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EXECUTIVE SUMMARY

The effects of poverty on health, including difficulty obtaining nutritious food, unemployment, and the burden of high rents are observed in the communities that Jamaica Hospital serves, particularly in East New York, Brooklyn, and in pockets of Southwest Queens and Jamaica.

Chronic diseases, obesity, tobacco use, behavioral health concerns, maternal morbidity, and late or no prenatal care were among the health issues highlighted in the community-level data analyses that Jamaica Hospital conducted for this Community Health Needs Assessment (CHNA). These health concerns were also identified by residents of the Hospital’s service area who responded to a health needs assessment survey sponsored by the Hospital during the spring and summer of 2019. Many of these health problems are caused in part by or exacerbated by the social determinants of health (SDH). The Hospital has begun focused efforts to address SDH, including the effects of discrimination, as part of its treatment of the whole person.

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

Tobacco use and secondhand smoke, as well as household/outdoor air pollution, were identified as ongoing community health concerns that are correlated with chronic disease, such as asthma and chronic obstructive pulmonary disease as well as cancer. Responding to the needs of the community, Jamaica Hospital has focused on improving tobacco cessation rates. The Hospital was awarded Gold Star Status from the NYC DOHMH’s Tobacco-Free Hospitals Campaign in recognition of its tobacco cessation programming and successes, and continues to comply with the Campaign’s standards.

With the benefit of community input, the Hospital has chosen to highlight the prevalence of these two health issues in its service area as well as the Hospital’s concerted efforts to address them in its three year comprehensive Community Service Plan and Implementation Plan. These initiatives are in alignment with the NYS Prevention Agenda Priorities and the Healthy People 2020 goals.

Full report can be obtained on the Hospital’s website: https://jamaicahospital.org/community-service-plan
INTRODUCTION

Hospital Overview and Data Sources

Jamaica Hospital Medical Center (JHMC), founded in 1891, is a not-for-profit 402-bed, Article 28 licensed facility located close to LaGuardia Airport, the John F. Kennedy International Airport, and several major highways (Van Wyck Expressway, Long Island Expressway, and Grand Central Parkway). The surrounding neighborhoods are culturally diverse, densely populated, urban areas of southern Queens and East New York, Brooklyn. JHMC’s primary service area (PSA) spans 36.3 square miles, covering the Queens neighborhoods of Jamaica and Southwest Queens (SWQ), as well as the Brooklyn neighborhood of East New York (ENY), which are home to 784,840 (2018) people.

The Hospital annually cares for approximately 19,627 inpatients including 1,681 newborns, 110,299 emergency department patients, and 336,725 ambulatory care patients. It offers a full array of general and specialty medical and surgical care; acute inpatient; emergency services (including its Level I Trauma Center and Primary Stroke Center; rehabilitation; pediatric; and psychiatric services (including its Comprehensive Psychiatric Emergency Program); ambulatory surgery. The Hospital is a NYS-designated Level 3 Perinatal Center with a Level III neonatal intensive care unit (NICU) and a WHO-designated Baby Friendly Hospital. The ambulatory care program provides a full range of medical and dental services on and off campus at nine PCMH-recognized Family Care Centers as well as three school based health centers.

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

The Hospital’s mission is To serve our patients and the community in a way that is second to none.

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

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

JHMC’s service area was determined by analyzing Statewide Planning and Research Cooperative System (SPARCS) 2017 discharge data at the zip code level. The UHF neighborhoods with the highest volumes of patients were determined to be the PSA. UHF neighborhoods with at least 3% of inpatient cases were considered the hospital’s secondary service area (SSA). The PSA and SSA together account for approximately 86% of the Hospital’s total inpatient cases, with the PSA accounting for 78% and the SSA 8%. The JHMC CHNA focuses on the Hospital’s PSA.

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

JHMC’s Primary Service Area
The PSA covers three UHF neighborhoods – Jamaica (408), Southwest Queens (407) and East New York (204). These three neighborhoods lie within two boroughs and multiple community districts as shown in Table 1.

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

<table>
<thead>
<tr>
<th>Zip Code</th>
<th>% of Discharges</th>
<th>Community District</th>
<th>UHF Neighborhood/(Code)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11412</td>
<td>2%</td>
<td>Jamaica and Hollis (12)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11414</td>
<td>3%</td>
<td>South Ozone Park and Howard Beach (10)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11415</td>
<td>2%</td>
<td>Kew Gardens and Woodhaven (9)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11416</td>
<td>4%</td>
<td>Kew Gardens and Woodhaven (9)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11417</td>
<td>4%</td>
<td>South Ozone Park and Howard Beach (10)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11418</td>
<td>7%</td>
<td>Kew Gardens and Woodhaven (9)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11419</td>
<td>8%</td>
<td>Kew Gardens and Woodhaven (9), South Ozone Park and Howard Beach (10)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11420</td>
<td>6%</td>
<td>South Ozone Park and Howard Beach (10)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11421</td>
<td>5%</td>
<td>Kew Gardens and Woodhaven (9)</td>
<td>Southwest Queens (407)</td>
</tr>
<tr>
<td>11423</td>
<td>1%</td>
<td>Hillcrest and Fresh Meadows (8), Jamaica and Hollis (12)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11430</td>
<td>1%</td>
<td>None (John F. Kennedy International Airport; residential population = 1841)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11432</td>
<td>4%</td>
<td>Hillcrest and Fresh Meadows (8), Jamaica and Hollis (12)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11433</td>
<td>5%</td>
<td>Jamaica and Hollis (12)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11434</td>
<td>7%</td>
<td>Jamaica and Hollis (12), Queens Village (13)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11435</td>
<td>7%</td>
<td>Hillcrest and Fresh Meadows (8), Jamaica and Hollis (12)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11436</td>
<td>4%</td>
<td>Jamaica and Hollis (12)</td>
<td>Jamaica (408)</td>
</tr>
<tr>
<td>11207</td>
<td>2%</td>
<td>Bushwick (4), East New York and Starrett City (5)</td>
<td>East New York (204)</td>
</tr>
<tr>
<td>11208</td>
<td>9%</td>
<td>East New York and Starrett City (5)</td>
<td>East New York (204)</td>
</tr>
<tr>
<td><strong>Total PSA</strong></td>
<td><strong>78%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 US. Census. 2010 Demographic Profile. Factfinder.census.gov
INTRODUCTION

Figure 1. Jamaica Hospital Medical Center’s Service Area

There are gaps in primary medical care, including dental care and mental health care across Queens, which are also evident in JHMC’s service area. Queens has seven neighborhoods that are designated as Medically Underserved Areas (MUA) by the Health Resources and Services Administration (HRSA); this designation is based on four factors: the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. The Kings Service Area MUA, which contains East New York, and the Queens Service Area MUA, which contains parts of Jamaica, cover JHMC’s service area. South Jamaica, a neighborhood within JHMC’s primary service area, also is a designated MUA. South Jamaica is also designated as a Primary Care Health Professional Shortage Area (HPSA) by HRSA, meaning there are less primary care professionals than are necessary to accommodate the population living in that area. Census tracts within South Jamaica are also designated as Mental Health HPSAs, meaning there are less mental health care professionals than are necessary to accommodate the population living in those areas. Within JHMC’s service area, there are two facilities (Joseph P. Addabbo Family Health Center and Project Samaritan Health Services) that received Mental Health HPSA designation because they provide mental health services to an area or population group designated as having a shortage.

The Hospital also offers primary care at eight community-based extension clinics in Southwest Queens and Jamaica, which provide pediatric primary care services and are NCQA NYS 2018 PCMH recognized: MediSys – ENY, MediSys – Jamaica, MediSys – Hollis, MediSys – Hollis Tudors, MediSys – St. Albans, MediSys – Richmond Hill, MediSys – Ozone Park (Medwise/Clocktower), and MediSys – Howard Beach. In addition, the Hospital provides ambulatory services at its Women’s Health Center, Family Dental Center, Mental Health Center, Sleep Center and affiliated Advanced Center for Psychotherapy. Services are also provided by the Hospital at three public schools: PS 155 (Elementary

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INTRODUCTION

School), PS 223 (Elementary School) and Campus Magnet High School. In Queens there are eight acute care hospitals including affiliated Flushing Hospital Medical Center (FHMC), 12 nursing homes, and 48 HRSA-supported Federally Qualified Health Centers (FQHC) or Look-Alikes that provide services in Queens County and nearby Brooklyn zip codes. Three other acute care hospitals serve the communities within JHMC’s PSA: Northwell Health Long Island Jewish Forest Hills Hospital and Long Island Jewish Medical Center, and Health + Hospitals/Queens Hospital Center. There are also many diagnostic and treatment centers, as well as numerous physician group practices, and individual physician offices that also serve this area.

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

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INTRODUCTION

Social Determinants of Health (SDH)

Social Determinants of Health (SDH) are defined by Healthy People 2020 as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions can affect a wide range of health risks and outcomes. The five key social determinants of health (SDH) domains include:

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

Integrating health and human services to address SDH can have a significant impact on health outcomes. Jamaica Hospital Medical Center will integrate SDH into its approach to address the Prevention Agenda Priority Areas identified by the New York State Department of Health in its Prevention Agenda 2019-24:

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

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

Sharing Report with the Public

The full report was distributed to the members of the Hospital's Board of Trustees, who approved it on November 25, 2019. Announcement of the report’s availability will be posted on the Hospital’s social media platforms. A copy can be obtained from the Hospital’s website: https://jamaicahospital.org/community-service-plan

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COMMUNITY HEALTH NEEDS ASSESSMENT

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

Community Statistics by Primary Service Area Neighborhood

Southwest Queens Neighborhood (Community Districts 9 & 10)

Demographics
The total resident population of Southwest Queens is approximately 278,085 (2018) with a 2.2% increase projected in the next five years. Twenty-two percent of residents are age 17 and under, 16% are over 65 years. There are an estimated 58,000 females of childbearing age (15 to 44 years). 8

Overall, the population of 278,085 residents is diverse. A third of Southwest Queens residents are Hispanic/Latino (33.5%; regardless of race; 23.1% are Asian and Pacific Islander; 18.7% are White non-Hispanic; and 12.4% are Black. All others, including mixed race, comprise 12.3%. 9 Half (50.5%) of Kew Gardens and Woodhaven residents are foreign born; 45.9% of South Ozone Park and Howard Beach residents are foreign born. 10 Richmond Hill, a community known for its large Indo-Guyanese, Indo-Trinidadian and Tobagonian, and Indo-Caribbean immigrant population, as well as Little Punjab, for its large Punjabi immigrant population, has the highest percentage of foreign born residents in Southwest Queens, 55%. 11

Social and Economic Stressors
In Kew Gardens and Woodhaven: 22% of residents live in poverty, compared with 19% of Queens overall and 20% in NYC. In South Ozone Park and Howard Beach, 19% of residents live in poverty.

Housing and Employment
South Ozone Park and Howard Beach’s unemployment rate (10%) is higher than the citywide average of 9%. Fifty-six percent of South Ozone Park and Howard Beach residents are rent burdened, a higher rate than residents citywide. Unemployment rates in Kew Gardens and Woodhaven are similar to the rest of NYC. More residents are rent burdened (55%), higher than the rest of Queens (53%) and 51% city wide. Overcrowded housing conditions (> 1 person/room) are less prevalent in Southwest Queens (8.8%) than in NYC (9.0%) or Queens (10.4%). 12

Education
Twenty-three percent of South Ozone Park and Howard Beach residents over 25 years have not completed high school, compared with 19% in both Queens and NYC; Kew Gardens and Woodhaven have similar rates to Queens and NYC.

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8 Claritas Company, Demographics Snapshot, 2018
9 Ibid.
COMMUNITY HEALTH NEEDS ASSESSMENT

Crime
Kew Gardens and Woodhaven residents have lower rates of incarceration (345/100,000) than NYC (425/100,000) in general, but higher rates than the rest of Queens (315/100,000). Aggregate rates for South Ozone Park and Howard Beach (381/100,000) follow a similar pattern. Assault-related hospitalizations in Kew Gardens are lower (43/100,000) than in Queens overall (37/100,000), South Ozone Park (32/100,000), and NYC (59/100,000).

Health
Seventy-seven percent of South Ozone Park and Howard Beach residents rank their health as “excellent,” “very good”, or “good”, similar to the rest of NYC (78%). Seventy-eight percent of Kew Gardens and Woodhaven residents rank their health as “excellent”, “very good”, or “good”.

Access to Health Care
Citywide, the percentage of uninsured New Yorkers decreased in the last five years, from 20% to 12%. In Kew Gardens and Woodhaven, 15% of adults are uninsured and 7% report going without needed medical care in the past 12 months, similar to the rest of NYC. In South Ozone Park and Howard Beach, 8% of adults are uninsured, similar to the rest of NYC, and 7% report going without needed medical care in the past 12 months, lower than the rest of NYC. Overall, 20.8% of residents receive Medicaid and 11.2% are uninsured in SW Queens while 48% are privately insured.

Nutrition
There are no farmers markets in Kew Gardens and Woodhaven. The supermarket to bodega ratio is 1:11, limiting access to fresh food. In Ozone Park and Howard Beach, the supermarket to bodega ratio is 1:8; however, there are no farmers’ markets available there, as well. More Southwest Queens residents (24.7%) report drinking at least one sugary drink a day, compared to Queens (21.4%) and NYC (23%) residents. In Southwest Queens 8.7% of residents reported they sometimes/often did not have enough food, lower than the other neighborhoods in JHMC’s service area.

