COMMUNITY HEALTH NEEDS ASSESSMENT

COMMUNITY SERVICE PLAN
and
Implementation Plan

2019 – 2021

FLUSHING HOSPITAL MEDICAL CENTER

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EXECUTIVE SUMMARY

The effects of poverty on health, including difficulty obtaining nutritious food, unemployment, and the burden of high rents are observed in the communities that Flushing Hospital serves, particularly in Flushing-Clearview and West Queens.

Chronic diseases, obesity, tobacco use, behavioral health concerns, maternal morbidity, and late or no prenatal care were among the health issues highlighted in the community-level data analyses that Flushing Hospital conducted for this Community Health Needs Assessment (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 the Hospital during the spring and summer of 2019. Many of these health problems are caused in part by or exacerbated by the social determinants of health (SDH). The Hospital has begun focused efforts to address SDH, including the effects of discrimination, as part of its treatment of the whole person.

Breastfeeding, which lowers the risk of death from infectious diseases in a child's first two years of life, and can also reduce the risk of childhood obesity as well as the risk of a woman developing breast or ovarian cancer, is still not practiced as often in parts of the Hospital's service area as it is in New York City overall. Flushing Hospital has focused on improving rates of exclusive breastfeeding among the women giving birth in the Hospital and those attending its ambulatory care centers with their infants, as well as among mothers in the community. The Hospital is designated as a Baby Friendly Hospital for offering an optimal level of care for infant feeding and mother/baby bonding.

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 as well as cancer. Responding to the needs of the community, Flushing Hospital has focused on improving tobacco cessation rates. The Hospital was awarded Gold Star Status from the NYC DOHMH's Tobacco-Free Hospitals Campaign in recognition of its tobacco cessation programming and successes, and continues to comply with the Campaign's standards.

With the benefit of community input, the Hospital has chosen to highlight the prevalence of these two health issues 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 and the Healthy People 2020 goals.

Full report can be obtained from the Hospital's website: https://flushinghospital.org/community-service-plan

INTRODUCTION

Hospital Overview and Data Sources

Flushing Hospital Medical Center (FHMC), established in 1884, is a not-for-profit 299 -bed, Article 28 licensed facility and teaching hospital. The surrounding neighborhoods are culturally diverse, densely populated, urban areas of northern and western Queens FHMC's primary service area (PSA) spans 24.4 square miles, covering the Queens neighborhoods of Flushing-Clearview and West Queens, which are home to 769,666 (2018) people.

The Hospital annually cares for approximately 15,903 inpatients including 2,107 newborns, 47,164 emergency department patients, and 111,426 ambulatory care patients. It offers a full array of general and specialty medical and surgical care; acute inpatient; emergency services (including designation as a Primary Stroke Center rehabilitation; pediatric; chemical dependency and psychiatric services; and ambulatory surgery. The Hospital is a NYS-designated Level 3 Perinatal Center with a Level III neonatal intensive care unit (NICU) and a WHO-designated Baby Friendly Hospital. The ambulatory care program provides a full range of medical, behavioral health and dental services on campus.

FHMC is part of an integrated health care delivery system, MediSys Health Network, which includes Jamaica Hospital in southern Queens, The Jamaica Hospital Nursing Home, located on Jamaica Hospital's campus, and a large multi-specialty physician group practice with offices on campus and in the community.

The Hospital's mission is To provide superior service to our patients and our community in a caring environment.

This Community Health Needs Assessment (CHNA) will examine the needs of the residents of these neighborhoods. Community health data describing FHMC's PSA population will be presented using quantitative public data from the New York City Department of Health and Mental Hygiene (DOHMH) and qualitative data obtained from residents in FHMC's community health needs survey. Other commonly used data sources include the New York State Department of Health and the U.S. Census American Community Survey. Following the presentation of CHNA data for Flushing-Clearview and West Queens, results of a CHNA survey in FHMC's service area will be discussed.

New York City (NYC) has different ways of describing and categorizing neighborhoods, which is relevant to how community health data are analyzed and presented. Neighborhoods are typically defined according to either NYC Community Districts or United Health Fund neighborhoods (an independent, nonprofit, health services research and philanthropic organization). There are 59 NYC Community Districts, which were established by local law in 1975. United Health Fund (UHF) neighborhoods consist of 34 neighborhoods, made up of adjoining zip code areas, designated to approximate NYC Community Planning districts. FHMC's PSA has traditionally been defined as covering the Queens neighborhoods of Flushing-Clearview and West Queens. These neighborhoods, as defined by the UHF, do not correspond exactly to distinct Community Districts, as shown in the table and map on the following pages.

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FHMC's service area was determined by analyzing Statewide Planning and Research Cooperative System (SPARCS) discharge data at the zip code level. The UHF neighborhoods with the highest volumes of patients were determined to be the PSA. UHF neighborhoods with at least 3% of inpatient cases were considered the hospital's secondary service area (SSA) The PSA and SSA together account for approximately 84% of the Hospital's total inpatient cases, with the PSA accounting for 57% and the SSA accounting for 27%. The FHMC CHNA focuses on the Hospital's PSA.

Most of the data in this report reflect FHMC's service area data from the NYC DOHMH's Community Health Profiles (2018) and the most recent years' Community Health Surveys. Data from other than these two sources will be footnoted. As the Community Health Profile data are organized by Community District, and the Community Health Survey data are organized by UHF neighborhood, FHMC has used both ways to describe neighborhoods. Additionally, the New York State Delivery System Reform Incentive Payment (DSRIP) Program's data, were aggregated into UHF neighborhoods and analyzed to better capture and describe FHMC's service area.

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FHMC's Primary Service Area

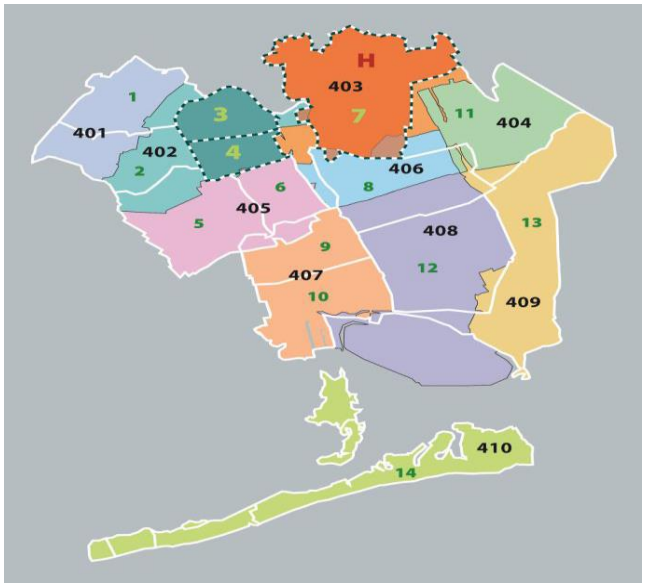
The PSA covers two UHF neighborhoods – Flushing-Clearview (403), and West Queens (402).

Table 1. FHMC PSA: Community District and UHF Neighborhood Crosswalk and Percent of Inpatient Discharges

Zip Code	% of Discharges	Queens Community District	UHF Neighborhood (Code)
11354	11%	Flushing and Whitestone (7)	Flushing-Clearview (403)
11355	11%	Flushing and Whitestone (7)	Flushing-Clearview (403)
11356	2%	Flushing and Whitestone (7)	Flushing-Clearview (403)
11357	4%	Flushing and Whitestone (7)	Flushing-Clearview (403)
11358	3%	Flushing and Whitestone (7)	Flushing-Clearview (403)
11359*	0	Flushing and Whitestone (7)	Flushing-Clearview (403)
11360	1%	Flushing and Whitestone (7)	Flushing-Clearview (403)
11368	11%	Jackson Heights (3), Elmhurst and Corona (4), Flushing and Whitestone (7)	West Queens (402)
11369	3%	Jackson Heights (3)	West Queens (402)
11370**	1%	Long Island City and Astoria (1)	West Queens (402)
11372	3%	Jackson Heights (3)	West Queens (402)
11373	4%	Elmhurst and Corona (4)	West Queens (402)
11377**	2%	Long Island City and Astoria (1), Woodside and Sunnyside (2)	West Queens (402)
11378**	1%	Woodside and Sunnyside (2), Ridgewood and Maspeth (5)	West Queens (402)
Total PSA	**57%**		

*This zip code has no population since it is a public park (Fort Totten Park).
**Signifies that only a very small percentage of Flushing Hospital's patients are from these zip codes , therefore, Community Districts 1, 2, and 5 were not included in CHNA analyses.

Figure 1. Flushing Hospital Medical Center's Service Area



United Health Fund (UHF) and Community District Overlay of Flushing Hospital's Primary Service Area: The white outlines and green numbers mark the Community Districts. The black numbers and outlines mark the UHF neighborhoods. The black dashed line signifies Flushing Hospital's primary service area. The **H** signifies the location of Flushing Hospital in zip code 11355 (Flushing-Clearview; Community District 7).

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There are gaps in primary medical care, including dental care and mental health care, across Queens, which are also evident in FHMC's service area. Queens has seven neighborhoods that are designated as Medically Underserved Areas/Populations (MUA/P) by the Health Resources and Services Administration (HRSA); 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. The Corona Service Area, which encompasses the Flushing-Clearview neighborhood, is designated as a MUP. The Medicaid-eligible population in West Queens (Me-West Queens) is 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 Medicaid-eligible population living in that area. Me-Queens is also designated as a Mental Health HPSA, meaning there are fewer mental health care professionals than are necessary to accommodate the population living in those areas.

In addition to Flushing Hospital Medical Center, there are eight acute care hospitals, 12 nursing homes, and 25 HRSA-supported Federally Qualified Health Centers (FQHC) or Look-Alikes that provide services in Queens County.[1] Three other hospitals provide acute care services in Flushing's primary service area, New York-Presbyterian/Queens, Northwell Health Long Island Jewish Forest Hills Hospital and Health + Hospitals/Elmhurst Hospital Center. Other providers in Flushing Hospital's service area offering primary and preventive health care services include many diagnostic and treatment centers; several physician group practices, and individual physician offices.

Inpatient psychiatric care is provided at Flushing Hospital Medical Center and at six other licensed facilities in Queens. In addition, there are 51 outpatient mental health services, support programs, emergency services, and residential facilities that provide mental health treatment to adults and children.[2] Creedmoor Addiction Treatment Center, a state-operated facility, serves Queens and the rest of New York City. Thirty-three chemical dependency treatment agencies and 63 individual providers in Queens provide chemical dependency prevention/treatment and impaired driving offender programs.3 Approximately 240 DATA-waivered practitioners in Queens are certified to provide buprenorphine treatment of opioid use disorder.

Although there are a large number of health care resources in FHMC's service area, the number of primary care and mental health providers is insufficient to meet the needs of area residents, as evidenced by the HRSA-designated HPSAs for the Medicaid eligible population in West Queens. In addition, numerous barriers exist for area residents to access appropriate and timely health care services, including lack of health insurance, limited provider evening and weekend hours, physicians who don't accept Medicaid, health literacy, lack of childcare, geographic proximity and lack of transportation, waiting lists for selected services, and lack of providers that speak a patient's language or are familiar with their culture.

[1] HRSA Data Warehouse. Health Centers and Look-alike Sites Site Directory. Accessed 5/29/2019: https://datawarehouse.hrsa.gov/HGDWReports/OneClickRptFilter.aspx?rptName=FAHCSiteList

[2] NYS OMH. Mental Health Program Directory. *Accessed online 6/14/2019:* https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages

[3] NYS OASAS. *Accessed online 6/14/2019.* https://www.oasas.ny.gov/providerDirectory/index.cfm

INTRODUCTION

Social Determinants of Health (SDH)

Social Determinants of Health (SDH) are defined by Healthy People 2020 as the conditions in the environments 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 social determinants of health (SDH) domains include:

- Economic stability;
- Education;
- Social and community context;
- Health and health care; and
- Neighborhood and environment.

Integrating health and human services to address SDH can have a significant impact on health outcomes.[4] FHMC integrates SDH into its approach to addressing the Prevention Agenda Priority Areas identified by the New York State Department of Health in its Prevention Agenda 2019-24:

I. Prevent Chronic Disease;
II. Promote a Healthy and Safe Environment;
III. Promote Healthy Women, Infants, and Children;
IV. Promote Well-Being and Prevent Mental and Substance Use Disorders; and
V. Prevent Communicable Diseases.

Within each Priority Area, Flushing Hospital analyzed and summarized data relevant to "focus areas" (e.g., "reduce obesity" and "reduce illness, disability, and death related to tobacco use and secondhand smoke exposure" are focus areas for the Prevent Chronic Disease priority). Data were primarily obtained from the NYC DOHMH 2018 Community Health Profiles and Community Health Surveys (EpiQuery); the New York State Department of Health's DSRIP Program's clinical metrics and performance data; and community-wide surveys that were administered as part of data collection for the 2014 Queens Community Needs Assessment (CNA). 2019 CHNA survey results from a recent survey sponsored by FHMC are discussed in a subsequent section.

Sharing Report with the Public

The full report was distributed to the members of the Hospital's Board of Trustees, who approved it on November 25, 2019. 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

[4] Social Determinants of Health and Community Based Organizations. NYS Department of Health retrieved May 8, 2019 https://www.health.ny.gov/health_care/medicaid/redesign/sdh/index.htm

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Note: Most of the charts in this report reflect FHMC's service area data from the NYC Department of Health and Mental Hygiene's Community Health Profiles and Community Health Surveys. As the Community Health Profile data are organized by Community District, and the Community Health Survey and DSRIP data are organized by UHF neighborhood, FHMC has used both ways to describe neighborhoods and provide a snapshot of the population characteristics.

Community Statistics by Primary Service Area Neighborhood

Flushing-Clearview Neighborhood (Community District 7)

Demographics

In 2018, the estimated total population of Flushing-Clearview was 275,573 with a 3.1% increase expected by 2023.[5] The population is diverse: 54% are Asian and Pacific Islanders, 16.5% are Hispanic, 2% are Black and 25% are White. Seventeen percent are age 17 years and under, 19% are over 65, and 51,507 are females of child-bearing age (15-44). [6]

Social and Economic Stressors

In 2018, the average household income is $84,889; however, poverty is prevalent: 11.3% of households have incomes under $15K; 10% have incomes between $15K and $25K. [7] Twenty-five percent of residents live in poverty, a rate much higher than Queens (19%) and NYC (20%).

Housing and Employment

The unemployment rate is lower (6%) compared to Queens (8%) and NYC (9%); however; the rent burden is higher (57%) compared to Queens (53%) and NYC (51%).

Education

Overall, Flushing and Whitestone residents are less educated compared to the rest of NYC. Only 28% of residents have completed high school,[8] a rate higher than Queens (19%) and NYC (19%) overall.

Crime

Incarceration rates are much lower than surrounding areas: 145/100,000 compared to Queens (315/100,000) and NYC (425/100,000), Non-fatal assault hospitalizations are also much lower: (17/100,000) compared to Queens (37/100,000) and NYC (59/100,000).

Health

Seventy-one percent of Flushing and Whitestone residents rank their health as "excellent," "very good", or "good," lower than Queens overall (76%) and NYC (78%).

Access to Health Care

Citywide, the percentage of uninsured New Yorkers decreased in the last five years from 20% to 12%. However, in Flushing and Whitestone, 14% of adults are uninsured and 8% report going without needed medical care in the past 12 months.

[5] Demographic Snapshot, The Claritas Company, 2018
[6] Ibid.
[7] Ibid
[8] Ibid.

Nutrition

The neighborhood offers two farmer's markets and has a ratio of one supermarket for every six bodegas.[9] In 2017, 8.7% of Flushing residents reported they were sometimes/often short of food, compared to Queens (8.6%) overall and NYC (9.6%). Fewer residents reported having more than one sugary drink per day (17%) than the rest of Queens (21%) and NYC overall (23%). In 2017, 17,076 households or 19% received SNAP benefits, lower than the NYC average (20.4%).[10]

Smoking

Current Smokers: A higher percentage of Flushing-Clearview residents smoke (18.6%) compared to Queens (12.2%) and NYC (13.4%). The age residents begin smoking (2016 data), per the NYC Community Health Survey, is usually between ages 13 and 17 years as shown in Table 2.

Table 2. Age Residents Began Smoking by Location

Age Groups	Flushing	Queens	NYC
12 and under	*	4.8%	6.9%
13-17 years	36.3%	41.8%	44.8%
18-20 years	27%	30.2%	29.5%
21 and over	27.5%	23.2%	18.8%

*Data not available

E-cigarette use is growing among younger residents. In the last 12 months (2017), in Queens, 14.3% of those between the ages of 18-24 years old reported they had tried e-cigarettes, compared to the same age group in 2014 (10.6%). Among NYC residents of all ages, 6.6% reported trying electronic cigarettes; Flushing-Clearview had an overall rate of 5.4% vs. 6.3% (Queens).

Alcohol Consumption

In Flushing-Clearview, 3.8% of adults self-identified as heavy drinkers, lower than the rate for Queens (5.1%) and NYC (5%).

HIV

Flushing-Clearview had a much lower rate of HIV testing than Queens and NYC as a whole, with more than half of the residents having never been tested.

	Flushing	Queens	NYC
Tested in the last 12 months	21%	29%	34%
Tested more than 12 months ago	22%	29%	31%
Never tested	57.5%	42%	34%

Vaccinations

Flushing had a slightly higher rate of flu vaccinations (46.1%) in 2017 compared to NYC (43.7%) and Queens (41.9%). The percent of Flushing and Whitestone teenagers that received the HPV vaccine was slightly higher (54%) than the rest of Queens but less than NYC overall (59%).

[9] Farmers Markets: NYC DOHMH Bureau of Chronic Disease Prevention and Tobacco Control, 2017; Supermarket to Bodega Ratio: New York State Department of Agriculture and Markets, October 2016

[10] Keeping Track of NYC's Children, Citizen's Committee for Children of New York (2017 data)

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Child Health

Children in Flushing and Whitestone have lower obesity rates than children in the rest of the city: 15% compared to 20% for Queens and the city at large. Blood Lead Level rates (mcg/dL) for children in Flushing-Clearview (under age 5) are much lower (7.7) than Queens (14.3) and NYC overall (16.5).[11] in Flushing are economically better off than the rest of NYC, with 0% living in concentrated poverty as compared to 14% in NYC and 1% in Queens.[12] Of babies born at Flushing Hospital, 50% are fed exclusively on breastmilk at discharge according to their mothers.

Infant Mortality

In Flushing and Whitestone, the infant mortality rate (2.6/1000 live births) is lower than the borough (4/1000 live births) and the citywide rate (4.4/1000 live births).

Adult Obesity

Flushing and Whitestone's adult obesity rate (13%) is significantly lower than Queens (22%) and NYC overall (24%).

Physical Exercise

Only 3% of Flushing and Whitestone streets have bike lanes, lower than NYC overall (10%). Sixty-nine percent of Flushing and Whitestone adults report getting any physical activity in the past 30 days, compared to 70% for Queens and 73% for NYC overall.

Chronic Disease

The incidence rates for Diabetes and Hypertension are lower than the rest of the city:

- Diabetes: Flushing and Whitestone (8%); Queens (11%) and NYC (11%)
- Hypertension: Flushing and Whitestone (22%); Queens (28%) and NYC (28%).

Prenatal Care

In 2016, 7.6% of pregnant women in Flushing and Whitestone (CD 7) received late or no prenatal care, a rate slightly less than Queens (8.2%) but higher than New York City (6.8%). Black women (13.2%) over four times more likely to go without prenatal care than white women (3.1%); and two times as likely, compared to Asian (6.0%) or Hispanic (7.0%) women.[13]

Avoidable Hospitalizations

The rate of avoidable hospitalizations among adults in Flushing and Whitestone (708/100,000) is significantly lower than the citywide rate (1,033/100,000) and Queens (1,352/100,000). "Avoidable hospitalizations" are those that can be prevented if residents have access to affordable and convenient quality primary care.

Premature Death

Cancer and heart disease are the leading causes of premature death (death before the age of 65) in Flushing and Whitestone, similar to the rest of NYC. However, Flushing and Whitestone residents die prematurely at a lower rate (115/100,000) compared to 169.5/100,000 in NYC overall. Lung cancer, colorectal cancer, and liver cancer are the three leading causes of cancer-related premature death in

[11] New York City Department of Health and Mental Hygiene NYC Tracking Program: Environment and Health Data Portal. [Childhood Lead Exposure; 2005-2016]; retrieved from http://a816-dohbesp.nyc.gov/IndicatorPublic/

[12] Keeping Track Online. Citizens Committee for Children of New York. (2916 data).

[13] Keeping Track Online. Citizens' Committee for Children of New York

Flushing and Whitestone. Life expectancy in Flushing and Whitestone is 84.3 years, 3.1 years longer than NYC overall.

Mental Health

The rate of adult psychiatric hospitalizations in Flushing and Whitestone (362/100,000) is lower than Queens (513/100,000) and the citywide rate (676/100,000). The self-reported rate of depression, as measured in an 8-point questionnaire targeting the previous two weeks, was slightly lower for Flushing and Whitestone residents (8.8%) compared to NYC overall (9.3%), but higher than the Borough of Queens (7.7).

West Queens Neighborhood (Community Districts 3, 4, & part of 7)

Demographics

In 2018, the estimated total population for West Queens was 494,092, with a 2.7% increase projected by 2023.[14] The population is diverse: 52.5% is Hispanic, 27.3% Asian & Pacific Islander; 4.1% Black; and 13.8% White.[15] Eleven percent of Flushing-Clearview hospital inpatient cases come from zip code 11368, Corona. The population of Elmhurst and Corona represent 188,000 of the total population of West Queens, 63% of whom were born outside of the United States. Jackson Heights's population in 2016 was 179,844, 60% of whom were born outside of the US. [16]

Social and Economic Stressors

The average household income in West Queens was $75,376 in 2018; however, 10.3% of household incomes fell below $15,000: 10% fell between $15,000 and $25,000, and 24.8% were between $25,000 and $50,000. There were 101,276 women of childbearing age (15-44 years).[17] In Elmhurst and Corona, 27% of residents live in poverty, compared with 20% of NYC residents. In Jackson Heights, 25% live in poverty.

Housing and Employment

Homes are crowded in West Queens, with 16.8% of homes having greater than one person/room compared to 9.1% in Queens and 8.7% in NYC.[18] The unemployment rates for Elmhurst and Corona (6%) and Jackson Heights (7%) are lower compared to Queens (8%) and NYC (9%); however; the rent burden is higher in Elmhurst and Corona (62%) and Jackson Heights (59%) compared to Queens (53%) and NYC (51%).

Air Quality

Elmhurst and Corona have slightly higher levels of fine particulate matter, the most harmful outdoor air pollutant - PM2.5 (7.7 mg/cm) compared to Queens (7.2) and NYC (7.5); the rate in Jackson Heights is better than in Elmhurst and Corona.

Education

Thirty percent of Elmhurst and Corona and Jackson Heights residents have not completed high school, higher than the Borough and NYC-wide rates of 19%.

[14] Demographics Snapshot, Claritas 2019.
[15] Ibid.
[16] Population, Race and Ethnicity and Age: U.S. Census Bureau Population Estimates, 2016; Born Outside the U.S. and English Proficiency: U.S. Census Bureau, American Community Survey, 2012-2016
[17] Demographics Snapshot, Claritas 2019
[18] Housing and Health in West Queens. NYC Environment and Health Portal. Accessed 5/25/2019: http://a816-dohbesp.nyc.gov/IndicatorPublic/QuickView.aspx?report_id=73

Crime

Elmhurst and Corona have a significantly lower rate of incarceration than the rest of the Borough and NYC at large: 227/100,000 compared to 315/100,000 for Queens and 425/100,000 for NYC; incarceration rates are higher in Jackson Heights (342/100,000) compared to Elmhurst and Corona. Compared to Queens (37/100,000) and NYC (59/100,000), Elmhurst and Corona (34/100,000) and Jackson Heights (33/100,000) have lower rates of non-fatal assault hospitalizations.

Health

Sixty-eight percent of Elmhurst and Corona residents rank their health as "excellent," "very good" or "good, compared to Queens 76% and NYC (78%). Seventy-two percent of Jackson Heights' residents rank their health as "excellent," "very good" or "good.

Access to Health Care

Citywide, the percentage of uninsured New Yorkers decreased in the last five years from 20% to 12%. In Elmhurst and Corona, 25% of adults are uninsured, higher than the rest of NYC, and 9% report going without needed medical care in the past 12 months. In Jackson Heights, 28% of adults are uninsured, higher than the rest of NYC and 11% report going without needed medical care in the past 12 months.

Nutrition

Elmhurst and Corona is home to one farmer's markets and has a ratio of one supermarket for every sixteen bodegas; Jackson Heights' ratio is 1:17. In 2017, 10% of West Queens residents reported they were sometimes/often short of food, compared to Queens (8.6%) overall and NYC (9.6%). The percentage of Elmhurst and Corona residents reporting having more than one sugary drink per day (20%) was slower than Queens (22%) and NYC overall (23%); in Jackson Heights, however, the rate was higher - 25%. Thirty-six percent of Elmhurst and Corona households and 30% of Jackson Heights' households received SNAP (food stamps) benefits in 2017, significantly higher than in Queens (22.8%) and NYC (29.4%).[19]

Smoking

A lower percentage (11.2%) of West Queens' residents currently smoke compared to Queens (12.2%) and NYC (13.4%). Those who smoke began early, nearly half before they turned 18. The age residents reported they began smoking is shown in Table 3.

Table 3. Age Residents Began Smoking by Location

Age Groups	West Queens	Queens	NYC
12 and under	9%	4.8%	6.9%
13-17 years	48.8%	41.8%	44.8%
18-20 years	32.9%	30.2%	29.5%
21 and over	17.4%	23.2%	18.8%

E-cigarette use is growing among younger residents. In the last 12 months (2016), in Queens, 14.3% of those between the ages of 18-24 reported they had tried e-cigarettes compared to the same age group in 2014 (10.6%).

[19] Keeping Track Database, Citizen's Committee for Children of New York (2017 data). Accessed 05/20/19 https://data.cccnewyork.org/data/map/142/snap-food-stamps#142/89/3/226/25/a

Alcohol Consumption

In West Queens, 6.1% of residents self-identified as heavy drinkers compared to the borough of Queens (5.1%) and NYC (5%).

HIV

	West Queens	Queens	NYC
Tested in the last 12 months	32%	29%	34%
Tested more than 12 months ago	33%	29%	31%
Never tested	34%	42%	34%

A higher percentage of West Queens residents were tested for HIV than in the Borough of Queens in the last 12 months, but the percentage was slightly less than NYC as a whole.

Vaccinations

West Queens had a similar rate (41.9%) of flu vaccinations in 2017 compared to NYC (43.7%) and Queens (41.9%). The percent of Elmhurst and Corona (75%) and Jackson Heights (81%) teenagers that received the HPV vaccine was markedly higher than the borough of Queens (52%) and NYC overall (59%).

Child Health

Children in Elmhurst and Corona and Jackson Heights have higher obesity rates than children in the rest of the city: 24% and 26%, respectively, compared to 20% for Queens and the City at large. In 2017, Blood Lead Level rates (9 mcg/dL) for children in West Queens (under 5 years) were higher (13.5) than the rest of Queens (12.5) and lower than NYC overall (14.5).[20]

Infant Mortality

In Elmhurst and Corona, the infant mortality rate (3.7/1,000 live births) is lower than the borough (4.0/1,000 live births) and the citywide rate (4.4/1,000 live births). Jackson Heights' infant mortality rate is similar to the citywide rate (4.2/1,000 live births).

Adult Obesity

Elmhurst and Corona's adult rate (23%) is similar to that of NYC (24%) and Queens (22%); obesity rates are lower in Jackson Heights (20%).

Physical Activity

Only 4% of Elmhurst and Corona streets have bike lanes, lower than Queens (6%) and NYC overall 10%. In Jackson Heights, however, the percentage was similar to the NYC rate. Sixty-nine percent of Elmhurst and Corona adults report getting any physical activity in the past 30 days, compared to 70% for Queens and 73% for NYC overall; rate was higher in Jackson Heights – (72%).

[20] NYC DOHMH NYC Tracking Program: Environment and Health Data Portal. Childhood Lead Exposure; 2005-2016; accessed 5/20/2019 http://a816-dohbesp.nyc.gov/IndicatorPublic/: Health Outcomes

Chronic Disease

The prevalence rates for Diabetes is higher than the rest of the city; rates for Hypertension are similar.

- Diabetes: Elmhurst and Corona (14%); Jackson Heights (13%); Queens (11%) and NYC (11%)
- Hypertension: Elmhurst and Corona (27%); Jackson Heights (29%); Queens (28%) and NYC (28%).

Prenatal Care

In 2017, in Elmhurst and Corona, the rate of expectant mothers receiving late or no prenatal care (8.5%) is higher than the borough rate in Queens (7.9%) and NYC (6.7%): the rate is slightly lower in Jackson Heights. NYC's Black women (12.8%) were much more likely to go without prenatal care than white (3.1%), Asian (5.3%), or Hispanic (7.2%) women.[21]

Avoidable Hospitalizations

The rate of avoidable hospitalizations among adults in Elmhurst and Corona and Jackson Heights are very similar (892/100,000 and 860/100,000, respectively), and they are lower than the citywide (1,033/100,000) and Queens (1,028/100,000) rates.

Premature Death

Cancer and heart disease are the leading causes of premature death (death before the age of 65) in Elmhurst and Corona, as well as in Jackson Heights, similar to the rest of NYC. However, residents die prematurely at a much lower rate (105/100,000) in Elmhurst and Corona, compared to 169.5/100,000 in NYC overall; Jackson Heights' premature death rate is higher than Elmhurst and Corona - 129.0/100,000. Lung cancer, colorectal cancer, and breast cancer in women are the three leading causes of cancer-related premature death. Life expectancy for Elmhurst and Corona residents is 85.6 years, 4.4 years longer than NYC overall; life expectancy in Jackson Heights is 84.7 years

Mental Health

The rate of adult psychiatric hospitalization in Elmhurst and Corona (449/100,000) is lower than Queens (513/100,000) and the citywide rate (676/100,000); Jackson Heights' rate is lower, 321/100,000. The self-reported rate of depression, as measured in an 8-point questionnaire targeting the previous two weeks, was significantly lower for West Queens residents (3.9%) than for Queens (7.7%) and NYC overall (9.3%).

[21] Keeping Track Online. Citizen's Committee for Children of New York. (2017 data). https://www.cccnewyork.org/data-reports/

COMMUNITY HEALTH NEEDS ASSESSMENT

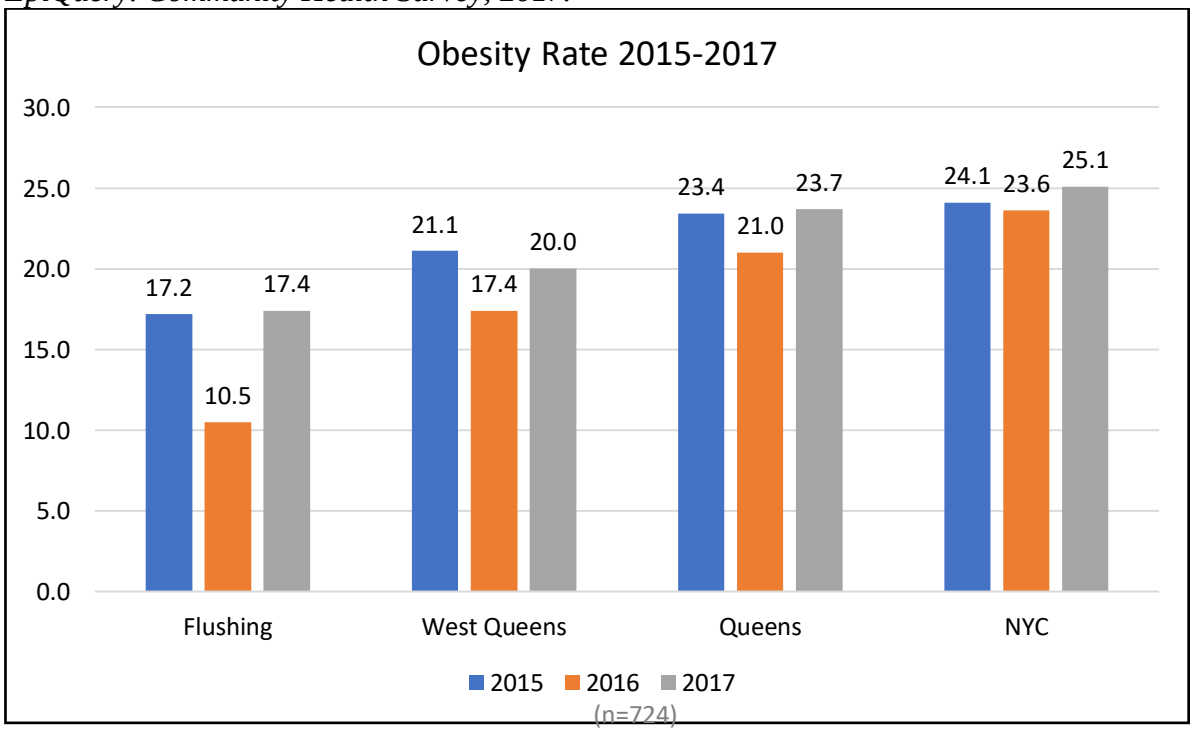
Community Statistics by New York State Prevention Agenda Priority Area

The overarching strategy of the Prevention Agenda is to implement public health approaches that improve the health and well-being of entire populations and achieve health equity. This strategy includes an emphasis on social determinants of health – defined by Healthy People 2020 as the conditions in the environments 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. The conditions in the environments where people live, work, and play have a significant influence on health status and quality of life and can be root causes of poor health and adverse outcomes.

