New York Methodist Hospital

Community Service Plan 2016-2018

1. This assessment and plan covers Kings County, New York, also known as the borough of Brooklyn.
2. We did not write a joint plan with our local health department.
3. New York Methodist Hospital (NYM)
4. Lyn Hill, Vice President for Communication and External Affairs, NYM, can be reached by telephone at 718.780.5367 or by email at lyh9001@nyp.org.

   Loren Avellino, Director of Community Outreach, NYM, can be reached by telephone at 718.780.5367 or by email at lpa9002@nyp.org.

Executive Summary

(Maximum four double-spaced pages. This report should be posted on your public website(s) and shared with community partners.) Include succinct statements that answer the following questions:

Include succinct statements that answer the following questions:
1. What are the Prevention Agenda priorities and the disparity you are working on with your community partners including the local health department and hospitals for the 2016-2018 period?
2. What has changed, if anything, with regard to the priorities you selected since 2013 including any emerging issues identified or being watched?
3. What data did you review to identify and confirm existing priorities or select new ones?
4. Which partners are you working with and what are their roles in the assessment and implementation processes?
5. How are you engaging the broad community in these efforts?
6. What specific evidence-based interventions/strategies/activities are being implemented to address the specific priorities and the health disparity and how were they selected?
7. How are progress and improvement being tracked to evaluate impact? What process measures are being used?

Executive Summary

Based on results from NYM's Community Health Survey, discussions with key informants in the community, and review of New York State's Prevention Area Priorities—which include, Prevent Chronic Diseases, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants, and Children, Promote Mental Health and Prevent Substance Abuse and Prevent HIV, STDs, Vaccine Preventable Diseases and Health-Care Associated Infections—New York Methodist Hospital has selected the following priorities for the 2016-2018 Community Service Plan:

1. Prevent Chronic Disease; focus on diabetes
2. Prevent Chronic Disease; focus on childhood obesity
3. Promote a Healthy and Safe Environment; reducing fall risk among most vulnerable populations

In 2013, we selected diabetes and obesity as our main priorities and we worked on these with our community partners. This year, we have identified the need to reduce fall risks among vulnerable populations as an emerging health disparity—one not sufficiently addressed by existing health infrastructure in Kings County. We have therefore added this to our prevention priorities.

With regard to the Hospital's focus on reducing childhood obesity to prevent chronic diseases, NYM will also consider breastfeeding rates, and seek to achieve "Baby-Friendly" status. In addition, NYM will expand its Dance Your Heart Healthy program by opening it to pre-teens and their parents, and adding a nutrition education component.

The data reviewed to identify and confirm existing priorities and the selection of new ones included the following sources:

New York State Department of Health (NYS DOH) Prevention Agenda Dashboard 2013-2017
2016 County Health Rankings & Roadmaps - New York Data
Kings County, New York _ County Health Rankings & Roadmaps (2016)
NYS DOH Health Sub-County Health Rankings (2016)
US Census Bureau American FactFinder - Community Facts
2014 Brooklyn DSRIP Community Needs Assessment
Results from New York Methodist Hospital's (NYM) 2016 Community Health Survey
NYM Department of Finance 2015 Statistical Exhibits
US Census Bureau 2015 American Community Survey – Year 1 Estimates
2010 US Census Bureau Findings
NYC DOHMH Environment & Health Data Portal
- Youth Consumption of Sugary Drinks (2011)
- Fall-Related Hospitalizations Among Older Adults (2012)
- Adult Consumption of Sugary Drinks (2014)
- Fall-related emergency department visits among older adults (2012)
- Heart Attack Hospitalizations (2013)
- Obese Adults (2014)
- Obese Adults by Poverty Level (2009-2014)

Obese Youth (2013)
US Census Bureau 2010-2014 American Community Survey 5-Year Estimates
NYC DOHMH 2015 New York City Community Health Profiles Atlas
NYC DOHMH TCNY 2020 Priorities
NYC DOHMH Vital Statistics Leading Causes of Injury Death (2009-2011)
Data from NYC Falls Coalition Meeting (Aug 2016)
CDC Morbidity and Mortality Weekly Report
Falls and Fall Injuries Among Adults Aged ≥65 Years — United States, 2014
CDC Behavioral Risk Factor Surveillance System (BRFSS) Annual Data (2014)

We are working with a number of community partners in the assessment and implementation process.

For our Prevent Chronic Disease; focus on diabetes, priority, we have identified:

- Everyone with Diabetes Counts New York/IPRO - Improvement Healthcare for the Common Good , which will provide peer leaders to run DSMEs, advertise classes, as well as provide training sessions for NYM staff to lead their own DSME workshops in the future.
- New York City's Department of Health and Mental Hygiene's (DOHMH) Diabetes Prevention Program, under the umbrella of Clinical-Community Program Linkages and the Primary Care Information Project, which will list classes in the QTAC physician and community referral portal.

