NewYork-Presbyterian Queens

56-45 Main Street, Flushing, NY 11355

Community Service Plan (CSP)

Implementation Plan 2019-2021

October 2019

Community Service Area:

50 New York City Neighborhood Tabulation Areas (NTAs) primarily in Queens county

Local Health Department(s) (LHDs):

The New York City Department of Health and Mental Hygiene
4209 28th St, Long Island City, NY 11101
Ana Gallego, Executive Director of Health Systems Planning and Policy
Email: agallego1@health.nyc.gov

Participating Hospital/Hospital System(s):

NewYork-Presbyterian Queens
56-45 Main Street, Flushing, NY 11355
Maureen Buglino, RN, Vice President, Ambulatory Care and Population Health
mabuglin@nyp.org

https://www.nyp.org/queens/about-us/community-service-plan

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Executive Summary

Introduction to Our Community Service Plan (CSP)

NewYork-Presbyterian Queens (NYP Queens), a member of the NewYork-Presbyterian Regional Hospital Network, completed a Community Health Needs Assessment (CHNA) to identify the needs of the community and develop a Community Service Plan (CSP) and detailed implementation plan to address the areas of highest need. Queens county, recognized as the most diverse county in the nation, requires a custom approach to community service planning to ensure alignment with the needs of the population. The leaders of NYP Queens are dedicated to the community with a mission to be the premier healthcare institution by providing excellence in clinical care, education, clinical research, and service. This document outlines the process, priorities, partners, and intended activities for 2019 – 2021. The CHNA process aligns with the 2019 – 2024 New York State Prevention Agenda (NYS PA); the state health improvement plan that develops action plans to improve the health and well-being of all New Yorkers and promotes health equity in all populations who experience disparities.

Partner Involvement & Commitment

NYP Queens collaborated with NewYork-Presbyterian, the New York City Department of Health and Mental Hygiene (DOHMH), Citizens' Committee for Children (CCC), Columbia University Mailman School of Public Health (CUMSPH), Weill Cornell Medicine, Greater New York Hospital Association (GNYHA), local community based organizations (CBOs), and the New York Academy of Medicine (NYAM) to adopt a community focused process of collecting and analyzing measurable data (quantitative) and views voiced by the community (qualitative) from a variety of sources. The

collaborative process ensured significant input from the key stakeholders and local community through surveys and focus groups conducted in multiple languages at multiple locations to engage the community in their setting.

Data Driven Priorities

The CHNA and CSP process was data driven. Measurable data along with community input from numerous sources were combined to analyze the health and challenges of our community. The analysis utilized focused neighborhood geography for measures and included data related to demographics, socioeconomic status, insurance status, social determinants of health, health status, health service utilization, and NYS PA. Measurable data sources include the CCC's Keeping Track Online; Open Data City of New York; Data2Go.NYC; NYC Health Atlas; NYC Mayor Report, the Association for Neighborhood & Housing Development; Behavioral Risk Factor Surveillance System (BRFSS), Claritas; NYC Community Health Profile; State Cancer Profiles; and U.S. Department of Agriculture. NYP Queens recognizes that community challenges are complex and healthcare outcomes are often linked to societal issues; therefore, community input sources of focus groups and community questionnaires were gathered and allowed for a diverse group of involvement with awareness to culture, race, language, age, gender identity, and sexual orientation. The collected data was ranked to provide insight into the communities with high disparities and was then prioritized to determine the highest needs for the communities and analyzed to establish focus areas and goals as outlined in the New York State Prevention Agenda.

Progress Improvement Tracking

Our team is committed to the successful implementation of each initiative and will utilize quality process improvement efforts quarterly to report on process and outcome measures in order to adapt each program to meet the annual expectations outlined as well as meet the needs of our community.

Community of Focus

Based on the completed data process, NYP Queens, in partnership with local community-based organizations, will target Corona and North Corona neighborhoods for the CSP. The community of Corona is culturally diverse and has unique challenges for health disparities and social determinants of health with childhood obesity rates of 26%, estimated 2.8 million missing meals, teen pregnancy rates of 68.9 per 1,000, 9.5% of pregnant women receiving late or no prenatal care, and new diagnosis of HIV, per 100,000, in North Corona of 32.3.

Priority Areas of Focus

The analyzed and prioritized data allowed for the identification of a community of focus as well as priority areas to impact the healthcare of the most vulnerable populations. NYP Queens will focus efforts related to the prevention of (1) chronic disease, (2) promotion of healthy women, infants, and children, and (3) communicable disease. To align with the constantly changing dynamics of the community, NYP Queens has revised the focus and initiatives as compared to the 2013 – 2016 CSP which included the prevention of chronic disease and prevention of HIV, STDs, Vaccine-Preventable Diseases and Healthcare-Associated Infections.

Priority Area & Goal	Intervention / Strategy
Healthy Eating & Food Security **Reduce Obesity & Risk of Chronic Disease**	
Goal 2.3 Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity	• Partner with community-based organizations to engage school-aged children in the FIT KIDS® program while educating parents and caretakers of nutrition and culturally focused meal preparation.
Promote Healthy Women, Infants, & Children	
Goal 1.1 Increase use of primary and preventative health care services by women of all ages with a focus on women of reproductive age	• Develop a teen pregnancy outreach and education program alongside an Article 28 school-based clinic for prevention and connection to care.
Prevent Communicable Diseases	
Goal 2.2 Viral Load Suppression	• Improve viral load suppression rates for the highest risk community with a culturally dynamic community-based program.

Introduction

NewYork-Presbyterian Queens (NYP Queens), located in Flushing, New York, is a community teaching hospital affiliated with Weill Cornell Medicine, serving Queens and metro New York residents. The 535-bed tertiary care facility provides services in 13 clinical departments and numerous subspecialties. NYP Queens is verified as a Level I Trauma Center by New York State and by the American College of Surgeons (ACS).

Annually, 15,000 surgeries and 4,000 infant deliveries are performed at NewYork-Presbyterian Queens; with its network of affiliated primary and multispecialty care physician practices and community-based health centers, the hospital provides approximately 162,000 ambulatory care visits and 124,000 emergency department visits annually.

