FLUSHING HOSPITAL MEDICAL CENTER

COMMUNITY HEALTH NEEDS ASSESSMENT

COMMUNITY SERVICE AND IMPLEMENTATION PLAN

An individual plan for Queens County

2025-2027

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This Community Health Needs Assessment (CHNA) and Community Service Plan (CSP) were developed by Flushing Hospital Medical Center (as an individual plan) for the people of Queens County.

Link to CHNA and CSP: https://flushinghospital.org/community/community-service-plan/

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EXECUTIVE SUMMARY

This document represents Flushing Hospital Medical Center's (FHMC) individual Community Health Needs Assessment (CHNA) and Community Service Plan for 2025-2027. It presents FHMC's strategy for addressing some of the most pressing needs of the communities it serves in Queens.

FHMC, established in 1884, serves a culturally diverse and densely populated urban area spanning 50 zip codes in Queens County. FHMC's primary service area (PSA) includes 33 zip codes located throughout Queens Community Districts 2 (Woodside and Sunnyside), 3 (Jackson Heights), 4 (Elmhurst and Corona), 7 (Flushing and Whitestone), 8 (Hillcrest and Fresh Meadows), 9 (Kew Gardens and Woodhaven), 10 (South Ozone Park and Howard Beach), and 12 (Jamaica and Hollis). Many of these communities face the impacts of poverty on health, including difficulty obtaining nutritious food, unemployment, and the burden of high rents.

To identify and confirm existing and new priorities for this 2025-2027 CHNA, FHMC presents data from various primary and secondary data sources, including a 2025 community health survey for service area residents and publicly available data through the New York City Department of Health and Mental Hygiene (NYCDOHMH), as described in more detail in the Introduction section. Chronic diseases, obesity, tobacco use, behavioral health concerns, maternal morbidity, late or no prenatal care, and colorectal cancer are among the health issues highlighted in the community-level data analyses that FHMC conducted for this 2025-2027 CHNA. These health concerns were also identified by residents of the Hospital's service area who responded to a health needs assessment survey sponsored by a coalition of hospitals during the spring of 2025. Social determinants of health (SDH), such as low educational attainment, unstable housing, poor physical conditions of neighborhoods, and low engagement in primary or preventative care, and mental or behavioral health care, all contribute to the high incidence and prevalence of chronic diseases as well as poor health outcomes in some service area neighborhoods. Other neighborhoods served by FHMC perform better than NYC as a whole. The data analyses presented in this document provide a high-level snapshot of the health status of residents in FHMC's primary service area, while illustrating the diversity of population-level health behaviors and outcomes across different Community Districts in the area. By highlighting these patterns on a neighborhood level, these data provide insight into the services and resources most needed by residents.

Prevention Agenda Priorities

Reducing tobacco use. Tobacco use and secondhand smoke, as well as household/outdoor air pollution, were identified as ongoing community health concerns that are correlated with chronic disease, such as asthma and chronic obstructive pulmonary disease, and cancer. Responding to the needs of the community, FHMC has focused on improving tobacco cessation rates in alignment with New York State (NYS) Prevention Agenda Objective 14.0: Reduce the percentage of adults who use tobacco products from 9.3% to 7.9% (Domain 2: Social and Community Context; Priority: Tobacco/E-Cigarette Use).

Increasing breastfeeding. Breastfeeding, which lowers the risk of death from infectious diseases in a child's first two years of life and can reduce the risk of childhood obesity, asthma, and the risk of a woman developing breast or ovarian cancer, is unevenly practiced in the FHMC service area and in New York City (NYC) overall. FHMC has focused on improving rates of exclusive breastfeeding among women giving birth in the Hospital and those attending its ambulatory care centers with their infants, as well as among mothers in the community, in alignment with NYS Prevention Agenda Objective 20.0. Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2% (Domain 2: Social & Community Context; Priority: Healthy Eating).

Increasing colorectal cancer screening. Colorectal cancer, a significant driver of premature death in NYC that can be prevented or ameliorated with regular screenings, was identified as a major community health concern in the neighborhoods that FHMC serves. Responding to the needs of the community, FHMC has focused on increasing colorectal cancer screening rates, in alignment with NYS Prevention Agenda Objective 33.0: Increase the percentage of adults ages 45-75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80.0% (Domain 4: Health Care Access & Quality; Priority: Preventive Services for Chronic Disease Prevention & Control).

With the benefit of quantitative health status data at the local level and the community's input about their health concerns, the Hospital has chosen to highlight the prevalence of these behaviors—tobacco use, breastfeeding, and colorectal cancer screening—in its service area as well as the Hospital's concerted efforts to address them in its three-year comprehensive Community Service Plan and Implementation Plan. These initiatives are in alignment with the NYS Prevention Agenda Priorities, Healthy People 2030 goals, and the citywide Healthy NYC campaign, which lists: "Prevent tobacco use, and reduce smoking and alcohol consumption" as a priority strategy to reduce deaths driven by chronic and diet-related diseases, including screenable cancers such as lung cancer; "Improve access to and quality of obstetric health care along the whole continuum of pregnancy, childbirth, and postnatal care" as a priority strategy to reduce deaths driven by maternal mortality; and "Increase prevention activities and social supports" as a priority strategy to reduce deaths driven by chronic and diet-related diseases, including screenable cancers such as colon cancer.

Partners and Roles

MediSys Health Network, including FHMC, Jamaica Hospital Medical Center, and all MediSys entities, is partnering with Memorial Sloan Kettering Cancer Center (MSKCC) to develop the Queens comprehensive cancer care center program, which includes working with their tobacco treatment program staff to improve our tobacco cessation program and training select FHMC staff in MSKCC's courses to become tobacco treatment specialists (TTS). As part of this partnership, affiliated Jamaica Hospital Medical Center operates a medical oncology clinic and a lung cancer screening program for its patients and patients referred by FHMC and community providers. Jamaica Hospital Medical Center is developing a facility on its campus to house the Queens Comprehensive Cancer Care Center. FHMC's ambulatory care department is leading the initiative to increase the percentage of FHMC's eligible patients who are screened for lung cancer. The Hospital has also worked with the New York City Treats Tobacco, a Health Systems

for a Tobacco Free NY program, to update its tobacco-free campus policy and will utilize their other resources, including seeking further consultation from this NYSDOH-funded program.

The Hospital continues its designation as a Baby-Friendly USA Hospital, offering an optimal level of care for infant feeding and mother-to-baby bonding. The Hospital will continue its long-standing partnerships with the Women, Infants and Children (WIC) program and with Public Health Solutions' Queens Healthy Start program, both of which work to ensure that babies and their families thrive. Other community partners, including faith-based groups, local advocacy groups, and individual community members, have been enlisted to increase awareness and to help devise strategies for increasing breastfeeding.

The partnership with MSKCC on cancer care includes a focus on screening to increase early detection and treatment of colorectal cancer and other cancers. The Hospital's ambulatory care department is leading the initiative to increase the percentage of FHMC's eligible patients who are screened for colorectal cancer. Community partners, including faith-based groups, local advocacy groups, and individual community members, will be enlisted to increase awareness and to help devise strategies for increasing screening and follow-up rates.

Interventions and Strategies

Interventions were selected from suggestions in the state's prevention agenda and relevant literature and were informed by reviewing the effectiveness of the Hospital's past interventions.

Tobacco cessation interventions include:
▪ Resume regular tobacco treatment program meetings to assess program effectiveness and make necessary course corrections.
▪ Provide staff training to assess patients for tobacco use, prescribe tobacco cessation medications, and refer to cessation counseling.
▪ Train patient navigators and other staff as tobacco treatment specialists (TTS).
▪ Track number and percentage of assessments and interventions, and prevalence of smoking for returning outpatient smokers.
▪ Refer eligible patients to the network's comprehensive, patient-centered lung cancer screening (LCS) program, including early detection and follow-up.
▪ Offer tobacco cessation information and referral to treatment at community events hosted or attended by hospital staff.
▪ Increase community awareness of tobacco cessation resources via social and print media.

Breastfeeding promotion interventions include:
• Educate the community about the importance of breastfeeding, chestfeeding, and prenatal care at community events hosted or attended by Hospital staff, via social media and print, and by engaging community groups such as Bridge to Life, Queens Library staff and patrons, and community-based physician practices.
• Remain available for mothers referred by community physician practices to assist them in breastfeeding and other pregnancy-related topics.
• Increase referrals to outpatient social support services and doula providers, including hosting navigators from Public Health Solutions (PHS) to engage patients in the ambulatory care center.

• Incorporate the Unite Us electronic portal into the workflow as a means of referral to the PHS Social Care Network.
• Train all pediatricians, obstetricians, and other clinical and support staff about breastfeeding annually.
• Send employees to a Certified Lactation Consultant (CLC) Course, sponsored by NYC DOHMH.
• Continue breastfeeding internship program for International Board of Lactation Consultant Examiners (IBCLC) certification, led by the hospital's IBCLC staff, with 4 interns per cycle, 2 cycles per year.
• Continue weekly interdisciplinary committee meetings focused on maintaining standards of care for Baby Friendly designation.
• Offer human milk from NY Milk Bank to preterm infants who meet the clinical guidelines when the mother is unable to produce enough of her own milk.
• Continue to give mothers at discharge the "warm line" number to the hospital IBCLC; continue offering this service to community members.
• Continue to give mothers at discharge the NYC warm line that provides telephonic breastfeeding support.
• Continue expanding enrollment in the hospital's CenteringPregnancy® site, a group prenatal care program that includes education sessions on breastfeeding.
• Maintain current high enrollment of women in the Hospital and WIC breastfeeding programs, support groups, and prenatal nutrition classes.
• Continue Talk and Tea, a weekly infant feeding support group in the ambulatory care center guided by an IBCLC once per week.
• Use Newborn Channel to educate postpartum patients.

Colorectal cancer screening promotion interventions include:
▪ Refine the hospital's comprehensive, direct referral, patient-centered colorectal cancer screening (CRCS) program, including automated patient reminders, distribution of psychoeducational materials, and automated data collection and reporting.
▪ Employ provider assessment and feedback systems to increase cancer screening per national guidelines.
▪ Establish routine educational forums for all providers and key support staff (and community providers) about the hospital's CRCS program.
▪ Increase the number of providers who are trained in Lifestyle Medicine.
▪ Partner with community-based organizations to promote access to prevention and screening services.
▪ Continue to integrate patient navigators into health care teams to improve chronic disease management.
▪ Continue to work with the NYS Cancer Screening Program to improve access to cancer screening and diagnostic testing for individuals without health insurance.
▪ Include community voices in identifying changes, solutions, and innovations needed to address disparities.

Progress and Evaluation

Process measures and tracking of progress for the Hospital's three main health priorities (tobacco use, breastfeeding, and colorectal cancer screening) include the following:

Tobacco cessation:
▪ Achieve a general medical/surgical outpatient (OP) smoking prevalence rate for those 18 and older at or below the NYS target (7.9%).
▪ Reduce behavioral health OP smoking prevalence rate below the current NYS rate for those 18 and older with frequent mental distress (14.2%).
▪ Achieve equality between white and non-white patients in offering smoking cessation interventions, including medication and counseling.
▪ Annual percentage increase of 2% in eligible patients in our system who receive low-dose CT (LDCT) screening for lung cancer.
▪ Follow-up annual screening on all patients who remain eligible.

Progress towards these objectives will be measured, and course corrections will be made by the tobacco treatment program group.

Breastfeeding promotion:
• Increase exclusive breastfeeding rate at discharge from the current rate of 12% to 17%.
• Increase predominantly breastfeeding rate at discharge from the current rate of 28% to 30%.
• Maintain breastfeeding equality among all racial/ethnic groups.
• Maintain Baby Friendly USA Designation (current redesignation runs from 2023-2028)
• Of the well-babies whose feeding history is documented in machine-readable form, maintain exclusive breastfeeding and predominantly breastfeeding rates at 90% or above at 3 and 6 months.

Progress towards these objectives will be measured, and course corrections will be made as needed by the Breastfeeding Committee.

Colorectal cancer screening promotion:
▪ Increase screening rates for 45-75 age group from 29% to 32% over the 3-year cycle.
▪ Increase screening rates for 45-54 age group from 22% to 25% over the 3-year cycle.
▪ Achieve equality in colorectal cancer screening rates between white and non-white patients.

Progress towards these objectives will be measured, and course corrections will be made as needed by the Colorectal Cancer Screening Group.

INTRODUCTION

Hospital Overview

Flushing Hospital Medical Center (FHMC), founded in 1884, is a not-for-profit, 299-bed, Article 28 licensed teaching hospital. The surrounding neighborhoods are culturally diverse, densely populated, urban areas of northern, western, and southern Queens. FHMC's primary service area (PSA) spans 49.1 square miles, covering 33 zip codes in the following neighborhoods: Woodside

and Maspeth (Queens Community District 2); East Elmhurst and Jackson Heights (Queens Community District 3); Corona and Elmhurst (Queens Community District 4); Flushing, College Point, Whitestone, and Bayside (Queens Community District 7); Fresh Meadows (Queens Community District 8); Kew Gardens, Ozone Park, Richmond Hill, South Richmond Hill, and Woodhaven (Queens Community District 9); Ozone Park, South Ozone Park, and Howard Beach (Queens Community District 10); and Jamaica, Hollis, and St. Albans (Queens Community District 12).

FHMC is part of the larger integrated health care delivery system, MediSys Health Network, which includes Jamaica Hospital Medical Center (JHMC) in southern Queens, The Jamaica Hospital Nursing Home (located on JHMC's campus), and TJH, a large multi-specialty physician group practice affiliated with FHMC, with offices on campus and in the community. FHMC's mission is to provide superior service to our patients and our community in a caring environment.

In 2024, FHMC cared for 13,142 inpatients (including 2,514 newborns), 40,186 total emergency department (ED) visits (including observations and admissions), and 125,241 ambulatory care clinic, ambulatory surgery, and other ambulatory visits. FHMC offers a full array of general and specialty medical and surgical care, including: emergency services (ambulance services and emergency department services); inpatient services (medical and surgical, stroke services, bariatric surgery, women's health, pediatrics, a Level III Neonatal Intensive Care Unit (NICU), palliative care and hospice, chemical dependence detoxification unit, and an involuntary inpatient psychiatric unit scheduled to open in mid-2026); ambulatory care services (medical and surgical, orthopedics, dental, mental health, ophthalmology, substance use, and ambulatory surgery); and affiliated multi-specialty physician practices. FHMC has received dozens of awards and recognitions for its exemplary care from a wide range of organizations, including Healthgrades, the National Committee for Quality Assurance (NCQA), the Joint Commission, Healthfirst Hospitals, the Center for Medicare and Medicaid Services (CMS), the Institute for Healthcare Improvement, the American Society for Bariatric Surgery, the American College of Emergency Room Physicians, the American College of Radiology, and the Baby-Friendly Hospital Initiative. A full list of recent awards and recognitions is displayed on page 13 of this document.

Data Sources

Primary Data Sources. This CHNA presents the results of qualitative data obtained from residents in a 2025 community health needs survey sponsored by a coalition of hospitals. The 2025 Community Health Needs Survey results in FHMC's service area represent a primary data source directly informing the evaluation of the health needs of the patient population and the identification of Hospital priorities.

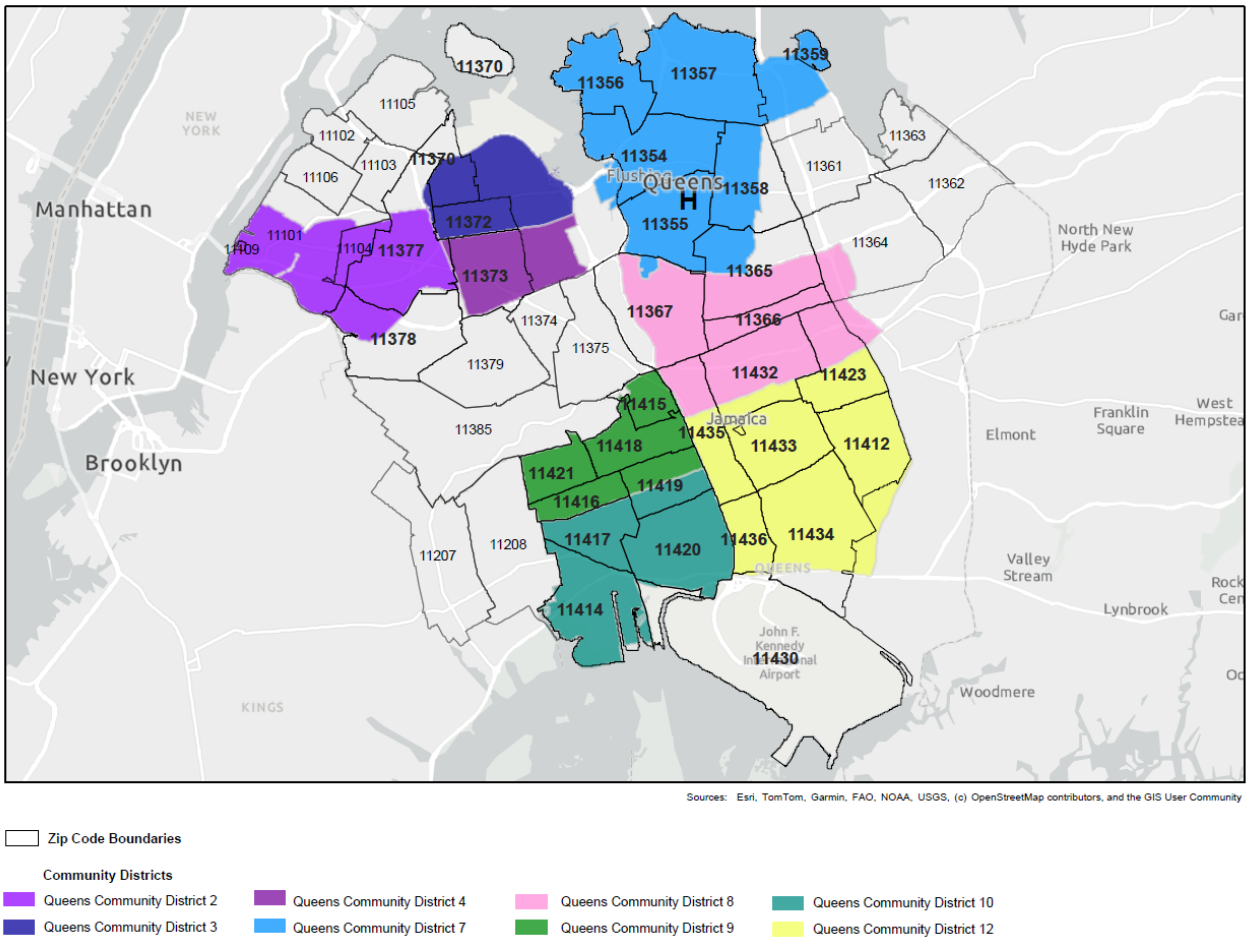
Secondary Data Sources. This CHNA examines the health needs of the residents of the neighborhoods served by the Hospital using secondary data from several sources. Community health data describing FHMC's PSA population is presented, primarily from quantitative public data from the New York City Department of Health and Mental Hygiene (NYC DOHMH). Other data sources include the New York State Department of Health (NYS DOH) and the U.S. Census

American Community Survey. Most of the secondary data in this report are from the NYC DOHMH's Community Health Profiles (updated 2025). All other data and sources are footnoted.

Defining FHMC's Primary and Secondary Service Area

In NYC, neighborhoods are described and categorized differently across agencies and organizations. These differences are relevant to how community health data are analyzed and presented in this document. As was done in the 2022-2024 CHNA, FHMC's 2025-2027 CHNA reports neighborhood data defined by NYC Community Districts or CDs (the 59 NYC CDs were established by local law in 1975) or United Health Fund (UHF) neighborhoods (an independent, nonprofit, health services research and philanthropic organization defining 34 NYC neighborhoods comprised of adjoining zip code areas, designated to approximate NYC Community Planning districts). Utilizing these schemas, FHMC's Primary Service (PSA) is defined as covering the Queens neighborhoods of Woodside, Sunnyside, Jackson Heights, Elmhurst, Corona, Flushing, Whitestone, Hillcrest, Fresh Meadows, Key Gardens, Woodhaven, South Ozone Park, Howard Beach, Jamaica, and Hollis. The neighborhood maps that follow display CDs with zip codes and neighborhoods located within them for the PSA. For this needs assessment, some health information may be presented either by CD or by UHF neighborhoods, depending on the most up-to-date source.

FHMC Primary Service Area Map



FHMC's service area was determined by analyzing 2024 Hospital electronic medical record (EMR) data for unduplicated patients by zip code of residence, excluding Emergency Department patients. FHMC assigned zip codes to neighborhoods using UHF neighborhood groups—zip codes with at least 1.0% of patients were included in the PSA, along with all other zip codes in the corresponding UHF neighborhood. Zip codes in other UHF neighborhoods that cumulatively had at least 1.7% of patients were included in the Secondary Service Area (SSA). FHMC has added several Community Districts to its PSA as the Hospital's reach has been growing to include more neighborhoods in western and southern Queens. Southern Queens is also served by affiliated JHMC, and referral of patients between the two Hospitals has grown in recent years. The FHMC CHNA addresses the Hospital's PSA.

FHMC's Primary Service Area

The PSA covers zip codes and neighborhoods in eight different community districts, which lie within the borough of Queens. The neighborhoods and zip codes served within the PSA community districts are shown in Table 1.

Table 1: FHMC PSA: Community District, Neighborhood, and Zip Code Crosswalk

Community District (CD)	Neighborhoods	Zip Codes	
Queens CD 2	Woodside Maspeth	11377	11378
Queens CD 3	East Elmhurst Jackson Heights	11369 11372	11370
Queens CD 4	Corona Elmhurst	11368	11373
Queens CD 7	Flushing College Point Whitestone Bayside	11354 11356 11358 11360	11355 11357 11359 11367
Queens CD 8	Fresh Meadows	11365	11366
Queens CD 9	Kew Gardens Ozone Park Richmond Hill South Richmond Hill Woodhaven	11415 11418 11421	11416 11419
Queens CD 10	Ozone Park South Ozone Park Howard Beach	11414 11420	11417
Queens CD 12	Jamaica Hollis Saint Albans	11412 11430 11433 11435	11423 11432 11434 11436

There are gaps in primary medical care, dental care, and mental health care across Queens, which are also evident in FHMC's service area. Queens has six neighborhoods that are designated as

Medically Underserved Areas (MUA) by the Health Resources and Services Administration (HRSA)[1]; this designation is based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. South Jamaica and Corona, neighborhoods within FHMC's primary service area, are also designated as an MUA and a Medically Underserved Population (Medicaid-eligible), respectively. The PSA neighborhoods of Jamaica, Ozone Park, and West Queens are designated as a Primary Care Health Professional Shortage Area (HPSA) by HRSA, meaning there are fewer primary care professionals than are necessary to accommodate the population living in that area.

In Queens, there are 8 hospitals other than FHMC, including affiliated JHMC, 20 nursing homes, and four HRSA-supported FQHCs or Look-Alikes that provide services in Queens County.[2] Three acute care hospitals, other than JHMC, serve the communities within FHMC's PSA: Northwell Health Long Island Jewish Forest Hills Hospital, Long Island Jewish Medical Center, and NYC Health+Hospitals/Queens Hospital Center. There are many diagnostic and treatment centers, as well as numerous physician group practices throughout Queens and Brooklyn, including 31 TJH locations (physician practices affiliated with FHMC).

Inpatient psychiatric care is provided at affiliated JHMC and at seven other licensed facilities in Queens. FHMC will begin providing involuntary inpatient psychiatric care in mid-2026. In addition, there are 71 outpatient mental health services (including those at FHMC and JHMC), support programs, emergency services, and residential facilities that provide mental health treatment to adults and children.[3] Creedmoor Psychiatric Center and NYC Children's Center – Queens Children's Campus serve Queens and the rest of NYC. Thirty-five chemical dependency treatment agencies (including the inpatient detoxification unit and outpatient Reflections clinic at FHMC), and 53 individual providers in Queens provide chemical dependency prevention or treatment and impaired driving offender programs.[4] Approximately 176 practitioners within five miles of FHMC's campus are certified to provide buprenorphine treatment of opioid use disorder.[5]

Social Determinants of Health (SDH)

Social Determinants of Health (SDH)—also known as Health-Related Social Needs (HRSN) within the U.S. Department of Health and Human Services and some other federal, state, and local agencies—are defined by Healthy People 2030 as the conditions in which 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. These conditions can affect a wide range of health risks and outcomes. The five key SDH domains include:

- Economic Stability;
- Education Access and Quality;
- Social and Community Context;

[1] HRSA Find. Data.HRSA.gov.
[2] HRSA Data Warehouse. Health Centers and Look-alike Sites Site Directory.
[3] NYS OMH. Mental Health Program Directory.
[4] NYS OASAS.
[5] SAMHSA. Buprenorphine Practitioner Locator.

- Health Care Access and Quality; and
- Neighborhood and Built Environment.

Integrating health and human services to address SDH can have a significant impact on health outcomes.[6] FHMC has always integrated SDH into its approach to patient care and maintains full compliance with the Social Security Act's Section 1115 waiver requirements for Medicaid. It has established a systematic approach to doing this by screening for SDH with a standardized tool. The results are entered automatically in the medical record, and referrals for high-scoring needs are made to local social service agencies via a closed-loop referral platform, which ensures that outcomes are shared with all parties. The Hospital has joined Public Health Solutions' WholeYouNYC, designated by the NYSDOH as a Social Care Network (SCN) to screen Medicaid members in Queens, Brooklyn, and Manhattan for health-related social needs (HRSN) and connect them to community resources and Medicaid-funded services, such as care management, food and nutrition services, housing supports, and transportation assistance. SCNs were established as a core part of the New York Health Equity Reform (NYHER) 1115 Waiver Demonstration Amendment, which endeavored to create a coordinated infrastructure and set of processes through which Medicaid recipients' unmet social needs can be identified, addressed, and supported through sustained funding. This heightened emphasis on HRSN (also referred to as SDH in this document), together with the high-quality clinical services provided by the Hospital, will ensure a systematic and highly effective approach to the Prevention Agenda Domains identified by the NYS DOH in its Prevention Agenda for the period 2025-2030:

- Domain 1. ECONOMIC STABILITY
- Domain 2. SOCIAL & COMMUNITY CONTEXT
- Domain 3. NEIGHBORHOOD & BUILT ENVIRONMENT
- Domain 4. HEALTH CARE ACCESS & QUALITY
- Domain 5. EDUCATION ACCESS & QUALITY

Within each Domain, FHMC analyzed and summarized data relevant to "Priorities," each of which contained specific "objectives" (e.g., "reduce the percentage of adults who use tobacco products," which is an objective for Priority 5: Tobacco/E-Cigarette Use under Domain 2: Social & Community Context). Data for these analyses were primarily obtained from the NYC DOHMH's 2025 Community Health Profiles and 2025 Community Health Surveys (community-wide surveys that were administered as part of data collection for the 2025-2027 Queens CHNA).

Community Engagement

In the Spring of 2025, FHMC collaborated with a consortium of area hospitals to survey adult residents of the service area about their own health and the health of their communities, as well as their opinions about the importance of a variety of health conditions and health related social needs identified in the state's prevention agenda and their satisfaction with how these needs are being addressed. FHMC's network of community partners assisted with spreading the word in the community about the survey and encouraging their networks to respond. The hospital

[6] NYS Department of Health. Social Determinants of Health and Community Based Organizations.

contracted with an independent consultant to provide secondary data on the demographics, health status, and health outcomes of the residents of the service area.

Sharing the Report

The full report was distributed to the members of the Hospital's Board of Trustees, who approved it in October 2025. Announcement of the report's availability will be posted on the Hospital's social media platforms. A copy can be obtained from the Hospital's website: https://flushinghospital.org/community-service-plan/

Flushing Hospital Medical Center Achievements

Gastrointestinal Care Excellence Award by Healthgrades

Pulmonary Care Excellence Award by Healthgrades

Obstetrics and Gynecology Excellence Award by Healthgrades

The Joint Commission Healthcare Equity Certification

Number 1 in Quality metrics amongst all Healthfirst Hospitals

American College of Radiology Diagnostic Imaging Center of Excellence

American College of Surgery Bariatric Center of Excellence (First in Queens)

Geriatric Emergency Department designation by American College of Emergency Physicians

New York State Patient-Centered Medical Home (NYS PCMH) through 2022 for all hospital and faculty practice sites

Institute for Healthcare Improvement Age Friendly Designation

Behavioral Medicine Care transition exemplary program awarded by CMS

Baby friendly designation (28% of hospitals nationally have this designation)

Flushing Hospital Medical Center

Emergency Services

- Ambulance Services
- Emergency Department

Inpatient Services

- Medical and Surgical
- Stroke Services
- Bariatric Surgery
- Women's Health
- Pediatrics
- Neonatal Intensive Care Unit
- Palliative Care and Hospice
- Psychiatric, involuntary*
- Chemical Dependence - Detoxification Beds

Ambulatory Care Services (on campus)

- Medical and Surgical
- Orthopedics
- Dental
- Mental Health
- Ophthalmology
- Chemical Dependence - Outpatient Rehabilitation
- Ambulatory Surgery

Multi-specialty Physician Practices (affiliated)

**Scheduled to open in mid-2026*

Statistics by Community District in Hospital's Primary Service Area

Note regarding references: Unless otherwise cited in endnotes, the 2025 NYC Planning Community Health Profiles were used as the source for PSA population demographic and health indicator data throughout this section. The Profiles draw information from the most recent data made publicly available by the U.S. Census Bureau and state and local agencies, which varies for each indicator (2010-2022).

Demographics

The overall resident primary service area (PSA) population is approximately 1,436,571 persons. This population includes 153,365 in Queens CD 2 (Woodside and Sunnyside), 177,841 in Queens CD 3 (Jackson Heights), 184,561 in Queens CD 4 (Elmhurst and Corona), 262,994 in Queens CD 7 (Flushing and Whitestone), 155,477 in Queens CD 8 (Hillcrest and Fresh Meadows), 146,449 in Queens CD 9 (Kew Gardens and Woodhaven), 124,663 in Queens CD 10 (South Ozone Park and Howard Beach), and 231,221 in Queens CD 12 (Jamaica and Hollis).[7]

Of all PSA community districts, Queens CD 9 has the youngest population. Queens CDs 2, 3, 4, 10, and 12 are comparable to the citywide age distribution, and the population of Queens CDs 7 and 8 is both older than that of NYC and the other CDs in the PSA (Figure 1).

In comparison to NYC, a greater proportion of residents in the PSA identify as other than non-Hispanic White (81% in the PSA vs. 68% in NYC), including several predominantly non-Hispanic Black communities in Queens CD 12 (66% non-Hispanic Black). The predominantly Asian immigrant, Asian-American, and Hispanic/Latino communities are located in Queens CD 2 (35% Hispanic/Latino and 36% non-Hispanic Asian), Queens CD 3 (29% Hispanic/Latino and 15% non-Hispanic Asian, as well as 22% non-Hispanic Black), Queens CD 4 (51% Hispanic/Latino and 36% non-Hispanic Asian), Queens CD 7 (16% Hispanic/Latino and 54% non-Hispanic Asian), Queens CD 8 (18% Hispanic/Latino and 36% non-Hispanic Asian), Queens CD 9 (41% Hispanic/Latino and 28% non-Hispanic Asian) and Queens CD 10 (24% Hispanic/Latino and 28% non-Hispanic Asian). Race and ethnicity profiles for all Community Districts in the PSA are depicted in Figure 2. Overall, the PSA is very racially and ethnically diverse, with large populations of foreign-born residents. Queens CD 4, which contains the Hispanic/Latino majority neighborhoods of Corona and North Corona, as well as a growing Chinatown in Elmhurst, has the highest percentage of foreign-born residents in the PSA at 63%. However, foreign-born residents in other PSA communities are still significant, as depicted in Figure 3.

[7] U.S. Census Bureau (2015-2019). American Community Survey 5-Year estimates. Retrieved from NYC Planning Community District Profiles for Queens Community District (CD) 2; Queens CD 3; Queens CD 4; Queens CD 7; Queens CD 9; Queens CD 10; and Queens CD 12.