For our Prevent Chronic Disease; focus on childhood obesity priority, which coincides with Promoting Healthy Women Infants and Children; focus on maternal and infant health, we have identified:

- DanceWave, a non-profit organization that will provide dance instructors to teach the parent/child exercise classes.
- The Brooklyn Children's Museum, which will provide a venue for dance and nutrition education classes.
- The New York City Department of Health and Mental Hygiene Breastfeeding Initiative Cohort 3, which will provide training and assistance to help NYM reach "Baby-Friendly" status and improve breastfeeding exclusivity and new parent education

For our Promote a Healthy and Safe Environment; reducing fall risk among most vulnerable populations priority, we have identified:

- Senior Umbrella Network of Brooklyn (Sun-B)) , which will provide Fall Prevention educational materials and access to their member network of community benefit organizations serving Brooklyn's older adult population.
- Jeff Rosenfeld, PhD, Environmental Gerontologist, Parsons School of Design, who will provide lectures, educational materials, and assessment of existing data regarding geriatric falls. It was Dr. Rosenfeld's suggestion that the Hospital assemble and distribute a simple fall prevention "kit" to be distributed to "treat and release patients" from the ER at the time of discharge. The kit will

contain: slip-resistant socks, a nighttime censored nightlight, a small flashlight with a wrist bracelet, glow-tape, and educational materials (see enclosed photo below).

- The Brooklyn Public Library, which will help to promote the fall prevention program and provide offsite venues for presentations to seniors.
- Good Neighbors of Park Slope, an organization of senior citizens, which will co-sponsor senior safety and fall prevention lectures and help to promote them.
- Heights and Hills, Supporting Brooklyn's Older Adults, which will host fall prevention workshops at some of their locations throughout Brooklyn.

Fall Prevention Kit Prototype:

The Brooklyn community helped to select the interventions via key informant meetings and a Community Health Survey which appeared on New York Methodist Hospital's website homepage, www.nym.org. The survey also appeared on NYM's social media channels and in the spring/summer 2016 edition of NYM's community health magazine, *Thrive*, which is mailed to 250,000 households in Brooklyn.

In addition to the input sought from the community, the programs and strategies developed by NYM as part of its Community Service Plan will be targeted to at-risk populations as identified in the Hospital' Community Health Needs Assessment.

The interventions and strategies were determined by reviewing results from NYM's Community Health Survey, along with the input derived from key informant meetings. State, county and zip code level statistical data were also reviewed. Finally, recommendations from the New York State Prevention Agenda Dashboard 2013-2017 were taken into consideration.

The goal of the intervention for the Prevent Chronic Disease; focus on diabetes is to increase access to high-quality chronic disease preventive care and management in clinical and community settings by offering diabetes self-management education (DSME) classes for community residents in both English and Spanish, and educating Hospital staff members to become trainers and lead additional DSMEs. NYM anticipates that those who attend classes will gain confidence and better control in the management of

their diabetes. Once our own staff is trained to lead these Stanford-modeled classes, the Hospital will have the capability to offer additional classes and impact even more members of the community who are living with diabetes.

The first intervention for the Prevent Chronic Disease; focus on childhood obesity priority, which also falls under the prevention area of Promoting Healthy Women Infants and Children, is to adopt policies and practices designed to implement standards that will support breastfeeding, quality nutrition, increased physical activity and reduced screen time in early child care settings and to increase staff training, community support and reinforcement of these regulations and policies. The Hospital has joined New York City's Breastfeeding Hospital Collaborative (NYC BHC) Cohort 3. As is the case for hospitals in the current NYCBHC, Cohort 3 will include in-person learning sessions, monthly action period webinars, semi-monthly coaching calls (participation as needed), mock assessments and site visits, access to a repository of free tools and resources to support pursuit of a "Baby Friendly" designation, and more. A second intervention for the Prevent Chronic Disease, focus on childhood obesity priority is to create a program to help incorporate dance/exercise classes and nutrition education into the lives of pre-teens and their parents. Classes will be offered at the Brooklyn Children's Museum in Crown Heights. NYM will use strategies derived from New York State Obesity Prevention Center for Excellence.

The goal of the first intervention for Promote a Healthy and Safe Environment; reducing fall risk among most vulnerable populations priority is to **i**mprove the design and maintenance of home environments to promote health and reduce related illness, by creating a Fall Prevention Program and assembling Fall Prevention Kits, with tools to help seniors safeguard their homes. NYM will reference the CDC's Guide for EBPs to Prevent Falls. A second intervention is intended to reduce factors that increase the risk of falls, particularly among the elderly and young children by promoting community-based programs for fall prevention. NYM will reference the CDC's Guide for EBPs to Prevent Falls.

The process measures used to track and evaluate the impact of the Prevent Chronic Disease; focus on diabetes priority include information retention quizzes, tracking attendance and attendee goal setting and monitoring achievements during and after each six-week Diabetes Self-Management Education session.

The process measures used to track and evaluate the Prevent Chronic Disease; focus on childhood obesity priority include pre and post class surveys, weight and waist measurements recorded throughout the duration of classes, and attendance tracking. Results will be monitored during and after each dance/education series.

The process measures used to track and evaluate the Promote a Healthy and Safe Environment; reducing fall risk among most vulnerable populations priority include polling senior citizens on regarding home safety measures in place and giving them kits to safeguard their homes. They will also be offered the opportunity to share stories on how they've implemented the safety information that has been provided. To attempt a reduction in the number of admissions due to falls, the Hospital will administer surveys administered to "treat and release" patients who come to the Emergency Room for falls.

Report

1. Provide a short description of the community being served and how the service area has been defined. This could be one county or several counties or parts of several counties. If this is a regional assessment and plan, the plan must describe each county's health issues and identify the process each county used to identify its priorities and how it will contribute to addressing them.

Although New York Methodist Hospital (NYM) is located in Park Slope and is an important healthcare, community service and economic anchor in the Park Slope neighborhood, it serves the entire borough of Brooklyn (Kings County) (Exhibit 1). Brooklyn is the largest of the five boroughs that make up New York City. Indeed, if it were a separate city, Brooklyn would be the fourth largest in the United States.

