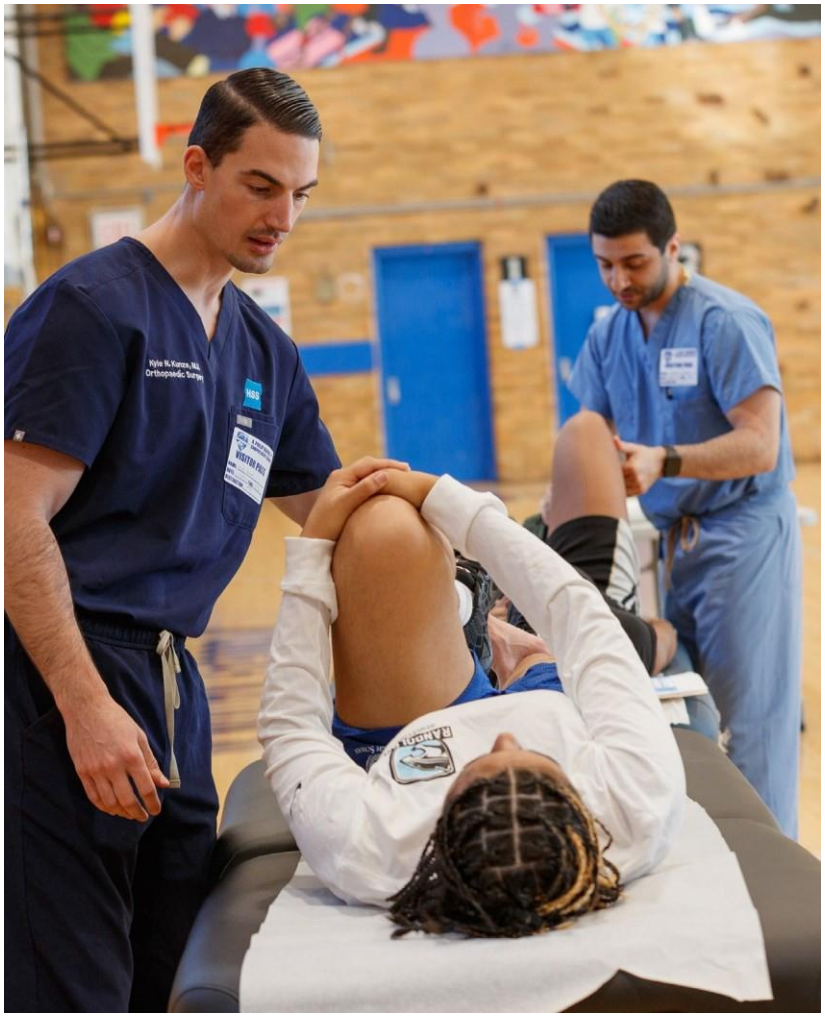
2025 – 2027

HSS Community Service Plan

Advancing the State's Public Health Priorities



Service Areas:
HSS' primary service area consists of the five boroughs of New York City (NYC) - Manhattan, Bronx, Brooklyn, Queens, and Staten Island; while its secondary service area is comprised of suburban areas in the Hudson Valley, New York; Northern and Central New Jersey; Connecticut; Long Island, New York; and Palm Beach and Collier Counties in Florida. 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.

Type of Plan:
Individual Plan

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Executive Summary

A. Prevention Agenda Priorities

Hospital for Special Surgery (HSS) has been a recognized leader in musculoskeletal medicine for more than a century. We have established an ongoing commitment to both physical and general wellness, patient care, research, professional education, and community programming. As such, HSS conducted a Community Health Needs Assessment (CHNA) in 2025 to identify significant musculoskeletal health concerns of residents in its primary and secondary service areas. The needs identified informed the Hospital's 2025 – 2027 Community Service Plan (CSP), a three-year implementation strategy that supports the New York State (NYS) Prevention Agenda 2025-2030 and satisfies the US Internal Revenue Service and the Affordable Care Act requirements for nonprofit hospitals. HSS's three-year community service plan will focus on three domains**: *Social and Community Context, Neighborhood and Built Environment, and Education Access and Quality***. It will concentrate on musculoskeletal and rheumatologic conditions, our areas of expertise. To further advance the NYS Health Improvement Plan and align with the state's priority areas, the strategies in the CSP report will specifically address:

- Anxiety and Stress
- Opportunities for Active Transportation and Physical Activity
- Opportunities for Continued Education

B. Data Review

In selecting our existing priorities, HSS reviewed national, state, and local data along with results from our community health needs assessment (CHNA). An in-depth review of public health data provided a broad array of health information that served as a framework for selecting the Hospital's existing focus areas and public health priorities. Specific data sources reviewed include:

- US Census Bureau
- New York City Department of Aging
- New York City Department of City Planning
- Centers for Disease Control and Prevention (CDC)
- World Population Review
- Health Resources and Services Administration (HRSA)
- Bureau of Labor Statistics (BLS)
- National Council on Aging
- New York City Department of Health and Mental Hygiene (NYC DOHMH)
- New York City Department of Homeless Services
- Florida Department of Health (FL DOH) – Palm Beach County CHIP
- NYC Community Health Survey
- Suffolk County Health Status Report
- NYC Department of Transportation – *Cycling Trends Report*
- American Health Ranking
- New York State Department of Health
- New York City Mayor's Office
- Healthy People 2030
- Neighborhood Health Atlas
- County Health Rankings & Roadmaps
- United Health Foundation
- Arthritis Foundation
- Feeding America – *Map the Meal Gap*
- USDA Economic Research Service – *Food Access Research Atlas*
- City Health Dashboard
- Connecticut Department of Public Health (CT DPH)
- New Jersey Department of Health (NJDOH)

C. Partners and Roles

Collaboration with the public, community partners, and internal stakeholders was central to the success of our approach in assessing community health needs, selecting public health priorities, and identifying education, outreach, and support initiatives. During the assessment and implementation process, HSS partnered with 24 community-based organizations (CBOs), city and state agencies, and universities with expertise in public health and deep knowledge of community needs. Representatives from these organizations contributed to survey development, including the use of validated measures, ensuring cultural relevance and health literacy. Community partners also reviewed CHNA findings and helped prioritize health needs, which was critical to driving the selection of our public health priorities. See the full CSP report for a complete list of community partners that were involved in this process.

D. Interventions and Strategies

HSS recognizes that public participation is vital to shaping and guiding community initiatives. Engagement began with soliciting public input on CHNA survey design, readability, and translations into Spanish, Chinese, Haitian Creole, and Russian to ensure cultural and linguistic accessibility. The Hospital further expanded outreach through a digital campaign and six multilingual community forums conducted in English, Spanish, and Chinese, engaging more than 1,300 participants across diverse stakeholder groups. During these forums, participants prioritized health needs using importance-based scoring and the Hanlon method, providing insights that directly informed CSP priorities and program design. HSS will continue to foster collaboration through ongoing social media and email engagement, as well as interactive data dashboards that share the impact of CSP programs with the community.
Drawing on this collaborative process, HSS integrated insights from staff, community partners, and the public to identify and implement evidence-based strategies and models that address the evolving healthcare needs of a diverse and aging community. These initiatives include:

1. **Aging with Dignity:** A psychosocial, peer-based support group utilizing group cognitive behavioral therapy (CBT) and creative arts interventions to reduce social isolation, stress, and anxiety, and improve coping skills among older adults.

2. **Asian Community Bone Health Initiative:** A community-based program offering self-management education (SME) workshops and a modified Arthritis Foundation Exercise Program, a low-impact chair-based exercise to help Asian older adults manage chronic musculoskeletal conditions and improve access to services.

3. **Healthcare Immersion Experience:** An evidence-based pipeline program engaging historically marginalized students in musculoskeletal medicine through immersive learning, mentorship, and hands-on clinical experiences to promote diversity in healthcare.

4. **Musculoskeletal Health Wellness Initiative:** Evidence-based self-management education and exercise programs such as Tai Chi to build knowledge, skills, and confidence in managing chronic musculoskeletal conditions.

5. **Rheumatology Wellness Initiative:** Community-based and patient-centered psychoeducational programs focused on rheumatoid arthritis and lupus, designed to enhance mental and emotional well-being by reducing stress and anxiety among culturally diverse communities.

To ensure HSS community health programs effectively address the needs of its diverse populations and achieve goals within each priority area, HSS systematically collects process and outcome measures to evaluate program reach, quality, and impact.

E. Progress and Evaluation

Progress and improvement will be measured through clearly defined process and outcome measures designed to evaluate program implementation, effectiveness, and overall community impact.

Priority: Anxiety & Stress
Increase the proportion of people living in New York who show resilience to challenges and stress.

- **Process Measures**
  - Number of programs conducted and at-risk populations reached
  - Percent of participants who were satisfied with the program and would recommend the program to others
- **Outcomes Measures (Short/Intermediate)**
  - Increased self-management skills learned
  - Increased knowledge or understanding of ways to decrease stress and anxiety
  - Improved physical and mental health
  - Increased access to psychosocial support and education programs among at-risk and vulnerable community members
  - Decreased report of feelings of social isolation/loneliness
  - Increased access to culturally tailored programs aimed at improving coping strategies and emotional support

Priority: Opportunities for Active Transportation and Physical Activity
Improve safe, affordable, and accessible active transportation, physical, and social activity.

- **Process Measures**
  - Number of programs conducted, and at-risk populations reached
  - Number of new partnerships developed with community-based organizations
  - Percent of participants who were satisfied with the program and would recommend the program to others
- **Outcome Measures (Short-Term / Intermediate)**
  - Increased self-management skills learned to manage pain, stress, and chronic conditions, including musculoskeletal disorders
  - Increased knowledge gained
  - Improved physical health and function scores, as well as mental health
  - Improved musculoskeletal health outcomes by decreasing musculoskeletal pain, stiffness, fatigue, and falls, and increasing the frequency of physical activity and self-efficacy
  - Increased confidence in managing chronic musculoskeletal conditions
  - Increased access among racially/ethnically diverse and underserved community members to musculoskeletal health programs

Priority: Opportunities for Continued Education
Enhance continued education to expand personal and professional development opportunities.

- **Process Measures**
  - Number of programs conducted and at-risk populations reached
  - Number of new partnerships developed with community-based organizations
  - Percent of participants who were satisfied with the program and would recommend the program to others

- **Outcome Measures (Short-Term / Intermediate)**
  - Increased knowledge gained in musculoskeletal medicine and careers
  - Increased feelings of belonging in medical spaces
  - Increased interest in pursuing a career in healthcare

Community Health Assessment

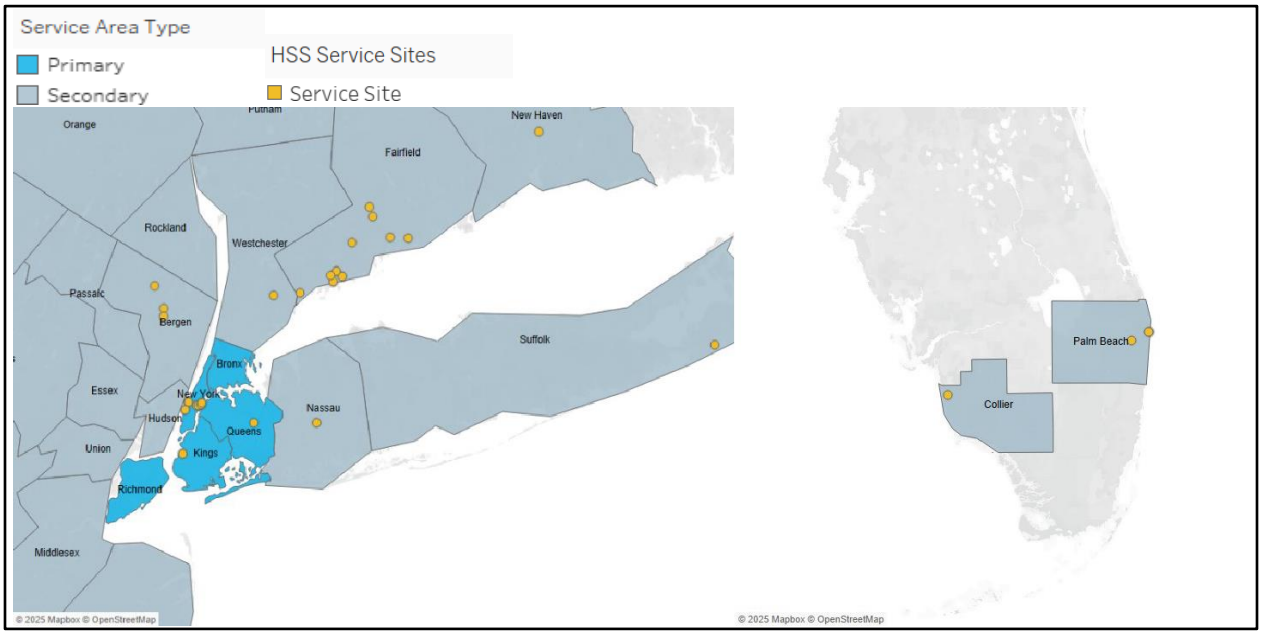
1. Community Description

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 interventions that improve the quality of life of patients and the public.

A. Service Areas

HSS's primary service area consists of the five New York City (NYC) boroughs—Manhattan, Bronx, Brooklyn, Queens, and Staten Island—as depicted in light blue. Its secondary service area comprises suburban areas in the Hudson Valley, New York; Northern and Central New Jersey; Connecticut; Long Island, New York; and Palm Beach and Collier Counties in Florida, as depicted in grey. The yellow dots represent individual HSS site locations across all service areas (Figure 2).

Figure 2. HSS Primary and Secondary Service Areas



Source: Hospital for Special Surgery (HSS) Education Institute

HSS operates 26 locations across Manhattan, Brooklyn, Queens, Long Island, Westchester, New Jersey, Connecticut, and Florida; 19 HSS Rehabilitation locations across Manhattan, Brooklyn, Westchester, New Jersey, Connecticut, and Florida; and 3 Ambulatory Care Centers across NYC (Adult Orthopedic and Specialty Care; Adult Rheumatology Care; and Pediatric Orthopedic, Rheumatology, and Specialty Care). However, given its specialized focus on musculoskeletal and rheumatologic care, the Hospital's impact extends beyond its immediate service area to communities worldwide, treating patients from over 96 countries.

B. Demographics of the Community

According to 2020 U.S. census data, the NYC community comprises an estimated 8,804,190 people.[1] Key demographic characteristics of the community are listed below:

- *Race/ethnicity:* In 2020, 41% of NYC residents identified as White, 29% identified as Hispanic or Latino, 24% identified as Black or African American, and 14% identified as Asian.[1]
- *Immigrant population:* Between 2016 and 2020, over one-third (36%) of the city's population was foreign-born.[1]
- *Age:* Over one-fifth (21%) of the population is under 18, and nearly 15% of the population is 65 or older.[1]
- *Sex:* 52% of NYC residents are female.[1]
- *Sexual Orientation:* In the New York metropolitan area (New York-Newark-Jersey City), 706,000 adults (18+) identify as LGBT, which is the highest number in any metropolitan area.[1]

Race/Ethnicity

HSS is dedicated to improving the health of all communities.

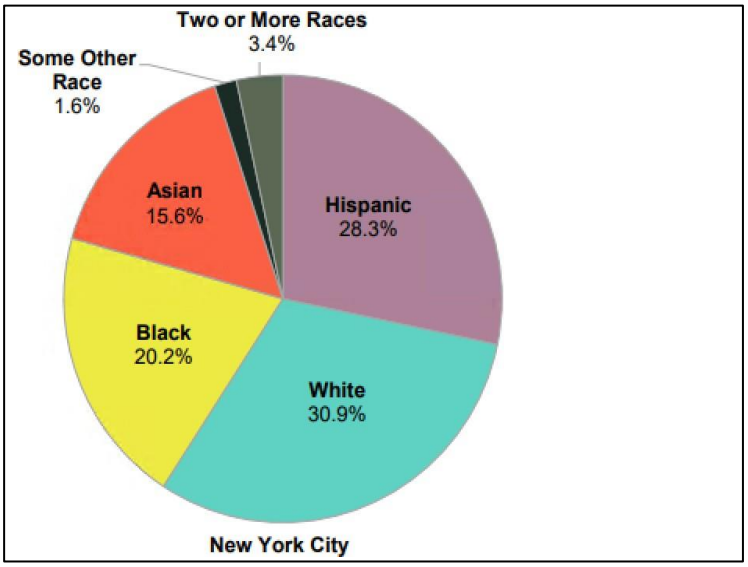
New York City's racial and ethnic composition illustrates the diversity of the population HSS serves: 30.9% of residents identify as White, 28.3% as Hispanic, 20.2% as Black, 15.6% as Asian, and smaller proportions identify as Two or More Races (3.4%), Some Other Race (1.6%) (see Figure 3 below).[9] For this reason, HSS strongly focuses on advancing health equity in the communities it serves.
Health disparities affecting communities in HSS service areas are highlighted below:

- Premature deaths: According to the New York State Department of Health 2020-2022 data, among deaths recorded for New York City residents, the proportion classified as premature deaths (under age 75) remains highest among non-Hispanic Black NYC residents (57.1%), followed by Hispanic (52.9%), Asian/Pacific Islander (41.8%), and White residents (33.6%)[2]
- Osteoporosis: According to the National Council on Aging, Black women with postmenopausal osteoporosis are more likely to remain undiagnosed, experience worse health outcomes after sustaining hip and other types of fractures and are less likely to receive treatment.[3]
- Arthritis: In the state of New York, American Indian or Alaska Native residents had the highest prevalence of arthritis (30.9%) of any racial or ethnic group in 2023, followed by White (27.6%), Other Race (26%), Multiracial (25.9%), Black (21.2%), Hispanic (18.1%), and Asian (11.7%) residents.[4]
- Poverty: According to NYCgov, Black residents experience higher rates of poverty (16.5%), followed by Hispanic residents (15.8%), Asian residents (14.6%), and White residents (8.8%).[5]

[1] U.S. Census Bureau. (n.d.). *New York City, New York*. data.census.gov. Retrieved April 16, 2025, from https://data.census.gov/profile/New_York_city,_New_York?g=160XX00US3651000
[2] New York State Department of Health. (n.d.). New York City: County Health Assessment Indicators. Retrieved April 16, 2025, from https://www.health.ny.gov/community/health_equity/reports/county/newyorkcity.htm
[3] National Council on Aging. (2024, January 10). *Osteoporosis: The risk factors for Black women*. https://www.ncoa.org/article/osteoporosis-the-risk-factors-for-black-women/
[4] United Health Foundation. (2025). *Arthritis in New York*. America's Health Rankings. Retrieved April 16, 2025, from https://www.americashealthrankings.org/explore/measures/Arthritis/NY
[5] Mayor's Office for Economic Opportunity. (2024, May). *New York City Government Poverty Measure 2021*. The City of New York.

https://www.nyc.gov/assets/opportunity/pdf/Poverty-2021.pdf

Figure 3. Population of New York City by Race/Hispanic Origin, 2020



Source: The City of New York, Department of City Planning (DCP), 2020 Census Briefing Booklet: Percentage of Population by Race/Hispanic Origin New York City, 2020, p. 24.[6]

Age

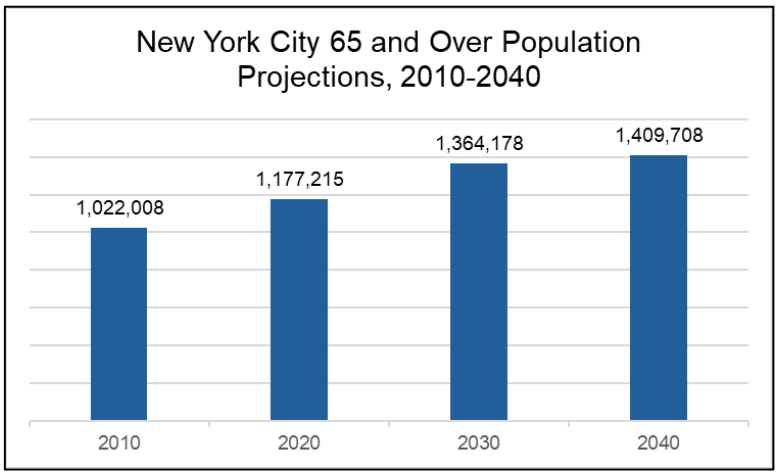
The older adult population continues to grow, with the New York City Department for the Aging projecting that by 2040, approximately 20.6% of NYC residents will be ages 60 and older, up from 17.2% in 2010[7]. As seen in Figure 4 below, the population of older adult residents (ages 65 and older) has been projected by the Department of City Planning to increase significantly from 1.0 million in 2010 to 1.4 million in 2040, based on 2010 estimates.[7] This has important implications for the health needs of an aging population in NYC, as older adults face unique health disparities:

- In 2021, 21.7% of older New Yorkers reported serious difficulty walking or climbing stairs, and 8.9% had limitations in basic self-care activities like dressing and bathing.
- About 29.2% of adults aged 60+ reported having some form of disability, with older women experiencing higher rates (32.1%) compared to men (25.1%).[7]
- Arthritis affects a significant portion of the older population, with approximately 49% of adults aged 65 and older in New York City reporting a diagnosis. This condition contributes to decreased mobility and increased dependency on health services.[7]
- Social isolation also presents a health concern, with 29.4% of adults aged 60+ living alone—rising to 48.0% for those aged 85 and older. Among those living alone, 37.4% live in poverty, further compounding risks related to health and wellness.[7]

[6] New York City Department of City Planning. (2021). Population size and growth [Infographic]. In 2020 Census briefing booklet: Percentage of Population by Race/Hispanic Origin New York City, 2020 (p. 24). https://www.nyc.gov/assets/planning/download/pdf/planning-level/nyc-population/census2020/dcp_2020-census-briefing-booklet-1.pdf

[7] New York City Department for the Aging. (2024, September). *2024 Annual Plan Summary: Covering April 1, 2024 – March 31, 2025.* https://www.nyc.gov/assets/dfta/downloads/pdf/reports/AnnualPlanSummary-2024.pdf

Figure 4. New York City Age 65+ Population Projections, 2010-2040

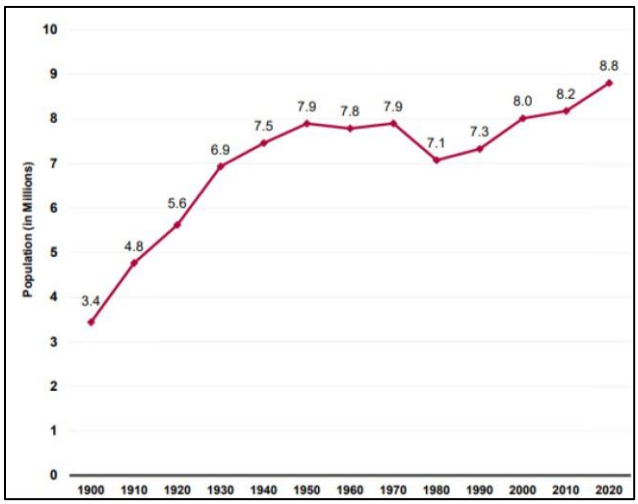


Source: The City of New York, Department of City Planning (DCP) adjusted decennial census data 2010; DCP Population Projections, 2020-2040 [8]

Population Size and Growth

New York City is the largest city in the U.S. Although the rate of population increase has slowed, the city's population has shown signs of recent recovery, with an estimated 8.48 million residents as of July 2024. However, the NYC Department of City Planning projections indicate that the city's overall population will remain relatively stable between 2020 and 2030, slightly decreasing from 8.80 million to 8.76 million. Each of the five boroughs has a different projected population trend: modest growth is expected in the Bronx and Staten Island (around 1%), while slight declines are anticipated in Brooklyn (–0.6%), Manhattan (–1.4%), and Queens (–1.1%).[6]

Figure 5. Population of New York City, 1900 to 2020



[8] The City of New York, Department of City Planning (DCP) adjusted decennial census data 2010; DCP Population Projections, 2020-2040

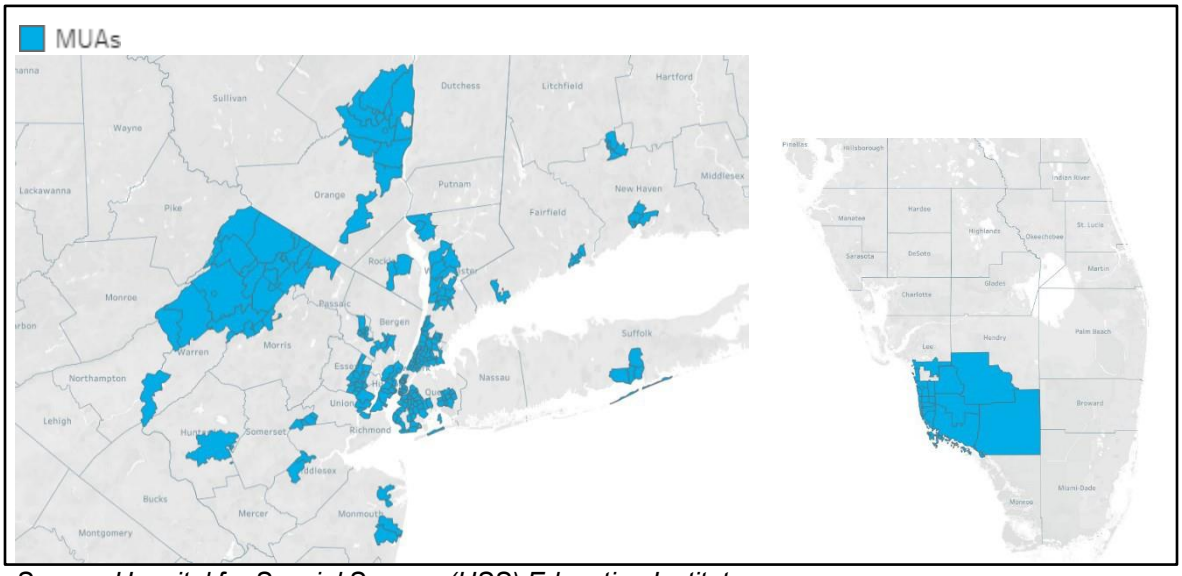
Source: The City of New York, Department of City Planning (DCP), 2020 Census Briefing Booklet: Population of New York City Boroughs, p. 14.[9]

Medically Underserved Areas (MUAs) and Priority Populations

The Health Resources and Services Administration (HRSA) defines medically underserved areas (MUAs) and medically underserved populations (MUPs) as those "with a lack of access to primary care services" and "shortage of primary care health services for a specific population subset within a geographic area."[10] In New York City, Medically Underserved Areas (MUAs) are present in all five boroughs, with the highest number in Brooklyn (Kings County) and the lowest in Staten Island (Richmond County).

Among the two Florida counties served by HSS, a designated MUA is present in Collier County but not in Palm Beach County, as shown in Figure 6 below[8]:

Figure 6. Medically Underserved Areas (MUAs) Within HSS Service Regions



Source: Hospital for Special Surgery (HSS) Education Institute

MUAs may face barriers to care due to several factors that align with the Social Determinants of Health (SDOH). The Department of Health and Human Services formally defines SDOH as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[11] They can be organized into five major categories. These are:

- Economic Stability
- Education Access and Quality
- Healthcare Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

[9] New York City Department of City Planning. (2021). Population size and growth [Infographic]. In 2020 Census briefing booklet: Population of New York City Boroughs (p. 14). https://www.nyc.gov/assets/planning/download/pdf/planning-level/nyc-population/census2020/dcp_2020-census-briefing-booklet-1.pdf

[10] Health Resources and Services Administration. (n.d.). *MUA Find*. U.S. Department of Health and Human Services. Retrieved April 16, 2025, from https://data.hrsa.gov/tools/shortage-area/mua-find

[11] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Social Determinants of Health – Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health

2. Health Status Description

This section provides an overview of lifestyle behaviors and their underlying barriers including physical inactivity, poor nutrition, limited food access, inadequate sleep, and unmet mental health needs across HSS service areas. It examines the population's overall health status and identifies key factors that contribute to current health challenges and disparities. Data are drawn from both primary and secondary sources, collected and analyzed using scientifically grounded methods in collaboration with community partners. Findings are compared across demographic groups and geographic regions to highlight trends, benchmarks, and inequities, providing essential context for understanding community health risks and informing future interventions.

Lifestyle and Behaviors

Barriers to Physical Activity

- In the Bronx, 32.5% of adults reported no leisure-time physical activity (vs. the NYC average of 22.6%). Safety was cited by 27% as a barrier, particularly in the South Bronx and Morrisania neighborhoods.[12]
- In Brooklyn, particularly East New York and Brownsville, 29.8% of adults were physically inactive, with 22% citing unsafe outdoor conditions and 19% reporting poor sidewalk access as reasons.[13]
- Jamaica, Queens had 26.4% inactivity rates, and 1 in 5 residents cited lack of walkable sidewalks or access to nearby parks.[10]
- Only 17.5% of adults in Bergen County, NJ, reported inactivity, one of the lowest rates in the state, but 14% still cited time or infrastructure as barriers.[14]

Nutrition and Healthy Eating Patterns

- In the Bronx, only 7.4% of adults consumed the recommended five daily servings of fruits and vegetables. Barriers included cost (36.2%) and poor availability (18.9%), especially in West Bronx and Mott Haven[10].
- In East Harlem, 28.7% of adults struggled with produce access; 41% cited cost, and 17% cited lack of nearby stores as primary challenges[10].
- South Queens residents consumed an average of 2.7 servings of fruits and vegetables per day, with 33.5% identifying cost as the top barrier.[15]
- On Long Island, 27% of adults in Nassau and Suffolk counties reported low fruit/vegetable intake. In central Suffolk, 38% of low-income residents listed cost as the leading barrier.[16]
- In Palm Beach County, FL, 31% of adults had insufficient produce intake. Cost (36%) and taste preferences (28%) were the top reported barriers.[17]
- Bergen County, NJ, fared better nutritionally, but 22.3% of adults still failed to meet dietary guidelines, with 18% reporting difficulty finding culturally appropriate or appealing healthy options.[18]

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[12] NYC Health + Hospitals. (2022). *Community Health Needs Assessment*. Retrieved from https://hhinternet.blob.core.windows.net/uploads/2022/07/community-health-needs-asssessment-2022.pdf
[13] New York City Department of Health and Mental Hygiene. (n.d.). *Active Design – Environment & Health Data Portal*. Retrieved April 16, 2025, from https://a816-dohbesp.nyc.gov/IndicatorPublic/data-explorer/active-design/?id=2388#display=summary
[14] New Jersey Department of Health. (n.d.). *Environment – New Jersey State Health Assessment Data (NJSHAD)*. Retrieved April 16, 2025, from https://www-doh.nj.gov/doh-shad/topic/Environment.html
[15] Department of Population Health, NYU Langone Health. (n.d.). *City Health Dashboard*. Retrieved April 16, 2025, from https://www.cityhealthdashboard.com/
[16] Suffolk County Department of Health Services. (2022). *Community Health Assessment and Improvement Plan 2022–2024*. Retrieved from https://www.suffolkcountyny.gov/Portals/0/DocumentsForms/HealthServices/Community%20Health%20Assessment/Suffolk%20County%20CHA_CHIP%202022-24.pdf
[17] Florida Department of Health in Palm Beach County. (n.d.). *Palm Beach County Community Health Improvement Plan 2022–2027*. Retrieved April 16, 2025, from https://palmbeach.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/community-health-improvement.html
[18] New Jersey Department of Health. (2025, January 23). *Hunger, food security, and maternal health: An interactive report.* https://www.nj.gov/health/news/2025/approved/20250123a.shtml

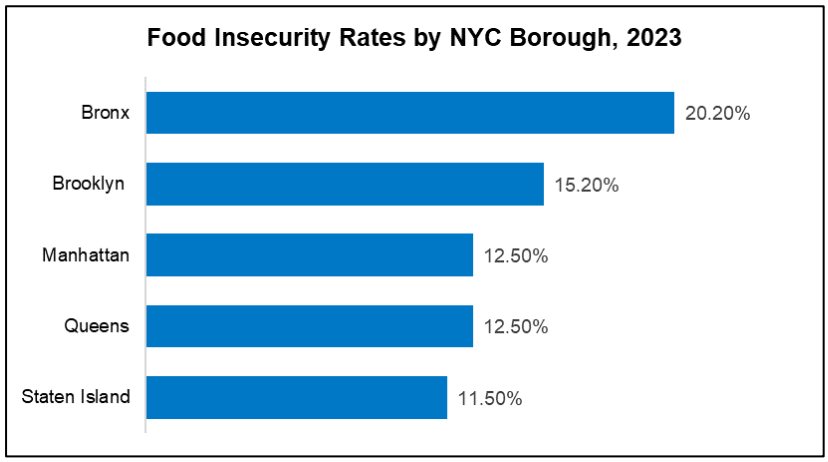
Unhealthy Food Access & Fast-Food Density

- From 2018 to 2023, fast-food outlets increased by 14% in Brooklyn, 13% in Queens, and 11% in the Bronx, particularly in neighborhoods with high poverty rates.[10]
- Food insecurity affected 20.2% of households in the Bronx, 16.3% in Brooklyn, and 13.4% in Palm Beach County.
- Adult obesity rates were 32.6% in the Bronx, 29.3% in Brooklyn, 27.5% in Queens, and 30.1% in Palm Beach County—all above national targets[10,12].

Food Affordability and Security

- Food insecurity affected 20.2% of households in the Bronx, 16.3% in Brooklyn, 13.4% in Palm Beach County, 11.1% in Florida overall, 10.5% in New York, 8.7% in Connecticut, and 7.8% in New Jersey.[19]
- Among food-insecure households, children faced a disproportionately higher risk: 1 in 5 children in Palm Beach County and over 1 in 4 in the Bronx were food insecure.[17]
- As of late 2023, the average cost per serving of fresh produce (e.g., fruits and vegetables) was $1.89, compared to $1.11 for typical fast-food items—a 70% affordability gap.[20]
- The United States Department of Agriculture (USDA) reports that in low-income zip codes, nearly 38% of households cite affordability as the primary barrier to purchasing healthy food, with transportation and store proximity as additional challenges.[21]
- In 2023, food insecurity affected 20.2% of residents in the Bronx, 15.2 percent in Brooklyn, 12.5% in both Queens and Manhattan, and 11.5% in Staten Island. This highlights significant disparities across New York City's boroughs, as seen in Figure 7 below.[22]

Figure 7. Food Insecurity Rates by NYC Borough



Source: NYC Mayor's Office of Food Policy. (2024). NYC Food by the Numbers: 2024 Food Metrics Report.

[19] Gundersen, C., Strayer, M., Dewey, A., Hake, M., & Engelhard, E. (2023). *Map the Meal Gap 2023: A Report on County and Congressional District Food Insecurity and County Food Cost in the United States in 2021*. Feeding America. https://www.feedingamerica.org/sites/default/files/2023-05/Map%20the%20Meal%20Gap%202023.pdf
[20] U.S. Bureau of Labor Statistics. (2024, May). *A year in review: Exploring consumer price trends in 2023*. Beyond the Numbers, 13(4). https://www.bls.gov/opub/btn/volume-13/a-year-in-review-exploring-consumer-price-trends-in-2023.htm
[21] U.S. Department of Agriculture, Economic Research Service. (n.d.). *Food Access Research Atlas*. Retrieved April 16, 2025, from https://www.ers.usda.gov/data-products/food-access-research-atlas/
[22] NYC Mayor's Office of Food Policy. (2024). *NYC Food by the Numbers: 2024 Food Metrics Report*. https://www.nyc.gov/assets/foodpolicy/downloads/pdf/NYC-Food-by-the-Numbers-2024.pdf

Sleep Habits

- In NYC, 38.4% of adults sleep fewer than seven hours per night. Sleep deprivation is linked to increased rates of obesity, diabetes, and depression.[23]
- Instances of sleep deprivation were highest in the Bronx and Brooklyn, where housing instability, shift work, and chronic stress contributed to sleep deficits.[10]
- In suburban areas like the Hudson Valley and CT, sleep issues were often linked to long commutes and economic stress.[16]
- In Palm Beach County, sleep insufficiency correlated with higher rates of hypertension and cardiovascular illness, particularly among older adults.[14]

Mental Health & Well-Being

- In NYC, 34% of adults with diagnosed mental health conditions reported unmet treatment needs; rates were highest among Asian communities.[10]
- New York ranks 1st and New Jersey 2nd in overall access to mental health care; Florida ranks 18th.[24]
- In Palm Beach County, 22.3% of adults reported symptoms of depression, but only 59% received adequate mental health care.[14]
- Across service areas, barriers include provider shortages, stigma, language access, and insurance limitations, especially in low-income and immigrant communities.[21]

F. Data Sources

Secondary data collection and analysis were conducted using local, state, and federal data and surveillance systems to provide existing insight and knowledge on a broad range of health issues in our community. Data collected includes socio-demographic data, socioeconomic status, medically underserved areas and priority populations in NY, social determinants of health, and health outcomes.

Sources of data include:

- U.S. Census Bureau
- New York City Department of Aging
- New York City Department of City Planning
- Centers for Disease Control and Prevention (CDC)
- World Population Review
- Health Resources and Services Administration (HRSA)
- Bureau of Labor Statistics (BLS)
- National Council on Aging
- New York City Department of Health and Mental Hygiene (NYC DOHMH)
- New York City Department of Homeless Services
- New York State Department of Health
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- Healthy People 2030
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- City Health Dashboard
- Connecticut Department of Public Health (CT DPH)
- New Jersey Department of Health (NJDOH)
- Florida Department of Health (FL DOH) – Palm Beach County CHIP
- NYC Community Health Survey
- Suffolk County Health Status Report
- NYC Department of Transportation – *Cycling Trends Report*
- American Health Ranking

[23] United Health Foundation. (2023). *America's Health Rankings: Annual Report 2023*. https://www.americashealthrankings.org/reports/annual/2023

[24] Reinert, M., Fritze, D., & Nguyen, T. (October 2022). *The State of Mental Health in America 2023*. Mental Health America. https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf

G. Data Collection Methods

An anonymous, large-scale community survey was conducted between January 15, 2025, and February 15, 2025, to determine our community's health care, education, and support needs regarding muscle, bone, and joint health. The survey assessed five main areas namely:

- Socio-demographic characteristics
- Health status and quality of life
- Health behavior and lifestyle
- Use of and access to care
- Health education

The 41-question survey was developed through the collective efforts of an eight-member HSS CHNA steering committee, internal stakeholders, community partners, and the public. Collaboration with these groups was crucial to the success of this survey, with valuable feedback provided on survey construction and length. To reach the diverse patient populations we serve, the survey was translated into Spanish, Chinese, Russian and Haitian Creole using a culturally sensitive back translation approach by certified translators. HSS utilized Alchemer, a web-based survey platform for the development and distribution of the electronic format of the survey. The survey included validated measures from several national and state health questionnaires such as:

- RAND 36-Item Short Form Survey (SF-36)
- AARP Telehealth Survey
- Behavioral Risk Factor Surveillance System (BRFSS) - Centers for Disease Control & Prevention
- Discrimination in Medical Settings (DMS) Scale
- Medicare Beneficiary Survey (MCBS)
- National Health Interview Survey (NHIS) - Centers for Disease Control & Prevention
- Patient-Reported Outcomes Measurement Information System (PROMIS)
- Self-Efficacy for Managing Chronic Disease 6-item Scale
- Single-Item Literacy Screener (SILS)
- Single-Item Sleep Quality Scale
- UCLA 3-Item Loneliness Scale

See **Appendix A** for sample CHNA surveys in English, Spanish, Chinese, Russian, and Haitian Creole.

Before survey implementation, HSS piloted the survey with community members to garner feedback and ensure survey items were relevant and easily understood. HSS also facilitated feedback from internal key stakeholders and community partners throughout the process of developing the survey. More details on how we engaged and obtained community input from various constituents are provided in the Community Input section of this report.

Recruitment and Sampling

A convenience sampling strategy was used to recruit individuals ≥ 18 years living within HSS' primary and secondary service areas to complete the community survey. An oversampling approach was used to engage hard-to-reach and medically underserved populations while ensuring feedback was captured from all patients. Recruitment strategies included the following:

- **Alchemer panel service:** This was used to administer the survey online and obtain community input from underserved and diverse populations by oversampling.

- **HSS patient targeting approach:** A list of over 320K patients aged 18 years and older who received medical services from all HSS locations between October 2021 and August 2024 were pulled from our electronic medical record (EMR) system, Epic. This allowed us to segment, target, and send the online survey to patients with no medical insurance, public insurance

(Medicaid), private insurance, living in medically underserved areas and who preferred to receive medical information in Spanish, Chinese, Russian or Haitian Creole.

- **Text Messaging:** To engage and obtain input from all HSS patients including those who are underserved and may not have access to a computer to complete the online survey, we used text message reminders to complete the survey.

- **Social Media Geo-Targeting**: To further garner input from the public, we used social media such as Facebook, LinkedIn, Instagram and Patch.com. In particular, Patch.com geo-targeted individuals aged 18 years and older living in specific zip codes within HSS' primary and secondary service areas. The MUAs were derived from the U.S. Department of Health and Human Services (http://www.hrsa.gov/shortage/mua/index.html).

- **Community Partners:** Grassroots efforts to engage members of the public in survey administration were conducted in partnership with community organizations. Surveys were distributed on-site at community partner centers (Americares Free Clinics, Arthritis Foundation, Over 60 Senior Center, and VNS Health: Chinatown Community Center) and through newsletters and social media (Brooklyn Cyclones, FC Monmouth, New York Red Bulls, New York Road Runners, Rethink Food). Additionally, we conducted in-person tabling at community events (i.e., New York Knicks game, Brooklyn Nets game).

In addition to our recruitment efforts described above in completing the online survey, other varied approaches such as in-person distribution at the hospital and posts on the HSS website were used to increase accessibility and survey response from our community.

Response Rates

A total of 31,792 community members responded to the community survey, with most responses in English (97%) and the remaining responses in Spanish (2%), Chinese (0.4%), Russian (0.3%), and Haitian Creole (<0.01%). Of the 31,792 community members that responded to our community survey, 44% reflected diverse backgrounds and medically underserved groups. Primary analyses were conducted on the total sample of 31,792 respondents. To capture insights from the diverse communities we serve, including regional sites, ambulatory care patients, and medically underserved groups, secondary analyses were conducted for the three sub-groups listed below, with results presented throughout this report.

- **HSS Ambulatory Care Centers; ACC (n= 481)**: This group represents HSS patients from more racially/ethnically diverse and lower socioeconomic backgrounds who receive care at ACC locations (i.e., 72nd street and Rheumatology, 6th floor)

- **Medically Underserved (n= 8,978)**: This group represents respondents who are low to middle income (annual household income <$150k) and report being uninsured, insured through Medicaid, living in a Medically Underserved Area (MUA), or receiving government assistance for nutrition, shelter, or cash needs

- **HSS Regional sites (n= 11,853):** This group represents respondents living in HSS regional locations (i.e., Long Island, NY; Westchester, NY and surrounding counties; Connecticut; New Jersey; Florida)

Statistical Analysis

For analysis, SPSS v. 30 was used to conduct descriptive summaries and logistic and linear regressions 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 specified above.

H. Community Engagement

HSS facilitated systematic feedback from its various 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 to engaging our constituents to obtain their input is described below.

CHNA Steering Committee and Internal Stakeholders

We involved various representatives from HSS departments in developing the community survey and interview guide. An eight-member HSS CHNA steering committee was formed to guide the development and implementation of the CHNA process, and ensure alignment with HSS values and strategic priorities, and the NYS prevention health agenda. The CHNA steering committee identified research questions to be addressed, drafted the individual survey questions, and identified community partners and internal stakeholders to be involved in the CHNA process.

Key internal stakeholders from various departments (i.e., Education Institute, Nursing, Social Work Programs, Nutrition, Rehabilitation, Ambulatory Care Centers, Language Services, Regional Markets, Office of Patient Experience, Medical Staff and Attendings, Development, Editorial Services, Digital Communications, and Quality) were integral in the community health assessment process by providing relevant feedback to the survey construction and the use of validated instruments. See **Appendices B and C** for members of the CHNA steering committee and internal stakeholders as well as detailed feedback from internal stakeholders.

Public Health Departments and Other Experts

HSS collaborated with the New York City Department of Health and Mental Hygiene and the Greater New York Hospital Association (GNYHA). Through these collaborations, we adopted a community-engaged approach that involved feedback in the development of our community survey, guidance on incorporating best practices for our CHNA, and participation in our community forum on July 17, 2025. We also participated in GNYHA's 2025-2030 Prevention Agenda Priorities Survey to provide input on health priorities to include in the New York State's 2025-2023 Prevention Agenda.

General Public

To facilitate input from the public, including medically underserved and low-income populations, on the construction of the community survey, we piloted the survey in English, Spanish, Chinese, Russian, and Haitian Creole from October 29-November 6, 2024, among 63 community members. This allowed us to obtain meaningful feedback about the length of the survey and ensure cultural relevancy and health literacy. See **Appendix D** for a summary of pilot feedback on the survey.

Community Partners

To facilitate active engagement among our community partners, we contacted 72 organizations requesting their involvement in the CHNA process. We received interest from 15 community partners to provide feedback on the community survey from 15 community partners. Feedback included the length of the survey, use of validated instruments, cultural relevance, and literacy level of the community survey. See **Appendix C** for detailed feedback from community partners.

Below outlines the list of community partners involved in survey construction, survey administration, and health prioritization:

- Americares Free Clinics*†‡
- Arthritis Foundation – Greater NY Area†
- Brooklyn Cyclones†
- Brooklyn Nets†

- Building One Community‡
- Concerned Home Managers for Elderly (COHME)*
- Columbia University Mailman School of Public Health*
- DOROT*‡
- FC Monmouth*†
- Jefferson Health*
- Lenox Hill Neighborhood House*
- Lupus Foundation of America*
- Lupus Research Alliance*
- Mount Sinai Hospital*
- New York City Department of Health and Mental Hygiene‡
- New York Knicks†
- New York Red Bulls†
- New York Road Runners†
- Over 60 Senior Center†
- Rethink Food†
- Spondylitis Association of America*
- Touro College Graduate School of Social Work*
- VNS Health*†‡
- Weill Cornell Clinical and Translational Science Center*

* Indicates participation in survey construction
† Indicates participation in survey administration
‡ Indicates participation in health prioritization

I. Relevant Health Indicators

Below is a summary of high-level findings from the community's survey regarding their musculoskeletal health challenges and healthcare needs.

- **Socio-Demographic Profile:** The CHNA survey engaged community members across all the populations we serve with intentional outreach to ensure representation of hard-to-reach and medically underserved populations. Majority of respondents identified as female (61.8%) and straight (90.6%), with the mean age of 51 years. The majority of respondents identified as White (70.1%) and Non-Hispanic Latino (83.5%), compared to 57.4% and 73.8% respectively in 2022. Overall, respondents had a high educational background, with 60.2% having completed college or a postgraduate education. Respondents represented all income levels, with the greatest proportion of respondents reporting an income greater than $200,000 (16.3%). Finally, by geographic location, majority of respondents (64.2%) reported living in New Jersey and New York City.

- **Health Status and Quality of Life:** The leading musculoskeletal conditions reported were osteoarthritis (46.0%), chronic pain (32.9%), and osteoporosis (24.4%). Among respondents with musculoskeletal conditions, lack of confidence to manage symptoms emerged as a health need, particularly among the ACC population where close to three-quarters (75.7%) of respondents reported low confidence. In assessing health status, most respondents reported less than two weeks of poor physical (86.0%) and mental health (84.8%). Physical function was worst in the ACC sample, where about 1 in 4 respondents (26.5%) were unable to walk for 15 minutes. Almost one-third (29.9%) of respondents reported falling in the past year, and 39.2% of those who fell sustained a fall-related injury. When asked about sleep, approximately 1 in 6 (16.0%) respondents reported terrible or poor sleep in the past seven days.

- **Health Behaviors and Lifestyle:** Physical activity was identified as a health need, with one-quarter of respondents (25.5%) reporting no physical activity of any kind in the past month. Older, female, Black, and medically underserved respondents were less likely to be physically active. Almost 2 in 10 (16.9%) reported pain that limits daily activity. With regards to healthy eating, about one-fifth (21.7%) of respondents had difficulty accessing food in the past year, and Hispanic and Latino respondents and respondents with no post-secondary education were more likely to face barriers to healthy eating. One-quarter (25.4%) of respondents experienced loneliness, which is lower than the national average (50.0%).