Figure 1. Age Demographics by Community District (%)

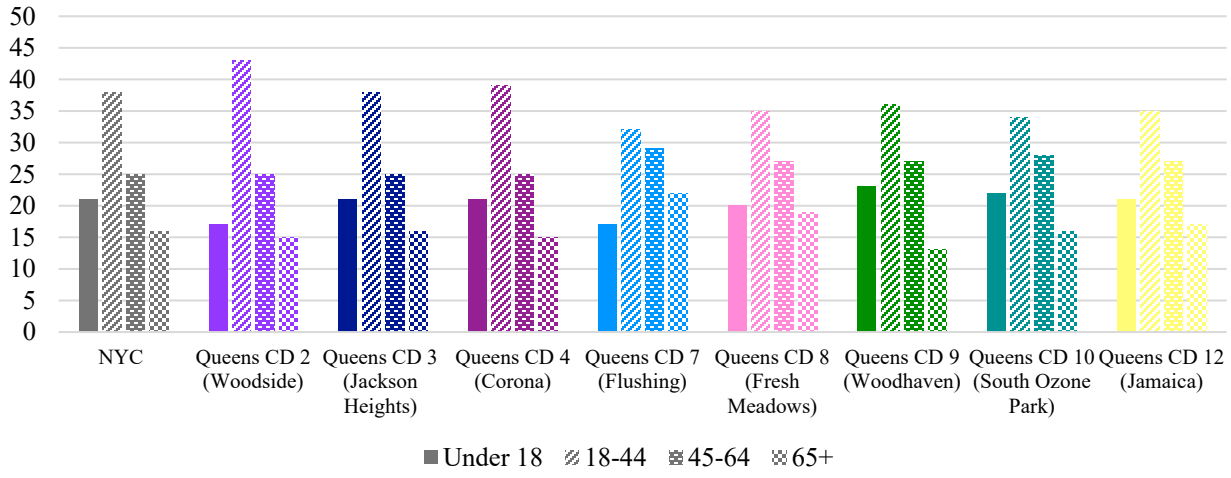
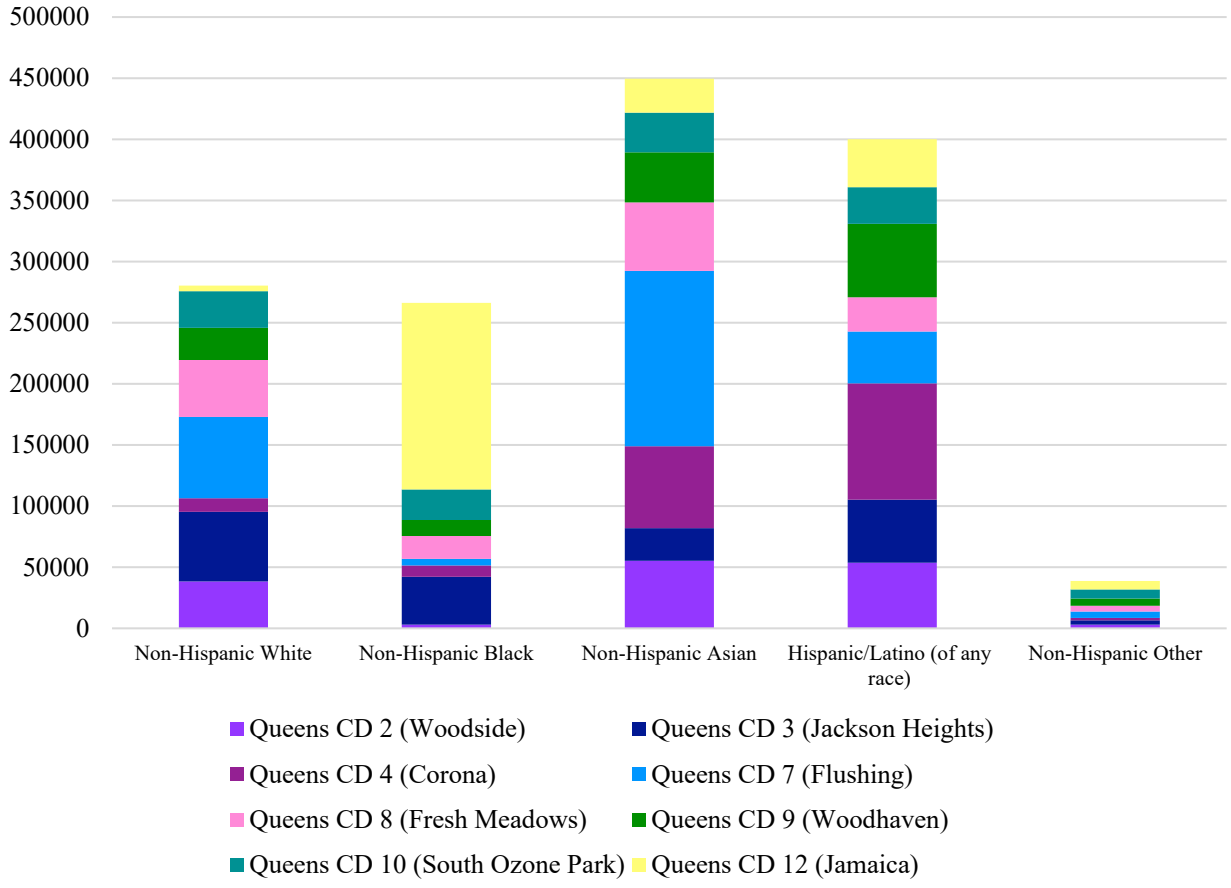
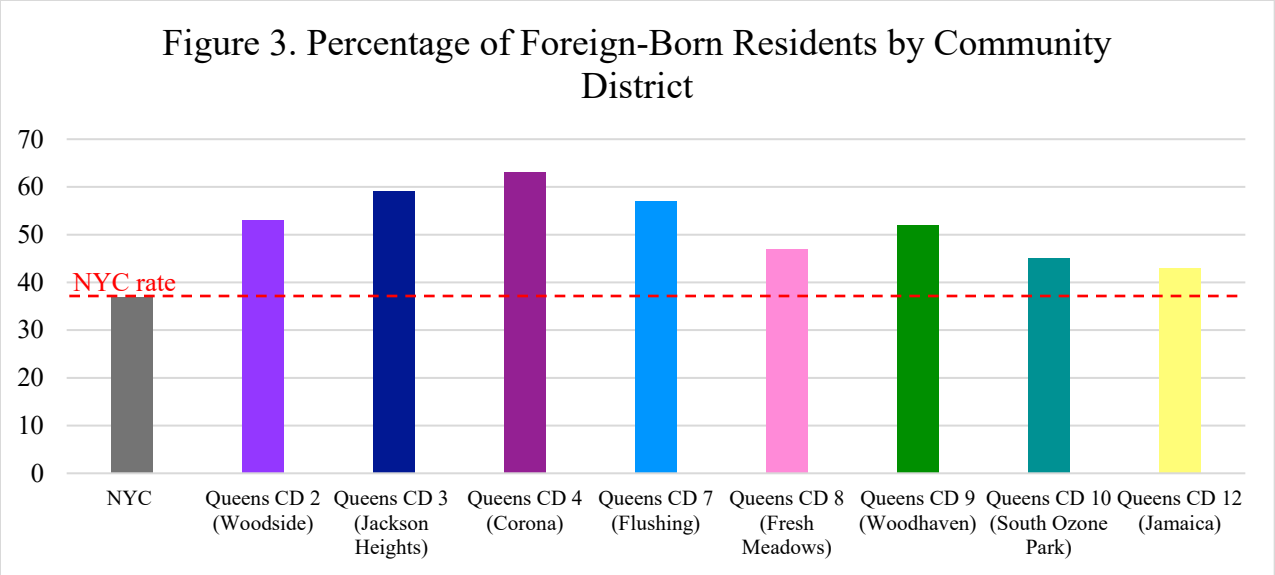


Figure 2. PSA Race and Ethnicity Profiles





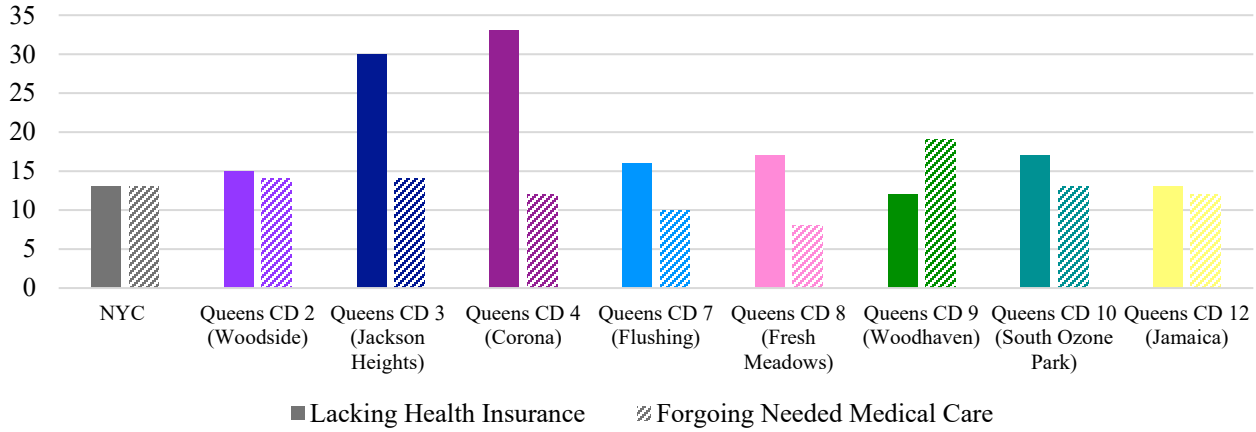
Determinants of Health

Access to Health Care

Consistent access to affordable health care through health insurance is a protective factor against a wide range of chronic and acute medical conditions.[8] Queens CD 9 (Kew Gardens and Woodhaven) has a lower uninsured rate than NYC, and the rate of Queens CD 12 (Jamaica and Hollis) equals that of NYC. However, the remaining CDs in the PSA have higher uninsured rates when compared to NYC, with uninsured rates as high as 30% in Queens CD 3 (Jackson Heights) and 33% in Queens CD 4 (Elmhurst and Corona). While the rates of uninsured residents and those who report forgoing needed medical care in the past 12 months are similar in Queens CD 2, Queens CD 12, and NYC as a whole, the same cannot be said for the remainder of the PSA. In Queens CD 3, Queens CD 4, Queens CD 7, Queens CD 8, and Queens CD 10, the uninsured rate is significantly greater than the rate of people forgoing care, while in Queens CD 9, the inverse is true, with a significantly higher rate of individuals forgoing care than those who are uninsured. These patterns are depicted in Figure 4.

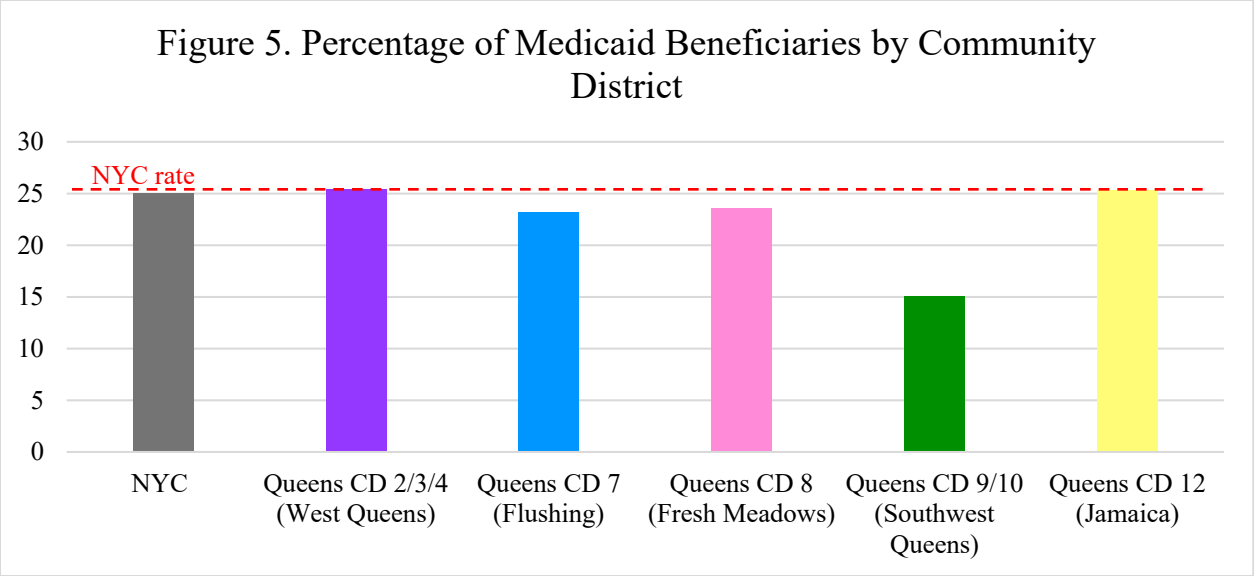
[8] McWilliams J. M. (2009). Health consequences of uninsurance among adults in the United States: recent evidence and implications. *The Milbank Quarterly*, *87*(2), 443–494. https://doi.org/10.1111/j.1468-0009.2009.00564.x

Figure 4. Percentage of Residents Lacking Health Insurance and Forgoing Needed Medical Care by Community District



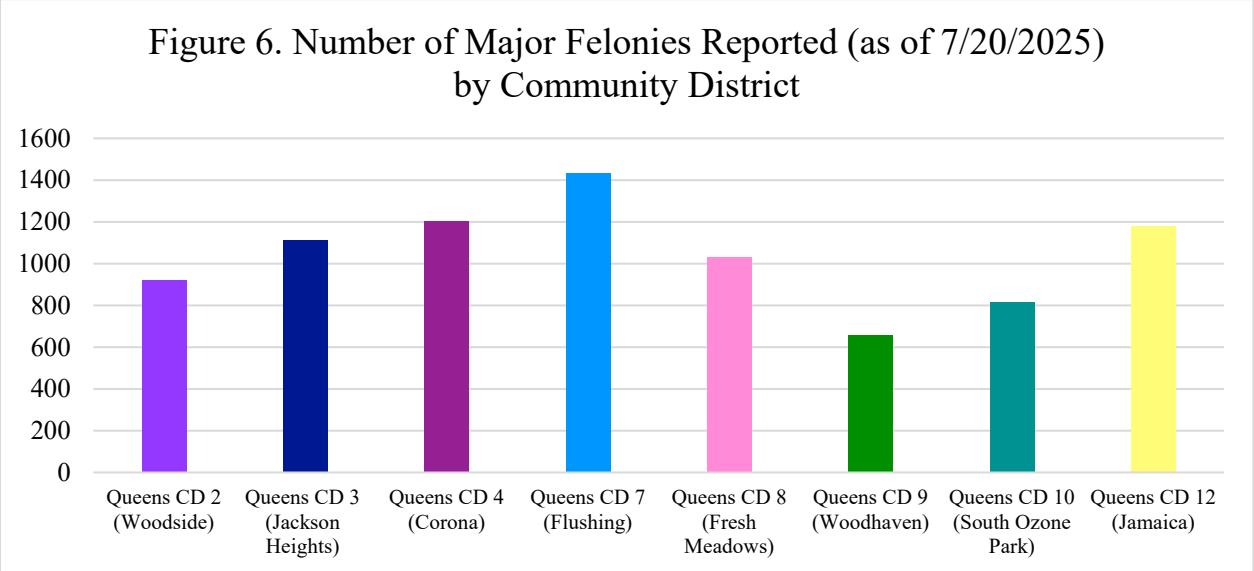
In NYC, 43.1% of the general population receives health insurance from a private entity, while 16.1% are insured by Medicare, 25.0% are insured by Medicaid, and 4.2% receive insurance through another program such as the U.S. Department of Health and Human Services Indian Health Service (IHS) or the U.S. Department of Veterans Affairs (VA).[9] The proportion of residents receiving private insurance coverage in FHMC's PSA varies by neighborhood—while between 45.5% and 55.2% of residents in Queens CD 8, CD 9, CD 10, and CD 12 have private health insurance, only 32.8-36.0% of Queens CD 2, 3, 4, and 7 residents receive private health insurance coverage.[10] The Medicare-insured rates across the PSA are consistent with NYC's estimate (16.1%), ranging from 13.1% in Queens CD 8 to 17.8% in Queens CDs 9 and 10.[11] The proportion of residents receiving health care services through Medicaid in Queens CDs 2, 3, 4, and 12 closely resembles the citywide value.[12] In contrast, the Medicaid-insured rates in Queens CD 9 and Queens CD 10 (both 15.0%), as well as Queens CD 7 (23.2%) and Queens CD 8 (23.6%), are lower than the city-wide value, as shown in Figure 5.[13] Notably, Queens CDs 7, 8, 9, and 10 have significant percentages of foreign-born residents, potentially indicating that the low Medicaid-insured rates in these neighborhoods may result from low-income households not having access to Medicaid due to their immigration status. Public health scholars have identified immigration status as a significant barrier to Medicaid eligibility and enrollment for undocumented individuals, arguing that expanding Medicaid to cover undocumented immigrants would serve as an evidence-based approach to improving population health.[14]

[9] New York City Community Health Survey, DOHMH, 2018.
[10] New York City Community Health Survey, DOHMH, 2018.
[11] New York City Community Health Survey, DOHMH, 2018.
[12] New York City Community Health Survey, DOHMH, 2018.
[13] New York City Community Health Survey, DOHMH, 2018.
[14] Bustamante, A. V., Chowdhury, M., & Ortega, A. N. (2025). Expanding Medicaid for Undocumented Immigrants: A Path to Better Coverage and Population Health. *American journal of public health*, *115*(6), 830–832. https://doi.org/10.2105/AJPH.2025.308131



Crime and Incarceration Rates

Crime rates in NYC are reported by Precinct. As of July 20, 2025, the number of major felony offenses (including murder and non-negligent manslaughter, rape, robbery, felony assault, burglary, grand larceny, and grand larceny of a motor vehicle) reported by Precinct in the PSA range from 658 in the 102nd Precinct (Queens CD 9) to 1,433 in the 109th Precinct (Queens CD 7), as depicted in Figure 6.[15]

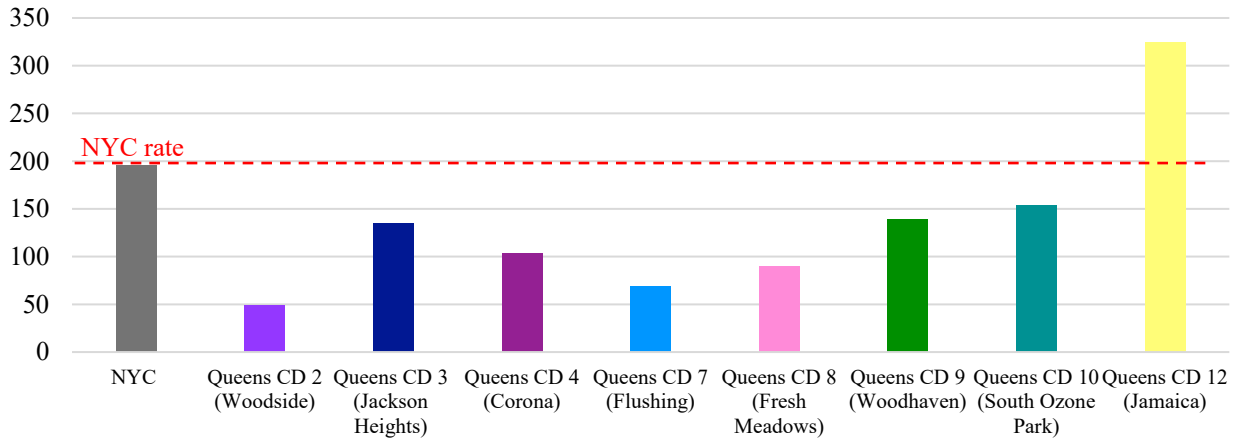


Incarceration rates for FHMC's primary service area vary considerably by Community District (Figure 7). Residents in Queens CD 12 experience the highest incarceration rates in the PSA by a wide margin at 324 cases per 100,000 residents, which is more than double that of Queens

[15] New York Police Department, 2025.

overall (136 cases per 100,000 residents) and greater than that of NYC (196 cases per 100,000 residents). While 9.3% of NYC adults report a history of criminal justice involvement (defined as any time spent in a juvenile or adult correctional facility, jail, prison, or detention center, or any time spent under probation or parole supervision), 6.5-8.1% of PSA residents report a history of criminal justice involvement.[16]

Figure 7. Incarceration Rate per 100,000 Adults Ages 16 and Older by Community District

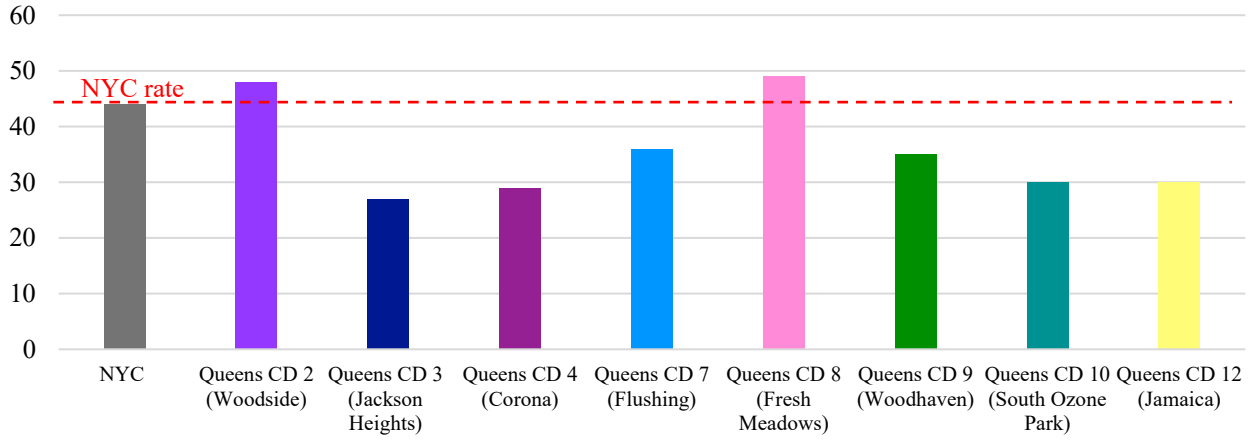


Education

High levels of educational attainment correlate with a number of positive health outcomes, including lower chronic disease rates and longer life expectancy.[17] Except for Queens CD 2 and Queens CD 8, where 48% and 49% of residents have post-secondary education, respectively, the post-secondary education rates throughout FHMC's PSA are considerably lower than those of NYC as a whole (27-36% in the PSA vs. 44% in NYC), particularly in the cases of Queens CDs 3, 4, 10, and 12, where the post-secondary education rate is under or equal to 30% (Figure 8).

[16] New York City Community Health Survey, DOHMH, 2018.
[17] Hummer RA, Hernandez EM. The Effect of Educational Attainment on Adult Mortality in the United States. *Popul Bull.* 2013;68(1):1-16.

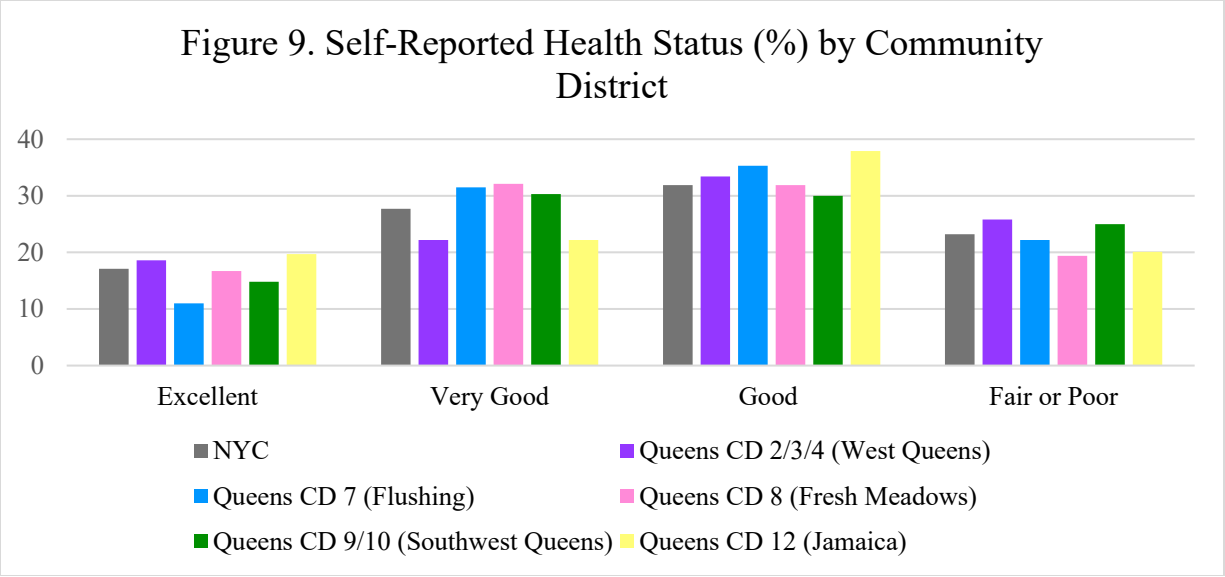
Figure 8. Percentage of Adults Over Age 25 Who Have Completed Post-Secondary Education by Community District



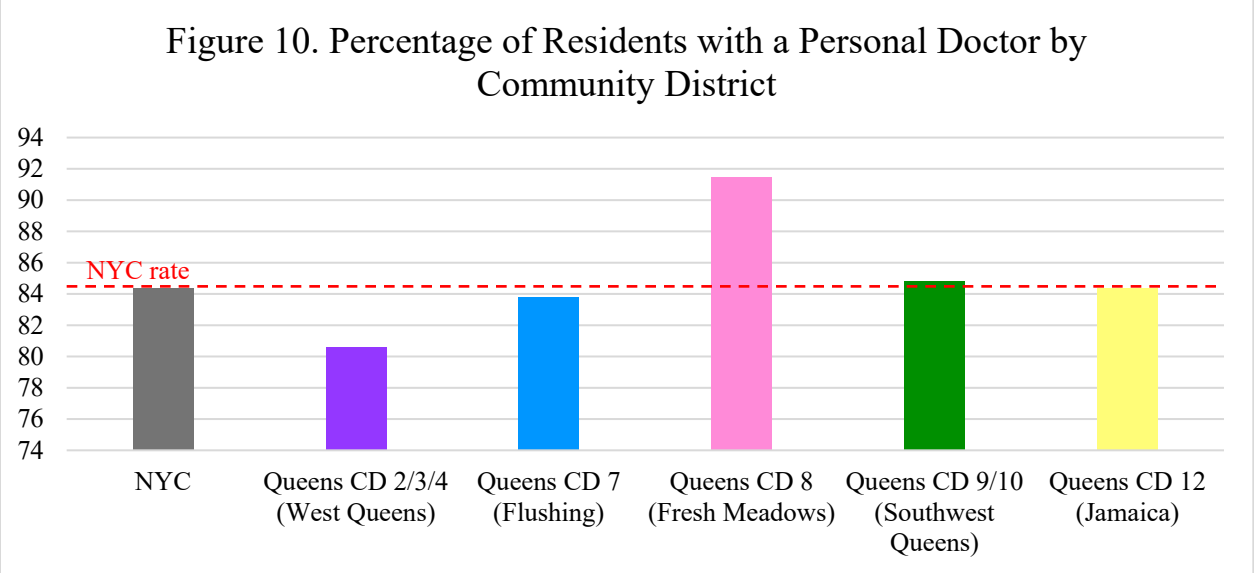
Health

Self-reported health can be a time-dependent predictor of mortality, with those reporting good health having longer lifespans on average than those with poor health.[18] In Queens CDs 7, 8, and 12, between 77.8% and 80.6% of residents who participated in the NYC Community Health Survey self-reported to be in "excellent," "very good," or "good" health, which is higher when compared to NYC overall (76.8%).[19] Additionally, 74.2% of residents in Queens CDs 2, 3, and 4, and 75.5% of residents in Queens CD 9 and Queens CD 10, self-report "good" or better health status.[20] These patterns are depicted in Figure 9.

[18] Lorem, G., Cook, S., Leon, D. A., Emaus, N., & Schirmer, H. (2020). Self-reported health as a predictor of mortality: A cohort study of its relation to other health measurements and observation time. *Scientific reports*, *10*(1), 4886. https://doi.org/10.1038/s41598-020-61603-0
[19] New York City Community Health Survey, DOHMH, 2018.
[20] New York City Community Health Survey, DOHMH, 2018.



One strong indicator of preventive care access is having a personal doctor—in NYC, 84.4% of residents report having a personal doctor, while the remaining 15.6% of residents do not.[21] While the proportions of residents with personal doctors surpass the citywide rate in Queens CD 8 and broadly resemble the citywide rate in Queens CD 9, 10, and 12, the rate is lower in the region encompassing Queens CDs 2, 3, and 4 (80.6%), as well as in Queens CD 7 (83.8%).[22] These values are shown in Figure 10.



In addition to self-reported indicators of health and preventive care access, county health data snapshots are also included (where health and well-being are measured by indicators of longevity, quality of life, and environmental, clinical, social, economic, and behavioral

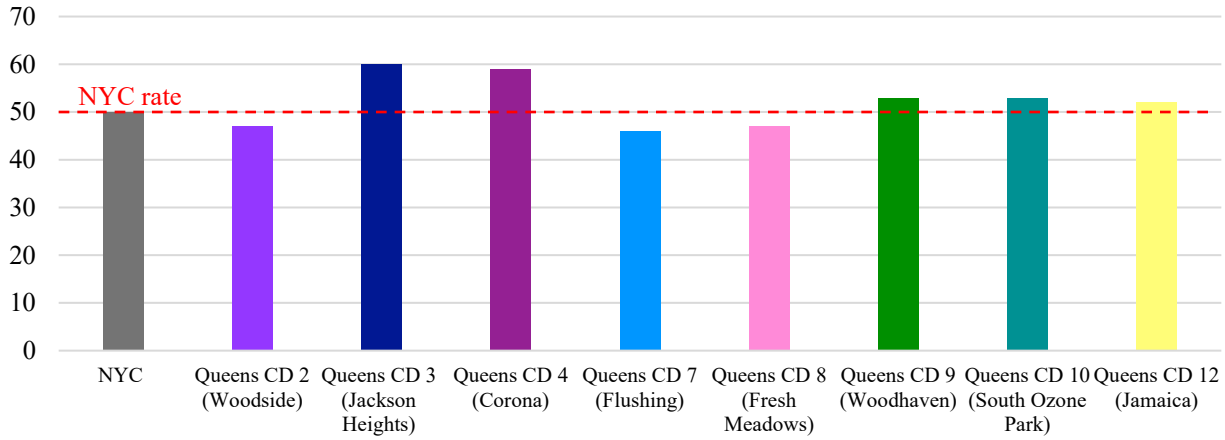
[21] New York City Community Health Survey, DOHMH, 2018.
[22] New York City Community Health Survey, DOHMH, 2018.

conditions that influence health). Of the 62 counties in NYS, Queens County (home to all CDs in the PSA) is ranked above average for population health and well-being, while it is ranked below average for community conditions, a term which encompasses health infrastructure, the physical environment, and social and economic factors in a given region.[23]

Housing and Employment

Access to affordable housing and employment opportunities with fair wages and benefits are closely associated with good health—conversely, long-term unemployment is associated with increased risk of mental illness, heart attack, and stroke,[24] while rent burden and evictions are associated with increased mortality.[25] Rent burdened households are defined as those that pay 35% or more of their income for housing, which can lead to difficulty in affording food, clothing, transportation, and health care.[26] As depicted in Figure 11, more residents are rent burdened in Queens CDs 3, 4, 9, 10, and 12 (60%, 59%, 53%, 53%, and 52% respectively) compared to all of Queens County (51%) and NYC as a whole (50%). The rent burden rates in Queens CD 2 (47%), Queens CD 7 (46%), and Queens CD 8 (47%), however, compare favorably with the citywide rate.

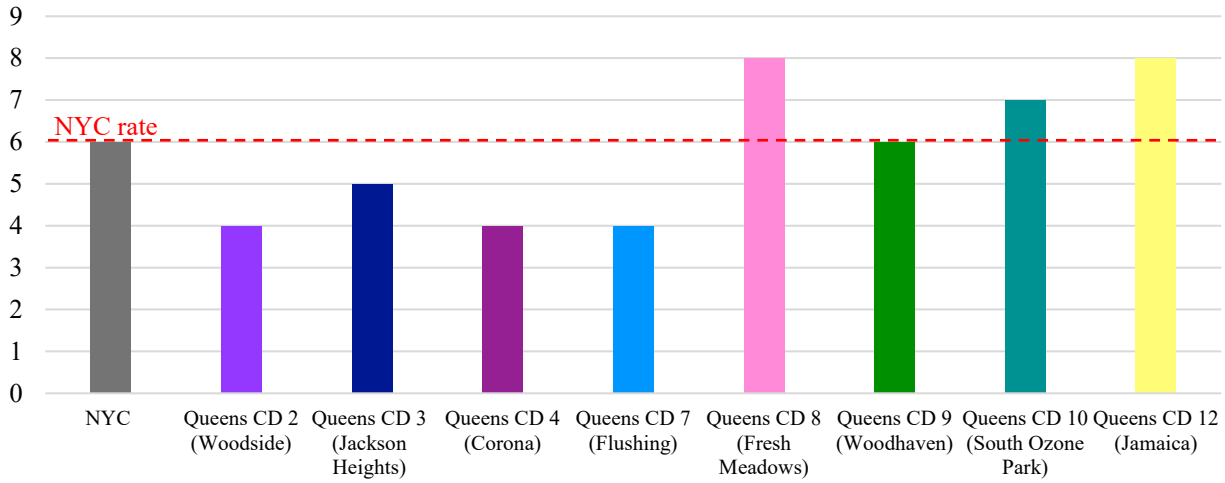
Figure 11. Percentage of Rent-Burdened Households by Community District



As shown in Figure 12, Queens CD 9's unemployment rate is comparable to the citywide average of six percent, and the unemployment rates in Queens CDs 2, 3, 4, and 7 compare favorably with the NYC rate. In contrast, Queens CD 10 has greater unemployment rates than the citywide average, and Queens CD 8 and CD 12 have the highest unemployment rate in the PSA (33% higher than the citywide average).

[23] County Health Rankings and Roadmaps, Robert Wood Johnson Foundation, 2025.
[24] Herbig, B., Dragano, N., & Angerer, P. (2013). Health in the long-term unemployed. *Deutsches Arzteblatt international*, *110*(23-24), 413–419. https://doi.org/10.3238/arztebl.2013.0413
[25] Graetz, N., Gershenson, C., Porter, S. R., Sandler, D. H., Lemmerman, E., & Desmond, M. (2024). The impacts of rent burden and eviction on mortality in the United States, 2000-2019. *Social science & medicine (1982)*, *340*, 116398. https://doi.org/10.1016/j.socscimed.2023.116398
[26] American Community Survey, United States Census Bureau, 2023.

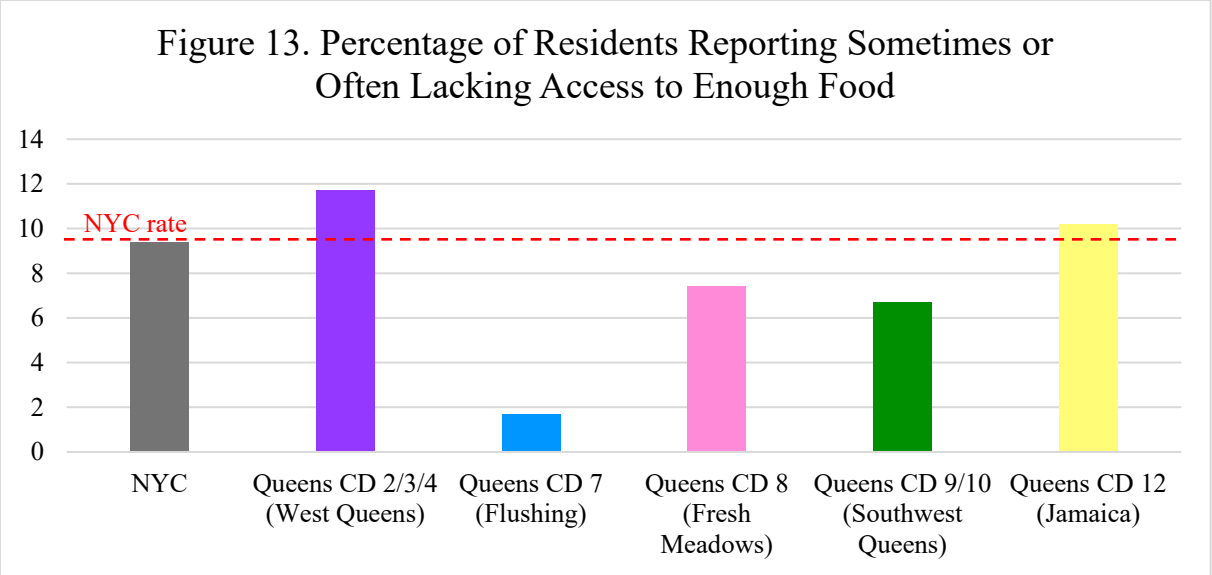
Figure 12. Unemployment Rate by Community District (%)



Nutrition

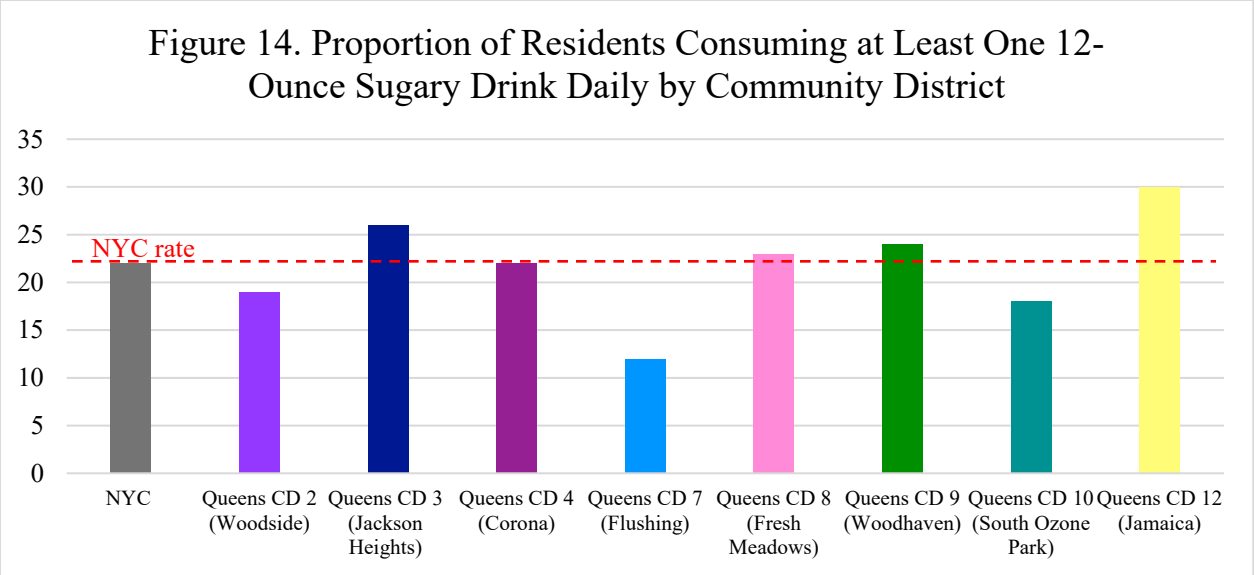
Food insecurity is defined as a household-level economic and social condition of limited or uncertain access to adequate food.[27] In NYC, 21.3% of individuals report having access to enough food but not the food of their choice, and 9.4% report "sometimes" or "often" not having access to enough food.[28] Compared to the citywide rate, the proportion of individuals lacking reliable access to the food of their choice is higher in Queens CD 12 (24.2%) and lower in the remainder of the PSA (12.5-19.8%).[29] While the percentage of individuals without reliable access to adequate food is lower than the NYC rate in Queens CD 8 (7.4%), Queens CD 9 and Queens CD 10 (6.7%), and Queens CD 7 (1.7%), the rate is higher than NYC in the region encompassing Queens CDs 2, 3, and 4 (11.7%) and in Queens CD 12 (10.2%).[30] Food insecurity is associated with elevated risk of a number of poor health outcomes, including diabetes[31]—notably, both Queens CD 3 and Queens CD 4 have elevated food insecurity rates and elevated diabetes rates compared to NYC as a whole (Figure 13).