In 2014, Brooklyn had a total population of over 2.6 million people from a wide variety of ethnic and socioeconomic backgrounds. Of the total number of people in Brooklyn in 2014, 926,640 were white, 826,500 were black, 332,160 were Asian, Native American and Pacific Islanders and 526,110 were Latino. (Those reporting as Latino or Hispanic are of Spanish origin but may be of any race.) While the white and black populations have remained relatively stable, increasing only slightly as the Brooklyn population increased, the Latino population has increased by 13 percent (consistent with Brooklyn's overall population increase) and the Asian, Native American and Pacific Island population has increased by 184 percent, far exceeding the overall Brooklyn increase. (Exhibit 2) The demography of Brooklyn has changed radically since 1990, which is reflected in the ethnic breakdown of Hospital discharges over the past 25 years (Exhibit 3).

At the turn of the 21st century, we were in a period of the largest influx of immigration to New York City since the early 1900s. According to the 2010 US census data, 37 percent of Brooklyn's residents were born outside of the United States and 46 percent of the borough's residents speak a language other than English in the home. What has made this wave of immigration to New York City especially unique is that the patterns of immigration are extremely diverse; of the various countries represented by Brooklyn residents, except for China (13 percent), no single one accounts for more than 10 percent of all first generation immigrants. New York's largest Afro-Caribbean community can be found in the Central Brooklyn neighborhoods of Crown Heights and Flatbush. Southwest Brooklyn (Bensonhurst and Bay Ridge), where Pakistani, Bangladeshi and Southeast Asian immigrants have merged with Russian and Chinese populations, houses the most diverse immigrant community. (Exhibits 4 and 5)

The number of Brooklyn men and women is fairly equal, at 47 percent and 53 percent respectively. Nearly 30 percent of Brookynites have earned a bachelor's degree or higher and 78 percent hold a high school diploma. Twenty-two percent of the Brooklyn population lives below the poverty line. It is well known that the population, in general, is aging and, in Brooklyn, the highest increases in the population are in the "baby boomer" groups (23 percent among those between the ages of 35 and 54; 61 percent among those between the ages of 55 and 59 and 21 percent among those between the ages of 60 and 74)(Exhibit 6).

During the years since 1990, the Hospital, which has seen an increase in its census of over 100 percent, (from 20,696 to 41,582 patients annually), has also increased its service to patients in every one

of Brooklyn's communities. As Exhibit 7 demonstrates, in some cases, the increase within neighborhoods is truly remarkable; for example, while the increase in the population of patients from the Hospital's surrounding areas of Brooklyn Heights, Downtown Brooklyn and Park Slope, is noticeable, it shows a 431 percent increase in patients from the Bedford Stuyvesant and Crown Heights communities, a 363 percent increase from Flatbush/East Flatbush, a 210 percent increase in patients from Canarsie/Flatlands and an 88 percent increase in patients from Sheepshead Bay/Coney Island. In addition, very large increases are evident (although the total numbers are smaller) in the Greenpoint/Williamsburg and East New York neighborhoods.

2. Provide a short summary of health and other data that was reviewed to identify health issues of concern in the community. This could include the Prevention Agenda Dashboard, County Health Rankings and/or other sources of data on demographics and health issues facing the community and the underlying conditions that contribute to their health.

The following l data sets and resources were consulted to conduct the Community Health Needs Assessment (CHNA) and resulting Community Service Plan (CSP):

New York State Prevention Agenda Dashboard 2013-2017
2016 County Health Rankings & Roadmaps - New York Data
Kings County, New York _ County Health Rankings & Roadmaps (2016)
NYS DOH Health Sub-County Health Rankings (2016)
US Census Bureau American FactFinder - Community Facts
2014 Brooklyn DSRIP Community Needs Assessment
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- Obese Adults (2014)
- Obese Adults by Poverty Level (2009-2014)
- Obese Youth (2013)

US Census Bureau 2010-2014 American Community Survey 5-Year Estimates
NYC DOHMH 2015 New York City Community Health Profiles Atlas
NYC DOHMH TCNY 2020 Priorities
NYC DOHMH Vital Statistics Leading Causes of Injury Death (2009-2011)
NYC DOHMH Health Disparities in New York City
Data from NYC Falls Coalition Meeting (Aug 2016)
CDC Morbidity and Mortality Weekly Report
- Falls and Fall Injuries Among Adults Aged ≥65 Years — United States, 2014

CDC Behavioral Risk Factor Surveillance System (BRFSS) Annual Data (2014)

Empire State Pride Agenda Foundation
LGBT Health and Human Services Needs in New York State
Center for American Progress
"How to Close the LGBT Health Disparities Gap"
Social and Personality Psychology Compass Abstract
Weighed Down by Stigma: How Weight-Based Social Identity Threat Contributes to Weight Gain and Poor Health
American Journal of Public Health Abstract
Obesity Stigma: Important Considerations for Public Health

3. Identify the two Prevention Agenda priorities and the health disparity being addressed with community partners including LHDs and hospitals and provide a description of the community engagement process that was used to select or confirm existing priorities.

