

TCNY/2020

**3RD ANNUAL
UPDATE
2018**



TAKECARE
NEW YORK



LETTER FROM THE COMMISSIONER



December 2018

Dear Partner,



I am pleased to share with you this Third Annual Update to Take Care New York 2020 (TCNY 2020), the New York City Health Department's blueprint for improving the health of all New Yorkers and advancing health equity across our city.

Much has changed since we originally published the TCNY blueprint in 2015. While New York City (NYC) remains as vibrant and resilient as ever, we now face new challenges as a city and as a country. Rollbacks of numerous social and environmental protections alongside the implementation of policies that tear families apart will potentially threaten many NYC communities that have fought to overcome centuries of injustice and inequality. The national context of fear and exclusion has wide-ranging effects on health, and as you will see in this report, many health inequities have endured or even intensified in NYC since 2015.

Thanks to the myriad stakeholders who have elevated health equity as a priority in NYC, many organizations and businesses across the five boroughs are collaborating to support health in their neighborhoods — but there is much more to do. It is more important than ever that we work together to protect and promote the health of all New Yorkers, no matter what neighborhood they live in, where they were born, or the size of their bank account.

All of us have a role to play in improving the health of our city, and we hope you are inspired by what you read in these pages to find new ways of contributing to the well-being of your fellow New Yorkers.

Sincerely,

Dr. Oxiris Barbot

Commissioner

New York City Department of Health and Mental Hygiene



INTRODUCTION

Health is influenced by more than just having a good doctor, inheriting certain genes or maintaining a healthy lifestyle. The housing in which we live, the communities and people who surround us and even the state of the economy all impact our ability to lead healthy lives.

In 2015, the New York City Health Department launched [Take Care New York 2020](#) (TCNY 2020), a blueprint for improving health and well-being in New York City (NYC) by the year 2020. TCNY 2020 defines success by how much we reduce inequities and the underlying drivers of those inequities in health outcomes. It looks at social factors like education and housing in addition to traditional health indicators, such as hospitalization rates. And it highlights the key role that community organizations and businesses play in supporting health in their neighborhoods. Taken together, these aspects of TCNY 2020 reflect our comprehensive approach to achieving health equity.

Since the launch of TCNY 2020, we have released annual reports highlighting our stakeholders' efforts to promote health equity. This Third Annual Update includes in-depth case studies describing specific projects from four organizations, as well as an update on our progress toward the City's targets for the year 2020. New Yorkers can learn more about in the complex factors influencing health within their own neighborhoods in the Health Department's [2018 Community Health Profiles](#).

The data in this year's TCNY update shows that we are not on track to meet all of our key targets for improving health and reducing health inequities. For example, although more Latino New Yorkers are receiving needed medical care, responses to our 2017 survey showed that fewer Latinos reported good health last year than in 2013. And despite all of our collective efforts, there has been little change in the citywide rate of early death and drug overdose deaths remain at epidemic levels. Data on all of the TCNY 2020 indicators can be found in the Appendix.

Unequal access to housing is one of the many complex drivers of health inequities. Housing quality and cost, the neighborhood environment in which housing is located, the services available near where people live, and the protections and resources that keep people in their homes and out of homelessness all affect health.¹ Currently, many New Yorkers face a crisis in housing. More than 30 percent of the city's residents are "severely rent burdened," meaning they spend more than 50 percent of their income on housing.² The New York City neighborhoods facing the highest percentages of rent burden are home primarily to people of color.³

A long history of discriminatory housing policies, including redlining (for a definition of "redlining," see Page 6), has concentrated poverty and poor health in communities of color. Achieving health equity will require improvements to the quality and affordability of housing in our communities. We have included additional information about the relationship between health and housing throughout this report to help all TCNY 2020 stakeholders understand how housing factors can negatively impact health.