- **Use of and Access to Care:** Respondents cited ‘social isolation/loneliness’ (8.2%), ‘lack of access to a doctor’s office’ (6.8%), ‘transportation problems’ (6.5%), ‘lack of job opportunities’ (6.2%), and ‘limited access to healthy foods’ (5.3%) as the top issues impacting their health and wellness. Survey data also indicates a need to address access to healthcare, with 34.7% of respondents reporting they could not access healthcare in the past 12 months, compared to 42.3% in 2022. The top barrier reported was difficulty getting an appointment (8.7%). Younger, Hispanic and Latino, Asian, and medically underserved respondents were less likely to access care that they needed. The most reported type of discrimination in medical settings was ‘doctor or nurse is not listening to you’ (41.7%). Significant disparities were seen such that lesbian, gay, and bisexual, Hispanic and Latino, non-White, medically underserved, and those with a musculoskeletal condition reported higher levels of discrimination. 22.0% of respondents needed assistance reading healthcare information, with Hispanic and Latino, Asian, American Indian/Alaska Native, those with no post-secondary education, those who are medically underserved, and those with a musculoskeletal condition more likely to need help reading healthcare information.

- **Health Education:** Lack of health education emerged as a major health need, with seven out of every ten respondents (70.5%) reporting no health education participation in the past 12 months. Medically underserved respondents and those who have a musculoskeletal condition were significantly less likely to participate in a health education program. The top reason for having not participated in health education was ‘did not know about the program’ (30.8%). Respondents expressed interest in virtual exercise classes (31.1%), on-demand videos (28.4%), and onsite exercise classes (26.2%). Top health topics of interest included ‘exercise’ (45.6%), ‘healthy eating’ (31.0%), ‘healthy aging’ (29.7%), ‘dealing with stress, anxiety, and depression’ (26.0%), and ‘ways to improve mobility’ (25.7%).

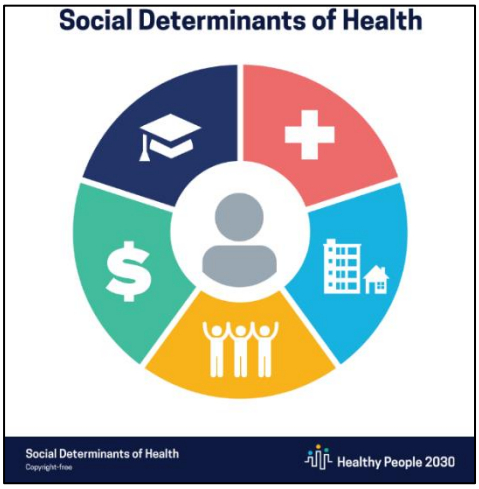
A detailed key finding report of the community survey results highlighting significant health disparities across all samples is available in **Appendix E**.

J. Health Challenges & Associated Risk Factors

Understanding the leading community health problems requires examining the broader social determinants of health (SDOH) which includes the economic, environmental, and social conditions that influence how people live, work, learn, and grow. This section provides an overview of these non-medical factors across HSS service areas, highlighting how they shape health outcomes, contribute to disparities, and inform community health priorities.

Social Determinants of Health

Figure 8. Social Determinants of Health



Source: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion; Social Determinants of Health[11]

To fully understand what drives health outcomes, it is important to look beyond medical care and consider the broader social and environmental context of people's lives. Public health research increasingly shows that the places where people live, work, learn, and grow play a major role in shaping their overall health. These non-medical influences are referred to as social determinants of health (SDOH). The secondary data review below highlights examples of SDOH within each domain as they appear across communities in New York City, Bergen County in New Jersey, and Collier and Palm Beach Counties in Florida.

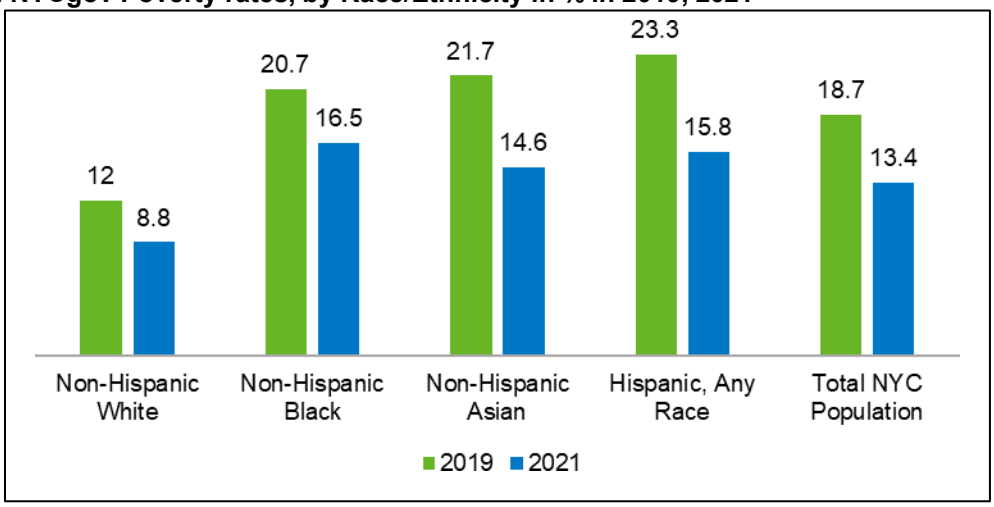
Economic Stability

Income and Poverty

- In Bergen County, New Jersey, 6.6% of residents lived below the poverty line, which is lower than the statewide poverty rate of approximately 9.8% during the same period.[25]
- In Collier County, Florida, 10.5% of residents lived below the poverty line in 2023, which is lower than the statewide average of 12.4%. In Palm Beach County, Florida, the poverty rate was 11.1% in 2023, also below the state average.[26]
- In 2021, approximately 13% of New York City residents lived in poverty, defined as having resources below the NYCGov poverty threshold of $40,288. An additional 35% lived near poverty, with resources between 100% and 150% of the threshold.[5]
- From 2017-2021, among the five boroughs, the Bronx had the highest neighborhood poverty rate (27%), followed by Brooklyn (19%), Manhattan (16%), Queens (11%), and Staten Island (10%).[10]
- By 2021, poverty rates in NYC had decreased overall. However, they remained highest among non-Hispanic Black residents (17%), followed by Hispanic residents (16%), non-Hispanic Asian (15%), and non-Hispanic White residents (9%)[5], as seen in Figure 9 below.

[25] U.S. Census Bureau. (2023). *QuickFacts: Bergen County, New Jersey*. https://www.census.gov/quickfacts/fact/table/bergencountynewjersey
[26] Data USA. (n.d.). Collier County, FL. Deloitte, Datawheel, & MIT Media Lab. Retrieved April 16, 2025, from https://datausa.io/profile/geo/collier-county-fl/

Figure 9. NYCgov Poverty rates, by Race/Ethnicity in % in 2019, 2021



Source: Mayor's Office for Economic Opportunity. (2024, May). New York City Government Poverty Measure 2021.

Unemployment

- Approximately 5% of civilians 16 years of age and older are unemployed in New York City.[27]
- Unemployment rates increased slightly across all five boroughs from January 2024 to January 2025, with the most significant increase in the Bronx (from 6.3% to 7.1%), followed by Brooklyn (5.1% to 5.4%), Manhattan (4.3% to 4.8%), Queens (4.2% to 4.7%), and Staten Island (4.3% to 4.6%) in January 2025.[28]
- In 2022, only 35% of working-age New Yorkers with disabilities were employed, and their unemployment rate (11.9%) was 7.6 points higher than for those without disabilities—exceeding the national gap of 4.7 points.[29]
- In Collier County, Florida, unemployment rose from 2.9% in 2024 to 3.8% in February 2025, remaining below the national rate of 4.1%[30].

Education Access and Quality

- In Bergen County, 92.7% of adults aged 25 and older have attained at least a high school diploma, and 53.3% hold a bachelor's degree or higher, both surpassing state and national averages.[26]
- In Palm Beach County, 89.1% of adults have a high school diploma or higher, and 39.6% hold a bachelor's degree or more. In Collier County, those figures are 90.0% and 40.3%, respectively.[27]
- Approximately 84% of New York City residents 25 years old or over have attained a high school diploma or higher.[10]
- Educational attainment of a college degree or higher was most common among residents in Manhattan (65%), followed by Brooklyn (44%), Staten Island (40%), Queens (36%), and Bronx (24%) in 2023.[10]
- In 2021, poverty rates were highest (22%) among NYC residents with less than a high school diploma, followed by those with a high school diploma or equivalent (16%), some college (16%), and a bachelor's degree or higher (7%).[5]

[27] New York State Department of Labor. (n.d.). *Home*. Retrieved April 16, 2025, from https://dol.ny.gov/
[28] New York State Department of Labor. (n.d.). *New York City Labor Market Briefing*. Retrieved April 16, 2025, from https://dol.ny.gov/labor-market-briefings
[29] Office of the New York State Comptroller. (n.d.). *Home*. Retrieved April 16, 2025, from https://www.osc.ny.gov/
[30] U.S. Bureau of Labor Statistics. (2025). *Unemployment rate in Collier County, FL*. Federal Reserve Bank of St. Louis. Retrieved from https://fred.stlouisfed.org/series/FLCOLL0URN

Healthcare Access and Quality

- In 2023, 16.3% of Palm Beach County residents under age 65 were uninsured, while the rate was higher in Collier County at 18.6%, both exceeding the national average.[27]
- In 2022, 78% of NYC residents ages 18 and older reported visiting a doctor for a routine checkup in the previous year.[12]
- In 2018, 11% of NYC residents reported not receiving needed medical care.[22]
- Approximately 12% of New York City adult residents do not have health insurance.[10]
- The Bronx had the lowest proportion (86%) of insured adults, followed by Queens (86%), Brooklyn (89%), Staten Island (90%), and Manhattan (91%) in 2022.[10]

Neighborhood and Built Environment

Housing and Homelessness

- In 2023, Bergen County reported 396 individuals experiencing homelessness, accounting for approximately 4% of New Jersey's total homeless population. Additionally, 49.7% of renter households in the county were considered cost-burdened, spending more than 30% of their income on housing.[31]
- The majority of NYC Department of Homeless Services (DHS) shelter residents identify as Hispanic (57% of single adults), followed by non-Hispanic Black (34% of single adults), despite Hispanic residents comprising only 28% of the NYC population.[32]
- The average daily number of individuals residing in NYC DHS shelters (84,822 in April 2025) comprised approximately 1% of the NYC population (8.5 million).[26]
- Nearly half (52%) of renter-occupied homes in NYC reported no maintenance defects. In comparison, half (50%) of all renter-occupied homes in New York City experienced a rent burden that equals or exceeds 30% of household income in the past 12 months.[33]
- In Collier County, Florida, 19.6% of its residents were living with severe housing problems in 2023.[27] Severe housing problems are defined as meeting at least one of the following: Lack of complete kitchen facilities or plumbing facilities, overcrowding, or severely cost-burdened occupants.[34]

Neighborhood Characteristics

- In Palm Beach County, Florida, a 2023 resident opinion survey indicated that 80% of residents felt safe in their neighborhoods, and 75% believed their neighbors were helpful. Additionally, approximately 12% reported having a family member who had been incarcerated.[35]
- Of the five boroughs, the Bronx had the lowest proportion (67%), and Staten Island had the highest proportion (81%) of adults who perceived their neighborhood as having helpful neighbors in 2018.[10]
- The perceived neighborhood safety varied by borough, with the lowest reported in the Bronx (73.3%) and the highest in Staten Island (90.0%), followed by Manhattan (89.8%), Queens (88.7%), and Brooklyn (85.5%).[10]
- The Bronx had the highest prevalence of adults reporting a family member spent time in a correctional facility or under supervision (14.2%), followed by Staten Island (13.2%), Manhattan (12.3%), Brooklyn (11.6%), and Queens (10.0%).[10]

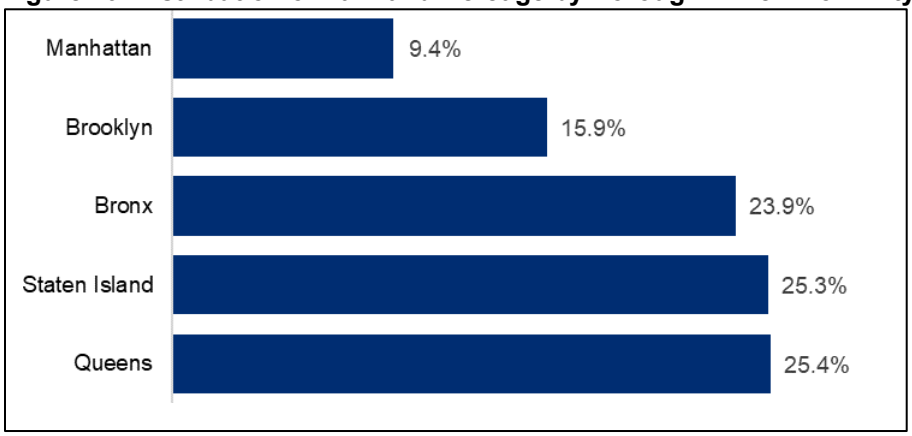
Parks, Outdoor Space Distribution & Access to Green Spaces

[31] U.S. Census Bureau. (2023). *Burdened Households (5-year estimate) in Bergen County, NJ*. https://fred.stlouisfed.org/series/DP04ACS034003
[32] U.S. Department of Homeland Security. (2024, March 11). *Fiscal Year 2025 Budget-in-Brief*. https://www.dhs.gov/sites/default/files/2024-04/2024_0311_fy_2025_budget_in_brief.pdf
[33] New York State Department of Labor. (n.d.). *New York City Economic Summary*. Retrieved April 16, 2025, from https://dol.ny.gov/labor-market-briefings
[34] America's Health Rankings. (n.d.). Severe housing problems. United Health Foundation. Retrieved April 16, 2025, from https://www.americashealthrankings.org/explore/measures/severe_housing_problems

[35] Palm Beach County Office of Financial Management & Budget. (2023). *2023 Palm Beach County Resident Opinion Survey Findings*. https://discover.pbc.gov/ofmb/PDF/2023_Palm_Beach_County_Resident_Opinion_Survey_Report.pdf

- Of the five boroughs, Manhattan (98%) contained the highest percentage of residents living who live within walking distance of a park, followed by the Bronx (92%), Brooklyn (84%), and Staten Island (71%).[10]
- Compared to New Jersey overall, where access to exercise opportunities was 84%–96%, Bergen County stood out, with 100% of residents living close to a park or recreation facility.[16]
- Palm Beach County offers extensive outdoor space. However, areas like Belle Glade and Riviera Beach have fewer shaded park areas and less access to walking trails or fitness zones, correlating with higher inactivity rates.[36]
- Walkability is strongest in urban centers like Manhattan and Hoboken, NJ, where infrastructure supports pedestrian movement. Suburban and rural areas show lower Walkability Index scores, with uneven sidewalk coverage and fewer safe crossings.[16]
- In New York City, Queens has the largest share of parkland acreage (25.4%), followed closely by Staten Island (24.3%) and the Bronx (23.9%). Brooklyn (15.9%) and Manhattan (9.4%) have comparatively less park acreage, as seen in Figure 10 below.[37]

Figure 10. Distribution of Parkland Acreage by Borough in New York City 2025



Source: The City of New York. (2025, May 4). Parks Properties. NYC Open Data.

Social and Community Context

Disabilities

- As of 2022, approximately 827,200 individuals aged 16 to 64 lived with disabilities in New York State, representing 6.7% of the working-age population.[38]
- An estimated 11% of NYC residents live with a disability, with a higher prevalence among older adults and low-income populations.[5]
- According to NYCgov, 77.4% of working-age residents with disabilities were unemployed, compared to 5.3% of those without disabilities.[5,24]

Language Preference

- The United States Census Bureau reported that 48% of New York City residents aged 5+ speak a language other than English at home.[1]
- Other languages spoken at home in New York City include Spanish (22.6%), Other Indo-European languages (13.2%), and Asian and Pacific Islander languages (8.9%).[1]
- Top spoken languages in the boroughs include the following:
  - Manhattan (Spanish 18.8%)[1]
  - Brooklyn (Other Indo-European Languages 18.1% and Spanish 14.7%)[1]

[36] Palm Beach County. (n.d.). *Open Data Portal*. Retrieved April 16, 2025, from https://opendata.pbcgov.org/
[37] The City of New York. (n.d.). *Parks Properties*. NYC Open Data. https://data.cityofnewyork.us/Recreation/Parks-Properties/enfh-gkve

[38] Office of the New York State Comptroller. (2023, April). *Employment Recovery Is Slow for New Yorkers with Disabilities*. https://www.osc.ny.gov/reports/employment-recovery-slow-new-yorkers-disabilities

- Queens (Spanish 23%)[1]
- The Bronx (Spanish 45.4%)[1]
- Staten Island (Other Indo-European Languages 11.4% and Spanish 11.2%)[1]

3. Community Assets & Resources

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, 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
- Columbia University Mailman School of Public Health
- Good Samaritan Hospital, Florida
- Gracie Square Hospital Asian Psychiatry Program
- HSS China Orthopedic Education Exchange
- Mt. Sinai Medical Center, Division of Rheumatology
- New York University Silberman School of Social Work
- NewYork-Presbyterian Hospital
- NewYork-Presbyterian/Columbia University Medical Center – The Men's Clinic at Audubon Clinic
- NewYork-Presbyterian/Morgan Stanley Children's Hospital at Columbia University Medical Center, Pediatric Rheumatology Service
- NewYork-Presbyterian/Weill Cornell Medical Center – Health Outreach® Program
- 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
- Weill Cornell Medical College, Office of Community Outreach & Engagement

Community-Based Organization Partners

- 92NY
- A. Philip Randolph High School
- All Community Adult Day Centers
- Amani Public Charter School
- American Heart Association, Fairfield & Westchester Counties
- American Red Cross
- AmeriCares Free Clinics
- Arthritis Foundation – FL & NY Chapters
- Asphalt Green
- Association of Chinese American Physicians (ACAP)
- Bayside High School
- Blondes Vs. Brunette Football
- Blue Ridge High School
- Breakaway Hoops
- Breaking Ground
- Breevort Senior Center
- Brooklyn Nets
- Bronx Health Link/ Public Health Solutions
- Building One Community
- CABS Health Network
- Cancer Support Community NYC & CT
- Cardoza High School
- Catholic Charities of Brooklyn & Queens
- Centercourt Sports
- Charter School of Excellence

- Chatham High School
- Chelsea Piers CT
- Children's Aid Society
- Chinatown Neighborhood Naturally Occurring Retirement Community (NNORC)
- Chinese American Medical Society (CAMS)
- Chinese-American Planning Council
- CUNYAC
- Chinese Consolidated Benevolent Association
- Collier Reserve Country Club
- Community Health Center, Inc.
- Concerned Home Managers for the Elderly (COHME)
- Cristo Rey High School Bronx
- Darien Library Inc
- Darien Senior Center
- Dominican College
- Dorot, Inc.
- East Harlem Community Health Committee (EHCHC)
- Edgehill
- Fifth Avenue Presbyterian Church
- Franklin Public Library
- Friends Academy High School
- Girl Scouts of Jersey Shore
- Golden Eagle Adult Day Center
- Good Neighbors of Park Slope
- Gouverneur Court
- Greenwich Alliance for Education
- Harlem Health/ Public Health Solutions
- Harlem Lacrosse
- Heights Older Adult Center
- Hempstead High School
- Industry City
- Inner City Scholarship Fund
- Integrity Social Work Services
- Isabella Geriatric Center
- Jewish Association Services for the Aged (JASA)
- Junior Achievement of Greater Fairfield Country
- KIPP High School
- LaGuardia Senior Citizens Center
- Lenox Hill Neighborhood House and (St. Peter's Church)
- Lupus Research Alliance
- Lupus Foundation of America
- Manhattan Country Day School
- Mary J. Blige Center for Women & Girls
- Marywood University
- Maspeth High School
- Medicare Rights Center
- Mott Street Senior Center
- New Canaan YMCA
- New York Chinatown Senior Citizen Center
- New York Foundation for Senior Citizens
- New York Liberty
- New York Knicks
- New York Mets
- New York Red Bulls
- New York Road Runners Club (NYRR)
- Nightingale High School
- Norwalk Senior Center, South Norwalk
- Oceanside Stallions Football
- Omni Fitness Center
- Over 60 Senior Neighborhood
- Planned Parenthood of NYC
- Prime Care Home Health Agency
- Presbyterian Senior Services
- Project Sunshine
- PS 76- Harlem
- Public School Athletic League
- Queens Center for Gay Seniors
- Queens Community Home
- RAIN, Inc.
- Raices Corona Senior Center
- Ridgewood YMCA
- Riseboro
- Sacred Heart High School
- Selfhelp Innovative Senior Center
- Senior Men's Association of Stamford
- Service Program for Older People
- Soundview Older Adult Center
- Southamptom Rotary Club
- 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
- Sunnyside Community Services, Inc.
- Tarrytown YMCA
- The Calhoun School
- The Center for Information & Study on Clinical Research Participation (CISCRIP)
- The Collegiate School
- The Myositis Association

- The Osborn Senior Center
- The Residence at Selleck's Woods
- The Scleroderma Foundation
- Urban Health Plan, Inc.
- Union Settlement
- University Settlement Neighborhood Center
- VNS Health
- Washington Lexington Senior Center
- Waveny LifeCare Network
- We Run Kings
- West Side Interagency Council on the Aging (WSIACA)
- Westport Library
- Women's Connection
- Xavier High School
- YMCA of Queens
- 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

Community Health Improvement Plan / Community Service Plan (CHIP/CSP)

This section outlines the process used to identify and prioritize major community health needs based on the findings of the Community Health Assessment, including methods for prioritization, community engagement in decision-making, justification for unmet needs, and the development of objectives, interventions, and action plans aligned with the 2025–2030 New York State Prevention Agenda.

Major Community Health Needs

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

1. Osteoarthritis
2. Chronic pain
3. Pain management
4. Lack of sleep
5. Osteoporosis
6. Lack of exercise
7. Poor physical function
8. Falls
9. Some other form of arthritis
10. Mental health

See **Appendices F-H** for a summary of the health rankings.

Prioritization Methods

HSS facilitated systematic feedback from its various 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 to engaging our constituents to obtain their input is described below.

Community engagement

Internal Stakeholders

An internal stakeholder meeting was held on July 14, 2025 with 24 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 understanding the health care gaps found for specific populations (e.g., older adults, Florida). See **Appendix F** for meeting minutes.

Community Partners

A community partners meeting was held on July 17, 2025 with seven individuals from five community partner organizations in attendance, including the New York City Department of Health and Mental Hygiene. During the meeting, we shared the CHNA results, solicited feedback and ranked health issues according to the communities they serve. CHNA results were received positively and there was extensive discussion about how community partners found the survey results to mirror the experiences of their constituents. Minutes of the community partners meeting, and ranking is available in Appendix G.

Public

To further HSS' commitment to developing programs that improve the health of all the diverse communities we serve, obtaining feedback from the public, including medically underserved populations,

such as low-income and minority groups were instrumental in driving the Hospital's selection of significant health needs to improve the health of communities where dramatic health disparities exist**.** Our approach to prioritizing and selecting health needs involved a digital outreach campaign and six community forums, which provided community members the opportunity to identify and rank priorities, and guided HSS in determining its public health priorities.

In order to reach medically underserved and hard-to-reach populations, HSS partnered with Community-Based Organizations (CBOs) serving these communities to advertise community forums. Specific dates, locations, and attendance for the community forums were as follows:

Table 3: Community Forums

Date	Audience	Language	Number of Participants
June 19, 2025	Community members and patients via email	English	1,195
June 25, 2025	VNS Health Chinatown Community Center	Chinese	47
June 25, 2025	HSS Ambulatory Care Center patients	English	9
June 26, 2025	HSS Social Work Programs participants	English	14
June 27, 2025	Community partners	English	7
July 15, 2025	HSS Internal Stakeholders	English	24
July 17, 2025	Building One Community	Spanish	11
TOTAL			1,307

See **Appendix H** for a summary of the community forums.

Community members were asked to rank ten health indicators, from a list of 20, identified in the CHNA according to the order of personal 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 top priorities for participants at the respective event. Rankings were administered in-person and online via Alchemer and Slido.

Community partners and HSS Internal Stakeholders were asked to prioritize the same list of 20 health needs using an adapted version of the Hanlon Method of Health Prioritization.[39] Each health need was rated on a scale of 1-3 against the following criteria: size of the problem, severity of the problem, and effectiveness of potential interventions. Priority scores were calculated based on the three criteria rankings using a set formula, with the highest score receiving the rank of 1. Prioritization was completed online via Alchemer.

See Appendices F-H for a summary of the health rankings.

Justification for unaddressed health needs

We are happy to report that each health need identified in the 2025 CHNHA is being addressed via the interventions outlined in the following pages.

[39] Hanlon, J. J. (1974). *Public health. Administration and practice* (pp. xii+-748).

Developing Objectives, Interventions and an Action Plan

Alignment with prevention agenda

As a specialty hospital focused on musculoskeletal and rheumatologic conditions, HSS is in a unique position to address the needs identified above. To ensure that the selection of public health priorities aligns with NYSDOH Prevention Agenda 2025-2027, HSS has chosen to focus on the following domains and priority areas:

- **Domain 2** Social & Community Context with emphasis on **Priority 1 Anxiety & Stress**
- **Domain 3** Neighborhood & Built Environment, with emphasis on **Priority 1 Opportunities for Active Transportation and Physical Activity**
- **Domain 5** Education Access & Quality with emphasis on **Priority 2 Opportunities for Continued Education,** a social determinant of health**.**

The rationale for the NYS public health priorities selected is described below –

*Domain**: Social & Community Context***

*Priority**: Anxiety & Stress***

*Objective 5.1 5.1**: Decrease the percentage of adults in households with an annual income of less than $25,000 who experience frequent mental distress from 21.0% to 18.9%.***

In the US, 37% of older adults experience social isolation. Older adults are at increased risk of social isolation and loneliness because of factors such as decreased mobility, worsening vision and hearing, inability to access transportation and chronic illness.[40] These factors contribute to emotional burdens, including anxiety, and depression. When left unaddressed, mental health issues in older adults with chronic illness can lead to delayed treatment, poorer health outcomes, and increased healthcare utilization.[41]

Emotionally, older adults face higher levels of stress, anxiety, and depression, often worsened by the absence of regular social interaction and support[42]. Physically, isolation has been linked to increased risks of cardiovascular problems, weakened immune function, and cognitive decline[43]. Interruptions to routine medical care and social services further exacerbated these issues, resulting in delayed diagnoses, unmanaged health conditions, and decreased mobility[44].

Additionally, individuals living with rheumatic conditions such as systemic lupus erythematosus (SLE) and rheumatoid arthritis (RA), often face significant mental health challenges, including stress, depression, anxiety, and social isolation[45]. Patients face numerous challenges, including accessing complex medical information, managing symptoms, all while processing the emotional impact of a chronic and potentially debilitating disease.

- SLE is a life-threatening, multi-system autoimmune disease that disproportionately affects African Americans, Asians, and Latinos, who experience significant disparities in disease severity and health outcomes. Cultural stigma surrounding chronic illness and mental health has been

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identified as a barrier to coping and emotional well-being among Hispanic/Latino, African American, and Asian patients living with SLE[46]. Additionally, Hispanic/Latino and African American teens and young adults disproportionately experience depression and have higher rates of suicide attempts.[4748]

- RA is a systemic autoimmune disease which affects approximately 1% of the global adult population[49] and profoundly affects physical and psychosocial functioning, including ability to work[5051] , participate in valued social and family roles and emotional well-being. Health disparities for Latinx RA patients, including higher rates of pain, disability, fatigue is well described in the literature.[5253545556575859] The prevalence of depression and anxiety among individuals with RA is significantly higher than in the general population[60]; further, the incidence is higher in Latinx individuals than in other ethnic groups, and exacerbated by cultural stigma around diagnosis and treatment in this community[61].

Effective mental health interventions are crucial for individuals living with rheumatic conditions and older adults, particularly from traditionally underserved communities in NYC. Research supports the efficacy of professionally led peer support groups to improve health behaviors and outcomes, including coping strategies, self-management behavior, emotional health and disease knowledge.[62] Additionally, participants benefit from reduced isolation, psychosocial support, and emotional connection[63]. Culturally tailored disease support and education programs, designed to meet the unique needs of marginalized communities, provide tools and strategies to promote self-management[646566], reduce stress and isolation and improve overall emotional well-being.

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Action and Impact: To decrease the percentage of adults in households with an annual income of less than $25,000 who experience frequent mental distress, HSS will implement the following evidence-based interventions with the goal of addressing the long-term effects of isolation in older adults and individuals living with chronic conditions:

- Accessible support groups and peer-based interventions, utilizing such as group-based Cognitive Behavioral Therapy (CBT), creative arts interventions, to reduce loneliness, increase emotional expression and foster connectedness among older adults
- healthcare education lectures and workshops to improve understanding of health conditions, support self-management, and enhance skills related to stress, sleep, and mental well-being.
- National support and education programs aimed at providing culturally relevant, bilingual programming to improve knowledge of SLE, RA, and chronic pain in older adults focusing on improving understanding of diagnosis, treatment, self-management, and the emotional impact of stress, anxiety, depression, and social isolation.

Program impact will be measured through process indicators such as the number of programs conducted, participant satisfaction, and reach among at-risk populations. Outcome measures will assess improvements in self-management skills, stress and anxiety reduction, physical and mental health, access to psychosocial support, and decreased feelings of social isolation.

Geographic Focus: HSS will focus its efforts in New York City, particularly within communities with high concentrations of economically underserved older adults and individuals living with chronic conditions.

Resource Commitment: HSS commits administrative and subject matter experts, as well as marketing development and implementation resources to support these interventions. As reported in the Hospital's 2023 IRS Form 990 filing, HSS spent net $14.1 million on Community Health Improvement Services.

Participant Role: Partnership with senior centers and social service organizations in New York City is vital to implementation of these interventions. As trusted health experts in their communities, we rely on our community partners for physical space, access to participants, knowledge exchange and a collaborative approach to marketing, recruitment and survey distribution/collection. Some partners will also join programming via Zoom.

Health equity: The proposed interventions will address the following disparities:

- Older adults, amongst who are medically and economically underserved; physically limited; socially isolated or living alone; and those with limited English proficiency who face significant barriers to care, resources, and community support.
- Individuals impacted by rheumatic conditions and chronic pain, from culturally diverse populations as well as a low socioeconomic status, and can use support for mental and emotional health.

HSS is committed to reducing the prevalences of anxiety and stress in older adults and individuals with chronic conditions, such as rheumatic conditions, through the implementation of evidence-based education and connection programs.

Domain 3: ***Neighborhood & Built Environment***

Priority: ***Opportunities for Active Transportation and Physical Activity***

Objective 21.0: ***Increase the prevalence of physical activity among all adults aged 18 years and older from 73.9% to 77.6%.***

Objective 21.1: ***Increase the prevalence of physical activity among all adults aged 18 years and older with an annual household income less than $25,000 from 56.7% to 59.5%.***

According to the National Institute of Health (NIH), Musculoskeletal (MSK) conditions such as arthritis, osteoporosis, chronic back pain, and joint disorders remain leading causes of disability and reduced quality of life. Arthritis alone affects over 58 million U.S. adults—roughly 1 in 4[67] [1]. These conditions disproportionately impact older adults, women, and historically underserved communities. Natural age-related declines in muscle and bone health heighten the risk of falls, fractures, and loss of independence, while social determinants of health—such as socioeconomic status, language, and neighborhood safety—exacerbate disparities in access to preventive care and safe exercise environments.

Of the many health related difficulties that older adults face, the Center for Disease Control (CDC) highlights musculoskeletal conditions as a public health issue. Osteoporosis and other bone health conditions are the leading cause of fractures in the aging population. According to the 2018 National Institute of Arthritis and Musculoskeletal and Skin Diseases, Asian women are at increased risk for developing osteoporosis since they tend to be slender with lower bone mass and avoid consuming dairy because of lactose intolerance. In summation, research and data highlights the need for musculoskeletal programming centered around the needs of vulnerable populations such as Asian seniors.

In 2022, Asian seniors made up 13.9% of the total Asian population in New York City, according to Asian American Federation (AAF). Of that population an alarming 43.4% are considered poor or low-income, reducing their access to healthcare services, highlighting a significant barrier. Additional data shows 6.5% of Asian seniors in New York City had no health care coverage while 30.9% were considered disabled. These findings showcase some of the health disparities for many Asian seniors that contribute to their overall quality of health[68].

Furthermore, research has shown limited English proficiency is a major issue and contributor to a lack of knowledge regarding the prevention and management of musculoskeletal health issues, as data has shown that 72% of Asian seniors have limited English proficiency, compared to 48% of the entire NYC Asian population.[69] Together these sources support the need for culturally competent material, increased avenues of access, and a reduction in language barriers when creating healthcare interventions. Physical activity is also protective against co-occurring chronic diseases such as diabetes, cardiovascular disease, and obesity. However, barriers such as cost, transportation, and limited culturally relevant programming continue to restrict access for high-risk populations.

Action and Impact: To increase the prevalence of physical activity among all adults aged 18 years and older, HSS will implement the following evidence-based interventions with the goal of reducing pain, improving mobility, and enhancing quality of life for individuals with arthritis and related musculoskeletal conditions.

- Self-management education programs delivered via webinars/lectures, workshops, and enduring video content, aimed at increasing knowledge, building self-management skills, and expanding access to affordable, evidence-based interventions, especially among older adults and racially/ethnically diverse communities

67 https://www.nia.nih.gov/health/falls-and-falls-prevention/falls-and-fractures-older-adults-causes-and-prevention
[68] *New York City Population & People,* https://datacenter.aafederation.org/nyc/population-people/
[69] Asian American Federation, https://www.aafederation.org/our-work/research/

To increase the prevalence of physical activity among all adults aged 18 years and older **with an annual household income less than $25,000**, HSS will implement community-based, culturally relevant and sensitive outreach and education programs, delivered in the predominant language spoken of the community to ensure accessibility, inclusion and cultural relevance, utilizing the following interventions:

- Implement Self-Management Education (SME) workshops to facilitate conversations on musculoskeletal health conditions such as osteoporosis, osteoarthritis, rheumatoid arthritis, fall prevention, back pain, and posture with the goal of increasing knowledge and adoption of preventive behaviors, such as diet, exercise, mental health and sleep as it relates to musculoskeletal health.
- Implement a modified Arthritis Foundation Exercise Program, a low-impact chair exercise class, evidence-based program, effective in improving functional ability and confidence in one's ability to exercise, tailored for modeling simple yet effective age-appropriate exercises through certified instructors experienced in culturally sensitive yoga practices.

Program impact will be measured through process indicators including the number of programs conducted, participant satisfaction, and reach among at-risk populations. Outcome measures will reflect increased self-management skills, knowledge, physical and mental health, improved musculoskeletal function, reduced pain and fatigue, greater confidence in managing chronic conditions, and expanded access to programs for diverse and underserved communities.

Geographic Focus: HSS will focus its community health intervention across New York City, Long Island, Westchester, and the surrounding Tri-State region, targeting neighborhoods with high proportions of adults experiencing arthritis and related musculoskeletal conditions**.**

Resource Commitment: HSS commits administrative and subject matter experts, as well marketing development and implementation resources to support these interventions. As reported in the Hospital's 2023 IRS Form 990 filing, HSS spent net $14.1 million on Community Health Improvement Services.

Participant Roles: Partnerships with community-based organizations in New York City, Long Island, Westchester, and the surrounding Tri-State region is vital to implementation of these interventions. As trusted health experts in their communities, we will work with Community-based Organizations to share in knowledge exchange and community priorities, provide a physical space for programming for in-person delivery, assist with marketing and recruitment of participants from diverse and underserved communities.

Health equity: The proposed interventions will address the following disparities:

- Specific populations with access-related issues, in medically underserved neighborhoods in NYC, Long Island, Westchester, and surrounding Tri-State region:
    - Population-specific: older adults, women, racially/ethnically diverse groups, and individuals living with chronic MSK conditions.
    - Access-related: Free or low-cost programming, bilingual/culturally relevant content, and hybrid delivery (virtual + in-person)
- Asian older adults, in NYC, with low socio-economic status, limited English proficiency and cultural barriers

In conclusion, to improve safe, affordable and accessible physical and social activity, HSS will implement evidence-based and culturally relevant interventions as well as promising practices to improve musculoskeletal health outcomes and enhance the quality of life of its community.

Domain: ***Education Access & Quality***

Priority: ***Opportunities for Continued Education***

Objective 42.0: ***Increase the percentage of high school seniors that attend a 2- or 4-year college from 70.2% to 77.0%.***

Underrepresented minority (URM) students face long-standing disparities in health, education, and economic opportunity. (Underrepresented minority is defined as any recognized minority group whose representation in healthcare is disproportionately lower when compared to the group's proportion in the general population[70]. Systemic inequities in education, such as underfunded schools and limited exposure to STEM careers, contribute to continued underrepresentation in medicine.

Currently, Black and Hispanic physicians, along with women in many specialties, make up a disproportionately small share of the U.S. healthcare workforce. Mora et al. (2022) projects that, at current rates, it would take over 90 years to achieve parity between the racial and ethnic composition of the physician workforce and the general population [71]. This lack of representation has direct implications for patient care. Evidence shows that racial concordance between patients and physicians is associated with improved healthcare utilization, greater patient satisfaction, and lower overall healthcare expenditures among URM populations [72].

Research supports the effectiveness of health career recruitment pipeline programs. Exposure to healthcare professions during high school is associated with increased interest in science careers, stronger academic performance, and higher matriculation rates into health-related programs[73]. Health profession pipeline programs have been shown to support entry into high-need specialties, advancing health equity[74].

Beyond academic outcomes, pipeline programs help foster a sense of belonging among URM students, which has a direct impact on mental health and academic persistence. Research highlights that fostering a sense of belonging in the STEM field significantly improves persistence among underrepresented, low-income students[75]. The Medical CHANGE study[76], which surveyed nearly 4,000 fourth-year medical students across 49 schools, found that Black medical students consistently reported lower sense of belonging and higher symptoms of depression compared to their White counterparts[77] . These findings underscore the need for comprehensive support programs that create inclusive environments with the potential to close critical gaps in the medical field and promote long-term health equity.

Actions and Impact: To increase the percentage of high school seniors that attend a 2- or 4-year college, HSS will implement an outreach and education program rooted in evidence-based practices to

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enhance continued education as well as expand personal and professional development opportunities utilizing the following interventions:

- Implementation of program designed to introduce URM students to musculoskeletal health and the role HSS plays in this field to help them understand the various career paths in muscle, bone and joint health and how one pursues these roles while highlighting the importance of representation and diversity in medicine.[78]
- Incorporation of interactive learning stations aimed to increase students' exposure and interest in healthcare,[79]

Program impact will be measured through the number of programs conducted, participant satisfaction, and reach among at-risk populations, as well as outcomes reflecting increased knowledge of musculoskeletal medicine and careers, greater sense of belonging in medical spaces, and heightened interest in pursuing healthcare professions.

Geographic Focus: HSS will concentrate its outreach and education initiatives across New York City and lower/upper Westchester County, focusing on high schools serving underrepresented and economically disadvantaged communities.

Resource Commitment HSS commits administrative and subject matter experts, as well marketing development and implementation resources to support these interventions. As reported in the Hospital's 2023 IRS Form 990 filing, HSS spent net $14.1 million on Community Health Improvement Services.

Participant Roles: Partnerships with community-based organizations in New York City and lower/upper Westchester are vital to these interventions. As trusted health experts in their communities, we partner with Community-based organizations to identify and recruit underrepresented, high-achieving high school students who have expressed interest in pursuing a career in medicine.

Health equity -The proposed interventions will address the following disparities:

- High School students from marginalized communities, in NYC and lower/upper Westchester, with limited exposure to careers in healthcare.

In conclusion, to address the health, education, and economic opportunity disparities that underrepresented minority (URM) students face, HSS aims to provide students with experiences that help them feel a sense of belonging in healthcare as well as expose them to the different roles one can play in the field.

4. Partner Engagement

Strong, sustainable partnerships with key stakeholders are essential to the success of HSS community health initiatives. HSS collaborates closely with community partners throughout the development, implementation, and evaluation of both hospital-led and joint programs. Ongoing engagement is maintained through regular meetings to identify community needs, gather feedback on program effectiveness, co-plan future initiatives, and share evaluation findings. To promote transparency and shared learning, program data and outcomes are communicated through interactive dashboards. Together with its partners, HSS employs continuous quality improvement (CQI) strategies using tools such as surveys, interviews, and debrief sessions—to assess impact, address emerging needs, and make timely program enhancements that ensure effectiveness and community relevance.

5. Sharing Findings with Community

HSS is deeply committed to improving the health and well-being of its patients and the broader public through the design, implementation, and evaluation of innovative community programs and services that align with its Community Service Plan (CSP). Transparent and inclusive communication of these initiatives is vital to ensuring community awareness, engagement, and accountability.
To reach diverse audiences and foster widespread understanding of its community health impact, HSS will disseminate the CSP Executive Summary and related program outcomes through multiple channels, including:

- The Hospital's Community Benefits webpage (https://www.hss.edu/community.asp), providing easy access to program information, updates, and data dashboards.
- Social media platforms such as Facebook, Instagram, X, and Patch.com to reach a broad and diverse audience in real time.
- The annual HSS Community Benefit Report, highlighting key initiatives, outcomes, and progress toward health equity goals.
- Interactive data dashboards showcasing metrics, trends, and community impact in a visually accessible format.
- Community forums offering opportunities for two-way dialogue, feedback, and partnership building.
- Targeted email campaigns to inform community partners, participants, and stakeholders of upcoming programs, results, and opportunities for collaboration.

Through these multi-channel strategies, HSS ensures that its community health efforts are communicated transparently, equitably, and effectively empowering communities to stay informed, engaged, and connected to the hospital's mission of advancing musculoskeletal health and well-being.

This Community Service Plan was adopted by HSS Mission Impact Committee of the Board of Trustees on October 22, 2025.

2025-2030 Prevention Agenda Workplan

Please refer to the excel workplan attached.

Appendices

Appendix A: Community Survey in All Languages

Community Health Needs Assessment (CHNA)

HSS wants to hear about your needs regarding muscle, bone, and joint conditions. This will help us to provide programs and services that are important to you. We do not need your name for this survey. Please return this survey no later than **February 15, 2025**, so that we can make sure your opinion counts. Thank you for your help!

A. Health Status and Quality of Life: Please choose your response from the options listed. If you are unsure, please give the best answer you can.

1. 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 (e.g., axial spondyloarthritis or psoriatic arthritis)	☐	☐
g) Osteoporosis	☐	☐
h) Spine deformity (e.g., scoliosis)	☐	☐
i) Chronic pain	☐	☐
j) Other: _____		

NOTE: If you answered "No" to all parts of Question 1, please SKIP to Question 3

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

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

3. Would you say that in general your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

4. 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
- ☐ 1-7 days
- ☐ 8-13 days
- ☐ 14 days or more

5. 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
- ☐ 1-7 days
- ☐ 8-13 days
- ☐ 14 days or more

6. Please respond to each question or statement by marking one box per row.

	Without any difficulty	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
a) Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
b) Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
c) Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
d) Are you able to run errands and shop?	☐	☐	☐	☐	☐

7. In the past 12 months, how many times have you fallen? _____

- ☐ None
- ☐ 1-2
- ☐ 3 or more
- ☐ Don't know

NOTE: If you answered "None" or "Don't know" to Question 7, please SKIP to Question 11

8. Did any of these fall(s) cause an injury?

☐ Yes ☐ No

9. Did you see a doctor or other healthcare professional about your fall(s)?

☐ Yes ☐ No

NOTE: If you answered "Yes" to Question 9, please SKIP to Question 11

10. Why did you not seek medical help for your fall? **Check all that apply**.

- ☐ My fall was not serious
- ☐ I could self-manage the outcomes of my fall
- ☐ I didn't want to waste my doctor's time
- ☐ I didn't want to be seen as "weak"
- ☐ I didn't think my doctor could do anything to help
- ☐ I don't want to lose my independence

- ☐ I don't have a regular health care provider
- ☐ I couldn't get an appointment
- ☐ I don't have health insurance
- ☐ I couldn't afford to see a doctor
- ☐ Other:_____

NOTE: The following question refers to your overall sleep quality for the *majority* of the nights in the *past 7 days ONLY*.

11. Please think about the quality of your sleep **overall**, such as how many hours of sleep you got, how easily you fell asleep, how often you woke up during the night (except to go to the bathroom), how often you woke up earlier than you had to in the morning, and how refreshing your sleep was.

During the **past 7 days**, how would you rate your sleep quality overall on a scale of 0 to 10, where "0" represents terrible sleep quality and "10" represents excellent sleep quality? **(Please mark only 1 box)**

Terrible	Poor			Fair			Good			Excellent
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

B. Health Behaviors & Lifestyle:

12. How often do you feel the way described in each of the following statements?

	Hardly ever	Some of the time	Often
a) How often do you feel that you lack companionship?	☐	☐	☐
b) How often do you feel left out?	☐	☐	☐
c) How often do you feel isolated from others?	☐	☐	☐

The next questions ask about physical activities such as exercise, sports, or physically active hobbies that you may do in your leisure time. Examples of physical activities include running, golf, gardening, walking, cycling, tennis, swimming, dancing, and other activities that require physical effort.

13. In the **past 30 days**, other than your job, did you participate in any physical activities or exercises such as running, golf, gardening, or walking for exercise?

☐ Yes ☐ No

NOTE: If you answered "Yes" to Question 12, please SKIP to Question 14

14. Why have you not participated in physical activities in the past 30 days? **Check all that apply.**

- ☐ It's hard to find a place to be physically active
- ☐ Physical activities cost too much money
- ☐ My health (for example, heart disease or having too much pain)
- ☐ My mental health (for example, depression or anxiety)
- ☐ I'm recovering from an injury

- ☐ I worry about getting injured
- ☐ Physical activity makes me feel uncomfortable
- ☐ Physical activity is not a priority of mine
- ☐ I am not confident in my ability to be physically active
- ☐ I don't know how to start being physically active
- ☐ I am too old to be physically active
- ☐ It's hard to find people to be active with
- ☐ Others have told me to avoid physical activity
- ☐ I don't have enough energy
- ☐ Other: _____

15. Over the past three months, how often did your pain limit your life or work activities?

- ☐ Never
- ☐ Some days
- ☐ Most days
- ☐ Every day

NOTE: If you answered "Never" to Question 14, please SKIP to Question 16

16. Over the past three months, did you use any of the following to manage your pain?

	Yes	No
a) Yoga, Tai Chi, or Qi Gong (chee-GONG)?	☐	☐
b) Other forms of exercise, such as walking, swimming, bike riding, stretching, or strength training?	☐	☐
c) Over-the-counter medications such as aspirin?	☐	☐
d) A pain reliever or opioid prescribed by a doctor, dentist, or other health professional?	☐	☐
e) Physical therapy, rehabilitative therapy, or occupational therapy?	☐	☐
f) Spinal manipulation or other forms of chiropractic care?	☐	☐
g) Massage	☐	☐
h) Meditation, guided imagery, or other relaxation techniques?	☐	☐
i) Other, Please specify: _____	☐	☐

17. How do you feel about the following statements regarding your diet and healthy eating? By healthy eating, we mean eating different foods that give you the nutrients you need to stay healthy, feel good, and have energy.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
a) I am able to find healthy foods where I shop and eat.	☐	☐	☐	☐	☐	☐
b) I am able to eat fruits and vegetables at most meals.	☐	☐	☐	☐	☐	☐
c) I am able to eat a variety of healthy foods.	☐	☐	☐	☐	☐	☐
d) I know how to choose healthy foods where I shop and eat.	☐	☐	☐	☐	☐	☐
e) If using a recipe to cook, I am able to make it healthier.	☐	☐	☐	☐	☐	☐
f) If I eat unhealthy foods, I am able to make healthier food choices later.	☐	☐	☐	☐	☐	☐
g) When I feel hungry, I am able to easily choose healthy food over less healthy options.	☐	☐	☐	☐	☐	☐

18. Is the following statement "often true, sometimes true, or never true": Within the past 12 months I worried whether my food would run out before I got money to buy more.

☐ Often true
☐ Sometimes true
☐ Never true

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.

