ONE BROOKLYN HEALTH SYSTEM

BROOKDALE
UNIVERSITY HOSPITAL MEDICAL CENTER

Interfaith
Medical Center

KINGSBROOK
JEWISH MEDICAL CENTER

2019–2021

IRS Implementation Strategy & NYS Community Service Plan

Brookdale Hospital Medical Center
One Brookdale Plaza
Brooklyn, NY 11212
718-240-5000

Interfaith Medical Center
1545 Atlantic Avenue
Brooklyn, NY 11213
718-613-4000

Kingsbrook Jewish Medical Center
585 Schenectady Avenue
Brooklyn, NY 11203
718-604-5000

2019 Community Service Plan Cover Page

1. **Service Area Covered in Assessment and Plan:** Central and Northeastern Brooklyn
2. **Participating Local Health Department**: Brooklyn Neighborhood Health Action Center at Bedford, NYC Department of Health & Mental Hygiene, 485 Throop Avenue, Brooklyn, NY 11221, BrooklynActionCenter@health.nyc.gov, (718) 637-5283
3. **Participating Hospital System**: One Brooklyn Health System, Inc. (OBHS) member hospitals:

Brookdale Hospital Medical Center	**Interfaith Medical Center**	**Kingsbrook Jewish Medical Center**
One Brookdale Plaza	1545 Atlantic Avenue	585 Schenectady Avenue
Brooklyn, NY 11212	Brooklyn, NY 11213	Brooklyn, NY 11203
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2019-2021
COMMUNITY HEALTH NEEDS ASSESSMENT
IMPLEMENTATION STRATEGY
and
COMMUNITY SERVICE PLAN

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Introduction

One Brooklyn Health System, Inc. (OBHS) is a not-for-profit, tax-exempt corporation licensed under Article 28 of the Public Health Law. OBHS is co-operator of Brookdale Hospital Medical Center (Brookdale), Interfaith Medical Center (Interfaith), and Kingsbrook Jewish Medical Center (Kingsbrook). OBHS member hospitals have strong, historic ties to the communities they serve as both vital anchor institutions and safety-net providers dedicated to providing high quality healthcare services to the residents of Central and Northeast Brooklyn. OBHS has embraced Northwell Health's, The Brooklyn Study: Reshaping the Future of Healthcare as a restructuring blueprint with the goal to preserve and enhance access to healthcare services in Brooklyn and create a financially sustainable system of care.

OBHS's mission statement is: "We provide greater access to high quality medical care and keep our communities healthy through an integrated care system that respects the diversity of our communities and addresses both the health needs and unique factors that shape them."

This document contains the 2019-2021 Community Health Needs Assessment (CHNA), federal Implementation Strategy (IS), and New York State Community Service Plan (CSP) for OBHS and its member hospitals, Brookdale, Interfaith, and Kingsbrook, which are all located in Medically Underserved Areas of Central and Northeast Brooklyn, New York (Kings County). This report will serve as a single planning document that will guide community health planning efforts and fulfill state and federal health law requirements regarding a CHNA, IS, and CSP for the 2019-2021 cycle. The report will be available on OBHS websites such as https://obhs.org/; visitors to the website will be able to access, download, and print a hard copy of the report for free. A paper copy will be available to the public without charge by contacting the offices of OBHS/Interfaith Strategic Planning, Brookdale External Affairs, or Kingsbrook Public Affairs.

The OBHS Board of Trustees approved this plan on November 15, 2019.

A. Executive Summary

1. In 2016, Brookdale Hospital Medical Center (Brookdale), Interfaith Medical Center (Interfaith), and Kingsbrook Jewish Medical Center (Kingsbrook) applied for and received from the NYS Public Health and Planning Council approval to establish One Brooklyn Health System (OBHS), a tax-exempt NY not-for-profit corporation that will preserve and enhance health care services in Central and Northeastern Brooklyn. In April 2018, OBHS became the active parent of the three system hospitals with representatives from the previous hospital boards becoming members of the new OBHS board of trustees. OBHS member hospitals have collaborated to address shared community health goals and have identified three shared Prevention Agenda priorities for the 2019-2021 community health planning period**: Prevent Chronic Disease, Promote Well-Being and Prevent Mental Health and Substance Use Disorders** as well as **Promote Health Women, Infants and Children.** The OBHS hospitals will collaborate with community partners to address premature mortality caused by disproportionately high rates of chronic diseases.

	One Brooklyn Health System			
Prevention Agenda Priority 2019-2021	**Brookdale**	**Interfaith**	**Kingsbrook**	**OBHS**
Prevent Chronic Diseases	✔	✔	✔	✔
Promote Well-Being and Prevent Mental and Substance Abuse Disorders	✔	✔	✔	✔
Promote a Healthy and Safe Environment		✔	✔	✔
Promote Healthy Women, Infants and Children	✔	✔	✔	✔
Prevent Communicable Diseases		✔	✔	✔

2. OBHS and its member hospitals reviewed community health data from County Health Rankings, City Health Dashboard, NYC Neighborhood Health Atlas, Take Care New York, NYC Department of Health and Mental Hygiene (DOHMH) 2018 Community Health Profiles, hospital clinical diagnosis and treatment data for OBHS patients, “The Brooklyn Study: Reshaping the Future of Healthcare”, and other data to identify priorities. In addition, OBHS adapted the Greater New York Hospital Association (GNYHA) Neighborhood Health Needs

Assessment tool to survey community members with a standardized set of questions. Finally, the findings and recommendations from the three Participatory Action Research reports for Central and Northeast Brooklyn serve as the cornerstone of OBHS' community service plan and guided OBHS' selection of Prevention Agenda priorities, goals, and interventions.

3. OBHS and its member hospitals will partner with community and faith-based organizations (CBOs and FBOs), other healthcare service providers in the community, elected officials representing OBHS' service areas, NYC DOHMH Brooklyn Neighborhood Health Action Center through local City Council initiatives, NYS DOH, businesses, health plans, community advisory boards/councils, and other stakeholders to address health needs. OBHS recognizes the importance of cross-sector collaboration as key to addressing social determinants of health and community engagement. In addition, Brookdale's Community Advisory Board, the Coalition to Transform Interfaith and Kingsbrook's Community Leadership Council are comprised of members of the community, faith leaders, and health partners who are charged with ensuring the voice of their community is represented and convene regularly to provide a community forum for updates on hospital activities and sponsor or publicize community health initiatives.
4. The evidence-based interventions that OBHS will implement were selected after review of the reports, surveys, and community health data detailed above in section A.1.2 and chosen from the NYS Prevention Agenda Action Plans with their corresponding Focus Area, Goals, and Interventions. As stated in OBHS' Mission Statement, each hospital has its own communities with its communities' respective diversity and health needs that require both similar and unique approaches; while the same priority areas and goals may have been selected, the interventions have been tailored based on available resources, existing partnerships and community input. Each of the hospitals have selected evidence-based interventions to address the same goals in their shared Priority areas of Prevent Chronic Diseases (PCD) and Promote Well-Being and

Prevent Mental and Substance Abuse Disorders (PWPMSUD):

NYS Prevention Agenda 2019-2021 – One Brooklyn Health System	
Priority	**Goal**
Prevent Chronic Disease	4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity
Promote Well-Being and Prevent Mental and Substance Use Disorders	2.4 Reduce the prevalence of major depressive disorders
Promote Healthy Women, Infants and Children	1.2: Reduce maternal mortality & morbidity

Interventions that each OBHS hospital will implement to address these and other priorities include and are not limited to:

Brookdale: **(**1) Participate in Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPS) initiatives. Conduct clinical process assessments; Establish personal "Plan of Care" protocol for chronic disease patients; Incorporate patient follow-up care and compliance tracking. (2) Incorporate evidence-based care into Patient-Centered Medical Home (PCMH) model. Brookdale has chosen Focus Area 2: Prevent Mental and Substance Use Disorders**,** with the following intervention: the implementation of IMPACT Collaborative Care. IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) is an intervention for patients who have a diagnosis of major depression or dysthymia, often in conjunction with another major health problem. IMPACT will be implemented within the framework of Brookdale's PCMH and will screen all patients 12 years old and older with PHQ-2PHQ-9 for depression, AUDIT-C/AUDIT for alcohol use, and DAST-1/DAST-10 for drug use. To support healthy women and children, Brookdale is planning to add the Centering Pregnancy Coordinator to the OB/GYN department staff to expand the program.

Interfaith: To support achieving Prevent Chronic Disease goal 4.3, Interfaith will implement intervention 4.3.2 *Promote evidence-based medical management in accordance with national*

guidelines. To support achieving Promote Well-Being and Prevent Mental and Substance Use Disorders goal 4.2, Interfaith will implement intervention 2.4.2 *Strengthening resources for families and caregivers*. To support achieving Promote Healthy Women, Infants and Children goal 1.2, Interfaith will implement intervention 1.2.3 *Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing*.

Kingsbrook: Having graduated to an Advanced Primary Care NYS certification-PCMH practice, Kingsbrook will support goal 4.3 by providing primary care and chronic disease treatment via a set of standards that describe clear and specific criteria; including organizing care around patients, working in teams and coordinating and tracking care over time, increasing screening rates for cardiovascular diseases, diabetes, breast, cervical and colorectal cancers, especially among populations experiencing health disparities. Kingsbrook will increase use of primary and preventive health care services by women of all ages with a focus on women of reproductive age. All OBHS hospitals' interventions have been selected to address the health disparity of premature mortality: Black/African-American New Yorkers die of the same leading causes of death as non-Black/African-American New Yorkers at a rate 45% higher than the general population.

5. Progress and improvement on the interventions listed above will be tracked through the family of measures OBHS identified in the NYS DOH Work Plan that will evaluate OBHS' evidence-based interventions and their impact. In addition to internal hospital metrics, such as percentage of patients enrolling and completing a program, family of measures that will be used to track progress will include state and national benchmarks from recognized entities such as the National Committee for Quality Assurance. Data will be analyzed using hospital electronic medical record (EMR) systems, and the specific data points that can be tracked include treatment outcomes and the number of patients screened and enrolled in disease prevention programs. In addition, OBHS member hospitals will use event-based surveys and other tools to measure

participation levels in disease education and prevention events for both adults and children hosted across the hospital system and in the community.

B. Community Health Assessment

Community Description, Demographics, and Data

1. Based on the recommendations in Northwell Health's "The Brooklyn Study: Reshaping the Future of Healthcare", in 2016, Brookdale, Interfaith and Kingsbrook applied for and received approval from the NYS Public Health and Planning Council to establish One Brooklyn Health System (OBHS), which will serve as an integrated, central health care delivery system that will preserve and enhance health care services in Central and Northeast Brooklyn.[1] OBHS member hospitals have come together to create this comprehensive community health needs assessment and community service plan; the collaborating facilities are all located in Kings County (Brooklyn) and have defined their community assessed as Central and Northeastern Brooklyn, demarcated by shared primary and secondary neighborhoods and ZIP codes:[2]

		OBHS Service Areas by Facility		
UHF Neighborhood	**ZIP Codes**	**Brookdale**	**Kingsbrook**	**Interfaith**
Bedford Stuyvesant/Crown Heights	11212	Primary	Primary	Secondary
East New York/ New Lots	11207	Primary	Secondary	Secondary
East New York/ New Lots	11208	Primary	Secondary	Secondary
Bedford Stuyvesant/Crown Heights	11233	Secondary	Secondary	Primary
Canarsie and Flatlands	11236	Secondary	Primary	Tertiary
Canarsie and Flatlands	11234	Tertiary	Tertiary	Tertiary
Canarsie and Flatlands	11239	Tertiary	Tertiary	
East Flatbush	11203	Tertiary	Primary	Tertiary
Bedford Stuyvesant/Crown Heights	11213		Primary	Primary
Bedford Stuyvesant/Crown Heights	11216		Tertiary	Primary
Bedford Stuyvesant/Crown Heights	11238			Secondary
Downtown Brooklyn/Heights/Slope	11205			Tertiary

[1] The Brooklyn Study: Reshaping the Future of Healthcare, https://www.northwell.edu/about/our-organization/northwell-ventures/brooklyn-study

[2] Brownsville is included in ZIP codes 11212 and 11233

Downtown Brooklyn/Heights/Slope	11217			Tertiary
East Flatbush	11210		Tertiary	Tertiary
East Flatbush	11225		Secondary	Secondary
East Flatbush	11226		Secondary	Tertiary
Williamsburg/Bushwick	11206			Tertiary
Williamsburg/Bushwick	11221		Tertiary	Secondary

Service area was determined based on OBHS hospitals' discharge data. Patient origin ZIP codes were ranked by frequency; primary service area was defined using a cutoff of 50%, i.e. 50% of patients came from the ZIP codes covered by the primary service area. The cut offs for secondary and tertiary service area were 75% and 85% respectively.

The data and discussion for the following sections have been compiled from the New York City Department of Health and Mental Hygiene (NYC DOHMH) Community Health Profiles 2018.[3] The OBHS primary and secondary service area ZIP codes are: 11212, 11207, 11208, 11233, 11236, 11203, 11213, 11216, 11238, 11225, 11226 and 11221. These correspond to Brooklyn's Community Districts 3, 5, 8, 9, 14, 16, 17 and 18. The Community Health Profiles for these Community Districts were used to assess the community health status and compare them to Brooklyn and New York City overall.

To measure overall health outcomes of the community, life expectancy and rates of premature mortality (death before age 65) were compared within the OBHS service area and with Brooklyn and NYC overall. Community District (CD) 16 Brownsville had the worst outcomes: life expectancy is 75.1 years and premature mortality rate is 356.1 per 100,000 people. Brownsville ranks the worst in life expectancy (lowest years) and premature mortality rate (highest rate) among all Community Districts in New York City. This rate is in stark contrast with the health of NYC, which "has never been better. Our city's life expectancy is 81.2 years, 2.5 years higher than the national average." When compared with the residents of Stuyvesant

[3] New York City Community Health Profiles: https://www1.nyc.gov/site/doh/data/data-publications/profiles.page#bk

Town and Turtle Bay who enjoy the highest life expectancy (85.9) across NYC, the community members of Brownsville are dying almost 11 years earlier. CD3- Bedford Stuyvesant also ranks poorly, 7th lowest in life expectancy (76.8 years) and 8th highest in premature mortality (283.8 per 100,000 people). The rest of the Community Districts in the OBHS service area have life expectancy rates at or below that of Brooklyn and NYC (82.9 and 81.2, respectively). The highest life expectancy among the OBHS Community Districts was 82.6, in CD-17 East Flatbush.

Table 1. Life Expectancy and Premature Mortality

Brooklyn Community District	Neighborhood	Life Expectancy (years)	Premature Mortality (per 100,00 people)
3	Bedford Stuyvesant	76.8	283.8
5	East New York and Starrett City	78.6	264.8
8	Crown Heights and Prospect Heights	79.3	234
9	South Crown Heights and Lefferts Gardens	81.2	195.5
14	Flatbush and Midwood	82.4	169.4
16	Brownsville	75.1	356.1
17	East Flatbush	82.6	206.1
18	Flatlands and Canarsie	82	164.7
-	Brooklyn	82.9	184.1
-	New York City	81.2	169.5

Examples of health disparities in the community served by OBHS include HIV; obesity, diabetes and hypertension; and psychiatric hospitalizations. Rates of new HIV diagnoses per 100,000 people are high in most of the OBHS community districts. All of the community districts have rates higher than both Brooklyn (22.1) and NYC overall (24), except for CD-18 Flatlands and Canarsie and CD-14 Flatbush and Midwood (17.9 and 23, respectively). Brownsville (CD-16) has the highest rate of new HIV diagnoses in Brooklyn and 2nd highest rate in NYC at 67.4, second only to Central Harlem at 69.6. Bedford Stuyvesant (CD-3) and Crown Heights and Prospect Heights (CD-8) both have HIV diagnosis rates more than twice the Brooklyn average: 55.1 and 44.3, respectively.