Priority Area 1: Prevent Chronic Disease

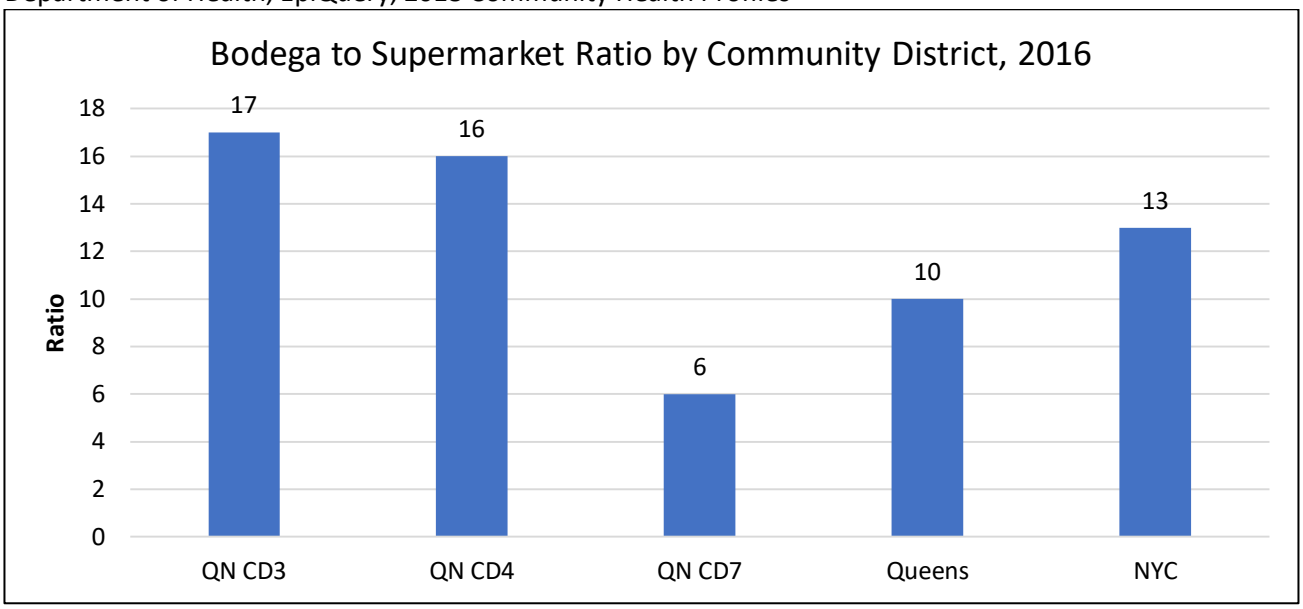
Focus Area 1: Healthy Eating and Food Security

Overarching Goal: Reduce obesity and the risk of chronic diseases. *Source: NYC DOHMH, EpiQuery. Community Health Survey, 2017.*



Comment: Body Mass Index (BMI) is calculated based on respondent's self-reported weight and height. A BMI between 25.0 and 29.9 is classified as overweight, and a BMI of 30 or greater is classified as obese. Obesity rates are lower in FHMC's service area than for Queens Borough or NYC, and below than the NYS Prevention Agenda target (24.2%) for 2019-2014.

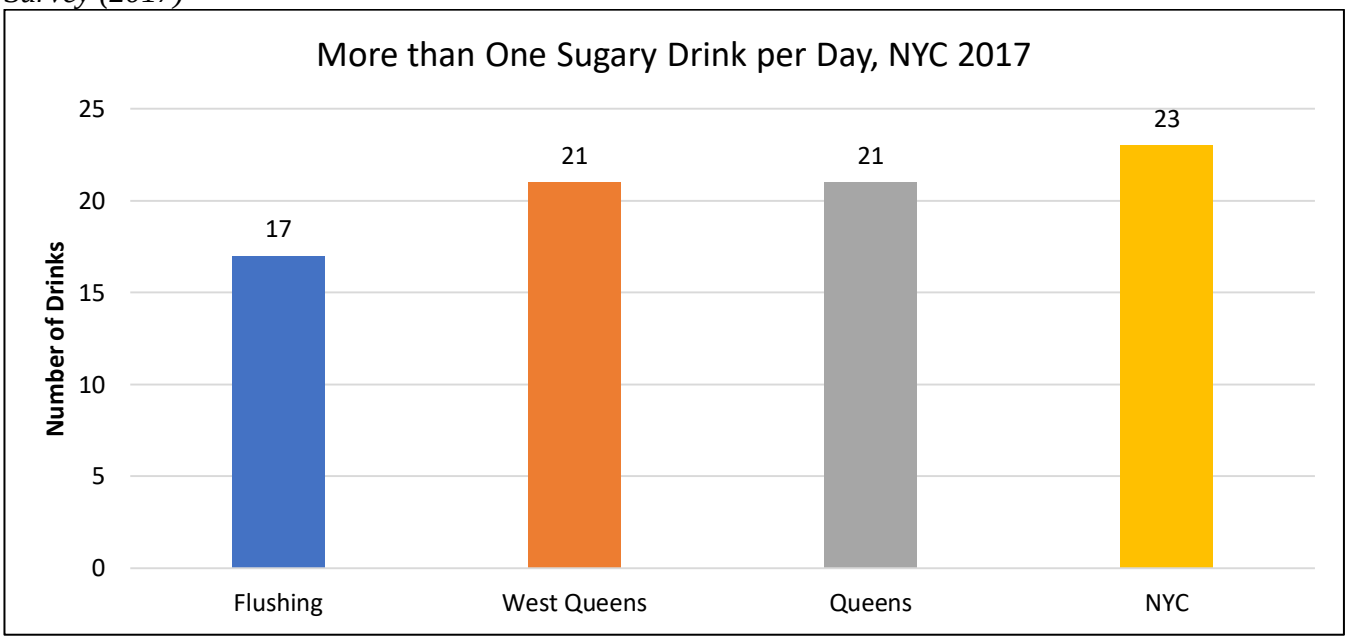
Goal 1.1: Increase access to healthy and affordable foods and beverages. *Source:* New York City Department of Health, EpiQuery, 2018 Community Health Profiles



Comment: Queens Community Districts 3 and 4 have higher bodega to supermarket ratios than Queens than QN CD7, Queens, and NYC, meaning that a less healthy food selection is available to residents. QN CD7, on the other hand has one of the best ratios in NYC.

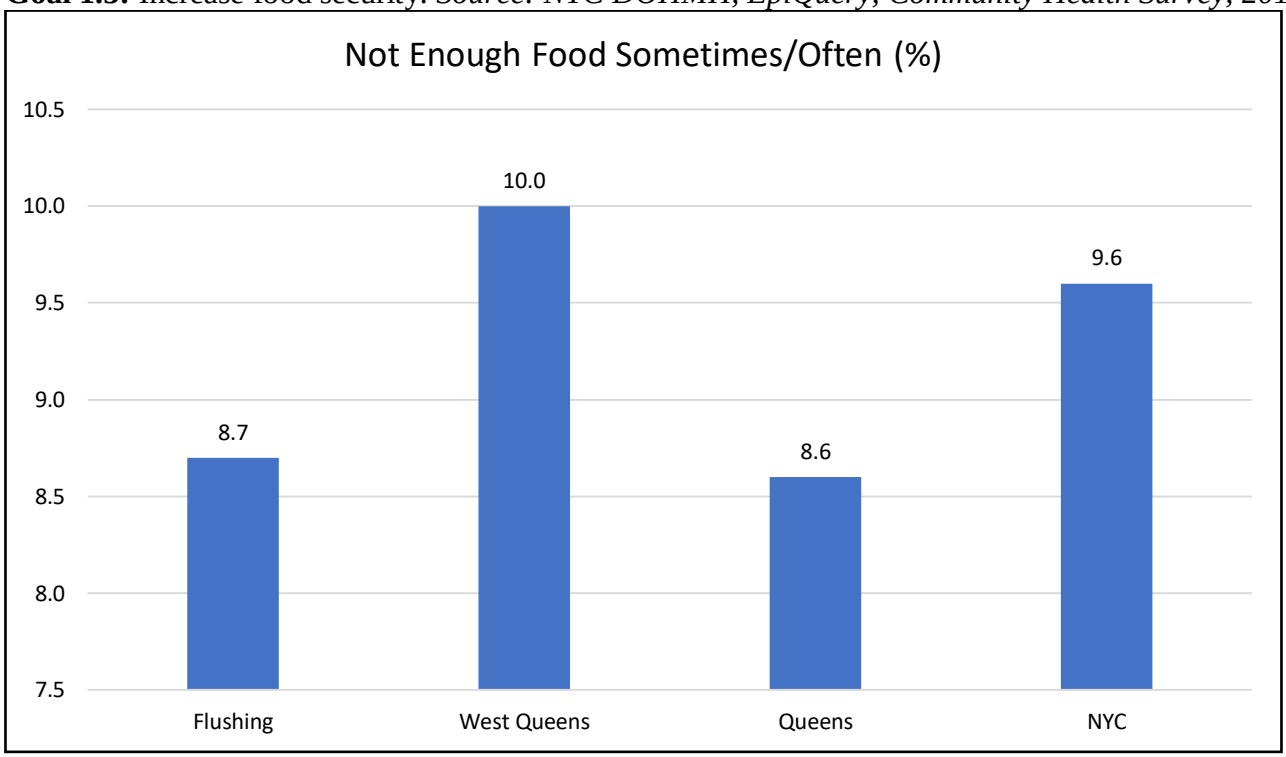
Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices

Goal 1.2: Consumption of unhealthy (sugary) drinks by adults. *Source: EpiQuery, Community Health Survey (2017)*



Comment: On average, Flushing-Clearview adult residents consumed less sugary drinks each day than West Queens, Queens, or NYC. West Queens drink consumption was the same as Queens and below the Prevention Agenda 2019-2024 benchmark (22.0%).

Goal 1.3: Increase food security. *Source: NYC DOHMH, EpiQuery, Community Health Survey, 2017*



Comment: In West Queens, 10% of adults reported that they sometimes or often did not have enough food, higher than Queens and NYC. Flushing-Clearview rates were below the Borough and City estimates. Flushing's rate should be interpreted with caution.

Resources and Accomplishments: FHMC strives to help its community members reduce obesity and empower them to make health-conscious nutrition decisions. The Hospital's services include nutritionists and diabetes educators, who can assist patients with developing healthy eating habits and reaching weight management goals. The Registered Dietitians at Flushing Hospital offers a monthly support group that consists of interactive sessions that aim to educate diabetic patients with lifestyle and professional recommendations from our highly qualified physicians, therapists, pharmacists, dietitians, and other clinical specialists. Support groups are also provided, along with personalized diet and nutritional counseling and psychological counseling to patients undergoing sleeve gastrectomy, gastric bypass, and similar weight reduction procedures at Flushing Hospital's Bariatric Surgical Service, which has been designated as a Center of Excellence. FHMC also participated in the NYC Department of Health and Mental Hygiene's "Healthy Hospital Food Initiative" to create a healthier food environment through such activities as meeting standards for food offered to inpatients, stocking vending machines with healthy foods and beverages and offering healthy choices in the hospital cafeteria. Breastfeeding is encouraged by Flushing Hospital's staff as another healthy means of helping postpartum mothers to shed weight gained during pregnancy and potentially reducing the risk of pediatric obesity and other health problems for their children. FHMC hosts a WIC program, which provides healthy food for low-income pregnant women, breastfeeding women, and women with children under age five.

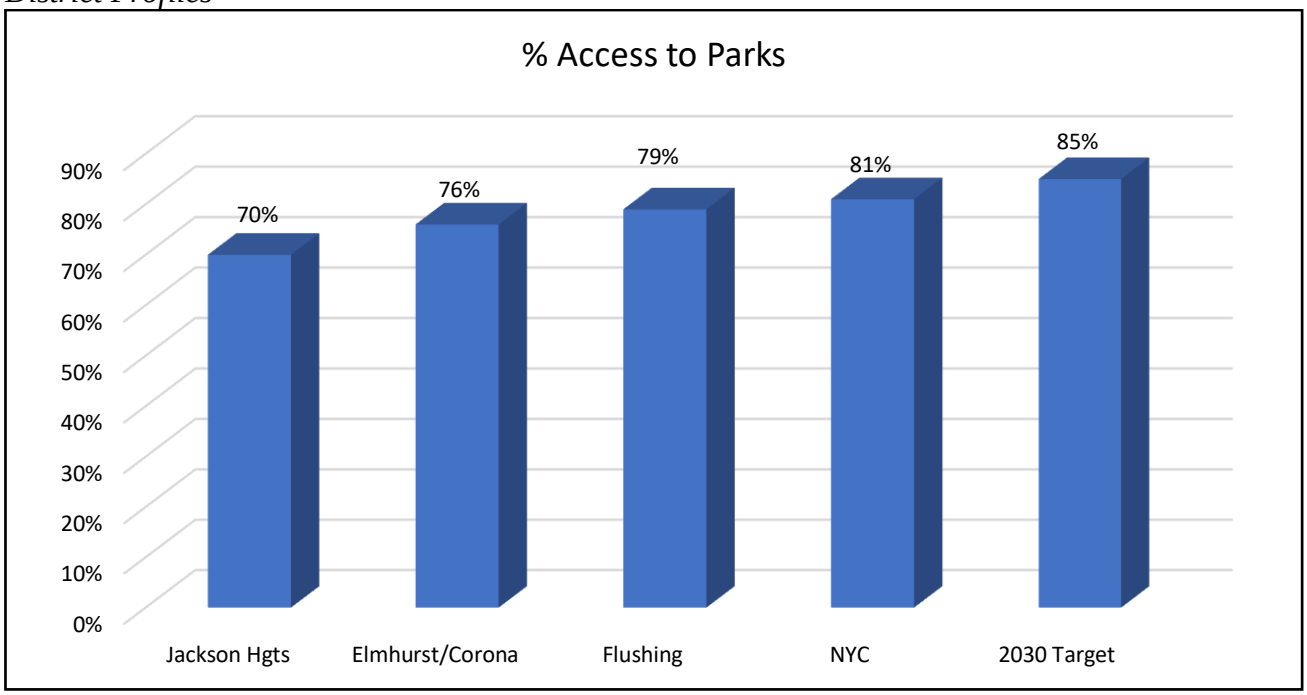
The NYC Department of Health and Mental Hygiene offers a "Health Bucks" program, through which fresh fruits and vegetables can be purchased at all farmers' markets in NYC. Five farmers' markets are located in FHMC's service area: Corona Greenmarket, Elmhurst Hospital Greenmarket, Flushing Greenmarket, Jackson Heights Greenmarket, and Queens Botanical Garden's Down to Earth Farmers' Market.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos with healthy recipes, how to combat adult and childhood obesity as well as tips to manage diabetes.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

Focus Area 2: Physical Activity

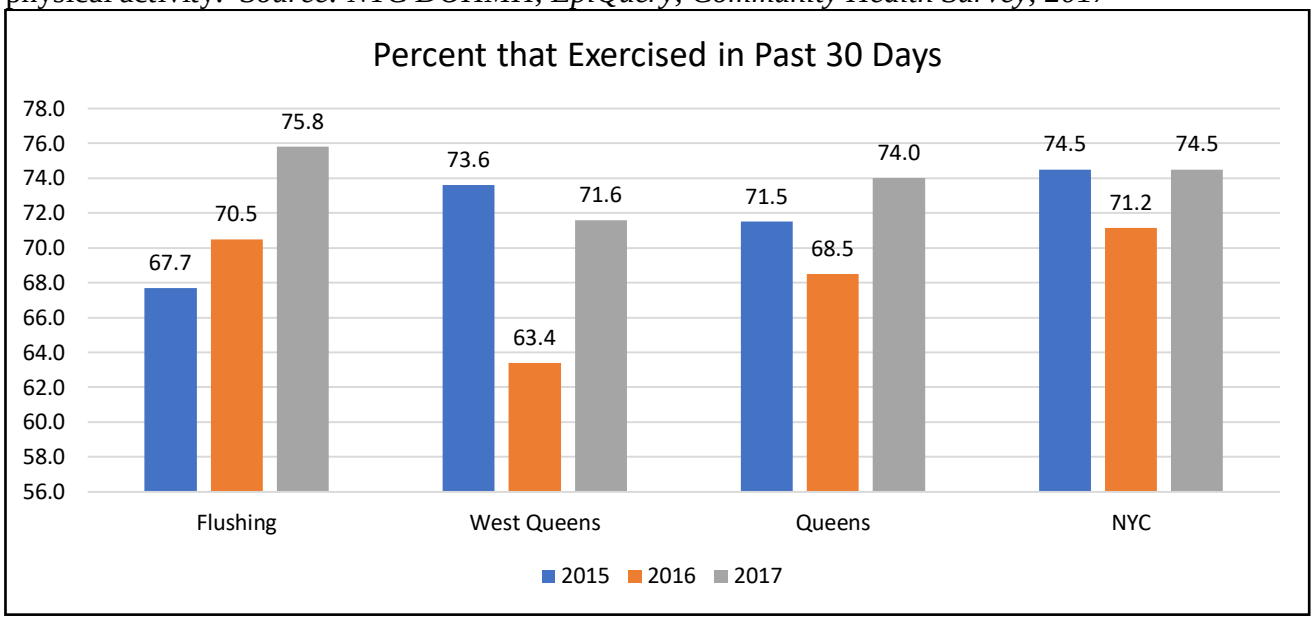
Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities. *Source: NYC Planning Department, Community District Profiles*



Comment: In 2016, access to parks in Flushing Hospital's service area is below that of NYC overall (81%) and the 2030 target (85%).

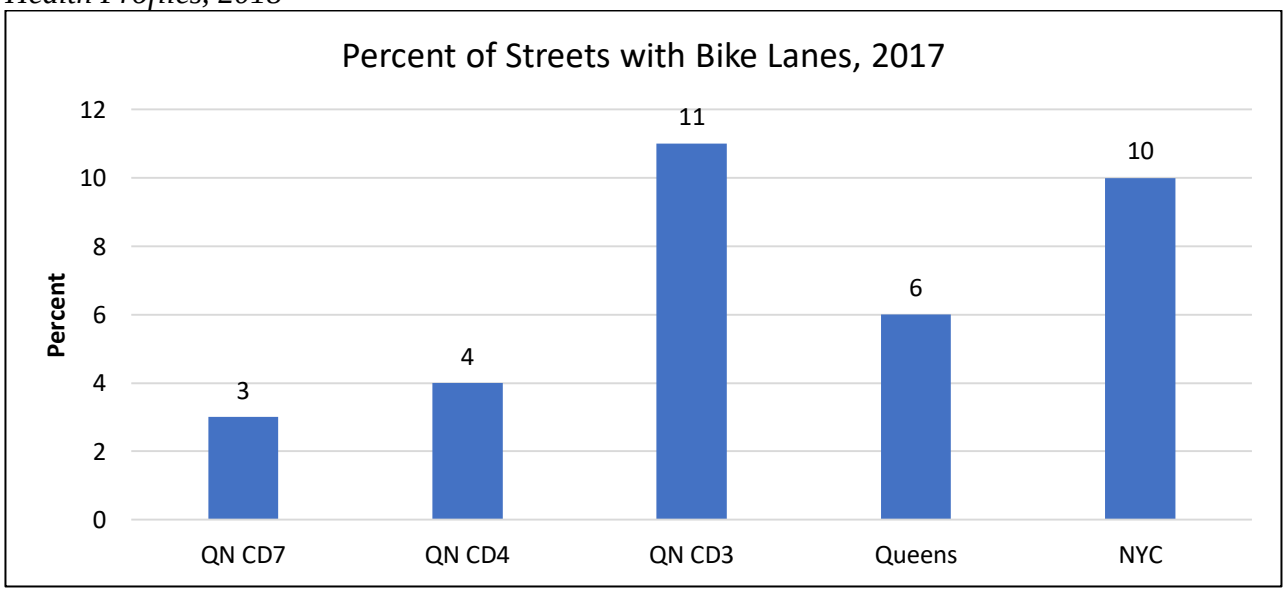
Goal 2.2: Promote school, childcare, and worksite environments that support physical activity for people of all ages and abilities

Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity. *Source: NYC DOHMH, EpiQuery, Community Health Survey, 2017*



Comment: Exercise among Flushing adults has increased between 2015 and 2017 and is higher than the NYC exercise rate. The percentage of West Queens' adults that exercised in the past 30 days declined during that period.

Goal 2.4: Increase access to safe indoor and outdoor places for physical activity. *Source: Community Health Profiles, 2018*



Comment: Except for Community District 3, the neighborhoods in Flushing Hospital's service area have a lower percentage of streets with bicycle lanes (3%-4%) compared to Queens (6%) and NYC (10%).

Resources and Accomplishments: Queens' largest public park (897 acres) Flushing Meadows-Corona Park, is located in Northern Queens and provides a wealth of recreational resources for area residents, including a recreational complex with an indoor Olympic pool and diving pool, and six playgrounds; athletic fields for soccer, baseball, football, and cricket; basketball, handball, volleyball, and tennis courts; miniature golf and driving range; an ice skating rink; and hiking trails and bike paths. Free outdoor yoga and Zumba fitness classes and golf lessons for children are offered in the summer. FHMC participates in the New York City Department of Parks and Recreation's Shape Up NYC program, which offers free drop-in fitness classes at multiple locations across NYC. The Hospital hosts a Shape Up NYC class, Zumba, once a week on its campus.

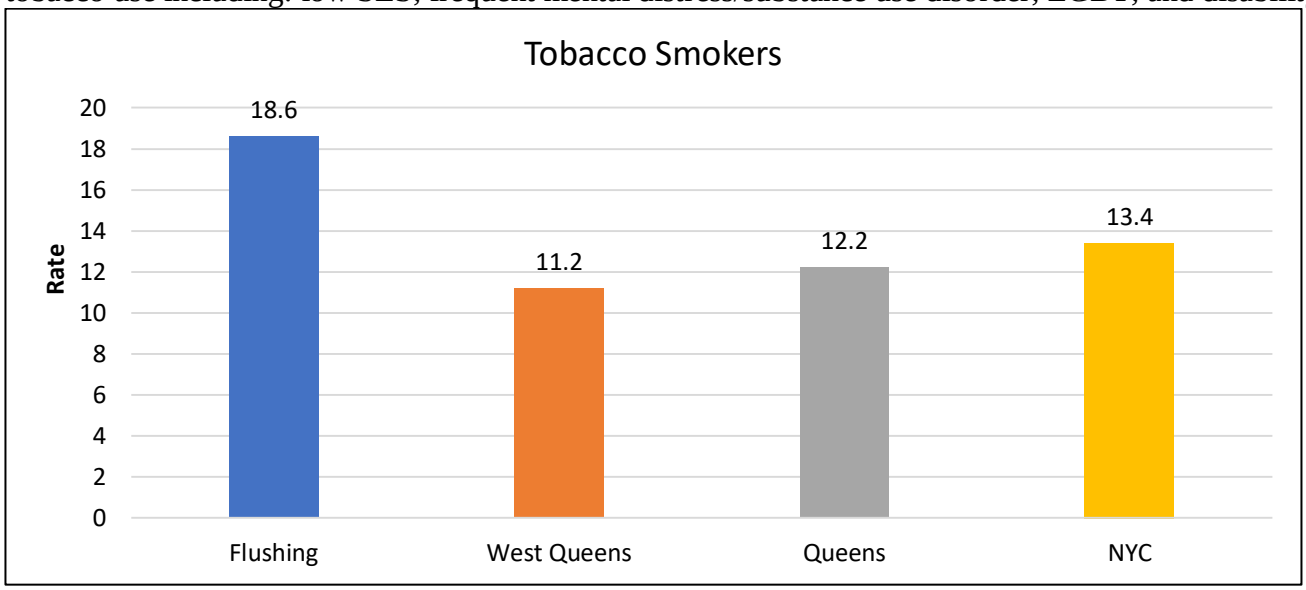
FHMC, through the Public Affairs Department, regularly posts articles and videos promoting the importance of physical activity and exercise in both adults and children.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

Focus Area 3: Tobacco Prevention

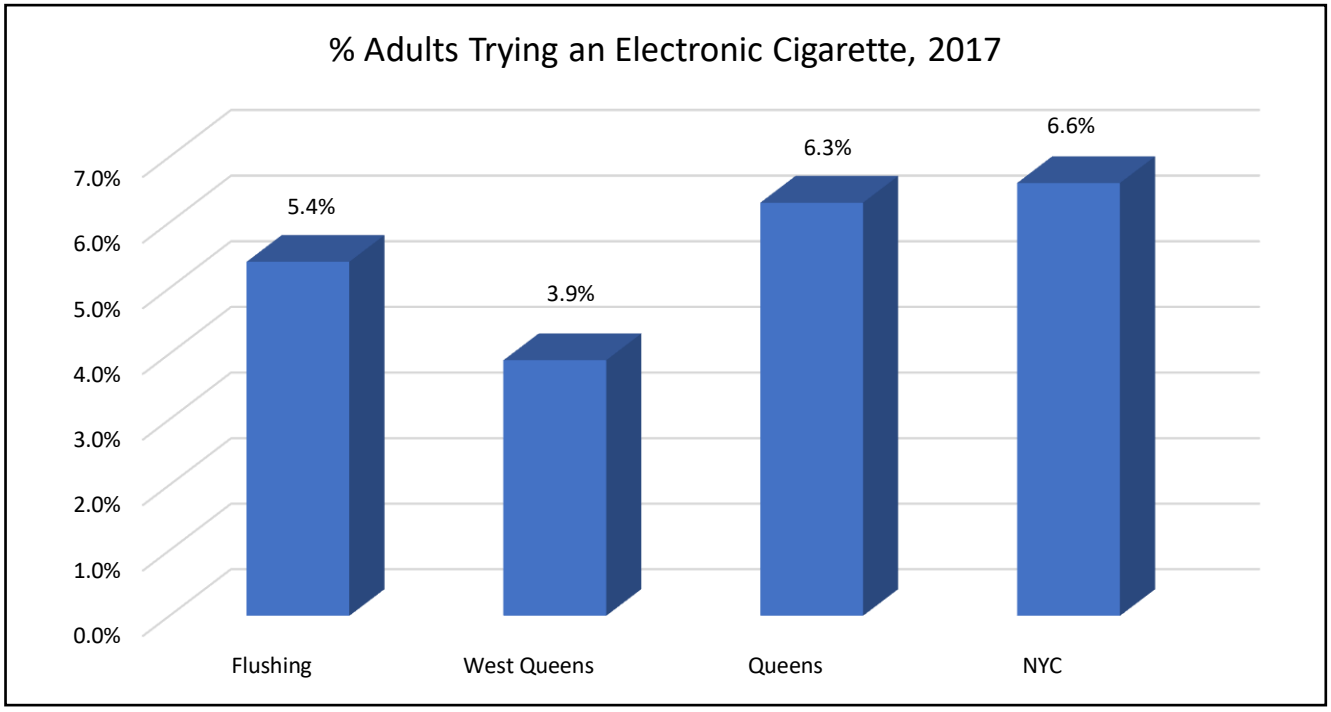
Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults. *Source: EpiQuery, Community Health Survey, 2017*

Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability.



Comment: Smoking rates are significantly higher in Flushing-Clearview than in West Queens, Queens, and NYC.

Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products. *Source: EpiQuery Community Health Survey, 2018*



Comment: More adults have tried e-cigarettes in Flushing than in West Queens. Both neighborhoods, however, have lower rates than Queens and NYC and have exceeded the Prevention Agenda goal of 7.0%.

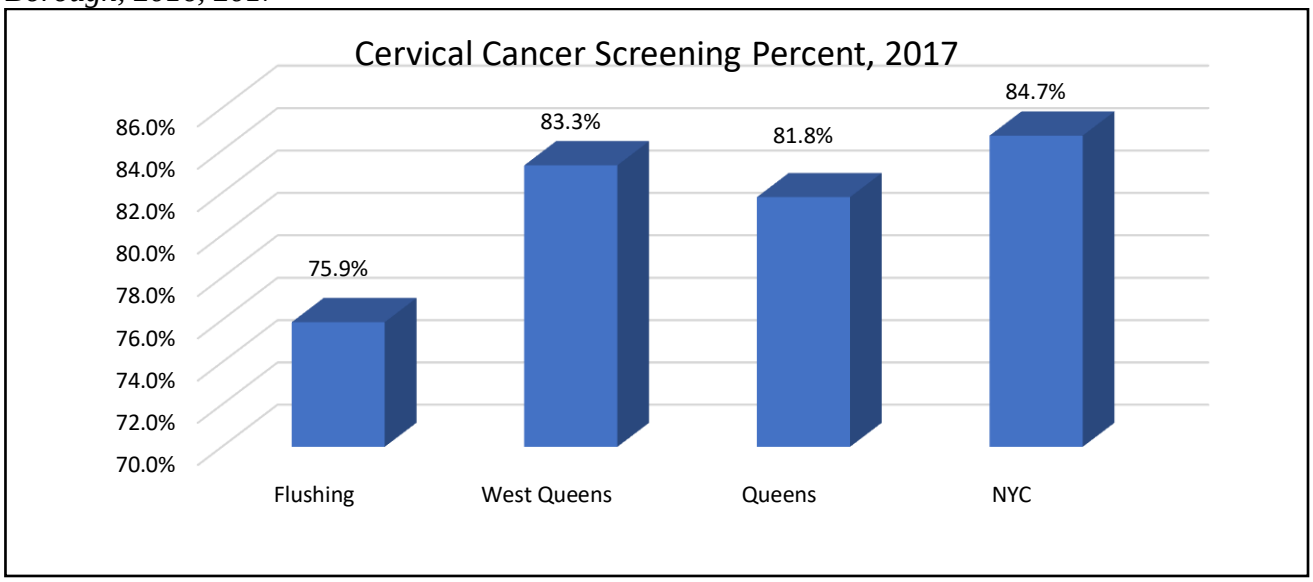
Resources and Accomplishments: FHMC has obtained and is maintaining the standards for Gold Star Recognition from the NYC Tobacco-Free Hospitals campaign for its tobacco cessation work with outpatients, inpatients, and employees. The Hospital has updated its electronic health record (EHR) system to introduce smoking cessation counseling prompts, to make electronic referrals from its EHR directly to the New York State Quit Line and to give all smokers educational literature about quitting at discharge. FHMC also earned a top award from Prevention Partners in the Patient Quit-Tobacco System assessment. Physicians conduct a mandatory 5-question assessment of all patients to screen for tobacco usage and gauge readiness to quit. In 2018, the Hospital assessed 94.7% of inpatients and 85.0% of outpatients; outpatients who required cessation interventions received them. Fewer inpatients are smokers, 20.8% compared to 22.4% in 2017. Patient navigators who are Freedom From Smoking facilitators offer free smoking cessation counseling and medication to all patients and employees who smoke. In 2018, the Hospital offered 19 outreach and educational events that reached more than 800 people and resulted in three smokers attending a smoking cessation class. In addition to FHMC's community-based efforts and programming aimed at reducing tobacco use, there are three other hospital-based tobacco cessation programs (Jamaica Hospital, New York Hospital Queens, and Elmhurst Hospital) in Queens.

FHMC, through the Public Affairs Department, regularly posts articles and videos warning of the dangers of using all tobacco and e-cigarette related products as well as offers information, such as tips and resources to quit smoking.

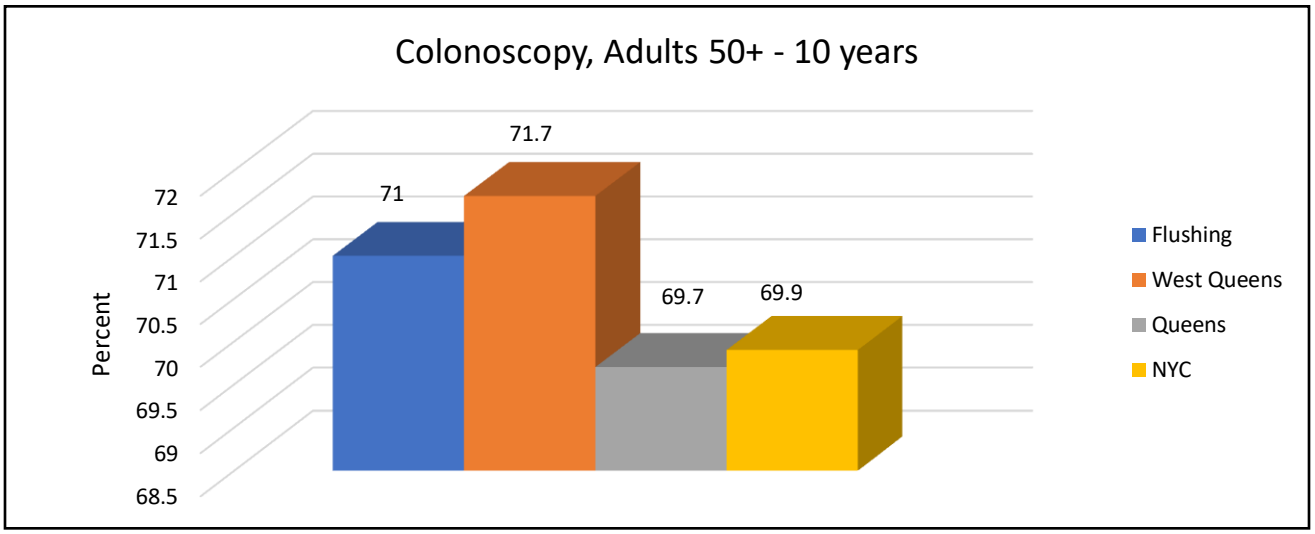
This information is shared on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

Focus Area 4: Preventive Care and Management

Goal 4.1: Increase cancer screening rates for breast, cervical and colorectal cancer. *Source: EpiQuery, Community Health Surveys, 2017; Community Health Surveys, 2017; Colon cancer screening by Borough, 2016, 2017*

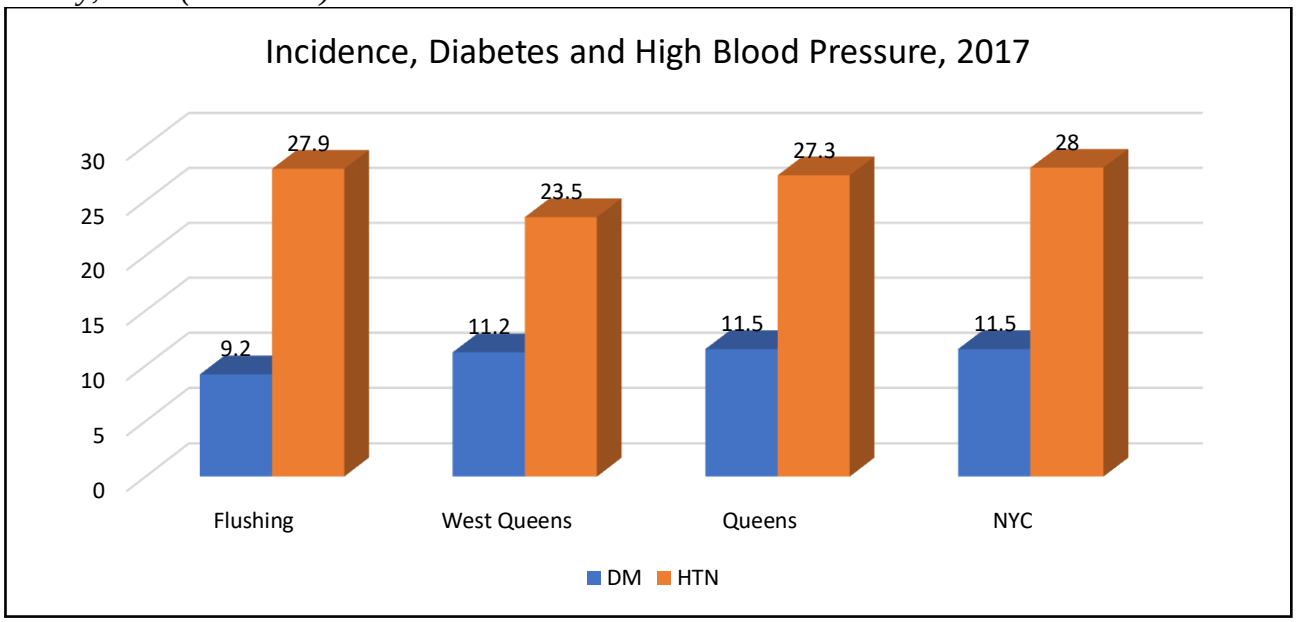


Comment: Screening rates for cervical cancer in women (Pap tests) in West Queens were comparable to Queens and NYC, while Flushing's rate was below 80%. Neither neighborhood reached the HP2020 benchmark of 93%.



