Gracie Square Hospital

Community Service Plan

(2022–2024)

1. **County(ies)/service area covered in this assessment and plan**

   The service area includes Bronx, Kings, Manhattan, Queens, Richmond, and Westchester Counties.

2. **Participating local health department(s) (LHDs) and contact information**

   The New York City Department of Health and Mental Hygiene
   4209 28th Street
   Long Island City, NY 11101

   Contact: Ana Gallego, MPH | Executive Director of Health Systems Planning and Policy
   Agallego1@health.nyc.gov

3. **Participating hospital/hospital system(s) and contact information**

   Gracie Square Hospital and NewYork-Presbyterian Hospital

   Contact: Andres Nieto | Senior Director, Community and Population Health
   nietoan@nyp.org

4. **Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals**

   Gracie Square Hospital and NewYork-Presbyterian Hospital partnered with the Center for Evaluation and Applied Research at The New York Academy of Medicine to complete the Community Health Needs Assessment and Community Service Plan.

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EXECUTIVE SUMMARY

Gracie Square Hospital is deeply committed to providing the highest-quality care to patients and supporting the health and well-being of the communities it serves. Established in 1958, Gracie Square is a 140-bed hospital situated on the Upper East Side of Manhattan affiliated with the NewYork-Presbyterian system. Gracie Square Hospital is the only freestanding inpatient behavioral health care institution in Manhattan and has developed tailored programs for specific age and cultural groups. In addition to mental health services and treatment, the hospital's care team provides addiction treatment for individuals living with substance use disorders.

Building from the information gained through the 2022–2024 Community Health Needs Assessment (CHNA), the Community Service Plan (CSP) describes a three-year plan for programs and activities to address health issues and improve health in the Gracie Square Hospital service area and priority communities, which are:

- Washington Heights, Manhattan
- Lower East Side and Chinatown, Manhattan

Prevention Agenda Priorities and Disparities

The Gracie Square Hospital CHNA included extensive primary and secondary data collection and analysis, as described in the section below. Considering findings from the CHNA, together with ongoing collaboration with its clinicians, administrative teams, and leadership of partnering community-based organizations (CBOs), the hospital selected the following Prevention Agenda priorities for its focus during the 2022–2024 Community Service Plan period. These priorities reflect community need, with a focus on addressing health disparities and promoting the optimal health and well-being of the communities served.

Selected Priorities

Promote Well-Being and Prevent Mental and Substance Use Disorders

Promote Well-Being

Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan

Mental and Substance Use Disorders Prevention

Goal 2.4 Reduce the prevalence of major depressive disorders

Data Reviewed to Identify and/or Confirm Priorities

Working in collaboration with The New York Academy of Medicine, we reviewed extensive primary and secondary data. These data included:

Primary data

- 42 focus groups with residents across the NewYork-Presbyterian Hospital service area, conducted in English, Spanish, and Mandarin
- 680 community member surveys, in English, Spanish, Russian, Haitian Creole, and simplified Chinese characters
- 25 interviews with key stakeholders including leadership and key staff from CBOs; healthcare providers; and representatives of government agencies, including departments of health

Secondary data

Publicly available data from:

1. Emory University, Rollins School of Public Health, *AIDSVu*
   https://aidsvu.org/
2. Centers for Disease Control and Prevention, National Center for Health Statistics, *PLACES: Local Data for Better Health*
   https://www.cdc.gov/places/index.html
3. Citizens' Committee for Children of New York, *Keeping Track Online: The Status of New York City Children*
   data.cccnewyork.org/
4. Data USA
   https://datausa.io/
5. IMAGE: NYC, Interactive Map of Aging
   http://imagenyc.nyam.org/map/
6. March of Dimes, *Peristats*
   https://www.marchofdimes.org/peristats/data?top=3
7. New York City Department of Health and Mental Hygiene
   a. *COVID-19 Data*
      https://www1.nyc.gov/site/doh/covid/covid-19-data-totals.page
   b. *Environment and Health Data Portal*
      https://a816-dohbesp.nyc.gov/IndicatorPublic/Subtopic.aspx
   c. *EpiQuery: NYC Interactive Health Data System*
      https://a816-health.nyc.gov/hdi/epiquery/
   d. *NYC Community Health Survey*
      https://www1.nyc.gov/site/doh/data/data-sets/community-health-survey.page
   e. *Vital Statistics Data*
      https://www1.nyc.gov/site/doh/data/data-sets/vital-statistics-data.page

8. New York City Open Data,
Housing Maintenance Code Violations
https://data.cityofnewyork.us/Housing-Development/Housing-Maintenance-Code-Violations/wvxf-dwi5

9. New York City Police Department,
Citywide Crime Statistics
https://www1.nyc.gov/site/nypd/stats/crime-statistics/citywide-crime-stats.page

10. New York State Cancer Registry
https://www.health.ny.gov/statistics/cancer/registry/

11. New York State Department of Health

    a. *County Health Indicators by Race/Ethnicity (CHIRE)*
    https://www.health.ny.gov/statistics/community/minority/county/index.htm

    b. *New York State Health Profiles*
    https://profiles.health.ny.gov/hospital/county_or_region/

    c. *Prevention Agenda Dashboard*
    https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

12. Princeton University, *Eviction Lab*
https://evictionlab.org/eviction-tracking/new-york-ny/

13. Robert Wood Johnson Foundation,
County Health Rankings & Roadmaps
http://www.countyhealthrankings.org/

14. Social Science Research Council,
Measure of America: DATA2GO.NYC
http://www.data2go.nyc

15. United States Census Bureau
https://data.census.gov/cedsci/

    a. *American Community Survey (ACS) 2016–2020 Estimates*
    https://www.census.gov/programs-surveys/acs

    b. *Quick Facts*
    https://www.census.gov/quickfacts/fact/table/US/PST045221

16. United States Department of Agriculture,
Food Access Research Atlas
https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/

17. Westchester Community Foundation,
Westchester Index
https://westchesterindex.org/

18. Westchester County Government,
Westchester County COVID-19 Dashboard
https://wcgis.maps.arcgis.com/apps/dashboards/280339d96db14efd9cc304dba0f3a71d

19. Where We Live NYC,
Explore Data: Health
https://wherewelive.cityofnewyork.us/explore-data/access-to-opportunity/health/

As part of the CHNA process, we also reviewed a large body of reports and relevant peer-reviewed literature, as listed in the CHNA bibliography.

Partners, Partner Roles, and Community Engagement

Gracie Square Hospital has ongoing collaborations with community- and faith-based partners, along with the New York City Department of Health and Mental Hygiene (DOHMH). Many of these organizations were involved in the assessment process and will be involved in implementation.

