HSS

HSS Community Health Needs Assessment

2019 Report & Implementation Plan

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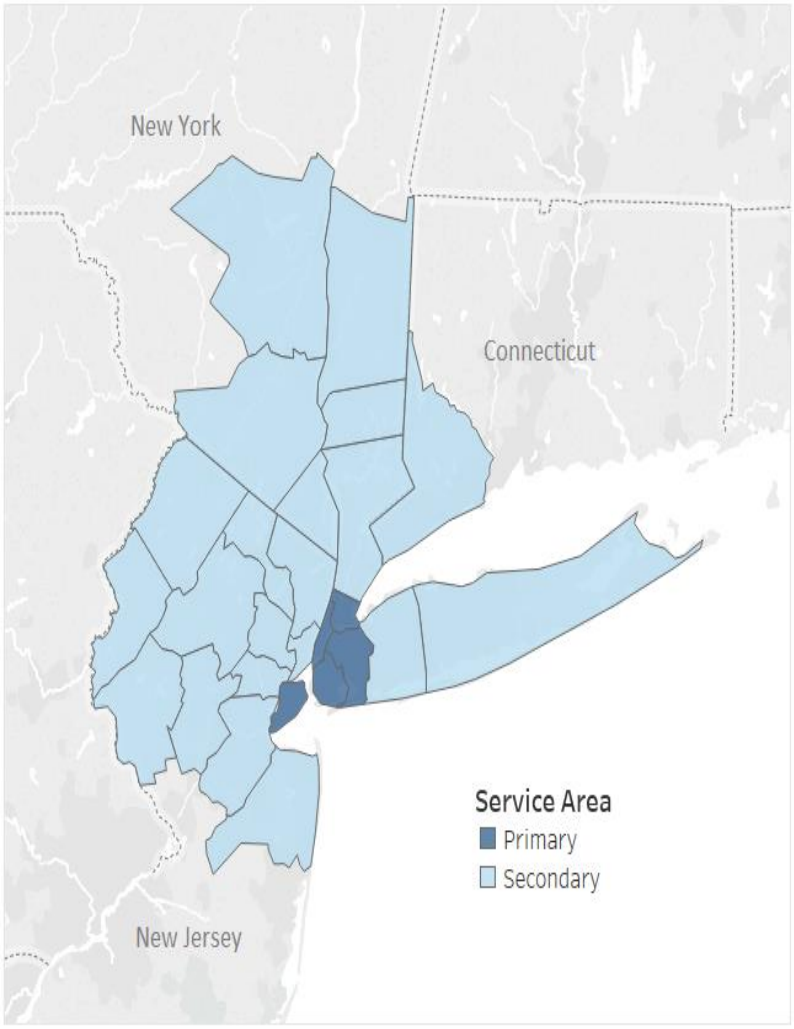
Hospital for Special Surgery (HSS) is the nation's oldest orthopedic hospital, world-renowned for its expertise in musculoskeletal and rheumatologic conditions. The Hospital's dedication to community service is exemplified by its history of implementing initiatives that improve the quality of life of patients and the public. In order to provide community programs that meet the needs of the community we serve, a community health needs assessment (CHNA) was implemented to provide insight to our community's: (1) health status and quality of life; (2) health behavior and lifestyle; (3) use of and access to care; (4) health education needs and (5) socio-demographic characteristics.

Section 1: Definition and Description of Community Served

A. Geographic Area

HSS' primary service area consists of the five boroughs of New York City (NYC) - Manhattan, Bronx, Brooklyn, Queens and Richmond; while its secondary service area is comprised of suburban areas in Northern NY, Northern and Central New Jersey, Connecticut and Long Island, as seen in Figure 1 below. Given its specialized focus on musculoskeletal and rheumatologic care, the Hospital's reach and impact extend beyond its immediate service area to communities around the world.

Figure 1. HSS Service Are



Service Area	Region	County
Primary	New York City	Bronx
		Kings
		Manhattan
		Queens
		Richmond
Secondary	Connecticut	Fairfield
	Long Island	Nassau
		Suffolk
	Northern and Central New Jersey	Bergen
		Essex
		Hudson
		Hunterdon
		Middlesex
		Monmouth
		Morris
		Passaic
		Somerset
		Sussex
		Union
		Warren
	Northern New York	Dutchess
		Orange
		Putnam
		Rockland
		Ulster
		Westchester

B. Target Population

HSS is committed to improving the health needs of many New Yorkers, particularly culturally diverse communities, LGBTQ+, children, adults and older adults that suffer from or are at risk of musculoskeletal and rheumatologic conditions**.** Understanding the musculoskeletal health needs of the population we are serving is crucial in identifying gaps and health disparities that exists.

C. Principal Functions

HSS is a 215-bed hospital specializing in musculoskeletal medicine - Orthopedics, Rheumatology and Rehabilitation where more than 31,000 surgical procedures are performed annually. HSS' commitment to providing the highest quality of care to its patients and improving the quality of life and mobility of the communities it serves is articulated in its Mission, Vision and Values statements, which are reviewed annually by the Hospital's Board of Trustees.

Mission

The Mission of HSS is to provide the highest quality patient care, improve mobility, and enhance the quality of life for all, while advancing the science of orthopedic surgery, rheumatology, and their related disciplines through research and education. We do this regardless of race, color, creed, sexual orientation, or ethnic origin.

Vision
The Vision of HSS is to lead the world as the most innovative source of medical care, the premier research institution, and the most trusted educator in the field of orthopedics, rheumatology, and their related disciplines.

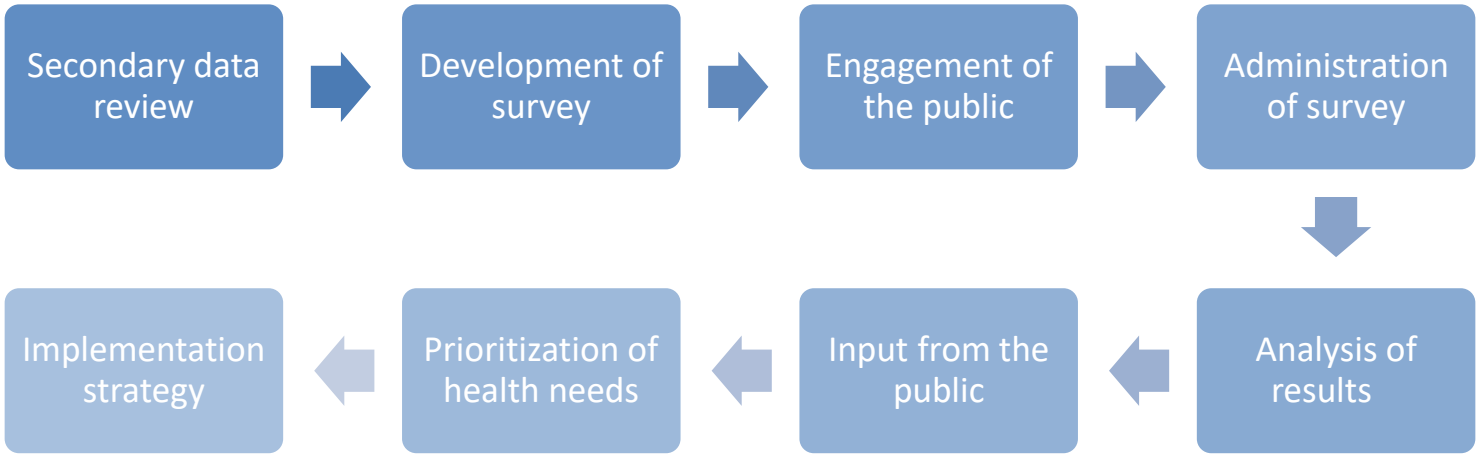
Values
HSS sets and adheres to the highest possible standards based on excellence, integrity, teamwork, creativity and passion.

The Hospital's Mission, Vision and Values are the foundation that drive HSS's efforts to provide the highest quality care – inclusively, with cultural sensitivity and without discrimination – to both patients and the public. This is accomplished by working collaboratively with its extensive community partners, empowering the community through in-depth support, outreach initiatives, and ongoing education and training on diverse populations (race, ethnicity, religion, and sexual orientation) while positioning itself to be the most trusted educator.

Section 2: Assessing Community Health Needs

The CHNA process for HSS was driven by the collection and analysis of primary and secondary data. Our community partners, such as government agencies, educational systems, community-based organizations (CBOs) and health and human service entities were engaged in this process to assess the needs of the community. This report is a summary of primary and secondary data collected throughout the CHNA process. The overall CHNA involved multiple steps that are depicted in the flow chart below.

Figure 2. 2019 CHNA Process



A. Secondary Data Review

A secondary data profile was compiled from local, state and federal data to provide essential information, insight and knowledge on a broad range of health issues in our community. In addition, the 2016 CHNA results were reviewed to provide a deeper understanding of the impact of musculoskeletal conditions in the community and were compared with state and national data. Data collected includes socio-economic information, health status and quality of life, health behavior and life style, and use and access to care. Sources of data include:

- 2016 HSS Community Health Needs Assessment
- Regional Community Health Needs Assessments
- Behavioral Risk Factor Surveillance System (BRFSS)
- U.S. Census Fact Finder (2018)
- NYC Health Department Community Health Profiles 2018

Demographics of the Community

According to 2018 census data, the NYC community consists of an estimated 8,398,748 people, of which 42% identified as White, 29% identified as Hispanic or Latino, 24% identified as Black or African American, and 14% identified as Asian.[1] This racial and ethnic diversity is further highlighted by the city's immigrant population – between 2013-2017, over one-third (37%) of the City's population was foreign-born.

At the same time, the older adult population continues to grow, with the New York City Department of Aging projecting that in 2040, approximately 21% of NYC residents will be ages 60 and older, up from 16% in 2000.[2] Compared to the population, older adults face unique health disparities:[3]

- Less than 40% of older adults are meeting the Centers for Disease Control and Prevention (CDC) recommendation of 150 minutes of moderate physical activity per week

[1] U.S. Census Bureau. (2018). *Quick facts – New York City, New York*. [Table]. Retrieved from https://www.census.gov/
[2] New York City Department for the Aging. (2018). *"Plan 2025": Aging Services in an Era of Rapid Population Growth*. New York, NY.
[3] New York City Department of Health and Mental Hygiene. (2019). *Health of Older Adults in New York City*. New York, NY.

- Over 70% of older adults face difficulties with activities of daily living, including bathing, dressing, walking, and climbing stairs
- In terms of musculoskeletal health, arthritis affects over half (51%) of all older adults in NYC

HSS has remained dedicated to improving the health of communities where dramatic health disparities exist in our primary and secondary service areas. According to the NYC Department of Health and Mental Hygiene (DOHMH) Community Health Profiles, the following health disparities exist:[4]

- In NYC, fall-related hospitalizations among adults ages 65 and older are highest in the South Beach and Willowbrook community districts of Staten Island and in the Upper East Side
- Only 65% living in Bensonhurst, Mott Haven and Melrose, and Hunts Point and Longwood reported participating in any physical activity in the past 30 days, compared to the NYC average of 73%

HSS is also dedicated to improving the health of Asian communities residing in Chinatown, Manhattan and Flushing, Queens. The Asian American community is the fastest growing racial group in the United States, and the fastest growing demographic of Asian American older adults is in New York City.[5] In 2016, Asian American older adults made up 16% of all older adults in New York City ages 50 years and older.[3] As a community, Asians in NYC are primarily an immigrant population that is rich in cultural and linguistic diversity.[6] Health disparities highlighted below exist among the Asian population in Chinatown as well as Flushing, Queens: [7,8]

- In both Chinatown and Flushing, the percentage of residents with limited English proficiency is higher than the NYC average of 23%, at 28% and 51% respectively
- The poverty rate for Flushing is 25% as compared to 20% in New York City
- Among older adults ages 65 years and older, falls-related hospitalizations were higher in Chinatown than the New York City average

Health status and quality of life

According to the New York City DOHMH, 22% of NYC residents self-reported their health as fair to poor, higher than the national average of 18.4 percent. [9,10] On the other hand, Paramus residents were less likely to self-report their health as fair or poor (10.8%).[11] Unlike self-reported health, New York City residents (12.8%) were less likely to report poor mental health than the national average (35.6%).[9,10] Regionally, the rates of poor mental health in Fairfield County, Westchester County, Paramus, and Nassau County were 12%, 11%, 10%, and 16% respectively. [11, 12,13,14]

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[4] New York City Department of Health and Mental Hygiene. (2018). *2018 Community Health Profiles Map Atlas*. New York, NY.
[5] Asian American Federation. (2016). *Asian American Seniors in New York City: An Updated Snapshot*. New York, NY.
[6] Asian American Federation. (2013). *Asian Americans of the Empire State: Growing Diversity and Common Needs*. New York, NY
[7] Hinterland K, Naidoo M, King L, Lewin V, Myerson G, Noumbissi B, Woodward M, Gould LH, Gwynn RC, Barbot O, Bassett MT. Community Health Profiles 2018, Queens Community District 7: Flushing and Whitestone; 2018; 49(59):1-20.
[8] Hinterland K, Naidoo M, King L, Lewin V, Myerson G, Noumbissi B, Woodward M, Gould LH, Gwynn RC, Barbot O, Bassett MT. Community Health Profiles 2018, Manhattan Community District 3: Lower East Side and Chinatown; 2018; 3(59):1-20.
[9] New York City Department of Health and Mental Hygiene. Epiquery: NYC Interactive Health Data System - Community Health Survey 2016. https://nyc.gov/health/epiquery
[10] Kaiser Family Foundation analysis of the Centers for Disease Control and Prevention (CDC)'s Behavioral Risk Factor Surveillance System (BRFSS) 2013-2017 Survey Results.
[11] Professional Research Consultants. (2016). 2016 Community Health Needs Assessment Report: The Valley Hospital Service Area. Omaha, NE.
[12] Stamford Health. (2016). *2016 Stamford Hospital Community Health Needs Assessment*. Retrieved from https://www.stamfordhealth.org/app/files/public/2254/Community-Health-Assessment-Needs.pdf
[13] Westchester County Department of Health. (2016). *2016-2018 Community Health Improvement Plan*. Retrieved from https://health.westchestergov.com/images/stories/Data-Stats/CHA-CHIP-Report2016-2018.pdf
[14] Northwell Health. (2016). *Northwell Health Community Service Plan 2016-2019: Nassau County Service Area CHNA*. Retrieved from https://www.northwell.edu/sites/northwell.edu/files/d7/Northwell%20Health%20Nassau%20County%20CHNA%202016.pdf

With regards to musculoskeletal and rheumatological conditions, HSS' 2016 CHNA found the prevalence of osteoarthritis to be 30.3 percent. While higher than the national prevalence of 22.7 percent, the finding was consistent with the numbers reported in Paramus (30.0%) and Suffolk County (30.6%).[11,12,15] Similarly, the prevalence of osteoporosis among HSS' service areas (27.6%) was higher compared to the national prevalence (10.3%).[16]

Health behavior and lifestyle

Nationally, the percentage of adults who are overweight or obese is 65.4, similar to what is observed in New York City (56%), Paramus (61.1%), and Suffolk County (59.6%).[9,10,11,12] This highlights the prevalence of unhealthy lifestyles, which is further reflected in rates of physical inactivity. Whereas 21% of the country do not meet the CDC physical activity guidelines, close to one-third (31%) of New York City residents do not meet the same guidelines, and over three-quarters (79%) of Suffolk County residents reported engaging in no physical activity in the past 30 days.[9,12]

In examining the current health behavior landscape, it has never been more crucial to also consider opioid use and abuse. Across the country, between 21 and 29 percent of patients misuse opioids prescribed for chronic pain.[17] In New York City alone, there were 1075 opioid-related overdose deaths reported in 2016, an alarming increase from the 753 deaths reported in 2015.[18] Furthermore, 18% of the 2016 opioid-related overdose deaths involved the use of prescription opioids.

Use of and access to care

Health coverage in the HSS service areas does not differ drastically by region. In New York City, 89.1% of residents have health insurance coverage compared to 94.9% in Paramus and 89.7% in Suffolk County.[11] However, disparities exist in access to care. In 2016, approximately one out of every ten (10.5%) New York City residents did not get access to health care when needed in the past year, a surprising finding considering that only 4.4% of people across the country reported the same.[9] Additionally in Stamford and Paramus, 21% and 40% of residents reported difficulties with healthcare access in the past year.[11]

B. Development of the CHNA survey

An anonymous, large-scale CHNA was conducted between March 1, 2019 and April 1, 2019 in order to determine our community's health care, educational and support needs in relation to muscle, bone and joint health. The CHNA will help:

- Guide strategic planning
- Inform our education, outreach and support programs

[15] Barbour KE, Helmick CG, Boring M, Brady TJ. (2017). *Vital Signs: Prevalence of Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation — United States, 2013–2015*. MMWR Morb Mortal Wkly Rep 2017; 66:246–253. DOI: http://dx.doi.org/10.15585/mmwr.mm6609e1.
[16] Wright, N. C., Looker, A. C., Saag, K. G., Curtis, J. R., Delzell, E. S., Randall, S., & Dawson-Hughes, B. (2014). The recent prevalence of osteoporosis and low bone mass in the United States based on bone mineral density at the femoral neck or lumbar spine. *Journal of bone and mineral research : the official journal of the American Society for Bone and Mineral Research*, *29*(11), 2520–2526. doi:10.1002/jbmr.2269
[17] National Institute on Drug Abuse. (2019). Opioid Overdose Crisis. Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis
[18] The City of New York Office of the Mayor. (2016). *Healing NYC: Preventing Overdoses, Saving Lives*. New York, NY.

- Determine any gaps that may exist in current programming
- Select the public health priorities of the Community Service Plan to support the statewide prevention agenda.

Survey Construction - Engagement of the public

A 60-question survey was developed through a collective effort by a four-member HSS CHNA steering committee, community partners, internal stakeholders and the public. The CHNA steering committee identified validated research questions to be addressed, drafted the individual survey questions, and identified community partners and internal stakeholders to review and provide input to survey development. Collaboration with these groups was crucial to the success of this survey, with valuable feedback provided on survey construction and length. In an effort to reach a culturally diverse community, the survey was translated into Spanish, Chinese and Russian using a culturally sensitive back translation approach. See Appendix A for sample CHNA surveys in English, Spanish, Chinese and Russian.

Below outlines the list of community partners involved in survey construction:

- Arthritis Foundation – New York Chapter
- Clinical & Translational Science Center (CTSC) – Weill Cornell Medicine
- New York Presbyterian Hospital
- Medicare Rights Center
- NYC DOHMH – Office of Policy, Planning and Strategic Data Use
- New York City Department of Aging
- S.L.E. Lupus Foundation
- Self – Help Innovative Senior Center
- Isabella Geriatric
- Touro College Graduate School of Social Work
- Visiting Nurses Services
- Charles B. Wang Community Health Center
- Spondylitis Association of America
- Stamford YMCA
- Charter School of Excellence
- NY Sports Connection

See Appendix B for detailed feedback from internal stakeholders and community partners

The CHNA was piloted for one month (October 15 – November 16, 2018) among 70 community members to obtain meaningful feedback about the survey and ensure cultural relevancy and health literacy. See Appendix C for detailed pilot feedback form and summary from the public.

Survey Administration

The survey was administered via six methods: mail, online, email, social media, QR codes, and in-person. Mailed surveys were sent to existing lists maintained by the HSS Public & Patient Education and the Social Work Department reaching 15,126 community residents. In an effort to reach the medically underserved population, two strategies were employed:

1. An oversampling approach was used in selecting zip codes identified as Medically Underserved Areas (MUA) derived from the U.S. Department of Health and Human Services

(http://www.hrsa.gov/shortage/mua/index.html). Household mailing lists were purchased and distributed to a randomly selected sample of 7,500 households of individuals aged 18 years and older in the MUA zip codes within HSS' primary and secondary service areas.

2. The use of Survey Gizmo Panel services to administer the CHNA survey online reaching 591 low income and diverse community residents.

Electronic surveys were sent via e-mail to HSS patients and existing email lists maintained by the Public and Patient Education and the Social Work Departments. Surveys were also posted on the HSS website, and social media outlets such as Facebook and Twitter. Lastly, post cards with QR-codes, and in-person surveys were distributed or displayed with instructions in some waiting areas within the hospital, and Ambulatory Care Centers (ACC), while others were administered in existing educational lectures/workshops within the community, and hospital-based programs.

Statistical Analysis

Descriptive statistics were used to analyze socio-demographic data, and Chi-squared tests were used to assess relationships between variables. SPSS version 26 was used to analyze the data, and significance was set at $p \leq 0.05$. Primary analysis was performed for the total sample. In order to further examine the total sample and identify health disparities that exists, secondary analyses were conducted in four sub-groups listed below:

- HSS Regional sites – This group represents HSS patients from HSS' regional locations i.e. Long Island, NY; Stamford, CT and Paramus, NJ
- HSS Ambulatory Care Centers (ACC) – This group represents HSS patients from more racially/ethnically diverse and lower socioeconomic backgrounds
- Public/uninsured respondents – This group represent respondents who either lacked health insurance or were covered by Medicaid or Medicare/Medicaid
- Medically Underserved Areas (MUA) – This group represent respondents from zip codes of Medically Underserved Areas (MUA) (http://www.hrsa.gov/shortage/mua/index.html)

CHNA Results

A total of 11,410 community members responded to the CHNA survey, with an overwhelming response in English (98.0%). The rest of the responses were in Spanish (1.1%), Chinese (0.8%) and Russian (0.2%). **Table 1** below shows the breakdown of responses by administration method with email yielding majority of the responses (80.6%). Table 1 below shows a detailed breakdown of responses by administration mode

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Table 1: 2019 CHNA Response Breakdown by Administration Method

Admin. Method	Subset	Language	Original N	Response Total	Response Rate	% Response of Total
Web	Facebook	English	N/A	13	N/A	0.1%
	Twitter	English	N/A	5		0.0%
	HSS website	English	N/A	18		0.2%
		Russian		1		
	PPED website	English	N/A	15		0.1%
	Web Total		**N/A**	**52**	**N/A**	**0.5%**
Survey Gizmo (panel service)	N/A	English	591	591	100%	5.2%
	Survey Gizmo Total		**591**	**591**	**100%**	**5.2%**
QR-codes	HSS sites (main campus and regional)	English	1000	13	1.3%	0.1%
	QR-code Total		**1000**	**13**	1.3%	0.1%
Email	PPED	English	694	221	31.8%	1.9%
	HSS Patient	English	105,062	8794	8.4%	77.1%
		Chinese		12		
		Russian		12		
		Spanish		58		
	Newsletter	English	8,311	20	0.2%	0.2%
		Chinese		1		
	Social Work	English	551	81	14.7%	0.7%
		Spanish		1		
	Email Total		**114618**	**9200**	**8.0%**	**80.6%**
Mail	PPED	English	13,900	465	3.3%	4.1%
		Spanish		1		
		QR-code		2		
	Social Work	English	1,226	69	5.6%	0.6%
		Chinese		11		
		Spanish		14		
		QR-code		8		
	Purchased	English	7,500	139	1.9%	1.2%
		Chinese		12		
		Russian		5		
		Spanish		19		
	Mail Total		**22626**	**745**	**3.3%**	**6.5%**
In Person	PPED	English	140	21	15.0%	0.2%
		Chinese		50		
	ACC (72nd Str, Rheum 6th floor)	English	645	313	48.5%	2.7%
		Russian		5		
		Spanish		23		
	Other HSS sites (HSS main 8th flr, Pt Access, Pavillion 3rd & 4th flr)	English	405	61	15.1%	0.5%
	Nursing	English	192	32	16.7%	0.3%
		Spanish		4		
	Regional sites (Long Island, Stamford, Paramus)	English	350	259	74.0%	2.3%
		Spanish		1		
	Social Work	English	130	39	30.0%	0.3%
		Spanish		1		
	In Person Total		**1862**	**809**	**61.7%**	**7.1%**
Grand Total				**11,410**		

HSS shared results of the CHNA survey with internal stakeholders, the aforementioned community partners and the public. Details on what we plan to do with these results are described in the latter part of this report. HSS will further disseminate these results to the public through an infographic report posted on social media, the Hospital's website, digital media, annual community benefit report, and the New York State Department of Health's (NYSDOH) CSP.

Summary findings and significant disparities that exists in the overall sample are discussed below.

Socio-Demographics

Findings from 11,410 respondents in the total sample revealed the following information regarding the socio-demographics of HSS' community:

- Majority were females (67%) with a mean age of 63.1 years (range: 18-99 years).
- Majority of the respondents identified as Whites/Caucasians (79%) and non-Hispanics/Latinos/Latinos (91%) while others identified as Hispanics/Latinos/Latinos (10%), Blacks/African Americans (10%), Asians (5%), American Indians (1%), and other races (7%).
- Respondents had high educational backgrounds with over half (65%) completing college and post graduate education.
- Respondents were mid to high level income earners with 23% earning $50,000 - $100,000K and 49% earn more than $100,000 of annual household income.
- English (96%) was the predominant language spoken at home.
- More than half of respondents (54%) were married; while 70% do not live alone with a majority living in Manhattan (24%).

In our sub-samples that represent our patient population from the ACC and respondents from MUAs, the majority were from racially/ethnically diverse communities with lower socio-economic backgrounds. Specifically, respondents in the ACC and MUAs sub-samples were more racially diverse (only 46% and 47% were Whites/Caucasians respectively), less educated (66% and 53%% had lower than a college degree respectively), and more likely to earn less than $50,000 of annual household income (80% and 58% respectively) and had public insurance or no insurance (72% and 38% respectively).

Health Status and Quality of Life

Overall health status of respondents (83%) was rated positively (good to excellent). The leading musculoskeletal condition in the community was Osteoarthritis (OA). Gender differences were seen in musculoskeletal conditions with females being more likely to have OA, Rheumatoid Arthritis (RA), Lupus, Fibromyalgia, and Osteoporosis (OP), while Gout was more common among males. Racial/ethnic disparities were also found with OA and OP being more prevalent in Whites/Caucasians and non-Hispanics/Latinos; RA in Hispanics/Latinos and Native Hawaiians; Lupus in Asians; and Fibromyalgia in American Indians. Among respondents diagnosed with a musculoskeletal condition, the most reported symptom experienced within 30 days were joint/bone pains or aches (84%), stiffness (79%) and muscle pains or aches (73%).

Over half of respondents (53%) reported some pain interference with usual/daily activities with a majority (65%) indicating stooping, bending or kneeling as the top difficulty. Significant health disparities in pain interference of more than two weeks were found among females and gender non-conforming respondents; those living in the Bronx; American Indians and Hispanics/Latinos; those age 35-50 years; those who were not physically active; and those with musculoskeletal conditions.

More than one-quarter of respondents (27%) fell in the past year with 67% informing their healthcare provider about their falls. Significant health disparities in falls were found among females and gender non-conforming respondents; those who lived in Manhattan; adults age 85+ years; African Americans and American Indians; those with musculoskeletal conditions; and those who were physically inactive.

One-quarter of respondents (25%) reported poor physical health for more than two weeks. Significant disparities were found in poor physical health of more than two weeks among Females; those age 51-65 years; non-Hispanics/Latinos; adults diagnosed with musculoskeletal condition, and those who were physically inactive. Most respondents reported no mental health problems (60%) but one-quarter of respondents from the Ambulatory Care Center (ACC) experienced frequent mental health problems. Significant health disparities were found such that American Indians; Hispanics/Latinos /Latinos; Gender non-conforming; the youngest (18-35 years) and the oldest respondents (86+ years); those who lived in the Bronx; those who were physically inactive; and those with musculoskeletal conditions reported frequent mental distress.

Health Behavior and Lifestyle

According to CDC recommended guidelines, regular physical activity (PA) is defined as at least 150 minutes of moderate activity, 75 minutes of vigorous activity, or at least one day of muscle-strengthening activities per week. Lack of PA was reported by many respondents with only 23% and 22% meeting CDC recommended levels of moderate and vigorous physical activity respectively, while half of respondents (50%) did muscle-strengthening exercise at least once a week. More than half of respondents (54%) had been told by their doctor in the past 12 months to do physical activity/exercise while 31% had been told to lose weight. Significant health disparities were found such that those living in Manhattan; females; Asians and Blacks/African Americans; Hispanics/Latinos; those aged 86+ years; and those with all musculoskeletal conditions did not meet CDC recommended levels of PA.

For diet, three-quarter of respondents (75%) reported eating healthy; however, 61% indicated interest to eat healthier. Significant health disparities were found in the public/uninsured sub-sample such that American Indians and Hispanics/Latinos, and those diagnosed with RA reported having a poor diet. Overall, the main barrier to eating healthy reported by nearly half of the respondents (44%) was “taking too much time and effort to prepare.” However, cost was reported as the top barrier to eating healthy in the ACC, public/uninsured and MUA sub-samples mainly among Hispanics.

For pain management, more than half of respondents (53%) reported using prescription pain killers with 86% indicating they should not take more than the recommended dosage of prescription medication when feeling pain more than usual. However, almost two-thirds of respondents (64%) reported never using complementary treatments (i.e. yoga, meditation, mindful breathing) to manage their pain. Significant health disparities were found such that males; those aged 86+ years and Native Hawaiians had never used complementary treatments. Also, adults with musculoskeletal conditions reported using prescription pain killers and never using complementary treatments to manage their pain.

Use of and Access to Care

Almost all respondents reported having some form of health insurance/coverage; however, some health disparities were found. Specifically, lack of insurance was found to be associated with respondents aged 18-35 years old; Whites/Caucasians; and non-Hispanics/Latinos. Majority of respondents reported taking preventive care measures over the past year, with almost three-quarters (74%) receiving a flu shot. However, only 10% reported receiving a STI/HIV screening. Almost all respondents (90%) had access to healthcare when they needed it. However, among those who had no access to healthcare, challenges in getting an appointment and cost were the leading barriers. While 94% of respondents stated that they generally followed their provider’s medical advice, common barriers to

adherence were concerns about side effects and feeling that treatment would not help. High provider-patient communication (i.e. generally took steps to communicate with their provider) was reported among majority of respondents; however, low provider-patient communication was seen among Whites/Caucasians; Non-Hispanics/Latinos; females; those aged 51-65 years; and those with lower levels of income and education. However, in the ACC and public/uninsured sub-samples, Blacks/African Americans had low patient-provider communication.

Lack of self-efficacy to manage their chronic condition was a concern among many respondents with more than half (51%) having no/little confidence in managing their musculoskeletal conditions. Lack of self-efficacy was mostly seen in females, those with a post-college education, and those diagnosed with OA. English was the most preferred language of reading medical or health care information among respondents. However, racial/ethnic disparities were found to be associated with low health literacy among Asians, Whites/Caucasians and non-Hispanics/Latinos/Latinos rating their spoken English as relatively poor; and preferring to discuss healthcare and reading medical instructions in non-English languages (i.e. Chinese and Russian). The most popular place for respondents to obtain health information or advice was the doctor's office (91%) followed by the Internet (55%), with 7% needing assistance when reading instructions, pamphlets, or other written health materials.

Health Education

There is a lack of knowledge of educational resources in the community with over three-quarter of respondents (79%) indicating that they had not taken an educational course or class to learn how to manage their musculoskeletal health/condition. This was mostly seen among those living in the Bronx; Males and gender non-conforming respondents; those aged 18-35 years; Native Hawaiians; and Hispanics/Latinos. There was also a lack of confidence among respondents that taking a course/class will help manage their musculoskeletal conditions with 45% being somewhat confident. Brochures/flyers (58%) and online lectures (50%) were the preferred platforms in receiving health education. In addition, participating in exercise classes was the most preferred health education activity among half of respondents (50%), followed by online lectures at HSS (47%) and podcasts (31%). The leading health topics that respondents were interested in were "How to exercise and manage my condition", Osteoarthritis (OA), and Back pain.

A detailed key finding report of the CHNA results highlighting significant health disparities is available in Appendix D.

Section 3: Input Representing the Broad Interest of the Community

HSS facilitated systematic feedback from its varied constituents (i.e. internal stakeholders, community partners including the local public health department, and the public) based on the CHNA results to guide the selection of the health needs and services to address in its community programming. Our approach in identifying, prioritizing and selecting significant health needs is described below.

a. Internal Stakeholders

Recognizing that the development of community health programming requires a concerted effort by all members of the organization, we involved various representatives from HSS departments (i.e. Education Institute, Nursing, Social Work, Nutrition, Rehabilitation, Ambulatory Care Centers, Service Excellence and Language Services, Regional Markets, Patient Experience, Medical Staff and Attendings, Development, Public Relations and Marketing, Digital Communications and Quality). The knowledge and experience of staff that have a vested interest in serving the community was essential in identifying and addressing the community's health needs. An internal stakeholder meeting was held on August 13, 2019 with 20 staff in attendance to discuss identified health priorities and explore areas for implementing initiatives, using CHNA results and stakeholders' awareness of community needs to guide the discussion. Discussions were focused on increasing awareness of educational resources and programs available to the community as well as healthcare providers through increased marketing efforts, and implementing digital programs (i.e. exercises, lectures and workshops) to increase program reach. See Appendix E for list of internal stakeholders, and minutes of the stakeholders meeting.

b. Community partners

Feedback from community partners was critical to driving the assessment and selection of public health priorities for the Hospital. Using results of the CHNA survey as the basis for discussion, HSS and its partners exchanged valuable information regarding community needs, explored areas for future collaboration, and solidified a mutual commitment to advancing public health. Furthermore, community partner knowledge of their respective communities helped to identify gaps in community programming – or more specifically, areas where HSS could use its areas of expertise to make a lasting public health impact.

The New York City DOHMH was actively involved in our CHNA process by providing input in the development of the survey and identifying significant health needs based on the CHNA results. A NYC DOHMH staff participated in our community partners meeting. See details about the meeting below.

A community partners meeting was held on June 19, 2019 with 23 individuals from five community partner organizations in attendance. During the meeting, we shared the CHNA results, elicited feedback and ranked health issues according to the communities they serve. CHNA results were received positively and there was extensive discussion about how results accurately depicted the various communities served and how these results could be used to impact the community at large. Specifically, there were discussions about access to educational programs and ways in which HSS could extend the reach of its programs. Minutes of the community partners meeting, and ranking is available in Appendix F.

c. General public including medically underserved and low-income population

To further HSS' commitment to developing programs that improve the health of our culturally diverse communities, obtaining feedback from the public and medically underserved, low-income, and minority populations was instrumental in driving the Hospital's selection of significant health needs to improve the health of communities where dramatic health disparities exist**.** Our approach in soliciting input from the public was through community forums. Seven community forums were held to allow community members an opportunity to identify

and prioritize health needs that provided HSS with the appropriate direction in selecting its public health priorities. Our marketing strategy for the community forums included distribution of flyers at public and patient education programs and awareness on social media i.e. Facebook. Furthermore, in order to reach low-income population, HSS partnered with Community-Based Organizations (CBOs) serving medically underserved communities to advertise community forums. Specific dates, locations, and attendance for the community forums were as follows:

Table 2: Community forum reach

Date	Location	Attendance
June 12, 2019	Stamford Senior Center, Stamford, CT	40
June 13, 2019	Building One Community Center, Stamford, CT	15
June 13, 2019	HSS Campus, NYC	14
June 14, 2019	Webinar	2
June 17, 2019	Chinatown Community Center, Visiting Nurse Service of New York, NY	53
June 20, 2019	Selfhelp Innovative Senior Center, Flushing, NY	22
June 26, 2019	Leonard Covello Senior Center, Carter Burden Network, Manhattan, NY	21
Total		**179**

A total of 179 community members participated in the community forums. At each community forum, participants were asked to rank the top 10 health indicators from a list of 25 identified in the CHNA according to order of importance (where 1 ranks the highest). Ranking results were calculated using a simple point system in which each ranking is assigned a point value from 1-10, with the indicator ranked 1 receiving 10 points and the indicator ranked 10 receiving 1 point. The indicators that received the most collective points were identified as the top priorities for the participants at each respective event. See Appendix G for summaries of community forums and details of ranking.

d. Additional Input

HSS also solicited additional input from the Greater New York Hospital Association (GNYHA), a trade association to inform the CHNA process. Additional in-person meetings and conference calls were held with GNYHA on 01/12/2018, 05/11/2018, 10/19/18, 12/14/2018, 03/13/2019 and 05/29/2019 to discuss the NYS DOH CSP requirements and federal requirements for the CHNA.

e. Public Comments from the 2016 CHNA

HSS posted the 2016 CHNA implementation plan on its website (https://www.hss.edu/community.asp), allowing the public to review and provide feedback on the 2016 CHNA Report and Implementation Plan. An email address (pped@hss.edu) was provided on the website to receive questions or comments. However, no comments were received**.**

Prioritization and selection of health needs

Based on significant health needs identified in the CHNA results, feedback from internal stakeholders, community partners, and the general public, the top 10 significant health needs identified were:

1. Osteoarthritis
2. Osteoporosis
3. Joints, muscle, and bone pains
4. Falls and balance
5. Rheumatoid arthritis
6. Stress and mental health

7. Lifestyle i.e. Poor diet, obesity, lack of exercise
8. Fatigue
9. Stiffness
10. Complementary alternatives to manage pain

Evaluation of 2016 CHNA Strategies

It is essential that community programs are frequently evaluated to meet the changing healthcare needs of our diverse and aging community. To this end, HSS identified and developed specific outcome measures to assess its reach and impact on the community. A detailed description of the impact of our strategies to address health needs identified in the 2016 CHNA is provided below:

1. **Obesity (Poor Diet and Lack of Physical Activity) in Children and Adults**: A seven-week interactive nutrition and physical activity education program was designed to provide children and families with essential knowledge about healthy eating and physical activity. Results show that 267 students from four NYC public schools were reached demonstrating statistically significant improvements in knowledge based pre and post scores on a battery of lesson-based questions. In particular, overall mean nutrition knowledge scores significantly increased from pre to post (44.7 to 59.9; $p \leq 0.001$). In addition, statistically significant knowledge gains were found in portion control (35% to 54%; $p \leq 0.001$), roast turkey as the leanest protein food (13% to 34% $p \leq 0.001$) and healthy activity for your heart (21% to 37%; $p \leq 0.001$). Furthermore, significant behavior improvements were also found in vegetable consumption (79% to 82%; $p \leq 0.001$), fruit juice consumption (62% to 51%; $p \leq 0.01$), participation in vigorous physical activity (75% to 82%; $p \leq 0.001$), and reduced fat milk consumption (31% to 47%; $p \leq 0.01$). In addition to the nutrition and physical activity education program, HSS conducted exercise classes and results show that adults reported a 34% increase in physical activity.

2. **Musculoskeletal and Rheumatologic Conditions & its Symptoms:** HSS implemented culturally relevant lectures and workshops aimed at increasing knowledge and self-management of musculoskeletal conditions and its symptoms. Knowledge, self-management skills, and program satisfaction were measured after participating in program to assess impact. Results show that we implemented 2,108 lectures/workshops reaching 22,563 community members. Evaluation of program data demonstrates that these lectures/workshops have had a positive impact on participants' knowledge (91%), and self-management skills (89%). In addition, 93% of participants were satisfied with our programs, and would recommend to a friend or family. In addition to the educational lectures/workshops, we conducted exercise programs aimed at reducing the impact of musculoskeletal conditions and its symptoms on the community. Results show that our exercise classes reached over 25,000 adults, demonstrating positive impact on key health outcomes i.e. self-reported pain, pain severity and interference, stiffness, fatigue, balance, and level of physical activity. Specifically, participants reported 43% decrease in muscle/joint pain ($p \leq 0.001$), 20% decrease in stiffness ($p \leq 0.001$), 28% decrease in fatigue ($p \leq 0.001$); 20% improvement in balance ($p \leq 0.001$); and 34% increase in physical activity.

Section 4: Implementation Strategy – Addressing Community Needs

HSS' implementation strategy is to provide targeted, culturally relevant programming that will address the top 10 community's health needs identified above. A listing of HSS' hospital-based, outreach and support initiatives in addressing identified health needs is seen in Table 3 below:

Table 3: Implementation strategy

Health Need	HSS Programs
1. Osteoarthritis	• Asian Community Bone Health Initiative • Musculoskeletal Health Wellness Initiative • Nursing Community Education Outreach Initiative • VOICES 60+ Senior Advocacy Program
2. Osteoporosis	• Asian Community Bone Health Initiative • Musculoskeletal Health Wellness Initiative • Nursing Community Education Outreach Initiative • VOICES 60+ Senior Advocacy Program
3. Joint, muscle, bone and pains	• Asian Community Bone Health Initiative • Charla de Lupus/Lupus Chat® • LANtern® Lupus Asian Network • Musculoskeletal Health Wellness Initiative • Nursing Community Education Outreach Initiative • VOICES 60+ Senior Advocacy Program
4. Falls and loss of balance	• Asian Community Bone Health Initiative • Musculoskeletal Health Wellness Initiative • Nursing Community Education Outreach Initiative • Asian Community Bone Health Initiative
5. Rheumatoid Arthritis (RA)	• Musculoskeletal Health Wellness Initiative • Nursing Community Education Outreach Initiative • Rheumatoid Arthritis (RA) Support and Education Programs
6. Stress and mental health	• Charla de Lupus/Lupus Chat® • Nursing Community Education Outreach Initiative • Pain and Stress Management Series • Rheumatoid Arthritis (RA) Support and Education Programs
7. Lifestyle i.e. poor diet, obesity, lack of exercise	• Musculoskeletal Health Wellness Initiative • Nursing Community Education Outreach Initiative • SNEAKER© Super Nutrition Education for All Kids to Eat Right
8. Fatigue	• Charla de Lupus/Lupus Chat® • LANtern® Lupus Asian Network • Musculoskeletal Health Wellness Initiative
9. Stiffness	• Asian Community Bone Health Initiative • Musculoskeletal Health Wellness Initiative
10. Complementary alternatives to manage pain	• Musculoskeletal Health Wellness Initiative • Pain and Stress Management Series

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A detailed description of how HSS' programs will address health needs, anticipated impact of implementation strategy, and planned collaboration with organizations is provided below.

1. **Asian Community Bone Health Initiative:** This initiative is comprised of culturally relevant educational and exercise programs (i.e. yoga and low impact chair exercises) designed to improve Asian seniors' management of their chronic musculoskeletal conditions (such as osteoarthritis and osteoporosis) and its symptoms (e.g. falls, stiffness, fatigue, muscle bone and joint pain) while also increasing access to care in this medically underserved community. The anticipated program impact includes improved musculoskeletal health by decreasing musculoskeletal pain, stiffness, fatigue and falls, and increasing frequency of physical activity and self-efficacy. This program is a community-based initiative and will partner with senior and community centers serving Asian older adults such as Selfhelp Innovative Senior Center and Chinatown Community Center, Visiting Nurse Service of New York in addressing the health need.

2. **Charla de Lupus/Lupus Chat®:** This is a social work led program that engages and trains peer volunteers to become empowering role models by providing culturally relevant strategies to help increase understanding of this complex illness and its treatment, improve medical adherence, and enhance coping and healthy behaviors. Comprehensive bilingual (English/Spanish) services include: the Charla Line, a toll-free national support and education helpline; weekly Onsite Peer Support Outreach at four hospital-based clinics, monthly Charla Teen and Parent Lupus Chat Groups; numerous communities, professional education and government collaborations. Anticipated program impact includes increased knowledge and self-management skills of lupus and its symptoms. The Charla de Lupus/Lupus Chat® will partner with community-based organizations throughout NYC such as Planned Parenthood of NYC and Community Healthcare Partners in addressing the health need.

3. **LANtern® Lupus Asian Network**: HSS LANtern is a national model for support and education of Asian Americans with lupus and their families. LANtern is the only hospital-based support and education program designed specifically for Asians/Asian Americans with lupus. Through its bilingual (Chinese) SupportLine, publications, community and professional programs, and capacity building, the program seeks to enhance awareness, understanding, coping and knowledge for Asian Americans with lupus and their loved ones. Anticipated program impact includes increased knowledge about high quality preventive care for the Asian community and improved clinical management of lupus and its symptoms. LANtern will partner with community-based, hospital-based and professional organizations such as Charles B. Wang Community Health Center, NY Presbyterian's Lower Manhattan Hospital's Community Partnership for Health (CCPH), Association of Chinese American Physicians (CAMS), the Lupus Research Alliance in addressing the health need.

