Mount Hope	76,275	65,116	11,159	58.1%
Melrose South-Mott Haven North	93,197	79,531	13,667	58.4%
East New York	72,584	61,575	11,009	54.5%
Ocean Hill	83,859	72,310	11,549	52.1%
Soundview-Bruckner	64,270	54,932	9,338	56.0%
West Concourse	76,091	65,209	10,882	58.1%
Bedford Park-Fordham North	71,431	61,073	10,358	57.5%
Kingsbridge Heights	64,092	53,978	10,114	56.5%
Belmont	69,465	60,029	9,436	58.0%
East Harlem North	84,563	72,751	11,812	57.6%
Stuyvesant Heights	71,352	62,968	8,384	54.2%
NYPH High Disparity Community	55,878	47,294	8,584	54.3%
New York City	46,079	38,314	7,765	52.4%
New York State	40,582	N/A	N/A	N/A

Source: NYC Health Data Atlas

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- There is higher than NYC average ED utilization overall.
- Among the neighborhoods with the highest crude rates for all ED visits are Mott Haven-Port Morris 93,415, Melrose South-Mott Haven North 93,197.4, and Claremont-Bathgate 91,170. These three also have the highest treat and release rates.
- The highest rates of inpatient stays via the ED is Seagate-Coney Island 16,391.3 and Starrett City 14,726.9.
- The highest average percentage of preventable ER treat and release visits, suggesting a lack of access to ambulatory care, is 59.8%, in Norwood.

Health Care Service Utilization: ER in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Emergency Dept: All Visits per 100,000 Population, Crude Rate	Emergency Dept: Treat and Release Visits, per 100,000 Population, Crude Rate	Emergency Dept: Visits Resulting in Inpatient Stays, per 100,000 Population, Crude Rate	Emergency Dept: % of Preventable Treat and Release Visits of All T&R Visits
West Farms-Bronx River	62,903	53,938	8,965	56.7%
Williamsbridge-Olinville	71,959	61,215	10,744	57.8%
Central Harlem North-Polo Grounds	78,266	67,773	10,492	58.5%
East Harlem South	77,991	67,585	10,406	58.4%
Seagate-Coney Island	72,986	56,595	16,391	52.4%
Norwood	81,069	69,757	11,312	59.8%
Bushwick South	67,158	58,598	8,560	56.0%
Soundview-Castle Hill-Clason Point-Ha	59,268	50,076	9,192	56.0%
Jamaica	61,954	53,677	8,277	56.1%
Starrett City	57,383	42,656	14,727	52.7%
Westchester-Unionport	59,151	51,227	7,924	56.2%
Crown Heights North	62,632	53,601	9,031	54.4%
Bedford	53,952	46,604	7,348	54.8%
South Jamaica	59,004	51,000	8,004	54.8%
Bronxdale	63,591	53,208	10,383	56.1%
Washington Heights South	53,168	46,473	6,695	56.6%
Bushwick North	54,379	48,049	6,330	56.5%
Cypress Hills-City Line	57,080	49,700	7,379	55.3%
Erasmus	59,403	50,481	8,922	55.1%
Hamilton Heights	54,138	47,028	7,110	57.4%
Eastchester-Edenwald-Baychester	61,744	52,396	9,348	56.8%
Marble Hill-Inwood	43,693	37,527	6,167	55.9%
Rugby-Remsen Village	59,085	49,924	9,161	56.7%
Manhattanville	61,015	53,565	7,450	58.9%
NYPH High Disparity Community	55,878	47,294	8,584	54.3%
New York City	46,079	38,314	7,765	52.4%
New York State	40,582	N/A	N/A	N/A

Source: NYC Health Data Atlas

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 4 continued

Health Care Service Utilization: ER in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Emergency Dept: All Visits per 100,000 Population, Crude Rate	Emergency Dept: Treat and Release Visits, per 100,000 Population, Crude Rate	Emergency Dept: Visits Resulting in Inpatient Stays, per 100,000 Population, Crude Rate	Emergency Dept: % of Preventable Treat and Release Visits of All T&R Visits
Lower East Side	53,639	44,901	8,738	57.1%
Gravesend	39,169	30,780	8,389	49.5%
Van Cortlandt Village	55,006	46,582	8,424	56.9%
Prospect Lefferts Gardens-Wingate	55,416	45,495	9,920	52.5%
Van Nest-Morris Park-Westchester Squ	57,863	49,450	8,414	54.4%
Hammels-Arverne-Edgemere	58,894	50,756	8,138	51.3%
Chinatown	32,426	26,418	6,008	47.7%
Far Rockaway-Bayswater	52,864	44,976	7,889	50.1%
Central Harlem South	59,155	51,410	7,746	57.5%
Parkchester	54,699	46,656	8,043	55.9%
West New Brighton-New Brighton-St. G	68,999	57,985	11,014	51.7%
Sunset Park East	32,120	25,699	6,421	48.5%
Queensbridge-Ravenswood-Long Islan	68,803	58,240	10,564	55.0%
Baisley Park	51,501	44,110	7,391	54.1%
Woodlawn-Wakefield	52,991	45,434	7,557	55.2%
Allerton-Pelham Gardens	42,528	32,992	9,537	53.6%
East Flatbush-Farragut	51,291	43,567	7,724	54.0%
Flatbush	44,126	36,518	7,609	52.2%
Sunset Park West	39,786	32,310	7,476	51.9%
Canarsie	44,536	36,665	7,871	53.8%
Crown Heights South	44,413	36,642	7,771	53.3%
Pelham Parkway	45,311	37,210	8,101	54.1%
Washington Heights North	37,579	31,837	5,742	54.1%
Brighton Beach	37,302	27,967	9,335	47.3%
Hollis	44,872	38,199	6,673	52.6%
NYPH High Disparity Community	55,878	47,294	8,584	54.3%
New York City	46,079	38,314	7,765	52.4%
New York State	40,582	N/A	N/A	N/A

Source: NYC Health Data Atlas

Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 3

Health Care Service Utilization: ER in the High Disparity NYC Communities, continued

NYC Neighborhood Tabulation Area	Emergency Dept: All Visits per 100,000 Population, Crude Rate	Emergency Dept: Treat and Release Visits, per 100,000 Population, Crude Rate	Emergency Dept: Visits Resulting in Inpatient Stays, per 100,000 Population, Crude Rate	Emergency Dept: % of Preventable Treat and Release Visits of All T&R Visits
Springfield Gardens North	45,521	38,812	6,709	53.8%
St. Albans	44,677	38,309	6,368	53.1%
Corona	56,574	49,557	7,017	50.0%
East Elmhurst	54,486	46,760	7,726	56.4%
Mariner's Harbor-Arlington-Port Ivory-(	55,486	46,548	8,938	51.6%
Williamsburg	23,151	17,069	6,082	45.3%
Fort Greene	51,193	42,673	8,520	53.5%
Jackson Heights	42,739	36,810	5,929	56.7%
Midwood	28,247	21,048	7,199	44.9%
South Ozone Park	38,818	32,976	5,843	53.6%
Flushing	31,814	23,621	8,193	46.0%
Flatlands	35,068	28,711	6,357	52.9%
Schuylerville-Throgs Neck-Edgewater F	34,745	28,456	6,289	52.1%
Richmond Hill	46,166	39,860	6,306	54.4%
North Corona	54,372	48,375	5,997	58.0%
Sheepshead Bay-Gerritsen Beach-Manl	32,692	23,751	8,941	47.2%
Co-op City	40,928	31,774	9,154	53.5%
Woodhaven	40,076	34,291	5,785	54.1%
Grymes Hill-Clifton-Fox Hills	45,170	37,338	7,832	51.9%
Queens Village	36,318	31,853	4,465	51.6%
Elmhurst	42,694	36,796	5,898	55.6%
Bensonhurst West	24,846	18,734	6,112	45.2%
Morningside Heights	36,662	31,069	5,592	54.2%
Port Richmond	48,625	40,044	8,581	48.7%
NYPH High Disparity Community	55,878	47,294	8,584	54.3%
New York City	46,079	38,314	7,765	52.4%
New York State	40,582	N/A	N/A	N/A

Source: NYC Health Data Atlas

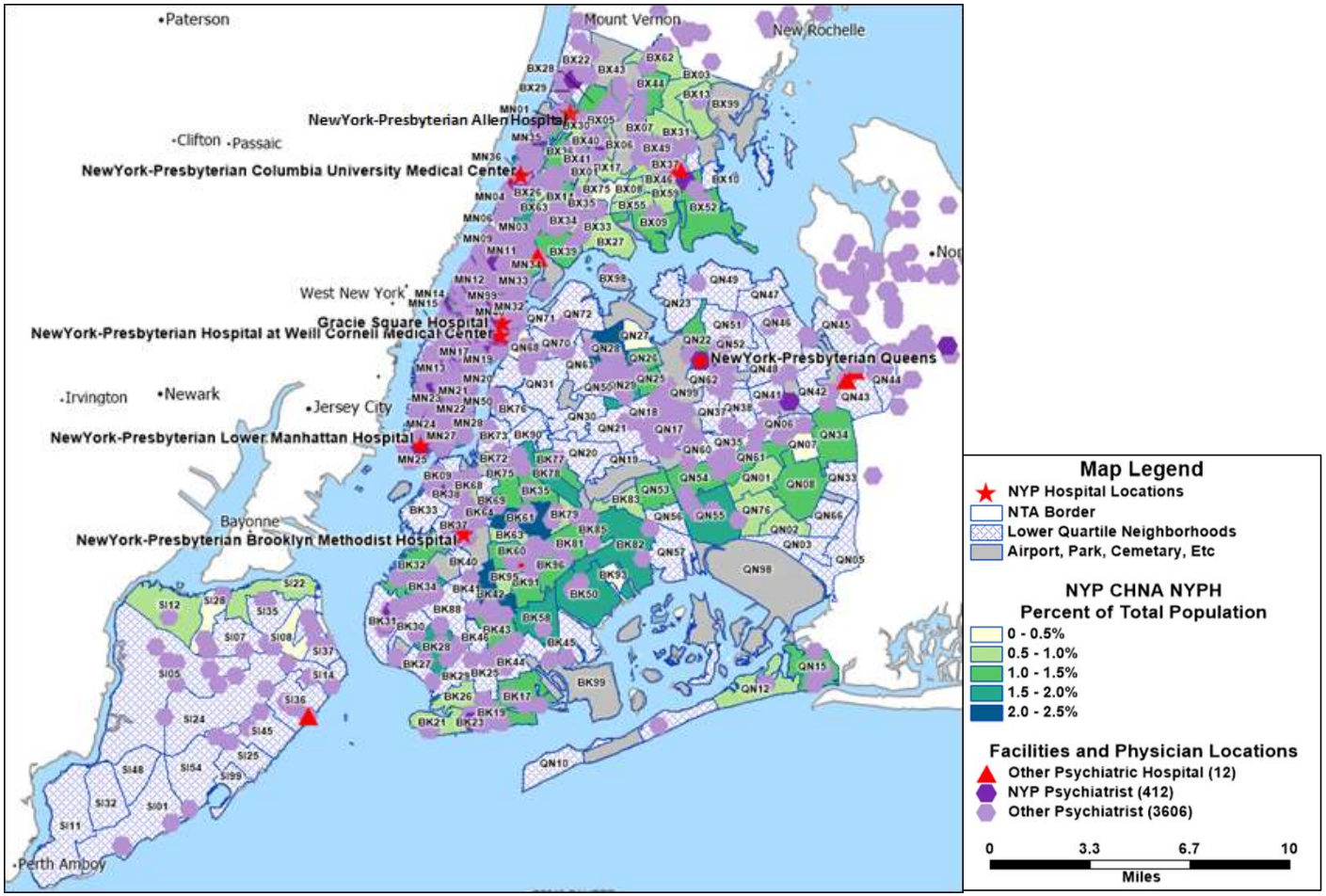
Indicates neighborhood statistic is more favorable than the NYC statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYC statistic

Indicates neighborhood statistic is less favorable than the NYC statistic by more than five percent

- NTA Quartile 3 continued

Psychiatric Hospitals and Physicians in the High Disparity NYC Community



- Behavioral health providers and facilities are lacking across the service area, a similar trend exists across New York state.
- Pockets of providers exist in lower quartile communities of need with disparate opportunities for access in high need populations.

NewYork-Presbyterian

Health Provider Assets in the NYPH High Disparity Communities

Asset Type	Quartile 1	Quartile 2	Quartile 3	Quartile 4	Total
Short Term Acute Care Hospital	15	10	14	15	54
VA Hospital	1	1	0	1	3
Childrens Hospital	3	0	0	3	6
Long Term Acute Care Hospital	0	0	2	2	4
Rehabilitation Hospital	1	0	0	0	1
Psychiatric Hospital	1	3	3	3	10
Federally Qualified Health Center	38	58	121	238	455
Urgent Care Clinic	53	77	45	43	218
Skilled Nursing Facility	13	45	66	40	164
Facility Total	**125**	**194**	**251**	**345**	**915**

Primary Care Physicians	390	332	335	376	1,433
Pediatricians	500	266	390	435	1,591
Psychiatrists	867	403	324	599	2,193
Physician Total	**1,757**	**1,001**	**1,049**	**1,410**	**5,217**

Data Source: Definitive Health

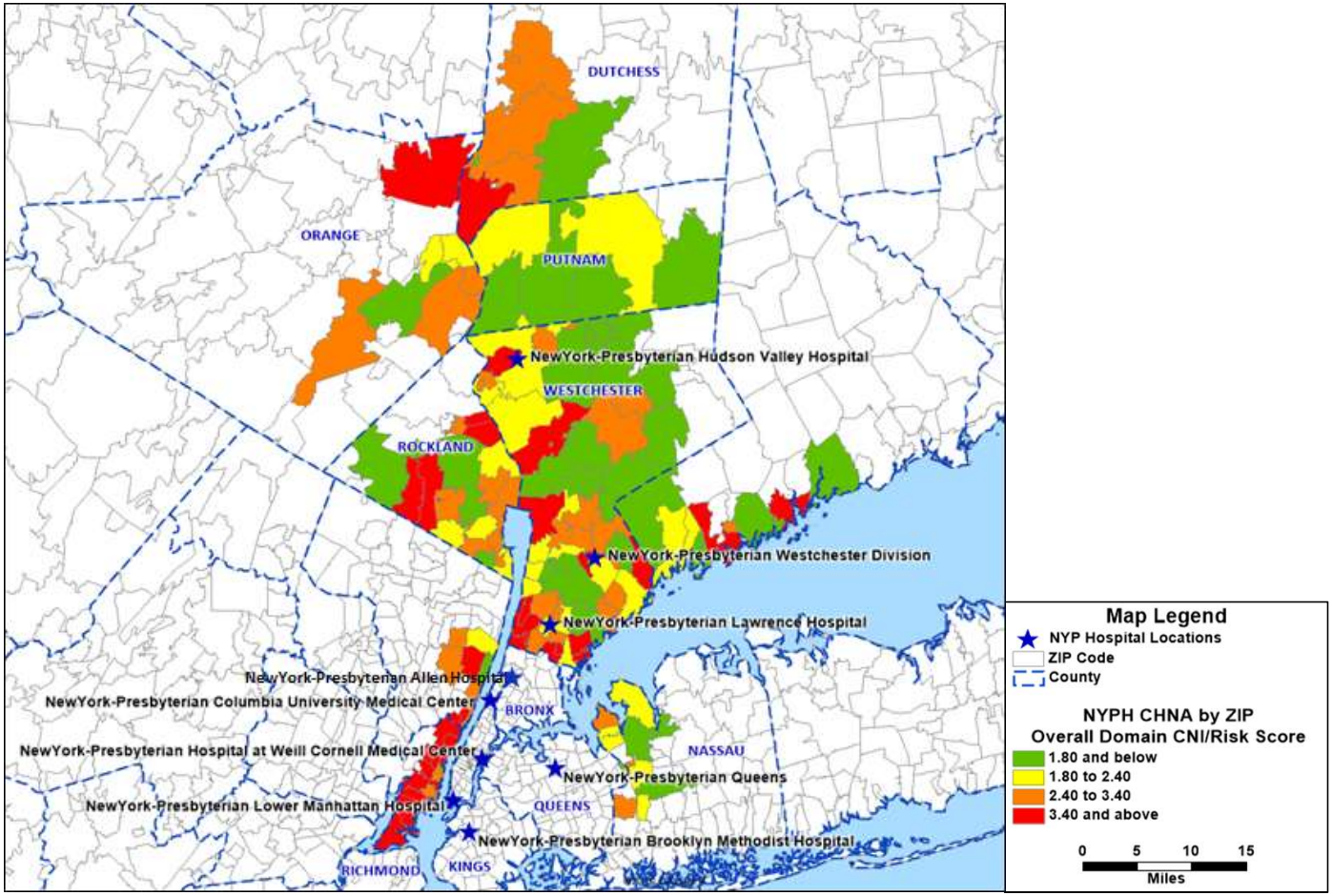
This table represents a count only and does not imply that all providers listed accept the most vulnerable populations of Medicaid, low-income, and/or uninsured patients.

AMAZING THINGS ARE HAPPENING HERE

Assessing the Health of the non-NYC Communities by County

NewYork-Presbyterian

NYPH Non-NYC Community Need Index (CNI) Analysis



- An analysis of community health need and risk of high resource utilization was also undertaken by ZIP code.
- The Community Need Index (CNI) score is an average of five different barrier scores that measure various socio-economic indicators of each community.
- The results show where there is more or less need comparatively between communities.

NewYork-Presbyterian

NYPH Non-NYC Communities of High Disparity Analysis
Higher Disparity Quartiles 3 & 4

ZIP	City	County	State	Overall Domain CNI/Risk Score	Quartile
07087	Union City	Hudson County	NJ	4.60	Quartile 4
07093	West New York	Hudson County	NJ	4.60	Quartile 4
07304	Jersey City	Hudson County	NJ	4.60	Quartile 4
10701	Yonkers	Westchester County	NY	4.60	Quartile 4
10705	Yonkers	Westchester County	NY	4.60	Quartile 4
07305	Jersey City	Hudson County	NJ	4.40	Quartile 4
07306	Jersey City	Hudson County	NJ	4.40	Quartile 4
10977	Spring Valley	Rockland County	NY	4.40	Quartile 4
07022	Fairview	Bergen County	NJ	4.20	Quartile 4
07047	North Bergen	Hudson County	NJ	4.20	Quartile 4
07086	Weehawken	Hudson County	NJ	4.20	Quartile 4
07307	Jersey City	Hudson County	NJ	4.20	Quartile 4
10927	Haverstraw	Rockland County	NY	4.20	Quartile 4
12550	Newburgh	Orange County	NY	4.20	Quartile 4
08701	Lakewood	Ocean County	NJ	4.00	Quartile 4
10550	Mount Vernon	Westchester County	NY	4.00	Quartile 4
10566	Peekskill	Westchester County	NY	4.00	Quartile 4
10573	Port Chester	Westchester County	NY	4.00	Quartile 4
10703	Yonkers	Westchester County	NY	4.00	Quartile 4
10801	New Rochelle	Westchester County	NY	4.00	Quartile 4
10993	West Haverstraw	Rockland County	NY	4.00	Quartile 4
12508	Beacon	Dutchess County	NY	4.00	Quartile 4
10553	Mount Vernon	Westchester County	NY	3.80	Quartile 4
10562	Ossining	Westchester County	NY	3.80	Quartile 4
10591	Tarrytown	Westchester County	NY	3.80	Quartile 4
10601	White Plains	Westchester County	NY	3.80	Quartile 4
10606	White Plains	Westchester County	NY	3.80	Quartile 4
06854	Norwalk	Fairfield County	CT	3.60	Quartile 4
06855	Norwalk	Fairfield County	CT	3.60	Quartile 4
06902	Stamford	Fairfield County	CT	3.60	Quartile 4

Source: http://cni.chw-interactive.org/

- Recognizing the variability among domains and individual indicators, 75 of the 152 ZIP codes were identified to be of comparatively higher disparity which could benefit from focused efforts of health improvement.
- The ZIP codes identified to be of comparatively lesser disparities, will also continue to benefit from the community health improvement efforts offered broadly by NYPH.

NYPH Non-NYC Communities of High Disparity Analysis
Higher Disparity Quartiles 3 & 4 and Lower Disparity Quartiles 1 & 2

ZIP	City	County	State	Overall Domain CNI/Risk Score	Quartile
07002	Bayonne	Hudson County	NJ	3.60	Quartile 4
07010	Cliffside Park	Bergen County	NJ	3.60	Quartile 4
07310	Jersey City	Hudson County	NJ	3.60	Quartile 4
07631	Englewood	Bergen County	NJ	3.60	Quartile 4
10805	New Rochelle	Westchester County	NY	3.60	Quartile 4
10952	Monsey	Rockland County	NY	3.60	Quartile 4
07020	Edgewater	Bergen County	NJ	3.40	Quartile 3
07302	Jersey City	Hudson County	NJ	3.40	Quartile 3
10552	Mount Vernon	Westchester County	NY	3.40	Quartile 3
10604	West Harrison	Westchester County	NY	3.40	Quartile 3
10704	Yonkers	Westchester County	NY	3.40	Quartile 3
10923	Garnerville	Rockland County	NY	3.40	Quartile 3
07024	Fort Lee	Bergen County	NJ	3.20	Quartile 3
07030	Hoboken	Hudson County	NJ	3.20	Quartile 3
07621	Bergenfield	Bergen County	NJ	3.20	Quartile 3
10507	Bedford Hills	Westchester County	NY	3.20	Quartile 3
10523	Elmsford	Westchester County	NY	3.20	Quartile 3
10976	Sparkill	Rockland County	NY	3.20	Quartile 3
10543	Mamaroneck	Westchester County	NY	3.00	Quartile 3
10596	Verplanck	Westchester County	NY	3.00	Quartile 3
10603	White Plains	Westchester County	NY	3.00	Quartile 3
10950	Monroe	Orange County	NY	3.00	Quartile 3
10954	Nanuet	Rockland County	NY	3.00	Quartile 3
10962	Orangeburg	Rockland County	NY	3.00	Quartile 3
10996	West Point	Orange County	NY	3.00	Quartile 3
06906	Stamford	Fairfield County	CT	2.80	Quartile 3
10528	Harrison	Westchester County	NY	2.80	Quartile 3
10547	Mohegan Lake	Westchester County	NY	2.80	Quartile 3
10549	Mount Kisco	Westchester County	NY	2.80	Quartile 3
10595	Valhalla	Westchester County	NY	2.80	Quartile 3

ZIP	City	County	State	Overall Domain CNI/Risk Score	Quartile
10710	Yonkers	Westchester County	NY	2.80	Quartile 3
10928	Highland Falls	Orange County	NY	2.80	Quartile 3
10960	Nyack	Rockland County	NY	2.80	Quartile 3
11003	Elmont	Nassau County	NY	2.80	Quartile 3
12603	Poughkeepsie	Dutchess County	NY	2.80	Quartile 3
12604	Poughkeepsie	Dutchess County	NY	2.80	Quartile 3
07666	Teaneck	Bergen County	NJ	2.60	Quartile 3
10511	Buchanan	Westchester County	NY	2.60	Quartile 3
10535	Jefferson Valley	Westchester County	NY	2.60	Quartile 3
10707	Tuckahoe	Westchester County	NY	2.60	Quartile 3
10989	Valley Cottage	Rockland County	NY	2.60	Quartile 3
11024	Great Neck	Nassau County	NY	2.60	Quartile 3
11042	New Hyde Park	Nassau County	NY	2.60	Quartile 3
12524	Fishkill	Dutchess County	NY	2.60	Quartile 3
12590	Wappingers Falls	Dutchess County	NY	2.60	Quartile 3
06830	Greenwich	Fairfield County	CT	2.40	Quartile 2
07670	Tenafly	Bergen County	NJ	2.40	Quartile 2
10520	Croton On Hudson	Westchester County	NY	2.40	Quartile 2
10522	Dobbs Ferry	Westchester County	NY	2.40	Quartile 2
10537	Lake Peekskill	Putnam County	NY	2.40	Quartile 2
10548	Montrose	Westchester County	NY	2.40	Quartile 2
10588	Shrub Oak	Westchester County	NY	2.40	Quartile 2
10605	White Plains	Westchester County	NY	2.40	Quartile 2
10968	Piermont	Rockland County	NY	2.40	Quartile 2
11050	Port Washington	Nassau County	NY	2.40	Quartile 2
06807	Cos Cob	Fairfield County	CT	2.20	Quartile 2
10512	Carmel	Putnam County	NY	2.20	Quartile 2
10516	Cold Spring	Putnam County	NY	2.20	Quartile 2
10532	Hawthorne	Westchester County	NY	2.20	Quartile 2
10580	Rye	Westchester County	NY	2.20	Quartile 2

NYPH Non-NYC Communities of High Disparity Analysis
Lower Disparity Quartiles 1 & 2

ZIP	City	County	State	Overall Domain CNI/Risk Score	Quartile
10607	White Plains	Westchester County	NY	2.20	Quartile 2
10706	Hastings On Hudson	Westchester County	NY	2.20	Quartile 2
10708	Bronxville	Westchester County	NY	2.20	Quartile 2
10709	Eastchester	Westchester County	NY	2.20	Quartile 2
10803	Pelham	Westchester County	NY	2.20	Quartile 2
10964	Palisades	Rockland County	NY	2.20	Quartile 2
10965	Pearl River	Rockland County	NY	2.20	Quartile 2
11010	Franklin Square	Nassau County	NY	2.20	Quartile 2
11021	Great Neck	Nassau County	NY	2.20	Quartile 2
11040	New Hyde Park	Nassau County	NY	2.20	Quartile 2
10533	Irvington	Westchester County	NY	2.00	Quartile 2
10567	Cortlandt Manor	Westchester County	NY	2.00	Quartile 2
10913	Blauvelt	Rockland County	NY	2.00	Quartile 2
10920	Congers	Rockland County	NY	2.00	Quartile 2
11023	Great Neck	Nassau County	NY	2.00	Quartile 2
12518	Cornwall	Orange County	NY	2.00	Quartile 2
12520	Cornwall On Hudson	Orange County	NY	2.00	Quartile 2
06831	Greenwich	Fairfield County	CT	1.80	Quartile 1
06878	Riverside	Fairfield County	CT	1.80	Quartile 1
07632	Englewood Cliffs	Bergen County	NJ	1.80	Quartile 1
10502	Ardsley	Westchester County	NY	1.80	Quartile 1
10505	Baldwin Place	Westchester County	NY	1.80	Quartile 1
10514	Chappaqua	Westchester County	NY	1.80	Quartile 1
10530	Hartsdale	Westchester County	NY	1.80	Quartile 1
10538	Larchmont	Westchester County	NY	1.80	Quartile 1
10570	Pleasantville	Westchester County	NY	1.80	Quartile 1
10577	Purchase	Westchester County	NY	1.80	Quartile 1
10579	Putnam Valley	Putnam County	NY	1.80	Quartile 1
10594	Thornwood	Westchester County	NY	1.80	Quartile 1
10956	New City	Rockland County	NY	1.80	Quartile 1

ZIP	City	County	State	Overall Domain CNI/Risk Score	Quartile
10983	Tappan	Rockland County	NY	1.80	Quartile 1
11030	Manhasset	Nassau County	NY	1.80	Quartile 1
06820	Darien	Fairfield County	CT	1.60	Quartile 1
06870	Old Greenwich	Fairfield County	CT	1.60	Quartile 1
10510	Briarcliff Manor	Westchester County	NY	1.60	Quartile 1
10546	Millwood	Westchester County	NY	1.60	Quartile 1
10583	Scarsdale	Westchester County	NY	1.60	Quartile 1
10804	New Rochelle	Westchester County	NY	1.60	Quartile 1
10930	Highland Mills	Orange County	NY	1.60	Quartile 1
10994	West Nyack	Rockland County	NY	1.60	Quartile 1
11576	Roslyn	Nassau County	NY	1.60	Quartile 1
12533	Hopewell Junction	Dutchess County	NY	1.60	Quartile 1
06880	Westport	Fairfield County	CT	1.40	Quartile 1
10504	Armonk	Westchester County	NY	1.40	Quartile 1
10506	Bedford	Westchester County	NY	1.40	Quartile 1
10524	Garrison	Putnam County	NY	1.40	Quartile 1
10527	Granite Springs	Westchester County	NY	1.40	Quartile 1
10536	Katonah	Westchester County	NY	1.40	Quartile 1
10541	Mahopac	Putnam County	NY	1.40	Quartile 1
10589	Somers	Westchester County	NY	1.40	Quartile 1
10598	Yorktown Heights	Westchester County	NY	1.40	Quartile 1
11530	Garden City	Nassau County	NY	1.40	Quartile 1
06853	Norwalk	Fairfield County	CT	1.20	Quartile 1
10501	Amawalk	Westchester County	NY	0.00	Quartile 1
10509	Brewster	Putnam County	NY	0.00	Quartile 1
10517	Crompond	Westchester County	NY	0.00	Quartile 1
10545	Maryknoll	Westchester County	NY	0.00	Quartile 1
10901	Suffern	Rockland County	NY	0.00	Quartile 1
11005	Floral Park	Queens County	NY	0.00	Quartile 1
12512	Chelsea	Dutchess County	NY	0.00	Quartile 1
07311	Jersey City	Hudson County	NJ	0.00	Quartile 1

NYPH Non-NYC Communities of High Disparity Method

The Community Need Index (CNI) score is an average of five different barrier scores that measure various socio-economic indicators of each community using the 2015 source data. These barriers, and the statistics that comprise them, were carefully chosen and tested individually by both Dignity Health and Truven Health:

1. Income Barrier	Percentage of households below poverty line, with head of household age 65 or more
	Percentage of families with children under 18 below poverty line
	Percentage of single female-headed families with children under 18 below poverty line
2. Cultural Barrier	Percentage of population that is minority (including Hispanic ethnicity)
	Percentage of population over age 5 that speaks English poorly or not at all
3. Education Barrier	Percentage of population over 25 without a high school diploma
4. Insurance Barrier	Percentage of population in the labor force, aged 16 or more, without employment
	Percentage of population without health insurance
5. Housing Barrier	Percentage of households renting their home

Every populated ZIP code in the United States is assigned a barrier score of 1,2,3,4, or 5 depending upon the ZIP code national rank (quintile). A score of 1 represents the lowest rank nationally for the statistics listed, while a score of 5 indicates the highest rank nationally.

For more information on the CNI score refer to http://cni.chw-interactive.org.

Assessing Non-NYC Communities by County Overview

There were ZIP codes part of the defined community, but which originated out of state (New Jersey and Connecticut). These were patients drawn to NYP due to our high quality academic medical centers. However, this CHNA focused directly on New York State communities, so the next pages reflect information specific to Counties in New York State **Dutchess, Nassau, Orange, Rockland, and Westchester.**

The Community Need Index (CNI) score was obtainable at the ZIP code level, but indicators for the non-New York City communities were publicly available at the county level. The following indicators have been selected to assess community health needs, to identify health disparities, to utilize in prioritizing the implementation strategies, and to support health intervention planning.

- **Demographics** (population, gender, age cohort, race/ethnicity, English only spoken at home, unemployment, disability status, single parent households, etc.)
- **Socioeconomic status** (poverty, Area Median Income (AMI) eligibility for housing financial assistance)
- **Insurance status** (uninsured, Medicaid enrolled)
- **Social Determinants of Health** (housing, food insecurity, social and safety environment, transportation)
- **Indicators of health** (healthy eating and physical activity, women, infants, and children, well-being & mental health, chronic disease, hospitalizations, and Emergency Department utilization)

Assessing Non-NYC by County Summary

Demographics and Socioeconomic Status

- In the subset of NewYork-Presbyterian Hospital's non-New York City communities, publicly available data were collected for Dutchess, Nassau, Orange, Rockland, and Westchester Counties.
- There is a total population of 3,371,867 in these 5 counties (41% from Nassau and 29% from Westchester).
- **In aggregate, these counties are 51.1% female and slightly older**, 17.1% of the population is 65+, compared to NYC, 12.5%, and NYS 16.3%.
- These **counties have a much lower minority population** at 41.4% than the NYC, 67%, and NYS 45.6% averages.
- Each county reports a **smaller percent of families below poverty (ranging 4.0% for Nassau to 10.4% for Rockland)** than the NYS average, 11.3%.
- In comparison to NYS averages **there are higher percentages of the population that speak only English at home and completed High School; there are fewer unemployed, disabled, and single parents.**
- Compared to the NYC average, there are **more people in these counties living in an Area Median Income (AMI) income band of $200,000 (except Orange),** and fewer **people living in an income band under $15,000.**

Assessing Non-NYC by County Summary

Social Determinants of Health

- **In Rockland, there is higher than average percentage of households with severe housing problems** 23.4%, compared to NYS 20.4% **and rent burden of 30% or more**, 45.0%, compared to NYS 39.2%. There is **higher than average housing insecurity in Orange,** 39.9%, NYS 36.4%.
- All counties report a **lower than NYS average of food insecurity**.
- The Social & Environmental Safety indicators assessed **(air quality, hospitalizations for assaults and violent crimes) are more favorable than the state averages**.
- **Commute times vary** by community ranging from 34 minutes in Rockland**.** In comparison, NYC is 27 minutes and NYS 36 minutes.

Health Status

- There are **higher than average self-reporting of percentage of the population consuming sweetened beverages, 26.5%, NYS 24.7% and a higher percentage of obesity in adult population in Orange, 69.6%,** NYS, 60.50%.
- Among all counties, there is a **below average percentage of the population self-reporting consumption of sufficient number of daily fruits and vegetables**, 28.7%, compared to NYS 31.5%, and an **average amount of percentage of the population self-reporting physical activity across all counties**, 73.8%, NYS 74.0%.
- Indicators for **maternal mortality rate** per 100,000 live births, 12.6, compared to NYS 18.7, percent of live births receiving **late prenatal care, 3.6%, NYS, 5.6% and rate of teen births per 1,000 women ages 15-19), 10.3, NYS 17.8% are better than average**.
- However, there is **higher rate of infant deaths (under one year old per 1,000 live births), in Orange 5.4, and Dutchess**, 6.0 than NYS 4.8, **and higher percentage of preterm births among all live births in Orange, 1.8% and Westchester** 1.8% than NYS 1.7%.

Assessing Non-NYC by County Summary

Health Status, continued

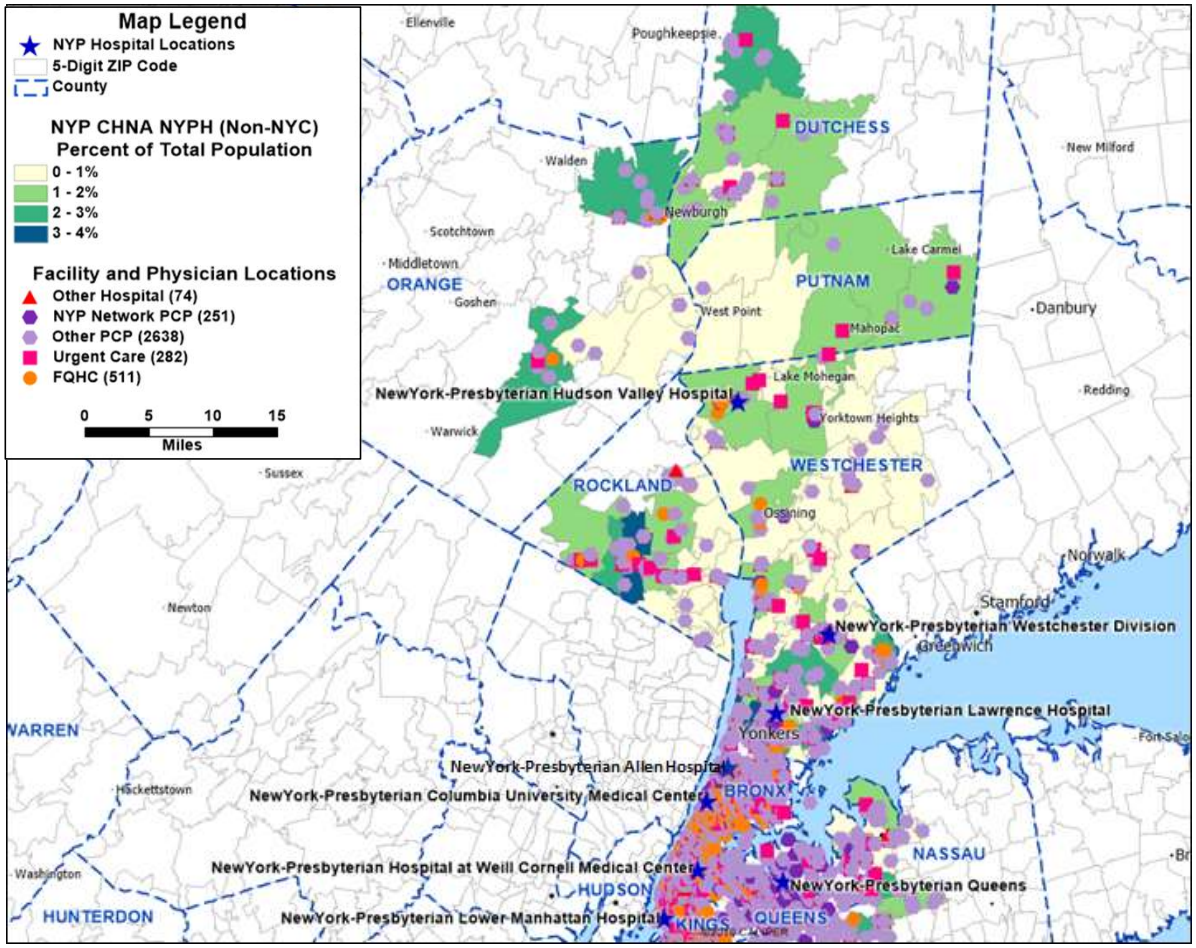
- Overall, Orange has a **higher than average percentage of premature deaths (aged less than 75 years), 42.7,** in comparison to the NYS average, 40.1.
- **Nassau, 14.6%, and Westchester, 12.4%, percentage of population self-reporting not getting needed medical care** in higher than NYS averages, 11.5%.
- **Dutchess,13.7%, and Orange, 11.8%, have a higher percentage of the population self-reporting poor mental health** than NYS average 10.7.
- **Dutchess has higher than average percentage of population self-reporting smoking**, 16.4%, NYS 14.5% **and Orange higher than average hypertension**, 30.4%, NYS 28.9%.
- Overall, **new diagnoses of HIV per 100,000 population are lower, 9.5,** than NYS 17.9.
- There is a **higher than average cancer incidence rate**
  - **for Nassau, all sites** 509.4, NYS 482.9.
  - **for Orange, colorectal** 41.3, NYS 38.9 **and lung** 65.5, NYS 58.9.
  - **for Rockland,** 136.2, and **Westchester,** 132.1, **prostate,** NYS 125.0.
  - **for all counties, breast** 142.4, NYS 130.7.