Smoking
In Ozone Park, the current smoking rate reported is 12.7%, lower than the NYC rate (13.4%), Yet, the rate of “former smoker” (20.4%) was higher than the NYC rate (18.4%), indicating success in smoking cessation efforts over time. The Kew Gardens rate was lower (11%) compared to 14% for Queens and NYC at large. Overall, in Southwest Queens 44% began smoking between the ages of 13 to17 years, 22.1% began between the ages of 18 to 20 years, and 22% began over the age of 21 years. Three percent began when they were less than 12 years old.

HIV
Over one third (35.2%) of Southwest Queens residents reported they had been tested for HIV in the last 12 months; while 35.8% reported they had never been tested. In 2017, incidence in Southwest Queen, 16.1/100,000 population, was below the Queens (26.1/100,000) and NYC (25.3/100,000).13

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COMMUNITY HEALTH NEEDS ASSESSMENT

Vaccinations
Forty-seven percent of teens ages 13 to 17 years in South Ozone Park and Howard Beach received all recommended doses of the HPV vaccine in 2016.\textsuperscript{14} Thirty-eight percent of South Ozone Park and Howard Beach adults report getting a flu vaccine in the same period, slightly less than the rest of NYC.

Child Health
Kew Gardens and Woodhaven have slightly higher rates of childhood obesity (22%) than South Ozone Park and Howard Beach (21%) Queens and the rest of NYC (20% in each community). Childhood hospitalization rates in Kew Gardens and Woodhaven (816/100,000) are higher than South Ozone Park and Howard Beach (656/100,000) and Queens (461/100,000).\textsuperscript{15} Among children in Southwest Queens tested for elevated blood lead levels, 19.7% had over 5 mcg/dL or greater, compared to 14.3% in Queens overall and 16.5% in NYC.\textsuperscript{16}

Adult Obesity
In Southwest Queens, 29.8% of adults are overweight, lower than the rates for Queens (34.1%) and NYC (32.2%). In contrast, obesity rates in Southwest Queens (30.2%) are higher than for Queens (23.7% and NYC at large (25.1%).

Physical Activity
In 2017, 71.1% of Southwest Queens residents reported some physical activity in the past 30 days, less than Queens (74%) and NYC (74.5%).

Chronic Disease
The diabetes rate in Southwest Queens is 14%, compared to both Queens and NYC at 11.5%. Hypertension rates are similar to that of Queens and NYC– 29% versus 27% in Queens and 28% in NYC.

Prenatal Care
Overall 6.8% of pregnant women in NYC had late (beginning third trimester) or no prenatal care, compared to Queens (8.2%) and Brooklyn (6.1%). South Ozone Park and Howard Beach (9.0%) and Kew Gardens and Woodhaven (8%) had higher rates of late or no prenatal care. 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.\textsuperscript{17}

Avoidable Hospitalizations
The rate of avoidable hospitalizations among adults in South Ozone Park and Howard Beach (1,181/100,000) is similar to Kew Gardens and Woodhaven (1,183/100,000). However, both communities have higher avoidable hospitalization rates than in Queens (1,028/100,000) and NYC (1,033/100,000).

\textsuperscript{14} HPV Vaccination: NYC DOHMH, Citywide Immunization Registry, 2017.
\textsuperscript{15} Avoidable Hospitalizations among Children: New York State Department of Health, Statewide Planning and Research Cooperative System (2014) as reported in NYC Community Health Profiles 2018.
\textsuperscript{16} Keeping Track Online: Citizen’s Committee for Children (2016 data).
\textsuperscript{17} 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
COMMUNITY HEALTH NEEDS ASSESSMENT

Premature Death
In South Ozone Park and Howard Beach, the collective premature death rate is slightly lower than the rest of NYC (154.6/100,000 versus 169.5/100,000, respectively). This lower rate is due primarily to less cancer or drug related deaths. In Kew Gardens, the premature death rate is (137.9/100,000). The three leading cases of cancer-related premature death in Kew Gardens are lung, breast, and colorectal cancer. Heart disease is the second leading cause of death at 30.4/100,000. Residents in Kew Gardens have a life expectancy of 82.9 years, 1.7 years longer than NYC overall. South Ozone Park and Howard Beach’s life expectancy is 81.7 years.

Mental Health
New York City residents reported a rate of current depression of 9.3%; higher than the overall Queens rate of 7.7%, but lower than the rates in both East New York (10.9%) and Jamaica (12.0%). The rate of adult psychiatric hospitalization in Kew Gardens (479/100,000) and South Ozone Park (488/100,000) are lower than the Queens’ rate (513/100,000) and that of NYC (676, 100,000).18

Jamaica Neighborhood (Queens Community Districts 8 & 12)
Demographics
The total population of Jamaica in 2018 was 303,163 residents with a 2.7% increase projected by 2023. Almost 50% of the population is Black non-Hispanic; 19.5% is Hispanic; 17.4% is Asian and Pacific Islanders; 6.2% is White non-Hispanic; and “all-others” comprise 7.4% of the population. Approximately 23% are under the age 17; 16% are over 65; and there are approximately 64,740 women of childbearing age (15-44).19 Half of Hillcrest and Fresh Meadows’s population (49.6%) are foreign born; in Jamaica and Hollis, 62.5% of residents are foreign born.20

Social and Economic Stressors
Poverty and its effects on health, particularly on mental/behavioral health and nutrition, are of significance in Jamaica. Living in high-poverty neighborhoods limits healthy options and makes it difficult to access quality health care and resources that promote health. In Jamaica, incomes are disparate—20% of residents earn less than $25,000 per year; 39.5% earn less than $50,000, despite an average median Income of $56,836.21 Poverty rates in Hillcrest and Fresh Meadows (22%) and Jamaica and Hollis (20%) are higher than the rate for Queens.

Housing and Employment
Access to affordable housing and employment opportunities with fair wages and benefits are also closely associated with good health. Jamaica and Hollis’ (Hollis is a small sub-neighborhood of approximately 20,000 residents who are primarily African-American) unemployment rate is over 30% higher than the citywide average of 9%; unemployment in Hillcrest and Fresh Meadows matches the NYC rate. Fifty-six percent of Jamaica and Hollis residents and 54% of Hillcrest and Fresh Meadows residents are rent burdened, a higher rate than residents citywide (51%). Rent burdened households pay more than 30% of their income for housing and may have difficulty affording food, clothing,
transportation, and health care. Compared with other NYC neighborhoods, housing in Jamaica is more crowded, with 10.7% having more than one person per room vs. 9.0% for NYC. Adults living in Jamaica reported higher rates of mold in the home (11.6%) than the rest of Queens (8.6%), and NYC (9.5%). Asthma hospitalizations for children ages 5-17 (25/100,000) are significantly higher than the borough of Queens (15.4/100,000), and slightly lower than NYC (27.2/100,000).

Education
Approximately 19% of Jamaica and Hollis residents did not complete high school; 29% have completed college, compared to 39% of residents in Queens and 43% citywide. Hillcrest and Fresh Meadows residents are more educated compared to residents of Jamaica and Hollis. In Hillcrest and Fresh Meadows, only 14% did not obtain a high school diploma, while 50% obtained a college degree.

Crime
Compared with the citywide rate, Jamaica and Hollis has a higher rate of assault-related hospitalizations (68/100,000 population 16+) compared to Hillcrest and Fresh Meadows (22/100,000), Queens at large (37/100,000), and NYC (59/100,000). The Jamaica and Hollis incarceration rate is significantly higher than the rest of NYC—789/100,000, compared to Hillcrest and Fresh Meadows (191/100,000), Queens, (315/100,000) and NYC at large (425/100,000).

Health
Eighty-two percent of Jamaica and Hollis residents rank their health as “excellent,” “very good” or “good,” compared to 76% in Queens, 78% in NYC, and 79% in Hillcrest and Fresh Meadows. Life expectancy of Jamaica and Hollis residents is 80.5 years or 0.7 years shorter than NYC overall, while Hillcrest and Fresh Meadows residents’ life expectancy is 2.7 years longer.

Access to Health Care
In 2017, 15.7% of Jamaica residents had no health insurance, higher than the rate for Queens (14.8%) and NYC (11.8%). A higher number of Jamaica residents (10.9%) reported they did not get needed medical care due to cost, compared to 8.6% in Queens and 10.3% (NYC). In 2016, 16.6% reported they did not fill prescriptions due to cost, higher than the rate for Queens (15.2%) or NYC (14.8%). The insurance profile of residents reveals that 19.9% are on Medicaid, 15% on Medicare, and 44% are privately insured.

Nutrition
Nearly one-third (31.3%) of Jamaica residents reported they drank one or more sugary drinks daily; as compared to 23% overall for NYC and 21.4% overall for Queens. Bodegas are less likely to have healthy food options than supermarkets. The lowest ratio among NYC community districts is one supermarket for every three bodegas (healthier): Jamaica and Hollis has 20 bodegas for every supermarket; Hillcrest and Fresh Meadows is healthier with a 1:5 ratio. More than one-third (36.4%) of Jamaica and Hollis households receive SNAP benefits, higher than Hillcrest and Fresh Meadows (19.2%), Queens (22.8%), and NYC (29.4%). More than one-tenth (10.5%) of Jamaica households

22 NYC Environmental & Health Portal.
23 Ibid.
24 Environment & Health Data Portal.
25 Keeping Track Online, Citizen’s Committee for Children (2017 data).
COMMUNITY HEALTH NEEDS ASSESSMENT

reported they sometimes/often did not have enough food, higher than food insecurity rates in Queens (8.6%), and NYC (9.6%).

Smoking
In the 2018 Community Health Profiles, 8% of Jamaica and Hollis residents reported they smoked, lower than the 14% rate for Hillcrest and Fresh Meadows, Queens, and NYC. In the 2016 Community Needs Assessment, 69% of smokers in Jamaica stated they began smoking in their youth (43.4%, ages 13-17 years; 22.1%, ages 18-20 years; with 28% starting over the age of 21 years). While e-cigarette use has declined in Queens and NYC since 2014, it has increased in the 18-24 age group.

HIV
In 2017, there were 400 new HIV diagnoses in Queens, or 19% of all HIV diagnoses in NYC. In 2017, 36.5% reported they had been tested for HIV in the last year, with 31% reporting they have never been tested. This compares favorably with NYC’s overall rates of 34.3% in the last year and 34.3% never tested. The incidence rate for HIV in Jamaica was second highest in the borough (25.2/100,000 population), after West Queens (26.1/100,000).

Vaccinations
Fifty-five percent of teens ages 13 to 17 in Jamaica and Hollis received all recommended doses of human papillomavirus (HPV) vaccine to protect against cancer, higher than Queens (52%), but lower than NYC (59%). HPV vaccination rates were lower in Hillcrest and Fresh Meadows (43%). One-third (34%) -of Jamaica and Hollis adults report getting a flu vaccine in the past 12 months, compared to 44% in Hillcrest and Fresh Meadows, 42% in Queens, and 43%, in all of NYC.

Child Health
Twenty-three percent of children in grades K-8 in Jamaica and Hollis are obese, compared to 20% in Queens and NYC overall; the child obesity rate is lower in Hillcrest and Fresh Meadows (18%). The rate of avoidable pediatric hospitalizations among children ages 4 and younger in Jamaica and Hollis (809/100,000) is 75% higher than the Queens rate (461/100,000) and 30% higher than NYC overall (623/100,000). Avoidable pediatric hospitalizations in Hillcrest and Fresh Meadows (403/100,000) are half that of Jamaica and Hollis. Among children tested for elevated blood lead levels in Jamaica, 17.1% had levels over 5 mcg/dL compared to 14.3% in Queens and 16.5% in NYC.

Adult Obesity
Overweight (34.2%) and obesity (32.8%) rates in adults were higher in Jamaica compared to 34.1% overweight and 23.7% obese for respondents in Queens. Manhattan’s respondents, in comparison, reported a much lower obesity rate (17.4%). The overweight rate in Manhattan (27.3%) is the lowest of the five boroughs.

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26 HIV/AIDS in Queens, NYC 2017. HIV Epidemiology and Field Service Program
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Physical Activity
In NYC overall, 74.5% of residents reported participating in some form of physical exercise during the past 30 days such as running, golf, gardening, or walking. Fewer Jamaica residents, 71.4%, reported exercising compared to 74% of Queens residents.

Chronic Disease
Jamaica residents have a higher rate of diabetes (15%) than Queens and NYC (11.5%). Hypertension rates are also significantly higher in Jamaica (37%) as compared to Queens (27%) and NYC (28%).

Prenatal Care
In Jamaica and Hollis, 12.5% of women had late (beginning in the third trimester) or no prenatal care. This rate is nearly two times higher than NYC (6.8%) and Brooklyn (6.1%) and exceeds that of Queens (8.2%). Women residing in Hillcrest and Fresh Meadows had significantly better prenatal care – 7.2% had late or no prenatal care. Overall in NYC, 13% of Black women, 7% of Hispanic, and 5% of Asian women received late or not prenatal care compared to 3.1% of White women. 29

Avoidable Hospitalizations
The rate of avoidable hospitalizations among adults in Jamaica and Hollis is substantially higher than the citywide rate—1,602/100,000 compared to 1,028/100,000 (Queens) and 1,033/100,000 (NYC). 30 Avoidable hospitalizations in Hillcrest and Fresh Meadows, 834/100,000 are lower than Queens and NYC rates.

