Community Health Needs Assessment

Prepared for
MOUNT SINAI ST. LUKE'S HOSPITAL
Mount Sinai St. Lukes's
Mount Sinai West

By
VERITÉ HEALTHCARE CONSULTING, LLC

December 31, 2017

ABOUT VERITÉ HEALTHCARE CONSULTING

Verité Healthcare Consulting, LLC (Verité) was founded in May 2006 and is located in Alexandria, Virginia. The firm serves clients throughout the United States as a resource that helps health care providers conduct Community Health Needs Assessments and develop Implementation Strategies to address significant health needs. Verité has conducted more than 50 needs assessments for hospitals, health systems, and community partnerships nationally since 2010.

The firm also helps hospitals, hospital associations, and policy makers with community benefit reporting, program infrastructure, compliance, and community benefit-related policy and guidelines development. Verité is a recognized national thought leader in community benefit and Community Health Needs Assessments.

The community health needs assessment prepared for Mount Sinai St. Luke's Hospital was directed by the firm's Vice President with an associate supporting the work. The firm's senior staff hold graduate degrees in relevant fields.

More information on the firm and its qualifications can be found at www.VeriteConsulting.com.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction

This community health needs assessment (CHNA) was conducted by Mount Sinai St. Luke's Hospital ("MSSL & MSW" or "the hospital") to identify community health needs and to inform development of an implementation strategy to address identified significant needs.

Mount Sinai St. Luke's Hospital is comprised of two campuses, Mount Sinai St. Luke's and Mount Sinai West, both in Manhattan. To enhance clarity, we use the following acronyms throughout this document:

Acronym	Entity
MSSL	Mount Sinai St. Luke's, the campus in the Upper West Side neighborhood, Manhattan
MSW	Mount Sinai West, the campus in the Chelsea and Clinton neighborhood, Manhattan
MSSL & MSW	Mount Sinai St. Luke's Hospital, the hospital facility with two campuses in Manhattan

This CHNA was conducted by MSSL & MSW to identify community health needs and to inform development of an implementation strategy to address identified significant needs.

OBJECTIVES AND METHODOLOGY

Regulatory Requirements

Federal law requires that tax-exempt hospital facilities conduct a CHNA every three years and adopt an Implementation Strategy that addresses significant community health needs.[1] Each tax-exempt hospital facility must conduct a CHNA that identifies the most significant health needs in the hospital's community. The regulations require that each hospital:

- Take into account input from persons representing the broad interests of the community, including those knowledgeable about public health issues, and
- Make the CHNA widely available to the public.

The CHNA report must include certain information including, but not limited to:

- A description of the community and how it was defined,
- A description of the methodology used to determine the community health needs, and
- A prioritized list of the community's health needs.

Tax-exempt hospital organizations also are required to report information about the CHNA process and about community benefits they provide on IRS Form 990, Schedule H. As described in the instructions to Schedule H, community benefits are programs or activities that provide treatment and/or promote health and healing as a response to identified community needs. To be reported, community need for the activity or program must be established. Need can be established by conducting a CHNA. Community benefit activities and programs also seek to achieve objectives, including:

- Improving access to health services,
- Enhancing public health,
- Advancing increased general knowledge, and
- Relieving government burden to improve health.[2]

CHNAs seek to identify significant health needs for particular geographic areas and populations by focusing on the following questions:

- ***Who*** in the community is most vulnerable in terms of health status or access to care?
- ***What*** are the unique health status and/or access needs for these populations?
- ***Where*** do these people live in the community?
- ***Why*** are these problems present?

The question of ***how*** each hospital can address significant community health needs is the subject of the separate Implementation Strategy.

[1] Internal Revenue Code, Section 501(r).
[2] Instructions for IRS form 990 Schedule H, 2015.

Methodology

Federal regulations that govern the CHNA process allow hospital facilities to define the community they serve based on "all of the relevant facts and circumstances," including the "geographic location" served by the hospital facility, "target populations served" (e.g., children, women, or the aged), and/or the hospital facility's principal functions (e.g., focus on a particular specialty area or targeted disease)."[3] The community defined by MSSL & MSW accounts for 54 percent of the hospital's 2016 inpatient discharges.

Secondary data from multiple sources were gathered and assessed. Considering a wide array of information is important when assessing community health needs to ensure the assessment captures a wide range of facts and perspectives and to increase confidence that significant community health needs have been identified accurately and objectively.[4]

Input from 104 individuals was received through key informant interviews. These informants represented the broad interests of the community and included individuals with special knowledge of or expertise in public health.

In addition, data were gathered to evaluate the impact of various services and programs identified in the previous CHNA process (*see* Appendix 1).

Certain community health needs were determined to be "significant" if they were identified as problematic in at least two of the following three data sources: (1) the most recently available secondary data regarding the community's health, (2) recent assessments developed by other organizations, and (3) input from the key informants who participated in the interview process.

In addition, data was gathered to evaluate the impact of various services and programs identified in the previous CHNA process (*see* Appendix 1).

[3] 501(r) Final Rule, 2014.

[4] Note that some data sources present data by borough and others present data by county. As boroughs correspond to counties, data are consistently presented throughout the report as boroughs to simplify presentation. Specifically, Bronx County corresponds to the borough of Bronx, Kings County corresponds to the borough of Brooklyn, New York County corresponds to the borough of Manhattan, Queens County corresponds to the borough of Queens, and Richmond County corresponds to the borough of Staten Island.

Collaborating Organizations

For this assessment, MSSL & MSW collaborated with the Mount Sinai Health System and its following hospitals: Mount Sinai Hospital & Mount Sinai Queens, Mount Sinai Beth Israel Hospital & Mount Sinai Brooklyn, and New York Eye & Ear Hospital. CHNAs for these hospitals were developed alongside the MSSL & MSW CHNA.

Information Gaps

This CHNA relies on multiple data sources and community input gathered between June and December 2017. A number of data limitations should be recognized when interpreting results. For example, some data (e.g., County Health Rankings, Community Health Status Indicators, Behavioral Risk Factors Surveillance System, and others) exist only at a county-wide level of detail. Those data sources do not allow assessment of health needs at a more granular level of detail, such as by ZIP Code or census tract.

Secondary data upon which this assessment relies measure community health in prior years. For example, the most recent mortality rates available for the region were data collected in 2014. The impacts of the most recent public policy developments, changes in the economy, and other community developments are not yet reflected in those data sets.

The findings of this CHNA may differ from those of others conducted in the community. Differences in data sources, communities assessed (e.g., hospital service areas versus counties or cities), and prioritization processes can contribute to differences in findings.

Significant Community Health Needs

The significant community health needs identified in this CHNA are, in alphabetical order, as follows:

- Aging Population
- Access to Mental Health Care and Poor Mental Health Status
- Access to Primary Health Care Services by Individuals with Limited Resources
- Chronic Diseases and Contributing Lifestyle Factors
- Environmental Determinants of Health
- Homelessness
- Navigating a Changing Health Care Provider Environment
- Poverty, Financial Hardship, and Basic Needs Insecurity
- Safe and Affordable Housing
- Socio-Economic, Racial, Cultural, Ethnic, and Linguistic Barriers to Care
- Substance Abuse

A summary of each of the health needs is below, along with supporting data and references to exhibit numbers that contain additional information.

Aging Population

The population is aging and "aging in place." This increase will increase needed support for healthcare, housing, transportation, and nutrition assistance.

- In every neighborhood in the MSSL & MSW community, the aged 65 and older cohort is expected to grow the most between 2017 and 2022, with a growth rate of over 15 percent overall **(Exhibit 4)**.
- In County Health Rankings, Manhattan compared unfavorably to the state rate for the percent of female Medicare enrollees (ages 67-69) that received mammography screenings **(Exhibit 29B)**.
- The asthma hospitalization rate for residents aged 65 years or older in Manhattan and New York City was higher than the state average **(Exhibit 39)**.
- Many interviewees identified the aging population as a primary concern in the community, particularly in regards to mobility, cognitive abilities, and issues with housing.

Access to Mental Health Care and Poor Mental Health Status

Mental health status is poor for many residents because of day-to-day pressures, substance abuse, and psychiatric disorders. The supply of mental health providers is insufficient to meet the demand for mental health services.

- In County Health Rankings, Manhattan compared unfavorably to the state rate in average number of mentally unhealthy days **(Exhibit 29B)**.
- Manhattan compared unfavorably to the state mortality rate for suicide **(Exhibit 30)**.
- In the CDC's Youth Risk Behavior Surveillance System (YRBSS), respondents in Manhattan and New York City were more likely to indicate that they felt sad every day for two weeks and stopped regular activities due to sadness **(Exhibit 48)**.
- Many other community needs assessments in New York City identified mental health and illness as a priority in the community **(Exhibit 61)**.
- Many interviewees identified mental health as an issue in the community, including anxiety, depression, and mental health's connection to substance abuse and homelessness. Isolation was also identified as an issue by participants, particularly among the elderly in the community.

Access to Primary Health Care Services by Individuals with Limited Resources

New York City has a robust health provider network. However, access to this network can be limited to individuals with limited financial resources, including lack of health insurance and relatively high deductibles / co-pays.

- The uninsured population in the neighborhoods of Central Harlem and Inwood & Washington Heights was greater than the state average **(Exhibit 18)**.
- In the New York City community health survey, residents of Inwood & Washington Heights had disproportionally high rates of waiting for a primary care physician visit and not having a primary care physician **(Exhibit 50A)**.
- Rates for ambulatory care sensitive conditions (ACSCs) in Central Harlem and Inwood & Washington Heights were disproportionately higher than the rest of the community **(Exhibit 52)**. High rates indicate potential problems with the availability or accessibility of ambulatory care and preventive services and can suggest areas for improvement in the health care system and ways to improve outcomes.
- Federally-designated Medically Underserved Areas (MUAs) and Primary Care Health Professional Shortage Areas (HPSAs) were present in the community **(Exhibits 56 and 57)**.
- Interviewees identified several issues that restrict access to primary health care services as significant needs in the community, including misunderstanding the rapidly changing healthcare system, concerns about recent hospital changes, and insurance restrictions.

Chronic Diseases and Contributing Lifestyle Factors

Chronic diseases in the community include asthma, diabetes, heart disease, HIV, hypertension, obesity, and strokes. Contributing lifestyle factors might also include other sexually transmitted infections.

- In County Health Rankings, Manhattan ranked 60th out of 62 New York counties in diabetes monitoring **(Exhibit 29A)**.
- The mortality rates for AIDS in both Manhattan and New York City were higher than the New York State average **(Exhibit 30)**.
- Incidence rates of communicable disease, particularly for HIV and AIDS, were higher in Manhattan and New York City than the state average **(Exhibits 36 and 37**).
- Asthma hospitalizations and mortalities were significantly higher in Manhattan than the state average **(Exhibit 39)**.
- In the CDC's Youth Risk Behavior Surveillance System (YRBSS), respondents in Manhattan and New York City indicated that they were less physically active, watched more television, and used the computer more than state averages **(Exhibit 48)**.
- Other community health needs assessments identified obesity and diabetes as significant health needs more than any other need in the community **(Exhibit 61)**.
- Interviewees identified to several obstacles to healthy behaviors as issues in the community, particularly physical inactivity, lack of access to healthy foods, lack of preventive treatments, and tobacco use.

Environmental Determinants of Health

Residents of local neighborhoods experience considerable traffic, pollution, crime, and noise. Transportation is difficult for individuals with limited mobility.

- Rates of violent crime, robbery, and aggravated assault were all above 50 percent or greater than the state average in New York City **(Exhibit 23)**.
- In County Health Rankings, Manhattan ranked in the bottom quartile of all New York counties in Physical Environment and Air Pollution – Particulate Matter **(Exhibit 29A)**.
- Asthma hospitalization rates were particularly high in Manhattan and New York City, possibly indicating issues with air quality and the surrounding environment **(Exhibit 39)**.
- Other community health needs assessments in New York City identified asthma and breathing issues and air quality as issues in the community **(Exhibit 61)**.
- Interviewees also identified environmental issues as a significant issue in the community, including air quality, traffic, noise, second-hand smoke, unsanitary conditions, and crime.

Homelessness

Homelessness is increasing in the community. Homeless is complex and intertwines other issues including affordable housing, access to mental health care, substance abuse, and poverty.

- The number of unsheltered individuals in New York City increased by an estimated 39.3 percent between 2016 and 2017. In Manhattan, this number increased by 50.1 percent **(Exhibit 27)**.
- In County Health Rankings, Manhattan ranked in the bottom quartile of all New York counties in Severe Housing Problems **(Exhibit 29A)**.
- Interviewees identified homeless as a significant concern in the community and indicated that the number of homeless individuals was increasing. Interviewees related the issue to poverty, mental health, and substance abuse. Women who are homeless were thought to be especially vulnerable to mistreatment and were reluctant to report incidences.

Navigating a Changing Health Care Provider Environment

Many changes in the health care provider environment are leading to anxiety by residents. Additional changes, such as the emergence of Urgent Care Clinics, are leading to residents to be uncertain of how to access healthcare services.

- Rates for ambulatory care sensitive conditions (ACSCs) in Central Harlem and Inwood & Washington Heights were disproportionately high (**Exhibit 52)**. High rates indicate potential problems with the availability or accessibility of ambulatory care and preventive services and can suggest areas for improvement in the health care system and ways to improve outcomes.
- Many interviewees expressed issues in navigating the changing health care provider environment. Specific issues identified include increased travel times to newer services, misinformation about changes, and gaps between expectations and service delivery options.
- Interviewees also expressed confusion about healthcare delivery options, insurance requirements and potential changes, and which providers residents could access.

Poverty, Financial Hardship, and Basic Needs Insecurity

Lower-income residents can experience considerable difficulty in accessing basic needs, including healthy food and safe, affordable housing. Primary care access can be limited due to the relatively high cost of deductible / co-pays. Unmet mental health needs may be an issue due to daily stress.

- Poverty rates in Manhattan were worse than the state and national averages. The poverty percentages for Asian and Hispanic or Latino residents were particularly higher than state and national comparisons **(Exhibit 13)**.
- Over 23 percent of households in Manhattan had an annual income of less than $25,000, with this rate above 30 percent in both Central Harlem and Inwood & Washington Heights **(Exhibit 14)**.
- Unemployment rates for Hispanic or Latino residents in Manhattan and New York City have been higher than state and national averages over recent history **(Exhibit 16)**.
- Manhattan ranked worse than state averages for children in poverty, high school graduation, and income inequality in County Health Rankings **(Exhibit 29B)**.
- A large portion of the MSSL & MSW community ranked in the "Highest Need" category in Community Need Index **(Exhibit 54)**.
- Financial pressures and hardships were identified by many interviewees as significant concerns in the community. Income inequality was thought to be increasing and, was a contributor to residents departing the community.

Safe and Affordable Housing

Inadequate housing contributes to poor health outcomes. Demand for housing in the neighborhood is increasing rents and new housing units will be market rates. Moderate income residents may need affordable housing options to continue to live in the community. Inadequate security and maintenance of residential properties, including NYCHA units, negatively influence health.

- According to the U.S. Department of Housing and Urban Development (HUD), the average months on waiting lists for subsidized housing were higher in Manhattan than the state and national averages **(Exhibit 25)**.
- The average number of years in public housing was longer in Manhattan than the New York City average **(Exhibit 26B)**.
- In County Health Rankings, Manhattan both ranked in the bottom quartile of all New York counties in Severe Housing Problems **(Exhibit 29A)**.
- Interviewees identified housing issues as a significant need in the community, including high and increasing rents, forced over-occupancy of units, and poor maintenance.

Socio-Economic, Racial, Cultural, Ethnic, and Linguistic Barriers to Care

Access to care may be limited by residents who do not feel welcomed by providers. Insufficient cultural competence and language limitations are barriers to foreign-born residents. For some U.S.-born residents, barriers may be influenced by real or perceived differences in services based on race, ethnicity, socioeconomic background, sexual orientation, and/or other issues. LGBTQ residents may be especially likely to perceive and/or experience access barriers.

- Many neighborhoods in the MSSL & MSW community are racially and ethnically diverse. Over 50 percent of residents in Central Harlem were Black, and over 66 percent of residents in Inwood & Washington Heights were Hispanic or Latino **(Exhibit 6**).
- The population that is linguistically isolated in the MSSL & MSW community was higher than the New York State and national averages, particularly in Inwood & Washington Heights **(Exhibit 10)**.
- More than 31 percent of the MSSL & MSW community was foreign born residents, compared to 23 percent state wide and 13 percent nationally **(Exhibit 11)**.
- The rates for cardiovascular disease mortality, diabetes mortality, and respiratory diseases greatly varied by race and ethnicity, with Black and Hispanic residents comparing particularly unfavorably to other cohorts in New York City **(Exhibits 34 and 40)**.
- Interviewees identified disparities among health as a particular concern, noting that outcomes and experiences varied by age, gender, race/ethnicity, and socioeconomic status. Cohorts of residents where distrust may be especially evident are low-income people-of-color, immigrants who do not speak English, and LGBTQ individuals.

Substance Abuse

Substance abuse in the community includes alcohol and multiple illegal substances. Alcohol abuse is evidenced by binge drinking in local bars and opioid abuse disproportionately impacts homeless individuals.

- Rates of young adult arrests for drug use, possession, or sales were significantly higher in Manhattan and New York City than the state average **(Exhibit 24)**.
- The percentage of women who drank alcohol during the last three months of pregnancy was significantly higher in Manhattan than the New York City average **(Exhibit 46)**.
- Drug-related hospitalizations were higher in Manhattan than the state average **(Exhibit 47)**.
- The percentage of adults who reported binge drinking during the past month was higher in Manhattan and New York City than the state average (**Exhibit 49C**).
- Many other CHNAs identified substance abuse as a prioritized need **(Exhibit 61)**.
- Interviewees identified substance abuse as a significant issue in the community, including its relation to homelessness.

CHNA DATA AND ANALYSIS

DEFINITION OF COMMUNITY ASSESSED

This section identifies and describes the community assessed by St. Luke's Hospital and how it was determined.

MSSL & MSW's community is comprised of 20 ZIP Codes encompassing sections of the borough of Manhattan (**Exhibit 1**). The community is divided into neighborhoods utilized by the New York State Department of Health;[5] 4 of the 42 neighborhoods in New York City are in the MSSL & MSW community.

Mount Sinai St. Luke's Hospital is comprised of two campuses, Mount Sinai St. Luke's and Mount Sinai West, both in Manhattan. To enhance clarity, we use the following acronyms throughout this document:

Acronym	Entity
MSSL	Mount Sinai St. Luke's, the campus in the Upper West Side neighborhood, Manhattan
MSW	Mount Sinai West, the campus in the Chelsea and Clinton neighborhood, Manhattan
MSSL & MSW	Mount Sinai St. Luke's Hospital, the hospital facility with two campuses in Manhattan

The MSSL & MSW community was estimated to have a 2015 population of approximately 817,216 persons in 2015.

The community definition was validated based on the geographic origins of discharges from MSSL and MSW. In 2016, the community collectively accounted for 54 percent of MSSL & MSW's overall inpatient discharges (**Exhibit 1**) and 60 percent of MSSL & MSW's New York City inpatient discharges.

[5] New York State Department of Health. (2006). ZIP Code Definitions of New York City Neighborhoods. Retrieved 2013, from: www.health.ny.gov/statistics/cancer/registry/appendix/neighborhoods.htm

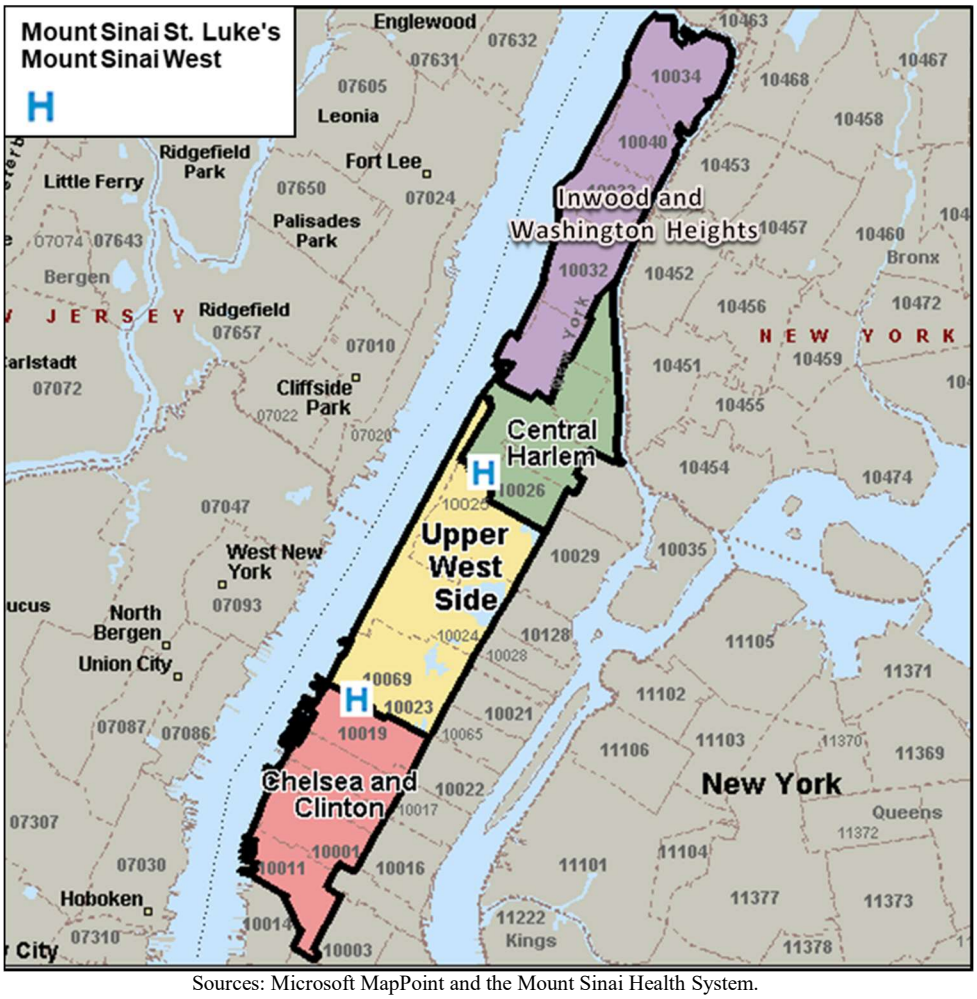
Exhibit 1: Community Population, 2015, and Inpatient Discharges, 2016

Neighborhood	2015 Population	2016 Discharges	Percent of Total Discharges	Percent of NYC Discharges
Central Harlem	177,406	5,330	14.1%	15.8%
Chelsea and Clinton	149,683	3,712	9.8%	11.0%
Inwood and Washington Heights	269,556	3,548	9.4%	10.5%
Upper West Side	220,571	7,777	20.6%	23.0%
Total MSSL & MSW Community	**817,216**	**20,367**	**53.9%**	**60.3%**
Other New York City Discharges		13,426	35.6%	39.7%
Other non-New York City Discharges		3,961	10.5%	
Total Discharges		**37,754**	**100.0%**	

Source: U.S. Census ACS 2015 5-year estimates and the Mount Sinai Health System.

Exhibit 2 presents a map displaying the 4 neighborhoods that comprise the MSSL & MSW community.

Exhibit 2: MSSL & MSW Community



Sources: Microsoft MapPoint and the Mount Sinai Health System.

The MSSL & MSW community consists of the neighborhoods of Chelsea & Clinton, Upper West Side, Central Harlem, and Inwood & Washington Heights.

SECONDARY DATA ASSESSMENT

This section presents secondary data regarding demographics, economic indicators, and health needs in the MSSL & MSW community.

Demographics

Population characteristics and changes influence health issues in and services needed by communities. A total of 817,216 people were estimated to reside in the MSSL & MSW community in 2015, with a projected population of 1,915,495 residents in 2022.

Exhibit 3 illustrates the total number of residents living in the community by neighborhood, and their distribution by sex and age in 2015.

Exhibit 3: Population by Age and Sex, 2015

Neighborhood	Ages 0-19	Ages 20-44	Ages 45-64	Ages 65+	Total Population
Central Harlem	**24.2%**	**42.8%**	**23.1%**	**9.9%**	**177,406**
Male	12.1%	20.0%	10.6%	3.5%	81,941
Female	12.1%	22.8%	12.5%	6.4%	95,465
Chelsea & Clinton	**10.1%**	**52.5%**	**24.6%**	**12.8%**	**149,683**
Male	4.4%	27.9%	13.7%	5.5%	77,143
Female	5.7%	24.6%	10.9%	7.3%	72,540
Inwood & Washington Heights	**19.7%**	**43.9%**	**24.6%**	**11.9%**	**269,556**
Male	10.3%	22.6%	11.5%	4.6%	131,853
Female	9.4%	21.3%	13.1%	7.3%	137,703
Upper West Side	**16.7%**	**39.0%**	**27.0%**	**17.4%**	**220,571**
Male	7.9%	17.3%	12.8%	7.3%	99,672
Female	8.8%	21.7%	14.2%	10.1%	120,899
Total MSSL & MSW Community	**18.1%**	**43.9%**	**25.0%**	**13.2%**	**817,216**
Male	9.0%	21.6%	12.1%	5.3%	390,609
Female	9.1%	22.3%	12.9%	7.9%	426,607

Source: U.S. Census Bureau, ACS 5 year estimates, 2011-2015.

In 2015, Central Harlem, Inwood & Washington Heights, and the Upper West Side had a higher proportion of women in the community. Chelsea & Clinton had a lower proportion of residents aged 0 to 19 years and a higher proportion of those aged 20 to 44 than any neighborhood in the community (**Exhibit 3**).

Exhibit 4 illustrates the total number of residents projected to live in the community by neighborhood, and their distribution by sex and age in 2017 and in 2022, comparing the projected growth rates of different cohorts and neighborhoods in the community.

Exhibit 4: Population by Age, Estimated 2017 and Projected 2022

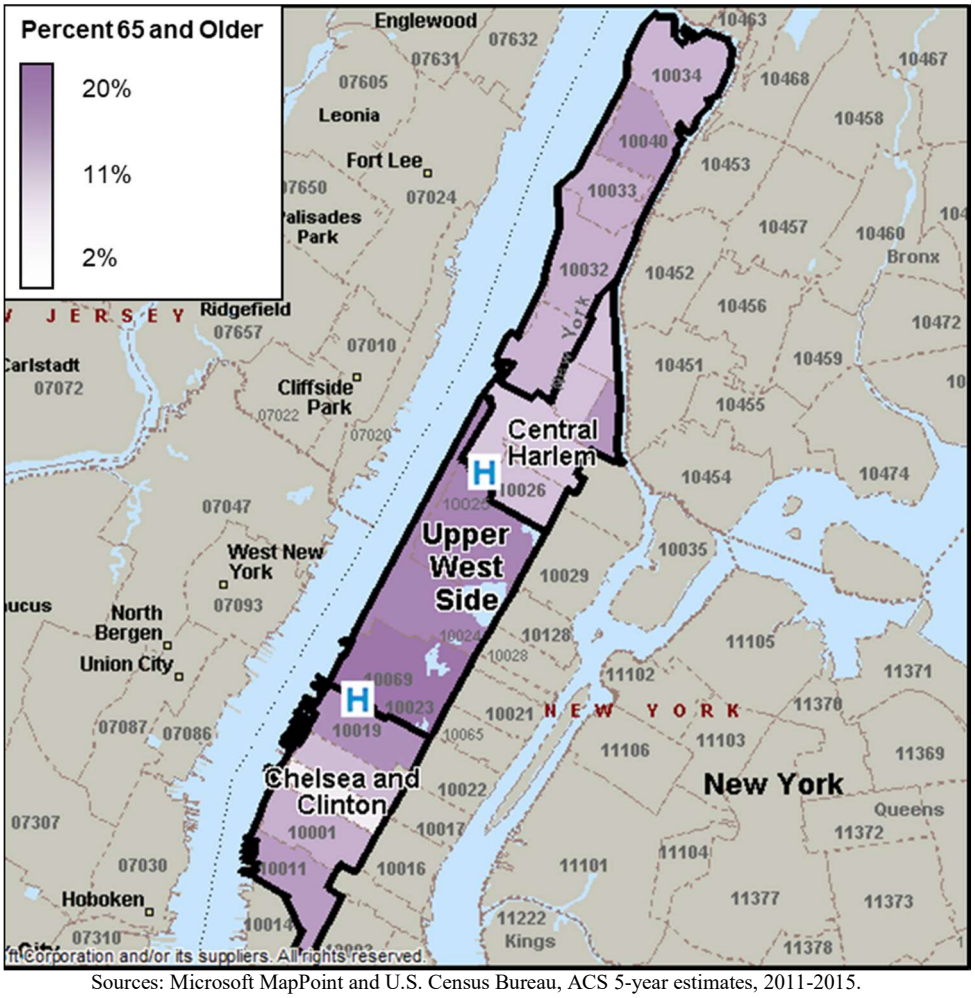
	2017 Population					2022 Population					Percent Change 2017-2022				
Neighborhood	Total	0-17	18-34	35-64	65+	Total	0-17	18-34	35-64	65+	Total	0-17	18-34	35-64	65+
Central Harlem	171,922	33,622	53,752	64,530	20,018	177,767	35,465	49,939	68,827	23,536	3.4%	5.5%	-7.1%	6.7%	17.6%
Chelsea & Clinton	158,186	15,309	51,343	69,386	22,148	166,045	17,590	45,262	76,581	26,612	5.0%	14.9%	-11.8%	10.4%	20.2%
Inwood & Washington Heights	252,021	47,666	73,648	96,771	33,936	255,000	50,107	64,618	101,463	38,812	1.2%	5.1%	-12.3%	4.8%	14.4%
Upper West Side	228,713	37,406	53,107	95,215	42,985	233,686	41,569	45,562	98,036	48,519	2.2%	11.1%	-14.2%	3.0%	12.9%
Total MSSL & MSW Community	**810,842**	**134,003**	**231,850**	**325,902**	**119,087**	**832,498**	**144,731**	**205,381**	**344,907**	**137,479**	**2.7%**	**8.0%**	**-11.4%**	**5.8%**	**15.4%**

Source: Truven Health Analytics 2017 via the Mount Sinai Health System.