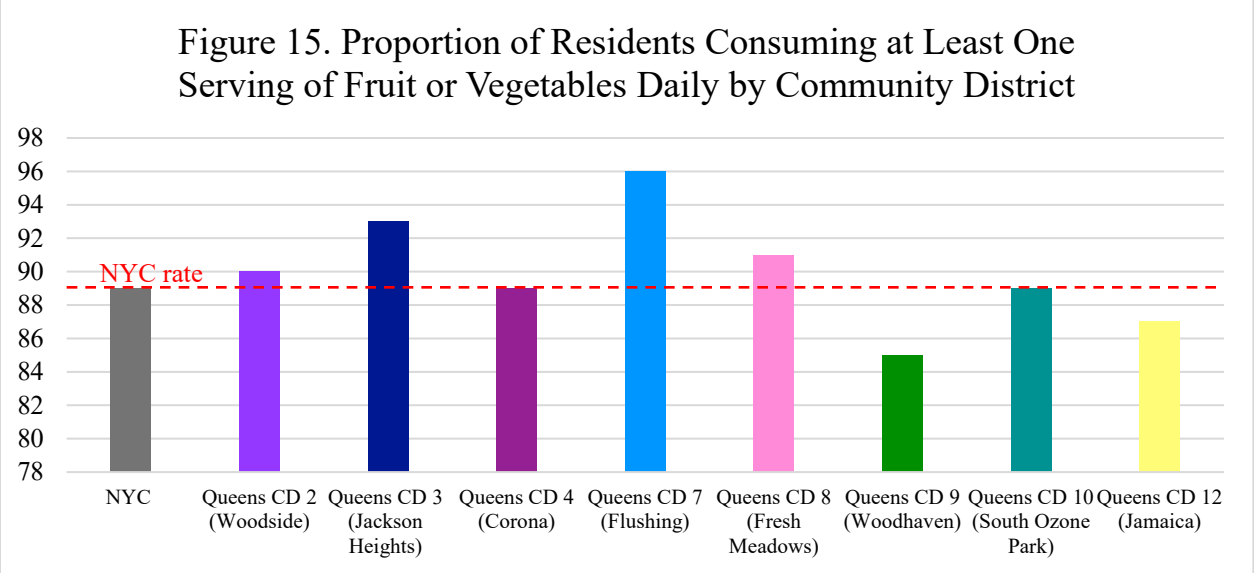
[27] U.S. Department of Agriculture, Economic Research Service. (n.d.). *Definitions of food security*.
[28] New York City Community Health Survey, DOHMH, 2018.
[29] New York City Community Health Survey, DOHMH, 2018.
[30] New York City Community Health Survey, DOHMH, 2018.
[31] Diabetes and Food Insecurity, *U.S. Centers for Disease Control and Prevention*, 2024. Accessed via https://www.cdc.gov/diabetes/healthy-eating/diabetes-food-insecurity.html



Many factors can influence an individual's food choices, including cost, geographic access, and nutritional value—these choices in turn influence overall health and can contribute to chronic disease risk. Some indicators of an individual's general access to nutritional foods include daily sugary drink consumption (a widely available and affordable energy source that can increase risk of dental problems, high blood pressure, and diabetes when consumed regularly)[32] and daily fruit and vegetable consumption (a measure of consistent access to nutrients such as vitamin C). Queens CD 3, 8, 9, and 12 all report higher rates of sugary drink consumption than NYC, and Queens CD 4's rate equals the citywide average, while the sugary drink consumption rates in Queens CD 2, Queens CD 7, and Queens CD 10 are lower than that of NYC (Figure 14). The proportion of PSA residents consuming at least one serving of vegetables daily is lower than the NYC rate in Queens CD 9 and Queens CD 12, equal to the NYC rate in Queens CD 4 and Queens CD 10, and greater than the NYC rate in Queens CDs 2, 3, 7, and 8 (Figure 15).

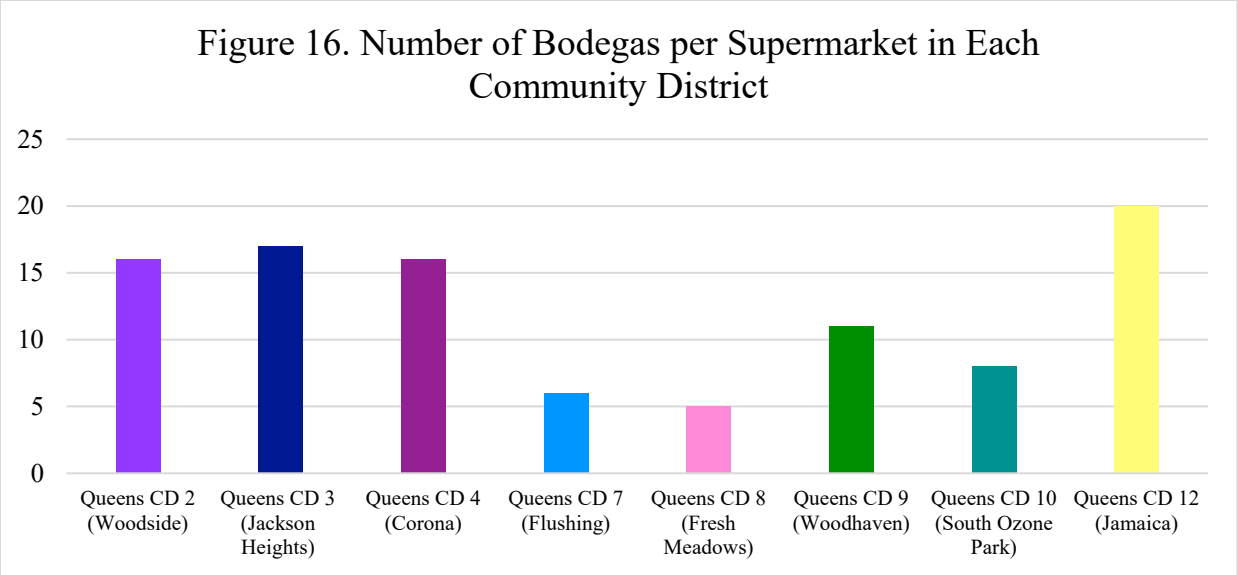
[32] Vartanian, L. R., Schwartz, M. B., & Brownell, K. D. (2007). Effects of soft drink consumption on nutrition and health: a systematic review and meta-analysis. *American journal of public health*, *97*(4), 667–675. https://doi.org/10.2105/AJPH.2005.083782





In NYC, bodegas are less likely than supermarkets to offer healthy food options to the communities they serve, making the supermarket-to-bodega ratio in a Community District a strong indicator of healthy food access on the neighborhood level. Across the city as a whole, these ratios vary from one supermarket to every three bodegas (1:3), the lowest ratio, to 1:57 at the highest, with lower ratios indicating greater access to healthy food.[33] In the PSA, Queens CD 8 has the lowest supermarket-to-bodega ratio at 1:5, followed by Queens CD 7 (1:6), Queens CD 10 (1:8), and Queens CD 9 (1:11). Queens CD 12 has the highest supermarket-to-bodega ratio in the PSA, with one supermarket for every 20 bodegas in the area (Figure 16).

[33] NYC Environment & Health Data Portal, 2022.



In the NYS DOH Prevention Agenda, nutrition encompasses breastfeeding as a critical source for infant sustenance—in the PSA, exclusive breastfeeding rates in the first five days of life range from 37.2% in Queens CD 7 to 54.9% in Queens CD 2, compared to the citywide rate of 40.4%.[34] Breastfeeding rates over time, breastfeeding duration, and linked outcomes, including infant mortality, preterm births, and low birthweight, are discussed in depth later in the document, beginning on page 54.

Physical Activity

In the PSA, the percentage of residents who reported having engaged in physical activity in the past 30 days varies by Community District. The physical activity rates in Queens CD 2 (78%), Queens CD 8 (75%), Queens CD 9 (76%), Queens CD 10 (75%), and Queens CD 12 (76%) compare favorably with the citywide value of 73%, with Queens CD 3's rate close behind (72%). Queens CD 4 and Queens CD 7 have lower physical activity rates than the rest of the PSA, with 61% and 60% of residents engaging in physical activity in the past 30 days, respectively. Regular physical activity is associated with a wide range of health benefits, including reduced risk of cardiovascular disease, type 2 diabetes, serious outcomes from infectious diseases, and some forms of cancer.[35]

Smoking

Current tobacco smoking rates in the PSA range from 9.3% in Queens CDs 2, 3, and 4 to 13.7% in Queens CD 7, compared to the citywide rate of 12.8%.[36] Current and former smoking rates over time, as well as smoking intensity, age of smoking initiation, and youth and e-cigarette use, are discussed in depth later in the document, beginning on page 47.

[34] Li W, Castro A, Gurung S, Maduro G, Sun Y, Seil K, and Van Wye G. Summary of Vital Statistics, 2022. New York, NY: Bureau of Vital Statistics, NYC DOHMH.

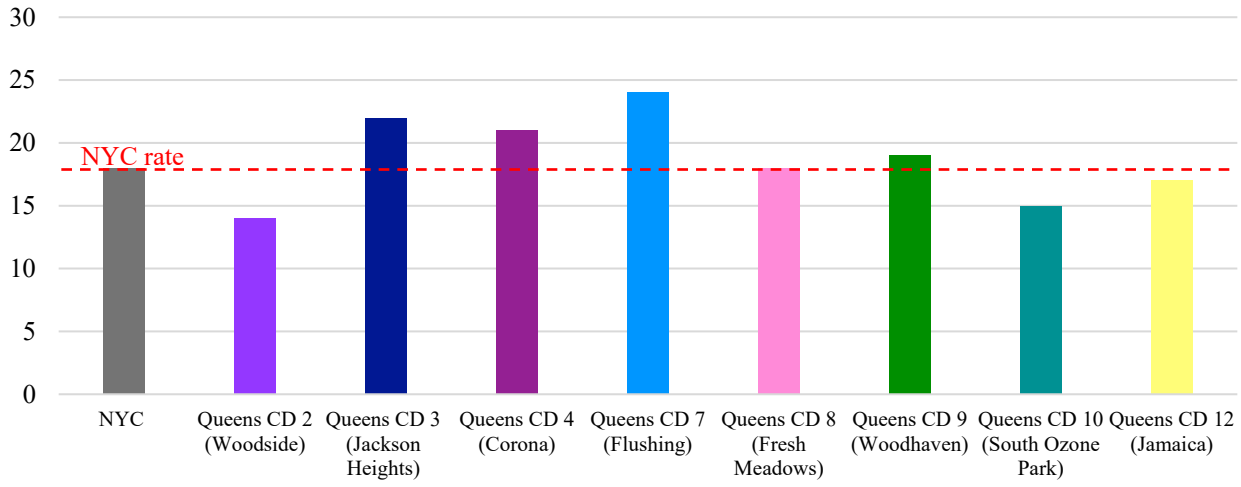
[35] Benefits of Physical Activity. *Centers for Disease Control and Prevention*, 2024.

[36] NYC Community Health Survey, DOHMH, 2018.

Social and Economic Stressors

Most of the PSA has experienced social and economic stressors. Poverty and its effects on health, particularly on mental/behavioral health and nutrition access, are of significance in the Community Districts served by FHMC. Living in high-poverty neighborhoods can severely limit healthy lifestyle options for residents and make it difficult to access quality health care and resources that promote health. Poverty rates for four of the seven FHMC PSA Community Districts (Queens CDs 3, 4, 7, 8, and 9) equal or exceed the rates in Queens County (17%), as well as NYC as a whole (18%) (Figure 17).

Figure 17. Poverty Rate by Community District (%)



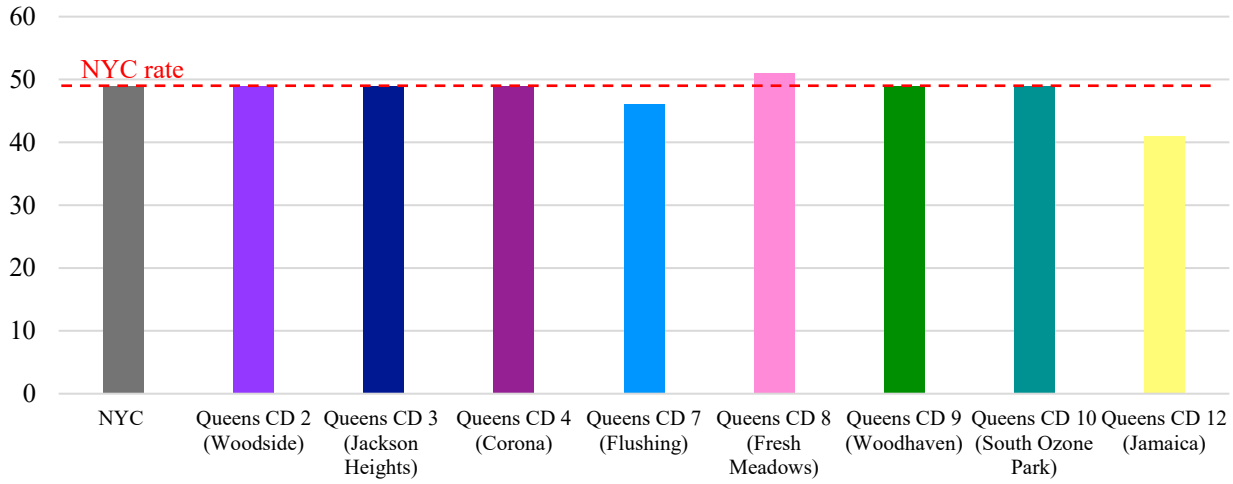
Vaccinations

Vaccinations dramatically decrease the risk of contracting or becoming seriously ill due to infectious disease among those who receive them; furthermore, high vaccination rates lower the risk of transmission to community members at elevated risk of infection (such as infants, elderly individuals, and those with compromised immune systems) through herd immunity. Vaccination rates are also indicators of preventive health care service utilization and community trust in the public health system. The human papillomavirus (HPV) vaccine, which protects against cancers caused by HPV, and the flu vaccine are used as proxies to illustrate vaccination rates in FHMC's service area. Across NYC, an estimated 77% of teens between 13 and 17 have received all recommended doses of the HPV vaccine. While the HPV vaccination rates in Queens CD 7 (85%) and Queens CD 12 (83%) exceed the citywide rate, and Queens CD 3 and Queens CD 4 are two of only four CDs citywide with a near-perfect >99% HPV vaccination rate, the rates in Queens CD 9 (74%), Queens CD 8 (67%), Queens CD 2 (67%), and Queens CD 10 (64%) are less favorable.

The majority of the PSA's annual flu vaccination rates resemble the city-wide rate of 49%, as depicted in Figure 12. However, two Community Districts in the PSA have lower rates when compared to citywide rates—Queens CD 7's annual flu vaccination rate is 46% and Queens CD 12's rate is 41% (Figure 18). Overall, the PSA's flu vaccination rates vary by Community

District, with additional efforts to promote flu vaccinations needed in Queens CDs 7 and 12 in particular.

Figure 18. Flu Vaccination Rates by Community District



The social determinants of health (SDH) discussed above fall into five major domains: (1) Economic stability, encompassing factors such as poverty, rent-burden, and unemployment; (2) Education access and quality, encompassing factors such as high school graduation rates, drop-out rates, and postsecondary educational attainment; (3) Healthcare access and quality, encompassing factors such as insurance coverage, affordability of care, and access to preventive care like vaccinations; (4) Neighborhood and built environment, encompassing factors such as access to outdoor spaces, transportation, availability of healthy food sources, and neighborhood safety; and (5) Social community context, encompassing factors such as race, ethnicity, immigration status, and crime and incarceration rates.[37] All these factors greatly impact the population health of the PSA, as illustrated through the health outcomes depicted in the following section.

Health Outcomes

Adult Obesity

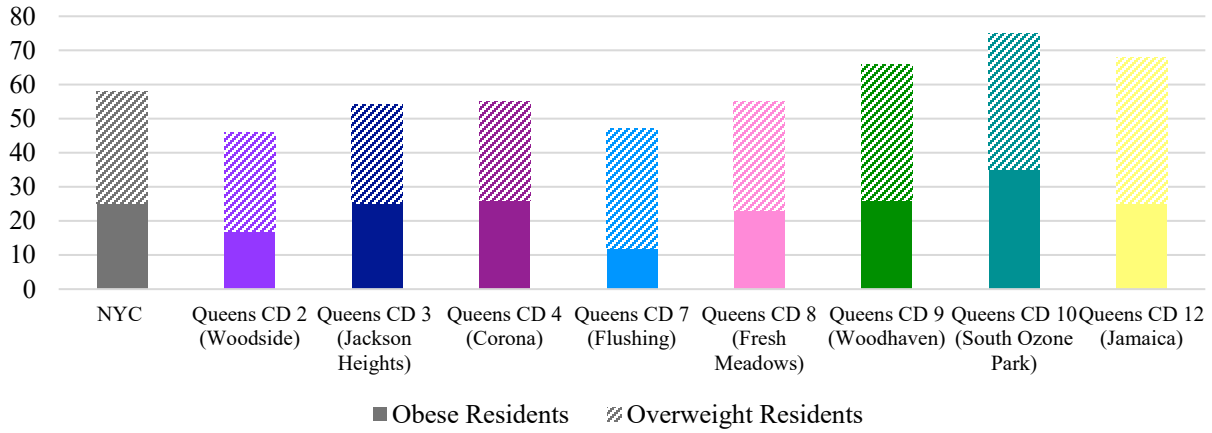
Individuals with a Body Mass Index (BMI) between 25.0 and 29.9 are classified as overweight but not obese. In the U.S., 30.7% of adults were classified as overweight between 2017 and 2018.[38] In NYC, that percentage is higher than the national rate, with 33.2% of adults that fall into this weight category, as depicted in Figure 19.[39] While the percentage of overweight but not obese people in Queens CDs 2, 3, 4, and 8 compares favorably with that of NYC, the percentage in the other neighborhoods in FHMC's PSA exceed that of NYC: 35.4% in Queens CD 7

[37] Social Determinants of Health, Healthy People 2030, 2025. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health
[38] Overweight and Obesity Statistics, National Institute of Diabetes and Digestive and Kidney Diseases, 2017-2018.
[39] New York City Community Health Survey, DOHMH, 2018.

(Flushing and Whitestone), 39.7% in Queens CD 9 (Kew Gardens and Woodhaven) and Queens CD 10 (South Ozone Park and Howard Beach), and 43.3% in Queens CD 12 (Jamaica and Hollis).[40]

Individuals with a BMI of 30.0 or greater are classified as obese, with 42.4% of U.S. adults in this category.[41] The adult obesity rate in Queens CD 4 and Queens CD 9 is 26%, higher than all of Queens (24%) and NYC (25%). Queens CD 3, Queens CD 8, and Queens CD 12 rates resemble the citywide rate, while Queens CD 2 (17%) and Queens CD 7 (12%) compare favorably with the citywide adult obesity rate. The highest adult obesity rate in the PSA is in Queens CD 10 (35%), a rate that is 46% greater than in Queens overall (24%). Figure 19 depicts the PSA's overweight and obesity rates by Community District.

Figure 19. Percentage of Overweight and Obese Residents by Community District

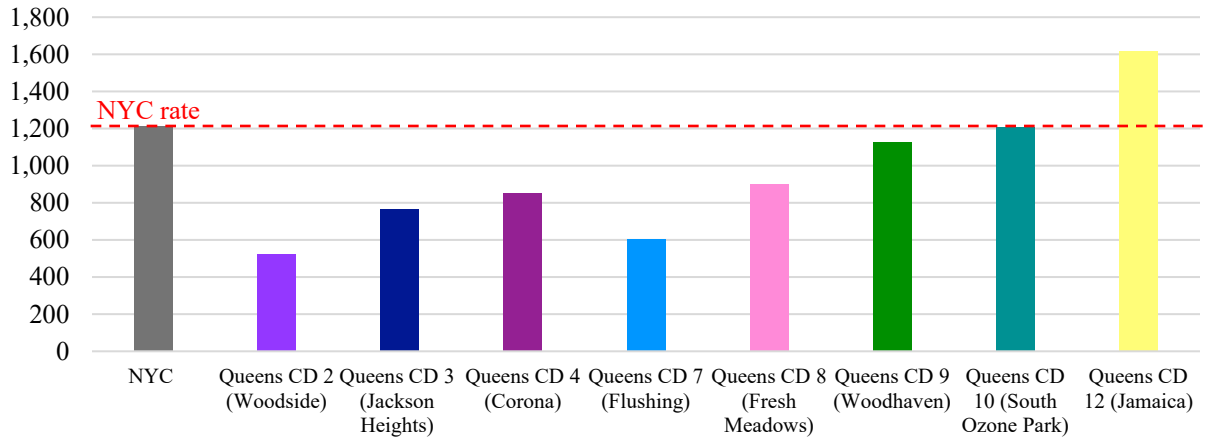


Avoidable Hospitalizations

The rate of avoidable hospitalizations (hospital visits that could have been prevented with timely access to outpatient preventive care) among adults in Queens CD 10 is comparable to that of NYC (1,213 per 100,000 people), while Queens CD 9 has a rate exceeding Queens County (997 per 100,000 people) but lower than NYC. Queens CD 12 has a much higher avoidable hospitalization rate than NYC at 1,619 per 100,000 people—to contrast, the remainder of the PSA has lower rates than the citywide and Queens-specific estimates, ranging from 523 per 100,000 people in Queens CD 2 to 901 per 100,000 people in Queens CD 8. The CD-specific hospitalization rates for the PSA are depicted in Figure 20.

[40] New York City Community Health Survey, DOHMH, 2018.
[41] Overweight and Obesity Statistics, National Institute of Diabetes and Digestive and Kidney Diseases, 2017-2018.

Figure 20. Avoidable Hospitalization Rates (per 100,000 people) by Community District



Child Health

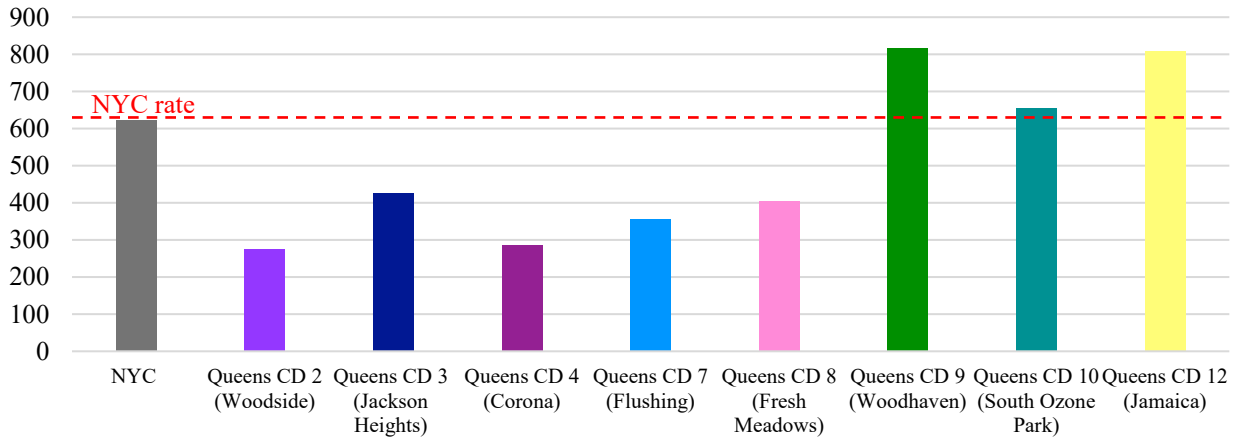
Several indicators are used here to illustrate the state of children's health in FHMC's PSA: obesity and asthma rates, avoidable hospitalizations, and infant mortality rate. Obesity in children and teens is calculated by percentile. Children falling within the 95th percentile or higher are categorized as obese, with 19.3% of U.S. children and adolescents falling within this category.[42] In NYC, 21% of public-school children in grades K-8 are classified as obese. The PSA's childhood obesity rate in Queens CD 10 equals the NYC rate, while the Queens CD 4, Queens CD 9, and Queens CD 12 rates are higher than the city-wide rates at 24%. The Queens CD 2, Queens CD 7, and Queens CD 8 rates are lower than the city-wide rates at 20%, 17%, and 17%, respectively. Queens CD 3's childhood obesity rate of 26% is the highest in the PSA, more than five times greater than the lowest CD-specific rate in the city (5% in Manhattan's Financial District).

The current childhood asthma rate in Queens County is 4.4%, lower than the city-wide prevalence rate of 7.0%.[43] The asthma hospitalization rate for children ages 0-17 years is higher in NYC when compared to NYS overall (20.1 cases per 1,000 children vs. 19.4 cases per 1,000 children), and Queens County (12.5 cases per 1,000 children).[44]

"Avoidable hospitalizations" are hospital visits that could have been prevented with timely access to outpatient preventive care. Among children ages four years and under, three of the eight CDs in the PSA (Queens CDs 9, 10, and 12) have higher avoidable hospitalization rates than the city and Queens County, as illustrated in Figure 21: NYC (623 per 100,000) and Queens (461 per 100,000). The remaining PSA Community Districts have lower rates, ranging from 274 per 100,000 in Queens CD 2 to 425 per 100,000 in Queens CD 3.

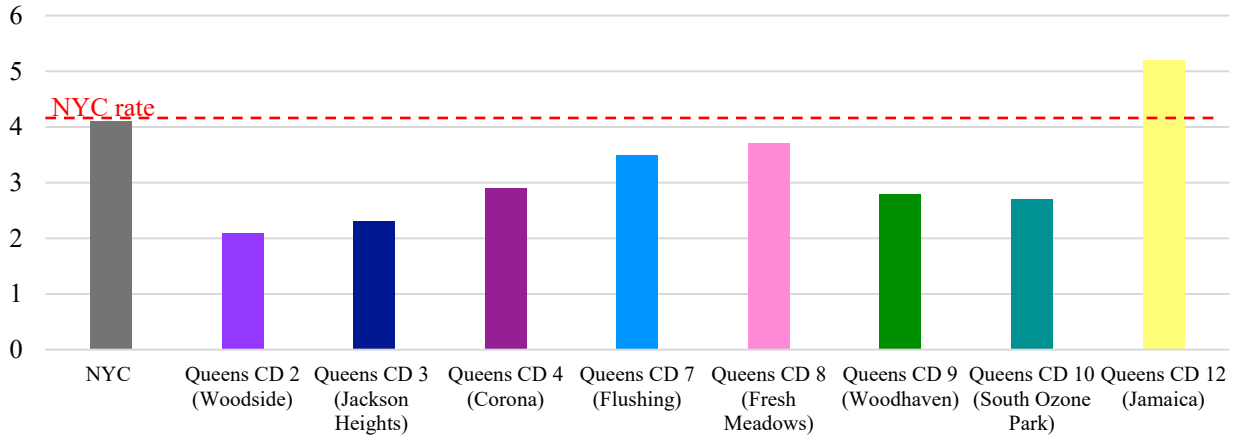
[42] Overweight and Obesity Statistics, National Institute of Diabetes and Digestive and Kidney Diseases, 2021.
[43] NYC Child Health Data, 2015.
[44] New York State Community Health Indicator Reports, NYS Department of Health, 2024.

Figure 21. Avoidable Hospitalizations (per 100,000) in Children Age 0-4 by Community District



Finally, the city-wide infant mortality rate, defined as the number of deaths in the first year of life per live births in the course of a year, is 4.0 deaths per 1,000 live births, which is lower than the U.S. rate of 5.6 deaths per 1,000 live births.[45,46] The infant mortality rates in the PSA compare favorably with the city-wide estimate in all Community Districts except Queens CD 12, where the infant mortality rate of 5.2 deaths per 1,000 live births is 30% greater than the NYC rate (Figure 22).[47]

Figure 22. Infant Mortality (per 1,000 Live Births) by Community District



[45] Infant Mortality, NYC Health, 2021.
[46] Maternal Infant Death, Infant Mortality, CDC, 2024.
[47] Infant Mortality, NYC Health, 2021

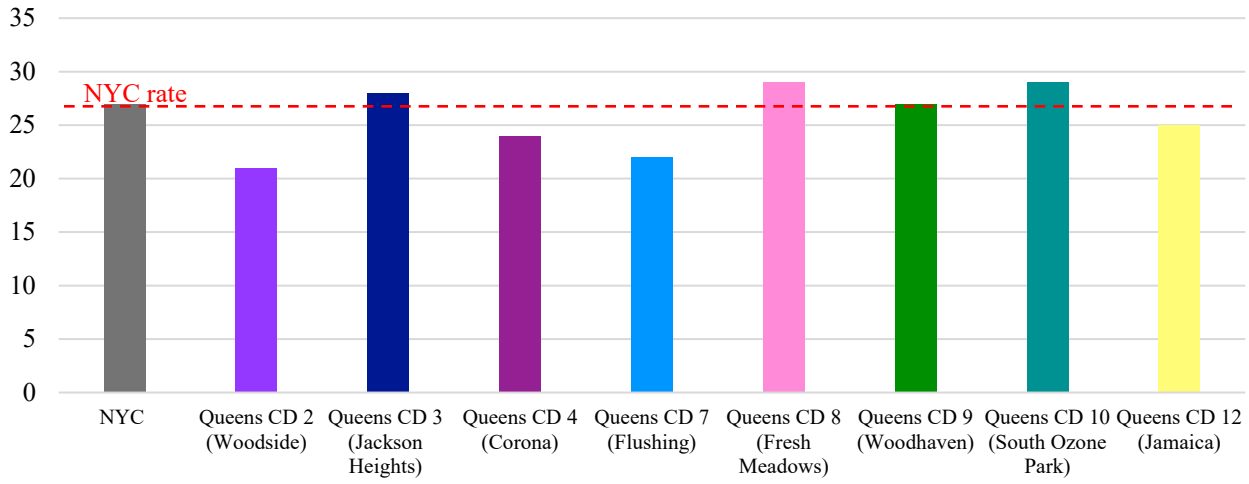
Chronic Disease

According to the Centers for Disease Control and Prevention (CDC), chronic diseases are defined as conditions that last one year or more, require ongoing medical attention, and/or limit a person's activities of daily living (e.g., heart disease, cancer, stroke, diabetes, chronic lung disease, etc.).[48] Sixty percent (60%) of adults in the U.S. have a chronic disease, and four in 10 adults have two or more.[49]

While 12% of NYC adults have diabetes, the adult diabetes rate in the PSA varies by Community District. In Queens CD 9 and Queens CD 4, 14% of adults have diabetes, and in Queens CD 3, Queens CD 10, and Queens CD 12, the rate is higher at 16%. However, the adult diabetes rate is lower than the city-wide estimate in Queens CD 2 (10%) and Queens CD 7 (9%), and equal to the NYC value in Queens CD 8 (12%). Diabetes is the fourth leading cause of premature death in Queens CD 10 and Queens CD 12, and the fifth leading cause of premature death in Queens CD 8 and Queens CD 9.

Four of the eight CDs in FHMC's PSA have hypertension rates that compare favorably with the NYC rate of 27%, ranging from 21% in Queens CD 2 to 25% in Queens CD 12 (Figure 23). Queens CD 9's hypertension rate equals the city-wide estimate, while the rates in Queens CD 3 (28%), Queens CD 8 (29%), and Queens CD 10 (29%) are greater than the NYC rate.

Figure 23. Hypertension Rates by Community District (%)

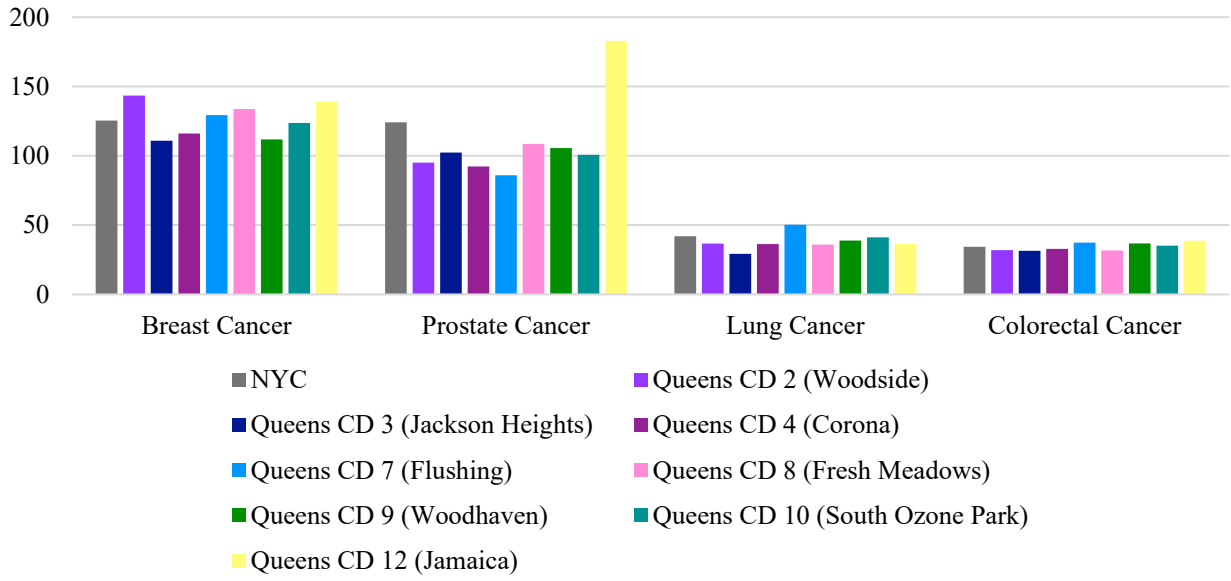


The average annual case rate for cancer in any form in NYC is 418.6 cases per 100,000 people, and the borough-specific value for Queens is 399.2 cases per 100,000 people.[50] The most common types of cancer in NYC are breast cancer (125.4 cases per 100,000 people), prostate

[48] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion: About Chronic Diseases.
[49]Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion: About Chronic Diseases.
[50] New York State Cancer Registry 2017-2021, New York State Department of Health, 2023.