Premature death
Cancer and heart disease are the leading causes of premature death (measured as death before the age of 65). However, Jamaica and Hollis residents die prematurely at a rate higher than NYC as a whole (190.1/100,000 versus 169.5/100,000, respectively). Lung cancer, breast cancer (among women), and colorectal cancer are the three leading causes of cancer-related premature deaths in Jamaica and Hollis. Homicide (9.5/100,000 before age 65) and accidents are also higher than the NYC average for premature death. In Hillcrest and Fresh Meadows, premature death rates are lower than NYC (121.2/100,000). The three leading causes of cancer-related premature deaths are lung cancer, colorectal cancer, and breast cancer. Drug-related deaths rank as the third highest cause of premature deaths in Hillcrest and Fresh Meadows.

Mental Health
Jamaica’s self-reported rate of depression is higher (12%) than the rest of Queens (7.7%) and NYC overall (9.3%). The rate of adult psychiatric hospitalization in Jamaica and Hollis (758/100,000) is higher than the rate in Queens (513/100,000) and in NYC overall (676/100,000). In Hillcrest and Fresh Meadows, the rate of psychiatric hospitalizations for adults, 552/100,000, is lower than NYC.

29 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
30 Ibid
COMMUNITY HEALTH NEEDS ASSESSMENT

**East New York Neighborhood (Brooklyn Community Districts 4 & 5)**

**Demographics**
When compared to the rest of NYC and the U.S. the population of East New York (ENY) is younger, less educated, poorer, and more ethnically diverse.\(^{31}\) The total resident population is 203,592; 49.4% are Black; 38.3% identify as Hispanic/Latino; 6.3% are Asian; 2.2% are White; and 3.8% represent all other racial/ethnic groups. Thirty-five percent of residents are foreign born.\(^{32}\) There are 47,505 women of child-bearing age (15 to 44 years).\(^{33}\)

**Social and Economic Stressors**
Thirty-five percent of household incomes are below $25,000; 58.8% are below $50,000. The median household income is $56,789 compared to the national average of $86,278.\(^{34}\) The poverty rate for East New York and Starrett City is the highest in JHMC’s service area, 30%, compared to Brooklyn (21%) and NYC overall (20%); Bushwick’s poverty rate is 25%.

**Housing and Employment**
Among the three neighborhoods served by JHMC, East New York residents experience the highest rate of overcrowded housing, with 13.8% of households living with greater than one person per room, compared to 9.0% in NYC and 10.4% in Brooklyn. Fifty-five percent of Bushwick renters are rent-burdened, spending more than 30% of their income on housing; 52% are rent-burdened in East New York, inclusive of Starrett City (a housing complex within ENY). Forty percent of renter-occupied homes are adequately maintained by landlords—free from heating breakdowns, cracks, holes, peeling paint, and other defects—in Bushwick and 38% in East New York and Starrett City, slightly better than NYC’s overall rate (44%). Thirty-four percent of East New York and Starrett City households report seeing cockroaches, which is a potential asthma trigger for residents of any age. The unemployment rate for East New York and Starrett City is 10% higher and Bushwick’s is 44% higher than the rest of the borough and that of NYC.

**Education**
Twenty-three percent of East New York and Starrett City residents did not finish high school compared to an average of 20% in Brooklyn and 19% in NYC; the percent of residents with college degrees is less than half that of NYC (21% vs. 43%). In Bushwick, 35% of residents did not receive a high school diploma, the highest in JHMC’s area, but 29% completed college.

**Crime**
East New York and Starrett City has a higher rate of assault-related hospitalizations—113/100,000 population, nearly double the Brooklyn and NYC rate (59/100,000) and 1.5 times higher than in Bushwick (72/100,000). The incarceration rate for individuals over the age of 16 in East New York and Starrett City was 1,065/100,000, more than twice that of Brooklyn (460/100,000) and NYC (425/100,000), and significantly higher than in Bushwick (610/100,000).

\(^{31}\) US Census Quick Facts: [https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork/PST120218](https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork/PST120218)


\(^{33}\) Claritas Company, Snapshot 2018.

\(^{34}\) Claritas Company, 2018 Snapshot.
COMMUNITY HEALTH NEEDS ASSESSMENT

Health
In East New York and Starrett City, 70% of residents reported their own health as “Good” to “Excellent”, compared to 77% in Brooklyn and 78% in NYC; reported health status was slightly better in Bushwick – 71%.

Access to Health Care
Twelve percent of East New York residents receive Medicare and 37% received Medicaid. Ten percent of East New York adults are uninsured; an uninsured rate that is lower than Brooklyn (12.1%) and NYC (11.8%). Nearly 7% report going without needed medical care in the past 12 months; a rate that is lower than both Brooklyn (11.7%) and NYC (10.3%).

Nutrition
The percentage of East New York and Starrett City adults (76%), as well as Bushwick residents (82%) who report eating at least one serving of fruits or vegetables in the past day (76%) is lower than the citywide average of 87%. While sugary drink consumption has decreased to 23% in NYC, nearly a third of ENY adults (31%) drink at least one sugary beverage per day; Bushwick’s consumption was the same as the City. While East New York and Starrett City is home to five farmers markets, the supermarket to bodega ratio is 1:13; the rate in Bushwick is worse – 1:31. In a 2017 survey, East New York and Starrett City ranked first of 59 locations in NYC for the number of households receiving SNAP benefits (34,852), representing one-third of households; Bushwick ranked 29th among the 59 community districts. Over 11% of East New York residents reported they sometimes/often did not have enough food, ranking it 8th highest among NYC community districts.

Smoking
Seventeen percent of East New York residents smoke, compared to Brooklyn (13.6%) and NYC (13.4%). Fifty-seven percent of smokers reported they began smoking between the ages of 13 to 17; 17% began between the ages of 18 to 20, and 22% began over the age of 21.

HIV
In the last year, although 47.4% of East New York residents have been tested for HIV, 23.5% have never been tested. In 2017, East New York experienced the highest incidence rate in New York City, 47.2/100,000 population, almost three times higher than Queens and almost twice that of NYC as a whole.

Vaccinations
Fifty-eight percent of teens 13 to 17 years in East New York and Starrett City received all recommended doses of HPV vaccine; a rate that is similar to Bushwick (57%) and NYC (59%), and higher than the Brooklyn average (43%). Only 35% of adults in East New York and Starrett City received a flu shot, less than Brooklyn (38%) and NYC (43%); the flu vaccination rate was slightly higher in Bushwick (37%).

35 Citizen’s Committee for Children. Keeping Track Online – Status of New York City Children. East New York
36 Community Health Profile, 2018, HIV status.
37 HPV Vaccination: NYCDOHMH, Citywide Immunization Registry, 2017
COMMUNITY HEALTH NEEDS ASSESSMENT

Child Health
Twenty-five percent of East New York and Starrett City and 28% of Bushwick children in grades K-8 are obese, higher than Brooklyn overall (19%) and NYC (20%). The rate of avoidable pediatric hospitalizations for children under the age of 4 (981/100,000) is much higher in East New York and Starrett City (981/100,000) than in Brooklyn (502/100,000) and NYC (623/100,000); Bushwick rates are somewhat lower (747/100,000). Sixteen percent of children (less than 6 years old) tested in East New York had elevated blood lead levels of 5 mcg/dl or greater, compared to 16.5% in NYC and 22.3% in Brooklyn overall.\(^38\)

Adult Obesity
Overweight (35.5%) and obesity (30.8%) rates in adults were higher in East New York compared to 32.0% overweight and 26.5% obese for respondents in Brooklyn. The percentage of adult East New Yorkers who are either overweight or obese, 70.2%, is the highest of the three JHMC PSA neighborhoods.

Physical Activity
A higher percentage of East New York residents, 72.4%, reported exercising in the past 30 days compared to 71.7% of Brooklyn residents. East New York’s rate, however, was lower than NYC (74.5%).

Chronic Disease
In 2017, 15.2% of East New York residents had ever been diagnosed with Diabetes, higher than in Brooklyn (11.6%) and NYC (11.5%). Thirty-seven percent had hypertension, a third higher than Brooklyn and NYC (28%).

Prenatal Care
Overall 6.8% of pregnant women in NYC had late (beginning third trimester) or no prenatal care, compared to Queens (8.2%) and Brooklyn (6.1%). East New York and Starrett City had a high rate (11.1%) of late or no prenatal care as compared to Bushwick (7.4%). In NYC, 13% of Black women, 7% of Hispanic, and 5% of Asian women received late or not prenatal care compared to 3.1% of White women. \(^39\)

Avoidable Hospitalizations
The rate of avoidable hospitalizations among adults residing in East New York and Starrett City is more than double the citywide rate — 2,245/100, compared to 1,420/100,000 in Brooklyn and 1,033/100,000 in NYC. Avoidable hospitalizations are lower in Bushwick, 1,897/100,000, but still almost double the NYC rate.

Premature Death
East New York and Starrett City has a higher rate of premature death, with cancer and heart disease as the two leading causes of premature death. Death rates from HIV, homicide, and diabetes rates are more than twice that of NYC, overall. Lung cancer, breast cancer (among women), and colorectal

\(^{38}\) Citizen’s Committee for Children. Keeping Track Online. Children under 6 with elevated blood levels, 2016

\(^{39}\) 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
cancer are the three leading causes of cancer-related premature death in East New York and Starrett City. The average life expectancy in East New York and Starrett City is 78.6 years, 2.6 years less than NYC overall. Premature death rates are higher in Bushwick (205.7/100,000) than in East New York and Starrett City. Death rates for cancer, heart disease, diabetes, and accidents are lower in Bushwick than East New York and Starrett City, while drug-related death rates are higher.

Mental Health
East New York residents report a depression rate of 10.9% which is higher than Brooklyn (8.4%) and NYC (9.3%). The rate of psychiatric hospitalization in East New York and Starrett City – (1,112/100,000) is higher than the rate in Brooklyn (684/100,000) and NYC (676/100,000). Psychiatric hospitalization rates are lower in bushwick - 574/100,000.
COMMUNITY HEALTH NEEDS ASSESSMENT

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

**Priority Area I: Prevent Chronic Disease**

**Focus Area 1: Healthy Eating and Food Security**

**Overarching Goal: Reduce obesity and the risk of chronic diseases**

![Obesity Rate 2015-2017 Graph]

*Comment:* Body Mass Index (BMI) is calculated based on respondent's self-reported weight and height. A BMI between 25.0 and 29.9 is classified as overweight, and a BMI of 30 or greater is classified as obese. Obesity rates are higher in JHMC’s service area than in the boroughs of Queens and Brooklyn or in NYC, and higher than the NYS Prevention Agenda target (24.2%) for 2019-2024.
**COMMUNITY HEALTH NEEDS ASSESSMENT**

**Goal 1.1:** Increase access to healthy and affordable foods and beverages

*Comment:* Residents of ENY, Jamaica, and SW Queens are more likely to consume at least 1 sugary drink per day, compared to NYC or the boroughs of Queens and Brooklyn, and are significantly higher than the Prevention Agenda 2019-2024 benchmark (22.0%). Consumption of sugary drinks can lead to obesity.

**Goal 1.2:** Increase skills and knowledge to support healthy food and beverage choices.  
Supermarket to Bodega Ratio.  *Data from NYC DOHMH, EpiQuery, 2018 Community Health Profiles*

*Comment:* The Bushwick community district has the highest supermarket to bodega ratio - for every 1 supermarket in Bushwick, there are 31 bodegas.-providing a less healthy food selection than other neighborhoods in the hospital’s service area.
Goal 1.3: Increase food security. *Data from Community Health Surveys, 2018 Food Insecurity (EpiQuery, 2017 data)*

**Comment:** In Jamaica and ENY, more than 10% of adults reported that they did not have enough food sometimes or often.

**Resources and Accomplishments:** JHMC strives to help its community members reduce obesity and empower them to make health-conscious nutrition decisions. The Hospital’s services include nutritionists and also Lifestyle Coaches, 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. JHMC participated in the NYC Department of Health and Mental Hygiene’s “Healthy Hospital Food Initiative” to create a healthier food environment through such activities as meeting standards for food offered to inpatients, stocking vending machines with healthy foods and beverages and offering healthy choices in the hospital cafeteria. Breastfeeding is encouraged by Jamaica Hospital’s staff as another healthy means of helping postpartum mothers to shed weight gained during pregnancy and potentially reducing the risk of pediatric obesity and other health problems for their children.