The broader community was engaged in the CHNA through:

- 42 focus groups with residents across the Gracie Square Hospital service area, conducted in a combination of English, Spanish, and Mandarin.
- 680 community member surveys, in English, Spanish, Russian, Haitian Creole, and simplified Chinese characters.

Through both activities, community member feedback regarding health needs and approaches to improve community health were solicited. In addition, input from community members who are participants in CSP programs was solicited as part of ongoing implementation and program evaluation. Such input ensures that programming addresses specific needs and is culturally and otherwise relevant to the target communities.

Evidence-Based Interventions and Their Selection

As described in the CSP narrative and the workplan, Gracie Square Hospital is implementing and/or collaborating on evidence-based interventions aimed at addressing health priorities and health disparities in the communities served. They are listed below, with cited references to the evidence base:

Promote Well-being and Prevent Mental and Substance Use Disorders

- Mental health first aid[1,2]
- Geriatric telepsychiatry[3,4]

Progress and Improvement Tracking

Gracie Square Hospital is committed to tracking progress and outcomes from the CSP programs and interventions. Findings are used to identify necessary mid-course corrections, to assess impact, and to plan for expansion and replication. A variety of methods are used including record reviews at baseline and follow-up; dashboards, which are reviewed by program managers; project meetings; and written update reports, which provide detailed information on activities (e.g., workshops held, number of participants, agencies represented, topics covered). Update reports indicate progress toward targets and describe facilitators and impediments faced during the reporting periods.

COMMUNITY HEALTH NEEDS ASSESSMENT

The Gracie Square Hospital CHNA was conducted in collaboration with the Center for Evaluation and Applied Research at The New York Academy of Medicine and NewYork-Presbyterian Hospital consistent with the requirements of the Internal Revenue Service (IRS) and guidance provided by the New York State Department of Health. A summary of the process and findings is provided below. The full CHNA is available on the Gracie Square Hospital website at: https://www.nygsh.org/community-health-needs.html.

The Gracie Square Hospital Community Health Needs Assessment (CHNA) engaged more than 700 community members from across New York City and Westchester County, asking them—in surveys, interviews, and focus groups—to describe the most pressing health issues and needs in their communities, as well as the assets and resources that support health and well-being. Their responses, together with information from a broad range of publicly available data sources (for example, the United States Census), are described throughout this report.

Findings across sources were largely consistent and show that many of the health issues and priorities identified in previous CHNAs remain the same: diabetes, high blood pressure, obesity, challenges related to diet and nutrition, poor mental health, and substance use. Health disparities, including in HIV rates and pregnancy-related outcomes, also remain. However, this CHNA comes on the heels of the global COVID-19 pandemic, which has had profound impacts that go beyond the direct implications of COVID-19 infection, including sustained social and emotional disruptions that continue to affect the daily lives of many people. This reality arose repeatedly in the CHNA process and provides essential context for the findings described here.

Description of the Community Being Served

Gracie Square Hospital serves the diverse population of New York City, Westchester County, and the surrounding area, including the following priority communities:

- Washington Heights, Manhattan
- Lower East Side and Chinatown, Manhattan

Demographics

New York City

According to the 2020 census, the population of New York City is more than 8.8 million, an increase of approximately eight percent from 2010. Brooklyn, New York City's largest borough, grew at the fastest rate (8% increase). The median age in New York City is 37.[5] Approximately 20% of the population is under age 18—a slight decline from 2010;[6] 15% are age 65 or older. Approximately 83% of New York City residents age 25 or older graduated from high school, and 39% graduated from college.[7] Ninety-three percent of New York City residents have health insurance; 44% are covered by employee plans, 29% are covered by Medicaid, and 9% are covered by Medicare.[5]

The population of New York City is racially and ethnically diverse: Approximately 30% of the residents are White, 20% Black, 28% Latino/a, and 16% Asian. Compared to 2010, there has been a decrease (-5%) in the Black population and a sizable increase in the Asian population (+34%). The Latino/a population increased by 7%.[6]

More than one-third of the population of New York City (~3 million people) were born outside the United States (U.S.); approximately 475,000 are undocumented. Just under half (48%) of New York City immigrants are limited English proficient (LEP). Overall, 22% of New York City residents are LEP—regardless of immigration status.[8] All New York City boroughs have large immigrant populations; Queens has proportionately the largest immigrant population: close to 50%.[5] The largest number of immigrants in New York City came from the Dominican Republic (13%) and China (12%), with smaller—but still sizable—populations from Jamaica, Mexico, Guyana, Ecuador, Bangladesh, Haiti, India, and Trinidad and Tobago.[9]

New York City's median household income in 2020 was approximately $67,000.[7] Disparities in income in the City are striking: The median household income in Greenwich Village in 2019, for example, was approximately $162,000, compared to $24,000 in the East Tremont section of the Bronx.[10] Approximately 17% of New York City residents have incomes below the poverty line.[7]

Westchester County

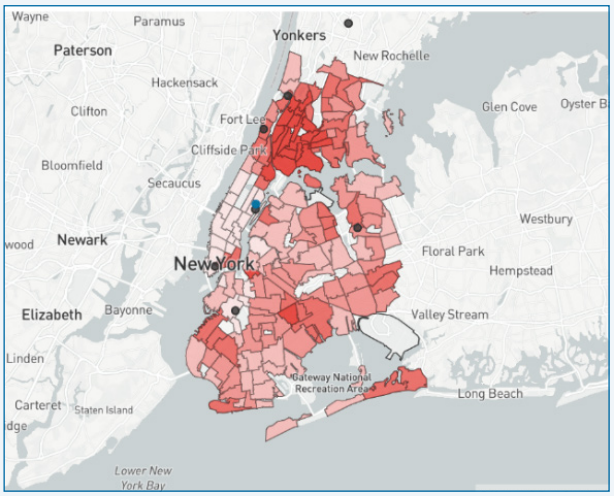
The population of Westchester County is just under 1 million, an increase of approximately 50,000 or 5% from 2010. Approximately 21% of the population is under age 18, and 18% of the population is over age 65.[11] The median age is 41.[12] Close to 90% of Westchester County residents graduated from high school, and 50% have a college degree.[11] Ninety-five percent of Westchester County residents have health insurance; 56% are covered by employee plans, 14% are covered by Medicaid, and 13% are covered by Medicare.[12] Just over half the population (53%) are White, 25% are Latino/a, 13% are Black, and 6% are Asian/Pacific Islander.[11] Approximately one-quarter of Westchester County residents were born outside the U.S.—a higher proportion than in New York State but lower than in New York City.[12]

