COMMUNITY HEALTH NEEDS ASSESSMENT

COMMUNITY SERVICE AND IMPLEMENTATION PLAN 2022-2024

FLUSHING HOSPITAL MEDICAL CENTER

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Executive Summary

FLUSHING HOSPITAL MEDICAL CENTER

EXECUTIVE SUMMARY

Flushing Hospital Medical Center (FHMC or Flushing Hospital), established in 1884, serves a culturally diverse, densely populated, urban area spanning 48 zip codes. FHMC's primary service area includes 14 zip codes located throughout Queens Community Districts 3 (East Elmhurst, Jackson Heights, and North Corona), 4 (Corona, Corona Heights, Elmhurst, and Lefrak City), and 7 (Auburndale, Bay Terrace, College Point, East Flushing, Flushing, Queensboro Hill, and Whitestone), as well as zip codes 11377 and 11378. In many of these communities, the effects of poverty on health, including difficulty obtaining nutritious food, unemployment, and the burden of high rents, are high.

Chronic diseases, obesity, tobacco use, behavioral health concerns, maternal morbidity, and late or no prenatal care are among the health issues highlighted in the community-level data analyses that FHMC conducted for this 2022-2024 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 a coalition of hospitals during the spring of 2022. As evidenced in the data and the survey responses, the social determinants of health (SDH) such as low educational attainment, unstable housing, poor physical conditions of neighborhoods, and low engagement in primary or preventative care and mental or behavioral health care, all contribute to the high incidence and prevalence of chronic diseases as well as poor health outcomes in some service area neighborhoods, while others perform better than NYC as a whole. The data analyses presented in this document provide a high-level snapshot of the health status of residents in FHMC's primary service area, while illustrating the diversity of population-level health behaviors and outcomes across different Community Districts in the area. By highlighting these patterns on a neighborhood level, these data provide insight into the services and resources most needed by residents. FHMC has adopted a focus on SDH through a new initiative to document these issues in the medical record using a standardized format and to address them in partnership with local community-based organizations using a closed loop technology platform to ensure that all parties are kept abreast of the social service supports received by each patient.

Breastfeeding, which lowers the risk of death from infectious diseases in a child's first two years of life and can reduce the risk of childhood obesity, asthma, and the risk of a woman developing breast or ovarian cancer, is unevenly practiced in the FHMC service area and in New York City (NYC) overall. FHMC has focused on improving rates of exclusive breastfeeding among women giving birth in the Hospital and those attending its ambulatory care centers with their infants, as well as among mothers in the community. The Hospital is designated as a Baby-Friendly USA Hospital that offers an optimal level of care for infant feeding and mother to 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, FHMC has focused on improving tobacco cessation rates. The Hospital was awarded Gold Star Status from the NYC Department of Health and Mental Hygiene's (DOHMH) 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 quantitative health status data at the local level and the community's input about their health concerns, the Hospital has chosen to highlight the prevalence of these behaviors—breastfeeding and tobacco use—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 New York State Prevention Agenda Priorities and the Healthy People 2030 goals.

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 14 zip codes in the following neighborhoods: East Elmhurst, Jackson Heights, and North Corona (Queens Community District 3); Corona, Corona Heights, Elmhurst, and Lefrak City (Queens Community District 4); and Auburndale, Bay Terrace, College Point, East Flushing, Flushing, Queensboro Hill, and Whitestone (Queens Community District 7); as well as zip codes 11377 and 11378.

In 2019 FHMC cared for approximately 16,000 inpatients including 2,100 newborns, 45,000 emergency department (ED) patients, and 89,000 ambulatory care patients. For the past two years, during the height of the pandemic, the Hospital saw fewer patients because non-urgent care was canceled or postponed. In 2021 patient volume decreased to approximately 12,000 inpatients and 35,000 ED patients. Ambulatory care saw a slight uptick - to 93,000 patients. The Hospital expects patient volume to return to pre-pandemic levels. FHMC 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 World Health Organization (WHO) Baby-Friendly USA designated Hospital. The ambulatory care program provides a full range of medical, behavioral health and dental services on campus. While FHMC has received dozens of awards and recognitions for its exemplary care, leadership has chosen to highlight five of the most prestigious accolades received since 2021:

- FHMC is recognized for delivering superior clinical outcomes in the care and treatment of strokes with the Healthgrades Stroke Care Excellence Award.
- FHMC was given the Healthgrades Labor and Delivery Excellence Award for its ongoing commitment to excellence in perinatal care.
- FHMC received the Healthgrades Obstetrics and Gynecology Excellence Award for consistently delivering superior patient outcomes in the specialty.
- FHMC has been accredited by the American Society for Metabolic and Bariatric Surgery as a Quality Program according to nationally recognized bariatric surgical standards.

FLUSHING HOSPITAL MEDICAL CENTER

Achievements and Awards

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

This Community Health Needs Assessment (CHNA) examines the health needs of the residents of the neighborhoods served by the Hospital using data from several sources. Community health data describing FHMC's PSA population will be presented, primarily from quantitative public data from the NYC DOHMH and qualitative data obtained from residents in a 2022 community health needs survey sponsored by a coalition of hospitals. Other data sources include the NYS Department of Health (DOH) and the U.S. Census American Community Survey. Following the presentation of health status data for the neighborhoods located in Queens Community Districts 3, 4, and 7, results of a CHNA survey in FHMC's service area are presented. Most of the data in this report are from the NYC DOHMH's Community Health Profiles (2018) and the 2022 Community Health Needs Survey results. All other data and sources are footnoted.

In NYC, neighborhoods are described and categorized differently across agencies and organizations. These differences are relevant to how community health data are analyzed and presented in this document. In the 2019-2021 CHNA, FHMC reported neighborhood data according to the traditional convention—either defined by NYC Community Districts or CDs (the 59 NYC CDs were established by local law in 1975) or United Health Fund (UHF) neighborhoods (an independent, nonprofit, health services research and philanthropic organization defining 34 NYC neighborhoods comprised of adjoining zip code areas, designated to approximate NYC Community Planning districts). Utilizing these schema, FHMC's Primary Service Area (PSA) has traditionally been defined as covering the Queens neighborhoods of Flushing-Clearview and West Queens. Resultant to the latest decennial census and American Community Survey, new geographies now reflect the post-redistricting political boundary changes enacted by the NYC Board of Elections (due to 2020 Census revisions to census tracts and blocks). The neighborhood maps which follow display CDs with the zip codes and neighborhoods located within them for the PSA. For the purposes of this needs assessment, some health information may be presented either by CD, or by UHF neighborhoods, depending on the most up to date source.

FHMC's service area was determined by analyzing Statewide Planning and Research Cooperative System (SPARCS) discharge data at the zip code level. The neighborhoods with the highest volumes of patients were determined to be the PSA. Neighborhoods with at least 2% 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 56% and the SSA 28%. The FHMC community health needs assessment will focus on the Hospital's PSA.

FHMC's Primary Service Area

The PSA covers zip codes and neighborhoods in three different community districts which lie within the borough of Queens, as well as two additional zip codes: 11377 and 11378 which together represent 3% of FHMC's inpatient population and therefore are considered a part of the PSA, even though they fall outside the identified community district boundaries. The neighborhoods and zip codes served within the PSA are shown in Table 1.

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

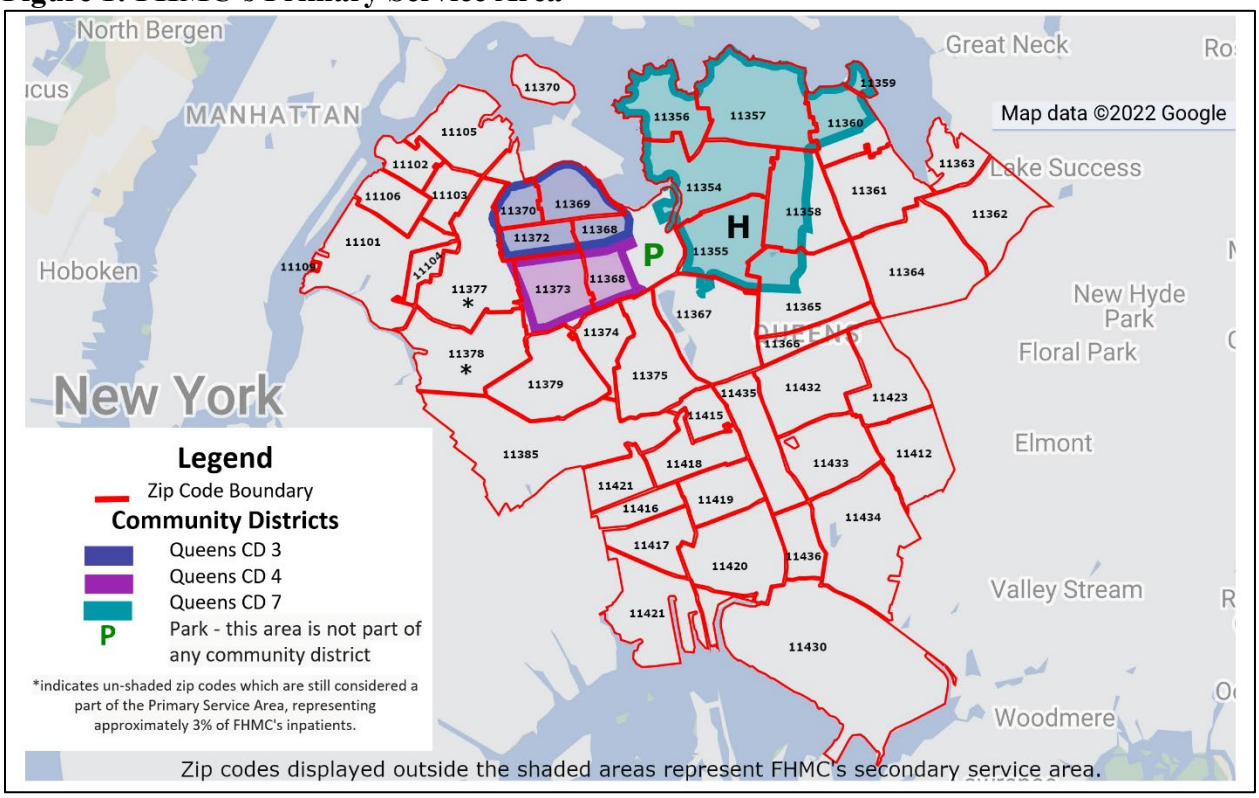
Community District (CD)	Neighborhoods	Zip Codes
Queens CD 3	North Corona East Elmhurst Jackson Heights	11368[‖] 11369 11370 11372
Queens CD 4	Corona Corona Heights Elmhurst Lefrak City	11368[‖] 11373
Queens CD 7	Auburndale Bay Terrace College Point East Flushing Flushing Queensboro Hill Whitestone	11354 11355 11356 11357 11358 11359 11360

*Not included in the table, zip codes 11377 and 11378 are also considered a part of the PSA.
[‖]Zip code 11368 includes the Corona and North Corona neighborhoods and overlaps both Queens CD 3 and Queens CD 4.

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)[1]; this designation is based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. Six neighborhoods in Queens, located in "service areas" assigned to them by HRSA, are designated as MUAs for primary care and are located in HRSA-assigned Queens, NW Queens, and South Jamaica Service Areas. The Medicaid-eligible population in the HRSA-assigned Corona Service Area, a MUP, 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.

[1] HRSA Find. Data.HRSA.gov.

Figure 1: FHMC's Primary Service Area



In addition to Flushing Hospital Medical Center, there are eight acute care hospitals, 12 nursing homes, and 35 HRSA-supported Federally Qualified Health Centers (FQHC) or Look-Alikes that provide services in Queens County.[2] Three other hospitals provide acute care services in FHMC'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 the 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 FHMC, at affiliated JHMC, and at seven other licensed facilities in Queens. In addition, there are 55 outpatient mental health services, support programs, emergency services, and residential facilities that provide mental health treatment to adults and children.[3] Creedmoor Addiction Treatment Center, a state-operated facility, serves Queens and the rest of NYC. Thirty chemical dependency treatment agencies and 84 individual providers in Queens provide chemical dependency prevention/treatment and impaired driving offender programs.[4] Approximately 240 DATA-waivered practitioners in Queens are certified to provide buprenorphine treatment of opioid use disorder. Of these, 45 practitioners are located in FHMC's PSA.[5]

[2] HRSA Data Warehouse. Find a Health Center. Accessed 09/20/2022: https://findahealthcenter.hrsa.gov/
[3] NYS OMH. Mental Health Program Directory. *Accessed online 09/19/2022:* https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages
[4] NYS OASAS. *Accessed online 09/20/2022.* https://www.oasas.ny.gov/providerDirectory/index.cfm
[5] SAMHSA. Buprenorphine Practitioner Locator.

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.

Social Determinants of Health (SDH)

Social Determinants of Health (SDH) are defined by Healthy People 2030 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 SDH domains include:

- Economic Stability;
- Education Access and Quality;
- Social and Community Context;
- Health Care Access and Quality; and
- Neighborhood and Built Environment.

Integrating health and human services to address SDH can have a significant impact on health outcomes.[6] FHMC has always integrated SDH into its approach to patient care. It is currently launching a systematic approach to doing this by screening for SDH with a standardized tool. The results are entered automatically in the medical record and referrals for high scoring needs are made to local social service agencies via a closed loop referral platform, which ensures that outcomes are shared with all parties. This heightened emphasis on SDH, together with the high-quality clinical services provided by the Hospital will ensure a systematic and highly effective approach to the Prevention Agenda Priority Areas identified by the NYS DOH in its Prevention Agenda for the period 2019-2024:

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, FHMC 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") which are focus areas for the Prevent Chronic Disease priority). Data were primarily obtained from the NYC DOHMH's 2018 Community Health Profiles and 2022 Community Health Surveys (community-wide surveys that were administered as part of data collection for the 2022-2024 Queens CHNA). 2022 CHNA survey results, sponsored by FHMC, are discussed in a subsequent section.

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

Sharing Report with the Public

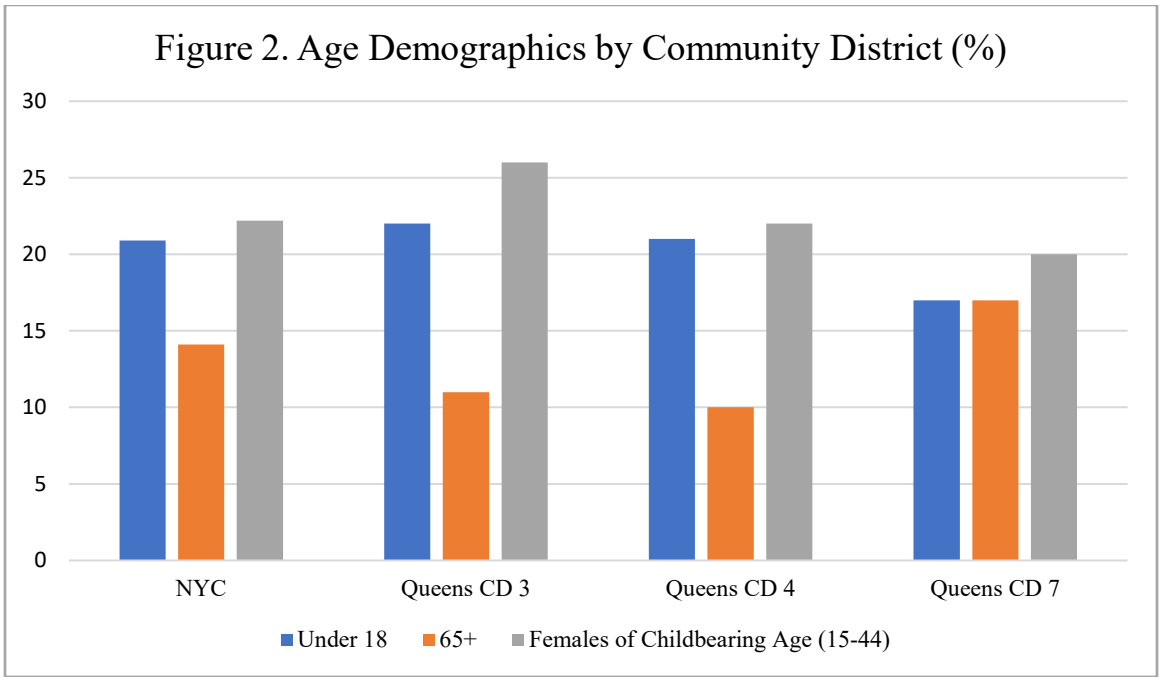
The full report was distributed to the members of the Hospital's Board of Trustees, who approved it in October 2022. Announcement of the report's availability will be posted on the Hospital's social media platforms. A copy can be obtained from the Hospital's website: https://flushinghospital.org/community/community-service-plan/

COMMUNITY HEALTH NEEDS ASSESSMENT

Statistics by Primary Service Area Community District

I. Demographics

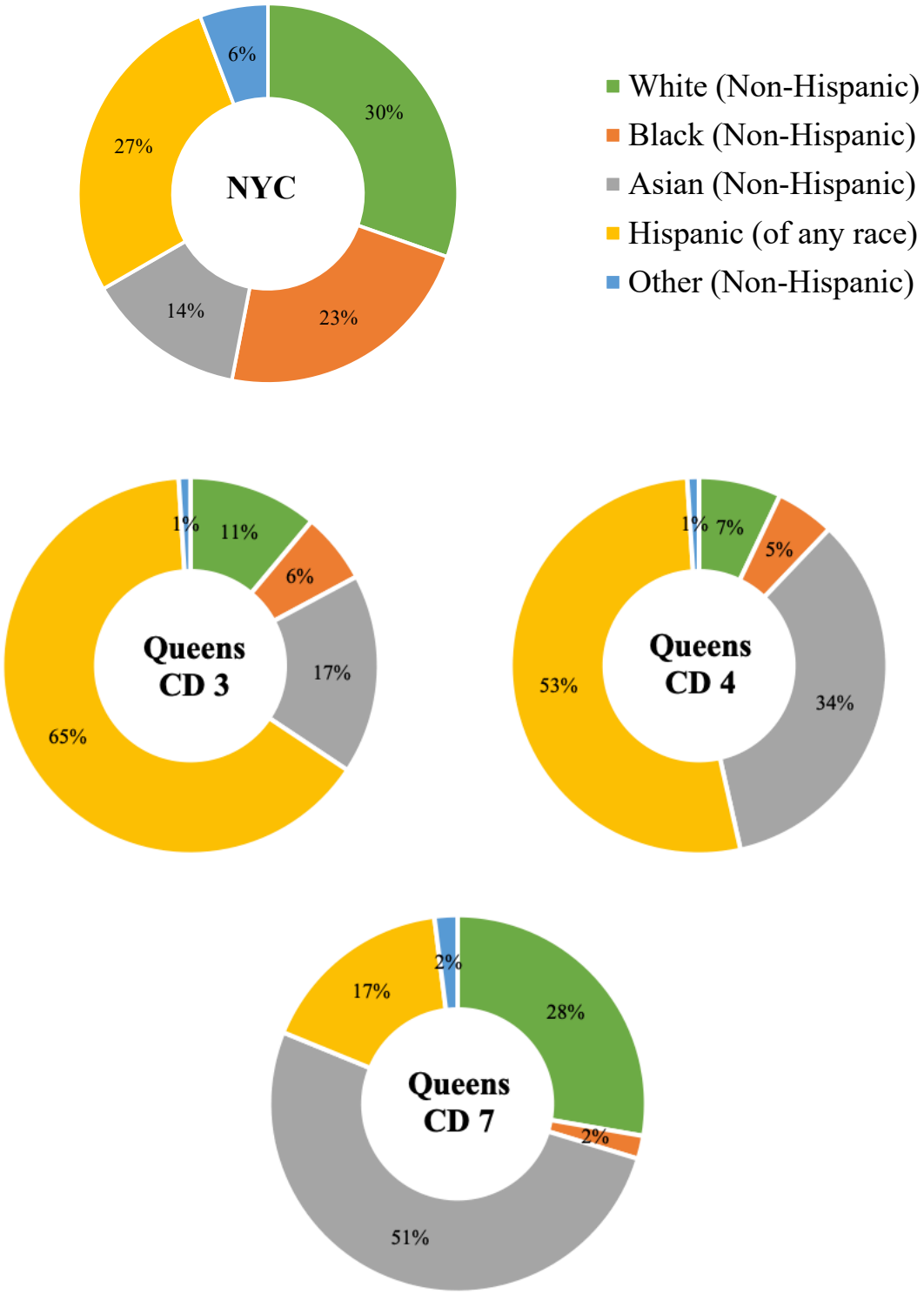
The overall resident primary service area (PSA) population is approximately 738,600. This population includes 178,000 in Queens Community District 3 (East Elmhurst, Jackson Heights, and North Corona), 183,900 in Queens Community District 4 (Corona, Corona Heights, Elmhurst, and Lefrak City), 255,700 in Queens Community District 7 (Auburndale, Bay Terrace, College Point, East Flushing, Flushing, Queensboro Hill, and Whitestone), 82,000 in zip code 11377, and 39,000 in zip code 11378.[7] Unless otherwise noted, the NYC Planning Community District Profiles were used for PSA population demographic data. The population of the PSA is slightly younger than that of NYC, with similar proportions of the population who are women of child-bearing age.



In comparison to NYC, a greater proportion of residents in the PSA identify as races other than White, including several predominantly Hispanic communities in Queens CD 3 and Queens CD 4 and predominantly Asian immigrant and Asian-American communities in Queens CD 7. Overall, the PSA is very racially and ethnically diverse, with large populations of foreign-born residents—63% of Queens CD 3 residents, 66% of Queens CD 4 residents, and 57% of Queens CD 7 residents are foreign-born.

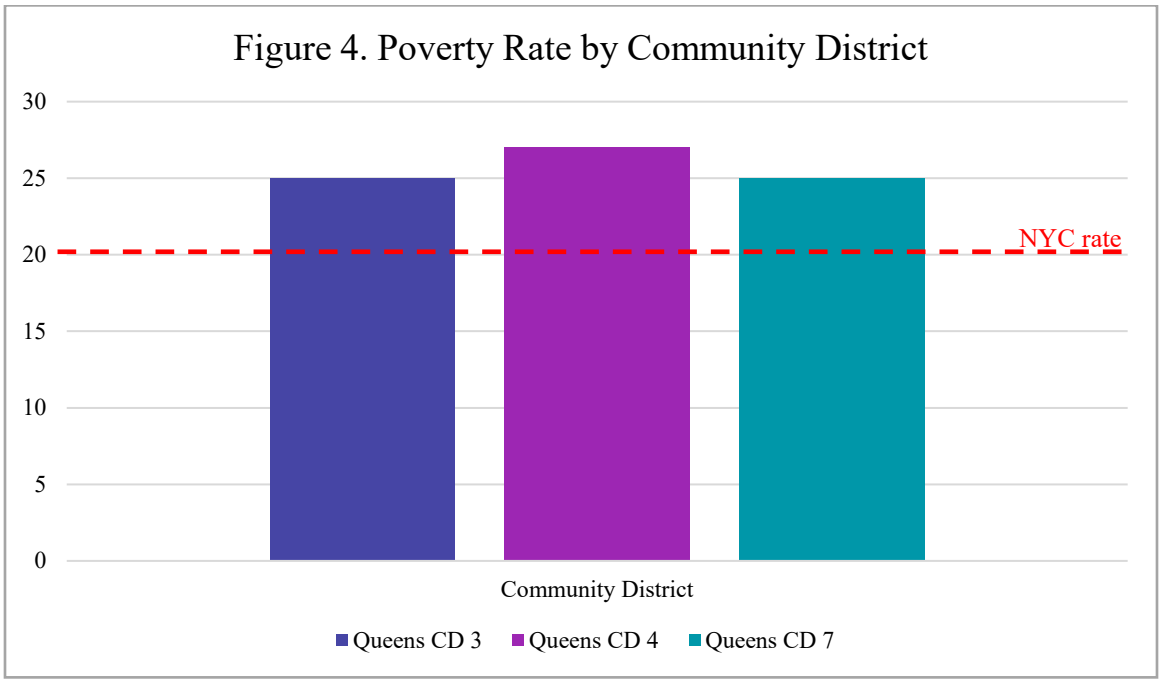
[7] U.S. Census Bureau (2014-2018). American Community Survey 5-Year estimates. Retrieved from NYC Planning Community District Profiles for Queens Community District (CD) 3; Queens CD 4; and Queens CD 7.

Figure 3. PSA Race and Ethnicity Profiles



II. Social and Economic Stressors

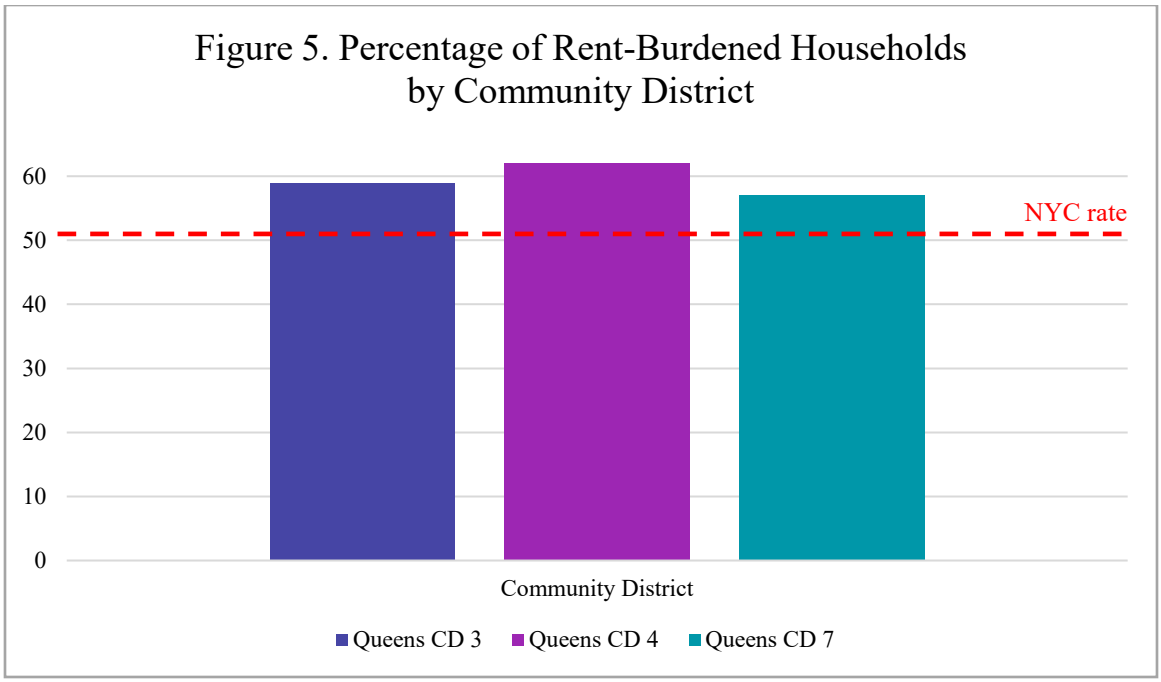
Most of the PSA has experienced social and economic stressors. Poverty and its effects on health, particularly on mental/behavioral health and nutrition, are of significance in the Community Districts served by FHMC. Living in high-poverty neighborhoods limits healthy lifestyle options for residents and makes it difficult to access quality health care and resources that promote health. Poverty rates for all three Community Districts in FHMC's PSA exceed the poverty rates in Queens and NYC as a whole.



