
# NewYork-Presbyterian
# Brooklyn Methodist Hospital

**506 6th St, Brooklyn, NY 11215**

# Community Service Plan (CSP)
# Implementation Plan 2019-2021

October 2019

## Community Service Area:

49 New York City Neighborhood Tabulation Areas (NTAs) mostly in Kings County.

## Local Health Department(s) (LHDs):

New York City Department of Health and Mental Hygiene
4209 28th St, Long Island City, NY 11101
Ana Gallego, Executive Director of Health Systems Planning and Policy
Email: agallego1@health.nyc.gov

## Participating Hospital/Hospital System(s):

NewYork-Presbyterian Brooklyn Methodist Hospital
Lisa Mainieri
VP Support Services
718-780-3301
Email: lim9003@nyp.org
https://www.nyp.org/brooklyn/about-us

# Contents

# Executive Summary

## Introduction to Our Community Service Plan (CSP)

The NewYork-Presbyterian Brooklyn Methodist Hospital (NYP-BMH) completed a Community Health Needs Assessment (CHNA) to identify the needs of our community and develop a Community Service Plan (CSP) and detailed implementation plan. Our commitment is to provide quality and compassionate care to our community and the CHNA process provides the ability to focus community-based efforts to address needs. The leaders of NYP-BMH are dedicated to our community with a mission is to provide excellent healthcare services in a compassionate and humane manner to the people who live and work in Brooklyn and its surrounding areas. This document outlines the process, priorities, partners, and intended community-based improvement activities for 2019 – 2021. Our priorities were determined from a data driven process and align with the 2019-2024 New York State Prevention Agenda (NYS PA) and align with the state's goal to promote health equity with a focus on physical health, mental health, and social determinants of health. Full reports related to the CHNA process can be found on our website at https://www.nyp.org/about-us/community-affairs/community-service-plans.

## Partner Involvement & Commitment

NYP-BMH collaborated with NewYork-Presbyterian leadership, the New York City Department of Health and Mental Hygiene (DOHMH), Citizens' Committee for Children (CCC), Columbia University Irving Medical Center (CUIMC), Weill Cornell Medical College (WCMC), Greater New York Hospital Association (GNYHA), local Community Based Organizations (CBOs), and the New York Academy of Medicine (NYAM) to adopt a community focused process of collecting and analyzing measurable data

(quantitative) and views voiced by the community (qualitative) from a variety of sources. The collaborative process ensured significant input from the key stakeholders and local community through questionnaires and focus groups conducted in several languages. This allowed NYP-BMH to develop a focused implementation plan to meet the needs of a targeted community with high disparities.

### *Data Driven Priorities*

NYP-BMH compiled measurable data and input from the community from numerous sources in order to analyze the health and challenges of our community. The analysis utilized focused neighborhood geography for metrics and included data related to demographics, socioeconomic status, insurance status, social determinants of health, health status, health service utilization, and priority areas from the NY State Prevention Agenda. Community input sources included focus groups and community questionnaires which allowed for a diverse representation of race, language, age, gender identity, and sexual orientation.

Data sources include the Citizens' Committee for Children Keeping Track Online; Open Data City of New York; Data2Go.NYC; NYC Health Atlas; NYC Mayor Report, the Association for Neighborhood & Housing Development; Behavioral Risk Factor Surveillance System (BRFSS), Claritas; NYC Community Health Profile, State Cancer Profiles, and U.S. Department of Agriculture. The collected data was ranked to provide detailed insight into the communities with high disparities and was then prioritized to determine the highest health priorities for the identified communities. The prioritized data provided insight into community health needs and challenges and allowed NYP-BMH to establish focus areas and goals to align with the NY State Prevention Agenda.

## *Progress Improvement Tracking*

Our team is committed to the successful implementation of each initiative and will utilize quality process improvement efforts annually to report on process and outcome measures in order to adapt each program to meet the annual expectations outlined as well as meet the needs of our community.

## *Community of Focus*

The NYP-BMH communities of high disparities are diverse neighborhoods with high rates of Medicaid enrollment, people living in poverty, low high school graduation rates, and high unemployment rates. The Crown Heights neighborhood (North and South) has high rates of adult obesity at 26% and 32% respectively, high crude rates of maternal morbidity per 10,000 deliveries at 372.5 and 234.6 respectively, and self-reported "poor mental health" at 10.5% for Kings County as a whole.

## *Priority Areas of Focus*

To align with the constantly changing dynamics of the community, NYP-BMH has revised the initiatives as compared to the 2013 – 2016 CSP and will target efforts in the Crown Heights neighborhood of Brooklyn with priority areas related to the prevention of (1) chronic disease, (2) promotion of healthy women, infants, and children, (3) prevent communicable diseases, and (4) promotion of well-being to prevent mental health and substance abuse

| Priority Area & Focus | Intervention / Strategy |
|---|---|
| **Prevent Chronic Disease** | |
| Goal 1.1 Increase Access to Healthy and Affordable Foods and Beverages<br>Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity | • Implementation of CHALK (Choosing Healthy & Active Lifestyles for Kids) to address food insecurities and obesity.<br>• Transitions of Care Model to address high-risk patients and provide care |
| **Promote Healthy Women, Infants, & Children** | |
| Goal 1.1 Increase use of primary and preventative health care services by women of all ages with a focus on women of reproductive age | • Develop a postpartum home visit program to partner with parents in order to improve health outcomes for parents and baby. |
| **Promote Well-Being & Prevent Mental & Substance Use Disorders** | |
| Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan | • Implement the Mental Health First Aid program for our providers and community-based partners. |
| **Prevent Communicable Diseases** | |
| Goal 2.2 - Increase Viral Suppression<br>Goal 4.1 - Increase the number of persons treated for Hepatitis C Virus (HCV)<br>Goal 4.2 Reduce the number of new HCV cases among people who inject drugs | • The ETE Initiative would create a HIV and HCV elimination strategy that would a) increase HIV and HCV testing and linkage to care, b) re-engage HIV+ and HCV+ individuals to care, and c) expand effective HIV and HCV prevention services, like PrEP and Medication Assisted Treatment.<br>• Utilizing existing multi-campus dashboards the NYP initiative would link, in real-time, all new HIV and HCV diagnoses, those (thousands) individuals out of care, and those in need of preventive services . Expanded deployment of a Health Priority Specialist in existing sites, like NYP EDs, would be the effector arm for the intervention. In addition to a major investment in a Mobile Medical Unit (MMU). |

## *Introduction*

NewYork-Presbyterian Brooklyn Methodist Hospital (NYP-BMH), located in Park Slope, is a voluntary, acute-care teaching hospital serving the people who live and work in Brooklyn and its surrounding areas. The mission of NYP-BMH is to provide excellent healthcare services in a compassionate and humane manner to the people who live and work in Brooklyn and its surrounding areas. This 651-bed teaching hospital has nine graduate medical education residency programs and six fellowship programs. NYP-BMH has one of only three cardiac surgery programs in Brooklyn and provides numerous services across other specialties.

The Hospital is a regional hospital of NewYork-Presbyterian and is affiliated with Weill Cornell Medicine. NewYork-Presbyterian (NYP) is one of the nation's most comprehensive, integrated academic health care delivery systems, dedicated to providing the highest quality, most compassionate care and service to patients in the New York metropolitan area, nationally, and globally. In collaboration with two renowned medical school partners, Weill Cornell Medicine and Columbia University Irving Medical Center, NewYork-Presbyterian is consistently recognized as a leader in medical education, ground-breaking research, and clinical innovation.

## *Purpose*

NYP-BMH is deeply committed to the community members residing in Brooklyn and the surrounding areas of New York City by delivering a range of innovative programs and services intended to educate and provide resources to prevent illness, maintain health, and improve the overall well-being of the community. The community health needs assessment (CHNA) process is undertaken every three years to determine the communities and health disparities that can be most positively impacted by focused interventions and initiatives supported by the health system. The CHNA aligns with the New York State 2019-2024 Prevention Agenda priorities to improve health equity for all New Yorkers through partnerships with community organizations to address social determinants of health (SDoH) and interventions to reduce disparities in health indicators. Through the NYS PA alignment with the health system CHNA process the state has improved its overall national ranking from 28$^{th}$ to 10$^{th}$ healthiest state since 2008.

NYP-BMH has completed this CHNA in order to update its understanding of the needs of local community members and the conditions that influence their well-being, and to assemble a three-year plan to enhance community health in areas identified as high disparity neighborhoods. The CHNA and service plan data collection and action planning process utilized by NYP-BMH was designed to achieve the following goals to ensure a comprehensive analysis of the community need:


## *Definition of Health*

The definition of health historically referenced only physical health, but the definition for this CHNA is rooted in the knowledge that it is increasingly important to understand the broader components of health and wellbeing and how it can be impacted and improved. For the purpose of this document:

> *Health is a holistic combination of physical health (absence of sickness or pain), mental health, and wellness for which there is an individual and a community wide responsibility.*

## *Process & Governance*

NYP-BMH engaged in a collaborative effort with NYP to create a collaborative, community focused approach to the development of the CHNA. A robust governance structure with representation from NYP's hospitals, including NYP-BMH, community members, and community health experts was created and included the following committees:

- *Data Committee* – managed the data collection and analysis process to ensure data integrity and inclusion of social determinant of health indicators and quality health indicators
- *Methods Committee* – created the processes to engage community members in the CHNA process through community health needs questionnaires and in-person focus groups
- *Steering Committee* – leadership engaged in oversight of the CHNA development and strategic decision making for the CHNA and CSP

In addition to the formal committee structure, NYP also convened Community Health Think Tank meetings across its seven campuses and regional hospitals to engage key clinical and operational leaders in the process of initiative planning and operationalization. The Community Health Think Tanks are intended to continuously engage key stakeholders in the performance feedback and improvement process and support evaluation impact monitoring and reporting for the CSPs.