County, state and zip code data were analyzed to identify the significant health needs in our service area as identified in the Hospital's Community Health Needs Assessment (CHNA). Data on disparities such as minority, income, sexual orientation and obesity stigmas were also reviewed in the CHNA (Attachment 1: CHNA). Discussions with key informants (Exhibit 8) and the results of the Community Health Survey also assisted in the identification of chief areas of concern (Exhibit 9). Chronic diseases with special focus on diabetes, obesity, and cancer were identified with regard to the area of chronic disease; respondents also expressed their desire for exercise programs and healthier food choices. Interest in fall and injury prevention programs was also noted as a serious concern among those surveyed. Below is a prioritized list of the top six results from NYM's Community Health Survey:

1. Diabetes Education/Screenings
2. Exercise Programs
3. Blood Pressure Screenings
4. Preventing Falls/Injuries
5. Healthier Food Choices
6. Cancer Screenings

Answer Choices	Responses	
Diabetes education/screenings	36.59%	75
Exercise programs	32.20%	66
Blood pressure screenings	30.73%	63
Preventing Falls/Injuries	29.27%	60
Healthier food choices	28.78%	59
Cancer screenings	28.78%	59
Cholesterol screenings	20.49%	42
Mental health services	19.51%	40
Nutritional education	19.02%	39
Drug & alcohol rehab services	16.59%	34
Heart disease education	14.15%	29
Dental screenings	12.20%	25
Emergency preparedness info	10.73%	22
Suicide prevention education	8.29%	17
HIV/AIDS & STD information	7.80%	16
Other (please specify) Responses	5.37%	11
Child and adult safety	4.88%	10
Vaccination/immunizations	4.88%	10
Prenatal care	3.90%	8
Total Respondents: 205		

Based on results from the Community Health Survey, discussions with key informants in the community, and review of New York State's Prevention Area Priorities, New York Methodist Hospital has selected the following prevention priorities:

1. Prevent Chronic Disease; focus on diabetes
2. Prevent Chronic Disease; focus on childhood obesity/ (overlaps with) Promote Healthy Women, Infants and Children; focus on maternal and infant health
3. Promote a Healthy and Safe Environment; reducing fall risk among most vulnerable populations

4. For each of at least two Prevention Agenda priorities, identify the goal(s) and objectives, the interventions/strategies/activities you are or will implement, and process measures with measurable and time-framed targets that will be used to track progress over the three-year period. Interventions should be evidence-based or promising practices. They can include activities currently underway and/or new strategies to be implemented. Process measures must be selected to track progress in implementing the strategies.

For each health priority that is or will be addressed:

a) Describe the actions the hospital intends to take to address the health issue and the anticipated impact of these actions
b) Identify resources the hospital will commit to address the health need
c) Describe the actions the LHD intends to take to address the health need and the anticipated impact of these actions
d) Identify resources the LHD will commit to address the health need
e) Describe the roles of other participants, stakeholders, other local governmental agencies, or other community based organizations including business, academia, etc. in addressing the priority
f) State whether the action(s) will address a health disparity and if so, how.

To provide this information, use a work plan chart like the one below. *The roles and contributions of LHDs and hospitals must be explicitly identified, either on one chart or separate charts for each organization.*

Priority/Focus Area:

Goal	*Outcome Objectives*	*Interventions/ Strategies/ Activities*	*Process Measures*	*Partner Role*	*Partner Resources*	*By When*	*Will action address disparity*

For some examples of CHIP work plans that include most of these components, see Appendix 1.

New York Methodist Hospital Community Service Plan 2016-2018 Intervention Chart

Goal	***Outcome Objectives***	***Overview***	***Intervention's evidence base***	***Where intervention will take place***	***Process Measures***
Prevent Chronic Disease: Diabetes	*Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings*	*Offer Diabetes Self Management Education (DSME) classes for community and educate staff to become trainers and lead their own DSMEs*	*Stanford model classes for DSME*	*One series of classes will take place at the Hospital (11215) and we will hold at least one other series of classes in one of our offsite locations in Flatbush, Brooklyn*	*Information retention quizzes, tracking attendance and attendee goal setting and achievements*
	Partner Role	***Partner resources (staff, money, etc)***	***By When***	***Will Action address disparity***	
	IPRO and DOHMH will provide Diabetes Prevention Program Referral/ Clinical-Community Program Linkages (QTAC)	*IPRO will provide DSME trainers and cover the cost for our staff to receive training to lead their own DSMEs*	*Our first DSME class series took place in the fall of 2016; subsequent classes will follow in 2017 and 2018. Staff trainings will take place beginning in 2017*	*Invitations to join the DSME will be sent to people with pre-diabetes or diabetes of all social-economic backgrounds, ages and ethnicities. Classes will be offered in English and Spanish. A cultural sensitivity packet will be distributed to group leaders on how to address the needs of all participants including those who are among the medically underserved*	
Goal	***Outcome Objectives***	***Overview***	***Intervention's evidence base***	***Where intervention will take place***	***Process Measures***
Prevent Chronic Diseases: Childhood Obesity	*Prevent childhood obesity through early child-care and schools*	*Offer parent and child exercise classes after school complemented by nutrition education*	*Institute of Medicine Obesity Prevention*	*Dance and nutrition classes will take place at the Brooklyn Children's Museum's after school program at PS 189 in Brownsville*	*Pre & post class surveys, weight and waist measurements throughout the duration of classes, and attendance tracking*

