

# **Community Health Needs Assessment**

*Prepared for*

**MOUNT SINAI BETH ISRAEL HOSPITAL**

*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 Beth Israel 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](http://www.VeriteConsulting.com).

# TABLE OF CONTENTS

<b>ABOUT VERITÉ HEALTHCARE CONSULTING.....</b>	<b>1</b>
<b>TABLE OF CONTENTS .....</b>	<b>2</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>4</b>
INTRODUCTION .....	4
<b>OBJECTIVES AND METHODOLOGY .....</b>	<b>5</b>
REGULATORY REQUIREMENTS.....	5
METHODOLOGY .....	6
<i>Collaborating Organizations</i> .....	7
<i>Information Gaps</i> .....	7
<b>SIGNIFICANT COMMUNITY HEALTH NEEDS .....</b>	<b>8</b>
<i>Aging Population</i> .....	8
<i>Access to Mental Health Care and Poor Mental Health Status</i> .....	9
<i>Access to Primary Health Care Services by Individuals with Limited Resources</i> .....	9
<i>Chronic Diseases and Contributing Lifestyle Factors</i> .....	10
<i>Environmental Determinants of Health</i> .....	10
<i>Homelessness</i> .....	11
<i>Navigating a Changing Health Care Provider Environment</i> .....	11
<i>Poverty, Financial Hardship, and Basic Needs Insecurity</i> .....	12
<i>Safe and Affordable Housing</i> .....	12
<i>Socio-Economic, Racial, Cultural, Ethnic, and Linguistic Barriers to Care</i> .....	13
<i>Substance Abuse</i> .....	13
<b>CHNA DATA AND ANALYSIS .....</b>	<b>14</b>
<b>DEFINITION OF COMMUNITY ASSESSED .....</b>	<b>15</b>
<b>SECONDARY DATA ASSESSMENT .....</b>	<b>20</b>
DEMOGRAPHICS .....	20
ECONOMIC INDICATORS.....	29
<i>People in Poverty</i> .....	29
<i>Household Income</i> .....	31
<i>Unemployment Rate</i> .....	33
<i>Insurance Status</i> .....	35
<i>Crime</i> .....	40
<i>Housing and Homelessness</i> .....	42
<i>State of New York and New York City Budget Trends</i> .....	45
LOCAL HEALTH STATUS AND ACCESS INDICATORS .....	54
<i>County Health Rankings</i> .....	54
<i>New York State Department of Health</i> .....	59
<i>Youth Risk Behavior Survey</i> .....	76
<i>New York Prevention Agenda 2013-2017</i> .....	78
<i>New York City Community Health Survey</i> .....	82
AMBULATORY CARE SENSITIVE CONDITIONS.....	86
<i>Borough/Neighborhood-Level Analysis</i> .....	86
<i>ACSC Conditions Analysis</i> .....	88
COMMUNITY NEED INDEX™ AND FOOD DESERTS.....	89
<i>Dignity Health Community Need Index</i> .....	89
<i>Food Deserts (Lack of Access to Nutritious and Affordable Food)</i> .....	91
MEDICALLY UNDERSERVED AREAS AND POPULATIONS .....	92
HEALTH PROFESSIONAL SHORTAGE AREAS .....	94
DESCRIPTION OF OTHER FACILITIES AND RESOURCES WITHIN THE COMMUNITY .....	98
FINDINGS OF OTHER RECENT COMMUNITY HEALTH NEEDS ASSESSMENTS.....	102
<b>PRIMARY DATA ASSESSMENT .....</b>	<b>103</b>
SUMMARY OF INTERVIEW FINDINGS .....	103
ISSUES IDENTIFIED BY INTERVIEW PARTICIPANTS .....	104
ORGANIZATIONS PROVIDING COMMUNITY INPUT.....	108

COMMUNITY SURVEY FINDINGS .....	109
<i>Characteristics of responses</i> .....	109
<i>Results</i> .....	110
COMMUNITY POLL .....	117
<b>SOURCES</b> .....	<b>119</b>
<b>APPENDIX - ACTIONS TAKEN SINCE PREVIOUS CHNA</b> .....	<b>122</b>

# EXECUTIVE SUMMARY

---

## Introduction

This community health needs assessment (CHNA) was conducted by Mount Sinai Beth Israel Hospital (“MSBI” or “the hospital”) to identify community health needs and to inform development of an implementation strategy to address identified significant needs.

The Mount Sinai Beth Israel Hospital is comprised of two campuses, Mount Sinai Beth Israel in Manhattan and Mount Sinai Brooklyn in Brooklyn. To enhance clarity, we use the following acronyms throughout this document:

Acronym	Entity
MSBI - Manhattan	Mount Sinai Beth Israel, the campus in Manhattan
MS - Brooklyn	Mount Sinai Brooklyn, the campus in Brooklyn
MSBI	Mount Sinai Beth Israel Hospital, the hospital facility with campuses in Manhattan and Brooklyn

This CHNA was conducted by MSBI 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.<sup>1</sup> 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.<sup>2</sup>

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.

---

<sup>1</sup> Internal Revenue Code, Section 501(r).

<sup>2</sup> 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).<sup>3</sup> The community defined by MSBI accounts for 60 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.<sup>4</sup>

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. Input was also received from a community survey issued during the summer of 2017. Additional input was received by a community poll conducted for this CHNA by SKDKnickerbocker in September 2017.

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.

---

<sup>3</sup> 501(r) Final Rule, 2014.

<sup>4</sup> 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, MSBI collaborated with the Mount Sinai Health System and its following hospitals: Mount Sinai Hospital & Mount Sinai Queens, Mount Sinai St. Luke's Hospital & Mount Sinai West, and New York Eye & Ear Infirmary of Mount Sinai. CHNAs for these hospitals were developed alongside the MSBI 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 MSBI community, the aged 65 and older cohort is expected to grow the most between 2017 and 2022, with a growth rate of over 16 percent overall (**Exhibit 4**).
- In County Health Rankings, both Brooklyn and 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 Brooklyn and New York City was more than 50 percent 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, both Brooklyn and Manhattan compared unfavorably to the state rate in average number of mentally unhealthy days. Brooklyn also compared unfavorably in the ratio of population to mental health providers (**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 Brooklyn, 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**).
- The rate of mental health providers in Brooklyn was lower than the state average (**Exhibit 60**).
- 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 Brooklyn overall and several Brooklyn neighborhoods in the MSBI community was greater than the state average (**Exhibit 18**).
- In County Health Rankings, Brooklyn ranked 56<sup>th</sup> out of 62 New York counties in Clinical Care (**Exhibit 29A**).
- Rates for ambulatory care sensitive conditions (ACSCs) in Brooklyn were significantly higher than the Manhattan averages (**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, Brooklyn ranked 49<sup>th</sup> out of 62 New York counties and Manhattan ranked 60<sup>th</sup> in diabetes monitoring (**Exhibit 29A**).
- The mortality rates for heart disease and diabetes mellitus in both Brooklyn and New York City was higher than the New York State average (**Exhibit 30**).
- Rates of communicable disease, particularly for HIV and AIDS, were higher in Brooklyn, Manhattan, and New York City than the state average (**Exhibits 36 and 37**).
- Asthma hospitalizations and mortalities were significantly higher in both Brooklyn and Manhattan than the state average (**Exhibit 39**).
- In the CDC's Youth Risk Behavior Surveillance System (YRBSS), respondents in Brooklyn, 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 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, Brooklyn and Manhattan both 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 Brooklyn, 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 while in Brooklyn, this number increased by 72.9 percent (**Exhibit 27**).
- In County Health Rankings, Brooklyn and Manhattan both 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, including St. Vincent's closure and the Mount Sinai Beth Israel transformation, 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.

- In County Health Rankings, Brooklyn ranked worse than the state average for preventable hospital stays (**Exhibit 29B**).
- Rates for ambulatory care sensitive conditions (ACSCs) in Brooklyn were significantly higher than the Manhattan averages (**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 Brooklyn and 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 27 percent of households in Brooklyn and over 21 percent in Manhattan had an annual income of less than \$25,000 (**Exhibit 14**).
- Unemployment rates in Brooklyn and New York City have been higher than state and national averages over recent history. Rates were particularly high for Black and Hispanic or Latino residents (**Exhibit 16**).
- Both Brooklyn and Manhattan ranked worse than state averages for children in poverty, high school graduation, and income inequality (**Exhibit 29B**).
- A large portion of the MSBI 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 Brooklyn and 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, Brooklyn and 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 MSBI community are racially and ethnically diverse. Over 40 percent of the Brooklyn MSBI community was Black, and over 20 percent of the Manhattan MSBI community was Asian (**Exhibit 6**).
- The population that is linguistically isolated in the MSBI community was significantly higher than the New York State and national averages. The Brooklyn MSBI average was more than 50 percent greater the state and national averages (**Exhibit 10**).
- More than 35 percent of the MSBI 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 Brooklyn, 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 Brooklyn and 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 Mount Sinai Beth Israel and how it was determined.

MSBI's community is comprised of 40 ZIP Codes encompassing sections of both the boroughs of Brooklyn and Manhattan (**Exhibit 1**). The community is divided into neighborhoods utilized by the New York State Department of Health;<sup>5</sup> 10 of the 42 neighborhoods in New York City are in the MSBI community.

The Mount Sinai Beth Israel Hospital is comprised of two campuses, Mount Sinai Beth Israel in Manhattan and Mount Sinai Brooklyn in Brooklyn. To enhance clarity, we use following acronyms throughout this document:

Acronym	Entity
MSBI – Manhattan	Mount Sinai Beth Israel, the campus in Manhattan
MS – Brooklyn	Mount Sinai Brooklyn, the campus in Brooklyn
MSBI	Mount Sinai Beth Israel Hospital, the hospital facility with campuses in Manhattan and Brooklyn

The MSBI community was estimated to have a 2015 population of approximately 1.76 million persons in 2015.

The community definition was validated based on the geographic origins of discharges from MSBI - Manhattan and MS - Brooklyn. In 2016, the community collectively accounted for 60 percent of MSBI's overall inpatient discharges (**Exhibit 1**) and 64 percent of MSBI's New York City inpatient discharges.

---

<sup>5</sup> 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](http://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
<b>Brooklyn MSBI Neighborhoods</b>	<b>1,145,718</b>	<b>13,271</b>	<b>32.8%</b>	<b>34.9%</b>
Bushwick & Williamsburg	222,360	2,013	5.0%	5.3%
Canarsie & Flatlands	207,112	3,969	9.8%	10.4%
Flatbush	302,525	1,912	4.7%	5.0%
Greenpoint	132,935	1,830	4.5%	4.8%
Southern Brooklyn	280,786	3,547	8.8%	9.3%
<b>Manhattan MSBI Neighborhoods</b>	<b>617,952</b>	<b>10,882</b>	<b>26.9%</b>	<b>28.6%</b>
Chelsea & Clinton	149,683	1,625	4.0%	4.3%
Gramercy Park & Murray Hill	129,167	851	2.1%	2.2%
Greenwich Village & Soho	82,305	820	2.0%	2.2%
Lower East Side	198,713	7,243	17.9%	19.1%
Lower Manhattan	58,084	343	0.8%	0.9%
<b>Total MSBI Community</b>	<b>1,763,670</b>	<b>24,153</b>	<b>59.7%</b>	<b>63.6%</b>
Other New York City Discharges		13,849	34.2%	36.4%
Other non-New York City Discharges		2,445	6.0%	
<b>Total Discharges</b>		<b>40,447</b>	<b>100.0%</b>	

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

Exhibit 2A presents a map displaying the 10 neighborhoods that comprise the MSBI community.

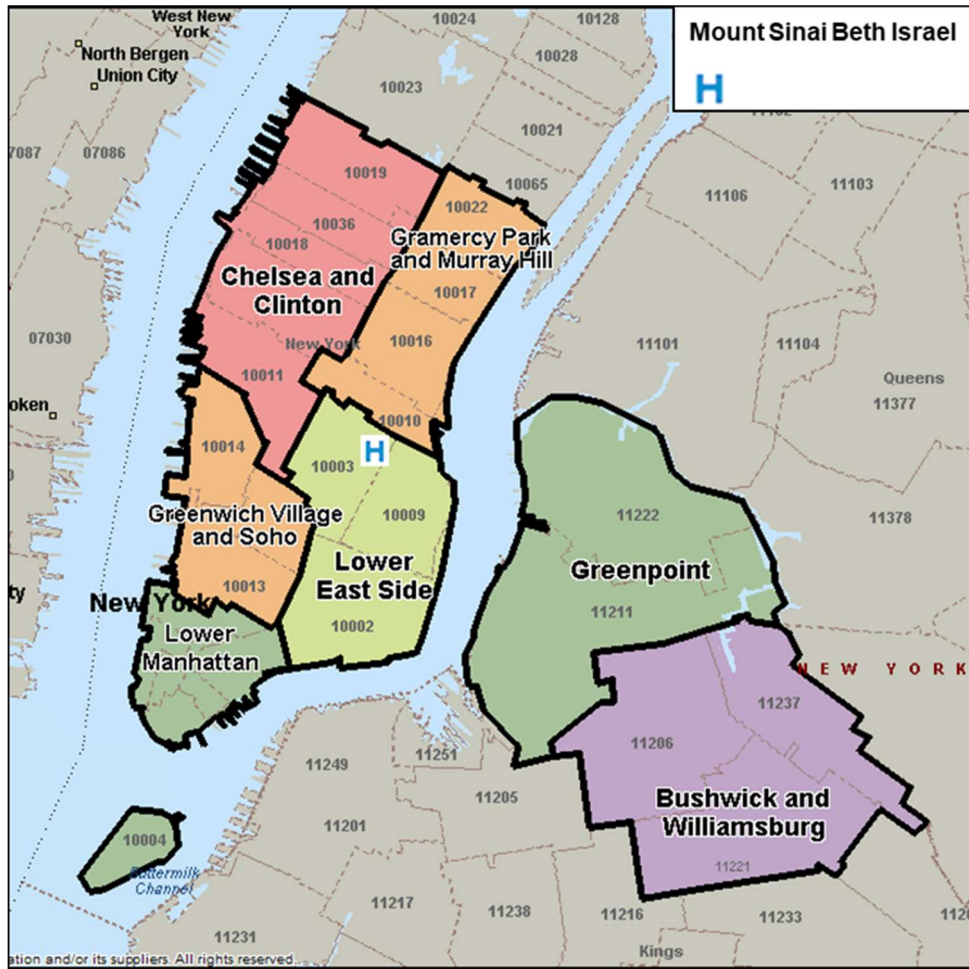
### Exhibit 2A: MSBI Community



Sources: Microsoft MapPoint and the Mount Sinai Health System.

Exhibit 2B presents a map displaying the seven neighborhoods that are proximate to MSBI - Manhattan.

Exhibit 2B: MSBI Community – Neighborhoods near MSBI - Manhattan

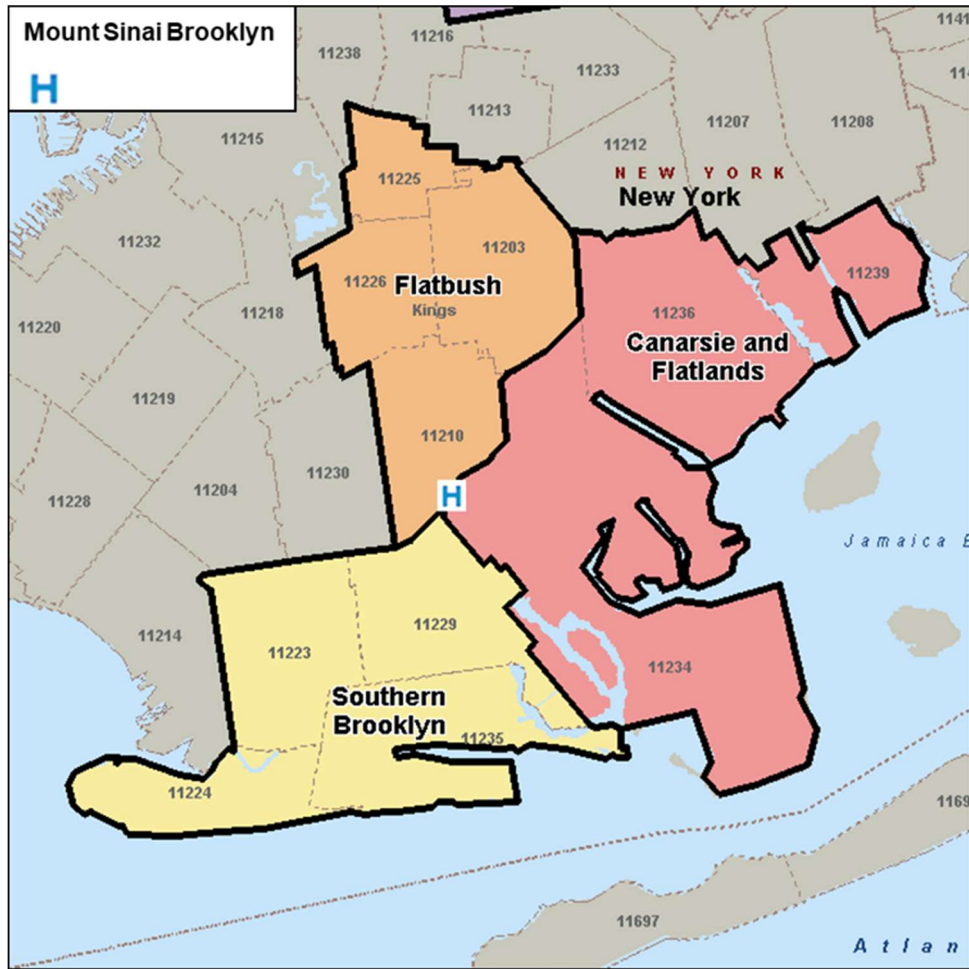


Sources: Microsoft MapPoint and the Mount Sinai Health System.

The Manhattan-portion of the MSBI community consists of the neighborhoods of Lower East Side, Lower Manhattan, Greenwich Village & Soho, Chelsea & Clinton, and Gramercy Park & Murray Hill. Also pictured are two of the community’s Brooklyn neighborhoods, Greenpoint and Bushwick & Williamsburg.

**Exhibit 2C** presents a map displaying the three neighborhoods that comprise the MSBI – Brooklyn community.

**Exhibit 2C: MSBI Community – Neighborhoods near MS - Brooklyn**



Sources: Microsoft MapPoint and the Mount Sinai Health System.

The Brooklyn-portion of the MSBI community consists of the neighborhoods of Flatbush, Canarsie & Flatlands, Southern Brooklyn, Greenpoint (pictured in 2B), and Bushwick & Williamsburg (pictured in 2B).

## SECONDARY DATA ASSESSMENT

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

### Demographics

Population characteristics and changes influence health issues in and services needed by communities. A total of 1,763,670 people were estimated to reside in the MSBI 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 by borough, and their distribution by sex and age in 2015.

**Exhibit 3: Population by Age and Sex, 2015**

Borough	Ages 0-19	Ages 20-44	Ages 45-64	Ages 65+	Total Population
<b>Brooklyn MSBI Neighborhoods</b>	<b>24.6%</b>	<b>38.2%</b>	<b>24.2%</b>	<b>13.0%</b>	<b>1,145,718</b>
Male	12.5%	18.4%	10.7%	5.2%	536,476
Female	12.1%	19.8%	13.5%	7.8%	609,242
<b>Manhattan MSBI Neighborhoods</b>	<b>13.0%</b>	<b>50.0%</b>	<b>23.2%</b>	<b>13.7%</b>	<b>617,952</b>
Male	6.3%	24.7%	11.9%	5.8%	301,227
Female	6.7%	25.3%	11.3%	7.9%	316,725
<b>Total MSBI Community</b>	<b>20.5%</b>	<b>42.3%</b>	<b>23.8%</b>	<b>13.2%</b>	<b>1,763,670</b>
Male	10.3%	20.6%	11.1%	5.4%	837,703
Female	10.2%	21.7%	12.7%	7.8%	925,967

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

In 2015, both Brooklyn and Manhattan had a higher proportion of women in the community. Manhattan had a lower proportion of residents aged 0 to 19 years and a higher proportion of those aged 20 to 44 than any other borough in New York City.