## *Partner Engagement*

In conducting the 2019 CHNA, NYP and its regional hospitals, inclusive of NYP-BMH, collaborated with the New York City Department of Health and Mental Hygiene, Citizens' Committee for Children of New York, Columbia University Irving Medical Center, Weill Cornell Medical College, New York Academy of Medicine, and Greater New York Hospital Association. Through these collaborations NYP was able to adopt a community-engagement approach that involved collecting and analyzing qualitative information and quantitative data from a variety of publicly available sources to comprehensively assess the health status of our communities. Each stakeholder added to the ongoing work by providing insight on the publicly available data for the various regions specific to the NYP-BMH high disparity communities, while providing guidance on collecting stakeholder and community feedback and incorporating best practices for the CHNA.

NYP-BMH validated and refined the quantitative data results through the use of (1) primary data and community input from facilitation of focus groups and administration of community health need questionnaires (CHNQ) to area residents as well as (2) leveraging other community assessments such as community roundtable discussions hosted by the Cornell Center for Health Equity (CCHEq) in partnership with the Weill Cornell Meyer Cancer Center; and the CCC's '*From Strengths to Solutions: An Asset-Based Approach to Meeting Community Needs in Brownsville'*.

NYP-BMH engaged NYAM to facilitate focus groups of community members to obtain their perspectives on the health and needs of the community at large. NYP-BMH partnered with several community-based organizations to host these six focus groups:

- NYP-BMH Community Advisory Board
- CAMBA
- Downtown Brooklyn Neighborhood Alliance
- Caribbean Women's Health Association
- Brooklyn Pride Center
- Shorefront Y

Specifically, for our four priority areas we have currently identified partners listed in the Community Health Improvement/Community Service Plan section, but will continue to evaluate need, opportunity and seek and/or potentially train new partners willing to innovatively collaborate upon community improvement interventions and activities towards the goals of the NYS Prevention Agenda.

## *Data Mining & Analytics*

NYP-BMH engaged in a dynamic data collection and analytic process to ensure that the community and its needs were well represented throughout the CHNA development process. NYP-BMH utilized both quantitative and qualitative data to create a picture of the health needs of the Brooklyn community. The quantitative data focused to measurable indicators at the Neighborhood Tabulation Area (NTA) for the community, while the qualitative data focused to the primary perspectives and input from the community members obtained through questionnaires and focus groups. Additionally, NYP-BMH utilized numerous additional data sources to provide a robust picture of the community including a roundtable discussion and cancer survey in partnership with Cornell Center for Health Equity (CCHEq) and HICCC respectively, and in-depth analysis from CCC of the Brownsville neighborhood.

## *Quantitative Data*

NYP-BMH utilized data sets from multiple sources to analyze community health need and risk of high disparity geography to the specific neighborhood level. The analysis utilized 29 indicators across five domains: demographics, income, insurance, access to care, and New York State Department of Health Prevention Agenda Priorities at the Neighborhood Tabulation Area (NTA) geography. Indicators were among categories of demographics, socioeconomic status, insurance status, social determinants of health, health status, and health service utilization were collected to assess community health needs and to identify disparities. These indicators were utilized in prioritizing the implementation strategies and to support health intervention planning (See data sources in Appendix A).

## *Qualitative Data*

Quantitative data was gathered, validated, and refined using (1) community input from facilitation of focus groups and administration of community health need questionnaires (CHNQs) to area residents as well as (2) leveraging other community assessments performed in the community. The community input from multiple sources allowed for a comprehensive representation of our community inclusive of multiple languages, socio-economic statuses, culture, race, age, and gender identity. Summaries of each qualitative input source is included below, and additional details can be found in the Community Health Needs Assessment at https://www.nyp.org/about-us/community-affairs/community-service-plans.

### *New York Academy of Medicine (NYAM) Focus Groups & Questionnaires*

NYP-BMH partnered with NYAM to conduct CHNQs and community member focus groups. The CHNQs were conducted at community events, with focus group participants and online, and were administered in several languages. The CHNQs were also distributed across the community of focus to ensure that respondents from all demographics were represented in the response rate. NYAM completed six focus groups and received 234 responses to the CHNQs with 59.8% being completed at in person events, 27.8% being completed online, and 12.4% completed by the NYP-BMH Community Advisory Board.

### *NYP-BMH Community Health Survey*

In addition to the efforts conducted by NYAM, NYP-BMH sponsored a Community Health Survey which appeared in an edition of their community health magazine, *Thrive*, which was mailed to 250,000 households in Brooklyn.

### *Brooklyn Cancer Roundtable*

The Cornell Center for Health Equity (CCHEq), in partnership with the Weill Cornell Meyer Cancer Center and NYP-BMH, hosted a series of community roundtable discussions during the Spring of 2019. The rationale for these

meetings was based upon the fact that cancers that are diagnosed early at a local stage of the disease are more amenable to successful treatment.

***Citizens' Committee for Children of New York***

In March of 2017, the Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data to identify assets or resources in Brownsville and Brooklyn. The resulting publication named '*From Strengths to Solutions: An Asset-Based Approach to Meeting Community Needs in Brownsville – A Citizens' Committee for Children of New York Report*' detailed the neighborhood of Brownsville, its biggest issues, numerous assets and specific recommendations for health – improving access to healthy affordable foods and promoting awareness and use of existing medical and mental health services.

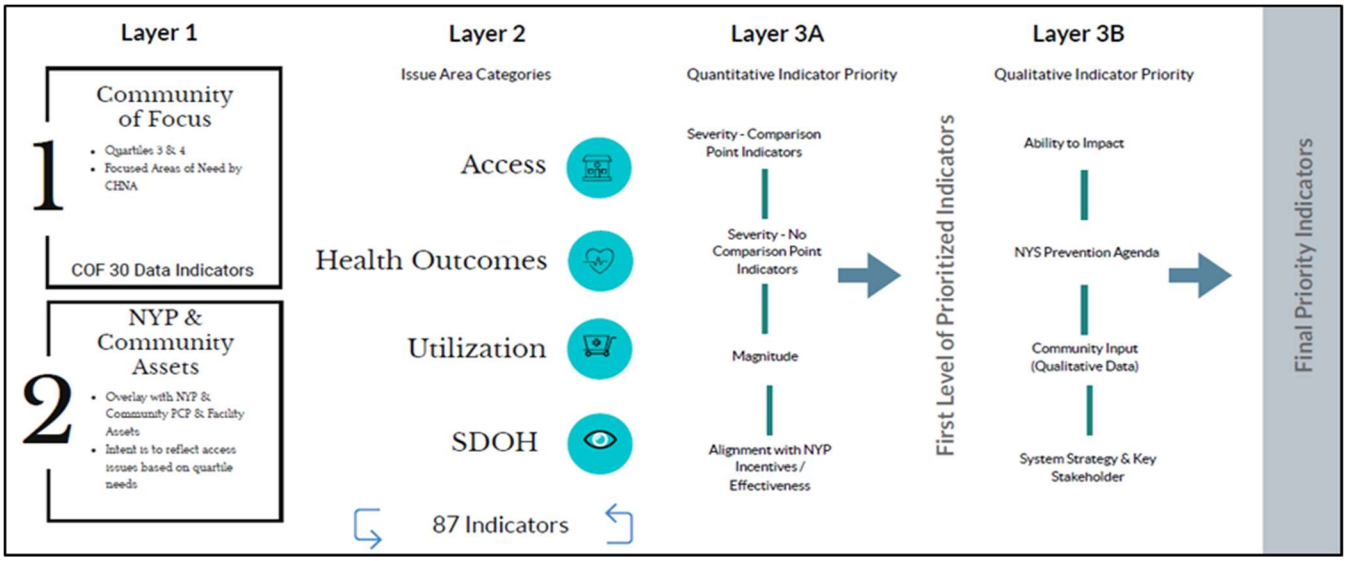
The qualitative community input summarized in the Community Health Assessment section was imperative to the strategic alignment and was utilized to prioritize the needs of the high disparity communities.

## *Disparity Prioritization Process*

A prioritization process was created to analyze the quantitative and qualitative data inputs collected through the CHNA process. The process had several layers in which the data was input and prioritized to arrive at the final priority indicators.

- *Layer 1* – the data from the community of focus for the 3rd and 4th quartiles (high risk areas) was utilized for the prioritization process
- *Layer 2* – The data indicators was categorized into four categories (1) Access, (2) Health Outcomes, (3) Utilization, and (4) Social Determinants of Health
- *Layer 3A* – the quantitative data was ranked based on three criteria (1) severity – with a comparison to NYC or without a comparison, (2) magnitude of the population impacted, and (3) alignment with current NYP-BMH initiatives

- *Layer 3B* – the 3rd and 4th quartile (highest risk) data from layer 3A was utilized for layer 3B of the model; the qualitative data for this section was ranked based on four indicators of (1) ability to impact the indicator, (2) alignment with the NYS PA, (3) Community Input, and (4) NYP system stakeholder input




## *Prioritized Findings*

Based on the prioritization process, NYP-BMH has numerous indicators in the 4th quartile as the highest priorities for the community. These indicators can be broadly grouped into:

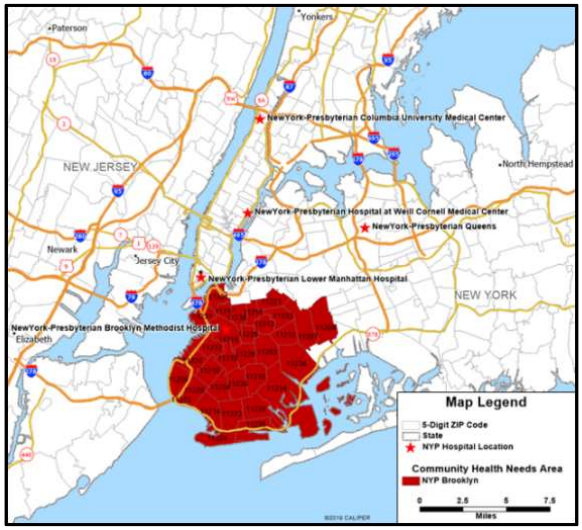
- Women's Health
- Obesity and Chronic Disease
- Mental Health and Substance Use
- Human Immunodeficiency Virus (HIV)
- Cancer

| CATEGORY | INDICATORS | QUARTILE |
|---|---|---|
| Health Outcomes | Childhood Obesity | 4th |
| Health Outcomes | Diabetes | 4th |
| Health Outcomes | Obesity | 4th |
| Health Outcomes | Physical Activity | 4th |
| Utilization | Hospitalizations: Preventable Diabetes | 4th |
| Access | Late or No Prenatal Care | 4th |
| Health Outcomes | Percentage of adults with poor mental health for 14 or more days in the last month | 4th |
| Health Outcomes | Cancer Incidence - All Sites | 4th |
| Health Outcomes | Cancer Incidence - Breast | 4th |
| SDoH | Binge Drinking | 4th |
| Utilization | Hospitalizations: Preventable Hypertension | 4th |
| Utilization | Hospitalizations: Psychiatric | 4th |
| SDoH | Current Smokers | 4th |
| Health Outcomes | HIV | 4th |
| Health Outcomes | Hypertension | 4th |

# COMMUNITY HEALTH ASSESSMENT & PRIORITIZED NEEDS

## *Our Community At Large*

The community definition for NewYork-Presbyterian Brooklyn Methodist Hospital was derived using 80% of ZIP codes from which NYP-BMH's patients originate and adding ZIP codes not among the original patient origin to create continuity in geographical boundaries, resulting in a total of 32 community ZIP codes, mainly within Kings County.

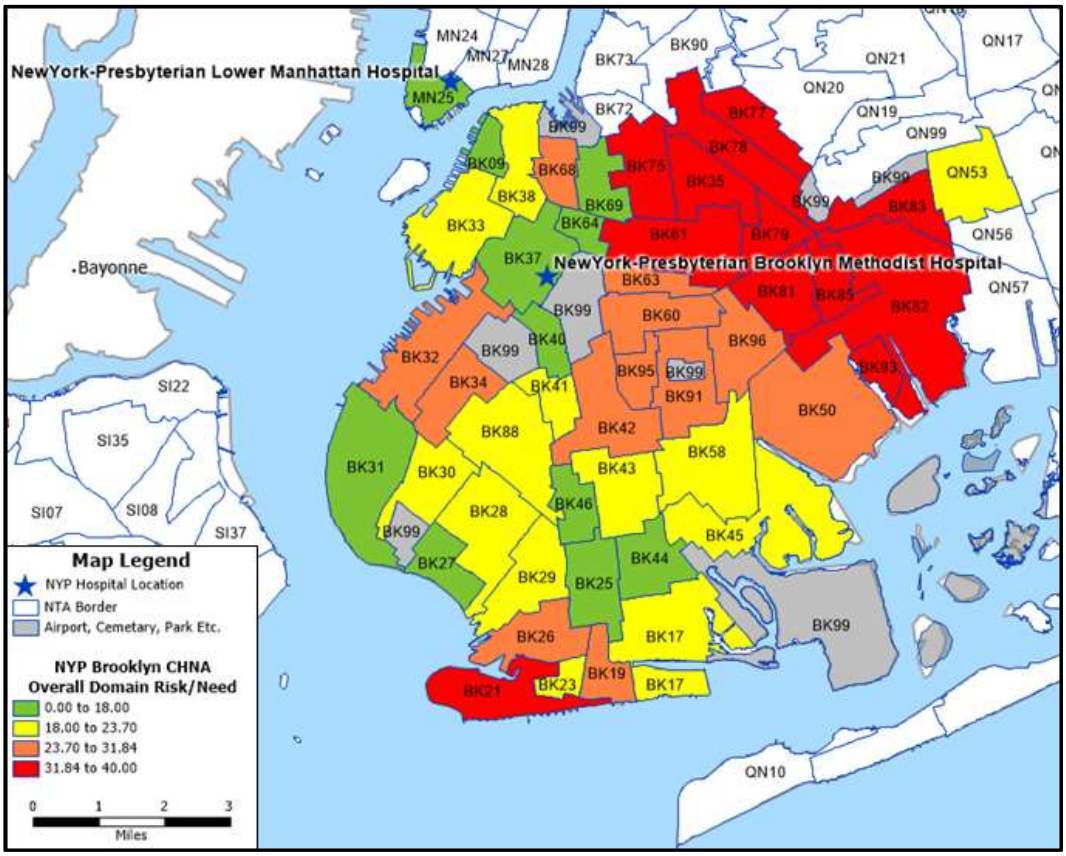



**NYP-BMH Defined Community Highlights**

| | | |
|---|---|---|
| **2.3M PEOPLE**<br>The defined community covers a geography of approximately 2.3M people | **2.2% GROWTH POPULATION**<br>Forecasted to grow faster, 2.2%, than the state average,1.5%, between 2019-2024 | **14.0% 65+ POPULATION**<br>Is slightly younger with only 14.0% of the population aged 65+ compared to 16.3% |
| **$91,909 HOUSEHOLD INCOME**<br>The average household income, $91,909, is lower than the average of New York State, $101,507 | **7.4% UNEMPLOYMENT RATE**<br>The unemployment rate, 7.4%, is 19% higher than the state benchmark, and there are fewer white-collar workers than the state average | **Higher Minority Population**<br>Higher non-White population, 65.9%, than the state 45.6%, driven by African Americans, 31.8%, followed by Hispanics, 17.2% |

## *Our Community of Focus*

To ensure the community service plan is focused on initiatives that impact the highest communities of disparity, NYP-BMH undertook an additional analysis of community health need at the Neighborhood Tabulation Area (NTA) geography based upon a composite of 29 different indicators. Indicators were carefully selected, across five domains: demographics, income, insurance, access to care, and New York State Department of Health Prevention Agenda Priorities. The objective was to identify the specific NTAs where there is a higher health need and/or a higher expectation of required resources. The defined community's 32 ZIP codes were cross-walked to 49 NTAs and then categorized into four quartiles based on identified disparities. Additional analysis was undertaken for the 24 NTAs of higher disparity in quartiles 3 and 4.



**NYP-BMH High Disparity Community Highlights**

| | | |
|---|---|---|
| **1.3M PEOPLE**  <br><br>The high disparity community covers a geography of approximately 1.3M people | **53.8% FEMALE**  <br><br>Is 53.8% female and slightly younger, 10.9% of the population is 65+, compared to NYC | **25.5% DID NOT COMPLETE HIGH SCHOOL**  <br><br>In aggregate, there are above NYC average percentages of residents that are foreign born, not graduated from high school, unemployed, and single parents. |
| **27.3% LIVING IN POVERTY**  <br><br>There are more living in poverty, all ages 27.3%, than the NYC average, 20.6%, and without health insurance, 15.5%, than the NYC average, 13.5% | **43.9% MEDICAID ENROLLMENT**  <br><br>Numerous neighborhoods also have a higher than average Medicaid enrollment, overall 43.9%, NYC 37.0% | **86.1% MINORITY POPULATION**  <br><br>Has a much higher minority population at 86.1% (especially Black and Hispanic/Latino) than does the NYC average 67% |

Acknowledging that there was variation across the NTAs among specific measurable indicators for demographics, socioeconomics, SDoH, health status, and utilization that each require a custom approach to community service planning, NYP-BMH selected a neighborhood with disparity scores in the top quartile for specific interventions: Crown Heights. Focusing interventions on this community will allow the hospital to contribute toward addressing health disparities there.

## *NYP BMH Data Highlights – High Disparity Community & Priority Areas*

In an effort to focus initiatives to make the largest impact to a high disparity community, the NYP-BMH team analyzed all data elements and isolated Crown Heights and the NYS PA priority areas of 1) Prevent Chronic Diseases, 2) Promote Healthy Women, Infants and Children, 3) Promote Well-Being and Prevent Mental and Substance Use Disorders, and 4) Prevent Communicable Disease. Below is a summary of the analytical findings for the focused communities:

### NYP-BMH Community of Focus Highlights

| | | |
|---|---|---|
| **Adult Obesity, Percent of Population**<br>Crown Heights North, 26.0% ↑<br>Crown Heights South, 32.0% ↑<br>Brooklyn High Disparity NTAs, 31.0%<br>NYC, 24.0% | **The crude rate of maternal morbidity, per 10,000 deliveries**<br>Crown Heights North, 372.5 ↑<br>Crown Heights South, 234.6 ↕<br>Brooklyn High Disparity NTAs, 342.9<br>NYC, 229.6 | **New diagnoses of HIV, per 100,000 population**<br>Crown Heights North, 44.3 ↑<br>Crown Heights South, 31.4 ↑<br>Brooklyn High Disparity NTAs, 36.3<br>NYC, 24.0 |
| **Child Obesity, Percent of Population**<br>Crown Heights North, 19.0% ↕<br>Crown Heights South, 19.0% ↕<br>Brooklyn High Disparity NTAs, 21.7%<br>NYC, 20.0% | **Rate of infant deaths (under one year old) per 1,000 live births**<br>Crown Heights North, 5.4 ↑<br>Crown Heights South, 3.5 ↓<br>Brooklyn High Disparity NTAs, 4.9<br>NYC, 4.4 | **New HCV diagnoses, per 100,000 population**<br>Crown Heights North, 91.6 ↑<br>Crown Heights South, 58.8 ↓<br>Brooklyn High Disparity, NTAs 81.6<br>NYC, 71.8 |
| **The percent of the population self-reporting "poor mental health"**<br>Indicator is a county statistic and the same for each Kings County NTA, 10.5% ↕ about the same as the NYC average 10.3% | | |

