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City Voices: New Yorkers on Health

Community Needs Assessment Overview

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"The amount of economic pressure: when you lose your job, then there goes the resources and increased pressure. It breaks you down. If you are a husband, there goes your manhood. Maybe there is no strong family foundation to talk to about it, no one close to tell them they are going through this, so they have to carry that. If there is no spiritual life, it eats them up inside. They become mentally ill, short- tempered."

– OLDER ADULT SERVICE PROVIDER, QUEENS

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ABSTRACT

In New York and around the nation, efforts are underway to transform the health care system to achieve the Triple Aim of lower costs, better care, and better health. Attention to low income populations and historically disadvantaged groups is key, given the health inequities such groups face. Recognizing these concerns, this report presents an overview of findings from a comprehensive community needs assessment (CNA) conducted on behalf of multiple large New York City (NYC) hospital systems and their partners. A CNA on a comparable scale, with respect to population and subject matter, has not been conducted in NYC previously.

As part of the CNA, we engaged primarily low income and uninsured NYC residents, and the agency and community-based organization (CBO) staff that work with them, and asked—through interviews, focus groups, and brief surveys—for descriptions of health priorities, concerns, and perceptions, as well as recommendations for programmatic and systemic changes that might improve health and the delivery of health care services.

In this overview of the CNA findings and the resulting data briefs, this series—City Voices: New Yorkers on Health—gives a voice to the health needs of people in the city who are oftentimes invisible or unheard. Each brief in the series does this by highlighting informative personal experiences covering a range of health-related issues and offering recommendations for individual, community, provider, and systemic approaches, which included: addressing the broader determinants of health, expanding community health worker programs, improving integration and coordination of care, health education, and targeted services to the highest need individuals. Several of these recommendations are consistent with New York State and NYC initiatives, such as the NYS Population Health Improvement Program, which seeks to promote health across communities; support for the Advanced Primary Care model, which integrates behavioral health and supportive services with primary care; and the NYC Connections to Care program, which links community based organizations and mental health providers. As additional programming is developed, our hope is that the findings described here—and in subsequent reports focusing on transgender health, mental health, immigrant health, nutrition, aging, and other topics—may prove useful to policy makers, program administrators, funders, and community residents.

OVERVIEW

Understanding the health needs of low-income populations and historically disadvantaged groups is key, given the health inequities such groups face. Within New York City (NYC), wide disparities in health exist according to race, ethnicity, neighborhood, and other factors—in large part because of differences in economic security, education, clean environments, safe neighborhoods, and healthy foods. Differential access to needed services compounds these disparities.

Recognizing these concerns, this report presents an overview of findings from a comprehensive community needs assessment (CNA) conducted in 2014 on behalf of multiple large hospital systems and their partners in the Bronx, Brooklyn, Manhattan and Queens.1 As part of the CNA, we engaged primarily low-income and uninsured NYC residents, and the agency and community-based organization staff that work with them, and asked—through interviews, focus groups, and surveys—for descriptions of health priorities, concerns, and perceptions, as well as recommendations for programmatic and systemic changes that might improve health and the delivery of health care services.2 This report, the first in a series, summarizes findings from those discussions and surveys.

A CNA on a comparable scale, with respect to population and subject matter, has not been conducted in NYC previously. Given the persistent health needs among low income New Yorkers, our intention in developing this series of reports is to make findings from the CNA available to multiple stakeholders—including policy makers, program administrators, funders, and community residents—so they may be used in the development of policy and programming that positively impacts the health and well-being of low income New Yorkers. We should note at the outset that the CNA focused on concerns and topics and areas where changes are due, thus the many strengths and assets of the target communities are, regrettably, under-represented in our findings.

[1] The CNA was conducted for applications for New York State DSRIP funding. DSRIP, a health reform initiative, is designed to restructure the health care delivery system with the primary goal of reducing avoidable hospital use. A list of participating hospital systems is provided in the acknowledgements.

[2] In addition to the primary data collection, described here, the CNA included secondary analysis of approximately 70 datasets. The full reports are available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/

FINDINGS

The CNA interviews, focus groups, and surveys were developed to respond to five main questions. Results from each of these activities were analyzed separately, using standard quantitative and qualitative research and analysis methods. The latter (qualitative methods) included coding of verbatim transcripts for pre-identified and emerging themes and a review of findings by multiple members of the research team. Below, we summarize main findings relevant to each of these questions.