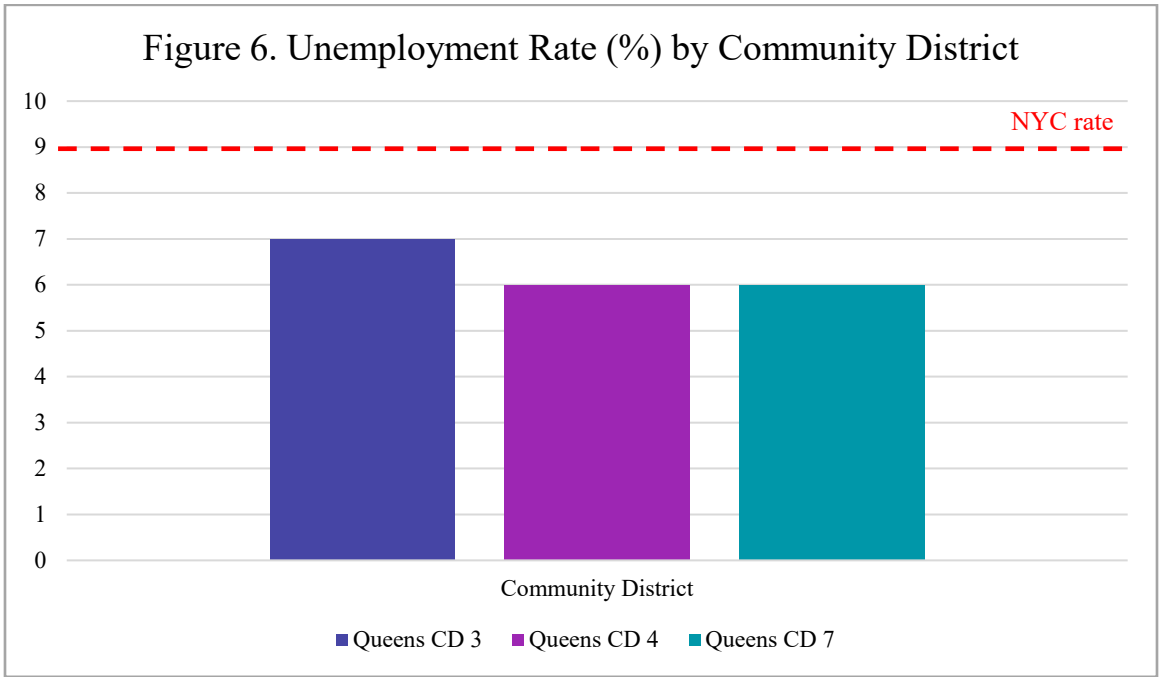
III. Housing and Employment

Access to affordable housing and employment opportunities with fair wages and benefits are closely associated with good health. Rent burdened households are defined as those that pay 35% or more of their income for housing and may have difficulty affording food, clothing, transportation, and health care.[8] More residents are rent burdened in FHMC's PSA than the rest of Queens (53%) and throughout NYC (51%).

[8] American Community Survey, United States Census Bureau, 2018.

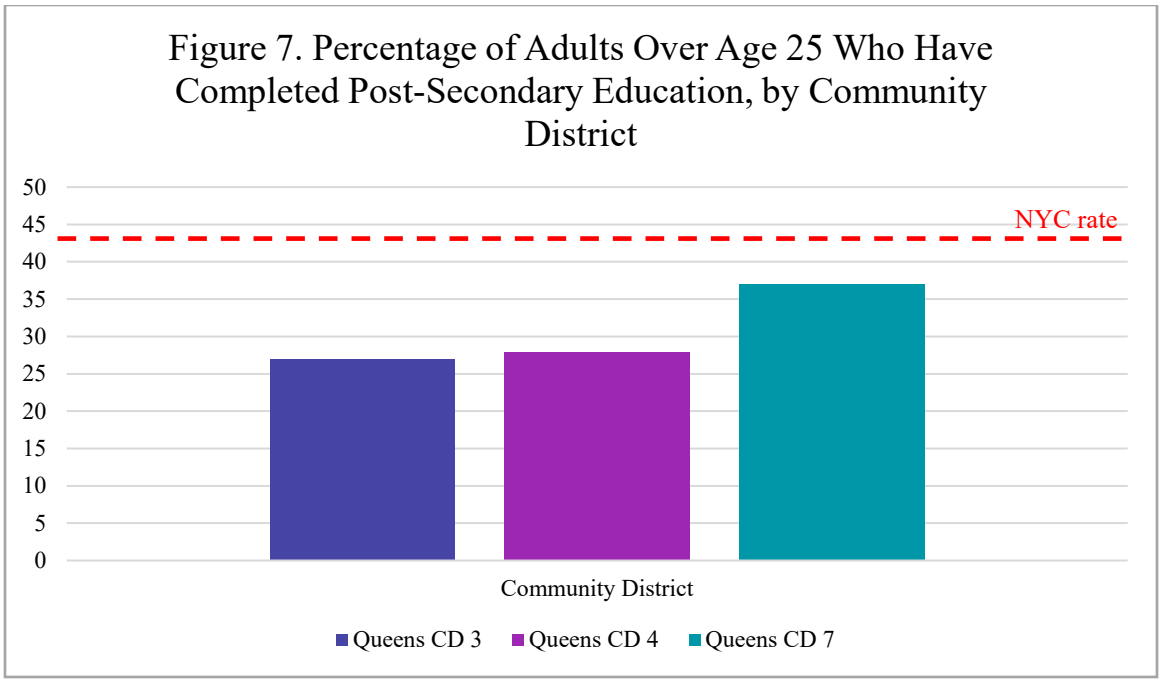


The PSA's unemployment rates, however, are more favorable than the citywide average, ranging from 6% to 7% compared to 8% in Queens and 9% in NYC.



IV. Education

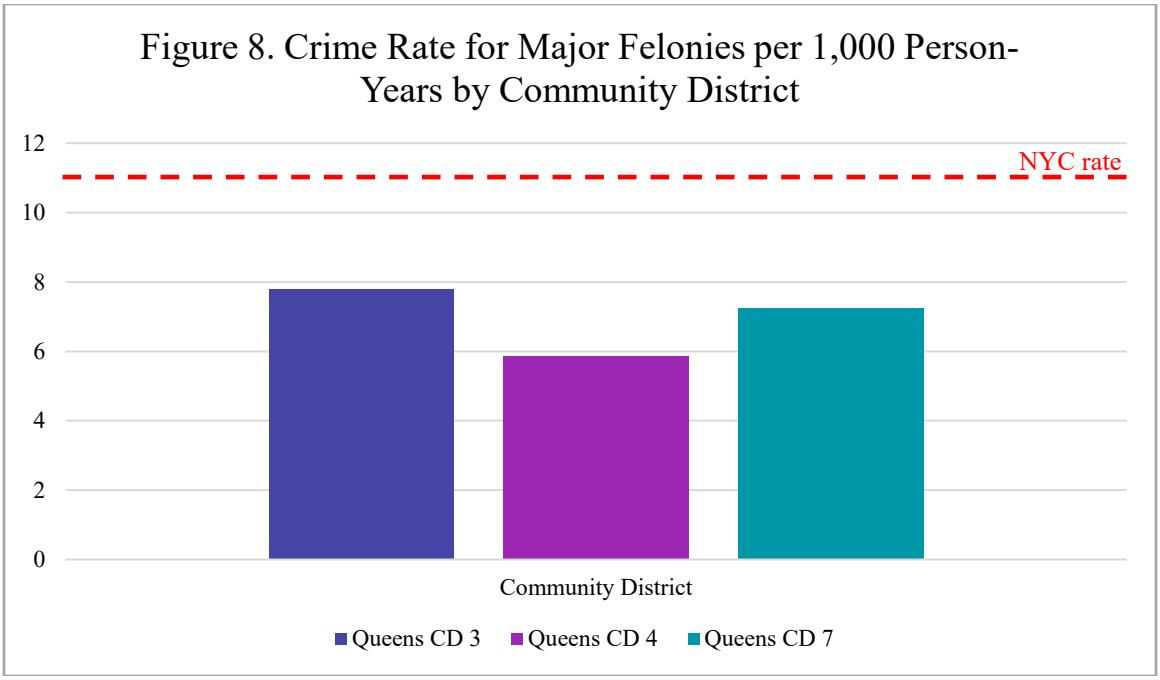
High levels of educational attainment correlate with a number of positive health outcomes, including lower chronic disease rates and longer life expectancies.[9] Post-secondary education rates in FHMC's PSA are lower than those of Queens and NYC.



V. Crime

Crime rates in FHMC's PSA vary slightly by community district, but are all below the city-wide rate. Queens CD 4 has the lowest crime rate in the PSA at 5.9 major felonies per 1,000 person-years, while Queens CD 3 has the highest rate at 7.8 major felonies per 1,000 person-years.

[9] Hummer RA, Hernandez EM. The Effect of Educational Attainment on Adult Mortality in the United States. *Popul Bull*. 2013;68(1):1-16.



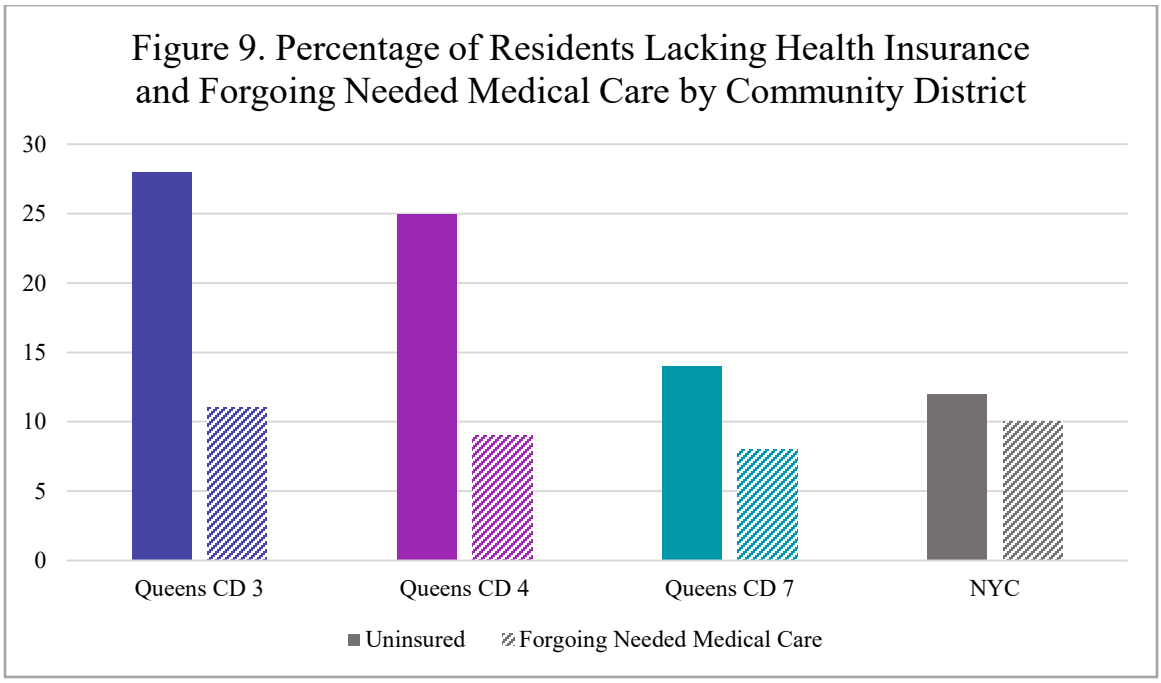
VI. Health

Seventy-two percent of Queens CD 3 residents self-report their health to be "excellent," "very good," or "good", while Queens CD 4 and Queens CD 7 exhibit lower rates (68% and 71%, respectively. These values are considerably lower than the Queens-specific and city-wide estimates (78% and 76%, respectively). Residents could consider various factors when self-reporting their health status, a measure that is purposely vague in order to capture a person's own assessment of their present general health. In county rankings, health outcomes refer to measurable indicators of longevity and quality of life, while health factors describe the environmental, clinical, social, economic and behavioral conditions that influence health. Of the 62 counties in NYS, Queens County (home to FHMC's PSA) is ranked highly for health outcomes (12th) but poorly for health factors (52nd).[10]

VII. Access to Health Care

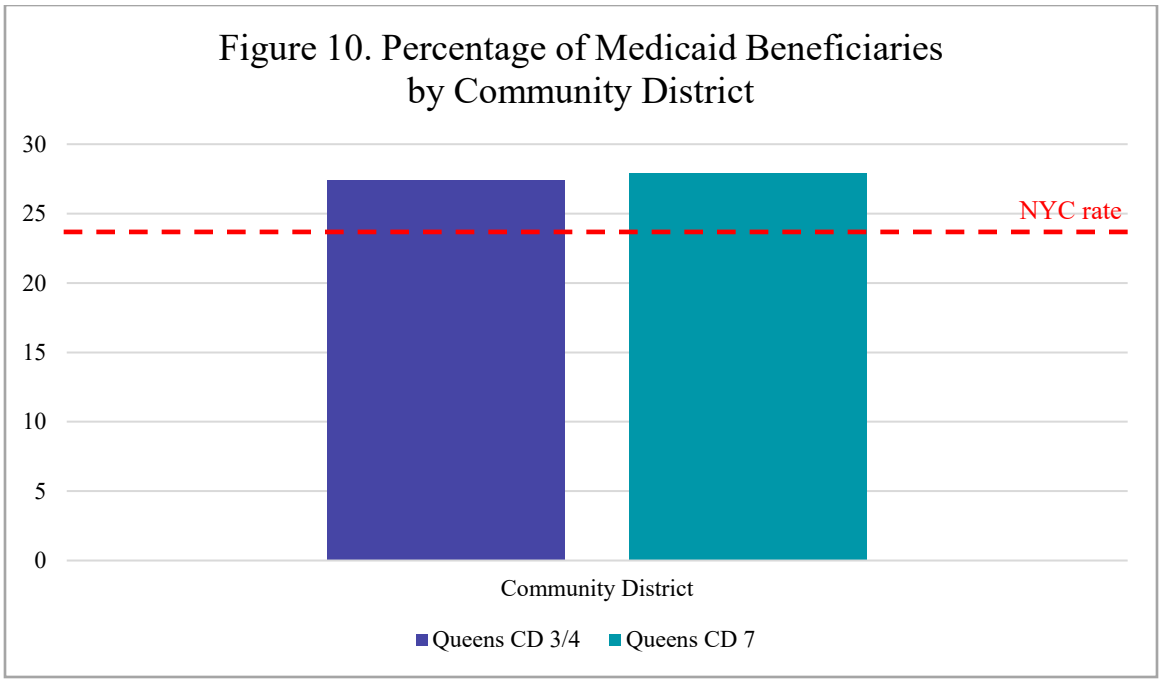
Citywide, the percentage of uninsured New Yorkers has decreased in the last five years from 20% to 12%.[11] The uninsured rate in Queens CD 7 is similar to that of NYC, but the uninsured rate in the region containing Queens CD 3 and Queens CD 4 is the second highest in the entire city.[12] To contrast, the proportion of individuals forgoing needed medical care is comparable to that of NYC throughout FHMC's PSA.

[10] County Health Rankings and Roadmaps, Robert Wood Johnson Foundation, 2022.
[11] New York City Community Health Survey, DOHMH, 2017.
[12] Ibid.



In NYC, 45.4% of the general population receive health insurance from a private entity, while 16.1% are insured by Medicare, 23.8% are insured by Medicaid, and 2.9% receive insurance through another program such as the Indian Health Service (IHS) or the Department of Veterans Affairs (VA).[13] The proportion of residents receiving private insurance coverage in FHMC's PSA varies by neighborhood, but is generally lower than the NYC rate—32.5% of residents in the area encompassing Queens CD 3 and Queens CD 4 and 43.4% of Queens CD 7 residents receive private health insurance coverage.[14] The Medicare-insured rates across the PSA range from significantly below city-wide levels (13.1% in Queens CD 3/4) to slightly greater (16.7% in Queens CD 7).[15] The Medicaid-insured rates in the PSA are consistently higher than the city-wide rates.[16]

[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.

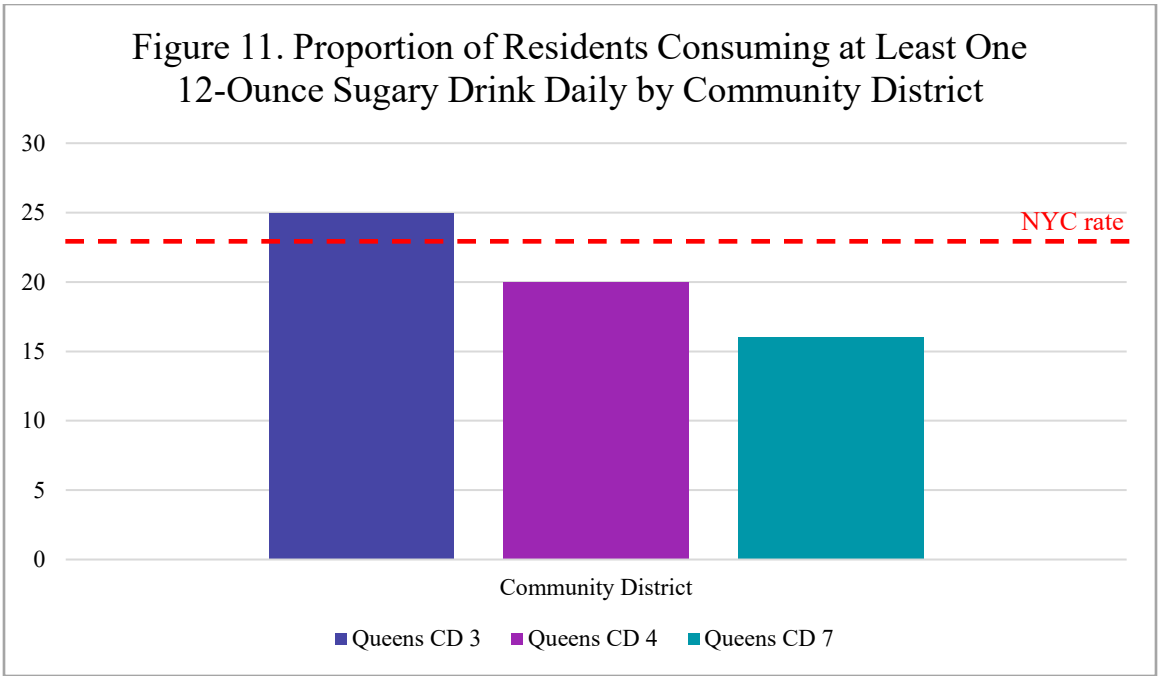


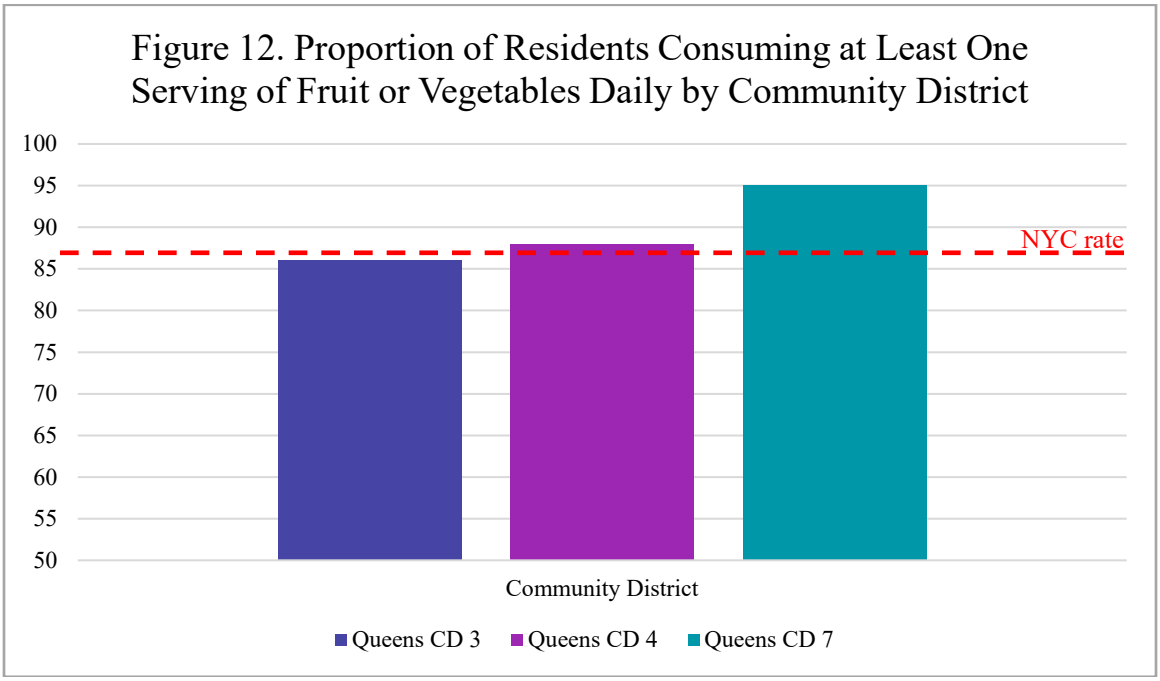
VIII. Nutrition

Food insecurity is defined as the state of not being able to reliably access sufficient affordable and nutritious food due to lack of resources. In NYC, 22.0% of individuals report having access to enough food but not the food of their choice and 9.6% report sometimes or often not having access to enough food.[17] In the area encompassing Queens CD 3 and Queens CD 4, the proportion of individuals lacking reliable access to the food of their choice is slightly greater than the city-wide estimate (25.1%), while the proportion in Queens CD 7 is slightly lower than the city-wide estimate (19.1%).[18] Similarly, the percentage of individuals without reliable access to enough food is slightly higher in Queens CD 3 and Queens CD 4 (10.0%) compared to NYC, while the rate is lower than NYC in Queens CD 7 (8.7%).[19]

Many factors can influence an individual's food choices, including cost, geographic access, and nutritional value—these choices in turn influence overall health and contribute to chronic disease risk. Some indicators of an individual's general access to nutritional foods include daily sugary drink consumption (a widely available and affordable energy source that can be detrimental to long-term dental health when consumed regularly) and daily fruit and vegetable consumption (a measure of consistent access to nutrients such as vitamin C). The sugary drink consumption rate in Queens CD 3 is greater than that of NYC, while Queens CD 4 and Queens CD 7 have lower rates than NYC. Similarly, the proportion of individuals consuming at least one serving of fruit or vegetables daily is greater than the city-wide estimate in Queens CD 4 and Queens CD 7, but lower in Queens CD 3.

[17] Ibid.
[18] Ibid.
[19] Ibid.

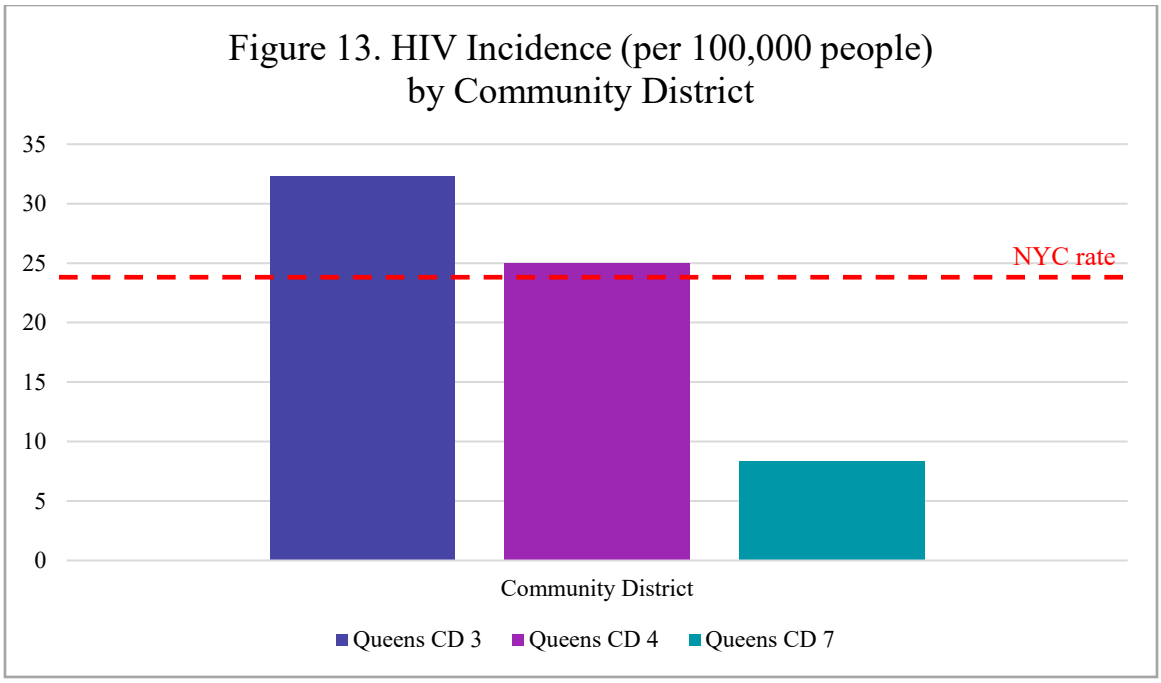




In NYC, bodegas are less likely to offer healthy food options than supermarkets to the communities they serve, making the supermarket to bodega ratio in a Community District a strong indicator of healthy food access on the neighborhood level. Across the city, these ratios vary from 1:3 at the lowest to 1:57 at the highest, with lower ratios indicating greater access to healthy food. In the PSA, Queens CD 7 has by far the most favorable supermarket to bodega ratio at 1:6, followed by Queens CD 4 (1:16) and Queens CD 3 (1:17).

