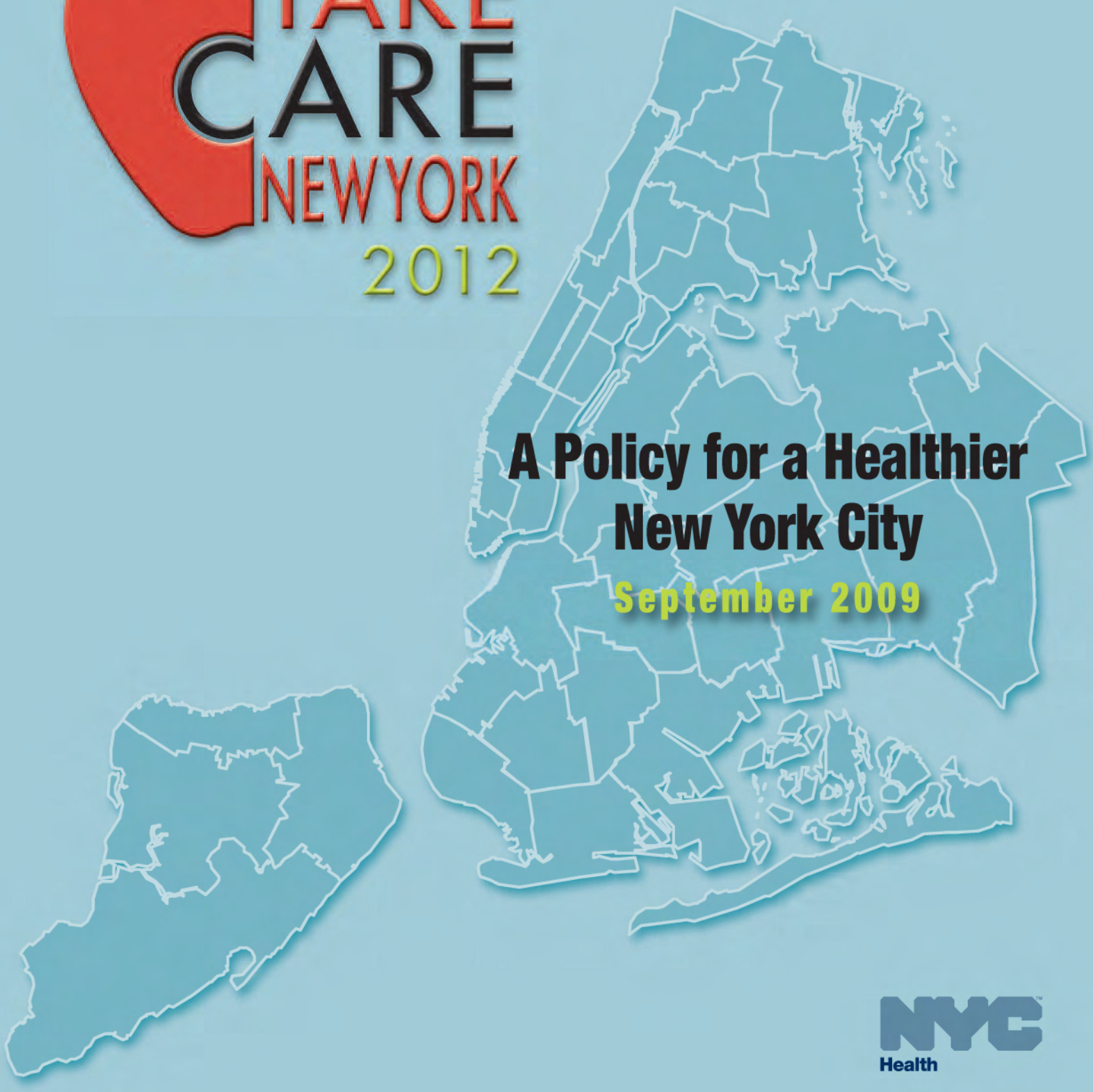
TAKE CARE NEW YORK 2012



A Policy for a Healthier New York City

September 2009

NYC Health

Table of Contents

Letter from the Mayor

Dear Fellow New Yorker,

New York City is a city of leaders. Great ideas and advancements are born here, setting an example for cities worldwide. Our health department is no exception. Charged with the monumental task of protecting and promoting the well-being of all New Yorkers, it consistently exceeds expectations. Thanks in part to the agency's groundbreaking initiatives, New Yorkers are living longer, healthier lives than ever before.

Take Care New York 2012 builds on the progress we have made. Since its inception in 2004, **Take Care New York** has generated important health initiatives and carefully monitored their impact. As a result, we now know more than ever about the challenges we face and the most promising ways to address them. **Take Care New York 2012** focuses intently on leading causes of preventable illness and premature death in New York City. It tackles killers such as heart disease, cancer, obesity and HIV/AIDS – and it sets out practical strategies for addressing underlying risk factors, from smoking and heavy alcohol consumption to the lack of access to wholesome food and safe places to exercise.

This bold blueprint can help us make New York City the model of a healthy place to live. Please join me in embracing and supporting it.

Sincerely,

Michael R. Bloomberg

Michael R. Bloomberg
Mayor

Letter from the Commissioner

Dear Fellow New Yorker,

New York City has long been a leader in addressing health challenges facing large and diverse populations. From improving water quality and sanitation in the 1800s to vaccinating residents against disease in the 1900s to leading the fight against smoking in the current century, the city's Department of Health and Mental Hygiene (DOHMH) has set high standards and improved population health through innovative strategies.

Launched in 2004, **Take Care New York** set a robust agenda for improving the health of New Yorkers by focusing on the most important issues affecting health and employing evidence-based interventions that work. In part because of these efforts, New Yorkers are living longer and infant mortality is declining. More New Yorkers have regular doctors, have quit smoking and are being screened for colorectal cancer than ever before.

Take Care New York 2012 sets new priorities and strategies for improving health. It is an action plan for policymakers, communities, organizations, businesses and individuals to promote good health. We will make changes – both large and small – to our physical and social environments, while working to improve health care and promote healthy behaviors.

Take Care New York 2012 differs from the 2004 **Take Care New York** agenda:

- It covers not only what can be done by individuals and medical providers, but also how community organizations, businesses and government can improve health.
- It adds a new focus on children's health – because of children's unique and important health needs, and our opportunity to promote life-long healthy behaviors.
- It addresses neighborhood conditions that affect health, such as access to healthy, affordable foods and safe housing.
- It emphasizes health disparities among New Yorkers of different races, ethnicities and income levels, and sets ambitious goals to reduce them by 2012.

This report describes the health department's plans to move New York City toward new goals. But the determinants of health are much broader than the health department can change alone. **Take Care New York 2012** calls on *all* New Yorkers – individuals and families, health care providers, community organizations, businesses and city agencies – to act. Working together, we can make New York City even healthier.

Sincerely,

Thomas Farley, M.D., M.P.H.
Commissioner

Introduction

Take Care New York 2012: A Policy for a Healthier New York City

Take Care New York 2012 is a comprehensive health policy for New York City. It lays out the health department's plans to help all New Yorkers live longer and healthier lives. And it offers ideas for how individuals can improve their own health, and how organizations can help them do it. **Take Care New York 2012** sets specific goals in 10 key areas selected for their public health importance and proven amenability to improvement.

Take Care New York was launched in 2004 as New York City's first comprehensive health policy agenda. It identified 10 steps New Yorkers could take to improve their health, and set ambitious and measurable goals for 2008. DOHMH worked with more than 400 organizations and businesses, developed and implemented many programs and tracked and measured the city's progress. By 2007, New Yorkers had surpassed goals in four priority areas: colorectal cancer screening, regular access to primary health care, smoking reduction and intimate-partner homicide reduction.

Take Care New York 2012 aims to build on these successes. We know even more now about the health of New Yorkers, about interventions that work, and about the challenges ahead. While New Yorkers are healthier than they were four years ago, health disparities persist, and the health care system has not fulfilled its potential to deliver high-quality care and preventive health services.

Take Care New York 2012 focuses on reducing health disparities, improving access to high-quality, prevention-oriented health care, and making all New York City neighborhoods healthy and safe places. Improving health requires coordinated action from all New Yorkers – individuals and families, health care providers, community organizations, businesses and government.

Implementing Take Care New York 2012

New York City aims to:

1. Promote Quality Health Care for All
2. Be Tobacco Free
3. Promote Physical Activity and Healthy Eating
4. Be Heart Healthy
5. Stop the Spread of HIV and Other Sexually Transmitted Infections
6. Recognize and Treat Depression
7. Reduce Risky Alcohol Use and Drug Dependence
8. Prevent and Detect Cancer
9. Raise Healthy Children
10. Make All Neighborhoods Healthy Places

Each chapter in this report focuses on one of these 10 priorities, sets objectives for improvement, and establishes indicators to track progress.

A Three-Pronged Approach

The objectives in this report are ambitious; they are specific, evidence-based and achievable; and they fall into three categories:

Policies: Developing laws, regulations and other policies that will improve environmental, economic and social conditions affecting health.

Prevention, Quality and Access: Emphasizing preventive health care, improving quality of care, and expanding access to care.

Health Promotion: Informing, educating and engaging New Yorkers to improve their health and the health of their communities.

Indicators: Tracking The City's Progress

A comprehensive set of indicators tracks progress in each of the 10 **Take Care New York 2012** priority areas. The indicators measure the impact of programs and interventions on the city's leading causes of disease and early death. Each chapter highlights a core indicator that is particularly significant and amenable to improvement (see **Figures 1-10, Figure 12**).[1] The complete set of indicators provides a clear way to track progress and measure success. The 10 core indicators are:

1. Preventable hospitalizations
2. Adults who currently smoke
3. Adults who consume an average of one or more sugar-sweetened beverages per day
4. Premature deaths from major cardiovascular disease
5. Men who have sex with men (MSM) who report using a condom every time they have anal sex
6. Adults with serious psychological distress who did not receive treatment
7. Hospitalizations for problems attributable to alcohol
8. Adults 50 and older who have had a colonoscopy in the last 10 years
9. Teen pregnancies
10. Poor housing quality, by neighborhood

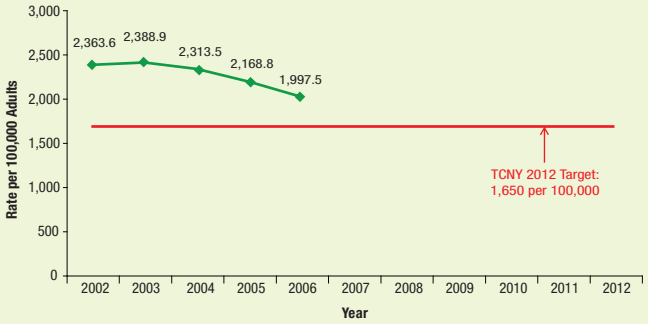
DOHMH has set a 2012 target for each indicator. Over the next four years, the health department will regularly measure progress toward each target. The targets vary widely – from a 5% decrease in the suicide rate to a 75% increase in the percentage of girls who have been vaccinated against human papillomavirus (HPV) – but even small changes can have a big impact when spread across a population. Every target we can meet will improve health for New Yorkers.

Baselines and targets for the indicators are expressed as rates or percentages. This makes it possible to compare the health status of different populations, or track one population's status over time.

But when interpreting percentages and rates, it is important to consider the total number of New Yorkers. The fact that 16.9 *percent* of adult New Yorkers smoke may sound modest, but it represents approximately one million people when applied to New York City. Likewise, a smoking-related death *rate* of 170 deaths per 100,000 adults may not sound dire, but it means that smoking kills 7,500 New Yorkers every year.

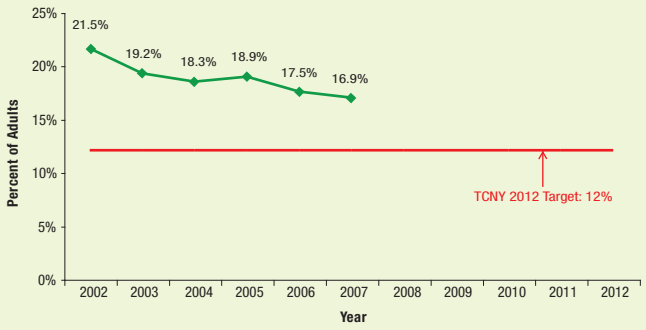
DOHMH will also track premature mortality (deaths among New Yorkers under 65) to measure the overall success of **Take Care New York 2012** (see **Figure 11**).

Figure 1. Preventable Hospitalizations, 2002 – 2006.



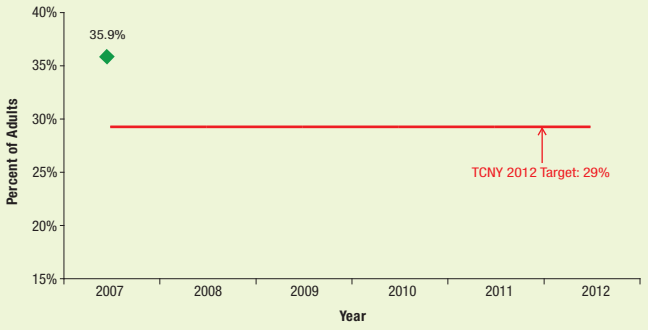
Source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), 2002-2006
Data are age adjusted

Figure 2. Adults Who Currently Smoke, 2002 – 2007.



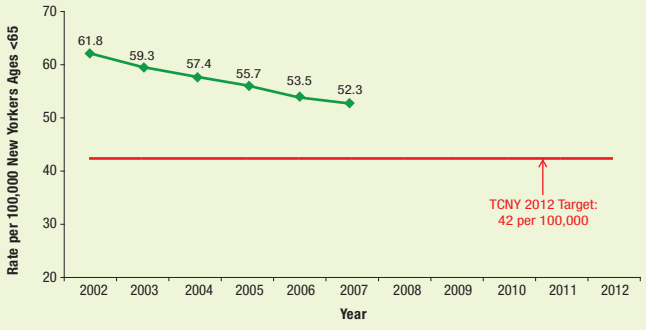
Source: NYC DOHMH Community Health Survey, 2002-2007
Data are age adjusted

Figure 3. Adults Who Consume an Average of One or More Sugar-Sweetened Beverages Per Day, 2007.



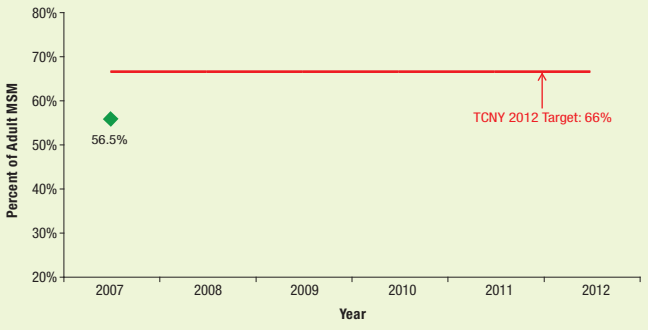
Source: NYC DOHMH Community Health Survey, 2007
Data are age adjusted

Figure 4. Premature Deaths from Major Cardiovascular Disease, 2002 – 2007.



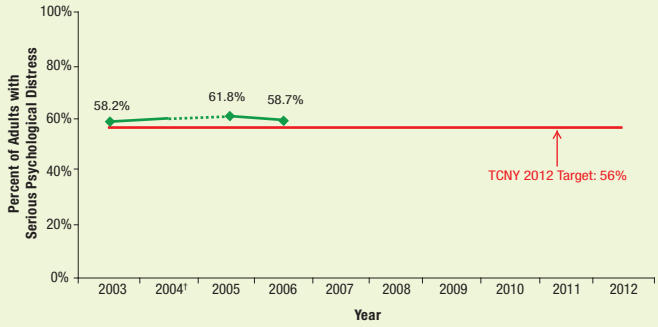
Source: NYC DOHMH Vital Statistics, 2002-2007
Data are age adjusted

Figure 5. Men Who Have Sex with Men (MSM) Who Report Using a Condom Every Time They Have Anal Sex, 2007.



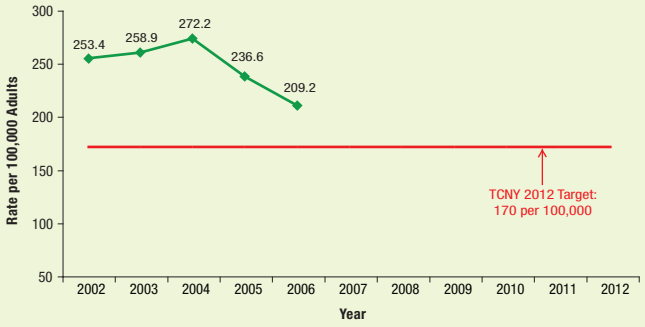
Source: NYC DOHMH Community Health Survey, 2007
Data are age adjusted

Figure 6. Adults with Serious Psychological Distress Who Did Not Receive Treatment*, 2003 – 2006.