In 2020, the median household income of Westchester County residents was just under $100,000. However, significant disparities exist. For example, the median household income in Scarsdale was more than $250,000, compared to $66,000 in Peekskill and $59,000 in Mount Vernon. Approximately 13% of Peekskill and Mount Vernon residents live below the poverty line, compared to 8% in Westchester County overall and 1% in Scarsdale.[11]

Health Status

The health status of New York City and Westchester County residents varies based on race and ethnicity[13,14] and the neighborhood in which the individuals reside.[15–17] Residents of neighborhoods with lower incomes and higher concentrations of Black and Latino/a residents have poorer health and higher rates of premature mortality, compared to higher-income neighborhoods and neighborhoods comprised of predominantly White residents.[17,18]

Fair or poor health in Gracie Square Hospital service area, New York City



Percent of adults that rate their health as fair or poor

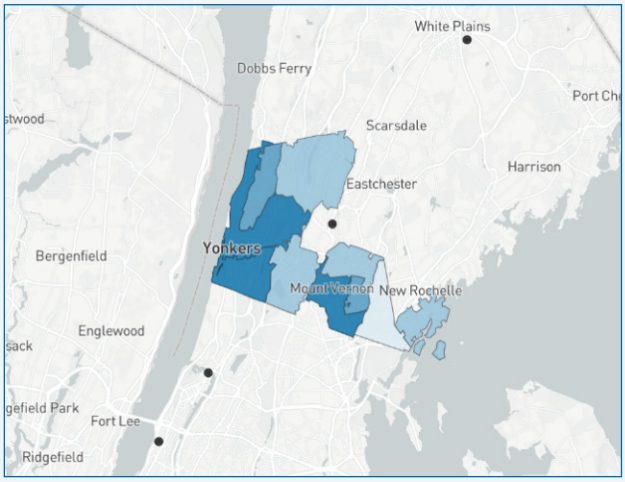
- 8%–14%
- 14%–20%
- 20%–25%
- 25%–31%
- 31%–38%

- Gracie Square Hospital location
- NewYork-Presbyterian Hospital locations*
- Neighborhood tabulation area

*In addition to the hospital sites, NewYork-Presbyterian has over 200 locations in New York City, Westchester County, and the surrounding area. These include primary and specialty care clinics, medical groups, and telemedicine services.

Source: CDC PLACES. 2021 data release. Data are for 2019. Available at: http://www.cdc.gov/places/index.html.

Fair or poor health in Westchester County



Percent of adults that rate their health as fair or poor

- 12%–16%
- 16%–21%
- 21%–24%
- 24%–26%

- NewYork-Presbyterian Hospital locations*
- ZIP codes

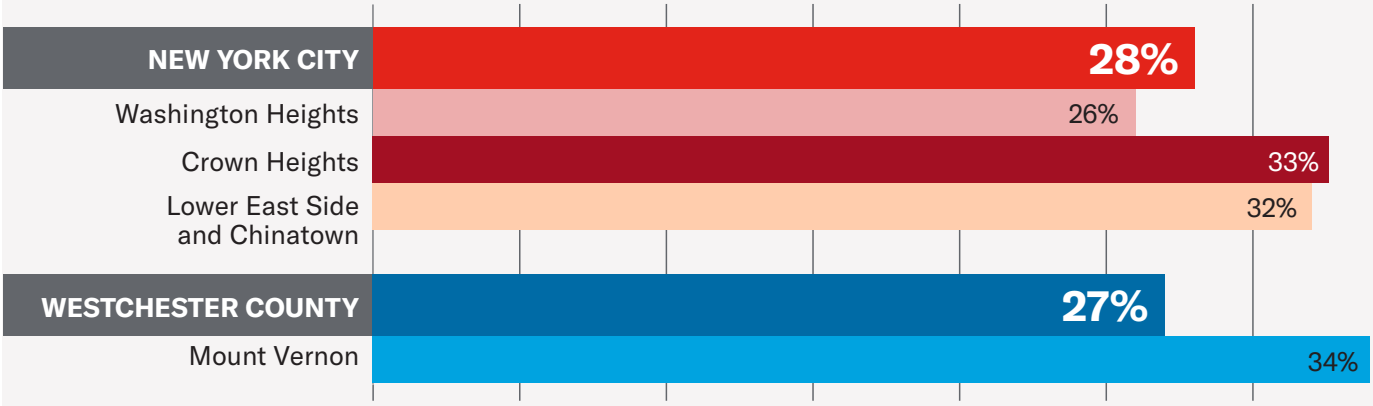
*In addition to the hospital sites, NewYork-Presbyterian has over 200 locations in New York City, Westchester County, and the surrounding area. These include primary and specialty care clinics, medical groups, and telemedicine services.

Source: CDC PLACES. 2021 data release. Data are for 2019. Available at: http://www.cdc.gov/places/index.html.

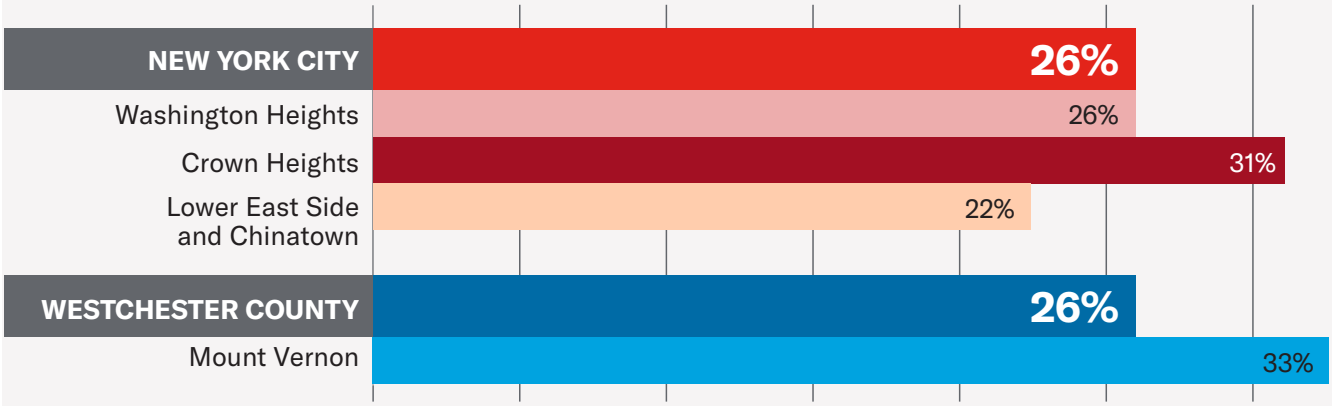
Across the regions served by Gracie Square Hospital, the most prevalent health conditions include high blood pressure (28% in New York City, 27% in Westchester County), obesity (26% in both New York City and Westchester County), and depression (16% in New York City and 15% in Westchester County).[19]

