2022–2024
IRS Implementation Strategy & NYS Community Service Plan

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

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

Kingsbrook Jewish Medical Center
585 Schenectady Avenue
Brooklyn, NY 11203
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2022 Community Service Plan Cover Page

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

Brookdale Hospital Medical Center	**Interfaith Medical Center**	**Kingsbrook Jewish Medical Center**
One Brookdale Plaza	1545 Atlantic Avenue	585 Schenectady Avenue
Brooklyn, NY 11212	Brooklyn, NY 11213	Brooklyn, NY 11203
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2022-2024
COMMUNITY HEALTH NEEDS ASSESSMENT
IMPLEMENTATION STRATEGY
and
COMMUNITY SERVICE PLAN

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Introduction

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

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

This document contains the 2022-2024 Community Health Needs Assessment (CHNA), federal Implementation Strategy (IS), and New York State Community Service Plan (CSP) for OBH and its member hospitals, Brookdale, Interfaith, and Kingsbrook, which are all located in Medically Underserved Areas of Central and Northeast Brooklyn, New York (Kings County). This report will serve as a single planning document that will guide community health planning efforts and fulfill state and federal health law requirements regarding a CHNA, IS, and CSP for the 2022-2024 cycle. The report will be available on OBH websites such as https://onebrooklynhealth.org/; visitors to the website will be able to access, download, and print a hard copy of the report for free. A paper copy will be available to the public without charge by

contacting the offices of OBH/Interfaith Strategic Planning, Brookdale External Affairs, or Kingsbrook Public Affairs.

The OBH Board of Trustees approved this plan on December 24, 2022.

A. Executive Summary

1. In 2016, Brookdale Hospital Medical Center (Brookdale), Interfaith Medical Center (Interfaith), and Kingsbrook Jewish Medical Center (Kingsbrook) applied for and received from the NYS Public Health and Planning Council approval to establish One Brooklyn Health System (OBH), a tax-exempt NY not-for-profit corporation that will preserve and enhance health care services in Central and Northeastern Brooklyn. In April 2018, OBH became the active parent of the three system hospitals with representatives from the previous hospital boards becoming members of the new OBH board of trustees.

OBH member hospitals have collaborated to develop shared community health goals and have identified a total of five shared Prevention Agenda priorities for the 2022-2024 community health planning period**: Prevent Chronic Disease, Promote Well-Being and Prevent Mental Health and Substance Use Disorders, Promote Healthy Women, Infants and Children, Promote a Healthy and Safe Environment,** as well as **Prevent Communicable Diseases.** The OBH hospitals will collaborate with community partners to address premature mortality caused by disproportionately high rates of chronic diseases. The plan will be executed at the different member facilities to address the specific needs identified by the communities served.

	One Brooklyn Health System			
Prevention Agenda Priority 2022-2024	**Brookdale**	**Interfaith**	**Kingsbrook**	**OBH**
Prevent Chronic Diseases	✔	✔	✔	✔
Promote Well-Being and Prevent Mental and Substance Abuse Disorders	✔	✔	✔	✔
Promote a Healthy and Safe Environment		✔	✔	✔
Promote Healthy Women, Infants and Children	✔	✔	✔	✔
Prevent Communicable Diseases	✔	✔	✔	✔

2. OBH and its member hospitals reviewed community health data from County Health Rankings, City Health Dashboard, NYC Neighborhood Health Atlas, Take Care New York, NYC Department of Health and Mental Hygiene (DOHMH) 2018 Community Health Profiles, NYC Speaks Survey, hospital clinical diagnosis and treatment data for OBH patients, "The Brooklyn Study: Reshaping the Future of Healthcare", and other data to identify priorities. In addition, OBH participated in the Greater New York Hospital Association (GNYHA) Community Health Needs Assessment Survey Collaborative and used the resulting shared questionnaire to survey local residents about health issues in the service area. A series of focus groups provided more in-depth discussion with community stakeholders. This research and analysis serve as the cornerstone of OBH's community service plan and guided OBH's selection of Prevention Agenda priorities, goals, and interventions.
3. OBH and its member hospitals will partner with community and faith-based organizations (CBOs and FBOs), other healthcare service providers in the community, elected officials representing OBH's service areas, NYC DOHMH Brooklyn Neighborhood Health Action Center through local City Council initiatives, NYS DOH, businesses, health plans, community advisory boards/councils, and other stakeholders to address health needs. OBH recognizes the importance of cross-sector collaboration as key to addressing social determinants of health and community engagement. In addition, Brookdale's Community Advisory Board, the Coalition to Transform Interfaith and Kingsbrook's Community Leadership Council are comprised of members of the community, faith leaders, and health partners who are charged with ensuring the voice of their community is represented and convene regularly to provide a community forum for updates on hospital activities and sponsor or publicize community health initiatives.

The evidence-based interventions that OBH will implement were selected after review of the reports, surveys, and community health data detailed above in section A.1.2 and chosen from the NYS Prevention Agenda Action Plans with their corresponding Focus Area, Goals, and Interventions. As stated in OBH's Mission Statement, OBH has embraced an integrated care system that provides greater access to health care while providing a person-centered approach to care. OBH provides greater access to healthcare while recognizing and respecting the diversity that makes up the communities served. It is with this philosophy of care that OBH has a unified Priority Agenda while tailoring the needs to the prevention plan that addresses both similar and unique interventions based on available resources, existing partnerships, and community input. Evidence-based interventions will be transformed to account for the unique cultural make-up of the communities served by each hospital, allowing for a comparison of outcomes across the healthcare system. This will enable OBH to identify best practices in addressing each priority area for future dissemination across the health system. Each of the hospitals have selected evidence-based interventions to address the same goals in their shared Priority areas:

NYS Prevention Agenda 2022-2024 – One Brooklyn Health System	
Priority Area	**Goal**
Prevent Chronic Disease	Focus Area 4: Preventive Care and Management Goal 4.3: Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes/prediabetes and obesity
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance Use Disorders Goal 2.4: Reduce the prevalence of major depressive disorders
Promote Healthy Women, Infants and Children	Focus Area 1; Maternal & Women's Health Goal 1.2: Reduce maternal mortality & morbidity
Promote a Healthy and Safe Environment	Focus Area 3: Built and Indoor Environments Goal 3.2.b. Increase the number of residences that are inspected for lead and other health hazards.
Prevent Communicable Diseases	Focus Area 1: Vaccine-Preventable Diseases Goal 1.2: Reduce Vaccination coverage disparities

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

Brookdale: will focus on interventions that will address the following Priority Areas: Prevent Chronic Diseases, Promote Well-being and Prevent Mental Illness and Substance Use Disorders, and Promote Healthy Women, Infants, and Children. Interventions include: expanded screenings, disease management, patient education and optimizing EPIC (EMR) to support patient tracking and disease management and incorporating evidence-based care into Patient-Centered Medical Home (PCMH) model.

Focus Area, "Prevent Mental and Substance Use Disorders" will see the expansion and implementation of IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) collaborative care model. IMPACT is an intervention for patients who have a diagnosis of major depression or dysthymia, often in conjunction with another major health problem. IMPACT will be implemented within the framework of Brookdale's PCMH and will screen all patients 12 years of age and older with the Patient Health Questionnaires 2 and 9 (PHQ-2/PHQ-9), a clinically validated tool for depression; Alcohol Use Disorders Identification Test (AUDIT-C/AUDIT) questionnaire and/or the Drug Abuse Screening Tests (brief and long form) (DAST-1/DAST-10). The IMPACT model is an evidence-based and "simpatico" tool that in addition to the Prevention Agenda is an asset to OBH's recently promulgated behavioral health strategic plan which has as one of its five (5) key goals, strengthening ambulatory integration of behavioral and physical health services.

To further support healthy women and children, one of Brookdale's goals related to the Maternal and Women's Health Focus area is to reduce maternal mortality and morbidity by facilitating small groups of pregnant women usually cohorted by due date in the Centering Pregnancy Program. The program promotes greater provider and patient contact, patient empowerment, friendships and better birth outcomes. Brookdale is planning the addition of the Centering Pregnancy Coordinator to the OB/GYN department staff to expand the program.

Interfaith: proposes a multi-pronged approach to address the five foci of the Priority Agenda. To support achieving the priority of Prevent[ing] Chronic Disease, Interfaith will implement expanded access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone. To support achieving Promote Well-Being and Prevent Mental and Substance Use Disorders, Interfaith will implement intervention *Strengthening resources for families and caregivers*. To support achieving Promote Healthy Women, Infants and Children Interfaith will implement intervention *Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing*.

Kingsbrook: Having graduated to an Advanced Primary Care NYS certification-PCMH practice, Kingsbrook will support goal 4.3: Promote the use of evidenced-based care to manage chronic diseases. This will be achieved by providing primary care and chronic disease treatment via a set of standards that describe clear and specific criteria, including organizing care around patients, working in teams to coordinate and track care over time, increasing screening rates for cardiovascular diseases, diabetes, breast, cervical and colorectal cancers, especially among

populations experiencing health disparities. Kingsbrook will increase use of primary and preventive health care services by women of all ages with a focus on women of reproductive age.

All OBH hospitals' interventions have been selected to address the health disparity of premature mortality: Black/African-American New Yorkers die of the same leading causes of death as non-Black/African-American New Yorkers at a rate 45% higher than the general population.

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

Program monitoring will be the responsibility of the OBH Strategic Planning Committee (SPC). The SPC is a multidisciplinary committee comprised of subject-matter experts in community advocacy, quality assurance, planning, administration, medicine, and business who have had tenure on the original hospital boards, prior to the facilities merging. The SPC meets regularly, at a minimum, bi-monthly. A program monitoring tool will be standardized across the

three sites and representatives of each facility will present progress on quarterly basis. This will allow for timely program modifications and corrective action plans based on the data.