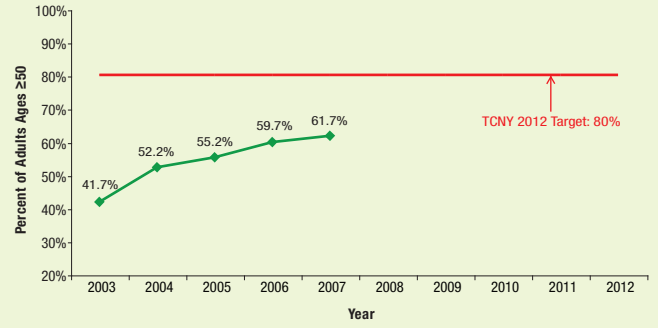
Source: NYC DOHMH Community Health Survey, 2003-2006
Data are age adjusted
*Treatment defined as: received any counseling or taken prescription medication for a mental hea th problem in the past 12 months
† Data not available for 2004

Figure 7. Hospitalizations for Problems Attributable to Alcohol, 2002 – 2006.



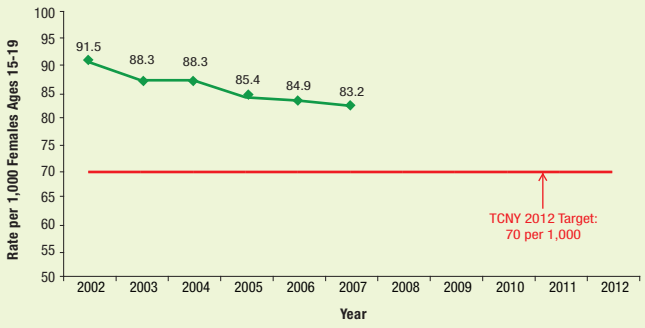
Source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), 2002-2006
Data are age adjusted

Figure 8. Adults 50 and Older Who Have Had a Colonoscopy in the Last 10 Years, 2003 – 2007.



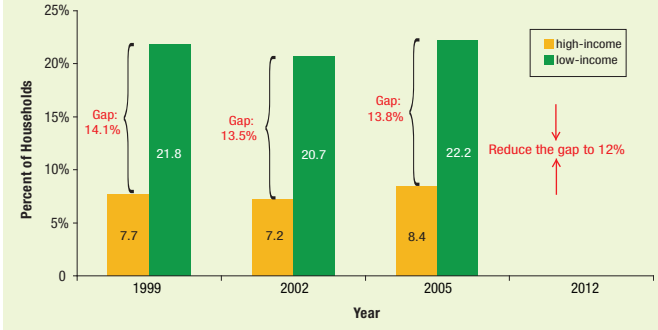
Source: NYC DOHMH Community Health Survey, 2003-2007
Data are age adjusted

Figure 9. Teen Pregnancies, 2002 – 2007.



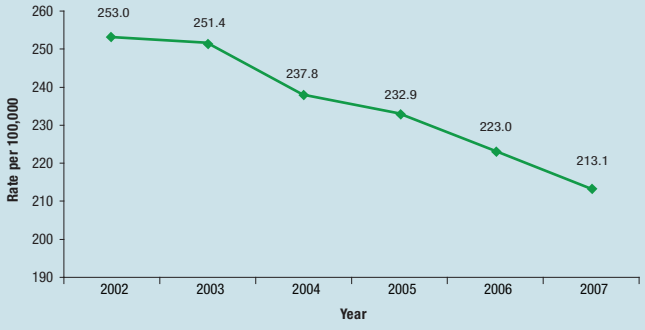
Source: NYC DOHMH Vital Statistics, 2002-2007

Figure 10. Poor Housing Quality, by Neighborhood.*



Source: NYC Housing and Vacancy Survey, 1999, 2002, 2005
*A Household is defined as having "poor housing quality" when the household is afflicted with three or more maintenance deficiencies. The gap between low income and high income neighborhoods in 2007 was 13.8%. DOHMH aims to reduce the gap to 12% by 2012.

Figure 11. Premature Death Rate, New Yorkers <65.



Source: NYC DOHMH Vital Statistics, 2002-2007
Data are age adjusted

Core Indicator Status and 2012 Targets*

Figure 12

TCNY 2012 Agenda Item	Core Indicator	Baseline†	2012 Target
1 Promote Quality Health Care for All	Preventable hospitalizations	1,997.5 per 100,000 (2006)	1,650 per 100,000 (17% decrease)
2 Be Tobacco Free	Adults who currently smoke	16.9%	12% (29% decrease)
3 Promote Physical Activity and Healthy Eating	Adults who consume an average of one or more sugar-sweetened beverages per day	35.9%	29% (20% decrease)
4 Be Heart Healthy	Premature deaths from major cardiovascular disease	52.3 per 100,000	42 per 100,000 (20% decrease)
5 Stop the Spread of HIV and Other Sexually Transmitted Infections	Men who have sex with men (MSM) who report using a condom every time they have anal sex	56.5%	66% (17% increase)
6 Recognize and Treat Depression	Adults with serious psychological distress who did not receive treatment	58.7% (2006)	56% (5% decrease)
7 Reduce Risky Alcohol Use and Drug Dependence	Hospitalizations for problems attributable to alcohol	209.2 per 100,000 (2006)	170 per 100,000 (19% decrease)
8 Prevent and Detect Cancer	Adults 50 and older who have had a colonoscopy in the last 10 years	61.7%	80% (30% increase)
9 Raise Healthy Children	Teen pregnancies	83.2 per 1,000	70 per 1,000 (16% decrease)
10 Make All Neighborhoods Healthy Places	Poor housing quality, by neighborhood	High-income neighborhood: 8.4% Low-income neighborhood: 22.2% (2005) } Gap: 13.8%	Reduce gap to: 12%

*See Technical Notes on page 34 for definitions of indicators, data sources and methodologies.
†Baseline data are from 2007 unless noted otherwise.

Health Disparities

Life expectancy in the United States has improved dramatically over the past 100 years. In New York City, average life expectancy is now 79 years, almost double what it was in 1901.[2] Longer life expectancy is mostly due to broad social advancements – clean water, adequate nutrition, decent housing and universal public primary and secondary education. But improvements have been uneven. New Yorkers with lower incomes and in certain racial and ethnic groups suffer far higher rates of preventable illnesses and premature death.

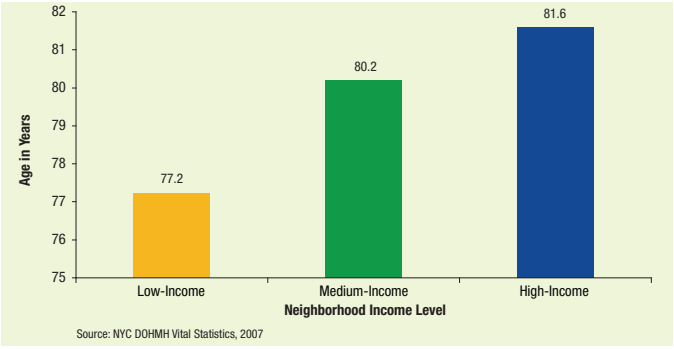
Income and race or ethnicity are major factors in health disparities, and often overlap – but not always. For example, black and Hispanic New Yorkers are generally poorer than white New Yorkers. As a result, a comparison between two racial/ethnic groups is usually also a comparison between a poorer and a wealthier group. When income alone is used for comparison, racial and ethnic differences fade for some health outcomes. For other health outcomes, racial/ethnic gaps persist in ways income alone cannot explain.[3]

New York City is one of the most racially and ethnically diverse cities in the United States. The city is also economically diverse, with a large gap between low and high incomes: the poorest half of New Yorkers earn less than 20% of the city's income, while the wealthiest 20% earn about half of the city's income. Despite New York City's diversity, its neighborhoods are often segregated by race, ethnicity and income. In the city's poorest neighborhoods – the South Bronx, East and Central Harlem, and North and Central Brooklyn – more than a third of all residents live in poverty. Black and Hispanic New Yorkers are more likely than white New Yorkers to live in these and other low-income neighborhoods.

The greatest health disparities exist between New York City's poorest areas, with large proportions of black and Hispanic residents, and its wealthiest areas, with high proportions of whites. In 2007, life expectancy in the city's poorest neighborhoods was nearly 4.5 years shorter than in the city's wealthiest neighborhoods (see **Figure 13**).[4] Infant mortality rates are almost twice as high[5] and rates of HIV diagnoses are the highest in the city's poorest neighborhoods.[6]

Take Care New York 2012 sets specific goals to address and reduce health disparities in each priority area by race and ethnicity, by income (at both individual and neighborhood levels), or by education level. Throughout this report, existing disparities are expressed as absolute differences and 2012 targets are referred to as a reduction in the "gap" (see **Figure 14**).

Figure 13. Life Expectancy by Neighborhood Income, 2007.



Source: NYC DOHMH Vital Statistics, 2007

Figure 14. Reduce the Gap

Health outcomes can be measured in many ways. Some examples include death rates, disease prevalence, screening rates and the proportion of people who engage in an unhealthy behavior.

Differences in health outcomes between two groups can be expressed in two ways:

An **absolute difference** is the value you get by simply subtracting one health measure from another. For example, if the death rate in one neighborhood is 50 per 100,000 and the death rate in another neighborhood is 60 per 100,000, the absolute difference, or gap, is 10 per 100,000.

A **relative difference** (also called "relative risk") uses a ratio to compare two groups. In describing the same neighborhoods above, we could say that the death rate is 1.2 times higher in one neighborhood than the other.

Throughout this document, indicators focus on health disparities between two groups of New Yorkers. The corresponding targets are set to reduce the gap, or absolute difference, between the two groups.

Neighborhood Health

The diversity of New York City neighborhoods is a defining and celebrated characteristic of the city. Neighborhoods are not simply groups of people; they are complex environments in which economic, social and physical factors combine to influence health. Despite widespread improvements in health throughout the city, *where* New Yorkers live still profoundly affects how healthy they are, especially when it comes to low-income neighborhoods.

Take Care New York 2012 includes a special focus on making *all* New York City neighborhoods healthy. Many of the health department's citywide programs and resources will be focused in low-income and minority neighborhoods. Improving the "built" environment (buildings, roads, utilities, homes, parks and all other man-made entities that form the physical characteristics of a community) and increasing access to services and opportunities are essential to make all New York City neighborhoods healthy.

Community Partners

Government, of course, cannot address health care challenges alone. **Take Care New York 2012** requires the involvement of individuals, health care providers, health insurers, community-based organizations and others.

More than 400 organizations have become **Take Care New York** partners since 2004. The health department serves as a valuable resource for partners, and connects partners with available services and with each other. Community partners provide an "on-the-ground" presence that expands the reach and visibility of **Take Care New York**. Many partners implement particular priorities and initiatives. Without these relationships **Take Care New York** would not succeed.

Data Sources and Publications

Take Care New York 2012 is evidence-based. The health department developed these goals and intervention strategies based on several data sources, including: the Community Health Survey (CHS), Statewide Planning and Research Cooperative System (SPARCS), Vital Statistics (VS) and the Youth Risk Behavior Survey (YRBS). For a complete description of these sources, as well as others used in the document, please see the Technical Notes on page 34.

1

NYC Aims to. . .

Promote Quality Health Care for All

Introduction

The current health care system in the United States is not structured to promote health or prevent disease. U.S. residents receive only about half of recommended preventive health services, which include immunizations, cancer screenings and management of chronic conditions such as diabetes or hypertension.[7]

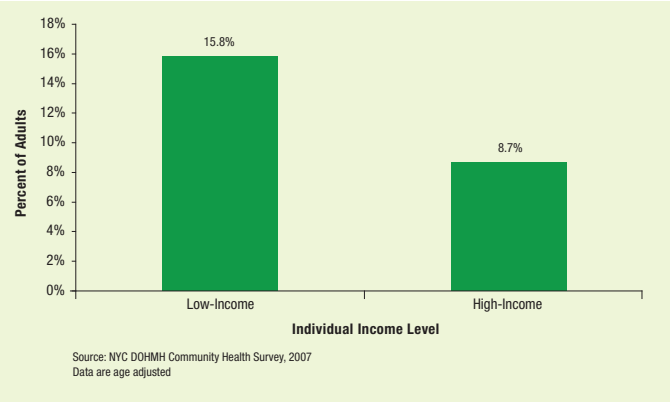
Providing high-quality, affordable health care for all New Yorkers calls for significant change: linking provider payments to improved patient outcomes, putting primary and preventive care first, and establishing universal health care and insurance coverage.

Widespread use of prevention-oriented electronic health records will help effect this change. Electronic health records can significantly improve quality and coordination of care, protect patient safety and reduce medical costs. Electronic health records enhance the efficiency of care and create greater provider accountability, and can decrease emergency department visits and hospitalizations for preventable conditions.

Health Disparities

Low-income New Yorkers generally have less access than those with higher incomes to primary and preventive services, and are the least likely to have health insurance or regular health care providers. In 2007, 11.1% of adult New Yorkers reported they did not receive necessary medical care in the last year[8] and nearly 16% of New Yorkers with incomes below 200% of the federal poverty level said they did not receive needed care (see **Figure 15**). Even among individuals with private insurance coverage, those with low incomes were less likely to have regular health care providers and less likely to access preventive care such as colonoscopies and Pap tests.[9]

Figure 15. Individual Income Level Disparity: Adults Who Did Not Get Needed Medical Care, 2007.



Source: NYC DOHMH Community Health Survey, 2007
Data are age adjusted

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Preventable hospitalizations	1,997.5 per 100,000 (2006)	1,650 per 100,000 (17% decrease)
Adults who did not get needed medical care	11.1%	9% (15% decrease)
Individual Income disparity:	Low-income: 15.8% / High-income: 8.7 % } Gap: 7.1%	Reduce the gap to: 5%

*See Technical Notes on page 35 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

I. Policies

Promote enhanced reimbursement for medical providers who use electronic health records.

DOHMH will continue to support widespread adoption of prevention-oriented electronic health records and encourage public and commercial health insurance plans to provide enhanced reimbursement, incentives or direct funding for providers who use them.

Reform the health care payment system to reward prevention.

The health department will advocate at the state and federal levels for improvements to provider reimbursement for primary and preventive care by linking payments to patient outcomes, preventive services and use of prevention-oriented electronic health records.

Promote universal health care and insurance.

DOHMH will support national and state health care reform efforts to care for uninsured New Yorkers and improve health insurance coverage and quality, and will seek to increase enrollment in public health insurance programs by supporting federal and state efforts to streamline the enrollment process.

II. Prevention, Quality and Access

Assist providers to successfully adopt and use electronic health records.

DOHMH will continue to assist New York City's medical providers, particularly those in underserved communities with a large percentage of Medicaid patients, to implement and effectively use prevention-oriented electronic health records.

Increase the number and quality of primary care providers in New York City.

The health department will help primary care providers, including physicians and mid-level practitioners, leverage benefits from federal and New York State programs that encourage recruitment and retention of health professionals, and will work to improve public health training of the health care workforce.

Case Study – New York City's Primary Care Information Project

Since its launch in 2005, the health department's Primary Care Information Project has become the country's largest electronic health record extension project. The Primary Care Information Project has introduced innovative, prevention-oriented health information technology to more than 1,400 primary care providers in New York City serving more than 1.4 million patients, mostly in low-income communities. The project helps primary care practices install electronic health record systems and train staff to use them to transform workflow and improve patient care. The Primary Care Information Project continues to pioneer initiatives that bring the power of technology to public health goals, with a special focus on prevention, improved outcomes, continuity of care and cost reduction.

Important features of the electronic health record include point-of-care reminders that help providers keep patients updated on preventive care services, tracking tools to enable outreach to patients in need of care, and automated quality reports that allow a practice to compare its performance to city averages in each of **Take Care New York 2012**'s priority areas.

Over the next four years, the Primary Care Information Project will double the number of providers and patients using its customized electronic health record. The project has launched an innovative pay-for-performance chronic disease prevention program. Participating practices will receive progress reports indicating their performance on key health measures for patients, including blood pressure, cholesterol levels and smoking cessation.

2

NYC Aims to. . .

