



## **A City-wide Child/Teen/Family Health Policy Agenda Developed by Communities for Communities**

**Bronx Child Health Coalition  
Brooklyn Child Health Coalition  
Manhattan Child Health Coalition & LES & Chinatown Subcommittee  
Queens Coalition for Healthy Families  
Staten Island Family Health Coalition  
Commission on the Public's Health System**

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**YES**

**NEW YORK**

**CAN!**

**A Child/Teen/Family Health**

**Policy Agenda**

**For New York City**

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## Acknowledgements

The Child Health Initiative is coordinated by the Commission on the Public's Health System, with overall responsibility for this project. Five borough coalitions are headed by experienced, well-rooted community-based organizations: The Bronx Health Link (Bronx); Brooklyn Perinatal Network (Brooklyn); Northern Manhattan Improvement Corporation (Manhattan) with IndoChina Sino Community Corporation leading a Lower East Side/Chinatown subcommittee; Make the Road New York (Queens); and El Centro del Inmigrantes (Staten Island).

The Policy Committee is involved in supporting the city-wide and borough coalition efforts. In addition to CPHS and the borough coalition leaders, the members of the Policy Committee are: ACS Head Start; Children's Defense Fund – New York; Citizens' Committee for Children of New York; Coalition for Asian American Children & Families; Doctors Council; New York Academy of Medicine; New York Chapter 3, American Academy of Pediatrics; New York City Health & Hospitals Corporation; New York Immigration Coalition; and Parent to Parent in New York State.

Judy Wessler of CPHS coordinated the writing of this document. Anthony Feliciano of CPHS designed the cover.

Each of the borough coalition leaders organized a Child Health Coalition in their borough. The **Borough Coalition Members are:**

**The Bronx: The Bronx Health Link;** 7<sup>th</sup> Avenue Head Start; American Academy of Pediatrics, NYS Chapter 3; Bronx Community Health Network; Coalition of Asian Americans Against Violence; Church Alive; Claremont Neighborhood Center; NYCHHC Daniel Webster Houses and Melrose Houses Child Health Clinics; For a Better Bronx; Freedom Community Center; NYCHHC Morrisania D&TC; We Stay/Nos Quedamos; WHEDCO.

**Brooklyn: Brooklyn Perinatal Network;** ACS, Office of Children & Family Health Services, Arab American Family Support Center, Caribbean Women's Health Association, Catholic Charities, Children's Defense Fund, Christopher Rose Community Empowerment Campaign (CRCEC), Christ the Rock International, Child Development Support Corp. (CDSC), Child Welfare Organizing Project, Community Action Project, Coney Island Hospital, Diaspora Community Services, East New York Diagnostic & Treatment Center, Family and Community Support Services, Fort Greene SNAP, FUREE, Great Southern Brooklyn Health Coalition, HRA/Office of Health Insurance Access, KCH Fifth Avenue Women's & Children Health Center; Lutheran Family Health Center Network – School Health Program; Medgar Evers College – Center for Law and Social Justice Program; New Dimensions in Care; NYCHHC Homecrest Child Health Center; North Brooklyn Network, Woodhull and Cumberland D&TC; Brooklyn Public Library at Grand Army Plaza.

**Manhattan: Northern Manhattan Improvement Corporation;** 129th Street Prayer Alliance; P.S. 368; Department of Health, Early Intervention Program; RACCOON; ASPIRA; New York City Housing Authority; HRA, Office of Health Insurance Access; Children's Aid Society, Manhattan/Staten Island Area Health Education Corporation (AHEC), Washington Health Child Health Clinic; Esperanza del Barrio; AAFE (Asian Americans for Equality); city Division for Youth and Community Development; Harlem Hospital; Metropolitan Hospital; SCAN El Faro Beacon School; St. Nicholas Child Health Clinic; Wilson Productions; NYU Dental;

**Lower East Side/Chinatown: IndoChina Sino America Community Center;** Asian Americans for Equality; Asian Pacific Islander Coalition on HIV/AIDS; Baruch Child Health Center; Chinatown Manpower Project; Chinese Progressive Association; Doctors Council; Coalition for Asian American Children and Families; Gouverneur Healthcare Services; Lower East Side Girls Club; MFY Legal Services; NYCDOH Early Intervention Program; and Vayl Training & Wellness Center.

**Queens: Make the Road New York;** RACCOON; NICE, Asian Americans for Equality; Queens Health Coalition; NAACP Queens Branch; PRAGATI; Ecuadorian International Center; Pan American International High School; LUCES Health Promoters Group; Filipino American Human Services, Inc.; Queens Library; Parents in Action Committee; NYC Health and Hospitals Corporation, Junction Child Health Clinic, Parsons Community Care Clinic; and Woodside Child Health Clinic.

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**Special Contributions** to *YES NEW YORK CAN!* were made by the following organizations:

- Citizens' Committee for Children in New York – for allowing us to use the data in their *Keeping Track of New York City Children* report.

- The Opportunity Agenda for using the Citizens' Committee for Children data to prepare maps for us, and for working with CPHS to prepare a video about this Initiative.
- Jeff Thrope and Karyn Bell, Manatt, Phelps & Phillips, LLP, law firm, along with Prof. Paula Galowitz and Lars Johnson and Sara Zier of NYU Law School, for providing legal research on the state and city School Health Program requirements.

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## **Table of Contents**

|   |       |
|---|-------|
| Acknowledgements  | 2-4   |
| Executive Summary   | 6-8   |
| Vision Statement – Policy Agenda                                  | 9-11  |
| Health Status of Children – including maps                        | 12-23 |
| Summary <i>Voices from the Community</i>                          | 24-26 |
| Policy Initiatives – School Health                                | 27-32 |
| Policy Initiatives – Bronx Child Health Coalition                 | 33-41 |
| Policy Initiatives – Brooklyn Child Health Coalition              | 42-44 |
| Policy Initiatives – Manhattan Child Health Coalition             | 45-47 |
| Policy Initiatives – Queens Coalition for Healthy Families        | 48-50 |
| Policy Initiatives – Staten Island Coalition for Healthy Families | 51-58 |

## **Executive Summary**

Change is in the air, in our hopes, in our dreams, and in our actions. *Yes New York Can!* is part of that change in the air. It is a community-led, community-driven organizing and planning effort that identifies and promotes a new paradigm for making New York a city filled with Healthy Children living in Healthy Communities.

*Yes New York Can!*, along with *Voices from the Community*, are two products of a year-long Initiative to celebrate the One Hundredth Anniversary of the city's Child Health Clinics, which represent a distinguished model of community-based, locally accessible primary care services for children. One hundred years ago was an extraordinary era for public health in the city. It was a time when free clean milk was distributed, children first received immunizations, nurses made visits to homes, and children's health and development were assessed and recorded. These activities were guided by a clear and consistent vision for children, based on the recognition of their developmental needs.

In recent years that vision has dimmed and faded; today we cannot find a vision for children's health in New York City. Yet as we look ahead to the next 100 years, we believe that such a vision is sorely needed. This 100<sup>th</sup> Anniversary provides the occasion for us to propose a new vision for the city's children. This vision has informed the development of a Health Policy Agenda for children and teenagers that is presented here, an Agenda that will be unique because its content will reflect the priorities of the community itself, expressed through borough child health coalitions led by community organizations.

For the past year, the Child Health Initiative has brought together community organizations in all five boroughs to work with CPHS and a Policy Committee in a pioneering project focused on the health needs of New York City's children and teenagers.

The Child Health Initiative recognizes that the current reality for children is:

- There are racial and ethnic disparities in access to health care services and in outcomes of health care.
- There are also geographic problems in the distribution of health care services and access to those services. These disparities can be seen, measured, and documented in services such as access to prenatal care and in outcomes of birth.
- There are wide variations in infant survival and in birth weight, depending on community of residence, race, and ethnicity.
- There are huge variations in the rate of children's hospitalizations for conditions that could be prevented or treated in the community, such as asthma, acute respiratory infections, and pneumonia.
- Some diseases, such as asthma, are much more prevalent in underserved communities.
- Children in New York City are more likely to use Emergency Room care than older adults – the opposite of what would usually be expected.

To address these and numerous other deficiencies and disparities that stunt the health of our children and young people, representatives of community organizations, professional organizations, child-serving agencies, advocacy groups, unions and others, came together to begin the process of building a Children's Health Policy Agenda.

The Child Health Initiative -- comprised of CPHS, five child health borough coalitions, and a Policy Committee with health and policy experts and children's advocates -- was organized to celebrate the Child Health Clinics, to gather voices from the community, and develop a Policy Agenda. *Yes New York Can!* is the Child/Teen/Family Health Policy Agenda developed by the Child Health Initiative. Over the past year, the Policy Committee helped to design a survey of parents about their children's health status and access to care. Similar questions were also used in focus groups with young people. The surveys and focus groups were administered and organized by the borough coalition leaders.

The two major principles guiding our vision is the need to works toward 1) Healthy Children and Young People and 2) Healthy Communities. Health care must emphasize primary and preventive care to ensure that children and young people are developing appropriately for their age and that potential problems are caught before they become more serious. The focus on children and young people is important because the early years are the time when healthy development, good nutrition, and the other components of health can form the rest of our years. It is also important for parents and children to live in healthy communities with satisfactory housing and a clean environment, the availability of parks and open spaces, access to nutritious food, and schools that educate children and young people. Each of these items is an integral component of a healthy community.

We also believe that it is important to involve the whole community -- community organizations, schools, houses of worship, and families -- in the development of recommendations for improving their communities and neighborhoods. The involvement of organizations and residents is critical in developing how needs can be met, and what is required to ensure a healthy community.

*Yes New York Can!* is our Agenda for the future direction of health care for children, young people and their families in New York. The results of the surveys and focus groups (*Voices from the Community*) helped inform the development of this Agenda. Each of the borough coalitions determined their priorities. They then decided on strategies for meeting those priorities. There is one citywide priority -- to fix the school health program so that it can work more effectively for the many children enrolled in both public and private schools in the city.

*Yes New York Can!* provides the following:

- A Vision Statement for Healthy Communities -- Healthy Children and Young People, which also lays out some of the major issues confronting children;

- Health Status of Children & their Communities – which includes ten maps that portray the major problem in communities;
- A Summary of *Voices from the Community*, the report of the Surveys and Focus Groups;
- A citywide Policy Initiative looking at the School Health Program.
- Policy Initiatives for each of the five boroughs:
  - The Bronx: Asthma; Obesity; and Mental Health – submitted by the Bronx Health Link.
  - Brooklyn: Lack of quality care; Access to care issues; Lack of service coordination – submitted by the Brooklyn Perinatal Network.
  - Manhattan – Nutrition – submitted by the Northern Manhattan Improvement Corporation. Asthma -- submitted by IndoChina Sino Community Center.
  - Queens – Asthma, Obesity/Overweight, and Access to care – submitted by Make the Road by Walking.
  - Staten Island – Access to treatment, Treatment for special needs populations, and Coordination and Access to Care – submitted by El Centro del Inmigrantes.

## **VISION FOR CHILD/TEEN/FAMILY HEALTH POLICY AGENDA** **Healthy Communities – Healthy Children and Young People**

As we celebrate the Hundred Year Anniversary of the Child Health Clinics, we salute them as living reminders of an extraordinary era in public health in New York City. It was a time when free milk was distributed, children first received immunizations, nurses visited their homes, and their health and development were assessed and recorded. These activities were guided by a clear and consistent vision for children, based on the recognition of their special nature and needs.

In recent years that vision has dimmed and faded; today we cannot find a vision for children's health in New York. Yet as we look ahead to the next one hundred years, we believe such a vision is sorely needed. This 100<sup>th</sup> Anniversary provides the occasion for us to propose a new vision for the city's children. This vision will inform the development of a Health Policy Agenda for children and teenagers, an agenda that will be unique because its content will reflect the priorities of the community itself, expressed through borough child health coalitions led by community organizations.

We know that healthy children become healthy adults; when children grow up healthy, the entire society benefits. **A healthy child is one who is developing to his or her full potential while experiencing physical, mental, and social well-being.** To achieve these conditions should be the right of every child, along with the companion right to comprehensive health care in a "medical home" that promotes health and prevents disease; this care should be family-centered, coordinated, compassionate, culturally competent, available and continuous.<sup>1</sup>

Our vision is one of a future when every child in New York will be born healthy and grow up healthy. But we recognize that the current reality for children is:

- There are racial and ethnic disparities in access to health care services and in outcomes of health care.
- There are also geographic problems in the distribution, and access to health care services. These disparities can be seen, measured, and documented in services such as access to prenatal care and in outcomes of birth.
- There are wide variations in infant survival and in birth weight, based on community of residence, race and ethnicity.
- There are huge variations in the rate of hospitalizations of children for conditions that could be prevented or treated in the community, such as asthma, acute respiratory infections, and pneumonia.
- Some diseases, such as asthma, are much more prevalent in underserved communities.
- Children in New York City are more likely to use Emergency Room care than older adults – the opposite of what would usually be expected.

The fulfillment of our vision requires recognition of today's realities for children and young people in New York City. Only with that knowledge can we begin to create a for

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<sup>1</sup> Policy Statement, American Academy of Pediatrics, The Medical Home. *Pediatrics*, 2002; 110:184-186,

children's health that will move us toward the goal of healthy children in healthy communities. Here are a few of the things we know:

- Almost 28% of the city's 2,000,000 children live in poverty;
- 16,790 children are in foster care;
- 12,313 children are homeless
- Over 35,000 children receive Early Intervention Services for developmental disabilities;
- The percent of children born at low birthweight to African-American mothers is almost twice as high as it is to whites;
- Fourteen percent of Latino and 12% of African American high school students are obese compared to 9% of Whites and 6% of Asian students.
- Children are hospitalized for asthma from East Harlem at over ten times the rate they are from Bay Ridge, Brooklyn;
- The number of children without health insurance is five times higher in Washington Heights than it is in Greenwich Village.

To address these and numerous other deficiencies and disparities that stunt the health of our children and young people, representatives of community organizations, professional organizations, child-serving agencies, advocacy groups, unions, and others came together to begin the process of building a children's health Policy Agenda. The concerns, ideas and recommendations of families in the neighborhoods were sought by means of a formal survey, through teen discussion groups, and at a variety of borough coalition meetings. Theirs is the dominant voice in the preparation of the agenda. Its authentic community origin will help guarantee that our vision will be realized.

## **THE CHILDREN'S HEALTH POLICY AGENDA**

### **Principles for the Agenda**

This Agenda is built upon the principles of equity, justice and civil rights for all children, young people, and their families. With these as a foundation we will achieve Healthy Children and Young People living in Healthy Communities.

### **Healthy Children and Young People:**

Health care must emphasize primary and preventive care to ensure that children and young people are developing appropriately for their age and that potential problems are caught before they become more serious. We believe that all children and young people have the right to *grow up healthy*. This includes, for example, children with special needs, both physical and mental/emotional, who should have access to specialized services that meet their needs. Early intervention has been shown to prevent later more serious problems. But we must ensure that early critical services do not end when a child "ages out" of a program.

The focus on children and young people is important because the early years are the time when healthy development, good nutrition, and the other components of health can form the rest of our years. All children and young people must have the right to health

insurance coverage, and access to health care services, regardless of their immigration status. All children and young people need to have a “medical home”, with access to quality, culturally competent and linguistically accessible health care services. Parents and young people have the right to act as their own, or their child’s advocate to ensure access and quality services are delivered -- with assistance available when needed.

**Healthy Communities:**

It is important for parents and their children to live in a healthy community with satisfactory housing and a clean environment, the availability of parks and open spaces, access to nutritious food, and schools that educate children and young people. Each of these items is a component part of a healthy community. Although this agenda will not directly address these issues, we strongly believe that it is important to set up relationships with people working on these issues and support each others initiatives.

We recognize the vast differences in the “healthy factor” among communities. The differences can be seen based on the income levels, race, ethnicity, language spoken, and immigration status of children and their families.

It is important to involve the community -- community organizations, schools, houses of worship, and families -- in the development of recommendations for their communities and neighborhoods. The recommendations of organizations and residents are critical in developing how needs can be met, and what is required to ensure a healthy community.

## **Health Status of Children & Their Communities in New York City**

Children are our most precious resource and the hope for the future. Change cannot come in the city, state, or nation if we do not cherish and nurture our children. Yet, in New York City many children live in vulnerable communities, in vulnerable families. There are large disparities in health status and in resources available in communities. The Child Health Initiative will portray some of the details of the living conditions for children in this city.