Table 2. HIV Diagnoses

Brooklyn Community District	Neighborhood	New HIV Diagnoses (per 100,000)
3	Bedford Stuyvesant	55.1
5	East New York and Starrett City	38.1
8	Crown Heights and Prospect Heights	44.3
9	South Crown Heights and Lefferts Gardens	31.4
14	Flatbush and Midwood	23
16	Brownsville	67.4
17	East Flatbush	35.6
18	Flatlands and Canarsie	17.9
-	Brooklyn	22.1
-	New York City	24

The comparison of obesity, diabetes and hypertension rates in adults for the OBHS service area is mixed. Brownsville (CD-16) has an obesity rate of 41%, the 3rd highest in NYC, however, at a 13% rate for diabetes and hypertension, Brownsville is similar to the Brooklyn and NYC averages (12% and 11%, respectively). Other poorly ranked neighborhoods include East New York and Starrett City (CD-5) ranking 8th highest in obesity rate and South Crown Heights and Lefferts Gardens (CD-9) and Flatlands and Canarsie (CD-18) ranking 9th and 10th highest in hypertension rates, respectively. All of the OBHS community districts have diabetes rates higher than the Brooklyn and NYC average.

Table 3. Obesity, Diabetes and Hypertension in Adults

Brooklyn Community District	Neighborhood	Obesity (%)	Diabetes (%)	Hypertension (%)
3	Bedford Stuyvesant	29	13	13
5	East New York and Starrett City	35	14	14
8	Crown Heights and Prospect Heights	26	13	13
9	South Crown Heights and Lefferts Gardens	32	15	15
14	Flatbush and Midwood	28	13	13
16	Brownsville	41	13	13
17	East Flatbush	34	15	15
18	Flatlands and Canarsie	30	14	14
-	Brooklyn	27	12	12
-	New York City	24	11	11

Psychiatric hospitalizations are high in the OBHS service area. Community Districts 3, 5, 8, 9, and 16 have psychiatric hospitalization rates exceeding 1,000 per 100,000 adults. Only Flatlands and Canarsie (CD-18) and Flatbush and Midwood (CD-14) have psychiatric rates below the averages for Brooklyn (684) and NYC (676). Brownsville has the 2nd highest rate of psychiatric hospitalizations in New York City with a rate of 1,897 per 100,000 adults, nearly three times the average rates in Brooklyn and in NYC. Other community districts that rankly highly in NYC are Crown Heights and Prospect Height (8th), East New York and Starrett City (9th) and Flatbush and Midwood (10th).

Table 4. Psychiatric Hospitalizations

Brooklyn Community District	Neighborhood	Psychiatric Hospitalizations (per 100,000 adults)
3	Bedford Stuyvesant	1,002
5	East New York and Starrett City	1,113
8	Crown Heights and Prospect Heights	1,149
9	South Crown Heights and Lefferts Gardens	1,102
14	Flatbush and Midwood	600
16	Brownsville	1,897
17	East Flatbush	800
18	Flatlands and Canarsie	534
-	Brooklyn	684
-	New York City	676

In the OBHS service area, residents experience economic stress in various forms. Most of the community districts have a higher percentage of residents living below the poverty level compared to Brooklyn and NYC overall (21% and 20%, respectively). The exceptions to this are CD-3 East Flatbush (19%) and CD-18 Flatlands and Canarsie (15%), which have lower percentages than both Brooklyn and NYC; CD-8 Crown Height and Prospect Heights has a poverty level of 21%, the same as Brooklyn and slightly higher than NYC. Within the service area, OBHS serves neighborhoods with a wide range of poverty level percentages. CD-5 East New York and Starrett City have the highest poverty level (30%) and is the 7th highest in New

York City and CD-18 Flatlands and Canarsie has the lowest (15%). Another indicator of the economic realities faced by Central Brooklyn is insurance coverage. OBHS patients are mainly insured through Medicaid and Medicare, and depend disproportionately on local safety net providers such as these hospitals. Almost all of the neighborhoods that OBHS hospitals serve have the HHS-designations of Health Professional Shortage Area (HPSA) and/or Medically Underserved Area (MUA).[4] Some of the factors that result in poor health outcomes for the population as a result of this area designation include high disease burden, lack of access to care, a shortage of primary care doctors, linguistic and cultural isolation, and low health literacy. Using another measure of economic stress, the rent burden is high in the OBHS service area. Rent burden is defined as homes whose gross rent (including utilities) is equal to or higher than 30 percent of household income in the past 12 months. Ranging from 50% to 57% in the OBHS service area, rent burden is elevated, but not extreme when compared Brooklyn (52%) and NYC (51%).

Table 5. Economic Stress

Brooklyn Community District	Neighborhood	Poverty (%)	Rent Burden (%)
3	Bedford Stuyvesant	23%	53%
5	East New York and Starrett City	30%	52%
8	Crown Heights and Prospect Heights	21%	50%
9	South Crown Heights and Lefferts Gardens	22%	55%
14	Flatbush and Midwood	22%	57%
16	Brownsville	28%	57%
17	East Flatbush	19%	54%
18	Flatlands and Canarsie	15%	50%
-	Brooklyn	21%	52%
-	New York City	20%	51%

[4] U.S. Health and Human Services/Health Resources and Services Administration, www.hpsafind.hrsa.gov

Part of the economic stress felt by community residents is influenced by changes in housing stock and housing demand. The data and discussion for changes in housing stock for the OBHS service area presented below are from the NYU Furman Center's State of New York City's Housing & Neighborhoods – 2017 Report. This report describes and analyzes recent changes in New York City's housing stock and possible implications of these changes. While it is important to consider the overall change in population, the change in adult population is a better indicator for the increase in housing demand. From 2000 to 2016, the increase in adult population varied widely across OBHS service area neighborhoods. Flatbush and Midwood (CD-14) had the smallest increase (0.3%) while Bedford Stuyvesant (CD-3) had the largest increase (38.2%). The overall adult population growth for Brooklyn and New York City was 11.8% and 10.9%, respectively. An increase in population will also increase the housing demand, driving the increase in prices, rents and housing values. A concurrent increase in housing units will offset these rising costs, however, in some neighborhoods the population growth far outpaces the growth in housing stock. This can be seen in Bedford Stuyvesant (CD-3) and Crown Heights and Prospect Heights (CD-8) where housing increased by around 19%.

Table 6. Changes to Population and Housing Units in OBHS Service Area

Brooklyn Community District	Neighborhood	% Change in Adult (18+) Population from 2000 to 2016	% Change in Housing Units from 2000 to 2016
3	Bedford Stuyvesant	38.2%	19.0%
5	East New York and Starrett City	19.6%	22.9%
8	Crown Heights and Prospect Heights	24.2%	19.8%
9	South Crown Heights and Lefferts Gardens	5.3%	10.8%
14	Flatbush and Midwood	.3%	3.0%
16	Brownsville	12.2%	15.8%
17	East Flatbush	3.2%	8.1%
18	Flatlands and Canarsie	10.0%	1.2%
-	Brooklyn	11.8%	10.8%
-	New York City	10.9%	8.2%

Citywide, there were more than 270,000 new housing units built between 2000 and 2016, but distribution varies widely. Among all neighborhoods, Flatbush and Midwood (CD-14) gained the fewest new units at 924. In comparison, neighborhoods with the most new units, Chelsea/Clinton/Midtown added over 28,000 new units. Similarly, other OBHS neighborhoods were ranked lowly: Flatlands/Canarsie (6th lowest), East Flatbush (11th lowest) and South Crown Heights (13th lowest). However, recently issued building permits may provide insight into future units in these neighborhoods. Between 2015 and 2017, Flatbush was issued authorization for 1,435 new units, making it the 34th lowest in the city. The neighborhoods with the most population growth (Bedford Stuyvesant, East New York and Starrett City, and Crown Heights and Prospect Heights) all experience modest increases in new units built and new building permits issued. Although NYC has had a rapid increase in housing units in recent decades signs show that the increased supply is not sufficient to meet increased housing demand caused by growth in adult population and job availability. Also, more households are severely over-crowded, prices are rising and the share of affordable housing has decreased. To meet increasing demand, NYC needs more housing units, particularly for lower income households. This trend is seen in parts of the OBHS service area, where neighborhood populations are growing rapidly.

Table 7. NYC Housing Units

Brooklyn Community District	Neighborhood	Units Built 2000 – 2016	Units Authorized by New Building Permits 2015 – 2017
3	Bedford Stuyvesant	6,803	2,932
5	East New York and Starrett City	6,645	1,344
8	Crown Heights and Prospect Heights	2,835	2,217
9	South Crown Heights and Lefferts Gardens	2,028	2,388
14	Flatbush and Midwood	924	1,435
16	Brownsville	6,803	1,443
17	East Flatbush	1,760	1,113
18	Flatlands and Canarsie	1,365	77
-	Brooklyn	80,142	34,283
-	New York City	273,260	87,130

The following tables describing OBHS' service area demographics and data are sourced from the New York City Population FactFinder, which provides "detailed population profiles showing critical demographic, social, economic, and housing statistics, and how these statistics have changed over time."[5] The data are based on the 2013-2017 American Community Survey:

Table 8. OBHS Service Area Population Census		
Zip Codes Included	11203, 11207, 11208, 11212, 11213, 11216, 11221, 11225, 11226, 11233, 11236, 11238	
Brooklyn Community Districts	3, 5, 8, 9, 14, 16, 17, 18	
	Number	*Percent*
Total population	1,181,171	-
Male	539,121	45.60%
Female	642,050	54.40%
Females of child bearing age (15-44)	275,338	23.31%
Median age (years)	34.8	
Under 19 years	307,567	26.00%
65 years and over	145,868	12.3%

Table 9. Race, Ethnicity and Citizenship Status		
Race/Hispanic Origin	*Number*	*Percent*
Total population	1,126,493	-
Hispanic/Latino (of any race)	186,268	16.50%
White Non-Hispanic	177,223	15.70%
Black/African American Non-Hispanic	694,168	61.60%
Asian Non-Hispanic	40,711	3.60%
Other race Non-Hispanic	28,123	2.5%
Place of Birth		
Total population	1,181,171	-
Native-born	750,317	63.50%
Born in United States	716,867	60.70%
Born in Puerto Rico, U.S. Island areas, or born abroad to American parent(s)	33,450	2.80%
Foreign-born	430,854	36.50%
Naturalized U.S. citizen	269,519	62.60%
Not a U.S. citizen	161,335	37.40%

[5] New York City Population FactFinder, https://popfactfinder.planning.nyc.gov/about

Table 10. Insurance, Employment and Education		
Insurance Status	*Number*	*Percent*
Total Population	1,176,592	-
With health insurance coverage	1,067,205	90.70%
With private health insurance	626,785	53.30%
With public coverage	531,605	45.20%
No health insurance coverage	109,387	9.30%
Employment Status		
Population 16 years and over	932,298	-
Civilian labor force	580,659	62.30%
Employed	527,646	56.60%
Unemployed	53,013	5.70%
Not in labor force	351,295	37.70%
Unemployment rate	-	9.10%
Educational Attainment		
Population 25 years and over	784,854	-
Less than 9th grade	61,141	7.80%
9th to 12th grade, no diploma	73,492	9.40%
High school graduate (or equivalency)	242,302	30.90%
Some college, no degree	130,070	16.60%
Associate's degree	56,722	7.20%
Bachelor's degree	137,609	17.50%
Graduate or professional degree	83,518	10.60%

Health Challenges and Social Determinants of Health

2. The Governor's Vital Brooklyn Initiative recognizes that Central Brooklyn is one of the most disadvantaged areas in all of New York State with social and economic indicators demonstrating measurably higher rates of obesity, diabetes and high blood pressure, limited access to healthy foods or opportunities for physical activity, high rates of violence and crime, wide economic disparities from unemployment, and poverty levels, and inadequate access to high quality health care and mental health services. [6] The New York State Department of Health (NYS DOH) has recognized that without Brookdale University Hospital Medical Center (Brookdale), Interfaith

[6] "Governor Cuomo Announces $1.4 Billion "Vital Brooklyn" Initiative to Transform Central Brooklyn" (Governor's Press Office Website, 2017) https://www.governor.ny.gov/news/governor-cuomo-announces-14-billion-vital-brooklyn-initiative-transform-central-brooklyn

Medical Center (Interfaith) and Kingsbrook Jewish Medical Center (Kingsbrook) vulnerable communities with the highest health care disparities in New York City and New York State would not receive essential health care services.

All OBHS hospitals are members of Community Care of Brooklyn (CCB), the second largest PPS in NYS with an attribution of 630,000 Medicaid beneficiaries. Through CCB, OBHS hospitals have been active and effective participants in the DSRIP program. Since 2016, CCB has supported a collaboration between the DuBois-Bunche Center for Public Policy at Medgar Evers College, community partners, and consultancies to build a deeper understanding of the social determinants of health in Central Brooklyn. In the summer of 2016, CCB in partnership with Brownsville Multi-Service Family Health Center hired MIT-affiliated urban planning consultancy, NextShift, to assemble a team of 28 young adults to engage in a Participatory Action Research (PAR) project to understand the East New York and Brownsville communities' priorities for health creation.

PAR is centered on Popular Education pedagogy that includes the view that neighborhood residents and local stakeholders are experts with critical insight into how best to identify community assets and address community challenges. PAR is a collaborative and dynamic approach to research that equitably involves community members, organizational representatives, and researchers in all aspects of the research project – from generating the questions asked, to analyzing and publishing the data as well as developing action strategies to address findings.

During the summer of 2016, the PAR I research team supported by key players CCB, NextShift and Brownsville Multi-Service Center used a survey of 525 residents; 23 interviews with key neighborhood stakeholders including healthcare institutions, labor leaders and civic organizations operating in Brownsville and East New York; and one focus group to explore five

dimensions of health and to develop a set of recommendations and action steps to create a healthier Brownsville and East New York. Key findings of the PAR I project included:

- Less than half of respondents rated their own health as "Very Good" or "Excellent." This figure was even lower among women than men.
- Residents reported facing significant barriers to physical activity, including inaccessible and unaffordable facilities, a lack of connection and support, and social challenges including sexual harassment and violence.
- More than half of respondents reported lack of access to affordable healthy food as a key obstacle to health.
- Respondents identified numerous social, cultural, and human assets in Brownsville and East New York, assets that are ready to be leveraged in the service of a healthier community. Stakeholders and residents strongly emphasized that culture is the key to building a healthier future.

The findings prompted CCB to prioritize food justice for intervention and helped inform local and state policy advocacy efforts. In March 2017, in support of DSRIP goals and largely consistent with the priority areas identified by PAR I, the Governor announced Vital Brooklyn, a $1.4 billion state investment in community health in Central Brooklyn. Vital Brooklyn proposes $700 million for community-based health care ($664 million awarded to OBHS in capital funding), mandating the creation of 36 new ambulatory care centers, $578 million for affordable housing and other community initiatives. In addition to affordable housing, the initiative targets seven critical sectors connected to the social determinants of health that were identified as integral to improving community health in the PAR I research. The sectors included food access, economic development and job creation driven by local institution of "anchor" procurement, and health-supporting civic infrastructure.