Be Tobacco Free

Introduction

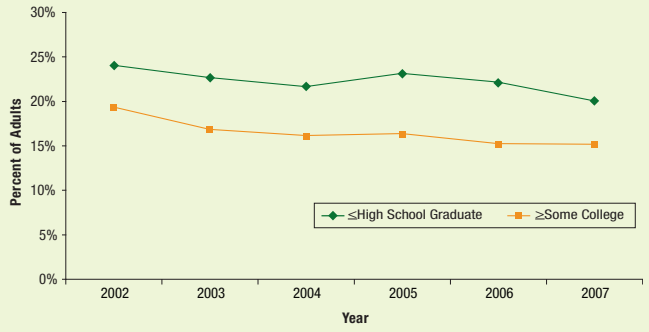
New York City has made considerable progress in reducing the number of smokers: between 2002 and 2007, there were 300,000 fewer adult smokers[10] and youth smoking also declined significantly.[11] Despite these successes, smoking remains the leading cause of preventable death, killing more than 7,400 New Yorkers every year.[12] Individuals who die of smoking-related illnesses lose an average of 14 years of life.[13]

Smoking greatly increases the risk of heart disease, stroke, cancer and many other illnesses. Second-hand smoke is also dangerous, and can lead to many of these same health problems. Infants whose parents smoke are more likely to die of sudden infant death syndrome and children who live with a smoker are more likely to have asthma, bronchitis, ear infections and pneumonia, and are twice as likely to become smokers themselves.[14]

Health Disparities

Certain groups in New York City have disproportionately high smoking rates, including low-income residents, blue-collar workers, people of Eastern European and Russian descent and residents of Staten Island.[15] The most pronounced difference in smoking rates in the city is between adults with a high school education or less and adults with at least some college education – in 2007, 20% of adults with less education smoked, compared to 15% of adults with higher levels of education (see **Figure 16**).[16]

Figure 16. Education Level Disparity:* Adults Who Currently Smoke, 2002 – 2007.



Source: NYC DOHMH Community Health Survey, 2002-2007
Data are age adjusted
*Data on education level are restricted to adults ages ≥25 years

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Adults who currently smoke	16.9%	12% (29% decrease)
Education–level disparity:	Low education: 20.0% / High education: 15.1% (Gap: 4.9%)	Reduce the gap to: 3%
High school students who currently smoke	8.5%	6% (29% decrease)
Deaths from smoking-related illnesses	169.8 per 100,000	155 per 100,000 (9% decrease)

*See Technical Notes on page 36 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

I. Policies

Ensure the high price of tobacco products by increasing local, state and federal taxes and reducing illegal sales.

DOHMH will advocate for city, state and federal tax increases on cigarettes and other tobacco products to reduce smoking among youth and adults, and support the enforcement of existing laws and the passage of new laws to minimize or eliminate the distribution of non-taxed and low-taxed cigarettes.

Advocate for the regulation of tobacco industry marketing practices.

DOHMH will advocate for the adoption of local laws and regulations to reduce the impact of tobacco advertising and other marketing practices, and introduce anti-tobacco messages in retail locations.

Reduce the availability and social acceptance of tobacco.

DOHMH will urge organizations and businesses in New York City to reject tobacco industry products, placement, funding and sponsorship.

Limit exposure to second-hand smoke.

The health department will continue to enforce New York City's 2002 Smoke-Free Air Act and will work with the city's Department of Parks and Recreation and other entities to expand smoke-free spaces to include city parks and public beaches.

II. Prevention, Quality and Access

Expand access to, and use of, smoking cessation services.

DOHMH will provide education, training and technical assistance on cessation treatment and counseling to health care providers, as well as continue distribution of free nicotine replacement therapy, and work with employers and insurers to increase coverage and use of smoking cessation benefits.

Incorporate tobacco screening, treatment and referral into electronic health records.

DOHMH will help health care providers prevent and reduce smoking through point-of-care tobacco screening and treatment reminders in electronic health records, and referral to cessation programs.

III. Health Promotion

Deliver high-impact media campaigns depicting the dangers of tobacco use.

DOHMH will continue to develop and implement aggressive anti-tobacco media campaigns on television and via print, Internet and radio outlets.

Promote anti-tobacco behaviors among individuals, communities, businesses, government organizations and others.

Through anti-tobacco media campaigns, the DOHMH website, and distribution of publications, the health department will continue to encourage New Yorkers to make their homes and environments smoke-free – an important way to reduce second-hand smoke exposure and to help smokers quit.[17]

Case Study – Increasing Quit Attempts through New York City's Anti-Smoking Media Campaigns

New York City experienced steep declines in adult smoking after state and city cigarette taxes increased and the city implemented the Smoke-Free Air Act of 2002. These decreasing rates, however, leveled out between 2003 and 2005.[18] In response, the health department launched an aggressive anti-tobacco media campaign in 2006, featuring graphic images and stories of people devastated by smoking-related illness and death. The ads urged smokers to call 311 for free help to quit. Among smokers who saw the ads (92%), 57% said their motivation to quit increased as a result.

In 2007, DOHMH ran another series of ads. Calls to 311 for help to quit rose more than four-fold between 2005 and 2007 – from 11,000 to more than 50,000. Smoking rates began to fall again, dropping 16.4% between 2005 and 2008.

DOHMH's 2007 original ad campaign "Cigarettes Are Eating You Alive," which graphically depicts the health consequences of smoking, has also been shown in Russia, Ukraine and Australia. A second original ad series featuring Marie, a New Yorker who required multiple amputations as a result of a smoking-related illness, generated more than 50 media stories after its 2008 launch and helped motivate more than 30,000 New Yorkers to call for help quitting smoking during the annual nicotine patch and gum program.

3

NYC Aims to…

Promote Physical Activity and Healthy Eating

Introduction

Unhealthy eating and lack of physical activity increase the risk of obesity and associated problems, including heart disease, stroke, diabetes, arthritis and cancer. In New York City, 57% of adults and 39% of children are overweight or obese, and one in three adult New Yorkers has either diabetes or pre-diabetes.[19] Obesity has increased significantly – from 2002 to 2004, New Yorkers collectively gained 10 million pounds, and this trend continued through 2007.[20] Obesity-related health problems account for almost 20% of Medicaid and Medicare expenditures.[21, 22]

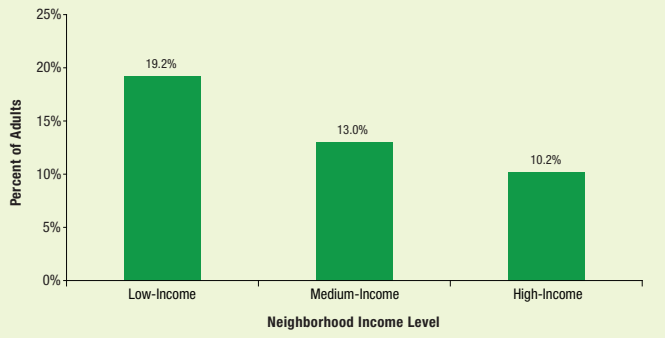
When asked in a 2004 survey, 14% of New Yorkers reported eating no fruits or vegetables at all on the previous day.[23] Most adults in this country eat much more salt than they should, and consume too much saturated fat.[24-26] Eating more fruits and vegetables is one way to protect against many chronic conditions, such as heart disease and type 2 diabetes.[27] Reducing the amount of high-sodium and high-fat foods consumed can help prevent high blood pressure and heart disease. Americans consume about 250 more calories per day than 30 years ago: about half of these extra calories come from sugar-sweetened drinks.[28]

Only one in four New Yorkers engages in physical activity 30 minutes per day, four days per week.[29] Being physically active is important for weight management – creating a healthy balance between calories consumed and burned – and for preventing a variety of chronic conditions and diseases, such as hypertension, diabetes, heart disease and some cancers.

Health Disparities

Poverty, lack of education, and race and ethnicity are all markers for disparities in levels of obesity. Poverty limits access to healthy, affordable foods and safe spaces for physical activity, increasing the risk of obesity, type 2 diabetes, cardiovascular disease and certain types of cancers.

Figure 17. Neighborhood Income Level Disparity: Adults Eating No Servings of Fruit and/or Vegetables in the Previous Day, 2004.



Source: NYC DOHMH Community Health Survey, 2004
Data are age adjusted

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Adults who consume an average of one or more sugar-sweetened beverages per day	35.9%	29% (20% decrease)
Adults eating no servings of fruits and/or vegetables in the previous day	14.1% (2004)	10% (30% decrease)
Neighborhood income disparity:	Low-Income: 19.2% / High-Income: 10.2% (2004) } Gap: 9%	Reduce the gap to: 3%
Adults who are physically inactive	29.2% (2005)	25% (14% decrease)
Adults who are obese (body mass index ≥30)	22.1%	No increase

*See Technical Notes on page 36 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

People who live in low-income neighborhoods consume fewer fruits and vegetables than do residents of medium- and high-income neighborhoods (see **Figure 17**).[30] Residents of low-income neighborhoods experience formidable barriers to purchasing fresh produce; perishable items are more expensive, and fewer grocery stores are located in neighborhoods where poverty is highest. Smaller stores often lack healthy foods, such as fresh produce, yet they have an overabundance of unhealthy products, such as sugar-sweetened beverages and calorie-dense snack foods. Individuals living in poorer neighborhoods also have less access to places for physical activity, such as safe and clean public parks, bike paths and recreation centers.

Older adults are also particularly affected by a lack of physical activity, which can contribute to an increased risk of falling. Falls account for approximately 300 deaths, 17,000 hospitalizations and 21,000 emergency department visits a year among New Yorkers older than 65. Even when fall-related injuries are minor, they can seriously affect older adults' quality of life by inducing a fear of falling, leading to self-imposed restrictions in physical activity, social isolation and depression.[31]

I. Policies

Reduce salt in processed foods.

DOHMH will work with food industry leaders, health organizations and public agencies on a voluntary plan to cut the amount of salt in processed food products nationally.

Enforce restaurant compliance with New York City regulations restricting the use of trans fat.

The health department will continue to monitor compliance with restricted use of trans fat in restaurants, since trans fat consumption raises cholesterol levels and is associated with heart disease.[32]

Promote more physical activity in schools, workplaces and community settings.

DOHMH will work with other city agencies, including the Department of Parks and Recreation and the Department of Transportation, to ensure that all New Yorkers have access to safe places near their homes where they can be physically active, including at schools, day care centers, community and senior centers, parks, and when traveling to and from work, school and other activities.

Increase the availability of healthy foods and opportunities for New Yorkers to make healthy eating choices.

The health department will work to increase the availability of fresh produce and other healthy foods in neighborhoods where access is limited, and to decrease the availability of unhealthy foods.

II. Prevention, Quality and Access

Encourage health care providers to promote physical activity and good nutrition.

DOHMH will help physicians facilitate healthy weight management by using electronic health records to document body mass index and health education to encourage children and parents to adopt healthy eating and physical activity habits.

III. Health Promotion

Expand physical activity programs in schools and community settings.

The health department will help schools, day care centers and other entities to augment physical activity opportunities for children, and will collaborate with the New York City Department of Parks and Recreation to increase availability of recreation programs for children and adults.

Engage older adults in physical activity to improve health and reduce falls.

In collaboration with the New York City Department for the Aging and senior centers throughout the city, DOHMH will increase opportunities for seniors to become more physically active, and will develop initiatives to prevent falls among older adults.

Promote reduced consumption of sugar-sweetened beverages.

The health department will develop media campaigns and educational materials to encourage New Yorkers to reduce the amount of sugar they consume, and to promote water as a no-calorie alternative to sugar-sweetened beverages.

Educate consumers about salt, healthy eating and physical activity.

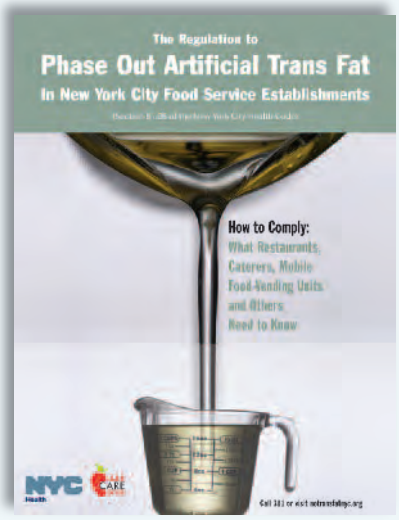
DOHMH will educate the public about negative health consequences associated with sodium consumption and will continue to collaborate with community partners on campaigns to promote healthy eating and physical activity.

Case Study – New York City Trans Fat Restriction to Make Restaurant Food Healthier

Consuming trans fat increases the risk of heart disease, a leading cause of death among New Yorkers. In 2005, the health department launched a citywide education campaign to encourage restaurants to voluntarily replace artificial trans fat with healthier oils. Even after the campaign, however, a survey revealed no decrease in the number of restaurants using trans fat for frying, baking or as a spread.

On December 5, 2006, the Board of Health approved a prohibition on artificial trans fat in New York City restaurants and other food service establishments. The regulation was the first of its kind in the United States. In November 2008, the regulation was fully in effect and more than 92% of restaurants in the city had achieved full compliance.

New York City quickly became a model for the country. By May 2009, 16 jurisdictions, including Philadelphia, Seattle and California, passed regulations to eliminate trans fats in restaurant food and 26 others were considering similar restrictions. The food service industry is following suit – more than 44 restaurant chains, nine grocery chains, four state fairs and 14 airline food providers and theme parks, such as Disney and Universal Parks, are implementing similar restrictions nationwide.



NYC Aims to. . .

4 Be Heart Healthy

Introduction

Heart disease is the leading cause of death in New York City[33] and the United States;[34] more than 23,000 New Yorkers die from heart disease and stroke each year.[35] Protection against a variety of related conditions and diseases, such as high blood pressure, high cholesterol and diabetes, is necessary to keep the heart healthy and prevent stroke. Smoking, obesity and physical inactivity increase the risks of these and other health problems.[36,37]

Health Disparities

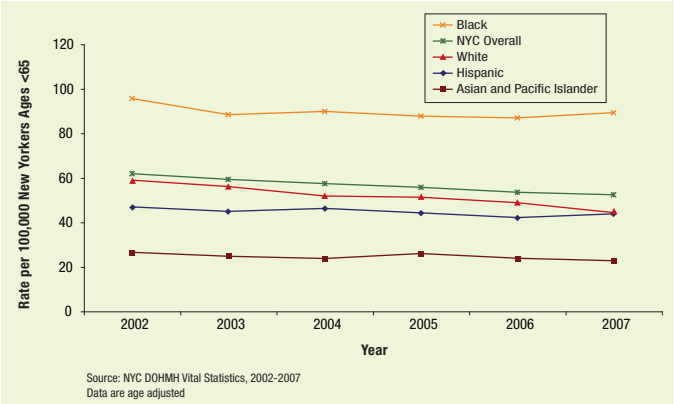
There are significant racial disparities in the prevalence and control of major cardiovascular disease risk factors, disease and preventable premature deaths. In 2007, black New Yorkers were twice as likely to die prematurely from cardiovascular disease than were whites (see **Figure 18**),[38] and were also more likely to have hypertension than were whites.[39] High blood pressure is widespread in New York City: one in four adults is affected and fewer than half have their condition under control.[40] Hypertension is more common in the South Bronx, East and Central Harlem, and North and Central Brooklyn, where 30% of adults have high blood pressure.[41]

I. Policies

Support changes to public and private health insurance programs to improve reimbursement for clinical preventive services.

DOHMH will advocate for changes in reimbursement to encourage improvements in managing chronic disease, such as improving hypertension control by increasing the distribution and use of automated home blood pressure monitors.

Figure 18. Racial/Ethnic Disparity: Premature Deaths from Major Cardiovascular Disease, 2002 – 2007.



Source: NYC DOHMH Vital Statistics, 2002-2007
Data are age adjusted

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Premature deaths from major cardiovascular disease	52.3 per 100,000	42 per 100,000 (20% decrease)
Racial/ethnic disparity:	Black: 89.3 per 100,000 White: 44.4 per 100,000 Gap: 44.9 per 100,000	Reduce the gap to: 30 per 100,000
Adults with hypertension needing to take medications and taking medications	74.2%	80% (8% increase)
Adults with high cholesterol taking medications	38.1%	41% (8% increase)

*See Technical Notes on page 37 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

II. Prevention, Quality and Access

Improve the quality of care for clinical preventive services.

The health department will develop drug treatment algorithms for hypertension, high cholesterol and diabetes, and establish institutional indicators and quality improvement programs to assess progress and promote improvements in managing these conditions.

Use electronic health records to improve the quality of clinical preventive services.

DOHMH's Primary Care Information Project will expand efforts to provide electronic health records that include enhanced functions for prevention, treatment and management of patients with hypertension, diabetes and other cardiovascular diseases and risk factors.

Increase access to free and low-cost medications to treat chronic diseases.

The health department will increase access to low-cost medications for cardiovascular disease, diabetes, hypertension and cholesterol by expanding use of the federally funded 340B Drug Pricing Program.[42]

Increase consumer access to blood pressure screenings in communities.

DOHMH will continue to promote blood pressure self-monitoring outside of medical settings, especially for people with poorly controlled hypertension, and continue to provide training and support for peer-led and community-based blood pressure screening and referral programs.

