# NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

2019-2021 Community Health Assessment and

Community Health Improvement Plan: Take Care New York 2024

**EXECUTIVE SUMMARY**

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Counties covered: Bronx, Kings, New York, Queens and Richmond.

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NYC Health

# 1 Executive Summary

## 1.1 Prevention Agenda Priorities

Take Care New York (TCNY) 2024 is the New York City (NYC) Department of Health and Mental Hygiene's (DOHMH; Health Department) blueprint for advancing health equity and giving everyone the chance to lead a healthier life.[1] It has three core functions—to instigate discussions among cross-sector stakeholders about what creates health and amplify the urgency of addressing health inequities; build new and strengthen existing networks that can support the development of multi-sector collaborations with shared priorities around eliminating health inequities; and catalyze action and ensure that stakeholders can effectively lead projects that will drive change in health inequities. We apply critical lenses to our work, as we know that racism and other forms of structural oppression, overlapping with economic inequalities and poverty, are the drivers of health inequities.

TCNY 2024 is the core of our Community Health Assessment and Community Health Improvement Plan. TCNY 2024 priorities align with the New York State Prevention Agenda. DOHMH is collaborating across sectors and agencies to advance TCNY goals, which touch on all Prevention Agenda priorities. While TCNY 2024 is a comprehensive plan, this report includes details of our plans to improve on two TCNY overarching indicators. One is premature mortality (death before age 65), for which the top leading causes include heart disease and diabetes. More than one in four adult New Yorkers report having hypertension,[2] the leading modifiable risk factor for heart disease and stroke. Black adults are almost twice as likely to die prematurely due to heart disease compared to White adults (78.4 vs. 41.7 per 100,000).[3] The second focus of this report is infant mortality (death before age 1), which remains three times higher for Black New Yorkers as compared to

[1] Mettey A, Garcia A, Isaac L, Linos N, Barbot O, Bassett MT. Take Care New York 2020: Every Neighborhood, Every New Yorker, Everyone's Health Counts. New York City Department of Health and Mental Hygiene. October 2015. https://www1.nyc.gov/assets/doh/downloads/pdf/tcny/tcny-2020.pdf

[2] NYC DOHMH Community Health Survey, 2017. https://a816-healthpsi.nyc.gov/epiquery/CHS/CHSXIndex.html

[3] New York City Department of Health and Mental Hygiene. Take the Pressure Off, NYC! Inaugural Plan. 2018; 1–57. https://www1.nyc.gov/assets/doh/downloads/pdf/csi/take-pressure-off-nyc-inaugural-plan.pdf

Whites.[4] These two TCNY indicators align with the following Prevention Agenda Priorities: **Prevent Chronic Diseases** and **Promote Healthy Women, Infants, and Children**.

## 1.2 Data

To produce TCNY 2024, the NYC Health Department reviewed a variety of data sources on diseases and deaths in NYC, looking for trends that unjustly affect some neighborhoods or groups more than others.[5] We looked for differences in health outcomes by age, race/ethnicity, gender, education, neighborhood poverty, immigration status, borough, and sexual orientation. We also looked at important aspects of daily life that affect health, such as housing, employment and education.

The Community Health Profiles summarize a large part of the information reviewed as part of the TCNY 2024 process (see 51 citywide maps and individual reports capturing the health of the 59 Community Districts across the city). Every year DOHMH's Summary of Vital Statistics highlights trends in the births and deaths that occur in NYC. These trends are used to inform our programs and policies. For the two Prevention Agenda priorities of this Community Health Assessment and Community Health Improvement Plan, we additionally used population health surveys, including the annual Community Health Survey and clinical data from primary care practices and registries to track hypertension, cancer and diabetes rates.

## 1.3 Partners

The NYC Health Department works with hospitals, local pharmacies, primary care providers, community-based organizations, city agencies and others to improve public health across the city. We partner with stakeholders and communities to provide direction and evaluation through a variety of advisory boards and initiative-specific coalitions. Our vision is that health impacts are considered as a regular part of decision

[4] Li W, Onyebeke C, Huynh M, Castro A, Falci L, Gurung S, Kennedy J, Maduro G, Sun Y, and Van Wye G. Summary of Vital Statistics, 2017. New York, NY : New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2019 https://www1.nyc.gov/assets/doh/downloads/pdf/vs/2017sum.pdf

[5] Mettey A, Garcia A, Isaac L, Linos N, Barbot O, Bassett MT. Take Care New York 2020: Every Neighborhood, Every New Yorker, Everyone's Health Counts. New York City Department of Health and Mental Hygiene. October 2015. https://www1.nyc.gov/assets/doh/downloads/pdf/tcny/tcny-2020.pdf

making within city government, the private sector, and non-profit organizations, and that these partners are transformed to become champions for health equity.

In our work to prevent chronic diseases, namely hypertension and diabetes, providers are supported through practice facilitation, pharmacists are taking an increased role in hypertension and diabetes control, and farmers markets are helping consumers buy and cook healthy food. On the infant death prevention front, home visiting programs continue to be developed and implemented, and connections between clinical and community services improved, expanding support to new parents. Internal programs, the public hospital system, and government and community-based partnerships are also working to expand crib distribution and safe sleep education.

## 1.4 Community Engagement

At the NYC Health Department, community engagement is a central element to our planning process; our policies and programs reflect the voices of NYC residents and the changes they want to see in their community. One example of how we captured these voices was the TCNY 2024 Planning and Visioning Convening in Spring 2019, where a cross-sectoral group of more than 35 stakeholders from across all five boroughs came together to discuss how to advance health equity in NYC. Additionally, in Fall 2019 DOHMH launched a broad outreach campaign, funding more than 25 organizations to use an interactive toolkit at 40 events citywide to engage many New Yorkers in conversations about what creates health, and to build excitement for the TCNY 2024 consultations.

To determine the top TCNY 2024 priorities at the community district and borough levels, in 2020 DOHMH will host more than 25 community consultations across the five boroughs, as well as consultations by population subgroups to engage groups who experience greater risk factors, worse access to care, and increased morbidity and mortality compared with the general population, such as youth, older adults, immigrants, transgender people, and people with disabilities.

To engage the community around our two reported Prevention Agenda priorities, we consulted with community members, community partner organizations, and leaders across a variety of sectors. Input was provided by multi-sectoral stakeholder groups such as the Diabetes Prevention Network and the Maternal and Infant Health Collaborative. Going forward, our programs will use a variety of embedded mechanisms to solicit feedback from stakeholders, including community members, people with lived experience, and health care providers.

## 1.5 Strategies and Interventions

The Community Health Improvement Plan in this document includes a portfolio of evidence-based and evidence-generating interventions. They were selected based on research about the anticipated impact on health and equity outcomes and informed by community partnerships. To prevent and manage chronic diseases, particularly hypertension and diabetes, we are providing practice facilitation support to primary care practices, assisting pharmacies to provide medication therapy management, and providing trainings to build organizational capacity to refer to and implement diabetes and pre-diabetes self-management programs. For infant death prevention, we are increasing capacity and competencies of infant home visiting programs and conducting citywide crib distribution and safe sleep education.

## 1.6 Tracking progress

TCNY 2024 uses the Primary Care Information Project Hub Population Health System Data to track progress and improvement in controlled high blood pressure and A1C levels, and data from NYC DOHMH Office of Vital Statistics to track infant deaths and the top causes of premature death. The programmatic process metrics are outlined in the Community Health Improvement Plan section of this document. They include volume of sites and individuals trained, monitoring of blood pressure and A1C level control, the number of families served by home-visiting programs, and uptake of infant safe sleep practices.