The NYC Department of Health and Mental Hygiene offers a “Health Bucks” program, through which fresh fruits and vegetables can be purchased at all farmers’ markets in NYC. The Hospital’s Women, Infants, and Children (WIC) program provides clients with Farmers’ Market Nutrition Program (FMNP) and eWIC funds to assist them with shopping for healthy food at the Farmstand. FMNP checks are also given to seniors: one hundred were given out during the 2019 season. Ten farmers’ markets are found in JHMC’s service area, including Jamaica Hospital Farm Stand, which offers a variety of seasonal fruits and vegetables, cooking demonstrations, and free health screenings once a week.
COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

Focus Area 2: Physical Activity

Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities. Access to parks. Data from NYC Planning Department, Community District Profiles, Access to Parks, 2016, from NYC Department of Parks and Recreation

Comment: Four of the 5 Community Districts served by JHMC have less access to bike lanes than NYC overall. Two of the 3 neighborhoods served by JHMC have less access to City parks than NYC overall. NYC has set a 2030 target of 85% of residents living within walking distance of a City park.
COMMUNITY HEALTH NEEDS ASSESSMENT

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

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

![Percent that Exercised in Past 30 Days](chart)

**Comment:** In 2017, 70% or more residents exercised in the past 30 days. Residents of 2 neighborhoods, Jamaica and SW Queens, are exercising more each year since 2015. Exercise habits dipped in East New York, Brooklyn, Queens, and NYC in 2016 but came back up in 2017.

**Resources and Accomplishments:** JHMC participates in the New York City Department of Parks and Recreation’s Shape Up NYC program, which offers free drop-in fitness classes at multiple locations across NYC. Several separate classes each week are offered at the Hospital’s MediFit Gym which are open to employees and members of the community. The number of classes varies according to the availability of volunteer instructors from the Shape Up NYC program.

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

This information is posted on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
Focus Area 3: Tobacco Prevention

Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (electronic cigarettes and similar devices) by youth and young adults.

Source: EpiQuery Community Health Survey 2017, 2016 data

Comment: Smoking rates are highest in ENY – 17.1%. Smoking rates in Jamaica are close to reaching the Prevention Agenda’s 2024 target of 11.0%. Queens, and Brooklyn have smoking rates higher than the 2017 NYC average (13.4%).

Comment: In Jamaica and SW Queens, nearly 45% of residents begin smoking between the ages of 13 and 17. ENY residents begin smoking at a younger age.
Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability.

Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products.

Source: EpiQuery Community Health Survey, 2018

Comment: The 18-24 year age group are most likely to try e-cigarettes and are the only age group that increased usage in 2017. The vaping rate in young adults in 2017 (13.7%) is nearly twice that of the Prevention Agenda goal of 7.0%.

Resources and Accomplishments: JHMC has obtained and is maintaining the standards for Gold Star status from the NYC Tobacco-Free Hospitals campaign for its tobacco cessation work with patients and employees. The Hospital has updated its electronic health record (EHR) system to introduce smoking cessation counseling prompts, to make electronic referrals from its EHR directly to the New York State Quit Line and to give all smokers educational literature about quitting at discharge. Physicians conduct a mandatory 5-question assessment of all patients to screen for tobacco usage and gauge readiness to quit. In 2018, the Hospital assessed 95% of inpatients and 92% of outpatients; outpatients who required cessation interventions received them. Fewer outpatients are smokers, 8.9% compared to 17.4% in 2017. Patient navigators who are Freedom From Smoking facilitators offer free smoking cessation counseling to all patients and employees who smoke. In 2018, the Hospital offered 22 outreach and educational events that reached 266 people and resulted in 37 signing up for a smoking cessation program. At its once a week seasonal Farmstand, and off-season in the main lobby, the Hospital recruits smokers to join tobacco cessation counseling sessions as well as offering Blood Pressure Screening and when staff is available, oral health screenings. In addition to JHMC’s community-based efforts and programming aimed at reducing tobacco use, there are three other hospital-based tobacco cessation programs (Flushing Hospital, New York Hospital Queens, and Elmhurst Hospital) in Queens.

JHMC, through the Public Affairs Department, regularly posts articles and videos warning of the dangers of using all tobacco and e-cigarette related products as well as offers information, such as tips and resources to quit smoking.
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This information is shared on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.

Focus Area 4: Preventive Care and Management

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

**Comment:** Cervical cancer screening rates in Jamaica’s service area which range between 81% and 85%, are similar to that of NYC but do not reach the HP2020 benchmark of 93%. Colon cancer screenings were stable from 2016 to 2017, except for ENY, where the percentage of residents who were screened for colon cancer increased from 58% to 78%, getting close to the 2019-2024 Prevention Agenda target of 80.0%.
COMMUNITY HEALTH NEEDS ASSESSMENT


**Comment:** ENY and Jamaica have the highest incidence of diabetes mellitus (DM) and hypertension (HTN) in the hospital’s service area. Percentages exceed borough and citywide averages.

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


**Comment:** Compliance with taking prescribed blood pressure medication is lowest in the Southwest Queens neighborhood. For SW Queens, no data was provided for 2017. The data was repressed due to imprecise and unreliable estimates. In Jamaica and ENY, medication compliance improved between 2015 and 2017.
COMMUNITY HEALTH NEEDS ASSESSMENT

Resources and Accomplishments: JHMC’s ambulatory care clinics have achieved the goal of National Center for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition at the highest level (Level 3) that offers each patient their own primary care practitioner who provides evidenced-based care and support and encouragement with self-management. The Hospital is a collaborative stakeholder in the Patient-Centered Primary Care Collaborative, which is dedicated to promoting policies and sharing best practices to support an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home.

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

A similar approach is being taken to provide expanded evidence-based care for diabetic patients. Patient navigators are providing health education and health coaching, as well as facilitating evidence-based National Diabetes Prevention Program (NDPP) sessions.

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

JHMC partners with the Cancer Services Program to offer free screenings to low-income and uninsured patients for breast, cervical, and colorectal cancers. Extended evening and weekend hours are offered.

JHMC 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.

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

This information is shared on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
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Priority Area II: Promote a Healthy and Safe Environment
Focus Area 1: Injuries, Violence and Occupational Health

Goal 1.1: Reduce falls among vulnerable populations. *Source: NYS DOH, Community Indicator Reports CHIRS*.

**Comment:** Among the elderly, the risks of falls increases with age, as does the hospitalization rate for falls. The fall hospitalization rate for Queens is higher than Brooklyn, NYC, or NYS. The combined hospitalization rate for the 65+ age group is 178.0/10,000 population, a little higher than the Prevention Agenda target – 170.1/10,000.

Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations. Assault-Related Hospitalizations and Incarceration Rates per 100,000.

*Source: NYC Community Health Profiles for Jamaica, Kew Gardens and Howard Beach, South Ozone Park and Eastern New York*

**Comment:** The assault-related hospitalization rate in ENY is almost double that of Brooklyn and NYC, and triple that of Howard Beach. ENY also has the highest incarceration rate.
Goal 1.3: Reduce occupational injuries and illness.  
Work-related hospitalizations per 100,000 employed persons aged 16 years and older.  
*Source: NYS DOH, Community Health Indicator Reports (CHIRS), 2014-2016*

![Graph showing work-related hospitalization rates](image)

**Comment:** The rates of occupational injuries resulting in hospitalization are lower in Queens (103.9) and Brooklyn (75.9) than Statewide (122.0).

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

![Graph showing bicycle injuries](image)

**Comment:** The police precincts in Brooklyn CD 4 and CD 5 (ENY) have the highest incidence of bicycle injuries. The vast majority of bicycle injuries are between bicycles and motor vehicles.
Resources and Accomplishments: JHMC is designated as a Level 1 Trauma Center that is available 24 hours a day, 7 days per week, and includes trauma, orthopedic, and neurosurgeons as well as physicians from a range of fields including emergency medicine, radiology, anesthesiology, intensive care, and rehabilitation medicine. JHMC sponsors research related to injury-prevention and improving clinical and behavioral outcomes of patients who have sustained injuries due to accidents or violent events. The Trauma Department received a grant from the Governors Traffic Safety Committee to address distracted walking and driving through community education and partnership with community organizations. The campaign, Be Aware Queens, aims to reduce accidents and injuries due to distracted driving and walking which has become more prevalent in recent years due to society's increased use of smart phones, applications, social media, and other attention grabbing tech. The nurses at JHMC 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 the environment they came. 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.

In addition to Jamaica Hospital’s Level 1 Trauma Center, Regional Trauma Center, services are available within Queens at Regional Trauma Centers at Elmhurst Hospital, New York-Presbyterian/Queens, and the Level I Pediatric Trauma Center at Long Island Jewish Medical Center. JHMC 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, such as Stay Active and Independent for Life (SAIL) and Tai Chi for Arthritis that are designed to promote healthy exercise habits, strengthen joints, increase stability, and reduce the likelihood of falls. There are five senior citizen centers offering evidence-based falls prevention programming in East New York (Brooklyn). Jamaica (Queens) has 12 senior citizen centers offering these programs, including three sites for Jamaica Service Programs for Older Adults (JSPOA). Southwest Queens has three senior citizen centers offering fall-prevention programs, including two Services Now for Adult Persons (SNAP) sites.

JHMC emergency department reported 770 fall-related trauma cases between January and November 2018. Senior citizens accounted for 68% of those cases. To address this critical issue, JHMC’s trauma division gathered data from its registry to pinpoint areas with the highest concentration of falls. Using that information, the injury prevention coordinator scheduled workshops at local senior centers to educate seniors on strategies to avoid falls. The workshops covered everything from identifying fall risk factors to home safety strategies and resources available to seniors, such as exercise programs. Using CDC’s Stopping Elderly Accidents, Deaths, and Injuries falls risk self-assessment survey, JHMC identified seniors at moderate to high risk of falling. This enabled the injury prevention coordinator to make recommendations and encourage seniors to speak with their physicians about better managing their risk of falling.

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

This information is shared on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
Focus Area 2: Outdoor Air Quality

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

Comment: Neighborhood pollution levels for fine particulate matter, the most harmful outdoor air pollutant, are similar to borough and citywide levels. Pollution levels for fine particulate matter vary by neighborhood, from a low of 7 micrograms in Jamaica and Hollis (as shown here) to 11.3 micrograms in Midtown (Manhattan, not pictured here).

Resources and Accomplishments: JHMC is part of the Asthma Coalition of Brooklyn and Queens (formed in 2012), in which organizations work together to improve the quality of life for people with asthma by engaging patients, families, healthcare providers, institutions and the community. JHMC’s Division of Pulmonary Medicine offers a wide variety of services to help diagnose and treat patients with lung disease, such as asthma. The Hospital’s Division of Allergy and Immunology focuses on the diagnosis and long-term treatment of allergic and immunologic conditions, such as asthma. JHMC’s Patient Navigators are trained to conduct group counseling in the “Freedom from Smoking” program by the American Lung Association. In 2018, JHMC was awarded the Stony-Wold Herbert Community Grant to train one respiratory therapist to become a Certified Asthma Educator, whose job is to educate all inpatients with asthma before discharge about how to manage their condition at home.

Trained JHMC clinic and school-based health center staff identify patients with persistent asthma symptoms and use evidence-based guidelines to patients and promote self-management of their condition. Asthma action plans are created for all patients and each patient receives a controller medication (inhaled corticosteroid). Asthma control tests are implemented periodically to evaluate and properly manage asthma and its symptoms. In the second year after implementation, 91% of patients had an asthma action plan and 100% were prescribed an inhaled corticosteroid.
Focus Area 3: Built and Indoor Environments

Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change.
Homes near structures rated good or excellent (%), 2014. Source: NYC DOHMH, Neighborhood Profiles, Environment & Health Data Portal, 2014

![Bar graph showing homes near structures rated good or higher in 2014. ENY: 51.3%, SW Queens: 85.3%, Jamaica: 75.0%, Brooklyn: 73.0%, Queens: 83.7%, NYC: 76.7%.]

Comment: Housing integrity is rated higher in SW Queens and Jamaica, as compared to ENY.

Goal 3.2: Promote healthy home and school environments.
Homes with mice or rats in building (percent), 2014. Source: NYC DOHMH, Neighborhood Profiles, Environment & Health Data Portal, 2014

![Bar graph showing homes with rodents in buildings. ENY: 34.5%, SW Queens: 14.9%, Jamaica: 15.6%, Brooklyn: 23.3%, Queens: 13.4%, NYC: 18.5%.]

Comment: ENY has almost double the number of homes with mice or rats in the building than the NYC average. The Bushwick neighborhood, home to the Bushwick public housing development, has been identified as one of NYC’s “hot spots” for rat infestation. In 2018, 12% of properties inspected by the NYC Health Department failed for rats.40 SW Queens and Jamaica are lower than NYC.

Resources and Accomplishments: Beginning in early 2019, patients who have housing and other legal issues that can negatively affect their health can receive legal advice at the new LegalHealth clinic recently funded by JHMC. Lack of access to safe and adequate housing, food, or secure employment can impede their ability to seek and receive appropriate healthcare series for themselves and their families. Every week, an attorney from LegalHealth, a division of the New York Legal Assistance Group, visits JHMC’s Ambulatory care Center to provide legal counsel to hospital patients on issues relating to housing complaints, government benefits and other unmet social needs. Addressing these issues will ultimately improve the health of JHMC’s patients and potentially reduce unnecessary ER visits and hospital admissions. Patients in need of temporary and/or permanent housing are referred to the NYC Department of Social Services, NYC Housing Authority, Queens Community House, and other community support agencies.