PREVALENT HEALTH CONDITIONS BY PRIORITY NEIGHBORHOOD

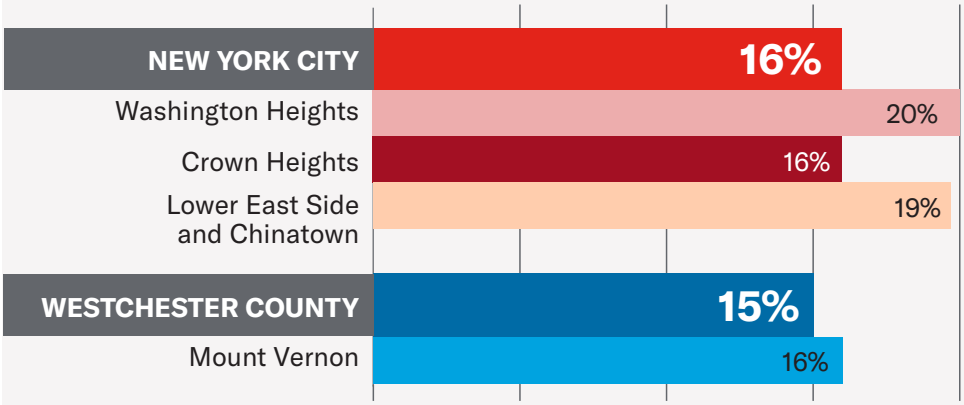
HYPERTENSION (HIGH BLOOD PRESSURE)



OBESITY



DEPRESSION



Source: CDC PLACES. 2021 Data Release. Available at: www.cdc.gov/places/index.html.

GRACIE SQUARE HOSPITAL

Health Challenges

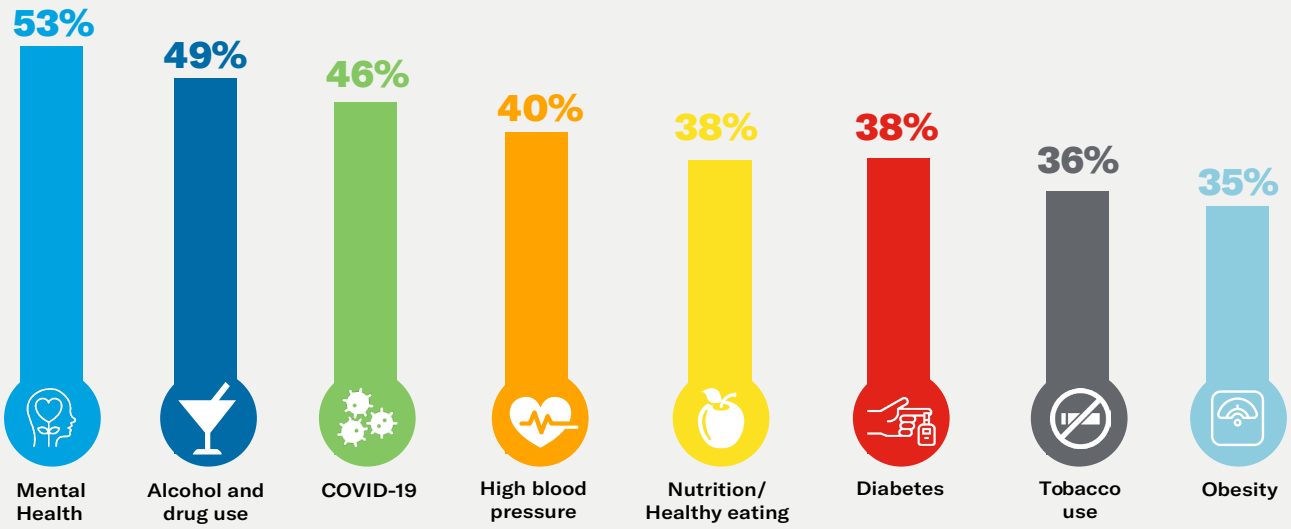
"I would say not having resources for food or not having money, unemployment, those affect our health. I would say...nutrition and mental health, I would say those two factors are huge stress, things that cause a lot of stress in your life. Stress affects your physical health, as well."

—Community focus group participant

Health conditions and behaviors of greatest concern

The conditions of greatest concern to individuals who completed the CHNA survey are shown in the figure below.

Greatest community health concerns[a]



Source: 2022 Gracie Square Hospital CHNA Survey.
[a] Multiple responses permitted

Below, the concerns noted in the surveys are grouped into four categories and elaborated upon: (1) mental health and substance use (including tobacco); (2) COVID-19; (3) food security, healthy eating, and obesity; and (4) high blood pressure, diabetes, and other chronic diseases. In addition, information is provided regarding HIV, as well as pregnancy and birth outcomes, due to persistent disparities in outcomes.

Mental Health and Substance Use

A growing mental health crisis is well documented in the literature,[20,21] and issues related to mental health and substance use consistently rose to the top in focus groups and interviews. Participants described mental health needs that had always existed and needs that had been exacerbated by the COVID-19 pandemic.

Participants also described significant and increasing gaps in mental health services, as well as some hesitancy to access the services that do exist. Increased use of alcohol, tobacco, and other drugs was partially attributed to untreated mental health issues. In addition, observing active drug use created a perception of an unsafe environment, which further exacerbated feelings of anxiety and depression.

> *"You might have a job, but it's not paying you enough. So, to dog the pain off all of that, you turn to drugs. Or you don't have a job. You're trying to get a job, but you're not getting it. So, let me dull the pain. I am lonely, so let me dull the pain. Let me drink or let me smoke."*
>
> *—Community focus group participant*

COVID-19

New York City was an epicenter of the early and deadly COVID-19 surge that began in March 2020, prior to the development of vaccines or medications. By March 2022, there were 2.3 million confirmed COVID-19 cases in New York City, with 159,000 hospitalizations and 40,000 deaths.[22] In all focus group discussions and key stakeholder interviews, the health and societal impacts of the COVID-19 pandemic were highlighted, including illness and death, as well as trauma, anxiety, depression, and severe financial challenges—with continuing implications for health and well-being. The impacts were most pronounced for populations already facing health disparities.