## NY State Community Health Indicator Trends

| Priority Area | NYC NTA | NY State Community Health Indicator Report Trends |
|---|---|---|
| **Prevent Chronic Disease**<br>Focus Area 1: Healthy Eating and Food Security | There are higher than NYC average percentages of obese adults:<br>Crown Heights North, 26.0%<br>Crown Heights South, 32.0%<br>Brooklyn High Disparity NTAs, 31.0%<br>NYC, 24.0%<br><br>There are lower than NYC average percentages of adults who 1+ serving of fruit / vegetable in 24 hours:<br>Crown Heights North, 84.0%<br>Crown Heights South, 81.0%<br>Brooklyn High Disparity NTAs, 82.1%<br>NYC, 87.0% | Trend data suggests that there may be some improvement among pre-school aged children, but continued efforts are needed among adults in Kings County. |
| **Promote Healthy, Women, Infants and Children**<br>Focus Area 1: Maternal & Women's Health | The crude rate of maternal morbidity per 10,000 deliveries is higher than NYC average:<br>Crown Heights North, 372.5<br>Crown Heights South, 234.6<br>Brooklyn High Disparity NTAs, 342.9<br>NYC, 229.6 | Trend data illustrates there has been no significant change in the performance of maternal mortality rate per 100,000 live births, in Kings County. |
| **Promote Well-Being and Prevent Mental and Substance Use Disorders**<br>Focus Area 1: Promote Well-Being<br>Focus Area 2: Prevent Mental and Substance Use Disorders | The percent of the population self-reporting "poor mental health" 10.5% is higher than the NYC average, 10.3% (this indicator is a Kings County statistic so is the same for each NTA) | Trend data are not available, but the community's need for available, affordable and convenient mental health services has been commented upon in the CHNQ. |
| **Prevent Communicable Diseases**<br>Focus Area 2: HIV<br>Focus Area 4: HCV | New diagnoses of HIV per 100,000 are higher than the NYC average:<br>Crown Heights North, 44.3<br>Crown Heights South, 31.4<br>Brooklyn High Disparity NTAs, 36.3<br>NYC, 24.0<br><br>New HCV diagnoses per 100,000 are higher than the NYC average<br>Crown Heights North, 91.6<br>Crown Heights South, 58.8<br>Brooklyn High Disparity NTAs, 81.6<br>NYC, 71.8 | The NY State Prevention Agenda is focused to a three-point plan to move closer to end the AIDS epidemic by decreasing the number of new HIV infections and to decrease the HIV prevalence in New York State. |

## *Community Challenges & Contributing Factors*

The NYP-BMH community is diverse having a younger, more minority, and economically challenged population. The SDoH concerns are concentrated upon language, safety, food insecurity, high cost of housing, and public transportation. Behavioral risk factors such as smoking, drinking, and consuming fruits and vegetables vary among the NTAs but are problematic for those in high-disparity neighborhoods. The qualitative analysis process of the CHNA allowed NYP-BMH the ability to gain the perspective of the community as to the top challenges and contributing factors to the outcomes of their health. Details of each qualitative effort can be found in the Community Health Needs Assessment complete document located at https://www.nyp.org/about-us/community-affairs/community-service-plans.

**Community Questionnaires**

The community health needs questionnaire (CHNQ) focused on basic demographics, health concerns (individual and community-wide), health care utilization, barriers to care, and use of NYP-BMH services. This data was collected between June and August 2019, in partnership with numerous community organizations, which were identified to represent a range of populations, e.g., older adults, immigrant, and homeless populations.

Respondents included NYP-BMH Community Advisory Board (NYP-BMH CAB) members and community residents, some of which were recruited using online platforms such as Craigslist. A total of 234 questionnaires were completed. Below is a summary of the most commonly reported community health issues and recommendations to improve community health follow:

| Mostly commonly reported community health issues * | | N=208 |
|---|---|---|
| **Community health issue** | **n** | **%** |
| Diabetes | 118 | 50.4% |
| High blood pressure | 112 | 47.9% |
| Alcohol & drug use | 109 | 46.6% |
| Cancer | 92 | 39.3% |
| Mental health | 90 | 38.5% |
| Heart disease | 89 | 38.0% |
| Obesity | 86 | 36.8% |
| Tobacco use | 76 | 32.5% |
| Physical activity | 71 | 30.3% |

* Multiple responses permitted.
Note: Responses selected fewer than 30% of the time are not presented.

Respondents also made recommendations on the best ways in which to improve community health:

| Recommendations to improve community health* | | N=234 |
|---|---|---|
| **Community health recommendations** | **n** | **%** |
| Improved housing conditions | 122 | 52.1% |
| Cleaner streets | 115 | 49.1% |
| Reduction in homelessness | 105 | 44.9% |
| Increased # of places for older adults to live and socialize in | 104 | 44.4% |
| Reduced air pollution | 91 | 38.9% |
| More parks and recreation centers | 84 | 35.9% |
| Reduced cigarette/vaping smoke | 84 | 35.9% |
| Reduced crime | 83 | 35.5% |
| More local jobs | 82 | 35.0% |
| Mold removal | 76 | 32.5% |
| ** Multiple responses permitted.* | | |

**Focus Groups**

Additionally NYAM partnered with five community based organizations and the NYP-BMH CAB to conduct focus groups to gain insights on health challenges, community health needs, and ways to inprove health for themseleves and the community at large. Participants were engaged in discussions, facilitated by NYAM or CBO staff trained by NYAM, on health care, exercise, food, available services in the community, telehealth, mental health, and more.

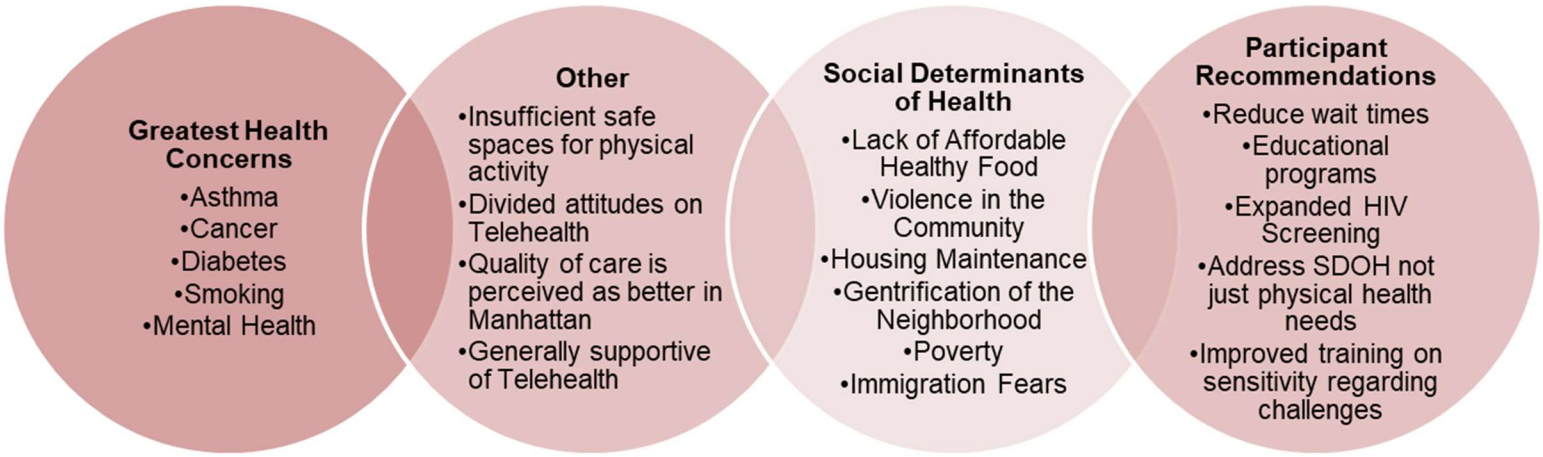
Participants were able to express their opinions on their personal experiences and the resources their communities have access to along with the challenges they face. Some notable quotes from the focus groups included:

*"I wanted an African American doctor or just I could not go to a – I just didn't feel comfortable going to a white doctor, male or female. I just didn't feel comfortable because I just – for someone to hold my baby, I wanted them to look like me. And I wanted them to look like my child."*

*"Smoking. Pollution in the air, different chemicals, the chemicals in household products. What we ingest or what we put on our skin – lotion, creams, oils. Definitely food. Twenty years ago, you didn't hear regularly – every day, somebody's dying from cancer... But now, it's like a phenomenon."*

*"And then everyone is frustrated. Food is expensive, so you're hungry on the train. And God forbid if you got two or three kids or you have a family. Childcare is really expensive. And you gotta work and provide childcare. You're on the train upset and somebody's stepping on your foot, they may hit you. It's just so much stuff. It's just how we say, "The thing that breaks the camel's back." It's just that one thing that sets it off."*

*"In terms of taking things outside of the hospital and showing people how to advocate for themselves how they need to be taking care of themselves…So, I'm gonna meet you outside and come into your community and tell you what the resources are in your four-block radius and also what things you can be doing within your community to have a much more holistic, healthy life."*