Regarding the Vital Brooklyn initiative, Governor Cuomo noted: "For too long investment in underserved communities has lacked the strategy necessary to end systemic social and economic disparity, but in Central Brooklyn those failed approaches stop today. We are going to employ a new holistic plan that will bring health and wellness to one of the most disadvantaged parts of the state." Vital Brooklyn is currently the largest state-based healthcare reform demonstration plan in the U.S. Its explicit focus on combating the social determinants of health by using participatory planning processes and long-term multi-stakeholder coordination to build a community-owned entrepreneurial ecosystem is an innovative and necessary departure from approaches that seek solely to improve healthcare access and cut costs. The success of the initial phase of PAR work, and the adoption of the priority interventions by Vital Brooklyn led to an additional PAR project (PAR II) initiated by Interfaith and Kingsbrook, with funding support from the New York Community Trust (NYCT) and CCB.

In the summer of 2017, Interfaith, Kingsbrook, NextShift and the Dubois-Bunche Center recruited, trained, and supervised a 48-person PAR II research team, which included local high school and college students, as well as Urban Planning graduate students from across the country. (UC Berkeley, MIT and Pratt.) The PAR II project sought to understand and investigate community perceptions of health and well-being in the Central Brooklyn communities of: Bedford Stuyvesant, Brownsville, Bushwick, Canarsie, Crown Heights, Cypress Hills/Ocean Hill, East Flatbush, East New York, Prospect Heights, and Prospect Lefferts Gardens, while focusing on and identifying priority social determinants of health in three neighborhoods: Bedford Stuyvesant, Crown Heights, and East Flatbush. The research was guided by a core question "How can residents build power to pool existing assets and demand increased investment in a healthier, more supportive and more affordable Central Brooklyn now, and in the future?" Using a survey of 1,026 residents (collected over a two-and-a-half week period), four

focus groups, and fifteen neighborhood stakeholder interviews, the team explored five health determinants and developed a set of recommendations and action steps to improve health in Central Brooklyn. The determinants of health included economic justice, youth and families, community and belonging, environmental justice, as well as housing and neighborhood services.

By working with youth from Central Brooklyn, PAR II sought to build a generation of community leaders invested in the future of their communities. The research diverged from typical research in that youth residents drove the research agenda, participating as full members of the collaborative research team. Community input from residents involved in focus groups and community forums where preliminary results and findings were reported back to the neighborhoods also largely informed the research recommendations. In addition, institutional leaders and local organizations involved in the research were invested in the Popular Education principle concept that the community is already equipped with the knowledge and power to create a healthier Central Brooklyn. They also recognize that substantial economic investment, trust, and dynamic collaborations are required to move this work. The PAR II research team arrived at four central findings:

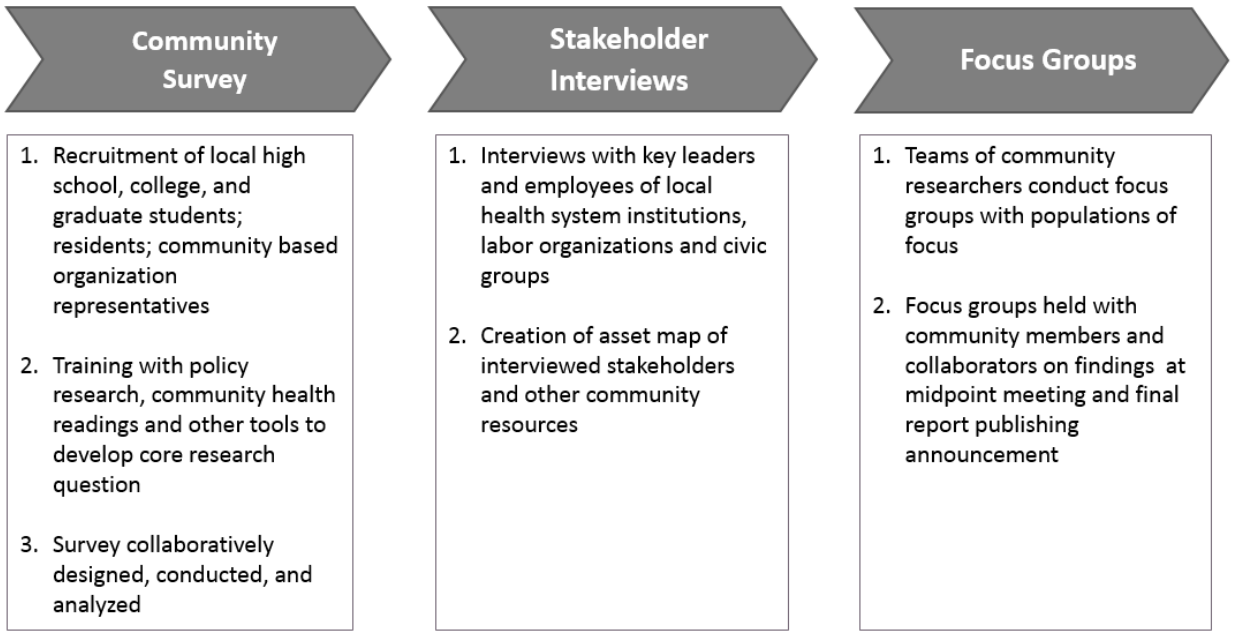
1. Gentrification, housing affordability, and neighborhood change are seen as top challenges affecting health in Central Brooklyn
2. There is a need to increase and support economic development and mobility
3. A redesigned health system can increase community health by building relationships between the community and health care leaders
4. Building a sustainable civic infrastructure is key to achieving any community-based health initiative goals

In addition to the PAR I and PAR II findings and recommendations, the latest published report of CCB's PAR III work has been incorporated into OBHS' community health needs assessment and community service plan.

During the summer of 2018, 42 students from Central Brooklyn high schools, colleges and universities came together under the banner of Wellness Empowerment for Brooklyn (WEB) as the Canarsie, Flatlands and Flatbush Participatory Action Research (CFF PAR) Team. The team was assembled to provide a youth- and community-generated understanding of how residents of Canarsie, Flatlands and Flatbush perceive their own health, the health of their community, and what types of changes they believe will improve health and wellbeing in their neighborhoods.

The body of PAR research in Central Brooklyn from 2016-2018 informs OBHS community health planning and is summarized below:

Figure 1. PAR Methodology Summary



PAR II Final Report Figure 4. Research question design process

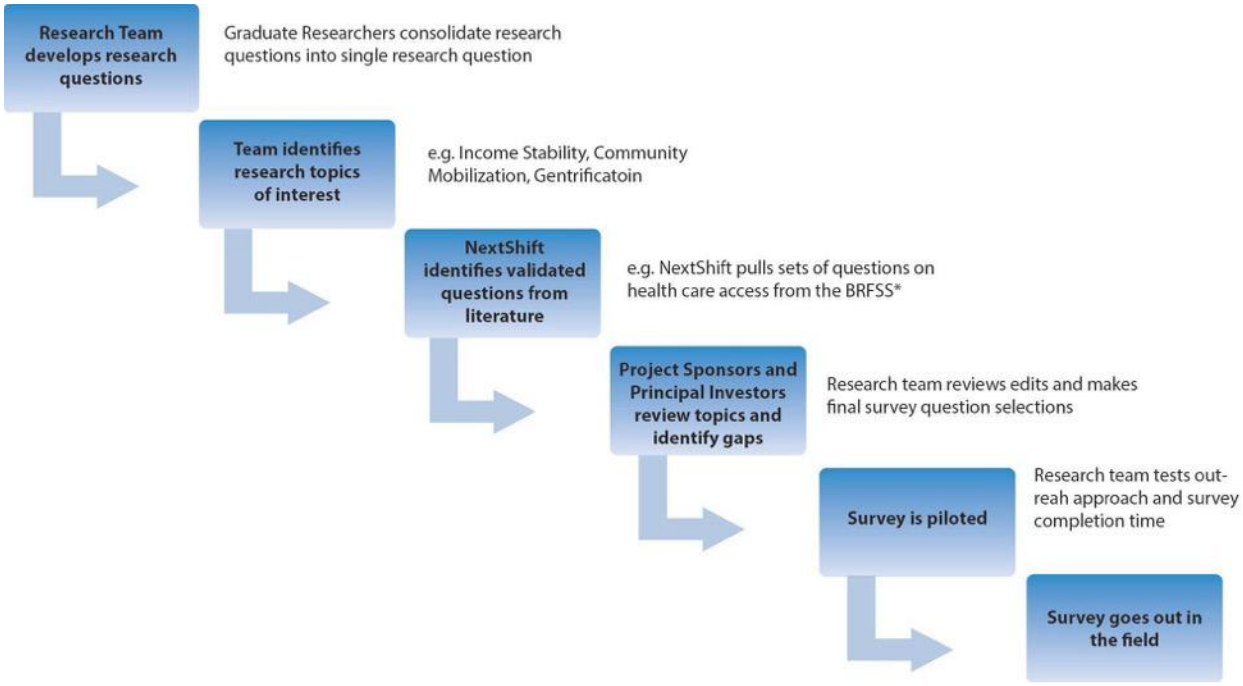


Figure 2. PAR Methodology Detail

PAR (Summer)	Neighborhoods	Researchers	Surveys	Interviews	Focus Groups
PAR 1 2016	Brownsville East New York	28	525	23	1
PAR 2 2017	Bed-Stuy Crown Heights East Flatbush	48	1,026	15	4
PAR 3 2018	Canarsie Flatlands Flatbush	42	1,063	17	4

Figure 3. Central Brooklyn Health Disparities, PAR 1-3 Key Findings

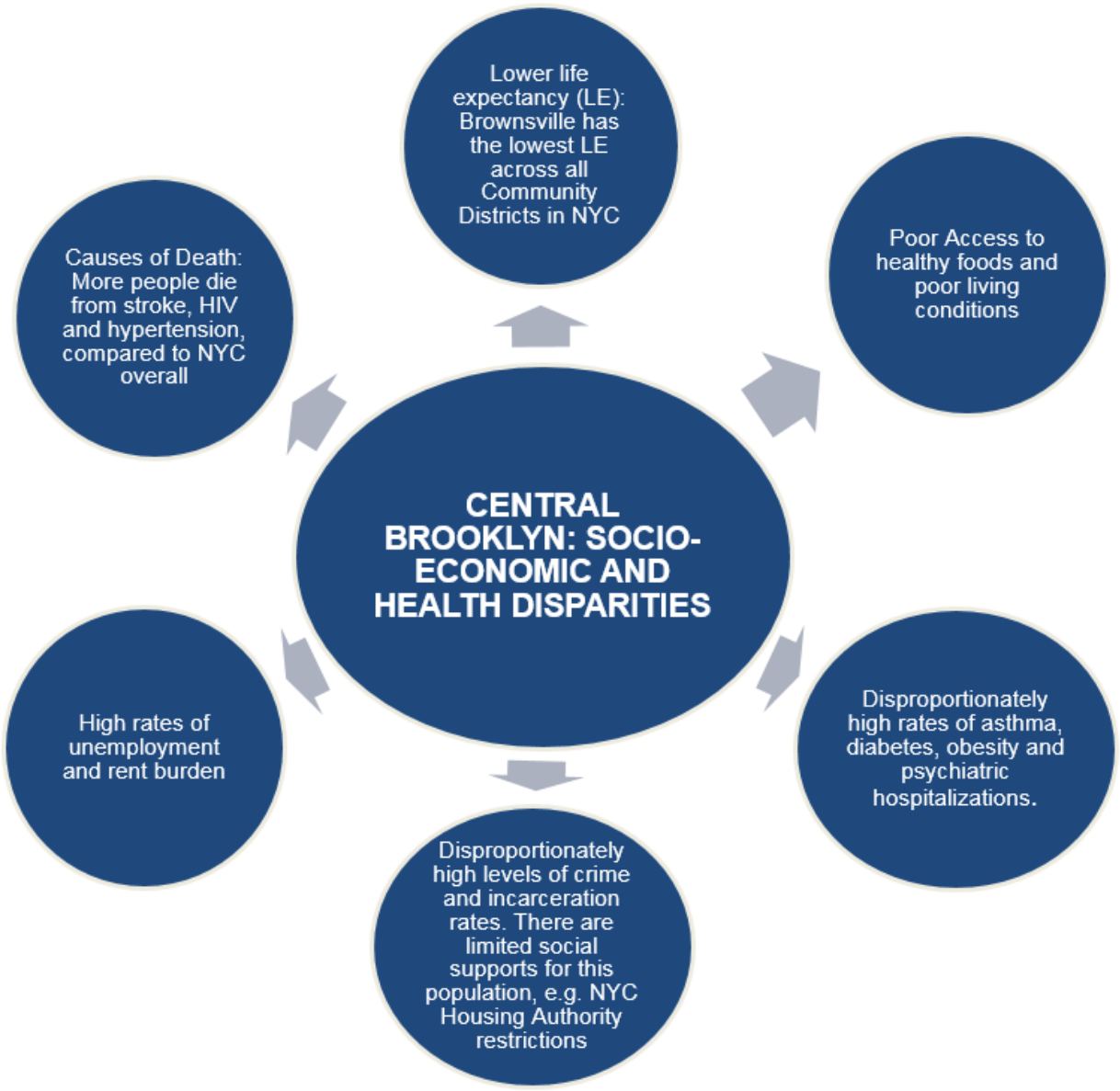


Figure 4. PAR 1-3 Findings and Recommendations Overview

PAR	Findings (Top Issues)	Recommendations
PAR 1 2016	1. Healthy Food Access 2. Barriers to Physical Activity	1. Food Justice and Nutrition- urban farming and organizing with bodegas 2. Free Physical Activity and Education-improve public spaces and wellness programs
PAR 2 2017	1. Gentrification/Housing Instability 2. Economic Opportunity 3. Sustainable Civic Infrastructure 4. Healthcare System Redesign	1. Invest in development strategies and housing 2. Partner locally to increase employment and entrepreneurship 3. Build local organizing capacity to support systems-level change 4. Deepen hospital-community relationships; focus on social determinants of health
PAR 3 2018	1. Cost of Living/Housing 2. Access to places for young adults 3. Safety 4. Healthy Food Access	1. Partner with local organizations to improve housing affordability and reduce evictions; 2. Support and increase youth development programs 3. Increase anti-violence programs, reduce recidivism and improve police-community relations 4. GrowNYC Green Carts, green markets, community gardens

Community Assets

3. All OBHS hospitals are active members of the Community Care of Brooklyn (CCB) performing provider system, or PPS. CCB has facilitated the strengthening of community assets in part by promoting hospital and community-based organization collaboration. CCB has built a high functioning and collaborative network of key stakeholders in Brooklyn including community-based organizations (CBOs), Federally Qualified Health Centers (FQHCs), Managed Care Organizations (MCOs), behavioral health providers, physicians, social services organizations, hospitals and others to jointly develop and implement initiatives to improve health. Together, this network has improved access to physical and behavioral health care; provided care management to vulnerable populations; strengthened primary care; increased access to palliative care; and engaged communities to address social determinants of health throughout the borough. The PPS network has achieved notable outcomes including a 30 percent reduction in potentially preventable readmissions over the 4-year DSRIP period. Some examples of the DSRIP projects undertaken by OBHS hospitals include:

Brookdale Hospital Medical Center

Brookdale made steady progress towards achieving the NYC Prevention Agenda goals selected for the three-year period 2016-2018. All goals were implemented within the framework of DSRIP, by focusing on disease screening, prevention and management for the major prevalent diseases, in partnership with local supportive service providers. Brookdale's Ambulatory Care Department is working with the DSRIP lead hospital, Maimonides Medical Center, and several DSRIP network organizations, to implement a variety of evidence-based prevention model initiatives focused on diabetes, obesity, heart-disease, high blood pressure, mental health, asthma and breast cancer. Brookdale's capacity to design and meet the overarching goals of DSRIP and NYS DOH (Triple Aim: Better Care, Better Outcomes, Lower Costs), has increased during 2018

and the first half of 2019. To date, Brookdale successfully passed three DSRIP Audits as part of the annual contract deliverables, which are tied to payments. Other programs, such as the Influenza/Pneumococcal Vaccine Initiative now being implemented in collaboration with the NYC Department of Health and Mental Hygiene (NYC DOHMH), are also part of a robust disease prevention strategy. Brookdale will continue to focus on both NYS Prevention Agenda priorities, expanding and sustaining the gains accomplished to date.