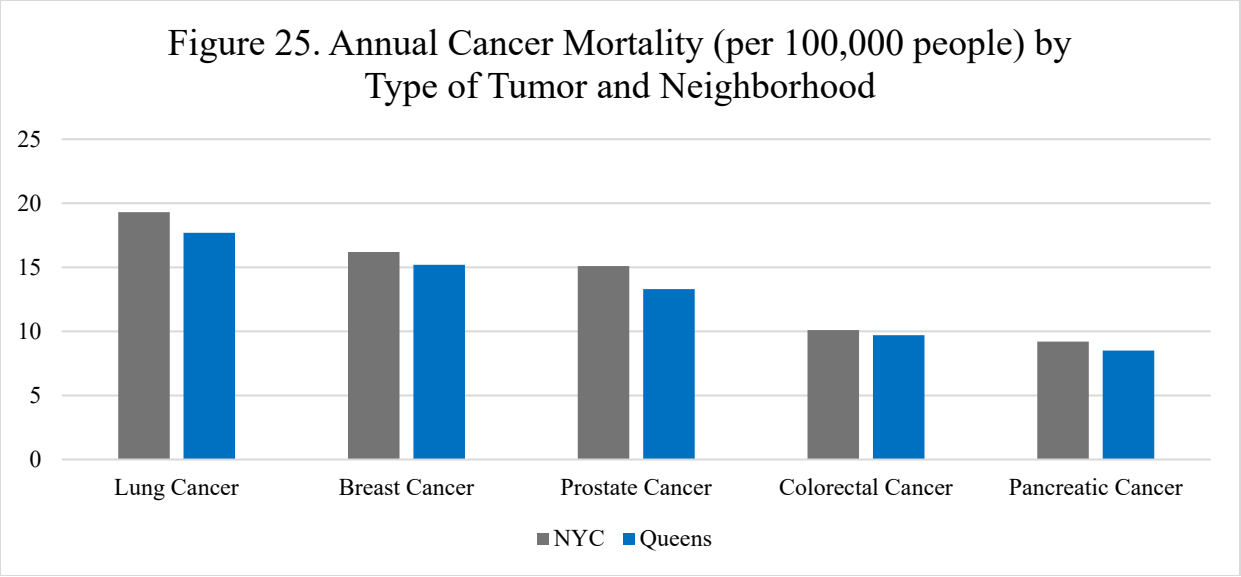
cancer (124.1 cases per 100,000 people), lung and bronchus cancer (42.0 cases per 100,000 people), and colorectal cancer (34.3 cases per 100,000 people).[51] The overall cancer rate in Queens CD 2 (408.7 cases per 100,000 people), Queens CD 7 (407.9 cases per 100,000 people) Queens CD 9 (400.6 cases per 100,000 people), Queens CD 10 (405.9 cases per 100,000 people), and Queens CD 12 (439.5 cases per 100,000 people) all exceed that of Queens to varying degrees—however, the cancer rates in Queens CD 3, Queens CD 4, and Queens CD 8 are the most favorable Community District-specific rates in the Borough at 362.7, 371.4, and 386.7 cases per 100,000 people, respectively.[52] The PSA's annual cancer incidence by type of tumor and Community District is shown in Figure 24.

Figure 24. Annual Cancer Incidence (per 100,000 people) by Type of Tumor and Community District



The most significant diagnoses contributing to cancer-related death in NYC are as follows: lung cancer (19.3 deaths per 100,000 population), breast cancer (16.0 deaths per 100,000 population), prostate cancer (13.4 deaths per 100,000 population), colon cancer (10.4 deaths per 100,000 population), and pancreatic cancer (10.0 deaths per 100,000 population).[53] The death rates for specific types of cancer in the PSA vary by Community District,[54] but cancer is among the top two leading causes of premature death in all Community Districts within FHMC's PSA, alongside heart disease. Among the top five types of cancer in Queens County, the rates of which are documented in the NYC Health Mortality Report (2021), the mortality rates are highest for lung cancer, as is the case in NYC and nationwide. City-wide and County-specific annual cancer mortality by type of tumor is shown in Figure 25.

[51] New York State Cancer Registry 2017-2021, New York State Department of Health, 2023.
[52] New York State Cancer Registry 2017-2021, New York State Department of Health, 2023.
[53] Mortality, NYC Health, 2021.
[54] Mortality, NYC Health, 2021.

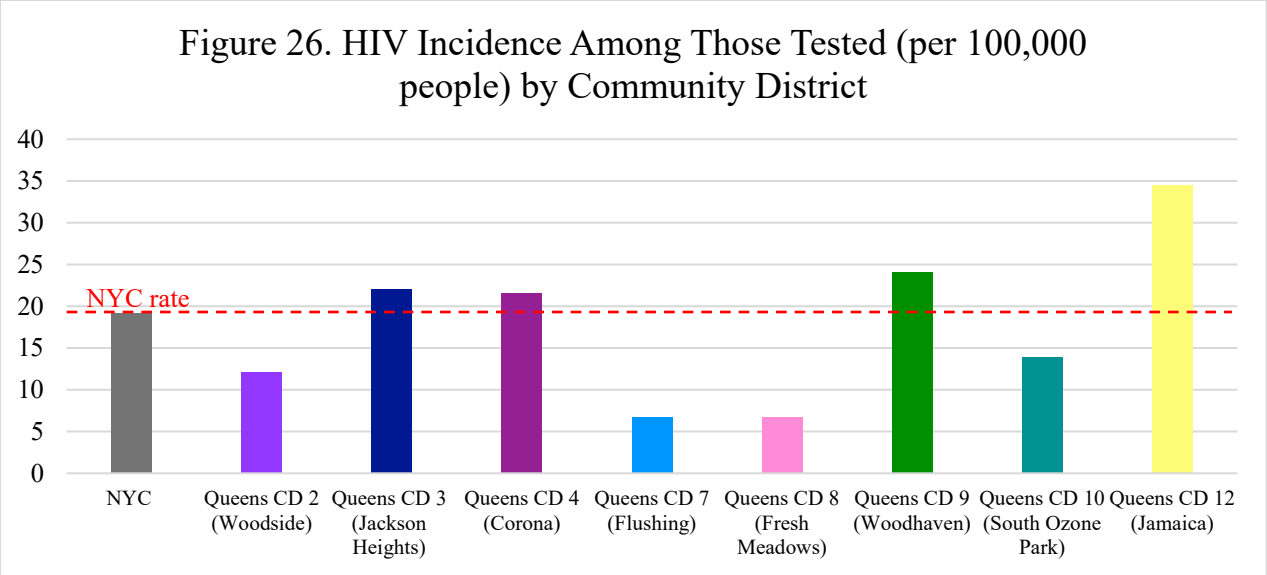


Some forms of cancer, including colorectal cancer, can be prevented or detected early through regular screenings—the U.S. Preventive Services Task Force recommends that adults ages 45-75 years old should be screened for colorectal cancer, with screenings provided for those over the age of 75 on a case-by-case basis.[55] Colorectal cancer screening rates, incidence, stage of diagnosis, survival, and mortality are discussed in depth later in the document, beginning on page 56.

Human Immunodeficiency Virus (HIV)

The incidence of Human Immunodeficiency Virus (HIV) is 19.2 new diagnoses among those tested per 100,000 people in NYC, with a Queens-specific incidence of 13.9 per 100,000 people. These rates are both higher than the U.S. incidence rate of 11.3 per 100,000.[56] The HIV incidence in Queens CDs 2, 7, 8 and 10 compares favorably with the Queens and citywide estimates, while the HIV incidence in Queens CDs 3, 4, 9 and 12 exceeds the Borough-specific and citywide rates (Figure 26). The CD-specific HIV incidence rates in the PSA are shown in Figure 26. HIV testing rates also vary by neighborhood in the PSA—in Queens CDs 2, 3, 4, 9, 10, and 12, approximately 31-40% of residents have been tested for HIV in the last 12 months, while only 14.4% of Queens CD 7 residents and 15.7% of Queens CD 8 residents have been tested for HIV in the same time interval.[57] While HIV is responsible for 3.6 premature deaths (defined as death before the age of 65) per 100,000 people across NYC, it is not among the top five leading causes of premature death in FHMC's PSA.

[55] Final Recommendation Statement on Colorectal Cancer: Screening, *U.S. Preventive Services Task Force*, 2021.
[56] Key Points: HIV Incidence, U.S. Statistics, HIV.gov, 2025.
[57] New York City Community Health Survey, DOHMH, 2018.



Long-Term Effects of the COVID-19 Pandemic

Since the seven-day average daily incidence of COVID-19 infection in NYC peaked in early January 2022 (at 43,877 confirmed and probable new cases per day), the incidence of COVID-19 has dropped dramatically and has remained consistently below 2,500 new cases per day since January 2023. From January to April 2025, the seven-day average daily incidence of new cases ranged from 347 to 613 citywide.[58] As of April 24, 2025, COVID-19 was responsible for 26 hospitalizations and one death daily in NYC, marking a significant decrease from the pandemic's peak hospitalization and death rates in April 2020 (1,657 hospitalizations and 775 deaths per day).[59] These decreases in case incidence, hospitalizations, and death rates are also observed across FHMC's PSA.[60] However, the citywide COVID-19 case rate and hospitalization rate remain significantly higher among Black/African American residents and Hispanic/Latino residents when compared with non-Hispanic White and Asian/Pacific Islander residents[61]—as FHMC's PSA is home to many racial and ethnic minority communities, COVID-19 prevention and treatment efforts remain a public health priority for FHMC.

One long-term impact of COVID-19 infection is Long COVID, a condition presenting as a range of symptoms that persist for weeks, months, or years following recovery from an initial COVID-19 infection, and can worsen with physical or mental activity.[62] FHMC's community health survey defines Long COVID as current symptoms lasting three months or longer following a COVID-19 infection that were not present before infection. Long COVID is a physical or mental impairment that can limit one or more major life activities, and is therefore a recognized disability under the Americans with Disabilities Act.[63] Nationally, the CDC estimates that 6.4%

[58] NYC Health, COVID-19, 2025. https://www.nyc.gov/site/doh/covid/covid-19-main.page
[59] NYC Health, COVID-19, 2025. https://www.nyc.gov/site/doh/covid/covid-19-main.page
[60] NYC Health, COVID-19, 2025. https://www.nyc.gov/site/doh/covid/covid-19-main.page
[61] NYC Health, COVID-19, 2025. https://www.nyc.gov/site/doh/covid/covid-19-main.page
[62] NYC Health, COVID-19, 2025. https://www.nyc.gov/site/doh/covid/covid-19-main.page
[63] US Department of Health and Human Services, "Guidance on 'Long COVID' as a Disability Under the ADA, Section 504, and Section 1557, 2021.

of adults with a history of COVID-19 infection go on to develop Long COVID, while the NYS-specific estimate is lower at 5.4%.[64] Vaccination remains the most effective prevention method against both initial COVID-19 infection and Long COVID. From the start of vaccine administration in December 2020 until the NYC Health Department stopped reporting new COVID-19 vaccination data on September 15, 2023, 97% of Queens residents received at least one dose, with 88% of Queens residents completing the primary vaccine series.[65]

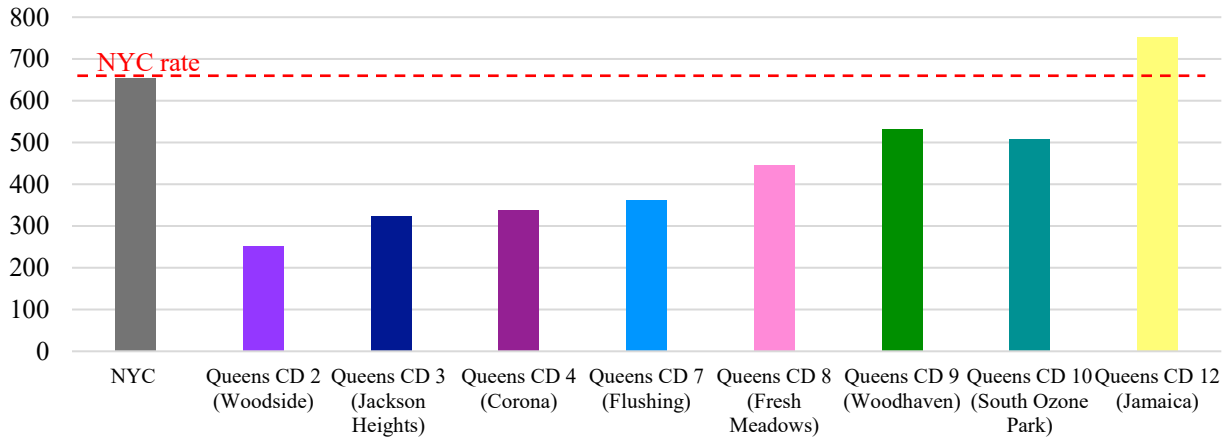
Mental Health

The prevalence rates of depression in the region encompassing Queens CDs 2, 3, 4, 7, and 12 range from 5.9% to 8.7%, and are lower than that of NYC as a whole (10.3%).[66] However, 11.2% of Queens CD 8 residents, and 11.8% of Queens CD 9 with Queens CD 10 residents report current depression.[67] People with depression have an increased risk of suicide,[68] as well as comorbid substance use disorders.[69] Suicide is the fifth leading cause of premature death in Queens CD 2, Queens CD 3, and Queens CD 10, and the fourth leading cause of premature death in Queens CD 7. Drug use is the third leading cause of premature death in all PSA Community Districts except Queens CD 3 and Queens CD 8, where it is the fourth leading cause of premature death.

The adult psychiatric hospitalization rates in Queens CD 9 and Queens CD 10 are 533 per 100,000 people and 508 per 100,000 people, respectively, which are lower than the NYC rate (655 per 100,000 people) but higher than the Queens rate (500 per 100,000 people). However, the Queens CD 12 psychiatric hospitalization rate is higher than both the Queens County and NYC rates at 753 per 100,000 people, while the psychiatric hospitalization rates in Queens CDs 2, 3, 4, 7, and 8 (ranging from 252 to 446 per 100,000 people) are lower than both Queens County and NYC rates. Figure 27 depicts the PSA's adult psychiatric hospitalization rates by Community District.

[64] Ford, N. D., Agedew, A., Dalton, A. F., Singleton, J., Perrine, C. G., & Saydah, S. (2024). Notes from the Field: Long COVID Prevalence Among Adults - United States, 2022. *MMWR. Morbidity and mortality weekly report*, *73*(6), 135–136. https://doi.org/10.15585/mmwr.mm7306a4
[65] NYC Health, COVID-19, 2025. https://www.nyc.gov/site/doh/covid/covid-19-main.page
[66] New York City Community Health Survey, DOHMH, 2017.
[67] New York City Community Health Survey, DOHMH, 2017.
[68] Angst, J., Angst, F., & Stassen, H. H. (1999). Suicide risk in patients with major depressive disorder. *The Journal of Clinical Psychiatry*, *60 Suppl 2*, 57–116.
[69] Davis, L., Uezato, A., Newell, J. M., & Frazier, E. (2008). Major depression and comorbid substance use disorders. *Current opinion in psychiatry*, *21*(1), 14–18. https://doi.org/10.1097/YCO.0b013e3282f32408

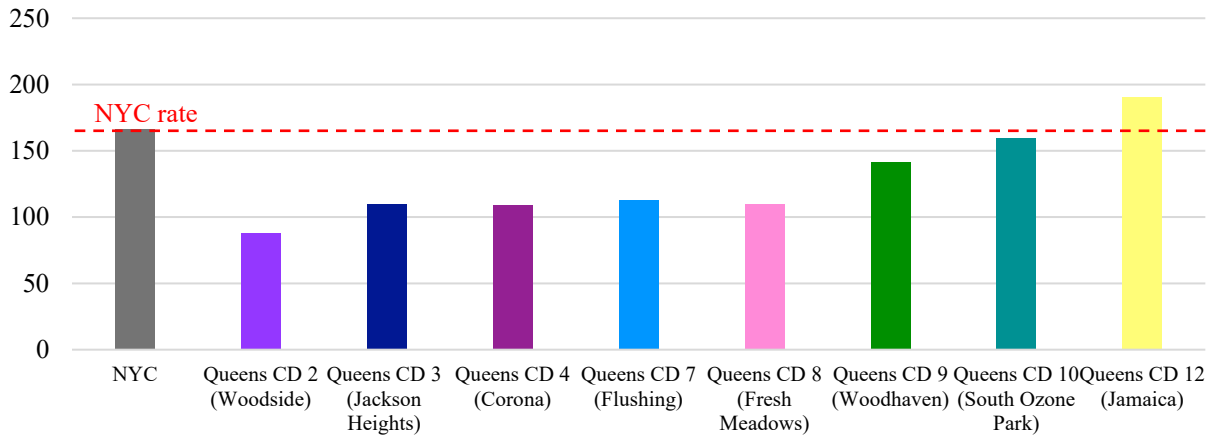
Figure 27. Adult Psychiatric Hospitalizations (per 100,000 people) by Community District



Premature Death

The premature death rates throughout the PSA are lower than or similar to the city-wide rate (166.6 deaths per 100,000 people), except for Queens CD 12, where the premature death rate of 190.5 deaths per 100,000 people is higher than that of NYC. These patterns are depicted in Figure 28.

Figure 28. Annual Premature Death Rate (per 100,000 people) by Community District



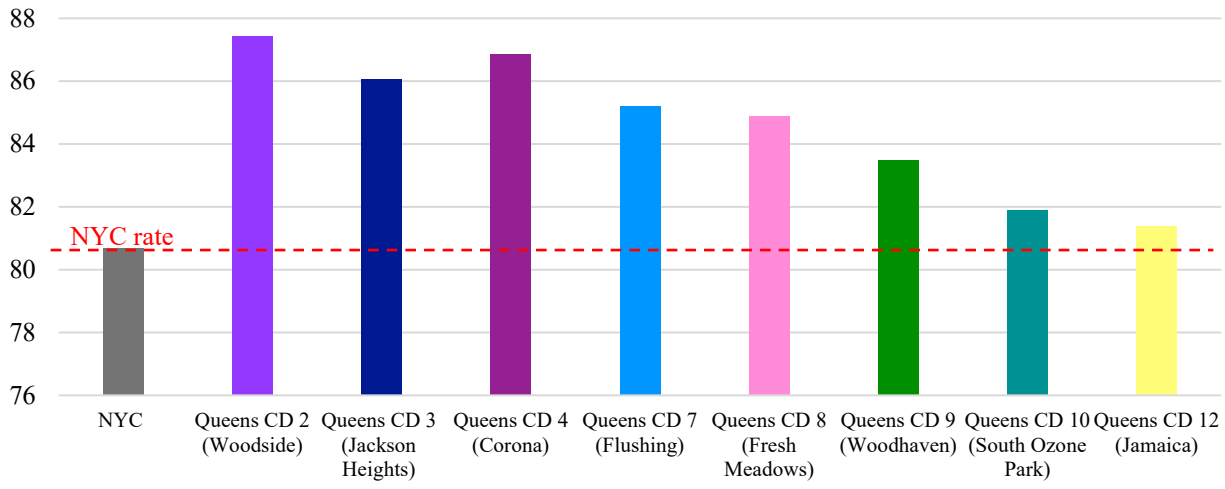
The top two leading causes of premature deaths throughout the PSA are cancer and heart disease, followed by drug use and accidents. Other common causes of premature death include suicide, stroke, and diabetes, as shown in Figure 29.

Figure 29. Leading Causes of Premature Death (per 100,000 people) by Community District

Rank	Queens CD 2	Queens CD 3	Queens CD 4	Queens CD 7	Queens CD 8	Queens CD 9	Queens CD 10	Queens CD 12
1	Cancer (29.1)	Cancer (31.4)	Cancer (36.3)	Cancer (36.5)	Cancer (28.7)	Cancer (33.6)	Cancer (38.7)	Heart Disease (48.3)
2	Heart Disease (15.6)	Heart Disease (16.7)	Heart Disease (19.3)	Heart Disease (21.3)	Heart Disease (21.5)	Heart Disease (30.4)	Heart Disease (34.6)	Cancer (41.8)
3	Drug Use (5.3)	Accidents (7.5)	Drug Use (5.8)	Drug Use (11.2)	Drug Use (8.2)	Drug Use (12)	Drug Use (11.8)	Drug Use (12.4)
4	Accidents (4.3)	Drug Use (7.4)	Accidents (5.1)	Suicide (5.5)	Suicide (4.8)	Accidents (6.9)	Diabetes (7.9)	Diabetes (8.8)
5	Suicide (3.2)	Suicide (5.0)	Stroke (3.6)	Accidents (4.3)	Diabetes (3.6)	Diabetes (5.8)	Suicide (8.0)	Stroke (6.5)

The average life expectancies in FHMC's PSA range from 81.4 years old in Queens CD 12 to 87.4 years old in Queens CD 2 (Figure 30), exceeding the citywide life expectancy of 80.7 years old and the national life expectancy rate of 78.4 years.[70,71]

Figure 30. Life Expectancy by Community District



[70] NYC DOHMH, Summary of Vital Statistics, 2021.
[71] Life Expectancy, National Center for Health Statistics, CDC, 2025.

Prenatal Care

The percentage of pregnant individuals receiving late or no prenatal care in NYC is 6.8%, but varies by Community District in the PSA, ranging from 5.3% in Queens CD 7 to 12.1% in Queens CD 12. Prenatal care is discussed in depth later in the document, beginning on page 54.

The Role of Determinants of Health in Shaping Health Outcomes in the PSA

Health outcomes are largely driven by non-clinical factors, with various models estimating that health outcomes are 55-80% driven by SDH, while only 20% of outcomes are attributable to medical care.[72] As depicted in the content above, the PSA's population disproportionately faces SDH that raise their risk of ill health effects when compared to NYC's population and consequently experiences elevated rates of a range of poor health outcomes. These SDH vary significantly by specific health factor and Community District, with some neighborhoods showing favorable rates in some metrics and less favorable rates in others—for example, Queens CD 3 and Queens CD 4 have the highest uninsured rates in the PSA, but lower incarceration rates than Queens CD 12 and lower felony counts than Queens CD 7, both of which have more favorable health insurance coverage rates. Queens CD 8 has the lowest rate of residents foregoing needed medical care among the PSA community districts and a high post-secondary education rate compared to the rest of the PSA and NYC as a whole, but also experiences a high unemployment rate and the second highest infant mortality rate among PSA community districts. Consequently, health outcomes also vary widely by metric and Community District. Among the North Queens Community Districts in the PSA (Queens CDs 2, 3, 4, and 7), which draw FHMC's greatest patient volume by zip code, Queens CD 3 has the highest hypertension rate, child avoidable hospitalization rate, and HIV incidence rate among those tested; Queens CD 4 has the greatest percentage of obese or overweight residents and the greatest adult avoidable hospitalization rate; and Queens CD 7 has the highest adult psychiatric hospitalization rate, the highest premature death rate, and the lowest life expectancy. In contrast, Queens CD 2 has more SDH indicators that are comparable to or more favorable than the citywide rates and consequently have better health outcomes and longer life expectancies than the populations in other North Queens CDs. However, even the more favorable rates in the PSA and throughout NYC need significant improvement, as the proportion of Queens residents experiencing premature death (24.2%) is still greater than the NYS DOH Prevention Agenda goal of 22.8%.[73] Improving health outcomes will require a holistic, multisector approach that strives not only to improve access to and quality of health care services but also promotes social and economic development directly benefiting the PSA's most underserved residents.

[72] Li, C., Mowery, D. L., Ma, X., Yang, R., Vurgun, U., Hwang, S., Donnelly, H. K., Bandhey, H., Akhtar, Z., Senathirajah, Y., Sadhu, E. M., Getzen, E., Freda, P. J., Long, Q., & Becich, M. J. (2024). Realizing the Potential of Social Determinants Data: A Scoping Review of Approaches for Screening, Linkage, Extraction, Analysis, and Interventions. *medRxiv: the preprint server for health sciences, 2024.02.04.24302242.* https://doi.org/10.1101/2024.02.04.24302242

[73] NYS DOH Prevention Agenda Dashboard, 2025.

COMMUNITY HEALTH SURVEY RESULTS

Background and Method

FHMC joined a multi-hospital Community Health Needs Assessment Survey Collaborative in the Spring of 2025 to learn about the main health and health-related social challenges facing residents of the Hospital's service area, including the primary service area (PSA) where most of its patients reside. The survey was translated into the 18 most common non-English languages spoken in New York State. It asked respondents to rank in order of importance 26 health conditions and social determinants of health issues that align with the 2025-2027 New York State Prevention Agenda. The survey also asked respondents to rank these 26 issues in order of satisfaction with services provided in the community.

Participating hospitals shared a common community survey with their community members in each hospital's defined service area. Responses from people who live in a hospital's service area were attributed to that hospital. Hospitals with overlapping service areas leveraged one another's outreach work to increase the total number of survey respondents.

The survey was promoted widely by FHMC. A QR code link to the electronic survey was included on flyers and posters requesting completion of the surveys. The flyers were sent to the District Managers of the local Community Planning Boards requesting their assistance in distributing the flyers to their Board Members. The Hospital also provided flyers to its network of community stakeholders, and to members of the community on the Hospital's e-mail list. Flyers and posters were also distributed in the outpatient clinics, emergency department and various other locations where members of the community are served. The link to the survey was also sent to patients via the Epic patient portal (MyChart), and it was promoted on the Hospital's social media platforms. An expanded definition of the primary service area (PSA), and the Hospital's efforts combined with those of collaborating hospitals resulted in a significant increase in the number of respondents overall and specifically in the PSA, which grew to 2,019 from 362 respondents when this survey was last done in 2022.

The following summary of survey results is from the Hospital's PSA. Responses differ somewhat by Community District (CD) within the PSA.

Survey Respondents Characteristics

Of the 2,019 PSA survey respondents, 76% responded using the English version of the survey, 20% responded using the Spanish version, 1% the Bengali version, 1% the Chinese version and small percentages in eight of the other 18 non-English languages offered. Slightly more than half did not answer the demographic questions. Of those who did answer the demographic questions, 72% were Cisgender woman (female), 27% were Cisgender man (male), and 1% were Cisgender minority. Thirty-two percent reported as Hispanic or Latino, 29% as Black or African American, 17% as White, 16% as Asian, 3% as Multi-Racial and/or Multi-Ethnic, 2% as American Indian or Alaska Native, and 1% each as Native Hawaiian or Pacific Islander, and Middle Eastern or North African. Ninety-six percent reported having health insurance, and 68% were covered by government-sponsored plans. Forty-eight percent (48%) reported being between ages 55 to 74, 30% were 35 to 54, 13% were 18 to 34, and 9% were 75 or older. See Appendix B for a table with PSA Respondent Demographics.

Health and Social Issues

In contrast to the relatively low response rate on demographic questions, most PSA respondents answered the questions about their own health. Thirty-seven percent (37%) of survey respondents reported having fair or poor physical health, and 24% reported fair or poor mental health. It is notable that the proportion of respondents reporting fair or poor physical and mental health was higher than in 2022 (29% and 14%, respectively, and much higher than it was in 2019 (27% and 12%, respectively). Thirty-four percent (34%) reported the overall health of their neighborhood as fair and six percent (6%) as poor.

Sixty-three percent (63%) reported having good, very good or excellent physical health and 76% reported good, very good or excellent mental health.

Approximately half of respondents reported on adverse Social Determinants of Health, and of those 46% reported having food insecurity and 39% reported having housing insecurity.

Respondents from the PSA ranked three (3) health and social issues as above average in importance relative to the other 23 issues but relatively below average in satisfaction with current services, thus needing attention. These are **Violence (including gun violence), Affordable housing and homelessness prevention** and **Mental health disorders (such as depression)**. In addition to these three issues, several other issues were ranked as high in importance but low in satisfaction in several of FHMC's CDs, including **Cancer, Diabetes and high blood sugar, Dental care, Stopping falls among elderly, Arthritis/disease of the joints,** and **Obesity in children and adults.**

Respondents from the PSA overall ranked 10 health and social conditions as above average in importance and above average in satisfaction with services, thus indicating that current efforts should be maintained. These **included Cancer, Dental care, Heart disease, Diabetes and high blood sugar, High blood pressure, Access to healthy/nutritious foods, Stopping falls among the elderly, Infectious diseases, Women's and maternal health care,** and **Arthritis/disease of the joints.** Satisfaction with current services varied by condition within each of the eight CDs.

PSA respondents ranked the remaining 13 health and social issues as below average in relative importance and of those, they ranked six (6) issues as relatively below average in satisfaction with services. These include **Assistance with basic needs like food, shelter, and clothing, Obesity in children and adults, Access to continuing education and job training programs, Job placement and employment support, Substance use disorder/addiction,** and **Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah**. Respondents from most CDs in the PSA also ranked these six (6) issues as relatively below average in importance but also as relatively below average in satisfaction with services.

Survey results show that the respondents in the Hospital's PSA are very concerned about a wide variety of health and social issues even those that they ranked as below average in importance. This is evidenced by the very tight range of scores indicating importance: on a scale of 1 - 5 no health or social issue was ranked under 3.62. On the same scale of 1 - 5 no issue was ranked higher than 3.21 in satisfaction with current services. These rankings indicate that the respondents believe there is a need to provide better services for all 26 health and social issues studied. See Table 1 below for Importance and Satisfaction Ratings in FHMC's PSA. See Appendix C for Importance and Satisfaction Ratings by CD within the PSA.

Table 1: Survey Importance and Satisfaction Ratings in FHMC's PSA

2025 GNYHA Community Health Needs Assessment Collaborative

Flushing Hospital Medical Center PSA

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Neighborhood and Built Environment	Violence (including gun violence)	4	4.27	Above Average	1,219	19	2.93	Below Average	1,088
Economic Stability	Affordable housing and homelessness prevention	9	4.17	Above Average	1,187	26	2.67	Below Average	1,074
Social and Community Context	Mental health disorders (such as depression)	11	4.12	Above Average	1,221	21	2.91	Below Average	1,059
Maintain Efforts									
Health Care Access and Quality	Cancer	1	4.39	Above Average	1,206	11	3.07	Above Average	1,013
Health Care Access and Quality	Dental care	2	4.30	Above Average	1,232	12	3.06	Above Average	1,108
Health Care Access and Quality	Heart disease	3	4.29	Above Average	1,207	3	3.20	Above Average	1,050
Health Care Access and Quality	Diabetes and high blood sugar	5	4.26	Above Average	1,228	4	3.14	Above Average	1,093
Health Care Access and Quality	High blood pressure	6	4.25	Above Average	1,231	1	3.21	Above Average	1,062
Economic Stability	Access to healthy/nutritious foods	7	4.24	Above Average	1,213	10	3.07	Above Average	1,100
Neighborhood and Built Environment	Stopping falls among elderly	8	4.24	Above Average	1,186	16	3.02	Above Average	1,002
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	10	4.13	Above Average	1,203	2	3.20	Above Average	1,075
Health Care Access and Quality	Women's and maternal health care	12	4.11	Above Average	1,155	6	3.11	Above Average	994
Health Care Access and Quality	Arthritis/disease of the joints	13	4.10	Above Average	1,181	17	3.01	Above Average	1,002
Relatively Lower Priority									
Economic Stability	Assistance with basic needs like food, shelter, and clothing	17	4.02	Below Average	1,211	20	2.93	Below Average	1,057
Health Care Access and Quality	Obesity in children and adults	18	4.02	Below Average	1,207	18	2.94	Below Average	1,017
Education Access and Quality	Access to continuing education and job training programs	20	3.97	Below Average	1,163	22	2.87	Below Average	993

Table 1: Survey Importance and Satisfaction Ratings in FHMC's PSA

2025 GNYHA Community Health Needs Assessment Collaborative

Flushing Hospital Medical Center PSA

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Economic Stability	Job placement and employment support	21	3.91	Below Average	1,160	23	2.82	Below Average	997
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	22	3.88	Below Average	1,172	24	2.81	Below Average	989
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	26	3.62	Below Average	1,175	25	2.74	Below Average	997
Health Care Access and Quality	Infant health	14	4.07	Below Average	1,136	5	3.13	Above Average	975
Health Care Access and Quality	Asthma, breathing issues, and lung disease	15	4.06	Below Average	1,227	7	3.09	Above Average	1,051
Health Care Access and Quality	Adolescent and child health	16	4.05	Below Average	1,185	8	3.08	Above Average	1,004
Education Access and Quality	School health and wellness programs	19	4.01	Below Average	1,155	9	3.08	Above Average	1,011
Health Care Access and Quality	Hepatitis C/liver disease	23	3.80	Below Average	1,120	14	3.04	Above Average	928
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	24	3.78	Below Average	1,146	13	3.05	Above Average	908
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	25	3.76	Below Average	1,154	15	3.03	Above Average	930

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

New York State Prevention Agenda Objectives Selected for Special Focus

The NYS Prevention Agenda is the State's Health Improvement Plan (SHIP), a six-year endeavor that serves as the blueprint for State and local action to improve the health and well-being of every individual in New York, with an aim to reduce health disparities and improve health equity. The 2025-2030 NYS Prevention Agenda identifies 24 key priorities (grouped into five domains), which are in alignment with social determinants of health as defined by Healthy People 2030.[74] Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The five Domains of the 2025-2030 NYS Prevention Agenda (each with coordinating Priorities and Objectives) include:

Domain 1. ECONOMIC STABILITY
Domain 2. SOCIAL & COMMUNITY CONTEXT
Domain 3. NEIGHBORHOOD & BUILT ENVIRONMENT
Domain 4. HEALTH CARE ACCESS & QUALITY
Domain 5. EDUCATION ACCESS & QUALITY

Many of the NYS Prevention Agenda's priorities share topics and themes with the NYC Department of Health and Mental Hygiene's Healthy NYC: NYC's Campaign for Healthier, Longer Lives, for which Flushing Hospital Medical Center (FHMC) is a sponsoring institution. Healthy NYC features ambitious "reach" goals to change health outcomes by targeting the major drivers of death and extreme racial inequities due to chronic and diet-related diseases, mental health, COVID-19, homicide, and maternal mortality.