**NYP-BMH Community Health Survey**

In addition to the efforts conducted by NYAM, NYP-BMH sponsored a Community Health Survey which appeared in an edition of their community health magazine, *Thrive*, which is mailed to 250,000 households in Brooklyn. Respondents identified the most important health concerns for the community, which follow:

| What are the most important health concerns in your community? | | N=69 |
|---|---|---|
| | n | % |
| Prevent Chronic Diseases (ex: cancer, hypertension, diabetes, asthma) | 44 | 63.77% |
| Promote a Healthy and Safe Environment | 32 | 46.38% |
| Promote Healthy Women, Infants and Children | 19 | 27.54% |
| Prevent HIV/STDs, Vaccine Preventable Diseases and Antimicrobial Resistance, and Healthcare Associated Infections | 5 | 7.25% |
| Promote Well Being and Prevent Mental and Substance Abuse Disorders | 30 | 43.48% |
| Prevent Chronic Diseases (ex: cancer, hypertension, diabetes, asthma) | 44 | 63.77% |
| Promote a Healthy and Safe Environment | 32 | 46.38% |
| Promote Healthy Women, Infants and Children | 19 | 27.54% |

Specific social determinants were identified as playing a role in preventing the community from accessing medical care:

| What prevents people in your community from accessing medical care? (Please check up to three) | | N=69 |
|---|---|---|
| | n | % |
| Fear (not ready to face/discuss a health problem) | 32 | 46.38% |
| No insurance | 32 | 46.38% |
| Unable to pay co-pays/deductibles | 29 | 42.03% |
| Don't trust doctors/hospitals | 16 | 23.19% |
| Cultural/religious beliefs | 14 | 20.29% |
| Language barriers | 12 | 17.39% |
| Don't understand when to see a doctor | 11 | 15.94% |
| Too much stress | 11 | 15.94% |
| Don't want to be judged by doctors | 10 | 14.49% |
| Don't know how to find doctors | 9 | 13.04% |
| There are no barriers | 7 | 10.14% |
| Unable to get transportation | 6 | 8.70% |
| Lack of availability of doctors | 5 | 7.25% |
| Other (please specify) | 5 | 7.25% |

Respondents also noted the most needed health screenings and information:

| What health screenings or education/information services are most needed in your community? (Please check up to three) | N=69 | |
|---|---|---|
| | n | % |
| Exercise programs | 23 | 33.33% |
| Blood pressure screenings | 22 | 31.88% |
| Mental health services | 19 | 27.54% |
| Healthy cooking demonstrations | 18 | 26.09% |
| Nutritional education | 16 | 23.19% |
| Diabetes education | 14 | 20.29% |
| Cancer prevention education | 13 | 18.84% |
| Healthy/affordable food choices | 13 | 18.84% |
| Cholesterol screenings | 12 | 17.39% |
| Diabetes screenings | 11 | 15.94% |
| Drug & alcohol rehab services | 11 | 15.94% |
| Cancer screenings | 10 | 14.49% |
| Dental screenings | 10 | 14.49% |
| Heart disease education | 8 | 11.59% |
| Preventing falls/injuries | 8 | 11.59% |
| Reduce addiction and overdose | 8 | 11.59% |
| Reduce violence | 8 | 11.59% |
| Support for children with special needs | 8 | 11.59% |
| Vaccination/immunizations | 8 | 11.59% |
| Help quitting smoking | 6 | 8.70% |
| Medication management education | 4 | 5.80% |
| Prenatal care | 4 | 5.80% |
| Other (please specify) | 4 | 5.80% |
| Increase breastfeeding rates | 3 | 4.35% |
| Reducing air/water pollution | 3 | 4.35% |
| Suicide prevention education | 3 | 4.35% |
| HIV/AIDS & STD information | 0 | 0.00% |
| Reduce maternal/infant deaths | 0 | 0.00% |

## Other Community Feedback – Focus on Cancer

Due to the tremendous burden of cancer on physical, mental, and economic well-being and recognizing that the senior age-cohort 65+ is disparately impacted by this disease, NYP-BMH is undertaking additional community feedback and research with a focus on cancer. The study was not complete at the time of publishing this Community Service Plan; highlights of preliminary findings and anticipated next steps follow:

### *Brooklyn Cancer Roundtable*

The Cornell Center for Health Equity (CCHEq) in partnership with the Weill Cornell Meyer Cancer Center and NYP-BMH hosted a series of community roundtable discussions during the Spring of 2019. The rationale for these meetings was based upon the fact that cancers that are diagnosed early at a local stage of the disease are more amenable to successful treatment. Increasing the percent of early diagnoses for most cancers will improve survival outcomes and, in some cases, may help to narrow cancer health disparities (wealth, race, and ethnicity) that exist in New York City.

The preliminary study resulted in this list of top barriers based upon the following question posed to roundtable participants:

*"As stakeholders in the health and wellness of this community, you are intimately familiar with the various strengths and resources available to residents in (insert name of the neighborhood). Thus among the six social determinants (Economic Stability, Neighborhood and Physical Environment, Education, Food, Community and Social Context, and Health Care System) which three do you believe exert the greatest barrier to the early detection and treatment of cancer in your community?"*

Top barriers identified in rank order included economic stability, education, and community and social context.

## Other Community Feedback – Focus on Pediatrics

### *Citizens' Committee for Children of New York*

In March of 2017, the Citizens' Committee for Children of New York (CCC) gathered quantitative and qualitative data to establish a method through which to identify assets or resources in the Brownsville neighborhood of Brooklyn, NY. The resulting publication named '*From Strengths to Solutions: An Asset-Based Approach to Meeting Community Needs in Brownsville – A Citizens' Committee for Children of New York Report'* detailed the neighborhood of Brownsville, its biggest issues, numerous assets, and specific recommendations for health – improving access to healthy affordable foods and promoting awareness and use of existing medical and mental health services.

The study found a shortage of many fundamental resources:

- Public transportation options, banks, food retail, housing support services, and after-school and summer programs for older youth are just some examples of resources that appear to be lacking.
- Fear of crime and violence in the community means that fewer people are using the resources—from parks to libraries to youth services—that do exist.
- Lack of affordable housing and support services.

In areas—such as childcare and medical care—issues related to convenience and quality, respectively, seem to serve as a deterrent to resource utilization:

- Many residents cited a lack of childcare and insufficient transportation options as impediments to finding and holding a job.
- Residents took issue with the quality of medical care facilities and schools in the area and expressed a willingness to travel whenever possible to access higher quality healthcare and education options.

Recommendations specific to health:

- Incentivize the opening of additional food retail—particularly in the southern part of Brownsville—and ensure that healthy food options are available to all Brownsville residents year-round.
- Explore opportunities to improve access to healthy affordable foods in the community such as shuttle or bus service to supermarkets in neighboring districts, and to increase awareness of the USDA pilot program, set to commence in August 2017, which will allow SNAP recipients to purchase groceries online.
- Conduct outreach to ensure that residents are aware of medical and mental health services and encourage utilization of necessary services, particularly prenatal care for pregnant women and mental health services.

In addition to the qualitative analytics, the NYP-BMH team utilized the measurable datasets to identify other unique characteristics of the community that impact the health status:

- The frequency of maternal morbidity and related pregnancy status issues are higher than NYC averages among the high disparity neighborhoods.
- Chronic diseases such as asthma, diabetes, hypertension, and HIV and HCV are higher than NYC averages.
- Avoidable hospitalizations and ED use is higher than the NYC average.

Such indicators with less than favorable results tend to reflect the lack of access to ambulatory care for conditions that would otherwise be managed utilizing chronic disease management protocols and could have prevented an admission into a hospital facility. The anticipated lack of ambulatory care utilization and/or access is a complicated issue that continues to be a challenge in high disparity communities. The presence of health care ambulatory facilities does not necessarily mean that vulnerable patient populations have access to care. Such patient populations are faced with challenges of lack of appointment availability, misalignment of Managed Care plan and

provider availability, and providers who are currently not accepting Medicaid or uninsured patients.

Along with the behavioral, environmental, and socioeconomic factors, the political environment of our New York communities plays a large role in the health outcomes of large high disparity populations. Below are examples of such health care policy impacts.

## *Health Care Policy Potential Impact*

The health care policy environment can and does contribute to community-wide health improvement or conversely, to its challenges. Several policies have been identified as affecting residents of New York and the environment in which NYP operates. The NYP Government and Community Affairs team will continue to monitor and communicate changes within the health care policy environment in order to inform patient care and community-based initiatives.

Initiatives in the CSP were developed considering the following policy environment:

**Federal Change in Public Charge Rule**

In August 2019, the Trump Administration announced a final rule that changes the policies used to determine whether an individual applying for admission or adjustment of status is inadmissible to the U.S. Under longstanding policy, the federal government can deny an individual entry into the U.S. or adjustment to legal permanent resident (LPR) status (i.e., a green card) if he or she is determined likely to become a "public charge." Once the rule is enacted, officials will now consider use of certain previously excluded programs, including non-emergency Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), and several housing programs, in public charge determinations. The changes will create new barriers to getting a green card or immigrating to the U.S. and likely lead to decreases in participation in Medicaid and other programs among immigrant families and their primarily U.S.-born children, beyond those directly affected by the new policy. Decreased participation in these programs would contribute to more uninsured individuals and negatively affect the health and financial stability of families and the growth and healthy development of their children.

**Affordable Care Act Challenge**

A group of states presented a legal challenge to the Affordable Care Act (ACA) on the grounds that the individual mandate was unconstitutional. The case is now before a

Federal Appeals Court, which could issue a ruling at any time. If the ACA were, in fact, ruled unconstitutional, that could mean health insurers could once again refuse coverage or otherwise discriminate against patients who have preexisting conditions. Additionally, it would mean that roughly 20 million people who obtained insurance after the ACA was implemented could lose it. The ACA also made other changes to the health care system, including: expanding Medicaid eligibility for low-income adults; requiring private insurance, Medicare, and Medicaid expansion coverage of preventive services with no cost sharing; phasing out the Medicare prescription drug "donut hole" coverage gap; establishing new national initiatives to promote public health, care quality, and delivery system reforms; and authorizing a variety of tax increases to finance these changes. All of these provisions could be eliminated.