**Exhibit 4** illustrates the total number of residents projected to live in the community by borough, 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

Neighborhood	2017 Population					2022 Population					Percent Change 2017-				
	0-17	18-34	35-64	65+	Total	0-17	18-34	35-64	65+	Total	0-17	18-34	35-64	65+	Total
<b>Brooklyn MSBI Community</b>	<b>269,418</b>	<b>311,511</b>	<b>445,267</b>	<b>168,396</b>	<b>1,194,592</b>	<b>284,946</b>	<b>291,619</b>	<b>466,044</b>	<b>196,168</b>	<b>1,238,777</b>	<b>5.8%</b>	<b>-6.4%</b>	<b>4.7%</b>	<b>16.5%</b>	<b>3.7%</b>
Bushwick & Williamsburg	71,923	81,430	92,865	24,141	270,359	76,320	77,933	103,640	29,001	286,894	6.1%	-4.3%	11.6%	20.1%	6.1%
Canarsie & Flatlands	44,469	48,696	79,563	30,799	203,527	46,212	47,132	79,587	36,576	209,507	3.9%	-3.2%	0.0%	18.8%	2.9%
Flatbush	71,908	77,764	121,015	43,132	313,819	75,494	71,294	123,621	50,669	321,078	5.0%	-8.3%	2.2%	17.5%	2.3%
Greenpoint	19,971	38,680	38,018	10,530	107,199	21,164	34,995	43,944	12,469	112,572	6.0%	-9.5%	15.6%	18.4%	5.0%
Southern Brooklyn	61,147	64,941	113,806	59,794	299,688	65,756	60,265	115,252	67,453	308,726	7.5%	-7.2%	1.3%	12.8%	3.0%
<b>Manhattan MSBI Community</b>	<b>74,639</b>	<b>222,761</b>	<b>260,224</b>	<b>95,416</b>	<b>653,040</b>	<b>83,644</b>	<b>198,192</b>	<b>283,970</b>	<b>110,912</b>	<b>676,718</b>	<b>12.1%</b>	<b>-11.0%</b>	<b>9.1%</b>	<b>16.2%</b>	<b>3.6%</b>
Chelsea & Clinton	15,309	51,343	69,386	22,148	158,186	17,590	45,262	76,581	26,612	166,045	14.9%	-11.8%	10.4%	20.2%	5.0%
Gramercy Park & Murray Hill	13,679	50,112	53,803	23,561	141,155	15,842	44,035	59,060	26,518	145,455	15.8%	-12.1%	9.8%	12.6%	3.0%
Greenwich Village & Soho	10,552	27,277	36,085	12,332	86,246	11,745	23,709	38,508	14,418	88,380	11.3%	-13.1%	6.7%	16.9%	2.5%
Lower East Side	25,238	69,333	77,140	31,597	203,308	26,681	62,240	82,164	36,179	207,264	5.7%	-10.2%	6.5%	14.5%	1.9%
Lower Manhattan	9,861	24,696	23,810	5,778	64,145	11,786	22,946	27,657	7,185	69,574	19.5%	-7.1%	16.2%	24.4%	8.5%

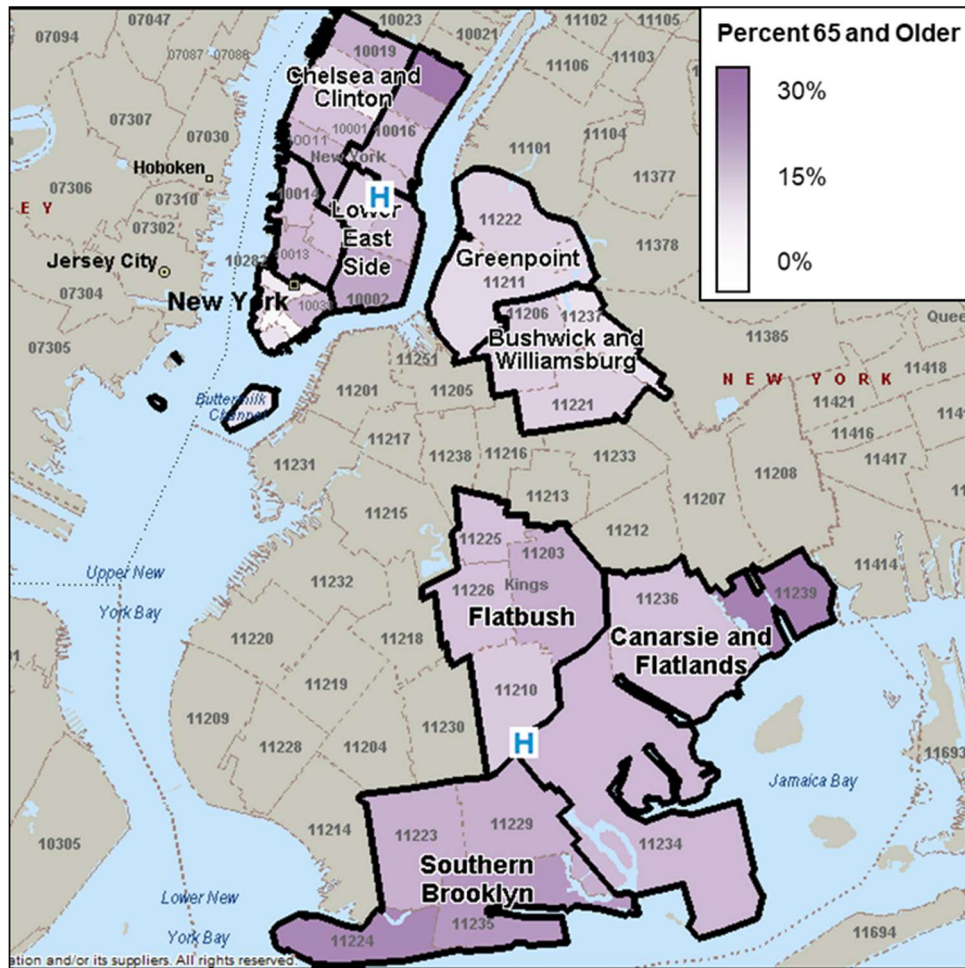
Source: Truven Health Analytics 2017 via the Mount Sinai Health System.

The total population of all neighborhoods in the community is expected to grow from 2017 to 2022. The neighborhoods of Lower Manhattan and Bushwick & Williamsburg are expected to grow most rapidly at 8.5 and 6.1 percent, respectively.

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 most neighborhoods.



### 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. The ZIP Codes of 10022 (Gramercy Park & Murray Hill), 11239 (Canarsie & Flatlands), and 11224 (Southern Brooklyn) had comparatively high proportions of this population cohort.

**Exhibit 6** indicates the distribution of the population by race in the MSBI 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)
<b>Brooklyn MSBI Community</b>	<b>1,145,718</b>	<b>42.6%</b>	<b>40.4%</b>	<b>7.4%</b>	<b>7.4%</b>	<b>2.1%</b>	<b>18.8%</b>
Bushwick & Williamsburg	222,360	41.2%	35.0%	5.2%	15.4%	3.1%	47.2%
Canarsie & Flatlands	207,112	24.3%	66.3%	4.0%	4.0%	1.4%	8.8%
Flatbush	302,525	15.7%	73.3%	2.9%	5.9%	2.1%	10.4%
Greenpoint	132,935	79.1%	5.2%	5.1%	7.9%	2.7%	21.4%
Southern Brooklyn	280,786	69.0%	6.9%	17.7%	4.9%	1.6%	11.4%
<b>Manhattan MSBI Community</b>	<b>617,952</b>	<b>65.6%</b>	<b>5.4%</b>	<b>20.1%</b>	<b>5.9%</b>	<b>3.0%</b>	<b>13.8%</b>
Chelsea & Clinton	149,683	70.4%	6.3%	15.7%	4.2%	3.3%	14.6%
Gramercy Park & Murray Hill	129,167	75.6%	3.5%	16.0%	2.8%	2.1%	8.4%
Greenwich Village & Soho	82,305	73.3%	2.8%	17.9%	2.5%	3.5%	6.7%
Lower East Side	198,713	52.6%	7.2%	26.1%	10.9%	3.2%	20.6%
Lower Manhattan	58,084	64.4%	4.3%	23.1%	5.0%	3.2%	10.9%
<b>Total MSBI Community</b>	<b>1,763,670</b>	<b>50.7%</b>	<b>28.1%</b>	<b>11.9%</b>	<b>6.9%</b>	<b>2.4%</b>	<b>17.0%</b>

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

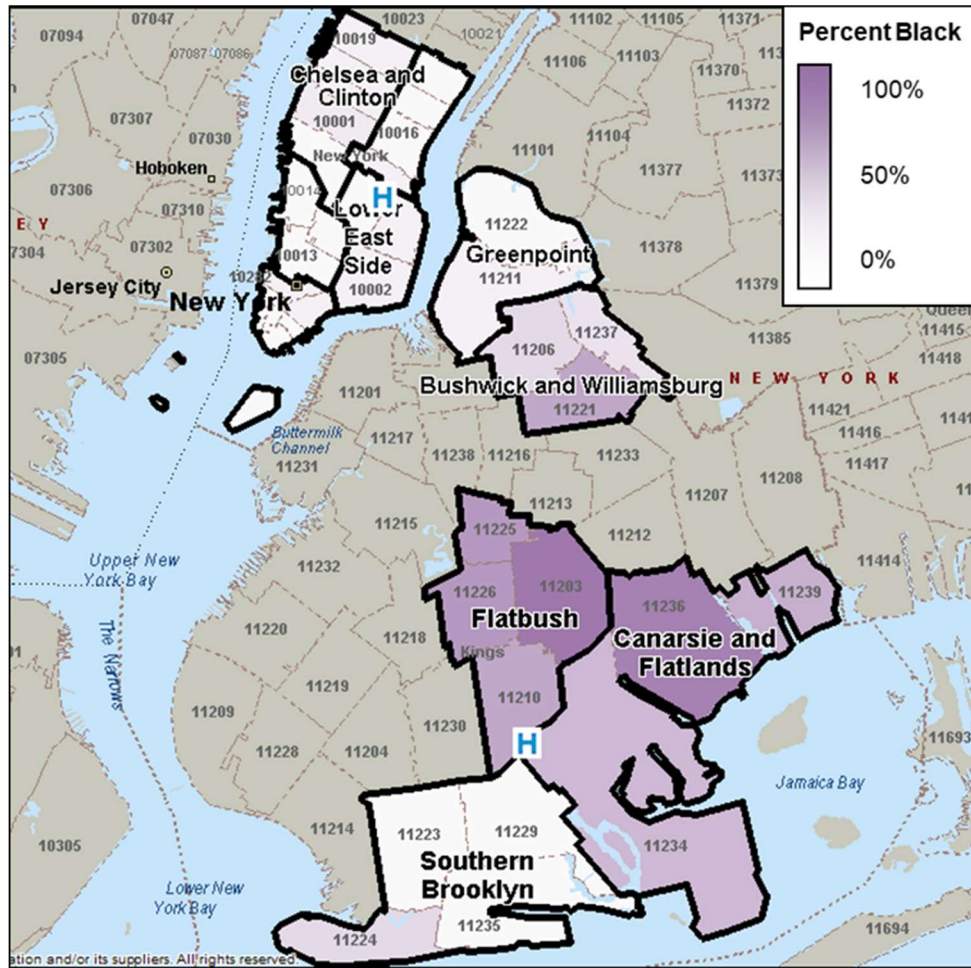
\* “Other Race” includes the following Census-designated race groups: American Indian / Alaska Native, Native Hawaiian / Pacific Islander, and Some Other Race

The MSBI community is very diverse. In 2015, 50.7 percent of the population was White, 28.1 percent was Black, 11.9 percent was Asian, and 17.0 percent was Hispanic (or Latino). Black populations were most prevalent in Brooklyn, and Manhattan had a higher proportion of Asian residents. 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.



The percentage of Black residents is highest in Flatbush, Canarsie & Flatlands, and Bushwick & Williamsburg. Asian residents are most concentrated in Manhattan ZIP Codes, particularly in Lower Manhattan and Lower East Side. Hispanic residents are most concentrated in Bushwick & Williamsburg (**Exhibits 7, 8, and 9**).

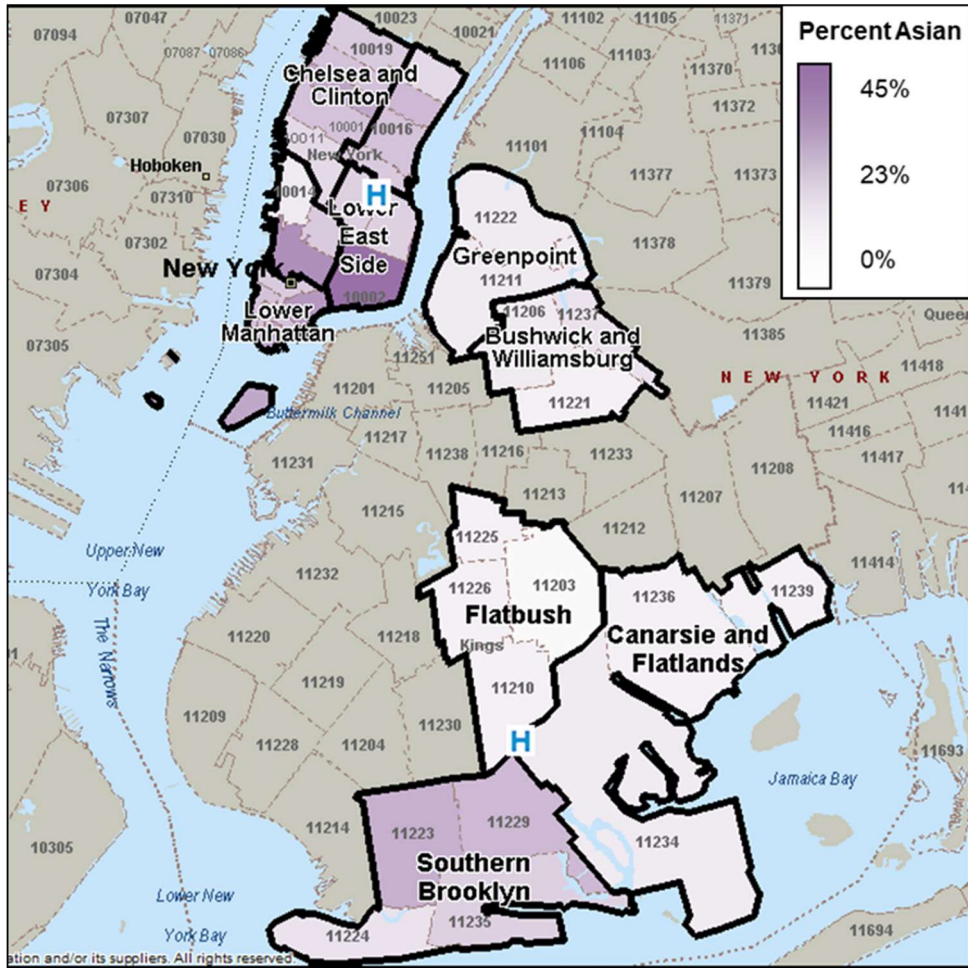
**Exhibit 7: Percent of Population – Black, 2015**



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.

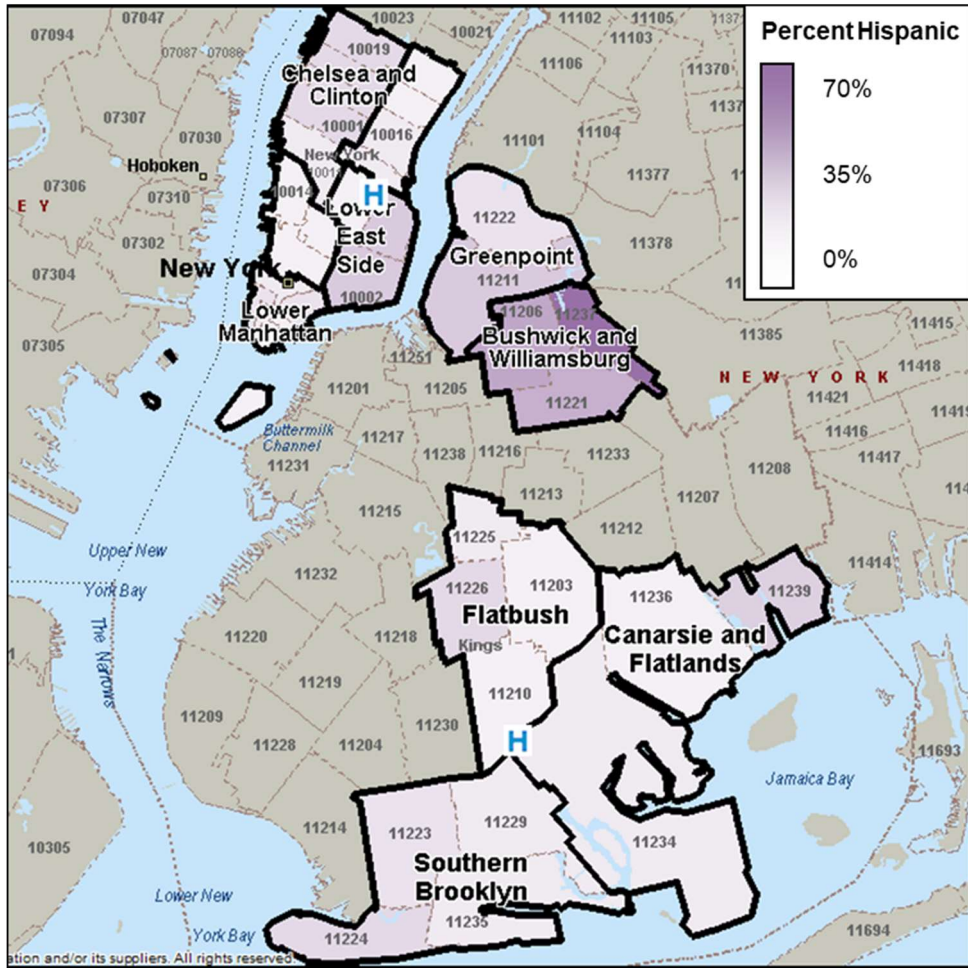
### Exhibit 8: Percent of Population – Asian, 2015



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**

Borough and Neighborhood	Population 25+ without High School Diploma	Population with a Disability	Population Linguistically Isolated
<b>Brooklyn MSBI Community</b>	<b>9.5%</b>	<b>10.1%</b>	<b>22.9%</b>
Bushwick & Williamsburg	16.0%	9.9%	25.4%
Canarsie & Flatlands	7.7%	9.9%	13.8%
Flatbush	8.5%	8.0%	14.0%
Greenpoint	7.6%	6.9%	20.8%
Southern Brooklyn	8.2%	14.1%	38.1%
<b>Manhattan MSBI Community</b>	<b>3.7%</b>	<b>8.7%</b>	<b>13.0%</b>
Chelsea & Clinton	2.8%	8.3%	9.6%
Gramercy Park & Murray Hill	1.7%	7.0%	6.0%
Greenwich Village & Soho	2.6%	6.6%	10.3%
Lower East Side	6.6%	11.9%	21.7%
Lower Manhattan	2.6%	5.8%	10.6%
<b>Total MSBI Community</b>	<b>7.3%</b>	<b>9.6%</b>	<b>19.3%</b>
<b>New York State</b>	<b>7.7%</b>	<b>11.1%</b>	<b>13.5%</b>
<b>United States</b>	<b>7.6%</b>	<b>12.4%</b>	<b>8.6%</b>

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

Key findings include:

- The Brooklyn community compared unfavorably to New York State and the U.S. for the percentage of residents aged 25 and older who did not graduate high school, particularly in Bushwick & Williamsburg.
- The percentage of residents who were linguistically isolated was higher than the state average in every neighborhood in the Brooklyn 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
<b>Brooklyn MSBI Community</b>	<b>1,145,718</b>	<b>8.8%</b>	<b>7.4%</b>	<b>0.9%</b>	<b>0.1%</b>	<b>22.8%</b>	<b>0.2%</b>	<b>40.2%</b>
Bushwick & Williamsburg	222,360	1.6%	4.1%	0.5%	0.1%	22.1%	0.1%	28.5%
Canarsie & Flatlands	207,112	4.1%	3.8%	1.2%	0.0%	32.0%	0.1%	41.2%
Flatbush	302,525	1.4%	2.7%	1.4%	0.0%	40.1%	0.3%	45.9%
Greenpoint	132,935	10.2%	4.1%	0.4%	0.3%	7.6%	0.6%	23.2%
Southern Brooklyn	280,786	25.4%	19.3%	0.8%	0.0%	5.0%	0.0%	50.6%
<b>Manhattan MSBI Community</b>	<b>617,952</b>	<b>6.6%</b>	<b>14.3%</b>	<b>0.6%</b>	<b>0.6%</b>	<b>4.4%</b>	<b>1.0%</b>	<b>27.6%</b>
Chelsea & Clinton	149,683	7.1%	11.2%	0.9%	0.6%	6.2%	1.3%	27.4%
Gramercy Park & Murray Hill	129,167	7.8%	11.0%	0.9%	0.4%	3.3%	0.9%	24.3%
Greenwich Village & Soho	82,305	7.1%	13.1%	0.5%	1.2%	2.5%	1.4%	25.8%
Lower East Side	198,713	4.7%	18.9%	0.4%	0.4%	4.9%	0.8%	30.1%
Lower Manhattan	58,084	8.6%	15.7%	0.6%	0.6%	3.6%	0.7%	29.7%
Total MSBI Community	1,763,670	8.1%	9.8%	0.8%	0.2%	16.3%	0.5%	35.8%
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. Brooklyn had the highest percentage of foreign born residents in the community, at 37.5 percent. Southern Brooklyn and Flatbush in particular had high foreign-born populations, each greater than 45 percent. Manhattan had 28.9 percent of foreign born residents. In both boroughs, the highest percentage of foreign born residents was from Latin America followed by Asia.



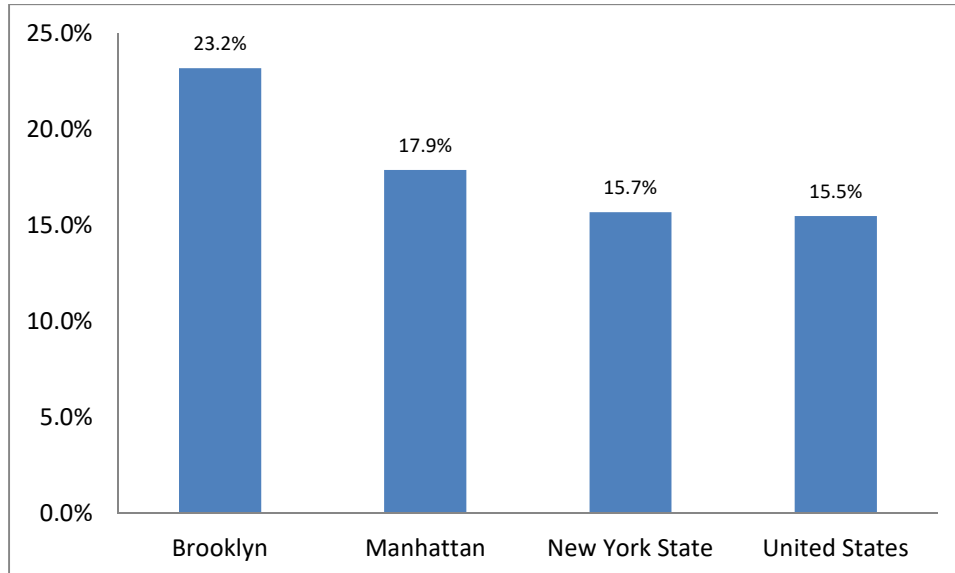
## Economic Indicators

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. Both Brooklyn and Manhattan Boroughs reported higher poverty rates than the New York State and U.S. averages (**Exhibit 12**).

