BUILDING BRIDGES TO

HEALTH & WELLNESS

A Community-Driven Health Report & Mapping Tool

Communities Together for Health Equity (CTHE)

CTHE MEMBERS

We express our gratitude to all our members, with special acknowledgment to the CBOs involved in the Overcoming Health Disparities Project (OHDP) and the dedicated Steering Committee (SC) members without whom this vital work would not have been possible.

- Adhikaar
- African Services Committee
- AIRnyc
- Arab American Family Support Center
- Arthur Ashe Institute for Urban Health
- Asian Community Care Organization
- Bait-ul Jamaat (House of Community)
- Bay Ridge Center
- Bronx Cooperative Development Initiative
- Bronx Health and Housing Consortium
- Brooklyn Center for Independence of the Disabled **(OHDP/SC)**
- Brooklyn Perinatal Network, Inc. **(SC)**
- Brooklyn Queens Long Island Area Health Education Center
- BWICA Educational Fund
- Caribbean Women's Health Association
- Center for the Integration and Advancement of New Americans **(OHDP)**
- Chhaya CDC
- Chinese-American Planning Council
- Christopher Rose Community Empowerment Campaign
- Coalition for Asian American Children and Families **(OHDP)**
- Commission on the Public's Health System **(SC)**
- Community Service Center of Greater Williamsburg
- Cooper Square Committee
- Council of Peoples of Organization, Inc.
- Damayan Migrant Workers Association
- El Centro del Inmigrante **(SC)**
- Emerald Isle Immigration Center
- Every Day is a Miracle
- Five Flags Co, Inc.
- Fort Greene Strategic Neighborhood Action Partnership
- Garden of Hope
- Good Old Lower East Side, Inc.
- Harvest Home Farmers Market
- Health People, Inc. **(SC)**
- Hope and Healing Family Center, Inc.
- IMPACCT Brooklyn
- India Home, Inc.
- Jahajee Sisters
- Jamaica Service Program for Older Adults
- Kings Against Violence Initiative **(OHDP)**
- Kingsbridge Heights Neighborhood and Improvement
- La Colmena **(OHDP)**
- La Jornada
- Latin Women in Action, Inc.
- Latino Commission on AIDS
- Manhattan Staten Island Area Health Education Center
- Mary Mitchell Family and Youth Center, Inc.
- Mekong NYC
- Minkwon Center for Community Action
- Muslim Sisters of Staten Island
- NAMI-NYC Staten Island
- National Working Positive Coalition
- Neighborhood Housing Services of Staten Island

- New York Memory Center
- New York Statewide Senior Action Council
- New York Tibetan Service Center
- Northern Manhattan Improvement Corporation **(OHDP)**
- Northwest Bronx Community & Clergy Coalition **(OHDP)**
- Picture the Homeless
- Polonians Organized to Minister to Our Communities
- RaisingHealth Partners (formerly Academy of Medical & Public Health Services **(OHDP)**
- South Asian Council for Social Services **(SC)**
- Staten Island Interfaith & Community Long Term Recovery Organization
- Staten Island Partnership for Community Wellness **(OHDP)**
- The Bronx Health Link
- The Hope Program/SSBx
- Undocublack Network **(OHDP)**
- Venture House
- Vision Urbana Inc.
- Voces Latinas, Inc. **(OHDP)**
- West Harlem Environmental Action
- Youth Action Programs and Homes, Inc.
- YWCA of Queens

We would also like to thank the authors for their contributions of this report: Camila Figueroa-Restrepo, Faven Araya, Isabel Nelson, Briana West, and Humberto Brown.

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INTRODUCTION

In the bustling city of New York, multiracial, multicultural, and multilingual realities exist, requiring a profound need to understand and address the underlying factors influencing health and well-being. This is particularly important among historically underserved and marginalized populations, including low income, communities of color, non-english speakers, youth, undocumented immigrants, LGBTQIA+, and people with disabilities, among others. These unique populations are oftentimes not adequately captured and represented in traditional community needs assessments conducted by larger institutions, resulting in disparities in access to needed resources and services, and thereby perpetuating systemic inequities.

Led by the Arthur Ashe Institute for Urban Health (AAIUH), Communities Together for Health Equity (CTHE) is a city-wide network of over 70 diverse community-based organizations (CBOs) formed in 2014, in response to the absence of meaningful community engagement in New York State's (NYS) healthcare delivery system transformation process. Utilizing a community-based participatory research (CBPR) approach to assess and address the social determinants of health (SDOH), we aim to ensure community voices are adequately and equitably represented in the design and implementation of a transformed healthcare system.

The foundation of our work is centered around a systematic approach to collaborative planning in which power is shared and decision making is based on group consensus. CTHE recognizes that people who have the highest risks, present the greatest needs, and are the hardest to reach, have learned from a history of institutionalized and systemic policies of exclusion not to trust the system. This report, developed and designed by CTHE’s grassroot CBOs, highlights the intersections among SDOHs, sheds light on the nuanced challenges vulnerable and marginalized groups experience, while also serves as a case study to demonstrate how CBOs collaboratively play an active role in assessing and addressing community needs.

With the support of the Mother Cabrini Health Foundation and the vision to create a healthier and more equitable city, it is our hope that this report provides essential insights to prioritize the most vulnerable populations, and empower policymakers, healthcare professionals, researchers, community members, and advocates to systematically integrate CBOs and the community in the design of interventions that foster transformative change.

OUR MODEL OF COMMUNITY ENGAGEMENT IN ACTION - INTEGRATING COMMUNITY VOICES

Aligned with the understanding that the closer to the community, the closer to an effective solution, CTHE has established a model of community engagement to actively integrate community voices into its approach.

1400 Over the course of two years, CTHE has reached over 1,400 NYC community residents who reflect a wide range of races and ethnicities, ages, languages spoken, and socioeconomic backgrounds. Our efforts involved assessing community needs, identifying priority issues, providing culturally and linguistically tailored education and resources, and creating spaces for community members to engage in community building activities to better understand and address SDOH. Integrating community input throughout each phase of the process has been integral to developing and implementing effective strategies to reach and engage diverse populations.

18 In 2021, a total of 18 culturally tailored educational workshops were hosted by CBOs citywide to facilitate dialogue around lived experiences engaging the healthcare system and assess for SDOH (n=537). Additional survey responses (n=378) were collected by leveraging the broader CTHE network, capturing a total of 915 completed needs assessments. Workshops were conducted in partnership with CBOs and held in-person and virtually, in the preferred language of respective communities, including Spanish, Mandarin, Bengali, ASL, Khmer, Vietnamese, and English.

In 2022, community voices were integrated into a refined approach of the SDOH assessment. Key enhancements include additional questions aimed at providing a more comprehensive understanding of the population's needs, demographics, and barriers to access essential services.

9 As a result, a series of nine community report-backs were conducted citywide, expanding the reach of the community needs assessment (n=506). This process facilitated a space for participants to provide their recommendations for needed interventions, leading to the development of a web-based resource guide, and a SDOH mapping tool featuring vetted information on healthcare resources and social services tailored to meet their specific needs. It also empowered them to serve as health advocates shaping local policies and practices aimed at improving health conditions, such as NYS's 1115 Medicaid Waiver.

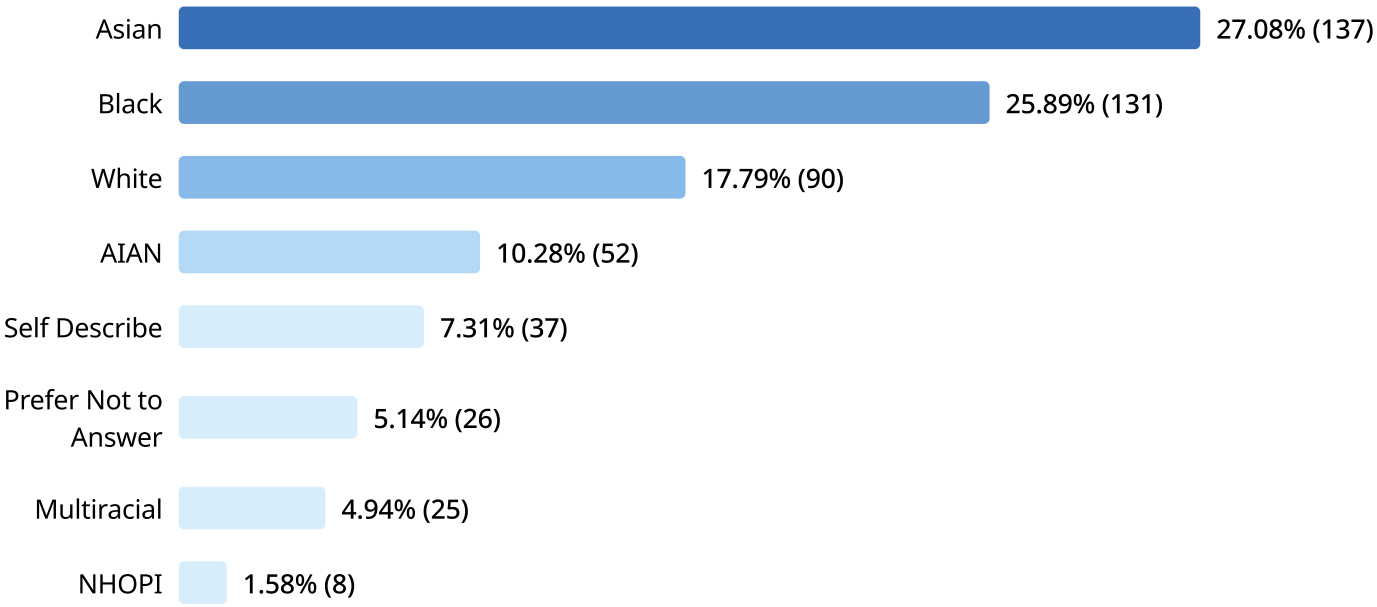
Additional details on the data collection and data analysis process can be found in Appendix A.