Focus Area 4: Water Quality

Goal 4.1: Protect water sources and ensure quality drinking water.
Percentage of school water outlets exceeding the lead limit of 15 ppb. Source: Health Data NY, Lead Testing in School Drinking Water Sampling and Results, 2017

Comment: ENY schools had the highest percentage (11.0%) of water outlets exceeding the lead limit (> 15 ppb) of the 3 neighborhoods. Jamaica and SW Queens were under the NYC average of 7.0%.
COMMUNITY HEALTH NEEDS ASSESSMENT

**Goal 4.2:** Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water.


<table>
<thead>
<tr>
<th>Borough</th>
<th>Water Samples Exceeding Bacteria Limits, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens</td>
<td>6.1%</td>
</tr>
<tr>
<td>Brooklyn</td>
<td>3.6%</td>
</tr>
<tr>
<td>Bronx</td>
<td>1.0%</td>
</tr>
<tr>
<td>Staten Island</td>
<td>8.9%</td>
</tr>
<tr>
<td>NYC</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

*Comment:* Queens' beaches exceeded safe water testing limits more frequently than the NYC average. Brooklyn's beaches were below NYC.

**Focus Area 5: Food and Consumer Products**

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

**Goal 5.2:** Improve food safety management.

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

<table>
<thead>
<tr>
<th>Borough</th>
<th>% or NYC Restaurants Receiving Grade A Inspection Score, 2018-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENY</td>
<td>80.8%</td>
</tr>
<tr>
<td>SW Queens</td>
<td>81.3%</td>
</tr>
<tr>
<td>Jamaica</td>
<td>82.8%</td>
</tr>
<tr>
<td>Brooklyn</td>
<td>83.0%</td>
</tr>
<tr>
<td>Queens</td>
<td>83.3%</td>
</tr>
<tr>
<td>NYC</td>
<td>83.9%</td>
</tr>
</tbody>
</table>

*Comment:* More than 80% of restaurants in the hospital's service received the highest scores on food safety inspections, comparable to borough and Citywide scores.
**Priority Area III: Promote Healthy Women, Infants and Children**

**Focus Area 1: Maternal & Women’s Health**

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

Percentage of women 18 years and older who have had a mammogram between October 1, 2014 and December 30, 2016. *Source: NYSDOH, NYS Community Health Indicator Reports, 2016; Keeping Track Online: Citizen’s Committee for Children*

**Comment**: Queens has a highest percentage of adult women having a mammogram within the last 2 years than Brooklyn - 75.7% vs. 71.8%. Queens' rate is higher than NYC or NYS.

**Comment**: Jamaica (12.5%) and ENY (11.1%) have exceptionally high percentages of pregnant women receiving late or no prenatal care.

**Comment:** The rate of life threatening complications for the mother during pregnancy and childbirth is 75% higher in ENY than the NYC average. The other service area neighborhoods have rates similar to NYC. None of the JHMC’s neighborhoods reach the Prevention Agenda goal – 202/10,000.

**Resource and Accomplishments:** JHMC offers CenteringPregnancy, patient-centered group prenatal care sessions facilitated by doctors, nurses, and midwives. After an initial assessment by their care provider, patients who so desired join a CenteringPregnancy group which meets for a total of 10, two-hour sessions through their pregnancy. Pregnant women have an opportunity to share their experiences, receive support, and empower one another, while learning how to maintain a healthy pregnancy. The Centering Pregnancy model has many benefits including a reduction in preterm births, higher birth weight, and increased breastfeeding rates.

JHMC conducts breast cancer screening for women, consistent with American Cancer Society guidelines, at its Women’s Health Center and offers extended hours nights and weekends. Free mammograms are provided to eligible women through New York State’s Cancer Services Program. In 2018, the Hospital was designated a Diagnostic Imaging Center of Excellence by the American College of Radiology for its high-quality imaging and diagnostic practices in many areas of radiology, including mammography.

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

This information is posted on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
Focus Area 2: Perinatal & Infant Health

Goal 2.1: Reduce infant mortality and morbidity.
Infant Mortality, Average Rate per 1000 Live Births 2014-2016. Source: EpiQuery. 3-Year Average Infant Mortality by Community District New York City, 2014-2016

Comment: Two Community Districts in Jamaica Hospital's service area, QN CD12 and BK CD5, have infant mortality rates that exceed the NYC average.


Comment: Brooklyn Community Districts 4 and 5 have the lower breastfeeding rates in Jamaica Hospital's service area and they are lower than Brooklyn, Queens, and NYC. In 2017, Queens CD9 had the higher breastfeeding rate. Between 2015 and 2017, the only Community District in the service area that showed an improved breastfeeding rate was BK CD4. Service area breastfeeding rates are significantly below the Prevention Agenda goal of 51.7% and the TCNY 2020 target of 81.9%.
Resources and Accomplishments; JHMC recognizes that supporting breastfeeding is an important public health priority. The Hospital achieved a 41% exclusively breastfeeding rate for mothers at discharge in 2018 up from 37% in 2015. As of June 20th, 2019 the rate was 32%. In May 2017, JHMC received and has 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). Hospital staff is dedicated to breastfeeding training efforts so they can share their knowledge with the community; all Pediatric, Obstetric, and Family Medicine providers have completed the recommended breastfeeding training. Jamaica Hospital Medical Center offers a weekly breastfeeding education program to patients and community members at its Women’s Health Center. The breastfeeding program, which is also available in Spanish, is taught by a certified midwife and is intended to familiarize mothers-to-be with proper breastfeeding techniques. JHMC, which was the first hospital in Queens to operate a milk depot, celebrated its two-year anniversary in October 2019. Over the past year, twelve mothers have donated 13,000 ounces of breast milk, a doubling of its first year’s success. The milk depot is a safe location where women approved by the New York Milk Bank (NYMB) can donate their excess breast milk to be distributed by NYMB to mothers who are unable to breastfeed their premature babies or infants with weakened immune systems. JHMC’s next goal is to provide pasteurized, banked donor human milk for Neonatal ICU babies who meet specific criteria including those whose mothers cannot provide sufficient breast milk. The immunological and nutritional benefits from pasteurized, banked donor milk are significant and may positively affect neonatal outcomes, including a reduction in the hospital length of stay.

JHMC is a New York State Department of Health-designated Level 3 Perinatal Center, meaning that it cares for patients requiring increasingly complex care and operates a neonatal intensive care unit (NICU). For the past four years, JHMC has maintained an active CenteringPregnancy® program, which facilitates support groups and prenatal visits for pregnant women participating in the program, and is currently expanding CenteringPregnancy® program to another ambulatory care site in its network. JHMC’s Women, Infants, and Children (WIC) program provides nutrition education, breastfeeding support, referrals, and a variety of nutritious foods to low-income pregnant, breastfeeding or postpartum women, infants and children up to age five to promote and support good health. Jamaica Hospital also operates a school-based health center program at Campus Magnet High School (Cambria Heights, Queens), and at two large elementary schools [PS 223 in Jamaica and PS (Q) 155 in South Ozone Park].

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

This information is posted on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
Focus Area 3: Child & Adolescent Health

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

**Goal 3.2:** Increase supports for children and youth with special health care needs

*Source:* Keeping Track Online, Citizens’ Committee for Children of New York, 2017

**Comment:** Queens Community District 10 has the highest percentage of children with disabilities (5.2%) in Jamaica Hospital's service area. It is higher than the NYC average (3.5%). The percentage of children with disabilities in four NYC Community Districts (Brooklyn CD 4 - 3.0%, Brooklyn CD 5 - 3.1%, Queens CD 9 - 2.8%, and Queens CD 12 - 2.5%) are lower than the NYC average.

**Goal 3.3:** Reduce dental caries among children.

Has a dentist or other health care provider ever told you that (CHILD) had dental cavities or decayed teeth? *Source:* NYC DOHMH, EpiQuery, Child Health Survey, 2017.

**Comment:** Queens has the second highest incidence of dental cavities among children ages 2-12 years of the 5 NYC boroughs - 25.4%
**Community Health Needs Assessment**

**Resources and Accomplishments:** The Hospital’s Pediatric Department operates a 24-bed inpatient pediatric unit, special care unit, neonatal ICU, and a well-baby nursery, and offers a range of pediatric outpatient primary and specialty care services, and a dedicated Pediatric section in its ED on the JHMC campus. JHMC’s Outpatient Mental Health clinic offers specialty mental health services for children and adolescents. The Hospital also offers primary care at eight community-based extension clinics in Southwest Queens and Jamaica, which provide pediatric primary care services and are NCQA NYS 2018 PCMH recognized: MediSys – ENY, MediSys – Jamaica, MediSys – Hollis, MediSys – Hollis Tudors, MediSys – St. Albans, MediSys – Richmond Hill, MediSys – Ozone Park (Medwise/Clocktower), and MediSys – Howard Beach. In addition, the Hospital provides ambulatory services at its Women’s Health Center, Family Dental Center, Mental Health Center, and affiliated Advanced Center for Psychotherapy. Services are also provided by the Hospital at three public schools: PS 155 (Elementary School), PS 223 (Elementary School) and Campus Magnet High School.

Now in its second year, the pediatric dental program of JHMC’s Department of Dental Medicine continues to grow and improve. A range of treatment services are provided including development of a dental home, caries assessment and fillings, sealants, cleanings, extractions, root canal therapy, crowns, oral hygiene instruction, nutritional counseling anesthesia, early interceptive orthodontic care, and trauma care. Licensed dental staff are trained to meet the specialized needs of patients with mental and physical disabilities.

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

This information is posted on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
Focus Area 4: Cross Cutting Healthy Women, Infants, & Children

Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations. Severe maternal morbidity rate per 100,000 deliveries; Infant mortality rate = number of infant deaths per 1,000 live births. Sources: NYC DOHMH, Bureau of Vital Statistics, SPARCS NYC DOHMH, Bureau of Vital Statistics, 2016;

Comment: SMM are life threatening complications that occur during pregnancy and childbirth. SMM, such as hemorrhage, pregnancy-induced hypertension, and embolism, may lead to maternal death.

Comment: Infant mortality rates are higher for non-white mothers. Blacks have the highest rates, 8.0 deaths/1,000 live births, over 3 times higher than whites.
COMMUNITY HEALTH NEEDS ASSESSMENT

**Resources and Accomplishments:** CenteringPregnancy, patient-centered group prenatal care model facilitated by doctors, nurses, and midwives, was adopted as a best practice at JHMC to address the disparities in maternal and infant birth outcomes for minority women. The Hospital is adding a second CenteringPregnancy® program at its St. Albans Family Care Center in partnership with Public Health Solutions, a community-based organization that has a strong focus on serving women and children. Preterm birth and low birthweight are leading cause of infant mortality, and in NYC, preterm births are significantly higher for all minority women than White women. Preterm rates for Black women are 12.2%; Hispanics (9.3%); and Asians (7.9); the rate is 7.3% for White women. CenteringPregnancy has been shown to reduce the rate of preterm and low weight babies, nearly eliminate the racial disparities in preterm birth among Black women.

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

**Focus Area 1: Promote Well Being**

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

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

**Comment:** More than 15% of the students living in ENY school districts are homeless, compared to 10.1% for NYC overall. The percentage of homeless students in SW Queens and Jamaica is under the NYC average.

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41 Citizen’s Committee for Children of NYC. Infant & maternal Health in NYC. data.cccnewyork.org
Resources and Accomplishments: Through its participation in DSRIP, JHMC has implemented many new practices and programs that focus on addressing the social determinants of health, where possible, in addition to responding to a patient’s medical complaint, and to promote well-being. This is being accomplished at JHMC by providing patient navigation services so that patients can obtain affordable health insurance, resolve barriers to accessing health care services, and provide supportive services to promote successful adoption and continuation of healthy behaviors. Some services are provided directly by or at JHMC facilities, such as the farmer’s market, LegalHealth, and free exercise classes. 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 JHMC facilities. The following member agencies of the Queens PPS provide examples of the breadth of supportive services that are more readily accessible to JHMC patients: Callen-Lorde Health Center, Center for Independence of the Disabled in New York, Children’s Aid Society, CommuniLife, Korean American Family Service Center, Queen Pride House, Selfhelp Community Services, Services & Advocacy for LGBT Elders (SAGE), and South Asian Council for Social Services.

Focus Area 2: Prevent Mental and Substance Use Disorders


Comment: Heavy drinking rates in JHMC’s service area are below the NYC average. Jamaica data is not available.
COMMUNITY HEALTH NEEDS ASSESSMENT


Comment: Drug-related deaths (per 100,000 population) in the hospital's service area were below the NYC rate in 2015 and in 2016, except for East New York (BK CD5). Drug-related deaths increased in the hospital’s service area in 2016 and exceed the HP2020 target of 11.3 deaths/100,000.

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

Goal 2.4: Reduce the prevalence of major depressive disorders
Current depression (in the past two weeks) as measured with an eight-item questionnaire that assesses symptoms of depression. Source: EpiQuery, 2016-2017.

Comment: Incidence of depression is higher in 2017 for residents of Jamaica and ENY.
COMMUNITY HEALTH NEEDS ASSESSMENT

**Goal 2.5:** Prevent suicides.
Suicide rate/100,000 population (age adjusted). *Source: New York City Department of Health and Mental Hygiene, EpiQuery, Mortality.*

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

**Comment:** Suicide rates in the hospital’s service area are below or equal to the borough and Citywide rates, except for SW Queens, whose rate is 20% higher than the NYC rate. Service area, borough, and NYC rates are below the Healthy People 2020 target of 10.2/100,000.