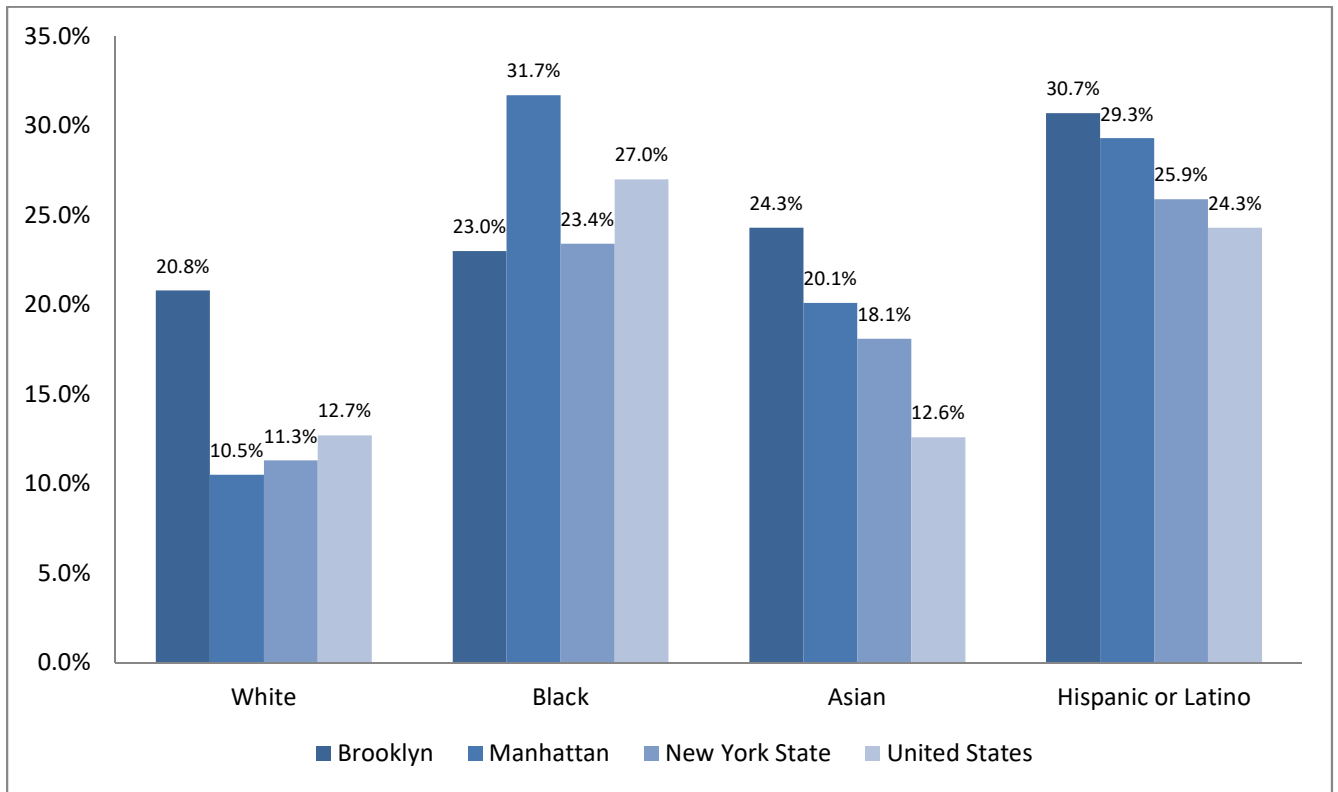
**Exhibit 12: Percent of People in Poverty, 2011-2015**



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

**Exhibit 13** presents poverty rates by race and ethnicity in each borough.

**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 Brooklyn, White, Asian, and Hispanic or Latino populations had higher poverty rates compared to state and national averages. 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. 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 two boroughs in the community in 2015, 27.7 percent of all households in Brooklyn and 21.6 percent of households in Manhattan 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**

Borough and Neighborhood	Occupied Housing Units	Average Median Income	Percent less than \$25,000 per year	Percent less than \$50,000 per year
<b>Brooklyn MSBI Community</b>	417,023	48,496	27.8%	47.7%
Bushwick & Williamsburg	75,025	37,710	35.0%	56.5%
Canarsie & Flatlands	70,989	61,417	20.0%	39.4%
Flatbush	108,514	47,225	24.7%	46.0%
Greenpoint	54,070	59,963	26.3%	42.8%
Southern Brooklyn	108,425	43,054	32.0%	51.0%
<b>Manhattan MSBI Community</b>	317,781	93,178	19.4%	30.0%
Chelsea & Clinton	84,714	95,924	16.6%	27.6%
Gramercy Park & Murray Hill	72,489	109,681	14.1%	24.0%
Greenwich Village & Soho	42,814	105,482	14.5%	24.2%
Lower East Side	90,605	61,605	29.8%	42.7%
Lower Manhattan	27,159	126,503	14.9%	20.8%

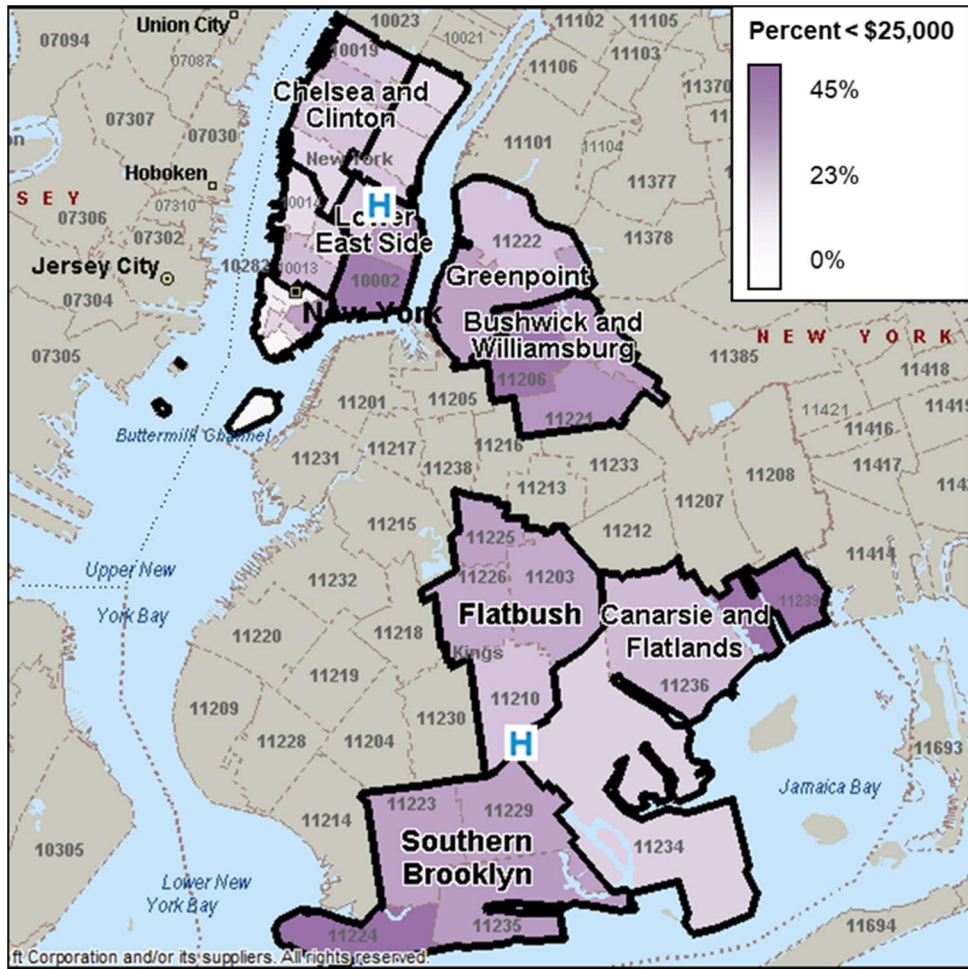
Source: U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

There was significant variation in low-income households among neighborhoods within most boroughs. The percentage of households with incomes below \$25,000 was 29.8 percent in the Lower East Side, for instance, compared to 19.4 percent for the Manhattan MSBI Community. Over 30 percent of households in the Brooklyn neighborhoods of Bushwick & Williamsburg and Southern Brooklyn had incomes less than \$25,000; these areas also had the lowest average household incomes.



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**



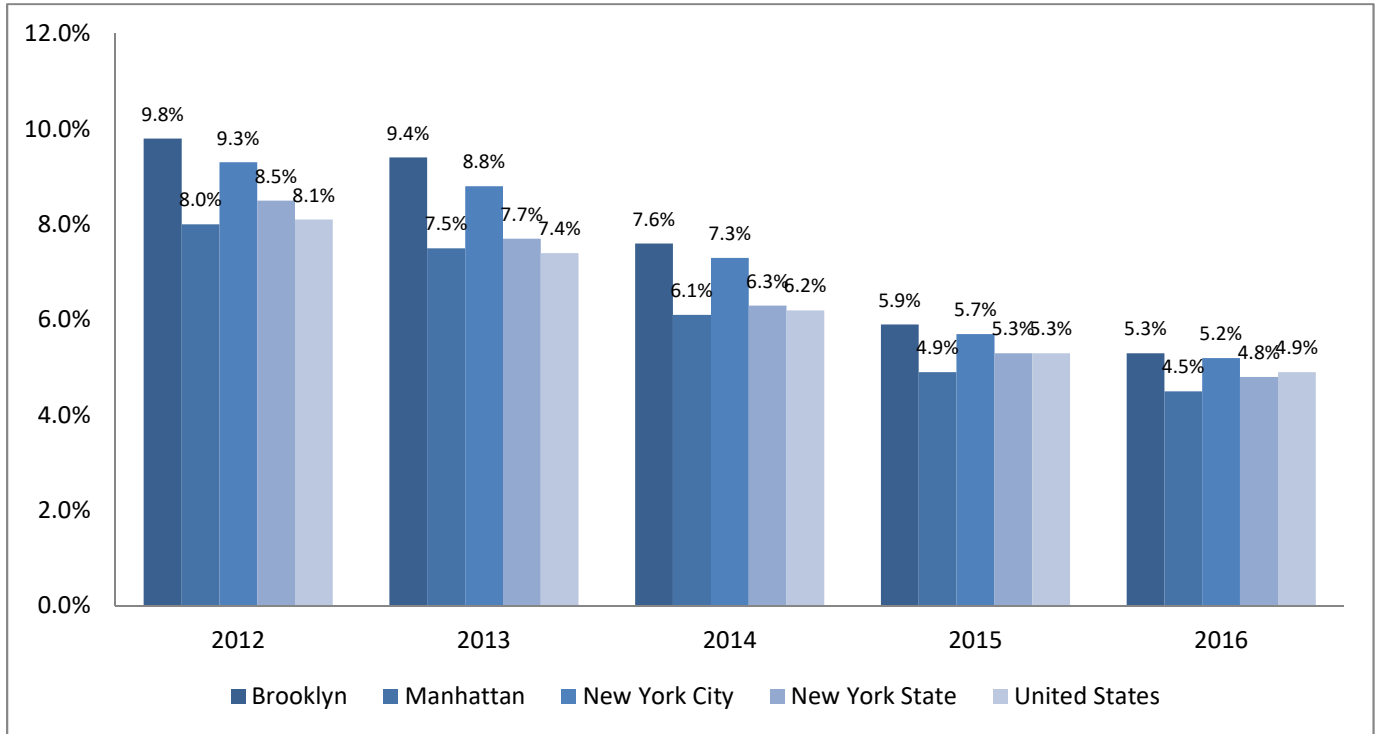
Sources: Microsoft MapPoint and U.S. Census Bureau, ACS 5-year estimates, 2011-2015.

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 each borough in the community, with New York City, New York State, and national averages for comparison.

**Exhibit 16: Unemployment Rates, 2012-2016**

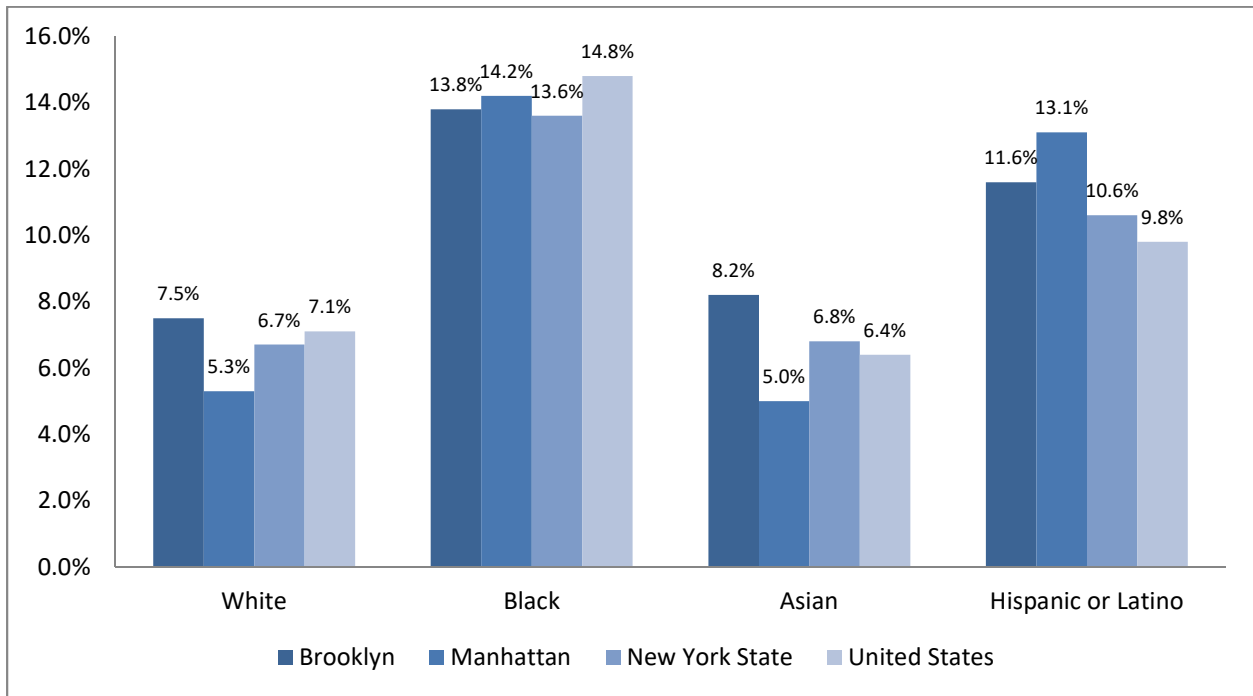


Source: U.S. Bureau of Labor Statistics, 2016.

Brooklyn and New York City as a whole experienced higher unemployment rates than the state and national averages for each year from 2012 through 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. Differences in unemployment rates were most evident in Manhattan. Brooklyn and Manhattan had higher rates of unemployment in the Black and Hispanic population than the state average. The White unemployment rate also was higher than the state and national averages in Brooklyn (**Exhibit 17**).

## Insurance Status

**Exhibit 18** displays the percent of the population in the MSBI community that is uninsured, with New York State and United States averages for comparison. Brooklyn reported a higher rate of uninsured residents than the New York State average.

**Exhibit 18: Uninsured Population, 2011-2015**

Borough and Neighborhood	Uninsured Population
<b>Brooklyn (entire borough)</b>	<b>12.0%</b>
Bushwick & Williamsburg	18.7%
Canarsie & Flatlands	8.9%
Flatbush	12.4%
Greenpoint	12.1%
Southern Brooklyn	9.5%
<b>Manhattan (entire borough)</b>	<b>8.9%</b>
Chelsea & Clinton	7.2%
Gramercy Park & Murray Hill	4.7%
Greenwich Village & Soho	5.3%
Lower East Side	8.6%
Lower Manhattan	5.1%
<b>New York State</b>	<b>9.7%</b>
<b>United States</b>	<b>13.0%</b>

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

The neighborhood of Bushwick & Williamsburg had a higher uninsured rate than both the New York State and United States average. Flatbush and Greenpoint both had higher rates of uninsured than the New York State and Brooklyn average. All Manhattan neighborhoods in the community had lower rates of uninsured residents than the Manhattan, state, and national average.

**Exhibit 19** portrays the distribution of MSBI 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: MSBI Discharges by Neighborhood and Payer, 2016**

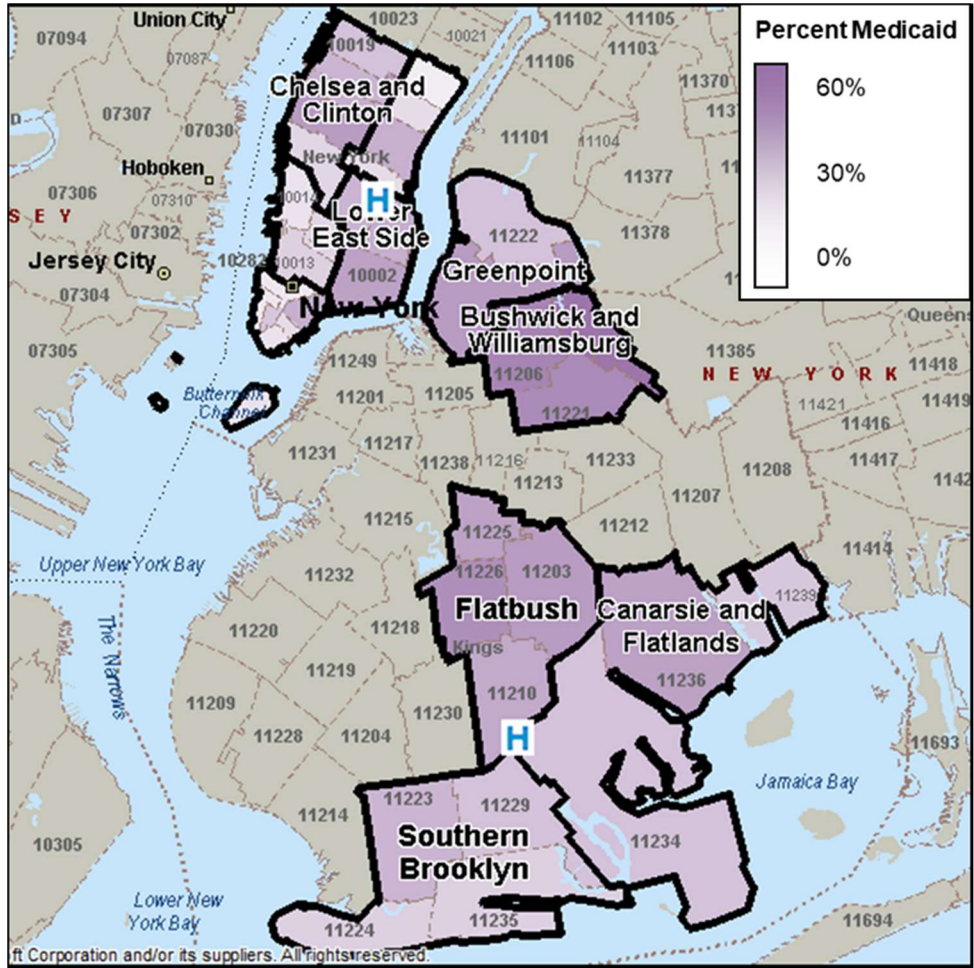
Borough and Neighborhood	Private Insurance	Medicaid	Medicare	Self-Pay	Other
<b>Brooklyn MSBI Community</b>	21.9%	35.8%	31.0%	9.9%	1.5%
Bushwick and Williamsburg	19.3%	49.0%	26.2%	3.2%	2.3%
Canarsie and Flatlands	26.4%	31.2%	36.2%	4.6%	1.6%
Flatbush	21.3%	41.8%	30.6%	4.9%	1.4%
Greenpoint	32.1%	36.8%	26.7%	3.2%	1.1%
Southern Brooklyn	18.8%	22.4%	32.9%	25.0%	0.9%
<b>Manhattan MSBI Community</b>	32.3%	27.0%	35.2%	4.4%	1.0%
Chelsea and Clinton	33.1%	27.7%	34.1%	4.2%	0.9%
Gramercy Park and Murray Hill	35.3%	21.7%	33.8%	7.7%	1.5%
Greenwich Village and Soho	46.3%	15.1%	34.1%	2.9%	1.7%
Lower East Side	21.8%	35.2%	39.2%	3.0%	0.8%
Lower Manhattan	47.5%	20.2%	28.0%	3.7%	0.7%
<b>Total MSBI Community</b>	<b>24.9%</b>	<b>33.2%</b>	<b>32.2%</b>	<b>8.3%</b>	<b>1.4%</b>

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 Manhattan, namely Lower Manhattan and Greenwich Village & Soho. Medicaid discharges were most prevalent in Brooklyn, with Bushwick and Williamsburg and Flatbush each over 40 percent Medicaid discharges. Medicare discharges were more prevalent in the Manhattan community than the Brooklyn community. Self-pay discharges were most concentrated Southern Brooklyn.