WHO WE REPRESENT

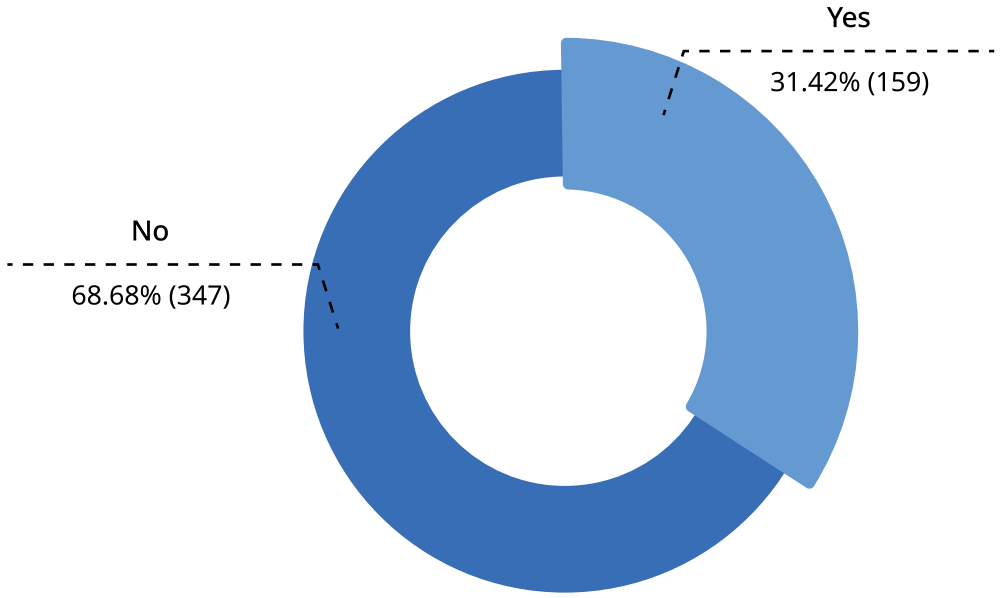
Understanding the demographic makeup of the communities served is essential for delivering culturally and linguistically appropriate care. This diversity enriches our cultural and nuanced understanding to better inform the delivery of healthcare, improve access to care, and inform policies that aim to address health disparities.

The following section highlights findings from the 2022 community needs assessment (n=506) This exploration is complemented by community voice (box in pink), additional data from our assessment (box in blue), as well as referenced comparison data from the most recent NYC Community Health Profiles (box in green).

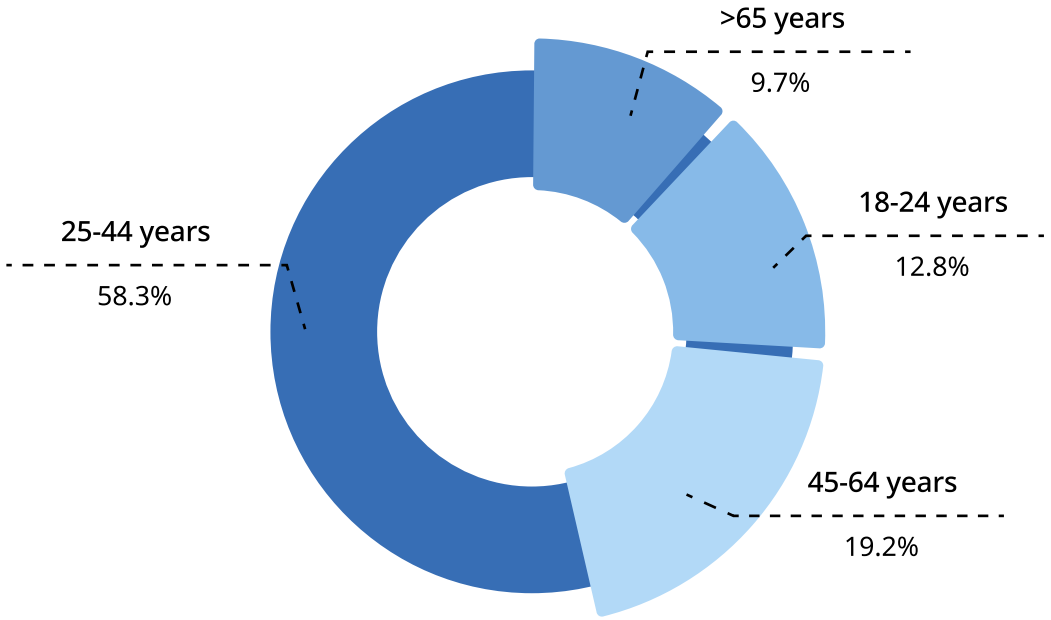
RACE / ETHNICITY



Identified as Hispanic/Latino-LatinX

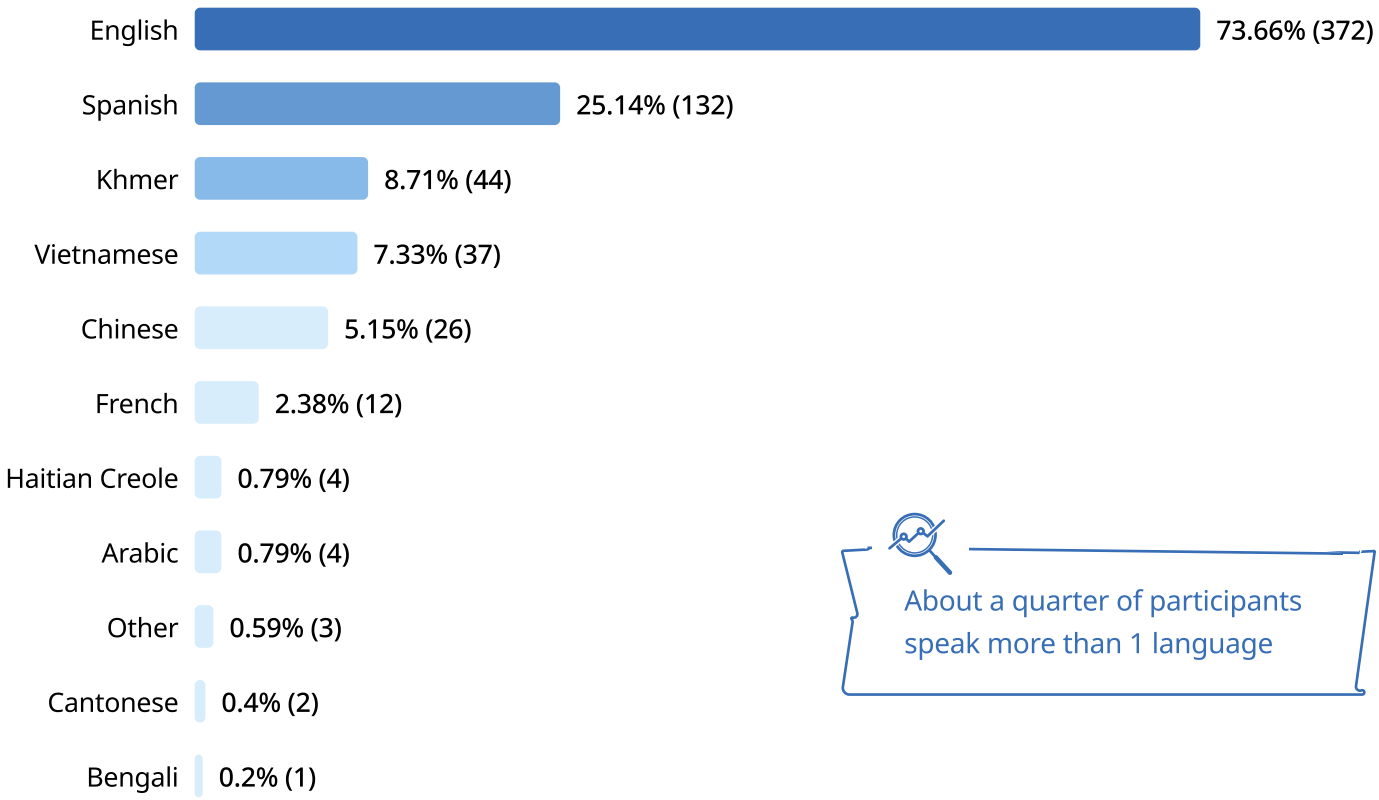


AGE



Compared to the NYC Community Health Profile, CTHE has a higher proportion of 25-44 year olds and 18-24 year olds.