IX. Human Immunodeficiency Virus (HIV)

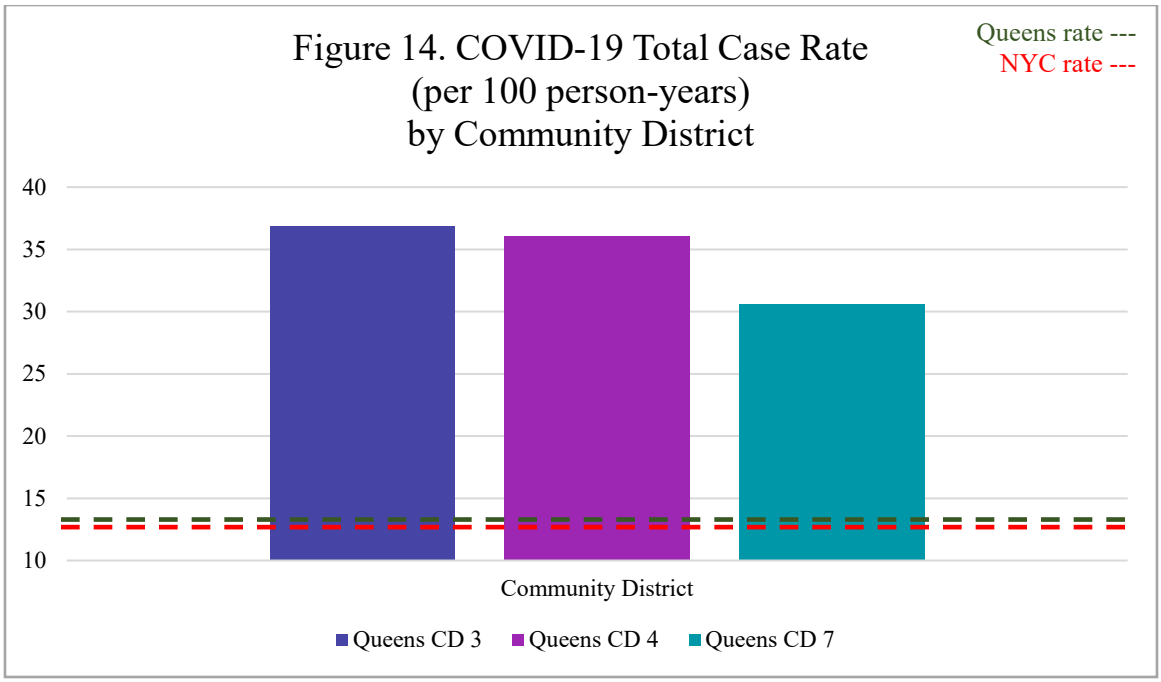
The incidence of Human Immunodeficiency Virus (HIV) is 24.0 new diagnoses per 100,000 people in NYC, with a Queens-specific incidence of 17.8 per 100,000 people. The HIV incidence in Queens CD 7 compares favorably with the Queens and citywide estimates, while Queens CD 3's incidence of 32.3 new diagnoses per 100,000 people is the highest in the PSA. HIV testing rates also vary by neighborhood in the PSA, ranging from 20.8% in Queens CD 7 to 32.4% in Queens CD 3 and Queens CD 4, but are consistently lower than the city-wide testing rate (34.3%).[20] HIV is the sixth leading cause of premature death in NYC (5.9 deaths per 100,000 people), but is not a leading cause of death in FHMC's PSA.



X. Public Health Impact of the COVID-19 Pandemic

COVID-19 has taken a disproportionate toll on the health, safety, and well-being of PSA residents, as total case rates for these Community Districts remain consistently higher than Queens-specific and city-wide estimates.[21] COVID-19 total case rates in Queens CD 3 and Queens CD 4 are almost triple those of Queens and NYC, and the Queens CD 7 rate is more than double those of Queens and NYC.[22]

[20] Ibid.
[21] COVID-19 Data: Neighborhood Data Profiles, NYC Health, 2022.
[22] Ibid.



The total death rates in these three Community Districts also exceed the Queens-specific rate (0.45 per 100 person-years) and city-wide rate (0.41 per 100 person-years).[23] Queens CD 4 has the lowest COVID-19 total death rate in the PSA at 0.54 per 100 person-years, while Queens CD 3 has a rate of 0.71 per 100,000 person-years.[24] The COVID-19 total death rate in Queens CD 7 is 1.02 per 100 person-years, making this CD's rate the highest in the PSA at more than double the Queens and NYC rates.[25]

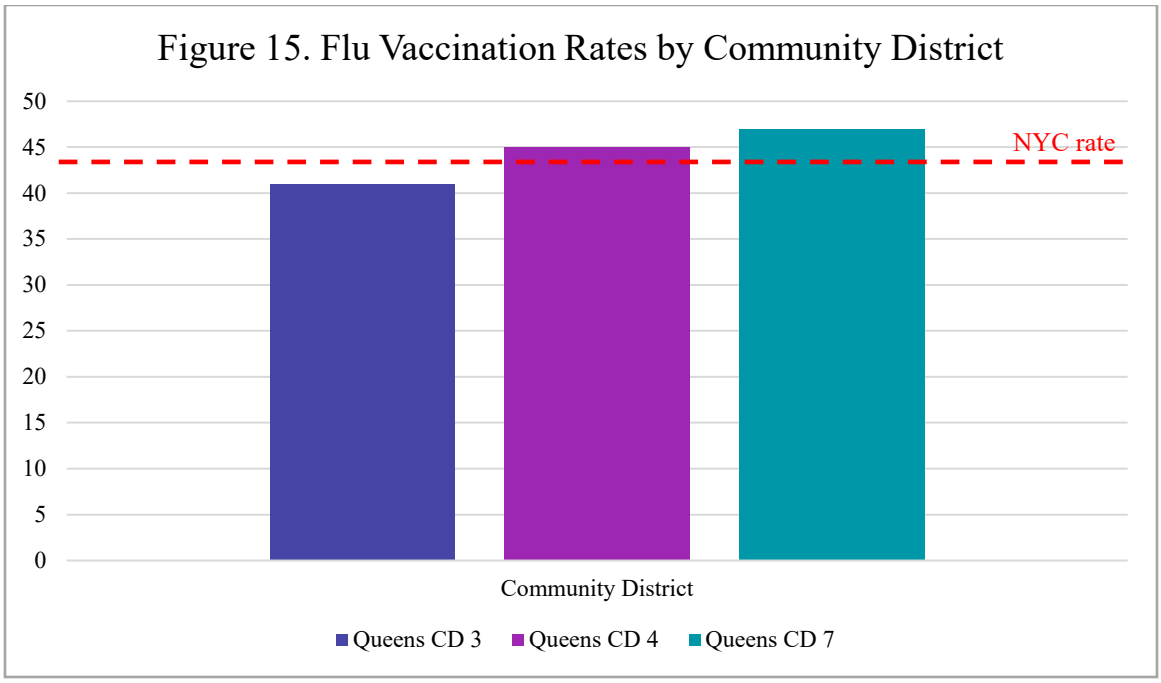
Receiving full vaccination against COVID-19 can dramatically reduce the risk of infection, hospitalization, and death. Throughout the PSA, almost all (>99.9%) residents are fully vaccinated.[26]

XI. Vaccinations

To illustrate vaccination rates in FHMC's service area, the human papillomavirus (HPV) vaccine, which protects against cancers caused by HPV, and the flu vaccine are referenced. Across NYC, an estimated 59% of teens ages 13 to 17 have received all recommended doses of the HPV vaccine. Within Queens CD 3 and Queens CD 4, HPV vaccination rates far exceed those of NYC, ranging from 75% to 81%. Queens CD 7 has the lowest HPV vaccination rate in FHMC's PSA, with just 54% of teens ages 13 to 17 having received all recommended doses of the vaccine.

Annual flu vaccination rates in the PSA vary by Community District, but largely resemble the city-wide rate of 43%.

[23] Ibid.
[24] Ibid.
[25] Ibid.
[26] Ibid.



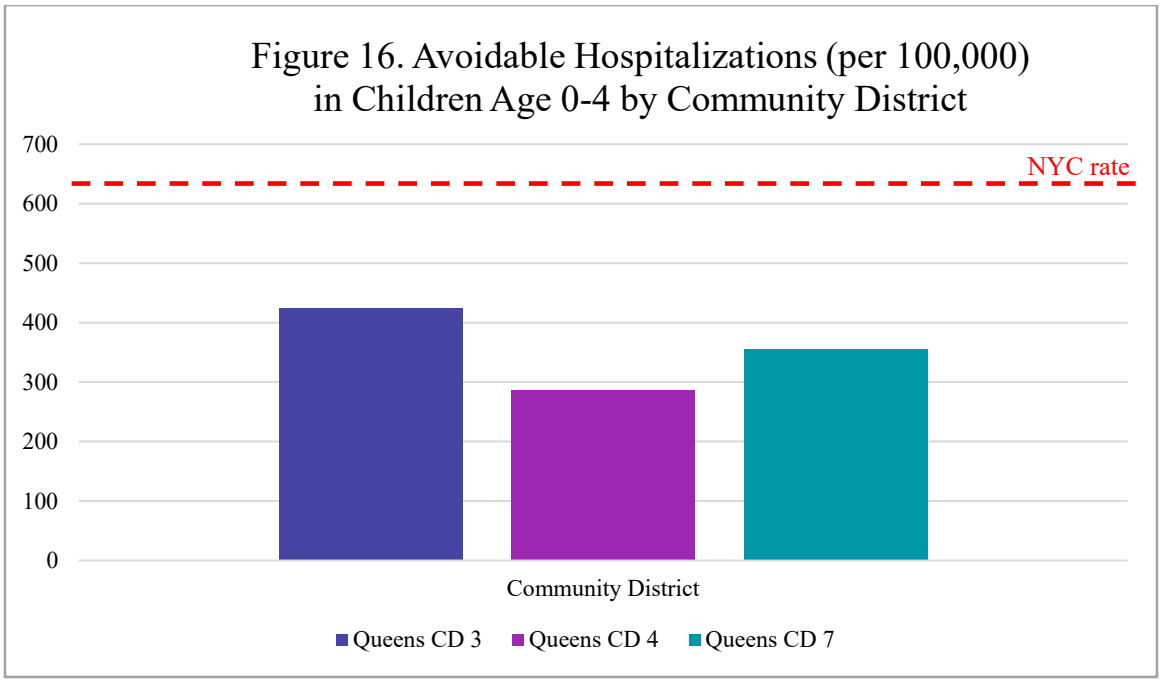
XII. Child Health

Several indicators are used here to illustrate the state of children's health in FHMC's PSA: obesity and asthma rates, avoidable hospitalizations, and the infant mortality rate. In NYC, 20% of public school children in grades K-8 are classified as obese. The childhood obesity rates in Queens CD 3 and Queens CD 4 are slightly higher than the city-wide rates, with 26% of Queens CD 3 children and 24% of Queens CD 4 children experiencing obesity. However, the childhood obesity rate in Queens CD 7 (15%) is the lowest in the PSA and 25% lower than the city-wide rate.

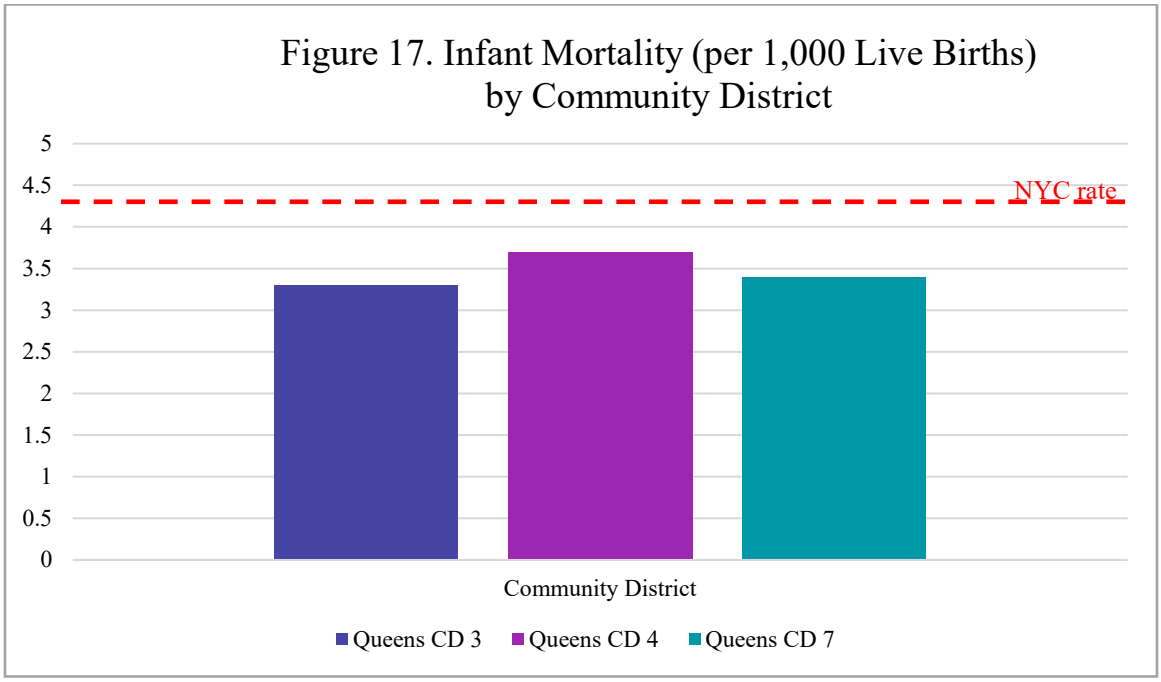
The current childhood asthma rate in Queens County is 4.4%, lower than the city-wide prevalence rate of 7.0%.[27] The asthma hospitalization rate for children ages 0-17 is higher in NYC compared to NYS (30.8 cases per 1,000 children vs. 20.3 cases per 1,000 children)—the Queens County rate (20.7 cases per 1,000 children) resembles that of NYS.[28]

"Avoidable hospitalizations" are hospital visits that could have been prevented with timely access to outpatient preventive care. Among children ages 4 and under, all CDs in the PSA have lower avoidable hospitalization rates than the rates for NYC (623 per 100,000) and Queens (461 per 100,000).

[27] NYC Child Health Data, 2015.
[28] New York State Community Health Indicator Reports, NYS Department of Health, 2021.



Finally, the city-wide infant mortality rate, defined as the number of deaths in the first year of life per live births in the course of a year, is 4.3 deaths per 1,000 live births.[29] While the infant mortality rate in the PSA varies slightly by Community District, Queens CD 3, Queens CD 4, and Queens CD 7 all have more favorable rates than NYC.[30]

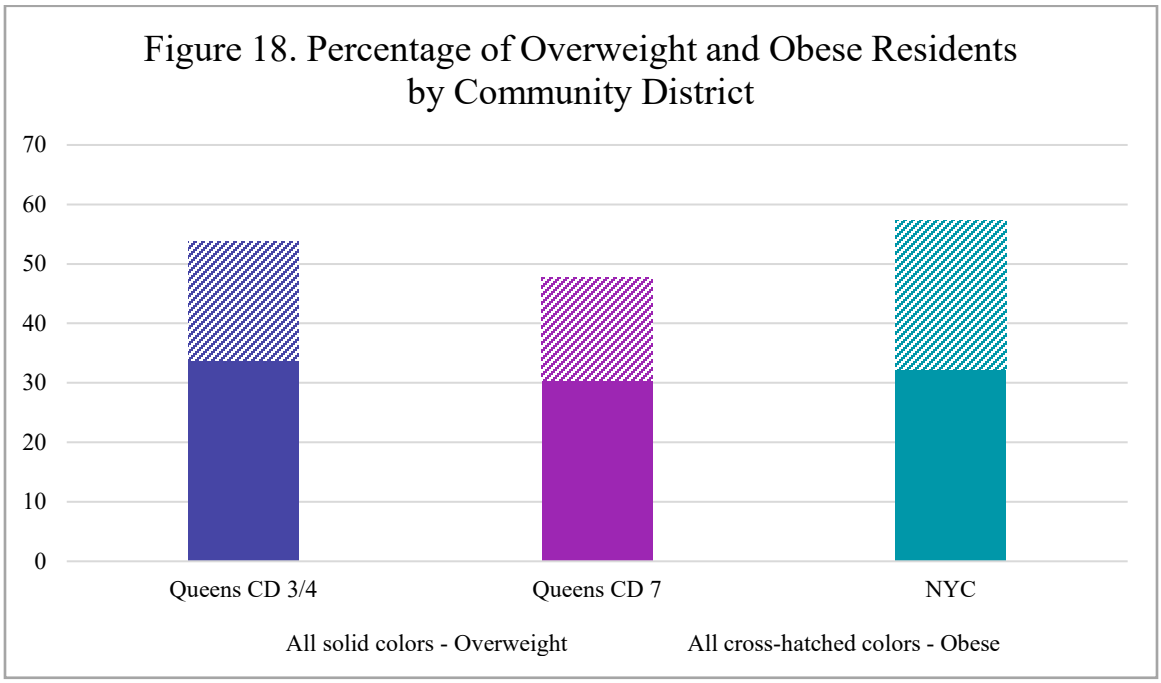


[29] Infant Mortality, NYC Health, 2017.
[30] Ibid.

XIII. Adult Obesity

Individuals with a Body Mass Index (BMI) between 25.0 and 29.9 are classified as overweight but not obese—in NYC, 32.2% of adults fall into this weight category.[31] The percentages of overweight but not obese residents in FHMC's PSA vary, ranging from below the city-wide rate in Queens CD 7 (30.4%) to slightly above the city-wide rate in the area encompassing Queens CD 3 and Queens CD 4 (33.7%).[32]

Individuals with a BMI of 30.0 or greater are classified as obese—in NYC, 25.2% of residents fall into this category.[33] The adult obesity rate in the PSA is consistently lower than that of the city, ranging from 17.4% to 20.0%.[34]



XIV. Physical Activity

In the PSA, the percentage of residents who have engaged in physical activity in the past 30 days is slightly lower than the estimate for NYC (73%). Seventy-two percent of Queens CD 3 residents, 69% percent of Queens CD 4 residents, and 69% of Queens CD 7 residents report exercising in the past 30 days.

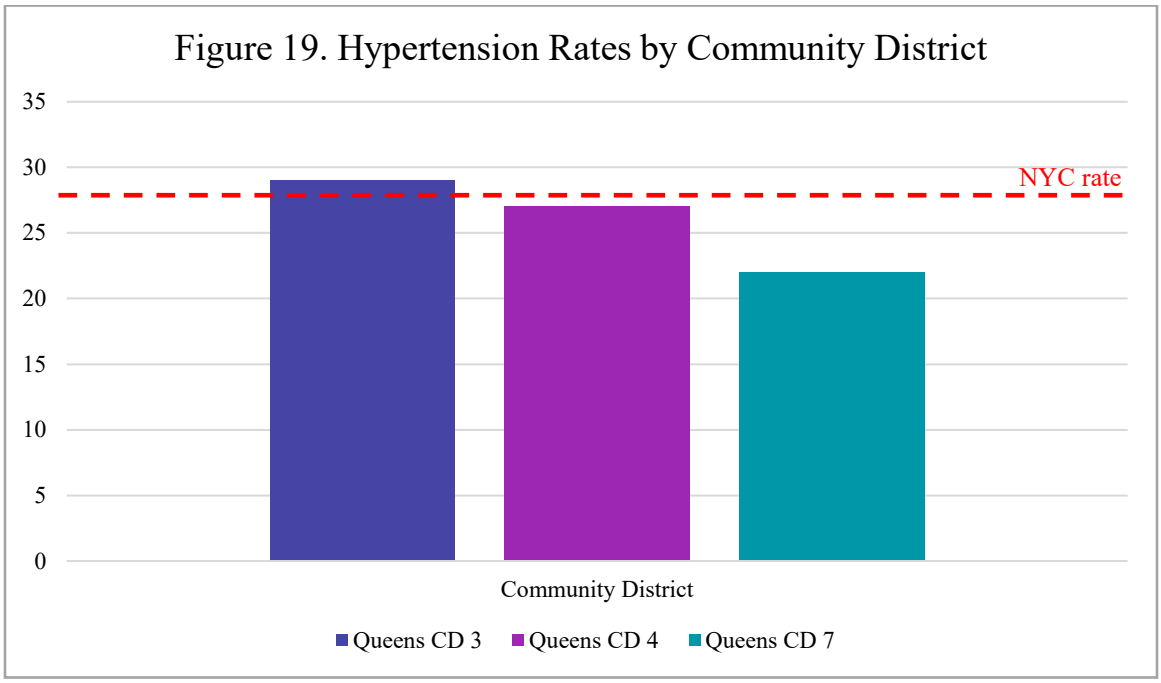
XV. Chronic Disease

According to the Centers for Disease Control and Prevention (CDC), chronic diseases are conditions that last one year or more, require ongoing medical attention and/or limit a person's activities of daily living (e.g., heart disease, cancer, stroke, diabetes, chronic lung disease, etc.).[35]

[31] New York City Community Health Survey, DOHMH, 2017.
[32] Ibid.
[33] Ibid.
[34] Ibid.
[35] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion: About Chronic Diseases.

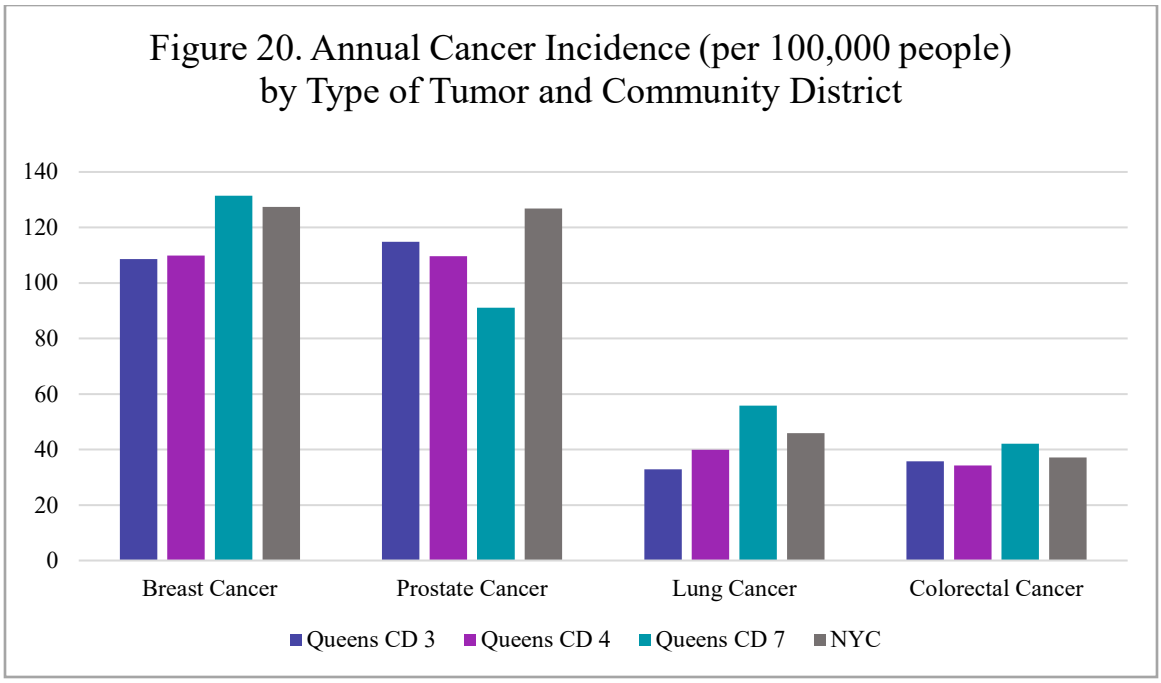
Sixty percent (60%) of adults in the United States has a chronic disease, and four in 10 adults have two or more.[36]

The adult diabetes rates in Queens CD 3 (13%) and Queens CD 4 (14%) are greater than that of NYC (11%). In Queens CD 7, however, 8% of residents have diabetes, making the CD-specific rate for that area 27% lower than the city-wide rate. In Queens CD 3 and Queens CD 4, hypertension rates resemble that of NYC. However, Queens CD 7's hypertension rate of 22% is the lowest in the PSA and 21% lower than that of NYC.