B. Community Health Assessment

Community Description, Demographics, and Data

1. OBH member hospitals have come together to create this comprehensive community health needs assessment and community service plan; the collaborating facilities are all located in Kings County (Brooklyn) and have defined their community assessed as Central and Northeastern Brooklyn, demarcated by shared primary and secondary neighborhoods and ZIP codes:[1]

		OBH Service Areas by Facility		
UHF Neighborhood	**ZIP Codes**	**Brookdale**	**Kingsbrook**	**Interfaith**
Bedford Stuyvesant/Crown Heights	11212	Primary	Primary	Secondary
East New York/ New Lots	11207	Primary	Secondary	Secondary
East New York/ New Lots	11208	Primary	Secondary	Secondary
Bedford Stuyvesant/Crown Heights	11233	Secondary	Secondary	Primary
Canarsie and Flatlands	11236	Secondary	Primary	Tertiary
Canarsie and Flatlands	11234	Tertiary	Tertiary	Tertiary
Canarsie and Flatlands	11239	Tertiary	Tertiary	
East Flatbush	11203	Tertiary	Primary	Tertiary
Bedford Stuyvesant/Crown Heights	11213		Primary	Primary
Bedford Stuyvesant/Crown Heights	11216		Tertiary	Primary
Bedford Stuyvesant/Crown Heights	11238			Secondary
Downtown Brooklyn/Heights/Slope	11205			Tertiary
Downtown Brooklyn/Heights/Slope	11217			Tertiary
East Flatbush	11210		Tertiary	Tertiary
East Flatbush	11225		Secondary	Secondary
East Flatbush	11226		Secondary	Tertiary
Williamsburg/Bushwick	11206			Tertiary
Williamsburg/Bushwick	11221		Tertiary	Secondary

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

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

The data and discussion for the following sections have been compiled from the New York City Department of Health and Mental Hygiene (NYC DOHMH) Community Health Profiles 2018.[2] This is the most recent data for the primary and secondary service areas with data at that level of granularity. The OBH primary and secondary service area ZIP codes are: 11212, 11207, 11208, 11233, 11236, 11203, 11213, 11216, 11238, 11225, 11226 and 11221. These correspond to Brooklyn's Community Districts 3, 5, 8, 9, 14, 16, 17 and 18. The Community Health Profiles for these Community Districts were used to assess the community health status and compare them to Brooklyn and New York City overall.

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

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

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

Table 1. Life Expectancy and Premature Mortality

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

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

Prospect Heights (CD-8) both have HIV diagnosis rates more than twice the Brooklyn average: 55.1 and 44.3, respectively.

Table 2. HIV Diagnoses

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

Table 3. Obesity, Diabetes and Hypertension in Adults

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

The comparison of obesity, diabetes and hypertension rates in adults for the OBH service area is mixed (Table 3). Brownsville (CD-16) has an obesity rate of 41%, the 3rd highest in NYC, however, at a 13% rate for diabetes and hypertension, Brownsville is similar to the Brooklyn and NYC averages (12% and 11%, respectively). Other poorly ranked neighborhoods include East

New York and Starrett City (CD-5) ranking 8th highest in obesity rate and South Crown Heights and Lefferts Gardens (CD-9) and Flatlands and Canarsie (CD-18) ranking 9th and 10th highest in hypertension rates, respectively. All of the OBH community districts have diabetes rates higher than the Brooklyn and NYC average.

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

Table 4. Psychiatric Hospitalizations

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

In the OBH service area, residents experience economic stress (Table 5) in various forms. Most of the community districts have a higher percentage of residents living below the poverty

level compared to Brooklyn and NYC overall (21% and 20%, respectively). The exceptions to this are CD-3 East Flatbush (19%) and CD-18 Flatlands and Canarsie (15%), which have lower percentages than both Brooklyn and NYC; CD-8 Crown Heights and Prospect Heights has a poverty level of 21%, the same as Brooklyn and slightly higher than NYC. Within the service area, OBH serves neighborhoods with a wide range of poverty level percentages. CD-5 East New York and Starrett City have the highest poverty level (30%) and is the 7th highest in New York City and CD-18 Flatlands and Canarsie has the lowest (15%). Another indicator of the economic realities faced by Central Brooklyn is insurance coverage. OBH patients are mainly insured through Medicaid and Medicare, and depend disproportionately on local safety net providers such as these hospitals. Almost all the neighborhoods that OBH hospitals serve have the HHS-designations of Health Professional Shortage Area (HPSA) and/or Medically Underserved Area (MUA).[3] Some of the factors that result in poor health outcomes for the population as a result of

Table 5. Economic Stress

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

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

this area designation include high disease burden, lack of access to care, a shortage of primary care doctors, linguistic and cultural isolation, and low health literacy. Using another measure of economic stress, the rent burden is high in the OBH service area. Rent burden is defined as homes whose gross rent (including utilities) is equal to or higher than 30 percent of household income in the past 12 months. Ranging from 50% to 57% in the OBH service area, rent burden is elevated, but not extreme when compared Brooklyn (52%) and NYC (51%).

Part of the economic stress felt by community residents is influenced by increasing cost of living. The data and discussion for housing affordability in the OBH service area presented below are from the NYU Furman Center's State of New York City's Housing & Neighborhoods in 2021. This report is published annually, and provides data and analysis about New York City's housing, land use, demographics and quality of life for each borough and each of the 59 community districts. For all years, the report includes a broad citywide analysis of New York City's housing and neighborhoods. In addition, data profiles are available for each of the boroughs and community districts. Each year, the report has a focus area of study. In 2021, the focus area was the geography of new housing units built over the last decade. It examined the number and distribution of new market-rate and income-restricted units. The report also analyzed the demographics of the areas where income-restricted and market-rate units were built.

For the purposes of this report, data was extracted from the neighborhood profiles across the OBH service area and compared to averages in Brooklyn and New York City. One indicator of economic stress is the increase in median rent. While median rents and overall cost of living have increased across the city, some neighborhoods have seen steeper increases than others (Table 6.). From 2007 to 2019, median gross rent increases varied widely in the OBH service

area. East New York and Starrett City (CD-5) had the smallest increase at 8%, compared to Bedford Stuyvesant (CD-3) at 47%. Crown Heights and Prospect Heights (CD-8) and Brownsville (CD-16) also experienced large increases in median rent. Other neighborhoods were closer to the average increases in Brooklyn (28%) and New York City (23%) such as Flatbush and Midwood (CD-14) at 25%. The increasing cost of rent compounds the economic stress as indicated in the previous section.

Table 6. Real Median Gross Rent in OBH Service Area (2021$)

Brooklyn Community District	Neighborhood	2007	2011	2015	2019	% Change 2007-2019
3	Bedford Stuyvesant	$1,030	$1,100	$1,380	$1,510	47%
5	East New York and Starrett City	$1,170	$1,230	$1,240	$1,260	8%
8	Crown Heights and Prospect Heights	$1,130	$1,250	$1,360	$1,630	44%
9	South Crown Heights and Lefferts Gardens	$1,180	$1,250	$1,400	$1,510	28%
14	Flatbush and Midwood	$1,250	$1,350	$1,470	$1,560	25%
16	Brownsville	$840	$980	$970	$1,170	39%
17	East Flatbush	$1,220	$1,270	$1,370	$1,500	23%
18	Flatlands and Canarsie	$1,380	$1,390	$1,480	$1,530	11%
-	Brooklyn	$1,220	$1,310	$1,440	$1,560	28%
-	New York City	$1,270	$1,380	$1,480	$1,560	23%

While the increasing cost of rent can be attributed to a variety of factors, it can also be offset by the addition of new housing units. In addition, income-restricted housing can provide relief for households that qualify. Across the city, most of new units targeted to low-income households were in neighborhoods with higher Black and Hispanic populations, higher poverty rates and lower sales prices and rents, compared to the neighborhoods with new market-rate units. Of all the boroughs, the Bronx had the largest portion of new low-income targeted units, followed by Brooklyn with the second most. Table 7 shows the number and distribution of new

Table 7. New Housing Units, by Income Level Restriction (2010-2020)

Brooklyn Community District	Neighborhood	Market Rate Units	Moderate and Middle-Income Units	Low Income Units	Income Targeting Unknown	Total New Units
3	Bedford Stuyvesant	4,902 (83%)	247 (4%)	759 (13%)	4 (0%)	5912
5	East New York and Starrett City	248 (7%)	26 (1%)	3,265 (92%)	7 (0%)	3546
8	Crown Heights and Prospect Heights	2,415 (70%)	299 (9%)	720 (21%)	94 (3%)	3474
9	South Crown Heights and Lefferts Gardens	1,595 (57%)	186 (7%)	1,023 (36%)	0 (0%)	2803
14	Flatbush and Midwood	2,146 (83%)	190 (7%)	264 (10%)	0 (0%)	2600
16	Brownsville	283 (13%)	57 (3%)	1,934 (85%)	16 (1%)	2262
17	East Flatbush	1,666 (74%)	445 (20%)	129 (6%)	0 (0%)	2240
18	Flatlands and Canarsie	112 (100%)	0 (0%)	0 (0%)	0 (0%)	112
-	Brooklyn	52,402 (74%)	3,276 (5%)	15,127 (21%)	129 (0%)	70851
-	New York City	125,615 (68%)	7,100 (4%)	51,950 (28%)	1,577 (1%)	185629

units in the OBH service area. Data regarding income-restricted units came from a variety of sources with limitations to data granularity. Because of this, the calculations in this report should be read as conservative estimates. Actual counts may be higher in some areas. Flatlands and Canarsie (CD-18) is reported to have much fewer new units than any of the other neighborhoods, and none had income targeting. This may be due to the lack of data. As reported, Bedford Stuyvesant (CD-3) had the highest number of new units at 5912. However, most of these (83%) were market-rate. On the other hand, East New York and Starrett City (CD-5) had the second highest total new units (3546). 92% were low-income targeted, and this area had the lowest increase in median rent prices. This may indicate a relationship between median

rent increase and the development of new housing units. That is, a high proportion of low-income units and a high total number of new units can help curb rising prices. However, this direct relationship is not obvious for all the neighborhoods. This may be due to the data limitations mentioned above, but it also indicates that there are other influencing factors. Overall, these increasing rent prices contribute to the economic stress for local residents. And while the new income-targeted units can help relieve this stress, many more units are needed meet demand and to curb the high rent increases.