Interfaith Medical Center

Interfaith's DSRIP-funded projects that support the Prevention Agenda include:

Emergency Department (ED) Navigation Services

An ED Navigator provides patients who frequently use the ED and are not linked to a primary care physician (PCP) linkage to outpatient care and primary care physicians. A care plan is completed and the ED Navigator will follow up with patients post-discharge from the ED to ensure that they are connected to a PCP and provided referrals to address any social determinants of health needs.

Home Blood Pressure Monitoring Program

With clinical support, patients are involved in a self-monitoring and management process to achieve control of their blood pressure and reaching blood pressure target goals mutually set by the PCP, the patient and the Health Coach.

Asthma Home Management Program

Community Health Workers conduct home visits with environmental assessments that identify triggers and mitigation opportunities, work with patients and the care team on the results of a

home-based assessment as well as required follow-ups for other referrals and provide asthma self-management education.

PCMH+ Initiative Chronic Disease Management Program

Through DSRIP, Interfaith received funding for two Health Coaches who develop care plans and self-management goals for patients living with cardiovascular disease, obesity and diabetes. The Health Coaches were expected to develop 300 care plans/self-management goals with patients per quarter from January through August 2019, 290 care plans/self-management goals between October and November and 200 care plans/self-management goals in December 2019. In 2020 the Health Coaches will develop 600 care plans per quarter for a total of 2400 care plans/self-management goals that year. Since the start of this program, patients have reported improvements in self-management of their conditions/diseases, increased compliance with their medical regimes. They also report improved relationships with not only the health coach but other members of the patient care team.

The Undetectables Program

HIV positive patients are provided with incentives to achieve viral suppression or to achieve and sustain being virally undetectable. The Undetectables Program is aligned with the NYS Governor's initiative to "End the Epidemic" by 2020. Currently there are 220 patients enrolled in IMC's Undetectable Program.

Collaborative Care Program (IMPACT)

Integrating behavioral health care with primary care is now widely considered an effective strategy for improving outcomes for individuals with behavioral health conditions. The Collaborative Care Program, also known as the Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model, enhances routine primary care by adding two key

services in addition to counseling services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving. IMC conducts behavioral screenings of primary care patients to identify patients who screen positive for depression, anxiety and other mental health conditions who may benefit from brief counseling and behavioral interventions such as Problem-Solving Treatment, Cognitive Behavioral Therapy and Behavioral Activation.

Kingsbrook Jewish Medical Center

Health Home (Creating an Integrated Delivery System)

Each OBHS hospital has paired with a care management agency that deploys on-site home health care coordinators to facilitate referrals. Kingsbrook partnered with CAMBA, a Brooklyn-based social services organization that provides social services to New Yorkers in need, to place Health Home care coordinators on Kingsbrook campus starting in 2016.

Care Transitions Intervention Model (Reduce 30-Day Re-admissions)

This model is focused on creating care plans for high risk-patients including collaborations with transitional care nurses for assessment of best practices. Care plans are established and entered on the PPS dashboard, which enables further collaboration with CAMBA on health home enrollment.

Emergency Department (ED) Navigation Services (Reduce Avoidable ED Visits)

An ED Navigator is embedded in the ED, targeting frequent users presenting with low severity needs. The ED Navigator follow-ups with patients and providers regarding appointments.

Integration of Behavioral Health and Primary (Population Health)

Funding received to strengthen mental health and substance abuse infrastructure across systems and to increase early access to and retention in HIV Care. A modified collaborative care model has been implemented, which integrates behavioral health into primary care settings. Integrated HIV/HCV screenings and care navigation have been instituted in Kingsbrook's Outpatient Specialty Centers and the Emergency Room.

Vital Brooklyn Community Assets

As part of OBHS' commitment to implementing community recommendations in the PAR reports, OBHS is collaborating with NYS Homes and Community Renewal (HCR) to advance the Vital Brooklyn initiative's $578 million commitment to build 4,000 units of affordable housing in Central Brooklyn. Specifically, OBHS is making parcels and/or buildings on its campuses available to be re-purposed for the development of this critical resource to address an important social determinant of health. For example:

A 40,000 square foot parking lot on the Brookdale Hospital Medical Center campus will be used to create 152 apartments affordable to a variety of income levels. The project will include the provision of on-site services for developmentally disabled individuals and individuals aging out of foster care, for whom some of the apartments will be built.

A building in which Interfaith Medical Center provides mental health service has been made available for the development of 57 apartments affordable to a variety of income levels of seniors and chronically homeless families. The housing developer will also re-build the hospital's program space.

A 21,000 square foot parking lot on Interfaith Medical Center's campus will be used to develop 119 units of housing for seniors, including a number of apartments for frail and elderly seniors who will receive on-site supportive services. This development will include the build-out of ambulatory care space on the first floor.

OBHS and NYS HCR also seek to develop eight high-quality, sustainable, and mixed-use permanently affordable housing developments that may include multi-family, senior, and/or supportive housing by repurposing land on the Kingsbrook Jewish Medical Center campus.

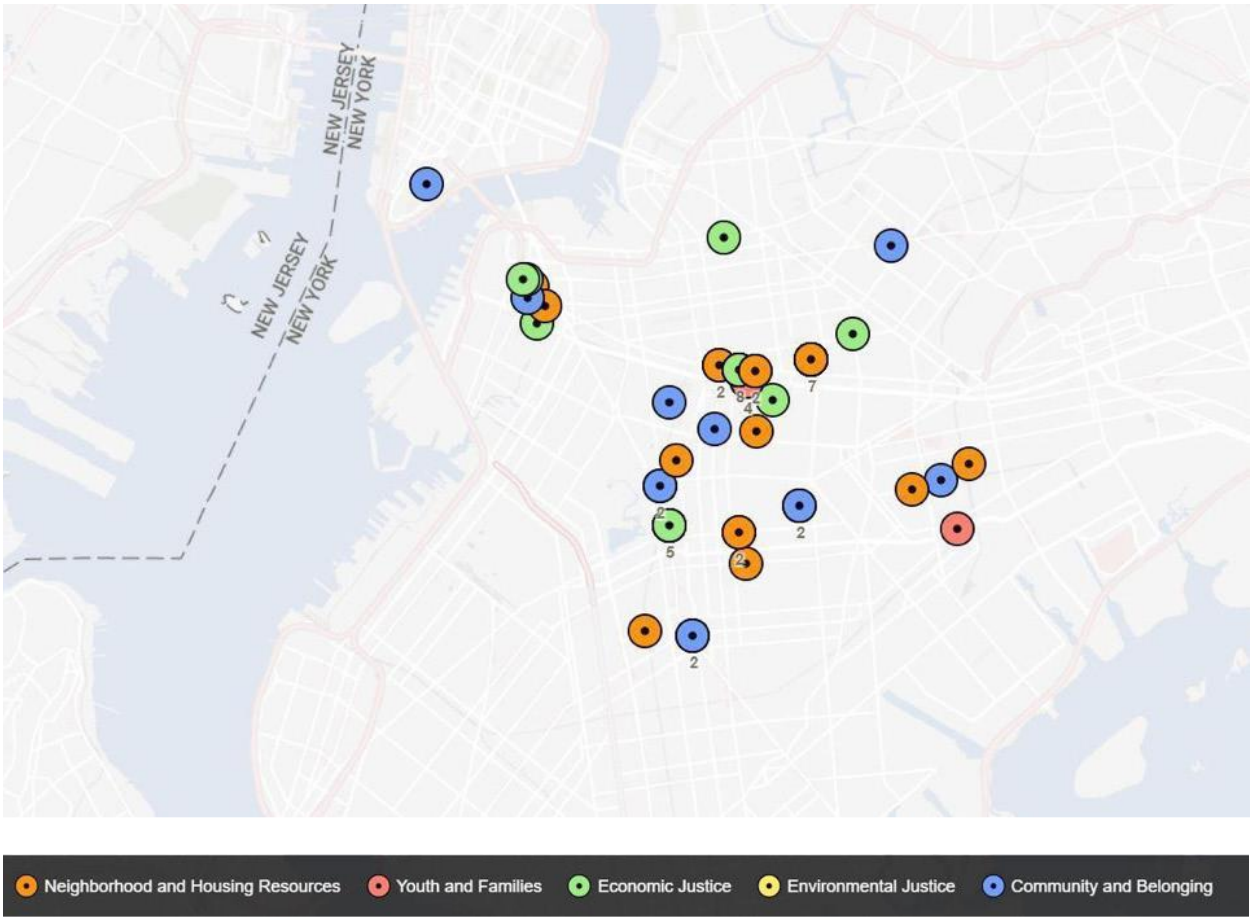
Maternal Health Community Assets

OBHS, SUNY Downstate and NYC Health and Hospitals agreed to jointly convene a Maternal Health Work Group comprised of clinical leadership from the hospitals, NYC DOHMH, community practitioners, community-based organizations, women's health advocates, midwives, doulas, FQHCs, etc., to develop recommendations for a comprehensive response to addressing the maternal mortality disparity in Brooklyn. The Work Group developed a proposal to redesign delivery of services in Central Brooklyn, which includes a single birthing center and expanded pre-post pregnancy services access. OBHS will continue to support the working group's goals of developing collaborations and policies that improve maternal health in Brooklyn.

A key component of PAR includes asset mapping as part of the research process, which has strengthened existing and created new relationships among the OBHS hospitals and community-based organizations providing social and other services to the most vulnerable residents of Brooklyn. The graduate research team, with support from the undergraduate team, conducted an asset mapping process informed by stakeholder interviews, and a series of focus groups to qualitatively examine questions of community health, mobilization and change. Asset mapping for community health is an innovative urban planning tool used both to identify and address the intersection of poverty, place and health status in low-income neighborhoods and to support urban development. Community assets can include human, physical, cultural, social, financial, and political elements within a neighborhood. Respondents identified numerous social, cultural, and human assets in Central Brooklyn, assets that are ready to be leveraged in the service of a healthier community. Stakeholders and residents strongly emphasized that culture is

the key to building a healthier future. The following figures and charts include the community assets and stakeholders identified during the PAR projects that OBHS will use to strengthen existing and to forge new partnerships.

PAR II Figure 5: Map of identified assets and actions, collected during the asset mapping process



PAR I Appendix Page 32: Stakeholders Interviewed

Stakeholder	Affiliation
Viola Greene-Walker	Community Board 16
Renee Muir	BMS
Karen Nelson	Maimonides Medical Center
Catherine Green	Arts East New York
Bruce Richard	SEIU1199
Michelle Neugebauer	CHLDC
Eric Smith	NYSNA
Denise West	Brooklyn Perinatal Network
Yvette Rouget	Brownsville Partnership
Quardean Lewis-Allen	Made in Brownsville
James Brodick	Brownsville Community Justice Center
Duane Kinnon	Friends of Brownsville Parks
David Vigil + Sadatu	East New York Farms
Ana Aguirre	United Community Centers
Reggie Bowman	Former NYCHA Citywide Council of Presidents
Layman Lee	Community Solutions/Brownsville Partnership
Anne Heller and Erasma Monticciolo	Power of Two
Salema Davis	The George Walker Junior Community Coalition
Crus Fuksman	NY Psychotherapy and Counseling Center
Jennifer Fields	Women's Prison Association
Grant Lindsay	East Brooklyn Congregations (EBC)
Kelebohile Nkhereanye	TWU and ENYFarms
Raphael Marte	Liberty Cafe

PAR II Appendix F Asset Map Organizational Chart

Organization	Neighborhood	Service Areas
Caribbean Women's Health	East Flatbush, Brownsville, Bed Stuy	Immigration, Health
Arthur Ashe Institute for Urban Health	Central Brooklyn	Health Education and Advocacy
Brooklyn Plaza Medical Center	Crown Heights, Bed Stuy, Fort Greene	Health Care
Brooklyn Movement Center	Central Brooklyn	Multi-Issue Organizing
Center for Health Equity	Crown Heights, East Flatbush, Brownsville, Bed Stuy	Health Equity
Bedford Stuyvesant Family Health Center	Bed Stuy	Health Care
Brooklyn Anti-Gentrification Network	Sunset Park, Fort Greene, Bed Stuy, Crown Heights, Bushwick, Flatbush (Central Brooklyn)	Gentrification, Immigration
Bedford Stuyvesant Restoration Corporation	Bed Stuy	Economic Self-Sufficiency
New York State Nurses Association	Brooklyn, Queens, Staten Island, New Jersey	Health Care
DuBois-Bunche Center at Medgar Evers College	N/A	Public Policy, Research
Kingsbrook Jewish Medical Center	East Flatbush	Health Care
Northeast Brooklyn Housing Corporation	Bedford Stuyvesant, Ocean Hill, Brownsville, East New York, Crown Heights (also, Bronx, Queens, Far Rockaway)	Housing, Food Justice, Youth Development
1199 SEIU United Healthcare Workers East	Brooklyn	Health Care
596 Acres	Manhattan, Brooklyn	Environmental Justice Community Organizing
Interfaith Medical Center	Bed Stuy, Crown Heights	Health Care

Assessment Methods and Sources

The findings and recommendations from the three Participatory Action Research reports for Central and Northeast Brooklyn conducted from the summers of 2016 through 2018 serve as the cornerstone of OBHS' community service plan and guided OBHS' selection of Prevention Agenda priorities, goals, and interventions. Participatory Action Research (PAR) is centered on the premise that local residents and stakeholders have the most insight on how to address community issues and assets. By training community members to become researchers, PAR aims to understand how the community perceives its own health, assesses priorities for health transformation in the researchers' own neighborhood, and expects real change with specific actions for wellness empowerment and positive health outcomes. OBHS used the PAR reports and recommendations to ensure the community's voice guided the selection of its next health planning cycle of goals, interventions, and metrics. The framework of PAR empowered community researchers to collaborate on designing their own core research question that guided their efforts for each PAR project:

PAR 1: In the summer of 2016, the Performing Provider System (PPS) known as Community Care of Brooklyn (CCB) supported a collaboration between the DuBois-Bunche Center for Public Policy at Medgar Evers College and the NextShift Collaborative, a team of consultants led by MIT Professor J. Phillip Thompson, to build a deeper understanding of the social determinants of cardiovascular health in Brownsville and East New York. They assembled a team of 28 young adults to engage in a Participatory Action Research (PAR) project to understand the community's priorities for health creation, guided by a core question: "How do we mobilize the Brownsville and East New York communities to address the social, physical and environmental inequalities that affect health?" Through a survey of 525 residents and interviews with 23 community stakeholders, the team explored the physical, mental, social, environmental

and financial dimensions of health and developed a number of recommendations to lay the foundation for collective action. The findings and recommendations were collected in a report that was shared in community forums, printed, and posted online.[7]