Support pharmacist participation in caring for patients with hypertension.

The health department will support pharmacists managing medication therapy for people with hypertension, including reimbursement from public and private payers, and identify other ways pharmacists can help New Yorkers control hypertension.

III. Health Promotion

Increase access to programs and tools to help individuals self-manage their chronic diseases.

DOHMH will pilot and support programs in clinical settings to increase and improve patient self-management of chronic diseases and conditions, including diabetes and pre-diabetes, hypertension and high cholesterol and obesity.

Case Study – New York City's *Health eHearts* Initiative

Heart disease is the leading cause of mortality in New York City, causing more than 23,000 deaths each year. In 2009, DOHMH's Primary Care Information Project launched New York City's *Health eHearts* to improve outcomes in four areas impacting heart health: **A**spirin, **B**lood Pressure Control, **C**holesterol Control, and **S**moking Cessation, or the "**ABC's**." The *Health eHearts* initiative is a one-year pilot[43] to reward and recognize primary care physicians who use electronic health records for helping adult patients achieve excellent heart health.

A	Aspirin for patients with ischemic vascular disease (IVD) or diabetes (DM)
B	Blood pressure controlled to recommended levels in patients with hypertension
C	Cholesterol controlled to recommended levels in patients with hypercholesterolemia
S	Smoking cessation treatment or counseling for current smokers

Health eHearts is a unique pay-for-performance program involving nearly 300 physicians at about 100 practices across New York City – community health centers and large and small practices representing approximately 100,000 patients. A randomly selected group of practices will receive quality payments based on positive patient outcomes. For every patient who meets a high standard of heart health, such as hypertensive patients who have their blood pressure controlled, the practice will receive a reward. Practices achieving successful outcomes in patients who are more difficult to treat, such as those with additional underlying health problems, will receive greater rewards. On average, each provider has the potential to earn $10,000 for their practice, up to a maximum of $100,000 per practice. Participating practices are also publicly recognized for their participation and commitment to improving heart health, and take part in evaluation activities to assess the effectiveness of the initiative.

DOHMH hopes *Health eHearts* will serve as a model rewards system for public and private health plans to encourage preventive care and improve heart health.

NYC Aims to…

5 Stop the Spread of HIV and Other Sexually Transmitted Infections

Introduction

New York City remains the epicenter of the HIV/AIDS epidemic in the United States; more than 100,000 New Yorkers are living with the infection[44] and thousands are unaware of their status. From 2001 to 2007, the number of New Yorkers living with HIV/AIDS increased by more than 17,000.[45] New HIV infections among young men who have sex with men (MSM) have been rising over the past decade, compared to men older than 30 who have sex with men, among whom new infection rates are declining.[46] Each year, more than 1,000 people in New York City first find out that they are HIV-positive when they are already sick with AIDS.[47]

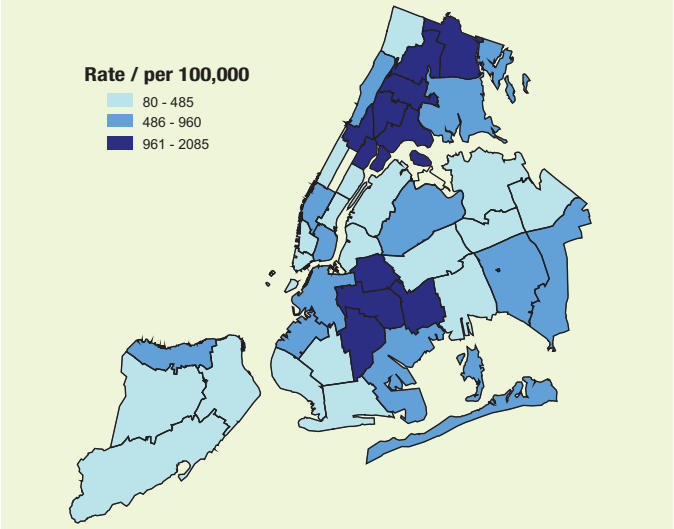
Approximately 75,000 New Yorkers were diagnosed in 2008 with gonorrhea, syphilis or chlamydia; many more are undiagnosed and untreated.[48] These infections can cause infertility, genital tract cancers, miscarriage and infections in newborns. Individuals with these sexually transmitted infections are two to five times more likely to acquire HIV, and HIV-infected individuals who also have other sexually transmitted infections are more likely to transmit HIV to their sex partners. Thus, screening, testing and treatment/management of other sexually transmitted infections are important and effective tools to prevent the spread of HIV.

Health Disparities

In New York City, substantial disparities exist in HIV/AIDS and other sexually transmitted infection rates across various racial and ethnic groups, and across neighborhoods. For example, deaths due to AIDS are six times higher in the poorest neighborhoods.[49] HIV has the starkest disparities of any sexually transmitted infection in New York City; in 2007, four times as many blacks and more than twice as many Hispanics were concurrently diagnosed with HIV and AIDS than were whites.[50]

Other sexually transmitted infections, such as syphilis, chlamydia, genital herpes and gonorrhea, are also more prevalent in certain racial and ethnic groups, and in certain neighborhoods (see **Figure 19**). Since syphilis case rates began to increase in the late 1990s, males have been disproportionately affected[51] and the rate of infection in black males is twice the rate seen in white males. Rates of chlamydia are 22 times higher among non-Hispanic black women and 12 times higher among Hispanic women than white women. Rates of genital herpes infections among black New Yorkers are more than three times higher, and among Hispanic New Yorkers more than two times higher, than among white New Yorkers. Disparities in infection rates for gonorrhea are even more pronounced: the rate among black women is 46 times higher than among white women.

Figure 19. Chlamydia Case Rate among Women in New York City by Neighborhood, 2007.



Source: NYC DOHMH Bureau of Sexually Transmitted Disease Control Quarterly Report, Vol. 6, No. 1, March 2008

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Men who have sex with men (MSM) who report using a condom every time they have anal sex	56.5%	66% (17% increase)
HIV/AIDS-related deaths	12.8 per 100,000	10 per 100,000 (22% decrease)
Racial/ethnic disparity:	Black: 30.9 per 100,000 White: 4.3 per 100,000 Gap: 26.6 per 100,000	Reduce the gap to: 21 per 100,000
Adults who have ever been tested for HIV	63.2%	72% (14% increase)
Sexually active women <26 years old screened for chlamydia infection	75.6%	82% (8% increase)

*See Technical Notes on page 37 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

I. Policies

Make voluntary HIV testing routine.

DOHMH aims to make HIV testing more accessible by funding hospitals, clinics and community-based organizations in all five boroughs to provide rapid HIV testing as a routine part of medical care, and to streamline patient consent and pre-test counseling requirements.

Create accountability for comprehensive HIV care.

The health department will work to create a single point of accountability for the HIV care system so that more individuals have a primary care provider who is responsible for providing comprehensive care that includes medical care, case management, risk-reduction counseling and a point of entry for other social services.

II. Prevention, Quality and Access

Improve access to quality HIV treatment and care coordination.

DOHMH will work to increase the number of persons living with HIV/AIDS in New York City who have access to coordinated, comprehensive health care and social services, and who receive primary care within three months of HIV diagnosis.

Increase routine voluntary screening for HIV and other sexually transmitted infections.

DOHMH will provide training for health care providers to routinely recognize and screen for HIV and other sexually transmitted infections in emergency departments, ambulatory care and inpatient settings; will work with community-based organizations to make routine, rapid HIV testing widely available, including for homeless and uninsured individuals; and will expand high school-based chlamydia and gonorrhea testing.

Promote timely management of partners to persons with chlamydia infection via Expedited Partner Therapy.

DOHMH will develop guidance for providers and patients about Expedited Partner Therapy, which enables providers to treat sex partners of people infected with chlamydia by allowing them to bring medications or prescriptions from the medical provider to their partners, without any required clinical assessment of the partners.

III. Health Promotion

Promote safer sexual behaviors, including consistent condom use and reducing the number of sex partners.

DOHMH will use both traditional and new media to promote safer sexual behaviors, and will work with communities and organizations to reinforce messages that encourage people with multiple sex partners to reduce their number of partners and use condoms consistently.

Promote large-scale testing initiatives to increase the number of New Yorkers who know their HIV status.

DOHMH plans to launch a citywide HIV testing initiative and media campaign to promote HIV testing in hospitals, clinics, community organizations, faith groups, businesses and schools.

Increase access to condoms.

The health department will increase efforts to make free male and female condoms more widely available and expand the city's Internet-based condom ordering and distribution system.

Case Study – Testing for and Treating Chlamydia and Gonorrhea in New York City Public High Schools

In spring 2006, DOHMH's Bureau of Sexually Transmitted Disease Control implemented the School-based Testing and Education Program for Urban Populations (*STEP-UP*), which provides HIV and sexually transmitted infection prevention education, and chlamydia and gonorrhea screening and treatment in public high schools. The program concentrates efforts in neighborhoods with high rates of chlamydia among adolescents.

After receiving classroom education about chlamydia and gonorrhea, students have the option to be tested for these infections. After one week, students can access their test results at any time, via telephone or Internet, through an automated reporting system. Health department staff follows up with students who tested positive for either infection to provide treatment and notify potentially infected partners that they should be tested and treated to stop the spread of infection.

During the 2007-2008 school year, *STEP-UP* educated more than 24,000 and tested nearly 12,000 high school students for chlamydia and gonorrhea in 89 schools. Overall, 7.3% of tested students were infected with chlamydia, gonorrhea or both. *STEP-UP* treated more than 95% of infected students and 75% of their partners who could be contacted, treating a total of 831 students.

Three expansions of *STEP-UP* are planned: (1) an Internet site that connects students with information on sexually transmitted infections, free or low-cost clinic locations, and access to their test results online or via telephone; (2) re-testing for chlamydia and gonorrhea three months after treatment; and (3) expansion to schools in all five boroughs.

6

NYC Aims to. . .

Recognize and Treat Depression

Introduction

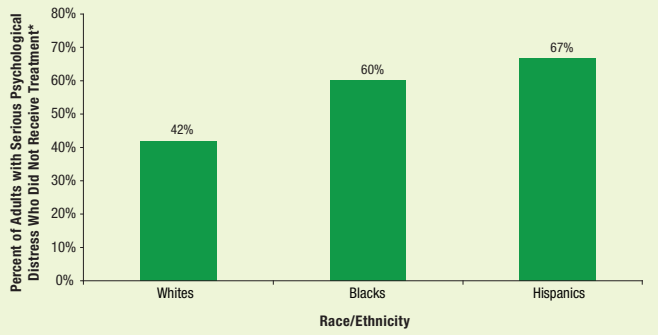
Depression[52] affects New Yorkers of all ages, socio-economic status and ethnic groups. It is a common and serious medical condition, characterized by pervasive low mood, loss of interest or pleasure in nearly all activities, and significant distress or impairment in social, occupational or other important areas of functioning. Other symptoms can include difficulty concentrating, loss of energy, trouble sleeping, changes in weight, feelings of worthlessness and recurrent thoughts of death or suicide.[53]

Each year, depression affects more than 400,000 (8%) of adult New Yorkers but only one in three of these individuals receives treatment.[54] Early detection and treatment can reduce suffering and improve quality of life. Depression can worsen the course and complicate the treatment of other health conditions such as diabetes and heart disease.[55] In its most tragic form, depression can lead to suicide.

Health Disparities

In New York City, lack of mental health care is a problem that disproportionately affects Hispanic and black New Yorkers. Among adult New Yorkers reporting serious psychological distress in 2006, 67% of Hispanics and 60% of blacks had not received treatment in the past 12 months compared with 42% of whites (see **Figure 20**).[56] These disparities arise from a variety of factors, including differences in access to mental health and general health care, variations in cultural attitudes toward mental illnesses and language barriers.

Figure 20. Racial/Ethnic Disparity: Adults with Serious Psychological Distress Who Did Not Receive Treatment for a Mental Health Problem in the Past 12 Months, 2006.



Source: NYC DOHMH Community Health Survey, 2006
Data are age adjusted
*Treatment defined as: Received any counse ing or taken prescription medication for a mental health problem in the past 12 months.

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Adults with serious psychological distress who did not receive treatment	58.7% (2006)	56% (5% decrease)
Racial/ethnic disparity:	(2006) Hispanic: 66.7% / White: 41.7% } Gap: 25%	Reduce the gap to: 23%
Suicides	5.6 per 100,000	5.3 per 100,000 (5% decrease)
Adults who have serious psychological distress that interferes with their life or activities	4.9% (2003)	No increase

*See Technical Notes on page 38 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

I. Policies

Advocate for expanded insurance coverage for treatment of depression and other mental health disorders.

DOHMH will advocate to strengthen New York State and federal laws[57,58] that require that mental health services are covered by health insurance plans in parity with physical health coverage.

Enhance surveillance of suicides in New York City to better inform prevention efforts.

The health department will expand its surveillance activities to better understand the circumstances surrounding New York City suicides, with particular emphasis on identifying opportunities for prevention.

Increase access to culturally competent mental health services.

DOHMH will advocate for New York State and federal incentive programs for providers to work in underserved communities, and to encourage minority and bilingual individuals to enter behavioral health professions.

II. Prevention, Quality and Access

Increase depression screening and effective management by primary care physicians.

The health department will work to increase the use of standard depression screening tools by disseminating provider education materials and trainings on depression identification and treatment, and working with primary care providers to utilize electronic health record systems for depression screening and management activities.

Address the mental health needs of special populations.

DOHMH will promote depression screening, referral and treatment for older adults and for women in the perinatal period by working with hospitals, obstetricians/gynecologists, pediatricians and community-based health professionals and organizations.

III. Health Promotion

Increase outreach and public education about depression.

The health department will provide education, screening and workplace wellness efforts to help people overcome barriers to seeking treatment for mental health disorders, such as a lack of knowledge and social stigma.

Case Study – New York City's Geriatric Depression Education, Screening and Referral Initiative

Older adults have higher rates of depression than the general population. To address this problem, the health department has collaborated with the New York City Department for the Aging and the Mental Health Association of New York City to educate providers and senior center participants about depression, to expand screening and to help those who need it get treatment.

In 2006, outreach efforts began on a small scale among Spanish-speaking seniors in the South Bronx, then expanded to include a variety of groups in all five boroughs. Over the next two years, the Initiative screened more than 2,000 older adults: of the 11% who showed signs of depression, most (69%) accepted a referral for care. Mental Health Association care managers followed up on initial screenings, helping depressed people connect with providers. Incentives, including cash transfer gift cards, were offered to those who saw a mental health professional. As a result of these efforts, the proportion of people who sought treatment rose to 44%, up from 28% the previous year. Workshops are now conducted in English, Spanish, Mandarin, Cantonese, Russian and Japanese.

New York City's Geriatric Depression Education, Screening and Referral Initiative has received the Aging Innovations Award from the National Association of Area Agencies on Aging, and the Innovation and Quality in Healthcare and Aging 2008 Award from the American Society on Aging.

7

NYC Aims to…

Reduce Risky Alcohol Use and Drug Dependence

Introduction

Alcohol and drug use contribute substantially to poor health, preventable injury and deaths in New York City. Studies demonstrate that as many as half of all injuries involve alcohol, and many more involve drugs or drugs and alcohol combined.[59] Accidental drug overdoses[60] and alcohol-related deaths[61,62] are among the leading causes of early death for adult New Yorkers. Alcohol consumption among adolescents is associated with the development of lifetime alcohol abuse or dependence later in life.[63]

Health Disparities

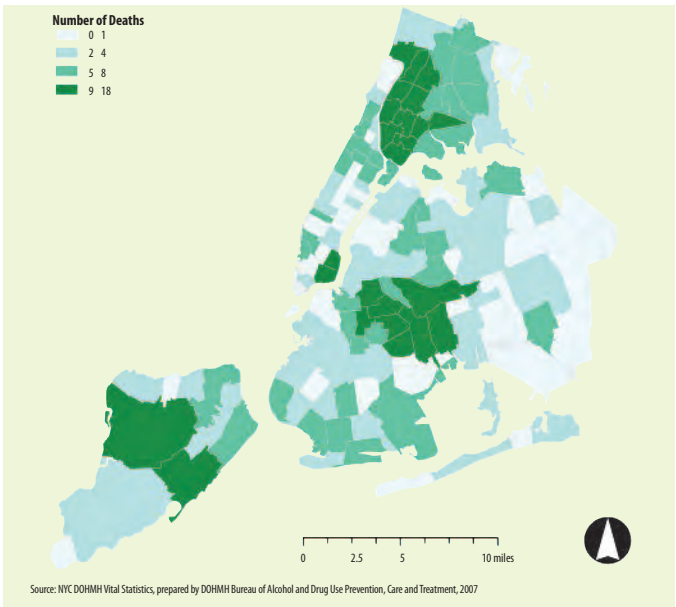
Although illicit drug use is widespread in New York City across many racial and ethnic groups and at all income levels, drug-related illness and death rates are persistently highest in New York City's poorest neighborhoods (see **Figure 21**).