19. What is the primary source of your insurance?

☐ A plan purchased through an employer or union (includes plans purchased through another person's employer)
☐ A private nongovernmental plan that you or another family member buys on your own
☐ Medicaid
☐ Medicare
☐ Medigap
☐ Children's Health Insurance Program (CHIP)
☐ Military related healthcare: TRICARE (formerly CHAMPUS) or VA
☐ Alaska Native, Indian Health Service, Tribal Health Services
☐ State sponsored health plan
☐ Some other source
☐ I do not have health insurance coverage
☐ Don't Know

20. Here is a list of some things that may affect people's health and well-being. What are the top problems that affect your health? **Please check all that apply**

☐ Lack of access to my doctor's office
☐ Lack of access to insurance
☐ Limited access to any foods
☐ Limited access to healthy foods
☐ Poor schools
☐ Lack of job opportunities
☐ Discrimination/ bias
☐ Social isolation/ loneliness
☐ Lack of affordable childcare
☐ Poor housing/ homelessness
☐ Lack of neighborhood safety
☐ Limited places to exercise
☐ Transportation problems
☐ Infectious diseases (Covid-19, flu, RSV, etc.)
☐ Other: _____
☐ Does not apply to me

21. There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the past 12 months? **Please check all that apply**

☐ Does not apply - I was able to get healthcare in the past 12 months
☐ Didn't have transportation
☐ Nervous about seeing a healthcare provider
☐ Couldn't find a doctor for the specialty I need
☐ Couldn't get an appointment
☐ Couldn't get time off work
☐ Couldn't get child care
☐ You provide care to an adult and could not leave him/her
☐ Couldn't afford the copay
☐ Your deductible was too high/or could not afford the deductible
☐ You had to pay out of pocket for some or all of the procedure
☐ Other reason: _____

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

a) Does not apply - always follow the medical advice of my doctor or healthcare provider	☐
b) Provider didn't explain treatment well enough (due to lack of time, uncaring attitude, or hard to understand)	☐
c) Did not feel treatment would help	☐
d) Concerned about the cost of treatment	☐
e) Forgot to take medicine / go for follow-up	☐
f) Provider doesn't understand my culture / language	☐
g) Condition not severe enough	☐
h) Worried about side effects of treatment	☐
i) Prefer to use complementary / alternative treatment	☐
j) Did not fit my schedule / not convenient for me	☐
k) Did not agree with the doctor / healthcare provider	☐

NOTE: Telehealth is the use of technology (i.e., smartphone, computer, tablet) to provide care when you and the doctor are not in the same place at the same time. For example: a video meeting or phone call with your healthcare provider.

23. What are some of the barriers you might experience in trying to use telehealth?
Check all that apply.

☐ I don't have any barriers
☐ I don't have a device (i.e., smartphone, computer, tablet)
☐ I don't have access to high-speed internet service
☐ I don't know how to use telehealth
☐ I am concerned about my health information remaining confidential
☐ I am concerned about the possibility of medical errors
☐ I am not sure that my doctor's office offers telehealth services
☐ I am not interested in telehealth
☐ I don't have a private space where I can take a call

24. During the past 12 months, have you used the Internet for any of the following reasons?

	Yes	**No**
a) To look for health or medical information.	☐	☐
b) To communicate with a doctor or doctor's office.	☐	☐
c) To look up medical test results.	☐	☐

25. Please think about all the times in your life when you have received healthcare. When getting healthcare, how often have any of the following things happened to you because of your race, ethnicity, color, language, sexual orientation, and/or gender identity?

	Never	Once in a while	Sometimes	A lot	Most of the time	Almost all of the time
a) You are treated with less courtesy than other people	☐	☐	☐	☐	☐	☐
b) You are treated with less respect than other people	☐	☐	☐	☐	☐	☐
c) You receive poorer service than others	☐	☐	☐	☐	☐	☐
d) A doctor or nurse acts as if they think you are not smart	☐	☐	☐	☐	☐	☐
e) A doctor or nurse acts as if they are afraid of you	☐	☐	☐	☐	☐	☐
f) A doctor or nurse acts as if they are better than you	☐	☐	☐	☐	☐	☐
g) You feel like a doctor or nurse is not listening to what you were saying	☐	☐	☐	☐	☐	☐

26. What language do you feel most comfortable **speaking** with your doctor or nurse?

☐ English
☐ Spanish
☐ Mandarin
☐ Cantonese
☐ Russian
☐ Arabic
☐ Hebrew
☐ Haitian Creole
☐ Other: _____

In which language would you feel most comfortable **reading** medical or healthcare instructions?

☐ English
☐ Spanish
☐ Chinese
☐ Russian
☐ Arabic
☐ Hebrew
☐ Haitian Creole
☐ Other: _____

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

☐ Never
☐ Rarely
☐ Sometimes
☐ Often
☐ Always

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

28. What are the top three reasons you did not participate in health education programs in the past 12 months? **Choose only your top 3 options.**

- ☐ Does not apply - I participated in health education programs in the past 12 months
- ☐ Could not afford it
- ☐ Lack of transportation
- ☐ Not sure where to go
- ☐ Fear or mistrust of doctors
- ☐ Infectious diseases (Covid-19, flu, RSV, etc.)
- ☐ Lack of time
- ☐ Scheduling conflicts
- ☐ Cultural/ religious barriers
- ☐ Language barriers (such as could not get health education in my language)
- ☐ Did not know about the program
- ☐ I am not interested in participating in a health education program

29. Which of the following health education formats/activities would you be interested in? **Check all that apply.**

- ☐ Onsite exercise classes
- ☐ Virtual exercise classes
- ☐ Onsite interactive small group workshops
- ☐ Virtual interactive small group workshops
- ☐ Onsite lectures
- ☐ Virtual lectures
- ☐ Podcasts (i.e., Audio programs you can listen to on your phone)
- ☐ On-demand videos (i.e., Videos available for downloading/streaming on your device, such as on Youtube)
- ☐ Social media posts (i.e., Facebook, Twitter/X, Instagram, TikTok etc.)
- ☐ Conference calls
- ☐ Support groups
- ☐ None of the above

30. What five health topics would you be interested in learning more about? **Choose only 5 options.**

- ☐ Exercise
- ☐ Managing my chronic condition
- ☐ Healthy eating
- ☐ Supporting a healthy lifestyle
- ☐ Dealing with stress, anxiety, and depression
- ☐ Ways to improve mobility
- ☐ Medication management
- ☐ Pain management
- ☐ Use of technology to manage health
- ☐ Managing my child's health
- ☐ Complementary treatments (i.e., Yoga, meditation, mindful breathing) to manage my health/ health condition
- ☐ Preparing a list of questions for my doctor or healthcare provider
- ☐ Discussing personal problems that may be related to my illness
- ☐ Asking questions about things I don't understand about my treatment
- ☐ Sexual health
- ☐ Infectious diseases (Covid, flu, RSV, etc.)
- ☐ Sports injury prevention
- ☐ Falls prevention
- ☐ Brain health
- ☐ Understanding insurance coverage
- ☐ Financial assistance options
- ☐ Healthy Aging
- ☐ Other: _____

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

31. What was your sex assigned at birth?
- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Other, Please specify: _____
- ☐ Prefer not to respond

32. What terms best express how you describe your gender identity?
- ☐ Man
- ☐ Woman
- ☐ Non-binary
- ☐ Transgender Woman
- ☐ Transgender Man
- ☐ Other (e.g., genderqueer, gender variant, or gender fluid), Please specify: _____
- ☐ Prefer not to respond

33. Do you think of yourself as:
- ☐ Straight, that is, not gay
- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Other, Please specify: _____
- ☐ Don't know
- ☐ Prefer not to respond

34. What is your age? _____

35. Do you consider yourself Hispanic/Latino? **Check all that apply.**
- ☐ Yes
  - ☐ Mexican, Mexican American, Chicano/a
  - ☐ Puerto Rican
  - ☐ Cuban
  - ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ No
- ☐ Don't know/Not sure
- ☐ Prefer not to respond

36. Which one of these groups would you say best represents your race? **Check all that apply.**
- ☐ American Indian / Alaska Native
- ☐ Asian
  - ☐ Asian Indian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Japanese
  - ☐ Korean
  - ☐ Vietnamese
  - ☐ Other Asian
- ☐ Black or African American
- ☐ Pacific Islander
  - ☐ Native Hawaiian
  - ☐ Guamanian or Chamorro
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ White
- ☐ Other: _____
- ☐ Don't know/Not sure
- ☐ Prefer not to respond

37. 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)
- ☐ Postgraduate (Masters, PhD)
- ☐ Prefer not to respond

38. 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
- ☐ Prefer not to respond

39. In the past 12 months, did you participate in one or more of the following government assistance programs? Please select all that apply.

- ☐ I did not participate in a government assistance program
- ☐ Nutrition assistance (e.g., SNAP, WIC etc.)
- ☐ Shelter assistance (e.g., public housing, housing vouchers, energy assistance etc.)
- ☐ Cash assistance (e.g., Supplemental Security Income (SSI), Welfare, TANF etc.)
- ☐ Social insurance (e.g., Social Security, unemployment)
- ☐ Veteran/Military benefits
- ☐ Disability benefits
- ☐ Other

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

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

Thank you for completing this survey!

Please return this survey no later than February 15, 2025, 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. **Drop off** at: Hospital for Special Surgery Education Institute (EI) office, located at: 517 East 71st Street, NY, NY 10021 – **Attn: Bertilia Trieu**

If you have any questions or concerns about the survey, please contact Bertilia Trieu, Manager, Outcomes & Data Analytics, at eioutcomes@hss.edu

Evaluación de las necesidades sanitarias de la comunidad (CHNA)

HSS quiere conocer sus necesidades con respecto a las condiciones de los músculos, los huesos y las articulaciones. Esto nos ayudará brindar programas y servicios que son importantes para usted. No necesitamos su nombre para esta encuesta. Envíe esta encuesta a más tardar el **15 de febrero del 2025**, para que podamos asegurarnos de que su opinión cuente. ¡Gracias por su ayuda!

A. Estado de salud y calidad de vida: seleccione su respuesta entre las opciones indicadas. Si no está seguro, seleccione la mejor respuesta que pueda.

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

	Sí	No
a) Osteoartritis (OA)	☐	☐
b) Artritis reumatoide (AR)	☐	☐
c) Lupus	☐	☐
d) Fibromialgia	☐	☐
e) Gota	☐	☐
f) Alguna otra forma de artritis (por ejemplo, espondiloartritis axial o artritis psoriásica)	☐	☐
g) Osteoporosis	☐	☐
h) Deformidad de la columna vertebral (por ejemplo, escoliosis)	☐	☐
i) Dolor crónico	☐	☐
j) Otro: _____		

NOTA: si respondió "No" a todas las partes de la pregunta 1, PASE a la pregunta 3

2. ¿Qué tan seguro está de poder controlar los síntomas de su afección ósea, muscular y/o articular para poder hacer las cosas que desea hacer?

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

3. ¿Diría que en general su salud es:

- ☐ Excelente
- ☐ Muy buena
- ☐ Buena
- ☐ Regular
- ☐ Deficiente

4. Pensando en su **salud física**, que incluye enfermedades físicas y lesiones, ¿cuántos de los **últimos 30 días** su salud física no fue buena?

- ☐ Ninguno
- ☐ 1 a 7 días
- ☐ 8 a 13 días
- ☐ 14 días o más

5. Pensando en su **salud mental**, que incluye estrés, depresión y problemas con las emociones, ¿cuántos de los **últimos 30 días** su salud mental no fue buena?

☐ Ninguno
☐ 1 a 7 días
☐ 8 a 13 días
☐ 14 días o más

6. Responda a cada pregunta o afirmación marcando una casilla por fila.

	Sin ninguna dificultad	Con un poco de dificultad	Con algo de dificultad	Con mucha dificultad	No puedo hacerlo
a) ¿Es usted capaz de hacer los quehaceres domésticos como pasar la aspiradora o trabajar en el jardín?	☐	☐	☐	☐	☐
b) ¿Es usted capaz de subir y bajar escaleras a un ritmo normal?	☐	☐	☐	☐	☐
c) ¿Es usted capaz de salir a caminar al menos 15 minutos?	☐	☐	☐	☐	☐
d) ¿Puede hacer mandados y salir de compras?	☐	☐	☐	☐	☐

7. En los últimos 12 meses, ¿cuántas veces te has caido? _____

☐ Ninguna
☐ 1 a 2
☐ 3 o más
☐ No sé

NOTA: si respondió "Ninguna" o "No sé" a la pregunta 7, PASE a la pregunta 11

8. ¿Alguna de esas caídas le causó alguna lesión?

☐ Sí ☐ No

9. ¿Consultó a un médico o a otro profesional de la salud por la caída?

☐ Sí ☐ No

NOTA: si respondió "Sí" a la pregunta 9, PASE a la pregunta 11

10. ¿Por qué no buscó ayuda médica por la caída? **Marque todas las opciones que correspondan**.

☐ Mi caída no fue grave
☐ Podría autogestionar las consecuencias de mi caída
☐ No quise hacerle perder el tiempo a mi médico
☐ No quería que me vieran como "débil"
☐ No pensé que mi médico pudiera hacer algo para ayudarme
☐ No quiero perder mi independencia
☐ No tengo un proveedor de atención médica habitual

☐ No pude conseguir una cita
☐ No tengo seguro médico
☐ No podía pagar la consulta médica.
☐ Otro:_____

NOTA: La siguiente pregunta se refiere a la calidad general de su sueño durante la *mayoría* de las noches de los *últimos 7 días SOLAMENTE*.

11. Lepedimos que considere la calidad de su sueño **en general**, como el número de horas que durmió, la facilidad con la que se quedó dormido, la frecuencia con la que se despertó durante la noche (excepto para ir al baño), la frecuencia con la que se despertó antes de lo que tenía que hacerlo por la mañana y lo reparador que fue su sueño.

Durante los **últimos 7 días**, ¿cómo calificaría la calidad del sueño en general en una escala del 0 al 10, donde "0" representa una calidad de sueño terrible y "10", una calidad de sueño excelente? **(Marque solo 1 casilla)**

Pésima	Mala			Regular			Buena			Excelente
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

B. Comportamientos de salud y estilo de vida:

12. ¿Con qué frecuencia se siente como se describe en cada uno de los siguientes enunciados?

	Casi nunca	Algunas veces	A menudo
a) ¿Con qué frecuencia siente que le falta compañía?	☐	☐	☐
b) ¿Con qué frecuencia se siente excluido?	☐	☐	☐
c) ¿Con qué frecuencia se siente aislado de los demás?	☐	☐	☐

Las siguientes preguntas se refieren a las actividades físicas como ejercicio, deportes o pasatiempos físicamente activos que puede hacer en su tiempo libre. Algunos ejemplos de actividades físicas incluyen correr, jugar al golf, hacer jardinería, caminar, andar en bicicleta, jugar al tenis, nadar, bailar y otras actividades que requieren esfuerzo físico.

13. En los **últimos 30 días**, aparte de su trabajo, ¿participó en alguna actividad física o ejercicio como correr, jugar al golf, hacer jardinería o caminar para hacer ejercicio?
☐ Sí ☐ No

NOTA: si respondió "Sí" a la pregunta 12, PASE a la pregunta 14

14. ¿Por qué no ha participado en actividades físicas en los últimos 30 días? **Marque todas las opciones que correspondan.**

- ☐ Es difícil encontrar un lugar para practicar actividad física
- ☐ Las actividades físicas cuestan demasiado dinero
- ☐ Mi salud (por ejemplo, enfermedad cardíaca o siento demasiado dolor)
- ☐ Mi salud mental (por ejemplo, depresión o ansiedad)
- ☐ Me estoy recuperando de una lesión
- ☐ Me preocupa lesionarme
- ☐ La actividad física me hace sentir incómodo
- ☐ La actividad física no es una prioridad para mí
- ☐ No estoy seguro de mi capacidad para estar físicamente activo
- ☐ No sé cómo empezar a ser físicamente activo
- ☐ Soy demasiado mayor para ser físicamente activo
- ☐ Es difícil encontrar personas con las que mantenerse activo
- ☐ Otras personas me han dicho que evite la actividad física
- ☐ No tengo suficiente energía
- ☐ Otro: _____

15. En los últimos tres meses, ¿con qué frecuencia el dolor limitó su vida o sus actividades laborales?

- ☐ Nunca
- ☐ Algunos días
- ☐ La mayoría de los días
- ☐ Todos los días

NOTA: si respondió "Nunca" a la pregunta 15, PASE a la pregunta 17

16. En los últimos tres meses, ¿utilizó alguna de las siguientes medidas para controlar su dolor?

	Sí	**No**
a) ¿Yoga, tai chi o qi gong (chee-GONG)?	☐	☐
b) ¿Otras formas de ejercicio, como caminar, nadar, andar en bicicleta, estirarse o entrenamiento de fuerza?	☐	☐
c) ¿Medicamentos sin recetacomo la aspirina?	☐	☐
d) ¿Un analgésico u opiáceo recetado por un médico, dentista u otro profesional sanitario?	☐	☐
e) *¿Fisioterapia, terapia de rehabilitación o terapia ocupacional?*	☐	☐
f) ¿Manipulación espinal u otras formas de atención quiropráctica?	☐	☐
g) Masaje	☐	☐
h) ¿Meditación, visualización guiada u otras técnicas de relajación?	☐	☐
i) Otro, especifique: _____	☐	☐

17. ¿Qué opina de los siguientes afirmaciones sobre su dieta y alimentación saludable? Por alimentación saludable nos referimos a comer diferentes alimentos que le aporten los nutrientes que necesita para mantenerse saludable, sentirse bien y tener energía.

	Totalmente en Desacuerdo	Desacuerdo	Neutral	De acuerdo	Totalmente de Acuerdo	No corresponde
a) Puedo encontrar alimentos saludables donde compro y como.	☐	☐	☐	☐	☐	☐
b) Puedo comer frutas y verduras en la mayoría de las comidas.	☐	☐	☐	☐	☐	☐
c) Puedo comer una variedad de alimentos saludables.	☐	☐	☐	☐	☐	☐
d) Sé cómo elegir alimentos saludables donde compro y como.	☐	☐	☐	☐	☐	☐
e) Si uso una receta para cocinar, puedo hacerla más saludable.	☐	☐	☐	☐	☐	☐
f) Si como alimentos poco saludables, después puedo reducir el consumo o elegir alimentos más saludables.	☐	☐	☐	☐	☐	☐
g) Cuando tengo hambre, puedo elegir fácilmente alimentos saludables en lugar de opciones menos saludables.	☐	☐	☐	☐	☐	☐

18. ¿La siguiente declaración es: "casi siempre cierto, Ocasionalmente cierto, o nunca cierto"?: En los últimos 12 meses me preocupaba que se me acabara la comida antes de tener dinero para comprar más.

☐ Casi siempre cierto
☐ Ocasionalmente cierto
☐ Nunca cierto

C. Uso y acceso a la atención de salud: Estas preguntas son sobre sus experiencias de atención médica y sus necesidades de educación médica. Elija su respuesta de las opciones enumeradas. Si no está seguro, selecionne la mejor respuesta que pueda.

19. ¿Cuál es la fuente <u>principal</u> de su seguro?

- ☐ Un plan adquirido a través de un empleador o sindicato (incluye planes adquiridos a través del empleador de otra persona)
- ☐ Un plan privado no gubernamental que usted u otro miembro de la familia compra por su cuenta
- ☐ Medicaid
- ☐ Medicare
- ☐ Medigap
- ☐ Programa de seguro médico para Niños (CHIP)
- ☐ Atención médica relacionada con el ejército: TRICARE (anteriormente CHAMPUS) o VA
- ☐ Servicio de salud para indígenas y nativos de Alaska, servicios de salud tribales
- ☐ Plan de salud patrocinado por el estado
- ☐ Alguna otra fuente
- ☐ No tengo cobertura de seguro médico
- ☐ No sé

20. Le presentamos una lista de algunas cosas que pueden afectar a la salud y el bienestar de las personas. ¿Cuáles son los principales problemas que afectan su salud? **Marque todas las opciones que correspondan**

- ☐ Falta de acceso al consultorio de mi médico
- ☐ Falta de acceso a seguros
- ☐ Acceso limitado a los alimentos
- ☐ Acceso limitado a los alimentos saludables
- ☐ Malas escuelas
- ☐ Falta de oportunidades laborales
- ☐ Discriminación o prejuicios
- ☐ Aislamiento social o soledad
- ☐ Falta de guarderías asequibles
- ☐ Vivienda deficiente o sinhogarismo
- ☐ Inseguridad en el vecindario
- ☐ Lugares limitados para hacer ejercicio
- ☐ Problemas de transporte
- ☐ Enfermedades infecciosas (covid-19, gripe, VSR, etc.)
- ☐ Otro: _____
- ☐ No es aplicable

21. Hay muchos motivos por los que las personas retrasar la atención médica. ¿Ha retrasado la atención médica por alguno de los siguientes motivos en los últimos 12 meses? **Marque todas las opciones que correspondan**

- ☐ No aplica: pude obtener atención médica en los últimos 12 meses
- ☐ No tenía transporte
- ☐ Nervios por acudir a un proveedor de atención médica
- ☐ No pude encontrar un médico de la especialidad que necesito
- ☐ No pude conseguir una cita
- ☐ No pude conseguir el tiempo libre del trabajo
- ☐ No pude conseguir guardería
- ☐ Cuida a un adulto y no puede dejarlo
- ☐ No pude pagar el copago
- ☐ El deducible era demasiado alto o no pude pagarlo
- ☐ Tuve que pagar de mi bolsillo una parte o la totalidad del procedimiento
- ☐ Otro motivo: _____

22. A veces la gente no sigue los consejos médicos de su médico u otro profesional de salud. Seleccione las razones que puedan aplicarse en su caso. **Marque todas las opciones que correspondan.**

a) No corresponde - siempre sigo los consejos de mi médico o proveedor de salud.	☐
b) El proveedor no le explicó el tratamiento lo suficientemente bien (por falta de tiempo, actitud indiferente o difícil de entender)	☐
c) No sintió que el tratamiento le ayudaría	☐
d) Preocupado por el coste del tratamiento	☐
e) Olvidó tomar la medicación / acudir al seguimiento	☐
f) El proveedor no entiende mi cultura/idioma	☐
g) Mi condición no es lo suficientemente grave	☐
h) Preocupado por los efectos secundarios del tratamiento	☐
i) Prefiere recurrir a un tratamiento complementario / alternativo	☐
j) No se ajustaba a mi horario/no me convenía	☐
k) No estaba de acuerdo con el médico / profesional de salud	☐

NOTA: La telesalud es el uso de la tecnología (es decir, smartphone, computadora, tablet) para brindarle atención médica cuando usted y el médico no están en el mismo lugar al mismo tiempo. Por ejemplo: una videoconferencia o una llamada telefónica con su profesional de salud.

23. ¿Cuáles son algunas de las barreras que podría experimentar al recurrir a la telesalud? **Marque todas las que correspondan.**

☐ No tengo ninguna barrera
☐ No tengo un dispositivo (es decir, teléfono inteligente, computadora, tableta)
☐ No tengo acceso al servicio de Internet de alta velocidad
☐ No sé cómo utilizar la telesalud
☐ Me preocupa que mi información médica siga siendo confidencial
☐ Me preocupa la posibilidad de que haya errores médicos
☐ No estoy seguro de que el consultorio de mi médico ofrezca servicios de telesalud
☐ No me interesa la telesalud
☐ No tengo un espacio privado donde pueda atender una llamada

24. En los últimos 12 meses, ¿ha utilizado Internet por alguno de los siguientes motivos?

	Sí	**No**
a) Para buscar información médica o de salud.	☐	☐
b) Para comunicarse con un médico o consultorio médico.	☐	☐
c) Para ver los resultados de pruebas médicas.	☐	☐

25. Piense en todos los momentos de su vida en los que ha recibido atención médica. Al recibir atención médica, ¿con qué frecuencia le sucedió alguna de las siguientes cosas por su raza, origen étnico, color, idioma, orientación sexual y/o identidad de género?

	Nunca	De vez en cuando	A veces	Mucho	La mayoría de las veces	Casi siempre
a) Le tratan con menos cortesía que otras personas.	☐	☐	☐	☐	☐	☐
b) Le tratan con menos respeto que a otras personas.	☐	☐	☐	☐	☐	☐
c) Recibe un servicio peor que los demás	☐	☐	☐	☐	☐	☐
d) Un médico o enfermera actúa como si pensara que usted no es inteligente	☐	☐	☐	☐	☐	☐
e) Un médico o enfermera actúa como si le tuviera miedo	☐	☐	☐	☐	☐	☐
f) Un médico o enfermera actúa como si fuera mejor que usted	☐	☐	☐	☐	☐	☐
g) Siente que un médico o un personal de enfermería no escuchan lo que usted decía	☐	☐	☐	☐	☐	☐

26. ¿En qué idioma se siente más cómodo **hablando** con su médico o enfermera?

☐ Inglés
☐ Español
☐ Mandarín
☐ Cantonés
☐ Ruso
☐ Árabe
☐ Hebreo
☐ Criollo haitiano
☐ Otro: _____

27. ¿En qué idioma se sentiría más cómodo **leyendo** instrucciones médicas o de atención médica?

☐ Inglés
☐ Español
☐ Chino
☐ Ruso
☐ Árabe
☐ Hebreo
☐ Criollo haitiano
☐ Otro: _____

28. ¿Con qué frecuencia necesita que alguien le ayude al leer instrucciones, folletos u otro material escrito de su médico o farmacia?

- ☐ Nunca
- ☐ Casi nunca
- ☐ A veces
- ☐ A menudo
- ☐ Siempre

D. Educación para la salud: El HSS ofrece programas de educación para la salud. Las siguientes preguntas nos ayudarán a identificar las necesidades de educación en salud de la comunidad.

29. ¿Cuáles son las tres razones principales por las que no participó en los programas de educación para la salud en los últimos 12 meses? **Elija solo sus 3 mejores opciones.**

- ☐ No aplica: participé en programas de educación para la salud en los últimos 12 meses
- ☐ No podía pagarlo
- ☐ Falta de transporte
- ☐ No estoy seguro de adónde ir
- ☐ Miedo o desconfianza de los médicos
- ☐ Enfermedades infecciosas (covid-19, gripe, VRS, etc.)
- ☐ Falta de tiempo
- ☐ Problemas de horario
- ☐ Barreras culturales o religiosas
- ☐ Barreras lingüísticas (por ejemplo, no pude recibir educación sanitaria en mi idioma)
- ☐ No sabía nada del programa
- ☐ No estoy interesado en participar en un programa de educación para la salud

30. ¿Cuál de los siguientes formatos/actividades de educación sobre la salud le interesarían? **Marque todas las opciones que correspondan**

- ☐ Clases de ejercicio presenciales
- ☐ Clases de ejercicio virtuales
- ☐ Talleres presenciales interactivos para grupos pequeños
- ☐ Talleres virtuales interactivos para grupos pequeños
- ☐ Conferencias presenciales
- ☐ Conferencias virtuales
- ☐ Pódcast (es decir, programas de audio que puede escuchar en el teléfono)
- ☐ Videos a la carta (es decir, videos disponibles para descargar o transmitir en su dispositivo, p. ej., en YouTube)
- ☐ Publicaciones en redes sociales (es decir, Facebook, Twitter/X, Instagram, TikTok, etc.)
- ☐ Llamadas en conferencia
- ☐ Grupos de apoyo
- ☐ Ninguno de las anteriores

31. ¿Sobre qué cinco temas de salud le interesaría aprender más? **Elija solo 5 opciones.**

- ☐ Ejercicio
- ☐ Cómo manejar mi enfermedad crónica
- ☐ Alimentación saludable
- ☐ Cómo apoyar un estilo de vida saludable
- ☐ Cómo afrontar el estrés, la ansiedad y la depresión
- ☐ Formas de mejorar la movilidad
- ☐ Manejo de medicamentos
- ☐ Manejo del dolor
- ☐ Uso de la tecnología para manejar la salud
- ☐ Cómo manejar la salud de mi hijo
- ☐ Tratamientos complementarios (es decir, yoga, meditación, respiración consciente) para controlar mi salud o enfermedad
- ☐ Cómo hacer una lista de preguntas para mi médico o proveedor de atención médica
- ☐ Hablar de problemas personales que pueden estar relacionados con mi enfermedad
- ☐ Hacer preguntas sobre cosas que no entiendo sobre mi tratamiento.
- ☐ Salud sexual
- ☐ Enfermedades infecciosas (covid, gripe, VRS, etc.)
- ☐ Prevención de lesiones deportivas
- ☐ Prevención de caídas
- ☐ Salud cerebral
- ☐ Cómo entender la cobertura del seguro
- ☐ Opciones de ayuda económica
- ☐ Envejecimiento saludable
- ☐ Otro: _____

E. Acerca de usted: Háblenos de usted y sus antecedentes para que podamos saber más de las comunidades a las que atendemos.

32. ¿Cuál fue su sexo asignado al nacer?

- ☐ Femenino
- ☐ Masculino
- ☐ Intersexual
- ☐ Otro, especifique: _____
- ☐ Prefiero no responder

33. ¿Qué términos expresan mejor cómo describe su identidad de género?

- ☐ Hombre
- ☐ Mujer
- ☐ No binario
- ☐ Mujer transgénero
- ☐ Hombre transgénero
- ☐ Otro (por ejemplo, queer, género variante o género fluido) Especifique: _____
- ☐ Prefiero no responder

34. Considera que usted es:

- ☐ Heterosexual, es decir, no es gay
- ☐ Lesbiana o gay
- ☐ Bisexual
- ☐ Otro, especifique: _____
- ☐ No sé
- ☐ Prefiero no responder

35. ¿Cuál es su edad? _____

36. ¿Se considera hispano/latino? **Marque todas las opciones que correspondan.**

- ☐ Sí
  - ☐ Mexicano, mexicano-estadounidense, chicano/a
  - ☐ Puertorriqueño
  - ☐ Cubano
  - ☐ Otro origen hispano, latino o español
- ☐ No
- ☐ No sé o no estoy seguro
- ☐ Prefiero no responder

37. ¿Cuál de estos grupos diría que representa mejor a su raza? **Marque todas las opciones que correspondan.**

- ☐ Indígena estadounidense o nativo de Alaska
- ☐ Asiático
  - ☐ Indio asiático
  - ☐ Chino
  - ☐ Filipino
  - ☐ Japonés
  - ☐ Coreano
  - ☐ Vietnamita
  - ☐ Otros asiáticos
- ☐ Negro o afroamericano
- ☐ Isleño del Pacífico
  - ☐ Hawaiano nativo
  - ☐ Guameño o chamorro
  - ☐ Samoano
  - ☐ Otros isleños del Pacífico
- ☐ Blanco
- ☐ Otro: _____
- ☐ No sé o no estoy seguro
- ☐ Prefiero no responder

38. ¿Cuál es el grado o año escolar más alto que completó?

- ☐ Nunca fui a la escuela o solo fui al jardín de infantes
- ☐ De 1.º a 8.º grados (primaria)
- ☐ De 9.º a 11.º grados (algunos de secundaria)
- ☐ 12.º grado o GED (graduado de secundaria)
- ☐ Universidad, de 1 a 3 años (algunos estudios universitarios o escuela técnica)
- ☐ Universidad, 4 años o más (egresado universitario)
- ☐ Posgrado (maestría, doctorado)
- ☐ Prefiero no responder

39. ¿Cuáles son los ingresos anuales de su hogar procedentes de todas las fuentes?

- ☐ Menos de $10,000
- ☐ Entre $10,000 y $14,999
- ☐ Entre $15,000 y $24,999
- ☐ Entre $25,000 y $34,999
- ☐ Entre $35,000 y $49,999
- ☐ Entre $50,000 y $74,999
- ☐ Entre $75,000 y $99,999
- ☐ Entre $100,000 y $149,999
- ☐ Entre $150,000 y $199,999
- ☐ $200,000 o más
- ☐ Prefiero no responder

40. En los últimos 12 meses, ¿participó en uno o más de los siguientes programas de ayuda gubernamental? Seleccione todas las opciones que correspondan.

☐ No participé en un programa de ayuda gubernamental
☐ Ayuda nutricional (por ejemplo, SNAP, WIC, etc.)
☐ Ayuda de vivienda (por ejemplo, vivienda pública, vales de vivienda, ayuda energética, etc.)
☐ Ayuda en efectivo (por ejemplo, seguridad de ingreso complementario (SSI), ayuda social, TANF, etc.)
☐ Seguro social (por ejemplo, seguridad social, cesantías)
☐ Beneficios para veteranos y militares
☐ Beneficios por discapacidad
☐ Otros

41. ¿Cuál es el código postal donde vive actualmente? _____

Use el espacio a continuación para informarnos si tiene alguna otra necesidad relacionada con los músculos, huesos, articulaciones o dolores que desea que sepamos en Hospital for Special Surgery:

¡Gracias por completar esta encuesta!

Envíe esta encuesta a más tardar el 15 de febrero del 2025, para que podamos asegurarnos de que su opinión cuente.

Envíenos la encuesta completa de una de las siguientes maneras:

3. **Por correo** usando el sobre prepagado adjunto
4. **Entréguela** en la oficina del Instituto Educativo de Hospital for Special Surgery, ubicada en: 517 East 71st Street, NY, NY 10021 – **Attn: Bertilia Trieu**

Si tiene alguna pregunta o inquietud sobre la encuesta, comuníquese con Bertilia Trieu, gerente de Resultados y Análisis de Datos, a eioutcomes@hss.edu

社區健康需求評估 (CHNA)

HSS 想了解您的肌肉、骨骼和關節疾病有關的需求。這能協助我們提供對您健康十分重要的計劃與服務。這是一份不具名問卷。請於 **2025 年 2 月 15 日**前繳回此問卷，確保您的意見受到採用。感謝您的幫助！

A. 健康狀況和生活品質：請從下列選項中選擇一個答案。
如果您不確定，請選擇最接近的答案。

1. 是否有醫生或醫療專業人士曾告知您患有 ...？

	是	否
a) 骨關節炎 (OA)	☐	☐
b) 類風濕性關節炎 (RA)	☐	☐
c) 紅斑狼瘡	☐	☐
d) 纖維肌痛症	☐	☐
e) 痛風	☐	☐
f) 其他類型的關節炎（例如：中軸性脊椎關節炎或乾癬性/銀屑病關節炎）	☐	☐
g) 骨質疏鬆症	☐	☐
h) 脊椎變形（例如：脊椎側彎）	☐	☐
i) 慢性疼痛	☐	☐
j) 其他：_____		

注意：如果您在問題 1的回答皆為「否」，請「跳至問題 3」。

2. 您有信心能夠好好管理骨骼、肌肉、和/或關節方面的症狀，不讓它妨礙您做想做的事嗎？

☐ 完全沒信心
☐ 有點信心
☐ 有信心
☐ 非常有信心

3. 您認為您的整體健康狀況為：

☐ 極好
☐ 非常好
☐ 好
☐ 尚可
☐ 不佳

4. 請回想您的**健康情況**，包括身體疾病和損傷；**在過去三十天中**， 您感到健康狀況不佳的狀況有多少天？

☐ 完全沒有
☐ 1-7 天
☐ 8-13 天
☐ 14 天或以上

5. 請回想您的**心理健康狀況**，包括壓力、憂鬱、情緒相關問題；**在過去三十天中**，您感到心理健康狀況不佳的狀況有多少天？

☐ 完全沒有
☐ 1-7 天
☐ 8-13 天
☐ 14 天或以上

6. 請在每一行問題勾選一個方格來回答。

	完全無困難	**稍微有點困難**	**有些困難**	**非常困難**	**無法做到**
a) 您是否能執行例如用吸塵器打掃或打理庭院等家務？	☐	☐	☐	☐	☐
b) 您是否能用正常步速上下樓梯？	☐	☐	☐	☐	☐
c) 您是否能散步至少 15 分鐘？	☐	☐	☐	☐	☐
d) 您是否能出門辦事和購物？	☐	☐	☐	☐	☐

7. 在過去 12 個月中，您跌倒過多少次？ _____

☐ 完全沒有
☐ 1-2 次
☐ 3 次或以上
☐ 不知道

注意：如果您在問題 7的回答為「完全沒有」或「不知道」，請「跳至問題 11」

8. 您是否曾因為任何一次跌倒而受傷？

☐ 是 ☐ 否

9. 您曾因為跌倒去看醫生或諮詢其他醫療保健專業人員嗎？

☐ 是 ☐ 否

注意：如果您在問題 9 的回答皆為「是」，請「跳至問題 11」

10. 請問您跌倒卻未尋求醫療協助的原因為何？ **勾選所有符合項目**。

☐ 我跌倒的狀況並不嚴重
☐ 我可以自行處理跌倒後的狀況
☐ 我不想浪費醫生的時間
☐ 我不想被人視作「軟弱」
☐ 我認為我的醫生無法幫助我
☐ 我不想失去我的自主性
☐ 我沒有固定的醫療服務提供者
☐ 我預約不到時間
☐ 我沒有健康保險
☐ 我負擔不起看醫生的費用

☐ 其他:_____

注意：下方問題只針對您在*過去 7 天中大多數*晚上的整體睡眠品質。

11. 請回想您的**整體**睡眠品質，例如睡眠時間長度、入睡容易程度、夜裡醒來的頻率（上廁所除**外**）、早上比預定時間提早起床的頻率以及睡醒後的體力恢復程度。

在過去**七天內**，根據 0 到 10 的等級，您如何評價自己的睡眠品質？ (0 代表睡眠品質很糟糕，10 代表睡眠品質相當良好) **（請只勾選 1 個方格）**

很糟		不佳			尚可			好			極好
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9		10

B. 健康行為和生活方式：

12. 您有多常感覺到以下陳述中所描述的感受？

	幾乎沒有	**有時**	**經常**
a) 您有多常感覺缺乏他人的陪伴？	☐	☐	☐
b) 您有多常感覺被冷落？	☐	☐	☐
c) 您有多常感覺遭到孤立？	☐	☐	☐

下列問題是關於您在閒暇時間可能會做的身體活動，例如運動鍛鍊、體育項目或閒暇時愛好的活動。 身體活動的例子包括跑步、打高爾夫球、園藝、散步、騎自行車、打網球、游泳、跳舞和其他需要耗費體力的活動。

13. 在**過去 30 天中**，除了工作以外，您是否有參加任何身體活動或運動如跑步、打高爾夫球、園藝或散步以鍛鍊身體？

☐ 是 ☐ 否

注意：如果您在問題 12的回答皆為「是」，請跳至「問題 14」

14. 請問在過去 30 天中，您為何未參與身體活動？ **勾選所有符合項目。**

- ☐ 不容易找到可以活動身體的地方
- ☐ 身體活動所需的費用太貴
- ☐ 個人健康問題(例如，心臟疾病或身體有許多病痛)
- ☐ 個人心理健康問題(例如，憂鬱或焦慮)
- ☐ 受傷恢復中
- ☐ 擔心會因從事活動受傷
- ☐ 身體活動讓我感到不舒服
- ☐ 身體活動不是我優先重視的事
- ☐ 我對自己活動身體的能力沒有信心
- ☐ 我不知道如何開始活動身體
- ☐ 年紀太老，不適合活動身體
- ☐ 不容易找到其他人和我一起活動身體
- ☐ 別人告訴我要避免身體活動
- ☐ 我沒有足夠體力
- ☐ 其他: _____

15. 在過去的三個月中，您因為疼痛影響到生活和工作的頻率？

☐ 從不
☐ 偶爾幾天
☐ 大多時候
☐ 每一天

注意：如果您在問題 14的回答為「從不」，請「跳至問題 16」

16. 在過去三個月中，您是否有使用下列任何方式控制您的疼痛？

	是	否
a) 瑜珈、太極或氣功？	☐	☐
b) 其他形式的運動，例如散步、游泳、騎腳踏車、伸展運動或肌力訓練？	☐	☐
c) 非處方藥物 (如阿司匹靈)？	☐	☐
d) 服用由醫生、牙科或其他醫療專業人員開立的止痛藥或類鴉片藥物？	☐	☐
e) 物理治療、復健治療或職能治療？	☐	☐
f) 脊椎徒手推拿或其他形式的整脊治療？	☐	☐
g) 按摩	☐	☐
h) 冥想、導引式意像療法或其他放鬆技巧？	☐	☐
i) 其他，請說明：_____	☐	☐

17. 關於個人飲食和健康飲食，您對下列的陳述有甚麼感受？所謂健康飲食，是指攝取各種令您保持健康、感覺良好及精力充沛的營養食物。

	非常不同意	不同意	中立	同意	非常同意	不適用
a) 我可以在我購物及用膳的地方找到健康食物。	☐	☐	☐	☐	☐	☐
b) 我可以在大部分餐點中吃到水果和蔬菜。	☐	☐	☐	☐	☐	☐
c) 我可以吃到多種健康食物。	☐	☐	☐	☐	☐	☐
d) 我知道如何在我購物和用膳的地方選擇健康食物。	☐	☐	☐	☐	☐	☐
e) 如果跟著食譜做，我可以把食材做得更健康。	☐	☐	☐	☐	☐	☐
f) 如果我吃到不健康的食物，我可以在以後減少攝取這些食物或選擇更健康的食物作為補償。	☐	☐	☐	☐	☐	☐

g)	當我感覺飢餓，我可以輕易選擇健康食物而非不太健康的食物。	☐	☐	☐	☐	☐	☐

18. 在過去的 12 個月內，您有多常擔心食物會在領到錢之前就吃完？您會說這種情況是：經常如此、有時如此，還是從未有過？

☐ 經常如此
☐ 有時如此
☐ 從未有過

C. 醫療服務的獲取和使用情況：以下問題涉及您的醫療體驗和醫療教育需求。請從下方所列選項選擇您的答案。
如果您不確定，請選擇最接近的答案。

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19. 您保險的主要來源是？

☐ 透過僱主或工會購買的計劃（包括透過他人的僱主購買的計劃）
☐ 您或其他家庭成員自行購買的私人非政府計劃
☐ 低收入居民醫療保險「白卡」
☐ 聯邦醫療保險「紅藍卡」
☐ Medigap補充醫療保險
☐ 兒童健康保險方案 (CHIP)
☐ 軍人衛生保健：TRICARE（前身為 CHAMPUS）或 VA
☐ 阿拉斯加原住民、印地安人醫療服務 (Indian Health Service)、Tribal Health Services (部落醫療計劃)
☐ 州資助的健康計劃
☐ 其他來源
☐ 我沒有健康保險
☐ 不知道

20. 以下列出了一些可能影響人們的健康和福祉的事項。影響您的健康的首要問題是什麼？ **請勾選所有符合項目**

☐ 前往家庭醫生診所不方便
☐ 保險不足
☐ 糧食短缺
☐ 缺乏健康食物
☐ 學校教育素質差
☐ 缺乏工作機會
☐ 歧視/ 偏見
☐ 社交孤立/ 孤獨
☐ 缺乏負擔得起的兒童看護
☐ 住房條件差/ 無家可歸
☐ 居住環境治安不佳
☐ 缺乏運動的地方/空間
☐ 交通問題
☐ 傳染病（Covid-19、流感、呼吸道融合病毒等）
☐ 其他：_____
☐ 不適用於我

21. 造成人們延遲取得醫療照護的原因有很多。 在過去 12 個月中，您是否因下列任何一項原因而延遲接受護理治療? **請勾選所有符合項目**

☐ 不適用：我在過去 12 個月內能取得醫療保健服務
☐ 沒有交通工具
☐ 見到醫療保健提供者會緊張
☐ 找不到我需要的專業醫生
☐ 無法取得預約
☐ 無法請假
☐ 無法取得托兒服務
☐ 您需要照顧一位成年人，並且必須隨身照料

☐ 負擔不起共付額 (co-pay)
☐ 您的自付額高昂/或負擔不起自付額
☐ 您必須自行負擔部分或全部治療的費用
☐ 其他原因: _____

22. 病患者有時候不願遵循醫生或其他醫療保健提供者的醫療建議。請選擇所有符合您的原因。**勾選所有符合項目。**

a) 不*適用*，我始終遵循醫生或醫療保健提供者的醫療建議	☐
b) 提供者未充分說明治療相關內容（因為時間不夠、態度漠不關心或說話難以理解）	☐
c) 感覺治療沒有幫助	☐
d) 擔心治療費用	☐
e) 忘記服藥/複診	☐
f) 提供者不理解我的文化/語言	☐
g) 病況沒有那麼嚴重	☐
h) 擔心治療的副作用	☐
i) 偏好使用補充/替代療法	☐
j) 治療時間不適合我的日程安排/對我來說不方便	☐
k) 不同意醫生/醫療保健提供者的建議	☐

注意：遠距醫療是指您和醫生同時在不同地域，透過科技的方式（即智慧型手機、電腦、平板電腦）提供照護。例如：與您的醫療保健提供者進行視訊會議或電話通話。

23. 您在使用遠距醫療時可能遇到哪些障礙？
勾選所有符合項目。

☐ 並未遇到任何障礙
☐ 我沒有裝置（即智慧型手機、電腦、平板電腦）
☐ 我沒有高速網路服務
☐ 我不知道如何使用遠距醫療
☐ 我擔心健康資訊的私隱機密性
☐ 我擔心發生醫療診斷錯誤的可能性
☐ 我不確定醫生辦公室是否提供遠距醫療服務
☐ 我對遠距醫療沒有興趣
☐ 我沒有接聽電話的私人空間

24. 在過去 12 個月中，您是否因以下原因使用過網路？

	是	否
a) 搜尋健康或醫療資訊。	☐	☐
b) 與醫生或醫生辦公室通訊。	☐	☐
c) 尋找醫療檢測結果。	☐	☐

25. 請回想您一生中接受醫療保健的所有時刻。在接受醫療保健服務時，因為您的人種、族裔、膚色、語言、性取向和/或性別認同，導致您遇到下列事項的頻率？

	從不	有過一次	有時候	經常	大多數時候	幾乎一直都是
a) 您得到較他人更不禮貌的對待	☐	☐	☐	☐	☐	☐
b) 您得到較他人更不尊重的對待	☐	☐	☐	☐	☐	☐
c) 您得到的服務待遇較其他人差	☐	☐	☐	☐	☐	☐
d) 醫生或護士的態度表現好像覺得您不夠聰明	☐	☐	☐	☐	☐	☐
e) 醫生或護士的態度表現好像他們害怕您	☐	☐	☐	☐	☐	☐
f) 醫生或護士的態度表現有種優越感	☐	☐	☐	☐	☐	☐
g) 您覺得醫生或護士沒有傾聽您說的話	☐	☐	☐	☐	☐	☐

26. 當您與醫生或護士交談時，覺得**使用**哪種語言最自在？

☐ 英語
☐ 西班牙語
☐ 普通話
☐ 廣東話
☐ 俄語
☐ 阿拉伯語
☐ 希伯來語
☐ 海地克里奧爾語
☐ 其他：_____

27. 當您**閱讀**醫療或保健說明時，您覺得使用哪種語言最自在？

☐ 英語
☐ 西班牙語
☐ 中文
☐ 俄語
☐ 阿拉伯語
☐ 希伯來語
☐ 海地克里奧爾語
☐ 其他：_____

28. 當您閱讀醫師或藥局的指示、小冊子或其他書面資料時，需要別人幫助您的頻率？

☐ 從不
☐ 不常
☐ 偶爾
☐ 經常
☐ 總是需要幫助

D. 健康教育：HSS 有提供健康教育計劃。下列問題將有助我們辨識社區的健康教育需求。

29. 在過去 12 個月中，您沒有參加健康教育計劃的最主要三個原因是？ **只需選擇前 3 個原因**：

- ☐ 不適用：我在過去 12 個月中有參加健康教育計劃
- ☐ 無法負擔
- ☐ 沒有交通工具
- ☐ 不知道哪裡有舉辦
- ☐ 害怕或不信任醫生
- ☐ 擔心傳染病（Covid-19、流感、呼吸道融合病毒等）
- ☐ 沒有時間
- ☐ 日程安排衝突
- ☐ 文化/宗教障礙
- ☐ 語言障礙（例如無法獲得以我的母語進行的健康教育）
- ☐ 不知道有這個計劃
- ☐ 沒有興趣參加健康教育計劃

30. 您對下列哪一種健康教育形式/活動感興趣？
勾選所有符合項目。

- ☐ 實體運動課程
- ☐ 線上運動課程
- ☐ 實體互動小組研討會
- ☐ 線上互動小組研討會
- ☐ 實體講座
- ☐ 線上講座
- ☐ 播客（例如您可以透過手機收聽的音訊節目）
- ☐ 點播影片（例如在您的裝置上可供下載或串流的影片，比如Youtube 影片）
- ☐ 社交媒體貼文（例如臉書、推特/X、IG、抖音等）
- ☐ 電話會議
- ☐ 支持小組
- ☐ 以上皆無

31. 您有興趣進一步了解哪五個健康主題？ **只能選擇 5 個項目。**

- ☐ 運動
- ☐ 管理我的慢性病
- ☐ 健康飲食
- ☐ 支持健康生活方式
- ☐ 應付壓力、焦慮與憂鬱
- ☐ 提升改善身體活動能力的方法
- ☐ 藥物管理
- ☐ 疼痛管理
- ☐ 使用科技管理健康
- ☐ 管理我的孩童健康
- ☐ 管理我的健康/健康狀況的補充療法（例如瑜伽、冥想、正念呼吸）
- ☐ 準備一份詢問我的醫生或醫療保健提供者的問題清單
- ☐ 討論可能與我的疾病有關的個人問題
- ☐ 詢問我對於治療不明白之處
- ☐ 性健康
- ☐ 傳染病（Covid -19、流感、呼吸道融合病毒等）
- ☐ 預防運動受傷
- ☐ 跌倒預防
- ☐ 大腦健康
- ☐ 了解保險承保範圍
- ☐ 財務援助選項
- ☐ 健康老齡化
- ☐ 其他：_____

E. 關於您:請分享有關您與您的背景資訊，以便我們能更了解我們所服務的社區。

32. 您出生時指定的性別是什麼？

☐ 女性
☐ 男性
☐ 雙性人
☐ 其他，請說明：_____
☐ 不想回答

33. 甚麼詞彙最能表達您的性別認同?