	Partner Role	***Partner resources (staff, money, etc)***	***By When***	***Will Action address disparity***	
	DanceWave and Brooklyn Museum will help to advertise classes and provide staff and space resources. Investors Bank will provide funding. First sessions will be held as part of Brooklyn Museum's after school program at PS 189 in Brownsville	*DanceWave will provide dance class instructors and Brooklyn Museum will provide location (PS 189). Investors Bank has awarded NYM a 5K grant to carry out the classes*	*Classes to begin within first six months of 2017*	*The classes will be offered in Brownsville, a neighborhood with socio-economic disadvantages and high rates of obesity among children & adults. A cultural sensitivity packet will be distributed to group leaders on how to address the needs of all participants including those who are among the medically underserved. Culturally appropriate nutrition education and materials will be offered.*	
Goal	***Outcome Objectives***	***Overview***	***Intervention's evidence base***	***Where intervention will take place***	***Process Measures***
Prevent Chronic Diseases: Childhood Obesity/ Promoting Healthy Women, Infants, and Children	*Increase the proportion of NYS babies who are breastfed. Expand the role of health care and health service providers and insurers in obesity prevention and become a Baby-Friendly Hospital*	*During the birth hospitalization Increase the percentage of infants born in NYS hospitals who are exclusively breastfed*	*The CDC Guide to Strategies to Support Breastfeeding Mothers and Babies and Baby Friendly USA*	*New York Methodist Hospital*	*Rates of breastfeeding exclusivity among inpatient births. Attendance tracking at Breastfeeding Support Groups*
	Partner Role	***Partner resources (staff, money, etc)***	***By When***	***Will Action address disparity***	
	NYC DOHMH will provide training sessions to help us achieve Baby-Friendly status, WIC peer counselors and breastfeeding moms will provide community input. Will work with Brooklyn's Breastfeeding Empowerment Zone (BEZ).	*NYC DOHMH provides training and support. WIC Peer Counselors provide input on reaching low-income mothers*	*Already in progress, NYM has joined the New York City Breastfeeding Hospital Collaborative (NYC BHC) Cohort 3*	*NYM will attempt to increase rates for all patients including, low-income and minority populations. The Hospital will also seek input from WIC peer counselors to ensure that education and outreach are available and accessible to all audiences*	

Goal	***Outcome Objectives***	***Overview***	***Intervention's evidence base***	***Where intervention will take place***	***Process Measures***
Promote a Healthy and Safe Environ-ment	*Reduce Fall Risks Among the Most Vulnerable Populations*	*Offer fall prevention workshops to seniors and provide them with a "Fall Prevention Kit" to help safeguard their homes*	*CDC's A Guide to Implementing Effective Community-Based Fall Prevention Programs*	*At New York Methodist Hospital and at Hospital's monthly senior seminar series which takes place at centrally located Brooklyn College (11210) and at senior centers throughout Brooklyn. In addition, patients who have come to the ER as a result of having fallen will be educated and enrolled into our Fall Prevention program*	*Polling seniors on how safe their homes are, and giving them kits to make their homes safer. Comparing "before" and "after" number of admissions due to falls*
	Partner Role	***Partner resources (staff, money, etc)***	***By When***	***Will Action address disparity***	
	Senior Umbrella Network of Brooklyn (SUN-B), NYM's ER physicians, and a consulting environmental gerontologist will collaborate on the program. The Brooklyn Public Library (BPL), Heights and Hills Senior Services and Good Neighbors of Park Slope (GNPS) will also lend support.	*Environmental gerontologist provides information sheets on home safety improvement, disseminated by the Hospital and SUN-B.* *BPL, Heights and Hills and GNPS can provide offsite venues/audiences for presentations to seniors*	*Already in progress, will continue throughout the course of this CSP planning and implementatio n phase*	*The program already addresses the elderly and those with difficulty walking. Program materials will be available in several different languages. A cultural sensitivity packet will be distributed to group leaders on how to address the needs of all participants including those who are among the medically underserved*	

5. Briefly describe the process that will be used to maintain engagement with local partners over the next three years, and the process that will be used to track progress and make mid-course corrections.

1. Prevent Chronic Disease; focus on diabetes
   At the end of each six-week DSME session data will be reviewed and assessed by IPRO and NYM. This will provide the opportunity to make mid-course corrections before a new DSME session is offered. For each new DSME session, the Hospital will utilize NYC DOHMH's Patient Referral Portal to list the classes. With this format, partners will be engaged at each newsix6-week session.

2. Prevent Chronic Disease; focus on childhood obesity/Promote Healthy Women Infants & Children; focus on maternal and infant health
   Dance & Nutrition Education Classes: For each session of dance classes, data will be reviewed and assessed by NYM. The data will be shared with the Brooklyn Children's Museum (BCM), Investor's Bank and DanceWave. NYM will also poll BCM and Dancewave to learn whether there are areas for improvement. This will apply to the next session of classes, and the cycle will continue throughout the course of the three-year CSP.

   Baby Friendly Status: The New York City Breastfeeding Hospital Collaborative has its own set of regulations and guidelines for progress tracking and reporting, to which NYM will adhere.

3. Promote a Healthy and Safe Environment; reducing fall risk among most vulnerable populations
   Fall Surveys in ER: The surveys will be conducted for every "treat and release" ER patient over 65 years of age. Survey data will be reviewed and shared with the environmental gerontologist and Emergency Medicine Department on a quarterly basis. Analysis of survey results will help to present if any mid-course corrections should be made.

   The Fall Prevention Program: Progress will be reviewed and shared with partners on a bi-annual basis, at which time it will be decided whether mid-course corrections should be made.

6. Briefly describe plans for the dissemination of the executive summary to the public and how it will be made widely available to the public including providing the website where it can be located.

The Executive Summary of the Community Service Plan will be posted on the Hospital's web site, www.nym.org, and the Hospital's Facebook and Twitter accounts will be used to direct visitors to that portion of the website. Press releases will be sent to all local newspapers announcing its availability on the site or by mail.