1. **To what extent are community and environmental conditions conducive to health promotion and disease prevention?**

Many CNA participants live in low income neighborhoods and clearly recognize that the local environment has significant health implications, directly affecting susceptibility to illness, prioritization (or de-prioritization) of health behaviors, and access to health-related resources. Participants described limited healthy food and activity choices in many neighborhoods: they noted the relatively high cost of healthy food options and the travel that may be required (depending on neighborhood) to purchase fresh fruit and vegetables. Many neighborhoods were reported to be overrun with processed and fast food. Although places to engage in physical activity were more generally accessible than healthy food, in several neighborhoods there were concerns about safety and appeal.

> ***.... a liquor store on every block. People don't look at that. There's a fast food store on every block. There's a Bojangles on every block. So, this is what we have on every block. Look in a one mile radius and this is 90 percent of what we have in our neighborhood. I don't know how you're gonna make healthy changes when the only thing that's there is bad quality food, cigarettes and booze. (Focus group participant, Bronx)***

It's easy to talk about exercising if I live in Battery Park. They just made the whole garden thing, you can walk, run, do anything you want. It's beautiful … How do you do that in Flatbush? (Key informant, CBO)

I had three conversations with the local supermarket: the manager and both of the owners. "Where's the organic? Where's a bunch of stuff"? "Oh," [he said], "People in this neighborhood don't eat like that." (Focus group participant, Brooklyn)

In communities with long histories of poverty and neglect, participants described frightening levels of violence, government disregard for resident well-being, and a disproportionate share of establishments—including commercial, governmental, and service oriented—that contribute to poor health.

In my neighborhood, they have a lot of chemical incinerators … We had to do a petition to get rid of the hazardous waste on Bruckner Boulevard, because when they were incinerating needles and surgical stuff, all sorts of hazardous stuff they were burning in our area and it caused a lot of people to have asthma. (Focus group participant, Bronx)

Coney Island has been like a warehouse, I think. That's why Coney Island has so many problems and so many needs. So they said like for about 30 years no monies had been invested in Coney Island. (Focus group participant, Brooklyn)

2. What are the primary health concerns and health needs of residents, overall and according to neighborhood and socio-demographic characteristics?

Nearly 30% of survey respondents reported being in fair or poor health. The most commonly reported health issues faced were high blood pressure (30%), depression or anxiety (26%), high cholesterol (25%), and chronic pain (23%). Eighteen percent reported having asthma and 16% had diabetes. Approximately 58% of survey respondents were overweight or obese. When considering their community in general, survey respondents reported that the most common health concerns were diabetes (a concern reported by 50%), drug and alcohol abuse (43%), high blood

pressure (41%), and obesity (33%). Focus group participants and key informants, when asked about community health issues, also commonly focused on diabetes:

> *In the Bronx, so many people have diabetes. The South Bronx has the highest rate for amputations as a direct result of diabetes. So a lot of people just think of it as a chronic disease, and like, "Everybody's living with diabetes." So they're not afraid of it. They kind of think, "My grandmother had it and my mother had it, so I'll get it too, at some point."* (Key informant, CBO)

> ***I think [the most significant health issue has] got to be the obesity, diabetes issue. I think it's because it's just so visual. You see it: so many people with canes and walkers. And now with the bike lanes, it's interesting. Sometimes I see more motorized wheelchairs than bikes on the bike lane... It breaks my heart to see the really young kids that are just so overweight, and they're still toddlers. (Key informant, CBO)***

In addition to the neighborhood factors described previously, personal factors—both economic and cultural—also impacted on health behaviors associated with obesity, diabetes and related conditions. Focus group participants with low incomes and working long hours repeatedly emphasized that exercise and a healthy diet were difficult to maintain given their financial and time constraints. Cultural preferences for certain high-calorie foods, as well as large serving sizes, were also acknowledged. Although many participants spoke of increased knowledge and concerted efforts to adopt healthy behaviors, change was considered difficult.