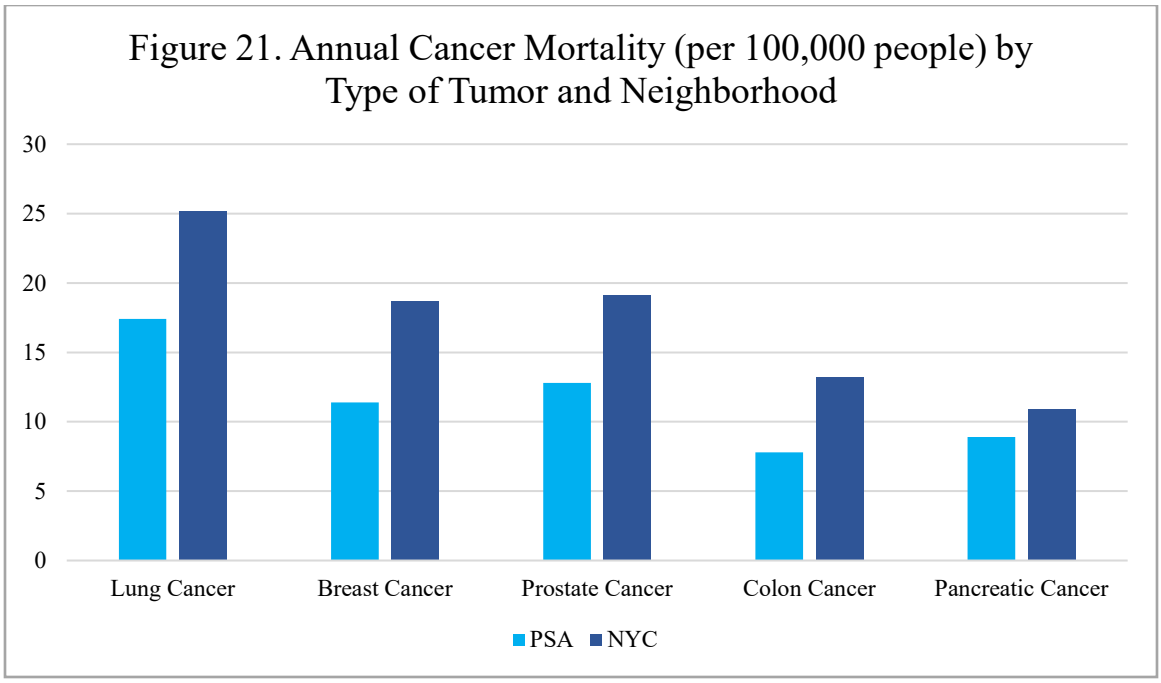
The average annual case rate for cancer in any form in NYC is 443.9 cases per 100,000 people—the borough-specific value for Queens is 425.0 cases per 100,000 people.[37] The most common types of cancer in NYC are breast cancer (127.4 cases per 100,000 person-years), prostate cancer (126.8 cases per 100,000 person-years), lung and bronchus cancer (45.9 cases per 100,000 person-years), and colorectal cancer (37.1 cases per 100,000 person-years).[38] The overall cancer rates in Queens CD 3 and Queens CD 4 (393.6 cases per 100,000 person-years and 403.3 cases per 100,000 person-years, respectively) are lower than those of Queens and NYC, while Queens CD 7's rate (447.7 cases per 100,000 person-years) is slightly greater than that of NYC.[39] The graph below illustrates annual incidence rates for specific types of cancer in the PSA.[40]

[36] Ibid.
[37] New York State Cancer Registry 2015-2019, New York State Department of Health, 2021.
[38] Ibid.
[39] Ibid.
[40] Ibid.



The most significant diagnoses contributing to cancer-related death in NYC are as follows: lung cancer (25.2 deaths per 100,000 population), prostate cancer (19.1 deaths per 100,000 population), breast cancer (18.7 deaths per 100,000 population), colon cancer (13.2 deaths per 100,000 population), and pancreatic cancer (10.9 deaths per 100,000 population).[41] Across FHMC's PSA the death rates attributable to lung, prostate, breast, colon, and pancreatic cancer are lower than those of NYC.[42]

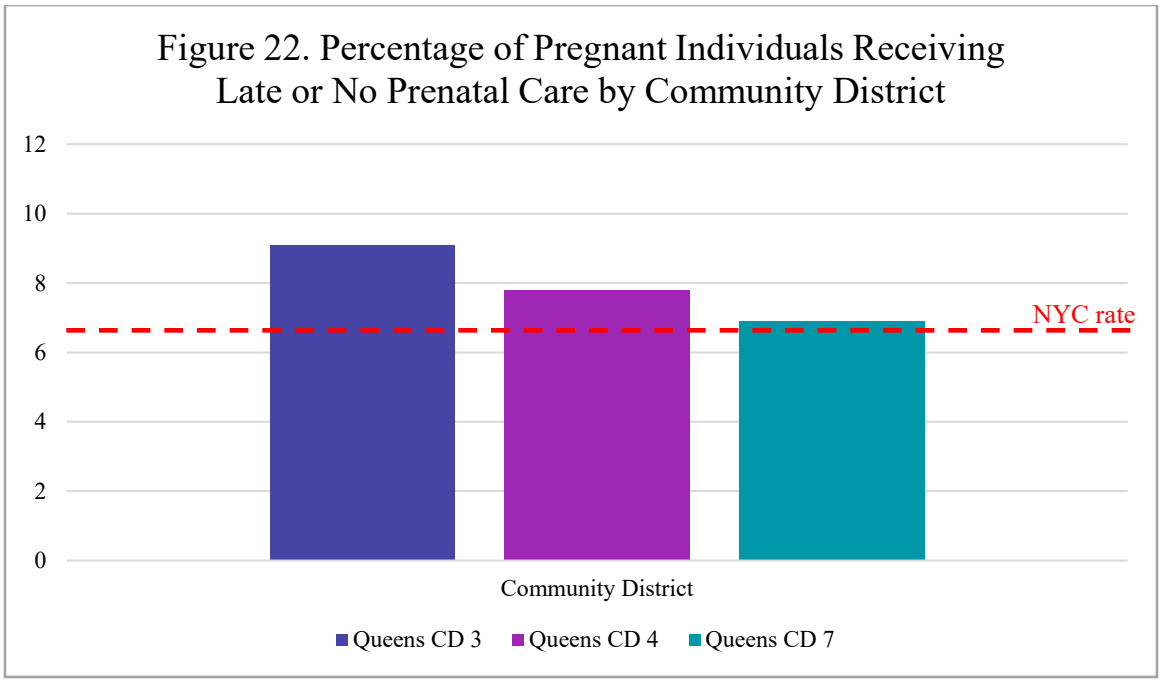
[41] Mortality, NYC Health, 2017.
[42] Ibid.



XVI. Prenatal Care

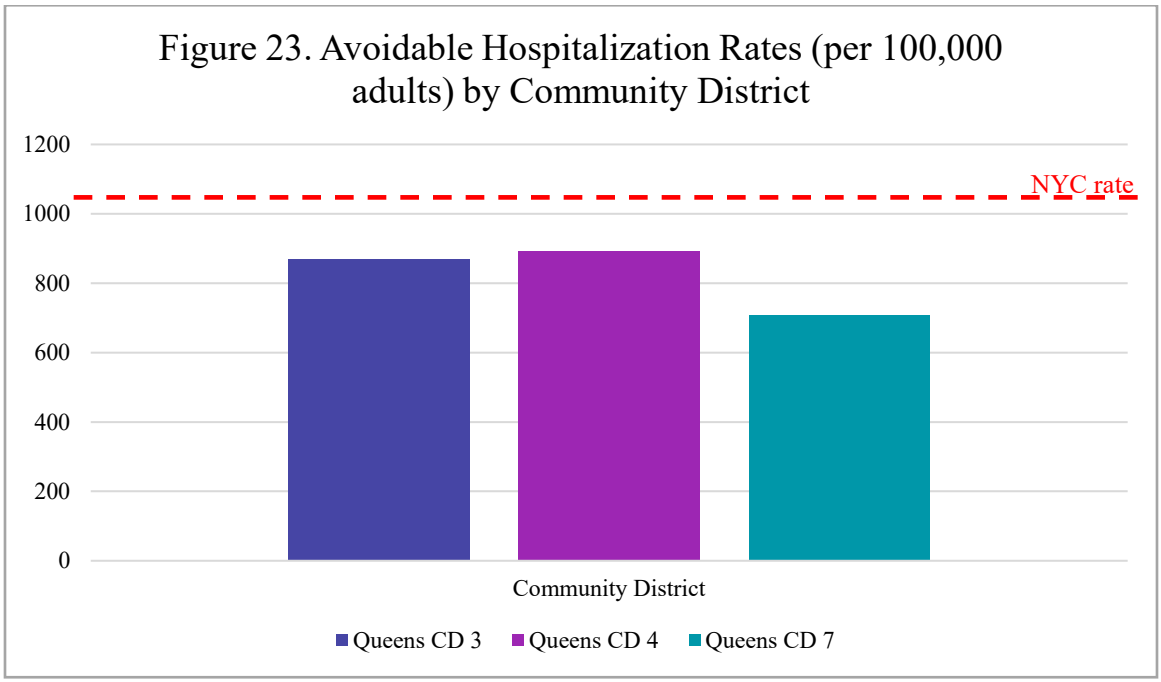
In Queens CD 7, the percentage of pregnant individuals receiving late or no prenatal care (6.9%) is lower than that of Queens (7.9%) but higher than that of NYC (6.7%)—the same is true of Queens CD 4, where 7.8% of pregnant residents received late or no prenatal care. In Queens CD 3, 9.1% of pregnant residents receive late or no prenatal care, making this estimate higher than both the NYC and Queens rates and the highest in the PSA. In NYC, 13% of Black women, 7% of Hispanic, and 5% of Asian women received late or no prenatal care compared to 3.1% of White women.[43]

[43] Keeping Track Online: Citizen's Committee for Children. https://data.cccnewyork.org/data/table/47/late-or-no-prenatal-care#1271/1470/22/a/a



XVII. Avoidable Hospitalizations

The rate of avoidable hospitalizations (hospital visits that could have been prevented with timely access to outpatient preventive care) among adults in the PSA is favorable when compared to that of NYC. However, the Queens CD 3 and Queens CD 4 adult avoidable hospitalization rates are still more than double the lowest CD-specific estimate in NYC (426 per 100,000 adults).



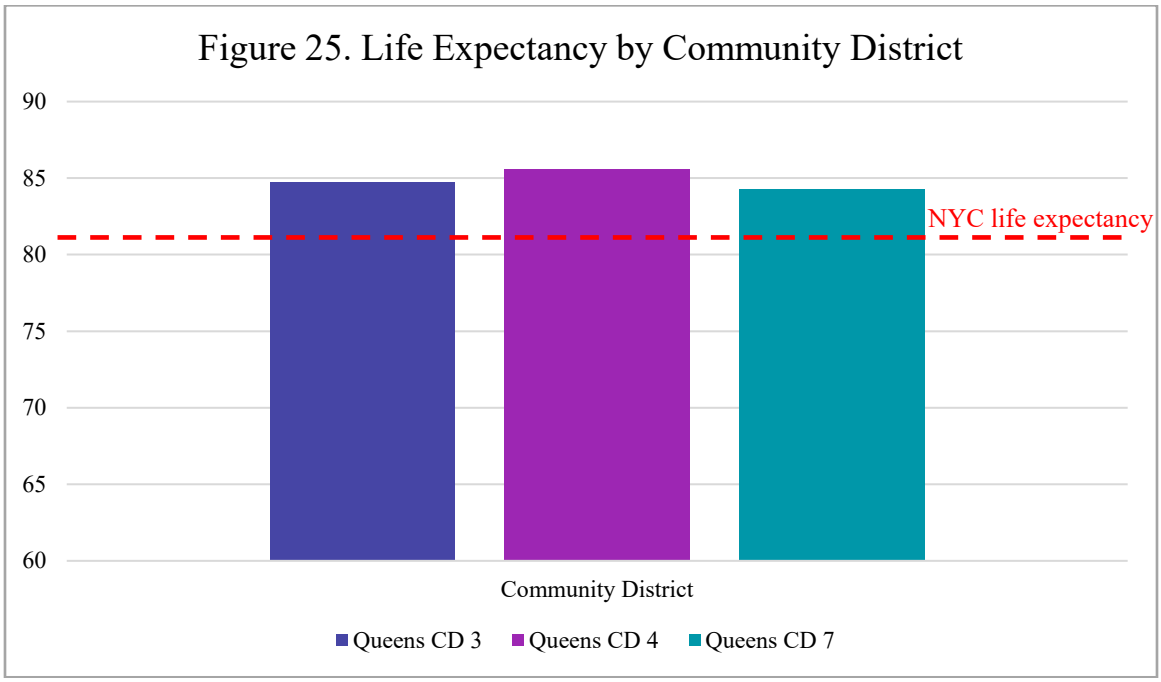
XVIII. Premature Death

The premature death rates in Queens CD 3 (120.9 deaths per 100,000 people), Queens CD 4 (105.2 deaths per 100,000 people), and Queens CD 7 (115.0 deaths per 100,000 people) are lower than the city-wide rate (169.5 deaths per 100,000 people). The leading causes of cancer-related premature deaths in the PSA are lung cancer, breast cancer (among women), and prostate cancer (among men). Other leading causes of premature death in the PSA include heart disease, suicide, accidents, drug-related deaths, and diabetes mellitus.

Figure 24. Leading Causes of Premature Death (per 100,000 people) by Community District

Rank	Queens CD 3	Queens CD 4	Queens CD 7
1	Cancer 35.7	Cancer 34.6	Cancer 38.2
2	Heart disease 21.1	Heart disease 16.3	Heart disease 21.5
3	Accidents 8.5	Accidents 5.3	Suicide 6.7
4	Suicide 4.4	Suicide 4.4	Drug-related 5.9
5	Drug-related 4.3	Diabetes 3.0	Accidents 4.4

As of 2019, NYC's life expectancy at birth is 81.3 years.[44] The life expectancies in FHMC's PSA exceed the city-wide estimate—ranging from 84.3 years (Queens CD 7) to 85.6 years (Queens CD 4).

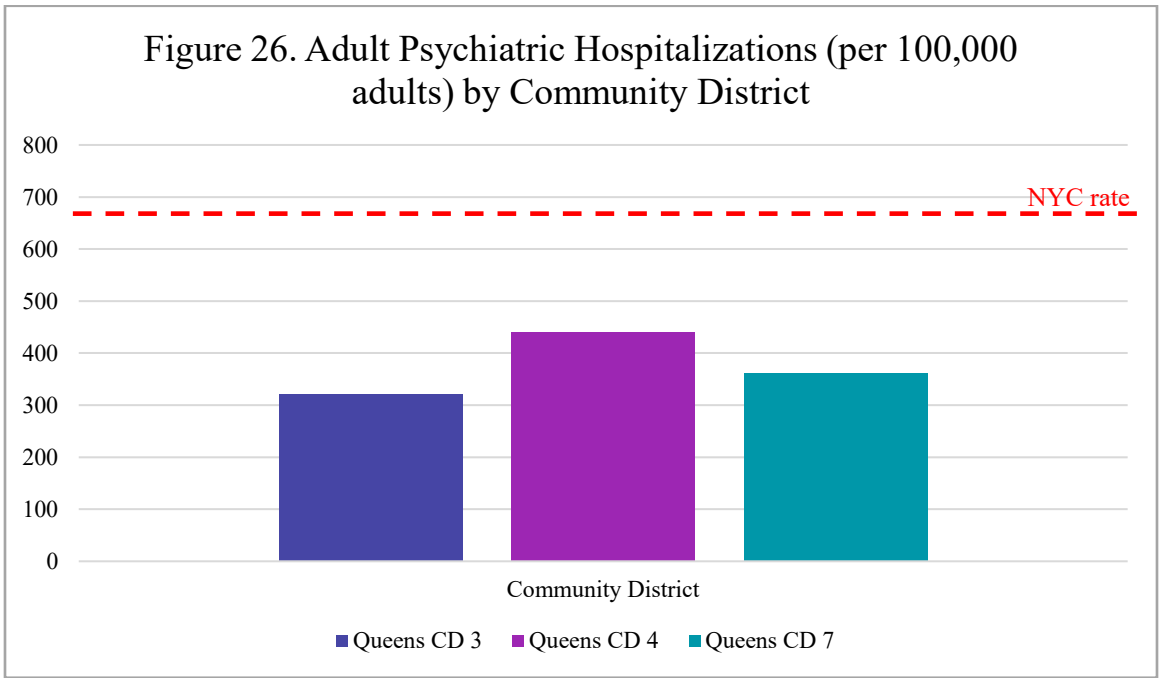


[44] New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics, 2019.

XIX. Mental Health

The prevalence of depression in the area encompassing Queens CD 3 and Queens CD 4 is 3.9%, an estimate 58% lower than that of NYC (9.3%).[45] Queens CD 7 exhibits a higher depression rate (8.8%), but still compares favorably against the city-wide estimate.[46]

Throughout the PSA, adult psychiatric hospitalization rates are lower than the city-wide rate of 676 hospitalizations per 100,000 adults and the Queens-specific rate of 513 hospitalizations per 100,000 adults. Queens CD 4 has the highest adult psychiatric hospitalization rate in the PSA with an estimate almost double that of the most favorable CD-specific rate in NYC (223 hospitalizations per 100,000 adults).



[45] New York City Community Health Survey, DOHMH, 2017.
[46] Ibid.

Top Two Focus Areas from the NYS Prevention Agenda

The overarching strategy of New York State's (NYS) Prevention Agenda is to improve the health and well-being of all New Yorkers and promote health equity in populations who experience disparities. This strategy includes an emphasis on social determinants of health–defined by Healthy People 2030 as the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. The NYS Prevention Agenda comprises or includes five Priority Areas, each with coordinating Focus Areas and Goals:

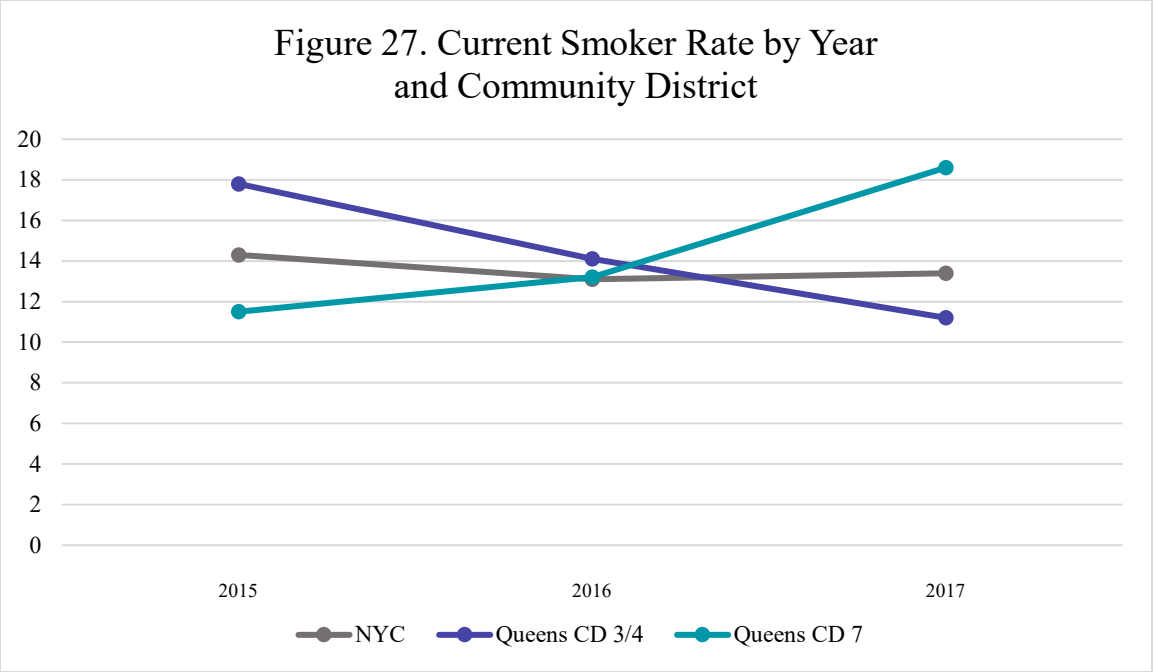
1. Priority Area 1. PREVENT CHRONIC DISEASES
2. Priority Area 2. PROMOTE A HEALTHY AND SAFE ENVIRONMENT
3. Priority Area 3. PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN
4. Priority Area 4. PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS
5. Priority Area 5. PREVENT COMMUNICABLE DISEASES

Based on results collected from its Community Health Survey, health status data in this report, and the Hospital's capabilities and resources, Flushing Hospital Medical Center (FHMC) has identified two NYS Prevention Agenda Focus Areas (corresponding to NYS Prevention Agenda Priority Areas 1 and 3) to address as a part of its 2022-2024 Community Service Plan: Tobacco Prevention and Perinatal and Infant Health. All NYS Prevention Agenda Priority Areas in FHMC's service area are affected by a myriad of social determinants of health. This recognition supports the view that health is "not simply about individual behavior or exposure to risk, but how the social and economic structure of a population shapes its health".[47]

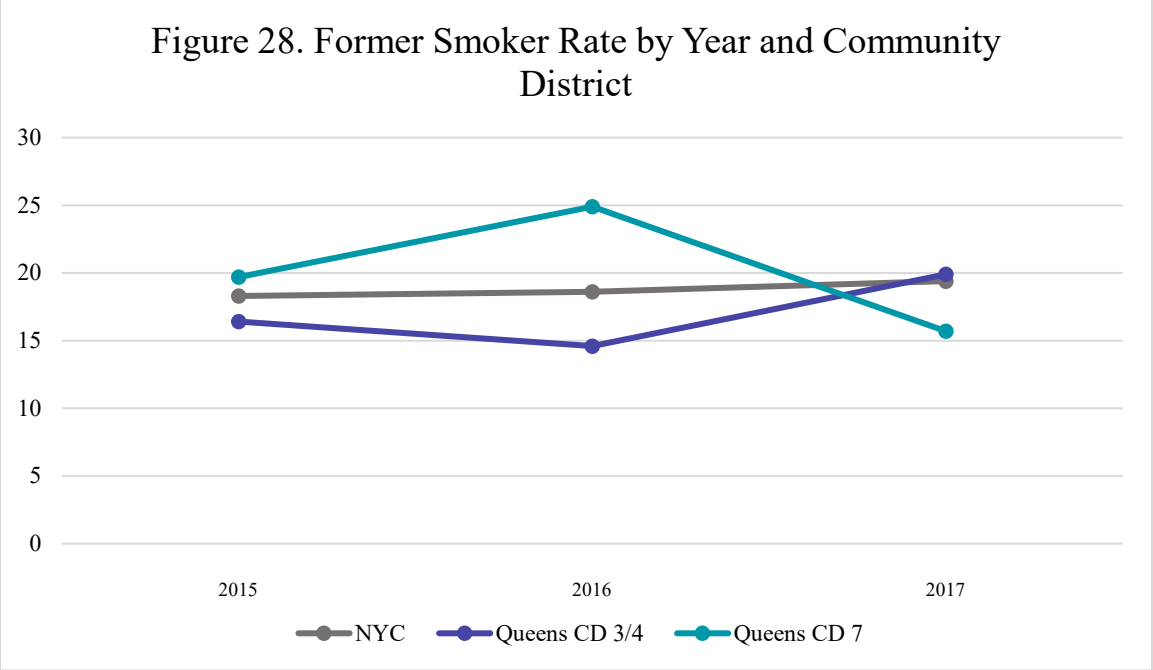
◆ Priority Area 1. PREVENT CHRONIC DISEASES.
Focus Area 3. Tobacco Prevention
Goal 3.2. Promote tobacco use cessation

Current Smokers. Smoking is known to cause a number of chronic and life-threatening health conditions, including several types of cancer, lung disease, heart disease, and chronic obstructive pulmonary disease (COPD).[48] In addition, exposure to tobacco smoke during pregnancy is a risk factor for poor infant health outcomes, including pre-term birth, birth defects, and sudden infant death syndrome (SIDS).[49] The proportion of current smokers in FHMC's PSA over time varies by community district (CD), as seen in Figure 27. Between 2015-2017, current smoker rates for Queens CD 3, 4, and 7 have shifted considerably.[50] In Queens CD 3 and Queens CD 4, the current smoker rate dropped over the three-year period displayed in Figure 27, while in Queens CD 7 the current smoker rate has increased and the city-wide rate has remained constant.[51]

[47] Social Determinants of Health, 2nd edition. Edited by Michael Marmot and Richard G. Wilkinson. Oxford University Press, 2006.
[48] Centers for Disease Control and Prevention, 2022.
[49] Ibid.
[50] New York City Community Health Survey, DOHMH, 2015-2017.
[51] Ibid.