Exhibit 1: New York Methodist Hospital Area Service Map

Exhibit 2: Brooklyn Population by Race: 1990-2015

RACE	1990	2000	2010	2015	2015 Percentage (rounded) of Total	Change 1990-2015	Percent Change (rounded) 1990-2013
White	922,290	888,770	907,350	953,660	36%	31,370	3%%
Black	801,830	878,900	822,560	827,400	31%	25,5700	3%
Asian/Other	113,390	207,370	278,730	330,640	13%	217,250	192%
Latino*	466,170	491,960	499,670	515,070	20%	48,900	10%
Total Population	2,303,680	2,467,010	2,508,520	2,626,770	100%	323,090	14%

SOURCE: Woods and Poole Kings County, New York 2015 (and previous) Data Pamphlet

Exhibit 3: New York Methodist Hospital Admissions/Discharges by Race (Including Newborns) 1990-2015 Comparison**

RACE	1990	1995	2000	2005	2010	2015
White		55%	51%	41%	38.2%	42%
Black		19%	29%	39%	37.8%	40%
Asian/Other		NA	NA	4%	8.5%	18%
Latino*		18%	17%	16%	15.5%	
Latino						14%

SOURCE: Finance Department, February 2016

*Latino refers to persons of Spanish origin who may be of any race.
**2015 percentages are based on discharges; all others are based on admissions.
***Calculation method differs from previous years. Latino ethnicity is documented separately from race. Self-identification may be by ethnicity (Latino) or by race (black, white or Asian).

Exhibit 4: Foreign-Born Rank Ordered by Country of Birth: Brooklyn, 2011

	Number	Percent
TOTAL	**946,511**	**100.0**
China	129,219	13.7
Jamaica	70,508	7.4
Haiti	61,550	6.5
Dominican Republic	55,007	5.8
Trinidad and Tobago	50,319	5.3
Mexico	49,977	5.3
Russia	47,631	5.0
Ukraine	43,804	4.6
Guyana	41,637	4.4
Ecuador	25,616	2.7
Poland	22,860	2.4
Barbados	16,375	1.7
Grenada	15,683	1.7
Bangladesh	14,268	1.5
Italy	14,091	1.5
Pakistan	14,026	1.5
Uzbekistan	11,394	1.2
St. Vincent and the Grenadines	10,941	1.2
Panama	10,625	1.1
Israel	9,725	1.0
All Others	231,255	24.4

SOURCE: The Newest New Yorkers - 2013 edition, New York City Department of City Planning
(Sources: U.S. Census Bureau, 2011 American Community Survey)

Exhibit 5: Top Twenty Brooklyn Neighborhoods of Residence for Foreign-Born Population in Brooklyn: 2007-2011

Neighborhood	Number of Foreign-Born	Three Largest Foreign-Born Groups
Bensonhurst	77,682	China, Italy, Russia
Sunset Park	64,029	China, Mexico, Dominican Republic
Flatbush	51,122	Haiti, Trinidad/Tobago
Crown Heights	49,058	Trinidad/Tobago, Jamaica, Haiti
Bushwick	48,528	Dominican Republic/Mexico, Ecuador
Canarsie	39,195	Jamaica, Haiti, Trinidad/Tobago
East New York	36,585	Jamaica, Dominican Republic, Guyana
Prospect Lefferts Gardens/Wingate	32,925	Jamaica, Haiti, Trinidad/Tobago
Borough Park	31,739	China, Israel. Poland
Flatlands	29,877	Haiti, Jamaica, Trinidad/Tobago
Rugby/Remsen Village	29,059	Jamaica, Trinidad/Tobago, Guyana,
Bay Ridge	27,432	China, Greece, Russia
East Flatbush/Farragut	26,658	Jamaica, Haiti, Trinidad/Tobago
Sheepshead Bay/Gerritsen Beach/Manhattan Beach	26,170	Ukraine, China, Russia
Brighton Beach	21,261	Ukraine, Russia, Mexico
Cyprus Hills/City Line	20,982	Dominican Republic, Guyana, Bengladesh
Midwood	20,731	Russia, Ukraine, Pakistan
Dyker Heights	19,001	China, Italy, Poland
Madison	18,682	China, Russia, Ukraine
Homecrest	18,072	Russia, Ukraine, China

SOURCE: The Newest New Yorkers - 2013 edition, New York City Department of City Planning
(Sources: U.S. Census Bureau, 2007-2011 American Community Survey Summary File, Population Division-New York City Department of City Planning)

Exhibit 6: Brooklyn Population by Age 1970-2015

Age	1970	1980	1990	2000	2010	2015	2015 Percent-age of total (round-ed)	Percent Change (round-ed) 1990-2015
Under 5	225,510	176,540	187,390	181,700	177,150	201,440	8%	7%
5-14	460,750	336,410	327,170	371,650	315,760	323,570	12%	-1%
15-34	765,140	744,650	754,870	750,320	792,900	796,950	30%	6%
35-54	584,820	470,390	562,350	677,890	665,780	693,190	27%	23%
55-59	146,730	118,750	94,830	106,470	143,000	153,329	6%	62%
60-74	324,340	278,050	256,230	245,310	278,780	317,040	12%	24%
75+	95,930	107,220	120,850	133,680	135,150	141,270	5%	17%
Total	2,603,210	2,232,000	2,303,680	2,467,010	2,508,520	2,626,770	100%	14%
Median Age	30	30.75	31.92	33.10	34.15	34.80		