Our mission is to provide our community with excellence in clinical care, patient safety, education, clinical research, and science while continually monitoring the needs of our community and ensuring our services cater to the diversity of the patients we serve. As the most diverse large county in the nation, it is our commitment to adapt our operations to the needs of Queens and surrounding counties.

The hospital is a member of the NewYork-Presbyterian Regional Hospital Network and is affiliated with Weill Cornell Medicine. NewYork-Presbyterian (NYP) is one of the nation's most comprehensive, integrated academic health care delivery organizations, dedicated to providing the highest quality, most compassionate care and service to patients in the New York metropolitan area, nationally, and globally. In collaboration with two renowned medical school partners, Weill Cornell Medicine and Columbia University Vagelos College of Physicians and Surgeons, NewYork-Presbyterian is consistently recognized as a leader in medical education, ground-breaking research, and clinical innovation.

Purpose

NYP Queens is deeply committed to the community members residing in Queens county and the surrounding areas of New York City by 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. The CHNA process is undertaken every three years to determine the high disparity communities and health needs that can be most positively impacted by focused interventions and initiatives supported by the health system

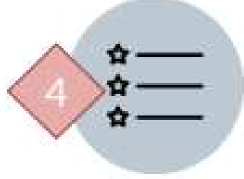
The CHNA aligns with the New York State 2019-2024 Prevention Agenda (NYS PA) priorities to improve health equity for all New Yorkers through partnerships with community organizations to address social determinants of health (SDoH) and interventions to reduce inequalities in health indicators. Through the NYS PA alignment with the NYP CHNA process, the state has improved its overall national ranking from 28th to 10th healthiest state since 2008. Our commitment as a facility within New York State is to align our efforts with that of the state and to strategically invest in opportunities to improve the health of the patients within our community.

NewYork-Presbyterian Queens (NYP Queens), a member of the NewYork-Presbyterian Regional Hospital Network, completed a CHNA to identify the needs of the community and develop a CSP and detailed implementation plan to address the areas of highest need. Queens county, recognized as the most diverse of a large county analysis across the nation, requires a custom approach to community service planning to ensure alignment with the needs of such a diverse population. The leaders of NYP Queens are dedicated to our community and we strive to be the premier healthcare institution using innovative healthcare techniques to address the healthcare and socio-economic challenges of our patients. The CHNA and CSP data collection and action planning were designed to achieve the following goals to ensure a comprehensive analysis of the community need:

Obtaining ***broad community input*** regarding local health including medically underserved and low-income populations

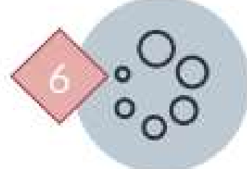
Collecting and evaluating ***quantitative data*** for multiple indicators of demographics, socioeconomic status, health, and social determinants

Preparing an analysis resulting in the ***identification of the high disparity neighborhoods*** in the NewYork-Presbyterian Queens community

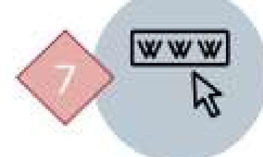


Prioritizing complex health needs utilizing a comprehensive model

Ensuring ***integration with the Priority Areas of the 2019-2024 New York State Prevention Agenda***



Including the ***description of each process and methodologies*** utilized



Making the CHNA ***results publicly available*** online

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 wellbeing and how it can be impacted and improved. For the purpose of this document:

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.

Process and Governance

NYP Queens engaged in a collaborative effort within NYP to create a collaborative, community focused approach to the development of the CHNA and CSP. A robust governance structure was created with representation from the regional hospital partners, community members, and community health experts. The following committees were convened for this process:

- *Data Committee* – managed the data collection and analysis process to ensure data integrity and inclusion of social determinant of health indicators and quality health indicators
- *Methods Committee* – created the processes to engage community members in the CHNA process through community health needs questionnaires and in-person focus groups
- *Steering Committee* – leadership engaged in oversight of the CHNA development and strategic decision making for the CHNA and CSP

In addition to the formal committee structure, Community Health Think Tank meetings were created across each hospital to engage key clinical and operational leaders in the process of initiative planning and operationalization. The Community Health Think Tanks are an ongoing process to continue to engage key stakeholders in a performance improvement process and provide feedback for reporting on the progress for the CSP.

Partner Engagement

In conducting the 2019 CHNA, NYP collaborated with the New York City Department of Health and Mental Hygiene (NYC DOHMH), Citizens' Committee for Children of New York (CCC), Columbia University Mailman School of Public Health (CUMSPH), Weill Cornell Medicine, New York Academy of Medicine (NYAM), and Greater New York Hospital Association (GNYHA). Through these collaborations NYP Queens was able to adopt a community-engagement approach that involved collecting and analyzing qualitative information and quantitative data from a variety of publicly available sources to comprehensively assess the health status of our communities. Each stakeholder added to the ongoing work by providing insight on the publicly available data for the various regions specific to the high disparity communities, while providing guidance on collecting stakeholder and community feedback and incorporating best practices.

NYP Queens engaged the New York Academy of Medicine (NYAM) to facilitate the focus groups of community members to obtain their perspectives on the health and needs of the community at large. Several community-based organizations hosted focus groups:

- Asian Americans for Equality
- Elmcor Youth & Adult Activities Inc.
- Make the Road New York
- Public Health Solutions
- The Korean Community Services of Metropolitan New York
- NewYork-Presbyterian Queens Community Advisory Board (NYP Queens CAB)

The ability to engage, analyze, and plan with our community-based partners allowed NYP Queens to develop thorough implementation plans utilizing evidence-based criteria and create initiative-based partnerships for 2019 – 2021.

Data Mining and Analytics

A dynamic data collection and analytic process was established to ensure the community and its needs were well represented throughout the CHNA development process. NYP Queens utilized both quantitative and qualitative data to create a picture of the health needs of the Queens community.