Assessing Non-NYC by County Summary

Health Care Service Utilization

- There is a **slightly lower rate of Total Hospitalizations age-adjusted per 10,000 population in the community**, 1,077, NYS 1,128.
- **Hospitalizations for specific conditions are higher than average for:**
  - **Drugs** in Dutchess, 29, and Orange, 33, compared to NYS, 23 .
  - **Falls** in Nassau, 37, compared to NYS, 34.
  - **Stroke** in Orange, 52, compared to NYS, 46.
- There are **fewer than average all ED visits per 100,000 population,** 32,004, compared to NYS, 40,582, and NYC 46,079.

Total Population and Key Health Care Providers in the Non-NYC Community, by ZIP



- Market saturation of health care providers reflects a composition of Hospitals, NYP network Primary Care providers, non-NYP Primary Care providers, Urgent Care facilities, and Federally Qualified Health Centers (FQHC's) in order to reflect pockets of need to address community access issues.
- Analysis of such saturation or lack of saturation in appropriate providers allows for strategic placement of services to address community needs.

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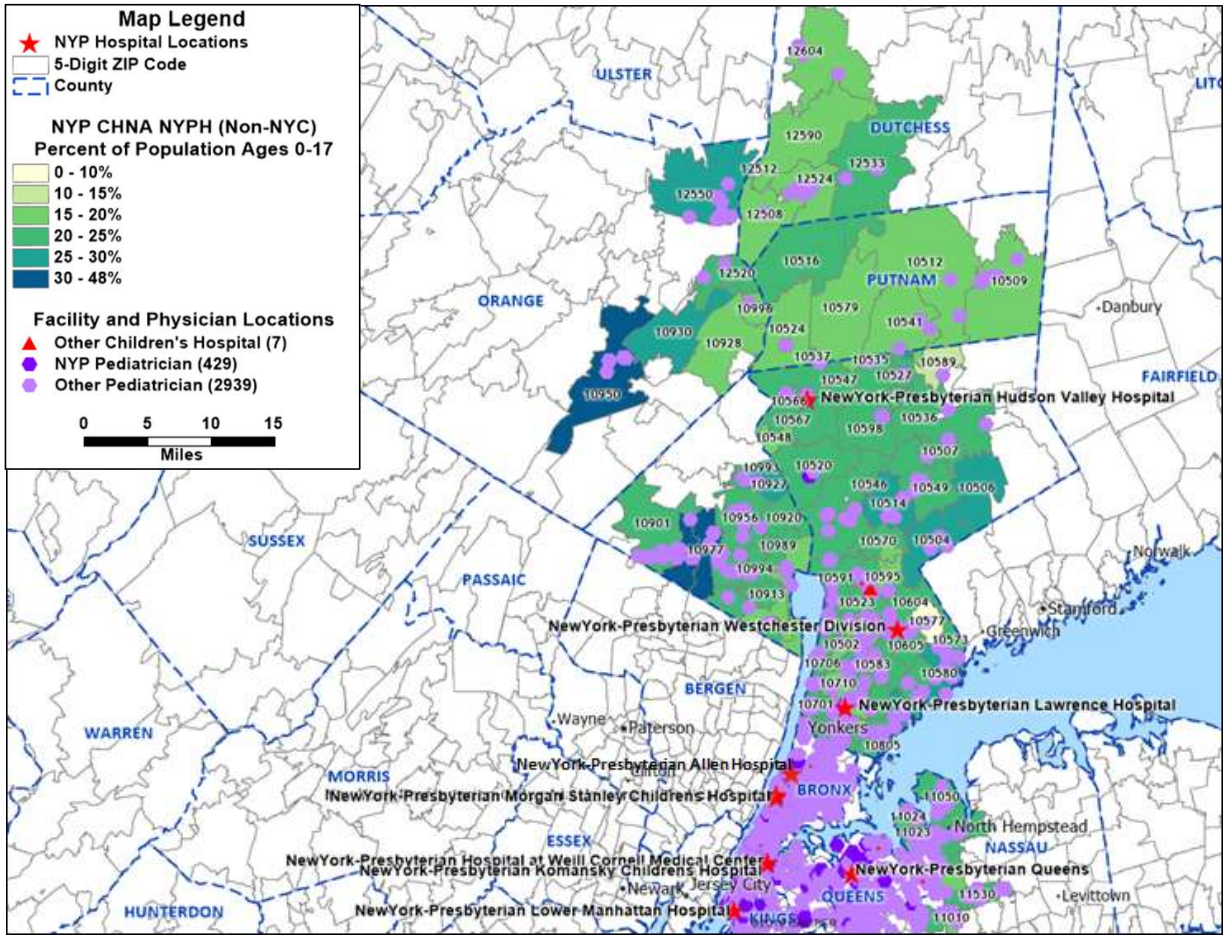
Pediatric Population and Key Health Care Providers in the Non-NYC Community, by ZIP



- Community assets are outlined to reflect potential pockets of community need specific pediatric populations.
- NYP and non-NYP pediatric practices are identified to allow for identification of gaps as well as potential partnership arenas to impact the community at large.

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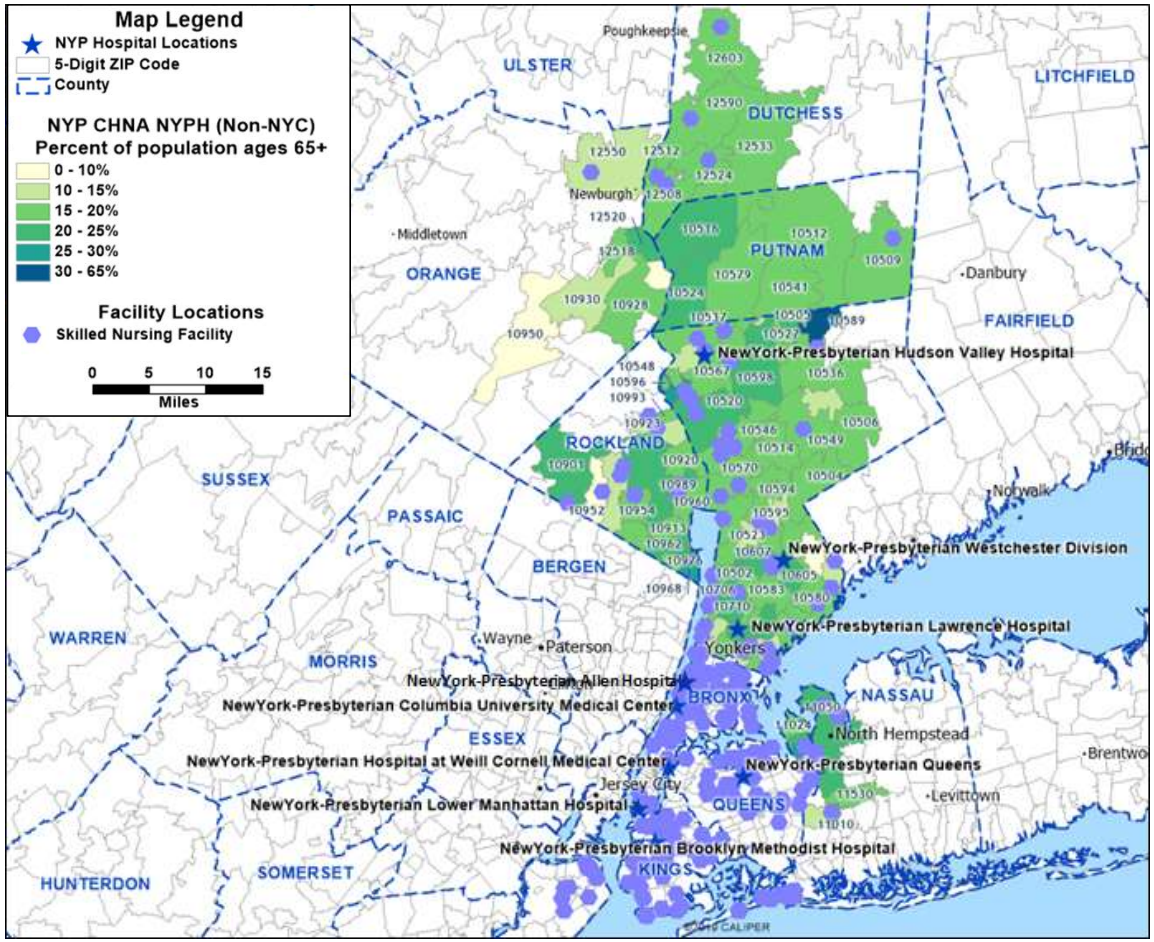
Senior Population and SNFs in Non-NYC Community, by ZIP



- Skilled Nursing Facilities are identified on the map to reflect potential access issues for concentrated senior populations.
- Communities have dispersed providers and SNF's targeting senior populations suggesting areas for focused strategies to impact long-term care and post-acute activity.

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Population Profile of Non-NYC Community, by County

County	Population (Total #)	Percent of female population	Percent of male population	Percent of population ages 0-17	Percent of population ages 18-24	Percent of population ages 25-44	Percent of population ages 45-64	Percent of population ages 65+
Dutchess	295,487	50.2%	49.8%	18.8%	11.1%	23.0%	29.4%	17.7%
Nassau	1,374,787	51.4%	48.6%	21.2%	9.2%	23.3%	28.2%	18.2%
Orange	384,955	50.0%	50.0%	25.0%	10.9%	23.3%	26.6%	14.2%
Rockland	331,929	51.0%	49.1%	27.6%	9.9%	22.5%	24.1%	15.9%
Westchester	984,709	51.6%	48.5%	21.9%	9.4%	23.6%	28.0%	17.1%
NYPH Non-NYC Communities	3,371,867	51.1%	48.9%	22.2%	9.7%	23.3%	27.7%	17.1%
New York City	8,354,889	52.4%	47.6%	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	19,903,676	51.4%	48.6%	21.0%	9.3%	27.1%	26.3%	16.3%

Source: Claritas

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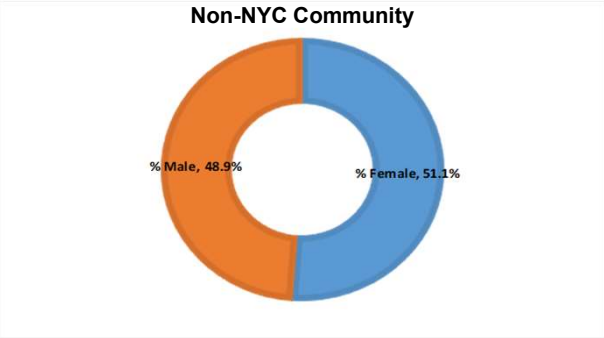
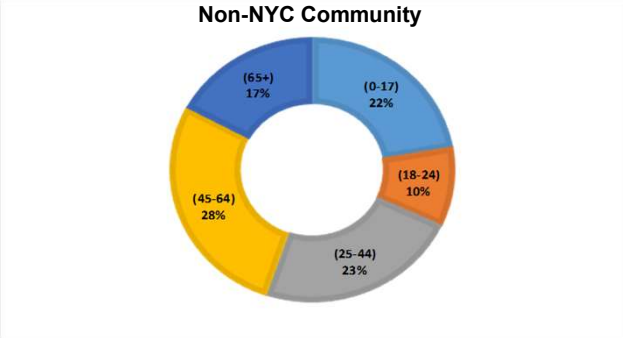


	% Female	% Male
NYPH Non-NYC Communities	51.1%	48.9%
New York City	52.4%	47.6%
New York State	51.4%	48.6%

Source: Claritas



	(0-17)	(18-24)	(25-44)	(45-64)	(65+)
NYPH Non-NYC Communities	22.2%	9.7%	23.3%	27.7%	17.1%
New York City	21.4%	10.1%	31.4%	24.6%	12.5%
New York State	21.0%	9.3%	27.1%	26.3%	16.3%

Source: Claritas

- Among the non-NYC counties, there is a total population of 3,371,867.
- 51.1% of the community is female and 48.9% is male, about the same as the NYS average.
- The population is slightly older, 17.1% of the population is 65+, compared to NYS, 16.3% or NYC, 12.5%.

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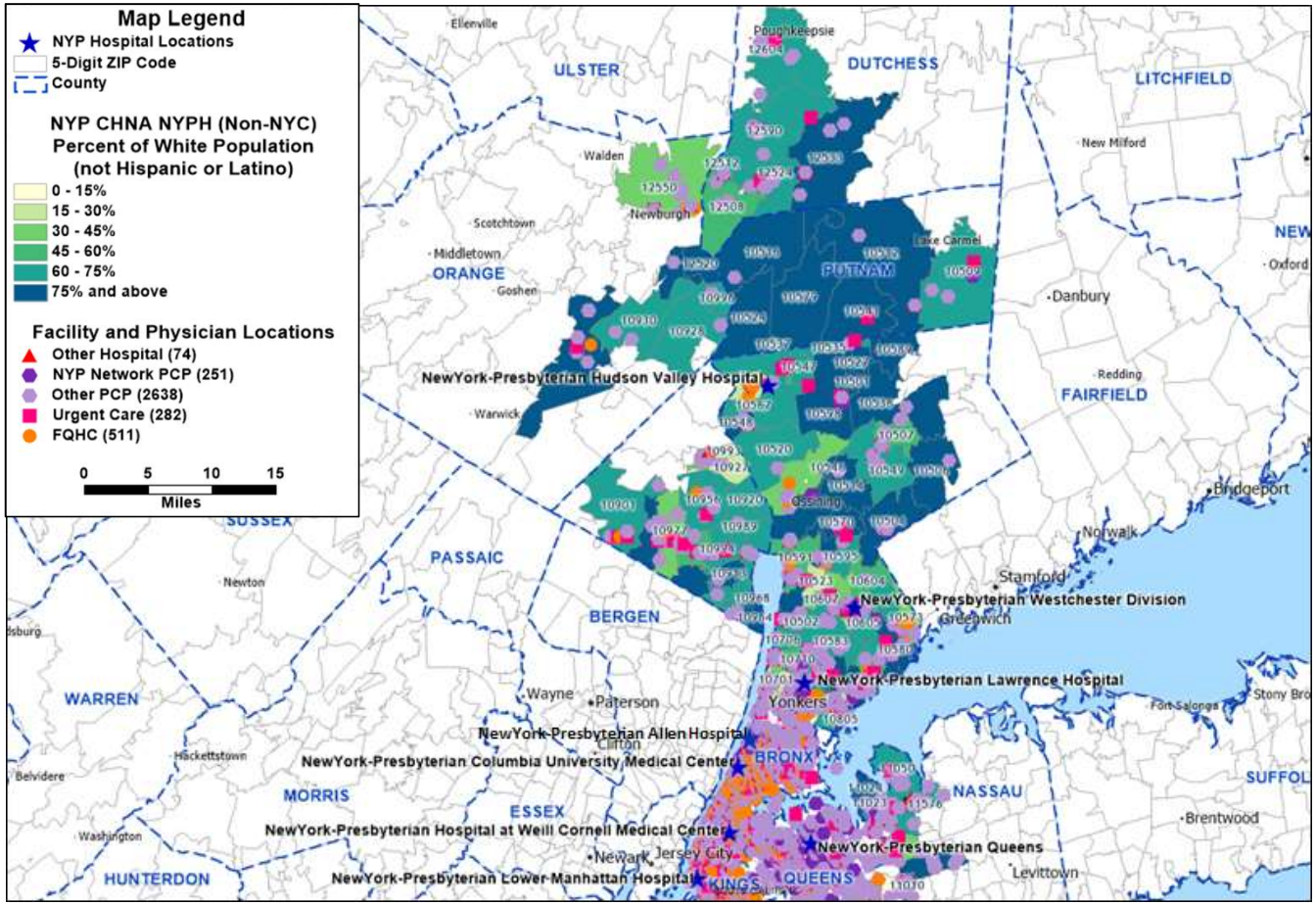
Population by Race / Ethnicity – White and Key Health Care Providers in Non-NYC Community



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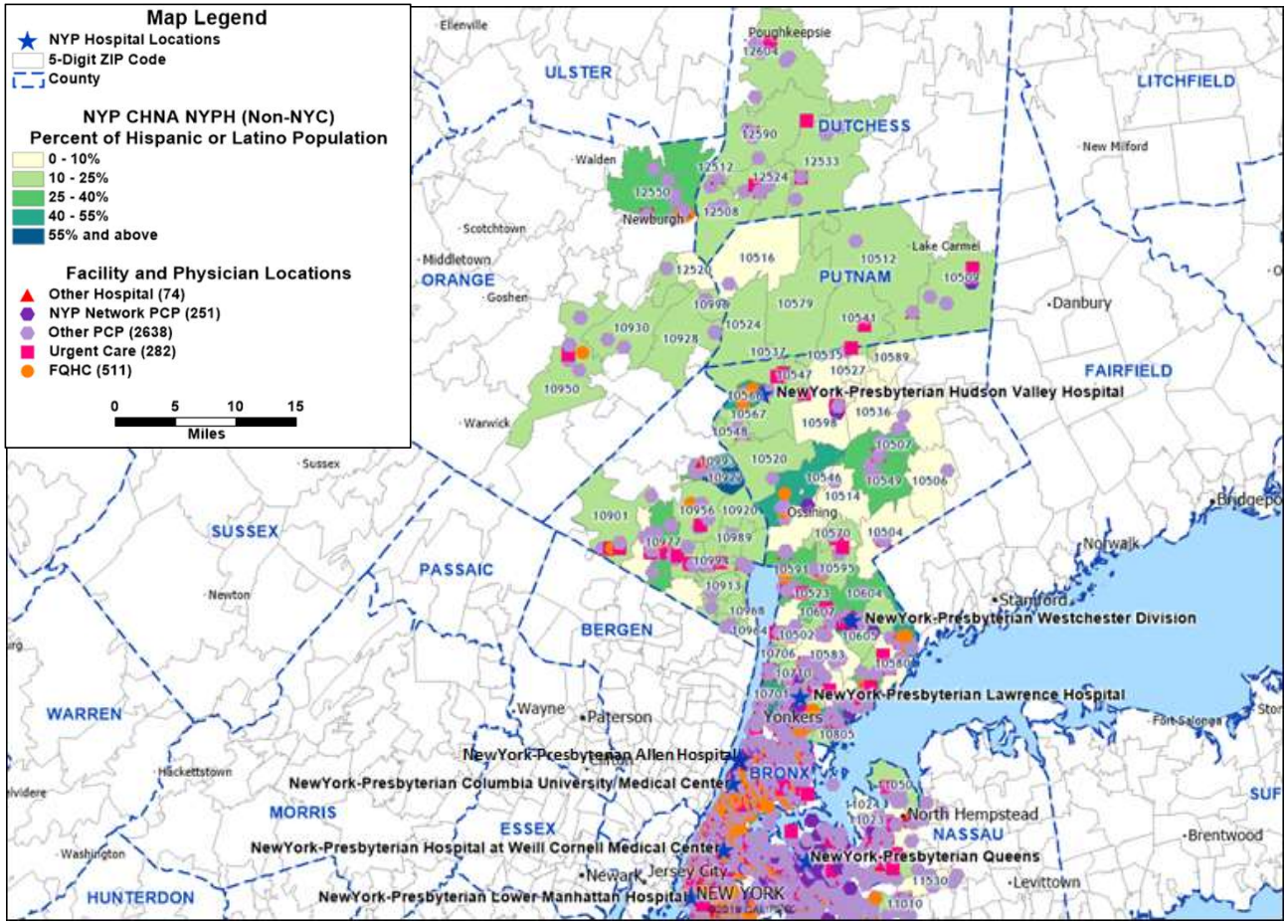
Population by Race / Ethnicity – Hispanic/Latino and Key Health Care Providers in Non-NYC Community



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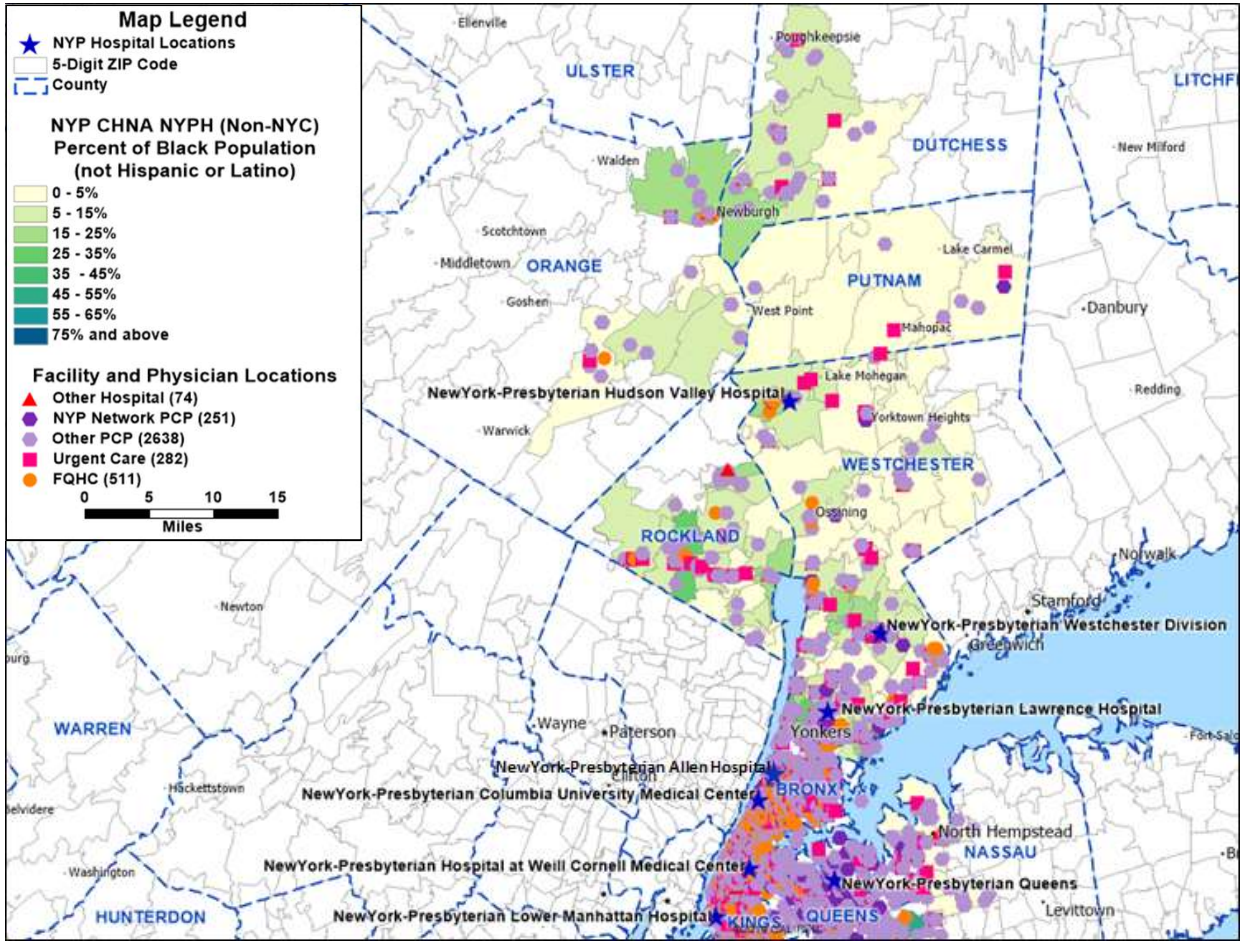
Population by Race / Ethnicity – Black and Key Health Care Providers in Non-NYC Community



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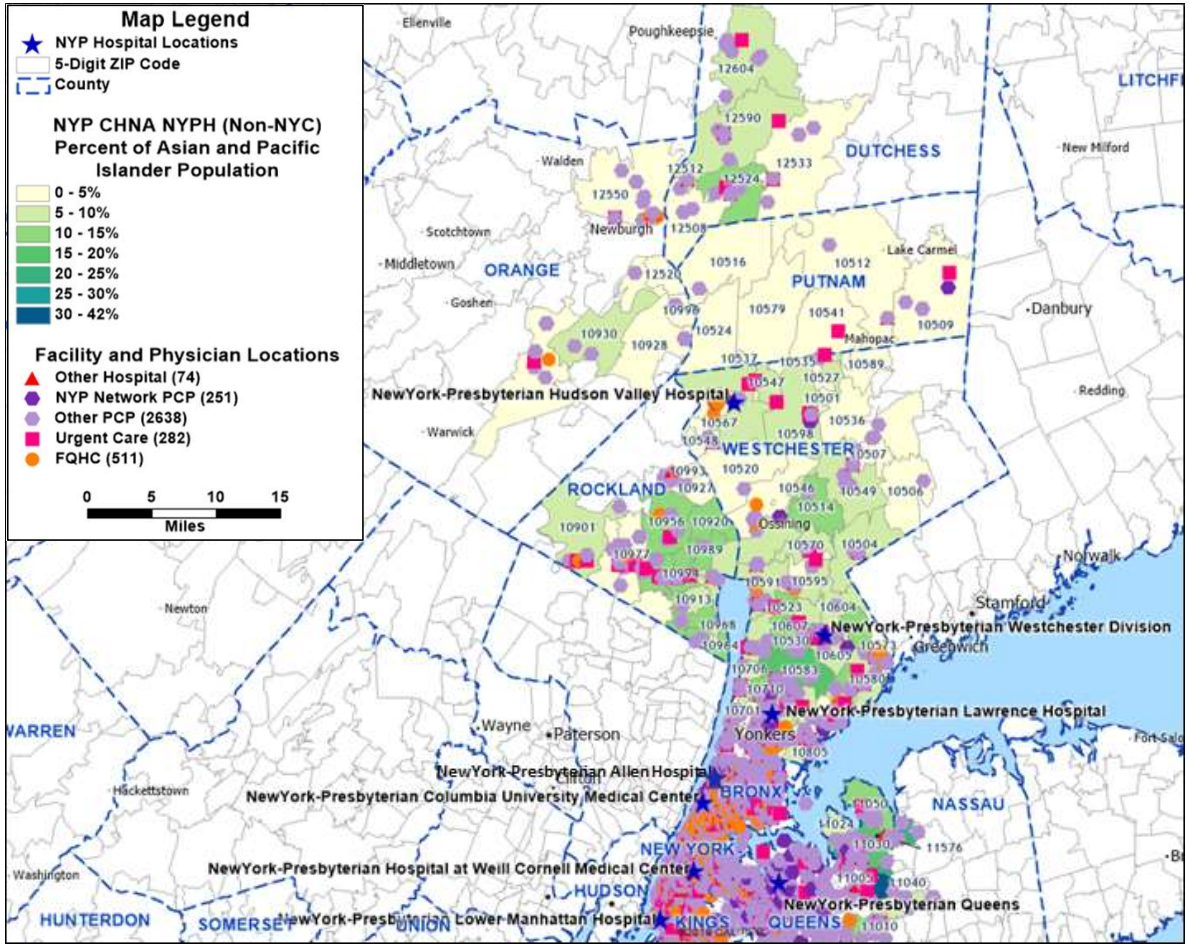
Population by Race / Ethnicity – Asian/Pacific Islander and Key Health Care Providers in Non-NYC Community



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Race / Ethnicity Profile of Non-NYC Community, by County

County	Percent of Hispanic or Latino population (any race)	Percent of White population (not Hispanic or Latino)	Percent of Black population (not Hispanic or Latino)	Percent of Asian and Pacific Islander population	Percent of all other race population
Dutchess	12.7%	70.4%	10.4%	3.9%	2.6%
Nassau	17.7%	58.6%	11.6%	10.0%	2.2%
Orange	21.0%	63.4%	10.2%	2.7%	2.7%
Rockland	18.4%	61.8%	11.5%	6.3%	1.9%
Westchester	25.5%	52.1%	13.6%	6.4%	2.4%
NYPH Non-NYC Communities	20.0%	58.6%	11.9%	7.2%	2.3%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: Claritas

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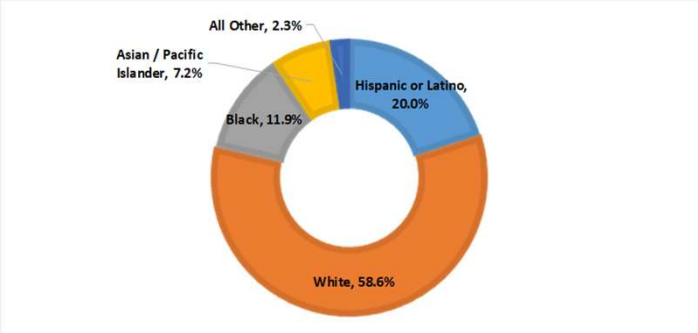
Non-NYC Community



	Hispanic or Latino	White	Black	Asian / Pacific Islander	All Other
NYPH Non-NYC Communities	20.0%	58.6%	11.9%	7.2%	2.3%
New York City	28.8%	32.7%	22.6%	13.2%	2.7%
New York State	19.6%	54.4%	14.3%	8.9%	2.8%

Source: Claritas

- Race/ethnicity composition can also help inform an understanding of the community and health service needs as well as potential cultural norms to consider in outreach and care delivery.
- Overall, the five county community is primarily White, 58.6%, Hispanic/Latino, 20.0%, and Black, 11.9%.
- The community has a higher percentage of White residents than the state and approximately the same percentage of Hispanic/Latino, but a slightly smaller percentage of Black residents.

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Poverty, Health Insurance Profile of Non-NYC Community, by County

County	2019 Families Below Poverty	2019 Families Below Poverty with children	Percentage of adults aged 18-64 years with health insurance	Percentage of children aged <19 years with health	Percent of population enrolled in Medicaid
Dutchess	5.7%	4.0%	90.2%	96.6%	22.6%
Nassau	4.0%	2.8%	91.2%	97.0%	23.9%
Orange	9.0%	6.7%	89.7%	96.5%	31.8%
Rockland	10.4%	8.8%	88.7%	95.9%	37.8%
Westchester	6.8%	4.6%	87.1%	96.6%	26.6%
NYPH Non-NYC Communities	6.2%	4.4%	89.5%	96.7%	26.8%
New York City	N/A	N/A	N/A	N/A	N/A
New York State	11.3%	8.2%	87.6%	96.6%	38.1%

Source: Claritas

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- Economic factors and insurance are the larger predictors of health outcomes, and also strongly influence health behavior.
- Overall, there are fewer families living in poverty, 6.2%, than the NYS average, 11.3%.
- There is about the same percentages of adults, 89.5%, and children, 96.7%, with health insurance as NYS adult, 87.6% and NYS children, 96.6% averages.
- There are fewer enrolled in Medicaid 26.8% than the NYS average 38.1%.

Other Risk Indicators for Non-NYC Community, by County

County	Speak Only English at Home	Percent Adults Age 25+ Not Completed High School	% of poulation ages 16+ unemployed	% of population reported disabled	% of households, single mother with children	% of households, single father with children
Dutchess	85.1%	10.0%	37.4%	4.1%	8.7%	3.2%
Nassau	71.7%	8.7%	35.3%	2.7%	6.1%	1.8%
Orange	75.5%	10.5%	35.9%	4.4%	9.3%	3.5%
Rockland	60.9%	13.8%	36.1%	3.1%	6.8%	1.9%
Westchester	67.0%	12.8%	35.1%	3.8%	9.4%	2.4%
NYPH Non-NYC Communities	70.9%	10.7%	35.6%	3.4%	7.7%	2.3%
New York City	N/A	19.9%	10.3%	10.3%	9.6%	2.3%
New York State	69.3%	13.8%	36.9%	4.9%	12.0%	3.2%

Source: Claritas; County-Level Behavioral Risk Factor Surveillance System

Illustrates neighborhood statistic is larger than the NYS statistic

Illustrates neighborhood statistic is equal to the NYS statistic

Ilustrates neighborhood statistic is smaller than the NYS statistic

- While none of these are conclusive determinants alone, these are other predictors of health outcome to consider – English-only speaking, those not graduating from high school, the unemployed, the disabled, and single parents.
- There is a slightly higher percentage of residents speaking English only at home, 70.9%, NYS, 69.3%.
- Overall, among the other indicators, not completed High School, unemployed, disabled, and single parents, there are lower than NYS averages.

Percent of People Living within Select Income Bands (% AMI) Non-NYC Community, by County

County	% of People Living within Income Band $200,000 or more	% of People Living within Income Band $100,000 to $199,999	% of People Living within Income Band $75,000 to $99,999	% of People Living within Income Band $50,000 to $74,999	% of People Living within Income Band $35,000 to $49,999	% of People Living within Income Band $25,000 to $34,999	% of People Living within Income Band $15,000 to $24,999	% of People Living within Income Band Under $15,000
Dutchess	11.2%	29.1%	12.6%	15.6%	10.7%	7.1%	6.5%	7.2%
Nassau	22.9%	33.0%	11.1%	11.2%	7.2%	5.3%	4.6%	4.7%
Orange	9.6%	29.2%	12.6%	14.1%	11.5%	6.8%	7.6%	8.7%
Rockland	18.3%	29.0%	10.6%	13.8%	9.3%	6.1%	6.7%	6.3%
Westchester	21.7%	26.5%	10.0%	12.5%	8.6%	6.2%	6.4%	8.1%
NYPH Non-NYC Communities	19.5%	29.9%	11.0%	12.6%	8.6%	6.0%	5.8%	6.5%
New York City	10.3%	21.2%	10.9%	14.7%	10.4%	7.8%	9.2%	15.4%
New York State	11.0%	23.5%	11.8%	14.9%	11.0%	7.9%	8.5%	11.4%

Source: Claritas

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- The Area Median Income (AMI) is the midpoint of a region's income distribution – half of families in a region earn more than the median and half earn less than the median.
- For housing policy, U.S. Department of Housing and Urban Development (HUD) sets income thresholds relative to the AMI to identify persons eligible for housing assistance.
- Compared to the NYS average, there are more people living in income bands of $200,000 or more 19.5%, NYS 11.0%, and fewer living in income bands under $15,000, 6.5%, compared to NYS 11.4%.

Housing and Food Insecurity for Non-NYC Community, by County

County	Severe Housing Problems	Housing Insecurity	Rent burden, 30% or more
Dutchess	18.0%	37.2%	38.6%
Nassau	19.4%	36.1%	40.2%
Orange	19.6%	39.9%	40.4%
Rockland	23.4%	37.8%	45.0%
Westchester	21.1%	32.7%	41.1%
NYPH Non-NYC Communities	20.2%	35.8%	40.8%
New York City	N/A	N/A	54.2%
New York State	20.4%	36.4%	39.2%

Source: County-Level Behavioral Risk Factor Surveillance System; RWJ County Health Rankings; Cares Engagement; State Comptroller

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

County	Food Insecurity
Dutchess	8.8
Nassau	5.6
Orange	8.4
Rockland	9.2
Westchester	7.7
NYPH Non-NYC Communities	7.2
New York City	Not Available
New York State	11.9

Source: RWJ County Health Rankings

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Ilustrates neighborhood statistic is smaller than the NYS statistic

- Housing and food insecurity can impact health significantly.
- In Rockland County, 23.4%, there is a higher percentage of severer housing problems than NYS, 20.4% and also their rent burden of 30% or more, 45.0%, is worse than the NYS average, 39.2%.
- There is more housing insecurity in Orange County, 39.9% than NYS, 36.4%.
- Food insecurity is better than the percentages in NYS, 11.9%.

NewYork-Presbyterian

Social & Environmental Safety and Transportation for Non-NYC Community, by County

County	Air Quality (Annual Avg. MCG per Cubic Meter of Fine Particle Matter)	Assault Hospitalization per 100,000 Population, Age Adjusted Rate	Violent Crime
Dutchess	1.4	3.0	203.7
Nassau	2.3	2.8	143.7
Orange	1.5	2.6	244.9
Rockland	1.9	1.5	121.3
Westchester	2.4	2.6	220.6
NYPH Non-NYC Communities	2.1	2.6	180.8
New York City	N/A	6.2	N/A
New York State	2.5	3.8	381.6

Source: Cares Engagement; New York State Community Health Indicator Reports (CHIRS)

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Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

County	Workers who commute by any form of transportation over 60 minutes each way.
Dutchess	35.0
Nassau	39.0
Orange	35.0
Rockland	34.0
Westchester	38.0
NYPH Non-NYC Communities	n/a
New York City	27.0
New York State	36.0

Source: Claritas

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Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percen

- The physical environment (pollution, access to safe streets & parks, etc.) also plays a key role in health and well-being. Long term health factors have also evolved to include social and familial support resources.
- Overall, air quality, 2.1, is favorable to the NYS average, 2.5 and significantly better than NYC, 7.5.
- Assault hospitalizations and violent crimes are better than NYS averages.
- Commute times to work vary among these counties. Nassau, 39.0 minutes and Westchester, 38.0 report the longer commutes.

Health Status Indicators: Healthy Eating & Physical Activity for Non-NYC Community, by County

County	Percentage of adults who ate in 24 hrs, 1+ serving fruit/veg	Percentage of adults who drink >1 sweetened beverages daily	Percentage of adults who report being obese	Child obesity, Students 95th percentile or higher	Percentage of adults w/ physical activity in last 30 days
Dutchess	24.2%	21.9%	27.0%	18.0%	74.7%
Nassau	31.7%	19.8%	22.9%	15.5%	72.1%
Orange	24.5%	25.5%	29.7%	19.0%	70.7%
Rockland	25.9%	23.1%	20.7%	15.0%	73.5%
Westchester	28.6%	18.5%	17.7%	13.7%	77.1%
NYPH Non-NYC Communities	28.7%	20.6%	22.3%	15.5%	73.8%
New York City	35.1%	23.0%	22.9%	Not Available	73.0%
New York State	31.5%	24.2%	25.5%	Not Available	74.0%

Source: County-Level Behavioral Risk Factor Surveillance System; New York State Community Health Indicator Reports (CHIRS)

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Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- Behaviors related to healthy eating and physical activity, though challenging to change, can directly contribute to improved health outcomes and fewer chronic illnesses.
- There is opportunity to increase the number of fruits and vegetables consumed by residents among all counties.
- The consumption of sweetened beverages is higher than the NYS average, 24.2%, in Orange County, 25.5%.
- There are more adults self-reporting obesity in Dutchess, 27.0% and Orange, 29.7%, than the NYS average, 25.5%.
- Child obesity is highest in Orange, 19.0%, NYS 17.3%.
- There is about the same amount of physical activity, 73.8%, compared to NYS, 74.0%.