Based on results collected from its Community Health Survey, health status data in this report, and the Hospital's capabilities and resources, FHMC has identified three objectives from the NYS Prevention Agenda to highlight in its 2025 Community Service Plan:

1. Reduce rates of tobacco use;
2. Increase breastfeeding rates; and
3. Increase colorectal cancer screening rates.

Reducing tobacco use and increasing breastfeeding are addressed under Domain 2 (Social and Community Context). Increasing colorectal cancer screening is addressed under Domain 4 (Health Care Access and Quality). The content of this section explains how these Domains are affected by a myriad of social determinants of health within FHMC's service area, as well as their alignment with the Healthy NYC campaign. This recognition supports the view that health is "not simply about individual behavior or risk exposure, but how the social and economic structure of a population shapes its health".[75]

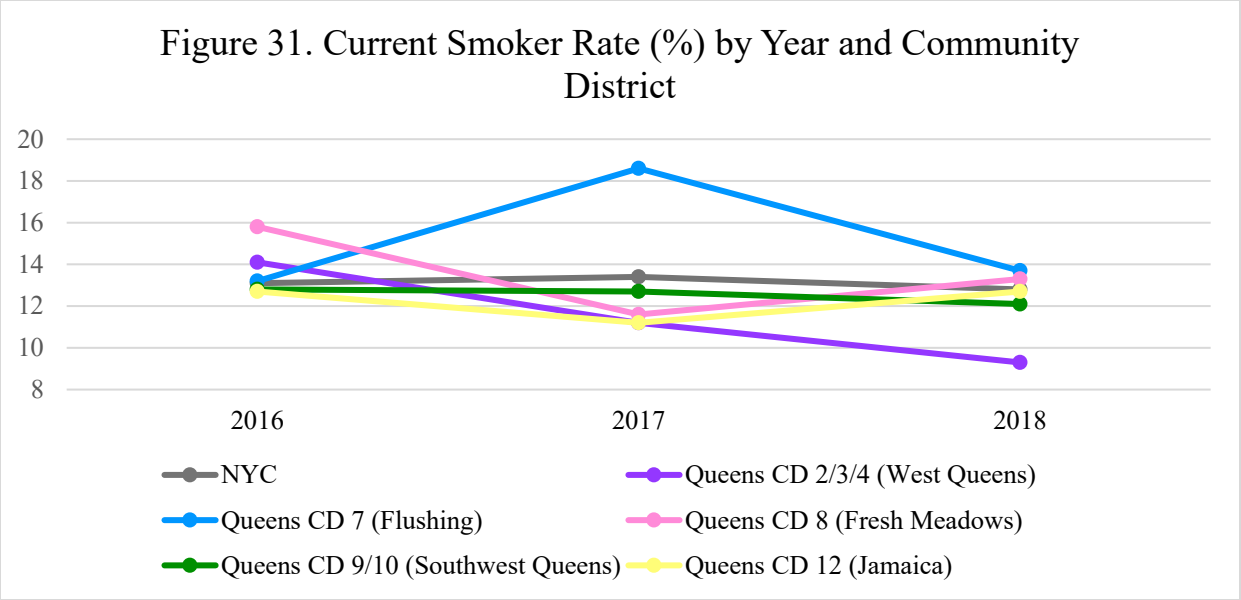
[74] Prevention Agenda 2025-2030: NYS's Health Improvement Plan. NYS Department of Health, 2025. Retrieved from https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/
[75] Social Determinants of Health, 2nd edition. Edited by Michael Marmot and Richard G. Wilkinson. Oxford University Press, 2006.

Domain 2. SOCIAL & COMMUNITY CONTEXT
Priority: Tobacco/E-Cigarette Use
NYS Objective 14.0. Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%

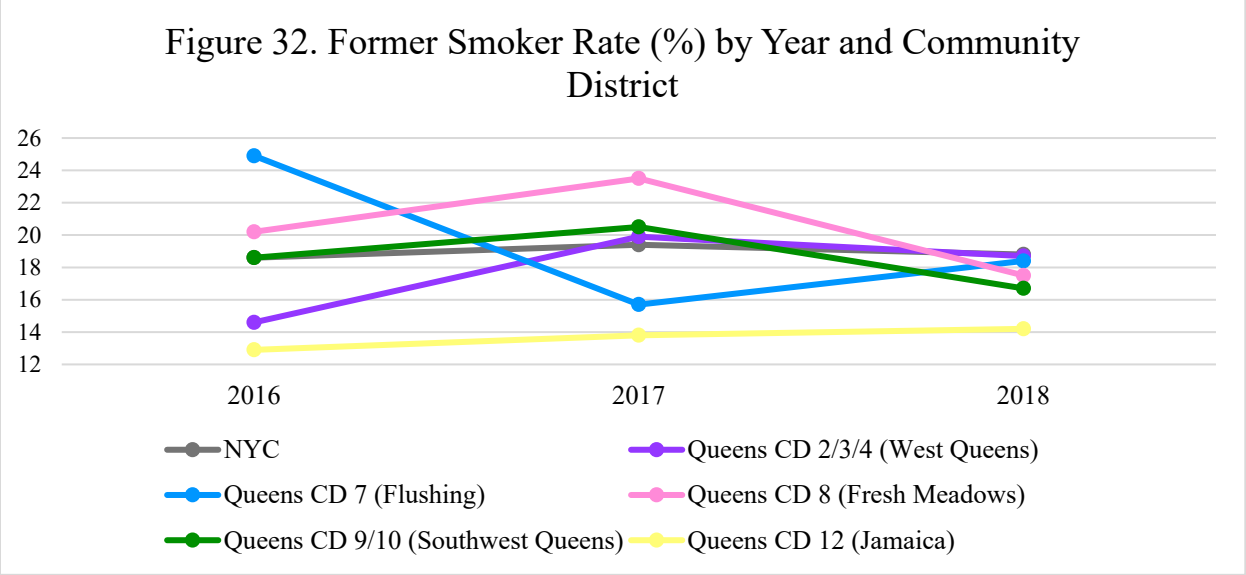
FHMC's focus on tobacco prevention and cessation aligns with the citywide Healthy NYC campaign, which lists "Prevent tobacco use, and reduce smoking and alcohol consumption" as a priority strategy to reduce deaths driven by chronic and diet-related diseases, including screenable cancers such as lung cancer.

Current Smokers. Smoking is known to cause several chronic and life-threatening health conditions, including several types of cancer, lung disease, heart disease, and chronic obstructive pulmonary disease (COPD).[76] In addition, exposure to tobacco smoke during pregnancy is a risk factor for poor infant health outcomes, including pre-term birth, birth defects, and sudden infant death syndrome (SIDS).[77] The proportion of current smokers in FHMC's PSA over time varies by community district (CD), as seen in Figure 31. Though fluctuation in the rates was observed between 2016-2018, current smoker rates for Queens CD 9 (Kew Gardens and Woodhaven), CD 10 (South Ozone Park and Howard Beach), and CD 12 (Jamaica and Hollis) across this three-year period remained lower than the city-wide rate.[78] The current smoker rate in the region encompassing Queens CD 2 (Woodside and Sunnyside), CD 3 (Jackson Heights), and CD 4 (Elmhurst and Corona) was higher than the NYC rate in 2016, but consistently decreased in the following years. In Queens CD 7 (Flushing and Whitestone) and Queens CD 8 (Hillcrest and Fresh Meadows), the current smoker rate has fluctuated between 2016 and 2018. However, the current smoking rate in Queens CD 7 is still the highest in the PSA and greater than the NYC value of 12.7%, which is much greater than the 2025-2030 NYS Prevention Agenda goal of 7.9%.[79]

[76] Centers for Disease Control and Prevention, 2025.
[77] Centers for Disease Control and Prevention, 2025.
[78] NYC Community Health Survey, DOHMH, 2016-2018.
[79] NYC Community Health Survey, DOHMH, 2016-2018.

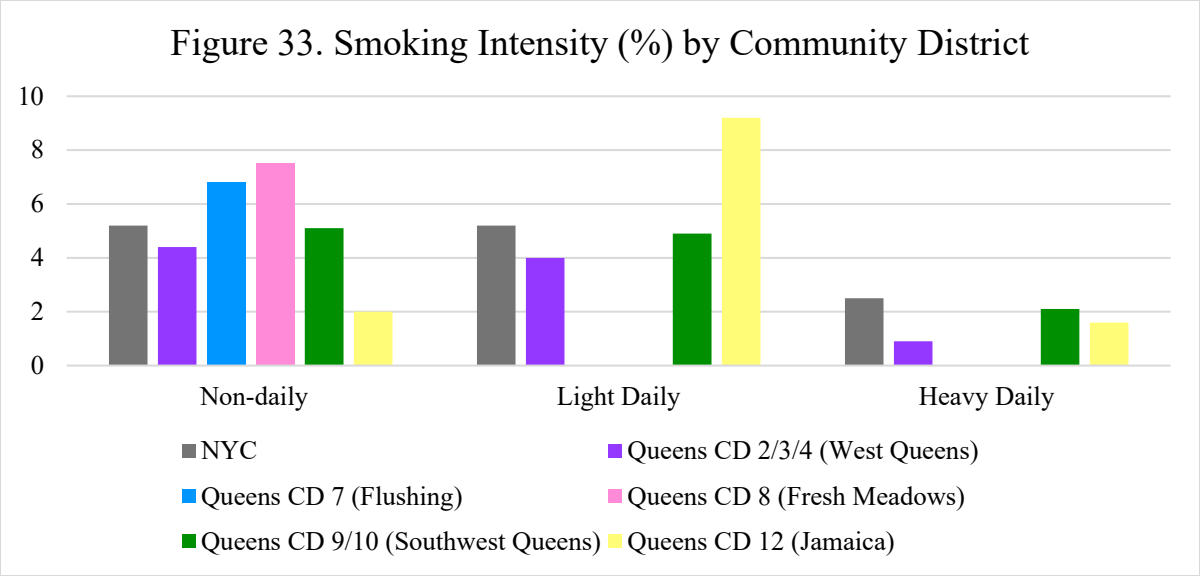


Former Smokers. The former smoking rate of a neighborhood is a strong indicator of the effectiveness of local smoking cessation efforts. In NYC and in each PSA CD, the percentage of former smokers increased between 2016 and 2017, except for Queens CD 7, where the former smoker rate decreased (Figure 32). However, former smoking rates throughout the PSA are lower than the citywide rate as of 2018.[80]

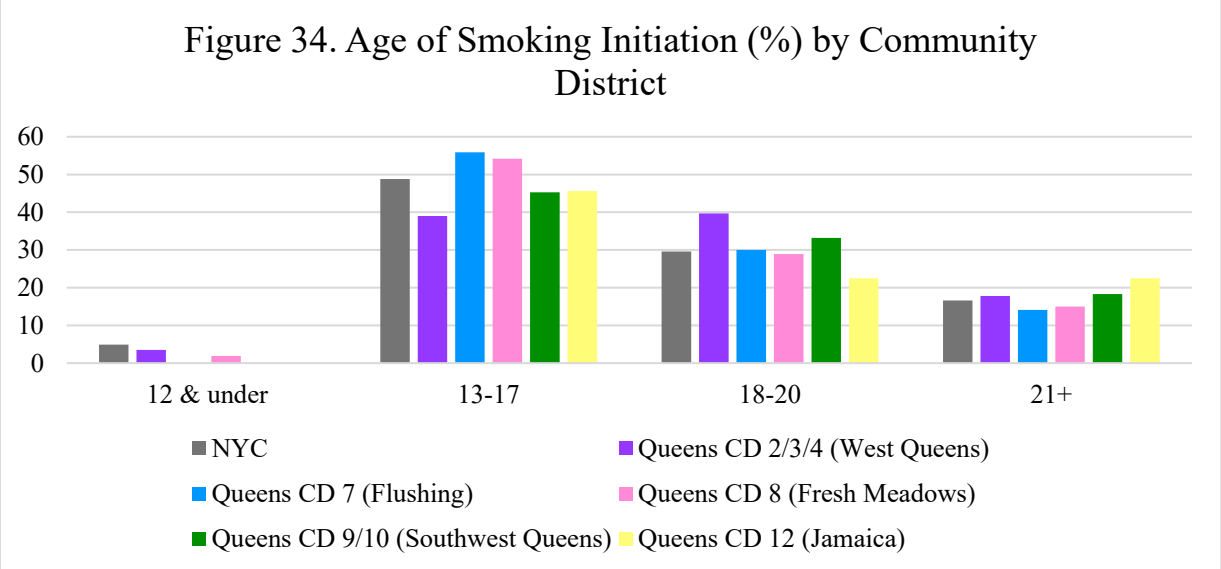


Smoking Intensity. In 2018, the vast majority of smokers in FHMC's PSA and NYC generally were either non-daily (smoking on some days but not on others) or light daily (smoking between one and 10 cigarettes daily) cigarette consumers, as seen in Figure 33.

[80] NYC Community Health Survey, DOHMH, 2016-2018.



Age of Smoking Initiation. In 2018, the percentage of smokers across the PSA who initiated smoking between 13 and 17 years old was less than the citywide rate, except for in Queens CD 7 and in Queens CD 8.[81] Still, with the vast majority of smokers in FHMC's PSA having begun smoking in adolescence (as displayed in Figure 34), it is evident that current smoking prevention efforts may be the most impactful if broadly targeted to young adolescent populations.

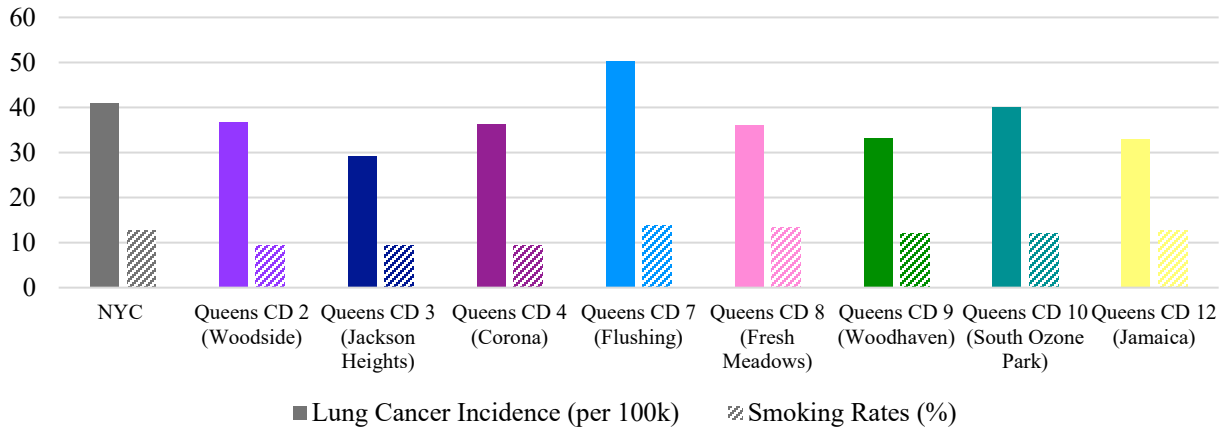


Smoking and Lung Cancer. Chronic smoking is highly associated with several life-threatening diseases, including cancers of the lung, throat, esophagus, and larynx;[82] therefore, the incidence of lung cancers in a given region can serve as an indicator of smoking's impact on the community's long-term health. In NYC, lung cancer is the third most common cancer and the

[81] NYC Community Health Survey, DOHMH, 2018
[82] Smoking and Tobacco Use, CDC, 2022.

deadliest.[83] The lung cancer incidence rates for Queens, and within most of FHMC's PSA (Figure 35), are lower than the citywide rate, but Queens CD 7's current smoker rates and lung cancer incidence rates are elevated compared to NYC, Queens, and other PSA Community Districts.[84] Lung cancer is still the leading cause of cancer mortality and the leading cause of premature death attributable to cancer in the PSA.[85] Smoking is a cause in more than 80% of lung cancer deaths.[86]

Figure 35. Smoking Rates and Lung Cancer Incidence Rates by Community District

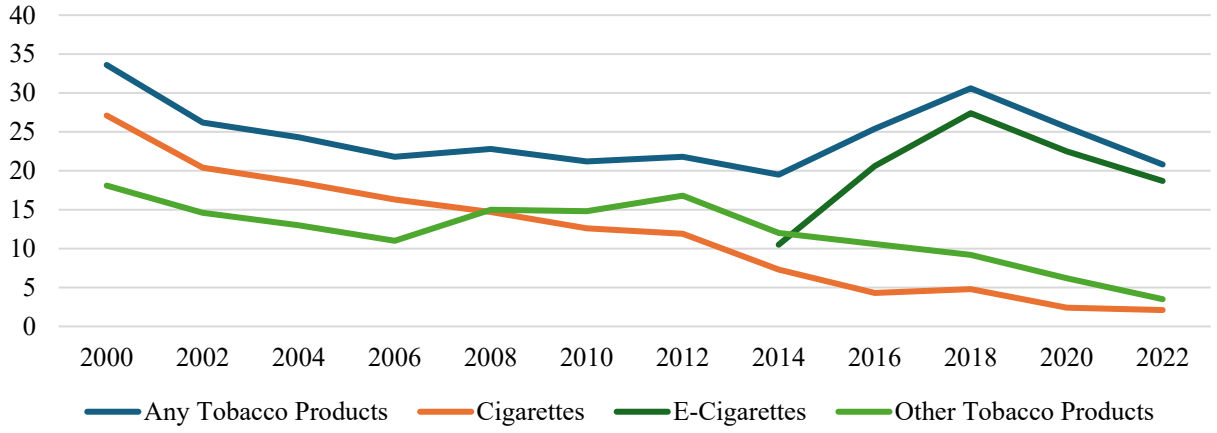


Youth and E-Cigarettes. Tobacco prevention and cessation efforts are particularly important among youth populations, as nicotine (tobacco's active ingredient) is a highly addictive chemical that can harm adolescent brain development.[87] In the first 14 years of the 21st century, youth tobacco product use declined steadily throughout NYS, with 33.6% of high school students using tobacco in 2000, then dropping to 19.5% of high school students in 2014.[88] However, youth tobacco product use has increased in recent years, peaking in 2018 at 30.6% before declining to 20.8% in 2022 (a value still 1.3 percentage points greater than the 2014 value).[89] This shift has largely been driven by the advent of e-cigarettes, which were introduced to North America in 2007.[90] While cigarettes were the most popular form of tobacco consumption among youth from 2000 until 2008, by 2010, youth use of "other tobacco products" surpassed that of cigarettes and has remained greater in the years since. E-cigarettes were introduced as a separate category of youth tobacco consumption in 2014, and since 2016 have consistently been reported as the most

[83] NYS Cancer Registry 2018-2022, NYS Department of Health, 2025.
[84] NYS Cancer Registry 2018-2022, NYS Department of Health, 2025.
[85] NYS Cancer Registry 2018-2022, NYS Department of Health, 2025.
[86] Lung Cancer, NYC Health, 2025.
[87] Smoking and Tobacco Use, U.S. Centers for Disease Control and Prevention, 2025.
[88] Bureau of Tobacco Control, NYS Department of Health, 2023. Accessed via https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume15/n1_youth_tobacco_use.pdf.
[89] Bureau of Tobacco Control, NYS Department of Health, 2023. Accessed via https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume15/n1_youth_tobacco_use.pdf.
[90] Bureau of Tobacco Control, NYS Department of Health, 2023. Accessed via https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume15/n1_youth_tobacco_use.pdf.

popular form of youth tobacco consumption.[91] While youth e-cigarette use has declined from 2018 to 2022, 90% of all high school-age tobacco users in NYS reported using e-cigarettes in 2022, compared to 10% using cigarettes and 17% using other tobacco products.[92] These patterns are depicted in Figure 36. Similar patterns emerge among NYC young adult (ages 18-24) populations—while 4% of NYC young adults reported e-cigarette use in 2014, 9% reported using e-cigarettes in 2020, and 15% reported using e-cigarettes in 2023.[93] Young adults in NYC are over seven times as likely to use e-cigarettes as they are to use cigarettes, and the prevalence of e-cigarette use is elevated among non-Hispanic White young adults, young men, and young adults identifying as gay, lesbian, or bisexual compared to other NYC young adults.[94] E-cigarettes, which contain high levels of nicotine as well as cancer-causing chemicals, heavy metals, and flavorings implicated in serious lung disease,[95] are a critical target for tobacco cessation programming tailored to adolescent and young adult populations. Targeted prevention and cessation efforts for a younger population could support youth and adolescents in becoming tobacco-free adults.

Figure 36. Percentage of NYS High School Students Using Tobacco Products, by Year and Type of Product



FHMC's current resources and recent accomplishments with respect to Tobacco/E-Cigarette Use

Prevention will be discussed in the Community Service Plan section, starting on page 68.

Domain 2. SOCIAL & COMMUNITY CONTEXT

Priority: Healthy Eating

[91] Bureau of Tobacco Control, NYS Department of Health, 2023. Accessed via https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume15/n1_youth_tobacco_use.pdf.

[92] Bureau of Tobacco Control, NYS Department of Health, 2023. Accessed via https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume15/n1_youth_tobacco_use.pdf.

[93] Merizier J, Dominianni C, Debchoudhury I, Orkin-Prol L, Jackson J, Fenlon J, Talati A. Youth and Young Adult Vaping in New York City. NYC Vital Signs 2025, 22(3); 1-4.

[94] Merizier J, Dominianni C, Debchoudhury I, Orkin-Prol L, Jackson J, Fenlon J, Talati A. Youth and Young Adult Vaping in New York City. NYC Vital Signs 2025, 22(3); 1-4.

[95] Health Effects of Vaping, U.S. Centers for Disease Control and Prevention, 2025.

NYS Objective 20.0. Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%.

FHMC's focus on breastfeeding promotion aligns with the citywide Healthy NYC campaign, which lists "Improve access to and quality of obstetric health care along the whole continuum of pregnancy, childbirth, and postnatal care" as a priority strategy to reduce deaths driven by maternal mortality.

Breastfeeding Rates. Breastfeeding children during early life is associated with numerous health benefits for lactating parents and their infants, including reduced risk of asthma, obesity, Type 1 diabetes, and sudden infant death syndrome (SIDS), as well as the prevention of infections, neurodevelopmental health benefits, and a lower risk of allergies.[96,97] FHMC, one of approximately 600 Baby-Friendly USA designated hospitals, implements evidence-based practices shown to increase breastfeeding initiation (timely initiation is defined by the World Health Organization as putting the newborn to the breast within one hour of birth) and duration (the American Academy of Pediatrics recommends that infants are exclusively breastfed for the first 6 months after birth, and together with complementary foods for two years or longer).[98,99] In NYC, the percentage of infants exclusively breastfed for the first five days of life has been gradually decreasing over the last three years, with a rate of 40.4% in 2022 (Figure 37).[100] While the exclusive breastfeeding rates in seven of the eight Community Districts in the PSA are consistently greater than, or equal to, the citywide rate, Queens CD 7's rate (37.2%) is 8.6% lower than the citywide rate (40.4%).[101]

[96] Breastfeeding, CDC, 2025.
[97] Shamir R. The Benefits of Breast Feeding. *Nestle Nutr Inst Workshop Ser.* 2016;86:67-76. doi:10.1159/000442724
[98] World Health Organization, UNICEF. Indicators for assessing infant and young child feeding practices.
[99] Meek, J and Noble, L. Technical Report: Breastfeeding and the Use of Human Milk. *Pediatrics* (2022) 150 (1): e2022057989.
[100] Li W, Castro A, Gurung S, Maduro G, Sun Y, Seil K, and Van Wye G. Summary of Vital Statistics, 2022. New York, NY: Bureau of Vital Statistics, NYC DOHMH.
[101] Li W, Castro A, Gurung S, Maduro G, Sun Y, Seil K, and Van Wye G. Summary of Vital Statistics, 2022. New York, NY: Bureau of Vital Statistics, NYC DOHMH.

Figure 37. Percentage of Infants Exclusively Breastfed During First 5 Days of Life By Community District

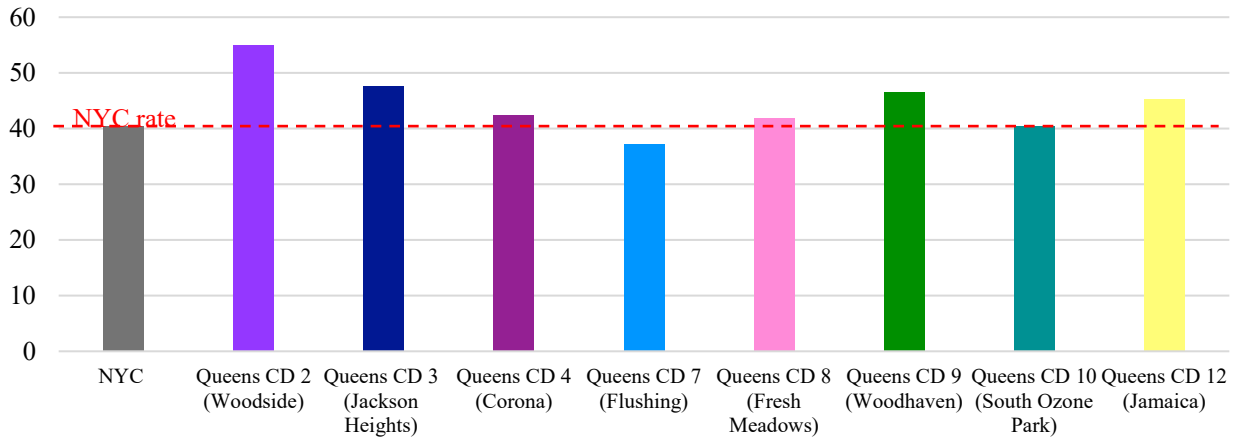
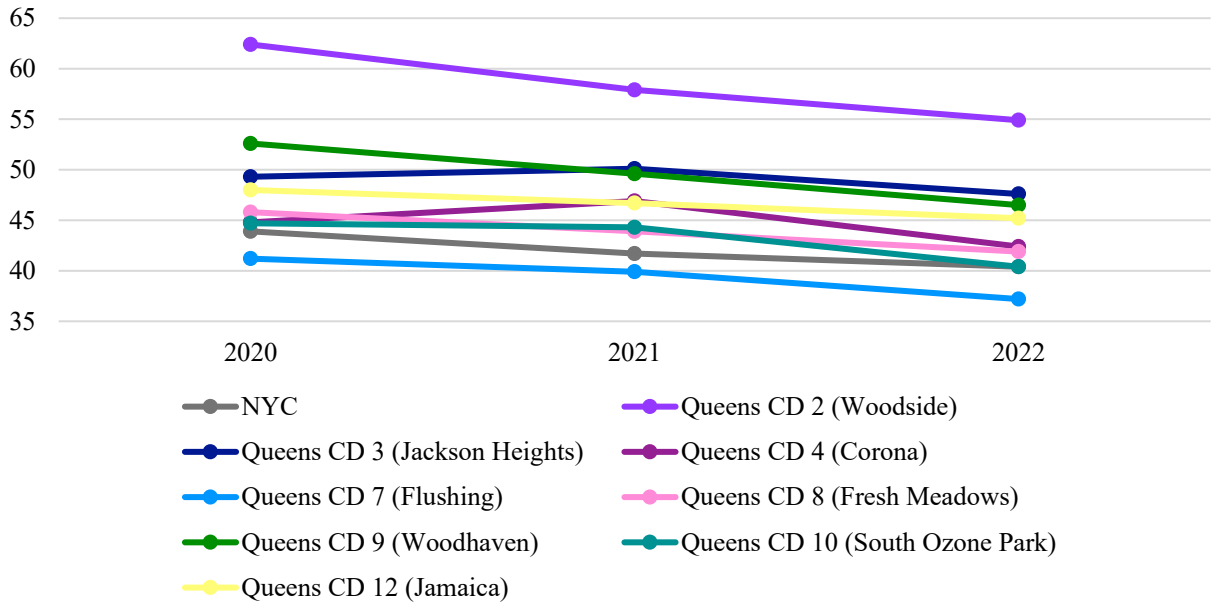


Figure 38. Exclusive Breastfeeding Rate by Year and Community District

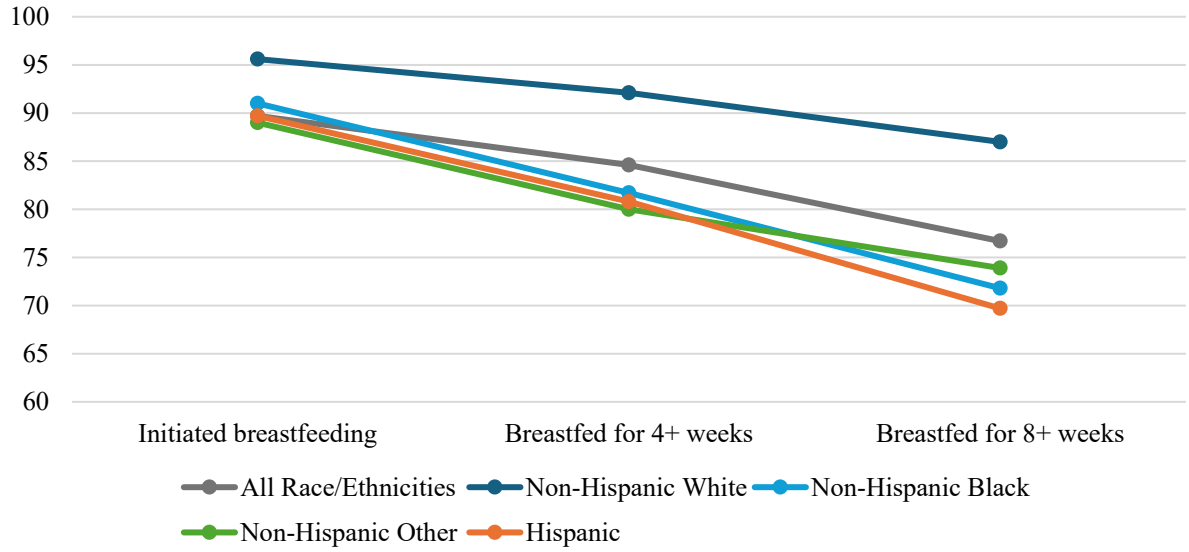


While any breastfeeding in early life has numerous health benefits, longer duration of breastfeeding is associated with reduced risk of hospitalization for infection during the first year of life, with each additional month of breastfeeding resulting in a four percent decrease in hospitalization risk.[102] In NYC, 89.7% of postpartum individuals initiate breastfeeding, 84.6%

[102] Christensen, N., Bruun, S., Søndergaard, J., Christesen, H. T., Fisker, N., Zachariassen, G., Sangild, P. T., & Husby, S. (2020). Breastfeeding and Infections in Early Childhood: A Cohort Study. *Pediatrics*, *146*(5), e20191892. https://doi.org/10.1542/peds.2019-1892

breastfeed for four weeks or more, and 76.7% breastfeed for eight weeks or more.[103] Notably, while the percentages of postpartum individuals initiating breastfeeding in NYC are similar across racial/ethnic groups, citywide disparities emerge in the duration of breastfeeding, as depicted in Figure 38. These data indicate a need to improve long-term supports and resources specifically tailored for breastfeeding individuals in the PSA who belong to racial and ethnic minority groups.

Figure 38. Percentage of Postpartum Individuals Breastfeeding in NYC by Duration and Race/Ethnicity

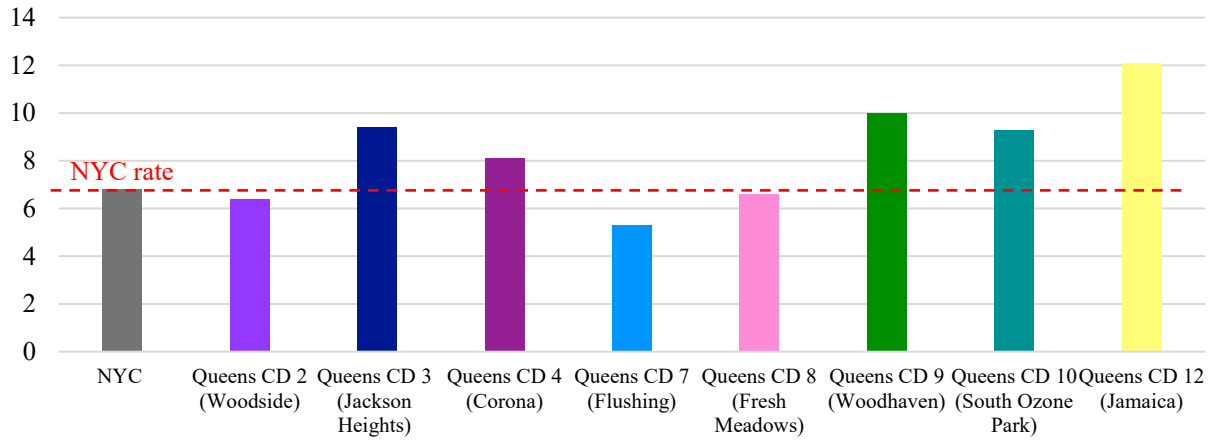


Prenatal Care Rates. Prenatal care visits serve as critical opportunities for breastfeeding promotion, as breastfeeding rates at six months postpartum are significantly higher among those who attend prenatal breastfeeding classes compared to those who do not.[104] In Queens CD 2, Queens CD 7, and Queens CD 8, the percentage of pregnant individuals receiving late or no prenatal care is lower than that of Queens County (7.8%) and of NYC (6.8%). The remaining CDs in the PSA have higher rates of inadequate prenatal care: 9.4% of Queens CD 3 residents, 8.1% of Queens CD 4 residents, 10.0% of Queens CD 9 residents, and 9.3% of Queens CD 10 residents experiencing pregnancy receive late or no prenatal care. In Queens CD 12, 12.1% of pregnant residents receive late or no prenatal care, an estimate that is 55% higher than that of Queens (7.8%) and more than 8.5 times greater than the lowest CD-specific estimate in NYC (1.4%). Figure 39 illustrates the percentage of pregnant individuals in each PSA CD receiving late or no prenatal care. It is important to note that in NYC, 13% of Black women, 7% of

[103] NYS Report of Breastfeeding Disparities, NYS Department of Health, 2025. Retrieved from https://health.ny.gov/community/pregnancy/breastfeeding/docs/2025_breastfeeding_disparities_report.pdf
[104] Rosen, I. M., Krueger, M. V., Carney, L. M., & Graham, J. A. (2008). Prenatal breastfeeding education and breastfeeding outcomes. *MCN. The American journal of maternal child nursing*, *33*(5), 315–319. https://doi.org/10.1097/01.NMC.0000334900.22215.ec

Hispanic women, and 5% of Asian women received late or no prenatal care compared to 3.1% of White women.[105]

Figure 39. Percentage of Pregnant Individuals Receiving Late or No Prenatal Care by Community District



Infant Mortality Rate. The infant mortality rate (measured as deaths within the first year of life per 1,000 live births) varies by community district within the PSA. In Queens CD 4, Queens CD 9, Queens CD 10, and Queens CD 12, the infant mortality rate has increased in recent years and is now higher than or equal to the citywide rate of 4.3 deaths per 1,000 live births, while the infant mortality rate has decreased in Queens CDs 2, 7, and 8, and has increased but is still lower than the city-wide rate in Queens CD 3.[106]

Preterm Birth Rates. A live birth that occurs before the 37th week of pregnancy is considered preterm. Preterm birth is associated with an elevated risk of infant mortality, as well as numerous poor long-term physical and neurodevelopmental health outcomes.[107] As seen in Figure E in Appendix A, Queens CD 12 has a much higher preterm birth rate than NYC, the 3rd highest rate in the city. Queens CD 10's preterm birth rate is also greater than that of NYC, while Queens CDs 3, 8, and 9's rates are similar to that of NYC. Queens' CDs 2, 4, and 7's rates are lower than those of NYC. High pre-term birth rates could signify the need for more comprehensive prenatal care services, including counseling, group visits, and telehealth modalities, and social service supports offered by community-based organizations such as Public Health Solutions.

Low Birthweight. Newborn infants who weigh under 2,500 grams (about 5.5 pounds) at birth are considered low birthweight babies. Low birthweight is a risk factor for infant morbidity and mortality, as well as several non-communicable diseases throughout the life course.[108] The

[105] Keeping Track Online: Citizen's Committee for Children. https://data.cccnewyork.org/data/table/47/late-or-no-prenatal-care#1271/1470/22/a/a
[106] Summary of Vital Statistics (2000-2021), NYC DOHMH, 2019-2021.
[107] Luu TM, Rehman Mian MO, Nuyt AM. Long-Term Impact of Preterm Birth: Neurodevelopmental and Physical Health Outcomes. *Clin Perinatal*. 2017;44(2):305-314. doi:10.1016/j.clp.2017.01.003
[108] Agbozo F, Abubakari A, Der J, Jahn A. Prevalence of low birth weight, macrosomia and stillbirth and their relationship to associated maternal risk factors in Hohoe Municipality, Ghana. *Midwifery*. 2016;40:200-206.