Quantitative Data

NYP Queens utilized numerous indicators for the quantitative, measurable, data set from multiple sources to analyze community health need and risk of high disparity geography to the specific neighborhood level. The analysis utilized 29 indicators across five domains: demographics, income, insurance, access to care, and New York State Department of Health Prevention Agenda Priorities (NYS PA) at the Neighborhood Tabulation Area (NTA) geography. Indicators included categories of demographics, socioeconomic status, insurance status, social determinants of health, health status, and health service utilization were collected to assess community health needs. These indicators were used to identify further areas of disparities and to prioritize the implementation strategies and support health intervention planning (See data sources in Appendix A).

Qualitative Data

Qualitative data was gathered, validated, and refined using (1) community input from facilitation of focus groups and administration of community health need questionnaires to area residents as well as (2) leveraging other community assessments performed in the community. The community input from multiple sources allowed for a comprehensive representation of our community inclusive of multiple languages, socio-economic statuses, culture, race, age, and gender identity. Summaries of each qualitative input source is included below, and additional details can be found in the CHNA at https://www.nyp.org/queens/about-us/community-service-plan.

Focus Groups and Questionnaires

NYAM was engaged to gain the voice of the community utilizing focus groups and community questionnaires. A community health needs questionnaire (CHNQ) was conducted with community members both online and in person in order to identify the most important health concerns as well as the most needed health improvements. Six focus groups were conducted, and two-hundred and eight questionnaires were completed within the Queens county catchment area.

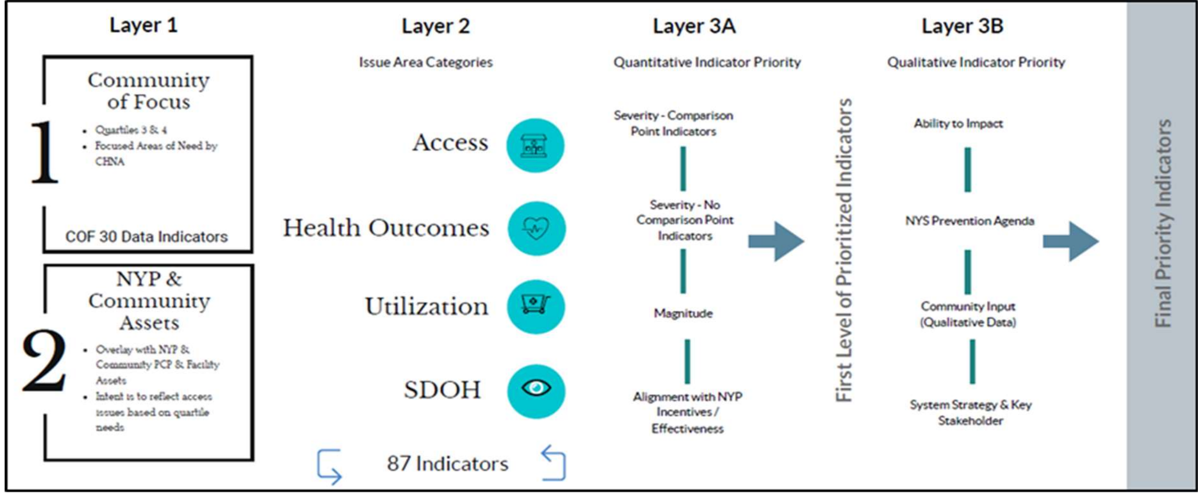
CCC's Elmhurst/Corona, Queens Report for Community Driven Solutions to Improve Child and Family Well-Being.

Citizens' Committee for Children of New York (CCC) utilized government data on child and family well-being, mapped community assets, and engaged in conversations with community members to prepare an assessment for District 4 - Elmhurst/Corona (five neighborhoods: Corona, North Corona, Elmhurst, Elmhurst-Maspeth, and East Elmhurst). The focus was to gain community input to identify areas of concerns and recommendations.

Data Prioritization Process

A prioritization process was created to analyze the quantitative and qualitative data inputs collected through the CHNA process. The process was built utilizing several layers and identified measurement criteria in which the data was input and prioritized to arrive at the final priority indicators.

- *Layer 1* – the data from the community of focus for the 3rd and 4th quartiles (high risk areas) was utilized for the prioritization process
- *Layer 2* – The data indicators was categorized into four categories: (1) Access, (2) Health Outcomes, (3) Utilization, and (4) Social Determinants of Health
- *Layer 3A* – the quantitative data was ranked based on three criteria: (1) severity – with a comparison to NYC or without a comparison, (2) magnitude of the population impacted, and (3) alignment with current NYP Queens initiatives
- *Layer 3B* – the 3rd and 4th quartile (highest risk) data from layer 3A was utilized for layer 3B of the model; the qualitative data for this section was ranked based on four indicators: (1) ability to impact the indicator, (2) alignment with the NYS PA, (3) Community Input, and (4) NYP stakeholder input



Prioritized Community Needs

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

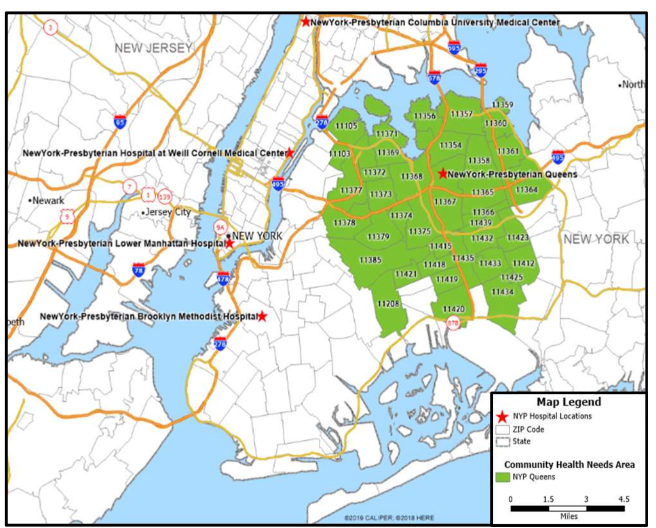
- Women's Health / Maternal Health
- Chronic Disease and Obesity
- Mental Health and Substance Abuse