Health Status Indicators: Women, Infants, & Children for Non-NYC Community, by County

County	Maternal mortality rate per 100,000 live births	Rate of infant deaths (under one year old) per 1,000 live births	Percent of live births receiving late prenatal care	Percent of preterm births among all live births	Rate of Teen Births (per 1,000 women ages 15 to 19)
Dutchess	12.5	6.0	3.0%	1.8%	9.2
Nassau	21.4	3.5	2.9%	1.6%	7.9
Orange	0.0	5.4	4.0%	1.6%	16.3
Rockland	0.0	3.5	4.7%	1.3%	12.3
Westchester	9.5	4.6	4.1%	1.8%	10.8
NYPH Non-NYC Communities	12.6	4.3	3.6%	1.6%	10.3
New York City	19.3	4.4	7.0%	9.1%	23.7
New York State	18.7	4.8	5.6%	1.7%	17.8

Source: New York State Community Health Indicator Reports (CHIRS)

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- The health status of infancy can impact long term health and the lack of early prenatal care can result in very costly neonatal and/or pediatric care needs.
- Overall, these counties are more favorable or about the same than the NYS averages for these indicators.
- However, Nassau, 21.4, has a higher maternal mortality rate than NYS, 18.7.
- Both Dutchess, 6.0, and Orange, 5.4, have a higher infant death rate than NYS, 4.8.
- Dutchess and Westchester, 1.8%, have a higher percent of pre-term births than NYS, 1.7%.

Health Status Indicators: Well-Being & Mental Health for Non-NYC Community, by County

County	Percentage premature deaths (aged less than 75 years)	Percentage of adults self-report health as good-excellent	Percentage of adults not getting needed medical care	Percentage of adults self-reporting poor mental health	Percentage of adults self-reporting binge drinking
Dutchess	40.5	4.9%	8.6%	13.7%	17.5%
Nassau	32.5	4.0%	14.6%	10.8%	18.3%
Orange	42.7	5.4%	11.1%	11.8%	15.7%
Rockland	36.2	3.4%	11.8%	8.0%	11.0%
Westchester	33.4	2.6%	12.4%	9.1%	20.7%
NYPH Non-NYC Communities	35.0	3.8%	12.8%	10.4%	17.9%
New York City	N/A	N/A	10.0%	10.3%	17.3%
New York State	40.1	4.0%	11.5%	10.7%	18.3%

Source: County-Level Behavioral Risk Factor Surveillance System; New York State Community Health Indicator Reports (CHIRS)

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- Key indicators for the health of a community include mortality rates and self reported physical and mental health status as well as general access to needed medical care.
- There is variance among these counties for these measures.
- Orange County has worse than NYS averages for premature deaths 42.7.
- There is worse, 12.8%, than NYS average, 11.5%, for not getting needed medical care.
- Rockland and Westchester are worse for self-reported good-excellent health.
- Dutchess 13.7% and Orange 11.8% self-report higher poor mental health than NYS 10.7%.
- Westchester also has higher than average self-reported binge drinking, 20.7%, NYS 18.3%.

Health Status Indicators: Chronic Disease for Non-NYC Community, by County

County	Percentage of adults with diabetes	Percentage of adults with hypertension	Percentage of adults reporting current smoking	Rate of new HIV diagnoses per 100,000 people
Dutchess	9.5%	27.5%	16.4%	8.1
Nassau	6.9%	28.2%	8.1%	9.4
Orange	8.9%	30.4%	13.2%	4.5
Rockland	6.0%	28.1%	6.6%	9.2
Westchester	7.6%	24.2%	9.4%	12.0
NYPH Non-NYC Communities	7.5%	27.2%	9.6%	9.5
New York City	11.0%	28.0%	14.0%	24.0
New York State	9.5%	28.9%	14.5%	17.9

Source: County-Level Behavioral Risk Factor Surveillance System; New York State Community Health Indicator Reports (CHIRS)

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

County	Percentage of adults with arthritis	Percentage of adults with CV (heart attack, coronary heart disease, or stroke)	Percentage of adults with COPD	Percentage of adults taking medication for high blood pressure
Dutchess	22.0%	6.1%	4.1%	67.0
Nassau	19.0%	6.4%	2.7%	42.8
Orange	21.1%	6.4%	4.4%	55.0
Rockland	20.5%	6.2%	3.1%	53.8
Westchester	19.7%	6.1%	3.8%	53.3
NYPH Non-NYC Communities	19.9%	6.3%	3.4%	50.5
New York City	18.5%	6.6%	3.7%	54.7
New York State	21.8%	7.0%	4.9%	55.6

Source: County-Level Behavioral Risk Factor Surveillance System

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- Behaviors like smoking can lead to chronic diseases, which are both costly and resource intensive to manage; prevention is a better alternative.
- Overall, these counties report better than or the same as the NYS averages for these indicators.
- Dutchess County has higher number of residents reporting smoking, 16.4%, NYS 14.5%, and a higher number of adults taking medication for high blood pressure, 67.0, 55.6.
- Orange County has a higher number of adults with hypertension, 30.4%, NYS 28.9%.
- Although there are adults living with HIV and Hepatitis C, the community rate of new diagnoses is better than average for HIV.

Health Status Indicators: Cancer Incidence for Non-NYC Community, by County

County	Cancer Incidence - All Sites	Cancer Incidence - Breast	Cancer Incidence - Colon and Rectum	Cancer Incidence - Lung	Cancer Incidence - Prostate
Dutchess	475.3	138.2	34.5	60.7	112.7
Nassau	509.4	145.0	38.7	54.1	134.9
Orange	501.5	138.4	41.3	65.5	116.5
Rockland	481.2	142.6	36.1	48.8	136.2
Westchester	478.6	141.4	35.8	48.4	132.1
NYPH Non-NYC Communities	493.7	142.4	37.5	53.8	130.2
New York City	477.7	131.3	39.8	60.2	131.7
New York State	482.9	130.7	38.9	58.9	125.0

Source: State Cancer Profiles

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Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- The diagnosis of cancer has a tremendous impact on the physical, mental and economic well-being of an individual and their families.
- All counties report higher than NYS breast cancer average 130.7.
- Nassau County, 509.4, has a higher than NYS average cancer incidence among all sites of cancer, compared to NYS 482.9.
- Orange County has higher than NYS averages for colorectal 41.3, NYS 38.9, and lung cancers 65.5, NYS 58.9.
- Three counties – Nassau, Rockland and Westchester each have higher than NYS' prostate cancer average 125.0.

Health Care Service Utilization: Hospitalizations for Non-NYC Community, by County

	Hospitalizations			
County	Age-adjusted total hospitalization rate per 10,000	Age-adjusted asthma hospitalization rate per 10,000	Age-adjusted diabetes hospitalization rate per 10,000	Hypertension hospitalization rate per 10,000 - 18+ years
Dutchess	984.2	13.4	22.0	3.0
Nassau	1,110.5	13.3	26.2	7.5
Orange	1,157.7	12.4	28.6	6.8
Rockland	1,063.3	10.8	21.6	3.6
Westchester	1,031.2	13.5	25.4	5.3
NYPH Non-NYC Communities	1,077.0	13.0	25.4	6.0
New York City	N/A	N/A	N/A	N/A
New York State	1,127.6	17.6	34.2	68.0

Source: New York State Community Health Indicator Reports (CHIRS)

Indicates neighborhood statistic is more favorable than the NYS statistic by more than five percent

Indicates neighborhood statistic is within five percent of the NYS statistic

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	Other Hospitalizations			
County	Asthma hospitalization rate per 10,000 - Aged 0-17 years	Drug-related hospitalization rate per 10,000	Age-adjusted falls hospitalization rate per 10,000	Cerebrovascular disease (stroke) hospitalization rate per 10,000
Dutchess	45.2	29.1	30.4	44.0
Nassau	42.8	17.2	37.4	42.6
Orange	21.2	32.5	34.9	51.6
Rockland	16.4	21.2	33.4	46.4
Westchester	37.4	21.5	32.6	40.2
NYPH Non-NYC Communities	36.4	21.6	34.7	43.4
New York City	N/A	N/A	N/A	N/A
New York State	54.0	22.6	34.0	45.6

Source: New York State Community Health Indicator Reports (CHIRS)

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Indicates neighborhood statistic is within five percent of the NYS statistic

Indicates neighborhood statistic is less favorable than the NYS statistic by more than five percent

- Hospitalization represents expensive and sometimes complex need for inpatient care.
- These counties compare favorably to the NYS averages for all hospitalizations, as well as asthma, diabetes and hypertension. However, Nassau County, 8, has a higher hospitalization rate for hypertension than NYS, 7.
- All counties compare favorably to the NYS averages for child asthma hospitalizations, but vary among drugs, falls, and stroke hospitalizations.

Health Care Service Utilization: ER for Non-NYC Community, by County

County	Emergency Dept: All Visits per 100,000 Population, Crude Rate
Dutchess	33,682
Nassau	29,403
Orange	38,268
Rockland	28,292
Westchester	33,933
NYPH Non-NYC Communities	32,004
New York City	46,079
New York State	40,582

Source: New York State Community Health Indicator Reports (CHIRS), note: converted CHIRS rate per 10k to per 100k

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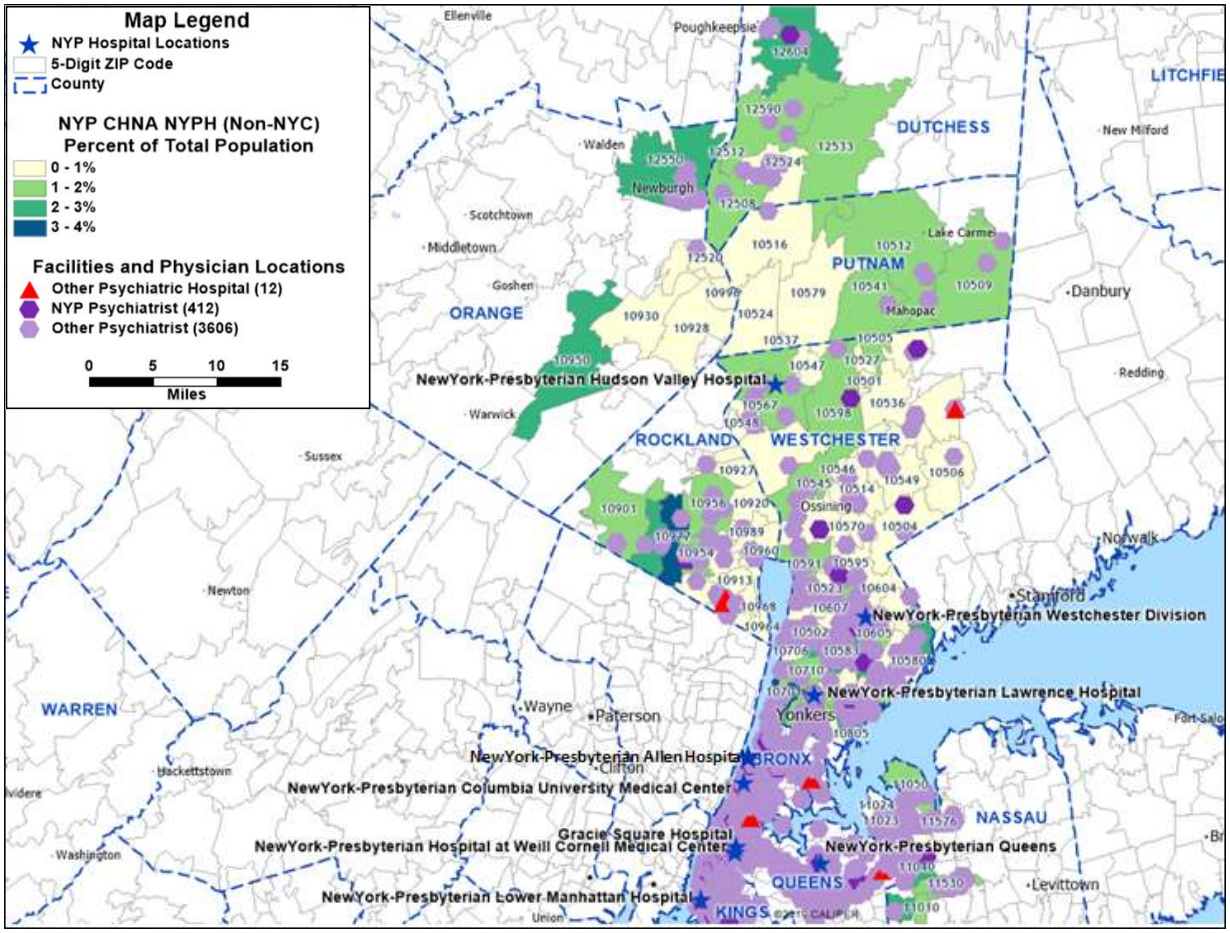
- Overall, these five counties, 33,004, compare favorably to the NYS averages for ED visits per 100,000, NYS 40,582.

Psychiatric Hospitals and Physicians in Non-NYC Community, by ZIP



- Behavioral health providers and facilities are lacking across the service area, a similar trend exists across New York state.
- Pockets of providers exist in lower quartile communities of need with disparate opportunities for access in high need populations.

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Health Provider Assets in the NYPH Non-NYC Communities

Asset Type	Quartile 1	Quartile 2	Quartile 3	Quartile 4	Total
Short Term Acute Care Hospital	4	6	4	9	23
VA Hospital	0	1	1	0	2
Childrens Hospital	0	1	2	0	3
Long Term Care	0	0	0	0	0
Rehabilitation Hospital	0	1	0	0	1
Psychiatric Hospital	1	0	2	0	3
Department of Defense Hospital	0	0	1	0	1
Federally Qualified Health Center	3	1	9	43	56
Urgent Care Clinic	20	10	23	11	64
Skilled Nursing Facility	7	14	12	29	62
Facility Total	**35**	**34**	**54**	**92**	**215**
Primary Care Physicians	55	59	57	11	182
Pediatricians	65	121	99	15	300
Psychiatrists	84	97	91	49	321
Physician Total	**204**	**277**	**247**	**75**	**803**

Data Source: Definitive Health

This table represents a count only and does not imply that all providers listed accept the most vulnerable populations of Medicaid, low-income, and/or uninsured patients.

AMAZING THINGS ARE HAPPENING HERE

Assessing the Health of Westchester County

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Assessing Westchester County Summary

The following information has been collected and **prepared by the Westchester County Health Department, specifically for the Westchester County community**, to assess community health needs, to identify health disparities, to utilize in prioritizing the implementation strategies, and to support health intervention planning.

- **Demographics** (population, gender, age cohort, by race)
- **Socioeconomic status** (education, unemployment, poverty and housing insecurity)
- **Health Status** (average age at death, birth weight, premature birth, high blood pressure, select causes of death and mortality rates)
- **Health Care Service Utilization** (hospitalizations and ER visits)

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Assessing Westchester County Summary

Demographics and Socioeconomic Status

- There are almost 1M people that reside in the Westchester County geography.
- Approximately, 52% of the county is female and 48% is male.
- About 22% of the county is under the age of 18, and **18% of the population is 65+, compared to NYS at 15.4%.**
- **White Alone is the most numerous race group**, 66.1%, but Hispanics comprise 23.6% of the population and are the largest minority group, followed by Black Alone, 14.4%.
- **A strong percentage of the population has attained a High School diploma or equivalent or a College degree**. This varies by race and ethnicity, with the White population more frequently attaining a Bachelor's Degree.
- The **unemployment rate in Westchester among all populations appears higher** than the NYS percentage of labor force unemployed, 4.7, but Blacks have the highest unemployment rate at 11%.
- In **Westchester County, 18% of Hispanic and 17% of Black populations are living in poverty** (higher than the NYS average of 14.8%).
- **Hispanic populations have the highest percentage of housing insecurity**, 63%, which is more than double the percentage of White Non-Hispanic populations, 26.1%, and higher than Black Non-Hispanic populations, 47.6%.

Assessing Westchester County Summary

Health Status

- The average age of death is lowest for minorities, 66.3 for Hispanics and 70.8 for Blacks. **Whites live 13 to 8 years longer than Hispanics or Blacks, respectively.**
- **The top causes of death for county residents are consistently diseases of the circulatory system**.
- **Low birthweight among infants is highest for Non-Hispanic Black women** 12.7% and Non-Hispanic Asian women, 8.8%. Hispanic women have the lowest rates of low birthweight, 6.7%, followed by Non-Hispanic White, 6.8%. The NYS percentage of low birthweight is 7.9%
- **Notably, all race/ethnicities have a higher than the average percent of premature births, but it is highest for Non-Hispanic Black women**, 15.7%. The NYS percentage of premature births with <37 weeks gestation is 8.8%.
- **Non-Hispanic Black populations have the highest rate of physician diagnosed high blood pressure**, 45.5%. The rates for White Non-Hispanics, 25.7%, and Hispanics,17.3%, are lower than the state average, 28.9%.
- While Non-Hispanic Black populations report **a high percentage of 1+ sugary drinks consumed daily**, Hispanic populations report the highest percentage.
- The **diabetes mortality rate among Non-Hispanic Blacks is highest, 25.3**, while the other race / ethnicities are lower than the NYS average, 17.0.

Assessing Westchester County Summary

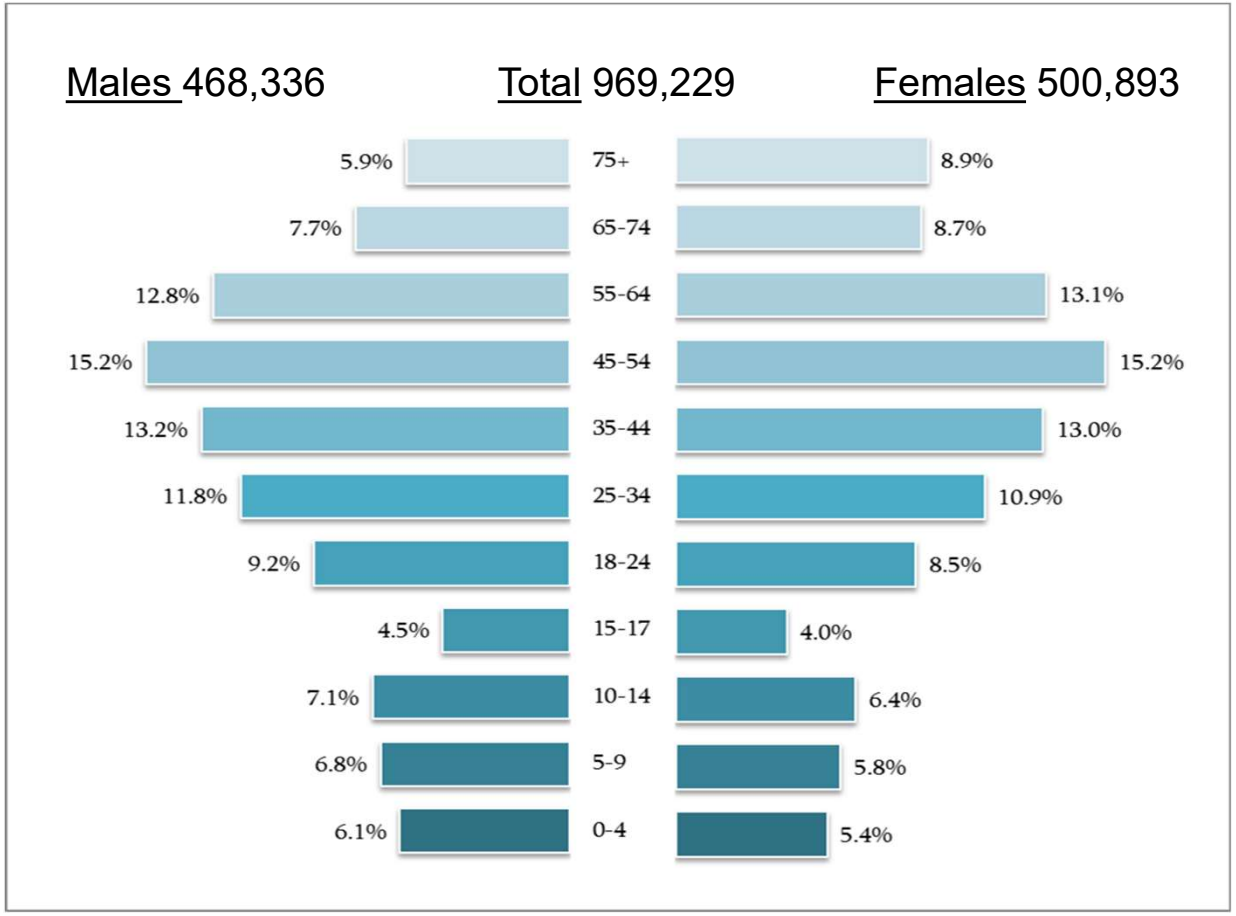
Health Status, continued

- **Black males' cancer incidence rate, 605.2, is higher than White males, 555.9 and higher than the NYS average,** 564.4. Conversely, Black females' cancer incidence rate 364.0, is lower than White females, 555.9, and both are lower than the state average.
- **Black males cancer mortality rate of 214.1 is higher than the state average**, 176.2, while White males rate of 167.4 is slightly lower than NYS average. Black females cancer mortality rate of 148.3 is lower than the state average, and White females rate of 130.7 is lower still.

Health Care Service Utilization

- In total, **county residents are more frequently hospitalized for circulatory system conditions** (cardiovascular issues).
  - Black populations are hospitalized most often for circulatory system conditions or mental disorders.
  - Hispanic populations are also hospitalized most often for circulatory system conditions or mental disorders, but at lower percentages than Blacks.
  - White populations are most frequently hospitalized for circulatory and digestive conditions.
- **Non-Hispanic Black populations have a significantly higher hospitalization rate**, 106.0, for heart disease than other race/ ethnicities ranging from 27.8 - 69.6.
- **Non-Hispanic Black populations also have higher mortality rates, 202.0, for heart disease related conditions** than others in the County, but these rates are lower than the NYS cardiovascular disease mortality rate per 100,000 of 272.2.
- The **top causes, among all races/ethnicities, for ER visits are injuries and poisonings followed by respiratory issues.** However, White populations top ER visits are for injuries and poisonings followed by cardiovascular disease.

Westchester County Population
Average of 2012-2016, Age and Sex



Source: U.S. Bureau of Census via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

- Age and gender composition help inform an understanding of the community and health service planning.
- There are almost 1M people that reside in the Westchester County geography.
- Approximately, 52% of the community is female and 48% is male.
- About 22% of the population is under the age of 18 and 18% of the population is 65 or older, compared to NYS at 15.4%.

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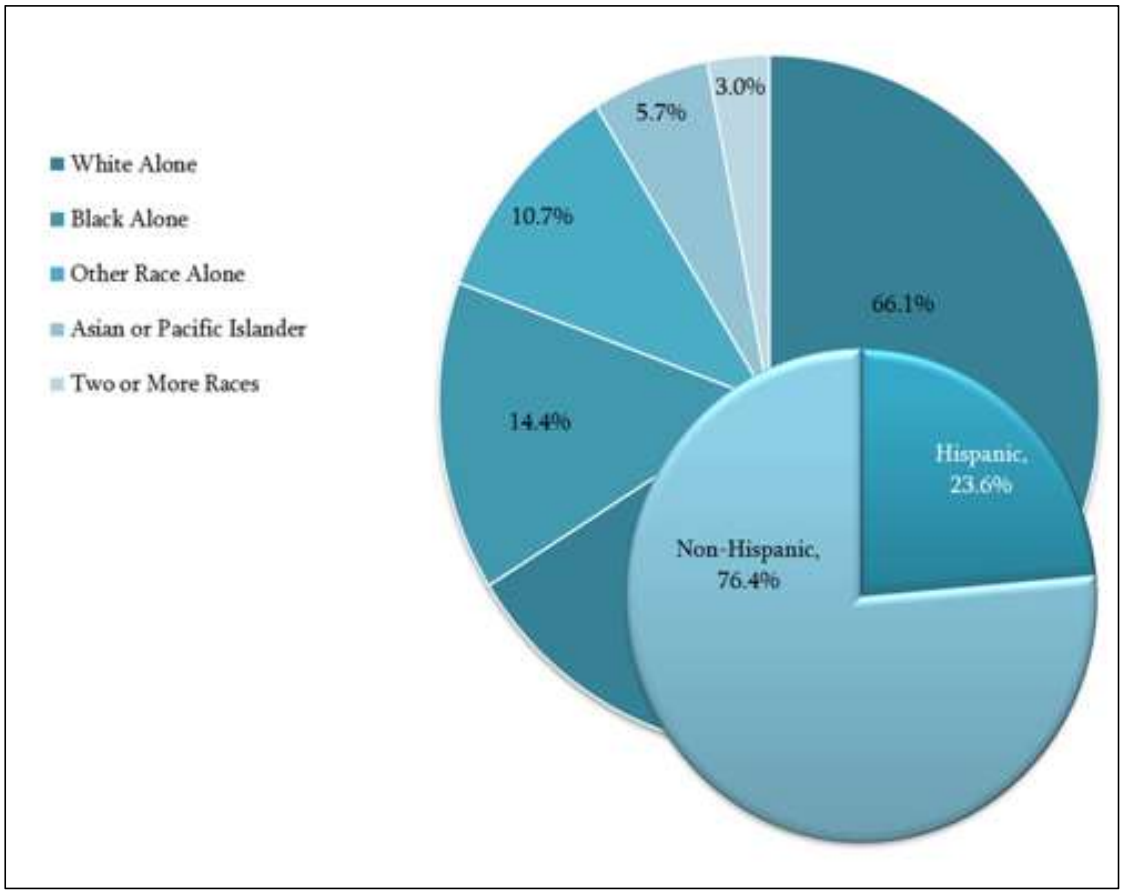
Westchester County Population
Average of 2012-2016, Race and Ethnicity



- Race/ethnicity composition can also help inform an understanding of the community and health service needs as well as potential cultural norms to consider in outreach and care delivery.
- White Alone is the most numerous race group, 66.1%.
- Hispanics comprise 23.6% of the population and are the largest minority group, followed by Black Alone, 14.4%.

Source: U.S. Bureau of Census via the Westchester County Health Department

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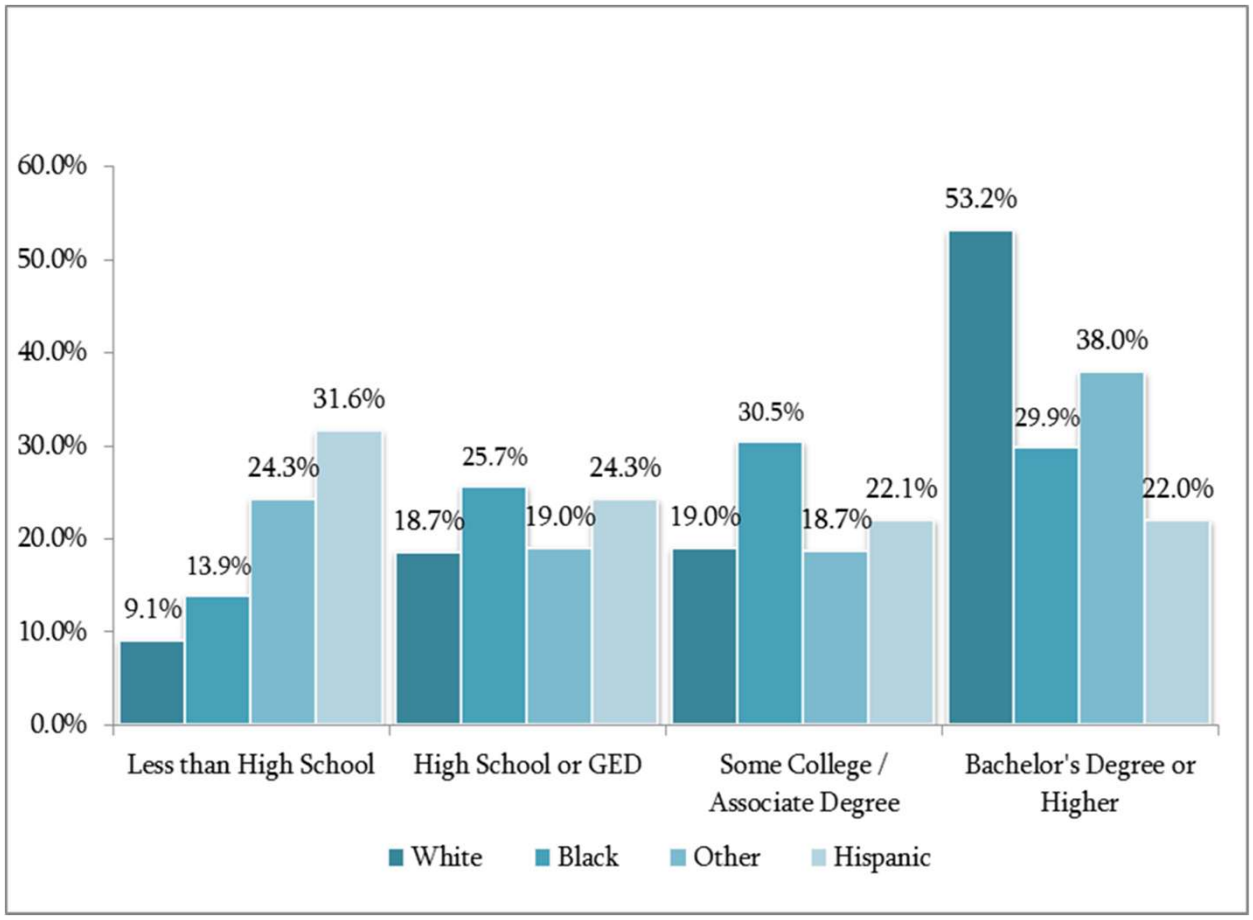
Westchester County Population
Average of 2012-2016, Race and Education



Source: U.S. Bureau of Census via the Westchester County Health Department

- While not a conclusive determinant alone, this is another predictor of health outcome to consider – level of educational attainment.
- A strong percentage of the population has attained a High School diploma or equivalent or a College degree.
- This varies by race and ethnicity, with the White population more frequently attaining a Bachelor's Degree.
- Hispanic persons have the highest percentage of not attaining a High School diploma.

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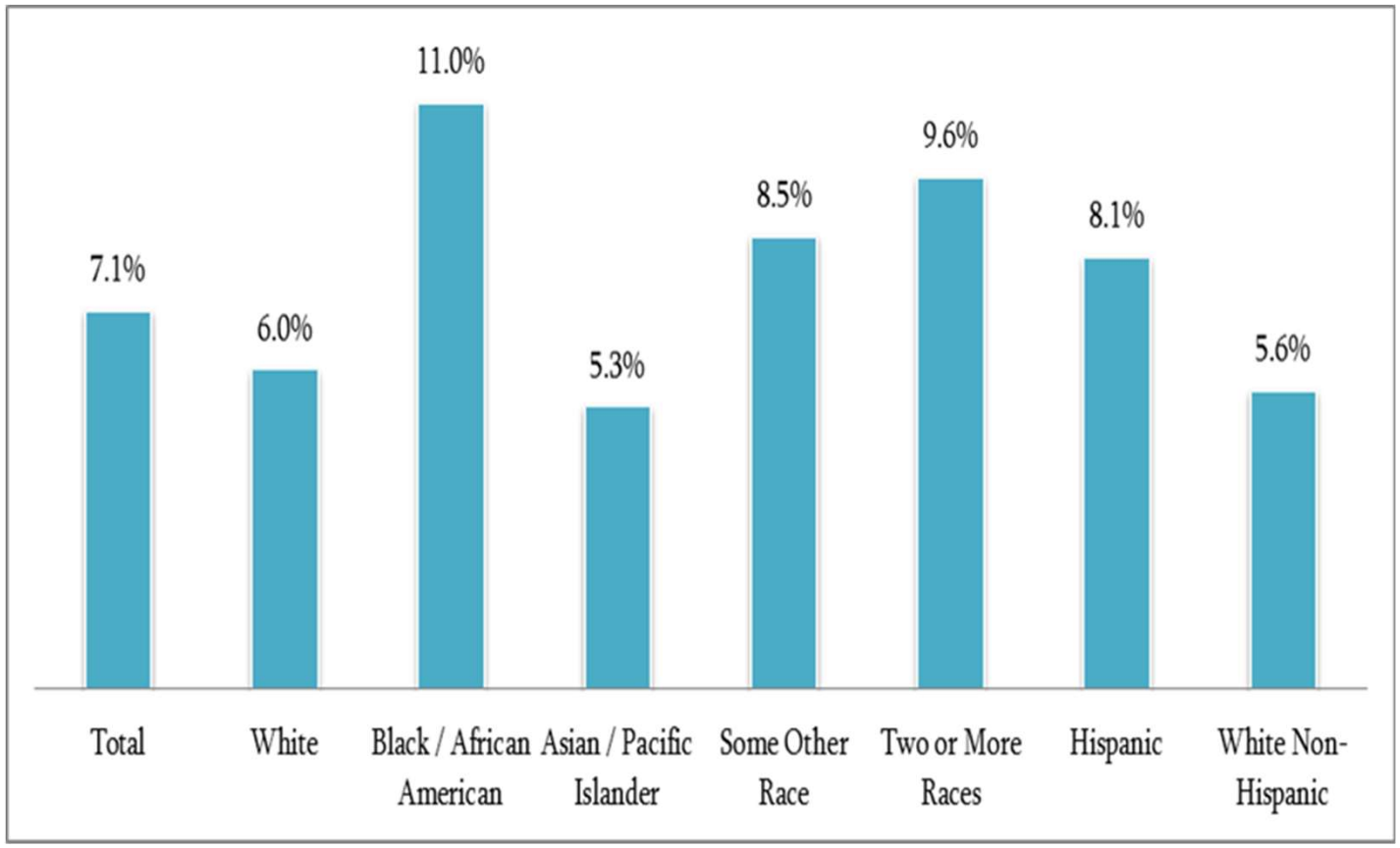
Westchester County Population
Average of 2012-2016, Race and Unemployment



- Another predictor of health outcome to consider is unemployment.
- The unemployment rate in Westchester among all populations appears higher than the NYS percentage of labor force unemployed, 4.7.
- This varies by race and ethnicity, with Blacks having the highest unemployment rate at 11%.

Source: U.S. Bureau of Census via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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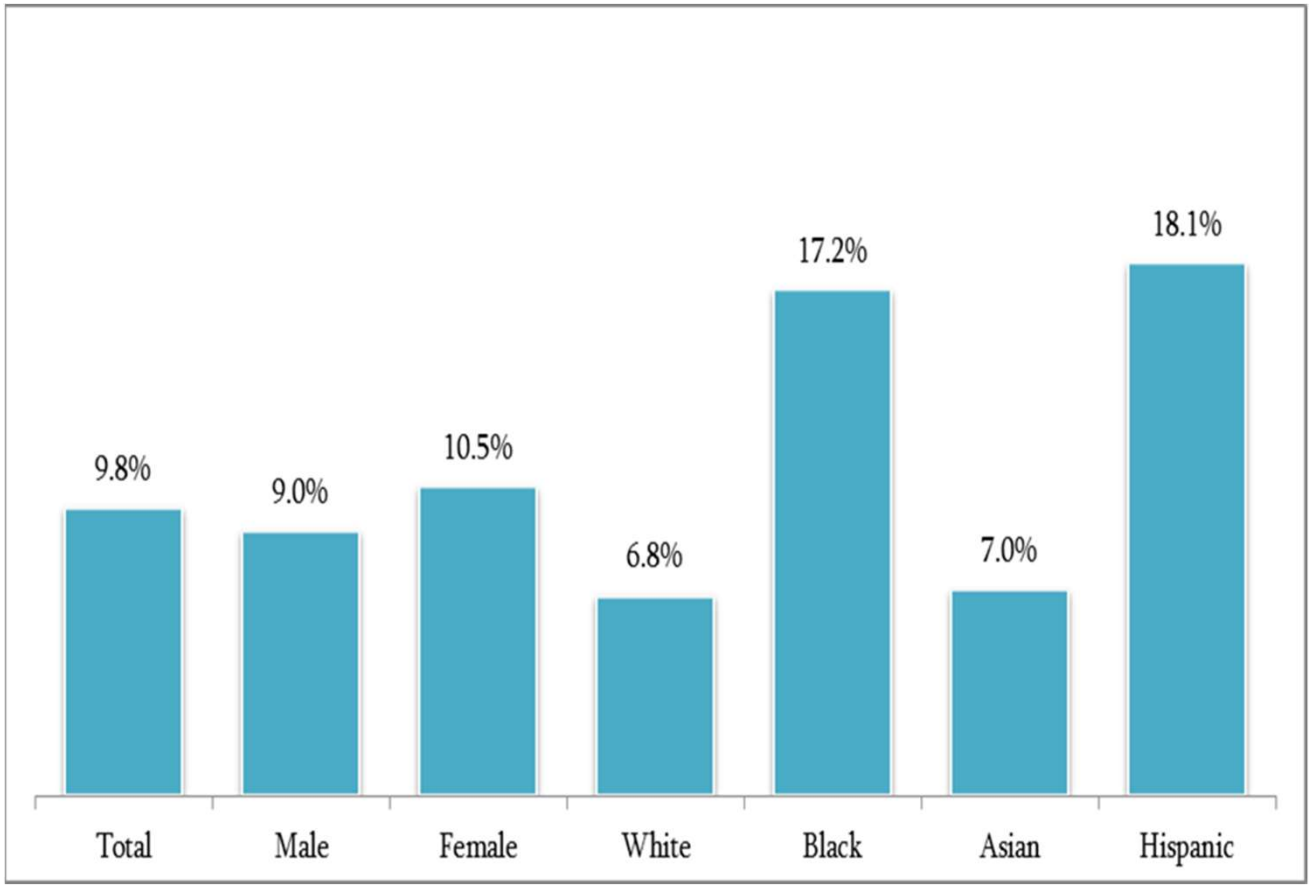
Westchester County Population
Average of 2012-2016, Race and Poverty



- Economic factors and insurance are the larger predictors of health outcomes, and also strongly influence health behavior.
- In Westchester County, 18% of Hispanic and 17% of Black populations are living in poverty.
- The NYS percentage of the population in poverty is 14.8%.