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

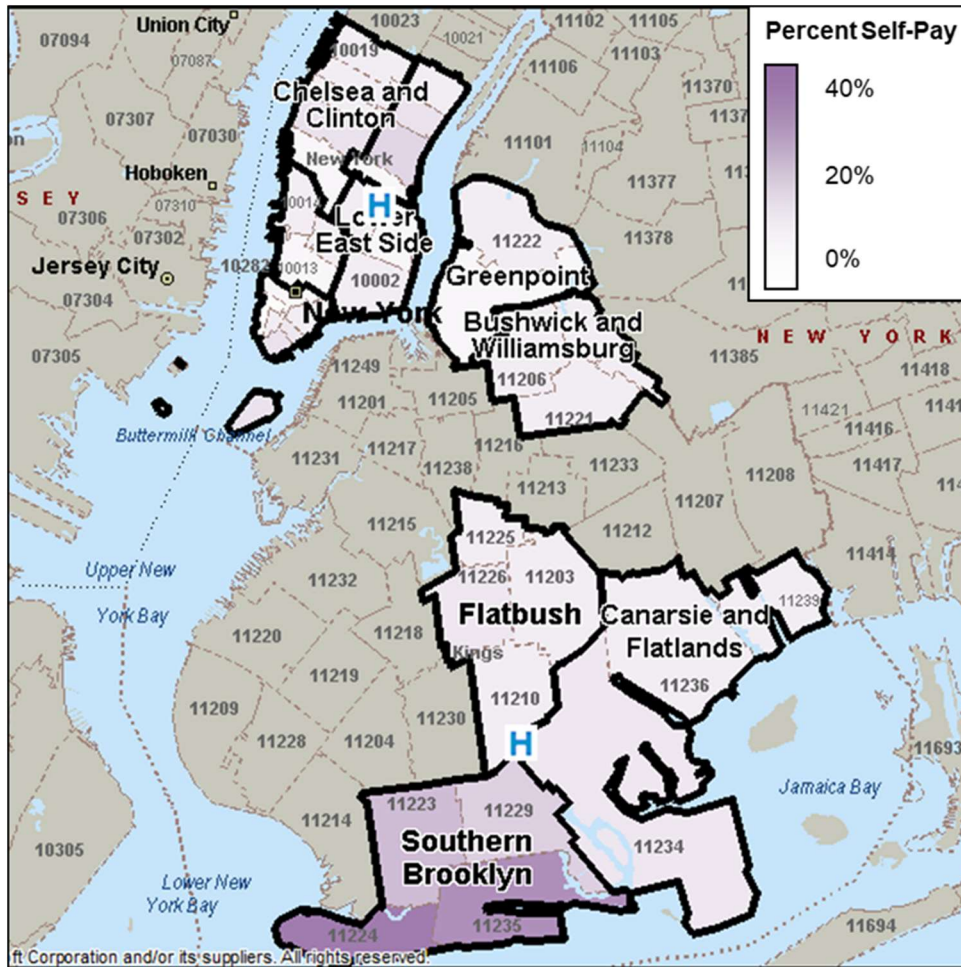
Exhibit 20: Medicaid Discharges by ZIP Code, 2016



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

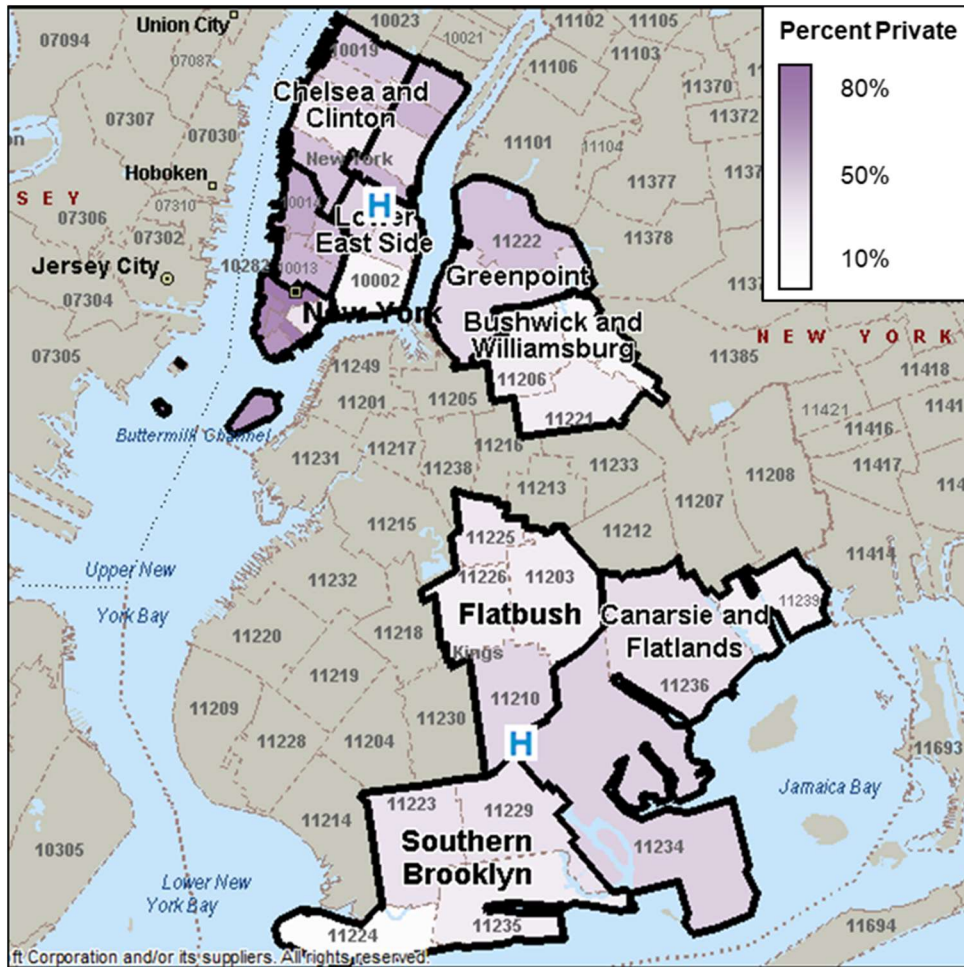


Exhibit 21: Self-Pay Discharges by ZIP Code, 2016



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
<b>Total Violent Crime</b>	<b>585.8</b>	<b>379.7</b>	<b>383.2</b>
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
<b>Total Property Crime</b>	<b>1,518.7</b>	<b>1,604.0</b>	<b>2,487.0</b>
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 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**

Borough	Young Adults - Driving While Intoxicated		Young Adults Arrests - Drug Use/Possession/Sale Arrests		Young Adult Arrests - Property Crimes Arrests	
	Number	Rate	Number	Rate	Number	Rate
Brooklyn	67	3.8	2,436	137.6	1,824	103.0
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
<b>New York State</b>	<b>3,334</b>	<b>21.4</b>	<b>17,155</b>	<b>110.2</b>	<b>19,664</b>	<b>126.3</b>

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.

## 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, with more than 50 percent of these residents living in Brooklyn and Manhattan. **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**

Borough	People in Subsidized Housing	Average Household Income	Spending per Unit per Month		Average Months on Waiting List
			Average Household Contribution	Average Federal Contribution	
Brooklyn	275,367	\$19,820	\$468	\$883	50
Manhattan	181,791	\$21,097	\$483	\$1,010	43
<b>New York State</b>	<b>1,173,703</b>	<b>\$18,350</b>	<b>\$437</b>	<b>\$842</b>	<b>42</b>
<b>United States</b>	<b>9,785,085</b>	<b>\$13,726</b>	<b>\$332</b>	<b>\$687</b>	<b>26</b>

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

Household and federal rent contributions per housing unit were higher in both Brooklyn and Manhattan than the state and U.S. averages. The average months on the wait list for subsidized housing in the two boroughs were 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.<sup>6</sup> 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
<b>Brooklyn</b>					
White	20.8%	64.2%	18.7%	9.0%	34.6%
Black	29.5%	31.9%	8.3%	32.8%	47.9%
Hispanic	27.8%	36.8%	8.7%	28.9%	48.1%
Asian	20.1%	32.5%	2.1%	5.3%	78.3%
Other	41.5%	26.7%	4.6%	39.0%	55.7%
<b>Total</b>	<b>28.2%</b>	<b>35.5%</b>	<b>8.8%</b>	<b>29.3%</b>	<b>48.1%</b>
<b>Manhattan</b>					
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%
<b>Total</b>	<b>23.7%</b>	<b>42.4%</b>	<b>10.7%</b>	<b>23.7%</b>	<b>45.3%</b>
<b>New York City</b>					
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%
<b>Total</b>	<b>27.3%</b>	<b>37.6%</b>	<b>9.5%</b>	<b>27.9%</b>	<b>46.7%</b>

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. In both boroughs, 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 both Brooklyn and Manhattan.

<sup>6</sup> 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** presents additional characteristics of NYCHA residents by borough.

**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
Brooklyn	2.3	\$23,609	21.0
Manhattan	2.2	\$24,639	24.9
<b>New York City</b>	<b>2.3</b>	<b>\$23,672</b>	<b>21.9</b>

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

The average NYCHA family size ranges from 2.2 to 2.3 persons in the community and New York City and average gross income is approximately \$24,000. 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
<b>Surface Areas</b>	<b>3,550</b>	<b>1,221</b>	<b>2,080</b>	<b>-41.4%</b>	<b>70.4%</b>
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%
<b>Subways</b>	<b>845</b>	<b>1,573</b>	<b>1,812</b>	<b>114.4%</b>	<b>15.2%</b>
<b>Total Unsheltered Individuals</b>	<b>4,395</b>	<b>2,794</b>	<b>3,892</b>	<b>-11.4%</b>	<b>39.3%</b>

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 Brooklyn and Manhattan, 1,583 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
<b>New York City</b>	<b>8,537,673</b>	<b>2,838</b>	<b>33.2</b>
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 2017 and FY 2018<sup>7</sup>

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 \$841 million, 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 \$68.2 million, or 3.5 percent;
  - The Office of Temporary and Disability Assistance budget increased \$84 million, or 6.2 percent.

<sup>7</sup> New York State Department of the Budget. (2017). *New York State Budget*. Retrieved 2017, from: [https://openbudget.ny.gov/overview/overview\\_SpendGrowth.html](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.”<sup>8</sup>

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

---

<sup>8</sup> 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 MSBI 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,<sup>9</sup> social and economic factors, and physical environment.<sup>10</sup> *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 whole county, data are labeled with the borough name. Specifically, Kings County corresponds to the borough of Brooklyn and New York County corresponds to the borough of Manhattan.*

---

<sup>9</sup>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.

<sup>10</sup>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	Brooklyn			Manhattan		
	2013	2017	Rank Change	2013	2017	Rank Change
<b>Health Outcomes</b>	49	33		21	11	
<b>Health Factors</b>	59	57		10	11	↓
<b>Length of Life</b>	44	12		9	2	
<b>Quality of Life</b>	58	58		54	52	
Poor physical health days	35	49	↓	27	25	
Poor mental health days	34	36	↓	36	23	
Drug Overdose Deaths	-	4		-	19	
<b>Health Behaviors</b>	13	11		2	3	↓
Adult Smoking	11	8		5	3	
Adult Obesity	7	4		1	1	
Excessive Drinking	8	10	↓	47	62	↓
Sexually Transmitted Infections	61	60		59	61	↓
Teen Births	51	42		32	22	
<b>Clinical Care</b>	58	56		10	6	
Primary Care Physicians	28	28		3	3	
Dentists	18	21	↓	1	1	
Mental Health Providers	21	26	↓	1	1	
Preventable Hospital Stays	40	28		6	3	
Diabetes Monitoring	39	49	↓	61	60	
<b>Social &amp; Economic Factors</b>	61	61		52	44	
Some College	26	23		1	1	
Unemployment	55	40		10	15	↓
Social Associations	56	59	↓	54	13	
Injury Deaths	3	2		1	4	↓
<b>Physical Environment</b>	49	57	↓	1	55	↓
Air pollution - particulate matter	51	58	↓	48	62	↓
Severe Housing Problems	-	61		-	58	

Source: County Health Rankings, 2017 and 2013.

In 2017, Brooklyn ranked in the bottom 50<sup>th</sup> percentile among New York counties for 15 of the 27 indicators assessed. Of those 15 indicators ranking in the bottom 50<sup>th</sup> percentile, 11 of them ranked in the bottom quartile, including Health Factors Index, Quality of Life, Clinical Care, Social and Economic Factors, and Physical Environment. Rankings for 9 indicators fell between 2013 and 2017.

Manhattan ranked in the bottom 50<sup>th</sup> percentile among New York counties for 8 of the 27 indicators assessed. Of those 8 indicators ranking in the bottom 50<sup>th</sup> percentile, 7 of them ranked in the bottom quartile, including Quality of Life and Physical Environment. Rankings for 8 indicators fell between the time periods.

**Exhibit 29B** provides data for each underlying indicator of the composite categories in the County Health Rankings.<sup>11</sup> 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.

---

<sup>11</sup>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](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	Brooklyn	Manhattan	New York State	U.S.
<b>Health Outcomes</b>					
Length of Life	Years of potential life lost before age 75 per 100,000 population	5,371.1	4,165.3	5,339.1	6,600.0
Quality of Life	Percent of adults reporting fair or poor health	17.1%	15.2%	16.2%	15.0%
	Average number of physically unhealthy days reported in past 30 days	3.9	3.6	3.8	3.6
	Average number of mentally unhealthy days reported in past 30 days	3.8	3.7	3.7	3.7
	Percent of live births with low birthweight (<2500 grams)	8.2%	8.6%	8.1%	8.0%
<b>Health Factors</b>					
<b>Health Behaviors</b>					
Adult Smoking	Percent of adults that report smoking >= 100 cigarettes and currently smoking	13.8%	11.9%	15.2%	18.0%
Adult Obesity	Percent of adults that report a BMI >= 30	22.7%	14.7%	24.6%	28.0%
Food Environment Index	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	6.8	7.8	8.0	7.3
Physical Inactivity	Percent of adults aged 20 and over reporting no leisure-time physical activity	25.9%	17.5%	24.0%	22.0%
Access to Exercise Opportunities	Percent of population with adequate access to locations for physical activity	96.8%	98.4%	90.7%	84.0%
Alcohol Impaired Driving Deaths	Percent of driving deaths with alcohol involvement	13.1%	7.9%	23.0%	30.0%
Excessive Drinking	Binge plus heavy drinking	17.7%	23.8%	18.2%	18.0%
STDs	Chlamydia rate per 100,000 population	686.1	771.8	502.8	456.1
Teen Births	Teen birth rate per 1,000 female population, ages 15-19	25.9	18.7	21.1	32.0
<b>Clinical Care</b>					
Uninsured	Percent of population under age 65 without health insurance	12.4%	8.9%	10.1%	14.0%
Primary Care Physicians	Ratio of population to primary care physicians	1602:1	723:1	1199:1	1,320:1
Dentists	Ratio of population to dentists	1656:1	579:1	1275:1	1,520:1
Mental Health Providers	Ratio of population to mental health providers	573:1	137:1	417:1	500:1
Preventable Hospital Stays	Hospitalization rate for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	50.4	35.4	47.6	50.0
Diabetic Screening	Percent of diabetic Medicare enrollees that receive HbA1c monitoring	85.0%	81.1%	85.9%	85.0%
Mammography Screening	Percent of female Medicare enrollees, ages 67-69, that receive mammography screening	57.7%	60.1%	62.1%	63.0%

Indicator Category	Data	Brooklyn	Manhattan	New York State	U.S.
<b>Health Factors (continued)</b>					
<b>Social &amp; Economic Factors</b>					
High School Graduation	Percent of ninth-grade cohort that graduates in four years	68.8%	69.6%	79.3%	83.0%
Some College	Percent of adults aged 25-44 years with some post-secondary education	63.9%	83.3%	66.7%	64.0%
Unemployment	Percent of population age 16+ unemployed but seeking work	5.9%	4.8%	5.3%	5.3%
Children in poverty	Percent of children under age 18 in poverty	31.5%	24.9%	22.3%	21.0%
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	6.4	8.8	5.7	5.0
Children in single-parent households	Percent of children that live in a household headed by single parent	38.3%	41.8%	34.9%	34.0%
Social Associations	Number of associations per 10,000 population	4.6	13.1	7.9	9.4
Violent Crime	Number of reported violent crime offenses per 100,000 population	620.9	621.1	394.1	380.0
Injury Deaths	Injury mortality per 100,000	32.3	33.1	44.0	62.0
<b>Physical Environment</b>					
Air Pollution	The average daily measure of fine particulate matter in micrograms per cubic meter (PM2.5) in a county	10.2	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	34.7%	25.4%	24.3%	19.0%
Drive Alone to Work	Percent of the workforce that drives alone to work	18.6%	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	55.2%	64.9%	36.3%	34.0%

Source: County Health Rankings, 2017

Both Brooklyn and Manhattan were more than fifty percent worse than state averages in violent crime and long commuters driving alone. Brooklyn compared unfavorably to state averages for nearly every indicator under health outcomes, clinical care, social and economic factors, and physical environment. Additionally, Manhattan had high rates of income inequality and chlamydia.

## 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
Brooklyn	182.7	140.8	19.7	5.9	26.3	18.2	19.7	24.8	138.8	5.0
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
<b>New York State</b>	<b>171.0</b>	<b>145.9</b>	<b>24.9</b>	<b>2.8</b>	<b>17.8</b>	<b>27.9</b>	<b>25.6</b>	<b>16.7</b>	<b>180.2</b>	<b>8.3</b>

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

Brooklyn, Manhattan, and New York City as a whole were more than 50 percent worse than the state for AIDS mortality. Brooklyn also had higher rates of heart disease, pneumonia, and diabetes deaths. Manhattan had higher rates of suicide.

### Exhibit 31: Cancer Indicators, 2013-2014

Indicator	Brooklyn	Manhattan	New York City	New York State
<b>All cancers</b>				
Incidence per 100,000	448.6	503.3	470.0	550.9
Mortality rate per 100,000	149.5	155.3	151.1	180.7
<b>Lip, oral cavity, and pharynx cancer</b>				
Incidence per 100,000	9.3	11.4	10.1	12.1
Mortality rate per 100,000	2.6	2.8	2.4	2.5
<b>Colon and rectum cancer</b>				
Incidence per 100,000	43.1	38.3	42.7	46.7
Mortality rate per 100,000	16.3	13.8	15.8	16.6
<b>Lung and bronchus cancer</b>				
Incidence per 100,000	48.2	55.2	51.3	69.6
Mortality rate per 100,000	32.3	34.3	33.4	46.4
<b>Female breast cancer</b>				
Incidence per 100,000	121.2	147.7	128.8	149.1
Mortality rate per 100,000	25.0	24.4	23.9	26.3
<b>Cervix uteri cancer</b>				
Incidence per 100,000	10.7	7.3	9.8	8.3
Mortality rate per 100,000	3.2	2.6	3.1	2.7
<b>Ovarian cancer</b>				
Incidence per 100,000	12.3	15.3	13.3	14.9
Mortality rate per 100,000	7.5	9.0	8.1	9.5
<b>Prostate cancer</b>				
Incidence per 100,000	134.9	145.0	141.4	156.7
Mortality rate per 100,000	18.5	19.7	18.0	18.3
<b>Melanoma cancer mortality</b>				
Mortality rate per 100,000	1.4	1.7	1.4	2.5
<b>Screenings</b>				
% 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)	77.3	70.5	74.9	77.8

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

Overall, Brooklyn and Manhattan compared favorably to the state for cancer incidence and mortality indicators. Cervical cancer incidence and mortality were issues in Brooklyn and New York City. Mammography screening was also problematic across the two boroughs and city.



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
<b>Brooklyn</b>				
White	56.2	13.8	22.0	1.9
Black	43.9	19.0	28.6	4.8
Asian/Pacific	59.6	12.1	8.9	-
Hispanic	32.6	16.8	18.9	3.8
Total	49.0	15.9	22.8	3.1
<b>Manhattan</b>				
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
<b>New York City</b>				
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
<b>New York State</b>				
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.

Colorectal, breast, and cervix uteri cancer mortality rates were high for Brooklyn overall. Cervix uteri cancer mortality was high for Manhattan overall. Black, Asian/Pacific, and Hispanic populations in both Brooklyn and Manhattan had higher rates of cancer for several indicators. White populations had higher rates of breast cancer mortality in Brooklyn and 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
Brooklyn	195.1	18.9	175.9	5.5
Manhattan	142.7	18.0	122.1	5.3
New York City	184.2	19.7	164.2	5.3
<b>New York State</b>	<b>180.1</b>	<b>25.6</b>	<b>140.7</b>	<b>12.2</b>

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

Brooklyn compared most unfavorably, with indicators for all diseases of the heart and coronary heart disease benchmarking worse than the state. These two indicators were also higher across New York City compared to state averages.

**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
<b>Brooklyn</b>					
White	202.7	14.6	183.6	5.8	13.5
Black	205.7	22.7	184.1	5.5	42.7
Asian/Pacific	91.5	19.7	83.4	2.0	12.7
Hispanic	171.6	20.3	154.8	5.3	31.6
Total	195.1	18.9	175.9	5.5	25.4
<b>Manhattan</b>					
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
<b>New York City</b>					
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
<b>New York State</b>					
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.

The diabetes mortality rate for Hispanic residents in Brooklyn was more than 50 percent worse than the state average for that population group. Heart diseases, including coronary heart disease, were problematic across the entire Brooklyn and New York City populations. Among racial and ethnic cohorts in Manhattan, the Black population in Manhattan exhibited the highest mortality rates for all indicators. Black and Hispanic populations typically had higher diabetes mortality rates than White populations.

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	Brooklyn	Manhattan	New York City	New York State
% of pregnant women in WIC who were pre-pregnancy overweight or obese (BMI 25 or higher)	45.4%	46.7%	48.1%	50.8%
% obese (95th percentile or higher) children in WIC (ages 2-4 years)	12.4%	12.8%	13.7%	14.3%
% of WIC mothers breastfeeding at 6 months	52.1%	39.4%	46.1%	38.2%
Age-adjusted % of adults overweight or obese (BMI 25 or higher) (2013-2014)	58.6%	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)	27.9%	22.1%	28.2%	27.1%
Age-adjusted % of adults with physician-diagnosed diabetes (2013-2014)	13.3%	7.9%	11.6%	8.9%
Age-adjusted cardiovascular disease mortality rate per 100,000	242.6	184.4	227.4	228.0
Age-adjusted cerebrovascular disease (stroke) mortality rate per 100,000	19.5	19.3	19.9	26.2
Mortality rate per 100,000	25.5	15.4	20.6	17.6

Source: New York State Department of Health, 2017.