**1115 Waiver – Delivery System Reform Incentive Payment (DSRIP) Program – 2.0 Extension**

New York State has filed for an extension of its 1115 Waiver for the DSRIP initiative. If approved, the extension would further support clinical transformation efforts focused on the Medicaid population. New and ongoing funding would allow continued investments in programs focused on: improving quality outcomes, enhancing workforce development, addressing social determinants of health, and increasing community-based clinical network development.

**Elimination of religious exemptions to vaccinations for school aged children**

Amid an ongoing measles outbreak, New York State enacted a law in June 2019 to eliminate nonmedical exemptions from school vaccination requirements. The law took effect immediately. While this issue continues to be challenged in the courts, it would favorably increase the number of vaccinations among schoolchildren, decreasing unnecessary outbreaks and potential severe illnesses and deaths.

**New York State Ban on Flavored E-cigarettes**

In September 2019, New York State attempted to enact an emergency ban on the sale of flavored electronic cigarettes and nicotine e-liquids. This move was temporarily

blocked by the courts but New York State continues to pursue a ban. The proposed ban is part of a growing response to combat the increase in young people using vape products, given the appeal of flavors to the youth market. There are some who have concerns that the ban will keep people smoking regular cigarettes who may have considered switching and lead to a "black market" for vaping products with untested or unknown ingredients.

**Marijuana Decriminalization**

Legislation was passed in June of 2019 to decriminalize the use of marijuana by expunging many past marijuana possession convictions and reducing the penalty for the possession of small amounts of the drug. The bill does not fully legalize the use of marijuana. The decriminalization of small amounts of marijuana, 25 grams or less, and automatic expungement of previous convictions could encourage the use of substances which could lead to other substance abuse disorders.

**Ending the Epidemic**

New York's Ending the Epidemic initiative seeks to maximize the availability of life-saving, transmission-interrupting treatment for HIV, saving lives and improving the health of New Yorkers. The overarching goal is to achieve the first ever decrease in HIV prevalence in New York State by the end of 2020. Primary objectives are to: identify persons with HIV who remain undiagnosed and link them to health care services, and retain them in the care system to prevent further transmission and improve their health.

In New York City, the goal is to reduce the number of new infections in the City to fewer than 600 by 2020. This target aligns with the State's goal of reducing new statewide infections to fewer than 750 by 2020. In New York City, the four primary objectives are to: increase access to HIV prevention services; promote innovative, optimal treatment for HIV; enhance methods for tracing HIV transmission; and improve sexual health equity for all New Yorkers

**Maternal Mortality Review Board**

Governor Cuomo signed legislation to create a Maternal Mortality Review Board charged to review the cause of each maternal death in New York State. New York City will also have a maternal mortality review board to review cases within the five boroughs. The Boards will make recommendations to the New York State Department of Health for clinical improvement strategies to improve overall health and outcomes of this population. They will also look at ways to reduce racial disparities in health outcomes.

**ThriveNYC**

ThriveNYC is an initiative created by New York City to improve access to mental health services, particularly for underserved populations. The program's goals include: enhancing connections to care, increasing services to vulnerable populations, and strengthening crisis prevention and responses. ThriveNYC initiatives include: Mental Health First Aid training programs, a public awareness campaign, mental health outreach and support for veterans, mental health services in youth shelters, and drop-in centers and newborn home visiting program in shelters.

## *Community Service Plan – Focus & Interventions*

## *Community of Focus*

Based on the data process of analytics and prioritization, **NYP-BMH will target efforts in the Crown Heights neighborhood of Brooklyn** to allow our teams to invest and concentrate efforts and directly impact a high need community within the three-years of the service plan.

## *Priority Areas of Focus & Initiatives*

The data outlined allowed the team to identify a community of focus as well as priority areas to impact the healthcare of the most vulnerable populations. The priority areas

differ from the prior 2016-2018 Community Service Plan which Included (a.) Prevent Chronic Disease: Focus on Diabetes, (b.) Prevent Chronic Disease: Focus on Childhood Obesity, and (c.) Promote a Healthy and Safe Environment; Reducing Fall Risk Among Most Vulnerable Populations.

NYP-BMH is committed to serving the community by providing a wide range of health care services and activities that are important and provide benefit to our community members. Our assessment shows that there are numerous and significant needs, and the hospital has chosen a selection of these needs in order to concentrate resources and efforts and focus evaluations on those initiatives which we believe we can most effectively execute on and which will provide the largest impact to our community. In addition, the prioritization model applied to significant community needs was rooted in the quantitative as well as the qualitative voice of the community helping to ensure that our selection was aligned with those needs ranked highly by our community members.

The selected initiatives and resulting Community Service Plan were reviewed and approved by senior leaders, hospital community advisory board members, and our CHNA Steering Committee in the context of our organizational mission, our clinical strengths, and partnerships.

NewYork-Presbyterian Brooklyn Methodist Hospital has selected the focused priorities for the 2019-2021 Community Service Plan, which were reviewed as well as approved by the Hospital's Executive Leadership and the Board of Trustees on December 3, 2019.

**2019-2021 Community Service Plan Initiatives:**

***Prevent Chronic Disease*** *– Focus Area 1: Reduce Obesity & the Risk of Chronic Disease*

Goal 1.1 - Increase access to healthy and affordable foods and beverages

***Objective –*** Utilize a culturally sensitive process to empower organizations to focus on nutrition and physical activity, Promote wellness through community-based partnerships, and address food insecurities.

**INTERVENTION EXPLAINED:** Choosing healthy & active lifestyles for kids (*CHALK*) is New York-Presbyterian's obesity prevention program. CHALK aims to address obesity using a socio ecological model as its theoretical framework. The program will drive system and environmental changes that produce long lasting improvements around wellness in the targeted community of Crown Heights, where food insecurity and obesity rates are high. CHALK's multipronged approach as currently implemented in Washington Heights/Inwood includes:

- Mobile market (client-choice style mobile food pantry serving food insecure patients by household size, up to 200 individuals per distribution; connection to community resources, cooking demonstrations, and benefits enrollment)
- Fruit and vegetable prescription program (coupons redeemable for produce at local farmers markets for patients seen at hospital community-based primary care sites ($10/month))
- Elementary schools partnership (non-prescriptive partnership model, creation of wellness councils, implementation of wellness policies, staff professional development, nutrition education, connection to community resources and partners, built environment changes that promote healthy lifestyles).

**EVIDENCE-BASE:**

1. **Mobile Market And Fruit And Vegetable Prescription Programs:**

Food insecurity is associated with poor health status (aha, 2017). Accordingly, CHALK's mobile market and fruit and vegetable prescription programs join health systems nationwide in developing best practices to address social determinants of health. Promedica, an early adopter in Toledo, Ohio, launched food pharmacy, nutrition consultation, and meal distribution programs that resulted in decreased emergency room utilization and increased primary care appointments, while reducing hospital readmissions by 53% (aha, 2017). Health-system led food pantries are an important resource for immigrant families in NYC who are less likely to access government programs (Gany et al, 2015). Obese, low income participants in fruit and

vegetable prescription programs have experienced greater reductions in BMI compared to a control group (Cavanah et al, 2016). This and other food insecurity initiatives can contribute to obesity-prevention (Chen Cheung et al, 2015). Rolling out initiatives in partnership with community leaders is recommended by the American academy of pediatrics toward reducing racial disparities in obesity (Trent et al, 2019). The mobile market is operated by Westside Campaign Against Hunger and will partner with NYP to implement the Mobile Market in Brooklyn.

American Hospital Association. (2017). *Social Determinants Of Health Series: Food Insecurity And The Role Of Hospitals.* Http://Www.Hpoe.Org/Reports-Hpoe/2017/Determinants-Health-Food-Insecurity-Role-Of-Hospitals.Pdf

Cavanagh, M., Jurkowski, J., Bozlak, C., Et Al. (2016). Veggie Rx: An Outcome Evaluation Of A Healthy Food Incentive Programme. *Public Health Nutrition, 20(14),* 2636-2641.

Chen Cheung, H., Shen, A., Oo, S, Et Al. (2015). Food Insecurity And Body Mass Index: A Longitudinal Mixed Methods Study, Chelsea, Massachusetts, 2009-2013. *Preventing Chronic Disease: Public Health Research, Practice And Policy, Cdc, 12,* 150001.

Gany, F., Lee, T., Loeb, R., Ramiraz, J., Et Al. (2015). Use Of Hospital-Based Food Pantries Among Low-Income Urban Cancer Patients. *Journal Of Community Health, 40(6)*, 1193-1200.

Trent, M., Doodley, D.G., Dougé, J. (2019). American Academy Of Pediatrics Policy Statement: The Impact Of Racism On Child And Adolescent Health. *Pediatrics, 144(2)*.

**2. Elementary Schools Partnership:**

CHALK's existing elementary school partnerships in northern Manhattan have increased access to healthy lifestyles for students and their families. The CHALK model strengthens school-based wellness councils and policy implementation, increases physical activity and nutrition programing, and connects stakeholders with community partners to support sustained success post-partnership (Jarpe-Ratner et al, 2013; Rausch et al, 2015).

Jarpe-Ratner E, Zamula A, Meyer D, Nieto A, McCord M. (2013). The Healthy Schools Healthy Families Program–Physical Activity Integration Into Elementary Schools In New York City. *Journal Of Community Medicine And Health Education, 3*, 194.

Rausch J C, Berger-Jenkins E, Nieto A, McCord, M & Meyer, D. (2015). Effect Of A School-Based Intervention On Parents' Nutrition And Exercise

Knowledge, Attitudes, And Behaviors. *American Journal Of Health Education, 46(1)*, 33-39.