4. **Musculoskeletal Health Wellness Initiative (MHI):**This initiative is comprised of hospital and community-based educational and exercise programs to raise awareness, educate and reduce the impact of musculoskeletal conditions in the community. The educational component of MHI offers lectures, workshops and webinars about musculoskeletal health-specific topics such as osteoarthritis, osteoporosis, and rheumatoid arthritis and some of the symptoms associated with these conditions (falls, fatigue, stiffness, and muscle, bone and joint pain), in addition to maintaining a healthy lifestyle. The exercise component of the initiative is comprised of weekly exercise classes such as Yoga, Pilates, Tai Chi, Dance, and Yogalates specifically designed for individuals that are suffering from or at risk of musculoskeletal and rheumatologic conditions. The anticipated program impact includes improved musculoskeletal health by decreasing musculoskeletal pain, stiffness, fatigue and falls, and increasing frequency of physical activity and self-efficacy. MHI will partner with Arthritis Foundation, and local community centers in NYC and Stamford in addressing the health need.

5. **Nursing Community Education Outreach Program (NCEOP):** This program targets underserved older adults living in the community. The program's overall goal is to deliver evidence-based educational content germane to issues appropriate for older adults. The quality educational sessions use teaching strategies and educational principles deigned to improve knowledge, skills and confidence to manage and prevent chronic diseases. Educational lectures are mainly delivered by HSS nursing staff, and topics are selected based upon needs assessment results and participant feedback, such as management of chronic conditions (i.e. osteoarthritis, osteoporosis and rheumatoid arthritis, obesity, etc.), falls prevention, vaccines, nutrition and medication safety. Anticipated program impact includes increased knowledge and self-management skills of chronic conditions. NCEOP will partner with CBOs such as the Carter Burden Network and Community Access, NYC Department of Education, and NY Presbyterian Clinical Translational Science Center in addressing the health need.

6. **Pain and Stress Management (PSM) Program:** This program is comprised of educational, and mindfulness based coping techniques to raise awareness, educate and improve the ability to cope with pain and stress. This program offers mind/body workshops, exercises such as Yoga, and expert-guided meditation to help reduce physical and mental stressors. All the educational programs are taught by experienced physicians, nurses, physical and occupational therapists, while Yoga workshops are led by certified yoga instructors. Anticipated program impact includes increased knowledge and self-management skills of coping with pain and stress. The PSM program will partner with subject matter experts such clinicians, social workers, certified yoga therapists in addressing the health need.

7. **Rheumatoid Arthritis (RA) Support and Education Programs:** This initiative addresses the psychoeducational needs of community members and their families living with long-standing rheumatoid arthritis, and for people newly diagnosed. These monthly programs feature a lecture on an RA-specific topic its management, presented by healthcare professionals, and are followed by a support group, co-facilitated by a social worker and a rheumatology nurse. Anticipated program impact includes enhancing self-management skills and self-efficacy around managing RA and its symptoms. The RA support and education programs will partner with Arthritis Foundation, Spondylitis Association of America, and Creaky Joints in addressing the health need.

8. **SNEAKER© Super Nutrition Education for All Kids to Eat Right:** This is a 7-week interactive nutrition and physical activity education program designed to provide children and families with essential knowledge about healthy eating and physical activity. The SNEAKER curriculum focuses on portion control, whole grains and fiber, fruits and vegetables, beverages, physical activity, protein and dairy, and fast food and snacks. The program provides interactive lessons that help to teach students the importance of eating a healthy, well-balanced diet and being physically active, encourage children to make healthier food choices, and educate students about how to be more physically active. Understanding the importance and influential role parents and caregivers have on a child's diet, SNEAKER© contains a parent/caregiver component wherein weekly newsletters are sent home to educate the parent/caregiver about the lessons their child learned in school so they can help foster healthy changes for the child and the entire family. The program is implemented in public schools and after-school programs largely located in medically underserved areas throughout NYC. Residents in these areas are predominantly Hispanic/Latino, African American and Asian. Anticipated program impact includes improving the nutrition knowledge of children and families as well as their food choices and level of physical activity. SNEAKER will partner with NYC Department of Education and public schools in addressing the health need.

9. **VOICES 60+ Senior Advocacy Program:** VOICES 60+ is designed to enhance the medical care experience of low income, ethnically diverse (primarily Hispanic) HSS patients 60 and older in these areas. The program helps patients to navigate and access support, education and communication resources needed to manage their rheumatologic or musculoskeletal conditions and its symptoms to improve their quality of life. In addition, the program provides services focused on identifying and addressing communication barriers between older adult patients and healthcare providers to optimize health outcomes. Anticipated program impact includes improved knowledge, and provider/patient communication that will enhance self-management skills of musculoskeletal conditions and its symptoms. VOICES 60+ will partner with social services and CBOs such as Carter Burder Network, Dorot, Inc., JASA, Lenox Hill Neighborhood House, Service Program for Older People (SPOP), Selfhelp Community Services, and Stanley Isaacs Neighborhood Center in addressing the health need.

Community Resources Available to Address Needs

HSS works to strengthen its extensive community education, wellness, support and outreach initiatives through its collaborations with community organizations, public schools, city and state agencies, universities, clinical settings, and the private sector. In addition to HSS' strategy in addressing identified health needs described above, below is a listing of existing healthcare facilities/community resources available to respond to these community health needs.

Clinical/Academic Partnerships

- Asian American/Asian Research Institute, City University of New York
- Charles B. Wang Community Health Center
- Chinese Community Partnership for Health, NewYork-Presbyterian/Lower Manhattan Hospital
- Clinical Translational Science Center, Community Engagement Core, Weill Cornell Medical College
- Coalition of Chinese American IPA
- HSS China Orthopedic Education Exchange
- Mt. Sinai Medical Center, Adolescent Health Center
- NewYork-Presbyterian/Morgan Stanley Children's Hospital at Columbia University Medical Center, Pediatric Rheumatology Service
- NewYork-Presbyterian/Columbia University Medical Center – The Mens Clinic at Audubon Clinic
- NewYork-Presbyterian/Weill Cornell Medical Center – Health Outreach® Program
- NewYork-Presbyterian Hospital
- New York University Silberman School of Social Work
- Touro College Graduate School of Social Work
- Translational Research Institute for Pain in Later Life (TRIPLL)
- University of Delaware
- Weill Cornell Medical College, Department of Psychiatry

Community-Based Organization Partners

- 92nd Y
- All Community Adult Day Centers
- Amani Public Charter School
- American Heart Association, Fairfield & Westchester Counties
- American Red Cross
- AmeriCares Free Clinics
- Arthritis Foundation – NY Chapter
- Asian Health and Social Service Council
- Asphalt Green
- Association of Chinese American Physicians (ACAP)
- Bayside High School
- Brown Gardens Assisted Living Facility
- Breakaway Hoops
- Blue Ridge High School
- Blondes Vs. Brunette Football
- Building One Community

- Cardoza High School
- Chinese American Medical Society (CAMS)
- Carter Burden Network, Leonard Covello Senior Program
- Centercourt Sports
- Charter School of Excellence
- Children's Aid Society
- Chinese-American Planning Council
- CUNYAC
- Chatham High School
- Chelsea Piers CT
- Chinese Consolidated Benevolent Association
- Community Health Center, Inc.
- Concerned Home Managers for the Elderly (COHME)
- Cristo Rey High School Bronx
- Dominican College
- Dorot, Inc.
- East Harlem Community Health Committee (EHCHC)
- Fifth Avenue Presbyterian Church
- Friends Academy High School
- Girl Scouts of Jersey Shore
- Golden Eagle Adult Day Center
- Gouverneur Court
- Greenwich Alliance for Education
- Harlem Lacrosse
- Hempstead High School
- Isabella Geriatric Center
- Jewish Association Services for the Aged (JASA)
- KIPP High School
- Lenox Hill Neighborhood House and (St. Peter's Church)
- LaGuardia Senior Citizens Center
- Lupus Research Alliance
- Lupus Foundation of America
- Manhattan Country Day School
- Marywood University
- Maspeth High School
- Medicare Rights Center
- Mott Street Senior Center
- Neighbors Link Stamford
- Norwalk Senior Center, South Norwalk
- New York Chinatown Senior Citizen Center
- New York Foundation for Senior Citizens
- New York Road Runners Club (NYRR)
- Nightingale High School
- Oceanside Stallions Football
- Over 60 Senior Neighborhood
- Planned Parenthood of NYC
- Prime Care Home Health Agency
- Project Sunshine
- PS 76- Harlem
- Public School Athletic League
- Sacred Heart High School
- Selfhelp Innovative Senior Center
- Service Program for Older People
- Spondylitis Association of America
- Stamford Department of Health
- Stamford Hospital
- Stamford Senior Center
- Stamford YMCA
- Stanley M. Isaacs Neighborhood Center
- St. Mary's School- Manhasset
- Tarrytown YMCA
- The Calhoun School
- The Center for Information & Study on Clinical Research Participation (CISCRIP)
- The Collegiate School
- The Myositis Association
- The Scleroderma Foundation
- Urban Health Plan, Inc.
- Visiting Nurse Service of New York
- Wendy Hilliard Gymnastics
- West Side Interagency Council on the Aging (WSIACA)
- Xavier High School
- YM & YWHA – Washington Heights/Inwood
- Young Women's Leadership School (Astoria)

Government/Public Partners

- MTA Paratransit Access-A-Ride Program
- National Institute for Arthritis and Musculoskeletal Disease (NIAMS) – National Multicultural Outreach Initiative
- New York City Department for the Aging

- New York City Department of Health and Mental Hygiene
- New York City Public Schools
- New York Public Libraries
- New York State Department of Health
- Office of Women's Health, U.S. Department of Health and Human Services
- Department of Youth and Community Development

CONCLUSION

Using results of the 2019 CHNA and systematic feedback from varied parties representing the general community, HSS was able to identify and prioritize the health needs to meet the community's needs. This information will continue to form the basis for the Hospital's strong dedication to improving mobility and quality of life, which are values that extend beyond its specialized focus on musculoskeletal and rheumatologic care.

This Community Health Needs Assessment (CHNA) Report and Implementation Plan has been adopted by HSS Community Benefit and Services Committee of the Board of Trustees.

Appendix A: CHNA Surveys in English, Spanish, Chinese and Russian

Community Health Needs Assessment (CHNA)

Scan to complete survey online

HSS wants to hear about your needs regarding muscle, bone, and joint conditions. This will help us to improve upon programs and services that are important to our patients and community. We do not need your name for this survey. Completing this survey will not affect your care at HSS. Please return this survey no later than **April 1, 2019**, so that we can make sure your opinion counts. Thank you for your help!

A. Health Status and Quality of Life: The following questions are about how you feel overall and about health conditions you may have. Please choose your response from the options listed. If you are unsure, please give the best answer you can.

A1. Would you say that in general your health is?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't Know

A2. Now thinking about your **physical health**, which includes physical illness and injury, for how many days during the **past 30 days** was your physical health not good?

- ☐ None
- ☐ Less than a week
- ☐ 1-2 weeks
- ☐ More than 2 weeks

A3. Have you ever been told by a doctor or other health professional that you have …?

		Yes	No
a)	Osteoarthritis (OA)	☐	☐
b)	Rheumatoid arthritis (RA)	☐	☐
c)	Lupus	☐	☐
d)	Fibromyalgia	☐	☐
e)	Gout	☐	☐
f)	Some other form of arthritis	☐	☐
g)	Osteoporosis	☐	☐
h)	Other: _____		

Note: If you answered "No" to ALL parts of Question A3, please SKIP to Question A6.

A4. Which of the following symptoms have you experienced within the **past 30 days due to your condition(s)**?

		Yes	No
a)	Joint / bone pain or aches	☐	☐
b)	Muscle pain or aches	☐	☐
c)	Stiffness	☐	☐
d)	Fatigue	☐	☐
e)	Weight changes	☐	☐
f)	Skin rash	☐	☐
g)	Hair loss	☐	☐
h)	Mood changes (feeling sad, irritable, etc.)	☐	☐
i)	Trouble with concentrating	☐	☐
j)	Changes in memory	☐	☐
k)	Problems with balance	☐	☐
l)	Other: _____		

A5. Are you now limited in any from your usual activities because of your arthritis or joint symptoms?

☐ Yes ☐ No ☐ Don't know

A6. In the past year, have you fallen down?

☐ Yes ☐ No ☐ Don't know

Note: If you answered "No" to Question A6, please SKIP to Question A9.

A7. If ***Yes***, did you break any bones as a result of your fall?

☐ Yes ☐ No ☐ Don't know

A8. Did you talk to your doctor or other healthcare provider about your fall(s)?

☐ Yes ☐ No ☐ Don't know

A9. Now thinking about your **mental health**, which includes stress, depression, and problems with emotions, for how many days during the **past 30 days** was your mental health not good?

☐ None
☐ Less than a week
☐ 1-2 weeks
☐ More than 2 weeks

A10. Over the **last 2 weeks**, how often have you been bothered by these problems?

	Not at all	Several days	More than half the days	Nearly everyday	Don't Know
a) Feeling nervous, anxious or on edge:	☐	☐	☐	☐	☐
b) Not being able to stop or control worrying:	☐	☐	☐	☐	☐
c) Feeling down, depressed or hopeless:	☐	☐	☒	☐	☐
d) Little interest or pleasure in doing things:	☐	☐	☐	☐	☐

A11. The next question asks about difficulties you may have completing certain activities because of a HEALTH PROBLEM. By "health problem" we mean any physical, mental, or emotional problem or illness (not including pregnancy).

By yourself and without using any special equipment, how difficult is it for you to…

	Not at all difficult	Only a little difficult	Some-what difficult	Very difficult	Can't do at all	Do not do this activity	Don't know
a) walk a quarter of a mile (about 3 city blocks)?	☐	☐	☐	☐	☐	☐	☐
b) walk up 10 steps without resting?	☐	☐	☐	☐	☐	☐	☐
c) stoop, bend or kneel?	☐	☐	☐	☐	☐	☐	☐
d) use your fingers to grasp or handle small objects?	☐	☒	☐	☐	☐	☐	☐

A12. During the **past 30 days**, how many days did **pain** make it hard for you to do your usual activities, such as personal care, work, or hobbies?

☐ None
☐ Less than a week
☐ 1-2 weeks
☐ More than 2 weeks

B. Health Behaviors & Lifestyle: The next series of questions are about physical activities or exercise you may do, about your eating habits, your sexual behavior and your use of prescription medication. Physical activity is anything that gets your body moving.

B1. How often do you do **vigorous leisure-time** physical activities for at least 25 minutes that cause **heavy** sweating or **large** increases in breathing or heart rate (such as running)?

☐ 5 or more times a week
☐ 3 – 4 times a week
☐ 1 – 2 times a week
☐ None

B2. How often do you do **light or moderate leisure-time** physical activities for at least 30 minutes that cause **only light** sweating or a **slight to moderate** increase in breathing or heart rate (such as walking)?

☐ 5 or more times a week
☐ 3 – 4 times a week
☐ 1 – 2 times a week
☐ None

B3. How often do you do leisure-time physical activities specifically designed to **strengthen your muscles** such as lifting

weights or doing calisthenics (such as push-ups, pull-ups, squats, jumping jacks)?

☐ 1 – 2 times a week
☐ Unable to do such activities
☐ Never

B4. In the past 12 months, has a doctor or other health professional suggested that you lose weight?

☐ Yes ☐ No ☐ Don't know

B5. In the past 12 months, has a doctor or other health professional suggested that you do physical activity or exercise?

☐ Yes ☐ No ☐ Don't know

B6. In general, how healthy is your overall diet? A healthy diet includes lean protein, low-fat dairy, fruits and vegetables, whole grains, and healthy fat.

☐ Extremely healthy
☐ Very healthy
☐ Healthy
☐ Somewhat healthy
☐ Not healthy at all

B7. Would you like to eat healthier?

☐ Yes ☐ No ☐ Don't know

Note: If you answered "No" to B7, please SKIP to Question B9.

B8. If you would like to eat healthier, what keeps you from doing so?

		Yes	**No**
a)	Healthy foods cost too much	☐	☐
b)	I do not like the taste	☐	☐
c)	I do not have any places where I live to find healthy food	☐	☐
d)	It takes too much time and effort to prepare	☐	☐
e)	I do not know what foods to eat	☐	☐
f)	Family and friends do not eat that way	☐	☐
g)	Other: _____		
h)	Does not apply - I already eat healthy	☐	☐

B9. Have your muscle, bone or joint condition(s) affected your sexual health?

☐ Yes ☐ No ☐ Don't know

B10. If yes, choose all that apply:

☐ Pregnancy
☐ Decreased sexual desire and satisfaction
☐ Increased sensitivity to being touched
☐ Urinary tract infection
☐ Vaginal Dryness
☐ Limitation of motion/pain
☐ Infertility
☐ Decreased sexual intercourse/intimacy
☐ Erectile dysfunction/ Impotence
☐ Decreased sense of sexual attractiveness
☐ Other: _____

B11. In the past 12 months, have you used any prescription pain relievers?

☐ Yes ☐ No ☐ Don't know

B12. In the past 12 months, how often have you used complementary treatments (such as yoga, meditation, mindful breathing) to manage your pain?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

B13. Do you agree or disagree with the following statement? "It is OK to take more than the recommended dosage of a prescription medication if you are feeling more pain than usual."

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree ☐ Not sure

C. Use of and Access to Care: These questions are about your healthcare experiences and healthcare education needs. Please choose your response from the options listed. If you are unsure, please give the best answer you can.

C1. Do you have any kind of health insurance coverage, including private health insurance or government plans such as Medicare or Medicaid?

☐ Yes ☐ No ☐ Don't know

Note: If you answered "No" or "Don't know" to Question C1, please SKIP to Question C3

C2. What is the primary source of your health care coverage?

☐ A plan purchased through an employer or union (includes plans purchased through another person's employer)
☐ A plan that you or another family member buys on your own
☐ Medicaid
☐ Medicare
☐ TRICARE (formerly CHAMPUS), VA, or Military
☐ Alaska Native, Indian Health Service, Tribal Health Services
☐ Some other source
☐ Don't Know

Note: Purchased health insurance through the Health Insurance Marketplace: If purchased on your own (or by a family member), select option 2, if Medicaid select option 3.

C3. If you do not currently have health insurance or you have not had insurance at any time in the **past 12 months**, what are the reasons why?

Check all that apply.

☐ My employer does not offer it
☐ I am self-employed
☐ I am currently unemployed
☐ I can't afford insurance
☐ I am healthy and don't think I need it
☐ Other reason: _____
☐ Not applicable

C4. Have you received the following **within the past 12 months**?

	Yes	No
a. Immunizations (such as flu shot)	☐	☐
b. Sexually Transmitted infection (STI)/ HIV screening	☐	☐

C5. Was there a time in the past 12 months when you needed medical care but did not get it?

Note: Medical care includes doctor's visits, tests, procedures, prescription medication and hospitalizations

☐ Yes ☐ No ☐ Don't know

Note: If you answered "No" or "Don't know" to Question C5, please SKIP to Question C7

C6. If Yes, what were the reasons why you could not do so? Check all that apply.

☐ Could not afford it
☐ No health insurance
☐ Service not covered by insurance
☐ Lack of transportation
☐ Hard to get an appointment
☐ Not sure where to go
☐ Family responsibilities (such as no child care available)
☐ Language services (such as could not get healthcare in my language)
☐ Office not patient-friendly (such as long wait time, hours not convenient)
☐ Other reason: _____

C7. How often do you follow your doctor or other healthcare provider's medical advice?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

C8. Sometimes people don't follow their doctor or other healthcare provider's medical advice. Please tell us the reasons that may apply to you. Check all that apply.

		Yes	No
a)	Provider didn't explain treatment well enough (due to lack of time, uncaring attitude, or hard to understand)	☐	☐
b)	Did not feel treatment would help	☐	☐
c)	Concerned about the cost of treatment	☐	☐
d)	Forgot to take medicine / go for follow-up	☐	☐
e)	Provider doesn't understand my culture / language	☐	☐
f)	Condition not severe enough to require treatment	☐	☐
g)	Worried about side effects of treatment	☐	☐
h)	Prefer to use complementary / alternative treatment	☐	☐
i)	Did not fit my schedule / not convenient for me	☐	☐
j)	Did not agree with the doctor / provider	☐	☐
k)	Other reason: _____		
l)	Does not apply - always follow the medical advice of my doctor or other healthcare provider	☐	☐

C9. When you visit your doctor (or other healthcare provider), how often do you do the following:

		Never	Sometimes	Usually	Always
a)	Prepare a list of questions for your doctor (or other healthcare provider)	☐	☐	☐	☐
b)	Ask questions about the things you don't understand about your treatment	☐	☐	☐	☐
c)	Discuss any personal problems that may be related to your illness	☐	☐	☐	☐

C10. How confident are you that you can manage symptoms of your bone, muscle and joint condition so that you can do the things that you want to do?

☐ Not at all confident ☐ Somewhat confident ☐ Confident ☐ Very confident

C11. How would you rate your ability to speak and understand English?

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor

C12. What is your preferred language for discussing healthcare?

☐ English
☐ Spanish
☐ Chinese
☐ Russian
☐ Other: _____

C13. In what language would you **prefer** reading medical or healthcare instruction?

☐ English
☐ Spanish
☐ Chinese
☐ Russian
☐ Other: _____

C14. How often do you need to have someone help you when you read instructions, pamphlets, or other written materials from your doctor or pharmacy?

☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

C15. Where do you usually obtain your health information/advice?

Check all that apply

- ☐ Clinic or health center
- ☐ Doctor's Office
- ☐ Health Maintenance Organization (HMO)
- ☐ Hospital Emergency Room
- ☐ Hospital Outpatient Department
- ☐ Family
- ☐ Friends/Colleagues
- ☐ Internet
- ☐ Other: _____
- ☐ Don't seek health information or advice often

D. Health Education: HSS provides health education programs. The following questions will help the Hospital identify the health education needs of the community.

D1. Have you EVER taken an educational course or class to learn how to manage your bone, muscle or joint health/condition?

- ☐ Yes
- ☐ No
- ☐ Don't know

D2. How confident are you that taking a course or class would help you manage your bone, muscle or joint health/condition?

- ☐ Not at all confident
- ☐ Somewhat confident
- ☐ Confident
- ☐ Very confident

D3. How do you prefer to receive educational information to manage your condition?

Check all that apply

- ☐ Lectures
- ☐ Small group workshops
- ☐ Waiting area demonstration
- ☐ Online lectures on your computer or mobile device
- ☐ Podcasts on your computer or mobile device
- ☐ Brochures/Flyers
- ☐ Other: _____

D4. Which of the following health education activities would you be interested in participating in?

Check all that apply.

- ☐ Exercise Classes such as T'ai Chi, Pilates or Yoga
- ☐ Workshops allowing for hands-on, small group learning
- ☐ Onsite lectures at HSS about prevention or management of bone, muscle or joint conditions and general wellness
- ☐ Online lectures on your computer/mobile device about prevention or management of bone, muscle or joint conditions and other health and wellness topics
- ☐ Podcasts, free audio and video programs available for downloading and viewing directly to your computer, consisting of interviews, patient testimonials, condition or treatment highlights and other subjects presented by our hospitals physicians and staff
- ☐ None of the above

D5. Which of the following health topics would you be interested in? Check all that apply.

- ☐ Osteoarthritis (OA)
- ☐ Rheumatoid arthritis (RA)
- ☐ Back pain
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Doctor-patient communication
- ☐ How to exercise and manage my condition
- ☐ Ways to improve my mobility
- ☐ Other: _____

E. About You: Please tell us about you and your background so that we can learn more about the communities we serve.

E1. What is your gender?

- ☐ Female
- ☐ Male
- ☐ Gender non-conforming
- ☐ Trans Female (MtF)
- ☐ Trans Male (FtM)

☐ Other: _____

E2. What is your sexual orientation?

☐ Straight
☐ Lesbian
☐ Gay
☐ Bisexual
☐ Something else
☐ Don't know

E3. What is your age? ____

E4. Do you consider yourself Hispanic/Latino?

☐ Yes ☐ No

E5. Which one of these groups would you say best represents your race?

Check all that apply

☐ American Indian / Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/ Other Pacific Islander
☐ White
☐ Other: _____

E6. Please tell us about your ethnicity; you can list as many as you prefer (for example: Chinese, Nigerian, Italian, Puerto Rican, Russian, etc.)

E7. Are you…...?

☐ Married
☐ Divorced
☐ Widowed
☐ Separated
☐ Never married
☐ Living together as a couple

E8. Do you live alone?

☐ Yes ☐ No

E9. What language(s) do you speak at home?

Check all that apply.

☐ English
☐ Spanish
☐ Chinese
☐ Russian
☐ Other: _____

E10. What is the highest grade or year of school you completed?

☐ Never attended school or only attended kindergarten
☐ Grades 1 through 8 (Elementary)
☐ Grades 9 through 11 (Some high school)
☐ Grade 12 or GED (High school graduate)
☐ College 1 year to 3 years (Some college or technical school)
☐ College 4 years or more (College graduate)
☐ Post graduate (Masters, PhD)

E11. Are you currently…?

☐ Employed
☐ Self-employed
☐ Out of work for 1 year or more
☐ Out of work for less than 1 year
☐ A Homemaker
☐ A Student
☐ Retired
☐ Unable to work

E12. What is your annual household income from all sources?

☐ Less than $10,000
☐ $10,000 – $14,999
☐ $15,000 – $24,999
☐ $25,000 – $34,999
☐ $35,000 – $49,999
☐ $50,000 – $74,999
☐ $75,000 – $99,999
☐ $100,000 – $149,999
☐ $150,000 – $199,999
☐ $200,000 or more

E13. Where do you currently live?

- ☐ Brooklyn
- ☐ Bronx
- ☐ Manhattan
- ☐ Queens
- ☐ Staten Island
- ☐ Long Island, Nassau County
- ☐ Long Island, Suffolk County
- ☐ Westchester
- ☐ New Jersey
- ☐ Connecticut
- ☐ Other: _____

E14. What is the zip code where you currently live? _____

E15. Please use the space below to share with us any other muscle, bone, joint, or rheumatology-related needs that you would like Hospital for Special Surgery to know about:

Please return this survey no later than April 1, 2019 so that we can make sure your opinion counts.

Please send the completed survey back to us in one of the following ways:

1. **Mail** using the enclosed pre-paid envelope
2. **Online** using the QR code on the first page of the survey
3. **Drop off** at: Hospital for Special Surgery Education & Academic Affairs Division office, located at: 517 East 71st Street, NY, NY 10021 – **Attn: Titilayo Ologhobo**

If you have any questions or concerns about the survey, please contact Titilayo Ologhobo, Associate Director, Outcomes, at 212-774-2185.

Evaluación de necesidades de salud de la comunidad (CHNA)

Escanear para completer la encuesta en línea

Hospital for Special Surgery (HSS) quiere conocer sus necesidades relacionadas con enfermedades de los músculos, los huesos y las articulaciones. Esto nos ayudará a mejorar los programas y servicios que sonn importantes para nuestros pacientes y la comunidad. No necesitamos su nombre para esta encuesta. Completar esta encuesta no afectará la atención que HSS le proporciona. Por favor regrese esta encuesta antes del **1 de abril del 2019** para poder asegurarnos de que su opinión sea tomada en cuenta. ¡Gracias por su ayuda!

A. Estado de salud y calidad de vida: Las siguientes preguntas se refieren a cómo se siente en general y los trastornos de salud que puede tener. Elija su respuesta de las opciones de la lista. Si no está seguro, responda de la mejor manera posible.

A1. En general, ¿diría que su salud es?

- ☐ Excelente
- ☐ Muy buena
- ☐ Buena
- ☐ Más o menos
- ☐ Mala
- ☐ No sé

A2. Considerando su **salud física**, incluyendo las enfermedades y lesiones físicas, durante los **últimos 30 días**, ¿cuántos días su salud física no fue buena?

- ☐ Ninguno
- ☐ Menos de una semana
- ☐ 1-2 semanas
- ☐ Más de 2 semanas

A3. ¿Alguna vez le ha dicho un médico u otro profesional de la salud que usted tiene...?

		Sí	No
i)	Osteoartritis (OA)	☐	☐
j)	Artritis reumatoide (AR)	☐	☐
k)	Lupus	☐	☐
l)	Fibromialgia	☐	☐
m)	Gota	☐	☐
n)	Otra forma de artritis	☐	☐
o)	Osteoporosis	☐	☐
p)	Otro: _____		

Nota: Si respondió "No" a TODAS las partes de la pregunta A3, PASE a la pregunta A6.

A4. ¿Cuál de los siguientes síntomas ha experimentado usted en los **últimos 30 días debido a su(s) enfermedad(es)**?

		Sí	No
m)	Molestias o dolores en las articulaciones/huesos	☐	☐
n)	Molestias o dolores en los músculos	☐	☐
o)	Rigidez	☐	☐
p)	Fatiga	☐	☐
q)	Cambios en el peso	☐	☐
r)	Erupción de piel	☐	☐
s)	Pérdida del cabello	☐	☐
t)	Cambios en el estado de ánimo (sentirse triste, irritable, etc.)	☐	☐
u)	Dificultad para concentrarse	☐	☐
v)	Cambios en la memoria	☐	☐
w)	Problemas con el equilibrio	☐	☐
x)	Otro: _____		

A5. En la actualidad, ¿se encuentra limitado de alguna manera en sus actividades habituales debido a la artritis o los síntomas en las articulaciones?

☐ Sí ☐ No ☐ No sé

A6. En el año pasado, ¿ha sufrido una caída?

☐Sí ☐ No ☐ No sé

Nota: Si respondió "No" a la pregunta A6, PASE a la pregunta A9.

A7. En caso ***afirmativo***, ¿se fracturó algún hueso como consecuencia de la caída?

☐ Sí ☐ No ☐ No sé

A8. ¿Habló con su médico u otro proveedor de la salud sobre su(s) caída(s)?

☐ Sí ☐ No ☐ No sé

A9. Considerando su **salud mental**, incluyendo estrés, depresión y problemas emocionales, durante los

últimos 30 días, ¿cuántos días su salud mental no fue buena?

☐ Ninguno ☐ Menos de 1 semana
☐ 1-2 semanas ☐ Más de 2 semanas

A10. En las **últimas 2 semanas**, ¿con qué frecuencia le han preocupado los siguientes problemas?

	Nunca	Varios días	Más de la mitad de los días	Casi todos los días	No sé
e) Sentirse nervioso, ansioso o con los nervios de punta:	☐	☐	☐	☐	☐
f) Incapaz de detener o controlar las preocupaciones:	☐	☐	☐	☐	☐
g) Sentirse triste, deprimido o desesperanzado:	☐	☐	☐	☐	☐
h) Poco interés o placer en hacer las cosas:	☐	☐	☐	☐	☐

A11. La siguiente pregunta trata sobre las dificultades que puede tener al realizar ciertas actividades a causa de un PROBLEMA DE SALUD. Por "problema de salud" nos referimos a cualquier problema o enfermedad física, mental o emocional (sin incluir el embarazo).

Por sí mismo y sin utilizar ningún equipo especial, ¿qué tan difícil es para usted…

	Para nada difícil	Solo un poco difícil	Algo difícil	Muy difícil	No pude hacerlo	No hice esta actividad	No sé
e) Caminar un cuarto de milla (aproximadamente 3 cuadras de ciudad)?	☐	☐	☐	☐	☐	☐	☐
f) Caminar 10 pasos sin descansar?	☐	☐	☐	☐	☐	☐	☐
g) Agacharse, inclinarse o arrodillarse?	☐	☐	☐	☐	☐	☐	☐
h) Usar los dedos para tomar o manipular objetos pequeños?	☐	☐	☐	☐	☐	☐	☐

A12. En los **últimos 30 días**, ¿cuántos días le dificultó el **dolor** llevar a cabo sus actividades habituales? (tales como cuidado personal, trabajo o pasatiempos)

☐ Ninguno ☐ Menos de 1 semana
☐ 1-2 semanas ☐ Más de 2 semanas

B. Comportamientos de salud y estilo de vida: La siguiente serie de preguntas se refiere a *actividades físicas o ejercicios* que usted puede hacer y sobre sus hábitos alimenticios, su comportamiento sexual y sobre el uso de medicamentos recetados. La actividad física es cualquier cosa que ponga a su cuerpo en movimiento.

B1. ¿Con qué frecuencia realiza actividades físicas **vigorosas en su tiempo libre** durante al menos 25 minutos que causen sudor **excesivo** o **grandes** aumentos en la frecuencia cardíaca o respiratoria (como correr)?

☐ 5 o más veces por semana
☐ 3 a 4 veces por semana
☐ 1 a 2 veces por semana
☐ Ninguna

B2. ¿Con qué frecuencia realiza actividades físicas **ligeras o moderadas en su tiempo libre** durante al menos 30 minutos que causen sudoración **ligera** o aumentos **ligeros a moderados** en la frecuencia cardíaca o respiratoria (como caminar)?

☐ 5 o más veces por semana
☐ 3 a 4 veces por semana
☐ 1 a 2 veces por semana
☐ Ninguna

B3. ¿Con qué frecuencia realiza actividades físicas en su tiempo libre diseñadas

específicamente para **fortalecer los músculos**, tales como levantar pesas o hacer ejercicios de calistenia (como flexiones, dominadas, sentadillas, saltos)?

☐ 1 a 2 veces por semana
☐ No puedo hacer este tipo de actividades
☐ Nunca

B4. En los últimos 12 meses, ¿le ha sugerido un médico u otro proveedor de la salud perder peso?

☐ Sí ☐ No ☐ No sé

B5. En los últimos 12 meses, le ha sugerido un médico u otro proveedor de la salud hacer actividad física o ejercicio?

☐ Sí ☐ No ☐ No sé

B6. En general, ¿qué tan saludable es su dieta total? Una dieta saludable incluye proteína magra, productos lácteos con bajo contenido de grasa, frutas y verduras, granos enteros y grasa saludable.

☐ Extremadamente saludable
☐ Muy saludable
☐ Saludable
☐ Algo saludable
☐ Para nada saludable

B7. ¿Le gustaría comer más sano?

☐ Sí ☐ No ☐ No sé

Nota: Si respondió "No" a la pregunta B7, PASE a la pregunta B9.

B8. Si desea comer más sano, ¿qué le impide hacerlo?

		Sí	**No**
i)	Los alimentos saludables cuestan demasiado dinero	☐	☐
j)	No me gusta el sabor	☐	☐
k)	Cerca de donde vivo, no hay ningún lugar donde encontrar comida sana	☐	☐
l)	Se necesita mucho tiempo y esfuerzo para preparar comida saludable	☐	☐
m)	No sé qué alimentos comer	☐	☐
n)	Mis familiares y amigos no comen de esa manera	☐	☐
o)	Otro: _____		
p)	No aplica - Yo ya me alimento de manera saludable	☐	☐

B9. ¿Su salud sexual se ha visto afectada por la enfermedad de sus músculos, huesos o articulaciones?

☐ Sí ☐ No ☐ No sé

B10. En caso afirmativo, elija todas las opciones que apliquen:

☐ Embarazo
☐ Disminución del deseo y la satisfacción sexual
☐ Aumento de la sensibilidad a ser tocado
☐ Infección del tracto urinario
☐ Sequedad vaginal
☐ Dolor/limitación de movimiento
☐ Infertilidad
☐ Disminución de las relaciones sexuales/encuentros íntimos
☐ Disfunción eréctil/Impotencia
☐ Disminución de sentirse atractivo sexualmente
☐ Otro:_____

B11. En los últimos 12 meses, ¿ha utilizado algún analgésico recetado?

☐ Sí ☐ No ☐ No sé

B12. En los últimos 12 meses, ¿con qué frecuencia ha utilizado tratamientos complementarios (como yoga, meditación, respiración consciente) para manejar el dolor?

☐ Nunca ☐ Menos de una vez al mes ☐ Una vez al mes ☐ Una vez a la semana ☐ A diario o casi a diario

B13. ¿Está de acuerdo o en desacuerdo con la siguiente afirmación? "Está bien tomar más de la dosis recomendada de un medicamento recetado si siente más dolor de lo habitual".

☐ Totalmente de acuerdo ☐ De acuerdo ☐ En desacuerdo ☐ En total desacuerdo
☐ No estoy seguro

C. Uso y acceso al cuidado: Estas preguntas son sobre sus experiencias de atención médica y necesidades de educación en salud. Elija su respuesta de las opciones de la lista. Si no está seguro, responda de la mejor manera posible.

C1. ¿Tiene alguna clase de cobertura de salud/seguro médico, incluye un seguro médico privado o planes del gobierno como Medicare o Medicaid?

☐ Sí ☐ No ☐ No sé

Nota: Si respondió "No" o "No sé" a la pregunta C1, PASE a la pregunta C3.

C2. ¿Cuál es la fuente principal de su cobertura de salud?

☐ Un plan adquirido a través de un empleador o sindicato (incluye planes comprados a través del empleador de otra persona)
☐ Un plan que usted u otro miembro de la familia compra por su cuenta
☐ Medicaid
☐ Medicare
☐ TRICARE (antes llamado CHAMPUS), VA, o militar
☐ Nativo de Alaska, Servicio de Salud Indígena, Servicios de Salud Tribal
☐ Algún otro seguro
☐ No sé

Nota: Compró un seguro de salud a través del mercado de Seguros de Salud: Si lo compró por su cuenta (o por medio de un miembro de la familia), seleccione la opción 2, si es Medicaid seleccione la opción 3.

C3. Si actualmente no tiene un seguro de salud o no ha tenido ningún seguro de salud en los **últimos 12 meses**, ¿cuáles son los motivos?

Marque todas las opciones que correspondan.

☐ Mi empleador no lo ofrece
☐ Trabajo por mi cuenta
☐ Actualmente estoy desempleado
☐ No puedo pagar un seguro médico
☐ Estoy saludable y creo que no lo necesito
☐ Otro motivo: _____
☐ No aplica

C4. ¿Ha recibido lo siguiente **en los últimos 12 meses**?:

	Sí	**No**
c. Vacunas (como la vacuna contra la gripe)	☐	☐
d. Evaluación de enfermedad de Transmisión Sexual (ETS)/ HIV	☐	☐

C5. ¿Hubo un momento en los **últimos 12 meses** cuando necesitó atención médica pero no la obtuvo?

Nota: La atención médica incluye visitas al médico, pruebas, procedimientos, medicamentos recetados y hospitalizaciones

☐ Sí ☐ No ☐ No sé

Nota: Si respondió "No" o "No sé" a la pregunta C5, PASE a la pregunta C7.

C6. En caso afirmativo, ¿cuáles fueron los motivos por los cuales no pudo hacerlo? Marque todas las opciones que correspondan.

☐ No podía pagar
☐ No tenía seguro de salud
☐ El servicio no está cubierto por el seguro
☐ Falta de transporte
☐ Es difícil conseguir una cita
☐ No estoy seguro de dónde ir
☐ Responsabilidades familiares (como no tener disponible el cuidado infantil)
☐ Servicios de idioma (no pude conseguir atención médica en mi idioma)
☐ Consultorio no amigable con el paciente (como largas horas de espera, horarios no convenientes)
☐ Otro motivo: _____

C7. ¿Con qué frecuencia sigue los consejos de su médico o de otro proveedor de la salud?

☐ Nunca ☐ Usualmente
☐ Algunas veces ☐ Siempre

C8. En ocasiones las personas no siguen el consejo médico de su médico u otros proveedores de atención médica. Cuéntenos los motivos por los cuales esto puede aplicarse en su caso. Marque todas las opciones que correspondan.

		Sí	**No**
m)	El proveedor no explicó el tratamiento lo suficientemente bien (debido a falta de tiempo, actitud indiferente o difícil de entender)	☐	☐
n)	No pensé que el tratamiento sería útil	☐	☐
o)	Me preocupó el costo del tratamiento	☐	☐
p)	Me olvidé de tomar el medicamento / ir al seguimiento	☐	☐
q)	El proveedor no entiende mi cultura / idioma	☐	☐
r)	La condición no es lo suficientemente grave como para requerir tratamiento	☐	☐
s)	Me preocupé por los efectos secundarios del tratamiento	☐	☐
t)	Prefiero usar un tratamiento complementario / alternativo	☐	☐
u)	No encajaba en mis horarios / no era conveniente para mí	☐	☐
v)	No estaba de acuerdo con el médico/proveedor	☐	☐
w)	Otro motivo: _____		
x)	No se aplica – Siempre sigo los consejos de mi médico u otros proveedores de la salud	☐	☐

C9. Cuando visita a su médico (u otro proveedor de atención médica), ¿con qué frecuencia hace lo siguiente?:

	Nunca	**Algunas veces**	**Habitualmente**	**Siempre**
d) Prepara una lista de preguntas para su médico (u otro proveedor de la salud)	☐	☐	☐	☐
e) Hace preguntas sobre las cosas que no entiende de su tratamiento	☐	☐	☐	☐
f) Discute cualquier problema personal que puede estar relacionado con su enfermedad	☐	☐	☐	☐

C10. ¿Qué tan seguro está usted de poder manejar los síntomas de su enfermedad de huesos, músculos y articulaciones a fin de poder hacer las cosas que le gusta hacer?

☐ Para nada seguro ☐ Un poco seguro ☐ Seguro ☐ Muy seguro

C11. ¿Cómo calificaría su capacidad de hablar y entender el inglés?

☐ Excelente
☐ Muy buena
☐ Buena
☐ Más o menos
☐ Mala

C12. ¿Cuál es su idioma preferido para discutir temas de salud?

☐ Inglés ☐ Ruso
☐ Español ☐ Otro: _____
☐ Chino

C13. ¿En qué idioma **preferiría** leer información médica o de salud?

☐ Inglés ☐ Ruso
☐ Español ☐ Otro: _____
☐ Chino

C14. ¿Con qué frecuencia necesita usted que otra persona le ayude a leer instrucciones, folletos u otros materiales por escrito que le haya dado su médico o la farmacia?

☐ Nunca ☐ A menudo
☐ Raras veces ☐ Siempre
☐ Algunas veces

C15. Por lo general, ¿dónde obtiene su información/consejos de salud?

Marque todo lo que corresponda

- ☐ Clínica o centro de salud
- ☐ Consultorio médico
- ☐ Organización de Mantenimiento de la Salud (HMO)
- ☐ Sala de emergencia del hospital
- ☐ Departamento de pacientes ambulatorios del hospital
- ☐ Familia
- ☐ Amigos/colegas
- ☐ Internet
- ☐ Otro: _____
- ☐ No busco información o asesoramiento de salud con frecuencia

D. Educación en Salud: HSS proporciona programas de educación en salud. Las siguientes preguntas ayudarán al Hospital a identificar las necesidades de educación en salud de la comunidad.

D1. ¿ALGUNA VEZ ha tomado un curso educativo o clase para aprender a manejar la salud/el problema de huesos, músculos o articulaciones que usted tiene?

- ☐ Sí
- ☐ No
- ☐ No sé

D2. ¿Qué tan seguro está en que tomar un curso o clase lo ayudaría a manejar la salud/el problema de huesos, músculos o articulaciones que usted tiene?

- ☐ Para nada seguro
- ☐ Algo seguro
- ☐ Seguro
- ☐ Muy seguro

D3. ¿Cómo prefiere recibir la información educativa para manejar su enfermedad?

Marque todas las que opciones que correspondan

- ☐ Conferencias
- ☐ Talleres de grupos pequeños
- ☐ Demostración en el área de espera
- ☐ Conferencias en línea en su computadora o dispositivo móvil
- ☐ Podcasts en su computadora o dispositivo móvil
- ☐ Folletos/volantes
- ☐ Otro: _____

D4. ¿En cuál de las siguientes actividades educativas en salud estaría interesado en participar?

Marque todas las opciones que correspondan

- ☐ Clases de ejercicio como taichí, Pilates o yoga
- ☐ Talleres que permitan el aprendizaje práctico, en pequeños grupos
- ☐ Conferencias en el sitio en HSS sobre prevención o manejo de enfermedades de huesos, músculos o articulaciones y bienestar general
- ☐ Conferencias en línea en su computadora/dispositivo móvil sobre prevención o manejo de enfermedades de huesos, músculos o articulaciones y otros temas de salud y bienestar
- ☐ Podcasts, programas gratuitos de audio y video disponibles para descargar y ver directamente en su computadora, que consisten en entrevistas, testimonios de pacientes, aspectos destacados del trastorno o del tratamiento, y otros temas presentados por nuestros médicos y personal de los hospitales
- ☐ Ninguna de los anteriores

D5. Cuál de los siguientes temas de salud le interesaría? Marque todo lo que corresponda.