OBH Service Area Demographics

The following tables describing OBH's service area demographics and data are sourced from the New York City Population FactFinder, which provides "detailed population profiles showing critical demographic, social, economic, and housing statistics."[4] The data are based on the 2016-2020 American Community Survey:

Table 8: OBH Service Area Population Census		
Zip Codes Included	11203, 11207, 11208, 11212, 11213, 11216, 11221, 11225, 11226, 11233, 11236, 11238	
Brooklyn Community Districts	3, 5, 8, 9, 14, 16, 17, 18	
	Number	*Percent*
Total population	1,158,585	100.00%
Male	530,130	45.80%
Female	628,455	54.20%
Females of child bearing age (15-44)	267,076	23.05%
Median age (years)	35.8	
Under 19 years	282,614	24.39%
65 years and over	159,691	13.80%

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

Table 9: Race, Ethnicity and Citizenship Status		
Race/Hispanic Origin	*Number*	*Percent*
Total population	1,158,585	-
Hispanic/Latino (of any race)	191,341	16.50%
White Non-Hispanic	221,339	19.10%
Black/African American Non-Hispanic	655,382	56.60%
Asian Non-Hispanic	50,337	4.30%
Other race Non-Hispanic	40,186	3.4%
Place of Birth		
Total population	1,158,585	-
Native-born	749,368	64.70%
Born in United States	716,438	61.80%
Born in Puerto Rico, U.S. Island areas, or born abroad to American parent(s)	33,930	2.90%
Foreign-born	409,217	35.350%
Naturalized U.S. citizen	268,487	65.60%
Not a U.S. citizen	140,730	34.40%

Table 10: Insurance, Employment and Education		
Insurance Status	*Number*	*Percent*
Total Population	1,152,983	-
With health insurance coverage	1,076,143	93.30%
With private health insurance	650,296	56.40%
With public coverage	526,332	45.60%
No health insurance coverage	76,840	6.70%
Employment Status		
Population 16 years and over	927,034	-
Civilian labor force	577,869	62.30%
Employed	536,340	57.90%
Unemployed	41,529	4.50%
Not in labor force	348,838	37.60%
Unemployment rate	-	7.20%
Educational Attainment		
Population 25 years and over	799,879	-
Less than 9th grade	52,315	6.50%
9th to 12th grade, no diploma	65,967	8.20%
High school graduate (or equivalency)	240,662	30.10%
Some college, no degree	126,701	15.80%
Associate's degree	56,264	7.00%
Bachelor's degree	160,490	20.10%
Graduate or professional degree	97,480	12.20%

Health Challenges and Social Determinants of Health

The Governor's Vital Brooklyn Initiative recognizes that Central Brooklyn is one of the most disadvantaged areas in all of New York State with social and economic indicators demonstrating measurably higher rates of obesity, diabetes and high blood pressure, limited access to healthy foods or opportunities for physical activity, high rates of violence and crime, wide economic disparities from unemployment, and poverty levels, and inadequate access to high quality health care and mental health services. [5] The New York State Department of Health (NYS DOH) has recognized that without Brookdale University Hospital Medical Center (Brookdale), Interfaith Medical Center (Interfaith) and Kingsbrook Jewish Medical Center (Kingsbrook) vulnerable communities with the highest health care disparities in New York City and New York State would not receive essential health care services.

Community Assets

3. All OBH hospitals are active members of the Community Care of Brooklyn (CCB) a community coalition that was borne from the DSRP initiative that ended in March of 2020. CCB has facilitated the strengthening of community assets in part by promoting hospital and community-based organization collaboration. CCB has built a high functioning and collaborative network of key stakeholders in Brooklyn including community-based organizations (CBOs), Federally Qualified Health Centers (FQHCs), Managed Care Organizations (MCOs), behavioral health providers, physicians, social services organizations, hospitals and others to jointly develop and implement initiatives to improve health. Together, this network has improved access to physical

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

and behavioral health care; provided care management to vulnerable populations; strengthened primary care; increased access to palliative care; and engaged communities to address social determinants of health throughout the borough.

Interfaith Medical Center

Much of the Prevention Agenda was supported by DSRIP-funded projects. DSRIP ended in March of 2020 and much of the programming was modified and some of the programs became part of the facility's service delivery model. They include:

The Asthma Home Management Program which is comprised of Community Health Workers (CHW) conducting home visits with environmental assessments that identify triggers and mitigation opportunities continues beyond the funding period. CHWs work with patients and the care team on the results of a home-based assessment as well as required follow-ups for other referrals and provide asthma self-management education. Currently there are 30 adults and 56 children enrolled in this program.

PCMH+ Initiative Chronic Disease Management Program Through DSRIP, Interfaith received funding for two Health Coaches who develop care plans and self-management goals for patients living with cardiovascular disease, obesity and diabetes. The program continues post-DSRP in a modified format. The Health Coaches are still part IMC's service delivery team and continue to assist in healthcare planning. The level of reporting has been modified.

Collaborative Care Program (IMPACT) continues beyond the DSRIP cycle. The integration of behavioral health care with primary care is now widely considered an effective strategy for improving outcomes for individuals with behavioral health conditions. The

Collaborative Care Program, also known as the Improving Mood – Providing Access to Collaborative Treatment (IMPACT) model, enhances routine primary care by adding two key services in addition to counseling services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving. Interfaith conducts behavioral screenings of primary care patients to identify patients who screen positive for depression, anxiety and other mental health conditions who may benefit from brief counseling and behavioral interventions such as Problem-Solving Treatment, Cognitive Behavioral Therapy and Behavioral Activation.

Kingsbrook Jewish Medical Center

Integration of Behavioral Health and Primary (Population Health)

OBH received capital funding from the Kings County Healthcare Transformation Grant to strengthen mental health and substance abuse infrastructure across systems. Funding was also secured to increase early access to and retention in HIV care. A modified collaborative care model ("IMPACT") has been implemented, which integrates behavioral health into primary care settings. Integrated HIV/HCV screenings and care navigation have been instituted in Kingsbrook's Outpatient Specialty Centers and the Emergency Room.

Vital Brooklyn Community Assets

In response to the community's identification of housing needs, OBH began a collaboration with NYS Homes and Community Renewal (HCR) to advance the Vital Brooklyn initiative's $578 million commitment to build 4,000 units of affordable housing in Central Brooklyn. Specifically, OBH has made parcels and/or buildings on its campuses available to be

re-purposed for the development of this critical resource to address an important social determinant of health. For example:

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

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

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

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

The projects are on schedule. Buildings on three of the projects have been erected and now units are being finalized. The 57-unit development has not broken ground yet but is part of the next phase. See the following table for progress.

OBH/IMC - VITAL BROOKLYN HOUSING HEALTHCARE ACCESS SITES			
VITAL Brooklyn Site	**OBHS Campus**	**# of Units**	**Anticipated Completion / Occupancy**
Site B: East 98th Street ("Brookdale Hospital") - HCR	**Brookdale**	152	N/A
Site A: 483-503 Herkimer Street ("Herkimer Gardens") - HCR	**Interfaith**	121	22-Dec
Site C: 1038 Broadway ("The Hart") - HCR	**Interfaith**	57	23-Dec
Site D: 528 Prospect Place ("Interfaith Bishop Walker") - HCR	**Interfaith**	N/A	N/A
Site I: 528 Prospect Place ("Bishop Walker Annex") - HCR	**Interfaith**	42	TBD
Site J: 1366 East New York Avenue ("The Rise") - HCR	**Interfaith**	66	Q1 2024
Sites E, F, G, H: 585 Schenectady Avenue ("Kingsbrook Estates") - HCR	**Kingsbrook**	266	May-24