SOURCE: Woods and Poole Kings County, New York 2015(and previous) Data Pamphlet

Exhibit 7: Summary of Discharges by Neighborhood, 1990-2015

Neighborhood	1990	1995	2000	2005	2010	2011	2012	2013	2014	2015	Percentage Change (rounded)	
											2013-2014	1990-2014
Greenpoint/ Williamsburg	244	313	563	656	815	833	806	798	904	789	-13%	223%
Downtown B'klyn/Heights/ Slope	5,700	5,436	5,452	5,221	5,845	5,900	5,788	6,491	6,936	6,747	-3%	18%
Bed Stuy/Crown Hts	1,424	2,245	3,449	5,013	6,781	6,982	6,765	7,121	7,565	7,783	3%	447%
East New York	367	409	643	1,026	1,308	1,513	1,420	1,555	1,578	1,618	3%	331%
Sunset Park	1,040	1,034	1,059	947	948	1,054	836	791	843	951	13%	-9%
Borough Park	2,109	2,788	2,911	2,772	3,127	3,119	2,395	2,321	2,263	2,344	4%	11%
Flatbush/East Flatbush	1,252	2,111	2,650	3,455	4,070	4,096	5,614	5,743	5,796	6,017	4%	381%
Canarsie/Flatlands	763	889	1,296	1,779	1,982	2,066	2,358	2,458	2,365	2,398	1%	214%
Bensonhurst/Bay Ridge	1,679	1,744	1,838	1,728	2,022	1,945	1,924	1,934	1,891	2,060	9%	23%
Coney Is/Sheeps-head Bay	1,599	2,565	3,418	3,227	3,031	3,169	3,246	3,296	3,000	3,197	7%	100%
Other/Unknown	1,653	1,909	2,042	1,947	2,954	3,479	3,374	3,501	3,290	3,433	4%	108%
Subtotal	17,810	21,457	25,321	27,771	32,883	34,067	34,526	36,009	36,431	37,337	2%	109%
Newborn	2,886	3,060	3,520	4,461	4,593	4,803	5,033	5,054	5,151	5,044	-2%	75%
Total	20,696	24,517	28,841	32,232	37,476	38,870	39,559	41,063	41,582	42,381	2%	105%

SOURCE: Department of Finance, February 2016

Exhibit 8: Key Informant Meeting Dates and Outcomes

- **4/17/2015:** Meeting with Senior Umbrella Network of Brooklyn (SUN-B) to discuss the need for fall prevention programming in Brooklyn. Partnership established.
    - Participants: Vicki Ellner, Founder and CEO of SUN-B, Angela Villanella, President and Chairperson of SUN-B Board of Directors, Alan Chen, VP/Secretary of SUN-B, Jeff Rosenfeld, Consultant to the Fall Prevention Program of SUN-B, Lyn Hill, Vice President for Communication and External Affairs, NYM, Loren Avellino, Director of Community Outreach, NYM.
- **6/24/2015:** Phone call with St. George's Episcopal Church in Crown Heights, Brooklyn to discuss needs of congregation and partnership at future health fairs. Partnership and participation in health fairs was established.
    - Participants: Denise Harris, NP, St. George's Episcopal Church Health Guild, Loren Avellino, Director of Community Outreach at NYM.
- **9/5/2015:** Meeting with Investors Bank Foundation to discuss grant funding opportunities for patient and community programming. Grant application submitted and NYM was awarded in August 2016.
    - Participants: Jennifer L. Smith, Assistant Vice President, Community Development Officer, Investor's Bank, Megan Schade, Grant Writer, NYM, Amanda Donikowski, Director of Development, NYM.
- **10/19/2015:** Meeting with Heights and Hills Senior Services to discuss needs of the organization's members and partnership opportunities. Community lectures and a Caregivers Support Group were established.
    - Participants: Judy Willig, LCSW, Executive Director, Heights and Hills, Supporting Brooklyn's Older Adults, and Lyn Hill, Vice President for Communication and External Affairs at NYM.
- **10/21/2015:** Phone conference with New York City's Department of Health and Mental Hygiene to discuss the possibility of offering Diabetes Self Management Education programs at NYM. (First class scheduled in September 2016, subsequent classes to follow.)
    - Participants: Stacia Studt, MS, Diabetes Prevention Program Liaison, NYC DOHMH, Victoria Foster, MPH, Manager of Clinical-Community Program Linkages, Primary Care Information Project, NYC DOHMH, Loren Avellino, Director of Community Outreach, NYM, and Mark Doublet, CDE, RD, Diabetes Educator, Diabetes Education and Resource Center, NYM.
- **1/5/2016:** Meeting with Jeff Rosenfeld, Ph.D., physician and nurse from NYM's Emergency Department and NYM community outreach team to discuss fall occurrences and resulting ER visits by elderly patients. Need for a data study on hospital fall admissions and resulting community outreach program were established.
    - Participants: Jeff Rosenfeld, PhD, Environmental Gerontologist, Parsons School of Design, Theodore Gaeta, MD, Vice-Chairman of Emergency Medicine, NYM, Paris Ayana-

Dattilo, RN, Trauma Program Manager, Department of Emergency Medicine, NYM, Lyn Hill, Vice President for Communication and External Affairs, NYM, and Loren Avellino, Director of Community Outreach, NYM.