Comment: The percentage of adults having colonoscopies to screen for colorectal cancer in West Queens is similar to the Queens and NYC average. Screening rates are lower in Flushing. West Queens and Flushing have not met the 2019-2024 Prevention Agenda target of 80.0%.

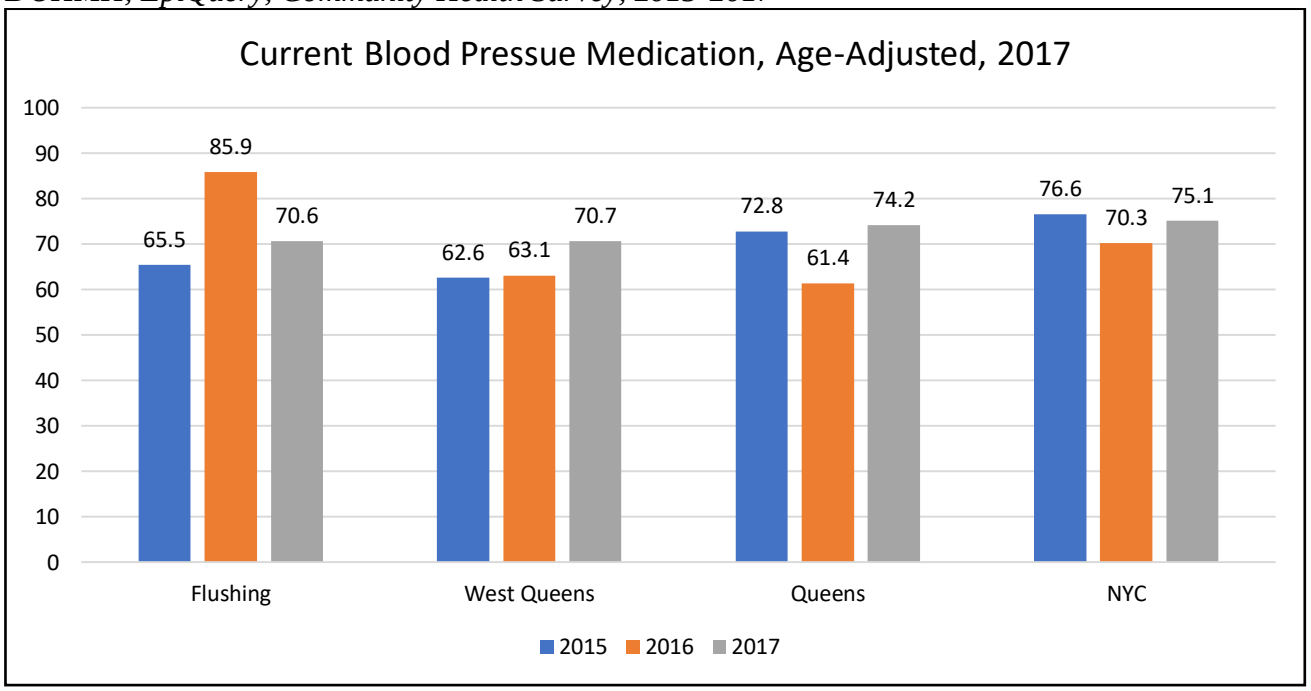
Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity. Percent told by a doctor that they have Diabetes or High Blood Pressure. Source: *EpiQuery Community Health Survey, 2018 (2017 data)*



Comment: West Queens has the highest incidence of diabetes in the hospital's service area, while Flushing has the highest rate of hypertension, which exceeds the Borough average.

Goal 4.3: Promote the use of evidence-based care to manage chronic diseases

Goal 4.4: Improve self-management skills for individuals with chronic conditions. *Source: NYC DOHMH, EpiQuery, Community Health Survey, 2015-2017*



Comment: Compliance with taking prescribed blood pressure medication in Flushing and West Queens is lower than in Queens and NYC.

Resources and Accomplishments: FHMC's on-site Ambulatory Care Center has achieved the goal of National Center for Quality Assurance (NCQA) NYS Patient-Centered Medical Home (NYS PCMH) recognition, an exclusive model of the NCQA PCMH program that supports NYS DOH's initiative to improve primary care through use of teamwork and technology to deliver comprehensive and coordinated patient-centered primary care. The Hospital is a collaborative stakeholder in the Patient-Centered Primary Care Collaborative, which is dedicated to promoting policies and sharing best practices to support an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home.

The Hospital offers free cancer screenings and referrals to highly specialized cancer services programs through a partnership with the NYS Cancer Services Program funded by the NYS DOH. It also operates a patient navigator program for colon cancer to increase show rates for screenings and necessary follow-up. Through a partnership with the NYC DOHMH it provides free cancer screenings for those without insurance or sufficient financial resources.

Through its participation in the NYS DSRIP initiative, the Hospital has implemented evidence-based best practices for cardiovascular management in all primary care locations. Primary care practices are addressing the total treatment needs of cardiovascular patients utilizing a multidisciplinary treatment team and making appropriate referrals for cardiology, nutrition, and other specialty services. Patient navigators are being used to provide supportive health coaching and follow-up to ensure that patients attend medical appointments and attain self-management goals.

A similar approach is being taken to provide expanded evidence-based care for diabetic patients. Patient navigators are providing health education and health coaching, as well as facilitating a weekly evidence-based Diabetes Prevention Program. Monthly diabetes support groups are conducted by a multidisciplinary group of clinical specialists. Registered Dietitians offer free nutritional classes, "What Can I Eat?" and monthly diabetes support groups to diabetic patients. To date, the FHMC National Diabetes Program has had 55 participants complete the program and 2 are currently attending the program; 25 are no longer at risk for diabetes.

For asthma management, the patient's PCP provides asthma education, which is augmented by a patient navigator who provides educational materials and health coaching. Development of individualized Asthma Action Plans that are integrated into the EHR and available through the patient portal facilitate continuity of care along all points of care.

FHMC is a member of the Take the Pressure Off, NYC! (TPO NYC!) Coalition. TPO, NYC! is a multi-sector, citywide initiative driven by a coalition of over 100 organizations from 13 sectors across NYC working together to prevent and control high blood pressure.

FHMC, through the Public Affairs Department, regularly posts articles and videos on the importance of preventative care and the management of the community's health including the management of conditions such as asthma, diabetes, hypertension, as well as the importance of cancer screenings, including breast, cervical, and colo-rectal cancers.

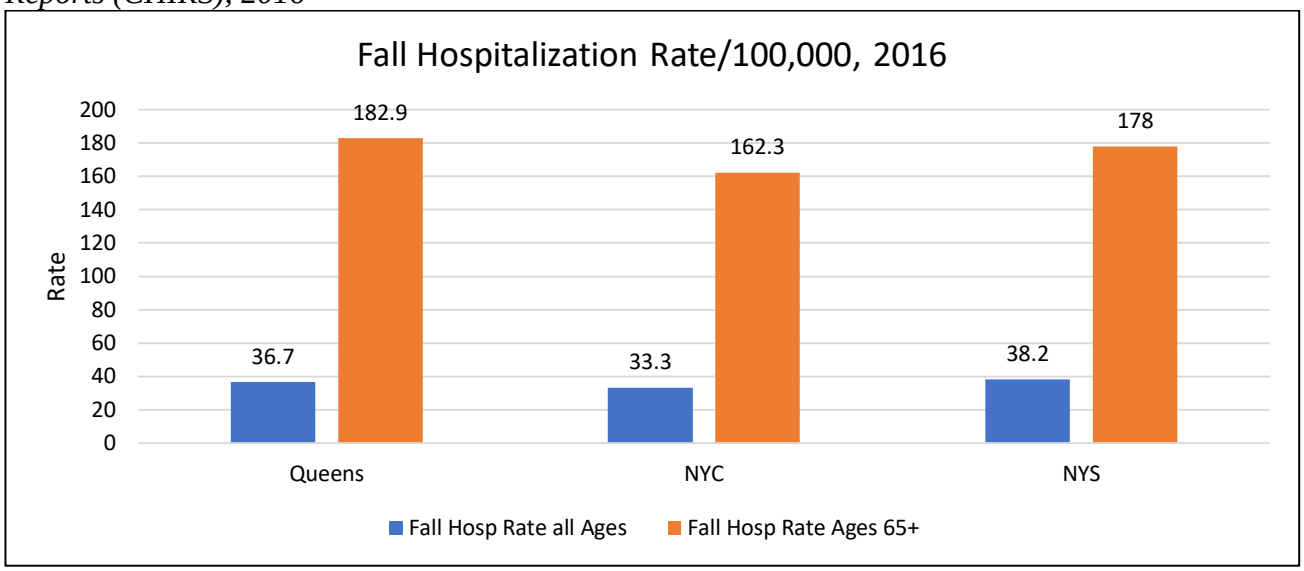
This information is shared on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

COMMUNITY HEALTH NEEDS ASSESSMENT

Priority Area II: Promote a Healthy and Safe Environment

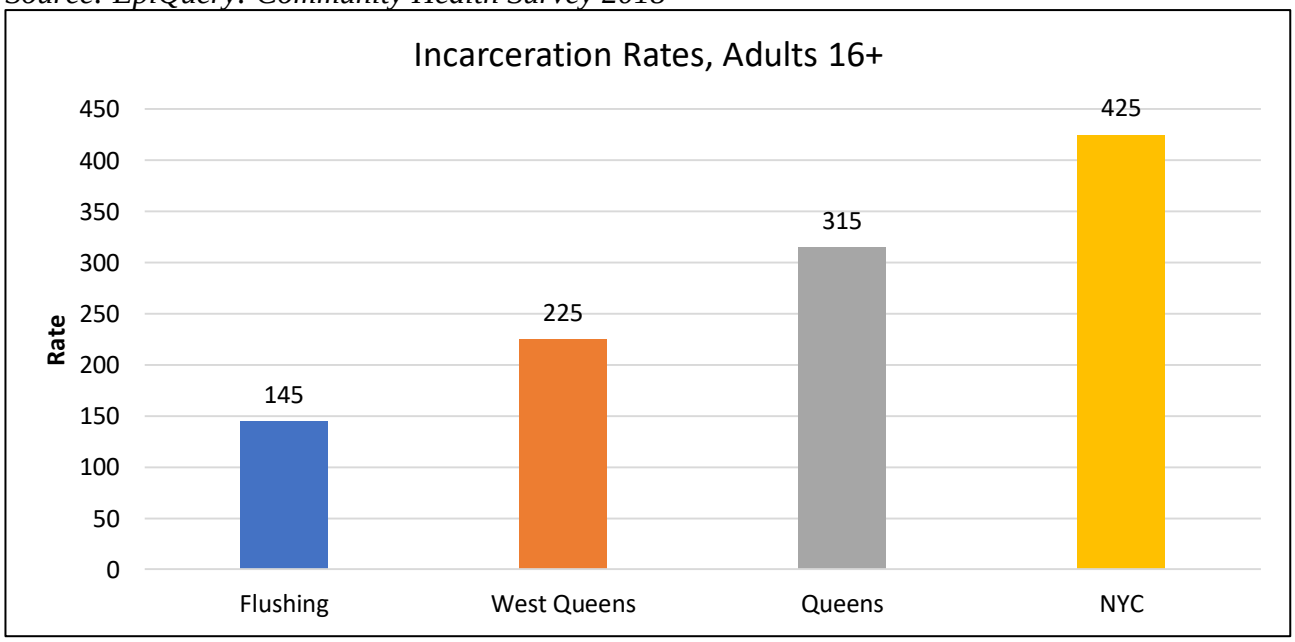
Focus Area 1: Injuries, Violence and Occupational Health

Goal 1.1: Reduce falls among vulnerable populations. *Source: NYSDOH, Community Health Indicator Reports (CHIRS), 2016*



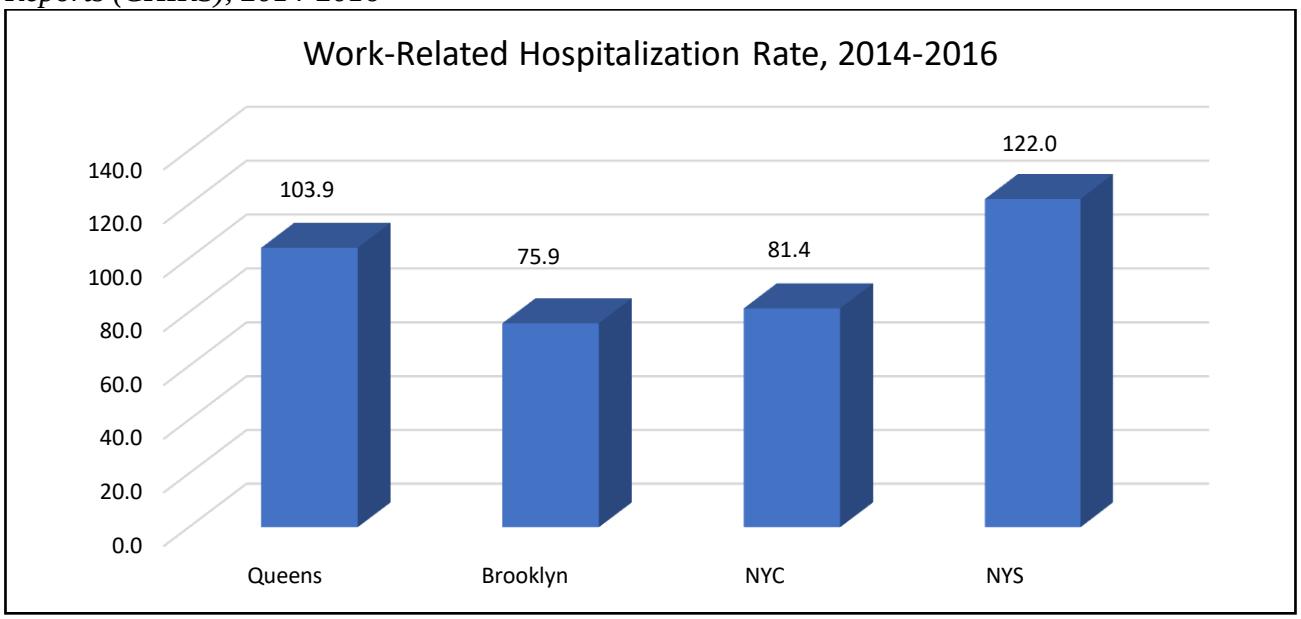
Comment: The risk of falls increases with age, as does the hospitalization rate for falls. The elderly fall hospitalization rate for Queens is higher than NYC, or NYS. For all age groups, the Queens' fall rate is higher than NYC but below the NYS average. The hospitalization rate for the 65+ age group is 182.9/10,000 population, higher than the Prevention Agenda target of 170.1/10,000.

Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations. *Source: EpiQuery: Community Health Survey 2018*



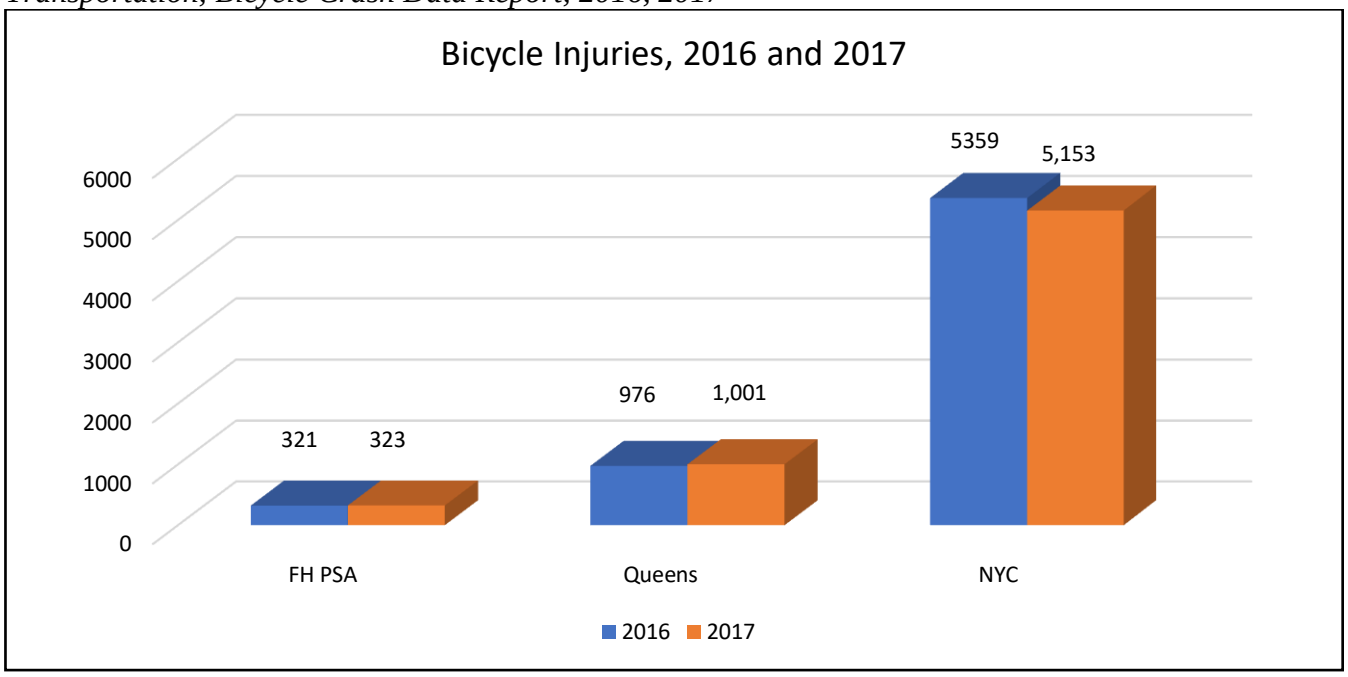
Comment: West Queens' jail incarceration rate is 1.5 times that of Flushing. Both neighborhoods have significantly lower incarceration rates than Queens or NYC.

Goal 1.3: Reduce occupational injuries and illness. *Source: NYS DOH, Community Health Indicator Reports (CHIRS), 2014-2016*



Comment: The rates of occupational injuries resulting in hospitalization in Queens (103.9) is higher than NYC (81.4), but below the NYS average (122.0).

Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists. *Source: NYC Dept. of Transportation, Bicycle Crash Data Report, 2016, 2017*



Comment: In Flushing Hospital's primary service area, the number of bicycle injuries remained the same from 2016 to 2017. Bicycle injuries in Queens increased 2.6%, while they declined 3.8% in NYC.

Resources and Accomplishments: Flushing Hospital's Emergency Department provides around-the-clock care for all adult, pediatric, and OB/GYN emergencies. And treats more than 44,000 patients each year. The Emergency Department is designated by the NYS DOH as a Primary Stroke Center within the 911 system. The Nurses at FHMC do a complete "at risk for fall assessment" at the time of admission and throughout the patient's hospitalization. The primary purpose of this assessment is to educate patients about falls in the facility and to minimize falls and injury related falls. The health care team with patient/family input will determine how safe it is for the patient to return back to their environment. If the patient requires additional services or placement in another facility after discharge (such as rehab, assisted living or long term care) arrangements will be made by the case manager/social worker.

Adult trauma cases are referred to Level 1 Regional Trauma Centers in Queens, located at Jamaica Hospital, Elmhurst Hospital, New York-Presbyterian/Queens: Long Island Jewish Medical Center operates the Level I Pediatric Trauma Center in Queens. FHMC refers senior citizens who are treated for fall-related injuries to senior citizen centers that provide classes, such as Stay Active and Independent for Life (SAIL) and Tai Chi for Arthritis that are designed to promote healthy exercise habits, strengthen joints, increase stability, and reduce the likelihood of falls. The NYC Department for the Aging recently received a federal grant to increase the availability of evidence-based falls prevention programs, *A Matter of Balance* and *Tai Chi for Arthritis*, through 20 community-based aging services providers in its network.

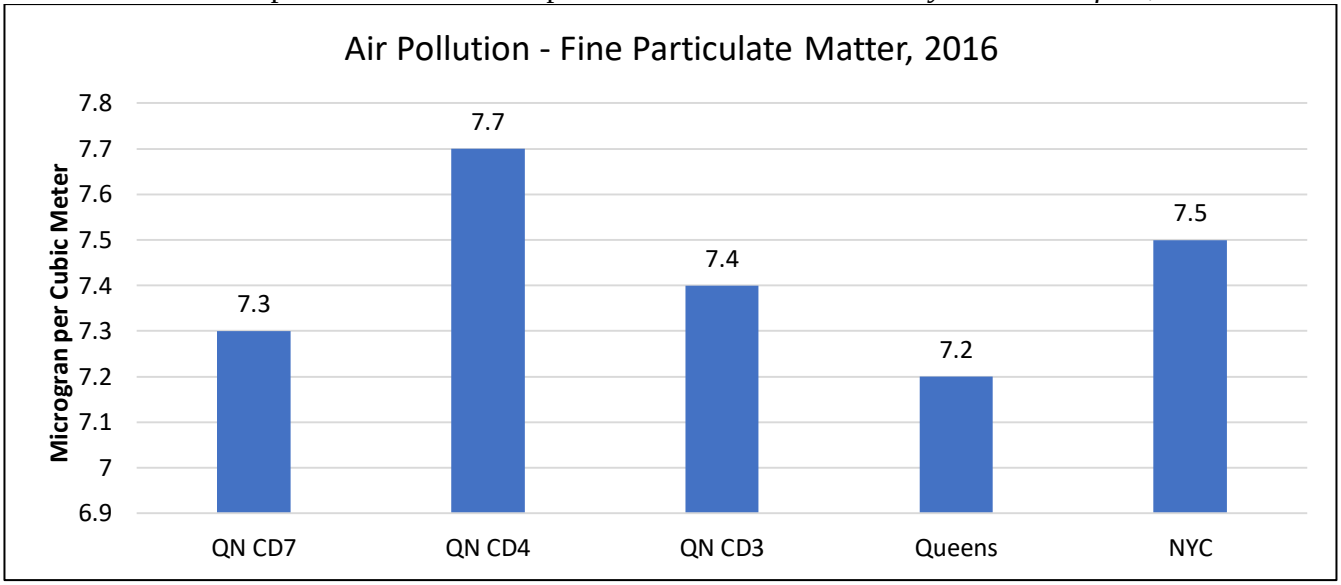
FHMC, through the Public Affairs Department, regularly posts articles and videos on injury prevention in the home, at the workplace and as well as automobile safety.

This information is shared on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

COMMUNITY HEALTH NEEDS ASSESSMENT

Focus Area 2: Outdoor Air Quality

Goal 2.1: Reduce exposure to outdoor air pollutants. *Source: Community Health Profiles, 2018*



Comment: Neighborhood pollution levels for fine particulate matter, the most harmful outdoor air pollutant, are similar to borough and citywide levels. Pollution levels for fine particulate matter by Community District, range from a low of 6.0 micrograms in QN CD14 to a high of 11.3 micrograms in MN CD5 (Manhattan).

Resources and Accomplishments: FHMC is part of the Asthma Coalition of Brooklyn and Queens (formed in 2012), in which organizations work together to improve the quality of life for people with asthma by engaging patients, families, healthcare providers, institutions and the community. The Hospital's Division of Allergy-Immunology focuses on the diagnosis and long-term treatment of allergies and respiratory illnesses such as asthma. FHMC's pulmonary function laboratory uses the latest equipment to diagnose and treat patients experiencing breathing abnormalities and acute and chronic lung disorders. The Hospital's Pediatric Asthma and Allergy Clinic provides asthma and allergy management treatment services to children. Flushing Hospital's Patient Navigators were trained to conduct group counseling in the "Freedom from Smoking" program by the American Lung Association. In addition to Flushing Hospital's resources, New York-Presbyterian/Queens also offers a Pediatric Asthma Center.

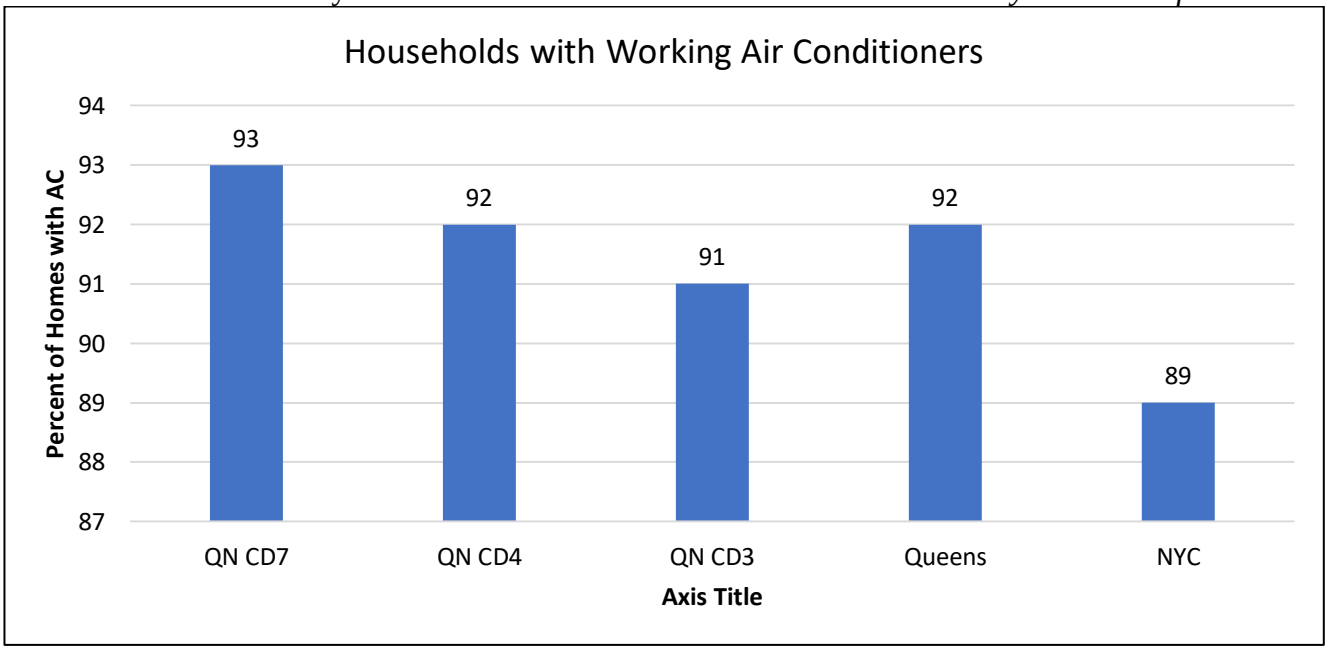
Focus Area 3: Built and Indoor Environments

Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change

Homes near structures rated good or excellent (%), 2014. *Source: NYC DOHMH, Neighborhood Profiles, Environment & Health Data Portal, 2014*

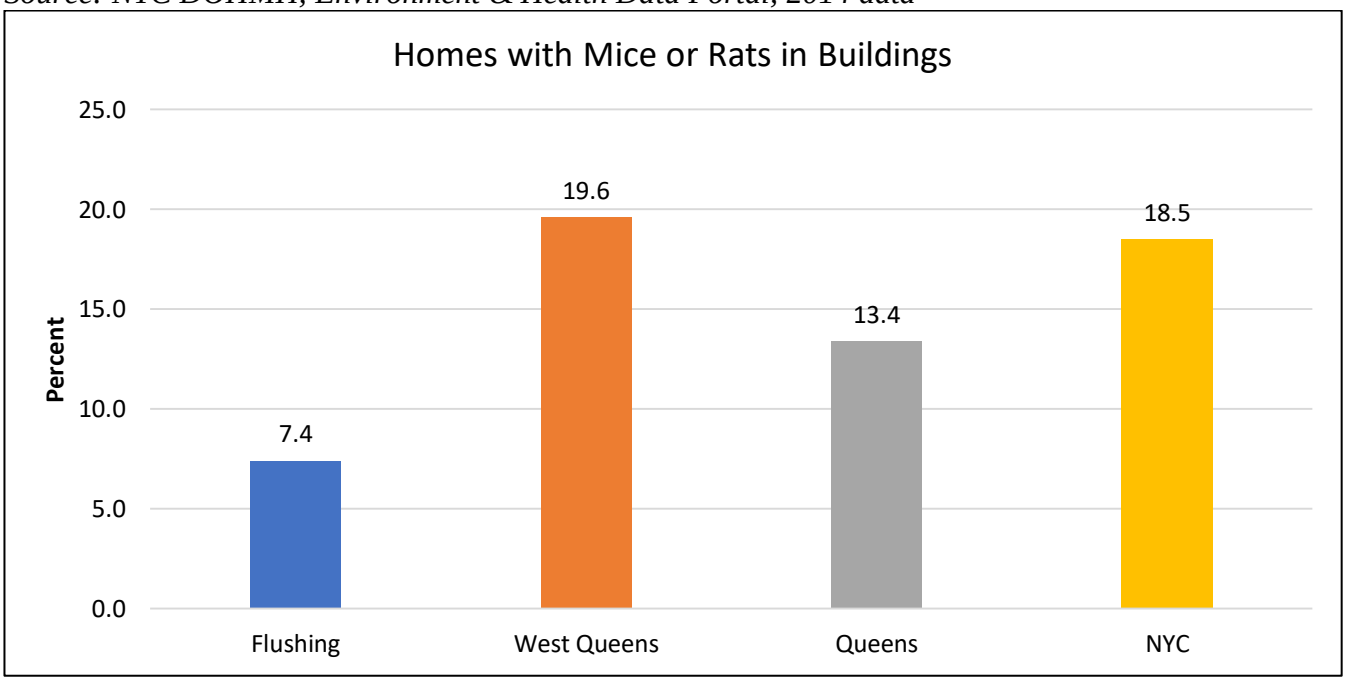
Comment: The housing stock in Flushing Hospital's service area is better than Queens and NYC, overall. More than 84% of residents rate the quality of structures near their homes as Good or Excellent.

Goal 3.2: Promote healthy home and school environments. *Source: Community Health Profiles. 2018*



Comment: The residents living in Flushing Hospital's service area are well protected from the threat of heat stroke in their home environment. Over 90% of the household have working air conditioners.

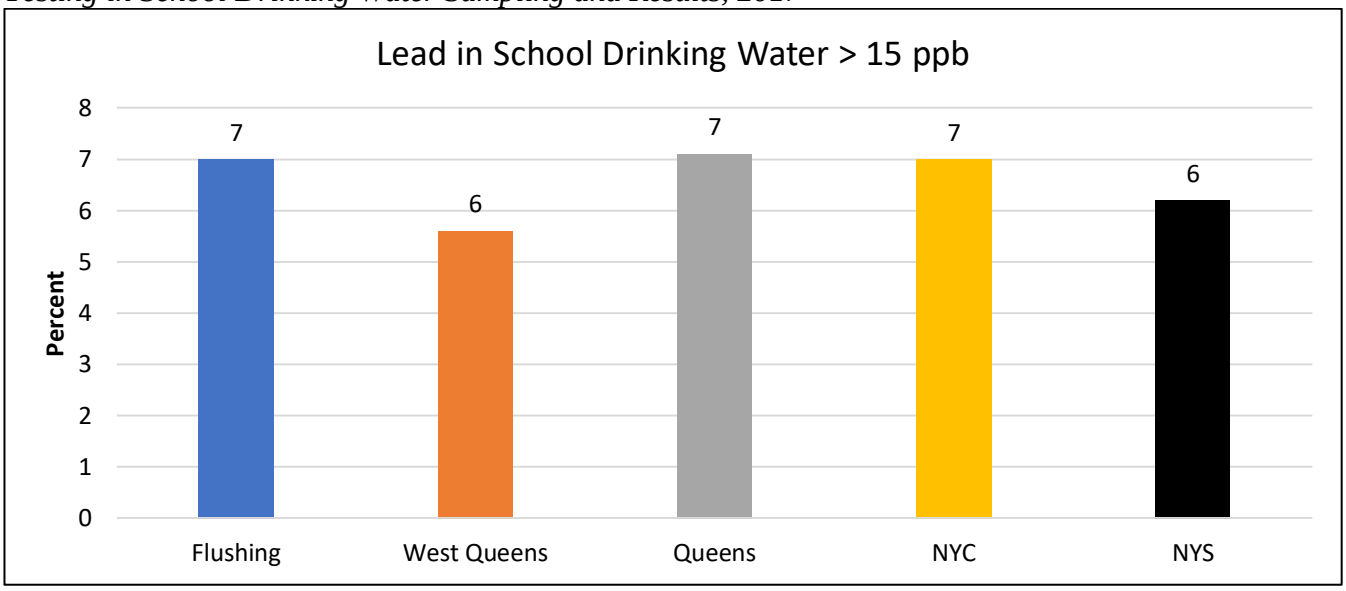
Source: NYC DOHMH, Environment & Health Data Portal, 2014 data



Comment: The percentage of homes with mice or rats in the building is higher in West Queens than in Flushing, Queens, and NYC.