Assessment Methods and Sources

Community Health Needs Assessment Survey

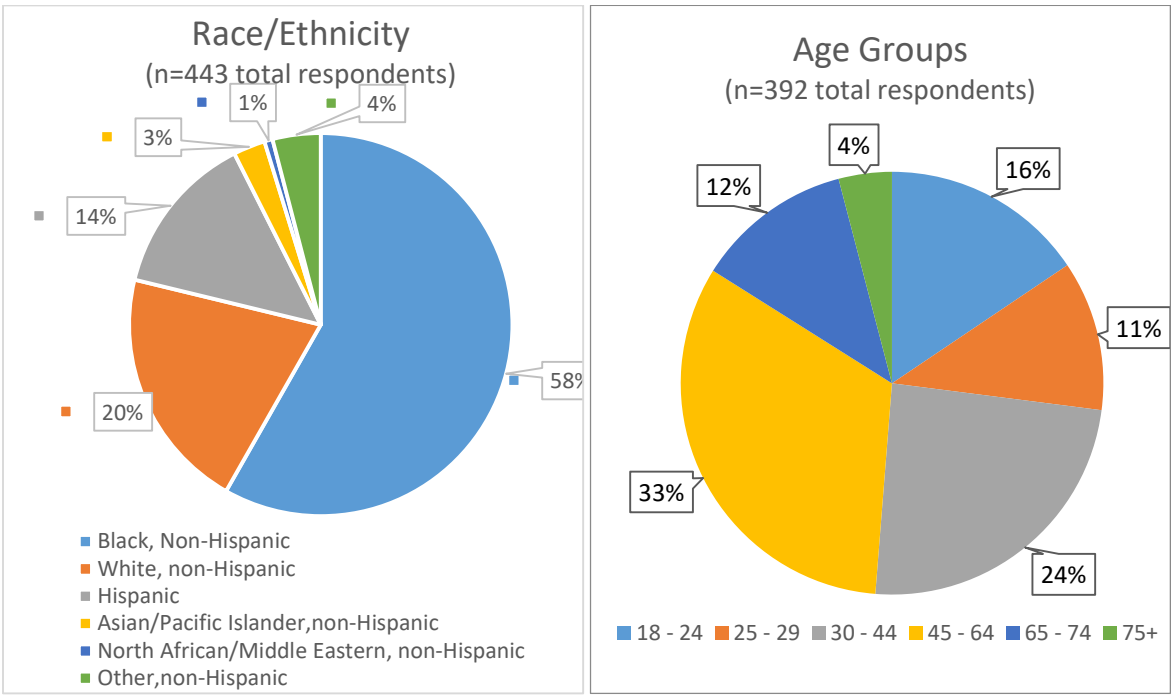
Greater New York Hospital Association (GNHYA) convened a Community Health Needs Assessment Survey Collaborative. Through this collaborative, member hospitals used a common survey tool that was disseminated throughout their communities. GNYHA developed a common community survey with input from GNYHA community health staff, GNYHA survey and outcomes research staff, and participating hospital members. Best practice approaches in survey design and needs assessment were used in the survey's development. Some questions were drawn from the existing Behavioral Risk Factor Surveillance Survey 2020 and the New York City Community Health Survey. Additional questions were developed to learn more about the impact of the COVID-19 pandemic, and telehealth access. The finalized survey questions were translated into ten languages: Arabic, Bengali, Chinese, Haitian Creole, Italian, Korean, Polish, Russian, Spanish and Yiddish. GNYHA developed an online, mobile friendly survey

form. The online survey was launched in April 2022 and ran through June 2022. The online survey was accessible through a custom URL and a QR code.

OBH and many other hospitals in New York City participated in the CHNA Survey Collaborative. At OBH, the online survey link was shared electronically in the email newsletter, staff intranet portals, member hospital websites and on social media accounts. The survey link was also shared with community partners and at outreach events. Flyers and posters with the URL and QR code were displayed at various OBH sites: hospital lobbies, off-site clinics, waiting rooms, etc. Following the closure of the online survey in June 2022, GNYHA compiled and analyzed the data from across the state. OBH provided the zip codes that defined its service area and GNHYA delivered the raw dataset and summary report of the surveys collected from residents in the OBH service area zip codes. The initial dataset provided by GNYHA had results from 439 respondents.

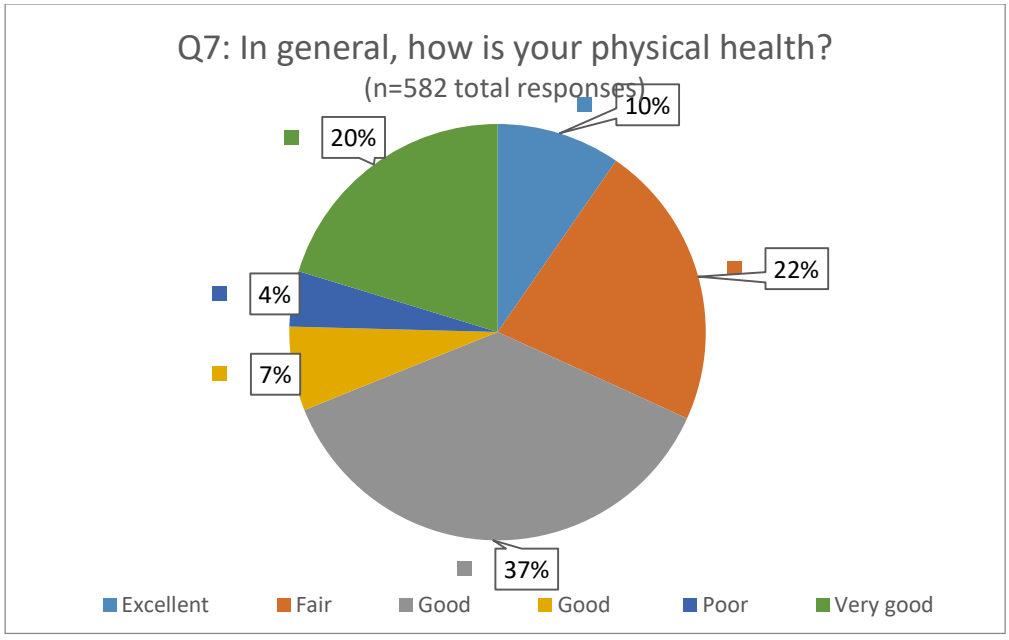
To supplement the data from the GNYHA online survey, paper surveys were also administered by OBH staff members at community events and meetings. In the GNYHA dataset, the demographics of the survey respondents skewed older; the 45 to 64 years age group was overrepresented compared to the population estimates from the 2020 American Community Survey. Additional paper surveys were conducted in August and September at community events. At these community events, OBH staff members targeted respondents that reside in the service area zip codes and were ages 18-44 years old. The responses from these paper surveys were entered manually and combined with the GNYHA dataset. This combined dataset had 585 surveys, and better represented the overall population in the service area. The complete dataset was cleaned and re-analyzed to determine the health concerns and priorities of local residents.

Figure 1: Community Health Needs Assessment Survey Demographics



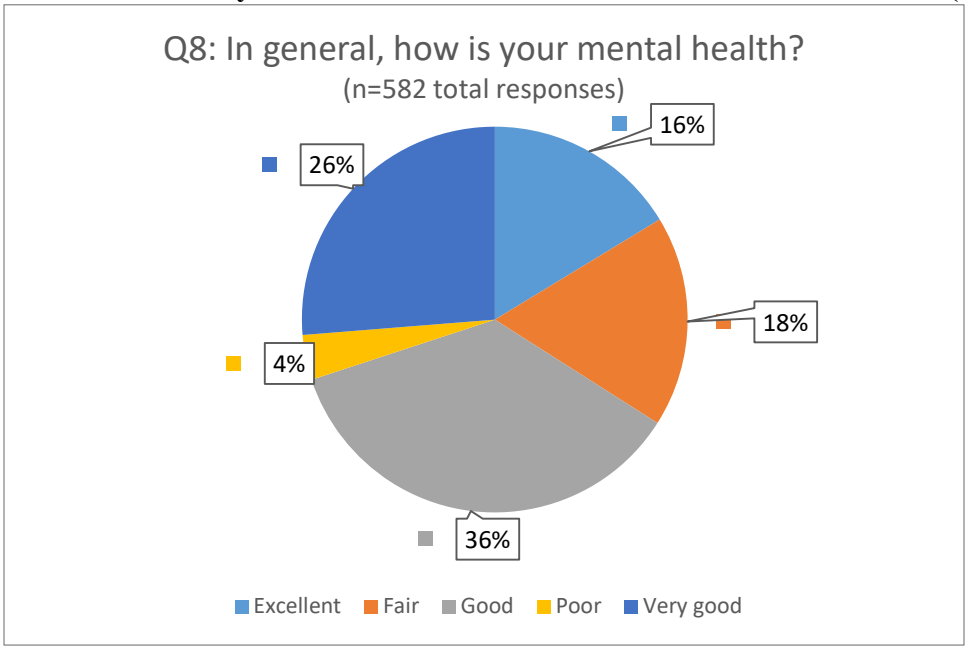
In question 7, community members were asked "In general, how is your physical health?" on a scale from Poor to Excellent:

Figure 2: Community Health Needs Assessment– Overall Physical Health (Q7)



In question 8, survey respondents were asked "In general, how is your mental health?" on a scale from Poor to Excellent:

Figure 3: Community Health Needs Assessment– Overall Mental Health (Q8)



In question 9, community members were given a list of 21 health conditions and issues, "For each of the following, please tell us: How important is each of the following to you and how satisfied are you with the current services in your neighborhood to address each health issue?" For this question each response was scored from on a scale of 1 to 5: Not at all, A little, Somewhat, Very and Extremely. An average Importance Score and Satisfaction Score was calculated for each health issue and then ranked from highest to lowest. These scores were then compared to the overall average scores for Importance and Satisfaction and categorized as Above Average or Below Average. Finally, the health conditions were grouped by priority: Needs Attention, Maintain Efforts and Relatively Lower Priority. The Needs Attention category included health issues rated with above average Importance scores and below average Satisfaction scores. The Maintain Efforts category has issues with above average scores for both Important and Satisfaction. The final grouping, Relatively Lower Priority, included any issues

with a below average Importance score. In this group, the health issues with below average Satisfaction scores were prioritized. Based on this methodology, the following health conditions were categorized as Needs Attention: Violence (including gun violence), Mental health/depression, Women's and maternal health care and Stopping falls among elderly (Figure 4).

NYC Speaks Survey

NYC Speaks was a six-month public engagement project designed to understand the priorities and needs of New Yorkers. The project was done in partnership between Mayor Adams administration, city government, civic organizations and philanthropy. The goal of NYC Speaks is to translate the ideas of communities and advocated into meaningful policy. The core of NYC Speaks was a citywide survey that started in January 2022 to quantify New Yorkers' priorities across 10 issue areas: health and well-being, arts and culture, housing and neighborhoods, economy and workforce, racial equity, climate and infrastructure, education and youth development, public safety, gender justice, and civic engagement. Canvassers were deployed in neighborhoods identified by the Taskforce on Racial Inclusion & Equity (TRIE), which was launched in April 2020 in response to the disproportionate impact of COVID-19 on communities of color. These priority neighborhoods were most impacted by COVID-19 and as well as other health and socioeconomic disparities. Survey data and results are publicly available in an interactive dashboard (https://nycspeaks.org/data/). Across the city, there were 43,589 adult respondents and 18,400 youth respondents. The final phase of NYC is drafting an Action Plan to address the issues identified in the survey. The final Action Plan is expected to be released in Fall 2022.