The total population of all neighborhoods in the community is expected to grow from 2017 to 2022. The neighborhood of Chelsea & Clinton is expected to grow most rapidly at 5.0 percent.

All neighborhoods are expected to experience an increase in population among the 0-17, 35-64, and 65+ cohorts. Additionally, all neighborhoods are expected to experience a decrease in population in the 18-34. The population aged 65 and older is expected to experience the highest growth rate in all neighborhoods (**Exhibit 4**).

Exhibit 5: Residents Aged 65+, 2015



Sources: Microsoft MapPoint and U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

The proportion of the population 65 years of age and older varies by ZIP Code. Upper West Side ZIP Codes 10023, 10024, and 10025 had comparatively high proportions of this population cohort, each above 16 percent (**Exhibit 5**).

Exhibit 6 indicates the distribution of the population by race in the MSSL & MSW community.

Exhibit 6: Distribution of Population by Race, 2015

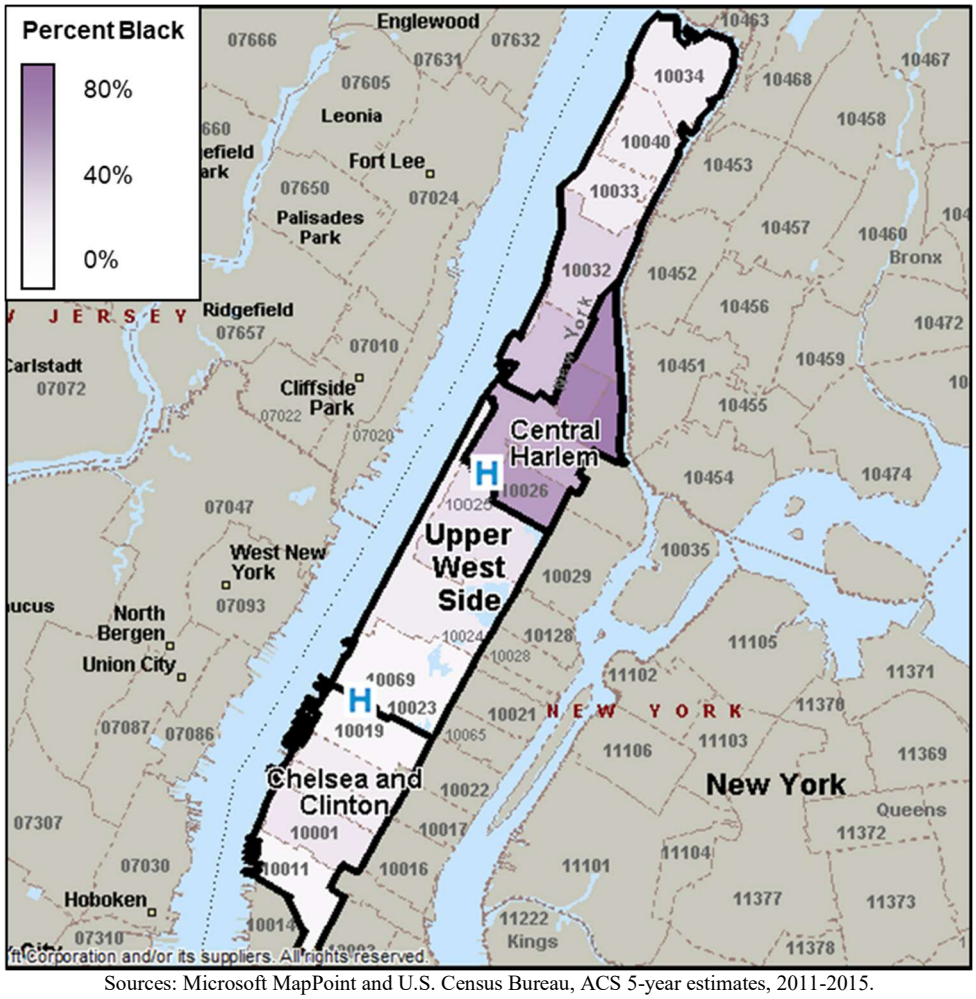
Neighborhood	Total Population 2015	White	Black	Asian	Other Race*	Two or More Races	Hispanic or Latino (Any Race)
Central Harlem	177,406	21.5%	56.3%	5.4%	12.1%	4.6%	23.9%
Chelsea & Clinton	149,683	70.4%	6.3%	15.7%	4.2%	3.3%	14.6%
Inwood & Washington Heights	269,556	34.3%	17.1%	2.9%	37.5%	8.1%	66.5%
Upper West Side	220,571	74.3%	8.6%	9.0%	4.7%	3.5%	15.8%
Total Community	**817,216**	**48.9%**	**21.3%**	**7.4%**	**17.0%**	**5.2%**	**34.0%**

Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.
* "Other Race" includes the following Census-designated race groups: American Indian / Alaska Native, Native Hawaiian / Pacific Islander, and Some Other Race

The MSSL & MSW community is very diverse. In 2015, 48.9 percent of the population was White, 21.3 percent was Black, 7.4 percent was Asian, and 34.0 percent was Hispanic (or Latino) (**Exhibit 6**). Identifying diversity within the community is important to assess health disparities and barriers to health care access experienced by different populations, including various racial and ethnic groups.

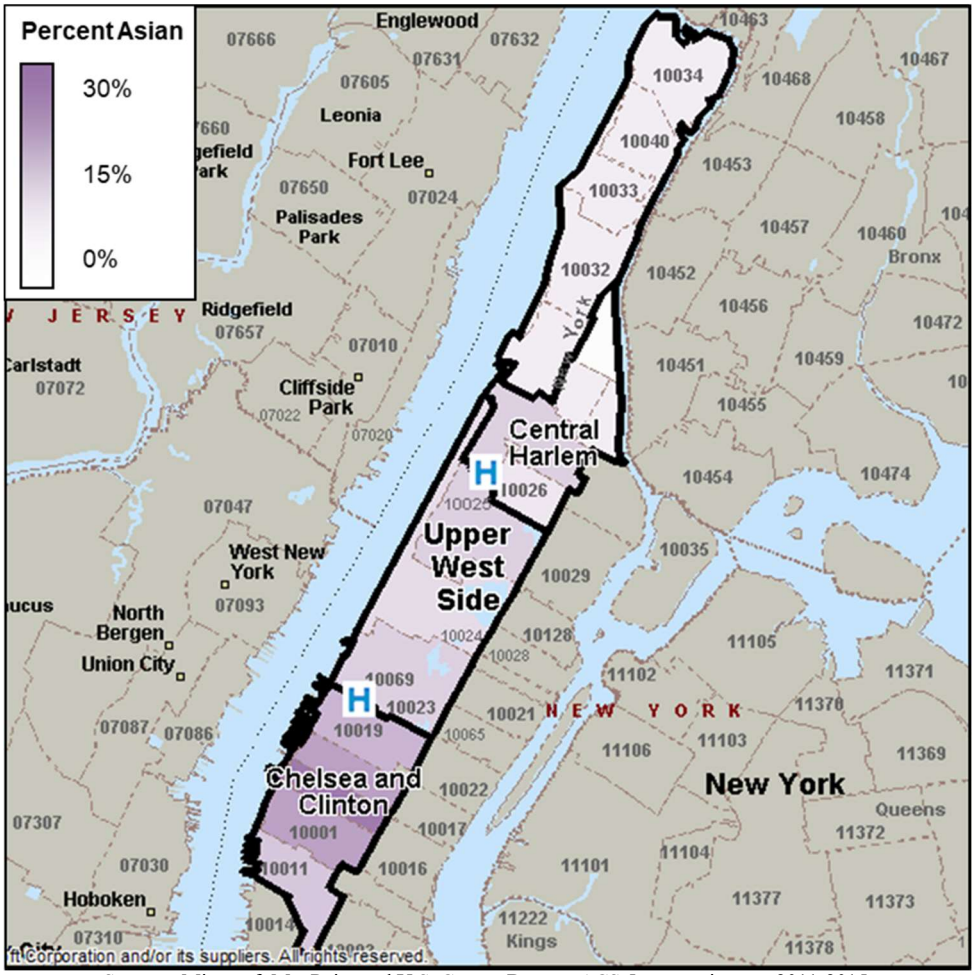
Black populations were most prevalent in Central Harlem. Chelsea & Clinton had a higher proportion of Asian residents. Inwood & Washington Heights had a large concentration of Hispanic or Latino residents (**Exhibits 7, 8,** and **9)**.

Exhibit 7: Percent of Population – Black, 2015



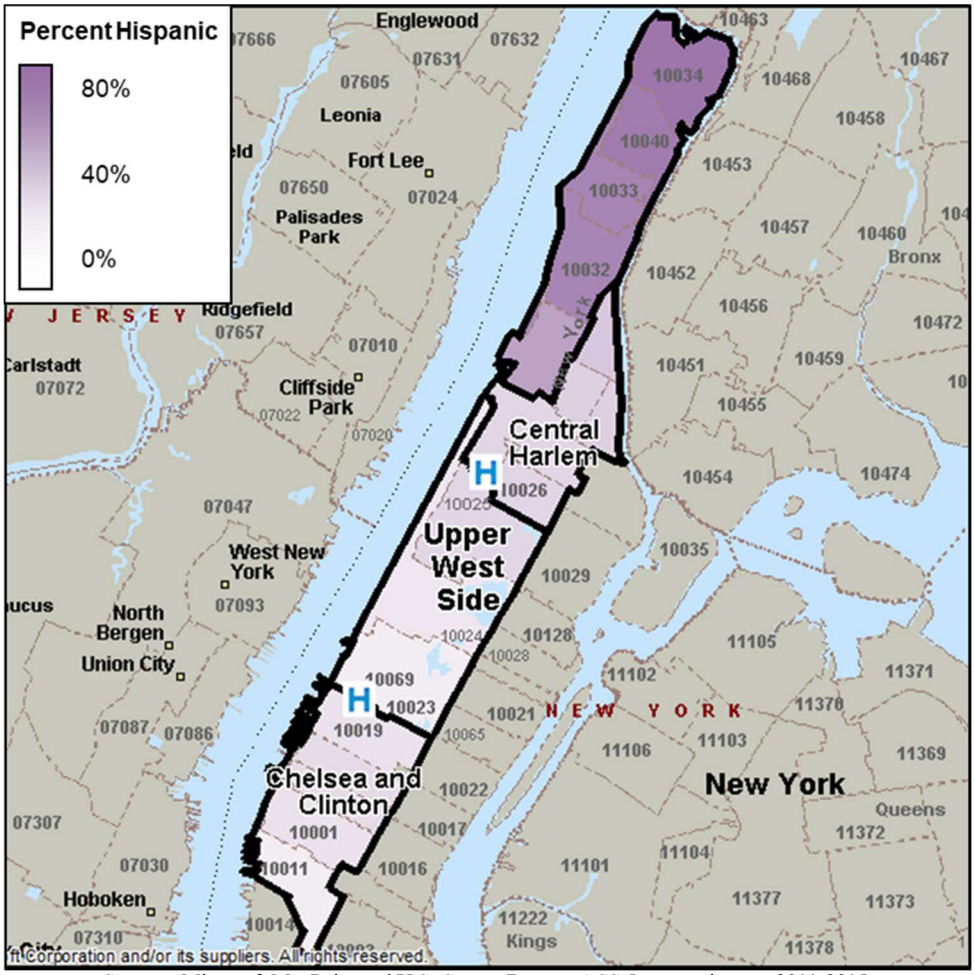
Sources: Microsoft MapPoint and U.S. Census Bureau, ACS 5-year estimates, 2011-2015.
Note that density of shading on this map is not comparable to the density of shading of other maps. The legend is specific to this map.

Exhibit 8: Percent of Population – Asian, 2015



Sources: Microsoft MapPoint and U.S. Census Bureau, ACS 5-year estimates, 2011-2015.
Note that density of shading on this map is not comparable to the density of shading of other maps. The legend is specific to this map.

Exhibit 9: Percent of Population – Hispanic (or Latino), 2015



Sources: Microsoft MapPoint and U.S. Census Bureau, ACS 5-year estimates, 2011-2015.
Note that density of shading on this map is not comparable to the density of shading of other maps. The legend is specific to this map.

Other community demographic indicators are presented in **Exhibit 10**.

Exhibit 10: Other Socioeconomic Indicators, 2011-2015

Neighborhood	Population 25+ without High School Diploma	Population with a Disability	Population Linguistically Isolated
Total Community	**6.2%**	**9.8%**	**15.8%**
Central Harlem	11.4%	12.2%	12.4%
Chelsea & Clinton	2.8%	8.3%	9.6%
Inwood & Washington Heights	11.8%	11.4%	35.6%
Upper West Side	3.4%	9.1%	9.0%
New York State	**7.7%**	**11.1%**	**13.5%**
United States	**7.6%**	**12.4%**	**8.6%**

Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

Key findings include:

- While the community compared favorably to New York State and the U.S. for the percentage of residents aged 25 and older who did not graduate high school, Central Harlem and Inwood & Washington Heights compared unfavorably.
- The percentage of residents who were linguistically isolated was higher than the state average in the community, and significantly higher than the U.S. figure. Linguistic isolation is defined as the population aged five and older who speak a language other than English and speak English less than "very well."

Exhibit 11 presents the percentage of residents by borough who are foreign born, and their geographic region of origin.

Exhibit 11: World Region of Birth of Foreign Born Residents as a Percent of Total Population, 2011-2015

Borough and Neighborhood	Total Population	Europe	Asia	Africa	Oceania	Latin America	Northern America	Total Foreign Born
Total Community	**817,216**	**4.4%**	**5.7%**	**1.7%**	**0.3%**	**18.9%**	**0.6%**	**31.6%**
Central Harlem	177,406	2.5%	4.5%	4.9%	0.1%	12.0%	0.3%	24.3%
Chelsea & Clinton	149,683	7.1%	11.2%	0.9%	0.6%	6.2%	1.3%	27.4%
Inwood & Washington Heights	269,556	2.4%	2.3%	0.9%	0.1%	39.8%	0.3%	45.7%
Upper West Side	220,571	6.6%	7.1%	0.6%	0.5%	7.5%	0.9%	23.2%
New York State	**19,673,174**	**3.8%**	**6.3%**	**0.9%**	**0.1%**	**11.1%**	**0.3%**	**22.5%**
United States	**316,515,021**	**1.5%**	**3.9%**	**0.6%**	**0.1%**	**6.8%**	**0.3%**	**13.2%**

Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

In New York State in 2015, 22.5 percent of the population was foreign born compared to 13.2 percent in the U.S. as a whole. These New York State residents were primarily from Latin America and Asia. Inwood & Washington Heights had the highest percentage of foreign born residents in the community, at 45.7 percent. This neighborhood had a particularly high population of residents born in Latin America. The community had 31.6 percent of foreign born residents, higher than the state and national rates (**Exhibit 11**).

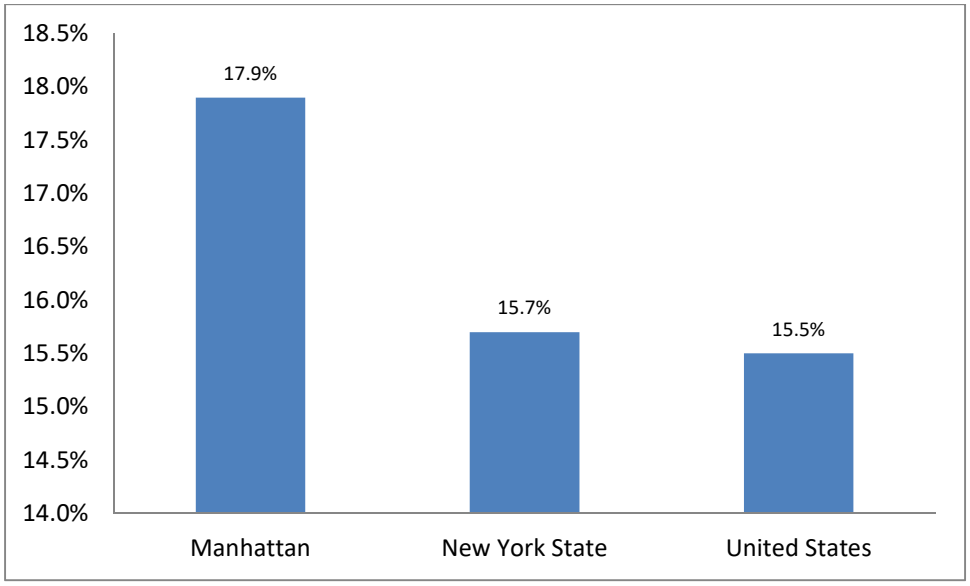
Economic Indicators

The following types of economic indicators with implications for health were assessed: (1) people in poverty; (2) household income; (3) unemployment rates; (4) insurance status; (5) crime; (6) housing and homelessness; and (7) State of New York and New York City budget trends.

People in Poverty

Many health needs are associated with poverty, making it important to understand poverty and other measures of economic well-being. According to the U.S. Census, in 2015 approximately 15.5 percent of people in the U.S., and 15.7 percent of people in New York State lived in poverty. Manhattan reported a higher poverty rate than the New York State and U.S. averages (**Exhibit 12**).

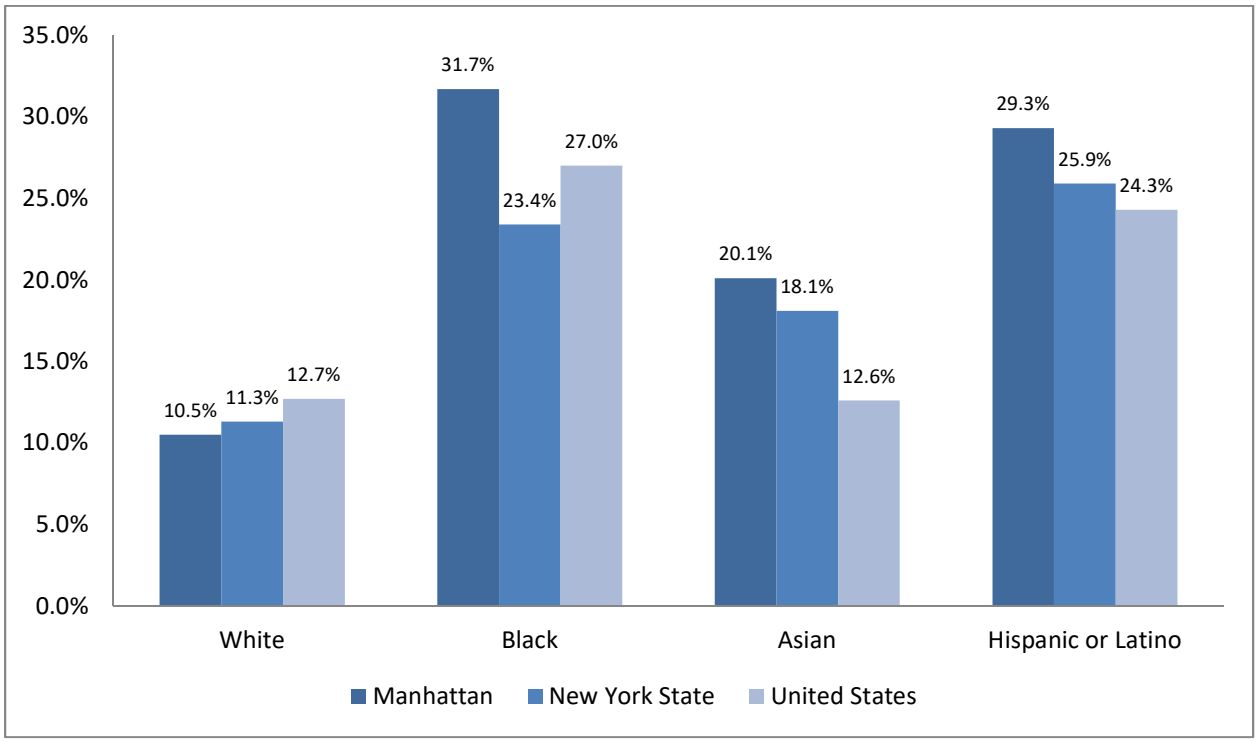
Exhibit 12: Percent of People in Poverty, 2011-2015



Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

Exhibit 13 presents poverty rates by race and ethnicity in the community.

Exhibit 13: Percent of People in Poverty, by Borough and Race / Ethnicity, 2011-2015



Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

In Manhattan, Black, Asian, and Hispanic or Latino populations had higher poverty rates compared to state and national averages. Non-White populations reported higher poverty rates than the White population in all areas. Manhattan showed high disparities between White and non-White poverty rates.

Household Income

Household income is assessed by many public and private agencies to determine household needs for low-income assistance programs. In the MSSL & MSW community in 2015, 23.8 percent of all households had incomes below $25,000, an approximation of the federal poverty level (FPL) for a family of four (**Exhibit 14**).

Exhibit 14: Percent Low-Income Households by Borough and Neighborhood, 2015

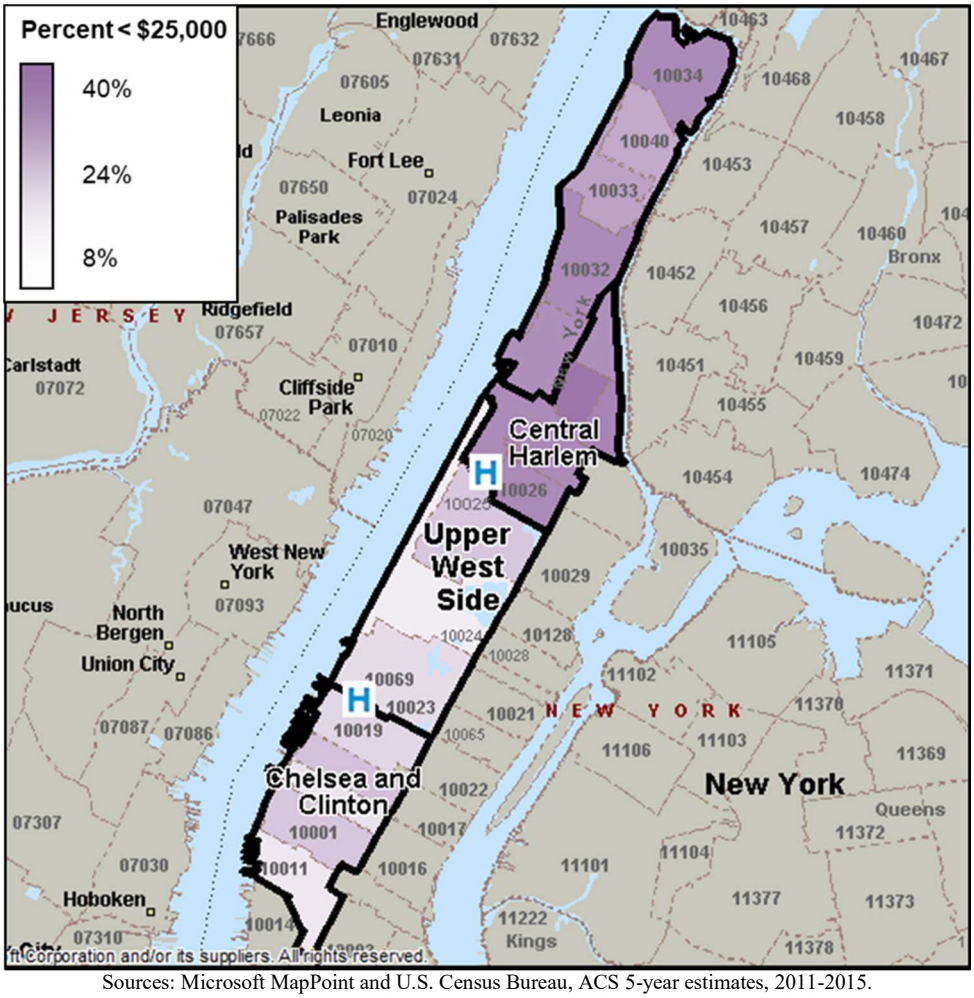
Neighborhood	Occupied Housing Units	Average Median Income	Percent less than $25,000 per year	Percent less than $50,000 per year
Total Community	**353,991**	**71,464**	**23.8%**	**37.4%**
Central Harlem	69,095	39,030	34.8%	52.1%
Chelsea & Clinton	84,714	95,924	16.6%	27.6%
Inwood & Washington Heights	92,446	41,901	31.1%	48.2%
Upper West Side	107,736	98,398	16.3%	26.3%

Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

There was significant variation in low-income households among neighborhoods within the community. The percentage of households with incomes below $25,000 was 34.8 percent in Central Harlem, for instance, compared to 16.3 percent in the Upper West Side (**Exhibit 14**).

Exhibit 15 presents a map of the percentage of households in the community with incomes under $25,000.