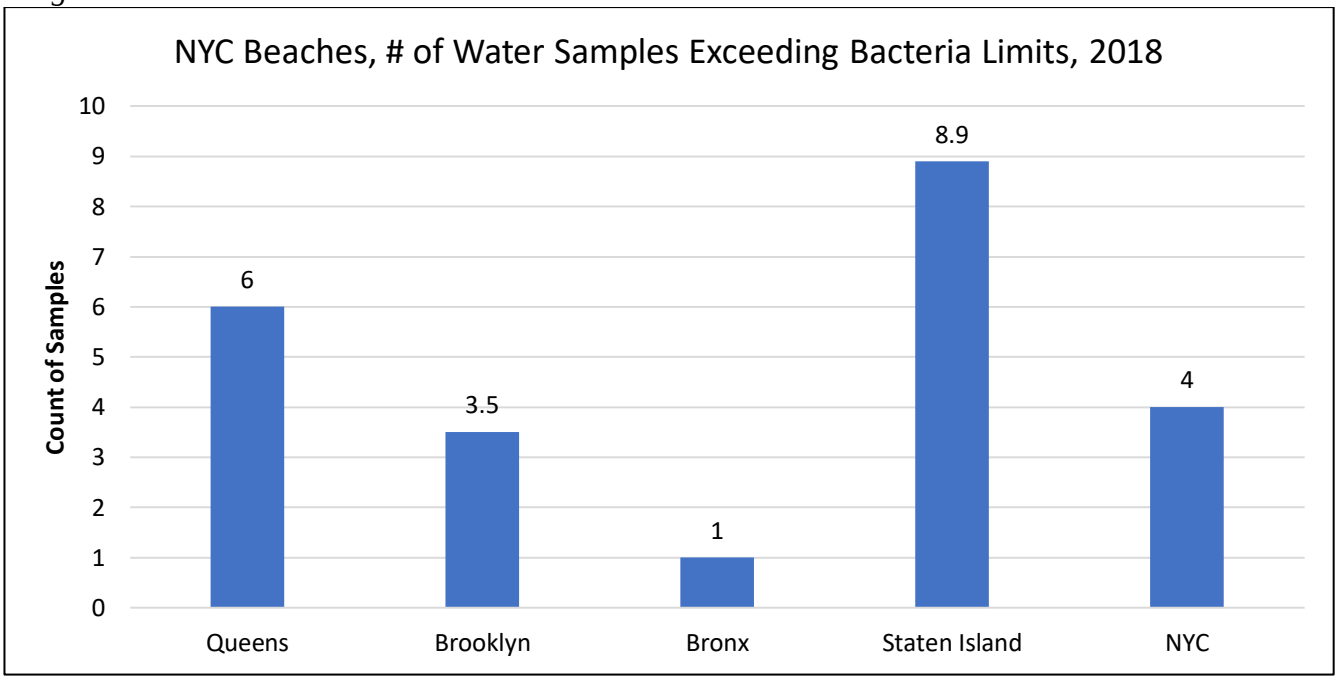
Focus Area 4: Water Quality

Goal 4.1: Protect water sources and ensure quality drinking water. *Source: Health Data NY, Lead Testing in School Drinking Water Sampling and Results, 2017*



Comment: In Flushing schools, 7.0% of water outlets exceeded the legal lead limit (> 15 ppb), the same as NYC. West Queens was below the NYC and NYS (6.2%) rates.

Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water. *Source: NYC DOHMH, NYC 2018 Beach Surveillance and Monitoring Program*

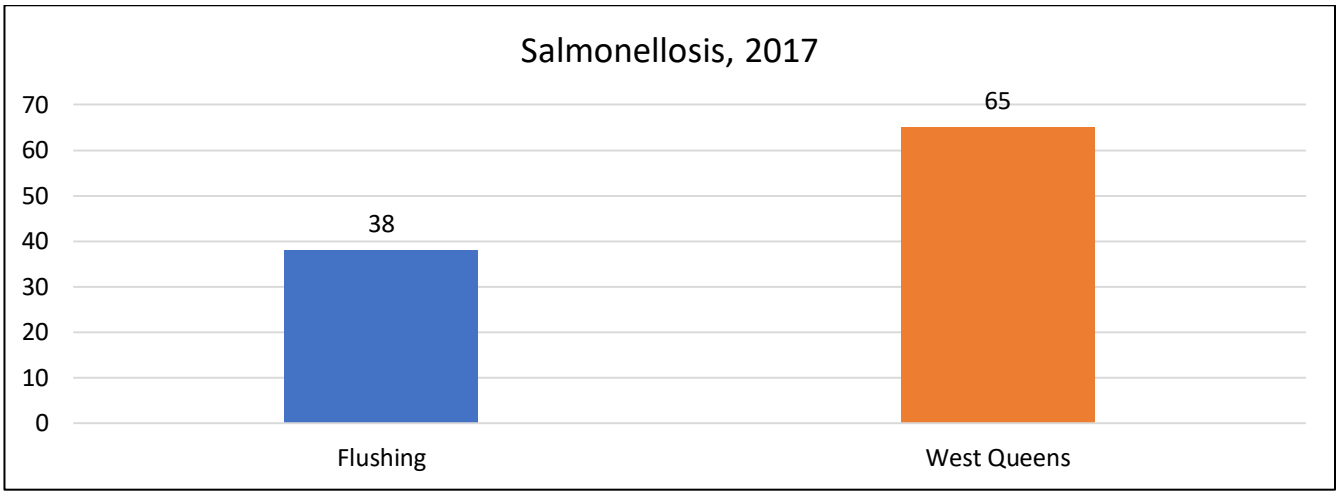


Comment: Queens' beaches exceeded safe water testing limits more frequently than the NYC average.

Focus Area 5: Food and Consumer Products

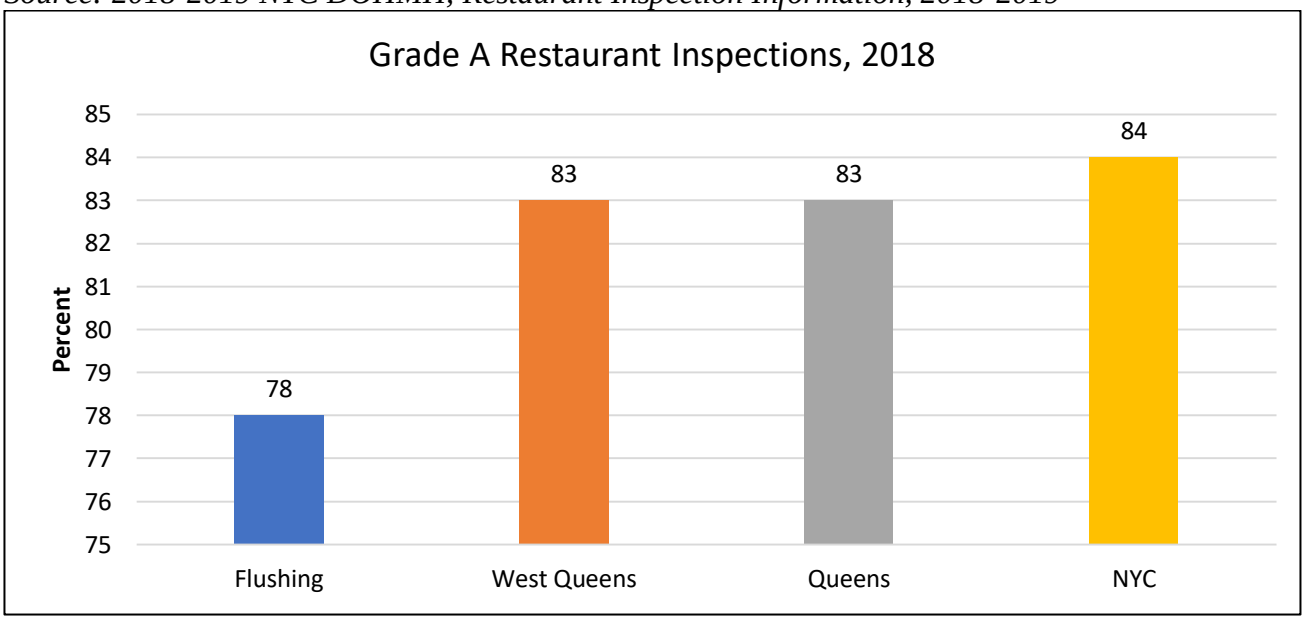
Goal 5.1: Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure

Goal 5.2: Improve Food Safety Management. *Source: NYC EpiQuery. Communicable* Surveillance Disease Data



Comment: Food poisoning cases from salmonella are higher in West Queens compared to Flushing.

Source: 2018-2019 NYC DOHMH, Restaurant Inspection Information, 2018-2019

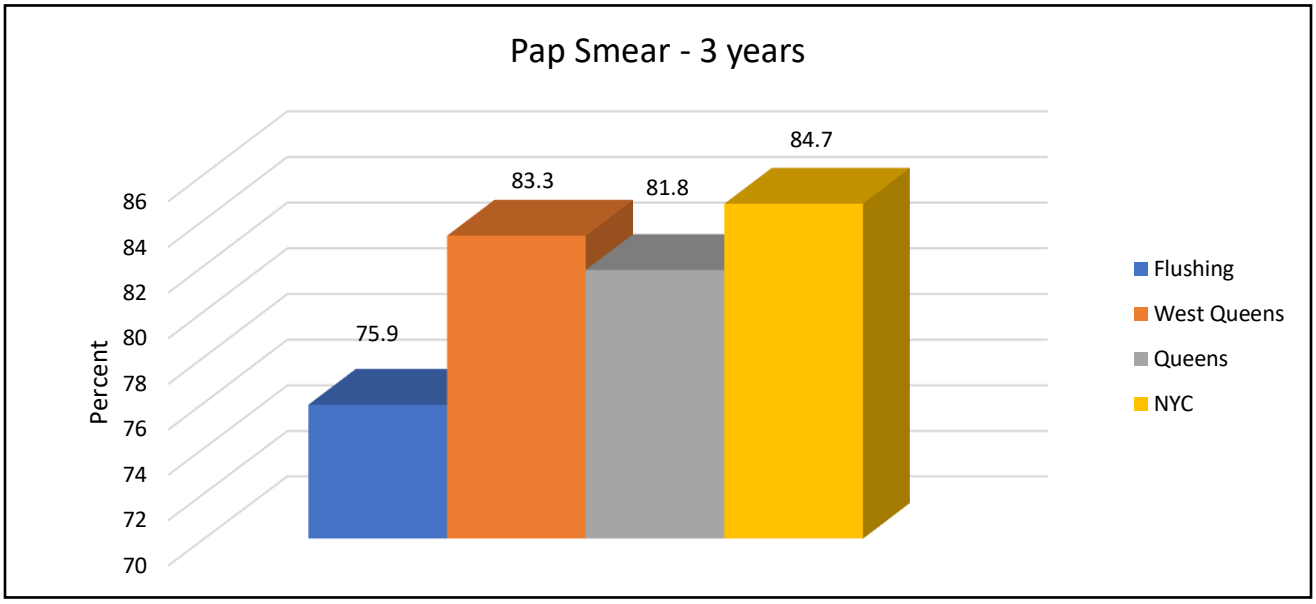


Comment: In West Queens, nearly 83% of restaurants received a score of A on food safety inspections, close to the borough and Citywide scores. Flushing had fewer restaurants with an A score - 78.4%.

Priority Area III: Promote Health Women, Infants and Children

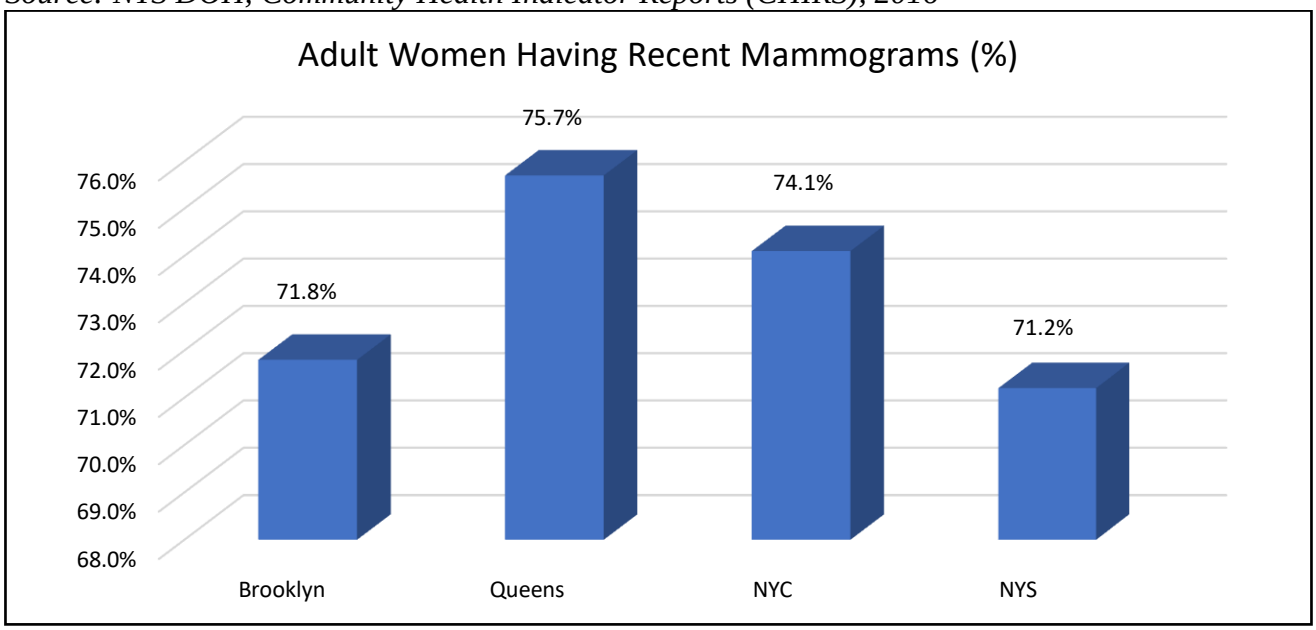
Focus Area 1: Maternal & Women's Health

Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age. *Source: EpiQuery, Community Health Surveys 2018.*



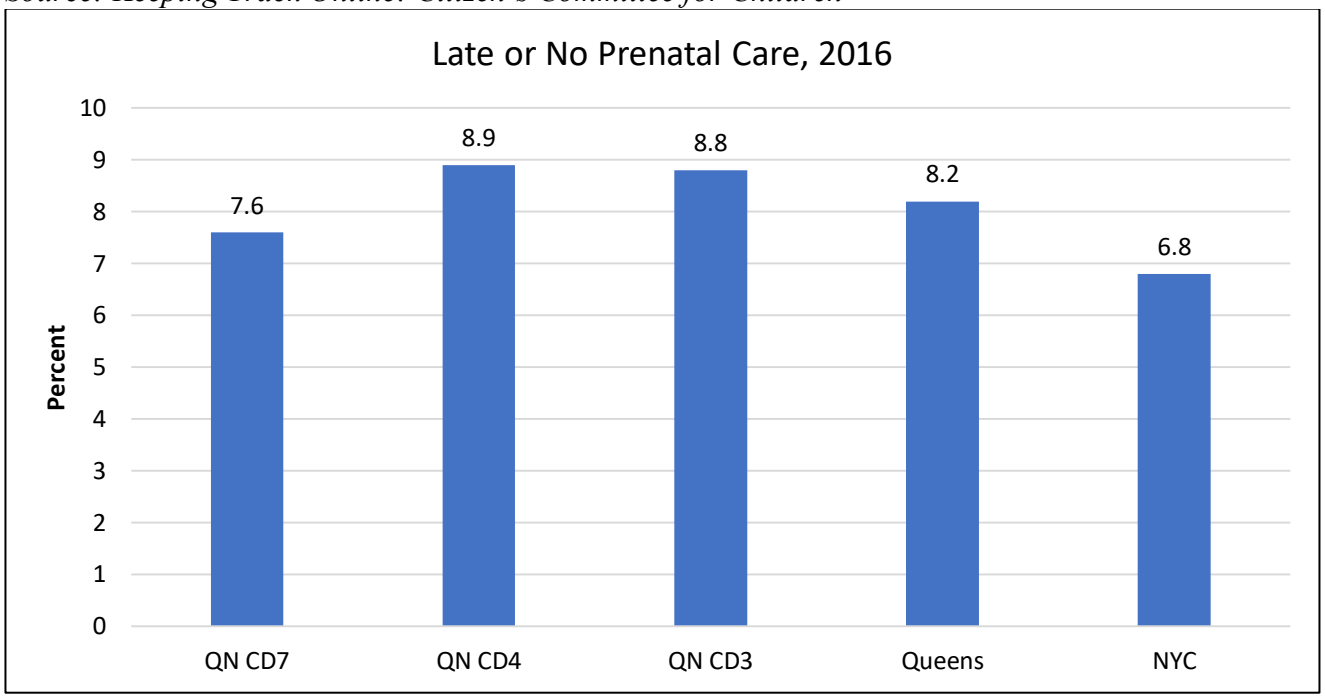
Comment: Pap smear rates in Flushing (75.9%) were lower than in West Queens (83.8%), Queens (81.8%), and in NYC (84.7%). Pap smears are used to screen for cervical cancer in women.

Source: NYS DOH, Community Health Indicator Reports (CHIRS), 2016



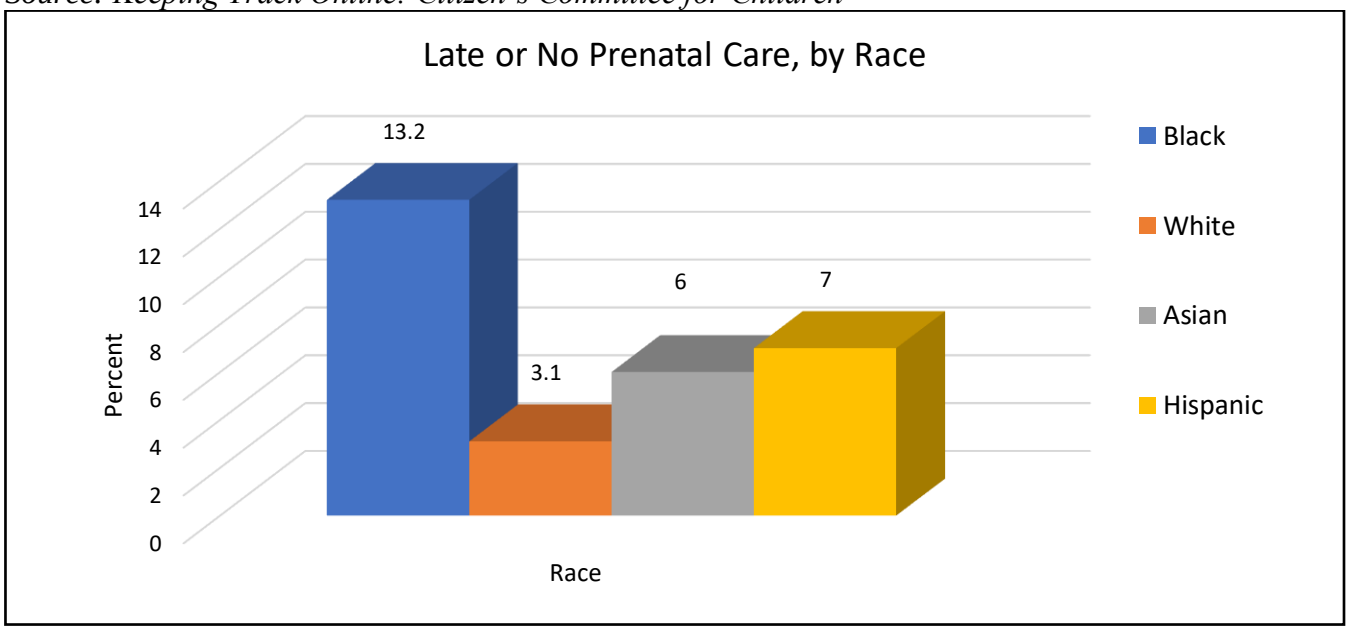
Comment: Women living in Queens are more likely to receive a mammogram, compared to women living in NYC or NYS. Mammograms are used to screen for breast cancer.

Source: Keeping Track Online: Citizen's Committee for Children



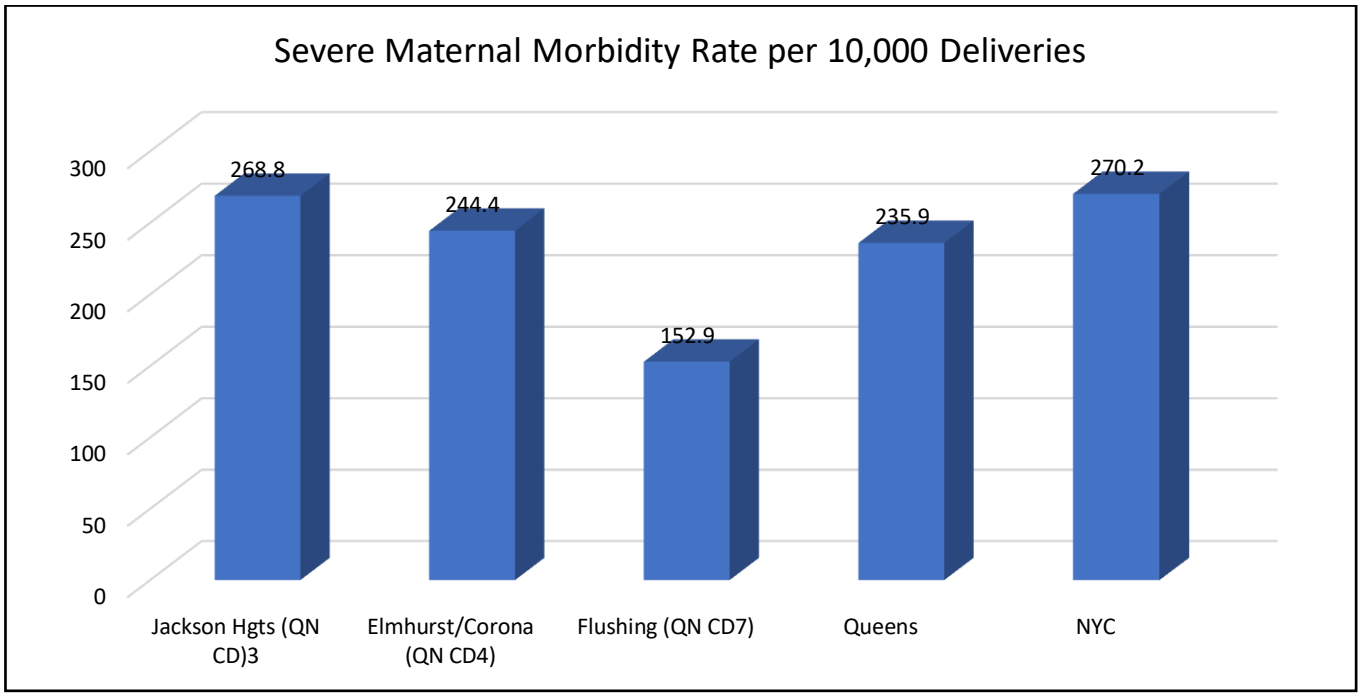
Comment: The percentage of women receiving no or late prenatal care in Queens Community Districts 3 and 4 is higher than for Queens or NYC.

Source: Keeping Track Online: Citizen's Committee for Children



Comment: In NYC, the percentage of women receiving no or late prenatal care is four times higher in Black women than White women. Rates for Hispanic and Asian women are twice as high.

Goal 1.2: Reduce maternal mortality and morbidity. *Source: NYC DOHMH, Bureau of Vital Statistics; SPARCS*



Comment: Flushing has the best (lowest) maternal morbidity rate among the 14 Community Districts in Queens. Maternal morbidity is significantly higher in Jackson Heights and Elmhurst/Corona, but below the NY rate. Flushing exceeds the Prevention Agenda goal – 202/10,000.

Resource and Accomplishments: FHMC has embarked on an initiative to use the March of Dimes model of group pregnancy care (almost the same as Centering, but without the cost). A nurse practitioner in the OB/Gyn Ambulatory Care Center will be overseeing the project which will start by the end of the year. She is bilingual Spanish and will give classes in Spanish.

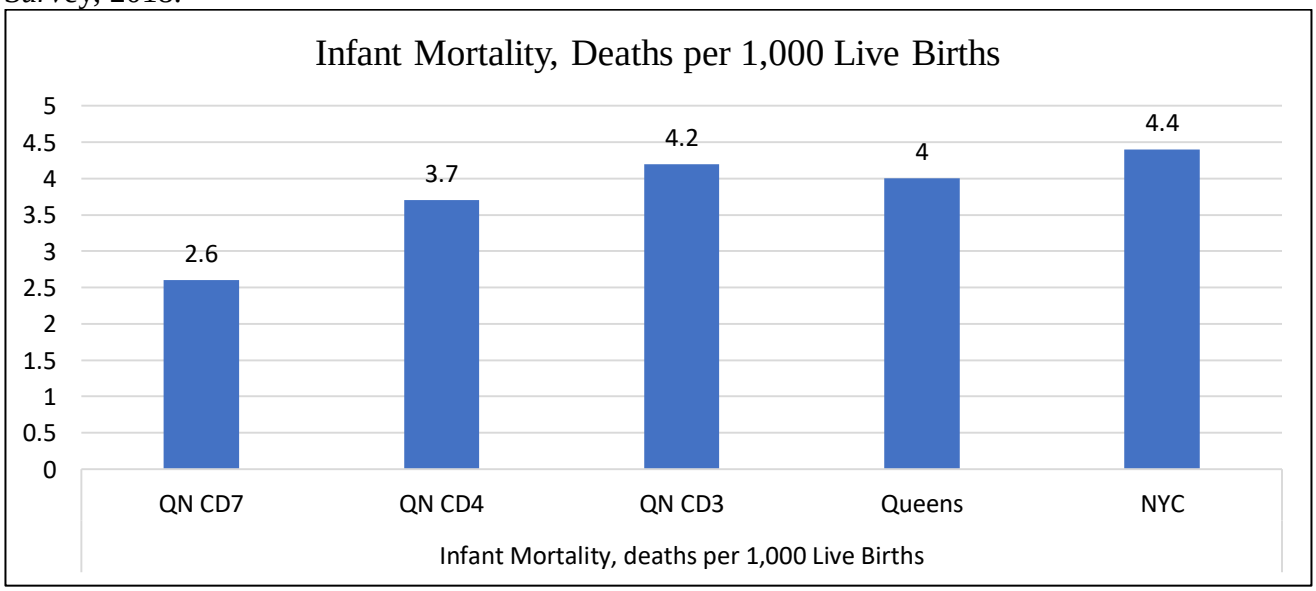
FHMC conducts breast cancer screening for women, consistent with American Cancer Society guidelines, at its Women's Health Center and offers extended hours nights and weekends. Free mammograms are provided to eligible women through New York State's Cancer Services Program.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos about the importance of pre-natal nutrition, exercise and participation in a pre-natal care program.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

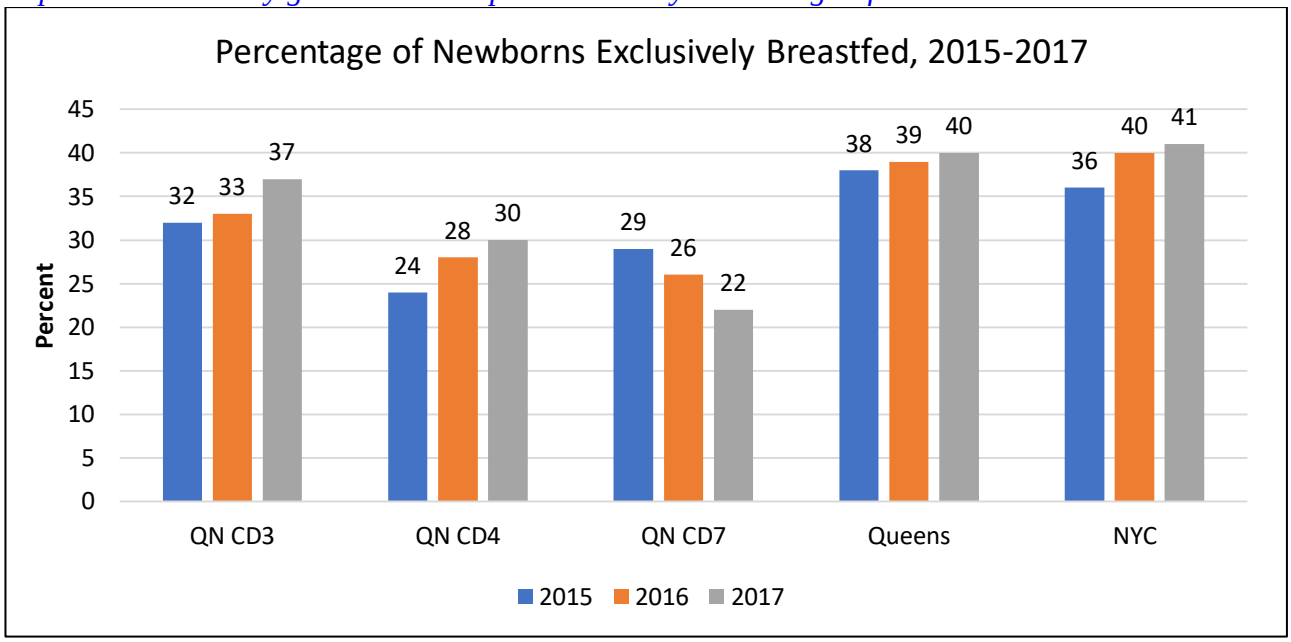
Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity per 1,000 live births. *Source: Community Health Surv*ey, 2018.



Comment: In Flushing Hospital's service area, Infant mortality rates are lowest in Queens Community District 4. All service area CDs have lower rates than the Borough of Queens (4.0) and NYC (4.4)

Goal 2.2: Increase breastfeeding. *Source: Hospital Maternity Percentage of Newborns Fed Breast Milk by Hospital: Latest Year. NYC Health Data.*
https://health.data.ny.gov/Health/Hospital-Maternity-Percentage-of-Newborns-Fed-Brea/nwmv-c6mq



Comment: Breastfeeding rates improved between 2015 and 2017 in Queens Community Districts 3 and 4, but declined in CD7. In each year, breastfeeding rates in Flushing Hospital's service area are lower than Queens and NYC and remain below the Prevention Agenda goal of 51.7access% and the TCNY 2020 target of 81.9%.

Resources and Accomplishments; FHMC recognizes that supporting breastfeeding is an important public health issue. The Hospital achieved a 50% exclusive breastfeeding rate in 2018, according to mothers at time of discharge. In July 2018, FHMC received the "Baby-Friendly USA" hospital designation, a global initiative launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), and has continued to meet the criteria for this designation. Hospital staff are dedicated to breastfeeding training efforts so they can share their knowledge with the community; all Pediatric, Obstetric, and Family Medicine providers have completed the recommended breastfeeding training. FHMC offers a weekly breastfeeding support group and infant feeding classes at its Women's Health Center. The breastfeeding program, which is also available in Spanish, is taught by a certified midwife and is intended to familiarize mothers-to-be with proper breastfeeding techniques.

FHMC is a New York State Department of Health-designated Level 3 Perinatal Center, meaning that it cares for patients requiring increasingly complex care and operates a neonatal intensive care unit (NICU). For more than 10 years.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos about how to care for your baby both during pregnancy and after delivery.

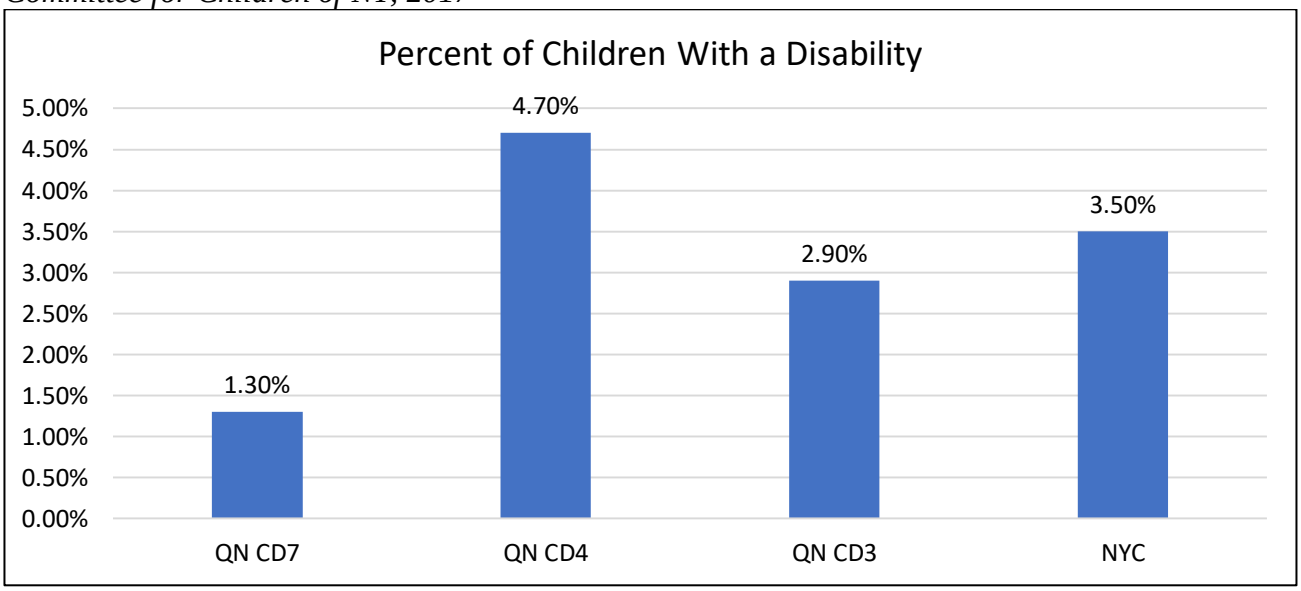
This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

COMMUNITY HEALTH NEEDS ASSESSMENT

Focus Area 3: Child & Adolescent Health

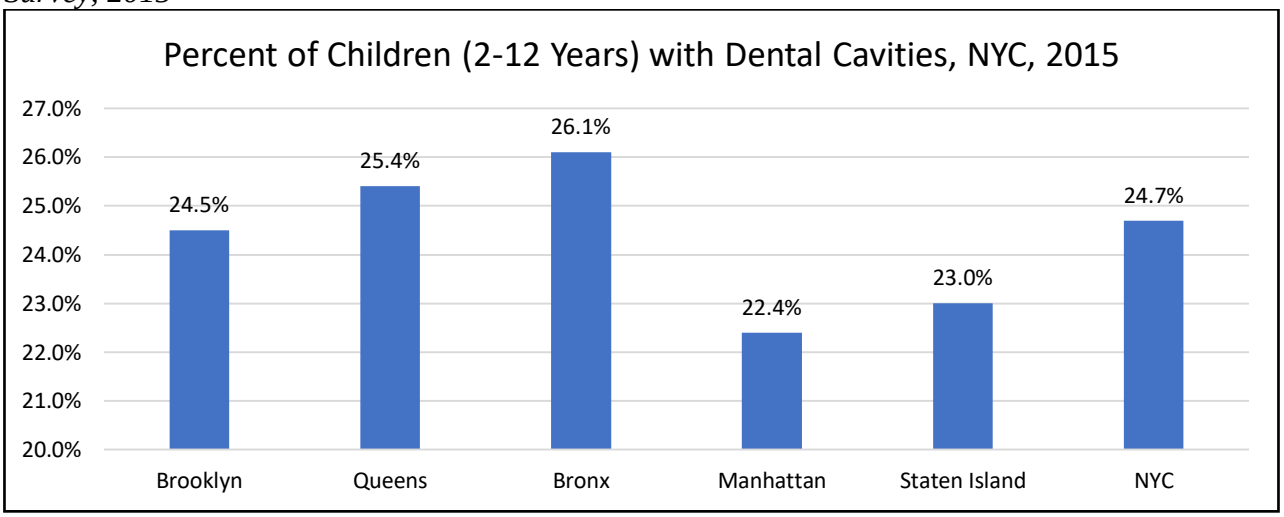
Goal 3.1: Support and enhance children and adolescents' social-emotional development and relationships

Goal 3.2: Increase supports for children and youth with special health care needs. *Source: Children's Committee for Children of NY, 2017*



Comment: Queens Community District 4 has the highest percentage of children with disabilities in Flushing Hospital's service area, 4.7%. It is higher than the NYC average (3.5%). The percentage of children with disabilities in QN CD3 (2.9%) and QN CD7 (1.3%) is lower than the City.

