

Primary Care Initiative Community Health Assessment

Final Report
August 21, 2008



Acknowledgements

By their very nature community health assessments are a collaborative effort. Accordingly, we at the New York City Health and Hospitals Corporation (HHC) would like to begin by expressing our deep appreciation to the numerous individuals and organizations who made the community health assessment possible, including the thousands of New Yorkers who agreed to participate in telephone surveys, field interviews and discussion groups. More than 3,000 surveys were conducted over the telephone or face –to-face. Fourteen (14) community-based organizations and their respective staff of more than 40 surveyors and discussion group facilitators conducted 1,509 field surveys in 12 languages and conducted 15 community-based discussion groups across all five boroughs of the city to obtain the community-level feedback for the community health assessment. The community organizations’ knowledge of the communities and target populations and their ability to engender the trust of survey and discussion group participants were essential to our success in gathering information from the people who traditional community health assessments often fail to reach.

We owe a debt of gratitude to the members of the Task Force on Primary Care which was convened by New York City Council Speaker Christine Quinn’s staff, with the assistance of the Commission on the Public’s Health System. This task force, comprised of representatives from many diverse community organizations, community health centers and others, strongly recommended that a community health assessment was integral to determining need and locations for primary care. Without their emphasis on the need for the voices of the community to inform planning and program funding processes, the Primary Care Initiative Community Health Assessment would not have been undertaken.

We extend special thanks to all of the participants of the Primary Care Initiative Workgroup whose insights were invaluable in identifying the targeted neighborhoods, developing strategies to gather information from hard-to-reach populations, and designing the assessment tools and methodologies.

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Finally, we are grateful for the vision and leadership of New York City Mayor Michael R. Bloomberg and City Council Speaker Quinn for their commitment to improving the health and health care of all New Yorkers.

To all of you, we offer our heartfelt thanks.

A handwritten signature in blue ink that reads "LaRay Brown". The signature is written in a cursive style with a long horizontal line extending to the right.

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Commission on the Public's Health System
Community Healthcare Network
Community Health Care Association of NY
Community Service Society of New York - NYC Managed Care Consumer Assistance Program
Hunter College
Institute for Urban Family Health
Korean Community Services of Metropolitan NY
Lehman College
Make the Road New York
New York City Council, Policy Division and Health Committee
New York City Department of Health and Mental Hygiene
New York City Health and Hospitals Corporation
New York City Office of the Deputy Mayor for Health and Human Services
New York Immigration Coalition
Primary Care Development Corporation
Project Hospitality
Ryan/Chelsea-Clinton Community Health Center
The Bronx Health Link
Urban Health Plan
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Caribbean Women's Health Association
Hearing Loss Association of America-Manhattan Chapter
Korean Community Services of Metropolitan New York
League for the Hard of Hearing
Make the Road New York
Pragati
Queens Health Coalition
Reconciliation and Culture Cooperative Network (RACCOON)
Rockaway Development and Revitalization Corporation (RDRC)
The Bronx Health Link
The Indochina Sino-American Community Center
The Restaurant Opportunities Center of New York (ROC-NY)

ROUNDTABLE KEY INFORMANTS

Children's Defense Fund
Esperanza del Barrio
Hispanic Federation
Safe Space, Inc.

PROJECT CONSULTANT

Tripp Umbach, Inc.

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Executive Summary

EXECUTIVE SUMMARY

REPORT OVERVIEW

This report summarizes the findings of an assessment of barriers to obtaining health care in underserved communities in New York City (NYC), with a focus on community residents' articulation of their experiences accessing primary health care. The stimulus for the implementation of a community health assessment came from a Task Force on Primary Care convened by New York City Council Speaker Christine Quinn's staff, assisted by the Commission on the Public's Health System. The diverse group of community organizations, staff from various Council Members' offices, community health centers, health care advocates, city health agencies, labor organizations, and academic institutions comprising the Task Force discussed the potential impact of the policy and facility-specific recommendations of the Commission on Health Care Facilities in the 21st Century on primary care access and capacity in New York City. The Task Force also identified a pressing need to formulate a strategy for leveraging funding for primary care expansion through the Health Care Efficiency and Accountability Law for New Yorkers (HEAL NY) and provisions of New York State's 1115 Medicaid waiver (the Federal-State Health Reform Partnership, or F-SHRP). Many Task Force members spoke of the dissolution of the primary care infrastructure in certain communities as a result of recent hospitals' closures or retrenchments in primary care operations. Task Force members also strongly recommended that any determination of need and location for primary care had to emanate from a community health assessment.

In late fiscal year 2006, Council Speaker Quinn announced a commitment to develop additional primary care capacity. In the City's fiscal year 2008 budget, the Mayor provided \$745,000 in expense funds to support the Primary Care Initiative (PCI). The New York City Health and Hospitals Corporation (HHC) was commissioned to conduct a community health assessment that would inform the use of PCI funding to expand primary care access and capacity in fiscal years 2008 through 2011. Findings of the community health assessment would also be shared with the New York State Department of Health to use in its HEAL NY funding decisions concerning New York City.

HHC established the PCI Workgroup to begin a collaborative effort to determine how community residents' perspectives concerning their health care needs and experiences in accessing primary care services could be assessed. The PCI Workgroup was also asked to advise on the identification of high-need communities in which initial investments should be made.

The PCI Workgroup agreed that the assessment should use both quantitative and qualitative methods to capture each targeted community's concerns. A survey instrument was developed and subsequently administered over the telephone and in the field (quantitative method) and discussion groups were conducted to glean more anecdotal and experiential information (qualitative method). As a precursor

to the survey and discussion group process, a representative array of underserved communities had to be systematically selected and defined so that Workgroup findings could be reliably used for planning and program development purposes. To identify these communities, the Workgroup relied on secondary data (i.e., data that has been previously collected) to measure those factors that typically influence access to health care in most communities. In addition, a subgroup of the PCI Workgroup was convened to identify targeted communities through the use of additional data and their own experience of working in underserved communities.

The Workgroup developed a telephone and field survey tool partly based on surveys successfully used in other parts of the country by local departments of health, community-based groups, and schools of public health to reach similar populations. HHC also retained Tripp Umbach, Inc. to conduct telephone surveys and collaborate with community-based organizations' (CBOs) staff on the administration of a face-to-face survey, co-facilitate discussion groups, and analyze the resulting quantitative and qualitative data. Tripp Umbach has expertise in providing customized market research and community needs assessment to health care organizations across the country and in New York City. Tripp Umbach contracted with fourteen CBOs with health care-related backgrounds, which were selected for their grass-roots expertise and credibility with local residents and health care consumers who are typically resistant to formal evaluation and survey efforts. Tripp Umbach and the contracted CBOs administered a 69-question survey over the telephone and via face-to-face field interviews. Of the 3,042 surveys completed, half were collected over the telephone and half through face-to-face interviews. CBO staff conducted the face-to-face surveys in the diverse languages spoken by community residents. In addition, Tripp Umbach and the CBOs co-facilitated 15 discussion groups. Finally, the PCI Workgroup and a discussion group with health and human services organizations serving New York City were convened to elicit feedback on survey results and discussion group findings.

To determine which New York City neighborhoods/regions to target for the community health assessments, all New York City ZIP codes were rated on the following ten variables related to poor health care access:

1. Percentage of households living in poverty
2. Medicaid-eligible population
3. Medicaid-eligible population per primary care provider
4. Percentage of population that is foreign-born
5. Preventable hospitalization rates – children
6. Preventable hospitalization rates – adults
7. Households living in linguistic isolation
8. Median household income
9. Number of uninsured patients using the New York City public hospital system
10. Located within a Health Professional Shortage Area (HPSA)

In each City ZIP code, each variable was measured on a scale from 1 to 10¹ with lower values reflecting less need and higher values reflecting more need. ZIP codes were ranked on the basis of their aggregate score across the ten criteria. Ten geographic clusters or communities were formed from the ZIP codes that had the highest composite scores, creating the ten targeted regions for the PCI assessment. It was further determined that surveys would be administered in 27 ZIP codes. In addition, the PCI Workgroup further refined the list of targeted communities through the use of additional data such as findings from prior assessments completed for similar areas and their experience of working in underserved communities. Because HHC and the Community Health Center of Richmond had engaged Tripp Umbach to conduct a study in 2007 which focused on health care access on Staten Island, it was determined that the PCI Workgroup could rely on the results of that survey as an essential component of the data for this report. The data from the 2007 study² has been integrated into this report's recommendations. In addition, one of the 15 discussion groups was conducted on Staten Island and this qualitative information is also reported in the study findings. Therefore, targeted communities from all five New York City boroughs are considered.

Please refer to Table 1: PCI Regions, ZIP Codes, and Neighborhoods below for information about the ten communities, their ZIP codes, and their associated neighborhoods.

Table 1: PCI Regions, ZIP Codes, and Neighborhoods

Regions	ZIP Codes	Neighborhoods
Brooklyn 1: North Brooklyn	11206, 11237, 11221	East Williamsburg, Bushwick, and Bedford Stuyvesant
Brooklyn 2: Central Brooklyn	11233, 11212, 11207, 11208	Brownsville, Crown Heights, East New York, and New Lots
Brooklyn 3: Flatbush	11226	Flatbush and Ditmas Park
Bronx 1: South Bronx	10452, 10456, 10454	Mott Haven, Melrose, Highbridge, and Morrisania
Bronx 2: Central Bronx	10458, 10453, 10457, 10460, 10472	University Heights, East Tremont, Fordham, and Morris Heights
Manhattan 1: East Harlem/ Central Harlem	10029, 10039	East Harlem and Central Harlem
Manhattan 2: Lower East Side	10002	Lower East Side and Chinatown
Queens 1: Western Queens	11377, 11373, 11368, 11106	Corona, Jackson Heights, Woodside, Elmhurst, LeFrak City, Astoria and Long Island City
Queens 2: Southeast Queens	11436, 11435, 11434	South Jamaica, Hollis, St. Albans, and Springfield Gardens
Queens 3: Far Rockaway	11691	Far Rockaway and Edgemere
Staten Island ³	All ZIP codes	All Staten Island neighborhoods

¹Number of uninsured patients using the NYC public hospital system used a scale of 1 to 20, giving this variable twice the weight of the other variables.

² Please refer to Appendix B: Staten Island Community Health Assessment on page 239.

³ This report utilizes the findings and recommendations from the 2007 Staten Island Community Health Assessment, commissioned by the Community Health Center of Richmond County (CHCR), as its main source of quantitative data for Staten Island. (See Footnote 2.)

FINDINGS

There is widespread agreement that easy access to primary care – the main vehicle of preventive medicine – is good public policy. Inadequate primary care capacity and access worsens health care status, allows chronic conditions to go unmanaged, and results in more expensive back-end care. Yet, despite the clear advantages of a health care system that promotes preventive care and ensures access to effective primary care, evidence from the Primary Care Initiative Community Health Assessment indicates that the experience of seeking and obtaining primary health care in New York City’s lower income neighborhoods is often a discouraging experience. Rather than reinforcing health seeking behavior, the experience is laden with deterrents.

When asked the question about which providers are most difficult to access, 49.7% of all survey respondents and a majority of discussion group participants reported that their neighborhood had an acute need for more dentists. In addition, more than one-third of the survey respondents said their neighborhood needed more primary care doctors. Fifteen percent of survey respondents who answered this question also identified difficulty accessing mental health services. These findings are not surprising in light of the fact that the study’s neighborhoods were, in part, chosen because of their designations as Health Professional Shortage Areas (HPSA). Nevertheless, they are compelling and require action.

Survey and discussion group participants alike consistently reported that they had to wait too long to get an appointment; they had to wait too long in the waiting room; that doctors and nurses did not listen to them or spend enough time with them; and that the cost of health care or lack of insurance was a significant impediment to receiving health care.

Discussion group participants highlighted additional problems. While it is recognized that language access in health care delivery is critical, many non-English speaking discussion group participants described barriers to care as a result of the lack of availability of translated forms and culturally competent interpreters. A common theme across discussion groups was that health care staff, including doctors, are often not sufficiently respectful of patients who have special needs or who are from a different demographic. Discussion group participants consistently reported that they experienced difficulty in navigating the health care system, particularly in obtaining health care coverage and locating the services they need. Discussion group participants also reported a lack of knowledge about where to go for reliable sources of health care information. Additionally, discussion group participants expressed a need for a simpler public health insurance application process and higher income eligibility levels for adults.

The Elderly find that accessing appropriate and affordable transportation is often challenging, particularly when they must use several specialists who are not co-located. Parents of children with physical or developmental disabilities also described the lack of co-located specialists as a significant barrier to their children receiving quality care. For example, autistic children can have difficulty adapting

to new environments, which is exactly what they must do when visiting specialists in numerous locations.

Overall, study participants highlighted a wide range of barriers to accessing high quality primary care in their neighborhoods. Fortunately, none are insurmountable. However, the creation of an efficient and effective primary care infrastructure requires investments beyond what the local government can realistically provide. Therefore, the City and the State must combine resources to address these issues.

RECOMMENDATIONS

We make the following recommendations based on what we have learned from the voices of more than 3,000 community residents.

1. Primary care capacity needs to be expanded in New York City. The PCI Community Health Assessment findings and other reports show that many communities in New York City lack access to this basic health care service. Primary Care Initiative and HEAL NY primary care funding must be allocated to increase staff capacity and capital development in target neighborhoods. The PCI Community Health Assessment findings should be used to drive these decisions.
2. Dental and mental health services are sorely lacking in many New York City communities. City/State task force(s) must be convened and charged with devising creative strategies to increase the availability of dental services and mental health services in medically underserved communities. The City's dental schools must be included as part of the solution to this problem. New York State's "Providers Across New York" program must be used to increase dentists and mental health capacity in targeted communities.
3. New York City and the State of New York must combine resources/leverage the availability of local (PCI), state (HEAL NY), and federal (F-SHRP) funding to effectively increase primary care capacity in target communities.
4. PCI funding priority must be given to health centers and other providers that serve low-income uninsured patients, and have in place fee scale policies that facilitate access and assist patients to obtain public health insurance.
5. Investments must be made in health centers and other primary care settings to train front-line and direct care staff in models of patient-centered care. In addition, resources should be made available to health centers and other primary care practices to re-engineer/redesign the patient care experience into one that is patient-centered and creates additional capacity with existing facility and staff resources.

There are proven strategies for re-engineering patient scheduling and patient flow which create capacity, reduce waiting times, create appointment access, facilitate communication between provider (teams) and patients, and increase continuity of patient care. Some health centers/providers may need one-time funding support to implement these strategies.

6. Although low-cost health services, public health insurance, and legal protection through Manny's Law (the New York State law that requires hospitals to establish procedures for providing financial assistance to patients) exist, better efforts must be made to educate particular communities about these resources. Grass roots community-based organizations should be supported so they may expand outreach and educational campaigns to target hard-to-reach groups and promote these resources. PCI and State funding should support these efforts where they are needed most.
7. Funding incentives must be made available for health centers and other primary care providers/organizations to develop or strengthen a culturally and linguistically responsive primary care service infrastructure. Specific incentives could be for:
 - a. Recruitment and training costs associated with the expansion of a cadre of culturally and linguistically competent staff and/or interpreters available for face-to-face interactions with patients.
 - b. Increased availability of remote telephone and video interpretation resources, if face-to-face skilled interpretation is not available, within primary care settings.
 - c. Development of mechanisms to coordinate/integrate language access services into program operations (e.g. creating flags in the scheduling system that alert staff of the need of patients requiring language access/interpreter services; embedding in reminder call mechanisms questions concerning language preference; etc.).
 - d. Development of curriculum for and skills training of the primary care workforce in patient centered care, cultural competency, linguistic proficiency and sensitivity to individuals with special needs (NYC's 311 system should make information available concerning providers that have completed the above-referenced skills training curriculum).
8. Resources must be made available to assist health centers/providers in providing self management support (e.g. education, care plans, etc.) for patients with special needs and/or chronic conditions. New funding may support ancillary staff or other means of making self-management resources available to patients.

9. Start up funding must be provided to expand capacity (e.g., specialists' hours; multi-specialty coordinated team practices, mental health consultation services, etc.) within existing primary care settings to address the service requirements of special needs populations.
10. Funding must be provided to support ancillary expenses associated with the coordination/integration of services for special needs patients into program operations (e.g., patient navigators; peer support; accommodation forms completed at registration or other methods that alert staff to the special needs of the patients; staff training, etc.)
11. Resources should be made available to health centers and other primary care providers for technical assistance which helps them maximize earned revenue (i.e., to obtain all of the funding they are entitled to from third party payers). Improved financial performance will enhance centers'/practices' sustainability thus helping them serve low-income communities.
12. Health centers' or other providers' should implement electronic, web-based, or other non-traditional methods of communicating with patients to increase access and facilitate improved provider/patient interaction; PCI resources could be used to support this initiative.
13. Funding should be made available for community-based organizations to implement a campaign that promotes the availability of prescription assistance programs (and how to obtain) to residents in high-need, underserved communities.
14. Funding should be provided to health centers and other providers for the installation of Assisted Listening Devices and other forms of technology that facilitate access to effective primary care by patients who are deaf or hearing impaired.



Overview

OVERVIEW

This report summarizes the findings of an assessment of barriers to obtaining health care in underserved communities in New York City (NYC), with a focus on community residents' articulation of their experiences accessing primary health care. The stimulus for the implementation of a community health assessment came from a Task Force on Primary Care convened by New York City Council Speaker Christine Quinn's staff, assisted by the Commission on the Public's Health. The diverse group of community organizations, staff from various Council Members' offices, community health centers, health care advocates, city health agencies, labor organizations, and academic institutions comprising the Task Force discussed the potential impact of the policy and facility-specific recommendations of the Commission on Health Care Facilities in the 21st Century on primary care access and capacity in New York City. The Task Force also identified a pressing need to formulate a strategy for leveraging funding for primary care expansion through the Health Care Efficiency and Accountability Law for New Yorkers (HEAL NY) and provisions of New York State's 1115 Medicaid waiver (the Federal-State Health Reform Partnership, or F-SHRP). Many Task Force members spoke of the dissolution of the primary care infrastructure in certain communities as a result of recent hospitals' closures or retrenchments in primary care operations. Task Force members also strongly recommended that any determination of need and location for primary care had to emanate from a community health assessment.

In late fiscal year 2006, Council Speaker Quinn announced a commitment to develop additional primary care capacity. In the City's fiscal year 2008 budget, the Mayor provided \$745,000 in expense funds to support the Primary Care Initiative (PCI). The New York City Health and Hospitals Corporation (HHC) was asked to conduct a community health assessment that would inform the use of PCI funding to expand primary care access and capacity in fiscal years 2008 through 2011. Findings of the community health assessment would also be shared with the New York State Department of Health to use in its HEAL NY funding decisions concerning New York City.

HHC established the PCI Workgroup to begin a collaborative effort to determine how community residents' perspectives concerning their health care needs and experiences in accessing primary care services could be assessed. The PCI Workgroup was also asked to advise on the identification of high-need communities in which initial investments must be made.

The Workgroup developed a telephone and field survey tool partly based on questionnaires used by local departments of health, community-based groups, and schools of public health to reach similar populations and HHC subsequently retained consulting firm Tripp Umbach to conduct telephone surveys, oversee administration of the field surveys and discussion groups, and to complete an analysis of resulting quantitative and qualitative data. Tripp Umbach has conducted customized market research and community health assessments across the country and in New York City. Fourteen community-

based organizations were selected to provide grass-roots expertise; conduct neighborhood based face-to-face field surveys in the diverse languages spoken by community residents, and to co-facilitate discussion groups. Finally, the PCI Workgroup and a discussion group with health and human services organizations serving New York City were convened to elicit feedback on survey results and discussion group findings.

One constraint regarding the assessment must be noted. A holistic community health assessment typically attempts to obtain – usually through existing data sources – information on current health care providers and services. Although this is a plethora of data on health status in New York City, there are few databases, public or proprietary, which identify both primary care provider and facility resources or provide that information at a level of detail appropriate/suitable for the present need. Such data would have added a valuable layer of information about access in the targeted communities. However, to undertake a complementary study to identify health resources in all of the selected regions would have been cost prohibitive. Therefore, the assessment did not attempt to identify services nor available providers in each region. However, an access indicator related to health resources – the number of physicians per capita in each New York City ZIP code – was one of the criteria used in the selection of the target neighborhoods/regions.



Methodology

METHODOLOGY

OVERVIEW

The PCI Community Health Assessment employed both quantitative and qualitative methods. The quantitative component consisted of a 69-question survey that was administered via telephone and face-to-face interviews in target communities. The qualitative approach consisted of conducting 15 discussion groups in multiple languages with diverse participants.

PCI TARGET COMMUNITIES

To determine which New York City communities to target for the field and telephone surveys, all New York City ZIP codes were rated on ten variables which have been identified as being predictive of poor health care access:

1. Percentage of households living in poverty⁴
2. Medicaid-eligible population⁵
3. Medicaid-eligible population per primary care provider⁶
4. Percentage of population that is foreign-born⁷
5. Preventable hospitalization rates – children⁸
6. Preventable hospitalization rates – adults⁹
7. Households living in linguistic isolation¹⁰
8. Median household income¹¹
9. Number of uninsured patients¹²
10. Located within a Health Professional Shortage Area (HPSA)¹³

In every ZIP code, each variable was measured on a scale from 1 to 10 with lower values reflecting less need and higher values reflecting greater need. ZIP codes were ranked on the basis of their aggregate scores across the ten criteria. Ten geographic clusters of ZIP codes were formed from those ZIP codes that had the highest composite scores, creating the ten targeted regions for the PCI Community Health

⁴ Source: Claritas Estimates for 2005 (projected from U.S. Census 2000).

⁵ Source: New York State Department of Health Medicaid Enrollment figures (FY 2005).

⁶ Source: Center for Health Workforce Studies, SUNY, Albany, NYS Physician Re-registration Survey, 2004-06

⁷ Source: U.S. Census (2000).

⁸ Source: New York University Center for Health and Public Service Research – Ambulatory Care Sensitive (ACS) hospitalization rates were developed using age-adjusted SPARCS data for New York City residents (2004).

⁹ Source: New York University Center for Health and Public Service Research – Ambulatory Care Sensitive (ACS) hospitalization rates were developed using age-adjusted SPARCS data for New York City residents (2004).

¹⁰ Source: U.S. Census (2000).

¹¹ Source: Claritas Estimates for 2005 (projected from U.S. Census 2000).

¹² Source: New York City Health and Hospitals Corporation patient utilization data (2006).

¹³ Source: United States Department of Health and Human Services – Health Resources and Services Administration: Health Professional Shortage Area website: <http://hpsafind.hrsa.gov>.

Assessment surveys. These regions encompassed 27 ZIP codes throughout four boroughs of New York City. Tripp Umbach had conducted a study in 2007 that focused on health care access issues on Staten Island, therefore it was determined that conducting a similar assessment one year later concerning this borough would be unnecessarily duplicative. Data from the household survey conducted as part of the 2007 Staten Island Community Health Assessment has been integrated into this report’s findings and a complete copy of the study is available in beginning . Additionally, one of the 15 discussion groups was conducted on Staten Island and this qualitative information is reported in report findings.

Tripp Umbach, a Pittsburg-based health research firm, was selected by HHC through a competitive bidding process to serve as the account administrator for fourteen community-based organizations (CBOs) contracted to serve in the role of community health evaluators. In this role, the CBOs were responsible for the administration of the face-to-face field surveys in assigned target communities and, in most cases, for facilitating discussion groups. Tripp Umbach was also charged with administering the survey via telephone. Tripp Umbach retained Telepoll, Inc. to conduct the telephone surveys.

CBOs were selected to participate in the PCI Community Health Assessment through a competitive process. The CBOs hired more than 40 surveyors and ensured that the surveyors collected the requisite number of field surveys in their respective communities. Moreover, the CBOs provided the project with grass-roots expertise, translation and interpretation services, and promotion of the surveys. The CBOs contributed as well to the development of discussion group protocols, the recruitment of discussion group participants who reflected the targeted subpopulations, and hosted the discussion groups. Table 2 below provides a list of the CBOs and their areas of focus.

Table 2: Community-based Organizations' Assigned Discussion Groups

Community-based Organizations (CBOs)	Target Community	Assigned Discussion Group
African Refuge	—	English Speaking West Africans in Staten Island
Brooklyn Perinatal Network	Brooklyn 2	African American Males / Black Men 21-50
Caribbean Women’s Health Association	Brooklyn 3	Domestic Workers
Hearing Loss Association of America- Manhattan Chapter	—	Hearing Impaired and Deaf Adults
Korean Community Services of Metropolitan NY	—	Korean Americans
League for the Hard of Hearing	—	Hearing Impaired and Deaf Adults
Make the Road New York	Brooklyn 1	Gay, Lesbian, Bisexual, Transgender and Questioning Adolescents (GLBTQ) Ages 15 -20
Pragati, Inc.	Queens 1	South Asian Elders
Queens Health Coalition	Queens 2	Female Victims of Domestic Violence; Parents of Children with Mental Illness
Reconciliation and Culture Cooperative Network (RACCOON)	—	Albanians in The Bronx

Community-based Organizations (CBOs)	Target Community	Assigned Discussion Group
Rockaway Development and Revitalization Corporation (RDRC)	Queens 3	Adolescents, Female and Male (Ages 13 -18) African American/ Black Men (Ages 62 and older)
The Bronx Health Link	Bronx 1	—
The Indochina Sino-American Community Center	Bronx 2 Manhattan 2	Chinese Elders Parents of Children with Physical and Developmental Disabilities
The Restaurant Opportunities Center of New York (ROC-NY)	Manhattan 1	—

QUANTITATIVE STRATEGY

Tripp Umbach and the contracted CBOs administered a 69-question survey over the telephone and via face-to-face interviews in the field.¹⁴ The survey instrument was comprised of two main components: predictor variables and outcome variables. A predictor variable is a variable with a statistically significant correlation with the survey outcomes. Examples of predictor variables covered in the survey are demographic information such as respondent’s age, household income, educational level, country of birth, and length of time in the United States and New York City. Outcome variables measured barriers to accessing health care services including health insurance status, travel time to see health care provider, and reasons for seeking health care services outside of one’s neighborhood.

Of the 3,042 surveys completed, half were collected over the telephone and half in the field. “Skip patterns” were incorporated throughout the survey instrument which allowed particular questions to be directed only to those respondents who fit certain criteria. As a result, no respondent answered all 69 questions and many answered considerably fewer. For the field surveys, hard-to-reach populations were identified in each of the ten regions. In most cases, the identified subpopulations were immigrant groups for whom English was not the primary language spoken. Accordingly, it was a requirement that all surveyors were native speakers of the language in which they conducted the survey. Surveys completed over the telephone were completed in English and Spanish, while field surveys were completed in the following 12 languages: Arabic, Bengali, Chinese, English, French, Haitian Creole, Hindi, Khmer, Korean, Spanish, Urdu, and Vietnamese.

Table 3 below provides a breakout of the total number of surveys collected by each methodology in each community.

¹⁴ The PCI household survey tool is provided in Appendix C: Primary Care Initiative Access Survey beginning on page 281.

Table 3: Telephone and Field Survey Methodology

Survey Method	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Telephone and Field Surveys	3,042	288	530	530	222	96	303	585	173	163	152
Field Surveys	1,509	144	261	266	105	36	152	331	72	76	66
Spanish Telephone Surveys	399	36	50	62	30	31	41	54	29	32	34
English Telephone Surveys	1,134	108	219	202	84	29	110	200	72	55	52

For the field survey, HHC, the PCI Workgroup, and the CBOs identified specific hard-to-reach populations in each of the ten communities. Identifying and actually reaching hard-to-reach populations was crucial to the value of an assessment of barriers to accessing health care, since it is the hard-to-reach who are most likely to experience barriers. In most cases, the identified subpopulations were immigrant groups for whom English was not their primary language. Accordingly, it was a requirement that all surveyors were native speakers of the language in which they conducted the survey. For statistical purposes, the goal was to collect at least 30 surveys from each subpopulation. The total number of surveys collected in each of the ten communities was apportioned based on each community's percent share of the total population in all ten communities.

Sample sizes in the ten communities are sufficiently large so that data from questions answered by all participants in each community sample are significant at the 95% confidence levels with margins of error ranging from 4.05% to 9.99%, depending on the community. Table 4 identifies the margin of error in each community.

Table 4: Margin of Error for 95% Confidence Level

Telephone and Field Surveys	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
95% Confidence Interval Margin of Error +/-	1.78	5.77	4.25	4.25	6.57	9.99	5.63	4.05	7.44	7.67	7.94

All surveyors participated in a mandatory full-day training session on the survey instrument. Training consisted of practice survey interviews and outreach strategies to reach targeted subgroups. A draft version of the PCI survey was field-tested by surveyors in early December 2007. Subsequent feedback from surveyors led to the elimination of 12 questions from the survey instrument, reducing the total number of questions from 81 to 69. Most survey respondents received a monetary incentive of up to \$20 upon completion of the survey. The CBOs submitted all completed surveys to Tripp Umbach staff who reviewed them for completeness and correct administration before entering them into the PCI database.

STATEN ISLAND

Tripp Umbach was retained by HHC and the Community Health Center of Richmond County to conduct a Staten Island Community Health Assessment in April 2007. A total of 695 household surveys were collected from Staten Island residents as a major component of this assessment. Of this total, 602 surveys were conducted via telephone with a minimum of 50 surveys collected from each of Staten Island's 12 ZIP codes. In addition, 93 surveys were collected in the field, via face-to-face interviews, to capture responses from undocumented/underserved immigrant populations on Staten Island. As a complement to the household survey, Tripp Umbach identified Staten Island neighborhoods of greatest need at the neighborhood, ZIP code, and Census Tract levels as part of the assessment. The April 2007 Staten Island Community Health Assessment findings are included in Appendix B, beginning on page 239.

QUALITATIVE STRATEGY

The qualitative component of the assessment consisted of conducting 15 discussion groups in multiple languages with a wide range of targeted populations. The PCI Workgroup and the CBOs selected the populations for each discussion group. Protocols for the discussion groups were developed by Tripp Umbach, HHC, the PCI Workgroup, and the CBOs and contained a common set of discussion questions used in all groups as well as questions unique to each group. Two examples of the common questions included, "What are the three biggest problems people face when seeking health care in your neighborhood?" and "Where do you get most of your health care – in or outside of your neighborhood?" An example of a question specific to a select discussion group was "Does your language, accent, or dialect impact your ability to communicate with health care providers and staff?"

The groups were co-facilitated by Tripp Umbach and the CBOs. Most discussion groups were two hours in length. Participants were often recruited from across the City.

At the start of each discussion group session, participants were asked to complete a brief questionnaire designed to collect basic demographic information and the top three health care access barriers participants had experienced. The first half of each session focused on a discussion of these barriers. The second half focused on the common questions developed as part of the discussion guide and those questions that were customized for each discussion group audience.

Ten of the 15 discussion groups were conducted in English and the remaining five were administered in Albanian, Bengali, Chinese, Korean, and Spanish. The selected audiences targeted for this component of the community health assessment were:

1. Adolescents (Female and Male, Ages 13 -18)
2. African American/Black Men (Ages 21-50)

3. African American/Black Men (Ages 62 and Older)
4. Albanians in The Bronx
5. Chinese Elders
6. Domestic Workers
7. English Speaking West Africans on Staten Island
8. Female Victims of Domestic Violence
9. Gay, Lesbian, Bisexual, Transgender, and Questioning (GLBTQ) Adolescents (Female and Male, Ages 15-20)
10. Hearing Impaired and Deaf Adults
11. Korean Americans
12. Mexican, Nicaraguan, and Ecuadorian Males (Ages 50 and older)
13. Parents of Children with Physical and Developmental Disabilities
14. Parents of Children with Mental Illness
15. South Asian Elders

All discussion groups were audio taped to ensure accurate transcription. Facilitating CBOs provided translated transcriptions of the discussion groups that were not conducted in English. Each discussion group participant received an incentive of up to \$20 for his/her participation. Discussion groups were conducted between February 28 and March 27, 2008.

CBO ROUNDTABLE DISCUSSION

On April 21, 2008, a 90-minute roundtable discussion was convened with representatives from four health and human service organizations serving the New York City area. The four organizations were The Hispanic Federation, The Children's Defense Fund, Safe Space, Inc., and Esperanza del Barrio. The goal of this meeting was to solicit feedback and validation of data collected as a part of the PCI community health assessment. The group was presented with the findings from the discussion groups and survey data and was asked to comment and provide insights concerning recommendations.



Discussion Group Findings

DISCUSSION GROUP FINDINGS

INTRODUCTION

Discussion groups were conducted to collect qualitative data to augment the findings from the PCI household survey. Moreover, the discussion groups provided information about the health care access experiences of special and unique populations that were not likely to be captured through the telephone and field survey processes.

This section of the report includes a compilation of the individual discussion group summaries and begins with a demographic profile of all discussion group participants. The summaries are presented in alphabetical order. Specific group recommendations are presented at the beginning of each discussion group summary followed by a demographic summary of group participants, a list of priority issues identified by the group, and descriptions of contributing factors. All recommendations carry an equal level of importance. Please note that the recommendations in this section represent the opinions of the actual discussion group participants only.

Table 5 below details the demographic profile of all discussion group participants. Reports on the individual discussion groups contain the demographic data specific to that group.

Table 5: Demographic Profile of All Discussion Group Participants

Demographic Category	All Discussion Groups
Total Participants (n=172)	
Gender (n=172)	
Male	48.84% (n=84)
Female	49.42% (n=85)
Transgender Male to Female	1.74% (n=3)
Education Level (n=167)	
Not a high school graduate, no GED	38.10% (n=64)
High school graduate or GED (grade 12)	19.05% (n=32)
Some college, no degree or Associate's degree, or certificate from vocational, business, or trade school	10.71% (n=17)
4-years of college or higher, with bachelor's degree or higher	30.36% (n=51)
Other	1.79% (n=3)
Employment Status (n=142)	
Work 35 or more hours per week	21.13% (n=30)
Work less than 35 hours per week	19.01% (n=27)
Unemployed	38.73% (n=55)
Retired	11.97% (n=17)
Student	.70% (n=1)
Other	8.45% (n=12)

Demographic Category	All Discussion Groups
Income Level (n=115)	
\$40,000 and lower	80.87% (n=93)
\$40,001 and higher	19.13% (n=22)
Insurance Status (n=160)	
Yes	74.38% (n=119)
No	25.63% (n=41)
Type of Insurance (n=73)	
Private health insurance	47.95% (n=35)
Public health insurance	24.66% (n=18)
Senior plans without Medicaid	27.40% (n=20)
Race (n=171)	
Asian	31.58% (n=54)
Black or African American	31.58% (n=54)
American Indian, Alaskan Native, or Indigenous	.58% (n=1)
White	22.22% (n=38)
Something else	14.04% (n=24)
Hispanic/Latino	91.67% (n=22)
Other	8.33% (n=2)

DISCUSSION GROUP KEY FINDINGS

While each of the 15 discussion groups targeted a unique audience, it is noteworthy that common themes emerged among them. The following are five key themes that were present in most of the discussion groups. These themes were selected because they were identified as recurring themes in a **minimum** of seven discussion groups.

1. Lack of information/knowledge of health care resources

Discussion group participants identified several subject areas for which knowledge of accessible health care information was lacking. These included information about: proper nutrition; chronic health conditions; the availability of family planning; and where and how to obtain free or low cost health care services, public health insurance programs, and public health insurance enrollment assistance.

2. Need more physicians/health centers in neighborhood

The majority of the discussion group participants reported the need for greater health care capacity in primary care offices to comprehensive multidisciplinary medical team settings that offer coordinated “one stop shopping” to the neighborhood’s special needs populations.

3. Provider-patient interaction

Many discussion group participants expressed a need for greater amounts of time with their providers. They also reported that they frequently leave a visit without full understanding of what to do next and are frustrated in their communications with providers. In addition, many discussion group participants

felt that there is an overall lack of sensitivity on the part of the health care community with regard to their specific needs or issues as patients. Whether the participants were teenagers, a gay, lesbian, bisexual, transgender, or questioning (GLBTQ) adolescent, parents with a disabled child, a senior citizen, or hearing impaired adult, the message was clear that many in the health care community are not mindful of the importance of being sensitive to patients with special needs or from a demographic different from their own.

4. Waiting times

Waiting times for appointments and in waiting rooms are too long according to discussion group participants.

5. Translation/interpretation services

For non-English speaking participants, communication and cultural competence was a key barrier to health care access. Participants mentioned that health insurance forms, registration forms, and instructions are often not translated into languages that participants speak or prefer to use when accessing health care services.

ADOLESCENTS (FEMALE AND MALE, AGES 13 – 18)

INTRODUCTION

On Wednesday, March 12, 2008, a discussion group was conducted at St. Joseph’s Hospital in Far Rockaway, NY. The Rockaway Development and Revitalization Corporation (RDRC) recruited participants for this group. The purpose of this discussion group was to identify health care service access issues affecting female and male adolescents (ages 13 to 18) and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for adolescents living in Far Rockaway. Below is a brief summary of their recommendations.

REDUCE WAIT TIMES

Hospitals, health care centers, and physician offices must improve patient flow and scheduling to reduce patient wait times.

INTERNET, TEXT, AND INSTANT MESSAGE TOOLS ARE THE BEST OUTREACH TOOLS TO SHARE HEALTH CARE INFORMATION WITH TEENS AND ADOLESCENTS

Group participants recommended the use of popular Internet-based social networking sites such as My Space and Face Book and instant messenger/ text messaging tools to connect teens to health care information and local health care resources.

ESTABLISH A TEEN HEALTH CENTER IN FAR ROCKAWAY

A teen health center in Far Rockaway would provide teens with a safe, drug free environment that offers clinical services and basic health education and information, in addition to offering a location for positive community activities for teens.

ACCESS TO SCHOOL NURSES

The school nurse is well positioned to serve as a credible source of health care information and resources for teens. The school nurse must be able to relate and respond to the needs of students.

DEMOGRAPHICS

A total of 14 adolescents participated in the 1.5 hour discussion group. Following are some key demographic characteristics defining the group that participated.

Table 6: Demographic Profile of Adolescents (Female and Male, Ages 13 – 18) Discussion Group

Category	Demographic Findings
ZIP Code	64.3% 11691 (n=9) 35.7% 11692 (n=5)
Age (Average Age)	15.8
Gender	21.4% Male (n=3) 78.6% Female (n=11)
Education Level	100% Still in middle school or high school (n=14)
Employment Status	21.4% Work less than 35 hours per week (n=3) 57.1% Unemployed (n=8) 21.4% No Answer (n=3)
Income Level	100% No Answer (n=14)
Insurance Status	50.0% Yes (n=7) 7.1% No (n=1) 42.9% Don't know / Not Sure (n=6)
Race	78.6% Black or African American (n=11) 7.1% American Indian, Alaskan Native, or Indigenous (n=1) 14.3% Other: Latino (n=2)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the biggest problems adolescents face when seeking health care services in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Long wait times for health care services
2. Lack of knowledge and information about health care/not knowing where to go for help/ not knowing how to ask their health care provider for help
3. Limited options for adolescents in Far Rockaway
4. Access to school nurse

LONG WAIT TIMES FOR HEALTH CARE SERVICES

Participants in the group felt that the amount of time they spent waiting to get health care services at provider offices was too long. Many participants reported that they are not usually seen by their health care provider in a timely manner even when they arrive early for their medical appointment.

CONTRIBUTING FACTORS

Appointment times are set but not kept by the health care provider

Many participants in the group stated that when they had pre-set appointments at a physician's office or clinic that they are kept waiting for a considerable amount of time. Long wait times are often a deterrent for seeking health care services.

Waiting at the emergency room for care

According to participants, wait times in the emergency room are even longer and may be as long as 3 hours or more.

GROUP SUGGESTIONS/RECOMMENDATIONS

Reduce wait times

Hospitals, health care centers, and physician offices should revamp patient flow and scheduling processes to reduce patient wait times.

LACK OF KNOWLEDGE AND INFORMATION ABOUT HEALTH CARE/NOT KNOWING WHERE TO GO FOR HELP/NOT KNOWING HOW TO ASK THEIR HEALTH CARE PROVIDER FOR HELP

Many participants in the group did not know where to go for help when they needed health care services (such as family planning services) or how to communicate effectively with their health care provider. In addition, many in the group expressed fear about going to the doctor because they did not understand the process, why they were getting certain tests and vaccinations or the medical terminology used by their physician.

CONTRIBUTING FACTORS

Provider and patient communication barriers

Participants reported that they visited their health care provider without being accompanied by their parents. Some in the group felt that the doctor treated them differently when their parents were with them compared to when they were seeing the doctor alone. There is a perception from the participants

that the quality of care they receive when they are alone is poorer than when they are accompanied by their parent/guardian.

Participants reported that the doctor does not need to try to act “cool” in order to make friends with them, but rather the doctor should talk to them and explain things as if they are equals (professional approach). They stated that the communication should be clear between patient and provider about who, what, where, when and why. Participants wanted to understand what was happening during their visit. They were also interested in learning about their diagnosis to lessen their fear and anxiety. The participants wanted to receive more direction from their physicians about what they should do regarding their personal care. Many of the participants often felt rushed through their visit. However, many felt that their physician listens to them and does the right thing.

Family planning access and trust

Many participants were unfamiliar with the term “family planning” but understood the importance of using condoms to avoid pregnancy and disease. However, it was clear that teenage pregnancy is a major issue for teens in Far Rockaway. Many female participants stated that it is not uncommon to see a teen (as young as 14 years old) pushing a stroller in the neighborhood. Some participants in the group expressed that they did not have a trusted person (family member, guardian, or health care professional) to talk to about accessing family planning services or to advise them on how to prevent an unwanted pregnancy. Participants wanted to be able to access information about family planning services without the involvement of their parents.

Lack of knowledge of health care issues and needs

The participants in the group did not have a great deal of knowledge about healthy lifestyles or behaviors. Many of the teens did not understand the meaning of the term, “balanced diet.” Most teens admitted that they consumed mostly fast food and did not have a regular exercise routine. In fact, many felt that the need to maintain a healthy lifestyle did not apply to them at their current age. It is noteworthy that the participants stated that they had health class for one semester in school but there were no further health care educational sessions made available to them. The group expressed interest in learning more about health issues and to understand how to stay healthy. Some participants felt that the doctor’s office should have posters about disease prevention and specific ways to stay healthy to help them become more informed.

GROUP SUGGESTIONS/RECOMMENDATIONS

Internet, text, and instant message tools are the best outreach tools to share health care information with teens and adolescents. Participants expressed a desire to have the ability to ask questions about health care concerns/issues utilizing the tools adolescents commonly use to communicate. Social networking sites such as My Space and Face Book as well as instant/text messaging tools were identified

by group participants as the best outreach vehicles to share health care information with teens and to connect teens to local health care resources.

LIMITED OPPORTUNITIES FOR ADOLESCENTS IN FAR ROCKAWAY

It was clearly expressed by the group that there were not many social opportunities for adolescents in Far Rockaway. Many of the participants expressed that their neighborhood is not safe because of gang violence and drugs. They stated that there were no positive venues for them to go and “hang out” in the community. Most tend to venture outside of their homes only for very specific reasons. Most teens were interested in forums such as this discussion group to share their health care issues and concerns.

CONTRIBUTING FACTORS

Transportation in and out of Far Rockaway is difficult

There is very little for teens to do in Far Rockaway. For entertainment, most participants reported that they normally would have to go to Jamaica, Queens or take the A Train into Brooklyn.

GROUP SUGGESTIONS/RECOMMENDATIONS

Community teen health center

Establish a teen health center in Far Rockaway where teens can gather in a safe, drug free environment, obtain clinical services and engage in positive community activities. The teen health center would be an ideal venue to educate teens about healthy behaviors and lifestyles.

SCHOOL NURSE ACCESS

Many participants stated that they were unclear about the job description and responsibilities of their school nurse. The teens felt that the nurse did not try to meet their needs when they sought medical assistance at school.

CONTRIBUTING FACTORS

School nurse was not helpful to teens when they needed assistance

While the participants understood the nurse could not dispense medications without parental permission, the group felt that the nurse was not at all helpful and could not relate to them.

GROUP SUGGESTIONS/RECOMMENDATIONS

Access to school nurses

The school nurse is well positioned to serve as a credible source of health care information and access resources for teens. The school nurse must be able to relate and respond to the needs of students.

Disaster readiness

Participants reported that schools should be equipped with a medical facility in the event of an emergency. Participants also stated that more medical supplies should be available in schools for use by students.

AFRICAN AMERICAN/BLACK MEN (AGES 21 – 50)

INTRODUCTION

On Tuesday, March 13, 2008, a discussion group was conducted at Bedford Stuyvesant Family Center in Brooklyn, NY. The purpose of this discussion group was to identify health care service access issues affecting African American/Black men (ages 21 – 50) and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for African American/Black Men (ages 21-50) living in New York City. Below is a brief summary of the recommendations.

CREATE AFRICAN AMERICAN MEN’S HEALTH AWARENESS SUPPORT GROUPS

African American men need to take a more proactive role in spreading the word about the importance of seeking regular health care to their family and friends. African American men are the most effective outreach tool to educate their peers about the importance of preventive health care and adopting a healthy lifestyle. Establishing these support groups will encourage health care information sharing and promote health care seeking behaviors among African American men.

PROMOTE AND ENCOURAGE HEALTH CARE SEEKING BEHAVIORS IN YOUNG AFRICAN AMERICAN MALES

Participants reported that children, especially African American male children, should be taught at an early age that seeking care and acknowledging pain is not a sign of weakness but a sign of strength. This message must be continuously shared by parents and the community at large to encourage future health seeking behaviors.

PROVIDE ONGOING CUSTOMER SERVICE TRAINING TO FRONT LINE HEALTH CARE WORKERS AT HOSPITALS, CLINICS, AND PHYSICIAN OFFICES

Provide customer service training opportunities for front line health care workers to promote a high level of professionalism in the treatment of patients.

RECRUIT MORE HIGH QUALITY PRIMARY AND SPECIALTY CARE PHYSICIANS TO PRACTICE IN SMALL OFFICE SETTINGS IN THE COMMUNITY

The current perception is that quality health care is provided in a small office setting rather than a large hospital. Bring back the concept of private practice/ neighborhood physician/family doctor in order to eliminate the perception that seeking care locally results in poor health care delivery.

ENCOURAGEMENT AND INVESTMENT IN THE HEALTH CARE INFRASTRUCTURE OF AFRICAN AMERICAN COMMUNITIES

Encourage and assist African Americans in the community who aspire to attend medical school. Develop programs and incentives for them to practice in the community after they have graduated.

DEMOGRAPHICS

A total of eight African American males participated in the 2 hour discussion group. The following are some key demographic characteristics defining the group.

Table 7: Demographic Profile of African American/Black Men (Ages 21 – 50) Discussion Group Participants

Category	Demographic Findings
ZIP Code	12.5% 11206 (n=1) 12.5% 11207 (n=1) 12.5% 11210 (n=1) 12.5% 11216 (n=1) 12.5% 11221 (n=1) 12.5% 11226 (n=1) 25.0% 11233 (n=2)
Age (Average Age)	34.6
Gender	100% Male (n=8)
Education Level	12.5% Some middle school or some high school, no diploma (grades 7-11) (n=1) 25.0% Some college, no degree (n=2) 12.5% High school graduate or GED (n=1) 50.0% 4 years of college or higher, with bachelor’s degree or higher (n=4)
Employment Status	75.0% Work 35 or more hours per week (n=6) 12.5% Unemployed (n=1) 12.5% Other: Student (n=1)
Income Level	37.5% between \$40,000-\$60,000 (n=3) 12.5% between \$60,001 - \$80,000 (n=1) 12.5% More than 100,000 (n=1) 37.5% no response (n=3)

Category	Demographic Findings
Insurance Status	87.5% Yes (n=7) <ul style="list-style-type: none"> - 28.6% Aetna (n=2) - 14.3% Empire Plan (n=1) - 14.3% Medicaid (n=1) - 14.3% 1199 Members Choice (n=1) - 14.3% United Health Care (n=1) - 14.3% Not Identified 12.5% No (n=1)
Race	100% Black or African American (n=8)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe are the biggest challenges African American men face when obtaining health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Lack of knowledge about the health care system/quality of information
2. Health care affordability and health care seeking behaviors
3. Quality of care/appointment wait times

LACK OF KNOWLEDGE OF HEALTH CARE SYSTEM/LACK OF QUALITY OF INFORMATION

Participants in the group felt that the complexity of the health care system and the great amount of health care information they needed to sift through was a challenge. Navigating through the health insurance companies (public and private), hospitals, clinics, and billing systems is daunting for them, as it is for most health care consumers. Some younger participants in the group felt that there is a lack of information about health care options and diseases. However, upon further discussion, all agreed that despite a great deal of information available about health care issues and diseases, it is difficult to identify which information is accurate and useful.

CONTRIBUTING FACTORS

Need for quality, trusted source of health care information

The participants in the group felt that with so much information available on the internet, in the newspaper and at doctor's offices, it was difficult to identify quality sources of information. The group

stated that they needed to establish a “personal connection” with a doctor, a friend or mentor in order to build trust. They do not necessarily trust the medical establishment because of previous experiences but instead preferred to receive information about health care from a trusted source, such as a family doctor, family member, or friend.

African American men do not communicate health issues and concerns with their peers

Participants reported that they usually do not share health information, issues, or concerns with their peers. The group felt that men should start sharing more information with each other and their families about healthy lifestyles and how and when to seek health care services.

Promotion of the importance of preventive health care and healthy lifestyles

There was a general consensus among participants that health care beliefs and practices are taught by the family matriarch. Growing up, these men were told by their mothers to take care of themselves and to get regular checkups. Many in the group stated that their fathers died at an early age because of a lack of attention to their personal health. While many in the group understood the importance of preventive health care (cholesterol checks, blood pressure, prostate screening and colonoscopy), they agreed that there is a relatively weak emphasis on preventive care for males within the African American culture. Some participants in the group did not seek out regular screenings or health care.

GROUP RECOMMENDATIONS

Create African American men’s health awareness support groups

African American men need to take a more proactive role in spreading the word to their family and friends about the importance of developing healthy lifestyles and seeking regular health care services. These support groups will encourage interaction, health care information sharing, and foster a stronger sense of community and trust.

Promote and encourage health care seeking behaviors in young African American males

African American male children should be taught at an early age that seeking health care services and acknowledging pain is not a sign of weakness but a sign of strength. Participants stated that young children need to hear the message of “taking care of himself or herself” from every adult they encounter. The encouragement of better health and spreading positive messages about health care should be the responsibility of everyone.

HEALTH CARE AFFORDABILITY AND HEALTH CARE SEEKING BEHAVIORS

Even with clinics and hospitals offering low cost fee-for-service plans and sliding fee scales, the real issue is affordability in relation to family incomes. Due to limited employment opportunities for African

American males in the community, men often have to make choices about the best way to spend their limited dollars. Oftentimes, men are forced to choose against seeking care sooner because other pressing family necessities (groceries, clothing, rent, transportation, etc.) compete for their dollars. Many in the group felt that women and children have more health care options/programs than men.

CONTRIBUTING FACTORS

Cost benefit analysis of seeking health care services

Many African American men in the community do not have the luxury to take a paid or unpaid day off of work to seek medical attention. Participants in the group, regardless of income level, stated that when they are ill they complete a cost-benefit analysis before seeking health care. If they believe they can effectively treat their illness with over-the-counter medication and avoid seeking professional medical care which may cause them to miss work, then they will do so. Participants in the group felt that it was their job to be the primary financial provider in their family and missing work was not an option.

African American males are socialized at a young age to ignore pain and discomfort

Participants in the group stated that many men put their personal health care on the “backburner” unless it is an absolute emergency. The reasons given for not seeking health care centered on issues of masculinity and manhood. Participants stated that they were told to “tough it out” and “not cry” when they were hurt as children or in physical pain. This mindset has continued to shape their health care seeking behaviors throughout their lives and may at times prevent them from seeking necessary care.

Minimal knowledge about how the health care system works including patient expectations when seeking health care services

One participant stated they did not know how the health care system worked and the financial responsibilities of the patient. Participants felt that providing African American males with an explanation of how the process works would greatly reduce anxiety and increase their likelihood of seeking health care services.

Eliminate the stigma of seeking care for particular diseases

Participants stated that there are still societal stigmas associated with seeking treatment and testing for certain diseases such as HIV/AIDS. Participants were concerned that if people do not sufficiently understand diseases, they are more likely to be afraid to talk about them, and are less likely to seek testing and/or treatment.

GROUP SUGGESTIONS/RECOMMENDATIONS

Create a health care services checklist

Develop and provide a checklist for patients and providers that describe the steps that the patient and provider need to follow in order to achieve quality health care outcomes.

QUALITY OF NEIGHBORHOOD CARE AND APPOINTMENT WAIT TIMES

Quality of neighborhood care and wait times for appointments were discussed at length during the group session. Participants stated that it was unacceptable to arrive at 9:00 am for a health care appointment and not complete the visit until noon. It is noteworthy that there was no difference in wait times for those with private or public insurance. In addition, participants stated that it is commonly believed that top quality health care services are not available in their neighborhood.

CONTRIBUTING FACTORS

Proactively choosing health care providers outside of their community

Participants reported that many African American males will seek health care outside of their community because there is a perception that their community's health care is of a lower quality than what is being offered in Manhattan or "downtown." There is a strong bias towards selecting care outside of their community-based on previous experiences when seeking care near where they live. One participant stated that they cannot find the types and quality of doctors they need in their community. He stated that he proactively would plan his children's appointments outside of the neighborhood to avoid getting care locally.

Lack of professionalism from front line health care workers at health care provider offices

The group stated that the health care community (doctors' offices, clinics, and hospitals) must provide ongoing training of their front line staff on how to treat patients with respect and to provide quality customer service. The group felt that it is very unprofessional for a staff person to be on a personal call during work hours and ignore patients as they are being registered to see the doctor. The level of professionalism at area facilities needs to be elevated to a higher standard.

Continue to move toward patient-centered health care

It was discussed that while the health care delivery model has shifted to a more patient-centered focus in recent years, there is still much work to be done in this area. The health care industry as a whole needs to continue to strive toward being more customer service oriented to retain and meet the needs of patients.

Community hospitals and clinics have a negative image in the community

Neighborhood hospitals have to work to improve their image in the community and improve customer service. Providing information about hospital performance evaluations and ratings would be useful to health care consumers.

Provide more specialty care providers in the neighborhood and bring back the concept of “neighborhood doctors.”

Participants felt that if more doctors could be recruited to the area and work in smaller settings, then more residents would seek care locally. In addition, it was felt that specialists should have set days when they see patients in the community in order to decrease the need to leave the neighborhood for care.

GROUP SUGGESTIONS/RECOMMENDATIONS

Provide ongoing customer service training to front line health care workers at hospitals, clinics, and physician offices

Provide ongoing customer service training opportunities for front line health care workers to promote a high level of professionalism in the treatment of patients.

Recruit more high quality primary and specialty care physicians to practice in small office settings in the community

The perception is that quality care is provided in a small office setting not a large hospital. Bring back the concept of the neighborhood physician/family doctor in order to eliminate the perception that seeking care locally results in poor health care delivery.

Encouragement and investment in health care infrastructure of African American communities

Encourage and assist African Americans in the community who aspire to attend medical school. Develop programs and incentives for them to practice in the community after they have graduated.

AFRICAN AMERICAN/BLACK MEN (AGES 62 AND OLDER)

INTRODUCTION

On Wednesday, March 12, 2008, a discussion group was conducted at St. Joseph's Hospital located in Far Rockaway, New York. The purpose of this discussion group was to identify health care service access issues affecting African American/Black men (ages 62 and older) and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for African American/Black Men (ages 62 and older) living in New York City. Below is a brief summary of the recommendations.

PREFERRED QUALITY HEALTH CARE SERVICES CLOSE TO HOME

Increase the amount of centralized primary, specialty, and diagnostic care in Far Rockaway that is available to all residents regardless of type of health insurance.

PROMOTE PREVENTIVE HEALTH CARE SCREENINGS

Educate the African American male community about the importance of preventive screenings and provide comprehensive information about how conditions such as colon and prostate cancer are treated. Providers need to be proactive in discussing these procedures and screenings with African American male patients.

STRENGTHEN THE COMMUNICATION BETWEEN DOCTORS

Communication between primary care physicians and specialty care providers is a critical component of patient care coordination and management.

INCREASE AWARENESS OF HEALTH CARE RESOURCES

Promote health care information and resources such as prescription drug assistance programs, health insurance, and wellness information in the African American community by placing flyers and other health materials in public settings including doctor's offices, clinics, hospitals, and churches.

DEMOGRAPHICS

A total of five African Americans participated in the 1.5 hour discussion group. The following are some key demographic characteristics defining the group that participated.

Table 8: Demographic Profile of African American/Black Men (Ages 62 and Older) Discussion Group Participants

Category	Demographic Findings
ZIP Code	80.0% 11691 (n=4) 20.0% 11693 (n=1)
Age (Average Age)	72
Gender	100% Male (n=5)
Education Level	20.0% Some middle school or some high school, no diploma (grades 7-11) (n= 1) 60.0% High school graduate or GED (n=3) 20.0% No answer (n=1)
Employment Status	100% Retired
Income Level	20.0% between \$10,001-\$20,000 (n=1) 40.0% between \$20,001 - \$40,000 (n=2) 20.0% between \$40,001 - \$60,000 (n=1) 20.0% no response (n=1)
Insurance Status	100% Yes (n=5) - 20.0% GHI (n=1) - 20.0% Medicare (n=1) - 20.0% HealthFirst (n=1) - 20.0% HIP VIP (n=1) - 20.0% Elder Plan (n=1)
Race	100% Black or African American (n=5)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the biggest problems African American men have when obtaining health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Accessing quality health care services close to home
2. Preventive care screenings
3. Strengthen the communication between providers

4. Cost of health care and prescription medication

HEALTH CARE ACCESS IS EASIEST CLOSEST TO HOME/CENTRALIZED CARE

Participants in this group accessed health care quite regularly for physicals and for chronic illnesses such as prostate cancer, colon cancer, and seizures. All participants reported that they preferred to access care closer to home with a regular provider that they trusted. However, some participants reported that they had to travel long distances or had long waits to obtain specialty care and diagnostic testing.

CONTRIBUTING FACTORS

Preference is to seek health care in the community

Obtaining health services within Far Rockaway is the preferred option for discussion group participants. Access to transportation and establishing a relationship with a health care provider were reasons why participants preferred receiving care in their neighborhood. Most participants reported positive health care experiences at many of the health care facilities in Far Rockaway.

Acceptance of type of health insurance, type of clinic services and accessing specialty care are often the reason for having to leave the neighborhood for health care

One participant stated that he had to wait a considerable amount of time for health care services because of a malfunctioning machine at a local health clinic and because his health insurance was not accepted at other area locations. When specific specialty services/tests are needed, and they are not available locally, participants stated that they have to travel to get care. One participant stated that having to go from one HIP Center to another is often frustrating and challenging when seeking health care. For those who had centralized services, it was a preferred option.

Transportation

Because of Far Rockaway's location, transportation to other areas in the City to obtain health care services is expensive, time consuming, and difficult.

GROUP SUGGESTIONS/RECOMMENDATIONS

Universal health care access

Increase the amount of centralized primary, specialty, and diagnostic care in Far Rockaway that is available to all residents regardless of insurance type.

PREVENTIVE HEALTH CARE SCREENINGS

All men in the group were prostate cancer survivors and had undergone surgery, chemotherapy, and radiation to treat their cancer. All participants expressed the importance of getting regular preventive screenings (blood pressure, diabetes, and cholesterol) but stated that there is misunderstanding in the African American community about certain screenings – specifically prostate cancer screening and colonoscopy. In addition, participants said that African American men are not used to seeking preventive care and typically avoid seeking medical care unless they are quite ill. Some participants had not received their screenings on the recommended schedule.

CONTRIBUTING FACTORS

Misperceptions about what the diagnosis of prostate cancer means

For many in the group, they stated that they were reluctant to obtain prostate cancer screening because they thought that the treatment of prostate cancer would make them impotent and reduce their ability to perform sexually. They stated that this perception is very common amongst African American males.

Colonoscopy

Some participants in the group did not receive a colonoscopy at the recommended age of 50 but understood that they must be checked for colon cancer every five years. For those who did not receive the screening at the recommended age, they stated that their doctor did not communicate the importance of having this screening and did not feel it was necessary. The invasive nature of the test made many felt it was not “masculine” for them to take this test.

GROUP SUGGESTIONS/RECOMMENDATIONS

Increase awareness within the African American community of the importance of preventive screenings

Educate the African American male community about the importance of obtaining preventive health screenings, and what a diagnosis of colon cancer or a prostate cancer means. Providers need to be proactive in discussing these procedures and screenings with their African American male patients.

COMMUNICATION BETWEEN PRIMARY CARE AND SPECIALTY CARE PHYSICIANS

The group shared an opinion that communication is lacking between primary care physicians and specialty care providers.

CONTRIBUTING FACTORS

Doctors need to communicate more effectively with each other

Participants reported that doctors do not communicate with one another regarding the care of patients. The group expressed that their regular doctor does not communicate or follow-up with specialty care providers to discuss their health care status or needs. It was stated that it should not be the sole responsibility of the patient to communicate information back and forth between their physicians. The group noted that a lack of communication between doctors diminishes their perception of the overall quality of care and trust in the health care services that they receive.

GROUP SUGGESTIONS/RECOMMENDATIONS

Better communication between doctors

Develop a formal care coordination system that will encourage communication between primary care doctors and specialists to improve health care outcomes for patients.

COST OF HEALTH CARE AND PRESCRIPTION MEDICATION

While all participants reported having health insurance, their co-payments for visits and prescription medication varied based on type of health insurance coverage. Many participants stated that there needs to be universal health care coverage to make health care services available to all people. There was much information sharing about how to reduce out-of-pocket health care costs especially for prescription drugs through existing programs.

CONTRIBUTING FACTORS

Discount prescription medication programs are available

One participant informed the group about the various prescription drug assistance programs that he is using to reduce his out-of-pocket costs for prescription medicine. Information about these various prescription discount programs was provided to him by his doctor. Many participants in the group were not aware of these programs.

GROUP SUGGESTIONS/RECOMMENDATIONS

Community awareness methods

Promote the availability of prescription assistance programs and other health care resources to the African American community by making this information available in public settings including doctor's offices, clinics, hospitals, and houses of worship.

ALBANIANS IN THE BRONX

INTRODUCTION

On Tuesday, March 4, 2008, a discussion group was conducted at the Four Star Restaurant located in The Bronx for Albanians living in Bronx by RACCOON, Inc. The purpose of this discussion group was to identify health care service access issues affecting Albanians living in The Bronx and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for Albanians living in New York City. Below is a brief summary of their recommendations.

INCREASE ACCESS TO PRESCRIPTION MEDICATION AND DENTAL CARE SERVICES

Provide low-cost/no cost prescription medication to those on a limited income. Advocate for low-cost medication (i.e., generic brands) for physicians to prescribe to patients who have difficulty paying for medication. Provide low-cost dental services to those in the community and advocate for the inclusion of dental care services as a covered benefit in health insurance plans.

RECRUIT ADDITIONAL PHYSICIANS TO SERVE THE COMMUNITY, DISTRIBUTE EXISTING HEALTH CARE SERVICES MORE EFFECTIVELY, AND IMPROVE THE MARKETING OF THESE SERVICES

Recruit more physicians to serve the community, create better marketing materials, and distribute existing health care services more effectively.