**Resources and Accomplishments:** JHMC offers a wide range of inpatient outpatient, and community-based mental health services serving patients across the lifespan. The Department of Psychiatry and Mental Health has a dedicated Psychiatric Emergency Department with a six-bed observation unit to evaluate adults with acute psychiatric symptoms and provide crisis intervention. When necessary, patients can be admitted to one of two, 28-bed adult psychiatric units. The department operates a Comprehensive Psychiatric Emergency Program and operates two community mobile crisis teams. The Mental Health Clinic offers group, individual, family, and couples therapy, medication management, and specialty services for children, adolescents, and adults on an outpatient basis. Comprehensive, culturally sensitive inpatient and outpatient chemical dependency services are offered at JHMC’s sister facility in Queens, Flushing Hospital.

JHMC has adopted the IMPACT model for depression at its Family Care Center sites and conducts universal screening for depression in its primary care practices. Dedicated Depression Care Managers conduct the evidence-based IMPACT intervention with patients who have moderate to severe depression. Patients who need further treatment are referred to the Hospital’s outpatient Mental Health Clinic where they can speak to a mental health professional about depression, suicide, or any other mental health disorder.

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

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

Priority Area V: Prevent Communicable Diseases

Focus Area 1: Vaccine-Preventable Diseases

Goal 1.1: Improve vaccination rates. Source: EpiQuery, Community Health Surveys 2016-2017

![Vaccination Rates - Pneumonia and Influenza](image)

**Comment**: SW Queens’ pneumonia vaccination rate (2016) is the highest of the 3 neighborhoods and exceeds NYC’s rate.

Goal 1.2: Reduce vaccination coverage disparities

![% of Children Vaccinated, NYC, 2017](image)

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

Resources and Accomplishments:  Since the NYC measles outbreak began in the fall of 2018, JHMC providers have redoubled efforts to encourage all parents to vaccinate their children with the measles-mumps-rubella (MMR) vaccine, as recommended by the CDC. The Hospital is also posting measles outbreak updates on its online health education newsletter – Health Beat. Although the vast majority of the measles cases are occurring in the Orthodox Jewish communities in Brooklyn, outside of JHMC’s service area, medical staff is taking extra precautions to ensure that all adults and children are immunized for measures or have immunity.

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

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

Focus Area 2: Human Immunodeficiency Virus (HIV)


Goal 2.2: Increase viral suppression

![New HIV Cases per 100,000 Population, NYC, 2016 and 2017](chart)

Comment: In 2016 and 2017, new HIV cases were: highest in East New York compared to any other area (SW Queens, Jamaica, Brooklyn, Queens, and NYC overall), and lowest in SW Queens compared to any other area.
Comment: In the neighborhood of East New York, 77% of adults have been tested for HIV with 48% of adults tested in the last year. HIV testing has occurred at a much higher rate in East New York compared to other Jamaica Hospital service area neighborhoods, and is higher than Brooklyn, Queens, and NYC overall.

Resources and Accomplishments: JHMC’s ambulatory care center is designated by NYS DOH as an HIV Primary Medical Care Provider and offers testing annually to patients ages 13-64 in both its Emergency Department and clinics. Health education and risk reduction education and counseling are provided around HIV, STD, and HCV to promote and reinforce safer behaviors. In addition to JHMC’s Division of Infectious Disease services, the Queens’ service area (as defined in the Queens CNA) has 49 Infectious Disease physicians. There are three hospitals in Queens that are licensed as AIDS Centers (Elmhurst Hospital, Queens Hospital Center, and New York-Presbyterian/Queens). Queens also has 25 agencies with 180 service sites that offer HIV related services, including Ryan White and CDC Prevention programs. These services include HIV Prevention and Outreach efforts such as sexual and behavioral health for HIV prevention, condom distribution, harm reduction, testing and linkage to care, and syringe exchange. PrEP (pre-exposure prophylaxis) and PEP (post exposure prophylaxis) services for uninsured people in Queens are available at the Community Health Network-Family Health Center and NYC Health and Hospitals-Elmhurst.

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

This information is posted on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
Focus Area 3: Sexually Transmitted Infections (STIs)

**Goal 3.1:** Reduce the annual rate of growth for STIs


**Comment:** The ENY neighborhood has the highest incidence of syphilis in the hospital's service area and it continues to increase. SW Queens, although having the lowest syphilis rate in the service area, showed the largest increase in cases between 2015 and 2016 - 30%. The boroughs of Queens and Brooklyn, and NYC showed double-digit increases from 2015 to 2016.

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

**Comment:** The ENY neighborhood has the highest incidence of gonorrhea in the hospital's service area and it continues to increase. SW Queens, although having the lowest gonorrhea rate, showed the largest increase in cases between 2015 and 2016 - 30%. The boroughs of Queens and Brooklyn, and NYC showed double-digit increases from 2015 to 2016.
increase in cases between 2015 and 2016 - 30%. All neighborhoods exceed the Prevention Agenda goal - a 4% annual increase.

**Resources and Accomplishments:** JHMC’s ambulatory care center, which is designated by NYS DOH as an HIV Primary Medical Care Provider, and the Women’s Health Center, conducts targeted screening for sexually transmitted diseases such as Chlamydia, gonorrhea, and syphilis and refers patients to appropriate follow-up medical care, partner services, and prevention counseling.

**Focus Area 4: Hepatitis C Virus (HCV)**

**Goal 4.1:** Increase the number of persons treated for HCV

Treatment initiation among people newly reported with a positive hepatitis C RNA tests, 2015-2017.

*Source: NYC DOHMH, NYC Hepatitis A, B & C Annual Report 2017*

![Treatment Initiation for Newly Positive Hepatitis C., New York City, 2015-2017](image)

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

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

New Hepatitis C Reports per 100,000 people, 2016 and 2017. *Source: NYC DOHMH, EpiQuery, Communicable Disease Surveillance Data, Hepatitis C, 2016 and 2017*

<table>
<thead>
<tr>
<th>ENY</th>
<th>SW Queens</th>
<th>Jamaica</th>
<th>Brooklyn</th>
<th>Queens</th>
<th>NYC</th>
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<td>59.3</td>
<td>29.4</td>
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</tr>
</tbody>
</table>

**Comment:** In Jamaica Hospital’s service area, ENY had the highest rate of new cases of hepatitis C., more than double the Queens rate, and exceeding NYC by 37%.

**Resources and Accomplishments:** JHMC administered 2,111 hepatitis B birth doses to newborns in 2017, representing 99% of all births, as an important cooperative strategy to prevent hepatitis B in infants.

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

This information is posted on all of the hospital’s social media platforms (Facebook, Twitter, Instagram, YouTube). This information is also distributed to the community via the hospital’s electronic community newsletter.
Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections

**Goal 5.1:** Improve infection control in healthcare facilities

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

**Goal 5.2:** Reduce infections caused by multidrug resistant organisms and C. difficile

*Comment:* Hospitals in Queens performed better than the NYC and NYS averages for infections caused by Clostridium difficile (C. difficile), a multidrug resistant organism that can cause death.
**Goal 5.3:** Reduce inappropriate antibiotic use

Antibiotic Prescriptions Dispensed in U.S. Community Pharmacies per 1,000 Population, All classes, 2016. *Source: CDC, Outpatient Antibiotic Usage Data. 2011-2016*

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

**Resources and Accomplishments:** JHMC’s physician practices participated in the United Hospital Fund’s Outpatient Antibiotic Stewardship Initiative in an effort to reduce inappropriate use of antibiotics to treat viral illnesses such as colds and flu. Physicians and patients were educated about when antibiotics are necessary and when they are not. Modifications were made to the Hospital’s EHR system to require physicians to provide more extensive documentation when prescribing antibiotics. The Initiative yielded positive results, reducing antibiotic prescribing by 65%.

JHMC, along with affiliated FHMC, received a federal grant to implement electronic reporting of antibiotic use and resistance into a national database.

Results from the 2018 Leapfrog Hospital Survey show that JHMC has effectively instituted several management structures and procedures to protect patients from errors, accidents, and injuries. JHMC ranked alongside the best performing hospitals for the following practice measures: Doctors order medications through a computer; specially trained doctors care for ICU patients; effective leadership to prevent errors; track and reduce risks to patients; enough qualified nurses, and handwashing. JHMC medical staff have developed an Antibiotic Stewardship Program to educate physicians and patients about when antibiotics are necessary and when they are not.

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

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

Community Health Survey Results

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

Greater New York Hospital Associated (GNYHA) developed a model survey tool that MediSys tailored for its communities. The surveys, which were translated into Spanish and Mandarin to provide additional access to the survey, were loaded into a HIPAA protected web-based SurveyMonkey platform. From April through mid-September 2019, the Hospital sent the survey to community residents by email and also distributed it at numerous gatherings of local community based organizations, including the Hospital’s Community Advisory Board, three of the Hospital’s ambulatory care centers, three Community Boards, five faith-based organizations, three NYPD Precinct Councils, two schools, and 15 civic associations. The Hospital received 724 completed surveys, of which 501 were from residents of the Hospital’s primary service area (PSA), which encompasses Jamaica Queens, Southwest Queens and East New York, Brooklyn.43 Surveys completed online were captured directly in the SurveyMonkey platform. Paper surveys were entered into the platform by Hospital staff and volunteers.

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

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

Population Characteristics
Survey respondents came from all Queens neighborhoods and several Brooklyn neighborhoods. For All Respondents - socio-demographic characteristics included: 71% female, 53% Black/African American, 21% White, 5% Asian, 14% of Hispanic or Latino descent, 94% had health insurance, 27% were 65-74 years old, 19% were 55-64, and 19% 35-54. Fifteen percent of survey respondents reported having fair or poor physical health, and 8% fair or poor mental health.

For PSA respondents - socio-demographic characteristics included: 70% female, 44% Black/African American, 25% White, 7% Asian, 17% of Hispanic or Latino descent, 93% had health insurance, 25% were 65-74 years old, 20% were 55-64, and 22% 35-54. Seventeen percent of survey respondents reported having fair or poor physical health, and 8% fair or poor mental health.

The following summary of survey results (Table 1) pertains to the responses from the Hospital’s PSA, where the majority of its patients reside. Responses differ somewhat by neighborhood and zip code area within the PSA, and by gender, age, race, ethnicity, education, employment and having insurance or not.

43 These areas are United Health Fund (UHF) Neighborhoods, made up of adjoining zip code areas, and designated to approximate NYC Community Planning districts.
## Table 1: Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>PSA (n=501)</th>
<th>Characteristic</th>
<th>PSA (n=501)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>Hispanic or Latino descent</td>
<td>17%</td>
</tr>
<tr>
<td>18-24</td>
<td>4%</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>10%</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>35-54</td>
<td>22%</td>
<td>Less than high school</td>
<td>6%</td>
</tr>
<tr>
<td>55-64</td>
<td>20%</td>
<td>High school diploma/GED</td>
<td>22%</td>
</tr>
<tr>
<td>65-74</td>
<td>25%</td>
<td>Technical school or Some college</td>
<td>24%</td>
</tr>
<tr>
<td>75-84</td>
<td>14%</td>
<td>College graduate/Bachelor’s degree</td>
<td>27%</td>
</tr>
<tr>
<td>85+</td>
<td>4%</td>
<td>Graduate/professional degree</td>
<td>16%</td>
</tr>
<tr>
<td>No Response</td>
<td>2%</td>
<td>Employment status</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>Retired</td>
<td>40%</td>
</tr>
<tr>
<td>Female</td>
<td>70%</td>
<td>Full-time, Part-time or Self-employed</td>
<td>48%</td>
</tr>
<tr>
<td>Male</td>
<td>27%</td>
<td>Not employed, Unable to work</td>
<td>9%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1%</td>
<td>Homemaker, Student</td>
<td>5%</td>
</tr>
<tr>
<td>No Response / Prefer to self-describe</td>
<td>2%</td>
<td>Have health insurance</td>
<td>93%</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td>Have health insurance</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>44%</td>
<td>Self assessment of physical health</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>25%</td>
<td>Self assessment of physical health</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>7%</td>
<td>Poor, Fair</td>
<td>17%</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>1%</td>
<td>Good, Very Good, Excellent</td>
<td>81%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>1%</td>
<td>Self assessment of mental health</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
<td>Poor, Fair</td>
<td>8%</td>
</tr>
<tr>
<td>No Response</td>
<td>12%</td>
<td>Good, Very Good, Excellent</td>
<td>90%</td>
</tr>
</tbody>
</table>
Neighborhood Health Issues

Five percent of respondents rated the health of their neighborhood as Poor, 28% as Fair, 61% as Good, Very Good or Excellent. They felt that the following health concerns in their neighborhood were Very/Extremely important:

Table 2: Issues

<table>
<thead>
<tr>
<th></th>
<th>PSA (n=456)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very/Extremely Important</td>
</tr>
<tr>
<td>Cancer</td>
<td>73%</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>72%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>73%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>69%</td>
</tr>
<tr>
<td>Women’s health and infant care</td>
<td>69%</td>
</tr>
<tr>
<td>Mental health/depression</td>
<td>66%</td>
</tr>
<tr>
<td>Substance use problems (including alcohol and drugs)</td>
<td>66%</td>
</tr>
<tr>
<td>Falls prevention among elderly and small children</td>
<td>65%</td>
</tr>
<tr>
<td>Obesity in children and adults</td>
<td>64%</td>
</tr>
<tr>
<td>Asthma/breathing problems</td>
<td>62%</td>
</tr>
<tr>
<td>Dental care</td>
<td>60%</td>
</tr>
<tr>
<td>Smoking/tobacco use/vaping</td>
<td>59%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>57%</td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STIs)</td>
<td>56%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>52%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>51%</td>
</tr>
</tbody>
</table>

The top five issues that were rated Very/Extremely Important - Cancer, High blood pressure, Heart disease, Diabetes, and Women’s health and infant care - fell into a very tight range (69% - 73%) on average across all population groups. However, there was a wide variation by zip code on all the issues. On average fewer Males (27% of respondents) than Females rated issues as Very/Extremely Important other than Asthma/Breathing Problems. Across all race groups Cancer was rated as Very/Extremely Important by 73% (the highest ranking) of respondents. For Heart disease, which was also rated as Very/Extremely Important by 73% on average, 78% of Blacks /African Americans rated it as Very/Extremely Important. More Blacks /African Americans (44% of respondents) than the other race groups thought all the issues were Very/Extremely Important. Fewer Hispanics (17% of respondents) than non-Hispanics rated any issue Very/Extremely Important, other than Sexually Transmitted Infections. Fifty-one percent or more of respondents considered each of the 16 issues as Very/Extremely Important.