Manhattan compared favorably to the state for obesity-related indicators. Brooklyn exhibited higher rates than state averages for several indicators, including physical activity, diabetes, and cardiovascular disease.

**Exhibit 36** presents communicable disease incidence rates for the MSBI community.

**Exhibit 36: Communicable Disease Indicators, 2011-2014**

Indicator	Brooklyn	Manhattan	New York City	New York State
Pertussis incidence per 100,000	2.5	3.6	3.3	8.8
Mumps incidence per 100,000	0.3	0.5	0.3	0.2
H. influenza incidence per 100,000	1.5	1.9	1.7	1.7
Hepatitis A incidence per 100,000	0.8	0.9	0.8	0.7
Acute hepatitis B incidence per 100,000	0.7	1.0	0.9	0.6
Tuberculosis incidence per 100,000	7.9	6.2	8.0	4.5
Salmonella incidence per 100,000	15.1	12.6	13.7	12.9
Shigella incidence per 100,000	8.6	5.8	5.3	4.8
% of adults 65 years and older with flu shot in last year (2013-2014)	55.9%	56.7%	59.2%	72.4%
% of adults 65 years and older who ever received pneumonia shot	44.6%	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.

Both boroughs in the community compared unfavorably in the incidence rates of mumps, hepatitis A and B, tuberculosis, shigella, and flu and pneumonia vaccinations. Brooklyn compared particularly unfavorably for tuberculosis and shigella. Manhattan had high rates of mumps and hepatitis B.

**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	Brooklyn	Manhattan	New York City	New York State
Male	1,262.8	2,541.8	1,532.5	811.1
Female	581.1	518.3	563.5	313.4
White	286.9	1,058.8	530.3	193.6
Black	1,654.6	3,358.2	1,908.3	1,527.3
Hispanic	1,198.3	1,748.1	1,290.8	1,068.6
Asian/Pacific Islander	81.8	236.8	107.9	89.0
Native American	128.9	630.9	210.8	92.6
Total	922.0	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 both Brooklyn and Manhattan for the male, black, and Hispanic cohorts.

As illustrated in **Exhibit 38**, Brooklyn, 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
<b>Brooklyn</b>				
Male	548	239	40.3	18.3
Female	136	102	9.5	7.6
White	91	24	8.8	2.4
Black	381	230	44.4	27.1
Hispanic	179	74	31.4	14.7
Asian/Pacific Islander	6	2	1.5	0.4
Native American	-	-	-	-
Total	684	341	24.2	12.7
<b>Manhattan</b>				
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
<b>New York City</b>				
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
<b>New York State</b>				
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 Brooklyn and Manhattan.

**Exhibit 39: Respiratory-Related Indicators, 2011-2013**

Indicator	Brooklyn	Manhattan	New York City	New York State
Age-adjusted CLRD mortality rate per 100,000	19.3	18.1	20.6	30.7
Asthma hospitalization rate per 10,000	28.2	20.8	27.8	18.2
Ages 0-4 years	63.1	56.1	73.8	50.5
Ages 5-14 years	31.4	32.3	35.5	20.5
Ages 0-17 years	38.7	38.1	43.9	26.6
Ages 5-64 years	21.0	15.1	20.9	13.8
Ages 15-24 years	10.4	9.2	11.3	6.8
Ages 25-44 years	10.2	6.6	10.7	8.6
Ages 45-64 years	36.0	26.2	32.5	19.7
Ages 65 years or older	56.2	41.0	48.6	29.4
Age-adjusted asthma mortality rate per 100,000	2.1	1.9	2.0	1.3
Age-adjusted % of adults with current asthma (2013-2014)	7.9	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, particularly in Brooklyn. Brooklyn's asthma hospitalization and mortality rates were more than 50 percent worse than the New York State average from 2011-2013. Asthma hospitalization and mortality rates in Manhattan were higher than the state rates.



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
<b>Brooklyn</b>				
White	7.0	5.8	19.6	18.6
Black	46.0	76.5	17.8	58.4
Asian/Pacific	5.0	4.7	13.8	9.7
Hispanic	37.6	37.3	22.0	50.5
Total	27.0	38.1	19.0	39.4
<b>Manhattan</b>				
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
<b>New York City</b>				
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
<b>New York State</b>				
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 both Brooklyn and Manhattan. Non-White populations in Manhattan chronic lower respiratory disease mortality rates were higher than the state. In Brooklyn, non-White populations' chronic lower respiratory disease hospitalizations 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**
Brooklyn	10.5%	7.8%	6.0%	3.9	50.8
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

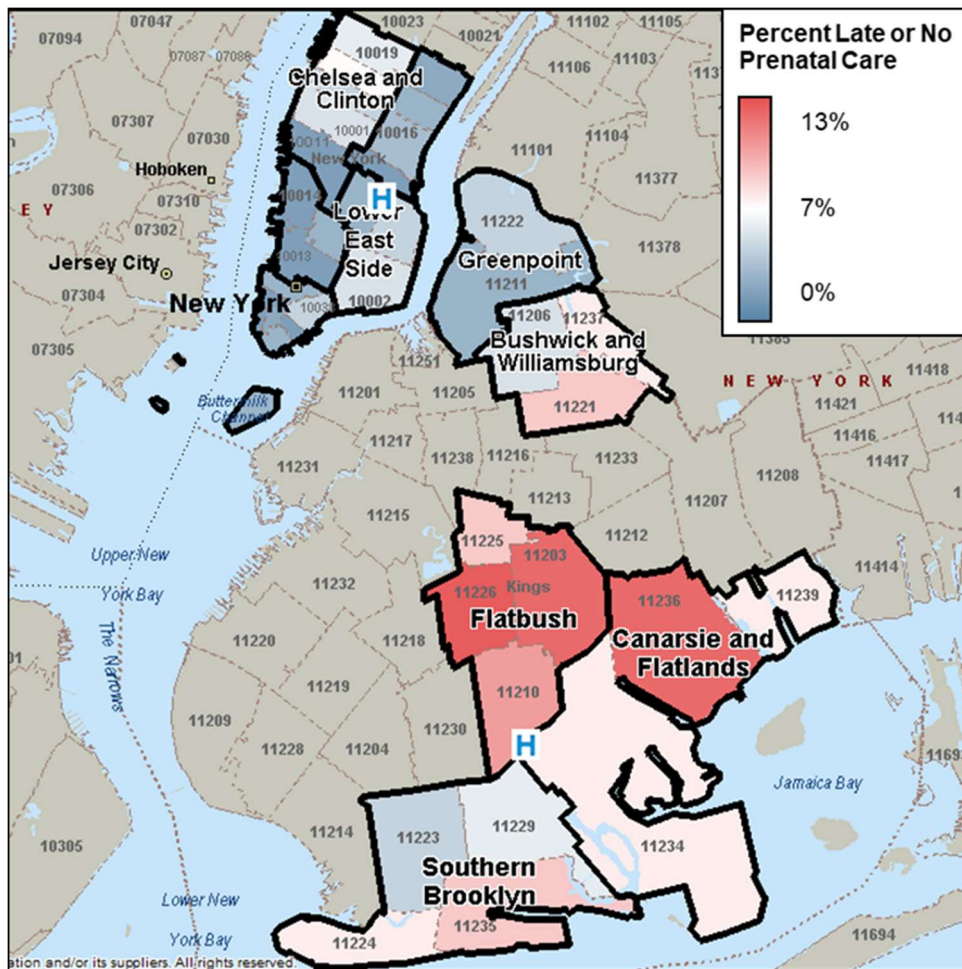
\*\*Teen pregnancy rates are per 1,000 females ages 15-19

Teen pregnancy (ages 15-19) rates were higher in Brooklyn, Manhattan, and New York City, compared to the state. Low birth weight averages were higher in Manhattan and New York City, as was late or prenatal care in Brooklyn and New York City, compared to the state.



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**

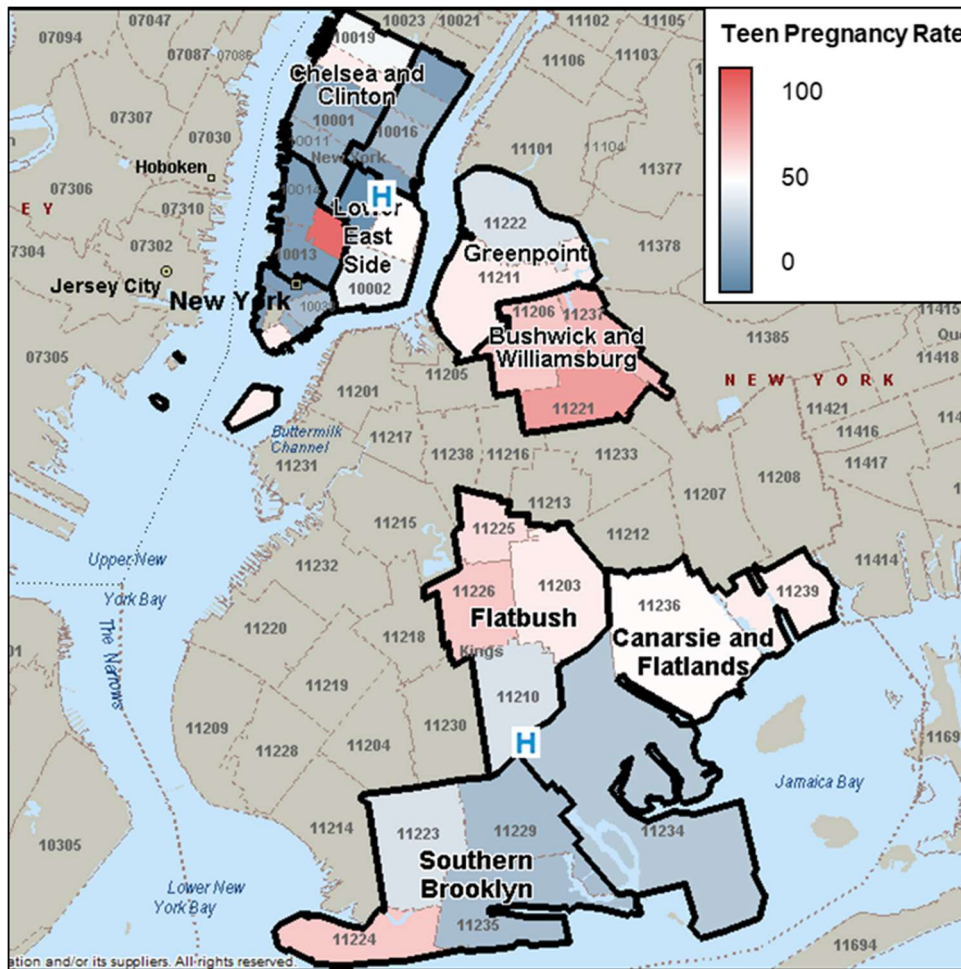


Sources: Microsoft MapPoint and New York State Department of Health, 2017.

Brooklyn neighborhoods Flatbush and Canarsie & Flatlands experienced high rates of mothers who received 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 10012 in Greenwich Village & Soho exhibited the highest teen pregnancy rate of 90 cases per 1,000 females ages 15-19. Bushwick & Williamsburg (Brooklyn) ZIP Codes 11221 and 11237 also had high rates of teen pregnancy, each over 68 cases per 1,000.



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 (1 <sup>st</sup> 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
<b>Brooklyn</b>						
White	79.1%	73.7%	7.4%	5.4%	4.6	2.4
Black	65.9%	61.6%	15.8%	12.4%	44.1	6.7
Asian/Pacific	76.5%	75.5%	8.9%	6.9%	1.8	1.7
Hispanic	71.7%	71.4%	12.0%	7.6%	40.0	3.8
Total	74.0%	70.5%	10.5%	7.8%	28.3	3.9
<b>Manhattan</b>						
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
<b>New York City</b>						
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
<b>New York State</b>						
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 Brooklyn and Manhattan benchmarked well to state averages for maternal and infant health indicators with the exception of teen pregnancy in both boroughs and low birthweight births in Manhattan. 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
<b>Borough</b>			
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%
<b>Race / Ethnicity</b>			
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%
<b>Education</b>			
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%
<b>New York City Total</b>	<b>9.8%</b>	<b>92.1%</b>	<b>2.0%</b>

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 Brooklyn and 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
<b>Brooklyn</b>				
White	2.8	20.5	18.3	6.7
Black	4.2	16.4	26.2	2.9
Asian/Pacific	3.8	9.9	2.1	4.1
Hispanic	4.5	20.0	25.8	4.1
Total	3.7	18.0	23.3	4.8
<b>Manhattan</b>				
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
<b>New York City</b>				
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
<b>New York State</b>				
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 Brooklyn and 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. Across the entire community, the drug-related hospitalization rates for the Black and Hispanic populations were higher than other cohorts. Although the boroughs 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 nationwide comparisons. **Exhibit 48** compares the prevalence of various indicators for Brooklyn, 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		Brooklyn	Manhattan	NYC	NYS	U.S.
Alcohol or Tobacco Use	Binge Drinking (5 or More Drinks in the Past Month)	5.2%	12.0%	8.5%	<b>15.6%</b>	<b>17.7%</b>
	Consumed At Least One Alcoholic Drink in the Past Month	17.7%	26.3%	20.9%	<b>29.7%</b>	<b>32.8%</b>
	Smoking in the Past Month	5.9%	5.3%	5.8%	<b>8.8%</b>	<b>10.8%</b>
Asthma	Ever Been Told They Have Asthma	20.4%	26.6%	24.2%	<b>25.6%</b>	<b>22.8%</b>
General Physical or Mental Health	Attempted Suicide One or More Times During the Past 12 Months	7.1%	8.2%	8.3%	<b>9.9%</b>	<b>8.6%</b>
	Felt Sad (Every Day for 2 weeks) & Stopped Regular Activities due to Sadness	29.2%	29.8%	29.4%	<b>28.6%</b>	<b>29.9%</b>
Physical Activity	Not Physically Active for 60 Minutes Per Day for 7 Days Per Week	21.2%	19.6%	20.5%	<b>18.8%</b>	<b>14.3%</b>
	Three or More Hours of Leisure Computer Use Per Day on School Days	47.3%	42.6%	45.6%	<b>37.2%</b>	<b>41.7%</b>
	Three or More Hours of TV Per Day on School Days	30.6%	26.4%	28.9%	<b>24.2%</b>	<b>24.7%</b>
Sexual Behavior and Orientation	Ever Had Sexual Intercourse	25.5%	29.5%	27.2%	<b>30.4%</b>	<b>41.2%</b>
	No Method of Contraception	16.9%	17.1%	17.7%	<b>15.1%</b>	<b>13.8%</b>
Substance Abuse	Cocaine Use During Lifetime	3.7%	4.4%	4.4%	<b>7.6%</b>	<b>5.2%</b>
	Heroin Use During Lifetime	2.0%	2.3%	2.5%	<b>4.8%</b>	<b>2.1%</b>
	Marijuana Use in the Past Month	14.1%	21.6%	15.9%	<b>19.3%</b>	<b>21.7%</b>
Violence	Experienced sexual dating violence	11.1%	11.6%	11.4%	<b>14.7%</b>	<b>10.6%</b>
	Experienced physical dating violence	12.7%	11.3%	12.0%	<b>11.5%</b>	<b>9.6%</b>
Weight and Nutrition	One or More Sugary Drinks Consumed in the Past 7 Days	73.0%	67.4%	71.0%	<b>65.9%</b>	<b>73.8%</b>
	Overweight or Obese	26.4%	28.7%	27.9%	<b>27.0%</b>	<b>29.9%</b>

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.

Both boroughs and New York City exhibited comparatively high percentages of youth who felt sad and stopped regular activities due to sadness, physical activity, time spent on the computer and television, and sugary drink consumption. Both boroughs also compared unfavorably in youth using methods of contraception during sexual activity.

### **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 borough's baseline data to the 2017 target.

Brooklyn and Manhattan both had a large number of indicators that were worse than the 2017 target. Both boroughs 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 to White non-Hispanic percentage of unintended pregnancies; and
- Ratio of Hispanic to White non-Hispanic percentage of unintended pregnancies.

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

Prevention Agenda 2013-2017 Priority Areas and Indicators	Data Year(s)	Brooklyn	Manhattan	New York City	New York State	NYS Target
<b>Improve Health Status and Reduce Health Disparities</b>						
Percentage of premature deaths (before age 65 years)	2015	27.9%	22.0%	26.4%	23.3%	<b>21.8%</b>
Premature deaths: Ratio of Black non-Hispanics to White non-Hispanics	2013-2015	2.0	1.9	2.1	1.9	<b>1.9</b>
Premature deaths: Ratio of Hispanics to White non-Hispanics	2013-2015	2.0	1.6	2.0	1.9	<b>1.9</b>
Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	2014	147.5	111.0	138.7	119.5	<b>122.0</b>
Preventable hospitalizations: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	2.2	4.8	2.4	2.2	<b>1.9</b>
Preventable hospitalizations: Ratio of Hispanics to White non-Hispanics	2012-2014	1.8	2.8	1.7	1.4	<b>1.4</b>
Percentage of adults (aged 18-64) with health insurance	2015	87.0%	91.0%	-	89.8%	<b>100.0%</b>
Age-adjusted percentage of adults who have a regular health care provider - Aged 18+ years	2012	81.4%	82.4%	81.7%	82.0%	<b>90.8%</b>
<b>Promote a Healthy and Safe Environment</b>						
Rate of hospitalizations due to falls per 10,000 - Aged 65+ years	2014	156.4	180.7	175.3	183.6	<b>204.6</b>
Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years	2014	406.6	429.6	437.0	440.1	<b>429.1</b>
Assault-related hospitalization rate per 10,000 population	2012-2014	5.7	4.8	5.9	3.6	<b>4.3</b>
Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	5.4	11.3	11.5	7.0	<b>6.7</b>
Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics	2012-2014	2.9	4.2	4.0	3.2	<b>2.8</b>
Assault-related hospitalization: Ratio of low-income ZIP Codes to non-low-income ZIP Codes	2012-2014	1.8	2.7	2.4	3.3	<b>2.9</b>
Percentage of employed civilian workers age 16 and over who use alternate modes of transportation to work or work from home	2011-2015	80.4%	90.2%	76.3%	46.1%	<b>49.2%</b>
Percentage of residents served by community water systems with optimally fluoridated water	2016	100.0%	100.0%	100.0%	71.1%	<b>78.5%</b>

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)	Brooklyn	Manhattan	New York City	New York State	NYS Target
<b>Prevent Chronic Diseases</b>						
Percentage of adults who are obese	2012	26.8%	14.5%	24.1%	25.0%	23.2%
Percentage of children and adolescents who are obese	2012-2013	21.2%	18.8%	21.4%	21.4%	19.7%
Percentage of cigarette smoking among adults	2012	16.1%	15.6%	15.6%	15.2%	12.3%
Asthma emergency department visit rate per 10,000 population	2014	131.5	121.0	135.3	86.2	75.1
Asthma emergency department visit rate per 10,000 - Aged 0-4 years	2014	229.7	278.1	301.9	205.7	196.5
Age-adjusted heart attack hospitalization rate per 10,000 population	2014	14.5	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	3.3	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	7.6	5.7	7.2	6.6	4.9
<b>Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections</b>						
Percentage of adults with flu immunization - Aged 65+ years	2012	55.9%	69.2%	61.8%	59.7%	70.0%
Newly diagnosed HIV case rate per 100,000 population	2013-2015	28.3	41.3	29.7	15.9	16.1
Difference in rates (Black and White) of newly diagnosed HIV cases	2013-2015	42.5	54.1	38.0	36.1	46.8
Difference in rates (Hispanic and White) of newly diagnosed HIV cases	2013-2015	22.9	26.8	22.0	23.1	26.6
Gonorrhea case rate per 100,000 women - Aged 15-44 years	2015	249.2	177.9	222.8	201.8	183.4
Gonorrhea case rate per 100,000 men - Aged 15-44 years	2015	540.5	1050.4	594.0	377.6	199.5
Chlamydia case rate per 100,000 women - Aged 15-44 years	2015	1822.0	1552.3	1873.5	1575.7	1458.0
Primary and secondary syphilis case rate per 100,000 men	2015	30.1	69.0	35.9	20.3	10.1
Primary and secondary syphilis case rate per 100,000 women	2015	1.4	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)	Brooklyn	Manhattan	New York City	New York State	NYS Target
<b>Promote Healthy Women, Infants, and Children</b>						
Percentage of preterm births	2015	10.0%	10.4%	10.5%	10.5%	10.2%
Premature births: Ratio of Black non-Hispanics to White non-Hispanics	2013-2015	2.2	1.5	1.8	1.7	1.4
Premature births: Ratio of Hispanics to White non-Hispanics	2013-2015	1.7	1.1	1.4	1.3	1.1
Premature births: Ratio of Medicaid births to non-Medicaid births	2013-2015	1.1	1.1	1.0	1.1	1.0
Maternal mortality rate per 100,000 births	2013-2015	20.1	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	73.1%	72.3%	73.5%	72.0%	76.9%
Percentage of children (aged under 19 years) with health insurance	2015	97.6%	97.6%	-	97.4%	100.0%
Adolescent pregnancy rate per 1,000 females - Aged 15-17 years	2014	23.3	26.4	25.3	17.0	25.6
Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics	2012-2014	9.7	4.8	6.0	5.3	4.9
Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics	2012-2014	8.8	2.8	5.3	4.7	4.1
Percentage of unintended pregnancy among live births	2015	19.9%	16.5%	21.9%	23.7%	23.8%
Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic	2015	4.3	4.3	3.6	2.2	1.9
Unintended pregnancy: Ratio of Hispanics to White non-Hispanics	2015	3.3	3.7	2.9	1.7	1.4
Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births	2015	1.7	3.0	1.8	1.8	1.5
<b>Promote Mental Health and Prevent Substance Abuse</b>						
Age-adjusted percentage of adult binge drinking during the past month	2012	16.4%	26.2%	19.6%	17.8%	18.4%
Age-adjusted suicide death rate per 100,000 population	2013-2015	4.9	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 borough and neighborhood. Data are shaded based on the key below.