Goal 3.3: Reduce dental caries among children. *Source: NYC DOHMH, EpiQuery, Child Health Survey, 2015*



Comment: Of the 5 boroughs, Queens has the 2nd highest percentage of children with dental caries (25.4%), after the Bronx (26.1%). The dental caries rate in Queens also exceeds that of NYC (24.7%).

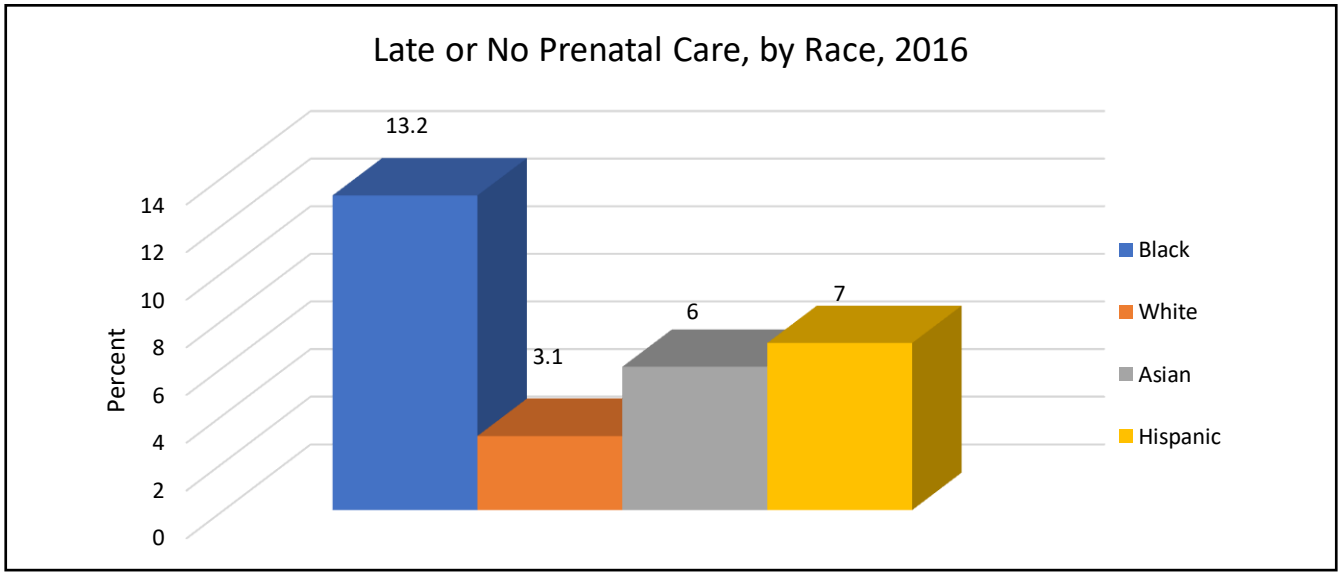
Resources and Accomplishments: The Hospital's Pediatric Department operates a 20-bed inpatient pediatric unit, a neonatal intensive care unit NICU), and a newborn nursery, and offers a range of pediatric outpatient primary and specialty care services at its Pediatric Ambulatory Center. FHMC's TJH Developmental and Behavioral Pediatric program offers evaluations for pediatric patients with academic, developmental, behavioral and social concerns. Common diagnoses identified and managed include autism spectrum disorder, intellectual disability disorder, learning disorders, attention deficit hyperactivity disorder (ADHD), developmental language disorder, and cerebral palsy. The Hospital's outpatient Mental Health Clinic provides diagnostic assessment, individual and group psychotherapy, and family counseling to children and adolescents, in addition to adults.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos about how to provide all aspects of clinical, emotional, and psychological care for children from birth through adolescence.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

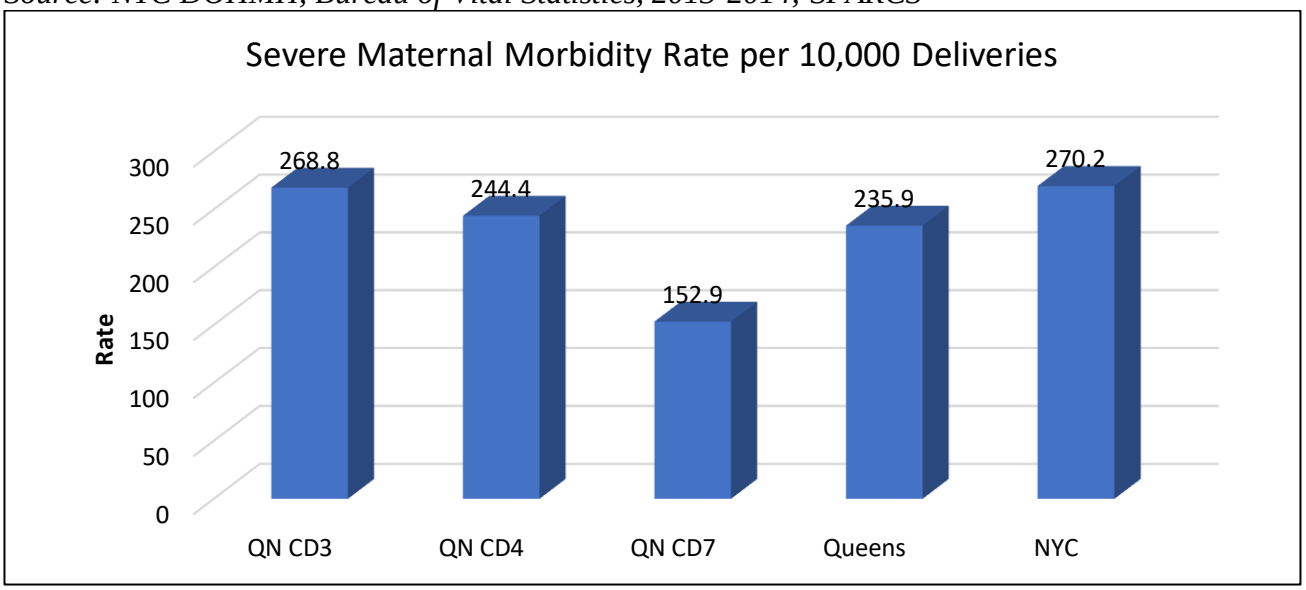
Focus Area 4: Cross Cutting Healthy Women, Infants, & Children

Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations. *Source: Citizens' Committee for Children of New York (2018)*



Comment: In NYC, the percentage of women receiving no or late prenatal care is four times higher in Black women than White women. Rates for Hispanic and Asian women are twice as high.

Source: NYC DOHMH, Bureau of Vital Statistics, 2013-2014; SPARCS



Comment: Community District 4 has the best (lowest) maternal morbidity rate among the 14 Community Districts in Queens. Maternal morbidity is significantly higher in QN CD 3 and QN CD4, but below the NY rate.

Resources and Accomplishments: We have embarked on planning to use the March of Dimes model of group pregnancy care (almost the same as Centering, but without the cost). I have a new nurse practitioner starting in the OB/Gyn ACC next week and she will be overseeing the project. She is bilingual Spanish and will have classes in Spanish. So, at this time, we don't have Centering, but will do so within four-eight weeks.

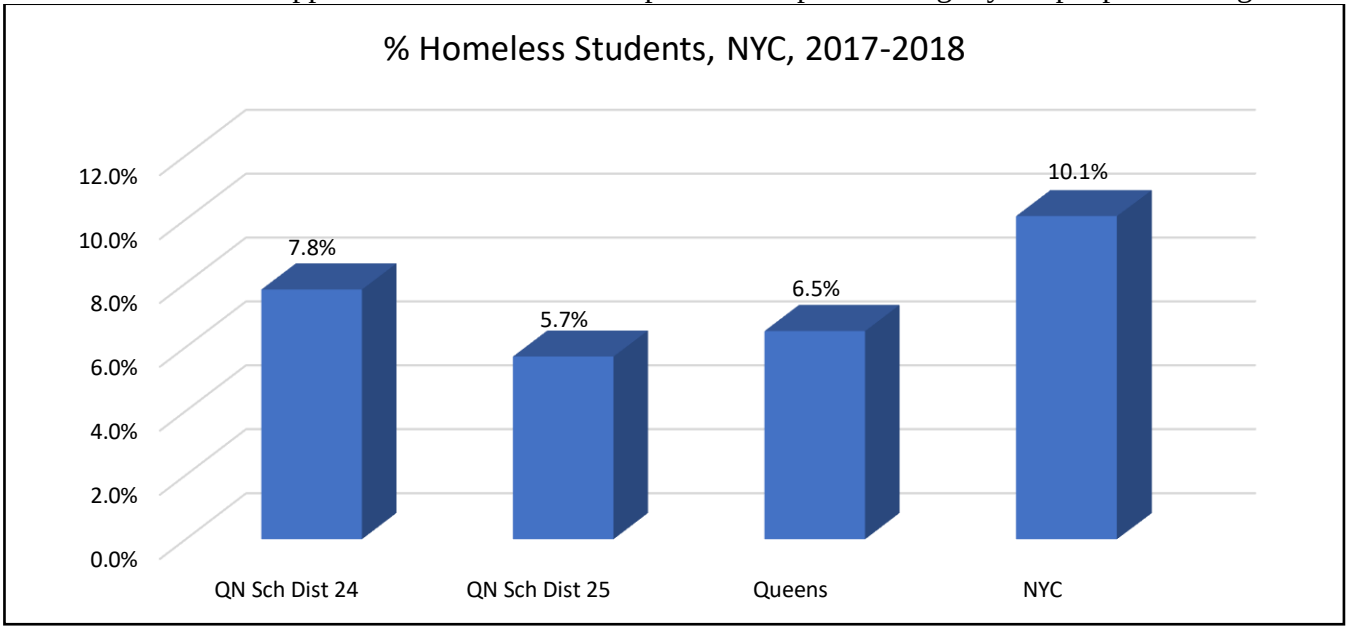
COMMUNITY HEALTH NEEDS ASSESSMENT

Priority Area IV: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 1: Promote Well Being

Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
Students identified as homeless during the 2017-2018 school year, New York City. *Source: NYSTeachs. NYS Education Department, Student Information Repository System (SIRS). Data on homelessness in NYC*

Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages

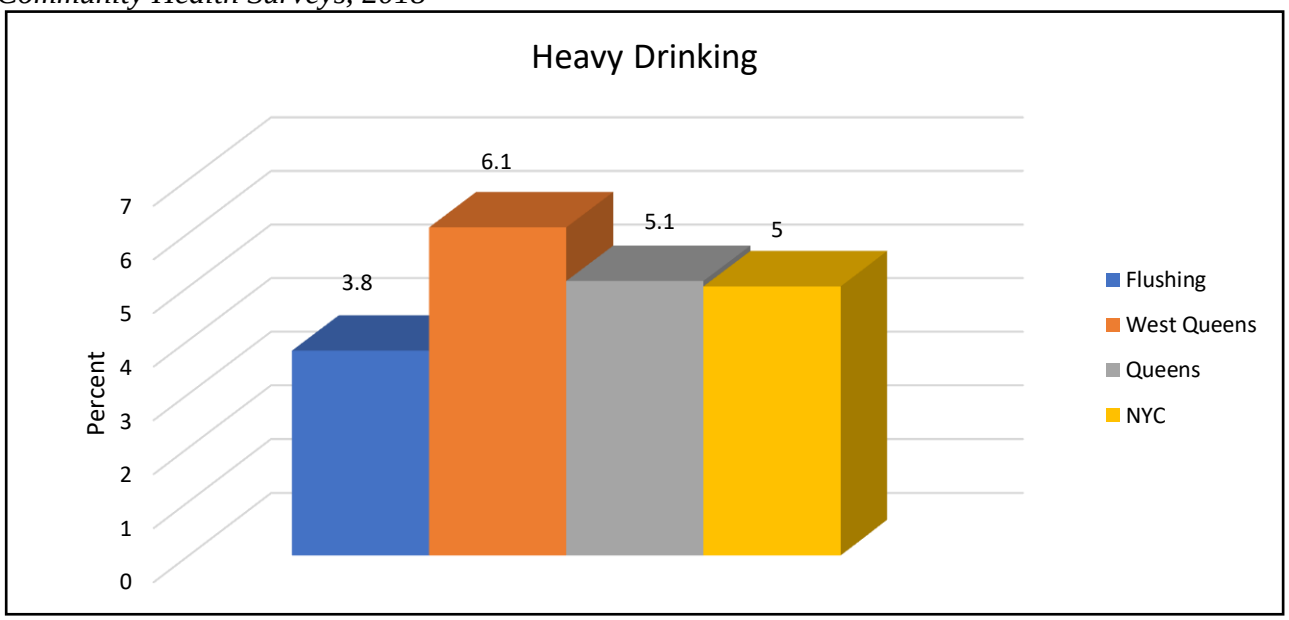


Comment: The school districts in Flushing Hospital's service area have a lower percentage of homeless students than NYC.

Resources and Accomplishments: Through its participation in DSRIP, FHMC has implemented many new practices and programs that focus on addressing the social determinants of health, where possible, in addition to responding to a patient's medical complaint, and to promote well-being. This is being accomplished at FHMC by providing patient navigation services so that patients can obtain affordable health insurance, resolve barriers to accessing health care services, and provide supportive services to promote successful adoption and continuation of healthy behaviors. Some services are provided directly by FHMC or other MediSys facilities, such Legal Health, and free drop-in Shape Up NYC exercise classes on campus. Others are provided by referrals to trusted community partners that offer supportive social services that are tailored to a specific patient need or a specific patient population (e.g., medically underserved, low-income, and minority populations), and that complement the medical care being provided at FHMC facilities. The following member agencies of SOMOS Community Care PPS provide examples of the breadth of supportive services that are more readily accessible to FHMC patients: Callen-Lorde Health Center, Center for Independence of the Disabled in New York, Children's Aid Society, CommuniLife, Korean American Family Service Center, Queen Pride House, Selfhelp Community Services, Services & Advocacy for LGBT Elders (SAGE), and South Asian Council for Social Services.

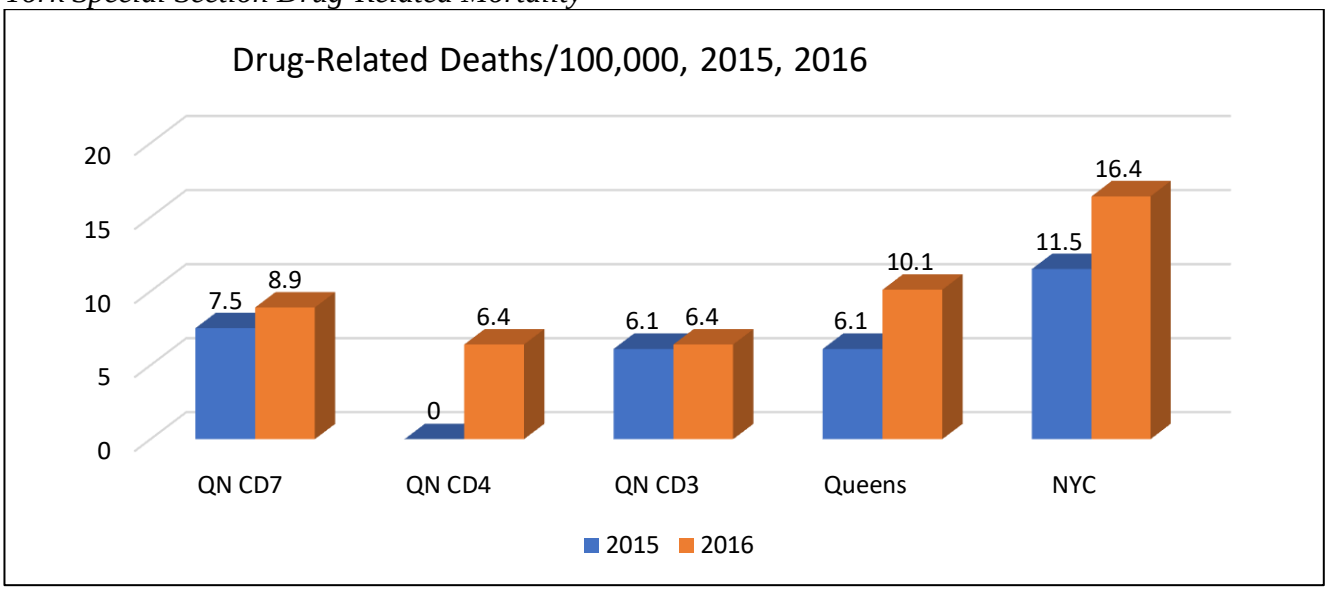
Focus Area 2: Prevent Mental and Substance Use Disorders

Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults. *Source: EpiQuery, Community Health Surveys, 2018*



Comment: Heavy drinking among adults is 6.1% in West Queens, higher than Flushing, Queens, and NYC.

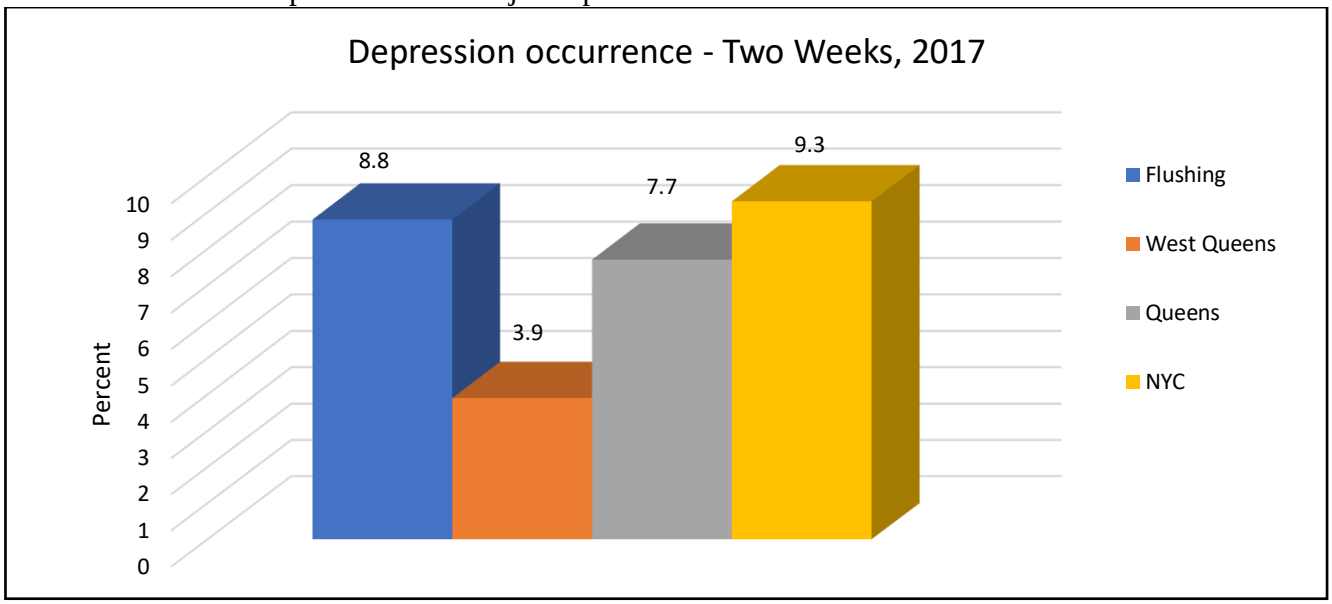
Goal 2.2: Prevent opioid and other substance misuse and deaths.
Age-Adjusted Drug-related Death rates by Community District of Residence - New York City, 2016.
Source: NYC DOHMH, Bureau of Vital Statistics, Summary of Vital Statistics 2016, The City of New York Special Section Drug-Related Mortality



Comment: the Community Districts served by Flushing Hospital, drug-related deaths rose in 2016, but remain lower than the rest of Queens and NYC.

Goal 2.3: Prevent and address adverse childhood experiences (ACEs)

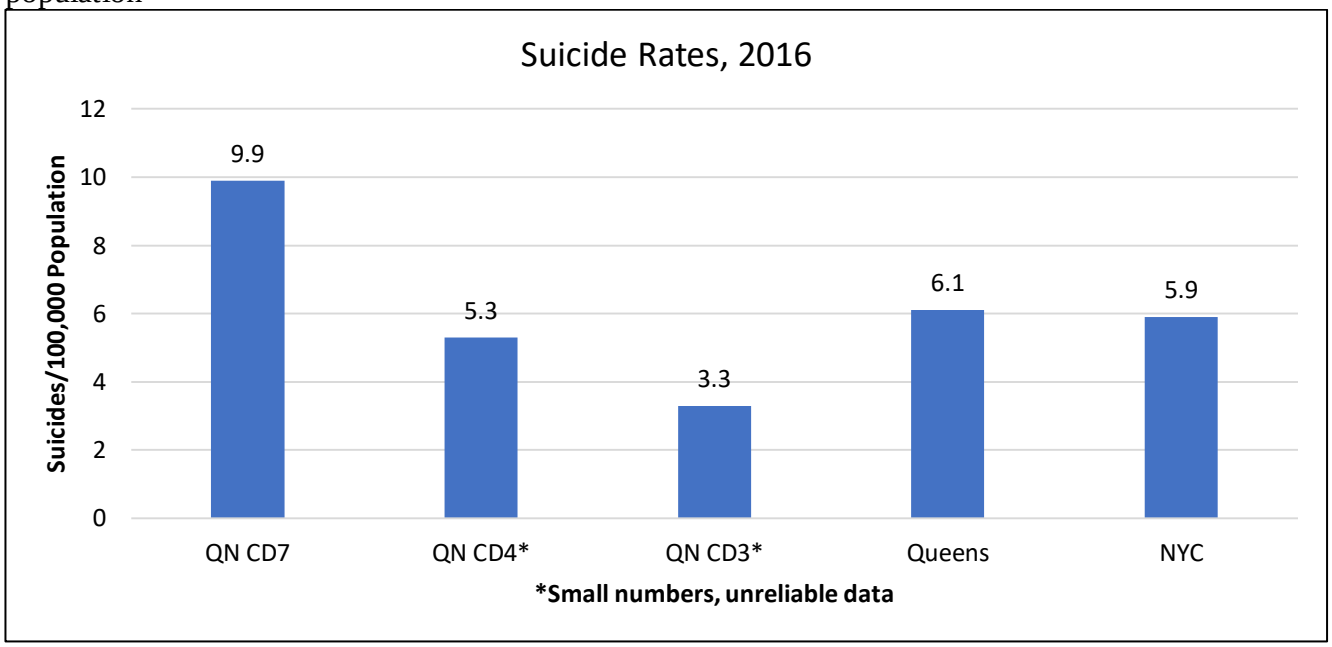
Goal 2.4: Reduce the prevalence of major depressive disorders



Comment: The incidence of adult depression is lower in Flushing Hospital's service area than for NYC overall. The percentage of adults with depression is 8.8% (Flushing) and 3.9% (West Queens).

Goal 2.5: Prevent suicides. *Source: NYC DOHMH, EpiQuery, Mortality, 2016*

Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population



Comment: Queens Community District 7 has the highest suicide rate in Queens and the 4th highest in NYC. Suicide rates in QN CD4 and QN CD3 are below the the Queens and NYC averages. Service area, borough, and NYC rates are below the Healthy People 2020 target of 10.2/100,000.:

COMMUNITY HEALTH NEEDS ASSESSMENT

Resources and Accomplishments: Flushing Hospital's Addiction Treatment Division provides comprehensive assessments and treatment of alcohol and chemical dependency through its inpatient Chemical Dependency Unit and its Reflections Outpatient Program. Both programs are licensed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) and are staffed by a multidisciplinary team of professionals skilled in the treatment of addiction. FHMC's Department of Psychiatry, including its large mental health outpatient service and its 18-bed voluntary inpatient unit, promote the coordination of mental health care, including increasing depression screening rates and providing appropriate and timely treatment when indicated. Flushing Hospital's healthcare providers have integrated behavioral health services into primary care, conducting depression screenings at all primary care visits. Mothers who give birth at Flushing Hospital complete a Maternal Depression Screening prior to being discharged; if indicated, mothers receive intervention services to treat postpartum depression. The Hospital has also integrated primary care into treatment services at its Mental Health Center.

In addition to behavioral health services offered through Flushing Hospital's Department of Psychiatry, the Hospital's service area is home to over a dozen NYS Office of Mental Health licensed outpatient, emergency, support and residential treatment providers for children, adolescents, and adults. Creedmoor Psychiatric Center, the state-operated facility serving Queens, provides a continuum of adult inpatient, outpatient, and related psychiatric services, as well as addiction treatment. The Queens Campus of the New York City Children's Center provides behavioral health services to children with serious emotional disturbances. Fourteen NYS Office of Alcoholism and Substance Abuse (OASAS)-certified facilities provide bedded, outpatient, and outpatient opioid treatment substance use disorder treatment.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos about the identification, diagnosis and treatment of a variety of mental health and substance abuse disorders.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter

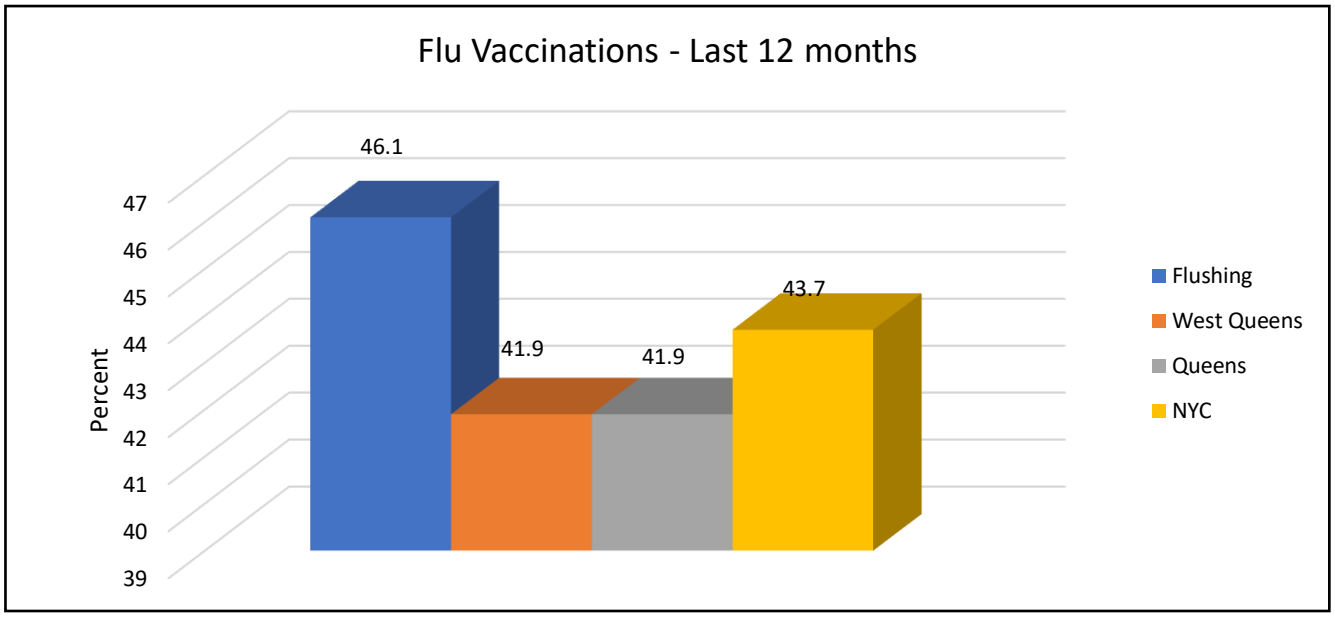
COMMUNITY HEALTH NEEDS ASSESSMENT

Priority Area V: Prevent Communicable Diseases

Focus Area 1: Vaccine-Preventable Diseases

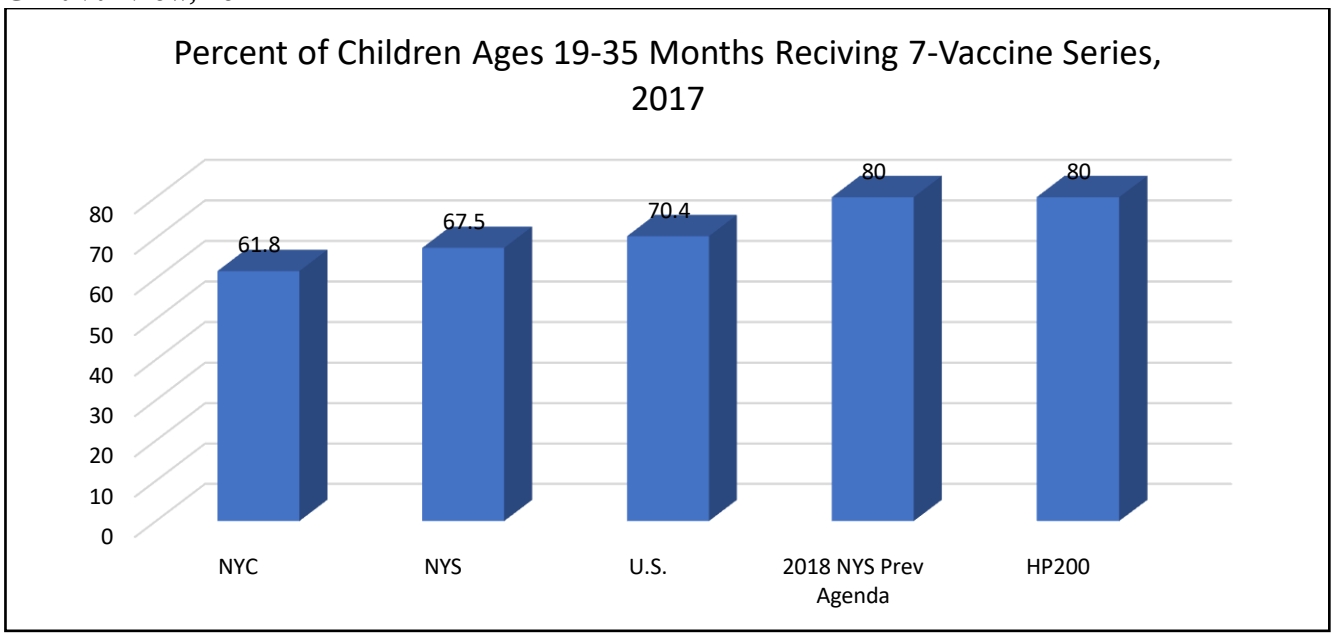
Goal 1.1: Improve Vaccination Rates. *Source: EpiQuery, Community Health Surveys.* 2018

Goal 1.2: Reduce vaccination coverage disparities



Comment: Flu vaccination rates are higher in Flushing than West Queens, Queens, and NYC. The flu vaccination rate in West Queens is the same as Queens but lower than that of NYC.

Child vaccination coverage, ages 19-35 months, combined 7-vaccine series, 2017. *Source: CDC, ChildVaxView, 2017*



Comment: NYC's child vaccination rate for the combined 7-vaccine series (61.8%) are lower than state and federal averages. In addition, it does not meet the New York State Prevention Agenda 80% target.