IMPROVE THE DISTRIBUTION OF COMMUNITY OUTREACH MATERIALS (INCLUDING HEALTH INFORMATION) WITHIN THE COMMUNITY

The group wanted to obtain more health and community information in The Bronx and participate as a community in meaningful and significant ways at the grass-roots (local) level. While most of the group are retired, many are highly educated and would be willing to “roll up their sleeves” and assist in any manner needed.

PROVIDE INTERPRETATION SERVICES TO IMMIGRANTS WHOSE PRIMARY LANGUAGE IS NOT ENGLISH

Provide interpretation services to those seeking health care, especially in The Bronx which is heavily populated with immigrants from Albania. This service should be obtainable in all health care offices and outlets.

DEMOGRAPHICS

A total of 22 Albanians participated in the 1.5 hour long discussion group. Following are some key demographic characteristics defining the group that participated:

Table 9: Demographic Profile of Albanians in The Bronx Discussion Group Participants

Category	Demographic Findings
ZIP Code	27.3% 10469 (n=6) 22.7% 10465 (n=5) 31.8% 10457 (n=7) 18.2% 10471 (n=4)
Age (Average Age)	Over 60
Gender	36.3% Females (n=8) 63.6% Males (n=14)
Education Level	18.2% 6 th grade or less (n=4) 27.3% High school graduate or GED (grade 12) (n=6) 54.5% 4-years of college or higher, with bachelor’s degree or higher (n=12)
Employment Status	13.6% Work 35 or more hours per week (n=3) 22.7% Work less than 35 hours per week (n=5) 63.6% Unemployed (n=14)
Income Level	86.4% \$0 - \$10,000 (n=19) 4.5% \$10,001 - \$20,000 (n=1) 4.5% \$40,001 - \$60,000 (n=1) 4.5% No answer (n=1)
Insurance Status	81.8% Yes (n=18) 18.1% No (n=4)
Race	100% White (22)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the biggest problems Albanian adults have when obtaining health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Uninsured/ underinsured/ inability to pay for health care services
2. Need for interpretation services
3. Need assistance with navigating the health care system and understanding the various health insurance coverage options

UNINSURED/UNDERINSURED/INABILITY TO PAY FOR HEALTH CARE SERVICES

Participants reported that those who live on a fixed income cannot afford to pay for health care services. Many are forced to alter their lifestyles in order to maintain their health.

CONTRIBUTING FACTORS

Inability to afford health care services, including prescription medication

Affording prescription medication is an issue for most discussion group participants. Most are senior citizens living on a fixed income who cannot afford the high costs and out-of-pocket expenses of obtaining prescription medication. One participant felt it is pointless to seek medical intervention for an ailment when the patient cannot afford the monthly medication to eradicate or stabilize his/her condition.

Costly out-of-pocket fees place a financial strain on seniors needing health care services

Participants reported that the guidelines and restrictions of health insurance plans are strict. The coverage provided for health care services is limited. These limitations include the types of health care services that are covered, percentage of health care costs covered by plan, and patient qualification for certain health care services. Borrowing money from financial institutions to cover health care costs was an avenue one participant was forced to take. Because of a chronic heart condition, one participant reported that he had to alter his lifestyle habits (eating a healthy diet, obtaining regular good care, and taking his prescription medication) all at a costly rate. There are additional stress factors due to the unforeseen future costs of health maintenance.

Lack of dental coverage and health insurance

Obtaining dental care services is difficult and expensive in this community because dental services are not readily available. It perplexed those in the discussion group that this type of health service is not covered by health insurance plans. Participants reported that utilizing the emergency room was their only option for obtaining needed dental care services.

Jacobi Medical Center is a main source of health care services for the Albanian community

Most of the participants reported that they obtain most of their routine health care services at Jacobi Medical Center, which provides language assistance to those within the Albanian community. Some go to Manhattan from The Bronx, where Albanian-speaking physicians have practices.

Preference is to seek health care services in their community

Acquiring health care services within their community is preferred. However, Albanian-speaking physicians in Manhattan are commonly used because of the strong cultural bond felt due to shared language and heritage. Barriers such as cost, transportation, health care clinic/provider hours, language differences, types of services offered, difficulty obtaining appointments and poor interactions with health care staff were some of the problems participants encountered when obtaining health care services.

GROUP SUGGESTIONS/RECOMMENDATIONS

Increase access to prescription medication and dental care services

Provide low-cost/no cost prescription medication to those on a fixed/limited income. Advocate for low-cost prescription drugs (i.e., generic brands) for physicians to prescribe to patients who have difficulty paying for medication. Provide low-cost dental services to those in the community and advocate for the inclusion of dental care services as a covered benefit in health insurance plans.

Recruit additional physicians to serve the community

Recruit more physicians to serve the Albanian community.

Improve the distribution of community outreach materials (including health promotion information) within the community

The group wanted to obtain more health and overall community information about services available in The Bronx in order to participate as a community in meaningful and significant ways. While most of the group are retired, many are highly educated and would be willing to “roll up their sleeves” and assist in any manner needed.

NEED FOR INTERPRETATION SERVICES

Participants stated that the inability to communicate using the same language is a significant barrier to accessing health care services.

CONTRIBUTING FACTORS

Communication challenges identified as a major health care access barrier

The ability to communicate with a health care professional is critically important to many in the group. Picking up prescription medication can be a daunting task because communication is often difficult for both parties. Assistance from family members with knowledge of the English language is frequently used to translate prescription instructions. Grandchildren will often accompany their grandparents in case questions arise. While children are not well suited to be medical interpreters, they are often the only available option when interpretation services are needed but not available. Participants stated that it is difficult to rely consistently on family members. Participants praised Albanian physicians who go above and beyond to meet the needs of their patients. When asked to imagine an ideal health care visit, participants reported that they preferred being addressed in their own language and their discussions preceding the visit being understood.

GROUP SUGGESTIONS/RECOMMENDATIONS

Supply interpretation services to immigrants whose primary language is not English, especially residents seeking health care services

Provide translation services to those seeking care, especially in The Bronx, which is heavily populated with immigrants from Albania. This service should be obtainable in all health care offices and outlets.

NEED ASSISTANCE WITH NAVIGATING THE HEALTH CARE SYSTEM AND UNDERSTANDING THE VARIOUS HEALTH INSURANCE COVERAGE OPTIONS

Some participants were concerned about their ability to qualify for and obtain health insurance coverage.

CONTRIBUTING FACTORS

Lack of knowledge of where to go to obtain assistance with obtaining health insurance coverage

The younger participants in the group (those under the age of 40) did not seek any type of health services because they considered themselves to be healthy. However, they discussed being unsure if they qualify for health coverage. They also stated they did not know how to navigate the health care system or how to apply for needed health care services. If health services were needed, the hospital emergency room was seen as being the only outlet for those in this age group.

GROUP SUGGESTIONS/RECOMMENDATIONS

There were no suggestions.

ADDITIONAL QUESTIONS ASKED AND RESPONSES

After discussing each of the major barriers identified by participants, there was time remaining to discuss additional questions. A summary of the group's responses follows:

- Participants of this discussion group expressed gratitude to RACCOON, Inc. and to the Mayor for initiating this type of meeting in which concerns related to health care and access issues are discussed.
- There is a sense of community where the discussion group participants live. Many feel a connection to each other and lack of loneliness due to the high concentration of Albanians living in their area.
- There is a need for community activities for all ages. The group cited having community sponsored activities in Albania and they would like to have similar activities in The Bronx.
- Physical wellness is important to this group. Their heritage provides a history of eating a balanced meal and exercising. However, it is hard to afford healthy food options in the city. Growing vegetables to offset some of the healthy food costs is unrealistic because of the urban setting.
- The group perceives The Bronx to be unkempt and dirty. Citizens need to be more active and responsible for their community when funding is not allocated to keep their neighborhood clean. These individuals were surprised to see the lack of cleanliness throughout The Bronx and would like to tackle the issue at a local level. They need assistance in mobilizing and figuring out how they can impact local government and organizations.

CHINESE ELDERS

INTRODUCTION

On Tuesday, March 4, 2008 a discussion group was conducted for Chinese elders at the Indochina Sino-American Community Center located in Chinatown, Manhattan, New York. The purpose of this discussion group was to identify health care service access issues affecting Chinese elders and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for Chinese elders living in New York City. Below is a brief summary of the recommendations.

NEED FOR MORE PHYSICIANS

Participants say there is a need for more physicians in their community to help reduce the wait times at health care facilities and improve the wait time for getting an appointment.

TRANSLATION/INTERPRETATION SERVICES

Participants recommended having translation/interpretation services available at all health care facilities, which should be sufficient to meet the needs of patients and their visiting or accompanying family members. The participants would like to see physician offices and all health care facilities have at least one person on each floor that is able to assist them with interpretation services.

TRANSLATION OF MEDICAL FORMS

Participants would like health insurance statements, prescription and physician instructions, and notices of change of health coverage benefits translated into Chinese to ensure that they are well informed.

GOVERNMENT SHOULD PROVIDE BETTER COVERAGE

Participants reported that the government should provide better prescription drugs coverage for Chinese elders and others.

DEMOGRAPHICS

A total of thirteen Chinese elders participated in the two-hour discussion group. Below are some key demographic characteristics which define the group that participated.

Table 10: Demographic Profile of Chinese Elders Discussion Group Participants

Category	Demographic Findings
ZIP Code	38.5% ZIP code 10002 (n=5) 23.1% ZIP code 10013 (n=3) 7.7% ZIP code 10038 (n=1) 30.8% No Response (n=4)
Age (Average Age)	75
Gender	46.2% Female (n=6) 53.8% Male (n=7)
Education Level	38.5% 6 th grade or less (n=5) 38.5% Some middle school or some high school, no diploma, grades 7-11 (n=5) 23.1% High school graduate or GED, grade 12 (n=3)
Employment Status	7.7% Work 35 or more hours per week (n=1) 61.5% Other (n=8) 30.8% No answer (n=4)
Income Level	84.6% \$0-\$10,000 (n=11) 7.7% \$10,001-\$20,000 (n=1) 7.7% No answer (n=1)
Insurance Status	100% Yes (n=13) -76.9% Both Medicare and Medicaid (n=10) -15.4% Medicaid only (n=2) -7.7% Medicare only (n=1)
Race	100% Asian (n=13)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems Chinese elders have getting health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Process to obtain health care services is too long
2. Translation/interpretation services

3. Preference for name brand prescription drugs
4. Inadequate health insurance coverage/ inability to pay for services
5. Transportation services

PROCESS TO OBTAIN HEALTH CARE SERVICES IS TOO LONG

Participants reported that the process of getting health care services in New York City is difficult and takes too much time.

CONTRIBUTING FACTORS

The US health care system is very different when compared to China's system of health care delivery

Participants stated that the health care system in China was much more efficient when that nation was more socialistic and less capitalistic. They believe that physicians in China will treat patients immediately especially in an emergency situation. In the United States, wait times to see a physician in the emergency room can last as long as eight to ten hours.

Physicians are late getting to appointments due to extensive responsibilities

Participants stated that visits to a physician's office may take an entire day in some cases. Participants understand that physicians have other responsibilities making rounds at the hospital and have many patients to see. However, participants feel that they should not have to wait an entire day because of problems related to physician shortages, double booking of appointments, or other responsibilities.

The admissions/registration and referral processes are time consuming and difficult

Participants have a feeling of distrust and frustration in being able to register quickly when at a health care facility. Participants explained that language and cultural barriers make filling out registration forms and communicating with health care staff difficult.

Lack of trust of health care providers

Participants also feel like they are being taken advantage of or manipulated unfairly by physicians who refer them to other physicians without a real health need in order to make more money. Participants feel they are being run around to too many unnecessary appointments which cost them time and money.

GROUP SUGGESTIONS/RECOMMENDATIONS

Need for more physicians

Participants say that there is a need for more physicians in their community to help reduce the wait time at health care facilities and improve the wait time for an appointment.

TRANSLATION/INTERPRETATION SERVICES

Participants stated the inability to communicate using the same language is a significant barrier to accessing health care services.

CONTRIBUTING FACTORS

Scheduling appointments and the registration process

The participants stated that simply scheduling appointments or registering at a health care facility is almost impossible unless they have a family member who can interpret for them. This concern encompasses both the completion of paper forms and communicating with health care staff verbally. Participants stated that most health care facility telephone systems do not have a Chinese greeting or language option.

Health insurance statements

Participants are very frustrated with not being able to read their health insurance statements. Health insurance statements printed in English are confusing and stressful to Chinese elders because they do not understand what the statements say and what amount of money they owe to the health insurance company or if they owe any money at all. The language barriers keep them from providing verbal or written comments or responses when they need to or want to.

Medical instructions

Participants are afraid that they will not be able to follow or understand the instructions provided by the physician or health care staff related to prescriptions, referrals, and other physician instructions for post-appointment care.

Direct communication with physician and health care staff

Participants fear that they are not able to really understand or trust the physician they are visiting because of existing language barriers. Participants stated their frustration during appointments when having various treatments administered (i.e., testing, shots, prescription medications) because they are not sure why they must receive the treatments. Participants also stated they are frustrated because

they are not able to understand what their friends or family members are experiencing during their visits. Participants are concerned for their loved ones and would like to have feedback on their progress during a visit to a health care facility, but are unable to due to the language barrier.

Psychological stress

Language interpretation is extremely critical in reducing their psychological stress and empowering them in partnering with the doctor. For example, while waiting for hours to be seen at the emergency room, it is very nerve-wrecking when nobody communicates with you about what will happen to you and when it will happen.

GROUP SUGGESTIONS/RECOMMENDATIONS

Interpretation services

Participants stated part of their distrust of physicians and other staff deals with language barriers and the inability to communicate effectively. Participants recommend having interpretation services available at all health care facilities, which should be sufficient to meet the needs of both the patients and their visiting or accompanying family members. The participants would like to see physician offices and all health care facilities have at least one person on each floor that is able to assist them with translation or interpretation services.

Medical forms translated into Chinese

Participants want to see health insurance statements, prescriptions, and all physician instructions, particularly important notices regarding any change in their health insurance benefits, translated into Chinese to ensure that they understand things correctly.

PREFERENCE FOR NAME BRAND PRESCRIPTION DRUGS

Chinese elders are very frustrated that they are forced to take generic medications instead of name brand medications.

CONTRIBUTING FACTORS

Generic drugs do not work as well as name brand drugs

Participants stated that generic drugs do not work as effectively or as quickly as name brand drugs. Participants stated that the generic drugs prescribed sometimes do not work at all, but believe that name brand drugs would work the first time prescribed.

Health insurance plans do not cover name brand drugs

Participants explained they are frustrated that their health insurance plans typically do not cover brand name drugs forcing them to settle for generic drugs. Participants stated many doctors request they change their health coverage plan to accommodate the name brand drugs, but they are unable to do so due to financial constraints. The switching of drugs at the pharmacy is time consuming as it involves contacting the doctor, causing delay in getting their prescription filled.

GROUP SUGGESTIONS/RECOMMENDATIONS

Government should provide better prescription drug coverage

Participants feel that the government should provide better coverage for Chinese elders and others when it comes to prescription drugs. Participants feel this would reduce the cost of providing health care because the ineffectiveness of using generic drugs leads to additional and unnecessary physician appointments and drug orders.

INADEQUATE HEALTH INSURANCE COVERAGE/INABILITY TO PAY FOR SERVICES

Chinese elders are very concerned about their ability to pay for or have their health insurance cover their health care needs.

CONTRIBUTING FACTORS

Level of health insurance coverage

Participants stated that their health insurance coverage does not cover all of their health care needs. Participants stated this is true especially for those Chinese elders who do not have both Medicare and Medicaid.

Household income

Participants explained they are unable to afford the services that their insurance does not cover. Participants stated they are concerned about policy changes requiring a co-payment of \$3.00 to \$4.00 per visit to physician offices even for those people who have Medicare and/or Medicaid. As seniors, it is not uncommon that they may visit the doctor a few times a month and the co-payment adds up and becomes a real financial hardship. Due to previous concerns regarding language barriers and a distrust of physicians, participants again stated their concern that they are being taken advantage of and receiving unnecessary services which cost them more money.

Private Doctor's Office

Approximately fifty percent of the participants go to a private doctor's office and fifty percent go to a health clinic for the majority of their health care needs. The reason why participants choose these two locations depends upon their health insurance coverage or ability to pay for services. Most participants would prefer to go to a private doctor's office if they have the means to pay for the visit.

GROUP SUGGESTIONS/RECOMMENDATIONS

Improve public health insurance coverage

Participants say they need the government to provide better coverage for people using Medicare and/or Medicaid.

TRANSPORTATION SERVICES

Chinese elders stated transportation to and from health care provider offices is also a significant barrier.

CONTRIBUTING FACTORS

City bus systems do not arrive frequently enough

Participants stated that a thirty minute to an hour wait is typically expected when using the city bus system to travel to medical appointments. They stated that often a few buses arrive at the same time because of poor monitoring of the bus schedule.

Subway system is not an option

Participants stated that the subway system is not an option because they are unable to read the signs and understand which stops they should get off at. Using the bus provides participants with an ability to at least see outside through the windows and know where they are even if they cannot read the signs. Because the subway is underground, participants do not have the same advantage.

Senior metro cards can easily be damaged

Participants stated that Senior Metro Cards for the bus can be easily damaged and take weeks to get a replacement card that can be scanned properly at the turn-style entrance.

Prefer care in their neighborhood

Participants stated unanimously that the only reason why they would go outside of their neighborhood for care is because of a referral for specialty services by their primary care doctor. Participants receive the majority of their health care within their neighborhood by their primary care doctor or local hospital.

GROUP SUGGESTIONS/RECOMMENDATIONS

The group did not have any suggestions.

DOMESTIC WORKERS

INTRODUCTION

On Wednesday March 5, 2008 a discussion group was conducted for domestic workers at the Caribbean Women’s Health Association in Brooklyn, New York City. The purpose of this discussion group was to identify health care service access issues affecting domestic workers and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for domestic workers living in New York City. Below is a brief summary of the recommendations.

CLINICS AND DOCTORS’ OFFICES SHOULD ACCEPT ALL FORMS OF HEALTH INSURANCE

Participants recommend that local clinics and doctors’ offices should accept all forms of health insurance coverage.

PUBLIC HEALTH INSURANCE ELIGIBILITY RULES ARE UNFAIR

Participants did not feel it is right that they are punished for making a little too much money to qualify for public health insurance coverage.

TRANSLATED COPIES OF THE APPLICATION

Applications for health insurance should be translated from English into other popular languages and be made available throughout the City. This would help ease the burden of applying for public health insurance.

OUTREACH SERVICES

Participants also said that outreach within the community needs to be done to help people who have difficulty filling out the applications for public health insurance or other public benefits due to language, cultural, or literacy barriers.

INTERPRETATION SERVICES

Participants say that health care facilities and social worker’s offices should have interpretation services available to help domestic workers communicate more effectively and get pointed in the right direction.

PUBLIC SOURCES OF INFORMATION

Participants say information regarding available health care resources – including public health insurance programs – should be available in public venues and community gathering spots such as beauty salons, barber shops, laundromats, and supermarkets. The information provided should be clear and offer instruction about how and where to apply for health insurance. A list of health care facilities that serve individuals with varying levels of income and health insurance coverage should be readily available in these settings.

PATIENT’S HEALTH SHOULD BE FIRST PRIORITY

Participants reported that in emergency situations health care providers should first focus on treating the patient to prevent serious problems. Secondary focus should be placed on completing registration forms.

NEED MORE FREE CLINICS

Participants say that communities in Brooklyn should be evaluated for placement of free clinics to help provide services to those who are unable to pay for services or uninsured.

DEMOGRAPHICS

A total of nine domestic workers participated in the two-hour discussion group. Below are some key demographic characteristics which define the group that participated.

Table 11: Demographic Profile of Domestic Workers Discussion Group Participants

Category	Demographic Findings
ZIP Code	44.4% ZIP code 11226, (4) 22.2% ZIP code 11233, (2) 11.1% ZIP code 11213, (1) 11.1% ZIP code 11221, (1) 11.1% No Response, (1)
Age (Average Age)	31
Gender	100% Female (9)

Category	Demographic Findings
Education Level	44.4% High school graduate or GED, grade 12, (4) 22.2% Some college, no degree (2) 11.1% Associate’s degree, or certificate from vocational, business, or trade school 22.2% 4-years of college or higher, with bachelor’s degree or higher (2)
Employment Status	44.4% Work 35 or more hours per week (4) 22.2% Work less than 35 hours per week (2) 22.2% Unemployed (2) 11.1% No answer (1)
Income Level	33.3% \$0-\$10,000 (3) 11.1% \$10,001-\$20,000 (1) 33.3% \$20,001-\$40,000 (3) 11.1% \$40,001-\$60,000 (1) 11.1% No answer (1)
Insurance Status	22.2% Yes (2) 100% Medicaid only (2) 77.8% No (7)
Race	100% Black/West Indians (9)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems domestic workers have getting health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Inadequate health coverage/ cannot afford to pay for health care services
2. Not having proper documents to apply for health insurance
3. Not having knowledge of where to go for health care assistance
4. Too many steps to receive service
5. Need more free clinics

INADEQUATE HEALTH COVERAGE/CANNOT AFFORD TO PAY FOR HEALTH CARE SERVICES

Participants stated that due to a lack of health coverage and low-income status they have a difficult time covering the costs of health care services. Only two participants in the discussion group had health insurance coverage while the remaining participants were uninsured.

CONTRIBUTING FACTORS

Jobs do not provide quality health insurance coverage

Participants stated that the types of jobs they had been able to obtain did not provide them with quality health insurance coverage. Six of the nine participants reported that they had no college education which prohibits them from obtaining jobs which may provide quality health care insurance coverage.

Undocumented status

Participants stated that many of their peers were afraid to apply for public health insurance because they do not want to be reported to immigration services.

Do not qualify for health insurance

Participants stated that it is better to work less or have kids in order to qualify for public health insurance coverage (i.e., Medicaid). Two of the participants stated that they made a little bit too much money at their jobs which prevents them from qualifying for Medicaid. Participants stated that this provides them with no incentive to work more hours and make more money.

Unable to pay for services

Participants stated they are had not been able to pay for even basic services such as laboratory or diagnostic tests. Participants are reported concerns about co-payments which accompany Medicaid. Participants stated they are unable to make these co-payments at every single appointment.

Health insurance does not cover all health care needs

Participants stated that many doctors and clinics in their neighborhoods do not accept all forms of health insurance. Participants referenced stories regarding peers with basic health insurance coverage who were turned away and were not able to receive service. As a result, these peers had to travel to another neighborhood for care. They reported that the cost of traveling to another neighborhood has often been a deterrent to receiving health care services.

GROUP SUGGESTIONS/RECOMMENDATIONS

Clinics and doctors' offices should accept all forms of health insurance

Participants recommended that local clinics and doctors' offices need to accept all forms of health insurance coverage.

Public health insurance eligibility rules are unfair

Participants stated they felt that there should be an incentive for people to work harder not less to qualify for public health insurance coverage. Participants reported that they do not feel it is right that they are punished for making too much money to qualify for public health insurance coverage.

NOT HAVING PROPER DOCUMENTS TO APPLY FOR HEALTH INSURANCE

Participants reported having trouble applying for public health insurance programs.

CONTRIBUTING FACTORS

Applications are long and hard to understand

The participants stated the applications for public health insurance are too long and hard to fill out. For many peers, participants stated that the terminology is difficult to understand and the information requested in the application is very personal.

Applications are only available in English

Participants stated that many domestic workers cannot read English well and do not understand the material they are reading. They reported that is especially a challenge to domestic workers who are new to the United States, who do not speak English, and are not able to fill out the forms.

Availability of applications

Participants stated it is difficult to figure out where you need to go to find applications. Participants reported that applications should be more readily available in public settings.

Renewal process

Participants reported that they understood why they have to renew their application, but they do not believe that they should have to fill out an entirely new form each time. Participants stated that they would rather have the social worker ask them questions about any changes to their information rather than go through the entire application process each time.

GROUP SUGGESTIONS/RECOMMENDATIONS

Make applications more readily available

Participants stated that information regarding where to go and how to apply for health insurance should be posted in public places such as beauty salons, barber shops, supermarkets, and laundromats.

Translated copies of public health insurance applications

Participants said that applications for health insurance should be translated from English into other popular languages throughout the city to ease the burden of applying for public health insurance.

Outreach services

Participants also said that outreach within the community should be done to help people who have difficulty filling out the application due to language, cultural, or literacy barriers.

NOT HAVING KNOWLEDGE OF WHERE TO GO FOR HEALTH CARE ASSISTANCE

Participants stated that they are often unsure of where they should go for help to meet their health care needs.

CONTRIBUTING FACTORS

Health care facilities

Participants stated they were unsure of which facility (i.e., hospital, clinic, doctor's office) they should go to for health care services. Much of the confusion related to understanding where they can go for care, which health care facilities accept their health insurance and where they can obtain free health care services if they are uninsured.

Best health insurance plans

Participants explained that they were unsure which health insurance plan is best suited to meet their needs.

Inability to communicate and cultural barriers

Participants said that they were discouraged by the fact that many domestic workers are unable to communicate effectively in order to be pointed in the right direction. Participants pointed to language and cultural barriers as reasons why peers are unable to understand the health care system in their neighborhood. Participants stated many social workers and providers are insensitive to the language and cultural barriers present.

Confidentiality

Participants explained that due to their culture and the nature of how information is shared, they had been hesitant to visit a doctor of their own cultural and language background for fear of the information being shared in their own community despite confidentiality laws like HIPPA. Participants stated that culturally their community shares everything, so they would not feel comfortable visiting a member of their community for health care services.

Lack of trust in providers

Participants also referenced past effects of cultural insensitivity to African Americans – citing the “Tuskegee Study” where African Americans were used to participate in unsafe medical testing. Participants also reported that many African American residents in low-income neighborhoods are still afraid to receive flu shots and other forms of services because they do not trust providers or the health care system as a result of past events such as the “Tuskegee Study.”

Religious beliefs

Participants explained that for some of their peers, it is considered not “Godly” to receive certain services such as a blood transfusion. Participants also noted that the religion and cultures of some community members leads them to prefer home remedies or care. Participants stated these peers have more faith in their home remedies than the current health care system.

Immigration status

Many domestic workers stated that they were afraid that if they presented themselves to a hospital or other health care facility, they would be reported to immigration services. As a result, they often lie on registration or insurance forms about their contact information. Participants stated that many peers will ultimately not seek care for fear of being deported. Rather, they hope that their health problem goes away.

GROUP SUGGESTIONS/RECOMMENDATIONS

Translation/interpretation services

Participants said that health care facilities and social worker’s offices should have interpretation services available to help domestic workers communicate more effectively and get pointed in the right direction.

Health care information should be made available in public settings

Participants said that information regarding available health care resources in their community should be available in community gathering spots such as beauty salons, barber shopts, supermarkets, and

laundromats. Information should be clear as to where to go for care for persons with varying levels of health insurance and income.

TOO MANY STEPS TO RECEIVE HEALTH CARE SERVICES

Participants reported that they had been frustrated with all of the steps it takes to receive health care services and obtain public health insurance coverage.

CONTRIBUTING FACTORS

Registration/admissions

Participants stated they had been frustrated with the registration/admissions process especially in emergency situations. Participants noted that they did not understand why a person cannot be treated first to avoid further complications before having to complete financial paperwork.

Long waits

Participants explained that they had been frustrated with the long waits in emergency rooms, clinics, and doctors' offices.

Public health insurance application process

Participants also shared their frustration with the application process for health insurance. The participants' opinion was that this process takes too long and involves too many people.

GROUP SUGGESTIONS/RECOMMENDATIONS

Patient's health should be first priority

Participants stated that in emergency situations health care providers' first focus should be on treating the patient first to prevent more serious problems, and that their secondary focus should be placed on completing the paperwork.

NEED MORE FREE CLINICS

Participants stated that they were in need of access to more free clinics in their neighborhoods.

CONTRIBUTING FACTORS

Health insurance not accepted and/or inability to pay for services

Participants stated many health care facilities have not provided services because they did not have adequate/preferred health insurance coverage or were unable to pay for services.

Transportation

Participants explained that they were aware of a few facilities where they could receive free care outside of their neighborhood, but they were unable to go there for services because they could not afford to pay for transportation.

GROUP SUGGESTIONS/RECOMMENDATIONS

Need for more clinics which serve low income, uninsured patients.

Participants stated that communities in Brooklyn should be evaluated for placement of clinics to help provide services to those who are unable to pay for services or uninsured.

ADDITIONAL QUESTIONS ASKED AND RESPONSES

After discussing each of the top five problems or barriers that the domestic worker participants stated they had in accessing health care services, the Caribbean Women's Health Association co-facilitator asked some questions which were specifically customized for the domestic workers audience. Below is the response to one of the posed questions. The responses from other customized questions were incorporated into the priority issues listed above.

DOES MEDICAL TERMINOLOGY PRESENT A BARRIER TO UTILIZING HEALTH CARE?

- Participants stated they were uncomfortable with the terminology used by doctors in writing prescriptions or communicating instructions for treatment of themselves or a family member.
- Participants reported that doctors often provided care instructions in a rushed manner with little to no attention to patient comprehension of their instructions.
- Participants also stated their lack of trust of doctors who prescribe medication or methods of treatment before the patient has completed their explanation of their ailment/symptoms.
- Participants reported that they understood that doctors are busy and have many patients but would appreciate the courtesy of listening first. One participant cited an example of receiving the wrong medication due to an inappropriate diagnosis.

- Participants said that doctors should receive confirmation from another doctor on staff before finalizing the prescription or treatment of a diagnosis as a quality control measure.

ENGLISH SPEAKING WEST AFRICANS IN STATEN ISLAND

INTRODUCTION

On Thursday, March 6, 2008 a discussion group was conducted for West Africans in the offices of African Refuge in the Stapleton neighborhood of Staten Island, New York. The purpose of this discussion group was to identify health care service access issues affecting West Africans in Staten Island and to identify potential solutions to resolve these concerns for this specific population.

In addition to the discussion group conducted with West Africans on Staten Island, a household survey, and secondary data survey had been conducted in April of 2007 by HHC and Tripp Umbach with the main goal of identifying a location on Staten Island for a Federally Qualified Health Center. The key findings from this separate study begin on page 239.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for West Africans living in New York City. None of these recommendations are inconsistent with findings from the 2007 survey. Below is a brief summary of the discussion group's recommendations.

BUILD A COMMUNITY HEALTH CENTER THAT IS ACCESSIBLE AND USER FRIENDLY

Provide community health centers for adolescents and adults that are readily available to those in need and that do not have a lot of "red tape" and administrative policies that often make seeking care difficult. Among their services, they could offer therapy to immigrants from war-torn countries (such as many in West Africa) and those who have trouble assimilating to their new environment.

ACCEPT HEALTH INSURANCE UNIVERSALLY, WITHOUT EXCEPTION

To give patients real choice, providers should accept whatever health insurance plans patients have.

ORGANIZATIONS NEED TO GET INVOLVED

The participants felt that large organizations, such as the local unions, should support policies that help employees maintain their health coverage.

PROMOTE QUICKER AND EASIER ACCESS TO GOVERNMENT DOCUMENTS

Quicker turnaround periods when applying for government documents or paperwork would alleviate some access issues.

PROVIDE ASSISTANCE IN OBTAINING HEALTH CARE AND GOVERNMENT SERVICES AND DOCUMENTS

Many would like to have assistance when inquiring about and obtaining health care and government services and documents. Accessing these types of services is cumbersome and difficult for group participants to comprehend.

IMPLEMENT UNIVERSAL TREATMENT STANDARDS

Treatment standards should be the same, regardless of the patient's insurance or ability to pay.

OPEN LINES OF COMMUNICATION

Physicians need to spend more time communicating with their patients, by asking and answering questions, discussing treatment options, and explaining prescriptions.

MAKE INFORMATION AVAILABLE TO THOSE IN THE COMMUNITY

Distribute consumer rights and health information through community-based organizations such as African Refuge.

DEMOGRAPHICS

A total of 12 West Africans participated in the two-hour discussion group. Following are some key demographic characteristics defining the group that participated:

Table 12: Demographic Profile of English Speaking West Africans in Staten Island Discussion Group

Category	Demographic Findings
ZIP Code	8.3% 10334 (n=1) 91.7% 10304 (n=11)
Age (Average Age)	48
Gender	41% Females (n=5) 58% Males (n=7)

Category	Demographic Findings
Education Level	16.6% 6 th grade or less (n=2) 8.3% Some middle school or some high school, no diploma (grades 7 -11) (n=1) 33.3% High school graduate or GED (grade 12) (n=4) 25.0% Associate’s degree, or certificate from vocational, business, or trade school (n=3) 16.6% 4-years of college or higher, with bachelor’s degree or higher (n=2)
Employment Status	25.0% Work 35 or more hours per week (n=3) 50.0% Unemployed (n=6) 25.0% No Answer (n=3)
Income Level	41.6% \$0 - \$10,000 (n=5) 8.3% \$10,001 - \$20,000 (n=1) 16.6% \$20,001 - \$40,000 (n=2) 33.3% No answer (n=4)
Insurance Status	58.3% Yes (n=7) - 28.6% Medicaid (n=2) - 14.3% Medicare (n=1) - 14.3% Empire Insurance (n=1) - 14.3% Union (n=1) - 28.6% 1199 (n=2) 41.6% No (n=5)
Race	100% Black (n=12)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems West Africans in Staten Island face when obtaining health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Inadequate insurance and health services coverage/no insurance/inability to pay for health care services
2. Lack of employment opportunities/poor wages
3. A lack of proper legal documentation required to obtain services (i.e., not being a documented citizen)
4. Lack of opportunity to be educated about the health care system
5. Lack of knowledge about where to go for help

INADEQUATE INSURANCE AND HEALTH SERVICES COVERAGE/NO INSURANCE/ INABILITY TO PAY FOR HEALTH CARE SERVICES

A number of participants stated that health insurance was not available to them because they did not have the economic means to purchase coverage. Only seven out of twelve participants reported having health insurance coverage.

CONTRIBUTING FACTORS

Costly out-of-pocket expenses associated with health services and insurance

Participants noted that lack of health coverage is a significant problem for those in the community and high cost is one of the main reasons participants do not obtain health services and/or have health insurance.

Health insurance plans not accepted universally

Participants reported that many health providers do not accept certain health plans, which make it difficult for those participants who are in need of medical care and are seeking medical services. Navigating through the health care system adds frustration when looking for physician care.

Costly dental health plans

Dental coverage was another type of health care coverage that participants reported was not obtainable by many in the group. It was stated that dental coverage was too expensive.

Inaccessible health centers for those in the community

Participants stated that health centers are available, but obtaining services in Staten Island is difficult. Participants reported health insurance restrictions that make obtaining care cumbersome. Participants cited long waiting periods and inflexibility with payment as factors dissuading participants from using these health centers.

GROUP SUGGESTIONS/RECOMMENDATIONS

Build a health center that is accessible and user friendly

Provide community health centers for adolescents and adults that are readily available to those in need and that do not have a lot of “red tape” and administrative policies that often make seeking care difficult. Among their services, they could offer therapy to immigrants from war-torn countries (such as many in West Africa) and those who have trouble assimilating to their new environment.

Accept health insurance universally, without exception

To give patients real choice, providers should accept whatever health insurance plans patients have.

LACK OF EMPLOYMENT OPPORTUNITIES/POOR WAGES

Participants often stated that employment opportunities are limited. Half of those in the discussion group reported that they were unemployed.

CONTRIBUTING FACTORS

Strict employment regulations and restrictions in obtaining health insurance coverage from employers

Participants reported that some employers required employees to adhere to mandatory monthly hours in order to maintain their health care coverage. One participant stated that she feared that her health coverage would be dropped if she were unable to maintain her work hours due to sickness. She also noted that if her insurance coverage was dropped, her employers would continue to deduct money to cover her participation in the health plan. Participants stated that in some circumstances where employees who were sick and were unable to work, health coverage is dropped completely because work hour quotas were unmet.

Expensive health plans are difficult to balance on a fixed income

Employee contributions, co-pays, and prescription medication fees that were reported as being too much of a financial burden.

Low-paying jobs

Poor wages from their employers was a theme among the group, particularly in light of the high cost of health care – even when you have insurance.

GROUP SUGGESTIONS AND RECOMMENDATIONS

Organizations need to get involved

The participants felt that large organizations, such as the local unions, should support policies that help employees maintain their health coverage.

LACK OF PROPER LEGAL DOCUMENTATION REQUIRED TO OBTAIN SERVICES (I.E., NOT BEING A DOCUMENTED CITIZEN)

Participants stated that obtaining legal documentation to become a US citizen is a long and difficult process.

CONTRIBUTING FACTORS

Having improper paperwork and going through the process to obtain legal documentation

Many in the group stressed the need for health services. Participants stated that when applying for government health services without the appropriate documentation and support, obtaining health care services was difficult. Many in the group stated that they felt helpless – especially because they were unaccustomed to the rules and guidelines of many government programs. They stated that obtaining any type of legal documentation for residency and citizenship was a long process.

Many participants unfamiliar with US health care system

Many in the group reported that they did not have any experience in navigating the health care system and were often quite confused about where they should go for help. There was an expectation that the United States helps its citizens, but the participants did not feel they were receiving this assistance.

Fear of deportation prevalent among members of the discussion group

Participants reported an ever-present fear of deportation if legal paperwork is unavailable when seeking health services. The group expressed their hope that the United States would provide the means through which everyone can obtain health coverage.

GROUP SUGGESTIONS/RECOMMENDATIONS

Promote quicker and easier access to government documents

Quicker turnaround periods when applying for government documents or paperwork would alleviate some access issues.

Provide assistance in obtaining health care and government services and documents

Many would like to have assistance when inquiring about and obtaining health care and government services and documents. Accessing these types of services is cumbersome and difficult for group participants to comprehend.

LACK OF OPPORTUNITY TO BE EDUCATED ABOUT THE HEALTH CARE SYSTEM

Participants stated that educational programming that covers how to access health care and promote a better understanding of the health care system should be developed and made readily available.

CONTRIBUTING FACTORS

Limited life experiences in the US health care system

Living in the country for only a few months, one participant felt that the care she received was limited and the quality of care was poor because she did not have insurance and did not comprehend the treatment she obtained. She stated that she wanted to understand the health care system better.

Perception of improper health care services due to types of insurance coverage

A participant described the mistrust of Medicaid coverage among those in her family. She believed that different types of health insurance plans dictated the type of care a patient receives. Because Medicaid is not a private insurance plan, the care her father received was poor in her perception.

Lack of understanding and comprehension of prescription medication

For one participant, not understanding how to take his prescription medication often caused him not to take his medication. Due to his low proficiency in English, no one was able to explain the appropriate amount and frequency of use after his physician appointment.

GROUP SUGGESTIONS/RECOMMENDATIONS

Implement universal treatment standards

Treatment standards should be the same, regardless of the patient's insurance or ability to pay.

Open lines of communication

Participants stated that physicians need to spend more time communicating with their patients by asking and answering questions, discussing treatment options, and explaining prescriptions.

LACK OF KNOWLEDGE ABOUT WHERE TO GO FOR HELP

Participants stated that they wanted more access to information about health care services, diseases, and treatments.

CONTRIBUTING FACTORS

Guidance, assistance, and obtaining information

Many in the group reported that they were unsure where they could go for information on health care coverage. Community-based organizations such as African Refuge were cited several times as being the only facility providing information to individuals in their community.

Cultural acceptance

Some group members were surprised that health care services were difficult to obtain in the United States. They stated that in their home countries, health care was available to everyone who needed services, regardless of ability to pay. The group could not comprehend why many in the United States could not obtain health care and why so many were uninsured. There was confusion why we could not provide universal health care coverage to its citizens like Canada and European countries.

Understanding health care treatment and care

Participants stated that when they did not fully understand their diagnosis, they would not question or argue with the health care providers by bringing up what they believed could be better treatment. They felt that diagnoses were often made quickly and without much thought, which was especially unwelcomed given how long they often have to wait to see a provider. There was a perception within the group that prescription medication was a quick fix meant to replace follow-up treatment and care.

GROUP SUGGESTIONS/RECOMMENDATIONS

Make information available to those in the community

Distribute consumer rights and health information materials through community-based organizations that serve the English speaking West African population, such as African Refuge.

ADDITIONAL QUESTIONS ASKED AND RESPONSES

After covering each of the top problems or barriers the group participants stated they had in accessing health care services, there was time left to cover additional questions. Below is a summary of the overall comments and responses provided by the group.

COMMUNITY ACTIVITIES AND COMMUNITY TIES

Crime was reported as being prevalent in the community – especially in the summer. Participants reported that there were not enough after-school activities and summer programs to keep local youths occupied. Some in the group expressed feeling more protected because of the close-knit community

and the cultural history they shared. According to the participants, there was a sense of community within their own ethnic group.

CULTURAL INFLUENCES AND GROUP ACCEPTANCE

Participants noted a growing pressure among parents to shield youngsters from drugs, crime, gangs, and adolescent sex. They hoped their children understood and accepted their history and culture in addition to not adopting an “Americanized” image.

AVAILABLE COMMUNITY SERVICES

Participants stated that lack of available childcare was an issue – especially for those willing to work. Participants mentioned feeling trapped because they do not know where they can go to seek help with childcare.

GROUP SUGGESTIONS/RECOMMENDATIONS

Create community programs and organizations

Participants stated that a community center could have a positive influence on youths in the community. A community center also could provide an outlet for those seeking information and activities and provide therapy to immigrants from war-torn countries and those who have trouble assimilating to their new environment.

ADDITIONAL DATA FINDINGS FROM STATEN ISLAND HOUSEHOLD SURVEY AND SECONDARY DATA STUDY

The study conducted on Staten Island in 2007 revealed disparities between the northern and southern half of the island. The northern portion of the island is comprised of the Port Richmond and Stapleton/Saint George neighborhoods. These two neighborhoods contain higher percentages of residents living below the poverty level, having no health insurance or a primary care provider, and a greater tendency to use hospital emergency departments as compared to Staten Island overall.

Table 13 below illustrates some of the key data points in the Stapleton/St. George and Port Richmond neighborhoods in the northern half of the island as compared to Staten island overall.

Table 13: Key Data Points in the Stapleton/St. George and Port Richmond Neighborhoods

Item ¹⁵	Port Richmond	Stapleton/ St. George	Staten Island
Percentage of residents living below the poverty level	17%	14%	10%
Percentage of residents without a personal doctor	20%	20%	15%
Go to ED when sick or need health	10%	9%	6%
Uninsured now	14%	15%	11%

The survey data collected in this study revealed a high percentage of respondents who have a need for a community health center for primary care services. The table below reveals some of these key data points for Staten Island overall with comparisons to ZIP code 10304. Two methodologies were used to collect the surveys for this study including telephone and hand-collected field surveys. The first percentage score or average is the data collected from telephone surveys only, and the second percentage score or average is the data collected from the telephone and field surveys combined.

Table 14: Key Data Points for ZIP Code 10304 in Comparison with all of Staten Island

Item ¹⁶	ZIP Code 10304	Staten Island
Percentage of respondents who would use a health center if available	60%/ 72%	55%/59%
Mean score of respondents who stated there is a need for a health center in their community (<i>scale of 1 to 5 where 1 is not needed at all and 5 is needed to a great extent</i>)	3.73/4.16	3.46/3.59
Percentage of respondents stating they have a need for medical services which they cannot find	24%/38%	17%/20%

¹⁵ Source: New York City Department of Health and Mental Hygiene Community Health Profiles, Second Edition, 2006.

¹⁶ Source: Tripp Umbach Staten Island Household Survey, 2007.

FEMALE VICTIMS OF DOMESTIC VIOLENCE

INTRODUCTION

On Wednesday, March 5, 2008, a discussion group was conducted with female victims of domestic violence. The discussion group was held at the main office of Queens Health Coalition in Queens, New York. The purpose of this discussion group was to identify health care service access issues affecting female victims of domestic violence and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for female victims of domestic violence living in New York City. Below is a brief summary of the recommendations.

UNIVERSAL HEALTH CARE COVERAGE

Provide health insurance coverage for those who do not have health insurance and for those who are underinsured. Assist those who do not qualify for public health insurance programs and are uninsured by expanding Medicaid/Medicare eligibility guidelines. Provide a comprehensive benefit package including coverage for dental care. While out-of-pocket expenses are expected, these costs should be minimal and affordable to all.

ADDRESS THE ISSUE OF HIGH COST PRESCRIPTION MEDICATION

Financial assistance is needed for families who regularly use prescription medication.

PROVIDE ACCESSIBLE HEALTH CARE SERVICES IN NEIGHBORHOODS

Provide high quality health clinics that are readily accessible in neighborhoods. Services should be made available throughout the week not only at designated times. Health insurance coverage should be accepted universally, especially for parents seeking pediatric health care services.

DEMOGRAPHICS

A total of six people participated in the hour long discussion group. Following are some key demographic characteristics defining the group that participated in the discussion.

Table 15: Demographic Profile of Female Victims of Domestic Violence Discussion Group

Category	Demographic Findings
ZIP Code	16.7% 11357 (n=1) 16.7% 11367 (n=1) 16.7% 11106 (n=1) 50.0% 11354 (n=3)
Age (Average Age)	39
Gender	100% Females (n=6)
Education Level	16.7% 6 th grade or less (n=1) 16.7% Some middle school or some high school, no diploma (grades 7 -11) (n=1) 16.7% High school graduate or GED (grade 12) (n=1) 16.7% Some college, no degree (n=1) 33.3% 4-years of college or higher, with bachelor’s degree or higher (n=2)
Employment Status	50.0% Work 35 or more hours per week (n=3) 33.3% Work less than 35 hours per week (n=2) 16.7% Unemployed (n=1)
Income Level	16.7% \$0 - \$10,000 (n=1) 16.7% \$10,001 - \$20,000 (n=1) 16.7% \$20,001 - \$40,000 (n=1) 16.7% \$40,001 - \$60,000 (n=1) 16.7% \$80,001 - \$100,000 (n=1) 16.7% No answer (n=1)
Insurance Status	50.0% Yes (n=3) - 33.3% = Child Health Plus(n=1) - 33.3% = Wellcare (n=1) - 33.3% = Federal Blue Cross Blue Shield (n=1) 50.0% No (n=3)
Race	83.3% Asian (n=5) 16.7% Hispanic (n=1)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems that female victims of domestic violence have when obtaining health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Not eligible for health insurance coverage/underinsured
2. High cost of health care services

3. Obtaining health care from health care providers

NOT ELIGIBLE FOR HEALTH INSURANCE COVERAGE/UNDERINSURED

A number of participants stated that health insurance was not available to them because they did not have the financial means to purchase coverage. For those who did have health insurance coverage, there were always additional out-of-pocket expenses when seeking health care services. Only 50% of the respondents who participated in the discussion group reported to having health insurance coverage.

CONTRIBUTING FACTORS

Not qualifying for public health insurance coverage

Several group participants reported that they did not qualify for public health insurance coverage because their annual household income was higher than the required income eligibility limit. While some in the group made too much money to obtain public health insurance, they were still unable to afford private health insurance because of low household income. Participants reported that some preventive health screenings and health maintenance services were not obtained due to the lack of health coverage. Many in the group only sought services in emergency situations.

Lack of dental coverage and access to quality dental services

One of the biggest problems reported by the participants in their community was not having dental coverage. Access to dental care was reported as another form of health care that was unobtainable by many in the group because of its high cost. Bi-annual oral screenings were not obtained. Participants noted that they had limited accessible information about choosing a qualified dentist. Referrals were usually obtained from health care professionals and by word of mouth. According to the participants, written materials on a dentist's qualifications and background did not exist. Overall, costly out-of-pocket expenses when obtaining dental services was a problem for participants.

Affordable health care services

Participants stated that affordable health care services need to be provided to all. While many in the group are uninsured or deemed themselves underinsured, they were all desperate to have affordable health care. Participants reported that they were all responsible for some form of out-of-pocket expenses when seeking health care services. These costs deterred many of them from seeking preventive health care services. Participants also stated that health insurance plans should also include coverage for dental care.

GROUP SUGGESTIONS/RECOMMENDATIONS

Universal health care coverage

Participants recommended providing health insurance coverage for those who are uninsured and underinsured by expanding eligibility guidelines for public health insurance such as Medicaid/Medicare. They also suggested providing a comprehensive benefit package that covers dental care services with minimal out-of-pocket costs that is affordable to all.

HIGH COST OF HEALTH CARE SERVICES

Many in the group cited costly out-of-pocket expenses as being a deterrent to obtaining health care services. Paying for physician appointments and prescription medication was reported as being costly for participants because many were on a fixed or limited income.

CONTRIBUTING FACTORS

High cost of health care services/ being cost conscious

Participants reported that obtaining health services is costly. These costs include the cost for consultation/diagnosis by the physician and post treatment care including prescription medicine. One participant sought services in the emergency room and was unaware of the exorbitant out-of-pocket expenses. She lost her eligibility for Medicaid and did not have private health insurance. She stated that her experience in the emergency room taught her the need to be a cost conscious “shopper” for health care services in her community.

Limiting health care services only to US Citizens

One participant directly linked the high cost of health care services in her neighborhood to the influx of undocumented immigrants using medical services in her neighborhood. She was strongly against undocumented immigrants using health care services in her community because she felt it took away from citizens accessing health care services and increased the cost of obtaining health care.

Costly Prescription Medications

Participants reported that out-of-pocket expense for prescription medication is problematic especially for those living on a fixed income.

GROUP SUGGESTIONS AND RECOMMENDATIONS

Address the issue of high cost prescription medicine

Financial assistance is needed for families who regularly use prescription medication, which could include providing lower cost prescription medication.

OBTAINING HEALTH CARE FROM HEALTH CARE PROVIDERS

The group indicated that they received health care services through their primary care physicians or at emergency rooms at local hospitals. The group expressed wanting to obtain affordable, quality health care.

CONTRIBUTING FACTORS

Lengthy waiting periods for physician appointments

Long waiting periods for a physician appointment and long waiting periods in the emergency room is frustrating for those who have sought health care services. One participant cited a wait time of months to obtain a physician appointment. Use of the emergency room was the only alternative available to participants who could not obtain a physician appointment in a “reasonable” time frame.

Differences in quality of health care services

Participants reported that emergency room care differs among hospitals. They stated that health services obtained from the emergency room at Jamaica Hospital was poor and below the standard of other community/borough hospitals. Health care services received from Flushing Hospital were well received by group participants. However, one participant stated that the cost of services provided at Flushing Hospital was more expensive than other hospitals.

Mistrust of physicians

Physicians who persistently prescribe medication were worrisome for one participant. She preferred homeopathic treatments as an alternative remedy instead of the constant use of prescription medication. There was a feeling of mistrust by the patient of the physician if a diagnosis required prescription drugs, especially if the patient believes it is not necessary.

Asian Americans faced fewer barriers accessing immediate health care services

One Asian American female participant reported that scheduling an appointment with her physician is relatively easy when she is in need of immediate medical care. For her, appointments with her physician are often obtainable within a short time frame. The participant further indicated that seeking health

care from Asian physicians is not problematic. Based on their culture, Asian physicians will adjust their schedule if immediate care for a patient is needed. Asian American group participants reported that they prefer to use a physician who is of the same heritage. It is their perception that the physician will know the patient better. There is a higher level of trust when care is obtained from a health care professional who can communicate and understand the history/culture of the patient.

Asian American group participants further reported that in China, adults do not seek preventive health care services or screenings. Seeking preventive care services is not part of their culture.

Limited options when immediate health care is needed

One participant reported that her options for obtaining immediate health care services are few due to her physician's limited operating hours at her neighborhood health clinic. Participants reported that it is difficult to schedule pediatric appointments at health facilities that are close to their homes because these facilities do not accept Medicaid. Transportation costs are often an issue if they have to travel outside of their neighborhood to seek pediatric care. One participant stated her child does not have a pediatrician and she regularly uses the emergency room as a regular source of care for her child. Participants reported that there is an available health clinic on Jamaica Avenue but the health care services at this clinic were rated as being poor. As a result, most group participants go outside of their neighborhood to obtain health care services.

Access to the emergency room is always available

Participants reported that regardless of health insurance status utilizing the emergency room is an option for those who are in need of immediate health care services. The cost to obtain emergency room care is an afterthought for many participants. Participants reported that they did not know who is responsible for the health care costs incurred if a patient cannot afford to pay for services obtained in the emergency room. They were unaware as to how the hospital is reimbursed for providing such care.

GROUP SUGGESTIONS/RECOMMENDATIONS

Provide high quality health clinics that are readily available in their neighborhood.

Health care services should be made available throughout the week not only at designated times. Health insurance coverage should be accepted universally, especially for parents seeking pediatric services.

ADDITIONAL QUESTIONS ASKED AND RESPONSES

After discussing each of the top three barriers females of domestic violence stated that they have in accessing health care services, there was time left to cover additional questions. Below is a summary of the responses provided by the group.

- Most in the group were unaware of the quality and safety of their local public schools.
- Finding employment would be easier for parents with younger children if full day kindergarten was implemented.
- Communication is not an issue for one Hispanic American when seeking health care services. There have been some occasions when members of her family have had difficulty understanding, comprehending, and communicating with a health care provider. However, due to the large Hispanic population interpretation is often provided at the hospital.
- The need for health insurance may not be a concern for those who are considered young adults. Being young, healthy, and having a busy lifestyle deters young adults from thinking they need health insurance until a health care problem occurs.

GAY, LESBIAN, BISEXUAL, TRANSGENDER, AND QUESTIONING (GLBTQ) ADOLESCENTS (FEMALE AND MALE, AGES 15 – 20)

INTRODUCTION

On Wednesday, March 26, 2008, a discussion group was conducted at Make the Road NY in Bushwick, Brooklyn, NY with gay, lesbian, bisexual, transgender, and questioning (GLBTQ) adolescents (female and male, ages 15 – 20). The purpose of this discussion group was to identify health care service access issues affecting GLBTQ adolescents and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for gay, lesbian, bisexual, transgender and questioning adolescents (female and male, ages 15 – 20) living in New York City. Below is a brief summary of the recommendations.

PROVIDE SENSITIVITY TRAINING TO PHYSICIANS AND THE HEALTH CARE COMMUNITY ABOUT HOW TO TREAT THE GLBTQ COMMUNITY

The group stated that they wanted to feel comfortable about communicating with their health care provider and to feel understood, which would improve the overall quality of care provided.

GENERATE AN OPTIONAL FORM WHICH THE GLBTQ COMMUNITY COULD USE TO INFORM THE HEALTH CARE PROVIDER ABOUT THEIR IDENTITY

For those participants who felt comfortable relating the information to their provider, this form would allow the doctor/nurse to be aware of their sexual identity prior to being seen to avoid unnecessary questions.

INCREASE THE QUALITY OF CARE PROVIDED IN THE COMMUNITY

The group stated that if local clinics could reduce wait times, have cleaner/more efficient facilities and have more/higher quality physicians, this would improve health care delivery in their neighborhood.

EDUCATE THE COMMUNITY ABOUT GLBTQ ISSUES AND HOW TO BE RESPECTFUL

The group felt that if the community could better understand GLBTQ issues, they would feel more comfortable in their neighborhood and with their sexual identity.

DEMOGRAPHICS

A total of 14 GLBTQ adolescents participated in the two-hour discussion group. Following are some key demographic characteristics defining the group that participated.

Table 16: Demographic Profile of GLBTQ Adolescents (Female and Male, Ages 15 – 20) Discussion Group

Category	Demographic Findings
ZIP Code	7.1% 11205 (n=1) 7.1% 11208 (n=1) 7.1% 11212 (n=1) 7.1% 11218 (n=1) 7.1% 11230 (n=1) 7.1% 11412 (n=1) 7.1% 11433 (n=1) 14.3% 11103 (n=2) 14.3% 11237 (n=2) 21.4% 11221 (n=3)
Age (Average Age)	17.4
Gender	42.9% Male (n=6) 35.7% Female (n=5) 21.4% Transgender Male to Female (n=3)
Education Level	78.6% Still in high school (n=11) 14.3% High school graduate or GED (n=2) 7.1% Some college, no degree (n=1)
Employment Status	21.4% Work less than 35 hours per week (n=3) 71.4% Unemployed (n=10) 7.1% No Answer (n=1)
Income Level	100% No Answer (n=14)
Insurance Status	78.6% Yes (n=11) - 18.2% GHI (n=2) - 9.1% Medicare (n=1) - 9.1% Health care Plus (n=1) - 9.1% AmeriChoice (n=1) - 9.1% Medicaid (n=1) - 9.1% HealthFirst (n=1) - 9.1% 1199 Members Choice (n=1) - 27.3% Not identified (n=3) 21.4% No (n=3)
Race	28.6% Black or African American (n=4) 50.0% Other: Latino (n=7) - 14.3% Other (n=2) 7.1% No Answer (n=1)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the biggest problems GLBTQ adolescents have when obtaining health care in their community. The responses were then

ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Communicating about sexual identity with the health care provider
2. Quality of neighborhood care versus care in Manhattan
3. Understanding and acceptance of the GLBTQ community

COMMUNICATING ABOUT SEXUAL IDENTITY WITH HEALTH CARE PROVIDER

The issue of communicating with a health care provider and the staff about sexual identity was identified as a top priority for participants in the discussion group. They felt that the doctors and nurses, not practicing in GLBTQ friendly clinics, did not understand the fact that they were gay, lesbian, or transgender, and it was difficult to communicate with health care professionals as a result. Many participants reported that they did not understand why physicians asked so many questions about their sexual history.

CONTRIBUTING FACTORS

Transgender adolescents stated that they have difficulties when seeking care in non-GLBTQ friendly facilities

The transgender participants stated that they have tried to go to providers that understood the challenges surrounding their sexuality. When seeking care at non-GLBTQ friendly facilities, participants reported that many of the hospital staff did not understand the needs of a transgender community and treated them disrespectfully. Two transgender adolescents stated that when they sought care locally, the nurses addressed them by their birth name and male identity as opposed to their current gender identity. Despite repeated attempts on the part of the patient to tell the nursing staff how to address them, the nurse refused to comply.

Many gay, lesbian, and bisexual adolescents do not communicate with their doctor about their sexual identity

The group did not feel that it was necessary to tell their doctor about their sexual identity unless the reason that they were seeking care was directly related. Participants stated that they felt neighborhood health care providers were not used to GLBTQ patients. They reported that physicians in Manhattan would have a better understanding and communicate better because they see more GLBTQ patients.

One facility specifically mentioned by participants as a place to seek care was Callen-Lorde¹⁷ in Manhattan. However, it was stated that the facility was not currently accepting as many patients as it had been. Consequently, it was difficult to get an appointment. One medical facility informed a participant to seek care at Callen-Lorde when the issue of sexual identity was raised.

Some hospitals, clinics, and health care providers are not GLBTQ friendly

One participant stated that while they did not expect a “rainbow flag flying outside,” they wanted to be treated with respect and dignity when seeking care. The GLBTQ adolescents stated that they would like to be accepted for who they are, and not worry about communicating their sexual identity with their physicians. One young woman stated that the health care provider repeatedly asked her if she was sexually active and on birth control, when she replied that she was a lesbian, the doctor did not seem to understand and repeated the question again.

GROUP SUGGESTIONS/RECOMMENDATIONS

Provide sensitivity training to physicians and the health care community about how to treat the GLBTQ community

The group stated that they wanted to feel comfortable about communicating with their health care provider and to feel understood which would improve the overall quality of care provided.

Generate an optional form which the GLBTQ community could use to inform the health care provider about their identity

For those participants who felt comfortable relating the information to their provider, this form would allow them to inform the doctor/nurse of their sexual identity prior to being seen to avoid unnecessary questions.

QUALITY OF NEIGHBORHOOD HEALTH CARE COMPARED TO HEALTH CARE SERVICES DELIVERED IN MANHATTAN

Participants in the discussion group sought health care in a wide variety of locations including: the hospital, emergency room, clinics, and private physicians. For those participants with health insurance (n=11), there was not an issue getting care but for those without health insurance (n=3), medical care was reported as being costly. Participants stated that they had no issues seeking care outside of their

¹⁷According to their web site (www.callen-lorde.org), “Callen-Lorde Community Health Center is New York City's only primary health care center dedicated to meeting the health care needs of the lesbian, gay, bisexual and transgender (LGBT) communities and people living with HIV/AIDS – regardless of any patient's ability to pay.”

neighborhood and that they were well-informed about how to protect themselves from pregnancy, sexually transmitted diseases, including HIV/AIDS, and where to get testing.

CONTRIBUTING FACTORS

Prefer to get health care outside of their community

Many of the participants stated that they preferred to seek care outside of their neighborhoods. Participants felt that hospitals in Manhattan (e.g., Beth Israel, NY Presbyterian, and NYU Medical Center) provided better care and better information than local hospitals. Participants clearly stated that they trusted the care more in Manhattan than the care in their neighborhood. It was the group's perception that local hospitals and health care providers were not high quality and did not care about providing high quality care. One participant in the group stated that socioeconomic status and race seemed to play a role in the quality of care.

It is noteworthy that many participants in the group stated that they preferred to go to the "white people's hospital" in Manhattan as opposed to the hospitals located in their community. Another reason that participants sought care outside of their neighborhood is because they are were "out" to their parents and did not want them to find out from the physician.

The perception is that neighborhood doctors are not as knowledgeable or well educated as those in Manhattan

Participants stated that they believed that doctors in Manhattan were better trained, attended better medical schools, while local neighborhood doctors did not have the same high level of training and education.

Quality health care facilities are clean, have friendly and professional staff, and are efficient

When participants in the group were asked to describe a quality health care facility, they stated that a quality facility has "shiny floors, shiny doors, and smells good." The environment is quiet and controlled without homeless people and drug-addicted people in the lobby. In addition, doctors should be friendly, patient, understanding, and communicative with their patients.

The amount of paperwork required to obtaining health care services or insurance is overwhelming

Participants in the group stated that the amount of paperwork required to be treated or to qualify for health insurance prevented them from receiving treatment quickly. One participant who sought care stated that NY Presbyterian provided immediate care and brought the paperwork to them directly after they have been admitted. This is in comparison to Wyckoff Hospital where patients had to wait and the process was slowed-down considerably. The participants stated that they needed assistance in completing the paperwork.

Wait times for health care visits are too long

Participants stated that when they arrived for health care appointments, they often had to wait four hours before being seen by a health care professional. Wait times in the emergency room were even longer. The group felt that the emergency rooms needed to set up a “fast track” system so 0020patients are seen quickly and do not have to wait as long.

GROUP SUGGESTIONS/RECOMMENDATIONS

Increase the quality of care provided in the community

The group stated that if neighborhood clinics could reduce wait times, have cleaner/more efficient facilities, and have better quality physicians this would improve health care delivery in their neighborhood.

UNDERSTANDING AND ACCEPTANCE OF THE GLBTQ COMMUNITY

The participants stated that the overall community is not accepting or understanding of their GLBTQ status. Gay, lesbian and transgender adolescents stated that they have received comments and stares from community members when they are with their partners on the street.

Derogatory comments from the community-at-large

Many in the group reported that they had been subjected to derogatory comments and have received stares when they are walking with their girlfriend/boyfriend down the street. They stated their belief that there is no place that they would be accepted. One male participant, who has not fully divulged his sexual preference, reported being the target of harassment on a regular basis.

GROUP SUGGESTIONS/RECOMMENDATIONS

Educate the community about GLBTQ issues and how to be respectful

The group felt that if the community could better understand GLBTQ issues they would feel more comfortable in their neighborhood and with their sexual identity.