Exhibit 15: Percent Households Less Than $25,000 Annual Income, 2015

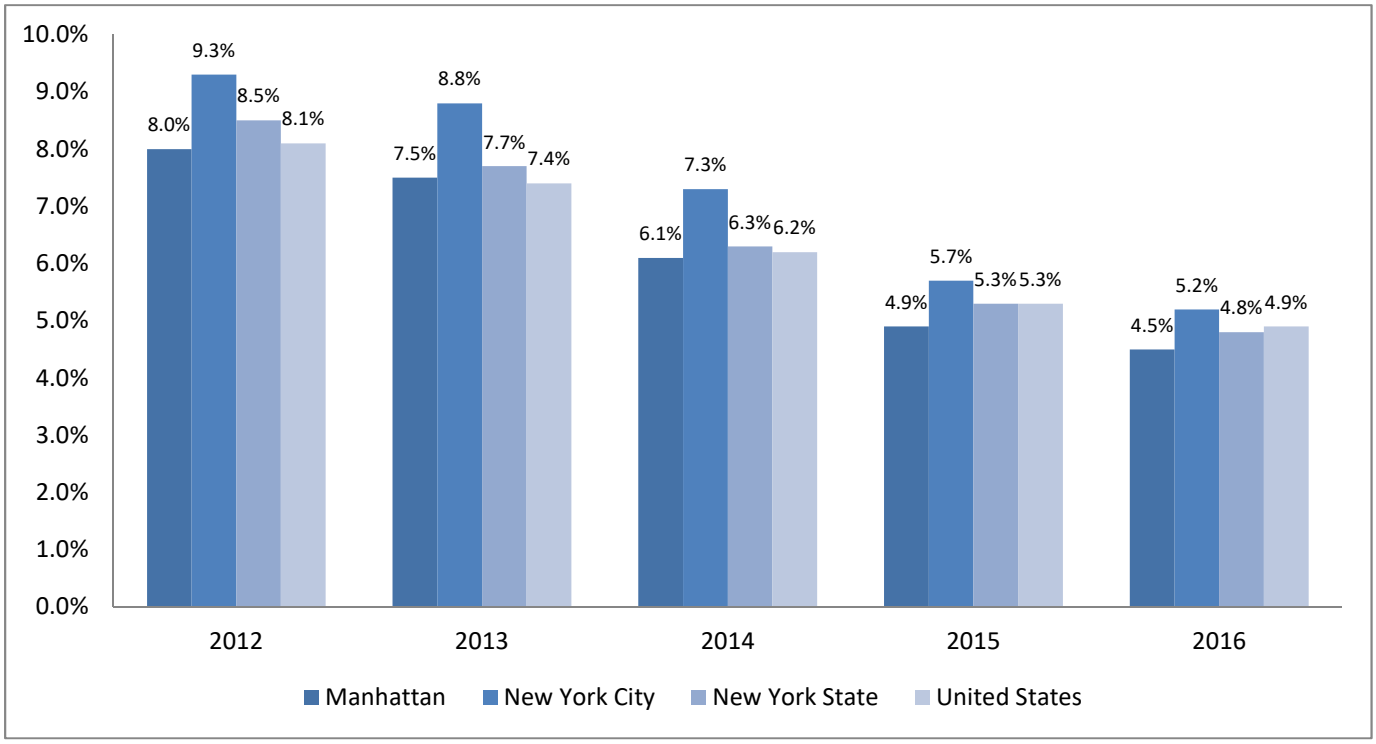


Sources: Microsoft MapPoint and U.S. Census Bureau, ACS 5-year estimates, 2011-2015.
Note that density of shading on this map is not comparable to the density of shading of other maps. The legend is specific to this map.

Unemployment Rate

Exhibit 16 shows the unemployment rate for Manhattan, with New York City, New York State, and national averages for comparison.

Exhibit 16: Unemployment Rates, 2012-2016

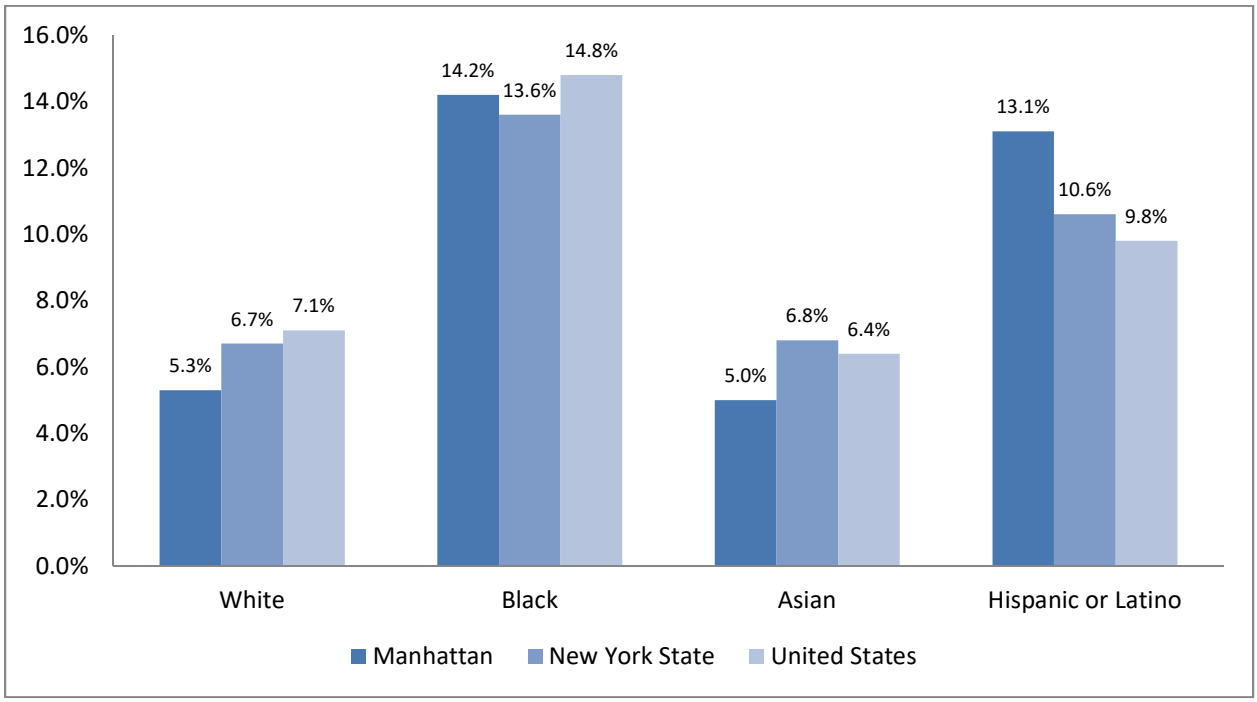


Source: U.S. Bureau of Labor Statistics, 2016.

Since 2014, Manhattan has experienced lower unemployment rates than New York City, New York State, and national averages. All areas show a decrease in unemployment from 2012 to 2016.

Exhibit 17 presents unemployment rates by race and ethnicity in each borough.

Exhibit 17: Unemployment Rates by Race and Ethnicity, 2011-2015



Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

The Black and Hispanic populations reported higher unemployment rates than other cohorts over the period 2011-2015. Manhattan had higher rates of unemployment in the Black and Hispanic population than the state average (**Exhibit 17**).

Insurance Status

Exhibit 18 displays the percent of the population in the MSSL & MSW community that is uninsured, with New York State and United States averages for comparison.

Exhibit 18: Uninsured Population, 2011-2015

Borough and Neighborhood	Uninsured Population
Manhattan (as a whole)	**8.9%**
Central Harlem	11.6%
Chelsea & Clinton	7.2%
Inwood & Washington Heights	15.5%
Upper West Side	5.8%
New York State	**9.7%**
United States	**13.0%**

Source: U.S. Census ACS 5-year estimates 2011-2015.

The neighborhood of Inwood & Washington Heights had a higher uninsured rate than both the New York State and United States average. Central Harlem had a higher rate of uninsured than the New York State and Manhattan average.

Exhibit 19 portrays the distribution of MSSL & MSW community discharges by neighborhood and by payer. This information helps to identify where higher percentages of self-pay individuals and Medicaid recipients live within the community.

Exhibit 19: MSSL & MSW Discharges by Neighborhood and Payer, 2016

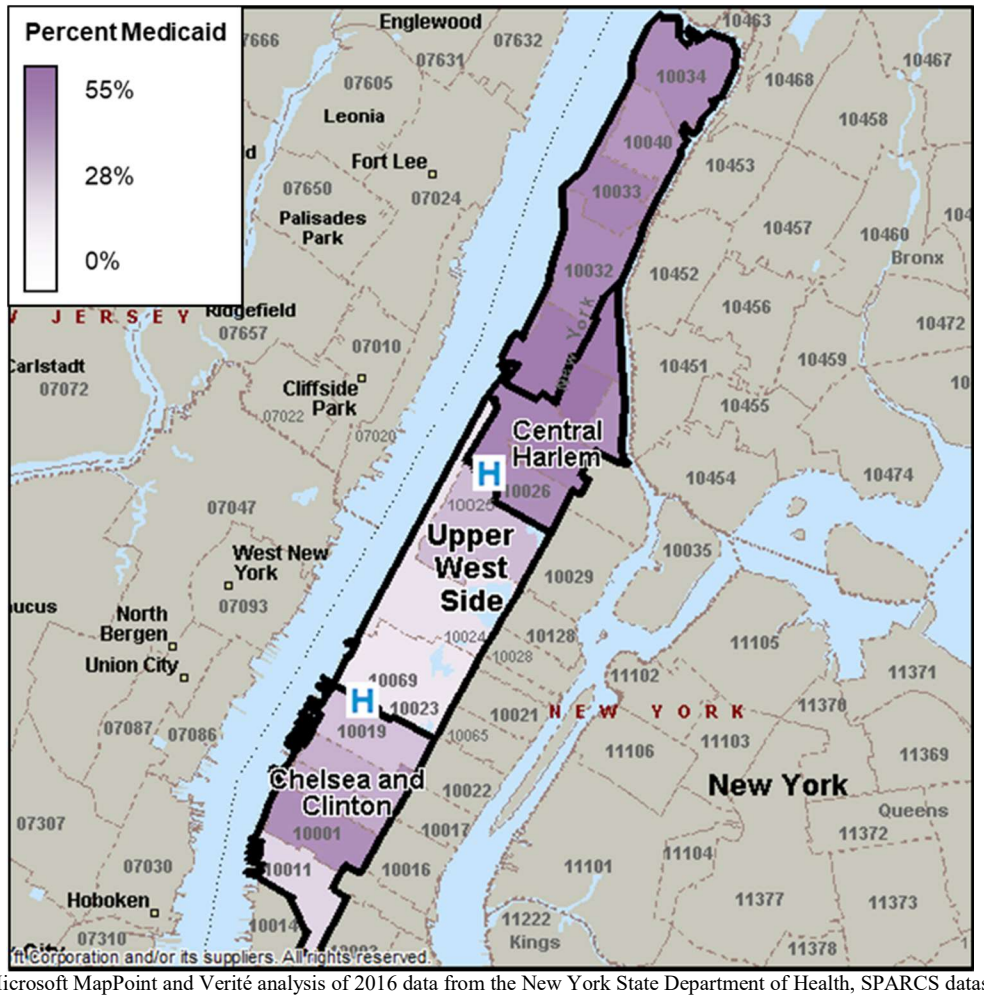
Neighborhood	Private Insurance	Medicaid	Medicare	Self-Pay	Other
Total Community	**25.4%**	**35.5%**	**35.0%**	**3.1%**	**1.0%**
Central Harlem	18.2%	46.1%	31.2%	3.4%	1.2%
Chelsea & Clinton	33.1%	27.7%	34.1%	4.2%	0.9%
Inwood & Washington Heights	17.5%	44.8%	33.2%	3.6%	1.0%
Upper West Side	38.9%	16.5%	42.3%	1.4%	0.8%

Source: Verité analysis of 2016 data from the New York State Department of Health, SPARCS dataset via the Mount Sinai Health System Health System

The highest percentages of discharges for private insurance were from Chelsea & Clinton and the Upper West Side. Medicaid discharges were most prevalent Central Harlem and Inwood & Washington Heights. Medicare discharges were more prevalent in the Upper West Side. Self-pay discharges were most concentrated in Chelsea & Clinton **(Exhibit 19)**.

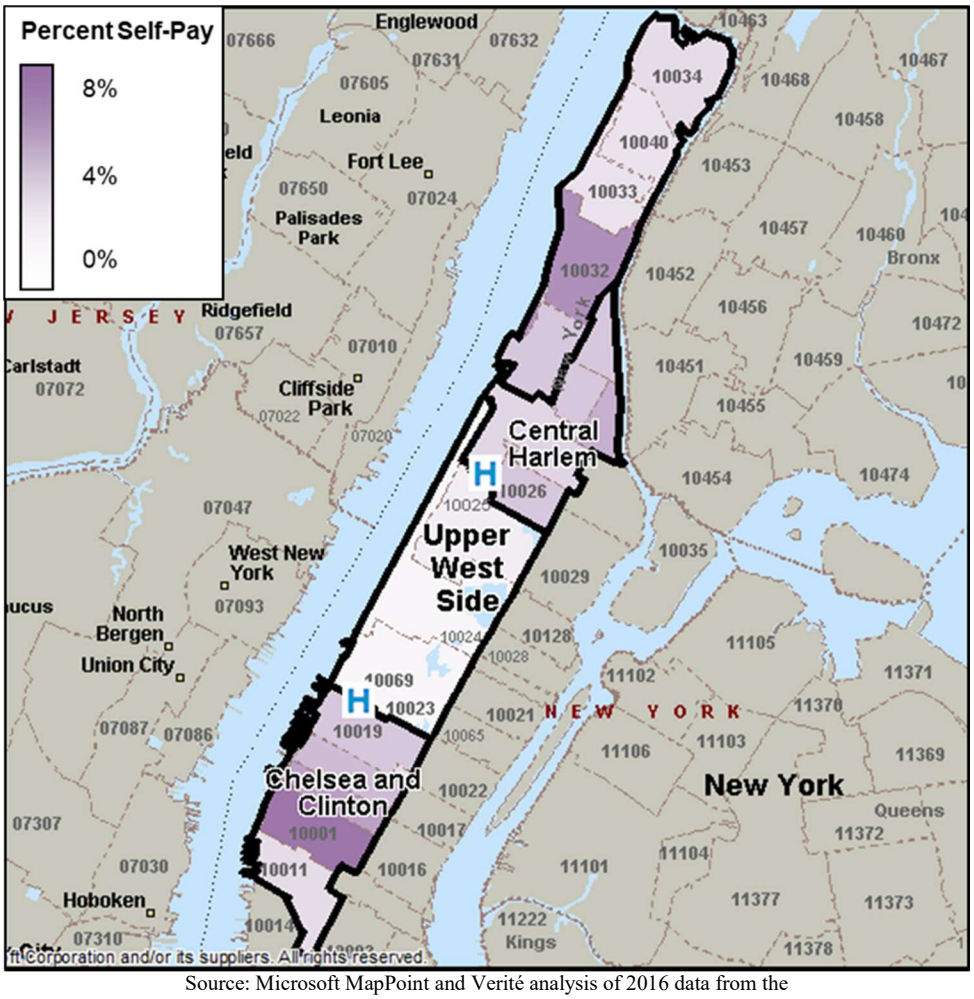
Exhibits 20, **21**, and **22** present MSSL & MSW community discharges at a ZIP code level.

Exhibit 20: Medicaid Discharges by ZIP Code, 2016



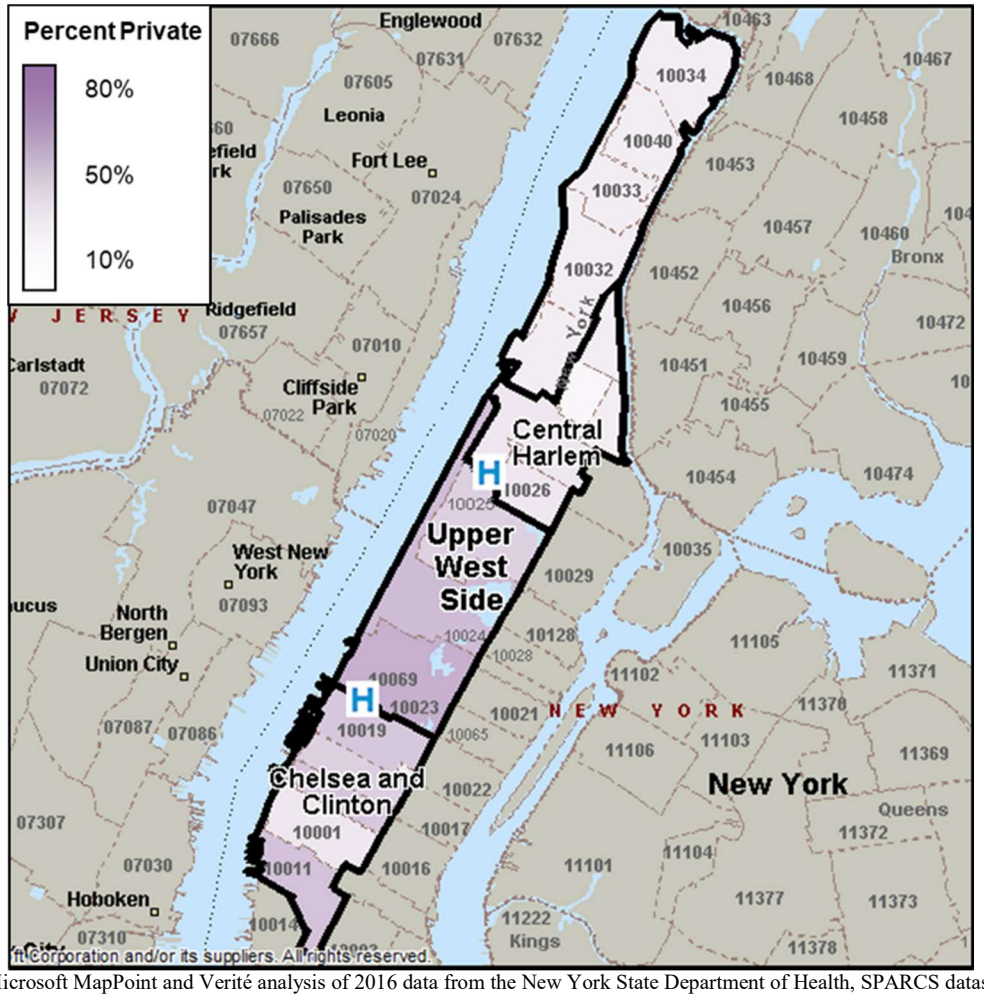
Source: Microsoft MapPoint and Verité analysis of 2016 data from the New York State Department of Health, SPARCS dataset via the Mount Sinai Health System

Exhibit 21: Self-Pay Discharges by ZIP Code, 2016



Source: Microsoft MapPoint and Verité analysis of 2016 data from the
New York State Department of Health, SPARCS dataset via the Mount Sinai Health System

Exhibit 22: Private Discharges by ZIP Code, 2016



Source: Microsoft MapPoint and Verité analysis of 2016 data from the New York State Department of Health, SPARCS dataset via the Mount Sinai Health System

Crime

A safe environment supports community health by helping to prevent injury and promote recreation and good mental health. The Federal Bureau of Investigation's Uniform Crime Reporting Program provides data on violent and property crimes (**Exhibit 23**).

Exhibit 23: Crime Rates per 100,000 Population, 2014-2015

Indicator	New York City	New York State	United States
Total Violent Crime	585.8	**379.7**	**383.2**
Murder and Non-negligent Manslaughter	4.1	**3.1**	**4.9**
Rape	26.2	**30.7**	**38.6**
Robbery	198.2	**120.9**	**101.9**
Aggravated Assault	357.2	**225.0**	**237.8**
Total Property Crime	1,518.7	**1,604.0**	**2,487.0**
Burglary	164.9	**223.7**	**491.4**
Larceny-Theft	1,267.4	**1,303.0**	**1,775.4**
Motor Vehicle Theft	86.4	**77.4**	**220.2**

Source: Federal Bureau of Investigation, Uniform Crime Reporting Program, 2015.

New York City had comparatively high rates of violent crime in 2015, including murder and non-negligent manslaughter, robbery, and aggravated assault. New York City has lower rates than the state for property crimes except for motor vehicle thefts (**Exhibit 23**).

Exhibit 24 presents crime rates among the young adult population aged 16-21, by borough in the community.

Exhibit 24: Young Adult Crime Rates per 10,000 Population, 2015

	Young Adults - Driving While Intoxicated		Young Adults Arrests - Drug Use/Possession/Sale Arrests		Young Adult Arrests - Property Crimes Arrests	
Borough	Number	Rate	Number	Rate	Number	Rate
Manhattan	70	7.2	2,412	249.2	2,941	303.8
New York City	363	6.2	10,501	179.9	8,362	143.2
New York State	**3,334**	**21.4**	**17,155**	**110.2**	**19,664**	**126.3**

Source: NYS Division of Criminal Justice Services via Kids' Well-being Indicators Clearinghouse, 2015.
Rates are per 10,000 young adults aged 16-21 years. Data were presented by county, see Introduction.

Young adult rates of driving while intoxicated compared well to the state. Drug use, possession, or sale arrest rates were more than 50 percent worse than the state average in Manhattan and New York City as a whole. Young adults residing in Manhattan also exhibited high rates of arrests from property crime (**Exhibit 24**).

Housing and Homelessness

According to the U.S. Department of Housing and Urban Development (HUD), approximately 800,000 people in the five boroughs of New York City lived in HUD-subsidized housing in 2016. **Exhibit 25** provides average household spending, average federal contribution, and wait times across all HUD programs.

Exhibit 25: HUD-Subsidized Housing Estimates, All Programs, 2016

			Spending per Unit per Month		
Borough	People in Subsidized Housing	Average Household Income	Average Household Contribution	Average Federal Contribution	Average Months on Waiting List
Manhattan	181,791	$21,097	$483	$1,010	43
New York State	**1,173,703**	**$18,350**	**$437**	**$842**	**42**
United States	**9,785,085**	**$13,726**	**$332**	**$687**	**26**

Source: U.S. Department of Housing and Urban Development, 2016.

Household and federal rent contributions per housing unit were higher in Manhattan than the state and U.S. averages. The average months on the wait list for subsidized housing in Manhattan was higher than state and national averages as well.

The New York City Housing Authority (NYCHA) is responsible for administering the City's Public Housing program and certain Section 8 Programs.[6] **Exhibit 26A** presents characteristics of NYCHA residents by race and ethnicity.

Exhibit 26A: Characteristics of Families and Individuals Served by NYCHA, 2017

Race and Ethnicity	Percentage of NYCHA Population Under 18	Percentage of NYCHA Families with Head of Household 62+	Percentage of NYCHA Population 62+ and Living Alone	Percentage of NYCHA Families with One Parent and Minors Under 18	Percentage of NYCHA Families with One or More Employed
Manhattan					
White	18.0%	55.8%	20.8%	13.4%	36.7%
Black	27.4%	34.7%	9.6%	29.2%	44.6%
Hispanic	23.4%	44.4%	11.7%	23.9%	43.7%
Asian	13.0%	56.0%	8.0%	5.5%	58.5%
Other	40.9%	33.3%	4.6%	26.2%	53.9%
Total	**23.7%**	**42.4%**	**10.7%**	**23.7%**	**45.3%**
New York City					
White	19.7%	59.7%	19.9%	12.0%	33.9%
Black	29.7%	32.3%	8.6%	31.7%	47.2%
Hispanic	26.9%	39.2%	10.0%	28.0%	46.1%
Asian	14.6%	52.3%	7.0%	5.4%	60.5%
Other	40.5%	34.1%	6.0%	31.7%	52.2%
Total	**27.3%**	**37.6%**	**9.5%**	**27.9%**	**46.7%**

Source: New York City Housing Authority, Resident Data Book Summary, 2017.

Of the NYCHA population, White families are more likely than other cohorts to have a head of household that is over the age of 62. Manhattan reports a high percentage of NYCHA residents who are 62 years and older and living alone. Black and Hispanic populations have higher percentages of single parent families compared to other cohorts. White families in NYCHA housing are less likely to have a member employed than other cohorts in Manhattan (**Exhibit 26A**).

Exhibit 26B presents additional characteristics of NYCHA residents by borough.

[6] New York City Housing Authority (NYCHA). (2017, April). About NYCHA Fact Sheet. Retrieved 2017, from: https://www1.nyc.gov/assets/nycha/downloads/pdf/factsheet.pdf

Exhibit 26B: Characteristics of Families and Individuals Served by NYCHA, 2017

Borough	Average NYCHA Family Size	Average Gross Income	Average Number of Years in Public Housing
Manhattan	2.2	$24,639	24.9
New York City	**2.3**	**$23,672**	**21.9**

Source: New York City Housing Authority, Resident Data Book Summary, 2017.

The average NYCHA family size was 2.2 persons in the community and average gross income is approximately $24,600. Manhattan residents served by NYCHA report longer tenures in public housing at an average of 25 years compared to the New York City average of 22 years.

The New York City Department of Homeless Services provides short-term, emergency shelter for individuals and families and engages in homelessness prevention initiatives. Each year, the Department conducts the Homeless Outreach Population Estimate (HOPE) survey, a point-in time-estimate of unsheltered individuals. **Exhibit 27** provides the results of the 2017 estimate.

Exhibit 27: Unsheltered Individuals, 2005-2017

Borough	Unsheltered 2005	Unsheltered 2016	Unsheltered 2017	Percent Change 2005-2017	Percent Change 2016-2017
Surface Areas	**3,550**	**1,221**	**2,080**	**-41.4%**	**70.4%**
Manhattan	1,805	813	1,220	-32.4%	50.1%
Bronx	587	43	255	-56.6%	493.0%
Brooklyn	592	210	363	-38.7%	72.9%
Queens	335	110	199	-40.6%	80.9%
Staten Island	231	45	43	-81.4%	-4.4%
Subways	**845**	**1,573**	**1,812**	**114.4%**	**15.2%**
Total Unsheltered Individuals	**4,395**	**2,794**	**3,892**	**-11.4%**	**39.3%**

Source: New York City Department of Homeless Services, 2017.

In 2017, an estimated 3,892 people in New York City were unsheltered, an 11 percent decrease from 2005 but a 39 percent increase from 2016. In Manhattan, 1,220 people were unsheltered (excluding those residing in subways).

New York City's overall rate of homelessness (33.2 per 100,000) is lower than that of many other large cities (**Exhibit 28**).

Exhibit 28: Homelessness Rate, Selected Cities, 2016

City or Metropolitan Area	Total Population	Unsheltered Homeless	Rate per 100,000
San Francisco	870,887	4,358	500.4
Los Angeles City & County	10,137,915	32,781	323.4
Seattle/King County	2,149,970	4,505	209.5
District of Columbia	681,170	318	46.7
Chicago	2,704,958	1,243	46.0
Philadelphia	1,567,872	705	45.0
Miami/Dade County	2,712,945	982	36.2
New York City	**8,537,673**	**2,838**	**33.2**
Boston	673,184	167	24.8

Source: Verité analysis of data from the U.S. Department of Housing and Urban Development, 2017, and the U.S. Census, 2017.

State of New York and New York City Budget Trends

Examining recent trends in public budgets for health care, public health, and social services can illuminate the availability of public services that support the health of the community.

New York State Budget Changes between FY 2017and FY 2018[7]

The State of New York's FY 2017-2018 budget includes both funding increases and decreases from FY 2016-2017 for health-related services. Changes include:

- **Health**
  - The overall health budget increased $841million, or 4.1 percent;
  - The Office for the Aging budget decreased $1.77 million, or 1.4 percent;
  - The Department of Health budget increased $845 million, or 4.1 percent; and
  - The Office of the Medicaid Inspector General decreased $1.96 million, or 9.5 percent.
- **Social Welfare**
  - The Social Welfare budget increased by $24.4 million, or 0.7 percent;
  - The Office of Children and Family Services budget decreased $68.2million, or 3.5 percent;
  - The Office of Temporary and Disability Assistance budget increased $84 million, or 6.2 percent.

[7] New York State Department of the Budget. (2017). *New York State Budget.* Retrieved 2017, from: https://openbudget.ny.gov/overview/overview_SpendGrowth.html

- **Mental Hygiene**
    - The overall Mental Hygiene budget increased $41.9 million, or by 0.6 percent;
    - The Office of Alcoholism and Substance Abuse Services increased $23.7 million, or 5.6 percent;
    - The Justice Center for the Protection of People with Special Needs budget was increased by $2.0 million, or 5.1 percent;
    - The Office of Mental Health budget increased $152,000, or by 0.0 percent;
    - Funding for the Department of Mental Hygiene's budget of $227,000 was eliminated; and
    - The Office for People with Developmental Disabilities increased $16.3 million, or 0.6 percent.

New York City Budget Changes between FY 2017 and FY 2018

The New York City Council developed its budget for FY 2018 to be prepared for "an unexpected financial downturn, as well as the possibility of devastating federal cuts to vital services." The Council developed the budget to "bolster essential City programs and services that support New Yorkers, especially the most vulnerable." [8]

Included in the budget are Council initiatives for programs and services which are intended to respond to needs unmet by city services. Such programs and services are provided by non-profit organizations, which are allocated discretionary funds from the Council. Funding is intended to support local communities while maintaining budget stability.

The Council funded multiple organizations for numerous programs across various budget categories. FY 2018 budget categories that related to health are as follows:

- Anti-Poverty
- Children's Services
- Community Development
- Criminal Justice Services
- Domestic Violence Services
- Education
- Food Initiatives
- Health Services
- Homeless Services
- Housing
- Immigrant Services
- Mental Health Services
- Senior Services
- Youth Services
- Young Women's Initiative

[8] New York City Council Finance Division (2017), *Fiscal Year 2018 Adopted Expense Budget, Adjustment Summary / Schedule C.*

A summary of programs by budget category, including a comparison to the FY 2017 budget, is below.