- ☐ Osteoartritis (OA)
- ☐ Artritis reumatoide (AR)
- ☐ Dolor de espalda
- ☐ Gota
- ☐ Fibromialgia
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Comunicación médico-paciente
- ☐ Como ejercitar y controlar mi condición
- ☐ Formas de mejorar mi movilidad
- ☐ Otro: _____

E. Acerca de usted: Cuéntenos acerca de usted y sus antecedentes para que podamos conocer más sobre las comunidades que atendemos.

E1. ¿Cuál es su sexo?

☐ Femenino
☐ Masculino
☐ No conforme con el género
☐ Trans mujer (MtF)
☐ Trans hombre (FtM)
☐ Otro: _____

E2. ¿Cuál es su orientación sexual?

☐ Heterosexual
☐ Lesbiana
☐ Gay
☐ Bisexual
☐ Algo diferente
☐ No sé

E3. ¿Qué edad tiene? ____

E4. ¿Se considera usted Hispano/Latino?

☐ Sí ☐ No

E5. ¿Cuál de estos grupos diría usted que representa mejor a su raza?

Marque todas las opciones que correspondan

☐ Indio americano/nativo de Alaska
☐ Asiático
☐ Negro o afroamericano
☐ Nativo de Hawái/ Otra isla del Pacífico
☐ Blanco
☐ Otro: _____

E6. Cuéntenos sobre su origen étnico; usted puede enumerar todas las que prefiera (por ejemplo: chino, nigeriano, italiano, puertorriqueño, ruso, etc.)

E7. ¿Es usted…?

☐ Casado
☐ Divorciado
☐ Viudo
☐ Separado
☐ Nunca me casé
☐ Vivo con mi pareja

E9. ¿Qué idioma(s) habla en casa? Marque todas las que correspondan.

☐ Inglés
☐ Español
☐ Chino
☐ Ruso
☐ Otro: _____

E10. ¿Cuál es el grado o año escolar más alto alcanzado?

☐ Nunca fui a la escuela o solo al kínder
☐ Grados 1 al 8 (Elemental)
☐ Grados 9 al 11 (algo de escuela secundaria)
☐ Grado 12 o GED (graduado de escuela secundaria)
☐ 1 a 3 años de Universidad (algo de estudios universitarios o técnicos)
☐ 4 años de Universidad o más (graduado universitario)
☐ Posgrado (Maestría, PhD)

E11. ¿Es/está usted actualmente…?

☐ Empleado
☐ Trabajo por cuenta propia
☐ Sin trabajo por 1 año o más
☐ Sin trabajo por menos de 1 año
☐ Amo/ama de casa
☐ Estudiante
☐ Jubilado
☐ Incapacitado para trabajar

E12. ¿Cuál es el ingreso anual de su hogar? (sumando todas las fuentes)

☐ Menos de $10,000
☐ $10,000 – $14,999
☐ $15,000 – $24,999
☐ $25,000 – $34,999
☐ $35,000 – $49,999
☐ $50,000 – $74,999
☐ $75,000 – $99,999
☐ $100,000 – $149,999
☐ $150,000 – $199,999
☐ $200,000 o más

E8. ¿Vive solo?

☐ Sí ☐ No

E13. ¿Dónde vive?

☐ Brooklyn
☐ Bronx
☐ Manhattan
☐ Queens
☐ Staten Island
☐ Long Island, Condado de Nassau
☐ Long Island, Condado de Suffolk
☐ Westchester
☐ New Jersey
☐ Connecticut
☐ Otro: _____

E14. ¿Cuál es el código postal del lugar donde vive actualmente? _____

E15. Use el espacio a continuación para compartir con nosotros cualquier otra necesidad relacionada con los músculos, los huesos, las articulaciones o de reumatología que le gustaría que el Hospital for Special Surgery conociera:

Por favor regrese esta encuesta antes del 1 de abril del 2019 para poder asegurarnos de que su opinión sea tomada en cuenta.

Envíenos de regreso la encuesta completa en una de las siguientes maneras:

4. **Por correo** en el sobre prepago adjunto
5. **En línea** usando el código QR en la primera página de la encuesta
6. **Entrega personal** en: Oficina de la división de asuntos académicos y educativos del Hospital for Special Surgery, ubicada en: 517 East 71st Street, NY, NY 10021 –
Attn: Titilayo Ologhobo

Si tiene alguna pregunta o inquietud acerca de la encuesta, por favor póngase en contacto con Titilayo Ologhobo, Director Asociado de Resultados, llamando al 212-774-2185.

社區健康需求評估（CHNA）

扫描二维码已在网上完成问卷

Hospital for Special Surgery (HSS) 想了解您对有關肌肉、骨骼和關節狀況方面的需求。這會幫助我們加強對患者和社區的重要計劃和服務。您不需要在這份問卷調查中具名。填寫這份問卷調查將不會影響您在HSS接受的任何醫療照護。請在**2019年4月1日之前**交回這份問卷調查，以便我們確保您的意見會被納入考量。感謝您的協助！

A. 健康狀況和生活品質：以下問題是關於您的整體感覺以及您可能有的健康狀況。請從所列選項中選擇您的回答。如果您不確定，請盡可能給出最佳答案。

A1. 一般來說，您會怎樣形容您的健康狀況？

☐極佳
☐非常好
☐好
☐一般
☐不好
☐不知道

A2. 現在，請想想您的**身體狀況**，包括身體上的疾病和受傷。在**過去30天**內，有多少天您覺得身體健康狀況不好？

☐ 無
☐ 少於1週
☐ 1-2週
☐ 超過2週

A3. 是否曾有醫生或其他醫療保健提供者告訴您患有……

		是	否
q)	骨關節炎(OA)	☐	☐
r)	風濕性關節炎(RA)	☐	☐
s)	紅斑狼瘡	☐	☐
t)	纖維肌痛	☐	☐
u)	痛風	☐	☐
v)	一些其他形式的關節炎	☐	☐
w)	骨質疏鬆症	☐	☐

x) 其他：_____

注意：如果您對問題A3的所有項目都回答「否」，請跳至問題A6。

A4. **在過去30天內，由於您的疾病**您出現過以下哪些症狀？

		是	否
y)	關節/骨骼疼痛	☐	☐
z)	肌肉疼痛	☐	☐
aa)	僵硬	☐	☐
bb)	疲倦	☐	☐
cc)	體重變化	☐	☐
dd)	皮疹	☐	☐
ee)	脫髮	☐	☐
ff)	情緒變化（感覺悲傷、易怒等）	☐	☐
gg)	無法集中注意力	☐	☐
hh)	記憶力變化	☐	☐
ii)	平衡出現問題	☐	☐

jj) 其他：_____

A5. 您現在是否因為您的關節炎或關節症狀而在您的任何日常活動中受到任何限制？

☐是 ☐否 ☐不知道

A6. 在過去一年中，您是否摔倒過？

☐是 ☐否 ☐不知道

注意：如果您對問題A6回答「否」，請跳至問題A9。

A7. 如果***是***，您是否因摔倒而造成骨折？

☐是 ☐否 ☐不知道

A8. 您是否和您的醫生或其他醫護人員談論過您摔倒的事？

☐是 ☐否 ☐不知道

A9. 現在，請想想您的**心理健康**，包括壓力、抑鬱和情緒問題。在**過去30天**內，有多少天您的心理健康狀況不好？

☐ 無 ☐ 少於1週 ☐ 1-2週 ☐ 超過2週

A10. 在**過去2週**內，您多常受到這些問題所困擾？

	完全沒有	有幾天	超過一半時間	幾乎每天	不知道
i) 感覺緊張、焦慮或煩躁不安：	☐	☐	☐	☐	☐
j) 無法停止或控制擔憂：	☐	☐	☐	☐	☐
k) 感覺情緒低落、憂鬱或無助：	☐	☐	☐	☐	☐
l) 做事時沒有什麼興趣或樂趣：	☐	☐	☐	☐	☐

A11. 這個問題要詢問您在進行某些活動時因為**健康問題**而遇到的困難。「健康問題」是指任何身體、心理或情緒上的問題或疾病（不包括懷孕）。

在不使用任何特別器具的情況下，您要自己完成以下活動有多困難？

	一點都不困難	僅有一點點困難	有些困難	非常困難	完全無法做	不進行這一活動	不知道
i) 行走四分之一英里——大約是城裡的3個街口	☐	☐	☐	☐	☐	☐	☐
j) 在不休息的情況下往上走10級台階	☐	☐	☐	☐	☐	☐	☐
k) 俯身、彎腰或跪下	☐	☐	☐	☐	☐	☐	☐
l) 用您的手指抓住小物件	☐	☐	☐	☐	☐	☐	☐

A12. 在**過去30天**內，有多少天是因為**疼痛而**使您難以進行日常活動，比如個人清潔保養、工作或從事嗜好活動？

☐ 無　☐ 少於1週　☐ 1-2週　☐ 超過2週

B. 健康行為與生活方式：接下來的一系列問題是關於您可能進行的體能活動或運動、您的飲食習慣、您的性行為，以及您使用的處方藥。體能活動是指使您身體移動的任何活動。

B1. 您多常**在閒暇時間**從事每次至少25分鐘、導致**大量**出汗或者呼吸或心跳**大幅**加快的**劇烈**體能活動（如跑步）？

☐ 一週5次或更多
☐ 一週3 – 4次
☐ 一週1 – 2次
☐ 無

B2. 您多常**在閒暇時間**從事每次至少30分鐘、**僅**導致**少量**出汗或者呼吸或心跳**輕微到中度**加快的**輕度或中度**體能活動（如散步）？

☐ 一週5次或更多
☐ 一週3 – 4次
☐ 一週1 – 2次
☐ 無

B3. 您多常在閒暇時間從事專門為**增強肌力**所設計的體能活動，如重量訓練或徒手健身運動（如伏地挺身、引體向上、深蹲、開合跳）？

☐ 一週1 – 2次
☐ 沒有能力進行這樣的活動
☐ 從來沒有

B4. 在過去12個月內，是否有醫生或其他健康專業人士建議您減輕體重？

☐是　☐否　☐不知道

B5. 在過去12個月內，是否有醫生或其他健康專業人士建議您從事體能活動或運動？

☐是　☐否　☐不知道

B6. 總體而言，您的飲食有多健康？健康飲食包括精益蛋白質、低脂乳製品、水果和蔬菜、全穀類和健康的脂肪。

☐ 極健康
☐ 非常健康
☐ 健康
☐ 有點健康
☐ 完全不健康

B7. 您想要吃得更健康嗎？

☐ 是　　☐ 否　　☐ 不知道

注意：如果您對問題B7回答「否」，請跳至問題B9。

B8. 如果您想要吃得更健康，什麼會阻礙您這樣做？

		是	否
q)	健康食品太貴	☐	☐
r)	我不喜歡這種味道	☐	☐
s)	在我住的附近沒有任何地方可以找到健康食品	☐	☐
t)	需要花太多時間和精力來準備	☐	☐
u)	我不知道該吃什麼食物	☐	☐
v)	家人和朋友不這樣吃	☐	☐
w)	其他：_____		
x)	不適用——我已經吃得很健康	☐	☐

B9. 您的肌肉、骨骼或關節狀況是否影響了您的性功能健康？

☐是　　☐否　　☐不知道

B10. 如果是，請選擇所有適用項目：

☐ 懷孕
☐ 性慾和滿意度下降
☐. 被觸摸時的敏感度增加
☐尿道感染
☐ 陰道乾澀
☐ 動作受限/疼痛
☐ 不孕
☐ 性交/親密接觸減少
☐ 勃起功能障礙/陽痿
☐覺得性吸引力下降
☐ 其他：_____

B11. 在過去的12個月內，您是否曾使用任何處方鎮痛藥？

☐ 是　☐ 否　☐ 不知道

B12. 在過去的12個月內，您多常使用輔助治療（如瑜珈、冥想、 正念呼吸）來管理您的疼痛？

☐ 從未　☐ 每月不到一次　☐ 每月　☐ 每週　☐ 每天或幾乎每天

B13. 您同意或不同意以下說法？「如果您覺得比平常更痛，可以服用比建議劑量更多的處藥。」

☐ 非常同意　☐ 同意　☐ 不同意　☐ 非常不同意 ☐ 不確定

C. 醫療資源使用狀況：這些問題是關於您的醫療保健經歷和醫療保健教育需求。請從所列選項中選擇您的答案。如果您不確定，請盡可能給出最佳答案。

C1. 您是否有任何一種健康保險，包括私人健康保險或政府保險計劃（如Medicare/紅藍卡或Medicaid/白卡）？

☐. 是　　☐ 否　　☐ 不知道

注意：如果您對問題C1回答「否」，請跳至問題C3

C2. 您的健康保險主要來源是什麼？

☐通過僱主或工會購買的保險計劃（包括通過他人的僱主購買的保險計劃）
☐ 您或另一位家庭成員自己購買的保險計劃
☐ 醫療補助計劃（Medicaid/白卡）
☐ 聯邦醫療保險（Medicare/紅藍卡）
☐TRICARE（原CHAMPUS）、退伍軍人（VA）或現役軍人（Military）
☐ 阿拉斯加原住民、印第安人健康服務、部落健康服務
☐ 其他來源
☐ 不知道

注意：通過健康保險市場（Health Insurance Marketplace）購買的健康保險：如果是您自己（或家庭成員）購買，請選第2個選項，如果是醫療補助計劃（Medicaid/白卡），請選第3個選項。

C3. 如果您目前沒有保險，或者在**過去12個月**內有過沒有保險的情況 ，原因是什麼？
請勾選所有適用項目。

☐ 我的僱主沒有提供
☐ 我是自僱人士
☐ 我目前失業
☐ 我負擔不起保險
☐ 我健康良好，覺得我不需要
☐ 其他原因：_____
☐ 不適用

C4. 在過去12個月內，您是否接受過以下項目：

	是	否
e. 預防接種（如流感疫苗）	☐	☐
f. 性傳播感染(STI)/愛滋病毒(HIV)檢查	☐	☐

C5. 在**過去12個月內**，您是否有過需要醫療護理但卻得不到的時候？

注意：醫療護理包括醫生看診、檢查、醫療程序、處方藥和住院。

☐ 是 ☐ 否 ☐ 不知道

注意：如果您對問題C5回答「否」或「不知道」，請跳至問題C7

C6. 如果有過，那您得不到醫療護理的原因是什麼？請勾選所有適用項目。

☐ 負擔不起
☐ 沒有健康保險
☐ 保險不承保該服務
☐ 缺乏交通工具
☐ 很難預約
☐ 不確定該去哪裡
☐家庭責任（比如無人可照顧小孩）
☐語言服務（比如沒有使用我說的語言的醫護人員）
☐診所對患者而言不太方便（比如等候時間長、營業時間不方便）
☐ 其他原因：_____

C7. 您多常會遵照醫生或其他醫療保健提供者的醫囑來做？

☐ 從來不會 ☐ 通常都會
☐ 有時候會 ☐ 總是遵循

C8. 人們有時並不遵照醫生或其他醫療保健提供者的醫囑來做。請告訴我們可能適用於您的原因。請勾選所有適用項目。

	是	否
y) 醫療保健提供者對治療的講解不夠詳細（由於時間不夠、漠不關心的態度或難以理解他所說的）	☐	☐
z) 感覺治療不會有幫助	☐	☐
aa) 擔心治療費用	☐	☐
bb) 忘了服藥/忘了去複診	☐	☐
cc) 醫療保健提供者不了解我的文化/語言	☐	☐
dd) 狀況沒有嚴重到需要治療的程度	☐	☐
ee) 擔心治療的副作用	☐	☐
ff) 比較喜歡用輔助/替代療法	☐	☐
gg) 不適合我的時間表/對我來說不方便	☐	☐
hh) 不同意醫生/醫療保健提供者的意見	☐	☐
ii) 其他原因：_____		
jj) 不適用——總是遵循醫生或其他醫療保健提供者的醫囑		☐

C9. 當您看醫生（或其他醫療保健提供者）時，您多常會做以下事項：

	從未	有時	通常	總是
g) 把要問您的醫生（或其他醫療保健提供者）的問題準備好	☐	☐	☐	☐
h) 就有關治療中您不了解的部分提問	☐	☐	☐	☐
i) 討論可能與您的疾病有關的任何私人困難	☐	☐	☐	☐

C10. 您是否有信心能管理好您在骨骼、肌肉和關節疾病方面的症狀，以便能做自己想做的事？

☐ 完全沒信心 ☐ 有些信心 ☐ 有信心 ☐ 非常有信心

C11. 您會如何評價您說英語和理解英語的能力？

☐ 極佳
☐ 很好
☐ 好
☐ 一般
☐ 不好

C12. 您比較喜歡用哪種語言討論醫療保健問題？

☐英語 ☐俄文
☐西班牙語 ☐其他：_____
☐中文

C13. 您**比較喜歡**用哪種語言閱讀醫療保健指示？

☐英語 ☐俄文
☐西班牙語 ☐其他：_____
☐中文

C14. 當您閱讀醫生或藥房提供的指示、說明書以及其他書面資料時，您多常需要他人幫助來理解其內容？

☐ 從未
☐ 很少
☐ 有時
☐ 經常
☐ 總是

C15. 您通常從哪裡獲得健康資訊/建議？

請勾選所有適用項目。

☐ 診所或健康中心
☐ 醫生診所
☐ 健康維護組織(HMO)
☐ 醫院急診室
☐ 醫院門診部
☐ 家人
☐ 朋友/同事
☐ 網際網路
☐ 其他：_____
☐ 不常尋求健康資訊或建議

D. 健康教育：HSS提供健康教育課程。以下問題將幫助本院了解社區的健康教育需求。

D1. 您是否曾經上過健康教育課程，學習如何管理您的骨骼、肌肉或關節健康/狀況？

☐ 是
☐ 否
☐ 不知道

D2. 您對透過上課來幫助您管理骨骼、肌肉或關節的健康/狀況有多少信心？

☐ 完全沒信心
☐ 有些信心
☐ 有信心
☐ 非常有信心

D3. 您偏好以何種方式獲得有關管理病症的教育資訊？

請勾選所有適用項目。

☐ 講課
☐ 小組研習班
☐ 候診區文件資料
☐ 在您的電腦或行動裝置上收看線上講課
☐ 在您的電腦或行動裝置上收聽/收看節目
☐ 小冊子/傳單
☐ 其他：_____

D4. 您有興趣參加以下哪些健康教育活動？

請勾選所有適用項目。

☐ 運動課，例如太極拳、彼拉提斯或瑜珈
☐ 可進行實作和小組學習的研習班
☐ 到HSS參加有關預防或管理骨骼、肌肉或關節狀況和整體健康的現場講課
☐ 在您的電腦或行動裝置上收看有關預防或管理骨骼、肌肉或關節狀況和其他健康主題的線上講課
☐ 可下載和直接在電腦上收聽/收看的節目、免費音訊和視訊課程，包括訪問、病人現身說法、病症或治療重點提示，以及其他由本院醫師和工作人員講述的主題
☐ 以上皆非

D5. 您对以下哪些健康话题有兴趣？ 請勾選所有適用項目。

☐ 骨關節炎(OA)
☐ 風濕性關節炎(RA)
☐ 背痛
☐ 痛風
☐ 纖維肌痛
☐ 紅斑狼瘡
☐ 骨質疏鬆症
☐ 医患沟通
☐ 如何锻炼和管理我的病情
☐ 如何提高我的机动性
☐ 其他: _____

E. 關於您：請向我們介紹一下您自己和您的背景，讓我們更了解本院所服務的社區。

E1. 您的性別？
☐ 女
☐ 男
☐ 非常規性別者
☐ 變性女(MtF)
☐ 變性男(FtM)
☐. 其他：_____

E2. 您的性取向？
☐ 異性戀
☐ 女同性戀
☐ 男同性戀
☐ 雙性戀
☐ 其他
☐ 不知道

E3. 您的年齡？_____

E4. 您認為自己是西語裔/拉丁裔嗎？

☐ 是 ☐ 否

E5. 您認為以下何者最能代表您的種族？

請勾選所有適用項目

☐ 美國印第安人/阿拉斯加原住民
☐ 亞裔
☐. 黑人或非裔美國人
☐ 夏威夷原住民/其他太平洋島民
☐ 白人
☐ 其他：_____

E6. 請告訴我們您的族裔；您想列舉多少就可以列舉多少（例如：華人、奈及利亞人、義大利人、波多黎各人、俄羅斯人等等）

E7. 您目前是……？
☐ 已婚
☐ 離婚
☐ 喪偶
☐ 分居
☐ 從未結過婚
☐ 同居伴侶

E8. 您一個人住嗎？

☐. 是 ☐ 否

E9. 您在家中說什麼語言？

請勾選所有適用項目。

☐ 英語
☐ 西班牙語
☐ 中文
☐ 俄文
☐ 其他：_____

E10. 您讀完的最高年級或學歷是什麼？

☐ 沒有上過學或只上過幼稚園
☐ 1-8年級（小學到初中）
☐ 9-11年級（高中肄業）
☐ 12年級或GED（高中畢業或同等學歷）
☐ 大學1-3年（大學肄業或技術學院）
☐. 大學4年或以上（大學畢業）
☐ 學士後（碩士、博士）

E11. 您目前是……？
☐ 受僱
☐ 自僱
☐ 沒有工作1年或更久
☐ 沒有工作不到1年
☐ 家庭主婦/夫
☐ 學生
☐ 退休
☐ 無法工作

E12. 您家庭每年的總收入是多少？
☐ 少於 $10,000
☐ $10,000 – $14,999
☐ $15,000 – $24,999
☐ $25,000 – $34,999
☐ $35,000 – $49,999
☐ $50,000 – $74,999
☐ $75,000 – $99,999
☐ $100,000 – $149,999
☐ $150,000 – $199,999
☐ $200,000或以上

E13.您住在哪裡？
☐ 布魯克林
☐ 布朗士
☐ 曼哈頓
☐ 皇后區
☐ 史丹頓島
☐ 長島、納蘇郡
☐ 長島、蘇福克郡
☐ 韋斯切斯特/Westchester
☐ 紐澤西州
☐ 康乃狄克州
☐ 其他: _____

E14. 您目前居住地的郵遞區號是多少？_____

E15. 如果您在肌肉、骨骼、關節或風濕病方面有其他任何需求想要讓Hospital for Special Surgery知道，請使用以下空白處與我們分享：

請最遲在2019年4月1日前交回這份問卷調查，以便我們確保您的意見會被納入考量。

請將完成的問卷調查以下面任一方式送回給我們：

7. 使用隨附的預付郵資信封**郵寄**。
8. 使用第一页的二维码已在网上完成
9. 送交至：

Attn: Titilayo Ologhobo
Hospital for Special Surgery Education & Academic Affairs Division
517 East 71st Street, NY, NY 10021

如果您對問卷調查有任何問題或顧慮，請聯絡Outcomes部門副主任Titilayo Ologhobo，電話：212-774-2185

Оценка потребностей населения в сфере здравоохранения (CHNA)

Просканируйте, чтобы заполнить опросник онлайн

В Госпитале специальной хирургии (англ. HSS) хотели бы узнать о Ваших потребностях, касающихся состояния мышц, костей и суставов. Это поможет нам улучшить программы и услуги, которые имеют важное значение для наших пациентов и населения. Для этого опросника нам не потребуется Ваше имя. Заполнение этого опросника не повлияет на Ваше лечение в HSS. Пожалуйста, верните этот опросник не позднее **1 апреля 2019 г.**, чтобы мы могли убедиться в том, что Ваше мнение учтено. Благодарим Вас за помощь!

A. Состояние здоровья и качество жизни: В следующих вопросах речь пойдет о том, как Вы себя чувствуете в целом, и о состояниях здоровья, которые у Вас могут быть. Пожалуйста, выберите свой ответ их приведенных вариантов.
Если Вы не уверены, пожалуйста, укажите как можно более подходящий ответ.

A1. Как бы Вы оценили состояние вашего здоровья в целом?

- ☐ Отличное
- ☐ Очень хорошее
- ☐ Хорошее
- ☐ Нормальное
- ☐ Слабое
- ☐ Не знаю

A2. Теперь, если подумать о Вашем **физическом здоровье**, которое включает в себя физические заболевания и травмы, то на протяжении скольких дней в течение **последних 30 дней** Ваше физическое здоровье не было хорошим?

- ☐ Ни одного
- ☐ Менее недели
- ☐ 1-2 недели
- ☐ Более 2 недель

A3. Вам когда-нибудь говорил врач или другой специалист в сфере здравоохранения, что у Вас есть…?

		Да	Нет
y)	Остеоартрит (OA)	☐	☐
z)	Ревматоидный артрит (РА)	☐	☐
aa)	Волчанка	☐	☐
bb)	Фибромиалгия	☐	☐
cc)	Подагра	☐	☐
dd)	Какая-либо другая форма артрита	☐	☐
ee)	Остеопороз	☐	☐
ff)	Прочее: _____		

Примечание: Если Вы ответили «Нет» на ВСЕ части Вопроса A3, пожалуйста, ПЕРЕЙДИТЕ к Вопросу A6.

A4. Какой из следующих симптомов Вы испытывали в течение **последних 30 дней в связи с Вашим(и) состоянием(ями) здоровья**?

		Да	Нет
kk)	Боль или болезненность в суставах/костях	☐	☐
ll)	Боль или болезненность в мышцах	☐	☐
mm)	Скованность	☐	☐
nn)	Утомление	☐	☐
oo)	Изменения в весе	☐	☐
pp)	Кожная сыпь	☐	☐
qq)	Потеря волос	☐	☐
rr)	Изменения в настроении (чувство грусти, раздражения и т.д.)	☐	☐
ss)	Трудности с концентрацией	☐	☐
tt)	Изменения в памяти	☐	☐
uu)	Проблемы с равновесием	☐	☐
vv)	Прочее: _____		

A5. В настоящий момент Вы испытываете какие-либо ограничения в любом из обычных видов деятельности вследствие Вашего артрита или симптомов, связанных с суставами?

☐ Да ☐ Нет ☐ Не знаю

A6. Падали ли Вы в течение последнего года?

☐ Да ☐ Нет ☐ Не знаю

Примечание: Если вы ответили «Нет» на Вопрос A6, пожалуйста, ПЕРЕЙДИТЕ к Вопросу A9.

A7. Если ***Да***, то в результате Вашего падения, Вы ломали какие-нибудь кости?

☐ Да ☐ Нет ☐ Не знаю

A8. Вы разговаривали со своим врачом или другим поставщиком медицинских услуг о Вашем(их) падении(ях)?

☐ Да ☐ Нет ☐ Не знаю

A9. А теперь, если подумать о Вашем **психическом здоровье**, которое включает в себя стресс, депрессию и проблемы с эмоциями, то на протяжении скольких дней в течение **последних 30 дней** Ваше психическое здоровье не было хорошим?

☐ Ни одного ☐ Менее недели

☐ 1-2 недели ☐ Более 2 недель

A10. На протяжении **последних 2 недель**, как часто Вас беспокоили следующие проблемы?

	Совсем не беспокоили	Несколько дней	Более половины дней	Почти каждый день	Не знаю
m) Чувство нервозности, тревожности или пребывания на грани:	☐	☐	☐	☐	☐
n) Неспособность прекратить или контролировать свое беспокойство:	☐	☐	☐	☐	☐
o) Чувство подавленности, депрессии или безнадежности:	☐	☐	☐	☐	☐
p) Небольшой интерес или удовольствие в выполнении вещей:	☐	☐	☐	☐	☐

A11. В следующем вопросе речь пойдет о трудностях, которые Вы можете испытывать при выполнении определенных действий в связи с ПРОБЛЕМАМИ СО ЗДОРОВЬЕМ. Под «проблемами со здоровьем» мы подразумеваем любые физические, психические или эмоциональные проблемы или заболевание (не включая беременность).

Насколько для Вас сложно выполнять следующие действия самостоятельно и без использования каких-либо специальных устройств…

	Совсем не сложно	Только немного сложно	В некоторой степени сложно	Очень сложно	Совсем не могу делать	Не выполняю этого действия	Не знаю
m) пройти четверть мили (приблизительно 3 городских квартала)?	☐	☐	☐	☐	☐	☐	☐
n) подняться на 10 ступенек без отдыха?	☐	☐	☐	☐	☐	☐	☐
o) наклониться, согнуться или стать на колено?	☐	☐	☐	☐	☐	☐	☐
p) с помощью пальцев поднимать или использовать маленькие предметы?	☐	☐	☐	☐	☐	☐	☐

A12. На протяжении **последних 30 дней**, в течение скольких дней **боль** приводила к тому, что Вам было сложно выполнять обычные действия, такие как уход за собой, работа или хобби?

☐ Ни одного ☐ Менее недели
☐ 1-2 недели ☐ Более 2 недель

B. Поведение и стиль жизни, связанные со здоровьем: В следующей серии вопросов речь пойдет о физической активности и упражнениях, которые Вы можете выполнять, о Ваших привычках в отношении питания, Вашем половом поведении и использовании рецептурных лекарств. Под физической активностью понимается все, что способствует движению Вашего тела.

B1. Как часто **в свободное время** Вы выполняете **энергичные** физические упражнения в течение как минимум 25 минут, которые приводят к **сильному** потоотделению и **высокому** повышению частоты дыхания или сердцебиения (например, бег)?

☐ 5 или более раз в неделю
☐ 3 – 4 раза в неделю
☐ 1 – 2 раза в неделю
☐ Никогда

B2. Как часто **в свободное время** Вы выполняете **легкие или умеренные** физические упражнения в течение как минимум 30 минут, которые приводят **лишь к легкому** потоотделению либо **к небольшому или умеренному** повышению частоты дыхания или сердцебиения (например, ходьба)?

☐ 5 или более раз в неделю
☐ 3 – 4 раза в неделю
☐ 1 – 2 раза в неделю
☐ Никогда

B3. Как часто в свободное время Вы выполняете физические упражнения, разработанные **для**

укрепления мышц, например, упражнения с поднятием тяжестей или зарядку (такие как отжимания, приседания, прыжки ноги вместе, ноги врозь)?

☐ 1 – 2 раза в неделю
☐ Не могу выполнять такие действия
☐ Никогда

B4. В течение последних 12 месяцев врач или другой специалист в сфере здравоохранения Вам советовал потерять вес?

☐ Да ☐ Нет ☐ Не знаю

B5. В течение последних 12 месяцев врач или другой специалист в сфере здравоохранения Вам советовал выполнять физическую нагрузку или упражнения?

☐ Да ☐ Нет ☐ Не знаю

B6. В целом, насколько здоровым является Ваше питание? Здоровое питание включает в себя постный белок, молочные продукты с низким содержанием жира, фрукты и овощи, цельные зерна и здоровые жиры.

☐ Чрезвычайно здоровое
☐ Очень здоровое
☐ Здоровое
☐ В некоторой степени здоровое
☐ Совсем не здоровое

B7. Вы бы хотели употреблять более здоровую пищу?

☐ Да ☐ Нет ☐ Не знаю

Примечание: Если Вы ответили «Нет» на Вопрос B7, пожалуйста, ПЕРЕЙДИТЕ к Вопросу B9.

B8. Если Вы хотите употреблять более здоровую пищу, что Вам в этом мешает?

		Да	**Нет**
y)	Здоровая пища слишком дорого стоит	☐	☐
z)	Мне не нравится ее вкус	☐	☐
aa)	Там, где я живу, нет мест, где можно найти здоровую пищу	☐	☐
bb)	На ее приготовление уходит слишком много времени и усилий	☐	☐
cc)	Я не знаю, какие продукты питания употреблять	☐	☐
dd)	Семья и друзья так не едят	☐	☐
ee)	Прочее: _____		
ff)	Не применимо – Я уже придерживаюсь здорового питания	☐	☐

B9. Влияет ли состояние(я) Ваших мышц, костей или суставов на Ваше половое здоровье?

☐ Да ☐ Нет ☐ Не знаю

B10. Если Да, то выберите все применимые варианты:

☐ Беременность
☐ Пониженное половое влечение и удовлетворение
☐ Повышенная чувствительность к прикосновению
☐ Инфекция мочевыводящих путей
☐ Сухость влагалища
☐ Ограничения движений/боль
☐ Бесплодие
☐ Сокращенный половой акт/близость
☐ Эректильная дисфункция/импотенция
☐ Пониженное ощущение половой привлекательности
☐ Прочее: _____

B11. В течение последних 12 месяцев Вы использовали какие-либо рецептурные обезболивающие средства?

☐ Да ☐ Нет ☐ Не знаю

B12. В течение последних 12 месяцев, как часто Вы использовали комплементарные методы лечения (такие как йога, медитация, осознанное дыхание) для купирования боли?

☐ Никогда ☐ Менее раза в месяц ☐ Ежемесячно ☐ Еженедельно
☐ Ежедневно или почти ежедневно

B13. Вы согласны или нет со следующим утверждением? «Можно принимать больше рекомендованной дозы рецептурного лекарства, если Вы чувствуете более сильную боль, чем обычно».

☐ Очень согласен(сна) ☐ Согласен(сна) ☐ Не согласен(сна)
☐ Очень не согласен(сна) ☐ Не уверен(а)

C. Использование и доступ к лечению: В этих вопросах речь пойдет о Вашем опыте и потребностях в обучении в сфере здравоохранения. Пожалуйста, выберите свой ответ из приведенных вариантов. Если Вы не уверены, пожалуйста, укажите как можно более подходящий ответ.

C1. У Вас есть какое-либо страховое покрытие, включая частную медицинскую страховку или государственные планы, такие как Medicare или Medicaid?

☐ Да ☐ Нет ☐ Не знаю

Примечание: Если вы ответили «Нет» или «Не знаю» на Вопрос C1, пожалуйста, ПЕРЕЙДИТЕ к Вопросу C3

C2. Что является основным источником Вашего медицинского покрытия?

☐ План, приобретенный через работодателя или союз (в том числе планы, приобретенные через работодателя другого человека)
☐ План, который Вы или другой член семьи приобретает самостоятельно
☐ Medicaid
☐ Medicare
☐ TRICARE (ранее известный как CHAMPUS), VA или план страхования военнослужащих
☐ Услуги здравоохранения Alaska Native, Health Service, Tribal Health Services
☐ Какой-либо другой источник
☐ Не знаю

Примечание: Медицинская страховка, приобретенная через Биржу медицинского страхования (Health Insurance Marketplace): Если она приобретена самостоятельно (или членом семьи), выберите вариант 2, если через Medicaid, выберите вариант 3.

C3. Если в настоящий момент у Вас нет медицинской страховки или у Вас не было страховки в какой-либо промежуток времени в течение **последних 12 месяцев**, какие на то были причины?

Отметьте все применимые варианты.

☐ Мой работодатель не предлагает страховку
☐ Я индивидуальный предприниматель
☐ В настоящее время я безработный(ая)
☐ Я не могу позволить себе страховку
☐ Я здоровый(ая) и не думаю, что она мне нужна
☐ Другая причина: _____
☐ Не применимо

C4. В течение последних 12 месяцев Вы получали следующее?

	Да	**Нет**
g. Иммунизации (например, прививку от гриппа)	☐	☐
h. Скрининг на инфекции, передаваемые половым путем (ИППП)/ВИЧ	☐	☐

C5. В течение последних 12 месяцев случались ли ситуации, когда Вам была необходима медицинская помощь, но Вы ее не получали?

Примечание: Медицинская помощь включает в себя посещения врача, анализы, процедуры, рецептурные лекарства и госпитализации

☐ Да ☐ Нет ☐ Не знаю

Примечание: Если вы ответили «Нет» или «Не знаю» на Вопрос C5, пожалуйста, ПЕРЕЙДИТЕ к Вопросу C7

C6. Если Да, то по каким причинам Вы не могли этого сделать? Отметьте все применимые варианты.

☐ Не мог(ла) себе этого позволить
☐ Отсутствие медицинской страховки
☐ Услуга не покрывалась страховкой
☐ Отсутствие транспортировки
☐ Сложно записаться на прием
☐ Не уверен(а), куда нужно идти
☐ Семейные обстоятельства (например, отсутствие помощи по уходу за ребенком)
☐ Языковые услуги (например, не мог(ла) получить медицинское обслуживание на моем языке)
☐ Офис, не учитывающий удобство пациентов (например, долгое время ожидания, неудобное время работы)
☐ Другая причина: _____

C7. Как часто Вы следуете медицинскому совету своего врача или другого поставщика медицинских услуг?

☐ Никогда
☐ Иногда
☐ Обычно
☐ Всегда

C8. Иногда люди не следуют медицинскому совету своего врача или другого поставщика медицинских услуг.

Пожалуйста, сообщите нам причины, которые могут относиться к Вам. Отметьте все применимые варианты.

	Да	Нет
kk) Поставщик недостаточно хорошо объяснил суть лечения (вследствие недостатка времени, небрежного отношения или трудностей с пониманием)	☐	☐
ll) Не думаю, что лечение поможет	☐	☐
mm) Обеспокоен(а) по поводу стоимости лечения	☐	☐
nn) Забыл(а) принять лекарство/прийти на последующее наблюдение	☐	☐
oo) Поставщик не понимает моей культуры/моего языка	☐	☐
pp) Состояние недостаточно серьезное, чтобы для него требовалось лечение	☐	☐
qq) Обеспокоен(а) по поводу побочных эффектов лечения	☐	☐
rr) Предпочитаю использовать комплементарные/альтернативные виды лечения	☐	☐
ss) Не помещалось в моем графике/неудобно для меня	☐	☐
tt) Не согласен(сна) с врачом/поставщиком	☐	☐
uu) Другая причина: _____		
vv) Не применимо – всегда следую совету моего врача или другого поставщика медицинских услуг	☐	☐

C9. Когда Вы приходите на прием к своему врачу (или другому поставщику медицинских услуг), как часто Вы делаете следующее:

	Никогда	Иногда	Обычно	Всегда
j) Подготавливаете список вопросов для Вашего врача (или другого поставщика медицинских услуг)	☐	☐	☐	☐
k) Задаете вопросы о вещах, которые Вы не понимаете в Вашем лечении	☐	☐	☐	☐
l) Обсуждаете любые личные проблемы, которые могут быть связаны с Вашим заболеванием	☐	☐	☐	☐

C10. Насколько Вы уверены в том, что Вы можете контролировать симптомы Вашего состояния костей, мышц и суставов так, чтобы Вы могли делать вещи, которые хотите делать?

☐ Совсем не уверен(а) ☐ В некоторой степени уверен(а) ☐ Уверен(а)

☐ Очень уверен(а)

C11. Как бы Вы оценили свою способность разговаривать и понимать на английском языке?

☐ Отлично
☐ Очень хорошо
☐ Хорошо
☐ Нормально
☐ Плохо

C12. Язык, на котором Вы бы предпочли обсуждать вопросы здравоохранения?

☐ Английский
☐ Испанский
☐ Китайский
☐ Русский
☐ Другой: _____

C13. Язык, на котором Вы бы предпочли читать медицинские указания или указания, связанные с вопросами здравоохранения?

☐ Английский
☐ Испанский
☐ Китайский
☐ Русский
☐ Другой: _____

C14. Как часто Вы нуждаетесь в чьей-либо помощи, когда Вы читаете указания, памфлеты или другие письменные материалы, полученные от Вашего врача или из аптеки?

☐ Никогда
☐ Редко
☐ Иногда
☐ Часто
☐ Всегда

C15. Где Вы обычно получаете информацию/совет в отношении здоровья?

Отметьте все применимые варианты

- ☐ Клиника или центр здоровья
- ☐ Офис врача
- ☐ Организация здравоохранения (HMO)
- ☐ Пункт неотложной помощи в больнице
- ☐ Амбулаторное отделение больницы
- ☐ Семья
- ☐ Друзья/коллеги
- ☐ Интернет
- ☐ Прочее: _____
- ☐ Нечасто ищу информацию или совет в отношении здоровья

D. Обучение в сфере здравоохранения: HSS предоставляет программы обучения в сфере здравоохранения. Следующие вопросы помогут Госпиталю определить потребности населения в обучении относительно здравоохранения.

D1. Вы КОГДА-НИБУДЬ проходили обучающий курс или занятия, чтобы узнать, как поддерживать здоровье/состояние Ваших костей, мышц или суставов?

- ☐ Да
- ☐ Нет
- ☐ Не знаю

D2. Насколько Вы уверены, что прохождение обучающего курса или занятий поможет Вам в поддержании здоровья/состояния Ваших костей, мышц или суставов?

- ☐ Совсем не уверен(а)
- ☐ В некоторой степени уверен(а)
- ☐ Уверен(а)
- ☐ Очень уверен(а)

D3. Как Вы предпочитаете получать обучающую информацию для контроля Вашего состояния?

Отметьте все применимые варианты

- ☐ Лекции
- ☐ Занятия в небольших группах
- ☐ Наглядный показ в зоне ожидания
- ☐ Лекции на Вашем компьютере или мобильном устройстве в Интернете
- ☐ Подкасты на Вашем компьютере или мобильном устройстве
- ☐ Брошюры/листовки
- ☐ Прочее: _____

D4. В каких из следующих видах деятельности, связанных с обучением в сфере здравоохранения, вы бы хотели поучаствовать?

Отметьте все применимые варианты.

- ☐ Уроки физической культуры, такие как тайчи, пилатес или йога
- ☐ Занятия, позволяющие получить практическое обучение в небольших группах
- ☐ Лекции на территории HSS о предотвращении или контроле состояний, связанных с костями, мышцами или суставами, и о хорошем самочувствии в целом
- ☐ Лекции в Интернете на Вашем компьютере/мобильном устройстве о предотвращении или контроле состояний, связанных с костями, мышцами или суставами, и других темах о здоровье и хорошем самочувствии
- ☐ Подкасты, бесплатные аудио и видео программы, доступные для скачивания и просмотра прямо на Вашем компьютере, включающие в себя интервью, утверждения пациентов, основные положения о медицинских состояниях или лечении и другие темы, предоставленные нашими врачами и персоналом в больнице
- ☐ Ничего из вышеуказанного

D5. Какие из следующих тем, касающихся здоровья, заинтересовали бы вас? Отметьте все применимое.

- ☐Остеоартрит (OA)
- ☐Ревматоидный артрит (РА)
- ☐ Боль в спине
- ☐Подагра
- ☐Фибромиалгия
- ☐Волчанка
- ☐Остеопороз
- ☐ Взаимодействие «врач – пациент»
- ☐ Как заниматься спортом при моем состоянии и как его контролировать
- ☐ Способы улучшения моей подвижности
- ☐ Другое: _____

E. Информация о Вас: Пожалуйста, расскажите нам о себе и Вашей истории жизни, чтобы мы могли больше узнать об обслуживаемом нами населении.

E1. Укажите свою половую принадлежность.

☐ Женщина
☐ Мужчина
☐ Неподтвержденный пол
☐ Транссексуал М→Ж (MtF)
☐ Транссексуал Ж→М (FtM)
☐ Прочее: _____

E2. Укажите свою половую ориентацию.

☐ Традиционная
☐ Лесбиянка
☐ Гей
☐ Бисексуал
☐ Что-то еще
☐ Не знаю

E3. Сколько Вам лет? ____

E4 Считаете ли Вы, что у Вас испаноязычное/латиноамериканское происхождение?

☐ Да ☐ Нет

E5. По Вашему мнению, какая из этих групп наилучшим образом представляет Вашу расу?

Отметьте все применимые варианты

☐ Американский индеец/коренной житель Аляски
☐ Азиат
☐ Черный или афроамериканец
☐ Коренной житель Гавайи/других тихоокеанских островов
☐ Белый
☐ Прочее: _____

E6. Пожалуйста, скажите нам о Вашей этнической принадлежности; Вы можете перечислить столько вариантов, сколько предпочтете (например: китаец, нигериец, итальянец, пуэрториканец, русский и т.д.)

E7. Вы …...?

☐ Состоите в браке
☐ Разведены
☐ Вдовец/вдова
☐ Проживаете отдельно от супруга(и)
☐ Никогда не были замужем/женаты
☐ Живете вместе в паре

E8. Вы живете одни?

☐ Да ☐ Нет

E9. На каком(их) языке(ах) Вы разговариваете дома?

Отметьте все применимые варианты.

☐ Английский
☐ Испанский
☐ Китайский
☐ Русский
☐ Другой: _____

E10. Что является наивысшим классом или годом обучения в школе, который Вы завершили?

☐ Никогда не ходил(а) в школу или только ходил(а) в нулевой класс
☐ С 1 по 8 класс (Начальная школа)
☐ С 9 по11 класс (Некоторые старшие классы)
☐ 12 классов или общее образование (Выпускник общеобразовательной школы)
☐ От 1 до 3 лет колледжа (Некоторое образование в колледже или техникуме)
☐ 4 или более лет колледжа (Выпускник колледжа)
☐ Последипломное образование (Степень магистра, доктора наук)

E11. В настоящее время Вы…?