HEARING IMPAIRED AND DEAF ADULTS

INTRODUCTION

On Wednesday, March 5, 2008, a discussion group was conducted with hearing impaired and deaf adults. The discussion was sponsored by the Hearing Loss Association of America and was facilitated in a conference room rented from the United Federation of Teachers located in Midtown Manhattan in New York City. The purpose of this discussion group was to identify health care service access issues affecting hearing impaired and deaf adults and to identify potential solutions to resolve these concerns for this specific population. The discussion was aided by Computer Assisted Real time Transcription (CART) which allowed persons with profound hearing loss to read and participate in the conversation as it took place.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for hearing impaired and deaf adults living in New York City. Below is a brief summary of the recommendations.

BEST PRACTICE EXAMPLE: STATEN ISLAND UNIVERSITY HOSPITAL

Participants said that they need all hospitals should adopt to use the registration form that Staten Island University Hospital uses for people with disabilities. The form is completed by all patients when they register and asks patients to identify the types of assistance they need during their visit.¹⁸

SENSITIVITY TRAINING AND EDUCATION

Participants stated it should be a requirement for all health care providers and staff to receive sensitivity training to educate providers better about the needs of hearing impaired and deaf patients during their visits.

VERBAL INSTRUCTIONS, MEDICAL INFORMATION, DIAGNOSES, SELF-CARE, MEDICATION, AND ALL OTHER PERTINENT INFORMATION SHOULD BE IN WRITING

Participants with hearing loss requested that verbal instructions be given slowly and providers be required to repeat the instructions to make sure they are understood.

¹⁸ To see a copy of this form go to: <http://www.siu.edu/forms/Reasonable%20Accommodations%20Form.pdf>

LABELS ON PATIENT FOLDERS

Participants stated that providers should place labels on patient files to indicate that they have hearing loss and state the patient's preferred method of hearing assistance during appointments.

DRY ERASE BOARDS

Participants stated one simple way to help providers and staff communicate with persons with hearing loss is by providing a dry erase board to write on.

INPATIENT SETTING

Participants stated signs above the bed which indicate that the patient has a hearing loss have worked well at hospitals and recommend this practice be adopted at all health care facilities.

COMMUNICATION AMONG STAFF

Participants stated that when a person with hearing loss arrives for an appointment that the medical staff need to be trained to communicate this to other staff so they are aware of the patient's needs.

CITY-WIDE CAMPAIGN

Participants stated the education needs of hearing impaired and deaf persons extend beyond the health care setting and should be communicated city-wide through a public education campaign.

E-MAIL

Participants say they should be able to schedule appointments by e-mail and have doctor follow up communication e-mailed to them as well.

MANDATED ASSISTED LISTENING DEVICES (ALDS) IN HEALTH CARE FACILITIES

Participants say that all health care facilities and provider offices should have some minimum requirements placed upon them to provide ALDs. Participants listed numerous devices which could have the potential to help persons with hearing loss in the health care setting. The devices mentioned included pocket talkers, FM systems, TTYs,¹⁹ CAPTEL,²⁰ audio loops, on site and remote Computer Assisted Real Time Transcription (CART), working dogs, and transparent masks for doctors allowing lip reading.

¹⁹ Teletypewriter. Also called a "text telephone."

²⁰ Captioned telephone.

HEARING AIDS SHOULD BE COVERED BY HEALTH INSURANCE

Hearing aids are very expensive and rarely covered by health insurance.

DEMOGRAPHICS

A total of twelve hearing impaired and deaf adults participated in the two hour discussion group. Below are some key demographic characteristics which define the group that participated.

Table 17: Demographic Profile of Hearing Impaired and Deaf Adults Discussion Group

Category	Demographic Findings
ZIP Code	25% ZIP code 10023, (n=3) 8.3% ZIP code 10304, (n=1) 8.3% ZIP code 10314 (n=1) 8.3% ZIP code 11204 (n=1) 8.3% ZIP code 10009 (n=1) 8.3% ZIP code 10025 (n=1) 8.3% ZIP code 10016 (n=1) 8.3% ZIP code 10001 (n=1) 8.3% ZIP code 10282 (n=1) 8.3% ZIP code 11375 (n=1)
Age (Average Age)	68
Gender	83.3% Female (n=10) 16.7% Male (n=2)
Education Level	8.3% Some college, no degree (n=1) 16.7% Associate’s degree, or certificate from vocational, business, or trade school (n=2) 75% 4-years of college or higher, with bachelor’s degree or higher (n=9)
Employment Status	33.3% Work less than 35 hours per week (n=4) 66.6% Other (n=8) 100% Retired (n=8)
Income Level	16.7% \$20,001-\$40,000 (n=2) 16.7% \$40,001-\$60,000 (n=2) 8.3% \$80,001-\$100,000 (n=1) 58.3% No answer (n=7)
Insurance Status	100% Yes (n=12) -50% Medicare only (n=6) -16.7% Oxford (n=2) -8.3% Medicare/GHI (n=1) -8.3% Empire Blue Cross (n=1) -16.7% No answer (n=2)
Race	100% White/Caucasian (n=12)

For the Hearing Impaired and Deaf discussion group, a special set of descriptive questions were asked of participants prior to the discussion to more clearly define and understand the level of hearing loss and assistive hearing devices that the group uses.

- 100% of the participants described their hearing loss as either “Severe” or “Profound.”
- The average length of time participants have experienced hearing loss is 35 years.
- 50% of the participants wear two hearing aids
- 67% of participants wear their hearing aids behind their ears
- 33% of participants have a Cochlear Implant (CI)
 - 50% of CI users use a hearing aid with their CI
- Two participants have hearing dogs
- Telephone Assistance
 - 83% use an amplified telephone
 - 42% use Cap Tel
 - One participant uses TTY

Chart 1: Percentage of participants who use assistive listening devices (ALDs)

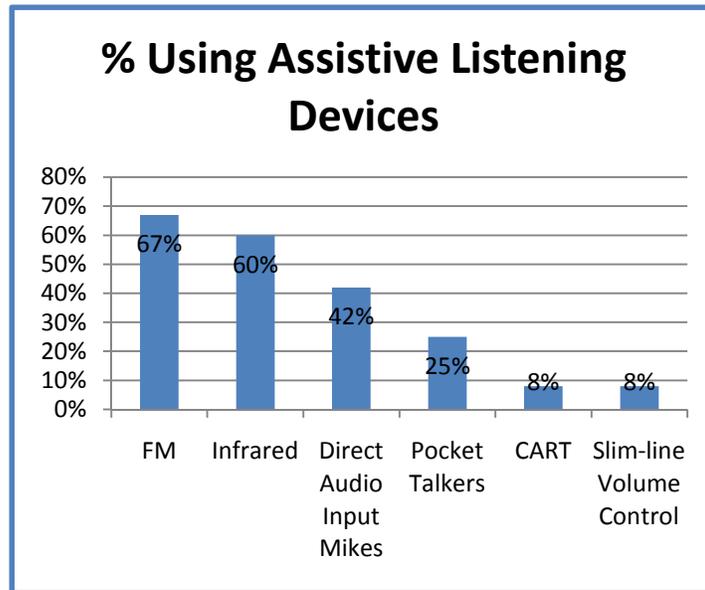


Chart 2: Percentage of participants who use alerting devices

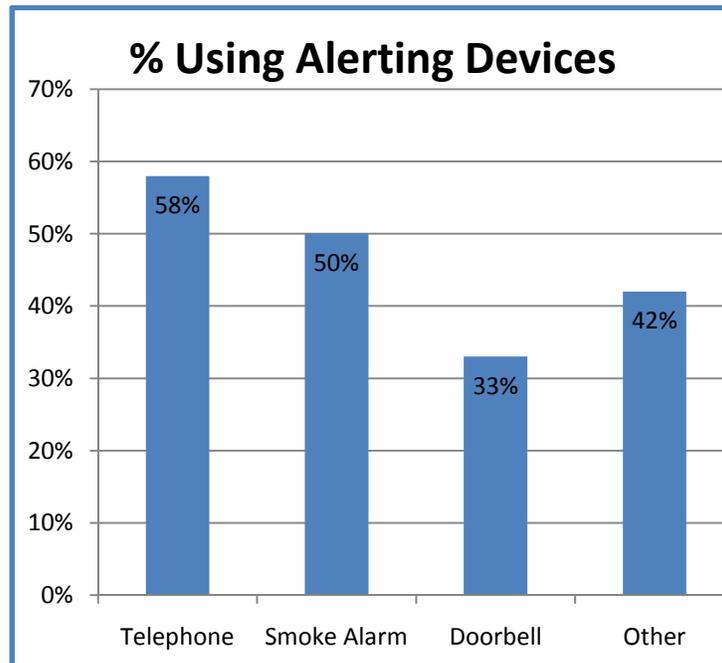
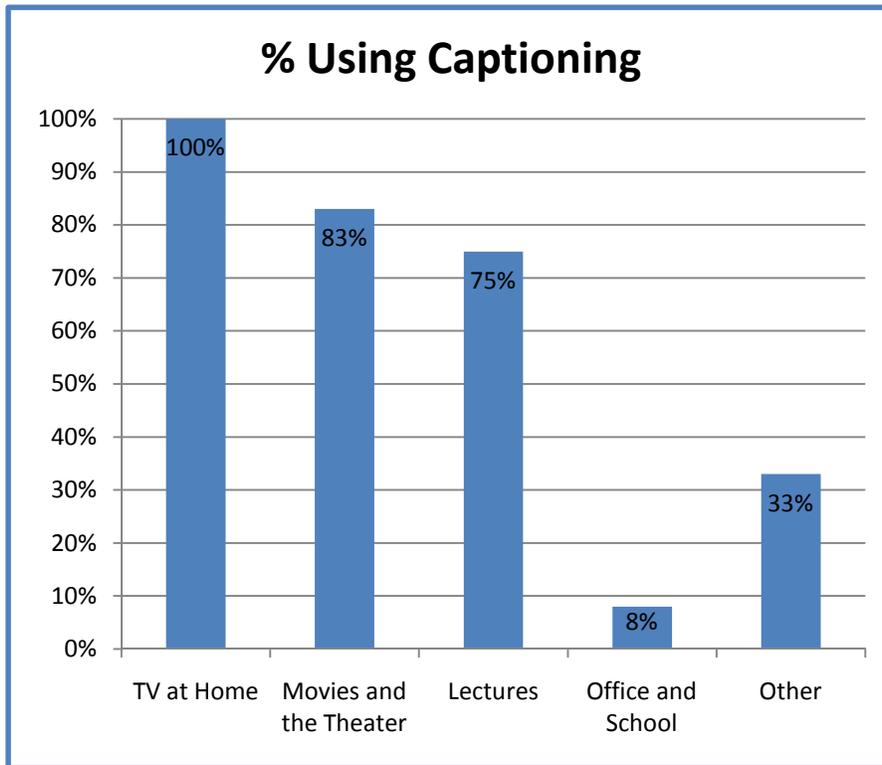


Chart 3: Percentage of participants who use captioning devices



PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems hearing impaired and deaf adults have getting health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Communicating with providers
2. Communicating with people who answer the telephone/physician follow up by telephone
3. Assistive listening devices in health care facilities

COMMUNICATING WITH PROVIDERS

Participants feel that communicating with providers is their number one barrier to accessing quality health care services.

CONTRIBUTING FACTORS

Doctors do not take hearing loss seriously

Participants stated doctors do not take hearing loss seriously enough because they do not understand what it is like to have hearing problems. Participants stated doctors do not understand the importance of details when treating patients with hearing loss. For example, the impact of background noise on a patient's ability to communicate with the doctor is very important to manage when treating a patient with hearing loss. Participants also feel that doctors do not understand the magnitude of people with hearing loss. Participants stated that national studies estimate ten percent of people have hearing loss.²¹ According to 2006 US Census estimates, the population of New York City is 8.2 million, so an estimated 820,000 people in New York City suffer from hearing loss.

An important safety issue

Health care providers are not aware that people with hearing loss often have trouble understanding verbal instructions even though they may not acknowledge this problem because they are embarrassed, scared or feel too rushed. Participants stated that they sometimes do not hear or misunderstand verbal diagnoses, self-care and medication instructions given in person or over the telephone by doctors, nurses and other health care personnel, which can create a frightening and potentially dangerous situation.

Appointments are rushed because providers have too many patients

Participants stated they feel that doctors simply do not take the necessary time to communicate clearly with them because doctors have too many patients. While the participants could clearly understand the workloads doctors have, they believe that taking the time to communicate clearly with hearing impaired and deaf patients will save time and money in the long-run.

Providers are insensitive to the needs of hearing impaired and deaf patients

Participants stated that most providers are insensitive to the needs of patients with hearing loss. Many participants stated they have asked providers repeatedly to "face them and look at me" when speaking. Patients with hearing loss ask doctors to "face me and look at me" so they can read their lips only to have the provider turn their back or not look up while speaking. This is very frustrating to hearing impaired and deaf persons because they are not able to communicate effectively. Participants also stated that providers typically are impatient during visits with deaf or hearing impaired patients because it takes more time to communicate. Participants also stated that many providers do not know the importance of assistive listening devices (ALDs) to patients and believe that patients are using their ALDs

²¹ Source: League for the Hard of Hearing (http://www.lhh.org/about_hearing_loss/index.html)

to audio record appointments. In many cases, according to the participants, providers do not understand how the different types of ALDs work or what they are.

Providers with foreign accents

Participants stated that one of the major challenges in accessing health care in New York City is that many providers have accented speech due to their cultural background. This is a problem for hearing impaired and deaf patients because accents make it very difficult for persons with hearing loss to lip read and communicate effectively with the provider. While ALDs are helpful, persons with severe or profound hearing loss must also be able to read lips during a conversation to communicate effectively.

Registration/waiting area

Participants stated that communicating with waiting area staff is also difficult. Many times, persons with hearing loss do not hear their name called when it is their turn to see the doctor and are skipped over for appointments as a result. Participants are also frustrated with the insensitivity shown to patients with hearing loss during registration. Participants stated they are typically not asked if they have problems with hearing loss, need ALDs, or other types of assistance during their visit.

GROUP SUGGESTION/RECOMMENDATIONS

Best practice example Staten Island University Hospital

Participants stated that they need all hospitals to use the registration form that Staten Island University Hospital uses for people with disabilities. This form asks patients as they register what types of assistance they need during their visit.²²

Sensitivity training and education

Participants stated they feel it should be a requirement for all health care providers and staff to receive sensitivity training to educate providers better about the needs of hearing impaired and deaf patients during their visits. It is recommended that training take place on an annual basis. Participants also felt that college credit should be provided as an incentive to students in college for taking these courses.

Verbal instructions, medical information, diagnoses, self-care, medication, and all other pertinent information should be in writing

Participants with hearing loss requested verbal instructions are given slowly and patients be required to repeat them to make sure they are understood. If necessary, instructions should be typed into a laptop computer or hand held communication device so they can be read. Participants also requested health

²² To see a copy of this form go to: <http://www.siu.edu/forms/Reasonable%20Accommodations%20Form.pdf>

care personnel develop forms to check off or fill in important relevant information and give, e-mail or mail this information to the patients to avoid any misunderstandings.

Labels on patient folders

Participants stated that providers should place labels on patient files to indicate that they have hearing loss and state the patient's preferred method of hearing assistance during appointments.

Dry erase boards

Participants stated one simple way to help providers and staff communicate with persons with hearing loss is by providing a dry erase board to write on. These boards should be held up with the patients name on it so that they know it is their turn for their appointment. Pencil and paper would be a good alternative.

Inpatient setting

Participants stated signs above their bed which indicate they have hearing loss have worked well at hospitals and recommend this practice be adopted at all health care facilities.

Communication among staff

Participants stated once a person with hearing loss arrives for an appointment that the medical staff need to be trained to communicate this to other staff so they are aware of the patient's needs.

City-wide campaign

Participants stated the needs of hearing impaired and deaf persons extends beyond the health care setting and should be communicated city-wide through a public education campaign.

COMMUNICATING WITH PEOPLE WHO ANSWER THE TELEPHONE/PHYSICIAN FOLLOW UP BY TELEPHONE

Participants reported having great difficulty communicating by telephone without ALDs.

CONTRIBUTING FACTORS

Staff who answers the telephone

The participants stated they have difficulty scheduling appointments by telephone because many times the person on the other end of the telephone gets impatient with them or does not have the appropriate technology. In many cases, the lack of patience does not provide the person with hearing loss the ability to use technology on their end of the line which could improve the conversation flow.

Physician follow up

Participants stated most providers will only communicate by telephone in order to follow up with hearing impaired and deaf patients. Participants stated that most providers are typically in a hurry to communicate with them on the telephone and they do not clearly get the intended message. As a result, persons with hearing loss have difficulty understanding critical information including their test results and instructions from their doctors, which can be dangerous for the patient.

GROUP SUGGESTION/RECOMMENDATIONS

E-mail

Participants stated that they should be able to schedule appointments by e-mail and have doctor follow up communication e-mailed to them as well. Having information clearly stated in text is the best way to communicate with persons with hearing loss.

ASSISTIVE LISTENING DEVICES IN HEALTH CARE FACILITIES

Participants stated that there are many forms of technology, which can now be implemented in the health care setting.

CONTRIBUTING FACTORS

Not enough health care facilities or providers offices provide ALDs

Participants stated that many health care facilities do not have an assistive listening device which makes it extremely difficult to communicate.

Emergency situations

Participants explained that in some cases it is possible to bring a friend/relative with them to help them communicate. However, in an emergency situation this is not possible and the need for ALDs is even stronger.

Use of ALDs for other purposes

Participants reported being discouraged by the fact that many health care facilities do not have ALDs available. This frustration becomes exacerbated by the fact that many other facilities of lesser importance do offer ALDs. Movie theaters, concert halls, and theaters are a few examples of entertainment venues which take steps to help accommodate the needs of persons with hearing loss.

GROUP SUGGESTION/RECOMMENDATIONS

Mandated ALDs in health care facilities

Participants stated that all health care facilities and provider offices should have some minimum requirements placed upon them to provide ALDs. Participants felt one device per floor or twelve devices per facility would be adequate for hospitals and at least one device should be available in a provider's office.

Devices

Participants listed numerous devices which could have the potential to help persons with hearing loss in the health care setting. The devices mentioned included pocket talkers, FM systems, TTYs, CAPTEL, audio loops, on site and remote Computer Assisted Real Time Transcription (CART), working dogs, and transparent masks for doctors allowing lip reading.

ADDITIONAL QUESTIONS ASKED AND RESPONSES

After covering each of the top three problems or barriers hearing impaired and deaf participants stated they have in accessing health care services, there was some time left to cover additional questions. Below is a summary of the question which was asked and the responses provided by the group.

Describe what an ideal visit to a health care provider would be like for you, starting with the moment you arrive in the clinic or office.

Participants stated the ideal visit would:

- Start with an e-mail communication from the patient followed by a return e-mail communication from the provider to schedule an appointment.
- When the patient arrives at the health care provider's facility, the patient would then be given a form to answer questions regarding assistance for disability needs so that the appropriate ALD could be used to help the patient communicate with the provider during the visit.
- When it is the patients turn to see the doctor, they would have a pager that would buzz or light up similar to the ones restaurants use to seat people, or use dry erase boards/pencil and paper with the patient's name.
- Doctor's instructions would be typed for the patient.
- Doctor's follow up communication would be e-mailed to the patient.

KOREAN AMERICANS

INTRODUCTION

On Thursday, March 6, 2008 a discussion group was conducted with Korean Americans living in New York City. The discussion group was conducted at the Korean Community Services (KCS) Community Center located in Flushing, Queens. The purpose of this discussion group was to identify health care service access issues affecting Korean Americans and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for Korean Americans living in New York City. Below is a brief summary of the recommendations.

TRANSLATION/INTERPRETATION SERVICES

Participants stated that they need providers' offices and hospitals to provide more comprehensive translation and interpretation services for non-English speaking populations.

PHYSICIAN RECRUITMENT

Participants stated that they feel there is a need for more doctors to lighten the work load of physicians which should help improve provider attitudes towards patients. Participants also say there is a need for more Korean doctors.

COMPASSIONATE TREATMENT

Participants stated providers including doctors and nurses should be better trained to treat their patients in a more compassionate manner.

REDUCE WAIT TIMES

Participants say wait times need to be significantly reduced, and linked the wait time to an inappropriate ratio of physicians to patients.

DEMOGRAPHICS

A total of twelve Korean Americans participated in the two hour discussion group. Below are some key demographic characteristics which define the group that participated.

Table 18: Demographic Profile of Korean Americans Discussion Group

Category	Demographic Findings
ZIP Code	25.0% ZIP code 11377 (n=3) 16.7% ZIP code 11373 (n=2) 8.3% ZIP code 11368 (n=1) 8.3% ZIP code 11378 (n=1) 8.3% ZIP code 11360 (n=1) 8.3% ZIP code 11714 (n=1) 8.3% ZIP code 11372 (n=1) 8.3% ZIP code 11354 (n=1) 8.3% ZIP code 11358 (n=1)
Age (Average Age)	56
Gender	66.6% Female (n=8) 33.3% Male (n=4)
Education Level	8.3% Some middle school or some high school, no diploma grades 7-11 (n=1) 8.3% High school graduate or GED grade 12 (n=1) 8.3% Some college, no degree (n=1) 66.6% 4-years of college or higher, with bachelor’s degree or higher (n=8) 8.3% No answer (n=1)
Employment Status	33.3% Work 35 or more hours per week (n=4) 25.0% Work less than 35 hours per week (n=3) 8.3% Unemployed (n=1) 25.0% Other (n=3) 8.3% No answer (n=1)
Income Level	8.3% \$0-\$10,000 (n=1) 25.0% \$10,001-\$20,000 (n=3) 25.0% \$20,001-\$40,000 (n=3) 16.7% \$40,001-\$60,000 (n=2) 25.0% No answer (n=3)
Insurance Status	33.3% Yes (n=4) -25% Medicare and Medicaid (n=1) -25% HIP (n=1) -50% Don’t know/not sure (n=2) 41.7% No (n=5) 16.7% Don’t know/not sure (n=2) 8.3% No answer (n=1)
Race	100% Asian (n=12)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems Korean Americans have getting health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Communicating with providers
2. Attitudes of doctors and nurses
3. Understanding the US medical system

COMMUNICATING WITH PROVIDERS

Participants reported that communicating with providers is their number one barrier to accessing quality health care services.

CONTRIBUTING FACTORS

Language barriers

Participants stated that it is difficult for them to articulate their specific health care needs to providers. Participants attributed this to an inability to speak English well, but also to an inability to translate common medical terminology or expressions from Korean into English. For example, one participant stated they know how to say “gastrointestinal endoscope” in Korean, but they cannot say the same term in English.

Korean providers

Participants stated it is very difficult to communicate with providers who are not Korean. Participants stated they have used body language and facial expressions as a means of communication if the doctor is not Korean.

Not familiar with language line services

Only five participants out of twelve knew about language line for interpretation services in hospitals.

Unsatisfactory services

Participants stated the quality of services that they receive is poor in part because of their inability to communicate with the provider.

GROUP SUGGESTIONS/RECOMMENDATIONS

Translation/Interpretation services

Participants said that they need physician offices and hospitals to provide more comprehensive translation and interpretation services for non-English speaking populations.

ATTITUDES OF DOCTORS AND NURSES

Participants stated the attitudes of doctors and nurses have an impact on receiving quality health care services.

CONTRIBUTING FACTORS

Cultural differences

The participants stated they feel there are cultural differences between American and Korean doctors, which result in different attitudes. Participants stated American doctors typically mistreat Korean patients simply because they are frustrated with their inability to communicate to the patient in English. Participants feel Korean doctors mistreat patients because of a cultural behavior of “authoritativeness” towards others and having too many patients. Participants also stated that Korean patients have very high expectations, which are sometimes unreasonable and result in disappointment.

Shortage of doctors and nurses

Participants stated the poor attitudes from doctors and nurses stem from the increasing volume of patients doctors try to see on a daily basis. Participants stated there has to be a better provider to patient ratio in order to lessen the burden/patient load on the current staff.

Not enough Korean doctors

Participants stated if they are unsatisfied with a Korean doctor because of his/her attitude, it is difficult to change providers because there are not enough doctors who speak Korean.

Inability to speak English

Participants stated their inability to speak English results in discrimination. Participants stated providers will “put their file or chart on the bottom of the pile” simply because they do not want to deal with someone who cannot speak English. Participants do not see this as racial discrimination but see it as language discrimination.

GROUP SUGGESTIONS/RECOMMENDATIONS

Physician recruitment

Participants stated they feel there is a need for more doctors to lighten the work load of physicians which should help improve provider attitudes towards patients. Participants also suggested a need for more Korean doctors.

Compassionate treatment

Participants stated providers including doctors and nurses should be better trained to treat their patients in a more compassionate manner.

UNDERSTANDING THE US MEDICAL SYSTEM

Participants stated that there are many differences between the medical systems in the United States versus the medical system in Korea. Participants have a difficult time getting used to these differences and it becomes a barrier to accessing health care services.

CONTRIBUTING FACTORS

Procedure

Participants stated that they are frustrated with all of the steps involved with seeing a doctor in the US. Participants stated they can go directly to the doctor or specialist they need to see for treatment in Korea. Because of this ability to go directly to the doctor or specialist, the referral system in the US, which requires seeing a primary care provider first before being able to see a specialist, is cumbersome and redundant in participants’ minds.

Registration process

Participants stated they are frustrated by all of the registration forms which must be filled out at a doctor’s office or hospital because the forms are typically in English. They are not sure what they are signing and would like to have someone who could translate/interpret the forms for them.

Cultural differences

Participants stated there is an emphasis in Korean culture on passive learning, which teaches Koreans to be submissive to authoritative persons or entities. Participants stated they are sent from one needless appointment to the next simply because they are afraid to speak out for themselves.

GROUP SUGGESTIONS/RECOMMENDATIONS

Reduce wait times

Participants stated the wait times at hospitals and doctors' offices are too long. They reported that wait times need to be significantly reduced, but linked long wait times to an inappropriate ratio of physicians to patients.

MEXICAN, NICARAGUAN, AND ECUADORIAN MALES (AGES 50 AND OLDER)

INTRODUCTION

On Tuesday, March 11, 2008, a discussion group was conducted at the main office of Make the Road New York located in Bushwick, for Latino males (50 years and older) in Brooklyn, New York. The purpose of this discussion group was to identify health care service access issues affecting Latino males 50 years and older in Brooklyn and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for Mexican, Nicaraguan, and Ecuadorian males (ages 50 and older) living in New York City. Below is a brief summary of the recommendations.

NEED FOR HIGH QUALITY INTERPRETATION SERVICES

Quality interpretation services from native speakers should be provided at health care facilities. Health care professionals can be bilingual; however, if the patient population they serve is primarily Spanish speaking, the primary language should be of the native tongue. In some health care facilities, health care professionals cater to the clientele they serve.

MAKE HEALTH CARE SERVICES AFFORDABLE

Provide high quality care that is affordable for the patient by allowing the patient to pay for services based on their household income.

CREATE “ONE-STOP SHOP” NEIGHBORHOOD HEALTH CARE FACILITIES

Provide routine and specialty health care services at neighborhood clinics that can be accessed by all. Specialty services would tackle common health concerns such as heart disease, diabetes etc.

CREATE A UNIVERSAL PATIENT MEDICAL HISTORY DATABASE

Create a universal patient database and a standardized intake form to collect patients’ medical history and personal information. This database will eliminate the need to have patients repetitively complete the same registration forms.

CREATE COMMUNITY CLINICS TO ADDRESS SPECIFICALLY THE NEEDS OF BILINGUAL AND UNINSURED PATIENTS

Create community clinics that provide bilingual services to target the population they serve. Create an environment that reinforces a safe, trusting surrounding because many of the patients/clients are undocumented. Poor communities provide a sliding scale fee for patients which will allow them to pay for health care services based on their income. Primary and specialty care services should also be provided for those who do not have health insurance.

DISSEMINATE HEALTH SERVICE INFORMATION TO THE COMMUNITY

Work with community-based organizations to distribute information to reach all members of the community.

DEMOGRAPHICS

A total of 11 Latino males 50 years and older participated in the two-hour discussion group. Following are some key demographic characteristics defining the group that participated.

Table 19: Demographic Profile of Mexican, Nicaraguan, and Ecuadorian Males (Ages 50 and Older) Discussion Group

Category	Demographic Findings
ZIP Code	9.1% 11206 (n=1) 9.1% 11235 (n=1) 9.1% 11377 (n=1) 27.3% 11385 (n=3) 45.5% 11237 (n=5)
Age (Average Age)	59
Gender	100% Male (n=11)
Education Level	27.3% 6 th grade or less (n= 3) 27.3% High school graduate or GED (grade 12) (n=3) 27.3% 4-years of college or higher, with bachelor’s degree or higher (n=3) 18.2% No response (n=2)
Employment Status	27.3% Work 35 or more hours per week (3) 27.3% Work less than 35 hours per week (3) 45.5% Unemployed (5)
Income Level	54.5% between \$0 -\$10,000 (n=6) 9.1% between \$10,001 - \$20,000 (n=1) 36.4% no response (n=4)

Category	Demographic Findings
Insurance Status	36.4% Yes (n=4) - 25.0% HIP - 75.0% Not identified 63.6% No (n=7)
Race	18.2% White (n=2) 81.8% Latino (n=9)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the greatest challenges Latino males 50 years and older have experienced when obtaining health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Communication barriers
2. Obtaining health care services
3. Inability to pay for health insurance and health care services
4. Lack of available health care information

COMMUNICATION BARRIERS

Participants stated that the inability to communicate is a significant barrier to accessing health care services.

CONTRIBUTING FACTORS

Limited interpretation services at hospitals and other health care facilities

Participants reported communication problems when obtaining health care services. In most cases, interpreters are not available and this often leads to misinformation about diagnosis and treatment. At hospitals, interpretation services are often limited to the use of special language lines that are accessed via telephones placed strategically throughout the hospital. One participant reported that he waited several hours to be seen at a health care facility only to be told that the services he needed had to be sought elsewhere for his condition. He had great difficulty understanding why he was not being treated for his condition. Subsequently, it took several hours of relaying information between him and the health care provider before he was able to comprehend what was needed on his end.

Quality of interpretation services

Participants noted that a certain level of trust needs to be established with the patient even if an interpreter is provided. While these services are available in some medical facilities, the interpretation itself may not be accurate. The interpreter may not be familiar with the medical terminology and or the dialectic of the patient. It is often hard to decipher if what is being communicated between patient and interpreter will be correctly translated to the health care professional. There is often a high level of comfort when a health care professional can communicate openly in Spanish. Patients are better able to describe their ailment and current health conditions. With such a high level of trust and comfort, family members and friends will utilize this health care professional and/or the health care facility regularly.

Not all Spanish interpreters are native Spanish speakers

There was a sense amongst those in the group that some interpreters do not comprehend Spanish on the same level as a native Spanish speaker. There is a perception that interpreters do not exactly describe the patient's ailment and condition. It is important that trust is created between the interpreter, the patient, and the health care professional.

Ideal health care situations

In an ideal situation, discussion group participants stated that they preferred having health care professionals speak the language of the patient. Participants thought that aggravation ensues between the patient and the physician when communication is the main barrier to obtaining quality health care services.

GROUP SUGGESTIONS/RECOMMENDATIONS

Need high quality interpretation services

Quality interpretation services from native speakers should be provided at health care facilities. If the population they serve is heavily dominated with Spanish speaking patients, then health care professionals should be bilingual and use Spanish as the primary language. In some health facilities, health care professionals cater to the clientele they serve.

Need access to translated prescription usage instructions

While the Medicaid program provides access to prescription drugs, there is little to no access to translated prescription drug information including usage instructions. This information is mostly only available in English. The group recommended that prescription drug information and usage guidelines should be translated, if requested.

OBTAINING HEALTH CARE/HEALTH SERVICES

For most in the group, maintaining their health is a very high priority.

CONTRIBUTING FACTORS

Traveling outside of the neighborhood for health care services

Regardless of health insurance coverage, most of the discussion group participants travel outside of their neighborhood to obtain health care services. One participant travels as far as Elmhurst. A participant who has health insurance coverage reported that some health services may not be covered by their health insurance. Hence, they travel outside of their neighborhood to health care facilities where the services maybe less costly, compared to a private physician's office and/or hospital.

For almost all of the discussion group participants, obtaining and seeking care within their neighborhood is preferred. Specialized care may not be provided at local clinics and travel is required to obtain this type of care. The time and cost to travel outside of the neighborhood is burdensome.

Obtaining health care services from specific facilities

Health care facilities such as Wyckoff Heights Medical Center, Bellevue Hospital Center, and Woodhull Medical and Mental Health Center were some places discussion group participants sought health care services. Past history, personal experiences with the medical staff, lower cost medical services, and lower prescription medication rates are additional reasons why some in the group continue to use health services from these facilities.

Long waiting periods in the emergency room

Participants cited poor past experiences such as waiting long hours in the hospital emergency room, not being able to obtain specialty referrals, and receiving poor health care, that led some participants to evaluate seeking services at different medical facilities. One participant cited being billed for an emergency room visit when the physician's diagnosis was simply a referral to seek a specialist for his ailment. Seeking multiple opinions on a single ailment is costly.

Ideal health care visit

An ideal health care visit would consist of someone guiding the patient through the diagnosis, the medication to treat the ailment, understanding the visit, and address billing issues that may arise while at the health care facility. Obtaining specialty referrals with ease and being able to communicate in the patient's native tongue would also be an ideal situation. Reducing the paperwork each medical facility requires of the patient in order to treat the patient's health issues would also be ideal (i.e., patient history/insurance forms at the doctor's office, laboratories, x-ray locations etc.).

GROUP SUGGESTIONS/RECOMMENDATIONS

Make health care services affordable

Provide high quality health care that is affordable for the patient. Allowing the patient to pay for services based on their household income.

“One-stop shop” health care facility

Provide routine and specialty health care services at neighborhood clinics that are accessible to all. The specialty services would include treatment for heart disease, diabetes, etc.

A universal database containing the patient’s medical history and personal information

Install a system where one standardized form is needed to obtain all of the patient’s medical history without having the patient fill the information repeatedly.

Universal Health Care

Providing health care that is accessible to all.

INABILITY TO PAY FOR HEALTH INSURANCE AND HEALTH CARE SERVICES

The high cost of health insurance is a deterrent to why most in the group do not have health insurance.

CONTRIBUTING FACTORS

Participants cannot afford health care services

Most participants reported that they do not have health insurance and accessing information about where to obtain affordable care is difficult without community-based organizations. Not having health insurance was the main reason why some discussion group participants did not have a primary care physician. Participants discussed wanting to obtain health screenings but noted that the costs associated with such services were too expensive. Participants on a limited and/or low-income budget reported that they cannot afford private health insurance coverage. Participants who are low-income reported that they need additional support obtaining and maintaining their health insurance.

GROUP SUGGESTIONS/RECOMMENDATIONS

Provide community health clinics

Create community clinics that provide bilingual services to target the population they serve. Create an environment that reinforces a safe, trusting surrounding because many of the patients/clients are

undocumented. In a poor community, allow for a sliding scale fee where patients can pay for health services based on their income. Primary care and specialty services should also be provided for those who do not have health insurance.

LACK OF ACCESS TO HEALTH CARE INFORMATION

Participants reported that there is a need for sharing and disseminating health service information in the community. While some bilingual information is available, many in the community do not know where services may be obtained. Hospitals and community centers have a wealth of information but the information needs to trickle down to the community members.

GROUP SUGGESTIONS/RECOMMENDATIONS

Disseminate health service information to the community

Work with community-based organizations to distribute information to reach all members of the community.

PARENTS OF CHILDREN WITH PHYSICAL AND DEVELOPMENTAL DISABILITIES

INTRODUCTION

On Thursday, March 27, 2008, a discussion group was conducted with Parents of Children with Disabilities at the Indochina Sino-American Community Center located in Chinatown, Manhattan, New York. The purpose of this discussion group was to identify health care service access issues affecting parents of children with physical and developmental disabilities in New York City and to identify potential solutions to resolve these concerns for this specific population. The discussion was designed to have the parents speak from their perspective regarding the issues children with disabilities face in accessing health care services.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for parents of children with physical and developmental disabilities living in New York City. Below is a brief summary of the recommendations participants made on behalf of their children.

TRAINING FOR DOCTORS

Participants stated that they need all doctors to be trained on how to treat children with disabilities.

FACILITY DESIGNED SPECIFICALLY FOR PERSONS WITH DISABILITIES

Participants stated that there is a need for a specialty facility that is designed to treat patients with disabilities.

TRANSLATION/INTERPRETATION SERVICES

Participants said that there is a need for staff at doctor's offices to assist with translation/interpretation services. (Note: 80% of the participants were Chinese speaking.)

PUBLIC HEALTH INSURANCE QUALIFICATIONS

Participants stated that there should not be any income or disability level restrictions placed on public insurance applications for children with special needs.

ID CARDS FOR CHILDREN WITH DISABILITIES

Participants reported that they need ID cards for children with disabilities that include doctors' signatures verifying the child's diagnosis, disability diagnosis, and a description of the diagnosis.

DEMOGRAPHICS AND TYPES OF DISABILITIES

A total of fourteen parents of children with disabilities participated in the two-hour discussion group. Following are some key demographic characteristics which define the children of the group that participated.

Table 20: Demographic Profile of Parents of Children with Physical and Developmental Disabilities Discussion Group

Category	Demographic Findings
ZIP Code	14.3% ZIP code 10013, (2) 14.3% ZIP code 11229, (2) 14.3% ZIP code 10003, (2) 14.3% ZIP code 11373, (2) 7.1% ZIP code 11211, (1) 7.1% ZIP code 11235, (1) 7.1% ZIP code 10002, (1) 7.1% ZIP code 11355, (1) 7.1% ZIP code 11386, (1) 7.1% ZIP code 11385, (1)
Age (Average Age)	7
Gender	21.4% Female (3) 78.6% Male (11)
Education Level	57.1% 6 th grade or less (8) 21.4% Some middle school or some high school, no diploma grades 7-11, (3) 21.4% Other (3) - 33.3% Pre-Kindergarten (1) - 33.3% Head Start (1) - 33.3% Kindergarten (1)
Employment Status	N/A
Income Level	28.6% \$0-\$10,000 (4) 28.6% \$10,001-\$20,000 (4) 7.1% \$20,001-\$40,000 (1) 21.4% \$40,001-\$60,000 (3) 14.3% \$60,001-\$80,000 (2)

Category	Demographic Findings
Insurance Status	64.3% Yes (9) -25% Medicare and Medicaid (1) -25% HIP (1) 50% Don't know/not sure (2) 14.3% No (2) 21.4% No answer (3)
Race	64.3% Asian (9) 21.4% Hispanic (3) 14.3% White/Chinese (2)

There were a variety of disabilities represented in the discussion group. Participants were asked to describe what disabilities their children have. Below is a bulleted summary of their responses:

- Speech delay
- ADHD
- Low muscle tone
- Autism
- Bone structure on head (during birth child's soft spot on top of head was open from the forehead to the back of the head) not closing
- Auditory processing problems
- Lack of senses including sight, taste, smell, touch, hearing
- Dyslexia
- Selective mute
- Heart arrhythmia

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems children with disabilities have getting health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Translation and interpretation services
2. Doctors and office staff do not know how to treat persons with disabilities
3. Wait time for appointments is too long
4. Difficult to find doctors/ specialists

5. Health insurance not accepted

TRANSLATION AND INTERPRETATION SERVICES

Participants reported that translation and interpretation services for non-English speaking residents are a barrier to helping their children access quality health care services. Most participants in this group primarily speak Chinese and have limited English speaking capabilities.

CONTRIBUTING FACTORS

Emergency situations

Participants, who primarily speak Chinese, stated emergency situations are particularly stressful for them because they are afraid they will not be able to communicate clearly in a time efficient manner with the provider on behalf of their child. The communication issue is complicated by the child's disability which prevents the child from being able to communicate effectively with the provider.

Communicating with the provider and staff

Participants, who primarily speak and write in Chinese, stated that the inability to communicate clearly with the provider impacts many aspects of the appointment. The registration process is more cumbersome because registration forms are typically in English. Wait times are longer because of the language barrier and the child's disability, which makes communicating with office staff more difficult. Participants are also afraid that they are not clearly communicating their child's disability and resultant health needs to the provider

GROUP SUGGESTIONS/RECOMMENDATIONS

Translation/Interpretation services

Participants said that there is a need for staff at doctors' offices to assist with translation/interpretation services for parents who do not speak English well.

DOCTORS AND OFFICE STAFF DO NOT KNOW HOW TO TREAT PERSONS WITH DISABILITIES

Participants' past experiences have caused them to have concerns regarding the knowledge-base and sensitivity levels of health care providers with regard to treating persons with disabilities.

CONTRIBUTING FACTORS

Children's inability to work with providers

The participants stated children with disabilities are not able to work well with the providers. Children with disabilities cannot communicate well with the doctors related to their health needs. Participants also stated that children with disabilities like Autism become frustrated very easily due to long waits or unfamiliar settings which cause them to act out, scream, or hit.

Insensitive treatment

Participants stated most providers who are not specialized in treating children with disabilities become frustrated with the child and treat the child poorly. Participants cited examples of providers who will put children with disabilities at the end of the waiting line simply because they do not want to take the extra time to deal with a child with a disability, which only increases the child's frustration.

Participants also cited examples of providers who will yell at the child if the child is acting out or screaming. Insensitive treatment is especially damaging to children with developmental disabilities because one bad experience with a provider will prevent the child from ever being able to visit that same provider again. Participants stated their children have excellent memories and will not try to behave for the provider once they have a negative experience.

Doctor's offices and clinics are poorly designed

Participants stated that doctors' offices and clinics are often too small and do not have the necessary equipment to treat a child with disabilities. Participants stated there are not enough facilities within New York City which are customized to treat persons with disabilities.

GROUP SUGGESTIONS/RECOMMENDATIONS

ID cards for children with disabilities

Participants stated that they need ID cards for children with disabilities to include doctors' signatures, disability diagnosis, and a description of the diagnosis for parents to present during a doctor's visit so that children may be seen quicker and have a successful visit.

Training for doctors

Participants stated that all doctors should be trained on how to treat children with disabilities, so they are more prepared when a child with a disability comes in for a visit. Participants stated doctors who are trained provide for a more efficient and successful experience.

WAIT TIME FOR APPOINTMENTS IS TOO LONG

Participants are very concerned about the long wait times to have a provider see their children.

CONTRIBUTING FACTORS

Children do not react well to long wait times

Participants stated children with disabilities have a difficult time dealing with long waits at the doctor's office. Participants stated children with developmental disabilities do not understand why they have to wait and are not patient enough. This leads to the children screaming, crying, and getting upset. If a child with a developmental disability is subject to a long wait, the negative experience that results makes it difficult for the child to not only get through the current appointment but future appointments as well. This is a very difficult situation for the parents because finding a doctor who understands how to treat children with disabilities is not easy and becomes frustrating to the parents.

Difficult to find Doctors and specialists

Participants stated finding a doctor or specialist who is well-trained for treating children disabilities is a challenge.

CONTRIBUTING FACTORS

Most doctors are not trained well

Participants stated there simply are not enough doctors who specialize in or are trained well to treat children with varying types of disabilities. This lack of understanding and training leads to inefficient appointments and poor outcomes.

Types of doctors

Participants stated eye doctors, dentists, and neurologists who are trained to treat children with disabilities are the toughest to find.

Must go outside of neighborhood for specialty care

For primary care services, participants get most of their care within their neighborhood, but most go outside of their neighborhood for specialty care. One hundred percent of the participants stated they have a primary care doctor. Participants would prefer to access care within their neighborhood because travel is difficult especially for children with disabilities.

GROUP SUGGESTIONS/RECOMMENDATIONS

Facility designed specifically for persons with disabilities

Participants stated that there is a need for a specialty facility that is designed to treat patients with disabilities. Participants referenced “Article 16” clinics which have the equipment, multi-disciplinary staff, and knowledge to treat persons with disabilities successfully.

HEALTH INSURANCE NOT ACCEPTED

Participants stated that finding a provider who will accept their health insurance is difficult.

CONTRIBUTING FACTORS

Eligibility for Medicaid coverage

There are strict eligibility guidelines for special needs children to qualify for Medicaid coverage. Participants stated that a child must have an IQ under 70 to qualify and that certain types of disabilities do not meet these standards but still require significant health care coverage for proper treatment.

Medication and numerous appointments

Participants stated that medication for children with disabilities is essential but also expensive without insurance. Children with disabilities typically have to see doctors more frequently. Low income families who do not qualify for public health insurance are unable to get the necessary treatment that their children need due to their inability to pay for services.

Prefer a doctor’s office

Participants stated that they would prefer to go to a doctor’s office, but many times have to go to an emergency room because their insurance or lack of insurance prevents them from going to the doctor’s office.

GROUP SUGGESTIONS/RECOMMENDATIONS

Public health insurance qualifications

Participants say there should not be any income or disability level restrictions placed on public insurance applications for children with special needs. All children with special needs should qualify for Medicaid regardless of whether parents have an income level that is higher than Medicaid qualification requirements, or regardless of the severity of the child’s disability.

ADDITIONAL QUESTIONS ASKED AND RESPONSES

After covering each of the top three problems or barriers parents of children with physical and developmental disabilities stated they have in accessing health care services, there was some time left to cover additional questions. Below is a summary of the question, which was asked and the response provided by the group.

As a parent of a child with disabilities, are you able to gain access to services for your own health needs after dealing with your child's needs?

Participants' responses were unanimous. Parents only go if it is an emergency situation for them because they already take enough time off of work for their children and cannot afford to pay for services above and beyond what they pay for their children.

PARENTS OF CHILDREN WITH MENTAL ILLNESS

INTRODUCTION

On Wednesday, March 5, 2008, a discussion group was conducted for parents of children with mental illness at Queens Health Coalition in Queens, New York. The purpose of this discussion group was to identify health care service access issues affecting parents of children with mental illness in New York City and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for parents of children with mental illness living in New York City. Below is a brief summary of the recommendations.

PROVIDE LOW COST PRIVATE HEALTH COVERAGE

Provide low cost private health insurance coverage to families who do not qualify for public health insurance programs such as Medicaid or Medicare. This would accommodate families who narrowly miss the income eligibility limits for public health insurance programs. Health coverage would especially be targeted to adults who in most cases do not have any type of health insurance coverage.

BETTER ACCESS OBTAINING PHYSICIAN APPOINTMENTS

Lessen the length of time it takes patients to obtain a physician appointment to reduce use of emergency rooms.

INCREASE ACCESS TO FREE OR LOW COST HEALTH SCREENINGS

Provide free or low cost preventive health care screenings at clinics and other types of health care facilities. Make these health screenings available to all who are in need of these services.

REEXAMINE HOUSEHOLD INCOME CRITERIA FOR APPLICANTS SEEKING PUBLIC HEALTH INSURANCE COVERAGE

Adjust how the government (state, federal, and city) decides who qualifies for health insurance based on other factors besides, which income group bracket applicants fall under.

IMPROVE ACCESS TO DENTAL CARE SERVICES FOR LOW INCOME FAMILIES

Provide dental programs to assist low-income families. Address ways in which dental services could be provided to those seeking this type of service.

BUILD A HIGH QUALITY HEALTH CLINIC IN THE COMMUNITY

Place high quality health clinics in the community for everyone (i.e., those who are insured, uninsured, and underinsured) to access. Allow clinics to accept patients even if they do not reside in the neighborhood/community. Adhere to scheduled appointment times. Expand the type of health services that are available at clinics. Provide comprehensive services at the clinic (a “one-stop shop” facility).

DEMOGRAPHICS

A total of six parents participated in the hour long discussion group. Following are some key demographic characteristics defining the group that participated in the discussion.

Table 21: Demographic Profile of Parents of Children with Mental Illness Discussion Group

Category	Demographic Findings
ZIP Code	16.7% 11358 (n=1) 16.7% 11212 (n=1) 16.7% 11429 (n=1) 16.7% 11422 (n=1) 33.3% 11434 (n=2)
Age (Average Age)	38
Gender	90.0% Females (n=5) 10.0% Male (n=1)
Education Level	33.3% High school graduate or GED (grade 12) (n=2) 50.0% Some college, no degree (n=3) 16.6% 4-years of college or higher, with bachelor’s degree or higher (n=1)
Employment Status	16.6% Work 35 or more hours per week (n=1) 33.3% Work less than 35 hours per week (n=2) 50.0% Unemployed (n=3)
Income Level	33.3% \$0 - \$10,000 (n=2) 16.6% \$10,001 - \$20,000 (n=1) 33.3% \$20,001 - \$40,000 (n=2) 16.6% \$40,001 - \$60,000 (n=1)
Insurance Status	66.6% Yes (n=4) - 25.0% Child Health Plus (n=1) - 25.0% Fidelis (n=1) - 25.0% Amerigroup (n=1) - 25.0% Medicare(n=1) 33.3% No (n=2)

Category	Demographic Findings
Race	83.3% Black or African American (n=5) 16.7% Asian (n=1)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the biggest problems parents with mentally challenged children have in getting health care services in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Long waiting periods for services/ confusing application
2. Limited income/low wages
3. Ineligibility for health insurance programs
4. Lack of knowledge of where to go for help
5. Inadequate services/inconvenient service locations

LONG WAITING PERIODS FOR SERVICES/CONFUSING APPLICATION PROCESS

Parents indicated that obtaining health care services is difficult with long waiting periods when setting physician appointments. Visits are further complicated by the guidelines and process for families trying to apply for public health insurance programs. Participants reported that obtaining health care is a long and arduous process.

CONTRIBUTING FACTORS

Inadequate health coverage

Participants questioned how the average person qualifies for public health insurance coverage. The group was in agreement that children (in this situation, children under the ages of 18) are adequately insured through government programs if they cannot obtain private health insurance. Health coverage for children is always available in some form. However, adults who cannot afford private health insurance, and those who do not qualify for public health insurance programs are most likely to have health care access issues. Prevention services are needed for adults. Adults cannot obtain preventive health care if they are uninsured but it is critical for adults to stay healthy for their children. The process for getting insurance and eligibility standards for parents should be much simpler.

The waiting period

Parents do not wait to obtain a health care appointment with a health provider when care is needed; they seek health care services immediately. Without a healthy parent, the family structure will certainly be affected. The impact is greater on those parents who do not have extended family support. Parents need to stay healthy because they cannot afford physician visits or afford to get their children sick.

Perception of health care services

Participants reported that the health department provides health care to their children. Participants went on to say that appointment times are often inflexible. Some reasons for being inflexible include: long waiting periods obtaining appointments, long waiting periods waiting to be seen at the clinic/physician office and difficulty obtaining sub-specialist appointments. Overall, some in the group felt that if their children had better health insurance, they would also receive better health services. Those who are underprivileged have a certain type of insurance, and the group's perception is that they receive lower quality health care services because of the type of insurance.

Receiving substandard services

Participants stated that obtaining x-rays and scheduling appointments for MRIs should not be a long and arduous task. The health department needs to be more willing to help serve their targeted population. One perception among the participants was that the health department does not understand their market and does not provide services in a manner that meet the needs of their customers. Professionals do not have the answers to many of their patients' health concerns. Common services such as referrals can be difficult for many in this group. It was reiterated that, for adults, seeking health services is cumbersome. Students seeking health services will also have difficulty navigating the health system because they are uninsured. Ideally, health concerns should be addressed at the onset of a crisis before the situation manifests itself into a larger problem. The group questioned why the system will not address these simple problems.

GROUP SUGGESTIONS/RECOMMENDATIONS

Provide very low cost health insurance coverage

Provide low cost health insurance coverage to those families who do not qualify for private insurance or public health insurance programs such as Medicaid and Medicare.

Improve access to appointments with physician appointments

Improve the length of time it takes patients to obtain a physician appointment to reduce use of emergency rooms.

Increase access to free or low cost health screenings

Provide preventive health screenings at clinics or health care facilities at no cost or at a low cost rate.

LIMITED INCOME/LOW WAGES

Participants indicated that by not having better paying jobs and not having sufficient funds to allocate to purchasing private health insurance coverage, they will not be able to receive health care services.

CONTRIBUTING FACTORS

Living expenses

Living in a large metropolitan city can be challenging. Expenses such as food, rent, daycare, and transportation are so expensive that it makes obtaining health care unrealistic. One participant expressed her desire to obtain affordable health coverage but felt the health insurance coverage plan offered by her employer was too expensive based on her income. Shifting funds from another area such as food or rent to obtain health insurance was impossible.

High cost of medical services

It was discussed that some hospital emergency rooms provide a higher level of care than others. One discussion group participant who received quality care at the emergency room subsequently received a medical bill that she could not afford. She said that on her limited income, she could not redirect funds from her very tight budget to pay for her medical bills and the procedures that followed. She was, however, pleased that she was able to arrange a low minimum monthly payment with the hospital without any consequences.

GROUP SUGGESTIONS/RECOMMENDATIONS

Need for affordable health insurance coverage

Provide affordable health insurance coverage plans to families on a sliding fee scale system. Address the need for health insurance coverage for families who do not qualify for public health insurance programs and cannot afford to purchase private insurance.

INELIGIBILITY FOR PUBLIC HEALTH INSURANCE

The group reported that qualifying for health insurance is very difficult. There are many factors that do not allow a low-income family to obtain public health insurance programs.

CONTRIBUTING FACTORS

Eligibility criteria for public health insurance programs

The group discussed the unrealistic criteria for obtaining public health coverage. One participant did not qualify for public health insurance because her annual household income exceeds the income eligibility criteria for the program. Due to this limitation, she seeks health care services at local clinics. In her opinion, the government is satisfied with only providing services to children and the elderly population. However, the government falls short of providing for parents who fall in the coverage gap. For emergencies, services are sought at the emergency room but this incurs costly out of pocket expenses (hundreds of dollars). Other countries provide free health care to their citizens and many in the group cannot understand why Americans do not have similar health care opportunities available to them.

Dental care services

All participants reported difficulties obtaining dental care appointments. They further stated that the out-of-pocket expenses deter them from receiving annual dental care check-ups. Health organizations need to extend their services further into the community to reach their target audience. While clinics are available for general health care services, other services including dental care services are not readily available.

Lack of preventive screenings for men

Participants reported that men do not receive proper care and men's preventive health care services do not exist. There should be services specifically targeted towards men equivalent to gynecological services for women. It is uncommon for a man to obtain routine health screenings without a physician's recommendation.

GROUP SUGGESTIONS/RECOMMENDATIONS

Reexamine the household income eligibility requirements for public health insurance programs

Adjust how the government (state, federal, and city) decides who qualifies for public health insurance based on other factors in addition household income.

Improve access to dental care services for low income families

Provide dental programs to meet the needs of low-income families.

Provide health screenings to parents who do not have health insurance

Provide preventive health screenings not only for women but also for men.

LACK OF KNOWLEDGE OF WHERE TO GO FOR HELP

Traveling outside of the community to receive health care services at local clinics is not unusual for those in the discussion group.

CONTRIBUTING FACTORS

Seeking health care services outside of the community

Participants noted that it is not uncommon for participants to travel outside of their neighborhood to seek health care services at a clinic. There was an overall feeling that the health care system is not conducive to families. The process of going from one government agency to another trying to obtain health services is difficult on many levels. Discussion group participants cited obtaining additional health care services at clinics and being served by familiar health care professionals were reasons why they travel outside of the neighborhood to obtain care. They were quick to note that not all clinics provide quality care.

Health care services at the clinic

Participants reported that clinics offer some free and reduced cost services; however, research is needed from the patient's end to locate these types of services. While clinics are an available option to many in the community, appointment times do not occur at the allocated time. Most participants agreed that while clinic appointment times are scheduled for patients, there is no guarantee that the patient will be seen by a health care professional on the day of the appointment. In most cases, waiting to be seen takes hours. Participants explained that there are certain days the clinic provides certain types of services (i.e., gynecological appointments are provided only on certain days of the week). Participants agree that health services need to be expanded to include all days of the week.

The group reported that those who obtain services from a clinic do not have a primary care physician they see routinely. However, all female group participants reported that they do have an obstetrician/gynecologist who they see regularly. Some participants stated that they are willing to travel outside of their community for care if it meets the needs of their families. It was noted that some clinics provide patients with metro cards as an incentive for their continued use of the facility. Metro cards were provided by these clinics because many of their patients cited transportation as being an issue getting to the clinic.

GROUP SUGGESTIONS/RECOMMENDATIONS

Build a high quality clinic in the community

Place high quality health clinics in the community for all (insured and uninsured) to access. Allow clinics to accept patients even if they do not reside in the immediate community. If clinic appointments are scheduled, adhere to scheduled appointment times. Expand the type of health services that are available at clinics. Provide comprehensive services at the clinic (i.e., a “one-stop shop” facility).

INADEQUATE SERVICES/INCONVENIENT SERVICE LOCATIONS

Overall, the group indicated that while care was obtainable through health clinics and the emergency rooms at local hospitals, the group hoped for better health services through a private physician and/ or a community-based health clinic.

CONTRIBUTING FACTORS

Lack of preventive health services in the community

Participants said that preventive services are not available for those who are trying to seek health screenings such as pap smears. Preventive health screenings at clinics are unavailable for men. Health care overall is limited for men who are seeking services. One participant indicated that she would falsify information if her son needed care. Her son did not qualify for health coverage and she felt this would be her only outlet. Visiting the ER is not cost effective when seeking preventive health services.

Lack of ability to purchase health insurance

Participants reported that it is difficult for many households, especially those headed by a single parent, to be able to afford purchase health insurance. There was discussion among the group that large gaps exist between what employers pay for health insurance and what the state pays for health insurance. Costs for health insurance should be stable across the board.

Inequalities in the delivery of health care service

Some participants stated that HIV/ AIDS patients receive better care than patients who do not have the disease. One participant did not want to minimize the consequences of having AIDS but there was a perception that available treatment and available prescription medication was provided to those who had the disease. Because the topic of HIV/AIDS generates media attention, some participants in the group believe that first class health services will be provided to those people who have the disease.

There is a perception from one discussion group participant that clinical services are better in areas such as Long Island and Staten Island. Most health care consumers in these communities have private

doctors. For residents who do not have private doctors, there are clinics that provide wonderful care in these boroughs. Health clinics on Long Island provide all the medical services a patient would need. The ability to obtain lab work, x-rays, etc., and other medical services in one facility is very convenient for patients. However, these clinics are only accessible to those who live in those communities.

GROUP SUGGESTIONS/RECOMMENDATIONS

Provide health care services to all in need

Expand the type of care that is available to men and women. Overall, provide high quality care and expand services available to the community.

ADDITIONAL QUESTIONS ASKED AND RESPONSES

After covering each of the top problems or barriers parents with mentally challenged children have in accessing health care services, there was time to discuss additional questions. Below is a summary of responses which were discussed during the group by the participants.

- Police officers need to be more dispersed in the community to protect better the residents not just the merchants in the neighborhood. The community needs prevention strategies and education programs on gun violence and programs to deter children from joining gangs.
- Mobile health vans and clinical services are not available in some communities, but overall many are content with their community and its infrastructure.
- Some participants felt that there is often a lack of compassion among medical professionals. Training should be provided to those who provide services to the public. The group stated that often nurses and administrative people have poor attitudes and are judgmental to those seeking health services at clinics and other medical facilities.

SOUTH ASIAN ELDERS

INTRODUCTION

On Wednesday, February 27, 2008, a discussion group was conducted with South Asian Elders. The discussion was sponsored by Pragati and was facilitated at Queens Borough Hall located in Kew Gardens, Queens. The purpose of this discussion group was to identify health care service access issues affecting South Asian Elders in New York City and to identify potential solutions to resolve these concerns for this specific population.

GROUP RECOMMENDATIONS

The group provided many recommendations to improve health care access for South Asian Elders living in New York City. Below is a brief summary of the recommendations.

ELIMINATE COMMUNICATION BARRIERS

Participants say they need primary care physicians and specialists who can speak their language to eliminate communication barriers.

TRANSPORTATION

Participants say they need funds for local community organizations to operate a van that will be available to elders to help them get to their medical appointments.

MULTI-SPECIALTY HEALTH CARE FACILITIES

Participants reported that there should be health care centers located in each neighborhood that caters to the needs of elderly patients. These health care facilities would have multiple health care specialties, most often utilized by seniors, co-located in one building/facility thus providing seniors with easy access to health care services. This approach to health care delivery would eliminate the need for seniors to travel outside of their neighborhoods to many different places for health care services.

PROVIDE A CARE COORDINATOR

Participants say there is a need to have a Care Coordinator for elders with complicated health care conditions to improve wait times to see doctors, schedule appointments, and handle patient complaints.

IMPROVE ACCESS TO INFORMATION ABOUT HEALTH INSURANCE PROGRAMS AND OTHER HEALTH CARE RESOURCES

Participants stated there is a need for ongoing education regarding how Medicare, Medicaid, and Medicaid managed care works and other health care resources.

ASSISTED LIVING HOUSING

Participants say there is a need for affordable assisted living housing for elders.

DEMOGRAPHICS AND LANGUAGES SPOKEN

A total of fourteen South Asian Elders participated in the two-hour discussion group. Below are some key demographic characteristics which define the group that participated.

Table 22: Demographic Profile of South Asian Elders Discussion Group

Category	Demographic Findings
ZIP Code	21.4%, 11372 (n=3) 14.3%, 10034 (n=2) 7.1%, 11367 (n=1) 7.1%, 11355 (n=1) 7.1%, 11373 (n=1) 7.1%, 11370 (n=1) 7.1%, 11734 (n=1) 7.1%, 11374 (n=1) 7.1%, 11358 (n=1) 7.1%, 11356 (n=1) 7.1%, 11343 (n=1)
Age (Average Age)	69.6
Gender	64.3% Females (n=9) 35.7% Males (n=5)
Education Level	21.4% Some middle school or some high school, no diploma (grades 7-11) (n=3) 14.3% High school graduate or GED (grade 12) (n=2) 7.1% Some college, no degree (n=1) 42.9% 4-years of college or higher, with bachelor’s degree or higher (n=6) 14.3% Other (n=2) <ul style="list-style-type: none"> - 50% Masters (n=1) - 50% MBA (n=1)

Category	Demographic Findings
Employment Status	14.3% Work 35 or more hours per week (n=2) 28.6% Unemployed (n=4) 35.7% Other (n=5) - 80% Retired (n=4) - 20% Dependent (n=1) 21.4% No Answer (n=3)
Income Level	42.9% \$0 - \$10,000 (n=6) 14.3% \$10,001 - \$20,000 (n=2) 14.3% \$20,001 - \$40,000 (n=2) 7.1% \$40,001 - \$60,000 (n=1) 21.4% No answer (n=3)
Insurance Status	92.9% Yes (n=13) - 30.8% Medicare (n=4) - 23.0% Medicaid (n=3) - 7.7% Medicare and Medicaid (n=1) - 7.7% Family Health Plus (n=1) - 7.7% Help (n=1) - 7.7% Metro Plus (n=1) - 15.4% No Answer (n=2) 7.1% No (n=1)
Race	100% Asian (14)

PROBLEM IDENTIFICATION

Prior to the discussion, participants were asked to list what they believe to be the three biggest problems South Asian Elders have getting health care in their community. The responses were then ranked and scored to generate themes for discussion. All of the participants completed this exercise and were involved in the discussion of the following issues:

PRIORITY ISSUES

1. Transportation
2. Communication Barriers
3. Long waiting times
4. Uninsured/underinsured

TRANSPORTATION

Participants stated transportation is a barrier to accessing health care services.