I. Policies

Reduce access to alcohol among youth and limit sales practices that promote heavy drinking.

DOHMH will advocate for policies that reduce access to alcohol by adolescents and for limits on sales practices in communities and campuses that promote drinking among adolescents and heavy drinking among adults.

Figure 21. Drug Overdose Deaths by Zip Code of Residence in New York City, 2007.



Source: NYC DOHMH Vital Statistics, prepared by DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment, 2007

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Hospitalizations for problems attributable to alcohol	209.2 per 100,000 (2006)	170 per 100,000 (19% decrease)
Unintentional drug-related overdose deaths	9.7 per 100,000	8 per 100,000 (18 % decrease)
Neighborhood income disparity:	Low-income: 14.3 per 100,000 High-income: 5.6 per 100,000 Gap: 8.7 per 100,000	Reduce the gap to: 5 per 100,000
High school students who consumed alcohol in the past 30 days	33.5%	28% (16% decrease)

*See Technical Notes on page 39 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

Expand alternatives to incarceration in correctional settings and promote alternatives to incarcerating for low-level drug offenses.

The health department will promote alternatives to incarceration for low-level drug offenses, including reinvestment of cost savings into high-quality, evidence-based substance abuse treatment services, mental health services and job training and placement programs, and will promote effective substance abuse programs in correctional settings and for individuals upon release from jails or prisons.

II. Prevention, Quality and Access

Increase screening and brief intervention for alcohol and drug abuse problems.

DOHMH will work to expand the use of, and reimbursement for, screening and brief intervention, an evidence-based tool for identifying and appropriately treating alcohol and drug use problems.

Increase the use of buprenorphine treatment for opioid dependence.

The health department will advocate for a flexible means of introducing buprenorphine treatment in primary care settings and evidence-based alternatives to medical office induction, along with expanded public and private insurance coverage of buprenorphine treatment to ensure coordinated and broad access for all New Yorkers.

Expand overdose prevention education and access to naloxone.[64]

DOHMH will collaborate with other agencies, health care providers, homeless shelters, hospitals, emergency medical services and correctional settings to provide overdose prevention education and response training, intra-nasal naloxone and technical assistance, focusing on communities where drug-related injuries and death disparities are greatest.

III. Health Promotion

Counter-advertising campaigns.

DOHMH will develop targeted counter-advertising media campaigns to reduce the impact of alcohol advertising on youth and adult drinking.

Increase job placement services for people with recent or chronic histories of alcohol and drug use.

The health department will work to expand and improve job training and placement services for people with histories of alcohol and drug use to support recovery and opportunities for change.

Case Study – Use of Buprenorphine to Treat Opioid Dependence in New York City

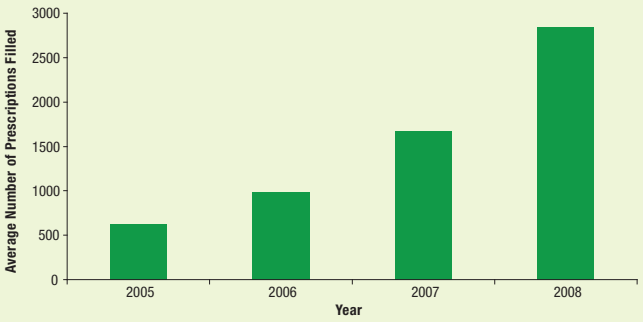
Buprenorphine was approved by the Food and Drug Administration in October 2002 to treat opioid dependence. Buprenorphine has fewer side effects and a lower risk of abuse than methadone. Primary care physicians can prescribe it, and patients can fill prescriptions at pharmacies, avoiding daily clinic visits that can interfere with activities and employment.

Since its approval, DOHMH has worked to expand the availability of buprenorphine and to educate providers and opioid-dependent individuals about its benefits (see **Figure 22**).

To prescribe buprenorphine, federal law requires physicians to complete a certification course and obtain a Drug Enforcement Agency license. Since 2004, the health department has sponsored certification courses at least once a year and has trained nearly 1,000 physicians as buprenorphine prescribers. A physician mentoring program connects newly certified physicians with experienced peers to share treatment approaches and patient outcomes. The health department will continue to encourage the U.S. Congress to eliminate provider certification requirements to increase the availability of buprenorphine.

Much of the DOHMH's public education outreach on the benefits of buprenorphine takes place in communities where drug-related injuries and deaths are highest. The health department distributes lower-literacy patient brochures in English and Spanish, publishes clinical guidelines, and has operated a public health detailing campaign to reach clinicians in neighborhoods with the highest rates of drug problems. In 2008, DOHMH initiated a successful peer education program, sending individuals experienced with buprenorphine use to provide basic education sessions to opioid-dependent individuals at program and service venues.

Figure 22. Average Monthly Buprenorphine Prescriptions by Unique Patient in New York City, October 2005 – December 2008.



Source: New York State Department of Health Bureau of Narcotics Enforcement, prepared by DOHMH Bureau of Alcohol and Drug Use Prevention, Care and Treatment, October 2005-December 2008

8

NYC Aims to. . .

Prevent and Detect Cancer

Introduction

Cancer is the second leading cause of death in New York City, killing approximately 13,000 New Yorkers every year.[65] Cancer-related illnesses and deaths can be significantly decreased by reducing smoking and obesity, detecting cancer and precancerous conditions early, and providing vaccination and timely treatment.

Two major cancers – cervical and colorectal – are preventable. Colonoscopies, Pap tests and the human papillomavirus (HPV) vaccine, all underused in New York City, are critical to prevent these cancers.

Health Disparities

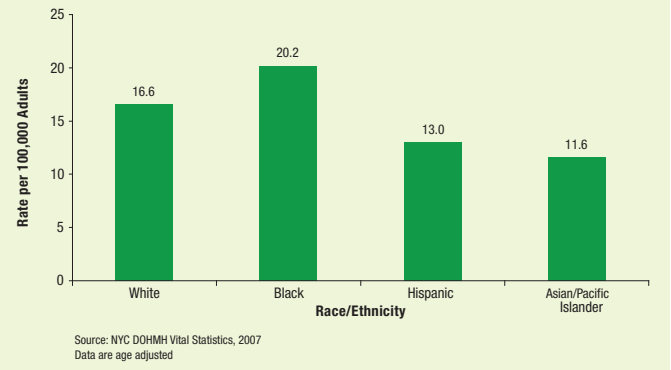
There are significant racial and ethnic health disparities in colorectal cancer death rates. Asians had the lowest colorectal cancer death rates in 2007, followed by Hispanics and whites. Despite high screening rates, colorectal death rates remain highest among blacks (see **Figure 23**).[66] While death rates fell between 2002 and 2007 for most racial groups, the disparity between blacks and whites increased.

I. Policies

Promote routine human papillomavirus vaccination among all girls ages 11 to 12 years, and "catch-up" vaccination for girls ages 13 to 18 years.

DOHMH will work with public and private insurers and medical providers to increase vaccination rates. It will work to reduce financial barriers to HPV vaccination by advocating for adequate provider reimbursement for vaccines; by enrolling new providers in the federal Vaccines for Children program (which provides free vaccines for Medicaid recipients and uninsured children); and by financing vaccines for underinsured children.

Figure 23. Racial/Ethnic Disparity: Deaths from Colorectal Cancer in New York City, 2007.



Source: NYC DOHMH Vital Statistics, 2007
Data are age adjusted

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Adults 50 and older who have had a colonoscopy in the last 10 years	61.7%	80% (30% increase)
Colorectal cancer deaths	16.3 per 100,000	14 per 100,000 (12% decrease)
Racial/ethnic disparity:	Black: 20.2 per 100,000 White: 16.6 per 100,000 Gap: 3.6 per 100,000	Reduce the gap to: 2 per 100,000
Girls ages 13-17 years who have received HPV vaccination	14.3% (2008)	25% (75% increase)

*See Technical Notes on page 39 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

Increase access to cancer treatment programs to help colorectal cancer patients pay for care.

DOHMH will seek to expand access to programs such as the New York State Medicaid Cancer Treatment Program to all New Yorkers who need treatment for colorectal cancer or pre-cancerous conditions.[67]

II. Prevention, Quality and Access

Increase support for colorectal cancer screening among people 50 and older.

The health department will advocate for increased screening through the Citywide Colon Cancer Control Coalition,[68] which includes gastroenterologists, primary care physicians, health plans, advocacy groups, professional associations, policymakers and workplace wellness programs.

Implement electronic health records to encourage routine cancer screening and follow-up care.

DOHMH will promote the use of electronic health records to refer and schedule cancer screenings through point-of-care clinical decision tools, and encourage the use of direct endoscopic referrals.

Use the Citywide Immunization Registry to encourage human papillomavirus vaccination.

The health department will promote use of the Citywide Immunization Registry to identify girls in need of the HPV vaccination and completion of the three-dose series.

III. Health Promotion

Increase public awareness of the importance of cancer screenings and how and when to obtain them.

DOHMH, in collaboration with strategic partners, will continue to educate the public on the importance of cancer screenings for breast, colorectal and cervical cancers, and when and how to get screened.

Increase public awareness about the importance of human papillomavirus vaccination.

The health department will educate parents, teenagers and providers about the HPV vaccine and the importance of delivering the vaccine early and completing the three-dose series, and will address safety concerns.

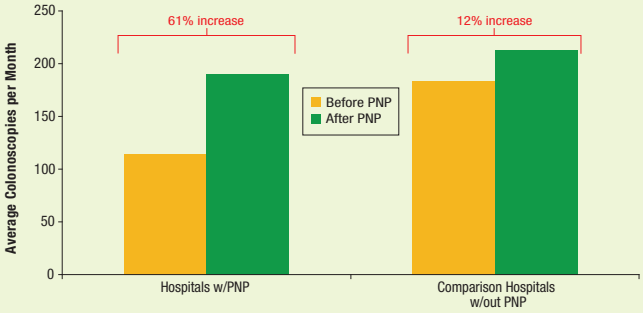
Case Study – New York City's Patient Navigator Program

The city's Patient Navigator Program provides culturally competent individual assistance to colonoscopy patients, from referral to procedure preparation through colonoscopy and follow-up. The goals of patient navigation are to improve colorectal cancer screening rates, lower "no-show" rates, reduce disparities and eliminate barriers to care.

DOHMH piloted a navigator program at three city hospitals from 2003 to 2006. In 2007, navigator programs helped eliminate colonoscopy screening disparities among white, black and Hispanic New Yorkers, and narrowed the screening disparity between Asians and whites. In 2009, 14 public and private hospitals in New York City are offering navigator programs.

In a survey of patients who worked with a patient navigator, 64% said they would not have completed the colonoscopy without the navigator; 98% were "very satisfied" or "satisfied" with their experience, and 96% said they would return for a colonoscopy in 10 years. Hospitals with navigator programs demonstrate increased colonoscopy volume and decrease the number of patients with incomplete colonoscopies (see **Figure 24**).

Figure 24. Average Colonoscopy Volume Per Month Before and After Implementation of the Patient Navigator Program (PNP).*



Source: NYC DOHMH Cancer Prevention and Control Program, Bureau of Chronic Disease
*Data are from the periods 12 months prior to and 18 months after PNP implementation.

9

NYC Aims to. . .

Raise Healthy Children

Introduction

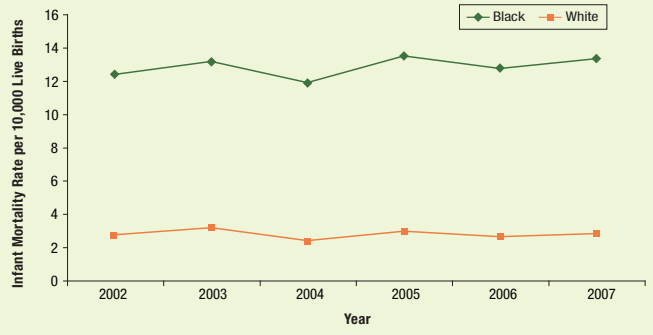
The well-being of almost two million New York City infants, children and adolescents is an important public health priority. Children's health is complex and affected by many factors and conditions. Age-appropriate primary and preventive care are important for healthy growth and development. Key issues that affect children's health include:

- Teen pregnancy, which has not decreased in New York City for the past five years and remains much higher than the national rate[69]
- Immunizations, which protect children from serious and life-threatening diseases
- Breastfeeding, which significantly benefits maternal and infant health (formula-fed infants are at increased risk for many infections, cancers and other illnesses)[70]
- Asthma, the most common cause of hospitalization for New York City children under age 14[71]
- Lead paint, the primary source of childhood lead poisoning,[72] which can result in learning and behavior problems and delays in mental development[73,74]
- Developmental disabilities, which cause school-aged children to have more doctor visits, more hospital stays, lower school attendance and a greater risk of repeating grades.[75-78]

Health Disparities

Persistent disparities in health outcomes often originate during pregnancy or infancy.[79–83] Two of the most significant racial and ethnic health disparities in New York City are the infant mortality and teen pregnancy rates.[84, 85] Overall, Puerto Rican and black infants are 1.5 to 2.5 times more likely to die in the first year of life than are white infants.[86] Black infants are more than four times more likely than are white infants to die in the first year of life due to injury or sudden infant death syndrome (see **Figure 25**). Hispanic and black teenagers have approximately five times higher pregnancy rates than do white teens.[87]

Figure 25. Racial/Ethnic Disparity: Infant Mortality Rate Due to Injury and Sudden Infant Death Syndrome, 2002 – 2007.



Source: NYC DOHMH Vital Statistics prepared by DOHMH Bureau of Maternal, Infant and Reproductive Health, 2002-2007

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Teen pregnancies	83.2 per 1,000	70 per 1,000 (16% decrease)
Racial/ethnic disparity	Black: 122.1 per 1,000 / White: 20.8 per 1,000 — Gap: 101.3 per 1,000	Reduce the gap to: 82 per 1,000
Infant mortality rate	5.4 per 1,000	5.0 per 1,000 (7% decrease)
Racial/ethnic disparity: Infant deaths due to injuries and sudden infant death syndrome	Black: 13.3 per 10,000 / White: 2.8 per 10,000 — Gap: 10.5 per 10,000	Reduce the gap to: 9 per 10,000
Mothers who exclusively breastfeed for at least two months	32%	45% (40% increase)

*See Technical Notes on page 40 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

I. Policies

Reduce teen pregnancies.

DOHMH will work to reduce teen pregnancies by expanding access to reproductive health services, including contraceptives, in school-based health centers in high schools, and by providing age-appropriate, comprehensive sex education in middle and high schools.

Increase childhood vaccinations.

DOHMH will advocate for implementation of different models of vaccine purchasing and distribution to providers in order to reduce barriers to timely and complete childhood vaccinations, and will support expanded use of newer vaccines that are not required for school attendance, such as the HPV vaccine.

Reduce lead hazards.

The health department will promote local and federal policies to reduce lead paint hazards in homes, schools and child care centers, and support policies limiting the use of lead in toys, health remedies, cosmetics and consumer products, especially those intended for use by children and pregnant women.

Encourage breastfeeding.

DOHMH will support policies that encourage mothers to breastfeed exclusively for at least six months, including promoting breastfeeding-friendly hospitals and Women, Infant and Children (WIC) program sites, and workplace lactation rooms.

Expand early childhood development programs, such as the Nurse-Family Partnership home visiting program for new mothers.

The health department will expand the Nurse-Family Partnership,[88] identify other evidence-based programs to improve early childhood development, and secure stable and increased public, and private funding for these programs.

Improve preventive care for asthma in children.

The health department will advocate for public and private insurance coverage of standardized case management and home environmental services for children with poorly controlled asthma, and will implement evidence-based programs and access to asthma medicine in schools and day care centers.

II. Prevention, Quality and Access

Integrate reproductive health services into primary care.

DOHMH will support extending Medicaid eligibility for pregnant women from six weeks to at least one year postpartum, and provide education and technical assistance to primary care providers on routine assessment of reproductive health needs and appropriate contraception.[89]

Improve early identification of children with developmental disorders.

DOHMH will encourage providers to identify children at risk for developmental disorders by promoting the use of evidence-based guidelines for developmental screening during each well-child preventive care visit and appropriate referral to the health department's Early Intervention Program.[90]

Promote asthma self-management and standards of care.

The health department will support incorporating written asthma self-management plans, prompts and reports into electronic health records in primary care settings, and promote the use of national and state asthma guidelines by providers.

Increase the number of children who are fully vaccinated.

The health department will use the City Immunization Registry to identify neighborhoods with low vaccination rates; support providers by alerting them when immunizations are due; send quarterly updates to providers on the immunization status of all children in their practices; and facilitate interoperability with provider electronic health record systems.