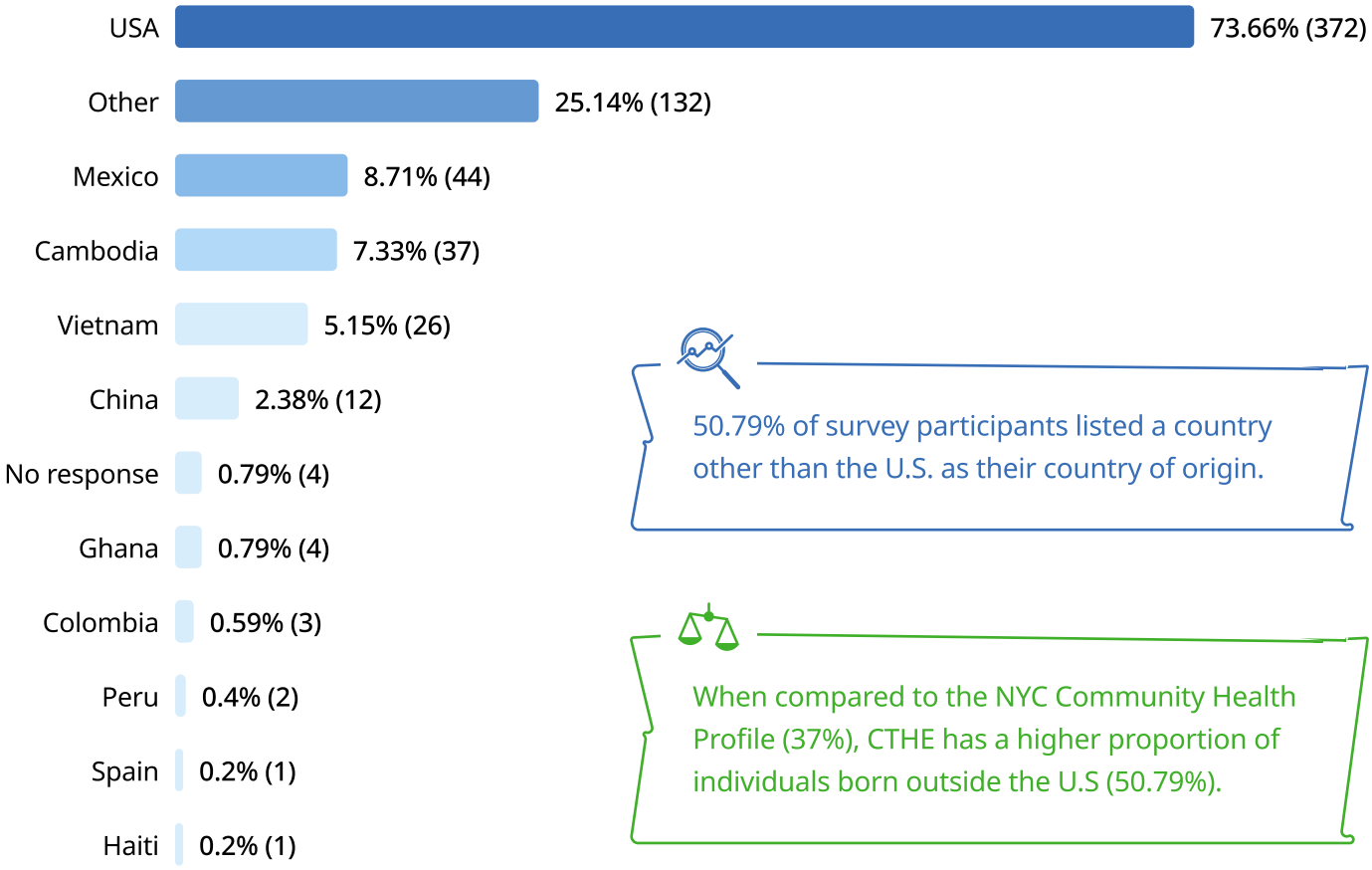
LANGUAGE SPOKEN



About a quarter of participants speak more than 1 language

**Participants could list more than one language so percentages will not add to 100. One participant left this question blank.*

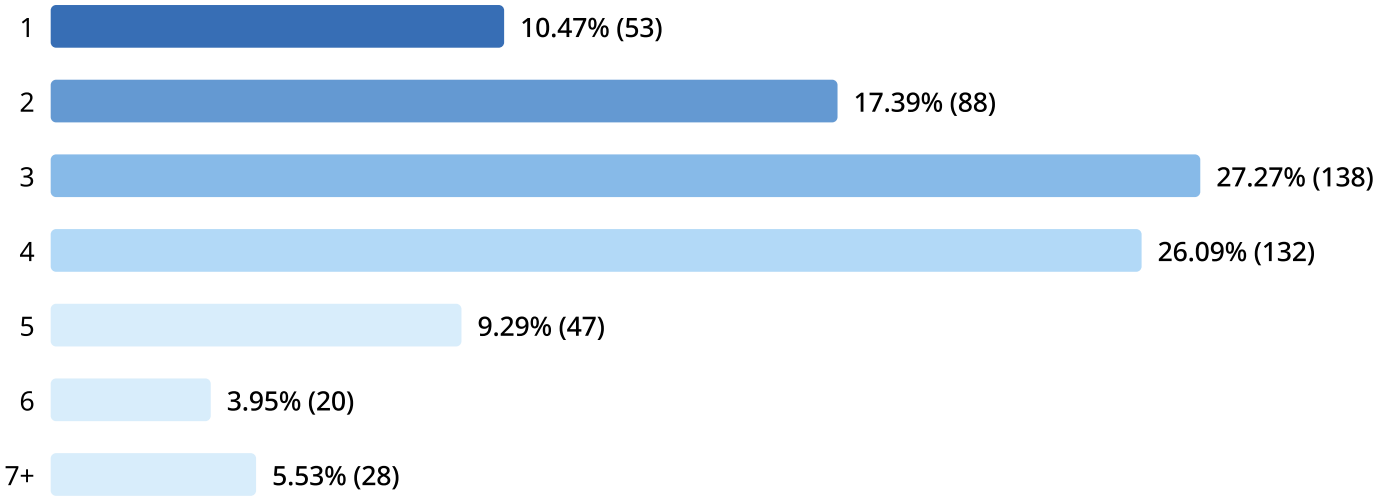
COUNTRY OF ORIGIN



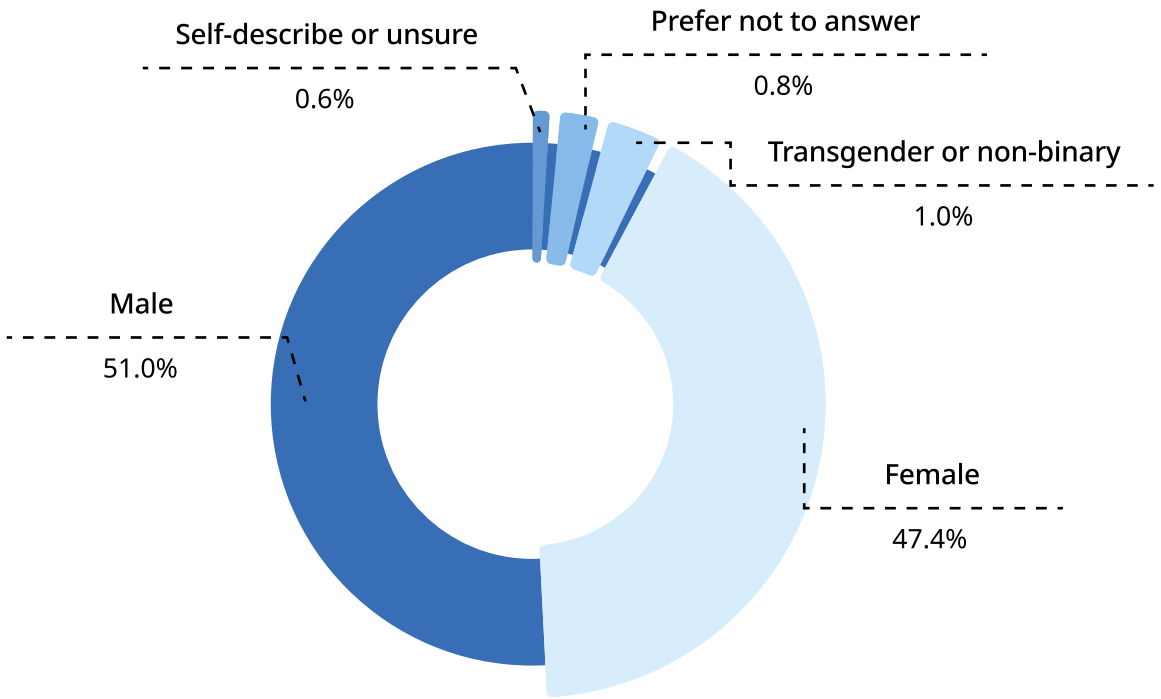
50.79% of survey participants listed a country other than the U.S. as their country of origin.

When compared to the NYC Community Health Profile (37%), CTHE has a higher proportion of individuals born outside the U.S (50.79%).