CONTRIBUTING FACTORS

Subway stairs are difficult for elders

Participants stated walking up and down subway stairs is very difficult. Participants believe more stations should have elevators or escalators.

Taxis are too expensive

Participants cited examples of having to travel over forty blocks to get to a health care appointment. In some cases, participants have to take a taxi and are unable to afford the cab fare.

Not all elders are eligible for the Access-A-Ride program

Participants stated the application process for Access-a-Ride is very cumbersome and need assistance completing these forms. Elders who do qualify for the Access-a-Ride program complained of long wait times for pick-ups before and after appointments. Eligible elders also reported that they are often told by Access-a-Ride staff to take a taxi and request reimbursement from Access-a-Ride.

GROUP SUGGESTION/RECOMMENDATIONS

Transportation

Participants say they need funds for local community organizations to operate a van that will be available to elders to help them get to their medical appointments.

TRANSLATION INTERPRETATION SERVICES

Participants stated translation and interpretation services are a barrier to accessing health care services.

CONTRIBUTING FACTORS

Visits to hospitals and specialists

The majority of participants stated they have primary care physicians who speak their language. However, language/communication barriers arise most frequently when they visit hospitals and specialists who are unable to speak in their language. Participants reported that it is often very difficult for them to find specialists who speak their language. Participants cited specific examples of long waits in the emergency room because they were unable to communicate with the staff.

Staff attitudes

Participants stated the behavior of providers is “harsh” and “rude” when dealing with patients who are unable to speak English. Specifically, participants stated nurses and receptionists are the most likely to treat them disrespectfully.

GROUP SUGGESTION/RECOMMENDATIONS

Eliminate communication barriers

Participants say they need specialists who can speak their language.

LONG WAITING TIMES

Participants state the waiting times at doctors’ offices and hospitals are too long.

CONTRIBUTING FACTORS

Long wait time to get appointments

Participants stated they have to wait too long to schedule an appointment and feel elders should be given priority in scheduling.

Long wait times at doctor’s offices and hospitals

Participants explained they often wait two hours or more to see a doctor for both office visits and hospital appointments. Participants attribute the long wait to “heavy double booking” of appointments. The majority of the health care access challenges faced by participants arise from situations when they are seeking care from specialists and hospitals they are not used to visiting.

Loyalty to primary care physicians

All participants have a primary care provider; the majority of which are located within the participants’ neighborhoods. Participants stated they do not seek care outside of their neighborhood because they are very loyal to the long-term relationships they have with their current providers.

GROUP SUGGESTION/RECOMMENDATIONS

Multi-Specialty health care centers

Participants say there should be multi-specialty centers located in each neighborhood that are customized to delivery elderly friendly health care services. The centers should be equipped to provide many of the health care services that are utilized by the elderly.

Provide a care coordinator

Participants say there is a need to have a Care Coordinator for elders with complicated health care conditions to improve wait times to see doctors, schedule appointments, and handle patient complaints.

UNINSURED/UNDERINSURED

Participants state their insurance does not cover all of their health care needs.

CONTRIBUTING FACTORS

Access to private doctors

Participants stated some doctor's offices do not accept Medicaid or Medicare. Patients are asked to give up front payments ranging from \$200-\$300 per visit. This is not affordable for most elders.

Access to prescription drugs

One participant reported that she lost Medicaid eligibility because she did not understand the Medicaid renewal process. As a result, she lost Medicaid eligibility for two months and had no means of paying for her medicine. As a last resort, she had to make arrangements to obtain her medicine from her home country. Participants also stated Medicaid often does not cover the prescribed medications they need.

GROUP SUGGESTION/RECOMMENDATIONS

Improve access to information about public health insurance programs and other health care resources: Participants stated there is a need for ongoing education regarding how Medicare, Medicaid, and Medicaid managed care works and other health care resources.

HEALTH AND HUMAN SERVICES CBO ROUNDTABLE DISCUSSION

In order to test the validity of the PCI Community Health Assessment data collected via the household surveys and discussion groups, on Monday, April 21, 2008, a 90-minute roundtable discussion was held with four representatives from health and human service organizations serving the New York City area specifically, the Children’s Defense Fund, the Hispanic Federation, Safe Space Inc., and Esperanza del Barrio. The goal of this meeting was to solicit feedback and validation of data collected as a part of the Community Health Assessment. The group was presented a series of PowerPoint slides summarizing the findings of the discussion groups and survey data. The participants were then asked to comment specifically on the findings.

KEY FINDINGS FROM THE ROUNDTABLE DISCUSSION

The participants in the group felt that the survey data and discussion group findings supported what they had heard from the populations they served, observed first-hand, or found through other studies completed on the subject of health care access. The one issue that did surprise the participants was the finding that people still did not know how to access public health insurance programs despite the fact that there are many initiatives/venues across the City to promote public health insurance programs.

Based upon the data presented, the group discussed various strategies, ideas, and recommendations with regard to providing better health care access to vulnerable populations.

COMMUNICATION AND CULTURAL COMPETENCE

- One recommendation from the group with regard to promoting better understanding with patients who do not speak English as their primary language went beyond the provision of quality translation/interpretation services. A member of the group stated that often times the issue is not that materials are not translated into different languages but that the participants are not literate and cannot understand the forms. To assist those patients who are unable to read even properly translated documents, it was felt that a liaison be available to assist the patients in understanding and filling out the forms. It was stated that this person should not be the receptionist but rather a new position to help people “navigate” the forms and the system. These “Patient Navigators” could assist in making the health care delivery system more understandable and easier to access.
- Another recommendation made to increase communication between providers and patients was to have visuals/drawings available to show the patients while the doctor and interpreter go through the explanations of their disease or diagnosis to bridge the gap in understanding between the patient and provider.

- With regard to the cultural competence of physician and health care staff, the group stated that there should be required coursework in medical school for physicians about cultural competence. Continuing Medical Education credits should be mandatory for doctors and nurses in the field of cultural competence.

CREATING A MEDICAL HOME

- It was discussed in the group that despite efforts to create a medical home for people, a large percentage of people did not report having a medical home according to the survey data. The group felt that a full-fledged medical home needed to be constructed with the specialty care, laboratory/diagnostic services and pharmacy co-located within the same building (e.g., Kaiser Permanente). This would ensure continuity of care and be a “one-stop” shop where patients would know that their medical insurance would be accepted, that their providers would be communicating, and that they would have one medical record.

PHYSICIANS IN MEDICALLY UNDERSERVED AREAS

- There was discussion in the group about the issue of waiting times for appointments and while in the waiting room. The group felt that this did point to two factors: 1) physician shortages; and 2) a need to monitor and track patient loads by physician. It was clear that the group had heard their constituencies voice similar concerns but that more needed to be done to solve the issue. One recommendation with regard to the physician shortages was to support the Doctors Across New York Program. This program is intended to help the more than 25 percent of New York's population who live in areas designated as under-served. The program would set aside \$2 million a year to create a physician loan repayment program that would help as many as 100 doctors a year. If the doctor stays in an under-served area for the minimum requirement of two years, 30 percent of the loan would be paid off. Payments would grow each year to the point where it would be paid off after five years. The repayment is capped at \$150,000.
- Another recommendation was to provide physicians with incentives. Due to the high cost of malpractice insurance and low reimbursement rates from Medicaid, many providers do not have a choice but to prioritize focusing on volume rather than quality. Subsidizing their time may be a way to increase quality.

DISSEMINATING INFORMATION TO THE COMMUNITY

- Also noted within the discussion was that people do not know where to go for health care and how to sign up for public health insurance. The question was raised by the group “How are we missing people?” The group felt that grass-roots mobilizing was the most effective way to get

information out to the community because for most people they get their information from a trusted source or word-of-mouth.

- One participant recommended that a medical geographer be retained to map out all existing health care services (clinics, hospitals, etc.) in concert with the Bus and Subway lines. This data could be placed on subway trains as a part of a broader advertising campaign indicating where health care was available along the subway stops. Local physicians and nurses could be used in the ads to highlight diversity and quality of care. (For Example: Dr. Smith is your local physician in Bushwick, Brooklyn. He graduated from Dartmouth School of Medicine and also practices at NY Presbyterian)



Telephone and Field Survey Findings

TELEPHONE AND FIELD SURVEY FINDINGS

INTRODUCTION

The data presented in this section of the report includes a demographic profile of all survey respondents for both field and telephone survey methodologies for all ten PCI regions/communities combined.

ALL REGIONS SUMMARY

Prior to presenting data from each of the ten PCI regions, here are some data for all the regional combined.

Table 23: Demographic Data of All Respondents to the Telephone and Field Surveys In Comparison To New York City Figures

Demographic Category	All Regions	NYC
Average age of survey participants (years)	44.8	35.9 ²³
Percentage who are female	60.4%	52.3% ²⁴
Average time living in NYC (years)	23.3	Not available
Percentage born outside the United States	67.8%	36.9% ²⁴
Percentage who speak a language other than English in their household	50.6%	44.5% ²⁴
Percentage who report they are a non-White race	88.6%	65.2% ²⁴
Percentage who identify themselves as being of Hispanic origin	30.1%	27.6% ²⁴
Percentage with household income at \$20,000 or below	46.9%	28.9% ²⁵
Percentage who finished high school or less	56.1%	32.5% ²⁴
Percentage who work 35 or more hours each week	49.4%	Not available

²³ Value reflects median age of New York City residents per the 2006 American Community Survey.

²⁴ Source: 2006 American Community Survey.

²⁵ Value reflects percent of households with household income under \$20,000 per US Census Bureau 2000 Census.

Chart 4: Racial Breakdown of All Telephone and Field Survey Respondents

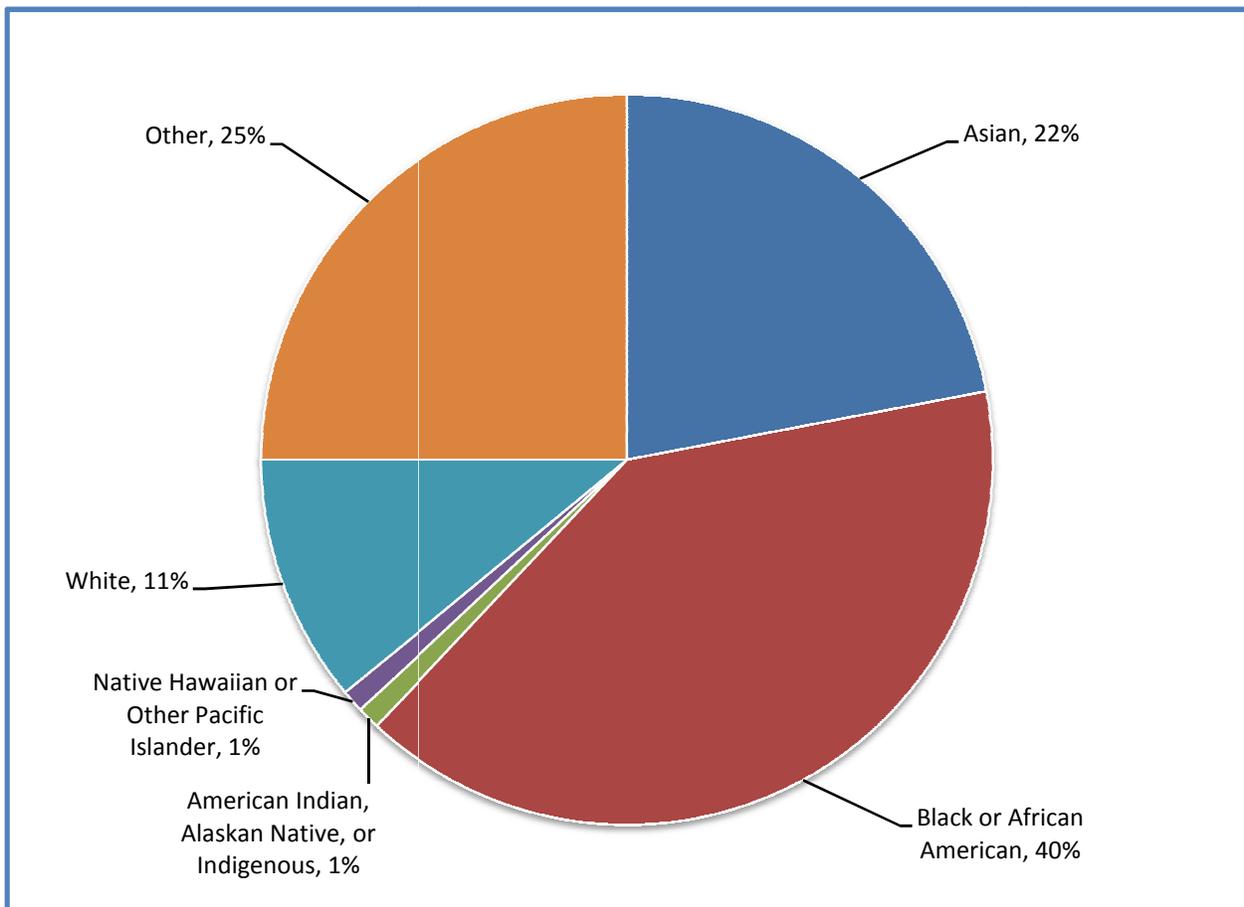


Table 24: Household Income of Telephone and Field Survey Respondents

Household Income Range	All Regions
\$0-\$10,000	21.3%
\$10,001-\$20,000	25.6%
\$20,001-\$40,000	25.9%
\$40,001-\$60,000	13.4%
\$60,001-\$80,000	6.0%
\$80,001-\$100,000	3.6%
More than \$100,000	4.2%

Almost half of the participants surveyed (46.9%) reported a household income at or below \$20,000 a year. The average household size is 2.9 people.

Table 25: Telephone and Field Survey Key Findings – All Regions

Survey Key Finding	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	85.4%
Percentage who now have health insurance	74%
Percentage who report having a medical home	56%

- Just over half (51.7%) of respondents get all of their health care services in their neighborhood. Significantly more respondents (85.4%) reported that it would be most convenient to get their health care in their neighborhood.
- The main reasons respondents seek health care outside of their neighborhood include seeking care from a specialist, being referred to another provider, and preference for another provider.
- More than half (56.5%) of respondents reported having a medical home.²⁶ Although most respondents’ medical homes are in their borough of residence, Manhattan is the medical home for the highest percentage of respondents (28.4%).

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (42.7%)
2. Needed an appointment sooner than the appointment time offered (31.3%)
3. Doctor or nurse did not spend enough time with us (23.6%)
4. Could not afford to pay the bill (20.8%)
5. Doctor or nurse did not listen carefully enough (20.2%)

The top five main reasons for getting health care outside of the neighborhood are:

1. I get care from a specialist in another neighborhood (22.7%)
2. Prefer a doctor or nurse who is in another neighborhood (20.8%)
3. Was referred to or assigned a doctor or nurse in another neighborhood (16%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (7.7%)

²⁶ In health care literature, the term “medical home” means the primary care base from which other care is arranged. In the PCI Community Health Assessment, “medical home” was defined as “one place more than any other place that you go to for your health care.”

5. My doctor or nurse is close to my job or school (7.5%)

The top five provider types that participant households have had difficulty accessing in their neighborhood are:

1. Dentist (49.7%)
2. A doctor or nurse you go to for your basic health care needs (30.8%)
3. Pediatrician (22.1%)
4. Mental health counselor (14.8%)
5. Family planning services (10.5%)

BRONX 1

INTRODUCTION

Bronx 1 encompasses ZIP codes 10452, 10454, and 10456 in the South Bronx.

Map 2 provides an illustration of the ZIP codes surveyed. In total, 288 telephone and field surveys were collected throughout the communities of Mott Haven, Melrose, Highbridge, and Morrisania.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Bronx 1 to obtain a representative sample of the population. In addition, The Bronx Health Link, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 26 below.

Map 1: Bronx 1 Region

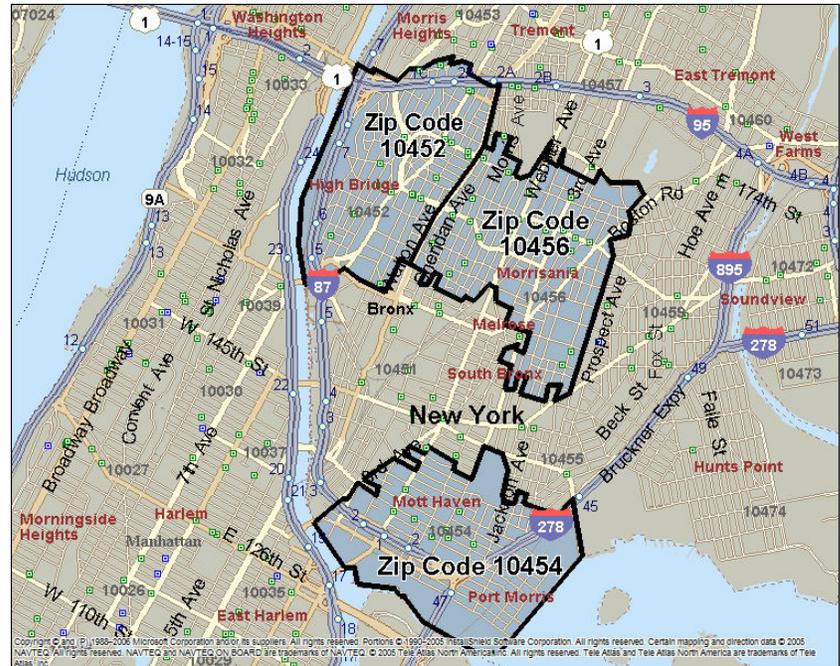


Table 26: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Bronx 1

Targeted Subgroup	# Returned Surveys
African American	10
Honduran	30
Mexican	14
Puerto Rican	30
English Speaking West African	30
French Speaking West African	30

Table 27: Bronx 1 Telephone and Field Survey Participant Demographics

Demographic Category	Bronx 1	All Regions
Average age of survey participants	47.5	44.8
Percentage who are female	61%	61%
Average time living in NYC (years)	27	23.3
Percent born outside the United States	65.8%	68%
Percentage who speak a language other than English in their household	46.9%	50.6%
Percentage who report they are a non-White race	95%	89%
Percentage who identify themselves as being of Hispanic origin	35.3%	30%

Chart 5: Racial Breakdown of Bronx 1 Telephone and Field Survey Respondents

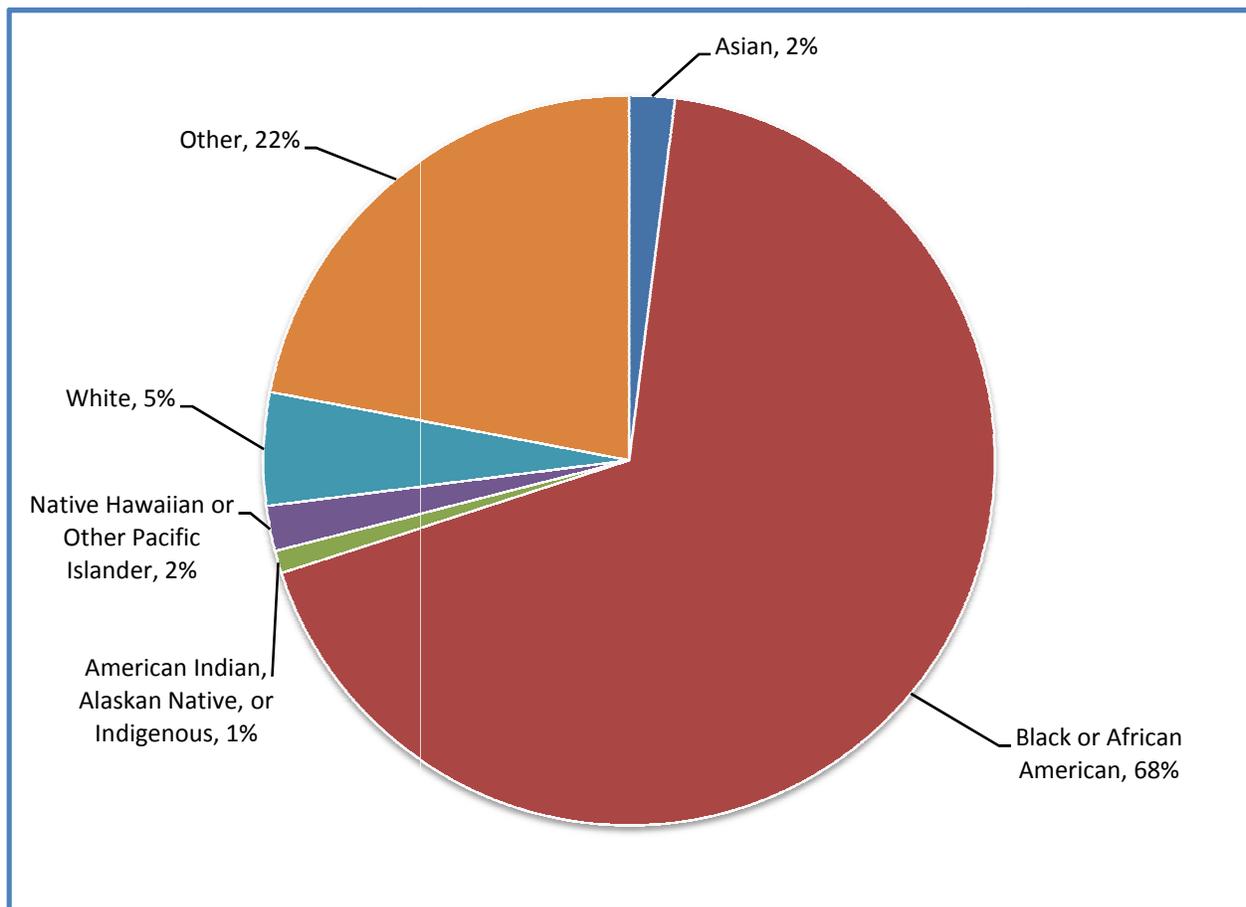


Table 28: Household Income of Bronx 1 Telephone and Field Survey Respondents

Annual Household Income	Bronx 1	All Regions
\$0-\$10,000	20.2%	21.3%
\$10,001-\$20,000	28.9%	25.6%
\$20,001-\$40,000	30.6%	25.9%
\$40,001-\$60,000	7.5%	13.4%
\$60,001-\$80,000	6.9%	6.0%
\$80,001-\$100,000	5.2%	3.6%
More than \$100,000	.6%	4.2%

Almost half of the participants surveyed (49.1%) reported a household income at or below \$20,000 a year. The average household size is 2.7 people.

SURVEY KEY FINDINGS

Table 29: Survey Key Findings for Bronx 1

Finding	Bronx 1	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	58.4%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	90%	85.4%
Percentage who now have health insurance	75.2%	74%
Percentage who report having a medical home	45%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (43.2%)
2. Needed an appointment sooner than the appointment time offered (37.5%)
3. Doctor or nurse did not spend enough time with us (29.5%)
4. Doctor or nurse did not listen carefully enough (26.1%)
5. Could not afford to pay the bill (22.7%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. I get care from a specialist in another neighborhood (60.0%)
2. Was referred to or assigned a doctor or nurse in another neighborhood (38.8%)

3. Prefer a doctor or nurse who is in another neighborhood (37.6%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (30.6%)
5. Not satisfied with doctor or nurse I found in my neighborhood (20.0%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (41.3%)
2. Mental health counselor (29.3%)
3. A doctor or nurse you go to for your basic health care needs (25.3%)
4. Traditional healer (17.3%)
5. Prenatal care/mid-wife/ obstetrician/gynecologist (16.0%)

BRONX 2

INTRODUCTION

Bronx 2 encompasses ZIP codes 10458, 10453, 10457, 10460, and 10472 in the central Bronx. Map 2 provides an illustration of the ZIP codes surveyed. In total, 530 telephone and field surveys were collected throughout the communities of University Heights, East Tremont, Fordham, and Morris Heights.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Bronx 2 to obtain a representative sample of the population. In addition, The Indochina Sino-American Community Center, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 30 below.

Map 2: Bronx 2 Region

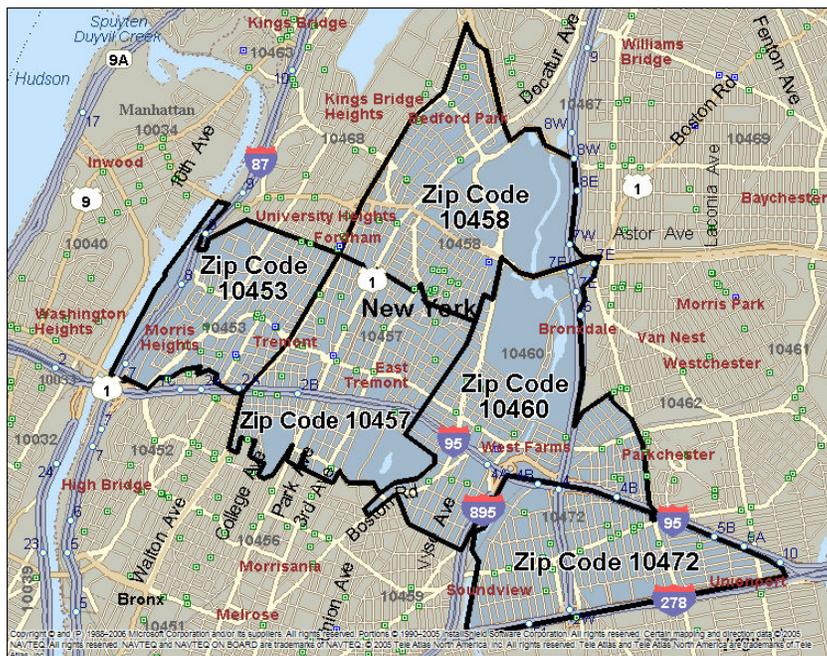


Table 30: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Bronx 2

Targeted Subgroup	# Returned Surveys
Arab	65
Cambodian	35
Chinese	36
Filipino	30
Korean	29
French Speaking West African	36
Vietnamese	30

Table 31: Bronx 2 Telephone and Field Survey Participant Demographics

Demographic Category	Bronx 2	All Regions
Average age of survey participants	45.8	44.8
Percentage who are female	57%	61%
Average time living in NYC (years)	22.7	23.3
Percentage born outside the United States	68.7%	68%
Percentage who speak a language other than English in their household	53.7%	50.6%
Percentage who report they are a non-White race	87%	89%
Percentage who identify themselves as being of Hispanic origin	14.8%	30%

Chart 6: Racial breakdown of Bronx 2 survey respondents

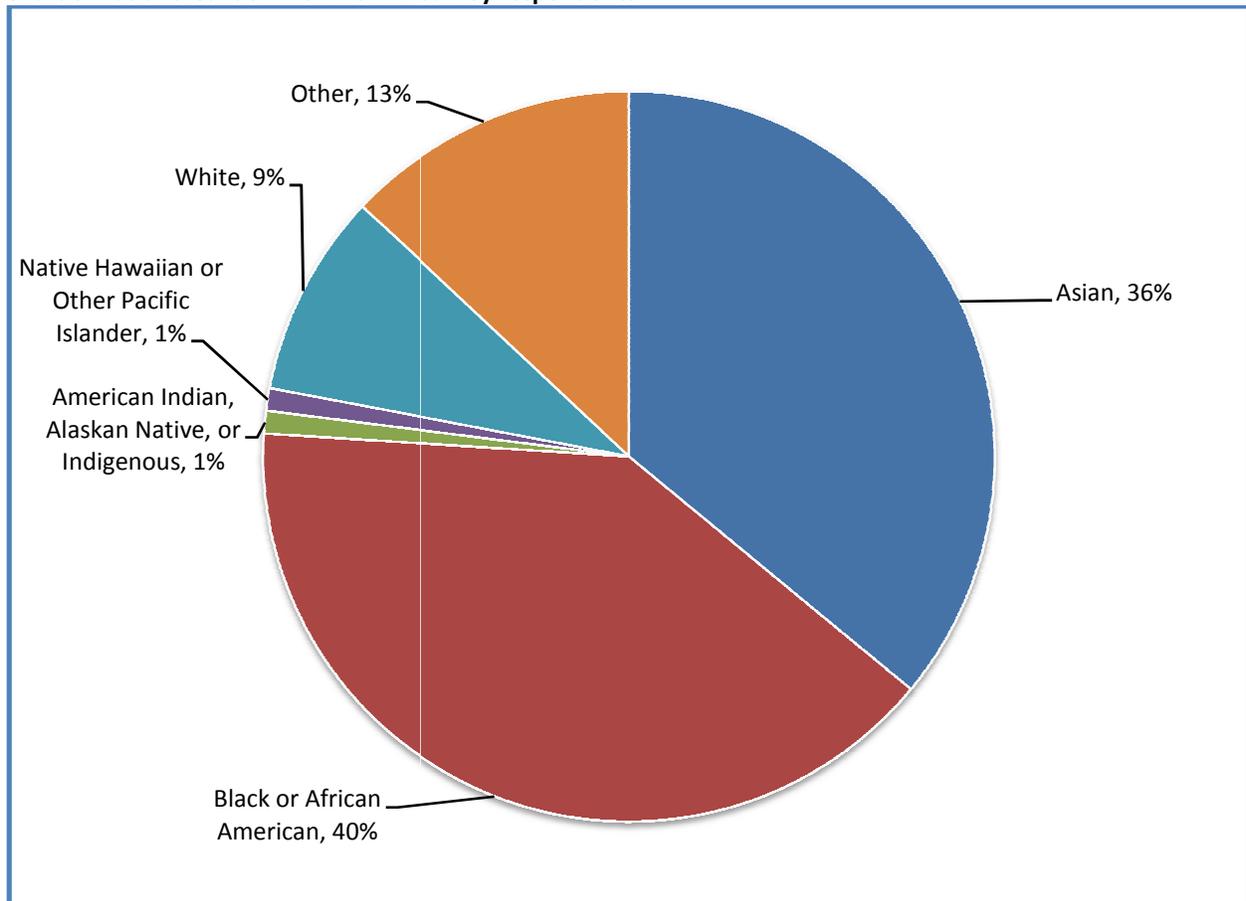


Table 32: Household Income of Bronx 2 Telephone and Field Survey Respondents

Annual Household Income	Bronx 2	All Regions
\$0-\$10,000	23.1%	21.3%
\$10,001-\$20,000	25.6%	25.6%
\$20,001-\$40,000	22.8%	25.9%
\$40,001-\$60,000	15.8%	13.4%
\$60,001-\$80,000	7.3%	6.0%
\$80,001-\$100,000	2.3%	3.6%
More than \$100,000	3.1%	4.2%

Almost half of the participants surveyed (48.7%) reported a household income at or below \$20,000 a year. The average household size is 2.9 people.

SURVEY KEY FINDINGS

Table 33: Survey Key Findings for Bronx 2

Finding	Bronx 2	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	52.9%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	84.3%	85.4%
Percentage who now have health insurance	77.8%	74%
Percentage who report having a medical home	63.6%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (47.1%)
2. Needed an appointment sooner than the appointment time offered (36.8%)
3. Could not afford to pay the bill (23.2%)
4. Doctor or nurse did not spend enough time with us (21.3%)
5. Insurance did not pay for what was needed (20.0%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. Was referred to or assigned a doctor or nurse in another neighborhood (53.3%)
2. Prefer a doctor or nurse who is in another neighborhood (52.1%)

3. I get care from a specialist in another neighborhood (50.3%)
4. My doctor or nurse is close to my job or school (38.2%)
5. I do not have confidence in the quality of care I would receive in my neighborhood (30.3%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (48.5%)
2. A doctor or nurse you go to for your basic health care needs (29.3%)
3. Pediatrician/baby doctor (18.2%)
4. Family planning services (13.1%)
5. Mental health counselor (10.1%)

BROOKLYN 1

INTRODUCTION

Brooklyn 1 encompasses ZIP codes 11206, 11237, and 11221 in North Brooklyn.

Map 3 provides an illustration of the ZIP codes surveyed. In total, 303 telephone and field surveys were collected throughout the communities of East Williamsburg, Bushwick, and Bedford-Stuyvesant.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Brooklyn 1 to obtain a representative sample of the population. In addition, Make the Road New York, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 34 below.

Map 3: Brooklyn 1 Region

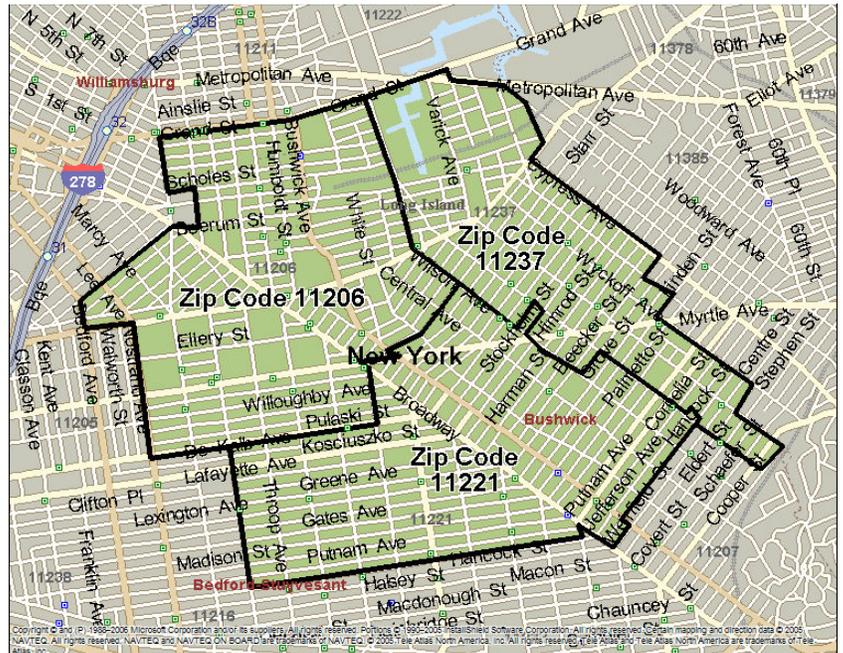


Table 34: Targeted Hard to Reach Populations and Number of Field Surveys for Brooklyn 1

Targeted Subgroup	# Returned Surveys
Chinese	30
Dominican	31
Ecuadorian	30
Mexican and Salvadorian	31
West Indian	30

Table 35: Brooklyn 1 Telephone and Field Survey Participant Demographics

Demographic Category	Brooklyn 1	All Regions
Average age of survey participants	41.9	44.8
Percentage who are female	65.7%	61%
Average time living in NYC (years)	21.1	23.3
Percentage born outside the United States	72.3%	68%
Percentage who speak a language other than English in their household	53.4%	50.6%
Percentage who report they are a non-White race	90.4%	89%
Percentage who identify themselves as being of Hispanic origin	52%	30%

Chart 7: Racial Breakdown of Brooklyn 1 Telephone and Field Survey Respondents

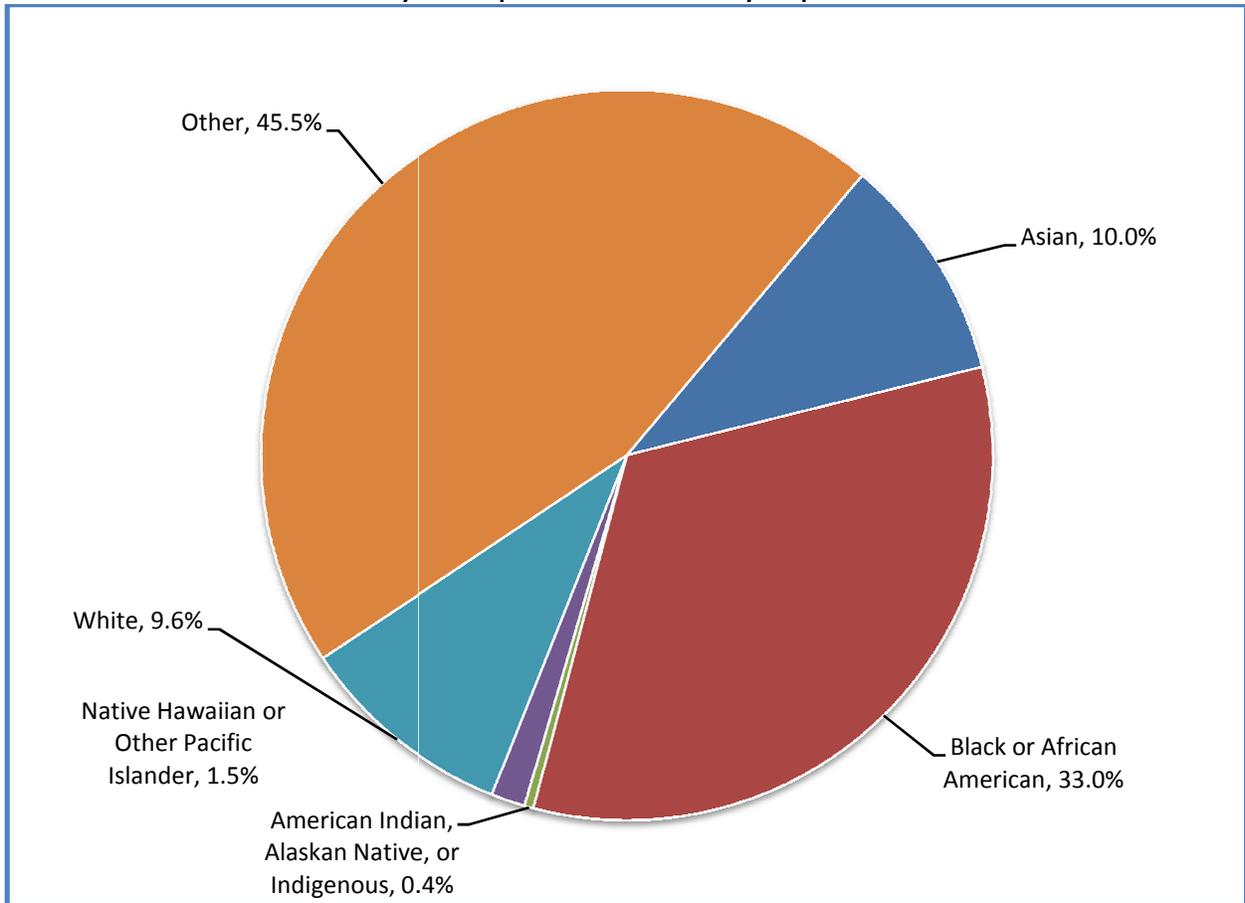


Table 36: Household Income of Brooklyn 1 Telephone and Field Survey Respondents

Annual Household Income	Brooklyn 1	All Regions
\$0-\$10,000	21.2%	21.3%
\$10,001-\$20,000	31.4%	25.6%
\$20,001-\$40,000	27.9%	25.9%
\$40,001-\$60,000	10.6%	13.4%
\$60,001-\$80,000	4.4%	6.0%
\$80,001-\$100,000	3.1%	3.6%
More than \$100,000	1.3%	4.2%

Just over half of the participants surveyed (52.6%) reported a household income at or below \$20,000 a year. The average household size is 3.0 people.

SURVEY KEY FINDINGS

Table 37: Survey Key Findings for Brooklyn 1

Finding	Brooklyn 1	NYC
Percentage of participants who report they receive all of their health care in their neighborhood	45.2%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	88.5%	85.4%
Percentage who now have health insurance	74.2%	74%
Percentage who report having a medical home	57.4%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are

1. Had to wait too long in the waiting room (45.7%)
2. Needed an appointment sooner than the appointment time offered (33.3%)
3. Doctor or nurse did not spend enough time with us (23.8%)
4. Could not afford to pay the bill (19.0%)
5. Doctor or nurse no longer accepted our insurance (19.0%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. I get care from a specialist in another neighborhood (45.1%)
2. Was referred to or assigned a doctor or nurse in another neighborhood (43.1%)
3. Prefer a doctor or nurse who is in another neighborhood (40.2%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (35.3%)

5. My doctor or nurse is close to my job or school (26.5%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (47.5%)
2. A doctor or nurse you go to for your basic health care needs (41.0%)
3. Pediatrician/baby doctor (31.1%)
4. Prenatal care/mid-wife/ obstetrician/gynecologist (27.9%)
5. Family planning services (14.8%)

BROOKLYN 2

INTRODUCTION

Brooklyn 2 encompasses ZIP codes 11233, 11212, 11207 and 11208 in Central Brooklyn. Map 4 provides an illustration of the ZIP codes surveyed. In total, 585 telephone and field surveys were collected throughout the communities of Brownsville, Crown Heights, East New York, and New Lots.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Brooklyn 2 to obtain a representative sample of the population. In addition, Brooklyn Perinatal Network, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 38 below.

Map 4: Brooklyn 2 Region



Table 38: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Brooklyn 2

Targeted Subgroup	# Returned Surveys
African American Female	85
African American Male	53
Arab	60
Central American	23
Chinese	30
Haitian	43
Hispanic American Male	37

Table 39: Brooklyn 2 Telephone and Field Survey Participant Demographics

Demographic Category	Brooklyn 2	All Regions
Average age of survey participants	43	44.8
Percentage who are female	56.5%	61%
Average time living in NYC (years)	24.4	23.3
Percentage born outside the United States	57.0%	68%
Percentage who speak a language other than English in their household	32.7%	50.6%
Percentage who report they are a non-White race	96.4%	89%
Percentage who identify themselves as being of Hispanic origin	27.1%	30%

Chart 8: Racial Breakdown of Brooklyn 2 Telephone and Field Survey Respondents

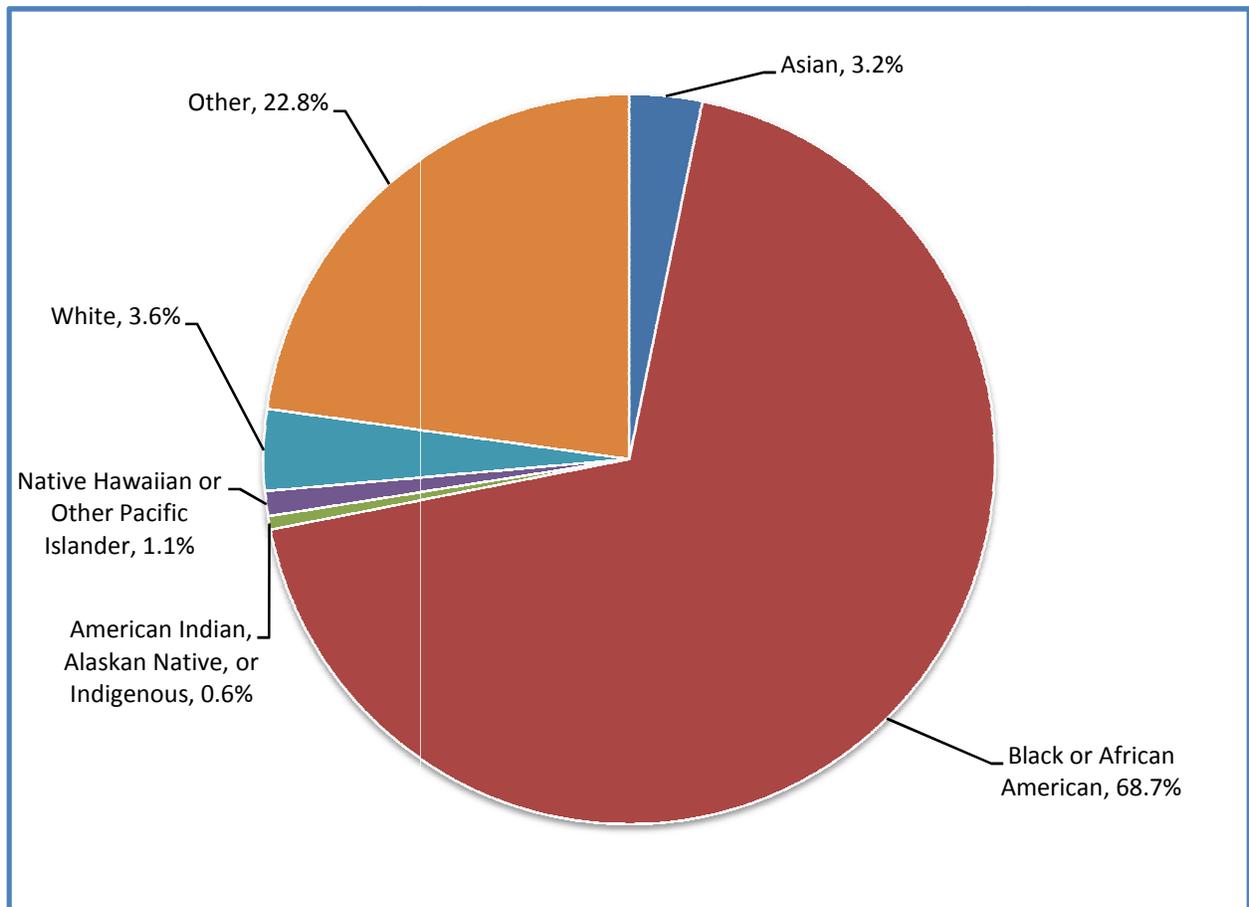


Table 40: Household Income of Brooklyn 2 Telephone and Field Survey Respondents

Annual Household Income	Brooklyn 2	All Regions
\$0-\$10,000	22.5%	21.3%
\$10,001-\$20,000	22.1%	25.6%
\$20,001-\$40,000	32.1%	25.9%
\$40,001-\$60,000	14.5%	13.4%
\$60,001-\$80,000	4.7%	6.0%
\$80,001-\$100,000	1.6%	3.6%
More than \$100,000	2.5%	4.2%

Almost half of the participants surveyed (44.6%) reported a household income at or below \$20,000 a year. The average household size is 2.9 people.

SURVEY KEY FINDINGS

Table 41: Survey Key Findings for Brooklyn 2

Findings	Brooklyn 2	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	42.5%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	85.4%	85.4%
Percentage who now have health insurance	72.9%	74%
Percentage who report having a medical home	51.5%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (39.3%)
2. Needed an appointment sooner than the appointment time offered (28.1%)
3. Doctor or nurse did not spend enough time with us (22.5%)
4. Could not afford to pay the bill (21.9%)
5. Doctor or Nurse did not listen carefully enough (19.1%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. I get care from a specialist in another neighborhood (57.1%)
2. Was referred to or assigned a doctor or nurse in another neighborhood (51.6%)

3. Prefer a doctor or nurse who is in another neighborhood (50.7%)
4. Not satisfied with doctor or nurse I found in my neighborhood (26.9%)
5. I do not have confidence in the quality of care I would receive in my neighborhood (25.1%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (47.1%)
2. A doctor or nurse you go to for your basic health care needs (37.0%)
3. Pediatrician/baby doctor (24.4%)
4. Prenatal care/mid-wife/ obstetrician/gynecologist (19.3%)
5. Mental health counselor (12.6%)

BROOKLYN 3

INTRODUCTION

Brooklyn 3 encompasses ZIP code 11226 in the neighborhoods of Flatbush and Ditmas Park. Map 5 provides an illustration of this ZIP code. In total, 173 telephone and field surveys were collected.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Brooklyn 3 to obtain a representative sample of the population. In addition, Caribbean Women’s Health Association, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 42 below.

Map 5: Brooklyn 3 Region



Table 42: Targeted Hard to Reach Populations and Number of Field Surveys for Brooklyn 3

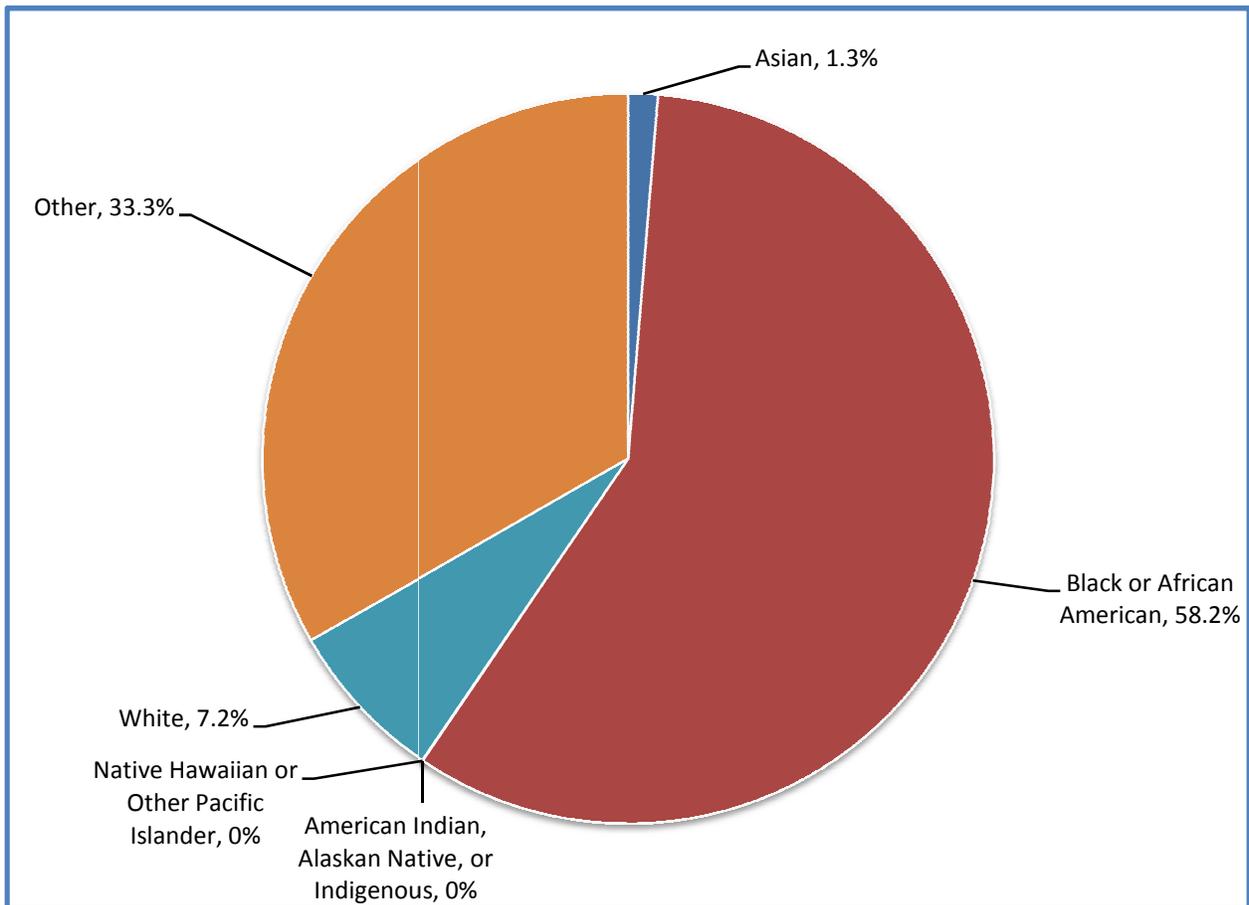
Targeted Subgroup	# Returned Surveys
Haitian	29
Mexican	36
Panamanian	7

Table 43: Brooklyn 3 Telephone and Field Survey Participant Demographics

Demographic Category	Brooklyn 3	All Regions
Average age of survey participants	43.6	44.8
Percentage who are female	67.1%	61%
Average time living in NYC (years)	19.2	23.3
Percentage born outside the United States	86.2%	68%
Percentage who speak a language other than English in their household	53.1%	50.6%
Percentage who report they are a non-White race	92.8%	89%
Percentage who identify themselves as being of Hispanic origin	44.2%	30%

RACE

Chart 9: Racial Breakdown of Brooklyn 3 Telephone and Field Survey Respondents



More than half of the participants surveyed (59%) reported a household income at or below \$20,000 a year. The average household size is 3.0 people.

Table 44: Household Income of Brooklyn 3 Telephone and Field Survey Respondents

Annual Household Income	Brooklyn 3	All Regions
\$0-\$10,000	32.5%	21.3%
\$10,001-\$20,000	26.5%	25.6%
\$20,001-\$40,000	22.2%	25.9%
\$40,001-\$60,000	6.8%	13.4%
\$60,001-\$80,000	3.4%	6.0%
\$80,001-\$100,000	4.3%	3.6%
More than \$100,000	4.3%	4.2%

SURVEY KEY FINDINGS

Table 45: Survey Key Findings for Brooklyn 3

Finding	Brooklyn 3	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	66.9%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	89.3%	85.4%
Percentage who now have health insurance	64.9%	74%
Percentage who report having a medical home	50.8%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (54.4%)
2. Needed an appointment sooner than the appointment time offered (42.6%)
3. Doctor or nurse did not spend enough time with us (32.4%)
4. Doctor or nurse did not listen carefully enough (29.4%)
5. Could not afford to pay the bill (26.5%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. Prefer a doctor or nurse who is in another neighborhood (46.2%)
2. Was referred to or assigned a doctor or nurse in another neighborhood (43.6%)
3. I get care from a specialist in another neighborhood (41.0%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (30.8%)

5. Not satisfied with doctor or nurse I found in my neighborhood (25.6%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (53.6%)
2. A doctor or nurse you go to for your basic health care needs (25.0%)
3. Mental health counselor (25.0%)
4. Family planning services (21.4%)
5. Prenatal care/mid-wife/ obstetrician/gynecologist (10.7%)

MANHATTAN 1

INTRODUCTION

Manhattan 1 encompasses ZIP codes 10029 in East Harlem and 10039 in Central Harlem. Map 6 provides an illustration of the ZIP codes surveyed. In total, 163 telephone and field surveys were collected in East and Central Harlem.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Manhattan 1 to obtain a representative sample of the population. In addition, The Restaurant Opportunities Center of New York, a non-profit organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 46 below.

Map 6: Manhattan 1 Region

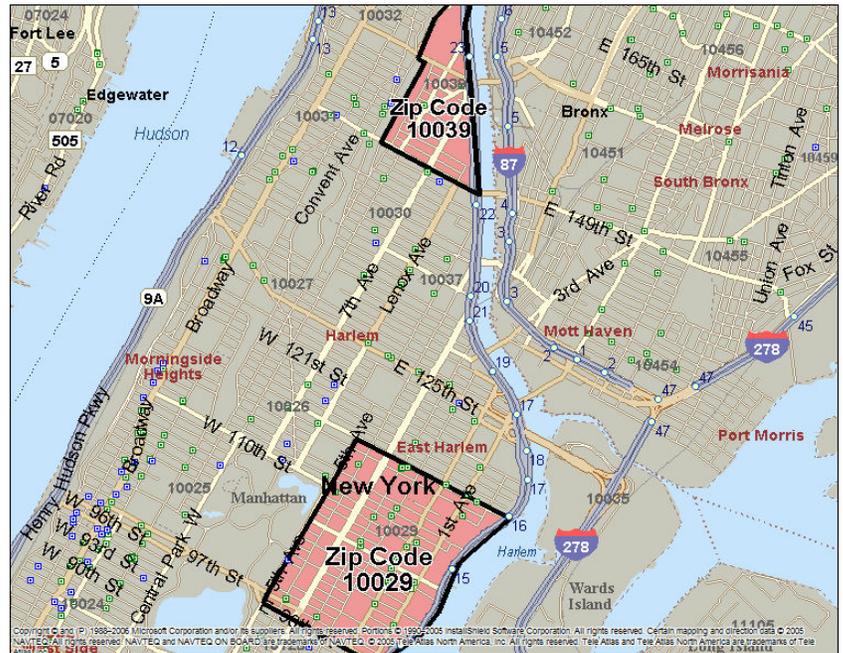


Table 46: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Manhattan 1

Targeted Subgroup	# Returned Surveys
Chinese	25
French Speaking West African	26
Mexican	25

Table 47: Manhattan 1 Telephone and Field Survey Participant Demographics

Demographic Category	Manhattan 1	All Regions
Average age of survey participants	45.2	44.8
Percentage who are female	54.0%	61%
Average time living in NYC (years)	21.7	23.3
Percentage born outside the United States	67.9%	68%
Percentage who speak a language other than English in their household	58.7%	50.6%
Percentage who report they are a non-White race	91.3%	89%
Percentage who identify themselves as being of Hispanic origin	37.1%	30%

Chart 10: Racial Breakdown of Manhattan 1 Telephone and Field Survey Respondents

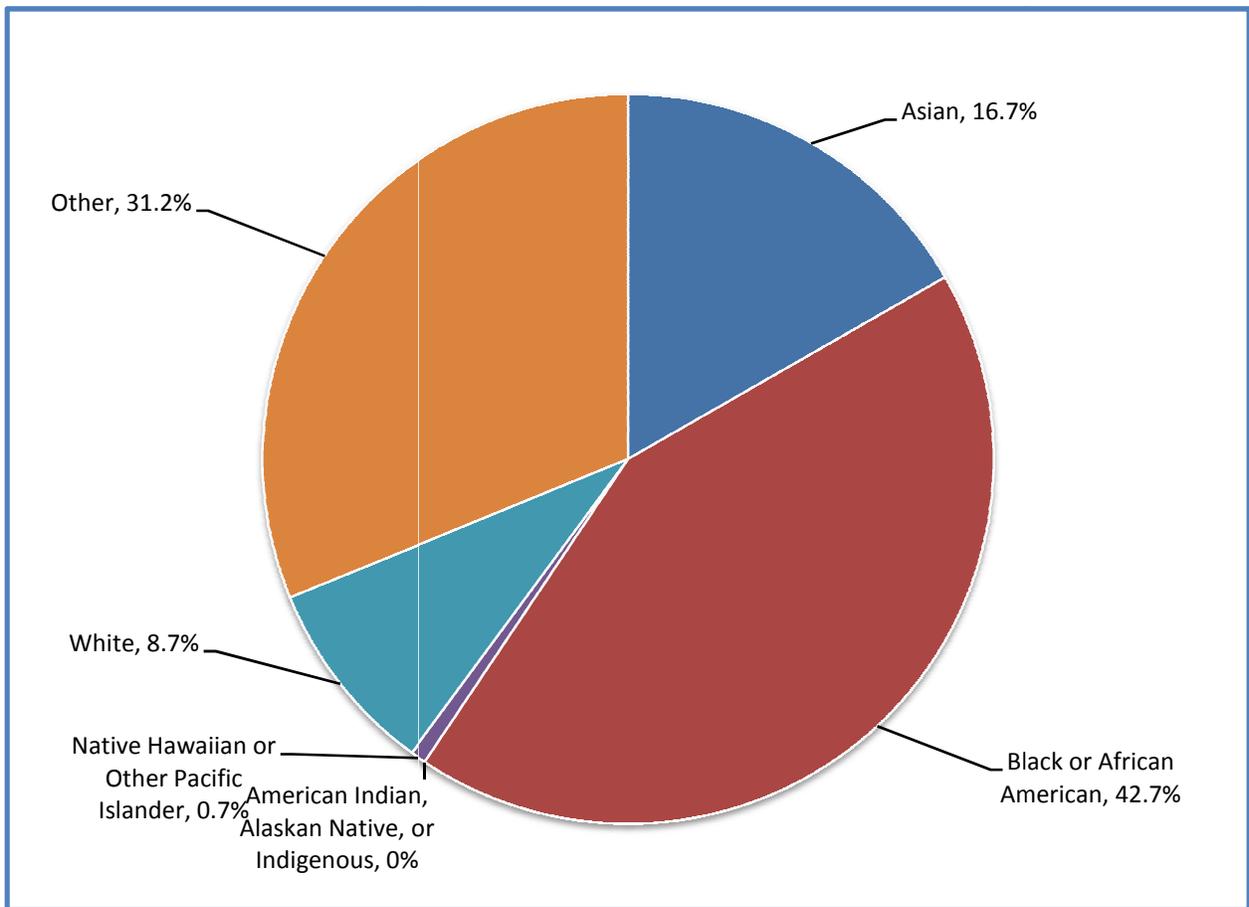


Table 48: Household Income of Manhattan Telephone and Field Survey Respondents

Annual Household Income	Manhattan 1	All Regions
\$0-\$10,000	29.0%	21.3%
\$10,001-\$20,000	26.2%	25.6%
\$20,001-\$40,000	21.5%	25.9%
\$40,001-\$60,000	10.3%	13.4%
\$60,001-\$80,000	5.6%	6.0%
\$80,001-\$100,000	3.7%	3.6%
More than \$100,000	3.7%	4.2%

More than half of the participants surveyed (55.2%) reported a household income at or below \$20,000 a year. The average household size is 2.8 people.

SURVEY KEY FINDINGS

Table 49: Survey Key Findings for Manhattan 1

Finding	Manhattan 1	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	60.8%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	89.1%	85.4%
Percentage who now have health insurance	58.6%	74%
Percentage who report having a medical home	55.0%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (50.0%)
2. Needed an appointment sooner than the appointment time offered (32.5%)
3. Doctor or nurse did not spend enough time with us (27.5%)
4. They did not return our telephone call (25.0%)
5. Doctor or nurse did not listen carefully enough (20.0%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. I get care from a specialist in another neighborhood (55.9%)
2. Prefer a doctor or nurse who is in another neighborhood (47.1%)
3. Was referred to or assigned a doctor or nurse in another neighborhood (41.2%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (32.4%)

5. My doctor or nurse is close to my job or school (23.5%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (42.3%)
2. A doctor or nurse you go to for your basic health care needs (42.3%)
3. Prenatal care/mid-wife/ obstetrician/gynecologist (15.4%)
4. Pediatrician/baby doctor (11.5%)
5. Mental health counselor (11.5%)

MANHATTAN 2

INTRODUCTION

Manhattan 2 encompasses ZIP code 10002 on the Lower East Side. Map 7 provides an illustration of this ZIP code. In total, 152 telephone and field surveys were collected in Chinatown on the Lower East Side.

Map 7: Manhattan 2 Region



TARGETED SUBGROUPS

A random sample of telephone surveys was collected in Manhattan 2 to obtain a representative sample of the population. In addition, The Indochina Sino-American Community Center, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in the Table 50 below.