☐ 男性
☐ 女性
☐ 非二元性別
☐ 跨性別女性
☐ 跨性別男性
☐ 其他(例如性別酷兒、性別變體、性別流動
請說明：_____
☐ 不想回答

34. 您認為自己是:

☐ 異性戀者，即非同性戀者
☐ 女同性戀者或男同性戀者
☐ 雙性戀者
☐ 其他，請說明：_____
☐ 不知道
☐ 不想回答

35. 您的年齡？ ____

36. 您認為自己是西班牙裔或拉丁裔嗎？ **勾選所有符合項目。**

☐ 是
  ☐ 墨西哥裔、墨西哥裔美國人、奇卡諾人
  ☐ 波多黎各人
  ☐ 古巴人
  ☐ 其他西班牙裔、拉丁裔或西班牙發源地人士
☐ 否
☐ 不知道/不確定
☐ 不想回答

37. 你認為這些群體中的哪項最能代表你的種族? **勾選所有符合項目。**

☒ 美國印第安人或阿拉斯加原住民
☐ 亞洲人
  ☐ 亞洲印度人
  ☐ 中國人
  ☐ 菲律賓人
  ☐ 日本人

- ☐ 韓國人
- ☐ 越南人
- ☐ 其他亞洲人

☐ 黑人或非裔美國人
☐ 太平洋島民

- ☐ 夏威夷原住民
- ☐ 關島人或查莫羅人
- ☐ 薩摩亞人
- ☐ 其他太平洋島民

☐ 白人
☐ 其他：_____
☐ 不知道/不確定
☐ 不想回答

38. 你完成的最高學級或學業程度是?

☐ 從未上過學或只上過幼稚園
☐ 1 年級到 8 年級 (小學)
☐ 9 年級到 11 年級 (部分中學)
☐ 12年級或普通教育發展證書 (高中畢業)
☐ 大學 1 年級到 3 年級 (部分大學或技術學校)
☐ 大學 4 年級或以上 (大學畢業)
☐ 研究生 (碩士、博士)
☐ 不想回答

39. 您的家庭年收入包括所有經濟來源是多少？

☐ 低於 $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
☐不想回答

40. 在過去 12 個月中，您是否有參與下列一或多個政府援助計劃？ 請勾選所有符合項目：

☐ 我並未參與任何政府補助計劃
☐ 營養援助計劃「糧食券 」(例如：美國補充營養協助計畫 (SNAP)、婦女、嬰兒與孩童計畫 (WIC) 等)
☐ 庇護所援助計劃 (例如公共住宅、房屋補助券、能源援助等)
☐ 現金援助計劃 (例如：社會安全生活補助金 (SSI)、社會福利、貧窮家庭暫時性救助金 (TANF) 等)
☐ 社會保險 (例如社會保障、失業津貼)
☐ 退伍軍人/軍人福利

☐ 身障福利
☐ 其他

41. 您目前居住地的郵遞區號是？ _____

請利用下方空白處與我們分享您在肌肉、骨骼、關節或疼痛方面的需求，讓特殊外科醫院更好地了解您的情況。

感謝您填寫這份問卷！

請於 2025 年 2 月 15 日前繳回此問卷，確保您的意見受到採用。

5. 請透過以下其中一種方式將完成的問卷寄回給我們：**郵寄：** 請使用隨附的預付郵資信封
6. **親自提交**：請送到特殊外科醫院教育機構 (EI) 辦公室 (Hospital for Special Surgery Education Institute (EI) office)；地址：517 East 71st Street, NY, NY 10021；**收件人: Bertilia Trieu**

如有任何與評估問卷相關的問題或疑慮，請聯繫Bertilia Trieu (結果及數據分析經理)，請將電子郵件傳送至：eioutcomes@hss.edu

Оценка потребностей в области общественного здравоохранения (CHNA)

Специалисты HSS хотят узнать о ваших потребностях, связанных с заболеваниями мышц, костей и суставов. Это поможет нам предоставлять программы и услуги, которые важны для вас. Для этого опроса нам не нужно ваше имя. Верните анкету этого опроса не позднее **15 февраля 2025 г.**, чтобы мы гарантированно учли ваше мнение. Спасибо за помощь!

A. Состояние здоровья и качество жизни: выберите ответ из предложенных вариантов. Если не уверены в ответе, выберите максимально подходящий ответ из возможных.

1. Говорил ли вам когда-нибудь врач или другой медицинский работник, что у вас...?

	Да	Нет
a) Остеоартрит (OA)	☐	☐
b) Ревматоидный артрит (РА)	☐	☐
c) Волчанка	☐	☐
d) Фибромиалгия	☐	☐
e) Подагра	☐	☐
f) Некоторые другие формы артрита (например, аксиальный спондилоартрит или псориатический артрит)	☐	☐
g) Остеопороз	☐	☐
h) Деформация позвоночника (например, сколиоз)	☐	☐
i) Хроническая боль	☐	☐
j) Другое: _____		

ПРИМЕЧАНИЕ: если вы ответили «Нет» на все части вопроса 1, ПЕРЕЙДИТЕ к вопросу 3.

2. Насколько вы уверены, что сможете контролировать симптомы заболеваний костей, мышц и/или суставов, чтобы иметь возможность делать то, что хотите?

☐ Совсем не уверен(-а)
☐ Довольно уверен(-а)
☐ Уверен(-а)
☐ Полностью уверен(-а)

3. Можете ли вы сказать, что в целом состояние вашего здоровья:

☐ Отличное
☐ Очень хорошее
☐ Хорошее
☐ Удовлетворительное
☐ Плохое

4. Если подумать о вашем **физическом здоровье**, которое включает в себя физические заболевания и травмы, сколько дней в течение **последних 30 дней** ваше физическое здоровье было плохим?

☐ Ни одного дня

☐ 1–7 дней
☐ 8–13 дней
☐ 14 дней и более

5. Если подумать о вашем **психическом здоровье**, которое включает в себя стресс, депрессию и проблемы с эмоциями, в течение скольких дней в течение **последние 30 дней** ваше психическое здоровье было плохим?
☐ Ни одного дня
☐ 1–7 дней
☐ 8–13 дней
☐ 14 дней и более

6. Ответьте на каждый вопрос или утверждение, отметив одну ячейку в каждой строке.

	Без каких-либо затруднений	**С небольшими трудностями**	**С некоторыми трудностями**	**С большим трудом**	**Не могу выполнять**
a) Можете ли вы выполнять такие домашние обязанности, как уборка пылесосом или работа во дворе?	☐	☐	☐	☐	☐
b) Можете ли вы подниматься и спускаться по лестнице в обычном темпе?	☐	☐	☐	☐	☐
c) Можете ли вы гулять пешком хотя бы 15 минут?	☐	☐	☐	☐	☐
d) Можете ли вы выполнять поручения и ходить по магазинам?	☐	☐	☐	☐	☒

7. Сколько раз вы падали за последние 12 месяцев? _____
☐ Ни разу
☐ 1–2
☐ 3 или больше
☐ Не знаю

ПРИМЕЧАНИЕ: если вы ответили «Нет» или «Не знаю» на вопрос 7, ПЕРЕЙДИТЕ к вопросу 11.

8. Привело ли какое-либо из этих падений к травме?
☐ Да ☐ Нет

9. Обращались ли вы к врачу или другому медицинскому работнику по поводу падения(-ий)?
☐ Да ☐ Нет

ПРИМЕЧАНИЕ: если вы ответили «Да» на вопрос 9, ПЕРЕЙДИТЕ к вопросу 11.

10. Почему вы не обратились за медицинской помощью после падения? **Отметьте все подходящие варианты**.

☐ Мое падение не было серьезным.
☐ Я смог(-ла) сам справиться с результатами своего падения
☐ Я не хотел(-а) тратить впустую время своего врача.
☐ Я не хотел(-а), чтобы меня считали «слабым(-ой)»
☐ Я не думал(-а), что мой врач сможет мне чем-то помочь.
☐ Я не хочу терять свою самостоятельность.
☐ У меня нет постоянного поставщика медицинских услуг
☐ Я не смог(-ла) записаться на прием
☐ У меня нет медицинской страховки
☐ Я не мог(-ла) позволить себе пойти к врачу.
☐ Другое:_____

ПРИМЕЧАНИЕ: следующий вопрос касается общего качества вашего сна в *большинство* ночей *ТОЛЬКО за последние 7 дней*.

11. Подумайте об **общем** качестве вашего сна, например, сколько часов вы спали, насколько легко вы засыпали, как часто вы просыпались ночью (за исключением похода в туалет), как часто вы просыпались раньше времени утром и насколько освежающим был ваш сон.

Как бы Вы оценили качество своего сна за **последние 7 дней** по шкале от 0 до 10, где «0» — очень плохое качество сна, а «10» — прекрасное качество сна? **(Отметьте только 1 ячейку)**

Ужасный	Плохой			Удовлетворительный			Хороший			Отличный
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

B. Здоровое поведение и образ жизни

12. Как часто вы чувствуете себя так, как описано в каждом из следующих утверждений?

	Почти никогда	**Иногда**	**Часто**
a) Вам не хватает общения	☐	☐	☐
b) Вы чувствуете себя обделенным(-ой)	☐	☐	☐
c) Вы чувствуете себя изолированным(-ой) от других людей	☐	☐	☐

Следующие вопросы касаются физической активности, такой как физические упражнения, спорт или физически активные хобби, которыми вы можете заниматься в свободное время. Примерами

физической активности являются бег, гольф, садоводство, ходьба, езда на велосипеде, теннис, плавание, танцы и другие виды деятельности, требующие физических усилий.

13. В **последние 30 дней**, помимо работы, занимались ли вы какой-либо физической деятельностью или упражнениями, например бегом, гольфом, садоводством или ходьбой в качестве упражнения?

☐ Да ☐ Нет

ПРИМЕЧАНИЕ: если вы ответили «Да» на вопрос 13, ПЕРЕЙДИТЕ к вопросу 15.

14. Почему вы не занимались физической активностью в течение последних 30 дней? **Отметьте все подходящие варианты.**

- ☐ Трудно найти место, где можно заниматься физической активностью.
- ☐ Физические нагрузки стоят слишком много денег
- ☐ Мое здоровье (например, болезнь сердца или сильные боли)
- ☐ Мое психическое здоровье (например, депрессия или тревожность)
- ☐ Я восстанавливаюсь после травмы.
- ☐ Я беспокоюсь о том, что могу получить травму.
- ☐ Физическая активность заставляет меня чувствовать себя некомфортно
- ☐ Физическая активность не является моим приоритетом
- ☐ Я не уверен(-а) в своей способности быть физически активным
- ☐ Я не знаю, как начать быть физически активным.
- ☐ Я слишком стар(-а), чтобы быть физически активным.
- ☐ Трудно найти людей, с которыми можно вести активную жизнь
- ☐ Другие люди советовали мне избегать физической активности.
- ☐ У меня недостаточно энергии.
- ☐ Другое: _____

15. Как часто за последние три месяца боль ограничивала вашу жизнь или работу?

- ☐ Никогда
- ☐ Несколько дней
- ☐ Большинство дней
- ☐ Каждый день

ПРИМЕЧАНИЕ: если вы ответили «Никогда» на вопрос 14, ПЕРЕЙДИТЕ к вопросу 16.

16. За последние три месяца вы использовали какие-либо из следующих способов для облегчения боли?

	Да	Нет
a) Йога, тайцзи или цигун (чи-ГУН)	☐	☐
b) Другие виды упражнений, такие как ходьба, плавание, езда на велосипеде, растяжка или силовые тренировки	☐	☐
c) Безрецептурные препараты, такие как аспирин	☐	☐
d) Обезболивающее или опиоид, прописанный врачом, стоматологом или другим медицинским работником	☐	☐
e) Физиотерапия, реабилитационная терапия или трудотерапия	☐	☐
f) Мануальная терапия позвоночника или другие формы мануальной терапии	☐	☐
g) Массаж	☐	☐
h) Медитация, управляемое воображение или другие техники релаксации	☐	☐
i) Другое, укажите: _____	☐	☐

17. Как вы относитесь к следующим утверждениям относительно вашего рациона и здорового питания? Под здоровым питанием мы подразумеваем употребление в пищу различных продуктов, которые обеспечивают вас питательными веществами, необходимыми для поддержания здоровья, хорошего самочувствия и энергии.

	Категорически не согласен(-на)	Не согласен (-на)	Нейтральное отношение	Согласен (-на)	Полностью согласен(-на)	Не применимо
h) Я могу найти здоровую пищу там, где я покупаю и ем.	☐	☐	☐	☐	☐	☐
i) Я могу есть фрукты и овощи при большинстве приемов пищи.	☐	☐	☐	☐	☐	☐
j) Я могу есть разнообразную здоровую пищу.	☐	☐	☐	☐	☐	☐
k) Я знаю, как выбирать здоровую пищу там, где я	☐	☐	☐	☐	☐	☐

покупаю и ем.						
l) Если я буду готовить по рецепту, я смогу сделать еду более полезной.	☐	☐	☐	☐	☐	☐
m) Если я ем нездоровую пищу, я смогу сократить ее потребление или перейти на более здоровую пищу позже.	☐	☐	☐	☐	☐	☐
n) Когда я чувствую голод, я могу легко выбрать здоровую пищу вместо менее здоровой.	☐	☐	☐	☐	☐	☐

18. Является ли следующее утверждение «часто верным, иногда верным или всегда неверным»? В течение последних 12 месяцев я беспокоился(-ась), закончится ли моя еда прежде, чем у меня появятся деньги, чтобы купить еще.

☐ Часто правда
☐ Иногда правда
☐ Никогда не было правдой

C. Использование медицинской помощи и доступ к ней: эти вопросы касаются вашего опыта в сфере здравоохранения и потребностей в медицинском просвещении. Выберите свой ответ из предложенных вариантов.
Если не уверены в ответе, выберите максимально подходящий ответ из возможных.

19. Какая ваша основная страховка?

☐ План, приобретенный через работодателя или профсоюз (включая планы, приобретенные через работодателя другого лица)
☐ Частный негосударственный план, который вы приобрели или другой член семьи приобрел самостоятельно
☐ Medicaid
☐ Medicare
☐ Medigap
☐ Программа медицинского страхования детей (CHIP)

☐ Военное здравоохранение: TRICARE (ранее CHAMPUS) или VA
☐ Коренные жители Аляски, Служба здравоохранения индейцев, Служба здравоохранения племен
☐ План медицинского страхования, спонсируемый штатом
☐ Другой источник
☐ У меня нет медицинской страховки
☐ Не знаю

20. Вот список некоторых моментов, которые могут повлиять на здоровье и благополучие людей. Какие основные проблемы влияют на ваше здоровье? **Отметьте все подходящие варианты**

☐ Отсутствие доступа к кабинету врача
☐ Отсутствие доступа к страхованию
☐ Ограниченный доступ к любым продуктам питания
☐ Ограниченный доступ к здоровой пище
☐ Плохие школы
☐ Отсутствие возможностей трудоустройства
☐ Дискриминация/предвзятость
☐ Социальная изоляция/одиночество
☐ Отсутствие доступного ухода за детьми
☐ Плохое жилье/бездомность
☐ Отсутствие безопасности в районе
☐ Ограниченное количество мест для занятий спортом
☐ Проблемы с транспортом
☐ Инфекционные заболевания (COVID-19, грипп, PCB и т. д.)
☐ Другое: _____
☐ Не применимо ко мне

21. Существует множество причин, по которым люди откладывают обращение за медицинской помощью. Откладывали ли вы обращение за медицинской помощью по любой из следующих причин за последние 12 месяцев?

☐ Не применимо — мне удалось получить медицинскую помощь за последние 12 месяцев
☐ Не было транспорта
☐ Нервничаю перед визитом к врачу
☐ Не удалось найти врача нужной мне специальности
☐ Не удалось записаться на прием
☐ Не удалось отпроситься с работы
☐ Не удалось получить услуги ухода за ребенком
☐ Вы ухаживаете за взрослым человеком и не можете его оставить
☐ Не смог(-ла) позволить себе доплату
☐ Ваш непокрываемый страховкой минимум (франшиза) был слишком высоким/или вы не могли позволить себе оплатить этот минимум
☐ Вам пришлось бы заплатить из своего кармана за часть процедуры или всю процедуру
☐ Другая причина: _____

22. Иногда люди не следуют медицинским рекомендациям своего врача или другого поставщика медицинских услуг.
Выберите причины, которые могут быть актуальны для вас. **Отметьте все подходящие варианты.**

a) Не применимо — всегда следую медицинским рекомендациям моего врача или поставщика медицинских услуг	☐
b) Врач недостаточно хорошо объяснил суть лечения (из-за нехватки времени, безразличного отношения или трудностей в понимании)	☐
c) Не чувствовал(-а), что лечение поможет	☐
d) Обеспокоенность по поводу стоимости лечения	☐
e) Забыл(-а) принять лекарство/сходить на контрольный осмотр	☐
f) Поставщик не понимает мою культуру/язык	☐
g) Состояние недостаточно тяжелое	☐
h) Беспокоюсь о побочных эффектах лечения	☐
i) Предпочитаю использовать дополнительное/альтернативное лечение	☐
j) Лечение не вписывалось в мой график/мне было неудобно	☐
k) Не согласен(-на) с врачом/поставщиком медицинских услуг	☐

ПРИМЕЧАНИЕ: телемедицина — это использование технологий (например, смартфона, компьютера, планшета) для оказания медицинской помощи, когда вы и врач не находитесь в одном месте в одно и то же время. Примеры: видеоконференция или телефонный звонок вашему лечащему врачу.

23. С какими препятствиями вы можете столкнуться при использовании телемедицины?
Отметьте все подходящие варианты.

☐ У меня нет никаких барьеров
☐ У меня нет устройства (например, смартфона, компьютера, планшета)
☐ У меня нет доступа к высокоскоростному интернету
☐ Я не знаю, как пользоваться телемедициной
☐ Я обеспокоен(-а) тем, что информация о моем здоровье останется конфиденциальной.
☐ Я обеспокоен(-а) возможностью врачебных ошибок
☐ Я не уверен(-а), что кабинет моего врача предлагает услуги телемедицины
☐ Меня не интересует телемедицина.
☐ У меня нет личного пространства, где я мог(-ла) бы принять звонок.

24. За последние 12 месяцев пользовались ли вы Интернетом по любой из следующих причин?

	Да	**Нет**
a) Для поиска информации о здоровье или медицине.	☐	☐
b) Для связи с врачом или кабинетом врача.	☐	☐
c) Чтобы посмотреть результаты медицинских анализов.	☐	☐

25. Подумайте обо всех случаях в вашей жизни, когда вы получали медицинскую помощь. Как часто при получении медицинской помощи с вами случались какие-либо из следующих вещей из-за вашей расы, этнической принадлежности, цвета кожи, языка, сексуальной ориентации и/или гендерной идентичности?

	Никогда	**Время от времени**	**Иногда**	**Часто**	**В большинстве случаев**	**Почти все время**
a) К вам относятся менее вежливо, чем к другим людям	☐	☐	☐	☐	☐	☐
b) К вам относятся с меньшим уважением, чем к другим людям	☐	☐	☐	☐	☐	☐
c) Вы получаете худшее обслуживание, чем другие	☐	☐	☐	☐	☐	☐
d) Врач или медсестра ведут себя так, как будто считают вас глупым(-ой)	☐	☐	☐	☐	☐	☐
e) Врач или медсестра ведут себя так, будто боятся вас	☐	☐	☐	☐	☐	☐
f) Врач или медсестра ведут себя так, как будто они лучше вас	☐	☐	☐	☐	☐	☐
g) У вас такое чувство, будто врач или медсестра не слушают, что вы говорите	☐	☐	☐	☐	☐	☐

26. На каком языке вам наиболее комфортно **общаться** с вашим врачом или медсестрой?

☐ Английский
☐ Испанский
☐ Мандаринский китайский
☐ Кантонский китайский
☐ Русский
☐ Арабский
☐ Иврит
☐ Гаитянский креольский
☐ Другой: _____

27. На каком языке вам наиболее комфортно **читать** медицинские указания или указания в отношении охраны здоровья?

☐ Английский
☐ Испанский
☐ Китайский
☐ Русский
☐ Арабский
☐ Иврит
☐ Гаитянский креольский
☐ Другой: _____

28. Как часто вам требуется помощь других людей при чтении инструкций, рекомендаций и других материалов от врача или из аптеки?

☐ Никогда
☐ Редко
☐ Иногда
☐ Часто
☐ Всегда

D. Медицинское просвещение: HSS реализует программы медицинского просвещения. Следующие вопросы помогут нам определить потребности сообщества в области медицинского просвещения.

29. Назовите три основные причины, по которым вы не принимали участия в программах медицинского просвещения за последние 12 месяцев? **Выберите только 3 лучших варианта.**

☐Не применимо — я принимал(-а) участие в программах медицинского просвещения в течение последних 12 месяцев.
☐ Не мог(-ла) себе этого позволить.
☐ Отсутствие транспорта
☐ Точно не знаю, куда обращаться
☐ Страх или недоверие к врачам
☐ Инфекционные заболевания (COVID-19, грипп, РСВ и т. д.)
☐ Нехватка времени
☐ Конфликты в расписании
☐ Культурные/религиозные барьеры
☐ Языковые барьеры (например, невозможность получить услуги медицинского просвещения на моем языке)
☐ Не знал(-а) о программе
☐ Меня не интересует участие в программе медицинского просвещения.

30. Какие из следующих форматов/мероприятий в области медицинского просвещения были бы вам интересны?
Отметьте все подходящие варианты.

☐ Занятия по физкультуре по месту моего нахождения
☐ Виртуальные занятия по физкультуре
☐ Интерактивные семинары в малых группах месту моего нахождения
☐ Виртуальные интерактивные семинары в малых группах
☐ Лекции месту моего нахождения
☐ Виртуальные лекции
☐ Подкасты (т. е. аудиопрограммы, которые можно слушать на телефоне)
☐ Видео по запросу (т. е. видео, доступные для загрузки/трансляции на вашем устройстве, например, на Youtube)
☐ Посты в соцсетях (например, Facebook, Twitter/X, Instagram, TikTok и т. д.)
☐ Телефонные и видеоконференции
☐ Группы поддержки
☐ Ни один из вышеперечисленных вариантов

31. О каких пяти темах здравоохранения вам было бы интересно узнать больше? **Выберите только 5 вариантов.**

☐ Физические упражнения
☐ Управление моим хроническим заболеванием
☐ Здоровое питание
☐ Поддержка здорового образа жизни
☐ Борьба со стрессом, тревогой и депрессией
☐ Способы улучшения мобильности
☐ Управление приемом лекарств
☐ Лечение боли
☐ Использование технологий для управления здоровьем
☐ Управление здоровьем моего ребенка
☐ Дополнительные методы лечения (например, йога, медитация, осознанное дыхание) для управления моим здоровьем/состоянием здоровья
☐ Подготовка списка вопросов для моего врача или поставщика медицинских услуг
☐ Обсуждение личных проблем, которые могут быть связаны с моей болезнью
☐ Получение ответов на вопросы о вещах, которые я не понимаю в своем лечении
☐ Сексуальное здоровье
☐ Инфекционные заболевания (COVID, грипп, PCB и т. д.)
☐ Профилактика спортивных травм
☐ Предотвращение падений
☐ Здоровье мозга
☐ Понимание страхового покрытия
☐ Варианты финансовой помощи
☐ Здоровое старение
☐ Другое: _____

E. О вас: расскажите нам о себе и своем прошлом, чтобы мы могли больше узнать о сообществах, которые мы обслуживаем.

32. Какой пол был определен у вас при рождении?
☐ Женский
☐ Мужской
☐ Гермафродит
☐ Другой, укажите: _____
☐ Предпочитаю не отвечать

33. Какие термины лучше всего выражают то, как вы описываете свою гендерную идентичность?
☐ Мужчина
☐ Женщина
☐ Небинарная персона
☐ Трансгендерная женщина
☐ Трансгендерный мужчина
☐ Другое (например, гендерквир, гендерный вариант или гендерная текучесть), Пожалуйста, укажите: _____
☐ Предпочитаю не отвечать

34. Вы считаете себя:
☐ Натуралом, то есть не геем
☐ Лесбиянкой или геем
☐ Бисексуальным(-ой)
☐ Другое, пожалуйста, укажите: _____
☐ Не знаю
☐ Предпочитаю не отвечать

35. Ваш возраст? _____

36. Считаете ли вы себя испаноговорящим/латиноамериканцем? **Отметьте все подходящие варианты.**

☐ Да
- ☐ Мексиканец(-ка), мексикано-американец(ка), чикано/а
- ☐ Пуэрториканец(-ка)
- ☐ Кубинец(-ка)
- ☐ Другой испаноговорящий(-ая), латиноамериканец(-ка) или лицо испанского происхождения

☐ Нет
☐ Не знаю/не уверен(-а)
☐ Предпочитаю не отвечать

37. Какая из этих групп, по вашему мнению, лучше всего отражает вашу расу? **Отметьте все подходящие варианты.**

- ☐ Американские индейцы/коренные жители Аляски
- ☐ Азиаты
  - ☐ Азиаты-индусы
  - ☐ Китайский
  - ☐ Филиппинцы
  - ☐ Японцы/g2>
  - ☐ Корейцы
  - ☐ Вьетнамцы
  - ☐ Другие азиаты
- ☐ Черные или афроамериканцы
- ☐ Выходцы с тихоокеанских островов
  - ☐ Коренные гавайцы
  - ☐ Гуамцы или чаморро
  - ☐ Самоанцы
  - ☐ Другие выходцы с тихоокеанских островов
- ☐ Белые
- ☐ Другой вариант: _____
- ☐ Не знаю/Не уверен(-а)
- ☐ Предпочитаю не отвечать

38. Какой самый старший класс или год обучения вы закончили?

☐ Никогда не ходил(-а) в школу или ходил(-а) только в детский сад
☐ Классы с 1-го по 8-й (базовые классы)
☐ Классы с 9-го по 11-й (несколько старших классов)
☐ 12 класс или GED (выпускник средней школы)
☐ Колледж от 1 года до 3 лет (колледж или техническое училище)
☐ Колледж 4 года или более (выпускник колледжа)
☐ Аспирантура (магистратура, докторская степень)
☐ Предпочитаю не отвечать

39. Какой годовой доход вашей семьи из всех источников?

☐ Менее 10 000 долларов США
☐ 10 000–14 999 долларов США
☐ 15 000–24 999 долларов США
☐ 25 000–34 999 долларов США
☐ 35 000–49 999 долларов США
☐ 50 000–74 999 долларов США
☐ 75 000–99 999 долларов США
☐ 100 000–149 999 долларов США
☐ 150 000–199 999 долларов США

☐ 200 000 долларов США или больше
☐ Предпочитаю не отвечать

40. За последние 12 месяцев принимали ли Вы участие в одной или нескольких из следующих программ государственной помощи? Пожалуйста, выберите все подходящие варианты.
☐ Я не участвовал(-а) в программе государственной помощи
☐ Помощь с питанием (например, SNAP, WIC и т. д.)
☐ Помощь с жильем (например, государственное жилье, жилищные ваучеры, помощь с оплатой энергии и т. д.)
☐ Денежная помощь (например, дополнительный социальный доход (SSI), социальное обеспечение, TANF и т. д.)
☐ Социальное страхование (например, социальное обеспечение, пособие по безработице)
☐ Льготы для ветеранов/военных
☐ Пособия по инвалидности
☐ Другое

41. Какой почтовый индекс вашего места жительства? _____

Используйте место ниже, чтобы сообщить нам о любых других потребностях в лечении мышц, костей, суставов или боли, о которых Вы хотели бы уведомить Больницу специальной хирургии:

Спасибо за прохождение опроса!

Верните анкету этого опроса не позднее 15 февраля 2025 г., чтобы мы гарантированно учли ваше мнение.

Пожалуйста, отправьте нам заполненную анкету опроса одним из следующих способов:

7. **По почте** — используйте прилагаемый предоплаченный конверт
8. **Опустите в ящик для корреспонденции** в Офисе Института образования больницы специальной хирургии (EI), расположенном по адресу: 517 East 71st Street, NY, NY 10021 – **Attn: Bertilia Trieu**

Если у вас возникли вопросы или сомнения по поводу опроса, свяжитесь с Бертилией Триеу, менеджером по результатам и анализу данных, по адресу eioutcomes@hss.edu.

Evalyasyon Bezwen Sante Kominotè yo (Community Health Needs Assesment, CHNA)

HSS vle konnen bezwen ou gen konsènan pwoblèm nan misk, zo, ak jwenti. Sa ap ede nou bay pwogram ak sèvis ki enpòtan pou ou. Nou pa bezwen non ou pou sondaj sa a. Tanpri retounen sondaj sa a anvan dat **15 fevriye 2025** pou nou ka asire opinyon ou gen enpòtans. Mèsi pou èd ou!

A. Estati Sante ak Kalite Lavi: Tanpri chwazi repons ou nan opsyon yo ki lis la. Si ou pa sèten, tanpri bay pi bon repons ou kapab.

1. Èske yon doktè oswa lòt pwofesyonèl sante te janm di w ou genyen …?

	Wi	Non
a) Osteyowatrit (OA)	☐	☐
b) Atrit rimatoyid (AR)	☐	☐
c) Lipis	☐	☐
d) Fibromyalji	☐	☐
e) Gout	☐	☐
f) Yon lòt fòm atrit (pa egzanp, espondilowatrit aksyal oswa atrit psoryatik)	☐	☐
g) Osteyopowoz	☐	☐
h) Defo nan kolòn vètebral (pa egzanp, eskolyoz)	☐	☐
i) Doulè kwonik	☐	☐
j) Lòt: _____		

NÒT: Si ou te reponn "Non" pou tout pati nan Kesyon 1 an, tanpri SOTE Kesyon 2 an epi ale nan Kesyon 3.

2. Nan ki nivo ou santi w konfyan ou kapab jere sentòm nan kondisyon zo, misk, ak/oswa jwenti ou pou w ka fè bagay ou vle fè?

- ☐ Pa gen okenn konfyans ditou
- ☐ Yon ti kras konfyans
- ☐ Konfyans
- ☐ Trè konfyans

3. Èske ou ta di an jeneral, sante ou:

- ☐ Ekselan
- ☐ Trè Bon
- ☐ Bon
- ☐ Mwayen
- ☐ Pa bon menm

4. Lè w panse ak **sante fizik** ou, sa vle di maladi ak blesi fizik, konbyen jou sou **30 jou ki sot pase yo** sante fizik ou pa te bon?

- ☐ Okenn
- ☐ 1-7 jou

☐ 8-13 jou
☐ 14 jou oswa plis

5. Lè w panse ak **sante mantal** ou, sa vle di estrès, depresyon, ak pwoblèm emosyonèl, konbyen jou sou **30 jou ki sot pase yo** sante mantal ou pa te bon?
☐ Okenn
☐ 1-7 jou
☐ 8-13 jou
☐ 14 jou oswa plis

6. Tanpri reponn chak kesyon oswa deklarasyon lè w make yon bwat pou chak ranje.

	San okenn difikilte	**Avèk yon ti difikilte**	**Avèk kèk difikilte**	**Avèk anpil difikilte**	**Pa kapab fè**
a) Èske ou kapab fè travay tankou pase aspiratè oswa travay nan jaden?	☐	☐	☐	☐	☐
b) Èske ou kapab monte ak desann eskalye nan yon ritm nòmal?	☐	☐	☐	☐	☐
c) Èske ou kapab fè yon mache pou omwen 15 minit?	☐	☐	☐	☐	☐
d) Èske ou kapab fè komisyon ak fè makèt?	☐	☐	☐	☐	☐

7. Nan 12 mwa ki sot pase yo, konbyen fwa ou te tonbe? _____
☐ Okenn
☐ 1-2
☐ 3 oswa plis
☐ Pa konnen

NÒT: Si ou te reponn "Okenn" oswa "Pa konnen" pou Kesyon 7 la, tanpri SOTE Kesyon 11 an

8. Èske youn nan tonbe sa yo te lakòz yon blesi?
☐ Wi ☐ Non

9. Èske ou te wè yon doktè oswa yon lòt pwofesyonèl sante chak lè w te tonbe yo?
☐ Wi ☐ Non

NÒT: Si ou te reponn "Wi" pou Kesyon 9 la, tanpri SOTE Kesyon 11 lan

10. Poukisa ou pa t chèche èd medikal pou chak lè w tonbe yo? **Make tout sa ki aplike**.
☐ Mwen pa t tonbe grav
☐ Mwen te kapab jere konsekans yo chak lè m tonbe yo poukont mwen
☐ Mwen pa t vle gaspiye tan doktè mwen
☐ Mwen pa t vle yo wè m kòm yon moun ki "fèb"
☐ Mwen pa t panse doktè mwen te ka fè anyen pou ede mwen
☐ Mwen pa vle pèdi endepandans mwen
☐ Mwen pa gen yon pwofesyonèl swen sante regilye

☐ Mwen pa t kapab jwenn yon randevou
☐ Mwen pa gen asirans sante
☐ Mwen pa t kapab peye pou wè yon doktè
☐ Lòt:_____

NÒT: Kesyon sa a refere a bon jan kalite dòmi ou an jeneral pou *majorite* swa yo nan *7 dènye jou yo SÈLMAN*.

11. Tanpri reflechi sou bon jan kalite dòmi ou **an jeneral**, tankou konbyen èdtan dòmi ou te fè, kijan ou te fasil fèmen je w pou w dòmi, konbyen fwa ou te reveye pandan nuit lan (pa konte lè w ale nan twalèt yo), konbyen fwa ou te reveye pi bonè pase ou lè w te bezwen fè sa nan maten, ak kijan dòmi ou te rafrechi lespri w.

Pandan **7 jou ki sot pase yo** , Ki jan ou ta ka evalye kalite somèy ou an jeneral sou yon echèl 0 a 10, kote "0" reprezante yon kalite somèy ki terib epi "10" reprezante yon kalite somèy ki ekselan? **(Tanpri tyeke 1 kazye sèlman)**

Terib	Pòv			Mwayen			Bon			Ekselan
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

B. Konpòtman Sante ak Fason Viv:

12. Konbyen fwa ou santi w jan sa dekri nan chak nan deklarasyon sa yo?

	Preske jamè	**Pafwa**	**Souvan**
a) A ki frekans ou santi ou manke konpayi?	☐	☐	☐
b) A ki frekans ou santi ou eskli?	☐	☐	☐
c) A ki frekans ou santi ou izole de lòt moun yo?	☐	☐	☐

Pwochen kesyon yo mande sou aktivite fizik tankou fè egzèsis, espò, oswa aktivite fizik ou ka fè pandan tan lib ou. Egzanp aktivite fizik yo enkli kouri, gòlf, jadinaj, mache, siklis, tenis, naje, danse, ak lòt aktivite ki mande efò fizik.

13. Nan **30 jou ki sot pase yo**, apa de travay ou, èske ou te patisipe nan nenpòt aktivite fizik oswa egzèsis tankou kouri, gòlf, jadinaj, oswa mache pou fè egzèsis?
☐ Wi ☐ Non

NÒT: Si ou te reponn "Wi" pou Kesyon 13 la, tanpri SOTE Kesyon 15 lan

14. Poukisa ou pa te patisipe nan aktivite fizik nan 30 dènye jou yo? **Make tout sa ki aplike.**
☐ Li difisil pou jwenn yon kote pou fè aktivite fizik
☐ Aktivite fizik yo koute twòp lajan
☐ Sante mwen (pa egzanp, maladi kè oswa twòp doulè)

- ☐ Sante mantal mwen (pa egzanp, depresyon oswa enkyetid)
- ☐ Mwen ap refè apre yon blesi
- ☐ Mwen enkyete m pou m pa blese
- ☐ Aktivite fizik fè m santi m alèz
- ☐ Aktivite fizik pa yon priyorite pou mwen
- ☐ Mwen pa konfyans nan kapasite mwen pou fè aktivite fizik
- ☐ Mwen pa konnen kijan pou m kòmanse fè aktivite fizik
- ☐ Mwen twò granmoun pou m fè aktivite fizik
- ☐ Li difisil pou jwenn moun pou fè aktivite ansanm avèk mwen
- ☐ Gen lòt moun ki te di m evite fè aktivite fizik
- ☐ Mwen pa gen ase enèji
- ☐ Lòt: _____

15. Pandan twa mwa ki sot pase yo, konbyen fwa doulè ou te limite aktivite lavi oswa travay ou?

- ☐ Pa janm
- ☐ Kèk jou
- ☐ Pifò jou
- ☐ Chak jou

NÒT: Si ou te reponn "Pa janm" pou Kesyon 14 la, tanpri SOTE Kesyon 16 lan

16. Pandan twa mwa ki sot pase yo, èske ou te itilize youn nan bagay sa yo pou jere doulè ou?

	Wi	**Non**
a) Yoga, Tai Chi, oswa Qi Gong (chee-GONG)?	☐	☐
b) Lòt fòm egzèsis, tankou mache, naje, monte bisiklèt, etiraj, oswa fòmasyon fòs?	☐	☐
c) Medikaman san preskripsyon tankou aspirin?	☐	☐
d) Yon soulajman pou doulè oswa opyoyid yon doktè, dantis, oswa yon lòt pwofesyonèl sante te preskri w?	☐	☐
e) *Terapi fizik, terapi reyabilitasyon, oswa terapi okipasyonèl?*	☐	☐
f) Manipilasyon nan kolòn vètebral oswa lòt fòm swen kiropraktik?	☐	☐
g) Masaj	☐	☐
h) Meditasyon, imaj gide, oswa lòt teknik detant?	☐	☐
i) Lòt, Tanpri presize: _____	☐	☐

17. Kijan ou santi w konsènan deklarasyon sa yo sou rejim alimantè ou ak manje ki an sante? Lè nou di manje ki an sante, nou vle di manje diferan kalite manje ki ba ou eleman nitritif ou bezwen pou rete an sante, santi w byen, epi gen enèji.

	Vreman pa dakò	**Pa dakò**	**Net**	**Dakò**	**Vreman Dakò**	**Pa aplikab**
a) Mwen kapab jwenn manje sen kote mwen fè makèt ak kote mwen manje.	☐	☐	☐	☐	☐	☐
b) Mwen kapab manje fwi ak legim nan pifò repa yo.	☐	☐	☐	☐	☐	☐

c) Mwen kapab manje yon varyete de manje sen.	☐	☐	☐	☐	☐	☐
d) Mwen konnen kijan pou m chwazi manje sen kote mwen fè makèt ak kote mwen manje.	☐	☐	☐	☐	☐	☐
e) Lè mwen itilize yon resèt pou kwit manje, mwen kapab fè li pi sen.	☐	☐	☐	☐	☐	☐
f) Si mwen manje manje ki pa sen, mwen kapab diminye oswa fè chwa manje ki pi sen pita.	☐	☐	☐	☐	☐	☐
g) Lè m santi m grangou, mwen kapab fasilman chwazi manje ki sen olye de opsyon ki mwens sen.	☐	☐	☐	☐	☐	☐

18. Èske deklarasyon sa a "souvan vre, pafwa vre, oswa pa janm vre": Nan 12 mwa ki sot pase yo, mwen te enkyè pou si manje mwen ta fini anvan mwen ta jwenn lajan pou achte plis.

☐ Souvan vre
☐ Pafwa vre
☐ Pa janm vre

C. Rekou ak Aksè ak Swen: Kesyon sa yo se sou eksperyans ou nan kesyon swen sante ak bezwen ou sou kesyon fòmasyon nan domèn sa. Tanpri chwazi repons ou an pami opsyon yo pwopoze yo. Si ou pa sèten, tanpri bay pi bon repons ou kapab.

19. Ki sous prensipal asirans ou a?

☐ Yon abònman plan ki fèt pa entèmedyè anplwayè ou a oswa yon sendika (sa gen ladan abònman plan ki fèt pa entèmedyè anplwayè yon lòt moun)
☐ Yon plan prive non gouvènmantal ou menm oswa yon lòt manm nan fanmi w achte sou non w
☐ Medicaid
☐ Medicare
☐ Medigap
☐ Children's Health Insurance Program (CHIP)
☐ Swen Sante ki gen rapò ak lame: TRICARE (ki te rele CHAMPUS) oswa VA
☐ Natif Alaska, Indian Health Service, Sèvis Sante Tribal
☐ Plan sante ki finanse pa Leta
☐ lòt sous
☐ Mwen pa gen kouvèti asirans sante
☐ Mwen pa konnen

20. Men yon lis bagay ki ka afekte sante ak byenèt moun yo. Ki prensipal pwoblèm ki afekte sante ou? **Tanpri tyeke tout sa ki aplike yo**

☐ Manke aksè ak kabinè doktè mwen an
☐ Manke aksè ak asirans
☐ Aksè limite ak tout manje yo
☐ Aksè limite ak bon manje
☐ Move lekòl
☐ Manke opòtinite pou jwenn travay
☐ Diskriminasyon/ prejije
☐ Izolasyon sosyal/ solitid
☐ Manke sèvis gadri pou timoun ki abòdab
☐ Move lojman/ sanzabri

☐ Manke sekirite nan katye a
☐ Pa gen ase espas pou fè egzèsis
☐ Pwoblèm Transpò
☐ Maladi Enfektye (Covid-19, grip, RSV, etc.)
☐ Lòt: _____
☐ Pa aplike pou mwen

21. Gen anpil rezon kifè moun yo pran tan anvan yo chache swen medikal. Èske ou retade swen ou yo pou youn nan rezon sa yo pandan 12 dènye mwa yo?

☐ Pa aplike - mwen te kapab jwenn swen sante pandan 12 dènye mwa yo
☐ Pa t gen transpò
☐ Nève ak lide pou konsilte yon pwofesyonèl swen sante
☐ Pa ka jwenn doktè pou espesyalite mwen bezwen an
☐ Pa ka jwenn yon randevou
☐ Pa ka jwenn konje nan travay la
☐ Pa ka jwenn gadri pou timoun
☐ Ou ap okipe yon adilt epi ou pa ka kite l
☐ Pa ka peye kopèman an
☐ Dediktib ou a te twò wo/ oswa ou pa t ka peye dediktib la
☐ Ou te gen pou w peye kèk oswa tout pwosedi yo ak lajan nan pòch ou
☐ Lòt rezon: _____

22. Pafwa moun yo pa swiv konsèy doktè yo a oswa lòt pwofesyonèl swen medikal. Tanpri seleksyone youn nan rezon ki aplike pou ou yo. **Make tout sa ki aplike.**

a) Pa aplike - m toujou swiv konsèy doktè mwen an oswa pwofesyonèl swen sante mwen an	☐
b) Pwofesyonèl swen sante a pa t esplike tretman an ase byen (akoz manke tan, mank enterè oswa paske li difisil pou konprann)	☐
c) Pa te panse tretman an t ap itil	☐
d) Preyokipe pa pri tretman an	☐
e) Bliye pran medikaman an / fè swivi	☐
f) Pwofesyonèl swen sante a pa konprann kilti / lang mwen	☐
g) Maladi a pa t grav ase	☐
h) Enkyete akoz efè segondè tretman an	☐
i) Prefere itilize yon tretman konplemantè / altènatif	☐
j) Pa t koresponn ak orè mwen / pa konvenab pou mwen	☐
k) Pa t dakò ak doktè a / pwofesyonèl swen sante a	☐

REMAK: Telesante se itilizasyon teknoloji (sa vle di telefòn entèlijan, òdinatè, tablèt) pou bay swen lè ou menm ak doktè a pa menm kote nan menm moman an. Pa egzanp: yon rankont pa videyo oswa yon apèl ak pwofesyonèl swen sante a ou a.

23. Ki obstak ou ka rankontre lè w ap eseye itilize telesante?
Make tout sa ki aplike.

☐ Mwen pa gen okenn obstak
☐ Mwen pa gen aparèy (sa vle di, telefòn entèlijan, òdinatè, tablet)
☐ Mwen pa gen aksè ak sèvis entènèt rapid
☐ Mwen pa konn kòman pou m itilize telesante
☐ Mwen enkyè pou konfidansyalite enfòmasyon sou sante mwen
☐ Mwen enkyè akoz posibilite pou gen erè medikal

☐ Mwen pa sèten kabinè doktè mwen an ofri sèvis telesante
☐ Mwen pa entèrese ak sèvis telesante
☐ Mwen pa gen yon espas prive kote pou m reponn apèl

24. Pandan 12 dènye mwa yo, èske ou te itilize entènèt pou youn nan rezon sa yo?

	Wi	Non
a) Pou chache enfòmasyon medikal oswa sou lasante.	☐	☐
b) *Pou pale ak yon doktè oswa biwo doktè a.*	☐	☐
c) Pou chache rezilta tès medikal.	☐	☐

25. Tanpri panse ak tout moman nan vi w kote ou te resevwa swen sante. Lè ou ap resevwa swen sante, a ki frekans youn nan bagay sa yo rive w akoz ras ou, orijin etnik ou, koulè ou, lang ou, oryantasyon seksyèl ou ak/oswa idantite jan ou?

	Jamè	Detanzantan	Kèk fwa	Anpil fwa	Pifò tan yo	Prèske tout tan
a) Yo trete w ak mwens koutwazi pase lòt moun yo	☐	☐	☐	☐	☐	☐
b) Yo trete w ak mwens respè pase lòt moun yo	☐	☐	☐	☐	☐	☐
c) Ou resevwa pi move sèvis pase lòt yo	☐	☐	☐	☐	☐	☐
d) Yon doktè oswa yon enfimyè ap aji tankou yo panse ou pa entèlijan	☐	☐	☐	☐	☐	☐
e) Yon doktè oswa yon enfimyè ap aji tankou yo pè ou	☐	☐	☐	☐	☐	☐
f) Yon doktè oswa yon enfimyè ap aji tankou yo pi bon pase w	☐	☐	☐	☐	☐	☐
g) Ou gen enpresyon yon doktè oswa yon enfimyè pa t ap tande sa ou t ap di a	☐	☐	☐	☐	☐	☐

26. Nan ki lang ou santi ou plis alèz pou w **pale** ak doktè oswa enfimyè ou a?

☐ Anglè
☐ Panyòl
☐ Mandaren
☐ Kantonè
☐ Ris
☐ Arab
☐ Ebre
☐ Kreyòl Ayisyen
☐ Lòt: _____

27. Nan ki lang ou santi ou pi alèz pou ou **li** enstriksyon medikal yo oswa swen sante yo?

- ☐ Anglè
- ☐ Panyòl
- ☐ Chinwa
- ☐ Ris
- ☐ Arab
- ☐ Ebre
- ☐ Kreyòl Ayisyen
- ☐ Lòt: _____

28. Konbyen fwa nan yon peryòd tan detèmine ou gen yon moun ki vin ede w li enstriksyon, livrè, oswa lòt materyèl alekri doktè oswa famasi w voye ba w?