- **Anti-Poverty** – Initiatives "address income disparities throughout the five boroughs."
    - Anti-Poverty Initiatives, administered through multiple City agencies, is budgeted in FY 2018 at $2,800,000, which is unchanged from FY 2017.

- **Children's Services** – "Initiatives support child care programs and reflect the Council's goal of increasing access to early childhood education programs."
    - Discretionary Child Care programs, administered through the Administration for Children's Services (ACS) is budgeted in FY 2018 at $9,855,190, an increase of $500,121 from FY 2017;
    - The City's First Readers program, administered through the Department of Youth and Community Development (DYCD), is budgeted for FY 2018 at $4,242,000, an increase of $1,450,000 from FY 2017; and
    - Child Care Vouchers, administered in FY 2017 by ACS and budgeted at $3,000,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C.

- **Community Development** – The Council continues "funding to community-based organizations that support a broad range of community and capacity-building efforts."
    - The Adult Literacy Initiative, administered by DYCD, is budgeted for FY 2018 at $6,000,000, which is unchanged from FY 2017;
    - The Communities of Color Nonprofit Stabilization Fund, administered by DYCD, is budgeted for FY 2018 at $3,700,000, an increase of $1,200,000 from FY 2017;
    - The Digital Inclusion and Literacy Initiative, administered by DYCD, is budgeted for FY 2018 at $3,060,000, an increase of $1,020,000 from FY 2017;
    - The Diversity, Inclusion and Equity in Tech Initiative, administered by DYCD and the New York City Housing Authority (NYCHA) is budgeted for FY 2018 at $700,000, new funding for this programmatic area as the Initiative did not appear in the FY 2017 Adopted Expense Budget Schedule C; and
    - The Social Justice Postgraduate Fellowship, administered by the Department of Citywide Administrative Services (DCAS), is budgeted for FY 2018 at $900,000, an increase of $300,000 from FY 2017.

- **Criminal Justice Services** – Continued funding "reflects the Council's steadfast vision of reducing incarceration costs, promoting increased equality, and seeking highly innovative paths for criminal justice reform."
    - Alternatives to Incarceration, administered by the Mayor's Office of Criminal Justice (MOCJ), is budgeted for FY 2018 at $6,407,000, an increase of $775,000 from FY 2017;
    - The Bail Fund, administered by MOCJ, is budgeted for FY 2018 at $1,400,000, which is unchanged from FY 2017;
    - The Center for Court Innovation, administered by MOCJ, is budgeted for FY 2018 at $1,710,000, an increase of $1,210,000 from FY 2017;
    - The Initiative to Combat Sexual Assault, administered by MOCJ, is budgeted for FY 2018 at $1,348,000, which is unchanged from FY 2017;

- Support for Victims of Human Trafficking, administered by MOCJ, is budgeted for FY 2018 at $1,000,000, an increase of $250,000 from FY 2017; and
- Video Visitation, administered by the Brooklyn Public Library (BPL), the New York Public Library (NYPL), and the Queens Borough Public Library (QBPL), is budgeted for FY 2018 at $600,000, new funding for this programmatic area as the Initiative did not appear in the FY 2017 Adopted Expense Budget Schedule C.

- **Domestic Violence Services** – The Council's funding "supports services for survivors of domestic violence and their families, which includes prevention, case management, crisis intervention, legal services, referrals, counseling, education, technical assistance, training, and community outreach."
  - The Domestic Violence and Empowerment (DoVE) Initiative, administered by MOCJ, is budgeted for FY 2018 at $7,805,000, an increase of $1,500,000 from FY 2017; and
  - The Supportive Alternatives to Violent Encounters (SAVE), administered by ACS, the Human Resources Administration (HRA), and MOCJ, is budgeted for FY 2018 at $1,950,000, which is unchanged from FY 2017.

- **Education** –The Council's "initiatives provide direct benefits that support school budgets and students' needs, … including mental health services for students, dropout prevention programs, LGBTQ inclusive curriculum, and STEM education."
  - Bridge to Tomorrow, administered in FY 2017 by the Department of Education (DOE) and budgeted at $1,150,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
  - The Child Mind Institute, administered by DOE, is budgeted for FY 2018 at $500,000, which is unchanged from FY 2017;
  - Community Schools, administered by DOE, is budgeted for FY 2018 at $2,250,000, an increase of $1,025,000 from FY 2017;
  - The Dropout Prevention and Intervention Initiative, administered by DOE, is budgeted for FY 2018 at $1,585,000, a decrease of $10,000 from FY 2017;
  - Educational Programs for Students, administered by DOE, is budgeted for FY 2018 at $3,890,000, an increase of $915,000 from FY 2017;
  - The Jill Chaifetz Helpline, administered by DYCD, is budgeted for FY 2018 at $245,000, which is unchanged from FY 2017;
  - The LGBTQ Inclusive Curriculum, administered by DOE, is budgeted for FY 2018 at $200,000, an increase of $45,000 from FY 2017;
  - Physical Education and Fitness, administered by DOE / Department of Youth and Community Development (DYCD), is budgeted for FY 2018 at $1,925.000, which is unchanged from FY 2017;
  - The Restorative Justice Program, administered by DOE, is budgeted for FY 2018 at $1,300,000, which is unchanged from FY 2017;
  - Support for Educators, administered by DOE, is budgeted for FY 2018 at $20,804,500, an increase of $8,060,000 from FY 2017; and
  - The Urban Advantage, administered by DOE, is budgeted for FY 2018 at 3,500,000, which is unchanged from FY 2017.

- **Food Initiatives** – The Council's "food initiatives support critical programs that assist low-income New Yorkers in accessing food and federal benefits … including school pantries, as well as programs that help low income New Yorkers access Earned Income Tax Credits (EITC) and Supplemental Nutrition Assistance Program (SNAP) benefits."
    - Access to Healthy Food and Nutritional Education, administered by DYCD, is budgeted for FY 2018 at $930,000, which is unchanged from FY 2017;
    - The Food Access and Benefits, administered by HRA, is budgeted for FY 2018 at $725,000, which is unchanged from FY 2017; and
    - The Food Pantries, administered by DYCD, is budgeted for FY 2018 at $4,000,000, which is unchanged from FY 2017.

- **Health Services** –"Health Services initiatives funded by the Council in Fiscal 2018 demonstrate the Council's commitment to reducing health disparities and promoting health equity throughout the five boroughs."
    - Access Health, administered by the Department of Health and Mental Hygiene (DOHMH), is budgeted for FY 2018 at $1,187,000, an increase of $117,000 from FY 2017;
    - Beating Hearts, administered by DOHMH, is budgeted for FY 2018 at $350,000, which is unchanged from FY 2017;
    - Cancer Services, administered by DOHMH, is budgeted for FY 2018 at $790,500, which is unchanged from FY 2017;
    - Child Health and Wellness, administered by DOHMH, is budgeted for FY 2018 at $646,000, which is unchanged from FY 2017;
    - Ending the Epidemic, administered by DOHMH, is budgeted for FY 2018 at $6,295,000, an increase of 700000 from FY 2017;
    - HIV/AIDS Faith Based, administered by DOHMH, is budgeted for FY 2018 at $1,360,000, a decrease of $200,000 from FY 2017;
    - Maternal Health Services, administered by DOHMH, is budgeted for FY 2018 at $1,192,818, a decrease of $237,182 from FY 2017;
    - The Nurse Family Partnership, administered by DOHMH, is budgeted for FY 2018 at $2,000,000, which is unchanged from FY 2017;
    - Reproductive & Sexual Health Services, administered by DOHMH, is budgeted for FY 2018 at $344,788, an increase of $84,788 from FY 2017; and
    - Viral Hepatitis Prevention, administered by DOHMH, is budgeted for FY 2018 at $1,423,658, an increase of $237,182 from FY 2017.

- **Homeless Services** – The Council's initiatives include "emergency grants to families in financial crisis and at risk of eviction to keep them in their homes … [and] an innovative approach to addressing the mental health and emotional needs of families."
    - The Children and Families in NYC Homeless System, administered by the Department of Homeless Services (DHS), is budgeted for FY 2018 at $1,000,000, which is unchanged from FY 2017; and
    - The Citywide Homeless Prevention Fund, administered by DHS, is budgeted for FY 2018 at $820,000, which is unchanged from FY 2017.

- **Housing** –Council funding provides "a critical resource to ensure that communities access the tools, resources, and programming necessary to address local housing needs."
    - Community Housing Preservation Strategies, administered by the Department of Housing Preservation and Development (HPD), is budgeted for FY 2018 at $3,651,000, which is unchanged from FY 2017;
    - Financial Empowerment for NYC Renters, administered by HPD and the Department of Consumer Affairs (DCA), is budgeted for FY 2018 at $450,000, which is unchanged from FY 2017;
    - The Foreclosure Buyback Initiative, administered by HPD, is budgeted for FY 2018 at $1,000,000, which is unchanged from FY 2017;
    - The Housing Information Project (SHIP), administered by HPD, is budgeted for FY 2018 at $300,000, which is unchanged from FY 2017;
    - The HPD Alternative Enforcement Program (AEP), administered by HPD, is budgeted for FY 2018 at $750,000, which is unchanged from FY 2017;
    - The Home Loan Program, administered by HPD and HRA, is budgeted for FY 2018 at $1,500,000, which is unchanged from FY 2017;
    - The Mortgage Foreclosure Prevention Program, administered by HPD, is budgeted for FY 2018 at $1,000,000, which is unchanged from FY 2017; and
    - Stabilizing NYC, administered by HPD, is budgeted for FY 2018 at $2,500,000, an increase of $500,000 from FY 2017.

- **Immigrant Services** – The Council included funds for "immigrant services that reflect the Council's continued commitment to ensuring that immigrant New Yorkers have access to legal assistance for both detained and non-detained persons, health services, and other wraparound services."
    - The CUNY Citizenship NOW! Program, administered by the City University of New York (CUNY), is budgeted for FY 2018 at $2,000,000, which is unchanged from FY 2017;
    - The Immigrant Health Initiative, administered by DOHMH, is budgeted for FY 2018 at $1,500,000, which is unchanged from FY 2017;
    - The Immigrant Opportunities Initiative, administered by HRA, is budgeted for FY 2018 at $2,600,000, which is unchanged from FY 2017;
    - Key to the City, administered by DYCD, is budgeted for FY 2018 at $700,000, new funding for this programmatic area as Key to the City did not appear in the FY 2017 Adopted Expense Budget Schedule C; and
    - The Immigrant Resource Center, administered by DYCD, is budgeted for FY 2018 at $500,000, a decrease of $5,730,000 from FY 2017;
    - The New York Immigrant Family Unity Project, administered by HRA, is budgeted for FY 2018 at $10,000,000, an increase of $9,300,000 from FY 2017; and
    - Unaccompanied Minors and Families, administered by HRA, is budgeted for FY 2018 at $2,000,000, an increase of $1,500,000 from FY 2017.

- **Mental Health Services** – "The Mental Health Services initiatives funded by the Council demonstrate the Council's commitment to supporting the mental health needs of New Yorkers, particularly the most vulnerable and marginalized populations, such as isolated seniors, court-involved youth, and traumatized children."
    - Autism Awareness, administered by DOHMH, is budgeted for FY 2018 at $3,236,846, a decrease of $78,540 from FY 2017;
    - Children Under Five, administered by DOHMH, is budgeted for FY 2018 at $1,002,000, which is unchanged from FY 2017;
    - Court-Involved Youth Mental Health, administered by DOHMH, is budgeted for FY 2018 at $2,050,000, an increase of $150,000 from FY 2017;
    - Developmental, Psychological & Behavioral Health Services, administered by DOHMH, is budgeted for FY 2018 at $2,179,390, an increase of $40,000 from FY 2017;
    - Geriatric Mental Health, administered by DOHMH, is budgeted for FY 2018 at $1,905,540, an increase of $78,540 from FY 2017;
    - LGBTQ Youth All-Borough Mental Health, administered by DOHMH, is budgeted for FY 2018 at $1,200,000, an increase of $200,000 from FY 2017;
    - Medicaid Redesign Transition, administered by DOHMH, is budgeted for FY 2018 at $500,000, which is unchanged from FY 2017; and
    - Mental Health Services for Vulnerable Populations, administered by DOHMH, is budgeted for FY 2018 at $1,218,000, an increase of $125,000 from FY 2017.

- **Senior Services** – Initiatives for seniors include "innovative services for niche senior populations, including Holocaust Survivors, immigrants, and LGBT seniors" as well as "senior center programming and elder abuse prevention."
    - Access to Critical Services for Seniors, administered by the Department for the Aging (DFTA), is budgeted for FY 2018 at 1180000, which is unchanged from FY 2017;
    - Borough Presidents' Discretionary Funding Restoration, administered by DFTA, is budgeted for FY 2018 at $1,129,774, which is unchanged from FY 2017;
    - DFTA Core Services Enhancement, administered in FY 2017 by DFTA and budgeted at $660,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
    - Elder Abuse Enhancement, administered by DFTA, is budgeted for FY 2018 at $335,000, which is unchanged from FY 2017;
    - The Healthy Aging Initiative, administered by DFTA, is budgeted for FY 2018 at $1,810,000, which is unchanged from FY 2017;
    - The Elie Wiesel Holocaust Survivors Initiative, administered by DFTA, is budgeted for FY 2018 at $3,000,000, an increase of $500,000 from FY 2017;
    - Information and Referral Services, administered by DFTA, is budgeted for FY 2018 at $407,811, which is unchanged from FY 2017;
    - LGBT Senior Services in Every Borough, administered by DFTA, is budgeted for FY 2018 at $1,500,000, which is unchanged from FY 2017;
    - Naturally Occurring Retirement Communities (NORCs), administered by DFTA, is budgeted for FY 2018 at $3,850,000, which is unchanged from FY 2017;

- Support Our Seniors, administered by DFTA, is budgeted for FY 2018 at $3,060,000, an increase of $1,020,000 from FY 2017;
- Senior Centers for Immigrant Populations, administered by DFTA, is budgeted for FY 2018 at $1,500,000, which is unchanged from FY 2017;
- Senior Centers, Programs, and Services Enhancement, administered by DFTA, is budgeted for FY 2018 at $3,000,000, a decrease of $5,78,000 from FY 2017; and
- Social Adult Day Care Enhancement, administered by DFTA, is budgeted for FY 2018 at $1,055,556, an increase of $105,556 from FY 2017.

- **Youth Services** – The City budget continues funding for "community-based organizations that support a broad range of youth services."
  - The Afterschool Enrichment Initiative, administered by DYCD, is budgeted for FY 2018 at $5,725,000, an increase of $300,000 from FY 2017;
  - Anti-Violence Youth Programs, administered in FY 2017 by DYCD and budgeted at $250,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
  - Big Brothers Big Sisters of New York City, administered by DYCD, is budgeted for FY 2018 at $1,200,000, which is unchanged from FY 2017;
  - Civic Education in New York City Schools, administered by DYCD, is budgeted for FY 2018 at $500,000, which is unchanged from FY 2017;
  - COMPASS, administered by DYCD, is budgeted for FY 2018 at $1,813,600, a decrease of $6,186,400 from FY 2017;
  - The Sports Training and Rolemodels for Success Initiative, administered by DYCD, is budgeted for FY 2018 at $1,200,000, which is unchanged from FY 2017;
  - Student Voter Registration Day, administered in FY 2017 by DYCD and budgeted at $400,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
  - The Year-Round Employment Program, administered by DYCD, is budgeted for FY 2018 at $8,000,000, a decrease of $3,000,000 from FY 2017; and
  - The YouthBuild Project Initiative, administered by DYCD, is budgeted for FY 2018 at $2,100,000, which is unchanged from FY 2017.

- **Young Women's Initiative** – The City Council continues support for the Young Women's Initiative, which seeks "to build a blueprint for investing in the future of young women and girls in New York City over the long-term, especially those of color."
  - The Dedicated Contraceptive Fund, administered by DOHMH, is budgeted for FY 2018 at $400,000, which is unchanged from FY 2017;
  - Wrap-Around Support for Transitional-Aged Foster Youth, administered by HRA, is budgeted for FY 2018 at $500,000, which is unchanged from FY 2017;
  - Gender Equity Liaisons, administered in 2017 by DOHMH, DOE, DYCD, HPD, and HRA and budgeted at $500,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
  - The Expand Transgender Healthcare Training, administered by the Health and Hospitals Corporation (H+H), is budgeted for FY 2018 at $150,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;

- The Initiative for Immigrant Survivors of Domestic Violence, administered by MOCJ, is budgeted for FY 2018 at $250,000, which is unchanged from FY 2017;
- The Power Action Change Empowerment (PACE) Initiative for Young Adults, administered in FY 2017 by MOCJ and budgeted at $250,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
- The Post-Arrest Diversion Program, administered by SIDA, is budgeted for FY 2018 at $1,025,000, an increase of $775,000 from FY 2017;
- The Prevent Sexual Assault (PSA) Initiative for Young Adults, administered by MOCJ, is budgeted for FY 2018 at $225,000, a decrease of $25,000 from FY 2017;
- The Step In and Stop It Initiative to Address Bystander Intervention, administered by MOCJ, is budgeted for FY 2018 at $154,000, a decrease of $96,000 from FY 2017;
- Transgender Specific Healthcare Training, administered in FY 2017 by H+H and budgeted at $250,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
- HRA Teen RAPP Enhancement, administered by HRA, is budgeted for FY 2018 at $250,000, new funding for this programmatic area as HRA Teen RAPP Enhancement did not appear in the FY 2017 Adopted Expense Budget Schedule C;
- The Warrant Reduction Events, administered in FY 2017 by District Attorneys and budgeted at $175,000, did not appear in the FY 2018 Adopted Expense Budget Schedule C;
- Work-Based Learning Internships, administered by DOE, is budgeted for FY 2018 at $600,000, which is unchanged from FY 2017;
- Young Women's Leadership Development, administered by DYCD, is budgeted for FY 2018 at $946,000, an increase of $121,000 from FY 2017; and
- The ACS Youth Health Initiative, administered by ACS, is budgeted for FY 2018 at $500,000, which is unchanged from FY 2017.

Local Health Status and Access Indicators

This section examines health status and access to care data for the MSSL & MSW community from several sources. The data include: (1) County Health Rankings, (2) New York State Department of Health, (3) Youth Risk Behavioral Surveillance System, (4) New York Prevention Agenda 2013-2017, and (5) New York City Community Survey.

Note: New York City analyzes the health of community districts. Included in these comprehensive profiles are assessments of health, housing, air quality, and food accessibility. These New York City Community Health Profiles can be accessed at: https://www1.nyc.gov/site/doh/data/data-publications/profiles.page.

County Health Rankings

County Health Rankings, a University of Wisconsin Population Health Institute initiative funded by the Robert Wood Johnson Foundation, incorporates a variety of health status indicators into a system that ranks each county/city within each state in terms of "health factors" and "health outcomes." These health factors and outcomes are composite measures based on several variables grouped into the following categories: health behaviors, clinical care,[9] social and economic factors, and physical environment.[10] *County Health Rankings* is updated annually. *County Health Rankings 2017* relies on data from 2006 to 2015, with most data from 2011 to 2015.

Exhibit 29A presents 2013 and 2017 rankings for each available indicator category. Rankings indicate how the county ranked in relation to all 62 counties in the New York, with 1 indicating the most favorable rankings and 62 the least favorable. The table also indicates if rankings fell between 2013 and 2017.

Note: County Health Rankings present data by county rather than borough. As each borough corresponds to a whole county, data are labeled with the borough name. Specifically, New York County corresponds to the borough of Manhattan.

[9] A composite measure of Access to Care, which examines the percent of the population without health insurance and ratio of population to primary care physicians, and Quality of Care, which examines the hospitalization rate for ambulatory care sensitive conditions, whether diabetic Medicare patients are receiving HbA1C screening, and percent of chronically ill Medicare enrollees in hospice care in the last 8 months of life.

[10] A composite measure that examines Environmental Quality, which measures the number of air pollution-particulate matter days and air pollution-ozone days, and Built Environment, which measures access to healthy foods and recreational facilities and the percent of restaurants that are fast food.

Exhibit 29A: County Rank among 62 New York Counties, 2013-2017

Indicator	Manhattan		
	2013	2017	Rank Change
Health Outcomes	**21**	**11**	
Health Factors	**10**	**11**	↓
Length of Life	**9**	**2**	
Quality of Life	**54**	**52**	
Poor physical health days	27	25	
Poor mental health days	36	23	
Drug Overdose Deaths	-	19	
Health Behaviors	**2**	**3**	↓
Adult Smoking	5	3	
Adult Obesity	1	1	
Excessive Drinking	47	62	↓
Sexually Transmitted Infections	59	61	↓
Teen Births	32	22	
Clinical Care	**10**	**6**	
Primary Care Physicians	3	3	
Dentists	1	1	
Mental Health Providers	1	1	
Preventable Hospital Stays	6	3	
Diabetes Monitoring	61	60	
Social & Economic Factors	**52**	**44**	
Some College	1	1	
Unemployment	10	15	↓
Social Associations	54	13	
Injury Deaths	1	4	↓
Physical Environment	**1**	**55**	↓
Air pollution - particulate matter	48	62	↓
Severe Housing Problems	-	58	

Source: County Health Rankings, 2017 and 2013.

In 2017, Manhattan ranked in the bottom 50th percentile among New York counties for 8 of the 27 indicators assessed. Of those 8 indicators ranking in the bottom 50th percentile, 7 of them ranked in the bottom quartile, including Quality of Life and Physical Environment. Manhattan ranked last in the state for Excessive Drinking and Air Pollution – Particulate Matter. Rankings for 8 indictors fell between the time periods.

Exhibit 29B provides data for each underlying indicator of the composite categories in the County Health Rankings.[11] The County Health Rankings methodology provides a comparison of counties within a state to one another.

It also is important to analyze how these same indicators compare to the state and national averages. For example, the community's violent crime rate was more than 50 percent worse than the state average, and the boroughs were shaded to reflect this relationship.

[11]County Health Rankings provides details about what each indicator measures, how it is defined, and data sources at http://www.countyhealthrankings.org/sites/default/files/resources/2013Measures_datasources_years.pdf

Exhibit 29B: Borough Data Compared to State and U.S. Average, 2017

Indicator Category	Data	Manhattan	New York State	U.S.
Health Outcomes				
Length of Life	Years of potential life lost before age 75 per 100,000 population	4,165.3	5,339.1	6,600.0
Quality of Life	Percent of adults reporting fair or poor health	15.2%	16.2%	15.0%
	Average number of physically unhealthy days reported in past 30 days	3.6	3.8	3.6
	Average number of mentally unhealthy days reported in past 30 days	3.7	3.7	3.7
	Percent of live births with low birthweight (<2500 grams)	8.6%	8.1%	8.0%
Health Factors				
Health Behaviors				
Adult Smoking	Percent of adults that report smoking >= 100 cigarettes and currently smoking	11.9%	15.2%	18.0%
Adult Obesity	Percent of adults that report a BMI >= 30	14.7%	24.6%	28.0%
Food Environment Index	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.8	8.0	7.3
Physical Inactivity	Percent of adults aged 20 and over reporting no leisure-time physical activity	17.5%	24.0%	22.0%
Access to Exercise Opportunities	Percent of population with adequate access to locations for physical activity	98.4%	90.7%	84.0%
Alcohol Impaired Driving Deaths	Percent of driving deaths with alcohol involvement	7.9%	23.0%	30.0%
Excessive Drinking	Binge plus heavy drinking	23.8%	18.2%	18.0%
STDs	Chlamydia rate per 100,000 population	771.8	502.8	456.1
Teen Births	Teen birth rate per 1,000 female population, ages 15-19	18.7	21.1	32.0
Clinical Care				
Uninsured	Percent of population under age 65 without health insurance	8.9%	10.1%	14.0%
Primary Care Physicians	Ratio of population to primary care physicians	723:1	1199:1	1,320:1
Dentists	Ratio of population to dentists	579:1	1275:1	1,520:1
Mental Health Providers	Ratio of population to mental health providers	137:1	417:1	500:1
Preventable Hospital Stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	35.4	47.6	50.0
Diabetic Screening	Percent of diabetic Medicare enrollees that receive HbA1c monitoring	81.1%	85.9%	85.0%
Mammography Screening	Percent of female Medicare enrollees, ages 67-69, that receive mammography screening	60.1%	62.1%	63.0%

Indicator Category	Data	Manhattan	New York State	U.S.
Health Outcomes				
Social & Economic Factors				
High School Graduation	Percent of ninth-grade cohort that graduates in four years	69.6%	79.3%	83.0%
Some College	Percent of adults aged 25-44 years with some post-secondary education	83.3%	66.7%	64.0%
Unemployment	Percent of population age 16+ unemployed but seeking work	4.8%	5.3%	5.3%
Children in poverty	Percent of children under age 18 in poverty	24.9%	22.3%	21.0%
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	8.8	5.7	5.0
Children in single-parent households	Percent of children that live in a household headed by single parent	41.8%	34.9%	34.0%
Social Associations	Number of associations per 10,000 population	13.1	7.9	9.4
Violent Crime	Number of reported violent crime offenses per 100,000 population	621.1	394.1	380.0
Injury Deaths	Injury mortality per 100,000	33.1	44.0	62.0
Physical Environment				
Air Pollution	The average daily measure of fine particulate matter in micrograms per cubic meter (PM2.5) in a county	11.1	8.6	8.7
Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities	25.4%	24.3%	19.0%
Drive Alone to Work	Percent of the workforce that drives alone to work	6.1%	53.2%	76.0%
Long Commute- Drive Alone	Among workers who commute in their car alone, the percent that commute more than 30 minutes	64.9%	36.3%	34.0%

Source: County Health Rankings, 2017

Manhattan was more than fifty percent worse than state averages in chlamydia rate, income inequality, violent crime, and long commute – drive alone. Additionally, Manhattan compared unfavorable for mentally unhealthy days, low birthweight births, food environment index, excessive drinking, diabetic and mammography screening, high school graduation rate, children in poverty and single-parent households, air pollution, and severe housing problems.

New York State Department of Health

The New York State Department of Health collects data regarding a number of health issues. **Exhibit 30** presents a summary of selected causes of death by borough. Data presented in **Exhibit 31** through **Exhibit 47** present more in depth data analyses pertaining to cancer, cardiovascular disease, obesity, communicable diseases, respiratory-related indicators, maternal and infant health, and injury and substance abuse. Data by race and ethnicity are included, where available.

Exhibit 30: Selected Causes of Death, Rates per 100,000 Population, 2014

Area	Diseases of the Heart	Malignant Neoplasms	Cerebro-vascular Disease	Acquired Immune Deficiency Syndrome (AIDS)	Pneumonia	Chronic Lower Respiratory Diseases (CLRD)	Accidents (Total)	Diabetes Mellitus	All Other Causes	Suicide
Manhattan	137.2	132.3	18.0	6.0	16.5	19.0	18.8	14.8	143.2	8.6
New York City	175.9	137.9	20.0	5.5	23.4	20.2	19.3	19.6	143.2	6.1
New York State	**171.0**	**145.9**	**24.9**	**2.8**	**17.8**	**27.9**	**25.6**	**16.7**	**180.2**	**8.3**

Source: New York State Department of Health, 2017.
Rates are age adjusted.

Manhattan and New York City as a whole were more than 50 percent worse than the state for AIDS mortality. Manhattan also had a higher rate of suicide than the state average.

Exhibit 31: Cancer Indicators, 2013-2014

Indicator	Manhattan	New York City	New York State
All cancers			
Incidence per 100,000	503.3	470.0	550.9
Mortality rate per 100,000	155.3	151.1	180.7
Lip, oral cavity, and pharynx cancer			
Incidence per 100,000	11.4	10.1	12.1
Mortality rate per 100,000	2.8	2.4	2.5
Colon and rectum cancer			
Incidence per 100,000	38.3	42.7	46.7
Mortality rate per 100,000	13.8	15.8	16.6
Lung and bronchus cancer			
Incidence per 100,000	55.2	51.3	69.6
Mortality rate per 100,000	34.3	33.4	46.4
Female breast cancer			
Incidence per 100,000	147.7	128.8	149.1
Mortality rate per 100,000	24.4	23.9	26.3
Cervix uteri cancer			
Incidence per 100,000	7.3	9.8	8.3
Mortality rate per 100,000	2.6	3.1	2.7
Ovarian cancer			
Incidence per 100,000	15.3	13.3	14.9
Mortality rate per 100,000	9.0	8.1	9.5
Prostate cancer			
Incidence per 100,000	145.0	141.4	156.7
Mortality rate per 100,000	19.7	18.0	18.3
Melanoma cancer mortality			
Mortality rate per 100,000	1.7	1.4	2.5
Screenings			
% of women 18 years and older with pap smear in past 3 years (2008-2009)	-	71.9	74.2
% of women 40 years and older with mammography screening in past 2 years (2008-2009)	70.5	74.9	77.8

Source: New York State Department of Health, 2017.
All rates are age-adjusted.