☐ Трудоустроены
☐ Индивидуальный предприниматель
☐ Не работаете 1 или более лет
☐ Не работаете менее 1 года
☐ Заботитесь о домашнем хозяйстве
☐ Студент(ка)
☐ Пенсионер(ка)
☐ Не можете работать

E12. Каков Ваш ежегодный семейный доход из всех источников?

☐ Менее $10,000
☐ $10,000 – $14,999
☐ $15,000 – $24,999
☐ $25,000 – $34,999
☐ $35,000 – $49,999
☐ $50,000 – $74,999
☐ $75,000 – $99,999
☐ $100,000 – $149,999
☐ $150,000 – $199,999
☐ $200,000 или более

E13. В настоящее время, где Вы живете?

- ☐ Бруклин
- ☐ Бронкс
- ☐ Манхэттен
- ☐ Куинс
- ☐ Статен-Айленд
- ☐ Лонг-Айленд, округ Нассо
- ☐ Лонг-Айленд, округ Саффолк
- ☐ Уэстчестер
- ☐ Нью-Джерси
- ☐ Коннектикут
- ☐ Прочее: _____

E14. Укажите почтовый код в месте, где Вы живете в настоящее время. _____

E15. Пожалуйста, используйте предоставленное ниже место, чтобы рассказать нам о любых других потребностях, связанных с мышцами, костями, суставами или ревматологией, о которых Вы бы хотели сообщить Госпиталю специальной хирургии:

Просим Вас вернуть этот опросник не позднее 1 апреля 2019 г., чтобы мы могли убедиться в том, что Ваше мнение учтено.

Пожалуйста, отправьте заполненный опросник обратно нам с помощью одного из следующих способов:

10. **По почте**, используя прилагаемый предоплаченный конверт
11. **Онлайн**, используя QR-код на первой странице опросника
12. **Принесите** по адресу: Госпиталь специальной хирургии (Hospital for Special Surgery) Отделение офиса обучения и академических дел (Education & Academic Affairs Division office), расположенный по адресу: 517 East 71st Street, NY, NY 10021 – **Attn: Titilayo Ologhobo**

Если у Вас возникнут какие-либо вопросы или беспокойства по поводу опросника, пожалуйста, свяжитесь с Титилайо Ологобо (Titilayo Ologhobo), Заместитель директора, Отдел результатов исследований, по телефону 212-774-2185.

Appendix B. Feedback from internal stakeholders and community partners

2019 CHNA Internal & External Feedback Summary

Karen Juliano (HSS)

- B3 – Why a different scale
- B12 & B13 – switch the order
- C3 – Not applicable??
- C4 – Spell out STD/STI/HIV
- C14 – Spacing looks off

Dr. Kenny Kwong (Touro College Graduate School of Social Work)

- The proposed survey overall looks very good, with clear wording of questions and answer choices, literacy appropriate, also comprehensive in capturing much useful information.
- Though some questions are extracted from validated instruments, there are some exceptions of slightly modifying the instrument. I see that you just extract a few items from each of a number of instruments, if we used standardized instruments including multiple items and involving more complex scoring and interpretation based on the total scores, then yes use those instruments as they are or if we modify/select/add items, I usually determine internal consistencies to further enhance the validity of the instrument. But if you select a few items from here and there and your intention is to produce meaning data to inform programs, then you still can make some changes in the questions and response categories.
- Some questions like A2, A8 etc, the answer choices require numeric literacy as participants need to count how many days in a month, perhaps consider, none, less than a week, 1-2 weeks, more than 2 weeks.
- For B1, B2, B3, can we use the same response categories, for example for B1, can we also unable to do such activities, and for B3, you only list 1-2 times, so it's not possible that they can do so more frequently?
- Q12, the current proposed answer choices may make it slightly more difficult to interpret.
- C10 what about quite confident instead of confident
- D3 will also allow the respondents to check all that apply?
- Overall, it's very clear and well designed.

Dr. Linda Russell (HSS)

- I think it is ok. It will take some time for pts to fill out

Diane Gross (SLE Lupus Foundation)

- I think you did a great job on this as usual.
- For Q B12, I'd suggest saying past 12 months like the other questions instead of past year.
- After C1, if they answered No or Don't Know should they skip to C3? Only if they answered yes to C1 does C2 make sense.
- I understand the C15 is a validated question, but I think lumping Doctor's Office or HMO together doesn't make a lot of sense. Would suggest breaking into two and instead of HMO, say Insurance Company. Not sure why the focus is on HMO, would make sense for a Kaiser like model but not here in NYC.

Dr. Susan Cha (HSS)

- Survey looks pretty good to me – length seems appropriate. I like that it's broken down into sections.

Carol Ban (Isabella Geriatric)

- The survey is very comprehensive and easy to understand.
- C2 – You might add, "Insurance through my employer or union's retirement plan" since that is very common
- C8 – You might add, "problems with my health insurance". For instance, the plan doesn't cover the prescription, or coverage is inactive. Also, in this section, there are so many options it could be overwhelming, and patients could ignore it instead. I recommend consolidating the options

Yajie Zhu (Charles B. Wang Community Health Center)

- A2 - The scale requires people to recall back 30 days, and they have to count and add up the days. Maybe consider the non-numerical response options.
- B1 - I am not sure about the reading level of vigorous. Maybe change it into ACTIVE?
- C4 - Flu shot doesn't belong to the screening category.
- C15 - Need to spell out the HMO - Health Maintenance Organization. Not many lay people understand what is a Health Maintenance Organization

Chao Wu (HSS)

- Revised survey intro - HSS wants to hear about your needs regarding muscle, bone, and joint conditions. This will help us to improve upon programs and services that are important to our patients and community. We do not need your name for this survey and your participation on completing this survey will not affect your care at HSS. Please return this survey no later than April 15, 2019, so that we can make sure your opinion counts. Thank you for your help!

Scott Possley (HSS)

- Fine from my perspective

Jane Qui (Self – Help Innovative Senior Center)

- It looks a little bit too long for a community-dwelling senior. However, it depends on who will be the target for the survey.

Laura Ilowite (Arthritis Foundation)

- Overall, I thought it was pretty comprehensive
- Rephrased A2 - For how many days during the **past 30 days** was your physical health <u>not good</u>?
- A3 (option h) - How is this different than "some other form of arthritis?" Do we need both?
- A4 (option h) - I would remove the feelings in parenthesis as mood changes can be both positive and negative – this can depend on medications the patient is on, personal events in their life, or any comorbidities including mental health diagnoses.
- A10 - I would write "the following" instead of "these." When I first read it I thought the question was talking about the problems listed in A9
- B1 - Leisure time is mentioned on a few occasions in this section. Why does leisure time matter?

- B8 (option h) - The boxes next to this question are confusing. I think there should be a box under YES and NO.
- D4 (option 3) - From a health literacy standpoint, these seem advanced. I wonder if you wrote "my conditions" instead of "musculoskeletal or rheumatologic" though that leaves a lot a room for interpretation.

Page Carol (HSS)

- Overall, I think the survey is comprehensive without being repetitive, and is clearly laid out and easy to understand.
- A10 and B12. If you are able to change: consider providing answer choices that cover the whole range (as for example in A9) rather than discrete points; for example, as currently written in A10, if someone was bothered by these symptoms one day in the past 2 weeks, there isn't an accurate answer.
- A11. If you are able to change: consider separating stooping/bending from kneeling as the answer may be different for each.
- C14. Remove extra space before "Never".
- D1 and D2. Change "and" to "or" ("…bone, muscle and or joint health/condition").

Elin Aslanyan (Spondylitis Association of America)

- This is a great, thorough survey and I look forward to learning the outcomes! Congrats!
- maybe asking on what topics / conditions specifically they would like additional educational content or resources.
- A3 – I'm with SAA, so of course I have to point out that Spondyloarthritis, which is more common than RA (at 2.7 million impacted in the US) is not listed as an option here (: - it would include AS, and PsA – diseases and populations I believe HSS does serve.
- A4 – the "due to your condition" question ending seems to be assigning cause and effect, and people may be unable to do that. I would leave that ending out for clarity.
- B1 – B3 seem a bit awkwardly worded to me. I think it's the word "leisure-time" that stands out the most as unnecessary / possibly confusing.
- B5- maybe 'increase" instead of "do physical activity…"
- B6 – Since the question is "how healthy" I'd expect the responses to be something like "very healthy" "Somewhat healthy" etc.
- B10 – I'm confused that pregnancy would be included here.
- B13 – typo. Period should be inside quotation mark.
- C6: The Language option – I'd add word "services" so that it's "could not get healthcare services in my language."
- C:14 – Formatting thing: the first option of 'Never' seems misaligned with the rest of them.
- D3: Option that has "Web-based lectures." If applicable, I'd add "/ mobile devices" at the end of the option. Some may only have access to a smart phone for all online needs.
- D4:
- Also – same on the option starting with "Podcasts…" maybe just say "available for online viewing"

- E10: Just a note: it's possible to have attended college for 4 or more years and not graduate. (part time, having difficulties passing classes, etc.)
- E11: I'd clarify if you're looking for gross or net income.

Appendix C. Feedback from the public

2019 HSS Community Health Needs Assessment (CHNA)
Community Pilot Feedback Summary

Overall Statistics

*Timeframe***:** 10/15/18-11/16/18
Total N in Pilot: 70

- English: 50
- Chinese: 6
- Spanish: 10
- Russian: 4

Pilot Audiences:

English

- PPED team
- PPED team pilot in their friend/family (in person & Web)
- PPED yoga, tai chi classes
- SurveyGizmo panel service

Chinese

- Mott Street Senior Center community members (in person)
- Brown Gardens community members (in person)

Spanish

- Warren and Dekalb Community Access (in person)
- Voices 60+ (in person)
- Washington Heights (in person)
- Stamford underserved community

Russian

- Community members (in person)

General Feedback

<u>Complete Time (Minutes)</u>

- **All: Min-5; Max-60; Average- 15.9**
    - English
        - Min- 5; Max-40; Average- 12.2
    - Chinese
        - Min- 15; Max-45; Average- 25
    - Spanish
        - Min- 10; Max-60; Average- 31.4
    - Russian
        - Min- 10; Max-35; Average- 20

Summary

Respondents only had comments about specific questions/notes.

- Community members (Russian)
  - Survey is long
  - Liked that the survey is available in Russian
- Community members (Spanish)
  - Survey is very long
- Online response
  - C4: The word "received" is misleading when asking about STI/HIV contraction
- PPED Family/friend
  - The word "received" is misleading when asking about STI/HIV contraction
- Stamford Spanish participants
  - E1, E2: Questions were confusing
  - E5: Confused about race and ethnicity.
  - E12: Why is this question asked? Used to seeing this type of question on financial assistance applications
- Program participants
  - **PPED**
    - Note after C2: "I had to read it a few times"
      - Note: Purchased health insurance through the Health Insurance Marketplace: if purchased on your own (or by a family member), select option 2, if Medicaid select option 3.
    - Note after C5: "Didn't know if I should move on if I answered 'don't know' but it made sense when I skipped to the next question"
      - Note: Medical care includes doctor's visits, tests, procedures, prescription medication and hospitalizations
  - **Charla de Lupus**
    - A1: Worded weirdly, did not seem clear to me as reader. Had to read it twice
  - **Voices 60+**
    - B12: Include acupuncture as an example
    - C8: Too wordy (the question)

Appendix D. Detailed key findings of the CHNA results

*Please note - Physical activity and PA are used interchangeably in this report

Executive Summary

Background

In 2019, Hospital for Special Surgery (HSS) developed a Community Health Needs Assessment (CHNA) survey to assess the needs of its community and guide the development of the New York State Department of Health (NYSDOH) comprehensive Community Service Plan. The survey explored several areas: (1) health status and quality of life, (2) health behavior and lifestyle, (3) use of and access to care, and (4) socio-demographic characteristics.

Methodology

The survey was administered in Spanish, Chinese and Russian with an overwhelming response in English (98.0%), and implemented through various means (i.e. the web, email, QR-code, Survey Gizmo, mail and in-person) over a four-week time frame (March 1 – April 1, 2019). Surveys were completed by 11,410 patients and community members with email yielding majority of the responses (81%).

Results

The section below highlights findings from key areas explored in the survey.

1. **Socio-demographic characteristics.** The socio-demographic profile of survey respondents indicated that the majority were females (67%) with a mean age of 63.1 (range: 18-99 years). Majority of the respondents were Whites/Caucasians (79%) and non-Hispanics/Latinos/Latinos (91%) while others identified as Hispanics/Latinos/Latinos (10%), Blacks/African Americans (10%), Asians (5%), American Indians (1%), and other races (7%). Respondents had high educational backgrounds with over half (65%) completing college and post graduate education. Respondents were mid to high level income earners with 23% earning $50,000 - $100,000K and 49% earning more than $100,000 of annual household income. English (96%) was the predominant language spoken at home. More than half of respondents (54%) were married; while 70% do not live alone with a majority living in Manhattan (24%).

2. **Health status and Quality of Life.** Overall health status of respondents (83%) was rated positively (good to excellent). The leading musculoskeletal condition in the community was Osteoarthritis (OA). Among respondents diagnosed with a musculoskeletal condition, the most reported symptom experienced within 30 days were joint/bone pains or aches (84%), stiffness (79%) and muscle pains or aches (73%). Over half of respondents (53%) reported some pain interference with usual/daily activities with a majority (65%) indicating stooping, bending or kneeling as the top difficulty. More than a-quarter of respondents (27%) fell in the past year with 67% informing their healthcare provider about their falls. One-quarter of respondents (25%) reported poor physical health for more than two weeks while most respondents reported no mental health problems (60%).

3. **Health behavior and lifestyles.** According to Centers for Disease Control and Prevention (CDC) recommended guidelines, regular physical activity (PA) was defined as at least 150 minutes of moderate activity, 75 minutes of vigorous activity, or at least one day of muscle-strengthening activities per week. Lack of PA was a concern such that over two-thirds of respondents (69%) reported not meeting CDC's recommended levels of PA (moderate, vigorous, muscle strengthening).

*Please note - Physical activity and PA are used interchangeably in this report

More than half of respondents (54%) had been told by their doctor in the past 12 months to do physical activity/exercise while 31% had been told to lose weight. For diet, three-quarter of respondents (75%) reported eating healthy; however, 61% indicated interest to eat healthier. For pain management, more than half of respondents (53%) reported using prescription pain killers with 86% disagreeing to taking more than the recommended dosage of prescription medication when feeling pain more than usual. However, almost two-thirds of respondents (64%) reported never using complementary treatments (i.e. yoga, meditation, mindful breathing) to manage their pain.

4. **Use of and Access to Care.** Almost all respondents (97%) reported having some form of health insurance/coverage with a majority having Medicare (53%). Most respondents reported taking preventive care measures over the past year, with almost three-quarters (74%) receiving a flu shot. However, only 10% reported receiving a STI/HIV screening. Almost all respondents (90%) had access to healthcare when they needed it. However, among those who had no access to healthcare, challenges in getting an appointment and cost were the leading barriers. While 94% of respondents stated that they generally followed their provider's medical advice, common barriers to adherence were concerns about side effects and feeling that treatment would not help. High provider-patient communication (i.e. generally took steps to communicate with their provider) was also reported among majority of respondents (83%). Lack of self-efficacy to manage chronic condition was a concern among many respondents with more than half (51%) having no/little confidence in managing their musculoskeletal conditions. English was the most preferred language of reading medical or health care information among respondents. The most popular place for respondents to obtain health information or advice was the doctor's office (91%) followed by the Internet (55%) with 7% needing assistance when reading instructions, pamphlets, or other written health materials.
5. **Health Education Needs.** There is a lack of educational awareness in the community with over three-quarter of respondents (79%) indicating that they had not taken an educational class to learn how to manage their musculoskeletal health/condition. There was also a lack of confidence among respondents that taking a course/class will help manage their musculoskeletal conditions with 68% having little/no confidence. Brochures/flyers (58%) and online lectures (50%) were the preferred platforms in receiving health education. In addition, participating in exercise classes was the most preferred health education activity among half of respondents (50%), followed by online lectures at HSS (47%) and podcasts (31%). The leading health topics that respondents were interested in were How to exercise and manage my condition, Osteoarthritis (OA), and Back pain.

Conclusion

Ultimately, the data uncovered by the assessment will lead to the prioritization of our community health needs and contribute to meaningful discussions with the public and community partners via the community forums. This will support program development and the implementation of the Hospital's three-year Community Service Plan (CSP), which will include evidence-based programs and services that are important to members of the HSS community.

See detailed key findings of the 2019 CHNA survey below.

*Please note - Physical activity and PA are used interchangeably in this report

Key Findings Report

Background

HSS conducted an anonymous, large-scale Community Health Needs Assessment (CHNA) survey from March 1 to April 1, 2019 to assess the needs of the community served and guide the development of the New York State Department of Health (NYSDOH) comprehensive Community Service Plan. The survey explored several areas which include:

- Social demographic characteristics
- Health status and quality of life
- Health behavior and lifestyle
- Use of and access to care
- Educational needs

Methodology

- The CHNA survey was completed by 11,410 HSS patients and members of its community
- The CHNA survey was administered in English, Spanish, Chinese and Russian with an overwhelming response in English (98.0%). The rest of the responses were in Spanish (1.1%), Chinese (0.8%) and Russian (0.2%)
- The CHNA survey was administered online (i.e. web and email via Survey Gizmo), by mail and in-person with email yielding majority of the responses (80.6%). Table 1 below shows a detailed breakdown of responses by administration mode

Data Analysis

- Primary analyses were conducted in the total sample of 11,410 respondents
- In order to further examine the total sample, and identify health disparities that exists, secondary analyses were conducted in four sub-groups listed below with results presented throughout this report.
    - HSS Regional sites (n=260) – This group represents HSS patients from HSS' regional locations i.e. Long Island, NY; Stamford, CT and Paramus, NJ
    - HSS Ambulatory Care Centers; ACC (n = 341) – This group represents HSS patients from more racially/ethnically diverse and lower socioeconomic backgrounds i.e. 72nd street and Rheumatology, 6th floor
    - Public/uninsured respondents (n = 1,015) – This group represent respondents who either lacked health insurance or were covered by Medicaid or Medicare/Medicaid
    - Medically Underserved Areas (MUA) (n=1,170) – This group represent respondents from zip codes of Medically Underserved Areas (MUA) (http://www.hrsa.gov/shortage/mua/index.html)

Results

- This report highlights results from descriptive summaries, chi-tests and correlations to determine statistically significant associations between socio-demographics, health status and quality of life, health behavior and lifestyle, use of and access to care and educational needs across all samples

*Please note - Physical activity and PA are used interchangeably in this report

Table 1: 2019 CHNA Response Breakdown by Administration Method

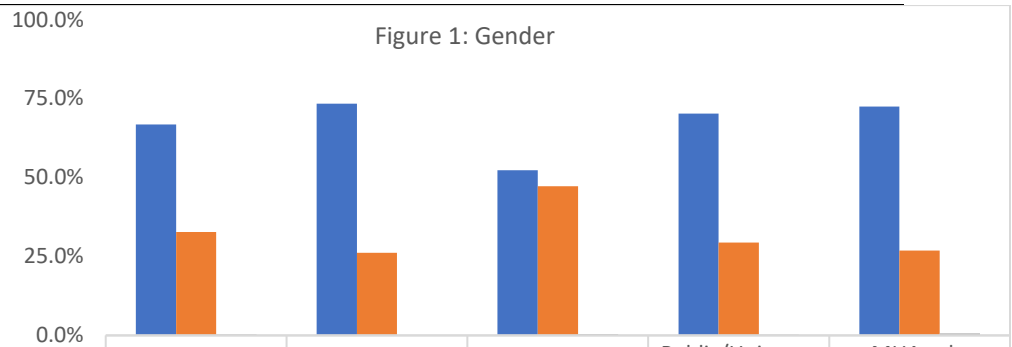
Admin. Method	Subset	Language	Original N	Response Total	Response Rate	% Response of Total
Web	Facebook	English	N/A	13	N/A	0.1%
	Twitter	English	N/A	5		0.0%
	HSS website	English	N/A	18		0.2%
		Russian		1		
	PPED website	English	N/A	15		0.1%
	Web Total		**N/A**	**52**	**N/A**	**0.5%**
Survey Gizmo (panel service)	N/A	English	591	591	100%	5.2%
	Survey Gizmo Total		**591**	**591**	**100%**	**5.2%**
QR-codes	HSS sites (main campus and regional)	English	1000	13	1.3%	0.1%
	QR-code Total		**1000**	**13**	1.3%	0.1%
Email	PPED	English	694	221	31.8%	1.9%
	HSS Patient	English	105,062	8794	8.4%	77.1%
		Chinese		12		
		Russian		12		
		Spanish		58		
	Newsletter	English	8,311	20	0.2%	0.2%
		Chinese		1		
	Social Work	English	551	81	14.7%	0.7%
		Spanish		1		
	Email Total		**114618**	**9200**	**8.0%**	**80.6%**
Mail	PPED	English	13,900	465	3.3%	4.1%
		Spanish		1		
		QR-code		2		
	Social Work	English	1,226	69	5.6%	0.6%
		Chinese		11		
		Spanish		14		
		QR-code		8		
	Purchased	English	7,500	139	1.9%	1.2%
		Chinese		12		
		Russian		5		
		Spanish		19		
	Mail Total		**22626**	**745**	**3.3%**	**6.5%**
In Person	PPED	English	140	21	15.0%	0.2%
		Chinese		50		
	ACC (72nd Str, Rheum 6th floor)	English	645	313	48.5%	2.7%
		Russian		5		
		Spanish		23		
	Other HSS sites (HSS main 8th flr, Pt Access, Pavillion 3rd & 4th flr)	English	405	61	15.1%	0.5%
	Nursing	English	192	32	16.7%	0.3%
		Spanish		4		
	Regional sites (Long Island, Stamford, Paramus)	English	350	259	74.0%	2.3%
		Spanish		1		
	Social Work	English	130	39	30.0%	0.3%
		Spanish		1		
	In Person Total		**1862**	**809**	**61.7%**	**7.1%**
Grand Total				**11,410**		

*Please note - P

A. Socio-Demographic Profile

Gender

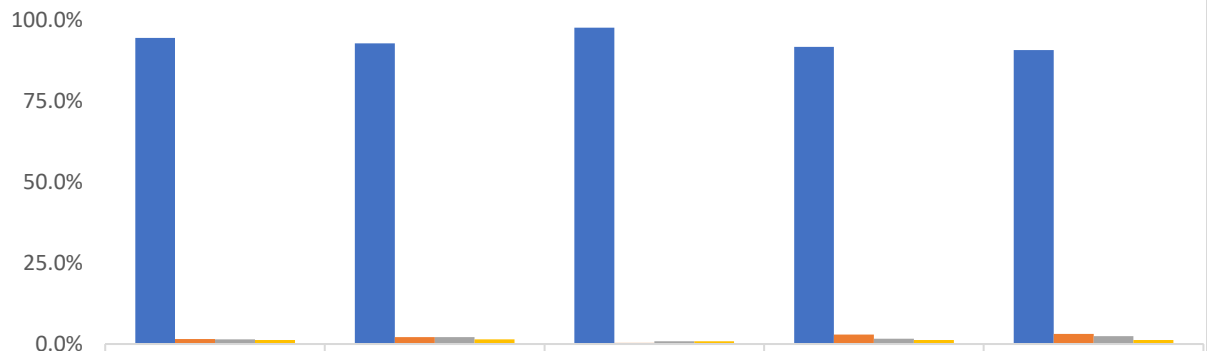
Figure 1: Gender



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Female	66.8%	73.4%	52.3%	70.3%	72.5%
Male	32.8%	26.2%	47.3%	29.4%	26.9%
Other (trans male, trans female, gender non-comforming)	0.3%	0.0%	0.4%	0.2%	0.6%

Sexual Orientation

Figure 2: Sexual Orientation

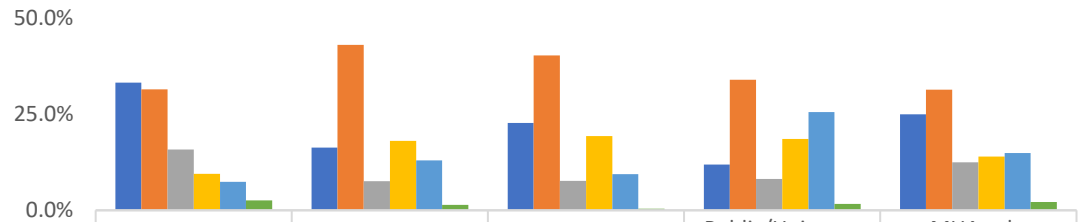


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Straight	94.4%	92.7%	97.5%	91.6%	90.6%
Bisexual	1.5%	2.1%	0.4%	2.9%	3.1%
Gay	1.4%	2.1%	0.8%	1.6%	2.4%
Lesbian	1.2%	1.4%	0.8%	1.2%	1.2%

Age

*Please note - Physical activity and PA are used interchangeably in this report

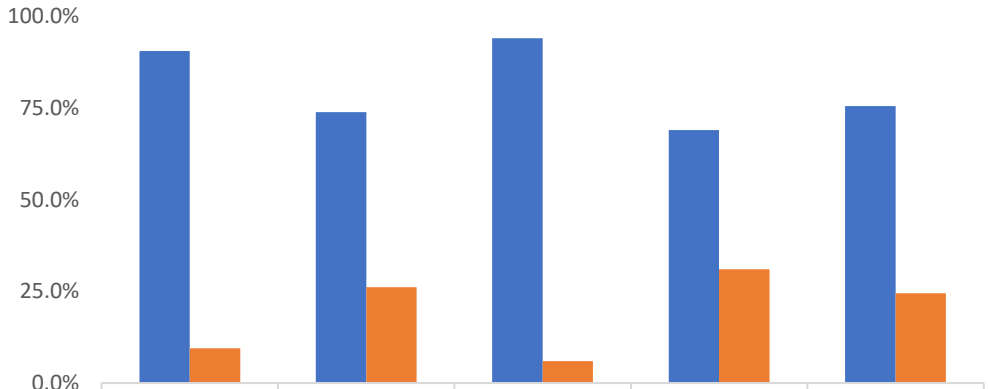
Figure 3: Age group



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
66-75 years	33.2%	16.3%	22.7%	11.9%	25.0%
51-65 years	31.5%	43.1%	40.3%	34.0%	31.4%
76-85 years	15.8%	7.6%	7.7%	8.2%	12.5%
36-50 years	9.5%	18.1%	19.3%	18.6%	14.0%
18-35 years	7.4%	13.0%	9.4%	25.6%	14.9%
86+ years	2.6%	1.4%	0.4%	1.7%	2.2%

Ethnicity

Figure 4: Hispanic/Latino

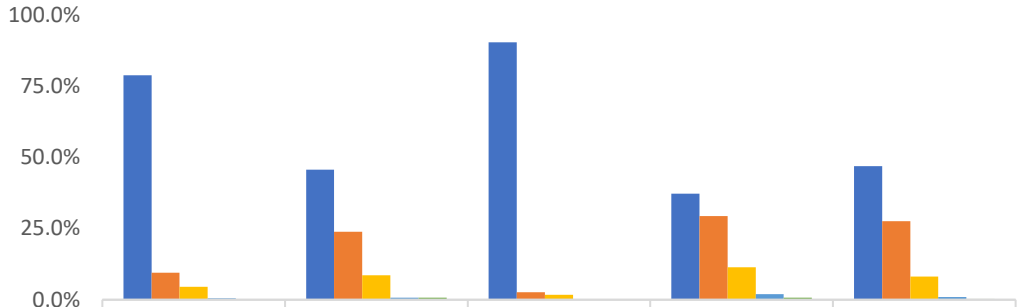


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
No	90.5%	73.9%	94.0%	69.0%	75.5%
Yes	9.5%	26.1%	6.0%	31.0%	24.5%

*Please note - Physical activity and PA are used interchangeably in this report

Race

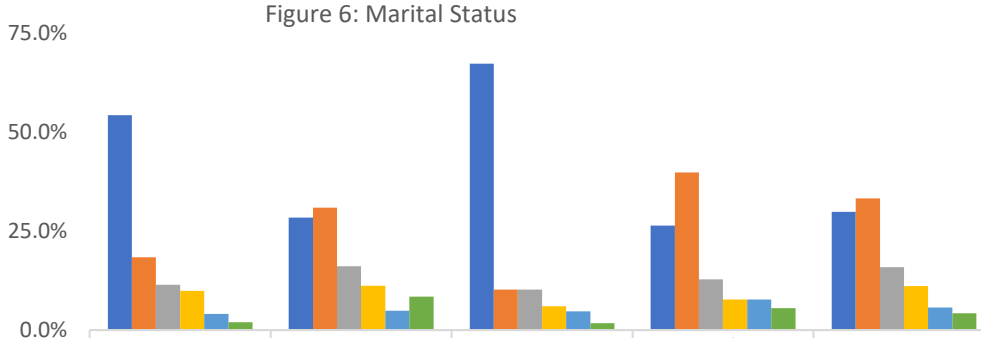
Figure 5: Race



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
White	78.8%	45.7%	90.4%	37.2%	46.9%
Black or African American	9.5%	23.9%	2.6%	29.4%	27.6%
Asian	4.6%	8.6%	1.8%	11.4%	8.1%
American Indian/Alaska Native	0.5%	0.7%	0.0%	2.0%	1.0%
Native Hawaiian/Other Pacific Islander	0.1%	0.7%	0.0%	0.7%	0.3%

Marital status

Figure 6: Marital Status

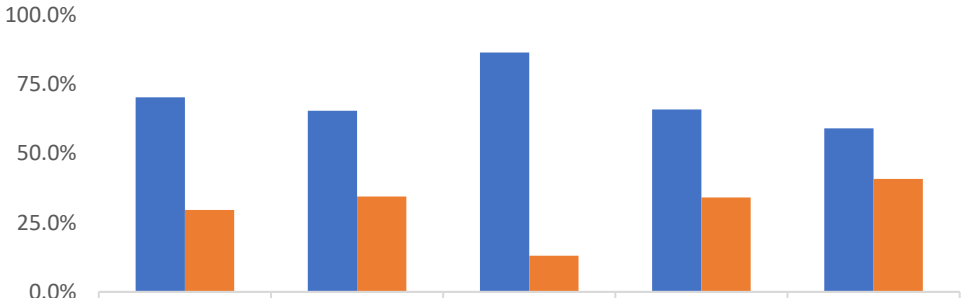


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Married	54.2%	28.4%	67.2%	26.4%	29.8%
Never married	18.4%	30.9%	10.2%	39.8%	33.2%
Divorced	11.4%	16.1%	10.2%	12.8%	15.9%
Widowed	9.9%	11.2%	6.0%	7.7%	11.1%
Living together as a couple	4.1%	4.9%	4.7%	7.7%	5.7%
Separated	2.0%	8.4%	1.7%	5.5%	4.2%

*Please note - Physical activity and PA are used interchangeably in this report

Living Alone

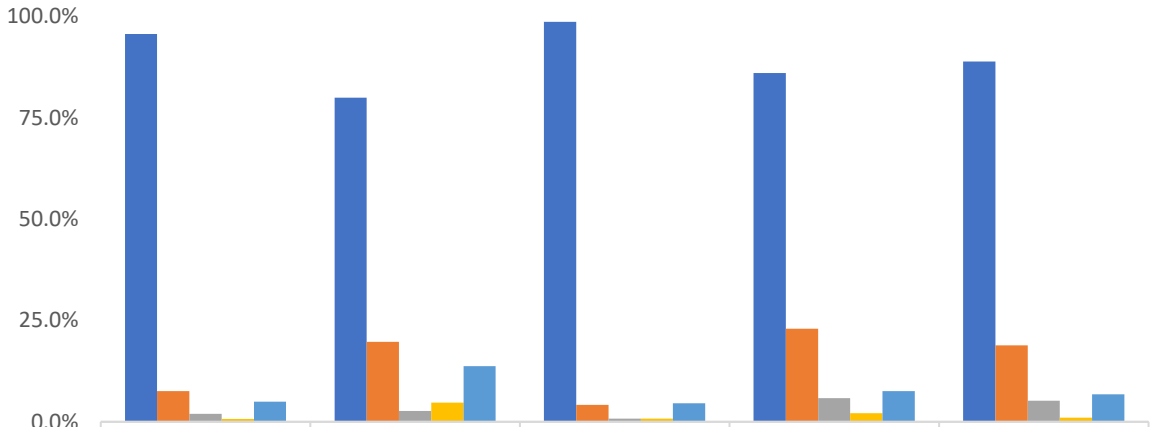
Figure 7: Live Alone



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
No	70.4%	65.5%	86.6%	65.9%	59.1%
Yes	29.6%	34.5%	13.1%	34.1%	40.9%

Spoken Language

Figure 8: Spoken Language

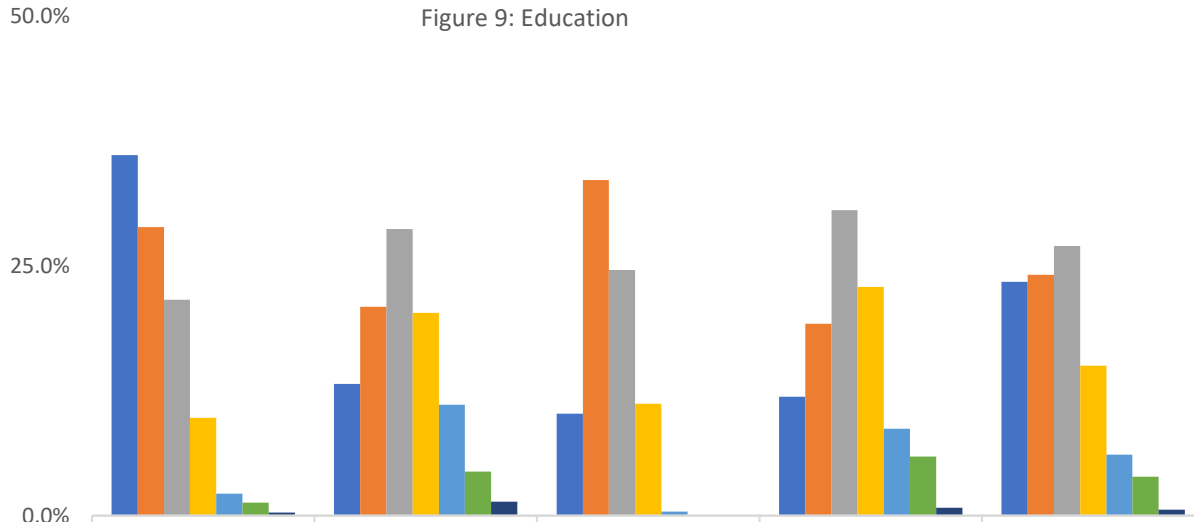


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
English	95.7%	80.0%	98.7%	86.1%	88.9%
Spanish	7.6%	19.7%	4.2%	23.0%	18.9%
Chinese	2.0%	2.7%	0.8%	5.8%	5.2%
Russian	0.7%	4.7%	0.8%	2.1%	1.0%
Other	5.0%	13.7%	4.6%	7.6%	6.8%

*Please note - Physical activity and PA are used interchangeably in this report

Education

Figure 9: Education

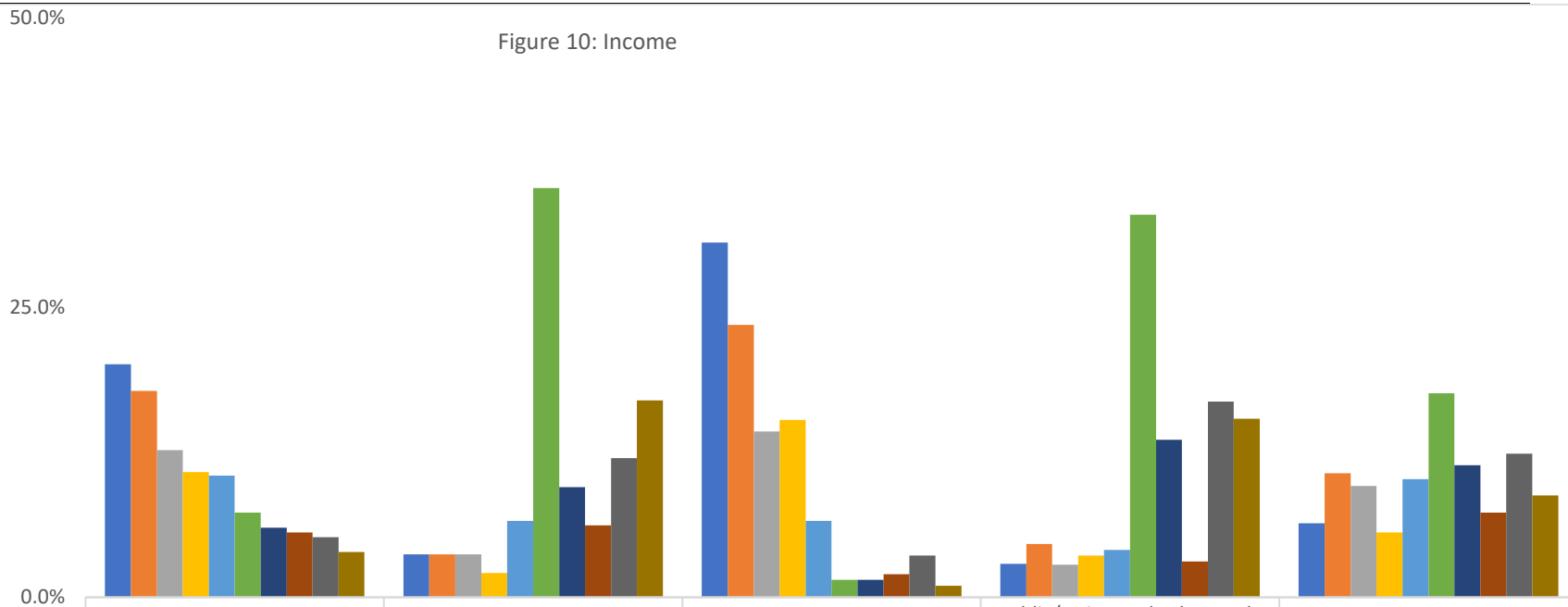


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Post graduate (Masters, PhD)	36.1%	13.2%	10.2%	11.9%	23.4%
College 4 years or more (College graduate)	28.9%	20.9%	33.6%	19.2%	24.1%
College 1 year to 3 years (Some college or technical school)	21.6%	28.7%	24.6%	30.6%	27.0%
Grade 12 or GED (High school graduate)	9.8%	20.3%	11.2%	22.9%	15.0%
Grades 9 through 11 (Some high school)	2.2%	11.1%	0.4%	8.7%	6.1%
Grades 1 through 8 (Elementary)	1.3%	4.4%	0.0%	5.9%	3.9%
Never attended school or only attended kindergarten	0.3%	1.4%	0.0%	0.8%	0.6%

*Please note - Physical activity and PA are used interchangeably in this report

Income

Figure 10: Income

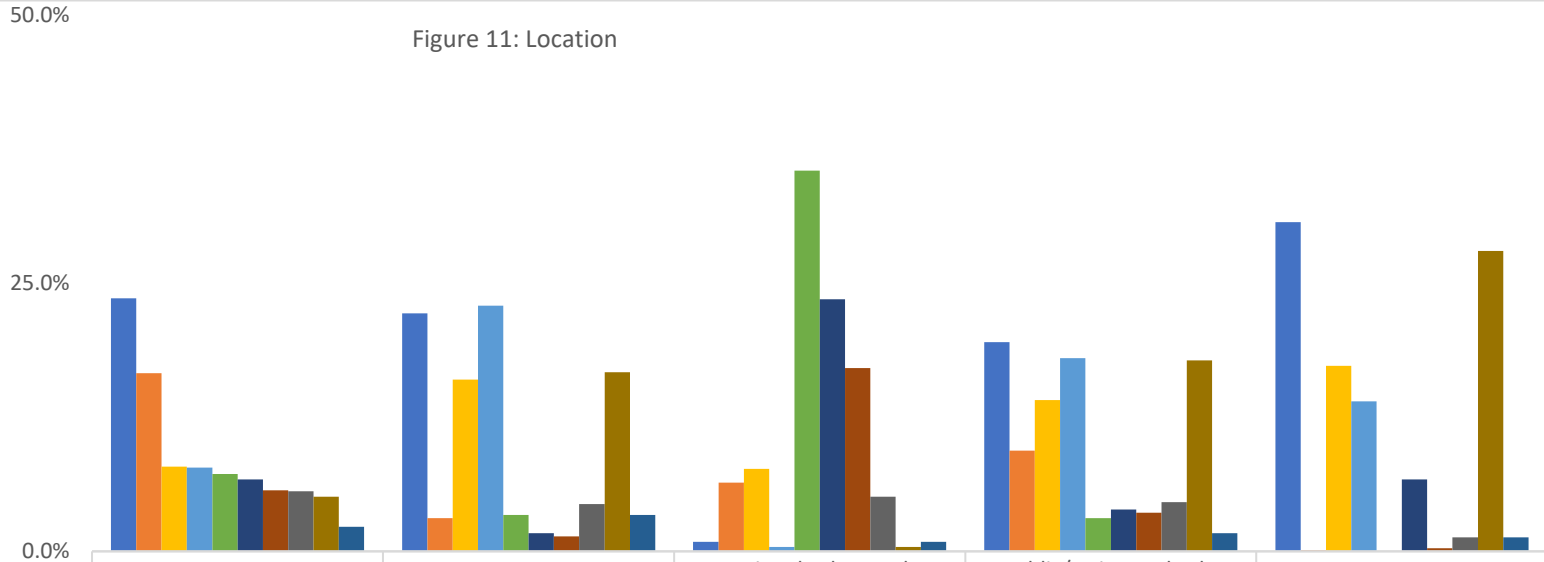


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
$200,000 or more	20.1%	3.7%	30.6%	2.9%	6.4%
$100,000-$149,999	17.8%	3.7%	23.5%	4.6%	10.7%
$75,000-$99,999	12.7%	3.7%	14.3%	2.8%	9.6%
$150,000-$199,999	10.8%	2.1%	15.3%	3.6%	5.6%
$50,000-$74,999	10.5%	6.6%	6.6%	4.1%	10.2%
Less than $10,000	7.3%	35.3%	1.5%	33.0%	17.6%
$25,000-$34,999	6.0%	9.5%	1.5%	13.6%	11.4%
$35,000-$49,999	5.6%	6.2%	2.0%	3.1%	7.3%
$15,000-$24,999	5.2%	12.0%	3.6%	16.9%	12.4%
$10,000-$14,999	3.9%	17.0%	1.0%	15.4%	8.8%

*Please note - Physical activity and PA are used interchangeably in this report

Geographic location

Figure 11: Location



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Manhattan	23.6%	22.2%	0.9%	19.5%	30.7%
New Jersey	16.6%	3.1%	6.4%	9.4%	0.1%
Queens	7.9%	16.0%	7.7%	14.1%	17.3%
Brooklyn	7.8%	22.9%	0.4%	18.0%	14.0%
Long Island, Nassau County	7.2%	3.4%	35.5%	3.1%	0.0%
Connecticut	6.7%	1.7%	23.5%	3.9%	6.7%
Long Island, Suffolk County	5.7%	1.4%	17.1%	3.6%	0.3%
Westchester	5.6%	4.4%	5.1%	4.6%	1.3%
Bronx	5.1%	16.7%	0.4%	17.8%	28.0%
Staten Island	2.3%	3.4%	0.9%	1.7%	1.3%

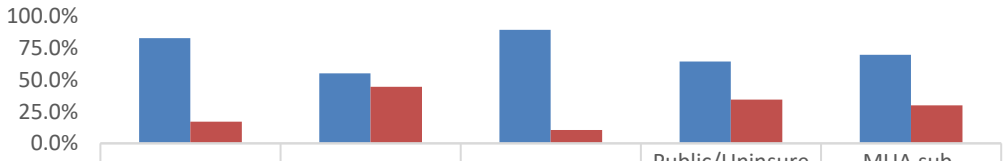
*Please note - Physical activity and PA are used interchangeably in this report

A. Health Status & Quality of Life

General Health

- Figure 12 below highlights respondents' rating of their general health
- Majority of the respondents across all samples rated their general health as excellent/very good/good
- 21.6% of the total sample, 49.1% of the ACC sub-sample, 49.5% of the public/uninsured sub-sample and 34% of the MUA sub-sample rated their health negatively (poor or fair), compared to 22.4% in New York City and 15.9% nationally