Table 50: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Manhattan 2

Targeted Subgroup	# Returned Surveys
Chinese (Fujianese)	36
Other Asian	30

Table 51: Manhattan 2 Telephone and Field Survey Participant Demographics

Demographic Category	Manhattan 2	All Regions
Average age of survey participants	49.4	44.8
Percentage who are female	69.7%	61%
Average time living in NYC (years)	23.9	23.3
Percentage born outside the United States	68.9%	68%
Percentage who speak a language other than English in their household	63.2%	50.6%
Percentage who report they are a non-White race	70.7%	89%
Percentage who identify themselves as being of Hispanic origin	24.0%	30%

Chart 11: Racial Breakdown of Manhattan 2 Telephone and Field Survey Respondents

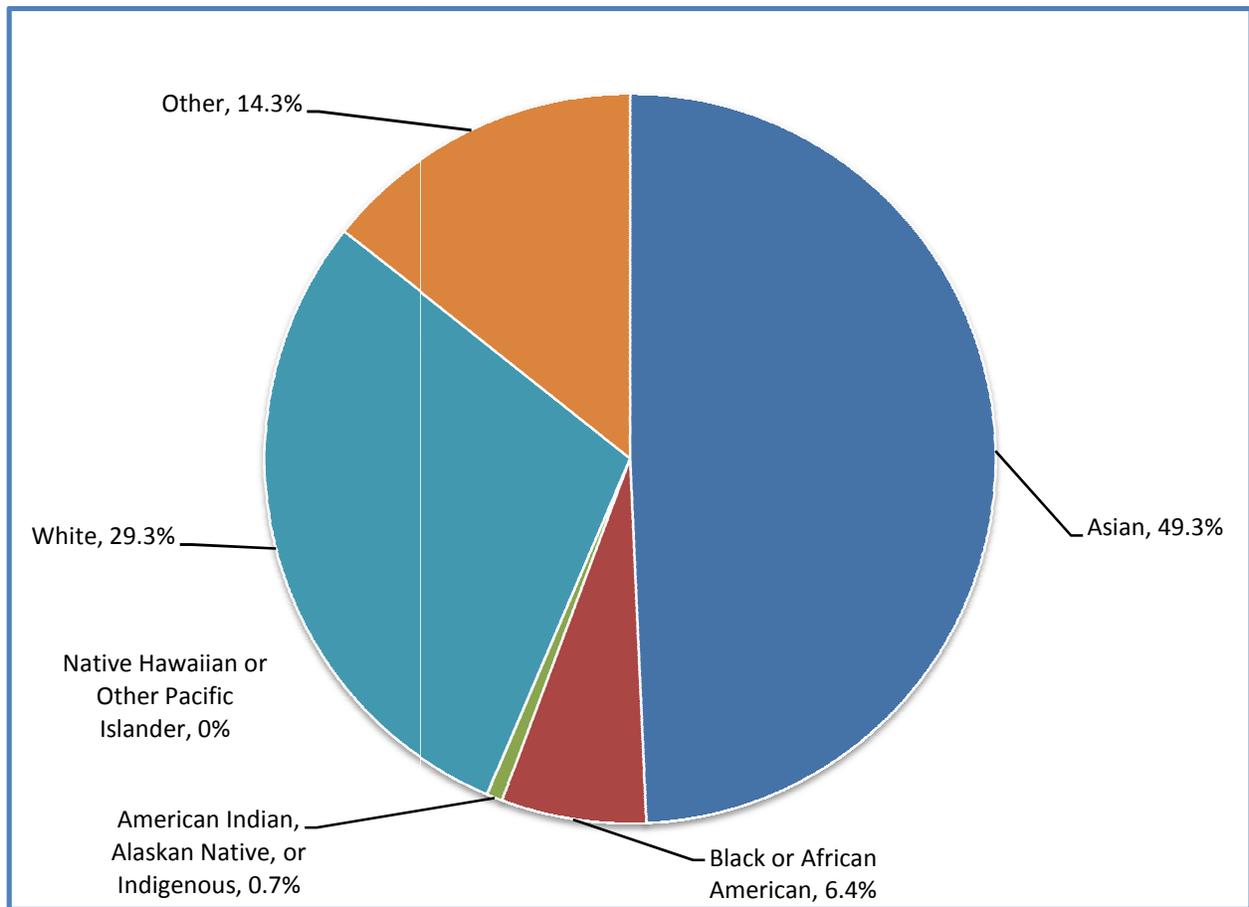


Table 52: Household Income of Manhattan 2 Telephone and Field Survey Participants

Annual Household Income	Manhattan 2	All Regions
\$0-\$10,000	25.8%	21.3%
\$10,001-\$20,000	25.8%	25.6%
\$20,001-\$40,000	15.8%	25.9%
\$40,001-\$60,000	11.7%	13.4%
\$60,001-\$80,000	2.5%	6.0%
\$80,001-\$100,000	5.8%	3.6%
More than \$100,000	12.5%	4.2%

More than half of the participants surveyed (51.6%) reported a household income at or below \$20,000 a year. The average household size is 2.7 people.

SURVEY KEY FINDINGS

Table 53: Survey Key Findings for Manhattan 2

Finding	Manhattan 2	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	69.8%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	84.8%	85.4%
Percentage who now have health insurance	86.2%	74%
Percentage who report having a medical home	75.4%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (37.3%)
2. Needed an appointment sooner than the appointment time offered (20.3%)
3. Doctor or nurse did not spend enough time with us (18.6%)
4. Doctor or nurse did not listen carefully enough (18.6%)
5. Insurance did not pay for what was needed (11.9%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. I get care from a specialist in another neighborhood (70.3%)
2. Was referred to or assigned a doctor or nurse in another neighborhood (56.8%)
3. I do not have confidence in the quality of care I would receive in my neighborhood (43.2%)
4. Prefer a doctor or nurse who is in another neighborhood (40.5%)

5. My doctor or nurse is close to my job or school (21.6%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (62.1%)
2. A doctor or nurse you go to for your basic health care needs (13.8%)
3. Pediatrician/baby doctor (13.8%)
4. Prenatal care/mid-wife/ obstetrician/gynecologist (10.3%)
5. Family planning services (10.3%)

QUEENS 1

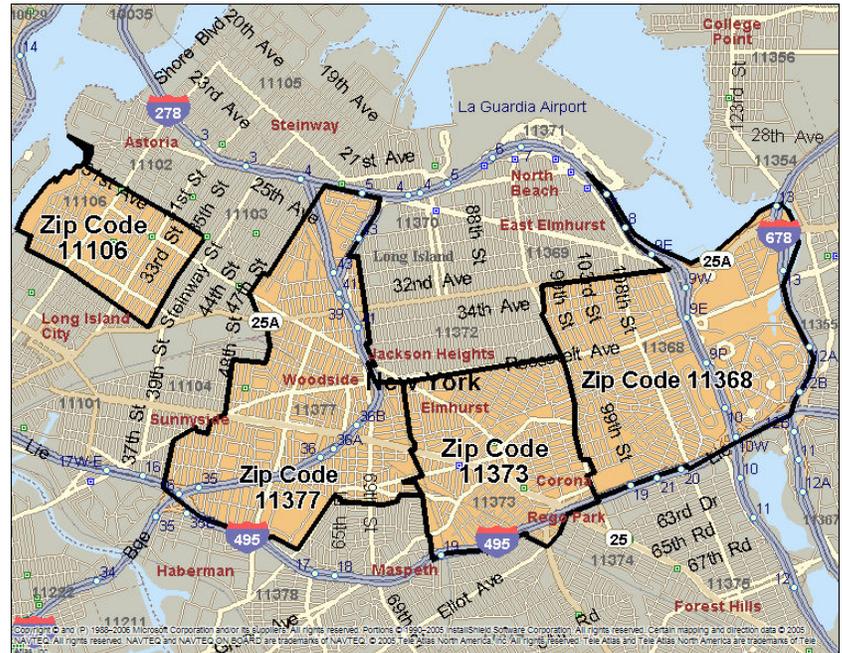
INTRODUCTION

Queens 1 encompasses ZIP codes 11377, 11373, 11368, and 11106 in West Queens.

Map 8 provides an illustration of these ZIP codes. In total, 530 telephone and field surveys were collected in these ZIP codes throughout the communities of Corona, Jackson Heights, Woodside, Elmhurst, Lefrak City, Astoria, and Long Island City.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

Map 8: Queens 1 Region



A random sample of telephone surveys was collected in Queens 1 to obtain a representative sample of the population. In addition, Pragati, Inc. – a community-based organization – collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 54 below.

Table 54: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Queens 1

Targeted Subgroup	# Returned Surveys
Arab	40
Bengali	40
Chinese	35
Filipino	38
Indian	40
Korean	35
Pakistani	38

Table 55: Queens 1 Telephone and Field Survey Participant Demographics

Demographic Category	Queens 1	All Regions
Average age of survey participants	46	44.8
Percentage who are female	61.7%	61%
Average time living in NYC (years)	22.4	23.3
Percentage born outside the United States	74.5%	68%
Percentage who speak a language other than English in their household	63.8%	50.6%
Percentage who report they are a non-White race	75.3%	89%
Percentage who identify themselves as being of Hispanic origin	17.3%	30%

Chart 12: Racial Breakdown of Queens 1 Telephone and Field Survey Respondents

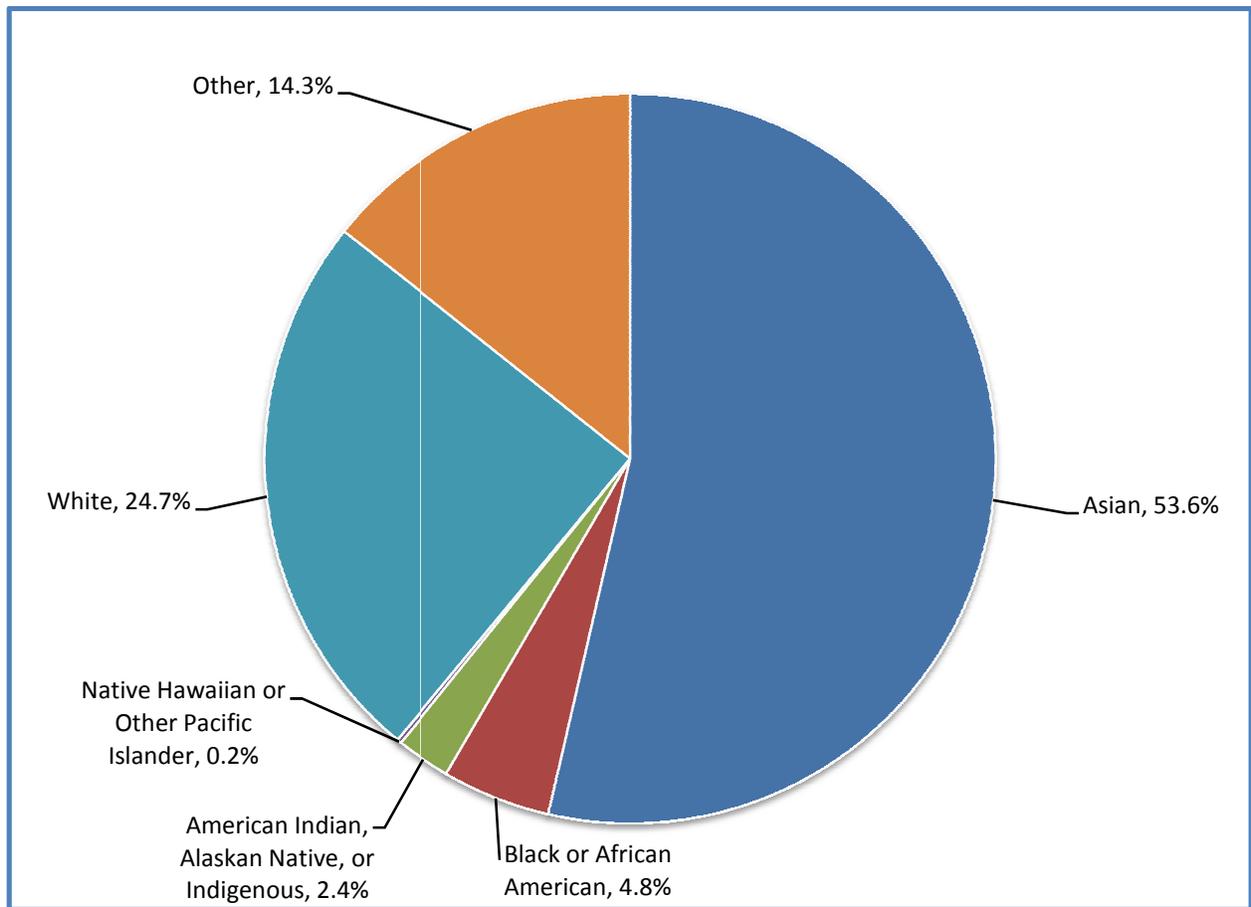


Table 56: Household Income of Queens 1 Telephone and Field Survey Respondents

Annual Household Income	Queens 1	All Regions
\$0-\$10,000	13.3%	21.3%
\$10,001-\$20,000	22.7%	25.6%
\$20,001-\$40,000	26.8%	25.9%
\$40,001-\$60,000	14.6%	13.4%
\$60,001-\$80,000	9.9%	6.0%
\$80,001-\$100,000	4.9%	3.6%
More than \$100,000	7.8%	4.2%

Just over one-third of the participants surveyed (36%) reported a household income at or below \$20,000 a year. The average household size is 2.9 people.

SURVEY KEY FINDINGS

Table 57: Survey Key Findings for Queens 1

Finding	Queens 1	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	46.7%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	78.0%	85.4%
Percentage who now have health insurance	74.5%	74%
Percentage who report having a medical home	60.5%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (39.5%)
2. Needed an appointment sooner than the appointment time offered (22.9%)
3. Doctor or nurse did not spend enough time with us (21.7%)
4. Doctor or nurse did not listen carefully enough (19.7%)
5. Could not afford to pay the bill (19.1%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. I get care from a specialist in another neighborhood (65.0%)
2. Prefer a doctor or nurse in another neighborhood (48.0%)
3. Was referred to or assigned a doctor or nurse in another neighborhood (42.5%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (24.0%)
5. My doctor or nurse is close to my job or school (19.5%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (50.9%)
2. Pediatrician/baby doctor (27.3%)
3. A doctor or nurse you go to for your basic health care needs (23.6%)
4. Prenatal care/mid-wife/ obstetrician/gynecologist (18.2%)
5. Traditional healer (12.7%)

QUEENS 2

INTRODUCTION

Queens 2 encompasses ZIP codes 11436, 11435, and 11434 in Southeast Queens. Map 9 provides an illustration of these ZIP codes. In total, 222 telephone and field surveys were collected in Jamaica/Southeast Queens throughout the communities of South Jamaica, Hollis, St. Albans, and Springfield Gardens.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Queens 2 to obtain a representative sample of the population. In addition, the Queens Health Coalition, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 58 below.

Map 9: Queens 2 Region

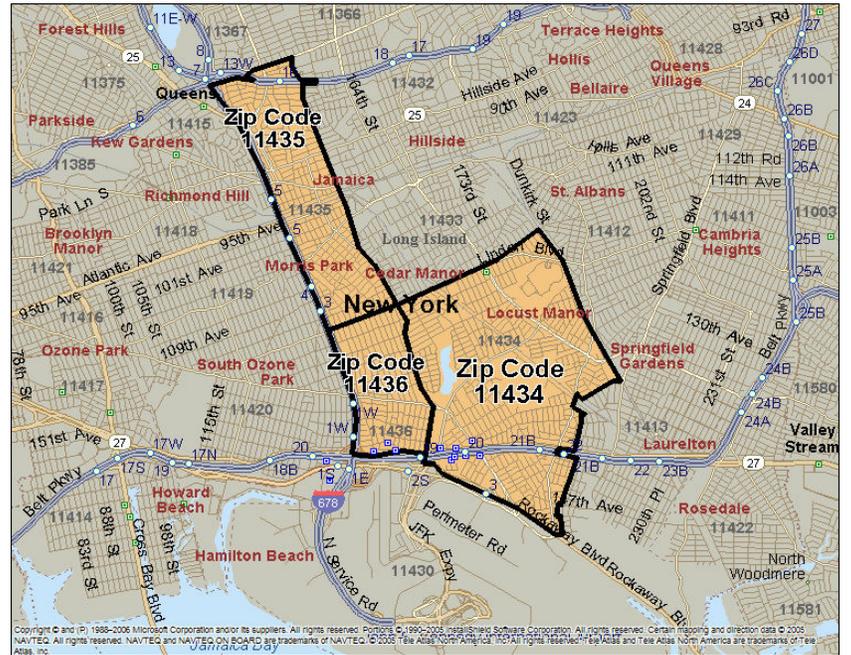


Table 58: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Queens 2

Targeted Subgroup	# Returned Surveys
Jamaicans	37
Haitians	36
Latinos	32

Table 59: Queens 2 Telephone and Field Survey Participant Demographics

Demographic Category	Queens 2	All Regions
Average age of survey participants	43	44.8
Percentage who are female	58.4%	61%
Average time living in NYC (years)	27.6	23.3
Percentage born outside the United States	53.0%	68%
Percentage who speak a language other than English in their household	35.1%	50.6%
Percentage who report they are a non-White race	95.2%	89%
Percentage who identify themselves as being of Hispanic origin	37.4%	30%

Chart 13: Racial Breakdown of Queens 2 Telephone and Field Survey Respondents

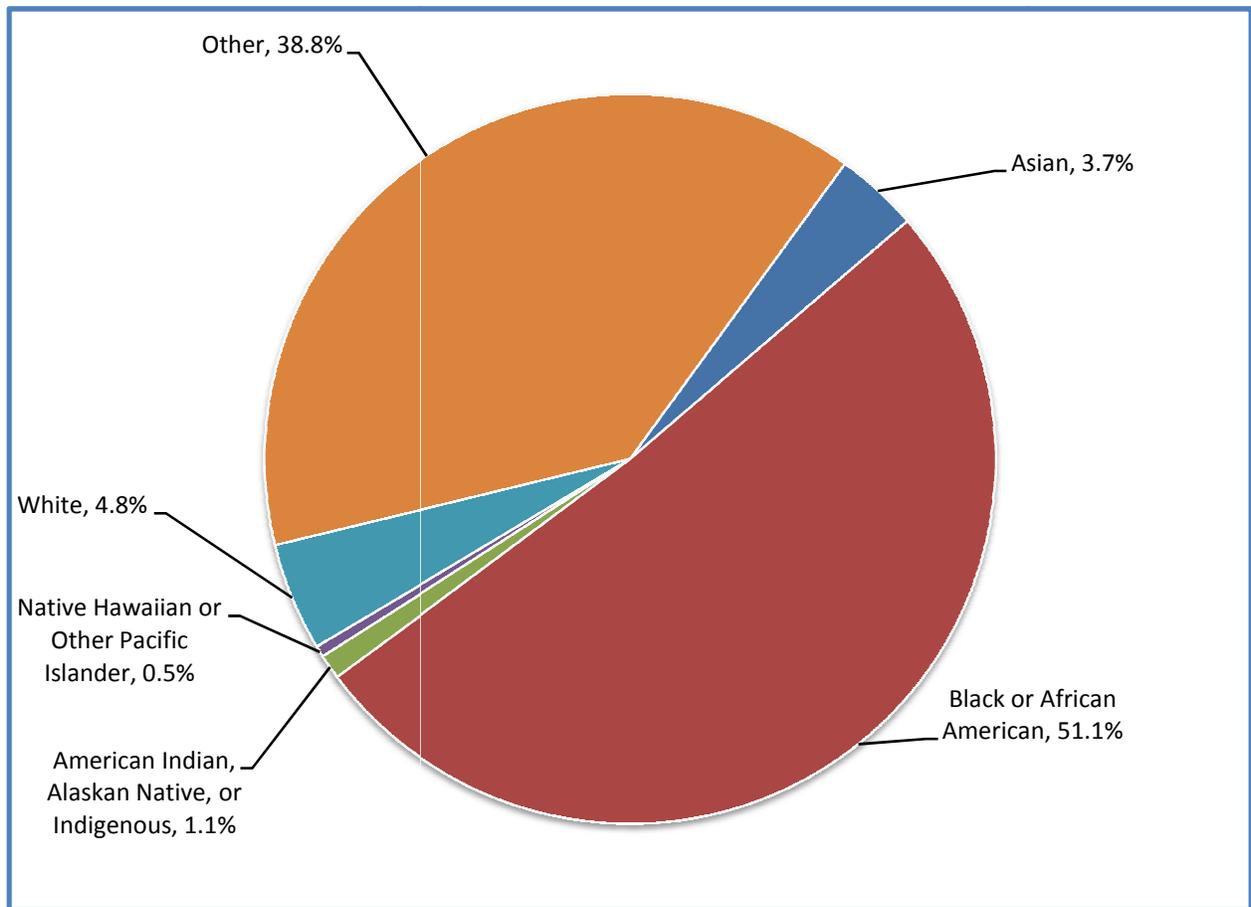


Table 60: Household Income of Queens 2 Telephone and Field Survey Respondents

Annual Household Income	Queens 2	All Regions
\$0-\$10,000	14.9%	21.3%
\$10,001-\$20,000	25.0%	25.6%
\$20,001-\$40,000	23.2%	25.9%
\$40,001-\$60,000	21.4%	13.4%
\$60,001-\$80,000	4.8%	6.0%
\$80,001-\$100,000	6.0%	3.6%
More than \$100,000	4.8%	4.2%

Nearly 40 percent of the participants surveyed (39.9%) reported a household income at or below \$20,000 a year. The average household size is 2.9 people.

SURVEY KEY FINDINGS

Table 61: Survey Key Findings for Queens 2

Finding	Queens 2	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	51.2%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	86.9%	85.4%
Percentage who now have health insurance	75.2%	74%
Percentage who report having a medical home	52.1%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Had to wait too long in the waiting room (39.8%)
2. Needed an appointment sooner than the appointment time offered (32.5%)
3. Their hours were not convenient (25.3%)
4. Doctor or nurse did not spend enough time with us (22.9%)
5. Doctor or nurse did not listen carefully enough (20.5%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. I get care from a specialist in another neighborhood (60.8%)
2. Was referred to or assigned a doctor or nurse in another neighborhood (55.7%)

3. Prefer a doctor or nurse in another neighborhood (53.2%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (24.1%)
5. My doctor or nurse is close to my job or school (24.1%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (55.3%)
2. A doctor or nurse you go to for your basic health care needs (42.6%)
3. Pediatrician/baby doctor (34.0%)
4. Prenatal care/mid-wife/ obstetrician/gynecologist (27.7%)
5. Mental health counselor (27.7%)

QUEENS 3

INTRODUCTION

Queens 3 encompasses ZIP code 11691 in Far Rockaway. Map 10 provides an illustration of the ZIP code. In total, 96 telephone and field surveys were collected in Far Rockaway throughout the communities of Far Rockaway and Edgemere.

INFORMATION ABOUT THE TARGETED SUBGROUPS AND SURVEY RESPONDENTS

A random sample of telephone surveys was collected in Queens 3 to obtain a representative sample of the population. In addition, Rockaway Development and Revitalization Corporation, a community-based organization, collected an equal number of field surveys from specified hard-to-reach populations which the telephone survey did not capture. These populations are listed in Table 62 below.

Map 10: Queens 3 Region



Table 62: Targeted Hard to Reach Populations and Number of Field Surveys Analyzed for Queens 3

Targeted Subgroup	# Returned Surveys
Central Americans	36

Table 63: Queens 3 Telephone and Field Survey Participant Demographics

Demographic Category	Queens 3	All Regions
Average age of survey participants	43.2	44.8
Percentage who are female	69.1%	61%
Average time living in NYC (years)	20	23.3
Percentage born outside the United States	79.6%	68%
Percentage who speak a language other than English in their household	65.6%	50.6%
Percentage who report they are a non-White race	86.1%	89%
Percentage who identify themselves as being of Hispanic origin	62.8%	30%

Chart 14: Racial Breakdown of Queens 3 Telephone and Field Survey Respondents

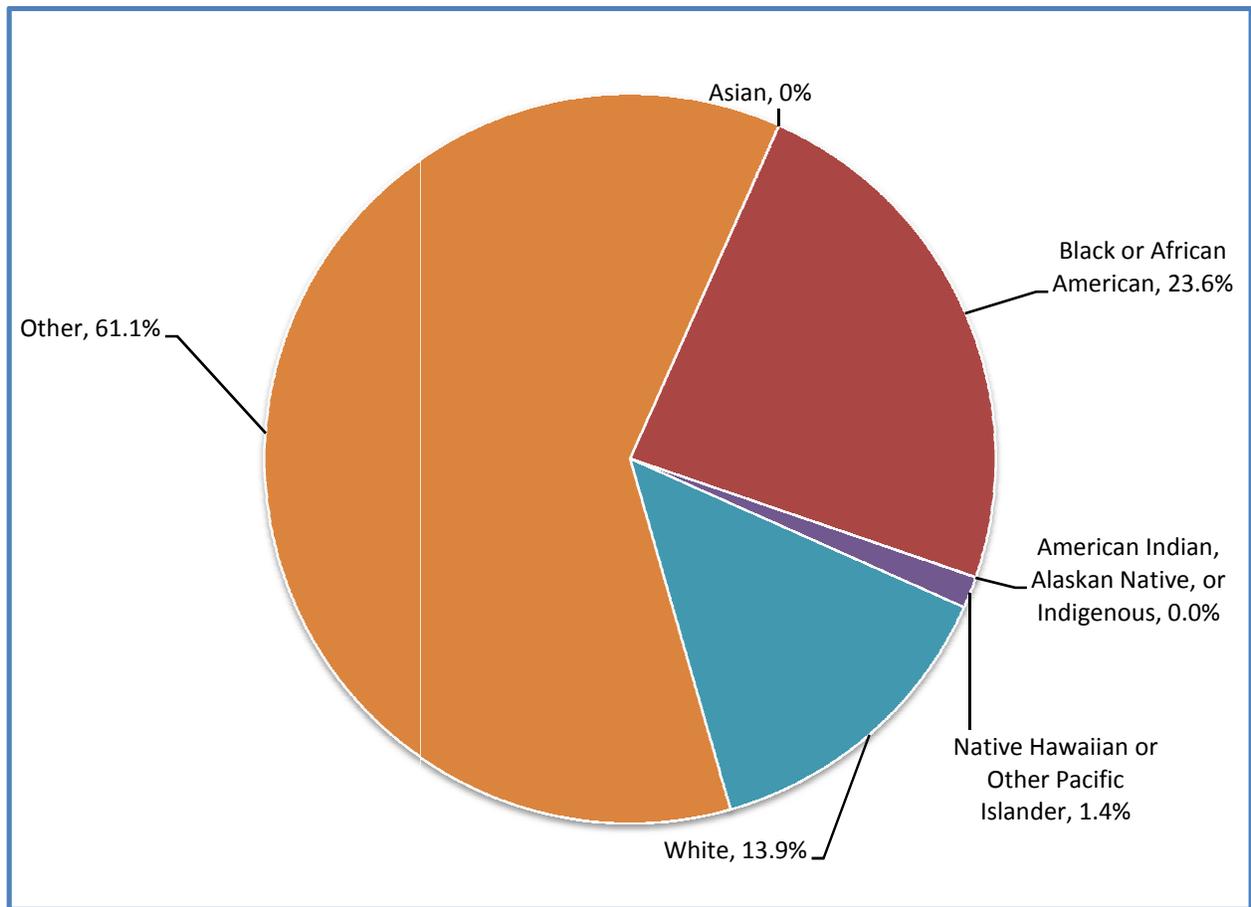


Table 64: Household Income of Queens 3 Telephone and Field Survey Respondents

Annual Household Income	Queens 3	All Regions
\$0-\$10,000	29.6%	21.3%
\$10,001-\$20,000	35.2%	25.6%
\$20,001-\$40,000	14.1%	25.9%
\$40,001-\$60,000	9.9%	13.4%
\$60,001-\$80,000	4.2%	6.0%
\$80,001-\$100,000	2.8%	3.6%
More than \$100,000	4.2%	4.2%

Just under two-thirds of the participants surveyed (64.8%) reported a household income at or below \$20,000 a year. The average household size is 3.8 people.

SURVEY KEY FINDINGS

Table 65: Survey Key Findings for Queens 3

Finding	Queens 3	All Regions
Percentage of participants who report they receive all of their health care in their neighborhood	53.6%	51.7%
Percentage who said it would be most convenient to get their health care in their neighborhood, rather than near work or some other place	88.9%	85.4%
Percentage who now have health insurance	64.2%	74%
Percentage who report having a medical home	41.7%	56%

The top five barriers identified by survey respondents to seeing a doctor or nurse in their neighborhood are:

1. Could not afford the co-pay (36.6%)
2. Could not afford to pay the bill (36.6%)
3. Had to wait too long in the waiting room (31.7%)
4. Did not know we could get a free translator (24.4%)
5. Their hours were not convenient (22.0%)

The top five reasons identified by survey respondents for going outside their neighborhood to see a doctor or nurse are:

1. Prefer a doctor or nurse in another neighborhood (67.7%)
2. I get care from a specialist in another neighborhood (58.1%)
3. Was referred to or assigned a doctor or nurse in another neighborhood (51.6%)
4. I do not have confidence in the quality of care I would receive in my neighborhood (48.4%)

5. My doctor or nurse is close to my job or school (38.7%)

The top five provider categories participants' households have had difficulty accessing in their neighborhood:

1. Dentist (69.2%)
2. A doctor or nurse you go to for your basic health care needs (23.1%)
3. Pediatrician/baby doctor (19.2%)
4. Prenatal care/mid-wife/ obstetrician/gynecologist (19.2%)
5. Mental health counselor (11.5%)

STATEN ISLAND

Please refer to Appendix B: Staten Island Community Health Assessment on page 239 for community survey information for Staten Island presented in August 2007. Results from the Staten Island household survey revealed a high rate of lack of health insurance among respondents from the northern two neighborhoods – Port Richmond and Stapleton/Saint George (ZIP codes 10302 and 10304, respectively). In these ZIP codes, the survey demonstrated high percentages of uninsured respondents, significant percentages of respondents looking for doctors/medical services. In addition to the reported high need for a health center in their community, survey respondents also stated that they would use a health center if one were available to them. While there is a current community health center within reach of residents in Port Richmond (ZIP code 10302), there is a clear need for a second community health center in Stapleton/St. George within reach and accessible by community residents.

Table 66 below illustrates the responses from the Staten Island Community Health Assessment Household Survey in ZIP codes 10302 and 10304. The percentage-based responses are broken out between telephone survey respondents alone (marked “SI Telephone”) compared to telephone survey respondents combined with field survey respondents (marked “SI Combined”).

Table 66: Staten Island Household Survey Results for ZIP Codes 10302 and 10304 – April 2007.

	10302		10304	
	Port Richmond	Stapleton/St. George	Port Richmond	Stapleton/St. George
	SI	SI	SI	SI
	Telephone	Combined	Telephone	Combined
Percentage of respondents without health insurance	0%	3%	14%	17%
Percentage of respondents with children/no children’s health insurance	36%	36%	39%	36%
Percentage of respondents without dental insurance	20%	21%	32%	34%
Percentage of respondents without a primary health provider	2%	3%	8%	15%
Percentage of respondents who would use a health center if available	72%	74%	60%	72%
Need for a health center in your community (Scale of 1 to 5 where 5 is great need)	3.89	3.89	3.73	4.16
Percentage of respondents looking for doctors	10%	12%	18%	28%
Percentage of respondents looking for medical services	18%	20%	24%	38%

Tripp Umbach and FT Solutions, the survey consultants, presented information that included the following:

HOUSEHOLD SURVEY

The survey consultants conducted 602 telephone surveys from residents of Staten Island. Participants were called at random with 50 surveys collected within each of the 12 ZIP codes on Staten Island. The main goal of the survey was to assess the major health needs and issues regarding access to service that face residents of Staten Island. CHCR also collected 93 hand distributed surveys in an attempt to capture responses from the undocumented/underserved immigrant populations on Staten Island. Data for the household survey are reported by phone survey alone and by aggregate of phone and hand distributed surveys.

PROVIDER SURVEY

The survey consultants collected 60 fax surveys of providers throughout Staten Island. The purpose of the survey was to assess the capacity of providers on Staten Island as well as issues related to their payor mix, ability to take on new patients, services to immigrant populations, and the health care needs of the community from the providers' perspective.

SECONDARY DATA REVIEW

The survey consultants used secondary data to supplement the primary survey research conducted with residents and providers. Sources included physician workforce data collected by the Center for Workforce Development, survey research conducted by HHC and CHCR, Claritas demographic data at the Census Tract level, AHA hospital and provider data, and studies conducted by The New York City Department of Health and Mental Hygiene.

ASSET INVENTORY SURVEY

The survey consultants collected 43 surveys via fax, phone, and e-mail from federal, state, and local service agencies providing health and social services to the residents of Staten Island. The purpose of the survey was to identify the capacity of organizations to serve the residents of Staten Island including their abilities to provide language interpretation service to immigrant populations.



Conclusions and Recommendations

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

There is widespread agreement that easy access to primary care – the main vehicle of preventive medicine – is good public policy. Inadequate primary care capacity and access worsens health care status, allows chronic conditions to go unmanaged, and results in more expensive back-end care. Yet, despite the clear advantages of a health care system that promotes preventive care and ensures access to effective primary care, evidence from the Primary Care Initiative community health assessment indicates that the experience of seeking and obtaining primary health care in New York City’s lower income neighborhoods is often a discouraging experience. Rather than reinforcing health seeking behavior, the experience is laden with deterrents.

FINDINGS: OVERARCHING THEMES

Some of the overarching themes identified in the findings from the survey and the discussion groups included:

- People prefer to receive their health care in their neighborhood.
- There are real, or strongly perceived, shortages of specialists and some primary care providers (internists, pediatricians, obstetrician/gynecologists, dentists, and mental health professionals).
- People reported that accessing dental care in their neighborhoods was more difficult than accessing any other type of health care.
- Long waits for appointments to see a doctor and long waits in waiting rooms are major barriers to obtaining health care in the studied neighborhoods.
- The cost of health care or lack of health insurance was cited as a significant impediment to getting health care.
- Respondents find the health system difficult to navigate. They do not know where to obtain reliable information about low-cost health insurance or assistance in becoming insured.
- People reported that interactions with health care providers are unsatisfactory. They are concerned that providers do not listen or spend sufficient time with them. Respondents who speak languages other than English as their primary language identified communication and cultural insensitivity as significant barriers to health care access.

- People reported a need for “one-stop shopping” settings, where primary care providers and specialists could offer better coordinated care.

Discussion group participants highlighted additional problems. For the elderly, finding appropriate and affordable transportation is often challenging, particularly when going to several specialists who are not co-located. Parents with children with physical or developmental disabilities also described the lack of co-located specialists as a barrier to receiving quality care. For example, autistic children can have difficulty adapting to new environments, which is exactly what they must do when visiting specialists in numerous locations. While language access in health care services delivery is critical, many non-English speaking discussion group participants described barriers due to the inadequate provision of translated forms and interpreters and culturally competent care.

Finally, when asked the question about which providers are most difficult to access, 49.7% of all survey respondents and a majority of discussion group participants reported that their neighborhood had an acute need for more dentists. In addition, more than one-third of the survey respondents said their neighborhood needed more primary care doctors. Fifteen percent of survey respondents who answered this question also identified difficulty accessing mental health services. These findings are not surprising in light of the fact that the study’s neighborhoods were, in part, chosen because of their designations as Health Professional Shortage Areas (HPSA). Nevertheless, they are compelling and require action.

Survey and discussion group participants highlighted a wide range of barriers to accessing high quality primary care in their neighborhoods. Fortunately, none are insurmountable. However, the creation of an efficient and effective primary care infrastructure requires investments beyond what the local government can realistically provide.

RECOMMENDATIONS

Primary care capacity in some New York City communities is insufficient and some community residents go without preventive and basic health services. The implementation of a community health assessment is only one element in what necessarily must be a comprehensive agenda to reshape and strengthen New York City’s primary care infrastructure to increase access for all New Yorkers. The findings from the survey and discussion groups provide a blueprint for the work necessary to reduce barriers to accessible and effective primary care. We make the following recommendations based on what we have learned from the voices of more than 3,000 community residents.

1. Primary care capacity needs to be expanded in New York City. The PCI Community Health Assessment findings and other reports show that many communities in New York City lack access to this basic health care service. Primary Care Initiative and HEAL NY primary care funding must be allocated to increase staff capacity and capital development in target

neighborhoods. The PCI Community Health Assessment findings should be used to drive these decisions.

2. Dental and mental health services are sorely lacking in many NYC communities. City/State task force(s) must be convened and charged with devising creative strategies to increase the availability of dental services and mental health services in medically underserved communities. The City's dental schools must be included as part of the solution to this problem. New York State's "Providers Across New York" program must be used to increase dentists and mental health capacity in targeted communities.
3. New York City and the State of New York must combine resources/leverage the availability of local (PCI), state (HEAL NY), and federal (F-SHRP) funding to effectively increase primary care capacity in target communities.
4. PCI funding priority must be given to health centers and other providers that serve low-income uninsured patients, and have in place fee scale policies that facilitate access and assist patients to obtain public health insurance.
5. Investments must be made in health centers and other primary care settings to train front-line and direct care staff in models of patient-centered care. In addition, resources should be made available to health centers and other primary care practices to re-engineer /redesign the patient care experience into one that is patient-centered and creates additional capacity with existing facility and staff resources.

There are proven strategies for re-engineering patient scheduling and patient flow which create capacity, reduce waiting times, create appointment access, facilitate communication between provider (teams) and patients, and increase continuity of patient care. Some health centers/providers may need one-time funding support to implement these strategies.

6. Although low-cost health services, public health insurance, and legal protection through Manny's Law (the New York State law that requires hospitals to establish procedures for providing financial assistance to patients) exist, better efforts must be made to educate particular communities about these resources. Grass roots community-based organizations should be supported so they may expand outreach and educational campaigns to target hard-to-reach groups and promote these resources. PCI and State funding should support these efforts where they are needed most.
7. Funding incentives must be made available for health centers and other primary care providers/organizations to develop or strengthen a culturally and linguistically responsive primary care service infrastructure. Specific incentives could be for:

- a. Recruitment and training costs associated with the expansion of a cadre of culturally and linguistically competent staff and/or interpreters available for face-to-face interactions with patients.
 - b. Increased availability of remote telephone and video interpretation resources, if face-to-face skilled interpretation is not available, within primary care settings.
 - c. Development of mechanisms to coordinate/integrate language access services into program operations (e.g. creating flags in the scheduling system that alert staff of the need of patients requiring language access/interpreter services; embedding in reminder call mechanisms questions concerning language preference; etc.).
 - d. Development of curriculum for and skills training of the primary care workforce in patient centered care, cultural competency, linguistic proficiency and sensitivity to individuals with special needs (NYC's 311 system should make information available concerning providers that have completed the above-referenced skills training curriculum).
8. Resources must be made available to assist health centers/providers in providing self management support (e.g. education, care plans, etc.) for patients with special needs and/or chronic conditions. New funding may support ancillary staff or other means of making self-management resources available to patients.
 9. Start up funding must be provided to expand capacity (e.g., specialists' hours; multi-specialty coordinated team practices, mental health consultation services, etc.) within existing primary care settings to address the service requirements of special needs populations.
 10. Funding must be provided to support ancillary expenses associated with the coordination/integration of services for special needs patients into program operations (e.g., patient navigators; peer support; accommodation forms completed at registration or other methods that alert staff to the special needs of the patients; staff training, etc.)
 11. Resources should be made available to health centers and other primary care providers for technical assistance which helps them maximize earned revenue (i.e., to obtain all of the funding they are entitled to from third party payers). Improved financial performance will enhance centers'/practices' sustainability thus helping them serve low-income communities.
 12. Health centers' or other providers' should implement electronic, web-based, or other non-traditional methods of communicating with patients to increase access and facilitate improved provider/patient interaction; PCI resources could be used to support this initiative.

13. Funding should be made available for community-based organizations to implement a campaign that promotes the availability of prescription assistance programs (and how to obtain) to residents in high-need, underserved communities.
14. Funding should be provided to health centers and other providers for the installation of Assisted Listening Devices and other forms of technology that facilitate access to effective primary care by patients who are deaf or hearing impaired.



Appendix A: Key Survey Findings

APPENDIX A: KEY SURVEY FINDINGS

INTRODUCTION

The tables and charts presented in this Appendix are key demographic and survey findings from all regions combined and individual communities included in the survey.

GUIDE TO ANNOTATIONS

Tripp Umbach completed statistical significance testing (95% confidence interval) for the highest responses received in each non-demographic survey question. If a response is significantly higher than one in its group, a red notation will be made above the survey finding in the table. Below is a detailed explanation of how to interpret the statistical significance findings.

Table 67: Guide to Key Survey Finding Annotations

Notation	Explanation
All	The percentage point is significantly higher than the rest of the percentage points within the same column.
BCD	The percentage point is significantly higher than only the percentage points in rows B, C, and D within the same column.
BDE	The percentage point is significantly higher than only the percentage points in rows B, D, and E within the same column.
C	The percentage point is significantly higher than only the percentage point in row C within the same column.
CDE	The percentage point is significantly higher than only the percentage points in rows C, D, and E within the same column.
DE	The percentage point is significantly higher than only the percentage points in rows D and E within the same column.
E	The percentage point is significantly higher than only the percentage point in row E within the same column.

AGE AND GENDER

The average respondent is 44.8 years of age. 60% of the respondents are female.

Exhibit 1: Age – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,919	280	505	516	211	82	294	561	165	158	147
Average age of adult survey participant	44.8	47.5	45.8	46.0	43.0	43.2	41.9	43.0	43.6	45.2	49.4
Average age of child survey participant	8.9	8.7	9.1	9.7	8.7	7.9	8.2	8.7	8.6	10.4	7.3

Exhibit 2: Gender – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,996	287	510	528	219	94	300	573	170	163	152
Female	60.4%	60.6%	56.5%	61.7%	58.4%	69.1%	65.7%	56.5%	67.1%	54.0%	69.7%
Male	39.4%	39.4%	43.3%	38.3%	41.6%	30.9%	34.0%	42.6%	32.9%	46.0%	30.3%
Transgender Female to Male	.1%	0%	.2%	0%	0%	0%	0%	.5%	0%	0%	0%
Transgender Male to Female	.1%	0%	0%	0%	0%	0%	0%	.3%	0%	0%	0%

EDUCATIONAL LEVEL

More than half (56.1%) of respondents have a high school diploma or less.

Exhibit 3: Highest Level of Education Completed – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,921	267	500	511	218	91	293	564	166	160	151
Not a high school graduate	26.0%	35.2%	20.2%	16.6%	13.8%	44.0%	37.2%	22.5%	27.7%	46.9%	34.4%
High school graduate or GED	30.1%	27.7%	33.0%	29.0%	30.3%	25.3%	27.6%	33.5%	38.6%	25.6%	19.2%
Some college, no degree	17.3%	19.1%	14.8%	15.9%	28.4%	11.0%	16.0%	22.2%	13.3%	10.0%	10.6%
Associates degree or certificate from vocational, business, or trade school	8.5%	7.1%	7.8%	8.6%	13.3%	3.3%	6.8%	11.2%	7.8%	3.8%	7.9
Bachelors degree or higher	17.6%	10.9%	24.2%	29.0%	14.2%	16.5%	11.9%	9.4%	12.0%	13.1%	27.8%

COUNTRY OF BIRTH

More than two thirds (67.8%) of the respondents are foreign born.

Exhibit 4: Country of Birth – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,858	257	502	510	213	93	289	525	159	159	151
United States	32.2%	34.2%	31.3%	25.5%	46.9%	20.4%	27.7%	43.0%	13.8%	32.1%	31.1%
Non-U.S.	67.8%	65.8%	68.7%	74.5%	53.1%	79.6%	72.3%	57%	86.2%	67.9%	68.9%

TOP TEN NON-US COUNTRIES OF BIRTH

Exhibit 5: Top Ten Non-US Countries of Birth – Telephone and Field Survey Residents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Mexico	5.7%	5.4%	.6%	3.5%	1.9%	0%	14.9%	4.8%	15.7%	19.5%	0%
Dominican Republic	5.1%	3.5%	4.4%	1.0%	5.6%	3.2%	13.8%	5.3%	2.5%	8.8%	6.6%
China	4.7%	0%	6.2%	4.1%	0%	0%	6.2%	1.0%	0%	14.5%	23.2%
Jamaica	3.8%	1.6%	3.2%	.2%	5.2%	5.4%	6.9%	7.4%	6.9%	.6%	0%
Haiti	3.5%	.4%	.2%	.2%	16.4%	1.1%	0%	6.9%	15.7%	0%	0%
Puerto Rico	3.3%	11.7%	1.8%	.6%	2.3%	4.3%	2.8%	3.0%	1.9%	3.1%	7.3%
Ecuador	2.6%	1.2%	.4%	3.3%	3.3%	2.2%	10.4%	1.7%	1.3%	.6%	1.3%
Philippines	2.4%	.8%	4.8%	8.2%	0%	0%	.3%	0%	0%	0%	0%
Yemen	2.4%	0%	6.2%	1.0%	0%	0%	0%	0%	4.0%	6.9%	0%
Bangladesh	2.1%	.8%	1.0%	9.6%	.5%	0%	0%	.6%	0%	0%	.7%

AVERAGE NUMBER OF YEARS IN THE UNITED STATES/AVERAGE NUMBER OF YEARS IN NEW YORK CITY

Residents have lived in NYC 23.3 years on average.

Exhibit 6: Average Number of Years in the US/NYC -- Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Average years living in US	25.7	30.0	25.1	24.8	30.3	21.1	23.2	26.3	20.5	25.3	29.1
Average years living in NYC	23.3	27.0	22.7	22.4	27.6	20.0	21.1	24.4	19.2	21.7	23.9

RACE

88.6% of respondents were non-White.

Exhibit 7: Race – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,542	204	428	461	188	72	270	476	153	150	140
Asian	21.6%	2.0%	36.0%	53.6%	3.7%	0%	10.0%	3.2%	1.3%	16.7%	49.3%
Black or African American	40.1%	67.6%	39.5%	4.8%	51.1%	23.6%	33.0%	68.7%	58.2%	42.7%	6.4%
Native Hawaiian or Other Pacific Islander	1.1%	1.0%	1.2%	2.4%	.5%	1.4%	.4%	1.1%	0%	.7%	0%
American Indian, Alaskan Native, or Indigenous	.8%	2.0%	1.2%	.2%	1.1%	0%	1.5%	.6%	0%	0%	.7%
White	11.4%	5.4%	8.9%	24.7%	4.8%	13.9%	9.6%	3.6%	7.2%	8.7%	29.3%
Something else	25.0%	22.0%	13.2%	14.3%	38.8%	61.1%	45.5%	22.8%	33.3%	31.2%	14.3%

Exhibit 8: Percentage of Hispanic Origin – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,630	241	438	444	206	78	275	480	163	159	146
Yes	30.1%	35.3%	14.8%	17.3%	37.4%	62.8%	52.0%	27.1%	44.2%	37.1%	24.0%
No	69.9%	64.7%	85.2%	82.7%	62.6%	37.2%	48.0%	72.9%	55.8%	62.9%	76.0%

ETHNICITY

Exhibit 9: Ten Most Reported Ethnicities – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,285	222	373	404	166	79	240	420	117	128	136
Hispanic	19.1%	19.4%	9.9%	7.9%	28.3%	65.8%	34.2%	20.2%	23.9%	8.6%	14.0%
Black	14.2%	28.4%	12.9%	1.7%	18.7%	6.3%	18.8%	22.6%	15.4%	9.4%	.7%
African American	11.4%	12.6%	13.4%	1.5%	10.2%	6.3%	9.6%	21.9%	15.4%	13.3%	2.9%
Chinese	5.5%	0%	8.3%	5.9%	0%	0%	8.8%	1.0%	0%	6.3%	27.2%
Haitian	2.8%	.5%	0%	.2%	18.1%	0%	0%	4.0%	13.7%	0%	0%
White	2.8%	.9%	1.9%	5.2%	1.8%	2.5%	2.5%	.5%	1.7%	2.3%	11.0%
Filipino	2.7%	0%	7.5%	8.4%	0%	0%	0%	0%	0%	0%	0%
African	2.7%	7.2%	5.6%	1.5%	1.8%	0%	.4%	1.4%	4.3%	2.3%	0%
Asian	2.7%	.5%	1.3%	7.4%	.6%	0%	.8%	.7%	0%	13.3%	1.5%
Korean	2.5%	0%	6.2%	8.7%	0%	0%	0%	0%	0%	0%	0%

LIVING PATTERNS

3.9% of the respondents have been homeless in the last 12 months.

Exhibit 10: Percentage Reporting Homeless in the Last 12 Months/Average # of Times Moved in the Last 12 Months – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,752	241	467	457	201	94	289	538	161	154	150
Yes	3.9%	3.3%	2.6%	1.1%	6.5%	3.2%	6.2%	6.1%	6.2%	1.9%	2.0%
No	95.6%	96.3%	97.2%	98.5%	93.5%	96.8%	91.7%	93.9%	93.2%	97.4%	98.0%
Average number of times moved in last 12 months	.4	.4	.3	.3	.3	.4	.5	.5	.6	.3	.4

LANGUAGE SPOKEN AT HOME

50.6% of the respondents speak a language other than English.

Exhibit 11: Ten Most Reported Languages Spoken at Home – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,886	256	490	517	211	93	296	556	160	155	152
English	49.4%	53.1%	46.3%	36.2%	64.9%	34.4%	46.6%	67.3%	46.9%	41.3%	36.8%
Spanish	22.2%	30.1%	8.8%	11.4%	22.3%	62.4%	42.2%	20.0%	29.4%	30.3%	17.1%
Arabic	4.6%	0%	11.6%	7.2%	0%	0%	0%	4.7%	8.1%	0%	0%
Bengali	2.1%	.8%	1.0%	9.7%	0%	0%	0%	.5%	0%	0%	.7%
Korean	2.0%	0%	4.7%	6.8%	0%	0%	0%	0%	0%	0%	0%
Chinese	1.8%	0%	5.5%	1.0%	0%	0%	1.7%	1.6%	0%	3.2%	1.3%
French	1.8%	9.4%	2.0%	.4%	.9%	0%	0%	.5%	1.9%	4.5%	0%
Creole	1.6%	0%	0%	0%	.9%	1.1%	0%	4.3%	12.5%	0%	0%
Vietnamese	1.4%	0%	6.1%	0%	0%	0%	0%	0%	0%	0%	6.6%
Tagalog	1.3%	0%	1.4%	5.6%	0%	0%	.3%	0%	0%	0%	0%

HOUSEHOLD SIZE AND INCOME

46.9% of respondents reported a household income of \$20,000 or below.

Exhibit 12: Average Household Size – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total answering	2,787	207	494	497	213	91	287	525	161	160	152
Average Household Size	2.9	2.7	2.9	2.9	2.9	3.8	3.0	2.9	3.0	2.8	2.7

Exhibit 13: Annual Household Income – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,169	173	355	384	168	71	226	448	117	107	120
\$0-\$10,000	21.3%	20.2%	23.1%	13.3%	14.9%	29.6%	21.2%	22.5%	32.5%	29.0%	25.8%
\$10,001-\$20,000	25.6%	28.9%	25.6%	22.7%	25.0%	35.2%	31.4%	22.1%	26.5%	26.2%	25.8%
\$20,001-\$40,000	25.9%	30.6%	22.8%	26.8%	23.2%	14.1%	27.9%	32.1%	22.2%	21.5%	15.8%
\$40,001-\$60,000	13.4%	7.5%	15.8%	14.6%	21.4%	9.9%	10.6%	14.5%	6.8%	10.3%	11.7%
\$60,001-\$80,000	6.0%	6.9%	7.3%	9.9%	4.8%	4.2%	4.4%	4.7%	3.4%	5.6%	2.5%
\$80,001-\$100,000	3.6%	5.2%	2.3%	4.9%	6.0%	2.8%	3.1%	1.6%	4.3%	3.7%	5.8%
More than \$100,000	4.2%	.6%	3.1%	7.8%	4.8%	4.2%	1.3%	2.5%	4.3%	3.7%	12.5%

EMPLOYMENT

Almost half (49.4%) of the respondents work 35 + hours per week.

Exhibit 14: Employment Status – Telephone and Field Survey Respondents

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,607	201	472	449	206	81	249	493	151	154	151
Work 35+ hours/week only for wages	38.2%	29.4%	38.6%	35.2%	37.9%	45.7%	32.5%	47.3%	35.1%	44.2%	30.5%
Work 35+ hours/week only self-employed	8.8%	10.4%	10.2%	10.2%	4.9%	9.9%	6.8%	6.7%	7.9%	14.3%	7.9%
Work 35+ hours/week for wages and self-employed	2.4%	8.5%	2.1%	.9%	1.0%	0%	2.8%	3.4%	2.6%	1.3%	0%
Work less than 35 hours per week: only work for wages	8.9%	7.0%	9.3%	8.0%	11.2%	11.1%	12.9%	8.1%	8.6%	3.2%	11.3%
Work less than 35 hours per week: only self-employed	3.3%	1.0%	2.8%	3.3%	3.4%	2.5%	6.0%	2.6%	4.0%	4.5%	4.6%
Work less than 35 hours per week: combined self-employed and work for wages	1.3%	1.0%	.6%	1.6%	1.5%	2.5%	.4%	1.2%	1.3%	2.6%	2.6%
Day laborer	2.2%	0%	1.9%	2.7%	1.5%	0%	3.2%	.2%	0%	3.2%	13.2%
Unemployed less than 1 year	4.7%	2.0%	5.5%	2.9%	9.2%	1.2%	6.4%	4.1%	5.3%	4.5%	5.3%
Unemployed 1 year or more	6.1%	6.0%	4.9%	7.1%	3.9%	3.7%	8.0%	6.3%	8.6%	3.9%	6.6%
Student	2.5%	1.5%	2.1%	3.1%	4.9%	1.2%	3.2%	2.4%	5.3%	0%	0%
Student, not working	2.7%	2.0%	4.2%	3.6%	3.4%	0%	1.6%	1.2%	4.6%	.6%	3.3%
Retired	15.7%	20.9%	14.6%	18.5%	18.4%	14.8%	12.0%	12.0%	13.2%	13.6%	22.5%
Disabled	5.3%	10.0%	6.8%	2.4%	3.4%	6.2%	5.2%	5.7%	4.0%	5.2%	5.3%

TOP FIVE BARRIERS TO SEEING A DOCTOR OR NURSE IN NEIGHBORHOOD

“Waiting too long for services,” “quality of care,” and “affordability of services” are the top barriers to accessing care. NOTE: ALL “TOP FIVE BARRIERS” TABLES ARE MULTIPLE RESPONSE TABLES. THE PERCENTAGES EXCEED 100%

Exhibit 15: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, All Regions

Reason		% All Regions
Total Answering		974
A	Had to wait too long in the waiting room	All ²⁷ 42.7%
B	Needed an appointment sooner than the appointment time offered	31.3%
C	Doctor or nurse did not spend enough time with us	23.6%
D	Could not afford to pay the bill	20.8%
E	Doctor or nurse did not listen carefully enough	20.2%

Exhibit 16: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Bronx 1

Reason		% Bronx 1
Total Answering		88
A	Had to wait too long in the waiting room	DE 43.2%
B	Needed an appointment sooner than the appointment time offered	37.5%
C	Doctor or nurse did not spend enough time with us	29.5%
D	Doctor or nurse did not listen carefully enough	26.1%
E	Could not afford to pay the bill	22.7%

Exhibit 17: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Bronx 2

Reason		% Bronx 2
Total Answering		155
A	Had to wait too long in the waiting room	CDE 47.1%
B	Needed an appointment sooner than the appointment time offered	36.8%
C	Could not afford to pay the bill	23.2%
D	Doctor or nurse did not spend enough time with us	21.3%
E	Insurance did not pay for what was needed	20.0%

²⁷ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

Exhibit 18: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Queens 1

Reason		% Queens 1
Total Answering		157
A	Had to wait too long in the waiting room	All ²⁸ 39.5%
B	Needed an appointment sooner than the appointment time offered	22.9%
C	Doctor or nurse did not spend enough time with us	21.7%
D	Doctor or nurse did not listen carefully enough	19.7%
E	Could not afford to pay the bill	19.1%

Exhibit 19: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Queens 2

Reason		% Queens 2
Total Answering		83
A	Had to wait too long in the waiting room	CDE 39.8%
B	Needed an appointment sooner than the appointment time offered	32.5%
C	Their hours were not convenient	25.3%
D	Doctor or nurse did not spend enough time with us	22.9%
E	Doctor or nurse did not listen carefully enough	20.5%

Exhibit 20: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Queens 3

Reason		% Queens 3
Total Answering		41
A	Could not afford the co-pay	36.6%
B	Could not afford to pay the bill	36.6%
C	Had to wait too long in the waiting room	31.7%
D	Did not know we could get a free translator	24.4%
E	Their hours were not convenient	22.0%

²⁸ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

Exhibit 21: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Brooklyn 1

Reason		% Brooklyn 1
Total Answering		105
A	Had to wait too long in the waiting room	CDE ²⁹ 45.7%
B	Needed an appointment sooner than the appointment time offered	33.3%
C	Doctor or nurse did not spend enough time with us	23.8%
D	Could not afford to pay the bill	19.0%
E	Doctor or nurse no longer accepted our insurance	19.0%

Exhibit 22: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Brooklyn 2

Reason		% Brooklyn 2
Total Answering		178
A	Had to wait too long in the waiting room	CDE 39.3%
B	Needed an appointment sooner than the appointment time offered	28.1%
C	Doctor or nurse did not spend enough time with us	22.5%
D	Could not afford to pay the bill	21.9%
E	Doctor or nurse did not listen carefully enough	19.1%

Exhibit 23: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Brooklyn 3

Reason		% Brooklyn 3
Total Answering		68
A	Had to wait too long in the waiting room	CDE 54.4%
B	Needed an appointment sooner than the appointment time offered	42.6%
C	Doctor or nurse did not spend enough time with us	32.4%
D	Doctor or nurse did not listen carefully enough	29.4%
E	Could not afford to pay the bill	26.5%

²⁹ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

Exhibit 24: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Manhattan 1

Reason		% Manhattan 1
Total Answering		40
A	Had to wait too long in the waiting room	CDE ³⁰ 50.0%
B	Needed an appointment sooner than the appointment time offered	32.5%
C	Doctor or nurse did not spend enough time with us	27.5%
D	They did not return our telephone call	25.0%
E	Doctor or nurse did not listen carefully enough	20.0%

Exhibit 25: Top Five Barriers to Seeing a Doctor or Nurse in My Neighborhood – Telephone and Field Survey Respondents, Manhattan 2

Reason		% Manhattan 2
Total Answering		59
A	Had to wait too long in the waiting room	All 37.3%
B	Needed an appointment sooner than the appointment time offered	20.3%
C	Doctor or nurse did not spend enough time with us	18.6%
D	Doctor or nurse did not listen carefully enough	18.6%
E	Insurance did not pay for what was needed	11.9%

³⁰ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

TOP FIVE PROVIDER TYPES DIFFICULT TO ACCESS IN THEIR NEIGHBORHOOD

Dentists, primary care providers, and pediatricians are the most difficult to access in the respondents' neighborhood.

Exhibit 26: Five Most Frequently Reported Provider Types that are Difficult to Access in My Neighborhood – Telephone and Field Surveys

		All Regions ³¹	Bx1 ³²	Bx2 ³³	Qns1 ³⁴	Qns2 ³⁵	Qns3 ³⁶	Bk1 ³⁷	Bk2 ³⁸	Bk3 ³⁹	Man1 ⁴⁰	Man2 ⁴¹
Total Answering		620	75	99	110	47	26	61	119	28	26	29
A	Dentist	All ⁴² 49.7%	BCD 41.3%	All 48.5%	All 50.9%	CDE 55.3%	All 69.2%	DE 47.5%	CDE 47.1%	All 53.6%	CDE 42.3%	All 62.1%
B	A doctor or nurse you go to for your basic health care needs	30.8%	25.3%	29.3%	23.6%	42.6%	23.1%	41.0%	37.0%	25.0%	CDE 42.3%	13.8%
C	Pediatrician/baby doctor	22.1%	14.7%	18.2%	27.3%	34.0%	19.2%	31.1%	24.4%	7.1%	11.5%	13.8%
D	Prenatal care/mid-wife/ob/gyn	17.6%	16.0%	9.1%	18.2%	27.7%	19.2%	27.9%	19.3%	10.7%	15.4%	10.3%
E	Mental health counselor	14.8%	29.3%	10.1%	10.0%	27.7%	11.5%	9.8%	12.6%	25.0%	11.5%	6.9%

³¹ This Exhibit lists the top five answers for all PCI Community Health Assessment regions *combined*. Results for the individual regions are presented here to be compared against the “All Regions” figure. Results for the individual regions may or may not be the actual “top five” response for that region.

³² See Survey Key Findings for Bronx 1 beginning on page 159 for more details.

³³ See Survey Key Findings for Bronx 2 beginning on on page 163 for more details.

³⁴ See Survey Key Findings for Queens 1 beginning on page 187 for more details.

³⁵ See Survey Key Findings for Queens 2 beginning on page 191 for more details.

³⁶ See Survey Key Findings for Queens 3 beginning on page 195 for more details.

³⁷ See Survey Key Findings for Brooklyn 1 beginning on page 167 for more details.

³⁸ See Survey Key Findings for Brooklyn 2 beginning on page 171 for more details.

³⁹ See Survey Key Findings for Brooklyn 3 beginning on page 175 for more details.

⁴⁰ See Survey Key Findings for Manhattan 1 beginning on page 179 for more details.

⁴¹ See Survey Key Findings for Manhattan 2 beginning on page 183 for more details.

⁴² See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

ACCESSING HEALTH CARE IN THE NEIGHBORHOOD

More than half (51.7%) of respondents are getting all of their health care services in their neighborhoods.

Exhibit 27: Portion of My Health Care that I Obtain in My Neighborhood – Telephone and Field Surveys

Portion of Health Care Obtains in My Neighborhood	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,179	209	376	398	166	69	199	412	124	97	129
All	All ⁴³ 51.7%	All 58.4%	All 52.9%	All 46.7%	All 51.2%	All 53.6%	All 45.2%	All 42.5%	All 66.9%	All 60.8%	All 69.8%
More than half	6.7%	4.3%	8.8%	7.0%	5.4%	11.6%	10.1%	5.1%	5.6%	4.1%	6.2%
About half	4.0%	2.4%	4.0%	4.8%	1.8%	2.9%	3.5%	4.9%	5.6%	7.2%	1.6%
Less than half	7.3%	5.3%	7.2%	6.8%	7.8%	2.9%	12.1%	10.0%	3.2%	5.2%	3.9%
None	30.3%	29.7%	27.1%	34.7%	33.7%	29.0%	29.1%	37.6%	18.5%	22.7%	18.6%

TOP FIVE REASONS FOR GETTING HEALTH CARE OUTSIDE OF THE NEIGHBORHOOD

“I get care from a specialist in another neighborhood” was the top reason for getting health care outside of the neighborhood.

Exhibit 28: Five Most Reported Reasons for Seeking Care Outside of My Neighborhood – Telephone and Field Surveys

Reason	All Regions ⁴⁴	Bx1 ⁴⁵	Bx2 ⁴⁶	Qns1 ⁴⁷	Qns2 ⁴⁸	Qns3 ⁴⁹	Bk1 ⁵⁰	Bk2 ⁵¹	Bk3 ⁵²	Man1 ⁵³	Man2 ⁵⁴
Total Answering	991	85	165	200	79	31	102	219	39	34	37
A I get care from a specialist in another neighborhood	All 56.7%	All 60.0%	50.3%	All 65.0%	DE 60.8%	58.1%	E 45.1%	DE 57.1%	41.0%	DE 55.9%	BDE 70.3%
B Prefer a doctor or nurse in another neighborhood	48.2%	37.6%	52.1%	48.0%	53.2%	E 67.7%	40.2%	50.7%	46.2%	47.1%	40.5%

⁴³ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

⁴⁴ This Exhibit lists the top five answers for all PCI Community Health Assessment regions *combined*. Results for the individual regions are presented here to be compared against the “All Regions” figure. Results for the individual regions may or may not be the actual “top five” response for that region.

⁴⁵ See Survey Key Findings for Bronx 1 beginning on page 159 for more details.

⁴⁶ See Survey Key Findings for Bronx 2 beginning on on page 163 for more details.

⁴⁷ See Survey Key Findings for Queens 1 beginning on page 187 for more details.

⁴⁸ See Survey Key Findings for Queens 2 beginning on page 191 for more details.

⁴⁹ See Survey Key Findings for Queens 3 beginning on page 195 for more details.

⁵⁰ See Survey Key Findings for Brooklyn 1 beginning on page 167 for more details.

⁵¹ See Survey Key Findings for Brooklyn 2 beginning on page 171 for more details.

⁵² See Survey Key Findings for Brooklyn 3 beginning on page 175 for more details.

⁵³ See Survey Key Findings for Manhattan 1 beginning on page 179 for more details.

⁵⁴ See Survey Key Findings for Manhattan 2 beginning on page 183 for more details.