> *I work so hard that I don't have time to eat right. I'm trying to eat healthy foods, but I work twelve hours a day, five days a week. So when I come home I'm ready to go to sleep. I try to eat the right things, but then I go back to eating junk food.* (Focus group participant, Brooklyn)

> *I think, from a West Indian type of background, food is comfort. It's a huge part of culture. You go to any birthday, funeral, whatever, there's going to be food. Our relationship [to food] is not very healthy. We're raised where you have to eat everything on your plate, even if you're full.* (Focus group participant, Brooklyn)

In addition to diabetes and other obesity-related health conditions, asthma was a great concern in particular neighborhoods, including the South Bronx, East Harlem, Jamaica, Red Hook and Bushwick, where indoor and outdoor environmental conditions, including crowding, were described as particularly poor:

> ***We call it the asthma alley because, if you know the city well, you know, 87 Highway, you have the Cross Bronx, then you have 95, so there's a triangle in the South Bronx, and the number of trucks ... the traffic 24/7 is jam-packed. And the inner roads, all the pollution, particulate matter, you know, all those things fairly contribute a lot. And, of course, with the environment of the housing units, you have the mold and the cockroaches, and rodents ... We give first. We just treat them in the asthma room, and then we discharge them ... They go back home and they have the same triggers and they get worse. (Key informant, provider)***

> *I think the most common thing we see is a child with severe asthma who doesn't have a proper sleeping arrangement. So, we see kids sharing beds with a sibling or two, or they're sleeping with their parents, or on a mattress on the floor. I had to justify buying beds as an asthma intervention in the beginning. So I had to build this argument ... and say, "We need this emergency assistance money, because a child with asthma should not be on a mattress on the floor. There's more of a concentration of particles."* (Key informant, CBO)

Behavioral health issues, particularly depression, were readily acknowledged. As noted above, survey respondents reported high rates of depression or anxiety (26%), as well as community level concerns related to drug and alcohol abuse (43%). A large number of focus group participants attributed poor mental health —including anxiety, depression and "stress,"—to socioeconomic factors, including unemployment, lack of affordable housing, and poverty.

The amount of economic pressure: when you lose your job, then there goes the resources and increased pressure. It breaks you down. If you are a husband, there goes your manhood. Maybe there is no strong family foundation to talk to about it, no one close to tell them they are going through this, so they have to carry that. If there is no spiritual life, it eats them up inside. They become mentally ill, short- tempered. (Focus group participant, Brooklyn)

Several participants described linkages between depression and distinct personal factors, including older age and stigmatized characteristics such as sexual preference/gender identity, and disability. Although such connections were less commonly noted than those focused on the broader social causes (e.g., poverty), they were described as significant:

> *I think for many LGBT people, they're separate from other minority groups, the isolation from levels of support starts at a very young age and it's within the family and within the local community and so there is a lot of affective issues that people experience just from an early age onward.*
> (Key informant, health care organization)

3. What are the health-related programming and services available to community residents, what organizations are providing the services, and what are the service gaps?

Participants reported relatively good access to most types of medical care, although there were reports that disparities exist across boroughs (e.g., perceived lower quality care in the Bronx, poorer access to specialist services outside Manhattan). Eighty-two percent of survey respondents reported that they had a primary care provider or personal doctor, and 84% reported that had a routine check-up in the last 12 months. However, more than one quarter of respondents reported that there was a time in the last year when they needed health care but did not get it. The most commonly noted reasons for neglected care were "not insured" (38%), "cost of co-pays" (18%), "could not get an appointment soon or at the right time" (15%), and "had other responsibilities (e.g., work, family; 9%). In focus group discussions, financial barriers to health services were most commonly described:

I was a diabetic. I had to fight [it alone] for 10 years, because I had no insurance and no place to support me. Even I didn't report my disease to my wife and children. I decided to cure it by myself. The problem is that the middle income and middle age groups in society do not usually benefit from government-controlled health insurance programs like Medicaid and Medicare. (Focus group participant, Queens)

I get one brand name [medication] where there is a co-pay. … For 30 tablets every month I will be paying $45 for co-pay. So I cannot support that kind of a co-pay, so I skipped taking—especially my medication for diabetes. (Focus group participant, Brooklyn)

My doctor said to get a colonoscopy, but I said, "I'll wait two more years." The company I work for, they don't really cover everything. I pay $150 to get no health care, and I can't pay another $200 for a colonoscopy. I need to keep my house. I'd rather pay for insurance for my car. I have to pick and choose. I am the working poor and it is terrible. (Focus group participant, Brooklyn)

Although several key informants from behavioral health organizations felt supply was generally sufficient, many community members and key informants from other types of organizations described shortages, as well as barriers—most notably, stigma. Self-medicating with drugs and alcohol was frequently mentioned as an alternative to utilization of behavioral health services, despite the adverse consequences thereof.