Figure 12: General health ratings



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Positive (good/very good/ excellent)	82.9%	55.3%	89.5%	64.5%	69.9%
Negative (fair/poor)	17.1%	44.7%	10.5%	34.5%	30.1%

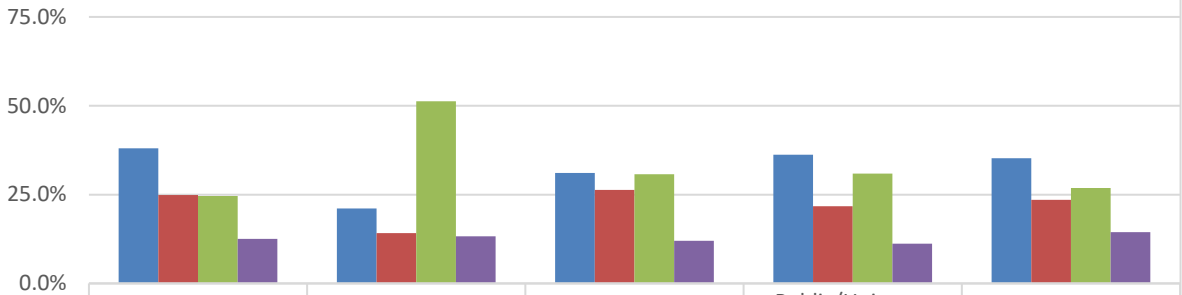
- General health was significantly associated with race and ethnicity such that:
  - Hispanics/Latinos were more likely to rate their health negatively in the total sample (30.6% ; p $\leq$0.001), public/uninsured (40.1%; p $\leq$0.001), ACC (55.4%; p $\leq$0.01) and MUA sub-samples (36.3%; p $\leq$0.001)
  - American Indians (33.3%) were more likely to rate their health negatively in the total sample (33.3%; p $\leq$0.001), public/uninsured (50.0%; p $\leq$0.001) and MUA sub-samples (54.5%; p $\leq$0.001)

Physical Health

- Figure 13 shows the physically unhealthy days in the past 30 days (i.e. physical health including physical illness and injury) reported by respondents from all samples:
  - Using the CDC Healthy Days measure and physically unhealthy definition to access physical health, results show that majority of respondents in all samples were physically healthy except in the ACC sub-sample, where most respondents (51.3%) experienced 1-2 weeks of poor physical health. See below for details:

*Please note - Physical activity and PA are used interchangeably in this report

Figure 13: Physically unhealthy days in the past 30 days



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
None	38.0%	21.1%	31.1%	36.2%	35.2%
More than 2 weeks	24.9%	14.2%	26.3%	21.7%	23.5%
1-2 weeks	24.6%	51.3%	30.7%	30.9%	26.9%
Less than a week	12.5%	13.3%	12.0%	11.2%	14.4%

In the total sample, statistically significant associations were found with regards to physical health:

- Physical health was significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA ($p \leq 0.001$), RA ($p \leq 0.001$), Lupus ($p \leq 0.001$), Fibromyalgia ($p \leq 0.001$), Gout ($p \leq 0.05$), some other form of arthritis ($p \leq 0.001$) and OP ($p \leq 0.001$) were more likely to report 14+ days of poor physical health
- Physical health was significantly associated with gender such that:
  - Females (69.9%) were more likely to report 14+ days of poor physical health compared to males (29.6%); $p \leq 0.01$
- Physical health was significantly associated with age such that:
  - Respondents between the age of 51-65 years (34.5%) and 66-75 (29.9%) were more likely to report more than 2 weeks of poor physical health; $p \leq 0.001$
- Physical health was significantly associated with ethnicity such that:
  - Non-Hispanics/Latinos (88.3%) were more likely to report more than 2 weeks of poor physical health compared to Hispanics/Latinos (11.7%); $p \leq 0.001$
- Physical health was significantly associated with physical activity (PA) such that:
  - Those who did not meet CDC-recommended levels of moderate PA (85.1%) were more likely to report more than 2 weeks of poor physical health; $p \leq 0.001$
  - Those who did not meet CDC-recommended levels of vigorous PA (86.3%) were more likely to report more than 2 weeks of poor physical health; $p \leq 0.01$
  - Those who did not meet CDC-recommended levels of muscle strengthening PA (66.4%) were more likely to report more than 2 weeks of poor physical health; $p \leq 0.001$ level

In the regional sub- sample, statistically significant associations were found with regards to physical health:

- Physical health was significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with having some other form of arthritis were more likely to report more than 2 weeks of being physically unhealthy; $p \leq 0.05$
- Physical health was significantly associated with physical activity (PA) such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Those who did not meet CDC-recommended levels of vigorous PA (83.6%) were more likely to report more than 2 weeks of poor physical health; p ≤0.05
  - Those who did not meet CDC-recommended levels of muscle strengthening (63.0%) were more likely to report more than 2 weeks of poor physical health; p ≤0.001

In the public/uninsured sub-sample, statistically significant associations were found with regards to physical health:

- Physical health was significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (p ≤0.001), RA (p ≤0.001), Lupus (p ≤0.001), Fibromyalgia (p ≤ 0.001), Gout (p ≤ 0.01), some other form of arthritis (p ≤ 0.001) and OP (p ≤ 0.001) were more likely to report more than 2 weeks of poor physical health
- Physical health was significantly associated with age such that:
  - Respondents between the age of 51-65 years (41.9%) were more likely to report more than 2 weeks of poor physical health; p ≤ 0.001
- Physical health was significantly associated with PA such that:
  - Those who did not meet CDC-recommended levels of moderate PA (86.9%) were more likely to report more than 2 weeks of poor physical health; p ≤0.05
  - Those who did not meet CDC-recommended levels of muscle strengthening (74.2%) were more likely to report more than 2 weeks of poor physical health; p ≤0.001

In the MUA sub-sample, statistically significant associations were also found with regards to physical health:

- Physical health was significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (p ≤0.001), RA (p ≤0.001), Lupus (p ≤0.001), Fibromyalgia (p ≤ 0.001), Gout (p ≤ 0.01), some other form of arthritis (p ≤ 0.001) and OP (p ≤ 0.001) were more likely to report more than 2 weeks of poor physical health
- Physical health was significantly associated with age such that respondents between the age of 51-65 years (37.2%) were more likely to report more than 2 weeks of poor physical health; p ≤ 0.05
- Physical health was significantly associated with race and ethnicity such that Whites/Caucasians (48.7%) were more likely to report more than 2 weeks of poor physical health; p ≤ 0.001
- Physical health was significantly associated with PA such that:
  - Those who did not meet CDC-recommended levels of moderate PA (88.6%) were more likely to report more than 2 weeks of poor physical health; p ≤0.001
  - Those who did not meet CDC-recommended levels of vigorous PA (87.8%) were more likely to report more than 2 weeks of poor physical health; p ≤0.01
  - Those who did not meet CDC-recommended levels of muscle strengthening (74.3%) were more likely to report more than 2 weeks of poor physical health ;p ≤0.001

Musculoskeletal Conditions

- Table 2 depict respondents who had been diagnosed with various musculoskeletal and rheumatologic conditions

*Please note - Physical activity and PA are used interchangeably in this report

- Across all five samples, OA was the leading musculoskeletal condition reported. These results align with national statistics showing that OA is the most common form of arthritis (affecting over 30 million adults in 2015 per CDC).

Table 2: Musculoskeletal conditions

	Total (n=11,410)	ACC sub-sample (n=341)	Regional subsample (n=260)	Public/Uninsured subsample (n=1,015)	MUA sub-sample (n=1,170)
Osteoarthritis (OA)	64.5%	49.0%	57.4%	48.9%	56.1%
Some other form of arthritis	30.7%	33.9%	41.1%	38.4%	32.4%
Osteoporosis (OP)	25.8%	20.1%	19.1%	22.1%	23.3%
Rheumatoid arthritis (RA)	15.3%	34.3%	9.9%	30.3%	24.6%
Gout	6.8%	5.9%	6.4%	7.0%	7.0%
Fibromyalgia	6.5%	10.0%	6.4%	11.6%	8.2%
Lupus	4.4%	9.6%	1.4%	11.6%	9.7%

Reported Symptoms Associated with Musculoskeletal Conditions

- Table 3 below show respondents diagnosed with musculoskeletal conditions and their symptoms
- Results show that joint/ bone pain or aches, muscle pain or aches and stiffness were the three most common symptoms among respondents with musculoskeletal conditions, as depicted in the table below:

Table 3: Reported symptoms associated with musculoskeletal conditions

	Total (n=11,410)	ACC sub-sample (n=341)	Regional subsample (n=260)	Public/Uninsured subsample (n=1,015)	MUA sub-sample (n=1,170)
Joint/ bone pain or aches	84.0%	90.0%	94.1%	86.4%	84.4%
Stiffness	78.5%	72.3%	79.3%	71.1%	74.1%
Muscle pain or aches	72.7%	82.3%	74.1%	76.0%	74.5%
Fatigue	51.5%	58.0%	48.1%	57.5%	54.8%
Problems with balance	34.3%	51.5%	26.7%	43.0%	39.8%
Mood changes	26.7%	44.6%	17.0%	42.3%	38.1%
Trouble with concentrating	21.2%	33.3%	10.4%	34.3%	29.0%
Changes in memory	17.5%	28.6%	5.9%	31.1%	25.7%
Weight changes	17.4%	29.0%	12.6%	31.7%	26.6%
Hair loss	13.0%	20.8%	5.2%	24.0%	19.8%
Skin rash	12.6%	16.5%	8.9%	19.4%	15.4%

- In the total sample, statistically significant associations were found among respondents experiencing certain symptoms based on their musculoskeletal conditions, as shown in Table 4 below
- Respondents in the total sample who had RA, Fibromyalgia and some other form of arthritis experienced all 11 symptoms highlighted in Table 4 below

*Please note - Physical activity and PA are used interchangeably in this report

- Majority of respondents in the total (53.4%), ACC (83.5%), regional (76.6%), public/uninsured (69.0%) and MUA (58.8%) samples who reported arthritis or joint symptoms experienced limitations in their daily activities

Table 4: Musculoskeletal Conditions by Reported Symptoms – Total Sample

	OA	RA	Lupus	Fibromyalgia	Gout	Some other form of OA	OP
Joint/ bone pain or aches	***	***	**	***		***	
Stiffness	***	***		***		***	
Muscle pain or aches	***	***	***	***		***	***
Fatigue	***	***	***	***	**	***	***
Problems with balance	***	***	***	***	***	***	***
Mood changes	**	***	***	***	**	***	***
Trouble with concentrating	*	***	***	***	*	***	***
Changes in memory		***	***	***	***	***	***
Weight changes		***	***	***	***	***	**
Hair loss		***	***	***		***	***
Skin rash		***	***	***	*	***	***

***	denotes statistically significant associations between the condition and reported symptom at the p < 0.001 level
**	denotes statistically significant associations between the condition and reported symptom at the p < 0.01 level
*	denotes statistically significant associations between the condition and reported symptom at the p < 0.05 level

In the total sample, significant socio-demographic differences were found with regards to musculoskeletal conditions:

- Musculoskeletal conditions were significantly associated with geographic locations such that:
  - Respondents living in Manhattan were more likely to be diagnosed with OA (55.5%) and OP (33.2%); p ≤0.001
  - Respondents living in the Bronx (23.2%) followed by Queens (20.6%) were more likely to be diagnosed with RA; p ≤0.001
  - Respondents living in Queens and Staten Island, were more likely to be diagnosed with Lupus (9.6% and 9.2% respectively; p <0.001) and Gout (31.1% each; p <0.01 level)
- Musculoskeletal conditions were significantly associated with gender, such that:
  - Females were more likely to report having OA (55.5%, p ≤ 0.001), RA (14.9%, p ≤ 0.001), Lupus (5.5%; p ≤ 0.001), Fibromyalgia (7.7%; p ≤ 0.001), and OP (29.0%; p ≤ 0.001). While males were more likely to have Gout (11.9%; p ≤ 0.001) and some other form of arthritis (28.6%; p ≤ 0.01). The data aligns with CDC findings stating that most types of arthritis are more common in women, while gout is more common in men.
- Musculoskeletal conditions were significantly associated with age such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Respondents aged 18-35 years (7.7%) and 36-50 years (8.9%) were more likely to be diagnosed with Lupus, and the likelihood decreased with respondents age ($p \leq 0.001$)
  - Respondents aged 66-75 years were more likely to have OA (62.7%), some other form of arthritis (27.0%), OP (25.7%), RA (14.6%), Gout (7.8%) and Fibromyalgia (6.4%); $p \leq 0.001$
  - Respondents aged 76-85 years were more likely to be diagnosed with OA (61.4%), OP (36.9%), some other form of arthritis (30.3%), RA (15.1%) and Gout (8.3%); $p \leq 0.001$
  - Respondents aged 86+ years were more likely to be diagnosed with OA (60.5%), OP (45.4%), some other form of arthritis (36.6%), Gout (13.7%) and RA (12.3%); $p \leq 0.001$
- Musculoskeletal conditions were significantly associated with race and ethnicity such that:
  - Whites/Caucasians more likely to report having OA (55.2%) and OP (23.4%); $p \leq 0.001$
  - Native Hawaiians were more likely to report having RA (25.0%); $p \leq 0.001$
  - Asians were more likely to report having Lupus (16.5%); $p \leq 0.001$
  - American Indians were more likely to report having some other form of OA (27.6%) and Fibromyalgia (12.9%); $p \leq 0.01$
  - Non-Hispanics/Latinos were more likely to report having OA (52.9%), some other form of arthritis (25.6%), OP (22.3%) and Gout (6.4%); $p \leq 0.001$. While Hispanics/Latinos were more likely to report having RA (22.3%), Lupus (9.5%) and Fibromyalgia (9.5%); $p \leq 0.001$

In the regional sub-sample, significant socio-demographic differences were found with regards to musculoskeletal conditions:

- Musculoskeletal conditions were significantly associated with gender such that females were more likely to report having OP (21.9%) compared to males (3.3%); $p \leq 0.001$
- Musculoskeletal conditions were significantly associated with age, such that respondents aged 66-75 years and 76-85 years were more likely to be diagnosed with OA (78.6% and 72.4% respectively; $p \leq 0.001$) and OP (25.0% and 18.4%; $p \leq 0.05$ respectively)

In the ACC sub-sample, significant socio-demographic differences were found with regards to musculoskeletal conditions:

- Musculoskeletal conditions were significantly associated with gender such that females were more likely to report having OP (33.1%; $p \leq 0.001$), Lupus (15.7%; $p \leq 0.01$) and Fibromyalgia (14.8%; $p \leq 0.05$).
- Musculoskeletal conditions were significantly associated with age, such that respondents aged 76-85 years and 66-75 years were more likely to be diagnosed with OA (78.6% and 72.4% respectively; $p \leq 0.001$) and OP (90.0% and 41.7 % respectively; $p \leq 0.05$)
- Musculoskeletal conditions were significantly associated with ethnicity such that Hispanics/Latinos were more likely to report having RA (52.1%; $p \leq 0.01$), and Fibromyalgia (20.0; $p \leq 0.05\%$)

In the public/uninsured sub-sample, significant socio-demographic differences were found with regards to musculoskeletal conditions:

- Musculoskeletal conditions were significantly associated with geographic locations such that:
  - Respondents living in Staten Island were more likely to be diagnosed with OA (50%; $p \leq 0.05$), Fibromyalgia (36.4%; $p \leq 0.05$) and Lupus (30%; $p \leq 0.01$). While respondents living in Manhattan were more likely to be diagnosed with OP (23.4%; $p \leq 0.05$)

*Please note - Physical activity and PA are used interchangeably in this report

- Musculoskeletal conditions were significantly associated with gender, such that females were more likely to report having OA (34.0%; $p \leq 0.001$), RA (22.7%; $p \leq 0.01$), OP (18.5%; $p \leq 0.001$) and Lupus (10.5%; $p \leq 0.01$)
- Musculoskeletal conditions were significantly associated with age such that:
    - Respondents aged 66-75 years were more likely to have OA (62.7%) and Fibromyalgia (18.3%); $p \leq 0.001$
    - Respondents aged 76-85 years were more likely to be diagnosed with OA (63.5%), RA (44.6%), Gout (20.9%) and OP (40.0%); $p \leq 0.001$
    - Respondents aged 86+ years were more likely to be diagnosed with some other form of arthritis (72.7%%); $p \leq 0.001$
- Musculoskeletal conditions were significantly associated with race and ethnicity such that:
    - Asians were more likely to report having OP (22.1%); $p \leq 0.05$
    - Whites/Caucasians (31.8%) and American Indians (31.3%) were more likely to report having some other form of arthritis; $p \leq 0.05$
    - Non-Hispanics/Latinos were more likely to report having OA (32%; $p \leq 0.01$) while Hispanics/Latinos were more likely to report having RA (25%; $p \leq 0.01$) and Fibromyalgia (10.1%; $p \leq 0.05$)

In the MUA sub-sample, significant socio-demographic differences were found with regards to musculoskeletal conditions:

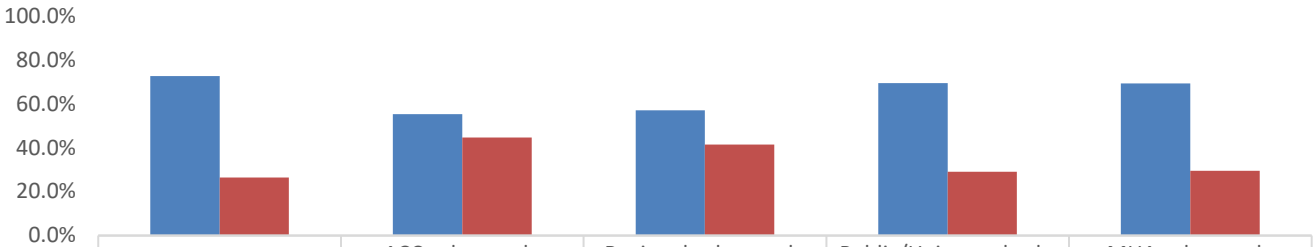
- Musculoskeletal conditions were significantly associated with gender such that:
    - Females were more likely to report having OA (46.3%; $p \leq 0.001$), RA (20.6%; $p \leq 0.05$), OP (23.2%; $p \leq 0.001$), Fibromyalgia (8.7%; $p \leq 0.01$) and Lupus (10.3%; $p \leq 0.01$)
    - Males were more likely to report having Gout (9.4%; $p \leq 0.05$)
- Musculoskeletal conditions were significantly associated with age, such that:
    - Respondents aged 66-75 years were more likely to have RA (26%; $p \leq 0.001$)
    - Respondents aged 76-85 years were more likely to be diagnosed with some other form of arthritis (37.8%; $p \leq 0.001$)
    - Respondents aged 86+ years were more likely to be diagnosed with OA (68.2%), OP (58.8%) and Gout (12.5%); $p \leq 0.001$
- Musculoskeletal conditions were significantly associated with race and ethnicity such that:
    - Whites/Caucasians (52.3%%; $p \leq 0.05$) and Non-Hispanics/Latinos (46.2%; $p \leq 0.001$) were more likely to report having OA
    - American Indians and Hispanics/Latinos were more likely to report having RA (40%;$p \leq 0.05$ and 25.4%;$p \leq 0.01$ respectively) and Fibromyalgia (27.3%; $p \leq 0.05$ and 11.0%; $p \leq 0.01$ respectively)
    - Asians were more likely to report having Lupus (26.2%); $p \leq 0.001$

Falls & Fractures

- Figure 14 shows if respondents had fallen down in the past year
- Majority of respondents indicated that they had not fallen in the past year. See below for details:

*Please note - Physical activity and PA are used interchangeably in this report

Figure 14: Falls in the past year



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
No	72.7%	55.3%	57.1%	69.4%	69.3%
Yes	26.5%	44.7%	41.4%	29.0%	29.5%

- In all samples, 16.1% of the total, 18.8% of ACC, 6.4% of regional, 14.3% of public/uninsured and 14.4% of MUA respondents reported fractures from their falls
- Among those who had fallen, majority of respondents in the total (66.8%), ACC (71.9%), regional (59.6%), public/uninsured (65.7%) and MUA (68.8%) samples had talked to their doctor or healthcare provider about their fall

In the total sample, significant differences were found with regards to falls

- Falls were significantly associated with geographic location such that:
  - Respondents living in Manhattan (31.6%), Brooklyn (29.4%), Westchester (26.6%) and Queen (26.4%) were more likely to fall; $p \leq 0.001$
  - Among the respondents living in Queens that fell, 73.7% talked to their doctor or healthcare provider about their falls; $p \leq 0.01$
- Falls were significantly associated with gender such that:
  - Falls were more common among females (28.9%) and gender non-conforming (50%); $p \leq 0.001$
- Falls were significantly associated with age such that:
  - The oldest respondents (aged 86+ years) were more likely (40.2%) to fall, followed by those aged 76-85 years (32.3%); $p \leq 0.001$. This data supports research showing that the severity of falls-related consequences increase with age, such that in 2012, older New Yorkers accounted for more than 2/3 of all adult fall-related deaths and hospitalizations.
  - Among respondents aged 76-85 years that fell, 20.3% reported fractures from their fall; $p \leq 0.001$
  - Among respondents aged 85+ years and 76-85 years (81.2% and 71.2% respectively) talked to their doctor or healthcare provider about their fall; $p \leq 0.001$
- Falls were significantly associated with race such that:
  - American Indians (37.5%) and African Americans (28.4%) were more likely to fall; $p \leq 0.001$
  - Among the American Indians that fell, 16.7% reported fractures from their fall; $p \leq 0.001$
- Falls were significantly associated with physical activity (PA) such that:
  - Those who did not meet CDC-recommended levels of vigorous PA (27.6%) were more likely to fall; $p \leq 0.001$. Among these respondents, 61.6% reported their falls to their doctor; $p \leq 0.05$

*Please note - Physical activity and PA are used interchangeably in this report

  - Respondents who did not meet CDC-recommended levels of muscle strengthening (29.7%) were more likely to fall; p ≤0.001. Among these respondents, 63.7% reported their falls to their doctor; p ≤0.001
  - This data strongly support research that has shown that physical inactivity and a sedentary lifestyle are risk factors for developing fragility fractures, and that PA reduces the risk of osteoporosis, fractures, and falls-related injuries
- Falls were significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (28.9%; p ≤ 0.001), RA (33.3%; p ≤ 0.001), Lupus (71%; p ≤ 0.05), Fibromyalgia (38.9%; p ≤ 0.001), Gout (31.6%;p ≤ 0.05), some other form of arthritis (28%; p ≤ 0.05), and OP (34%;p ≤ 0.001) were more likely to fall in the past year

In the ACC sub-sample, significant associations were found with regards to falls:

- Falls were significantly associated with musculoskeletal conditions such that respondents diagnosed with OA (51.3%; p ≤ 0.05) were more likely to fall in the past year

In the public/uninsured sub-sample, significant associations were found with regards to falls:

- Falls were significantly associated with physical activity (PA) such that:
  - Those who did not meet CDC-recommended levels of moderate PA (26.5%) were more likely to fall; p ≤0.05. Among these respondents, 57.3% reported their falls to their doctor; p ≤0.05
- Falls were significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (38.3%; p ≤ 0.001), RA (40.2%; p ≤ 0.001), Lupus (41.9%; p ≤ 0.01), Fibromyalgia (54%; p ≤ 0.001), Gout (51.4%;p ≤ 0.01), some other form of arthritis (35.6%; p ≤ 0.01), and OP (41.7%;p ≤ 0.001) were more likely to fall in the past year.

In the MUA sub-sample, significant associations were found with regards to falls:

- Falls were significantly associated with gender such that falls were more common among females (31.3%) and gender non-conforming (80%); p ≤ 0.05
- Falls were significantly associated with age such that:
  - The oldest respondents (aged 86+ years) were more likely (54.2%) to fall, followed by those aged 76-85 years (35.1%); p ≤ 0.05. Among respondents aged 85+ years and 76-85 years (76.9% and 69.6% respectively) talked to their doctor or healthcare provider about their fall; p ≤ 0.011
- Falls were significantly associated with physical activity (PA) such that Those who did not meet CDC-recommended levels of moderate PA (32.1%) were more likely to fall; p ≤0.01.
- Falls were significantly associated with musculoskeletal conditions such that
  - Respondents diagnosed with OA (34.6%; p ≤ 0.01), RA (38.9%; p ≤ 0.01), Lupus (38.9%; p ≤ 0.05) and Fibromyalgia (47.5%; p ≤ 0.01) were more likely to fall in the past year

Mental Health

- Table 5 shows mentally unhealthy days in the past 30 days (i.e. mental health which included stress, depression, and problems with emotion) from all samples:
  - Majority of respondents across all five samples reported no mentally unhealthy days in the past 30 days

*Please note - Physical activity and PA are used interchangeably in this report

- However, using the CDC Healthy Days measure and mentally unhealthy definition to access mental health, results show that 24.5% of respondents from the ACC sub-sample were mentally unhealthy.

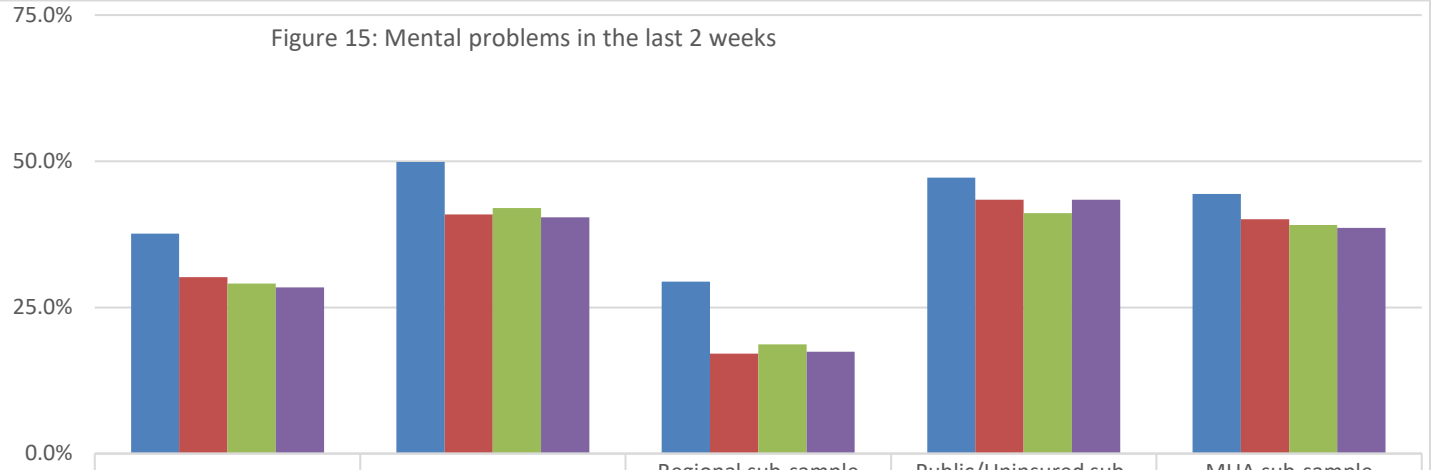
Table 5: Mentally unhealthy in the past 30 days

Mentally Unhealthy	Total (N=11,710)	ACC sub-sample (n=341)	Regional subsample (n=260)	Public/Uninsured subsample (n=1,015)	MUA sub-sample (n=1,170)
None	60.3%	51.0%	72.0%	50.1%	50.8%
Less than one week	22.9%	16.3%	16.9%	21.0%	21.2%
1-2 weeks	7.6%	8.2%	4.5%	12.3%	14.0%
More than 2 weeks	9.2%	24.5%	6.6%	16.7%	13.9%

- Figure 15 below highlights respondents' experiences with mental health problems within the past two weeks.
- Across all five samples, feeling nervous, anxious or on edge was the leading mental problem reported.

*Please note - Physical activity and PA are used interchangeably in this report

Figure 15: Mental problems in the last 2 weeks



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Feeling nervous, anxious or on edge	37.6%	49.9%	29.4%	47.2%	44.4%
Feeling down, depressed or hopeless	30.2%	40.9%	17.1%	43.4%	40.1%
Not being able to stop or control worrying	29.1%	42.0%	18.7%	41.1%	39.1%
Little interest or pleasure in doing things	28.4%	40.4%	17.4%	43.4%	38.6%

In the total sample, statistically significant associations were found with regards to mental health:

- Mental health was significantly associated with geographic location such that:
  - Respondents living in the Bronx (16.4%) were more likely to report more than 2 weeks of poor mental health; $p \leq 0.001$
- Mental health was significantly associated with gender such that:
  - Respondents who considered themselves to be Gender non-conforming (30.0%) were more likely to report more than 2 weeks of poor mental health; $p \leq 0.001$
- Mental health was significantly associated with age such that:
  - The youngest respondents (18-35 years) and oldest respondents (86+ years) were more likely to report more than 2 weeks of poor mental health (14.8% and 11.9% respectively; $p \leq 0.001$)
- Mental health was significantly associated with race and ethnicity such that:
  - American Indians (18.8%) followed by Hispanics/Latinos (17.2%) and Other race (16.6%) were more likely to report more than 2 weeks of poor mental health ($p \leq 0.001$)

*Please note - Physical activity and PA are used interchangeably in this report

- Mental health was significantly associated with musculoskeletal conditions such that:
    - Respondents with OA (9.3%;p ≤0.001), RA (14.1%;p ≤0.001), Lupus (19.6%p ≤0.001), Fibromyalgia (20.7%; p ≤ 0.001), some other form of arthritis (11.7%; p ≤ 0.001) and OP (11.8%); p ≤ 0.001 were more likely to report more than 2 weeks of poor mental health
- Mental health was significantly associated with physical activity (PA) such that:
    - Those who did not meet CDC-recommended levels of vigorous PA (10.1%) were more likely to report poor mental health; p ≤0.001
    - Those who did not meet CDC-recommended levels of moderate PA (10.0%) were more likely to report poor mental health; p ≤0.001
    - Respondents who did not meet CDC-recommended levels of muscle strengthening (12.4%) were more likely to report poor mental health; p ≤0.001.

In the regional sub-sample, statistically significant associations were found with regards to mental health:

- Mental health was significantly associated with age such that:
    - Respondents aged 66-75 years (8.0%) and 51-65 years (7.9%) more likely to report more than 2 weeks of poor mental health; p ≤ 0.05
- Mental health was significantly associated with musculoskeletal conditions such that:
    - Respondents with Fibromyalgia (11.1%; p ≤ 0.05) were more likely to report more than 2 weeks of poor mental health

In the public/uninsured sub-sample, statistically significant associations were found with regards to mental health:

- Mental health was significantly associated with ethnicity such that Hispanics/Latinos (21.6%) were more likely to report more than 2 weeks of poor mental health; p ≤ 0.001
- Mental health was significantly associated with musculoskeletal conditions such that:
    - Respondents with RA (25.6%; p ≤0.001), Lupus (29.0%; p ≤0.001), Fibromyalgia (25.8%; p ≤ 0.01), some other form of arthritis (22.7%; p ≤ 0.01) and OP (18.4%; p ≤ 0.05) were more likely to report more than 2 weeks of poor mental health

In the MUA sub-sample, statistically significant associations were found with regards to mental health:

- Mental health was significantly associated with age such that:
    - Respondents aged 18-35 years (15.8%) and 51-65 years (15.7%) were more likely to report more than 2 weeks of poor mental health; p ≤ 0.001
- Mental health was significantly associated with race and ethnicity such that:
    - Native Hawaiians (33.3%; p ≤ 0.01) followed by Other race (20.2%; p ≤ 0.01) and Hispanics/Latinos (19.9%; p ≤ 0.001) were more likely to report more than 2 weeks of poor mental health
- Mental health was significantly associated with physical activity such that:
    - Respondents who did not meet CDC-recommended levels of muscle strengthening (17.1%) were more likely to report poor mental health; p ≤0.05
- Mental health was significantly associated with musculoskeletal conditions such that:

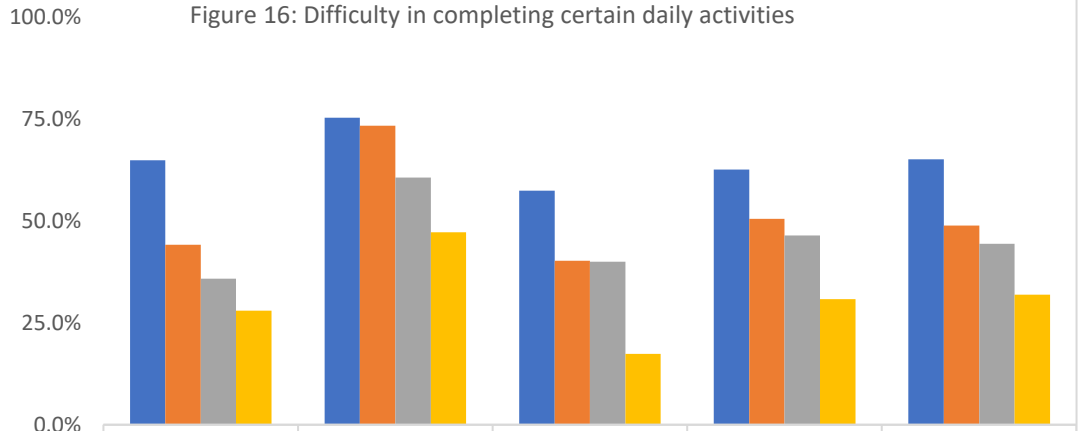
*Please note - Physical activity and PA are used interchangeably in this report

- Respondents diagnosed with OA (17.3%; p ≤0.01), RA (21.8%; p ≤0.001), Lupus (28.2%; p ≤0.001), Fibromyalgia (25.4%; p ≤ 0.001), some other form of arthritis (19.9%; p ≤ 0.01) and OP (22.0%; p ≤ 0.01) were more likely to report more than 2 weeks of poor mental health

Difficulty in Certain Daily Activities

- Figure 16 below highlights difficulty in completing certain daily activities in all samples
- Among respondents from all five samples, stooping, bending or kneeling was the most common reported difficulty

Figure 16: Difficulty in completing certain daily activities



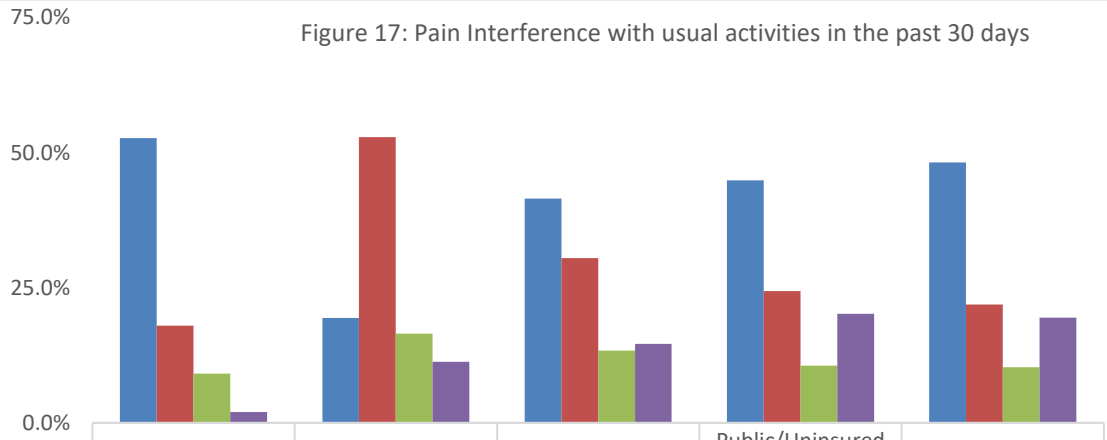
	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Stoop, bend and kneel	64.8%	75.3%	57.4%	62.6%	65.1%
Walk a quarter of a mile (about 3 city blocks)	44.1%	73.3%	40.2%	50.5%	48.8%
Walk up 10 steps without resting	35.8%	60.6%	40.0%	46.4%	44.4%
Use your fingers to grasp or handle small objects	28.0%	47.2%	17.4%	30.8%	31.9%

*Please note - Physical activity and PA are used interchangeably in this report

Pain Interference

- Figure 17 below shows pain interference with usual activities in the past 30 days in all samples
- Majority of the respondents in all samples experienced no pain inference except in the ACC sub-sample, where most respondents (52.9%) reported 14 days or more of pain interference in the past 30 days

Figure 17: Pain Interference with usual activities in the past 30 days



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
None	52.7%	19.4%	41.5%	44.9%	48.2%
More than 2 weeks	18.0%	52.9%	30.5%	24.4%	21.9%
1-2 weeks	9.1%	16.5%	13.4%	10.6%	10.3%
Less than a week	2.0%	11.3%	14.6%	20.2%	19.5%

In the total sample, statistically significant associations were found with regards to pain interference:

- Pain interference was significantly associated with geographic location such that:
  - Respondents living in the Bronx (22.4%) followed by Long Island - Nassau and Suffolk counties (21.5% and 21.4% respectively) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$
- Pain interference was significantly associated with gender such that:
  - Females (18.9%) and gender non-conforming (30.0%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
- Pain interference was significantly associated with age such that:
  - Respondents aged 36-50 years (23.1%) followed by 51-65 years (21.6%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$
- Pain interference was significantly associated with race and ethnicity such that:
  - American Indians (25.8%) followed by Other race (24.8%) and Hispanics/Latinos (23.5%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$.
- Pain interference was significantly associated with PA such that:
  - Those who did not meet CDC-recommended levels of vigorous (20.1%), moderate (19.4%) and muscle strengthening (24.9%) PA were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$

*Please note - Physical activity and PA are used interchangeably in this report

  - Respondents who were told by their doctor to lose weight (20.9%) and do exercise/PA (19.4%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$
- Pain interference was significantly associated with diet such that:
  - Respondents who reported eating unhealthy diets (23.7%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$
- Pain interference was significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (20.0%; $p \leq 0.001$), RA (28.0%; $p \leq 0.001$), Lupus (27.3%; $p \leq 0.001$), Fibromyalgia (37.7%; $p \leq 0.001$), Gout (20.4%;$p \leq 0.05$), some other form of arthritis (25.2%; $p \leq 0.001$) and OP (20.2%; $p \leq 0.001$) were more likely to report pain interference with their usual activities for more than 2 weeks

In the ACC sub-sample, statistically significant associations were found with regards to pain interference:

- Pain interference was significantly associated with PA such that:
  - Respondents who did not meet CDC-recommended levels of muscle strengthening (59.3%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.01$.
  - Respondents who were told by their doctor to lose weight (55.4%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
  - Respondents who were not told by their doctor to do exercise/PA (54.6%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.01$
- Pain interference was significantly associated with diet such that:
  - Respondents who reported eating unhealthy diets (23.7%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$
- Pain interference was significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (58.9%; $p \leq 0.05$) were more likely to report pain interference with their usual activities for more than 2 weeks

In the regional sub-sample, statistically significant associations were found with regards to pain interference:

- Pain interference was significantly associated with PA such that:
  - Respondents who did not meet CDC-recommended levels of muscle strengthening (37.6%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.01$.
- Pain interference was significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with RA (15.4%; $p \leq 0.01$) were more likely to report pain interference with their usual activities for more than 2 weeks

In the public/uninsured sub-sample, statistically significant associations were found with regards to pain interference:

- Pain interference was significantly associated with geographic location such that:
  - Respondents living in Staten Island (56.3%) followed by Long Island - Nassau County (40.7%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
- Pain interference was significantly associated with gender such that:
  - Females (25.9%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
- Pain interference was significantly associated with age such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Respondents aged 51-65 years (33.5%) followed by 66-75 years (31.1%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$
- Pain interference was significantly associated with PA such that:
  - Those who did not meet CDC-recommended levels of vigorous (25.5%; $p \leq 0.05$) and muscle strengthening PA (32.7%; $p \leq 0.001$) were more likely to report pain interference with their usual activities for 14+ days;
  - Respondents who were told by their doctor to lose weight (28.8%; $p \leq 0.01$) and do exercise/PA (26.2%; $p \leq 0.001$) were more likely to report pain interference with their usual activities for 14+ days
- Pain interference was significantly associated with diet such that:
  - Respondents who reported eating unhealth diets (27.0%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
- Pain interference was significantly associated with musculoskeletal conditions such that:
  - Respondents with diagnosed OA (38.9%; $p \leq 0.001$), RA (43.8%; $p \leq 0.001$), Lupus (35.5%; $p \leq 0.01$), Fibromyalgia (46.8%; $p \leq 0.001$), Gout (43.2%; $p \leq 0.01$), some other form of arthritis (35.0%; $p \leq 0.001$) and OP (39.8%; $p \leq 0.001$) were more likely to report pain interference with their usual activities for more than 2 weeks

In the MUA sub-sample, statistically significant associations were found with regards to pain interference:

- Pain interference was significantly associated with geographic location such that:
  - Respondents living in the Staten Island (40.0%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
- Pain interference was significantly associated with gender such that:
  - Females (23.8%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
- Pain interference was significantly associated with age such that:
  - Respondents aged 51-65 years (29.8%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.01$
- Pain interference was significantly associated with race and ethnicity such that:
  - Other race (30.5%; $p \leq 0.01$) followed by American Indian (27.3%; $p \leq 0.01$) and Hispanics/Latinos (26.1%; $p \leq 0.05$) were more likely to report pain interference with their usual activities for 14+ days.
- Pain interference was significantly associated with PA such that:
  - Those who did not meet CDC-recommended levels of vigorous (23.2%; $p \leq 0.01$), moderate (23.7%; $p \leq 0.01$) and muscle strengthening (29.7%; $p \leq 0.001$.) were more likely to report pain interference with their usual activities for 14+ days
  - Respondents who were told by their doctor to do exercise/PA (23.8%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.001$
- Pain interference was significantly associated with diet such that:
  - Respondents who reported eating unhealthy diets (29.2%) were more likely to report pain interference with their usual activities for 14+ days; $p \leq 0.05$
- Statistically significant associations were found between pain interference and musculoskeletal conditions such that:

*Please note - Physical activity and PA are used interchangeably in this report

- Respondents with diagnosed OA (31.1%; p ≤0.001), RA (38.4%; p ≤0.001), Lupus (31.9%; p ≤0.05), Fibromyalgia (46.7%; p ≤ 0.001), Gout (42.3%; p ≤ 0.001), some other form of arthritis (32.8%; p ≤ 0.001) and OP (32.2%; p ≤ 0.001) were more likely to report pain interference with their usual activities for more than 2 weeks

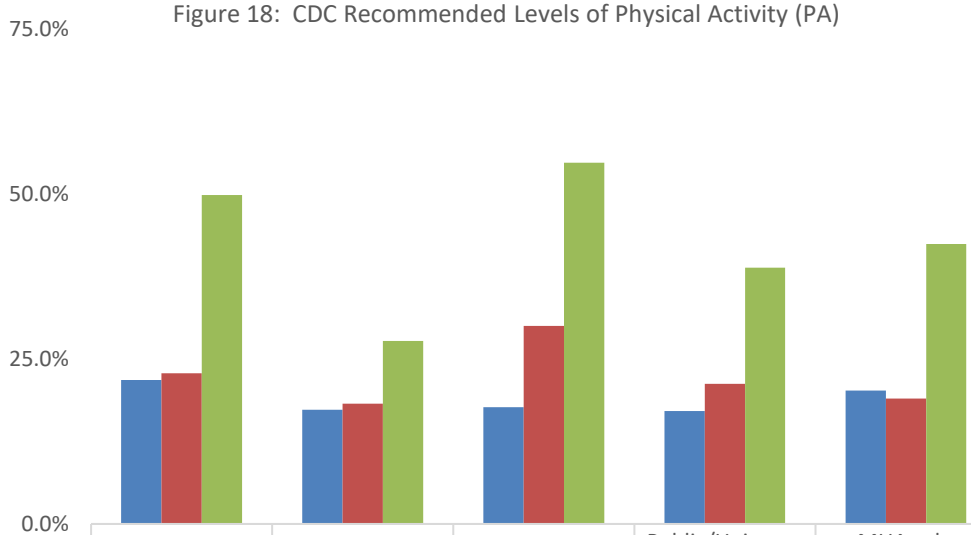
B. Health Behavior & Life Style

Physical Activity (PA)

According to CDC physical activity guidelines, adults need at least 150 minutes of moderate leisure-time physical activities, 75 minutes vigorous leisure-time physical activities, and at least one day of muscle-strengthening activities per week.