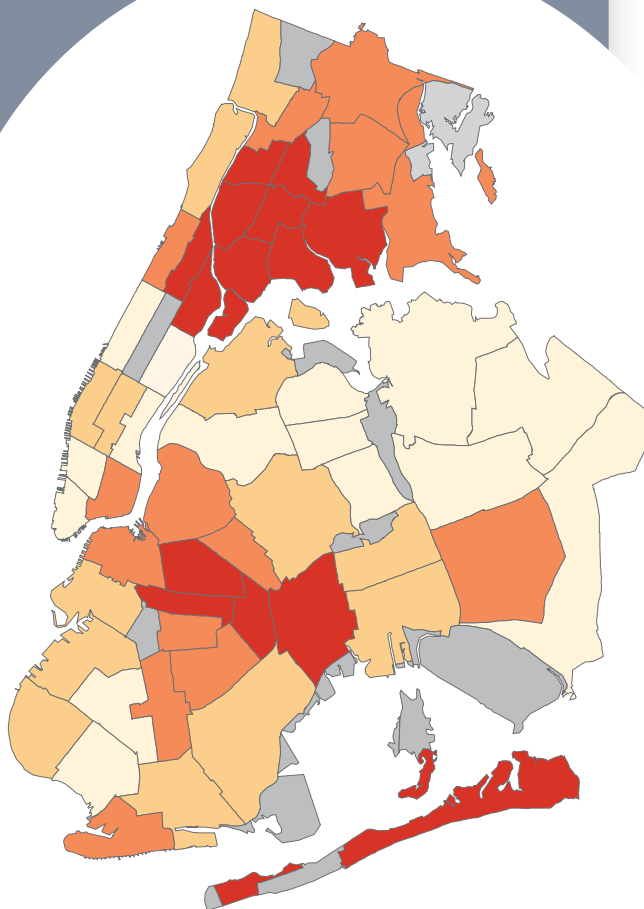
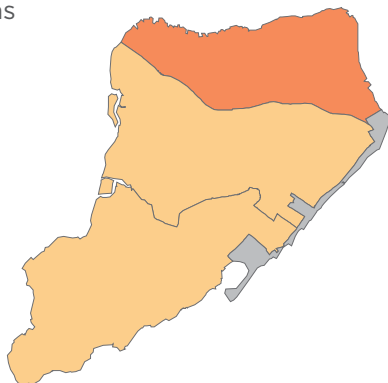
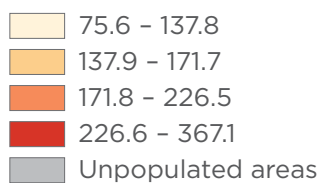


REDLINING

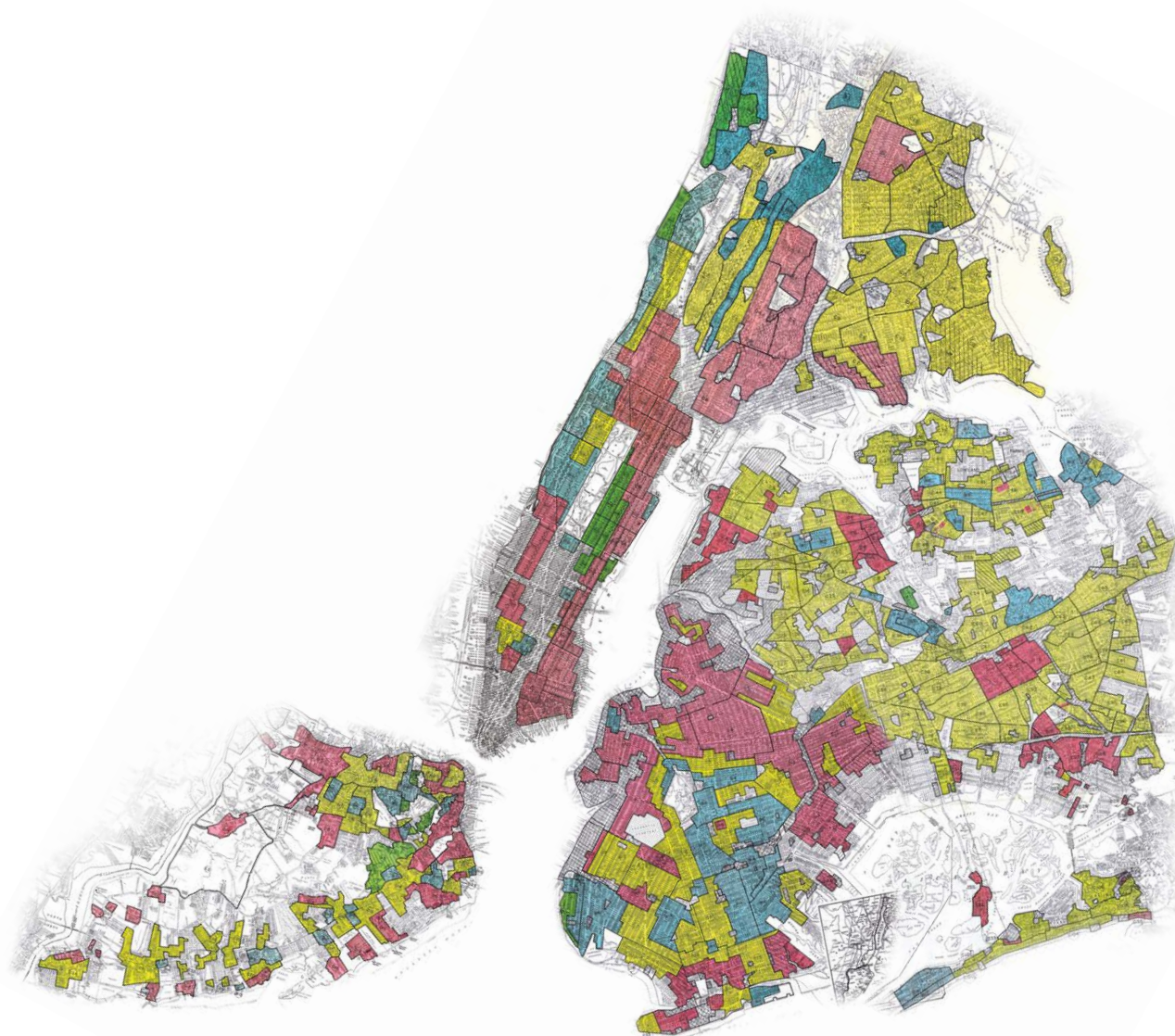
The term “redlining” describes a government-sponsored banking practice that began in the 1930s. Banks used color-coded maps to approve or deny mortgages to families across the United States. Neighborhoods outlined in red on these maps were deemed “too risky” for government-backed lending. These neighborhoods were usually home to communities of color and by denying these communities mortgages and home improvement loans, redlining worsened racial and economic segregation. Although the practice of redlining was declared illegal in the late 1960s, its impact persists today; it has contributed to housing instability, inequitable access to health-promoting resources, and unhealthy living conditions. Redlining’s influence on health is clear when you compare a map of redlined communities with a map of health outcomes (see the maps on Pages 6 and 7).