Overall, Manhattan compared favorably to the state for cancer incidence and mortality indicators. Manhattan compared unfavorably in lip, oral cavity, and pharynx cancer mortality, prostate cancer mortality, ovarian cancer incidence, and mammography screening.

Exhibit 32 presents cancer indicators by race and ethnicity.

Exhibit 32: Cancer Indicators by Race and Ethnicity, 2011-2013

Borough and Race/Ethnicity	Lung Cancer Incidence	Colorectal Cancer Mortality	Breast Cancer Mortality	Cervix Uteri Cancer Mortality
Manhattan				
White	52.8	9.7	21.0	1.5
Black	69.3	20.0	29.9	5.3
Asian/Pacific	45.5	13.0	10.7	-
Hispanic	35.1	12.4	15.9	2.6
Total	50.6	12.2	20.2	2.5
New York City				
White	59.0	14.2	21.7	1.9
Black	49.7	18.3	27.8	4.8
Asian/Pacific	45.0	10.7	8.9	1.9
Hispanic	33.0	13.6	15.5	3.3
Total	49.7	14.7	20.7	2.9
New York State				
White	68.2	13.8	20.7	2.0
Black	53.6	17.6	27.6	4.4
Asian/Pacific	41.5	10.2	8.8	1.8
Hispanic	32.9	12.6	15.0	3.0
Total	60.9	14.0	20.5	2.4

Source: New York State Department of Health, 2017.
All rates are age adjusted per 100,000 population.

Cervix uteri cancer mortality was high for Manhattan overall. Black, Asian/Pacific, and Hispanic populations in Manhattan had higher rates of cancer for several indicators. White and Black populations had higher rates of breast cancer mortality in Manhattan.

Exhibit 33 presents cardiovascular disease-related indicators by borough compared to the state.

Exhibit 33: Cardiovascular Disease Indicators, 2012-2014

Area	Diseases of the Heart Mortality	Cerebrovascular Disease Mortality	Coronary Heart Disease Mortality	Congestive Heart Failure Mortality
Manhattan	142.7	18.0	122.1	5.3
New York City	184.2	19.7	164.2	5.3
New York State	**180.1**	**25.6**	**140.7**	**12.2**

Source: New York State Department of Health, 2017.
All rates are age-adjusted and per 100,000 population.

Manhattan compared favorably to the state for all cardiovascular disease indicators. In New York City, heart disease mortality and coronary heart disease mortality was higher than the state average.

Exhibit 34 presents cardiovascular disease and diabetes indicators by borough, race, and ethnicity.

Exhibit 34: Cardiovascular Disease and Diabetes Mortality Rates by Race and Ethnicity, 2012-2014

Borough and Race/Ethnicity	Diseases of the Heart Mortality	Cerebrovascular Disease Mortality	Coronary Heart Disease Mortality	Congestive Heart Failure Mortality	Diabetes Mortality
Manhattan					
White	124.0	13.5	105.7	5.1	6.8
Black	241.7	29.0	209.1	7.3	36.9
Asian/Pacific	93.7	18.2	77.7	3.9	12.0
Hispanic	126.7	19.5	108.7	4.1	20.7
Total	142.7	18.0	122.1	5.3	15.3
New York City					
White	194.8	16.4	174.4	5.8	12.8
Black	215.5	24.2	191.1	5.7	36.6
Asian/Pacific	98.1	18.8	87.9	2.3	13.2
Hispanic	143.8	20.1	128.3	4.1	21.8
Total	184.2	19.7	164.2	5.3	20.4
New York State					
White	182.8	25.5	138.4	13.9	14.2
Black	213.1	28.1	180.8	8.2	34.4
Asian/Pacific	95.3	19.0	83.7	3.5	12.1
Hispanic	136.2	20.8	118.2	5.1	20.0
Total	180.1	25.6	140.7	12.2	17.4

Source: New York State Department of Health, 2017.
All rates are age adjusted per 100,000 population.

Among racial and ethnic cohorts in Manhattan, the Black population exhibited the highest mortality rates for all indicators. Heart disease mortality for all cohorts in New York City was higher than the state average. Black and Hispanic populations typically had higher diabetes mortality rates than White populations in both Manhattan and New York City.

Obesity increases the risk for many health conditions. Obesity measures, health behaviors that contribute to obesity, and obesity-related chronic diseases are reported in **Exhibit 35.**

Exhibit 35: Obesity-Related Indicators, 2010-2014

Indicator	Manhattan	New York City	New York State
% of pregnant women in WIC who were pre-pregnancy overweight or obese (BMI 25 or higher)	46.7%	48.1%	50.8%
% obese (95th percentile or higher) children in WIC (ages 2-4 years)	12.8%	13.7%	14.3%
% of WIC mothers breastfeeding at 6 months	39.4%	46.1%	38.2%
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2013-2014)	45.1%	58.0%	60.5%
Age-adjusted % of adults who did not participate in leisure time physical activity in last 30 days (2013-2014)	22.1%	28.2%	27.1%
Age-adjusted % of adults with physician-diagnosed diabetes (2013-2014)	7.9%	11.6%	8.9%
Age-adjusted cardiovascular disease mortality rate per 100,000	184.4	227.4	228.0
Age-adjusted cerebrovascular disease (stroke) mortality rate per 100,000	19.3	19.9	26.2
Mortality rate per 100,000	15.4	20.6	17.6

Source: New York State Department of Health, 2017.

Manhattan compared favorably to the state for obesity-related indicators. New York City compared unfavorably for participating in physical activity and diabetes.

Exhibit 36 presents communicable disease incidence rates for the MSSL & MSW community.

Exhibit 36: Communicable Disease Indicators, 2011-2014

Indicator	Manhattan	New York City	New York State
Pertussis incidence per 100,000	3.6	3.3	8.8
Mumps incidence per 100,000	0.5	0.3	0.2
H. influenza incidence per 100,000	1.9	1.7	1.7
Hepatitis A incidence per 100,000	0.9	0.8	0.7
Acute hepatitis B incidence per 100,000	1.0	0.9	0.6
Tuberculosis incidence per 100,000	6.2	8.0	4.5
Salmonella incidence per 100,000	12.6	13.7	12.9
Shigella incidence per 100,000	5.8	5.3	4.8
% of adults 65 years and older with flu shot in last year (2013-2014)	56.7%	59.2%	72.4%
% of adults 65 years and older who ever received pneumonia shot	60.0%	53.8%	65.1%

Source: New York State Department of Health, 2013, New York City Department of Health and Mental Hygiene, 2013, and Cornell University, Program of Applied Demographics, 2017.

Manhattan compared unfavorably to state rates for many communicable disease indicators, including incidence rates of mumps, influenza, hepatitis A and B, tuberculosis, shigella, and flu and pneumonia vaccinations.

Exhibits 37 and **38** present prevalence and new diagnosis rates for HIV and AIDS.

Exhibit 37: Living HIV and AIDS Cases, Prevalence Rate per 100,000, 2015

Cohort	Manhattan	New York City	New York State
Male	2,541.8	1,532.5	811.1
Female	518.3	563.5	313.4
White	1,058.8	530.3	193.6
Black	3,358.2	1,908.3	1,527.3
Hispanic	1,748.1	1,290.8	1,068.6
Asian/Pacific Islander	236.8	107.9	89.0
Native American	630.9	210.8	92.6
Total	1,442.7	1,021.6	554.7

Source: New York State Department of Health, Bureau of HIV/AIDS Epidemiology, 2015.
All rates are age-adjusted.

The prevalence rate of HIV and AIDS in New York City as a whole was nearly twice as high as the state average in 2015. Manhattan compared particularly unfavorably, with the rate for every demographic cohort more than fifty percent higher than state averages. Rates were particularly high in Manhattan for the male, black, and Hispanic cohorts.

As illustrated in **Exhibit 38**, Manhattan and New York City as a whole reported new HIV and AIDs case rates that were greater than 50 percent than the state average in 2015. New diagnoses among men, black residents, and Hispanic residents were particularly high.

Exhibit 38: Newly Diagnosed HIV and AIDS Cases, 2015

Borough and Demographic Cohort	HIV Diagnoses	AIDS Diagnoses	HIV Case Rate per 100,000	AIDS Case Rate per 100,000
Manhattan				
Male	536	195	56.0	23.1
Female	66	37	6.6	4.2
White	162	61	17.4	7.6
Black	167	75	67.2	32.5
Hispanic	211	68	43.4	15.5
Asian/Pacific Islander	19	7	7.2	3.0
Native American	-	2	-	52.8
Total	602	232	30.3	13.4
New York City				
Male	1,917	830	42.2	19.4
Female	457	274	9.7	6.1
White	349	120	11.5	4.3
Black	950	534	45.9	26.6
Hispanic	872	364	32.2	14.5
Asian/Pacific Islander	86	35	6.0	2.5
Native American	1	2	3.7	7.3
Total	2,374	1,104	25.4	12.4
New York State				
Male	2,515	1,094	25.0	11.1
Female	640	381	6.2	3.7
White	592	250	5.4	2.2
Black	1,240	656	39.3	21.8
Hispanic	1,056	446	26.5	12.2
Asian/Pacific Islander	96	38	4.8	2.0
Native American	1	2	1.4	2.8
Total	3,155	1,475	15.5	7.3

Source: New York State Department of Health, Bureau of HIV/AIDS Epidemiology, 2017.
All rates are age-adjusted.

Exhibit 39 presents data on chronic lower respiratory disease (CLRD) and asthma in Manhattan.

Exhibit 39: Respiratory-Related Indicators, 2011-2013

Indicator	Manhattan	New York City	New York State
Age-adjusted CLRD mortality rate per 100,000	18.1	20.6	30.7
Asthma hospitalization rate per 10,000	20.8	27.8	18.2
Ages 0-4 years	56.1	73.8	50.5
Ages 5-14 years	32.3	35.5	20.5
Ages 0-17 years	38.1	43.9	26.6
Ages 5-64 years	15.1	20.9	13.8
Ages 15-24 years	9.2	11.3	6.8
Ages 25-44 years	6.6	10.7	8.6
Ages 45-64 years	26.2	32.5	19.7
Ages 65 years or older	41.0	48.6	29.4
Age-adjusted asthma mortality rate per 100,000	1.9	2.0	1.3
Age-adjusted % of adults with current asthma (2013-2014)	8.5	8.8	10.1

Source: New York State Department of Health, 2017.

Data indicate that asthma is a health problem in the community. Asthma hospitalization and mortality rates in Manhattan were higher than the state rates overall and for nearly every age cohort.

Exhibit 40 presents respiratory asthma and CLRD indicators by race and ethnicity.

Exhibit 40: Respiratory Indicators by Race and Ethnicity, 2012-2014

Borough and Race/Ethnicity	Asthma hospitalizations	Asthma hospitalizations, aged 0-17 years	Chronic lower respiratory disease mortality	Chronic lower respiratory disease hospitalizations
Manhattan				
White	4.5	8.3	14.9	9.3
Black	53.9	86.3	29.9	69.2
Asian/Pacific	3.9	5.6	12.7	8.0
Hispanic	28.1	31.6	19.1	37.0
Total	22.6	38.6	18.3	31.3
New York City				
White	7.8	8.9	22.4	19.6
Black	44.1	74.6	21.3	57.1
Asian/Pacific	5.6	9.2	12.1	9.8
Hispanic	33.8	44.3	17.7	44.2
Total	27.6	44.4	20.4	40.0
New York State				
White	7.3	8.9	34.0	21.9
Black	38.0	59.2	22.1	52.1
Asian/Pacific	5.4	8.9	11.5	9.3
Hispanic	28.0	33.5	16.4	40.1
Total	17.6	27.0	29.8	32.3

Source: New York State Department of Health, 2017.
All rates are per 100,000 population.

Asthma hospitalizations were most severe for Black and Hispanic cohorts in Manhattan. Non-White populations in Manhattan chronic lower respiratory disease mortality rates were higher than the state.

Exhibits 41 through **46** present data related to maternal and infant health. **Exhibit 41** portrays maternal and infant health indicators by borough, New York City, and New York State.

Exhibit 41: Maternal and Infant Health Indicators, 2012-2014

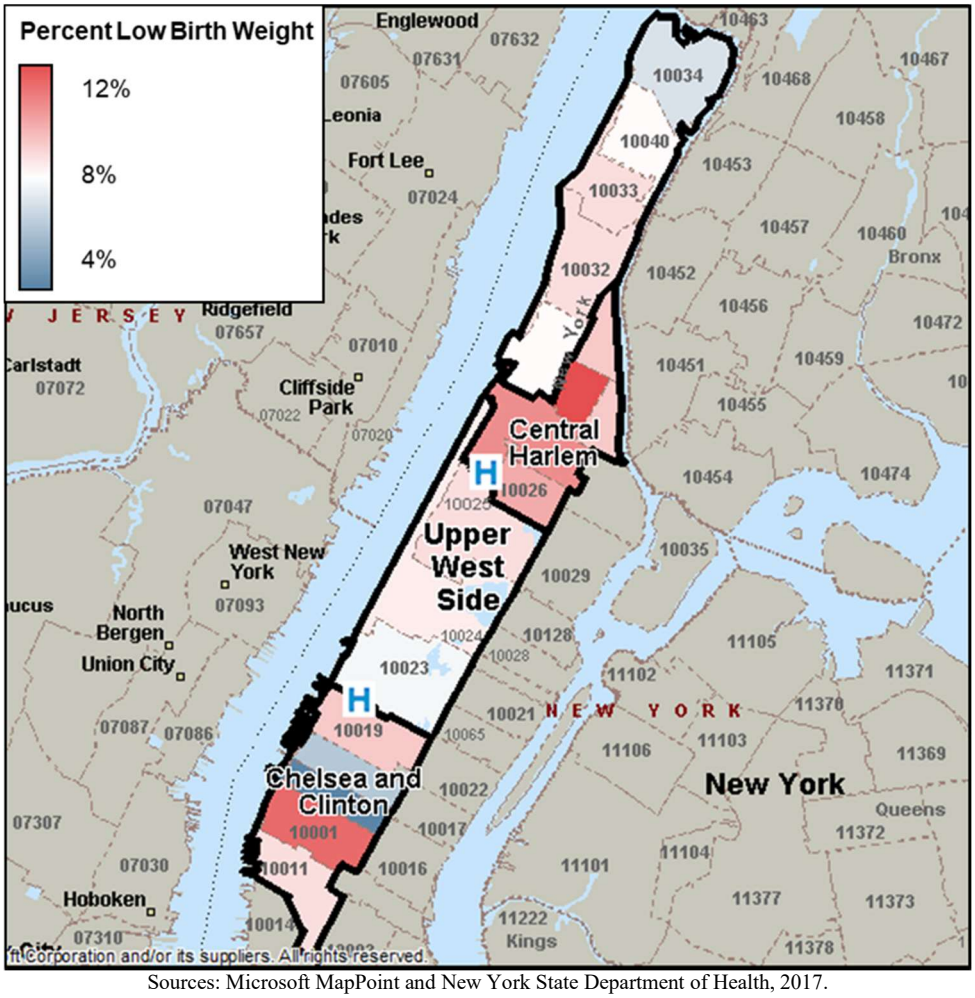
Borough	Premature Births	Low Birth Weight	Late or No Prenatal Care	Infant Death Rate*	Teen Pregnancy Rate 15-19**
Manhattan	10.6%	8.4%	5.1%	3.2	40.8
New York City	10.8%	8.2%	7.2%	4.2	52.3
New York State	10.8%	7.9%	5.6%	4.8	36.0

Sources: New York State Department of Health, 2017.
*Infant deaths per 1,000 live births
**Teen pregnancy rates are per 1,000 females ages 15-19

Teen pregnancy (ages 15-19) rates and low birth weight were higher in Manhattan and New York City, compared to the state.

Exhibits 42, 43, and **44** illustrate maternal and infant health indicators by ZIP Code. **Exhibit 42** illustrates maternal and infant health indicators by ZIP Code.

Exhibit 42: Low Birth Weight Infants by ZIP Code, 2012-2014

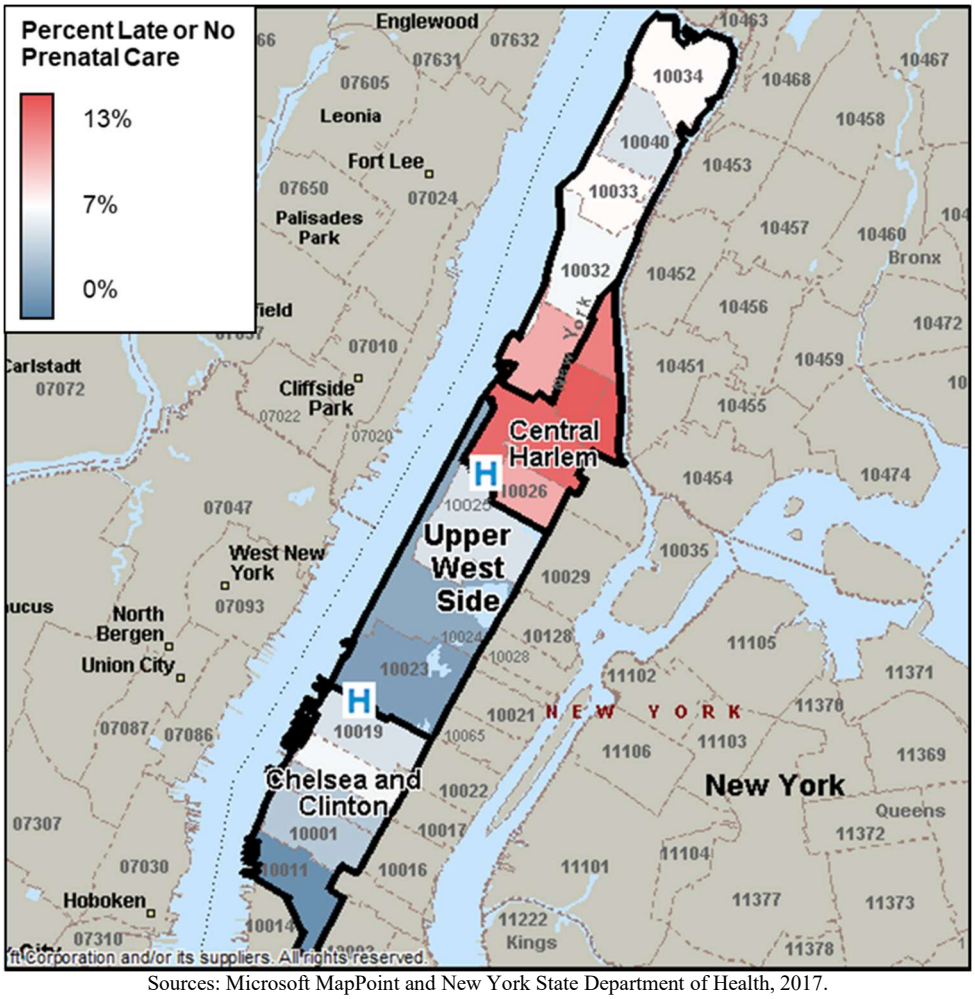


Sources: Microsoft MapPoint and New York State Department of Health, 2017.

ZIP Codes 10030 in Central Harlem and 10001 in Chelsea & Clinton had the highest percentage of low birthweight births, both above 11 percent.

Exhibit 43 illustrates late or no prenatal care by ZIP Code.

Exhibit 43: Mothers with Late or No Prenatal Care by ZIP Code, 2012-2014

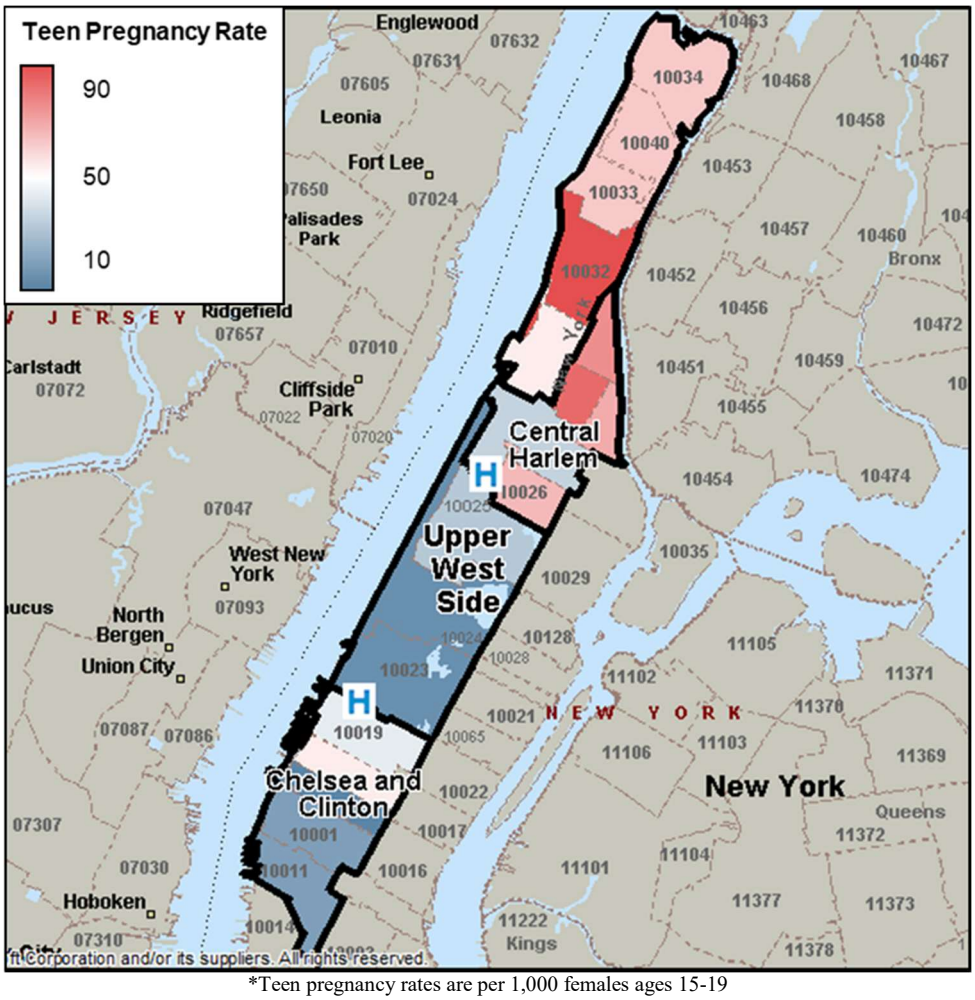


Sources: Microsoft MapPoint and New York State Department of Health, 2017.

ZIP Codes within Central Harlem were particularly unfavorable compared to the community for late or no prenatal care.

Exhibit 44 illustrates teen pregnancy rates by ZIP Code.

Exhibit 44: Teen Pregnancy Rate 15-19 by ZIP Code, 2012-2014*



*Teen pregnancy rates are per 1,000 females ages 15-19
Sources: Microsoft MapPoint and New York State Department of Health, 2017.

ZIP Code 10032 in Inwood & Washington Heights exhibited the highest teen pregnancy rate of 90 cases per 1,000 females ages 15-19. ZIP Codes throughout Inwood & Washington Heights and Central Harlem had the highest rates in the community.

Exhibit 45 presents maternal and child health indicators by race and ethnicity.

Exhibit 45: Maternal and Infant Health Indicators by Race and Ethnicity, 2012-2014

Borough and Race/Ethnicity	Percent Births with Early (1st Trimester) Prenatal Care	Percent Adequate Prenatal Care (Kotelchuck Index)	Percent Premature Births (< 37 Weeks Gestation)	Percent Low Birthweight Births (< 2.5 Kg)	Teen (Age 15-17) Pregnancy Rate per 1,000	Infant Mortality per 1,000 Live Births
Manhattan						
White	81.9%	78.2%	9.4%	7.6%	11.9	2.1
Black	61.9%	57.9%	15.0%	12.7%	56.6	7.2
Asian/Pacific	76.9%	72.5%	9.3%	7.8%	-	-
Hispanic	69.2%	65.9%	11.4%	8.1%	32.6	3.1
Total	75.3%	71.6%	10.6%	8.4%	31.7	3.2
New York City						
White	80.8%	75.8%	8.3%	6.2%	7.1	2.6
Black	62.3%	58.1%	14.6%	12.0%	43.1	7.3
Asian/Pacific	73.9%	70.4%	9.2%	7.9%	1.7	2.2
Hispanic	67.1%	64.6%	11.6%	7.8%	38.1	3.6
Total	71.6%	67.7%	10.8%	8.2%	29.8	4.2
New York State						
White	80.0%	75.1%	9.4%	6.6%	7.5	3.9
Black	63.5%	58.1%	15.0%	12.3%	38.5	8.9
Asian/Pacific	74.2%	70.1%	9.4%	8.0%	2.0	2.4
Hispanic	68.0%	64.0%	11.7%	7.6%	32.9	4.0
Total	73.7%	69.0%	10.8%	7.9%	19.6	4.8

Source: New York State Department of Health, 2017.

Overall, racial and ethnic cohorts in Manhattan benchmarked well to state averages for maternal and infant health indicators with the exception of teen pregnancy and low birthweight births. Teen pregnancy rates were greater than 50 percent the state averages for White residents and overall in Manhattan.

Exhibit 46 presents data from the New York City Pregnancy Risk Assessment Monitoring System (PRAMS), which assesses maternal experiences and behaviors before, during, and after pregnancy. In 2014, the percentage of women who drank alcohol during the last three months of pregnancy in Manhattan was more than double the New York City average. The percentages of White women and college graduates who drank alcohol during the last three months of pregnancy were approximately double the New York City average, while Hispanic populations and those with a high school diploma were more likely to smoke during pregnancy.

Exhibit 46: NYC PRAMS Indicators, 2014

Sociodemographic Characteristic	Women Who Drank Alcohol During Last 3 Months of Pregnancy	Women Who Report Ever Breastfeeding	Women Who Smoked During Last 3 Months of Pregnancy
Borough			
Manhattan	21.4%	96.9%	1.0%
Bronx	5.4%	92.7%	3.2%
Brooklyn	9.5%	91.7%	2.0%
Queens	6.7%	91.0%	1.8%
Staten Island	4.9%	82.1%	3.0%
Race / Ethnicity			
White non-Latina	17.6%	93.6%	1.9%
Black non-Latina	4.8%	92.6%	2.0%
Latina	6.5%	92.6%	2.5%
Asian/Pacific Islander	6.6%	87.4%	1.6%
Education			
Not a High School Graduate	2.3%	85.8%	2.0%
High School Graduate	4.1%	89.9%	3.4%
Some College	6.5%	92.1%	1.0%
College Graduate	18.6%	96.4%	1.6%
New York City Total	**9.8%**	**92.1%**	**2.0%**

Source: New York City Department of Health and Mental Hygiene,
Pregnancy Risk Assessment Monitoring System (PRAMS), 2014.
Data are weighted and are based on responses of 1,308 NYC women giving birth in 2014.

Exhibit 47 presents injury and behavioral health indicators by race and ethnicity in Manhattan.

Exhibit 47: Injury and Substance Abuse/Mental Health Indicators by Race and Ethnicity, 2012-2014

Borough and Race/Ethnicity	Motor Vehicle-related Mortality	Unintentional Injury Mortality	Drug-related Hospitalizations	Suicide Mortality
Manhattan				
White	2.0	15.4	14.4	9.0
Black	2.7	24.8	93.4	4.0
Asian/Pacific	2.3	11.1	2.3	5.2
Hispanic	2.9	17.9	31.4	6.4
Total	2.4	17.5	33.8	7.7
New York City				
White	2.8	22.3	20.8	8.1
Black	3.9	18.0	33.8	3.5
Asian/Pacific	3.3	10.6	1.9	5.4
Hispanic	3.6	17.9	22.6	4.4
Total	3.4	18.9	26.1	5.8
New York State				
White	6.4	30.2	20.2	10.1
Black	4.7	19.8	30.9	3.7
Asian/Pacific	3.1	10.4	2.0	5.2
Hispanic	4.8	19.7	19.5	4.5
Total	5.7	25.9	22.6	7.9

Source: New York State Department of Health, 2017.
All rates are age adjusted. Mortality rates are per 100,000 population and hospitalization rates are per 10,000 population.