Source: U.S. Bureau of Census via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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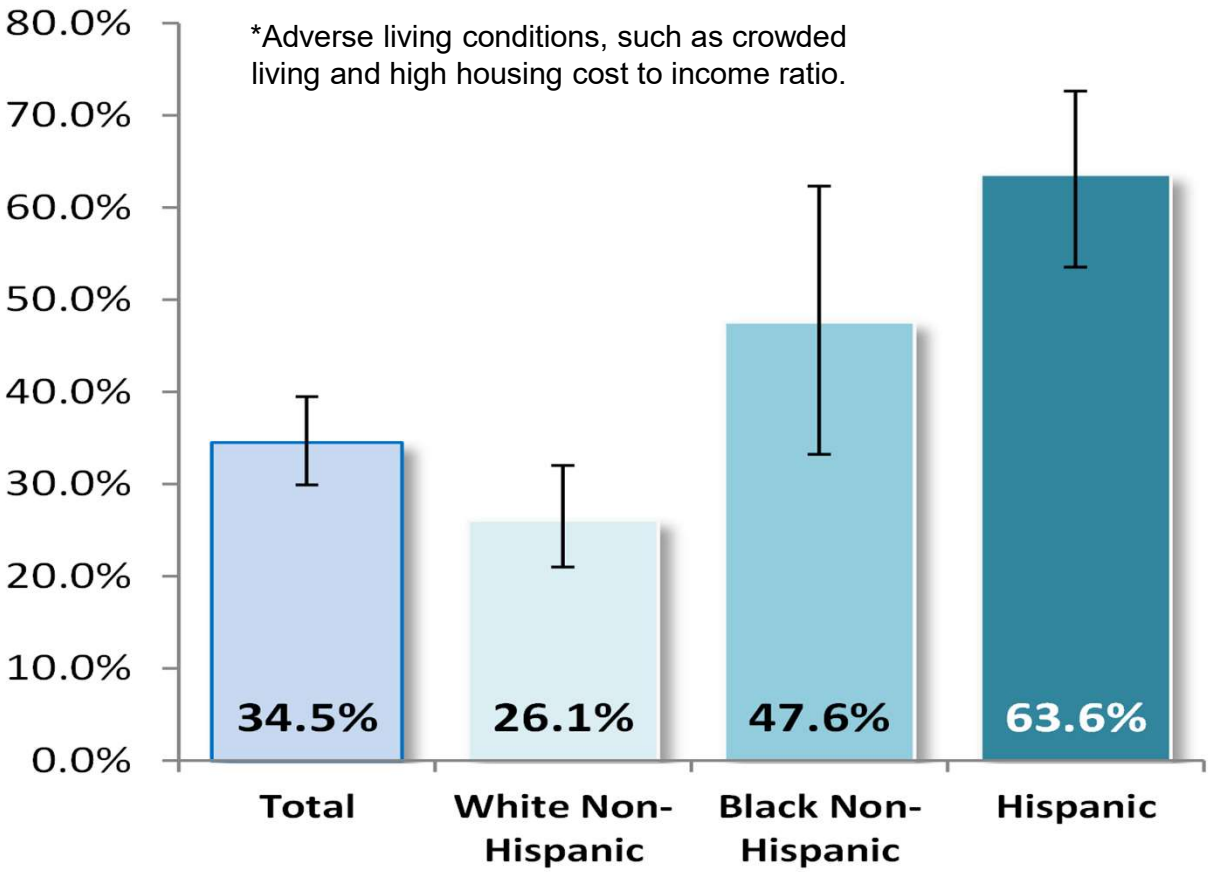
Westchester County Population - 2013-2014 Race and % Adults Experiencing Housing Insecurity* in the Past 12 Mos.



- Hispanic populations have the highest percentage of housing insecurity, 63%.
- This is more than double the percentage of White Non-Hispanic populations, 26.1% and higher than Black Non-Hispanic populations, 47.6%.

Source: Westchester County Health Department

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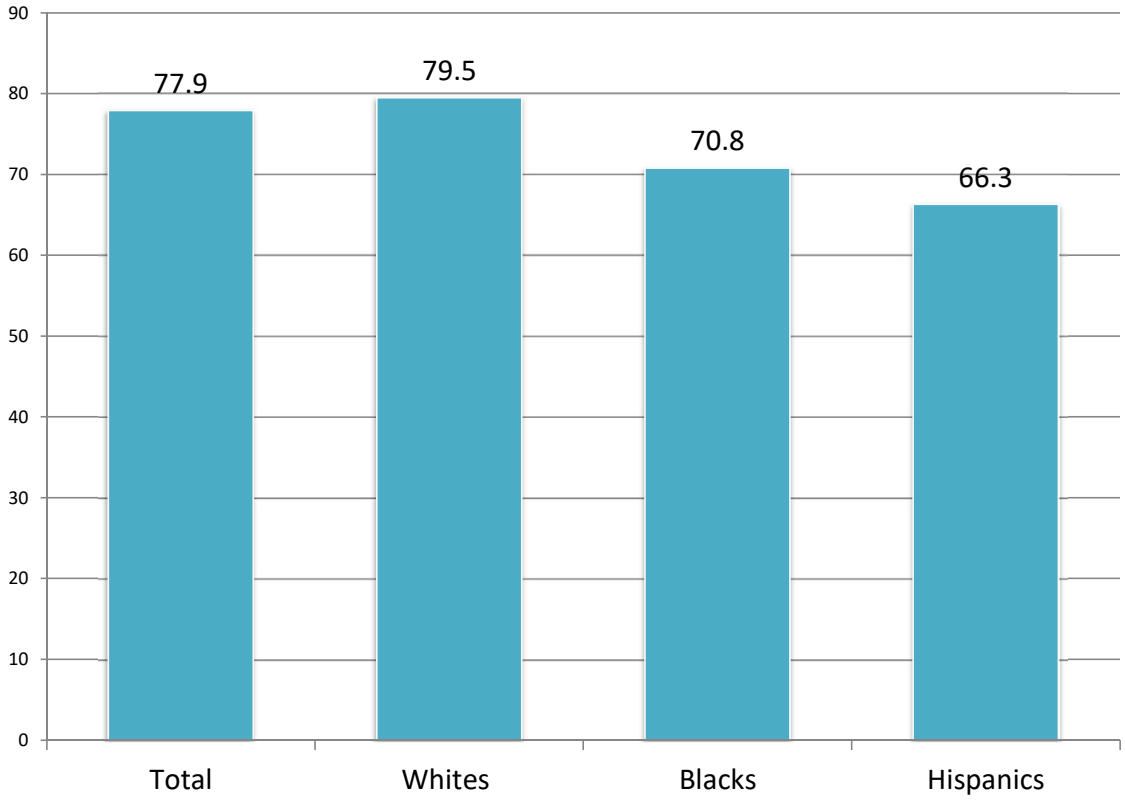
Westchester County Population
2015 Race and Average Age at Death



- Key indicators for the health of a community include mortality rates.
- The average age of death is lowest for minorities, 66.3 for Hispanics and 70.8 for Blacks.
- Whites live 13 to 8 years longer than Hispanics or Blacks, respectively.

Source: NYS Vital Statistics via the Westchester County Health Department

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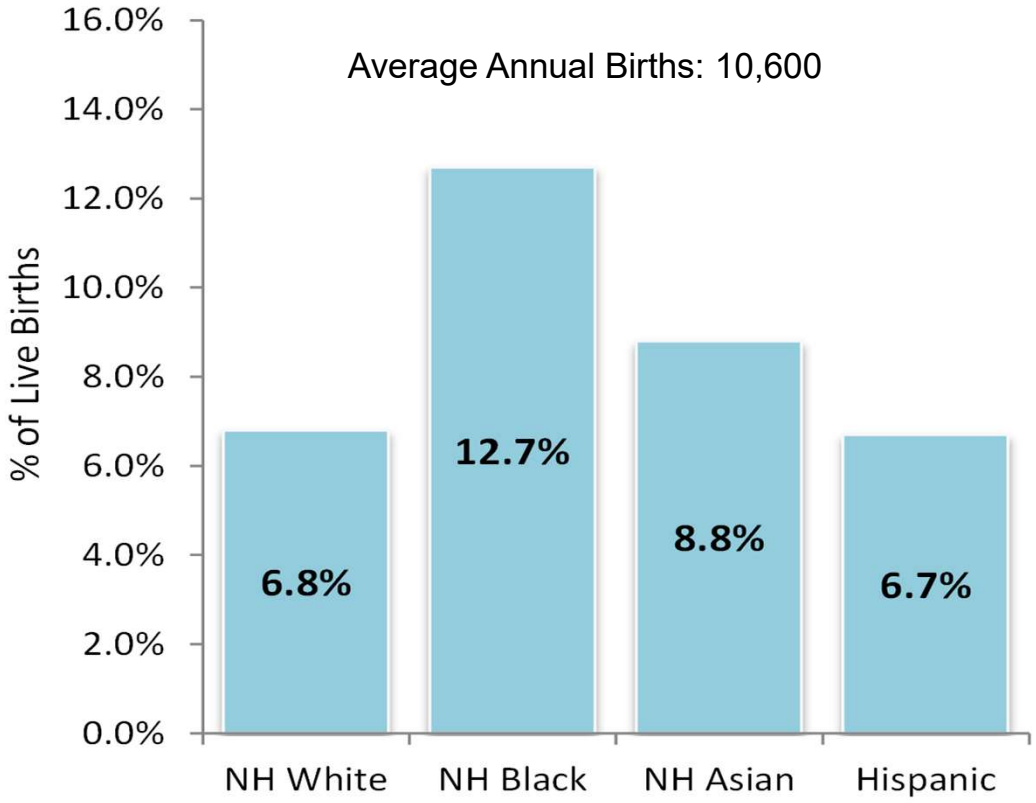
Westchester County Population
2015 Race and Top Causes of Death

	Total		White		Black		Hispanic	
	N	%	N	%	N	%	N	%
Total	6,689	100	5,556	100	832	100	401	100
Diseases of the circulatory system	2,451	36.64	2,074	37.33	272	32.69	124	30.92
Neoplasms	1,803	26.95	1,502	27.03	216	25.96	106	26.43
Diseases of the respiratory system Influenza	613	9.16	533	9.59	62	7.45	19	4.74
External causes of morbidity and mortality Accidents	290	4.34	232	4.18	40	4.81	39	9.73
Diseases of the nervous system	265	3.96	229	4.12	29	3.49	13	3.24
Certain infectious and parasitic diseases	247	3.69	180	3.24	55	6.61	18	4.49

Source: NYS Vital Statistics via the Westchester County Health Department

- The top causes of death, for County residents, are consistently diseases of the circulatory system (e.g. heart failure, hypertension, stroke, etc.).
- The number two cause of death is neoplasms (an abnormal mass of tissue that can be benign (not cancer) or malignant (cancer)).

Westchester County Population
2011-2013 Race and Births with Low Birthweight



- The health status of infancy can impact long term health.
- Low birthweight among infants is highest for Non-Hispanic Black women, 12.7% and Non-Hispanic Asian women, 8.8%.
- Hispanic women have the lowest rates of low birthweight, 6.7%, followed by Non-Hispanic White, 6.8%.
- The NYS percentage of low birthweight is 7.9%

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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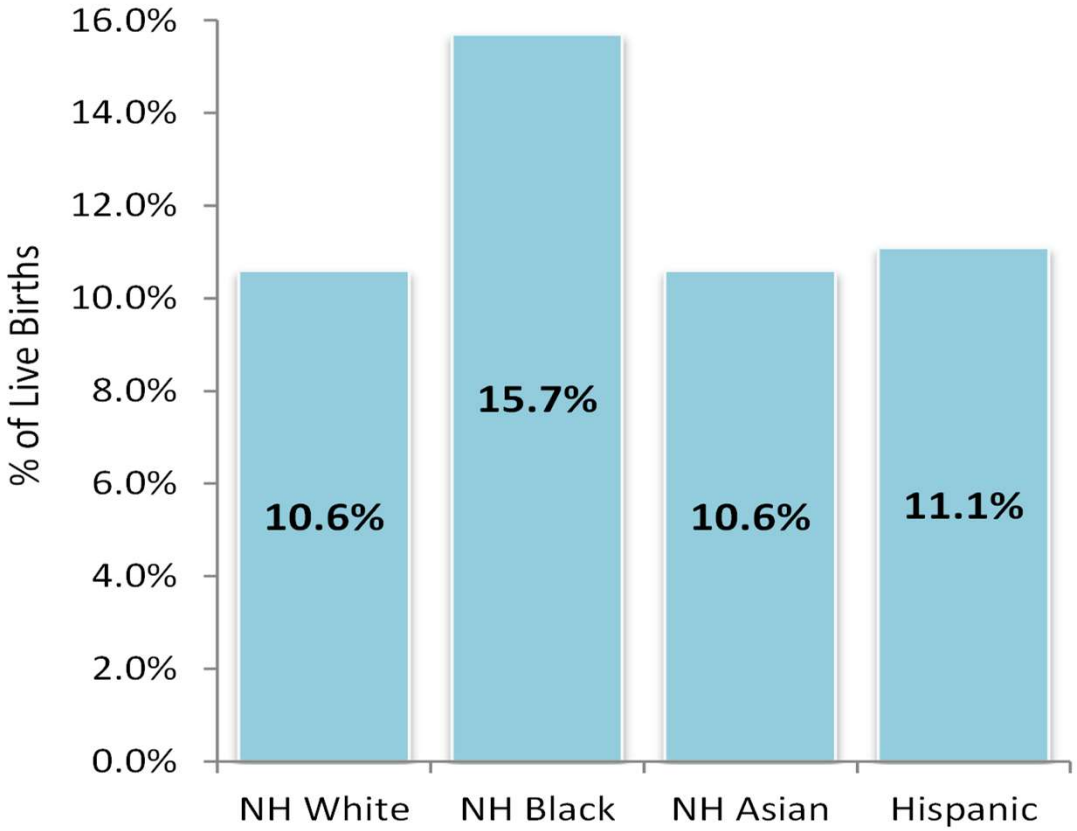
Westchester County Population
2011-2013 Race and Premature Births



- Premature births is highest for Non-Hispanic Black women, 15.7%.
- Notably, all populations in the County are higher than the NYS percentage of premature births with <37 weeks gestation at 8.8%.

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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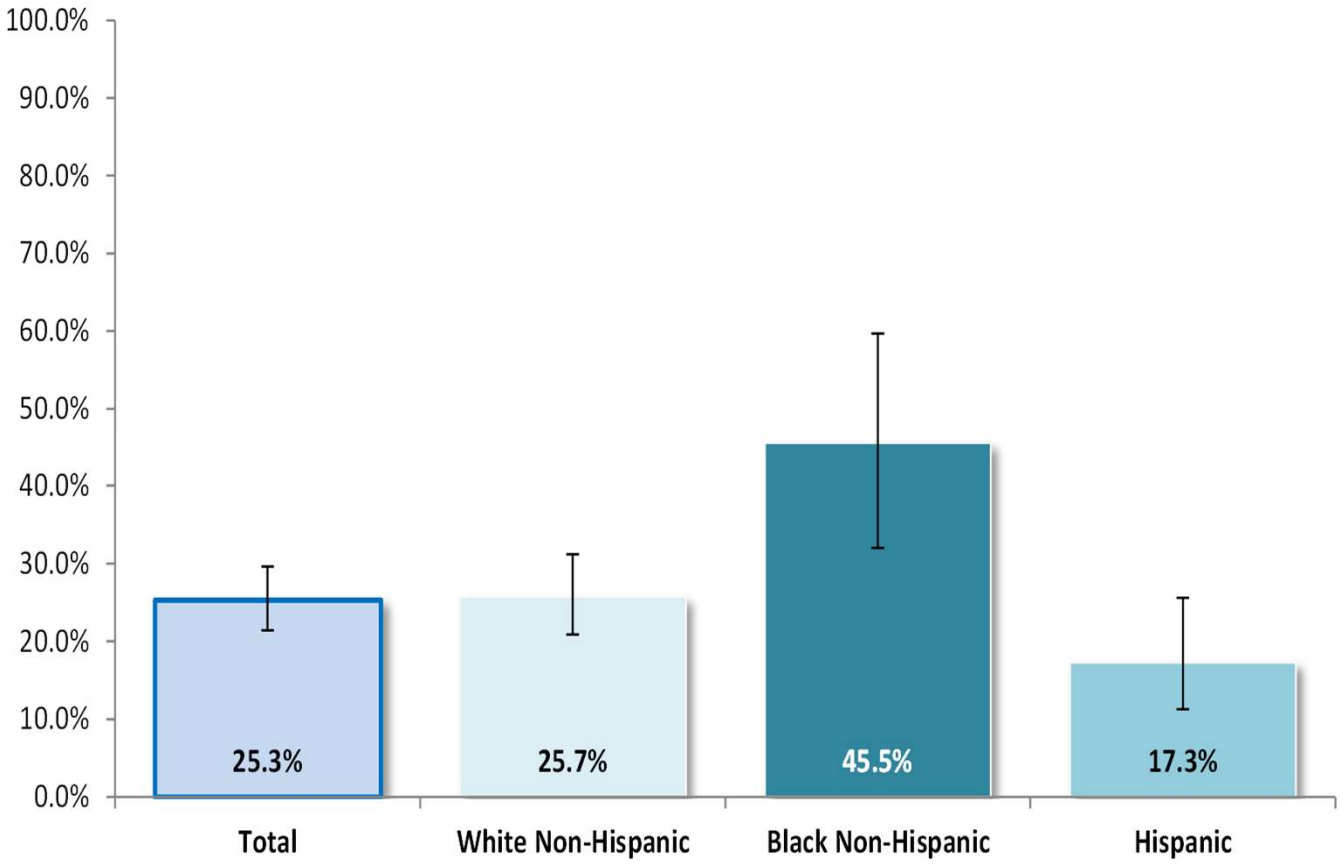
Westchester County Population
2013-2014 Race and Physician-Diagnosed High Blood Pressure



- Non-Hispanic Black populations have the highest rate of physician diagnosed high blood pressure, 45.5%.
- The NYS age-adjusted percentage of adults with physician diagnosed high blood pressure is 28.9%.
- The rates for White Non-Hispanics, 25.7%, and Hispanics,17.3%, are lower than the state average.

Source: NYS Extended BRFSS via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

Westchester gov.com

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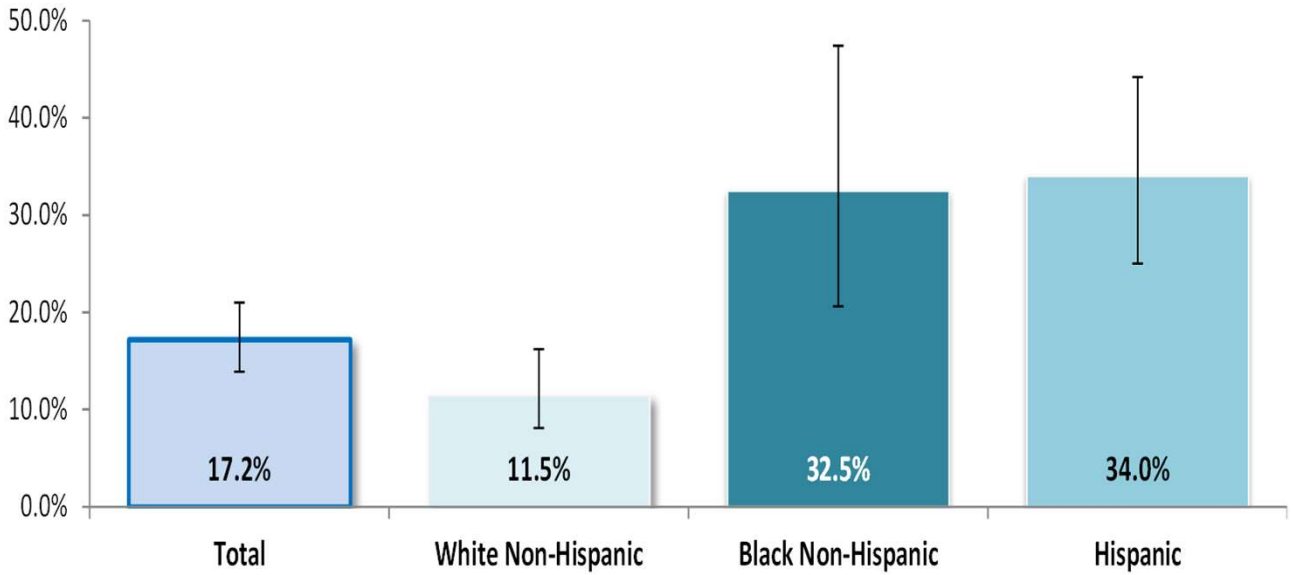
Westchester County Population
2013-2014 Race and % Adults Consuming One+ Sugary Drinks Daily



- Hispanic populations have the highest percentage of adults reported consuming one or more sugary drinks daily, 34.0%.
- Black Non-Hispanic also report a high percentage, 32.5%.

Source: NYS Extended BRFSS via the Westchester County Health Department

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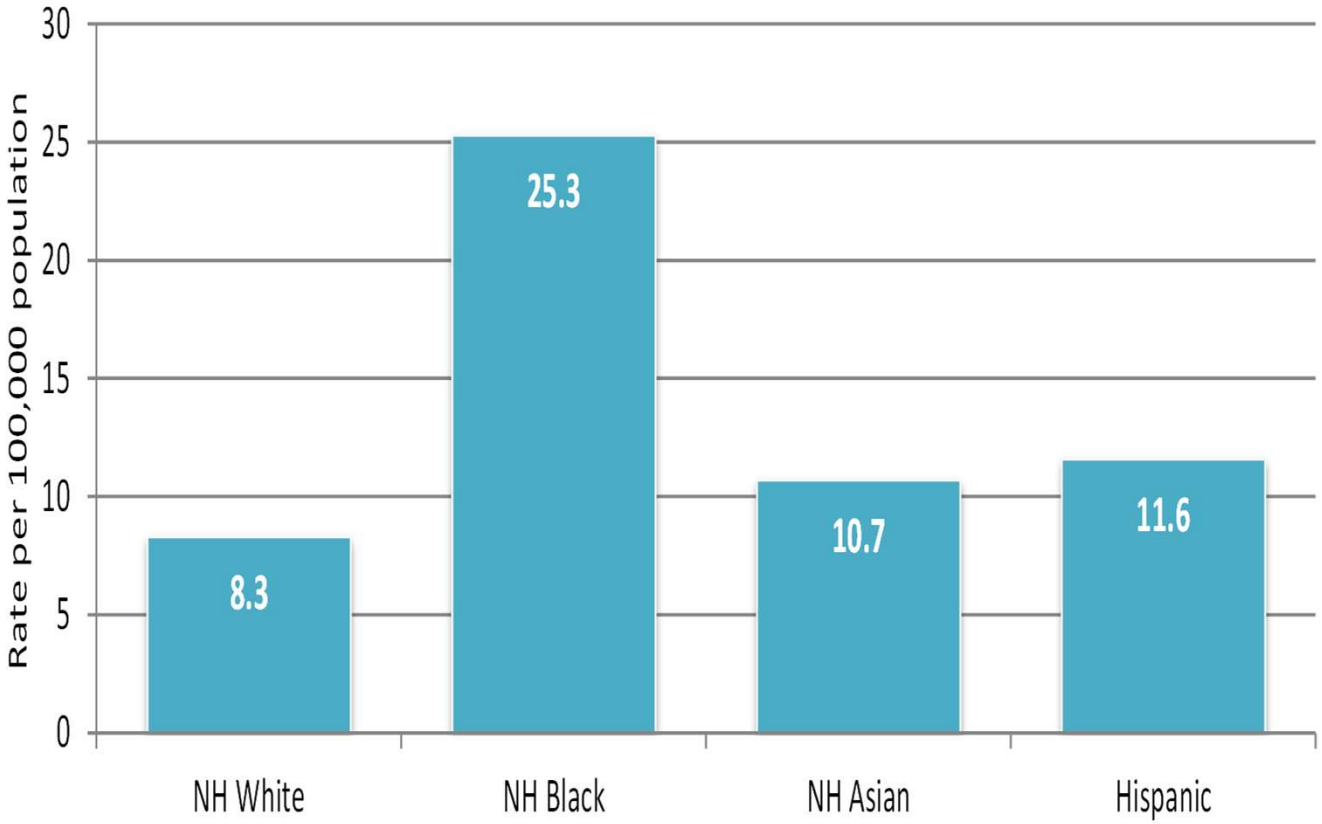
Westchester County Population
2011-2013 Race and Diabetes Mortality Rate



- The NYS age-adjusted diabetes mortality rate per 100,000 is 17.0.
- The rate among Non-Hispanic Blacks. 25.3, is higher than the NYS average, while the other race / ethnicities are lower.

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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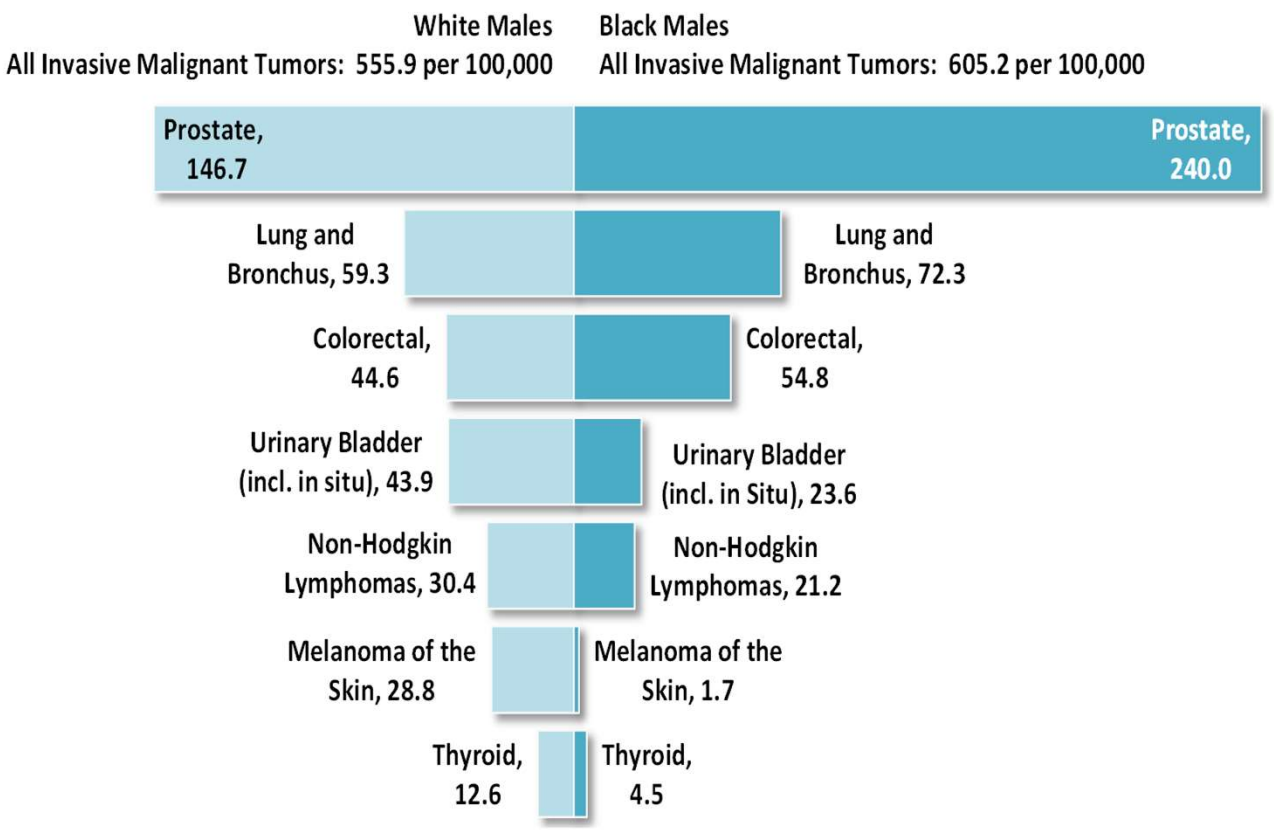
Westchester County Population
2008-2012 Race and Average Annual Incidence Rates (Males)



- The NYS total population (males and females both), all cancer incidence rate per 100,000 is 564.4.
- Black males' cancer incidence rate of 605.2 is higher than the state average, while the White males rate of 555.9 is slightly lower than average.
- Black males have a higher incidence than White males for all malignant tumors (cancers), lung cancer, and colorectal cancer.
- White males have the higher incidence among urinary bladder, Non-Hodgkin Lymphomas, skin melanomas and thyroid cancers.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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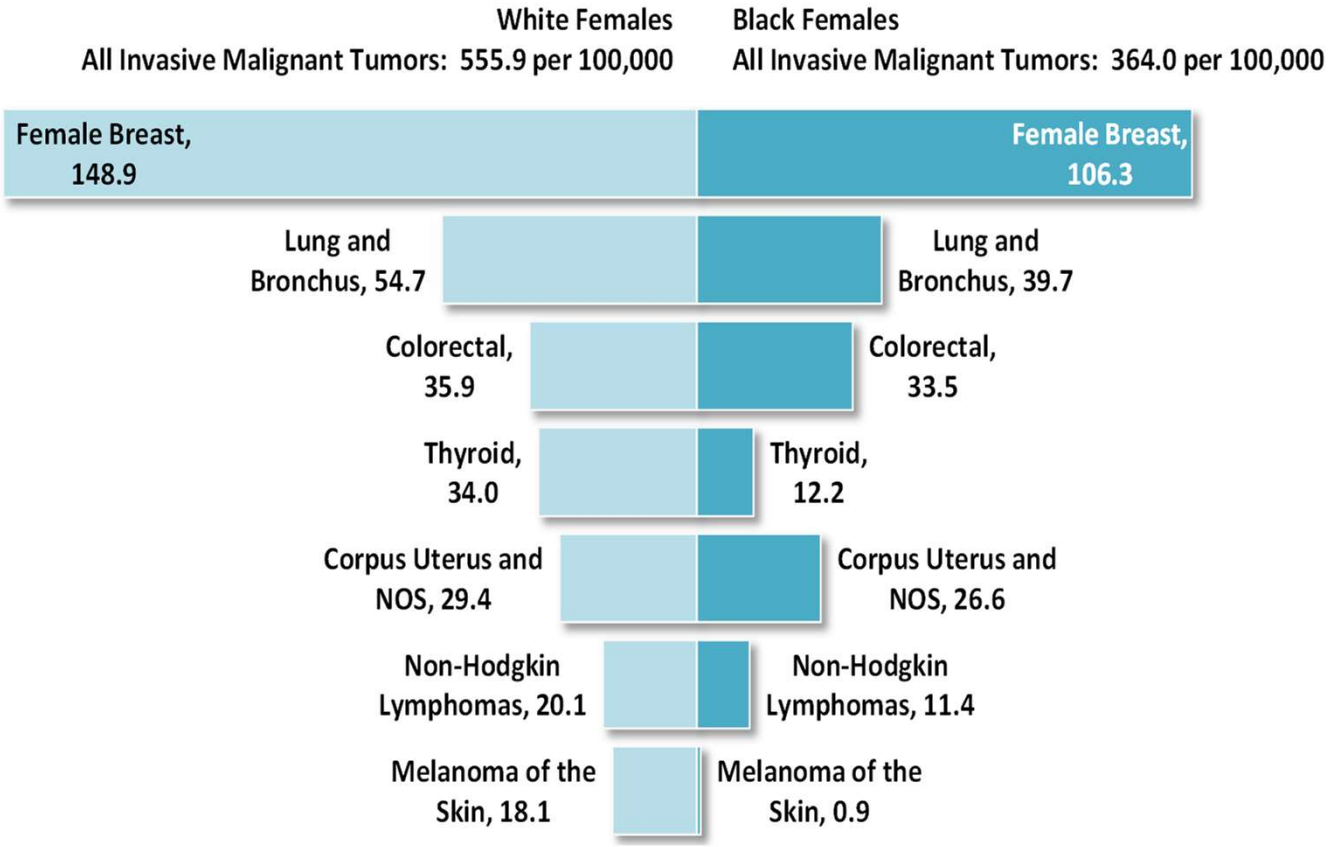
Westchester County Population
2008-2012 Race and Average Annual Incidence Rates (Females)



- The NYS total population (males and females both), all cancer incidence rate per 100,000 is 564.4.
- White females' incidence rate of 555.9 is slightly lower in comparison and Black Females is much lower than state average at 364.0.
- White females have the higher incidence among all the cancers listed here.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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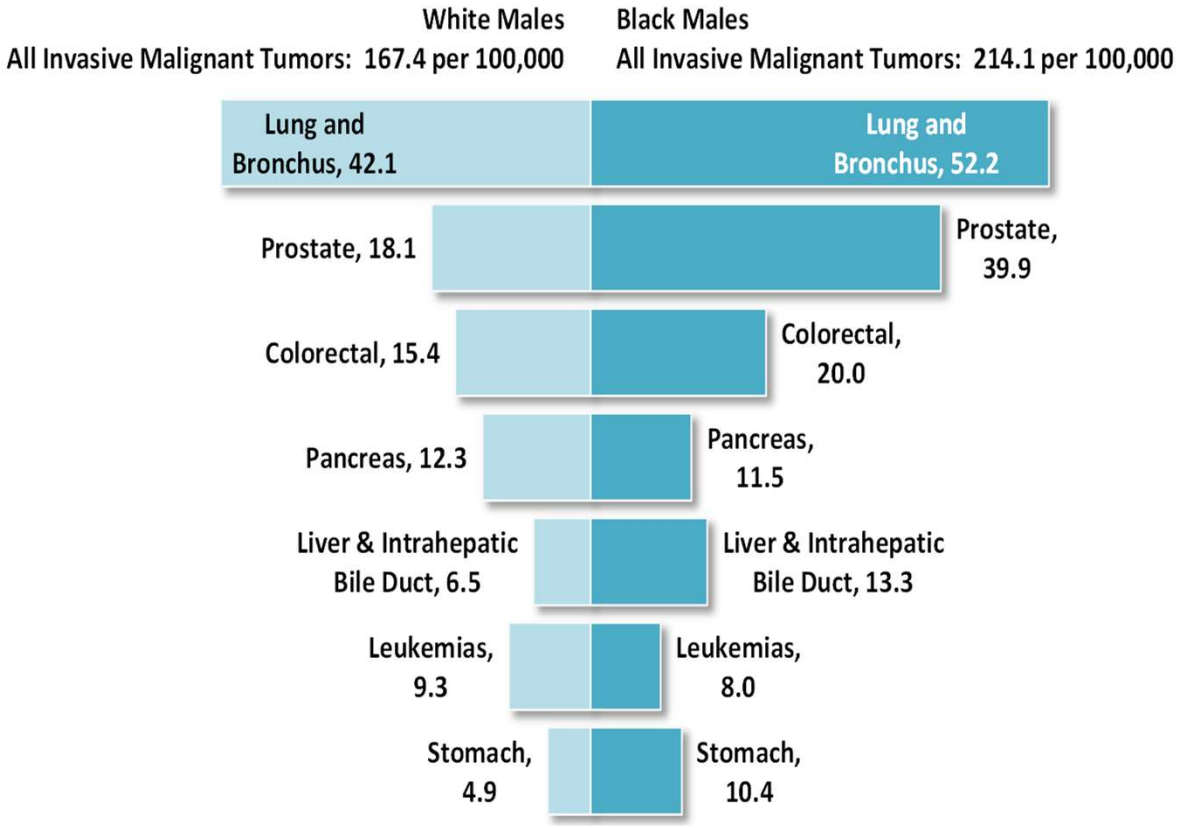
Westchester County Population
2008-2012 Race and Average Annual Mortality Rates (Males)



- The NYS total population (males and females both), all cancer mortality rate per 100,000 is 176.2.
- Black males' cancer mortality rate of 214.1 is higher than the state average, while White males rate of 167.4 is slightly lower than average.
- Black males have a higher incidence than White males for most of these cancers, with the exception of pancreatic cancer and leukemias.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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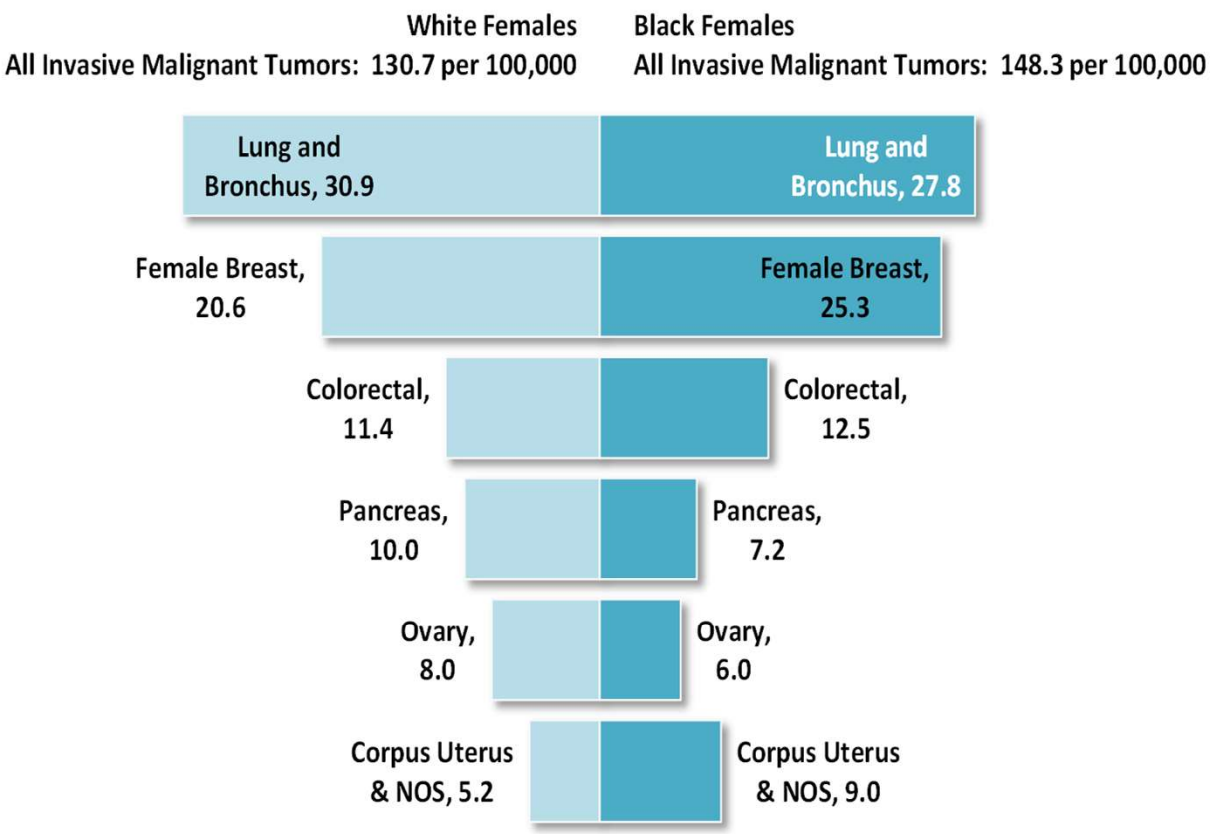
Westchester County Population
2008-2012 Race and Average Annual Mortality Rates (Females)



- The NYS total population (males and females both), all cancer mortality rate per 100,000 is 176.2.
- Black females' cancer mortality rate of 148.3 is lower than the state average, and White females rate of 130.7 is lower still.
- White females have the higher incidence among cancers of the lung, pancreas, and ovary.
- Black females have the higher incidence among cancers of the breast, colorectal, and uterus.