PAR 2: In the summer of 2017, NextShift, the Dubois-Bunche Center for Public Policy at Medgar Evers College, Interfaith, and Kingsbrook recruited, trained, and supervised a 48-person community-based PAR research team, which included local high school and college students, as well as urban planning graduate students from across the country. The PAR 2 project sought to understand and investigate community perceptions of health and well-being in Central Brooklyn (Bedford Stuyvesant, Brownsville, Bushwick, Canarsie, Crown Heights, Cypress Hills/Ocean Hill, East Flatbush, East New York, Prospect Heights, and Prospect Lefferts Gardens), while focusing on and identifying priority social determinants of health in three neighborhoods: Bedford Stuyvesant, Crown Heights, and East Flatbush. The research was guided by a core question "How can residents build power to pool existing assets and demand increased investment in a healthier, more supportive and more affordable Central Brooklyn now, and in the future?" Using a survey of 1,026 residents (collected over a two-and-a-half week period), four focus groups, and fifteen neighborhood stakeholder interviews, the team explored five health determinants and developed a set of recommendations and action steps to improve health in Central Brooklyn. The determinants of health include economic justice, youth and families, community and belonging, environmental justice, as well as housing and neighborhood services.[8]

PAR 3: In the summer of 2018, CCB, the MIT Community Innovators Lab, the DuBois-Bunche Center for Public Policy at Medgar Evers College, and Kingsborough Community

[7] Healthy Brooklyn: Community Centered Study – Proposed Health and Wellness Interventions in Brownsville and East New York, https://www.ccbrooklyn.org/media/file/FINAL_CCB_PAR_REPORT.PDF

[8] People-Focused Research: Creating Health in Brooklyn – Participatory Action Research in Bedford Stuyvesant , Crown Heights, and East Flatbush, https://www.ccbrooklyn.org/media/file/PAR%202%20Report%20and%20Appendix.pdf

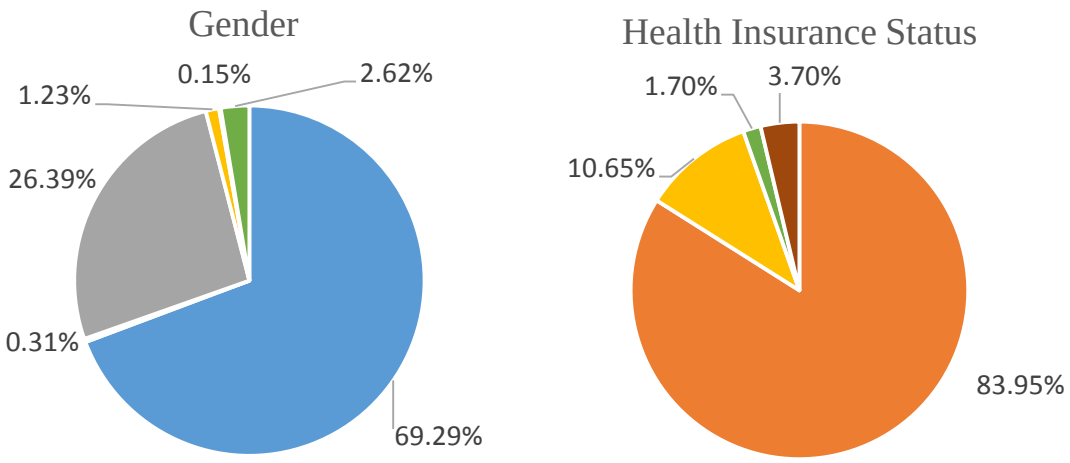
College convened a 42-person research team that included college students from Medgar Evers and Kingsborough Community College, as well as 26 high school students from the Academy for Conservation and the Environment, the Academy of Hospitality and Tourism, the High School for Innovation in Advertising and Media, the High School for Medical Professions, the High School for Youth and Community Development, Science, Technology, and Research (STAR) Early College High School, the Urban Action Academy High School, and Victory Collegiate High School. The team came together to engage local community members and key stakeholders in Canarsie, Flatlands and Flatbush (CFF) for community-wellness focused participatory action research (PAR). Titled "CFF PAR," the research was guided by the research team's collaboratively developed core question: "What policies/initiatives must be developed and in what ways can CFF residents collaborate to increase advocacy for resources to alleviate the harmful impacts on wellness?" Through a survey of 1,063 residents, 4 focus groups, and interviews with 17 community stakeholders, the PAR CFF team explored Education, Violence, Social Health, Physical Environment, Physical Health, Stress, Economic Health, and Social Exclusion--the 8 categories they identified as the key social determinants of health within the three neighborhoods.[9]

The recommendations in each PAR report were developed based on key findings from the survey, focus groups, and stakeholder interviews conducted over the corresponding summer. Follow-up cross-sector stakeholder briefing meetings on the findings with CCB, New York State Nurses Association (NYSNA), 1199 Service Employees International Union (1199 SEIU), the Center for Health Equity, local healthcare leaders (including OBHS hospitals where some of the community forums and briefings were held), also contributed.

[9] People-Focused Research: Participatory Action Research in Canarsie, Flatlands, and Flatbush, Summer 2018, https://www.ccbrooklyn.org/media/file/People%20Focused%20Research%20Participatory%20Action%20Research%20in%20Canarsie%20Flatlands%20and%20Flatbush.pdf

Because the first PAR took place more than three years ago and not all OBHS service area ZIP codes were covered in subsequent PARs, OBHS supplemented the research from the PAR projects by conducting a Neighborhood Health Needs Assessment survey in July and August of 2019. Greater New York Hospital Association (GNYHA) developed a model survey tool for its member hospitals to use in preparing their 2019 CHNA and CSP reports. In order to meet the needs of residents in the OBHS service area, the survey team requested the model survey be translated into Spanish and Haitian Creole. The survey team included summer intern college students from Ladders for Leaders (Elza Antoine and Erica Zhou) and Medgar Evers College (Abeera Khalid, Chenise O'Garro and Abibatou Sitou) as well as OBHS staff members. A target sample size was determined using the total population of the OBHS service area ZIP codes, based on 2017 estimates. Survey distribution was proportional to the service area level and the relative population size of each ZIP code. The summer intern team, based out of the IMC campus, used this sampling methodology to select survey locations based on ZIP code. Survey locations were chosen in high traffic areas and included sites such as local library branches, shopping areas and pedestrian malls, senior centers, community events or fairs (e.g. International African Arts Festival, BK Food and Wellness Festival, Council Member Cornegy's Annual Senior Swim) and religious institutions. In addition, surveys were administered by OBHS staff members on-site at clinical locations. Over the course of five weeks, surveys were administered in over twenty locations throughout Central Brooklyn. The survey team then transcribed the responses into a dataset, which was closed on August 13, 2019 with a total of 820 surveys. Data analysis was focused on the subset of surveys completed by residents from the OBHS service areas.

Figure 5 Neighborhood Health Needs Assessment Survey Demographics



Total: 648 Surveys within OBHS service area

Average Age: 51 years (of 620 numerical answers)

Gender: 69.29% Female; 26.39% Male; 0.15% Transgender Female;
0.31% Genderqueer; 3.85% Blank or "Prefer not to say"

Race and Ethnicity: 82% Black or African American
8.64% Hispanic/Latino Descent

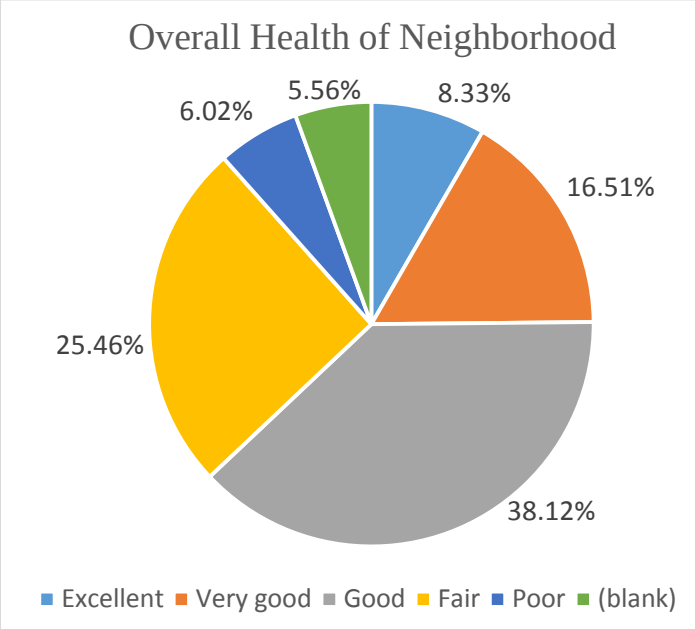
Health Insurance Status: 83.95% Insured; 10.65% Not Insured
1.70% Not sure; 3.70% [Blank]

Figure 6 Distribution of Neighborhood Health Needs Assessment Surveys Completed in OBHS Service Areas

				Number of Surveys Required				
	UHF Neighborhood	Zip Codes	ACS 5-Year Estimates by ZIP	Based on 95% confidence interval and 5% margin of error	Based on 95% confidence interval and 5% margin of error (oversampling by 50%)	As of 8/13/2019	Remaining for 384 Sample	Remaining for Oversampled
Primary and Secondary	Bedford Stuyvesant/Crown Heights	11212	82,831	25	38	86	-60	-47
	East New York/ New Lots	11207	92,580	28	42	45	-17	-3
	East New York/ New Lots	11208	99,145	30	45	46	-16	-1
	Bedford Stuyvesant/Crown Heights	11233	74,982	23	34	52	-29	-18
	Canarsie and Flatlands	11236	100,633	30	46	50	-20	-4
	East Flatbush	11203	75,989	23	34	57	-34	-23
	Bedford Stuyvesant/Crown Heights	11213	66,503	20	30	69	-49	-39
	Bedford Stuyvesant/Crown Heights	11216	57,410	17	26	39	-22	-13
	Bedford Stuyvesant/Crown Heights	11238	55,398	17	25	15	2	10
	East Flatbush	11225	59,497	18	27	46	-28	-19
	East Flatbush	11226	102,585	31	47	49	-18	-2
	Williamsburg/Bushwick	11221	84,536	26	38	23	3	15
Tertiary	Canarsie and Flatlands	11234	97,741	11	16	16	-5	0
	Canarsie and Flatlands	11239	12,713	1	2	9	-8	-7
	Downtown Brooklyn/Heights/Slope	11205	45,148	5	7	6	-1	1
	Downtown Brooklyn/Heights/Slope	11217	39,687	4	6	6	-2	0
	East Flatbush	11210	68,988	8	11	12	-4	-1
	Williamsburg/Bushwick	11206	87,767	10	14	15	-5	-1
	All other Brooklyn zip codes			57.6	86.4			
	Service Area Subtotal			326	490	641		
	Total		1,304,133	384	576			

In question 1 of the Neighborhood Health Needs Assessment, community members were asked "How would you rate the overall health of the residents in your neighborhood?" on a scale from Poor to Excellent:

Figure 7 Neighborhood Health Needs Assessment – Perception of Overall Health (Q1)



In questions 2, community members were asked to rate a list of 18 issues by how important they are to the health of residents in their neighborhood. The issues were rated on a Likert Scale based on importance (Not at all Important – Extremely Important), and then were ranked by importance for each OBHS member institutions service area, and for OBHS overall. The most important issues chosen by residents were similar across the OBHS service areas:

Figure 8 Neighborhood Health Needs Assessment – Most Important Issues Grid (Q2)[10]

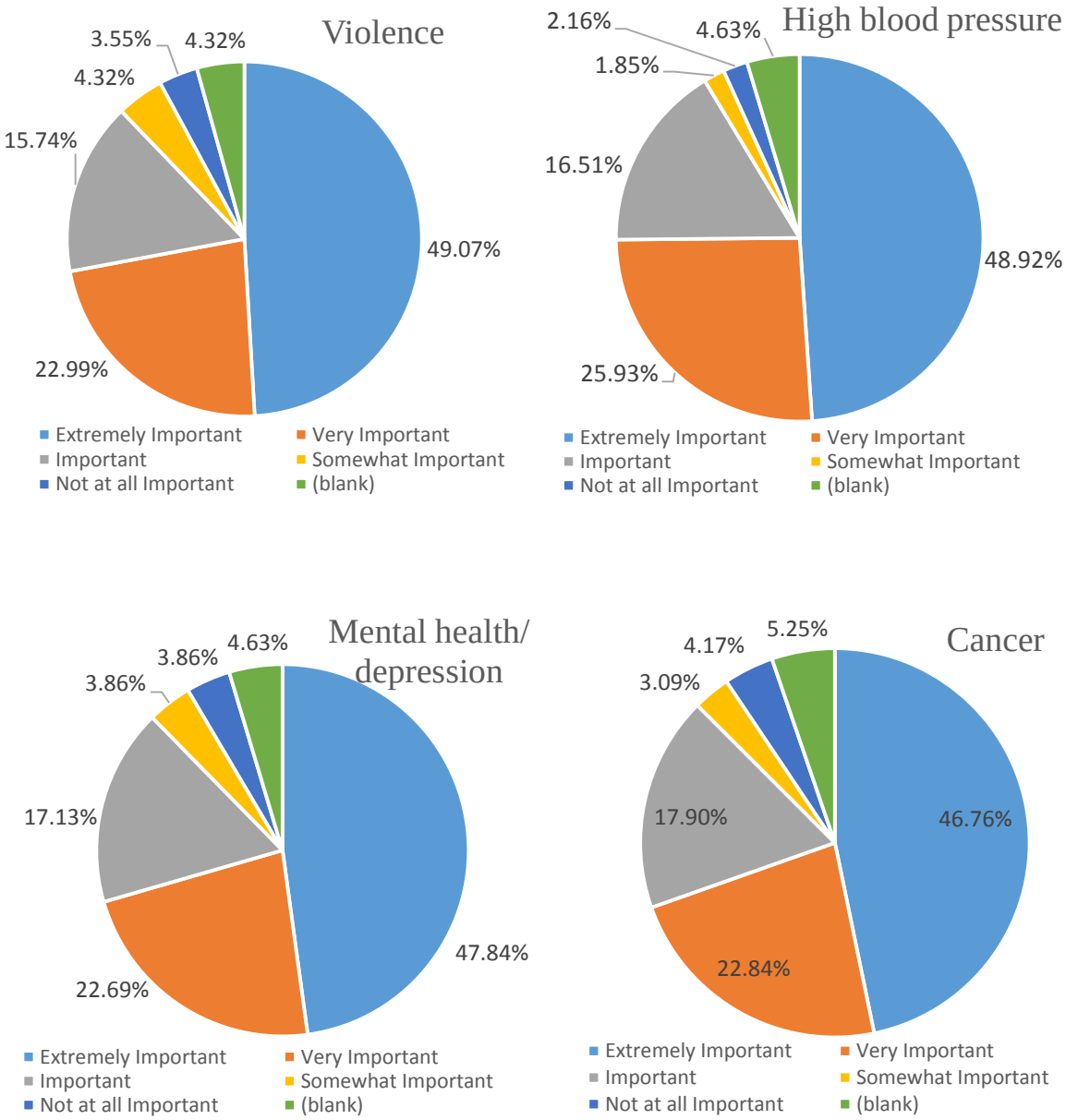
	Most Important Issues for Residents from OBHS Service Areas			
Rank	**Brookdale**	**Interfaith**	**Kingsbrook**	**OBHS**
1	Mental health / Depression	Violence	Violence	Violence
2	High Blood Pressure	High Blood Pressure	High Blood Pressure	High Blood Pressure
3	Violence	Mental health / Depression	Mental health / Depression	Mental health / Depression
4	Women's Health and Prenatal Care	Cancer	Cancer	Cancer
5	HIV/AIDS	Women's Health and Prenatal Care	HIV/AIDS	Women's Health and Prenatal Care

OBHS recognizes the value that these rankings from a small sample size of the community provide when considered in context with the thousands of PAR surveys conducted. Kingsbrook has selected a violence prevention intervention as part of its work plan for the Prevention Agenda. In addition, all OBHS hospitals have selected interventions that address directly or indirectly hypertension (high blood pressure) and depression. For example, Brookdale provides blood pressure gauges to patients who have been diagnosed with hypertension through a Blood Pressure Monitoring Loaner Program with nurses serving as "health coaches" to assist patients with establishing and monitoring self-management goals, provide educational

[10] Remaining health issues that were not ranked in top five: HIV/AIDS; Obesity in children and adults; Dental care; Sexually Transmitted Diseases (STDs); Fall prevention among elderly and children; Diabetes; Smoking/tobacco use/vaping; Substance use (including alcohol and drug use); Heart disease; Women's health and prenatal care; Arthritis; Hepatitis C; Access to healthy/nutritious foods; Other, please specify: _____

information to patients and refer patients to medication management and nutritional services for additional support; one of the DSRIP projects supporting the Prevention Agenda that Interfaith is participating in is the Home Blood Pressure Monitoring Program; and Kingsbrook: has achieved full CDC Diabetes Prevention Program Recognition and will continue best practices to help patients control blood pressure.