> *"I just also want to underscore that poor communities, and communities that have been excluded from many things, suffer from everything worse than anybody else, and we saw that in the horrendous [COVID] numbers that came out—of people who were hospitalized and died, et cetera."*
>
> *—Community focus group participant*

Food Security, Healthy Eating, and Obesity

Many New York City and Westchester County residents faced job loss or reduced income as a result of the COVID-19 pandemic. Those most likely to be negatively impacted were those with the fewest economic resources to begin with.[23] The consequence of financial constraints most commonly discussed was food insecurity. Use of food pantries and other food-relief services increased dramatically during the COVID-19 pandemic, and many people participating in the CHNA reported that need is still high, despite improvements in the job market. Participants connected the high cost of food—and, in particular, the high cost of fruits and vegetables—to unhealthy food habits and obesity. Poor food environments, including limited access to healthy food and an abundance of unhealthy options, were also cited as an underlying reason for obesity and ill health.

High Blood Pressure, Diabetes, and Other Chronic Diseases

Approximately 45% of the U.S. population[24] and 85% of older adults have at least one chronic condition; approximately 60% of older adults have two or more chronic conditions.[25] Survey and focus group participants emphasized the importance of addressing chronic disease, recognizing the high rates and the implications for those affected. They understood the links between dietary behavior, physical activity, environmental conditions, and chronic disease, as well as the challenges of maintaining good health with limited income and/or living in low-resource environments.

"[Diabetes]—it's a killer definitely for this population. Going back to the lack of good food and the lack of accessible healthcare and all that contributes to all of that. That's a huge killer in our neighborhood."

—Key stakeholder interviewee

HIV

In 2014, the New York State Department of Health launched the "Ending the Epidemic" (ETE) initiative with an overarching goal of achieving the first-ever decrease in HIV prevalence in New York State by the end of 2020. Although notable progress has been made, including dramatic declines in HIV incidence, prevalence, and improved indicators of disease management,[26–28] the COVID-19 pandemic posed new challenges—including diversion of healthcare resources and reduced use of healthcare services—that prevented achievement of the ETE goals according to the initial timeline.[26]

Throughout New York State, low-income communities and communities of color bear a disproportionate burden of HIV infection,[27] and gay, bisexual, and other men who have sex with men (MSM) continue to be most affected by the disease.[27] Focus group participants and key stakeholder interviewees recognized that HIV is better controlled than in the past and that HIV testing, prevention, and health services are available in their communities, although not everyone is aware of their availability. Greater access to information on medications to prevent infection, as well as services to address the complex social and medical needs of HIV-infected individuals, were emphasized.

Pregnancy and Birth Outcomes

Over 100,000 babies are born in New York City and Westchester County each year.[29] Rates of adverse birth outcomes vary substantially by race, with Black communities consistently experiencing the largest inequities. In New York City, the infant mortality rate is over three times higher for babies born to Black parents than to White parents (7.4 infant deaths vs. 2.3 infant deaths per 1,000 live births).

In Westchester County, the infant mortality rate is nearly twice as high for babies born to Black parents as for babies born to White parents (5.0 vs. 2.4 per 1,000 live births).[30] Focus group participants described substantial inequities in healthcare access and quality related to pregnancy and birth. A hesitancy to seek care among some pregnant patients was attributed to fear and distrust resulting from negative interactions with the healthcare system. While some focus group participants were aware of pregnancy-related supports and programs, many described a need for more information and resources geared toward pregnancy and childbirth.

"Just ensuring that information that might be really pressing to the current moment is being shared [would be helpful]. Especially as it concerns access to nutrition or materials that would help you to have a healthy baby."

—Community focus group participant

Assets and Resources

A variety of resources are available in New York City and Westchester County to promote good health and to assist individuals and families facing challenges that affect their health and well-being. These include community- and faith-based organizations (CBOs and FBOs), government programs and services, school-based resources, and informal networks and support systems. New York City and Westchester County are also home to parks, cultural institutions, and commercial establishments that are highly valued by residents.

Community-Based Organizations

CBOs and FBOs often serve as trusted sources of support, information, and camaraderie. Their services are often relatively easy to access, because they are neighborhood-based and commonly offered free of charge. Many employ staff that speak the same language and have a similar background or ethnicity to the people served. They generally offer or refer to an array of services that address the social determinants of health, helping people address their needs in a coordinated fashion.

CBOs sometimes employ community health workers (CHWs) or caseworkers to assist clients or members to navigate and access governmental programs, including SNAP and public insurance, to provide health education and support disease management,[31] and to serve as liaisons to healthcare systems. CHWs, who typically share characteristics with the community they work in (e.g., language, ethnicity, neighborhood of residence), can serve as more accessible sources of information to community members less comfortable in or underserved by larger institutions,[31,32] facilitating improved health outcomes.[33]

Many CBOs that engaged in the CHNA process represent important assets for the community. These include but are not limited to:

- ARC A. Philip Randolph Senior Center, part of a network of senior centers in Manhattan, aims to support older adults and help them to remain in their homes and communities. The center provides support in areas that include housing, food security, finances, health, and transportation.
- Brooklyn Community Pride Center provides services and support to the borough's LGBTQ+ community through original programming and partnerships with other organizations.
- CAMBA is a nonprofit agency that provides over 160 programs focused on economic stability, educational fulfillment, strong families, and a healthy life.
- Caribbean Women's Health Association (CWHA) provides comprehensive, culturally appropriate health, immigration, and social support services to a diverse constituency. The organization focuses on women's health, HIV/AIDS, immigration, SNAP, Medicaid/health insurance enrollment, and domestic violence.
- Community Healthcare Network (CHN) is a not-for-profit organization providing more than 80,000 New Yorkers with primary and behavioral healthcare, dental, nutrition, wellness, and other needed support services. The CHN network is made up of 14 federally qualified health centers located in Brooklyn, the Bronx, Queens, and Manhattan, along with mobile vans that bring health services to underserved communities throughout New York City.
- The Community League of the Heights (CLOTH) is a multi-service community development organization that works to address poverty and disinvestment in Washington Heights. Its work includes advocacy, organizing, and services related to housing, education, health, and neighborhood improvement.
- Feeding Westchester, in collaboration with 225 community partners and meal programs, accesses and distributes food and other resources to communities across Westchester County, helping to reduce hunger.
- Hamilton-Madison House is a voluntary, nonprofit settlement house dedicated to improving the quality of life of its community, primarily those in the Two Bridges/Chinatown area of Manhattan's Lower East Side.
- Harlem Pride was established in 2010 to "empower Harlem's Same Gender Loving (SGL)/LGBTQ+ community to improve its physical, mental, and economic health and wellness." Harlem Pride focuses on providing services as well as increasing the visibility of and advocating for the Harlem SGL/LGBTQ+ community.
- Make the Road New York (MRNY) supports immigrant and working-class communities through legal and survival services focused on discrimination, abuse, and poverty; education to develop community members' abilities to lead; community organizing; and policy innovation. MRNY primarily serves a Spanish-speaking population in Brooklyn, Queens, Staten Island, Long Island, and Westchester County.
- Mount Vernon Neighborhood Health Center (MVNHC) is a federally qualified health center with a mobile health unit and eight locations, including two Mount Vernon schools and two area homeless shelters. MVNHC provides services to over 105,000 patients in and around Westchester County.
- Sun River Health, with more than 40 health centers in New York City, the Hudson Valley, and Long Island, provides comprehensive healthcare, regardless of insurance status and ability to pay. Services include primary care, dental care, behavioral/mental health, women's health/ob-gyn, pediatrics, podiatry, substance use treatment, HIV prevention and care, urgent care, and nutritional services.