Source: NYS Cancer Registry via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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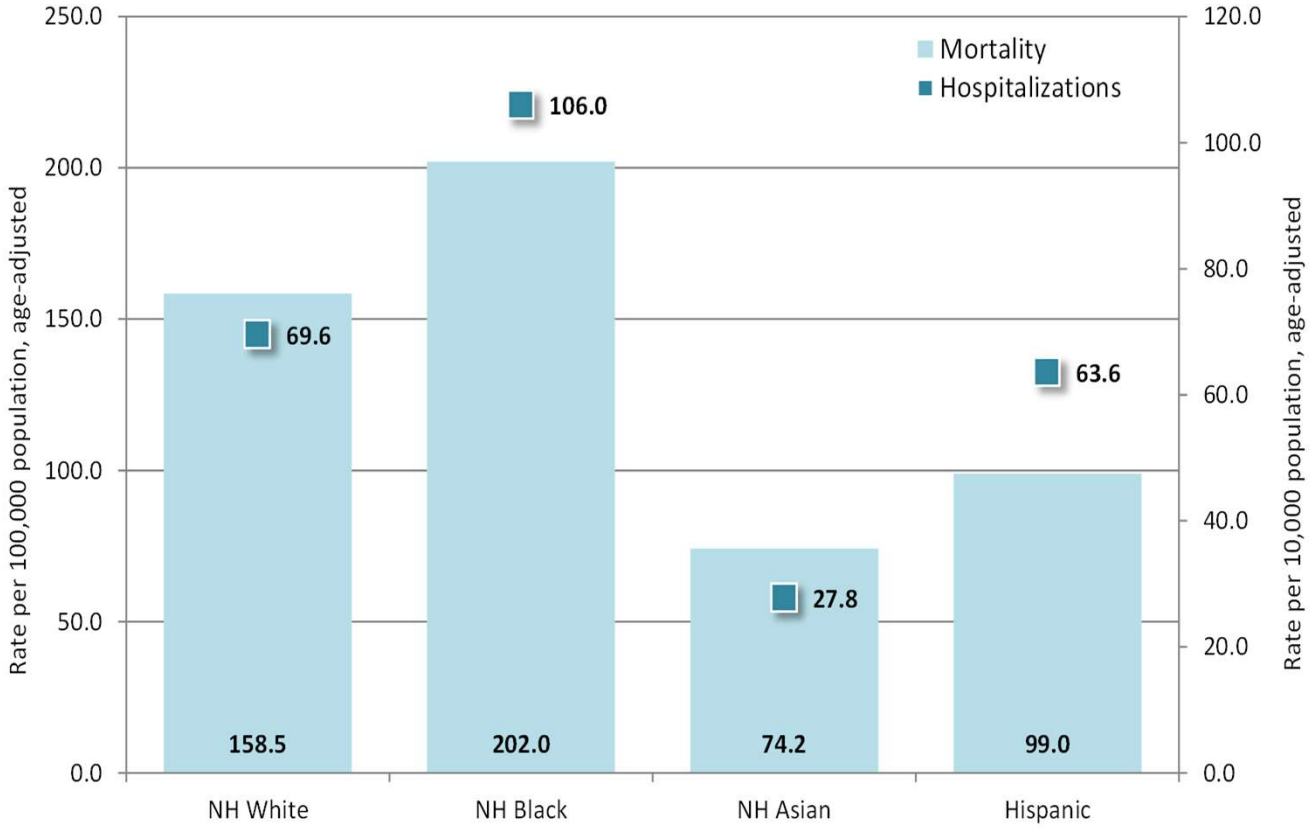
Westchester County Population
2008 Race and Top Causes of Hospitalization

	Total		White		Black		Hispanic	
	N	%	N	%	N	%	N	%
Total	111,638	100.00	71,579	100.00	19,662	100.00	15,299	100.00
Circulatory System	15,570	13.95	10,877	15.20	2,550	12.97	1,179	7.71
Mental Disorders	8,881	7.96	4,626	6.46	2,461	12.52	1,136	7.43
Digestive System	8,880	7.95	6,048	8.45	1,350	6.87	1,313	8.58
Respiratory System	7,773	6.96	5,247	7.33	1,410	7.17	949	6.20
Neoplasms (including benign)	6,027	5.40	4,241	5.92	965	4.91	484	3.16
Musculoskeletal System and Connective Tissue	5,349	4.79	3,980	5.56	702	3.57	386	2.52
Injury and Poisoning	4,832	4.33	3,400	4.75	583	2.97	511	3.34
Genitourinary System	4,473	4.01	2,981	4.16	738	3.75	607	3.97

- In total, county residents are more frequently hospitalized for circulatory system conditions (cardiovascular issues).
- Black populations are hospitalized most often for circulatory system conditions or mental disorders.
- Hispanic populations are also hospitalized most often for circulatory system conditions or mental disorders, but at lower percentages than Blacks.
- White populations are most frequently hospitalized for circulatory and digestive conditions.

Source: NYS SPARCS via the Westchester County Health Department

Westchester County Population
2011-2013 Race and Heart Disease Mortality and Hospitalizations



- Non-Hispanic Black populations have a significantly higher hospitalization rate, 106.0, for heart disease than other race/ethnicities ranging 27.8 - 69.6.
- Non-Hispanic Black populations also have higher mortality rates 202.0, for heart disease related conditions than others in the County, but these rates are lower than the NYS cardiovascular disease mortality rate per 100,000 of 272.2.

Source: NYS Vital Statistics via the Westchester County Health Department and New York State Community Health Indicator Reports (CHIRS)

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Westchester County Population
2008 Race and Top Causes of Emergency Room Visits

	Total		White		Black		Hispanic	
	N	%	N	%	N	%	N	%
Total	295,123	100.00	159,351	100.00	71,516	100.00	62,499	100.00
Injuries and poisonings	**76,071**	25.78	**45,670**	28.66	**14,980**	20.95	**14,114**	22.58
Diseases of the respiratory system	**33,486**	11.35	**15,729**	9.87	**9,820**	13.73	**8,698**	13.92
General symptoms	**27,282**	9.24	**14,726**	9.24	**6,343**	8.87	**6,689**	10.70
Diseases of the cardiovascular system	**26,910**	9.12	**16,711**	10.49	**6,095**	8.52	**3,277**	5.24
Diseases of the digestive system	**23,745**	8.05	**12,867**	8.07	**5,400**	7.55	**5,691**	9.11
Diseases of the musculoskeletal &	**19,658**	6.66	**10,147**	6.37	**5,621**	7.86	**3,686**	5.90
Mental disorders	**15,847**	5.37	**7,756**	4.87	**4,020**	5.62	**2,845**	4.55
Diseases of the urogenital system	**14,720**	4.99	**7,951**	4.99	**3,525**	4.93	**3,401**	5.44

- The top causes, among all races/ethnicities, for ER visits are injuries and poisonings followed by respiratory issues.
- However, White populations top reasons for ER visits are injuries and poisonings followed by cardiovascular disease.

Source: NYS SPARCS via the Westchester County Health Department

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AMAZING THINGS ARE HAPPENING HERE

Key Health Policy Impact

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Key Health Policies Potentially Impacting the NYPH Community

The health care policy environment can and does contribute to community wide health improvement or conversely to its challenges. For this study, several policies have been identified and described.

Federal Change in Public Charge Rule

Potential unfavorable impact to the willingness of residents with a green card or those who may apply for one to seek and/or access care because fear of losing citizenship status.

In August 2019, the Trump Administration announced a final rule that changes the policies used to determine whether an individual applying for admission or adjustment of status is inadmissible to the U.S. Under longstanding policy, the federal government can deny an individual entry into the U.S. or adjustment to legal permanent resident (LPR) status (i.e., a green card) if he or she is determined likely to become a public charge. Under the rule, officials will newly consider use of certain previously excluded programs, including non-emergency Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), and several housing programs, in public charge determinations. The changes will create new barriers to getting a green card or immigrating to the U.S. and likely lead to decreases in participation in Medicaid and other programs among immigrant families and their primarily U.S.-born children beyond those directly affected by the new policy. Decreased participation in these programs would contribute to more uninsured individuals and negatively affect the health and financial stability of families and the growth and healthy development of their children.

Key Health Policies Potentially Impacting the NYPH Community

Affordable Care Act (ACA) Challenge in Texas:

Could unfavorably impact persons, who have since 2019 been able to obtain health insurance and ACA protections.

A group of states, including Texas challenged the Affordable Care Act on the grounds that the individual mandate with no tax penalty was not a tax and therefore unconstitutional. A Federal Judge in Texas agreed with this reasoning and ruled that the individual mandate is unconstitutional without a tax penalty and that the law should be struck down.

The case is now before a Federal Appeals Court in New Orleans which could rule issue a ruling at any time. The stakes of the lawsuit are significant. If the ACA were, in fact, ruled unconstitutional, that could mean that health insurers could once again refuse coverage or otherwise discriminate against patients who have preexisting conditions. Additionally, it would mean that roughly 20 million people who obtained insurance after the ACA was implemented could lose it. The ACA also made other sweeping changes to the health care system, including: expanding Medicaid eligibility for low-income adults; requiring private insurance, Medicare, and Medicaid expansion coverage of preventive services with no cost sharing; phasing out the Medicare prescription drug “donut hole” coverage gap; establishing new national initiatives to promote public health, care quality, and delivery system reforms; and authorizing a variety of tax increases to finance these changes. All of these provisions could be overturned if the trial court’s decision is upheld.

Key Health Policies Potentially Impacting the NYPH Community

1115 Waiver – Delivery System Reform Incentive Payment (DSRIP) Program – 2.0 Extension

The extension of the DSRIP program would allow health systems and networks to invest in transformative clinical initiatives to impact the Medicaid population. The discontinuation of this program could result in the removal of programs due to the ability to sustain projects and partnerships.

New York State announced they will seek a four-year 1115 Waiver extension to the current DSRIP initiative. If approved, the extension would further support clinical transformation efforts focused to the Medicaid populations associated to 25 Performing Provider Systems (PPS). New and ongoing funding would allow continued investments in programs focused on: improving quality outcomes, enhancing workforce development, addressing social determinants of health, and increasing community-based clinical network development. The extension would expand on existing activity and establish new programs.

Maternal Mortality Review Board

The review board would focus to improvement strategies for preventing future deaths and improving overall health outcomes targeting maternal populations with an emphasis to reduce racial disparities in health outcomes.

Governor Cuomo signed legislation to create a Maternal Mortality Review Board charged to review the cause of each maternal death in New York State. New York City will also have a maternal mortality review board to review cases within the five boroughs. The Boards will make recommendations to the New York State Department of Health for clinical improvement strategies to improve overall health and outcomes of this population. They will also look at ways to reduce racial disparities in health outcomes. The work of the board would aid DSRIP initiatives addressing access to care and coordination since Medicaid accounts for more than 50 percent of births within the state.

Key Health Policies Potentially Impacting the NYPH Community

Ending the Epidemic

Initiative focused upon treatment persons with HIV with the goal of reducing HIV prevalence in NY.

New York State and New York City are working on a plan to the end the AIDS epidemic. The Ending the Epidemic (ETE) initiative seeks to maximize the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. The overarching goal is to achieve the first ever decrease in HIV prevalence by the end of New York State by the end of 2020. Primary objectives are to: identify persons with HIV who remain undiagnosed and link them to health care services, and retain them in the care system to prevent further transmission and improve their health.

In New York City, the goal is to reduce the number of new infections in the City to fewer than 600 by 2020. This target aligns with the State's goal of reducing new statewide infections to fewer than 750 by 2020. In New York City, the four primary objectives are to: increase access to HIV prevention services; promote innovative, optimal treatment for HIV; enhance methods for tracing HIV transmission; and improve sexual health equity for all New Yorkers

ThriveNYC

Initiative focused upon improving access to mental health services for the underserved.

ThriveNYC is an initiative created by New York City to improve access to mental health services, particularly for underserved populations. The program's goals include: enhancing connections to care, increasing services to vulnerable populations, and strengthening crisis prevention and responses. ThriveNYC initiatives include: mental health first aid programs, a public awareness campaign, mental health outreach and support for veterans, mental health services in youth shelters, and drop-in centers and newborn home visiting program in shelters.

Key Health Policies Potentially Impacting the NYPH Community

Elimination of religious exemptions to vaccinations for school aged children:

While this issue continues to be debated publicly, this is elimination of religion exemption is intended to increase the number of vaccinations among schoolchildren decreasing unnecessary outbreaks and potential severe illnesses and deaths.

Amid an ongoing measles outbreak, New York State enacted a new law in June to eliminate nonmedical exemptions from school vaccination requirements. The law took effect immediately. While this issue continues to be challenged in the courts, it would favorably increase the number of vaccinations among schoolchildren decreasing unnecessary outbreaks and potential severe illnesses and deaths.

New York State Ban on Flavored E-cigarettes

Emergency ban is focused upon reducing the use of vaping products by New York youth.

In September, New York State enacted an emergency ban on the sale of flavored electronic cigarettes and nicotine e-liquids. The ban is part of a growing response to combat the increase in young people using vape products, given the appeal of flavors to the youth market. There are some who have concerns that the ban will keep people smoking regular cigarettes who may have considered switching and lead to a “black market” for vaping products with untested or unknown ingredients.

Key Health Policies Potentially Impacting the NYPH Community

NY State Opioid Tax

To begin to fight the opioid epidemic, the state of NY placed an excise tax on opioids sold to or within the state in order to help victims of the opioid crisis.

The tax, which went into effect July 1, 2019, is anticipated to generate $100 million in revenue for the state to allow administration to address the opioid crisis within the state of NY. The tax is based on the amount of opioid in each unit sold as well as wholesale acquisition cost and applies to whatever entity makes the first sale. The impact will be seen by manufacturers and wholesale organizations since initiation as numerous pharmaceutical manufacturers have discontinued shipments to the state.

Marijuana Decriminalization

The decriminalization of small amounts of marijuana, 25 grams or less, and automatic expungement of previous convictions could encourage the use of substances which could lead to other substance abuse disorders in high disparity communities.

Legislation was passed in June of 2019 to decriminalize the use of marijuana by expunging many past marijuana possession convictions and reducing the penalty for the possession of small amounts of the drug. The bill does not fully legalize the use of marijuana.

AMAZING THINGS ARE HAPPENING HERE

Community Input

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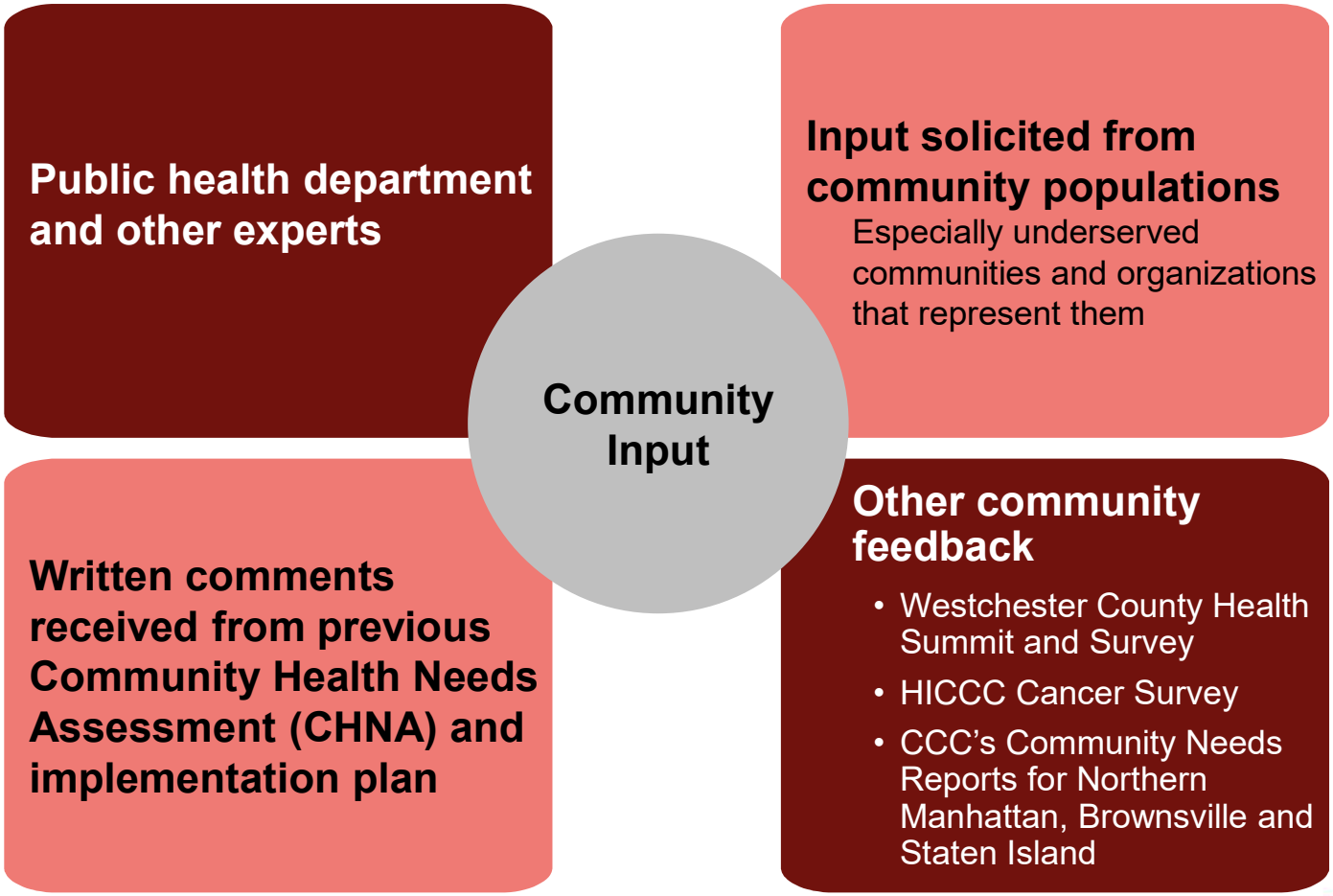
Overview of Community Input



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Public health department and other experts

In conducting the 2019 CHNA, NYP and NYPH collaborated with the New York City Department of Health and Mental Hygiene (DOHMH), Westchester County Department of Health (WCDH), Citizens Committee for Children (CCC), Columbia University Mailman School of Public Health (CUMSPH), and Greater New York Hospital Association (GNYHA).

Through these collaborations we were able to adopt a community-engaged approach that involved collecting and analyzing quantitative and qualitative data from a variety of publicly available sources to comprehensively assess the health status of our communities. Each stakeholder added to our ongoing work by providing insight on the publicly available data for the various regions specific to the NYPH High Disparity Communities, while providing guidance on collecting stakeholder and community feedback and incorporating best practices for our CHNA.

Community Populations – Community Health Needs Questionnaire Method

The Center for Evaluation and Applied Research (CEAR) at the New York Academy of Medicine (NYAM) administered the Community Health Needs Questionnaire (CHNQ), which was developed in collaboration with the NewYork-Presbyterian CHNA Steering and Methods Committees of which the Citizens' Committee for Children in New York (CCC) was a member.

The CHNQ focused on basic demographics, health concerns (individual and community-wide), health care utilization, barriers to care, and use of NYP services. NYAM began collecting this data in June 2019, in partnership with numerous community organizations, which were identified in collaboration with NYP and represent a range of populations, e.g., older adults, immigrant, and homeless populations.

Respondents included community advisory board members and community residents, some of which were recruited using online platforms such as Craigslist.

CHNQs were self-administered or administered by NYAM staff or staff and volunteers at community organizations, who are trained and supported in survey administration by NYAM staff.

The resident CHNQs were completed by NYPH community residents, ages 18 and older.

The CHNQ was translated and administered in Spanish, English, Korean, Chinese, Russian, and Haitian Creole.

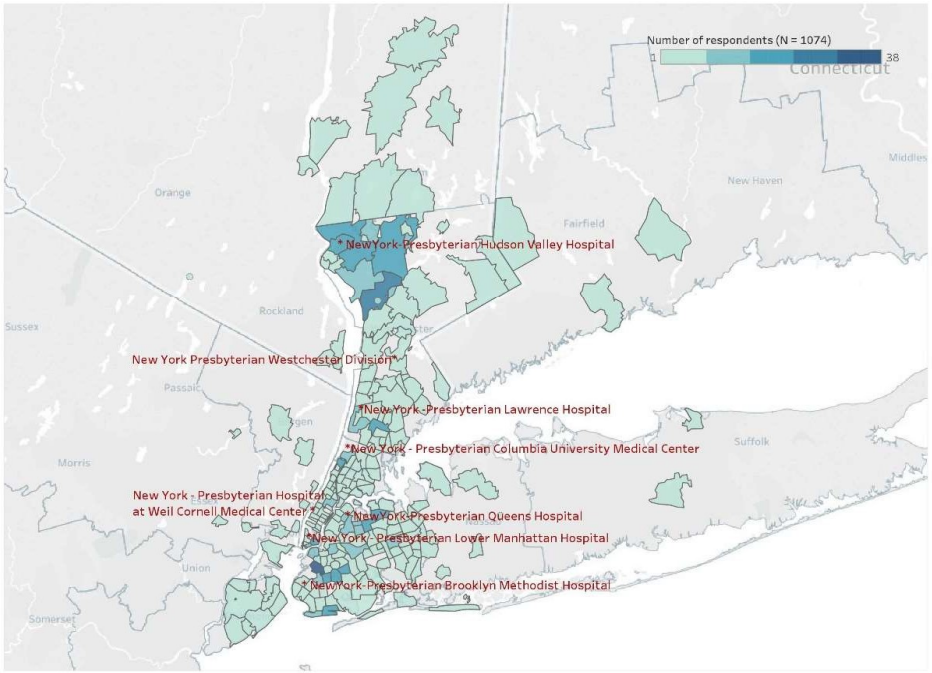
Participants received a gift card valued at $10 for completing the CHNQ.

Community Populations – Community Health Needs Questionnaire Results

1,074 questionnaires were completed

- 49.1% In person
- 43.9% Online
- 7.0% NYP Community Advisory Boards (CABs)

NYPH Community Health Needs Assessment defined region - questionnaire respondents



Most commonly reported community health issues *		N=1,074
Community health issue	**n**	**%**
Alcohol & drug use	478	44.5%
High blood pressure	444	41.3%
Diabetes	437	40.7%
Mental health	411	38.3%
Cancer	398	37.1%
Obesity	377	35.1%
Tobacco use	335	31.2%

* Multiple responses permitted.
Note: Responses selected fewer than 30% of the time are not presented.

Recommendations to improve community health*		N=1,074
Community health recommendations	**n**	**%**
Improved housing conditions	452	42.1%
Increased # of places for older adults to live and socialize in	449	41.8%
Reduced cigarette/vaping smoke	430	40.0%
More local jobs	403	37.5%
Cleaner streets	402	37.4%
Reduced air pollution	390	36.3%
Reduction in homelessness	358	33.3%
More parks and recreation centers	352	32.8%
Reduced crime	315	29.3%
Mold removal	272	25.3%

*Multiple responses permitted
Note: Responses selected fewer than 24% of the time are not presented

NewYork-Presbyterian

Community Populations – Focus Group Method

The Center for Evaluation and Applied Research (CEAR) at the New York Academy of Medicine (NYAM) developed a semi-structured focus group guide in collaboration with the NewYork-Presbyterian CHNA Steering and Methods Committees and with input from the Citizens' Committee for Children in New York (CCC) who has extensive experience related to qualitative research methods.

Facilitation of the CHNA focus groups were conducted by NYAM staff or by community based organization hosts. All were experienced in focus group facilitation and trained by NYAM on the CHNA protocol. All groups also had a trained co-facilitator, responsible for logistics and note taking.

Focus groups were recruited by community based organizations identified by the NewYork-Presbyterian CHNA Steering and Methods Committees and that agreed to host these sessions.

Each focus group was approximately ninety minutes in length. Participants completed either the full Community Health Needs Questionnaire (CHNQ) or an abridged version, focused on demographics, health status, and other individual characteristics.

Participants were informed of the voluntary nature of participation (overall and for specific questions) and that results would be reported without names or identifying characteristics. Guidelines for discussion were also presented at the start of the groups, which included, for example, the importance of hearing from all participants and the facilitator role in guiding the discussion.

All groups were audio recorded and professionally transcribed; non-English focus groups were professionally translated.

Community Populations – Focus Group Results

Greatest Health Issues

“Even in my own family, you can see that. Diabetes is—it’s like you’re guaranteed to get it sometime down the road if you’re Hispanic, pretty much.”

“Diabetes, obesity, hypertension, and lack of healthy food choices are – they all go together in this neighborhood. You see nothing but Popeye's, McDonald's. When I go into BJ's, and go shopping, I see people buying nothing but salt and sugar foods. “

“With the asthma and the cancer. I don't know. It's a lot of correlation, I don't know if it's causation, but when 9/11 happened and being that we live in the neighborhood, there was so many people that I've known that didn't work down there but they passed away from cancer. And then just with the development of a lot of buildings that's coming up in a lot of materials that they're using, we're inhaling it. So, a lot of people now is getting diagnosed with a lot of respiratory issues and this is – a census was taken down here so this is nothing I'm just making up. So, they have statistics that – it's a lot of – I'm not saying it's causation but it's a lot of correlation.”

“Well, it’s an experience that I had through having cancer. You go to the hospital, and everything is –nobody knows anybody. You go into this room, and you wait for the next thing to happen, and then, when you’re lucky enough – like I was – that it was self-contained, they operate and leave, but there’s no follow-up. I was almost waiting for, “My God, is something else gonna happen?” But, there’s no support group for after care, which I think is something that needs to be there.”

Community Populations – Focus Group Results

Mental and Behavioral Issues

"There's a lot of depression in this community, especially, I would say, in this center, because when you get older and you can't do certain things, you tend to be depressed."

"Parents are hesitant of getting their child evaluated because they think their child is stigmatized as crazy. And kids themselves will feel like, "Oh, I know a friend who's in special education, and they're this way. That means I'm that way too." So, they don't necessarily think they need the help either. So, they're reticent to say anything about how they feel."

"Originally, when we started offering the services, we thought there would be a huge barrier to folks in acknowledging mental health as a need, something that they'd be willing to address. We've actually found the reverse – there is sort of an immense pent-up demand for services from us, including folks who don't screen at a clinical level of need, and they're like, "I hear you have therapists available. Can we get signed up?" ... So, the two things that we have found are: a) the potential demand is even higher than what it looks like before people get the psycho-ed and b) it makes a huge difference to be able to access that kind of initial knowledge and entry-level treatment – therapy rather than pharmaceutical or psychiatric services at a community level."

"think we come from a generation where mental health – we don't talk about that. Nobody goes to counselors. Forget it. Psychiatrists – forget it. But, the truth of the matter is there's a tremendous need for it, but there's a stigma around it."

Community Populations – Focus Group Results

Alcohol and Drug Use	"When it comes to mental health issues, a lot of people are ashamed to admit that they have a problem, you know? So, they turn to alcohol, or they turn to the drugs"
	"My kids are in their early thirties, late twenties, and I'd say from their high school, a good ten kids died from OD in the school district. I think across the school districts in Westchester and around the country, there's been a really high rate of students in college, or just out of college, who OD'd."
Food & Nutrition	"All you have to do is walk down the street and you'll see what's available. It's like pizza, Chinese food, McDonald's, Wendy's... I mean this isn't a food desert like Camden or Newark, but it's still pretty bad."
	"Well, I think for some folks, depending upon what part of the community you're speaking about, the healthiest food is the most expensive food, it's the furthest away from some folks who are living in certain parts of the community, and folks who may not necessarily have their own individual transportation. So, I think providing more ... access and equity across the board for everything. Getting that food in the hands of kids and getting that food in the hands of seniors who are insecure in their own food – I think that's a real challenge in our community and many others. "

Community Populations – Focus Group Results

Physical Activity	"I'm involved in a lot of exercise programs. I'm crazed for it now. One of the exercise programs I went to was Skills in Motion where we deal with falls and what to do when you fall."
	"The access is there. Everything is there. It's just that…in my own family, I've just noticed they're too tired to do it. They work from seven to seven every day, Sunday through Saturday, so when am I going to work out? I have kids to take care of."
	"So, like the parks exist, but they aren't safe. There's violence happening."
Housing	"And that's why many of our clients double up. Because they can't afford Harlem anymore. And in New York City, rent is high period. And then you can have two families living in one apartment. And then to say, all of this is a very stressful situation, because they live it. And then, many of our clients are – our program is basically focused in Central Harlem and then East Harlem, and then many of our clients are moving to the Bronx, that's where they can afford. And so, it's very stressful when you don't know where you're gonna live. You're gonna have to go to a shelter, where are your kids gonna go. And then, "Do I have a roof over my head."
	"And the gamut can range of, "Do I pay my rent or do I eat. Do I pay my rent or do I go to the doctor." It's constantly juggling."

Community Populations – Focus Group Results

Transportation	"Well, most of the subway stations in this community are not ADA compliant, and they need to be. It's disgraceful."
	"If you're older, it's not going to be – if you don't have a car, how are you going to get there? You can't walk there if you're older and you have problems."
Older Adults and Social Determinants of Health	"Hearing. I'm very hard of hearing. It's even a problem listening to everybody here. I can't afford hearing aids. They're not covered by Medicare. This is an issue."
	"Mobility issues factor into this also. If it's difficult for you to leave your apartment or expensive because you have to take a car service, then you are not likely to do it. Especially when it gets dark and cold and the streets are icy and slippery. Isolation causes depression right there without anything else happening."
	"So, I think depression. We have a lot of high rises here but also a lot of walk-up buildings. So as people age, right, we're talking about Chinatown for example, people become homebound because they're afraid that they cannot walk down the stairs. They are afraid that they're gonna fall, so if they live alone because their children are all grown and they are out of state or out of Chinatown, they become depressed because they cannot go outside. They cannot go to the senior center."

Community Populations – Focus Group Results

Immigrants and Social Determinants of Health	"It's the environment that lends itself to that kind of thing. People come here, they don't speak the language, there's generally a lot of anxiety about food and paying the rent and just getting a job. So, I just think it's a natural environment to have some mental health issues, and I think maybe addressing that proactively is something that should come out of this report."
	"I guess immigration status is one for us that affects everything that you qualify for. And even if you do qualify for it, because of public charge, you don't wanna touch it... It's a major issue. They're disenrolling from programs because of fear. They won't touch SNAP; they won't touch WIC. "
	"When we cannot speak without our own – the English language, when we don't speak, we cannot tell what we feel, what we have problems, then doctors don't understand some medical issues."
Healthcare Access, Use, and Insurance	"I would rather do urgent care for walk in issues than my doctor. Because urgent care will take you 15 minutes. My doctor wait is a couple hours, if I don't have an appointment."
	"Well, in all fairness to the hospital, they do have clinics all over the community. There's a large Medicaid population for whom they provide health care. Every person is not getting the health care they need, there's no question about that, but a large number do. So, we can't minimize that either."
	"The better insurance, the better health care you get. And it doesn't matter whether you're dying. If you can't pay, you can't play."
	"Mental health service does not do that. They do not do outreach."

Community Populations – Focus Group Results

Perspectives on Telehealth	"It will be okay for some problems such as headache, fever and so on. But if it is a big problem, how can a doctor give you an examination when you are not there?"
	"I haven't done it yet, but the big advantage to me is: do you really wanna go in a waiting room in flu season when everyone's hacking all over you."
	"Okay, the computer makes everything easier and all of that. But there are things that should remain old-fashioned. Like the doctor should see you in person. Maybe you didn't notice that there was something wrong with you but if the doctor sees you in person and he's like doing the medical exams personally, he can diagnose you with something you didn't know about."
Social and Supportive Services	"So, there [at this organization] they offer ESL, resume building, HHA [home health aide] classes with job placement. They also do basic computer classes so you can learn how to do your own resume, how to look for jobs, how to look for apartments. And they also help with the lottery for affordable housing. "
	"They have the senior centers with line dancing and anything you'd want – they're free if you live in Yonkers."
	"It's called The Nest…They also provide a lot of support. It's similar to this [organization]. And once a month you can go to – well, they also offer free yoga lessons and with – and they help with childcare. And they also help with English lessons. And they say that once or twice a month you can sit down and talk to someone and share your concerns or personal problems. It doesn't matter. But you have to share with someone. You can tell them what you are going through either something bad or sad. And I think that is good. I never heard of anything like that before. "

Community Populations – Focus Group Results

Faith Based Organizations

"I am Catholic and my daughter she goes to church for communion, but I haven't heard anything about them offering – or asking us – they do ask us to be volunteers, but they don't offer to help, no. And the church where my daughter goes to, there is a school but it's a private school. And none of the things that they offer are free. You have to pay for everything."

"There was an AA group that met over at St. Peter's Church, but I don't know if they still meet there."

Disparities in Available Services

"There isn't a social service office here in Tuckahoe who will help with the benefits like food stamps, Medicaid and things like that."

"I think number one in this community, there's nothing for housing or to homelessness whatsoever."

"There's not even a social services in New Rochelle. You gotta go outside the town."

"I would like to have a work program to help you get a job, and don't discriminate. Just don't look at the – you gotta do a background check, you gotta do this – I know it's right, nobody's hurting anybody on a daily basis. Give people a chance…Once you get charges and stuff, they don't even give you another chance. You're just out there trying to live, and it falls back on this – depression."

Community Populations – Focus Group Results

Additional Programs & Services Needed	"For me, what you were saying how other people come here, I have noticed that, in the basketball courts, there are people from everywhere that come here. And from mere observation, I've noticed it's older men. And so, for me, it's like one of the problems is there's really not anything for the kids that get out of Tuckahoe High School. If they choose to go to a community school and they're home, they really don't have a lot to do"
	"And there aren't any programs in our community where I can say, "Be hospitalized or spend a year or six months so you can be clean that way you can be a better father for your son." But I can't do this because this is missing in our community. What they do give them is syringes so they – so they can get a clean dose. Other than that there's nothing in this community like a rehab center so he can be a part of the community again, so he can be a good person"
	"There's a need for leadership and mentorship. The Police Department is fantastic. I wouldn't say anything against them. They're fantastic as far as response is concerned, but they lack in mentoring these boys."
Culturally Competent Care	"Okay, we've had several deaths in the area, tragic deaths, violent deaths, and things like that, and the kids mourning – They're not kids, they're young people, okay, and they're mourning and they're acting out in ways that they really shouldn't… And I feel that there are trauma specialists who should come in, in these kinds of situations. I know they do it in communities, which are more affluent or whatever. They need to do it here, too, because they've got to find a way of expressing themselves creatively, or expressing themselves in a positive way, without doing damage to things, doing damage to people, and getting people upset, everything like that. "
	"Provide more bilingual staff. I know that language barriers make it really hard for people to get what they need. Sometimes they don't have somebody to translate for them, so it's easier for you as a person to explain what's happening to you as opposed to tell them that this is happening to me, and then they tell them."

Community Populations – Focus Group Results

Increased Access and Availability

"I'm surprised by how long you have to wait in the hospital's waiting room for the simplest thing."

"So, make the home visit program accessible and actually to become a model … for those seniors or homebound patients"

"My thing is what we need to do is give back to the kids, to children, have screenings or programs within the school systems themselves to have the kids grow up with the insight of how to care for themselves because a lot of them is not getting it at home today. A lot of them don't even know their own bodies. So, I think that would be a nice start then from there."

"Like you see sometimes these vans and buses that go around for blood pressure screenings or for this or that. Maybe something like that. I mean, to come literally into the neighborhood and be there so that people are more likely to walk in there than they are to try and find a therapist on their own."

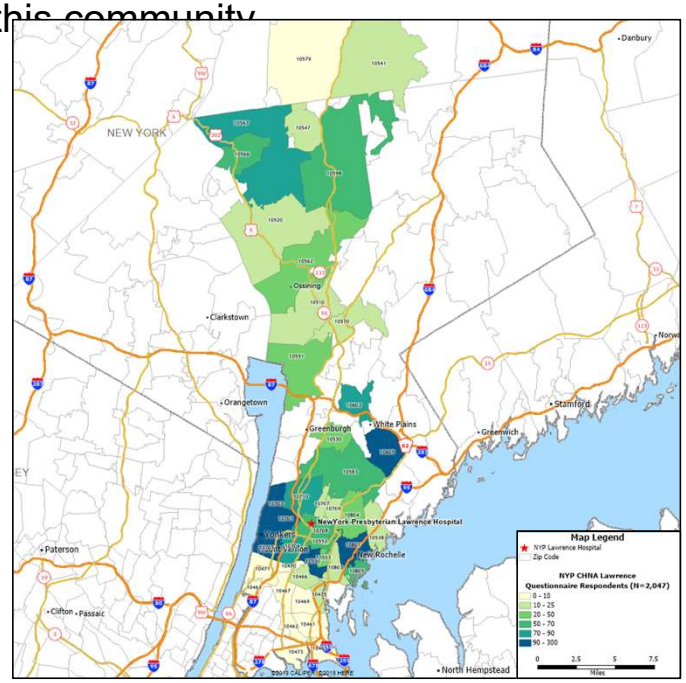
Improve Community Outreach

"Disseminate the information the same way that we disseminate information about a $200 sneaker – pair of sneakers. We have the possibility to put that on our buses, on our trains to educate people about availability of services."