Figure 9 Neighborhood Health Needs Assessment – Most Important Issues Pie Charts (Q2)



C. Community Service Plan

Identification of Prevention Agenda Priorities

1. In 2016, Brookdale Hospital Medical Center (Brookdale), Interfaith Medical Center (Interfaith), and Kingsbrook Jewish Medical Center (Kingsbrook) applied for and received from the NYS Public Health and Planning Council approval to establish One Brooklyn Health System (OBHS), a tax-exempt NY not-for-profit corporation that will preserve and enhance health care services in Central and Northeast Brooklyn. In April 2018, OBHS became the active parent of the three system hospitals with various representatives from the previous hospital boards becoming members of the new OBHS board of trustees. Staff from across the three OBHS hospitals have come together on behalf of the OBHS Strategic Planning Committee of the board to review community health data from County Health Rankings, City Health Dashboard, NYC Neighborhood Health Atlas, Take Care New York, NYC Department of Health and Mental Hygiene (DOHMH) 2018 Community Health Profiles, hospital clinical diagnosis and treatment data for OBHS patients, "The Brooklyn Study: Reshaping the Future of Healthcare, and other data to identify new and confirm existing priorities, goals and interventions from the pool of recommendations provided by the community via surveys and PAR reports. In addition, the Strategic Planning Committee of the OBHS Board of Trustees, which oversaw the development of this Implementation Strategy and Community Service Plan, invited representatives from the local NYC Department of Health and Mental Hygiene to present on health disparities in communities served by OBHS in order to provide input representing the broad interests of the community. Written and in person comments from the community on the hospitals' most recently conducted community health needs assessment and most recently adopted Implementation Strategy and Community Service Plan also informed the identification of health priorities.

OBHS hospitals have collaborated to identify shared community health goals and have selected three shared Prevention Agenda priorities that all hospitals will address for the 2019-2021 community health planning period: **Prevent Chronic Disease**, **Promote Well-Being and Prevent Mental Health and Substance Use Disorders**, and **Promote Healthy Women, Infants and Children**. Two of the three OBHS hospitals will also address the priorities of **Promote a Healthy and Safe Environment** and **Prevent Communicable Diseases.**

The hospitals will address other priority areas as well to provide evidence-based interventions tailored to their community:

	One Brooklyn Health System			
Prevention Agenda Priority 2019-2021	**Brookdale**	**Interfaith**	**Kingsbrook**	**OBHS**
Prevent Chronic Diseases	✔	✔	✔	✔
Promote Well-Being and Prevent Mental and Substance Abuse Disorders	✔	✔	✔	✔
Promote a Healthy and Safe Environment		✔	✔	✔
Promote Healthy Women, Infants and Children	✔	✔	✔	✔
Prevent Communicable Diseases		✔	✔	✔

The OBHS hospitals will collaborate with each other and with community partners to address the disparity in their services areas of premature mortality of Black/African-American New Yorkers caused by disproportionately high rates of chronic diseases.

Central Brooklyn faces many health disparities and social issues that have a negative impact on community health and OBHS and its member hospitals have limited resources to contend with all the systemic problems facing healthcare. In accordance with federal (IRS) requirements to disclose which significant health needs will not be addressed officially through OBHS's Implementation Strategy, the following pages include examples of health issues and needs identified through the community health needs assessment that OBHS hospitals will not address directly through its community service plan and Prevention Agenda work:

Brookdale

HIV/AIDS

Brookdale continues to work with community partners and across Brookdale departments to diagnose and treat patients with HIV/AIDS. In 2018, Brookdale formed an alliance with the State University of New York - Downstate Medical Center (SUNY) to support HIV diagnosis and treatment efforts. The New York City Department of Health (NYCDOH) Community Health Profiles 2018 Atlas reports that Brownsville, part of Brookdale's primary service area, had 67.4/100,000 new HIV diagnoses in 2018, the second highest rate in New York City (NYC). The rate for the borough of Brooklyn was 22.1/100,000.

Diabetes – Brookdale's outpatient clinics provide care for patients that have been diagnosed with diabetes, supported by a cutting-edge electronic health records system that is equipped to prompt primary care doctors to refer patients to the critical continuum of specialty care typically recommended for diabetic patients (Ophthalmology, Podiatry, etc.). In November 2018, Brookdale launched the ***CDC Diabetes Prevention Recognition Program***, an evidence based one-year pilot model that is designed for people who have prediabetes or are at risk for developing Type 2 Diabetes. The focus is on weight loss through exercise, healthy eating and behavior modification. The best practices learned from this model will be incorporated throughout Brookdale's primary care network. In April 2019 launched a ***Diabetes Self-Management Program*** in partnership with the insurance provider HealthFirst. This free educational program for persons with diabetes is providing patients with education on nutrition, exercise, medication and preventable complications of diabetes. The program consists of 6 weekly classes led by peer trainers.

Crime – For the past few decades, Brookdale's primary service area has been the epicenter of gun violence in the borough of Brooklyn. Brookdale's Emergency Room treats a gunshot wound every 36 hours. Non-fatal hospitalizations for Brownsville, one of Brookdale's primary service area neighborhoods, was 175/100,000, the second highest in NYC. Since crime has been identified as one of the social determinants of health, it is imperative that Brookdale seek out the community collaborations that will address the factors that lead to crime. According to the NYC DOH Community Profile Atlas 2018, Brookdale's primary service area of Brownsville had a Jail Incarceration rate of 1,698/100,000, the second highest in NYC, and significantly higher than the 59/100,000 for the rest of the borough of Brooklyn. The linchpin of Brookdale's efforts is its gun-violence prevention program ***"It Starts Here,"*** launched in 2016. The ISH program works with key stakeholders such as local middle and high schools, the United Federation of Teachers, community-based youth organizations and local law enforcement to conduct a one-day anti-violence intensive experience for middle and high-school youth (ages 12-17), followed by school-based activities that are designed to reinforce positive behaviors in youth. Specifically, ISH is designed to teach youth about the health and criminal justice consequences of gun violence, and equip them with a variety of youth development skills, in an effort to reduce their likelihood of succumbing to involvement with gangs, gun-violence and other criminal activity. Youth are encouraged to become proactive by becoming ambassadors for non-violence in their schools and larger community

<u>Interfaith</u>

Violence – Interfaith is a member of the Anti-Bullying Partnership to Prevent Violence and Suicide coalition, comprised of City and nonprofit agencies, along with NYC Councilman Robert E. Cornegy, Jr., working in Bedford-Stuyvesant to increase parents' awareness of the role social media plays in teen violence. The partnership kicked off in the summer and fall of 2017

with the Safe Summer Initiative, a campaign in District 16 schools to achieve the following: 1) Increase the capacity of parents to recognize the signs of unhealthy internet usage among their children. 2) Identify community resources that are available in helping them to combat these issues. 3) Prevent the practice of young people using verbal and physical violence to solve social conflicts. Coalition Partners include Councilman Robert E. Cornegy Jr., Kings County District Attorney's Office and the Bureau of Youth Diversion and Initiatives, Brownstoners of Bedford Stuyvesant, Interfaith Medical Center, All For One, Restoration Plaza, New York City Police Department (79th and 81st Precincts and their clergy), Thrive NYC and First Lady Chirlane McCray's Office, New York City Commission on Human Rights and Samaritans NYC.

Kingsbrook

Food Access & Food Insecurity – Kingsbrook has initiated a partnership with The Campaign Against Hunger, a local community-based organization and "SuperPantry emporium" that offers nutrition education classes; workshops; cooking demonstrations; social services including NAP registration, health insurance enrollment, tax filing preparation and more. The partnership kicked off with a community outreach event with special remarks by Brooklyn Borough President Eric Adams. The event included needed services such as: organic food distribution, SNAP card enrollment and free tax services. This partnership is designed to eliminate barriers to social services and provide needed resources to underserved residents in the community.

Priority Goals and Objectives

2. Each OBHS hospital conducted its own community health needs assessment and published a community service plan for the previous Prevention Agenda period of 2016-2018. The following sections include hospital-specific summaries of 2016-2018 accomplishments and how they relate to the evidence-based interventions OBHS will implement together:

Brookdale:

Brookdale made steady progress towards achieving the NYC Prevention Agenda goals selected for the three-year period 2016-2018. The first priority Brookdale chose was Prevent Chronic Diseases, with focus area *Increase access to high quality chronic disease preventive care and management in both clinical and community settings* and it involved the following goals:

- GOAL 1: Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.
- GOAL 2: Promote evidence-based care to manage chronic diseases.
- GOAL 3: Promote culturally-relevant chronic disease management education.

For the priority of Promote Mental Health and Prevent Substance Abuse, Brookdale chose focus area *Strengthen infrastructure* and identified the following goals:

- GOAL 1: Support integration of MEB (Mental, Emotional and Behavioral) health within chronic disease prevention strategies.
- GOAL 2: Strengthen infrastructure for MEB health promotion and MEB disorder prevention.

All goals were implemented within the framework of the NYS DSRIP program, a comprehensive initiative that is focused on encouraging sustainable changes to the healthcare delivery model of hospitals, by focusing on disease screening, prevention and management for the major prevalent diseases, in partnership with local supportive service providers. Brookdale's Ambulatory Care Department is working with the DSRIP lead hospital, Maimonides Medical Center, and several DSRIP participants, to implement a variety of evidence-based prevention model initiatives across Brookdale (diabetes, obesity, heart-disease, high blood pressure, mental health, asthma, breast cancer). Brookdale's capacity to design and meet the overarching goals of

DSRIP and NYS DOH (triple aim: Better Care, Better Outcomes, Lower Costs), has increased during 2018 and the first half of 2019. To date, Brookdale successfully passed three DSRIP Audits as part of the annual contract deliverables, which are tied to payments. Several other programs, such as the Influenza/Pneumococcal Vaccine Initiative now being implemented in collaboration with NYC DOH, are part of a robust disease prevention strategy. Brookdale will continue to focus on both NYS Prevention Agenda priorities, to expand and sustain the gains accomplished to date.

For the 2019-2021 Prevention Agenda period, Brookdale's evidence-based interventions will include: **(**1) Participate in Delivery System Reform Incentive Payment (DSRIP) Performing Provider Systems (PPS) initiatives. Conduct clinical process assessments; Establish personal "Plan of Care" protocol for chronic disease patients; Incorporate patient follow-up care and compliance tracking; work with External Affairs Department to develop strategy around East Brooklyn community outreach and education. (2) Incorporate evidence-based care into Patient-Centered Medical Home (PCMH) model. Work with PPS partners, Department Chairs, clinic administrators to identify and assess feasibility of evidence-based models; work with community partners to determine infrastructure that is now in place and what is needed to support evidence-based disease management and promotion. Brookdale has chosen Focus Area 2: Prevent Mental and Substance Use Disorders**,** with the following intervention: the implementation of IMPACT Collaborative Care. IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) is an intervention for patients who have a diagnosis of major depression or dysthymia, often in conjunction with another major health problem. IMPACT will be implemented within the framework of Brookdale's PCMH and will screen all patients 12 years old and older with PHQ-2PHQ-9 for depression, AUDIT-C/AUDIT for alcohol use, and DAST-

1/DAST-10 for drug use. The full list of Brookdale's Prevention Agenda priorities, goals, objectives, evidence-based interventions, and process measures include:

NYS Prevention Agenda 2019-2021 – Brookdale Hospital Medical Center			
Priority: Prevent Chronic Diseases			
Goal	**Objective**	**Interventions**	**Family of Measures**
4.1 Increase cancer screening rates	Assess current screening and disease management practices at Brookdale clinics and points of service, to determine capacity to incorporate and/or expand screenings, disease management, and patient education for East Brooklyn; Assess EPIC (Brookdale's EMR) support needed to accomplish goal.	Participate in DSRIP PPS initiatives. Conduct clinical process assessments; Establish personal "Plan of Care" protocol for chronic disease patients; Incorporate patient follow-up care and compliance tracking; Work with External Affairs Dept. to develop strategy around East Brooklyn community outreach and education.	Assessment of clinics and service delivery points of service complete; strategic planning sessions for community outreach and education conducted; EPIC capacity enhancements needed to support increase in screenings and disease management identified.
4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	Assess current screening and disease management practices at Brookdale clinics and points of service, to determine capacity to incorporate and/or expand screenings, disease management, and patient education for East Brooklyn; Assess EPIC (Brookdale's EMR) support needed to accomplish goal.		
4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	Assess Brookdale's capacity to educate Brookdale clinicians on the importance of promoting chronic disease management in East Brooklyn; Review Brookdale's ability to accommodate all patient insurance options, to serve more patients.	Incorporate evidence-based care into PCMH model now being adopted by Brookdale. Work with PPS partners, Dept. Chairs, clinic administrators to identify and assess feasibility of evidence-based models; work with community partners to determine infrastructure that is now in place and what is needed to support evidence-based disease management and promotion.	Assessment of Brookdale's clinical and operational capacity to promote evidence-based care programs completed; strategic planning sessions for community outreach to promote disease management at Brookdale.

NYS Prevention Agenda 2019-2021 – Brookdale Hospital Medical Center			
Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders			
Goal	**Objective**	**Interventions**	**Family of Measures**
2.4 Reduce the prevalence of major depressive disorders	Integrate behavioral health into PCMH care delivery by implementing the IMPACT model of collaborative care.	The implementation of Collaborative Care/IMPACT, within the framework of Brookdale's PCMH, will encompass the following core activities: 1) Screening all patients 12 yrs old and older with PHQ-2PHQ-9 for depression, AUDIT-C/AUDIT for alcohol us, and DAST-1/DAST-10 for drug use; 2) If patients screen positive, refer to the appropriate on-site behavioral health experts and document in EHR. 3) Designate individual(s) as Behavioral Health Care Manager, to provide a range of services to patients with mild to moderate depression, anxiety, or to patients who screen positive for substance abuse. 4) Hire or	Implementation of IMPACT; staff hired; DSRIP measures; IMPACT patient outcomes, as recorded in EPIC

		designate a consulting psychiatrist 5) Appoint Practice Champion who will spearhead adopting IMPACT.	