Figure 4. Importance and Satisfaction Ratings for Select Health Condition

One Brooklyn Health
Community Health Needs Assessment Survey 2022
Importance and Satisfaction Ratings for Select Health Conditions

(n= 585 total respondents)

Health Condition	How Important Is this Issue to you? 1= "Not at all" 2= "A little" 3= "Somewhat" 4= "Very" 5= "Extremely"			How satisfied are you with the current services in your neighborhood? 1= "Not at all" 2= "A little" 3= "Somewhat" 4= "Very" 5= "Extremely"		
	Importance Rank*	Importance Score^	Importance Relative to Other Health Conditions	Satisfaction Rank**	Satisfaction Score^	Satisfaction Relative to Other Health Conditions
Needs Attention						
Violence (including gun violence)	1	4.26	Above Average	21	2.22	Below Average
Mental health/depression	5	4.10	Above Average	19	2.55	Below Average
Women's and maternal health care	7	4.02	Above Average	14	2.74	Below Average
Stopping falls among elderly	10	3.88	Above Average	16	2.68	Below Average
Maintain Efforts						
Access to healthy/nutritious foods	2	4.19	Above Average	8	2.83	Above Average
COVID-19	3	4.18	Above Average	1	3.25	Above Average
Dental care	4	4.15	Above Average	3	2.89	Above Average
Cancer	6	4.02	Above Average	12	2.76	Above Average
High blood pressure	8	3.97	Above Average	4	2.88	Above Average
Heart disease	9	3.91	Above Average	6	2.86	Above Average
Relatively Lower Priority						
Obesity in children and adults	13	3.79	Below Average	18	2.57	Below Average
Arthritis/disease of the joints	15	3.73	Below Average	15	2.70	Below Average
Substance use disorder/drug addiction (including alcohol use disorder)	17	3.72	Below Average	20	2.41	Below Average
Sexually Transmitted Infections (STIs)	18	3.67	Below Average	13	2.75	Below Average
Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	19	3.54	Below Average	17	2.62	Below Average
Adolescent and child health	11	3.87	Below Average	5	2.87	Above Average
Diabetes/elevated sugar in the blood	12	3.84	Below Average	10	2.77	Above Average
Infant health	14	3.77	Below Average	2	2.91	Above Average
Asthma/breathing problems or lung disease	16	3.72	Below Average	7	2.86	Above Average
Hepatitis C/liver disease	20	3.52	Below Average	11	2.76	Above Average
HIV/AIDS (Acquired Immune Deficiency Syndrome)	21	3.49	Below Average	9	2.79	Above Average

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

There are several advantages to utilizing the NYC Speaks survey results. Many of the priority neighborhoods are in Central Brooklyn, in the OBH service area. From the 15 zip codes in the OBH service area, there were 5269 respondents. As with GNYHA Survey and the American Community Survey, the NYC Speaks survey was conducted among respondents aged 18 and over. A separate NYC Youth Speaks Survey was conducted in partnership with the NYC Department of Education. In the OBH service area, there were 963 NYC Youth Speaks survey respondents. Survey respondents were aged 14-17 years old and were asked about topics including education, transportation, housing, climate change, public safety, arts and culture, and racial equity. The NYC Youth Speaks data provides unique insight from young people, who are not often represented by other surveys. In addition, both surveys include questions regarding COVID-19 response and recovery across the various topics.

For the OBH CHNA, data extraction was focused on questions in the Health & Wellbeing section for residents in the 15 OBH service area zip codes. Figure 5 shows the top 3 responses for each of the questions:

Figure 5: Top 3 Responses for Health & Wellbeing questions- NYC Speaks Survey	
12. What kind of health services do you want to see more of in your community? (Select all that apply)	
1.	Grocery stores and farmer's markets
2.	Parks and open spaces
3.	One-stop shops for physical and mental healthcare and community health resources
13. What would help your community have greater access to healthy foods? (Select top 3)	
1.	More farmers markets
2.	More options for healthy foods in public schools
3.	Expanding SNAP programs
14. What mental health resources should the City government prioritize? (Select top 3)	
1.	Provide mental health professionals & social workers in every public school
2.	Holistic programs (ex. Housing & healthcare) for people suffering from mental illness
3.	Enforcement of existing mental health insurance coverage laws
15. Which of the following actions do you support the City taking to limit Covid-19? (Select all that apply)	
1.	Hybrid work models to enable remote work
2.	Indoor mask requirements
3.	Mandated vaccination to enter congregate settings (events)

When asked about health services, NYC Speaks respondents from the OBH service area wanted to see more grocery store and farmers' markets, parks and open space, and one-stop shops for physical and mental healthcare and community health resources. For greater access to healthy foods, respondents highly ranked more farmers markets, more options for healthy foods in public schools and expanding SNAP programs. Regarding mental health resources, respondents wanted the City government to prioritize providing mental health professionals and social workers in every public school, holistic programs for people suffering from mental illness and the enforcement of existing mental health insurance coverage laws. TRIE and NYS Speaks surveys were prompted by the COVID-19 pandemic. To limit COVID-19, respondents were most supportive of hybrid work models to enable remote work, indoor mask requirements and mandated vaccination to enter congregate settings.

Compared to the adult respondents in the NYC Speaks Survey, the Youth respondents had many of the same priorities (Figure 6). However, there was some variation for each question in the Health & Wellbeing category. Youth respondents wanted to see more indoor gyms, fitness centers and pools. For greater access to healthy foods, they prioritized more affordable hot food.

Figure 6: Top 3 Responses for Health & Wellbeing questions- NYC Youth Speaks Survey	
9. What kind of health services do you want to see more of in your community? (Select All that apply)	
1.	Indoor gyms, fitness centers, and pools
2.	Grocery stores and farmer's markets
3.	Parks and open spaces
10. What would help your community have greater access to healthy foods? (Select top 3)	
1.	More affordable hot food
2.	Expand SNAP programs
3.	More options for healthy foods in public schools
11. What mental health resources should the City government prioritize? (Select top 3)	
1.	Prevention and assistance programs for survivors of Intimate Partner Violence
2.	Provide mental health professionals & social workers in every public school
3.	Help people suffering from addiction
12. Which of the following actions do you support the City taking to limit Covid-19? (Select all that apply)	
1.	Close in-person school and shift to virtual learning when rates are high
2.	Hybrid work models to enable remote work
3.	Indoor mask requirements

They felt that the City government should prioritize prevention and assistance programs for survivors of Intimate Partner Violence and provide help to people suffering from addiction. To limit COVID-19, youth respondents supported closing in-person school and shifting to virtual learn when rates are high. While not surprising, these survey responses demonstrate how priorities differ between young people and adults in New York City.

Focus Groups

To contextualize the data obtained from the GNYHA survey and the survey conducted by OBH, a series of five focus groups were conducted. A focus group guide was created to obtain input on what is working in the healthcare system, where the unmet needs are, and what can be implemented to improve health outcomes. The groups were comprised of consumers of health care (e.g., Interfaith's Patient Advisory Group), civic leadership (Community Board 3), the Health Committee Chairs of Kingsbrook and Brookdale, and the Coalition to Transform Interfaith. Collectively we were able to obtain representation from each member facility of the OBH network.

When asked to address areas of greatest need, one participant spoke of the need for comprehensive, behavioral health and substance use treatment that is coordinated between in-house care and post discharge follow-up:

- *... like mental health and drug abuse, advocacy, um and programs. And what uh recovery programs really look like for them, because a lot of those things are tied together. Um, my 31 year old niece just die um drug related uh May 12th of this year, and she visited, and then in and out of the drug program at Interfaith specifically. And um, it's just like something that I wanted to add probably earlier that I've missed out on. Is that like um? I don't know how many people really connect going to the hospital establishments with Brooklyn. One health being a place that has like extension clinics.*

Issues about access were raised. In addition to finding appropriate programs in the area, insurance becomes a barrier. Once a program is found, *"they're probably either attached to*

nobody, because you know, um having a medical insurance is an issue in our community, too right like having in maintaining um Health insurance is the issue." In any event, the need for follow-up care post discharge is essential. This care ideally should be in the community.

Consumers of healthcare also pointed out that communication can be challenging when navigating healthcare. For example, consumers of OBH services pointed out that they are not always informed when their doctor leaves. Often, this is not found out until the next visit. Further, as noted above, comprehensive, community care post-discharge is essential to keep people healthy.

Participants in the focus groups were asked about the access to healthy foods, the response was negative. One participant pointed out:

- *[Other than the] occasional farmers market, but not on a consistent basis. I consistently have to go outside of the neighborhood.*

Others in the group agreed with the lack of access to food. She pointed out:

- *Yeah, I agree. I agree. I'll um. I mean, you have some fruit stands uh we got some supermarkets, but even what's available there is not like a full spectrum of like nutritious food.*

In terms of access to venues for exercise, the group was less involved in gyms and more in favor of utilizing public spaces for activity. They identified parks, playgrounds, and walking paths as convenient and mostly safe. However, the issue of danger associated with using these spaces is still high.