- Figure 18 below illustrates CDC recommended levels of PA in all samples
- Lack of PA was a concern for many respondents, such that majority of respondents across all five samples did not meet CDC's recommended levels of moderate and vigorous PA

Figure 18: CDC Recommended Levels of Physical Activity (PA)

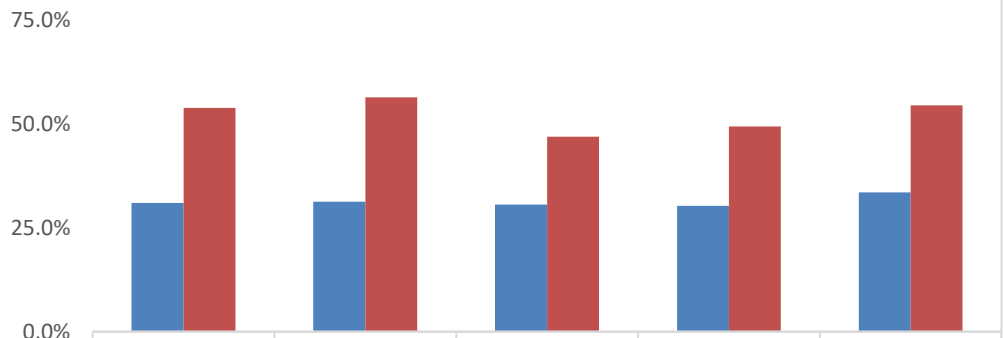


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Moderate/Light (≥3/week)	21.8%	17.3%	17.7%	17.1%	20.2%
Vigorous (≥3/week)	22.8%	18.2%	30.0%	21.2%	19.0%
Muscle strengthening (1-2 times/week)	49.8%	27.7%	54.7%	38.8%	42.4%

- Figure 19 below illustrates the percentage of respondents across the five samples that had been told by their doctor to lose weight and do exercise/PA in the past 12 months

*Please note - Physical activity and PA are used interchangeably in this report

Figure 19: Recommendation to lose weight and do exercise/PA in the past 12 months



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Told by doctor to lose weight	31.0%	31.3%	30.6%	30.3%	33.5%
Told by doctor to do exercise/PA	53.9%	56.4%	46.9%	49.4%	54.5%

In the total sample, statistically significant associations were found with regards to levels of PA:

- Physical activity was found to be significantly associated with geographic location such that:
  - Respondents living in Staten Island did not meet CDC-recommended levels of vigorous (89.9%) and moderate PA (91.0%); $p \leq 0.001$
  - Respondents living in Queens were less likely to meet CDC-recommended levels of muscle strengthening PA (62.5%); $p \leq 0.001$
  - Respondents living in Manhattan (74.2%) followed by those living in Connecticut (71.6%) were less likely to be told by their doctors to lose weight; $p \leq 0.001$
- Physical activity was found to be significantly associated with gender such that:
  - Females (80.6%) and gender non-conforming respondents (80.0%) did not meet CDC-recommended levels of vigorous PA; $p \leq 0.001$
  - Females (53.7%) were less likely to meet CDC-recommended levels of muscle strengthening; $p \leq 0.001$
  - Non-gender conforming respondents (88.9%) and females (70.5%) were less likely to be told by their doctors to lose weight; $p \leq 0.001$
  - Females (55.4%) were more likely to be told by their doctors to do exercise/PA; $p \leq 0.05$
- Physical activity was found to be significantly associated with age such that:
  - Respondents aged 86+ years (91.1%) followed by 76-85 years (83.2%) did not meet CDC-recommended levels of vigorous PA; $p \leq 0.001$
  - Respondents aged 86+ years (86.9%) followed by 76-85 years (78.4%) were more likely to be told by their doctor to lose weight; $p \leq 0.001$
  - Respondents aged 66-75 years (56.8%) were more likely to be told by their doctors to do exercise/PA while respondents aged 18-35 years (57.2%) were less likely to be told by their doctors to exercise/PA; $p \leq 0.001$
- Physical activity was found to be significantly associated with race and ethnicity such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Asians followed by Blacks/African Americans were less likely to meet CDC-recommended levels of vigorous (83.4% and 80.1% respectively; $p \leq 0.01$) and moderate PA (85.2% and 84.7% respectively; $p \leq 0.001$)
  - Hispanics/Latinos were less likely to meet CDC-recommended levels of moderate (83.3%) and muscle strengthening PA (59.5%); $p < 0.001$
  - Native Hawaiians (85.7%; $p \leq 0.001$) and Non-Hispanics/Latinos (69.1%; $p \leq 0.05$) were less likely to be told by their doctor to lose weight
- Physical activity was found to be significantly associated with musculoskeletal conditions such that
  - Respondents with OA (74.7%; $p \leq 0.001$), RA (84.3%; $p \leq 0.001$), Lupus (81.9%; $p \leq 0.001$), Fibromyalgia (86.1%; $p \leq 0.001$), some other form of arthritis (79.4%; $p \leq 0.01$) and OP (82.7%; $p \leq 0.001$) were less likely to meet CDC-recommended levels of vigorous PA; $p \leq 0.001$
  - Respondents with diagnosed RA (84.7%; $p \leq 0.001$), Fibromyalgia (84.1%; $p \leq 0.01$) and some other form of arthritis (81.7%; $p \leq 0.001$) were less likely to meet CDC-recommended levels of moderate PA
  - Respondents with diagnosed RA (64.9%; $p \leq 0.001$), Lupus (65.2%; $p \leq 0.001$), Fibromyalgia (71.2%; $p \leq 0.001$), Gout (56.2%;$p \leq 0.01$), some other form of arthritis (56.3%; $p \leq 0.01$) and OP (55.2%; $p \leq 0.001$) were less likely to meet CDC-recommended levels of muscle strengthening PA
  - Respondents with diagnosed OA (72.0%; $p \leq 0.001$), RA (63.3%; $p \leq 0.001$), Fibromyalgia (56.9%; $p \leq 0.001$), Gout (53.9%;$p \leq 0.001$), some other form of arthritis (64.7%; $p \leq 0.01$) and OP (79.4%; $p \leq 0.001$) were less likely to be told by their doctor to lose weight
  - Respondents diagnosed with OA (58.8%; $p \leq 0.001$), RA (60.1%; $p \leq 0.001$), Lupus (59.1%; $p \leq 0.05$), Fibromyalgia (68.8%; $p \leq 0.001$), Gout (60.3%; $p \leq 0.001$), some other form of arthritis (59.3%; $p \leq 0.01$) and OP (60.3%; $p \leq 0.001$) were more likely to be told by their doctor to do exercise/PA

In the ACC sub- sample, statistically significant associations were found with regards to levels of PA:

- Physical activity was found to be significantly associated with gender such that:
  - Females (78.8%) were less likely to meet CDC-recommended levels of muscle strengthening PA; $p \leq 0.01$
  - Males (79.5%) were more likely to be told by their doctors to lose weight; $p \leq 0.05$
- Physical activity was found to be significantly associated with musculoskeletal condition such that:
  - Respondents with diagnosed OA (89.1%; $p \leq 0.05$) were less likely to meet CDC-recommended levels of vigorous PA
  - Respondents with Fibromyalgia (95.5%; $p \leq 0.05$) were less likely to meet CDC-recommended levels of moderate PA
  - Respondents with Lupus (90.5%; $p \leq 0.05$) were less likely to meet CDC-recommended levels of muscle strengthening PA
  - Respondents with diagnosed OA (55.0%; $p \leq 0.01$) and Fibromyalgia (61.9%; $p \leq 0.01$) were less likely to be told by their doctor to lose weight
  - Respondents with diagnosed OA (64.5%; $p \leq 0.05$) were more likely to be told by their doctor to do exercise/PA

In the regional sub- sample, statistically significant associations were found with regards to level of PA:

- Physical activity was found to be significantly associated with age such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Respondents aged 86+ years and 76-85 years were less likely to meet CDC-recommended levels of vigorous (100% and 88.9% respectively) and muscle strengthening PA (100% and 72.2% respectively); $p \leq 0.01$
  - The oldest (86+ years) and youngest (18-35 years) respondents were less likely to be told by their doctor to lose weight (100% and 90.9% respectively); $p \leq 0.05$
- Physical activity was found to be significantly associated with race such that:
  - Other race (91.7%) followed by Whites/Caucasians (84.9%) did not meet CDC-recommended levels of moderate PA; $p \leq 0.01$
- Physical activity was found to be significantly associated with musculoskeletal conditions such that:
  - Respondents with diagnosed Gout (100%; $p \leq 0.05$,), some other form of arthritis (80.4%; $p \leq 0.05$) did not meet CDC-recommended levels of vigorous PA
  - Respondents with diagnosed Gout (77.8%; $p \leq 0.05$) did not meet CDC-recommended levels of moderate PA
  - Respondents with some other form of arthritis (62.5%; $p \leq 0.001$) did not meet CDC-recommended levels of muscle strengthening PA
  - Respondents with diagnosed OP (92.0%; $p \leq 0.01$) were less likely to be told by their doctor to lose weight
  - Respondents with diagnosed RA (76.9%; $p \leq 0.05$) and Gout (88.9%; $p \leq 0.05$) were more likely to be told by their doctor to do exercise/PA

In the public/uninsured sub- sample, statistically significant associations were found with regards to levels of PA:

- Physical activity was found to be significantly associated with gender such that:
  - Females did not meet CDC-recommended levels of vigorous (82.0%; $p \leq 0.01$) and muscle strengthening PA (66.7%;$p \leq 0.001$)
  - Females (66.9%) were less likely to be told by their doctors to lose weight; $p \leq 0.05$
- Physical activity was found to be significantly associated with age such that:
  - Respondents aged 86+ years (87.5%) did not meet CDC-recommended levels of muscle strengthening PA; $p \leq 0.001$
  - The oldest respondents (86+ years) were less likely to be told by their doctor to lose weight (81.3%); $p \leq 0.05$
  - The oldest (86+ years) and youngest (18-35 years) respondents were less likely to be told by their doctor to PA (62.5% and 60.4% respectively); $p \leq 0.01$
- Physical activity was found to be significantly associated with race and ethnicity such that:
  - Asians did not meet CDC-recommended levels of moderate PA (87.3%); $p \leq 0.05$
  - Non-Hispanics/Latinos did not meet CDC-recommended levels of vigorous PA (81.9%; $p \leq 0.01$) while Hispanics/Latinos did not meet CDC-recommended levels of moderate PA (86.8%; $p \leq 0.05$)
- Physical activity was found to be significantly associated with musculoskeletal conditions such that:
  - Respondents with OP (88.9%; $p \leq 0.01$) did not meet CDC-recommended levels of vigorous PA
  - Respondents with OA (69.2%; $p \leq 0.001$) did not meet CDC-recommended levels of moderate PA
  - Respondents with RA (75.2%; $p \leq 0.001$), Fibromyalgia (74.2%; $p \leq 0.05$), some other form of arthritis (65.0%; $p \leq 0.05$) and OP (72.9%; $p \leq 0.01$) did not meet CDC-recommended levels of muscle strengthening PA

*Please note - Physical activity and PA are used interchangeably in this report

- Respondents diagnosed with OA (59.8%; p ≤0.001), RA (58.6%; p ≤0.001), Fibromyalgia (50.8%; p ≤ 0.05), Gout (50.0%; p ≤ 0.05), some other form of arthritis (62.0%; p ≤ 0.01) were less likely to be told by their doctor to lose weight
- Respondents diagnosed with OA (61.0%; p ≤0.001), RA (61.5%; p ≤0.001), Lupus (68.3%;%; p ≤0.001), Fibromyalgia (66.7%; p ≤ 0.01), some other form of arthritis (58.7%; p ≤ 0.01) and OP (61.2%; p ≤ 0.01) were more likely to be told by their doctor to do exercise/PA

In the MUA sub- sample, statistically significant associations were found with regards to levels of PA:

- Physical activity was found to be significantly associated with gender such that:
  - Females did not meet CDC-recommended levels of vigorous (83.6%) and muscle strengthening (60.3%) PA; p ≤ 0.01
  - Females (57.1%) were more likely to be told by their doctors to lose weight; p ≤ 0.05
- Physical activity was found to be significantly associated with age such that:
  - Respondents aged 66-75 years (85.8%) did not meet CDC-recommended levels of vigorous PA; p ≤ 0.01
  - Respondents aged 86+ years (62.5%) did not meet CDC-recommended levels of muscle strengthening PA; p ≤ 0.05
  - Respondents 76-85 years (77.7%) were less likely to be told by their doctor to lose weight; p ≤ 0.01
  - Respondents 86+ years (60.0%) followed by 66-75 years (59.3%) were more likely to be told by their doctor to do exercise/PA; p ≤ 0.05
- Physical activity was found to be significantly associated with race and ethnicity such that:
  - Native Hawaiian (100%) followed by Blacks/African Americans (86.7%) did not meet CDC-recommended levels of moderate PA; p ≤ 0.001)
  - Non-Hispanics/Latinos did not meet CDC-recommended levels of vigorous PA (82.6%; p ≤ 0.05) while Hispanics/Latinos did not meet CDC-recommended levels of moderate PA (84.7%; p ≤ 0.05)
- Physical activity was found to be significantly associated with musculoskeletal conditions such that:
  - Respondents with OA (84.8%; p ≤ 0.05) did not meet CDC-recommended levels of vigorous PA
  - Respondents with OA (69.2%; p ≤ 0.001), RA (87.5%; p ≤ 0.01) and some other form of arthritis (84.7%; p ≤ 0.05) did not meet CDC-recommended levels of moderate PA
  - Respondents with OA (62.7%; p ≤ 0.001), RA (70.6%; p ≤ 0.001), Fibromyalgia (78.3%; p ≤ 0.001), Gout (76.9%; p ≤ 0.01), some other form of arthritis (63.9%; p ≤ 0.05) and OP (69.2%; p ≤ 0.001) did not meet CDC-recommended levels of muscle strengthening PA
  - Respondents with diagnosed OA (61.6%; p ≤0.01), RA (58.6%; p ≤0.001), Gout (51.9%; p ≤ 0.05) and some other form of arthritis (55.5%; p ≤ 0.001) were less likely to be told by their doctor to lose weight
  - Respondents with diagnosed OA (62.4%; p ≤0.001), RA (62.5%; p ≤0.01), Fibromyalgia (77.0%; p ≤ 0.001), some other form of arthritis (62.3%; p ≤ 0.01) and OP (65.9%; p ≤ 0.001) were more likely to be told by their doctor to do exercise/PA

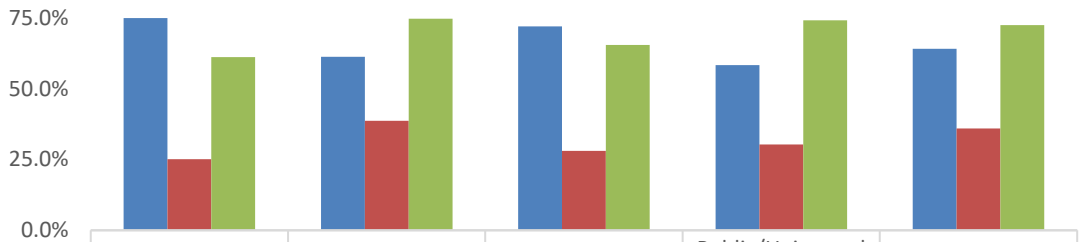
Diet

- Figure 20 below illustrates the overall diet of respondents across the five samples

*Please note - Physical activity and PA are used interchangeably in this report

- Majority of respondents across all five sample reported a healthy overall diet; however, they would like to eat healthier

Figure 20: Overall diet



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Healthy	74.9%	61.3%	72.0%	58.3%	64.1%
Not Healthy	25.1%	38.7%	28.0%	30.3%	35.9%
Would like to eat healthier	61.2%	74.7%	65.4%	74.2%	72.5%

In the total sample, statistically significant associations were found with regards to diet:

- Overall diet was found to be significantly associated with geographic location such that:
  - Respondents living in Manhattan (78.8%) were more likely to report that their overall diet as healthy; $p \leq 0.001$. While respondents living in the Bronx (78.3%) were more likely to indicate interest in eating healthier; $p \leq 0.001$
- Overall diet was found to be significantly associated with gender such that:
  - Females (63.0%) and gender non-conforming respondents (70.0%) were more likely to indicate interest in eating healthier; $p \leq 0.05$
- Overall diet was found to be significantly associated with age such that:
  - Respondents aged 76-85 years (82.0%) followed by 86+ years (81.8%) were more likely to report that their overall diet as healthy; $p \leq 0.001$
  - Respondents aged 18-35 years and 36-50 years (72.6%) were more likely to indicate interest in eating healthier; $p \leq 0.001$
- Overall diet was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (78.0%), Non-Hispanics/Latinos (76.2%) and Asians (72.9%) were more likely to report that their overall diet as healthy; $p \leq 0.001$
  - Hispanics/Latinos (78.5%), Asians (77.7%) and American Indians (76.7%) were more likely to indicate interest in eating healthier; $p \leq 0.001$
- Overall diet was found to be significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (77.5%; $p \leq 0.001$), RA (66.4%; $p \leq 0.001$), Lupus (66.8%; $p \leq 0.01$), Fibromyalgia (67.5%; $p \leq 0.001$), Gout (70.5%; $p \leq 0.05$), some other form of arthritis (71.5%; $p \leq 0.001$) and OP (79.0%; $p \leq 0.001$) were more likely to report that their overall diet as healthy
  - Respondents diagnosed with RA (66.2%; $p \leq 0.001$), Lupus (71.25; $p \leq 0.001$), Fibromyalgia (73%; $p \leq 0.001$), some other form of arthritis (63.0%; $p \leq 0.05$) and OP (56.5%; $p \leq 0.001$) were more likely to indicate interest in eating healthier

*Please note - Physical activity and PA are used interchangeably in this report

In the ACC sub-sample, statistically significant associations were found with regards to diet:

- Overall diet was found to be significantly associated with race and ethnicity such that:
    - Asians (75.0%) were more likely to report that their overall diet as healthy; $p \leq 0.001$. While Hispanics/Latinos (84.3%) were more likely to indicate interest in eating healthier; $p \leq 0.05$
- Overall diet was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents with Fibromyalgia were more likely to report that their overall diet as unhealthy (100%; $p \leq 0.01$) and indicate interest in eating healthier (73%; $p \leq 0.001$)

In the regional sub-sample, statistically significant associations were found with regards to diet:

- Overall diet was found to be significantly associated with musculoskeletal conditions such that respondents with OP (59.1%; $p \leq 0.01$) were more likely to indicate interest in eating healthier

In the public/uninsured sub-sample, statistically significant associations were found with regards to diet:

- Overall diet was found to be significantly associated with geographic location such that:
    - Respondents living in Staten Island (68.8%) were more likely to report that their overall diet as healthy; $p \leq 0.05$.
- Overall diet was found to be significantly associated with gender such that:
    - Males (70.6%) were more likely to report that their overall diet as healthy; $p \leq 0.001$.
- Overall diet was found to be significantly associated with age such that:
    - Respondents aged 66-75 (80.0%) years were more likely to indicate interest in eating healthier; $p \leq 0.05$
- Overall diet was found to be significantly associated with race and ethnicity such that:
    - Asians (72.1%) and non-Hispanics/Latinos (63.0%) were more likely to report that their overall diet as healthy while American Indians (61.1%) and Hispanics/Latinos (53.1%) were more likely to report that their overall diet as unhealthy; $p \leq 0.001$
    - Hispanics/Latinos (81.1%; $p \leq 0.01$) and Asians (81.4%; $p \leq 0.05$) were more likely to indicate interest in eating healthier
- Overall diet was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents diagnosed with RA (51.4%; $p \leq 0.01$) were more likely to report that their overall diet as unhealthy while respondents with Lupus (83.9%; $p \leq 0.05$) were more likely to indicate interest in eating healthier

In the MUA sub-sample, statistically significant associations were found with regards to diet:

- Overall diet was found to be significantly associated with geographic location such that:
    - Respondents living in Westchester (93.3%) were more likely to report that their overall diet as healthy; $p \leq 0.001$.
- Overall diet was found to be significantly associated with age such that:
    - Respondents aged 66-75 years (73.6%) were more likely to report that their overall diet as healthy; while those aged 36-50 years (82.9%) were more likely to indicate interest in eating healthier; $p \leq 0.001$
- Overall diet was found to be significantly associated with race and ethnicity such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Asians (76.4%), Whites/Caucasians (73.8%) and non-Hispanics/Latinos (68.9%) were more likely to report that their overall diet as healthy; $p \leq 0.001$
  - Hispanics/Latinos (83.9%), Asians (80.5%; $p \leq 0.001$) and Blacks/African Americans (80.5%) were more likely to indicate interest in eating healthier; $p \leq 0.001$
- Overall diet was found to be significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with RA (50%; $p \leq 0.01$), Fibromyalgia (52.5%; $p \leq 0.05$), Gout (51.9%; $p \leq 0.05$) and some other form of arthritis (55.0%; $p \leq 0.001$) were more likely to report that their overall diet as healthy
  - Respondents diagnosed with OA (66.3%; $p \leq 0.01$), Lupus (88.9%; $p \leq 0.01$) and Fibromyalgia (86.7%; $p \leq 0.01$) were more likely to indicate interest in eating healthier

Barriers to Eating Healthy

- Table 6 below shows barriers to eating healthy in all samples
- When asked to identify the barriers to eating more healthily, the leading responses involved "cost", "taking too much time to prepare", and "family/friend not eating healthy" across all samples, as seen in table below:

Table 6: Healthy eating barriers

	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Takes too much time to prepare	43.5%	30.5%	47.4%	35.3%	40.1%
Family/ friend do not eat healthy	29.3%	21.8%	30.7%	30.9%	29.6%
Cost	24.3%	46.6%	14.9%	57.6%	44.0%
Don't like the taste	22.3%	13.8%	18.4%	23.7%	24.0%
Don't know what to eat	21.0%	28.2%	16.7%	33.2%	23.9%
Don't have the place to buy	7.6%	10.9%	4.4%	19.4%	15.3%

In the total sample, statistically significant associations were found with regards to barriers to eating healthy:

- Barriers to eating healthy was found to be significantly associated with geographic location such that:
  - Respondents living in Queens (52.3%%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.001$
- Barriers to eating healthy was found to be significantly associated with age such that:
  - Respondents aged between 18-35 years were more likely to report "cost" (56.1%) and "family and friends do not eat that way" (38.5%) as barriers to eating healthy; $p \leq 0.001$. While respondents aged between 36-50 years (56.5%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.001$
- Barriers to eating healthy was found to be significantly associated with race and ethnicity such that:
  - Blacks/African Americans (53.7%) and Hispanics/Latinos (55.2%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.001$
  - Asians (55.4%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.001$

*Please note - Physical activity and PA are used interchangeably in this report

  - American Indians (52.4%) were more likely to report "family and friends do not eat that way" as a barrier to eating healthy; $p \leq 0.01$

In the ACC sub-sample, statistically significant associations were found with regards to barriers to eating healthy

- Barriers to eating healthy was found to be significantly associated with ethnicity such that:
  - Hispanics/Latinos (82.4%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.01$
  - Non-Hispanics/Latinos (57.7%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.05$

In the regional sub-sample, statistically significant associations were found with regards to barriers to eating healthy

- Barriers to eating healthy was found to be significantly associated ethnicity such that Hispanics/Latinos (50.9%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.05$

In the public/uninsured sub-sample, statistically significant associations were found with regards to barriers to eating healthy

- Barriers to eating healthy was found to be significantly associated with geographic location such that:
  - Respondents living in Manhattan (75.9%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.001$
  - Respondents living in Staten Island (55.6%) and Queens (54.8%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.05$
- Barriers to eating healthy was found to be significantly associated with age such that:
  - Respondents aged between 18-35 (66.7%) years and 66-75 years (66.1%) were more likely to report "cost" (56.1%) as a barrier to eating healthy; $p \leq 0.01$
  - While respondents aged between 86+ years (75%) were more likely to report "family and friends do not eat that way" as a barrier to eating healthy; $p \leq 0.05$
- Barriers to eating healthy was found to be significantly associated with race and ethnicity such that:
  - Asians (69.1%), Blacks/African Americans (67.5%) and American Indian (53.8%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.001$
  - Hispanics/Latinos (69.7%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.001$
  - Asians (58.8%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.001$
  - American Indians (63.6%) were more likely to report "family and friends do not eat that way" as a barrier to eating healthy; $p \leq 0.01$

In the MUA sub-sample, statistically significant associations were found with regards to barriers to eating healthy

- Barriers to eating healthy was found to be significantly associated with geographic location such that:
  - Respondents living in the Bronx (54.2%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.05$
  - Respondents living in Queens (55.1%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.01$
- Barriers to eating healthy was found to be significantly associated with age such that:

*Please note - Physical activity and PA are used interchangeably in this report

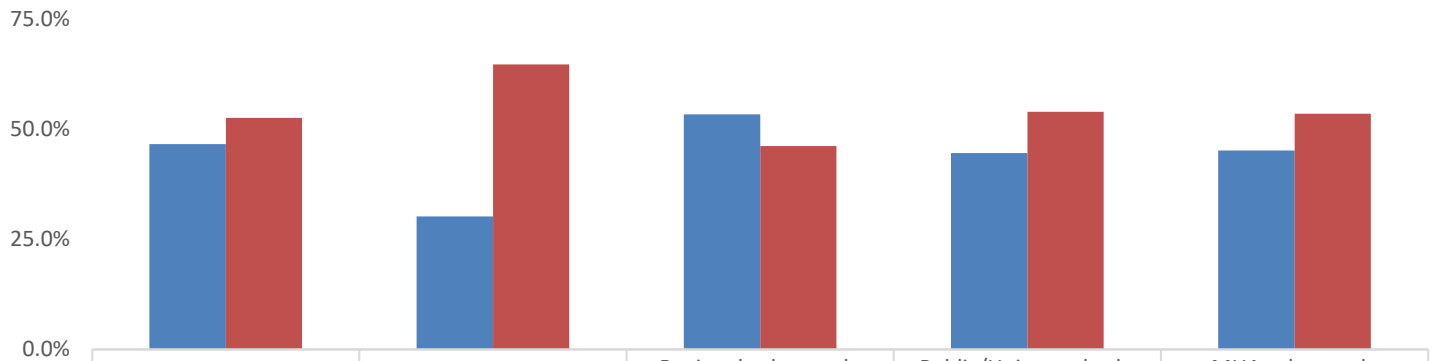
  - Respondents aged between 18-35 (57.9%) years and 36-50 years (55.4%) were more likely to report "cost"; $p \leq 0.001$
  - While respondents aged between 86+ years (75%) were more likely to report "family and friends do not eat that way" as a barrier to eating healthy; $p \leq 0.05$
- Barriers to eating healthy was found to be significantly associated with race and ethnicity such that:
  - Asians (62.3%) and Hispanics/Latinos (66.7%) were more likely to report "cost" as a barrier to eating healthy; $p \leq 0.001$
  - Asians (69.5%) were more likely to report "takes too much time to prepare" as a barrier to eating healthy; $p \leq 0.001$

*Please note - Physical activity and PA are used interchangeably in this report

Pain Management

- Figure 21 below illustrates the use of prescription pain relivers in the past 12 months across the five samples
- Majority of respondents across all samples reported using prescription pain relievers in the past 12 months except in the regional sub-sample. See below for details:

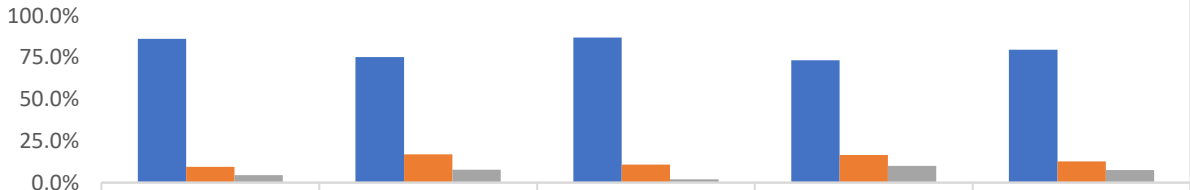
Figure 21: Prescription of pain relievers



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
No	46.7%	30.2%	53.4%	44.6%	45.2%
Yes	52.6%	64.8%	46.2%	54.0%	53.6%

- Figure 22 below illustrates respondents' level of agreement to taking more than recommended dosage of prescription medication when feeling pain more than usual across the five samples
- Majority of respondents disagreed to taking more than recommended dosage of prescription when feeling pain more than usual. See below for details:

Figure 22: Taking more than recommended dosage of prescription medication

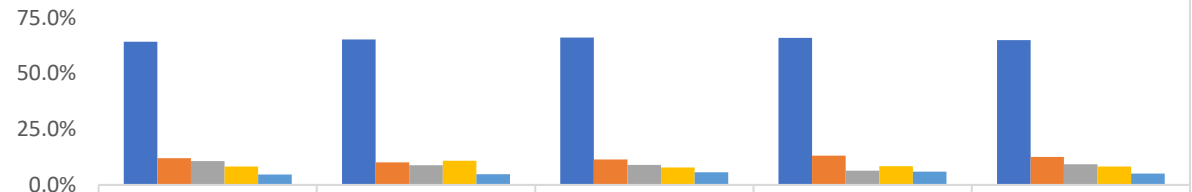


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Disagree/Strongly Disagree	86.2%	75.4%	87.0%	73.4%	79.8%
Strongly Agree/Agree	9.4%	16.9%	10.9%	16.6%	12.7%
Not Sure	4.4%	7.7%	2.0%	10.0%	7.5%

- Figure 23 below illustrates respondents' use of complementary treatments (i.e. yoga, meditation, mindful breathing) to manage pain across the five samples
- Majority of respondents have never used complementary treatments (i.e. yoga, meditation, mindful breathing) to manage their pain

*Please note - Physical activity and PA are used interchangeably in this report

Figure 23: Use of complementary treatments to manage pain



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Never	64.3%	65.2%	66.1%	66.0%	65.0%
Less than monthly	12.0%	10.2%	11.4%	13.2%	12.5%
Weekly	10.7%	8.9%	9.0%	6.4%	9.2%
Daily or almost daily	8.3%	10.9%	7.8%	8.4%	8.3%
Monthly	4.7%	4.8%	5.7%	6.0%	5.1%

In the total sample, statistically significant associations were found with regards to pain management:

- Pain management was found to be significantly associated with gender such that:
  - Males (75.6%) reported never using complementary treatments to manage their pain; $p < 0.001$
- Pain management was found to be significantly associated with age such that:
  - Respondents aged 51-65 years were more likely to use prescription pain relievers (56.8%) and reported never using complementary treatments to manage their pain (61.5%); $p < 0.001$
  - Respondents aged 86+ years also reported never using complementary treatments to manage their pain (75.4%); $p < 0.001$
- Pain management was found to be significantly associated with race and ethnicity such that:
  - Native Hawaiians (71.4%) reported never using complementary treatments to manage their pain; $p < 0.05$
- Pain management was found to be significantly associated with musculoskeletal conditions such that:
  - Respondents diagnosed with OA (57.5%; $p \leq 0.001$), RA (66.8%; $p \leq 0.001$), Lupus (59.6%; $p \leq 0.01$), Fibromyalgia (71.1%; $p \leq 0.001$), Gout (63.9%; $p \leq 0.001$) and some other form of arthritis (58.6%; $p \leq 0.001$) were more likely to use prescription pain relievers
  - Respondents diagnosed with OA (61.4%; $p \leq 0.001$), RA (58.5%; $p \leq 0.001$), Lupus (51.4%; $p \leq 0.001$), Fibromyalgia (48.9%; $p \leq 0.001$) and OP (60.0%; $p \leq 0.001$) reported never using complementary treatments to manage their pain

In the ACC sub-sample, statistically significant associations were found with regards to pain management:

- Pain management was found to be significantly associated with geographic location such that:
  - Respondents living in Queens (77.3%) reported never using complementary treatments to manage their pain; $p \leq 0.001$
- Pain management was found to be significantly associated with gender such that:
  - Females (66.2%) reported never using complementary treatments to manage their pain; $p < 0.05$
- Pain management was found to be significantly associated with age such that:

*Please note - Physical activity and PA are used interchangeably in this report

    - Respondents aged 51-65 years were more likely to use prescription pain relievers (71.7%) to manage their pain (61.5%); $p \leq 0.05$
- Pain management was found to be significantly associated with race and ethnicity such that:
    - Native Hawaiians (71.4%) reported never using complementary treatments to manage their pain; $p \leq 0.05$
- Pain management was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents diagnosed with OA (72.7%; $p \leq 0.05$), RA (74.7%; $p \leq 0.05$), Fibromyalgia (85.7%; $p \leq 0.05$) and some other form of arthritis (79.5%; $p \leq 0.001$) were more likely to use prescription pain relievers

In the regional sub-sample, statistically significant associations were found with regards to pain management:

- Pain management was found to be significantly associated with gender such that:
    - Males (78.8%) reported never using complementary treatments to manage their pain; $p \leq 0.001$
- Pain management was found to be significantly associated with age such that:
    - Respondents aged 76-85 years (76.5%) and 66-75 years (72.0%) reported never using complementary treatments to manage their pain; $p \leq 0.01$
- Pain management was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents diagnosed with Gout (87.5%; $p \leq 0.05$) were more likely to use prescription pain relievers
    - Respondents diagnosed with OA (66.7%; $p \leq 0.01$) and Fibromyalgia (33.3%; $p \leq 0.001$) reported never using complementary treatments to manage their pain

In the public/uninsured sub-sample, statistically significant associations were found with regards to pain management:

- Pain management was found to be significantly associated with gender such that:
    - Males (52.7%; $p \leq 0.05$) were more likely to use prescription pain relievers and reported never using complementary treatments to manage their pain (69.4%; $p \leq 0.01$)
- Pain management was found to be significantly associated with age such that:
    - Respondents aged 18-35 years were more likely to use prescription pain relievers (67.1%); $p \leq 0.01$
    - Respondents aged 86+ years also reported never using complementary treatments to manage their pain (75.0%); $p < 0.01$
- Pain management was found to be significantly associated with race and ethnicity such that:
    - Native Hawaiians (71.4%) reported never using complementary treatments to manage their pain; $p < 0.05$
- Pain management was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents diagnosed with OA (60.0%; $p \leq 0.001$), RA (81.4%; $p \leq 0.001$), Lupus (54.4%; $p \leq 0.05$), Fibromyalgia (79.0%; $p \leq 0.001$), Gout (86.9%; $p \leq 0.001$), some other form of arthritis (71.2%; $p \leq 0.001$) and OP (71.2%; $p \leq 0.001$) were more likely to use prescription pain relievers
    - Respondents diagnosed with OA (61.4%; $p \leq 0.001$), Lupus (51.4%; $p \leq 0.001$) and OP (61.2%; $p \leq 0.001$) reported never using complementary treatments to manage their pain

*Please note - Physical activity and PA are used interchangeably in this report

In the MUA sub-sample, statistically significant associations were found with regards to pain management:

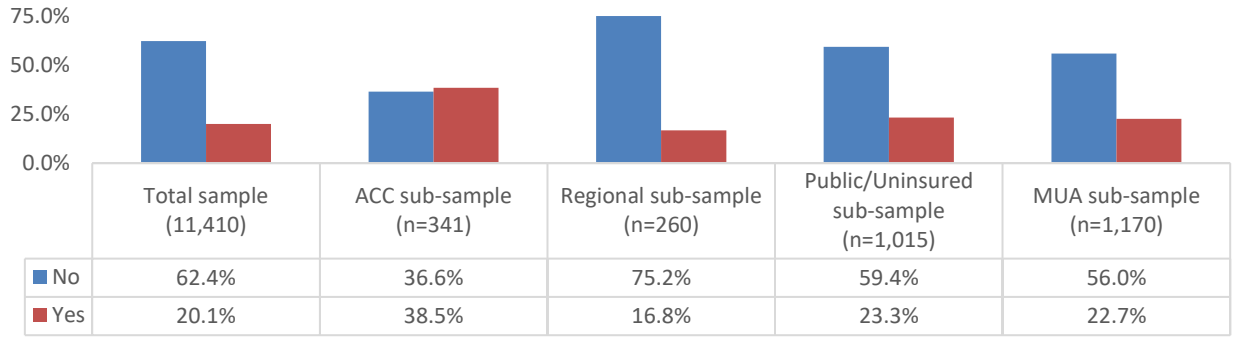
- Pain management was found to be significantly associated with gender such that:
    - Males (74.5%) reported never using complementary treatments to manage their pain; $p \leq 0.05$)
- Pain management was found to be significantly associated with age such that:
    - Respondents aged 18-35 years were more likely to use prescription pain relievers (61.7%); $p \leq 0.01$
    - Respondents aged 86+ years also reported never using complementary treatments to manage their pain (69.6%); $p < 0.01$
- Pain management was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents diagnosed with OA (62.0%; $p \leq 0.001$), RA (76.4%; $p \leq 0.001$), Fibromyalgia (70.0%; $p \leq 0.01$), Gout (67.3%; $p \leq 0.05$) and some other form of arthritis (65.3%; $p \leq 0.001$) were more likely to use prescription pain relievers
    - Respondents diagnosed with OA (60.9%; $p \leq 0.001$) and OP (60.7%; $p \leq 0.001$) reported never using complementary treatments to manage their pain

*Please note - Physical activity and PA are used interchangeably in this report

Sexual Health

- Figure 24 below illustrates if respondents diagnosed with musculoskeletal conditions affected their sexual health
- Majority of respondents across all samples indicated that their musculoskeletal condition(s) did not affect their sexual health except in the ACC sub-sample. See below for details:

Figure 24: Musculoskeletal condition(s) affected sexual health



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
No	62.4%	36.6%	75.2%	59.4%	56.0%
Yes	20.1%	38.5%	16.8%	23.3%	22.7%

- When asked to specify the effect of muscle, bone or joint conditions on sexual health, the leading responses were limitation of motion; decreased sexual desire and satisfaction; and decreased sexual intercourse across all samples. See below for more details:

Table 7: The effects of musculoskeletal conditions on sexual health

	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Limitation of motion/pain	64.2%	59.6%	72.2%	58.7%	60.0%
Decreased sexual desire and satisfaction	53.7%	58.5%	55.6%	55.3%	54.0%
Decreased sexual intercourse/intimacy	42.8%	41.5%	44.4%	38.9%	40.4%
Decreased sense of sexual attractiveness	30.2%	25.5%	22.2%	33.2%	30.6%
Vaginal Dryness	20.6%	10.6%	11.1%	15.4%	18.3%
Erectile dysfunction/ Impotence	18.7%	11.7%	27.8%	16.8%	17.4%
Increased sensitivity to being touched	13.4%	14.9%	22.2%	15.9%	12.3%
Urinary tract infection	7.6%	6.4%	2.8%	8.7%	6.8%
Other	7.2%	10.6%	0.0%	11.1%	7.7%
Infertility	1.3%	4.3%	0.0%	2.9%	2.1%
Pregnancy	1.1%	2.1%	0.0%	2.9%	1.3%

In the total sample, statistically significant associations were found with regards to sexual health:

- Sexual health was found to be significantly associated with gender such that:
    - Trans females (100.0%) and Trans males (50.0%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.001$)

*Please note - Physical activity and PA are used interchangeably in this report

- Sexual health found to be significantly associated with age such that:
    - Respondents aged 36-50 years (25.5%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.001$)
- Sexual health was found to be significantly associated with race and ethnicity such that:
    - American Indians (30.0%) and Hispanics/Latinos (24.5%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.01$)

In the ACC sub-sample, statistically significant associations were found with regards to sexual health:

- Sexual health was found to be significantly associated with age such that:
    - Respondents aged 51-65 years (51.0%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.01$)
- Sexual health was found to be significantly associated with race such that:
    - American Indians (30.0%) and Hispanics/Latinos (24.5%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.01$)

In the public/uninsured sub-sample, statistically significant associations were found with regards to sexual health:

- Sexual health was found to be significantly associated with gender such that:
    - Males (28.2%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.05$)
- Sexual health was found to be significantly associated with age such that:
    - Respondents aged 51-65 years (31.4%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.001$)
- Sexual health was found to be significantly associated with race and ethnicity such that:
    - Whites/Caucasians (30.0%) and Hispanics/Latinos (25.6%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.01$)

In the MUA sub-sample, statistically significant associations were found with regards to sexual health:

- Sexual health was found to be significantly associated with gender such that:
    - Males (24.9%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.05$)
- Sexual health was found to be significantly associated with age such that:
    - Respondents aged 36-50 years (29.1%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.001$)
- Sexual health was found to be significantly associated with ethnicity such that:
    - Hispanics/Latinos (28.0%) were more likely to indicate their musculoskeletal conditions affected their sexual health; ($p \leq 0.05$)

C. Use of and Access to Care

Insurance Coverage

- Figure 25 below shows health insurance coverage among respondents in all samples
- Nearly all respondents in all samples had some form of health insurance coverage compared to 87.6% of New Yorkers. See details on insurance type specified in Table 8 below:

*Please note - Physical activity and PA are used interchangeably in this report

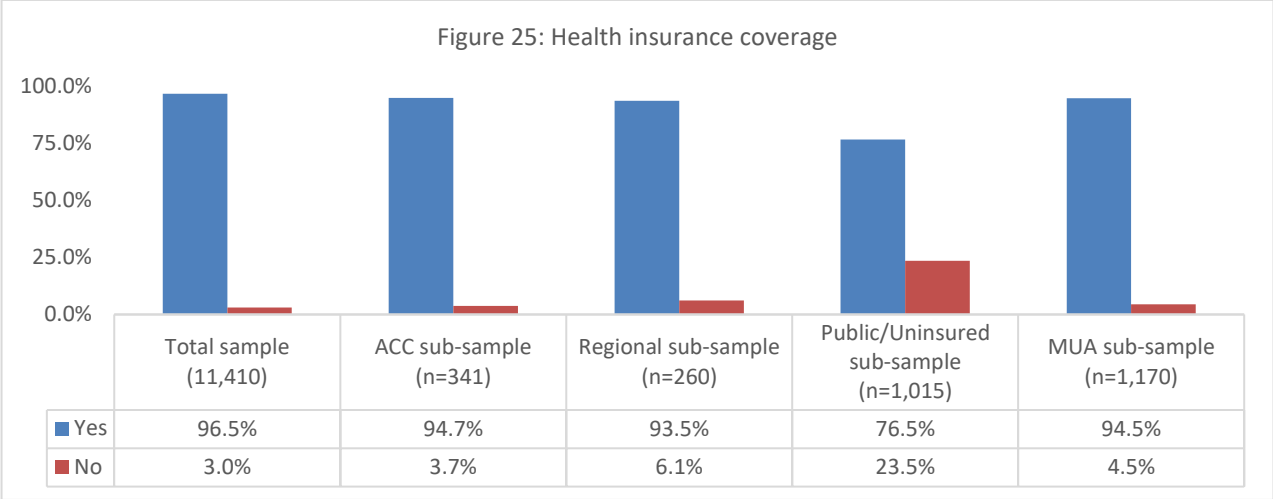


Table 8: Type of insurance coverage

	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Medicare	53.3%	38.7%	31.3%	29.4%	47.5%
A plan purchased through an employer or union	38.8%	11.7%	65.4%	2.3%	29.8%
Medicaid	10.6%	68.0%	1.9%	100.0%	33.3%
A plan that you or another family member buys on your own	8.0%	2.7%	4.8%	2.3%	4.8%
Some other source	2.2%	1.6%	0.0%	1.2%	2.0%
TRICARE (formerly CHAMPUS), VA, or Military	0.8%	0.4%	0.0%	0.4%	0.4%
Don't Know	0.5%	1.6%	0.0%	0.3%	0.6%
Alaska Native, Indian Health Service, Tribal Health Services	0.0%	0.0%	0.0%	0.1%	0.0%

In the total sample, statistically significant associations were found with regards to health insurance coverage:

- Health insurance coverage was found to be significantly associated with geographic location such that:
  - Respondents living in New jersey (21.7%) were more likely to have no insurance coverage; $p \leq 0.001$
- Health insurance coverage was found to be significantly associated with age such that:
  - Respondents aged 18-35 (37.6%) years were more likely to have no insurance coverage; $p \leq 0.001$;
- Health insurance coverage was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (43.7%) and non-Hispanics/Latinos (9.1%) were more likely to have no insurance coverage; $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with regards to health insurance coverage:

- Health insurance coverage was found to be significantly associated with geographic location such that:

*Please note - Physical activity and PA are used interchangeably in this report

- Respondents living in Manhattan (30.0%) were more likely to have no insurance coverage; $p \leq 0.05$

In the regional sub-sample, statistically significant associations were found with regards to health insurance coverage:

- Health insurance coverage was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (43.7%) and non-Hispanics/Latinos (9.1%) were more likely to have no insurance coverage; $p \leq 0.001$