CATEGORY	INDICATORS	QUARTILE
Health Outcomes	Childhood Obesity	4th
Health Outcomes	Cancer Incidence - All Sites*	4th
Health Outcomes	Obesity	4th
Health Outcomes	Physical Activity	4th
Health Outcomes	Diabetes	4th
Utilization	Hospitalizations: Preventable Diabetes*	4th
Health Outcomes	Percentage of adults with poor mental health for 14 or more days in the last month	4th
Health Outcomes	Hypertension	4th
SDoH	Current Smokers*	4th
SDoH	Binge Drinking*	4th
Health Outcomes	Teen Births*	4th
Utilization	Hospitalizations: Preventable Hypertension*	4th
SDoH	Meal Gap (# of Meals Needed per Year for Food Security) *	4th
Utilization	Hospitalizations: Alcohol*	4th
Utilization	Hospitalizations: Drug*	4th
Health Outcomes	Percentage of adults with diagnosed high blood pressure taking high blood pressure medication	4th
Access	Late or No Prenatal Care	4th
Health Outcomes	Infant Mortality*	4th

COMMUNITY HEALTH ASSESSMENT - PRIORITIZED NEEDS

Our Community At Large

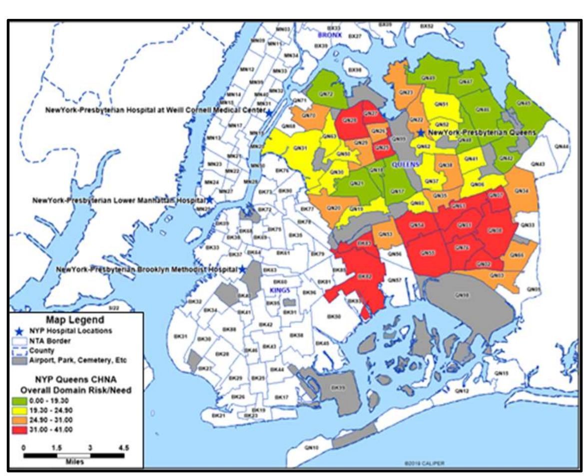
The community definition for NewYork-Presbyterian Queens was derived using 80% of ZIP codes from which NYP Queens' patients originate and adding ZIP codes not among the original patient origin to create continuity in geographical boundaries, resulting in a total of 41 community ZIP codes mainly within Queens county.



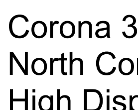
NYP Queens Defined Community Highlights

1.8M+ PEOPLE The defined community covers a geography of approximately 1.8M+ people	**2.7% GROWTH POPULATION** Forecasted to grow faster, 2.7%, than the state average,1.5%, between 2019-2024	**14.8% 65+ POPULATION** Is slightly younger with only 14.8% of the population aged 65+ compared to 16.3%
$86,554 HOUSEHOLD INCOME The average household income, $86,554, is lower than the average of New York State, $101,507	**6.2% UNEMPLOYMENT RATE** The unemployment rate, 6.2%, is the same as the New York State benchmark, but there are fewer white-collar workers than the state average	**HIGHER MINORITY POPULATION** Higher non-White population, 78.2%, than the state 45.6%, driven by Hispanics, 31.3%, followed by Asian/Hawaiian/ Pacific Islanders, 28.5%

Our Communities of Focus



To ensure the CSP is focused and NYP Queens implements initiatives that impact the highest disparity neighborhood(s), an additional analysis of community health need and risk of high resource utilization at the Neighborhood Tabulation Area (NTA) geography based upon a composite of 29 indicators. Indicators were carefully selected, across five domains: demographics, income, insurance, access to care, and New York State Department of Health Prevention Agenda Priorities (NYS PA). The objective was to identify the specific NTAs where there is a higher health need and/or a higher expectation of required resources. The defined community's 41 ZIP codes were cross walked to 50 NTAs and categorized into four quartiles. Additional analysis was undertaken for the 25 NTAs of higher disparity that fell into quartiles 3 and 4.

Adult Obesity, Percent of Population	**Percent of live births receiving late prenatal care**	**New diagnoses of HIV, per 100,000 population**
Corona 23.0% ↕ North Corona 20.0% ↓ High Disparity NTAs 23.3% NYC 24.0%	Corona 8.3% ↑ North Corona 9.4%% ↑ High Disparity NTAs 9.0% NYC 7.0%	Corona 25.0 ↑ North Corona 32.3 ↑ High Disparity NTAs 22.2 NYC 24.0
Child Obesity, Percent of Population	**Rate of Teen Births, per 1,000 women ages 15-19**	**New HCV diagnoses, per 100,000 population**
Corona 24.0% ↑ North Corona 26.0% ↑ High Disparity NTAs 21.2% NYC 20.0%	Corona 37.4 ↑ North Corona 68.9 ↑ High Disparity NTAs 25.0 NYC 23.7 	Corona 33.5 ↓ North Corona 36.7 ↓ High Disparity NTAs 51.9 NYC 71.8

Acknowledging that there was variation across the NTAs and counties among specific measurable indicators for demographics, socioeconomics, SDoH, health status, and utilization that each require a custom approach to community service planning, there were specific communities that frequently showed more need than the others. The ten NTAs with the top disparity scores include East New York, Jamaica, South Jamaica, Cypress Hills-City Line, Baisley Park, East Elmhurst, Hollis, Springfield Gardens North, Richmond Hill, and Corona.