Even after redlining was declared illegal, housing discrimination continued in different forms, such as predatory lending and racial steering, which is the practice of guiding prospective home buyers away from certain neighborhoods based on race. New York City is committed to addressing this history and closing the gap in health outcomes. Where We Live NYC (nyc.gov/wherewelive) is a bold new initiative led by the Department of Housing Preservation and Development that is working with residents, stakeholders and policymakers to identify and address the factors that contribute to segregation and inequitable neighborhood outcomes. Where We Live NYC and TCNY are two of the many ways in which City agencies ensure that NYC is the most resilient, equitable and sustainable city in the world.

Premature Mortality (death before age 65) Rate per 100,000 population



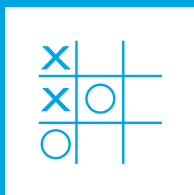
This map shows how mortgage lenders in the 1930s rated different New York City neighborhoods. People living in the neighborhoods in red (where the term “redlining” comes from) were often unable to get mortgages.



Residential Security Map

- LEGEND -

- A First Grade
- B Second Grade
- C Third Grade
- D Fourth Grade



PROMOTE HEALTHY CHILDHOODS



There are almost 3 million children and youth living in NYC⁴, and every one of them deserves the benefits that come with living in a city rich in diversity and resources. Sadly, not all NYC children have access to these opportunities from a very early age. The infant mortality rate for babies born to Black mothers remains three times higher than the rate for babies born to White mothers in NYC.⁵

It is critical that we support the health of mothers and their children. Group prenatal programs such as CenteringPregnancy (see page 10) help us do that. Research shows that CenteringPregnancy improves health outcomes for mothers and children by empowering patients and building a sense of community, and has the added benefit of improving provider satisfaction.^{6,7} We are on track to meet most of our targets related to promoting healthy childhoods, with more youth avoiding unintended pregnancy and graduating from high school and more maternity facilities providing high-quality care.

Stability and safety in the home are also key to a child's well-being. Young children who experience homelessness for more than six months are significantly more likely to be at risk for developmental delays and hospitalization, compared to their peers.⁸ Housing instability has reached epidemic levels in New York City and across the nation. Each year, almost 10 percent of New York City public school students experience homelessness.⁹

Households that pay more than 30 percent of their income in rent are more likely to experience eviction than those that do not.¹⁰ Furthermore, low-income tenants have historically been forced to navigate the housing court system without legal representation — State court officials estimated that only 1% of all tenants were represented in 2013, often resulting in tenant harassment and eviction.¹¹

In 2017, a tenant's Right to Counsel (Local Law 214-B) was established in New York City, guaranteeing that by 2022, all income-eligible tenants will have the right to an attorney when facing eviction in housing court.¹² Promoting healthy childhoods means taking additional steps such as these to address housing problems, in addition to the health care and community conditions experienced in childhood.



CASE STUDY: CenteringPregnancy



BACKGROUND

The Bedford-Stuyvesant Family Health Center (BSFHC) has provided care in Central Brooklyn neighborhoods like Bedford-Stuyvesant, Bushwick, Brownsville and Crown Heights since 1978, and Dr. Pascale Kersaint has been its medical director since 2007. In this role, she has seen many babies born too small, weighing less than 5 pounds or prematurely. For a long time, it was a problem without a solution. “We tried everything,” she says. “Nutritional counseling, behavioral health — but nothing worked.”