In the public/uninsured sub- sample, statistically significant associations were found with regards to health insurance coverage:

- Health insurance coverage was found to be significantly associated with geographic location such that:
  - Respondents living in New jersey (21.7%) were more likely to have no insurance coverage; $p \leq 0.001$
- Health insurance coverage was found to be significantly associated with age such that:
  - Respondents aged 18-35 (37.6%) years were more likely to have no insurance coverage; $p \leq 0.001$;

In the MUA sub-sample, statistically significant associations were found with regards to health insurance coverage:

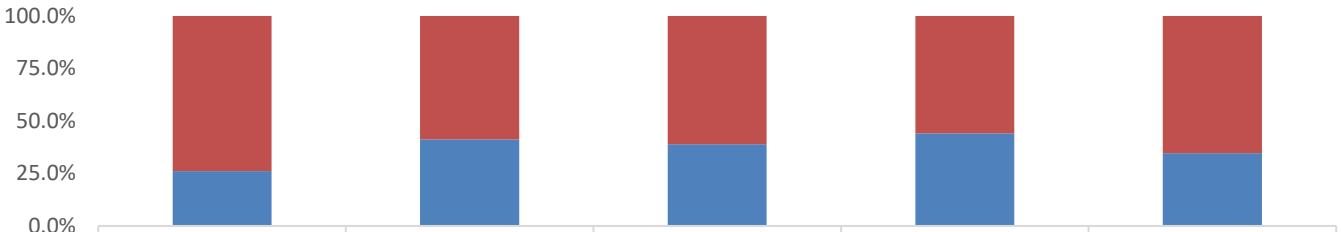
- Health insurance coverage was found to be significantly associated with age such that:
  - Respondents aged 18-35 (52.9%) years were more likely to have no insurance coverage; $p \leq 0.001$;
- Health insurance coverage was found to be significantly associated with race and ethnicity such that:
  - Blacks/African Americans (43.1%; $p \leq 0.01$) and non-Hispanics/Latinos (61.2%; $p \leq 0.05$) were more likely to have no insurance coverage

Immunizations & Health Screenings

- Figures 26 and 27 below shows health screenings received across all samples:

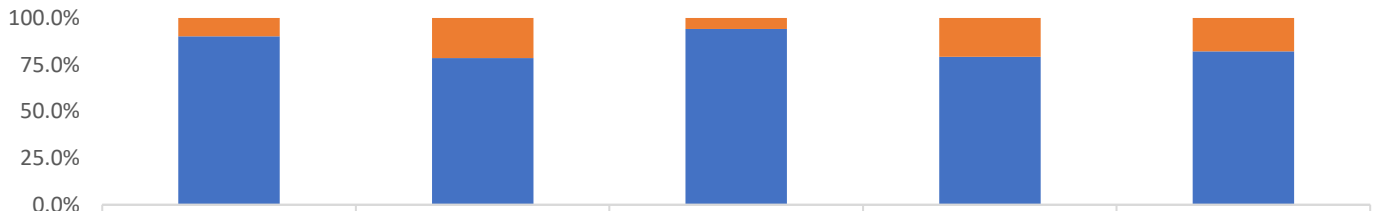
*Please note - Physical activity and PA are used interchangeably in this report

Figure 26: Immunizations (i.e. flu shots) in the past year



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Yes	73.9%	58.8%	61.1%	55.9%	65.4%
No	26.1%	41.2%	38.9%	44.1%	34.6%

Figure 27: STI/HIV Screening in the past year

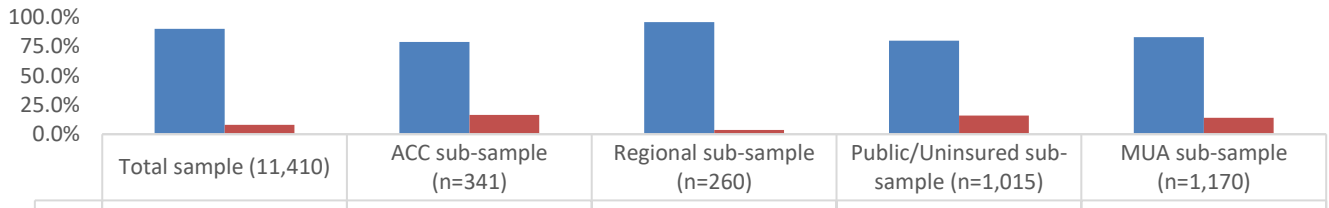


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Yes	9.8%	21.5%	5.9%	20.8%	17.9%
No	90.2%	78.5%	94.1%	79.2%	82.1%

Healthcare Access

- Figure 28 below shows access to medical care when needed in the past 12 months
- 8.1% of the total, 16.5% of the ACC, 3.7% of regional, 15.9% of public/uninsured and 14.1% of the MUA respondents indicated that they could not access a healthcare provider when they needed to in the past 12 months, compared to 5.3% of Americans and 12% of New Yorkers

Figure 28: Healthcare Access in the past 12 months



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
No	90.0%	78.9%	95.9%	80.0%	83.1%
Yes	8.1%	16.5%	3.7%	15.9%	14.1%

- Barriers to accessing necessary healthcare are listed in table 9 below, which indicates that accessibility issues and cost were the leading barriers cited across all samples

Table 9: Barriers to medical care in the past 12 months

	Total	ACC sub-	Regional	Public/Uninsured	MUA sub-

*Please note - Physical activity and PA are used interchangeably in this report

	sample (11,410)	sample (n=341)	sub-sample (n=260)	sub-sample (n=1,015)	sample (n=1,170)
Hard to get an appointment	26.9%	31.3%	33.3%	28.3%	26.2%
Cost	23.1%	21.9%	50.0%	28.3%	18.9%
Service not covered by insurance	20.1%	28.1%	16.7%	17.3%	13.9%
Office not patient-friendly (such as long wait time, hours not convenient)	16.2%	9.4%	16.7%	13.4%	17.2%
Not sure where to go	16.0%	15.6%	16.7%	14.2%	17.2%
Lack of transportation	9.6%	18.8%	0.0%	18.1%	9.8%
No health insurance	8.3%	25.0%	16.7%	26.8%	13.9%
Family responsibilities (such as no child care available)	7.3%	6.3%	33.3%	7.1%	8.2%
Language services (such as could not get healthcare in my language)	1.3%	0.0%	0.0%	3.1%	0.0%

In the total sample, statistically significant associations were found with barriers to healthcare:

- Healthcare access was found to be significantly associated with geographic location such that:
    - Respondents living in Manhattan (27.5%) were more likely to report that they were unable to access a healthcare provider in the past year; $p \leq 0.001$
- Healthcare access was found to be significantly associated with gender such that:
    - Females (69.2%) were more likely to report that they were unable to access a healthcare provider in the past year; $p \leq 0.05$
- Healthcare access was found to be significantly associated with age such that:
    - Respondents aged 51-65 years (35.4%) were more likely to report that they were unable to access a healthcare provider in the past year and indicated cost (39.3%) as a barrier; $p \leq 0.001$
- Healthcare access was found to be significantly associated with race and ethnicity such that:
    - Whites/Caucasians (65.8%; $p \leq 0.001$) were more likely to report that they were unable to access a healthcare provider in the past year and indicated cost (56.5%; $p \leq 0.5$) as a barrier
    - Non-Hispanics/Latinos (84.0%) were more likely to report that they were unable to access a healthcare provider in the past year; $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with barriers to healthcare:

- Healthcare access was found to be significantly associated with race and ethnicity such that:
    - Non-Hispanics/Latinos (73.2%) were more likely to report that they were unable to access a healthcare provider in the past year compared to Hispanics/Latinos (26.8%); $p \leq 0.01$

In the regional sub-sample, statistically significant associations were found with barriers to healthcare:

- Healthcare access was found to be significantly associated with race and ethnicity such that:
    - Whites/Caucasians (57.1%; $p \leq 0.01$) and Non-Hispanics/Latinos (71.4%) were more likely to report that they were unable to access a healthcare provider in the past year

In the public/uninsured sub-sample, statistically significant associations were found with barriers to healthcare:

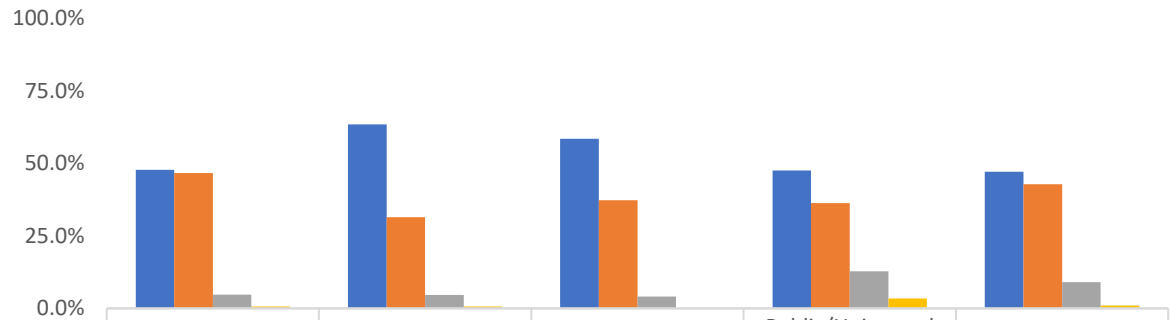
- Healthcare access was found to be significantly associated with race such that:
    - Blacks/African Americans were more likely to report cost (41.2%; $p \leq 0.01$) and accessibility issues (22.9%; $p \leq 0.01$) as barriers to healthcare in the past year

*Please note - Physical activity and PA are used interchangeably in this report

Adherence

- Figure 29 below shows adherence to medical advice
- Most respondents in all samples reported high levels of adherence with their healthcare providers' medical advice, stating that they "always" or "usually" followed their advice. These data dramatically contrast with research suggesting that around 40% of patients do not adhere to treatment regimens.

Figure 29: Adherence to medical advice



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Always	47.8%	63.4%	58.5%	47.5%	47.1%
Usually	46.7%	31.4%	37.3%	36.3%	42.8%
Sometime	4.7%	4.6%	4.1%	12.8%	9.1%
Never	0.7%	0.7%	0.0%	3.4%	1.0%

In the total sample, statistically significant associations were found with adherence to medical advice:

- Adherence to medical advice was found to be significantly associated with geographic location such that:
  - Respondents living in Manhattan (24.1%) were more adherent to medical advice; $p \leq 0.001$
- Adherence to medical advice was found to be significantly associated with gender such that:
  - Females (67.8%) were less adherent to medical advice; $p \leq 0.01$
- Adherence to medical advice was found to be significantly associated with age such that:
  - Respondents aged 18-35 years (36.9%) were less adherent to medical advice; $p \leq 0.001$
- Adherence to medical advice was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (81.5%) were more adherent to medical advice than the other races; $p \leq 0.001$
  - Non-Hispanics/Latinos (91.8%) were more adherent to medical advice than Hispanics/Latinos (8.2%); $p \leq 0.001$
- Adherence to medical advice was found to be significantly associated with musculoskeletal conditions such that:
  - Those diagnosed who OA (52.8%) were more adherent to medical advice; $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with adherence to medical advice:

- Adherence to medical advice was found to be significantly associated with race and ethnicity such that:
  - Blacks/African Americans (53.8%) were less adherent to medical advice; $p \leq 0.01$

In the regional sub-sample sample, statistically significant associations were found with adherence to medical

*Please note - Physical activity and PA are used interchangeably in this report

advice:

- Adherence to medical advice was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (91.5%) were more adherent to medical advice compared to the other races; $p \leq 0.01$

In the public/uninsured sub-sample, statistically significant associations were found with adherence to medical advice:

- Adherence to medical advice was found to be significantly associated with geographic location such that:
  - Respondents living in Brooklyn (21.9%) followed by the Bronx (20.5%) were less adherent to medical advice; $p \leq 0.05$
- Adherence to medical advice was found to be significantly associated with age such that:
  - Respondents aged 18-35 years (59.2%) were less adherent to medical advice; $p \leq 0.001$
- Adherence to medical advice was found to be significantly associated with race and ethnicity such that:
  - Blacks/African Americans (40.6%) were less adherent to medical advice; $p \leq 0.001$. While non-Hispanics/Latinos (71.2%) were more adherent to medical advice; $p \leq 0.01$

In the MUA sub-sample, statistically significant associations were found with adherence to medical advice:

- Adherence to medical advice was found to be significantly associated with geographic location such that:
  - Respondents living in the Bronx (40.0%) were less adherent to medical advice; $p \leq 0.05$
- Adherence to medical advice was found to be significantly associated with age such that:
  - Respondents aged 18-35 years (42.3%) were less adherent to medical advice; $p \leq 0.001$
- Adherence to medical advice was found to be significantly associated with race and ethnicity such that:
  - Blacks/African Americans (36.0%; $p \leq 0.001$) and non-Hispanics/Latinos (62.5%; $p \leq 0.01$) were less adherent to medical advice

Barriers to following Healthcare Provider's Medical Advice

- Table 10 below shows reported barriers to following a healthcare provider's medical advice
- When asked to provide reasons for not adhering to medical advice, results demonstrate that "concerns about side effects" and "not feeling that treatment was necessary" were the top two barriers cited by all samples. See below for more details

Table 10: Barriers to following healthcare provider's medical advice

	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Worried about side effects	30.9%	30.4%	21.2%	41.5%	38.2%
Didn't feel treatment would help	25.4%	20.1%	24.1%	29.5%	28.4%
Condition not severe enough	22.7%	10.9%	19.7%	22.5%	24.8%
Prefer to use complementary treatment	18.8%	15.8%	13.9%	24.8%	23.1%
Did not agree with doctor	16.3%	7.1%	14.6%	17.4%	16.2%

*Please note - Physical activity and PA are used interchangeably in this report

Concerned about the cost	16.0%	16.3%	11.7%	26.4%	21.3%
Provider didn't explain	15.0%	20.7%	13.1%	22.3%	19.3%
Forgot to take medicine	14.1%	20.7%	13.1%	27.5%	19.1%
Did not fit my schedule	13.7%	11.4%	22.6%	17.4%	16.6%
Provider doesn't understand my culture	2.1%	5.4%	2.2%	7.7%	4.5%

In the total sample, statistically significant associations were found with barriers to following medical advice:

- Barriers to following medical advice was found to be significantly associated with geographic location such that:
    - Respondents living in Manhattan (24.5%) were more likely to feel concerned about cost of treatment as a barrier to following medical advice; $p \leq 0.001$
- Barriers to following medical advice was found to be significantly associated with gender such that:
    - Females were more likely to report treatment would not help (69.5%), cost of treatment (72.6%), side effects (73.3%), and prefer to use complementary treatment (75.5%) as barriers to following medical advice ; $p \leq 0.001$
- Barriers to following medical advice was found to be significantly associated with age such that:
    - Respondents aged 66-75 years (31.9%) were more likely to feel that treatment would not help (31.9%; $p \leq 0.001$) as a barrier to following medical advice. While those aged 51-65 years were more likely to report cost of treatment (35.0%; $p \leq 0.001$), side effects (32.0%; $p \leq 0.01$) and prefer to use complementary treatment (35.2%) as barriers to following medical advice; $p \leq 0.001$
- Barriers to following medical advice was found to be significantly associated with race and ethnicity such that:
    - Whites/Caucasians were more likely to report cost of treatment (67.2%; $p \leq 0.001$), treatment would not help (77.2%; $p \leq 0.01$), and prefer to use complementary treatment (73.6%; $p \leq 0.001$) as barriers to following medical advice
    - Non-Hispanics/Latinos were more likely to report cost of treatment (86.0%; $p \leq 0.001$), side effects (89.0%; $p \leq 0.01$), and prefer to use complementary treatment (88.3%; $p \leq 0.01$) as barriers to following medical advice
- Barriers to following medical advice was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents diagnosed with OA (52.5%; $p \leq 0.01$) were more likely to report treatment would not help and side effects (51.9%; $p \leq 0.05$) as barriers to following medical advice

In the ACC sub-sample, statistically significant associations were found with barriers to following medical advice:

- Barriers to following medical advice was found to be significantly associated with age such that:
    - Respondents aged 18-35 years (33.3%) were more likely to report their condition was not severe enough as a barrier to following medical advice; $p \leq 0.05$
- Barriers to following medical advice was found to be significantly associated with musculoskeletal conditions such that:
    - Respondents diagnosed with OA were more likely to report treatment would not help (62.1%; $p \leq 0.05$) and side effects (59.5%; $p \leq 0.05$)

*Please note - Physical activity and PA are used interchangeably in this report

- Respondents diagnosed with OP (53.3%; $p \leq 0.05$) were more likely to report their condition was not severe enough as a barrier to following medical advice

In the regional sub-sample, statistically significant associations were found with barriers to following medical advice:

- Barriers to following medical advice was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians were more likely to report cost of treatment (68.8%; $p \leq 0.01$) and prefer to use complementary treatment (73.7%; $p \leq 0.05$) as barriers to following medical advice;
  - Non-Hispanics/Latinos were more likely to report cost of treatment (62.5%; $p \leq 0.001$) and prefer to use complementary treatment (77.8%; $p \leq 0.05$) as barriers to following medical advice

In the public/uninsured sub-sample, statistically significant associations were found with barriers to following medical advice:

- Barriers to following medical advice was found to be significantly associated with gender such that:
  - Females were more likely to report side effects (74.6%) as a barrier to following medical advice; $p \leq 0.05$
- Barriers to following medical advice was found to be significantly associated with age such that:
  - Respondents aged 18-35 years (38.6%) were more likely to report cost of treatment as a barrier to following medical advice; $p \leq 0.05$
- Barriers to following medical advice was found to be significantly associated with race and ethnicity such that:
  - Blacks/African Americans were more likely to report side effects (37.2%) as a barrier to following medical advice; $p \leq 0.05$

In the MUA sub-sample, statistically significant associations were found with barriers to following medical advice:

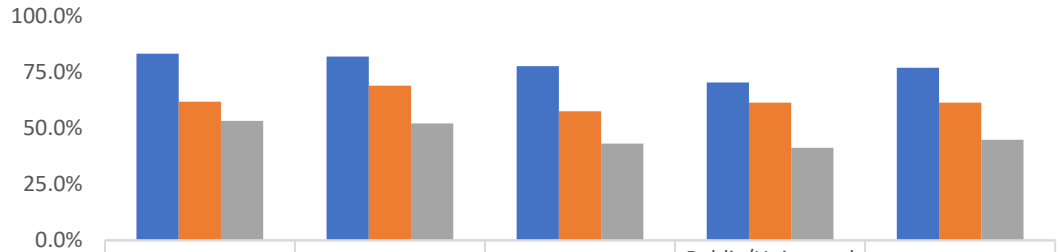
- Barriers to following medical advice was found to be significantly associated with gender such that:
  - Females were more likely to report treatment would not help (74.3%; $p \leq 0.05$), cost of treatment (78.1%; $p \leq 0.05$) and side effects (76.5%; $p \leq 0.01$) as barriers to following medical advice
- Barriers to following medical advice was found to be significantly associated with age such that:
  - Respondents aged 66-75 years (24.6%) were more likely to report prefer to use complementary treatment as a barrier to following medical advice; $p \leq 0.05$

Provider-Patient Communication

- Figure 30 below shows percentage of high provider-patient communication in all samples
- Most respondents in all samples reported high levels of provider-patient communication. See details below:

*Please note - Physical activity and PA are used interchangeably in this report

Figure 30: Patient-provider communication (usually to always)



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Ask questions about treatment	83.2%	81.9%	77.7%	70.4%	76.9%
Discuss any personal problems	61.8%	69.0%	57.5%	61.4%	61.4%
Prepare list of questions	53.3%	52.1%	43.1%	41.3%	44.8%

In the total sample, statistically significant associations were found with regards to lack of provider-patient communication:

- Lack of provider-patient communication was found to be associated with education such that:
  - Respondents with more than high school education were less likely to prepare a list of questions (36.5%) and ask questions about treatment (42.5%); $p \leq 0.001$
- Lack of provider-patient communication was found to be associated with geographic location such that:
  - Respondents living in Manhattan were less likely to prepare a list of questions (20.2%) and ask questions about treatment (42.5%); $p \leq 0.001$
- Lack of provider-patient communication was found to be associated with gender such that:
  - Females were less likely to prepare a list of questions (62.9%) and ask questions about treatment (61.2%); $p \leq 0.001$
- Lack of provider-patient communication was found to be associated with age such that:
  - Respondents aged 51-65 years were less likely to prepare a list of questions (34.5%; $p \leq 0.001$), ask questions about treatment (30.7%; $p \leq 0.001$) and discuss personal problems (30.4%; $p \leq 0.01$)
- Lack of provider-patient communication was found to be associated with race and ethnicity such that:
  - Whites/Caucasians were less likely to prepare a list of questions (74.8%), ask questions about treatment (65.9%) and discuss personal problems (78.4%); $p \leq 0.001$
  - Non-Hispanics/Latinos were less likely to prepare a list of question (88.4%) and ask questions about treatment (83.9%); $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with regards to lack of provider-patient communication:

- Lack of provider-patient communication was found to be associated with education, such that:
  - Respondents with more than high school education were less likely to ask questions about treatment (56.3%); $p \leq 0.001$

*Please note - Physical activity and PA are used interchangeably in this report

- Lack of provider-patient communication was found to be associated with race such that:
    - Blacks/African Americans (31.1%) were less likely ask questions about treatment; $p \leq 0.01$

In the regional sub-sample, statistically significant associations were found with regards to lack of provider-patient communication:

- Lack of provider-patient communication was found to be associated with education, such that:
    - Respondents with more than high school education were less likely to prepare a list of questions (40.9%); $p \leq 0.01$
- Lack of provider-patient communication was found to be associated with age such that:
    - Respondents aged 51-65 years were less likely to prepare a list of questions (44.0%); $p \leq 0.001$
- Lack of provider-patient communication was found to be associated with race and ethnicity, such that:
    - Whites/Caucasians were less likely to prepare a list of questions (85.2%; $p \leq 0.001$) and discuss personal problems (86.2%; $p \leq 0.05$)
    - Non-Hispanics/Latinos were less likely to prepare a list of question (89.3%) and ask questions about treatment (83.9%); $p \leq 0.001$

In the public/uninsured sub-sample, statistically significant associations were found with regards to lack of provider-patient communication:

- Lack of provider-patient communication was found to be associated with education such that:
    - Respondents with more than high school education were less likely to prepare a list of questions (59.1%) and ask questions about treatment (61.3%); $p \leq 0.001$
- Lack of provider-patient communication was found to be associated with geographic location, such that:
    - Respondents living in the Bronx were less likely to prepare a list of questions (20.0%); $p \leq 0.05$
- Lack of provider-patient communication was found to be associated with age, such that:
    - Respondents aged 18-35 years were less likely to prepare a list of questions (33.1%; $p \leq 0.001$), ask questions about treatment (37.2%; $p \leq 0.001$)
- Lack of provider-patient communication was found to be associated with race and ethnicity, such that:
    - Blacks/African Americans were less likely to prepare a list of questions (34.5%; $p \leq 0.01$) and ask questions about treatment (33.7%; $p \leq 0.001$)
    - Non-Hispanics/Latinos were less likely to ask questions about treatment (61.2%); $p \leq 0.01$

In the public/uninsured sub-sample, statistically significant associations were found with regards to lack of provider-patient communication:

- Lack of provider-patient communication was found to be associated with education such that:
    - Respondents with more than high school education were less likely to prepare a list of questions (46.5%) and ask questions about treatment (50.8%); $p \leq 0.001$
- Lack of provider-patient communication was found to be associated with age, such that:
    - Respondents aged 51-65 years were less likely to prepare a list of questions (29.0%; $p \leq 0.001$), ask questions about treatment (26.9%; $p \leq 0.001$), and
- Lack of provider-patient communication was found to be associated with race and ethnicity, such that:
    - Whites/Caucasians were less likely to prepare a list of questions (41.1%; $p \leq 0.001$), ask questions about treatment (32.2%; $p \leq 0.001$) and discuss personal problems (45.7%; $p \leq 0.01$)

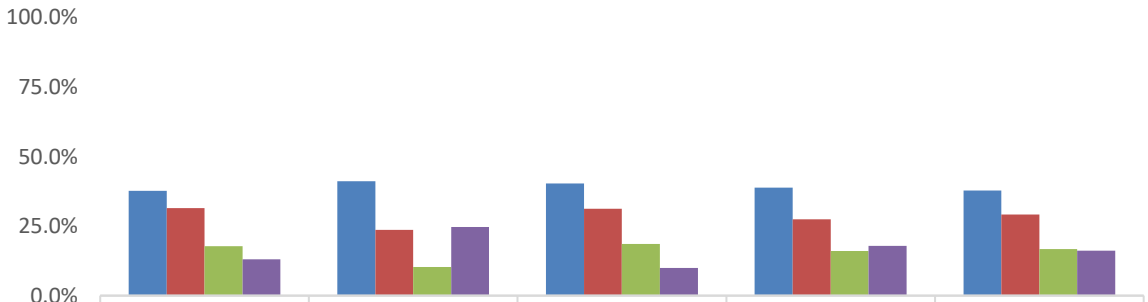
*Please note - Physical activity and PA are used interchangeably in this report

- Non-Hispanics/Latinos were less likely to prepare a list of questions (72.0%) and ask questions about treatment (65.3%); $p \leq 0.001$

Self-Efficacy

- Figure 31 below shows respondents' self-efficacy in managing their musculoskeletal conditions in all samples
- Majority of respondents across all samples reported being somewhat confident in managing symptoms of their musculoskeletal conditions. See below for more details

Figure 31: Self-efficacy in managing musculoskeletal conditions



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Somewhat confident	37.7%	41.2%	40.3%	38.8%	37.8%
Confident	31.5%	23.7%	31.2%	27.4%	29.2%
Very confident	17.8%	10.3%	18.6%	16.0%	16.7%
Not at all confident	13.1%	24.7%	10.0%	17.9%	16.2%

In the total sample, statistically significant associations were found with regards to lack of confidence in self-management:

- Lack of confidence in self-management was found to be significantly associated with education, such that respondents with post-college education (33.2%) were more likely to report little/no confidence in managing their condition; $p \leq 0.001$
- Lack of confidence in self-management was found to be significantly associated with gender, such that females (62.9%) were more likely to report little/no confidence in managing their condition; $p \leq 0.001$
- Lack of confidence in self-management was found to be significantly associated with musculoskeletal conditions, such that those diagnosed who OA (56.3%) were more likely to report little/no confidence in managing their condition; $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with regards to lack of confidence in self-management:

- Lack of confidence in self-management was found to be significantly associated with gender, such that females (78.9%) were more likely to report little/no confidence in managing their condition; $p \leq 0.01$

In the public/uninsured sub-sample, statistically significant associations were found with regards to lack of confidence in self-management:

*Please note - Physical activity and PA are used interchangeably in this report

- Lack of confidence in self-management was found to be significantly associated with education, such that respondents with more than high school education (54.7%) were more likely to report little/no confidence in managing their condition; $p \leq 0.001$
- Lack of confidence in self-management was found to be significantly associated with gender, such that females (74.2%) were more likely to report little/no confidence in managing their condition; $p \leq 0.001$
- Lack of confidence in self-management was found to be significantly associated race, such that Whites/Caucasians (34.43%) were more likely to report little/no confidence in managing their condition; $p \leq 0.05$

In the MUA sub-sample, statistically significant associations were found with regards to lack of confidence in self-management:

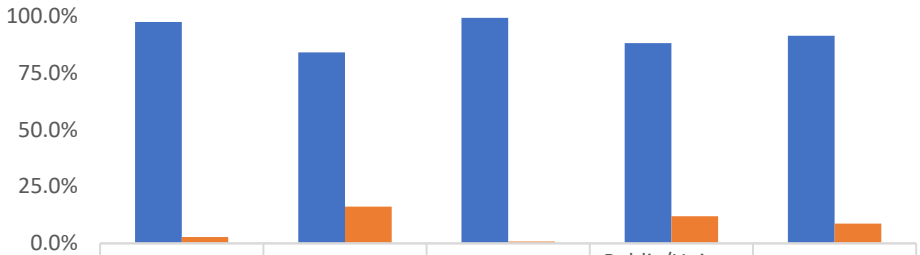
- Lack of confidence in self-management was found to be significantly associated with education, such that: respondents with more than high school education (42.2%) were more likely to report little/no confidence in managing their condition; $p \leq 0.05$
- Lack of confidence in self-management was found to be significantly associated with gender, such that females (76.1%) were more likely to report little/no confidence in managing their condition; $p \leq 0.01$

Health Literacy

- Figure 32 below shows respondents' ability to speak and understand English
- Majority of respondents across all samples rated their ability to speak and understand English from "good" to "excellent". See below for more details

*Please note - Physical activity and PA are used interchangeably in this report

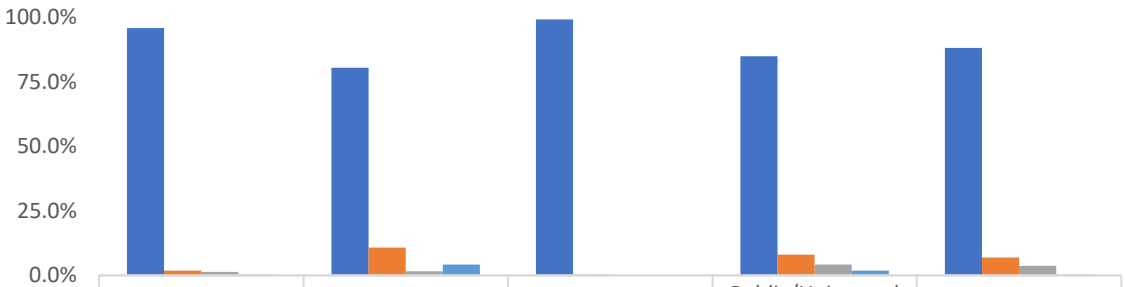
Figure 32: Abiity to speak and understand English



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Good/Very good/Excellent	97.3%	84.0%	99.2%	88.0%	91.3%
Poor/Fair	2.8%	16.1%	0.8%	12.0%	8.7%

- Figure 33 below shows preferred language for discussing healthcare across all samples
- Majority of respondents across all samples preferred English for discussing health. See below for more details:

Figure 33: Prefered language for discussing healthcare

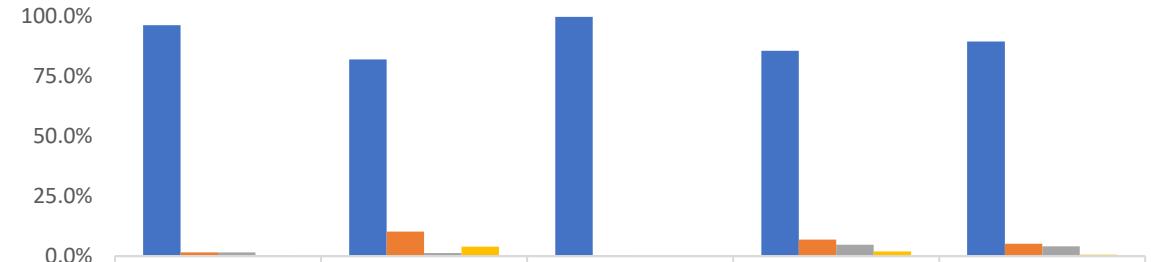


	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
English	95.8%	80.4%	99.2%	84.9%	88.2%
Spanish	1.9%	10.8%	0.4%	8.0%	6.9%
Chinese	1.3%	1.6%	0.0%	4.2%	3.7%
Russian	0.4%	4.2%	0.0%	1.8%	0.4%

- Figure 34 below shows preferred language for reading medical instruction across all samples
- Majority of respondents across all samples preferred English for reading medical instructions. See below for more details:

*Please note - Physical activity and PA are used interchangeably in this report

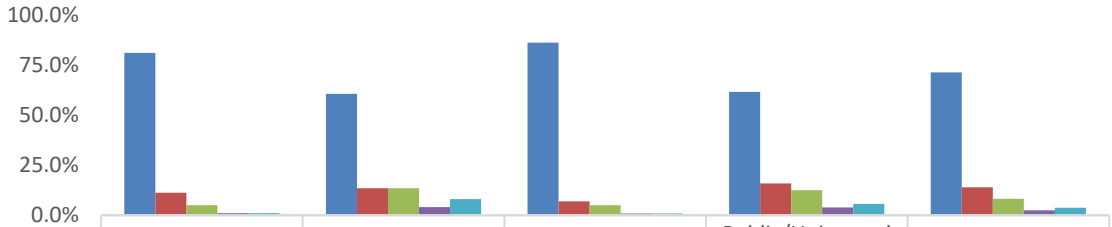
Figure 34: Prefered language for reading medical instructions



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
English	96.1%	81.9%	99.6%	85.5%	89.4%
Spanish	1.5%	10.2%	0.4%	6.9%	5.2%
Chinese	1.5%	1.3%	0.0%	4.7%	4.1%
Russian	0.4%	3.9%	0.0%	1.9%	0.6%

- Table 35 below shows if respondents need assistance in reading healthcare information across all samples
- Majority of respondents across all samples reported they never needed assistance when reading instructions, pamphlets, or other written materials from doctors or pharmacies. See below for details:

Figure 35: Need assistance in reading healthcare information



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Never	81.2%	60.7%	86.4%	61.8%	71.5%
Rarely	11.2%	13.6%	7.0%	16.0%	14.0%
Sometimes	5.1%	13.6%	5.0%	12.6%	8.3%
Often	1.1%	4.1%	0.8%	3.9%	2.5%
Always	1.1%	8.1%	0.8%	5.7%	3.7%

In the total sample, statistically significant associations were found with regards to health literacy:

- Health literacy was found to be significantly associated with race and ethnicity such that:
  - Asians (46.0%) and non-Hispanics/Latinos (67.8%) reported their ability to speak English as "Poor"; $p \leq 0.001$
  - Asians preferred discussing (98.9%) healthcare information in Chinese while Whites/Caucasians preferred reading (92.3%) healthcare information in Russian; $p \leq 0.001$

*Please note - Physical activity and PA are used interchangeably in this report

- Non-Hispanics/Latinos (100%) preferred discussing and reading healthcare information in Russian; $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with regards to health literacy:

- Health literacy was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (58.3%) and non-Hispanics/Latinos (66.7%) reported their ability to speak English as "Poor"; $p \leq 0.001$
  - Whites/Caucasians and Asians (100%) preferred discussing and reading healthcare information in non-English (Russian and Chinese); $p \leq 0.001$
  - Non-Hispanics/Latinos (100%) preferred discussing and reading healthcare information in non-English (Chinese and Russian); $p \leq 0.001$

In the regional sub-sample, statistically significant associations were found with regards to health literacy:

- Health literacy was found to be significantly associated with race and ethnicity such that:
  - Other race (100%) preferred discussing and reading healthcare information in Spanish; $p \leq 0.001$
  - Hispanics/Latinos (100%) preferred discussing healthcare information in Spanish; $p \leq 0.001$

In the public/uninsured sub-sample, statistically significant associations were found with regards to health literacy:

- Health literacy was found to be significantly associated with race and ethnicity such that:
  - Asians (41.8%) and non-Hispanics/Latinos (63.8%) reported their ability to speak English as "Poor"; $p \leq 0.001$
  - Asians (100%) preferred discussing healthcare information in Chinese while Whites/Caucasians (93.8%) preferred reading medical instruction in Russian; $p \leq 0.001$
  - Non-Hispanics/Latinos (100%) preferred discussing and reading healthcare information in Russian; $p \leq 0.001$

In the MUA sub-sample, statistically significant associations were found with regards to health literacy:

- Health literacy was found to be significantly associated with race and ethnicity such that:
  - Asians (51.2%) and non-Hispanics/Latinos (58.3%) reported their ability to speak English as "Poor"; $p \leq 0.001$
  - Asians and Whites/Caucasians (100%) preferred discussing healthcare information in non-English (Chinese and Russian) while Asians (90.5%) preferred reading medical instruction in Chinese; $p \leq 0.001$
  - Non-Hispanics/Latinos (100%) preferred discussing healthcare information in non-English (Chinese and Russian) while reading healthcare information was preferred in Russian; $p \leq 0.001$

Health Information/Advice

- Table 11 below shows where respondents usually obtain health information and advice
- Most respondents indicated the "Doctor's office" as where they would usually obtain health information. See below for more details:

*Please note - Physical activity and PA are used interchangeably in this report

Table 11: Health information/advice resources

	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Doctor's office	91.1%	85.5%	95.4%	78.7%	85.6%
Internet	54.8%	30.9%	44.7%	38.2%	47.6%
Friends/Colleagues	25.9%	14.5%	24.1%	18.8%	22.5%
Family	24.5%	22.0%	27.8%	23.1%	22.6%
Clinic or health center	15.4%	36.6%	7.6%	36.9%	28.9%
Hospital Outpatient Department	6.7%	11.7%	3.8%	12.7%	10.4%
Don't seek health information or advice often	6.5%	4.6%	2.5%	5.2%	7.6%
Hospital Emergency Room	5.7%	10.3%	2.5%	14.1%	8.1%
Health Maintenance Organization (HMO)	3.9%	2.8%	2.1%	6.7%	7.2%

In the total sample, statistically significant associations were found with regards to obtaining health information:

- Obtaining health information was found to be significantly associated with education such that:
  - Respondents who completed high school or GED education (21.9%) were more likely to obtain health information/advice from a clinic or health center; $p \leq 0.001$
  - Respondents with post-college education were more likely to obtain health information/advice from the doctor's office (91.3%), internet (60.0%) and family/colleagues (29.9%); $p \leq 0.001$
- Obtaining health information was found to be significantly associated with geographic location such that:
  - Respondents living in Bronx (34.1%) were more likely to obtain health information/advice from a clinic/health center (34.1%); $p \leq 0.001$
  - Respondents living in Connecticut (92.6%) were more likely to obtain health information/advice from a doctor's office; $p \leq 0.001$
  - Respondents living in Manhattan (30.4%) were more likely to obtain health information/advice from friends/colleagues; $p \leq 0.001$
  - Respondents living in Westchester (61.5%) were more likely to obtain health information/advice from the internet; $p \leq 0.001$
- Obtaining health information was found to be significantly associated with gender such that:
  - Gender non-conforming respondents (40.0%) were more likely to obtain health information/advice from friends/colleagues; $p \leq 0.001$
  - Females (54.4%) were more likely to obtain health information/advice from the internet; $p \leq 0.001$
- Obtaining health information was found to be significantly associated with age such that:
  - Respondents aged 18-35 (64.3%) were more likely to obtain health information/advice from a clinic/health center; $p \leq 0.001$
  - Respondents aged 66-75 years (90.7%) and 76-85 years (90.0%) were more likely to obtain health information/advice from a doctor's office; $p \leq 0.001$

*Please note - Physical activity and PA are used interchangeably in this report

  - Respondents aged 66-75 years (56.5%) were more likely to obtain health information/advice from the internet; $p \leq 0.001$
- Obtaining health information was found to be significantly associated with race/ethnicity such that:
  - American Indians (43.3%) were more likely to obtain health information/advice from a clinic/health center; $p \leq 0.001$
  - Whites/Caucasians were more likely to obtain health information/advice from a doctor's office (91.3%), friends/colleagues (26.7%) and internet (56.5%); $p \leq 0.001$
  - Hispanics/Latinos were more likely to obtain health information/advice from a clinic/health center (32.8%) while Non-Hispanics/Latinos were more likely to obtain health information/advice a doctor's office (89.8), friends/colleagues (26.1%) and the internet (54.8%); $p \leq 0.001$

In the ACC sample, statistically significant associations were found with regards to obtaining health information

- Obtaining health information was found to be significantly associated with education such that:
  - Respondents with post-college education were more likely to obtain health information/advice from a doctor's office (92.3%; $p \leq 0.001$) and the internet (35.9%; $p \leq 0.05$);
- Obtaining health information was found to be significantly associated with race/ethnicity such that:
  - American Indians (100.0%) were more likely to obtain health information/advice a doctor's office; $p \leq 0.001$
  - Hispanics/Latinos were more likely to obtain health information/advice from a clinic/health center (48.6%; $p \leq 0.01$) while Non-Hispanics/Latinos were more likely to obtain health information/advice from a doctor's office (84.8%; $p \leq 0.001$)

In the sub-regional sample, statistically significant associations were found with regards to obtaining health information:

- Obtaining health information was found to be significantly associated with gender such that:
  - Females were more likely to obtain health information/advice from a doctor's office (93.6%; $p \leq 0.01$)
- Obtaining health information was found to be significantly associated with age such that:
  - Respondents aged 18-35 (18.2%; $p \leq 0.01$) were more likely to obtain health information/advice from a clinic/health center while those aged 36-50 years (60.0%; $p \leq 0.05$) were more likely to obtain health information/advice from the internet
- Obtaining health information was found to be significantly associated with race/ethnicity such that:
  - Blacks/African Americans (92.7%) were more likely to obtain health information/advice from a doctor's office; $p \leq 0.01$. While Asians (75.0%) were more likely to obtain health information/advice from friends/colleagues; $p \leq 0.05$.