Disparities are evident in the number of drug-related hospitalizations for non-White populations in Manhattan from 2012-2014. The drug-related hospitalization rate for Black and Hispanic populations in Manhattan were more than 50 percent higher than state averages for those cohorts. Although the Manhattan and New York City compared favorably to the state for suicide mortality, rates were consistently highest in the White population.

Youth Risk Behavior Survey

Data collected as part of the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Surveillance System (YRBSS) are based on national, state, territorial, tribal, and neighborhood school-based surveys that gather data from young adults in grades 9 through 12 on health-risk behaviors such as drug and tobacco use, unhealthy dietary behaviors, sexual behavior, and the prevalence of asthma. The survey is conducted every two years.

The New York City Department of Health and Mental Hygiene released borough-level results from their 2015 Youth Risk Behavior Survey (YRBS), a part of the CDC's YRBSS. Analysis of YRBS data can identify localized health issues and trends, and enable borough, state, or nation-wide comparisons. **Exhibit 48** compares the prevalence of various indicators for Manhattan and New York City to New York State and the U.S.

Exhibit 48: YRBS Indicators and Variation from New York State and the U.S., 2015

Indicator		Manhattan	NYC	NYS	U.S.
Alcohol or Tobacco Use	Binge Drinking (5 or More Drinks in the Past Month)	12.0%	8.5%	**15.6%**	**17.7%**
	Consumed At Least One Alcoholic Drink in the Past Month	26.3%	20.9%	**29.7%**	**32.8%**
	Smoking in the Past Month	5.3%	5.8%	**8.8%**	**10.8%**
Asthma	Ever Been Told They Have Asthma	26.6%	24.2%	**25.6%**	**22.8%**
General Physical or Mental Health	Attempted Suicide One or More Times During the Past 12 Months	8.2%	8.3%	**9.9%**	**8.6%**
	Felt Sad (Every Day for 2 weeks) & Stopped Regular Activities due to Sadness	29.8%	29.4%	**28.6%**	**29.9%**
Physical Activity	Not Physically Active for 60 Minutes Per Day for 7 Days Per Week	19.6%	20.5%	**18.8%**	**14.3%**
	Three or More Hours of Leisure Computer Use Per Day on School Days	42.6%	45.6%	**37.2%**	**41.7%**
	Three or More Hours of TV Per Day on School Days	26.4%	28.9%	**24.2%**	**24.7%**
Sexual Behavior and Orientation	Ever Had Sexual Intercourse	29.5%	27.2%	**30.4%**	**41.2%**
	No Method of Contraception	17.1%	17.7%	**15.1%**	**13.8%**
Substance Abuse	Cocaine Use During Lifetime	4.4%	4.4%	**7.6%**	**5.2%**
	Heroin Use During Lifetime	2.3%	2.5%	**4.8%**	**2.1%**
	Marijuana Use in the Past Month	21.6%	15.9%	**19.3%**	**21.7%**
Violence	Experienced sexual dating violence	11.6%	11.4%	**14.7%**	**10.6%**
	Experienced physical dating violence	11.3%	12.0%	**11.5%**	**9.6%**
Weight and Nutrition	One or More Sugary Drinks Consumed in the Past 7 Days	67.4%	71.0%	**65.9%**	**73.8%**
	Overweight or Obese	28.7%	27.9%	**27.0%**	**29.9%**

Source: Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System via the New York City Department of Health and Mental Hygiene, 2017.

Manhattan and New York City exhibited comparatively high percentages of youth who felt sad and stopped regular activities due to sadness, physical inactivity, time spent on the computer and television, no method of contraception, sugary drink consumption, and overweight or obese.

New York Prevention Agenda 2013-2017

The New York Prevention Agenda is the state's health improvement plan for 2013-2017. Five priority areas were identified to improve the health of state residents and to reduce disparities:

- Prevent chronic diseases;
- Promote a healthy and safe environment;
- Promote healthy women, infants, and children;
- Promote mental health and prevent substance abuse; and
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare-associated infections action plan.

The state developed tracking indicators or goals for indicators relating to each priority area. Baseline data are available for each borough along with a target for the year 2017. **Exhibit 49 A**, **B**, and **C** compares each Manhattan's baseline data to the 2017 target.

Manhattan had a large number of indicators that were worse than the 2017 target. The borough and New York City as a whole were greater than 50 percent worse than the 2017 target for the following indicators (**Exhibit 49A**, **B**, and **C**):

- Asthma emergency department visit rate per 10,000;
- Newly diagnosed HIV case rate per 100,000;
- Gonorrhea case rate per 100,000 for men ages 15-44;
- Primary and secondary syphilis case rate per 100,000 males and females;
- Ratio of Black non-Hispanic and Hispanic to White non-Hispanic percentage of unintended pregnancies; and
- Ratio of Black non-Hispanic to White non-Hispanic assault-related hospitalizations

Exhibit 49A: Prevention Agenda 2013-2017 Indicators Compared to Objectives

Prevention Agenda 2013-2017 Priority Areas and Indicators	Data Year(s)	Manhattan	New York City	New York State	NYS Target
Improve Health Status and Reduce Health Disparities					
Percentage of premature deaths (before age 65 years)	2015	22.0%	26.4%	23.3%	**21.8%**
Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics	2013-2015	1.9	2.1	1.9	**1.9**
Premature deaths: Ratio of Hispanics to White non-Hispanics	2013-2015	1.6	2.0	1.9	**1.9**
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	2014	111.0	138.7	119.5	**122.0**
Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	4.8	2.4	2.2	**1.9**
Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics	2012-2014	2.8	1.7	1.4	**1.4**
Percentage of adults (aged 18-64) with health insurance	2015	91.0%	-	89.8%	**100.0%**
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2012	82.4%	81.7%	82.0%	**90.8%**
Promote a Healthy and Safe Environment					
Rate of hospitalizations due to falls per 10,000 - Aged 65+ years	2014	180.7	175.3	183.6	**204.6**
Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years	2014	429.6	437.0	440.1	**429.1**
Assault-related hospitalization rate per 10,000 population	2012-2014	4.8	5.9	3.6	**4.3**
Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	11.3	11.5	7.0	**6.7**
Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics	2012-2014	4.2	4.0	3.2	**2.8**
Assault-related hospitalization: Ratio of low-income ZIP codes to non-low-income ZIP codes	2012-2014	2.7	2.4	3.3	**2.9**
Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home	2011-2015	90.2%	76.3%	46.1%	**49.2%**
Percentage of residents served by community water systems with optimally fluoridated water	2016	100.0%	100.0%	71.1%	**78.5%**

Source: New York State Department of Health, 2017.

Exhibit 49B: Prevention Agenda 2013-2017 Indicators Compared to Objectives

Prevention Agenda 2013-2017 Priority Areas and Indicators	Data Year(s)	Manhattan	New York City	New York State	NYS Target
Prevent Chronic Diseases					
Percentage of adults who are obese	2012	14.5%	24.1%	25.0%	23.2%
Percentage of children and adolescents who are obese	2012-2013	18.8%	21.4%	21.4%	19.7%
Percentage of cigarette smoking among adults	2012	15.6%	15.6%	15.2%	12.3%
Asthma emergency department visit rate per 10,000 population	2014	121.0	135.3	86.2	75.1
Asthma emergency department visit rate per 10,000 - Aged 0-4 years	2014	278.1	301.9	205.7	196.5
Age-adjusted heart attack hospitalization rate per 10,000 population	2014	9.4	12.6	14.0	14.0
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years	2012-2014	3.8	3.3	2.9	3.1
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years	2012-2014	5.7	7.2	6.6	4.9
Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections					
Percentage of adults with flu immunization - Aged 65+ years	2012	69.2%	61.8%	59.7%	70.0%
Newly diagnosed HIV case rate per 100,000 population	2013-2015	41.3	29.7	15.9	16.1
Difference in rates (Black and White) of newly diagnosed HIV cases	2013-2015	54.1	38.0	36.1	46.8
Difference in rates (Hispanic and White) of newly diagnosed HIV cases	2013-2015	26.8	22.0	23.1	26.6
Gonorrhea case rate per 100,000 women - Aged 15-44 years	2015	177.9	222.8	201.8	183.4
Gonorrhea case rate per 100,000 men - Aged 15-44 years	2015	1050.4	594.0	377.6	199.5
Chlamydia case rate per 100,000 women - Aged 15-44 years	2015	1552.3	1873.5	1575.7	1458.0
Primary and secondary syphilis case rate per 100,000 men	2015	69.0	35.9	20.3	10.1
Primary and secondary syphilis case rate per 100,000 women	2015	1.4	1.2	0.7	0.4

Source: New York State Department of Health, 2017.

Exhibit 49C: Prevention Agenda 2013-2017 Indicators Compared to Objectives

Prevention Agenda 2013-2017 Priority Areas and Indicators	Data Year(s)	Manhattan	New York City	New York State	NYS Target
Promote Healthy Women, Infants, and Children					
Percentage of preterm births	2015	10.4%	10.5%	10.5%	10.2%
Premature births: Ratio of Black non-Hispanics to White non-Hispanics	2013-2015	1.5	1.8	1.7	1.4
Premature births: Ratio of Hispanics to White non-Hispanics	2013-2015	1.1	1.4	1.3	1.1
Premature births: Ratio of Medicaid births to non-Medicaid births	2013-2015	1.1	1.0	1.1	1.0
Maternal mortality rate per 100,000 births	2013-2015	18.3	22.9	20.9	21.0
Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs	2015	72.3%	73.5%	72.0%	76.9%
Percentage of children (aged under 19 years) with health insurance	2015	97.6%	-	97.4%	100.0%
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	2014	26.4	25.3	17.0	25.6
Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	4.8	6.0	5.3	4.9
Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics	2012-2014	2.8	5.3	4.7	4.1
Percentage of unintended pregnancy among live births	2015	16.5%	21.9%	23.7%	23.8%
Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic	2015	4.3	3.6	2.2	1.9
Unintended pregnancy: Ratio of Hispanics to White non-Hispanics	2015	3.7	2.9	1.7	1.4
Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births	2015	3.0	1.8	1.8	1.5
Promote Mental Health and Prevent Substance Abuse					
Age-adjusted percentage of adult binge drinking during the past month	2012	26.2%	19.6%	17.8%	18.4%
Age-adjusted suicide death rate per 100,000 population	2013-2015	7.7	5.8	7.9	5.9

Source: New York State Department of Health, 2017.

New York City Community Health Survey

The New York City Department of Health and Mental Hygiene (DOHMH) conducts an annual survey of City residents regarding health behaviors and chronic diseases. The survey sample size is approximately 10,000 adults aged 18 years and older. Data are available at a city, borough, and neighborhood/neighborhood level. **Exhibits 50 A**, **B**, **C, and D** present selected indicators related to health care access, chronic conditions, health behaviors, and mental health by neighborhood. Data are shaded based on the key below.

Exhibit 50A summarizes access indicators for MSSL & MSW neighborhoods.

Exhibit 50A: NYC Community Health Survey, Access Indicators, 2015

Borough and Neighborhood	4+ Day Wait for PCP Visit	Percentage Who Had Medicaid	Percentage Who Had Medicare	Percentage Who Were Uninsured	Did Not Receive Medical Care	No PCP
Manhattan	**19.7%**	**17.9%**	**14.9%**	**9.9%**	**10.4%**	**16.3%**
Washington Heights - Inwood	25.8%	24.1%	15.7%	18.7%	17.0%	21.1%
Central Harlem - Morningside Heights	24.0%	25.3%	11.8%	5.3%	7.2%	13.9%
Upper West Side	10.1%	11.8%	15.9%	7.8%	9.5%	10.2%
Chelsea - Clinton & Greenwich Village - Soho	20.0%	17.2%	15.6%	12.2%	10.6%	18.4%

Source: New York City Department of Health and Mental Hygiene, 2015.

Overall, residents of Washington Heights & Inwood and Central Harlem were more likely to experience a wait of four or more days a PCP visit and have Medicaid. Residents of Washington Heights & Inwood were more likely to be uninsured, not receive medical care, and not have a primary care physician.

Exhibit 50B summarizes chronic conditions within MSSL & MSW neighborhoods.

Exhibit 50B: NYC Community Health Survey, Chronic Conditions, 2015

Borough and Neighborhood	Ever Had High Blood Pressure	Ever Told You Have Diabetes	Overweight and Obese
Manhattan	**23.8%**	**9.0%**	**47.1%**
Washington Heights - Inwood	28.9%	14.1%	62.9%
Central Harlem - Morningside Heights	33.8%	13.7%	60.0%
Upper West Side	18.8%	6.9%	42.8%
Chelsea - Clinton & Greenwich Village - Soho	16.8%	4.8%	39.2%

Source: New York City Department of Health and Mental Hygiene, 2015.

Overall, residents of Washington Heights & Inwood and Central Harlem were more likely to ever had high blood pressure, diabetes, and be overweight or obese.

Exhibit 50C summarizes health behaviors within MSSL & MSW neighborhoods.

Exhibit 50C: NYC Community Health Survey, Health Behaviors, 2015

Borough and Neighborhood	Binge Drinker*	Current Smoker	No Exercise in the Past 30 Days	Consumed on Average More than One Sugary Beverage	Consumed 0 Servings of Fruit and/or Vegetables Yesterday**
Manhattan	**26.5%**	**13.2%**	**18.0%**	**17.4%**	**9.5%**
Washington Heights - Inwood	27.2%	12.0%	23.2%	26.3%	15.6%
Central Harlem - Morningside Heights	21.4%	12.8%	25.8%	28.2%	12.0%
Upper West Side	20.4%	13.0%	8.9%	11.3%	7.1%
Chelsea - Clinton & Greenwich Village - Soho	25.4%	13.2%	15.8%	13.1%	9.2%

Source: New York City Department of Health and Mental Hygiene, 2015.
*Binge drinking is defined as five or more drinks on one occasion for males and four or more drinks on one occasion for females.
**A serving equals one medium apple, a handful of broccoli, or a cup of carrots

Residents of Washington Heights & Inwood and Chelsea & Clinton were more likely to binge drink, while residents of Chelsea & Clinton were more likely to be current smokers. Residents of Washington Heights & Inwood and Central Harlem were more likely to have had no exercise in the past 30 days, consume sugary beverages, and consume no servings of fruit and vegetables.

Exhibit 50D summarizes mental health indicators within MSSL & MSW neighborhoods.

Exhibit 50D: NYC Community Health Survey, Mental Health Indicators, 2015

Borough and Neighborhood	Serious Psychological Distress	Did not receive Mental Health Services	Received Mental Health Treatment
Manhattan	**16.4%**	**5.1%**	**40.2%**
Washington Heights - Inwood	9.0%	9.0%	17.0%
Central Harlem - Morningside Heights	3.7%	3.7%	50.7%
Upper West Side	1.3%	1.3%	0.0%
Chelsea - Clinton & Greenwich Village - Soho	4.8%	4.8%	70.5%

Source: New York City Department of Health and Mental Hygiene, 2015.

Residents of Washington Heights & Inwood were more likely to have serious psychological distress and not receive mental health services in the MSSL & MSW neighborhoods.

Ambulatory Care Sensitive Conditions

This section examines the frequency of discharges for Ambulatory Care Sensitive Conditions (ACSCs) from MSSL & MSW's community.

ACSCs are health "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease."[12] As such, rates of hospitalization for these conditions can "provide insight into the quality of the health care system outside of the hospital," including the accessibility and utilization of primary care, preventive care and health education, as well as the ability to navigate to these services. Among these conditions are: diabetes, perforated appendixes, chronic obstructive pulmonary disease (COPD), hypertension, heart failure, dehydration, bacterial pneumonia, urinary tract infection, and asthma. Disproportionately high rates of discharges for ACSC indicate potential problems with the availability or accessibility of ambulatory care and preventive services, and can suggest areas for improvement in the community's health care system and ways to improve outcomes.

Borough/Neighborhood-Level Analysis

Exhibit 51 indicates the percentage of discharges from all hospitals in the MSSL & MSW community that were for ACSCs, by payer.

Exhibit 51: Discharges for ACSC by Borough and Payer, 2016

Neighborhood	Private	Medicaid	Medicare	Self-Pay	Other	Total
Central Harlem	7.5%	10.2%	18.6%	12.7%	11.3%	13.1%
Chelsea and Clinton	4.9%	7.4%	12.2%	4.5%	1.8%	8.6%
Inwood and Washington Heights	6.5%	9.9%	17.1%	9.5%	3.7%	12.3%
Upper West Side	3.6%	9.2%	11.8%	9.1%	1.6%	9.0%
Total	**5.3%**	**9.5%**	**15.1%**	**9.3%**	**4.7%**	**11.1%**

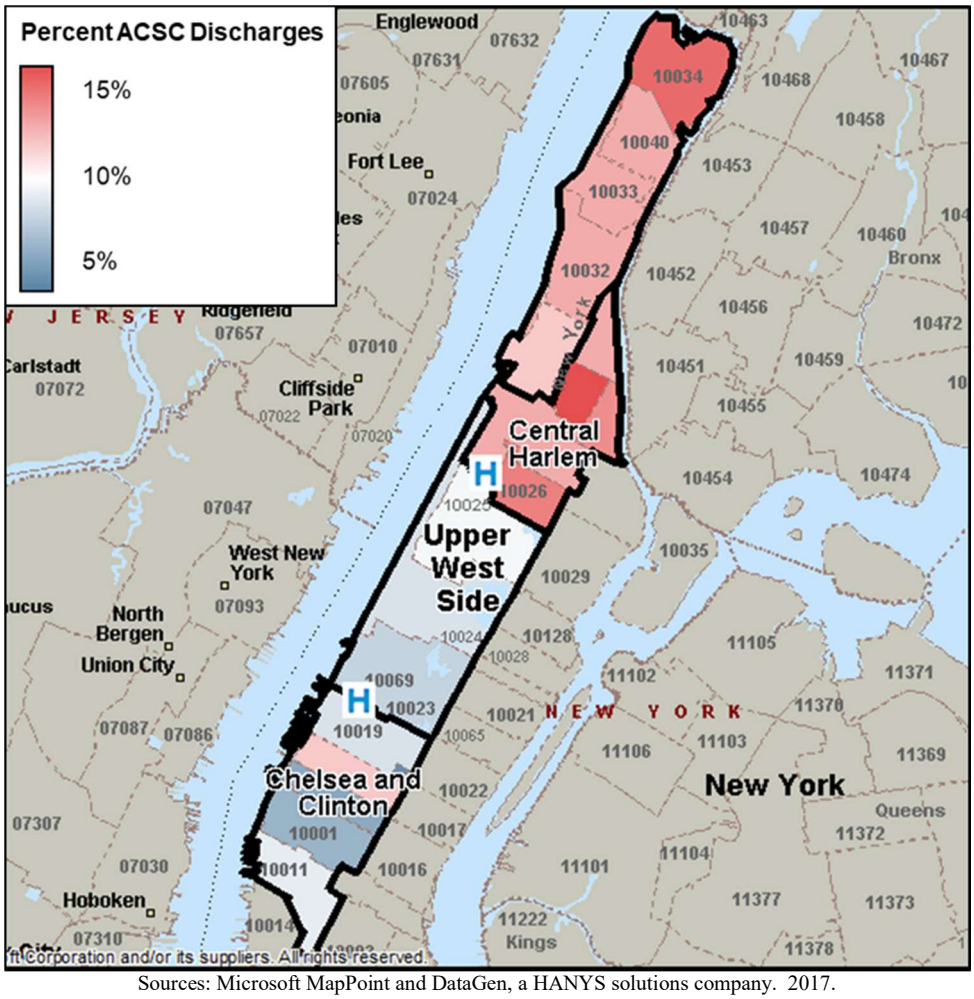
Source: DataGen, a HANYS solutions company, 2017.

The table indicates that 11.1 percent of discharges in the community were for ACSCs in 2016. Medicare patients and patients from Central Harlem in the community had the highest proportions of discharges for ACSCs (**Exhibit 51**).

[12]Agency for Healthcare Research and Quality (AHRQ). (2013). *Prevention Quality Indicators*. Retrieved 2013, from: http://archive.ahrq.gov/data/hcup/factbk5/factbk5d.htm

Exhibit 52 illustrates the rate of discharges from all hospitals in the community that were for ACSCs, by neighborhood by 100,000 residents 18 years and older.

Exhibit 52: Discharges for ACSC by Neighborhood, 2015



Sources: Microsoft MapPoint and DataGen, a HANYS solutions company. 2017.

The ACSC discharge rates were higher in Inwood & Washington Heights and Central Harlem. ZIP Code 10030 was particularly high, at 14.9 percent.

ACSC Conditions Analysis

Exhibit 53 displays the frequency and percentage of all hospital discharges of residents in the MSSL & MSW community for ACSC by age and condition. For each condition, the percentage figures indicate the proportion of discharges in each age cohort.

Exhibit 53: ACSC Discharges of MSSL & MSW Community Members from all hospitals by Condition and Age, 2016

Condition	0 to 17	18 to 39	40 to 64	65+	Total
Heart Failure	0.0%	2.2%	30.5%	67.2%	2,143
COPD or asthma in older adults	0.0%	0.0%	49.9%	50.1%	1,466
Bacterial pneumonia	0.0%	8.8%	31.6%	59.6%	788
Urinary tract infection	0.0%	9.1%	17.9%	73.0%	755
Dehydration	0.0%	8.4%	23.3%	68.3%	688
Diabetes long-term complication	0.0%	11.5%	48.1%	40.4%	607
Perforated appendix	0.0%	54.4%	31.8%	13.9%	548
Pediatric asthma	0.0%	29.4%	41.6%	29.0%	452
Diabetes short-term complication	100.0%	0.0%	0.0%	0.0%	432
Uncontrolled diabetes	0.0%	9.5%	41.0%	49.5%	378
Hypertension	0.0%	6.9%	40.8%	52.3%	304
Asthma in younger adults	0.0%	100.0%	0.0%	0.0%	146
Pediatric gastroenteritis	100.0%	0.0%	0.0%	0.0%	118
Pediatric perforated appendix	100.0%	0.0%	0.0%	0.0%	98
Pediatric urinary tract infection	100.0%	0.0%	0.0%	0.0%	49
Pediatric diabetes short-term complications	100.0%	0.0%	0.0%	0.0%	28

Source: DataGen, a HANYS solutions company, 2017.

The top five ACSC conditions in the MSSL & MSW community by number of discharges were heart failure, COPD or asthma in older adults, bacterial pneumonia, urinary tract infection, and dehydration.

Patients aged 65 years and over had the highest percentage of discharges for ACSC conditions, followed by the 40 to 64 year old cohort.

Community Need Index™ and Food Deserts

Dignity Health Community Need Index

Dignity Health, a California-based hospital system, developed and has made widely available for public use a *Community Need Index*™ that measures barriers to health care access by borough/county and ZIP Code.[13] The index is based on five social and economic indicators:

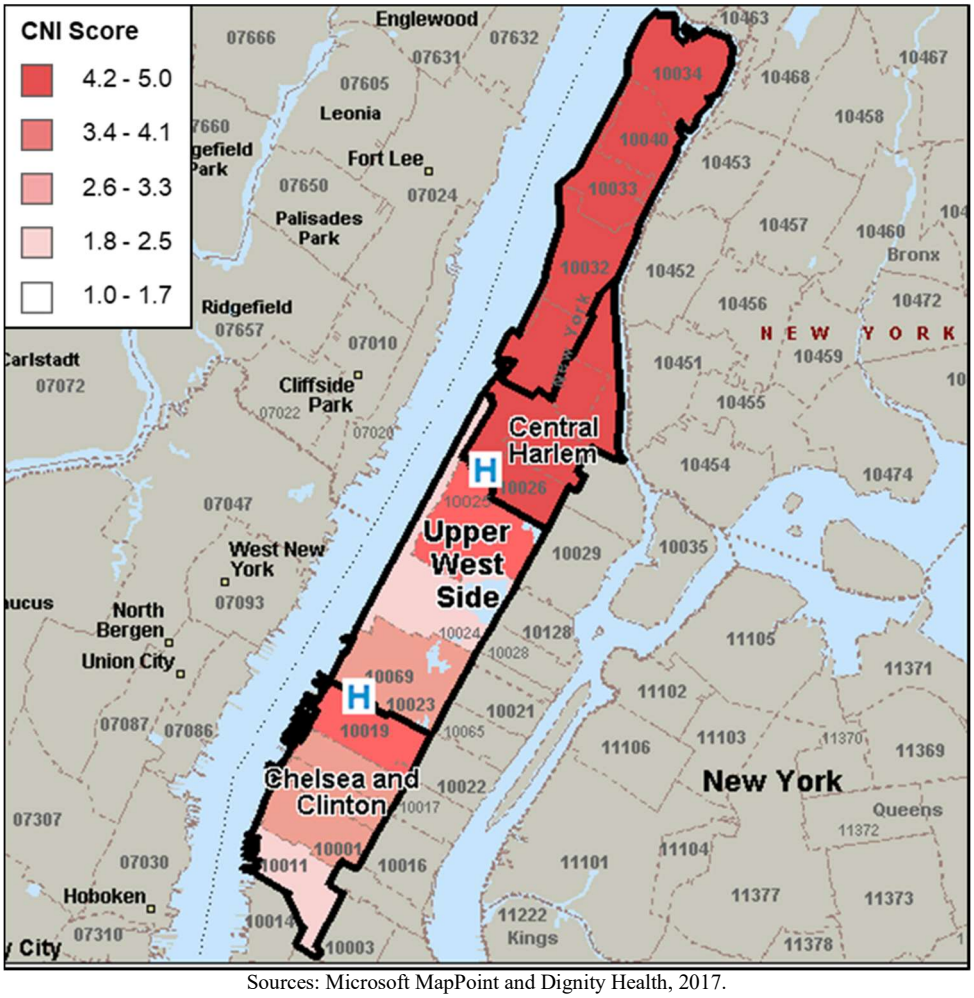
- The percentage of elders, children, and single parents living in poverty;
- The percentage of adults over the age of 25 with limited English proficiency, and the percentage of the population that is non-White;
- The percentage of the population without a high school diploma;
- The percentage of uninsured and unemployed residents; and
- The percentage of the population renting houses.

The *Community Need Index*™ calculates a score for each ZIP Code based on these indicators. Scores range from "Lowest Need" (1.0-1.7) to "Highest Need" (4.2-5.0).

[13]Dignity Health. (n.d.). *Community Needs Index*. Retrieved 2013, from: http://cni.chw-interactive.org/

Exhibit 54 presents the *Community Need Index*™ (CNI) score of each ZIP Code in the MSSL & MSW community.

Exhibit 54: Community Need Index™ Score by ZIP Code



Sources: Microsoft MapPoint and Dignity Health, 2017.