In 2015, Dr. Kersaint learned about an opportunity to receive free training, materials and start-up support for CenteringPregnancy, a group prenatal care model associated with lower rates of preterm birth and low birthweight, as well as higher rates of breastfeeding, greater patient satisfaction and improved outcomes. She applied this new approach at BSFHC in 2016 with funding and technical assistance from Healthy Start Brooklyn, a program based in the Health Department’s Brooklyn Neighborhood Health Action Center.



Dr. Pascale Kersaint, BSFHC Medical Director



PROCESS

BSFHC began by training staff members to facilitate the CenteringPregnancy sessions. Sixteen staff members completed a basic two-day training and four staff members later received advanced training.

Each CenteringPregnancy group includes six to 12 women with similar due dates. Group members meet with a medical provider and another staff facilitator 10 times over the course of their pregnancy for two hours each session — much longer than an average prenatal visit. Perhaps the most important part of the program is the peer support: Participants not only get support from their doctors or midwives, but from each other, which is one of the most compelling components of this model. Nurse Darshanna Sessoms, who coordinates CenteringPregnancy at BSFHC, says, “We still get emails and photos from our graduates. They get together, email each other, Facebook, FaceTime.”

BSFHC and two other Brooklyn facilities have come together to talk about their successes and challenges, trade tips and advice, and consult with experts from the Centering Healthcare Institute, the organization that created the CenteringPregnancy model. This collaboration will bring CenteringPregnancy to even more women in Central Brooklyn.





CHALLENGES AND OPPORTUNITIES

Initial funding covered training, materials and two years of start-up support, but did not allow for hiring new employees. Existing staff members added this role to their already full workloads. However, once staff saw the benefits of the program, the whole organization looked for ways to support it. Another challenge was finding a space to hold the group sessions. BSFHC discovered that by holding the health assessments in a separate room they were still able to provide the benefits of the group discussions and activities.



PROGRESS

Dr. Kersaint reports that in 2017, mothers who participated in CenteringPregnancy had low-birthweight babies at less than half the rate of other BSFHC patients. In addition, she says, only 10 percent of CenteringPregnancy patients have premature births (versus 17 percent of those receiving conventional care), and CenteringPregnancy patients attend more of their prenatal and postpartum visits. To see a video about this program, visit [youtube.com/nychealth](https://www.youtube.com/nychealth) and search for “Bedford-Stuyvesant Family Health Center.”



RECOMMENDATIONS

Providers who establish group prenatal care programming can maximize its impact if they do the following:

1

Involve institutional leadership early in the process so leadership understands the benefits of group prenatal care and becomes invested in maintaining it.

2

Make group prenatal care the standard of care, by using an opt-out model for enrollment rather than asking patients to opt in.

3

Offer sessions in the evening or on weekends, to make the program accessible for women who work.

4

Allocate at least 20 percent of one person's staff time to coordinating the program.



“ I was hesitant at first — I didn’t want to tell all my business to people I didn’t know — but [the doctor] said, ‘Just check it out.’ I’m so glad I did! It was so nice to be in a group of people who understood what you were going through. ”

– First-time mom and CenteringPregnancy BSFHC patient



CREATE HEALTHIER NEIGHBORHOODS



Streets, buildings, open spaces and people make up the fabric of our communities and affect our health. The healthier our neighborhoods and homes are, the easier it is for us to be healthy.

There are many ways to promote health in the home, and in doing so, support health in the community. For example, access to air conditioning can help prevent heat-related health problems, including heat stroke and poor sleep quality.¹³ Air conditioning can also reduce exposure to outdoor air pollutants, such as ozone, through filtering. Outdoor air pollutants, dust, pests such as mice and cockroaches, mold and secondhand smoke can all worsen asthma — a leading reason for emergency department visits among children.

Building owners and landlords can support the health of their tenants by keeping apartments well-maintained. But in low-income and predominantly Black and Latino neighborhoods in NYC, most homes have maintenance defects.¹⁴ It is in these same communities that we see higher rates of chronic disease and preventable injury that are triggered or made worse by poor housing quality. Although disparities continue to exist, citywide efforts to address housing problems are paying off — new data shows that fewer homes had maintenance defects in 2017 than in 2014, both across the city and in very high-poverty neighborhoods.

Relationships also influence health. Social isolation can negatively affect health, especially in older adults, whereas social cohesion—shared values and trust among neighbors—can have a powerful positive effect on health.^{15,16} When neighbors trust each other, and believe that collective action can lead to positive change, they are more likely to work together to make their neighborhood a better place to live. When TCNY 2020 was first launched, it included a placeholder for measuring social cohesion in New York City. Since then, we have asked thousands of New Yorkers about the helpfulness of their neighbors, a key factor of social cohesion. In 2017, 79 percent said they “agree” or “strongly agree” that people in their neighborhood are willing to help each other. Over the coming years, we will look at how this and other elements of social cohesion affect community health.