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

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

Changes to Improve Neighborhood Health
The top three changes that respondents reported would most improve the health of the people in their neighborhoods:

Table 3: Changes

<table>
<thead>
<tr>
<th>Change</th>
<th>Very/Extremely Important</th>
<th>Range Across Zip Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>More affordable healthcare, including medical care, mental health care and medications</td>
<td>52%</td>
<td>37% - 75%</td>
</tr>
<tr>
<td>Better education and job training</td>
<td>37%</td>
<td>17% - 70%</td>
</tr>
<tr>
<td>More affordable housing</td>
<td>34%</td>
<td>18% - 50%</td>
</tr>
<tr>
<td>More access to healthy and affordable foods and beverages</td>
<td>32%</td>
<td>7% - 60%</td>
</tr>
<tr>
<td>More local jobs</td>
<td>26%</td>
<td>8% - 40%</td>
</tr>
<tr>
<td>More places where older adults can live and socialize</td>
<td>21%</td>
<td>3% - 53%</td>
</tr>
<tr>
<td>Less domestic violence, such as child abuse, elder abuse, spousal and partner abuse</td>
<td>16%</td>
<td>5% - 27%</td>
</tr>
<tr>
<td>Better public transportation</td>
<td>13%</td>
<td>0% - 23%</td>
</tr>
<tr>
<td>Better housing conditions</td>
<td>15%</td>
<td>0% - 37%</td>
</tr>
<tr>
<td>More access to quality child care</td>
<td>12%</td>
<td>4% - 46%</td>
</tr>
<tr>
<td>More access to parks and places to exercise</td>
<td>11%</td>
<td>0% - 19%</td>
</tr>
<tr>
<td>More language assistance in healthcare settings</td>
<td>5%</td>
<td>0% - 14%</td>
</tr>
<tr>
<td>Less human and/or sex trafficking</td>
<td>5%</td>
<td>0% - 11%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>0% - 8%</td>
</tr>
<tr>
<td>No Response</td>
<td>4%</td>
<td>0% - 20%</td>
</tr>
</tbody>
</table>

More affordable healthcare outranked the other “top three changes” that respondents thought would most improve the health of people in their neighborhoods. Those with health insurance (93% of respondents) made this recommendation, which reflects the existing and well-known gaps in coverage of necessary care and prevention in the current health insurance system. This recommendation is perfectly aligned with the perception of respondents that there are many Very/Extremely Important health issues that must be addressed in the Hospital’s PSA, and underscores that affordability is fundamental to ensure access to healthcare, including prevention. In response to the question: “What would make you avoid getting medical care from a health care provider?” 32% said High cost of care. Other reasons for avoiding care had to do with availability and convenience issues such as Lack of available appointments (16%), Not enough time to go (11%), Lack of transportation (9%), Difficult to find child care (3%). Over time these problems may be ameliorated to some extent by the expansion of urgent care centers, retail clinics and telemedicine. However, these options are less available in low income communities and communities with many immigrants. The Hospital is taking steps to expand ambulatory care services by adding 26 new exam rooms on campus, and building an urgent care center,
which will provide an alternative to the ER for those with low acuity issues. Both projects are funded by a grant from the NYS Department of Health.

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

Selection of Prevention Agenda Priorities

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

JHMC Programs Addressing Top Community Health Issues

- In relation to Cancer, one of the three health issues identified in the Hospital’s community health needs assessment survey, the Hospital offers free cancer screenings and referrals to highly specialized cancer services programs through a partnership with the Cancer Services Program Queens funded by the Bureau of Cancer Prevention and Control. The Hospital operates a patient navigator program for colon cancer to increase show rates for screenings and necessary follow-up. In partnership partner with the NYC DOHMH the Hospital arranges for free cancer screenings for those without insurance or sufficient financial resources.
- In relation to Heart disease, also one of the top three issues, through its DSRIP participation it implemented evidence-based best practices for cardiovascular disease management in all its ambulatory care practices;
- In relation to High blood pressure, another of the top three issues, it is a member of Take the Pressure Off, NYC!, a multi-sector city-wide collaborative working in communities to prevent and control high blood pressure. Also, free blood pressure screenings, depression screening, and other screening services are offered to the community at numerous health fairs throughout the year, and free blood pressure screening is offered once weekly at the hospital’s farm stand during the season and in the main lobby the rest of the year.
- In relation to Diabetes, the fourth highest rated community health issue, free National Diabetes Prevention Program sessions are offered to people identified as having pre-diabetes.
- In relation to Women’s Health and Infant Care, which is tied with Diabetes as the fourth highest issue, the Hospital offers a weekly breastfeeding support group to patients and community members; the program is also available in Spanish. The Hospital operates a Milk Depot where mothers can donate their excess breast milk to be distributed by the New York Milk Bank to mothers who are unable to breastfeed their premature babies or infants with weakened immune systems.
- In relation to Obesity, another high ranked health issue, in partnership with NYC’s Shape Up NYC program, several free drop in fitness classes are offered each week on the Hospital’s campus to community residents. The Hospital also sponsors a weekly farmstand during the season that accepts SNAP, FMNP checks, Health Bucks and other benefit programs.
- In relation to HIV/AIDS, also a high ranked health issue, the Hospital routinely offers HIV testing in emergency departments and all outpatient clinics. The Hospital operates an HIV Medical clinic and works in concert with the NYS DOH AIDS Institute in initiatives to “End the Epidemic”.
COMMUNITY SERVICE PLAN

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

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

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

- **Alignment with NYS Prevention Agenda Priorities**
  - Prevent Chronic Disease, Focus Area 3: - Tobacco Prevention, Goal 3.2: Promote Tobacco Use Cessation; and
  - Promote Healthy Women, Infants and Children, Focus Area 3: Perinatal and Infant Health; Goal 2.2: Increase Breast Feeding;

- **Alignment with Healthy 2020 Goals and objectives:**
  - Goal: Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure.
    - Objective: Reduce cigarette smoking by adults.
  - Goal: Improve the health and well-being of women, infants, children, and families.
    - Objective: Increase the proportion of infants who are breastfed.

- **Alignment with Survey Results**
  - Smoking/tobacco use/vaping rated as Very/Extremely Important by 59% of all survey respondents in PSA and 64% of Black/African American respondents;
  - Connection between Smoking/Tobacco use/vaping and Cancer and Heart disease (both rated Very/Extremely Important by 73%);
  - Women’s health and infant care rated by 69% by all PSA respondents and by 73% of Females as Very/Extremely Important. Exclusive Breastfeeding is a very important practice in ensuring good health for women and their infants.

- **Alignment with Hospital’s Priorities**
  - Continuing recognition for following best practices for tobacco cessation as evidenced by earning a Gold Star from NYC’s Tobacco-Free Hospital campaign and continuing to adhere to standards and retain the designation as a Baby Friendly Hospital.
  - Resources already committed and work groups already working to implement comprehensive Hospital-wide programs for these two prevention priorities;

- **Addresses a disparity of impact/burden on people living in poverty, as measured by the proportion of people affected who are covered by Medicaid.**

- **Potential for significant improvement in individual and community health and quality of life by decreasing tobacco use and increasing breastfeeding.**

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

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

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

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

-----------------------------------------------------------------------------------------------------------------------------

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

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

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

JHMC Priority 1: Promote Tobacco Cessation

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

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

**JHMC Priority 1: Promote Tobacco Cessation**

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Objectives</th>
<th>Interventions/Strategies/Activities</th>
</tr>
</thead>
</table>
| General Medical/Surgical (M/S) Patients Aged 13 and Above – Assessments and Interventions for All Patients, and Increased Number of Quitters Over Three Year Cycle. | 1) Maintain current outpatient smoking prevalence rate below NYS target.  
2) Achieve 95% or greater assessment rate for outpatients and inpatients.  
3) Increase annual interventions for returning outpatient smokers to 85% or greater; 65% or greater for inpatients. Note: The basic intervention is counseling. Other possible interventions include educational materials, prescriptions for medications, and/or referral for smoking cessation classes/support.  
4) Increase prescriptions for smoking cessation benefits among Medicaid and Medicaid Managed Care smokers to achieve NYS benefit use target of 26.2% over three year cycle. | Family of Interventions:  
- Train and re-train all M/S providers to use the smoking module in the electronic health record (EHR).  
- Track assessments and interventions for all patients, and prevalence of smoking for returning OP smokers.  
- Review disparity data and develop intervention plan.  
- Connect EHR to NYS Quitline for instant referrals; provider will refer all who consent (clarified provider is involved).  
- Document and track use of NYS Quitline.  
- Continue automated EHR discharge process to provide information to all smokers on quit strategies and medications.  
- Update internal reporting system on smoking cessation data to capture all new/renamed treatment areas.  
- Review data quarterly and target specific providers with a message to achieve better tobacco control among their patients for 2019 - 2021.  
- Provide quarterly communication to all departments about smoking cessation results to develop better "procedures and work-flows to facilitate the delivery of tobacco dependence treatment" especially among behavioral health (BH) and low SES patients for 2019 - 2021.  
- Train new navigators to be FFS facilitators.  
- Offer extended availability of hours for the FFS workshop (i.e. an evening workshop for participants that work traditional 9-5 schedules).  
- Attend Ambulatory Clinics’ monthly staff meetings, on a bi-annual basis, to remind providers about Smoking Cessation Resources (FFS workshops, NYS Smokers’ Quit line and Quit Plan from EHR).  
- Provide Health Bucks and nutrition education to FFS participants to incentivize attendance. |

NOTE: NYS smoking prevalence target of 11% for adults and 15.3% among adults with low socio-economic status (SES), using Medicaid coverage as a proxy.  

NOTE: NYS interventions target of 60.1%.
### IMPLEMENTATION PLAN

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

**JHMC Priority 1: Promote Tobacco Cessation**

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Objectives</th>
<th>Interventions/Strategies/Activities</th>
</tr>
</thead>
</table>
| Behavioral Health Patients Above Aged 13 – Assessments, Interventions for all Patients, and Increased Number of Quitters in Three Cycle. | 1) Maintain current outpatient smoking prevalence rate below NYS target.  
2) Achieve 75% or greater assessment rate of outpatients and 95% or greater of inpatients.  
3) Achieve 90% or greater intervention rate for outpatients and inpatients.  
Note: Interventions include counseling and prescriptions for medication.  
4) Increase prescriptions for smoking cessation benefits among Medicaid and Medicaid Managed Care smokers to achieve NYS benefit use target of 26.2% over three year cycle. | Family of Interventions  
- Train and re-train all BH providers to use the smoking module in the EHR.  
- Track assessments and interventions for all patients, and smoking prevalence for returning OP smokers.  
- Review disparity data and develop intervention plan.  
- Increase awareness via Social Media and print media.  
- Connect EHR to NYS Quitline for instant referrals; provider will refer all who consent.  
- Document and track use of NYS Quitline.  
- Automate EHR discharge process to provide information to all smokers on quit strategies and medications.  
- Update internal reporting system on smoking cessation data to capture all new/renamed treatment areas.  
- Secure data from the Hospital’s DSRIP Max Project and Care Transitions, and ensure that smoking cessation counseling is provided during post-discharge follow up of these patients for 2019 - 2021.  
- Review data quarterly and target specific providers with a message to achieve better tobacco control among their patients for 2019 - 2021.  
- Provide quarterly communication to all departments about smoking cessation results to develop better "procedures and workflows to facilitate the delivery of tobacco dependence treatment" especially among BH and low SES patients for 2019 - 2021. |

NOTE: NYS smoking prevalence target of 20.1% among adults who report poor mental health.
IMPLEMENTATION PLAN