There are almost two million children living in New York City. One of every four residents is a young person under the age of 19. Nearly one-half, or one million children live in vulnerable communities. Citizens' Committee for Children of New York (CCC) keeps track of the living conditions of children and documents these conditions.<sup>2</sup> The data in the maps (Attachment A) and discussed below comes from CCC's report. The information is presented for Community Districts (Community Board [CB]), which are more natural boundaries and more understandable for residents than the traditional way of presenting this data. The information presented below is a small snapshot of communities, for a more detailed description of many more factors, contact CCC or go on its web site for the full report.<sup>3</sup>

Based on this data, and other data contained in *Keeping Track*, the following communities are at most risk to Children's Health Well-Being: Bedford Stuyvesant (CB 3, Brooklyn); Brownsville (CB 6, Brooklyn); Central Harlem (CB 10, Manhattan); Crown Heights North (CB 8, Brooklyn); East Flatbush (CB 17, Brooklyn); East New York (CB 5, Brooklyn); Jamaica & St. Albans (CB 12, Queens); Morrisania (CB 3, Bronx); Mott Haven (CB 1, Bronx); and The Rockaways (CB 14, Queens).

The highest risk for overall well being in three boroughs is found in:

- The Bronx: Mott Haven, Hunts Point, Morrisania, University Heights, East Tremont, Highbridge, and Fordham (all highest risk).
- Brooklyn: Bedford Stuyvesant, Crown Heights North, and Bushwick (all highest risk).
- Manhattan: Central Harlem, West Harlem/Manhattanville, and East Harlem (all highest risk).

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<sup>2</sup> *Keeping Track of New York City's Children*. 2008. Citizens' Committee for Children of New York. [www.ccnnewyork.org](http://www.ccnnewyork.org)

<sup>3</sup> Ibid.

## Key to Maps

### **Manhattan Community Districts**

101 Civic Center, Wall Street \*102 Greenwich Village, Noho, Soho, Little Italy \*103 Lower East Side, Chinatown \*104 Chelsea, Clinton \*105 Midtown, Times Square \*106 Murray Hill, East Midtown \*107 Lincoln Square, Upper West Side \*108 Upper East Side, Yorkville, Roosevelt Island \*109 West Harlem, Manhattanville \*110 Central Harlem \*111 East Harlem  
112 Washington Heights, Inwood.

### **Bronx Community Districts**

201 Mott Haven, Melrose \*202 Hunts Point, Longwood \*203 Morrisania, Claremont, Crotona Park East \*204 Highbridge, Concourse \*205 Morris Heights, University Heights, Fordham \*206 East Tremont \*207 Kingsbridge Heights, Bedford Park, Fordham, University Heights \*  
208 Riverdale, Marble Hill \*209 Soundview, Castle Hill, \*210 Throgs Neck, Pelham Bay, , City Island \*211 Morris Park, Pelham Parkway \*212 Williamsbridge, Baychester

### **Brooklyn Community Districts**

301 Greenpoint, Williamsburg \*302 Downtown Brooklyn, Fort Greene, Brooklyn Heights, Boerum Hill \*303 Bedford Stuyvesant \*304 Bushwick \*305 East New York \*306 Red Hook, Park Slope, Carroll Gardens, Cobble Hill \*307 Sunset Park, Windsor Terrace \*308 Crown Heights, Prospect Heights, \*309 Crown Heights South, Prospect \*310 Bay Ridge, Dyker Heights \*311 Bensonhurst, \*312 Borough Park, Midwood \*313 Coney Island, Brighton Beach  
\*314 Flatbush, Ocean Parkway, Midwood \*315 Sheepshead Bay, Manhattan Beach  
\*316 Ocean Hill, Brownsville \*317 Flatbush, Northeast Flatbush \*318 Canarsie

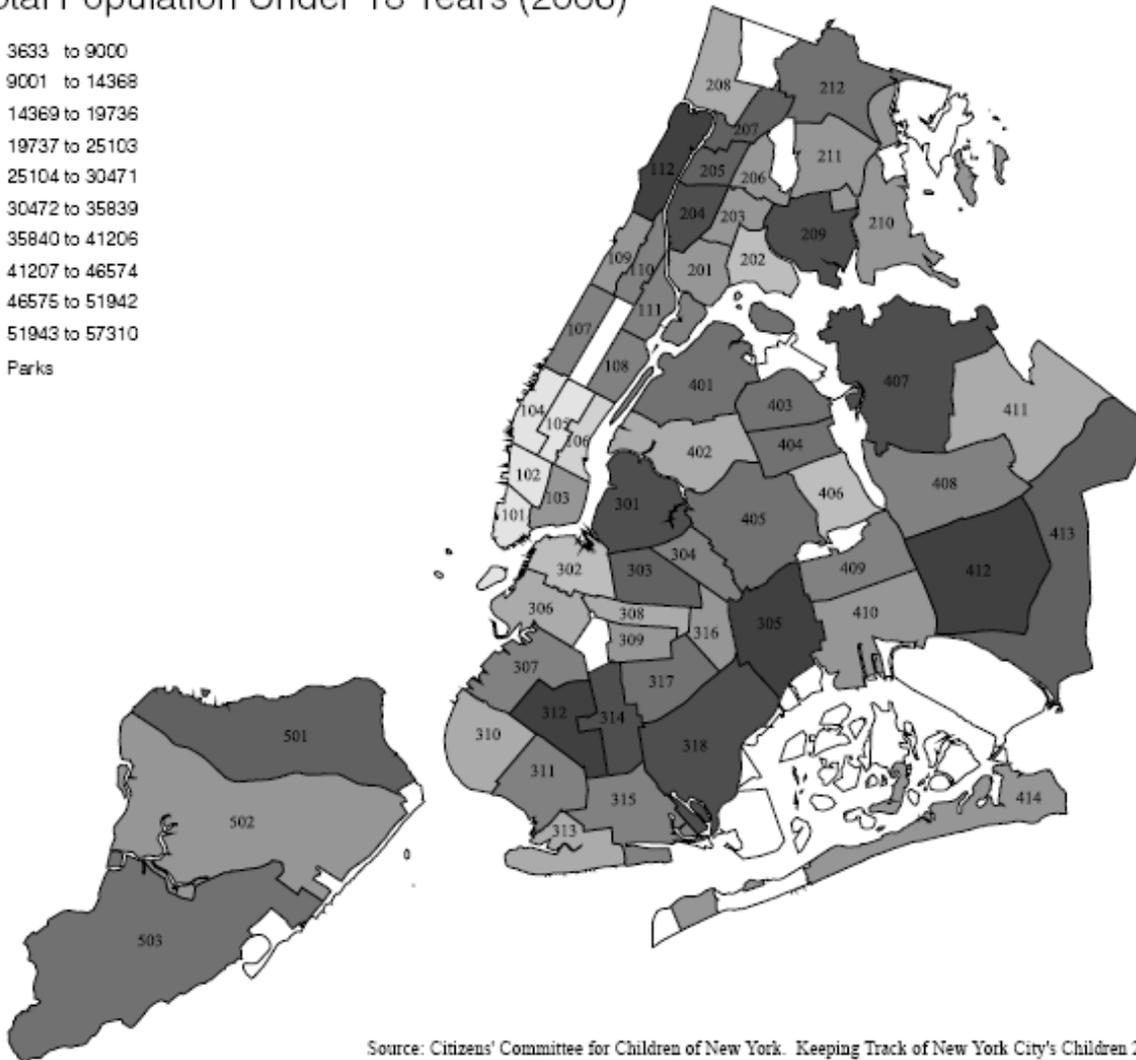
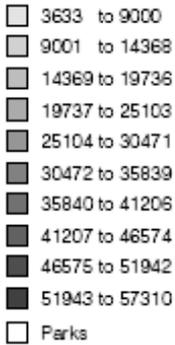
### **Queens Community Districts**

401 Astoria, Long Island City \*402 Sunnyside, Woodside \*403 Jackson Heights, East Elmhurst, North Corona \*404 Elmhurst, Corona \*405 Maspeth, Middle Village, Ridgewood,  
\*406 Rego Park, Forest Hills \*407 Flushing, Whitestone, College Point \*408 Fresh Meadows, Kew Gardens Hills, Jamaica Hills \*409 Woodhaven, Richmond Hill, Kew Gardens  
\*410 Howard Beach, Ozone Park, South Ozone Park \*411 Bayside, Douglaston, Little Neck  
\*412 Jamaica, South Jamaica, Hollis, St. Albans \*413 Laurelton, Cambria Heights, Queens Village, Glen Oaks \*414 The Rockaways, Broad Channel

### **Staten Island Community Districts**

501 North Island \*502 Mid-Island \*503 South Island

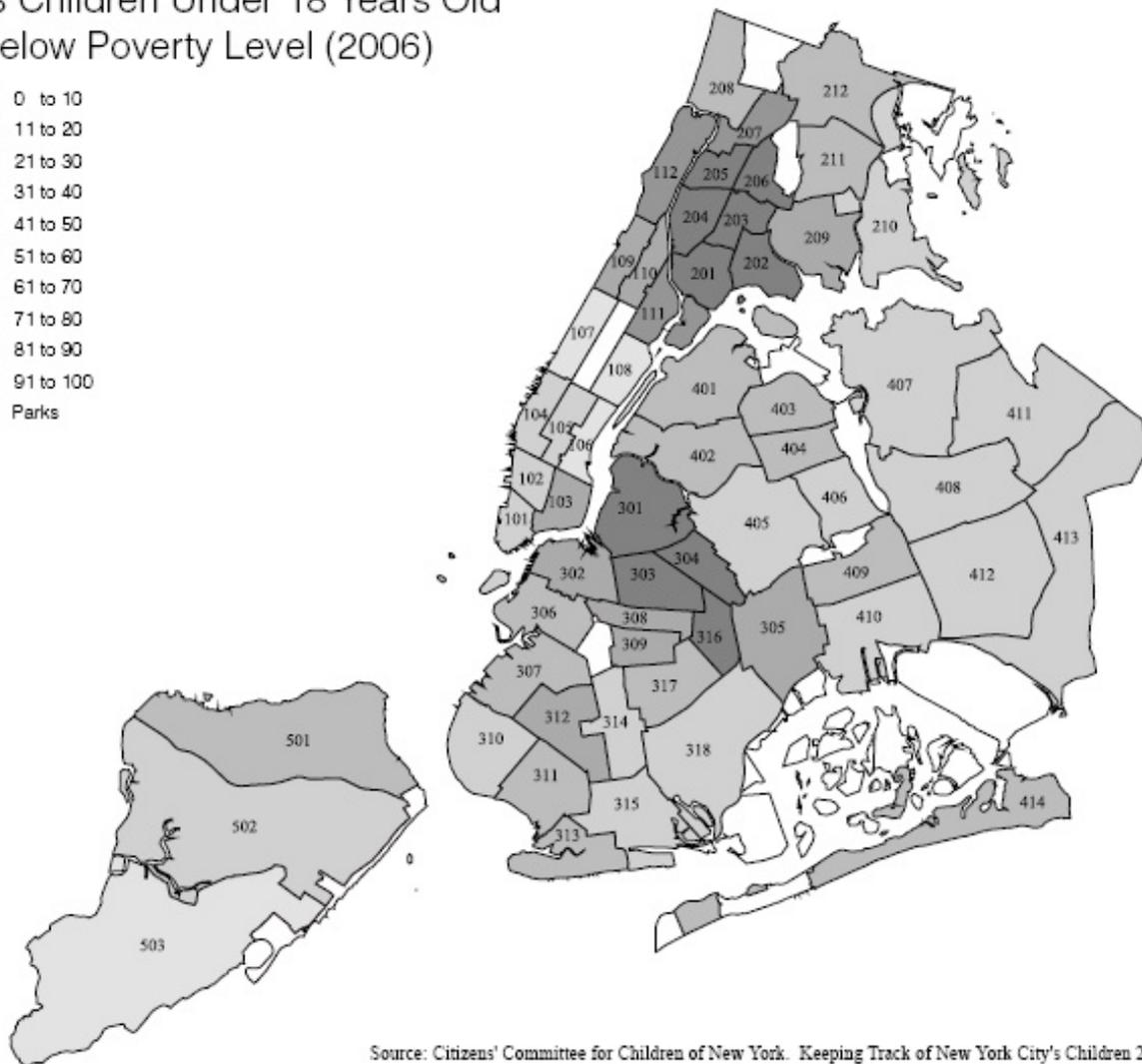
## Total Population Under 18 Years (2006)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
 Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- Map #1 – Total Population Under 18 years.** There are large concentrations of children living in several communities. They are: Washington Heights and Inwood (CB 12, Manhattan); Highbridge and the Concourse (CB 4, Bronx); Soundview and Castle Hill (CB 9, Bronx); Flushing and Whitestone (CB 7, Queens); Jamaica, Hollis, and St. Albans (CB 12, Queens); Greenpoint and Williamsburg (CB 1, Brooklyn); East New York (CB 5, Brooklyn); Borough Park (CB 12, Brooklyn); Flatbush (CB 14, Brooklyn); Canarsie (CB 18, Brooklyn); and North Island (CB 1, Staten Island).

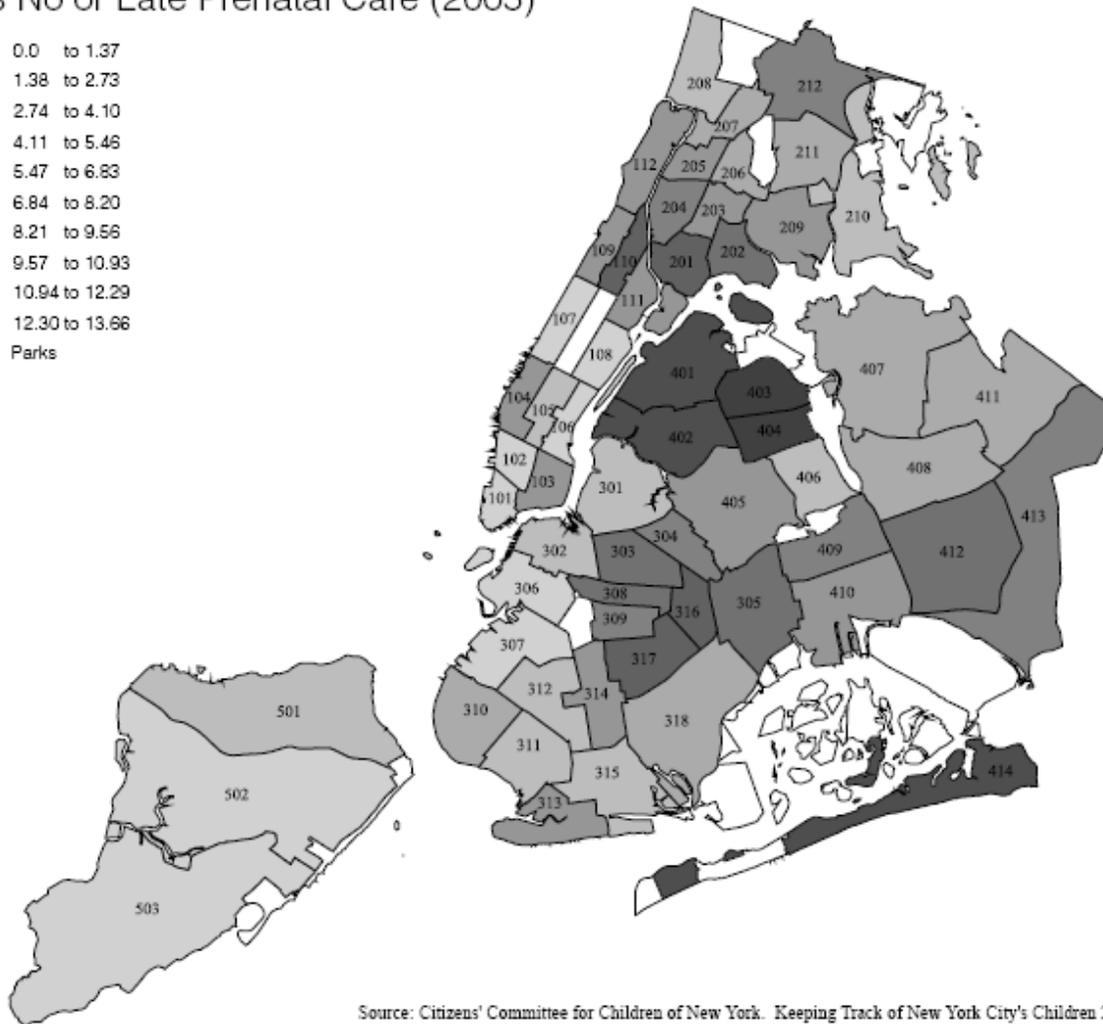
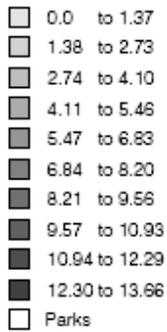
% Children Under 18 Years Old  
Below Poverty Level (2006)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- Map #2 -- % of Children Under 18 Years Old Living Below the Poverty Level.** The following communities had more than 50% of children living below the poverty level: Mott Haven (CB 1, Bronx); Hunts Point (CB 2, Bronx); Melrose and Morrisania (CB 3, Bronx); Highbridge (CB 4, Bronx); Morris Heights (CB 5, Bronx); East Tremont (CB 6, Bronx); Williamsburg and Greenpoint (CB 1, Brooklyn); Bedford Stuyvesant (CB 3, Brooklyn); Bushwick (CB 4, Brooklyn); Ocean Hill Brownsville (CB 16, Brooklyn).