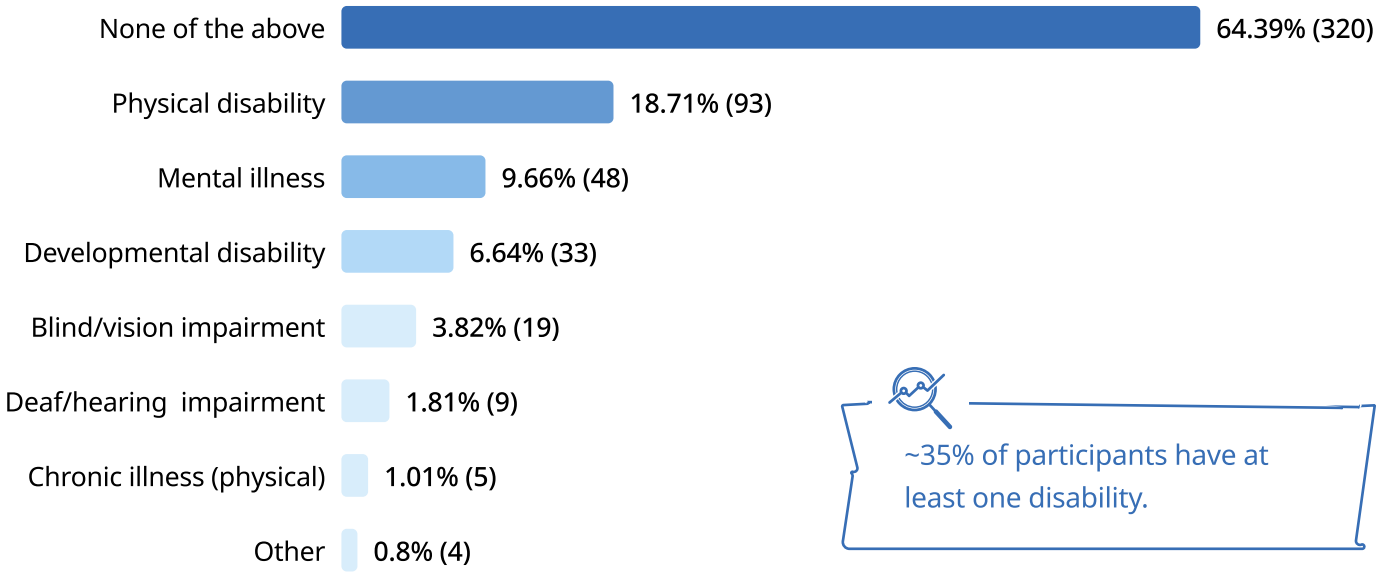
FAMILY/HOUSEHOLD SIZE



GENDER



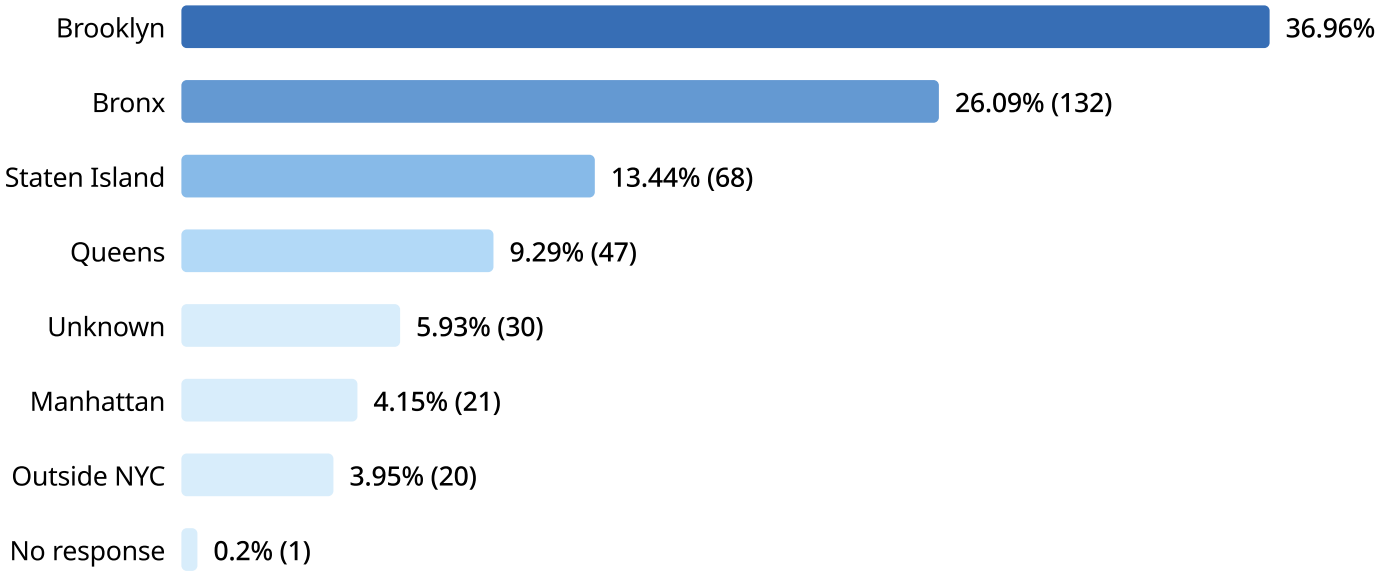
DISABILITY



~35% of participants have at least one disability.

**Participants could list more than one disability so percentages will not add to 100. 9 participant left this question blank.*

BOROUGH

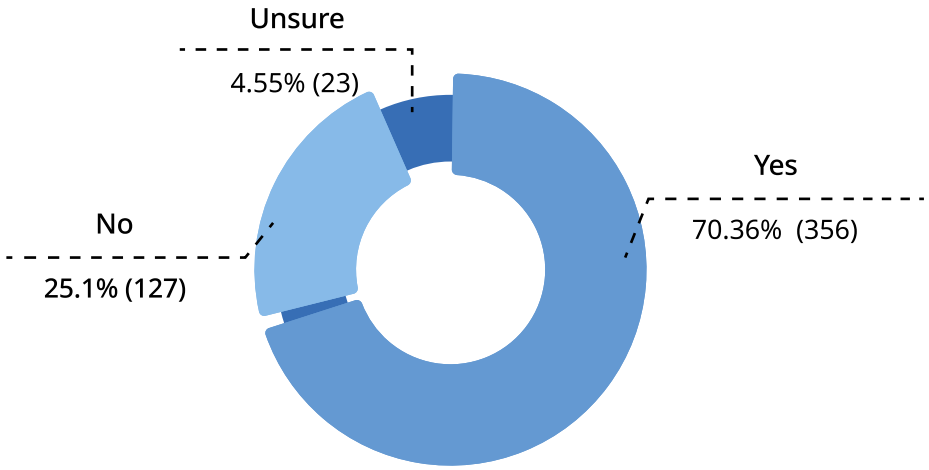

Brooklyn
36.96%
Bronx
26.09% (132)
Staten Island
13.44% (68)
Queens
9.29% (47)
Unknown
5.93% (30)
Manhattan
4.15% (21)
Outside NYC
3.95% (20)
No response
0.2% (1)

COMMUNITY NEEDS ASSESSMENT - FINDINGS 2022

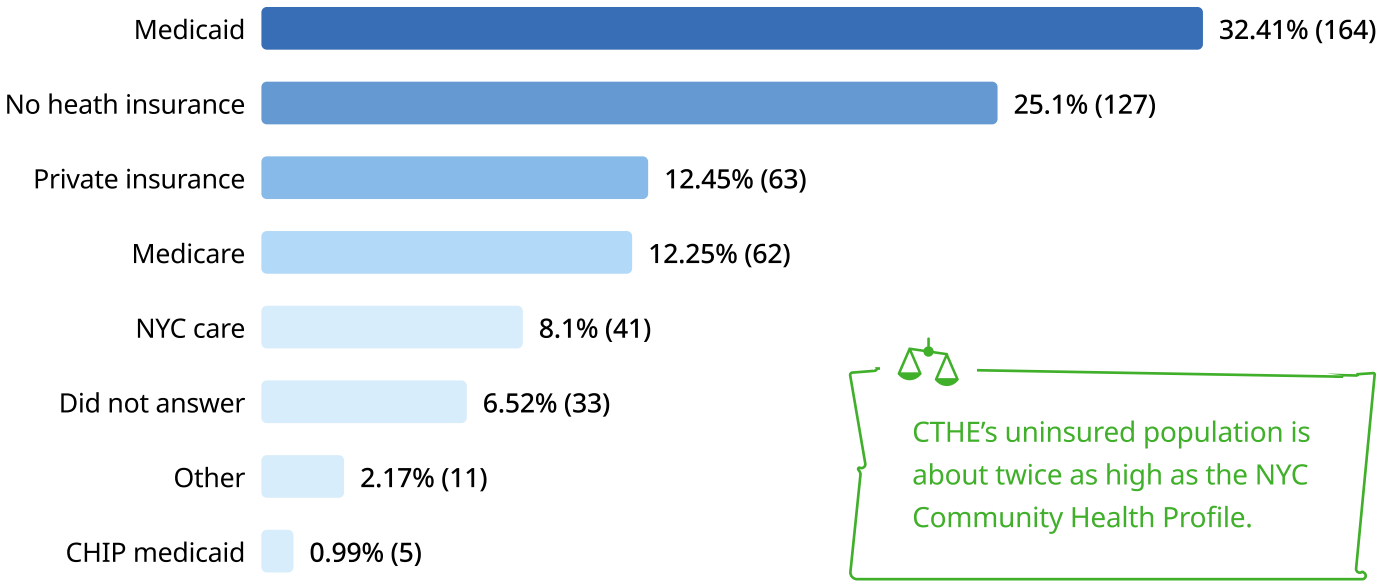
HEALTHCARE

HEALTH INSURANCE

Health insurance coverage is associated with improved access to health services. Uninsured adults are less likely to receive preventative services for chronic conditions such as diabetes, cancer and cardiovascular disease.[1]



Type of Health Insurance



CTHE's uninsured population is about twice as high as the NYC Community Health Profile.