Resources and Accomplishments: Since the NYC measles outbreak began in the fall of 2018, FHMC providers have focused on encouraging all parents to vaccinate their children with the measles- mumps-rubella (MMR) vaccine, as recommended by the American Academy of Pediatrics and the CDC. The Hospital is also posting measles outbreak updates on its online health education newsletter – *Health Beat*. Although the vast majority of the measles cases are occurring in the Orthodox Jewish communities in Brooklyn, outside of FHMC's service area, medical staff are taking extra precautions to ensure that all adults and children are immunized for measures or have immunity. The NYC Department of Health and Mental Hygiene no longer operates a walk-in immunization clinic in Queens. Adults and children seeking low or no-cost immunizations need to travel to the Fort Greene Health Center in Brooklyn.[22]

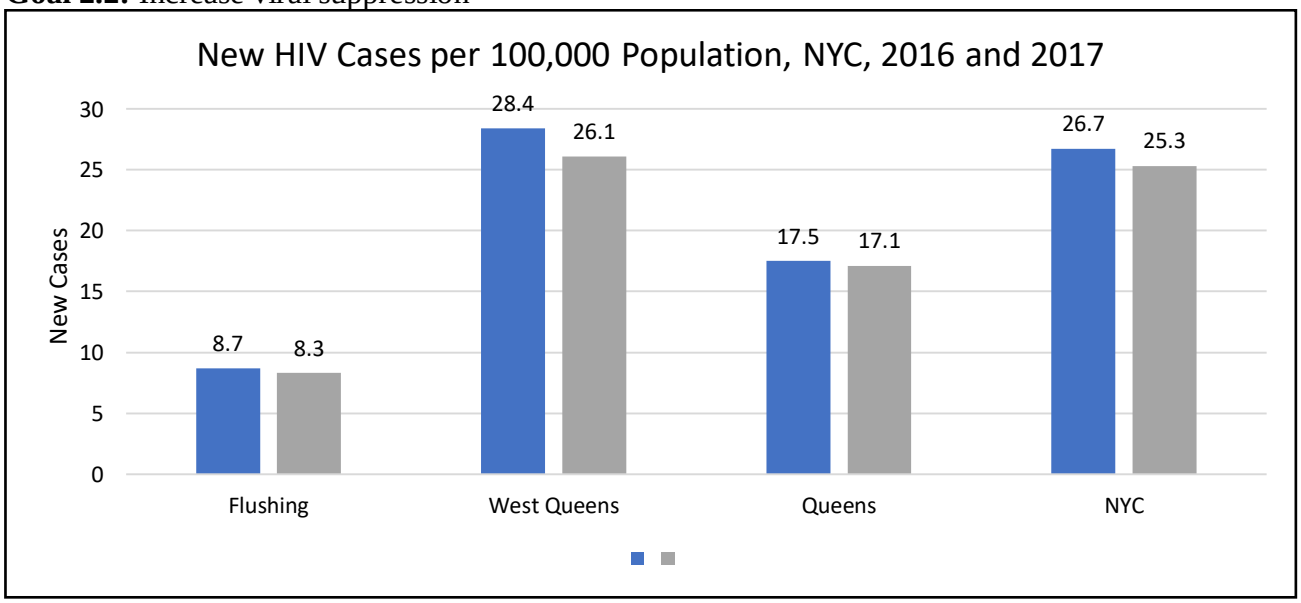
FHMC, through the Public Affairs Department, regularly posts educational articles and videos about the importance of vaccinations to prevent a variety of diseases including influenza, pneumonia, measles mumps & rubella (MMR) and others.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

Focus Area 2: Human Immunodeficiency Virus (HIV)

Goal 2.1: Decrease HIV morbidity (new HIV diagnoses) *Source: New York City Department of Health and Mental Hygiene, New York City HIV/AIDS Annual Surveillance Statistics 2016 and 2017*

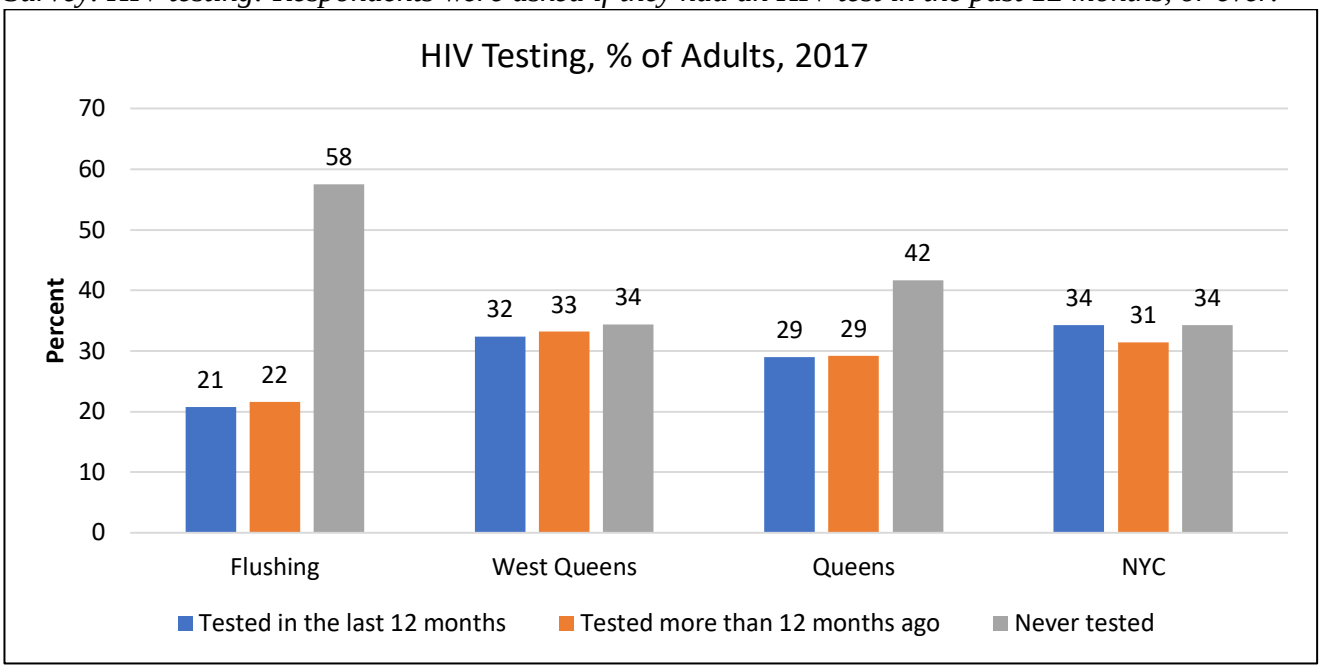
Goal 2.2: Increase viral suppression



Comment: In 2016 and 2017, new HIV cases were much lower in the neighborhood of Flushing, compared to West Queens, Queens, and NYC overall. From 2016 to 2017, new cases of HIV declined in Flushing Hospital's service area, as well as in Queens and NYC overall.

[22] NYC DOHMH. Immunization Clinics. https://www1.nyc.gov/site/doh/services/immunization-clinics.page

Source: New York City Department of Health and Mental Hygiene, EpiQuery, 2017 Community Health Survey. HIV testing: Respondents were asked if they had an HIV test in the past 12 months, or ever.



Comment: The percentage of adults who have never been tested for HIV in the neighborhood of Flushing is much higher than in West Queens, the Borough of Queens, and NYC overall. In West Queens, 65% of adults have been tested for HIV, the same as for NYC.

Resources and Accomplishments: FHMC offers HV testing annually to patients ages 13-64 in its inpatient units, Emergency Department, and clinics. Patients who are HIV positive are cared for at FHMC or referred to other community service programs for supportive services, as necessary.

In addition to FHMC's Division of Infectious Disease services, the Queens' service area (as defined in the Queens CNA) has 49 Infectious Disease physicians. There are three hospitals in Queens that are licensed as AIDS Centers (Elmhurst Hospital, Queens Hospital Center, and New York-Presbyterian/Queens).[23] Queens also has 25 agencies with 180 service sites that offer HIV related services, including Ryan White and CDC Prevention programs. These services include HIV Prevention and Outreach efforts such as sexual and behavioral health for HIV prevention, condom distribution, harm reduction, testing and linkage to care, and syringe exchange. PrEP (pre-exposure prophylaxis) and PEP (post exposure prophylaxis) services for uninsured people in Queens is available at the Community Health Network-Family Health Center and NYC Health and Hospitals-Elmhurst.

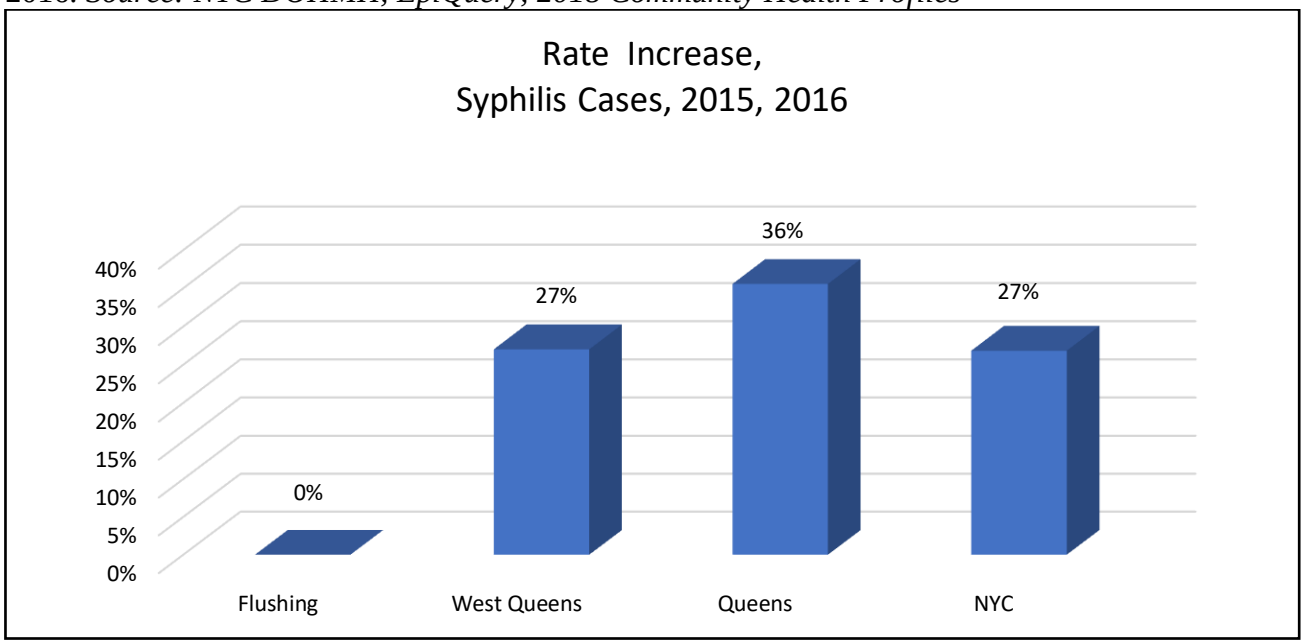
FHMC, through the Public Affairs Department, regularly posts educational articles and videos about prevention of HIV.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter

[23] NYS Department of Health. Hospital Profiles. http://profiles.health.ny.gov/hospital/counnty_or_region:081/serice:AIDS+Center

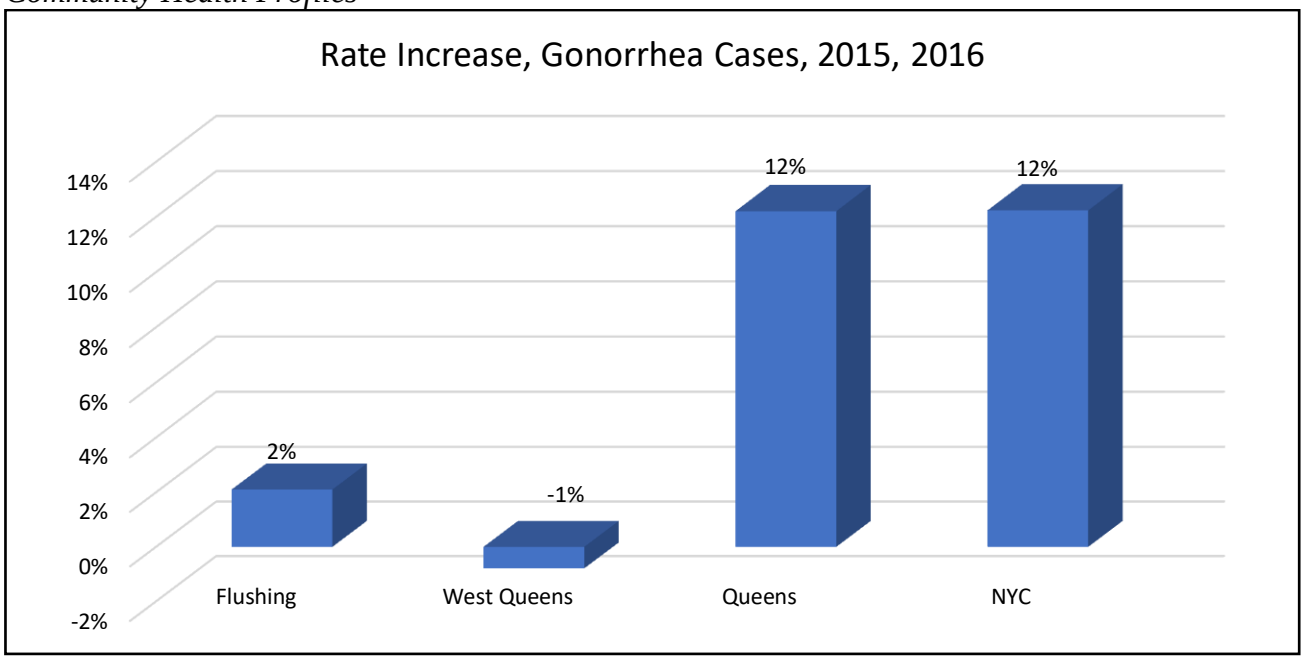
Focus Area 3: Sexually Transmitted Infections (STIs)

Goal 3.1: Reduce the annual rate of growth for STIs. Syphilis case numbers and case rates, 2015 and 2016. *Source: NYC DOHMH, EpiQuery, 2018 Community Health Profiles*



Comment: New syphilis cases increased by 27% in West Queens from 2015 to 2016, from 16.3/100,000 to 20.7/100,000. West Queens has the highest syphilis rate in Queen. NYC and Queens also experienced significant increases. Flushing's syphilis cases remained low. Except for Flushing, all neighborhoods exceed the Prevention Agenda goal - a 4% annual increase.

Gonorrhea case numbers and case rates, 2015 2016. *Source: NYC DOHMH, EpiQuery, 2018 Community Health Profiles*

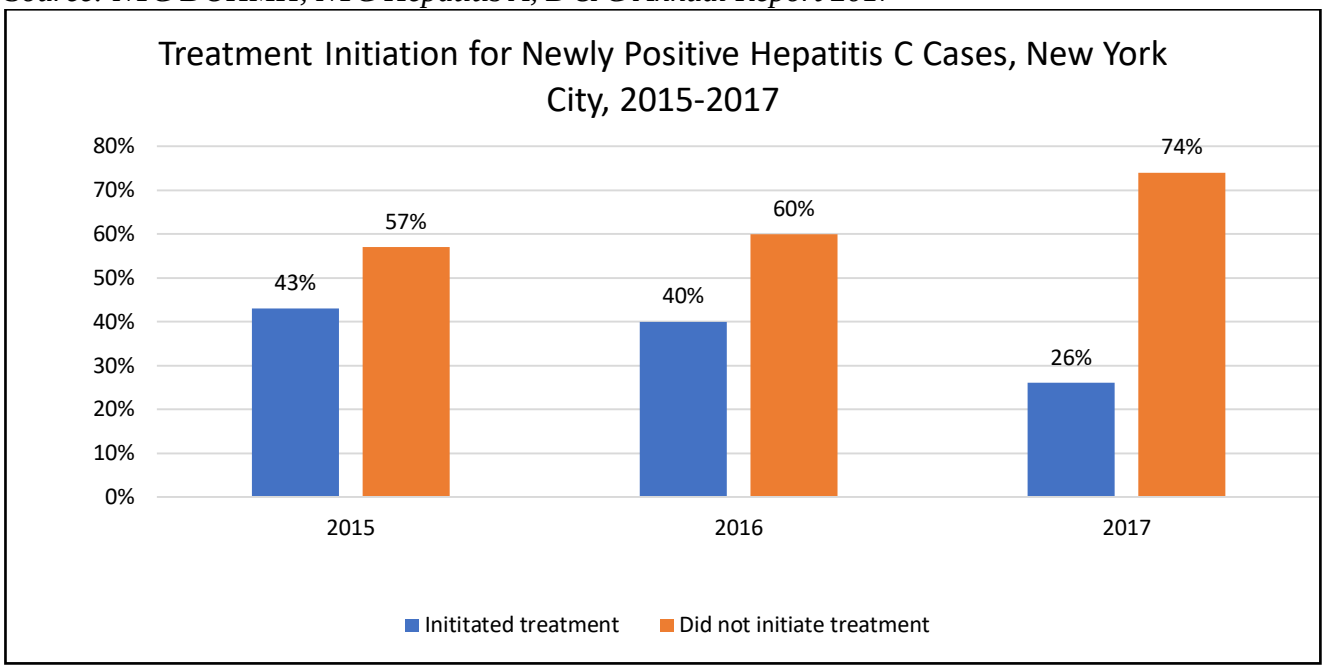


Comment: Flushing Hospital's service area did not experience the same increase in gonorrhea cases as Queens and NYC. Flushing cases increased 2%, while West Queens showed a small decrease in cases.

Resources and Accomplishments: FHMC's Ambulatory Care Center, a designated Patient-Centered Medical Home, and the Women's Health Center conduct targeted screening for sexually transmitted diseases such as Chlamydia, gonorrhea, and syphilis and refers patients to appropriate follow-up medical care, partner services, and prevention counseling. Low or no-cost testing for sexually transmitted diseases is available at NYC Department of Health and Mental Hygiene's Sexual Health Clinics in Corona and Jamaica, Queens.[24]

Focus Area 4: Hepatitis C Virus (HCV)

Goal 4.1: Increase the number of persons treated for HCV
Treatment initiation among people newly reported with a positive hepatitis C RNA tests, 2015-2017.
Source: NYC DOHMH, NYC Hepatitis A, B & C Annual Report 2017

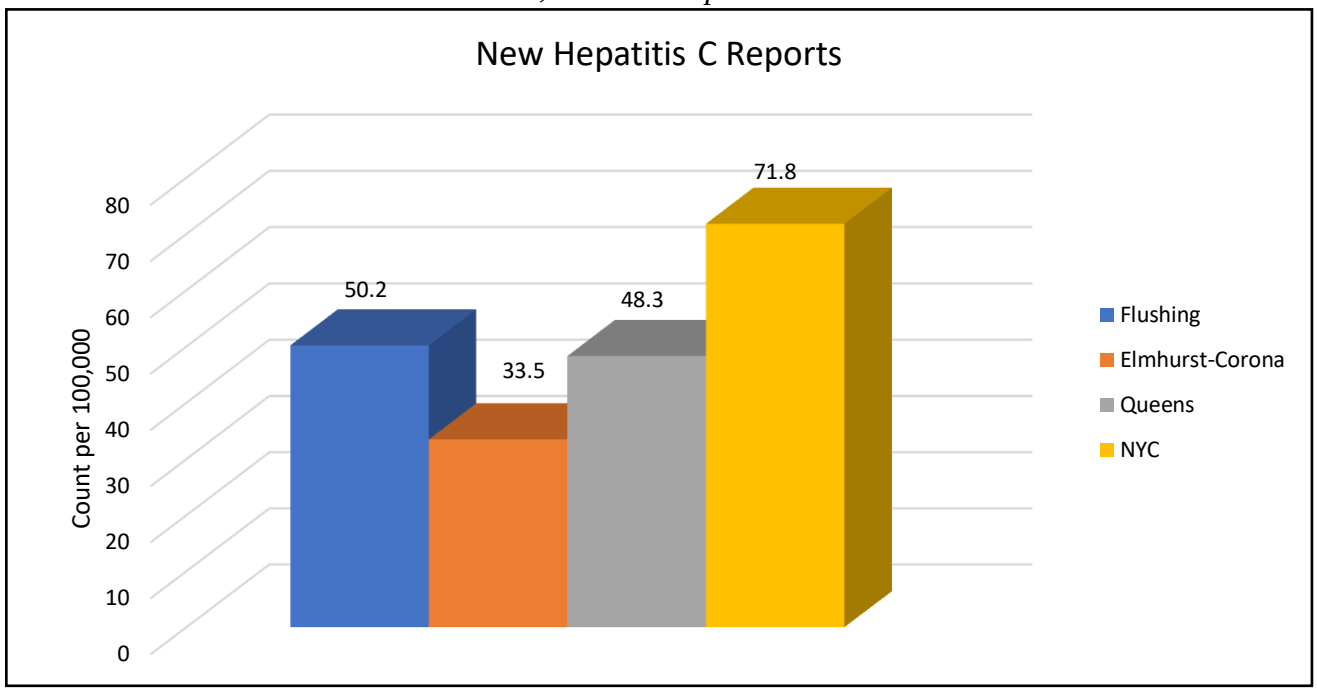


Comment: From 2015 - 2017, fewer New Yorkers testing positive for Hepatitis C elected to initiate treatment for the disease.

[24] NYC DOHMH. Sexual Health Clinics. https://www1.nyc.gov/site/doh/services/sexual-health-clinics.page

Goal 4.2: Reduce the number of new HCV cases among people who inject drugs

New Hepatitis C reports per 100,000 population (2017). *Source: NYC DOHMH, EpiQuery, Communicable Disease Surveillance Data, Chronic Hepatitis C*



Comment: In Flushing Hospital's service area, West Queens has the highest rate of new hepatitis C cases. Both West Queens and Flushing have lower rates than NYC overall.

Resources and Accomplishments: Free or sliding-scale hepatitis C testing is available at the AIDS Center of Queens County (Woodside), ACQCC @ Jamaica, and the Community Healthcare Network-Jamaica Health Center.[25] Hepatitis C treatment is available on a no-cost or sliding scale basis at Community Healthcare Network's Jamaica Health Center.

FHMC administered 2,769 hepatitis B birth doses to newborns in 2017, representing 99.1% of all births, as an important cooperative strategy to prevent hepatitis B in infants.[26]

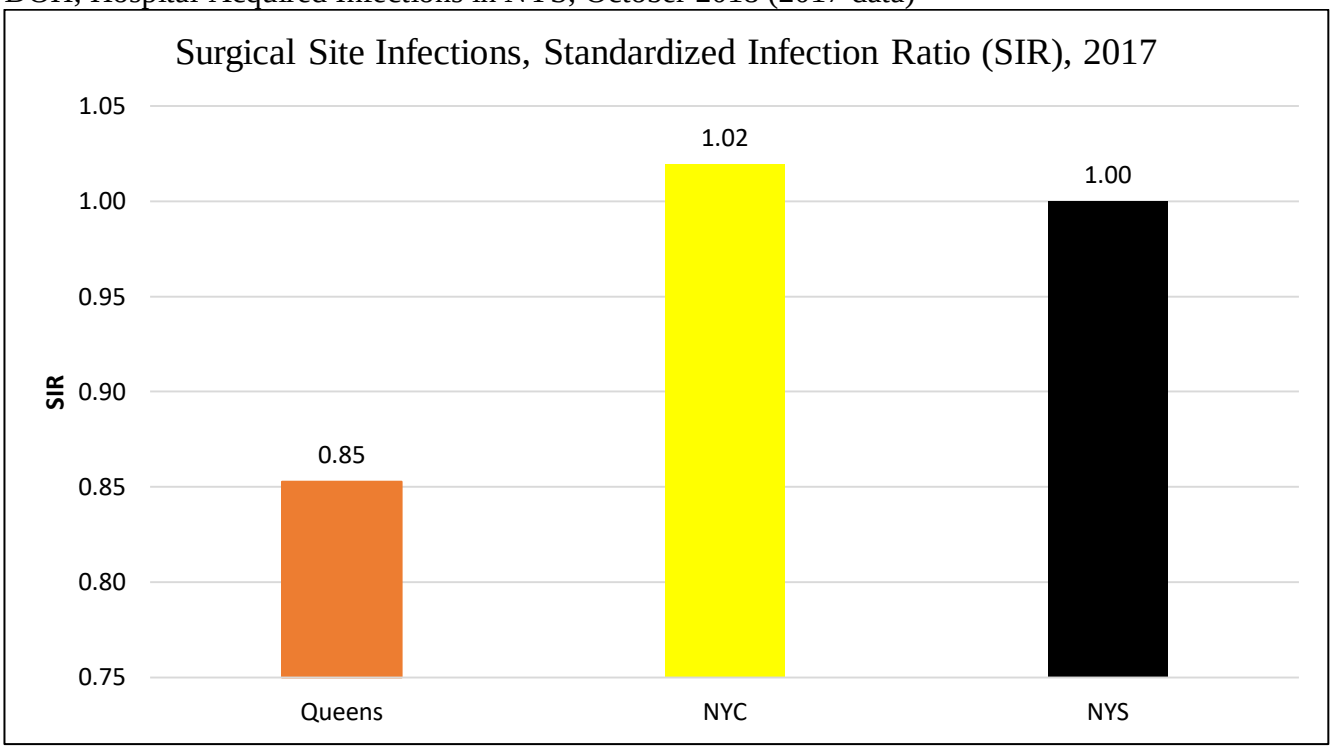
FHMC, through the Public Affairs Department, regularly posts educational articles and videos about the importance of the Hepatitis C Virus vaccination.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter.

[25] NYC DOHMH. NYC Health Map. Hepatitis C Testing. https://a816-healthpsi.nyc.gov/NYCHealthMap
[26] NYC DOHMH. Hepatitis B Birth Dose Coverage by Facility, 2017. https://www1.nyc.gov/site/doh/providers/health-topics/hepatitis-b-and-pregnancy.page

Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections

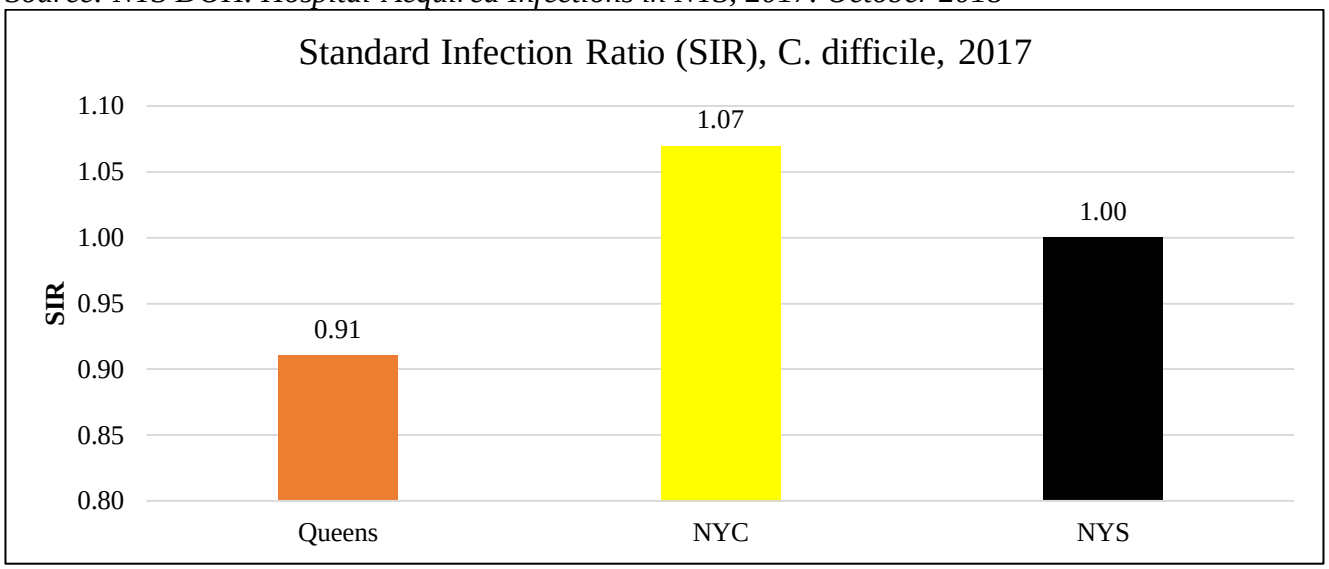
Goal 5.1: Improve infection control in healthcare facilities
Standard infection ratio - surgical site infection and CLABSI, 2017, Queens Hospitals. Source: NYS DOH, Hospital-Acquired Infections in NYS, October 2018 (2017 data)



Comment: In Queens' hospitals, the Standardized Infection Ratio (SIR) for surgical site infections was better than the NYC ratio and the NYS average. Surgical site infections were lower than predicted for the following procedures: colon, hip replacement, abdominal hysterectomy, and coronary artery bypass graft (CABG) surgical site infections.

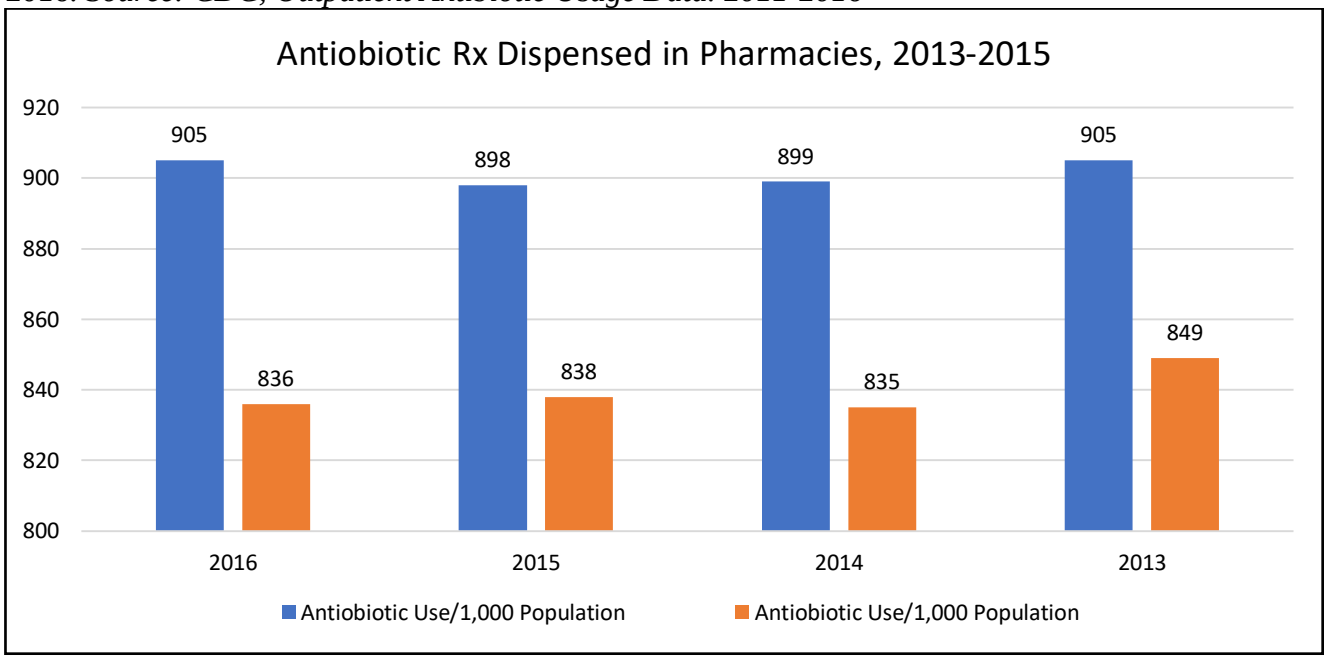
Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile. *Source: Medicare.gov. Hospital Compare*

Standard infection ratio - Hospital Onset Clostridium difficile Infections (CDI), 2016 and 2017
Source: NYS DOH. Hospital-Acquired Infections in NYS, 2017. October 2018



Comment: Hospitals in Queens performed better than the NYC and NYS averages for infections caused by Clostridium difficile (C. difficile), a multidrug resistant organism that can cause death.

Goal 5.3: Reduce inappropriate antibiotic use
Antibiotic Prescriptions Dispensed in U.S. Community Pharmacies per 1000 Population, All classes, 2016. *Source: CDC, Outpatient Antibiotic Usage Data. 2011-2016*



Comment: NYS antibiotic dispensing rates are 6% - 8% higher than the U.S. Antibiotic dispensing rates in NYS remained stable between 2013 and 2016, while the U.S. rate decreased slightly.

Resources and Accomplishments: FHMC has participated in the HANYS' Antibiotic Stewardship Collaborative in an effort to reduce inappropriate use of antibiotics to treat viral illnesses such as colds and flu.

Results from the 2018 Leapfrog Hospital Survey27 show that FHMC has effectively instituted several management structures and procedures to protect patients from errors, accidents, and injuries. The Hospital ranked alongside the best performing hospitals for the following process measures: doctors order medications through a computer, specially trained doctors care for ICU patients effective leadership to prevent errors, staff work together to prevent errors, track and reduce risks to patients, enough qualified nurses, and handwashing. Based on CMS data, FHMC scores matched that of the best performing U.S. hospitals for the following outcomes: dangerous object left in patient's body, air or gas bubble in the blood, and patient falls and injuries.

FHMC received a grant to implement electronic reporting of antibiotic use and resistance into a national database.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos about the over and misuse of antibiotics and the resulting consequences.

This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital's electronic community newsletter

[27] The Leapfrog Group. Leapfrog Hospital Safety Grade. https://www.leapfroggroup.org/data-users/leapfrog-hospital-safety-grade

COMMUNITY HEALTH NEEDS ASSESSMENT

Community Health Survey Results

Background and Method

A survey of community residents was performed so that the Hospital would have direct input from residents about the health of the communities it serves and the main health and health service challenges facing these communities. This report describes the primary data collection (survey) methodology and analysis of survey results.

Greater New York Hospital Associated (GNYHA) developed a model survey tool that MediSys tailored for its communities. The surveys, which were translated into Spanish and Mandarin to provide additional access to the survey, were loaded into a HIPAA protected web-based SurveyMonkey platform. From April through mid-September 2019, the Hospital sent the survey to community residents by email and also distributed it at numerous gatherings of local community based organizations, including the Hospital's Community Advisory Board, the Hospital's ambulatory care center, three Community Boards, one NYPD Precinct Council, and two civic associations. The Hospital received 245 completed surveys, of which 196 were from residents of the Hospital's primary service area (PSA), which encompasses Flushing-Clearview and West Queens.[28] Surveys completed online were captured directly in the SurveyMonkey platform. Paper surveys were entered into the platform by Hospital staff and volunteers.

Data were analyzed by GNYHA staff according to standard statistical methods, using Microsoft Excel. Means and proportions were generated, overall and by neighborhood. Although the survey sample cannot be considered representative of the catchment areas in a statistical sense, and gaps are unavoidable, the combination of Hospital clinic based and organizational outreach facilitated the engagement of a targeted yet diverse population, including both individuals connected and unconnected to services.

A summary of findings from the primary service area (PSA) is presented in chart form in Appendix A.

Population Characteristics

Survey respondents came from all Queens neighborhoods. For All Respondents - socio-demographic characteristics included: 63%% female, 34% White, 15% Asian, 7% Black/African American, 51% of Hispanic or Latino descent, 69% had health insurance, 8% were 65-74 years old, 18% were 55-64, 34% were 35-54 and 18% were 25-34 years old. Twenty-two percent of survey respondents reported having fair or poor physical health, and 11% fair or poor mental health.

For PSA respondents - socio-demographic characteristics included: 65% female, 28% White, 16% Asian, 7% Black/African American, 63% of Hispanic or Latino descent, 63% had health insurance, 7% were 65-74 years old, 13% were 55-64, 37% were 35-54 and 19% 25-34. Twenty-seven percent of survey respondents reported having fair or poor physical health, and 12% fair or poor mental health.

The following summary of survey results (Table 1) pertains to the responses from the Hospital's PSA, where the majority of its patients reside. Responses differ somewhat by neighborhood and zip code area

[28] These areas are United Health Fund (UHF) Neighborhoods, made up of adjoining zip code areas, and designated to approximate NYC Community Planning districts.

within the PSA, and by gender, age, race, ethnicity, education, employment and having insurance or not.