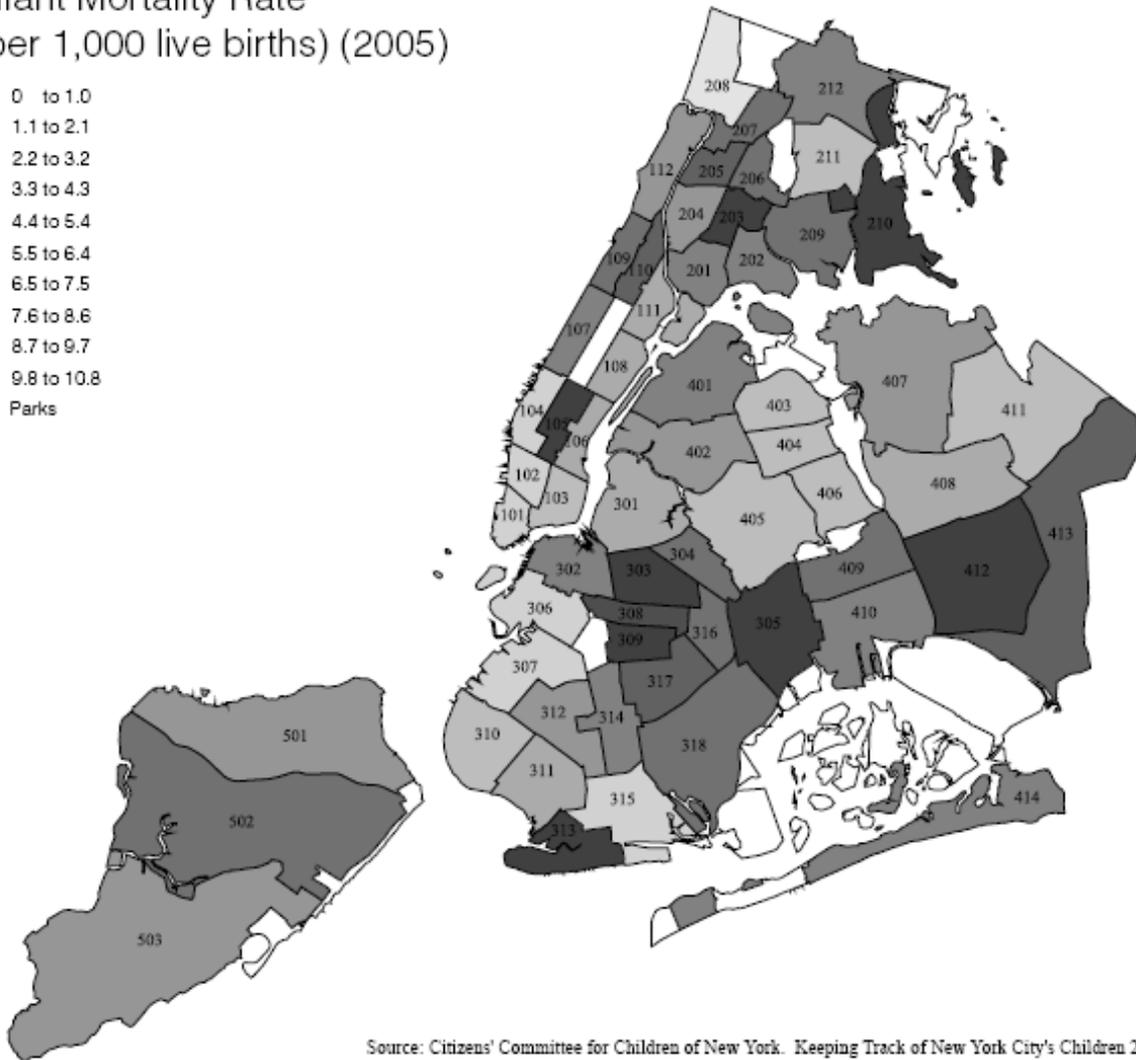
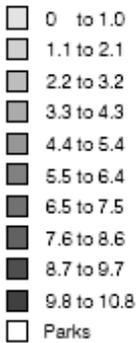
## % No or Late Prenatal Care (2005)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- Map #3 -- % of Pregnant Women Receiving Late or No Prenatal Care.** Late care can indicate an access to care problem. Late care is often linked to infant mortality and babies born too little or too soon. The following communities had high percentages (10 or more %) of women receiving late or no prenatal care: Central Harlem (CB 10, Manhattan); Mott Haven and Melrose (CB 1, Bronx); Astoria and Long Island City (CB 1, Queens); Sunnyside (CB 2, Queens); Jackson Heights (CB 3, Queens); Elmhurst & Corona (CB 4, Queens); The Rockaways (CB 14, Queens); Ocean Hill Brownsville (CB 16, Brooklyn); and Flatbush (CB 17, Brooklyn).

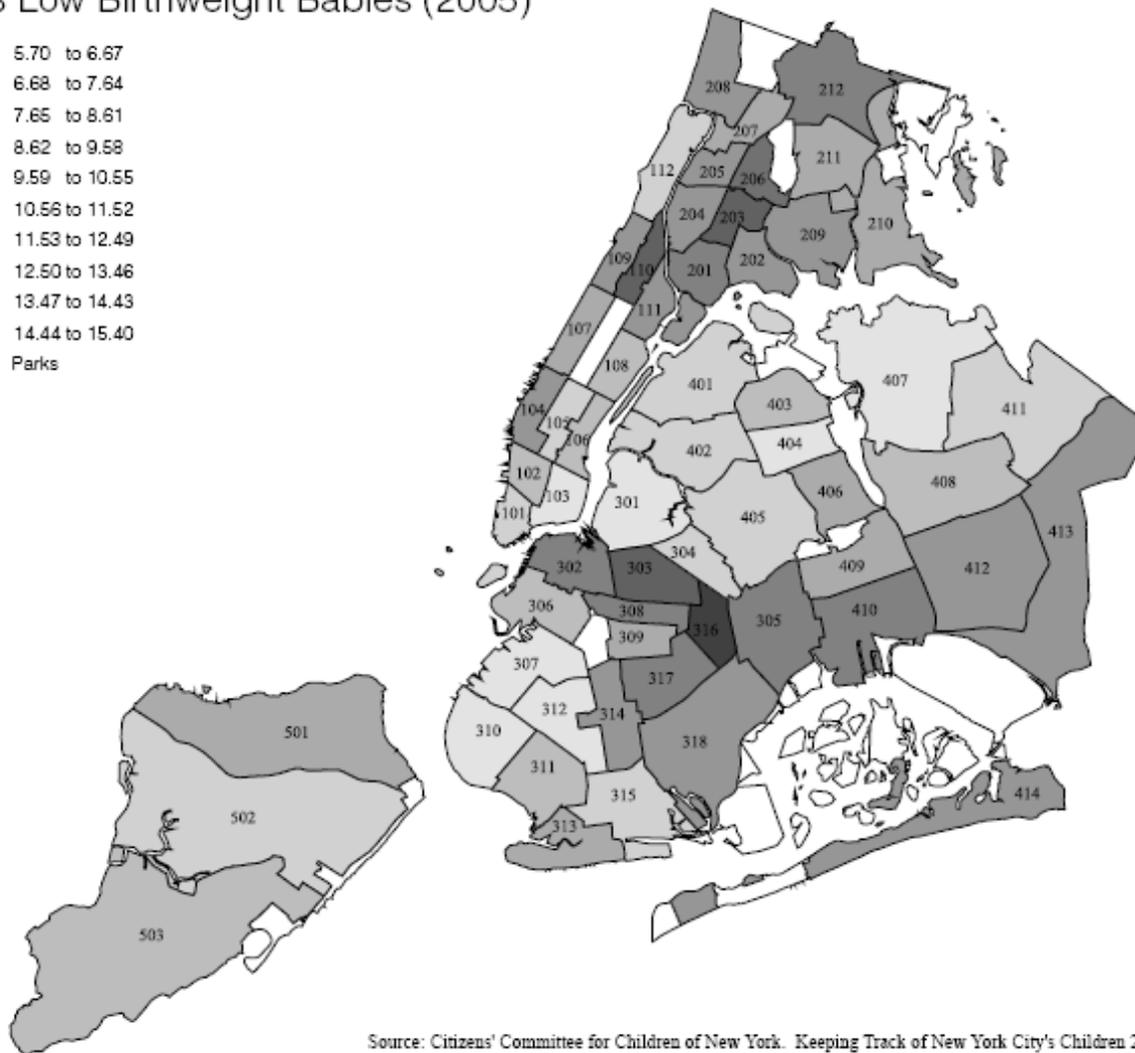
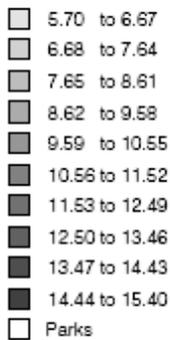
Infant Mortality Rate  
(per 1,000 live births) (2005)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- Map #4 – Infant Mortality Rate.** This is the rate of babies who die in their first year of life for each 1,000 live births. Infant mortality rates are often higher in African American and Latino communities. Communities with Infant Mortality Rates of 8.7 or more: Midtown (CB 5, Manhattan); West Harlem (CB 9, Manhattan); Central Harlem (CB 10, Manhattan); Melrose and Morrisania (CB 3, Bronx); Throgs Neck (CB 10, Bronx); Bedford Stuyvesant (CB 3, Brooklyn); East New York (CB 5, Brooklyn); Crown Heights (CB 8 and 9, Brooklyn); Coney Island (CB 13, Brooklyn); Jamaica, Hollis and St. Albans (CB 12, Queens).

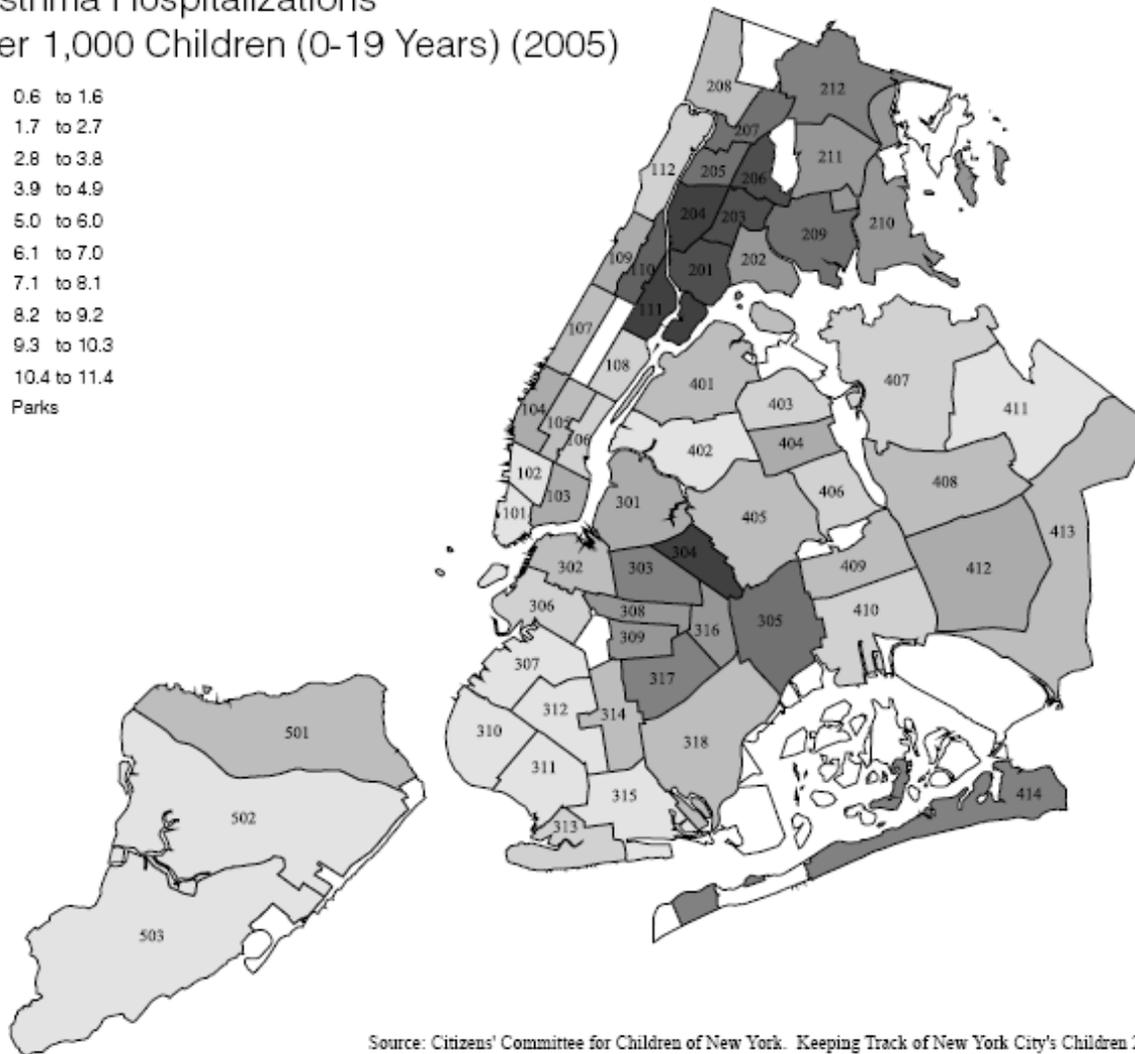
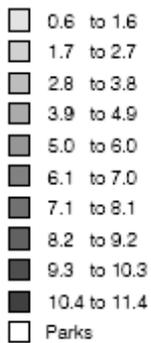
## % Low Birthweight Babies (2005)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
 Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- Map #5 - % of Low Birthweight Babies.** This is the number of babies that are born too small at under 5.5 pounds at birth. More African American babies are born at low birthweight. The communities with high rates of babies born too small are: Central Harlem (CB 10, Manhattan); Melrose and Morrisania (CB 3, Bronx); Bedford Stuyvesant (CB 3, Brooklyn); Ocean Hill and Brownsville (CB 16, Brooklyn).

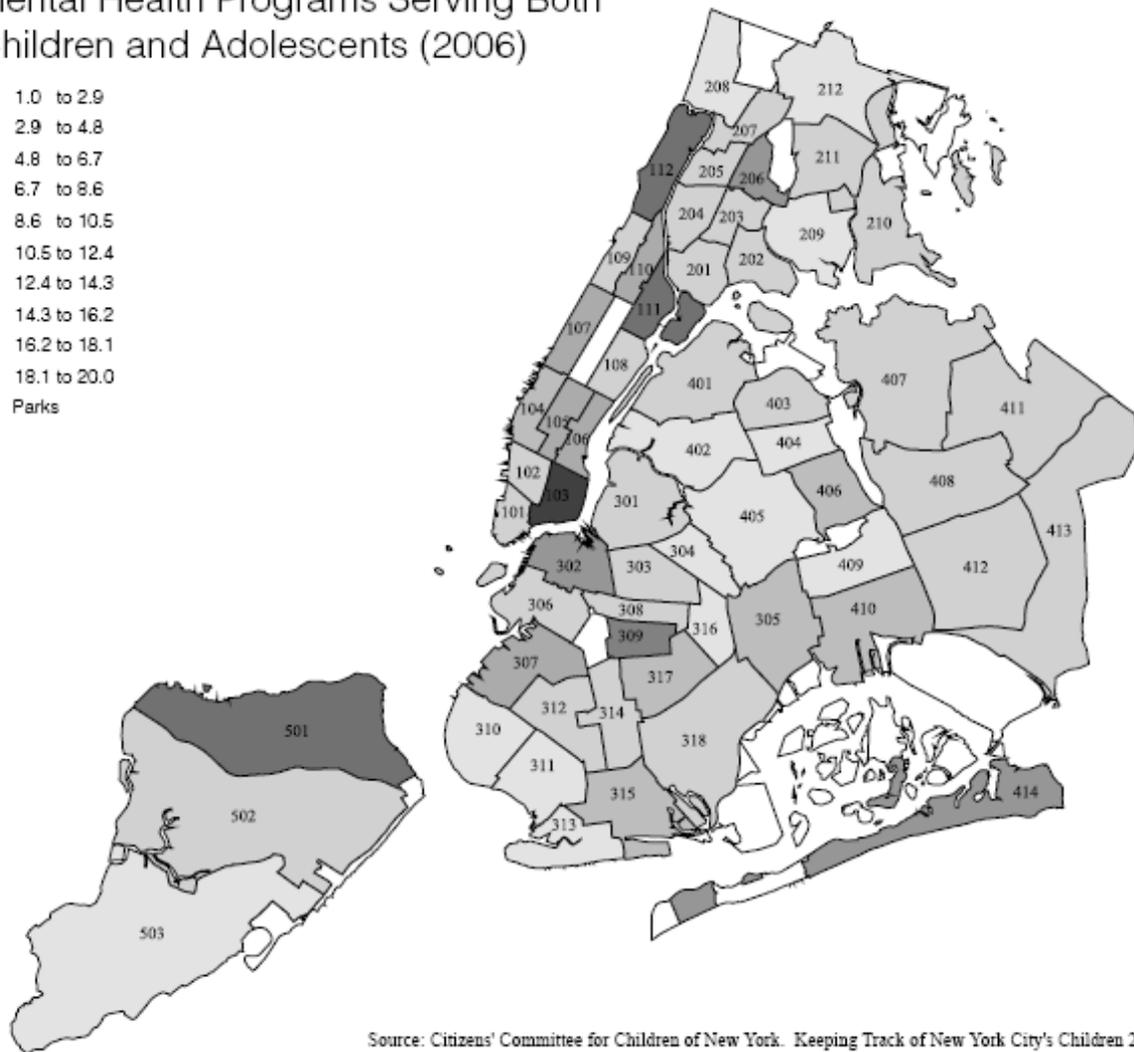
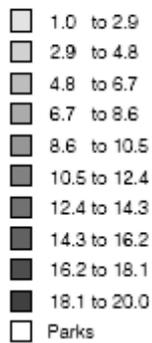
## Asthma Hospitalizations per 1,000 Children (0-19 Years) (2005)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- Map #6 – Asthma Hospitalizations per 1,000 Children.** Asthma is a treatable illness and hospitalizations can be prevented. The rate of hospitalizations of children for asthma is high in the Latino communities. The communities with high rates of avoidable hospitalizations for this illness are: Central Harlem (CB 10, Manhattan); East Harlem (CB 11, Manhattan); Mott Haven and Melrose (CB 1, Bronx); Melrose and Morrisania (CB 3, Bronx); Highbridge (CB 4, Bronx); East Tremont (CB 6, Bronx); Throgs Neck (CB 9, Bronx); Bushwick (CB 4, Brooklyn); East New York (CB 5, Brooklyn).