- **1/7/2016:** Email inquiry and exchange with the United Federation of Teachers to discuss the health concerns of the union's members and seek partnership opportunities. Partnership established and physician lectures arranged.
    - Participants: Brittany Bowden, Health and Cancer Helpline Case Worker, United Federation of Teachers Welfare Fund, and Loren Avellino, Director of Community Outreach, NYM.
- **2/24/2016:** Meeting with NYC DOHMH's Clinical-Community Program Linkages, Primary Care Information Project to discuss implementation of a Diabetes Self-Management Education (DSME) program at NYM and patient referrals into existing workshops listed in the QTAC patient referral portal.
    - Participants: Stacia Studt, MS, Diabetes Prevention Program Liaison, NYC DOHMH, Victoria Foster, MPH, Manager of Clinical-Community Program Linkages, Primary Care Information Project, NYC DOHMH, Loren Avellino, Director of Community Outreach, NYM, Lori Cortina, CDE, RD, Diabetes Educator, Diabetes Education and Resource Center, NYM, and Mark Doublet, CDE, RD, Diabetes Educator, Diabetes Education and Resource Center, NYM.
- **3/16/2016:** Email inquiry and follow-up from Good Neighbors of Park Slope (GNPS) regarding community programming for senior citizens in Brooklyn.
    - Participants: Jasmine Melzer, Good Neighbors of Park Slope, Andi Peretz, Activities Committee Coordinator, GNPS, Lyn Hill, Vice President for Communication and External Affairs, NYM, and Loren Avellino, Director of Community Outreach, NYM.
- **5/5/2016:** Conference call with NYC DOHMH and IPRO to discuss next steps in establishing DSMEs at NYM.
    - Participants: Stacia Studt, MS, Diabetes Prevention Program Liaison, NYC DOHMH, Victoria Foster, MPH, Manager of Clinical-Community Program Linkages, Primary Care Information Project, NYC DOHMH, Maria Regalado, Diabetes Prevention Program Referral Coordinator, Clinical-Community Program Linkages, Primary Care Information Project, NYC DOHMH, Loren Avellino, Director of Community Outreach, NYM, and Janice Hidalgo-Meléndez, Director, Everyone with Diabetes Counts New York, IPRO, Improvement Healthcare for the Common Good.
- **6/9/2016:** Conference call among Brooklyn Hospitals and NYC DOHMH to discuss the possibility of collaborating on a Joint-Community Service Plan. Some common prevention agenda priorities were selected, but the majority of participants did not agree to a joint-plan.
    - Participants: Community Affairs representatives from several Brooklyn hospitals including Lyn Hill, Vice President for Communication and External Affairs, NYM, and Loren Avellino, Director of Community Outreach, NYM, Vidushi Jain, MPH, Community Engagement Coordinator, PHIP, Center for Health Equity, Office of the First Deputy

Commissioner, NYCDOHMH, Ana Gallego, MPH, Director of Policy and Health Systems Analysis, Office of the First Deputy Commissioner, NYC DOHMH

- **6/13/2016:** Phone call with Minister John Williams of New Creation Community Health Empowerment, Inc. (NCCHE) to discuss prevalence of diabetes in West Indian communities of Brooklyn.
    - Participants: Minister John Williams of New Creation Community Health Empowerment, Inc. (NCCHE) and Loren Avellino, Director of Community Outreach, NYM.
- **6/22/2016:** Meeting with Senior Umbrella Network of Brooklyn (SUN-B) to discuss next partnership terms and sponsorship of the organization's Fall Prevention Program. NYM signed on as the sole Hospital sponsor of SUN-B's Fall Prevention Program.
    - Participants : Vicki Ellner, Founder and CEO, SUN-B, Alan Chen, VP/Secretary, SUN-B, Lyn Hill, Vice President for Communication and External Affairs , NYM, Loren Avellino, Director of Community Outreach, NYM.
- **7/14/2016:** Meeting with Brooklyn Public Library (BPL) representatives to discuss funding and partnership opportunities. Contact between director of community outreach at NYM and director of corporate relations at BPL established.
    - Participants: Lauren Arana, Director of Individual Giving, BPL, Development, Lyn Hill, Vice President f for Communication and External Affairs. NYM, Samantha Dodds, Director of Corporate Relations, BPL.
- **8/2/2016:** Meeting with Brooklyn Public Library representatives to discuss collaborations in community programming and scope of partnership.
    - Participants: Samantha Dodds, Director of Corporate Relations, BPL, Taina Evans, Coordinator, Older Adults Services, BPL, Sheila Schofer, Coordinator of Young Adult Services, BPL, Sharron Leahy, BPL, and Loren Avellino, Director of Community Outreach, NYM.
- **8/11/2016:** Phone call with Brooklyn Children's Museum representative to discuss the possibility of offering Diabetes Self Management Education programs and dance classes at the museum. Next steps were established to implement classes in 2017.
    - Participants: Stephanie Wilchfort, President and CEO, Brooklyn Children's Museum, and Loren Avellino, Director of Community Outreach.
- **10/21/2016:** Phone call with Park Slope YMCA to discuss partnership opportunities for community outreach.
    - Participants: Tara Hopkins, Program Director at the Park Slope YMCA, and Loren Avellino, Director of Community Outreach.
- **10/21/2016:** Follow-up phone call with Brooklyn Children's Museum to discuss next steps in planning for a children & parents exercise program. It was concluded that it will focus mostly on children at the Museum's afterschool program, located at PS 189 in Brownsville.
    - Participants: Petrushka Bazin Larsen, Vice President, Programs & Education at the Brooklyn Children's Museum, and Loren Avellino, Director of Community Outreach.

Exhibit 9: Results of Community Health Survey (as of October 2016)