Primary Care Initiative
 Community Health Assessment
 Appendix A: Key Survey Findings

Reason		All Regions ⁴⁴	Bx1 ⁴⁵	Bx2 ⁴⁶	Qns1 ⁴⁷	Qns2 ⁴⁸	Qns3 ⁴⁹	Bk1 ⁵⁰	Bk2 ⁵¹	Bk3 ⁵²	Man1 ⁵³	Man2 ⁵⁴
C	Was referred to or assigned a doctor or nurse in another neighborhood	47.9%	38.8%	53.3% DE	42.5%	55.7%	51.6%	43.1%	51.6%	43.6%	41.2%	56.8%
D	I do not have confidence in the quality of care I would receive in my neighborhood	29.1%	30.6%	30.3%	24.0%	24.1%	48.4%	35.3%	25.1%	30.8%	32.4%	43.2%
E	My doctor or nurse is close to my job or school	24.0%	10.6%	38.2%	19.5%	24.1%	38.7%	26.5%	19.6%	25.6%	23.5%	21.6%

TOP FIVE MAIN REASONS FOR GETTING HEALTH CARE OUTSIDE OF THE NEIGHBORHOOD

The main reasons respondents seek health care outside of their neighborhood include preference for another provider and seeking care from a specialist.

Exhibit 29: Five Most Frequently Report "Main" Reason for Obtaining Care Outside of My Neighborhood – Telephone and Field Surveys

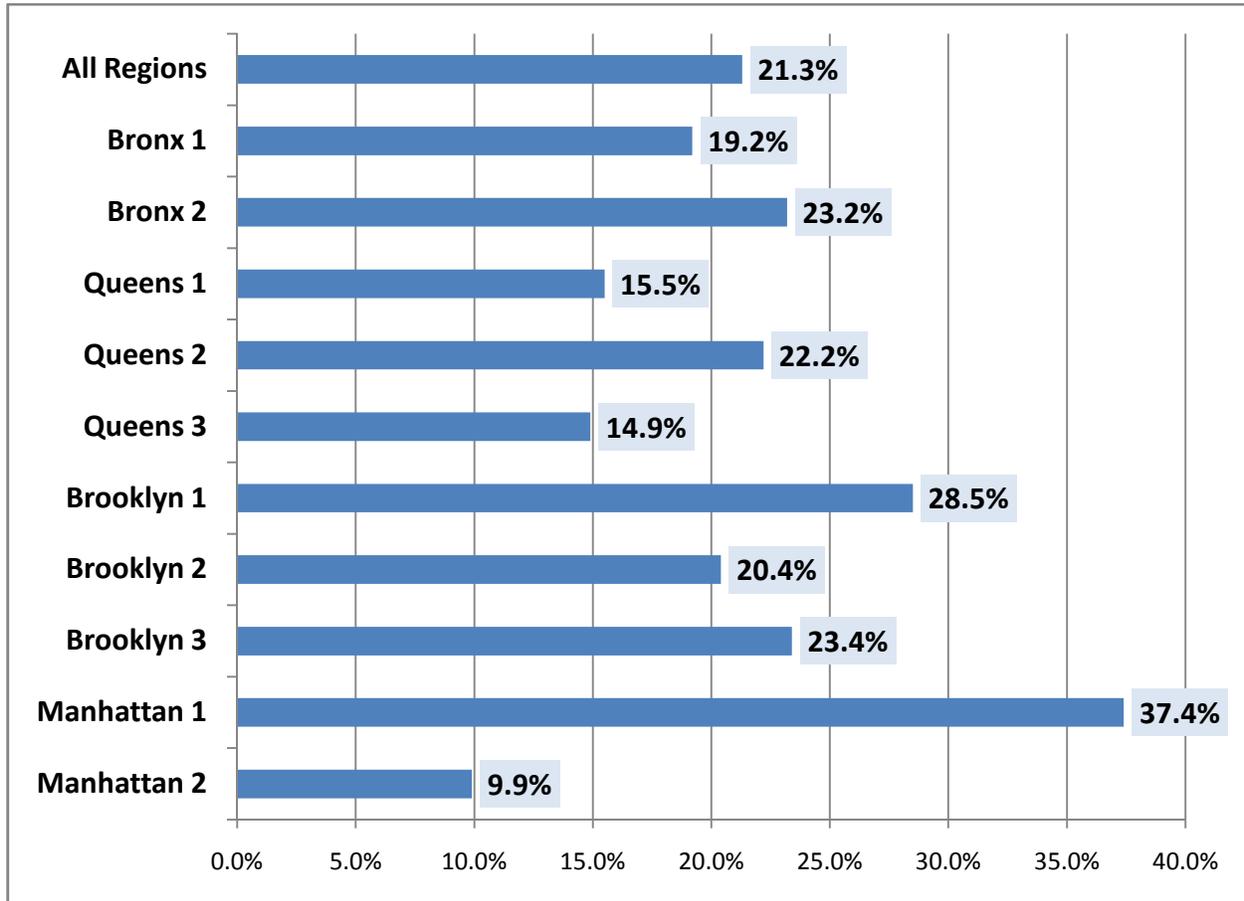
Reason		All Regions ⁵⁵	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering		718	71	108	151	55	28	75	142	31	27	30
A	I get care from a specialist in another neighborhood	CDE ⁵⁶ 22.7%	19.7%	CDE 26.9%	CDE 32.5%	21.8%	17.9%	16.0%	17.6%	19.4%	18.5%	20.0%
B	Prefer a doctor or nurse who is in another neighborhood	20.8%	E 22.5%	17.6%	23.2%	DE 29.1%	17.9%	12.0%	DE 22.5%	22.6%	18.5%	16.7%
C	Was referred to or assigned a doctor or nurse in another neighborhood	16.0%	16.9%	13.0%	13.2%	16.4%	17.9%	17.3%	20.4%	16.1%	11.1%	16.7%
D	I do not have confidence in the quality care I would receive in my neighborhood	7.7%	12.7%	7.4%	5.3%	5.5%	14.3%	9.3%	5.6%	9.7%	3.7%	13.3%
E	My doctor or nurse is close to my job or school	7.5%	1.4%	10.2%	6.0%	1.8%	10.7%	10.7%	7.0%	9.7%	18.5%	10.0%

⁵⁵ This Exhibit lists the top five answers for all PCI Community Health Assessment regions *combined*. Results for the individual regions are presented here to be compared against the “All Regions” figure. Results for the individual regions may or may not be the actual “top five” response for that region.

⁵⁶ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

RESPONDENTS NOT GETTING HEALTH CARE IN LAST 2 YEARS OR SINCE MOVING TO NEIGHBORHOOD IF RESPONDENT LIVED IN NEIGHBORHOOD LESS THAN 2 YEARS

Exhibit 30: Percentage of respondents living in the neighborhood less than two years who answered “no” to receiving health care in the last two years (n=3,011)



REASONS FOR NOT GETTING HEALTH CARE

The top reason for not getting health care is “I did not need to.”

Exhibit 31: Top Three Reasons for Not Obtaining Health Care – Telephone and Field Surveys

Telephone and Field Surveys	All Regions ⁵⁷	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	529	39	111	73	43	13	56	97	30	55	12
A I needed to but was not able to	27.8%	25.6%	25.2%	37.0%	20.9%	23.1%	23.2%	25.8%	33.3%	34.5%	25.0%
B I did not need to	All ⁵⁸ 61.6%	All 61.5%	All 68.5%	All 61.6%	All 65.1%	All 76.9%	All 62.5%	All 62.9%	C 50.0%	C 50.9%	33.3%
C I did not want to	10.6%	12.8%	6.3%	1.4%	14.0%	0%	14.3%	11.3%	16.7%	14.5%	41.7%

TOP FIVE REASONS FOR NOT GETTING HEALTH CARE DESPITE THE NEED

Affordability is the top reason for not getting health care despite having a need.

Exhibit 32: Top five reasons for not getting health care despite the need

Telephone and Field Surveys	All Regions ⁵⁹	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	128	8	26	18	9	3	13	25	9	15	2
A I could not afford it	All 77.3%	All 87.5%	All 65.4%	All 94.4%	All 77.8%	All 100%	All 69.2%	All 68.0%	All 88.9%	All 80.0%	All 100%
B I was too busy	18.8%	12.5%	26.9%	16.7%	0%	0%	15.4%	32.0%	22.2%	6.7%	0%
C I needed an appointment sooner than the appointment time they offered	15.6%	25.0%	11.5%	22.2%	0%	0%	23.1%	20.0%	33.3%	0%	0%
D I did not know how to find a health care provider	12.5%	25.0%	26.9%	16.7%	11.1%	0%	0%	4.0%	22.2%	0%	0%
E I could not find a health care provider or translator who speaks my language	11.7%	0%	3.8%	5.6%	0%	0%	23.1%	16.0%	44.4%	13.3%	0%

⁵⁷ This Exhibit lists the top five answers for all PCI Community Health Assessment regions *combined*. Results for the individual regions are presented here to be compared against the “All Regions” figure. Results for the individual regions may or may not be the actual “top five” response for that region.

⁵⁸ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

⁵⁹ This Exhibit lists the top three answers for all PCI Community Health Assessment regions *combined*. Results for the individual regions are presented here to be compared against the “All Regions” figure. Results for the individual regions may or may not be the actual “top three” response for that region.

MOST CONVENIENT LOCATION FOR GETTING HEALTH CARE

The majority of respondents (85.4%) prefer to receive care near where they live rather than work or some other place.

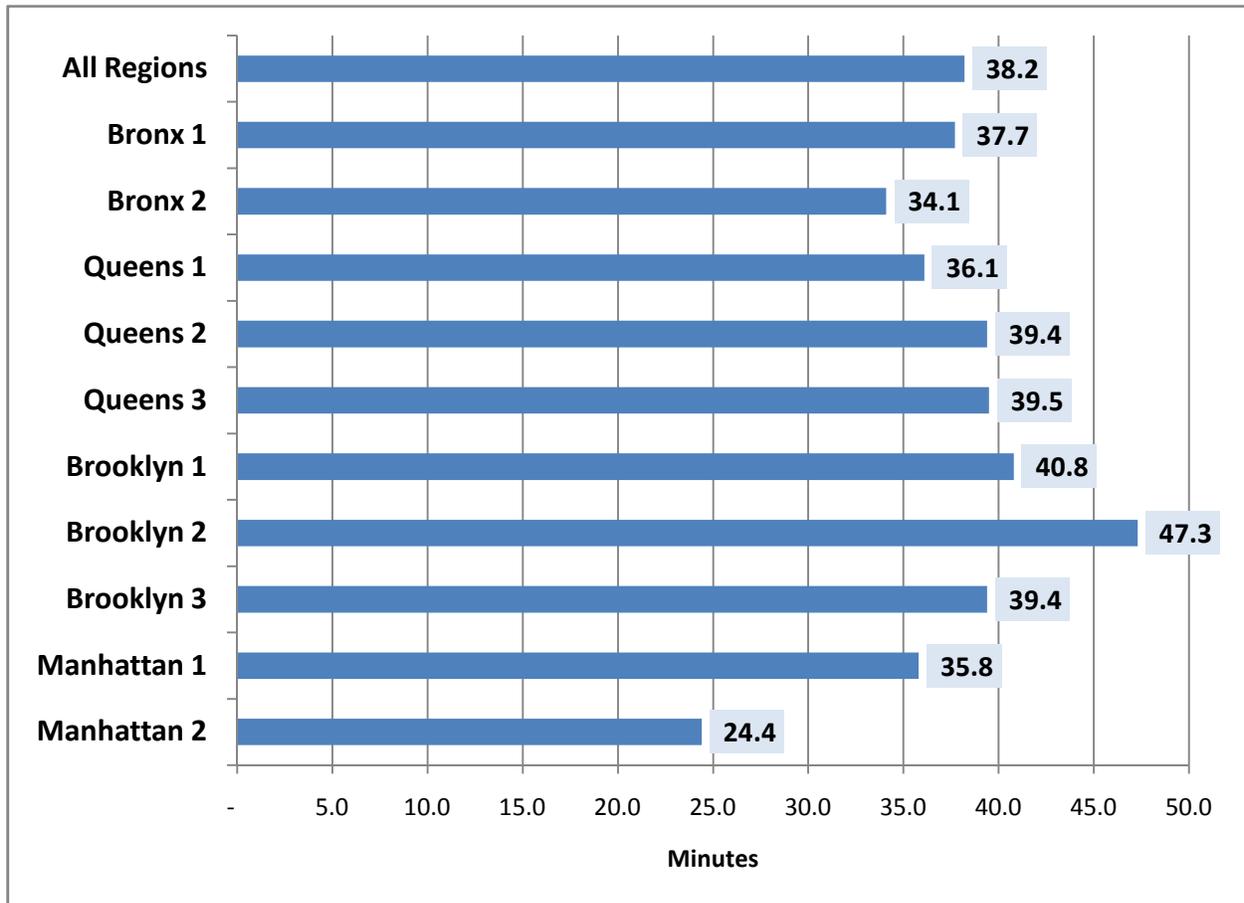
Exhibit 33: Preferred Location for Receiving Care – Telephone and Field Surveys

	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	2,670	259	477	432	183	90	262	534	159	129	145
A Near where I live	All ⁶⁰ 85.4%	All 90.0%	All 84.3%	All 78.0%	All 86.9%	All 88.9%	All 88.5%	All 85.4%	All 89.3%	All 89.1%	All 84.8%
B Near where I work	11.5%	6.9%	12.4%	19.7%	9.8%	10.0%	8.8%	9.6%	10.1%	6.2%	14.5%
C Some other place	3.1%	3.1%	3.3%	2.3%	3.3%	1.1%	2.7%	5.0%	.6%	4.7%	.7%

⁶⁰ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

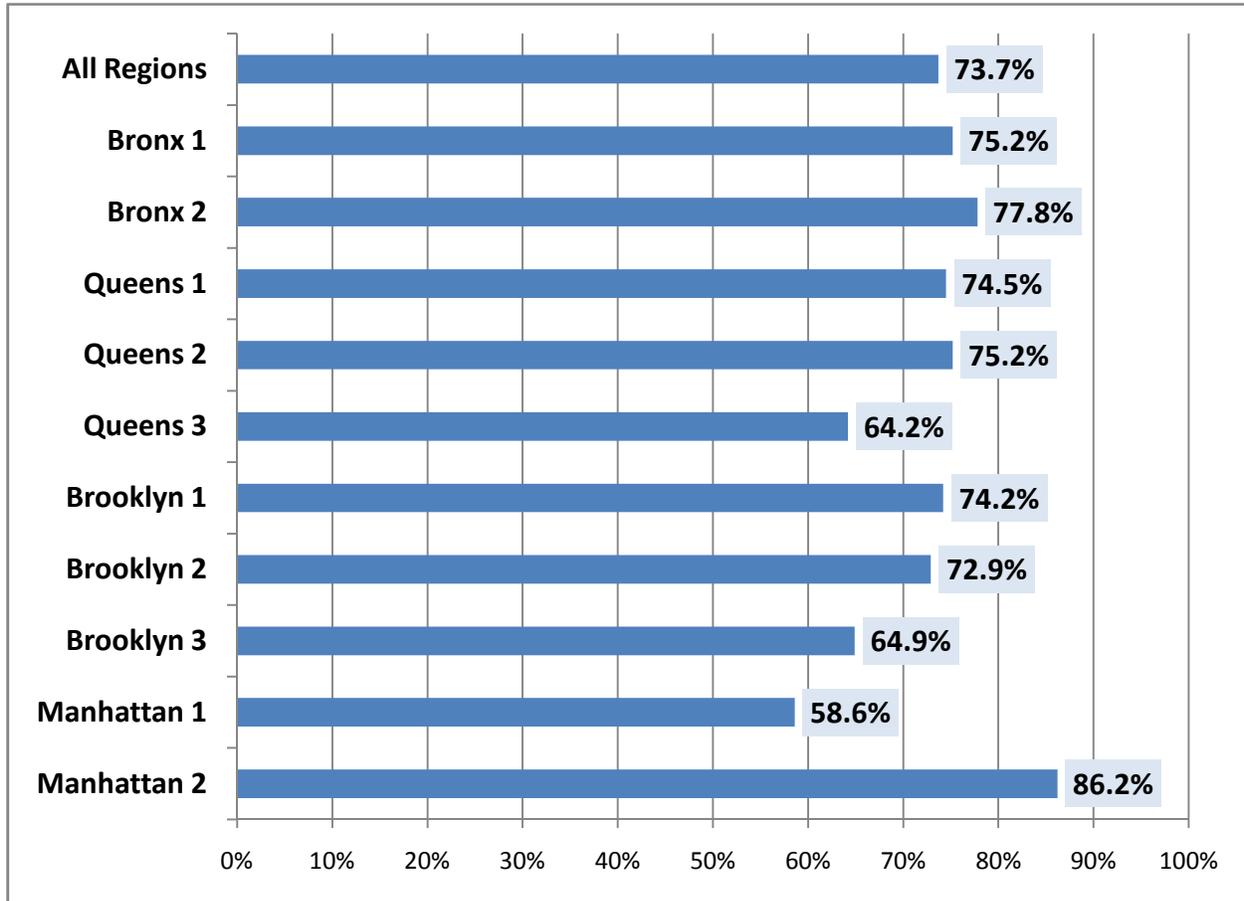
AVERAGE TRAVEL TIME TO WORK/OTHER PLACES

Exhibit 34: Average travel time to work/other place (n=308) – Telephone and Field Surveys



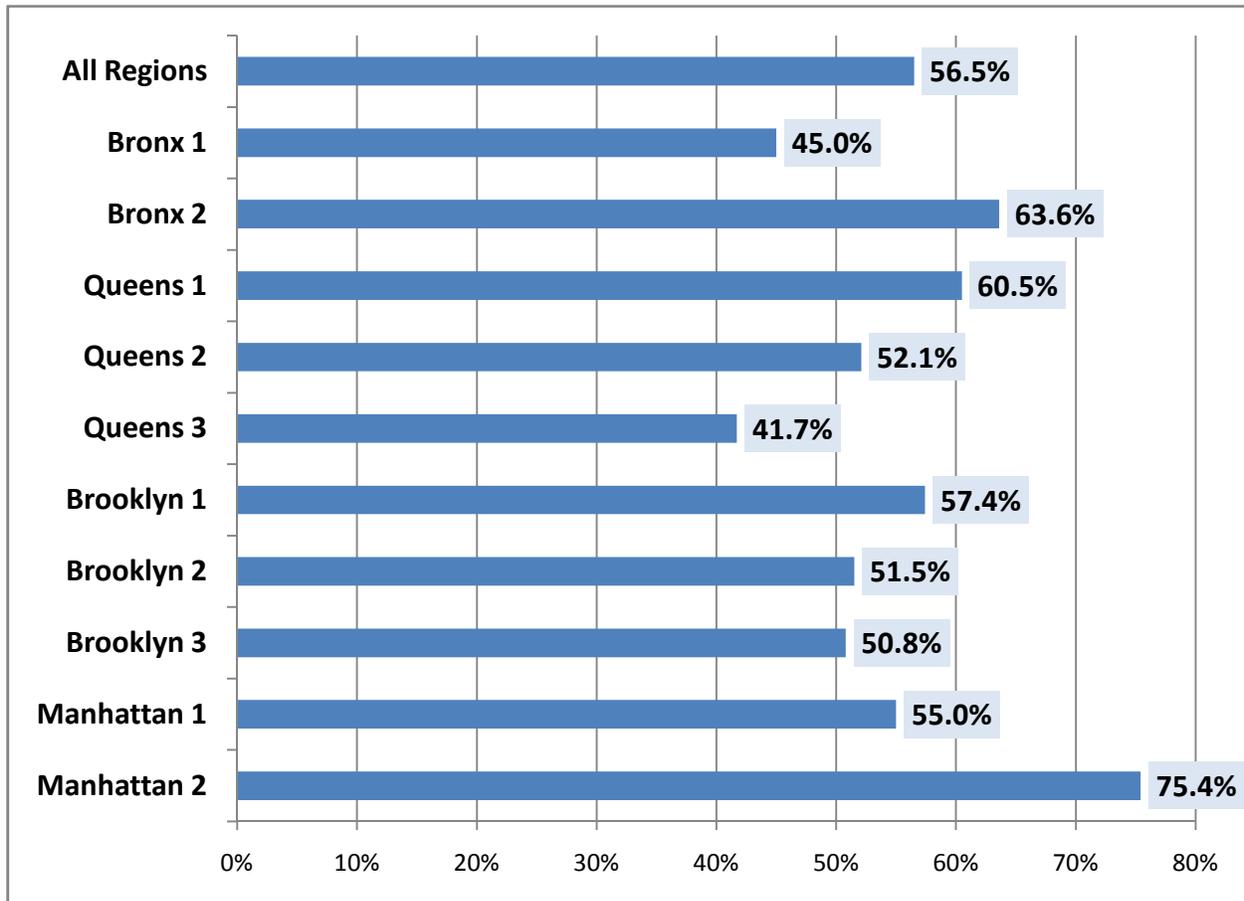
HAVING HEALTH INSURANCE

Exhibit 35: Percentage of respondents who answered "yes" to having health insurance (n=3,014)



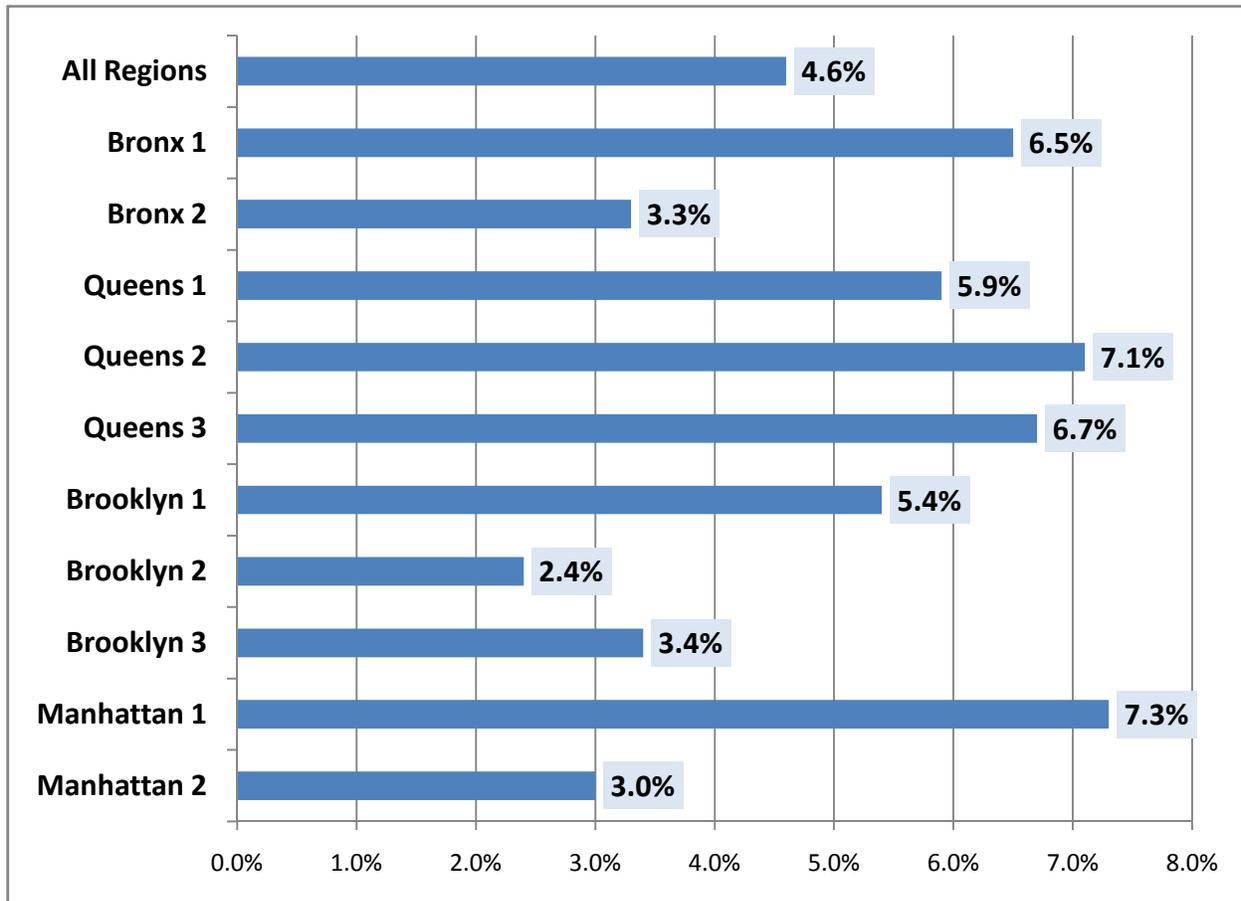
HAVING A MEDICAL HOME

Exhibit 36: Percentage of respondents to answered "yes" to having a medical home (n=2,217)



EMERGENCY ROOM AS MEDICAL HOME

Exhibit 37: Percentage of respondents who indicated "Emergency Room" as their medical home (n=1,234)



BOROUGH OF MEDICAL HOME

Most respondents' medical homes are in the boroughs where they live. However, Manhattan is the medical home for the highest percentage of respondents city-wide.

Exhibit 38: Borough of respondents' medical home – Telephone and Field Surveys

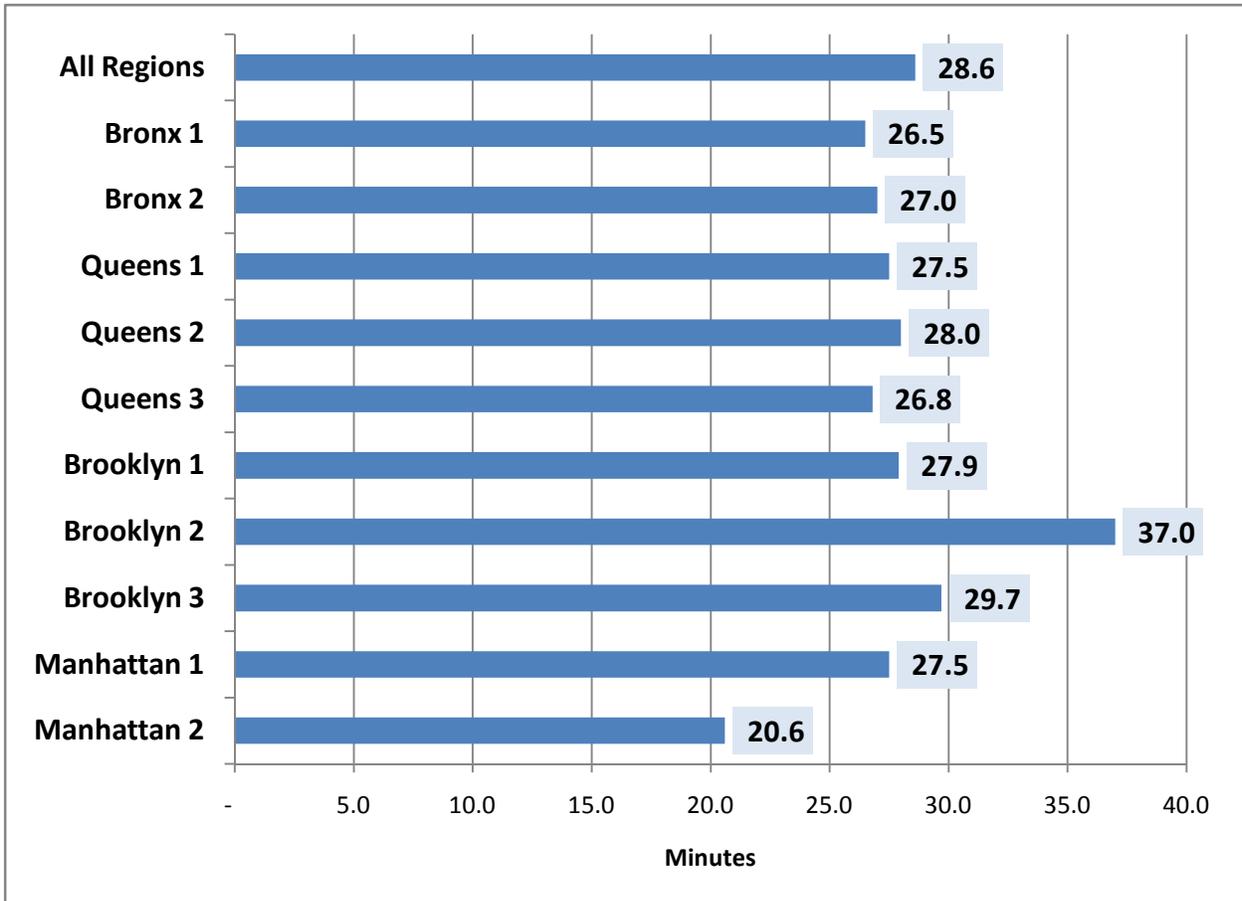
Telephone and Field Surveys	All Regions ⁶¹	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	1,215	93	240	245	83	26	110	208	60	52	98
A Manhattan	All ⁶² 28.4%	24.7%	17.5%	22.9%	14.5%	7.7%	29.1%	12.0%	13.3%	All 96.2%	All 96.9%
B Brooklyn	24.0%	1.1%	.4%	2.0%	4.8%	11.5%	All 58.2%	All 78.4%	All 83.3%	0%	1.0%
C Queens	23.9%	1.1%	4.2%	All 70.2%	All 77.1%	All 65.4%	8.2%	6.3%	1.7%	1.9%	2.0%
D Bronx	21.8%	All 69.9%	All 75.8%	2.0%	1.2%	0%	3.6%	2.9%	1.7%	1.9%	0%
E Staten Island	0.2%	0%	.4%	.4%	1.2%	0%	0%	0%	0%	0%	0%

⁶¹ This Exhibit lists the top five answers for all PCI Community Health Assessment regions *combined*. Results for the individual regions are presented here to be compared against the “All Regions” figure. Results for the individual regions may or may not be the actual “top five” response for that region.

⁶² See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.

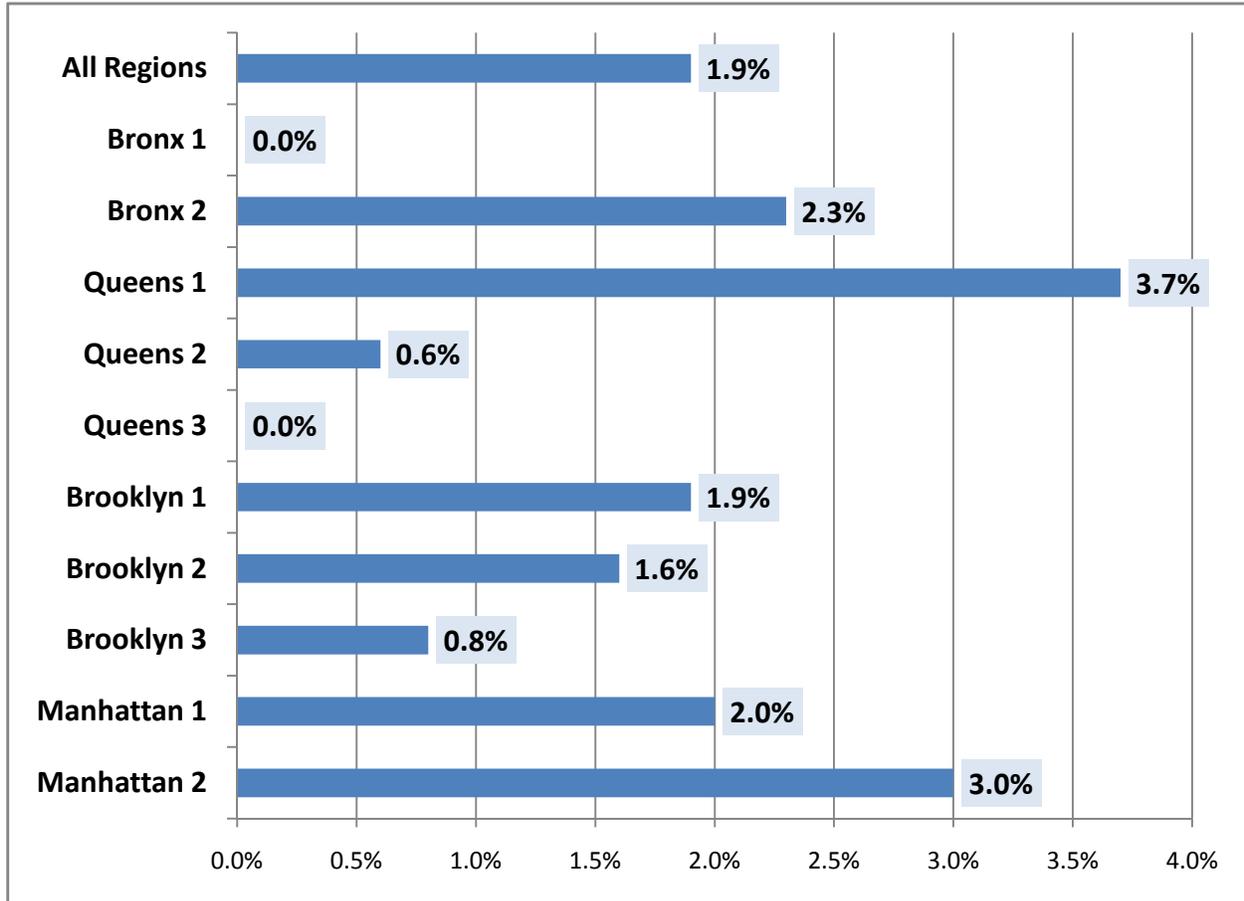
TRAVEL TIME TO MEDICAL HOME

Exhibit 39: Average travel time (in minutes) to respondents' medical home (n=1,550)



WHO GOES TO TRADITIONAL HEALERS?

Exhibit 40: Percentage of respondents who indicated that they get most of their health care from "traditional healers" (n=2,328)



REASONS WHY PEOPLE GO TO TRADITIONAL HEALERS

Exhibit 41: Reasons why people go to traditional healers – Telephone and Field Surveys

Telephone and Field Surveys	All Regions	Bx1	Bx2	Qns1	Qns2	Qns3	Bk1	Bk2	Bk3	Man1	Man2
Total Answering	54	1	9	17	1	0	4	10	2	3	7
I prefer traditional healers to doctors or nurses	All ⁶³ 55.6%	100%	44.4%	70.6%	100%	0%	0%	50.0%	100%	0%	71.4%
I prefer a doctor or nurse but cannot afford it	31.5%	0%	33.3%	29.4%	100%	0%	25.0%	50.0%	0%	33.3%	14.3%
My traditional healer speaks my language and it is too hard to find a doctor or nurse who speaks my language	16.7%	0%	11.1%	5.9%	0%	0%	50.0%	10.0%	0%	66.7%	28.6%

⁶³ See Guide to Key Survey Finding Annotations on page 209 for an explanation of the letter codes used on in these tables.



**Appendix B:
Staten Island
Community Health
Assessment**

APPENDIX B: STATEN ISLAND COMMUNITY HEALTH ASSESSMENT

FINAL EXECUTIVE REPORT: AUGUST 29, 2009
PREPARED BY TRIPP UMBACH AND FT SOLUTIONS⁶⁴

I. PROJECT INTRODUCTION AND METHODOLOGY

In April 2007, Tripp Umbach and FT Solutions were retained by the Community Health Center of Richmond County (CHCR) to perform a community health needs assessment for Staten Island, NY. CHCR currently manages and operates a free health center providing primary care and specialty services to the residents of the Port Richmond (PR) neighborhood located in the northwest corner of Staten Island. The current health center provides services to residents of Staten Island who are members of Medically Underserved Populations (MUPs), Medically Underserved Areas (MUAs), and Health Provider Shortage Areas (HPSAs) who do not have regular access to health care services. Realizing there is a greater need within Staten Island for additional health centers due to growing populations of undocumented immigrants in MUAs, MUPs, and HPSAs, CHCR charged Tripp Umbach and FT Solutions with identifying potential communities within Staten Island which may be suitable for the development of a second CHCR site for a primary care health center. The Executive Summary that follows illustrates the key data points collected during the community health needs assessment in support of the current CHCR site and a recommended second site for a new health center development.

In order to understand the health needs of Staten Island more clearly, Tripp Umbach and FT Solutions developed a program of research analyses designed to help identify specific areas and populations on Staten Island that demonstrated the need for more accessible primary health care services. Primary and secondary data were used in the research and included:

Initial Project Planning Meeting: The goal of the initial planning meeting was to review and finalize the goals of the project as well as to further define the geographic scope and identify existing sources of data.

1. **Household Survey:** Tripp Umbach and FT Solutions collected 602 telephone surveys from residents of Staten Island. Participants were called at random with 50 surveys collected within

⁶⁴ This Appendix is adapted from “Staten Island Community Health Assessment: Final Executive Report, August 29, 2007,” prepared by Tripp Umbach and FT Solutions. Data from the household survey component of this assessment have been integrated into the findings and recommendations of the Primary Care Initiative Community Health Assessment Final Report.

The content of this Appendix represents the main portion of the original August 29, 2007 report. However, the formatting of the original report has been changed as follows:

- Although the references to “Charts,” “Figures,” and “Tables” in the original Staten Island document remain, their numbering has been changed to be consistent with the numbering of this PCI document.
- The formatting of the original Staten Island document’s headings, text, tables, and charts have been changed to be consistent with the formatting of this PCI document.

each of the 12 ZIP codes on Staten Island. The main goal of the survey was to assess the major health needs and issues regarding access to service that face residents of Staten Island. CHCR also collected 93 hand distributed surveys in an attempt to capture responses from the undocumented/underserved immigrant populations on Staten Island. Data for the household survey is reported by phone survey alone and by aggregate of phone and hand distributed surveys.

2. **Provider Survey:** Tripp Umbach and FT Solutions collected 60 fax surveys of providers throughout Staten Island. The purpose of the survey was to assess the capacity of providers on Staten Island as well as issues related to their payor mix, ability to take on new patients, services to immigrant populations, and the health care needs of the community from the providers' perspective.
3. **Secondary Data Review:** Tripp Umbach and FT Solutions used secondary data to supplement the primary survey research conducted with residents and providers. Sources included physician workforce data collected by the Center for Workforce Development, survey research conducted by HHC and CHCR, Claritas demographic data at the Census Tract level, AHA hospital and provider data, and studies conducted by The New York City Department of Health and Mental Hygiene.
4. **Asset Inventory Survey:** Tripp Umbach and FT Solutions collected 43 surveys via fax, phone, and e-mail from federal, state, and local service agencies providing health and social services to the residents of Staten Island. The purpose of the survey was to identify the capacity of organizations to serve the residents of Staten Island including their abilities to provide language interpretation service to immigrant populations.

The data provided in this report support the need for the development and implementation of a health care delivery system on Staten Island designed to meet the primary health care needs of medically underserved residents in the identified neighborhoods. This study provides a statistical base to determine the eligibility of pockets of residents that may qualify for designation as a MUA or MUP by the U.S. Department of Health and Human Services/Health Resources and Services Administration (DHHS/HRSA).

In the immediate near term, the development of accessible community health service programs that meet the program expectations and requirements for DHHS/HRSA designation as a Federally Qualified Health Center (FQHC) Look-Alike organization may prove beneficial if future federal support is made available for new primary care access points. FQHC Look-Alike organizations receive no Section 330 Federal funding, but are eligible for enhanced Medicaid and Medicare reimbursement and may be able to participate in other federally supported programs and services. If additional federal funding becomes available for the development of new primary care access points, programs on Staten Island will be in an

advanced stage of readiness by having in place community-based health care programs that meet federal requirements.

The summary that follows provides an overview of the key findings from the Staten Island community health needs assessment presented to representatives of CHCR and the New York City Health and Hospitals Corporation on August 20, 2007.

Table 68 below defines some key terms which are used frequently throughout the report.

Table 68: Key Terms – Staten Island Community Health Assessment

Acronym	Term
CT	Census Tract
SI	Staten Island
PR	Port Richmond
SSG	Stapleton St. George
WB	Willowbrook/Mid-Island
SBT	South Beach/Tottenville
SI Combined	Staten Island Phone and Hand Distributed Household Survey Data Combined
SI Phone	Staten Island Phone Household Survey Alone

II. KEY FINDINGS AND RECOMMENDATIONS

Locate New Health Center in Stapleton/St. George ZIP Code 10304 – Census Tract 29

Staten Island is a very diverse community within New York City. The Borough is composed of four neighborhoods, twelve ZIP codes, and 110 Census Tracts. Tripp Umbach and FT Solutions collected data at all three geographic levels to determine the precise location on Staten Island which has the greatest need for a primary care center. Data analyses began by finding the neighborhood(s) which demonstrated the greatest need for a health center and then focused within the identified neighborhood(s) to find the ZIP code(s) which are in greatest need of a health center. From within the identified ZIP code(s), Tripp Umbach and FT Solutions then searched for Census Tract clusters which the data demonstrated the greatest need for a health center. The data suggest that CHCR develop a second comprehensive primary care center within the Stapleton/St. George (SSG) neighborhood – ZIP code 10304 – Census Tract 29. Research conducted by Tripp Umbach and FT Solutions shows that this area has high percentages of low-income/uninsured/minority populations who are in search of health providers. The data demonstrates a clear need for a health center in this area.

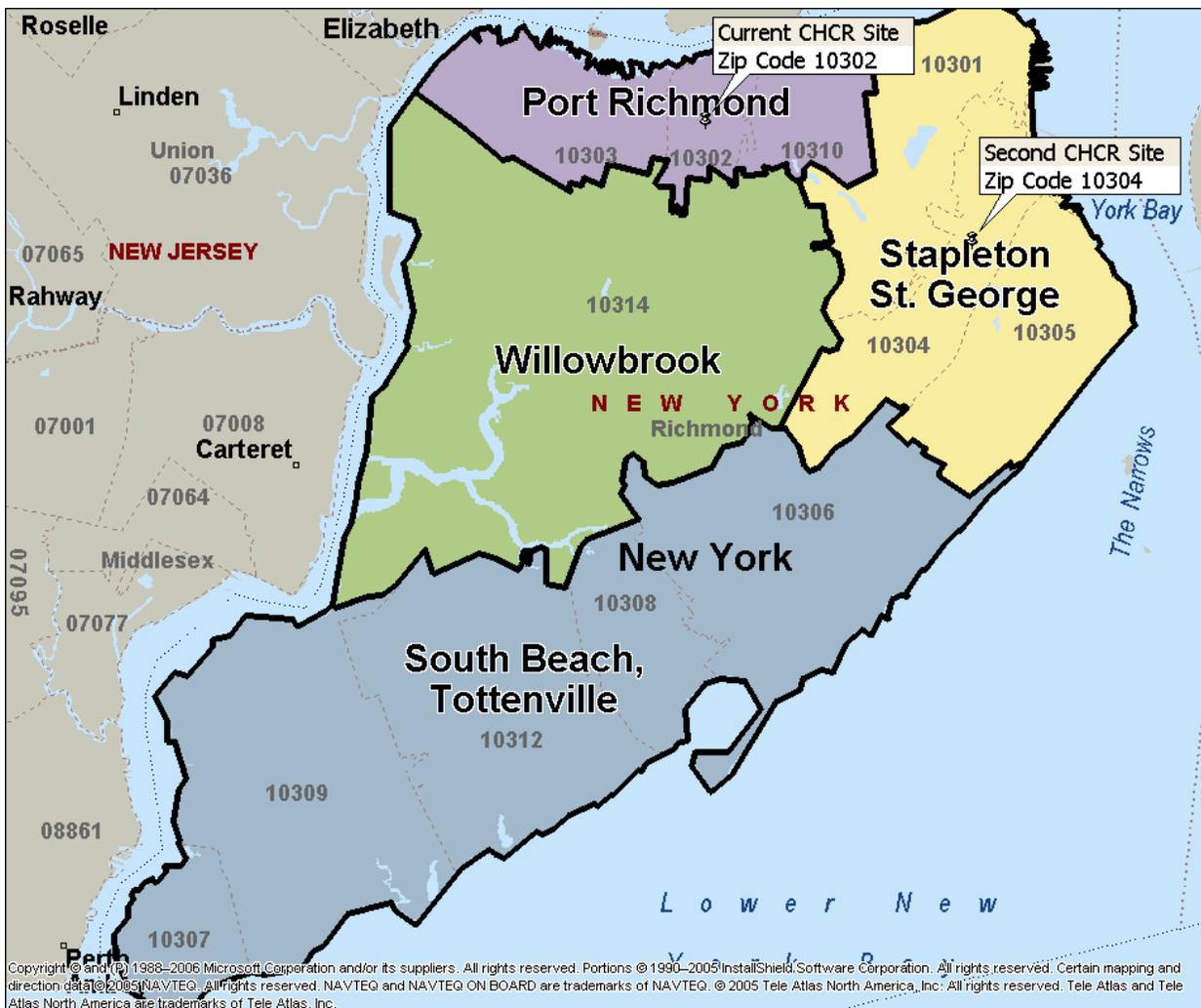
The following statements are key findings generated from the most critical data pieces collected by Tripp Umbach and FT Solutions in support of this recommendation. The key findings begin building support for the above recommendation at the macro neighborhood level and then funnel down to the micro Census Tract (CT) level. The data provided within the key findings provides support for both the

current CHCR site located in Port Richmond (PR) and the recommended second site in Stapleton St. George (SSG).

Key Finding #1: The Northern Neighborhoods on Staten Island Have Significant Size Populations That Are Poor, Uninsured, and Without A Health Care Provider

Staten Island is comprised of four main neighborhoods including Port Richmond (PR), Stapleton/ St. George (SSG), Willowbrook (WB), and South Beach Tottenville (SBT). Figure 1 below illustrates these four neighborhoods.

Figure 1: Staten Island UHF Neighborhoods – Staten Island Community Health Assessment



The northern two neighborhoods including PR and SSG have significant size populations that are poor, uninsured, and without a primary health care provider. An estimated 35,800 residents living within PR

and SSG do not have a primary care provider, 26,944 PR and SSG residents are living below the poverty level, and 26,222 PR and SSG residents do not have health insurance. PR and SSG also have significantly high percentages of residents who are either foreign born or minority populations.

Table 69: Port Richmond and Stapleton/St. George – Staten Island Community Health Assessment

	Port Richmond		Stapleton/ St. George	
Total Population (Census 2000)	62,800		116,200	
% and number of residents living below the poverty level	17%	(10,676)	14%	(16,268)
% and number of residents who are foreign born	18%	(11,304)	22%	(25,564)
% and number of residents who are minorities	55%	(34,540)	44%	(51,128)
% and number of residents without health insurance	14%	(8,792)	15%	(17,430)
% and number of residents without a primary care provider	20%	(12,560)	20%	(23,240)

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

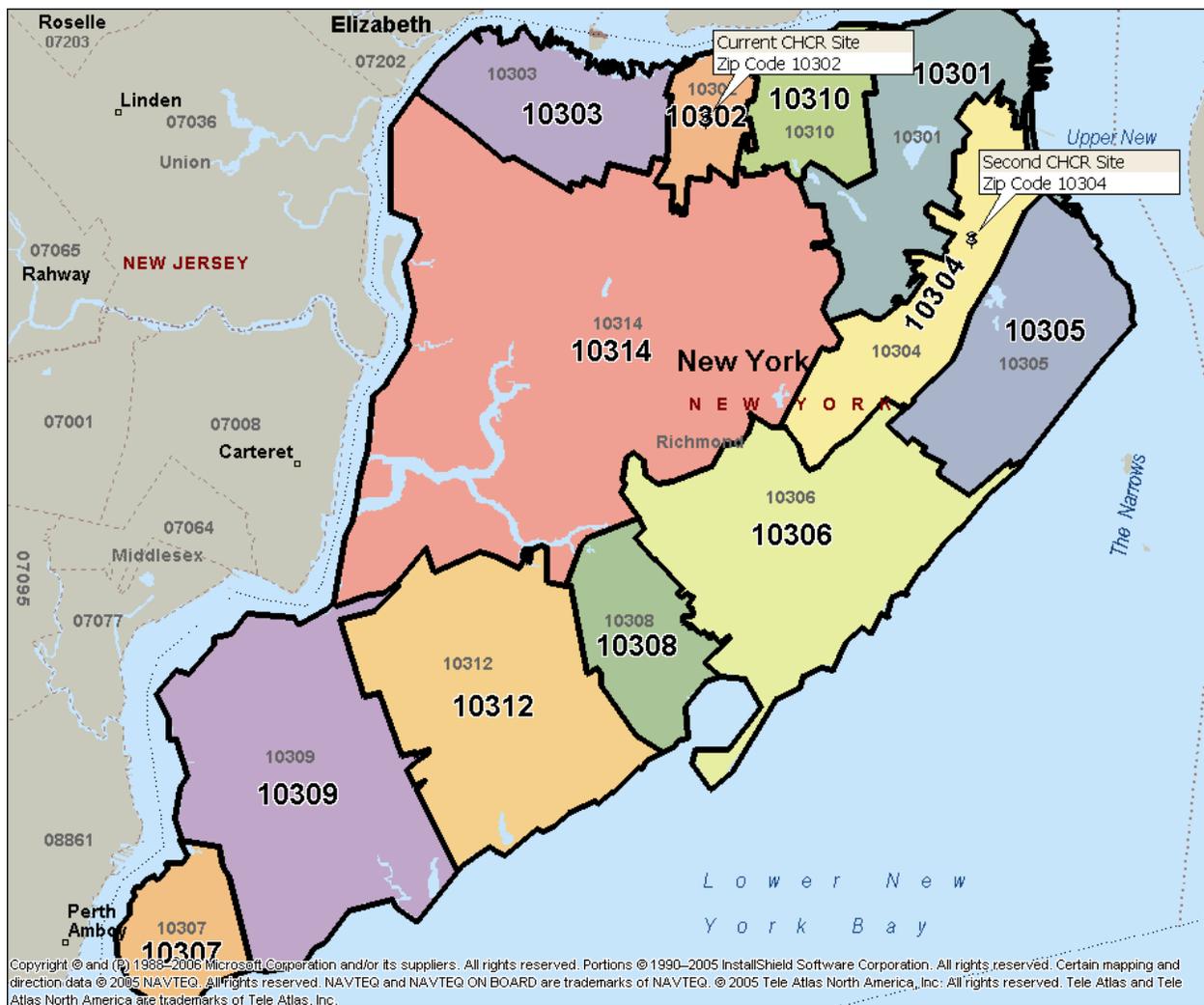
By comparison, the southern two neighborhoods including WB and SBT have significantly lower percentages of residents who are poor, uninsured, and without a primary care provider.

- Only 7% of WB residents and 5% of SBT residents live below the poverty level.
- 90% of WB residents and 94% of SBT residents have health insurance.
- 15% of WB residents and 10% of SBT residents are without a primary care provider.

Key Finding #2: ZIP codes 10304 (SSG) and 10302 (PR) Illustrated High Levels of Need for a Primary Care Center According to Household Survey Respondents

There are 12 ZIP codes on Staten Island as illustrated Figure 2 below. Tripp Umbach and FT Solutions surveyed households at random via the telephone within each ZIP code. CHCR also surveyed local populations of undocumented immigrants to supplement the phone surveys.

Figure 2: Staten Island ZIP codes – Staten Island Community Health Assessment



Results from the household survey revealed a strong need for primary health care centers in both ZIP code 10302 (current CHCR site) and ZIP code 10304 (second CHCR site). The survey demonstrated significantly high percentages of uninsured respondents, high percentages of respondents without a primary care provider and/or looking for doctors, and high percentages of respondents looking for medical services which are currently unavailable to them in their community. Respondents from ZIP

codes 10302 and 10304 reported a strong need for a health center in their community and the majority of respondents stated they would use a health center if one was made available to them.

Table 70 below illustrates the responses from the household survey by ZIP code. The percentage based responses are broken out between phone survey respondents alone (SI Phone) compared to phone survey and hand distributed survey respondents combined (SI Combined).

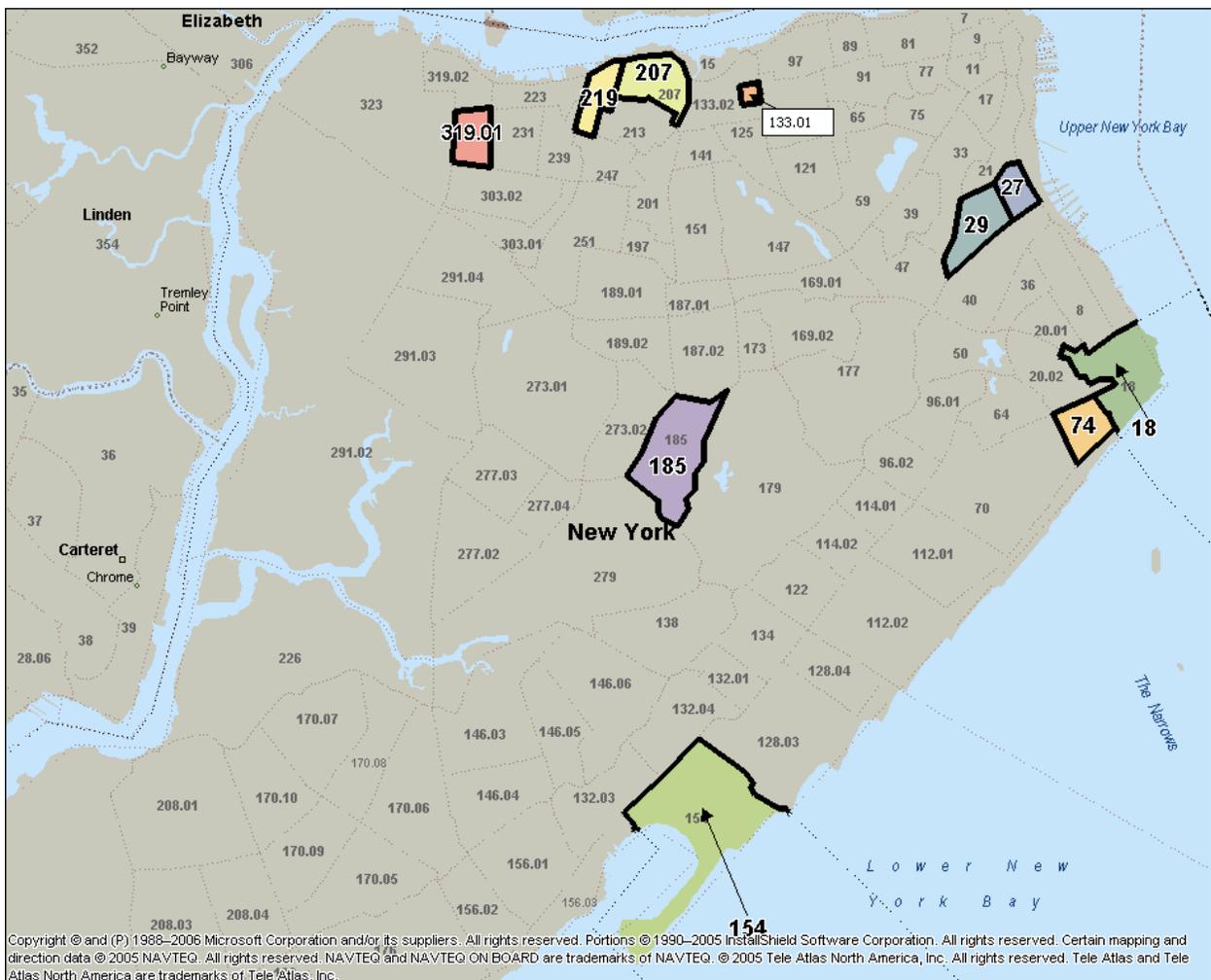
Table 70: Household Survey Results for ZIP codes 10302 and 10304 – Staten Island Community Health Assessment

	10302 Port Richmond		10304 Stapleton/St. George	
	SI Telephone	SI Combined	SI Telephone	SI Combined
Percentage of respondents without health insurance	0%	3%	14%	17%
Percentage of respondents with children/no children's health insurance	36%	36%	39%	36%
Percentage of respondents without dental insurance	20%	21%	32%	34%
Percentage of respondents without a primary health provider	2%	3%	8%	15%
Percentage of respondents who would use a health center if available	72%	74%	60%	72%
Need for a health center in your community (Scale of 1 to 5 where 5 is great need)	3.89	3.89	3.73	4.16
Percentage of respondents looking for doctors	10%	12%	18%	28%
Percentage of respondents looking for medical services	18%	20%	24%	38%

Key Finding #3: Eight of the Top 10 Lowest Median Household Income Census Tracts Are Located In Port Richmond and Stapleton St. George

Staten Island contains 110 Census Tracts. A Census Tract is a small, relatively permanent statistical subdivision of a county (smaller than ZIP codes) established by the US Census and designed to be homogenous with respect to population characteristics, economic status, and living conditions. Census Tracts usually have between 2,500 and 8,000 residents. Figure 3 below highlights the top 10 lowest median household income Census Tracts on Staten Island.

Figure 3: Staten Island Low Income Census Tracts – Staten Island Community Health Assessment



As shown in Figure 3 above and Table 71 below, 8 of the top 10 lowest median household income Census Tracts on Staten Island are located in PR and SSG. Income data at both the neighborhood level and CT level show a sharp disparity between the northern half of Staten Island (PR and SSG) and the

southern half of Staten Island (WB and SBT). The Census Tracts highlighted in red from Table 71 are located in or around both the current CHCR site and the recommended second CHCR site.

Table 71: Top 10 Lowest Median Household Income Census Tracts – Staten Island Community Health Assessment

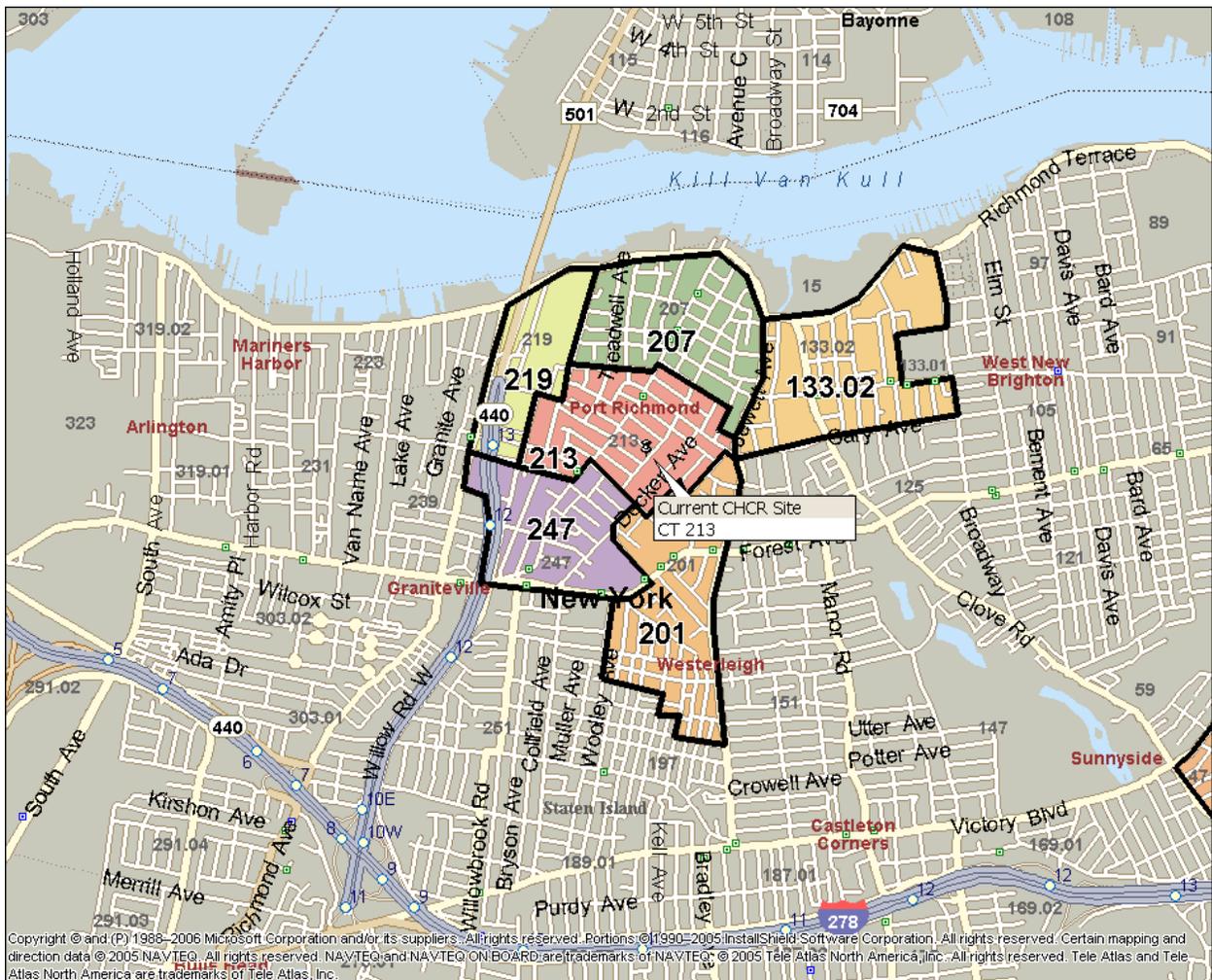
Census Tract	UHF Neighborhood	2007 Median Household Income	2012 Projected Median Household Income	% Change
185	Willowbrook	\$9,999	\$9,999	0%
133.01	Port Richmond	\$15,169	\$16,500	9%
154	South Beach Tottenville	\$17,500	\$27,500	57%
29	Stapleton St. George	\$17,976	\$19,021	6%
219	Port Richmond	\$29,792	\$31,667	6%
27	Stapleton St. George	\$30,625	\$33,000	8%
319.01	Port Richmond	\$31,588	\$34,455	9%
207	Port Richmond	\$32,721	\$34,449	5%
18	Stapleton St. George	\$34,583	\$37,035	7%
74	Stapleton St. George	\$34,820	\$37,983	9%

- Source: Claritas 2007.
- Census Tracts highlighted in red are located in or around current CHCR site and future recommended CHCR site.
- 2007 Median Household Income in CT 021300 (site of current CHCR in Port Richmond) is \$57,233 and projected to be \$61,790 in 2012.

Key Finding #4: The Current CHCR Site (Port Richmond, ZIP code 10302, Census Tract 213) is Surrounded By and Includes Census Tracts with Strong Numbers of Households Below the Poverty Level and Unemployed Residents

Figure 4 below illustrates CT 213 (location of the current CHCR site) and five bordering CTs (219, 207, 133.02, 247, and 201).

Figure 4: Current CHCR Site and Surrounding Census Tracts – Staten Island Community Health Assessment



The current CHCR site shown in Figure 4 above is located in a CT cluster with a significant population base (19,777 residents) and more than 6,000 households. The average median household income of CT 213 and the five neighboring CTs is \$47,178. Approximately 10% of the households within this area are below the federal poverty level. Four percent of the residents or 751 people living in this area are currently unemployed.

The six CTs which comprises the area of the current CHCR site are listed in Table 72 below. Five out of the six CTs are located within ZIP code 10302 and the Port Richmond neighborhood in the northern half of Staten Island. Data collected from ZIP code 10302 and the Port Richmond neighborhood revealed strong percentages of the population without health insurance, low levels of access to care, and a strong need for a health center (see Key Finding #1 on page 242 and Key Finding #2 on page 245). The six CTs are also bordered by Interstate 278 to the South and State Route 440 to the West of the CT cluster which form barriers for residents living on the opposite sides of the interstates to accessing the current CHCR site.