In the black community, going to a therapist, what they call a shrink, it's taboo. Black communities, Hispanic communities, don't believe in therapy. So when we think something is wrong, we self-medicate. We think we can manage it, and you don't realize that you have a real problem, because you won't seek out the help. (Focus group participant, Brooklyn)

Care coordination was described as a key service for populations with high service needs, given excessive fragmentation within the health care system, as well as recognition that supportive services are often necessary to maintain optimal health. However, availability of care coordination services was limited and job expectations (e.g., high volume, challenging client populations) and low reimbursement levels were inconsistent with the delivery of quality services. Furthermore, providers are not necessarily sufficiently incentivized to communicate with care coordinators.

> ***We're required to go to providers, individual PCP's and psychiatrists, and get information from them both about their care … or the lab work that's been done, tests, reports, anything that they're doing with our patient. We need to get access to that information so that we can help to provide better care. … So if they get prescribed a specific medication, we can say, "Are you taking that medication? Where are you at with it? Have you filled the prescription?" Those kind of things. The problem is, on the provider's side, they don't get paid. No one's telling them–no one's saying to them from the funder level … "You must communicate with these people."… So, the providers ignore us. (Key Informant, CBO)***

Despite health care reform, insurance issues significantly impacted utilization of health care services. Complaints regarding insurance included expense, incomprehensibility, and the limitations it places on choice. Limitations on choice were particularly problematic for individuals with special needs, including individuals with disabilities and those with limited English proficiency. Lack of insurance was, not surprisingly, a more common problem in immigrant communities, due to limitations on immigrant eligibility for public insurance programs, as well as more limited access to employer–sponsored care (due to restricted job opportunities). However, community members and key informants report that income restrictions for Medicaid are unrealistically low, and self–purchased coverage is too expensive for low–income populations, given the difficulties of paying for basic necessities like food and housing in NYC.

4. **Are there differences in access, use and perceptions of health-related programming and services according to neighborhood and according to ethnic, racial, and language groups?**

Populations with special needs, such as foreign born, individuals with disabilities, LGBT persons, individuals involved in the criminal justice system, and the homeless, described a variety of access issues. For example, foreign born populations described the implications of inadequate language services (from quality and quantity perspectives) and lack of culturally competent care. In addition, they reported that a lack of comfort and familiarity with the American health care system and recommended practices—especially practices related to preventive care—significantly impacted their use of existing health services.

> ***[We need] the doctors who speak [Arabic] or staff who speak [Arabic], because I don't want to end up calling the janitor or the security guard to translate for these patients. I want trained staff, nurses and doctors. … Who is helping them to fill out the forms when they walk into clinics and hospitals? … Who fills out the forms for them? … They bring their children. (Focus group participant, Brooklyn)***

It's a cultural issue. Where we come from greatly impacts our behaviors, and it's clear, in Africa, health is not a priority. It's a fact. The fact that health isn't a priority and the financial difficulties, they go together. This combination is devastating for us. I have a certain level of education, but I swear, as long as I'm not caput, I won't go to the hospital. (Focus group participant, Bronx)

In Queens, one of the biggest barriers to health care is the ethnic diversity that exists here. So it's not even just about language. Language, of course, is a barrier, but more easily addressed than cultural barriers. And in some cultures, seeking out healthcare is just not something that they do. They're not comfortable with it, especially if a person has a questionable immigration status. (Key informant, CBO)

Key informants and focus group participants described a high prevalence of distress in foreign born populations, due to factors that include the migration experience, poverty, long work hours, social isolation (due, in part, to limited English language skills), and disparities between the expectations with which they arrived in the U.S. and their day-to-day reality.

> ***From day one in the United States, there is mental pressure. There is depression and frustration because [their] experiences, qualification and education from [their home country] are not compatible with the demands here. There is no job satisfaction. We aspire to do well in this country, but the realization of not being able to is frustrating. (Focus group participant, Queens)***

In what ways can health promotion and health care needs be better addressed, overall and for distinct populations?

Key informants and focus group participants offered a number of recommendations –and described promising practices—that they felt would effectively improve health and/or the delivery of health care services. These recommendations included community and environmental changes which address social conditions that impact on health, assistance with navigation, health education, care coordination, targeted services for high need individuals, and removal of systemic barriers and inefficiencies within the delivery system. Selected recommendations are described below:

Addressing Broader Determinants of Health: Recommended community and environmental changes focused on poverty reduction, increased access to affordable healthy food and stable housing, reductions in toxins related to traffic and sanitation, more equitable geographic distribution of services targeting high need individuals, and reversal of public sector neglect of low-income neighborhoods.