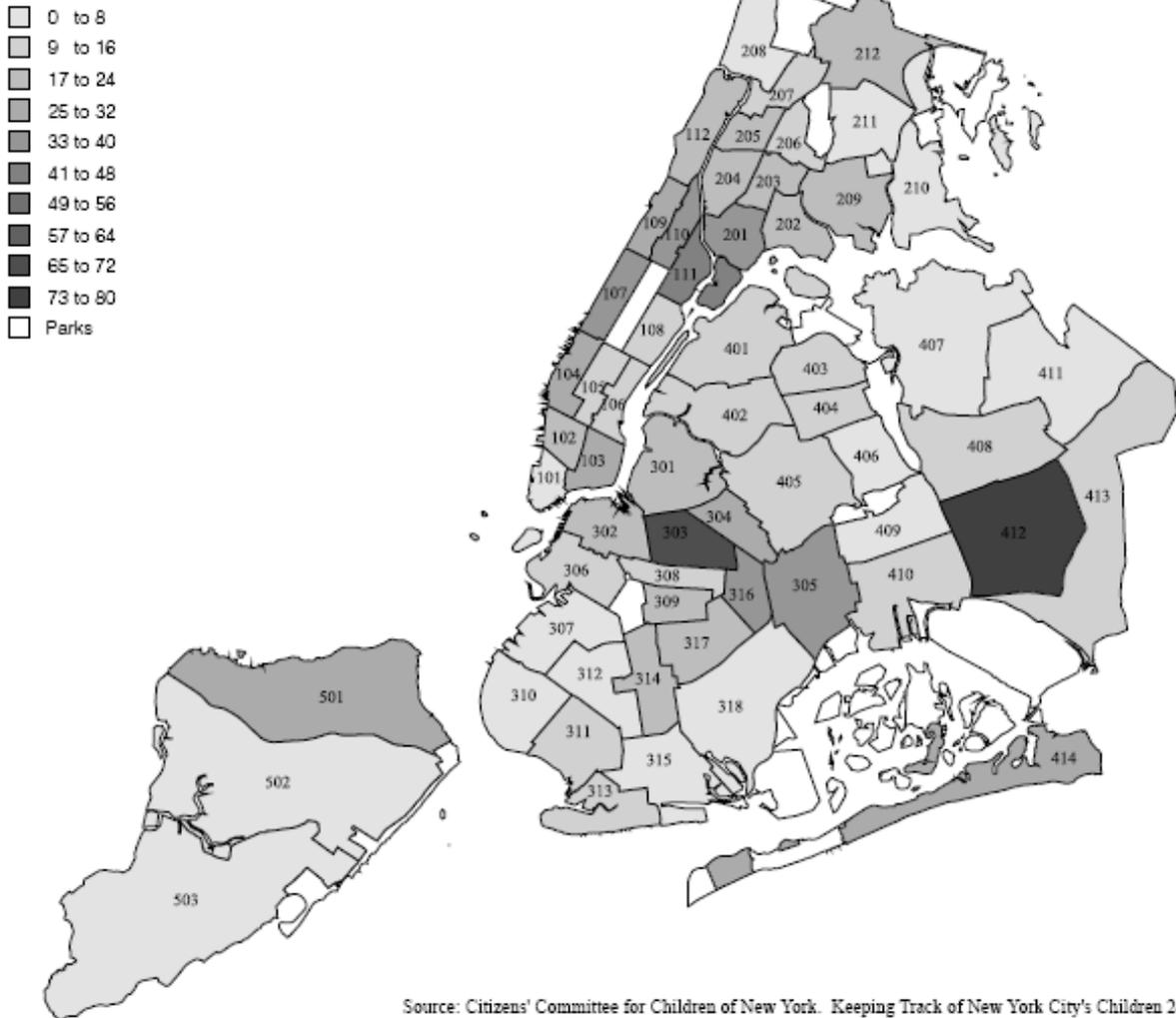
## Mental Health Programs Serving Both Children and Adolescents (2006)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

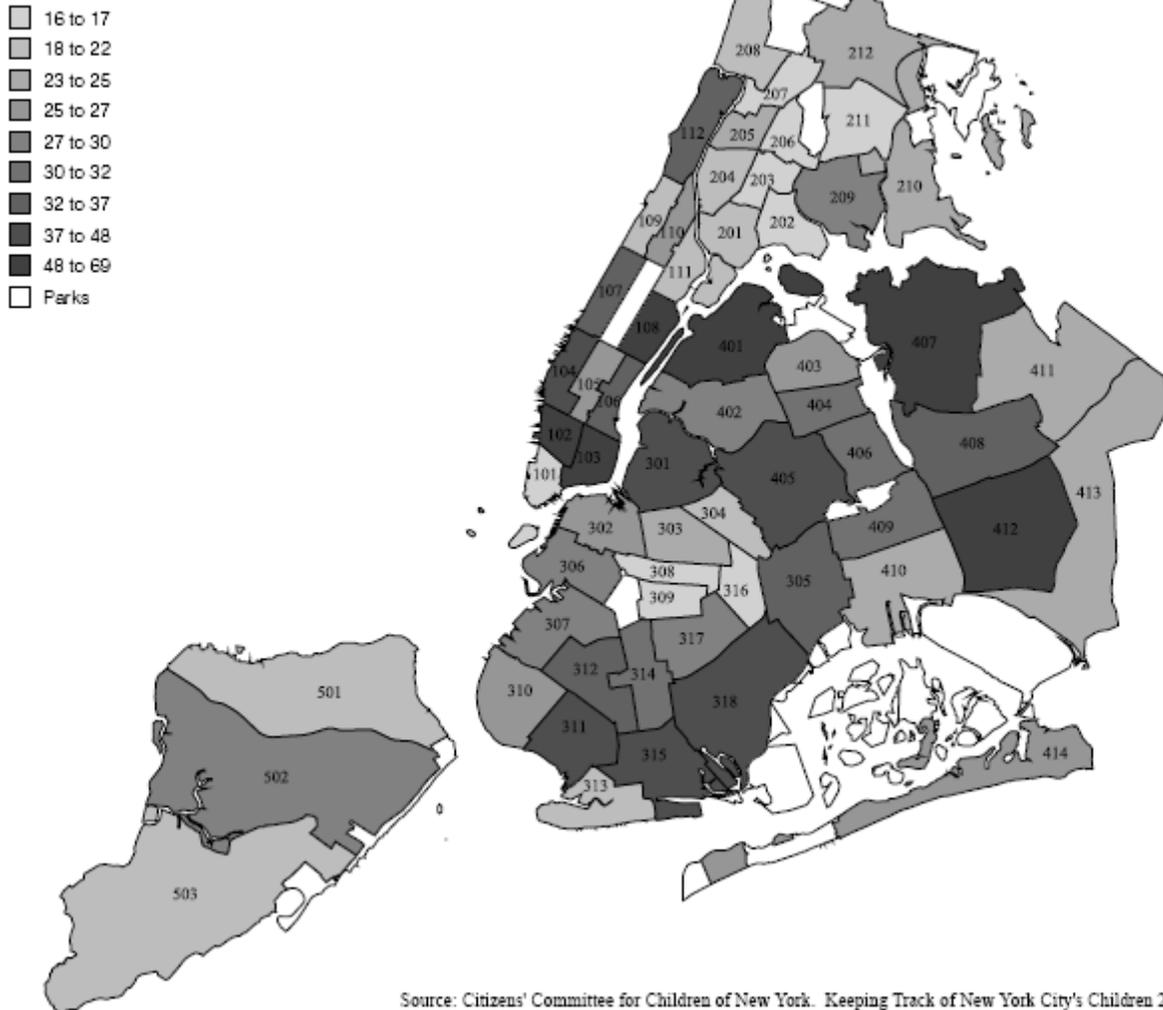
- Map #7 – Mental Health programs serving both children and adolescents.** Access to mental health programs within communities is important. As in health care generally, there is a maldistribution of resources and most communities have few resources to treat the mental health needs of the younger population. (Note: this is not an evaluation of the quality or the cultural competence of the available programs). Only the following communities have ten or more programs serving this population: Lower East Side and Chinatown (CB 3, Manhattan); East Harlem (CB 11, Manhattan); Washington Heights and Inwood (CB 12, Manhattan); East Tremont (CB 6, Bronx); Crown Heights (CB 9, Brooklyn); North Island (CB 1, Staten Island).

## Food Pantries (2006)



- **Map #8 – Number of Food Pantries.** Large numbers of food pantries in a Community District could indicate lack of access to other sources of food, and high rates of food insecurity. However the absence of large numbers of food pantries does not indicate food security, but rather may mean that organizations have not developed this type of program. Several communities have 40 or more food pantries: East Harlem (CB 11, Manhattan); Bedford Stuyvesant (CB 3, Brooklyn); and Jamaica, Hollis and St. Albans (CB 12, Queens).

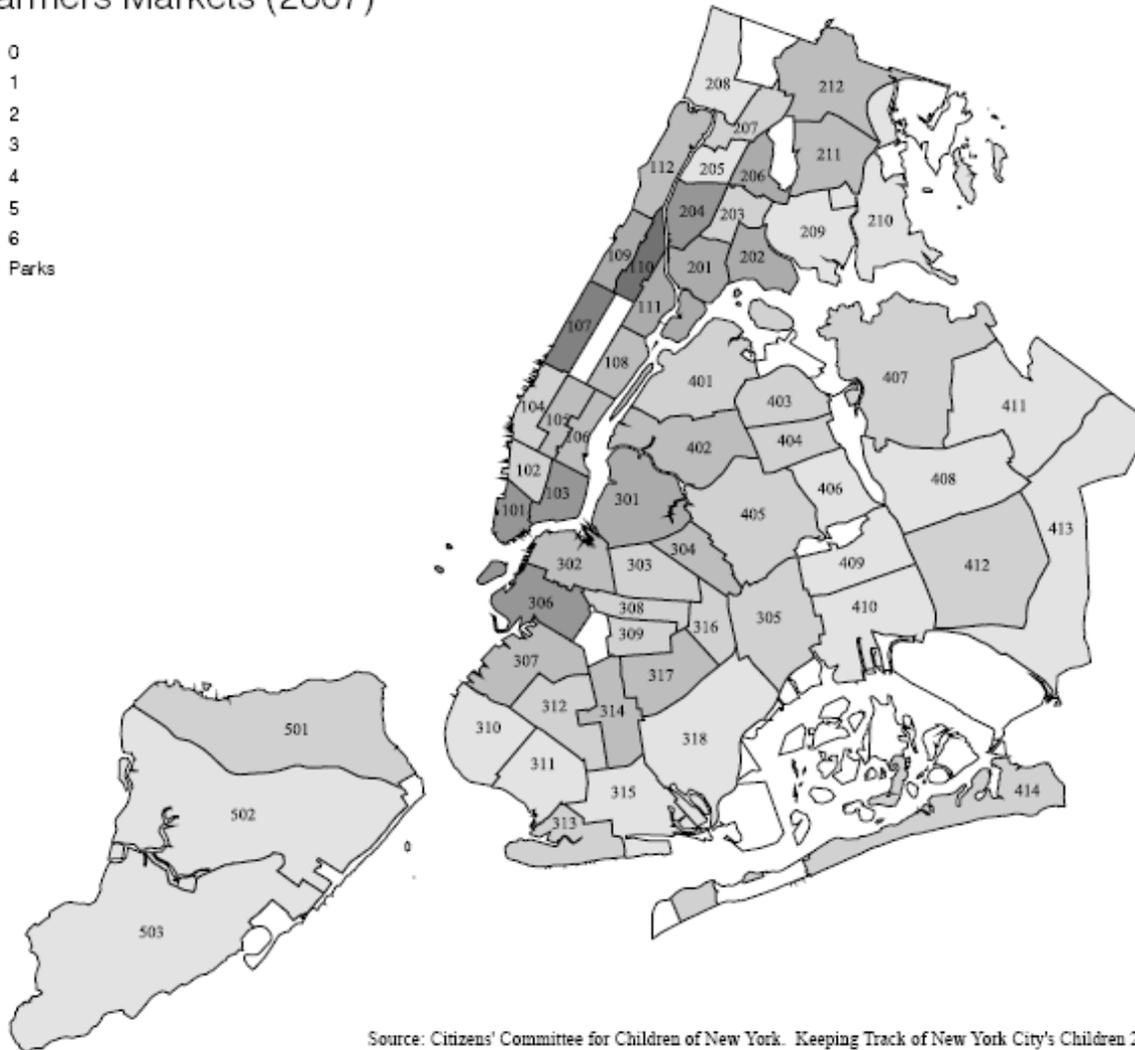
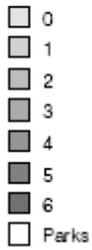
## Supermarkets and Grocery Stores (2007)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
 Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- **Map #9 – Supermarkets and Grocery Stores.** The availability of supermarkets and grocery stores could indicate a greater variety of places to shop for food. Several communities do not have a large number of places to shop. These communities have 25 or fewer food stores: West Harlem (CB 9, Manhattan); East Harlem (CB 11, Manhattan); Mott Haven (CB 1, Bronx); Hunts Point (CB 2, Bronx); Melrose (CB 3, Bronx); Highbridge (CB 4, Bronx); Morris Heights (CB 5, Bronx); East Tremont (CB 6, Bronx); Kingsbridge (CB 7, Bronx); Marble Hill and Riverdale (CB 8, Bronx); Morris Park (CB 11, Bronx); Bayside (CB 11, Queens); Laurelton (CB 13, Queens); The Rockaways (CB 14, Queens); Bushwick (CB 4, Brooklyn); Crown Heights (CB 8, Brooklyn); Crown Heights South (CB 9, Brooklyn); Coney Island (CB 13, Brooklyn); Ocean Hill and Brownsville (CB 16, Brooklyn); Mid Island (CB 2, Staten Island).

## Farmers Markets (2007)



Source: Citizens' Committee for Children of New York. Keeping Track of New York City's Children 2008.  
 Prepared by The Opportunity Agenda for the Commission on the Public's Health System.

- Map #10 – Farmers Markets.** The availability of Farmers Markets can mean access to fresh fruits and vegetables, highly recommended foods. Only a few Community Districts in New York City have four or more Farmers Markets available. These communities are: Downtown, Wall Street (CB 1, Manhattan); Lower East Side and Chinatown (CB 3, Manhattan); Upper West Side (CB 7, Manhattan); Central Harlem (CB 10, Manhattan); Highbridge (CB 4, Bronx); East Tremont (CB 6, Bronx); Greenpoint and Williamsburg (CB 1, Brooklyn); Red Hook and Park Slope (CB 6, Brooklyn).

## Voices from the Community

Before writing this agenda, the Child Health Initiative developed a survey and the Borough Coalition members interviewed 659 parents in twelve languages and conducted 12 focus groups with young people. *Yes New York Can!* is in part based on the important findings in *Voices from the Community*. A summary of the results of the surveys and focus groups is produced below as a backdrop to the development of this Child/Teen/Family Health Policy Agenda. These voices were important in the drafting of the Policy Agenda.

### **Results of the Surveys**

The picture drawn from the surveys is somewhat complex, particularly as the responses from the close-ended questions are contrasted with the responses to the open-ended questions. The picture at first looks rosy.