- ☐ Jamè
- ☐ Raman
- ☐ Pafwa
- ☐ Souvan
- ☐ Toujou

D. Edikasyon sou Lasante: HSS ofri pwogram edikasyon sou lasante. Kesyon sa yo ap ede nou idantifye bezwen kominote a nan kesyon edikasyon sou lasante.

29. Ki twa prensipal rezon ki lakoz ou pa patisipe nan pwogram edikasyon sou lasante yo pandan 12 dènye mwa. **Chwazi sèlman 3 premye prensipal opsyon ou yo.**

- ☐ Pa aplike - Mwen patisipe nan pwogram edikasyon sou lasante yo pandan 12 dènye mwa yo
- ☐ Pa t ka pèmèt mwen sa
- ☐ Manke mwayen transpò
- ☐ Pa vrèman konn kote pou w ale
- ☐ Pè oswa pa fè doktè yo konfyans
- ☐ Maladi enfektye (Covid-19, grip, RSV, etc.)
- ☐ Manke tan
- ☐ Konfli Orè
- ☐ Baryè Kiltirèl/ relijye
- ☐ Baryè lang (Pa egzanp paka jwenn enfòmasyon sou lasante nan lang mwen)
- ☐ Pa konnen pwogram lan
- ☐ Mwen pa swete patisipe nan yon program edikasyon sou lasante

30. Kiyès pami fòma/aktivite edikasyon sou lasante sa yo ki enterèse w?
Make tout sa ki aplike.

- ☐ Kou egzèsis an prezansyèl
- ☐ Kou egzèsis vityèl
- ☐ Atelye entèraktif an ti gwoup an prezansyèl
- ☐ Atelye entèraktif vityèl, an ti gwoup
- ☐ Lekti an prezansyèl
- ☐ Lekti Vityèl
- ☐ Podkas (sa vle di, Pwogram odyo ou ka tande sou telefòn ou)
- ☐ Videyo sou demann (sa vle di, Videyo disponib pou telechajeman/streaming sou aparèy ou a tankou sou Youtube)
- ☐ Piblikasyon sou medya sosyal yo (sa vle di, Facebook, Twitter/X, Instagram, TikTok etc.)
- ☐ Apèl Konferans
- ☐ Gwoup sipò
- ☐ Okenn nan sa ki anwo yo

31. Ki senk sijè sou lasante ou ta renmen konnen plis sou yo. **Chwazi 5 opsyon sèlman.**

☐ Egzèsis
☐ Jesyon maladi kwonik yo
☐ Byen manje
☐ Sipòte yon estil vi ki an sante
☐ Fè fas ak estrès, anksyete epi depresyon
☐ Fason pou amelyore mobilite
☐ Jesyon Medikaman
☐ Jesyon doulè
☐ Itilizasyon teknoloji pou jere lasante
☐ Jesyon sante piti mwen
☐ Tretman konplemantè (pa egzanp, Yoga, meditasyon, respirasyon atantif) pou jere sante/eta sante mwen
☐ Prepare yon lis kesyon pou doktè mwen an oswa pwofesyonèl swen sante mwen an
☐ Diskite sou pwoblèm pèsònèl ki ka gen rapò ak maladi mwen an
☐ Poze kesyon sou sa mwen pa konprann nan tretman mwen an
☐ Sante seksyèl
☐ Maladi Enfektye (Covid, grip, RSV, etc.)
☐ Prevansyon Blesi nan kad Espò
☐ Prevansyon kont so
☐ Sante sèvo a
☐ Konpreyansyon sou kouvèti asirans
☐ Opsyon èd finansye
☐ Vyeyi an Sante
☐ Lòt: _____

E. A pwopo oumenm: tanpri pale nou de ou ak pakou ou pou nou ka konn plis sou kominote nou ap sèvi yo.

32. Ki sèks yo te atribye ak ou lè w te fèt?
☐ Femèl
☐ Mal
☐ Entèsèks
☐ Lòt, Tanpri presize: _____
☐ Prefere pa reponn

33. Ki tèm ki eksprime pi byen fason ou dekri idantite jan ou?
☐ Gason
☐ Fanm
☐ Non binè
☐ Fanm Transjan
☐ Gason Transjan
☐ Lòt (e.g., jennndèkwi (genderqueer), jan varyan (gender variant), oswa jan fliyid (gender fluid)),
Tanpri presize: _____
☐ Prefere pa reponn

34. Èske ou konsevwa tèt ou antanke:
☐ Etewo, ki pa gay (masisi)
☐ Lesbyèn oswa gay
☐ Biseksyèl
☐ Lòt, Tanpri presize: _____
☐ Pa konnen
☐ Prefere pa reponn

35. Ki laj ou? _____

36. Èske ou konsidere tèt ou tankou Ispanik/Latino? **Make tout sa ki aplike.**

- ☐ Wi
  - ☐ Meksiken, Meksiken Ameriken, Chikano/a
  - ☐ Pòtoriken
  - ☐ Kiben
  - ☐ Lòt orijin Ispanik, Latino oswa Espanyòl
- ☐ Non
- ☐ Pa konnen/Pa sèten
- ☐ Prefere pa reponn

37. Kiyès nan gwoup sa yo ki reprezante pi byen ras ou a? **Make tout sa ki aplike.**

- ☐ Endyen Ameriken / Natif Alaska
- ☐ Azyatik
  - ☐ Endyen Azyatik
  - ☐ Chinwa
  - ☐ Filipyen
  - ☐ Japonè
  - ☐ Koreyen
  - ☐ Vyetnamyen
  - ☐ Lòt Azyatik
- ☐ Nwa oswa Afwo Ameriken
- ☐ Zile Pasifik
  - ☐ Natif Awayen
  - ☐ Gwameyen oswa Chamowo
  - ☐ Samoan
  - ☐ Lòt Zile Pasifik la
- ☐ Blan
- ☐ Lòt: _____
- ☐ Pa konnen/Pa sèten
- ☐ Prefere pa reponn

38. Ki nivo etid ki pi wo ou rive fini?

- ☐ Pa t janm al lekòl oswa frekante sèlman lekòl matènèl
- ☐ 1ye ane rive nan 8 ane (Elemantè)
- ☐ 9 yèm a 11 yèm ane (Kèk lise)
- ☐ 12 yèm ane oswa GED (Diplòm Etid segondè)
- ☐ Etid siperyè 1 an a 3 an (Kèk inivèsite oswa ekòl teknik)
- ☐ Inivèsite 4 an oswa plis (Diplòm inivèsite)
- ☐ Diplòm Twazyèm Sik (Mastè, Doktora)
- ☐ Prefere pa reponn

39. Ki revni anyèl fwaye ou ak tout sous yo konbine ansanm?

- ☐ Mwen pase $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 oswa plis
- ☐ Prefere pa reponn

40. Nan 12 mwa ki sot pase yo, èske ou te patisipe nan youn oswa plizyè nan pwogram asistans gouvènman sa yo? Tanpri chwazi tout sa ki aplikab yo.

☐ Mwen pa t patisipe nan yon pwogram èd leta.
☐ Asistans nitrisyon (pa egzanp, SNAP, WIC elatriye)
☐ Asistans abri (egzanp, lojman piblik, bon lojman, asistans enèji elatriye)
☐ Asistans Lajan Kach (egzanp, Revni Sekirite Siplemantè (SSI), Byennèt, TANF elatriye)
☐ Asirans sosyal (egzanp Sekirite Sosyal, chomaj)
☐ Avantaj Veteran/Milite
☐ Avantaj pou andikap
☐ Lòt

41. Ki kòd postal kote ou abite kounya a? _____

Tanpri itilize espas ki anba a pou w pataje avèk nou nenpòt lòt bezwen konsènan misk, zo, jwenti, oswa doulè ou ta renmen lopital pou operasyon espesyal la konnen sou ou:

Mèsi paske ou konplete sondaj sa!

Tanpri retounen sondaj sa a anvan dat 15 fevriye 2025 pou nou ka asire opinyon ou gen enpòtans.

Tanpri voye sondaj la tounen ban nou nan youn nan adrès sa yo:

9. **Lapòs** ak itilizasyon anvlòp prepeye ki nan atachman an
10. **Depo** nan: Biwo Hospital for Special Surgery Education Institute (EI), ki nan: 517 East 71st Street, NY, NY 10021 – **Attn: Bertilia Trieu**

Si ou gen nenpòt kesyon oswa preyokipasyon sou sondaj la, tanpri kontakte Bertilia Trieu, Responsab Rezilta ak Analiz Done yo, nan eioutcomes@hss.edu

Appendix B: List of Internal Stakeholders

Name	Title	Department
Ann Marie McDonald	Vice President	Quality
Anne Bass, MD	MD	Medical Staff-Attendings
Brian Goonan	Clinical Specialist	Rehab
Catherine MacLean, MD	Consultant	Value
Dalia Abusharr	Associate Director	Language Services
Deborah McInerney	Associate Director	Nutrition
Denise Miles	AVP	Education Institute
Heather Woolf	Vice President	HSS Florida
Ingrid Herrera-Capoziello	AVP	Nursing
Jennifer Castoro	Director	Editorial Services
Jessica Lefkowitz	AVP	Sports Medicine institute
Jian Sun	Associate Director	Digital Communications
Jillian Rose	Vice President, Chief Health Equity Officer	Ambulatory Care Centers; Office of Health Equity; Office of Diversity, Equity & Inclusion
Kate Purnell	SVP, Chief Patient Access and Experience Officer	Office of Patient Experience
Linda Russell, MD	MD	Medical Staff-Attendings
Melissa Flores	Assistant Director	Office of Health Equity
Pamela Villagomez-Sanchez	Senior Director	Education Institute
Priscilla Calvache	Director	Social Work Programs
Reesa Kaufman	Executive Director	Development
Roberta Horton	AVP	Social Work Programs
Robyn Wiesel	Senior Director	Education Institute
Sandra Goldsmith	AVP	Education Institute
Stephen Haskins, MD	Chief Medical Diversity Officer	Office of Diversity, Equity & Inclusion

Appendix C: Input from Key Stakeholders and Community Partners

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
Health Status and Quality of Life	1. Have you ever been told by a doctor or other health professional that you have …?	Hypertension portion of 2024 NHIS	**Robyn Wiesel**: "… would like to see options related to orthopedic conditions. In CE&O we [don't] focus on most of these topics [.]" **Catherine MacLean:** "…Should there be a response category for spinal disease, perhaps 'spine deformity'[.]" **Jen Castoro:** • "want to add a "None of the above" option so people don't have to check off all of the Nos?" • RE: NOTE: "Replace "No" with None of the above (if you change it)"	**Melissa Velez | Spondylitis Association of America**: "Axial spondyloarthritis/ankylosing spondylitis was not listed specifically as a choice in question 1."
Health Status and Quality of Life	2. 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?	Self-Efficacy for Managing Chronic Disease 6-Item Scale 2015 Stanford	**Jen Castoro:** Replace "…muscle and joint…" with "and/or"	
Health Status and Quality of Life	3. Would you say that in general your health is:	Core Section 1: Health Status 2022 BRFSS		**Yuan Zhang | Columbia University SPH**: Responses to Q4 and Q5 could be influenced by how respondents answer Q3. Respondents might feel that they should not choose "Excellent," "Very Good," or "Good" in Q4-5 if they have reported any days of poor physical or cognitive health.
Health Status and Quality of Life	4. Thinking about your physical health, which includes physical illness and injury, for how many days during the **past 30 days** was your	Core Section 2: Healthy Days 2022 BRFSS	**Ann Marie McDonald** "… would it be helpful to give context to the recipient related to "not good"?" **Jen Castoro:** "This is a little tricky with all the clauses. I would suggest breaking it up:	

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
	physical health not good?		• Think about your physical health. This includes illnesses and injuries. During how many of the past 30 days was your physical health not good? • The original is around a grade 12; the rewrite is below a 7."	
Health Status and Quality of Life	5. 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?	Core Section 2: Healthy Days 2022 BRFSS	**Ann Marie McDonald** "… would it be helpful to give context to the recipient related to "not good"?" **Jen Castoro:** "Same comment here about breaking it up: • Think about your mental health. This includes stress, depression, and problems with emotions. During how many of the past 30 days was your mental health not good? • Original is grade 12 on one measure; rewrite is below 6."	
Health Status and Quality of Life	6. Please respond to each question or statement by marking one box per row.	PROMIS Adult SF v2.0 Physical Function 24a 2024 Health Measures		**Laura Radensky | COHME Home Care: "**Question 10… numbers are grouped together works well and question 6 took me a few minutes to figure out the chart so… group it… like 10 is in terms of format[.]" **Karen Ng | LFA Asian Support Group:** "6d - "Are you able to run errands & shop?" - vague because technically can do errands and shop online so doesn't require much energy expenditure[.]"

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
				Yuan Zhang | Columbia University SPH: Consider adding an option like "I don't do this."
Health Status and Quality of Life	7. In the past year, have you fallen down?	Health Status portion of the Medicare Beneficiary Survey (MCBS)	**Catherine MacLean:** "Among people who have fallen, should ask how many times and whether they [had] sustained an injury. Three or more falls in a year and/or having sustained an injury defines a group at high risk that should be evaluated. (next question on the survey)."	**Charles Markham | DOROT:** "…it says... NOTE: If you answered "No" to Question 7, please SKIP to Question 10. I think it is meant to say Skip Question 8 & 9[.]"
Health Status and Quality of Life	8. Did you see a doctor or other health care professional about your fall(s)?	Adapted from a validated tool for assessing health seeking behaviors PhenX Toolkit 2023 NIMHD	**Jen Castoro:** "Same comment here about breaking it up: • Think about your mental health. This includes stress, depression, and problems with emotions. During how many of the past 30 days was your mental health not good? Original is grade 12 on one measure; rewrite is below 6."	**Charles Markham | DOROT:** "[N]OTE: If you answered "Yes" to Question 8, please SKIP to Question 10 In question 12. Under Question 8 You have this statement. I think it is meant to say Please [Skip] Question 9?" **Yuan Zhang | Columbia University SPH**: Respondents may have had multiple falls; they may have sought medical help for some, but not others
Health Status and Quality of Life	9. Why did you not seek medical help for your fall? Check all that apply.	No single validated tool used. Question is based on prompts & responses from several studies. Family Practice, 2014 JAGS, 2018	**Catherine MacLean:** "Response options for Q9 should include access (e.g. I don't have a regular health care provider AND I couldn't get an appointment) and cost (I couldn't afford it or was concerned about the cost or some such thing). **Laura Robbins:** "Add response option to address	**Kenny Kwong | Touro University Graduate School of Social Work:** "Comments on some questions: Q9 - answer choices can be modified, appears too general or subjective like seen as weak, not want to waste the doctor's time. If break down barriers in seeking care for their fall, like

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
		SGS, 2022	access (e.g., I don't have a PCP)"	psychological, practical/logistical or medical related responses[.]"
Health Status and Quality of Life	10. Please think about the quality of your sleep overall, such as how many hours of sleep you got, how easily you fell asleep, how often you woke up during the night (except to go to the bathroom), how often you woke up earlier than you had to in the morning, and how refreshing your sleep was. During the past 7 days, how would you rate your sleep quality overall? (Please mark only 1 box)	Sleep Quality Scale 2018 JCSM	**Jen Castoro:** • " Suggest breaking this up as well for readability: NOTE: The following question refers to your overall sleep quality for the past 7 nights ONLY. Choose the answer that applies to most of the nights." • "I realize this is from the validated tool, but it clocks a very high reading level. Even breaking it into two sentences would help: Please think about the quality of your sleep overall. This includes how many hours... • It would be ideal to format into a bulleted list, but I realize there may not be room for this."	**Kenny Kwong | Touro University Graduate School of Social Work:** "Q10, answer choices, either from poor to excellent a 10-point scale, what point you will mark? [terrible] or poor very similar[.]"
Health Behaviors & Lifestyle	11. In the past 30 days, other than your job, did you participate in any physical activities or exercises such as running, golf, gardening, or walking for exercise?	Core Section 4: Exercise 2022 BRFSS	**Jen Castoro: "**Some suggestions for breaking this up as well: • The next questions ask about physical activities. These include exercise, sports, or active hobbies that you	**Yuan Zhang | Columbia University SPH**: Does physical labor count?

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
			may do in your free time. Some examples are running, golf, gardening, walking, cycling, tennis, swimming, dancing, and other activities that require you to move your body. • Possible to move the job clause? • In the past 30 days, did you do any physical activities or exercises such as running, golf, gardening, or walking for exercise? Do not include activity you did for your job."	
Health Behaviors & Lifestyle	12. Why have you not participated in physical activities in the past 30 days? Check all that apply.	Inventory of Physical Activity Barriers (IPAB) 2022 The Gerontologist		**Laura Radensky | COHME Home Care**: "…include ":experiencing too much pain" . That is an important reason". **Charles Markham | DOROT:** "One of the options says " I am too old to be physically active" I think could be rephrased to "I feel I am too old to be physically active" otherwise I feel it makes an assumption that there is a set age where it is too old to be physically active[.]" **Kenny Kwong | Touro University Graduate School of Social Work:** "Q12 - many answer choices, some are overlapping, any possibility to

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
				condense them into fewer categories?" **Karen Ng | LFA Asian Support Group:** "barriers to physical activity are overlapping and not defined well, would also group them differently (i.e. put the "It's hard to ..." choices together)"
Health Behaviors & Lifestyle	13. Over the past three months, how often did your pain limit your life or work activities?	Chronic Pain portion of 2020 NHIS		
Health Behaviors & Lifestyle	14. Over the past three months, did you use any of the following to manage your pain?	Chronic Pain portion of the 2020 NHIS	**Robyn Wiesel:** "… self medicated not OTC[.]"	**Karen Ng | LFA Asian Support Group:** "don't need question marks after each choice[.]"
Health Behaviors & Lifestyle	15. How strongly do you disagree or agree with the following statements regarding healthy eating?	HEWSE Scale 2014 Texas Tech University	**Jen Castoro:** "…following statements [about] healthy eating?" a) "…able to [eat] fruits…" b) N/A c) Consider "I know how to choose healthy foods... ?" d) "able to [change] recipes…" e) N/A f) "…able to [eat] in unhealthy…" I don't really like "indulge in" as a term--implies that it's never acceptable/feels a little judge-y …I am able to [make healthier choices later]." **Laura Robbins**: Add question regarding access to food	**Karen Gottlieb | Americares Free Clinic:** "Regarding healthy eating # 15 - I might include a question regarding affordability of food, making choices based on price, scarcity of food to feed family. I do see this addressed in #18 along with other SDOH, maybe that is enough." **Kenny Kwong | Touro University Graduate School of Social Work:** "Q15 To what extent do you agree with the following statements (instead of how strongly you disagree or agree) [.]"
Health Behaviors & Lifestyle	16. How often do you feel the way described in each of the following statements?	3-Item Loneliness Scale 2004 UCLA	**Jen Castoro: "**This is a little hard to read as phrased. What about making into a statement? "Choose the	**Kenny Kwong | Touro University Graduate School of Social Work:** "Q16 not helpful the question and answer

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
			option below that matches how often you feel each feeling." ?"	currently composed, if it is important to explore their sense of social isolation and social support that may relate to how they manage their conditions, perhaps locate a standardized scale for that topic."
Use of and Access to Care	17. What is the primary source of your insurance?	Core Section 3: Health Care Access 2022 BRFSS		
Use of and Access to Care	18. Here is a list of some things that may affect people's health and well-being. What are the top 5 problems that affect your health? Please check all that apply	PRAPRAE 2016 NACHC	**Jen Castoro:** "This is confusing--do we want them to stop at 5 or literally choose all if they all apply?"	**Diane Gross | Lupus Research Alliance:** "lack of access to doctor's office could be different things - the hours, transportation, insurance, etc. - does that matter for your purposes? Otherwise, looks good." **Laura Radensky | COHME Home Care**: "…question re: 5 top problems is very broad and a little vague."
Use of and Access to Care	19. There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the past 12 months?	Health Care Access and Utilization 2022 All of Us	**Laura Robbins**: "Add response option for could not find a doctor for the specialty[.]" **Jen Castoro:** • "If there's any way to bring this question down to the next page above the answers, that would be good." • "Nervous about seeing a [healthcare] provider"	**Karen Gottlieb | Americares Free Clinic:** "…does not include it takes months to get a [doctor's] appointment - that is a big reason for delay[.]"
Use of and Access to Care	20. Sometimes people don't follow their doctor or other	Not validated tool, designed		

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
	healthcare provider's medical advice. Please select the reasons that may apply to you. Check all that apply.	for 2022 CHNA		
Use of and Access to Care	21. What are some of the barriers you might experience in trying to use telehealth? Check all that apply.	Adapted from the 2022 AARP Telehealth Survey	**Jen Castoro: Regarding** NOTE: "…when you and the [provider] are not…phone call with your [doctor]."	**Diane Gross | Lupus Research Alliance:** "…one possible reason not to use telehealth is lack of a private space where you can talk freely with the HCP."
Use of and Access to Care	22. During the past 12 months, have you used the Internet for any of the following reasons?	Internet Access and Health Information Tech portion of 2023 NHIS		
Use of and Access to Care	23. Please think about all the times in your life when you have gotten health care. When getting health care, how often have any of the following things happened to you because of your race, ethnicity, or color?	Discrimination in Medical Settings (DMS) Scale	**Catherine MacLean:** "…Whether care was influenced by gender or sexual orientation." **Laura Robbins:** "Rephrase to "please think about all the times in your life when you have received health care"[.]" **Jen Castoro:** "…when you have gotten [healthcare]. When getting [healthcare]…"	**Charles Markham | DOROT:** "For question 23 options D, E, and F should be made gender neutral statements. For [e]xample A doctor or nurse acts as if he or she thinks you are not smart Replace He or She with They.....A doctor or nurse acts as if they think you are not smart[.]" **Karen Ng | LFA Asian Support Group:** "distinction between "courtesy" and "respect" can be nuanced[.]" **Yuan Zhang | Columbia University SPH**: Would you also consider factors such as sex/gender and English proficiency?
Use of and Access to Care	24. What language do you feel most comfortable speaking with your doctor or nurse?	AHA Institute for Diversity and Health Equity		

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
Use of and Access to Care	25. In which language would you feel most comfortable reading medical or health care instructions?	AHA Institute for Diversity and Health Equity	**Jen Castoro:** "…reading medical or [healthcare] instructions?"	
Use of and Access to Care	26. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	Single Item Literacy Screener (SILS) 2006 BMC		**Karen Gottlieb | Americares Free Clinic:** "…is really important in designing education material - infographics vs text for example" **Karen Ng | LFA Asian Support Group:** "would want to know who serves as medical translator[.]"
Health Education	27. What are the top three reasons you did not participate in health education programs in the past 12 months? Choose only your top 3 options.	Not validated tool, designed for 2022 CHNA	**Jen Castoro:** • "at HSS or generally?" • "I think lack of interest might also be useful to ask about. Or maybe no topics of interest?"	**Karen Gottlieb | Americares Free Clinic:** "…might add child care and conflicts with my work schedule (info on best time to do programs) [.]" **Karen Ng | LFA Asian Support Group:** "option of wasn't interested in the topics offered, also this question was unclear in terms of whether it was in-person or online health education programs[.]"
Health Education	28. Which of the following health education formats/activities would you be interested in? Check all that apply.	Not validated tool, designed for 2022 CHNA	**Jen Castoro:** "maybe In-person vs. Onsite since that's a closer corollary?"	**Karen Gottlieb | Americares Free Clinic:** Also, question about when is the best time for class (morning, afternoon, evening, etc[.]) Maybe best location offering HSS, hospital and/or other available locations[.]" **Melissa Velez | Spondylitis Association of America:** "May help to define some of the formats in question 28, e.g. "Podcasts (audio programs you can listen to on your phone)"
Health Education	29. What five health topics would you be interested in learning	Not validated tool, designed	**Jen Castoro:** Regarding "Complementary treatments…": "move this	**Kenny Kwong | Touro University Graduate School of Social Work:** "Q29 - some

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
	more about? Choose only 5 options.	for 2022 CHNA	down to the next line so it doesn't overlap with the check box	answer choices are not health topics - like financial assistance options, preparing the list of questions modify the question like name 5 of the following topics that you want to discuss and learn more to enhance…" **Leslie Kerr | Mount Sinai Medical Center:** "question #29 has too many choices- it needs to be shortened or have the options condensed."
About You	30. What was your sex assigned at birth?	PhenX Toolkit 2023 NIH		
About You	31. What terms best express how you describe your gender identity?	PhenX Toolkit 2023 NIH		
About You	32. Do you think of yourself as:	Sexual Orientation portion of 2024 NHIS		
About You	33. What is your age? ____	2023 BRFSS		**Teresa Lin | VNS Health:** "should there be a range of ages say: 40-49; 50-59; 60-69....seems like almost all other questions have "drop down" boxes or ranges of answers[.]"
About You	34. Do you consider yourself Hispanic/Latino? Check all that apply.	Core Section 8: Demographics 2022 BRFSS		
About You	35. Which one of these groups would you say best represents your race? Check all that apply.	2023 BRFSS		
About You	36. What is the highest grade or year of school you completed?	2023 BRFSS		**Diane Gross | Lupus Research Alliance:** "I understand # 36 is validated but there is a difference between completing college and attending college and/or a technical school - rather

CHNA Survey Domain	CHNA Survey Question	Validated Tool	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
				than number of years of college it seems like asking if they have an AA, BA/BS or some completed a technical training would be more accurate."
About You	37. What is your annual household income from all sources?	2023 BRFSS		
About You	38. What is the zip code where you currently live?	Not validated		

Additional Comments	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
General/layout	**Anne Bass:** "The survey looks good. " **Reesa Kaufman**: "I think it looks great." **Stephen Haskins:** "Thank you for sharing - the survey is quite extensive, and I look forward to learning more about the results." **Randi Arias:** "Overall the content is great…" **Heather Woolf:** "Looks great!" **Robyn Wiesel**: "looks awesome!" **Ann Marie McDonald** "2 suggestions 1. Question 27 perhaps Bold and capitalize the negative "NOT"." **Jen Castoro**: • Just make sure the font is large enough and check boxes are big/clear enough. • It's an excellent survey! • Introduction paragraph: First sentence, remove "conditions". Second sentence remove "important". • Regarding "Please use the space below to share with us any other health-related needs that you think would be helpful for us to know about:" I realize it's nonspecific but I'm wondering if by limiting it to ortho/rheum you might miss something useful. Like weight issues, for instance."	**Laura Radensky | COHME Home Care** • **General**: "Good survey but I could see someone feeling it is too much info at one sitting." "Is the survey available in different languages? If so, should that be mentioned at the top?" **Leslie Kerr | Mount Sinai Medical Center:** "larger print, questionnaire available in other languages". **Lula Phillips | Weill Cornell Medicine CTSC:** • **Layout:** "…If you expect seniors [to read this form]- prints small, boxes and lines can become confusing" • **General:** "Some questions seen prying-what are you going to do if they respond with limited access to food, [homelessness], limited place to exercise, or transportation problem. If [you're] not going to provide some sort of wellness support and or check, why bother?" **Amanda Gerulski | Lenox Hill Neighborhood House:** "Perhaps increasing font size". **Karen Gottlieb | Americares Free Clinic:** "I think they are grouped together logically." **Teresa Lin | VNS Health:** • "Hope the survey will be offered in other major languages as well." **James Davis | FC Monmouth:** • **Layout**: "Maybe condensing the size or spacing so that it does not look as lengthy for patients? Although some patients may have eyesight issues so that should be a factor considered as well." • **General:** "Looks great!" **Cindy Hou | Jefferson Health:** • **Layout**: "fewer answer choices[.]" "survey length[.]" **Kenny Kwong | Touro University Graduate School of Social Work:** "No comment. Overall, the survey is comprehensive." **Karen Ng | LFA Asian Support Group:** "Multiple "if X, then skip to Y" instructions are confusing. Instead, if there's a way to visually layout the page like a decision tree, it might help."

Additional Comments	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
		Diane Gross | Lupus Research Alliance: "It is very tight and having it spaced out more would make it easier to read, particularly questions like #20, more space between lines or alternate highlighted lines, a way to easily go across and answer in the right line[.]" **Carla Menezes| Lupus Research Alliance**: "I think this survey is comprehensive and will provide a lot of important data about our community."
Health literacy suggestions	**Randi Arias:** "I would recommend rewording some of the questions to improve readability." **Catherine MacLean:** "Would start with a single item health literacy question and if the person has limited literacy, would let them opt out [to] the survey unless they had a [surrogate] to help (and if so would identify that)[.]" **Bella Elogoodin:** "I would recommend adding a question related to how we can continue supporting the population who may be visually impaired as well as hearing impaired[.]"	**Lula Phillips | Weill Cornell Medicine CTSC:** "Yes-…a lot of words that need clarifying for example: 1. quality of health a definition 2. meaning of symptoms 3. is stiffness considered pain or just discomfort 4. how are you defining general health -this is a loaded culture question 5. make sure all the need to see words are [embolden] - such as except, not 6. What do you mean by avoid physical activity 7. What do [you] mean by others told me to avoid physical activity? Who is others? Family, Acquaintances, Health Care Provides And define health care providers?" **Karen Gottlieb | Americares Free Clinic:** "The questions that are asked, "why did you not" can be confusing…more so when translated into Spanish. Would at minimum bold "not" so it stands out[.]" **Cindy Hou | Jefferson Health:** "the font of the surveys is small there are a few questions on language, but the whole survey is in English - is this available in other languages[?]"
Length	**Catherine MacLean:** "Seems long."	**Laura Radensky | COHME Home Care**: "Questionnaire overall is long". **Karen Gottlieb | Americares Free Clinic:** "It is a little long and may be intimidating to some participants." **Cindy Hou | Jefferson Health:** "the whole survey is very long with lots of answer choices[.]"
Anything that can be cut?	**Catherine MacLean:** "I'm not clear on the specific purpose of asking so many detailed questions about functional status, mental health. If there is not a specific purpose, you	**Lula Phillips | Weill Cornell Medicine CTSC:** "Yes-all the ones that require additional [clarification] as listed."

Additional Comments	Internal Feedback (HSS stakeholders)	External Feedback (Community partners)
	could eliminate many of those questions."	
Anything left out?	**Stephen Haskins:** "I noticed there is only one question that alludes to housing insecurity. Do you think it might be worthwhile to have a few more exclusive questions related to housing? **Catherine MacLean:** "Access! • Suggest asking if people have a regular PCP and if they have a regular specialist to treat their arthritis. • Suggest exploring whether they are able to get appointments with those clinicians. • Suggest probing those without access about factors that affect access. "	**James Davis | FC Monmouth:** "The only thing that comes to mind is asking if an individual has had a physical or recently been to a doctor to check on their health. Or phrasing it when was the last time you had a physical and give dates range ie. 1-3 months, 6-12 months, 1-3 years, 5-10 years etc. Then maybe a follow up question of were there any health defects noted in that checkup?" **Cindy Hou | Jefferson Health:** "question about social isolation[.]" **Charles Markham | DOROT:** "No this was very comprehensive[.]" **Carla Menezes | Lupus Research Alliance**: "I think the survey could have an additional question related to how often the person experiences pain. Also, a question on how fatigue may impact QoL may be helpful."
Anything to cut/condense?		**Charles Markham | DOROT:** "No, I didn't find anything repetitive[.]" **Kenny Kwong | Touro University Graduate School of Social Work:** • "Currently there are multiple questions on fall, healthy eating, health and well-being, access to care, exercising, use of [technology], etc[.] and you offer many answer choices on all possible barriers, that may appear repetitious. • The participants look at these answers which suggest many barriers but to each question; not sure how to make this less [repetitious]. • Perhaps in each of these topics such as communication with medical doctors, healthy eating, exercising, managing specific conditions like preventing fall, begin to ask their level of satisfaction, then a question on what makes them [satisfied] in performing so, and another question that if they are not satisfied, any barriers that they have encountered and try to condense to fewer answer choices (also easier to analyze or interpret the results)."

Appendix D: Input from the Public

Overall Statistics

Timeframe: October 29 – November 6, 2024

Language	Sample Size by Source		Total
	HSS Education Institute	Community Members	
English	19	21	40
Spanish	1	2	3
Chinese	0	4	4
Russian	0	1	1
Haitian Creole	0	0	0
Total	**25**	**38**	**63**

Language	Time to Complete Survey (Minutes)		
	Minimum	Maximum	Average
English	2	45	12.5
Spanish	11.9	34.6	21.9
Chinese	30	46	38.2
Russian	13	13	13
Haitian Creole	N/A	N/A	N/A
Average	21.9	34.65	21.4

Pilot Audiences:

Language	Audience
English	• HSS Education Institute • Community Members
Spanish	• Community Members
Chinese	
Russian	
Haitian Creole	N/A

General Feedback:

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
Health Status and Quality of Life	39. Have you ever been told by a doctor or other health professional that you have …?	Hypertension portion of 2024 NHIS		**English** • Are there specific diagnoses you are looking for? **Chinese** • For "Other" option, reword instructions to 「輸入其他病症」
Health Status and Quality of Life	40. 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?	Self-Efficacy for Managing Chronic Disease 6-Item Scale 2015 Stanford		
Health Status and Quality of Life	41. Would you say that in general your health is:	Core Section 1: Health Status 2022 BRFSS		
Health Status and Quality of Life	42. 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?	Core Section 2: Healthy Days 2022 BRFSS		**English:** • "Not good" is unclear
Health Status and Quality of Life	43. 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?	Core Section 2: Healthy Days 2022 BRFSS		**English:** • "Not good" is unclear
Health Status and Quality of Life	44. Please respond to each question or statement by marking one box per row.	PROMIS Adult SF v2.0 Physical Function 24a 2024 Health Measures		
Health Status and	45. In the past year, have you fallen down?	Health Status portion of the		

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
Quality of Life		Medicare Beneficiary Survey (MCBS)		
Health Status and Quality of Life	46. Did any of these fall(s) cause an injury?	Not validated tool		
Health Status and Quality of Life	47. Did you see a doctor or other health care professional about your fall(s)?	Adapted from a validated tool for assessing health seeking behaviors PhenX Toolkit 2023 NIMHD		
Health Status and Quality of Life	48. Why did you not seek medical help for your fall? Check all that apply.	No single validated tool used. Question is based on prompts & responses from several studies. Family Practice, 2014 JAGS, 2018 SGS, 2022		
Health Status and Quality of Life	49. Please think about the quality of your sleep overall, such as how many hours of sleep you got, how easily you fell asleep, how often you woke up during the night (except to go to the bathroom), how often you woke up earlier than you had to in the morning, and how refreshing your sleep was. During the past 7 days, how would you rate your sleep quality	Sleep Quality Scale 2018 JCSM	**English** • On mobile, the combination of number ranking and "poor/fair/good" ranking is confusing. Consider adding directions that 0 = worst sleep quality and 10 = best sleep quality • I didn't understand why there were multiples of "poor"	**Chinese** • The scale from 0-10 contains repeating labels

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
	overall? (Please mark only 1 box)		"fair" and "good" – is this a mistake?	
Health Behaviors & Lifestyle	50. In the past 30 days, other than your job, did you participate in any physical activities or exercises such as running, golf, gardening, or walking for exercise?	Core Section 4: Exercise 2022 BRFSS		
Health Behaviors & Lifestyle	51. Why have you not participated in physical activities in the past 30 days? Check all that apply.	Inventory of Physical Activity Barriers (IPAB) 2022 The Gerontologist		
Health Behaviors & Lifestyle	52. Over the past three months, how often did your pain limit your life or work activities?	Chronic Pain portion of 2020 NHIS		
Health Behaviors & Lifestyle	53. Over the past three months, did you use any of the following to manage your pain?	Chronic Pain portion of the 2020 NHIS		
Health Behaviors & Lifestyle	54. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.	Hunger Vital Signs	**English** • The transition to the question is abrupt. Switch it with #17.	**English** • Change pronouns from "we" to "you" to match other questions • Confusing because it is a double-barreled question • Hard to follow • Assumes there is a "we" **Chinese** • Question should read "the food you bought" instead of "the food we bought"
Health Behaviors & Lifestyle	55. How strongly do you disagree or agree with the following statements regarding healthy eating?	HEWSE Scale 2014 Texas Tech University		**English** • Transition to question awkward, need transition statement or move elsewhere • Wording for f) was confusing, not sure if

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
				"cut back" is referring to the unhealthy food or healthy food • I answered all the questions in #1 because they were radio buttons, but by the time I got to #17 I guessed that some of the answers might be optional, and they were. I think radio buttons tend to imply a mandatory nature, but this setup did not preclude me from completing either question! **Chinese** • Reword 「我可以在」 to 「我能在」
Health Behaviors & Lifestyle	56. How often do you feel the way described in each of the following statements?	3-Item Loneliness Scale 2004 UCLA		**English** • Abrupt transition to subject
Use of and Access to Care	57. What is the primary source of your insurance?	Core Section 3: Health Care Access 2022 BRFSS		**English** • Transition to question awkward, need transition statement or move elsewhere
Use of and Access to Care	58. Here is a list of some things that may affect people's health and well-being. What are the top 5 problems that affect your health? Please check all that apply	PRAPRAE 2016 NACHC		**English** • Add a "does not apply" option • There was no "does not apply" button
Use of and Access to Care	59. There are many reasons people delay getting medical care. Have you delayed getting care for any of the following reasons in the past 12 months?	Health Care Access and Utilization 2022 All of Us		

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
Use of and Access to Care	60. Sometimes people don't follow their doctor or other healthcare provider's medical advice. Please select the reasons that may apply to you. Check all that apply.	Not validated tool, designed for 2022 CHNA	**English** • I wonder if there is a way to make this more inviting without making it too wordy • Instead of "d) Concerned about the cost of treatment" that could be presented as "I do not have to choose between paying for my treatment and paying for other things that are important to me." Or instead of "j) Did not fit my schedule / not convenient for me" it could be "The treatment as prescribed does not fit with my daily routine."	**English** • Instead of a "Yes" and "No" column that needs to be checked for each question, just use a multi-select dropdown with check boxes to alleviate survey burden • Option A ("Does not Apply") Double negatives? Not sure from wording about answer yes vs no • There was an extra "Yes/No" at the end • Change Yes/No to check all that apply • It says check all that apply, but there are yes/no boxes for each **Spanish** • The "Yes/No" option was not clear
Use of and Access to Care	61. What are some of the barriers you might experience in trying to use telehealth? Check all that apply.	Adapted from the 2022 AARP Telehealth Survey		**English** • Question was unclear
Use of and Access to Care	62. During the past 12 months, have you used the Internet for any of the following reasons?	Internet Access and Health Information Tech portion of 2023 NHIS		**English** • Not clear • It's not that the question is unclear, but i communicate with a doctor via text which is sometimes connected to the internet, but may not be.
Use of and Access to Care	63. Please think about all the times in your life when you have gotten health care. When getting health care, how often have any of the following things happened to you because of your	Discrimination in Medical Settings (DMS) Scale	**English** • "People treat you with less courtesy than others" and "People treat you with less respect than others" - not	**English** • You're asking the participant to assume it was because of their identities or if they definitely know it was because of it? Those are two different questions and you'll likely get

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
	race, ethnicity, or color?		sure both are necessary as they are so similar - people might get confused as to what the difference is	different answers depending on how you phrase the question
Use of and Access to Care	64. What language do you feel most comfortable speaking with your doctor or nurse?	AHA Institute for Diversity and Health Equity		
Use of and Access to Care	65. In which language would you feel most comfortable reading medical or health care instructions?	AHA Institute for Diversity and Health Equity		
Use of and Access to Care	66. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	Single Item Literacy Screener (SILS) 2006 BMC		
Health Education	67. What are the top three reasons you did not participate in health education programs in the past 12 months? Choose only your top 3 options.	Not validated tool, designed for 2022 CHNA		**Chinese** • "Not Applicable" option repeats
Health Education	68. Which of the following health education formats/activities would you be interested in? Check all that apply.	Not validated tool, designed for 2022 CHNA		
Health Education	69. What five health topics would you be interested in learning more about? Choose only 5 options.	Not validated tool, designed for 2022 CHNA		
About You	70. What was your sex assigned at birth?	PhenX Toolkit 2023 NIH		

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
About You	71. What terms best express how you describe your gender identity?	PhenX Toolkit 2023 NIH		
About You	72. Do you think of yourself as:	Sexual Orientation portion of 2024 NHIS		**English** • Why use “straight, not heterosexual”? Also why say gay and not include lesbian when defining what “straight” isn’t? But then you say “lesbian and gay” as an option
About You	73. What is your age? ____	2023 BRFSS		
About You	74. Do you consider yourself Hispanic/Latino? Check all that apply.	Core Section 8: Demographics 2022 BRFSS		
About You	75. Which one of these groups would you say best represents your race? Check all that apply.	2023 BRFSS		
About You	76. What is the highest grade or year of school you completed?	2023 BRFSS		
About You	77. What is your annual household income from all sources?	2023 BRFSS		
About You	78. In the past 12 months, did you participate in one or more of the following government assistance programs? Please select all that apply.	Not validated		
About You	79. What is the zip code where you currently live?	Not validated		
About You	80. Please use the space below to share with us any other orthopedic, or rheumatology-related needs that you would	Not validated		**English** • Wasn’t sure if this was pertaining to me as an individual or if it was asking in general

CHNA Survey Domain	CHNA Survey Question	Validated Tool	HSS Education Institute	Community Members
	like Hospital for Special Surgery to know about:			**Russian** • I don't know exactly what problems relate to these areas

Additional Comments	HSS Education Institute	Community Members
General/ Layout	**English** • Yes/No questions - They were clear, HOWEVER, wondering if someone has to answer every option with a Yes/No ... or if they can just mark those that apply (i.e., YES) and move on -- I'd suggest the latter for ease of use if it's feasible	**Chinese** • There is an issue with the numbering, starting from Q2. This caused a chain reaction, leading to a disconnect in the logical flow of the prompts beginning at question 7 • Referencing the paper questionnaire, the following questions are not numbered in the online form: 2, 8, 9, 10, 13, 15. **English** • Add a “submission” button to the end and a confirmation page • The answers should be in the same order to choose from • Just want to flag that these text input fields don't expand when inputting my response (on desktop) so I can't see what i'm writing. (the box doesn't wrap, expand or flex so I can see the content).

Appendix E: Key Findings Report of the Community Survey

Community Survey Key Findings Report

Table of Contents

List of Abbreviations

The following abbreviations are used throughout the report.

ACC	HSS Ambulatory Care Centers
MUA	Medically Underserved Area
MSK	MSK
OA	Osteoarthritis
OP	Osteoporosis
CP	Chronic Pain
RA	Rheumatoid Arthritis
ANHPI	Asian, Native Hawaiian, or Pacific Islander
AI/AN	American Indian/Alaska Native
LGB	Lesbian, Gay, or Bisexual

Community Survey Key Findings

HSS conducted a Community Health Needs Assessment (CHNA) from January 15 to February 15, 2025, 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 (CSP). This report highlights key findings from the community survey.

The community survey was a large-scale anonymous survey completed by 31,792 HSS patients and community members. It assessed several areas:

- Socio-demographic characteristics
- Health status and quality of life
- Health behavior and lifestyle
- Use of and access to care
- Health education

The survey was administered in English, Spanish, Chinese, Russian, and Haitian Creole with an overwhelming response in English (97.3%). The rest of the responses were in Spanish (2.0%), Chinese (0.4%), Russian (0.3%), and Haitian Creole (<0.1%). The CHNA survey was administered online (i.e., web, social media, and email via Alchemer), by mail, and in-person (i.e., paper surveys, QR-codes). Table 1 below shows a detailed breakdown of responses and response rates by administration method.

Table 1. Response Rates by Administration Method

Administration Method	Subset	Number of Responses	Sample Size	Response Rate
Alchemer	Panel Service	7,225	6,000	120.0%
Email	Patients	16,915	292,667	5.8%
Email	HSS Community Education & Outreach	653	8,212	8.0%
Email	HSS Social Work	28	766	3.7%
Email	Community Partners	1	N/A	N/A
Email	HSS Newsletter	6	N/A	N/A
Text Message	Patients	5,859	288,376	2.0%
In-Person	Patients	268	N/A	N/A
In-Person	Community Members	112	N/A	N/A
Poster QR Code	Patients	1	N/A	N/A
Postcard QR Code	Patients	59	N/A	N/A
Mail	HSS Community Education & Outreach	212	2632	8.1%
Mail	HSS Social Work	39	529	7.4%
Social Media	Facebook	154	N/A	N/A
Social Media	Patch.com	44	N/A	N/A
Social Media	LinkedIn	35	N/A	N/A
Social Media	Community Partner	147	N/A	N/A
Web	HSS Community Education & Outreach Event Website	3	N/A	N/A
Web	HSS Move Better Feel Better Website	5	N/A	N/A

Survey Analysis

Primary analyses were conducted in the total sample of 31,792 respondents. To further examine the total sample and identify health disparities that exist, secondary analyses were conducted in the three sub-groups listed below, with results presented throughout this report.

- HSS Ambulatory Care Centers; ACC (n=481)
  - This group represents HSS patients from more racially/ethnically diverse and lower socioeconomic backgrounds who receive care at ACC locations (i.e., 72nd street and Rheumatology, 6th floor)
- HSS Regional sites (n=11,853)
  - This group represents respondents living in HSS regional locations (i.e., Long Island, NY; Westchester, NY and surrounding counties; Connecticut; New Jersey; Florida)
- Medically underserved respondents (n=8,978)
  - This group represents respondents who are low to middle income (annual household income <$150k) and report being uninsured, insured through Medicaid, living in a Medically Underserved Area (MUA), or receiving government assistance for nutrition, shelter, or cash needs.

Survey Results

This section highlights results from descriptive summaries and regression models to identify 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.

A. Socio-Demographic Profile

The following tables show the socio-demographic profile of the 2025 CHNA respondents.