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

JHMC Priority 1: Promote Tobacco Cessation

<table>
<thead>
<tr>
<th>Goal 4</th>
<th>Objectives</th>
<th>Interventions/Strategies/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Tobacco Cessation Knowledge among Community Residents and Providers</td>
<td>1) Provide tobacco cessation education resources and techniques to top 10% of voluntary attending physicians annually, and increase this number over three year cycle by at least 5%. 2) Provide education and sign-up opportunities for Quit classes at 12-15 community educational events per year, in partnership with community organizations. 3) Offer four FFS classes per year.</td>
<td>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.  • Send tobacco cessation educational materials and resources to a select group of community providers.  • Participate in community health events/fairs and provide our community Smoking Cessation Resources (i.e. FFS workshops and NYS Smokers’ Quit line)  • List Hospital's services as Smoking Cessation Program providers on 311 listings and NYS Smokers Quit line listings, thereby extending the network to which we offer help beyond our patients or immediate community.</td>
</tr>
</tbody>
</table>
New York State Priority Area: Promote Healthy Women, Infants, and Children
Focus Area 2: Perinatal and Infant Health
Goal 2.2: Increase Breastfeeding

JHMC Priority 2: Increase Breastfeeding

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Objectives</th>
<th>Interventions/Strategies/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive Breastfeeding at Discharge for as Many Patients as Clinically Possible and Culturally Acceptable</td>
<td>1) Achieve exclusive breastfeeding (BF) rate at discharge of 41%. 2) Maintain exclusive BF equality between Medicaid and non-Medicaid enrollees. 3) Achieve Skin-to-Skin contact for newborn babies:  - Vaginal Births = 95%  - C-Section Births = 86%. 4) Achieve Rooming-In for 95% of newborns. 5) Achieve 95% or greater training rate in recommended BF education:  - Medical providers  - Maternal/Child nurses. 6) Receive and administer pasteurized human milk from the Milk Bank to serve our NICU patients in 2020.</td>
<td>Family of Interventions:  - Increase enrollment in CenteringPregnancy® at Womens Health Center (WHC); add more Centering sites.  - Implement BF volunteer peer counseling program, with 4 volunteers.  - Provide IP BF support, and for complicated cases, by an International Board Certified Lactation Consultant (IBCLC) or Certified Nurse Midwife.  - Start daily inpatient BF classes run by an IBCLC or Registered Nurse (RN) from Mother-Baby Unit; track referrals to postpartum resources.  - Maintain weekly BF peer support group, guided by a BF counselor.  - Public Health Solutions (PHS) makes weekly rounds on Mother/Baby units to enroll mothers in support services; RNs and/or Clinical Nurse Manager do this daily for all mothers.  - Send patient navigators to Certified Lactation Counselor (CLC) courses.  - The lactation consultant offers drop-in services to mothers experiencing BF problems.  - Continue to hold educational programs including annual grand rounds for clinical staff in obstetrics, pediatrics and family medicine for 2020 and 2021.</td>
</tr>
</tbody>
</table>

NOTE: NYS target of 51.7%.  
NOTE: NYS target of 38.2% for Medicaid.
IMPLEMENTATION PLAN

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

JHMC Priority 2: Increase Breastfeeding

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Objectives</th>
<th>Interventions/Strategies/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby Friendly USA designation</td>
<td>Maintain Baby Friendly USA designation.</td>
<td>Continue multidisciplinary committee meetings and initiatives.</td>
</tr>
</tbody>
</table>
**IMPLEMENTATION PLAN**

**New York State Priority Area: Promote Healthy Women, Infants, and Children**

**Focus Area 2: Perinatal and Infant Health**

**Goal 2.2: Increase Breastfeeding**

**JHMC Priority 2: Increase Breastfeeding**

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Objectives</th>
<th>Interventions/Strategies/Activities</th>
</tr>
</thead>
</table>
| Exclusive Breastfeeding at 3 and 6 Months for as Many Patients as Clinically Possible | 1) Increase measurable documentation of well-baby feeding history by 10% per year in three year cycle.  
2) Increase exclusive BF rates at 3 and 6 months for the Hospital’s well babies by 10% per year in three year cycle.  
3) Train all pediatricians and family medicine physicians about BF. | Family of Interventions:  
• Revise EHR to capture babies' feeding history at every visit for first year of life by adding the appropriate dot-phase documentation tool for providers for 2020.  
• Increase communication in the pre-natal clinics regarding PHS’s Mother/Baby and Family Support services, e.g., Healthy Start and Nurse/Family Partnership.  
• Operate a Breast Milk Depot.  
• Continue to hold repeat educational programs including grand rounds for clinical staff in obstetrics, pediatrics and family medicine for 2020 and 2021.  
• Initiate an on-site CLC certification program hosted by Healthy Children of Cape Cod at JHMC for 2020.  
• Clinics will send an RN and/or LPN to the CLC educational program (when available slot is open with DOH and/or when the on-site Healthy Children's children CLC program is established on JHMC's campus) for 2020 and 2021.  
• Initiate an automatic referral via EHR to Women, Infants and Children and Healthy Start on first prenatal visit for 2020 and 2021. |
## JHMC Priority 2: Increase Breastfeeding

<table>
<thead>
<tr>
<th>Goal 4</th>
<th>Objectives</th>
<th>Interventions/Strategies/Activities</th>
</tr>
</thead>
</table>
| Increase Knowledge of Community Residents and Providers about the Benefits of Breastfeeding. | 1) Provide BF education resources and support including Breastfeeding Friendly Practice (BFFP) standards to top 10% of voluntary attending pediatricians annually, and increase this number over three year cycle by at least 5%.  
2) Increase participation by mothers and mothers-to-be in BF education and support services by at least 5% over three year cycle. | Family of Interventions  
• Provide resources and guidance to selected community practice sites to assist them in adhering to standards for BFFP.  
• Develop BF education programs with PHS at local libraries and other locations, in multiple languages as possible.  
• Publicize the Hospital’s BF-related programs via Hospital’s social media and on external sites, including print media.  
Participate in BF advocacy programs such as annual BF Subway Caravan to City Hall.  
• JHMC WIC program will continue to offer weekly BF classes to pre-natal patients, and daily one-on-one BF and nutrition education services to established postpartum patients on a walk-in basis. |
How would you rate the overall health of the residents of your neighborhood?

- Poor: 5%
- Fair: 28%
- Good: 46%
- Very Good: 12%
- Excellent: 3%
- No Response: 7%

% of Respondents (n=501)
APPENDIX A – Survey Charts

How important are the following issues to the health of the people in your neighborhood?

<table>
<thead>
<tr>
<th>Issue</th>
<th>Important</th>
<th>Very Important</th>
<th>Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>18%</td>
<td>25%</td>
<td>47%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>19%</td>
<td>26%</td>
<td>43%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>15%</td>
<td>28%</td>
<td>45%</td>
</tr>
<tr>
<td>Cancer</td>
<td>15%</td>
<td>28%</td>
<td>45%</td>
</tr>
<tr>
<td>Women’s health and infant care</td>
<td>18%</td>
<td>28%</td>
<td>42%</td>
</tr>
<tr>
<td>Asthma/breathing problems</td>
<td>25%</td>
<td>28%</td>
<td>34%</td>
</tr>
<tr>
<td>Falls prevention among elderly and small children</td>
<td>20%</td>
<td>29%</td>
<td>36%</td>
</tr>
<tr>
<td>Dental care</td>
<td>25%</td>
<td>29%</td>
<td>31%</td>
</tr>
<tr>
<td>Substance use problems (including alcohol and drugs)</td>
<td>18%</td>
<td>25%</td>
<td>41%</td>
</tr>
<tr>
<td>Mental health/depression</td>
<td>18%</td>
<td>25%</td>
<td>41%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>32%</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Obesity in children and adults</td>
<td>17%</td>
<td>27%</td>
<td>37%</td>
</tr>
<tr>
<td>Smoking/tobacco use/vaping</td>
<td>20%</td>
<td>27%</td>
<td>33%</td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STIs)</td>
<td>22%</td>
<td>24%</td>
<td>33%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>21%</td>
<td>23%</td>
<td>34%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>23%</td>
<td>24%</td>
<td>27%</td>
</tr>
</tbody>
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</thead>
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<tr>
<td>Cancer</td>
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<td>45%</td>
</tr>
<tr>
<td>Heart disease</td>
<td>28%</td>
<td>45%</td>
</tr>
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<tr>
<td>Women’s health and infant care</td>
<td>28%</td>
<td>42%</td>
</tr>
<tr>
<td>Mental health/depression</td>
<td>25%</td>
<td>91%</td>
</tr>
<tr>
<td>Substance use problems (including alcohol and drugs)</td>
<td>25%</td>
<td>41%</td>
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<tr>
<td>Falls prevention among elderly and small children</td>
<td>29%</td>
<td>35%</td>
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<td>Obesity in children and adults</td>
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<td>28%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>24%</td>
<td>27%</td>
</tr>
</tbody>
</table>
What are the TOP THREE changes that you believe would most improve the health of the people in your neighborhood?

- More affordable healthcare, including medical care, mental health care and...
  52% (n=456)
- Better education and job training
  37%
- More affordable housing
  34%
- More access to healthy and affordable foods and beverages
  32%
- More local jobs
  26%
- More places where older adults can live and socialize
  21%
- Less domestic violence, such as child abuse, elder abuse, spousal and partner...
  16%
- Better housing conditions
  15%
- Better public transportation
  13%
- More access to quality child care
  12%
- More access to parks and places to exercise
  11%
- More language assistance in healthcare settings
  5%
- Less human and/or sex trafficking
  5%
- Other
  2%
- No Response
  4%

% of Respondents
APPENDIX A – Survey Charts

How would you describe your physical health?

- Poor: 2%
- Fair: 15%
- Good: 42%
- Very Good: 33%
- Excellent: 7%
- No Response: 2%

% of Respondents (n=501)

How would you describe your mental health?

- Poor: 1%
- Fair: 7%
- Good: 30%
- Very Good: 31%
- Excellent: 30%
- No Response: 2%

% of Respondents (n=501)
APPENDIX A – Survey Charts

What would make you avoid getting medical care from a health care provider?

<table>
<thead>
<tr>
<th>Response</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing; I make time to go</td>
<td>50%</td>
</tr>
<tr>
<td>High cost of care</td>
<td>32%</td>
</tr>
<tr>
<td>Doctor’s office doesn’t have available appointments</td>
<td>16%</td>
</tr>
<tr>
<td>Do not have insurance</td>
<td>13%</td>
</tr>
<tr>
<td>Not enough time to go</td>
<td>11%</td>
</tr>
<tr>
<td>Lack of transportation</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t like to go</td>
<td>6%</td>
</tr>
<tr>
<td>Don’t understand the benefit of seeing a provider</td>
<td>3%</td>
</tr>
<tr>
<td>Difficult to find child care</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
<tr>
<td>No Response</td>
<td>6%</td>
</tr>
</tbody>
</table>

(n=501)
APPENDIX A – Survey Charts

Where do you go MOST OFTEN when you are sick?

- Doctor's office: 71%
- Urgent care center: 11%
- Hospital emergency room: 7%
- Other: 2%
- No Response: 8%

% of Respondents (n=501)
APPENDIX A – Survey Charts

What is your age?

<table>
<thead>
<tr>
<th>Age</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>0%</td>
</tr>
<tr>
<td>18-24</td>
<td>4%</td>
</tr>
<tr>
<td>25-34</td>
<td>10%</td>
</tr>
<tr>
<td>35-54</td>
<td>22%</td>
</tr>
<tr>
<td>55-64</td>
<td>20%</td>
</tr>
<tr>
<td>65-74</td>
<td>25%</td>
</tr>
<tr>
<td>75-84</td>
<td>14%</td>
</tr>
<tr>
<td>85+</td>
<td>4%</td>
</tr>
<tr>
<td>No Response</td>
<td>2%</td>
</tr>
</tbody>
</table>

(n=501)
Are you of Hispanic or Latino descent?

- Yes: 77%
- No: 17%
- No Response: 6%
Which of the following best describes your race?

- Black or African American: 44%
- White: 25%
- Asian: 7%
- American Indian or Alaskan Native: 1%
- Native Hawaiian or Other Pacific Islander: 1%
- Other: 13%
- No Response: 12%

% of Respondents (n=501)
APPENDIX A – Survey Charts

Do you think of yourself as...

<table>
<thead>
<tr>
<th>Gender</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>70%</td>
</tr>
<tr>
<td>Male</td>
<td>27%</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1%</td>
</tr>
<tr>
<td>No Response / Prefer to self-describe</td>
<td>2%</td>
</tr>
</tbody>
</table>

(% of Respondents (n=501))
APPENDIX A – Survey Charts

What is your highest level of education?

- Less than high school: 6%
- High school diploma/GED: 22%
- Technical school: 3%
- Some college: 21%
- College graduate/Bachelor’s degree: 27%
- Graduate/professional degree (such as Master’s, JD, MD): 16%
- Other: 2%
- No Response: 4%

% of Respondents (n=501)
What is your current employment status?

- Retired: 40%
- Full-time employed: 35%
- Self-employed: 7%
- Part-time employed: 6%
- Not employed: 6%
- Unable to work: 4%
- Homemaker: 3%
- Student: 2%
- No Response: 1%

% of Respondents (n=501)
Do you have health insurance?

- Yes: 93%
- No: 4%
- Not Sure: 1%
- No Response: 2%

n=501
APPENDIX A – Survey Charts

Respondent Service Area

<table>
<thead>
<tr>
<th>Service Area</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jamaica</td>
<td>48%</td>
</tr>
<tr>
<td>Southwest Queens</td>
<td>45%</td>
</tr>
<tr>
<td>East New York &amp; New Lots</td>
<td>7%</td>
</tr>
</tbody>
</table>

(n=501)