**Participants could not choose multiple options so dual beneficiaries are not represented*

"Most of the time we don't have clarity on the type of insurance or coverage we have [...] I don't even know how to make an appointment [...]"

(Anonymous)

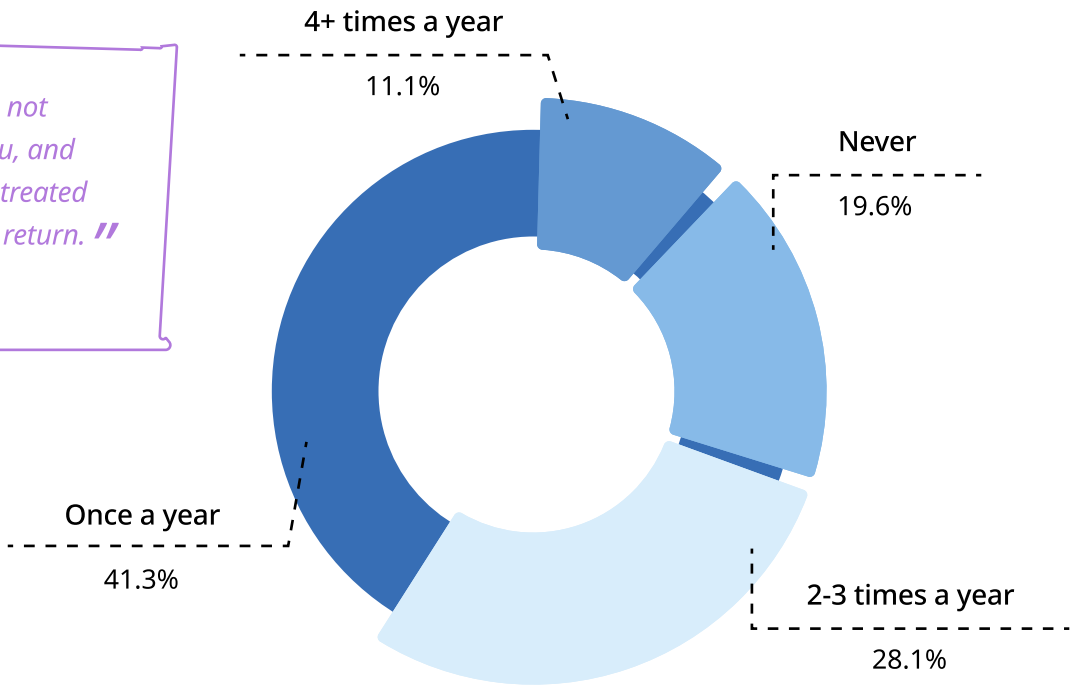
[1] Office of Disease Prevention and Health Promotion (n.d.). Access to Health Services. US Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

HOSPITAL UTILIZATION

Hospital admissions are an important contributor to health care costs and overpopulation in hospitals. Admission and readmission rates can also be an indicator of poor health status. [2]

Hospital Visits

> *"The hospital does not explain things to you, and instead you feel mistreated and discouraged to return."*
>
> *(Anonymous)*

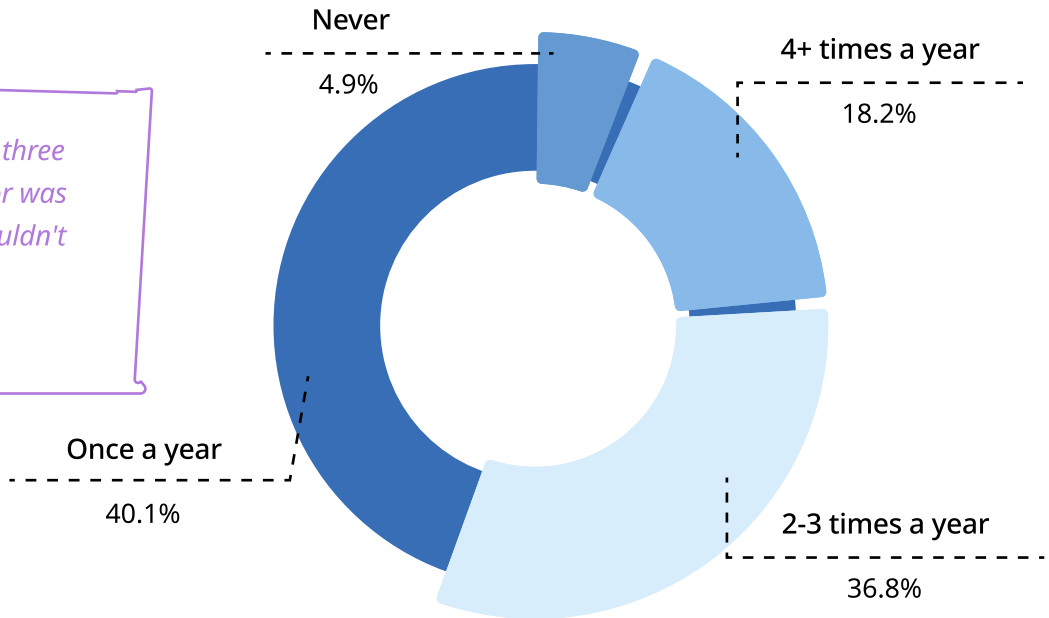


PRIMARY CARE UTILIZATION

Regular visits to a Primary Care Provider (PCP) helps prevent, detect and manage disease and illness. [3]

Primary Care Visits

> *"I had to reschedule three times. Then, the doctor was so busy that year, I couldn't see the doctor."*
>
> *(Anonymous)*

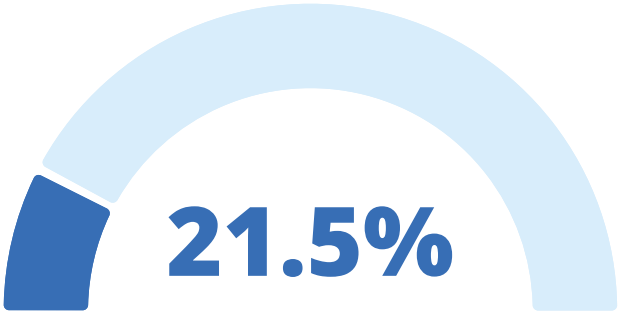


[2] Huang, M., Van der Borght, C., Leithaus, M., Flamaing, J., & Goderis, G. (2020). Patients' perceptions of frequent hospital admissions: a qualitative interview study with older people above 65 years of age. BMC geriatrics, 20, 1-12.

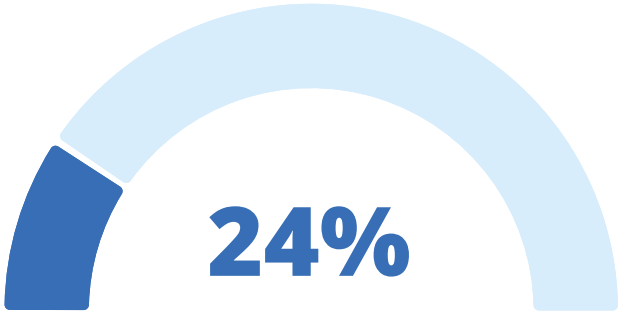
[3] Office of Disease Prevention and Health Promotion (n.d.). Access to Health Services. US Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

BARRIERS TO HEALTHCARE

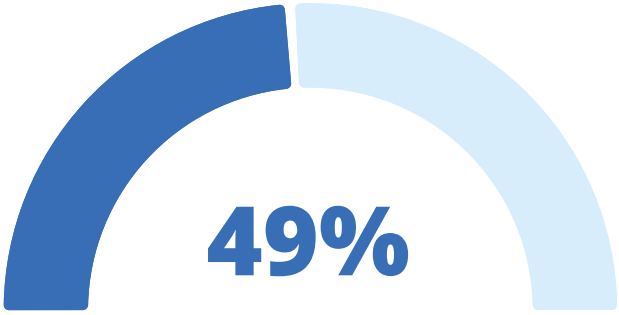
Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities. [4]



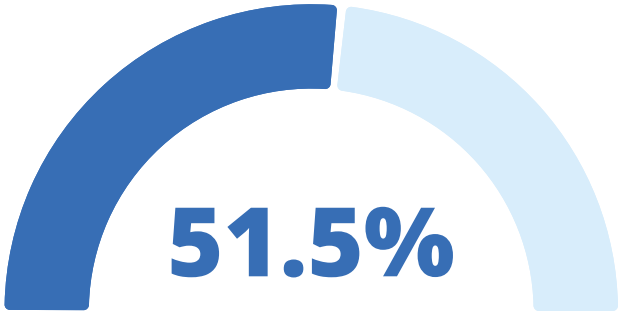
of participants **do not feel confident using the internet** to make health decisions



of participants always or often have **difficulty understanding information** about health status



of participants say **unreliable transportation is a barrier** to healthcare, work or getting things for daily life



of participants say **childcare problems** sometimes or often make it difficult to access healthcare