Table 72: Current CHCR Site Census Tracts – Staten Island Community Health Assessment

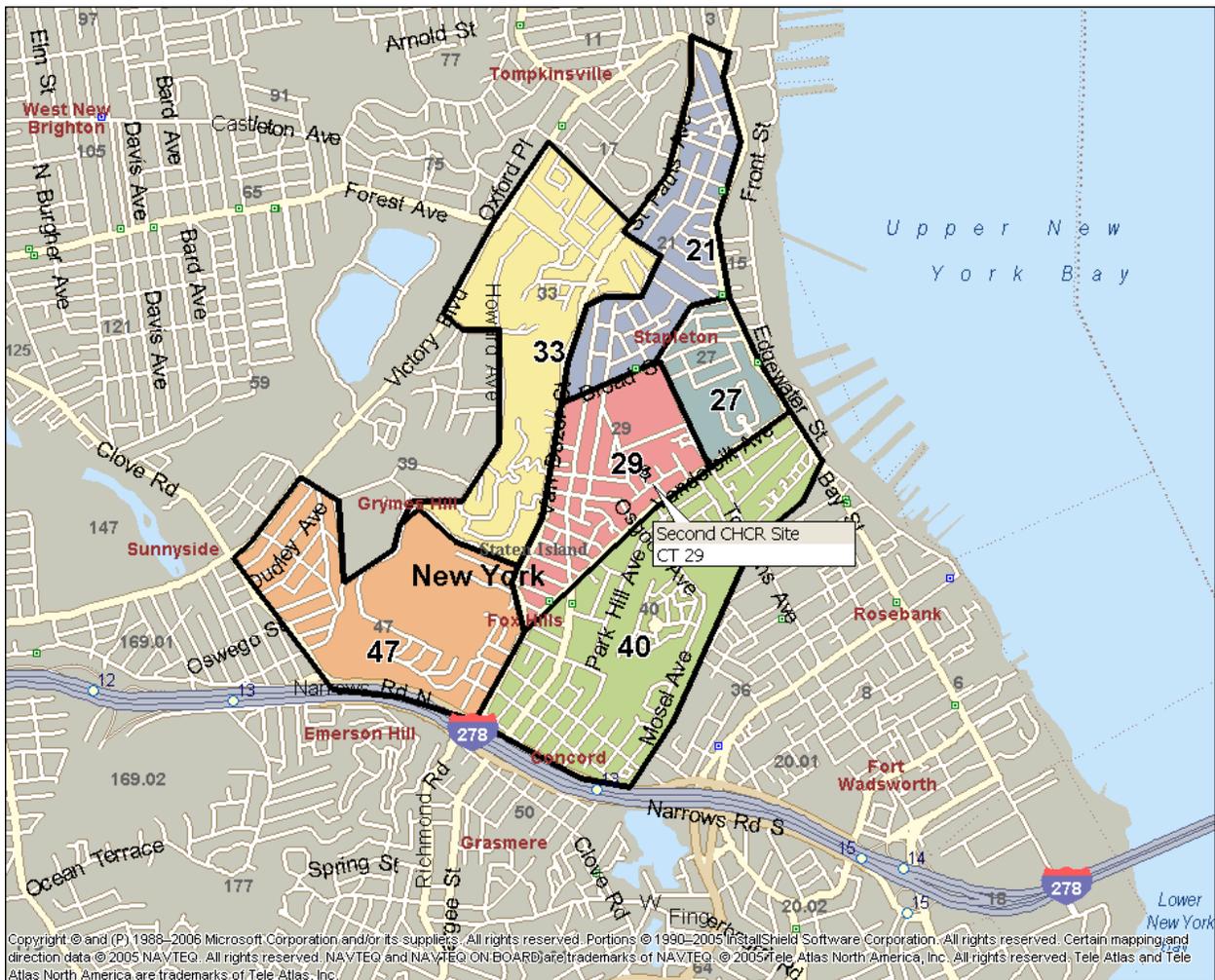
Census Tract	ZIP Code	2007 Median Household Income	2007 Population	2007 Unemployed	2007 Households	2007 Households Below Poverty Level
219	10302	\$29,792	1,091	70	361	110
207	10302	\$32,721	5,497	263	1646	244
133.02	10310	\$39,419	2,769	88	808	89
247	10302	\$48,953	2,507	19	916	66
213	10302	\$57,233	4,354	261	1,377	80
201	10302	\$74,951	3,559	50	1,229	25
Total/Average		\$47,178	19,777	751	6,337	614

- Source: Claritas 2007.
- The average Staten Island family household has 3.33 people living in it.
- The average Staten Island household has 2.74 people living in it.

Key Finding #5: The Recommended Second CHCR Site (Stapleton St. George, ZIP code 10304, Census Tract 29) is Surrounded by and Includes Census Tracts with Strong Numbers of Households Below the Poverty Level and Unemployed Residents

Figure 5 below illustrates CT 29 (location of the recommended second CHCR site) and five bordering CTs (47, 33, 21, 27, and 40).

Figure 5: Recommended Second CHCR Site and Surrounding Census Tracts – Staten Island Community Health Assessment



The recommended second CHCR site shown in Figure 5 above is located in a CT cluster with a significant population base (31,270 residents) and almost 10,000 households. The average median household income of CT 29 and the five neighboring CTs is \$43,784. Approximately 17% of the households within this area are below the federal poverty level. Over 6% of the residents or 1,908 people living in this area are currently unemployed.

The six CTs which comprises the area of the recommended second CHCR site are listed in Table 73 below. Five out of the six CTs are located within ZIP code 10304 and the Stapleton St. George neighborhood in the northern half of Staten Island. Data collected from ZIP code 10304 and the Stapleton St. George neighborhood revealed strong percentages of the population without health insurance, low levels of access to care, and a strong need for a health center (see key findings 1 and 2 on pp. 6-9). The six CTs are also bordered by Interstate 278 to the South of the CT cluster which forms a barrier for residents living on the opposite side of the interstate to accessing the recommended second CHCR site.

Table 73: Recommended Second CHCR Site Census Tracts – Staten Island Community Health Assessment

Census Tract	ZIP Code	2007 Median Household Income	2007 Population	2007 Unemployed	2007 Households	2007 Households Below Poverty Level
29	10304	\$17,976	5,900	374	1,745	619
27	10304	\$30,625	1,945	63	385	55
40	10305	\$39,503	12,769	839	4,148	800
21	10304	\$42,839	3,698	172	1,175	126
33	10304 10301	\$62,081	3,400	109	1,309	62
47	10304 10301	\$69,680	3,558	350	1,119	32
Total/Average		\$43,784	31,270	1,908	9,881	1,694

- Source: Claritas 2007.
- The average Staten Island family household has 3.33 people living in it.
- The average Staten Island household has 2.74 people living in it.

III. STATEN ISLAND OVERVIEW

According to 2006 Community Health Profile Reports produced by the New York City Department of Health and Mental Hygiene, Staten Island is home to some 443,700 residents. Table 74 breaks down the population of Staten Island by neighborhood. The Southshore/South Beach/Tottenville neighborhood is by far the largest population on Staten Island covering 5 different ZIP codes including 10306, 10307, 10308, 10309, and 10312.

Table 74: Population – Staten Island Community Health Assessment

Neighborhood	Population (U.S. Census 2000)
Port Richmond (PR)	62,800
Willowbrook/Mid-Island (WB/MI)	84,800
Stapleton, St. George (SSG)	116,200
Southshore/South Beach Tottenville (SS/SBT)	179,900

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

The population on Staten Island is very similar from an age standpoint to that of New York City overall. The one exception is the Port Richmond Neighborhood which is shown to be a slightly younger population than the rest of Staten Island. Table 75 below shows the age distribution of Staten Island compared to New York City overall.

Table 75: Age Distribution – Staten Island Community Health Assessment

Age	NYC	Staten Island	Port Richmond	Stapleton/ St. George	Willowbrook Mid-Island	Southshore South Beach Tottenville
0-17 years	24%	25%	31%	25%	24%	25%
18-24 years	10%	9%	9%	9%	8%	8%
25-44 years	33%	31%	30%	32%	29%	31%
45-64 years	21%	23%	20%	22%	26%	25%
65+ years	12%	12%	10%	12%	13%	11%

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

Compared to New York City, Staten Island has a significantly lower poverty rate. Table 76 on page 254 shows this discrepancy. However, Staten Island itself is split in half economically. The two northern neighborhoods including Port Richmond and Stapleton/St. George have significantly higher poverty rates when compared to the southern half of Staten Island (Willowbrook/Mid-Island, Southshore/South Beach Tottenville).

Table 76: Poverty – Staten Island Community Health Assessment

	NYC	Staten Island	Port Richmond	Stapleton St. George	Willowbrook Mid-Island	Southshore South Beach Tottenville
Percentage of residents living below the poverty level	21%	10%	17%	14%	7%	5%

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

The number of residents on Staten Island with a college degree is significantly less than that of New York City overall. However, Staten Island has a higher percentage of high school graduates.

Table 77: Educational Attainment – Staten Island Community Health Assessment

Education	NYC	Staten Island	Port Richmond	Stapleton St. George	Willowbrook Mid-Island	Southshore South Beach Tottenville
Up to 8 th grade	12%	5%	7%	8%	4%	4%
Some high school, no diploma	16%	12%	15%	14%	10%	10%
High school diploma	25%	34%	33%	30%	33%	37%
Some college, no degree	20%	26%	26%	24%	26%	27%
College graduate	27%	23%	19%	24%	23%	22%

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

When compared to New York City, Staten Island has less than half the same percentage of residents who are foreign born. Within Staten Island, Stapleton/St. George has the highest percentage of foreign born residents at 22%. Table 78 below illustrates the percentage of foreign born residents by neighborhood.

Table 78: Foreign Born – Staten Island Community Health Assessment

	NYC	Staten Island	Port Richmond	Stapleton St. George	Willowbrook Mid-Island	Southshore South Beach Tottenville
Percentage of residents who are foreign born	36%	16%	18%	22%	16%	12%

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

As with the poverty rate, Staten Island is again divided between the northern neighborhoods and the southern neighborhoods with regard to race/ethnicity. The southern neighborhoods (WB/MI and SS/SBT) have significantly higher percentages of white residents than do the northern neighborhoods (PR and SSG). The northern part of Staten Island is significantly more diverse than the southern part.

The diversity within the northern part of Staten Island creates unique challenges to health care including health literacy, language interpretation, and cultural barriers that are not as prevalent within more homogeneous communities.

Table 79: Race/Ethnicity – Staten Island Community Health Assessment

Race	NYC	Staten Island	Port Richmond	Stapleton St. George	Willowbrook Mid-Island	Southshore South Beach Tottenville
White	35%	71%	45%	56%	76%	88%
African American	24%	9%	24%	18%	3%	1%
Hispanic	27%	12%	24%	17%	8%	7%
Asian	10%	6%	4%	6%	11%	3%
Other	4%	2%	3%	3%	2%	1%

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

Access to care is a primary concern for this community health needs assessment. To further understand this issue, Tripp Umbach and FT Solutions tracked data related to primary care providers and health insurance statistics. Within both of these measures illustrated in Table 80 and Table 81, Staten Island outperforms New York City by significant margins. By itself, Staten Island again shows a disparity between its northern and southern residents. Port Richmond and Stapleton/St. George have significantly higher percentages of residents without a primary care provider and health insurance.

Table 80: Primary Provider – Staten Island Community Health Assessment

	NYC	Staten Island	Port Richmond	Stapleton St. George	Willowbrook Mid-Island	Southshore South Beach Tottenville
% of residents without a personal doctor	24%	15%	20%	20%	15%	10%
Go to ED when sick or need health advice	8%	6%	10%	9%	8%	2%

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

Table 81: Health Insurance – Staten Island Community Health Assessment

Insurance	NYC	Staten Island	Port Richmond	Stapleton St. George	Willowbrook Mid-Island	Southshore South Beach Tottenville
Insured now, and for entire past year	71%	83%	75%	78%	82%	91%
Insured now, but uninsured some time in past year	11%	6%	11%	7%	8%	3%
Uninsured now	18%	11%	14%	15%	10%	6%

- Source: New York City Department of Health and Mental Hygiene Community Health Profiles; Second Edition, 2006.

IV. CLARITAS DEMOGRAPHIC PROJECTIONS

Staten Island is composed of 110 Census Tracts within the four major neighborhoods. Recent studies show that 16 of the 110 Census Tracts are Community Development Block Grant (CDBG) eligible. CDBG eligible Census Tracts are areas where at least 51% of the residents are low and moderate-income persons (less than 80% of the 2000 Census Median Family Income, or \$41,700 for a family of four). All but one of these CDBG Census Tracts is found within the northern two neighborhoods (PR and SSG). The remaining CDBG eligible Census Tract (185) is found within the Willowbrook/Mid-Island neighborhood which is located in the heart of Staten Island. All 110 Census Tracts are shown in Figure 1 on page 16.

Within the 16 CDBG eligible Census Tracts, 9 of the 2007 estimated top 10 lowest median household income Census Tracts may be found. Table 82 below illustrates these Census Tracts by 2007 estimates and 2012 projected median household income levels.

Table 82: Top Lowest Median Household Income Census Tracts – Staten Island Community Health Assessment

Census Tract	UHF Neighborhood	2007 Median Household Income	2012 Projected Median Household Income	% Change
185	Willowbrook	\$9,999	\$9,999	0%
133.01	Port Richmond	\$15,169	\$16,500	9%
154	South Beach Tottenville	\$17,500	\$27,500	57%
29	Stapleton St. George	\$17,976	\$19,021	6%
219	Port Richmond	\$29,792	\$31,667	6%
27	Stapleton St. George	\$30,625	\$33,000	8%
319.01	Port Richmond	\$31,588	\$34,455	9%
207	Port Richmond	\$32,721	\$34,449	5%
18	Stapleton St. George	\$34,583	\$37,035	7%
74	Stapleton St. George	\$34,820	\$37,983	9%

- Sources: Claritas 2007.

Table 83 on page 258 illustrates the top Census Tracts related to families below the poverty level. Overall, 6 out of the 10 Census Tracts with the highest numbers of families below the poverty level fall within the Stapleton/St. George neighborhood.

Table 83: Top 10 Census Tracts – Families below Poverty, Married Couples with Children – Staten Island Community Health Assessment

Census Tract	UHF Neighborhood	2007 Families Below Poverty, Married Couple with Children	2012 Projected Families Below Poverty, Married Couple with Children	% Change
29	Stapleton St. George	140	148	6%
74	Stapleton St. George	111	126	14%
40	Stapleton St. George	96	101	5%
277.03	Willowbrook	91	94	3%
50	Stapleton St. George	89	90	1%
70	Stapleton St. George	82	84	2%
128.03	South Beach Tottenville	75	77	3%
21	Stapleton St. George	63	63	0%
207	Port Richmond	61	64	5%
219	Port Richmond	56	59	5%

- Source: Claritas 2007.
- Census tracts highlighted in red are also found in Table 82 on page 257.

Table 84 illustrates the top 10 Census Tracts related to unemployment levels for the population age 16+. Stapleton/St. George stands out again as it has the three highest Census Tracts related to the number of unemployed persons. Also of note is Port Richmond. Port Richmond has 3 Census Tracts included in Table 84 with an average projected rate of unemployment increase of 9% by 2012.

Table 84: Top 10 Census Tracts Population Age 16+ Unemployed – Staten Island Community Health Assessment

Census Tract	UHF Neighborhood	2007 Population Age 16+ Unemployed	2012 Projected Population Age 16+ Unemployed	% Change
40	Stapleton/St. George	839	917	9%
29	Stapleton/St. George	374	395	6%
47	Stapleton/St. George	351	364	4%
231	Port Richmond	313	354	13%
291.04	Willowbrook	295	293	-1%
170.10	South Beach Tottenville	283	295	4%

Census Tract	UHF Neighborhood	2007 Population Age 16+ Unemployed	2012 Projected Population Age 16+ Unemployed	% Change
128.03	South Beach Tottenville	275	284	3%
207	Port Richmond	263	285	8%
213	Port Richmond	261	277	6%
208.01	South Beach Tottenville	255	275	8%

- Source: Claritas 2007.
- Census Tracts highlighted in red are also found in Table 82 on page 257.

Table 85 below illustrates the top 10 lowest median household income Census Tracts originally shown in by population growth. Six out of the top 10 poorest Census Tracts on Staten Island are also within the top 20 fastest growing Census Tracts on Staten Island. This includes the #1 overall fastest projected area of growth on Staten Island (74) which is located within the Stapleton/St. George neighborhood.

Table 85: Top 10 Lowest Median Household Income Census Tracts by Population Growth – Staten Island Community Health Assessment

Census Tract	UHF Neighborhood	2007 Estimated Population	2012 Projected Population	% Change (Growth Rank)
74	Stapleton St. George	5074	5856	15% (#1)
319.01	Port Richmond	3935	4281	9% (#8)
18	Stapleton St. George	1235	1322	7% (#12)
207	Port Richmond	5497	5856	7% (#14)
219	Port Richmond	1091	1160	6% (#18)
185	Willowbrook	444	472	6% (#19)
29	Stapleton St. George	5900	6178	5% (#27)
27	Stapleton St. George	1945	2013	4% (#41)
15	South Beach Tottenville	11	11	0% (#88)
133.01	Port Richmond	1604	1507	-6% (#109)

- Source: Claritas 2007.

V. HOUSEHOLD SURVEY

Tripp Umbach and FT Solutions conducted a household survey process to assess the current health status of Staten Island residents and their level of access to care. The sample of households surveyed was selected at random through a phone and hand distribution methodology.

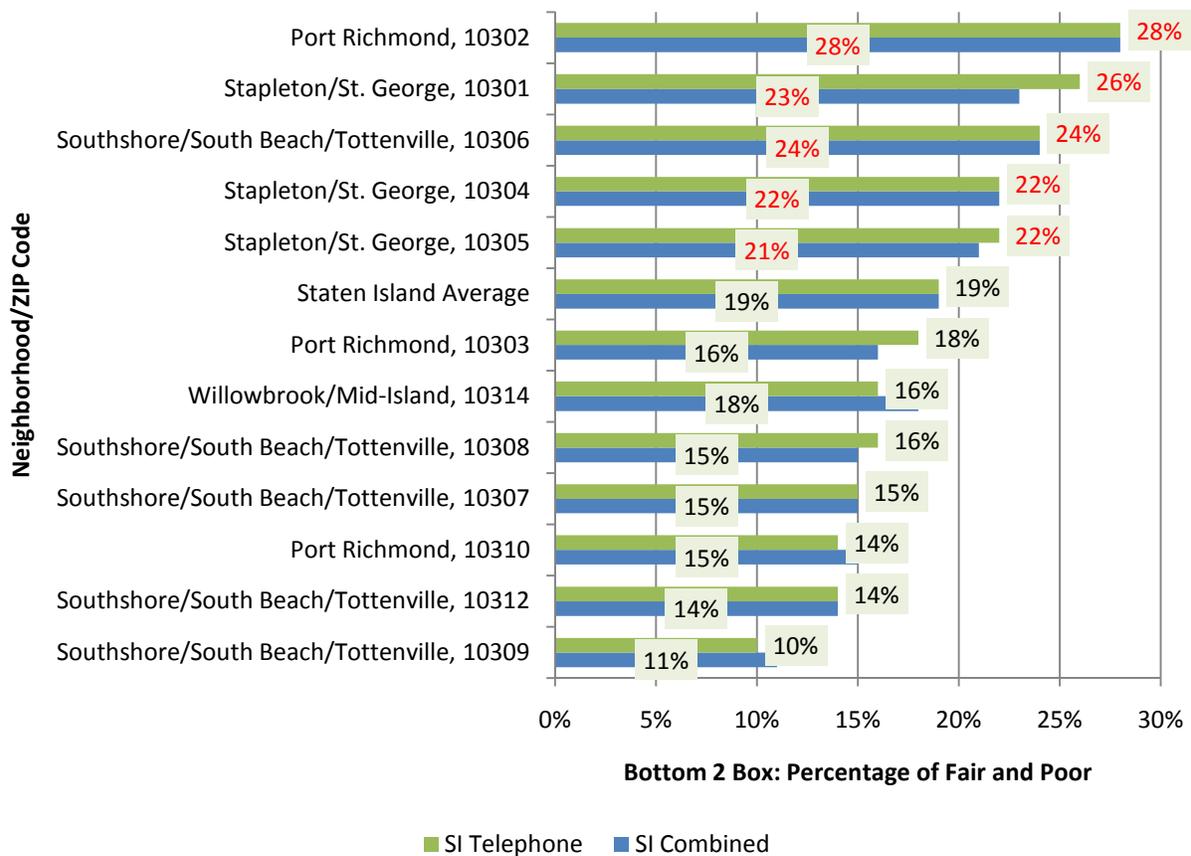
In total:

- 12 ZIP codes surveyed: 10301, 10302, 10303, 10304, 10305, 10306, 10307, 10308, 10309, 10310, 10312, 10314
- 50 surveys were collected via phone within each ZIP code for a total of 602 surveys
- 93 hand distributed surveys were also collected from local undocumented immigrant populations to supplement the database
- 695 total surveys collected for analysis: Sample was significant at the 95% confidence interval with a margin of error of +/- 3.7%.
- Data reported in aggregate and ZIP code level
- Data reported as SI Combined (Phone survey + Hand Distributed Surveys n=695), SI HD (Hand Distributed Survey Alone n=93), and SI Phone (Phone Survey Alone n=602)
- 4 Staten Island Neighborhoods
 - Port Richmond (PR): 10303, 10302, and 10310
 - Stapleton/St. George (SSG): 10301, 10304, 10305
 - Willowbrook/Mid Island (WB/MI): 10314
 - Southshore/South Beach Tottenville (SS/SBT): 10306, 10307, 10308, 10309, 10312

Tripp Umbach and FT Solutions asked Staten Island residents a series of questions related to their health status including leading health indicators such as (being told by a health professional within the past two years that they have) high cholesterol, high blood pressure, diabetes, obesity, and mental health or emotional problems. The results of these questions were mixed as there is no obvious trend in the data showing that one section of Staten Island is healthier or less healthy than the others. However, when respondents were asked to rate their overall health status, residents from the northern part of Staten Island had a significantly higher percentage of respondents who rated their health status as “fair” or “poor” when compared to respondents from the southern part of Staten Island.

Chart 15 below shows the percentages of respondents by ZIP code who rated their health in general as “fair” or “poor”. On average, 19% of respondents on Staten Island feel their general health is “fair” or “poor”. Out of the 12 ZIP codes, 5 had an average rating above the Staten Island rating, 80% of which are located in the northern part (PR and SSG) of the island.

Chart 15: Overall Rating of Health – Staten Island Community Health Assessment

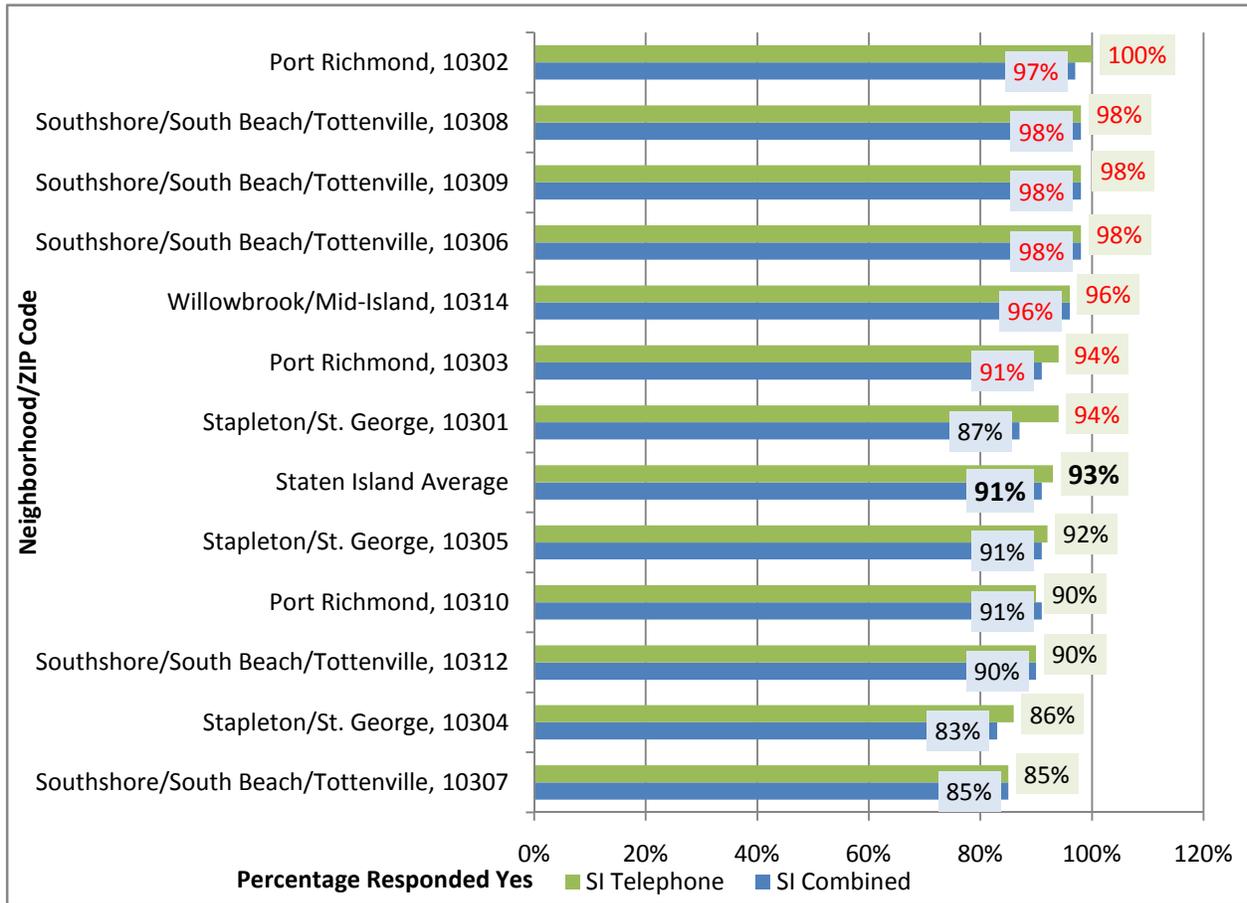


- Percentages highlighted in red are above average.

According to data provided by the New York City Department of Health and Mental Hygiene, 11% of the population within Staten Island is uninsured and 15% of the population is without a primary care provider. The household survey conducted by Tripp Umbach and FT Solutions shows 7% of phone survey respondents (8% phone and hand distributed) not having a health insurance plan that covers the majority of health care expenses and 6% of respondents (8% phone and hand distributed) not having a primary care provider that they go to most often for their health care needs.

Chart 16 below illustrates the percentage of respondents to the household survey who stated they have a health insurance plan that covers the majority of their health care expenses.

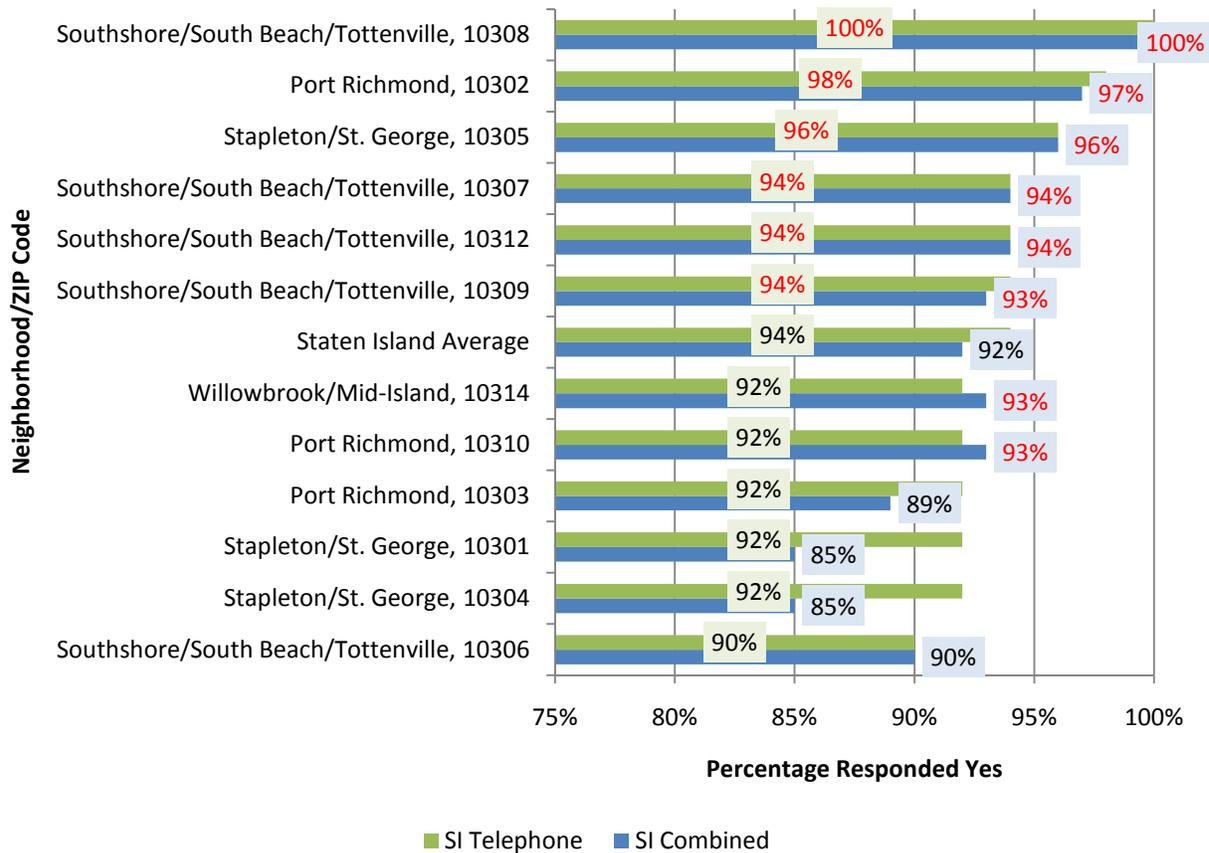
Chart 16: Health Insurance – Staten Island Community Health Assessment



- Percentages highlighted in red are above average.

Chart 17 below illustrates the percentage of respondents who have a primary care provider that they go to most often for their health care needs. Half of the 12 ZIP codes fell below the Staten Island average. Four of the six below average ZIP codes are located within the northern neighborhoods of Staten Island.

Chart 17: Main Health Provider – Staten Island Community Health Assessment



- Percentages highlighted in red are above average.

Survey respondents were also asked if they would use a health center or have a need for a health center in their neighborhood. Chart 18 on page 265 and Chart 19 on page 266 illustrate the responses to these questions. Not surprisingly, ZIP code 10302 in Port Richmond, along with ZIP code 10304, have the highest percentage of respondents who would use a Health Center if available to them. ZIP code 10302 in Port Richmond makes sense because it is the location of the current CHCR site. ZIP code 10304 also makes sense because it is the ZIP code with the second lowest percentage of respondents with health insurance and a primary care provider. Overall, there are five ZIP codes where respondents’ responses were above the Staten Island average related to using a health center if available. Four of the 5 above average ZIP codes are located in the northern half of Staten Island.

Chart 18: Respondents Who Would Use a Health Center if Available – Staten Island Community Health Assessment

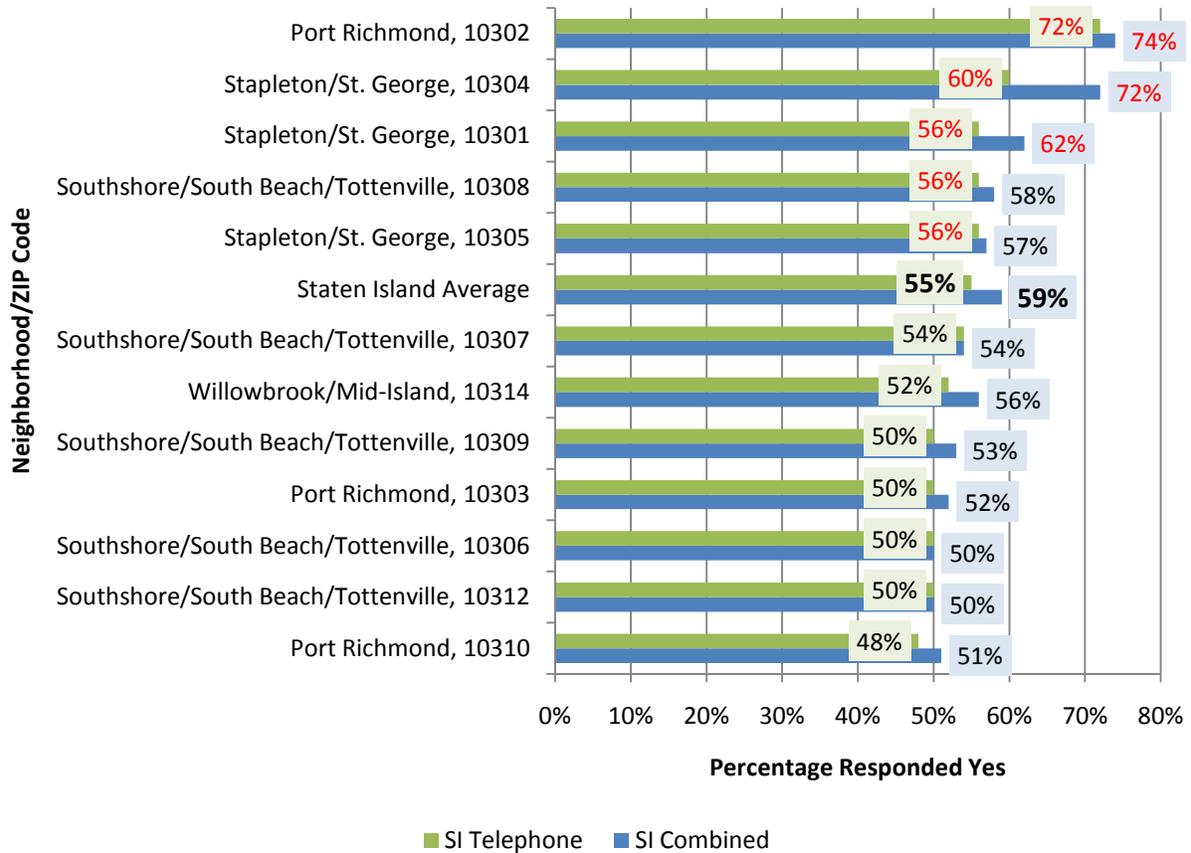
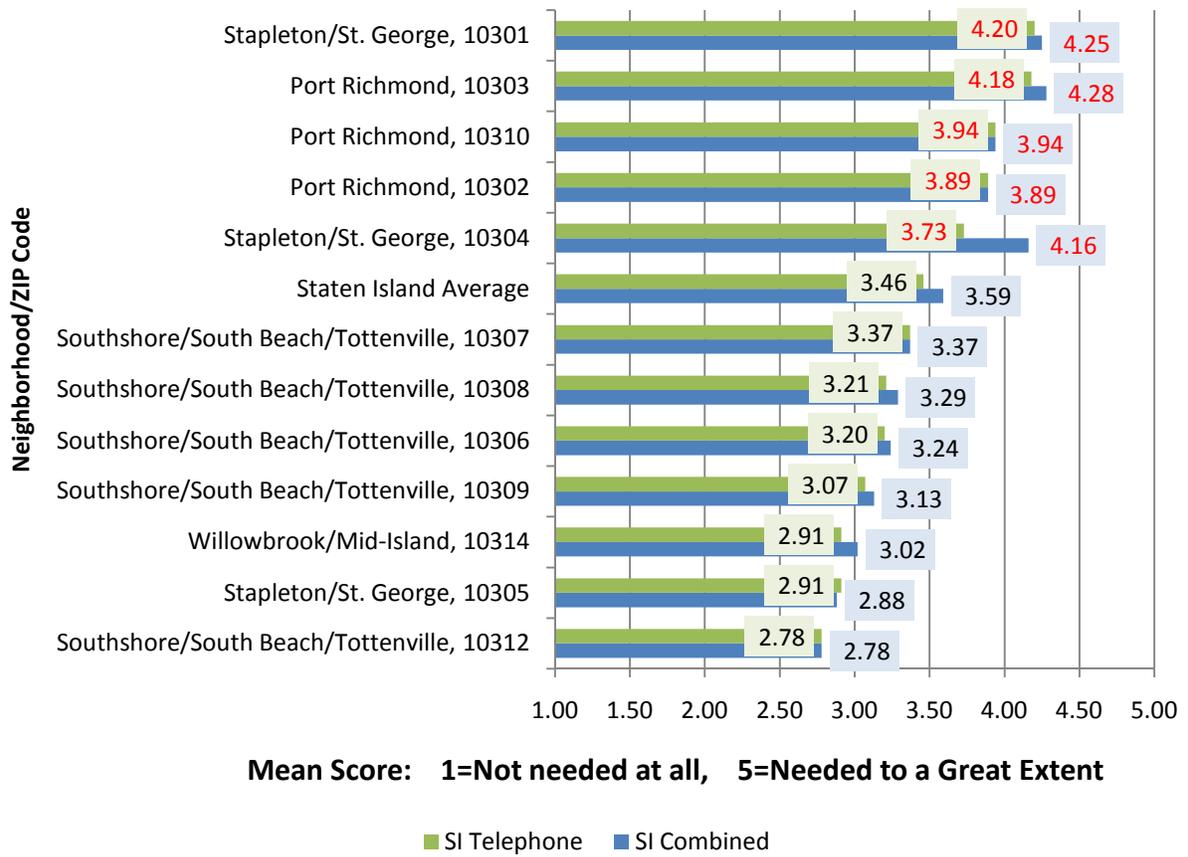


Chart 19 on page 266 demonstrates the need for a health center in each ZIP code from the perspective of the respondents. Survey respondents were asked to rate the level of need for a health center in their neighborhood on a scale of 1 to 5 where 1 is “not needed at all” and 5 is “needed to a great extent”. Mean scores were calculated and reported in rank order by ZIP code. The average score for Staten Island was 3.46. Five ZIP codes reported a greater need for a health center than the overall average. All five are located in the northern part of Staten Island. In fact, only one northern ZIP code (10305) did not see a great need for a health center in the community.

Chart 19: Need for a Health Center in Your Community – Staten Island Community Health Assessment

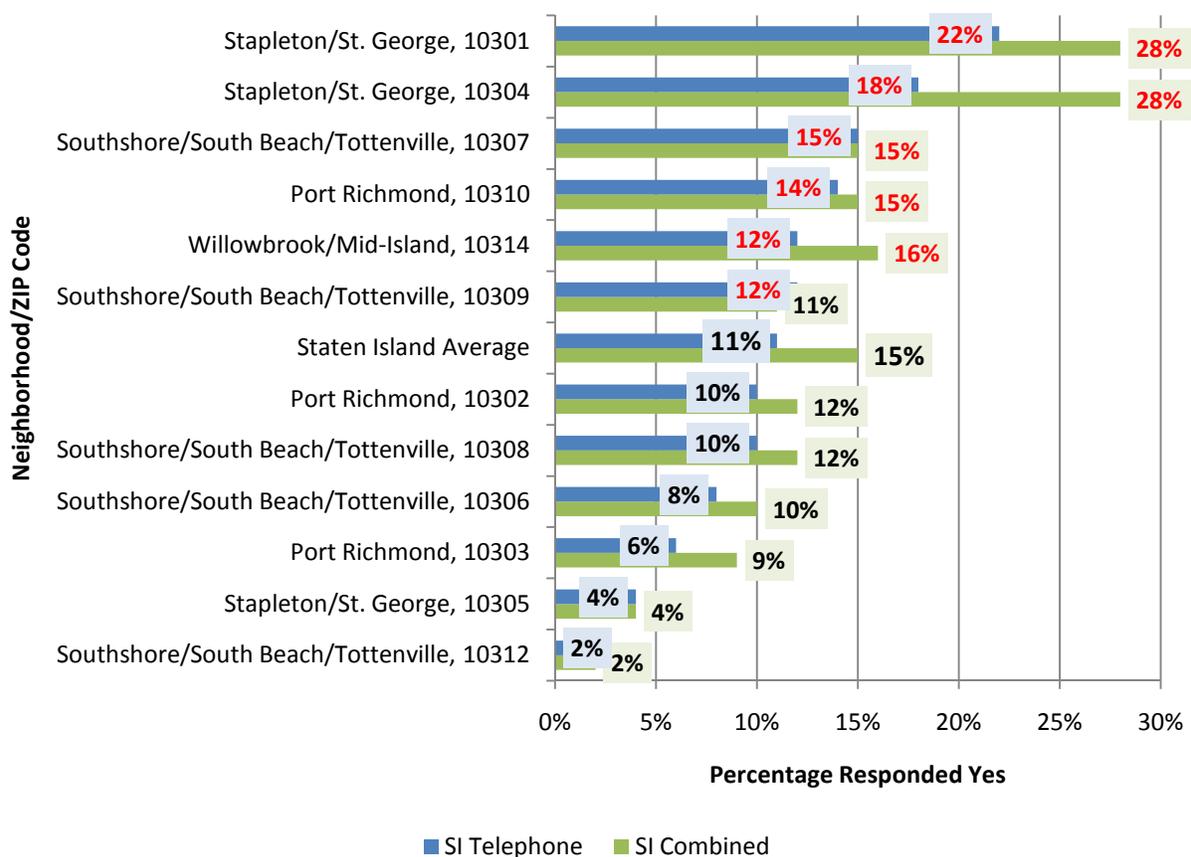


- Mean Scores highlighted in red are above average

Survey respondents were also asked if they are looking for a doctor or are having trouble finding specific types of medical services that are not currently available in their neighborhood. Chart 20 below and Chart 21 on page 268 illustrate the responses.

Overall, only three ZIP codes reported a significantly higher than average need related to looking for doctors. Two of these ZIP codes 10304 and 10305 are located in Stapleton/St. George. Regardless of ZIP code, the number one type of doctor residents are looking for are family doctors at 16% with number two being mental wellness doctors at 9%.

Chart 20: Looking for a Doctor – Staten Island Community Health Assessment

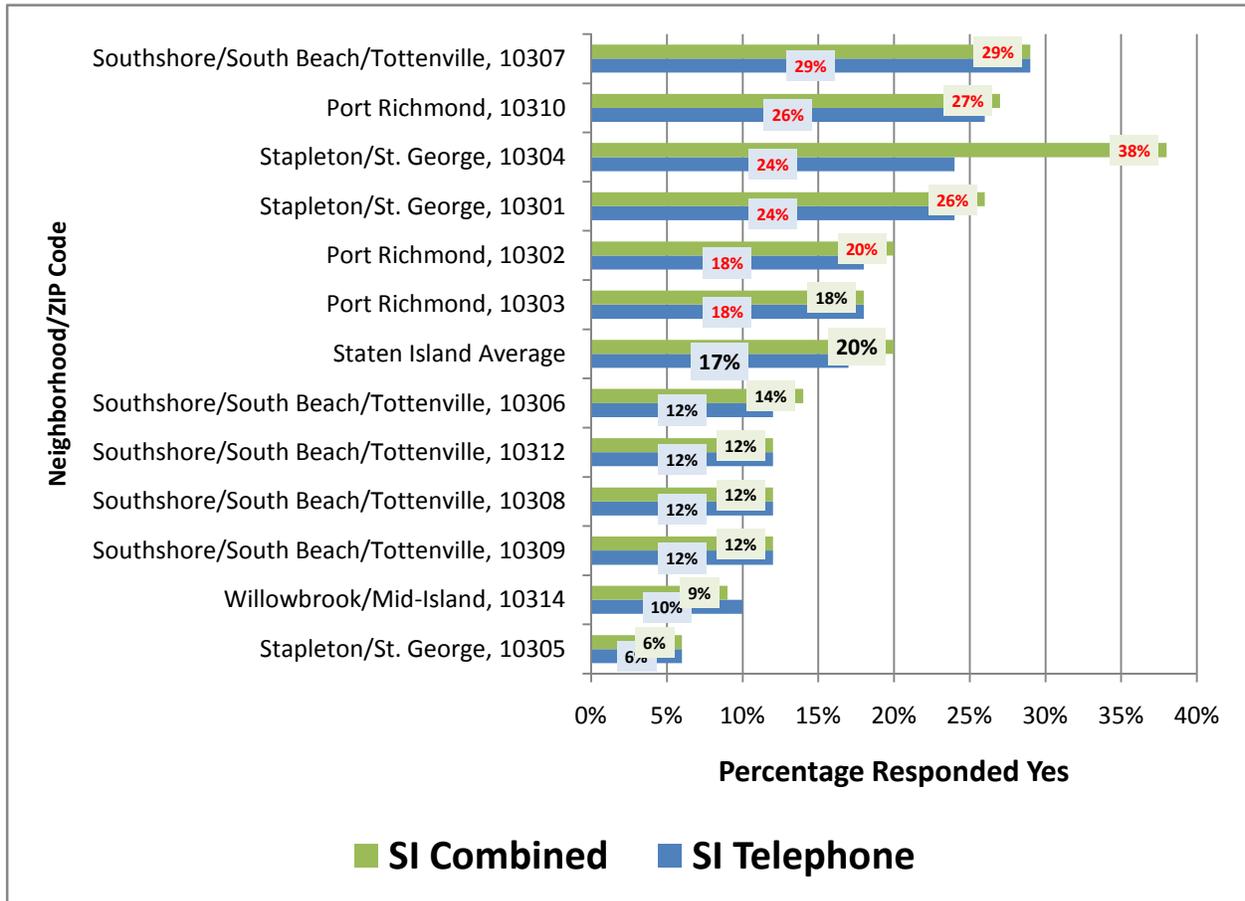


- Percentages highlighted in red are above average.

There are four ZIP codes stating a significantly higher need for medical services than the Staten Island average of 17%. Three of the significantly above average ZIP codes are located in the northern part of

Staten Island (PR and SSG). The number one response, regardless of ZIP code, for specific types of medical services needed is hospitals/free clinics at 29%.

Chart 21: Need for Medical Services – Staten Island Community Health Assessment



- Percentages highlighted in red are below average.

VI. PROVIDER SURVEY AND RELATED SECONDARY DATA

The shortage of primary care physicians has left millions of Americans without primary health care services, creating a population of medically disenfranchised individuals who lack access to “medical homes” (such as a family doctor or clinic).⁶⁵ Nearly one in five Americans – 56 million individuals – are medically disenfranchised, meaning they have inadequate or no access to primary care physicians because of the shortage of such physicians.

The medically disenfranchised come from all income levels, racial backgrounds and ethnic groups, and it is important to note that most of these individuals have health insurance. However, they all lack one vital health care component – a medical home to address basic health care needs. “Having insurance coverage without a source of care is as worthless as having currency without a marketplace,” said Joseph Feaster Jr., Speaker of the House of National Association of Community Health Centers (NACHC). Feaster added, “If you have a health care home -- whether you have insurance or not -- you are more likely to have better and lower health care costs. You also are less likely to visit a hospital emergency room or get admitted to a hospital.”

“The toll of unmet health care needs among these health care have-nots is incalculable, and the tragic outcomes they experience are appalling,” said Feaster. On a national level, the report stated:

- More than 1 million people in each of 21 states are medically disenfranchised.
- Three states – Florida, Texas, and California – are home to nearly 30 percent of the nation's medically disenfranchised. Florida has about 8 million of the medically disenfranchised, Texas, 4.6 million and California, 4 million.
- Nearly half of all U.S. counties have medically disenfranchised populations who are struggling without a community health center located within their counties.

Richmond County is experiencing similar issues to the rest of the nation with regard to primary care physician shortage. Issues exist in pockets throughout the entire County, which points to issues of insufficient availability of physicians and specialists.

According to the 2005 *Annual New York Physician Workforce Profile*, within Richmond County there are a total of 1,266 physicians (FTEs). Their average age is 50 years old, 28% are female, and 80% have completed their residency training within the State of New York. These numbers are comparable to New York City and the State of New York.

⁶⁵ Source: “Access Denied: A Look at America’s Disenfranchised.” 2007. National Association of Community Health Centers (NACHC), and the American Academy of Family Physician's Robert Graham Center.

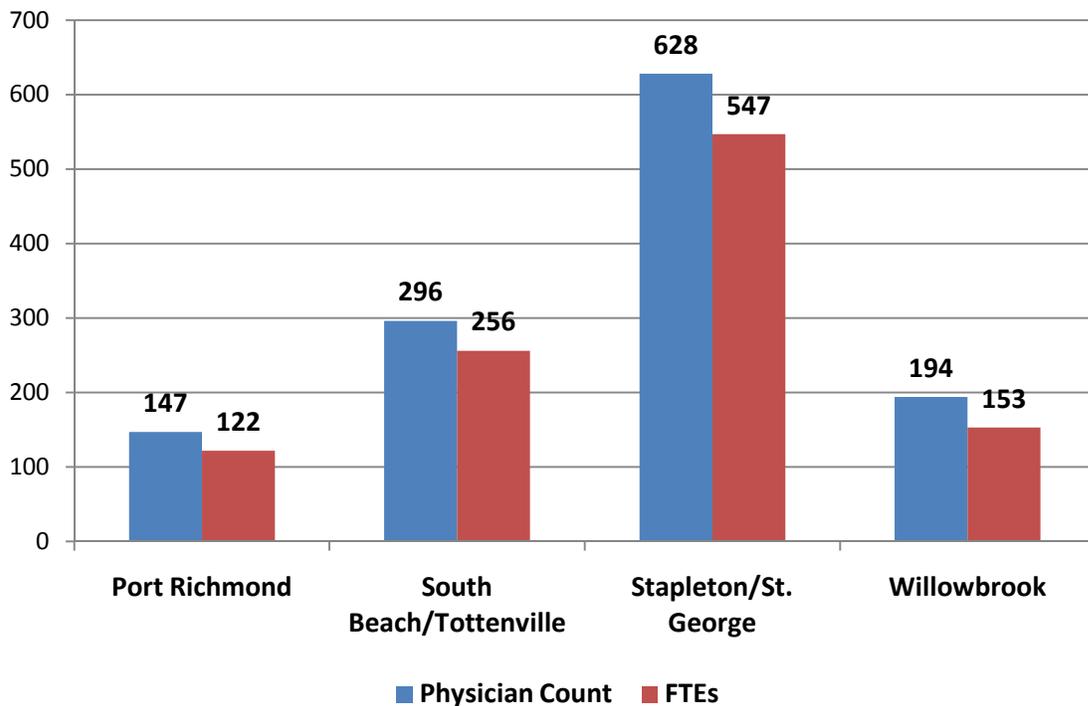
Table 86: Profile of Active Patient Care Physicians (2005) – Staten Island Community Health Assessment

	Richmond County	New York City	New York State
2005 Population	466,519	8,113,728	19,282,162
Profile of Active Patient Care Physicians, 2005			
Number of Physicians	1,266	29,559	61,931
Full Time Equivalents (FTEs)	1,255	25,249	55,390
Average Age	50	51	51
Percent Female	28%	32%	29%
Percent Underrepresented Minority	6%	13%	10%
Percent International Medical School Graduates (IMGs)	58%	40%	35%
Percent NY Medical School Graduates	28%	35%	38%
Percent with Residency Training in NY	80%	83%	76%

When broken out by Staten Island neighborhoods, Stapleton/St. George has the highest number of physicians with 547 FTEs. Port Richmond has the lowest number of physicians with 122 FTEs.

Chart 22: Total Physicians by Staten Island Neighborhood – Staten Island Community Health Assessment

Physicians by Staten Island Neighborhood



- Source: SUNY Center for Workforce Development

Physician supply data analyses from 2001 to 2005 show that Richmond County has lost 17% of primary care physicians (FTE) per 100k population. Non-Primary Care doctors have increased since 2001 by 18%. It is noteworthy that the FTE count of obstetrician/gynecologists has decreased by 14% and general surgery has decreased by 42%.⁶⁶

⁶⁶ Source: Annual New York Physician Workforce Profile, 2006 Edition.

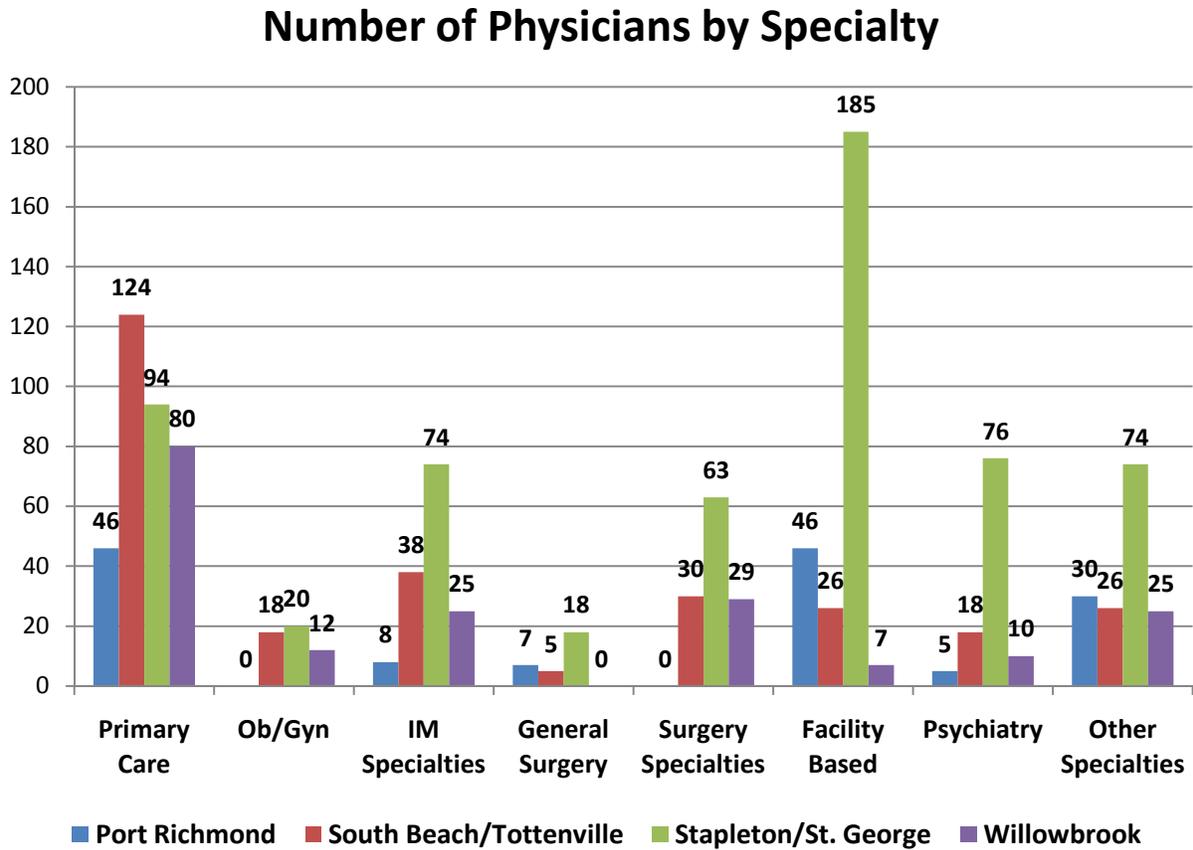
Table 87: Physician Supply 2001 – 2005 – Staten Island Community Health Assessment

Physician Supply 2005					Change in Supply, 2001 – 2005			
Specialty Group	Physician Counts	FTE Counts	Physicians per 100k Population	FTEs per 100k population	Physician Counts	FTE Counts	% Physicians per 100K Population	% FTEs per 100K Population
Primary Care	343	325	74	70	-39	-52	-13%	-17%
Non-Primary Care	893	904	192	194	141	162	15%	18%
Ob/Gyn	65	62	14	13	-9	-8	-15%	-14%
IM Specialties	146	152	31	33	30	32	22%	22%
General Surgery	32	26	7	6	-8	-17	-22%	-42%
Surgical Specialties	122	131	26	28	29	32	27%	29%
Facility Based	265	287	57	62	111	123	66%	69%
Psychiatry	108	105	23	23	5	18	2%	16%
Total (All Physicians)	1,266	1,255	271	269	103	113	5%	6%

- Other physician specialties are not displayed but are included in the non-primary care total.

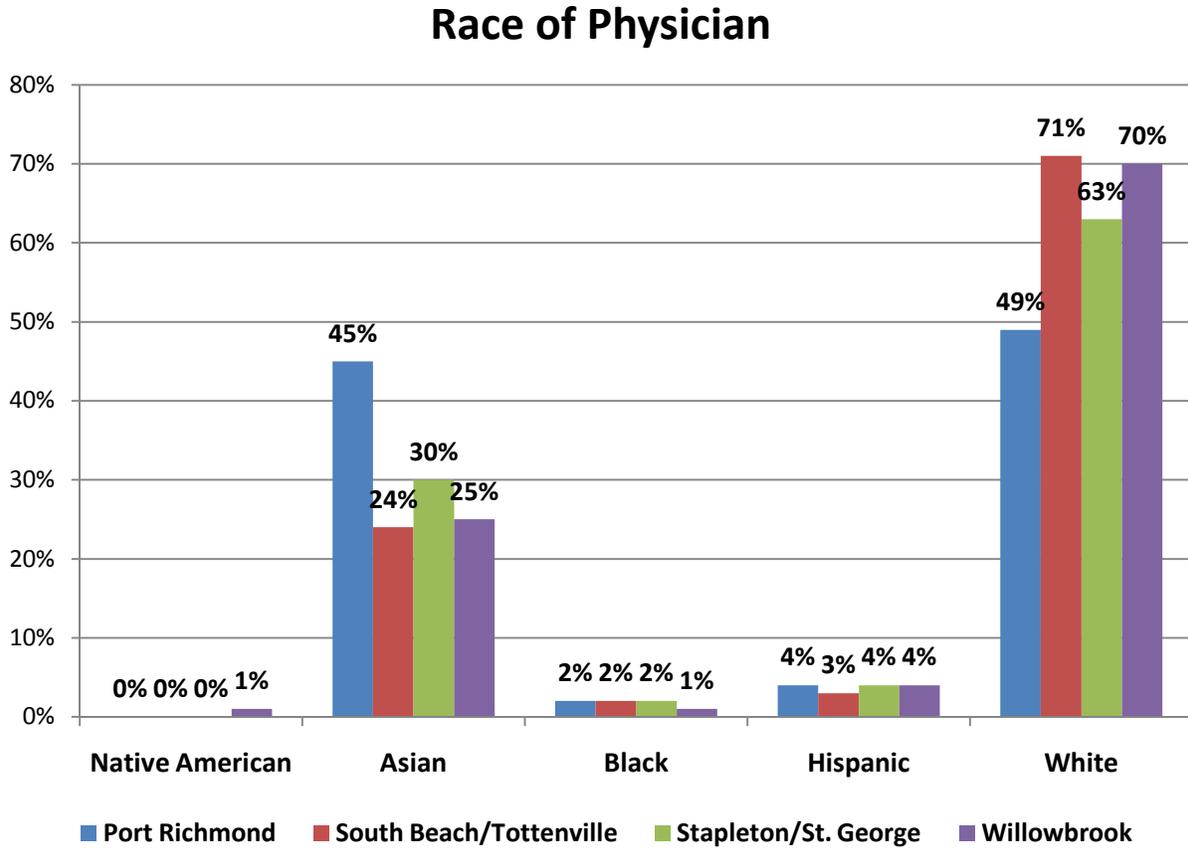
South Beach/Tottenville has largest number of Primary Care doctors and Port Richmond has the lowest number. Internal Medicine Specialties, Surgery Specialties, Psychiatry, and Other Specialties are also highest in Stapleton/St. George.

Chart 23: Number of Physicians by Specialty – Staten Island Community Health Assessment



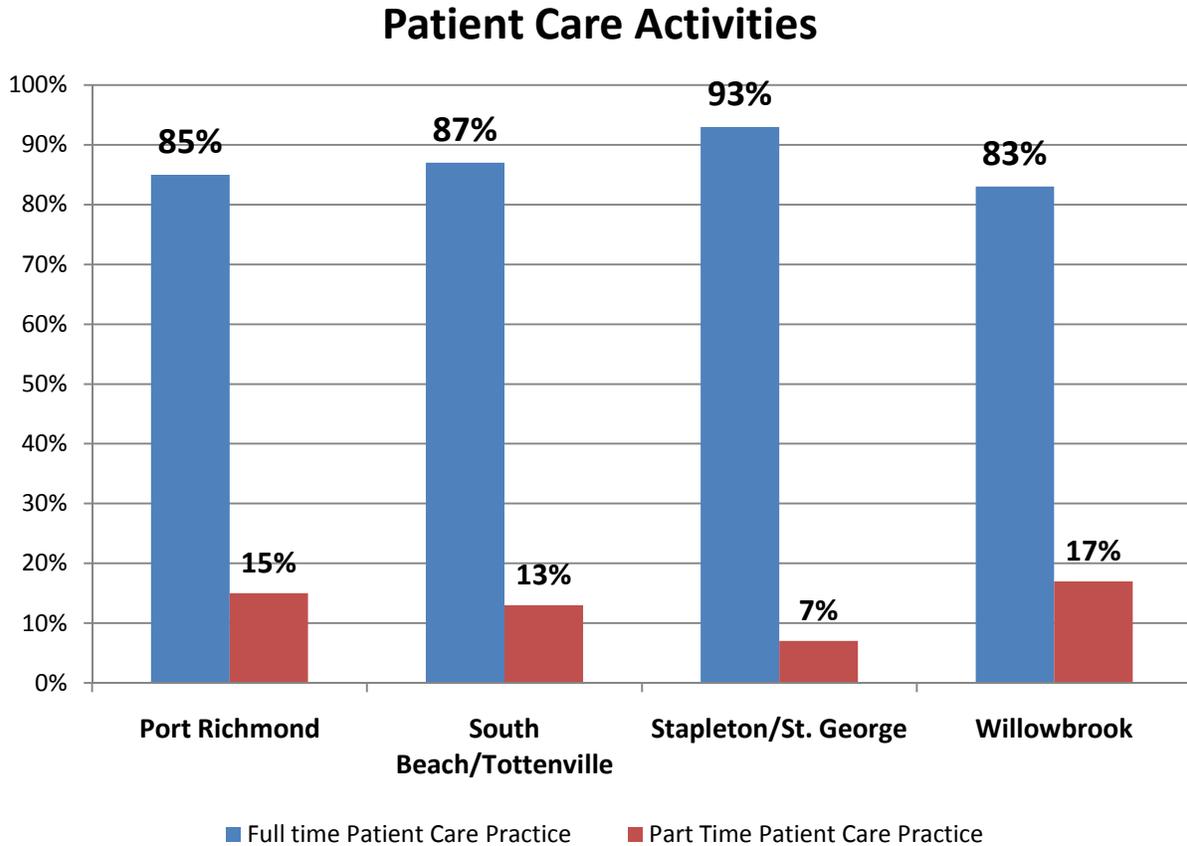
The majority of physicians in South Beach/Tottenville, and Willowbrook reported that their race as White. In Port Richmond, there are a larger percentage of physicians who reported their race as Asian (45%) than all other communities; however 49% reported their race as White. It is noteworthy that not a large percentage of physicians reported their race as Native American, Black, or Hispanic in any of the communities.