"So, go back to like when you said spread the knowledge and then people will know, there's a lot of programs here for kids, but not any for adults. And the adults have to take care of kids at the same time, so it needs to be more of a universal effort to make sure that everyone as a whole feels good. "

Westchester County Survey – Analysis for Lawrence defined community

This analysis is based on a subset of the Westchester County survey for southern Westchester County, specific to the communities served by Lawrence and the NYP Westchester Behavioral Health Center. Westchester County completed 3,524 surveys and 2,047 respondents reside within the this community



Priority Health Issues in the community where I live*		
Mental health	783	38.3%
Chronic disease screening and care	647	31.6%
Food and nutrition	547	26.7%
Obesity	539	26.3%
Environments that promote well-being & active lifestyles	445	21.7%
Child and adolescent health	425	20.8%
Smoking, vaping, and secondhand smoke	411	20.1%
Substance use disorders	375	18.3%
Physical activity	301	14.7%
Violence	252	12.3%
Food safety and chemicals in consumer products	242	11.8%
Injuries, such as falls, work-injuries, or traffic-injuries	184	9.0%
Maternal and women's health	179	8.7%
Water quality	159	7.8%
Vaccinations/immunizations	151	7.4%
Antibiotic resistance and healthcare associated infections	136	6.6%
Sexually transmitted diseases	130	6.4%
Outdoor air quality	126	6.2%
Newborn and infant health	124	6.1%
HIV/AIDS	96	4.7%
Hepatitis C	45	2.2%

*multiple responses permitted
Note: Percentages may not add up to 100%, due to missing responses.

Westchester County Community Health Summit Summary

The Westchester County Health Planning Coalition collaboratively hosted a Community Health Summit on April 5, 2019 in White Plains, NY. The purpose of this meeting was to elicit feedback from the local community, government and health and social service providers related to their perspective on the health and social needs of their clients with the goal of advancing the New York State Department of Health's 2019-2024 Prevention Agenda (NYSPA) to:

1. Improve the health of New Yorkers in five priority areas; and
2. Reduce health disparities for racial, ethnic, disability and low socioeconomic groups, as well as other populations who experience them.

Over 70 attendees across health and community based organizations participated in the Premier facilitated breakout sessions and a Gallery Walk intended to promote conversation focused upon four of the New York State Department of Health's 2019-2024 Prevention Agenda (NYSPA):

1. **Prevent Chronic Diseases** - chronic disease continues to be a major burden including heart diseases, cancers, diabetes, and asthma
2. **Promote a Healthy and Safe Environment** - in the past several years, water quality has become a major issue that warrants attention and broader environmental factors impact health
3. **Promote Healthy Women, Infants and Children** – there continue to be disparities related to infant mortality, preterm birth, and maternal mortality
4. **Promote Well-being and Prevent Mental and Substance Use Disorder** - opioid overdose has become a major issue, over the past few years

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Westchester County Community Health Summit Summary continued

While familiarity with the topics varied between individuals, all were engaged and focused upon identifying concerns and proposing actionable solutions. Although the facilitated breakout sessions were convened around four very different Priority Areas, common themes emerged across these discussions:

There are many strengths & resources existing in the community.

- Schools and many other non-traditional organizations in the County provide important settings for the delivery of resources for education, training and other needed assistance
- Healthcare organizations across the County were identified as expert resources and critical to coordinate and collaborate with to meet essential needs
- Health providers and Community Based Organizations are skilled at fostering connections, building coalitions, developing networks and collaboration (e.g. this Community Health Summit)
- There is a solid foundation from which to integrate existing and launch new programs

Identification of barriers and gaps is the first step to improvement.

- Begin education and training for healthy behaviors as young as possible (target children and adolescents)
- Observed inconsistent and fragmented education across the community
- Develop culturally specific guidance and messaging (e.g. healthy eating) that is essential for effective communication
- Create safe environments for persons seeking help (undocumented, family violence, mental health disorder stigmas, etc.)
- Understand and align current programs as a first step before building new programs
- Inventory the community's current programs/assets and publish a resource directory in a centralized location that is easily accessible to residents (website, a dedicated phone line, etc.)
- Lack of funding (solo efforts are more challenging to start and to resource thus requiring partnership and collaboration)

Westchester County Community Health Summit Summary continued

There are action items which could benefit all four Priority Areas.

- Utilize social media for education, increased awareness and communication
- Improve transitions and coordination across entire continuum of health providers and community based organizations
- Embrace a person-centric language that is universal to all to increase awareness and reduce stigma, for all too common health needs (mental health, substance use disorders, reproductive health, domestic violence, etc.)
- Include in the care planning process all categories of provider, family and caregiver
- Focus efforts on the basic needs, before trying to address other needs

Social Determinants of Health must be considered when developing strategies.

- Jobs are needed and employers should promote health, offer childcare, and more
- Economic status inequality exists
- Affordable, healthy food is needed and there is a lack of green/farmers markets
- Public transportation is limited across the Westchester County
- There is a need in the community for affordable housing (both permanent and transitional purposes)
- Air quality is inconsistent, and pollutants are carried by the wind from Ohio
- Water quality is threatened due to improper disposal of pharmaceuticals
- Undocumented status frequently restricts outreach to resources due to fear
- Safe places are needed for all to walk, play, exercise and socially engage
- Disparities range across race, gender and age
- Language barriers exist

Westchester County Community Health Summit Summary continued

The session for each prevention agenda topic allowed clinical and non-clinical providers to offer an engaged depiction of the needs of the community and included:

NYSPA #1: Prevent Chronic Diseases

- Chronic diseases were acknowledged as primarily cancer, cardiovascular disease and diabetes.
- Education begins at school to create healthy choices and habits and is critical throughout the age spectrum to promote healthy lifestyle behaviors.
- Economic and “safety” disparities remain throughout the county.
- There are adequate and appropriate resources across the county, but coordination is lacking.
- **ACTION:** Support and leverage existing community resources across homes, schools, churches, CBOs, etc. to address chronic diseases.

NYSPA #2: Promote a Healthy and Safe Environment

- There is an increased recognition that health improvement requires broader approaches addressing social, economic and environmental factors.
- An environment of trust and culturally safe communication must exist between the community and its residents to affect change.
- Ease of access will continue to impact choice and utilization.
- There is need to change the financial incentive structure of public assistance to pay for healthy food options.
- Work is needed with local organizations to increase access to healthier food options.
- **ACTION:** Address currently fragmented and inconsistent education and communication.

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Westchester County Community Health Summit Summary continued

NYSPA #3: Promote Healthy Women, Infants and Children

- The health of women, infants, children and families is fundamental to overall community health.
- There is an abundance of existing resources, but there is a lack of coordination for a communal and publicly accessible platform.
- **ACTION:** Design community awareness campaigns and messaging focused upon prenatal and infant care.
- **ACTION:** Health systems need a holistic care approach that eliminates silos across the continuum.

NYSPA #4: Promote Well-being & Prevent Mental and Substance Use Disorders

- Mental health and substance use disorder was a more popular topic than promoting well-being.
- Inclusivity is needed for extending care planning to family and caregivers and promoting a multidisciplinary approach in treatment.
- There are geographical and affordability barriers to access of mental health care.
- **ACTION:** Break down silos and collaborate through forums such as the 2019 Health Summit.

The results of this report will be used by the Westchester County Health Planning Coalition to help drive this engaged group of community advocates' strategic plan for community health and wellness improvement via a three year community service plan. A full copy of the Westchester County Community Health Summit report may be obtained by emailing a request to community@nyp.org.

Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment

Methods:

- The survey is being administered to patients from HICCC oncology clinics and NYPH ambulatory care network (ACN) clinics, and at community sites including housing shelters in the Bronx through collaboration with COE community partners. Family members of patients are being surveyed too, as many residents in the CA reside within multi-generational households.
- Eligible HICCC cancer patients were identified through the HICCC's Database Shared Resource (DBSR). Patients were contacted via e-mail to participate in the online survey, and they each received four e-mail reminders. When they clicked the survey link, they were directed to a Qualtrics form to complete an online consent. After agreeing to participate, they completed a 35-minute online survey. At the end of the survey, participants were asked if they were willing to share the survey with any family members. All participants and family members who completed the survey and provided mailing addresses received a $10 Target gift card which was sent to their home.
- Data collection for HICCC cancer patients began in May. In the summer of 2019, permission was granted to send surveys to ACN patients and recently the first round of contact with ACN patients was initiated. In addition to surveying patients through the HICCC and ACN, surveys have been conducted in the community in collaboration with community partners. The community health needs assessment is expected to be completed by December 31, 2019.

Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment

Summary of Preliminary Analyses

Selected Key Metrics	HICCC (n=634)	ACN (n=235)	Community (n=152)	Total (n=1021)
Demographics	(%)	(%)	(%)	(%)
Age - Mean	52.1	41.8	42.6	48.2
Hispanic	27.6	70.2	73	44.2
Foreign-born	22.7	29.4	50	28.3
Below Poverty Level	18.5	48.9	37.5	28.3
Primary Prevention Summary				
Overweight (BMI 25-29)	29.7	13.6	27.6	25.7
Obese (BMI ≥30)	27.3	25.5	31.6	27.5
Physically Active	50.6	48.1	51.3	50.1
Current Smoker	1.7	4.3	5.3	2.8
Use of alternate tobacco products (hookah, vape, etc.)	7.9	20.4	1.7	11.3
With Cancer Family History	46.5	32.8	17.8	39.1
Interested in Genetic Testing	67.7	76.2	59.2	68.4
Ever Been Screened for Cancer				
Mammography (n=349)	95.6	90.7	85.7	93.1
Colonoscopy (n=460)	92	84.2	60.3	86.7
Stool Test (n=460)	32.5	27.6	15.5	29.6
Pap Test (n=670)	90.6	86	70.7	86.4
Healthcare Access				
Has Healthcare Coverage	91.2	92.3	69.7	88.2
In Past 12 Months Needed a Doctor but Couldn't Go because of Cost	10.3	11.9	15.1	11.3
Social Determinants				
Number of People in Household – Mean	2.8	3.1	2.9	2.9
Living in Stable Housing in Past 2 Months	92.6	89.4	73.7	89
Worries about Unstable Housing in Next 2 Months	8.5	16.2	15.1	11.3
Easy to buy healthy foods in neighborhood	83.3	80.4	71.1	80.8
≤High School Education	15	21.7	48.7	21.5

Preliminary Analyses Support:

1) Strong interest in genetic screening information across cancer patients and family members, NYPH ambulatory care network (ACN) patients, and the community. Herbert Irving Comprehensive Cancer Center (HICCC) Community Outreach and Engagement (COE) has developed and tested in over 500 individuals (60% of the workshops conducted in Spanish) a precision medicine curriculum that has been very successful in teaching complex concepts like the difference between sporadic and germline mutations.
2) Even though there is a low report of current cigarette smoking, there is a high report the use of alternative tobacco products (hookah, vape, etc.), as high as 20% in patients from ACN clinics.
3) The cancer screening rates are high in the ACN and community respondents, with the exception of colorectal screening rates that are lower in the community.

Next Steps:

- After completion of the target enrollment, a full data analyses will be conducted to examine differences across sources of respondents as well as differences based on demographics, including race/ethnicity, age, geographic location, and socioeconomic status.

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Herbert Irving Comprehensive Cancer Center (HICCC) of Columbia University Cancer Community Health Needs Assessment

This table summarizes the ongoing relevant screening, cancer vaccination, and risk factor data in the HICCC Catchment Area (CA).

Cancer screening and risk factor data in the HICCC CA

		Neighborhoods in NCA				*HICCC CA by County*							
	US (ref)	WH/I	South Bronx	Central Harlem	UWS	Manhattan	Bronx	Westchester	Brooklyn	Queens	Rockland	Staten Island	Bergen
Mammography	78.3	87	76.7	61	70.2	78.6	84	84.8	79.8	81	72	75.1	81.4
Cervical Cancer	81.3	87.9	86.3	87.5	91.5	79.3	80.5	79	81.3	79.6	79.1	86.4	85.3
Colorectal Cancer	69.8	72.1	62.4	78.7	76.5	67.7	71.5	71.3	68.4	61.3	66.8	64.2	64.5
HPV Vaccination (boys and girls)	48.6	72	78	67	52	63	70	23.3*	43	52	9.3*	27	†
Fruit and Vegetable	82	81	83	84	92	90	83	71.4	86	89	74.1	90	†
Any Physical Activity	76.9	77	65	73	83	81	70	77.1	72	70	73.5	75	48.2
Legend		-74.90%	Lower than the US rate				No difference from US rate				Higher than the US rate		110%
Obesity	30.2	26	34	34	10	15	32	17.7	27	22	20.7	25	19.3
Binge Drinking	16.9	24	12	17	19	25	14	20.7	15	15	11	18	14.7
Current Smoker	16.4	13	15	10	10	13	14	9.4	14	14	6.6	16	10.8
Sugary Beverages	32.1	23	34	29	12	17	34	18.5	24	22	23.1	26	†
Legend		-66.90%	Lower than the US rate				No difference from US rate				Higher than the US rate		47.90%

*Girls only; †Data not available

Sources: County Screening: NYC Epi Query 2014 (mammography), 2017 (cervical and colorectal) (https://a816-healthpsi.nyc.gov/epiquery/CHS/CHSXIndex.html); County Risk Factors: NYC DOHMH Community Profiles 2018 (https://www1.nyc.gov/site/doh/data/data-publications/profiles.page); County Screening Rates: NY BRFSS 2016 (https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/data), NJ BRFSS 2015-2017 (https://www-doh.state.nj.us/doh-shad/indicator/view/BrstMamExam.County.html); Rockland and Westchester HPV Vaccination Rates: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/indicator_map.htm; County Risk Factors: NYC DOHMH Community Profiles 2018, NY BRFSS 2016, NJ BRFSS 2015-2017; National, Regional, State, and Selected Local Area Vaccination Coverage Among Adolescents Aged 13–17 Years — United States, 2018. MMWR. 2019; Vol 68/No. 33; HPV rates matched to NYC data time frame (2017).

Summary: CCC's Asset based approach to meeting community needs in Brownsville

Citizens' Committee for Children

Access the full report on the CCC New York website at https://www.cccnewyork.org/wp-content/uploads/2017/03/CCC-Brownsville-Report.pdf.

Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data on Brownsville to establish a method through which to identify assets or resources in the neighborhood of Brownsville in Brooklyn.

The report detailed the neighborhood of Brownsville in Brooklyn is home to over 61,000 residents, including nearly 19,000 children, and is one of several communities in New York City where outcomes along traditional measures of well-being are consistently well below the city average, with children and families experiencing high rates of poverty, crime and homelessness, and poor outcomes in health and education.

In the 2016 edition of CCC's annual Community Risk Ranking, the Brownsville-Ocean Hill community district ranked 4th out of 59 community districts in overall risk, making it one of the highest ranked communities in terms of cumulative risk to well-being.

The study found a shortage of many fundamental resources that should exist in any New York City community:

- **Public transportation options, banks, food retail, housing support services, and after-school and summer programs for older youth** are just some examples of **resources that appear to be lacking.**
- **Fear of crime and violence in the community means that fewer people are using the resources**—from parks to libraries to youth services—**that do exist.**
- L**ack of affordable housing and support services** designed to keep residents in their homes.

Summary: CCC's Asset based approach to meeting community needs in Brownsville continued

In areas—such as childcare and medical care—issues related to convenience and quality, respectively, seem to serve as a deterrent to resource utilization:

- Many residents cited a **lack of childcare and insufficient transportation options as impediments to finding and holding a job**.
- Residents took **issue with the quality of medical care facilities and schools in the area** and expressed a willingness to travel whenever possible to access higher quality healthcare and education options.

Recommendations specific to health:

- **Incentivize the opening of additional food retail**—particularly in the southern part of Brownsville—and ensure that healthy food options are available to all Brownsville residents year-round.
- **Explore opportunities to improve access to healthy affordable foods** in the community, such as shuttle or bus service to supermarkets in neighboring districts, and to increase awareness of the USDA pilot program, set to commence in August 2017, which will allow SNAP recipients to purchase groceries online.
- **Conduct outreach to ensure that residents are aware of medical and mental health services and encourage utilization** of necessary services, particularly pre-natal care for pregnant women and mental health services.

Summary: CCC's Elmhurst/Corona, Queens Report for Community Driven Solutions to Improve Child and Family Well-being

Placeholder - pending CCC approval to use

Citizens' Committee for Children

Access the full report on the CCC New York website at https://www.cccnewyork.org/

Citizens' Committee for Children of New York (CCC) utilized existing government data on child and family well-being, mapped community assets and engaged in conversations with community members to prepare an assessment for Elmhurst/Corona.

The report details Queens Community District 4 - Elmhurst/Corona - and the five neighborhoods in the area: Corona, North Corona, Elmhurst, Elmhurst-Maspeth, and East Elmhurst.

Elmhurst/Corona is culturally diverse and has the largest share of immigrant households of any Community District (CD) in the city—a meaningful designation for a community located in the borough of Queens, the most diverse county in the United States.

- The Elmhurst/Corona CD has the **highest share of foreign-born residents, with nearly two-thirds of the population hailing from outside the country**.
- **More than 50% of the district identifies as Latinx**, and the share of Latinx children is north of 60%.
- **A third of households in the district are considered "linguistically isolated**," meaning no one in the household age 14 or older speaks English "very well."
- In 2017, **more than half of all children in the district lived in households below 200% of the Federal Poverty Level.**
- Employment and labor force participation is high, but the types of **jobs held by residents may not provide enough income to support a family.**
- **Despite** a **declining rate of uninsured children, lack of insurance continues to be an issue.**
- **Only 54% of residents consider their housing to be affordable**, and the consequences of rising rents mean that overcrowded units and 'doubled up' families are more common.

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Summary: CCC's Elmhurst/Corona, Queens Report for Community Driven Solutions to Improve Child and Family Well-being

Placeholder - pending CCC approval to use

The most common needs raised during conversations:

- Affordable Housing to Reduce Overcrowding
- Opportunities for Families to Spend Time Together
- Multigenerational Approaches to Mental Health
- Supports for Immigrant Households
- Early Education and Afterschool Programing
- Safety in Public Spaces and at Home
- Information and Support to Access Existing Opportunities

Recommendations specific to health:

- Further **develop public awareness campaigns and multilingual advertising about health insurance and health care programs** to inform residents, especially those who may be undocumented, about free or low-cost programs available to all New Yorkers
- **Boost public awareness of existing health care programs and services** through local multilingual media and advertising in schools, laundromats, doctor's offices, libraries, and public transit
- **Invest in farmer's markets and local stores to provide healthy, organic, and affordable produce** in the neighborhood
- **Ensure families who are eligible for SNAP, WIC, and similar programs, or who need emergency food are able to access these services** in spite of federal policies, such as the "Public Charge Rule," which target these programs to manipulate immigration policy

Summary: Report on improving the needs of children and families living in the North Shore of Staten Island

Citizens' Committee for Children

Access the full report on the CCC New York website at https://www.cccnewyork.org/wp-content/uploads/2018/09/North-Shore-Report.pdf

Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data on seven neighborhoods that make up the North Shore—Grymes Hill-Park Hill, Mariner's Harbor, Port Richmond, Stapleton, St. George-New Brighton, West Brighton, and Westerleigh.

The North Shore is a microcosm of New York City as a whole in a way that most community districts are not:

- The **North Shore is one of only 10 community districts in the city where no racial/ethnic group represents more than 40% of the population**. However, across the seven neighborhoods that make up the North Shore, the demographic characteristics of the population and outcomes vary greatly.

Another area in which the North Shore embodies NYC is the vast disparities in income that exist across the district:

- **No other community district has such high shares of residents both living in poor households and in higher income households,** and there are large differences in average income across and within neighborhoods.
- There is **no subway service in and out of Staten Island**, meaning residents are largely reliant on the bus or their own vehicles to move across the district and into other boroughs. However, access to a vehicle varies dramatically by income level.
- **Uninsured rates among children and adults on the North Shore are lower than citywide, but some caregivers interviewed shared frustrations with finding health care providers** on the North Shore who accept their insurance.

NewYork-Presbyterian

Summary: Report on improving the needs of children and families living in the North Shore of Staten Island continued

In order to address these challenges and others, residents and service providers have come together to engage in efforts to improve outcomes across the range of issues impacting child and family well-being:

- This community has **developed multiple collective impact initiatives** (a term describing a systematic approach to collaboration among organizations aligned by a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and support from a backbone organization tasked with coordinating the partnership) to improve their overall well-being.
- Among these initiatives are - Staten Island Child Wellness Initiative; City Harvest; Community Health Action of Staten Island; Child Asthma Coalition; Staten Island Perinatal Network; Staten Island Performing Provider System; Staten Island Mental Health Society; Tackling Youth Substance Abuse (TYSA); Heroin Overdose Prevention and Education (HOPE) and others.

Recommendations specific to health outcomes and access:

- **Create outreach and awareness campaigns to ensure North Shore residents who are uninsured and eligible for Medicaid or other health coverage plans are enrolled**, as well as taking advantage of nutrition programs such as WIC and SNAP.
- **Convene health care providers and health-focused coalitions** on Staten Island to develop ways to address barriers residents face, finding providers within the borough who accept their health insurance coverage, especially specialized health care providers.
- **Expand on existing nutrition and food security initiatives**, by offering shuttle van services for low income residents who live far from large food retail locations and promoting EBT card payment for grocery deliveries.
- **Explore innovative ways to create more green spaces** in areas where residents are not within walking distance to a park and/or bring children to parks outside of their neighborhood.

Summary: CCC's Comprehensive Assessment of the needs of children and families in Northern Manhattan

Citizens' Committee for Children

Access the full report on the CCC New York website at https://www.cccnewyork.org/wp-content/uploads/2018/05/CCC-Northern-Manhattan_FINAL.pdf.

Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data (interviewing service providers and holding workshops and focus groups for residents to express their views and inform the report topics) on northern Manhattan to provide a comprehensive assessment of the needs of children and families in the area, and available resources.

The report focuses on the community districts of West Harlem, Central Harlem, and Washington Heights, and identified that children and families facing multiple risks to well-being are disproportionately black and Latino.

Findings suggest the neighborhoods of northern Manhattan each face unique challenges:

- Manhattanville in West Harlem has the lowest levels of employment among adults and lowest average household income;
- Central Harlem has the highest rates of homelessness and most worrisome child and adult health outcomes; and
- Washington Heights faces high levels of linguistic isolation and low levels of adult educational attainment.

There are also issues that are universal across these neighborhoods:

- The poverty rate in each northern Manhattan neighborhood is higher than the citywide rate.
- At schools in each neighborhood (with the exception of Morningside Heights in West Harlem) students perform well below the citywide level in state-mandated English Language Arts and Math exams.

Summary: CCC's Comprehensive Assessment of the needs of children and families in Northern Manhattan continued

The data also point to areas in which there has been significant improvement in northern Manhattan:

- The uninsured rate for both children and adults has decreased substantially—faster than it has citywide—and only 1% of children in West Harlem and Washington Heights lack health insurance.
- The teen birth rate has dropped considerably in each district, at a faster rate than it has citywide.
- Poverty rates are higher and average incomes are lower. However, each northern Manhattan community district has experienced greater increases in average income—and larger decreases in poverty.

Recommendations specific to health and wellness:

- **Increase outreach to promote and improve participation in WIC** and other health and nutrition programs
- **Promote a whole-family approach to physical and mental health services** by offering both children and caregivers social supports and other types of assistance when one or the other receives assessment or treatment
- **Establish linkages between mental health service providers and institutions outside of health and mental health clinics**—such as schools, churches, libraries and other community-based organizations—in an effort to reduce barriers and stigma around accessing mental health services
- **Leverage schools, churches, and community-based organizations** to establish and/or host peer supports for parents and young people

Written comments on most recently adopted CHNA and implementation strategy

NewYork-Presbyterian Hospital has not received written comments regarding its 2016-2018 Community Health Needs Assessment nor its 2016-2018 Community Service Plan.

Your feedback on this report is welcomed. You may send written comments to or request more information on this 2019 Community Health Needs Assessment at community@nyp.org.

AMAZING THINGS ARE HAPPENING HERE

Prioritization of Significant Health Needs

NewYork-Presbyterian

Westchester County Health Planning Coalition Selected Priorities

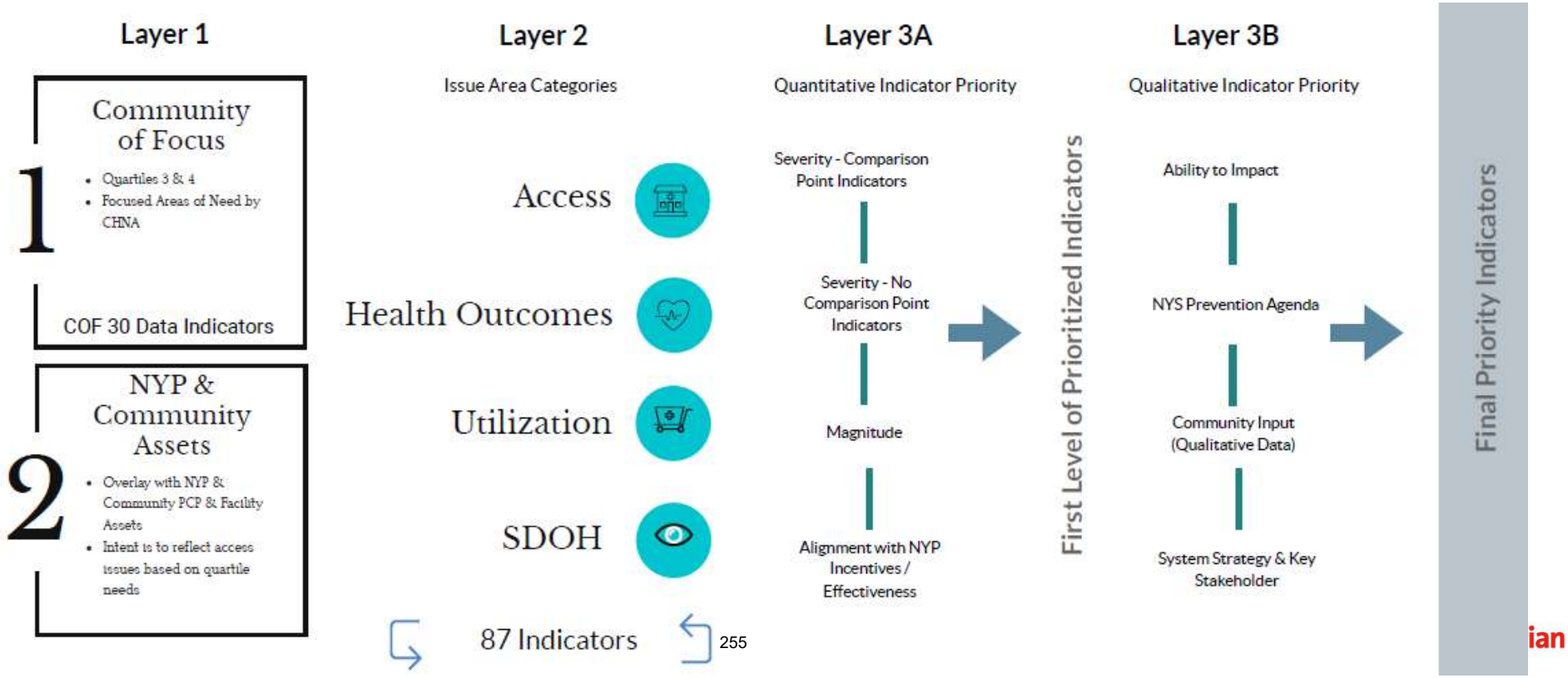
The Westchester County Health Planning Coalition (WCHPC), inclusive of the Westchester County Department of Health (WCDOH) and the sixteen local Westchester County Hospitals, formed in response to the New York State Department of Health's appeal that each county's local health department, hospitals/hospital systems and other community partners collectively work together to identify and address local health priorities associated with the New York State Prevention Agenda (NYSPA).

Together they selected the below planned areas of focus for the next 3 years:

1. Prevent Chronic Diseases
2. Promote Well-Being and Prevent Mental and Substance Abuse Disorder

Prioritization of Significant Health Needs – Overview of Method

The prioritization method allowed the NYP team to narrow a vast amount of quantitative and qualitative data sets and define the highest disparity community and health indicators impacting that community. The model utilizes a layered approach based on the Hanlon method to incorporate the quantitative and qualitative data as well as the alignment with NYP initiatives and resources and key stakeholder input.



Prioritization of Significant Health Needs – Overview of Method

Full Model with Ranking and Weighting

		Prioritization Category	Definition	Type	1 - LOW	2 - MODERATE	3 - HIGH	Weight
Layer 1	**Layer 2**	**Layer 3**						**Priority Value**
		Layer A - Identify Significant Health Needs Step #1						
Community of Focus - COF Indicators Define Areas of Need	Issue Area Categories Access Health Outcomes Utilization SDOH	Severity - Comparison Point Indicators	Seriousness of Problem Variance to Local or State Comparison Point	Objective - Data Pre-Populated	Comparison Variance to be determined upon indicator analysis (range)	Comparison Variance to be determined upon indicator analysis (range)	Comparison Variance to be determined upon indicator analysis (range)	30%
		Severity - Non Comparison Point Indicators	Seriousness of Problem Key Stakeholder Perception of Serverity	Subjective - Key Stakeholder Input	Hanlon Method 0 - Not Serious 1 - 2 - Relatively Not Serious	Hanlon Method 3 - 4 - Moderatley Serious 5 - 6 - Serious	Hanlon Method 7 - 8 - Relatively Serious 9 - 10 - Very Serious	5%
		Magnitude	Size of Problem Amount of Population Impacted	Objective - Data Pre-Populated	Hanlon Method 1 - 4 .1% - .99%	Hanlon Method 5 or 6 1% - 9.99%	Hanlon Method 7 - 10 > 10% of population	40%
		Alignment with NYP Initiatives / Effectiveness of Initiatives to Need	Alignment of NYP Active Initiatives & the Effectiveness of Initiatives	Objective - Initiative Tracker & Population Health Think Tank Meeting #2	Hanlon Method 0 -< 5% effective 1 - 2 - 5% - 20% effective	Hanlon Method 3 - 4 - 20% - 40% effective 5 - 6 - 40% - 60% effective	Hanlon Method 7 - 8 - 60% - 80% effective 9 - 10 - 80% - 100% effective	25%
		Layer B - Identify Significant Health Needs Step #2						
		Availability to Impact / Available New Resources of Funding / People / Process	Resources Available & Funding Availability Community Partnership Impact Patient Compliance Impact	Subjective - Key Stakeholder Input Population Health Think Tank Meeting #2	Hanlon Method 0 -< 5% potential 1 - 2 - 5% - 20% potential	Hanlon Method 3 - 4 - 20% - 40% potential 5 - 6 - 40% - 60% potential	Hanlon Method 7 - 8 - 60% - 80% potential 9 - 10 - 80% - 100% potential	10%
		NYS Prevention Agenda	Prevention Agenda Initiative	Objective - Data Pre-Populated	Not on Prevention Agenda & Not on Previous CSP	On Prevention Agenda & Not on Previous CSP	On Prevention Agenda & On previous CSP	40%
		Community Input (Focus Groups & Surveys)	NYAM Key Findings Summaries from Focus Groups & Surveys	Objective - Data Pre-Populated	Pending NYAM Summaries Occurrence Count for focus group & surveys			40%
		System Strategy & Key Stakeholder Input	System & Key Stakeholder Subjective Input	Subjective - Key Stakeholder Input Population Health Think Tank Meeting #2	0 - 10 Score by Leader & Rank Ordering in Category			10%

Prioritization of Significant Health Needs

The data identification and prioritization process for NYPH resulted in numerous indicators falling into the 4th quartiles. At a high level, these indicators can generally be grouped into:

1. Women's Health
2. Obesity
3. Mental Health & Substance Abuse
4. HIV
5. Cancer

These will be used to inform the CSP strategy for NYPH. The focus will not preclude NYPH from initiatives not related to the focused priorities but allows NYP to invest in new opportunities of impact. Existing hospital strategies related to cancer, hypertension, cardiovascular, etc. will continue to evolve as leading strategies.

Geography	CATEGORY	INDICATORS	QUARTILE
NYC & Non-NYC Counties	SDoH	Binge Drinking	4th
NYC	Health Outcomes	Cancer Incidence - Lung	4th
NYC & Non-NYC Counties	Utilization	Hospitalizations: Drug	4th
Non-NYC	Health Outcomes	Cancer Incidence - Prostate	4th
NYC & Non-NYC Counties	Health Outcomes	Diabetes	4th
Non-NYC	Health Outcomes	HIV	4th
NYC & Non-NYC Counties	Health Outcomes	Physical Activity	4th
Non-NYC	Health Outcomes	% of adults taking high blood pressure medication	4th
NYC & Non-NYC Counties	Utilization	Hospitalizations: Psychiatric	4th
Non-NYC	Health Outcomes	Cancer Incidence - All Sites	4th
NYC & Non-NYC Counties	Health Outcomes	Cancer Incidence - Breast	4th
Non-NYC	Health Outcomes	Cancer Incidence - Colon and Rectum	4th
NYC & Non-NYC Counties	Health Outcomes	Childhood Obesity	4th
Non-NYC	Utilization	Hospitalizations: Preventable Diabetes	4th
Non-NYC	Utilization	Hospitalizations: Preventable Hypertension	4th
NYC & Non-NYC Counties	Health Outcomes	Obesity	4th
Non-NYC	SDoH	Current Smokers	4th
Non-NYC	Utilization	Hospitalizations: Alcohol	4th
NYC & Non-NYC Counties	Health Outcomes	Preterm Births	4th
Non-NYC	SDoH	Sugary Drink Consumption	4th
Non-NYC	Health Outcomes	Teen Births	4th
NYC & Non-NYC Counties	Health Outcomes	Hep C	4th

AMAZING THINGS ARE HAPPENING HERE

Previously Conducted CHNA

NewYork-Presbyterian

NYPH Impact Evaluation of 2016-2018 Implementation Strategy

- The NYPH 2016 CHNA found that chronic diseases, mental health, and HIV were important areas of need in the NYPH service areas.
  - Community members and focus group participants reinforced public health data, identifying cancer, cardiovascular disease, asthma, depression, diabetes, and obesity as major concerns.
  - Tobacco use was cited as a major contributor to all of the chronic diseases identified in NYPH's service area and was targeted in the 2016 Plan with an evidence-based set of tobacco cessation interventions.
  - In addition, our analysis found disparities in the incidence, prevalence, and treatment of HIV in the NYPH service areas.