> *I think it's less about [health care] access and more about all of the other things that are hindering access: poverty, chaotic drug use, unstable housing, hunger.* (Key Informant, CBO)

Reduced Financial Barriers: Financial barriers to optimal health and health care were noted repeatedly. Focus group participants, in response to a question regarding what should change in health care, overwhelming cited insurance, including its expense, complications, and the limitations it places on choice. Key informants also noted that reducing barriers related to insurance and cost would promote improved access to necessary care.

> *You have to break down these insurance barriers. I mean, that's what dictates how we operate. We actually have patients who can come to us for OB services, but they can't come to us for pediatric services. They can come to us for general care, but they can't come for dentist, I mean it's absurd.* (Provider focus group, Queens)

Community Health Workers: Several CNA participants described the significance of community health workers (CHWs), and the multiple roles they played (or could play) in promoting health and appropriate health care use, particularly with respect to navigating complicated components of the health care system, including health insurance and hospitals. From the perspective of CNA participants, training and employment of CHWs not only benefited patients and clients but also provided important training and employment opportunities for community members.

A great model is the community health worker model. This cooperative idea is training, hiring people from the community to improve people's health. Who's better than someone who's next to you? … if he looks like you, and he has family who comes from [the same place], they get trained in a way to do it. (Key informant, CBO)

Care Coordination/Case Management: Across populations and conditions, care coordinator and case management models were described as highly effective approaches for improving health and reducing health care use. Multiple key informants cited research that demonstrated positive outcomes resulting from implementation of care coordination programs. Responsibilities of care coordinators included linkage between multiple providers, health education, assistance with accessing entitlement and supportive services, and monitoring the stability and engagement of clients. Care coordination was seen as valuable, in part, because of excessive fragmentation within the health care system.

> *My mom is a frail older woman. When I see how often she has to go back to the same hospital to different clinics in the course of a week, I think, "Why can't they just make a schedule where the patient goes one day and has four appointments?" … And if there was an inpatient coordinator who handled all of this, so, Mrs. Smith could plan and have podiatry, psychiatry, gastro and gynecology all in one day and to not have to create a life that revolves around medical appointments, people would be more likely to do it. And I think it would end up being efficient and cost effective also.* (Key informant, CBO)

Health Education: Health education was a common theme in interviews and focus groups, incorporating recommendations for education of the broader public, as well as individual level education regarding management of complex health conditions. Education topics recommended by CNA participants included diabetes, nutrition, exercise, mental health, HIV and sexual health, health and health care literacy, tobacco and other substance use, as well as access and appropriate use of health care services.

> ***I have heard many people say, "But, I want a place where I can go and learn what to eat and how to buy food and how to prepare meals be-cause of my condition, but allows me to also save money because I'm on food stamps." (Focus group participant, Manhattan)***

Targeted Services for Highest Need Individuals. High need populations, including the recently incarcerated, homeless, and those with significant behavioral health issues, were described as needing targeted services to improve health and reduce expensive and inefficient utilization of the health care system. In addressing high need populations, recommendations focused on enhanced case management and coordination of care across sectors, sensitivity to special needs, recognition that optimal health is contingent upon stability with respect to basic needs and providing services where people are:

> *The [supportive housing] staff is there for relapse … making sure that the main goal is housing stability, right? So, doing everything they can so the person doesn't lose their apartment. Which would happen, or probably did happen, in their past life, particularly with mental illness or substance abuse. You decompensate and there's nobody there to help you before you lose your apartment. So you end up in the shelter, the jail, the psych unit. (Key informant, advocacy)*

Greater sensitivity to the needs of individuals with disabilities was also recommended, given their disproportionately low income, high health needs, and multiple difficulties accessing care.

> ***When people with disabilities go to seek care, someone sees them in terms of their diagnosis. "Oh, you are the person with [multiple sclerosis]. You are the person with the [traumatic brain injury]. You are the person with cerebral palsy." And so you are not seen as the person who is sexually active and needs advice about that. Or who may be drinking excessively. Or who may be drugging and self-medicating. You are not seen as the person who needs vaccinations. (Key informant, advocacy)***

DESIGN & METHODOLOGY

The design and methodology of the CNA were developed by The New York Academy of Medicine (The Academy), working closely with collaborating health systems across the four boroughs. There were five overarching questions for the interview, focus group and survey components of the CNA, namely:

1. To what extent are community and environmental conditions conducive to health promotion and disease prevention?
2. What are the primary health concerns and health needs of residents, overall and according to neighborhood and socio-demographic characteristics?
3. What are the health-related programming and services available to community residents, what organizations are providing the services, and what are the service gaps?
4. Are there differences in access, use and perceptions of health-related programming and services according to neighborhood and according to ethnic, racial, and language groups?
5. In what ways can health promotion and health care needs be better addressed, overall and for distinct populations?