- *Um, you know threat, or what have you? Even our own neighborhood. So we, you know, is the dread, if you care about people shooting, or if you want to go to the part, so I think, in terms of it, depends on what part of the neighborhood you are in. But I think in a lot of parts of the neighborhood you still have that threat factor where you know it, it might be dangerous to go, but in the part, you know, even though you might have it so.*

There was a stated need for more community venues for exercise and outdoor leisure activities and increased programming. For example:

- *Okay, Park. Healthy parks create community gardens, creates, uh, say, spaces for uh their cognitive abilities uh places. Um! To help the senior citizens get active, you know. Have all types of um programs, the meals on wheels, but you know more healthier options. Um, and have facilities uh people like. Just go around um to take them out if you know their family can't do it,*

- *gardens to help people take ownership of their health, and that would, and how that would look would be gardens, school um programs. So that way people will not have to go to the hospital*

The impact of chronic disease management was identified as a significant need in this community, especially in diabetes management. It was pointed out that for people with diabetes [there is a need to] *have more programs to educate them on how they can eat healthier, so they don't have to rely on insulin like how to basically take ownership of their own health. So, in short, um create programs, educational programs*.

The impact of COVID 19 still radiates with this community. Those currently employed had different experiences. Some were working from home for a brief period and are now returning to the workplace. There is mixed opinion on the value of masks and other PPS, with some feeling it should be optional while others feel even more is needed. The most significant revelation had to do with vaccination. One participant stated that she *chose not to take this Covid nineteen vaccination.* Instead, she *changed [her], you know, lifestyle to accommodate [her] own body's immunity.* She stated that she and others in her circle had contracted Covid so they are relying on natural immunity.

In general, focus group input supports a Prevention Agenda that focuses on chronic disease prevention/management, behavioral health, substance use, healthy living, and management of communicable disease.

C. Community Service Plan

Identification of Prevention Agenda Priorities

1. In April 2018 One Brooklyn Health System became the active parent of the three system hospitals: Brookdale Hospital Medical Center (Brookdale), Interfaith Medical Center (Interfaith), and Kingsbrook Jewish Medical Center (Kingsbrook). Over the past four years, OBH has been strengthening its brand as the safety net healthcare system in Central and Northeast Brooklyn. Continuity was achieved with the inclusion of various representatives from the previous hospital boards becoming members of the new OBH board of trustees. The OBH Strategic Planning Committee of the board with planning staffs from each member hospital, reviewed community health data from County Health Rankings, City Health Dashboard, NYC Neighborhood Health Atlas, Take Care New York, NYC Department of Health and Mental Hygiene (DOHMH) 2018 Community Health Profiles, hospital clinical diagnosis and treatment data for OBH patients, "The Brooklyn Study: Reshaping the Future of Healthcare, and other data to identify new and confirm existing priorities, goals and interventions from the pool of recommendations provided by the community via surveys. In addition, the Strategic Planning Committee of the OBH Board of Trustees, which oversaw the development of this Implementation Strategy and Community Service Plan, invited representatives from the local NYC Department of Health and Mental Hygiene to present on health disparities in communities served by OBH in order to provide input representing the broad interests of the community. Written and in person comments from the community on the OBH's most recently conducted community health needs assessment and most recently adopted Implementation Strategy and Community Service Plan also informed the identification of health priorities.

OBH hospitals have collaborated to identify shared community health goals and have selected three shared Prevention Agenda priorities that all hospitals will address for the 2022-2024 community health planning period: **Prevent Chronic Disease**, **Promote Well-Being and**

Prevent Mental Health and Substance Use Disorders, and **Promote Healthy Women, Infants and Children**. Two of the three OBH hospitals will also address the priorities of **Promote a Healthy and Safe Environment** and **Prevent Communicable Diseases.**

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

	One Brooklyn Health System			
Prevention Agenda Priority 2022-2024	**Brookdale**	**Interfaith**	**Kingsbrook**	**OBH**
Prevent Chronic Diseases	✔	✔	✔	✔
Promote Well-Being and Prevent Mental and Substance Abuse Disorders	✔	✔	✔	✔
Promote a Healthy and Safe Environment		✔	✔	✔
Promote Healthy Women, Infants and Children	✔	✔	✔	✔
Prevent Communicable Diseases		✔	✔	✔

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

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

<u>Brookdale</u>

***HIV/AIDS*: BHMC** continues to work with community partners and across Brookdale departments to diagnose and treat patients with HIV/AIDS. BHMC's alliance with the State

University of New York - Downstate Medical Center (SUNY) to support HIV diagnosis and treatment efforts is still in effect. The New York City Department of Health (NYCDOH) Community Health Profiles 2018 Atlas reports that Brownsville, part of Brookdale's primary service area, had 67.4/100,000 new HIV diagnoses in 2018, the second highest rate in New York City (NYC). The rate for the borough of Brooklyn was 22.1/100,000.

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

Crime – For the past few decades, Brookdale's primary service area has been the epicenter of gun violence in the borough of Brooklyn. Brookdale's Emergency Room treats a gunshot wound every 36 hours. Non-fatal hospitalizations for Brownsville, one of Brookdale's primary service area neighborhoods, was 175/100,000, the second highest in NYC. Since crime has been identified as one of the social determinants of health, it is imperative that Brookdale seek out the community collaborations that will address the factors that lead to crime. According to the NYC

DOH Community Profile Atlas 2018, Brookdale's primary service area of Brownsville had a Jail Incarceration rate of 1,698/100,000, the second highest in NYC, and significantly higher than the 59/100,000 for the rest of the borough of Brooklyn. The linchpin of Brookdale's efforts is its gun-violence prevention program ***"It Starts Here,"*** launched in 2016. The ISH program works with the violence interruption nonprofit "Elite Learners" and other key stakeholders such as local middle and high schools, the United Federation of Teachers, community-based youth organizations and local law enforcement to conduct a one-day anti-violence intensive experience for middle and high-school youth (ages 12-17), followed by school-based activities that are designed to reinforce positive behaviors in youth. Specifically, ISH is designed to teach youth about the health and criminal justice consequences of gun violence and equip them with a variety of youth development skills, in an effort to reduce their likelihood of succumbing to involvement with gangs, gun-violence and other criminal activity. Youth are encouraged to become proactive by becoming ambassadors for non-violence in their schools and larger community

Interfaith

Violence – Interfaith is a member of the Anti-Bullying Partnership to Prevent Violence and Suicide coalition, comprised of City and nonprofit agencies, along with NYC Councilman Robert E. Cornegy, Jr., working in Bedford-Stuyvesant to increase parents' awareness of the role social media plays in teen violence. The partnership kicked off in the summer and fall of 2017 with the Safe Summer Initiative, a campaign in District 16 schools to achieve the following: 1) Increase the capacity of parents to recognize the signs of unhealthy internet usage among their children. 2) Identify community resources that are available in helping them to combat these issues. 3) Prevent the practice of young people using verbal and physical violence to solve social conflicts. Coalition Partners include Councilman Robert E. Cornegy Jr., Kings County District Attorney's Office and the Bureau of Youth Diversion and Initiatives, Brownstoners of Bedford

Stuyvesant, Interfaith Medical Center, All For One, Restoration Plaza, New York City Police Department (79th and 81st Precincts and their clergy), New York City Commission on Human Rights and Samaritans NYC.

Kingsbrook

Food Access & Food Insecurity – Continuing our focus on food access & food insecurity, in 2021 Kingsbrook initiated a new partnership with St. John's Bread & Life, a local church-based organization that respects the dignity and rights of all persons by ensuring access to healthy, nutritious food and comprehensive human services resulting in self-sufficiency and stability. Bread & Life hosted several farmers markets on the Kingsbrook campus, providing fresh seasonal fruits and vegetables to our patients and their families free of charge. This collaboration was most helpful in our efforts to eliminate barriers to healthy foods for underserved residents of our community, especially during COVID. This grant funded program was halted in 2022 due to exhausted contributions.

Priority Goals and Objectives

2. Each OBH hospital conducted its own community health needs assessment and published a community service plan for the previous Prevention Agenda period of 2019-2021. The following sections include hospital-specific summaries of 2019-2021accomplishments and how they relate to the evidence-based interventions OBH will implement together in 2022 – 2024.

Brookdale:

Brookdale made steady progress towards achieving the NYC Prevention Agenda goals selected for the three-year period 2019-2021. Priority areas included: Prevent Chronic Diseases, Promote Mental Health and Prevent Substance Abuse Disorders, Promote Healthy Women, Infants and Children (Table 11).

Table 11: Brookdale Hospital Center's 2019-2021 Prevention Plan		
Priority Area	Focus Area	Goal
Prevent Chronic Diseases	Preventive Care and Management	Increase cancer screening rates
	Preventive Care and Management	Increase early detection of cardiovascular disease, diabetes and prediabetes, and obesity
	Preventive Care Management	Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity
Promote Mental Health and Prevent Substance Use Disorders	Prevent mental and substance user disorders	Reduce the prevalence of major depressive disorders
Promote Healthy Women, Infants, and Children	Maternal and women's health	Increase use of primary and preventive healthcare services by women with a focus on women of reproductive age.
	Maternal and women's health	Reduce maternal mortality and morbidity.

Goals were implemented within the framework of existing programs including the NYS DSRIP programs and the Patient-Centered Medical Home (PCMH). Programming is part of comprehensive initiative that encourage sustainable change in hospital healthcare delivery, focusing on disease screening, prevention and management of ambulatory care sensitive conditions. The DSRIP program ended in March of 2020, however while it was active, Brookdale's Ambulatory Care Department was working with the DSRIP lead hospital, Maimonides Medical Center, and several DSRIP participants, to implement a variety of evidence-based prevention model initiatives across Brookdale (diabetes, obesity, heart-disease, high blood pressure, mental health, asthma, breast cancer).

During the 2019-2021 Prevention Agenda period, Brookdale participated in several initiatives (e.g., Patient Centered Medical Home, Quality Incentive programs and Maimonides PPS ACO initiative) to conduct clinical process assessments to ensure patients are risk stratified and individualized care plans are developed for chronic disease patients. As a result, at the end of

2021, Brookdale showed significant growth in its cancer screening rates. In 2020 breast cancer screening rates were at 72% and in 2021 at 61%. Colorectal cancer screening rates were at 65% in 2020 and grew to 69% in 2021. The dip in breast cancer screening rates between 2020 and 2021 is consistent with reductions in preventive screenings during the COVID 19 pandemic, however, the rates are increasing post-COVID. (Table 12).