**Exhibit 50A** summarizes access indicators for MSBI 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
<b>Brooklyn overall</b>	<b>15.7%</b>	<b>28.9%</b>	<b>14.3%</b>	<b>12.3%</b>	<b>10.2%</b>	<b>17.2%</b>
Greenpoint	23.6%	37.5%	16.9%	8.6%	15.5%	18.0%
Flatbush	14.4%	24.4%	14.5%	14.3%	6.7%	14.6%
Canarsie & Flatlands	14.2%	19.5%	11.5%	8.5%	8.7%	9.7%
Southern Brooklyn	10.9%	32.3%	14.4%	11.3%	11.6%	10.6%
Bushwick & Williamsburg	20.0%	36.7%	14.6%	10.4%	15.1%	20.1%
<b>Manhattan overall</b>	<b>19.7%</b>	<b>17.9%</b>	<b>14.9%</b>	<b>9.9%</b>	<b>10.4%</b>	<b>16.3%</b>
Upper East Side and Gramercy Park & Murray Hill	22.1%	6.8%	13.4%	7.8%	9.3%	18.7%
Chelsea & Clinton and Greenwich Village & Soho	20.0%	17.2%	15.6%	12.2%	10.6%	18.4%
Lower East Side and Lower Manhattan	18.2%	21.7%	17.3%	5.2%	6.9%	11.4%
<b>New York City</b>	<b>18.0%</b>	<b>25.8%</b>	<b>15.0%</b>	<b>12.6%</b>	<b>9.9%</b>	<b>23.0%</b>

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

Overall, residents of Manhattan MSBI Neighborhoods were more likely to experience a wait of four or more days a PCP visit, although residents Greenpoint were most likely to experience such a wait. The percentage of residents with Medicaid was higher than the New York City percentage for all Brooklyn MSBI neighborhoods, except for Flatbush. Residents of Greenpoint and the Lower East Side and Lower Manhattan were most likely to have Medicare than other neighborhoods. Residents of Flatbush were more likely to be uninsured than the residents of New York City overall. Residents of Greenpoint and Bushwick & Williamsburg were most likely to not receive medical care. Residents of the MSBI community were more likely to have a PCP than residents of New York City overall.

**Exhibit 50B** summarizes chronic conditions within MSBI neighborhoods.

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

Borough and Neighborhood	Ever Had High Blood Pressure	Ever Told You Have Diabetes	Overweight or Obese
<b>Brooklyn overall</b>	<b>30.5%</b>	<b>12.4%</b>	<b>58.7%</b>
Greenpoint	22.3%	9.4%	52.4%
Flatbush	34.8%	13.7%	69.0%
Canarsie & Flatlands	38.5%	13.9%	65.1%
Southern Brooklyn	30.7%	13.7%	55.9%
Bushwick & Williamsburg	31.8%	15.0%	62.0%
<b>Manhattan overall</b>	<b>23.8%</b>	<b>9.0%</b>	<b>47.1%</b>
Upper East Side and Gramercy Park & Murray Hill	21.4%	4.1%	41.9%
Chelsea & Clinton and Greenwich Village & Soho	16.8%	4.8%	39.2%
Lower East Side and Lower Manhattan	23.1%	9.3%	35.4%
<b>New York City</b>	<b>28.8%</b>	<b>11.6%</b>	<b>57.2%</b>

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

Overall, residents of Manhattan MSBI Neighborhoods were more likely to have been told of high blood pressure, except for residents of Greenpoint. Residents of Bush & Williamsburg were most likely to have been told of diabetes, with nearly one in six informed of this condition. Over half of New York City residents are overweight or obese, with the highest rate in the MSBI community for residents of Flatbush, at nearly 70 percent.

Exhibit 50C summarizes health behaviors within MSBI 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**
<b>Brooklyn overall</b>	<b>15.8%</b>	<b>14.8%</b>	<b>27.3%</b>	<b>22.9%</b>	<b>13.7%</b>
Greenpoint	21.0%	20.7%	22.1%	8.2%	9.4%
Flatbush	13.2%	9.4%	27.1%	33.6%	24.8%
Canarsie & Flatlands	13.9%	8.0%	23.6%	22.5%	19.7%
Southern Brooklyn	10.0%	18.4%	31.6%	18.5%	9.2%
Bushwick & Williamsburg	17.3%	18.0%	30.3%	28.0%	19.2%
<b>Manhattan overall</b>	<b>26.5%</b>	<b>13.2%</b>	<b>18.0%</b>	<b>17.4%</b>	<b>9.5%</b>
Upper East Side and Gramercy Park & Murray Hill	36.2%	10.2%	12.4%	14.3%	6.5%
Chelsea & Clinton and Greenwich Village & Soho	25.4%	13.2%	15.8%	13.1%	9.2%
Lower East Side and Lower Manhattan	25.3%	17.0%	20.2%	12.6%	7.0%
<b>New York City</b>	<b>17.2%</b>	<b>14.3%</b>	<b>25.5%</b>	<b>23.7%</b>	<b>12.1%</b>

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

Overall, residents of Manhattan MSBI Neighborhoods were more likely to report binge drinking, with more than one-third of Upper East Side and Gramercy Park & Murray Hill residents reporting binge drinking. The highest rate of reported current smoking was in Greenpoint, with more than one in five residents reporting smoking. Nearly one in four New York City residents did not exercise in the past 30 days, with even higher non-exercise rates for residents of Flatbush, Southern Brooklyn, and Bushwick & Williamsburg. The highest rate of sugary beverage consumption was reported by residents of Flatbush, where more than one-third reported such consumption. Residents of Flatbush also were most likely to forego consumption of fruits and vegetables, where nearly one in four reported zero fruit and vegetable consumption.

**Exhibit 50D** summarizes mental health indicators within MSBI neighborhoods.

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

Borough and Neighborhood	Serious Psychological Distress	Did not Receive Mental Health Treatment
<b>Brooklyn overall</b>	<b>6.1%</b>	<b>54.9%</b>
Greenpoint	3.0%	-
Flatbush	6.1%	79.1%
Canarsie & Flatlands	6.0%	36.1%
Southern Brooklyn	10.1%	36.8%
Bushwick & Williamsburg	8.0%	58.5%
<b>Manhattan overall</b>	<b>5.1%</b>	<b>56.8%</b>
Upper East Side and Gramercy Park & Murray Hill	3.7%	-
Chelsea & Clinton and Greenwich Village & Soho	4.8%	29.5%
Lower East Side and Lower Manhattan	5.9%	55.2%
<b>New York City</b>	<b>5.4%</b>	<b>45.9%</b>

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

Overall, more than one in twenty residents of New York City reported conditions considered to be consistent with serious psychological distress, with more than one in residents of Southern Brooklyn reporting such conditions. Of these residents, nearly half did not receive mental health services, with residents of Bushwick & Williamsburg least likely to receive treatment.

## Ambulatory Care Sensitive Conditions

This section examines the frequency of discharges for Ambulatory Care Sensitive Conditions (ACSCs) from MSBI'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.”<sup>12</sup> 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 MSBI community that were for ACSCs, by payer.

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

Borough and Neighborhood	Private	Medicaid	Medicare	Self-Pay	Other	Total
<b>Brooklyn MSBI Neighborhoods</b>	<b>6.8%</b>	<b>8.9%</b>	<b>17.2%</b>	<b>10.4%</b>	<b>4.4%</b>	<b>12.1%</b>
Bushwick and Williamsburg	6.4%	8.9%	18.7%	7.8%	1.1%	11.8%
Canarsie and Flatlands	6.7%	10.2%	17.1%	12.6%	4.2%	12.6%
Flatbush	6.6%	8.9%	17.1%	11.4%	7.7%	11.8%
Greenpoint	2.9%	5.3%	17.5%	7.7%	4.2%	9.3%
Southern Brooklyn	5.5%	7.6%	16.4%	6.7%	0.9%	11.9%
<b>Manhattan MSBI Neighborhoods</b>	<b>4.3%</b>	<b>6.9%</b>	<b>13.4%</b>	<b>4.8%</b>	<b>4.3%</b>	<b>8.9%</b>
Chelsea and Clinton	3.5%	7.1%	12.1%	3.7%	1.8%	8.1%
Gramercy Park and Murray Hill	2.5%	5.0%	11.3%	4.0%	4.0%	6.8%
Greenwich Village and Soho	2.8%	3.7%	11.9%	3.0%	6.5%	7.0%
Lower East Side	4.4%	6.8%	15.2%	6.5%	5.9%	10.2%
Lower Manhattan	2.2%	9.7%	15.3%	2.3%	0.0%	8.7%
<b>Grand Total</b>	<b>4.9%</b>	<b>8.0%</b>	<b>16.0%</b>	<b>7.5%</b>	<b>3.9%</b>	<b>10.8%</b>

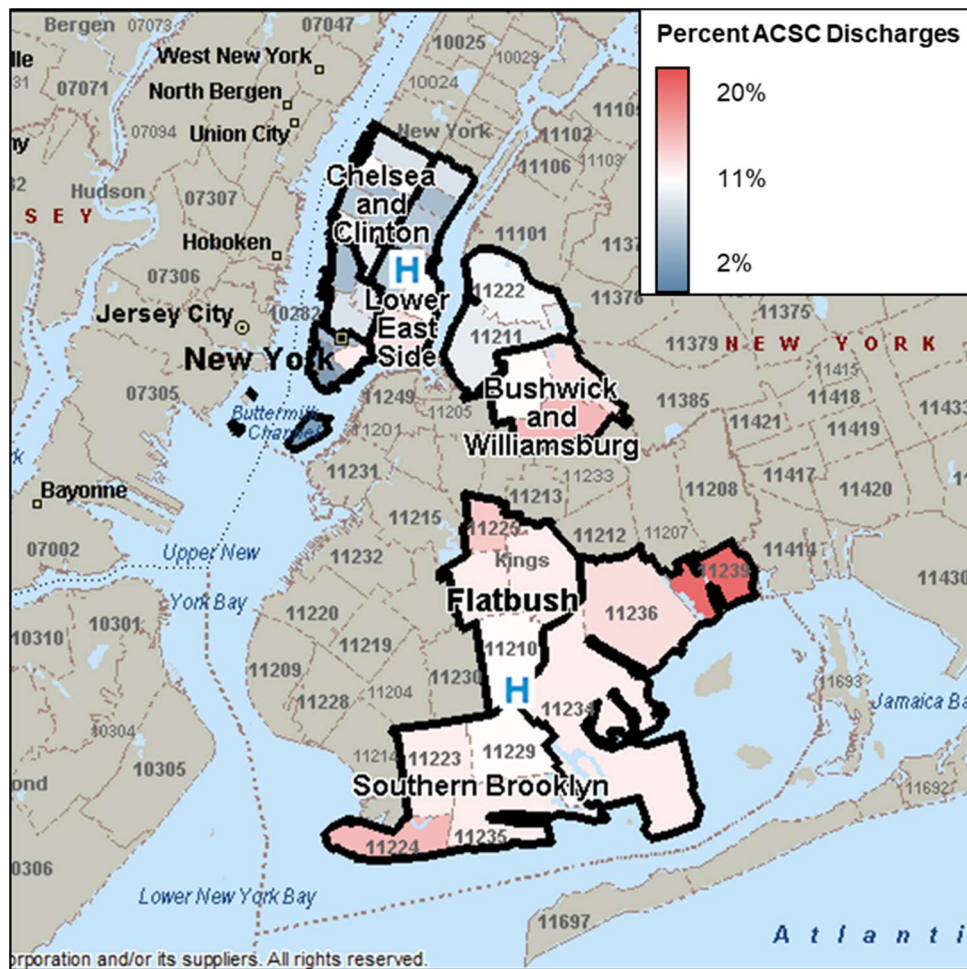
Source: DataGen, a HANYS solutions company, 2017.

The table indicates that 10.8 percent of discharges in the community were for ACSCs in 2016. Medicare patients and patients from Brooklyn neighborhoods in the community had the highest proportions of discharges for ACSCs.

<sup>12</sup>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 Brooklyn, particularly in ZIP Codes 11239 (Canarsie & Flatlands), 11224 (Southern Brooklyn), and 11221 (Bushwick and Williamsburg), all with rates over 14 percent.

In Manhattan, the highest rates were in Lower East Side ZIP Code 10002 and in Lower Manhattan ZIP Code 10038.

## ACSC Conditions Analysis

**Exhibit 53** displays the frequency and percentage of all hospital discharges of residents in the MSBI 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 MSBI 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%	1.7%	27.1%	71.2%	4,956
COPD or asthma in older adults	0.0%	0.0%	45.0%	55.0%	3,170
Bacterial pneumonia	0.0%	8.3%	30.2%	61.5%	1,843
Urinary tract infection	0.0%	7.2%	16.6%	76.3%	1,691
Dehydration	0.0%	8.5%	23.2%	68.2%	1,351
Diabetes long-term complication	0.0%	7.2%	52.6%	40.3%	1,170
Perforated appendix	0.0%	55.8%	31.5%	12.7%	946
Pediatric asthma	0.0%	31.0%	34.2%	34.8%	928
Diabetes short-term complication	0.0%	6.8%	33.2%	60.0%	843
Uncontrolled diabetes	100.0%	0.0%	0.0%	0.0%	811
Hypertension	0.0%	8.5%	34.9%	56.6%	708
Asthma in younger adults	0.0%	100.0%	0.0%	0.0%	222
Pediatric gastroenteritis	100.0%	0.0%	0.0%	0.0%	211
Pediatric perforated appendix	100.0%	0.0%	0.0%	0.0%	197
Pediatric urinary tract infection	100.0%	0.0%	0.0%	0.0%	71
Pediatric diabetes short-term complications	100.0%	0.0%	0.0%	0.0%	69

Source: DataGen, a HANYS solutions company, 2017.

The top five ACSC conditions in the MSBI 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.<sup>13</sup> 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.

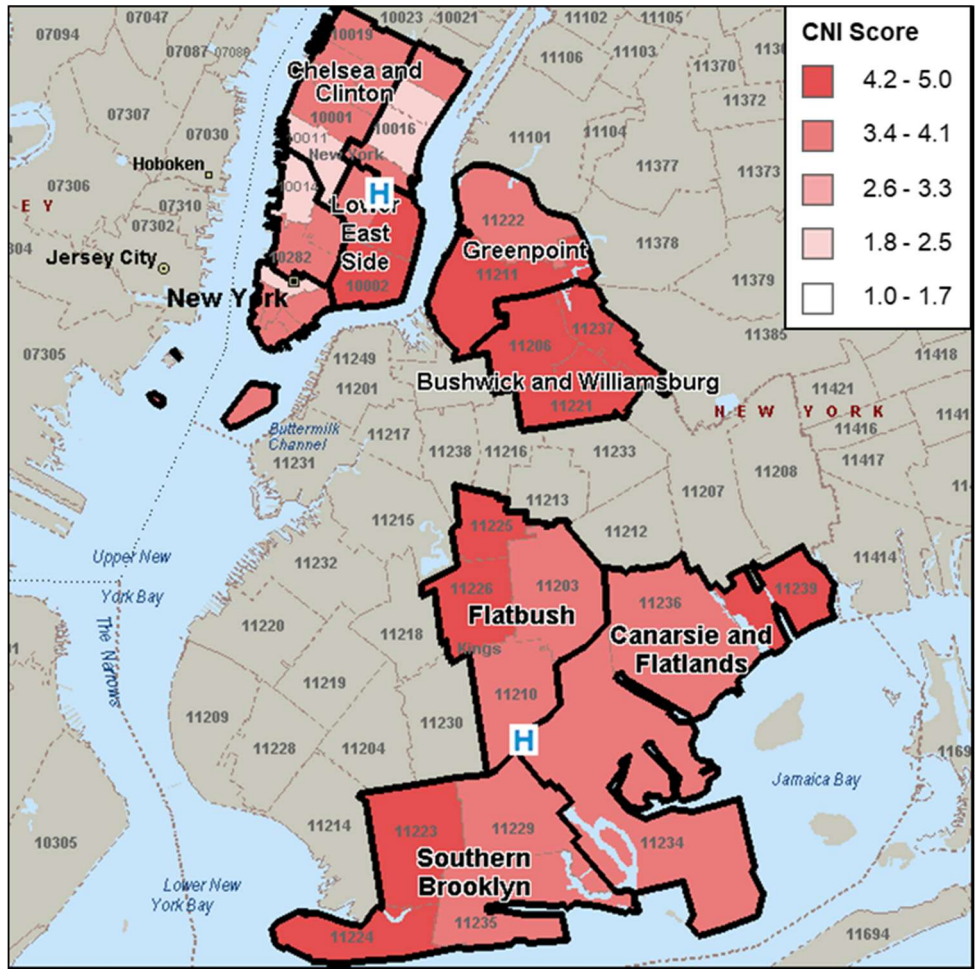
The *Community Need Index*™ calculates a score for each ZIP Code based on these indicators. Scores range from “Lowest Need” (1.0-1.7) to “Highest Need” (4.2-5.0).

---

<sup>13</sup>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 MSBI community.

**Exhibit 54: Community Need Index™ Score by ZIP Code**



Sources: Microsoft MapPoint and Dignity Health, 2017.

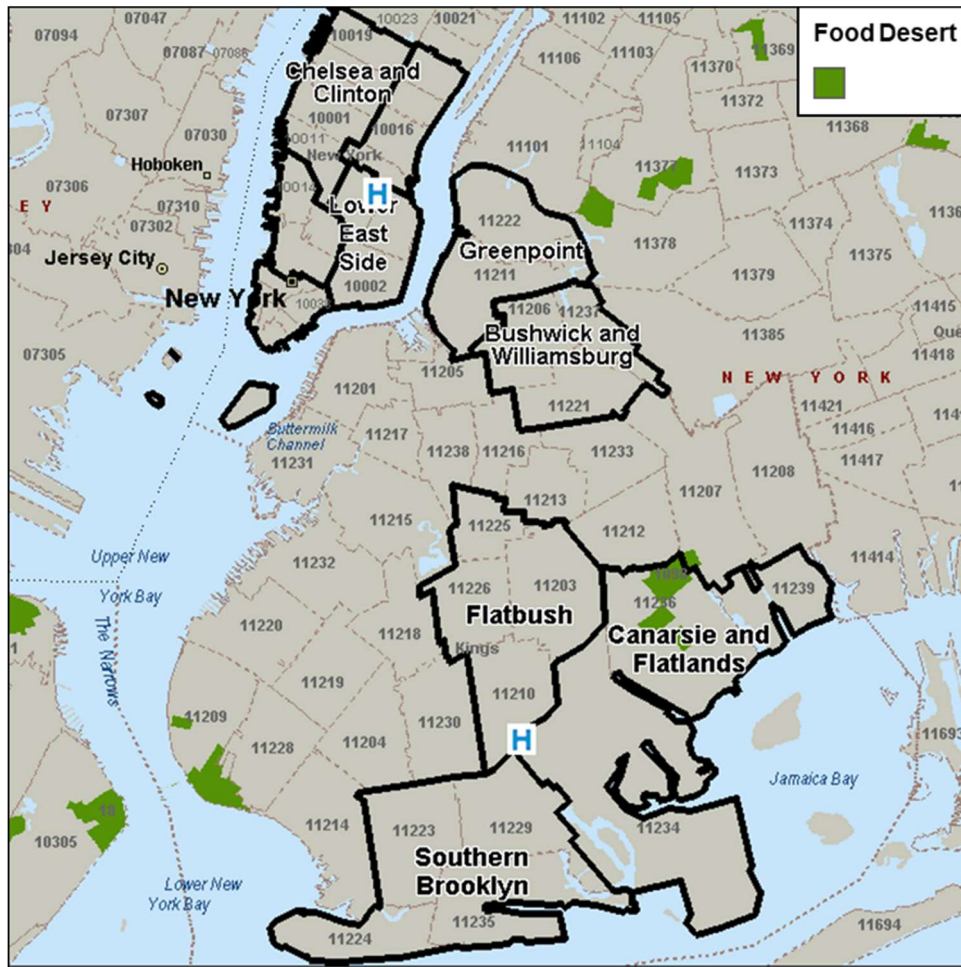
A large portion of the community ranked in the “Highest Need” category. ZIP Codes in the Lower East Side, Bushwick & Williamsburg, Canarsie & Flatlands, and Southern Brooklyn demonstrated the highest need.

## 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 MSBI community.

**Exhibit 55: Food Deserts by Census Tract, 2015**



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

Food deserts are present in Canarsie & Flatlands (Brooklyn) within the MSBI 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.<sup>14</sup>

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.”<sup>15</sup>

**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 Bushwick and Williamsburg, Chelsea and Clinton, and the Lower East Side.