Chart 24: Race of Physician – Staten Island Community Health Assessment



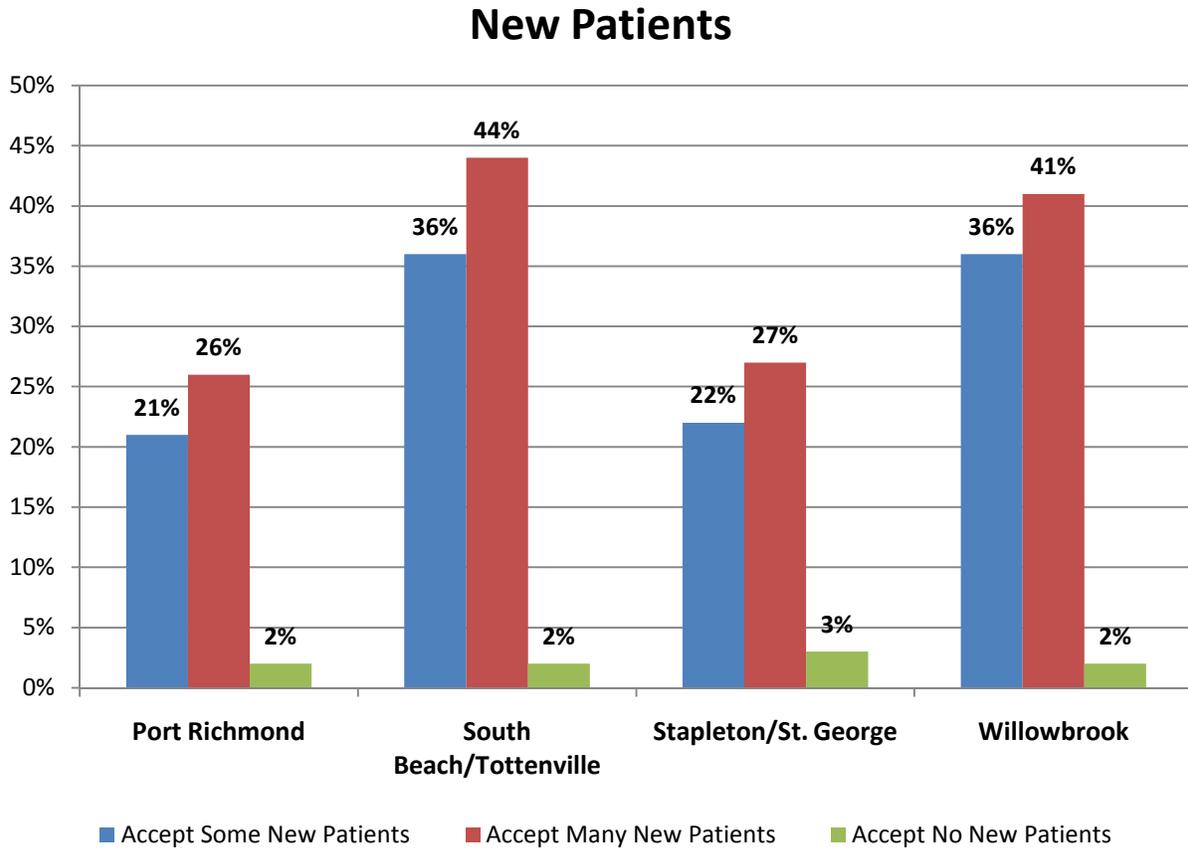
The majority of physicians in all communities reported that they are engaged in full-time patient care.

Chart 25: Patient Care Activities – Staten Island Community Health Assessment



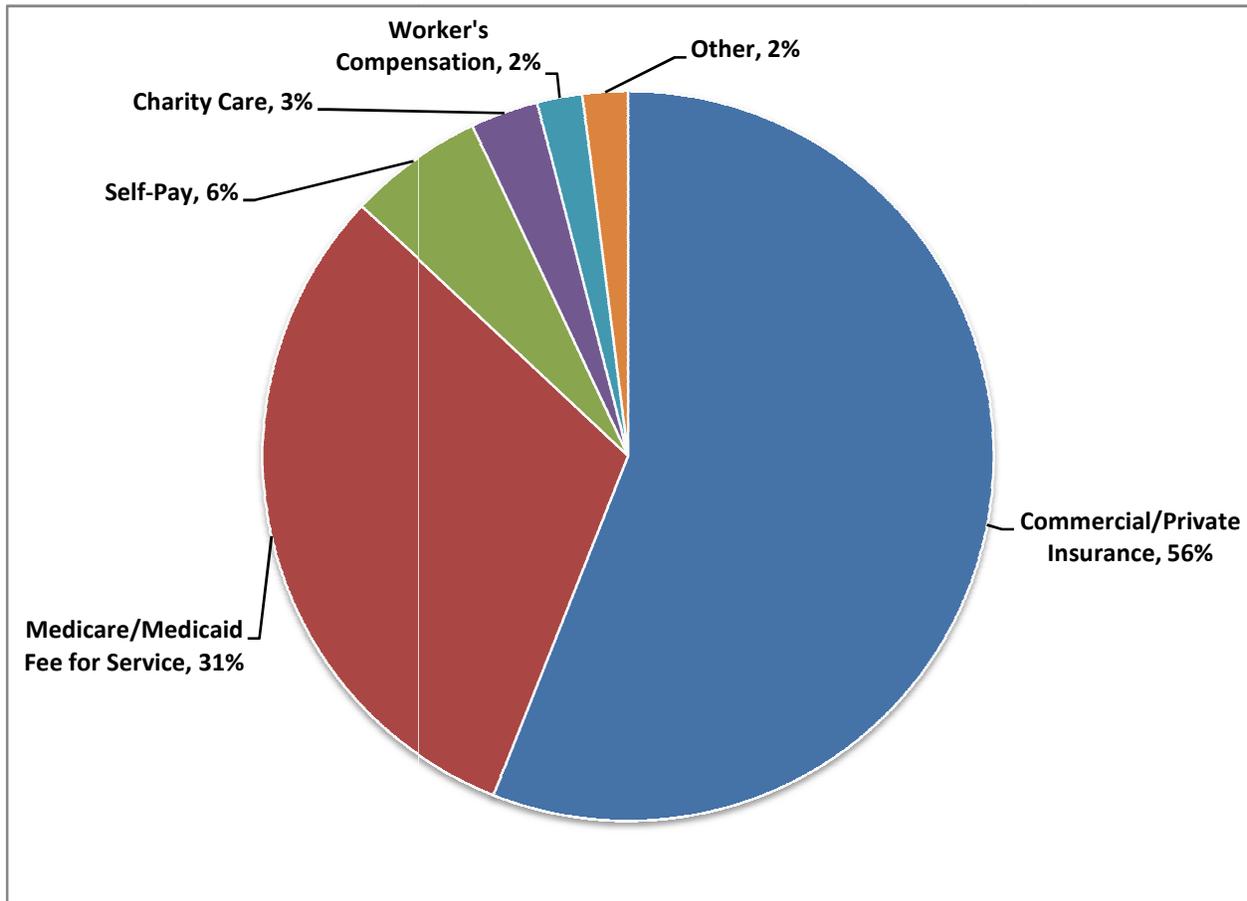
The SUNY Center for Workforce Development data reveals that physicians report that they are either accepting some new patients or many new patients. However, it is important to note that the data do not report what kinds of new patients the physicians are accepting by insurance type.

Chart 26: Acceptance of New Patients – Staten Island Community Health Assessment



When looking at the payor mix of physicians surveyed by Tripp Umbach, over half of the physician's overall payor mix are made up of private insurance companies and 31% of patients are Medicare/Medicaid Fee for Service.

Chart 27: Overall Physician Payor Mix – Staten Island Community Health Assessment



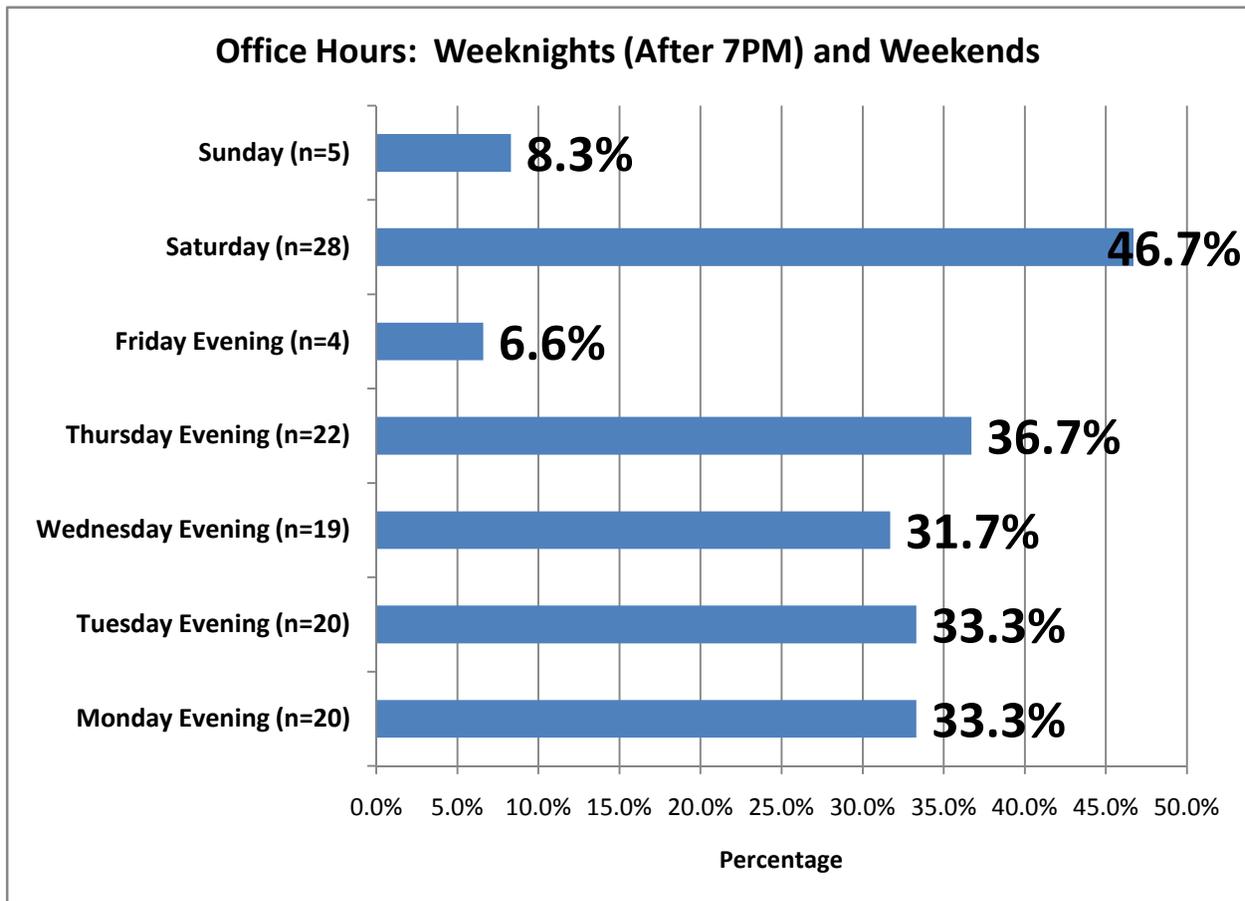
Further analysis of the payor mix reveals that:

- 50% of physicians surveyed stated that they accept Medicaid patients. Of this 50% Medicaid patients represent 10.2% of their patient base.
- 58% of physicians stated that they serve Family Health Plus patients. Of this 58%, Family Health Plus patients represent 4.9% of their patient base.
- 39% of physicians stated that they serve Child Health Plus patients. Of this 39%, Child Health Plus patients represent 5.2% of their patient base.
- 50% of physicians stated that they accept a sliding fee scale based on income or ability to pay. Of this 50%, patients utilizing a sliding fee scale represent 2.8% of their patient base.

The above payor mix details show that Medicaid does not represent a large percentage of their overall payor mix.

Physicians were also asked to detail their operating hours. The chart below shows that 46.7% of respondents reported having office hours on Saturday, but only 8.3% reported having office hours on Sunday. Only 6.6% of physicians have Friday evening hours.

Chart 28: Evening and Weekend Hours on Staten Island – Staten Island Community Health Assessment



Also, professional translation services for those patients who do not speak English as a first language are not frequently offered. However, 73% of physicians stated that they provide language interpretation services for their patients. Spanish, Italian, and Russian were the top 3 languages that are offered. Survey results show that the physician and staff provide these services to their patients. As the minority population on Staten Island increases, it becomes critical to provide greater access to professional translation services.

ADDITIONAL INFORMATION:

For more information about the research and analysis presented in this report, please contact the research team listed below.

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Appendix C:
Primary Care Initiative
Community Health Assessment Survey

APPENDIX C: PRIMARY CARE INITIATIVE COMMUNITY HEALTH ASSESSMENT SURVEY

This Appendix contains reproductions of the actual tool used in the survey.⁶⁷

Surveyor's Name: _____

Date of Survey: _____

Neighborhood survey conducted in: _____

Notes to interviewer:

1. Text that you read aloud to participants is in a **non-italicized bold font**. When words are underlined, say them with greater emphasis. To save on ink, response options (which you will read most of the time to participant) are not in bold. Instructions to you, the surveyor, are in non-bold italics and are not read aloud to the participant.
2. Whenever you see **(their neighborhood)** in a question, replace it by saying the name of the participant's neighborhood.
3. Whenever you see **(in the last 2 years/since moving to their neighborhood)** in a question, say "**in the last 2 years**" if the participant has lived in the neighborhood 2 or more years, or say "**since moving to (their neighborhood)**" if they've lived in the neighborhood less than 2 years.
4. When reading response options to specific questions, don't read "Don't know/not sure" and "Refused" options. Only offer these as options when the participant seems to be leaning in either of those directions.
5. If they are leaning towards "don't know/not sure," try strategies for helping them choose another answer, such as clarifying the question, or giving examples of what a "Yes" or "No" response might be.
6. Enter the data below for persons who qualify for the survey.

Are you 18 or older? (yes/no) _____

What ZIP code do you live in? _____

What neighborhood do you live in? _____

How long have you lived in this neighborhood? ____ years ____ months

Do you have any children age 18 or younger who are in your care? (yes / no) _____

For those who qualify: MUST BE READ

I will be asking you questions about your experience with health care in New York City. (If they have a child in their care), I will also ask you about your child's experience. All of your answers are confidential and we will not ask you your name or

⁶⁷ As noted on page 20 in the "Methodology" section of this report, "All surveyors participated in a mandatory full day training session on the survey instrument. Training included mock survey interviews, survey pre-screening and administration, and outreach strategies to reach targeted subgroups. A draft version of the PCI household survey was field tested by surveyors in early December 2007. Feedback from surveyors led to the elimination of twelve questions from the survey instrument and reduced the tool from 81 questions to 69."

social security number. Your participation is voluntary and you may quit the survey at any time. You can refuse to answer any question you do not want to answer. Finally, if you do not know or are not sure of your answer to any question just tell me "I'm not sure."

Do you understand? yes / no (circle one response)

Do you have any questions? yes / no (circle one response)

If no, or when all questions are answered: **Great, let's begin.**

I. ADULTS

Ask everyone

1.	Do you have any kind of health care coverage such as Medicaid, Medicare, an HMO, private health insurance, or the VA, which is also called the Veterans Administration? (check only one)
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (skip to Q4)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q1 = Yes

2.	What type of health care insurance do you use to pay for your doctor or hospital bills? Is it insurance through: (check only one)
<input type="checkbox"/>	Your employer
<input type="checkbox"/>	Someone else's employer
<input type="checkbox"/>	A plan that you or someone else buys on your own
<input type="checkbox"/>	Medicare
<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	Family Health Plus
<input type="checkbox"/>	The military, CHAMPUS, TriCare, or the VA
<input type="checkbox"/>	Some other source: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q1 = Yes

3.	During the last 12 months, was there <u>any</u> time when you did NOT have health insurance at all? (read only if necessary) (check only one)
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No, I had coverage during all of the last 12 months (skip to Q7)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q1 = No

4.	During the last 12 months, was there <u>any</u> time when you DID have any kind of health insurance? (Read only if necessary) (check only one)
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No, I never had coverage during the last 12 months
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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Ask if Q1 = No

5.	I am going to read a list of reasons why people do not have health insurance. After I read each one, say "yes" if it is true for you. (check all that apply)	
5a.	<input type="checkbox"/>	I can't afford it
5b.	<input type="checkbox"/>	My job doesn't offer it
5c.	<input type="checkbox"/>	I'm not eligible for the plan where I work
5d.	<input type="checkbox"/>	My employee contribution is too expensive
5e.	<input type="checkbox"/>	My co-pay is too expensive
5f.	<input type="checkbox"/>	My family situation changed
5g.	<input type="checkbox"/>	I tried but the process was too difficult
5h.	<input type="checkbox"/>	My income is too high for Medicaid or Family Health Plus
5i.	<input type="checkbox"/>	I lost my eligibility for Medicaid or Family Health Plus
5j.	<input type="checkbox"/>	I'm confused about applying for Medicaid or Family Health Plus
5k.	<input type="checkbox"/>	I'm afraid that applying for Medicaid or Family Health Plus will affect my immigration status
5l.	<input type="checkbox"/>	I'm not eligible for Medicaid or Family Health Plus because of my immigration status
5m.	<input type="checkbox"/>	Could not obtain documentation or an identification card
5n.	<input type="checkbox"/>	My application for Medicaid or Family Health Plus was rejected and I don't know why
5o.	<input type="checkbox"/>	I'm a veteran and the Veterans Administration pays for my health care
5p.	<input type="checkbox"/>	I don't feel I need it
		Can you think of any other reasons I didn't mention?
5q.	<input type="checkbox"/>	_____

5r.	<input type="checkbox"/>	_____
5s.	<input type="checkbox"/>	_____

5t.	<input type="checkbox"/>	Don't know/not sure
5u.	<input type="checkbox"/>	Refused

Ask if they said Yes to more than one item in Q5

6.	What is the <u>main</u> reason you do not now have health insurance? (check only one)	
	<input type="checkbox"/>	_____ (enter the corresponding response number here, e.g., "5m")
	<input type="checkbox"/>	Don't know/not sure
	<input type="checkbox"/>	Refused

MUST READ: The next questions ask you about your experiences getting health care in New York City (in the last 2 years/since moving to). But first, I want to describe two ways that people can get health care in New York City. One way is to go to a doctor or nurse who works in a hospital, clinic, or private office and who provides the kind of health care that is very common in the United States. In this survey we will call these people "doctors and nurses." Another way is to see a person who uses older, more traditional methods of health care than someone who works in a hospital. These people may practice herbal medicine, acupuncture, Ayurvedic medicine, traditional Chinese medicine, Unani medicine, ifa medicine, or use spiritual practices. In this survey we will call these people "traditional healers." Does this make sense to you? [If not, ask participant what is not clear and try to explain again.] When I use the term "health care provider" I mean someone who is a doctor, a nurse, or a traditional healer.

Also, just to remind you, the next questions are all about the health care you received (in the last 2 years/since moving to ____).

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7.	Have you gone to a health care provider (in the last 2 years/since moving to ___)? <i>(read only if necessary) (check only one)</i>
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No <i>(skip to Q20)</i>
<input type="checkbox"/>	Don't know/not sure <i>(skip to Q9)</i>
<input type="checkbox"/>	Refused <i>(skip to Q9)</i>

Ask if Q7 = Yes

8.	What are all the reasons you have gone to a health care provider (in the last 2 years/since moving to ___)? <i>(check all that apply)</i>
8a.	<input type="checkbox"/> A medical emergency
8b.	<input type="checkbox"/> Needed a medical test
8c.	<input type="checkbox"/> Didn't feel well
8d.	<input type="checkbox"/> Needed a note from a health care professional
8e.	<input type="checkbox"/> A regular check-up
8f.	<input type="checkbox"/> Can you think of any other reasons?
	<input type="checkbox"/> _____
8g.	<input type="checkbox"/> _____
8h.	<input type="checkbox"/> Don't know/not sure
8i.	<input type="checkbox"/> Refused

Ask if you asked Q8

9.	Who did you get <u>most</u> of your health care from (in the last 2 years/since moving to ___)? <i>(most = more than half) (check only one)</i>
<input type="checkbox"/>	A doctor or nurse <i>(skip to Q12)</i>
<input type="checkbox"/>	A traditional healer
<input type="checkbox"/>	Other <i>(can include about half from each of above):</i> _____ <i>(skip to Q12 if this does not indicate traditional healer)</i>
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q9 = Traditional healer or Other includes or indicates a Traditional healer

10.	I'll read you a list of reasons why people go to a (traditional healer/insert "Other" response). After I read each one, say "yes" if it is true for you. <i>(check all that apply)</i>
10a.	<input type="checkbox"/> I prefer traditional healers to doctors or nurses
10b.	<input type="checkbox"/> Why do you prefer traditional healers?

10c.	<input type="checkbox"/> I prefer a doctor or nurse but cannot afford it
10d.	<input type="checkbox"/> I prefer a doctor or nurse but do not know how to find one
10e.	<input type="checkbox"/> My traditional healer speaks my language and it is too hard to find a doctor or nurse who speaks my language
	Can you think of any other reasons?
10f.	<input type="checkbox"/> _____
10g.	<input type="checkbox"/> _____
10h.	<input type="checkbox"/> _____
10i.	<input type="checkbox"/> Don't know/not sure
10j.	<input type="checkbox"/> Refused

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Ask if they said Yes to ~~more than one~~ reason in Q10

11.	What is the main reason you have gone to a (traditional healer/insert "Other" response)? (check only one)
<input type="checkbox"/>	_____ (enter the corresponding response number here, e.g., "10a")
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

If participant has not seen a doctor or nurse, skip to Q15, otherwise go to Q12

Ask if Q9 = Doctor or nurse or Other indicates a doctor or nurse

12.	Of all your visits to a doctor or nurse (in the last 2 years/since moving to __) how many were in (their neighborhood)? (check only one)
<input type="checkbox"/>	All (skip to Q15)
<input type="checkbox"/>	More than half
<input type="checkbox"/>	About half
<input type="checkbox"/>	Less than half
<input type="checkbox"/>	None
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q12 indicates they went to a doctor or nurse outside their neighborhood

13.	I'll read you a list of reasons why people go to a doctor or nurse outside their neighborhood. After I read each one, say "yes" if it is true for you. (check all that apply)
13a.	<input type="checkbox"/> I get care from a specialist in another neighborhood (if needed, give examples of specialists like "specialists are doctors who usually provide health care for one kind of problem, like a heart problem, or a kidney problem, or a skin problem")
13b.	<input type="checkbox"/> What kind of specialist(s)? _____
13c.	<input type="checkbox"/> _____
13d.	<input type="checkbox"/> _____
13e.	<input type="checkbox"/> Could not afford doctor or nurse I found in my neighborhood
13f.	<input type="checkbox"/> Was referred to or assigned a doctor or nurse in another neighborhood
13g.	<input type="checkbox"/> Not satisfied with doctor or nurse I found in my neighborhood
13h.	<input type="checkbox"/> Why were you not satisfied? _____
13i.	<input type="checkbox"/> Could not find doctor or nurse or translator in my neighborhood who speaks my language
13j.	<input type="checkbox"/> My doctor or nurse is close to my job or school
13k.	<input type="checkbox"/> I do not have confidence in the quality of care I would receive in my neighborhood
13l.	<input type="checkbox"/> Could not find a doctor or nurse in my neighborhood
13m.	<input type="checkbox"/> Prefer a doctor or nurse who is in another neighborhood
13n.	<input type="checkbox"/> Why do you prefer a doctor or nurse who is in another neighborhood? _____
13o.	<input type="checkbox"/> Doctor or nurse I found in my neighborhood did not take my insurance
13p.	<input type="checkbox"/> Can you think of any other reasons? _____
13q.	<input type="checkbox"/> _____
13r.	<input type="checkbox"/> _____

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13s. Don't know/not sure
 13t. Refused

Ask if they said Yes to more than one reason in Q13

14. **What is the main reason you went to a doctor or nurse outside (their neighborhood)?** (check only one)
 _____ (enter the corresponding response number here, e.g., "13g")
 Don't know/not sure
 Refused

Ask if Q7 = Yes

15. **(In the last 2 years/since moving to __), did you go to one place more than any other place for your health care?** (one place = one building location like one office, clinic, or hospital) (check only one)
 Yes (this means they went to one place more than one time and this was more than they went anywhere else)
 No (skip to Q25)
 Don't know/not sure (skip to Q25)
 Refused (skip to Q25)

Ask if Q15 = Yes

16. **What kind of place is this?** (read only if necessary) (check only one)
 Doctor's or nurse's office or clinic
 Traditional healer's office or clinic
 Community health clinic or health center
 Clinic in a hospital
 Hospital emergency room
 Another kind of place: _____
 Don't know/not sure
 Refused

Ask if Q15 = Yes

17. **What borough is this place in?** (check only one)
 The Bronx
 Brooklyn
 Manhattan
 Queens
 Staten Island
 Another location: _____

 Don't know/not sure
 Refused

Ask if Q17 = a NYC borough

18. **What neighborhood is this place in?** (read from list only if necessary): _____

Ask if Q15 = Yes

19. **How long does it usually take you to get there?** (make sure participant knows this is the travel time of their usual door-to-door trip to that place, whether that's from work, home, or elsewhere) (check only one)
 _____ hours _____ minutes
 Don't know/not sure
 Refused

Skip to Q25

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Ask if Q7 = No

20.	For non-emergency care, who would you have gone to for health care? (check only one)
<input type="checkbox"/>	A doctor or nurse
<input type="checkbox"/>	A traditional healer
<input type="checkbox"/>	Some other kind of health care provider: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q7 = No

21.	Why have you not gone to a (insert Q20 response)? (check only one)
<input type="checkbox"/>	I needed to but was not able to
<input type="checkbox"/>	I did not need to
<input type="checkbox"/>	I did not want to
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q21 = Needed to but was not able to

22.	I'll read you a list of reasons why people may not be able to go to a health care provider when they need to. After I read each one, say "yes" if it was true for you. (check all that apply)
22a.	<input type="checkbox"/> I could not afford it
22b.	<input type="checkbox"/> I could not find a health care provider who accepted Medicaid, Family Health Plus, or Medicare
22c.	<input type="checkbox"/> I could not find a health care provider who accepted my private insurance
22d.	<input type="checkbox"/> Insurance did not pay for what I needed
22e.	<input type="checkbox"/> What was this? _____
22f.	<input type="checkbox"/> I could not find a health care provider or translator who speaks my language
22g.	<input type="checkbox"/> I did not know I could get a free translator
22h.	<input type="checkbox"/> I'm afraid that going to a doctor or nurse will affect my immigration status
22i.	<input type="checkbox"/> I tried but the staff did not respect me
22j.	<input type="checkbox"/> I was too busy
22k.	<input type="checkbox"/> It was difficult to find transportation
22l.	<input type="checkbox"/> Transportation was too expensive
22m.	<input type="checkbox"/> I did not know how to find a health care provider
22n.	<input type="checkbox"/> I did not know how to make an appointment
22o.	<input type="checkbox"/> I did not have a health care provider's phone number
22p.	<input type="checkbox"/> They were hard to reach by phone
22q.	<input type="checkbox"/> I needed an appointment sooner than the appointment time they offered
22r.	<input type="checkbox"/> They were not taking new patients
22s.	<input type="checkbox"/> Their hours were not convenient
22t.	<input type="checkbox"/> I had to wait too long in the waiting room
22u.	<input type="checkbox"/> It was difficult to get childcare
22v.	<input type="checkbox"/> Can you think of any other reasons? _____
22w.	<input type="checkbox"/> _____
22x.	<input type="checkbox"/> _____
22y.	<input type="checkbox"/> Don't know/not sure
22z.	<input type="checkbox"/> Refused

Ask if they said Yes to more than one reason in Q22

23.	What is the main reason you were not able to get health care (in the last 2 years/since moving to ___)? (check only one)
<input type="checkbox"/>	_____ (enter corresponding response number here, e.g., "22d")
<input type="checkbox"/>	Don't know/not sure

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Refused

Ask if Q21 = Did not need to or Did not want to

24.	Why did you not (need to/want to) go to a (insert Q20 response)? (check all that apply)
24a.	<input type="checkbox"/> I am in good health
24b.	<input type="checkbox"/> I do not trust (insert Q20 response)
24c.	<input type="checkbox"/> I do not like going to (insert Q20 response)
24d.	<input type="checkbox"/> I am afraid to go to (insert Q20 response)
24e.	<input type="checkbox"/> I am able to take care of my own health problems on my own
24f.	<input type="checkbox"/> Can you think of any other reasons? _____ _____
24g.	<input type="checkbox"/> _____ _____
24h.	<input type="checkbox"/> _____ _____
24i.	<input type="checkbox"/> Don't know/not sure
24j.	<input type="checkbox"/> Refused

Ask everyone

25.	Where would it be most convenient for you to get your health care? (check only one)
<input type="checkbox"/>	Near where I live
<input type="checkbox"/>	Near where I work
<input type="checkbox"/>	Some other place: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q25 = Near work or "Some other place"

26.	How long does it take you to get to your job/ (insert name of some other place)?
<input type="checkbox"/>	_____ hours _____ minutes
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Throughout the survey, when we say "household," we mean the people who live with you and who are children in your care, your parents, your siblings, and your partner or spouse.

Ask everyone

27.	Using the above definition, how many people currently live in your household? (Include yourself) _____ (if only 1, skip to Q57)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask everyone

28.	How many people live in your apartment, condominium, or home? _____ (people who live in a separate apartment within a house should not be counted)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

II. CHILDREN

Ask everyone

28a.	How many people now living in your household are 18 or younger? _____ <i>(if no one 18 or younger, skip to Q57)</i>
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q28a = 1child

29.	How old is this child? _____ years _____ months <i>(if they're not sure, ask them if they know if the child is between 0-5 or 6-13 or 14-18. If they know this, enter that age range above. If this does not help them, check "don't know/not sure.")</i>
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q28 > 1child

30.	We are going to ask some questions only about the <u>last</u> child to have a birthday in your household. How old is the last child to have a birthday in your household? _____ years _____ months <i>(if they're not sure, ask them if they know if the child is between 0-5 or 6-13 or 14-18. If they know this, enter that age range above. If this does not help them, check "don't know/not sure.")</i>
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q28a > 0 children

31.	Does this child have any kind of health care coverage such as Medicaid, Medicare, an HMO, private health insurance, or the VA, which is also called the Veterans Administration? <i>(check only one)</i>
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No <i>(skip to Q34)</i>
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q31 = Yes

32.	What type of health care insurance pays for this child's doctor or hospital bills? Is it insurance through: <i>(check only one)</i>
<input type="checkbox"/>	Your employer
<input type="checkbox"/>	Someone else's employer
<input type="checkbox"/>	A plan that you or someone else buys on your own
<input type="checkbox"/>	Medicare
<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	Child Health Plus
<input type="checkbox"/>	The military, CHAMPUS, TriCare, or the VA
<input type="checkbox"/>	Some other source: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q31 = Yes

33.	During the last 12 months, was there <u>any</u> time when this child did NOT have health insurance at all? <i>(read only if necessary) (check only one)</i>
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No, my child had coverage during all of the last 12 months
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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Ask if Q31 = No

34.	During the last 12 months, was there <u>any</u> time when this child DID have any kind of health insurance? (read only if necessary) (check only one)
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No, my child never had coverage during the last 12 months
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q31 = No

35.	I am going to read a list of reasons why people do not have health insurance. After I read each one, say "yes" if it is true for this child. (check all that apply)
35a.	<input type="checkbox"/> We can't afford it
35b.	<input type="checkbox"/> Our jobs don't offer it
35c.	<input type="checkbox"/> We're not eligible for the plan where we work
35d.	<input type="checkbox"/> Our employee contributions are too expensive
35e.	<input type="checkbox"/> Our co-pay is too expensive
35f.	<input type="checkbox"/> We tried but the process was too difficult
35g.	<input type="checkbox"/> Our income is too high for Medicaid or Child Health Plus
35h.	<input type="checkbox"/> We lost our eligibility for Medicaid or Child Health Plus
35i.	<input type="checkbox"/> We're confused about applying for Medicaid or Child Health Plus
35j.	<input type="checkbox"/> We're afraid that applying for Medicaid or Child Health Plus will affect our immigration status
35k.	<input type="checkbox"/> This child is not eligible for Medicaid because of their immigration status
35l.	<input type="checkbox"/> Our application for Medicaid or Child Health Plus was rejected and I don't know why
35m.	<input type="checkbox"/> We don't feel this child needs it
35n.	<input type="checkbox"/> Can you think of any other reasons?

35o.	<input type="checkbox"/> _____

35p.	<input type="checkbox"/> _____
35q.	<input type="checkbox"/> Don't know/not sure
35r.	<input type="checkbox"/> Refused

Ask if they said Yes to more than one item in Q35

36.	What is the <u>main</u> reason this child does not now have health insurance? (check only one)
<input type="checkbox"/>	_____ (enter the corresponding response number here)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

MUST READ and ASK: Do you remember the difference between "doctors and nurses" and "traditional healers" that I described earlier? (if yes, go on; if no, read or summarize the following :) A doctor or nurse is a health care provider who works in a hospital, clinic, or private office and who provides the kind of health care that is very common in the United States. In this survey we call these people "doctors and nurses." Traditional healers are health care providers who use older, more traditional methods of health care than someone who works in a hospital. These people may practice herbal medicine, acupuncture, Ayurvedic medicine, traditional Chinese medicine, Unani medicine, Ifa medicine, or use spiritual practices. In this survey we call these people "traditional healers." Does this make sense?

And just to remind you, the next questions are about the health care this child received (in the last 2 years/since moving to ____).

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Ask if Q28 > 0

37.	Has this child gone to a health care provider (in the last 2 years/since moving to ___)? (check only one)
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (skip to Q50)
<input type="checkbox"/>	Don't know/not sure (skip to Q39)
<input type="checkbox"/>	Refused (skip to Q39)

Ask if Q37 = Yes

38.	What are all the reasons this child has gone to a health care provider (in the last 2 years/since moving to ___)? (check all that apply)
38a.	<input type="checkbox"/> A medical emergency
38b.	<input type="checkbox"/> Needed a medical test
38c.	<input type="checkbox"/> Didn't feel well
38d.	<input type="checkbox"/> Needed a note from a health care professional
38e.	<input type="checkbox"/> A regular check-up
	Can you think of any other reasons?
38f.	<input type="checkbox"/> _____
38g.	<input type="checkbox"/> _____
38h.	<input type="checkbox"/> _____
38i.	<input type="checkbox"/> Don't know/not sure
38j.	<input type="checkbox"/> Refused

Ask if you asked Q38

39.	Who did this child get <u>most</u> of their health care from (in the last 2 years/since moving to ___)? (most = more than half) (check only one)
<input type="checkbox"/>	A doctor or nurse (skip to Q42)
<input type="checkbox"/>	A traditional healer
<input type="checkbox"/>	Other (can include about half from each of above): _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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Ask if Q39 = Traditional healer or Other includes or indicates a Traditional healer

40.	I'll read you a list of reasons why people go to a [traditional healer/insert "Other" response]. After I read each one, say "Yes" if it is true for this child. (check all that apply)
40a.	<input type="checkbox"/> We prefer traditional healers to doctors or nurses
40b.	<input type="checkbox"/> Why do you prefer traditional healers? _____
40c.	<input type="checkbox"/> We prefer a doctor or nurse but cannot afford it
40d.	<input type="checkbox"/> We prefer a doctor or nurse but do not know how to find one
40e.	<input type="checkbox"/> Our traditional healer speaks our language and it is too hard to find a doctor or nurse who speaks our language
40f.	<input type="checkbox"/> Can you think of any other reasons? _____
40g.	<input type="checkbox"/> _____
40h.	<input type="checkbox"/> _____
40i.	<input type="checkbox"/> Don't know/not sure
40j.	<input type="checkbox"/> Refused

Ask if they said Yes to more than one reason in Q40.

41.	What is the main reason this child has gone to a (traditional healer/insert "Other" response)? (check only one)
<input type="checkbox"/>	_____ (enter the corresponding response number here)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

If child has only seen traditional healers in the last 2 years, skip to Q45, otherwise go to Q42

Ask if Q39 = Doctor or nurse or Other indicates a doctor or nurse

42.	Of all this child's visits to a doctor or nurse (in the last 2 years/since moving to __) how many were in (their neighborhood)? (check only one)
<input type="checkbox"/>	All (skip to Q45)
<input type="checkbox"/>	More than half
<input type="checkbox"/>	About half
<input type="checkbox"/>	Less than half
<input type="checkbox"/>	None
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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Ask if Q42 indicates they went to a doctor or nurse outside their neighborhood

43.	I'll read you a list of reasons why people go to a doctor or nurse outside their neighborhood. After I read each one, say "yes" if it is true for this child. (check all that apply)
43a.	<input type="checkbox"/> This child gets care from a specialist in another neighborhood (if needed, give examples of specialists like "specialists are doctors who usually provide health care for one kind of problem, like a heart problem, or a kidney problem, or a skin problem")
43b.	<input type="checkbox"/> What kind of specialist(s)? _____
43c.	<input type="checkbox"/> _____
43d.	<input type="checkbox"/> _____
43e.	<input type="checkbox"/> Could not afford doctor or nurse we found in our neighborhood
43f.	<input type="checkbox"/> Not satisfied with doctor or nurse we found in our neighborhood
43g.	<input type="checkbox"/> Why were you not satisfied? _____
43h.	<input type="checkbox"/> Could not find doctor or nurse or translator in our neighborhood who speaks our language
43i.	<input type="checkbox"/> This child's doctor or nurse is close to their job or school
43j.	<input type="checkbox"/> Could not find a doctor or nurse in our neighborhood
43k.	<input type="checkbox"/> Prefer a doctor or nurse who is in another neighborhood
43l.	<input type="checkbox"/> Why do you prefer a doctor or nurse who is in another neighborhood? _____
43m.	<input type="checkbox"/> Wanted our family's health care to be in one place
43n.	<input type="checkbox"/> Doctor or nurse we found in our neighborhood did not take this child's insurance
43o.	<input type="checkbox"/> Can you think of any other reasons? _____
43p.	<input type="checkbox"/> _____
43q.	<input type="checkbox"/> _____
43r.	<input type="checkbox"/> Don't know/not sure
43s.	<input type="checkbox"/> Refused

Ask if they said Yes to more than one reason in Q43

44.	What is the <u>main</u> reason this child went to a doctor or nurse outside (their neighborhood)? (check only one)
<input type="checkbox"/>	_____ (enter the corresponding response number here)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q37 = Yes

45.	(In the last 2 years/since moving to __), did this child go to one place more than any other place for their health care? (one place = one building location like one office, clinic, or hospital) (check only one)
<input type="checkbox"/>	Yes (this means they went to <u>one place</u> more than one time and this was more than they went anywhere else)
<input type="checkbox"/>	No (skip to Q55)
<input type="checkbox"/>	Don't know/not sure (skip to Q55)
<input type="checkbox"/>	Refused (skip to Q55)

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Ask if 45 = Yes

46.	What kind of place is this? (Read only if necessary) (check only one)
<input type="checkbox"/>	Doctor's or nurse's office or clinic
<input type="checkbox"/>	Traditional healer's office or clinic
<input type="checkbox"/>	Community health clinic or health center
<input type="checkbox"/>	School clinic
<input type="checkbox"/>	Clinic in a hospital
<input type="checkbox"/>	Hospital emergency room
<input type="checkbox"/>	Another kind of place: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q45 = Yes

47.	What borough is this place in? (check only one)
<input type="checkbox"/>	The Bronx
<input type="checkbox"/>	Brooklyn
<input type="checkbox"/>	Manhattan
<input type="checkbox"/>	Queens
<input type="checkbox"/>	Staten Island
<input type="checkbox"/>	Another location: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q47 = a NYC borough

48.	What neighborhood is this place in? (read from list if necessary) _____
------------	--------------------------------------------------------------------------------

Ask if Q45 = Yes

49.	How long does it usually take this child to get there? (make sure participant knows this is the travel time of the child's usual door-to-door trip to that place, whether from school, home, or elsewhere) (check only one)
<input type="checkbox"/>	_____ hours _____ minutes
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Skip to Q55

Ask if Q37 = No

50.	For non-emergency care, who would this child have gone to for health care? (check only one)
<input type="checkbox"/>	A doctor or nurse
<input type="checkbox"/>	A traditional healer
<input type="checkbox"/>	Some other kind of health care provider: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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Ask if Q37 = No

51.	Why has this child not gone to a health care provider? (check only one)
<input type="checkbox"/>	He/she needed to but was not able to
<input type="checkbox"/>	He/she did not need to
<input type="checkbox"/>	We did not want to
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask if Q51 = Needed to but was not able to

52.	I'll read you a list of reasons why people may not be able to go to a health care provider when they need to. After I read each one, say "yes" if it was true for this child. (check all that apply)
52a.	<input type="checkbox"/> We could not afford it
52b.	<input type="checkbox"/> We could not find a health care provider who accepted Medicaid, Child Health Plus, or Medicare
52c.	<input type="checkbox"/> We could not find a health care provider who accepted this child's private insurance
52d.	<input type="checkbox"/> Insurance did not pay for what this child needed
52e.	<input type="checkbox"/> What was this? _____
52f.	<input type="checkbox"/> We could not find a health care provider or translator who speaks our language
52g.	<input type="checkbox"/> We did not know we could get a free translator
52h.	<input type="checkbox"/> We tried but the staff did not respect us
52i.	<input type="checkbox"/> We were too busy
52j.	<input type="checkbox"/> It was difficult to find transportation
52k.	<input type="checkbox"/> Transportation was too expensive
52l.	<input type="checkbox"/> We did not know how to find a health care provider
52m.	<input type="checkbox"/> We did not know how to make an appointment
52n.	<input type="checkbox"/> We did not have a health care provider's phone number
52o.	<input type="checkbox"/> They were hard to reach by phone
52p.	<input type="checkbox"/> This child needed an appointment sooner than the appointment time they offered
52q.	<input type="checkbox"/> They were not taking new patients
52r.	<input type="checkbox"/> Their hours were not convenient
52s.	<input type="checkbox"/> We had to wait too long in the waiting room
52t.	<input type="checkbox"/> It was difficult to get childcare
52u.	<input type="checkbox"/> Can you think of any other reasons?
	<input type="checkbox"/> _____
52v.	<input type="checkbox"/> _____
52w.	<input type="checkbox"/> _____
52x.	<input type="checkbox"/> Don't know/not sure
52y.	<input type="checkbox"/> Refused

Ask if they said Yes to more than one reason in Q52

53.	What is the <u>main</u> reason this child was not able to get health care (in the last 2 years/since moving to ___)? (check only one)
<input type="checkbox"/>	_____ (enter corresponding response number here)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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Ask if Q51 = Did not need to or Did not want to

54.	Why did this child not (need to/want to) go to a (insert Q50 response)? (check all that apply)	
54a.	<input type="checkbox"/>	He/she is in good health
54b.	<input type="checkbox"/>	We do not trust (insert Q50 response)
54c.	<input type="checkbox"/>	He/she does not like going to (insert Q50 response)
54d.	<input type="checkbox"/>	He/she is afraid to go to (insert Q50 response)
54e.	<input type="checkbox"/>	We are able to take care of this child's health problems on our own
54f.	<input type="checkbox"/>	Can you think of any other reasons?
	<input type="checkbox"/>	_____
54g.	<input type="checkbox"/>	_____
54h.	<input type="checkbox"/>	_____
54i.	<input type="checkbox"/>	Don't know/not sure
54j.	<input type="checkbox"/>	Refused

Ask everyone

55.	Where would it be most convenient for this child to get their health care? (check only one)	
<input type="checkbox"/>	Near where we live	
<input type="checkbox"/>	Near where he/she goes to school or work	
<input type="checkbox"/>	Some other place (specify):	

<input type="checkbox"/>	Don't know/not sure	
<input type="checkbox"/>	Refused	

Ask if Q55 = Near work or "Some other place"

56.	How long does it take this child to get to school/work/ (insert name of this other place)?	
<input type="checkbox"/>	_____	minutes
<input type="checkbox"/>	Don't know/not sure	
<input type="checkbox"/>	Refused	

III. BARRIERS TO CARE

Ask everyone

57.	<i>(Open-ended question)</i> Are there any medical or health-related services you think your neighborhood needs more of? If so, what are these services?

Ask only if you do not already know the answer based on participant's previous responses

58.	Have you or has someone in your household looked for or gone to a doctor or nurse in (their neighborhood) (in the last 2 years/since moving to ___)? (check only one)
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (skip to Q64)
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Ask only if participant or household member has gone to or looked for a doctor or nurse in their neighborhood

59.	(In the last 2 years/since moving to ____), did you or anyone in your household ever have difficulty getting access to any of the following health care providers in (their neighborhood)? (check all that apply)
59a.	<input type="checkbox"/> Dentist
59b.	<input type="checkbox"/> Mental health counselor
59c.	<input type="checkbox"/> Traditional healer
59d.	<input type="checkbox"/> Drug counselor
59e.	<input type="checkbox"/> Prenatal care/mid-wife/OB/GYN
59f.	<input type="checkbox"/> Pediatrician/baby doctor
59g.	<input type="checkbox"/> Family planning services
59h.	<input type="checkbox"/> Traditional healer
59i.	<input type="checkbox"/> A doctor or nurse you go to for your basic health care needs
59j.	Can you think of any other kinds of providers you've had difficulty getting access to in (their neighborhood)? _____
59k.	<input type="checkbox"/> _____
59l.	<input type="checkbox"/> _____
59m.	<input type="checkbox"/> _____

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Ask Q60 if you asked Q59. You do not need to ask about a barrier if prior responses made it clear it was not a barrier to getting health care in their neighborhood.

The next few questions are about your and your household's experiences with doctors or nurses or their staff in (their neighborhood) (in the last 2 years/since moving to ____). After each statement I read, say "yes" if it was true for you or someone in your household

60.	Has it been difficult to see a doctor or nurse in (their neighborhood) because: <i>(check all that apply)</i>	
60a.	<input type="checkbox"/>	Could not find a doctor, nurse or translator who speaks our language
60b.	<input type="checkbox"/>	Did not know we could get a free translator
60c.	<input type="checkbox"/>	Staff did not respect us
60d.	<input type="checkbox"/>	Doctor or nurse did not listen carefully enough
60e.	<input type="checkbox"/>	Doctor or nurse did not spend enough time with us
60f.	<input type="checkbox"/>	Was there anything else like this that made it difficult?
	_____	_____

61.	Has it been difficult to see a doctor or nurse in (their neighborhood) because: <i>(check all that apply)</i>	
61a.	<input type="checkbox"/>	Difficult to find transportation
61b.	<input type="checkbox"/>	Transportation was too expensive
61c.	<input type="checkbox"/>	Took too much time to get there
61d.	<input type="checkbox"/>	Was there anything else like this that made it difficult?
	_____	_____

62.	Has it been difficult to see a doctor or nurse in (their neighborhood) because: <i>(check all that apply)</i>	
62a.	<input type="checkbox"/>	Could not find a doctor or nurse in (their neighborhood) who accepts Medicaid, Child Health Plus, Family Health Plus or Medicare
62b.	<input type="checkbox"/>	Could not find a doctor or nurse in (their neighborhood) who accepts our private insurance
62c.	<input type="checkbox"/>	Doctor or nurse no longer accepted our insurance
62d.	<input type="checkbox"/>	Could not afford the co-pay
62e.	<input type="checkbox"/>	Could not afford to pay the bill
62f.	<input type="checkbox"/>	Insurance did not pay for what was needed
62g.	<input type="checkbox"/>	What is this? _____
62h.	<input type="checkbox"/>	Was there anything else like this that made it difficult?
	_____	_____

63.	Has it been difficult to see a doctor or nurse in (their neighborhood) because: <i>(check all that apply)</i>	
63a.	<input type="checkbox"/>	Did not know how to find a doctor or nurse
63b.	<input type="checkbox"/>	Did not know how to make an appointment
63c.	<input type="checkbox"/>	Did not have a doctor's or nurse's phone number
63d.	<input type="checkbox"/>	They were hard to reach by phone
63e.	<input type="checkbox"/>	They did not return our phone call
63f.	<input type="checkbox"/>	Needed an appointment sooner than the appointment time offered
63g.	<input type="checkbox"/>	They were not taking new patients
63h.	<input type="checkbox"/>	Their hours were not convenient
63i.	<input type="checkbox"/>	Had to wait too long in the waiting room
63j.	<input type="checkbox"/>	Difficult to get childcare
63k.	<input type="checkbox"/>	Filling out the forms was too complicated
63l.	<input type="checkbox"/>	Our doctor or nurse moved and have not found a new one
63m.	<input type="checkbox"/>	Last doctor or nurse would not release records
63n.	<input type="checkbox"/>	Is there anything else you can think of that has made it difficult to see a primary care doctor or nurse in your neighborhood?
	_____	_____

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IV. DEMOGRAPHIC QUESTIONS

64.	What is your age? _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

65.	What is your gender? <i>(check only one)</i>
<input type="checkbox"/>	Female
<input type="checkbox"/>	Male
<input type="checkbox"/>	Transgender female to male
<input type="checkbox"/>	Transgender male to female
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

66.	What is the highest grade or year of school you have completed? <i>(read only if necessary) (check only one)</i>
<input type="checkbox"/>	6 th grade or less
<input type="checkbox"/>	Some middle school or some high school, no diploma (grades 7 – 11)
<input type="checkbox"/>	High school graduate or GED (grade 12)
<input type="checkbox"/>	Some college, no degree
<input type="checkbox"/>	Associates degree, or certificate from vocational, business, or trade school
<input type="checkbox"/>	4-years of college or higher, with bachelors degree or higher
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

67.	What country were you born in? _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

68.	In total, how long have you lived in the US? _____ years _____ months <i>(If they have lived in the US off and on, ask them to sum the amount of time they've lived in the US)</i>
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

69.	In total, how long have you lived in New York City? _____ years _____ months <i>(If they have lived in NYC off and on, ask them to sum the amount of time they've lived in NYC)</i>
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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70.	What race do you identify with most? <i>(Read only if necessary) (check only one)</i>
70a.	<input type="checkbox"/> Asian
70b.	<input type="checkbox"/> Black or African American
70c.	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
70d.	<input type="checkbox"/> American Indian, Alaskan Native or Indigenous
70e.	<input type="checkbox"/> White
70f.	<input type="checkbox"/> Something else (specify): _____
70g.	<input type="checkbox"/> Don't know/not sure
70h.	<input type="checkbox"/> Refused

70b.	Are you of Hispanic or Latino origin? <i>(check only one)</i>
70ba.	<input type="checkbox"/> Yes
70bb.	<input type="checkbox"/> No
70bc.	<input type="checkbox"/> Don't know/not sure
70bd.	<input type="checkbox"/> Refused

71.	What ethnicity do you identify with most?
	<i>(For example: Hispanic, Black Hispanic, Vietnamese, Jewish, Haitian, etc.)</i>

	<input type="checkbox"/> Don't know/not sure
	<input type="checkbox"/> Refused

72.	In the last 12 months, were you ever homeless or have to stay in a shelter or stay with someone else to avoid being homeless? <i>(check only one)</i>
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

73.	In the last 12 months, how many times have you moved? _____
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

74.	What language is mostly spoken in your household? _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

75.	Which other languages are you able to speak?
75a.	<input type="checkbox"/> _____
75b.	<input type="checkbox"/> _____
75c.	<input type="checkbox"/> _____
75d.	<input type="checkbox"/> _____
75e.	<input type="checkbox"/> Don't know/not sure
75f.	<input type="checkbox"/> Refused

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 Community Health Assessment
 Appendix C: Primary Care Initiative Access Survey

76.	Please rate your English skills:	Peer	Fair	Good	Excellent	Don't know/ not sure	Refused
76a.	Speaking	==	==	==	==	==	==
76b.	Listening	==	==	==	==	==	==
76c.	Reading	==	==	==	==	==	==

77.	What is your annual household income from all sources? (If needed, say "include money from jobs, social security, unemployment benefits, public assistance, retirement income, etc.") (If they only know their weekly income, take that and multiply by 52 to get their annual income)
<input type="checkbox"/>	\$0 - \$10,000
<input type="checkbox"/>	\$10,001 - \$20,000
<input type="checkbox"/>	\$20,001 - \$40,000
<input type="checkbox"/>	\$40,001- \$60,000
<input type="checkbox"/>	\$60,001 - \$80,000
<input type="checkbox"/>	\$80,001 - \$100,000
<input type="checkbox"/>	More than \$100,000
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

78.	What is your current employment status? (check all that apply)
<input type="checkbox"/>	Work 35 or more hours per week: only employed for wages
<input type="checkbox"/>	Work 35 or more hours per week: only self-employed
<input type="checkbox"/>	Work 35 or more hours per week: combined self-employed and work for wages
<input type="checkbox"/>	Work less than 35 hours per week: only work for wages
<input type="checkbox"/>	Work less than 35 hours per week: only self-employed
<input type="checkbox"/>	Work less than 35 hours per week: combined self-employed and work for wages
<input type="checkbox"/>	Day laborer
<input type="checkbox"/>	Unemployed less than 1 year
<input type="checkbox"/>	Unemployed 1 year or more
<input type="checkbox"/>	Student
<input type="checkbox"/>	Student, not working
<input type="checkbox"/>	Retired
<input type="checkbox"/>	Disabled
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

Please know that your answers to the next questions are confidential and will not be reported to Immigration Services. Also, you do not need to answer them if you are not comfortable.

79.	Are you a citizen of the United States? (check one only)
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Application pending
<input type="checkbox"/>	Don't know/not sure
<input type="checkbox"/>	Refused

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Ask if Q79 = No, Don't know/not sure, or Refused

80.	Are you a permanent resident with a green card? <i>(Can also say: "People call this a green card but the color can also be pink, blue, or white") (check one only)</i>
—	Yes
—	No
—	Application pending
—	Don't know/not sure
—	Refused

81.	<i>(Open-ended question)</i> Is there anything more you want to tell us about your experiences getting health care in (their neighborhood)?

Thank you very much for helping us with the survey. If you would like a copy of the report that will be based on this survey, you can stop by or call (name of your organization) this coming May. Here is a card with our address and phone number.



Appendix D:
Primary Care Initiative
Community Health Assessment
Screening Sheet

APPENDIX D: PRIMARY CARE INITIATIVE COMMUNITY HEALTH ASSESSMENT SCREENING SHEET

Date: _____

Surveyor's or Staff Member's Name: _____

CBO Name:

Instructions:

- 1) *On the back side of this sheet enter the precise location of each place you recruited participants on today's date (e.g., the name of the street, the name and location of an event, or the name and location of a venue like a non-profit organization).*
- 2) *Use tick marks to record the outcome of each interaction. Tick marks are made in groups of five: the first four in a group are vertical lines and the fifth in the group is a slash across these vertical lines. Like this: HHH HHH HHH III = 18 interactions.*
- 3) *When making initial contact with potential participants read or say:*

Hi, my name is _____ . I work with _____ (name of your organization). We are doing a survey that takes about 15 to 30 minutes to complete. The survey is about people's experiences getting health care in New York City. We are doing this survey for the New York City Mayor's Office and the City Council. They will use the information we collect to make it easier for people to get health care, especially in their neighborhood. The New York City government will start making decisions in the spring of 2008 about what improvements to make. Are you interested in participating? (If no, thank them for their time; if yes, say Great, let me just ask you a few questions to see if you're eligible.) Ask them the qualifying questions in the table below and if they qualify, enter their answers on the first page of the survey and then begin.

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 Community Health Assessment
 Appendix D: Community Health Assessment Screening Sheet

A) Are you 18 or older? Must be 18 or older to participate	B) What ZIP code do you live in? Only residents living in the ZIP codes below are eligible. If they are not sure of the ZIP code, ask them the nearest intersection where they live and consult your map to identify their ZIP code as best you can.	C) What neighborhood do you live in? If they aren't sure of the name of their neighborhood, you can offer the following suggestions based on the ZIP code they give you.	D) How long have you lived in this neighborhood? They must have lived in neighborhood 6 months or longer to participate	E) Do you have any children age 18 and younger who are in your care? If yes, they must fill out the children's section of the survey.
	Bronx-1: 10452, 10454, 10456	→ Mott Haven, Melrose, Highbridge, Fordham, Morrisania		
	Bronx-2: 10453, 10457, 10458, 10460, 10472	→ University Heights, East Tremont, Fordham, Bronx Park, Morris Heights, Highbridge, East Tremont, West Farms, Soundview		
	Queens-1: 11106, 11368, 11373, 11377	→ Astoria, Long Island City, Corona, Jackson Heights, Woodside, Elmhurst, Lefrak City		
	Queens-2: 11434, 11435, 11436	→ Jamaica, South Jamaica, Rochdale Village, Briarwood, Hollis, St. Albans, Springfield Gardens, South Ozone Park		
	Queens-3: 11691	→ Far Rockaway, Edgemere		
	Brooklyn-1: 11206, 11221, 11237	→ East Williamsburg, Bushwick, Bedford Stuyvesant		
	Brooklyn-2: 11207, 11208, 11212, 11233	→ Brownsville, Crown Heights, East New York, New Lots, Spring Creek, Ocean Hill		
	Brooklyn-3: 11226	→ Flatbush, Ditmas Park		
	Manhattan-1: 10029, 10039	→ East Harlem, Central Harlem		
	Manhattan-2: 10002	→ Lower East Side, Chinatown		

Primary Care Initiative
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 Appendix D: Community Health Assessment Screening Sheet

Location:					
Said No	Said Yes but not eligible	Said Yes, was eligible, but stopped taking survey before completing it (no incentive payment)	Finished survey	Scheduled appointment to take survey at a later time	This was a scheduled appointment and they finished taking the survey

Location:					
Said No	Said Yes but not eligible	Said Yes, was eligible, but stopped taking survey before completing it (no incentive payment)	Finished survey	Scheduled appointment to take survey at a later time	This was a scheduled appointment and they finished taking the survey

Location:					
Said No	Said Yes but not eligible	Said Yes, was eligible, but stopped taking survey before completing it (no incentive payment)	Finished survey	Scheduled appointment to take survey at a later time	This was a scheduled appointment and they finished taking the survey



Appendix E:
Discussion Group
Demographic Form

APPENDIX E: DISCUSSION GROUP DEMOGRAPHIC FORM

GROUP LOCATION

DATE

Please complete this registration form. You do not need to answer any question that makes you uncomfortable. If you have any questions, please ask us!

1. **What ZIP code do you live in?** _____
2. **What is your age?** _____
3. **What is your gender? (check only one)**
 - Female
 - Male
 - Transgender female to male
 - Transgender male to female
 - Other (*specify*): _____
 - No answer
4. **What race do you identify with most? (check only one)**
 - Asian
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - American Indian, Alaskan Native, or Indigenous
 - White
 - Something else (*specify*): _____
 - No answer
5. **What is the highest grade or year in school you have completed? (check only one)**
 - 6th grade or less
 - Some middle school or some high school, no diploma (grades 7 -11)
 - High school graduate or GED (grade 12)
 - Some college, no degree
 - Associate's degree, or certificate from vocational, business, or trade school
 - 4-years of college or higher, with bachelor's degree or higher
 - Other: _____
 - No answer

6. Do you work now? (check only one)

- Work 35 or more hours per week
- Work less than 35 hours per week
- Unemployed
- Other: _____
- No answer

7. Do you have any kind of health care coverage, such as Medicaid, Medicare, Child Health Plus, or Family Health Plus? (check only one)

- Yes
- No
- Don't know/not sure
- No answer

8. If you have health care coverage, what kind? (check only one)

- _____
- Don't know/not sure
 - No answer

9. What is your annual household income from all sources, including money from jobs, social security, unemployment benefits, public assistance, and retirement income? (check only one)

- \$0 - \$10,000
- \$10,001 - \$20,000
- \$20,001 - \$40,000
- \$40,001 - \$60,000
- \$60,001 - \$80,000
- \$80,001 - \$100,000
- More than \$100,000
- No answer

10. What do you think are the 3 biggest problems you have getting health care in your community?

The biggest
problem

The second
biggest problem

The third biggest
problem



Appendix F: General Discussion Group Guide

APPENDIX F: GENERAL DISCUSSION GROUP TOPIC GUIDE

I. GREETINGS

<Greet participants and direct them to fill out brief registration form that includes demographics and the following information gathering question :>

“What are the 3 biggest problems you have faced getting health care services in your neighborhood?”

(Rank order priority health care access issues according to point system provided in the registration form)

II. GROUP DISCUSSION FORMAT

A. Introduction

Thanks for coming here today. My name is _____, and I work with the [name of CBO]. We are doing this discussion group for New York City’s Mayor and the City Council. They will use the information we collect to make it easier for people to get health care in New York City, and they’ll start making their decisions about what improvements to make starting this spring.

Our goal is that everyone here will feel comfortable speaking openly and contributing to our discussion. There are no wrong answers, just different experiences, and points of view. So please feel free to share your experiences and your point of view, even if it is different from what others have said.

Your comments will be summarized in a report, but nobody here will be identified by name, and no comment will be connected to any individual, so you can be sure of your anonymity.

Because we are taping this discussion so that we can write our report, it is important for everyone to speak up and that only one person talks at a time.

My role will be to ask questions and listen. I’ll be asking about a dozen questions, and I’ll be moving the discussion from one question to the next. It is important for us to hear from all of you tonight because you all have different and valuable experiences. If we haven’t heard from some of you, don’t be surprised if I call on you to share something about your experiences.

Does anyone have any questions before we begin?

Everyone introduces him or herself

I'd like to start by going around the table and have everyone introduce themselves. Tell us what you would like to be called and: [some options]

- A. If you won the lottery, what would you do with the money?
- B. What is your favorite television show and what you do you like about it?
- C. If you could take a vacation anywhere in the world, where would it be and why?

B. Questions

1. <Review items that came up as top 3 concerns and discuss each using the following format:>

- a. Please describe what you meant by _____ being an issue with health care access?
 - b. Why do you think _____ is a problem in this community?
 - c. What do you think would be the most effective way to help solve this problem?
- <Summarize>

REPEAT QUESTION 1 FOR EACH ITEM THAT CAME UP AS A TOP CONCERN

ADDITIONAL DISCUSSION QUESTIONS FOR EACH GROUP

- 1. Describe what it's like for you to live in your neighborhood, in terms of safety, transportation, the schools, or the feeling of community there.
- 2. Do you spend a lot of time out in your neighborhood?
 - What kinds of things do you like to do in your neighborhood or what kinds of things would you like to do in your neighborhood that you're not able to?
- 3. Of the things that are most important to you, where does taking care of your health needs fit?
 - If people say it's a low priority, ask Why is this the case?
- 4. Where do you get most of your health care now, in your neighborhood or outside of your neighborhood?
 - If outside neighborhood, ask Why this is the case?
- 5. Where would it be most convenient to get your health care? In your neighborhood or outside of your neighborhood?

- In either case, ask why do you feel this way?
6. What kind of place do you go to most often for your health care (e.g., doctor's office, ER, etc.)?
 - Why do you go here for health care?
 - Would you prefer to go somewhere else? Why or why not?
 7. Is this the same place where other members of your family receive their health care?
 - Why or why not?
 8. How many of you have a regular doctor who you've gone to more than once?
 - For those of you who do not have a regular doctor, why not?
 9. Have any of you had problems getting the health care that you need?
 - If yes, what types of problems have you experienced? (e.g., cost, transportation, hours, language differences, types of services offered, interactions with health care staff)
 - Have you been able to fix any of these problems? If so, how did you do it?
 10. If the Mayor asked your advice about how to spend money making health care better in your neighborhood, what would you tell him?
 11. Describe what an ideal visit to a health care provider would be like for you, starting with the moment you arrive in the clinic or office.
 12. Is there anything we haven't discussed today that you would like to talk about?



Appendix G: Tables of Figures

APPENDIX G: TABLES OF FIGURES

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