Gender

Table 2. Gender

Gender	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Female	61.8%	70.2%	58.2%	61.1%
Male	36.7%	27.0%	40.6%	37.6%
Non-binary	0.2%	0.0%	0.2%	0.4%
Transgender Woman	0.1%	0.0%	<0.1%	0.1%
Transgender Man	0.1%	0.0%	0.1%	0.2%
Other	0.2%	0.9%	0.2%	0.2%
Prefer not to respond	0.9%	1.8%	0.7%	0.4%

Age

Table 3. Age

Age Group (years)	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
60-79	33.3%	37.0%	34.4%	17.7%
20-39	32.0%	17.5%	32.0%	46.0%
40-59	25.7%	37.7%	25.3%	30.2%
80+	6.3%	5.8%	5.4%	2.5%
<20	2.7%	1.9%	3.0%	3.6%

Sexual Orientation

Table 4. Sexual Orientation

Sexual Orientation	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Straight	90.6%	87.1%	92.7%	86.4%
Lesbian or gay	3.0%	2.8%	1.9%	4.1%
Bisexual	2.8%	2.2%	2.5%	5.6%
Other	0.5%	2.2%	0.3%	0.7%
Don't know	0.4%	0.9%	0.3%	0.8%
Prefer not to respond	2.7%	4.7%	2.3%	2.3%

Ethnicity

Table 5. Ethnicity

Ethnicity	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Non-Hispanic/Latino	83.5%	70.1%	84.5%	65.8%
Hispanic/Latino	15.5%	28.5%	14.8%	32.9%
Prefer not to respond	0.7%	1.2%	0.5%	0.7%
Don’t know/Not sure	0.2%	0.2%	0.2%	0.6%

Hispanic/Latino Origin

Table 6. Hispanic/Latino Origin

Hispanic/Latino Origin	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Puerto Rican	40.4%	39.7%	34.4%	43.5%
Other	37.8%	48.8%	37.0%	34.2%
Mexican, Mexican American, Chicano/a	16.3%	0.0%	23.1%	18.8%
Cuban	7.3%	7.2%	8.7%	5.8%

Race

Table 7. Race

Race	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
White	70.1%	39.9%	74.6%	41.6%
Black or African American	16.5%	25.3%	15.0%	37.5%
Asian	5.1%	6.2%	4.0%	6.8%
Other	4.8%	10.8%	3.8%	8.5%
American Indian/Alaska Native	1.6%	2.6%	1.4%	3.2%
Native Hawaiian/Other Pacific Islander	0.6%	0.3%	0.7%	1.4%
Prefer Not to Respond	3.8%	5.4%	3.2%	3.5%
Don't know/Not sure	1.3%	2.6%	1.1%	2.6%

Asian Origin

Table 8. Asian Origin

Asian Origin	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Chinese	29.9%	16.7%	22.4%	29.7%
Asian Indian	21.9%	12.5%	32.9%	24.9%
Filipino	12.1%	4.2%	16.5%	10.7%
Korean	6.4%	0.0%	10.3%	5.6%
Japanese	4.8%	2.1%	4.8%	5.7%
Vietnamese	1.2%	0.0%	1.8%	1.3%
Other	7.9%	10.8%	3.8%	12.4%

Education

Table 9. Education Level

Education Level	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Postgraduate (Masters, PhD)	33.0%	11.6%	32.1%	14.2%
College 4 years or more (College graduate)	27.2%	20.9%	27.5%	20.3%
College 1 year to 3 years (Some college or technical school)	18.5%	28.7%	19.5%	22.5%
Grade 12 or GED (High school graduate)	15.7%	24.1%	16.1%	31.9%
Grades 9 through 11 (Some high school)	3.3%	7.2%	3.1%	7.9%
Grades 1 through 8 (Elementary)	0.8%	3.8%	0.6%	1.9%
Never attended school or only attended kindergarten	0.2%	0.3%	0.1%	0.5%
Prefer Not to Respond	1.3%	3.4%	0.9%	0.7%

Annual Household Income

Table 10. Annual Household Income

Annual Household Income	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
$200,000+	16.3%	0.7%	16.2%	0.0%
$100,000-$149,999	11.9%	1.6%	12.0%	11.2%
$50,000-$74,999	9.3%	5.6%	9.5%	13.0%
$75,000-$99,999	8.4%	3.6%	8.5%	9.5%
$150,000-$199,999	7.2%	0.3%	7.1%	0.0%
$35,000-$49,999	5.9%	6.5%	6.1%	16.1%
Less than $10,000	5.7%	19.0%	5.9%	15.4%
$15,000-$24,999	5.1%	18.0%	5.4%	13.9%
$25,000-$34,999	4.5%	7.5%	4.7%	12.1%
$10,000-$14,999	3.2%	16.7%	3.4%	8.7%
Prefer Not to Respond	22.4%	20.6%	21.3%	13.2%

Geographic Location

Table 11. Geographic Location

Location	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Manhattan	19.8%	21.3%	0.0%	16.2%
New Jersey	17.9%	2.2%	33.3%	16.0%
Westchester and surrounding counties	11.9%	7.9%	22.2%	9.4%
Brooklyn	9.6%	23.5%	0.0%	16.0%
Connecticut	9.3%	0.7%	17.4%	10.6%
Florida	8.1%	0.0%	15.1%	4.2%
Queens	8.0%	19.9%	0.0%	8.0%
Long Island	6.5%	2.9%	12.1%	2.6%
Bronx	6.4%	17.7%	0.0%	13.7%
Staten Island	2.5%	4.0%	0.0%	1.8%

B. Health Status and Quality of Life

Musculoskeletal (MSK) Conditions

Table 12 shows respondents who have been diagnosed with various MSK and rheumatologic conditions. Across all samples except Medically Underserved, osteoarthritis was the leading condition reported, followed by chronic pain, and then osteoporosis. This is consistent with national findings where osteoarthritis is a leading cause of disability.[80] Reports of osteoarthritis, chronic pain, and osteoporosis in the total sample were all higher in 2025 compared to the 2022 CHNA. Among the Medically Underserved sub-sample, the leading condition reported was CP, followed by OA and OP.

Table 12. MSK conditions

MSK Condition	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Osteoarthritis (OA)	46.0%	55.7%	44.0%	28.5%
Chronic Pain (CP)	32.9%	55.6%	31.2%	29.7%
Osteoporosis (OP)	24.4%	28.4%	20.5%	15.1%
Spine deformity	19.9%	29.0%	18.1%	14.5%
Some other form of arthritis	15.3%	21.1%	13.8%	12.5%
Rheumatoid arthritis (RA)	11.3%	25.8%	9.9%	12.4%
Gout	7.0%	8.5%	7.2%	6.0%
Fibromyalgia	5.3%	12.6%	4.9%	6.1%
Lupus	2.6%	6.0%	2.5%	3.8%

[80] US Burden of Disease Collaborators, Mokdad, A. H., Ballestros, K., Echko, M., Glenn, S., Olsen, H. E., Mullany, E., Lee, A., Khan, A. R., Ahmadi, A., Ferrari, A. J., Kasaeian, A., Werdecker, A., Carter, A., Zipkin, B., Sartorius, B., Serdar, B., Sykes, B. L., Troeger, C., Fitzmaurice, C., … Murray, C. J. L. (2018). The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. JAMA, 319(14), 1444–1472. https://doi.org/10.1001/jama.2018.0158

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, and medically underserved status were conducted to observe statistically significant associations between MSK (MSK) conditions and each of the following predictor variables:

- Age
  - 40-59 year-old respondents had significantly **higher** odds of reporting all MSK conditions (OA, CP, OP, RA, gout, fibromyalgia, lupus, and some other form of arthritis) except spine deformity compared to those ages 18-39
  - 60-79 year-old respondents had significantly **higher** odds of reporting all MSK conditions (OA, CP, OP, spine deformity, RA, gout, fibromyalgia, lupus, and some other form of arthritis) compared to those ages 18-39
  - 80+ year-old respondents had significantly **higher** odds of reporting OA, CP, OP, RA, gout, lupus, and other form of arthritis compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting OA, CP, OP, spine deformity, RA, fibromyalgia, and lupus compared to men
  - Women had significantly **lower** odds of reporting gout and some other form of arthritis compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting spine deformity, gout, and lupus compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting OA and spine deformity compared to non-Hispanic or Latino respondents
  - Hispanic and Latino respondents had significantly **higher** odds of reporting RA and fibromyalgia compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents had significantly **lower** odds of reporting OA, OP, spine deformity, and some other form of arthritis than White respondents
  - ANHPI respondents had significantly **lower** odds of reporting OA, CP, some other form of arthritis compared to White respondents
  - ANHPI respondents had significantly **higher** odds of reporting gout compared to White respondents
  - AI/AN respondents had significantly **higher** odds of reporting OA, CP, OP, spine deformity, RA, gout, fibromyalgia, lupus, and some other form of arthritis compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly **lower** odds of reporting OA and spine deformity compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **higher** odds of reporting OA, OP, spine deformity, and lupus compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly **higher** odds of reporting CP and RA compared to those who were not Medically Underserved

ACC SAMPLE

Regression models adjusting for age, gender, ethnicity, race, education, and medically underserved status[81] were conducted to observe statistically significant associations between MSK conditions and each of the following predictor variables:

- Age
  - 60+ year-old respondents had significantly **higher** odds of reporting OA, OP, CP compared to those 59 and under
- Gender
  - Women had significantly **higher** odds of reporting RA compared to men
- Race
  - Black and African American respondents had significantly **higher** odds of reporting RA compared to White respondents

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, and medically underserved status were conducted to observe statistically significant associations between sociodemographic variables and each of the following MSK conditions:

- Age
  - 40-59 year-old respondents had significantly **higher** odds of reporting OA, CP, OP, RA, gout, fibromyalgia, and other form of arthritis compared to those ages 18-39
  - 60-79 year-old respondents had significantly **higher** odds of OA, CP, RA, fibromyalgia, gout, OP, spine deformity, and other form of arthritis compared to those ages 18-39
  - 80+ year-old respondents had significantly **higher** odds of reporting OA, CP, OP, RA, gout, lupus, spine deformity, and other form of arthritis compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting OA, CP, OP, spine deformity, fibromyalgia, and lupus compared to men
  - Women had significantly **lower** odds of reporting gout and some other form of arthritis compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting spine deformity and gout compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting OA and spine deformity compared to non-Hispanic or Latino respondents
  - Hispanic and Latino respondents had significantly **higher** odds of reporting lupus and fibromyalgia compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents had significantly **lower** odds of reporting OA, OP, and spine deformity compared to White respondents
  - ANHPI respondents had significantly **lower** odds of reporting OA, CP, some other form of arthritis, spine deformity, and fibromyalgia compared to White respondents
  - AI/AN respondents had significantly **higher** odds of reporting CP, gout, and lupus compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly **higher** odds of reporting OA, spine deformity, and lupus compared to those with some college or a college degree

[81] In ACC samples, age and race variables were recategorized into binary and three-level variables (respectively) due to a smaller sample size. Sexuality was removed from regression models due to low variance.

- Medically Underserved
  - Those who are Medically Underserved had significantly **higher** odds of reporting RA compared to those who were not Medically Underserved

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, and education were conducted to observe statistically significant associations between MSK conditions and each of the following predictor variables:

- Age
  - 40-59 year-old respondents had significantly **higher** odds of reporting OA, CP, OP, RA, gout, fibromyalgia, and other form of arthritis compared to those ages 18-39
  - 60-79 year-old respondents had significantly **higher** odds of reporting all MSK conditions (OA, CP, OP, spine deformity, RA, gout, fibromyalgia, and some other form of arthritis) except lupus compared to those ages 18-39
  - 60-79 year-old respondents had significantly **lower** odds of reporting lupus compared to those ages 18-39
  - 80+ year-old respondents had significantly **higher** odds of reporting OA, CP, OP, RA, gout, spine deformity, and other form of arthritis compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting OA, CP, OP, spine deformity, RA, fibromyalgia compared to men
  - Women had significantly **lower** odds of reporting gout compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting spine deformity, gout, and lupus compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting OA and spine deformity compared to non-Hispanic or Latino respondents
  - Hispanic and Latino respondents had significantly **higher** odds of reporting RA compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents had significantly **lower** odds of reporting OA, OP, spine deformity, and some other form of arthritis than White respondents
  - ANHPI respondents had significantly **lower** odds of reporting OA, RA, CP, spine deformity, and some other form of arthritis compared to White respondents
  - AI/AN respondents had significantly **higher** odds of reporting OA, CP, OP, RA, gout, fibromyalgia, lupus, and some other form of arthritis than White respondents
- Education
  - Respondents with no post-secondary education had significantly **lower** odds of reporting OA compared to those with some college or a college degree
  - Respondents with no post-secondary education had significantly **higher** odds of reporting lupus and some other form of arthritis compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **higher** odds of reporting OA, OP, spine deformity, and lupus compared to those with some college or a college degree

Confidence to Manage Symptoms

Table 13 shows confidence in managing symptoms among respondents with MSK conditions. In the total sample, over half of the respondents (58.8%) reported being somewhat/not at all confident in managing symptoms. In the ACC sub-sample, about three quarters of respondents reported being somewhat/not at all confident in symptom management. A higher proportion of respondents in the total sample reported being somewhat/not at all confident in symptom management in 2025 (58.8%) compared to 2022 (44.9%).

A binary outcome variable was used in regression analysis predicting the odds of a respondent being "somewhat confident, confident, or very confident" in their ability to manage the symptoms of their MSK condition(s).

Table 13. Confidence to manage symptoms of MSK condition

Confidence Level	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Somewhat confident	44.9%	49.9%	44.1%	47.2%
Confident	27.3%	18.6%	28.3%	25.2%
Very confident	13.9%	5.8%	15.0%	11.9%
Not at all confident	13.9%	25.8%	12.5%	15.7%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and specific MSK conditions was conducted to observe statistically significant associations between confidence in symptom management and predictor variables among those who reported having any MSK condition:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly **lower** odds of reporting confidence in symptom management compared to those ages 18-39
- Race
  - Black and African American respondents had significantly **higher** odds of reporting confidence in symptom management than White respondents
- Reporting an MSK condition
  - Respondents with OA, fibromyalgia, spine deformity, and CP had significantly **lower** odds of reporting confidence in symptom management compared to those who had an MSK condition but did not report OA, fibromyalgia, spine deformity, or CP, respectively

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and specific MSK conditions was conducted to observe statistically significant associations between confidence in symptom management and predictor variables among those who reported having any MSK condition:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly **lower** odds of reporting confidence in symptom management compared to those ages 18-39
- Reporting an MSK condition
  - Respondents with CP had significantly **lower** odds of reporting confidence in symptom management than those who had an MSK condition but did not report chronic pain

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and specific MSK conditions was conducted to observe statistically significant associations between confidence in symptom management and predictor variables among those who reported having any MSK condition:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly **lower** odds of reporting confidence in symptom management compared to those ages 18-39
- Race
  - Black and African American respondents had significantly **higher** odds of reporting confidence in symptom management than White respondents
- Reporting an MSK condition
  - Respondents with OA and CP had significantly **lower** odds of reporting confidence in symptom management than those who had an MSK condition but did not report OA or CP, respectively

General Health

Table 14 shows self-rated general health. Across all samples, respondents reporting fair or poor general health (23.8%) was higher compared to national (19.4%) and NY State (17.0%) data[82]. The ACC sub-sample had the highest proportion of respondents reporting fair or poor general health at 48.5%.
A binary outcome variable was used in regression analysis predicting the odds of reporting that, in general, their health is "good, very good, or excellent."

Table 14. Self-rated general health

Self-rated general health	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Good	39.2%	35.7%	38.0%	37.1%
Very Good	29.0%	11.1%	30.7%	20.3%
Fair	18.0%	35.0%	16.7%	25.2%
Excellent	8.0%	4.7%	8.0%	4.2%
Poor	5.8%	13.5%	6.6%	13.2%

[82] Kaiser Family Foundation. (2023). *Adult Self-Reported Health Status*. https://www.kff.org/other/state-indicator/adult-self-reported-health-status/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between good general health and each of the following predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly **higher** odds of reporting good general health compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting good general health compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting good general health compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting good general health compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents had significantly **lower** odds of reporting good general health compared to White respondents
  - AI/AN respondents had significantly **lower** odds of reporting good general health compared to White respondents
  - ANHPI respondents had significantly **lower** odds of reporting good general health compared to White respondents
- Medically underserved
  - Those who are medically underserved had significantly **lower** odds of reporting good general health compared to those who were not medically underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting good general health compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between self-reported general health and each of the following predictor variables:

- Gender
  - Women had significantly **lower** odds of reporting good general health compared to men
- Education
  - Respondents with no post-secondary education had significantly **lower** odds of reporting good general health compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **lower** odds of reporting good general health compared to those with no reported MSK condition

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between good general health and each of the following predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly **higher** odds of reporting good general health compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting good general health compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting good general health compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly **lower** odds of reporting good general health compared to White respondents
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting good general health compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between self-reported general health and each of the following predictor variables:

- Age
  - 40-59 and 60-79 year-old respondents had significantly **higher** odds of reporting good general health compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting good general health compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting good general health compared to straight respondents
- Race
  - AI/AN respondents had significantly **lower** odds of reporting good general health compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly **lower** odds of reporting good general health compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting good general health compared to those with no reported MSK condition

Physical Health

Table 15 shows the number of physically unhealthy days, including physical illness and injury, in the past 30 days as measured using the CDC Healthy Days Measures. Fourteen percent of respondents in the total sample reported 14 days or more of poor physical health in the past month, which is similar to national levels (12.6%).[83] About one in three respondents in the ACC sub-sample reported 14 days or more of poor physical health in the past month, the highest proportion across samples.

[83] UnitedHealth Foundation (2023). *Frequent Physical Distress in the United States*. America's Health Rankings. https://www.americashealthrankings.org/explore/measures/Physical_distress

Table 15. Poor physical health days

Number of Poor Physical Health Days	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
None	42.1%	24.3%	44.2%	41.5%
1-7 days	35.0%	26.9%	34.9%	34.0%
14 days or more	14.0%	34.5%	12.6%	14.6%
8-13 days	8.9%	14.4%	8.3%	9.9%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between having 14 days or more of poor physical health and each of the following predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those ages 18-39
- Race
  - Black or African American respondents had significantly **lower** odds of reporting 14 days or more of poor physical health in the past month compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly **lower** odds of reporting 14 days or more of poor physical health in the past month compared to those with some college or a college degree
- Medically underserved
  - Those who are medically underserved had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those who were not medically underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between having 14 days or more of poor physical health and each of the following predictor variables:

- Age
  - 40-59 year-old respondents had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those ages 18-39
- Race
  - Black or African American respondents had significantly **lower** odds of reporting 14 days or more of poor physical health in the past month compared to White respondents
  - ANHPI respondents had significantly **lower** odds of reporting 14 days or more of poor physical health in the past month compared to White respondents

- Education
  - Respondents with a postgraduate degree had significantly **lower** odds of reporting 14 days or more of poor physical health in the past month compared to those with some college or a college degree
- Medically underserved
  - Those who are medically underserved had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those who were not medically underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE
A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between having 14 days or more of poor physical health and each of the following predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those ages 18-39
- Race
  - Black or African American respondents had significantly **lower** odds of reporting 14 days or more of poor physical health in the past month compared to White respondents
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting 14 days or more of poor physical health in the past month compared to those with no reported MSK condition

Mental Health

Table 16 shows poor mental health days (i.e., including stress, depression, and problems with emotion) in the past 30 days, as measured using the CDC Healthy Days Measures. 8.1% of respondents in the total sample reported 14 days or more of poor mental health in the past month, which is lower than national (15.4%) and NY state (14.2%) estimates.[84] The ACC sub-sample had the highest proportion of respondents reporting 14 days or more of poor mental health in the past month (15.2%).

Table 16. Poor mental health days

Number of Poor Mental Health Days	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
None	56.1%	46.1%	58.4%	46.2%
1-7 days	28.5%	30.2%	27.4%	30.9%
14 days or more	8.1%	15.2%	7.3%	12.0%
8-13 days	7.3%	8.5%	6.9%	10.9%

[84] America's Health Rankings. (2023). *Frequent Mental Distress*. UnitedHealth Foundation. https://www.americashealthrankings.org/explore/measures/mental_distress/ny

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between having 14 days or more of poor mental health and each of the following predictor variables:

- Age
  - 60-79 and 80+year-old respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to straight respondents
- Education
  - Respondents with a postgraduate degree had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to those with some college or a college degree
- Medically underserved
  - Those who are medically underserved had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to those who were not medically underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between having 14 days or more of poor mental health and each of the following predictor variables:

- Age
  - 60-79 and 80+ year-old respondents had significantly **lower** reporting 14 days or more of poor mental health in the past month compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to non-Hispanic or Latino respondents
- Education
  - Respondents with a postgraduate degree had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to those with some college or a college degree
- Race
  - AI/AN respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to White respondents

- Medically underserved
  - Those who are medically underserved had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to those who were not medically underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between having 14 days or more of poor mental health and each of the following predictor variables:

- Age
  - 40-59 year-old respondents had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to those ages 18-39
  - 60-79 and 80+year-old respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to men
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to White respondents
  - ANHPI respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to White respondents
  - AI/AN respondents had significantly **lower** odds of reporting 14 days or more of poor mental health in the past month compared to White respondents
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting 14 days or more of poor mental health in the past month compared to those with no reported MSK condition

Physical function

Table 17 shows physical function as measured by the PROMIS instrument[85] across four domains – ability to do chores, go up stairs, walk 15 minutes, and run errands. An aggregated PROMIS score was used for regression analysis representing one's overall physical function as calculated based on responses to each of the four questions about ability to perform activities. The raw score is then converted to a T-score with a scale of 22.5 – 57, where higher scores indicate better physical function.

In the total, regional, and medically underserved samples, more people reported they were "Unable to do" the task of "chores" compared to any other domain of physical function. In the ACC sub-sample, the domain with highest proportion of "Unable to do" responses was "walk 15 minutes." Across all domains, the ACC sub-sample reported the poorest physical function.

[85] PROMIS Health Organization and PROMIS Cooperative Group. (2016). PROMIS® Item Bank v2.0 – Physical Function – Short Form 4a.

Table 17. PROMIS Physical Function – Ability to do chores

Ability to do chores	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Without any difficulty	46.0%	17.6%	48.7%	48.6%
With some difficulty	47.9%	63.2	46.1%	45.2%
Unable to do	6.1%	19.3%	5.1%	6.2%

Table 18. PROMIS Physical Function – Ability to go up stairs

Ability to go up stairs	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Without any difficulty	44.2%	17.2%	48.8%	47.6%
With some difficulty	51.1%	68%	47.2%	47.6%
Unable to do	4.7%	14.8%	3.9%	4.9%

Table 19. PROMIS Physical Function – Ability to walk 15 minutes

Ability to walk 15 minutes	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Without any difficulty	59.8%	11.5%	61.8%	57.9%
With some difficulty	35.2%	62.1%	33.2%	37.1%
Unable to do	5.0%	26.5%	5.0%	5.0%

Table 20. PROMIS Physical Function – Ability to run errands

Ability to run errands	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Without any difficulty	61.3%	25.6%	65.8%	57.1%
With some difficulty	35.1%	60.0%	31.5%	38.5%
Unable to do	3.6%	14.4%	2.7%	4.4%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between physical function scores and each of the following predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents reported significantly **worse** physical function compared to those ages 18-39
- Gender
  - Women reported significantly **worse** physical function compared to men
- Sexuality
  - LGB respondents reported significantly **worse** physical function compared to straight respondents

- Ethnicity
  - Hispanic and Latino respondents reported significantly **worse** physical function compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents reported significantly **worse** physical function compared to White respondents
  - ANHPI respondents reported significantly **better** physical function compared to White respondents
- Education
  - Respondents with no post-secondary education reported significantly **worse** physical function compared to those with some college or a college degree
  - Respondents with a postgraduate degree reported significantly **better** physical function compared to those with some college or a college degree
- Medically underserved
  - Those who are Medically Underserved reported significantly **worse** physical function compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly **worse** physical function compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having a MSK condition was conducted to observe statistically significant associations between physical function scores and each of the following predictor variables:

- Education
  - Respondents with a postgraduate degree reported significantly **better** physical function compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly **worse** physical function compared to those with no reported MSK condition

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between physical function scores and each of the following predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents reported significantly **worse** physical function compared to those ages 18-39
- Gender
  - Women reported significantly **worse** physical function compared to men
- Race
  - ANHPI respondents reported significantly **better** physical function compared to White respondents.
- Education
  - Respondents with no post-secondary education reported significantly **worse** physical function compared to those with some college or a college degree
- Medically underserved
  - Those who are Medically Underserved reported significantly **worse** physical function compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly **worse** physical function compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between physical function scores and each of the following predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents reported significantly **worse** physical function compared to those ages 18-39
- Gender
  - Women reported significantly **worse** physical function compared to men
- Sexuality
  - LGB respondents reported significantly **worse** physical function compared to straight respondents
- Race
  - AI/AN respondents reported significantly worse physical function compared to White respondents
  - ANHPI respondents reported significantly better physical function compared to White respondents
- Education
  - Respondents with no post-secondary education reported significantly worse physical function compared to those with some college or a college degree
  - Respondents with a postgraduate degree reported significantly better physical function compared to those with some college or a college degree
- Medically underserved
  - Those who are Medically Underserved reported significantly **worse** physical function compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly **worse** physical function compared to those with no reported MSK condition

Falls

Table 21 shows the percentage of respondents who have fallen in the past year. In the total sample, 29.9% of respondents reported falling in the past year. The medically underserved sub-sample had the highest proportion of respondents who reported any falls in the past year (34.9%).

Table 21. Falls in the past year

Number of falls in past 12 months	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
None	70.1%	67.1%	71.0%	65.2%
1-2 falls	24.7%	26.0%	23.9%	26.6%
3 or more falls	5.2%	6.9%	5.1%	8.3%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, sleep, loneliness, and physical activity were conducted to observe statistically significant associations between either reporting any falls in the past year or reporting 3 or more falls in the past year and each of the following predictor variables:

- Age

  - 40-59 year-old respondents had significantly **lower** odds of reporting any falls in the past year and **lower** odds of reporting 3 or more falls in the past year compared to those ages 18-39
  - 60-79 year-old respondents had significantly **lower** odds of reporting any falls in the past year and **lower** odds of reporting 3 or more falls in the past year compared to those ages 18-39
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting any falls in the past year compared to straight respondents
- Race
  - Multiracial respondents had significantly **higher** odds of reporting any falls in the past year than White respondents
  - AI/AN respondents had significantly **higher** odds of reporting any falls in the past year than White respondents
  - ANHPI respondents had significantly **lower** odds of reporting any falls in the past year than White respondents
- Education
  - Respondents with a postgraduate degree had significantly **higher** odds of reporting 3 or more falls in the past year compared to those with some college or a college degree
- Medically underserved
  - Those who are Medically Underserved had significantly **higher** odds of reporting any falls in the past year and **higher** odds of reporting 3 or more falls in the past year compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting any falls in the past year and **higher** odds of reporting 3 or more falls in the past year compared to those with no reported MSK condition
- Sleep quality
  - The odds of reporting any falls in the past year significantly **decreases** with every increase in sleep quality scores
- Loneliness
  - Those who reported loneliness had significantly **higher** odds of reporting any falls in the past year and higher odds of reporting 3 or more falls in the past year compared to those who did not report loneliness
- Physical activity
  - Those who reported physical activity in the past month had significantly **lower** odds of reporting a past year fall and **lower** odds of reporting 3 or more falls in the past year compared to those with no physical activity in the past month

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, sleep, loneliness, and physical activity were conducted to observe statistically significant associations between the number of reported any falls in the past year and each of the following predictor variables:

- Age
  - 40-59 year-old respondents had significantly **lower** odds of reporting any falls in the past year and **lower** odds of reporting 3 or more falls in the past year compared to those ages 18-39

  - 60-79 year-old respondents had significantly **lower** odds of reporting any falls in the past year compared to those ages 18-39
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting any falls in the past year compared to straight respondents
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting any falls in the past year and **higher** odds of reporting 3 or more falls in the past year compared to those with no reported MSK condition
- Sleep quality
  - The odds of reporting any falls in the past year significantly **decreases** with every increase in sleep quality scores
- Loneliness
  - Those who reported loneliness had significantly **higher** odds of reporting any falls in the past year and **higher** odds of reporting 3 or more falls in the past year compared to those who did not report loneliness
- Physical activity
  - Those who reported physical activity in the past month had significantly **lower** odds of reporting any falls in the past year compared to those with no physical activity in the past month

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, having any MSK condition, sleep, loneliness, and physical activity were conducted to observe statistically significant associations between the number of reported past year falls and each of the following predictor variables:

- Age
  - 40-59 and 60-79 year-old respondents had significantly **lower** odds of reporting any falls in the past year compared to those ages 18-39
- Sexuality
  - LGB respondents had significantly **higher** odds of reporting any falls in the past year compared to straight respondents
- Race
  - Multiracial respondents had significantly **higher** odds of reporting any falls in the past year than White respondents
  - AI/AN respondents had significantly **higher** odds of reporting any falls in the past year than White respondents
- Education
  - Respondents with a postgraduate degree had significantly **higher** odds of reporting 3 or more falls in the past year compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting any falls in the past year and **higher** odds of reporting 3 or more falls in the past year compared to those with no reported MSK condition
- Sleep quality
  - The odds of reporting any falls in the past year significantly **decreases** with every increase in sleep quality scores
- Loneliness
  - Those who reported loneliness had significantly **higher** odds of reporting any falls in the past year compared to those who did not report loneliness
- Physical activity

- Those who reported physical activity in the past month had significantly **lower** odds of reporting any falls in the past year to those with no physical activity in the past month

Table 22. Fall(s) resulted in injury

Fall(s) resulted in injury	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
No	60.8%	59.0%	62.1%	61.8%
Yes	39.2%	41.0%	37.9%	38.2%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, sleep, loneliness, and physical activity was conducted to observe statistically significant associations between reporting a fall-related injury and each of the following predictor variables:

- Age
  - 40-59 year-old respondents had significantly **higher** odds of reporting a fall-related injury compared to those ages 18-39
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting a fall-related injury compared to those with no reported MSK condition
- Loneliness
  - Those who report loneliness had significantly **higher** odds of reporting a fall-related injury to those who did not report loneliness
- Physical activity
  - Those who reported physical activity in the past month had significantly **higher** odds of reporting a fall-related injury to those with no physical activity in the past month

ACC SAMPLE

No significant associations were found in this sub-sample

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, sleep, loneliness, and physical activity was conducted to observe statistically significant associations between reporting a fall-related injury and each of the following predictor variables:

- Education
  - Respondents with a postgraduate degree had significantly lower odds of reporting a fall-related injury compared to those with some college or a college degree
    -
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting a fall-related injury compared to those with no reported MSK condition
- Loneliness

- Those who report loneliness had significantly higher odds of reporting a fall-related injury to those who did not report loneliness

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, having any MSK condition, sleep, loneliness, and physical activity was conducted to observe statistically significant associations between reporting a fall-related injury and each of the following predictor variables:

- Age
  - 40-59 year-old respondents had significantly **higher** odds of reporting a fall-related injury compared to those ages 18-39
- Ethnicity
  - Hispanic and Latino respondents reported significantly **higher** odds of reporting a fall-related injury compared to non-Hispanic or Latino respondents
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting a fall-related injury compared to those with no reported MSK condition
- Loneliness
  - Those who report loneliness had significantly **higher** odds of reporting a fall-related injury to those who did not report loneliness
- Physical activity
  - Those who reported physical activity in the past month had significantly **higher** odds of reporting a fall-related injury to those with no physical activity in the past month

Table 23 shows that across all samples, the majority of respondents with any falls in the past year did not consult a physician about their fall. The top two reasons reported for not seeking medical help for a fall were “My fall was not serious” and “I could self-manage the outcomes of my fall,” which was consistent across all samples (Table 24). Notably, a much higher proportion of ACC respondents (23.4%) reported “I didn’t want to waste my doctor’s time” as a reason for not seeking medical help compared to the total sample (5.4%).

Table 23. Consulted a physician about past year fall

Consulted a physician about past year fall	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
No	56.7%	54.3%	58.2%	57.4%
Yes	43.3%	45.7%	41.8%	42.6%

Table 24. Reasons for not seeking medical help for a fall

Reasons for not seeking medical help	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
My fall was not serious	68.8%	45.3%	71.3%	66.6%
I could self-manage the outcomes of my fall	39.0%	34.9%	38.2%	33.5%

I didn't think my doctor could do anything to help	8.3%	8.1%	7.7%	9.4%
I didn't want to waste my doctor's time	5.4%	23.4%	10.2%	8.3%
I didn't want to be seen as "weak"	3.5%	5.8%	3.2%	5.9%
I don't want to lose my independence	2.6%	4.7%	2.2%	3.9%
I don't have a regular health care provider	1.8%	3.5%	1.8%	3.3%
I couldn't get an appointment	1.4%	3.5%	1.4%	2.2%
I couldn't afford to see a doctor	1.3%	1.2%	1.5%	2.7%
I don't have health insurance	0.7%	0.0%	1.1%	1.7%
Other reason for not reporting fall	4.2%	9.3%	3.2%	3.1%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, loneliness, and reporting a fall-related injury were conducted to observe statistically significant associations between the top reasons for not seeking health care for a fall and predictor variables among those who reported any falls in the past year:

- Age
  - 80+ year-old respondents had significantly **higher** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to those ages 18-39
- Gender
  - Women had significantly **higher** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to non-Hispanic or Latino respondents
- Education
  - Respondents with no post-secondary education had significantly **lower** odds of reporting ability to self-manage outcomes and "I didn't think my doctor could do anything to help" as reasons for not seeing a doctor for a fall compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **higher** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to those with some college or a college degree
- Race
  - AI/AN respondents had significantly **lower** odds of reporting "Fall was not serious" as a reason for not seeing a doctor for a fall than White respondents
- Medically Underserved
  - Those who are Medically Underserved had significantly **lower** odds of reporting "Fall was not serious" as a reason for not seeing a doctor for a fall compared to those who were not Medically Underserved

- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **lower** odds of reporting "Fall was not serious" as a reason for not seeing a doctor for a fall compared to those with no reported MSK condition
  - Those who reported having any MSK condition had significantly **higher** odds of reporting ability to self-manage outcomes and "I didn't think my doctor could do anything to help" as reasons for not seeing a doctor for a fall compared to those with no reported MSK condition
- Loneliness
  - Those who report loneliness had significantly **lower** odds of reporting "Fall was not serious" as a reason for not seeing a doctor for a fall than those who did not report loneliness
  - Those who report loneliness had significantly **higher** odds of reporting "I didn't think my doctor could do anything to help" as a reason for not seeing a doctor for a fall than those who did not report loneliness
- Reporting a fall-related injury
  - Those who reported a fall-related injury had significantly **lower** odds of reporting "Fall was not serious" as a reason for not seeing a doctor for a fall than those who did not report a fall-related injury
  - Those who reported a fall-related injury had significantly **higher** odds of reporting ability to self-manage outcomes and "I didn't think my doctor could do anything to help" as reasons for not seeing a doctor for a fall than those who did not report a fall-related injury

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, loneliness, and reporting a fall-related injury were conducted to observe statistically significant associations between the top reasons for not seeking health care for a fall and predictor variables among those who reported any falls in the past year:

- Gender
  - Women reported significantly **higher** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to men
- Sexuality
  - LGB respondents had significantly **lower** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly **lower** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to non-Hispanic or Latino respondents
- Education
  - Respondents with a postgraduate degree had significantly **higher** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly **lower** odds of reporting "Fall was not serious" as a reason for not seeing a doctor for a fall compared to those with no reported MSK condition

    - Those who reported having any MSK condition had significantly **higher** odds of reporting ability to self-manage outcomes and “I didn’t think my doctor could do anything to help” as reasons for not seeing a doctor for a fall compared to those with no reported MSK condition
- Loneliness
    - Those who report loneliness had significantly **lower** odds of reporting “Fall was not serious” as a reason for not seeing a doctor for a fall than those who did not report loneliness
- Reporting a fall-related injury
    - Those who reported a fall-related injury had significantly **lower** odds of reporting “Fall was not serious” as a reason for not seeing a doctor for a fall than those who did not report a fall-related injury
    - Those who reported a fall-related injury had significantly **higher** odds of reporting ability to self-manage outcomes and “I didn’t think my doctor could do anything to help” as reasons for not seeing a doctor for a fall than those who did not report a fall-related injury

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, having any MSK condition, loneliness, and reporting a fall-related injury were conducted to observe statistically significant associations between the top reasons for not seeking health care for a fall and predictor variables among those who reported any falls in the past year:

- Age
    - 80+ year-old respondents had significantly **higher** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to those ages 18-39
- Sexuality
    - LGB respondents had significantly **lower** odds of reporting “fall was not serious” as a reason for not seeing a doctor for a fall compared to straight respondents
- Ethnicity
    - Hispanic and Latino respondents had significantly **lower** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to non-Hispanic or Latino respondents
- Education
    - Respondents with a postgraduate degree had significantly **higher** odds of reporting ability to self-manage outcomes as a reason for not seeing a doctor for a fall compared to those with some college or a college degree
    - Respondents with a postgraduate degree had significantly **lower** odds of reporting “fall was not serious” as a reason for not seeing a doctor for a fall compared to those with some college or a college degree
- Race
    - AI/AN respondents had significantly **lower** odds of reporting “fall was not serious” as a reason for not seeing a doctor for a fall compared to White respondents
- Reporting an MSK condition
    - Those who reported having any MSK condition had significantly **lower** odds of reporting “Fall was not serious” as a reason for not seeing a doctor for a fall compared to those with no reported MSK condition
    - Those who reported having any MSK condition had significantly **higher** odds of reporting ability to self-manage outcomes and “I didn’t think my doctor could do anything to help” as reasons for not seeing a doctor for a fall compared to those with no reported MSK condition
- Loneliness
    - Those who report loneliness had significantly **lower** odds of reporting “Fall was not serious” as a reason for not seeing a doctor for a fall than those who did not report loneliness

- Reporting a fall-related injury
  - Those who reported a fall-related injury had significantly **lower** odds of reporting "Fall was not serious" as a reason for not seeing a doctor for a fall than those who did not report a fall-related injury
  - Those who reported a fall-related injury had significantly **higher** odds of reporting ability to self-manage outcomes and "I didn't think my doctor could do anything to help" as reasons for not seeing a doctor for a fall than those who did not report a fall-related injury

Sleep Quality

The Single-Item Sleep Quality Scale (SQS)[86] was used to measure respondents' sleep quality in the past seven days (Table 25). The ACC sub-sample had higher proportions of respondents who reported poor or terrible sleep (32.0%) compared to the total sample (16.7%). The raw sleep quality scale score was used for analysis. The scale ranges from 1 to 10 with 1 representing the worst possible sleep and 10 representing the best possible sleep.

Table 25. Sleep quality in the past 7 days

Quality of Sleep in Past 7 Days	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Good	42.4%	26.9%	44.5%	36.3%
Fair	34.3%	37.0%	33.8%	35.0%
Poor	13.8%	25.3%	12.6%	16.4%
Excellent	6.6%	4.1%	6.8%	7.5%
Terrible	2.9%	6.7%	2.2%	4.8%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between sleep quality and predictor variables:

- Age
  - 40-59 year-old respondents reported significantly worse sleep compared to those ages 18-39
  - 80+ year-old respondents reported significantly better sleep compared to those ages 18-39
- Gender
  - Women reported significantly worse sleep compared to men
- Sexuality
  - LGB respondents reported significantly worse sleep compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents reported significantly worse sleep compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents reported significantly better sleep than White respondents.
- Education
  - Respondents with no post-secondary education reported significantly worse sleep compared to those with some college or a college degree

[86] Snyder E, Cai B, DeMuro C, Morrison MF, Ball W. A New Single-Item Sleep Quality Scale: Results of Psychometric Evaluation in Patients With Chronic Primary Insomnia and Depression. J Clin Sleep Med. 2018;14(11):1849-1857. Published 2018 Nov 15. doi:10.5664/jcsm.7478

  - Respondents with a postgraduate degree reported significantly better sleep compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved reported significantly worse sleep compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly worse sleep compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between sleep quality and predictor variables:

- Age
  - Those 60 years or older had significantly better sleep, on average reporting sleep quality scores 1.1 points higher than that of respondents under 60
- Reporting an MSK condition
  - Those who reported any MSK condition had significantly worse sleep, on average reporting sleep quality scores 1.7 points lower than that of respondents with no reported MSK conditions

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between sleep quality and predictor variables:

- Age
  - 40-59 year-old respondents reported significantly worse sleep compared to those ages 18-39
  - 80+ year-old respondents reported significantly better sleep compared to those ages 18-39
- Gender
  - Women reported significantly worse sleep compared to men
- Sexuality
  - LGB respondents reported significantly worse sleep compared to straight respondents
- Race
  - ANHPI respondents reported significantly better sleep than White respondents.
- Education
  - Respondents with a postgraduate degree reported significantly better sleep compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved reported significantly worse sleep compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly worse sleep compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between sleep quality and predictor variables:

- Age
  - 40-59 year-old respondents reported significantly worse sleep compared to those ages 18-39

- 80+ year-old respondents reported significantly better sleep compared to those ages 18-39
- Gender
  - Women reported significantly worse sleep compared to men
- Sexuality
  - LGB respondents reported significantly worse sleep compared to straight respondents
- Race
  - ANHPI respondents reported significantly better sleep than White respondents
- Education
  - Respondents with no post-secondary education reported significantly worse sleep compared to those with some college or a college degree
  - Respondents with a postgraduate degree reported significantly better sleep compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly worse sleep compared to those with no reported MSK condition.

C. Health Behaviors and Lifestyle

Social isolation

The UCLA 3-Item Loneliness Scale was used to determine whether respondents experience loneliness. Table 26 shows that about a quarter of respondents in the total sample experience loneliness, which is lower than the national average (about 50%).[87] The medically underserved sub-sample had the highest prevalence of loneliness (40.8%).

Table 26. Social isolation/loneliness

Experiences loneliness	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
No	74.6%	63.6%	76.7%	59.2%
Yes	25.4%	36.4%	23.3%	40.8%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting loneliness and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting loneliness compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting loneliness compared to men
- Sexuality
  - LGB respondents had significantly higher odds of reporting loneliness compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting loneliness compared to non-Hispanic or Latino respondents

[87] US Department of Health and Human Services (2023). *Our Epidemic of Loneliness and Isolation: The US Surgeon General's Advisory on the Healing Effects of Social Connection and Community.*

- Race
  - Black and African American respondents had significantly higher odds of reporting loneliness compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly lower odds of reporting loneliness compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting loneliness compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting loneliness compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting loneliness and predictor variables:

- Age
  - 60-79 and 80+ year-old respondents had significantly lower odds of reporting loneliness compared to those ages 18-39
- Sexuality
  - LGB respondents had significantly higher odds of reporting loneliness compared to straight respondents
- Education
  - Respondents with a postgraduate degree had significantly lower odds of reporting loneliness compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting loneliness compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting loneliness compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between reporting loneliness and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting loneliness compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting loneliness compared to men
- Sexuality
  - LGB respondents had significantly higher odds of reporting loneliness compared to straight respondents
- Education

- Respondents with a postgraduate degree had significantly lower odds of reporting loneliness compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting loneliness compared to those with no reported MSK condition

Physical Activity

Table 27 shows the percentage of respondents who reported any physical activity or exercise (e.g., running, golf, gardening, or walking for exercise) in the past 30 days. About a quarter of respondents in the total sample reported no physical activity in the past month, which is similar to national data (25.3%)[88] and slightly lower than New York City levels (29.2%).[89]

Table 27. Physical activity in the past month

Reported any physical activity in past 30 days	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Yes	74.9%	47.4%	75.9%	68.1%
No	25.5%	52.6%	24.1%	31.9%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, confidence in MSK symptom management, sleep quality, and reporting any falls in the past year was conducted to observe statistically significant associations between physical activity in the past month and predictor variables:

- Education
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting physical activity in the past month compared to those ages 18-39.
- Gender
  - Women had significantly lower odds of reporting physical activity in the past month compared to men
- Race
  - Black and African American respondents had significantly lower odds of reporting physical activity in the past month compared to White respondents
- Education
  - Respondents no post-secondary education had significantly lower odds of reporting physical activity in the past month compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of reporting physical activity in the past month compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of reporting physical activity in the past month compared to those who were not Medically Underserved
- Confidence in MSK symptom management
  - Those who reported confidence in their ability to manage MSK symptoms had significantly higher odds of reporting physical activity in the past month compared to those who did not feel confident in MSK symptom management
- Sleep quality

[88] Centers for Disease Control and Prevention (2025). *Adult Physical Inactivity Outside of Work*. https://www.cdc.gov/physical-activity/php/data/inactivity-maps.html
[89] New York City Department of Health (2022). *Environment & Health Data Portal*. https://a816-dohbesp.nyc.gov/IndicatorPublic/data-explorer/physical-activity/?id=2060#display=summary

  - The odds of reporting physical activity in the past month significantly increases with every increase in sleep quality scores
- Reporting any falls in the past year
  - Those who reported any falls in the past year had significantly lower odds of reporting physical activity in the past month compared to those who reported no falls in the past year

ACC SAMPLE

No significant associations were found in this sub-sample

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, confidence in MSK symptom management, sleep quality, and reporting any falls in the past year was conducted to observe statistically significant associations between physical activity in the past month and predictor variables.

- Age
  - 80+ year-old respondents had significantly lower odds of reporting physical activity in the past month compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting physical activity in the past month compared to men
- Education
  - Respondents with no post-secondary education had significantly lower odds of reporting physical activity in the past month compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of reporting physical activity in the past month compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of reporting physical activity in the past month compared to those who were not Medically Underserved
- Confidence in MSK symptom management
  - Those who reported confidence in their ability to manage MSK symptoms had significantly higher odds of reporting physical activity in the past month compared to those who lacked confidence in MSK symptom management
- Sleep quality
  - The odds of reporting physical activity in the past month significantly increases with every increase in sleep quality scores

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, having any MSK condition, confidence in MSK symptom management, sleep quality, and reporting any falls in the past year was conducted to observe statistically significant associations between physical activity in the past month and predictor variables.

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting physical activity in the past month compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting physical activity in the past month compared to men
- Race
  - ANHPI respondents had significantly higher odds of reporting physical activity in the past month compared to White respondents

- Education
  - Respondents with a postgraduate degree had significantly higher odds of reporting physical activity in the past month compared to those with some college or a college degree
- Confidence in MSK symptom management
  - Those who reported confidence in their ability to manage MSK symptoms had significantly higher odds of reporting physical activity in the past month compared to those who lacked confidence in MSK symptom management
- Sleep quality
  - The odds of reporting physical activity in the past month significantly increases with every increase in sleep quality scores
- Reporting any falls in the past year
  - Those who reported any falls in the past year had significantly lower odds of reporting physical activity in the past month compared to those who reported no falls in the past year

Table 28 shows that across all samples, the most commonly reported reasons for not participating in physical activity were “My health” and “I don’t have enough energy.” Notably, one in five respondents in the medically underserved sample gave “My mental health” as a reason for not participating in physical activity compared to just 12.6% of respondents in the total sample.

Table 28. Reasons for not participating in physical activity

Reasons for not participating in physical activity	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
My health (for example, heart disease or having too much pain)	29.0%	37.0%	30.3%	26.4%
I don’t have enough energy	22.9%	21.8%	22.5%	23.8%
I am not confident in my ability to be physically active	17.9%	19.9%	18.1%	15.3%
I’m recovering from an injury	15.7%	9.5%	16.2%	12.3%
I worry about getting injured	13.8%	19.0%	12.9%	14.4%
My mental health (for example, depression or anxiety)	12.6%	9.5%	12.3%	20.0%
Physical activity is not a priority of mine	10.6%	4.7%	11.3%	10.2%
It’s hard to find a place to be physically active	10.4%	10.9%	9.7%	14.9%
It’s hard to find people to be active with	7.3%	9.0%	6.8%	9.1%
Physical activities cost too much money	6.9%	7.6%	5.9%	10.4%
Physical activity makes me feel uncomfortable	6.5%	9.0%	6.7%	7.1%
I don’t know how to start being physically active	5.6%	7.6%	5.3%	7.3%
I am too old to be physically active	4.3%	5.2%	3.8%	4.4%
Others have told me to avoid physical activity	1.5%	3.8%	1.4%	2.2%
Other	21.9%	24.2%	22.3%	15.9%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, confidence in MSK symptom management, sleep quality, and reporting any falls in the past year were conducted to observe statistically significant associations between the top reported barriers to physical activity and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly higher odds of reporting “No energy” as a barrier to physical activity compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting “No energy” as a barrier to physical activity compared to men
    -
- Ethnicity
  - Hispanic and Latino respondents had significantly lower odds of reporting “My health” as a barrier to physical activity compared to non-Hispanic or Latino respondent
- Race
  - Black and African American respondents had significantly lower odds of reporting “My health” as a barrier to physical activity compared to White respondents
  - ANHPI respondents had significantly lower odds of reporting “My health” as a barrier to physical activity compared to White respondents
- Confidence in MSK symptom management
  - Those who reported confidence in their ability to manage MSK symptoms had significantly lower odds of reporting “My health,” “No energy,” and “Not confident in my ability to be physically active” as barriers to physical activity compared to those who lacked confidence in MSK symptom management
- Reporting any falls in the past year
  - Those who reported any falls in the past year had significantly higher odds of reporting “My health” as a barrier to physical activity compared to those who reported no falls in the past year
- Sleep quality
  - The odds of reporting “No energy” as a barrier to physical activity significantly decreases with every increase in sleep quality scores

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, confidence in MSK symptom management, sleep quality, and reporting any falls in the past year were conducted to observe statistically significant associations between the top reported barriers to physical activity and predictor variables:

- Age
  - 80+ year-old respondents had significantly higher odds of reporting “No energy” as a barrier to physical activity compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting “No energy” as a barrier to physical activity compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly lower odds of reporting “My health” and “Not confident in my ability to be physically active” as barriers to physical activity compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents had significantly lower odds of reporting “My health” as a barrier to physical activity compared to White respondents
  - ANHPI respondents had significantly lower odds of reporting “My health” as a barrier to physical activity compared to White respondents
- Medically Underserved

  - Those who are Medically Underserved had significantly higher odds of reporting “Not confident in my ability to be physically active” as a barrier to physical activity compared to those who were not Medically Underserved
- Confidence in MSK symptom management
  - Those who reported confidence in their ability to manage MSK symptoms had significantly lower odds of reporting “My health” and “Not confident in my ability to be physically active” as barriers to physical activity compared to those who lacked confidence in MSK symptom management
- Reporting any falls in the past year
  - Those who reported any falls in the past year had significantly higher odds of reporting “My health” as a barrier to physical activity compared to those who reported no falls in the past year
- Sleep quality
  - The odds of reporting “My health” as barriers to physical activity significantly decreases with every increase in sleep quality scores

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, having any MSK condition, confidence in MSK symptom management, sleep quality, and reporting any falls in the past year were conducted to observe statistically significant associations between the top reported barriers to physical activity and predictor variables

- Age
  - 40-59 and 80+ year-old respondents had significantly higher odds of reporting “No energy” as a barrier to physical activity compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting “No energy” as a barrier to physical activity compared to men
- Confidence in MSK symptom management
  - Those who reported confidence in their ability to manage MSK symptoms had significantly lower odds of reporting “My health,” “No energy,” and “Not confident in my ability to be physically active” as barriers to physical activity compared to those who lacked confidence in MSK symptom management
- Reporting any falls in the past year
  - Those who reported any falls in the past year had significantly higher odds of reporting “My health” and “No energy” as a barrier to physical activity compared to those who reported no falls in the past year
- Sleep quality
  - The odds of reporting “No energy” and “My health” as a barrier to physical activity significantly decreases with every increase in sleep quality scores

Pain Management

Table 29 shows that 16.9% of respondents reported experiencing pain that limits daily activity most days or every day, which is more than national levels (8.5%).[90] The ACC sub-sample had a substantially higher proportion (45.1%) of respondents who reported experiencing pain that limits daily activity most days or every day compared to the total sample (16.9%).