CASE STUDY: Community Health Workers



BACKGROUND

Approximately 4,000 school-age children in Staten Island have asthma, and 1,200 of these children suffer from symptoms more than once a week. The Staten Island Asthma Coalition — a collaboration of local health providers, the Staten Island Borough President's Office, community organizations and the Health Department — was established in 2016 to help families manage their children's asthma and reduce the negative impacts, such as medical emergencies and school absences¹⁷.

The coalition uses a multipronged approach to improve health outcomes among children with asthma, including an asthma community health worker pilot program through Make the Road New York. Community health workers are trusted community members who share common racial and ethnic backgrounds, cultures, languages and life experiences with the communities they serve. In partnership with health care providers, community health workers can help people better manage their health conditions.



PROCESS

Health care providers who participate in the community health worker pilot program introduce the child's family to a community health worker. Maritza Puma, a community health worker from the community organization Make the Road New York, begins by meeting the family at the clinic or health facility. Maritza coaches the family on how to reduce asthma symptoms and triggers in their day-to-day life, helps to coordinate their care and equips them with the tools to advocate for their health.

Maritza assesses the family's home for potential asthma triggers and other environmental health hazards. If she identifies a health hazard, she refers the family to the Health Department and/or Neighborhood Housing Services of Staten Island. These organizations offer home services such as integrated pest management to address mice and cockroaches that can trigger asthma in the home.



“My experience with Maritza at Make the Road New York has been incredible. She has helped me so much, not just with my daughter's asthma but also in receiving other services in my community.”

– Make the Road client



CHALLENGES AND OPPORTUNITIES

One of the biggest challenges for the asthma community health worker pilot program is that some families do not consent to integrated pest management or mold remediation services, which would address health hazards in the home. Some families who rent their apartments are reluctant to give consent because they fear retaliation from their landlord or building owner. For immigrant families, these fears may include deportation. It can also be challenging to reach the family about scheduling follow-up visits for services even if consent is received.

However, because they engage directly with the family at home, community health workers have opportunities to address any variety of challenges or barriers. In addition to telling families about the available services, community health workers can also provide general health education. Clients may also receive resources for legal assistance if they fear landlord retaliation.



PROGRESS

Make the Road New York has received 116 clinical referrals, conducted 88 home visits and made 22 referrals for environmental intervention services between 2017 and August 2018. Clients have reported seeing improvements in their child's health after receiving care coordination services and integrated pest management. To see a video about this program, visit [youtube.com/nychealth](https://www.youtube.com/nychealth) and search for "Make the Road New York."



RECOMMENDATIONS

Organizations that employ or would benefit from employing community health workers can take the following steps to make sure clinical-community interventions are effective:

1

Cultivate strong relationships between community health workers and health care providers, so that patients are connected to additional services that can benefit them.

2

Make sure community health workers are visible and readily available in clinical facilities.

3

Ensure that a housing attorney or advocate is available for clients to reduce the risk of landlord retaliation. For free legal aid information, visit [lawhelpny.org](https://www.lawhelpny.org).



SUPPORT HEALTHY LIVING



The choices people make are affected by the options they have and the environments in which they live. For example, people may find it difficult to eat healthy foods if their local store doesn't carry healthy food options or if those options are too expensive.¹⁸ After controlling for socioeconomic factors, we still see less access to health-promoting goods and services in communities of color¹⁹ — and companies heavily market unhealthy options to those same communities.²⁰ The inequitable distribution of neighborhood resources contributes to health disparities, or unequal health outcomes, between neighborhoods.²¹ To reach our health equity goals, we must undo these patterns and make sure that all New Yorkers have access to the resources that contribute to good health.

Even in healthy environments, it is difficult for any person to change their habits. Although organizations across the city work to support healthy behaviors, there has been limited progress toward some of our Healthy Living targets. For example, New Yorkers still consume sugary drinks at the same rate as they did in 2015.

Organizations can help people make healthy choices by providing healthy foods in meetings, working to remove sugary drink advertisements in neighborhoods and encouraging people to use the stairs. Similarly, having a policy on smoking in residential buildings protects the health of all New Yorkers from the harms of secondhand smoke.²² In 2018, New York City passed Local Law 147, which requires residential buildings with three or more residential units to create a policy on smoking and to share it with current and future tenants. The case study on page 18 shows how one

building adopted such a policy. The New York City Housing Authority (NYCHA), New York City's largest residential landlord, also started Smoke-Free NYCHA in 2018. This policy, which forbids smoking anywhere within NYCHA buildings or within 25 feet of a building, is an important step in creating healthier indoor air for public housing residents and employees.

The opioid epidemic is another factor affecting healthy living in NYC. In March 2017 the City launched HealingNYC, a comprehensive strategy to address the opioid epidemic. Data on drug overdose deaths in 2017 shows that the rate of increase slowed down significantly, but that neighborhoods with the highest rates of poverty had the highest rates of overdose. Poverty, unstable housing and other social challenges such as the historical treatment of substance use as a criminal issue rather than a health issue continue to underlie the high risk of overdose in high-poverty neighborhoods. Additional citywide efforts to improve housing, economic opportunity, and physical and mental health will help bend the curve of the epidemic.