- Almost all children are covered by health insurance – 601 families (93%) had insured children.
- Almost all children have a “regular” source of care – 618 families (95.3%) said their children have a regular doctor or clinic.
- Many children were able to get “regular” check-ups – 525 families (80%) said their children get check-ups all of the time.
- Many children were able to have an appointment in less than a week’s time – 443 families (73.1%) were able to get appointments for their children in less than one week.
- Parents were able to ask and get their questions answered about their child’s medical care – 484 families (73.6%) always get their questions answered.

But the picture appears less rosy when looking at the responses to other questions.

- Overwhelmingly in the surveys, children were reported as having specific health problems, including: asthma; overweight/obese; dental problems; and attention or behavior problems.
- When asked what medical problems of children they see in their community – the most frequent mentioned concerns were: asthma, overweight, and diabetes.
- Children in 95 families (14.5%) were hospitalized in the last twelve months. The percent of hospitalizations was higher in Queens and in Staten Island.
- Children in 243 families (37.2%) used an Emergency Room in the last twelve months. The percent of Emergency Room visits was very high in the Bronx (49.6%) and in Staten Island (50%).
- Parents in 69 families (10.5%) reported that they had to travel one or more hours to medical care for their children.
- Parents in 124 families (25.9%) who speak a primary language other-than-English were not able to find a doctor or clinic that spoke their language. This is more of a problem in the Bronx (28.4%); in Queens (26.2%); and in Staten Island (48%).
- Parents in 144 families (32.2%) who speak a primary language other-than-English were not provided with interpreters. Based on the number of parents that

responded to this question in each borough, this was a large problem in Brooklyn (34.4%) and in Staten Island (63.4%).

The picture is bleaker when reviewing the parents' responses to the open-ended questions at the end of the survey. Some examples of the quotes include:

- “Sometimes the doctor or nurse has problem to understand me because of the language barriers and the cultural differences.” (Bronx)
- “They should have more clinics for children that suffer asthma, obesity, diabetes, or cancer in our community and also they should hire more staff in those clinics that speak our language.” (Brooklyn)
- “Have health community to go to sensitivity training to understand culture and language barriers.” (Manhattan)
- “HMO taking too many children – like a bakery. And have to wait too long and little time with patients. Like commercials – see you take a number.” (Queens)
- “More clinics. Doctor take more time with the patient. They need more equipment in the clinics so they don't have to travel too far to see the specialist.” (Staten Island)

### **The Focus Groups**

Twelve focus groups were convened with 114 young people participating. Young people were involved to ensure that their voices were also heard because of the belief that parents do not always know what their teenagers are thinking. Questions for these focus groups were drawn from the parent survey and slightly altered to the interests and perceptions of young people.

**Most important health problems:** The health care problems and concerns of the young people differed from their parents, with a greater focus on HIV, AIDS, STD's (Sexually Transmitted Diseases), pregnancy and other consequences of unprotected sex. Pressures on young people, particularly for new immigrants, led to concerns about mental health issues and stress. In the Staten Island focus groups, concerns centered more on access to care and attention from medical staff. Some of the participants felt there is a “need to treat immigrant youth with dignity and attention.”

**Definition of being healthy:** Most teens stated that good nutrition, good hygiene, and exercise meant being healthy. There was some discussion about access to preventive care to maintain good health. A few of the focus groups discussed how spiritual health or spirituality contributed to the quality of their overall health. Some participants did not believe that they live in a healthy community, but rather in a “hood” where mostly Black and Hispanic people live.

**Regular doctor or clinic:** Most of the participants had access to a regular doctor or clinic in their neighborhood, with one group in the Bronx able to access healthcare in their school. In one Manhattan focus group and one in Staten Island healthcare was accessed through the Emergency Room.

**Travel to access care:** About 25% of the participants had to travel for healthcare services. Young people in Staten Island, Brooklyn, and the Bronx reported having to travel far to get medical care. Some Brooklyn participants did not like the way they are treated in teaching hospitals – groups of staff walked into their room without permission, and some felt “like it was an experiment.”

**Communication during medical exam:** Most participants said they were able to communicate well with their doctors, although some cited a problem because “the doctor doesn’t speak good English, sometimes it is hard to understand him.” Some participants raised concern about the doctor communicating more with the parent rather than the young person.

**Understand what is happening during medical exam:** Responses to this question varied widely. One group in Staten Island felt rushed and not listened to in Emergency Rooms. Focus group participants in Brooklyn felt empowered to ask questions. One Brooklyn participant said that “doctors are not like the olden days. Man you got these interns coming in from college ad stuff like that. Before back in the day, the doctors would take the time you know and handle you as a patient you know, talk confidentially with you. Now you go there and you could hear the doctor in the next room telling the patient what’s wrong with him.” Some participants looked for alternate sources of information through brochures or looking up information online.

**Health insurance coverage:** A majority of the participants had health insurance cards or had access to health care in a clinic.

**Changes if you had power for a day:** Some groups wanted to see their communities changed, some wanted to change the availability of health care, some wanted to change how they received treatment at their medical facilities, some wanted more information about sexually transmitted illnesses, and others wanted to make changes to the health care system as a whole. A large majority of participants wanted to have universal health coverage and care in the United States, citing other country’s programs. Brooklyn participants wanted improved patient services. There was a call from some focus groups for having clinics which opened according to students’ schedules, after school and on the weekends, so that students can access services (from the Bronx) or to have school-based clinics (from Queens).

## **Policy Initiatives**

- School Health Program
- Bronx Policy Initiatives
- Brooklyn Policy Initiatives
- Manhattan Policy Initiatives
- Queens Policy Initiatives
- Staten Island Policy Initiatives

Each of the borough Child Health Coalitions have developed Policy Initiatives based, in part, on the results of the surveys and focus groups they conducted in their boroughs, and in part based on the experience and knowledge of the borough coalition members. The policy initiatives from each borough will be detailed following the priority developed for a citywide initiative – the improvement of health care in the schools.

Since the last attempt to create a child health policy agenda in 1989<sup>4</sup>, millions of children have been born in New York City. They were born into a city without a vision that recognizes the unique opportunity that childhood presents to make the city a better place. This agenda is our legacy to the next generation of children born in New York. We create the “wish list” of services, programs, and initiatives that will ensure that the city is a better place for all babies, children, and adolescents as they grow into adulthood.

### **School Health**

The City of New York does not currently have a Child/Teen/Family Health Policy Agenda. Most of the focus in public health is centered on adults (*Take Care New York*) and on specific diseases such as Diabetes. A truly holistic examination of the needs of children is still required. This was not always the case. In 1989, there was a Commission on the Future of Child Health in New York City. In a report published in August 1989, the Commission presented an assessment of children’s health status, examined barriers to progress in meeting the needs of children, and profiled an effective child health system.<sup>5</sup> The recommendations called for: a “medical home” for each child; quality prenatal care; access to secondary and tertiary care; and the existence of community supports. This was a high-level, official commission that did not appear to be rooted in the communities of the city, as all of the members were professionals.

Child health became a focus again in 1992, along with a concerted look at school health services when the Mayor’s Advisory Council of Child Health produced several reports and recommendations.<sup>6</sup> At that time, there were 74 school-based health clinics in New

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<sup>4</sup> The Future of Child Health in New York City, August 1989. Commission on the Future of Child Health. Published by the New York City Department of Health.

<sup>5</sup> *The Future of Child Health in New York City*, August 1989.

<sup>6</sup> *Financing Health Care for Children and Youth: Agenda for Change*. October 1992. Child Health Action Management Plan, New York City Department of Health. Also: *Rebuilding School Health Services in New York City: A Vision for the Year 2000*. October 1992.

York City schools. Now 16 years later, there are school-based clinics in 126 of the 1,100 school buildings in the city, about ten percent of all schools. In one of the reports on school health, there were recommendations for placing additional professionals and paraprofessionals in each of the city's schools. An additional major recommendation was for the development of 50 school-based health clinics in schools located in neighborhoods without available medical resources.<sup>7</sup>

These important efforts evolved around a top down approach, with many high level professionals involved in these Task Forces, but with little to no community involvement in the study, the review, or the development of recommendations. Other reports have focused on school health services. In 1999, the city Comptroller's staff studied medical problem that could affect a child's ability to learn in three low-income districts, reviewing records to see if there is follow-up of care for children identified with problems.<sup>8</sup> In 2004, the City Council looked at the availability of school nurses primarily in non-public schools.<sup>9</sup> Finally the three public unions that provide staff for the school health program, prepared a review of the Department of Education and the Department of Health's role in providing school health services.<sup>10</sup>

The Child Health Initiative acknowledges that at different points in time in our city's history, there were official efforts to identify and ameliorate the problems found in children's health care services. Nevertheless, there does not appear to be a coordinated effort to address these issues in our current climate. It is particularly glaringly absent in the school health program jointly operated by the Department of Health & Mental Hygiene and the Department of Education. In *Yes New York Can!*, many of the problems we found are the same, or similar to those identified in the studies listed above although one would have expected some type of progress. Some of the recommendations made may even be similar to those in the earlier reports. The major difference is that this effort comes from the community, not from a top down approach. The need for CHANGE coming from the community is what we believe will make the difference. Important changes in social policy in this country have been more often than not grounded in a social movement. We hope that the voices of the community will initiate the change that is needed to provide New York City's children the health care they need and deserve.

### **Current Status of the School Health Program**

Just about every child attends public or private school. As such, they are a convenient site for providing health and mental health services, as well as tracking the health status of all children. It is often said that location is everything – and in this instance it is true that having services located in the schools themselves can make a major difference in access to care, particularly in medically underserved communities.

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<sup>7</sup> *Rebuilding School Health Services*.

<sup>8</sup> *Healthy Kids, Healthy Schools*. June 1999. Alan G. Hevesi, Comptroller.

<sup>9</sup> *Adding Insult to Injury: No School Nurse Available*. June 2004. Committee on Oversight and Investigations.

<sup>10</sup> *No More Studies: A Call for Action on School Health*. Not dated. Doctors Council, SEIU Local 10 MD; Local 436 United Federation of Nurses & Epidemiologists, DC 37, AFSCME; and the United Federation of Teachers.

Several people intimately involved with school health were interviewed for this Initiative.<sup>11</sup> A pro bono legal team provided research on applicable New York state laws and New York City rules governing certain health services in New York City public schools.<sup>12</sup> It is important to know the legal starting point in order to devise a way to fix a problem.

Among those interviewed, there was a difference of opinion about the effectiveness of the city's school health program and school-based health clinics, and which is preferable. The city's school health program is jointly administered by the Department of Health (DOH) and the Department of Education (DOE). The Director of the program reports to both city agencies. There was agreement that there is a shortage of nurses working in the school system, so there are vacant lines for nurses in both agencies – 680 nursing lines in DOE with about 100 vacancies and 880 nursing lines in DOH with about 100 vacancies. Some of these vacancies are filled through contract with agencies that provide nurses. Every elementary school has a nurse, Intermediate and High Schools don't always have this vital service, unless there is a student at the school with a need for special health attention (504 form for disability or and Individualized Education Plan [IEP]). Dr. Platt, Director of the city's Office of School Health, said that there are about 30 middle schools and 70 high schools that do not have a nurse assigned.<sup>13</sup>

The vision for the role of the nurses in the schools also differs. Public health nurses in the schools used to make home visits and provided case management in the schools, where they identified health problems and worked on helping the child and the family.<sup>14</sup> Children were required to have physical exams at specified grades and have forms showing the exam was provided.

Another area of concern is dental health services in the schools. At one point, dental care was provided for free in DOH dental clinics. Children were required to submit dental notes that showed they were under treatment, or had completed treatment.<sup>15</sup>

The city has an Automated Student Health Record (ASHR) which is operated by the DOE. Concerns were raised about public health nurses in DOH having complete access to this system.<sup>16</sup> This is a newly developed system to track the health status of

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<sup>11</sup> Dr. Roger Platt, Director Office of School Health. August 11, 2008. Judith Arroyo, RN, President of Local 436 representing the public health nurses in the schools, July 2, 2008. Ana Jimenez-Bautista and Beverly Colon, New York State Coalition for School-Based Health Centers. July 21<sup>st</sup> and 22<sup>nd</sup>, 2008.

<sup>12</sup> Memo from Jeffrey Thrope and Karyn E. Bell, Manatt, Phelps & Phillips, LLP to Judy Wessler, Commission on the Public's Health System. November 18, 2008. Legal research assisted by Prof. Paula Galowitz, and two law students: Lars Johnson and Sara Zier, NYU Law School.

<sup>13</sup> Dr. Platt, August 11, 2008.

<sup>14</sup> Judith Arroyo, July 2, 2008.

<sup>15</sup> Note: the Mayor has proposed the elimination of the city's Child Dental Clinics in his November 2008 city budget modification. This is a serious problem as dental services has been identified as the most difficult service to access.

<sup>16</sup> Judith Arroyo, July 2, 2008.

all children in the school system. One benefit of the system is the ability to obtain data, such as for asthma. According to Dr. Platt, children are identified and nurses can now focus on medication, and do not have to send the children home if they are having an attack.<sup>17</sup>

The other form of providing services in the school is through a school-based health clinic (SBHC). Currently there are 126 schools with these clinics (of the 1,100 school facilities), and ten of those are funded by the city DOH, five of the ten have recently opened. The benefit of a school having a school-based health clinic is that the on-site provider can serve as a “medical home” for the children, providing primary care services. This allows for better access to services where the children spend a lot of their time.<sup>18</sup> There are no uniform services provided by all SBHCs, as the services are largely dependent on funding and available school space. Reimbursement is available for SBHC services from Medicaid, but not from other third-party insurers. Parents have to consent to children receiving services in the SBHC. In schools where a SBHC is located, the DOH no longer places a public health nurse, so that sometimes creates a problem if not all of the children are enrolled in the SBHC.

School based mental health care is also an area of great need. Only approximately 80 schools have school-based mental health clinics.<sup>19</sup> Recent efforts have been made to increase funding for mental health services in the schools, but have not as yet been successful.<sup>20</sup> DOH has identified mental health providers in different communities that the schools can contract with, but have not provided additional funding for this service.

### **Legal Research**

A thorough review of state and local education and health laws, and local mandates, was done for the Child Health Initiative.<sup>21</sup> The information received through interviews summarized above did not shed light on all of the requirements for health services performed in the schools. It is surprising to note that the state law requirements for school health services are more expansive than those for New York City. In fact, New York City, Rochester, and Buffalo are exempt from significant state requirements.

New York State requires: “A general health certificate is required at entrance and at least twice in elementary and twice in secondary grades.”<sup>22</sup> Regulations further specify grades requiring health exam, which are on school entrance, and pre-K, K, 2, 4, 7, 10.<sup>23</sup> On the other hand, New York City has fewer requirements. All new students must receive a full physical exam within 1 year. Regulations recommend but don’t mandate ongoing annual health evaluations.<sup>24</sup> Student’s annual height/weight

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<sup>17</sup> Dr. Platt, August 11, 2008.

<sup>18</sup> Ana Jimenez-Bautista. July 21, 2008.

<sup>19</sup> <http://www.nyc.gov/cgi-bin/misc/pfprinter.cgi?action=print&sitename=DOHMH&printstyle...>

<sup>20</sup> *School-based Health Centers: A Model for Children’s Mental Health*. New York State Coalition for School-Based Health Centers. Fact Sheets. 2008

<sup>21</sup> Jeffrey Thrope and Karyn Bell. November 2008.

<sup>22</sup> Jeffrey Thrope and Karyn Bell. N.Y. EDUC. Law Sect. 903.

<sup>23</sup> *Ibid.* 8 N.Y.C.R.R. Sect. 136.3(b)(1).

<sup>24</sup> *Ibid.* Chancellor’s Regs, Sect. A-701.

measurements are taken at school; NYC Fitnessgram. The New York City Administrative Code sets standards for the number of school nurses to students.<sup>25</sup>

New York City requires that either the school or DOH must provide certain health services to students if a parent can no comply with requirements. These services include:

- School health services and medical care;
- Medical evaluations and completion of a form (CH205);
- Vision screening for pre-kindergarten, kindergarten and grade 1 students conducted by DOH staff. The schools are to provide all other vision screenings;
- Hearing screening conducted by DOH.<sup>26</sup>

All children must be immunized to attend school, unless granted exceptions for religious or medical reasons. All students must provide proof of immunization for all grade levels.<sup>27</sup> There is no exemption for New York City. The State Health Commissioner must conduct a study by January 1, 2009, on feasibility of providing free immunizations to everyone up to age 19.<sup>28</sup>

There is another new requirement for dental services, and New York City is not exempt. Effective September 2008, students must provide dental certificates on entrance to schools.<sup>29</sup> Oral examinations are strongly recommended at grades 5, 7, and 10.<sup>30</sup> This requirement is particularly noteworthy in light of city Department of Health and Mental Hygiene Services proposals to eliminate the Child Dental Clinics services.<sup>31</sup> According to the city Health Commissioner, only 45% of children in Medicaid Managed Care had seen a dentist in the past year.<sup>32</sup> Another recent survey of 3,000 city residents reported that over 49% said that dentists are the most difficult to find.<sup>33</sup>

### **Discussion and Policy Recommendations**

At a point in time, New York City's school health program exceeded the requirements of state law and the city was exempted from meeting the state requirements, except for certain services. This is no longer the case, so that attention must focus on what in the school health program needs to be rebuilt and how this can be accomplished. With large numbers of children and young people suffering from asthma and problems of overweight, along with a plethora of other conditions – found in the surveys and focus groups and in city data – the schools are an important location in an effort to improve the health status of children.