[90] Lucas, J. W. & Sohi, I. (2024). *Chronic Pain and High-Impact Chronic Pain in US Adults, 2023*. NCHS Data Brief, no 518. https://dx.doi.org/10.15620/cdc/169630

Table 29. How often do you experience pain that limits daily activity

How often do you experience pain that limits daily activity	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Some days	44.9%	39.9%	44.2%	40.8%
Never	38.2%	14.9%	40.2%	39.4%
Most days	11.1%	23.2%	10.5%	12.4%
Every day	5.8%	21.9%	5.1%	7.4%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting pain that limits daily activity and predictor variables:

- Age
  - 40-59 year-old respondents had significantly higher odds of reporting pain that limits their daily activities compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting pain that limits their daily activities compared to men
- Sexuality
  - LGB respondents had significantly higher odds of reporting pain that limits their daily activities compared to straight respondents
- Education
  - Respondents with a postgraduate degree had significantly lower odds of reporting pain that limits their daily activities compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting pain that limits their daily activities compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting pain that limits their daily activities compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting pain that limits daily activity and predictor variables:

- Age
  - 40-59 year-old respondents had significantly higher odds of reporting pain that limits their daily activities compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting pain that limits their daily activities compared to men

- Sexuality
  - LGB respondents had significantly higher odds of reporting pain that limits their daily activities compared to straight respondents
- Race
  - Multiracial respondents had significantly higher odds of reporting pain that limits their daily activities compared to White respondents
- Education
  - Respondents with no postsecondary education had significantly lower odds of reporting pain that limits their daily activities compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of reporting pain that limits their daily activities compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting pain that limits their daily activities compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between reporting pain that limits daily activity and predictor variables.

- Age
  - 40-59 year-old respondents had significantly higher odds of reporting pain that limits their daily activities compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting pain that limits their daily activities compared to men
- Sexuality
  - LGB respondents had significantly higher odds of reporting pain that limits their daily activities compared to straight respondents
- Race
  - Multiracial respondents had significantly higher odds of reporting pain that limits their daily activities compared to White respondents
- Education
  - Respondents with no postsecondary education had significantly lower odds of reporting pain that limits their daily activities compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of reporting pain that limits their daily activities compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting pain that limits their daily activities compared to those with no reported MSK condition

Table 30 shows that across samples, the majority of respondents use exercise (such as walking, swimming, or strength training; 75.2%) and over-the-counter medications (such as aspirin, ibuprofen, etc.; 68.6%) to manage their pain. Fewer respondents (8.7%) in the ACC sub-sample reported using yoga, tai chi, or qi gong to manage pain compared to the total sample (15.9%), while more respondents in the ACC sub-sample (41.8%) reported using a prescription pain reliever or opioid compared to the total sample (31.4%).

Table 30. Use of pain management techniques

Pain management techniques	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Other forms of exercise (walking, swimming, strength training, etc.)	75.2%	62.6%	75.2%	67.5%
Over-the-counter medications (aspirin, ibuprofen, etc.)	68.6%	62.3%	70.8%	61.4%
Physical therapy, rehabilitative therapy, or occupational therapy	41.9%	48.2%	40.5%	34.6%
A prescription pain reliever or opioid	31.4%	41.8%	31.4%	35.3%
Massage	28.9%	25.0%	27.9%	31.9%
Meditation, guided imagery, or other relaxation techniques	24.5%	20.8%	24.2%	29.5%
Yoga, Tai Chi or Qi Gong	15.9%	8.7%	15.4%	17.5%
Spinal manipulation or other chiropractic care	9.8%	7.4%	10.3%	10.6%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between using non-pharmaceutical approaches to pain management and predictor variables among those who report pain that limits daily activity:

- Age
  - 40-59 year-old, 60-79 year-old, and 80+ respondents had significantly lower odds of using non-pharmaceutical approaches to pain management compared to those ages 18-39
- Education
  - Respondents with no post-secondary education reported significantly lower odds of using non-pharmaceutical approaches to pain management compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of using non-pharmaceutical approaches to pain management compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of using non-pharmaceutical approaches to pain management compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of using non-pharmaceutical approaches to pain management compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations

between using non-pharmaceutical approaches to pain management and predictor variables among those who report pain that limits daily activity:

- Age
  - 40-59 year-old, 60-79 year-old, and 80+ respondents had significantly lower odds of using non-pharmaceutical approaches to pain management compared to those ages 18-39
- Race
  - Multiracial respondents had significantly higher odds of using non-pharmaceutical approaches to pain management compared to White respondents
- Education
  - Respondents with no post-secondary education reported significantly lower odds of using non-pharmaceutical approaches to pain management compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of using non-pharmaceutical approaches to pain management compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of using non-pharmaceutical approaches to pain management compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between using non-pharmaceutical approaches to pain management and predictor variables among those who report pain that limits daily activity:

- Age
  - 40-59 year-old, 60-79 year-old, and 80+ respondents had significantly lower odds of using non-pharmaceutical approaches to pain management compared to those ages 18-39
- Education
  - Respondents with no post-secondary education reported significantly lower odds of using non-pharmaceutical approaches to pain management compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of using non-pharmaceutical approaches to pain management compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of using non-pharmaceutical approaches to pain management compared to those with no reported MSK condition

Healthy Eating Self-Efficacy

Healthy eating self-efficacy was measured using the HEWSE scale. Table 31 shows the percentage of respondents who agree with each of the seven healthy eating beliefs. In the total sample, the lowest levels of agreement were with the beliefs “If using a recipe to cook, I am able to make it healthier” (69.2%) and “When I feel hungry, I am able to easily choose healthy foods over less healthy options” (64.9%). Across all seven healthy eating beliefs, the medically underserved sub-sample reported lower levels of agreement compared to the total sample.

Table 31. % Who agree with belief about healthy eating self-efficacy

Healthy eating beliefs	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
I know how to choose healthy foods where I shop and eat	87.3%	83.6%	87.6%	77.4%
I am able to find healthy foods where I shop and eat	86.5%	74.7%	87.1%	74.8%
I am able to eat a variety of healthy foods	84.8%	81.7%	85.3%	74.0%
I am able to eat fruits and vegetables at most meals	82.2%	77.8%	82.4%	73.4%
If I eat unhealthy foods, I am able to cut back or make healthier food choices later	78.8%	76.8%	78.8%	68.5%
If using a recipe to cook, I am able to make it healthier	69.2%	70.7%	68.9%	63.2%
When I feel hungry, I am able to easily choose healthy food over less healthy options	64.9%	62.1%	64.3%	57.0%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, and experiencing food insecurity were conducted to observe statistically significant associations between agreement with healthy eating beliefs and predictor variables.

- Age
  - 40-59 year-old and 60-79 year-old respondents had significantly higher odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat,” “I am able to eat fruits and vegetables at most meals,” “I am able to eat a variety of healthy foods,” “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” compared to those ages 18-39
  - 40-59 year-old, 60-79, and 80+ year-old respondents had significantly higher odds of agreement with the beliefs “I know how to choose healthy foods where I shop and eat” and “When I feel hungry, I am easily able to choose healthy food over less healthy options” compared to those ages 18-39
  - 40-59 year-old respondents had significantly higher odds of agreement with the belief “If using a recipe to cook, I am able to make it healthier” compared to those ages 18-39
  - 80+ year-old respondents had significantly lower odds of agreement with the belief “If using a recipe to cook, I am able to make it healthier” compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting agreement with the beliefs “I know how to choose healthy foods where I shop and eat” and “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” compared to men
- Sexuality
  - LGB respondents had significantly lower odds of reporting agreement with the beliefs “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” and “When I feel hungry, I am easily able to choose healthy food over less healthy options” compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly lower odds of agreement with all healthy eating beliefs compared to non-Hispanic or Latino respondents

- Race
  - AI/AN respondents had significantly lower odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat” and “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” compared to White respondents
  - ANHPI respondents had significantly higher odds of agreement with the belief “When I feel hungry, I am easily able to choose healthy food over less healthy options” compared to White respondents
- Education
  - Respondents with no post-secondary education reported significantly lower odds of agreement with all healthy eating beliefs compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat”, “I am able to eat fruits and vegetables at most meals”, “I am able to eat a variety of healthy foods”, “I know how to choose healthy foods where I shop and eat”, “If using a recipe to cook, I am able to make it healthier” and “When I feel hungry, I am easily able to choose healthy food over less healthy options” compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat”, “I am able to eat fruits and vegetables at most meals”, “I am able to eat a variety of healthy foods”, “I know how to choose healthy foods where I shop and eat”, and “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of agreement with the beliefs “I am able to eat fruits and vegetables at most meals” and “I am able to eat a variety of healthy foods” compared to those with no reported MSK condition
- Food insecurity
  - Those who reported experiencing food insecurity had significantly lower odds of agreement with all healthy eating beliefs compared to those who were not food insecure

ACC SAMPLE

Regression models adjusting for age, gender, ethnicity, race, education, medically underserved status, having any MSK condition, and experiencing food insecurity were conducted to observe statistically significant associations between agreement with healthy eating beliefs and predictor variables.

- Race
  - AI/AN, ANHPI, and Multiracial respondents had significantly lower odds of reporting agreement with the healthy eating beliefs “I am able to find healthy foods where I shop and eat” and “I am able to eat fruits and vegetables at most meals” compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly lower odds of reporting agreement with the healthy eating belief “I am able to find healthy foods where I shop and eat” compared to respondents with some college or a college degree
- Reporting an MSK condition
  - respondents with any MSK condition had significantly lower odds of reporting agreement with the healthy eating belief “I am able to find healthy foods where I shop and eat” compared to respondents with no MSK conditions
- Food insecurity
  - Respondents who experience food insecurity had significantly lower odds of reporting agreement with the healthy eating beliefs “I am able to find healthy foods where I shop and eat” and “I am able to eat fruits and vegetables at most meals” compared to respondents who do not experience food insecurity.

REGIONAL SAMPLE

Regression models adjusting for age, gender, ethnicity, race, education, medically underserved status, having any MSK condition, and experiencing food insecurity were conducted to observe statistically significant associations between agreement with healthy eating beliefs and predictor variables.

- Age
  - 40-59 year-old and 60-79 year-old respondents had significantly higher odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat,” “I am able to eat fruits and vegetables at most meals,” “I know how to choose healthy foods where I shop and eat,” “I am able to eat a variety of healthy foods,” “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” and “When I feel hungry, I am easily able to choose healthy food over less healthy options” compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting agreement with the beliefs “I am able to choose healthy foods where I shop and eat”, “If using a recipe to cook, I am able to make it healthier,” “I know how to choose healthy foods where I shop and eat” and “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly lower odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat,” “I know how to choose healthy foods where I shop and eat,” “If I eat unhealthy foods, I am able to cut back or make healthier food choices later,” compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of agreement with the beliefs “When I feel hungry, I am easily able to choose healthy food over less healthy options” and “I am able to eat fruits and vegetables at most meals” compared to White respondents
  - Black and African American respondents had significantly higher odds of agreement with the belief “I am able to eat fruits and vegetables at most meals” compared to White respondents
- Education
  - Respondents with no post-secondary education reported significantly lower odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat”, “I am able to eat fruits and vegetables at most meals”, “I am able to eat a variety of healthy foods”, “I know how to choose healthy foods where I shop and eat”, “If using a recipe to cook, I am able to make it healthier”, and “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat”, “I am able to eat a variety of healthy foods”, and “I know how to choose healthy foods where I shop and eat” compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat”, “I am able to eat fruits and vegetables at most meals”, “I am able to eat a variety of healthy foods”, “I know how to choose healthy foods where I shop and eat”, and “If I eat unhealthy foods, I am able to cut back or make healthier food choices later” compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of agreement with the belief “I am able to eat a variety of healthy foods” compared to those with no reported MSK condition
- Food insecurity
  - Those who reported experiencing food insecurity had significantly lower odds of agreement with the beliefs “I am able to find healthy foods where I shop and eat”, “I am able to eat fruits and vegetables at most meals”, “I am able to eat a variety of healthy foods”, “I know how to choose healthy foods where I shop and eat”, “If using a recipe to cook, I am able to make it healthier”, “If I

eat unhealthy foods, I am able to cut back or make healthier food choices later", and "When I feel hungry, I am easily able to choose healthy food over less healthy options" compared to those who were not food insecure

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition, and experiencing food insecurity were conducted to observe statistically significant associations between agreement with healthy eating beliefs and predictor variables.

- Age
  - 40-59 year-old and 60-79 year-old respondents had significantly higher odds of agreement with the beliefs "I am able to find healthy foods where I shop and eat," "I know how to choose healthy foods where I shop and eat," "I am able to eat a variety of healthy foods," "If I eat unhealthy foods, I am able to cut back or make healthier food choices later," and "When I feel hungry, I am easily able to choose healthy food over less healthy options" compared to those ages 18-39
  - 40-59 year-old, 60-79, and 80+ year-old respondents had significantly higher odds of agreement with the belief "I am able to eat fruits and vegetables at most meals" compared to those ages 18-39
  - 40-59 year-old respondents had significantly higher odds of agreement with the belief "If using a recipe to cook, I am able to make it healthier" compared to those ages 18-39.
- Gender
  - Women had significantly higher odds of reporting agreement with the belief "If I eat unhealthy foods, I am able to cut back or make healthier food choices later" compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly lower odds of agreement with all healthy eating beliefs except "When I feel hungry, I am able to easily choose healthy food over less healthy options" compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of agreement with the beliefs "When I feel hungry, I am easily able to choose healthy food over less healthy options" and "If using a recipe to cook, I am able to make it healthier" compared to White respondents
  - Black and African American respondents had significantly higher odds of agreement with the beliefs "If using a recipe to cook, I am able to make it healthier" and "I know how to choose healthy foods where I shop and eat" compared to White respondents
- Education
  - Respondents with no post-secondary education reported significantly lower odds of agreement with all healthy eating beliefs compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of agreement with the beliefs "I am able to find healthy foods where I shop and eat" and "I am able to eat a variety of healthy foods" "I know how to choose healthy foods where I shop and eat" compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of agreement with the belief "I am able to eat a variety of healthy foods" compared to those with no reported MSK condition
- Food insecurity
  - Those who reported experiencing food insecurity had significantly lower odds of agreement with all healthy eating beliefs compared to those who were not food insecure

Food insecurity

Table 32 shows that a little more than a fifth of respondents (21.7%) in the total sample experience food insecurity, which is higher than the prevalence of food insecurity at the national (13.5%) and NY state level (11.3%).[91] Rates of food insecurity are even higher in the medically underserved (52.9%) and ACC (45.2%) sub-samples.

Table 32. Food insecurity

Experiences food insecurity	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Yes	21.7%	45.2%	21.1%	52.9%
No	78.3%	54.8%	78.9%	47.1%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between food insecurity and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of experiencing food insecurity compared to those ages 18-39
- Sexuality
  - LGB respondents had significantly higher odds of experiencing food insecurity compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of experiencing food insecurity compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of experiencing food insecurity than White respondents
  - Black respondents had significantly higher odds of experiencing food insecurity than White respondents
  - ANHPI respondents had significantly higher odds of experiencing food insecurity than White respondents
  - AI/AN respondents had significantly higher odds of experiencing food insecurity than White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of experiencing food insecurity compared to those with some college or a college degree.
  - Respondents with a postgraduate degree had significantly lower odds of experiencing food insecurity compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of experiencing food insecurity compared to those who were not Medically Underserved
- Reporting an MSK condition

[91] Office of the New York State Comptroller. (2024). *Food Insecurity Persists Post-Pandemic*. https://www.osc.ny.gov/reports/food-insecurity-persists-post-pandemic

- Those who reported having any MSK condition had significantly higher odds of experiencing food insecurity compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between agreement with healthy eating beliefs and predictor variables:

- Education
  - Respondents with no post-secondary education had significantly higher odds of reporting food insecurity compared to those with some college or a college degree

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition was conducted to observe statistically significant associations between food insecurity and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of experiencing food insecurity compared to those ages 18-39
- Gender
  - Women had significantly higher odds of experiencing food insecurity compared to men
- Sexuality
  - LGB respondents had significantly higher odds of experiencing food insecurity compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of experiencing food insecurity compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of experiencing food insecurity than White respondents
  - Black respondents had significantly higher odds of experiencing food insecurity than White respondents
  - AI/AN respondents had significantly higher odds of experiencing food insecurity than White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of experiencing food insecurity compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of experiencing food insecurity compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of experiencing food insecurity compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of experiencing food insecurity compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between food insecurity and predictor variables.

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of experiencing food insecurity compared to those ages 18-39
- Gender
  - Women had significantly higher odds of experiencing food insecurity compared to men
- Sexuality
  - LGB respondents had significantly higher odds of experiencing food insecurity compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of experiencing food insecurity compared to non-Hispanic or Latino respondents
- Race
  - Black respondents had significantly higher odds of experiencing food insecurity than White respondents
  - AI/AN respondents had significantly higher odds of experiencing food insecurity than White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of experiencing food insecurity compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of experiencing food insecurity compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of experiencing food insecurity compared to those with no reported MSK condition

D. Use of and Access to Care

Insurance Coverage

Table 33 shows respondents' primary health insurance coverage. Uninsured respondents were a minority in the total (7.5%), ACC (2.5%), regional (6.7%), and medically underserved (7.2%) samples, though the proportion of uninsured in the total sample was higher than in 2022 (2.6%). In the total, regional, and medically underserved samples, the majority of respondents were covered by Medicare or a plan purchased through an employer or union, while the majority of respondents in the ACC sub-sample were instead covered by Medicaid (66.0%).

Table 33. Insurance coverage

Insurance Type	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Medicare	39.4%	21.1%	42.1%	27.1%
A plan purchased through an employer or union	35.2%	5.7%	33.1%	35.2%
Medicaid	11.9%	66.0%	14.0%	34.1%
A plan that you or another family member buys on your own	2.5%	0.0%	2.9%	3.8%
No health insurance coverage	7.5%	2.5%	6.7%	7.2%
State-sponsored health plan	1.0%	2.5%	1.3%	1.0%
Medigap	0.6%	0.0%	0.8%	0.6%
TRICARE (formerly CHAMPUS), VA, or Military	0.3%	0.0%	0.3%	0.3%
Children's Health Insurance Program (CHIP)	0.1%	0.0%	0.1%	0.1%
Alaska Native, Indian Health Service, Tribal Health Services	0.1%	0.2%	0.0%	0.1%
Some other source	0.9%	0.5%	0.9%	0.9%
Don't Know	0.8%	1.5%	0.9%	0.8%

Social Factors Impacting Health (Social Determinants of Health)

Respondents were asked about the top problems that impact their health and well-being (Tables 34A-E). Each table below corresponds with one of the five key domains that comprise the social determinants of health, as defined by the US Department of Health and Human Services' Healthy People 2030 initiative. Across every social determinant of health, there were a higher proportion of respondents in the medically underserved sub-sample than the total sample who reported experiencing a problem. The top five problems reported by respondents in the total sample were social isolation/loneliness (8.2%), lack of access to a doctor's office (6.8%), transportation problems (6.5%), lack of job opportunities (6.2%), and limited access to healthy foods (5.3%).

Table 34A. Health care access and quality

Social Factors Impacting Health	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Lack of access to doctor's office	6.8%	9.7%	7.0%	10.9%
Lack of access to insurance	4.3%	7.1%	5.0%	10.6%
Infectious disease (Covid-19, flu, RSV, etc.)	4.3%	4.0%	3.9%	6.1%

Table 34B. Education access and quality

Social Factors Impacting Health	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Poor schools	1.5%	0.2%	1.7%	4.1%
Lack of affordable childcare	1.5%	1.2%	1.6%	3.6%

Table 34C. Economic stability

Social Factors Impacting Health	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Lack of job opportunities	6.2%	6.9%	6.3%	15.5%
Limited access to any foods	3.4%	2.9%	4.1%	9.6%
Poor housing/homelessness	3.1%	5.7%	3.1%	8.7%

Table 34D. Social and community context

Social Factors Impacting Health	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Social isolation/loneliness	8.2%	10.9%	7.3%	15.0%
Discrimination/bias	3.3%	4.5%	3.2%	7.3%

Table 34E. Neighborhood and built environment

Social Factors Impacting Health	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Transportation problems	6.5%	15.0%	5.7%	13.7%
Limited access to healthy foods	5.3%	8.6%	5.3%	13.1%
Limited places to exercise	5.2%	8.3%	4.3%	8.3%
Lack of neighborhood safety	3.1%	6.9%	1.9%	7.2%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between reporting issues that align with each of the top five reported social determinants of health and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting “Lack of access to my doctor’s office,” “Lack of job opportunities,” “Social isolation/loneliness,” and “Limited access to healthy foods” compared to those ages 18-39

    - 60-79 and 80+ year-old respondents had significantly lower odds of reporting “Transportation problems” compared to those ages 18-39
- Gender
    - Women had significantly higher odds of reporting “Transportation problems” compared to men
- Sexuality
    - LGB respondents had significantly higher odds of reporting “Lack of access to my doctor’s office,” “Lack of job opportunities,” “Social isolation/loneliness,” “Transportation problems” compared to straight respondents
- Ethnicity
    - Hispanic and Latino respondents had significantly higher odds of reporting “Limited access to healthy foods” compared to non-Hispanic or Latino respondents
- Race
    - ANHPI respondents had significantly higher odds of reporting “Lack of job opportunities” and “Limited access to healthy foods” than White respondents
    - Multiracial respondents had significantly higher odds of reporting “Transportation problems” and “Limited access to healthy foods” than White respondents
    - Black and African American respondents had significantly higher odds of reporting “Lack of job opportunities,” “Transportation problems,” and “Limited access to healthy foods”
- Education
    - Respondents with no post-secondary education had significantly higher odds of reporting a “Lack of access to my doctor’s office”, compared to those with some college or a college degree
    - Respondents with a postgraduate degree had significantly lower odds of reporting “Lack of job opportunities,” “Transportation problems,” and “Limited access to healthy foods” compared to those with some college or a college degree
- Medically Underserved
    - Those who are Medically Underserved had significantly higher odds of reporting “Lack of access to my doctor’s office,” “Lack of job opportunities,” “Social isolation/loneliness,” “Transportation problems,” and “Limited access to healthy foods” compared to those who were not Medically Underserved
- Reporting an MSK condition
    - Those who reported having any MSK condition had significantly higher odds of reporting “Lack of access to my doctor’s office”, “Social isolation/loneliness,” “Transportation problems,” and “Limited access to healthy foods” compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, having any MSK condition were conducted to observe statistically significant associations between reporting issues that align with each of the top five reported social determinants of health and predictor variables:

- Age
    - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting issues related to “Lack of access to my doctor’s office,” “Lack of job opportunities,” and “Social isolation/loneliness” compared to those ages 18-39
    - 60-79 and 80+ year-old respondents had significantly lower odds of reporting issues related to “Transportation problems,” and “Limited access to healthy foods” compared to those ages 18-39
- Gender
    - Women had significantly higher odds of reporting “Transportation problems” compared to men
- Sexuality

  - LGB respondents had significantly higher odds of reporting issues related to “Social isolation/loneliness,” and “Transportation problems” compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting issues related to “Limited access to healthy foods” compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of reporting issues related to “Limited access to healthy foods” than White respondents
  - Multiracial respondents had significantly higher odds of reporting issues related to “Transportation problems” than White respondents
  - Black respondents had significantly higher odds of reporting issues related to “Lack of job opportunities,” “Transportation problems,” and “Limited access to healthy foods” than White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of reporting issues related to “Lack of access to my doctor’s office,” compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of reporting issues related to “Lack of job opportunities” compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting issues related to “Lack of access to my doctor’s office,” “Lack of job opportunities,” “Social isolation/loneliness,” “Transportation problems,” and “Limited access to healthy foods” compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting issues related to “Lack of job opportunities,” “Social isolation/loneliness,” “Transportation problems,” and “Limited access to healthy foods” compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, having any MSK condition were conducted to observe statistically significant associations between reporting issues that align with each of the top five reported social determinants of health and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting issues related to “Lack of access to my doctor’s office,” “Lack of job opportunities,” compared to those ages 18-39
  - 60–79-year-old respondents had significantly lower odds of reporting issues related to “Social isolation/loneliness,” compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly lower odds of reporting issues related to “Transportation problems” and “Limited access to healthy foods” compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting issues related to “Transportation problems,” compared to men
- Sexuality
  - LGB respondents had significantly higher odds of reporting issues related to “Lack of job opportunities,” “Social isolation/loneliness,” “Transportation problems,” compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting issues related to “Limited access to healthy foods” compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of reporting issues related to “Lack of access to my doctor’s office” and “Transportation problems,” than White respondents

  - Black respondents had significantly higher odds of reporting issues related to “Transportation problems” and “Limited access to healthy foods” than White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of reporting issues related to “Lack of access to my doctor’s office,” compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of reporting issues related to “Lack of job opportunities,” “Transportation problems,” and “Limited access to healthy foods” compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting issues related to “Lack of access to my doctor’s office,” “Lack of job opportunities,” “Social isolation/loneliness,” “Transportation problems,” and “Limited access to healthy foods” compared to those with no reported MSK condition

Barriers to Healthcare

Table 35 shows that approximately one-third of respondents (34.7%) in the total sample were unable to access healthcare in the past 12 months, a decline from 2022 (42.3%).

Table 35. Healthcare access in the past 12 months

Able to Get Healthcare in the Past 12 Months	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Yes	65.3%	51.3%	70.2%	54.6%
No	34.7%	48.7%	29.8%	45.4%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting any reason for delaying health care in the past 12 months and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of delaying health care for any reason compared to those ages 18-39
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of delaying health care for any reason compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of delaying health care for any reason compared to White respondents
  - Multiracial respondents had significantly higher odds of delaying health care for any reason compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of delaying health care for any reason compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of delaying health care for any reason compared to those who were not Medically Underserved
- Reporting an MSK condition

- Those who reported having any MSK condition had significantly higher odds of delaying health care for any reason compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between delaying health care for any reason and predictor variables:

- Age
  - Respondents age 60+ had significantly lower odds of reporting any reason for delaying health care in the last 12 months compared to respondents under 60.
- Race
  - Black and African American respondents had significantly lower odds of reporting any reason for delaying health care in the last 12 months compared to White respondents.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting any reason for delaying health care in the past 12 months and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of delaying health care for any reason compared to those ages 18-39
- Gender
  - Women had significantly lower odds of delaying health care for any reason compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of delaying health care for any reason compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of delaying health care for any reason compared to White respondents
  - Black and African American respondents had significantly higher odds of delaying health care for any reason compared to White respondents
  - AI/AN respondents had significantly higher odds of delaying health care for any reason compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of delaying health care for any reason compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of delaying health care for any reason compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of delaying health care for any reason compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between reporting any reason for delaying health care in the past 12 months and predictor variables:

- Age

  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of delaying health care for any reason compared to those ages 18-39
- Gender
  - Women had significantly lower odds of delaying health care for any reason compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of delaying health care for any reason compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of delaying health care for any reason compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of delaying health care for any reason compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having a MSK condition had significantly higher odds of delaying health care for any reason compared to those with no reported MSK condition

Table 36 shows that across all samples, the top reported reason for not getting care in the past 12 months was “could not get an appointment” (8.7%). In the medically underserved sub-sample, the second highest reported reason was “lack of transportation” (9.7%). In the ACC sub-sample, the second highest reported reason was “could not find a doctor for the specialty I need” (7.6%).

Table 36. Reasons for not getting healthcare in the past 12 months

Reasons for Not Getting Healthcare in Past 12 Months	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Could not get an appointment	8.7%	8.8%	8.2%	10.7%
Nervous about seeing a health care provider	4.7%	4.0%	4.9%	9.2%
Could not find a doctor for the specialty I need	4.6%	7.6%	4.5%	7.7%
You had to pay out of pocket for some or all of the procedure	4.6%	4.0%	4.4%	7.7%
Lack of transportation	3.7%	4.0%	4.2%	9.7%
Could not get time off work/school	3.0%	2.6%	3.4%	5.9%
Could not afford the copay	2.5%	3.6%	2.7%	5.9%
Your deductible was too high/or could not afford the deductible	2.1%	1.9%	2.0%	3.3%
You provide care to an adult and could not leave them	1.1%	1.2%	1.2%	2.3%
Lack of childcare	0.8%	1.2%	1.0%	2.1%
Other reason	4.0%	6.4%	3.7%	4.6%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top reported reasons for delaying health care in the past 12 months and predictor variables:

- Age

  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting “I couldn’t get an appointment,” and “Nervous about seeing a health care provider” as reasons for delaying care compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly lower odds of reporting “Had to pay out of pocket for some or all of the procedure,” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting “I couldn’t get an appointment” as a reason for delaying care compared to men
- Sexuality
  - LGB respondents had significantly higher odds of reporting “I couldn’t get an appointment” as a reason for delaying care compared to straight respondents
- Race
  - Multiracial respondents had significantly higher odds of reporting “Had to pay out of pocket for some or all of the procedure” as a reason for delaying care compared to White respondents
  - ANHPI respondents had significantly **higher** odds of reporting “Couldn’t find a doctor for the specialty I need” as a reason for delaying care compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly higher odds of reporting “I couldn’t get an appointment” as a reason for delaying care compared to those with some college or a college degree
  - Respondents with no post-secondary education had significantly lower odds of reporting “Had to pay out of pocket for some or all of the procedure” as reasons for delaying care compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting “I couldn’t get an appointment,” “Nervous about seeing a health care provider,” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting “I couldn’t get an appointment,” “Nervous about seeing a health care provider,” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top reported reasons for delaying health care in the past 12 months and predictor variables.

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting “I couldn’t get an appointment,” “Nervous about seeing a health care provider,” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly lower odds of reporting “Had to pay out of pocket for some or all of the procedure” as a reason for delaying care compared to those ages 18-39
- Race

    - Multiracial respondents had significantly higher odds of reporting “Had to pay out of pocket for some or all of the procedure” as a reason for delaying care compared to White respondents
    - ANHPI respondents had significantly **higher** odds of reporting “I couldn’t get an appointment” and “Couldn’t find a doctor for the specialty I need” as a reason for delaying care compared to White respondents
    - AI/AN respondents had significantly **higher** odds of reporting “I couldn’t get an appointment” as a reason for delaying care compared to White respondents
    - Black and African American respondents had significantly lower odds of reporting “Nervous about seeing a health care provider” as reasons for delaying care compared to White respondents
- Education
    - Respondents with a postgraduate degree had significantly **higher** odds of reporting “I couldn’t get an appointment” as a reason for delaying care compared to those with some college or a college degree
    - Respondents with no post-secondary education had significantly lower odds of reporting “Had to pay out of pocket for some or all of the procedure” as reasons for delaying care compared to those with some college or a college degree
- Medically Underserved
    - Those who are Medically Underserved had significantly higher odds of reporting “I couldn’t get an appointment,” “Nervous about seeing a health care provider,” “Had to pay out of pocket for some or all of the procedure,” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those who were not Medically Underserved
- Reporting an MSK condition
    - Those who reported having any MSK condition had significantly higher odds of reporting “I couldn’t get an appointment,” “Nervous about seeing a health care provider,” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition were conducted to observe statistically significant associations between the top reported reasons for delaying health care in the past 12 months and predictor variables.

- Age
    - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting “I couldn’t get an appointment,” “Nervous about seeing a health care provider” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those ages 18-39
    - 60-79 and 80+ year-old respondents had significantly lower odds of reporting “Had to pay out of pocket for some or all of the procedure,” and “Couldn’t find a doctor for the specialty I need” as reasons for delaying care compared to those ages 18-39
- Gender
    - Women had significantly lower odds of reporting “Nervous about seeing a health care provider” as a reason for delaying care compared to men
- Sexuality
    - LGB respondents had significantly higher odds of reporting “I couldn’t get an appointment” as a reason for delaying care compared to straight respondents
- Race
    - Multiracial respondents had significantly higher odds of reporting “Had to pay out of pocket for some or all of the procedure” as a reason for delaying care compared to White respondents
    - ANHPI respondents had significantly higher odds of reporting “I couldn’t get an appointment” and “Couldn’t find a doctor for the specialty I need” as a reason for delaying care compared to White respondents
- Education

- Respondents with no post-secondary education had significantly lower odds of reporting "Had to pay out of pocket for some or all of the procedure" as reasons for delaying care compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting "I couldn't get an appointment," "Nervous about seeing a health care provider," and "Couldn't find a doctor for the specialty I need" as reasons for delaying care compared to those with no reported MSK condition

Barriers to Adhering to Medical Advice

Table 37 indicates that most respondents in the total sample always followed their healthcare provider's advice in the past 12 months (65.7%). However, this was a decline from 2022, in which almost three-quarters (74.9%) of respondents reported always following medical advice. The medically underserved sub-sample had the smallest proportion of respondents who always followed medical advice (58.7%).

Among the total, ACC, and regional sub-samples, the most common reason for not following medical advice was "worried about side effects" (Table 38). The other top five reasons in the total sample were "did not feel treatment would help," "concerned about cost," "provider did not explain treatment well," and "condition not severe enough." In the medically underserved sub-sample, the top reported reason was instead "concerned about cost" (10.3%).

Table 37. Adherence to medical advice

Always Follow Medical Advice	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Yes	65.7%	62.7%	69.9%	58.7%
No	34.3%	37.3%	30.1%	41.3%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the reporting any reason for not following a doctor's advice in the past 12 months and predictor variables:

- Age
  - 40-59 and 60-79 year-old respondents had significantly lower odds of not following a doctor's advice for any reason compared to those ages 18-39
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of not following a doctor's advice for any reason compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of not following a doctor's advice for any reason than White respondents
  - ANHPI respondents had significantly higher odds of not following a doctor's advice for any reason compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of not following a doctor's advice for any reason compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of not following a doctor's advice for any reason compared to those who were not Medically Underserved

- Reporting an MSK condition
  - Those who reported having a MSK condition had significantly higher odds of not following a doctor's advice for any reason compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the reporting any reason for not following a doctor's advice in the past 12 months and predictor variables

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of not following a doctor's advice for any reason compared to those ages 18-39
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of not following a doctor's advice for any reason compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of not following a doctor's advice for any reason than White respondents
  - ANHPI respondents had significantly higher odds of not following a doctor's advice for any reason compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of not following a doctor's advice for any reason compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of not following a doctor's advice for any reason compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of not following a doctor's advice for any reason compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition were conducted to observe statistically significant associations between the reporting any reason for not following a doctor's advice in the past 12 months and predictor variables.

- Age
  - 40-59, 60-79 and 80+ year-old respondents had significantly lower odds of not following a doctor's advice for any reason compared to those ages 18-39
- Gender
  - Women had significantly lower odds of not following a doctor's advice for any reason compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of not following a doctor's advice for any reason compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of not following a doctor's advice for any reason than White respondents
  - ANHPI respondents had significantly higher odds of not following a doctor's advice for any reason compared to White respondents

- Education
  - Respondents with no post-secondary education had significantly higher odds of not following a doctor's advice for any reason compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having a MSK condition had significantly higher odds of not following a doctor's advice for any reason compared to those with no reported MSK condition

Table 38. Reasons for not following healthcare provider's advice

Reasons for Not Following Healthcare Provider's Advice	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Worried about side effects	8.0%	9.3%	7.9%	9.4%
Did not feel treatment would help	6.2%	3.9%	6.2%	9.5%
Concerned about cost	5.3%	4.2%	6.0%	10.3%
Provider did not explain treatment well	5.2%	2.9%	4.7%	8.1%
Condition not severe enough	3.9%	2.5%	4.3%	5.5%
Forgot to take medicine/go for follow-up	3.8%	1.7%	4.3%	7.7%
Did not agree with doctor	3.7%	3.9%	3.5%	4.3%
Prefer to use complementary/alternative treatment	3.3%	2.9%	3.3%	4.1%
Did not fit my schedule	2.9%	0.7%	2.8%	3.7%
Provider doesn't understand my culture/language	0.9%	0.7%	1.1%	2.3%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top reported reasons for treatment non-adherence in the past 12 months and predictor variables:

- Age
  - 80+ year-old respondents had significantly lower odds of reporting "Worried about side effects of treatment" as a reason for non-adherence compared to those ages 18-39
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting "Didn't think treatment would help" as a reason for delaying care compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting "Concerned about cost of treatment" as a reason for non-adherence compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of reporting "Worried about side effects of treatment" as a reason for non-adherence compared to White respondents

  - ANHPI respondents had significantly **higher** odds of reporting "Concerned about cost of treatment" as a reason for non-adherence compared to White respondents
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting "Worried about side effects of treatment," "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting "Worried about side effects of treatment," "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top reported reasons for treatment non-adherence in the past 12 months and predictor variables:

- Age
  - 80+ year-old respondents had significantly lower odds of reporting "Worried about side effects of treatment" as a reason for non-adherence compared to those ages 18-39
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting "Didn't think treatment would help" as a reason for delaying care compared to men
  - Women had significantly higher odds of reporting "Worried about side effects of treatment" as a reason for delaying care compared to men
- Sexuality
  - LGB respondents had significantly lower odds of reporting "Worried about side effects of treatment" as a reason for delaying care compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting "Concerned about cost of treatment" as a reason for non-adherence compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of reporting "Worried about side effects of treatment" as a reason for non-adherence compared to White respondents
  - ANHPI respondents had significantly **higher** odds of reporting "Concerned about cost of treatment" as a reason for non-adherence compared to White respondents
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting "Worried about side effects of treatment," "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition were conducted to observe statistically significant associations between the top reported reasons for treatment nonadherence in the past 12 months and predictor variables:

- Age
  - 80+ year-old respondents had significantly lower odds of reporting "Worried about side effects of treatment" as a reason for non-adherence compared to those ages 18-39
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting "Didn't think treatment would help" and "Concerned about cost of treatment" as a reason for delaying care compared to men
- Sexuality
  - LGB respondents had significantly lower odds of reporting "Worried about side effects of treatment" and "Concerned about cost of treatment" as a reason for delaying care compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting "Concerned about cost of treatment" as a reason for non-adherence compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of reporting "Worried about side effects of treatment" as a reason for non-adherence compared to White respondents
  - ANHPI respondents had significantly higher odds of reporting "Concerned about cost of treatment" as a reason for non-adherence compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly higher odds of reporting "Didn't think treatment would help" as a reason for delaying care compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting "Worried about side effects of treatment," "Didn't think treatment would help," and "Concerned about cost of treatment" as reasons for non-adherence compared to those with no reported MSK condition

Barriers to Telehealth Use

Table 39 indicates that across all samples, the majority of respondents (55.7%) had no barriers to telehealth, similar to national level data (54.0%).[92] The largest proportion of respondents with no telehealth barriers was in the regional sub-sample (71.4%). 11.3% of the total sample expressed no interest in using telehealth, down from 39.0% in 2022. The top barrier to using telehealth reported across all samples was "don't know how to use telehealth" (6.3%). In the medically underserved sub-sample, a higher proportion of respondents expressed concerns about confidentiality (8.1%) compared to the total sample (4.5%).

[92] Patient Access Network Foundation. (2024). *Nearly half of adults who use telehealth face barriers to accessing services*. https://www.panfoundation.org/nearly-half-of-adults-who-use-telehealth-face-barriers-to-accessing-services/

Table 39. Barriers to telehealth use

Barriers to Telehealth Use	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
No barriers to using telehealth	55.7%	55.1%	71.4%	59.2%
Not interested	11.3%	9.0%	10.8%	11.8%
Don't know how to use telehealth	6.3%	10.5%	5.9%	10.2%
Concerned about confidentiality	4.5%	3.3%	4.6%	8.1%
Concerned about medical errors	4.1%	2.6%	4.4%	7.2%
Not sure doctor offers telehealth	3.8%	3.8%	4.1%	6.0%
No high-speed internet	2.3%	2.6%	2.6%	6.2%
No device	1.6%	2.6%	1.6%	3.7%
No private space for telehealth calls	1.4%	2.1%	1.3%	2.9%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between the reporting of any barriers to telehealth use and predictor variables:

- Age
  - 40-59 and 60-79 year-old respondents had significantly lower odds of reporting barriers to using telehealth compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting barriers to using telehealth compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting barriers to using telehealth compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of reporting barriers to using telehealth than White respondents
  - Black respondents had significantly higher odds of reporting barriers to using telehealth than White respondents.
  - AI/AN respondents had significantly higher odds of reporting barriers to using telehealth than White respondents
  - ANHPI respondents had significantly higher odds of reporting barriers to using telehealth compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of reporting barriers to using telehealth compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of reporting barriers to using telehealth compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting barriers to using telehealth compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting barriers to using telehealth compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between barriers to telehealth use and predictor variables:

- Race
  - Black and African American respondents had significantly **lower** odds of reporting barriers to telehealth use compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of reporting barriers to telehealth use compared to those with some college or a college education

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between the reporting of any barriers to telehealth use and predictor variables:

- Age
  - 40-59 and 60-79 year-old respondents had significantly lower odds of reporting barriers to using telehealth compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting barriers to using telehealth compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting barriers to using telehealth compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of reporting barriers to using telehealth than White respondents
  - ANHPI respondents had significantly higher odds of reporting barriers to using telehealth compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of reporting barriers to using telehealth compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of reporting barriers to using telehealth compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting barriers to using telehealth compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting barriers to using telehealth compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between the reporting of any barriers to telehealth use and predictor variables:

- Age
  - 40-59 and 60-79 year-old respondents had significantly lower odds of reporting barriers to using telehealth compared to those ages 18-39
- Gender
  - Women had significantly lower odds of reporting barriers to using telehealth compared to men
- Ethnicity

  - Hispanic and Latino respondents had significantly higher odds of reporting barriers to using telehealth compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of reporting barriers to using telehealth than White respondents
  - ANHPI respondents had significantly higher odds of reporting barriers to using telehealth compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of reporting barriers to using telehealth compared to those with some college or a college degree.
  - Respondents with a postgraduate degree had significantly lower odds of reporting barriers to using telehealth compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting barriers to using telehealth compared to those with no reported MSK condition

Accessing health information on the Internet

Tables 40, 41, and 42 show how respondents use the internet to access health information. Approximately a quarter of respondents in the ACC and medically underserved sub-sample do not use the internet to look for health or medical information, compared to just 15.0% in the total sample. Higher proportions of the total sample used the internet to communicate with a doctor or doctor's office (72.2%) or look up test results (80.1%) compared to those in the ACC and medically underserved samples.

Table 40. Used Internet to look for health or medical information

Used Internet to look for health or medical information	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Yes	85.0%	73.8%	84.7%	75.3%
No	15.0%	26.2%	15.3%	24.7%

Table 41. Used Internet to communicate with a doctor or doctor's office

Used Internet to communicate with a doctor or doctor's office	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Yes	72.2%	62.5%	70.8%	61.0%
No	27.8%	37.5%	29.2%	39.0%

Table 42. Used Internet to look up medical test results

Used Internet to look up medical test results	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Yes	80.1%	69.6%	79.3%	65.7%
No	19.9%	30.4%	20.7%	34.3%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting the use of the internet for health information and communication and predictor variables:

- Age
  - 40-59 and 80+ year-old respondents had significantly lower odds of reporting the use of the internet for health information and communication compared to those ages 18-39
- Gender
  - women had significantly higher odds of reporting the use of the internet for health information and communication compared to men
- Race
  - AI/AN respondents had significantly lower odds of reporting the use of the internet for health information and communication than White respondents
  - ANHPI respondents had significantly lower odds of reporting the use of the internet for health information and communication compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly lower odds of reporting the use of the internet for health information and communication compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of reporting the use of the internet for health information and communication compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of reporting the use of the internet for health information and communication compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting the use of the internet for health information and communication compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between reporting the use of the internet for health information and communication and predictor variables:

- Age
  - 80+ year-old respondents had significantly lower odds of reporting the use of the internet for health information and communication compared to those ages 18-39
- Gender
  - women had significantly higher odds of reporting the use of the internet for health information and communication compared to men
- Race
  - ANHPI respondents had significantly lower odds of reporting the use of the internet for health information and communication compared to White respondents
- Education

  - Respondents with no post-secondary education had significantly lower odds of reporting the use of the internet for health information and communication compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of reporting the use of the internet for health information and communication compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of reporting the use of the internet for health information and communication compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting the use of the internet for health information and communication compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between reporting the use of the internet for health information and communication and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of reporting the use of the internet for health information and communication compared to those ages 18-39
- Gender
  - Women had significantly higher odds of reporting the use of the internet for health information and communication compared to men
- Race
  - ANHPI respondents had significantly lower odds of reporting the use of the internet for health information and communication compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly lower odds of reporting the use of the internet for health information and communication compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of reporting the use of the internet for health information and communication compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting the use of the internet for health information and communication compared to those with no reported MSK condition

Discrimination in Medical Settings

Perceived discrimination in medical settings on the basis of race, ethnicity, color, language, sexual orientation, and/or gender identity was measured using the Discrimination in Medical Settings (DMS) scale.[93] Overall, a higher proportion of respondents reported discriminatory experiences in the medically underserved sub-sample compared to the total, ACC, and regional samples (Table 43). Reports of discrimination were less frequent than in 2022. The top discriminatory experience reported across all samples was “doctor or nurse is not listening to you” (41.7%). In the medically underserved sub-sample, the second most reported experience was “you are treated with less courtesy than other people.”

[93] Peek, M. E., Nunez-Smith, M., Drum, M., & Lewis, T. T. (2011). Adapting the everyday discrimination scale to medical settings: reliability and validity testing in a sample of African American patients. *Ethnicity & disease*, *21*(4), 502.

For regression analysis, a composite score was generated with a range of 7-35 based on responses to 7 items on a 5-point Likert scale. A higher score corresponds with higher levels of perceived discrimination.