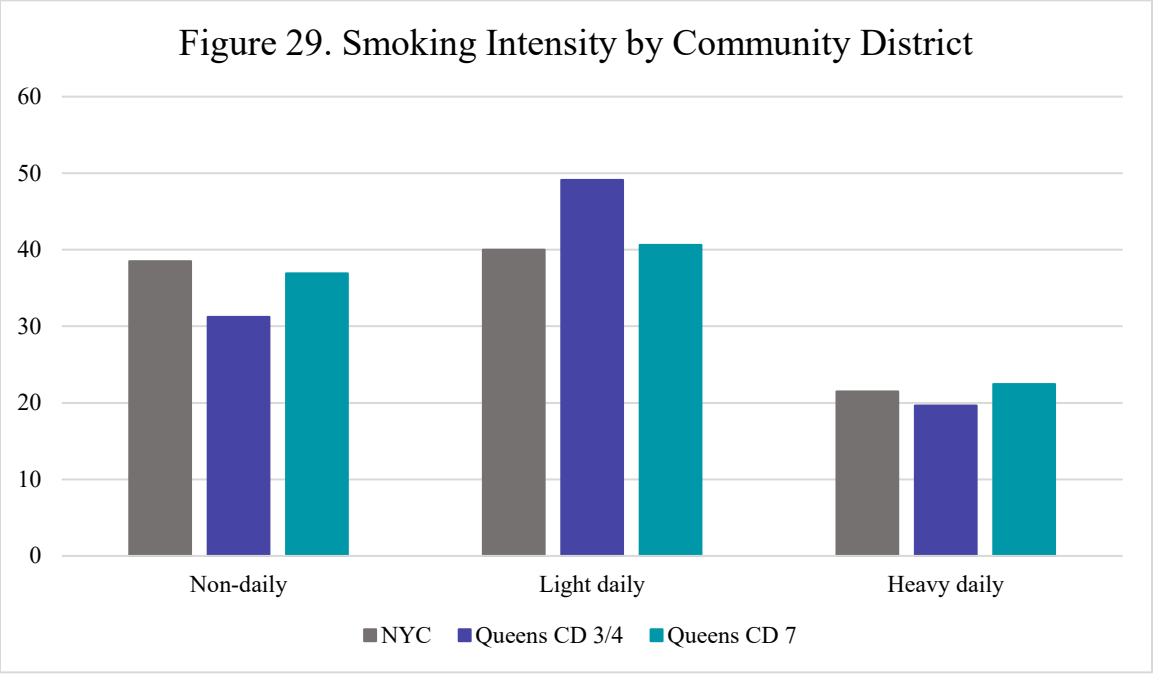


Former Smokers. The former smoking rate of a neighborhood is a strong indicator of the effectiveness of local smoking cessation efforts. In NYC and in Queens CD 3 and 4, the former smoking rate increased between 2015-2017 (Figure 28). However, Queens CD 7's former smoking rate has fluctuated in recent years.[52]



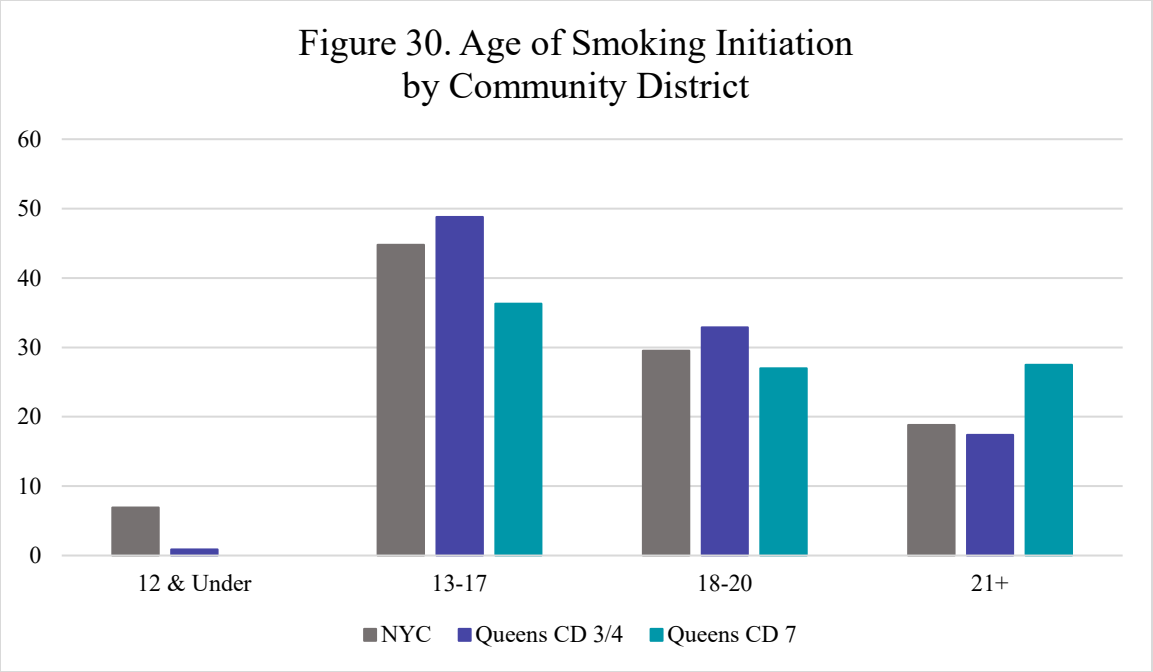
[52] New York City Community Health Survey, DOHMH, 2016.

Smoking Intensity. The vast majority of smokers in FHMC's PSA and NYC generally are either non-daily or light daily cigarette consumers, as seen in Figure 29.



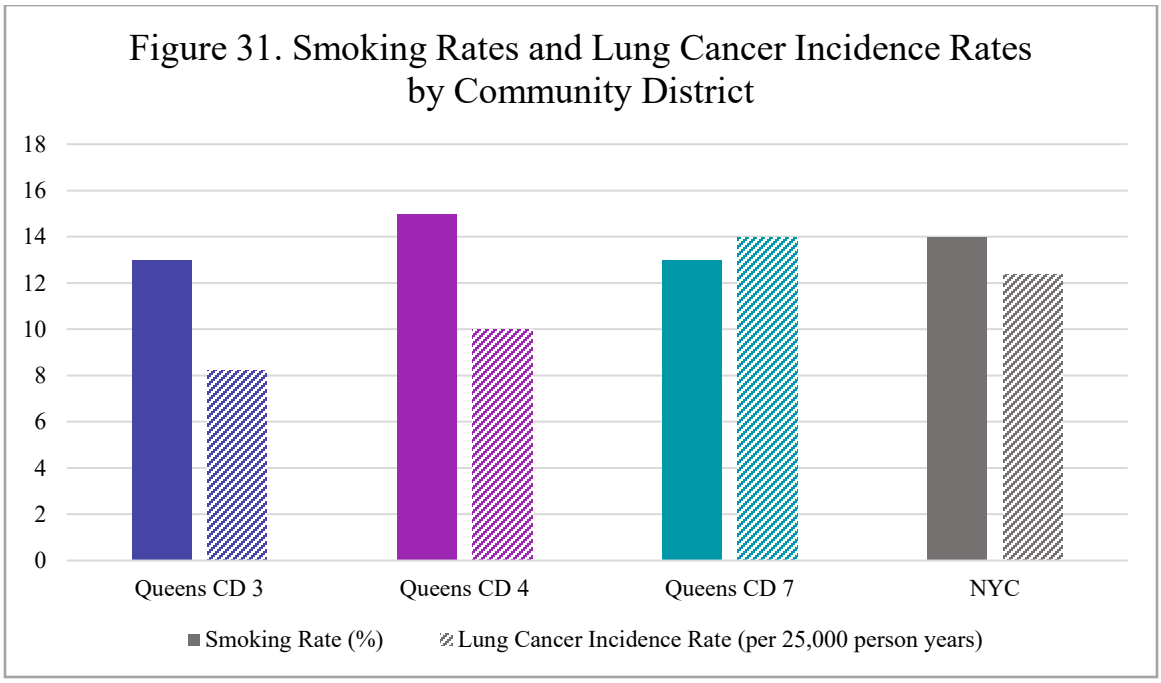
Age of Smoking Initiation. The percentage of smokers in FHMC's PSA who started smoking at age 12 or younger is negligible with almost all smokers in the PSA initiating at age 13 or older.[53] Since the vast majority of smokers in FHMC's PSA began smoking in adolescence, as displayed in Figure 30, it is evident that current smoking prevention efforts may be most impactful if broadly targeted to young adolescent populations.

[53] Ibid.



Smoking and Lung Cancer. Chronic smoking is highly associated with several life-threatening diseases including cancers of the lung, throat, esophagus, and larynx;[54] therefore, the incidence of lung cancers in a given region can serve as an indicator of smoking's impact on the community's long-term health. In NYC, lung cancer is the third most common cancer in the City.[55] The lung cancer incidence rates for Queens, and within most of FHMC's PSA, are slightly lower than the city-wide rate, though Queens CD 7's rate is slightly higher than that of NYC (Figure 31).[56] Lung cancer is still the leading cause of cancer mortality and the leading cause of premature death attributable to cancer in the PSA, and for NYC.[57] Almost 90% of all lung cancers are caused by smoking cigarettes.[58]

[54] Smoking and Tobacco Use, CDC, 2022.
[55] New York State Cancer Registry 2015-2019, New York State Department of Health, 2021.
[56] Ibid.
[57] Mortality, NYC Health, 2017.
[58] Ibid.



FHMC Tobacco Prevention Resources and Accomplishments:

- FHMC maintains the standards for Gold Star Recognition from the NYC Tobacco-Free Hospitals campaign for its tobacco cessation work with patients and employees.
- Physicians conduct a mandatory 5-question assessment of all patients to screen for tobacco usage and gauge readiness to quit. In 2021, the Hospital assessed 89% of inpatients and 71% of outpatients; 20% of outpatient smokers and 65% of inpatient smokers received cessation interventions. The low intervention rates were due to pressures on staffing from COVID-19.
- FHMC's Patient Navigators are trained to conduct group counseling in the "Freedom from Smoking" (FFS) program by the American Lung Association. Classes are being conducted virtually at this time.
- The Hospital's electronic health record (EHR) system uses smoking cessation counseling prompts to make electronic referrals directly to virtual quit sessions by the Hospital's or affiliated JHMC's FFS facilitators, as well as the New York State Quit Line, and to give all smokers educational literature about quitting.
- The Hospital is creating a Lung Cancer Screening program using low dose computed tomography scanning (LDCT) to detect lung cancer in former smokers who are identified and referred for LDCT and follow-up care due to their age and their duration and intensity of smoking as identified during intake in the ambulatory care setting.
- FHMC, as part of the MediSys Health Network, has announced the establishment of an enhanced cancer program in collaboration with Memorial Sloan Kettering (MSK) which will provide local, high-quality oncology services to the people of Queens. Every year, thousands of Queens residents are diagnosed with some form of cancer. Through the partnership with MSK, our culturally and ethnically diverse patient population will gain greater access to world-class care now and for generations to come.
- During the COVID-19 pandemic, in-person quit classes and outreach and educational events were canceled. Virtual classes are now offered by Hospital or affiliated JHMC staff.

Outreach and educational events including tobacco cessation are now taking place.

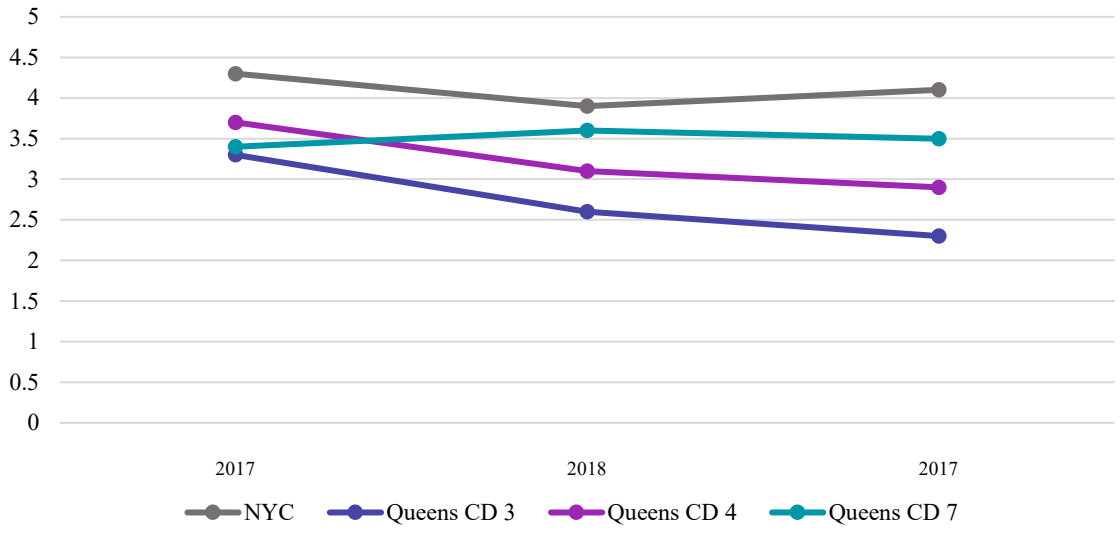
- In addition to the Hospital's community-based efforts and programming aimed at reducing tobacco use, there are other tobacco cessation programs in Queens, including affiliated Jamaica Hospital, New York Hospital Queens, H+H Queens and Elmhurst Hospitals, Charles B. Wang Community Health Center, Korean Community Services, and Queensborough Community Services.

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 offering educational 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) and also distributed to the community via the hospital's electronic community newsletter.

◆ Priority Area 3. PROMOTE HEALTHY WOMEN, INFANTS AND CHILDREN. Focus Area 2. Perinatal and Infant Health)
Goal 2.2. Increase breastfeeding

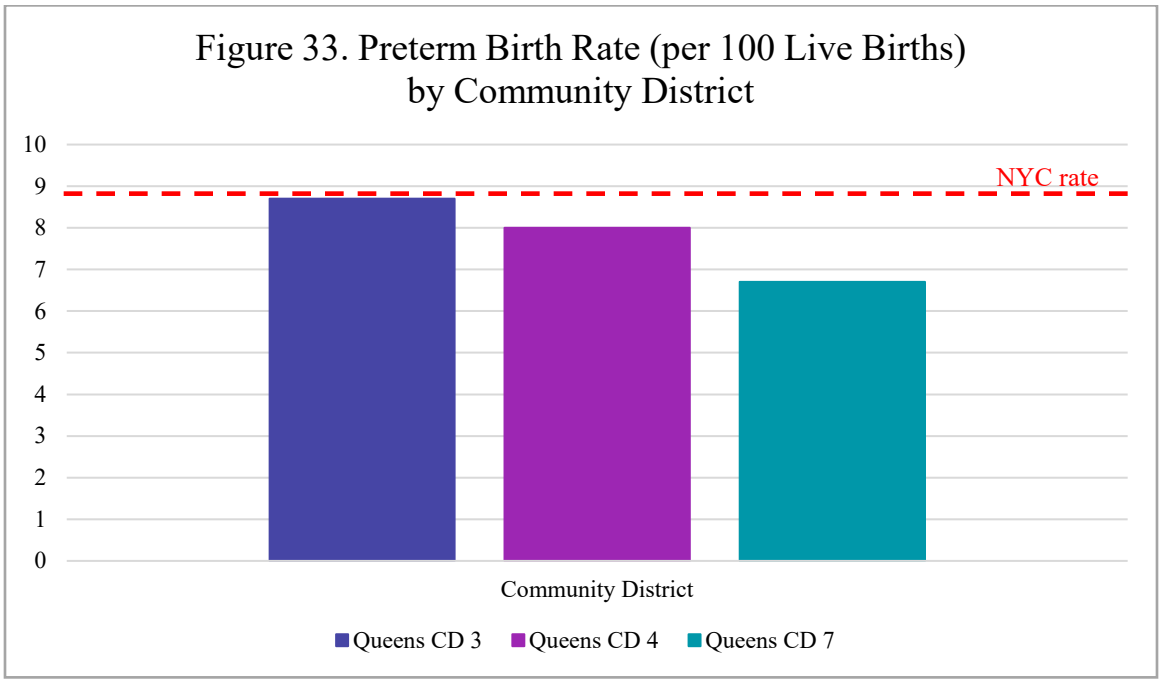
Infant Mortality Rate. The infant mortality rate (measured as deaths within the first year of life per 1,000 live births) varies by community district within the PSA. In all three Community Districts in FHMC's PSA, the infant mortality rate is consistently lower than that of NYC.[59] However, the rate in Queens CD 7 is increasing, while the other CDs in the PSA have decreasing rates and the NYC rate is fairly stable over time.[60] Figure 32 illustrates these patterns.

Figure 32. Infant Mortality Rate (per 1,000 Live Births) by Year and Community District



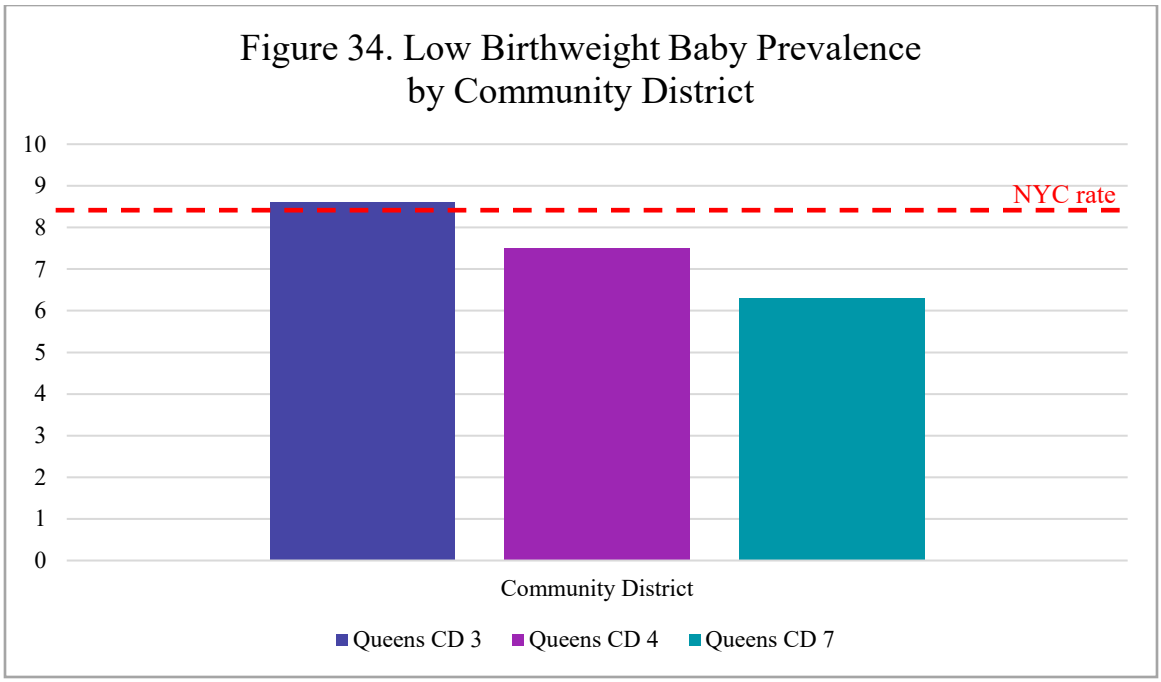
[59] Summary of Vital Statistics (2000-2019), NYC DOHMH, 2017-2019.
[60] Ibid.

Pre-term Birth Rates. A live birth that occurs before the 37th week of pregnancy is considered preterm. Preterm birth is associated with elevated risk of infant mortality, as well as numerous poor long-term physical and neurodevelopmental health outcomes.[61] While high pre-term birth rates could signify the need for more comprehensive prenatal services, all Community Districts in the PSA have lower preterm birthrates than NYC (Figure 33).[62] FHMC continues to strive for providing exemplary perinatal care (including comprehensive prenatal services) for its service area.



Low Birthweight. Newborn infants who weigh under 2,500 grams at birth are considered low birthweight babies. Low birthweight is a risk factor for infant morbidity and mortality, as well as several non-communicable diseases throughout the life course.[63] The prevalence of low birthweight babies varies by Community District in FHMC's PSA, ranging from 6.3% in Queens CD 7 (25% lower than the city-wide prevalence) to 8.6% in Queens CD 3 (2% higher than the city-wide prevalence.[64]

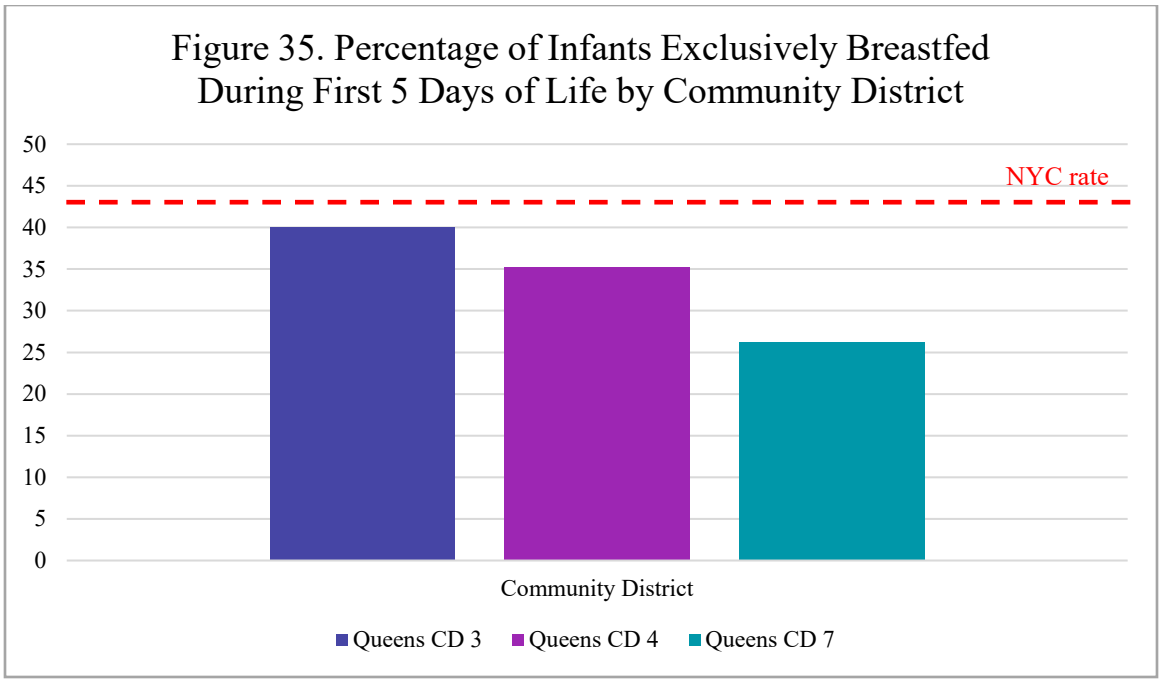
[61] Luu TM, Rehman Mian MO, Nuyt AM. Long-Term Impact of Preterm Birth: Neurodevelopmental and Physical Health Outcomes. *Clin Perinatol*. 2017;44(2):305-314. doi:10.1016/j.clp.2017.01.003
[62] Summary of Vital Statistics (2000-2019), NYC DOHMH, 2019.
[63] Agbozo F, Abubakari A, Der J, Jahn A. Prevalence of low birth weight, macrosomia and stillbirth and their relationship to associated maternal risk factors in Hohoe Municipality, Ghana. *Midwifery*. 2016;40:200-206. doi:10.1016/j.midw.2016.06.016
[64] Summary of Vital Statistics (2000-2019), NYC DOHMH, 2019.

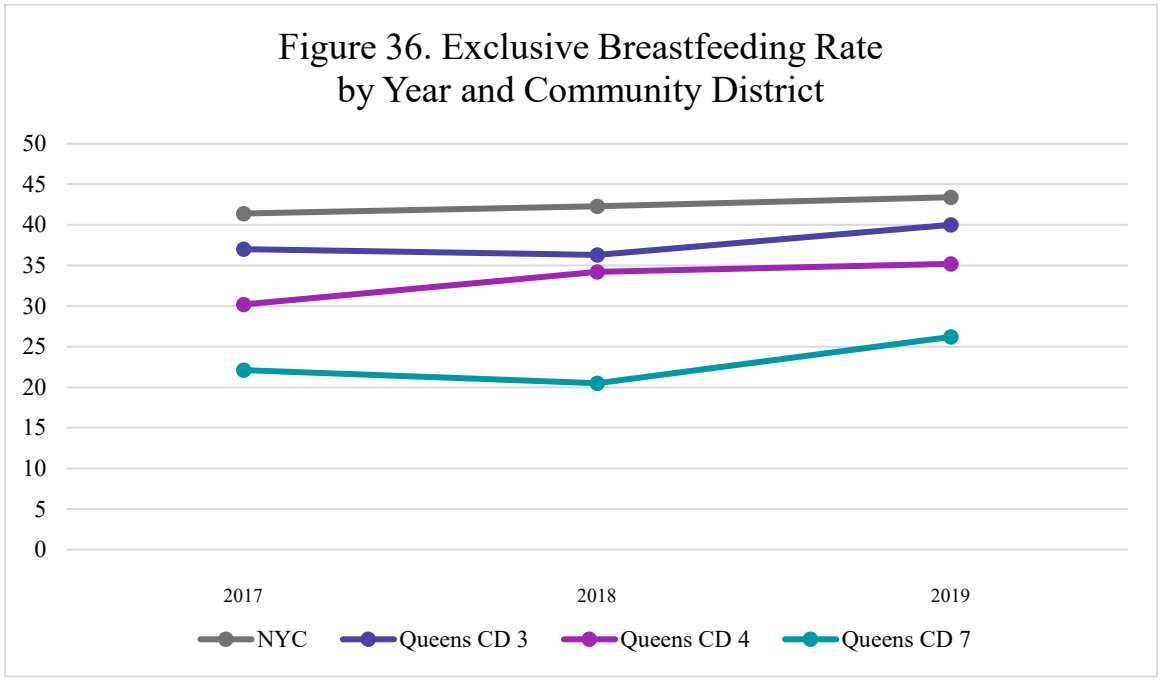


Breastfeeding Rates. Breastfeeding children during early life is associated with numerous health benefits for lactating parents and their infants, including reduced risk of asthma, obesity, Type 1 diabetes, and sudden infant death syndrome (SIDS), as well as prevention of infections, neurodevelopmental health benefits, and lowered risk of allergies.[65,66] FHMC, one of 595 Baby-Friendly USA designated hospitals, implements evidence-based practices shown to increase breastfeeding initiation (timely initiation is defined by the World Health Organization as putting the newborn to the breast within one hour of birth) and duration (the American Academy of Pediatrics recommends that infants are exclusively breastfed for the first 6 months after birth, and together with complementary foods for two years or longer).[67,68]

In NYC, the percentage of infants exclusively breastfed for the first five days of life has been gradually increasing over time, with 43.4% of newborn babies exclusively breastfed during the first 5 days of life in 2019.[69] Throughout the PSA, exclusive breastfeeding rates are lower than those of NYC, with slight improvements emerging over time.[70] Queens CD 7's exclusive breastfeeding rate is the 5th lowest in the city as of 2019, indicating an unmet need in FHMC's service area.[71]

[65] Breastfeeding, CDC, 2022.
[66] Shamir R. The Benefits of Breast Feeding. *Nestle Nutr Inst Workshop Ser*. 2016;86:67-76. doi:10.1159/000442724
[67] World Health Organization, UNICEF. Indicators for assessing infant and young child feeding practices.
[68] Meek, J and Noble, L. Technical Report: Breastfeeding and the Use of Human Milk. Pediatrics (2022) 150 (1): e2022057989.
[69] Summary of Vital Statistics (2000-2019), Bureau of Vital Statistics, DOHMH, 2019.
[70] Summary of Vital Statistics (2000-2019), NYC DOHMH, 2017-2019.
[71] Summary of Vital Statistics (2000-2019), NYC DOHMH, 2019.