NYP Queens Data Highlights – High Disparity Community & Priority Areas

In order to focus initiatives to make the largest impact to high disparity communities, the NYP Queens team analyzed all data elements and identified Corona and North Corona communities targeting (1) Obesity, (2) Women's Health, and (3) HIV/HCV. Below is a summary of the analytical findings for the focused communities:

NY State Community Health Indicator Trends

Priority Area	NYC NTA	NY State Community Health Indicator Report Trends
Prevent Chronic Disease Focus Area 1: Healthy Eating and Food Security	**Adult Obesity** Corona 23.0% North Corona 20.0% High Disparity NTAs 23.3% NYC 24.0% **Child Obesity** Corona 24.0% North Corona 26.0% High Disparity NTAs 21.2% NYC 20.0%	Trend data suggests that there may be some improvement among pre-school aged children, but continued efforts are needed among school aged children and adults, in Queens county.
Promote Healthy, Women, Infants and Children Focus Area 1: Maternal & Women's Health	**Rate of Teen Births (per 1,000 women ages 15 to 19)** Corona 37.4 North Corona 68.9 High Disparity NTAs 25.0 NYC 23.7	Trend data are not available.
Prevent Communicable Diseases Focus Area 2: HIV Focus Area 4: HCV	**New diagnoses of HIV per 100,000 population** Corona 25.0 North Corona 32.3 High Disparity NTAs 22.2 NYC 24.0 **New HCV diagnoses per 100,000 population** Corona 33.5 North Corona36.7 High Disparity NTAs 51.9 NYC 71.8	The NY State Prevention Agenda is focused to a three-point plan to move closer to end the AIDS epidemic by decreasing the number of new HIV infections and to decrease the HIV prevalence in New York State.

Community Challenges and Contributing factors

The qualitative analysis process of the CHNA allowed NYP Queens the ability to gain the perspective of the community on the top challenges and contributing factors to the outcomes of their health. The community health needs questionnaire (CHNQ) focused on basic demographics, health concerns (individual and community-wide), health care utilization, barriers to care, and use of NYP Queens services. This data was collected between June and August 2019, in partnership with numerous community organizations, which were identified to represent a range of populations, e.g., older adults, immigrant, and homeless populations.

Community Questionnaires

Respondents included NYP Queens Community Advisory Board (NYP Queens CAB) members and community residents, some of which were recruited using online platforms such as Craigslist. A total of 208 questionnaires were completed. Below is a summary of the most commonly reported community health issues and recommendations to improve community health:

Recommendations to improve community health*		N=208
Community health recommendations	**n**	**%**
Cleaner streets	98	47.1%
Improved housing conditions	88	42.3%
Reduced crime	81	38.9%
Reduced cigarette/vaping smoke	76	36.5%
More local jobs	75	36.1%
Increased # of places for older adults to live and socialize in	74	35.6%
Reduced air pollution	74	35.6%
Reduction in homelessness	70	33.7%
More parks and recreation centers	69	33.2%
Improved water quality	50	24.0%

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

Most commonly reported community health issues *		N=208
Community health issue	**n**	**%**
Diabetes	95	45.7%
High blood pressure	85	40.9%
Alcohol & drug use	79	38.0%
Mental health	76	36.5%
Obesity	74	35.6%
Cancer	70	33.7%
Tobacco use	64	30.8%

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

Focus Groups

The Center for Evaluation and Applied Research (CEAR) at NYAM developed a semi-structured focus group guide in collaboration with the NewYork-Presbyterian CHNA Steering Committee and Methods Committee and completed six focus groups:

- Asian Americans for Equality
- Elmcor Youth and Adult Activities, Inc.
- Make the Road New York
- Public Health Solutions
- The Korean Community Services of Metropolitan New York
- NewYork-Presbyterian Queens Community Advisory Board (NYP Queens CAB)

"It would be helpful if more hospitals, clinics, or even private psychologists or psychiatrists took Medicaid. Which the majority of at least the people I know have Medicaid."

Focus groups were approximately ninety minutes and voluntary with incentives provided to participants. The focus groups were conducted in multiple languages to address the diversity of Queens county. The following trends were consistent among groups:

Greatest Health Concerns
- Obesity
- Diabetes
- Gastritis
- Cancer
- Heart Disease
- Mental Health and Substance Abuse

SDoH
- Immigration
- Housing
- Access to Healthcare
- Physical Activity
- Lack of Affordable Health Food

Other
- Capaigns to reduce stigma for behavioral health
- Time, travel costs, and immigration feats have impacted patients seeking care

Participant Recommendations
- Improved language services and provider that are from the community they serve
- Nutrition programs for the community based on cultural backgrounds

"I think the biggest problem of Koreans is mental. Mental health. Because there should be a goal, a child, a relative, a goal like this, but there's no goal in their lives. Because there are no good economic conditions that I can expect as an immigrant here."

"I noticed something about this neighborhood [North Corona]. There's not a lot of good places to eat. Like, the food quality. Like, it's either rice and beans – which I like, but in the fast food type of way's not really good for you."

"Yeah. You walk in the street, everybody's afraid. ICE, ICE, ICE. That's definitely here."

Other Community Feedback – Focus on Pediatrics

In 2019, the Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data to establish a method through which to identify assets or resources in the Queens Community District 4 (Elmhurst/Corona). The resulting publication named '*Elmhurst/Corona, Queens: Community Driven Solutions to Improve Child and Family Well-being'* detailed this community, its biggest issues, numerous assets and specific recommendations for health.

The report of Queens Community District 4 (Elmhurst/Corona) included the five neighborhoods of Corona, North Corona, Elmhurst, Elmhurst-Maspeth, and East Elmhurst. The community input provided a diverse source of immigrant households and the most common needs raised during conversations included:

- Need of 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

The information gathered from all qualitative opportunities provided NYP Queens the opportunity to truly hear the voice of the community. The trends were utilized in the prioritization model to ensure the community voice was used as a measurement to prioritize the CSP initiatives. The qualitative process reflects behavioral, environmental, and socioeconomic factors that relate to our community. An additional factor that affects health is the New York State and federal policy environment. Below are examples of such policy changes.

Health Care Policy Potential Impact

The health care policy environment can and does contribute to community wide health improvement or conversely to its challenges. Several policies have been identified that are impacting the residents of New York and the environment that NYP and its partners are operating in. The NYP Queens leadership stays abreast to healthcare policy changes by partnering with the NYP Government and Community Affairs department to inform patient care and community-based initiatives. Initiatives outlined in the CSP were developed utilizing the following policy environment:

New York State Prevention Agenda

Positive changes to the community with focused action planning at the state and local level to promote health equity in all populations who experience disparities.