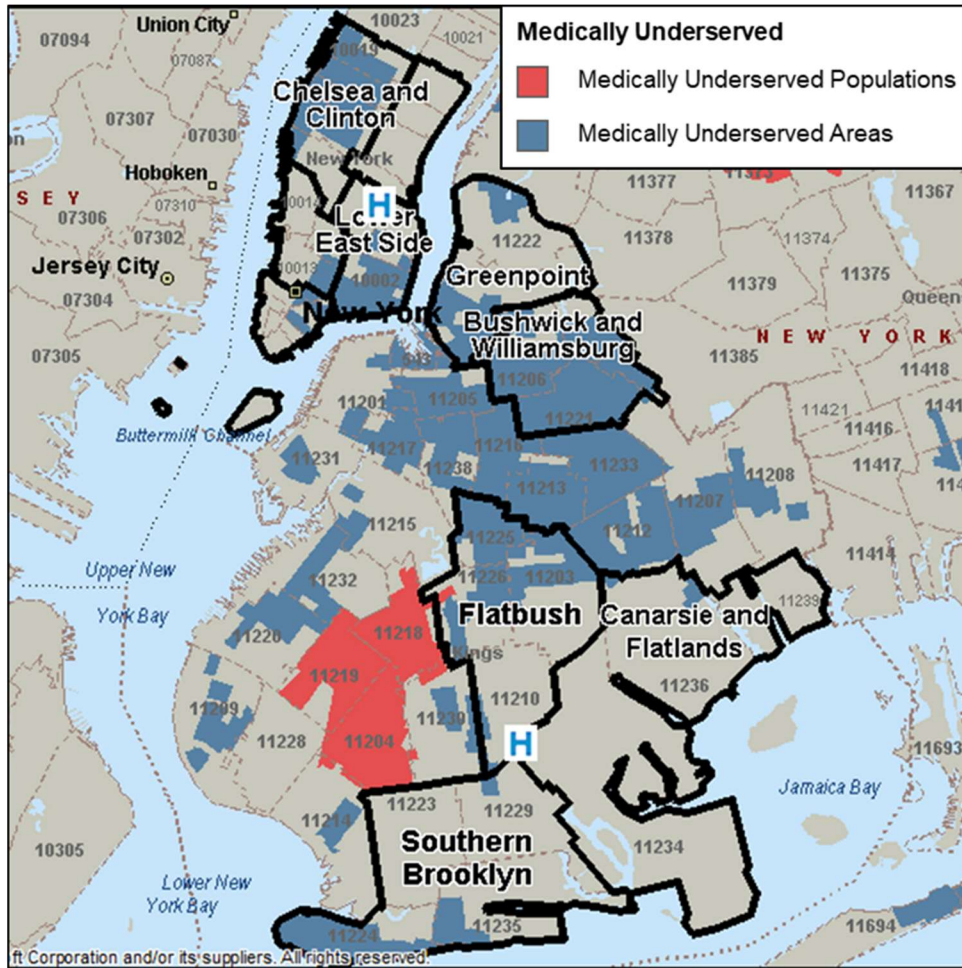
---

<sup>14</sup> 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>.

<sup>15</sup> *Ibid.*



**Exhibit 56: Location of Federally Designated Areas and Populations in the MSBI 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.

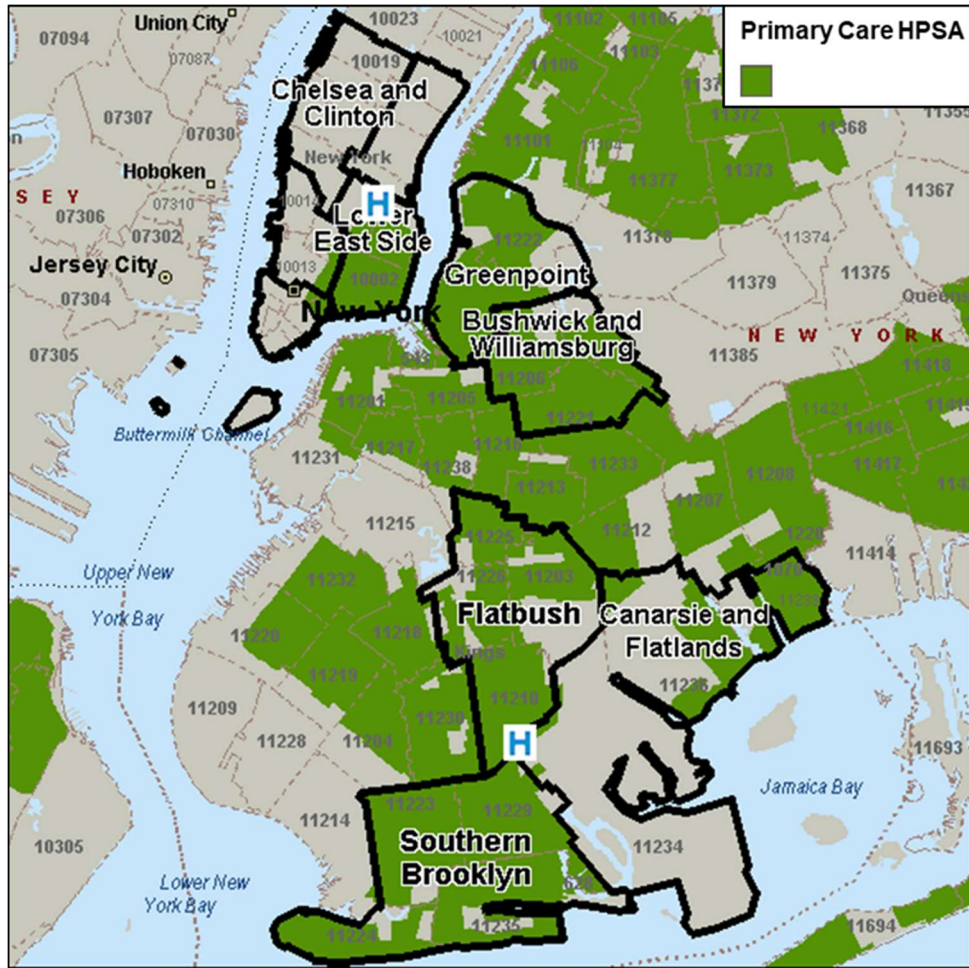
HPSAs can be: “(1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.”<sup>16</sup>

Areas and populations in the MSBI community are designated as HPSAs (**Exhibits 57**).

---

<sup>16</sup> 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>

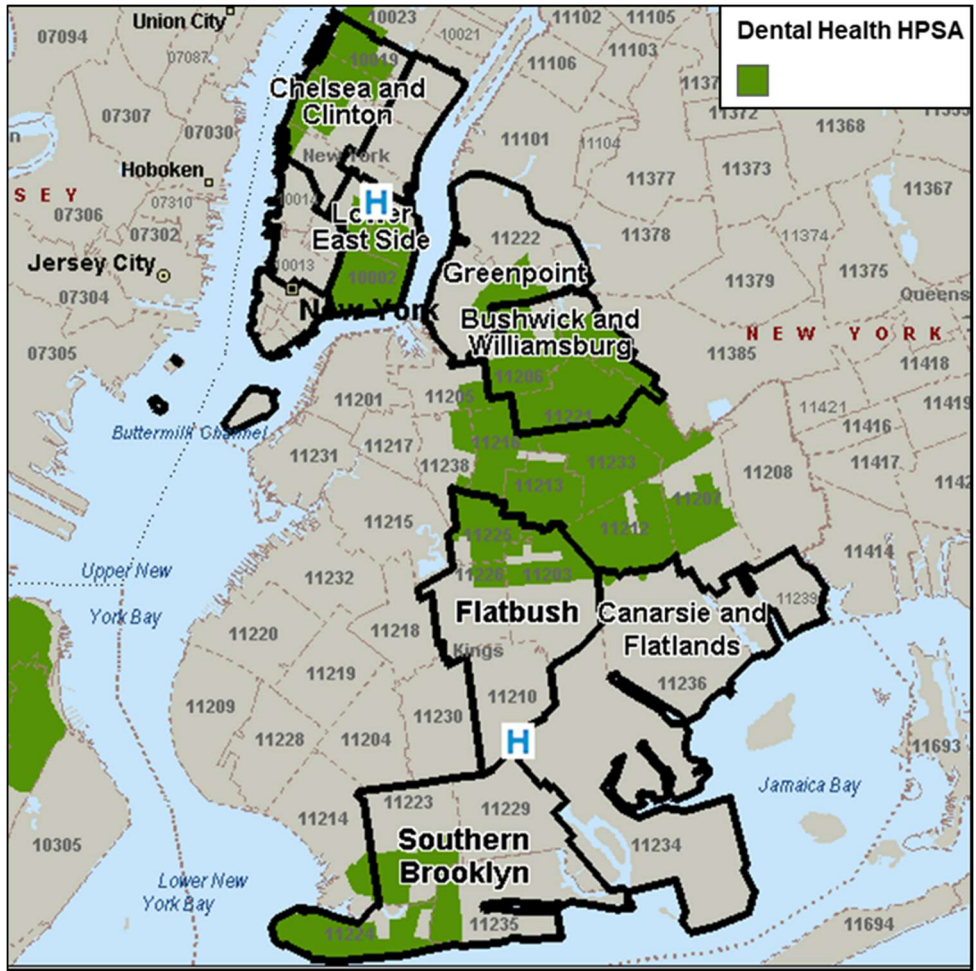
**Exhibit 57A: Location of Federally Designated Primary Care HPSA Census Tracts in the MSBI Community, 2017**



Sources: Microsoft MapPoint and HRSA, 2017.

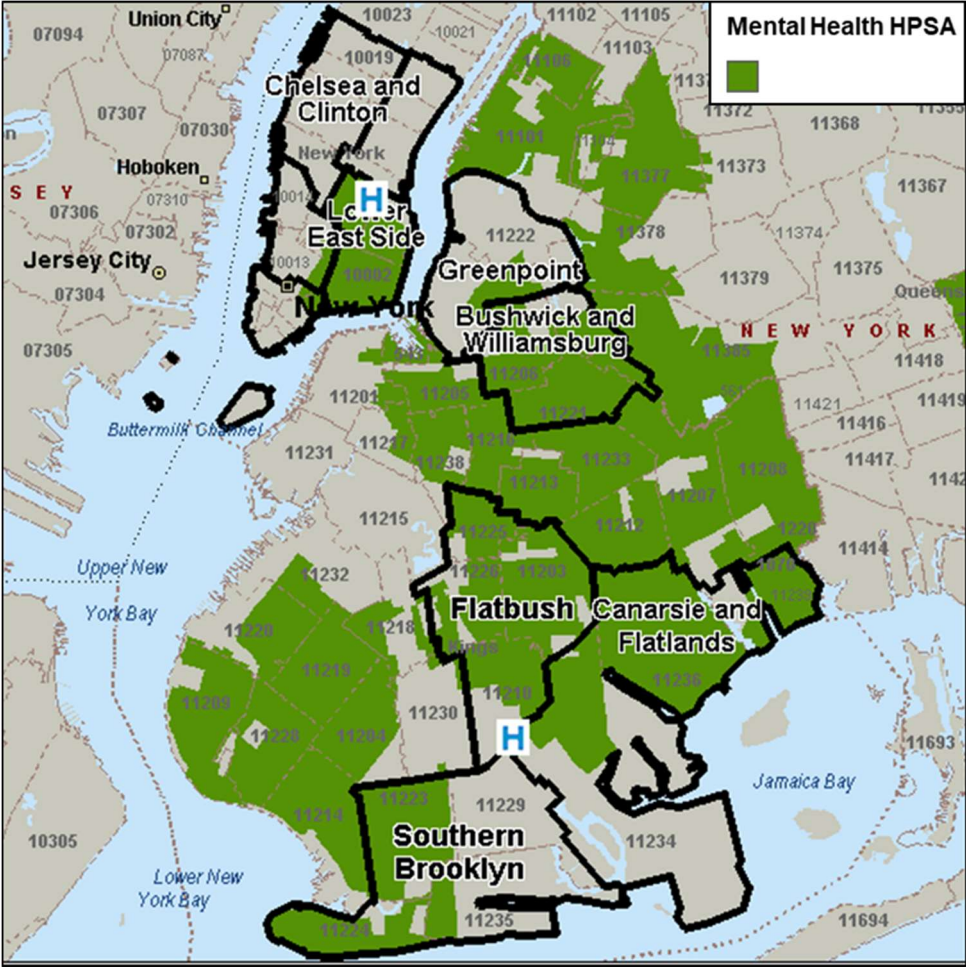


**Exhibit 57B: Location of Federally Designated Dental Health HPSA Census Tracts in the MSBI Community, 2017**



Sources: Microsoft MapPoint and HRSA, 2017.

**Exhibit 57C: Location of Federally Designated Mental Health HPSA Census Tracts in the MSBI Community, 2017**



Sources: Microsoft MapPoint and HRSA, 2017.

## Description of Other Facilities and Resources within the Community

The Mount Sinai Beth Israel 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 the community are designated as HPSA facilities (**Exhibit 58**).

### Exhibit 58: List of HPSA Facilities in the MSBI Community

HPSA Name	Facility Type	Primary Care	Dental	Mental
<b>Brooklyn</b>				
Bedford Stuyvesant	Comprehensive Health Center	•	•	•
Brooklyn Plaza Medical Center	Comprehensive Health Center	•	•	•
Brownsville Community	Comprehensive Health Center	•	•	•
Ezra Medical Center	Comprehensive Health Center	•	•	•
Housing Works, Inc.	Comprehensive Health Center	•	•	•
ICL Healthcare Choices, Inc.	Comprehensive Health Center	•	•	•
Kings County Hospital Center	State Mental Hospital			•
Metropolitan Detention Center - Brooklyn	Correctional Facility	•	•	•
ODA Primary Care Health	Comprehensive Health Center	•	•	•
Sunset Park Family Health	Comprehensive Health Center	•	•	•
Woodhull Mental Health Center	State Mental Hospital			•
<b>Manhattan</b>				
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 Brooklyn and Manhattan. **Exhibit 59** lists 35 hospital locations where community residents can receive services across all neighborhoods in Brooklyn and Manhattan. There are currently 15 hospital facilities in Brooklyn and 20 hospital facilities in Manhattan.

**Exhibit 59: Hospitals in the MSBI Community**

Borough	Hospital Name
Brooklyn	Brookdale Hospital Medical Center
Brooklyn	Brooklyn Hospital Center - Downtown Campus
Brooklyn	Coney Island Hospital
Brooklyn	Interfaith Medical Center
Brooklyn	Kings County Hospital Center
Brooklyn	Kingsbrook Jewish Medical Center
Brooklyn	Maimonides Medical Center
Brooklyn	Mount Sinai Brooklyn
Brooklyn	New York Community Hospital of Brooklyn, Inc.
Brooklyn	New York-Presbyterian Brooklyn Methodist Hospital
Brooklyn	NYU Lutheran Medical Center
Brooklyn	NYULMC - Cobble Hill
Brooklyn	University Hospital of Brooklyn
Brooklyn	Woodhull Medical & Mental Health Center
Brooklyn	Wyckoff Heights Medical Center
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. In Brooklyn, rates for primary care physicians, mental health providers, and dentists were lower than the state average.

**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
Brooklyn	1,637	62.4	4,605	174.5	1,592	60.4
Manhattan	2,263	138.3	11,983	729.9	2,840	172.7
<b>New York State</b>	<b>16,474</b>	<b>83.4</b>	<b>47,493</b>	<b>239.8</b>	<b>15,530</b>	<b>78.4</b>

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](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<sup>17</sup>, 2017.

<sup>17</sup> 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 Beth Israel 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 interview 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 travel times to Centers of Excellence and the closure of St. Vincent's Hospital Manhattan. 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, interview 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.

**Beth Israel Transformation and St. Vincent’s closure.** Several interview participants stated that some residents are highly concerned about potential negative impacts on services of the Beth Israel transformation plans and the St. Vincent closure. Concern about the planned Beth Israel transformation may be exacerbated as residents may not fully understand the plans. There is a perception that insufficient service capacity may result due to increases in the number of residents from new residential construction and greater health needs of an aging population. Development of Centers of Excellence and concentration of specialty services at other hospitals may create barriers to care as transportation options are limited for some residents, notably seniors and individuals with mobility problems.

**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 be 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. The healthcare system is complex and people rarely learn to navigate the system pre-need but their 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. Lack of understanding, exacerbated by wait time and/or other issues, may be incorrectly perceived by providers as non-compliance.

Interview 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.

Interview 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 were noted as 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. Financial resources may diminish with age. Support needs vary by mobility, hearing and vision ability, and cognitive levels. 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 suggested 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. Others do not consider the consequences of their behaviors but expect medical interventions to resolve any issues. For still 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 interviewees 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 indicated 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 MSBI community, representatives of these organizations provided insight that was applicable to different populations within the MSBI community, such as children and youth, seniors, and foreign-born residents.



## Community Survey Findings

As part of the planned changes at MSBI – Manhattan, the hospital formed a working group of elected officials and community groups to inform the transformation process. This working group suggested that the Mount Sinai Beth Israel CHNA process included a survey to illicit direct resident input. Per this suggestion, community input (primary data) was gathered through the design and administration of an online survey.<sup>18</sup> In total, 861 surveys were initiated from the online portal. A response was not required for most questions. It is important to note the following:

1. The survey utilized a convenience sampling methodology, and not a random sampling approach, such as one carried out by dialing randomly selected phone numbers;
2. As responses are self-reported, self-reported responses may be biased or purposely incorrect and; and
3. Individuals could take the survey multiple times.

For these reasons, findings from the survey are not generalizable to or representative of community-wide opinion. Results from the community survey have been included in this assessment because they may corroborate and supplement the other data sources, and may be helpful in identifying potential health disparities. Results of this survey are treated as an additional interview.

### Characteristics of responses

- Females were 71.6 percent of respondents (457 of 638 respondents), males were 27.6 percent (176 respondents), 0.2 percent were Transgender (1 respondent), 0.6 percent were Something Else (4 respondents), and an additional 22 respondents selected “Prefer not to answer;”
- Heterosexual individuals were 84.5 percent of respondents (516 of 610 respondents), Bisexual individuals were 2.0 percent (12 respondents), Gay individuals 10.2 percent (62 respondents), Queer individuals were 1.2 percent (10 respondents), individuals with other sexual orientation were 1.6 percent (10 respondents), and an additional 51 respondents selected “Prefer not to answer;”
- White / Caucasian individuals were 87.5 percent of respondents (539 of 616 respondents), Black or African American individuals were 1.2 percent of respondents (8 respondents), Asian individuals were 3.7 percent of respondents (23 respondents), Hispanic (or Latino / Latina) individuals were 2.8 percent of respondents (17 respondents), individuals of other race/ethnicities were 4.7 percent (29 respondents), and an additional 45 respondents selected “Prefer not to answer;”
- Individuals aged less than 25 were 0.8 percent of respondents (5 of 635 respondents), individuals aged 25-34 were 5.5 percent of respondents (35 respondents), individuals aged 35-44 were 9.3 percent of respondents (59 respondents), individuals aged 45-54

---

<sup>18</sup> As a transition is planned for the MSBI – Manhattan facilities, advisors suggested gathering additional community input. Input was solicited with both an online survey and poll. Results from these activities are treated as additional interview sessions for the Mount Sinai Beth Israel Hospital report.



were 14.8 percent of respondents (94 respondents), individuals aged 55-64 were 25.0 percent of respondents (159 respondents), individuals aged 65 or older were 44.6 percent of respondents (283 respondents), and an additional 25 respondents selected “Prefer not to answer;”;

- Individuals with household income less than \$25,000 were 8.9 percent of respondents (45 of 506 respondents), individuals with household income between \$25,000 and \$49,999 were 15.8 percent of respondents (80 respondents); individuals with household income between \$50,000 and \$99,999 were 27.3 percent of respondents (138 respondents); individuals with household income between \$100,000 and \$149,999 were 21.6 percent of respondents (109 respondents); individuals with household income over \$150,000 were 26.3 percent of respondents (133 respondents); and an additional 148 respondents selected “Prefer not to answer” or “I don’t know;” and
- Health insurance coverage was reported by 98.9 percent of respondents (636 of 643 respondents), 1.1 percent of respondents reported to be uninsured (7 respondents), and an additional 18 respondents selected “Prefer not to answer” or “I don’t know.”

## Results

Exhibits 63 through 69 summarize survey responses.

**Exhibit 63A: Question: What do you think are currently the most important health-related issues in your community/neighborhood? (Check up to 3)**

Issue	Count	Percent Responded
Access to physician, specialist, physician assistant, and/or nurse practitioner services	340	47.6%
Hospital accessibility	296	41.4%
Aging problems (e.g., arthritis, hearing/vision loss)	218	30.5%
Housing that is adequate, safe, and affordable	209	29.2%
Mental health problems	104	14.5%
Substance abuse (alcohol, illegal drugs, and/or prescription medications)	102	14.3%
Heart disease and stroke	88	12.3%
Accidents	80	11.2%
Overweight / obesity	61	8.5%
Cancer	56	7.8%
Transportation	47	6.6%
Alzheimer's disease / dementia	38	5.3%
Diabetes	33	4.6%
High blood pressure	30	4.2%
Lack of exercise	27	3.8%
Prescription drug accessibility	27	3.8%
Dental problems	24	3.4%
Nutrition	21	2.9%
Asthma	19	2.7%
Smoking / tobacco use	15	2.1%
Prenatal care	12	1.7%
Respiratory / lung disease	13	1.8%
Violence / homicide	12	1.7%
HIV / AIDS	9	1.3%
Infant health (e.g., premature births, low birth weight)	7	1.0%
Sexually transmitted infections	6	0.8%
Infectious diseases (e.g., hepatitis, tuberculosis, measles, mumps, rubella, pertussis)	5	0.7%
Rape / sexual assault	5	0.7%
Child abuse / child neglect	4	0.6%
Domestic violence	4	0.6%
Suicide	3	0.4%
Teenage pregnancy	3	0.4%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

More than 20 percent of respondents who selected at least one issue indicated that the following four issues were the most important health-related issues in the community/neighborhood: (1) Access to physician, specialist, physician assistant, and/or nurse practitioner services, (2) Hospital accessibility, (3) Aging problems (e.g., arthritis, hearing/vision loss), (4) Housing that is adequate, safe, and affordable. More than 10 percent (and less than 20 percent) indicated that the following four issues were the most important health-related issues in the community/neighborhood: (1) Mental health problems, (2) Substance abuse (alcohol, illegal drugs, and/or prescription medications), (3) Heart disease and stroke, and (4) Accidents.