III. Health Promotion

Increase public awareness of conditions, care and services that affect children's health.

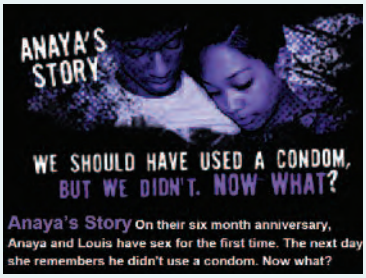
DOHMH will launch and continue public outreach and education campaigns for teens, parents and caregivers on topics that affect children's health, such as:

- Safe sleep practices
- The importance of breastfeeding to improve maternal and infant health outcomes
- The importance of young children being immunized against serious childhood diseases at appropriate times and information about the safety of vaccines
- The importance of preventing lead exposure to children and pregnant women

Case Study – New York City's Teen Pregnancy Prevention Program

The Bronx has the highest teen pregnancy rate of any borough in New York City. More than 11% of New York City women aged 15 to 19 become pregnant each year; in the South Bronx the rate is 13%. Although approximately 70% of sexually active teens in New York City (including the Bronx) report having used condoms, very few (less than 10%) report using more effective forms of birth control, such as oral contraceptives and long-acting reversible contraception.

In 2003, the health department began focusing resources and attention to reduce teen pregnancies in the South Bronx. DOHMH collaborated with the New York City Department of Education, Department of Youth and Community Development, local medical practices and community leaders to provide comprehensive, age-appropriate sex education, access to condoms and contraception, youth development opportunities and outreach and support to teen mothers.



Over the past five years, condom distribution has increased more than four-fold in the South Bronx, and Health Resource Rooms are in place in all South Bronx public high schools. Several hundred high school teachers have been trained to deliver a health education curriculum, which includes comprehensive sex education. School-based health centers in high schools and several community-based health centers have increased access to reproductive health services for teens, and the Nurse-Family Partnership has worked closely with more than 500 teen mothers in the South Bronx to help delay or prevent subsequent pregnancies.

10 NYC Aims to. . .

Make All Neighborhoods Healthy Places

Introduction

Despite widespread improvements in health throughout New York City, health status varies dramatically among neighborhoods, and the residents of some neighborhoods remain, on average, much less healthy than others.

Neighborhoods are complex environments in which economic, social and physical factors combine to influence health. Characteristics such as homes in disrepair, infestations of rodents and cockroaches, inadequate access to healthy foods, too few safe places to play and exercise, and aggressive marketing of tobacco and alcohol are disproportionately concentrated in certain neighborhoods. These conditions are often related to racial segregation and poverty, and contribute to an environment that negatively and profoundly affects health.

The highest disease burdens and shortest life expectancies in the city consistently occur in low-income neighborhoods with high proportions of black and Hispanic residents. Fewer supermarkets are located in low-income neighborhoods than in high-income neighborhoods[91] and lack of access to healthy foods available in supermarkets is associated with higher rates of diet-related conditions, such as diabetes and obesity.[92] Hospitalization rates due to pedestrian injuries among children are also highest in neighborhoods with the lowest incomes (see **Figure 26**).[93]

I. Policies

Make all neighborhoods safer and more conducive to walking, biking and active recreation.

The health department will work with the New York City Departments of Design and Construction, Transportation, and City Planning, as well as other city agencies, to improve pedestrian and bicyclist safety, create more green and active recreation spaces and develop street designs and public buildings that are better adapted to walking, bicycling and stair use.[94]

Increase access to healthy food – and decrease access to foods that are unhealthy – in all neighborhoods.

DOHMH will work with city agencies and community partners to identify ways to reduce sales of minimally nutritious foods, and increase the number of supermarkets and other stores selling healthy food in traditionally underserved neighborhoods.

Eliminate hazards that make homes unhealthy.

The health department will continue to work with landlords, tenants and the New York City Department of Housing Preservation and Development to enforce existing lead poisoning prevention laws, and to expand targeted screening and removal of lead paint hazards in high-risk dwellings. DOHMH will also enforce regulations designed to prevent other home hazards, including rodents, pests and missing or improperly installed window guards, smoke detectors and carbon monoxide detectors.

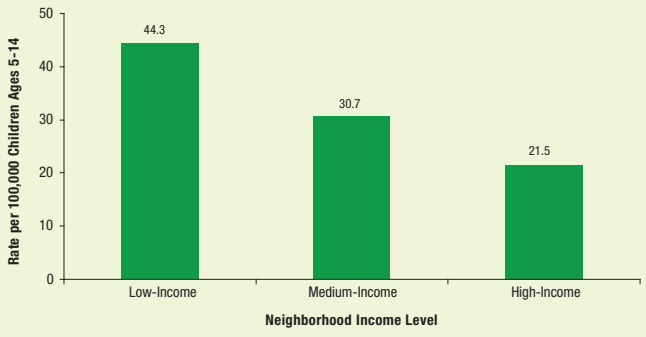
Reduce the presence of rats in neighborhoods.

The health department will proactively inspect neighborhoods for rats, and engage owners, pest professionals, civic associations, public agencies and elected officials in a concerted effort to eradicate rats and improve conditions to decrease to their presence.

Reduce exposure to outdoor advertising for tobacco.

DOHMH will advocate for the adoption of local laws and regulations to reduce the number and placement of tobacco advertisements, and continue to develop and implement anti-tobacco campaigns in disproportionately affected neighborhoods.

Figure 26. Neighborhood Income Level Disparity: Pedestrian Injury Hospitalizations for Children Ages 5-14 Years, 2006.



Source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), 2006

Implementing Take Care New York 2012

Indicators and Targets*

Indicator	Baseline†	2012 Target
Housing quality: Poor housing quality, by neighborhood	(2005) High-income neighborhood: 8.4% Low-income neighborhood: 22.2% } Gap: 13.8%	Reduce the gap to: 12%
Safety of walking and play spaces: Pedestrian injury hospitalizations for children	High-income neighborhood: 21.5 per 100,000 Low-income neighborhood: 44.3 per 100,000 } Gap: 22.8 per 100,000	Reduce the gap to: 20 per 100,000
Presence of rodents: Properties with signs of rats	(2008) Percent of inspected properties with signs of active rats: 8.5%	15% reduction on subsequent inspections

*See Technical Notes on page 40 for definitions of indicators, data sources and methodologies.
† Baseline data are from 2007 unless noted otherwise.

II. Prevention, Quality and Access

Work with providers serving high-need neighborhoods to ensure the availability of accessible, high-quality health care.

The health department will support equitable access to high-quality primary care and mental health services by promoting the widespread adoption of prevention-oriented electronic health records, improved provider-community service coordination, and the development and dissemination of best practices to improve patient care in New York City's underserved neighborhoods.

III. Health Promotion

Provide education about how New Yorkers can make their homes healthy, safe places.

DOHMH will continue to provide education, environmental assessment and enforcement around lead poisoning prevention, window guards, fire safety, integrated pest management, environmentally-friendly cleaning techniques and other issues.

Case Study – New York City's Lead Poisoning Prevention and Newborn Home Visiting Programs

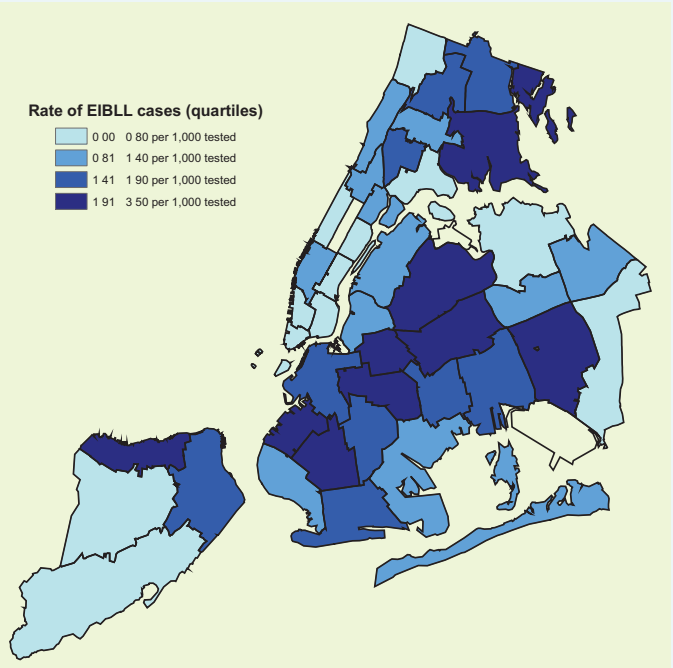
Lead poisoning remains a serious problem in New York City and disproportionately affects young children living in older, deteriorated housing in low-income neighborhoods (see **Figure 27**) and children of color. Children at risk for lead poisoning are also at greater risk for home health hazards linked to asthma and other injuries.

New York City has made a great deal of progress in reducing childhood lead poisoning: The number of young children with lead poisoning has dropped by 90% since 1995. The health department's Lead Poisoning Prevention Program uses a comprehensive approach to eliminate childhood lead poisoning. This includes innovative prevention, education and testing initiatives, focusing on populations and neighborhoods at greatest risk. In 2005, the health department launched the Newborn Home Visiting Program to proactively identify hazards in homes. During these visits, homes are assessed for lead paint and other environmental health hazards that are more prevalent in low-income neighborhoods, such as mold and pests, as well as for missing carbon monoxide and smoke alarms and window guards.

DOHMH has visited the homes of more than 20,000 newborns in neighborhoods with the highest health risks to check for lead paint and other hazards *before* lead poisoning and other injuries occur. If a hazard is identified, the home is referred for inspection and remediation. These visits, along with other proactive initiatives, have resulted in lead paint repairs in more than 2,100 homes.

The health department's innovative strategies for identifying and correcting home health hazards are at the forefront of an emerging national trend to expand environmental health interventions for children.

Figure 27. Environmental Intervention Blood Lead Level (EIBLL) Case Rates Varied by Neighborhood.*



*Rates of children (per 1,000 children tested), ages 0 to less than 18 years, newly identified with an Environmental Intervention Blood Lead Level (EIBLL): NYC, 2007.
Note: the United Hospital Fund (UHF) classifies New York City into 42 neighborhoods, comprised of contiguous zip codes.
Source: NYC DOHMH Lead Poisoning Prevention Program, 2007

Looking Forward

Take Care New York 2012 highlights major initiatives that will be most effective in improving the health of New Yorkers and sets specific, ambitious and achievable goals for each priority area.

Take Care New York 2012 is an evolving framework that will expand and transform as DOHMH learns more about the health of New Yorkers and the most effective interventions, and as state and federal policies develop and change. Since 2004, New York City has made numerous improvements in many areas of health, with visible and tangible results. **Take Care New York 2012** builds upon these efforts and continues to gain momentum in identifying and transforming social and environmental conditions, improving health care delivery and promoting individual and community actions to positively impact health.

The health department will track the indicators listed in this report, as well as other important measures of health, to assess the collective success of programs and policies, and evaluate and plan for challenges that remain. The health department will report upon progress made towards reaching each target in subsequent reports.

Take Care New York 2012 provides a renewed opportunity to engage partners in programs, outreach and advocacy to improve the health of all New Yorkers in all neighborhoods. The number of Take Care New York partners has grown to more than 400 community-based organizations, businesses, health care providers, city agencies, schools and others. DOHMH will continue to expand the number and diversity of partners and create more opportunities for partners to support and advance **Take Care New York 2012** goals.

Endnotes

Introduction

1. In Figures 1-10, green lines or points represent the actual rate; red lines depict the 2012 target. In Figures 3 and 5, data are not available for years before 2007. See Technical Notes on page 34 for data sources and adjustments.
2. New York City Department of Health and Mental Hygiene, Summary of Vital Statistics, 1961. Available at www.nyc.gov/html/doh/downloads/pdf/vs/1961sum.pdf. Accessed May 19, 2009.
3. Karpati A, Kerker B, Mostashari F, et al. Health Disparities in New York City. New York: New York City Department of Health and Mental Hygiene, 2004.
4. New York City Department of Health and Mental Hygiene, Office of Vital Statistics, January 2009.
5. New York City Department of Health and Mental Hygiene, Office of Vital Statistics, August 2008.
6. New York City HIV/AIDS Annual Surveillance Statistics 2007. HIV Epidemiology and Field Services Program, New York City Department of Health and Mental Hygiene, 2007. Available at www.nyc.gov/html/doh/downloads/pdf/ah/surveillance2007_tables_all.pdf. Accessed May 15, 2009.

Chapter 1

7. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl. J. Med*. 2003;348(26):2635-2645.
8. New York City Department of Health and Mental Hygiene, Community Health Survey, 2007.
9. New York City Department of Health and Mental Hygiene, Community Health Survey, 2007.

Chapter 2

10. New York City Department of Health and Mental Hygiene, Community Health Survey, 2002-2007.
11. New York City Department of Health and Mental Hygiene, Youth Risk Behavior Survey, 2001-2007.
12. Centers for Disease Control and Prevention. *Smoking-attributable mortality estimates based on the Centers for Disease Control and Prevention Adult SAMMEC (Smoking-attributable Mortality, Morbidity and Economic Costs) program*. http://apps.nccd.cdc.gov/sammec/. Accessed April 29, 2009.
13. Centers for Disease Control and Prevention. Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs—United States, 1995–1999. *MMWR*. 2002;51:300-303. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm. Accessed April 29, 2009.
14. U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Rockville, MD: OSG. 2007. Available at: www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet2.html. Accessed April 29, 2009.
15. New York City Department of Health and Mental Hygiene, Community Health Survey, 2007.
16. New York City Department of Health and Mental Hygiene, Community Health Survey, 2007.
17. Levy DT, Romano E, Mumford EA. Recent trends in home and work smoking bans. *Tobacco Control* 2004;13:258-263.
18. New York City Department of Health and Mental Hygiene. Epiquery: *NYC Interactive Health Data System: Smoking Status*, 2002-2005. Available at https://sasebiweb100.health.dohmh.nycnet/EpiQuery/. Accessed September 1, 2009.

Chapter 3

19. Thorpe LE, Upadhyah U, Chameny S, et al. Prevalence and Control of Diabetes and Impaired Fasting Glucose in New York City, 2004, *Diabetes Care*. 2009; 32(1):57-62.

20. Van Wye G, Kerker BD, Matte T, et al. Obesity and diabetes in New York City, 2002 and 2004. *Prev Chronic Dis*. 2008;Apr;5:A48.

21. Finkelstein EA, Fiebelkorn IC, Wang G. National medical spending attributable to overweight and obesity: how much and who's paying? *Health Affairs*. 2003;23:219-226.

22. Wolf A and Michael P. In: Nonas C and Foster GD, eds. *Managing Obesity: A Clinical Guide*. Chicago: ADA, 2009.

23. New York City Department of Health and Mental Hygiene, Community Health Survey, 2004.

24. Ayala C, Kuklina EV, Peral ZJ, et al. Application of lower sodium intake recommendations to adults–United States, 1999-2006. *MMWR* 2009;58(11):281-283.

25. Briefel RR, Johnson CL. Secular trends in dietary intake in the United States. *Annu Rev Nutr*. 2004;24(1):401-431.

26. U.S. Department of Health and Human Services. Nutrition and overweight. In: Healthy People 2010 Midcourse Review. Washington, DC: U.S. Department of Health and Human Services; 2005:1-25.

27. Jago R, Baranowski T, Baranowski JC. Fruit and vegetable availability: A micro environmental mediating variable? *Pub Health Nutr*. 2007; 10(7): 681-689,

28. Finkelstein EA, Ruhm CJ, Kosa KM. Economic causes and consequences of obesity. *Ann Rev Pub Health*. 2005; 26:239-257.

29. Roberts M, Kerker B, Mostashari F, et al. Obesity and Health: Risks and Behaviors. *NYC Vital Signs*. 2005, 4(2): 1–4.

30. New York City Department of Health and Mental Hygiene, Community Health Survey, 2004.

31. Vellas BJ, Wayne SJ, Romero L, et al. One-leg balance is an important predictor of injurious falls in older persons. *J Am Geriatr Soc*. 1997;45:735-738.

32. Mozaffarian D, Katan, MB, Ascherio A, et al. Trans fatty acids and cardiovascular disease. *N. Engl. J. Med*. April 13, 2006;354(15):1601-1613.

Chapter 4

33. New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2007.

34. Health 2007, National Center for Health Statistics; Centers for Disease Control and Prevention. Available at: www.cdc.gov/nchs/data/hus/hus07.pdf. Accessed April 22, 2009.

35. New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2007.

36. Wilson PW, D'Agostino RB, Levy D, et al. Prediction of coronary heart disease using risk factor categories. *Circulation*. 1998; 97(18):1837-1847.