> The Prevention Agenda is the state's health improvement plan that aligns expectations of the state and provider communities to address health equity and high disparate communities with a focus to improve healthcare for communities that need it most. The New York State Public Health and Health Planning Council, at the request of the Department of Health, establishes guidelines to target improvement efforts to increase access, education, outreach, and quality outcomes for designated categories of chronic disease, healthy and safe environment, healthy women, infants, and children, mental health and substance abuse, and communicable diseases.

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 is seeking a four-year 1115 Waiver extension to further support clinical transformation efforts focused to the Medicaid populations associated to 25 Performing Provider Systems (PPS). The extension would continue the federal and state investments with focus to quality outcomes and improvement, workforce development, social determinants of health, and community based and clinical network development. The extension would expand on existing activity and add new focus to the partnerships with the justice system, primary care / behavioral health integration, care coordination / care management / care transitions, mobile crisis teams and crisis respite services, Institutions of Mental Disease (IMD) patient transition, serious mental illness populations, social determinants of health, and alternative payment models.

Elimination of religious exemptions to vaccinations for school aged children:

While this issue continues to be debated publicly, this 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.

Ending the Epidemic

Initiative focused upon treatment of 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 lifesaving, 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

Maternal Mortality Review Board

The review board would focus on 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.

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. Some 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.

New York State Opioid Tax

To begin to fight the opioid epidemic, the State of New York 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 the 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 past marijuana possession convictions and reducing penalties for the possession of small amounts of the drug. The bill does not fully legalize the use of marijuana.

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.

Federal Change in Public Charge Rule

Potential unfavorable impact to the willingness of residents with a green card 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 may contribute to more uninsured individuals and negatively affect the health and financial stability of families and the healthy development of their children.

Affordable Care Act (ACA) Federal Ruling

Potential to unfavorably impact populations nation-wide, who have since 2019 been able to obtain health insurance and ACA protections. NYS lawmakers are currently debating Governor Cuomo's plan for codifying key ACA provisions and state regulatory protections into state law. It includes the ban on insurance limitations for pre-existing conditions, as well as the requirement that all insurance policies sold in New York cover the 10 essential benefits defined in the Affordable Care Act.

> A group of states 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 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 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 District court’s decision is upheld.

COMMUNITY SERVICE PLAN - FOCUS AND INTERVENTIONS

Community of Focus

Based on the data process of analytics and prioritization, ***NYP Queens will target efforts in the Corona and North Corona neighborhoods of Queens*** to allow our teams to invest and concentrate efforts and directly impact a high need community within the three-years of the service plan.

Priority Areas of Focus and Initiatives

The data outlined allowed the team to identify a community of focus as well as priority areas to impact the healthcare of the most vulnerable populations. The priority areas differ from the prior 2016-2018 CSP, which included increase access to high-quality chronic disease preventative care and management and prevent HIV and STDs with a focus on increasing screening rates of Hepatitis C. The previous CSP focus allowed NYP Queens to accomplish:

- Blood pressure screenings at 14 community health fair events totaling 815 community member free blood pressure readings
- Develop evidence-based care management risk techniques for pre-hypertension and hypertensive patients to ensure proper identification and care coordination
- Identification of patients with repeated blood pressure readings to ensure access to medical care
- Implementation of workflows for emergency department hepatitis C testing
- Connection of positive tests to primary care clinics

NYP Queens is committed to serving the community by providing a wide range of health care services and activities that are important and provide benefit to our community members. Our assessment shows that there are numerous and significant needs, and the hospital has chosen a selection of these needs in order to concentrate resources and efforts and focus evaluations on those initiatives which we believe we can most

effectively execute on and which will provide the largest impact to our community. In addition, the prioritization model applied to significant community needs was rooted in the quantitative as well as the qualitative voice of the community helping to ensure that our selection was aligned with those needs ranked highly by our community members.

The selected initiatives and resulting CSP were reviewed and approved by senior leaders, hospital community advisory board members, and our CHNA Steering Committee in the context of our organizational mission, our clinical strengths, and partnerships.

NewYork-Presbyterian Queens has selected the focused priorities for the 2019-2021 CSP, which were reviewed and approved by executive leadership and NYP Queens' governing body on December 3, 2019.

2019-2021 Community Service Plan Initiatives:

Prevent Chronic Disease – Focus Area 1: Reduce Obesity & the Risk of Chronic Disease

Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity.

Initiative – Partner with community-based organizations to engage school-aged children in the FIT KIDS® program while educating parents and caretakers of nutrition and culturally focused meal preparation.

Objective – Increase access to physical activity, educate kids and family members on food, nutrition, and preparation in order to reduce obesity in children.

FIT KIDS® is an evidence-based practice focused on core objectives of nutrition, exercise, and behavioral components for children and their families. The program is intended to focus on overweight children but has shown benefits to all children engaged as well as parents and caretakers. FIT KIDS® utilizes community-based engagements and outreach in order to improve children's nutritional status, increase physical activity, enhance self-esteem, and establish life-long habits. The program utilizes engagement and physical indicators such as Body Mass Index (BMI) and body circumference to establish pre and post measurements in order to analyze success within each engagement group. Along with measurable indicators, the program can assess self-esteem and behavioral factors, which can be improved by increased physical activity, expansion of food choices, and overall improvement of clinical health.

NYP Queens will partner with Corona based or surrounding area K-12 schools as well as community-based organizations, such as Public Health Solutions, to identify high-risk children and families, establish safe environments for physical activity, provide culturally focused nutritional support, education, and meal preparation utilizing a community-

based demonstration kitchen. The Corona community reflects rates ranging from 24% to 26% in North Corona as compared to the NY City rate of 20.0%. The program will utilize community-based partnerships to allow for additional programmatic support through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and SNAP program to address food insecurities. Programmatic support will include exercise physiology, dietician, social work, data analytics, and programmatic coordination to provide a multi-disciplinary approach. The program will be anchored by NYP Queens in order to provide clinical wrap services for patients identified with access to care gaps or immediate clinical needs.