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<sup>25</sup> Ibid. NYC Admin. Code 17-187.

<sup>26</sup> Ibid. 24 RCNY Sect. 49.05 and 24 RCNY Sect. 49.15 and DOE Chancellor Regulations Sect.A-701.

<sup>27</sup> Ibid. N.Y. EDUC. Law Sect. 914.

<sup>28</sup> Ibid. Pub. Health Law Sect. 613.

<sup>29</sup> Ibid. N.Y. EDUC. Law Sect. 903(2)(b); see also 8 N.Y.C.R.R. Sect.136.3(k).

<sup>30</sup> Chancellors Regulations Sect. A-701.

<sup>31</sup> Mayor's November 2008 budget modification.

<sup>32</sup> Testimony of Thomas Frieden. NYC Council Oversight budget hearing. November 20, 2008.

<sup>33</sup> Primary Care Initiative Community Health Assessment. Final Report. August, 21, 2008.

In *Voices from the Community*, the Child Health Initiative recommended that every child must have a “medical home” where comprehensive, ongoing, coordinated care is provided, and referrals are made for additional needed care.<sup>34</sup> The Child Health borough coalitions will be working on various aspects of this recommendation. The Child Health Initiative – Commission on the Public’s Health System, the five borough coalitions, and the Policy Committee – has chosen school health as a citywide issue to work on cooperatively. In this regard, there are short range and long range goals and recommendations that we make:

- **Short range recommendations include:**
  - Amend the state law to eliminate the exemption for New York City to comply with the Education Law and regulations. On the alternative, convince the city to incorporate all state standards.
  - Ensure that all New York City schools have a full-time nurse in the school; this requirement would include the middle and high schools.
  - Enforce the dental and other state requirements.
  - Ensure that all Medicaid-eligible children are being screened, diagnosed, and treated in accordance with the Medicaid EPSDT requirements. Longer range, work to expand these requirements to all children and young people.
  
- **Longer range recommendations include:**
  - Ensure that all children and young people in New York City have a “medical home” with an emphasis on prevention and primary care, and where these comprehensive services are provided in a culturally and linguistically competent way.
  - Expand the current number of 126 school-based health centers to additional schools where access to primary care is limited or not available.

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<sup>34</sup> *Voices from the Community*. November 2008.

## **Bronx Child Health Coalition Policy Development Document**

### **Issue Area: Asthma**

#### **Facts in brief:**

- 1) The Bronx is an epicenter of asthma; the county has some of the highest rates of asthma in the United States.
- 2) Rates of death from asthma in the Bronx are about three times higher than the national average.
- 3) Hospitalization rates are about five times higher. In some neighborhoods in the Bronx it is estimated that **30%** of the children have asthma.
- 4) Among borough children the hospitalization rates were 8.9 per 1000 compared to 5.4 per 1,000 citywide
- 5) The Bronx is one of 10 counties in the state that exceed current federal air quality standards for fine particle pollution. The entire NYC metropolitan area is also out of compliance with ozone standards, both of which have been shown to trigger asthma.
- 6) The borough has high truck traffic, and also high asthma rates. Its asthma hospitalization rate for boys and girls under 14 is 8.9 per 1,000 children, higher than that of any other borough, according to state health data. At the Children's Hospital at Montefiore Medical Center in the Bronx, 14 percent of the admissions in 2007 were asthma-related.
- 7) Poor children are disproportionately exposed to toxic matter and pound for pound children exhibit a higher biological vulnerability to the effects of exposure to these toxic materials
- 8) Research studies have shown an effect on asthma at levels even below the "safe" standard of EPA fine-particle pollution levels.
- 9) Housing quality in many parts of the Bronx is poor, with infestations of vermin and mold, despite best efforts of families. Research studies have shown an interaction between exposure to diesel traffic-related pollution and an exaggerated allergenic response to mice proteins and other indoor allergens.

#### **Issues:**

##### **What are the problems:**

- 1) Lack of access to quality care and a medical home leading to an overreliance on ER as a source of care for asthma
- 2) High levels of hospitalizations due to asthma
- 3) Unmanaged asthma due to a lack of education on asthma management techniques, triggers, peak flow meters, controller medications and other preventive measures
- 4) A decaying, older housing stock often subject to inadequate code enforcement that results in the unchecked presence of known asthma triggers.
- 5) Children in the South Bronx are twice as likely to attend a school near a highway as were children in other parts of the city
- 6) The public schools do not provide enough information and care to children about asthma prevention and care

- 7) Not all local providers follow current medical guidance in the treatment and management of asthma, and many have been uninterested in educational opportunities available to them

### **Focus Group Comments**

“Asthma is like a family friend – everyone has it and when it comes, we go to the emergency room”

Youth participating in the two focus groups all included asthma as an issue affecting their health and the health of the community

### **Survey Responses on asthma**

42% of survey respondents cited asthma as one of the major health problems in the borough.

### **Recommendations:**

What can be done to address the problem?

- 1) Increase level of education on asthma management techniques utilized by families and individuals to decrease or minimize the overreliance on ER as a source of care for asthma. Community-based, group health education based on the experience of the community and societal conditions offers an opportunity for patient asthma care empowerment and therefore we recommend these types of educational campaigns
- 2) Increase number of children with access to a medical home where they can access quality comprehensive health care that is family-centered, culturally competent, available and continuous including in the evening and at night, and that promotes the prevention of disease. Physicians who continue to prescribe rescue medications only to moderate to severe asthmatics need to be alerted that their medical licenses may be jeopardized.
- 3) Advocate that Medicaid formalize the provision of asthma education and home remediation as a reimbursable expense.
- 4) To provide the community with skills-based asthma education programs that are linguistically and culturally appropriate aimed at improving the level of asthma prevention and maintenance ability of parents, caregivers and others. We suggest further review of existing asthma programs both in NYC like the HCZ Asthma Program, and others such as the Seattle COAT to provide models of care to improve the level of educational services and health promotion techniques available to the affected community.
- 5) Create and implement an educational campaign that addresses the value of a medical home
- 6) Code enforcement of existing laws to ensure that the older Bronx housing stock is free of known asthma triggers such as mold, roaches, etc., and that NYCHA as well as other landlords prioritize homes of asthmatics for maintenance and Integrated Pest Management.
- 7) Funding for and expansion of the Asthma Free Schools

### **What do we have to do to address the issue on the community level?**

- 1) Conduct information campaigns on the issue of the importance of a medical home to ensure that children and youth with asthma access care, information and treatment on a continuous basis
- 2) Educate local elected officials about the asthma issue and the disproportionate effect that it is having on the children and youth of the Bronx.
- 3) Educate parents about asthma, pollution, healthy homes and diet
- 4) Strengthen existing laws and regulations related to clean air and asthma-safe housing
- 5) Participate in existing environmental justice campaigns in the borough
- 6) Collaborate with other environmental justice groups in the city
- 7) Advocate for compliance with the EPA standards and demand clean air in the South Bronx

### **Who needs to be involved?**

Parents

Health care provider including hospitals, health centers, local providers

Schools

Day Care centers, family day care providers and others engaged in the care and supervision of infants, children and adolescents.

Local elected officials – Office of the Borough President, Planning Boards, City Council members

Faith-based organizations

## **Bronx Child Health Coalition Policy Development Document**

### **Issue Area: Obesity**

Any child health agenda addressing obesity must also take on the levels of hunger, food insecurity and poverty with which this problem is inextricably tied. Poor children and their families face an increasingly hostile economic environment. Job losses, increasing food and housing costs and the diminution of existing safety net programs call for such a view. "Inconsistent access to nutritious food has been shown to be a main cause of the epidemic of overweight children among those living below the poverty level. Studies show that in response to inconsistent access to food, children tend to consume calorie-dense food when it is available, often leading to obesity." (Food Bank for NYC: Policy Report Series: *Child Hunger: The Unhealthy Return on Missed Investments*, 2008.) "Research shows that food-poor children are 90 percent more likely to have fair/poor health than excellent/good health. In New York City, more than one-half (53 percent) of elementary school children are overweight or obese."

### **Facts:**

#### **Food insecurity, hunger and poverty in the Bronx**

- 1) In a recent survey of anti-hunger agencies, conducted by the NYC Coalition Against Hunger, among Bronx respondents, 88% reported feeding an increased number of people in the last 12 months.

- 2) According to the Census Bureau's American Community Survey for 2007, 24% of families in the Bronx live in poverty and 38.1% of the children under 18 live in poverty.
- 3) The median family income in the Bronx is \$37,977 or 55% of the Manhattan median family of \$ 69,202.
- 4) Twenty-four percent of borough residents receive food stamps.
- 5) Poverty increases the likelihood of children becoming overweight, as does being a member of a minority population.<sup>35</sup>
- 6) Children are more vulnerable to obesity-related health problems because their bodies are growing and developing.<sup>36</sup>

### **Obesity in the Bronx**

- 1) Obesity is a major health problem in the country, the city and in the Bronx.
- 2) According to the NYCDOHMH, nearly 1 in 3 children in Head Start in the South Bronx is obese; nearly 1 in 4 children in public elementary schools in the South Bronx is obese; nearly 4 in 10 are overweight or obese and about 1 in 6 high school students in the South Bronx is obese; and 1 in 3 are overweight or obese.
- 3) Poverty and lack of access to nutritious food has been shown to result in poor health among children as evidenced by high rates of nutrition-related diseases including diabetes and obesity. <sup>37</sup>
- 5) It is possible that, given the increasing prevalence of severe overweight, some children will live shorter and less healthy lives than their parents.<sup>38</sup>

### **Issues:**

#### **What are the problems:**

### **Food Insecurity, hunger and poverty**

- 1) Current federal poverty measures, based on a model developed in the 1950's, fail to account for realistic living costs such as rent, fuel, medical care and other living expenses.
- 2) Guidelines for eligibility for programs such as WIC, SNAP (Supplemental Nutrition Assistance Program - food stamps) and others are inconsistent and do not reflect the need for cost of food in the current market.
- 3) In 2007, according to the NYC Food Bank report: "Child Hunger: The Unhealthy Return on Missed Investment", more than one out of five children in NYC received food in a soup kitchen or pantry, a 48% increase from 2006.
- 4) Despite the increase in the Federal minimum wage, more than 69% of children living in poverty have at least one working parent.
- 5) According to FRAC's survey of families living below 185 percent of poverty -- the Community Childhood Hunger Identification Project (CCHIP) -- hungry children suffer from two to four times as many individual health problems, such as unwanted weight

<sup>35</sup> Sherry B, Mei Z, Scanlon KS et al *Arch Pediat Adolesc Med.* 2004;158(12):1116-1118

<sup>36</sup> Society for Adolescent Medicine. Preventing and treating adolescent obesity: a position paper for the Society of Adolescent Medicine. *J Adolesc. Health.* 2006;38:784-787

<sup>37</sup> Child Hunger: The Unhealthy Return on Missed Investments

<sup>38</sup> Olshansky S, Passaro DJ, Hershov RC, et al

loss, fatigue, headaches, irritability, inability to concentrate and frequent colds, as compared to low-income children whose families do not experience food shortages. This relationship between hunger and health problems was unaffected by income. In other words, hunger had a strong effect on children's health no matter what the income level of their families

6) The infant mortality rate is closely linked to inadequate quantity or quality in the diet of the infant's mother. In 2006, the infant mortality rate in the certain neighborhoods in the Bronx exceeded the national and city levels. The highest infant mortality rates are in Mott Haven (12.7), Williamsbridge (11.6) and Morrisania (9.6). Mirroring national trends, the infant mortality rate in New York City among African Americans continues to be double that of whites, with Puerto Ricans close behind.

### **Lack of physical activity and school policy**

1) According to a May 5, 2008 article in the New York Sun, "Despite a legal mandate that gym classes be offered every school day, only 4% of New York City third-graders participate in daily physical education activities, a new report by the city's public advocate finds. The report, based on a survey of 100 randomly selected schools in the five boroughs, also concludes that only 12% of fourth-graders get the mandatory 120 minutes a week of physical education."

Inadequate nutrition education in schools

1) Education on nutrition is offered in the school system, however, it is not systematic, culturally sensitive or consistently available at all grade levels.

### **Focus Group Comments**

Youth participating in both focus groups all included exercise, eating well and not being overweight/obese as issues affecting their health and the health of the community

### **Recommendations:**

#### **What can be done to address the problem?:**

### **Government:**

- 1) Use of a universal school meal application and elimination of the means test application would address a barrier to enrollment and participation in the school meal program. It would reduce the burden of completing the forms and the stigma associated with receiving free school meals. It is estimated that many students in the New York City school system are eligible for the free school meal program but do not apply for fear of disclosing personal family information
- 2) Continued and expanded funding of the Special Supplemental Nutrition Assistance Program for Women, Infants and Children.
- 3) In the Bronx, we currently have 19 WIC Centers and would recommend expansion to 26, one in each zip code.
- 4) Conduct an outreach campaign to increase the level of participation in the WIC program. According to the NYCDOHMH, an estimated 50% of residents who are eligible are not enrolled in the program.

- 5) Engage in an outreach campaign for the Supplemental Nutrition Assistance Program (food stamps) to increase the low level of enrollment in the program specifically among immigrants who currently have a low level of participation in the program
- 6) Increase funding for Emergency Food programs in New York City
- 7) Public parks – provide activities in parks that promote physical exercise for community residents. This must include measures that assure a safe environment in the parks.

**School-based:**

- 1) Ensure that the capital budget for the Department of Education includes new gym and recreation spaces.
- 2) Ensure compliance by New York City schools with the NYS mandated physical activity requirements for children (120 minutes per week)
- 3) The Department of education must open the school doors to allow community residents to use facilities
- 4) Promote existing programs such as the Harlem Children’s Zone nutrition programs which emphasize healthy eating
- 5) Oversight of school meal program.

**Food Justice:**

- 1) Increase the availability of fresh, affordable and nutritious food in low-income communities – expanding Green Markets, Community Gardens and Green Carts.
- 2) Increase funding for programs that educate the community about nutrition and fitness. Such programs must be in highly visible locations such as busy shopping districts, libraries, schools, and other community venues.

**What do we have to do to address the issue on the community level:**

- 1) Conduct information campaigns promoting the importance of a medical home to ensure continuity of care to children and youth dealing with the issues of overweight and obesity. The campaign will emphasize the importance of quality, accessible care which includes health education, behavioral skills development, and disease prevention for overweight and obese children and adolescents.
- 2) Train pediatricians, family physicians and obstetrician/gynecologists in successful methods to promote healthy lifestyles. This should begin during prenatal care and should be offered at very well child visit.
- 3) Lobby local elected officials to take action which will result in changes necessary to establish and fund programs to address food insecurity, hunger and obesity in the Bronx.
- 4) Educate parents about the health risks of obesity, and about the importance of healthy lifestyles. Offer methods which have been proven to promote behavior change.
- 5) Coordinate the efforts of the many food justice advocates and groups in the city to create a unified message and unified campaign.

**Who needs to be involved?**

Parents/caregivers

Health care providers including hospitals, health centers, local providers, and insurers  
Schools

Day Care centers, family day care providers and others engaged in the care and supervision of infants, children and adolescents.

Local elected officials – Office of the Borough President, Planning Boards, City Council members

Faith-based organizations

Food justice advocates

## **Bronx Child Health Coalition Policy Development Document**

### **Issue Area: Mental Health**

Facts:

#### **Mental Health in New York State**

- 1) 1 in 10 children in New York State has a serious emotional disturbance
- 2) More children suffer from psychiatric illness than from autism, leukemia, diabetes and AIDS combined.
- 3) 70,000 children are expelled from pre-school each year for behavioral reasons.
- 4) Of the 600,000 who use public mental health facilities in New York State, 10 % are children.
- 5) There is a 2 to 4 month wait for intake appointments.
- 6) Suicide is the 3<sup>rd</sup> leading cause of death in 15-24 year olds.

#### **Mental Health Issues in the Bronx**

- 1) In 2007, 3420 children ages 18 and younger received mental health services per week in the Bronx.
- 2) In a survey conducted in 2003 of 21 Bronx-based mental health providers, 95% of the clinics identified day treatment as needed by unavailable.
- 3) In the same survey, 84% identified residential treatment as a necessary service but also unavailable.

### **Issues:**

#### **What are the problems?:**

- 1) Lack of culturally competent, linguistically appropriate mental health services for the community in the Bronx.
- 2) Lack of services specifically addressing the issues of young boys and male adolescents exposed to violence.
- 3) Lack of services for mother-baby dyad that promote attachment when the mother exhibits post partum depression.
- 4) Insufficient funding for clinic –based mental health services.
- 5) Medical providers need training on how to identify mental health problems and refer to appropriate providers when necessary.
- 6) Many social workers, in underserved areas like the Bronx, are dealing with complex cases. Too often, the caseload that many of these professionals carry is beyond what is recommended to guarantee optimum care.