Table 1: Demographic Characteristics

Characteristic	PSA (n=196)	Characteristic	PSA (n=196)
Age		**Hispanic or Latino descent**	63%
18-24	6%		
25-34	19%	**Education**	
35-54	37%	Less than High School	25%
55-64	13%	High School Diploma/GED	24%
65-74	7%	Technical school or Some College	22%
75-84	8%	College graduate/Bachelor's degree	11%
85+	2%	Graduate/professional degree	7%
No Response	4%	**Employment status**	
Gender		Retired	11%
Female	65%	Full-time, Part-time or Self-employed	42%
Male	28%	Not employed, Unable to work	9%
Prefer not to say	1%	Homemaker, Student	33%
No Response / Prefer to self-describe	7%		
Race		**Have health insurance**	63%
Black or African American	7%		
White	28%	**Self assessment of physical health**	
Asian	16%	Poor, Fair	27%
American Indian or Alaskan Native	5%	Good, Very Good, Excellent	71%
Native Hawaiian or Other Pacific Islander	1%	**Self assessment of mental health**	
Other	27%	Poor, Fair	12%
No Response	22%	Good, Very Good, Excellent	87%

The following summary of survey results pertains to the responses from the Hospital's PSA, where the majority of its patients reside

Neighborhood Health Issues
Eighteen percent of respondents rated the health of their neighborhood as Fair, three percent as Poor, 71% as Good, Very Good or Excellent. They felt that the following health concerns in their neighborhood were Very/Extremely Important:

Table 2: Issues	**PSA (n=196)**	
	Very/Extremely Important	**Range Across Zip Codes**
Diabetes	52%	36% - 56%
Falls prevention among elderly and small children	52%	45% - 55%
Women's health and infant care	51%	41% - 56%
Cancer	49%	34% - 61%
High blood pressure	49%	39% - 64%
Heart disease	49%	38% - 55%
Substance use problems (including alcohol and drugs)	48%	24% - 55%
Asthma/breathing problems	48%	41% - 55%
Smoking/tobacco use/vaping	47%	24% - 59%
Mental health/depression	46%	34% - 56%
Obesity in children and adults	45%	31% - 48%
HIV/AIDS	42%	31% - 55%
Sexually Transmitted Infections (STIs)	42%	28% - 64%
Dental care	41%	31% - 47%
Arthritis	35%	24% - 41%
Hepatitis C	35%	28% - 39%

The top six issues that were rated Very/Extremely Important – Diabetes, Falls Prevention, Women's Health and Infant Care, Cancer, High Blood Pressure, and Heart Disease fell into a very tight range (49% - 52%) on average across all population groups. However, there was a wide variation by zip code on all the issues. On average fewer Males (who represented 28% of respondents) than Females rated issues as Very/Extremely Important. Whites (28% respondents) rated all 16 issues as Very/Extremely Important, less often than Asians or Blacks. Fewer Hispanics (63% of respondents) than non-Hispanics rated any issue Very/Extremely Important, other than Women's Health and Infant Care, Obesity and Sexually Transmitted Infections. Thirty-five percent or more of respondents considered each of the 16 issues as Very/Extremely Important.

These results support the findings from the analysis of statistical health data (secondary data) collected by government and non-government agencies that is shown in previous sections of this report: the various population groups in the Hospital's PSA are very concerned about a wide variety of health issues.

Hospital's Interventions Addressing Top Health Issues

As detailed in the prior section for each of the NYS Prevention Agenda Priorities, the Hospital provides evidence-based prevention and treatment services for all the above health issues, and makes referrals to other facilities for several highly specialized services that the Hospital does not offer. Screening is offered at the Hospital and at many events in the community, with the aim of identifying problems early, encouraging people to seek appropriate and timely care, and making referrals for care upon request.

Changes to Improve Neighborhood Health

The top three changes that respondents reported would most improve the health of the people in their neighborhoods:

Table 3: Changes	**PSA (n=196)**	
	Very/Extremely Important	**Range Across Zip Codes**
More affordable healthcare, including medical care, mental health care and medications	37%	32% - 50%
Better education and job training	31%	27% - 50%
Better housing conditions	27%	20% - 39%
More affordable housing	26%	10% - 29%
Less domestic violence, such as child abuse, elder abuse, spousal and partner abuse	22%	10% - 26%
More access to healthy and affordable foods and beverages	22%	10% - 29%
More local jobs	19%	10% - 60%
More language assistance in healthcare settings	15%	4% - 20%
More access to quality child care	15%	8% - 25%
Less human and/or sex trafficking	11%	0% - 19%
More access to parks and places to exercise	10%	4% - 11%
More places where older adults can live and socialize	10%	0% - 19%
Better public transportation	10%	0% - 14%
Other	2%	0% - 4%
No Response	8%	3% - 16%

More affordable healthcare outranked the other "top three changes" that respondents thought would most improve the health of people in their neighborhoods. Even those with health insurance (65% of respondents) those without made this recommendation, which reflects the existing and well-known gaps in coverage of necessary care and prevention in the current health insurance system. This recommendation is perfectly aligned with the perception of respondents that there are many Very/Extremely Important health issues that must be addressed in the Hospital's PSA, and underscores that affordability is fundamental to ensure access to health care, including prevention. In response to the question: "What would make you avoid getting medical care from a health care provider?" 26% said High cost of care. Other reasons for avoiding care had to do with availability and convenience issues such as Lack of available appointments (9%), Not enough time to go (11%), Lack of transportation (6%), Difficult to find child care (6%). Over time these problems may be ameliorated to some extent by the expansion of urgent care centers, retail clinics and telemedicine. However, these options are less available in low income communities and communities with many immigrants.

The other recommended changes are a function of Social Determinants of Health (SDH), which are known to have more impact on people's health status than does the provision of health care services. The health care system has had little or no agency to address SDH. This has been the purview of government and non-profit social service support agencies. Health care providers routinely refer patients in need of these services to government or non-profit agencies but rarely get feedback about what happened, and even more rarely do all parties work together with the patient to craft and follow through on a comprehensive action plan. The separation into silos of the health and social service support systems has begun to change as DSRIP and Value Based Payment reforms are being introduced, but these problems cannot be addressed in any fundamental way by these payment reforms, even if health care sector shares its savings with social service support agencies who work on the problems related to SDH. The problems stemming from SDH are a function of inadequate investment to reduce poverty, unemployment and underemployment, sub-standard housing and homelessness among other problems. The problems stemming from underinvestment in certain communities are compounded in many cases by service provider discrimination against Blacks, Hispanics, immigrants and other groups. Efforts are underway to train all health care providers to identify and eliminate "implicit bias" in health care encounters.

COMMUNITY SERVICE PLAN

Selection of Prevention Agenda Priorities

As described in detail under the **Resources and Accomplishments** sections of the **COMMUNITY HEALTH NEEDS ASSESSMENT**, the Hospital's prevention priorities and its community prevention work are in line with many of the priorities and prevention strategies identified in the NYS Prevention Agenda and the community's priorities as identified in response to a community-wide survey performed this spring and summer by the Hospital. The Hospital would have no agency in some areas, such as decreasing the jail population, increasing homes with no maintenance defects and others that government agencies and social service advocacy and support agencies are better suited to address.

FHMC Programs Addressing Top Community Health Issues

- In relation to Diabetes, one of the two top health issues identified in the Hospital's community health needs assessment survey (52% said it was Very/Extremely Important), free National Diabetes Prevention Program sessions are offered to people identified as having pre-diabetes.
- In relation to Falls prevention, tied with Diabetes as the top health issue). Nursing staff screen for falls risk and refer patients as necessary upon discharge to community-based organizations or home care. Patients receiving rehabilitation are given intensive falls prevention training.
- In relation to Women's health and infant care (51% rated it as Very/Extremely Important), the Hospital offers a weekly breastfeeding support group to patients and community members; the program is also available in Spanish. The Hospital offers donor milk from the New York Milk Bank to preterm babies, when mothers are unable to produce enough milk for their newborn.
- In relation to Cancer, tied at 49% with Cancer and High blood pressure as one of the top health issues identified in the Hospital's community health needs assessment survey, the Hospital offers free cancer screenings and referrals to highly specialized cancer services programs through a partnership with the Cancer Services Program Queens funded by the Bureau of Cancer Prevention and Control. The Hospital operates a patient navigator program for colon cancer to increase show rates for screenings and necessary follow-up. In partnership with the NYC DOHMH the Hospital arranges for free cancer screenings for those without insurance or sufficient financial resources.
- In relation to Heart disease, also one of the top five issues, through its DSRIP participation it implemented evidence-based best practices for cardiovascular disease management in all its ambulatory care practices;
- In relation to High blood pressure, another of the top five issues, it is a member of Take the Pressure Off, NYC!, a multi-sector city-wide collaborative working in communities to prevent and control high blood pressure. Also, free blood pressure screenings, and other screening services are offered to the community at numerous health fairs throughout the year,
- In relation to Obesity, another high ranked health issue, in partnership with NYC's Shape Up NYC program, several free drop in fitness classes are offered each week on the Hospital's campus to community residents.
- In relation to HIV/AIDS, also a high ranked health issue, the Hospital routinely offers HIV testing in emergency departments and all outpatient clinics.

COMMUNITY SERVICE PLAN

Criteria Used in Selection of Priorities for Community Service Plan/Implementation Plan

The Hospital could have selected the above health issues or others cited in the Community Health Needs Assessment section to highlight and report on in its comprehensive 2019-2021 Community Service/Implementation Plan. However, based upon an analysis of community health statistics and the results of its consumer health needs survey, and its resources and capabilities the Hospital decided to continue to implement and to gather outcomes data for its comprehensive programs of evidence-based practices related to **decreasing tobacco use** within the community, and **increasing rates of exclusive breastfeeding** among mothers in the service area. The opinion of the community and Hospital leadership were considered in this decision.

FHMC elected to highlight these two particular programs using the following criteria:

- Alignment with NYS Prevention Agenda Priorities
    - Prevent Chronic Disease, Focus Area 3: - Tobacco Prevention, Goal 3.2: Promote Tobacco Use Cessation; and
    - Promote Healthy Women, Infants and Children, Focus Area 3: Perinatal and Infant Health; Goal 2.2: Increase Breast Feeding;
- Alignment with Healthy 2020 Goals and objectives:
    - Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.
        - Objective: Reduce cigarette smoking by adults.
    - Goal: Improve the health and well-being of women, infants, children, and families.
        - Objective: Increase the proportion of infants who are breastfed.
- Alignment with Survey Results
    - Smoking/tobacco use/vaping rated as Very/Extremely Important by 47% of all survey respondents in PSA and 54% of Black/African American PSA respondents;
    - Connection between Smoking/Tobacco use/vaping and Cancer and Heart disease (both rated Very/Extremely Important by 49%);
    - Women's health and infant care rated by 51% by all PSA respondents and by 57% of Females as Very/Extremely Important. Exclusive Breastfeeding is a very important practice in ensuring good health for women and their infants.
- Alignment with Hospital's Priorities
    - Continuing recognition for following best practices for tobacco cessation as evidenced by earning a Gold Star from NYC's Tobacco-Free Hospital campaign and continuing to adhere to standards and retain the designation as a Baby Friendly Hospital.
    - Resources already committed and work groups already working to implement comprehensive Hospital-wide programs for these two prevention priorities;
- Addresses a disparity of impact/burden on people living in poverty, as measured by the proportion of people affected who are covered by Medicaid.
- Potential for significant improvement in individual and community health and quality of life by decreasing tobacco use and increasing breastfeeding.

The Hospital places a high value on the important work of prevention, community outreach and education. These activities will not only reduce disease and disability within our community, but will also enable the Hospital to prosper under value-based payment arrangements.

COMMUNITY SERVICE PLAN

Using Hyper-local NYC Data in Communities with High Hospital Utilization

The Hospital has recently begun a partnership with the NYC Department of Health and Mental Hygiene (DOHMH) under the umbrella of their Strategic Blocks Initiative, which may help us to more effectively address these serious and very prevalent health care problems. DOHMH has provided three years of de-identified HIPAA-protected block level health care usage data to the Hospital. The data identifies blocks in Hospital's PSA that had high health care utilization at the Hospital over this time period, including the number of people from these blocks who were admitted to the Hospital's inpatient units and ER, the collective number of encounters they made, the types of housing in those blocks with the highest usage, e.g., shelters, public housing, senior housing, and the names of social service support agencies with locations in or near these housing complexes.

The Hospital is reviewing this hyper-local data with the intention of bringing health care services directly to these health care consumers in the places where they live, and seeking help in engaging them from the existing social service support agencies which may already have relationships with many of these health care consumers and, hopefully, have gained their trust.

The charts in the following section (**IMPLEMENTATION PLAN**) outline 2019-2021 Goals, Objectives, and Implementation Strategies for two of the Hospital's Prevention Agenda Priorities. Annual updates on achievements will be made available on these two priorities:

- Prevent Chronic Diseases - Focus Area 3: Tobacco Prevention, Goal 3.2. - Promote Tobacco Cessation
- Promote Healthy Women, Infants, and Children – Focus Area 2: Perinatal and Infant Health, Goal 2.2. - Increase Breastfeeding

IMPLEMENTATION PLAN

New York State Priority Area: Prevent Chronic Diseases
Focus Area 3: Tobacco Prevention
Goal 3.2: Promote Tobacco Cessation

FHMC Priority 1: Promote Tobacco Cessation

Goal 1	Objectives	Interventions/Strategies/Activities
Eliminate Tobacco Use on Hospital Campus	1) Counsel all self-identified smokers on staff annually. 2) Train all Patient Navigators in smoking cessation strategies. 3) Achieve and maintain standards for NYCDOHMH Gold Star status.	Family of Interventions: • Counsel and refer tobacco-using employees for treatment and promote quit assists such as medication, NYS Quitline referral, and Freedom From Smoking® (FFS) classes. • Train additional personnel as quit coaches.

IMPLEMENTATION PLAN

New York State Priority Area: Prevent Chronic Diseases
Focus Area 3: Tobacco Prevention
Goal 3.2: Promote Tobacco Cessation

FHMC Priority 1: Promote Tobacco Cessation

Goal 2	Objectives	Interventions/Strategies/Activities
General Medical/Surgical (M/S) Patients Aged 13 and Above – Assessments and Interventions for All Patients, and Increased Number of Quitters over Three Year Cycle. NOTE: NYS smoking prevalence target of 11% for adults and 15.3% among adults with low socio-economic status (SES), using Medicaid coverage as a proxy. NOTE: NYS interventions target of 60.1%.	1) Maintain current outpatient smoking prevalence rate below NYS target. 2) Achieve 95% or greater assessment rate for outpatients and inpatients. 3) Increase annual interventions for returning outpatient smokers to 85% or greater; 50% or greater for inpatients. Note: The basic intervention is counseling. Other possible interventions include educational materials, prescriptions for medications, and/or referral for smoking cessation classes/support. 4) Increase prescriptions for smoking cessation benefits among Medicaid and Medicaid Managed Care smokers to achieve NYS benefit use target of 26.2% over three year cycle.	Family of Interventions: • Train and re-train all M/S providers to use smoking module in electronic health record (EHR). • Track assessments and interventions for all patients, and prevalence of smoking for returning out-patient smokers. • Review disparity data and develop intervention plan. • Connect EHR to NYS Quitline for instant referrals, and refer all who consent. • Document and track use of NYS Quitline. • Continue automated EHR discharge process to provide information to all smokers on quit strategies and medications. ▪ Update internal reporting system on smoking cessation data to capture all new/renamed treatment areas. ▪ Secure data from Hospital's DSRIP Max Project and Care Transitions, and ensure smoking cessation counseling is provided during post-discharge follow up for 2019 - 2021. ▪ Review data quarterly and target specific providers with message to achieve better tobacco control among their patients for 2019 - 2021. ▪ Provide quarterly communication to all departments about smoking cessation results to develop better "procedures and work-flows to facilitate the delivery of tobacco dependence treatment" especially among behavioral health (BH) and low SES patients for 2019 - 2021. • Capture accurate data rates through all counseling streams. ▪ Patient Navigators will highlight smoking cessation collaborative efforts (Doctors Counseling, Quitline and FFS referrals and Patient Education) during weekly Ambulatory Care Center huddles.

IMPLEMENTATION PLAN

New York State Priority Area: Prevent Chronic Diseases
Focus Area 3: Tobacco Prevention
Goal 3.2: Promote Tobacco Cessation

FHMC Priority 1: Promote Tobacco Cessation

Goal 3	Objectives	Interventions/Strategies/Activities
Behavioral Health Patients Above Aged 13 - Assessments, Interventions for All Patients, and Increased Number of Quitters in Three Year Cycle. NOTE: NYS smoking prevalence target of 20.1% among adults who report poor mental health.	1) 1) Maintain current outpatient smoking prevalence rate below NYS target. 2) Achieve 65% or greater assessment rate of outpatients and 100% or greater of inpatients. 3) Achieve 90% or greater counseling rate for outpatients and inpatients. Note: The basic intervention is counseling. Prescriptions for medication, follow-up counseling and provision of educational materials are other possible interventions. 4) Increase prescriptions for smoking cessation benefits among Medicaid and Medicaid Managed Care smokers to achieve NYS benefit use target of 26.2% over three year cycle.	Family of Interventions: • Train and re-train all BH providers to use the smoking module in the EHR. • Track assessments and interventions for all patients, and smoking prevalence for returning OP smokers. • Review disparity data and develop intervention plan. ▪ Connect EHR to NYS Quitline for instant referrals; provider will refer all who consent. • Document and track use of NYS Quitline. • Automate EHR discharge process to provide information to all smokers on quit strategies and medications. ▪ Update internal reporting system on smoking cessation data to capture all new/renamed treatment areas. ▪ Secure data from Care Transitions, and ensure that smoking cessation counseling is provided during post-discharge follow up of these patients for 2019 - 2021. ▪ Review data quarterly and target specific providers with a message to achieve of better tobacco control among their patients for 2019 - 2021. ▪ Provide quarterly communication to all departments about smoking cessation results to develop better "procedures and work-flows to facilitate the delivery of tobacco dependence treatment" especially among BH and low SES patients for 2019 - 2021.

IMPLEMENTATION PLAN

New York State Priority Area: Prevent Chronic Diseases
Focus Area 3: Tobacco Prevention
Goal 3.2: Promote Tobacco Cessation

FHMC Priority 1: Promote Tobacco Cessation

Goal 4	Objectives	Interventions/Strategies/Activities
Improved Tobacco Cessation Knowledge among Community Residents and Providers	1) Provide tobacco cessation education resources and techniques to top 10% of voluntary attending physicians annually, and increase this number over three year cycle by at least 5%. 2) Provide education and sign-up opportunities for Quit classes at 12-15 community educational events per year, in partnership with community organizations. 3) Offer at least four FFS classes and eight One-on-One abbreviated Quit Plan per year in as many languages as possible – at least Korean, Spanish and English.	Family of Interventions: ▪ Provide tobacco cessation information at all health fairs and other community events hosted or attended by the Hospital, and (added the following) sign-up interested smokers for tobacco cessation classes. ▪ Send tobacco cessation educational materials and resources to a select group of community providers. ▪ Educate community providers about tobacco cessation assessment, intervention techniques and resources • Educate community providers about tobacco cessation assessment, intervention techniques and resources. • Increase awareness via Social Media and print media.

IMPLEMENTATION PLAN

New York State Priority Area: Promote Healthy Women, Infants, and Children
Focus Area 2: Perinatal and Infant Health
Goal 2.2: Increase Breastfeeding

FHMC Priority 2: Increase Breastfeeding

Goal 1	Objectives	Interventions/Strategies/Activities
Exclusive Breastfeeding at Discharge for as Many Patients as Clinically Possible and Culturally Acceptable NOTE: NYS target of 51.7%. NOTE: NYS target of 38.2% for Medicaid.	1) Increase exclusive breastfeeding (BF) rate at discharge by 2% per year. 2) Maintain exclusive BF equality between Medicaid and non-Medicaid enrollees. 3) Sustain 90% rooming-in of births with no contraindications. 4) Achieve 95% or greater training rate of: - Medical providers in recommended BF education. - Maternal/Child nurses in BF management, and new hires within 3 months. 5) Enroll 1,200 women in the Hospital's and WIC's breastfeeding programs, including breastfeeding support groups, prenatal nutrition class, child birth classes and mother-baby classes.	Family of Interventions: • Send employees working with mothers of childbearing age and newborns to Certified Lactation Counselor (CLC) courses. • Increase BF peer support group classes guided by an International Board Certified Lactation Consultant (IBCLC) to three times per week. • Continue daily visits to new mothers by nurses and IBCLC to support BF. • Continue classes given three times per week on the mother/baby units. Discharge classes are offered Monday-Friday (5x/week) • Continue referrals to postpartum resources, such as Women, Infants, and Children (WIC), and Public Health Solutions' support group. • Give patients telephone number to hospital IBCLC. • Make "warm line" available 18 hrs./day, including evening and weekend. • Continue Talk and Tea weekly BF support group. • Institute March of Dimes group care for prenatal visits with 10 or more patients /month. • Enroll majority of obstetrics patients in MediSys MyChart (electronic health record access portal) in order to make relevant educational materials easily available. • Offer donor human milk to all preterm infants when mothers are unable to produce enough of her own milk. • Use Omnicell to dispense and tally use of formula.

IMPLEMENTATION PLAN

New York State Priority Area: Promote Healthy Women, Infants, and Children
Focus Area 2: Perinatal and Infant Health
Goal 2.2: Increase Breastfeeding

FHMC Priority 2: Increase Breastfeeding

Goal 2	Objectives	Interventions/Strategies/Activities
Baby Friendly USA Designation	Sustain designation.	Continue multidisciplinary committee meetings and initiatives.

IMPLEMENTATION PLAN

New York State Priority Area: Promote Healthy Women, Infants, and Children
Focus Area 2: Perinatal and Infant Health
Goal 2.2: Increase Breastfeeding

FHMC Priority 2: Increase Breastfeeding

Goal 3	Objectives	Interventions/Strategies/Activities
Exclusive Breastfeeding at 3 and 6 Months for as Many Patients as Clinically Possible and Culturally Acceptable. NOTE: Healthy People 2020 Target 3 months: 46.2% 6 months: 25.2%.	1) Increase measurable documentation of well-baby feeding history by 10% per year in three year cycle. 2) Increase exclusive BF rates at 3 and 6 months for the Hospital's well babies by 10% per year in three year cycle. 3) Train all pediatricians and family medicine physicians about BF.	Family of Interventions: • Initiate an automatic referral via EHR to WIC and Healthy start on first prenatal visit for 2020 and 2021. • Increase referrals to out-patient support services and in hospital patient support groups. • Include Patient Navigators in Pediatric ACC to assist in referrals. • Schedule repeat BF education programs for ACC providers and staff to enhance patient support. • Increase referrals for use of breast pumps after discharge and once patient returns to work. • Promote New York State Breastfeeding Friendly Practice Designation to high volume pediatric practices. • Use Newborn Channel for postpartum to educate patients. • Enhance Smart Text for well child visit to document breastfeeding. • Schedule BF mothers' appointments at the same time in order to offer a group discussion on breastfeeding issues. • Assign breastfeeding volunteer counselor to assist in educating and guiding women during first six months of life. • Make available peer counselor speaking Urdu for women from Bangladesh on the mother/baby unit. • Schedule volunteer doula to support mothers during labor and postpartum with breastfeeding. • Assign staff to visit the Hotel Trade Council, private physician offices, library in order to teach topics related to breastfeeding, 24 hour rooming-in, skin-to-skin and other topics related to breastfeeding. • Review of documentation, interventions and audits to improve statistics taken from EMR to reflect the actual practices. • Keep mother and baby together if baby needs phototherapy. Baby stays in the room with the mother. • If mother is discharged and baby needs to stay in the hospital, the mother is given a space to stay with the baby 24 hours/day in order to exclusively breastfeed. • Breastpumps are to be ordered for all women that are in need of pumps to utilize at home.

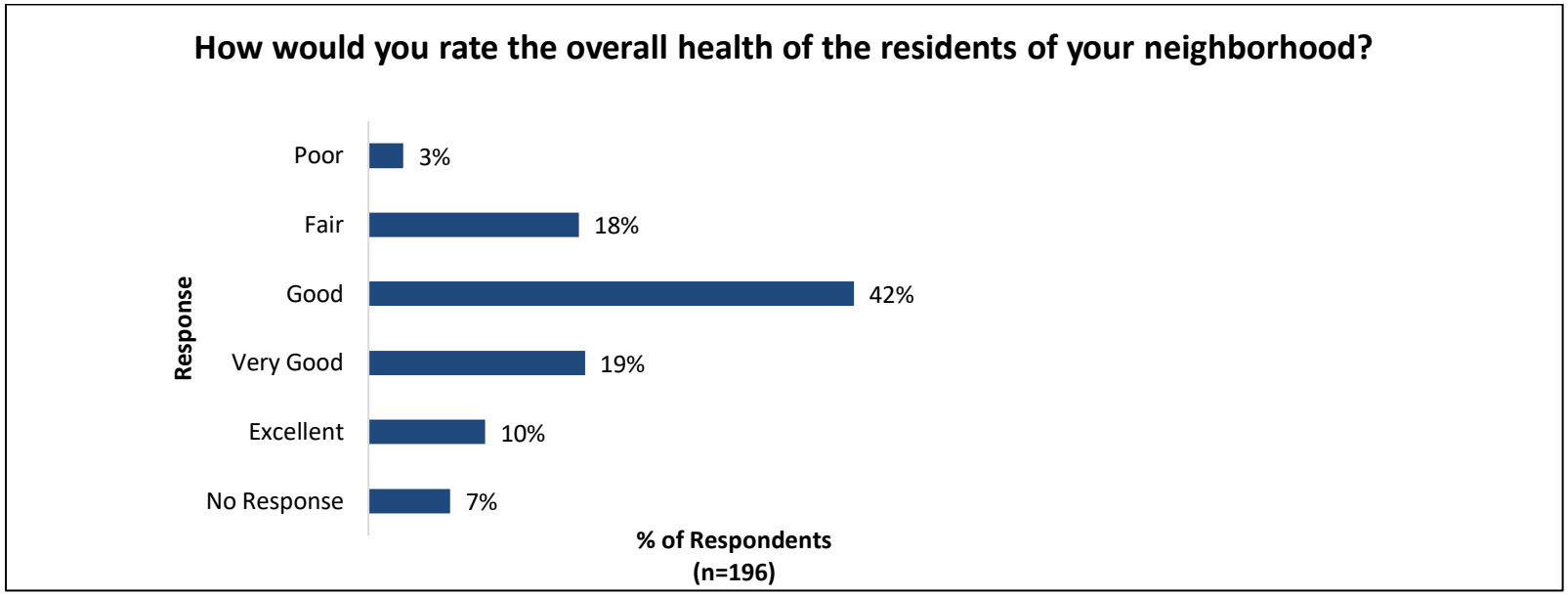
IMPLEMENTATION PLAN

New York State Priority Area: Promote Healthy Women, Infants, and Children
Focus Area 2: Perinatal and Infant Health
Goal 2.2: Increase Breastfeeding

FHMC Priority 2: Increase Breastfeeding

Goal 4	Objectives	Interventions/Strategies/Activities
Increase Knowledge of Community Residents and Providers about the Benefits of Breastfeeding.	1) Provide BF education resources and support including Breastfeeding Friendly Practice (BFFP) standards to top 10% of voluntary attending pediatricians annually, and increase this number over three year cycle by at least 5%. 2) Increase participation by mothers and mothers to be in BF education and support services by at least 5% over three year cycle.	Family of Interventions: • Provide resources and guidance to selected community practice sites to assist them in adhering to standards for BFFP. • Continue annual Baby Shower for the community to include education on breastfeeding. • Continue/develop new community partnerships to host BF education programs at local libraries and other locations twice a month or more, and in multiple languages. • Publicize the Hospital's BF-related programs via Hospital's social media and on external sites, including print media and electronic media, such as Medisys MyChart. • Initiate breastfeeding Volunteer program led by the IBCLC for group education supporting mother-infant dyads to sustain breastfeeding practices and increase breastfeeding duration.

APPENDIX A – Survey Charts



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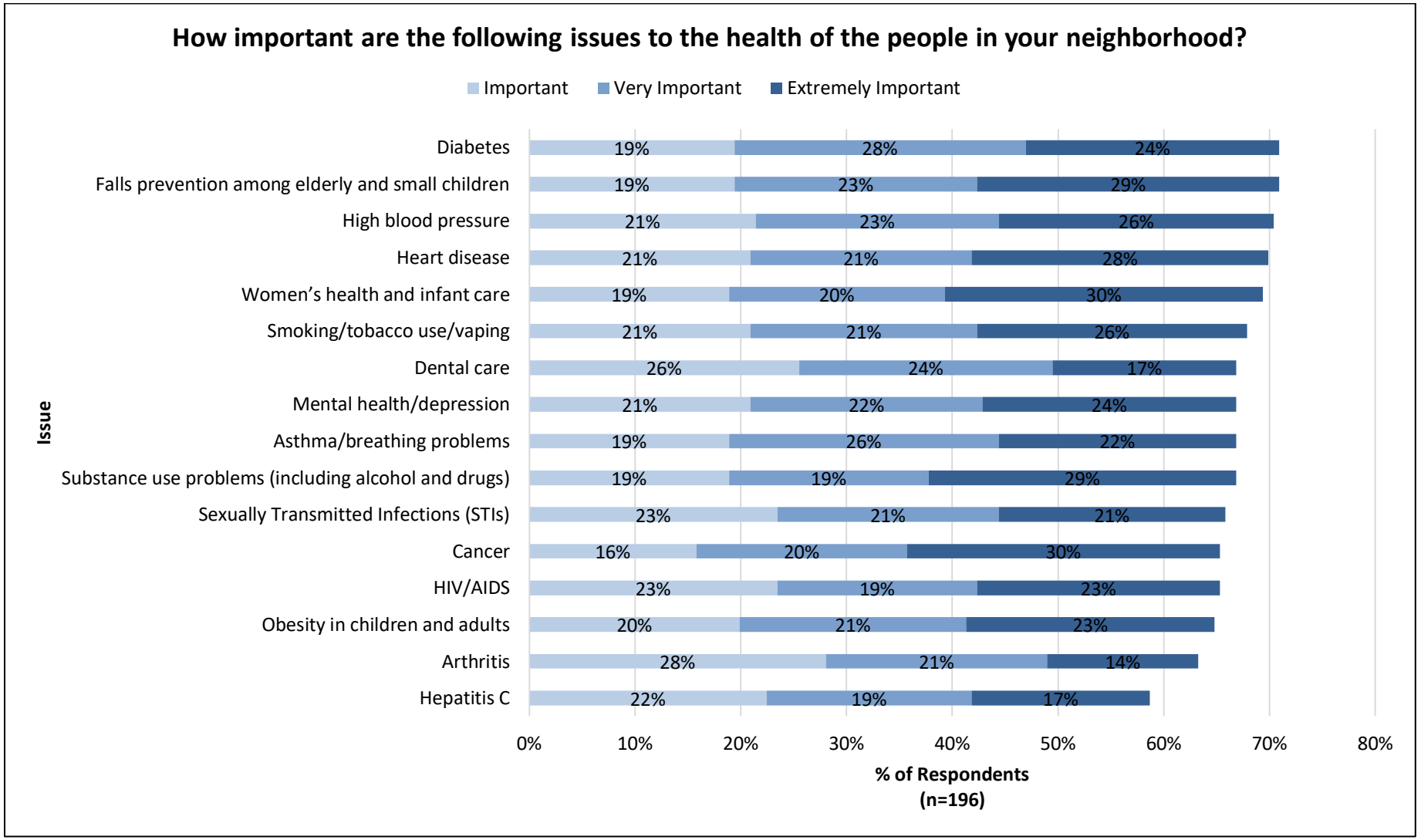

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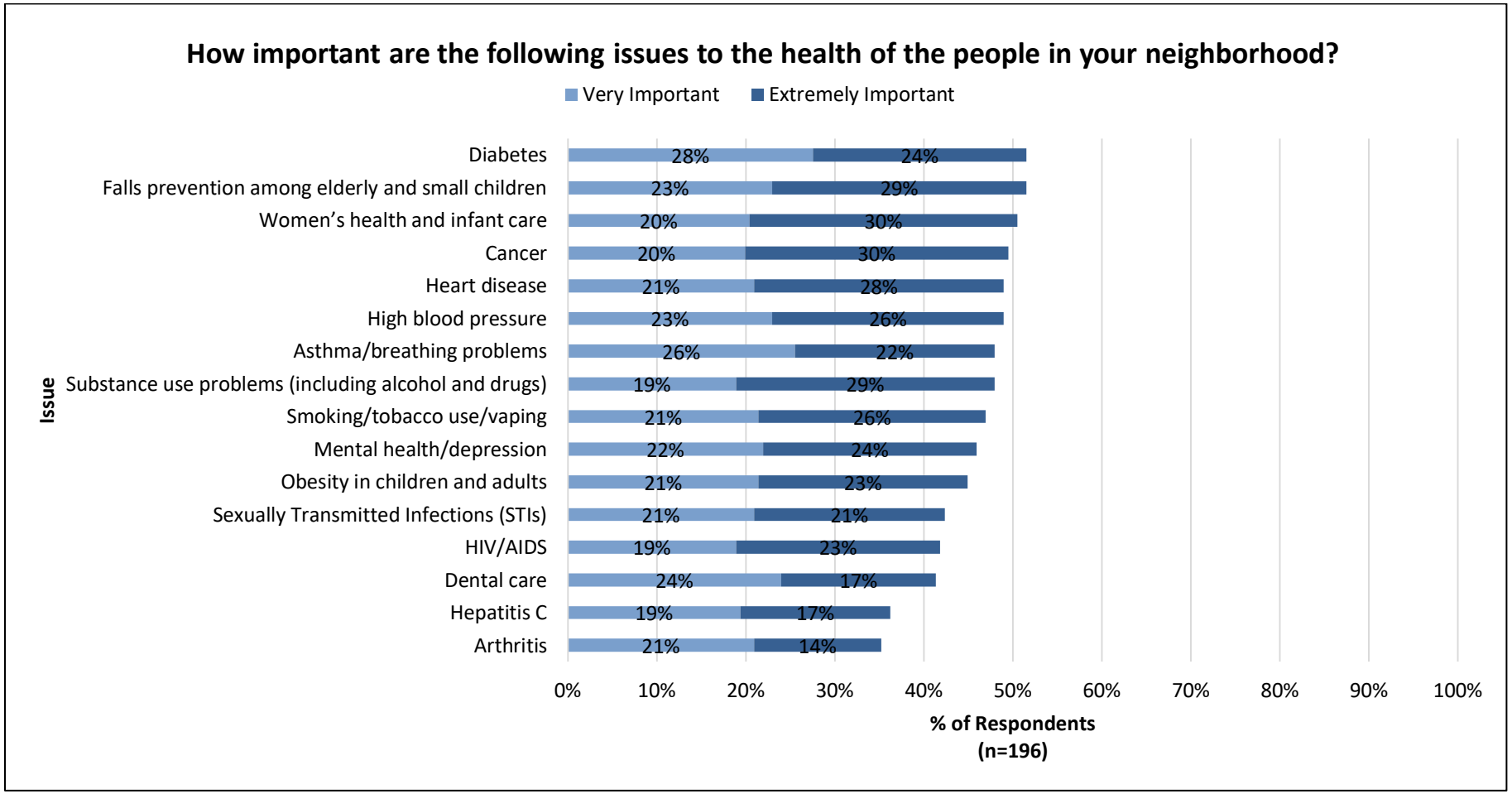