- Union Settlement serves 10,000 individuals each year at over a dozen East Harlem locations. Focus areas include early childhood education, youth programs, college and work readiness, adult education, senior programs, mental health counseling, and small business development.

Gracie Square Hospital also offers resources and collaborates with CBOs to ensure New York City residents are aware of and can access the hospital's behavioral health services:

- The Gracie Square Hospital Asian Psychiatry Program offers multilingual education and prevention programs through the NewYork-Presbyterian hospital system, as well as with partnered community organizations. Services include clearer access points for mental health services for Asian residents; information-sharing regarding mental health stigma and available behavioral health services; and stress management and development of coping skills.
- Gracie Square Hospital partners with a community liaison/emergency medical technician from New York City's Orthodox Jewish community and a Resource Specialist from the You Care L'Kasher Agency. The community liaison has also provided consultation and guidance on developing the Gracie Square Hospital Orthodox Focus Program.
- Gracie Square Hospital leads one of the first naloxone opioid overdose prevention programs in New York State. The hospital team holds Narcan training and distribution events to engage the public and increase awareness of overdose deaths and provide Narcan kits to those who are interested. To date, the hospital has provided 82 Narcan nasal spray rescue kits to community members and Gracie Square Hospital employees who participated in a training. In addition to community events, clinical nurses offer and provide Narcan nasal spray kits and patient education to appropriate patients at discharge. From January 2022 to October 2022, Gracie Square Hospital provided 540 kits to patients on discharge.
- In addition to the above, Gracie Square Hospital partners with the following organizations on education, outreach, and engagement related to behavioral health: Pathway Home, Hamilton-Madison House, The Bridge, Charles B. Wang Community Health Center, and the Realization Center.

NewYork-Presbyterian Hospital also offers numerous resources to support community health and well-being. These programs are led from various departments in the hospital, including:

- The Dalio Center for Health Justice works to address racism and discrimination and to advance health justice. The Center focuses on improving race and ethnicity documentation in healthcare, funding community and clinical programs, vaccine equity, and other activities that improve health outcomes for all.
- The NewYork-Presbyterian Government & Community Relations Team convenes community advisory boards at each of the hospital campuses; assists local communities through grant funding and other support; and works with local, state, and federal officials to support the health and safety of patients and communities.
- The Division of Community and Population Health connects community residents with medical and behavioral healthcare. Through a wide range of community health programs for children, adolescents, and adults, the division helps bring NewYork-Presbyterian Hospital's expertise and programs to schools, FBOs, and CBOs.

Healthcare and Hospitals

There are 62 hospitals in New York City and 16 hospitals in Westchester County,[34] as well as hospital-affiliated and private practices, federally qualified health centers, independent multispecialty practices, and urgent care centers. New York City is home to a significant number of safety-net providers including New York City Health + Hospitals, the largest public healthcare system in the U.S.

Hospitals in the area provide a range of clinical services that include primary and specialty care as well as emergency and urgent care services. New York City and Westchester County hospitals, including those in the NewYork-Presbyterian system, also offer a range of community health services that include but are not limited to chronic-disease and other health-related education, food access programs, tobacco use cessation, mental health promotion, and parenting support.[35] New York hospitals also partner with local CBOs to increase access to services and more broadly improve health within the communities they serve.[36]

Public Benefit Programs

Government-funded public benefit programs such as SNAP, WIC, and Medicaid provide eligible residents with essential support related to food, healthcare, and economic security. In addition to agency-specific offices, enrollment support for these programs is often embedded into community settings such as hospitals, libraries, health centers, and CBOs. Eligibility for these programs is based on income, household composition, and immigration status, meaning that many low-income New Yorkers born outside the U.S. are not eligible. In addition, stigma, the enrollment process, and benefit levels may all serve as barriers to access for some people.

Government Agency Services

To serve the needs of more than 8 million residents, the New York City government provides many resources to residents and has innovated to improve the breadth and accessibility of support available. Examples of health-promoting programs and services include:

- Free tobacco use and vaping cessation services (in-person and via phone-based apps) to assist those looking to quit or reduce smoking.
- Behavioral health supports including NYC Well, which offers a 24-hour hotline, mobile crisis teams, and training of mental health first-aid responders to be embedded in primary care and community settings.
- A vast shelter system, a multi-year citywide initiative to provide outreach and connect individuals who are living on the street with services, and many agencies that help place people into temporary and permanent housing.
- The deployment of hundreds of VITA volunteers who help residents file their taxes, including Earned Income and Child Tax Credit forms.
- NYC Care, which provides access to low- or no-cost healthcare for New Yorkers, including primary, preventative, and mental healthcare, and prescription medications, regardless of immigration status or ability to pay.

Many New York City initiatives are explicitly geared toward children and young people, although their impact may be broader. These include:

- Free breakfast and lunch for all students free of charge, which not only reduces food insecurity for families, but also improves behavioral and educational outcomes.
- Universal pre-kindergarten for 4-year-olds (and in the future, for 3-year-olds), which is associated with positive long-term educational outcomes and reduces childcare costs for parents, freeing up funds for other necessities.
- The Summer Youth Employment Program (SYEP) offers young people ages 14 to 24 career-exploration opportunities and paid work experience that foster workplace, social, and civic skill development. SYEP provides opportunities to young people who commonly face barriers to employment, including—but not limited to—homeless or runaway youth, justice-involved youth, youth in foster care, and youth in select public housing developments.