PSA's prevalence of low birthweight babies varies with respect to NYC (9.2%), as Figure F in Appendix A illustrates, ranging from a prevalence 20% lower than that of the city in Queens CD 2 (7.4%) to a prevalence 36% greater in Queens CD 12 (13.2%).[109]

FHMC's current resources and recent accomplishments with respect to Perinatal and Infant Health (including breastfeeding) will be discussed in the Community Service Plan section, starting on page 70.

Domain 4. HEALTH CARE ACCESS & QUALITY
Priority: Preventive Services for Chronic Disease Prevention & Control
NYS Objective 33.0: Increase the percentage of adults ages 45-75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80.0%.

FHMC's focus on colorectal cancer screening promotion aligns with the citywide Healthy NYC campaign, which lists "Increase prevention activities and social supports" as a priority strategy to reduce deaths driven by chronic and diet-related diseases, including screenable cancers such as colon cancer.

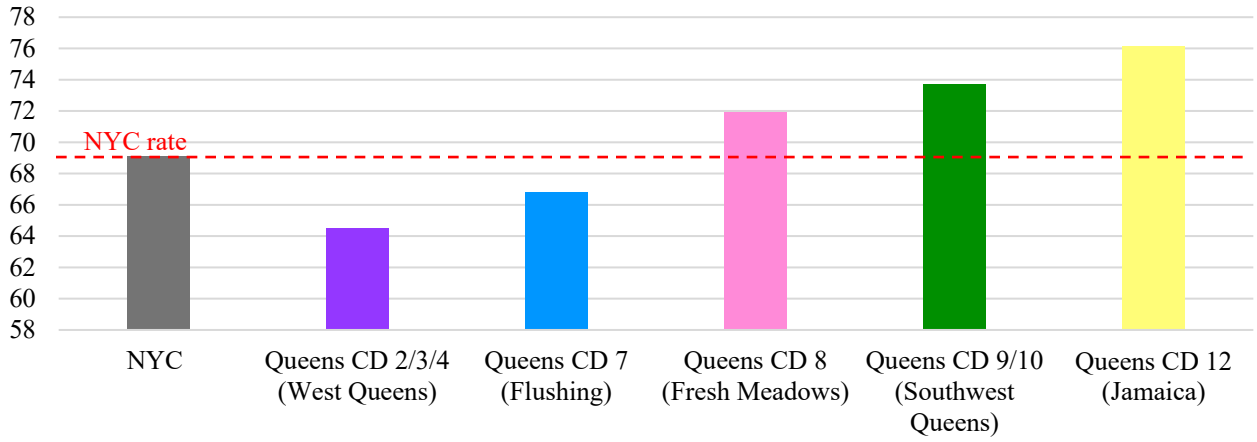
Colorectal Cancer Screening Rates. The U.S. Preventive Services Task Force recommends that adults ages 45-75 years old should be screened for colorectal cancer, with screenings provided for those over the age of 75 on a case-by-case basis.[110] Numerous types of screening are available, including: stool tests, such as the annual guaiac-based fecal occult blood test (gFOBT), the annual fecal immunochemical test (FIT), and the FIT-DNA test performed once every three years; a flexible sigmoidoscopy, performed every five years (or every ten years alongside an annual FIT); a colonoscopy, performed once every 10 years for those without increased risk; and a computed tomography (CT) or virtual colonoscopy, performed once every five years.[111] Throughout NYC, 69.1% of adults ages 50 years and older reported undergoing a colonoscopy at least once in the past ten years. While Queens CDs 8, 9, 10, and 12 have favorable colonoscopy rates compared to the NYC estimate, only 64.5% of residents aged 50 years and older in Queens CDs 2, 3, and 4, and 66.8% in Queens CD 7 have had a colonoscopy in the last decade as of 2018 (Figure 40).[112]

doi:10.1016/j.midw.2016.06.016

[109] Li W, Castro A, Gurung S, Maduro G, Sun Y, Seil K, and Van Wye G. Summary of Vital Statistics, 2022. New York, NY: Bureau of Vital Statistics, NYC DOHMH

[110] Final Recommendation Statement on Colorectal Cancer: Screening, *U.S. Preventive Services Task Force*, 2021.
[111] Screening for Colorectal Cancer, *Centers for Disease Control and Prevention*, 2024.
[112] NYC Community Health Survey, DOHMH, 2018.

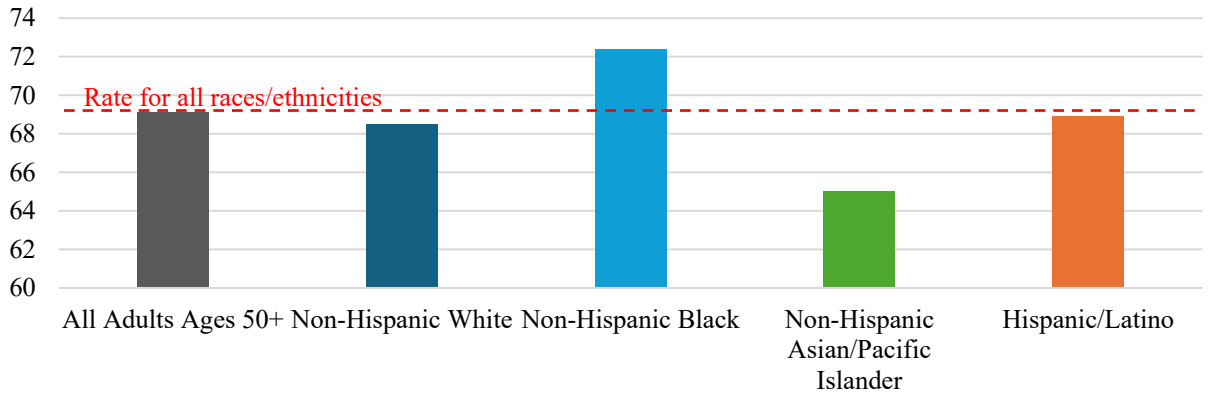
Figure 40. Percentage of Residents Ages 50+ Who Underwent a Colonoscopy in the Past 10 Years by Community District



Disparities in colorectal cancer screening rates persist throughout NYC among different sociodemographic groups. NYC residents aged 65 years and older are approximately 12% more likely to have had a colonoscopy in the past ten years than those aged 50-64 years (73.2% among ages 65+ vs. 65.6% among ages 50-64). Colonoscopy rates are highest among non-Hispanic Black older adults (72.4%), with Hispanic/Latino and non-Hispanic White adults having lower rates (68.9% and 68.5%, respectively), and the colonoscopy rate among Asian and Pacific Islander older adult residents (65.0%) being the lowest of all racial/ethnic groups in NYC (Figure 41).[113] Individuals with higher levels of education and living in higher income households are more likely to have had a colonoscopy in the past decade than those with lower education attainment and/or incomes—across NYC, college graduates' colonoscopy rate (74.1%) is approximately 13% greater than the rate for those who did not finish high school (65.8%), and the colonoscopy rate among the highest income quintile (78.4%) is approximately 18% greater than the rate for those in the lowest income quintile (66.2%).[114]

[113] NYC Community Health Survey, DOHMH, 2018.
[114] NYC Community Health Survey, DOHMH, 2018.

Figure 41. Percentage of NYC Residents Ages 50+ Who Underwent a Colonoscopy in the Past 10 Years by Race/Ethnicity

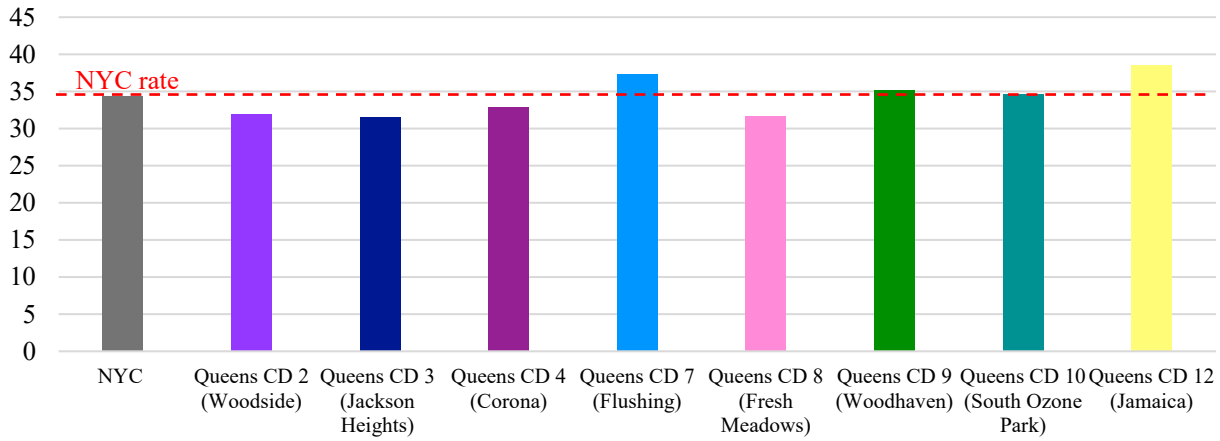


While there is no significant difference between the colonoscopy rates for NYC residents born inside the U.S. and the rates for foreign-born NYC residents, the proportion of immigrants reporting a colonoscopy in the past ten years increases with the amount of time spent in the U.S.–while 70.1% of NYC immigrants with at least ten years of residency in the U.S. have had a colonoscopy in the last decade, 63.9% of those with five to nine years of residency and only 41.6% of those with under five years of residency have had colonoscopies in the past ten years.[115] Across NYC, women and men have colonoscopies at similar rates (69.7% of women vs. 69.0% of men).[116] Beyond reflecting a need to improve colorectal cancer screening rates across all NYC communities, these statistics indicate a specific gap in colonoscopy access or awareness among older adults under the age of 65 years, Asian and Pacific Islanders, low-income individuals, and those with low educational attainment, and recent immigrants to the U.S. More targeted education to these groups about different screening options available and screening guidelines is recommended.

Colorectal Cancer Incidence. Throughout NYC, the incidence of colorectal cancer was 34.3 cases per 100,000 residents in 2023, making it the fourth most common form of cancer following breast cancer (125.4 cases per 100,000 people), prostate cancer (124.1 cases per 100,000 people), and lung and bronchus cancer (42.0 cases per 100,000 people).[117] Colorectal cancer is responsible for 6.9% of all new cancer diagnoses in NYC each year.[118] While the colorectal cancer incidence in most of the PSA is favorable or comparable to that of NYC, the incidence is significantly higher in Queens CD 12 and Queens CD 7 at 38.6 and 37.3 cases per 100,000 people, which are the second and third highest CD-specific incidences in Queens, as well as the ninth and 15th highest in NYC (Figure 42).[119]

[115] NYC Community Health Survey, DOHMH, 2018.
[116] NYC Community Health Survey, DOHMH, 2018.
[117] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.
[118] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.
[119] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.

Figure 42. Annual Colorectal Cancer Incidence (per 100,000 people) by Community District

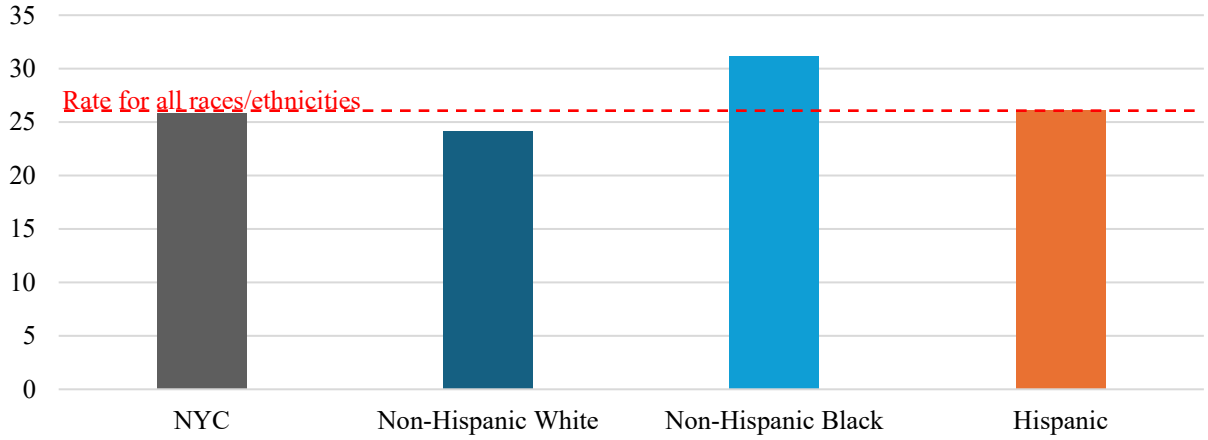


Racial, ethnic, and gender disparities in colorectal cancer incidence persist throughout NYC. While colorectal cancer incidence among Non-Hispanic Asian and Pacific Islander NYC residents (30.2 cases per 100,000 people) and Hispanic NYC residents (30.3 per 100,000 people) are below the citywide incidence, the non-Hispanic White and non-Hispanic Black incidences are greater than the citywide value at 35.9 cases per 100,000 people and 36.0 cases per 100,000 people, respectively.[120] The citywide incidence for males (39.8 cases per 100,000 people) is 33% greater than that of females (29.9 cases per 100,000 people), with non-Hispanic Black males experiencing the highest incidence of any group at 41.5 cases per 100,000 people.[121]

Colorectal Cancer Stage of Diagnosis. Cancer can be diagnosed at the local (early), regional (intermediate), or distant (advanced) stage, with those diagnosed in local/early stages having a greater chance of full recovery with treatment. Across NYC, 35.4% of colorectal cancers are diagnosed at the local stage, while 38.8% are diagnosed at the regional stage and 25.8% are diagnosed at the advanced stage—male and female colorectal cancer patients are diagnosed at the distant stage in similar proportions (25.9% vs. 25.7%).[122] However, racial disparities in stage of diagnosis persist throughout NYC, with over a third of non-Hispanic Black colorectal cancer patients diagnosed in the distant stage compared to less than a quarter of non-Hispanic White colorectal cancer patients (see Figure 43).[123]

[120] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.
[121] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.
[122] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.
[123] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.

Figure 43. Percentage of NYC Colorectal Cancer Patients Diagnosed at the Distant (Advanced) Stage by Race/Ethnicity

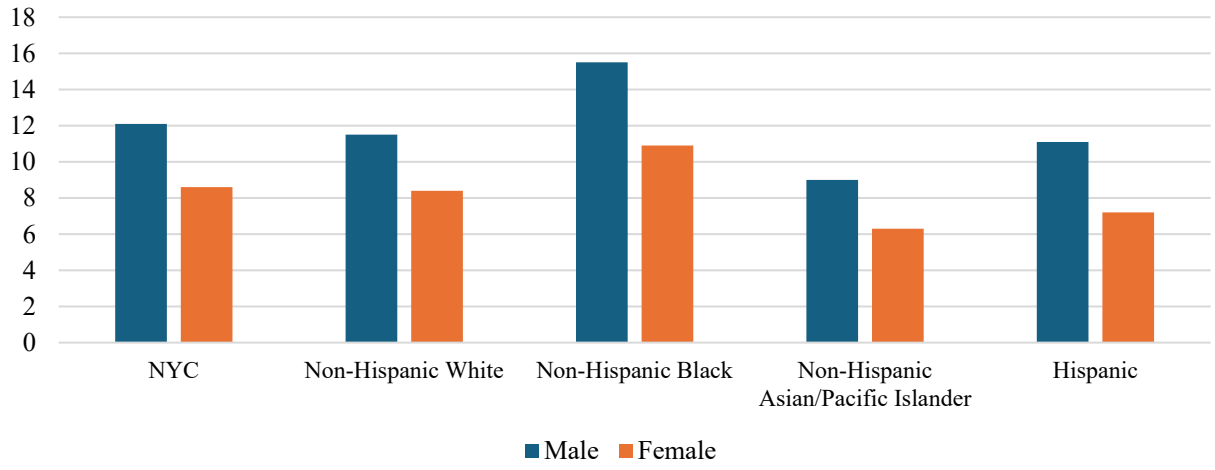


Colorectal Cancer Mortality and Survival. The colorectal cancer mortality rate in NYC is 10.1 deaths per 100,000 people annually, with Queens at 9.7 deaths. The five-year survival rate for colorectal cancer patients in NYC is 63.6%, with a rate of 64.5% in Queens. Among the approximately 38,710 colorectal cancer survivors living in NYC, 29.5% (11,420) are in Queens.

As is the case with colorectal cancer screening, incidence, and stage of diagnosis statistics, sociodemographic disparities in cancer mortality persist throughout NYC, with the male mortality rate elevated in comparison to the female rate (12.1 vs. 8.6 deaths per 100,000 people), and the non-Hispanic Black mortality rate (12.7 deaths per 100,000 people) elevated over all other racial and ethnic groups (9.9, 7.5, and 8.9 deaths per 100,000 people for non-Hispanic Whites, non-Hispanic Asian and Pacific Islanders, and Hispanic/Latinos, respectively).[124] Of all racial, ethnic, and sex subgroups in NYC, non-Hispanic Black males have the highest colorectal cancer mortality rate by far at 15.5 deaths per 100,000 people, followed by non-Hispanic White males (11.5 deaths per 100,000 people), Hispanic males (11.1 deaths per 100,000 people), and non-Hispanic Black females (10.9 deaths per 100,000 people) (Figure 44).[125]

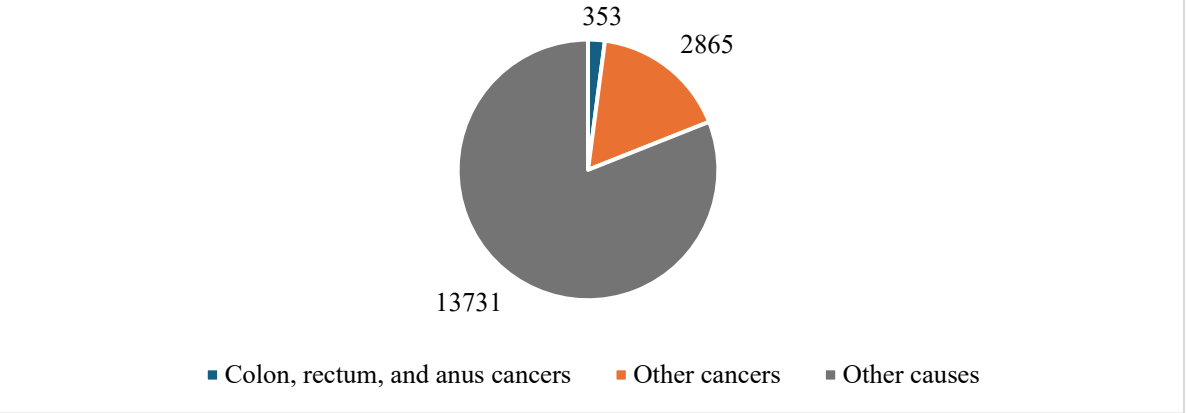
[124] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.
[125] NYS Cancer Registry 2017-2021, NYS Department of Health, 2023.

Figure 44. NYC Annual Colorectal Cancer Mortality Rate (per 100,000 people) by Race/Ethnicity and Sex



Annually, colon, rectum, and anal cancers are responsible for 5.1 premature deaths (before the age of 65) for every 100,000 NYC residents—in 2022 alone, 353 premature deaths in NYC were attributed to colon, rectum, and anal cancers (Figure 45).[126] Increasing awareness and accessibility of colorectal cancer screening services is therefore a key priority for FHMC in the Hospital's overarching aim to promote health and reduce premature mortality in the PSA.

Figure 45. Number of NYC Premature Deaths in 2022 by Cause of Death



FHMC's current resources and recent accomplishments with respect to Colorectal Cancer Screening will be discussed in the Community Service Plan section, starting on page 69.

[126] Li W, Castro A, Gurung S, Maduro G, Sun Y, Seil K, and Van Wye G. Summary of Vital Statistics, 2022. New York, NY: Bureau of Vital Statistics, NYC Department of Health and Mental Hygiene.

Additional Priorities from the NYS Prevention Agenda

Based on a review of its capabilities and resources, the needs of its service area communities, and the potential to improve the health of the service area, FHMC has chosen to devote special attention to three specific NYS Prevention Agenda Objectives which address the Hospital's three primary issues of concern for 2025-2030:

1. To reduce tobacco use;
2. To increase breastfeeding; and
3. To increase colorectal cancer screenings.

Following review and consensus agreement by senior leadership, significant resources have been made available to achieve these three Objectives.

The remainder of the NYS Prevention Agenda's Priorities are still significant to the experiences of individuals throughout the Hospital's service area, and the Hospital has programs to address many of these health problems, at least in part. However, these Priorities are not featured in the Hospital's 2025-2027 Community Service Plan/Implementation Plan with objectives and interventions and will not be tracked and updated over this three-year plan cycle. However, brief descriptions of the additional Priorities and statistics showing unmet community needs are presented below. The Community Service Plan section of this report starting on page 68. highlights some of the Hospital's initiatives that address these additional community needs. Figures which illustrate relevant statistics for these remaining Priorities can be viewed in Appendix A.

❖ Domain 2: SOCIAL AND COMMUNITY CONTEXT
Priority: Primary Prevention, Substance Misuse, and Overdose Prevention

Binge drinking, defined as the consumption of five or more drinks for men or four or more drinks for women on one or more occasions in the past 30 days, is associated with elevated short-term risk of acute health consequences such as injuries from accidents and alcohol overdoses, as well as long-term deleterious health effects such as obesity and cardiovascular disease.[127,128] While 18% of NYC residents self-report binge drinking in the past 30 days, the percentage of PSA residents self-reporting recent binge drinking ranges from eight percent in Queens CD 7 to 21% in Queens CD 2 (Figure A in Appendix A).

Drug use is among the top four leading causes of premature death (under the age of 65) throughout FHMC's PSA, ranging from 5.3 premature deaths per 100,000 people in Queens CD 2 to 12.4 premature deaths per 100,000 people in Queens CD 12—however these values still compare favorably with the citywide rate of 14.8 premature deaths per 100,000 people (Figure B in Appendix A). To help prevent drug-related deaths and address the short- and long-term health burdens associated with substance disorders, Queens County is currently home to 31 Office of

[127] White, A. M., Tapert, S., & Shukla, S. D. (2018). Binge Drinking. *Alcohol research : current reviews*, *39*(1), 1–3.
[128] Perez-Araluce, R., Bes-Rastrollo, M., Gea, A., Martínez-González, M. A., VanderWeele, T. J., & Chen, Y. (2025). Binge drinking and subsequent health and well-being among middle-aged Spanish adults: An outcome-wide analysis. *Preventive medicine*, *191*, 108209. https://doi.org/10.1016/j.ypmed.2024.108209

Addiction Services and Supports (OASAS) Substance Use Disorder Treatment Programs and five OASAS Substance Use Disorder Prevention Programs.[129]

FHMC's current resources and programs to tackle primary prevention, substance misuse, and overdose prevention align with the NYS Prevention Agenda Objective 10.0: Increase the number of unique individuals enrolled in OASAS treatment programs from 1,108.1 to 1,218.9; and Objective 12.0: Reduce the rate of overdose deaths involving drugs per 100,000 people from 32.3 to 22.6.

FHMC's current resources and recent accomplishments with respect to primary prevention, substance misuse, and overdose prevention will be discussed in the Community Service Plan, starting on page 69.

❖ **Domain 4: HEALTH CARE ACCESS AND QUALITY**
Priority: Access to and Use of Prenatal Care

Prenatal care is an essential form of preventive care that can reduce the risk of pregnancy complications, promote fetal health and development, ensure the safety of pregnant persons' medications and lifestyle choices, and serve as an opportunity for health education.[130] While the rate of timely prenatal care is favorable in Queens CDs 2, 7, and 8 compared to the citywide rate, the percentage of pregnant people who received late or no prenatal care is elevated throughout the remainder of FHMC's PSA. Queens CD 12 in southern Queens, also served by affiliated Jamaica Hospital experiences the highest rate at 12.1%, a value 78% greater than the NYC estimate (6.8%) (Figure C in Appendix A).

FHMC's current resources and programming to address access to and use of prenatal care align with the NYS Prevention Agenda: Objective 25.0: Increase the percentage of birthing persons who receive prenatal care during the first trimester from 80.7% to 83.0%.

FHMC's current resources and recent accomplishments with respect to prenatal care will be discussed in the Community Service Plan, starting on page 70.

Priority: Prevention of Infant & Maternal Mortality

While the infant mortality rates in Queens CDs 2, 3, 7, 8, 9, and 10 compare favorably with the citywide rate, the rates in Queens CD 4 and CD 12 are higher than the NYC average, indicating the need for targeted interventions for communities in Jackson Heights, Jamaica, and Hollis (Figure D in Appendix A).

In 2021, a total of 88 pregnancy-associated or pregnancy-related deaths occurred across NYC, 14 of which occurred in Queens.[131] Most maternal mortality cases in NYC affected Black non-

[129] NYS OASAS. https://webapps.oasas.ny.gov/providerDirectory/index.cfm#search_results
[130] What is prenatal care and why is it important? *NIH NICHD*, 2017. Retrieved from https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care
[131] Pregnancy-Associated Mortality in New York City, 2021. *NYC DOHMH*, 2024. Retrieved from https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2024.pdf

Hispanic and Hispanic individuals (76% of pregnancy-associated deaths and 73% of pregnancy-related deaths), with discrimination identified as a definite or probable contributing factor in 69% of pregnancy-associated death cases.[132] Seventy-four percent (74%) of pregnancy-associated deaths in NYC were preventable,[133] highlighting the urgent need to address the compounded effect of medical racism and sexism that continues to put the lives of birthing people of color at risk.

Throughout NYC, 11.4% of postpartum individuals report experiencing depressive symptoms after giving birth, and 5.8% are diagnosed with depression after giving birth.[134] Depressive symptoms are more commonly reported among non-Hispanic Black and non-Hispanic Asian postpartum individuals (Figure G in Appendix A), as well as among unmarried postpartum individuals compared to their married counterparts.[135] Non-Hispanic Black postpartum people are more likely to ask for help for postpartum depression than any other racial or ethnic group. Across all demographic groups diagnosed with postpartum depression across NYC, 67% of all postpartum people receive counseling, and 38% take prescription medication.[136]

FHMC's current resources and programs to prevent infant and maternal mortality align with the NYS Prevention Agenda Objective 26.0: Decrease the rate of infant mortality per 1,000 live births from 4.1 to 3.5; Objective 27.0: Decrease the rate of maternal mortality per 100,000 live births from 19.8 to 16.1; and Objective 28.0: Decrease percentage of birthing persons who experience symptoms of perinatal mood and anxiety disorder (PMAD) from 11.9% to 9.9%.

FHMC's current resources and recent accomplishments with respect to maternal and infant health will be discussed in the Community Service Plan, starting on page 70.

Priority: Preventive Services for Chronic Disease Control & Prevention

Hypertension is the leading cause of cardiovascular disease and premature death worldwide, and it often coexists with conditions like Type 2 diabetes and dyslipidemia.[137] While hypertension rates in Queens CDs 2, 4, 7, 9, and 12 are comparable to or better than the NYC average, the percentage of residents with high blood pressure is elevated in Queens CDs 3, 8, and 10. Among those with hypertension, less than two-thirds of residents in Queens CD 9, Queens CD 10, and

[132] Pregnancy-Associated Mortality in New York City, 2021. *NYC DOHMH*, 2024. Retrieved from https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2024.pdf
[133] Pregnancy-Associated Mortality in New York City, 2021. *NYC DOHMH*, 2024. Retrieved from https://www.nyc.gov/assets/doh/downloads/pdf/data/maternal-mortality-annual-report-2024.pdf
[134] Pregnancy Risk Assessment Monitoring System Report, 2022. *NYS Department of Health*, 2025. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/prams/reports/#annual
[135] Pregnancy Risk Assessment Monitoring System Report, 2022. *NYS Department of Health*, 2025. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/prams/reports/#annual
[136] Pregnancy Risk Assessment Monitoring System Report, 2022. *NYS Department of Health*, 2025. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/prams/reports/#annual
[137] Lauder, L., Mahfoud, F., Azizi, M., Bhatt, D. L., Ewen, S., Kario, K., Parati, G., Rossignol, P., Schlaich, M. P., Teo, K. K., Townsend, R. R., Tsioufis, C., Weber, M. A., Weber, T., & Böhm, M. (2023). Hypertension management in patients with cardiovascular comorbidities. *European heart journal*, *44*(23), 2066–2077. https://doi.org/10.1093/eurheartj/ehac395

Queens CD 12 are on high blood pressure medication, which is lower than the citywide rate of 74%. However, the percentage of hypertensive residents in Queens CD 8 who take medication resembles the city-wide rate, and in the Queens CDs 2, 3, and 4, the percentage of hypertensive residents who take medication exceeds the NYC rate at 88% (Figure H in Appendix A).[138] Blood pressure medication rates among Queens CD 7 residents with hypertension are not reported publicly due to the small sample size.[139]

Type 2 diabetes is a chronic condition characterized by the inability to utilize insulin efficiently, which leads to consistently high blood sugar, or hyperglycemia.[140] While 12% of NYC residents have diabetes, several community districts in the PSA have higher prevalences: 14% of Queens CDs 4 and 9 residents and 16% of Queens CDs 3, 10, and 12 residents have diabetes (Figure I in Appendix A).

FHMC's current resources and programming to address preventive services for chronic disease control and prevention align with the NYS Prevention Agenda Objective 29.0: Increase the percentage of adults ages 35+ who had a test for high blood sugar in the past year from 78.1% to 82.4%; and Objective 31.0: Increase the percentage of adults ages 18+ with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.

FHMC's current resources and recent accomplishments with respect to chronic disease control and prevention will be discussed in the Community Service Plan, starting on page 69.

Priority: Oral Health Care

Indicators of poor oral health, such as tooth loss and periodontal disease, are associated with elevated cardiovascular disease mortality and high respiratory mortality in older adults; however, many oral health problems are avoidable with regular preventive dental care.[141] Approximately one third (32.7%) of NYC adult residents have not had a dental visit in the past year, including 35.3% of Queens adult residents.[142] Across NYS, Medicaid recipients are far less likely to receive regular dental care than the general population—statewide, 69.5% of Medicaid enrollees have not had any dental visits in the last year, and an additional 4.2% of Medicaid enrollees only had a dental visit to address a specific problem, rather than a preventive visit (Figure J in Appendix A).[143] It is reasonable to surmise that this trend of low utilization translates similarly in the PSA, where Medicaid beneficiaries range from 15% in Queens CD 9 and 10 to almost 25%

[139] New York City Community Health Survey, DOHMH, 2018.

[140] American Diabetes Association. About Diabetes. Understanding Type 2 Diabetes. https://diabetes.org/about-diabetes/type-2

[141] Kotronia, E., Brown, H., Papacosta, A. O., Lennon, L. T., Weyant, R. J., Whincup, P. H., Wannamethee, S. G., & Ramsay, S. E. (2021). Oral health and all-cause, cardiovascular disease, and respiratory mortality in older people in the UK and USA. *Scientific reports*, *11*(1), 16452. https://doi.org/10.1038/s41598-021-95865-z

[142] NYS Community Health Indicator Reports Dashboard, 2019-2023. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/chirs/reports/#county

[143] NYS Community Health Indicator Reports Dashboard, 2019-2023. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/chirs/reports/#county

in Queens CDs 2, 3, and 4.[144] The evidence suggests that utilization of dental services is even lower in NYC than elsewhere in NYS.[145]

FHMC's current resources and programming to address oral health care align with the NYS Prevention Agenda Objective 33.0: Increase the percentage of Medicaid enrollees with at least one preventive dental visit within the last year from 25.8% to 27.1%.

FHMC's oral health services are noted in the Community Service Plan, starting on page 69.

Priority: Preventive Services

The NYC DOHMH recommends the following childhood vaccines to prevent the spread of communicable disease:

- DTaP, for diphtheria, pertussis (whooping cough), and tetanus;
- Hib, for Hemophilus influenzae type B;
- HBV, for Hepatitis B;
- MMR, for measles, mumps, and rubella;
- PCV13, for the Pneumococcus bacteria;
- Polio;
- Rotavirus; and
- Varicella, for chickenpox.[146]

NYC and NYS generally have high childhood vaccination rates compared with other U.S. urban centers and states. The MMR vaccination rate among 2023-2024 NYS kindergarteners was 97.7%, well above the 95% threshold for herd immunity.[147] NYC cases of pertussis (preventable with the DTaP vaccine) increased 169% from 2023 (253 cases) to 2024 (427 cases).[148] While there were no cases of measles (preventable with the MMR vaccine) in NYC in 2020-2022, there was one case in 2023, 14 cases in 2024, and six cases as of June 6, 2025 (Figure K in Appendix A).[149] Vaccination rates vary by type of vaccination and community district throughout the PSA (Figure L in Appendix A). The growing nationwide rise in vaccine hesitancy increases the risk of outbreaks.

[144] New York City Community Health Survey, DOHMH, 2018.
[145] NYS Community Health Indicator Reports Dashboard, 2019-2023. Retrieved from https://apps.health.ny.gov/public/tabvis/PHIG_Public/chirs/reports/#county
[146] Vaccine-Preventable Childhood Diseases, NYC DOHMH, 2025.
[147] Donnelly, M. Childhood Vaccination Coverage Remains High in New York, But State Not Fully in the Clear. *Healthbeat New York*, 2024. Retrieved from https://www.thecity.nyc/2024/10/16/child-vaccine-rates-new-york-measles-mumps-immunity/
[148] Donnelly, M. Childhood Vaccination Coverage Remains High in New York, But State Not Fully in the Clear. *Healthbeat New York*, 2024. Retrieved from https://www.thecity.nyc/2024/10/16/child-vaccine-rates-new-york-measles-mumps-immunity/
[149] Measles, NYC DOHMH, 2025. Retrieved from https://www.nyc.gov/site/doh/health/health-topics/measles.page#byyear

FHMC's current resources and programming to address preventive services align with the NYS Prevention Agenda Objective 35.0: Increase the up-to-date seven-vaccine immunization rate for children 24-35 months from 59.30% to 62.30%.

FHMC's current resources and recent accomplishments with respect to preventive services will be discussed in the Community Service Plan, starting on page 69.

COMMUNITY SERVICE PLAN

Selection of Prevention Agenda Priorities

The Hospital directly addresses most of the health problems in its service area and refers patients to specialized health care and social service providers for services it does not provide. In 2024 FHMC expended $1,791,172 on Community Benefit services.

Respondents to the 2025 community needs survey in the Hospital's PSA revealed that the top three health and social issues of high importance but low satisfaction with services are **Violence (including gun violence), Affordable housing and homelessness prevention,** and **Mental health disorders (such as depression)**. Analysis of quantitative data on neighborhood health and social issues corroborates the survey findings that these are major problems throughout the PSA. Although FHMC has not chosen any of these issues as priorities of focus for the CSP, the Hospital expends significant resources to address these issues.

Addressing Violence (including gun violence)

- FHMC treats the immediate needs of victims of violence in its Emergency Department which is undergoing the last phase of a major expansion and upgrade with grant funding from the NYSDOH. The Hospital's intensive care units (ICUs) where many victims of violence receive treatment will be upgraded in the near future, also with grant funding from the NYSDOH. Mental health and emotional support are readily available from Flushing Hospital's mental health professionals, both in-person and by telehealth. Victims of violence are referred to community-based agencies for additional services.
- Victims with extensive traumatic injuries are transferred to Jamaica Hospital for stabilization and advanced medical trauma care. JHMC's Violence Elimination and Trauma Outreach (VETO) Program provides these patients with personalized, community centered options to support long term recovery post discharge.
- Educational information on violence and injury prevention is shared on FHMC's social media platforms (Facebook, Twitter, Instagram, YouTube) and is also distributed to the community via its electronic community newsletter.