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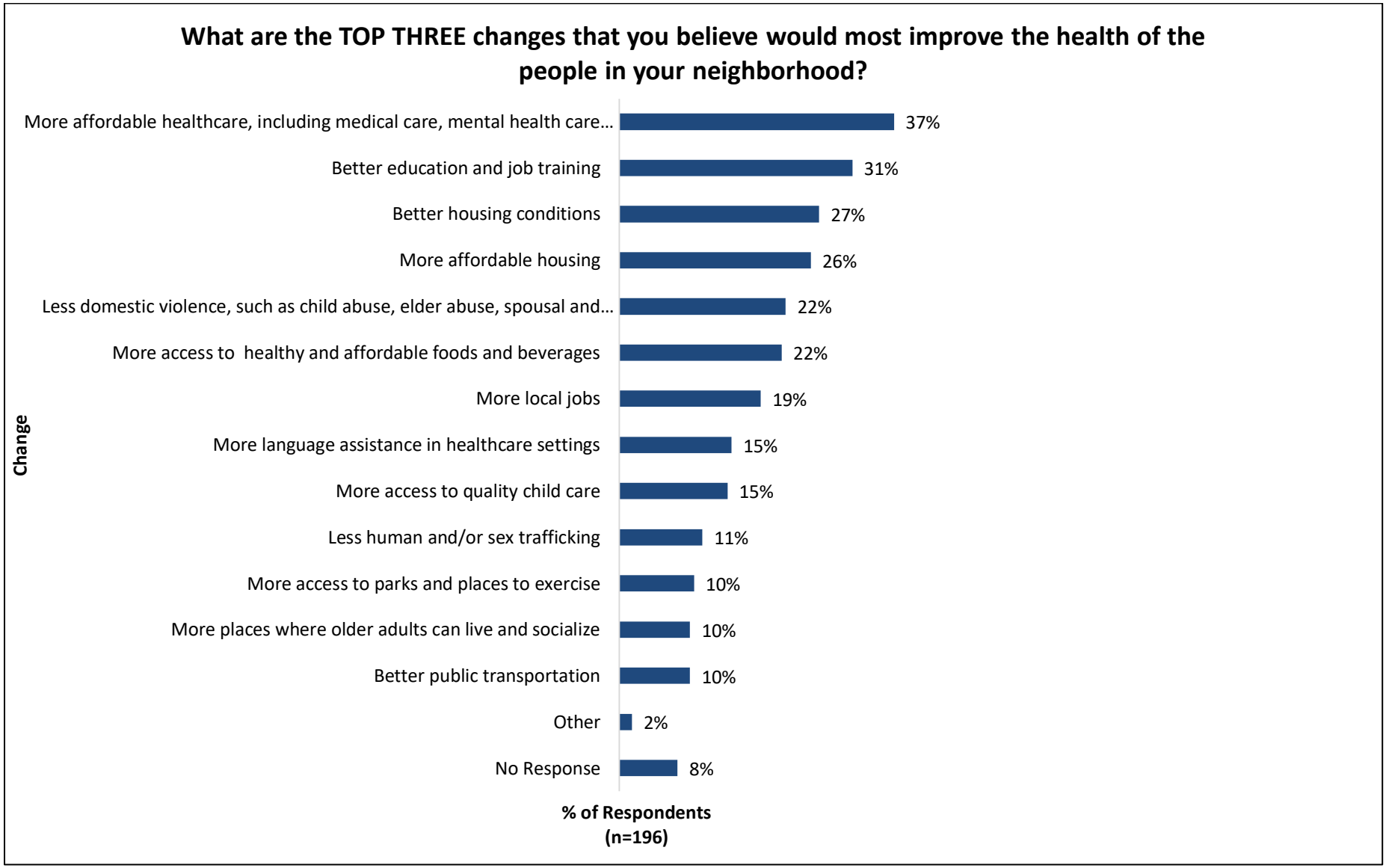

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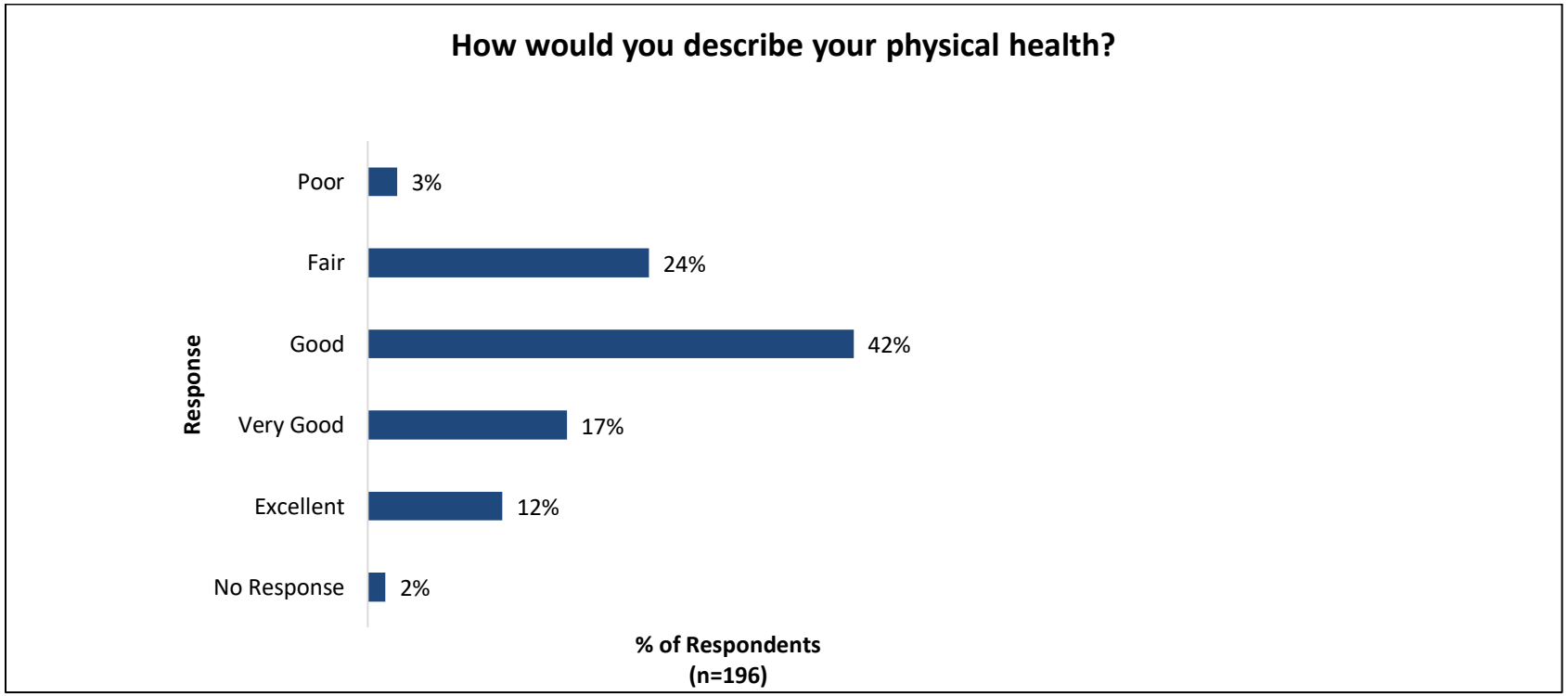

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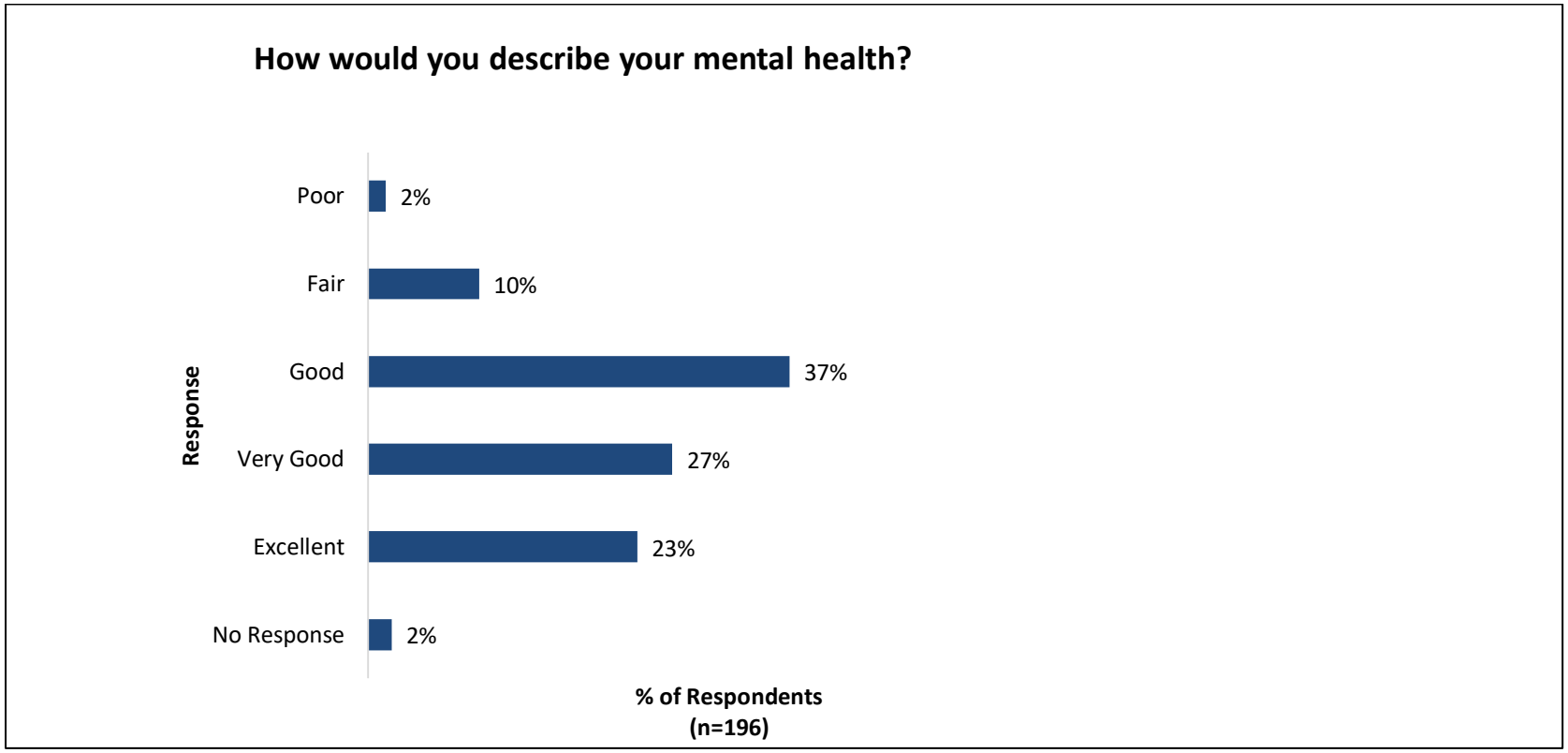

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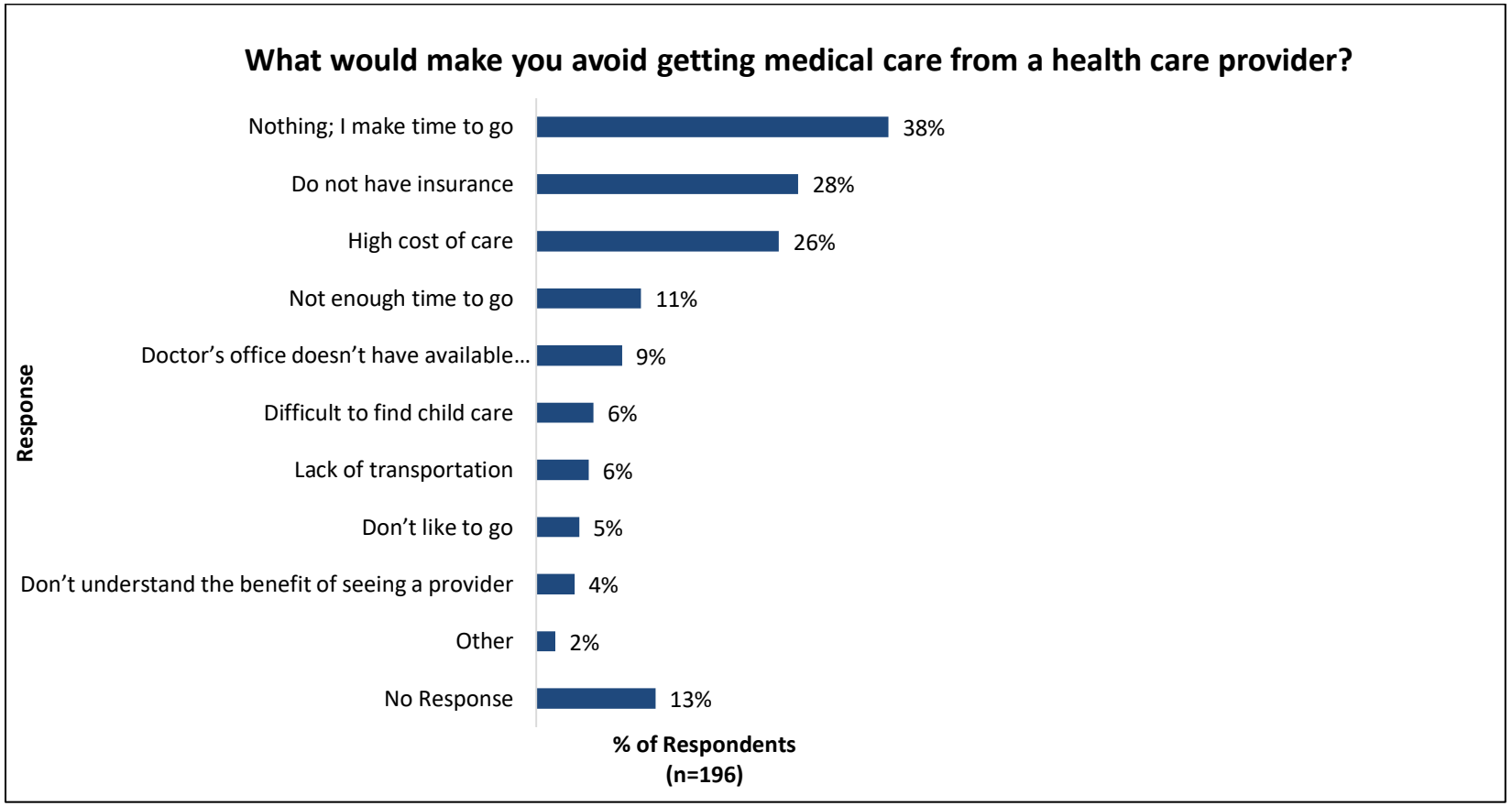

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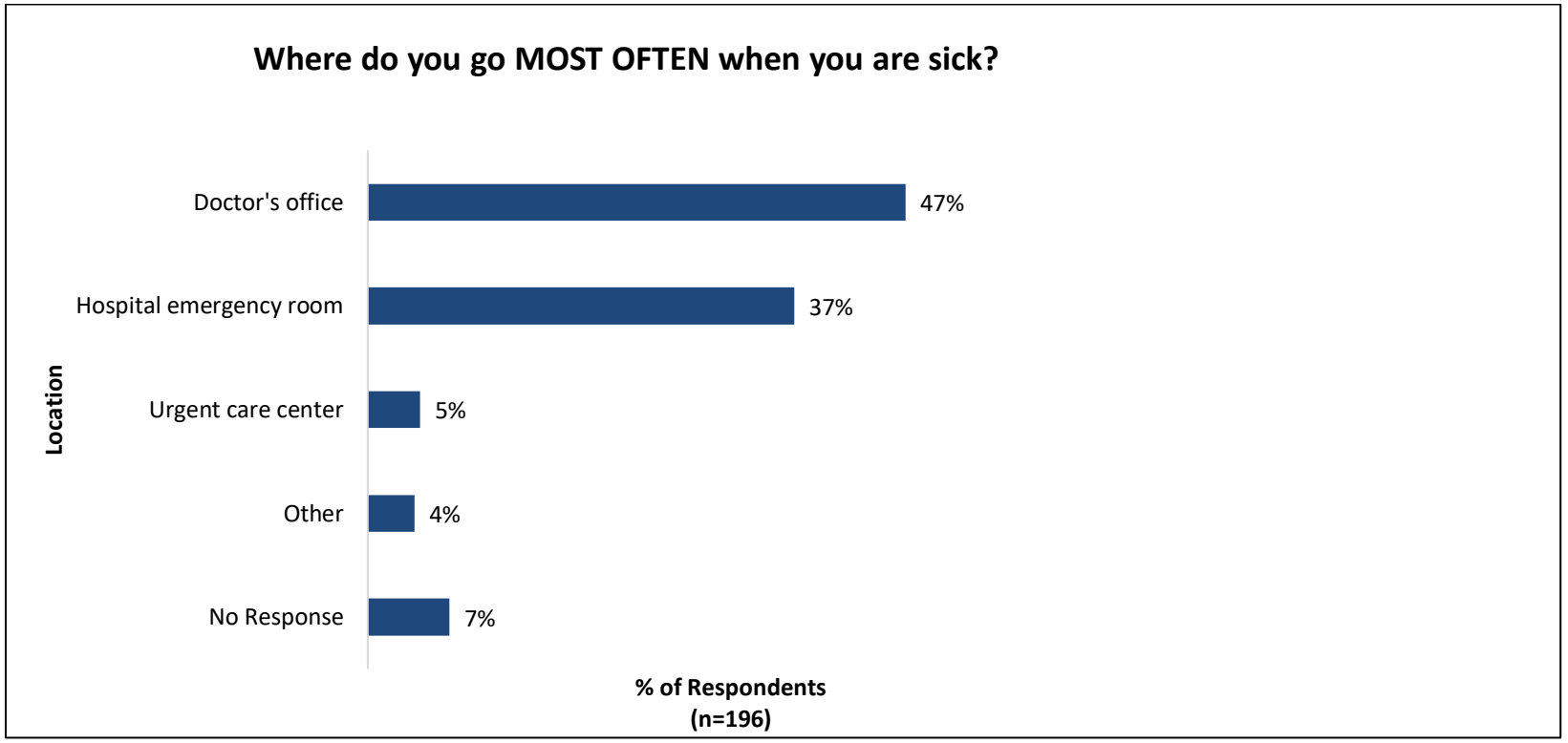

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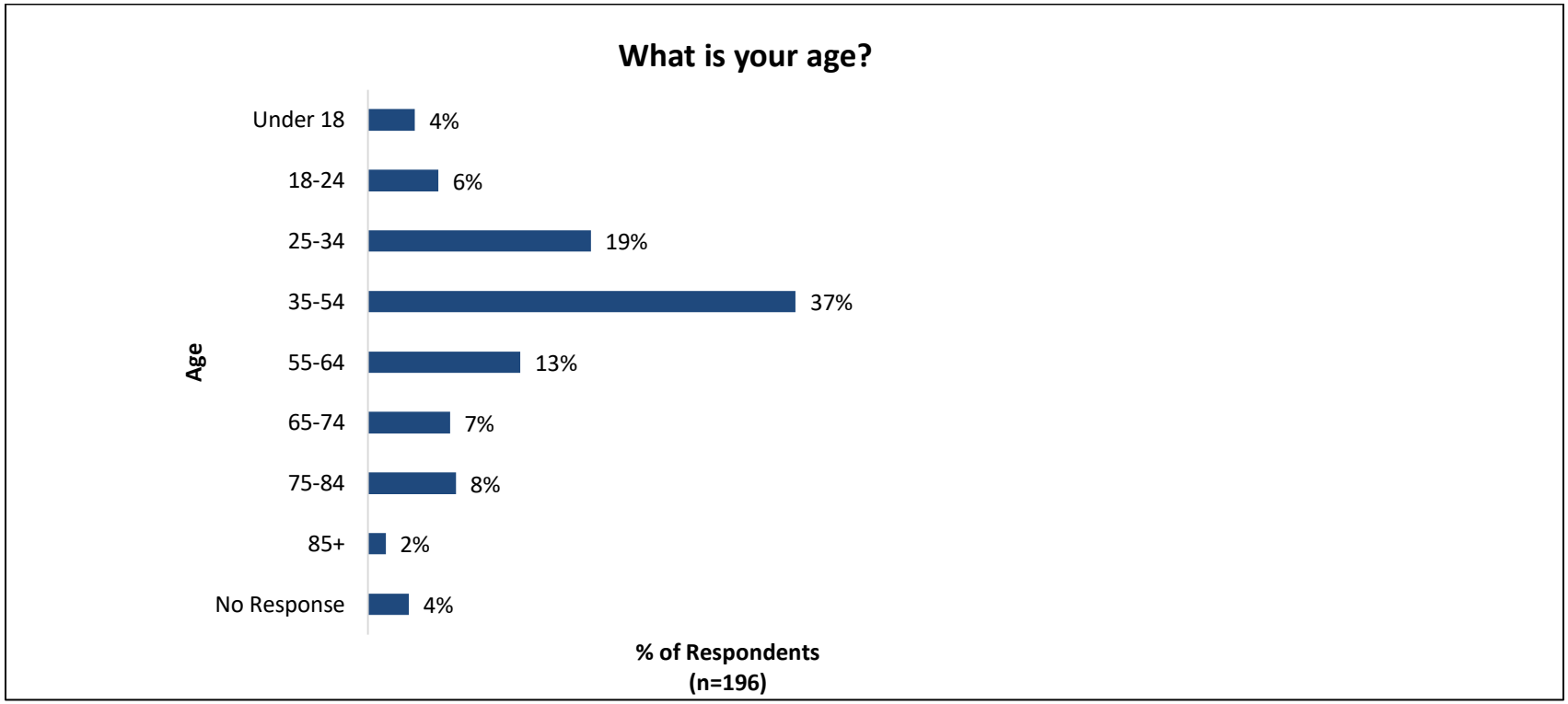

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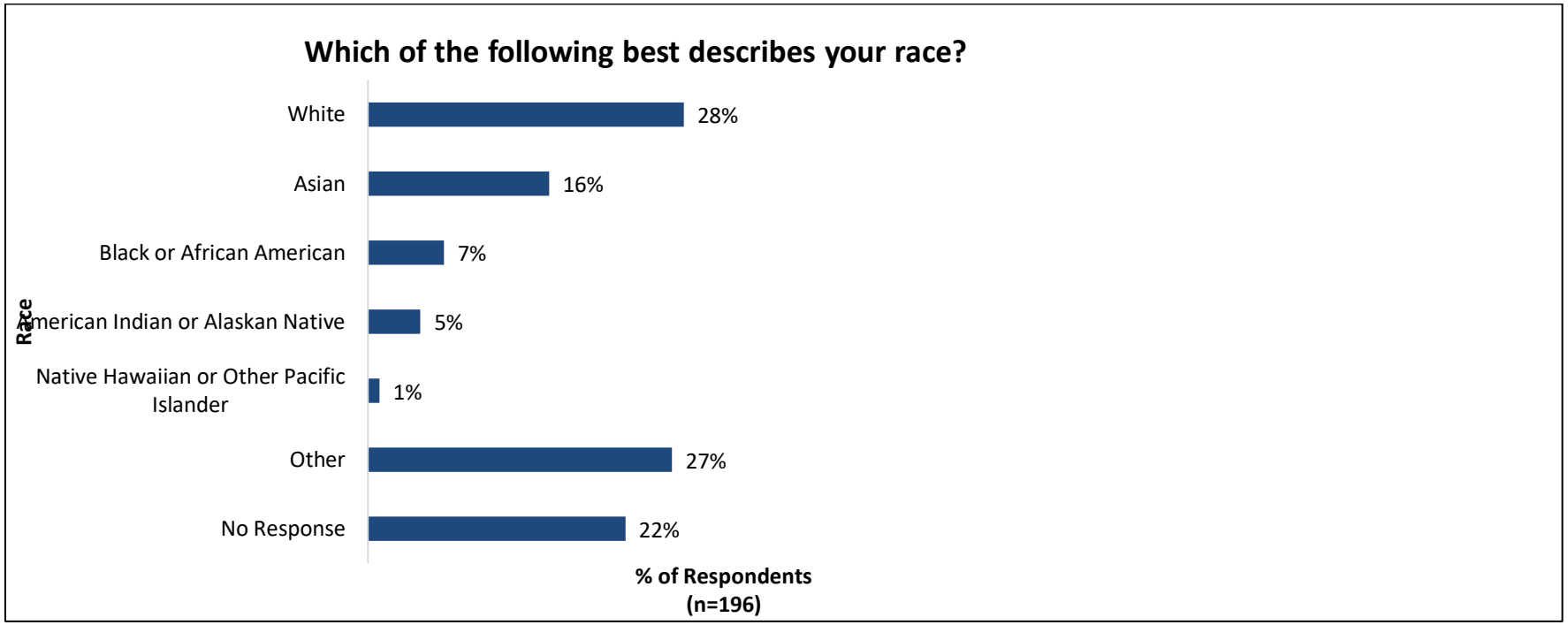

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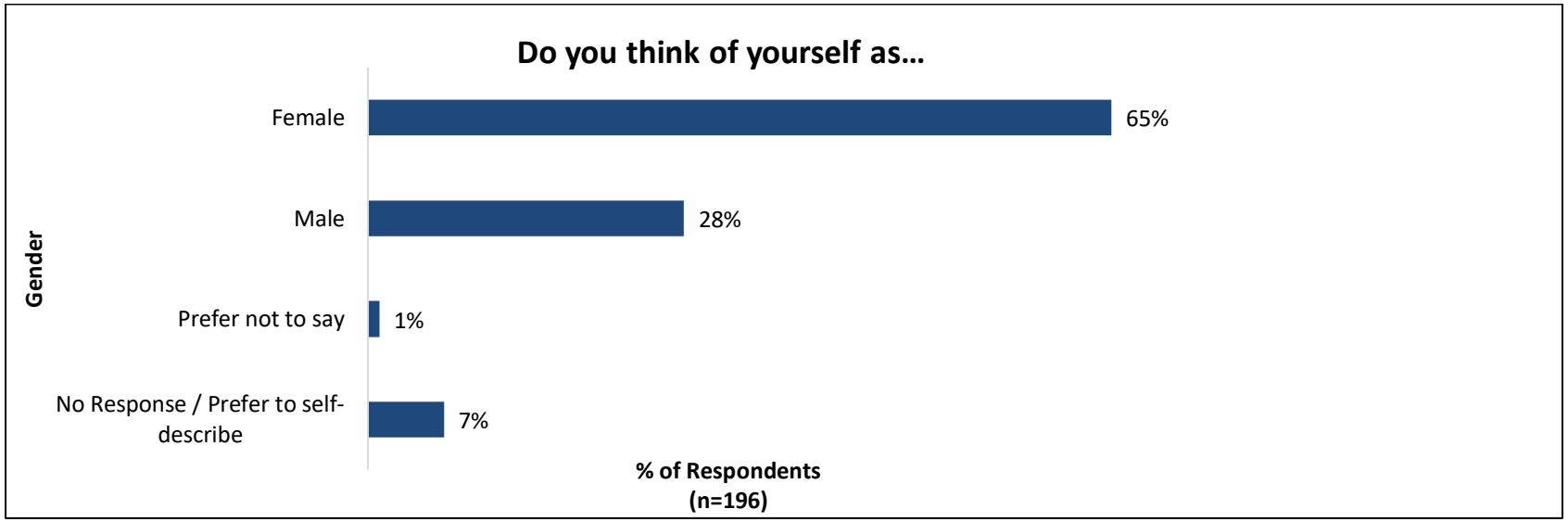

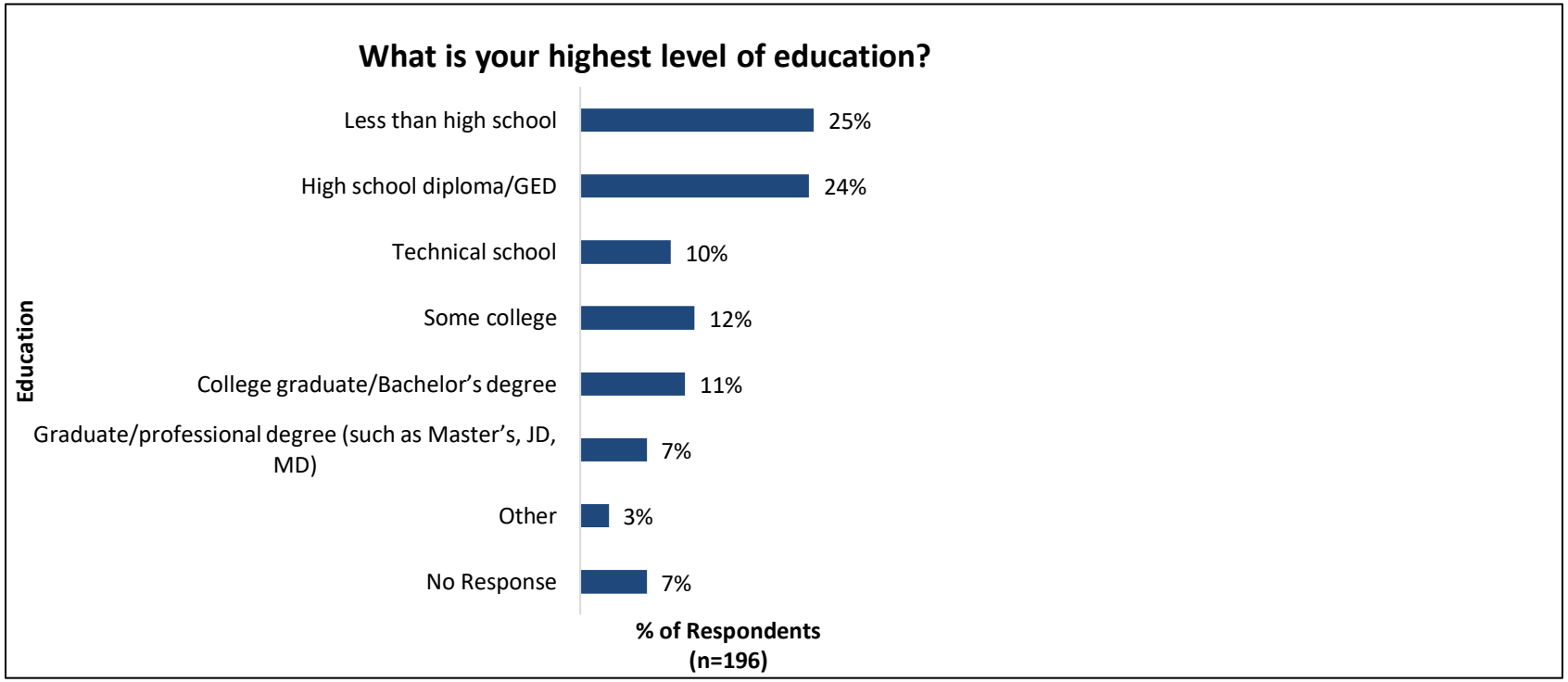

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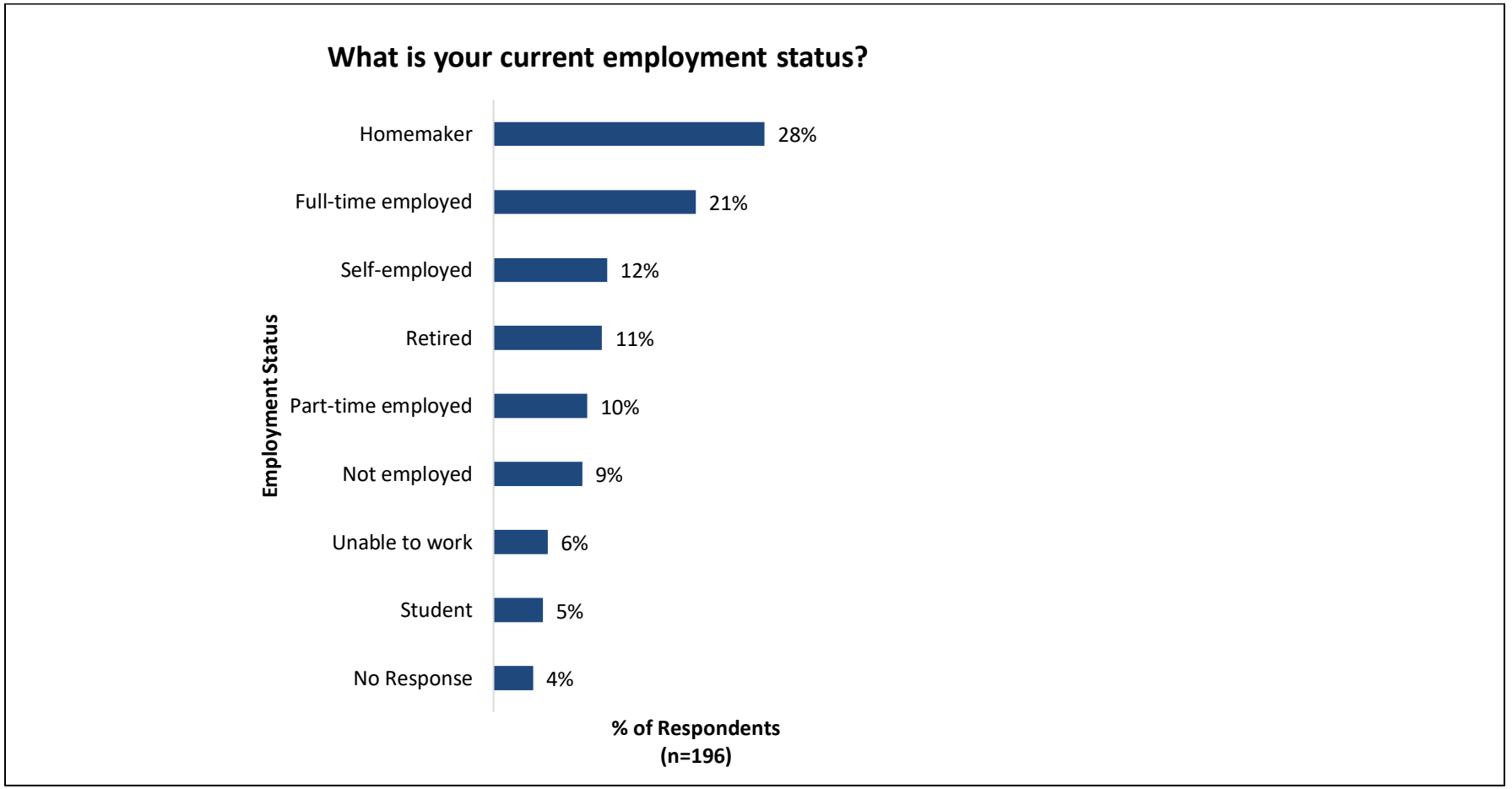

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