Westchester County—and its cities, towns, and villages—provides an array of services and supports to residents, which may include free or low-cost after-school and summer programs for youth; recreational programs for children, older adults, and the general community; community fairs and other public events; job opportunities for teens; and linkages to community-based, County, and State services. There are 20 post-secondary schools with campuses in Westchester County, including SUNY Purchase College and Sarah Lawrence College. SUNY Westchester Community College (WCC) offers more than 50 associate and certificate degrees. The Continuing Education Division of WCC is the largest unit in the state university system. It offers courses for people considering career choices or changes; customized training for businesses; programming for older adults; and an arts and culture series open to the public.

Neighbors Helping Neighbors

New York City and Westchester County residents—whether they are family members, neighbors, members of the same faith institution, or compatriots—have always assisted and supported one another. During the peak of the COVID-19 pandemic, the willingness of New Yorkers to help and promote one another was apparent—as were the many creative ways that help was provided. For example, essential workers were celebrated each evening from windows and balconies in New York City; informal mutual aid efforts expanded; and refrigerators were placed on City streets, providing a means for free food distribution.

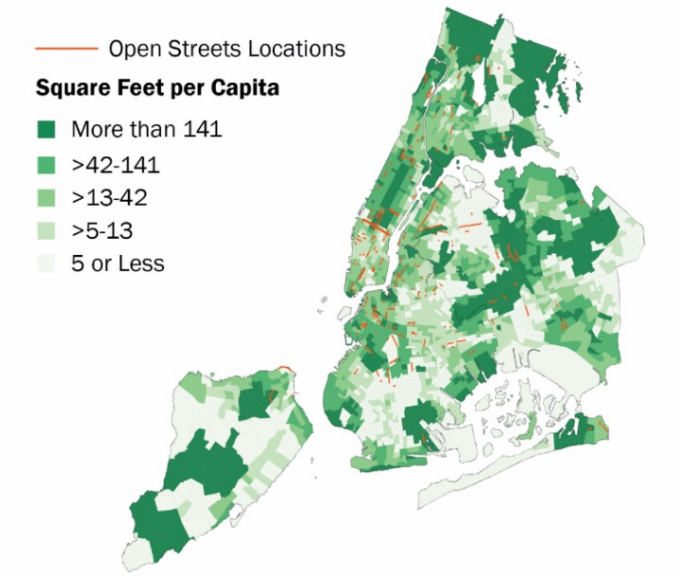
Parks and Green Space

Proximity to green space and dedicated spaces for safe walking, biking, and running promotes physical activity, mental and physical health, and social connectedness.[37–41] Across New York City and Westchester County, access to parks varies by neighborhood. In New York City, nearby park space per resident ranges from as little as two square feet to more than 140 square feet.[42]

The COVID-19 pandemic highlighted the importance of access to green, open, and outdoor space in urban communities, offering a refuge from the mental stress of confinement at home, as well as a relatively safe alternative for socializing and exercising. To increase access during the pandemic, New York City created Open Streets, which blocked off roadways and offered residents in all five boroughs traffic-free outdoor space. In 2020, 83 miles of roads were designated Open Streets by New York City, many of which were in neighborhoods with insufficient park access, such as Brownsville, Brooklyn, and Jackson Heights, Queens.[42]

In Westchester County, there are more than 18,000 acres of parkland, which include pools, beaches, trailways, nature centers, an amusement park, a working farm, historic sites, and an arboretum. In the decades since remediation began on the Hudson River, there has been notable improvement in water quality[43] and conversion of riverfront land for community and recreational use.

Some Areas of New York City Have More Access to Nearby Park Space and Open Streets Than Others



NOTE: Ranges are quintiles of city park space per capita.

COMMUNITY HEALTH IMPROVEMENT PLAN/ COMMUNITY SERVICE PLAN

Priorities and Their Identification

The community engagement process used to select and confirm priorities included:

- 42 focus groups with residents across the NewYork-Presbyterian Hospital service area, conducted in English, Spanish, and Mandarin.
- 680 community member surveys, in English, Spanish, Russian, Haitian Creole, and simplified Chinese characters.
- 25 interviews with key stakeholders including leadership and key staff from community-based organizations, healthcare providers, and representatives of government agencies, including departments of health.

Through each of these methods, community members and other key stakeholders were asked about the greatest health issues in their communities, improvements that would most affect community health, and their perceptions of the 2019–2022 NewYork-Presbyterian priorities. Community responses, combined with secondary data review (using the resources described in the Executive Summary) and semi-structured discussions with community-facing clinicians and staff, contributed to the selection of the Prevention Agenda priorities and goals listed in the table below. All of the selected priorities address disparities and promote health equity.

Following the table listing the priorities and goals, research informing the selected priorities is summarized. More extensive research reviews are included in the CHNA.

Promote Well-being and Prevent Mental Health and Substance Use Disorders

Mental Health and Substance Use

A growing mental health crisis is well documented in the literature,[20,21] and issues related to mental health and substance use consistently rose to the top in CHNA focus groups and interviews. Participants described mental health needs that had always existed and needs that had been exacerbated by the COVID-19 pandemic. Widespread loss of life, loss of jobs, stress, social isolation, disrupted services, reduced income, generalized fear, and general uncertainty have all contributed to poor mental health since the start of the pandemic.

Among those participating in the CHNA community survey, mental health and substance use were among the most commonly reported concerns:

- 53% responded that mental health is one of the biggest health concerns in their community.
- 49% responded that alcohol and drug use is one of the biggest health concerns in their community.
- 46% responded that safer or reduced drug and alcohol use would improve health in their community.
- 44% responded that reduced cigarette smoking/vaping would improve the health of their community.

According to a report by the New York Health Foundation, rates of self-reported poor mental health were over 30% in 2020, with higher rates for Black and Latino/a New Yorkers (39% and 42%, respectively), compared with White New Yorkers.[44] The New York City DOHMH Health Opinion Poll reported higher levels of anxiety (25%) and depression (18%) among adults in 2021 than in pre-pandemic years. The same poll found that, compared to White New Yorkers, people of color in New York City were more likely to experience risk factors for poor mental health, including the death of someone close to them or high financial stress.[45]

Selected Priorities

Promote Well-Being and Prevent Mental and Substance Use Disorders

Promote Well-Being

Goal 1.1 Strengthen opportunities to build well-being and resilience across the lifespan

Mental and Substance Use Disorders Prevention

Goal 2.4 Reduce the prevalence of major depressive disorders

Participants in the CHNA also described significant and increasing gaps in mental health services, as well as some hesitancy to access the services that do exist. Increased use of alcohol, tobacco, and other drugs was partially attributed to untreated mental health issues. Participants reported that seeing active drug use creates a perception of an unsafe environment, which further exacerbated feelings of anxiety and depression.