**PERFORMANCE MEASURES:**

- **Mobile market:** decrease food insecurity prevalence among patients participating in the program (5% decrease over 12 months); increase access to emergency food in underserved neighborhoods (10,000-20,000 lbs food distributed over 12 monthly distributions, reaching approximately 100-150 individuals per distribution); increase connection to external emergency food resources (30-50 households connected with local food pantries via optional site visit and maps customized by patient ZIP code)
- **Fruit and vegetable prescription program:** increase access to healthy and local produce (30-50 prescriptions redeemed by patients for fruit and vegetable coupons per season May-Nov, access to $10,000 in fruit and vegetable coupons redeemable for produce at farmers markets); increase fruit and vegetable prescription and coupon redemption (70% coupons redeemed for fresh fruits and vegetables per season)
- **Elementary schools partnerships:** increased participation in school wellness councils (25% increase over 12 month), development and adherence to wellness policy (25% increase in action items led by non-chalk members over 4 years); improve built environment (successful completion of at least one built environment improvement project per partnership); increase school capacity through connection to resources and CBO partners (3 key resource or partnership connections made each year).

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021**

- Recruit program coordinator to support expansion
- Partner with NYP CHALK team to train new staff on program strategy, partnership model, implementation and evaluation tools
- Finalize identification of community partners
- Build relationships between clinicians, school administrators, farmers markets, and community-based partners to co-design program rollout (one-on-one meetings and focus groups)
- With community input, identify programs to be tailored and implemented at each campus from pre-set menu of options: mobile market, fruit and vegetable prescription program, and school partnerships.
- Ongoing program evaluation and quality improvement

**Mobile Market and Fruit & Vegetable Prescription Programs:**

- Establish initial sites for mobile market and fruit & vegetable prescription programs (partner with local food pantries and farmers markets)
- Onsite planning and recruitment to launch selected program(s)
- Engage key stakeholders to compile feedback on initial rollout, co-design program improvements

- Identify sites and champions to facilitate continued program expansion
- Continue to assess and improve implementation strategy in collaboration with partners

**School partnership implemented:**

- Identify potential school partners and assess organizational readiness. Launch one partnership in September 2020; complete baseline school assessment.
- Continue engagement with current school partners

**IMPLEMENTATION PARTNER(S):**

- West Side Campaign Against Hunger
- GROW NYC
- Additional partnerships*

*CHALK is built on a responsive partnership model that couples capacity building support for grassroots community-based organizations with targeted resource connection, bridging local organizations, farmers markets, schools, NYP clinical teams, and patients. In year 1, program staff will conduct a community assets assessment in each target community to identify potential partners, service providers, and collaborators. Partnerships with 10 to 20 of these organizations (host sites, healthy food suppliers, and resource providers) will begin in year 2.

***Promote Healthy Women, Infants and Children*** *– Focus Area 1: Maternal & Women's Health*

Goal 1.1. - Increase use of primary and preventative health care services by women of all ages with a focus on women of reproductive age

**Objective**: This program aims to reduce racial, ethnic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.

**INTERVENTION EXPLAINED:**

Promote healthy women infants and children by providing peer and expert support to pregnant persons in order to promote optimal infant feeding, childbirth practices, and parental mental well-being. This program seeks to impact at least 10% of NYP Brooklyn Methodist Hospital birthing population, which amounts to over 500 expectant persons.

- Provide virtual and reality-based space where pregnant persons can engage in discourse with their peers.
- Follow several cohorts of 8-12 expectant parents and engage them in 3 pre-natal group visits (both in-person and virtually), and between 3-4 postpartum visits individually (both in-person and virtually), over the course of 3 months.
- Provide educational support by persons trained in infant feeding, infant care, birthing, and postpartum mental health screening.

There is a growing consensus to initiate care within the first three weeks postpartum, and the current recommendation of the American College of Obstetricians and Gynecologists (ACOG) is to evolve postpartum care into an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs. Per ACOG, the "comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being, including the following domains: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance." The World Health Organization recommends visits at three days, seven to 14 days, and six weeks postpartum, inclusive of newborn care.[1]

In addition, the early postpartum period is a critical time for establishing and supporting breastfeeding. To reach their breastfeeding goals, parents need continuity

[1] ACOG Committee Opinion No. 736: Optimizing Postpartum Care. Obstetrics & Gynecology. 131(5): e140-e150, May 2018.

of care, which is achieved by consistent and collaborative services well beyond the immediate birth period. Individual-level interventions have stronger evidence of effectiveness. These include professional support by physicians, midwives, or lactation counselors; peer support; or formal education sessions. A Cochrane review found that support by trained personnel (e.g., medical professionals, volunteers), face-to-face interventions, and interventions that took place over multiple encounters were more effective. Interventions should also engage parents with peers, as the social environment exerts a strong influence on new mothers and their willingness and ability to continue to breastfeed.[2] Countries that have implemented community-based support groups have succeeded in normalizing breastfeeding and increased their exclusive breastfeeding rates.[3]

**PERFORMANCE MEASURES:**
This program seeks to improve exclusive breastfeeding rates, improved infant feeding practices and reduce the instance of postpartum depression. Success will be measured in the number of babies that exclusively breastfed 6 months after discharge, infants reaching feeding milestones, and negative screenings for postpartum depression.

[2] Kramer MS, Kakuma R. Optimal duration of exclusive breastfeeding. Cochrane Database of Systematic Reviews 2012, Issue 8. Art. No.: CD003517. DOI: 10.1002/14651858.CD003517.pub2.
[3] https://www.who.int/en/news-room/feature-stories/detail/viet-nam-breastfeeding-campaign-normalizes-practice-improves-rates

***Prevent Communicable Diseases*** *– Focus Area 2: Human Immunodeficiency Virus (HIV) and Focus Area 4: Hepatitis C (HCV)*

Focus Area 2: Goal 2.2 - Increase Viral Suppression

Focus Area 4: Goal 4.1 - Increase the number of persons treated for Hepatitis C Virus (HCV)

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

**INTERVENTION EXPLAINED:** Ending the HIV and HCV epidemics in NYS is now a legitimate possibility and NYP is playing a leading role in this effort. The **NYP ETE Initiative** would create a multi-campus HIV and HCV elimination strategy that would a) increase HIV and HCV testing and linkage to care, b) re-engage HIV+ and HCV+ individuals to care, and c) expand effective HIV and HCV prevention services, like PrEP and MAT. Utilizing *existing* multi-campus dashboards an NYP 'Pilot' would link, in real-time, all new HIV and HCV diagnoses, those (thousands) individuals out of care, and those in need of preventive services[i]. Expanded deployment of a Health Priority Specialist in existing sites, like NYP Emergency Departments (NYP ED), would be the effector arm for the intervention. A major investment in a Mobile Medical Unit (MMU) would also help bring these needed services to communities surrounding our medical centers and additionally act as the nidus for new PrEP program growth at NYP-BMH. Collectively this multimodal, evidence based intervention could help NYP end the HIV and HCV epidemics in our targeted communities.

**PERFORMANCE MEASURES:** Performance indicators will be aligned with the HIV and HCV ETE measures promulgated by NYS and NYC, as well as project specific measure. These will include:

1. Number of monthly NYP-wide HIV and HCV tests performed, # of positives, % linked to care, viral suppression and cured (HCV).
2. Number of monthly PrEP evaluations, starts, and maintenance in care at 6 months.
3. Number of monthly care re-engagement opportunities, successful re-engagement, and viral load suppression at 3 months and 1 year.
4. Number of monthly MMU encounters and breakdown by visit type; Testing, Re-engagement, Sexual Health (STI, PrEP, PEP), and MAT.
5. Number of monthly NYP ED visits and hospitalizations for people living with HIV or HCV.

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021:**

- Hire project staff (Administrator, NP, Care Coordinators, Driver/Technician, and IT). These positions would be phased in during Y1
- Purchase Mobile Medical Unit
- Implement HIV and HCV Outreach Dashboards at NewYork-Presbyterian/Weill Cornell Medical Center and NYP-BMH
- Implement HIV/HCV/STI Nudge Reports at NYP/Weill Cornell and NYP-BMH
- Develop detailed QIP work-plan, data collection methods, and analytic reports
- Conduct detailed environmental survey of referral options for new diagnoses, re-engagement clients, PrEP/PEP clients, and OUD services
- Establish MMU schedule targeting high-risk neighborhoods and communities surrounding NYP-BKH
- Provide sexual health services (PEP/PrEP, STI screening and treatment) HIV and HCV testing and linkage to care, and direct HIV and HCV services via MMU
- Continue HIV and HCV Outreach Dashboard use at NYP/Weill Cornell and NYP-BMH via multi-institutional 'pilot' care coordinator
- Provide sexual health services (STI screening and treatment) at NYP-BMH via the MMU
- Integrate telemedicine visits into MMU clinical activities to scale clinical capacity
- surrounding the medical center
- Provide PEP/PrEP and HIV and HCV linkage and re-linkage services at NYP-BMH via the MMU
- Continue and expand MMU services at neighborhoods and high-risk communities surrounding NYP east and west campuses, including the provision of sexual health services (STI screening and treatment), HIV PEP/PrEP, direct HIV and HCV clinical services, and re-HIV engagement services
- Expand MMU telemedicine visits to scale outreach and engagement clinical capacity

**IMPLEMENTATION PARTNER(S):**

- Alliance For Positive Change
- Argus Community
- Housing Works
- NewYork-Presbyterian Brooklyn Medical Group
- Weil Cornell Medical College
- Columbia University Irving Medical Center

**REFERENCES:**

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***Prevent Chronic Disease*** *– Focus Area 4: Chronic Disease Preventive Care and Management*

Goal 4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity

**Objective**: The 30-Day Transitional care initiative is used by the care team as a time frame required to provide care coordination.