Addressing Affordable housing and homelessness prevention

- For all non-medical social issues, Hospital staff refer patients to trusted partner agencies who can address these problems, using an automated closed-loop referral and feedback process. This process starts with documentation in the EHR of social problems identified by the patient or family, referral of patients with one or more high risk scores to trusted partners, and receipt of feedback in the EHR about the outcome of the referral.
- The Hospital joined Public Health Solutions' WholeYouNYC program designated by the NYSDOH to screen Medicaid members in Queens, Brooklyn and Manhattan for health-related social needs (HRSN) - also referred to as SDH in this document. WholeYouNYC connects Medicaid members to community resources and Medicaid-funded services, such as care management, food and nutrition services, housing supports, and transportation assistance. The Hospital provides ongoing staff training aimed at reducing explicit and implicit bias in care, which are recognized as major factors in the disparities in care and outcomes that are found among the racial and ethnic minority groups and low-income groups who live in the Hospital's service areas.

Addressing Mental health disorders (such as depression)

- FHMC is constructing a 30-bed involuntary psychiatric unit and a companion Comprehensive Psychiatric Emergency Program (CPEP) including observation beds, which are supported by grants from the NYSDOH and NYSOMH.
- Ambulatory mental health services are offered both in-person and via telehealth in the Hospital's mental health center, which was recently renovated. When the inpatient unit is opened in mid-2026 the ambulatory center will also offer follow-up care to discharged patients.
- Flushing Hospital also operates a 30-bed inpatient detoxification unit and an ambulatory care center for substance use disorder treatment.
- Mental health services are offered to patients as they are going through stress-inducing treatment for cancer in JHMC's medical oncology clinic where patients from Flushing Hospital are referred for treatment. Pairing these services during the same visit eases the burden on the patient and increases the likelihood that they will receive the mental health treatment and emotional support they need. Mental health screening is done at the first pre-natal visit and if issues such as depression, anxiety and suicidal thoughts are identified, the patient is referred to the Hospital's mental health services, and a visit is set usually within two to three days. If the situation is urgent the patient would be seen right away.
- Educational information on mental health and substance use disorders is shared on FHMC's social media platforms (Facebook, Twitter, Instagram, YouTube) and is also distributed to the community via its electronic community newsletter.

Survey respondents rated 10 health and social issues as above average in importance and above average in satisfaction with services, thus indicating that current efforts should be maintained. These are **Cancer, Dental care, Heart disease, Diabetes and high blood sugar, High blood pressure, Access to healthy/nutritious foods, Stopping falls among the elderly, Infectious diseases, Women's and maternal health care,** and **Arthritis/disease of the joints.** FHMC has chosen Cancer, in particular lung cancer screening (as part of its tobacco cessation priority) and colorectal cancer screening, as well as Women's and maternal health care, in particular breastfeeding as prevention priorities because of their importance to the community, and the Hospital's resources and capabilities. Although the Hospital has not chosen the other issues listed here as priorities of focus for the CSP, the Hospital expends significant resources to address these issues.

- The Hospital aims to reduce the prevalence and burden of these conditions through a consistent focus on prevention in its ambulatory care center, and its dental care center. The ambulatory care center continues to be re-designated by the NYS National Center for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH), which ensures that each patient has their own primary care practitioner who provides evidence-based care and support and encouragement of healthy behaviors and self-management of disease.
- FHMC partners with the NYS Cancer Services Program which offers free screenings and treatment to low-income and uninsured patients for breast, cervical, and colorectal cancers.
- FHMC, as part of the MediSys Health Network, is benefiting from the developing partnership with Memorial Sloan Kettering Cancer Center (MSKCC), which is providing local, high-quality oncology services to the people of Queens. The collaboration started with an ambulatory medical oncology center and a lung cancer screening program located in

affiliated Jamaica Hospital, both available to FHMC patients, and a MediSys-wide initiative to increase colorectal cancer screening among eligible ambulatory care patients. Plans are proceeding to add other cancer care services including breast and prostate cancer, and to build a Queens comprehensive cancer center on Jamaica Hospital's campus funded by grants from NYSDOH and NYC elected officials. Each year, thousands of Queens residents are diagnosed with some form of cancer. Having a local comprehensive cancer center means patients no longer face long travel times to receive treatment. **Details of the resources invested in promoting lung cancer and colorectal cancer screening can be found in the Implementation Plan following this section.**

- Falls prevention is tackled from many angles. At the time of admission and throughout the patient's hospitalization, the nurses at FHMC assess each patient's risk for falls and make recommendations to prevent falls during the stay, and to ensure a safe after-care environment. FHMC's primary care physicians evaluate seniors' medications to ensure that adverse reactions to one or more medications, such as dizziness, are not contributing to a heightened falls risk.
- The Hospital refers patients who report food insecurity to its network of community partners for assistance in receiving benefits such as SNAP, WIC and medically tailored meals, and to local food pantries, and to WholeYouNYC which arranges for Medicaid-funded services, such as care management, food and nutrition services, housing supports, and transportation assistance.
- The Hospital offers a full range of services to women and children in its ambulatory care center, labor and delivery and post-partum suites, newborn nursery, NICU and pediatric units. The labor and delivery and post-partum suites have recently been expanded and upgraded, and the Hospital can now offer single-bedded rooms to all post-partum patients. To counteract the negative impacts on maternal and infant health from poverty and other HRSN, FHMC refers families to community-based agencies for social service support, including the opportunity to retain a doula. In addition to the typical one-on-one relationship between the pregnant patient and their obstetrician, FHMC operates a CenteringPregnancy® program, which offers group treatment guided by licensed professionals. Mental health screening is done at the first pre-natal visit and if issues are identified the patient is referred to the Hospital's mental health services. If the situation is urgent the patient would be seen right away. Comprehensive breastfeeding education and support are offered to inpatients, outpatients and the community. **Details of the resources invested in promoting breastfeeding can be found in the Implementation Plan following this section.**
- Educational information on prevention of disease and promotion of health is shared on FHMC's social media platforms (Facebook, Twitter, Instagram, YouTube) and is also distributed to the community via its electronic community newsletter.

Survey respondents rated six (6) issues below average in relative importance, and relatively below average in satisfaction with services. These include **Assistance with basic needs like food, shelter, and clothing, Obesity in children and adults, Access to continuing education and job training programs, Job placement and employment support, Substance use disorder/addiction, and Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah**.

- Most of these issues are health related social needs (HRSN) which the Hospital addresses by referring to community-based partners and, for Medicaid recipients, by referring to PHS' WholeYouNYC program, as described above. Treatment for Substance use

disorder/addiction is offered in the Hospital's inpatient detoxification unit and its ambulatory centers for substance use disorder and mental health.

- Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah is a special focus of FHMC's because of the devastating impact it has on health, and the evidence that tobacco cessation is one of the most effective ways to prevent many of the chronic diseases that afflict the residents of our service area. **Details of the resources invested in promoting tobacco cessation can be found in the Implementation Plan following this section.**

Prioritization Methods

While continuing its efforts to address the numerous health and social issues identified in the NYS Prevention Agenda, the Hospital's CHNA and NYC's HealthyNYC campaign, Hospital leadership decided based on community health data, survey results and the Hospital's resources and capabilities to continue its focus on its two prevention priorities and to add a third priority related to colorectal cancer screening in the upcoming 3-year cycle of its Community Service Plan/Implementation Plan:

- **Promote Tobacco Cessation**
- **Increase Breastfeeding**
- **Increase Colorectal Cancer Screening**

FHMC used the following criteria in selecting these three priorities:

- Alignment with NYS Prevention Agenda Priorities
  - Domain 2. Social and Community Context - Priority: Tobacco/E-Cigarette Use - NYS Objective 14.0. Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%
  - Domain 2. Social and Community Context - Priority: Healthy Eating - NYS Objective 20.0. Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%. and 20.1. Increase the percentage of Black, non-Hispanic infants who are exclusively breastfed in the hospital from 34.1% to 35.8%
  - Domain 4. Health Care Access and Quality - Priority: Preventive Services for Chronic Disease Prevention & Control - NYS Objective 33.0: Increase the percentage of adults ages 45-75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80.0%. and 33.1 Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 54.7% to 62.2%
- Alignment with Healthy People 2030 Objectives
  - Reduce current tobacco use in adults.
  - Increase the proportion of infants who are breastfed exclusively through age 6 months.
  - Increase the proportion of adults who get screened for colorectal cancer.
- Alignment with HealthyNYC
  - The Healthy NYC campaign lists "Prevent tobacco use and reduce smoking and alcohol consumption" as a priority strategy to reduce deaths driven by chronic and diet-related diseases, including screenable cancers such as lung cancer.
  - The Healthy NYC campaign lists "Improve access to and quality of obstetric health care along the whole continuum of pregnancy, childbirth, and postnatal care" as a priority strategy to reduce deaths driven by maternal mortality".
  - The Healthy NYC campaign lists "Increase prevention activities and social supports" as

a priority strategy to reduce deaths driven by chronic and diet-related diseases, including screenable cancers such as colon cancer.

- Alignment with community survey results and community health and social needs statistics
  - Cigarette smoking/tobacco use/vaping is rated as below average in relative satisfaction with services in the PSA.
  - Connection between Smoking/Tobacco use/vaping and Cancer and Heart disease is strong. PSA respondents rated Cancer and Heart disease as relatively high in importance.
  - Women's and maternity care is rated by PSA respondents overall as above average in importance and above average in satisfaction with services. However, CD 3 rated this issue below average in satisfaction with services.
  - Cancer care is rated by PSA respondents overall as above average in importance and above average in satisfaction with services. However, CDs 2 and 3 rated this issue below average in satisfaction with services.
- Alignment with key items on the hospital's agenda
  - Support training of staff as tobacco treatment specialists (TTS).
  - Increase referrals of smokers to the Network's lung cancer screening program to increase survival rates of smokers who develop lung cancer.
  - Adhere to Baby Friendly Hospital standards, which are designed to support exclusive breastfeeding, and retain the designation.
  - Support the Hospital's breastfeeding internship program for International Board of Lactation Consultant Examiners (IBCLC) certification to increase the number of IBCLCs in the community.
  - Provide breastfeeding support to mothers through at least the first six months of the infant's life.
  - Support a primary care initiative to increase colorectal cancer screening among eligible patients, and to ensure annual follow-up.
  - Eliminate health disparities and achieve health equity, including reducing explicit and implicit bias in the care of racial/ethnic minority groups and low-income groups who make up a significant percentage of the Hospital's patients and its communities.
  - Leverage the Hospital and MediSys Network-wide resources already committed, including work groups focused on these programs.
  - Focus attention and resources on programs with a high potential for significant improvement in health and quality of life.

The charts in the following section (Implementation Plan) outline the Hospital's 2025-2027 Goals, Objectives, and Interventions for the Hospital's three Prevention Priorities. Outcome data for each objective in the Implementation Plan will be shared in annual Plan updates.

IMPLEMENTATION PLAN 2025 - 2027

Domain 2: Social and Community Context
Priority: Tobacco/E-Cigarette Use
NYS Objective 14.0:
- Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.

FHMC Priority 1: Promote Tobacco Cessation

Hospital Goals	Objectives
1) Reduction in number and percentage of tobacco users among general medical/surgical and behavioral health patients aged 18 and above. 2) Increased use of LDCT lung cancer diagnostics to identify patients with lung cancer and ultimately increase lung cancer survival rate in the community.	▪ Achieve a general medical/surgical outpatient (OP) smoking prevalence rate for those 18 and older at or below NYS target (7.9%). ▪ Reduce behavioral health OP smoking prevalence rate below current NYS rate for those 18 and older with frequent mental distress (14.2%). ▪ Achieve equality between white and non-white patients in offering smoking cessation interventions, including medication and counseling. ▪ Annual percentage increase of 2% in eligible patients in our system who receive low dose CT (LDCT) screening for lung cancer. ▪ Follow-up annual screening on all patients who remain eligible.

Interventions/Strategies/Activities
▪ Resume regular tobacco treatment program meetings to assess program effectiveness and make necessary course corrections. ▪ Provide staff training to assess patients for tobacco use, prescribe tobacco cessation medications, and refer to cessation counseling. ▪ Train patient navigators and other staff as tobacco treatment specialists (TTS). ▪ Track number and percentage of assessments and interventions, and prevalence of smoking for returning outpatient smokers. ▪ Refer eligible patients to the network's comprehensive, patient-centered lung cancer screening (LCS) program, including early detection and follow-up. ▪ Offer tobacco cessation information and referral to treatment at community events hosted or attended by hospital staff. ▪ Increase community awareness of tobacco cessation resources via social and print media.

Domain 2: Social and Community Context
Priority: Healthy Eating
NYS Objective:

- 20.0 Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%.
- 20.1 Increase the percentage of Black, non-Hispanic infants who are exclusively breastfed in the hospital from 34.1% to 35.8%.

FHMC Priority 2: Increase Breastfeeding

Hospital Goals	Objectives
1. Exclusive or predominantly breastfeeding in hospital for as many patients as clinically possible and culturally acceptable 2. Exclusive breastfeeding at 3 and 6 months for as many patients as clinically possible and culturally acceptable	• Increase exclusive BF rate at discharge from current rate of 12% to 17%. • Increase predominantly BF rate at discharge from current rate of 28% to 30%. • Maintain BF equality among all racial/ethnic groups. • Maintain Baby Friendly USA Designation (current redesignation runs from 2023-2028) • Of the well-babies whose feeding history is documented in machine readable form, maintain BF exclusive and predominantly BF rates at 90% or above at 3 and 6 months.

Domain 2: Social and Community Context
Priority: Healthy Eating
NYS Objective:
- 20.0 Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%.
- 20.1 Increase the percentage of Black, non-Hispanic infants who are exclusively breastfed in the hospital from 34.1% to 35.8%.

FHMC Priority 2: Increase Breastfeeding

Interventions/Strategies/Activities
• Educate the community about the importance of breastfeeding, chestfeeding, and prenatal care at community events hosted or attended by Hospital staff, via social media and print and by engaging community groups such as Bridge to Life, Queens library staff and patrons, community-based physician practices. • Remain available for mothers referred by community physician practices to assist their patients in BF and other pregnancy related topics. • Increase referrals to outpatient social support services and doula providers, including hosting navigators from Public Health Solutions (PHS) to engage patients in the ambulatory care center. • Incorporate Unite Us electronic portal into the workflow as a means of referral to the PHS Social Care Network. • Train all pediatricians and obstetricians and other clinical and support staff about BF annually. • Send employees to Certified Lactation Consultant (CLC) Course, sponsored by NYC DOHMH. • Continue breastfeeding internship program for International Board of Lactation Consultant Examiners (IBCLC) certification, led by the hospital's IBCLC staff, with 4 interns per cycle, 2 cycles per year. • Continue weekly interdisciplinary committee meetings focused on maintaining standards of care for Baby Friendly designation. • Offer human milk from NY Milk Bank to preterm infants who meet the clinical guidelines when mother is unable to produce enough of her own milk. • Continue to give mothers at discharge the "warm line" number to hospital IBCLC; continue offering this service to community members. • Continue to provide access for mothers at discharge to the NYC warm line that provides telephonic BF support. • Continue expanding enrollment in the hospital's CenteringPregnancy® site, a group prenatal care program which includes education sessions on BF. • Maintain current high enrollment of women in the Hospital's and WIC's breastfeeding programs, support groups, prenatal nutrition classes. • Continue Talk and Tea weekly infant feeding support group in the ambulatory care center guided by an IBCLC once per week. • Use Newborn Channel to educate postpartum patients.

Domain 4: Health Care Access and Quality
Priority: Preventive Services for Chronic Disease Prevention & Control
NYS Objective:
- 33.0: Increase the percentage of adults ages 45-75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 71.6% to 80.0%.
- 33.1 Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 54.7% to 62.2%.

FHMC Priority 3: Increase Colorectal Cancer Screening

Hospital Goals	Objectives
1. All hospital primary care patients ages 45-75 years are up to date on colorectal cancer screening 2. Increased colorectal cancer survival rate in the community through early detection and follow up	▪ Increase screening rates for 45-75 age group from 29% to 32% over the 3-year cycle. ▪ Increase screening rates for 45-54 age group from 22% to 25% over the 3-year cycle. ▪ Achieve equality in colorectal cancer screening rates between white and non-white patients.

Interventions/Strategies/Activities
• Refine the hospital's comprehensive, direct referral, patient-centered colorectal cancer screening (CRCS) program, including automated patient reminders, distribution of psychoeducational materials, and automated data collection and reporting. • Employ provider assessment and feedback systems to increase cancer screening per national guidelines. • Establish routine educational forums for all providers and key support staff (and community providers) about the hospital's CRCS program. • Increase the number of providers who are trained in Lifestyle Medicine. • Partner with community-based organizations to promote access to prevention and screening services. • Continue to integrate patient navigators into health care teams to improve chronic disease management. • Continue to work with the NYS Cancer Screening Program to improve access to cancer screening and diagnostic testing for individuals without health insurance. • Include community voices in identifying changes, solutions, and innovations needed to address disparities.

Appendix A: Figures Addressing the NYS Prevention Agenda in FHMC's PSA

❖ **Domain 2: SOCIAL AND COMMUNITY CONTEXT**
Priority: Primary Prevention, Substance Misuse, and Overdose Prevention

Figure A. Percentage of Residents Self-Reporting Binge Drinking in the Past 30 Days by Community District

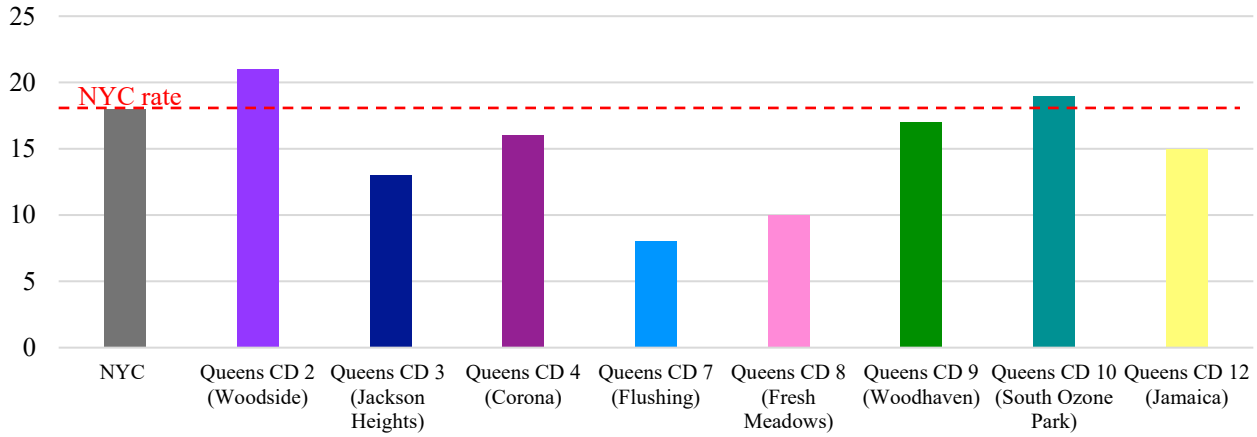
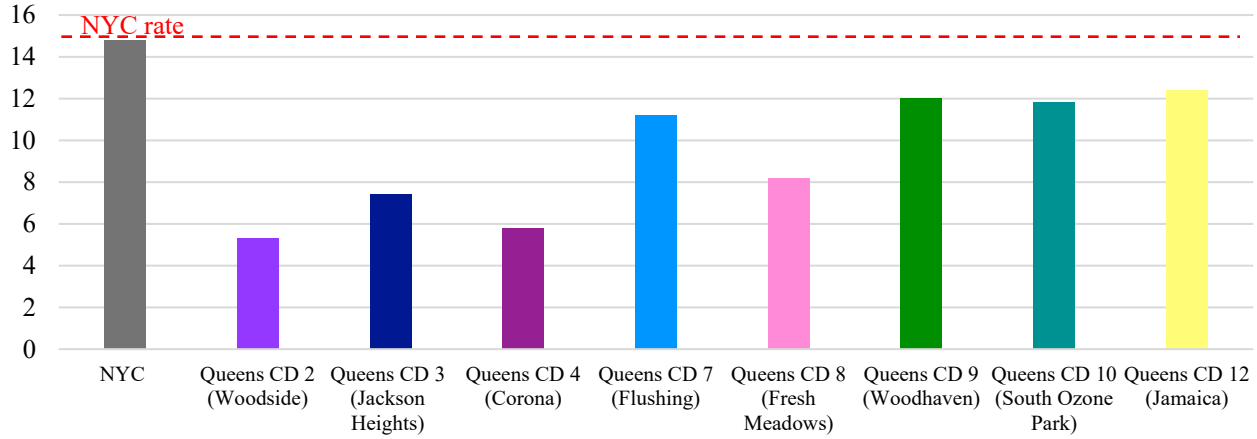
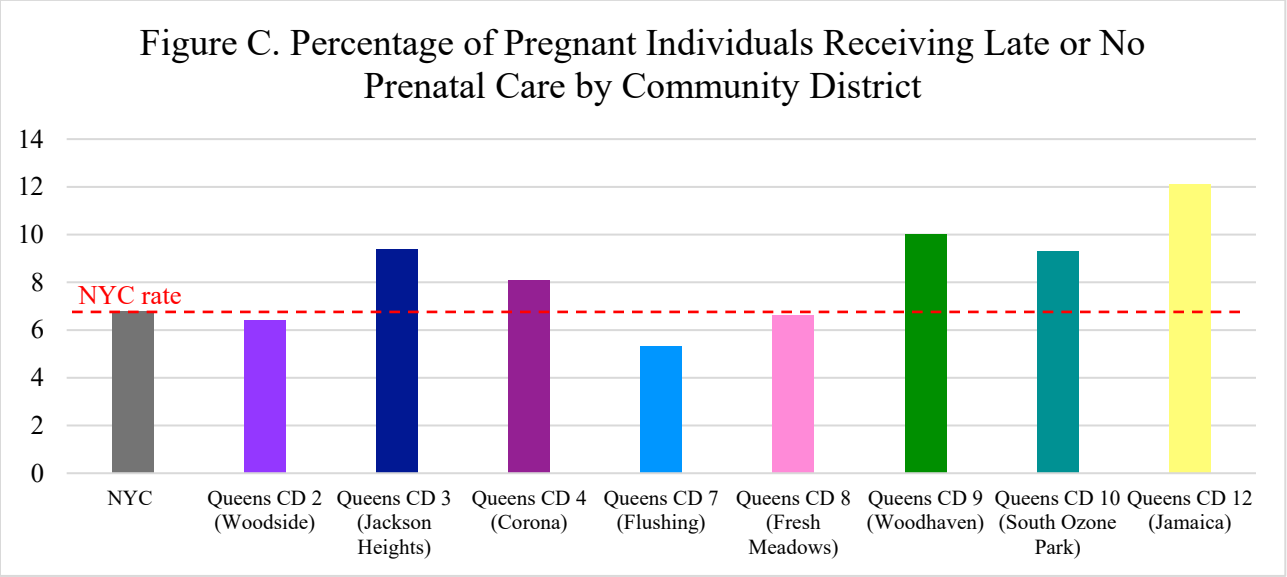


Figure B. Premature Deaths Attributable to Drug Use (per 100,000 Residents) by Community District



❖ **Domain 4: HEALTH CARE ACCESS AND QUALITY**
Priority: Access to and Use of Prenatal Care



Priority: Prevention of Infant & Maternal Mortality

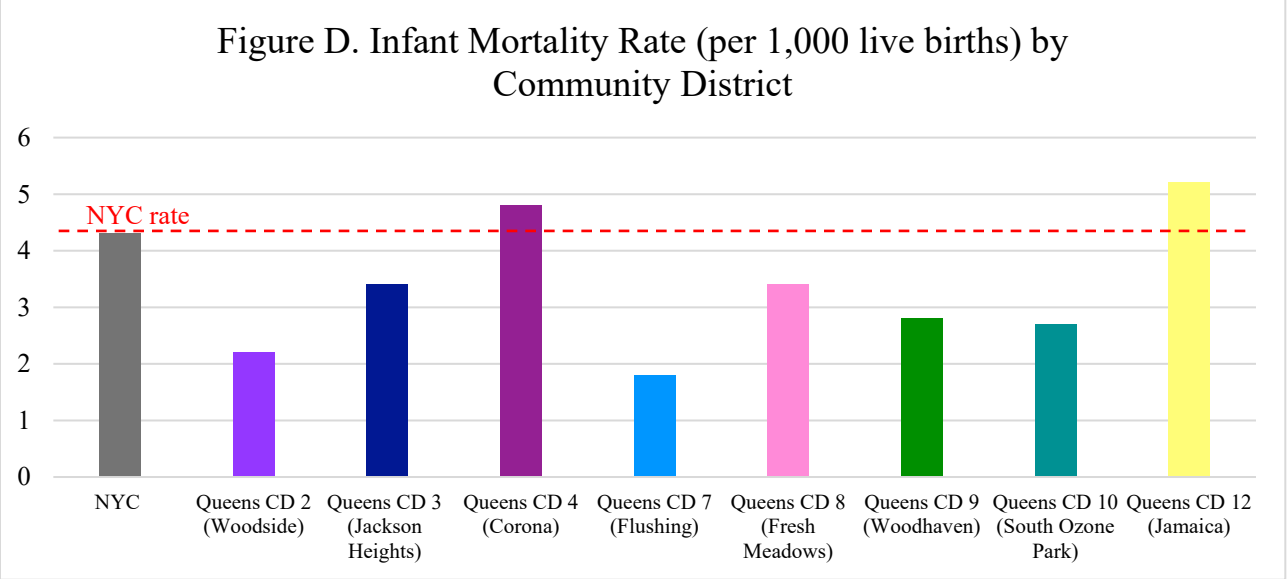


Figure E. Preterm Birth Rate by Community District

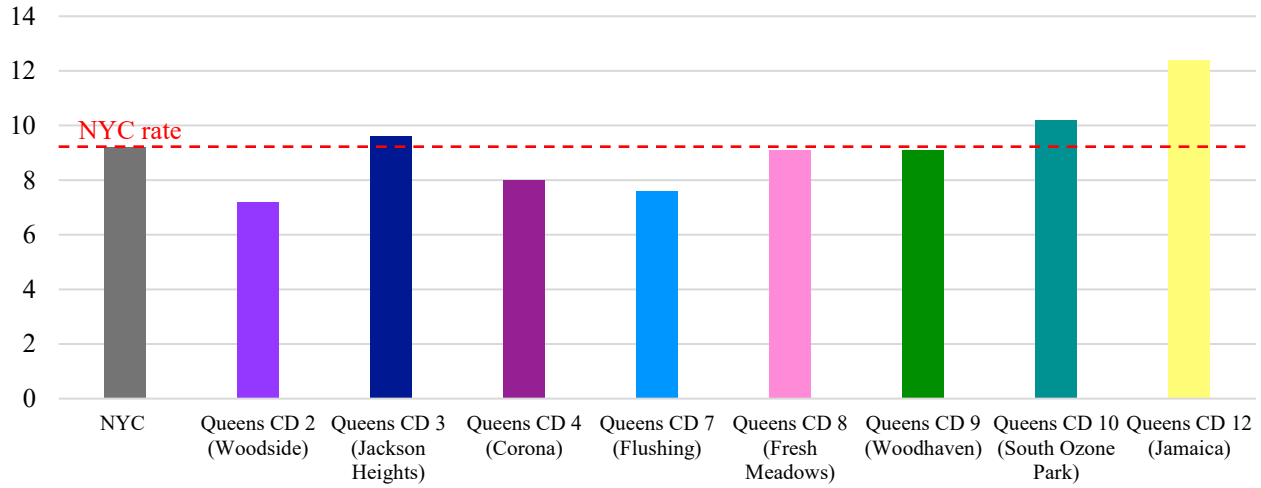


Figure F. Low Birthweight Baby Prevalence by Community District

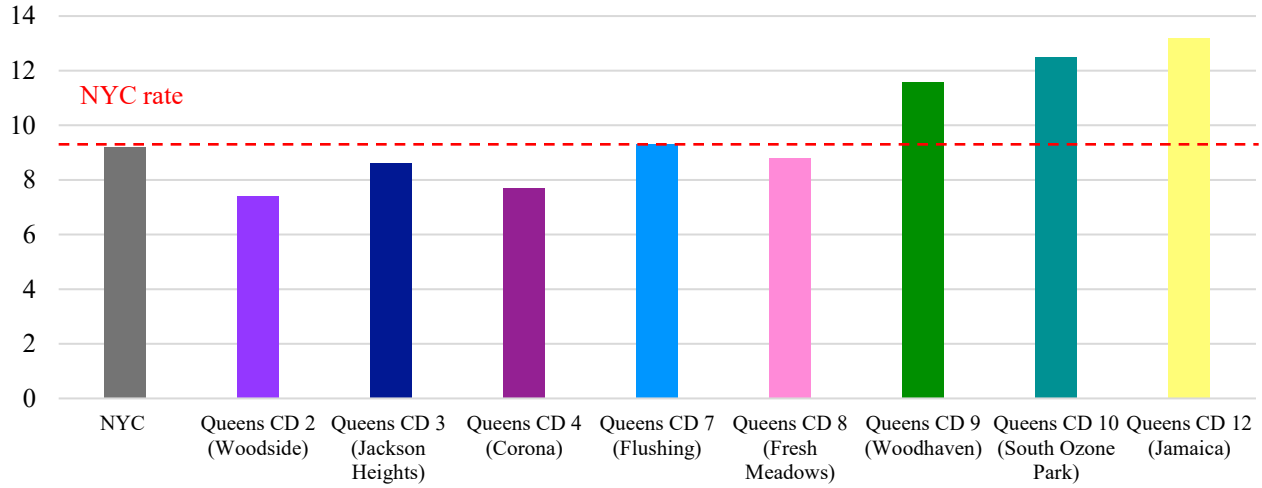
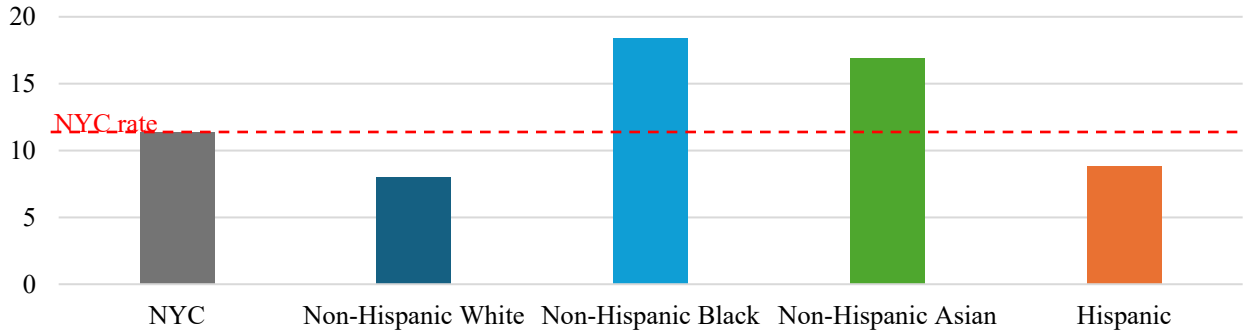
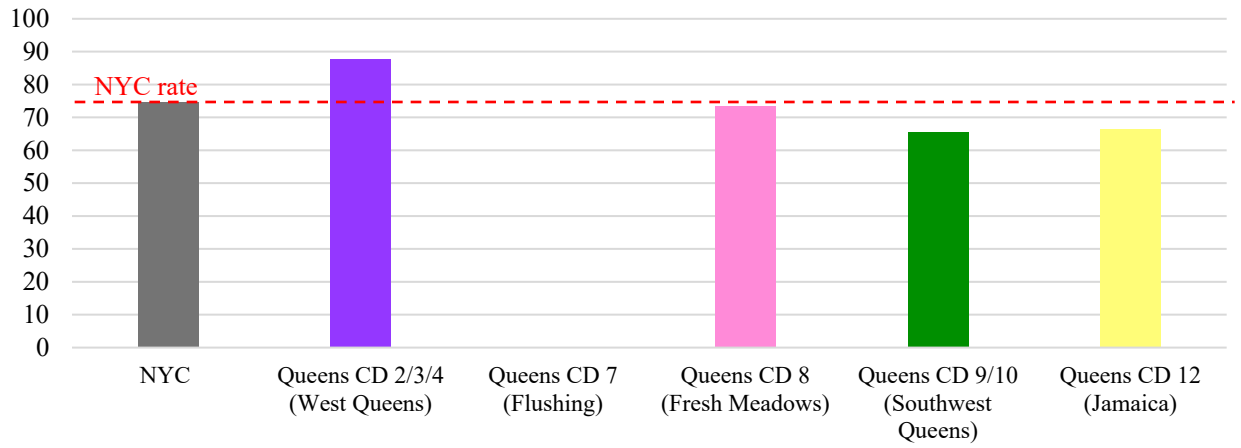


Figure G. Percentage of Postpartum NYC Residents Reporting Depressive Symptoms by Race/Ethnicity



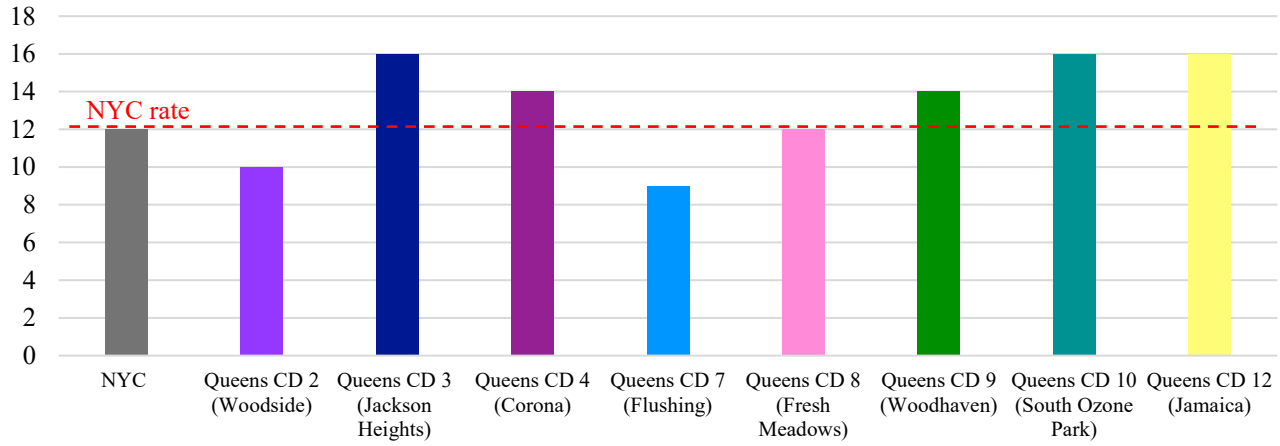
Priority: Preventive Services for Chronic Disease Control & Prevention

Figure H. Percentage of Individuals with Hypertension Currently Taking Blood Pressure Medication (by Community District)*



* Blood pressure medication rates among Queens CD 7 residents with hypertension are not reported publicly due to the small sample size.[1]

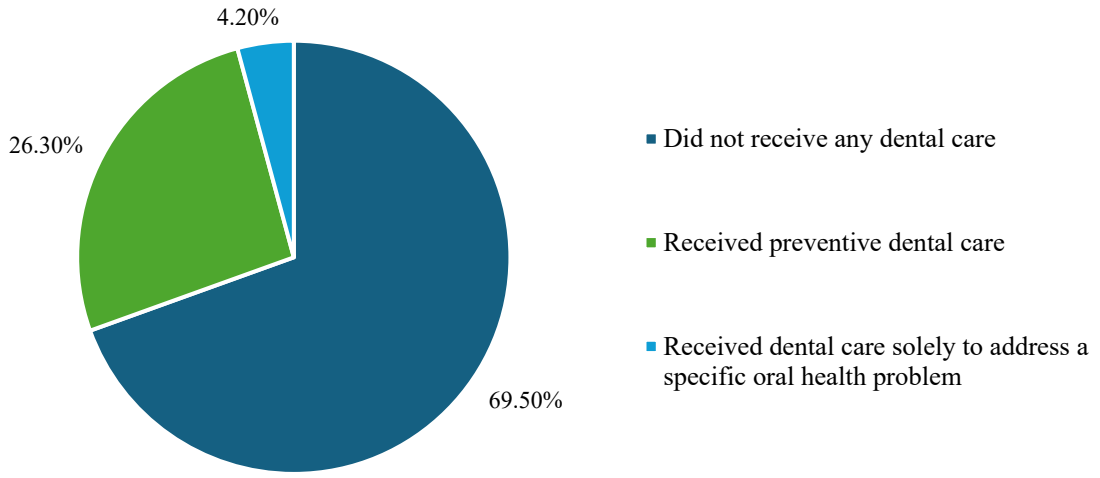
Figure I. Percentage of Individuals with Type 2 Diabetes by Community District



[1] New York City Community Health Survey, DOHMH, 2018.