- 7) The prenatal period is an optimal time to address issues of depression, loneliness and the effects of parenthood yet it is a missed opportunity because of the pressures of providing care to patients that present with more obvious medical issues. Screening tools should be utilized at regular intervals during the prenatal period to ensure timely and effective referral to appropriate sources of care. Optimally, all patients should have a yearly assessment by a social worker.
- 8) Trauma and its attendant long lasting effects must be recognized and addressed by providers using a strength-based approach to care – the goal of mental health treatment and care is the eventual empowerment of the patient to address the presenting issues of violence, depression, isolation and other psychiatric issues.

### **Recommendations:**

#### **What can be done to address the problem?**

What do we have to do to address the issue on the community level:

- 1) Conduct information campaigns promoting the importance of a medical home to ensure continuity of care to children and youth dealing with mental health issues. The campaign will emphasize the importance of quality, accessible care which includes education, behavioral skills development, and other mental health associated care for the child and family offered in a holistic, comprehensive way.
- 2) Train pediatricians, family physicians and other providers to identify and address mental health issues with clients. This will allow for appropriate referrals to and engagement with mental health providers.
- 3) Recruit, hire and train social workers skilled in assessment and case management of clients with complex bio-psycho-social issues.
- 4) Mental health screenings should begin during prenatal care and should be offered at every appropriate opportunity during the pre and post natal period including the well child visits.
- 5) We recommend utilization of the adolescent health care model which provides comprehensive, confidential, and holistic services to young people. These services should be provided in a “one stop” environment, open hours that are convenient to youth, with staff attuned to and expert in engaging youth. We recommend that the Mt. Sinai Adolescent Center model be viewed as a best practice in the field of adolescent health care.
- 6) Lobby local elected officials to take action which will result in changes necessary to establish and fund programs to address mental health issues in the Bronx.
- 7) Educate parents about mental health issues.
- 8) Provide workshops for families on child development, early intervention programs and how to navigate the system including special education.
- 9) Provide more school-based mental health programs which will assist in identification of and treatment of mental health issues.
- 10) Establish mother/baby in-patient program for mothers with severe post partum psychiatric problems.
- 11) Increase the number of specific programs to target families and children who have experienced trauma. This would include families traumatized by involvement in the child welfare system including foster care placement and

families experiencing post traumatic stress disorder stemming from exposure to violence and other traumas.

- 12) Providers must understand and provide care which utilizes a strengths-based approach to the treatment and care of mental health issues for the children and families of the Bronx.

**Who needs to be involved?**

Parents/caregivers

Health care providers including hospitals, health centers, local providers, and insurers

Schools

Day Care centers, family day care providers and others engaged in the care and supervision of infants, children and adolescents.

Local elected officials – Office of the Borough President, Planning Boards, City Council members

Faith-based organizations

Mental health advocates

Submitted by The Bronx Health Link.

## **Brooklyn Child Health Coalition Policy Development Document**

### **Background**

New York City, vast in resources, information and diversity, continue to have communities that feel that their most vulnerable individuals still do not have access to quality health care, information presented verbally or in writing in a culturally competent or appropriate manner, or services provided in a coordinated manner. Families that access care, still have complaints of receiving fragmented services and/or referrals, and though they are in institutions that are health facilities often times, they are not confident that they have accessed all necessary services for themselves or their children.

### **Issues/Presenting Problems**

Based on feedback from the surveys conducted during the Child Health Clinic initiative, discussion groups held with teens, experience of coalition and community members, findings from the New York City Primary Care Initiative, the Brooklyn Child Health Clinic Coalition has identified three major areas of concern. The areas of concern are:

- Lack of quality care;
- Access to Care issues;
- Lack of service coordination within health facilities as well as intra-agency referrals.

While each of these areas is important, three case studies were presented, each of them with a myriad of problems, however the overarching problem of “access to care” was highlighted.

It is believed that while children may get into care, if they do not access all of the services at a health facility, and/or the quality of care, which includes heavily on how the parent or teen was treated, they will not access other services at the facility, nor will they be encouraged to discuss their other needs.

### **Recommendations – Community level**

When investigating “access to care” issues, it must be recognized that quality of care issues directly impact access to care and exploration of system barriers, if addressed, may positively impact access to care issues. The following must be taken into consideration, when broaching this subject, at an individual, health care facility, inter-agency level and community level.

This information was gathered through administering the surveys, during coalition meetings and/or discussion groups, etc.

- Welcoming of staff at health care facility
- Time spent waiting to be seen at health facility,
- Difficulty in making appointments
- Professionalism or lack thereof;

- Providers needing to be patient friendly in terms of relaying information
- Language capacity, one language specific mentioned was lack of Arabic speaking doctors in the area;
- Culturally appropriateness;
- Fragmented referrals
- Transportation (travel time/expense, location of service)
- Lack of trust of the caregiver, and concerns of confidentiality

While the Brooklyn Coalition recognizes that they can not address all access to care issues, the consensus of the group is to **focus on a pilot project at one health care facility**. In so doing, it's the expectation of the Coalition that service coordination and quality of care will also be addressed in the context of "access to care". **The pilot will focus on the development of a Patient Navigation System (PNS).**

Overall, the system will build relationships within the facility and externally as well as track the families' services.

The system will seek to ensure that:

- A person onsite can assist patients by making sure they receive all services necessary onsite;
- All individuals are treated with respect and in a professional manner;
- Any problems, concerns are addressed prior to leaving the site, including the way the family was treated;
- Ensure that patients has a clear understanding of visit before leaving healthcare facility;
- Any referrals made are explained to the parent/teen;
- All referrals to return for care and/or to another facility (specialty care) are coordinated with other possible referrals for other children in family (if appropriate and possible) and convenient for the parent/teen;
- Transportation and resources needed to return for care and/or to keep an appointment offsite is explored with parent/teen in a non-judgmental way;
- As much as possible one provider/team is seen by the family on a consistent basis;
- All of the patient's questions were answered in a way they understood; and
- Other as needed

**The system is recommended to include:**

A Patient Navigator/Health Care Access Counselor, whose responsibilities are to:

- educate the patient(s)
- help coordinate referrals and other related services that patient may need
- ensure that all of the family's medical needs are addressed

**Others involved:**

- All staffing at facility
- Coalition members to promote pilot and engage others to adopt
- Administrative and policy makers to look at pilot for replication

**Desired outcome:**

- Address all services available on site
- Coordination of all aspects of care
- Developing a one stop shopping model (multi-service center)

Submitted by the Brooklyn Perinatal Network.

## **Manhattan Child Health Coalition Policy Development Document**

### **Issue Area: Nutrition**

- 1) We must formalize programs with public schools that have nutritionist, physicians, nurses and fitness experts come into schools to educate students and parents.
- 2) Investment in safe and clean green spaces in underserved neighborhoods so children have a place to play and exercise.
- 3) Have better meals served at schools, with tasty low fat foods served. Department of Education (DOE) should partner with Doctors, Providers, and nutritionists to work together in menu planning.

Issues:

### **What are the problems?:**

- 1) The underserved don't have access to nutritionist who can teach proper eating habits.
- 2) Need cleaner air, and better living environments.
- 3) Kids don't have enough recreational parks/areas to play and burn off calories.

Recommendations:

### **What can be done to address the problem?**

#### **Community-level**

- a) Safety Empowerment Zone
- b) Mandatory School workshops
- c) Public Hearings

What do we have to do to address the issue on the community level?

We must incorporate a basic youth health maintenance management workshop for teachers as part of their annual continuous education curriculum.

Collaborate with the public health sector to expand school based clinics in Harlem and the Washington Heights residential areas.

#### **Who needs to be involved?**

We should involve children, parents, DOE, and other stake holders.

If we can't get the school system to pay for some of these interventions, we might look at retired folks nutritionist, nurses, and physicians who would form a coalition to not only be watchdogs but also to be the actual providers of workshops on nutrition, physical activity, health concerns, etc.

#### **Desired outcome:**

- a) We would like to see early intervention programs, so that parents get the necessary information about their child's health. This will help those parents who claim their children are medically neglected get the tools needed to help their family's health.
- b) Bring in more supermarkets, grocery stores, and bodegas to underserved neighborhoods that sell nutritious and affordable food.

- c) We would like to see parents become more knowledgeable about what foods their children eat at home and are eating in schools during the day.

**City level**

- a) That our ideas are funded by the City to have them implemented in all schools.
- b) With our success the City can fund all schools in all boroughs
- c) The city would fund us around the establishment of a comprehensive school system for elementary schools

**What do we have to do to address the issue on the city level?**

Public Hearings

Community Board meetings

**Who needs to be involved?**

Elected Officials, City Officials, Department of Education parents, children, and other stake holders

**Desired outcome:**

- a) We get funded for the above project and it gets implemented city-wide

Submitted by the Northern Manhattan Improvement Corporation.

**Manhattan -- LES and Chinatown  
Policy Development Document**

**Issue Area: Asthma**

**Facts:**

- 1) 25 out of 67 surveys reported asthma (37%)
- 2) Contributing factors may include fumes from heavy traffic going to New Jersey through Holland Tunnel because many try to avoid paying Staten Island bound tolls at the Verrazano Bridge.
- 3) Another factor may include toxic air pollution following the collapse of Twin Towers.

Issues:

**What are the problems?**

As reported by coalition members:

- 1) Language barrier. For Chinese parents, there is an added barrier among different dialects.
- 2) Unable to navigate the health system. Immigrants often get lost in the maze.
- 3) Significant numbers of children have no regular check-up.
- 4) Promotion of existing health facilities in the community is needed. Public health facilities such as child health centers need to operate on a more convenient schedule for residents.
- 5) Specific diseases which are low among the general community, but high among certain ethnic groups, should be attended to, e.g. hepatitis B among Asians.

- 6) Mental health counseling among teens is needed. Related issues include sexual harassment for girls, bullying in schools for both boys and girls and confidentiality of health issues for teens.

Recommendations:

**What can be done to address the problem?:**

**Community-level**

- a) More translators are needed. Laws on right to translation need to be adhered to.
- b) Assistance and programs on Medicaid navigation should be offered.
- c) School nurses should work with community to present health education to children.
- d) Child health centers should become public health education sites and be integrated into the surrounding community.

**City level**

- a) Provide health education in schools with collaboration from community based organizations.

Submitted by the IndoChina Sino Community Center.

## **Queens Coalition for Healthy Families Policy Development Document**

Queens Coalition for Healthy Families presents the following Policy Development Document addressing some of the primary concerns around health access and care in the borough of Queens. While these are issues of most concern in light of recent research, surveys, and focus groups conducted in 2008, there are many more issues that persist and continue to pose challenges for families and children to access care in addition to health concerns that need to also be addressed. Families with foreign born parents and US born children face unique challenges when attempting to access care for their children. Cultural and linguistically sensitive services are key to connecting immigrant families to much needed health care for the whole family.

### **Demographics:**

The population of Queens is almost half foreign born, according to the NY Census 2000. Hispanics or Latinos make up 25% of the foreign-born Queens population, while the remaining 75% is composed of Asian (Chinese and Korean), South Asian, Filipino, and Haitians.

### **Issue area: Asthma, Obesity/Overweight, and Access to Care**

#### **Facts in brief:**

In a 2006 study on the health of immigrants in New York City, data suggests that foreign-born New Yorkers who have lived in the U.S. for four years or more report worse health than more recent arrivals (24% vs. 17%) and that they are more likely to be obese (16% vs. 12%).<sup>39</sup>

The leading causes of hospitalization in Queens for all age groups are similar to those in New York City as a whole, but the rates in Queens are generally somewhat lower. For children aged 9 years and less, asthma remains the leading cause of hospitalization. Pregnancy and related conditions, asthma and mental disorders are major causes of hospitalization among adolescents aged 10-17.<sup>40</sup>

#### **Issues:**

- Asthma, dental and obesity/weight issues were among the biggest concerns parents had with their children's health.
- Access to care and culturally/linguistically sensitive services were seen as persistent obstacles to access care for children in Queens.
- ER visits were high in Queens due to a variety of issues, among them lack of a medical home, lack of clear communication with physicians, maltreatment by clinic staff, distance and wait time (even with an appointment).

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<sup>39</sup> New York City Department of Health and Mental Hygiene. *The Health of Immigrants in New York City*, Take Care New York, The Commonwealth Fund; June 2006.

<sup>40</sup> New York City Department of Health and Mental Hygiene, Queens Borough Profile. 2002-6.

- Translation services; parents claimed they were either not offered any translation services or the services were limited and mediocre (making parents question quality of service).
- While some community members had little difficulty applying for public health benefits, they did find it very difficult to maintain their coverage. Recertification was a bigger challenge, especially if they did not receive recertification documents, their documents did not reach HRA by the deadline, or errors on the recertification document made it difficult to do it by mail (parents had to take time off work to walk-in documents to HRA offices).
- Children do not have many healthy options for school lunches.
- Children don't seem to get enough exercise at school.
- There are not enough after school programs where children can get more physical activity.
- There are not enough open park spaces where children can run and do sports, there are just a lot of the playgrounds.

**Specifically for Youth:**

- School safety and support for newly arrived immigrant youth.
- Integration support for youth and parents.
- Access to information for sexually active youth.
- Confidentiality for sexually active youth.

**Focus Group Comments:**

“It would be great if Doctors could spend more time with my kids, sometimes I feel like I spend more time in the waiting room than with the Doctor.”

“I wish there were more services for my (special needs) child, because I have to travel far just to get him to his specialist.”

“I don't like the way some of the clinic staff and the people at the Medicaid office treats us. They make you feel like you don't deserve health insurance. I don't think they care about their job either.”

**Recommendations**

**Community Level:**

- Community clinics must be pro-active in the care of children inside and outside of the clinic, such as home visits, phone calls, more accessible hours of service, walk-in service hours and community education projects.
- Community clinics should collaborate closer with community-based organizations, schools, churches, day-care centers, and other community institutions that work closely with low-income and immigrant neighborhoods.
- Schools need to provide more after school programs around physical activity. School counselors should also know more about where to take our children to get medical attention, immunizations, and information on specialized health issues.
- Clinics need to continually train their staff on cultural and linguistic sensitivity.
- Clinics and hospitals need to make it easier for patients to complain about services and treatment.

- Health education campaigns should be launched in order to teach the community about different health issues and risks, including emergency services.
- More counseling needs to be provided to youth who need it.

**City Level:**

- Councilmembers should pay more attention to what is going on in their borough around children’s health.
- Schools city-wide should incorporate more health issues and topics into their curriculum (especially with older youth).
- Schools city-wide should try to provide healthy lunches and more physical activity during and after school.
- No more child health clinics should be closed, more should be opened.
- Queens needs more specialty clinics for children, like dental, dermatological, and specialized care for disabled children.
- Schools should also try to offer some sort of dental care.
- Immigrant fears and concerns around confidentiality must be advertised and patients reminded that all services are confidential.

**Who needs to be involved?**

- Community Health clinics
- Private providers
- Hospitals, doctors, nurses, support staff, security guards
- Community-based organizations
- Schools: Counselors, Teachers, Principals, and Security Guards
- Day Care Centers
- Churches and other religious institutions
- Police/Fire Departments
- Business owners
- Community residents
- Local elected officials, their staff and planning/community boards.

**Note:** During the discussion of these concerns/issues and how to address them, community organizations that work with low-income and immigrant families, community members, providers and youth stressed that a medical home is essentially comprehensive care in a community environment that provides medical attention and support beyond the walls of the clinic. Health education, follow-up care and check-ups via phone calls or letters, home visits, medical attention at schools and counseling were among the many ways that were discussed that a medical home would support growing up in a healthy and community environment. It is desired that medical attention for children sincerely “care” for the growth and development of children and youth into healthy adults.

Submitted by Make the Road New York.

## **Staten Island Family Health Coalition Policy Development Document**

### **Issue Area: Access to Treatment**

#### **Facts:**

- 1) There is very limited access to specialty care for children and families on public health insurance on Staten Island. Such specialty care is virtually only available through voluntary hospital based clinics. Some specialty care is available only a couple of hours every month.
- 2) There is no easy access to primary care except for FQHCLA/CHCR (Federally Qualified Health Center Look-Alike/Community Health Center of Richmond) and HHC mobile medical unit on Staten Island for poor uninsured persons.
- 3) No hospital based clinics nor the CHCR FQHCLA currently offer urgi-care.
- 4) There is no easy access to diagnostic and specialty care for indigent uninsured persons on Staten Island.
- 5) There is no low cost prescription plan for uninsured poor persons on Staten Island.
- 6) There is only one high school-based primary care clinic on the Island.