Table 12: Benchmarks for Chronic Disease Initiative at Brookdale Medical Center			
Condition	2020 rate	2021 rate	Change
Chlamydia Screening	83% (626/753)	76% (559/734)	-9.2%
Meningococcal Vaccine	83% (263/315)	85% (286/338)	2.4%
Diabetes HBA1C under control	86% (396/462)	83% (345/414)	-3.6%

The priority area to Prevent Communicable Diseases focused on increasing COVID vaccination rates. From December 14, 2020 through October 13, 2022 a total of 30,688 vaccinations were provided to the BHMC community and an addition 6,934 BHMC staff were vaccinated. In the past month (10/14/2022 – 11/9/2022) a total of 279 community members and an additional 250 staff were either vaccinated or boosted. A total of 30,967 BHMC patients and nursing home patients and 7,184 staff were vaccinated or boosted during the CHNA period. Partnerships with the community and the 1199 union is credited with program success.

Interfaith

In its previous community health planning cycle from 2019-2021, Interfaith focused on the priority areas of Prevent Communicable Diseases; Prevent Chronic Diseases, Promote Well-being and Prevent Mental and Substance Use Disorders, Promote a Healthy and Safe Environment, and Promote Healthy Women, Infants, and Children. (Table 13).

Table 13: Interfaith Medical Center's 2019-2021 Prevention Plan		
Priority Area	Focus Area	Goal
Prevent Chronic Diseases	Healthy Eating and Food Security	Increase Food Security
	Preventive Care and Management	Promote evidence-based care to prevent chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes, and obesity
	Preventive Care and Management	In the community setting, improve self-management skills for individuals with chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity
Prevent Communicable Diseases	Vaccine Preventable Diseases	Improve vaccination rates
	Human Immunodeficiency Virus (HIV)	Increase viral suppression
	Sexually Transmitted Infections	Reduce the annual rate of growth for STIs
	Hepatitis C Virus (HCV)	Increase the number of persons treated for Hepatitis C Virus
Promote Well-being and Prevent Mental and Substance Use Disorders	Promote Well-being	Strengthen opportunities to build well-being and resilience across the lifespan
	Prevent Mental and Substance Use Disorders	Prevent opioid overdose deaths
	Prevent Mental and Substance Use Disorders	Reduce the prevalence of major depressive disorders.
Promote Healthy Women, Infants, and Children	Maternal & Women's Health	Increase use of primary and preventive health care services by women, with a focus on women of reproductive age
	Maternal & Women's Health	Reduce Maternal Mortality and Morbidity
	Child and Adolescent Health, including children with special health care needs (CSHCN)	Increase supports for children and youth with special health care needs
Promote a Healthy and Safe Environment	Built and Indoor Environments	Promote healthy home and school environments

Chronic Disease Prevention:

Food Insecurity: The Ambulatory Care Division assessed clients for food insecurity and found a high number of patients who were experiencing food insecurity. Our benefits navigator assists patients with applying for SNAP benefits and Interfaith (Bishop Walker) is a member of

the Tiered Engagement Network of the Food Bank for New York City (TEN Network) and can refer patients to food pantries within the TEN network. For the past 19 months, the Ambulatory Care Division partnered with the Newman Memorial United Methodist Church Community Development Corporation, a community-based organization that operates a food and hunger program to receive weekly deliveries of food pantry items for those individuals and families identified as being food insecure. Through the partnership with the Community Development Corporation Bishop Walker and the Primary Care Center has been able to provide meals to 1,360 patients (includes children, adults and seniors) who were identified with food insecurity.

Management of chronic asthma; Due to the COVID pandemic, the Asthma Home Management Program is not making home visits, but managing patients virtually, or through in-person encounters. The Asthma in Day Care Program currently serves 30 day care centers as required by the current contract, by providing staff and family education regarding asthma management, conduct brief respiratory questionnaires to identify children at risk for or have asthma and the Community Health Workers (CHWs) conduct environmental assessments to identify any environmental triggers in the partner day care centers that may trigger an acute asthma episode. Children have been referred to the pediatric clinic at Interfaith for care, who either did not have a PCP, or when pediatric offices were not open due to COVID-19. The Community Health Workers for the Asthma in Day Care Program participated in an initiative to distribute Personal Protective Equipment to the children and families who have a diagnosis of asthma. Through this initiative the Community Health Workers distributed 1,900 adult face masks, 3,250 children's face masks, 510 bottles of hand sanitizers to children and families of our partner day care centers. The Community Health Workers also distributed 102 pulse oximeters to families of the day care centers who were affected by COVID-19.

IMC has implemented an interdisciplinary approach to the management of patients with chronic diseases. There is an established chronic disease self-care management program that is coordinated by a multidisciplinary team that includes two health coaches, primary care physicians, residents, nursing staff, support services such as the Buprenorphine Treatment Program's Nurse Care Manager, the Behavioral Care Manager and members of the Care Coordination Team. The health coaches are the leads in ensuring patient compliance with medical regimen, providing coaching and working with patients to develop self-care management goals that would improve their health outcomes. The health coaches also led the chronic disease and diabetes self-management programs and with the implementation of the new EMR (EPIC), the attending physician can refer patients to the Health Coaches for management. Through the EMR, the Health Coaches can enroll patients in the chronic disease management program directly into EPIC, enabling better monitoring and tracking of patient outcomes. Due to the COVID pandemic we have been unable to have in-person group meetings and the plan is to set-up virtual groups. Training was provided to the health coaches and other members of the care coordination team as to how to conduct the Chronic Disease and Diabetes Self-Care Management groups virtually, conducted in partnership with one of our payers, Healthfirst.

The priority area to Prevent Communicable Diseases focused on increasing COVID-19 vaccination rates, increase viral load suppression among people with HIV, increase treatment among people with HCV, and reduce the growth rate of STIs. COVID-19 vaccine became available to the hospital on 12/14/2020, and within one year a total of 20,781 people were inoculated and 324 received booster shots. Partnerships with the community and the 1199 union is credited with program success.

In-person patient encounters for STI testing and treatment were drastically reduced as a result of the COVID-19 pandemic for the early part of 2020 but by the end of the year, through

outreach efforts by the case management teams, patients began to return to the clinic for in-person services including laboratory testing which included viral load testing, STI and HCV testing as well as having in-person physician visits versus virtual visits.

In order to prevent communicable disease, IMC provided a comprehensive program to assist people living with HIV/AIDS (PLWH) achieve undetectable viral load, resulting in reducing the possibility of transmission through sex. In addition, a total of 364 PLWH receive care in a comprehensive clinic that provides a one-stop shopping model of care. Over the first three quarters of 2022, 19% (68/363) were identified as in need of and connected to treatment and other supportive services (e.g., HARM and RAP) programs. During the same time period 21% tested positive for STIs and received treatment, education and prevention services.

Positive STI's for Q1 2021 (34)

Positive STI's for Q2 2021 (25)

Positive STI's for Q3 2021 (18)

77/364= **21%**

Finally, 3% (12/363) of PLWH seeking treatment at IMC tested positive for HCV and were provided treatment, follow-up care and patient education.

For the first three quarters of 2022 a total of 280 viral load tests were completed among the PLWH being treated at IMC's Bishop Walker Center. Of that number 71% (200/280) were undetectable.

The Promote Healthy Women, Infants and Children Priority focused on three areas with a goal to decrease racial disparities in maternal mortality rates, and to increase access to quality sexual education and appropriate levels of contraception. The program has been fully implemented, including the pregnancy intention screening, contraceptive counseling and the

provision of free contraceptives to patients ages 13 - 45. A sexual history questionnaire based on CDC guidelines, was developed and added to the electronic medical record in 2020, to enable the team to assess and determine the sexual and reproductive health needs of the patients served.

The team implemented the use of the Contraceptive Counseling Model developed by CAI (Contraceptive Access Initiative) which ensures that all providers are using an evidence-based approach to contraceptive counseling, that enables patients to make informed choices regarding contraceptive care.

To reach women of child-bearing age, the program sought to increase access to comprehensive gyn care. By the third quarter of 2020 (1/20 – 9/20) a total of 969 women received gyn care. That number grew to 1,343 in 2021 (1/21 – 9/21) and 1,215 in the third quarter of 2022 (1/22 – 9/22).

The ASQ screening was added to EPIC with the go-live of the EPIC implementation. IMC has a nurse who conducts screening also for Depression, Anxiety and, SDoH issues and refers those children and adults identified through screening for further interventions including behavioral health management.

Kingsbrook

The facility implemented an ambitious Prevention Plan to address the unmet needs of the community. The priority areas included: Prevent Chronic Diseases; Promote Well-being and Prevent Mental and Substance Use Disorder; Promote a Healthy and Safe Environment; and Prevent Communicable Diseases (Table 14).