37. Pearson TA, Blair SN, Daniels SR, et al. American Heart Association Guidelines for Primary Prevention of Cardiovascular Disease and Stroke: 2002 Update: Consensus Panel Guide to Comprehensive Risk Reduction for Adult Patients Without Coronary or Other Atherosclerotic Vascular Diseases. *Circulation*. 2002 Jul 16;106(3):388-391.

38. New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2007.

39. New York City Department of Health and Mental Hygiene, Community Health Survey, 2007.

40. Angell SY, Garg RK, Gwynn RC, et al. Prevalence, awareness, treatment, and predictors of control of hypertension in New York City. *Circ Cardiovasc Qual Outcomes*. 2008;1(1):46-53.

41. New York City Department of Health and Mental Hygiene, Community Health Survey, 2007.

42. The 340B Drug Pricing Program is a federal program funding grantees and other safety net health care providers to purchase prescription medications at significantly reduced prices. Additional information available at: www.hrsa.gov/opa/. Accessed September 1, 2009.

43. New York City's Health eHearts pilot is possible through the generous funding of the Robin Hood Foundation. The Robin Hood Foundation targets poverty in New York City by finding and funding the best and most effective programs and partnering with them to maximize results.

Chapter 5

44. New York City Department of Health and Mental Hygiene. HIV Epidemiology & Field Services Semiannual Report. New York: January 1 2007-December 31, 2007. Available at: www.nyc.gov/html/doh/downloads/pdf/dires/dires-2008-report-semi2.pdf. Accessed April 17, 2009.

45. New York City Department of Health and Mental Hygiene, HIV/AIDS Annual Surveillance Statistics, 2001-2007. Available at: www.nyc.gov/html/doh/html/ah/hivtables.shtml. Accessed June 15, 2009.

46. New York City Department of Health and Mental Hygiene, HIV/AIDS Annual Surveillance Statistics, 2001-2007. Available at: www.nyc.gov/html/doh/html/ah/hivtables.shtml. Accessed June 15, 2009.

47. New York City Department of Health and Mental Hygiene. HIV Epidemiology & Field Services Semiannual Report. New York: January 1 2007-December 31, 2007. Available at: www.nyc.gov/html/doh/downloads/pdf/dires/dires-2008-report-semi2.pdf. Accessed April 17, 2009.

48. New York City Department of Health and Mental Hygiene Bureau of Sexually Transmitted Disease Control Quarterly Report. Vol. 6, No. 4. New York: December 2008.

49. Karpati A, Kerker B, Mostashari F, et al. Health disparities in New York City. New York: New York City Department of Health and Mental Hygiene, 2004.

50. New York City Department of Health and Mental Hygiene. HIV Epidemiology & Field Services Semiannual Report. New York: January 1 2007-December 31, 2007. Available at: www.nyc.gov/html/doh/downloads/pdf/dires/dires-2008-report-semi2.pdf. Accessed April 17, 2009.

51. Over the past decade, syphilis infection has been almost exclusively transmitted between men having sex with other men.

Chapter 6

52. Throughout this discussion, "depression" refers to major depressive disorder. Note that depressive symptoms can occur in other major mood disorders, such as bipolar disorder (manic-depressive illness) and in milder forms such as dysthymic disorder (a form of chronic minor depression), as well as other conditions.

53. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Revised. Washington, DC: American Psychiatric Press; 2000.

54. Gwynn RC, McQuistion HL, McVeigh KH, et al. Prevalence, diagnosis, and treatment of depression and generalized anxiety disorder in a diverse urban community. *Psych Services*. 2008;59:641-647.

55. Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and depressive disorders. *Prev Chronic Dis.* 2005 Available at www.cdc.gov/pcd/issues/2005/jan/04_0066.htm. Accessed September 1, 2009.

56. New York City Department of Health and Mental Hygiene, Community Health Survey, 2006.

57. NYS Laws of 2006, Ch. 748 §§ 3103, 3201, 3221, 4303 and 4308.

58. Emergency Economic Stabilization Act, Pub. Law No. 110-343 § 512 (2008).

Chapter 7

59. D'Onofrio G and Degutis LC. Preventive care in the emergency department: screening and brief intervention for alcohol problems in the emergency department: a systematic review. *Acad Emerg Med*. 2002;9:627-638.

60. New York City Department of Health and Mental Hygiene, Office of Vital Statistics, 2007.

61. Mokdad AH, Marks JS, Stroup DF, et al. Actual causes of death in the United States, 2000. *JAMA*. 2004;291:1238-1245.

62. McGinnis JM and Foege WH. Mortality and morbidity attributable to use of addictive substances in the United States. *Proc Assoc Am Physicians*. 1999;111:109-118.

63. Grant BF and Dawson DA. Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. *J Subst Abuse*. 1997;9:103-110.

64. Naloxone is an opioid antagonist, traditionally used in emergency medicine that reverses the effects of opioid overdose (e.g., respiratory depression resulting from the overload of mu-receptors in the brain). Since April 1, 2006, New York State law supports the establishment of community-based opioid overdose prevention programs, to provide overdose prevention education and to prescribe and dispense naloxone to trained lay-persons, for administration to a third party in the event of a witnessed overdose.

Chapter 8

65. New York State Department of Health. Death Summary Information by Race/Ethnicity New York City – 2007. Vital Statistics of New York State 2007. Available at: www.health.state.ny.us/nysdoh/vital_statistics/2007/table31c.htm. Accessed April 23, 2009.

66. New York City Department of Health and Mental Hygiene, Office of Vital Statistics, 2007.

67. The Citywide Colon Cancer Control Coalition is a partnership between the New York City Department of Health and Mental Hygiene and a broad coalition of individuals and institutions committed to preventing colorectal cancer through advocacy, resource development and policy initiatives. www.nyc.gov/html/doh/html/cancer/cancercolon.shtml

68. Chapter 176 of the New York State Laws of 2006 expanded the Breast and Cervical Cancer Treatment Program to include treatment of colorectal and prostate cancer. Coverage for colorectal cancer treatment was implemented on April 1, 2007, but is available only for those patients identified through the Cancer Screening Program Partnerships. www.health.state.ny.us/nysdoh/bcctp/bcctp.htm

Chapter 9

69. New York City Department of Health and Mental Hygiene. *Teen Pregnancy in New York City: 1997-2007*. New York, NY: 2009. In press.

70. American Academy of Pediatrics: Policy Statement: Breastfeeding and the use of human milk, *Pediatrics* 2005; 2:496-506.

71. New York State Department of Health Statewide Planning and Research Cooperative System, 2006 (updated Aug 2007). Prepared by New York City Department of Health and Mental Hygiene, Bureau of Epidemiology Services, March 2009.

72. Chisolm JJ and Harrison HE. The exposure of children to lead. *Pediatrics*. 1956; 18: 943-958.

73. Canfield RL, Henderson CR, Cory-Slechta DA, et al. Intellectual impairment in children with blood lead concentrations below 10 µg per deciliter. *N Engl J Med*. 2003; 348:1517-1526.

74. Lanphear BP, Hornung R, Khoury J, et al. Low level environmental lead exposure and children's intellectual function: an international pooled analysis. *Environ Health Perspect*. 2005; 113: 894-899.

75. Boyle C, Decoufle P, Yeargin-Allsopp M. Prevalence and heath impact of developmental disabilities in US children. *Pediatrics*.1994;93(3):339-403.

76. Cordero J, Greenspan SI, Bauman ML, et al. CDC/ICDL Collaboration Report on a Framework for Early Identification and Preventive Intervention of Emotional and Developmental Challenges. November 11, 2006. Available at: www.icdl.com/dirFloortime/infant/documents/CDC-ICDLGuidelines-forEarlyID-PreventiveIntervention-11-11-06.pdf. Accessed April 22, 2009.

77. Rydz D, Srour M, Oskoui M, et al. Screening for developmental delay in the setting of a community pediatric clinic: a prospective assessment of parent report questionnaires. *Pediatrics*. 2006;118(4):1178-1186.

78. Committee on Children with Disabilities. Developmental surveillance and screening of infants and young children. *Pediatrics*. 2001;108(1):192-195.

79. Lu MC and Halfon N. Racial and ethnic disparities in birth outcomes: a life-course perspective. *Maternal and Child Health J*. 2003; 7(1):13-30.

80. Hogue CJ and Bremner J. Stress model for research into preterm delivery among black women. *Am J Obstet Gynecol*. 2005; 192, S47–55.

81. Thorpe LE, Berger D, Ellis JA, et al. Trends and racial/ethnic disparities in gestational diabetes among pregnant women in New York City, 1991-2001. *Am J Pub Health*. 2005; 95(9):1536-1539.

82. Whitehead NS, Callaghan W, Johnson C, et al. Racial, ethnic, and economic disparities in the prevalence of pregnancy complications. *Maternal and Child Health J*. 2009;13(2):198-205.

83. Ahluwalia IB, Morrow B, Hsia J. Why do women stop breastfeeding? Findings from the Pregnancy Risk Assessment and Monitoring System. *Pediatrics*. 2005; 116(6):1408-1412.

84. Reidpath DD and Allotey P. Infant mortality rate as an indicator of population health. *J Epidemiol Community Health*. 2003; 57:344-346.

85. *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*. Hoffman SD and Maynard RA, eds. Washington, DC: Urban Institute Press; 2008.

86. New York City Department of Health and Mental Hygiene. *Birth and Infant Mortality Trends, New York City (1997-2006)*. New York: 2008. Available at: www.nyc.gov/html/doh/downloads/pdf/ms/bimt-full-report.pdf. Accessed April 22, 2009.

87. New York City Department of Health and Mental Hygiene. *Summary of Vital Statistics*. New York: 2007. Available at: www.nyc.gov/html/doh/downloads/pdf/vs/2007sum.pdf. Accessed April 22, 2009.

88. The New York City Department of Health and Mental Hygiene's Nurse-Family Partnership is a nurse home visiting program for low-income, first time mothers. More information is available at: www.nyc.gov/html/doh/html/ms/ms-nfp.shtml.

89. A publication from the New York City Department of Health and Mental Hygiene, *Quick Guide to Contraception – Simple, State-of-the-Art Tips for Providers in Any Specialty* was designed to educate providers on integrating discussion of contraception options into their practices. Available at: www.nyc.gov/html/doh/downloads/pdf/ms/Quick_Guide_Contra_Online.pdf. Accessed April 29, 2009.

90. The New York City Department of Health and Mental Hygiene's Early Intervention program is available for children ages 0 to 3 years. More information is available at www.nyc.gov/html/doh/html/earlyint/earlyint.shtml.

Chapter 10

91. Going to Market: New York City's Neighborhood Grocery Store and Supermarket Shortage, New York City Department of City Planning, 2008. Available at: www.nyc.gov/html/dcp/pdf/supermarket_access/presentation_2008_10_29.pdf/ Accessed July 21, 2009.

92. New York City Department of Health and Mental Hygiene, Community Health Survey, 2007.

93. New York State Statewide Planning and Research Cooperative System, 2006.

94. Schieber RA and Vegega ME. National Strategies for Advancing Child Pedestrian Safety. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Available at: www.cdc.gov/ncipc/pedestrian/default.htm. Accessed April 21, 2009.

Take Care New York 2012 Indicator Technical Notes

Data Sources:

New York City Community Health Survey (CHS): The CHS is a telephone survey conducted annually among non-institutionalized adults aged 18 and older by the DOHMH's Division of Epidemiology, Bureau of Epidemiology Services. The survey is based on the CDC Behavioral Risk Factor Surveillance System. The CHS provides data on the health of New Yorkers, including both neighborhood and citywide estimates on a broad range of chronic diseases and behavioral risk factors. The CHS used a stratified random sample of United Hospital Fund neighborhoods in the city. Households were selected at random using a random digit dialing method and one adult in each household was randomly selected. Interviews were conducted in many languages, including English, Spanish, Russian and Mandarin. For complete methodology, visit www.nyc.gov/html/doh/html/survey/survey-2007.shtml.

Vital Statistics: The New York City Office of Vital Records is responsible for the registration of vital events – births, deaths and terminations of pregnancy – and registers, archives, amends and issues certified copies of these vital records. Data from these records are stored, analyzed, disclosed and reported for public health and government purposes. New York City birth and death statistics are now available on EpiQuery: Vital Statistics. www.nyc.gov/html/doh/html/vs/vs-epiquery.shtml

Youth Risk Behavior Survey (YRBS): The YRBS is a collaboration between the New York City DOHMH, the Department of Education and the U.S. Centers for Disease Control and Prevention. The survey is conducted in odd-numbered years and monitors health and risk behaviors among 9th-12th grade students in New York City public schools. The YRBS is designed to provide citywide estimates for all years and borough level estimates since 2003. In addition, the 2005 YRBS provides estimates for three District Public Health Office target areas. www.nyc.gov/html/doh/html/episrv/episrv-youthriskbehavior.shtml

New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS): SPARCS is a comprehensive data reporting system to collect information on discharges from hospitals. SPARCS collects patient level data on patient characteristics, diagnoses and treatments, services and charges for every hospital discharge, ambulatory surgery patient and emergency department admission in New York State. www.health.state.ny.us/statistics/sparcs/

Citywide Immunization Registry (CIR): CIR provides a central record-keeping system to track the immunization status of individual children and to monitor immunization levels in the population in a timely manner. The NYC Health Code requires that all physicians, nurse practitioners, and physician assistants who order the administration of an immunization for any individual age 18 years old and younger in New York City report the immunizations administered to the Registry within 14 days of administration. www.nyc.gov/html/doh/html/cir/a0b.html

The New York City Housing and Vacancy Survey (NYCHVS): NYCHVS is sponsored by the New York City Department of Housing Preservation and Development and is conducted approximately every 3 years to comply with New York State and New York City's rent regulation laws. The Census Bureau has conducted the survey for the city since 1965. www.census.gov/hhes/www/housing/nychvs/2005/overview.html

NYC DOHMH Rat Indexing Program: In December 2007, the health department started a new program to control rats in the Bronx. This program uses an inspectional process called "Rat Indexing" to proactively identify the presence of rats in neighborhoods, and to compare the severity of infestations among blocks and neighborhoods. Indexing involves the rapid inspection of every property in an established area for signs of rats, which include droppings, rub and gnaw marks, active burrows and live rats. This program also provides more detailed inspection findings and advice to property owners on how to correct conditions. https://gis.nyc.gov/doh/rip

Pregnancy Risk Assessment Monitoring System (PRAMS): PRAMS is an ongoing population-based survey of new mothers in New York City designed to monitor maternal experiences and behaviors before, during and after pregnancy. The 2007 data represent live births in January-December 2007, and are weighted to represent 122,222 live births in 2007. A 65% response rate was achieved in 2007. www.nyc.gov/html/doh/html/ms/ms-prams.shtml

The New York City Sexually Transmitted Disease Registry: The New York City Sexually Transmitted Disease Registry is a repository of laboratory and health care provider reports made to DOHMH for the 7 sexually transmitted diseases for which reporting is mandated in NYC: syphilis of all stages (including congenital syphilis), gonorrhea, chlamydia (including Lymphogranuloma venereum), chancroid, granuloma inguinale, and neonatal herpes.

Overall Definitions and Adjustments:

Neighborhood income definition:
In this report, neighborhoods are groups of zip codes defined by the United Hospital Fund. Neighborhood income is defined by the percent of households in the neighborhood below 200% of the federal poverty level, based on data from the US 2000 Census and separated into three groups: low-income (42.9%-69.7%), medium-income (30.3%-42.7%) and high-income (12.7%-30.1%).

Individual-level income definition:
In this report, low-income is defined as < 200% of the federal poverty level. High-income is defined as ≥200 % of the federal poverty level.

Adjustments:
Age-adjusted analyses are standardized to the year 2000 U.S. standard population.

Denominators:
All rates are calculated using DOHMH neighborhood population estimates, modified from US Census Bureau vintage population estimates.

For teen pregnancy data 2002 – 2006 displayed in Figure 9, rates are calculated using challenged and updated population estimates.

Targets:
Target percent increases and decreases are based on target values before rounding. 2012 Target values are rounded to the nearest whole number.

Introduction:

Premature Mortality (Figure 11):
Definition: Age-adjusted premature death rate (per 100,000) among persons ages <65 years old. Includes all events within NYC occurring to both residents and non-residents. Source: NYC DOHMH Vital Statistics, 2007

Life Expectancy (Figure 13):
Source: NYC DOHMH Vital Statistics, 2007
Definition: Life expectancy tables summarize the effect of mortality rates prevailing at a specific time on persons being born or living at that time. Deaths in calculation include NYC residents who died in NYC and the rest of New York State. Population data are from 2000 Census. Neighborhoods are aggregated from zip codes. Deaths with missing zip codes are not included in calculation.
Source: NYC DOHMH Vital Statistics, 2007

1. Promote Quality Health Care for All

Preventable hospitalization rate:
Definition: Age-adjusted hospitalization rate (per 100,000) for any ambulatory care sensitive (ACS) condition among NYC residents (≥18 years old).
Source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), 2006 (updated August 2007).
Prepared by NYC DOHMH, Bureau of Epidemiology Services, May 2009.