**INTERVENTION EXPLAINED:**

The American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society of Academic Emergency Medicine have worked together to develop consensus standards for transitional care.(Snow et. al. 2009)

The coordination of care across the health care continuum is crucial to the implementation, management, and evaluation of a patient's treatment plan. The transfer and receipt of patient information between different levels of care and locations ensure continuity and promote successful treatment. Unfortunately, breakdowns in these processes, as well as the ineffective handoff of information between care providers, can lead to poor transitions and miscommunication among providers (Mansukhani et. al.2015)

NYP-BMH's 30-Day Transitional care initiative is used by the care team as a time frame required to provide care coordination. The Transitions Care Team (TCT) identifies high utilizers and/or patients, who are 18 years of age and older, with a high LACE score, from Medicaid lists.

Between 2017 and 2018, the NYP-BMH care team has touched 2215 distinct patients across 5146 visits. This program will continue to identify and treat patients while ensuring continuity of care across health care settings.

**PERFORMANCE MEASURES**:

- Readmissions
- Warm hand-offs
- SDoH screenings and referrals – provide screenings and/ or referrals to 50-100% of eligible patients
- COPD trainings - provide trainings to 50-100% of eligible patients
- Medication follow-ups – provide follow-up to 80-100% of eligible patients

**IMPLEMENTATION PARTNER(S):**

- Housing Works Health Home
- Certified Home Health Agencies: CenterLight, MJHS and VNSNY
- Landauer MedStar DME
- Brooklyn Medical Care Practices / Mental Health Providers
- Doctor's on Call
- House call for the Home Bound
- Pella Care – Licensed Long-Term Home Health Agency/ HHA Services
- New York Legal Assistance Group - NYLAG
- HOMEBASE -- Homeless Prevention Network
- Federally Qualified Health Centers (FQHCs) – Provides medical care to underserved communities.
- Medical Answering Services (MAS) – Provides Transportation services to straight Medicaid patients.
- Lifeline Ambulance – Medical Transportation for Medicare Beneficiaries
- Interfaith Medical Center Sickle Cell Group Therapy
- Adult Protective Services
- Mobile Crisis Unit
- Assertive Community Treatment (ACT)

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***Promote Well-Being & Prevent Mental & Substance Use Disorders*** *– Focus Area: 1*

*Strengthen opportunities to build well-being and resilience across the lifespan*

Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan

**Objective**: Expand mental health first aid trainings to expand mental health education, increase prevention and address stigma

**INTERVENTION EXPLAINED:**

Mental health first aid (MHFA) is an international, evidence based, training program proven to be an effective intervention for mental health education, prevention and addressing stigma. Peer-reviewed studies show that individuals trained in the program achieve the following outcomes:

- Grow their knowledge of signs, symptoms, and risk factors of mental illnesses and addictions.
- Can identify multiple types of professional and self-help resources for individuals with a mental illness or addiction.
- Increase their confidence in and likelihood to help an individual in distress.
- Show increase mental wellness themselves.

NYP has been providing this training since 2015 through its Building Bridges, Knowledge, and Health Coalition and, in partnership with ThriveNYC, and has trained over 800 individuals. Mental Health First Aid USA is listed in the substance abuse and mental health services administration's national registry of evidence-based programs and practices.

**PERFORMANCE MEASURES**:

- Conduct assessment of staff across NYP BM to ascertain training need
- Conduct assessment of Community Based Organizations (CBO) and Faith Based Organizations (FBO) collaborators to ascertain training need
- Identify 8-15 CBO's and/or FBO'S annually in the Borough of Brooklyn
- Number of trainings and participants
- Number of referrals to services

**PERFORMANCE MEASURES AND TIME TARGETS 2019-2021**:

- Recruit one clinical coordinator and one outreach coordinator (new FTE's)
- Credential MHFA staff to lead trainings
- Begin outreach to community and faith based organizations in the Borough of Brooklyn

- Conduct 8-15 MHFA trainings a year

**IMPLEMENTATION PARTNER(S):**

- NYP-BMH Community Advisory Board w/ representation from 20 Brooklyn CBOs
- ThriveNYC
- NYP-BMH Department of Pastoral Care Advisory Committee
- Additional CBO's and FBO's will be identified as intervention outreach increases.

**REFERENCES**

https://www.mentalhealthfirstaid.org/cs/wp-content/uploads/2013/10/2018-MHFA-Research-Summary.pdf

## *Initiative Progress Tracking*

Progress tracking will be maintained by the NYP-BMH leadership team. Annual findings will be used as a quality performance improvement process to refine processes and program developmental efforts to ensure needs of the population are met. The findings will then to be used to compile an annual report to meet both the state and federal expectations of reporting.

## *Assets & Resources*

NYP-BMH recognizes that there are existing assets, resources, and partners which may be leveraged for both expertise and economies of scale to deploy initiatives collaboratively for the benefit of community health improvement. Several notable assets/resources follow.

| Asset Name | Brief Description |
|---|---|
| **Center for Community Health** | A six-story building currently in construction, will include an ambulatory surgery center, with 12 operating rooms for same-day surgery, a new special procedures suite with six rooms for endoscopy, bronchoscopy and pain management, a cancer center of excellence including an ambulatory infusion (chemotherapy) center and an expanded orthopedic institute. Diagnostic radiology services and physicians' offices will support these services. |
| **Pediatric After-Hours Center** | Children with any urgent, non-emergency medical issue can be seen after-hours on a walk-in basis. |
| **Robert Center for Community Health Navigation** | The Center will incorporate several Patient Navigators and Community Health Workers to improve patient-access to the hospital. Its mission is to support the health and well-being of patients through the delivery of culturally-sensitive, peer-based support in the emergency department, inpatient, outpatient and community settings. |
| **Child Life Program** | Dedicated to meeting the psychosocial and emotional needs of our pediatric patients and their families. The Program recognizes that treating the whole child and family is essential in the healthcare setting and facilitates therapeutic and recreational play, self-expressive activities, and preparation |

| | |
|---|---|
| | and procedural support in order to help children cope with trauma, illness, and hospitalization. |
| **Asian Health Institute** | The Asian Health Institute at NYP-BMH provides access to high-quality medical screening, and diagnostic and treatment services which are available at the hospital, including cardiovascular care, comprehensive cancer care, orthopedic care, urology services, neurology services, pulmonary care, liver disease management, and a full range of surgical services, including minimally invasive and robotic surgery. The Institute also provides access to volunteers who are bilingual in English and Chinese (who visit with patients daily) and a 24-hour Chinese-language telephone hotline. |
| **Department of Pastoral Care** | Includes chaplains who are Catholic, Protestant, Orthodox Jewish, Greek Orthodox, Buddhist, and Muslim. Non-sectarian chaplaincy services are available to patients 24/7. The Department has a Pastoral Care Advisory Committee that includes religious leaders from the community and meets quarterly. |
| **Healthy Aging Series** | For adults age 50 and older. The series takes place at Brooklyn College to accommodate the large number of patients we serve who come from the Flatbush and Midwood sections of Brooklyn. |
| **Fall Prevention Program** | The Fall Prevention Program seeks to provide older adults with the confidence and tools to help them age safely. The program is comprised of seminars on home safety, healthy living, and avoiding falls, given by experts in trauma and injury prevention, environmental gerontology, and public health. |
| **Carolyne E. Czap and Eugene A. Czap Alzheimer's Program** | Offers a full continuum of care for patients diagnosed with Alzheimer's disease and other memory and cognitive disorders. The Program also offers brain fitness training for older adults. |
| **Parkinson's Disease Program** | Provides all services related to the diagnosis and treatment of Parkinson's disease. The Program, an affiliate of the American Parkinson's Disease Society, is staffed by an expert team of neurologists, neurosurgeons, neuropsychologists, psychologists, psychiatrists, physician assistants, speech-language therapists and nurses. |
| **NYP Brooklyn Methodist Community Advisory Board** | NYP Advisory Board works with the Hospital to identify the needs of the community; advise how best to meet those needs; and facilitate communications between the Hospital and the community at large. |

## *Website Availability*

The Community Health Needs Assessment and Community Service Plan can be found on the NYP-BMH website at https://www.nyp.org/about-us/community-affairs/community-service-plans.

# APPENDIX A

## Quantitative Data Sources

| Data Source | Data Period | Publicly Available Website |
|---|---|---|
| Association for Neighborhood & Housing Development | 2018 | https://anhd.org/report/how-affordable-housing-threatened-your-neighborhood-2019 |
| Behavioral Risk Factor Surveillance System (BRFSS) New York State | 2016 | https://www.cdc.gov/brfss/index.html |
| Citizen's Committee for Children Keeping Track Online | 2017 | https://www.cccnewyork.org/ |
| Claritas | 2019 | N/A |
| Data City of New York | 2018 | https://opendata.cityofnewyork.us/ |
| Data2Go.NYC | Varies by indicator 2010-2016 | https://data2go.nyc |
| Definitive Healthcare | 2019 | N/A |
| New York City Mayor Report | 2005-2017 | https://www1.nyc.gov/site/opportunity/poverty-in-nyc/data-tool.page |
| Nielsen | 2019 | N/A |
| NYC Health Atlas | Varies by indicator 2010-2015 | https://www1.nyc.gov/site/doh/health/neighborhood-health/nyc-neighborhood-health-atlas.page |
| NYC Community Health Profiles | Varies by indicator 2011-2017 | https://www1.nyc.gov/site/doh/data/data-publications/profiles.page |
| Office of the State Comptroller | 2018 | https://www.osc.state.ny.us/localgov/pubs/research/foreclosure-update.pdf#search=%20foreclosure%20 |
| State Cancer Profiles | 2018 | https://statecancerprofiles.cancer.gov/ |
| U.S. Department of Agriculture | 2015 | https://www.fns.usda.gov/data-research |

[i] Rana AI, Mugavero MJ. How Big Data Science Can Improve Linkage and Retention in Care. Infectious Disease Clinics of North America. 2019 Sep;33(3):807-815. doi: 10.1016/j.idc.2019.05.009