FHMC Perinatal and Infant Health Resources and Accomplishments:

- FHMC recognizes that supporting breastfeeding is an important public health priority. The Hospital achieved a 15% exclusive breastfeeding rate at discharge in 2021.
- In July 2018, FHMC received and has since maintained the "Baby-Friendly USA" hospital designation, a global initiative launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). FHMC is proud to be one of hundreds of hospitals across the country to hold this designation, receiving accreditation through a

commitment to critical management procedures and key clinical practices highlighted in the Baby-Friendly Hospital Initiative's guidelines, Ten Steps to Successful Breastfeeding.

- FHMC's staff, including physicians, nurses, and certified lactation consultants offer frequent breastfeeding education and support to pre-natal, birthing, and post-partum patients.
- All Pediatric, Obstetric, and Family Medicine providers and nursing staff at FHMC complete the recommended breastfeeding training annually.
- 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 has operated a neonatal intensive care unit (NICU) for more than 10 years.
- The Women, Infants, and Children (WIC) program at the Hospital provides nutrition education, breastfeeding support, referrals, and a variety of nutritious foods to low-income pregnant, breastfeeding, or postpartum people, infants, and children up to age five to promote and support good health. Since the COVID-19 pandemic began, NYS has required all WIC programs to operate virtually, with the exception of select visits for hands on breastfeeding education and support and nutrition education by appointment. Virtual breastfeeding education classes will launch soon.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos about all aspects of pregnancy, delivery, and infant care, including topics such as nutrition, breastfeeding, neonatal intensive care, and child and adolescent health. This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube), and is also distributed to the community via the hospital's electronic community newsletter.

Additional Focus Areas from the NYS Prevention Agenda

The Hospital has chosen to devote special attention to two Goals within the Focus areas outlined above—Promote tobacco use cessation and Increase breastfeeding—based on review of its capabilities and resources, the needs of the community, and the potential of these programs to improve the health of its community. Senior management has devoted special attention and made available significant resources to achieve these two Goals.

The remainder of the NYS Prevention Agenda's Priority and Focus Areas are significant to the experiences of individuals throughout the Hospital's service area and the Hospital has many programs to address these health problems, at least in part. However, these Priority and Focus Areas are not featured in the Hospital's 2022-2024 Community Service Plan/Implementation Plan with objectives and interventions that will be tracked and updated over this three-year plan cycle. Brief descriptions of the remaining NYS Priority and Focus Areas are presented to highlight those experiences and some initiatives which address them. Additional Figures illustrating relevant statistics for these remaining Priority and Focus Areas can be viewed in Appendix A.

◆ Priority Area 1. PREVENT CHRONIC DISEASES
Focus Area 1: Healthy Eating and Food Security
Focus Area 2: Physical Activity
Focus Area 4: Preventive Care and Management

Regular moderate exercise and good nutrition have numerous health benefits and are associated with lower risk of chronic disease across the lifespan. In the PSA, the proportion of individuals self-reporting moderate exercise in the past 30 days range from 69% to 72% of residents, slightly lower than the city-wide estimate of 73%. The proportion of residents consuming at least one 12-ounce sugary drink daily varies by Community District (16-25% in the PSA vs. 23% in NYC), as does the proportion of residents consuming at least one serving of fruit or vegetables daily in the PSA (86-95% in the PSA vs. 87% in NYC). The proportion of individuals in FHMC's PSA lacking reliable access to food of their choice ranges from below the NYC estimate in Queens CD 7 (19.1%) to slightly above the city-wide value in Queens CD 3/4 (25.1%), and there are many more bodegas in the PSA compared to supermarkets (bodegas are typically smaller in size that supermarkets, with less healthy food options).

Consistent access to a personal doctor is a strong indicator of access to and utilization of preventive healthcare services in a community and can support the prevention or early detection of chronic diseases. In NYC generally, the proportion of residents with a personal doctor has remained constant in recent years, while the proportion of Queens CD 3 and Queens CD 4 residents with a personal doctor is lower than that of the city but increasing over time.[72] Queens CD 7 has the most favorable rate in the PSA, with 91% of residents having a personal doctor as of 2017.[73]

[72] New York City Community Health Survey, DOHMH, 2015-2017.
[73] Ibid.

The proportion of residents forgoing needed medical care in FHMC's PSA is decreasing over time, while the NYC estimate has remained constant at approximately 10%.[74] Most encouragingly, the proportion of Queens CD 7 residents forgoing needed care has considerably decreased in recent years, dropping from 9% in 2015 to just 4% in 2017.[75]

Limited access to preventive care services can increase the risk of developing a number of chronic conditions, including several that pose a threat to long-term cardiovascular health. One such condition is hypertension, also known as high blood pressure, which is a leading risk factor for cardiovascular disease and stroke. While the prevalence of hypertension in Queens CD 7 is lower than that of NYC, the remaining CDs in FHMC's PSA have comparable hypertension prevalence to the city-wide rate, signifying a need for additional preventive care resources and services as well as social service supports to aid patients in following their treatment and self-care regimens.

Another major consequence of poor access to preventive care and the negative effects of the Social Determinants of Health is avoidable hospitalizations—hospital stays that might have been prevented if the patient had reliable access to primary care services. All CDs in FHMC's PSA have lower adult avoidable hospitalization rates than the NYC rate; however, there is still work to be done to improve .utilization of preventive care services and consistent adherence to treatment regimens. Queens CDs 3, 4, and 7 adult avoidable hospitalization rates range from 708 to 892 cases per 100,000 adults, compared to 1,028 cases per 100,000 adults in Queens and 1,033 cases per 100,000 adults city-wide.

FHMC Chronic Disease Prevention 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 lead free National Diabetes Prevention Program (NDPP) classes to help people with pre-diabetes to manage their health, develop healthy eating habits and reach weight management goals. The Registered Dietitians at Flushing Hospital offer 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 weight reduction procedures at Flushing Hospital's Bariatric Surgical Service, which has been designated as a Center of Excellence.
- Monthly nutrition lectures are offered to community members in settings such as nursing facilities and religious organizations.
- FHMC continues to adhere to the standards of the NYC Department of Health and Mental Hygiene's "Healthy Hospital Food Initiative" to create a healthier food environment through offering a range of healthy food 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

[74] Ibid.
[75] Ibid.

postpartum mothers to shed weight gained during pregnancy and potentially reduce the risk of pediatric obesity and other health problems for their children.

- The Hospital's Women, Infants, and Children (WIC) program provides clients with Farmers' Market Nutrition Program (FMNP) and WIC funds to assist them with shopping for healthy food at farmers markets and farm stands.
- Shape Up NYC Fitness Classes were offered at no cost to staff and community residents on the Hospital's campus, but were canceled by NYC at the onset of the COVID-19 pandemic and have not yet resumed.
- FHMC's on-site Ambulatory Care Center has achieved recognition by the National Center for Quality Assurance (NCQA) Patient-Centered Medical Home (NYS PCMH), which offers each patient their own primary care practitioner who provides evidence-based care, support, and encouragement with self-management.
- FHMC offers free cancer screenings and referrals to highly specialized cancer services programs for eligible patients through a partnership with the NYS Cancer Services Program funded by the NYS DOH. A dedicated navigator guides the patients through this process.
- FHMC operates a patient navigator program for colon cancer to increase show rates for free screenings and necessary follow-up, in partnership with the NYC DOHMH-funded Community Cares Project.
- For asthma management, primary care providers at FHMC provide asthma education, which is augmented by a Patient Navigator who provides educational materials and health coaching. Individualized Asthma Action Plans are integrated into the EHR and are available through the patient portal, facilitating 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 promoting the importance of physical activity and exercise in both adults and children, as well as information on healthy recipes, how to combat adult and childhood obesity as well as tips to manage diabetes. In addition, FHMC 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 colorectal cancers. This information is posted on all of the hospital's social media platforms (Facebook, Twitter, Instagram, YouTube), and is also distributed to the community via the hospital's electronic community newsletter.

◆ Priority Area 2. PROMOTE A HEALTHY AND SAFE ENVIRONMENT
Focus Area 1: Injuries, Violence and Occupational Health
Focus Area 2: Outdoor Air Quality
Focus Area 3: Built and Indoor Environments
Focus Area 4: Water Quality
Focus Area 5: Food and Consumer Products

Neighborhood safety is an important social determinant of health—the non-fatal assault hospitalization rate is one indicator of the prevalence of violence in a Community District. Throughout FHMC's PSA, the non-fatal assault hospitalization rate is much lower than the city-

wide rate, ranging from 17 cases to 34 cases per 100,000 person-years compared to the city-wide rate of 59 cases per 100,000 person-years.

The conditions of a neighborhood's built environment, including rental home maintenance standards and outdoor pollution levels, can significantly impact the health and safety of the community. All CDs in the PSA have more favorable environmental indicators than NYC—while 44% of NYC rental homes are adequately maintained, the percentage of adequately maintained rental homes in the PSA ranges from 52% to 55%. The air pollution levels in the PSA are comparable to city-wide levels.

FHMC Healthy and Safe Environment Resources and Accomplishments:

- Flushing Hospital's Emergency Department provides around-the- clock care for all adult, pediatric, and OB/GYN emergencies and treated almost 35,000 patients in 2021. The Emergency Department is designated by the NYS DOH as a Primary Stroke Center within the 911 system.
- Adult trauma cases are referred to Level 1 Regional Trauma Centers in Queens, located at affiliated JHMC, at Elmhurst Hospital, and at New York-Presbyterian/Queens. Long Island Jewish Medical Center operates the Level I Pediatric Trauma Center in Queens.
- 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.
- The Hospital participates in the NYC Falls Prevention Coalition and refers senior citizens who are treated for fall-related injuries to senior citizen centers that provide classes designed to promote healthy exercise habits, strengthen joints, increase stability, and reduce the likelihood of falls.
- FHMC is part of the Asthma Coalition of Brooklyn and Queens, 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.
- Flushing Hospital's Patient Navigators are trained to conduct group counseling in the "Freedom from Smoking" program by the American Lung Association when classes are offered.

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

◆ Priority Area 3. PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN
Focus Area 1: Maternal & Women's Health
Focus Area 3: Child & Adolescent Health
Focus Area 4: Cross Cutting Healthy Women, Infants, & Children

One indicator of maternal health, adolescent health, and the accessibility of reproductive healthcare, education, and resources in a community is the teen birth rate. In the PSA, the teen birth rate varies by Community District—while Queens CD 7 has a lower teen birth rate than NYC, Queens CD 3 and Queens CD 4 have higher rates.

FHMC Healthy Women, Infants, and Children Resources and Accomplishments:

- FHMC conducts breast cancer screening for women, consistent with American Cancer Society guidelines, at its Women's Health Center and offers late evening and weekend hours for mammograms. Free mammograms are provided to eligible women through New York State's Cancer Services Program.
- 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 faculty practice Developmental and Behavioral Pediatric program offers evaluations for pediatric patients with academic, developmental, behavioral, and social concerns.
- 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 the importance of prenatal nutrition, exercise and participation in a pre-natal care program, as well as 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), and is also distributed to the community via the hospital's electronic community newsletter.

◆ Priority Area 4. PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS
Focus Area 1: Promote Well-Being
Focus Area 2: Prevent Mental and Substance Use Disorders

In general, mental health outcomes in the PSA are more favorable than city-wide outcomes. For example, the alcohol-related hospitalization rates in the PSA range from 357 to 748 cases per 100,000 person-years, while the city-wide rate is 1,019 cases per 100,000 person-years. Similarly, the drug-related hospitalization rates in the PSA range from 166 to 241 cases per 100,000 person-years, while the NYC rate is more than three times greater at 907 cases per 100,000 person-years.

FHMC Mental and Substance Use Disorder Resources and Accomplishments:

- FHMC has implemented many new practices and programs that focus on addressing the social determinants of health, in addition to responding to a patient's medical complaints. 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 access supportive services to promote successful adoption and continuation of healthy behaviors. Some services are provided directly by FHMC. 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 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.
- Birthing patients are screened for depression prenatally, on admission and during their postpartum visits. If indicated, patients receive intervention services to treat postpartum depression.
- The Hospital has also integrated primary care into treatment services at its Mental Health Center.

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

◆ Priority Area 5. PREVENT COMMUNICABLE DISEASES
Focus Area 1: Vaccine-Preventable Diseases
Focus Area 2: Human Immunodeficiency Virus (HIV)
Focus Area 3: Sexually Transmitted Infections (STIs)
Focus Area 4: Hepatitis C Virus (HCV)
Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections

Communicable diseases are medical conditions that can spread from one person to another through close contact—many communicable diseases can be prevented through simple public health interventions, such as frequent hand-washing, wearing surgical masks in crowded spaces, and using barrier methods of contraception during sexual contact. Despite this, communicable

diseases remain a common cause of death in NYC, with flu/pneumonia serving as the third leading cause of death in the city and HIV serving as the 10th leading cause of death. Throughout the PSA, the death rates attributable to flu/pneumonia are lower than the city-wide estimates (16.1-17.7 vs. 27.4 deaths per 100,000 people). HIV is not a leading cause of death in the PSA, but Queens CD 3's new infection rate is greater than the city-wide rate (32.3 cases per 100,000 person-years vs. 24.0 cases per 100,000 person-years).

The ongoing COVID-19 pandemic has been a major threat to the health and safety of New Yorkers since the city's first outbreak in early 2020. As of August 30, 2022, one of every three NYC residents has had COVID-19 and more than 41,000 people city-wide have died as a result of a COVID-19 infection.[76] COVID-19 has disproportionately affected residents within the PSA, especially in Queens CD 7.[77]

FHMC Communicable Disease Prevention Resources and Accomplishments:

- From March 2020 through June 2020, the Hospital was in the epicenter of the COVID-19 Pandemic and experienced an extremely large surge of COVID-19-positive patients with multiple waves occurring throughout 2020, 2021, and into 2022.[78] The Emergency Management Department formed a COVID-19 task force to oversee the response to the pandemic to ensure that resources were available and mobilized to deal with the tremendous influx of patients. Committees were created to address and respond to the wide-ranging impact on the hospital including Clinical Leadership, Operations, Supply Chain, and Human Resources. The COVID task force was constantly monitoring and/or in touch with the many Federal, State, and City agencies to ensure proper protocols/procedures were developed in response to the significant amount of information circulating, and regulations developed as well as accessing available support.
- FHMC's ambulatory care center provides vaccinations according to a standard age-specific protocol. Staff also reach out to patients whose vaccinations are not up to date and sponsor special community outreach campaigns when there are outbreaks of infectious diseases in the community, as they have done during the COVID-19 pandemic.

FHMC, through the Public Affairs Department, regularly posts educational articles and videos about prevention of HIV and the importance of vaccinations to prevent a variety of diseases including influenza, pneumonia, measles mumps & rubella (MMR), Hepatitis C and others. FHMC also 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), and is also distributed to the community via the hospital's electronic community newsletter.

[76] NYC COVID-19 Data Tracker, NYC DOH, 2022.
[77] Ibid.
[78] Ibid.

Community Health Survey Results

Background and Method

FHMC joined Greater New York Hospital Association's Community Health Needs Assessment Survey Collaborative in the Spring of 2022 to learn about the main health and health-related challenges facing residents of the Hospital's service area, especially the primary service area (PSA) where most of its patients reside. The survey was translated into the ten most common non-English languages spoken in New York State. It asked Respondents to rank in order of importance and satisfaction with services 21 health conditions/health-related issues that align with the New York State Prevention Agenda. Participating hospitals shared a common community survey with their community members in each hospital's defined service area. Responses from people who live in a hospital's service area were attributed to that hospital. Hospitals with overlapping service areas leveraged one another's outreach work to increase the total number of survey respondents.

The survey was promoted widely by FHMC. A QR code link to the electronic survey was included on flyers and posters requesting completion of the surveys. The flyers were sent to the District Managers of the local Community Planning Boards requesting their assistance in distributing the flyers to their Board Members. The Hospital also provided flyers to its Community Advisory Board, and to members of the community on the Hospital's e-mail list. Flyers and posters were also distributed in the outpatient clinics, emergency department and various other locations where members of the community are served. The link to the survey was also sent to patients via the Epic patient portal (MyChart).

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

Survey Respondents Characteristics

Of the 362 PSA survey respondents, almost all (94%) responded using the English version of the survey. One-third to nearly one-half did not answer the demographic questions. Of those who did answer the demographic questions, 62% were female,36% male, the rest non-binary, another gender or preferred not to say; 59% were White, non-Hispanic 20% Hispanic,14% Asian/Pacific Islander, non-Hispanic, 5% Black, non-Hispanic; ,100% had health insurance; 50% were 65 or older, 47% were 30-64, and 2% were 18-29. See Appendix B for table with PSA Respondent Demographics.

Health Issues

In contrast to the relatively low response rate on demographic questions, most PSA respondents answered the questions about their own health. Twenty-nine percent (29%) of survey respondents reported having fair or poor physical health, and 14% reported fair or poor mental health. The proportion of respondents reporting poor or fair physical and mental health was somewhat higher than it was in 2019 – 27% and 12%, respectively.

Fifteen percent (15%) of PSA respondents who answered the following question said "YES": "*In the last 12 months, was there a time when you needed medical care in-person but did not get it?*" Six percent (6%) said "YES" for care by phone or video. The percentage of YES responses in the CDs was similar.

Respondents from the PSA and its three (3) CDs ranked **Violence (including gun violence)** and **Mental health/depression** as above average in importance relative to the other 19 health

conditions but relatively below average in satisfaction with neighborhood services. PSA respondents and those from CDs 3 and 4 (which were analyzed together because of the low number of respondents) also ranked **Stopping falls among elderly** as above average in relative importance but relatively below average in satisfaction with neighborhood services. While only CD 7 respondents rated **Women's and maternal health care** relatively high in importance, **respondents** from the PSA and all CDs rated it below average in satisfaction with services. CDs 3 and 4 added **Asthma/breathing problems or lung disease** as highly important but below average in satisfaction.

Respondents from the PSA overall and each of the CDs, which have different demographic profiles, ranked additional conditions as highly important. These included **COVID-19, Cancer, Dental care, Heart disease, Diabetes, High blood pressure, Access to health/nutritious foods, Arthritis/disease of the joints**. Satisfaction with current neighborhood services was also relatively high.

PSA and CD respondents rated some conditions relatively lower in importance than others, including **Obesity in children and adults, Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah, Substance use disorder, Sexually transmitted infections, HIV/AIDS**. Satisfaction with neighborhood services for these conditions was relatively below average.

Survey results show that the various population groups in the Hospital's PSA are very concerned about a wide variety of health issues, including COVID-19 and the many chronic conditions that are prevalent in the service area. They are also burdened by the rise in violence, the high incidence of behavioral health problems and lack of access to needed medical and mental health care. Some service area communities had relatively high shooting incidents in 2021 and frequent mental distress (2019) as shown in Figures 1 and 2. Northwestern Queens communities adjacent to the Hospital's primary service area that were heavily impacted by COVID-19 and had high incidence rates of gun violence, also had frequent mental distress as shown in Figures 2 and 3 below. However, the preponderance of communities most heavily impacted by these three pandemics are in southeast Queens, the Rockaways, central and eastern Brooklyn, northern Staten Island and The Bronx.

Table 1 below shows Health Conditions Ratings in the PSA. See Appendix C for Health Conditions Ratings by CD within the PSA.
Figure 1 shows New York City Shooting Incidents per Precinct, 2021.[79]
Figure 2 shows areas in NYC with frequent mental distress.[80]
Figure 3 shows Police Precincts with high COVID-19 infection rates and high shooting incidents. [81]

[79] Reimagining Gun Violence and Public Safety for New York City", Office of the Public Advocate, September 2022.
.[80]Ibid.
[81]Ibid.

Table 1: Health Conditions Ratings in the PSA

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	1	4.59	Above Average	21	2.72	Below Average
Stopping falls among elderly	8	4.26	Above Average	14	3.14	Below Average
Mental health/depression	9	4.16	Above Average	19	2.89	Below Average
Maintain Efforts						
COVID-19	2	4.45	Above Average	1	3.69	Above Average
Dental care	3	4.44	Above Average	5	3.49	Above Average
Cancer	4	4.39	Above Average	7	3.38	Above Average
Heart disease	5	4.37	Above Average	4	3.51	Above Average
High blood pressure	6	4.27	Above Average	3	3.53	Above Average
Access to healthy/nutritious foods	7	4.27	Above Average	2	3.56	Above Average
Arthritis/disease of the joints	10	4.08	Above Average	11	3.26	Above Average
Diabetes/elevated sugar in the blood	11	3.98	Above Average	8	3.31	Above Average
Relatively Lower Priority						
Women's and maternal health care	13	3.91	Below Average	13	3.17	Below Average
Obesity in children and adults	15	3.84	Below Average	17	2.94	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	16	3.67	Below Average	18	2.93	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	17	3.65	Below Average	20	2.89	Below Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	20	3.08	Below Average	15	2.99	Below Average
Sexually Transmitted Infections (STIs)	21	3.07	Below Average	16	2.98	Below Average
Asthma/breathing problems or lung disease	12	3.94	Below Average	10	3.27	Above Average
Adolescent and child health	14	3.89	Below Average	6	3.40	Above Average
Infant health	18	3.64	Below Average	9	3.27	Above Average
Hepatitis C/liver disease	19	3.35	Below Average	12	3.22	Above Average

*How important is this issue to you?

**How satisfied are you with current services in your neighborhood?

^Rated on a 5-point scale from 1="Not at all" to 5="Extremely"

Figure 1

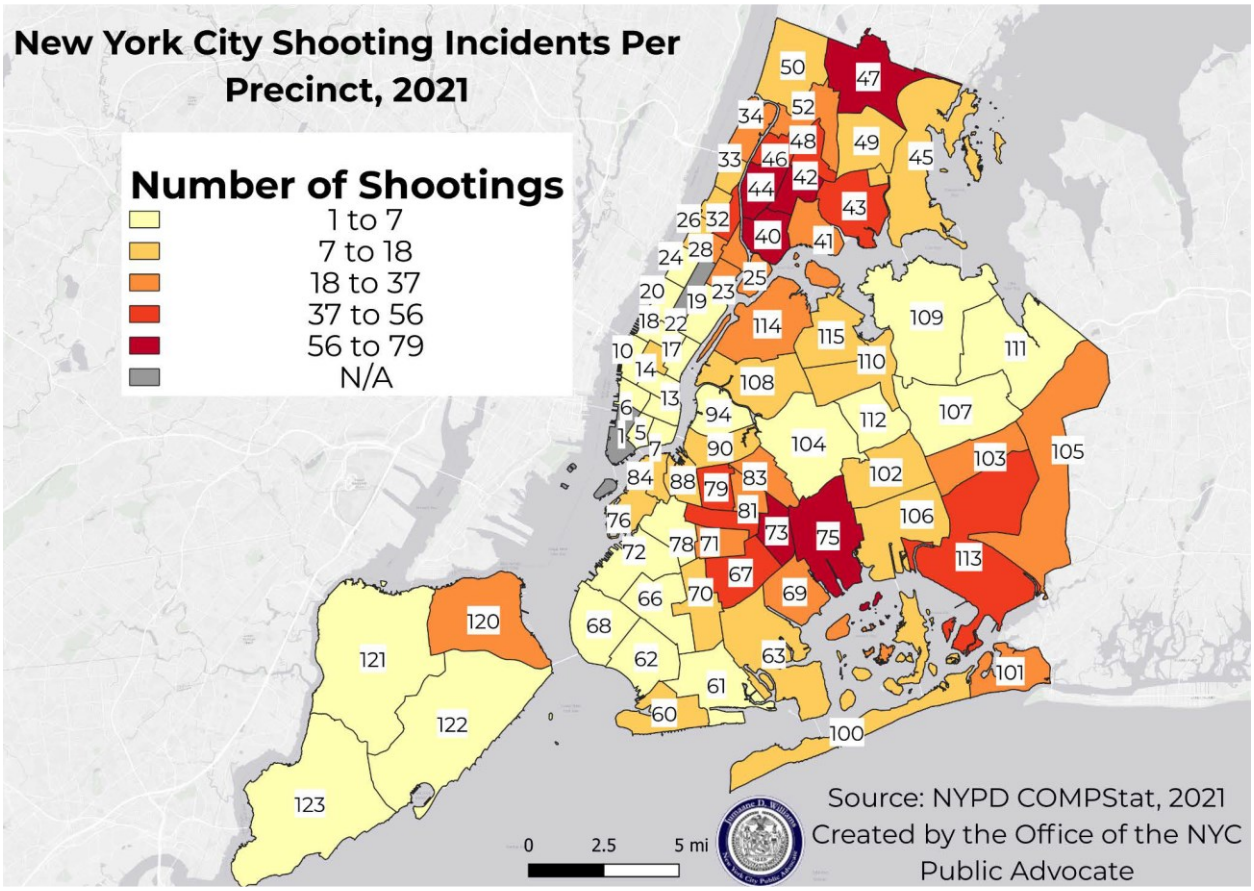

New York City Shooting Incidents Per Precinct, 2021
Number of Shootings
1 to 7
7 to 18
18 to 37
37 to 56
56 to 79
N/A
0
2.5
5 mi
Source: NYPD COMPStat, 2021
Created by the Office of the NYC Public Advocate