#### **Issues: What are the problems?**

- 1) Without access to urgi-care, child or adult recipients of public insurance or uninsured poor persons who are sick, may have to wait 2 -3 weeks for an appointment.
- 2) People are forced to utilize an exorbitantly expensive ED as an urgi center for minor illnesses; thereby increasing debt to the family and increasing usage of an already over-taxed emergency care system.
- 3) People end up self treating or spreading disease to others.
- 4) Without adherence to medication, people will not effectively complete their course of treatment.
- 5) Medication costs are exorbitant and totally unmanageable for the poor.
- 6) Without a public funded low cost prescription plan for the uninsured poor, the parents of impoverished children cannot access medication to complete a course of treatment for their own illness, which negatively impacts family health and care.
- 7) People can not, and should not have to, go off of Staten Island to secure low cost medication.
- 8) The uninsured poor have to travel to Brooklyn or Manhattan to receive diagnostic and specialty care, placing a severe transportation burden and making the care inaccessible.
- 9) Lack of continuity of care is a problem, especially if primary or tertiary care is received in one health care system on Staten Island and diagnostic and specialty care is received in another health care system off of Staten Island.
- 10) Waiting for specialty care appointments (up to seven months for dermatology, for example) results in poor health outcomes for child and adult recipients of public health insurance.
- 11) On Staten Island, persons without insurance cannot afford to seek preventive primary care.
- 12) There are very limited venues for accessing low cost or free health care for the uninsured poor.

13) Local schools as clinics are an innovative approach to engaging adolescents to become conscious and deliberate participators in their own health care. The high school based health clinics serves to address adolescent health care needs in a trusted environment. The clinic model is also an accessible venue and one stop shopping model for poor parents and especially new immigrant families who have already developed a trust relationship with their children's school. With a lack of outpatient clinic services in many poor neighborhoods on Staten Island, such a neighborhood based clinic option is a viable way to deliver integrated primary care for adolescents and their family members.

### **Recommendations: What can be done to address the problem?**

#### **Community-level**

We need to negotiate re-deployment of medical personnel to serve a 'drop in', walk in model of medical care for some portion of each day or each week. We need to work with HHC to develop and expand capacity for diagnostic and specialty care services on Staten Island for the uninsured poor and child and adult recipients of public health insurance.

- a) Advocate for urgent center hours at the HHC child health stations
- b) Advocate for urgent center hours at the CHCR.
- c) Advocate for urgent center hours at the voluntary hospital based clinics
- d) Advocate for increased clinic hours and additional specialty options for specialty care
- e) Advocate for increased reimbursement pool and special grant based funding for diagnostic and specialty care.
- f) Advocate for simple diagnostic services to be made available at Seaview Hospital (HHC facility)
- g) Long term, work with HHC to develop services at planned HHC diagnostic and specialty care centers at 51 Stuyvesant Place and 75 Vanderbilt Ave.
- h) Make widely available in the community information on the new sliding scale fees of hospital based and community based clinics according to Manny's Law.
- i) Monitor the implementation of Manny's Law.
- j) Advocate for increased capacity for primary care for the uninsured. We need to work with HHC to develop and expand specialty and diagnostic services on Staten Island for the uninsured poor and adult and child recipients of public health insurance.
- k) Advocate with HHC for a temporary plan for on-island diagnostic and specialty care for poor uninsured Staten Islanders
- l) Advocate for long term plan implementation for on-island diagnostic and specialty care for poor uninsured Staten islanders and adult and child recipients of public insurance
- m) Advocate for community medicine and loan forgiveness programs on SI to insure a pool of specialist doctors are attracted to serve in the Staten Island community and are willing to accept public insurance.
- n) Establish a low cost prescription plan on Staten Island.
- o) Widely disseminate information on enrollment and facilitate wide enrollment in prescription plan.
- p) Ensure that cost of medication does not exceed \$2 per prescription and that the plan includes psychotropic medication.

- q) Conduct a survey of high schools to determine interest in creating school based clinics.
- r) Advocate for funding of such a high school clinic at Port Richmond High School.

**Who needs to be involved?**

HHC, NYCDOHMH, NYS DOH, Board of Education, hospital administrators, CHCR administration, elected officials, health advocates and consumers, high school administrators, students and family members.

**Desired outcomes:**

- a) Establishment of urgi center hours at HHC child health stations in evening and on weekends.
- b) Establishment of urgi center hours at CHCR in evening and on weekends.
- c) Establishment of urgi center at hospital based clinics.
- d) Increased venues for primary care for the uninsured poor on Staten Island.
- e) Successful implementation of Manny’s Law.
- f) Reduced billing and debt to uninsured poor seeking medical care.
- g) Increased clinic hours for specialty care
- h) Establish temporary reimbursement pool for hospital based specialty and diagnostic care
- i) Establish long term solution for specialty and diagnostic care on Staten Island for uninsured and public insurance recipient families.
- j) Completion of a high school survey on school health clinics and dissemination of results.
- k) Established, accessible low cost prescription plan for the uninsured poor
- l) Inclusion of psychotropic medications in the prescription plan.

**What do we have to do to address the issue on the city/state/federal level?**

We need to negotiate with HHC and with the NYS DOH and HHS for increased reimbursement pools and special grant based funding. We need to participate in long term planning for indigent health care on Staten Island.

**City/State/Federal level**

- a) Establish urgi-center model for a portion of time at the soon to be established HHC primary, diagnostic and primary care centers.
- b) Establish urgi-center model for a portion of time on new mobile medical unit for Staten Island.
- c) Establish urgi center model for a portion of time at current FQHCLA/CHCR.
- d) Secure additional primary care capital funds for primary care expansion of CHCR sites on SI.
- e) Secure additional reimbursement pools for indigent health care with higher caps.
- f) Secure additional operational funds for primary care expansion on CHCR sites on SI.
- g) Secure expanded HHC primary care venues on Staten Island.
- h) Increased clinic hours for specialty care
- i) Establish temporary reimbursement pool for hospital based specialty and diagnostic care

- j) Advocate for long term implementation on-island plan for diagnostic and specialty care for the poor uninsured Staten islanders and adult and child recipients of public insurance
- k) Advocate for community medicine and loan forgiveness programs on SI to insure a pool of specialist doctors are attracted to serve in the Staten Island community and are willing to accept public insurance.
- l) Advocate for funding allocation to subsidize prescription program.
- m) Establish low cost prescription plan for uninsured Staten Islanders.
- n) Secure funding for Port Richmond High School clinic.

**Who needs to be involved?** HHC, local health advocates, elected officials at all levels of government, health care administrators, consumers

**Desired outcome:**

- a) Establish urgi center model for a portion of time at the soon to be established HHC primary, diagnostic and primary care centers.
- b) Establish urgi center model for a portion of time on new mobile medical unit for Staten Island.
- c) Development of additional CHCR/FQHC primary care clinics on Staten Island
- d) Development of additional HHC primary care clinics on Staten Island
- e) Increased indigent care reimbursement pool for Staten Island
- f) Continued access to specialty and primary care for poor uninsured on Staten Island (SIHA program to end 12/31/08)
- g) Support the opening of two planned HHC diagnostic and specialty clinics on Staten Island within 5 years.
- h) Increased pool of specialty doctors for community medicine programs on Staten Island.
- i) Establish low cost prescription plan for uninsured Staten Islanders.
- j) Secure funding for Port Richmond High School clinic.

**Staten Island Family Health Coalition  
Policy Development Document**

Issue Area: **Treatment for Special Needs Populations**

**Facts:**

**Mental Health**

- 1) There are only six inpatient psychiatric beds for children and adolescents on Staten Island
- 2) 24% of all inpatient children and adolescents with psychiatric illnesses are served in other boroughs due to lack of beds

**HIV/AIDS**

- 1) With the closing of the Richard Bayley AIDS Designated Center and HIV Pediatric Clinic at Richmond University Medical Center, Staten Island is now without an AIDS Designated Center and any HIV pediatric specialty care for pediatric populations. While Staten Island University Hospital has stepped up to the plate to integrate HIV+ children

into their adult HIV clinic, there is no infectious disease and HIV pediatric specialist serving the needs of these children.

2) Without an AIDS designated center and without a special needs plan serving any of Staten Island hospitals, children and adults with HIV are not able to fully participate in the soon to be instituted mandatory enrollment into HIV special needs plan for Medicaid HIV+ patients.

### **Substance Use**

1) No substance treatment services are available for children and adolescents through public health insurance.

2) No outpatient mental health or substance treatment services (except for limited sliding scale services) are available for the uninsured poor on Staten Island.

### **Physically Disabled Children/Multiply Diagnosed Children**

1) There is only one designated primary care facility at Staten Island University Hospital South available to the public and equipped to handle physically disabled and psychiatrically disabled children who are in need of special physical facilities and specialized competency and sensitivity on the part of medical personnel.

### **Issues: What are the problems?**

1) Without access to inpatient treatment, children and adolescents are not able to receive full range of psychiatric services in their home community.

2) Without access to inpatient treatment in the home community there is a discontinuity of care.

3) Without HIV pediatric care, no specialist is overseeing or has ongoing experience in, new treatment regimens or a wider cohort of children with which to participate in clinical trials and other research with the goal of prolonging the onset of HIV disease in seropositive children.

4) Without the ability to fully treat children and adolescents with substance use problems, these children and adolescents in need will not receive the early intervention services needed to avoid the social, criminal and human cost factors of continued alcohol and drug abuse as they mature into adulthood.

5) Lack of access to outpatient mental health or substance treatment services for uninsured poor adults on Staten Island allows mental illness and substance abuse to go untreated in impoverished communities, negatively impacting family units, increasing impoverishment and negatively impacting the social fabric of the community. Lack of access also leads to increased alcohol and drug use and ultimately behavior that is physically destructive to the abuser and to others.

6) Lack of competency, sensitivity and primary care settings (including waiting areas) that are sensitive to the needs of multiply diagnosed children place multiply diagnosed/children at significant barriers to achieving quality health care for this population.

### **Recommendations: What can be done to address the problem?**

#### **What do we have to do to address the issue on the community level ?**

Work with the SI Mental Health Council and the SI Committee for Alcoholism and Substance Abuse Services. We need to secure grant based funding for outpatient

services and we need to identify state funding for the inpatient beds. We need to work with the Staten Island HIV CARE Network to advocate for HIV pediatric specialty care, AIDS designated center and SNPS exemption for Staten Island.

### **Community-level and city level response**

- a) Advocate for specialized unit for inpatient psychiatric services of children and adolescents.
- b) Advocate for funding for additional children and adolescent psychiatric beds
- c) Advocate for grant based funding for outpatient substance treatment and mental health services for uninsured poor adults on Staten Island.
- d) Advocate for substance treatment and mental health services for recipients of Child Health Plus
- e) Advocate for HIV pediatric specialty care on Staten Island
- f) Seek exemption for Staten Island from the NYS Special Needs Plan until such time as there are viable SNPS options available on Staten Island.
- g) Encourage a local hospital to apply to be an AIDS designated center.
- h) Advocate for a dialogue process between parent advocates, community provider advocates and health care administrators of multiply diagnosed children to develop a joint plan to address unmet primary care and specialty care needs of special needs children.
- i) Implement cultural competency and sensitivity training program for medical staff working with physically and psychiatrically disabled children.

### **Who needs to be involved?**

Hospital mental health administrators, SI Mental Health Council, Staten Island Committee for Alcoholism and Substance Abuse Services, SI HIV CARE Network and its Executive committee, S.I. Disabilities Council, officials from OMH, DOHMH, OASAS, health care, mental health, children and AIDS advocates and consumers

### **Desired outcome:**

- a) Develop 15 additional children and adolescent psychiatric beds on Staten Island
- b) Develop sufficient mental health and substance treatment services for children/adolescents Child Health Plus recipients
- c) Develop grant based funding for substance treatment and mental health services for uninsured poor adults.
- d) Offer some level of HIV pediatric care on Staten Island.
- e) Secure SNPS exemption or delay of SNPS implementation on Staten Island.
- f) Increase venues for HIV outpatient care on Staten Island

## **Staten Island Family Health Coalition Policy Development Document**

### **Issue Area: Coordination and Access to Care**

#### **Facts:**

- 1) Of the four primary care venues and two tertiary care venues for recipients of public health insurance on Staten Island, there is not one managed care plan that is accepted

by all the venues (SIUH, RUMCSI, HHC Child Health Station and Community Health Center of Richmond)

- 2) There is no patient navigator system for families who are recipients of public health insurance and the uninsured poor on Staten Island.
- 3) There are not sufficient culturally appropriate interpretation services available in health care venues on Staten Island.
- 4) Staten Island is under represented in designated city funding (often from state sources) for prevention, screening, testing, education and special and early intervention programs.
- 5) Because S.I. does not have a city hospital we do not have a rape crisis center in any ED on Staten Island, and we do not have a rapid HIV testing program in our ED's..

### **Issues: What are the problems?**

- 1) The delivery of culturally incompetent and linguistically inappropriate health services can result in misdiagnoses or in misunderstanding of course of treatment by the patient.
- 2) Patients with cultural and linguistic barriers from impoverished contexts are not always able to negotiate a complex and fragmented Staten Island health care system, resulting in less capability to utilize the health care system to its fullest to serve the patient.
- 3) The fragmented health insurance system makes seamless continuity of care impossible on Staten Island, placing barriers to health care for the most vulnerable and least able to advocate for themselves communities.
- 4) S.I. does not have access to an array of prevention, screening and testing programs that are funded by NYS DOH and administered by NYC DOHMH.
- 5) Without access to prevention, education and screening in the non English speaking and impoverished communities where lack of access to health care is prevalent, families will not be privy to the lifestyle and diet changes needed to prevent disease.
- 6) Families will not be able to access community based screening, testing, or participate in early intervention programs that may identify potential indicators for major illness, such as diabetes, hypertension, TB, HIV, STI's, etc.
- 7) Basic services such as rape crisis center intervention and HIV rapid testing in ED's allow access to much needed services in crisis situations that allow for early intervention and immediate connection to services.

### **Recommendations: What can be done to address the problem?**

#### **What can be done on the community level?**

- a) Advocate for increased interpretation services in outpatient and inpatient venues and in all prescription information literature, discharge instructions and other written health care documents.
- b) Advocate for health navigator services for Staten Island's non English speaking uninsured poor and their publicly health insured children.
- c) Advocate among CHCR, RUMC, SIUH and HHC to agree on health insurance plan to be shared by all.
- c) Advocate for funding of rape crisis and rapid HIV testing services on Staten Island and identify potential sources of funding.

- d) Meet with key stakeholders at CHCR, RUMC and HHC to gain commitment to at least one shared health plan and for the implementation of translation and health navigator services.
- e) Meet with elected officials and city and state officials to secure funding for rape crisis and rapid HIV testing services.

**Who needs to be involved?** CHCR, RUMC, SIUH, HHC, health advocates, consumers, hospital administrators, elected officials and medical professionals

**Desired outcome:**

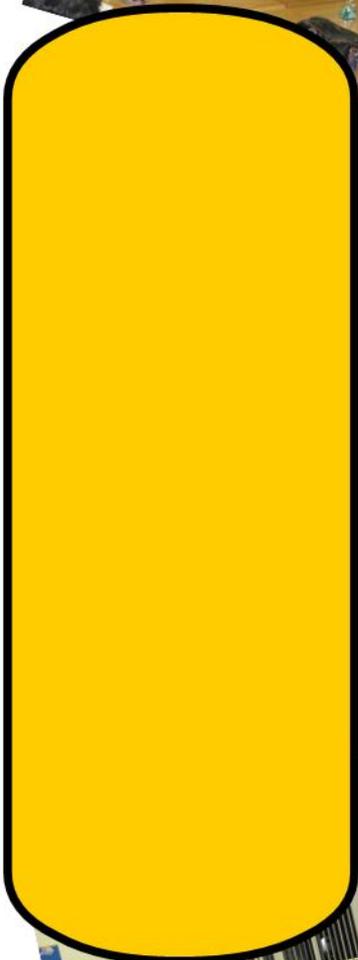
- a) One shared health care plan at HHC Staten Island clinics, CHCR and the voluntary hospitals of RUMCSI, SIUH.
- b) Increased use of interpretation services in all health care venues on Staten Island and in written documentation (discharge instructions, prescriptions instructions)
- c) Implementation of health navigator program for non English speaking uninsured poor and their publicly health insured children.
- d) Increased health literacy by the consumer population.
- e) Bring at least one testing or screening program to S.I. within the next two years.
- f) Develop a borough-wide plan for community education, prevention, testing and screening.
- g) Secure funding for prevention and education programs
- h) Rape crisis and rapid HIV testing services will be available in at least one venue on S.I.
- i) Revision of state and city RFP's for prevention, education and screening and intervention programs that include Staten Island or allocation across all five boroughs.

**What do we have to do to address this issue on the City level?**

- a) Advocate for acceptance of at least one common managed care plan for use at all three North Shore primary care venues.
- b) Advocate for funding to provide health navigator system for non English speaking uninsured poor and for their publicly health insured children.
- c) Advocate for funding for health literacy in native languages of non English speaking populations.
- d) Identify potential funding sources for prevention and education programs.
- e) Advocate for inclusion in city testing and screening programs designated for city hospitals only.

Submitted by El Centro del Inmigrantes.

# THE NEXT



# YEARS