In the public/uninsured sub-sample, statistically significant associations were found with regards to obtaining health information:

- Obtaining health information was found to be significantly associated with education such that:

*Please note - Physical activity and PA are used interchangeably in this report

    - Respondents with post-college education were more likely to obtain health information/advice from a doctor's office (85.0%; $p \leq 0.001$), friends/colleagues (30.1%; $p \leq 0.01$), and the internet (52.2%; $p \leq 0.001$)
- Obtaining health information was found to be significantly associated with geographic location such that:
    - Respondents living in Manhattan (34.1%) were more likely to obtain health information/advice from a clinic/health center while those living in Westchester (52.4%) were more likely to obtain health information/advice from the internet; $p \leq 0.01$
- Obtaining health information was found to be significantly associated with age such that:
    - Respondents aged 76-85 years (84.4%) were more likely to obtain health information/advice from a doctor's office; $p \leq 0.05$
- Obtaining health information was found to be significantly associated with race/ethnicity such that:
    - American Indians (44.4%) were more likely to obtain health information/advice from a clinic/health center while Whites/Caucasians (83.3%) were more likely to obtain health information/advice from a doctor's office; $p \leq 0.001$
    - Hispanics/Latinos (42.8%; $p \leq 0.001$) were more likely to obtain health information/advice from a clinic/health center while Non-Hispanics/Latinos were more likely to obtain health information/advice from a doctor's office (78.3%; $p \leq 0.01$) and friends/colleagues (19.8%; $p \leq 0.05$)

In the MUA sub-sample, statistically significant associations were found with regards to obtaining health information:

- Obtaining health information was found to be significantly associated with education such that:
    - Respondents who completed high school or GED (40.6%) were more likely to obtain health information/advice from a clinic or health center; $p \leq 0.001$
    - Respondents with post-college education were more likely to obtain health information/advice from a doctor's office (89.8%), family/colleagues (30.1%), and the internet (65.0%); $p \leq 0.001$
- Obtaining health information was found to be significantly associated with geographic location such that:
    - Respondents living in the Bronx (34.6%) were more likely to obtain health information/advice from a clinic/health center; $p \leq 0.01$ while those living in Suffolk and Nassau county (33.3%) were more likely to obtain health information/advice from the internet; $p \leq 0.05$
- Obtaining health information was found to be significantly associated with gender such that:
    - Gender non-conforming respondents were more likely to obtain health information/advice from friends/colleagues and the internet (60.0%); $p \leq 0.05$
- Obtaining health information was found to be significantly associated with age such that:
    - Respondents aged 18-35 (40.5%) were more likely to obtain health information/advice from a clinic/health center; $p \leq 0.001$ while those aged 76-85 years (90.8%) were more likely to obtain health information/advice from a doctor's office; $p \leq 0.05$
- Obtaining health information was found to be significantly associated with race/ethnicity such that:
    - American Indians (63.6%) were more likely to obtain health information/advice from a clinic/health center while Whites/Caucasians were more likely to obtain health

*Please note - Physical activity and PA are used interchangeably in this report

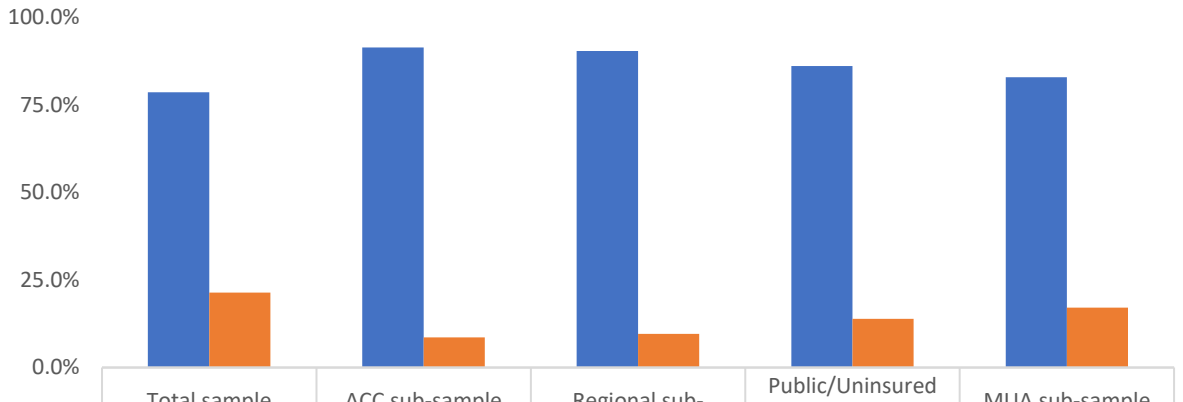
information/advice from a doctor's office (89.3%), friends/colleagues (28.9%) and the internet (55.6%); $p \leq 0.001$

- Hispanics/Latinos (40.1%; $p \leq 0.001$) were more likely to obtain health information/advice from a clinic/health center while Non-Hispanics/Latinos were more likely to obtain health information/advice from a doctor's office (83.6%; $p \leq 0.001$), friends/colleagues (24.1%; $p \leq 0.05$) and the internet (50.1%; $p \leq 0.001$)

Health Education Needs

- Figure 36 shows if respondents have taken any educational class/course to manage their musculoskeletal condition
- Majority of respondents across all samples indicated they had not taken an educational course or class to learn how to manage their musculoskeletal health/condition. See below for details

Figure 36: Taking an educational class/course to manage musculoskeletal health/conditions



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
No	78.6%	91.4%	90.4%	86.1%	82.9%
Yes	21.4%	8.6%	9.6%	13.9%	17.1%

In the total sample, statistically significant associations were found with regards to health education:

- Lack of health education was found to be significantly associated with geographic location such that:
  - Respondents living in the Bronx (85.3%) followed by Long Island – Nassau County (84.3%) and Westchester (82.9%) reported lack of education in managing their musculoskeletal condition(s); $p \leq 0.001$
- Lack of health education was found to be significantly associated with gender such that:
  - Most non-conforming gender (90.0%) and males (83.7%) reported lack of health education in managing their musculoskeletal condition(s); $p \leq 0.001$
- Lack of health education was found to be significantly associated with age such that:
  - Respondents aged 18-35 years (86.6%) reported lack of health education in managing their musculoskeletal condition; $p \leq 0.001$. This improved as respondents increased in age
- Lack of health education was found to be significantly associated with race/ethnicity such that:

*Please note - Physical activity and PA are used interchangeably in this report

- Native Hawaiians (100%) followed by Hispanics/Latinos (86.3%), American Indians (83.3%) and Blacks/African Americans (83.4%) reported lack of health education in managing their musculoskeletal condition(s); $p \leq 0.01$

In the public/uninsured sub-sample, statistically significant associations were found with regards to health education:

- Lack of health education was found to be significantly associated with geographic location such that:
  - Respondents living in the Bronx and Brooklyn (90.2%) reported lack of education in managing their musculoskeletal condition(s); $p \leq 0.05$
- Lack of health education was found to be significantly associated with race/ethnicity such that:
  - Hispanics/Latinos (89.6%) reported lack of education in managing their musculoskeletal condition(s); $p \leq 0.05$

In the MUA sub-sample, statistically significant associations were found with regards to health education:

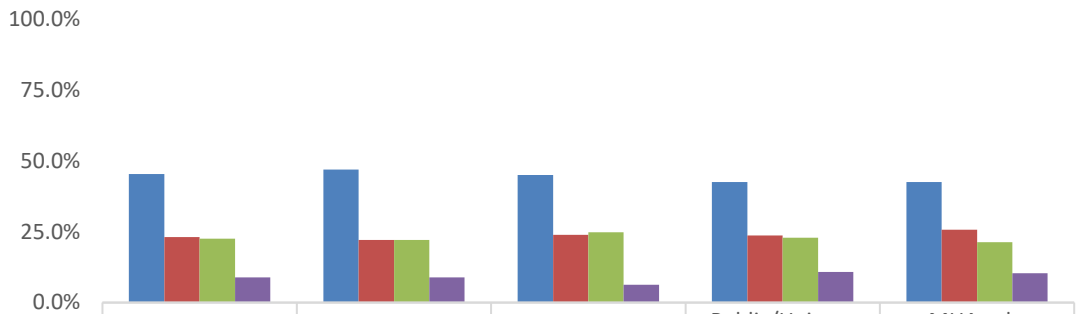
- Lack of health education was found to be significantly associated with geographic location such that:
  - Respondents living in Long Island – Nassau and Suffolk counties, and Westchester (100.0%) reported lack of education in managing their musculoskeletal condition(s); $p \leq 0.05$
- Lack of health education was found to be significantly associated with gender such that:
  - Males (88.0%) reported lack of education in managing their musculoskeletal condition(s); $p \leq 0.05$
- Lack of health education was found to be significantly associated with age such that:
  - Respondents aged 18-35 years (88.7%) reported lack of health education in managing their musculoskeletal condition(s); $p \leq 0.01$. This improved as respondents increased in age
- Lack of health education was found to be significantly associated with race/ethnicity such that:
  - Hispanics/Latinos (90.8%) reported lack of health education in managing their musculoskeletal condition(s); $p \leq 0.001$

Level of confidence - education to manage musculoskeletal conditions

- Figure 37 shows respondents' level of confidence that taking a course/class will help manage their musculoskeletal condition
- Majority of respondents across all samples reported being somewhat confident that taking a course/class will help manage their musculoskeletal conditions. See below for more details:

*Please note - Physical activity and PA are used interchangeably in this report

Figure 37: Confidence in taking educational classes to manage musculoskeletal conditions



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Somewhat	45.4%	46.9%	45.0%	42.6%	42.5%
Confident	23.1%	22.1%	23.9%	23.7%	25.7%
Not at all	22.6%	22.1%	24.8%	22.9%	21.3%
Very confident	8.9%	8.9%	6.3%	10.8%	10.4%

In the total sample, statistically significant associations were found with regards to confidence in taking educational classes to managing musculoskeletal conditions:

- Lack of confidence in taking educational classes to managing musculoskeletal conditions was found to be significantly associated with geographic location such that:
    - Respondents living in Manhattan (23.7%) and Westchester (23.7%) reported no confidence that taking a course/class will help manage their musculoskeletal conditions; $p \leq 0.01$
- Lack of confidence in taking educational classes to managing musculoskeletal conditions was found to be significantly associated with gender such that:
    - Non-conforming gender respondents (55.6%) followed by males (24.1%) reported no confidence that taking a course/class will help manage their musculoskeletal conditions; $p \leq 0.05$
- Lack of confidence in taking educational classes to managing musculoskeletal conditions was found to be significantly associated with race/ethnicity such that:
    - Most Whites/Caucasians (23.7%) and non-Hispanics/Latinos (22.7%) reported no confidence that taking a course/class will help manage their musculoskeletal conditions; $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with regards to confidence in taking educational classes to managing musculoskeletal conditions:

- Lack of confidence in taking educational classes to managing musculoskeletal conditions was found to be significantly associated with gender such that:
    - Most males (24.3%) reported no confidence that taking a course/class will help manage their musculoskeletal conditions; $p \leq 0.05$

*Please note - Physical activity and PA are used interchangeably in this report

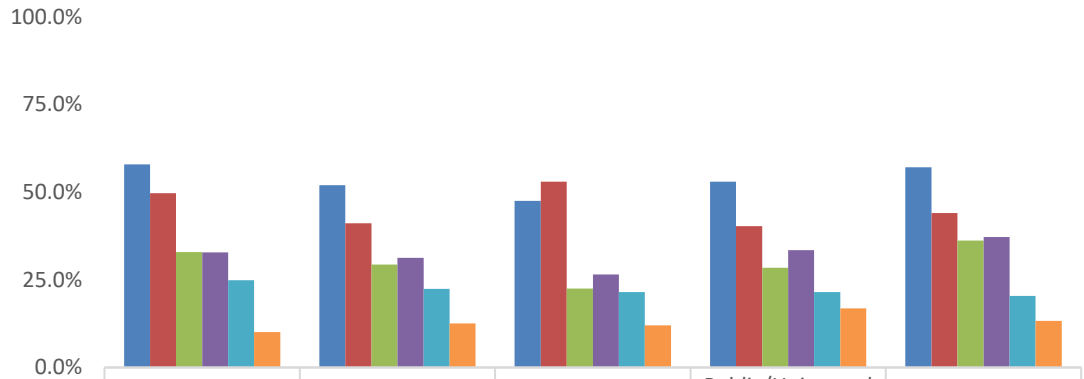
In the MUA sub-sample, statistically significant associations were found with regards to confidence in taking educational classes to managing musculoskeletal conditions:

- Lack of confidence in taking educational classes to managing musculoskeletal conditions was found to be significantly associated with race/ethnicity such that:
    - Most Whites/Caucasians (25.8%) reported no confidence that taking a course/class will help manage their musculoskeletal conditions; $p \leq 0.001$

Health Education Platform

- Figure 38 shows preferred platform to receive health education
- Majority of respondents across all samples indicated brochure/flyers, online lectures and lectures as the top three preferred platforms to receive health education. See below for more details:

Figure 38: Prefered Health Education Platform



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Brochure/flyers	57.9%	52.0%	47.5%	53.0%	57.1%
Online lectures	49.7%	41.1%	53.0%	40.3%	44.0%
Lectures	32.9%	29.3%	22.5%	28.4%	36.2%
Small groups workshops	32.8%	31.3%	26.5%	33.4%	37.2%
Podcasts	24.9%	22.4%	21.5%	21.5%	20.4%
Waiting area demo	10.1%	12.6%	12.0%	16.8%	13.3%

In the total sample, statistically significant associations were found with regards to preferred platform of receiving health education:

- Platform of receiving health education was found to be significantly associated with geographic location such that:
    - Respondents living in Manhattan (39.0%) indicated lectures as their preferred platform for receiving health education; $p \leq 0.001$
    - Respondents living in Westchester (52.6%) indicated online lectures as their preferred platform for receiving health education; $p \leq 0.001$
- Platform of receiving health education was found to be significantly associated with gender such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Females (32.9%) indicated brochure/flyers (53.0%; $p \leq 0.05$) and lectures (32.9%; $p \leq 0.001$) as their preferred platforms for receiving health education
- Platform of receiving health education was found to be significantly associated with age such that:
  - The oldest respondents (86+ years) indicated lectures (40.7%; $p \leq 0.001$) as their preferred platform for receiving health education
  - Respondents aged 51-65 years indicated online lectures (51.0%) as their preferred platform for receiving health education; $p \leq 0.001$
  - Respondents aged 66-75 years (55.6%) followed by those aged 76-85 years (54.1%) indicated brochures/flyers as their preferred platform for receiving health education; $p \leq 0.001$
- Platform of receiving health education was found to be significantly associated with race and ethnicity such that:
  - Asians (36.4%) indicated lectures as their preferred platform for receiving health education; $p \leq 0.05$
  - Whites/Caucasians (46.5%) followed by Blacks/African Americans (42.6%) indicated online lectures as their preferred platform for receiving health education; $p \leq 0.001$
  - American Indians (56.7%; $p \leq 0.01$) followed by Blacks/African Americans (55.0%; $p \leq 0.01$), White (52.8%; $p \leq 0.01$) and non-Hispanics/Latinos (52.9%; $p \leq 0.05$) indicated brochures/flyers as their preferred platform for receiving health education

In the ACC sub-sample, statistically significant associations were found with regards to preferred platform of receiving health education:

- Platform of receiving health education was found to be significantly associated with age such that:
  - The youngest respondents (18-35 years) indicated online lectures (43.6%) as their preferred platform for receiving health education; $p \leq 0.05$

In the regional sub-sample, statistically significant associations were found with regards to preferred platform of receiving health education:

- Platform of receiving health education was found to be significantly associated with age such that:
  - Respondents aged 36-50 years indicated online lectures (57.8%) as their preferred platform for receiving health education; $p \leq 0.05$

In the public/uninsured sub-sample, statistically significant associations were found with regards to preferred platform of receiving health education:

- Platform of receiving health education was found to be significantly associated with age such that:
  - Respondents aged 51-65 years (41.6%) followed by those aged 18-35 years (40.5%) indicated online lectures as their preferred platform for receiving health education; $p \leq 0.01$
  - Respondents aged 76-85 years (35.1%) followed by 66-75 years (33.3%) indicated lectures as their preferred platform for receiving health education; $p \leq 0.05$
  - Respondents aged 66-75 years (59.5%) followed by those aged 76-85 years (53.2%) indicated brochures/flyers as their preferred platform for receiving health education; $p \leq 0.01$

*Please note - Physical activity and PA are used interchangeably in this report

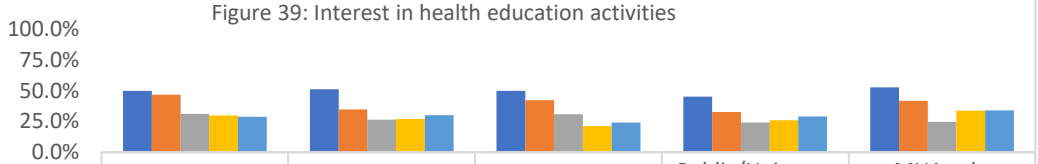
In the MUA sub-sample, statistically significant associations were found with regards to preferred platform of receiving health education:

- Platform of receiving health education was found to be significantly associated with age such that:
  - The oldest respondents (86+ years) indicated lectures (48.0%; $p \leq 0.001$) while the youngest respondents (18-35 years) indicated online lectures (46.4%; $p \leq 0.05$) as their preferred platform for receiving health education
  - Respondents aged 66-75 years (60.5%) indicated brochures/flyers as their preferred platform for receiving health education; $p \leq 0.01$
- Platform of receiving health education was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (46.3%) indicated online lectures as their preferred platform for receiving health education; $p \leq 0.01$

Interests in Health Education Activities

- Figure 39 shows health education activities that respondents are interested in
- Majority of respondents across all samples are interested in participating in exercise classes and online lectures. See below for more details:

Figure 39: Interest in health education activities



	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
Exercise classes	49.9%	51.2%	50.0%	45.3%	52.8%
Online lectures at HSS	46.8%	34.8%	42.4%	32.6%	41.9%
Podcasts	31.1%	26.6%	30.8%	24.2%	24.6%
Onsite lectures on computer/mobile device	29.8%	27.1%	21.2%	26.0%	33.8%
Workshops	28.7%	30.0%	24.2%	29.2%	34.1%

In the total sample, statistically significant associations were found with regards to preferred health education activity:

- Health education activity was found to be significantly associated with geographic location such that:
  - Respondents living in Manhattan indicated exercise classes (51.7%), workshops (33.6%) and onsite lectures (38.7%) as their preferred health education activities; $p \leq 0.001$
  - Respondents living in Long Island – Suffolk County (50.5%) followed by New Jersey (49.6%) indicated online lectures as their preferred health education activity; $p \leq 0.001$
  - Respondents living in Westchester (35.4%) indicated podcasts as their preferred health education activity; $p \leq 0.001$
- Health education activity was found to be significantly associated with gender such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Females indicated exercise classes (52.9%), workshops (30.3%) and onsite lectures (30.7%) as their preferred health education activities; $p \leq 0.001$
- Health education activity was found to be significantly associated with age such that:
  - Respondents aged 36-50 years reported exercise classes (55.1%; $p \leq 0.001$), podcasts (38.9%; $p \leq 0.001$), workshops (32.1%; $p \leq 0.01$) and onsite lectures (29.8%; $p \leq 0.01$) as their preferred health education activities
  - Respondents aged 51-65 years reported online lectures (49.4%; $p \leq 0.001$) as their preferred health education activity
- Health education activity was found to be significantly associated with race and ethnicity such that:
  - American Indians (33.3%) and Blacks/African Americans (32.9%) indicated workshops as their preferred health education activity; $p \leq 0.001$
  - Whites/Caucasians and non-Hispanics/Latinos indicated online lectures (47.0% and 45.2% respectively) and podcasts (31.3% and 30.3%) as their preferred health education activities; $p \leq 0.001$

In the ACC sub-sample, statistically significant associations were found with regards to preferred health education activity:

- Health education activities was found to be significantly associated with geographic location such that:
  - Respondents living in Staten Island indicated online lectures (60.5%) as their preferred health education activity; $p \leq 0.05$
- Health education activities was found to be significantly associated with age such that:
  - Respondents aged 36-50 years reported exercise classes podcasts (34.6%) as their preferred health education activity; $p \leq 0.05$

In the regional sub-sample, statistically significant associations were found with regards to preferred health education activity:

- Health education activity was found to be significantly associated with gender such that:
  - Females indicated exercise classes (53.6%) as their preferred health education activity; $p \leq 0.01$
- Health education activity was found to be significantly associated with age such that:
  - Respondents aged 36-50 years reported exercise classes podcasts (34.6%) as their preferred health education activity; $p \leq 0.05$
- Health education activity was found to be significantly associated with race and ethnicity such that:
  - Asians (75.0%) indicated onsite lectures as their preferred health education activity; $p \leq 0.05$

In the public/uninsured sub-sample, statistically significant associations were found with regards to preferred health education activity:

- Health education activity was found to be significantly associated with geographic location such that:
  - Respondents living in Long Island-Nassau County indicated exercise classes (58.6%) while those living in Long Island – Suffolk County (42.4%) indicated online lectures as their preferred health education activity; $p \leq 0.01$
- Health education activity was found to be significantly associated with gender such that:

*Please note - Physical activity and PA are used interchangeably in this report

  - Females indicated exercise classes (42.8%) as their preferred health education activity; $p \leq 0.05$
- Health education activity was found to be significantly associated with age such that:
  - Respondents aged 18-35 years reported exercise classes (44.0%) while those aged 51-65 years reported online lectures (28.4%) as their preferred health education activity; $p \leq 0.05$
- Health education activity was found to be significantly associated with race such that:
  - Whites/Caucasians indicated podcasts (28.4%) as their preferred health education activity; $p \leq 0.01$

In the MUA sub-sample, statistically significant associations were found with regards to preferred health education activity:

- Health education activity was found to be significantly associated with geographic location such that:
  - Respondents living in Manhattan indicated exercise classes (52.5%) while those living in Westchester (66.7%) indicated online lectures as their preferred health education activity; $p \leq 0.05$
- Health education activity was found to be significantly associated with gender such that:
  - Females indicated exercise classes (51.0%; $p \leq 0.001$), workshops (33.1%; $p \leq 0.05$) and onsite lectures (32.6%; $p \leq 0.01$) as their preferred health education activities
- Health education activity was found to be significantly associated with age such that:
  - Respondents aged 56-55 years reported exercise classes (54.8%) while those aged 66-75 years reported onsite lectures (36.3%) as their preferred health education activity; $p \leq 0.05$
- Health education activity was found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians indicated online lectures (48.0%; $p \leq 0.001$) and podcasts (27.3%; $p \leq 0.01$) as their preferred health education activities
  - Non-Hispanics/Latinos indicated exercise classes (49.1%; $p < 0.05$), online lectures (41.2%; $p < 0.001$), onsite lectures (31.8%; $p < 0.05$) and podcasts (23.6%; $p < 0.05$) as their preferred health education activities

Interests in Health Topics

- Table 12 shows health topics that respondents are interested in
- Across all samples, the most popular health topic is “How to exercise and manage my pain”. See below for more details:

Table 12: Interests in health topics

	Total sample (11,410)	ACC sub-sample (n=341)	Regional sub-sample (n=260)	Public/Uninsured sub-sample (n=1,015)	MUA sub-sample (n=1,170)
How to exercise and manage my condition	58.9%	57.6%	53.8%	53.5%	58.6%

*Please note - Physical activity and PA are used interchangeably in this report

OA	50.8%	47.6%	49.2%	36.1%	45.4%
Back pain	49.6%	53.6%	50.8%	51.6%	50.3%
Ways to improve my mobility	48.9%	52.4%	35.9%	45.6%	48.9%
OP	26.9%	24.0%	20.0%	20.0%	25.7%
RA	17.6%	37.6%	19.0%	25.8%	23.7%
Doctor-patient communication	16.6%	20.4%	12.8%	22.4%	23.1%
Fibromyalgia	7.4%	12.0%	11.3%	11.6%	10.0%
Gout	5.3%	6.8%	5.1%	6.4%	6.5%
Lupus	5.0%	10.4%	4.1%	10.4%	10.0%

In the total sample, statistically significant associations were found with regards to health topics:

- Specific health topics were found to be significantly associated with geographic location such that:
  - Respondents living in Staten Island (49.4%) followed by Manhattan (48.9%) and New Jersey (47.2%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.01$
- Specific health topics were found to be significantly associated with gender such that:
  - Females were more likely to report "OA" (48.8%; $p \leq 0.001$) and "How to exercise to manage my condition" (54.3%; $p \leq 0.05$) as health topics they would be interested in
- Specific health topics were found to be significantly associated with age such that:
  - Respondents aged 36-50 years (49.0%) were more likely to report "Back pain" as a health topic they would be interested in; $p \leq 0.01$
  - Respondents aged 66-75 years (52.9%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.001$
  - Respondents aged 76-85 years (48.5%) were more likely to report "Ways to improve my mobility" as a health topic they would be interested in; $p \leq 0.01$
- Specific health topics were found to be significantly associated with race and ethnicity such that:
  - Whites/Caucasians (48.1%) and non-Hispanics/Latinos (47.0%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.001$
  - American Indians (60.0%; $p \leq 0.05$) followed by Hispanics/Latinos (53.7%; $p \leq 0.001$) and Other race (51.0%; $p \leq 0.05$) were more likely to report "Back pain" as a health topic they would be interested in
  - Whites/Caucasians (53.9%) followed by Blacks/African Americans (53.3%) were more likely to report "How to exercise to manage my condition" as a health topic they would be interested in; $p \leq 0.05$

In the ACC sub-sample, statistically significant associations were found with regards to health topics:

- Specific health topics were found to be significantly associated with age such that:
  - Respondents aged 18-35 years (61.5%) were more likely to report "How to exercise and manage my condition" as a health topic they would be interested in; $p \leq 0.05$

In the regional sub-sample, statistically significant associations were found with regards to health topics:

*Please note - Physical activity and PA are used interchangeably in this report

- Specific health topics were found to be significantly associated with gender such that:
    - Females (48.0%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.05$
- Specific health topics were found to be significantly associated with age such that:
    - Respondents aged 18-35 years (68.2%) were more likely to report "How to exercise and manage my condition" as a health topic they would be interested in; $p \leq 0.01$
    - Respondents aged 66-75 years (62.3%) followed by respondents aged 76-85 year (61.1%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.01$
- Specific health topics were found to be significantly associated with race and ethnicity such that:
    - Hispanics/Latinos (64.3%) followed by Whites/Caucasians (28.6%) and Asians (25.0%) were more likely to report "ways to improve my mobility" as a health topic they would be interested in; $p \leq 0.01$

In the public/uninsured sub-sample, statistically significant associations were found with regards to health topics:

- Specific health topics were found to be significantly associated with geographic location such that:
    - Respondents living in Staten Island (50.0%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.05$
- Specific health topics were found to be significantly associated with gender such that:
    - Females were more likely to report "OA" (35.5%; $p \leq 0.01$) and "Back pain" (48.5%; $p \leq 0.05$) as health topics they would be interested in
- Specific health topics were found to be significantly associated with age such that:
    - Respondents aged 86+ years were more likely to report "OA" (56.3%; $p \leq 0.001$) and "Ways to improve my mobility" (56.3%; $p \leq 0.01$) as health topics they would be interested in
- Specific health topics were found to be significantly associated with race and ethnicity such that:
    - Whites/Caucasians (37.8%; $p \leq 0.05$) were more likely to report "OA" and "How to exercise to manage my condition" (51.5%; $p \leq 0.05$) as health topics they would be interested in
    - Non-Hispanics/Latinos (34.1%; $p \leq 0.05$) were more likely to report "OA" while Hispanics/Latinos (52.1%; $p \leq 0.01$) were more likely to report "Back pain" as health topics they would be interested in

In the MUA sub-sample, statistically significant associations were found with regards to health topics:

- Specific health topics were found to be significantly associated with gender such that:
    - Females (44.7%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.01$
- Specific health topics were found to be significantly associated with age such that:
    - Respondents aged 86+ years (68.0%) were more likely to report "OA" as a health topic they would be interested in; $p \leq 0.001$
- Specific health topics were found to be significantly associated with race and ethnicity such that:
    - Whites/Caucasians (49.3%; $p \leq 0.001$) were more likely to report "OA" and "How to exercise and manage my condition" (58.9%; $p \leq 0.05$) as health topics they would be interested in.

*Please note - Physical activity and PA are used interchangeably in this report

- While American Indians (90.9%; $p \leq 0.01$) were more likely to report "Back pain" as a health topic they would be interested in
- Non-Hispanics/Latinos (44.8%; $p \leq 0.001$) were more likely to report "OA" while Hispanics/Latinos (54.5%; $p \leq 0.01$) were more likely to report "Back pain" as health topics they would be interested in

*Please note - Physical activity and PA are used interchangeably in this report

Appendix E. List of internal stakeholders, and minutes of the stakeholders meeting

Internal Stakeholders for the 2019 HSS CHNA

	Name	Title	Department
1.	Jack Davis	Manager	Nursing
2.	Trish Quinlan	AVP Chief Learning Officer	Nursing
3.	Terry Karl	Assistant Director	Nutrition
4.	Page Carol	Director, Quality/Operational Excellence	Rehabilitation
5.	Keith Carlson	Senior Manager	Ambulatory Care Center – 72nd Str
6.	Jessica Kovac	Senior Director	Ambulatory Care Center – Rheumatology, 7th floor
7.	Bella Ellogoodin	AVP	Service Excellence and Language Services
8.	David Zeman	AVP	Regional markets
9.	Chao Wu	Chief Patient Experience Officer	Patient Experience
10.	Susan Cha, MD	Pediatrician	Med Staff-Attendings
11.	Julie Pelaez	Senior Director	Digital Communications
12.	Reesa Kaufman	Senior Director	Development
13.	Linda Russell, MD	Rehabilitation	Med Staff-Attendings
14.	Tracy Hickenbottom	Director	PR
15.	Scott Possley	AVP	Quality
16.	Roberta Horton	AVP	Social work program
17.	Jillian Rose	Director	Social work program
18.	Julio Cabanillas	Senior Director	Education Institute
19.	Pam Villagomez-Sanchez	Manager	Education Institute
20.	Robyn Wiesel	Associate Director	Education Institute
21.	Sandra Goldsmith	AVP	Education Institute

Community Health Needs Assessment (CHNA)
Internal Stakeholders Meeting Summary
August 13, 2019

Attendees:

Names
Leila Pikus
Keith Parmalee
Robin Brendel
Pooja Kapoor
Robyn Wiesel
Sandra Goldsmith
Jillian Rose
Joan Altman
Jack Davis
Roberta Horton
Marcia Ennis
Bella Elogoodin
Denise Miles
David Zeman
Alex Luo
Jessica Kovac
Linda Leff
Patricia Quinlan

Goal: The goal of the meeting was to share the CHNA results and elicit feedback from members of the HSS community who were involved with developing the CHNA.

CHNA Results

- CHNA results were presented at the meeting and were receive positively
- Attendees were interested in learning more about results for specific populations, including respondents who:
    - Receive care at HSS regional sites
    - Report having mental health issues
    - Report that education will help with managing their chronic illness
- Comments and questions were also made about current educational programming, specifically:
    - Lack of awareness about educational programs among HSS physicians
    - Expansion and marketing of digital programs
    - Affordability of HSS programs for low-income patients
    - Understanding needs of existing patients before expanding current programs

Appendix F. Minutes of community partners meeting, and prioritization of health needs

Community Health Needs Assessment (CHNA)
Community Partners Meeting Summary
June 19, 2019

Attendees:

Goal: The goal of the meeting was to share the CHNA results, elicit feedback and prioritize health needs.

Names	Organization
Adena Batterman	HSS
Alexandra Jurenko	
Ambar Tavera	
Eliza Ngan-Ditten	
Jack Davis	
Joan Westreich	
Juliette Kleinman	
Pamela Sanchez-Villagomez	
Priscilla Toral	
Roberta Horton	
Robyn Wiesel	
Sandra Goldsmith	
Amy Shah	New York City Department of Health and Mental Hygiene
Kenny Kwok	Touro College Graduate School of Social Work
Teresa Lin	Visiting Nurse Service of New York
Jeff Zhu	Weill Cornell Medicine Clinical and Translational Science Center

CHNA Results

- CHNA results were presented at the meeting and were receive positively
- Discussions largely focused around the sociodemographic disparities of the results, with breakdowns looking at the ambulatory care center sub-group, regional sub-group, public/uninsured subgroup, and medically underserved area sub-group
- Additional comments centered around areas with potential for growth, such as awareness of medical resources at complementary treatments
- Community partners extensively commented on whether the data fully represents the population served
    - Specifically, there were discussion around the large proportion of CHNA respondents who reported a high annual income
- Feedback highlighted requests to place an additional focus on the CHNA data collection methods

Ranking Results

- Community partners ranked health issues according to the communities they serve, and the top five health priorities identified were:
    1. Stress and mental health
    2. Osteoarthritis
    3. Lack of health education
    4. Fatigue
    5. Joint, muscle, or bone pain
    6. Rheumatoid arthritis
    7. Complementary alternatives to manage pain
    8. Falls and balance
    9. Lifestyle
    10. Osteoporosis

Appendix G. Summary report of community forums and prioritization of health needs

2019 HSS CHNA Community Forum Report

Goal: To share the Community Health Needs Assessment (CHNA) results and provide the opportunity for community members to prioritize their health needs.

Method: Eight community forums were hosted in the following locations below:

Table 1: Community forum details

Date	Location	Number of People Present
June 12, 2019	Stamford Senior Center Stamford, CT	40
June 13, 2019	Building One Community Center Stamford, CT	15
June 13, 2019	Hospital for Special Surgery	14
June 14, 2019	Webinar	2
June 17, 2019	Chinatown Community Center, Visiting Nurse Service of New York Manhattan, NY	53
June 19, 2019	Community Partners Meeting, Hospital for Special Surgery	23
June 20, 2019	Selfhelp Innovative Senior Center, Selfhelp Community Services Flushing, NY	22
June 26, 2019	Leonard Covello Senior Center, Carter Burden Network Manhattan, NY	21
Total		179

A total of 190 community members participated in the community forums. At each community forums, participants were asked to rank five health indicators, from a list of 25, identified in the CHNA according to order of importance (where 1 ranks the highest). Ranking results were calculated using a simple point system in which each ranking is assigned a point value from 1-5, with the indicator ranked 1 receiving 5 points and the indicator ranked 5 receiving 1 point. The indicators that received the most collective points were identified as the top priorities for the participants at the respective event. Surveys were administered on paper and electronically via an URL link.

Results: Community members were asked to rank the health needs most important to them and give their perspective on community health issues in an open discussion. Top five health needs varied across locations as seen in **Table 2** below.

Table 2. Health needs ranking

Rank	Overall (n= 131)	Stamford Senior Center (n-29)	Building One Community Center (n=12)	HSS (n= 13)	Webinar (n= 2)	Chinatown Community Center (n= 40)	Selfhelp Innovative Senior Center (n= 18)	Leonard Covello Senior Center (n= 17)
1	Osteoporosis	Joints, muscle, or bone pains	Rheumatoid arthritis	Osteoporosis	Complementary alternatives to manage pain	Osteoporosis	Osteoarthritis	Fatigue
2	Osteoarthritis	Osteoporosis	Joints, muscle, or bone pains (tied)	Osteoarthritis	Stiffness	Osteoarthritis	Osteoporosis	Stress and mental health
3	Joints, muscle, or bone pains	Falls and balance	Lack of health education (tied)	Fatigue	Osteoarthritis	Falls and balance	Rheumatoid arthritis	Gout
4	Falls and balance	Stress and mental health	Osteoarthritis	Stiffness	Stress and mental health	Joints, muscle, or bone pains	Joints, muscle, or bone pains	Stiffness
5	Rheumatoid arthritis	Lifestyle	Stress and mental health	Joints, muscle, or bone pains	Lifestyle	Rheumatoid arthritis	Falls and balance	Osteoporosis (tied)
6	Stress and mental health	Rheumatoid arthritis	Complementary alternatives to manage pain	Falls and balance	Joints, muscle, or bone pains	Gout	Gout	Osteoarthritis (tied)
7	Fatigue	Osteoarthritis	Lifestyle	Stress and mental health	Falls and balance	Lifestyle	Stiffness	Other forms of arthritis (tied)
8	Lifestyle i.e. Poor diet, obesity, lack of exercise	Lack of health education	Osteoporosis	Rheumatoid arthritis	Rheumatoid arthritis (tied)	Stress and mental health	Lifestyle	Falls and balance
9	Lack of health education	Complementary alternatives to manage pain	Fatigue	Complementary alternatives to manage pain	Osteoporosis, Fatigue (tied)	Fatigue	Fatigue	Joints, muscle, or bone pains
10	Stiffness	Fatigue	Falls and balance	Lifestyle	Gout, Lack of health education (tied)	Stiffness	Lack of health education	Lifestyle

Health Concerns

HSS engaged community members to discuss health issues and concerns in their local community. Although health needs differed across each location, one consistent theme across all community forums was the need for additional educational programs to help prevent and manage muscle, bone and joint health conditions. See below for health needs identified in each community forum:

- **Stamford Senior Center:** Community members expressed that language is a barrier when seeing a provider. Diet, falls prevention, mental health and bone health were indicated as important health issues.
- **Building One Community Center:** Community members requested information regarding access to the regional clinic.
- **HSS**: Community members considered treatment side effects and physician trust to be a barrier towards adherence to medical care. They also expressed interest in more advanced health education programming.
- **Chinatown Community Center, VNSNY**: Community members reported that they did not use complementary therapies for managing pain due to lack of knowledge but did express interest in receiving education around these therapies. With health education, community members indicated lectures, as the preferred education activity.
- **Selfhelp Innovative Senior Center**: Community members expressed that patient/provider communication was not an issue with primary care physicians with whom they have an established relationship, but more of an issue with specialists.
- **Leonard Covello Senior Center**: Community members indicated that osteoarthritis, falls prevention, and exercise are important health issues. Specifically, there was interest in learning how to exercise safely.

Demographic information (n=134)

- Nearly three-quarters (74.8%) of participants filled out an evaluation after participating in the community forum. As seen below, majority of community members were female (82.7%), aged 70-79 (45.9%), Non-Hispanic/Latino (61.7%) and Asians (55.9%).

Figure 1. Gender

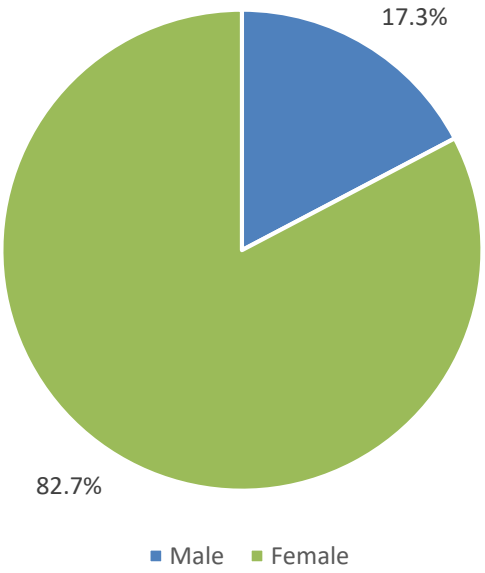


Figure 2. Age

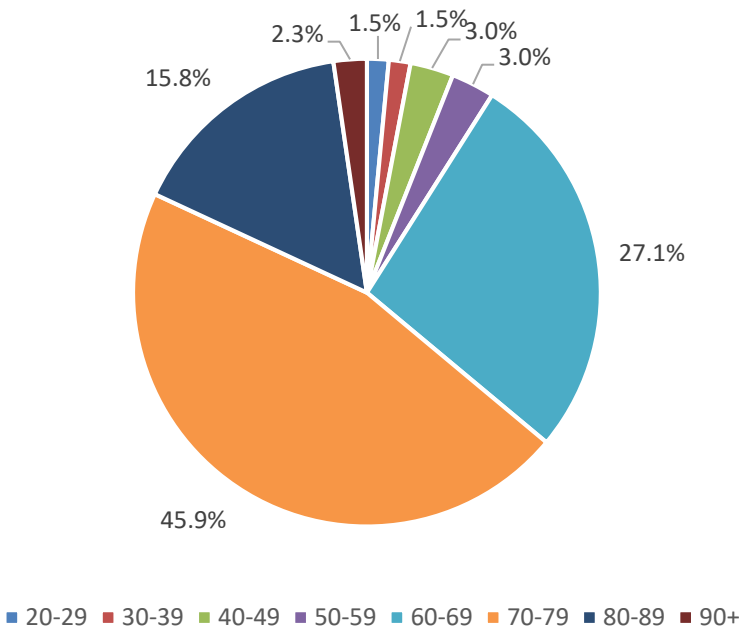


Figure 3. Ethnicity

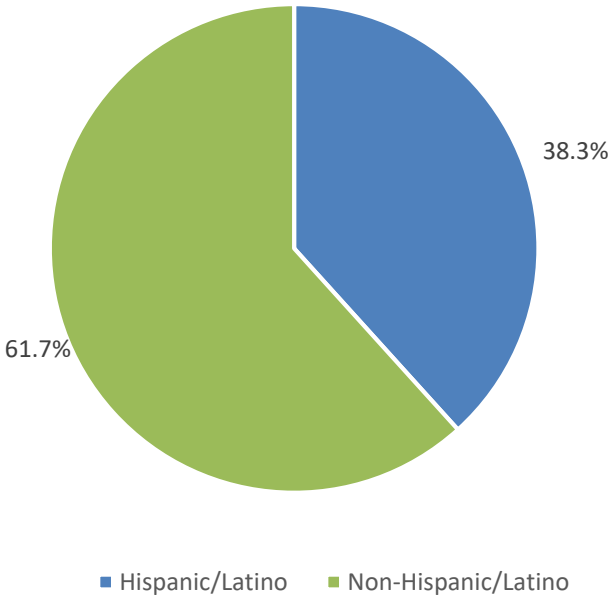
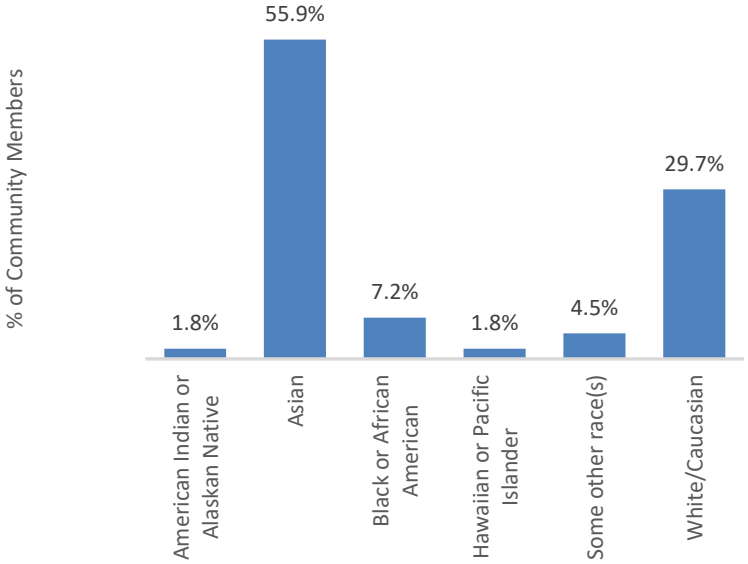


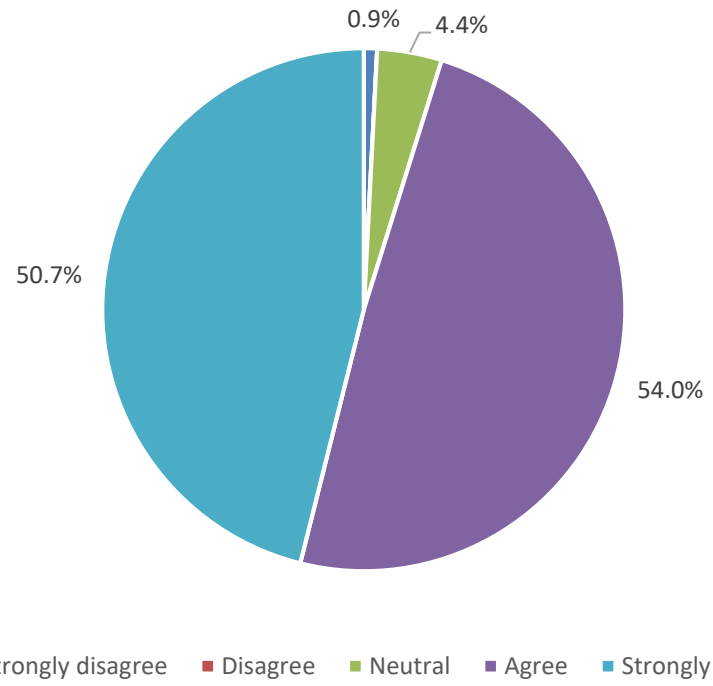
Figure 4. Race



Satisfaction (n=124)

- The community forums were well received by participants as 94.7% strongly agree/agree that they were satisfied with the forum.

Figure 5. Overall, I was satisfied with this program



- When asked about the most valuable component of the forum, major themes included the information/results, and the discussion component/audience interaction.
- When asked about how to improve the forum, common responses included having more forums/programs, offering more time for the audience to participate, and a greater focus on nutrition and mental health.

Appendix H. Minutes of HSS Community Benefit and Services Committee Meeting

Community Benefit & Services Committee Minutes
November 20, 2019
12:30 pm – 2:00 pm
Board Room, 8th Floor

Present: Anne Ehrenkranz; Laura Robbins; Elizabeth Pforzheimer; Sandra Goldsmith; Linda Russell, MD; Marc Gould; Deborah Sale; Irene Koch; Paula Root; Robyn Wiesel; Titilayo Ologhobo; Lise Scott; Jane Salmon, MD; Laurie Hodges Lapeyre; Lara Lerner; John B. Ehrenkranz; Nimali Jayasinghe; Kathy Leventhal; Paula Root

Unable to Attend: Jonathan Sobel; Betsy Gotbaum; Vivian Torres-Suarez; Doug Mintz, MD; Jennie DeScherer

Anne Ehrenkranz called the meeting to order. Minutes from the June meeting were accepted.

Titi Ologhobo presented a comprehensive review of the 2019 HSS Community Health Needs Assessment (CHNA) results and the Community Service Plan (CSP). The CHNA surveys the community about: quality of life, health behavior & styles, health education, socio-demographics and access to healthcare. Over 11,400 respondents indicated their top priorities are OA, Other forms of arthritis, and osteoporosis. The Community Service Plan includes 10 programs: SNEAKER, Asian Bone Community Health Initiative, Musculoskeletal Health Initiative, Pain and Stress Management Program, Leon Root, MD Pediatric Outreach Program (POP), Charla de Lupus, Lupus Asian Network (LANtern), Inflammatory Arthritis Support and Education Program, Voices 60+ Senior Advocacy Program, Nursing Community Education Outreach Program.

The committee unanimously approved and adopted both the Community Health Needs Assessment and the Community Service Plan.

Linda Russell, MD, announced that she is implementing an HSS Smoking Cessation program with NYC to launch January 1, 2020. The goal is to assist patients smoking cessation prior to surgery.

Jane Salmon, MD, led a discussion about this year's Community Service Award process which honored Dr. Swetha Pakala for her work with the Global Health Initiative, held at the home of Joel and Anne Ehrenkranz on Tuesday, September 24th. The event was very well received. It was decided that we will move forward with accepting applications for a 2020 honoree beginning Q1 2020. The award reception will be held September/October 2020. Final date to be determined.

Marc Gould presented the most recent HSS Community Benefit financials which includes HSS charitable care, 990 submissions, HSS financial aid policy and unreimbursed Medicaid numbers. HSS annual Community Benefit expenditures are at 3.07%

Sandra Goldsmith's presentation about Channel Partnerships will be held until the next meeting March 2020.

No further discussion.

Robyn Wiesel
Associate Director, Public and Patient Education