" I have experienced a lot of those barriers [...] Some [providers] have poor bedside manner. And all of this it's making you more sick than what you came in there for" "It's not just one experience, it's kind of this cumulative impact. "

(Anonymous)

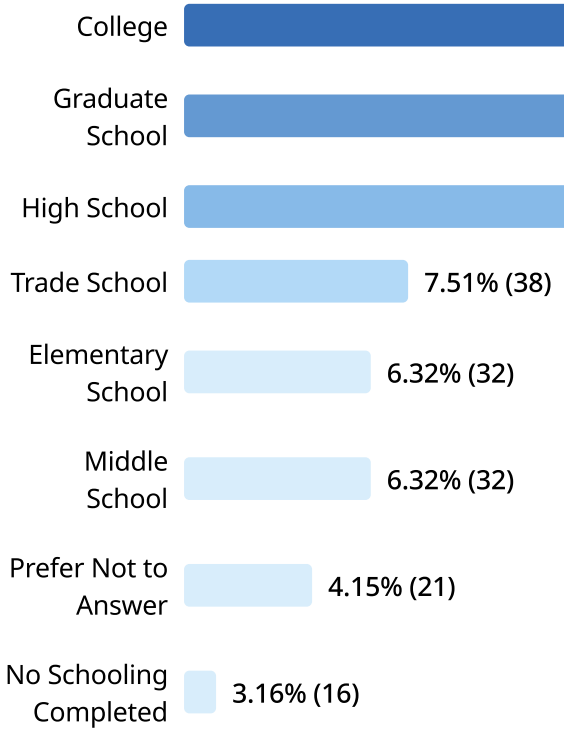
[4] Office of Disease Prevention and Health Promotion (n.d.). Access to Health Services. US Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services

SOCIAL DETERMINANTS OF HEALTH (SDOH)

SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. [5]

EDUCATION

Higher education levels have been linked to better health across the lifetime. [6] [7] Education impacts a person's literacy, employment opportunities, and access to insurance, all of which can influence health. [8]



Among survey respondents, 53.0% have completed at least a college degree.

Among New York City residents, 44% have completed at least a college degree, according to the NYC Community Health Profile.

"When you go to the hospital as a minority, usually there is an assumption from the provider that you are uneducated, that you may not understand much about what you came to the hospital for."

(Anonymous)

[5] Office of Disease Prevention and Health Promotion (n.d.). Social Determinants of Health. US Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health

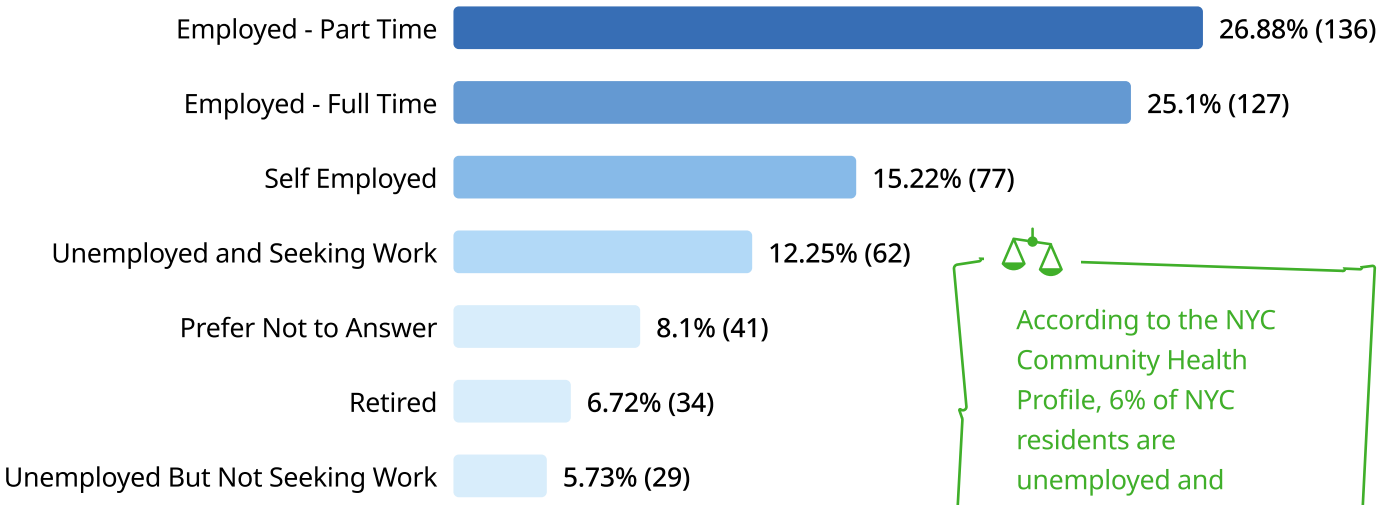
[6] Wu, Y. T., Daskalopoulou, C., Terrera, G. M., Niubo, A. S., Rodríguez-Artalejo, F., Ayuso-Mateos, J. L., ... & Prina, A. M. (2020). Education and wealth inequalities in healthy aging: a population-based study of eight harmonized cohorts in the Ageing Trajectories of Health: Longitudinal Opportunities and Synergies (ATHLOS) consortium. The Lancet. Public health, 5(7), e386.

[7] Office of Disease Prevention and Health Promotion (n.d.). Education Access and Quality. US Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/browse-objectives/education-access-and-quality

[8] Perez, N. P., Ahmad, H., Alemayehu, H., Newman, E. A., & Reyes-Ferral, C. (2022). The impact of social determinants of health on the overall wellbeing of children: A review for the pediatric surgeon. Journal of pediatric surgery, 57(4), 587-597.

EMPLOYMENT

People with steady employment are less likely to live in poverty and more likely to have access to resources that support health, such as health insurance. [9] In addition, unemployment and unstable employment has been connected to direct negative impacts on mental and physical health.[10] [11]



According to the NYC Community Health Profile, 6% of NYC residents are unemployed and seeking work.

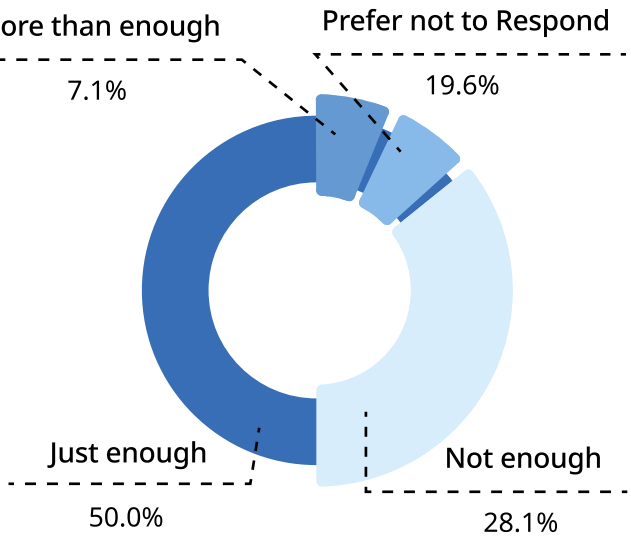
ECONOMIC CONDITIONS

Financial resources influence many aspects of a person's life, such as access to nutritious food, medical care, and stable housing, all of which impact health. Individuals with lower incomes and greater financial strain are more likely to have worse health across the lifetime. [12] [13] [14]

Economic Stability

Approximately 82% of survey respondents reported that there were times in the last year, when food didn't last, and there wasn't enough money to buy more.

Among NYC residents, 18% live in poverty according to the NYC Community Health Profile.



[9] Office of Disease Prevention and Health Promotion (n.d.). Economic Stability. US Department of Health and Human Services. https://shorturl.at/gpJK4

[10] Jaydarifard, S., Smith, S. S., Mann, D., Rossa, K. R., Salehi, E. N., Srinivasan, A. G., & Soleimanloo, S. S. (2023). Precarious employment and associated health and social consequences; a systematic review. Australian and New Zealand Journal of Public Health, 100074.

[11] Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. International review of psychiatry, 26(4), 392-407.

[12] Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: coming of age. Annual review of public health, 32, 381-398.

[13] Perez, N. P., Ahmad, H., Alemayehu, H., Newman, E. A., & Reyes-Ferral, C. (2022). The impact of social determinants of health on the overall wellbeing of children: A review for the pediatric surgeon. Journal of pediatric surgery, 57(4), 587-597.

[14] Kahn, J. R., & Pearlin, L. I. (2006). Financial strain over the life course and health among older adults. Journal of health and social behavior, 47(1), 17-31.