- Based on these findings, the 2016 CSP Plan laid out a plan for action aligned with the New York State Prevention Agenda Priorities to address three areas:
  1. Prevention of chronic diseases by increasing access to tobacco cessation resources,
  2. Promoting mental health and prevention of substance abuse, and
  3. P\revention of HIV, STDs, and vaccine preventable diseases.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Chronic Disease: Promote tobacco use cessation, especially among low SES populations and those with poor mental health	Increase access to smoking cessation resources	Identify patient materials; educate providers about resources and disseminate to patients	Y Complete	In addition to developing the online training for providers described below, the NewYork-Presbyterian (NYP) Performing Provider System (PPS) helped developed patient education materials, including information on Nicotine Replacement Therapy. The team also developed a tri-campus tobacco cessation brochure which is available to all Ambulatory Care Network (A.C.N.) patients.
		Create linkages with local healthcare providers to increase access	Y Complete	Referrals to New York State (NYS) Quitline did not materialize because of delays with Information Technology (IT). In 2017 NYP implemented a patient navigator program with a navigator dedicated to tobacco cessation. As of the writing of this report, the navigator has performed over 3,500 patient education sessions, made 2,600 patient touches that include pharmacy follow-up and appointment reminders. She has conducted several community events disseminating information to the larger community and providing information to adults who may not be part of the NYP network to other resources.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Chronic Disease: Promote tobacco use cessation, especially among low SES populations and those with poor mental health	Increase capacity to address and treat tobacco use amongst community residents	Promote policy change by participating in the citywide Smoke Free NYC (formerly Manhattan Smoke-Free Partnership)	Y In progress	• In 2017, NYP launched the NYPH-Columbia-Cornell Smoke Free Initiative. • In 2018, NYPH continued its relationship with the citywide Smoke Free NYC, attending the two coalition meetings.
		Disseminate smoking cessation information in Lower Manhattan, Upper Manhattan, and among low-income families on the Upper East Side	Y In progress	• NYPH conducted five wellness lectures for the community discussing the danger of smoking and its role as a contributing factor for many chronic illnesses. A total of 360 people attended, with 103 receiving a spirometry screening. • NYPH also implemented “Quit Smoking” – an interactive approach developed by the Chinese Community Partnership for Health (CCPH) to provide smoking cessation information during outreach initiatives to 250 community members. • In Jan – June of 2019 multiple wellness lectures on tobacco cessation within the context of chronic illness including HIV and substance use were offered. A total of 310 people attended these lectures that were held through the Ryan Center, Union Settlement, and Living Positive - organizations that service low-income populations living with HIV/AIDS and/or in recovery from substance use.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Chronic Disease: Promote tobacco use cessation, especially among low SES populations and those with poor mental health	Foster inter-disciplinary approach to treating tobacco use	Create online training modules for providers, supplemented with face-to-face sessions	Y Ongoing	NYP created an online training module based on standards from the Centers for Disease Control and Prevention (CDC) and NYC.gov. The training, which helps staff make more effective cessation referrals, is being offered to NYP staff, community organizations, and members of the NYP Delivery System Reform Incentive Payment (DSRIP) PPS. As of June 2019, approximately 210 NYPH providers and other team members (i.e. Medical Assistants and Social Workers) took the module, which is supplemented with face-to-face sessions.
		Implement electronic referral to NYS Quitline	N Replaced activity with Tobacco Cessation Service Texting Campaign	NYP had to suspend its plans to make electronic referrals to NYS Quitline because of IT challenges. In its place, it leveraged its existing IT platform to roll out an innovative texting campaign, with over 26,000 texts sent to a targeted patient population in 2018. In January 2019, the effort was expanded to include over 10K emails in addition to texting.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Chronic Disease: Promote tobacco use cessation, especially among low SES populations and those with poor mental health	Foster inter-disciplinary approach to treating tobacco use	★ New activity implemented since 2016 - Tobacco Cessation Dashboard Development	Y Complete	The NYPH ACN Tobacco Cessation Dashboard was developed in 2018 using Meaningful Use screening standards to allow the West Campus TCS team to monitor the following data points in order to tailor programming as needed: • Number/percentage of patients in the ACN screening for tobacco utilization- (34,853/42,290)=82% (2018); 86% (Aug 2019) • Number/percentage of patients in the ACN who were screened and identified as "Current Smoker"- (2,802/34,853)=8% (2018) 7% (Aug 2019) • Number/percentage of patients in the ACN who were screened and identified as nicotine dependent-(635/2,854)= 22% (2018); 29% (Aug 2019) • Number/percentage of patients in the ACN receiving a prescription related to tobacco cessation (i.e., Chantix)-(476/2,802)=17% (2018); 27% (Aug 2019) This information can be viewed at the practice and provider level to assess patient flow and providers who are prescribing tobacco cessation treatment on their own. It can also be analyzed at the patient level to include date of visit, patient demographics, and Meaningful Use designation of level of "Readiness to Quit". On average the dashboard is viewed by tobacco team members 2x/per week

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objectives	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Mental Health: • Promote mental, emotional and behavioral well-being in communities. • Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery • Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention	Provide community access to mental health programs	Westchester Campus will sponsor the Addictions Recovery Fair and Mental Health Fair to familiarize community residents with available resources in Westchester	Y	These planned activities were implemented in 2018, and some continue as part of NYP's mental health improvement efforts in the community. However, new evidence-based interventions were selected in place of these with the goal of improved measurement and impact.
	Provide information on mental health issues and tools to cope with them	Westchester Campus will sponsor a Community Lecture Series: 8 lectures per year providing information on a variety of mental health topics such as depression, autism, addictions, etc., and tools to address them	Y	
		Speakers' Bureau: Clinicians provide professional development, talks at houses of worship, etc., on mental health topics	Y	
		Community Newsletter	Y	

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objectives	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Mental Health: • Promote mental, emotional and behavioral well-being in communities. • Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery • Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention	Train community members to better identify the early signs of depression and other mental illnesses	Provide Free Mental Health First Aid (MHFA) and Youth MHFA courses	Y Ongoing	MHFA trainings have been offered to parents, teachers, NYP employees, and clergy. As of October 2018, over 200 individuals were trained. An additional 125 people were trained by August 2019. Pre- and Post- tests during mental health training and yearly surveys
		Invite local clergy to a Mental Health Breakfast Summit to promote awareness of the challenges of mental illness in our communities	Y Completed	In October 2018 NYPH hosted its second annual Mental Health Summit for faith leaders focused on trauma-informed care and fostering resiliency. Approximately 100 faith leaders attended the symposium. The third faith leaders summit is scheduled for October 2019.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objectives	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Mental Health: • Promote mental, emotional and behavioral well-being in communities. • Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery • Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention	Provide onsite assessment of mental health issues when no psychiatrist is present	Increase the availability of clinical assessment for Mental, Emotional, and Behavioral (MEB) health through the introduction of Tele- psychiatry in the Emergency Room (ER)	Y In progress	• Program was piloted with 8 students who used the School Based Behavioral Heath Telemedicine program in 2018 where they were able to have remote visits with a licensed psychiatrist. • Feed back from the program has received positive reviews, as students stated that they were comfortable with their tele-health visits, and were happy that they did not have to leave school for follow-up visits. • Second year of pilot program includes 6 students and 19 visits that used the School Based Behavioral Health Tele-Medicine program. • We were able to provide the service in 4 out of our seven School Based Health Center (SBHC) sites. While July through November 2018 were challenged by the absence of program psychiatrist due to maternity leave, we were able to build the caseload of psych patients beginning in December for this service though the rest of the academic year. • Recently, we finalized registration clinic codes for 3 additional sites which will allow for expansion of this service to all seven SBHC sites as soon as technology is provided (Avizia carts). Our goal is to continue to strategically utilize the one day of psychiatric consultation with Dr. Rego across our 7 SBHC sites and maximize her appointment schedule.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Mental Health: • Promote mental, emotional and behavioral well-being in communities. • Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery • Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention		★ New activity implemented since 2016 - The Behavioral Health (BH) Crisis Hub	Y Ongoing	Crisis Hub provides resources to manage community patients in crisis and also acts as a resource for providers needing linkage assistance. Community Health Workers insure that patients are linked to primary and mental health care in a timely manner. Since January 2017, 749 calls have been triaged by the Crisis Hub and assisted 560 patients with care ranging from referral information & resources, to face-to-face brief treatment/linkage. Referring sources include NYPH, Gracie Square, Mount Sinai Hospital, Metropolitan CMH, NIMC, and self referrals. The Crisis Hub has continued to serve an additional 140 patients this year. The services provided have been integrated into the Adult Outpatient Psychiatry clinic and is now working in unison with the larger service to provide access to behavioral health services. Linkage to community based organizations continues to be an important component of the model in creating a safety net in Northern Manhattan. Another component of the Crisis Hub is the Critical Time Intervention team, providing wrap around psychiatric care within the community. In 2019, the program has served 45 unique individuals including 24 new patients.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Mental Health: • Promote mental, emotional and behavioral well-being in communities. • Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery • Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention		★ New activity implemented since 2016 - Youth Hubs	Y Ongoing	In 2017, NYPH in collaboration with Columbia University Irving Medical Center, was awarded a grant from the Manhattan District Attorney's Office Criminal Justice Investment Initiative to launch a youth opportunity hub in northern Manhattan. In partnership with community-based organizations, NYP's Uptown Hub can serve over 250 at risk youths ages 14-25 with needed resources and services, including trauma-informed mental health treatment and substance use counseling. In 2018 the Hub enrolled 109 young adults with approximately 25% receiving behavioral health services at NYP. By Aug 2019, those numbers had increased to 265 and 80%, respectively.
		★ New activity implemented since 2016 - Development of a 16-member, community provider substance abuse work group to enhance referrals to licensed OASAS providers	Y Complete	Moreover, to tackle substance use disorder, NYP successfully developed a 16-organization the Substance Use Disorder (SUD) workgroup where community Providers work together to enhance referrals to licensed OASAS providers.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Mental Health: • Promote mental, emotional and behavioral well-being in communities. • Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery • Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention		★ New activity implemented since 2016 - Educational offerings to community providers of NARCAN training.	Y In Progress	NYPH and Weill Cornell Medicine collaborated to deliver five community trainings on using Naloxone to prevent overdoses. Eighty-four community members received this life-saving training on how to identify when an overdose may be happening and how to administer Naloxone.
		★ New activity implemented since 2016 - Development of partners with diversified levels of care including detox services, rehabilitation services and Medication Assisted Treatments (MAT) to strengthen the Substance Use Disorder (SUD) work group	Y Ongoing	This is an on-going endeavor as NYPH identifies more partners to include in the workgroup.
		★ New activity implemented since 2016 - Collaborative work with DOHMH around education and training for MAT providers.	Y Complete	Currently have had 10 providers trained in MAT, working with DOHMH for more training opportunities and to expand training to other portals within the hospital.
		★ New activity implemented since 2016 - Initiation of pilot program for expedited ambulatory MAT treatment	Y Complete	Implemented pilot. Currently serving patients identified in the NYPH portals with opioid use disorders.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Mental Health: • Promote mental, emotional and behavioral well-being in communities. • Support collaboration among professionals working in fields of mental, emotional, behavioral health promotion and chronic disease prevention, treatment and recovery • Strengthen infrastructure for mental, emotional behavioral health promotion, and mental, emotional behavioral disorder prevention		★ New activity implemented since 2016 - School Based Health Center trainings and community workshops	Y In Progress	• NYPH's 13 school-based mental health centers, which serve 23 public schools and 7 school based centers in Harlem, Washington Heights/Inwood, and the Bronx, provide ongoing teacher training in behavioral approaches and emotion regulation to improve mental health and educational outcomes for children from low socio-economic status (SES) and high community stress neighborhoods. • 69 classrooms teachers received training in behavioral approaches and emotional regulation to improve mental health and education outcomes. • # of parent workshops: 19 @ 5 schools, 193 parents attended • # of Parent Management Sessions (5 groups each 10 sessions) total of 61 parents attended. • # of District 6 Parents Association Meetings: 2 (19 participants each time)

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Communicable Disease: • Decrease HIV morbidity • Increase early access to and retention in HIV care • Decrease STD morbidity	Increase the number of Medicaid beneficiaries who received two sequential anti-retroviral medication scripts and/or attended two office visits within the previous 12 months	Increase early access to and retention in care for both undiagnosed and known HIV+ residents in order to increase viral suppression & prevent transmission and avoidable hospitalizations	Y In Progress	• The percentage of newly diagnosed patients who were virally suppressed increased from 62% in 2016 to 84% in 2017 at NYP Cornell. • The overall number of patients engaged in care was significantly higher between 2016 and 2017 (2,666 and 2,837 respectively), with 99% prescribed Antiretroviral Therapy (ART), and 90% of engaged patients were virally suppressed. • The Columbia Irving Medical Center campus also saw the number of previously diagnosed patients engaged in care significantly increase between 2016 and 2017, from 1,871 to 2,039. • In 2018, the NewYork-Presbyterian Hospital serviced 3,981 patients in the Columbia University Irving Medical Center campus (West campus). At the end of the year, our Comprehensive Health Program (CHP) had 2,092 active patients of which 287 were new to the program in 2018. Viral suppression among established patients (n=1813) was high at 88%. The rates of ARV therapy and viral load testing (VLT) were above optimal levels (99%) for these previously established patients. Analysis of new-to-care patients showed low rates of viral suppression (66%), but higher rates of ARV therapy (98%) and VLT (96%). continued on next page -

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Communicable Disease: • Decrease HIV morbidity • Increase early access to and retention in HIV care • Decrease STD morbidity	Increase the number of Medicaid beneficiaries who received two sequential anti-retroviral medication scripts and/or attended two office visits within the previous 12 months	Increase early access to and retention in care for both undiagnosed and known HIV+ residents in order to increase viral suppression & prevent transmission and avoidable hospitalizations	Y In Progress	continued from prior page • The rates of viral suppression are reflective of the ongoing challenges in engaging this group of patients. The majority of our new patients in 2018 were patients transferring their care and not those returning to care. A review of linkages to care among internally diagnosed patients revealed the need for improvement to linkage closer to diagnosis date. We faced some challenges providing adequate 3-day linkage to care for internally diagnosed patients. Of the 52 internally diagnosed patients, a quarter of these patients were linked to care within 3-days. However, linkage to care did improve over time to 42% within 7-days, 62% at 30-day and 71% at 90-day. Overall, 90% of the patients diagnosed internally at one of our ambulatory sites or the ED were linked to care. The rate of viral suppression among newly diagnosed patients was 72% excluding those who linked to care outside of NYP. However, for some of these patients, we could not confirm their engagement in HIV care. Among newly diagnosed patients, the rates of ARV therapy and VLT were high (89% and 95% respectively). Furthermore, patients newly diagnosed in the ambulatory setting showed optimal levels of suppression within 91-days of HIV care initiation, but improvements are needed for suppression after discharge among those diagnosed while inpatient.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Communicable Disease: • Decrease HIV morbidity • Increase early access to and retention in HIV care • Decrease STD morbidity	Increase the number of Medicaid beneficiaries who received two sequential anti-retroviral medication scripts and/or attended two office visits within the previous 12 months	Co-locate primary care, Hepatitis C Virus (HCV), psychiatry, substance abuse treatment, dental care, GYN care, geriatric services, anal cancer screening and treatment, social work and nutrition services at both the east and west NYP campuses	Y Complete	• Both NYP/East and West ambulatory programs: Comprehensive Health Program and Center for Special Studies who provide HCV care and treatment have co-located services including Care Coordination, Behavioral Health services for MH and SUD, nutrition services, and anal cancer screening. See HCV linkage data below.
		Promote the delivery of services (i.e., PrEP/PEP) at ambulatory centers, community partners to at-risk individuals (e.g., partner services) to keep them HIV-free	Y In Progress	• With the help of select programs (the NYPH Comprehensive Health Program and the NYPH Center for Special Studies) there has been a rapid expansion of HIV prevention services that include the promotion of pre-exposure prophylaxis, or PrEP, an HIV prevention strategy in which HIV-negative individuals take anti-HIV medications to reduce their risk of infection. Between 2016 & 2017, unique patients assessed for PrEP increased 324%, and patients started on PrEP increased 374%. Between 2017 and 2018, there was a continued expansion of HIV prevention services (Pre- and Post- exposure Prophylaxis, PrEP and PEP): – Unique patients assessed for PrEP increased from 830 (2017) to 952 (2018) – 567 unique patients started on PrEP in 2018 – 254 unique patients started on PEP in 2018 and 46 transition to PrEP

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Communicable Disease: • Decrease HIV morbidity • Increase early access to and retention in HIV care • Decrease STD morbidity	Increase the number of Medicaid beneficiaries who received two sequential anti-retroviral medication scripts and/or attended two office visits within the previous 12 months	Address co-factors that impact engagement in care and health outcomes, e.g., homelessness, substance use, history of incarceration, mental health: increase mental health services at NYP, link patients from NYP to programs addressing social determinants	Y In Progress	• The primary mechanism for addressing co-factors is through care coordination and community navigation. In 2017, 1,479 people received care coordination / community navigation services. - Clinic based intensive medical case management services for an active caseload of 137 patients - Transitions of care for 154 patients who had inpatient admissions. - Transitions of care for 391 patients who had ED admissions - Community based navigation for 664 patients.
	Increase access to HIV care	ED Navigator to refer patients to available infectious disease physicians at another campus or arrange to have physician on site	Y In Progress	• ED Navigators has utilized community providers and Weill Cornell physicians for referrals.
		Expand HIV testing and preventive services (PEP, PrEP) capacity to accommodate walk-ins and referrals	Y In Progress	• 40% increase of same day visits: 1,356 (10/15 - 9/16) vs. 1886 (10/16 - 9/17) to improve access for both PLWH and at risk of HIV • In 2018, CHP continued to support HIV testing and PrEP/PEP services during the CHP weekly evening clinic. This walk-in clinic accommodates same day services and referrals for HIV prevention services.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Communicable Disease: • Decrease HIV morbidity • Increase early access to and retention in HIV care • Decrease STD morbidity	Increase access and engagement in Hepatitis C (HCV) care; increase access to STD screening and treatment	Community partner joint staffing Mobile Medical Unit (MMU) for HIV testing, HIV prevention services, and identification of HIV+ clients lost to care to promote re- engagement. Identify and engage clients not currently in care or at risk for HIV and engage in prevention services	Y In Progress	• In 2017, outreach and engagement in care was facilitated through the REACH (Ready to End AIDS and Cure Hepatitis C) Collaborative between NYP and 6 Community Based Organizations. DSRIP funding through NYP supported 10 Community Health Workers / Peers and HIV/HCV testing supplies. Joint events included the following: 5/13/17- Big Bold and Beautiful Ball 5/27/17- Memorial Day Weekend testing 8/16/17- CLOTH Health Fair 9/12/17-Day of Hope 10/13/17- Take the Train? Take the Test! 11/16/17- Transgiving MMU was out of service for several months both due to primary Harlem United clinician resigned and van undergoing extensive maintenance.
		Implement multisite testing for STDs; REACH CHWs increase capacity for HIV/HCV testing	Y In Progress	• DSRIP funding through NYP helped to support 10 Community Health Workers and numerous community events that led to over 500 HIV/HCV test being administered through REACH (Ready to End AIDS and Cure Hepatitis C) a collaborative between NYP and six community-based organizations. • Through the REACH subcontracts, in 2017 286 HIV and HCV testing were administered in the community.

Impact Evaluation of 2016-2018 Implementation Strategy

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Communicable Disease: • Decrease HIV morbidity • Increase early access to and retention in HIV care • Decrease STD morbidity	Increase access and engagement in Hepatitis C (HCV) care; increase access to STD screening and treatment	Community partners and care coordinators link HCV patients to care at east and west NYP campuses	Y In Progress	Of the 40,876 pts that were screened for HCV at NYP/West Campus in 2018, 284 had active HCV. Of these patients: - 172 were linked to care - 39 were lost to follow-up - 40 were deceased/terminally ill - 10 were already in HCV care - 23 had incorrect contact information

Impact Evaluation of 2016-2018 Implementation Strategy NewYork-Presbyterian Lawrence Hospital

In 2016, NewYork-Presbyterian Lawrence Hospital worked as a member of the Westchester County Health and Hospital Planning Team (WCHHPT) under the guidance of the Westchester County Department of Health to plan and execute a county-wide Community Health Needs Assessment survey, and to collaborate on the identification of priority areas and planned health interventions for 2016-2018.

- Analysis of the County-wide survey results led members of the WCHHPT to **select the New York State Prevention Agenda Priority Area "Prevent Chronic Disease."**
- Within this selected priority, each hospital analyzed survey results from their own primary and secondary service areas to determine areas of focus and planned health interventions.

For 2016-2018, NewYork-Presbyterian Lawrence Hospital selected the following Focus Areas and Goals.

- **Focus Area 1:** Reduce Obesity in Children and Adults
- **Goal:** Expand the role of health service providers in nutritional education and obesity prevention.
- **Interventions:** Community Nutrition Education, Supporting Healthy Eating and Promoting Physical Activity through partnerships and outreach.

- **Focus Area 2:** Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
- **Goal:** Increase screening rates for cardiovascular diseases and breast, lung, skin and colorectal cancers, especially among disparate populations.
- **Interventions:** Screenings facilitated by Clinical Navigators in collaboration with Physicians, community initiatives including disease focused education campaigns, seminars and outreach events.

Impact Evaluation of 2016-2018 Implementation Strategy NewYork-Presbyterian Lawrence Hospital

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Prevent Chronic Disease: Reduce Obesity in Children and Adults Goal 1: Promote use of evidence-based care to reduce obesity and manage chronic disease by increasing participation of children and adults in education around nutrition, portion control, physical activity, and healthy cooking.	Expand nutritional and culinary literacy, improve confidence in healthy meal planning, improve mindful easing habits.	• Provide outreach to internal and external community through presentations at health events and seminars at schools, community centers, local businesses.	Y	The Dietary team participated in a variety of community events including presentations at senior centers, Health Fairs and to a Seniors event attracting more than 1000 older adults at the County Center in White Plains.
		• Host free monthly nutritional series “East Right, Live Long” offering different nutritional topics each month (e.g., Eating Well While Eating Out).	Y	The Eat Right Live Long Series was retired in 2018. However, the Dietary team continued to offer free nutrition programming each March during National Nutrition Month. Topics included: The Keto Diet; Sports Nutrition and Orthorexia.
		• Provide free BMI and waist circumference screenings to community in connection with national health observance (Go Red for Women in February, others). Provide heart-healthy cooking demonstrations with a cardiologist through “Dinner with the Doctor” monthly series.	Y	The team provided BMI Screenings at a Go Red for Women event; a cooking demonstration at the Hospital’s annual Be Well Bash; and education at a Meet the Doctor talk on obesity. Together with Community Affairs, the team is consistently seeking opportunities to provide screenings and education.
		• Provide interactive nutrition presentations to local schools (e.g. Grandparents Day at Traphagen Elem. With food modeling).	Y	Interactive presentations were provided at the Hospital’s annual Careers in Medicine event during the past three years attracting more than 1000 students and parents at high schools throughout Westchester County.
		• Integrate nutritional education and interventions into cancer center activities.	Y	The Dietary team provided education to the Hospital’s Cancer Center’s Support Group meetings.
		• Provide strategies for weight loss and refer patients to Outpatient Nutrition Program.	Y	The Outpatient Nutrition Dietitian’s role was moved off-site to two NYMPG Westchester practice locations in support Endocrinology and other service lines. Consequently, the program has seen an increase in patents served and an average weight loss of 11.2 pounds and an A1C decrease of 1.6%..
Goal 2: Promote physical activity.	Increase awareness and physical activity among staff.	• Staff participation in the annual NewYork-Presbyterian STEPS Challenge.	Y	NYP Lawrence staff volunteered to walk in hospital supported internal and external walks. A new onsite well-being Coach was hired and leads additional walks and offers regular health & wellness programs that increase physical fitness.
		• Staff participation in AHA Heart Walk.	Y	

Impact Evaluation of 2016-2018 Implementation Strategy
NewYork-Presbyterian Lawrence Hospital

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Prevent Chronic Disease: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings Goal 1: Cardiovascular Health – Reduce the number of cardiac related deaths.	Educate 500 high school and college students and other community members on how to deliver Hand Only CPR.	• Provide training in schools and at community events	Y	The Cath Lab team led the effort to perform Hands-Only CPR lessons in the community during this three-year period. In each year it exceeded its goal of 500 students. Training occurred at community events such as Careers in Medicine; National Night Out in New Rochelle, and at the Hospital's first ever Be Well Bash in 2018.
Goal 2: Increase screenings for cardiovascular diseases.	Reduce heart disease and cardiac issues through screening and prevention education activities.	• Identify individuals at risk for high blood pressure and cardiac issues, connect them to appropriate care, and follow up to see if they have pursued that care. • Host blood pressure and BMI/Waist Circumference screenings in February for Heart Month, and at community events such as during hospital's community flu shot program, health fairs, Grandparent's Day at school and others.	Y	An Interventional Cardiology brochure detailing Cath Lab services was developed and distributed at community education events. Clinicians tabled at events such as the Bronxville Farmer's Market where they provided heart health education. Physicians also presented cardiovascular information to local residents via the Hospital's Meet the Doctor series. The Hospital has created a Congestive Heart Failure program to provide patients with education. It is also identifying strategies for reducing readmissions. Plus, the team offered each year CPR training and Heart Health education during National Heart Month in February in collaboration with the Nursing and Dietary teams.

Impact Evaluation of 2016-2018 Implementation Strategy
NewYork-Presbyterian Lawrence Hospital

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Prevent Chronic Disease: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings Goal 1: Increase screening rates for breast cancer with a focus on underserved women.	Breast Health: Contact 800 women annually to reduce barriers to screenings as part of Gov. Cuomo's initiative to increase the breast cancer screening rate by 10% over the next five years.	• Provide a screening navigator to assist women who have not been screened according to guidelines find a location, overcome barriers to transportation, Spanish language, etc. and get screened.	Y	The screening navigator exceeded the goal starting from the start of the program in October 2017 through 2018. Contacts: 2,088 In need of Screening: 517 Referred to Screening: 248 Completed Screening: 174 In need of Diagnostic Follow Up: 26 Completed Follow Up: 19 Cancers Detected: 5

Impact Evaluation of 2016-2018 Implementation Strategy NewYork-Presbyterian Lawrence Hospital

Significant health need identified in 2016	Objective	Planned activities listed in the 2016 NY State DOH CSP	Y/N was the activity implemented?	Result or impact
Prevent Chronic Disease: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings Goal 2: Increase screening rates for colorectal cancers.	Raise awareness and screen colorectal cancers.	• Committed participant in "80 by 2018" national effort to reach 80% of adults age 50+ to be screened for colorectal cancer by 2018. • Clinical Navigator Services Community Outreach/Education Assistance to Physician Community Shared Decision Making Clinical Follow-Up.	Y	As a state, NY was slightly under the 80% goal coming just under seventy percent. The program continues to be in effect in 2019. Data for NYP Lawrence Lung Cancer Screenings: 2018 (thru 12/7/18): 233 2017: 232 Data for NYP Lawrence Colorectal Cancer Screenings: 2018 (thru 12/1/18): 1449 (a 36% increase) 2017: 1064 Data for patients contacted directly by our Screening Navigator in 2018: Individuals contacted: 139 Screens performed: 39 Individuals that had one screen: 16 Individuals who had two screens: 8 Individuals that had three screens: 1 Individuals that had four screens: 1 Total Low Dose CT: 20 Total Mammograms: 5 Total Colonoscopies: 8 Total Pap Smears: 3 Total Others: 3 Total referred to Breast Navigator: 5

AMAZING
THINGS
ARE
HAPPENING
HERE

Appendix

NewYork-Presbyterian

Communities of High Disparity Definition Indicators

Domain	Indicator	Source	Geographic Area	Period
Domain 1 – Demographics	Total population	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 1 – Demographics	Percent of population that is minority (including Hispanic ethnicity)	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 1 – Demographics	Percent of population ages 65 and older	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 1 – Demographics	Percent of population 5 years and older who report that they speak English "less than very well"	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 1 – Demographics	Percent of population ages 25 and older whose highest level of education is less than a high school diploma or GED	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 1 – Demographics	Percent of households Single Father With Children	Data2Go.NYC	Community District	2012-2016
Domain 1 – Demographics	Percent of households Single Mother With Children	Data2Go.NYC	Community District	2012-2016
Domain 2 – Income	Percent of population - all below 150% of NYC.gov threshold	NYC Mayor Report	Community District	2005-2017
Domain 2 - Income	Percent of population ages 0-17 living below the federal poverty level	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 2 - Income	Percent of population ages 65 and older living below the federal poverty level	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 2 - Income	Percent of renter households whose gross rent (rent plus electricity and heating fuel costs) is greater than 50% of their monthly pre-tax income	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 2 - Income	Percent of residents living in New York City Housing Authority (NYCHA) developments, excluding Section 8 housing	NYC Health Data Atlas	Neighborhood Tabulation Area	2015
Domain 3 – Insurance	Percent of the civilian (non-military) labor force ages 16 and older who are unemployed	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 3 - Insurance	Percent of civilian noninstitutionalized population with health insurance	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 3 - Insurance	Percent of civilian noninstitutionalized population ages 0-17 without health insurance	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 3 - Insurance	Percent of population continuously enrolled, for 11 months or more, in Medicaid	NYC Health Data Atlas	Neighborhood Tabulation Area	2015

Communities of High Disparity Definition Indicators

Domain	Indicator	Source	Geographic Area	Period
Domain 4 – Access to Care	Age-adjusted rate of all preventable hospitalizations per 100,000 population ages 18 and older	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 4 – Access to Care	Rate of avoidable adult hospitalizations per 100,000 adults ages 18 and older	NYC Community Health Profiles	Community District	2014
Domain 4 – Access to Care	Rate of avoidable pediatric hospitalizations per 100,000 adults ages 0 to 4	NYC Community Health Profiles	Community District	2014
Domain 5 – NYS DOH Prevention Agenda Priorities	Percent of occupied housing units with more than one occupant per room	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 5 – NYS DOH Prevention Agenda Priorities	Serious Housing Code Violations per 1,000 units	Data City of New York	Community District	2018
Domain 5 – NYS DOH Prevention Agenda Priorities	Families with Children in Homeless Shelters	Citizen's Committee for Children Keeping Track Online	Community District	2018
Domain 5 – NYS DOH Prevention Agenda Priorities	Percent of households receiving Food Stamp/SNAP benefits in the past 12 months	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Domain 5 – NYS DOH Prevention Agenda Priorities	Crude rate of severe maternal morbidity (SMM) per 10,000 deliveries	NYC Health Data Atlas	Neighborhood Tabulation Area	2008-2012
Domain 5 – NYS DOH Prevention Agenda Priorities	Deaths of infants under 1 year per 1,000 live births	Citizen's Committee for Children Keeping Track Online	Community District	2016
Domain 5 – NYS DOH Prevention Agenda Priorities	Age-adjusted rate of drug hospitalizations per 100,000 population ages 15-84	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Domain 5 – NYS DOH Prevention Agenda Priorities	Age-adjusted rate of psychiatric hospitalizations per 100,000 population ages 18 and older	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Domain 5 – NYS DOH Prevention Agenda Priorities	Crude rate of new HIV diagnoses in 2013 per 100,000 population, all ages	NYC Health Data Atlas	Neighborhood Tabulation Area	2013
Domain 5 – NYS DOH Prevention Agenda Priorities	Annual age-adjusted rate of newly reported chronic hepatitis B per 100,000 adults aged 18 and older	NYC Health Data Atlas	Neighborhood Tabulation Area	2013-2015

Assessment Data, Defined Community at a Glance Indicators

Indicator	Source	Geographic Area	Period
Total Population Growth by Age Cohort	Nielsen	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population by Race & Ethnicity	Nielsen	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Socioeconomic Profile – Household Income	Nielsen	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Households	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Ethnicity – Hispanic/Latino	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Hispanic Origin – Non Cuban/Mexican/Puerto Rican	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Home Language	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Marital Status	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population by Age	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Population by Race	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Median Age of Householder	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Presence of Children	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Type	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Housing Tenure	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Age of Housing	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Size	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Housing Units in Structure	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated

Assessment Data, Defined Community at a Glance Indicators

Indicator	Source	Geographic Area	Period
Education Attainment	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Education: Hispanic/Latino	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Poverty Status	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Income; Median and Average	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Household Income Distribution	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Occupational Class	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Unemployment Rate	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Method of Travel to Work	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated
Occupation	Claritas; Environics Analytics	Defined Community by ZIP Code; Benchmark is New York State	2019; Estimated

Assessment Data, Communities of High Disparity Indicators - NYC

Category	Indicator	Source	Geographic Area	Period
Demographics	Population (Total #)	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of female population	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of male population	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population ages 0-17	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population ages 18-24	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population ages 25-44	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population ages 45-64	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population ages 65 and older	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of Hispanic or Latino population (of any race)	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of White population (not Hispanic or Latino)	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of Black population (not Hispanic or Latino)	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of Asian and Pacific Islander population	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of all other race population	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population all ages living below federal poverty level	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population ages 0-17 living below federal poverty level	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population ages 65+ living below federal poverty level	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population without health insurance	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population enrolled in Medicaid	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014

Assessment Data, Communities of High Disparity Indicators - NYC

Category	Indicator	Source	Geographic Area	Period
Demographics	Percent of population born outside the U.S. or U.S. territories	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of population age 5+ report speaking English “less than very well”	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Demographics	Percent of adults age 25+ not completed High School	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Socioeconomics	Percent of population ages 16+ unemployed	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Socioeconomics	Percent of population reported disabled	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Socioeconomics	Percent of household, single mother with children	Data2Go.NYC	Community District	2012-2016
Socioeconomics	Percent of household, single father with children	Data2Go.NYC	Community District	2012-2016
Socioeconomics	Percent of people living within income band $200,000 or more	Citizen’s Committee for Children Keeping Track Online	Community District	2017
Socioeconomics	Percent of people living within income band $100,000 to $199,999	Citizen’s Committee for Children Keeping Track Online	Community District	2017
Socioeconomics	Percent of people living within income band $75,000 to $99,999	Citizen’s Committee for Children Keeping Track Online	Community District	2017
Socioeconomics	Percent of people living within income band $50,000 to $74,999	Citizen’s Committee for Children Keeping Track Online	Community District	2017
Socioeconomics	Percent of people living within income band $35,000 to $49,999	Citizen’s Committee for Children Keeping Track Online	Community District	2017
Socioeconomics	Percent of people living within income band $25,000 to $34,999	Citizen’s Committee for Children Keeping Track Online	Community District	2017
Socioeconomics	Percent of people living within income band $15,000 to $24,999	Citizen’s Committee for Children Keeping Track Online	Community District	2017
Socioeconomics	Percent of people living within income band under $15,000	Citizen’s Committee for Children Keeping Track Online	Community District	2017

Assessment Data, Communities of High Disparity Indicators - NYC

Category	Indicator	Source	Geographic Area	Period
Housing	Overcrowding; Percent of occupied housing units with more than one occupant per room	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Housing	Rent burden, i.e., rent plus electricity and heating fuel costs is greater than 30% of monthly pre-tax income	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Housing	Rent burden, i.e., rent plus electricity and heating fuel costs is greater than 50% of monthly pre-tax income	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Housing	Percentage of renter-occupied homes without maintenance defects	NYC Community Health Profiles	Community District	2014
Housing	Percent of residents living in public housing excluding Section 8	NYC Health Data Atlas	Neighborhood Tabulation Area	2015
Housing	Housing Maintenance code violations	Data City of New York	Neighborhood Tabulation Area	2018
Housing	Housing Maintenance code complaints	Data City of New York	Patient Address	2018
Housing	Evictions	Association for Neighborhood & Housing Development	Community District	2018
Housing	County Foreclosure Rate	Office of the New York State Comptroller	County	2018
Housing	Percent of families with children in shelter	Citizen's Committee for Children Keeping Track Online	Community District	2017
Housing	Homes Without Maintenance Defects	NYC Community Health Profiles	Community District	2014
Housing	Notice of Foreclosure Rate per 1,000 for 1-4 Unit and Condo Properties, 2018	Association for Neighborhood & Housing Development	Community District	2018
Housing	Notice of Foreclosure Rate per 1,000 for 5+ Unit Buildings, 2018	Association for Neighborhood & Housing Development	Community District	2018
Food & Nutrition	Percent of households receiving SNAP Benefits	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Food & Nutrition	Meal Gap; # of meals needed per year for food security	Data2Go.NYC	Community District	2014
Food & Nutrition	Food Desert	USDA	Census Tract	2015

Assessment Data, Communities of High Disparity Indicators - NYC

Category	Indicator	Source	Geographic Area	Period
Social & Environmental Safety	Air Quality (Annual Average MCG per Cubic Meter of Fine Particle Matter)	NYC Community Health Profiles	Community District	2016
Social & Environmental Safety	Percent of households with a person age 65+ living alone	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Social & Environmental Safety	Number of persons served by senior center program per 1,000 population ages 60+	NYC Health Data Atlas	Neighborhood Tabulation Area	2015
Social & Environmental Safety	Assault hospitalization per 100,000 population, age adjusted rate	NYC Health Data Atlas	Neighborhood Tabulation Area	2012-2014
Social & Environmental Safety	Felony crime complaints per 100,000 population, crude rate	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Social & Environmental Safety	Total number of arrests of 16 & 17 year olds	Citizen's Committee for Children Keeping Track Online	Borough	2017
Transportation	Percent of workers who commute by any form of transportation over 60 minutes each way	Data2Go.NYC	Community District	2010-2015
Health Status: Healthy Eating & Physical Activity	Percentage of adults who ate in 24 hours 1+ serving of fruit and vegetable	NYC Community Health Profiles	Community District	2015-2016
Health Status: Healthy Eating & Physical Activity	Percentage of adults who drink >1 sweetened beverage daily	NYC Community Health Profiles	Community District	2015-2016
Health Status: Healthy Eating & Physical Activity	Percentage of adults reporting obesity	NYC Community Health Profiles	Community District	2015-2016
Health Status: Healthy Eating & Physical Activity	Percentage of public school children (K to 8) with obesity	NYC Community Health Profiles	Community District	2016-2017
Health Status: Healthy Eating & Physical Activity	Percentage of adults with physical activity in last 30 days	NYC Community Health Profiles	Community District	2015-2016
Health Status: Women, Infants & Children	Crude rate of severe maternal morbidity per 10,000 deliveries	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Health Status: Women, Infants & Children	Rate of infant deaths (under 1 year old) per 1,000 live births	NYC Community Health Profiles	Community District	2013-2015
Health Status: Women, Infants & Children	Percent of live births receiving late prenatal care	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Health Status: Women, Infants & Children	Percent of preterm births among all live births	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Health Status: Women, Infants & Children	Rate of teen births (per 1,000 women ages 15-19)	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014

Assessment Data, Communities of High Disparity Indicators - NYC

Category	Indicator	Source	Geographic Area	Period
Health Status: Well-Being & Mental Health	Percentage of deaths that could have been averted (based on top 5 Neighborhood Tabulation Areas)	NYC Community Health Profiles	Community District	2011-2015
Health Status: Well-Being & Mental Health	Premature mortality per 100,000 population under ages 65	NYC Health Data Atlas	Neighborhood Tabulation Area	2010-2014
Health Status: Well-Being & Mental Health	Percentage of adults self-report health as good-excellent	NYC Community Health Profiles	Community District	2015-2016
Health Status: Well-Being & Mental Health	Percentage of adults not getting needed medical care	NYC Community Health Profiles	Community District	2015-2016
Health Status: Well-Being & Mental Health	Percentage of adults self-reporting poor mental health	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental Health	Percentage of adults self-reporting binge drinking	NYC Community Health Profiles	Community District	2015-2016
Health Status: Chronic Disease	Rate of ED visits for asthma per 10,000 children ages 5 to 17	NYC Community Health Profiles	Community District	2015
Health Status: Chronic Disease	Percentage of adults with diabetes	NYC Community Health Profiles	Community District	2015-2016
Health Status: Chronic Disease	Percentage of adults with hypertension	NYC Community Health Profiles	Community District	2015-2016
Health Status: Chronic Disease	Percentage of adults reporting current smoking	NYC Community Health Profiles	Community District	2015-2016
Health Status: Chronic Disease	Rate of new HIV diagnoses per 100,000 people	NYC Community Health Profiles	Community District	2016
Health Status: Chronic Disease	Rate of new hepatitis C diagnoses per 100,000 people	NYC Community Health Profiles	Community District	2016
Health Status: Chronic Disease	Percentage of adults with arthritis	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of Adults with CV (Heart Attack, Coronary Heart Disease, or Stroke)	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of Adults with COPD	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of Adults Taking Medication for High Blood Pressure	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016