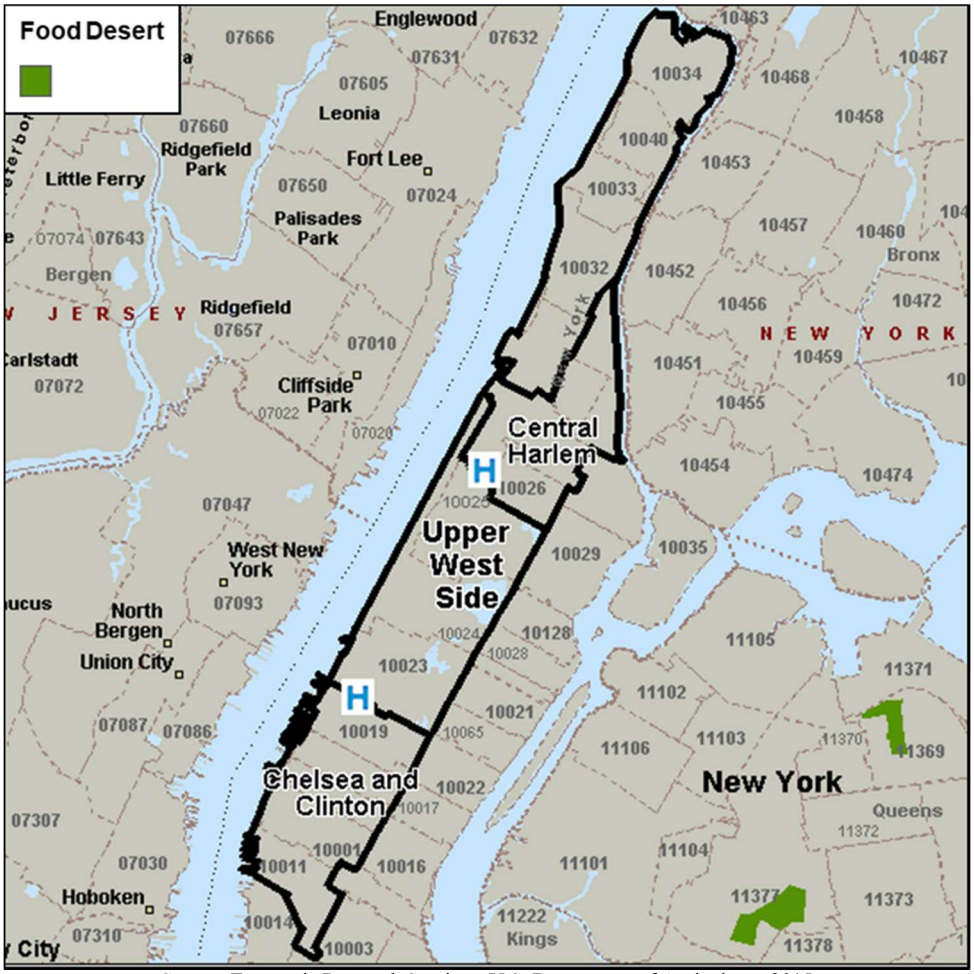
A large portion of the community ranked in the "Highest Need" category. All ZIP Codes in Central Harlem and Inwood & Washington Heights scored in the highest need category.

Food Deserts (Lack of Access to Nutritious and Affordable Food)

The U.S. Department of Agriculture's Economic Research Service estimates the number of people in each census tract that live in a "food desert," defined as low-income areas more than one-half mile from a supermarket or large grocery store in urban areas and more than 10 miles from a supermarket or large grocery store in rural areas. Many government-led initiatives aim to increase the availability of nutritious and affordable foods to people living in these food deserts.

Exhibit 55 illustrates the location of food deserts in the MSSL & MSW community.

Exhibit 55: Food Deserts by Census Tract, 2015



Source: Economic Research Services, U.S. Department of Agriculture, 2015

Food deserts are not present in the MSSL & MSW community.

Medically Underserved Areas and Populations

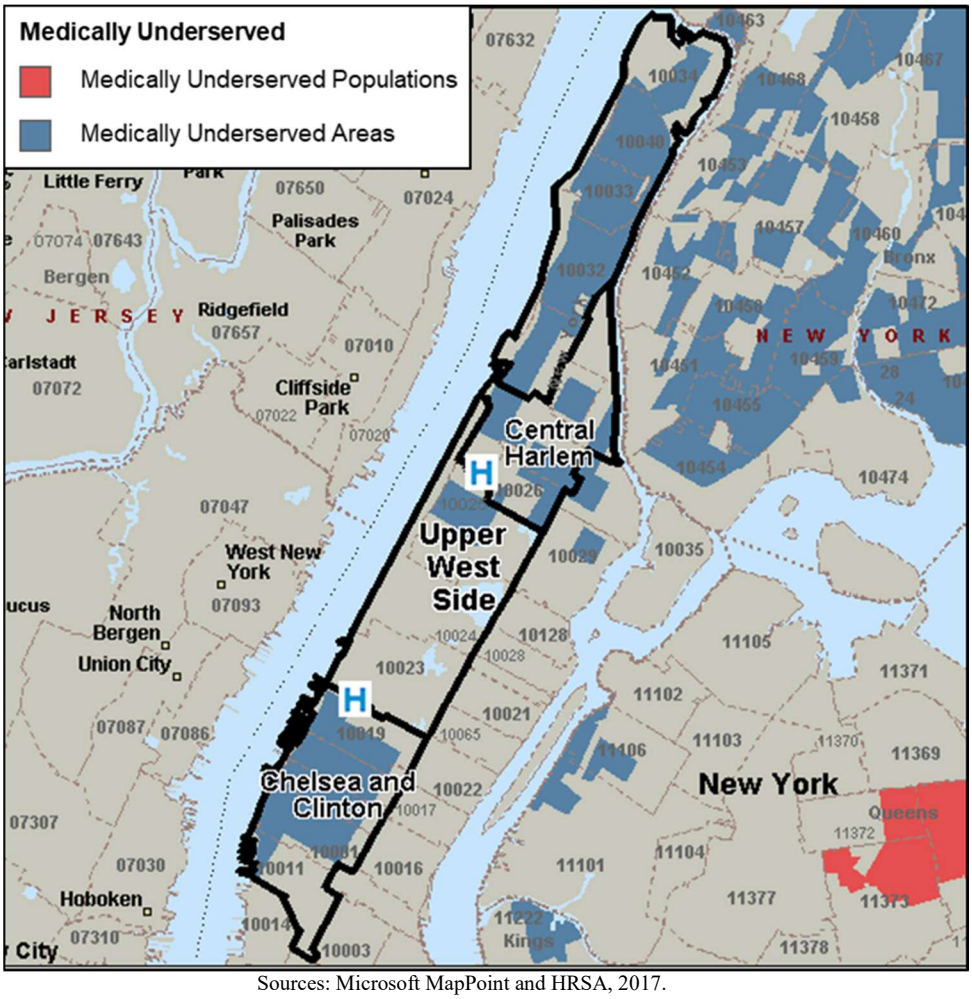
HRSA calculates an Index of Medical Underservice (IMU) score for communities across the U.S. The IMU score calculation includes the ratio of primary medical care physicians per 1,000 persons, the infant mortality rate, the percentage of the population with incomes below the poverty level, and the percentage of the population greater than age 64. IMU scores range from zero to 100, where 100 represents the least underserved and zero represents the most underserved.[14]

Any area or population receiving an IMU score of 62.0 or less qualifies for Medically Underserved Area (MUA) or Medically Underserved Population (MUP) designation. Federally Qualified Health Centers (FQHCs) may be established to serve MUAs and MUPs. Populations receiving MUP designation include groups within a geographic area with economic barriers or cultural and/or linguistic access barriers to receiving primary care. When a population group does not qualify for MUP status based on the IMU score, a MUP designation is made if "unusual local conditions which are a barrier to access to or the availability of personal health services exist and are documented, and if such a designation is recommended by the chief executive officer and local officials of the state where the requested population resides."[15]

Exhibit 56 shows parts of the community designated by HRSA as medically underserved. Census tracts throughout the community have been designated as Medically Underserved Areas, particularly in Inwood & Washington Heights and Chelsea & Clinton.

[14] U.S. Health Resources and Services Administration. (n.d.) *Guidelines for Medically Underserved Area and Population Designation*. Retrieved 2013, from http://bhpr.hrsa.gov/shortage/muaps/index.html.
[15] *Ibid.*

Exhibit 56: Location of Federally Designated Areas and Populations in the MSSL & MSW Community, 2017



Sources: Microsoft MapPoint and HRSA, 2017.

Health Professional Shortage Areas

An area can receive a federal Health Professional Shortage Area (HPSA) designation if a shortage of primary medical care, dental care, or mental health care professionals is found to be present.

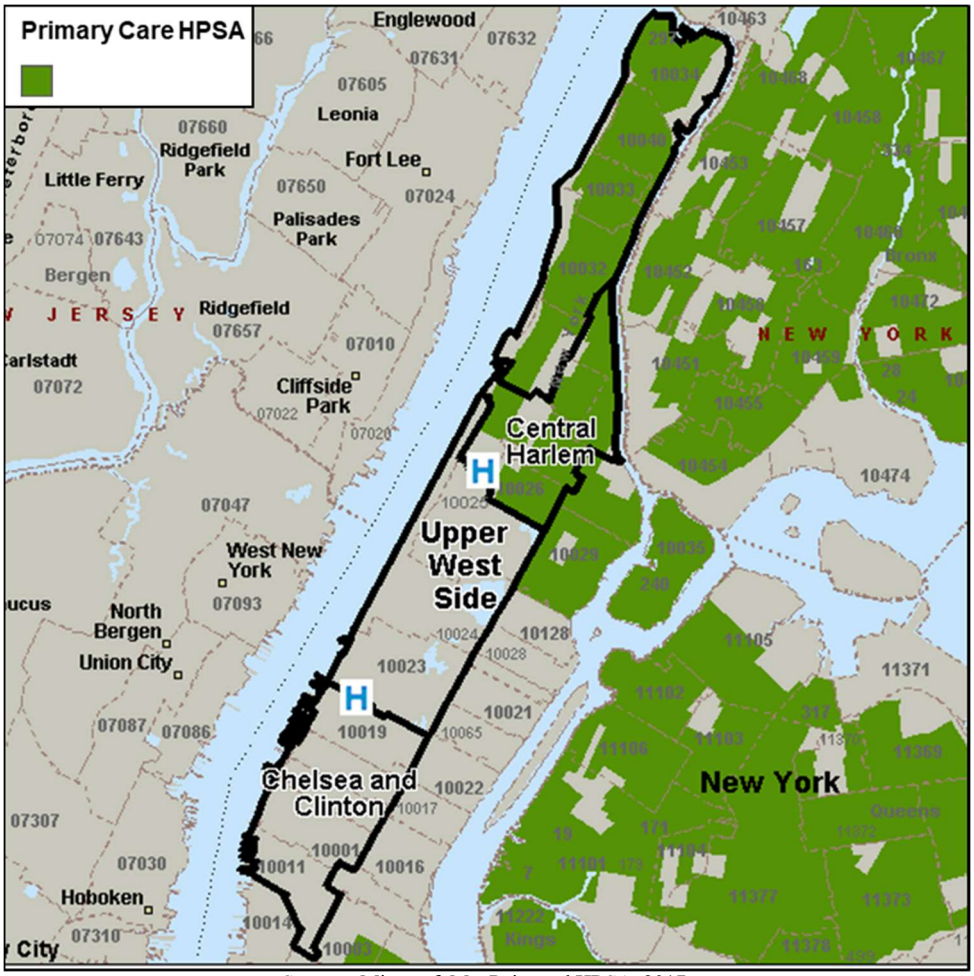
In addition to areas and populations that can be designated as HPSAs, a facility can receive federal HPSA designation and an additional Medicare payment if it provides primary medical care services to an area or population group identified as having inadequate access to primary care, dental, or mental health services.

HPSAs can be: "(1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility."[16]

Areas and populations in the MSSL & MSW community are designated as HPSAs (**Exhibits 57**). Medicaid eligible populations in parts of Manhattan are designated as HPSAs.

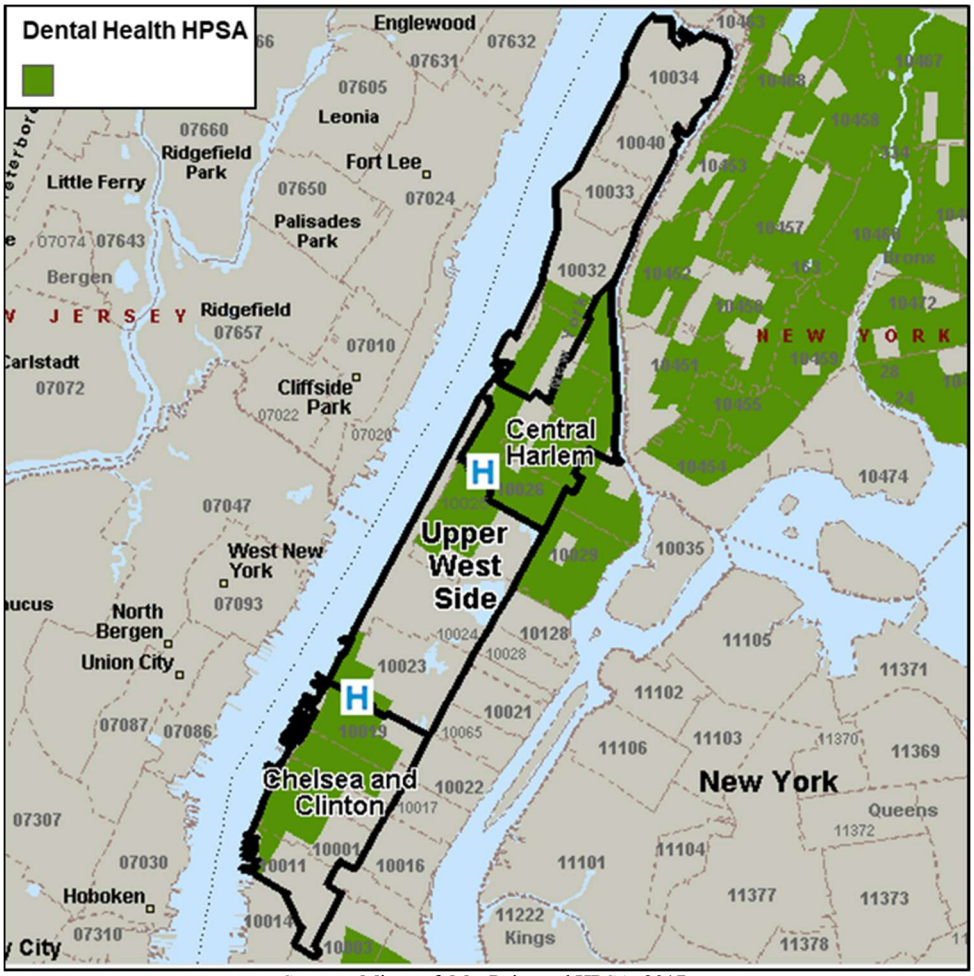
[16] U.S. Health Resources and Services Administration, Bureau of Health Professionals. (n.d.). *Health Professional Shortage Area Designation Criteria*. Retrieved 2013, from http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/index.html

Exhibit 57A: Location of Federally Designated Primary Care HPSA Census Tracts in the MSSL & MSW Community, 2017



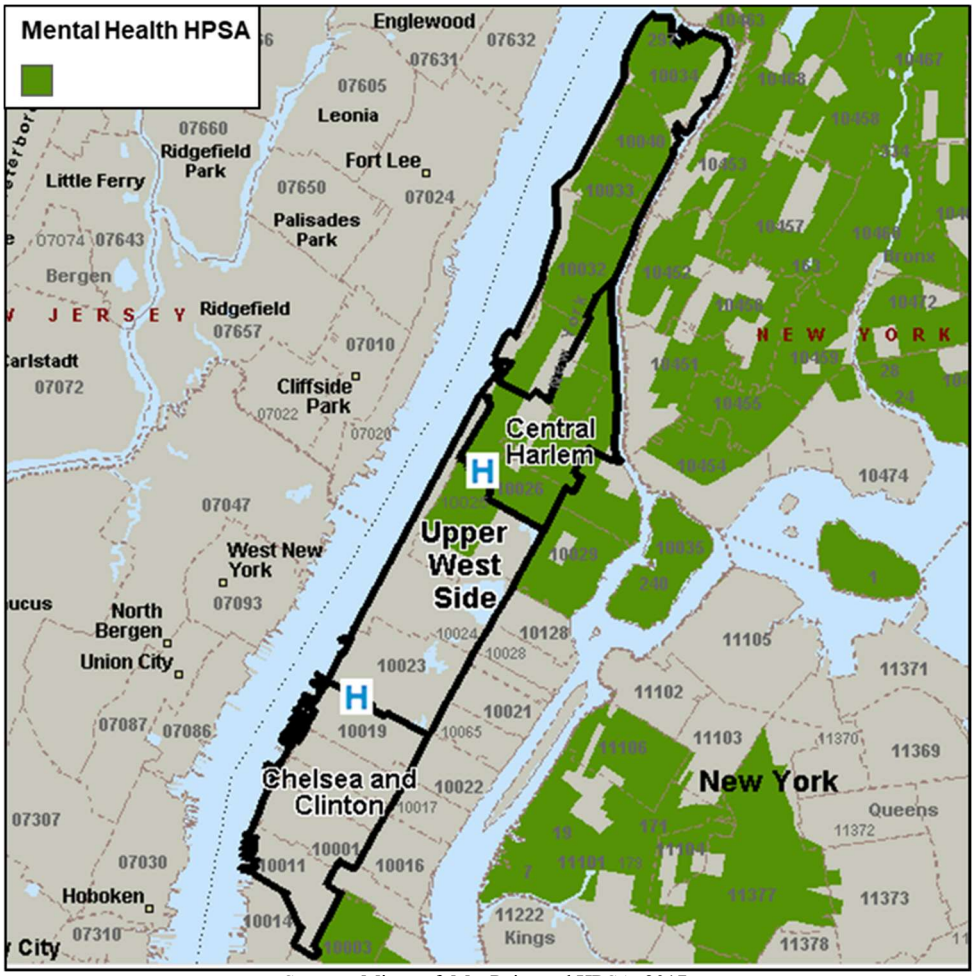
Sources: Microsoft MapPoint and HRSA, 2017.

Exhibit 57B: Location of Federally Designated Dental Health HPSA Census Tracts in the MSSL & MSW Community, 2017



Sources: Microsoft MapPoint and HRSA, 2017.

Exhibit 57C: Location of Federally Designated Mental Health HPSA Census Tracts in the MSSL & MSW Community, 2017



Sources: Microsoft MapPoint and HRSA, 2017.

Description of Other Facilities and Resources within the Community

The MSSL & MSW community contains a variety of resources that are available to meet the health needs identified in this CHNA. These resources include facilities designated as HPSAs, hospitals, FQHCs, health professionals, and other agencies and organizations.

Multiple facilities in Manhattan are designated as HPSA facilities (**Exhibit 58**).

Exhibit 58: List of HPSA Facilities in the MSSL & MSW Community

HPSA Name	Facility Type	Primary Care	Dental	Mental
Manhattan				
Ahrc Health Care, Inc.	Comprehensive Health Center	•	•	•
American Indian Community House	Native American Tribal Population	•		•
Asian & Pacific Islander Coalition on HIV/AIDS (AP	FHQC Look A Like	•	•	•
Bellevue Hospital	State Mental Hospital			•
Betances Health Center	Comprehensive Health Center	•	•	•
Boriken Neighborhood	Comprehensive Health Center	•	•	•
Charles B. Wang Community Health Center, Inc.	Comprehensive Health Center	•	•	•
Community Healthcare Network	Comprehensive Health Center	•	•	•
Covenant House	Comprehensive Health Center	•	•	•
Health Care for the Homeless	Comprehensive Health Center	•	•	•
Heritage Health and Housing, Inc.	Comprehensive Health Center	•	•	•
Institute for Family Health	Comprehensive Health Center	•	•	•
MCC-New York	Correctional Facility	•	•	•
Morningside Clinic	Other Facility	•		
Mount Sinai Adolescent Health Center	Other Facility	•		
New York Children's Health Project	Comprehensive Health Center	•	•	•
New York Health and Hospitals Corporation	FHQC Look A Like	•	•	•
Project Renewal	Comprehensive Health Center	•	•	•
Settlement Health	Comprehensive Health Center	•	•	•
The Floating Hospital	Comprehensive Health Center		•	
Upper Room AIDS Ministry, Inc.	Comprehensive Health Center	•	•	•
William F. Ryan Community Health Center	Comprehensive Health Center	•	•	•

Source: Health Resources and Services Administration, 2017.

There are numerous locations for community residents to receive hospital services in Manhattan. **Exhibit 59** lists hospital locations where community residents can receive services across all neighborhoods in Manhattan. There are currently 20 hospital facilities in Manhattan.

Exhibit 59: Hospitals in the MSSL & MSW Community

Borough	Hospital Name
Manhattan	Bellevue Hospital Center
Manhattan	Harlem Hospital Center
Manhattan	Henry J. Carter Specialty Hospital
Manhattan	Hospital for Special Surgery
Manhattan	Lenox Health Greenwich Village
Manhattan	Lenox Hill Hospital
Manhattan	Memorial Hospital for Cancer and Allied Diseases
Manhattan	Metropolitan Hospital Center
Manhattan	Mount Sinai Beth Israel
Manhattan	Mount Sinai Hospital
Manhattan	Mount Sinai St. Luke's
Manhattan	Mount Sinai West
Manhattan	New York Eye and Ear Infirmary of Mount Sinai
Manhattan	New York Presbyterian Hospital - Allen Hospital
Manhattan	New York Presbyterian Hospital - Columbia Presbyterian Center
Manhattan	New York Presbyterian Hospital - New York Weill Cornell Center
Manhattan	New York-Presbyterian/Lower Manhattan Hospital
Manhattan	NYU Hospital for Joint Diseases
Manhattan	NYU Hospitals Center
Manhattan	Rockefeller University Hospital

Federally Qualified Health Centers (FQHCs) were created by Congress to promote access to ambulatory care in areas designated as "medically underserved." These clinics receive cost-based reimbursement for Medicare and many also receive grant funding under Section 330 of the Public Health Service Act. FQHCs also receive a prospective payment rate for Medicaid services based on reasonable costs.

There are 370 FQHC site locations in the five boroughs of New York City, many of which also are designated as HPSAs. Some of the largest FQHCs include Community Healthcare Network, The Institute for Family Health, HELP/PSI, Access Community Health Center, the Joseph P. Addabbo Family Health Center, the William F. Ryan Community Health Network, and Lutheran HealthCare.

Exhibit 60 presents the rates of primary care physicians, mental health providers, and dentists in the community per 100,000 population. The rates of primary care, mental health providers, and dentists per 100,000 population are higher in Manhattan, compared to the state.

Exhibit 60: Health Professionals Rates per 100,000 Population by Borough

Borough	Primary Care Physicians		Mental Health Providers		Dentists	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Manhattan	2,263	138.3	11,983	729.9	2,840	172.7
New York State	**16,474**	**83.4**	**47,493**	**239.8**	**15,530**	**78.4**

Source: County Health Rankings, 2017.

A wide range of other agencies and organizations is available in the community to assist in meeting health needs. Community foundations, hospitals, and agencies assist residents in locating available resources. A small sample of referral resources includes the following:

- United Way of New York City
  http://www.unitedwaynyc.org/who-we-are/get-help
- Brooklyn Community Pride Center Resources:
  http://www.lgbtbrooklyn.org/resources
- CAI Global Ryan White Part B Mental Health Providers and Other Mental Health Resources:
  http://www.caiglobal.org/aimh/RWB%20MH%20Providers%20and%20MH%20resources.pdf
- Coalition for the Homeless Resource Guide:
  http://www.coalitionforthehomeless.org/resource-guide
- The Elmezzi Foundation Family Youth Guide:
  http://elmezzi.org/family-youth-guide/
- Mental Health Association of New York City Services:
  https://mhaofnyc.org/what-we-do/

- New York City Guide to Suicide Prevention, Services, and Resources: http://samaritansnyc.org/nyc-resource-guide/
- New York City – Mayor's Office to Combat Domestic Violence: http://www1.nyc.gov/site/ocdv/index.page
- NYU Langone Medical Center Free and Low Cost Health Resources in New York City: http://nycfreeclinic.med.nyu.edu/information-for-patients/health-resources
- Parent Guide News Parent & Child Resources: http://www.parentguidenews.com/Search/SpecialNeeds_ParentChildResources
- Weill Cornell Center for Human Rights Mental Health Services Guide: http://www.wcchr.com/resources/mental-health-resources-nyc

In addition to organizations listed in the resource guides, community resources that assist residents in meeting health needs include:

- Local chapters of national organizations, such as the Alzheimer's Association, American Cancer Society, American Heart Association, American Red Cross, Habitat for Humanity, YMCA, and YWCA
- Local places of worship
- Local first responders, including fire departments, police departments, and Emergency Medical Services (EMS)
- Local FQHCs and HPSA facilities (**Exhibit 58**)
- Local government agencies, Chambers of Commerce, and City Councils
- Local schools, colleges, and universities
- The New York City Department of Health and Mental Hygiene (DOHMH)

Findings of Other Recent Community Health Needs Assessments

Exhibit 61: Other Community Health Needs Assessments in New York City

Significant Need Identified	Total
Obesity	19
Diabetes	17
Mental Health/Illness	13
Hypertension	12
Heart Disease	11
Substance Abuse	11
High Cholesterol	9
Stroke	9
Cancer	6
Smoking or Tobacco Use	6
HIV	6
Maternal and Infant Health	6
Chronic Disease	6
Asthma and Breathing Issues	5
Access to Preventive Services	5
STDs	5
Injuries	4
Domestic Violence/ Violence	4
Air Quality	4
Inadequate Nutrition	4
Access to Primary Care	3
Reproductive Health	3
Exercise	3
Vaccine Preventable Disease	3
Healthcare Associated Infections	3

Source: Verité analysis of other New York City Community Health Needs Assessments[17], 2017.

[17] Other assessments reviewed include: Flushing Hospital Medical Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Kingsbrook Jewish Medical Center, Maimonides Medical Center, Montefiore Medical Center, NYCHH Bellevue , NYCHH Carter, NYCHH Coney Island, NYCHH Elmhurst, NYCHH Harlem, NYCHH Jacobi, NYCHH Kings County, NYCHH Lincoln, NYCHH Metropolitan, NYCHH North Central Bronx, NYCHH Queens, NYCHH Woodhull, New York Methodist Hospital, Memorial Sloan Kettering, New York Presbyterian Hospital , NYU Langone Medical Center, Richmond University Medical Center, St. John's Episcopal Hospital, Wyckoff Heights Medical Center, Hospital for Special Surgery, Northwell Health New York County, and Rockefeller University Hospital.

PRIMARY DATA ASSESSMENT

Summary of Interview Findings

Key informant interviews were conducted face-to-face and by telephone by Verité Healthcare Consulting from September through December 2017. The interviews were designed to obtain input on health needs from persons who represent the broad interests of the community served by Mount Sinai St. Luke's Hospital.

Forty-nine interview sessions were held with 104 individuals representing numerous organizations. Interviewees included: individuals with special knowledge of or expertise in public health; local public health department representative with information and expertise relevant to the health needs of the community; and individuals and organizations serving or representing medically underserved, low-income, and minority populations. The organizations that provided input are listed after the discussion of issues identified in the interviews.

Interviews were conducted using a structured discussion guide. Informants were asked to discuss community health issues and encouraged to think broadly about the social, behavioral, and other determinants of health. Interviewees were asked about issues related to health status, health care access and services, chronic health conditions, populations with special needs, and health disparities.

The frequency with which specific issues were mentioned and interviewees' perceptions of the severity (how serious or significant) and scope (how widespread) of each concern were assessed. The following health status issues and contributing factors were reported to be of greatest concern. They are grouped by topic with the topics presented in alphabetical order.

Issues Identified by Interview Participants

Robust health care services exist. Interview participants indicated that health care services in New York City are prevalent and readily accessible for individuals with comprehensive health insurance and/or the means to pay out-of-pocket for services. Provider options are especially prevalent in Manhattan, as residents of other boroughs often chose to travel to Manhattan for services. The city is also dense with transportation options to travel to providers, except for residents that have mobility, financial, and/or other limitations.

Rapidly changing healthcare system. A number of participants suggested that the health care delivery system is rapidly evolving. Changes include more services provided in an ambulatory setting rather than on an inpatient basis, development of "Centers of Excellence" to improve outcomes, decreasing lengths of stay for hospitalizations, emergence of urgent care centers and other on-demand options, and continuing advances in technology.

Although residents may appreciate the benefits of advances, interviewees indicated that there is dissatisfaction and fear with other changes, such as increased transportation effort to travel to Centers of Excellence. Concerns are worsened by misinformation about changes, as well as gaps between residents' expectations and service delivery options. Along with these changes, uncertainty about the potential changes to health insurance access offered by the Affordable Care Act (ACA) is creating stress and anxiety as some residents are worried about continued insurance coverage.

Similarly, some provider interviewees are concerned that ACA changes may destabilize the health care system. Also, some members of the health care system are reluctant to shift from an older, doctor-centric model of care to a broader team approach that includes more emphasis on nurse-led clinics and community health workers. Hampering collaboration is different electronic medical systems at different providers, which are not able to communicate efficiently. Increasing expectations of health care providers, including "customer service" expectations of patients, result in some providers leaving the health system prematurely.