NYS Prevention Agenda 2019-2021 – Brookdale Hospital Medical Center			
Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders			
Goal	**Objective**	**Interventions**	**Family of Measures**
1.1 Increase use of primary and preventive health care services by women, with a focus on women of reproductive age	Increase the number of women seeking prenatal care early in pregnancy. The early intervention will allow providers to fully assess the health of the mother and the pregnancy, and intervene early to improve outcome.	Increase patients' participation in the NYC DOH Centering Pregnancy model of prenatal care and delivery. The Centering Pregnancy is a National Recognized model of providing prenatal care in a group setting of up to 10 patients with similar gestational age. We plan to expand our Centering Program and also to introduce the program to other prenatal care providers in the area, including in area FQHCs. Centering Pregnancy has been shown to reduce stress and also prematurity in the participants. Increase participation and adherence to the prenatal care. Program empowers patients in their care. The program also increase compliance of the patients in attending their prenatal and postpartum visits. Participants of the program demonstrated increase rates in exclusive Breastfeeding.	Assessment of prenatal visits; Premature deliveries; Adherence to the postpartum visits; Breastfeeding rate
1.2 Reduce Maternal Mortality and Morbidity	In the United States. Approximately 700 women die annually from pregnancy associated complications. A major cause of maternal mortality and morbidity is maternal hemorrhage, secondary to abnormal placentation and prior uterine scar. The objective is prevention of Maternal death from maternal hemorrhage.	1. Decrease the cesarean section rate by decreasing the primary cesarean section rate and increasing the vaginal births after cesarean section rate. 2. Increase screening for abnormal placentation by increasing usage of an ultrasound scans with power doppler. 3. Annually review and update of a Brookdale's hemorrhage protocol. 4. Increase the frequencies of maternal hemorrhage drills to at least one every quarter. Include departments of Anesthesia, Blood Bank and Trauma services in addition to the OB/GYN to Labor and Delivery maternal hemorrhage drills. 4. Perform Mortality and Morbidity reviews of all maternal blood loss cases requiring blood transfusion of more than 4 units of PRBC. 5. Improve assessment of all patients prenatally, especially those in risk for hemorrhage. Alert Maternal Fetal Medicine and the Blood bank when the patient who is identified as at risk for the hemorrhage comes in to the hospital for Labor and Delivery. 6. Increase huddles, briefings and de-briefings for all patients at risk for hemorrhage or following a case of maternal hemorrhage.	Maternal mortality from hemorrhage related complications. Cesarean section rates and Primary Cesarean section rates. VBAC rate.

Interfaith

In its previous community health planning cycle from 2016-2018, Interfaith focused on the priority areas of Promote Mental Health and Prevent Substance Abuse as well as Prevent Chronic Disease. One of the evidence-based interventions selected was Mental Health First Aid Training, which successfully trained more than 157 community residents, including 67 frontline staff at Interfaith. Multiple one and two-day trainings were held monthly from the summer and fall of 2017 and continued through 2018 at Interfaith's main campus and included both community residents and a targeted focus on front line staff from security. Interfaith will continue to partner with the local NYC Department of Health and Mental Hygiene to co-host these trainings, however, for the current 2019-2024 Prevention Agenda cycle Interfaith will address mental health and substance abuse through other interventions.

For its other priority of Prevent Chronic Disease, Interfaith chose to implement Nutrition Standards as a recommended evidence-based intervention that focuses on increasing the number of institutions with nutrition standards for healthy food and beverage procurement. Interfaith has voluntarily adopted the NYC Healthy Hospital Food Initiative and now participates in the program that enables the hospital to receive recognition from the NYC public health department for meeting standards that improve the nutritional content of items offered in cafeterias, vending machines and patient meals. To continue this work and build on the systematic solutions theme, Interfaith will implement screening for food insecurity at its ambulatory care center, the Bishop Orris G. Walker. Jr. Health Care Center. The full list of Interfaith's Prevention Agenda 2019-2021 priorities, goals, objectives, evidence-based interventions, and process measures include:

NYS Prevention Agenda 2019-2021 – Interfaith Medical Center			
Priority: Prevent Chronic Diseases			
Goal	**Objective**	**Interventions**	**Family of Measures**
1.3 Increase food security	1.14 Increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000)	1.0.6 Screen for food insecurity, facilitate and actively support referral	Percentage of patients who screen positive for food insecurity Percentage of patients identified with food insecurity referred/linked to food supports partners
4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.3.3 Decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbA1c level indicated poor control (>9%) 4.3.7 Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups and, 4.3.8. Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups and, 4.3.10 Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	4.3.2 Promote evidence-based medical management in accordance with national guidelines.	Percentage of patients who demonstrate improvements in HbA1c level control Percentage of patients who experience decreases in asthma-related ED visits and hospitalizations and demonstrate improved ability to manage and prevent exacerbation of asthma.
4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.4.1 Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition	4.4.2 Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone.	Percentage of patients/community members who complete the Chronic Disease Self-Management Program and/or the Diabetes Self-Management Program

NYS Prevention Agenda 2019-2021 – Interfaith Medical Center			
Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders			
Goal	**Objective**	**Interventions**	**Family of Measures**
1.1 Strengthen opportunities to build well-being and resilience across the lifespan	1.1.1 Increase New York State's Opportunity Index Score by 5%	1.1.1 Support housing improvement, affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care	# of new affordable housing units # of individuals/families accessing new affordable housing units
2.2 Prevent opioid overdose deaths	2.2.2 Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 43.1 per 1,000 population.	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	Number of new clinicians licensed to prescribe Buprenorphine. Percentage of patients who enroll in the Buprenorphine program who reach the maintenance phase of the program.
2.4 Reduce the prevalence of major depressive disorders	2.4.1: Reduce the past year prevalence of major depressive episode among adults aged 18 or older by 5% to no more than 6.2%.	2.4.2 Strengthening resources for families and caregivers	Percentage of patients enrolled in the Collaborative Care Program (IMPACT) who report improvements in their mental and physical well-being

NYS Prevention Agenda 2019-2021 – Interfaith Medical Center			
Priority: Promote a Healthy and Safe Environment			
Goal	**Objective**	**Interventions**	**Family of Measures**
3.2: Promote healthy home and school environments	3.2.b. Increase the number of residences that are inspected for lead and other health hazards.	3.2.2 Promote the use of and increase referrals from healthcare providers, case management providers, community based agencies, and other to the Local Health Departments with Primary Prevention Programs (15 Programs cover 19 municipalities for home visits) and 19 Healthy Neighborhood Programs.	Enhance referral network to make referrals to both the childhood lead primary prevention program for home assessment and/or the healthy neighborhood program. Increase the percentage of home visits for individual's with poorly controlled asthma under the Health Neighborhoods Program. Percentage of patients all ages who report decreases in ED visits and Hospitalizations related to asthma.

NYS Prevention Agenda 2019-2021 – Interfaith Medical Center			
Priority: Promote Healthy Women, Infants and Children			
Goal	**Objective**	**Interventions**	**Family of Measures**
1.1: Increase use of primary and preventive health care services by women, with a focus on women of reproductive age	1.1.3: Increase the percentage of women ages 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy by 10% to 38.1%	1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.	Based on the Sexual and Reproductive Justice framework, will provide sexual and reproductive health care focusing on the following three measures: 1) Pregnancy Intention Screening - Percentage of women ages 13 - 45 at risk for unintended pregnancy that were screened for pregnancy intention within the last 12 months. 2) Most and Moderately Effective Methods - Percentage of women ages 13 - 45 years at risk of unintended pregnancy that are provided the most effective (i.e., female sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring or diaphragm) method of contraception. 3) Access to LARC: Percentage of women aged 13-45 years at risk of unintended pregnancy that are provided a long-acting reversible method of contraception (LARC), i.e., implants, intrauterine devices or systems (IUD/IUS).
1.2 Reduce Maternal Mortality and Morbidity	1.2.2: Decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate) by 34% to 3.1.	1.2.3: Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.	Based on the Sexual and Reproductive Justice framework, will provide sexual and reproductive health care focusing on the same measures as goal 1.1 and intervention 1.1.2
3.2: Increase supports for children and youth with special health care needs	3.2.2: Increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%..	3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.	Percentage of children identified with and/or at risk for social or emotional issues. Percentage of families who establish health and meaningful psychological relationships between a child and the primary caregiver through healthy interactions over time.

NYS Prevention Agenda 2019-2021 – Interfaith Medical Center			
Priority: Prevent Communicable Diseases			
Goal	**Objective**	**Interventions**	**Family of Measures**
2.2: Increase viral suppression	2.2.1 Increase the percentage of all persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 17% to 95%.	2.2.1 Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission.	Percentage of patient encounters that result in linkage to care, treatment and other supportive services for people living with HIV.
3.1: Reduce the annual rate of growth for STIs	3.1.1 Reduce the annual rate of growth for early syphilis by 50% to 10% 3.1.2 Reduce the annual rate of growth for gonorrhea by 50% to 4% 3.1.3 Reduce the annual rate of growth for chlamydia by 50% to 1%	3.1.2 Increase STI testing and treatment: Ensuring that all persons at risk for STIs have access to affordable, accessible, convenient, and culturally-responsive STI testing and treatment services	Percentage of patients testing positive for STIs who receive treatment, education and prevention services
4.1: Increase the number of persons treated for Hepatitis C Virus	4.1.1 Increase the number of Medicaid enrollees treated for HCV by 10% to 8,813.	4.1.1 Conduct educational campaign promoting testing and treatment for HCV.	Percentage of patients testing positive for HCV and received testing, treatment, follow-up care and patient education

Kingsbrook

The New York State Public Health and Health Planning Council approved a State Health Improvement Plan, The State Prevention Agenda, designed to serve as a guide to focus efforts to improve the health of all New York State residents over the course of five years. In conjunction with the NYS DOH's Prevention Agenda, the areas of Kingsbrook's focus are (1.) Prevent Chronic Disease, focus area: Chronic Disease Preventive Care and Management (goal 4:3: to

promote the use of evidence-based care to manage chronic disease), (2.) Prevention of Communicable Diseases, focus area: Human Immunodeficiency Virus (HIV) (goal 2.1: to decrease HIV morbidity (new HIV cases), (goal 2.2: Increase viral suppression) and focus area: Hepatitis C Virus (HCV) (goal 4.1: Increase the number of persons treated for HCV), (3). Promote Well-Being and Prevent Mental and Substance Abuse Disorders focus areas: 2:2: Prevent opioid and other substance misuse and deaths, (goal 2:4: Reduce the prevalence of major depressive disorders), (goal 2:5: Prevent suicides) and (4) Promote a Healthy and Safe Environment focus area: Injuries, Violence and Occupational Health (goal 1:2 Reduce violence by targeting prevention programs particularly to highest risk populations).

Having graduated to an Advanced Primary Care NYS certification-PCMH practice, Kingsbrook will support goal 4.3 by providing primary care and chronic disease treatment via a set of standards that describe clear and specific criteria; including organizing care around patients, working in teams and coordinating and tracking care over time, increasing screening rates for cardiovascular diseases, diabetes, breast, cervical and colorectal cancers, especially among populations experiencing health disparities. For example, the breast cancer screening standard will include tracking all women seen in the practice ages 40-69 to ensure they had a mammogram in the last 24-months. In addition, Kingsbrook achieved full CDC Diabetes Prevention Program Recognition and will continue best practices to help patients control blood pressure (<130/80 mm Hg) during measurement years. Kingsbrook will also support the priority *Prevention of Communicable Diseases, focus area 2 Human Immunodeficiency Virus (HIV), goal 2.2 Increase viral suppression* by increasing early access to and retention in HIV care.

The full list of Kingsbrook's Prevention Agenda priorities, goals, objectives, evidence-based interventions, and process measures include:

NYS Prevention Agenda 2019-2021 – Kingsbrook Jewish Medical Center			
Priority: Prevent Chronic Diseases			
Goal	**Objective**	**Interventions**	**Family of Measures**
4.3: Promote the use of evidenced base care to manage chronic disease	Increase efficiency, standardize procedures and streamline processes. Reduce cost and utilization and improve quality. Better manage patients with chronic conditions. Provider patient centered care in ambulatory settings which implement into workflow PCMH standards and measures.	**PATIENT CENTERED MEDICAL HOME (PCMH) MODULE**: Kingsbrook has graduated from the NCQA as a Level 3 PCMH standard to Advanced Primary Care (APC) NYS Certification, providing primary care and chronic disease treatment via a set of standards that describe clear and specific criteria; including organizing care around patients, working in teams and coordinating and tracking care over time.	Meaningful Use-Breast Cancer Screening: For women who had a mammogram in the last 24 months and all women seen in the practice 40-69 yrs old (20 plus charts reviewed manually for baseline values).
4.3: Promote the use of evidenced base care to manage chronic disease	Advancing diabetes care via the PCMH Chronic Care Model, with a focus on early recognition of the importance of patient – centered, self-management, patient empowerment, and team-based care.	**PATIENT CENTERED MEDICAL HOME (PCMH) MODULE**: This program for improving primary care, pertains to our chronic disease treatment via a set of standards that describe clear and specific criteria. The program is an expansion on Kingsbrook's original NCQA Diabetes Recognition Program and gives medical practices information about organizing care around patients, working in teams and coordinating and tracking care over time.	Measures: Diabetes Care: Blood pressure controlled (<130/80 mm Hg) Blood Pressure is <130/80 mmHg during the measurement year. Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or type 2) (100 plus charts reviewed manually for baseline values). HEIDIS Measures: Hemoglobin A1c (HbA1c) testing. HbA1c poor control (>9.0%). HbA1c control (<8.0%). HbA1c control (<7.0%) for a selected population. * Eye exam (retinal) performed. Medical attention for nephropathy. BP control (<140/90 mm Hg).
4.3: Promote the use of evidenced base care to manage chronic disease	Implement programs and services designed to improve the issues affecting cancer patients, while addressing a wide variety of cancer and/or treatment-related conditions and symptoms in a clinical setting.	THE KJMC CANCER REHAB PROGRAM Focused on improving the lives of survivors who suffer from the effects of cancer and its treatments. The program offers coordinated cancer rehabilitation care that is supported by a team of specially trained by cancer trained staff.	All measures address disease-related and treatment-related impairments; Decrease the number and/or severity of impairments and long-term problems; and, minimize survivors' distress and disability. Total number of patients for 2018 -47.
4.3: Promote the use of evidenced base care to manage chronic disease	Emphasize lifestyle interventions specifically for prevention of type 2 diabetes in persons who are high risk.	DIABETES PREVENTION PROGRAM: Consists of 1 year of sessions: 16 weekly sessions (participants must attend a minimum of 9); 2 months of bi-weekly sessions is best practice; 6 months of monthly sessions (participants must attend at least 4).	2018: 14 DPP Participants: 5% group weight loss from the 1st session to the 16th week, maintenance or improvement of 5% weight loss at 1 year. Requires 6 month data uploads to CMS through the Diabetes Prevention Recognition system.