CASE STUDY: Smoke-Free Housing



BACKGROUND

Secondhand smoke drifts easily from apartment to apartment, creating unhealthy conditions for everyone it reaches. In 2016, more than four in 10 adult New Yorkers (44 percent) reported smelling cigarette smoke coming into their home from another home, apartment or from outside.²³ Children exposed to secondhand smoke have higher risks of asthma attacks, sudden infant death syndrome (SIDS), and respiratory and ear infections. A smoke-free housing policy is the only effective way to ensure that residents are protected from the dangers of secondhand smoke.²⁴

Phyllis Goldstein, a resident of North Shore Towers (NST) in Queens who also serves on its board of directors, helped her co-op go smoke-free.



PROCESS

To get NST to adopt an official smoke-free policy, Goldstein had to convince two-thirds of shareholder residents to vote in favor of it. Goldstein worked with Northwell Health, NYC Smoke-Free and the Health Department to educate the board of directors and NST residents about the benefits of a smoke-free policy, the difficulty of blocking secondhand smoke from traveling between apartments and the legality of adding a smoke-free amendment to the lease.

Goldstein also recruited fifty residents to engage other members of the community in face-to-face dialogue about the issue, track who returned ballots and send voting reminders. In fall 2016, a supermajority of the residents voted to amend NST's lease so that cigarette smoking would be banned in all indoor areas, and on balconies and terraces.

“ When a board of directors works cooperatively and in the best interest of the community, it can accomplish miracles. Why did we do this? We are a community that works together; and we also breathe the same air. ”

– Phyllis Goldstein, Board Member, North Shore Towers





CHALLENGES AND OPPORTUNITIES

Board members learned from previous experience that too few residents participate in annual board elections to achieve a two-thirds vote in favor of amending the lease. For that reason, they opted to have a stand-alone election focusing solely on amending the proprietary lease to eliminate smoking from all interiors of the buildings.

“It was an arduous task,” Goldstein says, “but we had people who were gung-ho and believed in the smoking ban helping us day and night. I had people come up to me weeks after the vote, thanking me for my work.”



PROGRESS

The policy went into effect on January 1, 2017, making NST the largest cooperative in NYC to go smoke-free. There have been no official complaints and residents are reportedly happy with the new rule. To see a video about this effort, visit [youtube.com/nychealth](https://www.youtube.com/nychealth) and search for “North Shore Towers.”



RECOMMENDATIONS

New Yorkers who want their apartment buildings to adopt smoke-free policies can find success if they:

1

Conduct an anonymous survey to gauge the level of support for a smoke-free policy; a sample survey can be found on the Health Department’s smoke-free housing page (visit [nyc.gov/health](https://www.nyc.gov/health) and search for “smoke-free housing”).

2

Hold a community meeting to discuss the results of the survey, outline how a smoke-free policy could be started and address any concerns that residents may have.

3

Have a conversation with their building management and/or board of directors; materials to support these types of conversations are also available on the Health Department’s smoke-free housing page.



INCREASE ACCESS TO QUALITY CARE



The United States spends more on health care per person than any other industrialized nation²⁵ but sees much worse health outcomes.²⁶ This holds true in New York City where, even with the passage of the Affordable Care Act in 2010, which expanded access to health insurance, 10 percent of New Yorkers still do not have access to the care they need and deserve.²⁷ Where we live affects how easily we can access quality health care, and we are still dealing with our nation's segregated past; medical facilities that serve predominantly Black communities are often under-resourced and understaffed.²⁸

To provide fair and equitable access to care, the Health Department has worked with community partners to transform the City's STD Clinics into Sexual Health Clinics with an expanded menu of services. This transformation is part of the City's Ending the Epidemic (EtE) plan, which aims to end the HIV epidemic in New York City by 2020. Over half of the clients using pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) or anti-retroviral treatment services offered at the Clinics are Black or Latino men who have sex with men, the priority population in which we are looking to reduce HIV diagnoses by 2020. Health data available this year show we are on track to reduce the number of new HIV diagnoses citywide, including in men of color who have sex with men.

Health care providers and community organizations have a large role to play in helping New Yorkers meet not just their physical but also mental health and behavioral health needs. Providers should screen for substance use, depression, trauma, post-traumatic stress disorder and anxiety at physical health care visits. Additionally, screening patients for their social needs, such as housing, food or transportation assistance, and referring them to the appropriate resources can help prevent acute health issues in the future. Finally, the Health Department recommends that health care providers hire peer workers to serve as health educators and advocates for clients who use drugs, as described in the case study on Page 22.