The goals of the program will focus on engagement and outcome metrics for years 2021 – 2023.

Year 1: Develop partnerships with community-based organizations to outline programmatic details and budgets related to the multi-disciplinary program. Create a FIT KIDS® business plan, schedule of events, budget, CBO contracts, outreach materials, and recruit dedicated staff for the program.

Year 2: Implement the FIT KIDS® program utilizing the materials established in year 1 within a dedicated community of high-risk children.

Year 3: Continue to expand the engagement to additional children and initiate the demonstration kitchen for the education of culturally aware nutrition and food preparation for parents and caretakers.

	Children Enrolled	**# Family/caregivers participating in Healthy Eating Seminars**	**Physical Activity Improvement (Survey)**
Baseline	0	0	0
Year 1	0	0	0
Year 2	10	10	2% Increase # hours/week
Year 3	15	15	5% Increase # hours/week

Promote Healthy Women, Infants and Children – Focus Area 1: Maternal and Women's Health

Goal 1.1 - Increase use of primary and preventative health care services by women of all ages with a focus on women of reproductive age.

Initiative – Develop a teen pregnancy outreach and education program for prevention and connection to care alongside the implementation of an Article 28 school-based clinic (SBHC).

Objective – Reduce teen birth rate and improve clinical outcomes through peer educator model for teens in Corona Queens, NY.

NYP Queens is planning to partner with community-based organizations such as Public Health Solutions, Voces Latinas, and other local CBOs to create a preconception peer educator model for teens. The Preconception Peer Educator program is a promising practice that was developed by the Office of Minority Health (OMH)[1] to raise awareness among college students about the disproportionately high infant mortality rates among racial and ethnic minorities. This program, which was designed for college-aged students, will be adapted for teens and focused in the Corona Queens community. Additionally, NYP Queens will work towards opening an Article 28 clinic in a local feeder high school for the North Corona community. The clinic will partner with the identified community-based organizations to provide family planning and preconception education services to students and refer pregnant teens for early prenatal care. The Corona community has significantly higher rates of teen pregnancies, receive late prenatal care, and the trends are worsening for low birth weight compared to Queens county and NYC. The clinic will increase access to care, reproductive health, and mental health services to adolescents to improve quality of care while reducing time away from the classroom.

[1] Office of Minority Health Preconception Peer Educator (PPE) Program: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=9

Measure	NYC	Queens county High Disparity	Corona	North Corona
Rate of Teen Births (per 1,000 women ages 15-19)	23.7	25.0	37.4	68.9
Percent of Live Births Receiving Late Prenatal Care	7.0%	9.0%	9.9%	9.4%
Measure	**NYC**	**Queens county**	**Community District 4 (Corona/Elmhurst)**	
Low Birth Weight (<2,500gms)	10.3 (↑ 0.3)	9.8 (↑ 1.0)	8.6 (↑ 0.1)	

Teens will be identified and engaged for the program through the local schools, faith-based organizations, and relationships with local CBOs. The focus of the program will be to engage teens in preconception education, provide workforce experience and resume building opportunities for peers, and reduce teen birth rates while improving the clinical outcomes related to births for the Corona Queens community.

This initiative will be implemented and monitored over the three years of the CSP cycle with the following goals:

> Year 1: Identification of community-based organization partnerships to develop business plans, budget, outreach materials adapted to meet the needs of high-school students. Upon contract execution with CBOs, the team will create culturally competent outreach and education materials and recruit budgeted program staff. Additionally, the team will identify and select a school for an Article 28 school-based clinic in collaboration with NYS Department of Health Office of School Health. The selected school will serve students from the high disparity community identified of Corona and North Corona.

Year 2: Implementation of the peer conception education model in the Corona community utilizing peers in community-based settings. Design and planning of Article 28 school-based clinic with the NYC Office of Facility Development and the School Construction Authority, submit SHBC application to the NYS Department of Health Office of School Health, as well as the outreach and engagement plans for students, parents, and school staff at location.

Year 3: Increase peers, refine program, increase outreach, and publish program and any associated operational or clinical improvements. Launch of Article 28 school-based clinic inclusive of services to support reducing teen pregnancy including family planning, preconception education, and prenatal care referrals and services.

	# of Peers Trained & Implemented	# of Students Engaged in Peer Program	# of Pregnancies with Engaged Students (Goal of 0)	Article 28 School-Based Clinic
Baseline	0	0	0	0
Year 1	0	0	0	0
Year 2	3	15	0	0
Year 3	5	20	0	1

Prevent Communicable Disease – Focus Area 2: Human Immunodeficiency Virus (HIV)

Goal 2.2 – Increase viral suppression.

Objective – Improve viral load suppression rates for the highest risk community with a culturally dynamic community-based program.

Initiative – Implement a multi-disciplinary community-based program, inclusive of peer outreach, care management, and pharmacy case management, targeting the improvement of viral load suppression rates for the Hispanic population ages 13 – 29.

According to the AIDS Institute of the NY, New York State's persons living with diagnosed HIV (PLWDH) reported a 2016 rate of 70% viral load suppression which is lower than the 2020 National HIV AIDS Strategy (NHAS) target of 80% and the 2020 NYS Ending the Epidemic (ETE) target of 85%. Queens county, on average, reflects a 68% viral load suppression rate (VLSR) within six-months of diagnosis (NYC Health 2017 HIV Epidemiology and Field Service Program) with concerning trends for the Hispanic population and those diagnosed under the age of 29. The Hispanic population has a 2017 VLSR of 86% compared to the white population of 92% and a rate of new HIV diagnosis that is five times higher than the white population of Queens. The VLSR rate for ages 13-19 is 64% and ages 20-29 is 73% which suggests a considerable need for intervention. The rate of new HIV diagnosis for those 20-29 is considerably higher than other age group with an average annual rate of 156 between 2013 – 2017.