The convening of focus groups and administration of surveys were conducted in collaboration with a broad range of local community-based organizations (CBOs) targeting distinct populations, including residents of public housing, immigrants and minority populations, older adults and people with particular health issues. Street outreach was also used for survey administration in low-income neighborhoods, so as to include community members unconnected to the collaborating CBOs. Thus, compared to the population of NYC overall, survey and focus group participants—as described in more detail below—were more likely to have Medicaid or be uninsured, to be from minority populations, and to have limited English proficiency. In addition, there was intentional overrepresentation from those engaged with social service programs or with identified health issues.

STUDY PARTICIPANTS

Key Informants: Interviews were conducted with 41 key informants, who were selected in collaboration with the participating health systems, for their knowledge, experience, and linkages to target communities. The majority were staff (including direct service and administrators) of community based organizations that provide services to and/or advocate for low-income and uninsured NYC residents. Smaller numbers were medical providers and senior staff of relevant NYC governmental agencies. A portion had population specific expertise (e.g., particular immigrant groups, older adults, LGBT, children, and adolescents); others had expertise in specific issues, including housing, care coordination, environmental health, criminal justice, and homelessness.

Focus Group Participants: Eighty-one focus groups were convened, engaging diverse NYC community members, including older adults, immigrants (African, Asian, Caribbean, Latino), public housing residents, LGBT, survivors of domestic violence, individuals with particular health conditions, and individuals with disabilities. In addition to the consumer groups, we conducted a small number of focus groups with other stakeholders, including behavioral health providers, care coordinators, and hospital advisory board members. The mean age of focus group respondents was 49; 64% were female, 43% were black/African American, 34% Latino, 13% Asian, 17% were uninsured, and 54% were on Medicaid; 32% reported speaking a language other than English at home.

Survey Respondents: In total, 2,875 surveys were completed across four boroughs: 26% of survey respondents resided in the Bronx, 28% in Brooklyn, 23% in Manhattan, and 23% in Queens. Their ages ranged from 18 to 102, with an average age of 48. Just over one third (37%) were black/African American and just under one third (30%) were Latino; 43% had limited English proficiency (LEP). Approximately three-quarters (77%) had graduated from high school. Fifty-five percent were on Medicaid and 12% were uninsured.

DISCUSSION

Over 3,000 primarily low-income NYC residents and key stakeholders participated in and contributed to the CNA described here. They highlighted a range of health-related issues and offered recommendations for individual, community, provider, and systemic approaches, which include: addressing the broader determinants of health, expansion of community health worker programs, improved integration and coordination of care, health education, and targeted services to highest need individuals. Several of these recommendations are consistent with NYS and NYC initiatives, such as the NYS Population Health Improvement Program, which seeks to promote health across communities;[3] support for the Advanced Primary Care model, which integrates behavioral health and supportive services with primary care;[4] and the NYC Connections to Care program, a $30 million NYC initiative that links community based organizations and mental health providers.[5] As additional programing is developed, our hope is that the findings reported here, as well as subsequent reports focused on transgender health, mental health, immigrants, nutrition, physical activity, and aging, may prove useful to policy makers, program administrators, funders, and community residents.

This collection of voices provides a direct glimpse inside the health issues and needs of New Yorkers to help inform the many decisions that are being made on a daily basis by community- and health-providers, and policy makers. For more insights and perspectives directly from those in need, visit nyam.org to download the full City Voices: New Yorkers on Health series of reports.

The views presented in this publication are those of the authors and not necessarily those of The New York Academy of Medicine, or its Trustees, Officers or Staff.

[3] https://www.health.ny.gov/community/programs/population_health_improvement/

[4] https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_sim_project_narrative.pdf

[5] http://www.nyc.gov/html/fund/html/projects/connections-to-care.shtml

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About the Academy

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Established in 1847, The New York Academy of Medicine continues to address the health challenges facing New York City and the world's rapidly growing urban populations. We accomplish this through our Institute for Urban Health, home of interdisciplinary research, evaluation, policy and program initiatives; our world class historical medical library and its public programming in history, the humanities and the arts; and our Fellows program, a network of more than 2,000 experts elected by their peers from across the professions affecting health. Our current priorities are healthy aging, disease prevention, and eliminating health disparities.

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