Table 43. Discrimination in Medical Settings

Perceived Discrimination in Medical Settings	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
You feel like a doctor or nurse is not listening to what you were saying	41.7%	34.3%	40.1%	47.4%
A doctor or nurse acts as if they are better than you	27.3%	20.0%	26.6%	36.5%
You are treated with less courtesy than other people	26.6%	27.2%	23.7%	41.4%
You are treated with less respect than other people	25.7%	23.5%	23.1%	39.9%
A doctor or nurse acts as if they think you are not smart	25.9%	19.0%	24.8%	37.1%
You receive poorer service than others	23.1%	22.9%	21.1%	37.8%
A doctor or nurse acts as if they are afraid of you	9.0%	5.0%	8.7%	19.1%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between DMS scores and communication and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents reported significantly lower perceived discrimination scores compared to those ages 18-39
- Gender
  - Women reported significantly lower perceived discrimination scores compared to men
- Sexuality
  - LGB respondents reported significantly higher perceived discrimination scores compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents reported significantly higher perceived discrimination scores compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents reported significantly higher perceived discrimination scores than White respondents
  - AI/AN respondents reported significantly higher perceived discrimination scores than White respondents
  - ANHPI respondents reported significantly higher perceived discrimination scores than White respondents
  - Multiracial respondents reported significantly higher perceived discrimination scores than White respondents
- Medically Underserved
  - Those who are Medically Underserved reported significantly higher perceived discrimination scores compared to those who were not Medically Underserved
- Reporting an MSK condition

- Those who reported having any MSK condition reported significantly higher perceived discrimination scores compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between DMS scores and communication and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents reported significantly lower perceived discrimination scores compared to those ages 18-39
- Gender
  - Women reported significantly lower perceived discrimination scores compared to men
- Sexuality
  - LGB respondents reported significantly higher perceived discrimination scores compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents reported significantly higher perceived discrimination scores compared to non-Hispanic or Latino respondents
- Race
  - Black and African American respondents reported significantly higher perceived discrimination scores than White respondents
  - AI/AN respondents reported significantly higher perceived discrimination scores than White respondents
  - Multiracial respondents reported significantly higher perceived discrimination scores than White respondents
- Medically Underserved
  - Those who are Medically Underserved reported significantly higher perceived discrimination scores compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly higher perceived discrimination scores compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between DMS scores and communication and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents reported significantly lower perceived discrimination scores compared to those ages 18-39
- Gender
  - Women reported significantly lower perceived discrimination scores compared to men
- Sexuality
  - LGB respondents reported significantly higher perceived discrimination scores compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents reported significantly higher perceived discrimination scores compared to non-Hispanic or Latino respondents

- Race
  - Black and African American respondents reported significantly higher perceived discrimination scores than White respondents
  - AI/AN respondents reported significantly higher perceived discrimination scores than White respondents
- Reporting an MSK condition
  - Those who reported having any MSK condition reported significantly higher perceived discrimination scores compared to those with no reported MSK condition

Health Literacy

Consistent with the 2022 CHNA, the majority of respondents across all samples preferred English for discussing (Table 44) and reading (Table 45) medical issues/instructions. In the ACC sub-sample, about one in 10 respondents preferred Spanish for discussing and reading medical issues/instructions.

Table 44. Preferred language for discussing medical issues/instructions

Preferred Language for Discussing Medical Issues/Instructions	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
English	95.6%	79.5%	96.3%	90.8%
Spanish	2.9%	11.5%	3.0%	6.5%
Chinese	0.6%	1.2%	0.2%	1.3%
Russian	0.3%	3.2%	<0.1%	0.4%
Arabic	0.1%	0.9%	0.1%	0.2%
Haitian Creole	0.1%	0.6%	0.1%	0.2%
Hebrew	<0.1%	<0.1%	<0.1%	<0.1%
Other	0.4%	3.2%	0.3%	0.6%

Table 45. Preferred language for reading medical issues/instructions

Preferred Language for Reading Medical Issues/Instructions	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
English	96.1%	83.5%	96.5%	91.8%
Spanish	2.7%	10.6%	2.8%	6.1%
Chinese	0.7%	3.3%	0.2%	1.4%
Russian	0.1%	0.3%	0.2%	0.2%
Haitian Creole	0.1%	0.0%	0.1%	0.2%
Hebrew	0.1%	0.0%	0.1%	0.1%
Arabic	<0.1%	0.9%	<0.1%	0.1%
Other	0.2%	1.5%	0.2%	0.2%

Table 46 shows that the majority (78.0%) of respondents in the total sample never need assistance reading healthcare information. Notably, 10.2% of respondents in the ACC sub-sample always or often need assistance reading healthcare information, compared to just 2% of respondents in the total sample.

Table 46. Needs assistance reading healthcare information

Need Assistance Reading Healthcare Information	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Never	78.0%	62.2%	79.7%	68.1%
Rarely	13.3%	15.0%	12.4%	15.9%
Sometimes	6.7%	12.6%	6.5%	12.0%
Often	1.2%	6.0%	0.9%	2.4%
Always	0.8%	4.2%	0.5%	1.6%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between needing help to read healthcare information and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of needing help to read healthcare information compared to those ages 18-39
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of needing help to read healthcare information compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of needing help to read healthcare information than White respondents
  - ANHPI respondents had significantly higher odds of needing help to read healthcare information compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of needing help to read healthcare information compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of needing help to read healthcare information compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of needing help to read healthcare information compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of needing help to read healthcare information compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between needing help to read healthcare information and predictor variables.

- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting needing help to read healthcare information compared to non-Hispanic respondents.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between needing help to read healthcare information and predictor variables.

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of needing help to read healthcare information compared to those ages 18-39
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of needing help to read healthcare information compared to non-Hispanic or Latino respondents
- Race
  - AI/AN respondents had significantly higher odds of needing help to read healthcare information than White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of needing help to read healthcare information compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly lower odds of needing help to read healthcare information compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of needing help to read healthcare information compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having a MSK condition had significantly higher odds of needing help to read healthcare information compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between needing help to read medical instructions and predictor variables:

- Age
  - 40-59 and 60-79 year-old respondents had significantly lower odds of needing help to read healthcare information compared to those ages 18-39
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of needing help to read healthcare information compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of needing help to read healthcare information compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly higher odds of needing help to read healthcare information compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of needing help to read healthcare information compared to those with no reported MSK condition

E. Health Education

Participation in health education

Across all samples, the majority of respondents (70.5%) had not participated in a health education program in the past 12 months (Table 47). Participation in health education programs was highest in the regional sub-sample (32.3%) and lowest in the ACC sub-sample (19.5%).

Table 47. Participation in health education

Participated in Health Education in past 12 Months	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
No	70.5%	80.5%	67.7%	71.8%
Yes	29.5%	19.5%	32.3%	28.2%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between participation in a health education program in the past year and predictor variables:

- Age
  - 40-59 and 80+ year-old respondents had significantly lower odds of reporting participation in a health education program in the past year compared to those ages 18-39
- Race
  - Black or African American respondents had significantly higher odds of reporting participation in a health education program in the past year compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly higher odds of reporting participation in a health education program in the past year compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of reporting participation in a health education program in the past year compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of reporting participation in a health education program in the past year compared to those with no reported MSK condition

ACC SAMPLE

A regression model adjusting for age, gender, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between participation in a health education program in the past year and predictor variables:

- Race
  - AI/AN, ANHPI, and multiracial respondents had significantly lower odds of reporting participation in a health education program in the past year compared to White respondents

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between participation in a health education program in the past year and predictor variables:

- Age
  - 40-59 respondents had significantly lower odds of reporting participation in a health education program in the past year compared to those ages 18-39
- Race
  - Black or African American respondents had significantly higher odds of reporting participation in a health education program in the past year compared to White respondents
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of reporting participation in a health education program in the past year compared to those who were not Medically Underserved.
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of reporting participation in a health education program in the past year compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between participation in a health education program and predictor variables:

- Age
  - 80+ year-old respondents had significantly lower odds of reporting participation in a health education program in the past year compared to those ages 18-39
- Race
  - Black or African American respondents had significantly higher odds of reporting participation in a health education program in the past year compared to White respondents
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of reporting participation in a health education program in the past year compared to those with no reported MSK condition

Barriers to Health Education

Table 48 shows reasons why respondents did not participate in health education programs in the past 12 months. 23.5% of respondents in the total sample reported that they were not interested in health education programs. In all samples, the top reported reason for not participating in health education was “did not know about the program” (30.8%), though a smaller proportion of respondents reported this compared to 2022 (39.5%). The next highest reported reason in the total and regional samples was “lack of time,” while in the ACC and medically underserved samples, it was “not sure where to go.”

Table 48. Reasons for not participating in health education programs

Reasons for Not Participating in Health Education Programs	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Did not know about the program	30.8%	35.1%	29.5%	28.4%
Not interested	23.5%	16.1%	24.1%	17.2%
Lack of time	11.4%	9.5%	11.4%	13.1%
Not sure where to go	9.0%	13.7%	8.6%	15.7%
Scheduling conflicts	8.4%	6.6%	8.3%	9.4%
Lack of transportation	4.6%	4.6%	4.9%	4.6%
Could not afford it	4.2%	2.9%	4.4%	10.7%
Fear or mistrust of doctors	1.9%	1.0%	2.5%	4.7%
Infectious diseases (Covid-19, flu, RSV, etc.)	1.8%	1.7%	1.7%	3.2%
Language barriers	0.7%	2.4%	0.6%	1.6%
Cultural/religious barriers	0.5%	0.0%	0.6%	1.2%

TOTAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between the top barriers to participating in health education programs and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly higher odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly lower odds of reporting “Not sure where to go” and “Lack of time,” as reasons for not participating in health education compared to those ages 18-39
- Gender
  - Women reported significantly lower odds of reporting “Lack of time” as a reason for not participating in health education compared to men
  - Women reported significantly higher odds of reporting “Did not know about the program” as a reason for not participating in health education compared to men
- Sexuality
  - LGB respondents reported significantly higher odds of reporting “Did not know about the program” as a reason for not participating in health education compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting “Not sure where to go,” “Lack of time,” and “Scheduling conflicts” as reasons for not participating in health education compared to non-Hispanic and Latino respondents
  - Hispanic and Latino respondents had significantly lower odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to non-Hispanic and Latino respondents

- Race
  - ANHPI respondents had significantly higher odds of reporting “Not sure where to go,” “Lack of time,” and “Scheduling conflicts” as reasons for not participating in health education compared to White respondents
  - ANHPI respondents had significantly lower odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to White respondents
  - Black or African American respondents had significantly higher odds of reporting “Scheduling conflicts” as a reason for not participating in health education compared to White respondents
  - Black or African American respondents had significantly lower odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to White respondents
  - AI/AN respondents had significantly lower odds of reporting “Not interested” as a reason for not participating in health education compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly lower odds of reporting “Not sure where to go” as a reason for not participating in health education compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of reporting “Lack of time” as a reason for not participating in health education compared to those with some college or a college degree
  - Respondents with no post-secondary education had significantly lower odds of reporting “Lack of time,” “Scheduling conflicts,” and “Did not know about the program” as reasons for not participating in health education compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting “Not sure where to go” as a reason for not participating in health education compared to those who are not Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of reporting “Not interested” as a reason for not participating in health education compared to those who are not Medically Underserved
- Reporting an MSK condition
  - Those who reported having a MSK condition had significantly higher odds of reporting “Not sure where to go” and “Scheduling conflicts” as reasons for not participating in health education compared to those with no reported MSK condition
  - Those who reported having any MSK condition had significantly lower odds of “Not interested” as a reason for not participating in health education compared to those with no reported MSK condition

ACC SAMPLE

No significant associations were found in this sub-sample.

REGIONAL SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition was conducted to observe statistically significant associations between the top barriers to participating in health education programs and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly higher odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to those ages 18-39

- 60-79 and 80+ year-old respondents had significantly lower odds of reporting “Not sure where to go,” “Lack of time,” and “Scheduling conflicts” as reasons for not participating in health education compared to those ages 18-39
- Gender
  - Women reported significantly lower odds of reporting “Lack of time” as a reason for not participating in health education compared to men
  - Women reported significantly higher odds of reporting “Did not know about the program” as a reason for not participating in health education compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting “Not sure where to go,” “Lack of time,” and “Scheduling conflicts” as reasons for not participating in health education compared to non-Hispanic and Latino respondents
  - Hispanic and Latino respondents had significantly lower odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to non-Hispanic and Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of reporting “Scheduling conflicts” as a reason for not participating in health education compared to White respondents
  - ANHPI respondents had significantly lower odds of reporting “Not interested” as a reason for not participating in health education compared to White respondents
  - Black or African American respondents had significantly higher odds of reporting “Scheduling conflicts” as a reason for not participating in health education compared to White respondents
  - Black or African American respondents had significantly lower odds of reporting “Not interested” as a reason for not participating in health education compared to White respondents
  - AI/AN respondents had significantly lower odds of reporting “Not interested” as a reason for not participating in health education compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly lower odds of reporting “Not sure where to go” as a reason for not participating in health education compared to those with some college or a college degree
  - Respondents with no post-secondary education had significantly lower odds of reporting “Lack of time,” “Scheduling conflicts,” and “Did not know about the program” as reasons for not participating in health education compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of reporting “Not sure where to go” as a reason for not participating in health education compared to those who are not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting “Not sure where to go,” “Scheduling conflicts,” and “Lack of time” as reasons for not participating in health education compared to those with no reported MSK condition
  - Those who reported having any MSK condition had significantly lower odds of “Not interested” as a reason for not participating in health education compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

A regression model adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition was conducted to observe statistically significant associations between the top barriers to participating in health education programs and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly higher odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to those ages 18-39

  - 60-79 and 80+ year-old respondents had significantly lower odds of reporting “Not sure where to go,” as a reason for not participating in health education compared to those ages 18-39
  - 40-59 and 60-79 year-old respondents had significantly lower odds of reporting “Lack of time” as a reason for not participating in health education compared to those ages 18-39

- Gender
  - Women reported significantly lower odds of reporting “Lack of time” as a reason for not participating in health education compared to men
  - Women reported significantly higher odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to men
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of reporting “Not sure where to go,” “Lack of time,” “Scheduling conflicts” as reasons for not participating in health education compared to non-Hispanic and Latino respondents
  - Hispanic and Latino respondents had significantly lower odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to non-Hispanic and Latino respondents
- Race
  - ANHPI respondents had significantly lower odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to White respondents
  - Black or African American respondents had significantly higher odds of reporting “Scheduling conflicts” as a reason for not participating in health education compared to White respondents
  - Black or African American respondents had significantly lower odds of reporting “Did not know about the program” and “Not interested” as reasons for not participating in health education compared to White respondents
  - AI/AN respondents had significantly lower odds of reporting “Not interested” as a reason for not participating in health education compared to White respondents
- Education
  - Respondents with a postgraduate degree had significantly lower odds of reporting “Not sure where to go” as a reason for not participating in health education compared to those with some college or a college degree
  - Respondents with no post-secondary education had significantly lower odds of reporting “Lack of time,” “Scheduling conflicts,” and “Did not know about the program” as reasons for not participating in health education compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of reporting “Not sure where to go” and “Scheduling conflicts” as reasons for not participating in health education compared to those with no reported MSK condition
  - Those who reported having any MSK condition had significantly lower odds of “Not interested” as a reason for not participating in health education compared to those with no reported MSK condition

Health Education Activities of Interest

Table 49 shows respondents’ health education activities of interest. Virtual exercise classes were the top activities of interest across all samples (31.1%). In the total and regional samples, the second-highest reported activity of interest was on-demand videos, whereas onsite exercise classes were the most reported in the ACC and medically underserved sub-samples:

Table 49. Health education activities of interest

Health Education Activities	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Virtual exercise classes	31.1%	28.0%	31.1%	31.5%
On-demand videos	28.4%	19.0%	30.1%	24.3%
Onsite exercise classes	26.2%	26.3%	24.9%	30.2%
Virtual lectures	25.8%	12.9%	26.0%	21.2%
Podcasts	21.7%	13.2%	23.2%	18.9%
Virtual workshops	13.2%	13.9%	13.3%	15.8%
Onsite lectures	12.5%	11.2%	11.6%	13.7%
Social media posts	12.3%	10.5%	13.5%	18.5%
Onsite workshops	11.9%	15.4%	11.0%	16.6%
Support groups	11.8%	17.3%	10.7%	15.9%
Conference calls	5.7%	5.9%	5.6%	7.1%
None of the above	24.9%	22.7%	26.6%	21.4%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education formats and predictor variables:

- Age
  - 40-59, 60-79, 80+ year-old respondents had significantly **lower** odds of indicating a preference for onsite exercise classes compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly **lower** odds of indicating a preference for virtual exercise programs and podcasts compared to those ages 18-39
  - 80+ year-old respondents had significantly **lower** odds of indicating a preference for on-demand videos compared to those ages 18-39
- Gender
  - Women reported had significantly higher odds of indicating a preference for on-demand videos, virtual lectures, and podcasts compared to men
- Sexuality
  - LGB reported had significantly higher odds of indicating a preference for podcasts compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of indicating a preference for onsite exercise classes compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of indicating preference for on-demand videos and virtual exercise programs compared to White respondents
  - Black or African American respondents had significantly higher odds of indicating preference for virtual exercise programs and onsite exercise programs compared White respondents
  - ANHPI and Black respondents had significantly lower odds of indicating preference for podcasts compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly lower odds of indicating a preference for onsite exercise classes, virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with some college or a college degree

  - Respondents with a postgraduate degree had significantly higher odds of indicating a preference for virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with some college or a college degree
- Medically Underserved
  - Medically Underserved respondents had significantly lower odds of indicating a preference for on-demand videos and podcasts compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of indicating a preference for virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with no reported MSK condition

ACC SAMPLE

Regression models adjusting for age, gender, race, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education formats and predictor variables:

- Reporting an MSK condition
  - Respondents who reported having any MSK condition had significantly higher odds of indicating interest in onsite exercise classes compared to those with no reported MSK conditions

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education formats and predictor variables.

- Age
  - 40-59, 60-79, 80+ year-old respondents had significantly **lower** odds of indicating a preference for onsite exercise classes compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly **lower** odds of indicating a preference for virtual exercise programs and podcasts compared to those ages 18-39
  - 80+ year-old respondents had significantly **lower** odds of indicating a preference for on-demand videos compared to those ages 18-39
- Gender
  - Women reported had significantly higher odds of indicating a preference for virtual exercise classes, on-demand videos, virtual lectures, and podcasts compared to men
- Race
  - Multiracial respondents had significantly higher odds of indicating a preference for on-demand videos compared to White respondents
  - Black or African American respondents had significantly higher odds of indicating a preference for virtual exercise programs compared White respondents
  - ANHPI and Black respondents had significantly lower odds of indicating a preference for podcasts compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly lower odds of indicating a preference for onsite exercise classes, virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of indicating a preference for virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with some college or a college degree
- Medically Underserved

  - Medically Underserved respondents had significantly lower odds of indicating a preference for virtual exercise programs, on-demand videos and podcasts compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of indicating a preference for virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education formats and predictor variables:

- Age
  - 60-79 and 80+ year-old respondents had significantly **lower** odds of indicating a preference for virtual exercise programs and podcasts compared to those ages 18-39
  - 60-79 year-old respondents had significantly **lower** odds of indicating a preference for onsite exercise classes compared to those ages 18-39
- Gender
  - Women reported had significantly higher odds of indicating a preference for virtual exercise programs compared to men
- Sexuality
  - LGB reported had significantly higher odds of indicating a preference for podcasts compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of indicating a preference for onsite exercise classes compared to non-Hispanic or Latino respondents
- Race
  - Multiracial respondents had significantly higher odds of indicating a preference for on-demand videos and virtual exercise programs compared to White respondents
  - Black and African American respondents had significantly higher odds of indicating a preference for virtual exercise programs and onsite exercise programs compared White respondents
  - Black and African American respondents had significantly lower odds of indicating a preference for podcasts compared to White respondents
- Education
  - Respondents with no post-secondary education had significantly lower odds of indicating a preference for onsite exercise classes, virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly higher odds of indicating a preference for virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly higher odds of indicating a preference for virtual exercise programs, on-demand videos, virtual lectures, and podcasts compared to those with no reported MSK condition

Health Education Topics of Interest

Respondents were asked about various health topics of interest (Table 50). Consistent with 2022 data, exercise was the most popular health education topic across all samples. Interest in exercise was highest among the medically underserved sub-sample (51.5%). In the total, regional, and medically underserved samples, the second highest topic of interest was healthy eating, while it was “managing my chronic condition” in the ACC sub-sample (32.2%). Respondents in the medically underserved sub-sample had a

higher interest in “dealing with stress, anxiety, and depression” (35.5%) compared to the total sample (26.0%). The ACC sub-sample had a higher proportion of participants reporting an interest in pain management (30.5%) compared to the total sample (20.8%).

Table 50. Health education topics of interest

Health Education Topics	Total sample (n=31,792)	ACC sub-sample (n=481)	Regional sub-sample (n=11,853)	Medically Underserved Sub-Sample (n=8,978)
Exercise	45.6%	37.8%	46.6%	51.5%
Healthy eating	31.0%	31.2%	32.2%	42.8%
Healthy aging	29.7%	13.7%	30.9%	20.9%
Dealing with stress, anxiety, and depression	26.0%	22.2%	25.8%	35.5%
Ways to improve mobility	25.7%	28.0%	25.2%	24.0%
Managing my chronic condition	24.9%	32.2%	25.3%	24.8%
Supporting a healthy lifestyle	21.9%	17.3%	22.7%	26.5%
Complementary treatments	21.3%	18.3%	21.7%	17.9%
Pain management	20.8%	30.5%	20.8%	23.1%
Brain health	16.4%	9.5%	16.4%	13.5%
Falls prevention	10.0%	5.1%	9.2%	7.3%
Use of technology to manage health	8.0%	4.6%	8.7%	8.1%
Sports injury prevention	6.9%	3.7%	7.5%	4.1%
Understanding insurance coverage	5.5%	2.9%	5.3%	5.7%
Sexual health	5.2%	2.4%	5.6%	7.6%
Asking questions about things I don't understand about my treatment	5.1%	7.3%	5.2%	6.2%
Preparing questions for my healthcare provider	4.7%	7.1%	4.7%	5.2%
Medication management	4.0%	3.9%	4.3%	6.8%
Financial assistance options	3.4%	5.9%	3.1%	7.5%
Discussing personal problems that may be related to my illness	3.2%	6.8%	3.0%	4.7%
Infectious diseases (Covid-19, flu, RSV, etc.)	2.6%	1.0%	2.5%	3.3%
Managing my child's health	2.6%	2.2%	2.8%	5.0%
Other	3.1%	3.7%	3.2%	2.7%

TOTAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education topics and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of indicating interest in learning about exercise and dealing with stress, anxiety, and depression compared to those ages 18-39
  - 40-59, 60-79 and 80+ year-old respondents had significantly higher odds of indicating interest in learning about healthy aging compared to those ages 18-39

  - 60-79 and 80+ year-old respondents had significantly lower odds of indicating interest in learning about healthy eating compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly higher odds of indicating interest in learning about ways to improve mobility compared to those ages 18-39
- Gender
  - Women had significantly lower odds of indicating interest in learning about exercise, and ways to improve mobility compared to men
  - Women had significantly higher odds of indicating interest in learning about healthy aging and dealing with stress, anxiety, and depression compared to men
- Sexuality
  - LGB respondents had significantly higher odds of indicating interest in learning about dealing with stress, anxiety, and depression compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of indicating interest in learning about healthy eating and healthy aging compared to non-Hispanic or Latino respondents
- Race
  - Black or African American and ANHPI respondents had significantly higher odds of indicating interest in learning about exercise, healthy eating than White respondents
  - Multiracial respondents had significantly **higher** odds of indicating interest in learning about healthy aging and dealing with stress, anxiety, and depression than White respondents
- Education
  - Respondents with no post-secondary education had significantly **lower** odds of indicating interest in learning about healthy eating, healthy aging, dealing with stress, anxiety, and depression, and ways to improve mobility compared to those with some college or a college degree
  - Respondents with no post-secondary education had significantly higher odds of indicating interest in learning about exercise compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **lower** odds of indicating interest in learning about healthy eating and dealing with stress, anxiety, and depression compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **higher** odds of indicating interest in learning about healthy aging compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of indicating interest in learning about exercise and healthy aging compared to those who were not Medically Underserved
  - Those who are Medically Underserved had significantly higher odds of indicating interest in learning about dealing with stress, anxiety, and depression compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of indicating interest in learning about exercise, healthy eating, and healthy aging compared to those with no reported MSK condition
  - Those who reported having any MSK condition had significantly higher odds of indicating interest in learning about ways to improve mobility compared to those with no reported MSK condition

ACC SAMPLE

Regression models adjusting for age, gender, race, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education topics and predictor variables:

- Age
  - Respondents ages 60+ had significantly lower odds of indicating interest in learning about exercise compared to respondents under 60
- Gender

- Women had significantly lower odds of indicating interest in learning about exercise compared to men

REGIONAL SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education topics and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of indicating interest in learning about exercise compared to those ages 18-39
  - 40-59, 60-79, and 80+ year-old respondents had significantly higher odds of indicating interest in learning about healthy aging compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly lower odds of indicating interest in learning about dealing with stress, anxiety, and depression and healthy eating compared to those ages 18-39
- Gender
  - Women had significantly lower odds of indicating interest in learning about ways to improve mobility compared to men
  - Women had significantly higher odds of indicating interest in learning about healthy aging and dealing with stress, anxiety, and depression compared to men
- Sexuality
  - LGB respondents had significantly higher odds of indicating interest in learning about dealing with stress, anxiety, and depression compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of indicating interest in learning about healthy eating compared to non-Hispanic or Latino respondents
  - Hispanic and Latino respondents had significantly lower odds of indicating interest in learning about ways to improve mobility compared to non-Hispanic or Latino respondents
- Race
  - Black or African American respondents had significantly higher odds of indicating interest in learning about exercise and healthy eating than White respondents
  - ANHPI respondents had significantly higher odds of indicating interest in learning about exercise and healthy eating than White respondents
  - Multiracial respondents had significantly **higher** odds of indicating interest in learning about healthy aging, healthy eating, and dealing with stress, anxiety, and depression than White respondents
- Education
  - Respondents with no post-secondary education had significantly **lower** odds of indicating interest in learning about exercise, healthy aging, healthy eating, and dealing with stress, anxiety, and depression compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **lower** odds of indicating interest in learning about healthy aging and dealing with stress, anxiety, and depression compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **higher** odds of indicating interest in learning about healthy aging compared to those with some college or a college degree
- Medically Underserved
  - Those who are Medically Underserved had significantly lower odds of indicating interest in learning about healthy aging and exercise compared to those who were not Medically Underserved
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of indicating interest in learning about exercise and healthy rating compared to those with no reported MSK condition
  - Those who reported having any MSK condition had significantly higher odds of indicating interest in learning about ways to improve mobility compared to those with no reported MSK condition

MEDICALLY UNDERSERVED SAMPLE

Regression models adjusting for age, gender, sexuality, ethnicity, race, education, medically underserved status, and having any MSK condition were conducted to observe statistically significant associations between the top preferences for health education topics and predictor variables:

- Age
  - 40-59, 60-79, and 80+ year-old respondents had significantly lower odds of indicating interest in learning about exercise and compared to those ages 18-39
  - 40-59, 60-79 and 80+ year-old respondents had significantly higher odds of indicating interest in learning about healthy aging compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly lower odds of indicating interest in learning about healthy eating and dealing with stress, anxiety, and depression compared to those ages 18-39
  - 60-79 and 80+ year-old respondents had significantly higher odds of indicating interest in learning about ways to improve mobility compared to those ages 18-39
- Gender
  - Women had significantly lower odds of indicating interest in learning about exercise and ways to improve mobility compared to men
  - Women had significantly higher odds of indicating interest in learning about healthy eating, healthy aging, and dealing with stress, anxiety, and depression compared to men
- Sexuality
  - LGB respondents had significantly higher odds of indicating interest in learning about dealing with stress, anxiety, and depression compared to straight respondents
- Ethnicity
  - Hispanic and Latino respondents had significantly higher odds of indicating interest in learning about healthy eating compared to non-Hispanic or Latino respondents
- Race
  - ANHPI respondents had significantly higher odds of indicating interest in learning about healthy eating and healthy aging than White respondents
  - Black or African American respondents had significantly higher odds of indicating interest in learning about exercise and healthy eating than White respondents
  - Multiracial respondents had significantly **higher** odds of indicating interest in learning about healthy aging than White respondents
- Education
  - Respondents with no post-secondary education had significantly **lower** odds of indicating interest in learning about exercise, healthy eating, healthy aging, and dealing with stress, anxiety, and depression compared to those with some college or a college degree
  - Respondents with a postgraduate degree had significantly **lower** odds of indicating interest in learning about dealing with stress, anxiety, and depression compared to those with some college or a college degree
- Reporting an MSK condition
  - Those who reported having any MSK condition had significantly lower odds of indicating interest in learning about exercise, healthy eating, and healthy aging compared to those with no reported MSK condition
  - Those who reported having any MSK condition had significantly higher odds of indicating interest in learning about dealing with stress, anxiety, and depression and ways to improve mobility compared to those with no reported MSK condition

Appendix F: Minutes of Internal Stakeholders Meeting

CHNA Internal Stakeholders Meeting Minutes
July 14, 2025

Attendees: 24

- Adena Batterman
- Ann Marie McDonald
- Claire Murrin
- Dalia Abusharr
- Dylan Wasserman
- Eliza Ngan-Dittgen
- Heather Woolf
- Jenny Fowler
- Jess Lefkowitz
- Jian Sun
- Jillian Rose
- Josanne Francois
- Katharine Purnell
- Kimberly Cabrera
- Mary Rodriguez
- Nadia Murphy
- Pamela Sanchez-Villagomez
- Pooja Desai
- Priscilla Calvache
- Reesa Kaufman
- Robyn Wiesel
- Sandra Goldsmith
- Stephen Haskins

Goal
The goal of the meeting was to share the CHNA results, elicit feedback and prioritize health needs.

Discussion

- Internal stakeholders raised questions about the measurement of discrimination in the CHNA, with confirmation that the Everyday Discrimination Scale was used
- Concerns were expressed regarding food insecurity and the need for clearer strategies that healthcare providers can implement to address it
- Participants suggested further analysis of smaller, diverse population samples by ZIP code, and recommended exploration of barriers such as health literacy
- Discussion highlighted older adults' lower reported interest in health education, prompting questions about potential barriers they may face in accessing such resources
- Stakeholders inquired about how CHNA results compare to state and national trends; presenters confirmed that key findings reports include these comparisons
- Interest was expressed in comparing regional data, specifically between Florida and the tri-state area
- Across the total sample, pain management, fall prevention, and access to health education emerged as prominent needs among participants

Ranking Results
Using the Hanlon Method, internal stakeholders ranked health issues according to the patients and constituents they serve. The top ten health priorities identified were:

1. Osteoarthritis
2. Rheumatoid Arthritis
3. Chronic Pain
4. Pain management
5. Osteoporosis
6. Inability to Manage Chronic Conditions
7. Lupus
8. Lack of exercise
9. Falls
10. Poor Physical Function

Appendix G: Minutes of Community Partners Meeting and Prioritization of Health Needs

CHNA Community Partners Meeting Minutes
June 27, 2025

Attendees:11

Names	Organization
Bertilia Trieu	HSS
Serena Hou	
Caleigh Dwyer	
Titilayo Adeniran	
Karen Gottlieb	Americares Free Clinic
Fernanda Moreno Soto	Building One Community
Angela Fallon	VNS Health
Teresa Lin	VNS Health
Kay Mollica	DOROT Inc.
Emma Clippinger	NYC Department of Health & Mental Hygiene
Rebecca A. Friedman	NYC Department of Health & Mental Hygiene

Goal
The goal of the meeting was to share the CHNA results, elicit feedback and prioritize health needs.

Discussion
- Theresa from VNS Health shared that concerns such as isolation and health literacy were common across the communities served
- Theresa emphasized the success of HSS's partnership in Chinatown, highlighting the popularity of in-person, evidence-based exercise programs for older adults
- Participants noted that retirees over 60 are especially eager to remain active and value these community health initiatives
- Angela from VNS Health discussed findings from a recent focus group conducted with LGBTQ+ organizations in all five NYC boroughs
- She reported consistent themes with the CHNA results, particularly distrust of medical providers and a perceived lack of LGBTQ+ cultural competence
- Comments underscored the importance of culturally responsive care and the need for providers with experience serving LGBTQ+ communities

Ranking Results

Using the Hanlon Method, community partners ranked health issues according to the communities they serve. The top ten health priorities identified were:

1. Chronic Pain
2. Osteoarthritis
3. Some other form of arthritis
4. Falls
5. Fibromyalgia
6. Gout
7. Osteoporosis
8. Spine Deformity
9. Rheumatoid Arthritis
10. Lupus

Appendix H: Summary Report of Community Forums & Prioritization of Health Needs

Goal

To share the Community Health Needs Assessment (CHNA) results and provide the opportunity for community members to prioritize their health needs.

Method

Our approach to prioritizing and selecting health needs involved a digital outreach campaign and six community forums, with the groups below:

Table 1: Community forum details

Date	Audience	Number of Attendees
June 19, 2025	HSS Patients and community members – Digital outreach campaign	1,195
June 25, 2025	Community members – VNS Health Chinatown	47
June 25, 2025	Patients – HSS Ambulatory Care Center (ACC)	9
June 26, 2025	Community members – Social Work Programs	14
June 27, 2025	Community partners	11
July 14, 2025	HSS Internal stakeholders	24
July 17, 2025	Community members - Building One Community (B1C)	11

A total of 1,307 participants attended the community forums. Patients and community members were asked to rank ten health indicators, from a list of 20, identified in the CHNA according to order of personal 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 top priorities for participants at the respective event.

Community partners and HSS Internal Stakeholders were asked to prioritize the same list of 20 health needs using an adapted version of the Hanlon Method of Health Prioritization.[94] Each health need was rated on a scale of 1-3 against the following criteria: size of the problem, severity of the problem, and effectiveness of potential interventions. Priority scores were calculated based on the three criteria rankings using a set formula, with the highest score receiving the rank of 1. Prioritization was completed online via Alchemer.

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 after the presentation of CHNA findings. Top ten health needs varied across locations as seen in **Table 2** below

[94] Hanlon, J. J. (1974). *Public health. Administration and practice* (pp. xii+-748).

Table 2: Health Needs Rankin

Rank	Overall (n=1,297)	VNS (n=45)	ACC (n=6)	Social Work Programs (n=13)	Community Partners (n=3)	HSS Internal Stakeholders (n=12)	B1C (n=5)	HSS Patients & Community Members (n=1,195)
1	Osteoarthritis	Osteoarthritis	Osteoarthritis	Lupus	Chronic pain	Osteoarthritis	Mental Health	Osteoarthritis
2	Chronic Pain	Osteoporosis	Pain management	Chronic Pain	Osteoarthritis	Rheumatoid arthritis	Poor diet	Chronic Pain
3	Pain Management	Falls	Lack of Exercise	Osteoporosis	Some other form of arthritis	Chronic pain	Lack of exercise	Pain management
4	Lack of sleep	Lack of exercise	Poor diet	Pain Management	Falls	Pain management	Lack of healthcare	Lack of sleep
5	Osteoporosis	Rheumatoid arthritis	Lack of sleep	Lack of healthcare	Fibromyalgia	Osteoporosis	Lack of sleep	Lack of exercise
6	Lack of exercise	Lack of Sleep	Mental Health	Poor physical function	Gout	Inability to manage chronic conditions	Pain Management	Osteoporosis
7	Poor physical function	Gout	Poor physical function	Rheumatoid Arthritis	Osteoporosis	Lupus	Poor physical function	Poor Physical Function
8	Falls	Chronic Pain	Chronic Pain	Falls	Spine deformity	Lack of exercise	Isolation/lonelin ess	Falls
9	Some other form of arthritis	Poor physical function	Lupus	Lack of Sleep	Rheumatoid arthritis	Falls	Osteoarthritis	Some other form of arthritis
10	Mental Health	Mental Health	Rheumatoid arthritis	Mental Health	Lupus	Poor physical function	Rheumatoid Arthritis	Inability to manage chronic conditions

Health Concerns

HSS engaged community members to discuss health issues and concerns in their respective communities. One consistent theme across community forums was dissatisfaction with access to healthcare, due to long wait times and insurance limitations, and with provider interactions.

- **VNS:** The community voiced interest in lectures and exercise classes. Community members noted challenges in accessing healthcare due to discrimination and disrespect by doctors and nurses. One participant experienced dismissal due to her age. Another shared experiences about changing providers because of this.
- **ACC:** Patients shared concerns about limited time with doctors, lack of follow-up after surgery, and difficulty navigating out-of-network access and insurance coverage. While HSS was praised for strong surgical care, aftercare and emergency services were seen as lacking compared to other institutions. Transportation support was appreciated, but barriers around sleep, nighttime pain, and fall-related injuries were common. Participants discussed challenges with healthy eating, including food insecurity and uncertainty around safe cooking methods. Many expressed interest in chronic condition education, cooking classes, and free wellness resources, while paid exercise classes were not appealing. Social isolation after surgery, mental health during recovery, and the need for community support—especially among those with lupus—were emphasized. Suggestions for improving forums included offering note-taking materials, paper copies of slides, more inclusive sizing, and asking more about provider time.
- **Social Work Programs:** Participants described the complexity of managing MSK conditions, especially when treatment options are limited and the condition is compounded by age or other chronic illnesses. Falls were a major concern, with interest in prevention, safer responses, and understanding delayed impacts. Healthy eating challenges included concerns about plastics in food preparation and the lack of culturally sensitive nutrition education. Physical activity was described as painful but ultimately helpful, requiring motivation and a gradual return to movement. Pain management strategies like magnesium and vitamin D were of interest, and some found support in faith-based communities to cope with isolation. Many expressed deep frustration with the healthcare system, citing rushed appointments, ignored health records, lack of empathy, and a sense that medicine has become depersonalized and overly reliant on algorithms. Despite this, participants shared appreciation for HSS and programs like Charla, valuing both the content and the sense of community they provide.
- **Community Partners:** As noted in Appendix G, participants shared that concerns such as isolation, health literacy, distrust of medical providers and a perceived lack of LGBTQ+ cultural competence were consistent with what is experienced by their constituents. They noted that retirees over 60 are especially eager to remain active and value community health initiatives. Additionally, participants underscored the importance of culturally responsive care and the need for providers with experience serving LGBTQ+ communities
- **HSS Internal Stakeholders:** As noted in Appendix F, stakeholders suggested further analysis of smaller, diverse population samples by ZIP code, with a specific interest in comparing regional data, specifically between Florida and the tri-state area. and recommended exploration of barriers such as health literacy. Discussion highlighted the need for clear strategies to address food insecurity and barriers to health literacy and health education.

Demongraphics (n=67)
As seen below, the majority of forum participants were female (93.2%), Asian (78.7%), and non-Hispanic/Latino (72.3%). The largest age demographic was 70-79 years (40.4%), followed by 60-69 years.

Figure 1. Gender

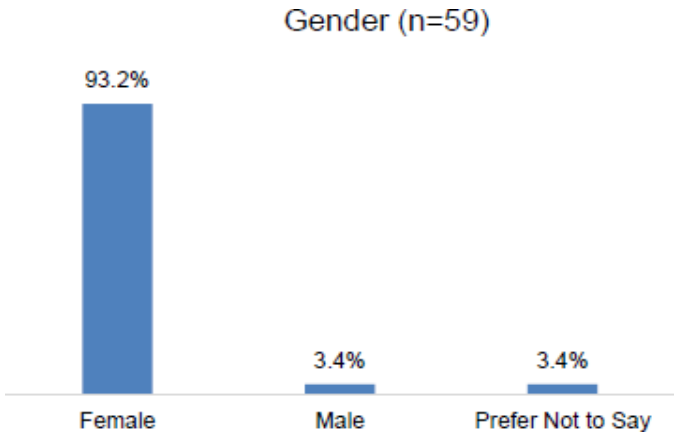


Figure 2. Age

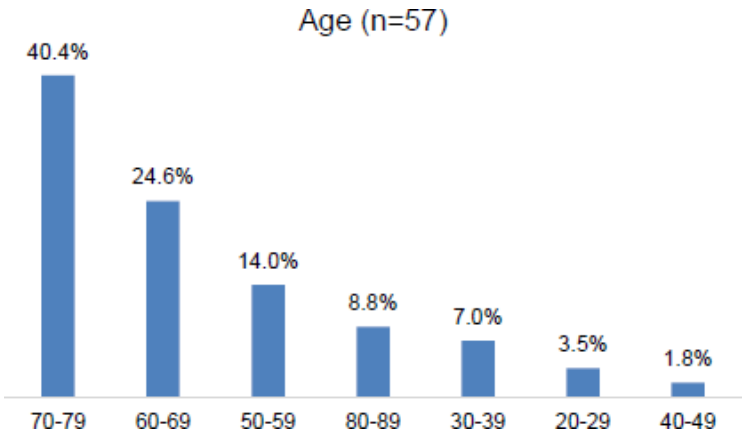


Figure 3. Ethnicity

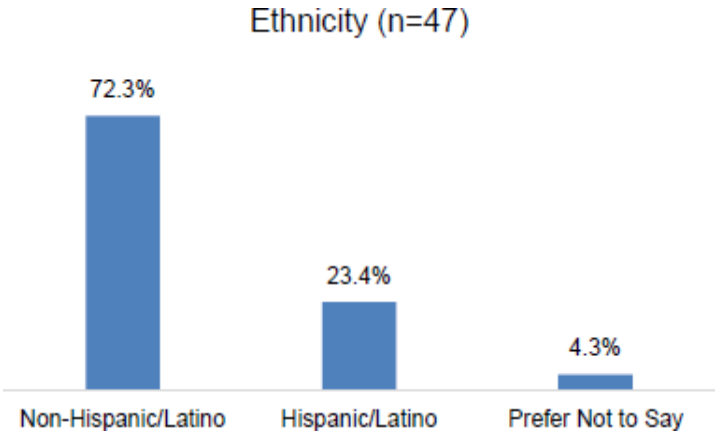
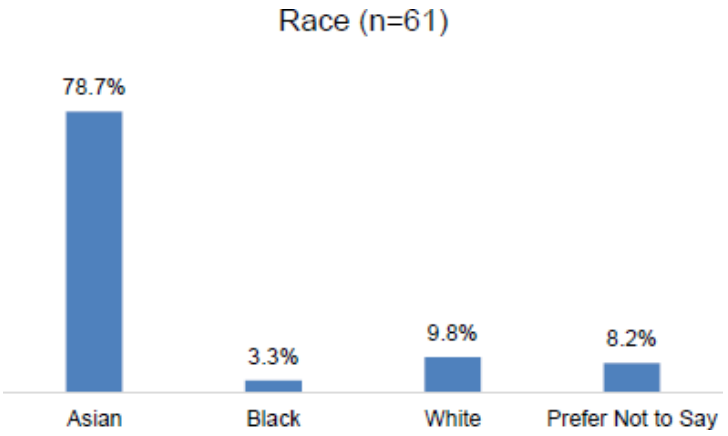
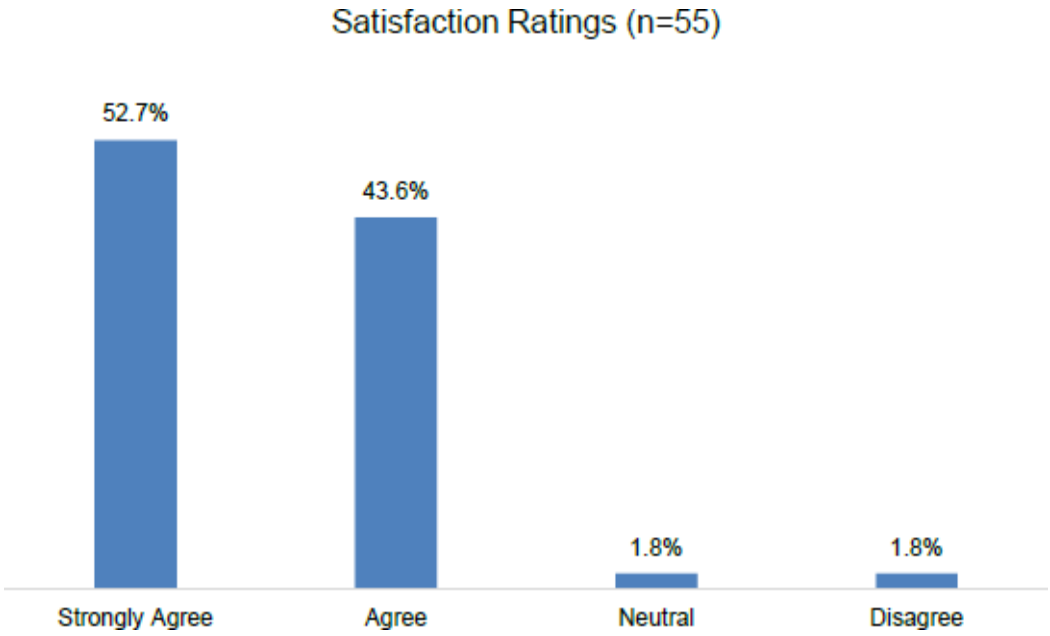


Figure 4. Race



Program Satisfaction (n=55)
The community forums were relatively well received by participants, as 96.4% strongly agree or agree that they were satisfied with this program. Only 3.6% responded neutral or disagree.

Figure 5. Overall, I was satisfied with this program:



When asked about the most valuable component of the forum, major themes included the interactive discussion (e.g., poll questions, Slido module), the opportunity to share and listen to others' experiences, and the educational presentations, particularly those focused on health topics and CHNA survey results. Many participants also noted the forum's empathetic tone, the value of learning about available resources, and the focus on bone health and exercise.
When asked about how to improve the forum, common suggestions included offering more frequent sessions, providing additional educational content (e.g., lectures on insurance, surgeries, and exercise), and increasing opportunities for interaction (e.g., more polls or surveys). A few participants also suggested adjusting the format—such as offering in-person options or different times of day—to improve accessibility. While many responded with "no suggestions" or were unsure, the overall tone indicated a desire for continuity and expanded engagement.

Appendix I. HSS Mission and Impact Committee Meeting

Mission Impact Committee Minutes
October 22, 2025
12:30 pm – 2:00 pm

Present: Leslie Cornfeld; Mary Cassai; Reggie Odom; Anne Ehrenkranz; Sandra Goldsmith; Nimali Jayasinghe; Robyn Wiesel; Deborah Sale; Linda Russell; MD, Laurie Hodges Lapeyre; Irene Koch; John B. Ehrenkranz; Titilayo Adeniran; Jillian Rose-Smith; Catherine Callagy; Todd Gorlewski; Jane Salmon, MD; Bryan Kelly, MD; Lise Scott; John Engelhardt; Katherine Purnell; Martha O'Brasky; Reetika Sachdeva

Unable to Attend: Paula Root; Jennie DeScherer; Stephanie March; Kathy Leventhal; Lara Lerner

Leslie Cornfeld called the meeting to order.

Mary Cassai discussed the change to the committee's name which will now be called Mission Impact Committee. She will co-lead the committee with Reggie Odom with Leslie Cornfeld as its Chair. The new charter was disseminated and will be reviewed for feedback and the next meeting.

Minutes from the March meeting were accepted.

Titi Adeniran presented the 2025 Community Health Needs Assessment and the 2025–2030 Community Service Plan. Using a large multi-language survey (31,792 respondents), public input, and community forums, the team identified top issues—osteoarthritis, chronic pain, and osteoporosis—along with risks such as low physical function, falls, low self-management confidence, sleep problems, loneliness, and food access challenges. Despite strong interest in exercise and wellness education, 71% had not participated in the past year, citing awareness and time barriers. Proposed interventions align with the NYS Prevention Agenda (e.g., Aging with Dignity, Rheumatology Wellness, MSK Wellness, Asian Community Bone Health, Healthcare Immersion Experience). The committee supported moving toward adoption, emphasizing outreach, equity, and clear evaluation metrics.

Robyn Wiesel called for a motion to adopt the Community Service Plan (CSP). Committee adopted. CHNA and CSP report will be added to the HSS website by EOY as per regulatory requirements.

Todd Gorlewski presented an overview of payor access at HSS. He reviewed Manhattan payer-mix trends from 2016 through the 2025 projection and examined Medicaid surgical volume; modeling showed that raising the Medicaid surgical payer mix from 2.4% to 3.0% in 2026 would add about 240 cases (to roughly 1,198), with a longer-term goal of reaching 4%. Todd also walked through IRS Schedule H Community Benefit categories and noted benchmarking from an EY informal survey of 15 East Coast hospitals in 2024, which showed a wide range of community-benefit spending (approximately 5.28%–26.72% of expenditures) with no regulatory minimum threshold.

No further discussion.
Robyn Wiesel, MCHES