NYP Queens continues to prioritize HIV/AIDS efforts by partnering with community-based organizations and non-hospital clinical providers in order to benefit the community. According to numerous studies in the NCBI database[2], viral load suppression improvement is reflected in efforts to improve medication adherence and utilize culturally aware care management techniques. The New York State Ending the AIDS Epidemic three-point plan includes literature

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4559146/

and promising practices specific to the use of peers and linkage to care for viral load suppression[34]. The evidence-based criteria allowed the NYP Queens team to develop a community-based initiative to partner with Voces Latinas, a community-based organization, as well as a community pharmacy for the young Hispanic population. The initiative will expand services of care management/patient navigation, outreach, education, access to care, access to medication, and pharmacy care management techniques in order to improve viral load suppression of the targeted community members. Voces Latinas will develop a Pro-Moviendo peer education model with a viral load suppression campaign which will influence the curriculum of all peers implemented as well as expand their current Care Management/Patient Navigation program. Alongside Voces Latinas and NYP Queens, the NYP Queens specialty pharmacy and a community-based pharmacy will offer pharmacy care management techniques with prescription delivery options to improve medication access and adherence for the identified group. NYP Queens will lead the multi-disciplinary program while offering access to care, data analytics, quality process improvement, and clinical subject matter experts and leadership. The program will be based primarily in Corona but will have the adaptability to serve other high needs communities as defined by the CSP initiative quality team that is created with the program.

This initiative will be implemented and monitored over the three years of the CSP cycle with the following goals:

> Year 1: Partner with community-based organization and NYP Queens pharmacy and community pharmacy to develop business plans, budget, viral load suppression peer curriculum, and a Quality Performance Improvement (QPI) team inclusive of clinical and non-clinical team members with data analytics capabilities to ensure ongoing analysis and updates to the program. Upon contract execution with CBO and pharmacy partners, the team will create culturally competent outreach and education materials and recruit budgeted program staff.

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3 https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/non_english_speaking_migrant_seasons_farm_workersandnew_immigrants_implementation_strategies.pdf

4 https://www.health.ny.gov/diseases/aids/ending_the_epidemic/docs/pharmacy_implementation_strategies.pdf

Year 2: Implementation of the peer model in the Corona community, expand care management/patient navigation services, develop the pharmacy care management protocol with physician and pharmacist leads, implement the pharmacy care management techniques on identified Hispanic patients within the age of 13 – 29, and develop lines of communication for access to care within the community.

Year 3: Increase peers, refine program, increase outreach, and publish program and any associated operational or clinical improvements.

	# of Peers Trained & Implemented	**# of HIV Patients Engaged – Peer or RX**	**Viral Load Suppression Rate Improvement**
Baseline	0	0	0
Year 1	0	0	0
Year 2	5	15	2%
Year 3	7	20	5%

Initiative Progress Tracking

Progress tracking will be maintained quarterly by the NYP Queens leadership team. Quarterly findings will be used as a quality performance improvement process to refine processes and program developmental efforts to ensure needs of the population are met. Quarterly data gathering will include community-based partners to ensure ongoing engagement and programmatic updates. The quarterly updates will then to be used to compile an annual report to meet both the state and federal expectations of reporting.

Assets and Resources

NYP Queens recognizes that there are existing assets, resources, and partners which may be leveraged for both expertise and economies of scale to deploy initiatives collaboratively for the benefit of community health improvement. Several notable assets/resources follow.

Asset Name	Brief Description
Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider System	The NYP Queens PPS was established to implement the deliverables outlined in the NYS DSRIP program for nine projects ranging from primary care, chronic disease, long-term care, behavioral health, and HIV efforts. The collaborative PPS established a high value network as well as administrative support staff and analytics to implement programs to impact quality outcomes of the high need Medicaid community.
Community Health Worker (CHW) and Patient Navigator Program	Community Health Workers and patient navigators from CBOs to support our patients in a variety of settings, including the patient's home, by helping them to navigate and connect to our hospital and community resources, to manage their own health and well-being, and to avoid preventable utilization.
NYP Queens Special Care Center	NYP Queens Special Care Center is a Designated AIDS Center (DAC) and provides multi-disciplinary care coordination and comprehensive care services to patients with HIV infection and AIDS.
The Family Health Center at Jackson Heights (FHC)	NYP Queens FHC is a Level 3 NYS, NCQA Designated Patient Center Medical Home (PCMH), NCQA Diabetes Center of Excellence, NY City Department of Health Honor Roll for HPV vaccinations for male and female adolescents and provides primary/preventative care for all ages as well as comprehensive women health services.

Website Availability

The CHNA and CSP can be found on the NYP Queens website at https://www.nyp.org/about-us/community-affairs/community-service-plans.

Appendix A

Quantitative Data Sources

Data Source	Data Period	Publicly Available Website
Association for Neighborhood and Housing Development	2018	https://anhd.org/report/how-affordable-housing-threatened-your-neighborhood-2019
Behavioral Risk Factor Surveillance System (BRFSS) New York State	2016	https://www.cdc.gov/brfss/index.html
Citizen's Committee for Children Keeping Track Online	2017	https://www.cccnewyork.org/
Claritas	2019	N/A
Data City of New York	2018	https://opendata.cityofnewyork.us/
Data2Go.NYC	Varies by indicator 2010-2016	https://data2go.nyc
Definitive Healthcare	2019	N/A
New York City Mayor Report	2005-2017	https://www1.nyc.gov/site/opportunity/poverty-in-nyc/data-tool.page
Nielsen	2019	N/A
NYC Health Atlas	Varies by indicator 2010-2015	https://www1.nyc.gov/site/doh/health/neighborhood-health/nyc-neighborhood-health-atlas.page
NYC Community Health Profiles	Varies by indicator 2011-2017	https://www1.nyc.gov/site/doh/data/data-publications/profiles.page
Office of the State Comptroller	2018	https://www.osc.state.ny.us/localgov/pubs/research/foreclosure-update.pdf#search=%20foreclosure%20
State Cancer Profiles	2018	https://statecancerprofiles.cancer.gov/
U.S. Department of Agriculture	2015	https://www.fns.usda.gov/data-research