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Figure 2

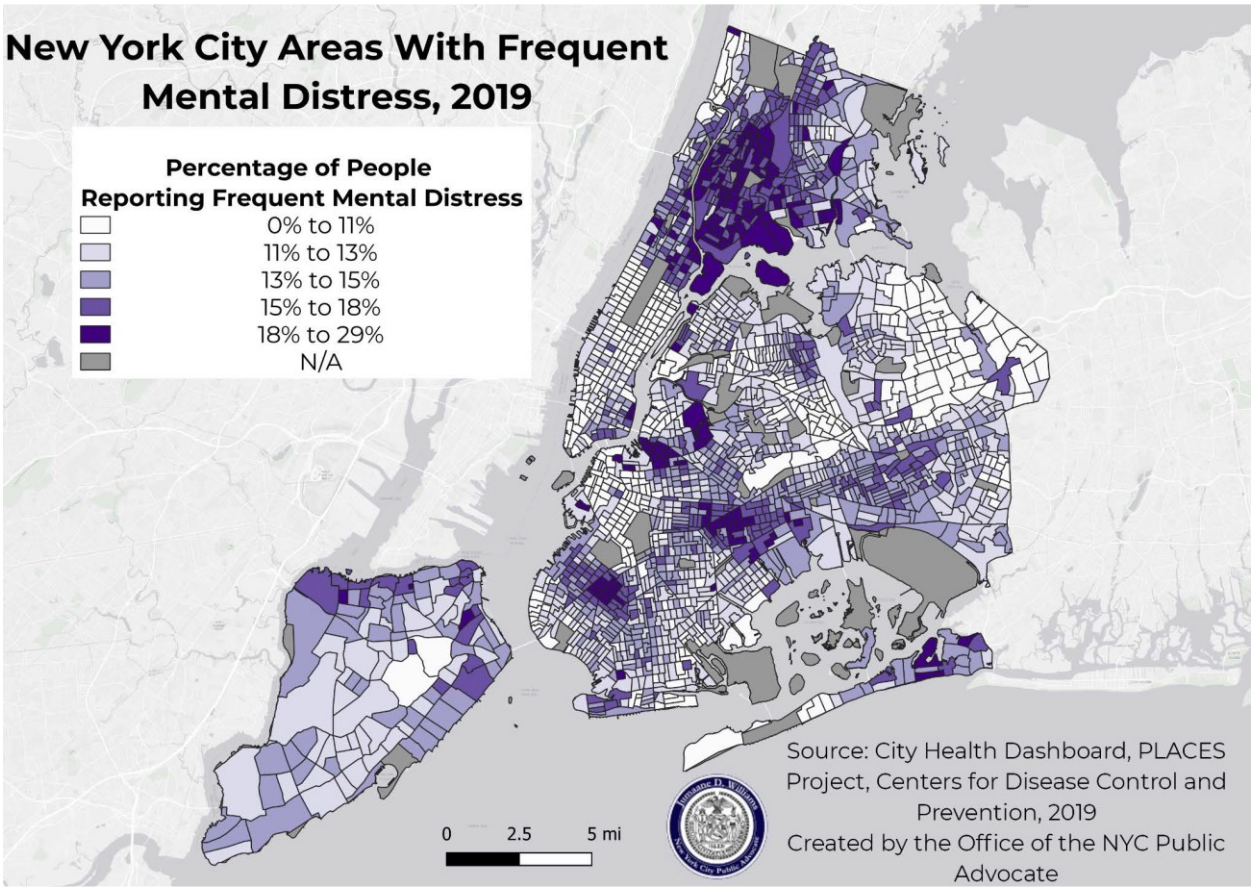
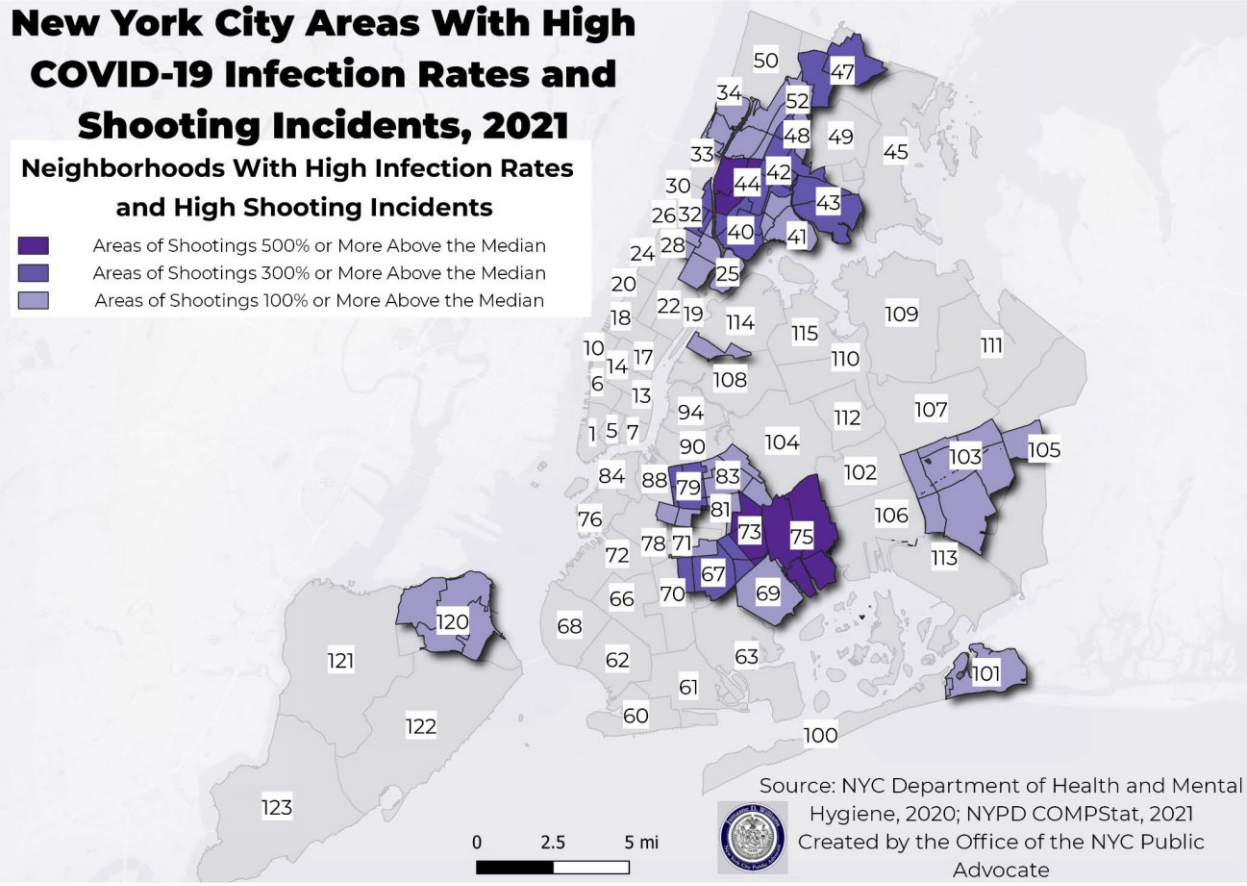

New York City Areas With Frequent Mental Distress, 2019
Percentage of People Reporting Frequent Mental Distress
0% to 11%
11% to 13%
13% to 15%
15% to 18%
18% to 29%
N/A
0
2.5
5 mi
Source: City Health Dashboard, PLACES Project, Centers for Disease Control and Prevention, 2019
Created by the Office of the NYC Public Advocate

Figure 3


New York City Areas With High COVID-19 Infection Rates and Shooting Incidents, 2021
Neighborhoods With High Infection Rates and High Shooting Incidents
Areas of Shootings 500% or More Above the Median
Areas of Shootings 300% or More Above the Median
Areas of Shootings 100% or More Above the Median
0
2.5
5 mi
Source: NYC Department of Health and Mental Hygiene, 2020; NYPD COMPStat, 2021
Created by the Office of the NYC Public Advocate

COMMUNITY SERVICE PLAN

Selection of Priorities

As described in the ***Resources and Accomplishments*** sections of the **COMMUNITY HEALTH NEEDS ASSESSMENT**, the Hospital directly addresses most of the health problems observed in its service area and included in the NYS Prevention Agenda. It refers patients to specialized health care providers for services it does not provide.

For non-medical social determinants of health (SDH) issues, such as food insecurity, unemployment or homelessness, staff routinely refers patients to trusted partner agencies who can address these problems. To keep better track of these referrals, the Hospital has recently implemented an automated closed-loop referral and feedback process, which starts with documentation of SDH problems in the EHR, referral of patients with one or more high risk scores to trusted partners, and receipt of feedback in the EHR about the outcome of the referral.

The Hospital is setting up a staff training program aimed at reducing explicit and implicit bias in care, which are recognized as major factors in the disparities in care that are found among the racial and ethnic minority groups who live in the Hospital's service areas. All nursing staff will participate in grand rounds on the topic this winter. Physicians will participate in similar training. Orientation for new hires will include implicit and explicit bias training.

Based on community health statistics, community health need survey results and the Hospital's resources and capabilities, Hospital leadership decided to continue its focus on two existing programs in the next 3-year cycle of its Community Service Plan/Implementation Plan:

- **Promote Tobacco Use Cessation**
- **Increase Breastfeeding**

FHMC used the following criteria in selecting these focus areas:

- Alignment with NYS Prevention Agenda Priorities:
    - Prevent Chronic Disease, Focus Area 3: - Tobacco Prevention, Goal 3.2: Promote Tobacco Use Cessation.
    - Promote Healthy Women, Infants and Children, Focus Area 2: Perinatal and Infant Health; Goal 2.2: Increase Breastfeeding.
- Alignment with Healthy People 2030 Objectives:
    - Reduce current tobacco use in adults.
    - Reduce current tobacco use in adolescents.
    - Increase the proportion of infants who are breastfed exclusively through age 6 months.
- Alignment with Survey Results
    - Cigarette smoking/tobacco use/vaping is rated as below average in relative satisfaction with services. Connection between Smoking/Tobacco use/vaping and Cancer and Heart disease is strong. Respondents rated Cancer and Heart disease as relatively high in importance.
    - Women's and maternity care is rated as relatively below average in satisfaction with services.

- Alignment with Key Items on the Hospital's Agenda
    - Follow best practices from NYC's Tobacco-Free Hospital campaign.
    - Implement a lung cancer screening program to increase survival rates of former smokers.
    - Adhere to Baby Friendly Hospital standards, including those related to breastfeeding, and retain the designation.
    - Provide breastfeeding support to mothers through at least the first six months of the infant's life.
    - Eliminate health disparities and achieve health equity, including reducing explicit and implicit bias, in the care of racial/ethnic minority groups who make up a significant percentage of the Hospital's patients and its communities.
    - Leverage Hospital and MediSys Network-wide resources already committed, including work groups focused on these programs.
    - Focus attention and resources on programs with a high potential for significant improvement in health and quality of life.

The charts in the following section (Implementation Plan) outline 2022-2024 Goals, Objectives, and Interventions for the Hospital's two Prevention Priorities. Outcome data for each objective in the Implementation Plan will be shared in annual Plan updates.

- 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) Identify smokers on staff, and counsel if appropriate. 2) Maintain standards for NYCDOHMH Gold Star status.	Family of Interventions: ▪ Counsel and refer tobacco-using employees for treatment, promote quit assists such as medication, NYS Quitline referral, and Freedom from Smoking® classes.

Goal 2	Objectives	Interventions/Strategies/Activities
General medical/surgical patients aged 13 and above: ▪ Assess all patients and provide interventions for all smokers. ▪ Increase number of quitters.	1) Maintain current outpatient smoking prevalence rate below NYS target (11%). 2) Achieve 95% or greater assessment rate for outpatients and inpatients; data gathering to include pack years. 3) Increase annual interventions for returning outpatient smokers to 85% or greater; 65% or greater for inpatients. 4) Identify and refer eligible former smokers to Lung Cancer Screening (LCS) program 5) Increase prescriptions for smoking cessation benefits among Medicaid and Medicaid Managed Care smokers to achieve NYS benefit use target of 26.2%.	Family of Interventions: ▪ Train and re-train all M/S providers to use the smoking module in the EHR, including active provider referrals to NYS Quitline and FFS classes/counseling by Hospital's Patient Navigators. ▪ Track assessments and interventions for all patients, and prevalence of smoking for returning OP smokers. ▪ Review disparity data and develop intervention plan. ▪ Review assessment and intervention data quarterly and determine action steps. ▪ Train new navigators to be FFS facilitators. ▪ Offer virtual FFS classes and offer evening hours for the FFS workshop for participants that work 9-5 schedules. ▪Consider resuming in-person classes. ▪Provide nutrition education to FFS participants. ▪When available from NYCDOHMH provide Health Bucks to incentivize attendance.

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: ▪ Assess all patients and provide interventions for all smokers. ▪ Increase number of quitters.	1) Decrease current outpatient smoking prevalence rate to NYS target of 20.1%. 2) Achieve 90% or greater annual assessment rate of outpatients and inpatients. 3) Achieve 90% or greater intervention rate for assessed smokers - outpatients and inpatients. 4) Identify and refer eligible former smokers to Lung Cancer Screening (LCS) program 5) Increase prescriptions for smoking cessation benefits among Medicaid and Medicaid Managed Care smokers to achieve NYS benefit use target of 26.2%.	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. ▪ Increase awareness via social media and print media.

Goal 4	Objectives	Interventions/Strategies/Activities
Improved tobacco cessation knowledge in the community.	1) Provide education and sign-up opportunities for Quit classes at 10 community educational events per year in partnership with community organizations. 2) Offer four FFS classes per year.	Family of Interventions: ▪ Include tobacco cessation information at all health fairs and other community events hosted or attended by the Hospital and sign-up interested smokers for tobacco cessation classes. ▪ Maintain Hospital's smoking services on 311 and NYS Smokers Quitline listings.

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 5	Objectives	Interventions/Strategies/Activities
Increased lung cancer survival rate in the community through early detection and follow up in a comprehensive, patient-centered lung cancer screening (LCS) program.	1) By March 1, 2023, establish a LCS program, with clinical oversight by the Director of Pulmonary Medicine, coordinated by an advanced practice nurse, including: a. Ambulatory care clinic dedicated to the education, counseling and continuing care of patients referred to the LCS program. b. Low dose CT (LDCT) screening. c. Sophisticated automated technology for diagnosis and for patient tracking and reporting. d. Virtual and in-person tobacco cessation classes and supports. e. Multidisciplinary team of clinical specialists, including pulmonologists, radiologists, oncologists, and thoracic surgeons, to oversee the care of patients with positive findings. 2) By March 1, 2023, establish program oversight by a multidisciplinary quality improvement committee. 3) By June 1, 2023, establish LCS program metrics, benchmarks, and targets.	Family of Interventions: ▪ By January 1, 2023, hire LCS program Coordinator. ▪ Identify space for the LCS program and establish clinic schedule. ▪ Acquire AI software to assist in diagnosis of lung disease and other abnormal findings from LDCT. ▪ Develop database for tracking program progress, protocols for data analysis and review, including for racial/ethnic disparities. ▪ Create an automated prompt in the EHR to alert the PCP of patients who are potentially eligible for LDCT. ▪ Reinforce the importance of complete documentation in the EHR of tobacco use history. ▪ Develop policies and procedures covering all aspects of the LCS program, including referral, patient flow, patient follow-up, and program oversight. ▪ By March 1, 2023, start education program about the LCS program for hospital providers and staff. ▪ By June 1, 2023, start education program for community providers to increase awareness of the availability of the LCS program.

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	1) Increase exclusive BF rate at discharge from current rate of 15%. 2) Maintain exclusive BF equality among all racial/ethnic groups. 3) Sustain 100% 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) Maintain enrollment of 2,500 women in the Hospital's and WIC's breastfeeding programs, support groups, prenatal nutrition class, childbirth classes, and mother-baby classes.	Family of Interventions: • Send employees working with mothers of childbearing age and newborns to Certified Lactation Consultant (CLC) Course, sponsored by NYC DOHMH. • Reinstitute (post COVID) breastfeeding internship program for International Board of Lactation Consultant Examiners (IBCLC) certification, led by the hospital's IBCLC staff. • Ensure that all babies remain with their mothers unless medically contraindicated. • Continue to keep mother and baby together if baby needs phototherapy. Baby stays in the room with the mother. • If baby is re-admitted, the mother is given a space to stay with the baby 24 hours/day in order to breastfeed. • Offer human milk from NY Milk Bank to all preterm infants when mother is unable to produce enough of her own milk. • Continue multiple daily visits to new mothers by nurses and IBCLC to support BF. • Continue bedside BF education and offer virtual education. • Continue providing language assistance services. • Increase referrals for use of breast pumps. • Continue referrals to postpartum resources, such as Women, Infants, and Children (WIC). • Give mothers "warm line" number to hospital IBCLC at discharge. • Personally assist majority of OB patients to enroll in My Chart to allow easy access to virtual education on infant feeding and other topics.

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	Anticipate site visit for re-designation in 2023.	Continue weekly interdisciplinary committee meetings.

Goal 3	Objectives	Interventions/Strategies/Activities
Exclusive Breastfeeding at 3 and 6 Months for as Many Patients as Clinically Possible and Culturally Acceptable.	1) Of well-babies whose feeding history is documented maintain BF rates at 90% or above at 3 and 6 months. 2) Train all pediatricians and obstetricians about BF annually. 3) Continue to offer BF education and support to post-partum mothers by IBCLC	Family of Interventions: • Initiate referral via EHR to WIC on first prenatal visit. • Increase referrals to outpatient support services, including mothers from the community. • Include Patient Navigators in ACC to assist in referrals. • Schedule BF education programs for ACC providers and staff to enhance patient support at least yearly. • Use Newborn Channel for postpartum to educate patients. • Schedule BF mothers' appointments with IBCLC at the same time in order to offer group support. • Continue providing language assistance services for postpartum mothers. • When WIC resumes in-person visits schedule volunteer peer counselors to support mothers during labor and postpartum with breastfeeding. • Reinstitute (post-COVID) Talk and Tea weekly infant feeding support group in the ambulatory center guided by an IBCLC once per week.

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.	Reinstitute (post-COVID) BF education programs in low-income areas, especially where racial/ethnic minorities are predominant.	Family of Interventions: • Remain available for mothers referred by community practice sites to assist their patients in BF. • Reinstitute (post-COVID) community partnerships to host BF education programs, such as local libraries. • Publicize the Hospital's BF-related programs via Hospital's social media and electronic media, such as MediSys MyChart, and on external sites, including print media. • Reinstitute (post-COVID) IBCLC internship program led by the IBCLC to increase the presence of IBCLCs in the community. • Resume (post-COVID) the assignment of staff to visit the Hotel Trade Council, private physician offices, and local libraries to teach topics related to breastfeeding.

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

◆ **Priority Area 1. PREVENT CHRONIC DISEASES**

Figure A. Proportion of Residents with a Personal Doctor by Year and Community District

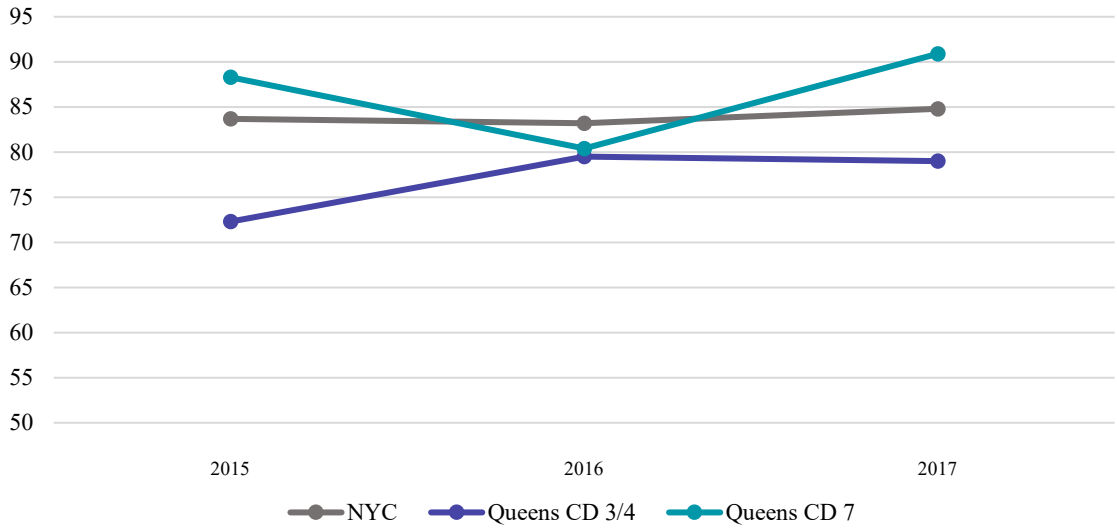
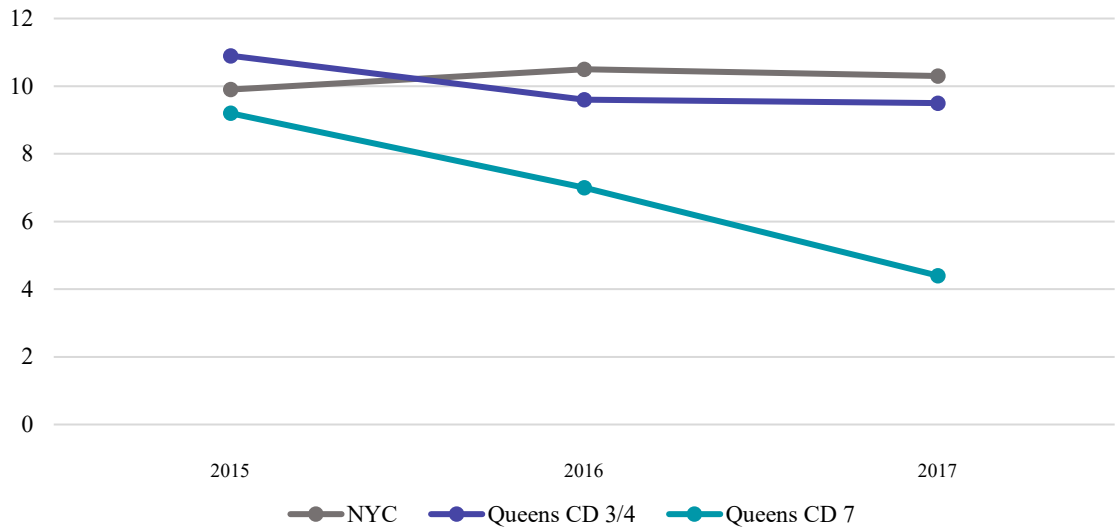


Figure B. Proportion of Residents Forgoing Needed Medical Care by Year and Community District



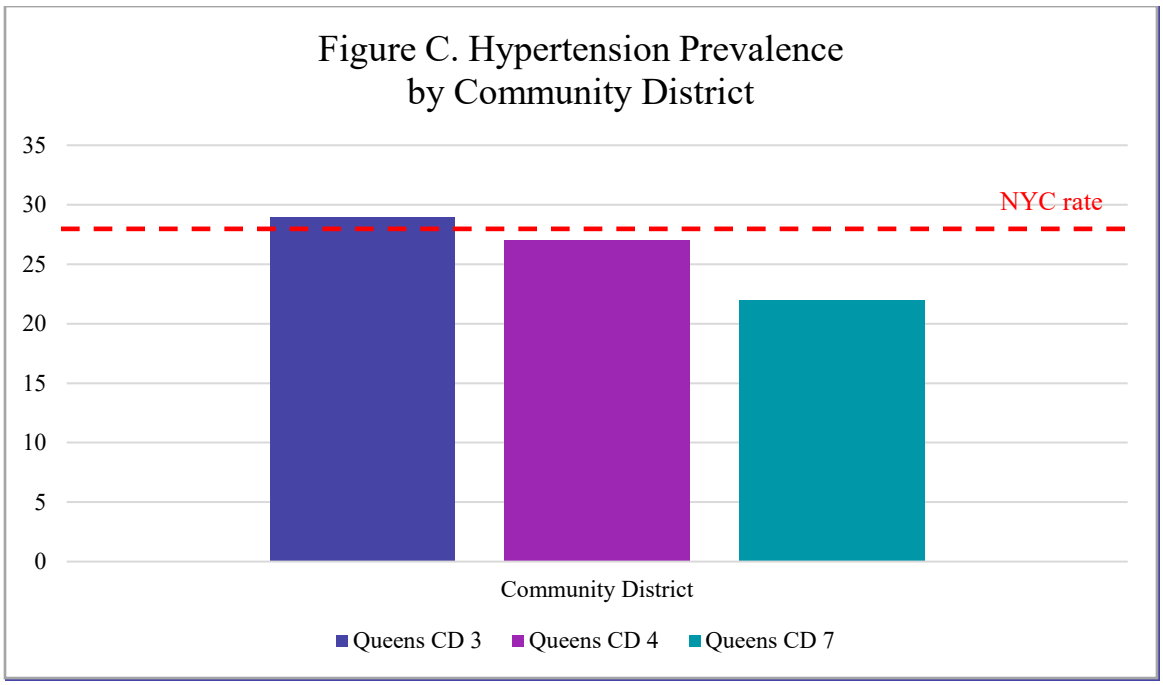


Figure C. Hypertension Prevalence by Community District
35
30
25
20
15
10
5
0
NYC rate
Community District
Queens CD 3
Queens CD 4
Queens CD 7