CASE STUDY: Peer Services



BACKGROUND

Peer-based services have many benefits for people who use drugs. Peers who have lived through the experience of substance use or overdose can offer knowledge and resources that help clients who use drugs improve their health and reduce the harms associated with drug use. Peers also help to create a sense of community among individuals who might otherwise be isolated and stigmatized. Trained peers can draw from their own experiences and their familiarity with the health care system to reach people at all points on the substance use continuum. Additionally, training and employing people with lived experience to serve as peer educators and advocates helps build peers' capacity for other forms of employment.

Many settings, including behavioral health centers, medical clinics and managed care organizations, can benefit from peer services. For the last 10 years, the nonprofit New York Harm Reduction Educators (NYHRE) has worked to develop the peer workforce through its UPRISE training and field practicum program. The biannual UPRISE program trains people with lived experience to provide health education and social service referrals to their peers. NYHRE often hires its own graduates into open positions at the organization.



PROCESS

When hiring peer educators and advocates, it is important to first acknowledge that they may be actively facing many stressors including poverty, trauma, stigma and marginalization. Offering mentorship and multiple peer-based positions with different types and levels of responsibility can help peers develop personally and professionally. For some individuals, a volunteer position may be the best long-term fit; for others, the experience of volunteering — maintaining a regular schedule, and building trust with colleagues and program participants — may be the first step toward sustained full-time employment as a peer worker.

Once an organization has hired a peer educator or advocate, it can help the individual succeed in their role by creating a supportive workplace culture — characterized by positive feedback, patience and good communication with employees. An organization's leadership and staff members should model the trust, inclusivity, flexibility and engagement that they desire from the peer worker.





CHALLENGES AND OPPORTUNITIES

Many of NYHRE's paid volunteers lack stable housing and spend much of their time outside — which results in frequent illness during the winter season. Scheduling managers to work alongside the peers and arranging back-up volunteers ensures that NYHRE can deliver core services.

Additionally, because of the stigma and bias toward people who use drugs, it may take time to build trusting relationships among existing organizational staff, peers and program participants. NYHRE facilitates trust-building by showing that it is committed to the peer workforce and the people it services and setting up systems and structures to support people with lived experience.

Peer workers present a valuable opportunity for an organization to better understand the challenges faced by people who have experience using drugs, and to stay true to the mission of promoting individual health and dignity.



PROGRESS

Peer services are critical to NYHRE's operating model; over the last two years, the collective efforts of NYHRE peer workers and other staff have enabled the organization to serve more than 7,000 individuals, train more than 5,000 people in overdose prevention and reverse 331 overdoses. To see a video about this program, visit youtube.com/nychealth and search for "New York Harm Reduction Educators."



RECOMMENDATIONS

Organizations who want to hire peer educators and advocates for clients who use drugs will be most successful if they:

1

Create a supportive environment that demonstrates flexibility to the peers' personal circumstances.

2

Offer low-barrier educational opportunities and low-pressure, stipend-based volunteer opportunities to help potential peer workers grow professionally.

3

Evaluate staff and volunteer performance by looking at how individuals fulfill their roles, rather than making decisions based on drug tests.

4

Facilitate trust by engaging peer workers in team-building processes and activities alongside existing staff.



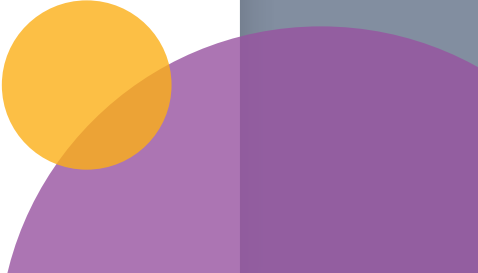
CONCLUSION

In the three years since we launched TCNY 2020, New York City has become healthier in many ways. Citywide efforts to promote healthy childhoods are helping our littlest New Yorkers get a better start in life and collaborations to prevent the spread of HIV are helping many people stay healthy.

But not all of the news is good news. Data from 2017 shows that the self-reported health of Latino New Yorkers has actually gotten worse since we launched TCNY 2020. We've also failed to make improvements to some key drivers of chronic disease such as sugary drink consumption. There is still more work to be done.

In last year's Second Annual Update, we published several ways that organizations could improve health in their communities. This year, we present four in-depth case studies of groups who are working to implement some of those ideas in their neighborhoods. Every New Yorker has a role to play in supporting health in their communities, and we hope that TCNY 2020 inspires new ideas for you to consider as you work to improve health in your neighborhood.

You can learn more about TCNY 2020, and what you can do to support health, by visiting nyc.gov/health/tcny2020.





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APPENDIX

TCNY 2020 INDICATORS AND HISTORICAL TREND DATA

The table below lists all of the TCNY 2020 indicators and goals, along with the available historical data from 2013, and the most recent available data, which is highlighted in a different color. Some of the target numbers have been updated to reflect changes in historical population estimates or to incorporate information that became available after publication of the original indicators. For definitions of these indicators and information on data sources, please see the original TCNY 2020 document at nyc.gov/health/tcny2020.