Adults who did not get needed medical care:
Definition: Age-adjusted percent of adults who did not get needed medical care in last 12 months
Source: NYC DOHMH Community Health Survey, 2007
Survey question: Was there a time in the past 12 months when you needed medical care, but did not get it?

Adults who did not get needed medical care – Individual income disparity:
Definition: Absolute difference/gap in age-adjusted percent of adults who did not get needed medical care in last 12 months, by individual-level income
Source: NYC DOHMH Community Health Survey, 2007

2. Be Tobacco Free

Adults who currently smoke:
Definition: Age-adjusted percent of adults who currently smoke
Source: NYC DOHMH Community Health Survey, 2007
Survey Questions: Have you smoked at least 100 cigarettes in your entire life?; Do you now smoke cigarettes every day, some days or not at all?

Adults who currently smoke – Education-level disparity:
Definition: Absolute difference/gap in age-adjusted percent of adults who currently smoke by education level.
Low education = high school or less; High education = some college or greater. Education level data are restricted to adults age ≥25 years old.
Source: NYC DOHMH Community Health Survey, 2007

High school students who currently smoke:
Definition: Percent of public high school students who currently smoke
Source: New York City Departments of Health and Mental Hygiene (DOHMH) and Education (DOE): New York City Youth Risk Behavior Survey, 2007.
Survey Question: During the past 30 days, on how many days did you smoke cigarettes?

Death rate from smoking-related illnesses:
Definition: Age-adjusted death rate (per 100,000) from smoking-related illnesses among persons ages 35 years or older. Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

3. Promote Physical Activity and Health Eating

Adults who consume an average of one or more sugar-sweetened beverages per day:
Definition: Age-adjusted percent of adults who report having an average of one or more soda and/or sugar-sweetened beverages per day
Source: NYC DOHMH Community Health Survey, 2007
Survey Questions: How often do you drink soda? Do not include diet soda or seltzer; How often do you drink other sweetened drinks like iced tea, sports drinks, fruit punch or other fruit-flavored drinks? Do not include diet soda, sugar free drinks or 100% juice.

Adults who are physically inactive:
Definition: Age-adjusted percent of New York City adults who report having no physical activity in the past 30 days
Source: NYC DOHMH Community Health Survey, 2005
Survey Question: During the past 30 days, other than your regular job, did you participate in any physical activities or exercise? Physical activities include such activities as running, calisthenics, golf, gardening, or walking.

Adults eating no servings of fruits and/or vegetables in the previous day:
Definition: Age-adjusted percent of adults who report eating no servings of fruits and/or vegetables in the previous day
Source: NYC DOHMH Community Health Survey, 2004
Survey Question: How many total servings of fruit and or vegetables did you eat yesterday? A serving would equal one medium apple, a handful of broccoli, or a cup of carrots.

Adults eating no servings of fruits and/or vegetables in the previous day – Neighborhood income disparity:
Definition: Absolute difference/gap in age-adjusted percentage of adults with no fruit and/or vegetable consumption by neighborhood income.
Source: NYC DOHMH Community Health Survey, 2004

Adults who are obese (BMI ≥30):
Definition: Age-adjusted percent of adults with body mass index (BMI) ≥30
Source: NYC DOHMH Community Health Survey, 2007
Survey Questions: About how tall are you without shoes?; About how much do you weigh without shoes?; Includes follow-up questions on critical height/weight for BMI. BMI calculated based on responses to height and weight and follow-up questions.

4. Be Heart Healthy

Major cardiovascular disease (CVD) premature death rate:
Definition: Age-adjusted cardiovascular disease (CVD) premature death rate (per 100,000) among persons ages <65 years old. Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

Major Cardiovascular disease (CVD) Premature death rate – Racial/ethnic disparity:
Definition: Absolute difference/gap in age-adjusted cardiovascular disease (CVD) death rate (per 100,000) among persons ages <65 years, by race/ethnicity. Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

Adults with hypertension needing to take medications and taking medications:
Definition: Age-adjusted percent of adults with high blood pressure and ever told by health care professional to take medication who are currently taking medicine for high blood pressure.
Source: NYC DOHMH Community Health Survey, 2007
Survey Questions: Have you ever been told by a doctor or other health care professional that you have hypertension, also called high blood pressure? Have you ever been told by a doctor, nurse, or other health professional that you need to take medicine for your high blood pressure?; Are you currently taking medication for your high blood pressure?

Adults with high cholesterol taking medications:
Definition: Age-adjusted percent of adults with high cholesterol who are currently taking medicine for high cholesterol
Source: NYC DOHMH Community Health Survey, 2007
Survey Questions: Have you ever been told by a doctor, nurse or other health professional that your blood cholesterol is high?; Are you currently taking medicine to lower your high cholesterol?

5. Stop the Spread of HIV and Other Sexually Transmitted Infections

Men who have sex with men (MSM) who report using a condom every time they have anal sex:
Definition: Age-adjusted percent of men who have sex with men (MSM) who used condoms every time during anal sex in the past 12 months
Source: NYC DOHMH Community Health Survey, 2007
Survey Questions: During the past 12 months, with how many men have you had sex?; In the past 12 months, have you had anal sex?; In the past 12 months, when you have had anal sex, have you or your partner used a condom? Every time, some of the time or never?

HIV/AIDS-related death rate:
Definition: Age-adjusted HIV/AIDS-related death rate (per 100,000). Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

HIV/AIDS-related death rate – Racial/ethnic disparity:
Definition: Absolute difference/gap in age-adjusted HIV/AIDS-related death rate (per 100,000) by race/ethnicity. Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

Adults who have ever been tested for HIV:
Definition: Age-adjusted percent of adults ages 18-64 years ever been tested for HIV
Source: NYC DOHMH Community Health Survey, 2007
Survey Question: Have you ever had an HIV test?

Sexually active women <26 years old screened for chlamydia:
Definition: Percent of sexually active teens and young adult women < 26 years old screened annually for chlamydia infection
Sources: DOHMH NYC Sexually Transmitted Disease Registry, 2007; NYC Youth Risk Behavior Survey, 2007; NYC DOHMH Community Health Survey, 2007; School screening prevalence data, 2007; Family Planning clinic prevalence data, 2005
Methodology: This calculation includes the following information: the number of women aged 15-25 in NYC, the proportion of those women who are sexually active, the number of chlamydia cases reported to the NYC DOHMH for women of those ages each year, the prevalence of chlamydia among women of those ages in a sample of the general population, and the repeat chlamydia trachomatis infection rate.

6. Recognize and Treat Depression

Adults with serious psychological distress who did not receive treatment:
Definition: Age-adjusted percent of adults with serious psychological distress who did not receive counseling or have taken a prescription medication in the last 12 months for a mental health problem
Source: NYC DOHMH Community Health Survey, 2006
Survey Question: During the past 30 days, how often did you feel: so sad that nothing could cheer you up, nervous, restless or fidgety, hopeless, that everything was an effort, worthless?; In the past 12 months, have you received any counseling or taken prescription medication for a mental health problem?

Adults with serious psychological distress who did not receive treatment – Racial/ethnic disparity:
Definition: Absolute difference/gap in age-adjusted percent of adults with serious psychological distress who did not receive counseling or have taken a prescription medication in the last 12 months for a mental health problem by race/ethnicity
Source: NYC DOHMH Community Health Survey, 2006

Suicide rate:
Definition: Age-adjusted suicide rate (per 100,000). Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

Adults who have serious psychological distress that interferes with their life or activities:
Definition: Age-adjusted percent of all adults who have serious psychological distress that interfered with their life activities some or a lot in the last 30 days (measured with K-6 scale)
Source: NYC DOHMH Community Health Survey, 2003
Survey Question: During the past 30 days, how often did you feel: so sad that nothing could cheer you up, nervous, restless or fidgety, hopeless, that everything was an effort, worthless? (2003; We just talked about a number of feelings you had during the past 30 days. Altogether, how much did these feelings interfere with your life or activities: a lot, some, a little, or not at all?)
Methodology: Serious psychological distress, also referred to as "non-specific psychological distress" or "NSPD", is measured using the K-6 scale which asks respondents how often during the preceding 30 days they felt sad, nervous, restless, hopeless, worthless, or that everything was an effort. Responses to these 6 feelings are measured on a scale of 0–4 ranging from "none of the time" to "all of the time". Responses are summed and those with scores greater than 12 are classified as having NSPD. (Kessler RC, Barker PR, Colpe LJ, et al. Screening for serious mental illness in the general population *Arch Gen Psychiatry*. 60(2), 184-189, 2003; McVeigh KH, Galea S, Thorpe LE, et al: The epidemiology of nonspecific psychological distress in New York City, 2002 and 2003. *Urban Health* 83:394–405, 2006).
The K-6 scale performs well as a population screening instrument for current depression.(see Cairney, J Veldhuizen BA, Wade TJ Evaluation of 2 Measures of Psychological Distress as Screeners for Depression in the General Population. *Can J Psychiatry;* 52:111–120, 2007). To calculate this measure among the adult population, the percent of those with NSPD who also said that their feelings interfered with their lives a lot or some (2003) was multiplied by the average NSPD measure over most of our survey years (6.3%).

7. Reduce Risky Alcohol Use and Drug Dependence

Hospitalization rate for alcohol-attributable diagnoses:
Definition: Age-adjusted rate (per 100,000) of wholly alcohol-attributable (in-patient) hospitalizations, based on principal diagnosis
Source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), 2006 (updated August 2007). Prepared by NYC DOHMH, Bureau of Epidemiology Services, May 2009.

Unintentional drug-related overdose death rate:
Definition: Age-adjusted rate (per 100,000) of unintentional drug-related overdose deaths. Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

Unintentional drug-related overdose death rate – Neighborhood income disparity:
Definition: Absolute difference/gap in age-adjusted unintentional drug-related overdose deaths by neighborhood (residence) income level. Includes all events within NYC occurring to NYC residents only.
Source: NYC DOHMH Vital Statistics, 2007

High school students who consumed alcohol in the past 30 days:
Definition: Percent of public high school students who consumed at least one drink of alcohol in last 30 days
Source: NYC Departments of Health and Mental Hygiene (DOHMH) and Education (DOE): NYC Youth Risk Behavior Survey (YRBS), 2007.
Survey Question: During the past 30 days, on how many days did you have at least one drink of alcohol?

8. Prevent and Detect Cancer

Adults 50 and older who have had a colonoscopy in the last 10 years:
Definition: Age-adjusted percent of adults ages 50 and older who have had a colonoscopy in the last 10 years
Source: NYC DOHMH Community Health Survey, 2007
Survey Question: Colonoscopy is an exam in which a tube is inserted in the rectum to view the bowel for signs of cancer or other health problems. Have you ever had a colonoscopy?; When was your most recent colonoscopy performed?

Colorectal cancer death rate:
Definition: Age-adjusted colorectal cancer death rate (per 100,000). Includes all events within NYC occurring to both residents and non-residents.
Source: NYC DOHMH Vital Statistics, 2007

Colorectal cancer death rate – Racial/ethnic disparity:
Definition: Absolute difference/gap in age-adjusted colorectal cancer death rate, by race/ethnicity
Source: NYC DOHMH Vital Statistics, 2007

Girls ages 13-17 years who have received HPV vaccination:
Definition: Percent of girls ages 13-17 years who have received HPV (human papillomavirus) vaccine. This indicator captures the number of females 13-17 years of age with 1, 2 and 3 doses of HPV vaccine based on doses reported to CIR.
Source: Citywide Immunization Registry, 2008

9. Raise Healthy Children

Teen pregnancy rate:
Definition: Pregnancy rate (per 1,000) among females ages 15-19 years. Includes NYC residents with NYC pregnancy events
Source: NYC DOHMH Vital Statistics, 2007

Teen pregnancy rate – Racial/ethnic disparity:
Definition: Absolute difference/gap in pregnancy rates (per 1,000) among resident females ages 15-19 years, by race/ethnicity
Source: NYC DOHMH Vital Statistics, 2007

Infant mortality rate:
Definition: Citywide infant mortality rate (per 1,000 live births). Includes all infant death and live birth events in NYC
Source: NYC DOHMH Vital Statistics, 2007

Infant death rate due to injuries and SIDS – Racial/ethnic disparity:
Definition: Absolute difference/gap in infant death rate (per 10,000 live births) due to injuries and Sudden Infant Death Syndrome (SIDS), by race/ethnicity. Includes all infant deaths with underlying cause due to International Classification of Diseases (ICD) 10th revision codes R95, V01-Y87.
Source: NYC DOHMH Vital Statistics compiled by DOHMH Bureau Maternal, Infant and Reproductive Health, 2007

Mothers who exclusively breastfeed for at least 2 months:
Definition: Percent of mothers who exclusively breastfeed for at least 2 months
Source: Pregnancy Risk Assessment Monitoring System (PRAMS), 2007
Methodology: Data are weighted and are based on 1,492 NYC women giving birth in 2007.
Survey Question: How old was your baby the first time you fed him or her anything besides breast milk?

10. Make All Neighborhoods Healthy Places

Housing Quality:
Poor housing quality, by neighborhood
Definition: Absolute difference/gap in percent of neighborhood households with poor housing quality between high- and low- income neighborhoods. A housing deficiency is any one of the following interior conditions, as reported by residents during an in-home interview. 'Poor housing quality' refers to households with 3 or more of the following deficiencies:
1. breakdown in heating equipment
2. additional heating required
3. rodent infestation
4. open cracks/holes in interior walls, ceilings or floors
5. broken plaster/peeling paint
6. toilet breakdowns
7. water leaks from outside the unit
Source: New York City Housing and Vacancy Survey, 2005

Safety of walking and play spaces:
Pedestrian hospitalization rates for children
Definition: Absolute difference/gap in pedestrian injury hospitalization rate per 100,000 for children ages 5-14 between low- and high-income neighborhoods. Rates are age-specific and hospitalizations are based on live discharges.
Source: New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS), 2006 (updated August 2007).
Prepared by NYC DOHMH, Bureau of Epidemiology Services, May 2009.

Presence of rodents:
Properties with signs of rats
Definition: Percent of proactively inspected properties (about 2/3 of the area of the Bronx) with signs of active rats. Rat Indexing involves the rapid inspection of every property in an established area for signs of rats, which include droppings, rub and gnaw marks, active burrows and live rats.
Source: DOHMH Rat Indexing Program, 2008

Acknowledgments:

Thank you to the following individuals who contributed to this report:

Adriana Andaluz, Sonia Angell, Oxiris Barbot, Jane Bedell, Elizabeth Beiger, Susan Blank, Anna Caffarelli, Thomas Cannell, Marie Casalino, Christina Chang, Janice Chisholm, Nancy Clark, Micaela Coady, Gerald Cohen, Geoffrey Cowley, Marnie Davidoff, Richard Delaney, Diana DeMartini, Laura DiGrande, Chris Glazek, Andrew Goodman, Prashil Govind, Daliah Heller, Elizabeth Jones, Deborah Kaplan, Adam Karpati, Daniel Kass, Mat Kendall, Maura Kennelly, Bonnie Kerker, Elizabeth Kilgore, Kevin Kinsella, Cortnie Lowe, Marian Krauskopf, Karen Lee, Dan Lehman, Jessica Leighton, Wenhui Li, Gil Maduro, Rebecca Mandell, Jenna Mandel-Ricci, Deborah Nagin, Cathy Nonas, Jennifer Norton, Amanda Parsons, Preeti Pathela, Sarah Perl, Roger Platt, Andrew Rein, Meighan Rogers, Judy Sackoff, Julie Schillinger, Aviva Schwarz, Ephraim Shapiro, Lynn Silver, Lesley Stalvey, Lise Stevens, Monica Sweeney, Lorna Thorpe, Lily Tom, Lucia Torian, Bonnie Um, Gretchen Van Wye, Stella Yi, Cristina Yunzal-Butler, Regina Zimmerman, Jane Zucker

Take Care New York Staff:
Louise Cohen, Deputy Commissioner
Cynthia Summers, Executive Director
Erica Desai, Policy Director
Hayley Figueroa, Policy Analyst
Zaida Guerrero, Partnership Director
Avital Havusha, Special Assistant
Fay Sliger, Policy Analyst
Maryellen Tria, Director of Special Projects

Suggested Citation: Summers C, Cohen L, Havusha A, Sliger F, Farley T. *Take Care New York 2012: A Policy for a Healthier New York City.* New York City Department of Health and Mental Hygiene, 2009.

NYC Health

TAKE CARE NEW YORK