The stresses associated with poverty, including food insecurity and housing disadvantage (e.g., housing insecurity, crowding, poor housing maintenance), also have a significant impact on mental health.[46–48] Poor mental health in turn impacts employability and earnings,[49] potentially creating a downward spiral. According to a 2018 analysis from New York City DOHMH, the prevalence of serious psychological distress was over three times greater among adults living in very high-poverty neighborhoods compared with those living in low-poverty neighborhoods.[50]

The prevalence of problematic substance use is difficult to assess; however, certain indicators—including overdose and overdose deaths—have shown disturbing trends. There were more overdose deaths in New York City in 2020 than any of the prior 20 years—a number (2,062) significantly higher than the previous year (1,497). The overdose death rate per 100,000 residents rose from 21.9 to 30.5 per 100,000 New York City residents during the same period. Black New Yorkers had the highest overdose death rate in 2020 (38.2 per 100,000 residents) and the largest rate increase from the previous year (+14.2 per 100,000). Fentanyl, a powerful synthetic opioid often combined with heroin, is responsible for nearly 80% of overdoses in New York City.[51] It is estimated that every four hours a New York City resident dies of an opioid overdose.[52]

Mental Health of Older Adults

In 2019, New York City and Westchester County had similar proportions of older adults, 15% and 18% respectively.[7] One in five older adults in New York City lives in poverty, higher than the general population of the City and the State.[53] In Westchester County, 11% of older adults live in poverty,[53] which is also higher than the poverty rate for the general population of the County.[7] Approximately one in three older adults in New York City lives alone, with the highest proportions among White and Black populations.[54] Living alone can increase the likelihood of social isolation, which has been associated with increased risk of mortality and cognitive decline.

The mental health needs of older adults in New York City are significant. Nine percent of older New Yorkers have depression as measured by a validated screening tool. Older adults in low-income households (16%) are more likely to have depression than are older adults in high-income households (2%). The rate of suicide among older men (11.9 per 100,000 men 65 and older) is higher than among older women (4.2 per 100,000 women 65 and older). The rate of suicide among older men (11.9 per 100,000 men 65 and older) is higher than among older women (4.2 per 100,000 women 65 and older).[54]

Intervention Strategies and Activities

In the table below, we provide a narrative description of the intervention strategies and their evidence base. A detailed workplan for Gracie Square Hospital's evidence-based interventions (using the required template) is submitted along with this report. The workplan includes goals, objectives, process measures, targets, time frames, partners, and specific geographic locations where the interventions will be focused.

A separate document submitted with this report includes all collaborating organizations and agencies that were engaged in the CHNA.

Promote Well-being and Prevent Mental Health and Substance Use Disorders		
Program Name & Priority Neighborhoods	**Description**	**Evidence Base**
Mental Health First Aid **Neighborhoods** ■ Washington Heights ■ Lower East Side and Chinatown	Mental Health First Aid (MHFA) is an international training program that builds skills on how to identify, understand, and respond to signs of mental illnesses and substance use disorders, and provide support to people experiencing problems and crises. Hospital staff, CBOs, and FBOs are offered the training to become certified Mental Health First Aiders; they can then support their communities and peers at an elevated risk for developing mental health challenges. Two trainings are offered: Adult Mental Health First Aid training teaches adults how to support other adults, and the Mental Health First Aid Youth training teaches adults how to support young people experiencing a mental health challenge or crisis.	Childs K, et al. An assessment of the utility of the Youth Mental Health First aid Training: Effectiveness, satisfaction, and universality. *Community Ment Heal Journal*. 2020;56:1581-1591. Available at: https://link.springer.com/article/10.1007/s10597-020-00612-9 Lee, OE, & Tokmic, F. Effectiveness of Mental Health First Aid training for underserved Latinx and Asian American immigrant communities. *Mental Health & Prevention*. 2019;13:68-74. Available at: https://www.sciencedirect.com/science/article/abs/pii/S2212657017301149 Additional studies at: https://www.mentalhealthfirstaid.org/wp-content/uploads/2022/08/22.08.11_MHFA-Research-Summary.pdf
Geriatric Telepsychiatry **Neighborhoods** ■ Washington Heights	In partnership with NewYork-Presbyterian Hospital, Gracie Square Hospital will implement a mental health program licensed by the Office of Mental Health providing treatment in the home, community, and clinic sites in targeted communities and for targeted patients utilizing in-person and tele-mental health modalities. The program will provide targeted substance use, mental health and suicide screening and interventions (e.g., diagnostic evaluations, individual and group psychotherapy, psychiatric medication management).	Gentry MT, et al. Geriatric Telepsychiatry: Systematic Review and Policy Considerations. *Am J Geriatr Psychiatry*. 2019;27(2):109-127. Doraiswamy S, et al. Telehealth use in geriatrics care during the covid-19 pandemic—A scoping review and evidence synthesis. *Int J Environ Res Public Health*. 2021;18(4).

Maintaining Engagement, Tracking Progress, and Mid-Course Corrections

Engagement of Local Partners

Gracie Square Hospital has developed and maintained strong collaborations with community-based organizations. The hospital recognizes that CBOs and other partners have expertise, strong ties to local residents, and important contributions to make toward promoting community health. To that end, Gracie Square Hospital holds regular meetings and check-ins with each community partner. These meetings involve opportunities for feedback and problem-solving, progress updates, discussion of barriers to effective implementation, and review of collected data, among other topics.

Data Collection and Review

Gracie Square Hospital is committed to tracking progress and outcomes from the CSP programs and interventions, to identify need for mid-course corrections to assess impact, and to plan for expansion and replications. A variety of methods are used, including participant surveys; social needs screening tools; record reviews at baseline and follow-up; dashboards, which are reviewed by program managers; site visits; project meetings; and written update reports, which provide detailed information on activities (e.g., workshops held, number of participants, agencies represented, topics covered). Update reports also indicate progress toward targets and describe facilitators and impediments faced during the reporting periods.

Data gathered are reviewed and discussed during project meetings. Any needed mid-program course corrections are identified and discussed during these meetings and the team identifies follow-up steps, including timelines and responsible parties.

Dissemination of Executive Summary and Community Service Plan

The Gracie Square Hospital Community Service Plan and Community Health Needs Assessment will be accessible to the public on the hospital's web site at https://www.nygsh.org/community-health-needs.html. In addition, the hospital will present the CHNA and CSP at advisory board meetings and at other meetings with community partners. Notice of availability of the CSP and CHNA will be included in hospital newsletters.

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