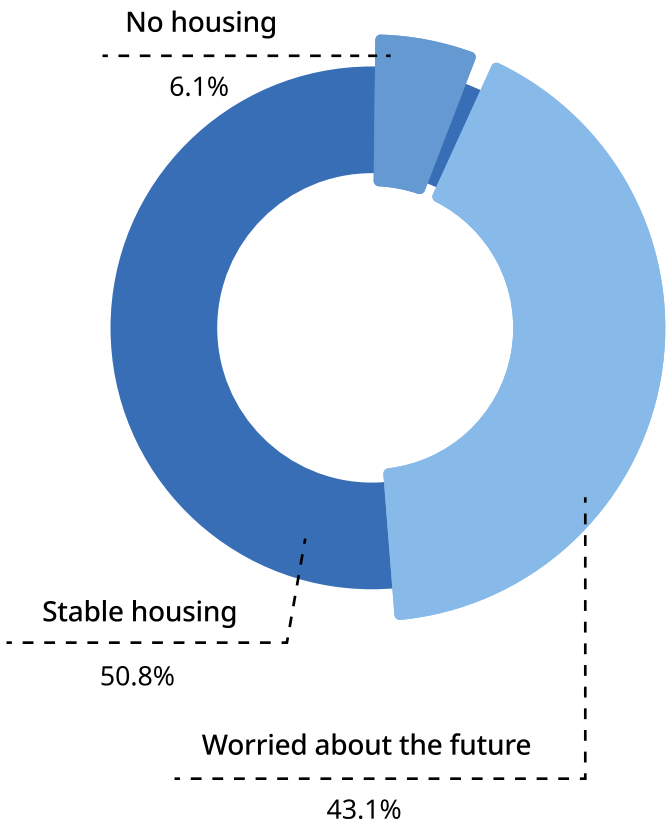
HOUSING

Lack of affordable, quality, and stable housing has been linked to worse physical and mental health outcomes. This can be due to direct impacts like unsafe housing conditions, or indirect impacts such as financial strain that causes individuals to forego food or medical care. [15]

Current Housing Situation

- Among CTHE survey participants, 68.2% had at least one housing maintenance issue.
- About 40% of participants never or only sometimes feel safe in their housing.
- More than a quarter of participants had their utilities threatened to be shut off in the last year.

52% of renter-occupied homes in NYC have no maintenance problems, according to the NYC Community Health Profile.



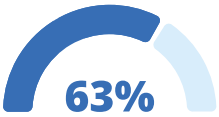
[15] Health Affairs (2018, June 7). Housing And Health: An Overview Of The Literature. https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/

MENTAL HEALTH & WELLNESS

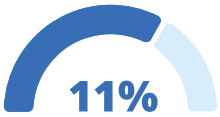
Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. [16] Poor mental health not only affects a person's ability to live a fulfilling life; it can also lead to physical and social problems with serious health outcomes. [17]

DEPRESSIVE SYMPTOMS & LONELINESS

Depression is one of the most common mental health disorders. Symptoms include feeling sad or hopeless, having little interest or pleasure in doing things and feeling tired or having little energy. [18]



reported feeling down, depressed, or hopeless nearly every day over the past two weeks



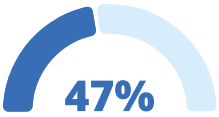
reported feeling lonely or isolated from others often or all of the time

Loneliness is the feeling of not being cared for, valued or seen by those around you. Loneliness can affect your sleep, your overall well-being and your ability to take care of yourself. It may lead to depression, anxiety and suicide.[19]

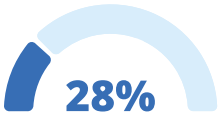
> *"[...] people really need to be connected to support for their mental health. And that can be done not only through a therapist or a counselor, but it can also be done through community support and programs."*
>
> *(Anonymous)*

COMMUNITY AND SOCIAL CONTEXT

Social support is defined as the support accessible to an individual through social ties to other individuals, groups, and the larger community. [20] Individuals lacking adequate support systems may experience adverse impacts on their health and well-being, particularly in the presence of psychosocial stressors. [21]



participants said they needed a **little or a lot more help** with daily activities.



participants said they **get all the help** they need.

> *"[Support] is not an option anymore. It's a necessity. It's what you need to do to survive. If I don't ask for help, I'm not going to be able to live comfortably."*
>
> *(Anonymous)*

[16] Center for Disease Control and Prevention (2023, April 25). About Mental Health. https://www.cdc.gov/mentalhealth/learn/index.htm

[17] Tulane University (2021, January 13). Understanding Mental Health as a Public Health Issue. Public Health Tulane. https://shorturl.at/iyz34

[18] NYC Vital Signs (2018, April 1). NYC Vital Signs - Depression among New York City Adults. NYC Health.

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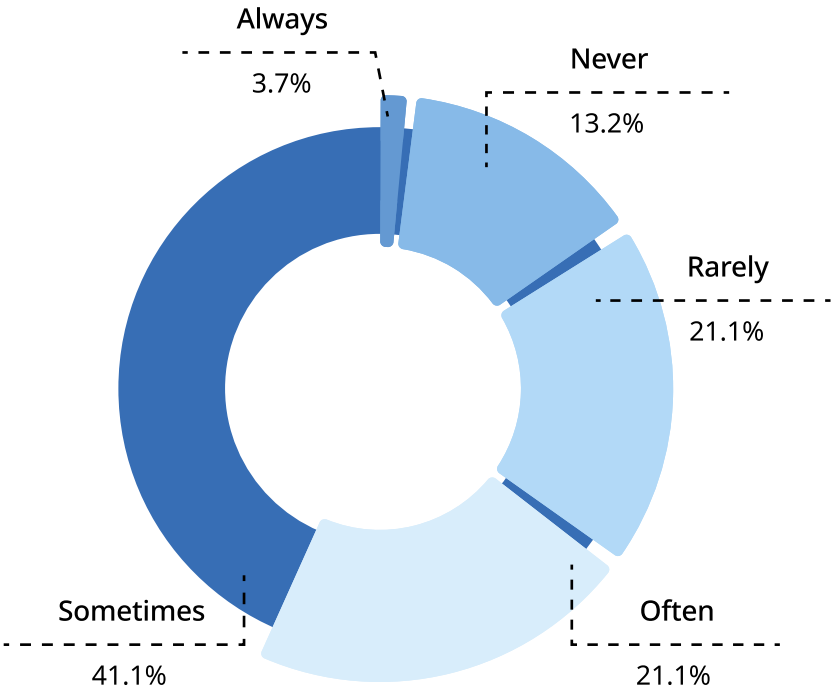
IMPACT ON PEOPLE WITH DISABILITIES

Adults with disabilities report experiencing frequent mental distress almost five times as often as adults without disabilities. People with disabilities may also experience traumatic stress due to the painful treatments received for their physical condition, as well as depression and anxiety from the isolation they experience. [22]

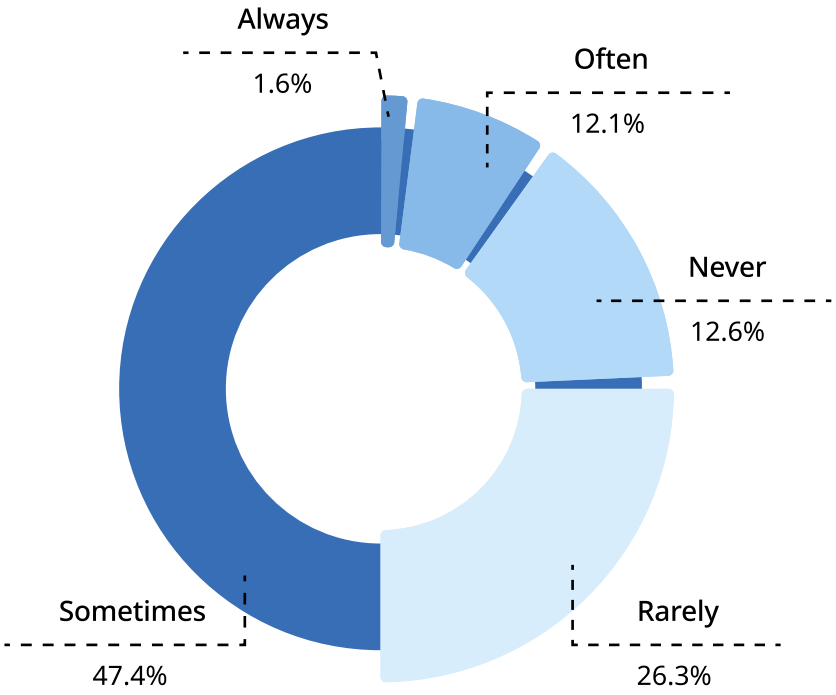
Experience difficulty doing errands alone due to a disability (n=190)



> *"There is this bias built into the system that makes a minority patient less credible in whatever opinion or understanding they have about the condition they are dealing with."*
>
> *(Anonymous)*

Experience difficulty concentrating, remembering things or making decisions due to a disability (n=190)

> *"The treatment is affected by this because you are treated based on how they understand what you're dealing with, not based on what you told them that you're dealing with."*
>
> *(Anonymous)*

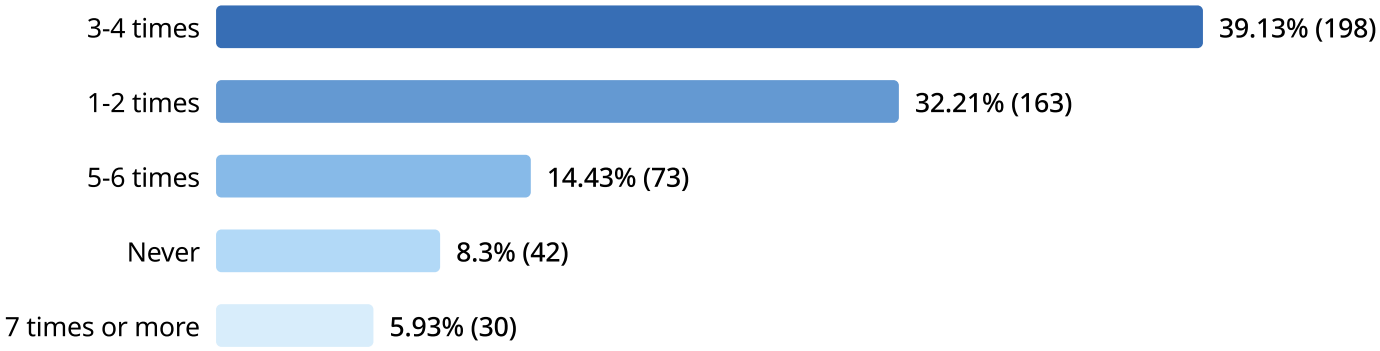


[22] National Alliance of Mental Illness (NAMI) (n.d.). People with Disabilities. https://shorturl.at/xIR59

EXERCISE

Regular exercise can have a profoundly positive impact on depression and anxiety. It also helps to relieve stress, improve memory, helps you sleep better, and boosts your overall mood. [23]

Exercise Frequency (Days per week of moderate exercise in the past month)



According to the NYC Community Health Profiles, 73% of New Yorkers reported getting any physical activity in the past 30 days.