Assessment Data, Communities of High Disparity Indicators - NYC

Category	Indicator	Source	Geographic Area	Period
Health Status: Cancer	Cancer Incidence - All Sites	State Cancer Profiles	County	2018
Health Status: Cancer	Cancer Incidence - Breast	State Cancer Profiles	County	2018
Health Status: Cancer	Cancer Incidence - Colon and Rectum	State Cancer Profiles	County	2018
Health Status: Cancer	Cancer Incidence - Lung	State Cancer Profiles	County	2018
Health Status: Cancer	Cancer Incidence - Prostate	State Cancer Profiles	County	2018
Health Care Service Utilization	Avoidable Hospitalizations per 100,000 population ages 18+ (PQI)	NYC Community Health Profiles	Community District	2014
Health Care Service Utilization	Avoidable Hospitalizations per 100,000 population ages 0-4 (PDI)	NYC Community Health Profiles	Community District	2014
Health Care Service Utilization	Preventable Hospitalizations: All per 100,000 population ages 18+	NYC Health Data Atlas	Neighborhood Tabulation Area	2012-2014
Health Care Service Utilization	Preventable Hospitalizations: Asthma per 100,000 population ages 18+	NYC Health Data Atlas	Neighborhood Tabulation Area	2012-2014
Health Care Service Utilization	Preventable Hospitalizations: Diabetes per 100,000 population ages 18+	NYC Health Data Atlas	Neighborhood Tabulation Area	2012-2014
Health Care Service Utilization	Preventable Hospitalizations: Hypertension per 100,000 population ages 18+	NYC Health Data Atlas	Neighborhood Tabulation Area	2012-2014
Health Care Service Utilization	Preventable Hospitalizations: Alcohol per 100,000 population ages 18+	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Health Care Service Utilization	Hospitalizations: Child Asthma per 10,000 population ages 5-14	NYC Health Data Atlas	Neighborhood Tabulation Area	2012-2014
Health Care Service Utilization	Hospitalizations: Drug per 100,000 population ages 15-84	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Health Care Service Utilization	Hospitalizations: Falls per 100,000 population ages 65+	NYC Health Data Atlas	Neighborhood Tabulation Area	2012-2014
Health Care Service Utilization	Preventable Hospitalizations: Psychiatric per 100,000 population ages 18+	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Health Care Service Utilization	Preventable Hospitalizations: Stroke per 100,000 population ages 18+	NYC Health Data Atlas	Neighborhood Tabulation Area	2014

Assessment Data, Communities of High Disparity Indicators - NYC

Category	Indicator	Source	Geographic Area	Period
Health Care Service Utilization	Emergency Dept.: All Visits per 100,000 population, crude rate	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Health Care Service Utilization	Emergency Dept: Treat and Release Visits per 100,000 population, crude rate	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Health Care Service Utilization	Emergency Dept: Visits Resulting in Inpatient Stays per 100,000 population, crude rate	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Health Care Service Utilization	Emergency Dept: Preventable Treat and Release Visits or all T&R visits	NYC Health Data Atlas	Neighborhood Tabulation Area	2014
Health Provider Assets	Facility - Hospital, Federally Qualified Health Center, Skilled Nursing Facility, and Urgent Care	Definitive Healthcare	Street Address	2019
Health Provider Assets	Physicians	Definitive Healthcare	Street Address	2019

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Demographics	Population (Total #)	Claritas	ZIP	2019, Estimated
Demographics	Percent of female population	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 0-17	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 18-24	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 25-44	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 45-64	Claritas	ZIP	2019, Estimated
Demographics	Percent of population ages 65 and older	Claritas	ZIP	2019, Estimated
Demographics	Percent of Hispanic or Latino population (of any race)	Claritas	ZIP	2019, Estimated
Demographics	Percent of White population (not Hispanic or Latino)	Claritas	ZIP	2019, Estimated
Demographics	Percent of Black population (not Hispanic or Latino)	Claritas	ZIP	2019, Estimated
Demographics	Percent of Asian and Pacific Islander population	Claritas	ZIP	2019, Estimated
Demographics	Percent of all other race population	Claritas	ZIP	2019, Estimated
Demographics	Families below poverty	Claritas	ZIP	2019, Estimated
Demographics	Families below poverty with children	Claritas	ZIP	2019, Estimated
Socioeconomics	Percentage of adults aged 18-64 years with health insurance	New York State Community Health Indicator Reports (CHIRS)	County	2016
Socioeconomics	Percentage of children <19 years with health insurance	New York State Community Health Indicator Reports (CHIRS)	County	2016
Socioeconomics	Percent of population enrolled in Medicaid	UHFNYC	County	2011-2015, ACS Estimate

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Socioeconomics	Speak only English at home	Claritas	ZIP	2019, Estimated
Socioeconomics	Percent of adults ages 25+ not completed high school	Claritas	ZIP	2019, Estimated
Socioeconomics	Percent of population ages 16+ unemployed	Claritas	ZIP	2019, Estimated
Socioeconomics	Percent of total population reported disabled	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Socioeconomics	% of household, single mother with children	Claritas	ZIP	2019, Estimated
Socioeconomics	% of household, single father with children	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $200,000 or more	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $100,000 to $199,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $75,000 to $99,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $50,000 to $74,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $35,000 to $49,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $25,000 to $34,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band $15,000 to $24,999	Claritas	ZIP	2019, Estimated
Socioeconomics	% of People Living within Income Band Under $15,000	Claritas	ZIP	2019, Estimated

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Housing	Severe Housing Problems	Robert Wood Johnson County Health Rankings State Cancer Profiles; ACS	County	2013-2017
Housing	Housing Insecurity	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Housing	Rent burden, 30% or more	Cares Engagement; ACS	County	2013-2017
Food & Nutrition	Food Insecurity	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Social & Environmental Safety	Air Quality (Annual Average MCG per Cubic Meter of Fine Particle Matter)	Cares Engagement; CDC	County	2012
Social & Environmental Safety	Assault Hospitalizations per 100,000 population, age adjusted rate	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Social & Environmental Safety	Violent Crime	Cares Engagement; FBI	County	2019
Transportation	Workers who commute by any form of transportation over 60 minutes away	Claritas	ZIP	2019, Estimated
Health Status: Healthy Eating & Physical Activity	Percentage of adults who ate in 24 hours, 1+ servings of fruit/vegetables	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Healthy Eating & Physical Activity	Percentage of adults who drink >1 sweetened beverages daily	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Healthy Eating & Physical Activity	Percentage of adults who report being obese	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Healthy Eating & Physical Activity	Childhood obesity, students 95th percentile or higher	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Healthy Eating & Physical Activity	Percentage of adults with physical activity in last 30 days	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Health Status: Women, Infants & Children	Maternal mortality rate per 100,000 live births	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Rate of infant deaths (under 1 year old) per 1,000 live births	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Percent of live births receiving late prenatal care	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Percent of preterm births among all live births	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Women, Infants & Children	Rate of teen births per 1,000 women ages 15-19	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percent of premature deaths (aged less than 75 years)	Cares Engagement; CHR	County	2015-2017
Health Status: Well-Being & Mental health	Percentage of adults that self-report health as good-excellent	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percentage of Adults not getting needed medical care	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percentage of adults self-reporting poor mental health	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Well-Being & Mental health	Percentage of adults self-reporting binge drinking	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults with diabetes	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults with hypertension	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults reporting current smoking	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Rate of new HIV diagnoses per 100,000 people	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014

Assessment Data, Communities of High Disparity Indicators - Non-NYC

Category	Indicator	Source	Geographic Area	Period
Health Status: Chronic Disease	Percentage of adults with arthritis	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults with cardiovascular disease (heart attack, coronary heart disease, or stroke)	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percent of adults with COPD	Behavioral Risk Factor Surveillance System (BRFSS) New York State	County	2016
Health Status: Chronic Disease	Percentage of adults taking medication for high blood pressure	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Status: Cancer	Cancer incidence – all sites, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – breast, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – rectum, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – lung, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Status: Cancer	Cancer incidence – prostate, age adjusted rate	State Cancer Profiles	County	2012-2016
Health Utilization	Hospitalizations: All, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Asthma, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Diabetes, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Hypertension, per 10,000 ages 18+	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Asthma, per 10,000 aged 0-17	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Drug related, per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Falls, age adjusted rate per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014
Health Utilization	Hospitalizations: Cardiovascular disease (stroke), per 10,000	New York State Community Health Indicator Reports (CHIRS)	County	2012-2014

Assessment Data, Health Provider Assets in the High Disparity Communities, Non-NYC

Category	Indicator	Source	Geographic Area	Period
Health Provider Assets	Facility - Hospital, Federally Qualified Health Center, Skilled Nursing Facility, and Urgent Care	Definitive Healthcare	Street Address	2019
Health Provider Assets	Physicians	Definitive Healthcare	Street Address	2019

Gaps Limiting Ability to Assess the Community Health Needs

A number of data sources, including state, county, and local resources were examined as part of this CHNA. One limitation of this study is that some data sources were not available for geographic boundaries at these localized levels (e.g., Neighborhood Tabulation Area).

Additionally, data publicly available was not always collected on an annual basis, meaning that some data indicators are several years old. In consideration of these limitations, the process of identifying health needs was based on both the quantitative and qualitative analyses.

Mental health and substance use indicators are limited due to privacy requirements creating challenges for assessing disparities. Similar self-reported statistics are estimated to be underreported due to the stigma of these health issues.

Hanlon Prioritization Method Pros and Cons

The Hanlon Method for Prioritizing Health Problems, utilized in this study, is a well-respected technique which objectively takes into consideration explicitly defined criteria and feasibility factors. Though a complex method, the Hanlon Method can be used with any size group and is advantageous when the desired outcome is an objective list of health priorities based on baseline data and numerical values.

- **PROS:** the PEARL component can be a useful feature as it offers relatively quantitative answers that are appealing for many.
  - **P**ropriety – Is a program for the health problem suitable?
  - **E**conomics – Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
  - **A**cceptability – Will a community accept the program? Is it wanted?
  - **R**esources – Is funding available or potentially available for program?
  - **L**egality – Do current laws allow program activities to be implemented?

  Eliminate any health problems which receive an answer of "No" to any of these PEARL factors or proceed with corrective action to ensure that potential health priorities meet all five of the feasibility factors.

- **CONS:** The process offers the lowest priorities for those issues where the solution requires additional resources or legal changes which may be problematic. Very complicated.

Source: https://www.cdc.gov/nphpsp/documents/Prioritization%20section%20from%20APEXPH%20in%20Practice.pdf

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Prevent Chronic Diseases	Focus Area 1: Healthy Eating and Food Security Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 1.1: Increase access to healthy and affordable foods and beverages
	Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
	Goal 1.3: Increase food security
	Focus Area 2: Physical Activity Overarching Goal: Reduce obesity and the risk of chronic diseases
	Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
	Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
	Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity
	Focus Area 3: Tobacco Prevention
	Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults
	Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
	Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products
	Focus Area 4: Preventive Care and Management
	Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
	Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity
	Goal 4.3: Promote the use of evidence-based care to manage chronic diseases
	Goal 4.4: Improve self-management skills for individuals with chronic conditions

Source: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Promote a Healthy and Safe Environment	Focus Area 1: Injuries, Violence and Occupational Health
	Goal 1.1: Reduce falls among vulnerable populations
	Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
	Goal 1.3: Reduce occupational injuries and illness
	Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists
	Focus Area 2: Outdoor Air Quality
	Goal 2.1: Reduce exposure to outdoor air pollutants
	Focus Area 3: Built and Indoor Environments
	Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
	Goal 3.2: Promote healthy home and school environments
	Focus Area 4: Water Quality
	Goal 4.1: Protect water sources and ensure quality drinking water
	Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
	Focus Area 5: Food and Consumer Products
	Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
	Goal 5.2: Improve food safety management

Source: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health
	Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
	Goal 1.2: Reduce maternal mortality and morbidity
	Focus Area 2: Perinatal & Infant Health
	Goal 2.1: Reduce infant mortality and morbidity
	Goal 2.2: Increase breastfeeding
	Focus Area 3: Child & Adolescent Health
	Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships
	Goal 3.2: Increase supports for children and youth with special health care needs
	Goal 3.3: Reduce dental caries among children
	Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
	Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Priority Area: Promote Well- Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being
	Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
	Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages
	Focus Area 2: Prevent Mental and Substance Use Disorders
	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults
	Goal 2.2: Prevent opioid and other substance misuse and deaths
	Goal 2.3: Prevent and address adverse childhood experiences (ACEs)
	Goal 2.4: Reduce the prevalence of major depressive disorders
	Goal 2.5: Prevent suicides
	Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population

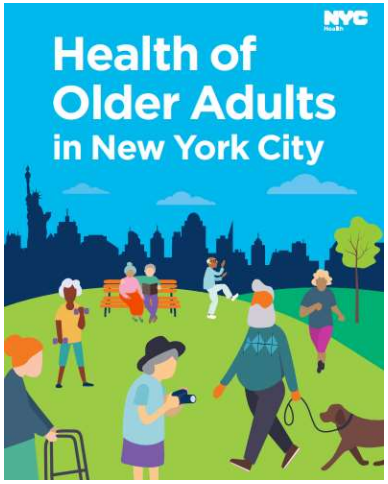
Source: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

New York State Department of Health Prevention Agenda 2019-2024

Priority Area: Prevent Communicable Diseases	Focus Area 1: Vaccine-Preventable Diseases
	Goal 1.1: Improve vaccination rates
	Goal 1.2: Reduce vaccination coverage disparities
	Focus Area 2: Human Immunodeficiency Virus (HIV)
	Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)
	Goal 2.2: Increase viral suppression
	Focus Area 3: Sexually Transmitted Infections (STIs)
	Goal 3.1: Reduce the annual rate of growth for STIs
	Focus Area 4: Hepatitis C Virus (HCV)
	Goal 4.1: Increase the number of persons treated for HCV
	Goal 4.2: Reduce the number of new HCV cases among people who inject drugs
	Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections
	Goal 5.1: Improve infection control in healthcare facilities
	Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile
	Goal 5.3: Reduce inappropriate antibiotic use

Source: https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/

Health of Older Adults in NYC Report Summary



Access the full report online at https://www1.nyc.gov/assets/doh/downloads/pdf/episrv/2019-older-adult-health.pdf.

The New York City Health Department prepared a summary of the health of older adults (NYC overall).

Heathy aging is defined in this report as more than growing older without having chronic health problems or diseases. “For older adults, healthy aging includes being able to meet basic needs, to learn, to be mobile, to build and maintain relationships, and to contribute to society.”

Demographics

- Older New Yorkers - those ages 65 and older - currently make up about 13% of NYC’s residents.
- New Yorkers are living longer than ever, with an impressive life expectancy of 81.2 years, 2.5 years longer than the national average.
- The number of older New Yorkers is projected to grow by over 41%, from 1,002,000 in 2010 to 1,410,000 by 2040.
- Forty-four percent of older New Yorkers identify as White, 22% as Black, 21% as Latino and 12% as Asian/Pacific Islander. Two percent identify as mixed race or another race or ethnicity, which is referred to as Other.
- Nearly half of older New Yorkers were born outside the U.S and come from 130 different countries and speak over 90 languages.
- Two-thirds of older adults speak English very well. Fifty-four percent of older adults in NYC speak English at home, 20% speak Spanish and 6% speak Chinese.
- Forty percent of older New Yorkers identify as men and 60% as women. Less than 1% of older New Yorkers identify as transgender men or women, an estimated 1,000 older adults.
- One in five older New Yorkers lives below the poverty level. Older adults who identify as Latino (27%) or Asian/Pacific Islander (26%) are more likely to live below the poverty level compared with those who identify as Black (19%) or White (17%).
- Nearly all older New Yorkers (97%) are covered by some form of health insurance but some still have to skip or postpone health services because of out-of-pocket health care costs like premiums, copayments and deductibles. Twelve percent of older adults are sometimes unable to afford the medicines they need.

Health of Older Adults in NYC Report Summary

Social Determinants of Health

- About one in three older adults in NYC lives alone.
- Ninety-three percent of older New Yorkers report having enough food to eat. White older adults (97%) are more likely than Black (94%) and Latino older adults (82%) to report having enough food to eat.
- An estimated 110,000 older New Yorkers live in public housing.
- In NYC in 2016, falls among older adults led to 289 deaths, 30,492 emergency department visits and 16,661 hospital stays.

Health Status

- Two percent of older adults in NYC have too little weight, 36% have overweight, 27% have obesity and 35% have a normal weight. Two in five older adults report they get the recommended 150 minutes of physical activity per week.
- Approximately 3% of older adults binge drink and 8% currently smoke.
- More than half of older New Yorkers rate their own health as “excellent,” “very good” or “good.” One-third of Latino and Asian/Pacific Islander older adults and about two-thirds of White and Black older adults rate their health as “good” to “excellent.”
- Older adults may have multiple chronic diseases such as diabetes, high blood pressure and chronic obstructive pulmonary disease (COPD). Estimates suggest that over 40% of older adults report taking five or more prescription medications.
- More than one quarter of older NYC adults have diabetes, two-thirds have high blood pressure and half of older New Yorkers have arthritis.
- Ten percent of older New Yorkers report that they have ever had a heart attack and 5% report having had a stroke.
- Three percent of older adults in NYC have asthma and 12% have COPD.
- Among people living with HIV/AIDS in NYC, one in 10 are older adults.

Health of Older Adults in NYC Report Summary

Behavioral Health

Depression

- Nine percent of older (age 65+) New Yorkers have depression as measured by a validated screening tool.
- Depression is more common among older women (12%) than older men (6%).
- Depression is more likely among Latino (14%) than White older adults (8%).
- Older adults in low-income households (16%) are more likely to have depression than are older adults in high-income households (2%, interpret estimate with caution due to small sample size).

Suicide

- In 2016, the rate of suicide among older adults was 7.4 per 100,000 population.
- The rate of suicide among older men (11.9 per 100,000 men 65 and older) is higher than among older women (4.2 per 100,000 women 65 and older).
- The rate of death due to suicide is higher among White older adults (11.8 per 100,000) compared with Asian/Pacific Islander (8.2 per 100,000), Latino (3.6 per 100,000) and Black older adults (1.9 per 100,000).

Subjective cognitive decline

- Thirteen percent of older New Yorkers report experiencing confusion or memory loss that is happening more often or getting worse.

Drug overdose deaths

- The most common substances associated with overdose deaths among older adults include opioids, cocaine and alcohol.
- The rate of drug overdose deaths among adults ages 65 to 84 years has more than doubled from 2014 to 2017 (3.5 to 7.7 per 100,000 population)

Health of Older Adults in NYC Report Summary

Cancer Incidence

- Cancer incidence increases with age.
- Among older women in NYC, the leading causes of cancer death are lung, breast and colorectal cancers.
- Among older men in NYC, the leading causes of cancer death are lung, prostate and lymphoid and hematopoietic (blood-related) cancers.

Application

- It is important to understand the unique health characteristics of this population. This report shares data on the health and well-being of older New Yorkers and supports efforts to make NYC a place where everyone has the opportunity to age with health and dignity.

Community Populations- Questionnaire Demographics

Demographics (N= 1,074)		
Age		
18-25	135	12.6%
26-35	246	23.0%
36-45	181	16.9%
46-55	138	12.9%
56-65	153	14.3%
66-75	123	11.5%
76-85	85	7.9%
86 +	9	0.8%
Gender		
Female	647	61.9%
Male	387	37.0%
Gender non-binary	9	0.9%
Transgender	2	0.2%
Self-described	1	0.1%
Sexual Orientation		
Heterosexual or straight	806	81.4%
Gay or lesbian	61	6.2%
Bisexual	45	4.5%
Asexual	44	4.4%
Self-describe	19	1.9%
Queer	15	1.5%
Race/ethnicity *		
White	529	49.3%
Black or African American	194	18.1%
Latino or Hispanic	163	15.2%
Asian or Asian American	150	14.0%
American Indian or Alaskan Native	13	1.2%
Other	23	2.1%
Born in the U.S.	725	69.9%

Demographics (N= 1,074)		
How well do you speak English?		
Very well	808	78.2%
Well	115	11.1%
Not well	90	8.7%
Not at all	20	1.9%
Education Completed		
Less than grade 8	31	3.0%
Grades 9-11	50	4.9%
Grade 12 or GED	142	13.8%
College 1 year to 3 years	227	22.1%
College 4 years or more	567	55.1%
Other	12	1.2%
Employment *		
Working	615	57.3%
Not working	191	17.8%
Retired	101	9.4%
Student	79	7.4%
Homemaker/Caregiver	58	5.4%
Volunteer	63	5.9%
Other	23	2.1%
Type of health insurance *		
Private/commercial	399	37.5%
Medicare	357	33.6%
Medicaid	280	26.3%
Uninsured	110	10.3%
Unsure of type	35	3.3%
VA	16	1.5%

* multiple responses permitted.

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Community Populations- Focus Group Demographics

Participant Demographics (N=341)		
	n	%
Gender		
Female	239	70.1%
Male	96	28.2%
Gender non-binary	2	0.6%
Missing	4	1.2%
Sexual Orientation		
Heterosexual or straight	270	79.2%
Asexual	15	4.4%
Gay or lesbian	15	4.4%
Bisexual	8	2.3%
Queer	3	0.9%
Self-described	4	1.2%
Missing	26	7.6%
Race/Ethnicity*		
White	107	31.4%
Black or African American	103	30.2%
Hispanic or Latino	70	20.5%
Asian or Asian American	48	14.1%
American Indian or Alaskan Native	5	1.5%
Other	18	5.3%
Born in the US		
Yes	205	60.1%
How well do you speak English?		
Very well	237	69.5%
Well	48	14.1%
Not well	31	9.1%
Not at all	17	5.0%
Missing	8	2.3%

Community Populations- Focus Group Demographics

Participant Demographics (N=341)		
Primary language spoken at home		
English	223	65.4%
Spanish	38	11.1%
Chinese (Mandarin, Cantonese, or other)	27	7.9%
Korean	10	2.9%
Russian	10	2.9%
Haitian Creole	8	2.3%
Greek	1	0.3%
Italian	1	0.3%
Urdu	1	0.3%
Other	5	1.5%
Missing	17	5.0%
Highest level of education completed		
College 4 years or more (Bachelor's, JD/MD/PhD)	151	44.3%
College 1 -3 years (some college, or technical school, associate's degree)	77	22.6%
Grade 12 or GED (High school graduate)	64	18.8%
Grades 1-8 (Elementary)	14	4.1%
Grades 9-11 (Some high school)	14	4.1%
Missing	14	4.1%
Other	6	1.8%
Never attended school or only kindergarten	1	0.3%
Insurance Status*		
Medicaid	121	35.5%
Medicare	115	33.7%
Private insurance	118	34.6%
Uninsured	22	6.5%
Don't know	18	5.3%

Participant Demographics (N=341)		
Employment status*		
Working	136	39.9%
Not working	82	24.0%
Retired	64	18.8%
Volunteer	31	9.1%
Homemaker/caregiver	20	5.9%
Student	18	5.3%
Other	63	18.5%
*Multiple responses allowed		

2019 CHNA NewYork-Presbyterian Focus Group Guide

1. To start, we'd like to hear a little about you, including how long you have lived in this community and one thing you like about it.
2. We're interested in hearing from you about health, so before we get into our more detailed questions, we want to hear from you first about how you define the term. Briefly, what does the word "health" mean to you?
3. What do you think are the greatest health issues for people in this community? (e.g., particularly common illnesses or problems)
    a. Why do you think [x health issue(s) mentioned] is so common here? (prompt if needed: age of the population, diet, lifestyle, pollution, other environmental factors)
4. [If not mentioned] Are there any particular mental health issues that people in this community face, including depression, anxiety, trauma, or stress?
    a. Why do you think [x mental health-related issue(s) mentioned] is/are significant here?
5. [If not mentioned in Q4] Is drug and alcohol use an issue in this community? Why or why not? What kind of services are available for people struggling with drug or alcohol use?

Now we're going to ask a little more about you and daily life in this community.

6. Can you tell us about the kind of food that you generally eat?
    a. How concerned are you about eating healthy? Why?
    b. How easy or hard is it to buy, eat and serve healthy food around here? Where do you go for food?
    c. What might make it easier to eat healthy?

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7. How easy or hard is it for people to exercise in this community? This includes things like walking, sports (like soccer and basketball), yoga, and other kinds of physical activity?
    a. Do you exercise?
    b. For those of you who do, what kind of exercise do you do and how often? Why?
    c. For those of you who don't, why not?
    d. How big a priority is exercise in this community? Can you explain?
    e. What might encourage people to exercise more than they do?
8. Health is more than just medical care and many things can affect health, including housing, transportation, employment, stress in daily life, etc. Does this idea ring true to you? Why or why not?
9. Are there any particular challenges, like the ones I just mentioned, that people in this community face (i.e., housing, transportation, employment, stress in daily life, etc.)?
    a. What about challenges related to housing?
    b. Transportation?
    c. Paying for food?
    d. Employment?
    e. Any others?
10. Are there things about this community that affect health in a positive way, for ex. good housing or access to healthy food?
11. What kinds of services exist in this community to help people deal with the challenges that we just discussed (If needed: like housing, transportation, employment)? Can you explain?
    a. What kinds of organizations do people look to for help with these challenges? Why?
    b. What about faith-based organizations like churches or mosques? Others?
    c. If you've ever used services like these, how helpful were they? Why/why not?

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Now I'd like to talk about healthcare.

12. Where do people here (in this room) go for health care?
    a. How did you choose where you go?
    b. How do you like it – what's good about it? What's bad?
    c. Do you schedule an annual check-up?
13. Who do people here talk to if they are feeling sad or anxious and need help with that? [Probe if necessary: a therapist? Someone at a community based organization? A religious leader? A friend or family member?]
    a. How willing are people to seek help for these kinds of issues?
    b. What might encourage people to get help for these types of issues?
14. How well do you think the services that are available for people dealing with stress, anxiety, depression or other mental health challenges serve the mental health needs of this community?
    a. Are there enough services? Not enough?
    b. Are there ways the services available could be better? Or are they fine as they are?
15. Overall, how easy or difficult do you think it is for you and others you know to get health care?
    a. What specifically makes it easy—or difficult—to get health care in this community?
    b. Is cost of services an issue?
    c. Is insurance an issue?
    d. Is language – or provider sensitivity an issue?
16. If you were able to talk to a doctor via telephone or computer (like a videochat) when you were sick, instead of going in to see the doctor in person, how likely would you be to use that service?
    a. Why or why not? [Prompt if needed: is it about your level of comfort using tech for this kind of thing? Or about your ability to access this kind of technology?

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This final set of questions are about some additional health related programs and resources.

17. If you want to learn about health – things like diabetes prevention, blood pressure or cancer screening, etc.—what kind of information is available to people in your community, if any?
    a. Who provides this information? How do they do that?
    b. Have you ever seen or gotten information like this being provided by a local hospital?
        i. If so, what was it about?
        ii. Did you attend? Why or why not?
    c. Who generally attends these programs—or looks for this kind of information?
18. What other kinds of programs exist in this community to help people stay healthy? This could be things like WIC, free exercise classes, or community health workers, for example.
    a. Has anyone used these programs?
    b. How helpful are they, in your opinion?
    c. What kind of programs do you think there could be more of?
19. Has anyone ever used a service like this? If yes, what did you think?
19. As we mentioned in the beginning of the group, the purpose of this conversation is to help NewYork-Presbyterian think about ways they can support the health of this community including things they do outside their walls. Are there any things we haven't talked about that you think NewYork-Presbyterian could do to help improve the health of the community?
20. Before we close, do you have any other comments about health or health care here – anything we haven't discussed?
21. Do you have any questions for us?

Thank you!

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2019 NewYork-Presbyterian Community Health Needs Questionnaire (CHNQ)

The New York Academy of Medicine is conducting this survey as part of a community health needs assessment for NewYork-Presbyterian (NYP), a network of hospitals and providers across New York City and Westchester. The purpose of this survey is to identify health issues that are important in your community. The information that you provide will help NYP to develop health services and programs. This survey is voluntary and you can skip individual questions. All your responses will be kept private.

Eligibility

1. How old are you?

- ☐ <18 [Thank you, unfortunately, you are not eligible for the survey]
- ☐ 18 - 25
- ☐ 26 – 35
- ☐ 36 – 45
- ☐ 46 – 55
- ☐ 56 – 65
- ☐ 66 – 75
- ☐ 76 – 85
- ☐ 86+

2. Where do you live?

- ☐ Bronx
- ☐ Brooklyn
- ☐ Manhattan
- ☐ Queens
- ☐ Staten Island
- ☐ Westchester
- ☐ Other, please specify: _____

3. What is your ZIP code? _____

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Health issues in your community

4. Overall, how would you rate the health of the people in the community where you live?

□ Excellent □ Very good □ Good □ Fair □ Poor

5. What do you think are the biggest health concerns in your community? (Check all that apply)

- ❑ Adolescent health
- ❑ Alcohol and drug use
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Exercise/physical activity
- ❑ Falls among older adults
- ❑ Heart disease
- ❑ Hepatitis C
- ❑ High blood pressure
- ❑ HIV/AIDS
- ❑ Maternal and child health
- ❑ Mental health (e.g., depression, suicide)
- ❑ Nutrition
- ❑ Obesity
- ❑ Sexually transmitted infections
- ❑ Sickle cell anemia
- ❑ Teen pregnancy
- ❑ Tobacco use
- ❑ Vaccinations
- ❑ Violence
- ❑ Other, please specify:

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6. Many things outside of medical care can impact daily health where you live. What are the top changes that you believe would improve the health of the residents of your community the most? (Check all that apply)

- ☐ Cleaner streets
- ☐ Improved housing conditions
- ☐ Improved water quality
- ☐ Increased number of places where older adults can live and socialize
- ☐ Increased public transportation
- ☐ Lead paint removal
- ☐ Mold removal
- ☐ More local jobs
- ☐ More parks and recreation centers
- ☐ Reduced air pollution
- ☐ Reduced cigarette/vaping smoke
- ☐ Reduced crime
- ☐ Reduced speeding on neighborhood streets
- ☐ Reduced traffic on neighborhood streets
- ☐ Reduction in homelessness
- ☐ Other: _____

Personal health and health care use

7. In general, would you say your health is…?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2019 NewYork-Presbyterian CHNQ

8. Has a doctor or other medical professional ever told you that you have any of the following . . .

	Yes	No
a. Arthritis	☐	☐
b. Asthma	☐	☐
c. Cancer (including skin cancer)	☐	☐
d. Chronic pain	☐	☐
e. COPD, emphysema or chronic bronchitis	☐	☐
f. Depression or anxiety	☐	☐
g. Diabetes	☐	☐
h. Drug or alcohol addiction	☐	☐
i. Heart disease	☐	☐
j. Hepatitis C	☐	☐
k. High blood pressure	☐	☐
l. High cholesterol	☐	☐
m. HIV/AIDS	☐	☐
n. Kidney disease	☐	☐
o. Obesity	☐	☐
p. Osteoporosis	☐	☐
q. Sexually transmitted diseases	☐	☐
r. Sickle cell anemia	☐	☐
Other:	☐	☐

2019 NewYork-Presbyterian CHNQ

9. Do you currently have health insurance?

- ☐ Yes
- ☐ No (Skip to Q10)
- ☐ Don't know (Skip to Q10)

9a. If yes, what type (Check all that apply)

- ☐ Medicaid
- ☐ Medicare
- ☐ Private/commercial
- ☐ VA
- ☐ Not sure what kind

10. Where do you most often go for health care? (Check one)

- ☐ Alternative care (e.g., herbalist, acupuncturist)
- ☐ Community health center
- ☐ Doctor's office
- ☐ Emergency room
- ☐ Hospital-based practice
- ☐ I don't go anywhere (skip to Q11)
- ☐ Pharmacy
- ☐ Spiritual healer or leader
- ☐ Urgent care
- ☐ Other, please specify:_____

10a. Is the place you go to part of NewYork-Presbyterian?

- ☐ Yes
- ☐ No
- ☐ Don't know

2019 NewYork-Presbyterian CHNQ

11. Was there a time in the past 12 months when you needed health care or health services but did not get it?

- ☐ Yes
- ☐ No (Skip to Q12)
- ☐ Don't know (Skip to Q12)

11a. Why didn't you get the care? (Check all that apply)

- ☐ Concerned about language or translation issues
- ☐ Couldn't get an appointment soon enough or at the right time
- ☐ Didn't have transportation
- ☐ Didn't know where to go
- ☐ Didn't realize I needed to see doctor
- ☐ Don't have a doctor
- ☐ Don't like to go
- ☐ Goes against my religious/cultural beliefs
- ☐ Had other responsibilities (e.g. work, childcare)
- ☐ High cost of care (e.g. co-pay, deductible)
- ☐ I thought I wouldn't get good care
- ☐ Not insured
- ☐ Other, please specify:_____

12. During the past 12 months, how many times have you gotten care in a hospital emergency room (ER)?

- ☐ None (Skip to Q13)
- ☐ 1 time
- ☐ 2 or more times
- ☐ Don't know

12a. Why did you choose to go to the ER? (Check all that apply)

- ☐ Didn't have insurance
- ☐ Didn't have transportation to doctor's office or clinic
- ☐ Doctor's office or clinic wasn't open
- ☐ Doctor told me to go to the ER
- ☐ Don't know
- ☐ Get most of my care at the ER
- ☐ Problem too serious for a doctor's office or clinic
- ☐ Other, please specify:_____

Hospital Services

13. Have you received medical care at any of the following NYP hospitals in the last 12 months? (Check all that apply)

- ☐ Gracie Square Hospital
- ☐ NYP Allen Hospital
- ☐ NYP Brooklyn Methodist Hospital
- ☐ NYP Columbia University Medical Center
- ☐ NYP David H. Koch Center
- ☐ NYP Hudson Valley Hospital
- ☐ NYP Komansky Children's Hospital
- ☐ NYP Lawrence Hospital
- ☐ NYP Lower Manhattan Hospital
- ☐ NYP Morgan Stanley Children's Hospital
- ☐ NYP Och Spine Hospital
- ☐ NYP Queens
- ☐ NYP Weill Cornell Medical Center
- ☐ NYP Westchester Division
- ☐ Other, please specify:_____
- ☐ No (Skip to Q14)

13a. Which services did you use? (Check all that apply)

- ☐ Adolescent health
- ☐ Birthing/Maternity
- ☐ Dental care
- ☐ Emergency department
- ☐ Heart/Cardiology care
- ☐ Pediatrics care
- ☐ Primary care (e.g. internal medicine)
- ☐ Radiology/Imaging
- ☐ Surgery
- ☐ Women's health
- ☐ Other, please specify:_____

2019 NewYork-Presbyterian CHNQ

13b. Have you participated in any of these programs in the last 12 months?

	Yes		No	
Ask appropriate follow-up for each item below (e.g., if "yes," ask if useful); Skip patterns will be used for each question.	I found it to be useful	I did not find it useful	However, I am interested	Not interested
i. Community fitness and nutrition programs (e.g. weight loss and cooking programs)				
ii. Community health education events and lectures				
iii. Community health screening (e.g. blood pressure, diabetes)				
iv. Community support groups				
v. LGBT support services				
vi. Mental health and family counseling				
vii. Quit smoking programs				
viii. Other, please specify:				

Information and Activities

14. Where do you get most of your health information? (Check all that apply)

- ☐ Books
- ☐ Community based organization
- ☐ Doctor or health care provider
- ☐ Family or friends
- ☐ Health department
- ☐ Health fairs
- ☐ Health insurance plan
- ☐ Internet
- ☐ Library
- ☐ Newspapers or magazines
- ☐ Radio
- ☐ Religious organizations (e.g., church, temple)
- ☐ School
- ☐ Television
- ☐ Workplace
- ☐ Other, specify: ____
- ☐ Don't know

15. Which of the following do you use to communicate with your healthcare provider? (Check all that apply)

- ☐ Email
- ☐ In-person
- ☐ Online provider portal (e.g., MyChart)
- ☐ Telephone
- ☐ Text messaging
- ☐ Video conferencing (e.g., FaceTime, Skype)
- ☐ Other, specify: _____

16. Do you regularly go to or participate in any of the following? (Check all that apply)

- ☐ Community center
- ☐ Gym or recreational center
- ☐ Library
- ☐ Local park & arts/cultural organization
- ☐ Neighborhood association (e.g., tenant association)
- ☐ Other community organizations
- ☐ Religious organization (e.g., church, temple)
- ☐ School
- ☐ Senior center
- ☐ Other, specify:
- ☐ None

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Demographics

17. What is your gender?

☐ Female ☐ Male ☐ Prefer to self-describe:_

☐ Gender non-binary ☐ Transgender

18. What is your sexual orientation?

☐ Asexual ☐ Gay, or lesbian ☐ Queer
☐ Bisexual ☐ Heterosexual or straight ☐ Prefer to self-describe:_

19. What is your race or ethnicity? (Check all that apply)

☐ American Indian or Alaskan Native ☐ Hispanic or Latino
☐ Asian or Asian American ☐ White
☐ Black or African American ☐ Other, please specify: _____

20. Were you born outside of the U.S.?

☐ Yes ☐ No (Skip to Q21)

20a. In what country were you born? _____

22. How well do you speak English?

☐ Very well ☐ Well ☐ Not well ☐ Not at all

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23. Do you prefer to get health care in a language other than English?

☐ Yes ☐ No (skip to Q24)

23a. Which language? _____

24. Where do you currently live or stay?

☐ Assisted living
☐ Group home
☐ Homeless, living in a shelter
☐ Homeless, living on the street
☐ Nursing/long term care
☐ Own an apartment/house
☐ Rent an apartment/house
☐ Staying with friends/family
☐ Three-quarter housing/Halfway house
☐ Other, please specify:_____

25.What is the highest level of education you completed? (Check one)

☐ Never attended school or only attended kindergarten
☐ Grades 1 through 8 (Elementary)
☐ Grades 9 through 11 (Some high school)
☐ Grade 12 or GED (High school graduate)
☐ College 1 year to 3 years (Some college or Technical school, Associate's degree)
☐ College 4 years or more (i.e. Bachelor's, JD/MD/PhD)
☐ Other, please specify: _____

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26. What is your employment status (Check all that apply)?

- ☐ Homemaker/caregiver
- ☐ Not working
- ☐ Student
- ☐ Volunteer
- ☐ Working
- ☐ Other, please specify:_____

27. How many people are part of your household, including yourself, children and adults? ___

28. During the past 30 days, have you felt angry, sad or frustrated as a result of how you were treated based on any of the following?

- ☐ Age
- ☐ Disability
- ☐ Economic status
- ☐ English language skills
- ☐ Gender
- ☐ Perceived immigration status
- ☐ Race/ethnicity
- ☐ Religion
- ☐ Sexual orientation
- ☐ Other, please specify: _
- ☐ No

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29.Would you be interested in participating in a focus group on health or receiving the survey results in the future? Your contact information will be maintained separately from your survey responses (Check all that apply)

- ☐ Yes, I am interested in participating in a focus group.
- ☐ Yes, I am interested in receiving the survey results.
- ☐ No, I am not interested in either. (Skip to end of survey)

29a. Please provide your contact information below

Name: _____

Email: _____

Phone Number: _____

Thank you for helping us better understand the health needs of your community!

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AMAZING THINGS ARE HAPPENING HERE

Thank You

Your feedback on this report is welcomed. You may send written comments to or request more information on this 2019 Community Health Needs Assessment at community@nyp.org.

NewYork-Presbyterian