**Exhibit 63B: Question: Other (please specify) \_\_\_\_\_?**

Issue	Count	Percent Responded
Emergency service access	13	16.7%
Hospital services	7	9.0%
Don't know	7	9.0%
Access to services	7	9.0%
Homelessness	6	7.7%
Noise	3	3.8%
Health insurance coverage	3	3.8%
Pedestrian safety	3	3.8%
Pollution	3	3.8%
Affordability	3	3.8%
Hospice care	2	2.6%
Prescription drugs	2	2.6%
Senior services	2	2.6%
Housing	1	1.3%
Pediatric services	1	1.3%
Provider staffing	1	1.3%
Caregiver input	1	1.3%
Podiatry	1	1.3%
Isolation	1	1.3%
Wealth / income inequality	1	1.3%
Rodents	1	1.3%
Mental Health	1	1.3%
Transportation	1	1.3%
Parkinson's Disease	1	1.3%
Infectious diseases	1	1.3%
Food Access	1	1.3%
Lack of input	1	1.3%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

Open-ended responses were coded into categories. More than 10 percent of the 78 respondents who selected “Other (please specify)” provided responses that were coded to Emergency service access.

**Exhibit 64: Question: Over the past 2-3 years, have these issues been improving, staying the same, or getting worse. Why?**

Comment	Count	Percent
Hospital Access - <i>getting worse</i>	160	27.4%
No change - <i>staying the same</i>	105	18.0%
Housing - <i>getting worse</i>	75	12.9%
Access to services - <i>getting worse</i>	54	9.3%
Aging population - <i>getting worse</i>	50	8.6%
Homelessness - <i>getting worse</i>	32	5.5%
Don't know	27	4.6%
Emergency services - <i>getting worse</i>	27	4.6%
Mental health - <i>getting worse</i>	25	4.3%
Affordability - <i>getting worse</i>	25	4.3%
Substance abuse - <i>getting worse</i>	23	3.9%
Change in demographics	19	3.3%
Transportation - <i>getting worse</i>	17	2.9%
Insurance participation - <i>getting worse</i>	12	2.1%
Traffic - <i>getting worse</i>	11	1.9%
Pedestrian safety - <i>getting worse</i>	11	1.9%
Improved access to health care - <i>improving</i>	10	1.7%
Pollution - <i>getting worse</i>	8	1.4%
Obesity - <i>getting worse</i>	7	1.2%
Food access - <i>getting worse</i>	7	1.2%
Dementia - <i>getting worse</i>	6	1.0%
Income disparity - <i>getting worse</i>	6	1.0%
Better - <i>improving</i>	5	0.9%
Cancer - <i>getting worse</i>	4	0.7%
Diet / exercise - <i>getting worse</i>	4	0.7%
Physical Activity - <i>getting worse</i>	3	0.5%
Opioid epidemic - <i>getting worse</i>	3	0.5%
Dental - <i>getting worse</i>	3	0.5%
Heart disease - <i>getting worse</i>	3	0.5%
Prescription drugs - <i>getting worse</i>	2	0.3%
Smoking - <i>getting worse</i>	2	0.3%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

Of the 583 respondents who provided input, 18.0 percent indicated that issues had stayed the same. Worsening hospital access was identified by more than 20 percent of respondents who provided input and worsening Housing was identified by more than 10 percent (and less than 20 percent) of these respondents.

**Exhibit 65: Question: In the last 30 days, did you:**

Behavior	"Yes" Percentage
Go the Emergency Room / Urgent Care Clinic	14.0%
Drive or ride-in a car without a seat belt	18.0%
Travel in a car with small children without using a car seat	1.6%
Spend more than 20 minutes in the sun without sunscreen	43.3%
Eat fast food more than once in a week	15.9%
Eat at least 2 servings of vegetables a day	72.5%
Eat at least 2 servings of fruit a day	67.6%
Sleep at least 8 hours a night	40.4%
Exercise for 30 minutes or more a day	54.7%
Have sex without using a condom or dental dam (if not in a monogamous relationship)	4.1%
Smoke cigarettes / cigars / pipes, chew tobacco, use snuff	7.6%
Use e-cigarettes	2.7%
Breathe second-hand smoke	40.2%
Use drugs prescribed for someone else	1.5%
Have more than 2 alcoholic drinks per day (men) or more than 1 alcoholic drink per day (women)	26.5%
Use marijuana or hashish	10.2%
Use prescribed opiates	5.5%
Use non-prescribed opiates	1.3%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

Response rates to these behavioral varied by question. The overall average number of responses was 674, with 657 responses to “Have sex without using a condom or dental dam (if not in a monogamous relationship)” and 681 responses to “Eat at least 2 servings of vegetables a day.” Selected highlights are below.

Over 40 percent of respondents selected “Yes” to “Spend more than 20 minutes in the sun without sunscreen” and “Breathe second-hand smoke.” More than 25 percent of respondents selected “Yes” to “Have more than 2 alcoholic drinks per day (men) or more than 1 alcoholic drink per day (women).” Additionally, 14 percent of respondents selected “Yes” to “Go the Emergency Room / Urgent Care Clinic.”

**Exhibit 66: Question: How many times have you and/or your family used a hospital emergency department for services in the past year?**

How many times?	Count	Percent
0	341	50.4%
1	168	24.8%
2	87	12.9%
3	43	6.4%
4	24	3.5%
5	6	0.9%
6	1	0.1%
7 or more	7	1.0%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

Of the 677 respondents who provided input, nearly half reported use of a hospital emergency department in the past year. Specifically, 24.8 percent of respondents reported one visit, 12.9 percent reported two, and 12.0 percent reported three or more visits.

**Exhibit 67: Question: Do you face difficulty accessing health care services because of the operating hours of physician offices?**

Option	Count	Percent
I always have difficulty because of the operating hours of physician offices	42	6.3%
I frequently have difficulty because of the operating hours of physician offices	86	12.9%
I sometimes have difficulty because of the operating hours of physician offices	246	36.8%
I rarely have difficulty because of the operating hours of physician offices	167	25.0%
I never have difficulty because of the operating hours of physician offices	117	17.5%
I prefer not to answer	11	1.6%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

Of the 669 respondents who provided input, 55.9 percent indicated that difficulty in accessing health care services because of the operating hours of physician offices. Specifically, 6.3 percent of respondents selected “always have difficulty,” 12.9 percent “frequently have difficulty,” and 36.8 percent “sometimes have difficulty.”

**Exhibit 68: Question: Do you face difficulty accessing health care services because of the location of physician offices?**

Option	Count	Percent
I always have difficulty because of the location of physician offices	38	5.7%
I frequently have difficulty because of the location of physician offices	55	8.2%
I sometimes have difficulty because of the location of physician offices	209	31.2%
I rarely have difficulty because of the location of physician offices	192	28.7%
I never have difficulty because of the location of physician offices	168	25.1%
I prefer not to answer	7	1.0%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

Of the 669 respondents who provided input, 45.1 percent indicated that difficulty in accessing health care services because of the location of physician offices. Specifically, 5.7 percent of respondents selected “always have difficulty,” 8.2 percent “frequently have difficulty,” and 31.2 percent “sometimes have difficulty.”

**Exhibit 69: Question: Do you face difficulty accessing health care services because of travel times to services?**

Option	Count	Percent
I always have difficulty because of travel times	41	6.1%
I frequently have difficulty because of travel times	68	10.2%
I sometimes have difficulty because of travel times	208	31.1%
I rarely have difficulty because of travel times	188	28.1%
I never have difficulty because of travel times	159	23.8%
I prefer not to answer	5	0.7%

Source: Survey conducted by Verité and Survey Monkey software, 2017.

Of the 669 respondents who provided input, 47.4 percent indicated that difficulty in accessing health care services because of travel times to services. Specifically, 6.1 percent of respondents selected “always have difficulty,” 10.2 percent “frequently have difficulty,” and 31.1 percent “sometimes have difficulty.”



## Community Poll

In September 2017, SKDKnickerbocker (SKDK) conducted an online poll of 450 adult residents living below 34th St. in New York City. SKDK's findings are below.



### Mount Sinai Community Poll

SKDK conducted an online poll between September 10-20, 2017 among 450 adults aged 18+, living below 34<sup>th</sup> St. in New York City, NY. Respondents were screened based on zip code and verified by voter and consumer lists. The poll was conducted in English, Spanish and Mandarin. Respondents were recruited in all three languages using a third-party vendor who specializes in online polls.

**Overall, the poll results make clear that people who live below 34<sup>th</sup> St. are generally neutral to positive about the direction of health services in the area. Furthermore, people think that access to providers is improving, and they are overwhelmingly satisfied with the availability of services.**

#### Access to Health Care

Overall, people are neutral to positive about the direction of health services in the area. 38% think that health services have gotten better in the past 2-3 years, 34% think services have stayed the same and only 16% say services have gotten worse. Men and young people (those aged 18-34) are particularly positive about the direction of health services (45% and 48%, respectively, think health services have gotten better). Older respondents (aged 55 and older) are the most negative group, but only a quarter think that health services have gotten worse.

There are a few key drivers of people's perception of health services: access to local medical facilities, quality and variety of services, and affordability. Among those who think that health services are getting better, many cite improved access to local medical facilities or improved quality and variety of services. On the flip side, those who think that health services are getting worse cite affordability of care and decreased access to local medical facilities.

Furthermore, across almost every demographic group there is a perception that access has improved over the last few years. The only demographic group with a net negative score is middle-aged people (those aged 35-54).

#### Other issues in the community

There is no consensus on what the most important health-related issue is. In a close-ended question with numerous options, ranging from cancer to housing, access to physician services is cited as the most important issue, but, critically, only by 23% of residents. In an open-ended question, cost tops the list at 17%, but again there's no clear standout.

VISIT: [SKDKNICK.COM](http://SKDKNICK.COM) • FOLLOW: [@SKDKNICK](https://twitter.com/SKDKNICK)



WASHINGTON • NEW YORK • LOS ANGELES • ALBANY

Within the population we polled, there is also a perception that HIV/AIDS, teenage pregnancy and nutrition have gotten better whereas substance abuse, housing that is adequate, safe, and affordable, mental health problems, and obesity are perceived to be getting worse.

### **Availability of services**

People are overwhelmingly satisfied with the availability of health services in the area, with 77% satisfied and only 17% dissatisfied. The most satisfied demographic groups are young people aged 18-34 (84%), people with household incomes over \$100k (85%), and residents of Gramercy Park and Murray Hill (90%). The most dissatisfied groups are residents in the East Village and Lower East Side (25%), older people (22%) and middle-aged people (21%) -- but even among these groups the majority are still satisfied.

In addition to widespread satisfaction with the availability of health services, very few people cite frequent hurdles to access. Only 19% report that operating hours always or frequently make access to health services more difficult. 13% of people report that travel times to health services always or frequently make access to health services more difficult, and 12% report office locations always or frequently are a hurdle. Older people are even less affected by these hurdles. Only 10% report always or frequently having difficulty accessing health services because of operating hours, 7% because of travel times and 7% because of office locations.

On the flip side, anywhere from half to a majority of all respondents report that these three things rarely or never make access more difficult (48%, 55%, and 60%, respectively).

Only 14% of respondents have used either an ER or urgent care in the last 30 days. Of those, nearly 80% have been to the ER specifically.

### **Hospital preferences**

Mount Sinai Beth Israel is the hospital of choice for 15% of people below 34<sup>th</sup> St., making it the second-most frequented hospital. NYU Hospitals Center is the hospital of choice for 17% of people and Bellevue Hospital Center is for 13%.

Older people are more likely to go to Mount Sinai Beth Israel – it's the most-frequented option for a quarter of older people. Lower-income people (20%) and residents of East Village and the Lower East Side (26%) are also more likely to go there.

**VISIT: [SKDKNICK.COM](http://SKDKNICK.COM) • FOLLOW: [@SKDKNICK](https://twitter.com/SKDKNICK)**

2

## 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](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](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](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](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](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<sup>19</sup>

---

Mount Sinai Beth Israel 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. We continue to evaluate the cumulative impact.

Previously, Mount Sinai Beth Israel identified a number of community health needs. The section below lists these health needs and related action items.

### 1. Aging Population (Seniors and Skilled Nursing Facilities)

Specific community service programs include the following:

Naturally Occurring Retirement Community (NORC) Co-op Village - MSBI provides a Registered Nurse to work with the senior community at Co-op Village residents. In 2016 there were 3619 recorded interventions a 2% increase over the 3549 interventions in 2013

Sage Senior Center - MSBI provides a Registered Nurse on part-time basis to counsel and monitor seniors at the Sage Senior Center o Manhattans Lower East Side. In 2016 there were 946 interventions a 2% increase over the 928 in 2013.

Mount Sinai Doctors Senior Health - At Mount Sinai Doctors Senior Health, primary care doctors, nurse practitioners and social workers specializing in geriatrics help adults age 65 and older achieve independence and a healthier, better quality of life. Support services are available for residents and caregivers. When appropriate, medical care and social services are provided in the home. Specific issues for which services are offered include the following:

- Memory loss and dementia;
- Depression;
- Osteoporosis;
- Incontinence; and
- Falling and balance problems.

---

<sup>19</sup> 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 Brooklyn, 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 ones listed below.

Mount Sinai Chelsea - Mount Sinai Chelsea, specializes in diagnosing and treating women who have breast or gynecological cancer men who need minor outpatient surgery or infusion therapy are also treated. Services include cancer diagnosis and treatment

Mount Sinai Union Square - Mount Sinai Union Square provides specialty and primary care, diagnostic services, labs, and a pharmacy. Mount Sinai Union Square also offers provides urgent care in a facility that is open 365 days a year.

Mount Sinai Doctors 309 West 23rd Street - Mount Sinai Doctors West 23<sup>rd</sup> Street provides comprehensive primary and specialty. Services appointments in advance and accept walk-ins. Both scheduled appointments in advance and walk-in appointments are offered.

Mount Sinai Doctors 55 East 34th Street - Mount Sinai Doctors East 34th Street provides a range of multi-specialty services. Specific services include the following:

- Cardiology;
- Dermatology;
- Diabetes education;
- Ear, nose, and throat;
- Gastroenterology;
- Gynecology;
- Internal Medicine;
- Immigration physicals;
- Ophthalmology;
- Orthopedics;
- Otolaryngology;
- Pain management;
- Podiatry;
- Radiology; and
- Urology.



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

Department of Psychiatry and Behavioral Sciences at Mount Sinai Beth Israel - The Department of Psychiatry and Behavioral Sciences at Mount Sinai Beth Israel provides comprehensive inpatient and outpatient services. Its training programs in psychiatry and psychology contribute substantially to the community's mental health resources. Specific programs, centers, and services of the Department include the following:

- Addiction psychiatry;
- Pharmacotherapy;
- Crisis intervention;
- All types of psychotherapy;
- Behavioral medicine;
- Child and adolescent services
- Geriatric psychiatry;
- General and specialty inpatient units; and
- Evening/weekend programs.

Inpatient Services - The Petrie campus of Mount Sinai Beth Israel includes a general psychiatric unit, a general geropsychiatric unit, and dual diagnosis unit that specializes in the treatment of patients with both psychiatric and substance abuse disorders. The inpatient service maintains a 92-bed capacity and is licensed by the New York State Office of Mental Health. Inpatient psychiatric treatment at Beth Israel focuses on the resolution of acute symptoms. Treatment consists of a wide range of somatic and psychosocial therapies, with a strong multidisciplinary approach. Each unit has two full-time board-certified attending psychiatrists, who coordinate all aspects of the patient care. Additional details are below.

- Patients in the General Psychiatric Unit are treated by a multidisciplinary team, including an attending psychiatrist, a psychiatric resident, a psychiatric nurse, a social worker, and an occupational therapist. The treatment of adolescents includes an assessment from the Division of Child and Adolescent Psychiatry. In addition, adolescents are provided schooling during the academic year through the New York Department of Education.
- The General Psychiatric Unit of 33 beds is primarily an adult service, but it also maintains several beds for adolescents and treats patients from the ages of 14 to 64. The staff is well trained and experienced in the treatment of acute aspects of psychiatric illnesses such as schizophrenia, bipolar disorder, major depression, severe anxiety disorders, and personality disorders.
- The Adult Service and a Geropsychiatry Service of 31 beds is available to treat individuals who are 65 years of age and older. Half of the beds on the unit are dedicated to working with geriatric patients who present with disorders such as late-life depression, late onset schizophrenia, delusional disorders, and behavioral disturbances secondary to a dementia. All patients are offered a multidisciplinary approach and the most current psychiatric treatments.

- The Psychiatric Outpatient Service is a comprehensive and innovative ambulatory mental health service located at the Petrie campus of Mount Sinai Beth Israel. Staffed by a large group of mental health professionals, including psychiatrists, psychologists, and social workers, specific services include full physical and psychosocial evaluations, psychiatric and psychological treatments, psychopharmacology, psychotherapy, psychological testing; and programs directed at assisting patients with special needs, such as addiction disorders or chronic mental illnesses.

#### 4. Substance abuse

Chemical dependency is a serious illness with debilitating symptoms. A chemically dependent person has lost the ability to willingly stop drinking, or taking a particular mood-altering drug despite the consequences it causes on their life. Specific community service programs include ones listed below.

- The Chemical Dependency Services at the Addiction Institute at Mount Sinai – Beth Israel provides services to help the chemically dependent person regain stability. As this program is located in a hospital (Mount Sinai Beth Israel’s Bernstein Pavilion), a wide range of services within the same vicinity. An interdisciplinary team is skilled in working with and treating addiction. This team includes social workers, addiction and substance abuse counselors, physicians, physician assistants and registered nurses.
- Detoxification (Detox) Services at the Addiction Institute at Mount Sinai are treatments for acute withdrawal require immediate attention. Treatment includes engagement, assessment, motivation, and referral. Detox is the first step to long-term treatment. Specialized detox services to pregnant women are provided.
- Inpatient rehabilitation (inpatient rehab), an intensive treatment modality that provides patients with a 24/7 structured therapeutic setting, is provided. Inpatient rehab is generally the first step in the recovery process after detox. Patients participating in the inpatient program are put on a routine that includes teaching them how to experience life without drugs or alcohol.
- Outpatient programs are provided as not all individuals require the intensity of inpatient services. Specific outpatient services include evaluation, ambulatory detoxification; outpatient day and evening services; DWI screening, assessment, and referral; brief therapy; psychiatric services.
- The Opioid Treatment Program Opioid Treatment Program is a comprehensive treatment program for individuals with an opioid addiction. A full range of services are available, including methadone treatment, buprenorphine treatment, counseling and treatment, case management, group treatment, educational and vocational counseling, annual physicals, general medical care, art therapy, psychiatric evaluation and medication management, and HIV counseling and testing. Opioid treatment reduces the incidence of HIV and other infectious diseases, dramatically decreases criminal behavior, and significantly improves the lives of those engaged in treatment.

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

MSBI provides primary care at its campuses, as well as physician practices throughout Manhattan and Brooklyn, 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. Specific community service programs include ones listed below.

The Mount Sinai Clinical Diabetes Institute provides highly specialized care for people with diabetes and related conditions. The Institute's network includes diabetes physicians, clinical diabetes educators, and allied specialists. The Institute works to prevent and manage diabetes, as well as complications from diabetes. Specific programs include the one below.

- Self-management classes provide by the Clinical Diabetes Institute includes free diabetes education classes for both type 1 and type 2 diabetes. Multicultural and multilingual certified diabetes instructors teach the classes. The curriculum helps individual learn how to control diabetes and prevent complications. The type 1 class reviews carbohydrate counting, insulin dosing, insulin to carbohydrate ratios, correction factors, dosing basal/long acting insulin, effects of exercise on bloods sugars, and many other topics. The type 2 diabetes classes review a variety of topics including hypoglycemic protocol, general healthy eating, stress and relaxation tips, and medications/insulins used for glycemic control.
- Nutrition Counseling is provided. The Institute's registered dietician teaches diabetes self-management and provides medical nutrition therapy. Dietary recommendations are based on the latest guidelines and tailored to other medical conditions, cultural food preferences, and personal circumstances.
- In-Office Hemoglobin A1C Testing provides an estimate of an individual's average blood sugar level over the last three months. Using novel technology, the A1C level is provided within six minutes from a drop of blood.
- Insulin Pump Therapy management allows for particular fine-tuning of an individual treatment regimen and eliminates the need for insulin injections.
- Continuous Glucose Monitoring (CGM) uses under-the-skin sensors to measure glucose levels continuously, 24 hours a day. CGM information about how medication, food, and exercise are affecting your blood glucose levels, which allows for adjustments in the treatment regime.
- Diabetes Prevention Program/Viva Fitness is a program with the YMCA of Greater New York that is targeted to adults who are at risk for diabetes or who have a diagnosis of prediabetes. This program is designed to reduce the risk for type 2 diabetes through education and motivation.
- The High-Risk Ob/Gyn Program provides diabetes education to pregnant women with diabetes is provided by obstetrics/gynecology departments throughout the Mount Sinai Health System.

The Mount Sinai Comprehensive Health Program-Downtown (MSCHP-Downtown) offers full service, quality health care to the HIV-positive residents of lower Manhattan. Formerly affiliated with Saint Vincent's Hospital, and now in combination with Mount Sinai's Jack Martin Clinic on the Upper East Side, MSCHP-Downtown is one the largest HIV programs in the country.

Mount Sinai Renal Services provides treatment of kidney diseases and is one of largest, most comprehensive kidney disease treatment, research, and education centers in the world. The Division of Nephrology at Mount Sinai provides comprehensive evaluation and treatment programs for all types of adult and pediatric kidney diseases and disorders.