DOMAIN	INDICATOR	CITYWIDE/ PRIORITY POPULATION	2013	2014	2015	2016	2017	2018	2020 Target
OVERARCHING	Self-Reported Health Status	Citywide	77%	78%	77%	78%	77%		82%
		Latinos	68%	68%	67%	70%	63%		73%
	Premature Mortality (rate per 100,000)	Citywide	191.1	186.0	184.5	189.4			169.9
		Blacks	276.1	269.8	273.4	281.3			234.7
	Infant Mortality (rate per 1,000)	Citywide	4.6	4.2	4.3	4.1			4.4
		Blacks	8.3	7.5	8.0	8.0			7.7
PROMOTE HEALTHY CHILDHOODS	Babies Born in "Baby-Friendly" Facilities	Citywide	5%	7%	9%	16%			35%
	Child Care	Citywide	x	x	65%	66%	66%	66%	70%
		Very High-Poverty	x	x	54%	55%	55%	55%	66%
	Teenage Pregnancy (rate per 1,000)	Citywide	52.9	47.3	40.5	36.2			40.0
		Very High-Poverty Neighborhoods	74.6	66.6	55.0	50.1			44.2
	High School Graduation	Citywide	65%	66%	68%	71%	73%	74%	↑
CREATE HEALTHIER NEIGHBORHOODS	Assault Hospitalizations ²⁹ (rate per 100,000)	Citywide	x	x	x	93			70
		Very High-Poverty Neighborhoods	x	x	x	158			110
	Fall-Related Hospitalizations ³⁰ (rate per 100,000)	Citywide	x	x	x	1,442			1,350
		Staten Island	x	x	x	2,103			1,900
	Air Quality (µg/m ³)	Citywide	6.65	6.50	5.10	5.30			6.10
	Homes With No Maintenance Defects	Citywide	x	44%	x	x	52%		47%
		Very High-Poverty Neighborhoods	x	32%	x	x	39%		36%
	Children's Visits To ED For Asthma (rate per 10,000)	Citywide	232	232	223	217			210
		Very High-Poverty Neighborhoods	370	391	396	389			318
	Jail Population	Citywide	11,827	11,408	10,240	9,790	9,500	8,896	↓
	Helpfulness of neighbors	Citywide	x	x	72%	72%	79%		↑

DOMAIN	INDICATOR	CITYWIDE/ PRIORITY POPULATION	2013	2014	2015	2016	2017	2018	2020 Target
SUPPORT HEALTHY LIVING	Obesity	Citywide	23%	25%	24%	24%	25%		23%
		Very High-Poverty Neighborhoods	29%	31%	31%	32%	33%		25%
	Sugary Drinks	Citywide	23%	23%	24%	23%	23%		19%
		Blacks & Latinos	32%	29%	32%	30%	31%		23%
	Physical Activity	Citywide	19%	x	21%	x	21%		22%
		Asian-Pacific Islander	14%	x	20%	x	17%		18%
	Sodium Intake (mg/day)	Citywide	x	x	x	x	x		3,019
		Blacks	x	x	x	x	x		3,129
	Smoking	Citywide	16%	14%	14%	13%	13%		12%
		High School Graduates	20%	18%	17%	17%	17%		14%
	Binge Drinking	Citywide	18%	17%	17%	17%	17%		17%
		18- to 24-Year-Olds	25%	24%	27%	26%	25%		23%
	Overdose Deaths (rate per 100,000)	Citywide	11.6	11.7	13.7	20.7	21.2		11.0
		Very High-Poverty	15.8	13.3	19.6	27.0	33.8		14.3
INCREASE ACCESS TO QUALITY CARE	Unmet Mental Health Need	Citywide	22%	x	23%	x	x		20%
		Very High & High-Poverty	30%	x	22%	x	x		22%
	Unmet Medical Need	Citywide	11%	10%	10%	11%	10%		9%
		Latinos	15%	14%	12%	12%	12%		10%
	Controlled High Blood Pressure	Citywide	67%	67%	67%	67%	68%		76%
		Blacks	62%	61%	62%	61%	62%		74%
	New HIV Diagnoses	Citywide	2,832	2,754	2,493	2,279			1,350
		Black & Latino MSM	1,148	1,124	1,036	876			486
	HIV Viral Suppression	Citywide	79%	81%	83%	84%			95%
		Blacks	75%	77%	79%	81%			95%

RESOURCES

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As our partners in this effort, your feedback is essential to the success of **TCNY/2020**. So please stay in touch with us. You can reach us at takecarenewyork@health.nyc.gov. We look forward to working with you to improve the lives of all New Yorkers.

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