Priority: Oral Health Care

Figure J. Dental Care Utilization Percentages Among NYS Medicaid Enrollees (2021-2023)



Priority: Preventive Services

Figure K. Number of Measles Cases in NYC by Year

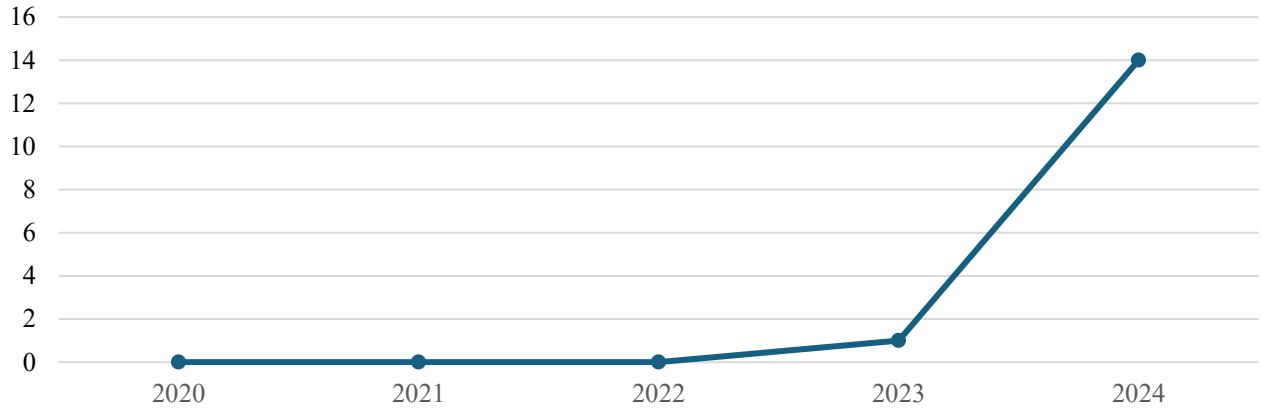
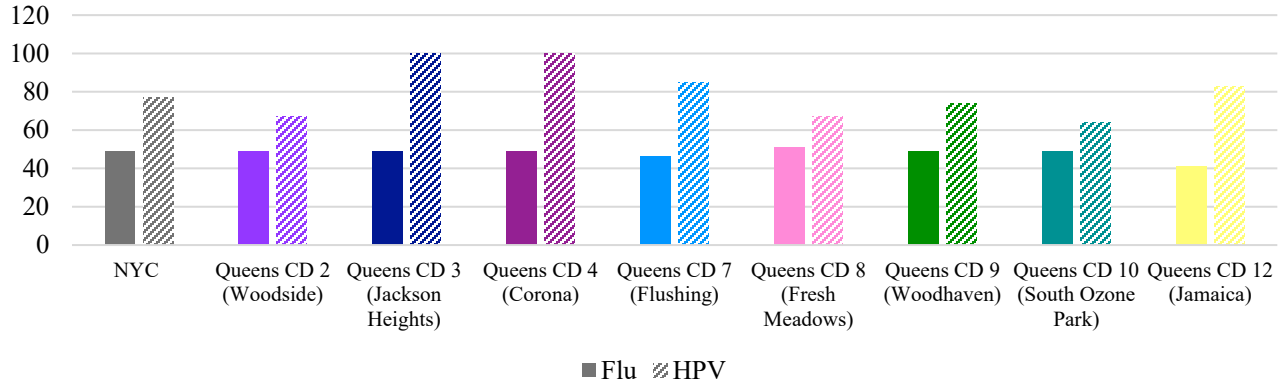


Figure L. Percentage of Adult Residents Receiving Flu Vaccinations and Teen Residents (Ages 13-17) Receiving HPV Vaccinations (by Community District)



APPENDIX B

2025 GNYHA Community Health Needs Assessment Collaborative

Flushing Hospital Medical Center PSA

Respondent Characteristics

Survey Administration Mode	Number	Percent
Online Survey	2,014	100%
Paper Survey	5	0%
Survey Administration Language	**Number**	**Percent**
English	1,527	76%
Spanish	412	20%
Arabic	5	0%
Bengali	27	1%
Burmese	0	0%
Chinese	15	1%
Chinese (Traditional)	4	0%
French	8	0%
Haitian Creole	5	0%
Hindi	5	0%
Italian	0	0%
Japanese	1	0%
Korean	8	0%
Nepali	0	0%
Polish	0	0%
Russian	0	0%
Urdu	2	0%
Uzbek	0	0%
Yiddish	0	0%
Health Insurance Source	**Number**	**Percent**
A plan purchased through an employer or union (including plans purchased through another person's employer)	256	26%
A private nongovernmental plan that you or another family member buys on your own	24	2%
Medicare	298	31%
Medigap	5	1%
Medicaid	267	27%
Children's Health Insurance Program (CHIP)	10	1%
Military related health care: TRICARE (CHAMPUS) /VA health care /CHAMP-VA	4	0%
Indian Health Services	0	0%
State sponsored health plan	50	5%
Other government program	22	2%
No coverage of any type	35	4%
Missing	1,048	

2025 GNYHA Community Health Needs Assessment Collaborative

Flushing Hospital Medical Center PSA

Respondent Characteristics

Race and Ethnicity (do not add to 100%)	Number	Percent
American Indian or Alaska Native alone or in combination	26	3%
Asian alone or in combination	157	17%
Black or African American alone or in combination	285	31%
Hispanic or Latino alone or in combination	312	34%
Middle Eastern or North African alone or in combination	9	1%
Native Hawaiian or Pacific Islander alone or in combination	9	1%
White alone or in combination	176	19%
Missing	1,090	

Race and Ethnicity (add to 100%, with Multiracial)	Number	Percent
American Indian or Alaska Native alone	17	2%
Asian alone	151	16%
Black or African American alone	266	29%
Hispanic or Latino alone	294	32%
Middle Eastern or North African alone	5	1%
Native Hawaiian or Pacific Islander alone	7	1%
White alone	159	17%
Multiracial and/or Multiethnic	30	3%
Missing	1,090	

Limited English Proficiency (LEP)	Number	Percent
Limited English Proficiency (LEP, Speak a language other than English and have at least some difficulty with English)	190	19%
Speak English Proficiently (English-only speaker or able to speak English very well)	791	81%
Missing	1,038	

2025 GNYHA Community Health Needs Assessment Collaborative

Flushing Hospital Medical Center PSA

Respondent Characteristics

Language Spoken at Home	Number	Percent
English-only speaker	526	55%
Spanish	257	27%
Arabic	6	1%
Bengali	27	3%
Burmese	1	0%
Chinese	23	2%
French	19	2%
Haitian Creole	14	1%
Hindi	16	2%
Italian	7	1%
Japanese	3	0%
Korean	6	1%
Nepali	2	0%
Polish	1	0%
Russian	6	1%
Urdu	15	2%
Yiddish	1	0%
Other	72	7%

Sexual Orientation	Number	Percent
Gay or lesbian	17	2%
Straight, that is not gay or lesbian	835	90%
Bisexual	29	3%
I use a different term	46	5%
Missing	1,092	

Gender Identity	Number	Percent
Cisgender Man	261	27%
Cisgender Woman	699	72%
Gender Minority	12	1%
Missing	1,047	

APPENDIX B

2025 GNYHA Community Health Needs Assessment Collaborative

Flushing Hospital Medical Center PSA

Respondent Characteristics

Age	Number	Percent
18 - 24	40	4%
25 - 34	88	9%
35 - 44	141	14%
45 - 54	159	16%
55 - 64	221	23%
65 - 74	246	25%
75+	84	9%
Missing	1,040	
Education	**Number**	**Percent**
Grades 8 (Elementary) or less	46	5%
Grades 9 through 11 (Some High School)	82	9%
Grade 12 or GED (High School Graduate)	255	27%
College 1 year to 3 years (Some college or technical school)	278	29%
College 4 years or more (College graduate)	300	31%
Missing	1,058	
Household Size	**Number**	**Percent**
1 person	192	21%
2 people	227	25%
3 people	161	18%
4 people	149	17%
5 or more people	169	19%
Missing	1,121	

Employment Status	Number	Percent
Employed for wages	352	38%
Self-employed	37	4%
Out of work for 1 year or more	42	5%
Out of work for less than 1 year	26	3%
A homemaker	66	7%
A student	26	3%
Retired	255	27%
Unable to work	128	14%
Missing	1,087	

2025 GNYHA Community Health Needs Assessment Collaborative

Flushing Hospital Medical Center PSA

Respondent Characteristics

Income	Number	Percent
Less than $20,000	254	30%
$20,000 to $24,999	94	11%
$25,000 to $34,999	110	13%
$35,000 to $49,999	102	12%
$50,000 to $74,999	136	16%
$75,000 to $99,999	61	7%
$100,000 to $149,999	59	7%
$150,000 to $199,999	28	3%
$200,000 or more	12	1%
Missing	1,163	

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 2

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Health Care Access and Quality	Cancer	1	4.74	Above Average	23	20	2.55	Below Average	20
Social and Community Context	Mental health disorders (such as depression)	2	4.45	Above Average	20	16	2.73	Below Average	15
Health Care Access and Quality	Diabetes and high blood sugar	3	4.35	Above Average	17	19	2.57	Below Average	14
Economic Stability	Affordable housing and homelessness prevention	9	4.19	Above Average	21	21	2.33	Below Average	21
Health Care Access and Quality	Dental care	10	4.12	Above Average	25	14	2.76	Below Average	21
Neighborhood and Built Environment	Stopping falls among elderly	12	4.05	Above Average	22	15	2.74	Below Average	19
Maintain Efforts									
Neighborhood and Built Environment	Violence (including gun violence)	4	4.35	Above Average	20	4	2.94	Above Average	18
Health Care Access and Quality	Women's and maternal health care	5	4.32	Above Average	22	8	2.88	Above Average	17
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	6	4.30	Above Average	23	3	3.00	Above Average	20
Health Care Access and Quality	Heart disease	7	4.29	Above Average	21	9	2.82	Above Average	17
Health Care Access and Quality	Arthritis/disease of the joints	8	4.21	Above Average	19	11	2.80	Above Average	15
Health Care Access and Quality	Obesity in children and adults	11	4.10	Above Average	21	4	2.94	Above Average	18
Economic Stability	Access to healthy/nutritious foods	12	4.05	Above Average	22	3	3.00	Above Average	19
Relatively Lower Priority									
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	14	3.90	Below Average	20	12	2.78	Below Average	18
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	16	3.86	Below Average	22	17	2.69	Below Average	16
Health Care Access and Quality	Hepatitis C/liver disease	18	3.67	Below Average	18	13	2.77	Below Average	13
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	20	3.61	Below Average	18	22	2.27	Below Average	15
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	23	3.39	Below Average	18	18	2.63	Below Average	16
Health Care Access and Quality	Adolescent and child health	13	4.00	Below Average	21	3	3.00	Above Average	18
Health Care Access and Quality	High blood pressure	13	4.00	Below Average	25	2	3.05	Above Average	20
Health Care Access and Quality	Infant health	13	4.00	Below Average	20	5	2.93	Above Average	15
Health Care Access and Quality	Asthma, breathing issues, and lung disease	15	3.89	Below Average	19	10	2.81	Above Average	16
Education Access and Quality	School health and wellness programs	17	3.68	Below Average	19	1	3.18	Above Average	17
Economic Stability	Job placement and employment support	19	3.64	Below Average	22	7	2.89	Above Average	18
Economic Stability	Assistance with basic needs like food, shelter, and clothing	21	3.55	Below Average	22	6	2.89	Above Average	19
Education Access and Quality	Access to continuing education and job training programs	22	3.50	Below Average	18	11	2.80	Above Average	15

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 3

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Health Care Access and Quality	Dental care	1	4.48	Above Average	23	15	2.85	Below Average	20
Health Care Access and Quality	Cancer	2	4.42	Above Average	24	10	2.90	Below Average	20
Neighborhood and Built Environment	Stopping falls among elderly	3	4.30	Above Average	23	11	2.89	Below Average	18
Neighborhood and Built Environment	Violence (including gun violence)	7	4.19	Above Average	21	17	2.81	Below Average	16
Social and Community Context	Mental health disorders (such as depression)	8	4.18	Above Average	22	21	2.68	Below Average	19
Health Care Access and Quality	Women's and maternal health care	11	4.09	Above Average	23	10	2.90	Below Average	20
Education Access and Quality	School health and wellness programs	12	4.05	Above Average	20	16	2.84	Below Average	19
Education Access and Quality	Access to continuing education and job training programs	13	4.05	Above Average	21	19	2.74	Below Average	19
Maintain Efforts									
Health Care Access and Quality	Heart disease	4	4.26	Above Average	23	1	3.24	Above Average	21
Health Care Access and Quality	High blood pressure	5	4.20	Above Average	25	7	2.95	Above Average	21
Economic Stability	Access to healthy/nutritious foods	6	4.19	Above Average	26	6	3.00	Above Average	24
Health Care Access and Quality	Adolescent and child health	9	4.13	Above Average	24	3	3.19	Above Average	21
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	9	4.13	Above Average	24	1	3.24	Above Average	21
Economic Stability	Job placement and employment support	9	4.13	Above Average	24	9	2.94	Above Average	18
Health Care Access and Quality	Infant health	10	4.09	Above Average	22	2	3.20	Above Average	20
Economic Stability	Assistance with basic needs like food, shelter, and clothing	14	4.05	Above Average	22	5	3.05	Above Average	20
Relatively Lower Priority									
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	15	4.00	Below Average	23	18	2.76	Below Average	21
Health Care Access and Quality	Obesity in children and adults	16	3.92	Below Average	25	14	2.86	Below Average	21
Economic Stability	Affordable housing and homelessness prevention	17	3.91	Below Average	22	20	2.72	Below Average	18
Health Care Access and Quality	Asthma, breathing issues, and lung disease	19	3.86	Below Average	21	22	2.65	Below Average	17
Health Care Access and Quality	Arthritis/disease of the joints	20	3.83	Below Average	24	10	2.90	Below Average	20
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	22	3.73	Below Average	22	12	2.88	Below Average	17
Health Care Access and Quality	Hepatitis C/liver disease	23	3.72	Below Average	25	13	2.86	Below Average	22
Health Care Access and Quality	Diabetes and high blood sugar	18	3.88	Below Average	25	4	3.13	Above Average	23
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	21	3.81	Below Average	26	7	2.95	Above Average	21
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	24	3.46	Below Average	24	8	2.95	Above Average	19

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 4

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Health Care Access and Quality	Arthritis/disease of the joints	6	4.12	Above Average	49	14	2.93	Below Average	43
Health Care Access and Quality	Obesity in children and adults	6	4.12	Above Average	49	19	2.85	Below Average	46
Economic Stability	Affordable housing and homelessness prevention	10	4.04	Above Average	54	20	2.81	Below Average	47
Maintain Efforts									
Health Care Access and Quality	Cancer	1	4.29	Above Average	52	10	3.02	Above Average	48
Health Care Access and Quality	Infant health	2	4.24	Above Average	49	11	3.02	Above Average	49
Health Care Access and Quality	Women's and maternal health care	3	4.22	Above Average	51	1	3.20	Above Average	51
Health Care Access and Quality	Heart disease	4	4.17	Above Average	47	2	3.14	Above Average	44
Health Care Access and Quality	Diabetes and high blood sugar	5	4.16	Above Average	49	9	3.02	Above Average	45
Education Access and Quality	School health and wellness programs	5	4.16	Above Average	49	3	3.12	Above Average	49
Economic Stability	Access to healthy/nutritious foods	7	4.12	Above Average	51	9	3.02	Above Average	45
Health Care Access and Quality	High blood pressure	8	4.10	Above Average	50	4	3.12	Above Average	50
Health Care Access and Quality	Dental care	9	4.10	Above Average	52	7	3.07	Above Average	45
Relatively Lower Priority									
Social and Community Context	Mental health disorders (such as depression)	12	4.02	Below Average	51	17	2.90	Below Average	48
Neighborhood and Built Environment	Stopping falls among elderly	13	4.02	Below Average	52	18	2.87	Below Average	45
Neighborhood and Built Environment	Violence (including gun violence)	14	4.00	Below Average	49	16	2.90	Below Average	42
Health Care Access and Quality	Asthma, breathing issues, and lung disease	15	3.98	Below Average	51	13	2.96	Below Average	48
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	17	3.98	Below Average	44	22	2.58	Below Average	43
Health Care Access and Quality	Hepatitis C/liver disease	19	3.93	Below Average	42	15	2.93	Below Average	42
Economic Stability	Assistance with basic needs like food, shelter, and clothing	21	3.80	Below Average	51	16	2.90	Below Average	42
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	23	3.69	Below Average	48	21	2.76	Below Average	45
Education Access and Quality	Access to continuing education and job training programs	11	4.02	Below Average	50	12	3.00	Above Average	43
Health Care Access and Quality	Adolescent and child health	16	3.98	Below Average	49	8	3.05	Above Average	44
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	18	3.96	Below Average	45	5	3.11	Above Average	46
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	18	3.96	Below Average	45	2	3.14	Above Average	44
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	20	3.90	Below Average	51	12	3.00	Above Average	44
Economic Stability	Job placement and employment support	22	3.78	Below Average	50	6	3.09	Above Average	45

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community Districts 3 and 4

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Neighborhood and Built Environment	Stopping falls among elderly	9	4.11	Above Average	75	21	2.87	Below Average	63
Social and Community Context	Mental health disorders (such as depression)	10	4.07	Above Average	73	23	2.84	Below Average	67
Neighborhood and Built Environment	Violence (including gun violence)	12	4.06	Above Average	70	19	2.88	Below Average	58
Health Care Access and Quality	Obesity in children and adults	13	4.05	Above Average	74	22	2.85	Below Average	67
Maintain Efforts									
Health Care Access and Quality	Cancer	1	4.33	Above Average	76	13	2.99	Above Average	68
Health Care Access and Quality	Dental care	2	4.21	Above Average	75	12	3.00	Above Average	65
Health Care Access and Quality	Heart disease	3	4.20	Above Average	70	1	3.17	Above Average	65
Health Care Access and Quality	Infant health	4	4.20	Above Average	71	6	3.07	Above Average	69
Health Care Access and Quality	Women's and maternal health care	5	4.18	Above Average	74	3	3.11	Above Average	71
Economic Stability	Access to healthy/nutritious foods	6	4.14	Above Average	77	11	3.01	Above Average	69
Health Care Access and Quality	High blood pressure	7	4.13	Above Average	75	7	3.07	Above Average	71
Education Access and Quality	School health and wellness programs	8	4.13	Above Average	69	10	3.04	Above Average	68
Health Care Access and Quality	Diabetes and high blood sugar	11	4.07	Above Average	74	8	3.06	Above Average	68
Relatively Lower Priority									
Education Access and Quality	Access to continuing education and job training programs	14	4.03	Below Average	71	17	2.92	Below Average	62
Health Care Access and Quality	Arthritis/disease of the joints	15	4.03	Below Average	73	16	2.92	Below Average	63
Economic Stability	Affordable housing and homelessness prevention	17	4.00	Below Average	76	25	2.78	Below Average	65
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	18	3.99	Below Average	67	26	2.64	Below Average	64
Health Care Access and Quality	Asthma, breathing issues, and lung disease	19	3.94	Below Average	72	20	2.88	Below Average	65
Economic Stability	Assistance with basic needs like food, shelter, and clothing	22	3.88	Below Average	73	15	2.95	Below Average	62
Health Care Access and Quality	Hepatitis C/liver disease	23	3.85	Below Average	67	18	2.91	Below Average	64
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	25	3.70	Below Average	70	24	2.79	Below Average	62
Health Care Access and Quality	Adolescent and child health	15	4.03	Below Average	73	4	3.09	Above Average	65
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	16	4.01	Below Average	69	2	3.15	Above Average	67
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	20	3.90	Below Average	71	5	3.08	Above Average	65
Economic Stability	Job placement and employment support	21	3.89	Below Average	74	9	3.05	Above Average	63
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	24	3.76	Below Average	75	14	2.98	Above Average	63

*How important is this issue to you?
**How satisfied are you with the current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 7

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Economic Stability	Affordable housing and homelessness prevention	9	3.90	Above Average	98	26	2.49	Below Average	91
Neighborhood and Built Environment	Stopping falls among elderly	10	3.85	Above Average	101	17	2.91	Below Average	77
Social and Community Context	Mental health disorders (such as depression)	14	3.82	Above Average	99	16	2.92	Below Average	83
Maintain Efforts									
Health Care Access and Quality	Cancer	1	4.13	Above Average	101	7	3.07	Above Average	86
Health Care Access and Quality	Dental care	2	4.08	Above Average	101	4	3.09	Above Average	89
Health Care Access and Quality	Diabetes and high blood sugar	3	4.07	Above Average	101	3	3.10	Above Average	86
Health Care Access and Quality	High blood pressure	4	4.05	Above Average	102	2	3.17	Above Average	88
Economic Stability	Access to healthy/nutritious foods	5	4.04	Above Average	101	14	2.98	Above Average	92
Health Care Access and Quality	Heart disease	6	3.98	Above Average	102	8	3.06	Above Average	86
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	7	3.92	Above Average	103	5	3.09	Above Average	91
Health Care Access and Quality	Arthritis/disease of the joints	8	3.91	Above Average	89	15	2.96	Above Average	72
Health Care Access and Quality	Asthma, breathing issues, and lung disease	11	3.84	Above Average	106	13	3.02	Above Average	89
Neighborhood and Built Environment	Violence (including gun violence)	12	3.83	Above Average	102	11	3.05	Above Average	88
Health Care Access and Quality	Infant health	13	3.82	Above Average	96	10	3.05	Above Average	79
Relatively Lower Priority									
Economic Stability	Job placement and employment support	18	3.69	Below Average	96	25	2.51	Below Average	84
Education Access and Quality	Access to continuing education and job training programs	19	3.65	Below Average	98	22	2.76	Below Average	83
Health Care Access and Quality	Obesity in children and adults	20	3.63	Below Average	98	18	2.88	Below Average	77
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	21	3.62	Below Average	91	23	2.67	Below Average	75
Economic Stability	Assistance with basic needs like food, shelter, and clothing	23	3.60	Below Average	101	24	2.63	Below Average	84
Health Care Access and Quality	Hepatitis C/liver disease	24	3.58	Below Average	91	19	2.84	Below Average	76
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	25	3.42	Below Average	97	21	2.79	Below Average	72
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	26	3.38	Below Average	96	20	2.80	Below Average	82
Education Access and Quality	School health and wellness programs	15	3.76	Below Average	100	6	3.08	Above Average	84
Health Care Access and Quality	Adolescent and child health	16	3.75	Below Average	96	9	3.05	Above Average	73
Health Care Access and Quality	Women's and maternal health care	17	3.73	Below Average	89	1	3.19	Above Average	70
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	22	3.60	Below Average	96	12	3.04	Above Average	72

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 8

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Health Care Access and Quality	Dental care	1	4.65	Above Average	20	15	3.21	Below Average	19
Health Care Access and Quality	Heart disease	2	4.59	Above Average	22	13	3.30	Below Average	20
Neighborhood and Built Environment	Violence (including gun violence)	2	4.59	Above Average	22	18	3.05	Below Average	22
Economic Stability	Access to healthy/nutritious foods	7	4.36	Above Average	22	14	3.26	Below Average	23
Health Care Access and Quality	Diabetes and high blood sugar	7	4.36	Above Average	22	13	3.30	Below Average	20
Neighborhood and Built Environment	Stopping falls among elderly	10	4.30	Above Average	23	13	3.30	Below Average	20
Health Care Access and Quality	Obesity in children and adults	12	4.23	Above Average	22	16	3.16	Below Average	19
Maintain Efforts									
Health Care Access and Quality	Cancer	3	4.55	Above Average	22	7	3.48	Above Average	21
Health Care Access and Quality	High blood pressure	4	4.50	Above Average	20	2	3.58	Above Average	19
Health Care Access and Quality	Asthma, breathing issues, and lung disease	5	4.38	Above Average	21	4	3.56	Above Average	18
Health Care Access and Quality	Arthritis/disease of the joints	6	4.38	Above Average	24	9	3.36	Above Average	22
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	8	4.35	Above Average	23	1	3.64	Above Average	22
Health Care Access and Quality	Infant health	9	4.33	Above Average	21	4	3.56	Above Average	18
Social and Community Context	Mental health disorders (such as depression)	11	4.24	Above Average	21	11	3.33	Above Average	21
Economic Stability	Assistance with basic needs like food, shelter, and clothing	12	4.23	Above Average	22	10	3.35	Above Average	20
Relatively Lower Priority									
Education Access and Quality	Access to continuing education and job training programs	13	4.17	Below Average	18	12	3.31	Below Average	16
Health Care Access and Quality	Adolescent and child health	14	4.13	Below Average	23	17	3.13	Below Average	24
Economic Stability	Affordable housing and homelessness prevention	17	4.00	Below Average	22	20	2.91	Below Average	22
Economic Stability	Job placement and employment support	17	4.00	Below Average	22	19	3.00	Below Average	20
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	21	3.14	Below Average	21	21	2.84	Below Average	19
Health Care Access and Quality	Women's and maternal health care	15	4.11	Below Average	19	11	3.33	Above Average	18
Education Access and Quality	School health and wellness programs	16	4.10	Below Average	21	8	3.45	Above Average	20
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	17	4.00	Below Average	21	3	3.56	Above Average	16
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	18	3.76	Below Average	21	2	3.58	Above Average	19
Health Care Access and Quality	Hepatitis C/liver disease	19	3.64	Below Average	22	6	3.50	Above Average	16
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	20	3.60	Below Average	20	5	3.54	Above Average	1

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 9

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Neighborhood and Built Environment	Stopping falls among elderly	7	4.18	Above Average	243	18	2.99	Below Average	204
Neighborhood and Built Environment	Violence (including gun violence)	8	4.17	Above Average	241	17	3.00	Below Average	212
Economic Stability	Affordable housing and homelessness prevention	10	4.08	Above Average	233	26	2.74	Below Average	214
Social and Community Context	Mental health disorders (such as depression)	12	4.07	Above Average	240	21	2.97	Below Average	206
Maintain Efforts									
Health Care Access and Quality	Cancer	1	4.28	Above Average	234	13	3.11	Above Average	199
Economic Stability	Access to healthy/nutritious foods	2	4.27	Above Average	229	7	3.14	Above Average	212
Health Care Access and Quality	Diabetes and high blood sugar	3	4.25	Above Average	248	2	3.25	Above Average	219
Health Care Access and Quality	Dental care	4	4.23	Above Average	235	9	3.13	Above Average	223
Health Care Access and Quality	Heart disease	5	4.22	Above Average	241	5	3.17	Above Average	209
Health Care Access and Quality	High blood pressure	6	4.19	Above Average	246	1	3.34	Above Average	208
Health Care Access and Quality	Women's and maternal health care	9	4.08	Above Average	224	6	3.15	Above Average	193
Health Care Access and Quality	Asthma, breathing issues, and lung disease	11	4.07	Above Average	240	15	3.09	Above Average	202
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	13	4.03	Above Average	233	3	3.23	Above Average	204
Health Care Access and Quality	Arthritis/disease of the joints	14	4.03	Above Average	238	14	3.10	Above Average	205
Relatively Lower Priority									
Economic Stability	Assistance with basic needs like food, shelter, and clothing	16	4.00	Below Average	239	19	2.98	Below Average	205
Health Care Access and Quality	Obesity in children and adults	17	3.98	Below Average	241	20	2.97	Below Average	198
Economic Stability	Job placement and employment support	19	3.93	Below Average	230	23	2.90	Below Average	199
Education Access and Quality	Access to continuing education and job training programs	20	3.91	Below Average	234	22	2.91	Below Average	201
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	25	3.75	Below Average	240	24	2.85	Below Average	203
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	26	3.57	Below Average	224	25	2.80	Below Average	192
Health Care Access and Quality	Adolescent and child health	15	4.02	Below Average	234	12	3.12	Above Average	198
Health Care Access and Quality	Infant health	18	3.96	Below Average	221	4	3.22	Above Average	190
Education Access and Quality	School health and wellness programs	21	3.90	Below Average	221	11	3.12	Above Average	191
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	22	3.85	Below Average	221	8	3.14	Above Average	185
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	23	3.83	Below Average	234	10	3.13	Above Average	195
Health Care Access and Quality	Hepatitis C/liver disease	24	3.81	Below Average	212	16	3.08	Above Average	18

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 10

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Neighborhood and Built Environment	Violence (including gun violence)	6	4.23	Above Average	264	16	2.92	Below Average	237
Health Care Access and Quality	Arthritis/disease of the joints	9	4.10	Above Average	252	19	2.84	Below Average	207
Economic Stability	Affordable housing and homelessness prevention	10	4.08	Above Average	251	24	2.68	Below Average	223
Social and Community Context	Mental health disorders (such as depression)	13	3.97	Above Average	270	20	2.83	Below Average	229
Maintain Efforts									
Health Care Access and Quality	Heart disease	1	4.36	Above Average	263	2	3.19	Above Average	227
Health Care Access and Quality	Cancer	2	4.35	Above Average	252	13	2.96	Above Average	199
Neighborhood and Built Environment	Stopping falls among elderly	3	4.28	Above Average	247	14	2.95	Above Average	198
Health Care Access and Quality	Dental care	4	4.28	Above Average	272	11	2.98	Above Average	233
Health Care Access and Quality	High blood pressure	5	4.28	Above Average	265	1	3.21	Above Average	223
Health Care Access and Quality	Diabetes and high blood sugar	7	4.20	Above Average	268	6	3.03	Above Average	235
Economic Stability	Access to healthy/nutritious foods	8	4.17	Above Average	267	4	3.10	Above Average	236
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	11	4.06	Above Average	252	3	3.11	Above Average	222
Health Care Access and Quality	Obesity in children and adults	12	3.99	Above Average	257	15	2.93	Above Average	209
Relatively Lower Priority									
Economic Stability	Assistance with basic needs like food, shelter, and clothing	14	3.95	Below Average	251	18	2.87	Below Average	218
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	19	3.85	Below Average	247	22	2.79	Below Average	205
Education Access and Quality	Access to continuing education and job training programs	21	3.78	Below Average	240	23	2.75	Below Average	197
Economic Stability	Job placement and employment support	22	3.69	Below Average	238	26	2.65	Below Average	200
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	23	3.64	Below Average	259	25	2.67	Below Average	204
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	25	3.44	Below Average	241	21	2.83	Below Average	174
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	26	3.41	Below Average	249	17	2.88	Below Average	195
Health Care Access and Quality	Asthma, breathing issues, and lung disease	15	3.94	Below Average	267	7	3.03	Above Average	225
Health Care Access and Quality	Women's and maternal health care	16	3.93	Below Average	244	9	2.99	Above Average	207
Education Access and Quality	School health and wellness programs	17	3.87	Below Average	241	8	3.00	Above Average	201
Health Care Access and Quality	Infant health	18	3.86	Below Average	237	5	3.04	Above Average	200
Health Care Access and Quality	Adolescent and child health	20	3.83	Below Average	253	12	2.96	Above Average	209
Health Care Access and Quality	Hepatitis C/liver disease	24	3.62	Below Average	235	10	2.98	Above Average	185

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

APPENDIX C

2025 GNYHA Community Health Needs Assessment Collaborative

Medisys Queens Community District 12

Importance and Satisfaction Ratings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Importance Number of Respondents	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions	Satisfaction Number of Respondents
Needs Attention									
Neighborhood and Built Environment	Violence (including gun violence)	2	4.45	Above Average	499	23	2.88	Below Average	452
Economic Stability	Affordable housing and homelessness prevention	6	4.36	Above Average	485	26	2.66	Below Average	437
Social and Community Context	Mental health disorders (such as depression)	10	4.27	Above Average	497	20	2.92	Below Average	437
Maintain Efforts									
Health Care Access and Quality	Cancer	1	4.50	Above Average	497	11	3.11	Above Average	419
Health Care Access and Quality	Dental care	3	4.41	Above Average	503	15	3.08	Above Average	457
Neighborhood and Built Environment	Stopping falls among elderly	4	4.36	Above Average	474	9	3.12	Above Average	420
Health Care Access and Quality	Diabetes and high blood sugar	5	4.36	Above Average	497	4	3.17	Above Average	450
Health Care Access and Quality	Heart disease	7	4.34	Above Average	487	1	3.26	Above Average	425
Health Care Access and Quality	High blood pressure	8	4.34	Above Average	497	3	3.17	Above Average	432
Economic Stability	Access to healthy/nutritious foods	9	4.33	Above Average	494	17	3.04	Above Average	448
Health Care Access and Quality	Women's and maternal health care	11	4.27	Above Average	482	8	3.13	Above Average	417
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	12	4.25	Above Average	499	2	3.24	Above Average	448
Health Care Access and Quality	Adolescent and child health	13	4.25	Above Average	484	7	3.13	Above Average	416
Health Care Access and Quality	Infant health	14	4.25	Above Average	469	5	3.16	Above Average	403
Relatively Lower Priority									
Economic Stability	Assistance with basic needs like food, shelter, and clothing	15	4.19	Below Average	502	18	2.97	Below Average	448
Education Access and Quality	Access to continuing education and job training programs	19	4.15	Below Average	483	21	2.91	Below Average	418
Health Care Access and Quality	Obesity in children and adults	20	4.12	Below Average	493	19	2.95	Below Average	428
Economic Stability	Job placement and employment support	21	4.07	Below Average	477	22	2.89	Below Average	412
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	22	4.00	Below Average	485	24	2.84	Below Average	407
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	26	3.68	Below Average	482	25	2.72	Below Average	421
Health Care Access and Quality	Asthma, breathing issues, and lung disease	16	4.19	Below Average	501	6	3.16	Above Average	435
Health Care Access and Quality	Arthritis/disease of the joints	17	4.18	Below Average	485	16	3.07	Above Average	417
Education Access and Quality	School health and wellness programs	18	4.17	Below Average	483	14	3.09	Above Average	429
Health Care Access and Quality	Sexually Transmitted Infections (STIs)	23	3.99	Below Average	464	12	3.10	Above Average	374
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	24	3.99	Below Average	473	10	3.12	Above Average	378
Health Care Access and Quality	Hepatitis C/liver disease	25	3.94	Below Average	474	13	3.09	Above Average	393

*How important is this issue to you?
**How satisfied are you with current services in your neighborhood?
^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

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