[23] Robinson, L., Segal, J., & Smith, M. (2019). The mental health benefits of exercise. Help Guide https://shorturl.at/LNOST

COMMUNITY NEEDS & REQUESTED RESOURCES

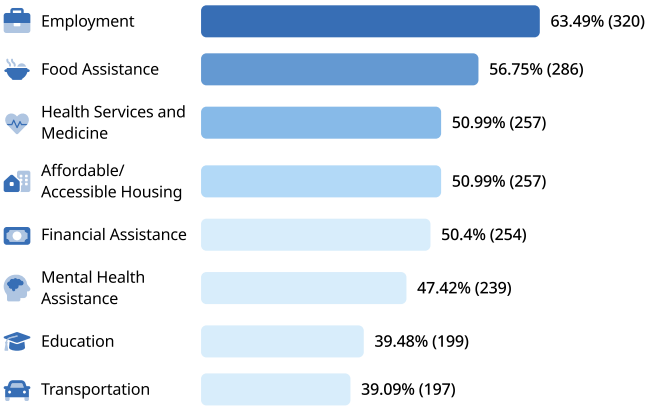
Understanding how individuals perceive community needs and what they report to be their specific needs is instrumental in crafting effective ways to address them as well as guiding allocation of resources. [24] By delving into the community's perceptions, we gained insights on what they identify or consider most important or urgent. Recognizing individual needs allows us to tailor services, personalize support and have a person-centered approach when linking individuals to needed services and resources.

TOP PRIORITY NEEDS

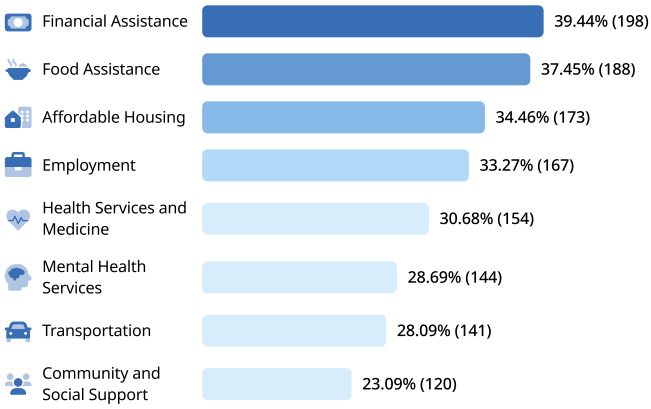
An intersectional approach to SDOHs is needed as it highlights that individual needs belong to multiple social categories, resulting in a distinct combination of social advantages or disadvantages that shape health outcomes. [25] The foundation of health and well-being is grounded in the presence of resources, support and opportunities. [26]

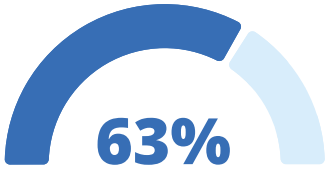
When asked about perception of community needs, employment (63.49%), food assistance (56.75%), and health services (50.99%) were the most frequently mentioned.The top self-reported communities needs were as followed: financial Assistance (39.44%), food Assistance (37.45%) and affordable Housing (34.46%)

Perceived community needs (n=502)



Self-reported individual needs (n=502)





requested assistance for **getting connected** to social care services

"Once someone got connected to someone they trusted, who was connected to that system, they had access to all of these resources that they weren't aware of [....]"

(Anonymous)

[24] Cohen-Mansfield, J., & Frank, J. (2008). Relationship between perceived needs and assessed needs for services in community-dwelling older persons. The Gerontologist, 48(4), 505-516.

[25] Díaz McConnell, E., Sheehan, C. M., & Lopez, A. (2023). An intersectional and social determinants of health framework for understanding Latinx psychological distress in 2020: Disentangling the effects of immigration policy and practices, the Trump Administration, and COVID-19-specific factors. Journal of Latinx Psychology, 11(1), 1.

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PATHWAYS TO CARE: CTHE SDOH MAPPING TOOL

A web-based platform to connect individuals with needed services and resources was developed as a result of the overwhelming number of individuals in need (<63%). Resources were compiled leveraging trusted relationships among CBOs to develop a comprehensive database of vetted programs and services citywide. This tool serves as a valuable resource for community members to self-seek services, as well as for community health workers, navigators and liaisons seeking to provide support, information and resources to their clients.

Access CTHE's SDOH mapping tool using the QR code below:

SCAN ME

CONCLUSION & IMPLICATIONS FOR POLICY

CBOs are known for their deep and nuanced understanding of community needs. This report serves as a testament of CBOs ability to collaborate and strategically design, develop and implement a community-driven community needs assessments and interventions responsive to community needs. In a time when NYS is actively designing policies and practices to prioritize SDOH, we hope this report demonstrates a model of community engagement that can be sustained, scaled, and replicated to address health disparities and advance health equity.

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In the preparation of this health report, we extend our heartfelt gratitude to a multitude of invaluable partners and individuals who have contributed to its development. First and foremost, we would like to express our deep appreciation to the community members who have generously shared their time, experiences, and insights, making this endeavor possible. We also thank Isabel Nelson, whose expertise in the data analysis process has been instrumental in shaping the quality and rigor of this report; Ed Fowler of FBrothers & Company, for his long-standing partnership with CTHE and design contributions to bring this report to life. We acknowledge with utmost respect and appreciation the unwavering support and collaborative efforts of CBOs - Overcoming Health Disparities, the broader CTHE Coalition, and the Arthur Ashe Institute for Urban Health for its leadership. Lastly, we extend our sincere thanks to the Mother Cabrini Health Foundation for their continuous support and partnership in our mission to improve community health and wellness and advance health equity.

APPENDIX A

DATA ANALYSIS

A mixed-methods data collection process was designed and implemented by CBOs to assess community needs. A community needs assessment tool was co-developed by adapting the PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) questionnaire and complemented by the WHOQOL (World Health Quality of Life) questionnaire which enabled us to gain insights into community members perspectives on their well-being, including physical health, mental health, social support, and overall quality of life.

The qualitative analysis in this study followed a systematic approach. We collected data through recorded educational workshops conducted between 2021-2022, transcribing them using Trint, and subsequently analyzed the transcriptions within the Dedoose software platform. To structure our analysis, a codebook was developed based on the research questions and thematic areas identified. Thematic analysis served as our primary analytical method, involving iterative coding and the identification of emergent themes. Additionally, Dedoose's visualization tools were utilized to create graphical representations of coded data, facilitating a deeper understanding of the findings. In the final phase of the analysis, we engaged in interpretation and reporting, where we explored overarching themes and placed them in context with the quantitative analysis. For this report, we systematically reviewed the coded data within Dedoose and selected pertinent quotations that exemplified key themes and insights from our qualitative analysis.

Data cleaning and descriptive statistics for the needs assessment were performed using R version 4.0.2. For survey data, participants under 18 years of age and those who did not complete the survey were excluded in the analysis. After these filters were applied, the final analytic dataset for 2021 included 915 participants, and for 2022, included 506 participants. Consent was obtained for all participants to participate in recorded workshops and the needs assessment survey. Participants could choose to not answer some questions in the survey. Unless otherwise noted, missing responses (marked as NA) were included when calculating percentages and are shown as their own category. For some questions, response categories or write-in responses were collapsed into larger categories. Comparison data are from the 2018 NYC Community Health Profiles.

LIMITATIONS

While this exploration has provided unique insights, there are some limitations. As the CTHE survey was intended to capture a specific group of people who are served by the participating CBOs within CTHE, it is not meant to provide insight in the general NYC population. Because this was not a randomized sample design, rather people choosing to participate, results may not capture the full population served by these CBOs in any given year. Rather, the data provides a snapshot in time which aims to highlight voices that are often overlooked. The small sample size prevented statistical subgroup comparisons or detailed subgroup descriptive statistics (e.g., by borough). Also, while we sometimes referenced comparison data from recent NYC Community Health Profiles, it's essential to note that these data were collected in different years from the CTHE survey data in this report, and differences could arise from various factors.

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