Further, participants suggested that consolidation within the health care delivery system may increase efficiency and improve continuity of care. However, consolidation may negatively impact vulnerable populations if the relationship with smaller-scale providers, with whom trust has developed over a long period, is altered when these providers become part of a larger system.

Insurance restrictions. The role of insurance rules that limit the care that some residents receive was discussed by a number of interview participants. These limitations may return residents to the community prematurely and lead to a revolving door of care. Compounding the issue is changing insurance requirements, provider participation, and high co-pays and deductibles. Further, some residents may not understand coverages and responsibilities of their policies, and may choose plans unwisely, based on promises of sales representatives rather than careful analysis. The impact of insurance restrictions and unknown coverage is that some residents forego services, such as ambulance transport, because they do not know the cost and fear that they will not able to afford the service provided. Additionally, lags and lapses in coverage complicate delivery of services.

Consumer confusion. Interview participants suggested that as healthcare delivery options and insurance requirements rapidly change, many people may not know which provider to choose for specific needs at specific times. People rarely learn to navigate the system pre-need and the cognitive ability to understand the system may be challenged during times of need. Navigation assistance and care coordination is needed, but coordinators and case workers are overwhelmed and have limited authority over health care decisions.

Interview participants also suggested that the process to implement care across a fragmented system can be cumbersome and time-consuming, including multi-level telephone trees, long lags to care, appointment times that interfere with school and work, and location of services. Language may further add to the challenge, including spoken dialects and written language barriers.

Participants noted that navigation needs vary by individual, depending on their knowledge base, experiences, and emotional status. Navigation assistance is needed for many residents in the community, including young adults, who may have little understanding how to access services, patient expectations, and insurance coverage options.

Disparities. Many interview participants discussed the differences in outcomes and experiences among residents, with variation by age, gender, race/ethnicity, and socioeconomic status. As a result, some residents distrust and may delay or refuse care because of real or perceived treatment disparities, language barriers, and lack of cultural competence from providers. Cohorts of residents where distrust may be especially evident are low-income people-of-color, immigrants who do not speak English, and LGBTQ individuals.

Interviewees indicated that residents who have experienced or perceived disparities are observant for biases in care delivery and compare treatment with other patients. As a result, LGBTQ residents may travel further for care because they wish to conceal their sexual orientation or gender identity in their neighborhood. Other residents, notably transgender individuals, may forego needed care or request the participation of patient advocates.

Participants also suggested that residents with disabilities are also vulnerable to limited provider options. Some residents are unable to receive services in facilities with stairs, narrow hallways, and/or equipment without transfer assistance.

Mental health and substance abuse needs. Interview participants focused on considerable mental health issues in the community, including anxiety and depression, as well as substance abuse, including opioids and hidden alcoholism. Interviewees suggested that unmet mental health and substance abuse needs may be particularly problematic for less-than-affluent residents, where these twin issues are evident in the increasing number of homeless people.

Interviewees suggested that mental health issues and treatment needs may vary by community cohorts. Seniors may be especially likely to suffer from depression. Although stigma around mental illness remains in many populations, culturally competent education and treatment are needed in the Hispanic and Chinese communities. Additionally, children are negatively impacted by unmet mental health needs of parents.

Aging population. Interview participants indicated that the community is aging, but that seniors are a diverse group and age does not determine needs. Needs can change rapidly, however, and diminished capacity may not be evident until there is a sentinel event. Support needs vary by mobility, hearing and vision ability, and cognitive levels. Polypharmacy issues can be significant. Hoarding may reduce some senior residents' acceptance of support.

For vulnerable seniors, interviewees stated that transportation can be a challenge due to stairs in the subway system and street traffic, including bicycles. Handicapped access transportation can be problematic. Additionally, outcome goals of longevity, rather than shorter, but higher quality life, are adding artificial demands to health care services.

Changing population. Most interview participants stated that the number of residents in the community is increasing. New residents include students, younger adults, families, and new residents from other countries. The existing population is changing, too, as LGBTQ residents become more visible and residents migrate for more affordable housing. The impact of these changes may be increased need for culturally competent health care options as there is much diversity in a small geographic area.

Isolation. Some interview participants stated that increasing disconnectedness with other members of the community is leading to isolation and depression for many residents, including both seniors and gay men. Seniors may need organized activities to get them out of their insular environment.

Obstacles to healthy behaviors. Interview participants indicated that some residents may simply not know how to be healthy. For others, entertainment options, including television and video games, may increase physical inactivity. Although upscale grocery stores have increased in the area, individuals with limited financial means have fewer choices, as more moderately priced grocery stores have closed. Additional prevention programs are needed to help residents respond to these obstacles.

Some participants suggested that cultural norms may contribute to poor nutrition, inactivity, and acceptance of medical examinations and/or treatments. Misinformation and lack of education may also be contributing factors. Also contributing to unhealthy behaviors can be the higher cost of healthier food, abundance of fast food options, large portion sizes, and nutritional content of prepared meals.

Interviewees also stated that tobacco use is an increasing unhealthy behavior. Tobacco use has expanded from traditional cigarettes and now includes hookahs and e-cigarettes. Smoking rates are high in the Chinese community and use is increasing in teens.

Financial pressures. Many participants stated that gentrification and income inequality are increasing and that lower-income residents are facing greater pressures to afford housing and food. As a result, some residents depart from the community. Costs of health care are also issues for some residents due to higher insurance deductibles and co-pays.

Healthcare providers, too, were thought to face financial pressures, especially with increasing rental rates in the area for their practices. As a result, some providers leave their practice or join systems because rents are unaffordable.

Safe and affordable housing needs. Interview participants indicated that high and increasing rents are resulting in overcrowding as some residents double or triple up their occupancy to afford rents. The health of some residents may be at-risk for asthma and other conditions due to pest infestation and/or poor building maintenance, including water, heat, and elevator access. Maintenance and security are particularly important issues for senior residents of NYC Housing Authority units.

Environment issues. Environmental factors including poor air quality, traffic, noise, second-hand smoke, unsanitary conditions, crime, and a resulting negative impact on residents' health, were reported by some interview participants. In addition to direct impacts, such as asthma, these factors have an indirect influence through increased stress.

Bike lanes are another environmental issue reported by some interviewees. The lack of warning noise of bicycles and the failure of cyclists to follow traffic signals increases the number of accidents and can greatly increase some residents' fear of bicyclist-pedestrian accidents, particularly among elderly residents.

Homelessness. Many respondents indicated that the number of homeless community members appears to be increasing. Homelessness is a particularly difficult issue because it frequently includes issues relating to poverty, mental health, and substance abuse. Homeless women are especially vulnerable to mistreatment and are reluctant to report incidences. Individual who live in shelters are at risk for communicable disease.

Organizations Providing Community Input

Forty-nine interview sessions were held with 104 individuals representing 40 organizations. Individuals associated with these organizations are below.

Organizations Interviewed	
ACMH Inc.	Morningside Heights Residents' Association
Astoria Blue Feather Early Learning Center	Mount Sinai - Mount Sinai Queens
BRC Senior Services Center	Mount Sinai - Mount Sinai Queens - Community Advisory Board
Callen-Lorde Community Health Center	Mount Sinai Beth Israel - Mount Sinai Brooklyn
Center for Independence of the Disabled in NY	Mount Sinai Community Advisory Council
Consolidated Edison, Inc.	Mount Sinai Health System
Coordinated Behavioral Care (CBC)	Mount Sinai St. Luke's - Mount Sinai West
Dominican Women's Development Center	MSSL & MSW
Educational Alliance	New York City Department of Health and Mental Hygiene
Hearing Loss Association of America, New York City Chapter	New York Common Pantry
Hellenic American Neighborhood Action Committee	New York Eye & Ear Infirmary of Mount Sinai
Instituto Duartiano de Nueva York	New York Political Club New Generation
La Academia Mundial de Bomberos Inc EEUU	Queens Community Board 1
Long Island City Partnership	Residents of the New York City Housing Authority
Lower Eastside Power Partnership	SHAREing & CAREing
Manhattan Community Board 3	STRIVE New York
Manhattan Community Board 4	Stuyvesant Town Peter Cooper Village Tenants Association
Manhattan Community Board 5	Union Square Partnership
Manhattan Community Board 6	William F. Ryan Community Health Center
Manhattan Community Board 7	William F. Ryan Community Health Network

Note: Interviews were conducted in collaboration with the CHNAs developed for other hospitals in the Mount Sinai Health System. Although some participating organizations serve residents of a different geographic area than the MSSL & MSW community, representatives of these organization provided insight that was applicable to different populations within the MSSL & MSW community, such as children and youth, seniors, and foreign-born residents.

SOURCES

DataGen, a HANYS solutions company. Analysis of 2016 inpatient hospital discharge data.

Dignity Health. *Community Needs Index.* Retrieved 2017, from http://cni.chw-interactive.org/.

Federal Bureau of Investigation, Uniform Crime Reporting Program. *Crime Rates [2014-2015]*. Retrieved 2017, from: http://www.fbi.gov/about-us/cjis/ucr/ucr.

Internal Revenue Code, Section 501(r).

Internal Revenue Service. *Instructions for IRS form 990 Schedule H, 2015*.

New York City Council Finance Division. *The City Council of the City of New York, Fiscal Year 2018 Adopted Expense Budget, Adjustment Summary / Schedule C [2017]*. Retrieved 2017, from https://council.nyc.gov/budget/wp-content/uploads/sites/54/2017/03/FY-2018-Schedule-C-Cover-Template-FINAL-MERGE.pdf.

New York City Department of Health and Mental Hygiene. *Community Health Survey.* Retrieved 2017, from https://a816-healthpsi.nyc.gov/epiquery/CHS/CHSXIndex.html.

New York City Department of Health and Mental Hygiene, Division of Family and Child Health. *Pregnancy Risk Assessment Monitoring System (PRAMS) [2014 data]*.

New York City Department of Homeless Services. *HOPE 2013 NYC Street Survey* and *HOPE: The NYC Street Survey, 2017 Results.*

New York City Housing Authority (NYCHA). *About NYCHA Fact Sheet [April 2017]*. Retrieved 2017, from: https://www1.nyc.gov/assets/nycha/downloads/pdf/factsheet.pdf.

New York City Housing Authority (NYCHA). *Resident Data Book Summary [2017]*. Retrieved 2017, from https://data.cityofnewyork.us/Housing-Development/NYCHA-Resident-Data-Book-Summary/5r5y-pvs3.

New York State, Bureau of Health Informatics, Division of Information and Statistics. *Vital Statistics Suicide Deaths by Age-Group, Race/Ethnicity, Resident County, Region and Gender: Beginning 2003*. Retrieved 2017, from https://health.data.ny.gov/Health/Vital-Statistics-Suicide-Deaths-by-Age-Group-Race-/j6fz-a4ta/data.

New York State, Bureau of HIV/AIDS Epidemiology, AIDS Institute, and New York State Department of Public Health. *New York State HIV/AIDS Annual Surveillance Report, for Cases Diagnosed through December 2015*. Retrieved 2017 from https://www.health.ny.gov/diseases/aids/general/statistics/annual/2015/2015_annual_surveillance_report.pdf.

New York State, Department of the Budget. *New York State Budget [2017]*. Retrieved 2017, from: http://openbudget.ny.gov/overview/overview_SpendGrowth.html.

New York State, Department of Health. *County Health Indicators by Race/Ethnicity (CHIRE)*. Retrieved 2017, from https://www.health.ny.gov/statistics/community/minority/county/index.htm.

New York State, Department of Health. *Hospitals by Region/County and Service*. Retrieved 2017, from https://profiles.health.ny.gov/hospital/county_or_region/region:new+york+metro+-+new+york+city.

New York State, Department of Health. *New York State County/ZIP Code Perinatal Data Profile - 2012-2014*. Retrieved 2017, from https://www.health.ny.gov/statistics/chac/perinatal/county/2012-2014/index.htm.

New York State, Department of Health. *Prevention Agenda 2013-2018*. Retrieved from https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=st.

New York State, Department of Health. *Statewide Planning and Research Cooperative System (SPARCS) Inpatient and Outpatient Data File [2016]*.

New York State, Division of Criminal Justice Services and Kids' Well-being Indicators Clearinghouse. *Young Adult Crime Rates [2015]*. Retrieved 2017, from: http://www.nyskwic.org/get_data/indicator_data.cfm.

New York State, Office of Public Health Practice. *Community Health Obesity and Diabetes Related Indicators: 2008 - 2012*. Retrieved 2017, from https://health.data.ny.gov/Health/Community-Health-Obesity-and-Diabetes-Related-Indi/tchg-ruva.

New York State, Public Health Information Group. *Community Health Indicator Reports (CHIRS): Latest Data*. Retrieved 2017, from https://health.data.ny.gov/Health/Community-Health-Indicator-Reports-CHIRS-Latest-Da/54ci-sdfi/data.

NYC Health Department, the Department of Education and the National Centers for Disease Control and Prevention. NYC Youth Risk Behavior Survey (YRBS) [2015]. Retrieved 2017, from https://nccd.cdc.gov/youthonline/app/Default.aspx.

SKDKnickerbocker. Mount Sinai Community Poll [Findings] (2017).

The Mount Sinai Health System. 2016 Discharge Data.

Truven Health Analytics. Population Estimates (2017) and Projections (2022).

United Hospital Fund (UHF). Neighborhood definitions.

U.S. Bureau of Labor Statistics. *Unemployment Rates [2012-2016]*. Retrieved 2017, from: http://www.bls.gov/.

U.S. Census Bureau. *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2016.* Retrieved 2017, from: http://www.census.gov/

U.S. Census Bureau. *Demographic Data: ACS 5 Year Estimates [2015]*. Retrieved 2017, from: http://www.census.gov/.

U.S. Department of Agriculture, Economic Research Service. *Food Access Research Atlas [2015]*. Retrieved 2017, from https://www.ers.usda.gov/data-products/food-access-research-atlas/download-the-data/.

U.S. Department of Health & Human Services, Health Resources & Services Administration. Shortage Areas. Retrieved 2017, from https://datawarehouse.hrsa.gov/data/datadownload.aspx.

U.S. Department of Housing and Urban Development. *Point-in-Time (PIT) estimates and national PIT estimates of homelessness [2007-2016]*. Retrieved 2017, from https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/.

U.S. Department of Housing and Urban Development. *Subsidized Households [2016]*. Retrieved 2017, from: https://www.huduser.gov/portal/datasets/assthsg.html.

University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. *County Health Rankings: Mobilizing Action Toward Community Health [2013* and *2017]*. Retrieved 2017, from: http://www.countyhealthrankings.org/.

APPENDIX - Actions Taken Since Previous CHNA[18]

Mount Sinai St. Luke's Hospital ("MSSL & MSW") uses evidence-based approaches in the delivery of healthcare services with the aim of achieving healthy outcomes for the community it serves. It undertakes periodic monitoring of its programs to measure and determine their effectiveness and ensure that best practices continue to be applied.

Given that the process for evaluating the impact of various services and programs on population health is longitudinal by nature, significant changes in health outcomes may not manifest for several community health needs assessment cycles. MSSL & MSW continues to evaluate the cumulative impact.

Previously, MSSL & MSW identified a number of community health needs. The section below lists these health needs and related action items.

1. Aging Population (Seniors and Adult Day Programs)

   Inpatient Geropsychiatry - Mount Sinai West's geropsychiatry inpatient unit offers a secure, quality health care option for adults age 55 and older with a psychiatric diagnosis. The program is also appropriate for younger patients with additional medical problems requiring special attention not found on a general psychiatric unit. A team of psychiatrists, nurse practitioners, geriatricians, social workers, nurses, and occupational and creative art therapists has received specific training to meet the unique needs of geropsychiatricpatients. As part of Mount Sinai St. Luke's Hospital, the staff closely collaborates with all the major medical and surgical specialties important to the geriatric population.

   Addiction in Seniors - At The Addiction Institute of New York, MSSL & MSW staff members provide the best possible treatments to help individuals from pre-birth to old age recover from substance addictions, such as alcohol, heroin, cocaine, nicotine, and other addictions; and offer a wide possible range of inpatient, outpatient, residential, and school programs for all levels of severity of illness and socioeconomic status.

   Senior Citizens Services Program - The Senior Citizens Services Program is tailored to meet the specific needs of the older individual. The program utilizes a holistic treatment approach that looks at the unique psychological, social, and health problems of older patients. Case management services are provided to help patients live independently in the community.

   NORC Program at Lincoln Square Neighborhood Houses - Mount Sinai West provides a registered nurse to the Naturally Occurring Retirement Community (NORC) Program at Lincoln Square Neighborhood Houses. The program includes monitoring of senior residents in the complex to prosper and successfully age in place. The program has seen modest increases since the last CHNA submission.

[18] Source: Mount Sinai Health System

2. Access to Preventive and Primary Care and Health Insurance (Access to Care, Neurology, Cardiology, Orthopedics, Pediatrics, Emergency Services, Health Education, Programs)

The hospital provides significant specialty care services for both inpatient and outpatient services, including but not limited to breast health, cardiology, diabetes services, gastroenterology, general surgery, and orthopedics. The hospital provides primary care at its campuses, as well as physician practices throughout Manhattan, and maintains affiliation agreements with City MD and CVS Minute Clinics. The hospital, together with The Mount Sinai Health System, is a leader providing quality health care to its patients regardless of their ability to pay. Specific community service programs include the following:

Mount Sinai Doctors West 147th Street - Residents of Harlem are offered quality healthcare within their neighborhood. Board-certified medical doctors emerge from diverse backgrounds to provide a broad range of healthcare services to meet the community's needs and access to all of the resources at Mount Sinai St. Luke's hospital. Both scheduled appointments in advance and walk-in appointments are offered. Specific services include the following:

- Primary Care;
- Check-ups, annual health assessments, and preventative care;
- Immunizations for adults, including flu shots;
- Urgent care, non-emergency care;
- Geriatric consultations and assessments;
- Education and support for those who care for chronically ill relatives;
- Coordination of home care services;
- Screenings for early detection of high risk conditions such as heart disease and diabetes; and
- Chronic care management for diseases such as diabetes, high blood pressure, asthma, chronic heart failure, chronic obstructive pulmonary disease (COPD) and arthritis.

Mount Sinai Doctors 1090 Amsterdam Avenue - Located in the Morningside Heights area, the primary care doctors at 1090 Amsterdam Avenue serve patients with a range of diseases and medical needs. Specific services include the following:

- Annual well-check;
- Management of chronic disease; and
- More complex care.

Mount Sinai Urgent Care and Multispecialty Physicians Upper West Side – Specific services of Mount Sinai Urgent Care and Multispecialty Physicians Upper West Side include the following:

- Specialized outpatient care;
- Management of chronic conditions;
- Pre- and post-hospital care;
- Urgent Care; and
- Point-of-lab tests.

Multispecialty Physicians – Specific services of the Mount Sinai Multispecialty Physicians Upper West Side include the following:

- Cardiology
- Dermatology
- Endocrinology
- Pediatric Urology
- Vascular and Endovascular Surgery

3. Access to Mental Health Care / Poor Mental Health Status

MSSL & MSW is dedicated to providing behavioral health services to meet the mental health needs of New York City. MSSL & MSW provides comprehensive, high-quality services that empower individuals to change their lives. MSSL & MSW effects changes in consumer education, outreach, and community collaboration; and helps to shape the future through leading-edge research and development of skilled professional staff to serve individuals and their communities.

Access Center Evaluation Service - The Access Center is the initial evaluative point of entry for those seeking psychiatric care at MSSL & MSW. All patients requesting treatment receive a comprehensive psychiatric evaluation that includes an extensive clinical interview and a standardized self-report outcome measure, Basis 24. Treatment recommendations are made if the various divisions of the Department of Psychiatry can offer appropriate treatment. If the programs of the Department of Psychiatry are unable to accommodate the patient's need for care, suggestions are made for care at other facilities.

Adult Inpatient Services – MSSL & MSW provides programs designed to accommodate the needs of each individual patient. On all inpatient psychiatric units, a therapeutic environment that promotes healing is provided. Active participation in the treatment process is encouraged.

Inpatient Psychiatry – MSSL & MSW's inpatient psychiatry units provide short-term, acute psychiatric treatment for adults ages 18 and older. Treatment modalities include group, family, and individual therapy and medication therapy. These services are

designed to stabilize and prepare the patient for appropriate follow-up treatment in an outpatient setting.

Inpatient Treatment Program - Individualized treatment plans are developed based on a comprehensive assessment of medical, psychiatric, psychological, social, and functional status. Treatment focuses on alleviating symptoms and solving problems in order to enhance patients' ability to function. Therapy programs are used to help patients understand mental illness, develop coping skills, and promote self-esteem. Treatment programs include the following:

- Psychopharmacological management (prescribed medications);
- Individual and group therapeutic activities;
- Environment structuring/therapeutic environment; and
- Patient/family education.

Adult Outpatient Clinic - The Acute Outpatient Psychiatry Clinic offers comprehensive outpatient treatment for persons diagnosed with Axis I or Axis II disorders whose course is characterized by acute, remitting episodes of illness. These include the treatment of persons with mood disorders, anxiety disorders, and other psychiatric disorders. Individuals with personality disorders are treated with a focus on a return to optimal functioning and improvement in their ability to live meaningful lives. Individuals with severe mental illnesses, such as schizophrenia and very unstable bipolar disorders are treated at the Psychiatric Recovery Center.

Group Therapy - A wide variety of short- and long-term groups meet weekly, targeted to focus on particular diagnoses. General psychotherapy groups are offered as well. Most individuals will participate in group, rather than individual, psychotherapy. A wide variety of short- and long-term groups meet weekly, targeted to focus on particular diagnoses. General psychotherapy groups are offered as well. Most individuals will participate in group, rather than individual, psychotherapy.

Individual Time-Limited Psychotherapy - Time-limited psychotherapy includes weekly cognitive-behavioral therapy (CBT), dialectical behavioral therapy (DBT), brief psychodynamic therapy, interpersonal psychotherapy, and supportive treatment.

Psychopharmacological Treatment - Medication therapy may be the sole therapy for some patients, although it is most effective when combined with either group or individual therapy. After an initial period of more frequent visits for stabilization and medication management, patients are generally seen monthly, moving toward less frequent visits.

Treatment for Spanish-Speaking Patients - OPC offers individual, group, and psychopharmacological treatment in Spanish.

Social Service Assessment - Patients needing assistance with housing, disability, and entitlement programs are referred to Mount Sinai St. Luke’s HEAL Center for further guidance.

Access Center Evaluation Service - The Access Center is the initial evaluative point of entry for those seeking psychiatric care at Mount Sinai West. All patients requesting treatment receive a comprehensive psychiatric evaluation that includes an extensive clinical interview and a standardized self-report outcome measure, Basis 24. Treatment recommendations are made if the various divisions of the Department of Psychiatry can offer appropriate treatment. If the programs of the Department of Psychiatry are unable to accommodate the patient's need for care, suggestions are made for care at other facilities.

The Child and Family Institute provides mental health and substance abuse treatment for patient's ages 0 to 18 years old. Several specialized treatment programs within the Department of Child and Adolescent Psychiatry at Mount Sinai West constitute a range of care.

4. Substance abuse

   The Child and Family Institute provides mental health and substance abuse treatment for patient's ages 0 to 18 years old. Several specialized treatment programs within the Department of Child and Adolescent Psychiatry at Mount Sinai West constitute a range of care.

   Addiction Institute at Mount Sinai is provides state-of-the-art, evidence-based treatment, training of professionals in addiction medicine, and research on the treatment of addictive disorders. With over 40 years of experience, The Addiction Institute at Mount Sinai provides a range of addiction treatment programs, as well as inpatient and outpatient services. Assessments and clinical decisions are made by our team of physicians, nurses, psychologists, and substance abuse counselors.

   The Addiction Institute at Mount Sinai – Mount Sinai St. Luke's Halfway House is more of a temporary home than a treatment facility to 24 uniquely diverse residents. Residents stay for a period of three to six months while pursuing housing as well as vocational, educational, and continued recovery plans. The program's goal is to assist the individual in becoming a drug-free, productive member of society.

5. Chronic Diseases and Contributing Lifestyle Factors (Diabetes, Asthma, Obesity, Hypertension, Pulmonary/Respiratory, Asthma Treatment, HIV/AIDS, Kidney Disease)

The hospital provides primary care at its campuses, as well as physician practices throughout Manhattan, and maintains affiliation agreements with City MD and CVS Minute Clinics. The hospital provides diabetes-related specialty care with endocrinology specialists and community education programs. The also hospital maintains close affiliation with the Mount Sinai Diabetes Institute, which maintains a team of doctors, nurses, and certified diabetes educators who are dedicated to providing comprehensive and integrated care.

Mount Sinai Heart at Mount Sinai St. Luke's, Cardiovascular Disease Prevention Program - The Mount Sinai Heart's Cardiovascular Disease Prevention Program was developed to help people reduce their risk for atherosclerosis, which is the leading cause of heart attack, stroke, and peripheral circulation problems. Unhealthy behaviors, such as

smoking, poor diet, or lack of exercise, compound the danger. Individuals enrolled in the Cardiovascular Disease Prevention Program learn how to modify their behavior to starve off illness — from what to eat for lunch to using the stairs instead of the elevator. Treatment elements include the following:

- Lifestyle evaluations to identify behaviors that affect heart health;
- Medical testing; and
- Comprehensive treatment plans.

The Department of Cardiovascular Surgery at Mount Sinai St. Luke's – The Depart of Cardiovascular Surgery provides state-of-the-art expertise in adult cardiac and thoracic surgery. A full spectrum of cardiovascular disease prevention, diagnosis, and treatment is provided, including the following"

- Coronary artery bypass grafting, including total arterial revascularization;
- Mitral valve repair, and atrial fibrillation surgery;
- Aortic valve reconstruction and aortic root surgery
- Reoperative cardiac surgery;
- Minimally invasive surgery, including video assisted surgery, cosmetic incisions, and fast-track recovery; and
- Robotic cardiac surgery.

State-of-the-Art Facility - The opening of the Al-Sabah Arrhythmia Institute allowed Mount Sinai St. Luke's and Mount Sinai West to consolidate all the arrhythmia service's patient care into one state-of-the-art facility. The Institute is designed to accommodate growing patient demand including shorter waiting periods for elective procedures in a patient focused environment. The Institute features the following:

- A clinical outpatient center, with a waiting area and information resources;
- Three electrophysiology laboratories for performing catheter-based procedures, device implantations, and diagnostic studies;
- A research laboratory for conducting both clinical and basic research on arrhythmia mechanisms and treatments; and
- An education center for training advanced fellows, practicing electrophysiologists and other medical professionals.

Lung-Pulmonology - Mount Sinai St. Luke's highly trained pulmonologists have extensive experience with diagnosis, treatment, and long-term care for pulmonology patients. Programs include the following:

- A smoking cessation program that incorporates medication and behavioral modification;
- The James P. Mara Center for Lung Disease that diagnoses and treats people with asthma and chronic lung diseases associated with COPD; and

- The Intensive Care Unit Simulation Lab that trains doctors in treating respiratory and other medical emergencies, using state-of-the-art audiovisual equipment linked to computerized manikins.

Neurology - The Department of Neurology at Mount Sinai West is a highly-integrated, multidisciplinary department specializing in the evaluation and treatment of people with neurological diseases.

The Mount Sinai West Stroke Center is a state-of-the-art facility at the forefront of diagnostics and therapies, and provides high-quality, compassionate care for life-threatening strokes. The key tests used to diagnose stroke are as follows:

- Imaging tests, including Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) tests, to provide information about the cause and location of a stroke and the extent of injury;
- Blood flow tests to reveal problems or dangerous changes in blood flow to the brain;
- Conventional Cerebral Angiography to evaluate the size and location of blockages in the brain;
- Echocardiography to create images of the heart and determine if there is an abnormality; and
- Newest stroke testing, such as computed tomography angiography (CTA) and NOVA, a non-invasive blood flow analysis system that uses magnetic resonance imaging to produce fully rotatable, 360-degree views of the blood vessels, allowing for precise identification of each vessel and its blood flow volume.

Raising Stroke Awareness – The Stroke Center with the American Stroke Association to increase awareness of how to defend against stroke.