4.3: Promote the use of evidenced base care to manage chronic disease	To gain CDC recognition which will allow us to recruit, enroll and retain Medicare and Medicaid beneficiaries from across the OBH system. This will make it easier for people to participate in affordable, high quality lifestyle change programs to reduce their risk of type 2 diabetes and improve overall health.	CDC NATIONAL DIABETES PREVENTION LOCAL DEPT OF HEALTH: Consists of 6 weekly sessions (1 ½ hour in length). Attendees must attend at least 4 sessions. Requires 2 trained leaders.	2018: 4 DSM participants: Self-management programs have been shown to lower A1C levels, prevent/reduce complications, improve quality of life and lower medical expenses by providing knowledge and building skills and abilities needed for effective self-care through informed decision making, problem solving, and collaboration with the health care team. Participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management programs.
4.3: Promote the use of evidenced base care to manage chronic disease	Implement advancements and specialty programs in Rehabilitation, Emergency Medicine and the Vascular Laboratory to help ensure the most comprehensive care, treatment and detection of stroke.	KJMC STROKE REHABILITATION PROGRAM: This program offers a holistic interdisciplinary team approach to treat impairments and activity limitations and restrictions of persons who have suffered from a stroke. (Included arthritis).	All measures address disease-related and treatment-related impairments; Decrease the number and/or severity of impairments and long-term problems; and, Minimize survivors' distress and disability
4.3: Promote the use of evidenced base care to manage chronic disease	To continually improve patient care management and maintain consistent compliance with Quality Measures embedded in the Pain Management framework.	GOLD STROKE RECOGNITION: Kingsbrook has received the American Heart Association/American Stroke Association's Get With The Guidelines®-Stroke Gold Quality Achievement Award with Target: StrokeSM Honor Roll	Measures: Recognizes the hospital's commitment and success ensuring that stroke patients receive the most appropriate treatment.
4.3: Promote the use of evidenced base care to manage chronic disease	Enhance stroke care in the community by using state-of-the-art technology, identifying patients who require urgent stroke interventions.	KJMC TELE-STROKE PROGRAM: specializes in the diagnosis and treatment of patients whose condition requires non-invasive, neuro-interventional care. (ABV).	Total interventions for 2018: Total Ischemic Stroke: 221. SDH: 10. ICH: 12, TIA: 47.
4.3: Promote the use of evidenced base care to manage chronic disease	Increase mammography volume by 5%. Increase CT outpatient volume by 5%.	RADIOLOGY SERVICES: Kingsbrook's Radiological Services include: X-Ray Digital Mammography Nuclear Medicine Ultra-Sound CAT (Computerized Axial Tomography) Scan MRI (Magnetic Resonance Imaging)	• CT volume 2018 =19,860 • Ultrasound volume 2018 =9,331 • Mammo volume 2018 = 2,450 10% volume increase in these services annually.

4.3: Promote the use of evidenced base care to manage chronic disease	To create a robust schedule for education and early detection throughout the year, that increases accessibility to a variety of chronic disease prevention and education options for those who are under or uninsured.	KINGSBROOK'S BEST HEALTH SCHOOL: In effort to increase access to high-quality chronic disease prevention care and management in the community setting, this unique health and wellness module offers education and screening efforts year-round to the community on and off the medical center campus. Comprised of a diverse curriculum offered by our medical staff, classes address chronic disease management which include a heavy focus on diabetes and its core morbidities. Our wide array of screenings include stroke, BMI/ obesity, asthma, spasticity, pain management and hypertension.	Measures included achieving 10% growth of this program consistently with a special focus on off-site "community setting" education. In 2018 we educated 3,163 community residents, out of which we screened about 1,784 persons predominately from our community setting promotional effort. In addition to this screening number, about 115 people received CPR training and certification.

NYS Prevention Agenda 2019-2021 – Kingsbrook Jewish Medical Center			
Priority: Promote Well-Being and Prevent Mental and Substance Use Disorders			
Goal	**Objective**	**Interventions**	**Family of Measures**
2:6 Reduce the mortality gap between those living with serious mental illness and the general population	Provide state-of-the-art, specialized care for numerous behavioral health issues. Our clinicians have a wide- range of expertise in psychiatric interventions including medication management, individual and group counseling, individually tailored treatment and discharge planning.	COMPREHENSIVE BEHAVIORAL HEALTH CENTER: The Comprehensive Behavioral Health Center is comprised of an Inpatient Geriatric Psychiatry Unit, an Adult Inpatient Unit and Outpatient services. The programs specialize in diagnostic treatment for patients 18 and older suffering from: depression, bipolar disorder, schizophrenia, dementia, anxiety and panic disorders.	MEASURES: Inpatient Geriatric and Adult Units: - Lower readmission rates - Decrease length of stay - Expansion of addiction services - Expansion of ECT service
2:6 Reduce the mortality gap between those living with serious mental illness and the general population	Collaborate with Federally Qualified Health Centers in the community in order to offer specialty care members of the community.	FEDERALLY QUALIFIED HEALTH CENTERS: Kingsbrook implements outreach efforts to neighboring health centers, facilitating behavioral mental health services.	Kingsbrook has secured participation from Brownsville Multi-service Health Center, Bright Point Health and Caribbean Women's Health. Other affiliations pending.
2:4 Reduce Prevalence of major depressive disorders	Depression screening for patients from the community to provide proper assessment and care.	MENTAL HEALTH SCREENINGS: In response to the growing mental health needs in the community, all patients are screened for	Patients are screened for depression in the primary care setting in effort to better aid recovery and treatment efforts to advance care. PHQ2 and PHQ9 screenings will be coordinated and monitored via a Depression Care

		suicide risk upon triage to the ED.	Manager, a vital role in the DSRIP/ PCMH module
2:5 Prevent Suicides	To help build a consistent effort around mental health awareness and education for the community and our medical staff. Special focus on identifying those in need of intervention and treatment.	LOCAL HEALTH DEPT: "THRIVE NYC" In partnership with multiple City agencies, ThriveNYC operates innovative initiatives that provide new and needed mental health services to historically underserved populations.	Enhancing connections to care Providing new services to vulnerable populations Strengthening crisis prevention and response Acting early Developing the mental health workforce of the future Activating workplaces
2:2 Prevent opioid and other substance misuse/ deaths	Bridge Back to Life Center, Inc. is fully accredited and New York State OASAS-Licensed, to operate chemical dependency treatment programs.	Bridge Back to Life Center, Inc. is Fully accredited and New York State OASAS-Licensed, to operate chemical dependency treatment programs.	Patients are screened by doctors and nurses at KJMC. Those in need referred to the program for assistance. (20) patients monthly have been referred to needed services.

NYS Prevention Agenda 2019-2021 – Kingsbrook Jewish Medical Center			
Priority: Promote a Healthy and Safe Environment			
Goal	**Objective**	**Interventions**	**Family of Measures**
1:2 Reduce violence by targeting prevention programs particularly to highest risk populations	Primary care patients with screen-detected social determinants were more likely to have depression, diabetes and hypertension. Fill critical gaps in the response and strengthen our accessibility to vulnerable populations.	Social Determinant & Domestic Violence Screening: HITS (Hurt, Insult, Threaten, Scream) module: Collects information re: conditions in a patient's environment that affect health and quality of life outcomes. Also screens women of childbearing age for intimate partner violence (IPV), such as domestic violence (DV), and provides or refers women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	Screenings started in July 2019, collecting 2,900 responses from patients screened for a variety of social determinants including domestic violence.

NYS Prevention Agenda 2019-2021 – Kingsbrook Jewish Medical Center			
Priority: Promote Healthy Women, Infants and Children			
Goal	**Objective**	**Interventions**	**Family of Measures**
1.1: Increase use of primary and preventive health care services by women, with a focus on women of reproductive age	Increase access to quality GYN and prenatal care.	Our modest GYN program includes an OB/GYN from our partner institution-Brookdale Hospital Medical Center and a midwife on Kingsbrook's main campus. The midwife takes on less complex cases and refers the	Health Screening & Diagnostic Evaluations: •Pap Smear, Ultrasound, Management and treatment of fibroids and cysts, treatment of genital warts and biopsies. • Gynecological Minimally Invasive Surgeries: Cryo therapy, Colposcopy, • Prenatal Care: Complete obstetric care, preconception pregnancy and high risk pregnancy.

		complex ones to the OB/GYN.	• STD Screening (Diagnostic & Treatment). • Family Planning, contraception counseling.
1.2 Reduce Maternal Mortality and Morbidity	1.2.2: Decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate) by 34% to 3.1.	1.2.3: Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.	Health Screening & Diagnostic Evaluations: •Pap Smear, Ultrasound, Management and treatment of fibroids and cysts, treatment of genital warts and biopsies. • Gynecological Minimally Invasive Surgeries: Cryo therapy, Colposcopy, • Prenatal Care: Complete obstetric care, preconception pregnancy and high risk pregnancy. • STD Screening (Diagnostic & Treatment). • Family Planning, contraception counseling.

NYS Prevention Agenda 2019-2021 – Kingsbrook Jewish Medical Center			
Priority: Prevent Communicable Diseases			
Goal	**Objective**	**Interventions**	**Family of Measures**
2:1 Decrease HIV morbidity (new HIV cases)	The program Quality objectives were developed to align with National HIV/AIDS Strategy to End HIV/ AIDS and the Epidemic by 2020. The key to decrease community HIV and prevent new transmission is by HIV viral load suppression. During the year 2017, -88% of the HIV positive patients were virally suppressed. 2016 – As per NYC Dept of Health 2016 HIV Care Continuum Dashboard indicated that the 85% of the HIV patients did achieve viral load suppression during that year.	DESIGNATED AIDS CENTER: Providing needed services to more than 600 patients each year, the Designated Aids Center (located at Kingsbrook's off-site family health center Pierre Toussaint) offers a broad array of services for people with HIV/AIDS and Hepatitis C.	HIV Screening Program: Jan 2018 - September 2018: 3326 HIV AG/AB, 4TH GEN tests performed. January 2019 - August 2019: 2727 HIV AG/AB, 4TH GEN tests performed 82 out of 2727 (3%) of tests were REACTIVE.HIV viral load % suppression among patients in care June 2018: 85.3% (233/273) June 2019: 87% (335/385)
4:1 Increase the number of persons treated for HCV	Supporting Kingsbrook's transition to 4th generation testing (on-site testing for both HIV and Hepatitis C with results within one hour).	CCB DETECTABLES PROGRAM: The Undetectables has since grown into one of the most visible HIV public health interventions. With support from the New York City Department of Health and Mental Hygiene (DOHMH) and Community Care of Brooklyn (CCB), 13 community-based health	January - August 2019 Data: 290 baseline viral loads recorded 253 viral load results were suppressed (≤200 copies/ml). 237 viral load results were "undetectable" (≤50 copies/ml).

		care organizations are now serving nearly 2,000 individuals through this program.	
2:2 Increase Viral Suppression	Increase linkage and retention efforts to ensure persons diagnosed with HIV are connected to health care to maximize virus suppression so they remain healthy and prevent further transmission -	**AMIDACARE LIVE YOUR LIFE UNDETECATBLE:** Provides patients who are enrolled with Amida Care with a financial incentive for each quarter (three-month period) of demonstrated viral load suppression (<200 copies/ml) along with their participation in supportive services like case management or other provider-recommended medication adherence support programs.	Undetectable members with qualifying viral loads (≤200 copies) are eligible to receive a $100 credit on their AmidaCare card every quarter.
2:1 Decrease HIV morbidity (new HIV cases)	Increase linkage and retention efforts to ensure persons diagnosed with HIV are connected to health care to maximize virus suppression so they remain healthy and prevent further transmission -	**VNSNY CHOICE SelectHealth 2019 HIV PCP Quarterly Quality Program**: The VNSNY CHOICE SelectHealth Program is only open to People Living with HIV/AIDS under the VNSNY CHOICE SelectHealth health plan.	2018 VNSNY SelectHealth: 15 Members 2019 VNSNY SelectHealth: 22 Members

Partner Engagement

3. OBHS and its member hospitals will partner with community and faith-based organizations (CBOs and FBOs), other healthcare service providers in the community, elected officials representing OBHS' service areas, the NYC DOHMH Brooklyn Neighborhood Health Action Center, local City Council initiatives, the NYS DOH, community advisory boards/councils, and other stakeholder processes already in place. These include the regular meetings held by the Brookdale Community Advisory Board, the Coalition to Transform Interfaith, and Kingsbrook's Community Leadership Council.

OBHS has a robust community outreach and engagement agenda across the hospital system to ensure accountability and partnership opportunities with these community health partners. For example, Brookdale's Community Advisory Board is charged with ensuring that the voice of the community is represented in Brookdale's decision making process. Staff work with departments across Brookdale to coordinate community meetings, health education fairs, disease prevention and wellness events, youth initiatives, and other activities designed to seek community input, disseminate health information about health issues and initiatives, and inform the community about treatment and care options. Similarly, the Coalition to Transform Interfaith convenes regularly to provide a community forum for updates on Interfaith's ongoing transformation and sponsor or publicize community health initiatives. At these monthly and regular meetings, Prevention Agenda progress and success will be reported on to enable further community collaboration and also identifying mid-course corrections or enhancements to OBHS' community health work.

OBHS will continue to work with its partners in the Community Action and Advocacy Work Group, which is convened by CCB and oversees the ongoing updates on PAR-related activities that implement PAR recommendations and also support the same goals as OBHS' Prevention Agenda evidence-based interventions, for example Interfaith working with CCB and a local community-based organization to create new hydroponic farms that may provide food supports to families identified with food insecurity.

OBHS member hospitals' partners that can provide additional support for the evidence-based interventions selected include:

- CCB - Asthma home-based self-management, The Undetectables
- NYS Quit-line Smokers, blood-pressure monitoring
- CDC National Diabetes Prevention Program

- NYC DOHMH - Maternal Care Connection Chronic Disease Program
- NYC DOHMH - Health Action Center; Healthfirst Insurance - Diabetes, other care management
- CAMBA Health Home - supportive services
- Brownsville Recreation Center – supportive services
- AmidaCare – The Live Your Undetectable Program, only open to People Living with HIV/AIDS under the AmidaCare health plan. The program provides patients who are enrolled with AmidaCare with a financial incentive of $100 for each quarter (three-month period) of demonstrated viral load suppression (<200 copies/ml) along with their participation in supportive services like case management or other provider-recommended medication adherence supports.
- VNSNY CHOICE SelectHealth – this program is only open to people living with HIV/AIDS under the VNSNY CHOICE SelectHealth health plan. VNSNY CHOICE recognizes and rewards HIV Primary Care Providers and Members who have achieved sustained viral load suppression.

Dissemination Plan and Community Engagement

4. The executive summary and full community service plan (CSP) will be available on OBHS's website and its member hospital websites at https://obhs.org/, http://www.brookdalehospital.org/, http://www.interfaithmedical.com/ and https://www.kingsbrook.org/; visitors to the websites will be able to access, download, and print a hard copy of the CSP for free. A paper copy will be available to the public without charge by contacting the Strategic Planning office at OBHS/Interfaith, External Affairs at Brookdale, or Public Affairs at Kingsbrook. OBHS' member hospitals will distribute the CSP to the community via their respective community representative groups including but not limited to: Brookdale's Community Advisory Board, the

Coalition to Transform Interfaith and Kingsbrook's Community Leadership Council as well as the Community Action and Advocacy Workgroup convened by Community Care of Brooklyn.

In addition, the CSP will be disseminated to the relevant Community Planning Boards. To ensure that internal stakeholders are also aware of the commitments made in the CSP, OBHS leadership will share the 2019-2021 priorities at senior staff and medical staff forums and Town Hall meetings.