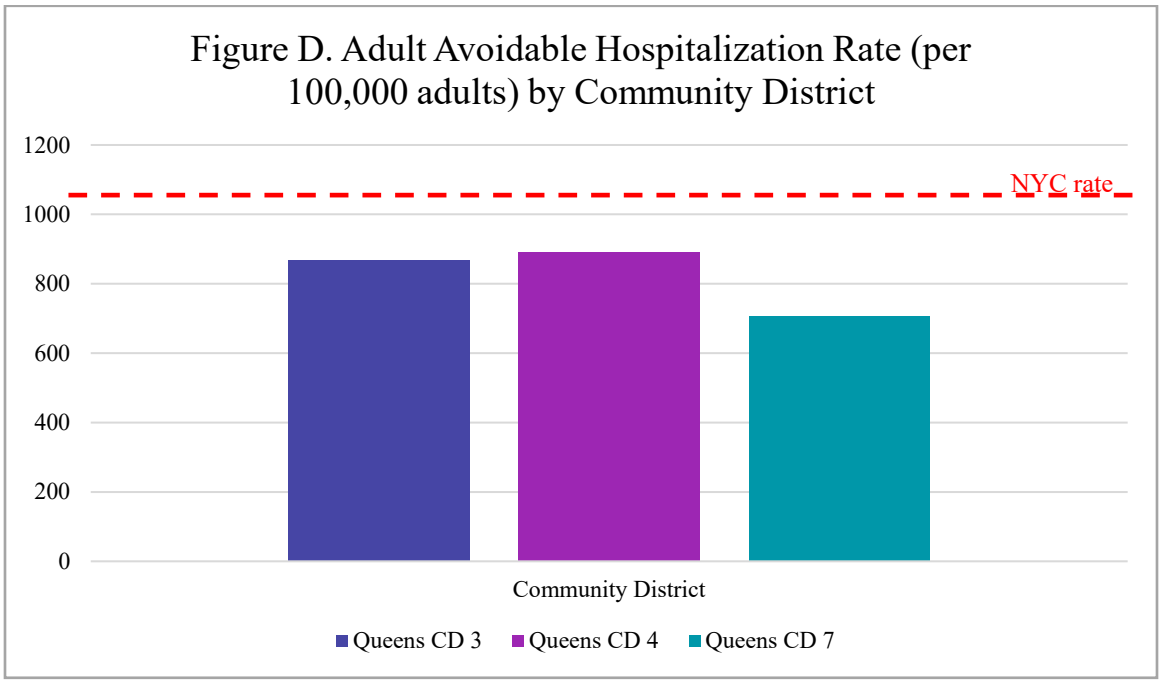
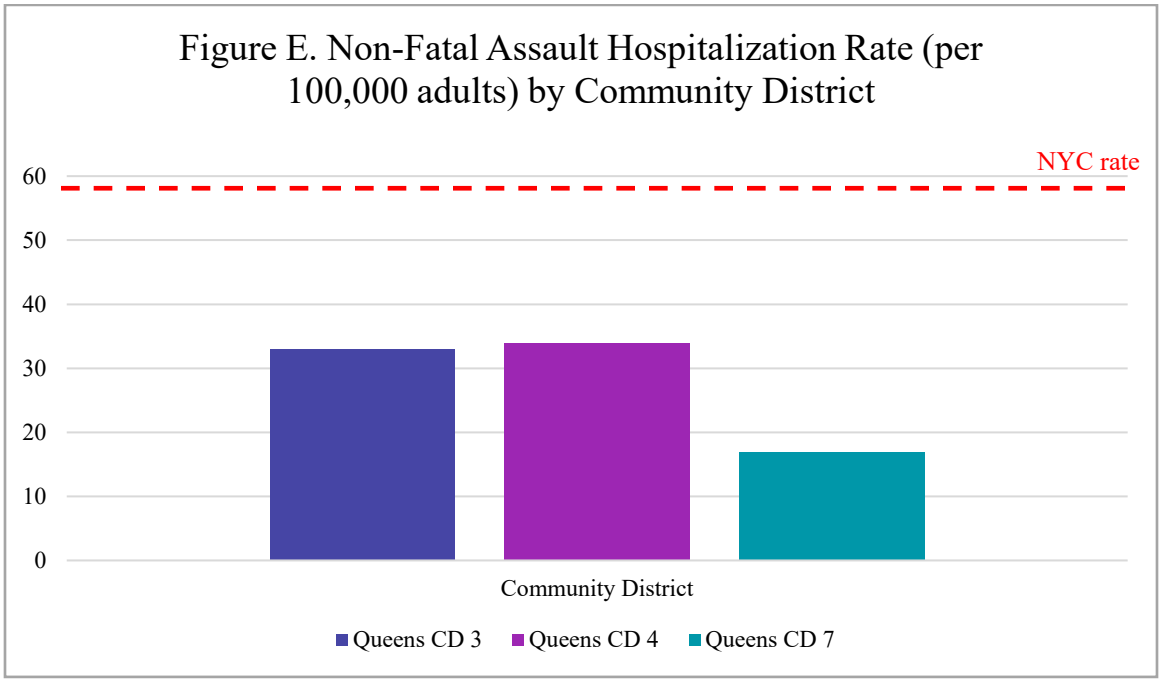
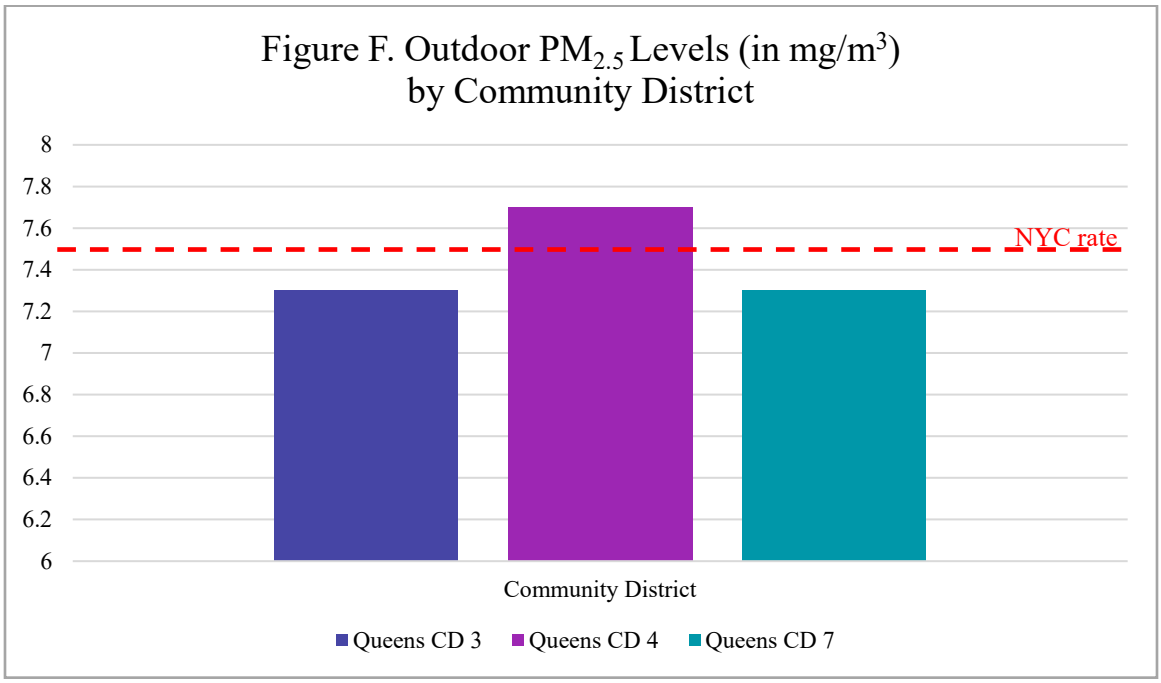


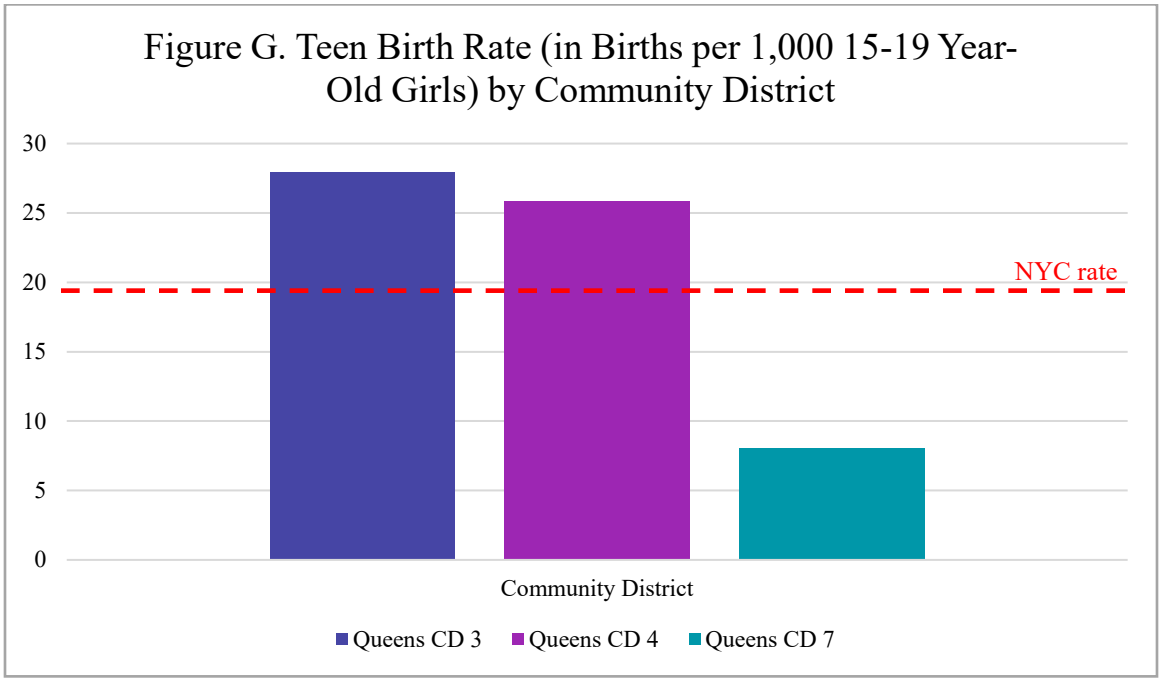
Figure D. Adult Avoidable Hospitalization Rate (per 100,000 adults) by Community District
1200
1000
800
600
400
200
0
NYC rate
Community District
Queens CD 3
Queens CD 4
Queens CD 7

◆ **Priority Area 2. PROMOTE A HEALTHY AND SAFE ENVIRONMENT**

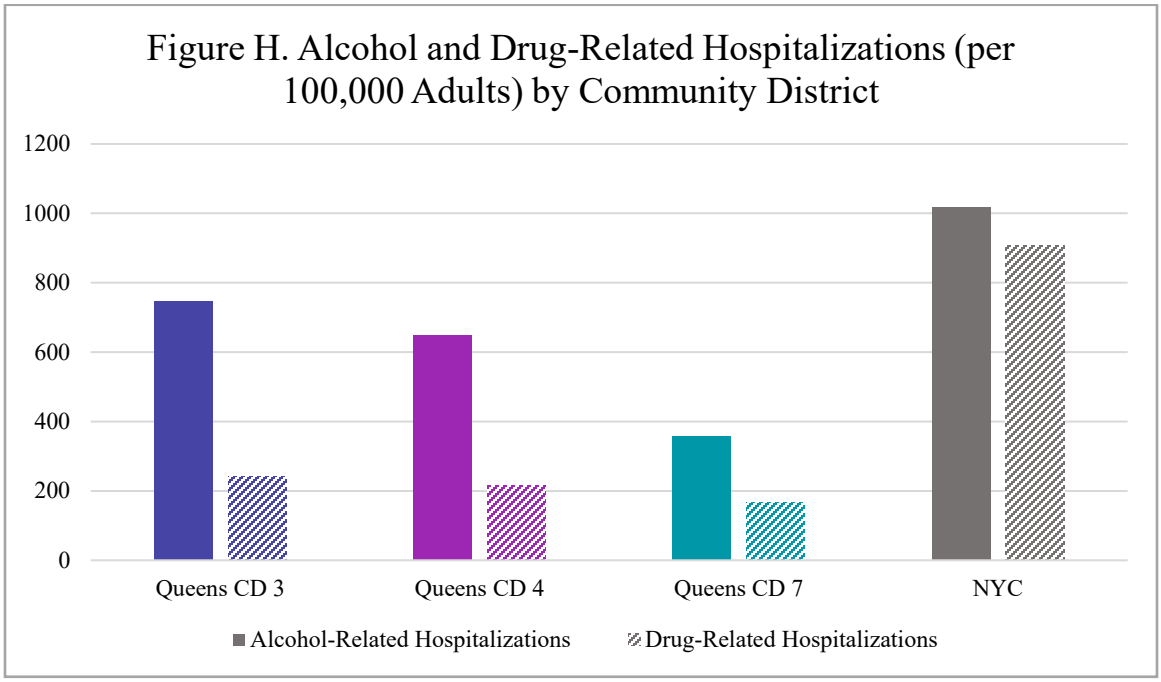




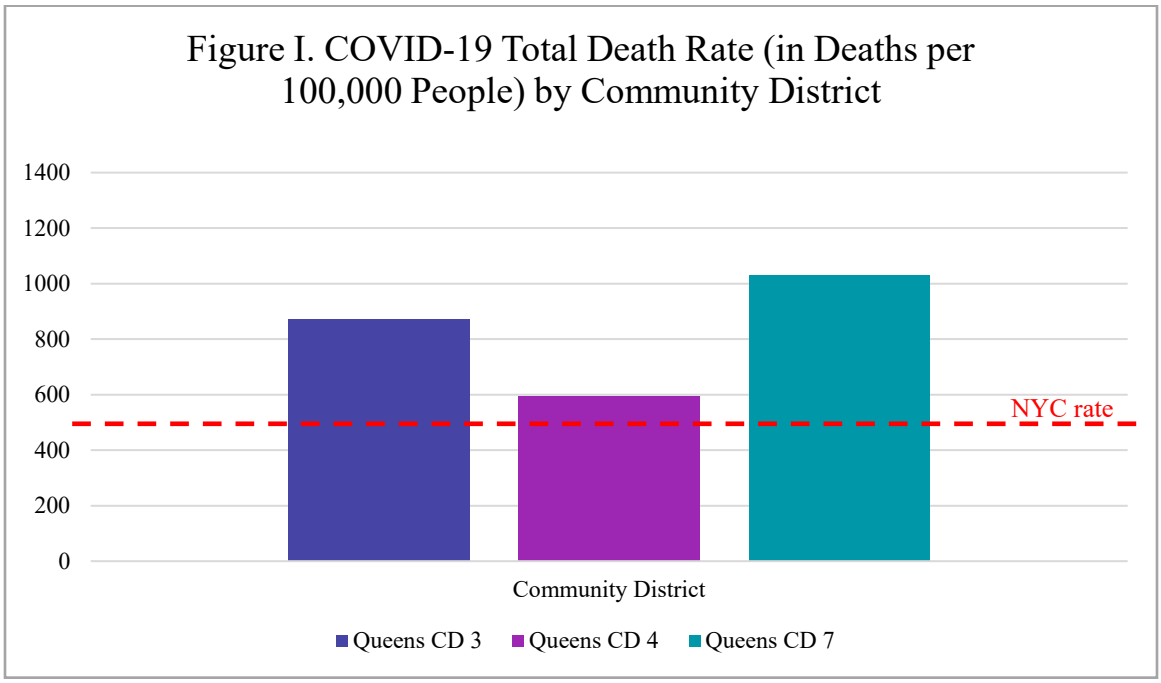
◆ **Priority Area 3. PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN**



◆ **Priority Area 4. PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS**



◆ **Priority Area 5. PREVENT COMMUNICABLE DISEASES**



Appendix B: PSA Respondent Demographics

GNYHA CHNA Survey Collaborative 2022
Primary Service Area Respondent Demographics
Flushing Hospital Medical Center

Question	Number	Percent
Total Sample		
Total Number of Qualified Respondents^	362	100%
Survey Language		
English	339	94%
Spanish	18	5%
Chinese	3	1%
Korean	2	1%
What is the primary language you speak at home?		
English	204	85%
Spanish	16	7%
Mandarin	4	2%
Cantonese	4	2%
Korean	2	1%
Bengali	1	0%
Other	9	4%
Missing	122	.
Age		
18 - 24	3	1%
25 - 29	2	1%
30 - 44	22	11%
45 - 64	73	36%
65 - 74	58	29%
75+	44	22%
Missing	160	.
Gender		
Female	152	62%
Male	88	36%
Non-binary, another gender	1	0%
Prefer not to say	5	2%
Missing	116	.

Sexual Identity		
Straight, that is not Gay	211	87%
Gay, Lesbian, or Bisexual	6	2%
Other	2	1%
Prefer not to say	24	10%
Missing	119	.
Race/Ethnicity		
White, non-Hispanic	141	59%
Hispanic	48	20%
Asian/Pacific Islander,non-Hispanic	34	14%
Black, non-Hispanic	12	5%
North African/Middle Eastern, non-Hispanic	1	0%
Other,non-Hispanic	5	2%
Missing	121	.
Hispanic/Latinx Origin or Ancestry		
Puerto Rican	13	28%
Colombian	8	17%
Other South American	7	15%
Dominican	6	13%
Other Central American	6	13%
Ecuadorian	5	11%
Cuban	1	2%
Other	1	2%
Missing	1	.
Some people in addition to being Black, have a certain heritage or ancestry. Do you identify with any of these?*		
A recent immigrant or the child of recent immigrants from Africa	35	69%
Caribbean or West Indian	8	50%
African American	6	38%

Asian Heritage or Ancestry		
ChineseÂ	20	59%
Asian Indian	5	15%
FilipinoÂ	4	12%
KoreanÂ	3	9%
OtherÂ	2	6%
Missing	1	.
Number of people who usually live or stay in this home/apartment		
1 person	61	27%
2 people	83	37%
3 people	42	19%
4 people	28	12%
5 or more people	11	5%
Missing	137	.
Highest grade or year of school completed		
Less than high school	5	2%
High school graduate	28	12%
Some college/technical school	56	24%
College graduate	147	62%
Missing	126	.
What is your current employment status?		
Retired	126	53%
Employed full-time for wages or salary	65	27%
Employed part-time for wages or salary	18	8%
Self-employed	9	4%
A homemaker	6	3%
Unable to work	6	3%
Unemployed for 1 year or more	4	2%
Unemployed for less than 1 year	2	1%
A student	2	1%
Missing	124	.
What is your household's annual household income from all sources, before taxes, in the last year?		
Less than $20,000	17	8%
$20,000 to $29,999	16	8%
$30,000 to $49,999	30	14%
$50,000 to $59,999	21	10%
$60,000 to $74,999	28	13%
$75,000 to $99,999	31	15%
$100,000 or more	68	32%
Missing	151	.
What type of health insurance do you use to pay for your doctor or hospital bills?		
Medicare	113	46%
A plan purchased through an employer or union	86	35%
Medicaid or other state program	28	11%
A plan that you or another family member buys on your own	8	3%
TRICARE (formerly CHAMPUS), VA, or Military	2	1%
Some other source	10	4%
Missing	115	.

^A qualified respondent is ages 18+ and living within the service area

*Percentages may not add up to 100% because respondents could choose more than one option

Appendix C: Health Conditions Ratings by CD within the PSA

GNYHA CHNA Survey Collaborative 2022
Importance and Satisfaction Ratings
Queens Community District 3 (East Elmhurst, Jackson Heights, and North Corona)

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	2	4.53	Above Average	21	2.14	Below Average
Stopping falls among elderly	6	4.47	Above Average	18	2.64	Below Average
Mental health/depression	9	4.25	Above Average	20	2.57	Below Average
Maintain Efforts						
Heart disease	1	4.70	Above Average	3	3.30	Above Average
COVID-19	3	4.50	Above Average	1	3.80	Above Average
High blood pressure	4	4.50	Above Average	4	3.30	Above Average
Dental care	5	4.47	Above Average	2	3.35	Above Average
Cancer	7	4.46	Above Average	13	3.00	Above Average
Access to healthy/nutritious foods	8	4.33	Above Average	8	3.17	Above Average
Arthritis/disease of the joints	10	4.24	Above Average	7	3.18	Above Average
Diabetes/elevated sugar in the blood	11	4.18	Above Average	11	3.07	Above Average
Asthma/breathing problems or lung disease	12	4.14	Above Average	12	3.00	Above Average
Relatively Lower Priority						
Obesity in children and adults	13	4.08	Below Average	19	2.59	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	14	4.00	Below Average	15	2.85	Below Average
Women's and maternal health care	16	3.91	Below Average	17	2.65	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	18	3.46	Below Average	16	2.68	Below Average
Sexually Transmitted Infections (STIs)	21	3.23	Below Average	14	2.89	Below Average
Adolescent and child health	15	3.98	Below Average	10	3.09	Above Average
Infant health	17	3.66	Below Average	6	3.25	Above Average
Hepatitis C/liver disease	19	3.39	Below Average	9	3.10	Above Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	20	3.26	Below Average	5	3.29	Above Average

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

GNYHA CHNA Survey Collaborative 2022
Importance and Satisfaction Ratings
Queens Community District 4 (Corona, Corona Heights, Elmhurst, and Lefrak City)

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	1	4.63	Above Average	20	2.61	Below Average
High blood pressure	3	4.51	Above Average	15	2.94	Below Average
Mental health/depression	4	4.51	Above Average	21	2.59	Below Average
Stopping falls among elderly	6	4.46	Above Average	17	2.83	Below Average
Asthma/breathing problems or lung disease	10	4.25	Above Average	14	2.94	Below Average
Maintain Efforts						
COVID-19	2	4.62	Above Average	2	3.21	Above Average
Heart disease	5	4.47	Above Average	9	3.09	Above Average
Cancer	7	4.41	Above Average	1	3.26	Above Average
Dental care	8	4.36	Above Average	10	3.05	Above Average
Access to healthy/nutritious foods	9	4.28	Above Average	3	3.19	Above Average
Adolescent and child health	11	4.24	Above Average	5	3.15	Above Average
Relatively Lower Priority						
Obesity in children and adults	12	4.17	Below Average	18	2.75	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	13	4.11	Below Average	19	2.72	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	14	4.06	Below Average	16	2.84	Below Average
Arthritis/disease of the joints	17	4.03	Below Average	13	2.97	Below Average
Diabetes/elevated sugar in the blood	15	4.03	Below Average	12	3.00	Above Average
Infant health	16	4.03	Below Average	11	3.03	Above Average
Women's and maternal health care	18	4.00	Below Average	6	3.13	Above Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	19	3.89	Below Average	7	3.12	Above Average
Hepatitis C/liver disease	20	3.86	Below Average	8	3.10	Above Average
Sexually Transmitted Infections (STIs)	21	3.86	Below Average	4	3.18	Above Average

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

GNYHA CHNA Survey Collaborative 2022
Importance and Satisfaction Ratings
Queens Community Districts 3 and 4

Community District 3 (East Elmhurst, Jackson Heights, and North Corona), Community District 4 (Corona, Corona Heights, Elmhurst, and Lefrak City)

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	2	4.58	Above Average	21	2.39	Below Average
Stopping falls among elderly	5	4.47	Above Average	17	2.75	Below Average
Mental health/depression	8	4.39	Above Average	20	2.58	Below Average
Asthma/breathing problems or lung disease	10	4.20	Above Average	14	2.97	Below Average
Maintain Efforts						
Heart disease	1	4.59	Above Average	3	3.19	Above Average
COVID-19	3	4.56	Above Average	1	3.49	Above Average
High blood pressure	4	4.51	Above Average	10	3.10	Above Average
Cancer	6	4.43	Above Average	6	3.15	Above Average
Dental care	7	4.42	Above Average	2	3.20	Above Average
Access to healthy/nutritious foods	9	4.30	Above Average	5	3.18	Above Average
Relatively Lower Priority						
Obesity in children and adults	12	4.12	Below Average	19	2.69	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	15	4.03	Below Average	16	2.85	Below Average
Women's and maternal health care	16	3.96	Below Average	15	2.94	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	18	3.79	Below Average	18	2.70	Below Average
Arthritis/disease of the joints	11	4.13	Below Average	11	3.07	Above Average
Diabetes/elevated sugar in the blood	13	4.11	Below Average	13	3.03	Above Average
Adolescent and child health	14	4.10	Below Average	8	3.12	Above Average
Infant health	17	3.85	Below Average	7	3.13	Above Average
Hepatitis C/liver disease	19	3.62	Below Average	9	3.10	Above Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	20	3.58	Below Average	4	3.19	Above Average
Sexually Transmitted Infections (STIs)	21	3.54	Below Average	12	3.07	Above Average

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

GNYHA CHNA Survey Collaborative 2022
Importance and Satisfaction Ratings
Queens Community District 7 (Auburndale, Bay Terrace, College Point, East Flushing, Flushing, Queensboro Hill, and Whitestone)

Health Condition	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	1	4.59	Above Average	20	2.88	Below Average
Mental health/depression	9	4.06	Above Average	16	3.06	Below Average
Women's and maternal health care	12	3.89	Above Average	13	3.28	Below Average
Maintain Efforts						
Dental care	2	4.45	Above Average	5	3.61	Above Average
COVID-19	3	4.41	Above Average	1	3.77	Above Average
Cancer	4	4.37	Above Average	7	3.48	Above Average
Heart disease	5	4.29	Above Average	4	3.66	Above Average
Access to healthy/nutritious foods	6	4.26	Above Average	3	3.69	Above Average
High blood pressure	7	4.18	Above Average	2	3.72	Above Average
Stopping falls among elderly	8	4.17	Above Average	12	3.32	Above Average
Arthritis/disease of the joints	10	4.06	Above Average	11	3.34	Above Average
Diabetes/elevated sugar in the blood	11	3.93	Above Average	8	3.43	Above Average
Relatively Lower Priority						
Obesity in children and adults	15	3.72	Below Average	15	3.08	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	16	3.62	Below Average	17	3.05	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	18	3.50	Below Average	19	2.91	Below Average
Hepatitis C/liver disease	19	3.25	Below Average	14	3.28	Below Average
Sexually Transmitted Infections (STIs)	20	2.87	Below Average	18	2.93	Below Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	21	2.87	Below Average	21	2.87	Below Average
Asthma/breathing problems or lung disease	13	3.85	Below Average	9	3.41	Above Average
Adolescent and child health	14	3.81	Below Average	6	3.51	Above Average
Infant health	17	3.55	Below Average	10	3.35	Above Average

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

COMMUNITY HEALTH NEEDS ASSESSMENT

COMMUNITY SERVICE AND IMPLEMENTATION PLAN 2022-2024

FLUSHING HOSPITAL MEDICAL CENTER