Table 14. Kingsbrook Jewish Medical Center's 2019-2021 Prevention Plan			
Priority Area	Focus Area	Goal	Objectives
Prevent Chronic Diseases	Preventive Care and Management	Promote the use of evidence based care to manage chronic disease.	a. Increase efficiency, standardize procedures, and streamline processes b. Advance diabetes care via the PCMH Chronic Care Model c. Implement programs to improve issues affecting cancer patients d. Lifestyle interventions to prevent diabetes 2 e. Increase infrastructure to allow for enrollment across OBH f. Implement advances to allow for comprehensive treatment of strokes g. Pain management improvements h. Increase mammography volume by 5%; increase CT volume by 5% i. Increase scheduling capacity for primary prevention
Promote Well-being and Prevent Mental and Substance Use Disorder	Promote Well-being	Reduce the mortality gap between those living with serious mental illness and the general population	Provide state of the art, specialized care for numerous behavioral health issues
	Promote Well-being	Reduce the morality gap between those living with serious mental illness and the general population	Collaborate with FQHCs in the community to offer specialty care in community.
	Promote Well-being	Reduce the prevalence of major depressive disorders	Depression screening to ensure proper assessment and care
	Promote Well-being	Prevent suicide	Increase mental health awareness and education for community and medical staff
	Promote Well-being	Prevent opioid and other substance misuses/deaths	Partner with Bridge Back to Life Center
Promote a Healthy and Safe Environment	Injuries, Violence and Occupational Health	Reduce violence by targeting prevention programs particularly to highest risk populations	Social determinants and domestic violence screening implantation
Promote Healthy Women, Infants and Children	Maternal & Women's Health	Increase use of primary and preventive health care services by women of all ages with a focus on women of reproductive age.	Increase access to quality GYN and prenatal care.
Prevent Communicable Diseases	Vaccine - Preventable Diseases	Decrease HIV morbidity (new HIV cases)	Reach an HIV viral suppression rate of 90%
	Vaccine - Preventable Diseases	Increase the number of persons treated for HCV	Implement on-site, 4th gen raped HCV testing, results within one hour

The program leveraged existing programs, including PCMH to meet its prevention of chronic disease objectives. Recertification of the PCMH designation was achieved in main ambulatory sites by November of 2022. Health coaches were integrated into care teams. The team was expanded to include Social Work staff to address depression. In 2021 ambulatory visits totaled 31,285 visits. We estimate the total to reach 34,656 by the end of 2022, representing an increase of 10.77% in visit volume. This more than doubles the goal of a 5% increase.

The Prevention Agenda recognized the unmet need of access to timely breast cancer screening by increasing volume by 5%. To date, screening mammograms have increased 6.6% from 2019 to 2020, exceeding projections.

Table 15. Breast Cancer Screening, 2019-2022

	2019 (Jan-Aug)	2021	2022 (Jan – Sep)
CT Volume	13,608	N/A	N/A
Ultrasound Volume	6,279	1,150	1,471
Mammogram Volume	1,527	2,614	2,539

Like all members of the NYC healthcare community, OBH was adversely impacted by the COVID pandemic. Due to the shutdowns there were reductions in in-person clinic visits and home visits. To address these issues, we continued to work with our local community boards community leadership councils, and community-based organizations to continue collaborative "virtual" education around chronic disease and early detection efforts. We are working to include our OBH Residency Programs to re-brand our education component to address issues most prevalent in the community such as: diabetes prevention, pain management, cultural sensitivity in health care, mental health, sexual health, stroke awareness and breast cancer prevention to name a few. In 2022 we reached our goal and educated over 750 community residents via these virtual and limited in-person platforms. Goal: to increase virtual reach by 10% by 12/2023.

During the pandemic, our community-based health center, Pierre Toussaint Family Health Center was closed. However, patients were able to seek care at Kingsbrook's main campus via the Behavioral Health Center and Outpatient Psychiatry. To meet the needs of patients in the community Kingsbrook maintained a robust referral service for FQHC patients in effort to address disparities in mental health care and treatment. Significant referrals were realized in 2021.

The depression screening program was successful. The reduction in performance in 2021 is attributed to a reduction in staff on the team. Results improved in 2022 with expansion of the team. There was a 5.3% gain in the number of screenings performed between 2020 and 2022. This exceeds to the goal of a 3% increase.

Table 16. Results of Depression Screening Initiative		
Time period	Unique Patients	Depression Screenings
1/2020 – 9/2020	1,826	3,027
1/2021 – 9/2021	1,657	2,334
1/2022 – 9/2022		3,187

Kingsbrook's HIV Screening Program is a robust, primary prevention program that is linked to internal medical services as well as a partner to community-based HIV intervention programs. They include CCB The Undetectables, AmidaCare's Live Your Life Undetectable, VNSNY CHOICE SelectHealth 2019 HIV PCP Quarterly Quality Program. See Table 17.

Table 17. Results of Kingsbrook's HIV testing program			
Time	HIV AG/AB 4th Gen tests performed	Number of tests reactive for HIV	Viral Load Suppression among patients in care
1/2018 – 9/2018	3,326		85.3% (233/273)
1/2019 – 8/2019	2,727	82 (3%)	87% (335/385)

Kingsbrook also plans to work with CAMBA to identify and enroll eligible People Living with HIV/AIDS (PLWH) into CAMBA's housing and food assistance programs.

In Dec. 2021, The NYC Health HIV Care Dashboard detailed Kingsbrook's Viral Load Suppression Rate at 83% (n=239) for the HIV Patient Care activity in 2020; and a suppression rate of 83% (n=236) in 2020-2021. The program is on track to meet its stated goal of 90% suppression rate.

KJMC's tele-stroke program specializes in the diagnosis and treatment of patients whose condition requires non-invasive, neuro-interventional care (ABV). Over the course of the project, KJMC moved its partnership from NYU Lutheran to OBH Brookdale, a comprehensive stroke center. This further strengthens the safety net and provides comprehensive care in a single setting. See Table 18 for a summary of tele-stroke services.

Table 18. Tele-Stroke Activity by Year at Kingsbrook Jewish Medical Center

Year	Ischemic Stroke	ICH	TIA	SDH
2018	221	12	47	10
2021	103	13	26	6
2022	114	9	31	4

Priority Goals and Objectives

One Brooklyn Health System has identified five Priority Areas to be included in its Prevention Agenda. These include: Prevent Chronic Diseases, Promote Well-being and Prevent Mental Illness and Substance Use Disorders, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants, and Children, and Prevent Communicable Diseases. Interventions will be tailored to fit the needs of the communities served by the different facilities and to meet the needs expressed during the needs assessment.

The 2022-2024 CHNA will be followed by OHMS's Strategic Planning Committee, which will oversee the evaluation of efforts. The Committee will meet quarterly to assess program progress and review all metrics. Outcome evaluation of the impact of the interventions will be used to identify best practices to be rolled out system wide.

Table 19				
NYS Prevention Agenda: 2022 – 2024: One Brooklyn Health System				
Priority: Prevent Chronic Diseases				
Goal	Objective	Interventions	Family of Measures	Facilities
1.3 Increase food security	1.14 Increase the percentage of adults with perceived food security (among adults with and annual household income <$25,000)	1.0.6 Screen for food insecurity, facilitate and actively support referral	Percentage of patients who screen positive for food insecurity Percentage of patients identified with food insecurity referred/linked to food support partners.	IMC
4.3 Promote evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.3.3 Decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbA1c level indicated poor control (>9%) 4.3.7 Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups and, 4.3.8. Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups and, 4.3.10 Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of	4.3.2 Promote evidence-based medical management in accordance with national guidelines.	Percentage of patients who demonstrate improvements in HbA1c level control Percentage of patients who experience decreases in asthma-related ED visits and hospitalizations and demonstrate improved ability to manage and prevent exacerbation of asthma.	BHMC IMC KJMC

	0.50 or greater during the measurement year			
4.4 In the community setting, improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity	4.4.1 Increase the percentage of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, cancer) who have taken a course or class to learn how to manage their condition	4.4.2 Expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management	Percentage of patients/community members who complete the Chronic Disease Self-management Program	BHMC IMC KJMC

Interfaith Medical Center (IMC) The challenges facing the communities served by OBH are extensive and complex. IMC will address the focus area: Prevent Chronic Disease by taking a wholistic approach. The first Focus Area is healthy eating and food security. The goals include:

- Increase food security
    - Decrease the percentage of children with obesity (among children ages 2-4 years participating in the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]); and
    - Decrease the percentage of children with obesity (among public school students in NYC) and,
    - Decrease the percentage of adults ages 18 years and older with obesity.
    - Screening for food insecurity and facilitating and actively supported referrals.

IMC will also address preventive care and management, by promoting evidence-based care to prevent and manage chronic diseases including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity. Objectives include:

- Decrease the Asthma ED visit rate per 10,000 for those aged 0-4, 0-17, and all age groups

- Decrease the Asthma hospitalization rate per 10,000 for those aged 0-4, 0-17, and all age groups
- Increase the percentage of members (ages 5-64), who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater
- Decrease the percentage of adult Medicaid members aged 18-44 with diabetes whose most recent HbA1c level indicated poor control (>9%)

IMC will also launch interventions to improve self-management skills for individuals with chronic diseases, including asthma, arthritis, cardiovascular disease, diabetes and prediabetes and obesity. Interventions include courses to learn how to manage their conditions (e.g., arthritis, asthma, CVD, diabetes, CKD, cancer). Programming will expand access to evidence-based self-management interventions for individuals with chronic disease (arthritis, asthma, cardiovascular disease, diabetes, prediabetes, and obesity) whose condition(s) is not well-controlled with guidelines-based medical management alone.

Kingsbrook Jewish Medical Center (KJMC) also is addressing the goal: Prevent Chronic Diseases with Objective to include Preventative Care and Management and Each facility has the goal to Prevent Chronic Diseases and the family of Interventions (4.3) Promote the use of evidence-based care to manage chronic disease. KJMC's objectives include:

- Increase efficiency, standardize procedures and streamline processes.
    - Reduce cost and utilization and improve quality.
    - Better manage patients with chronic conditions. Provider patient centered care in ambulatory settings which implement into workflow PCMH standards and measures.
- Advancing diabetes care via the PCMH Chronic Care Model, with a focus on early recognition of the importance of patient –centered, self-management, patient empowerment, and team-based care.
- Implement programs and services designed to improve the issues affecting cancer patients, while addressing a wide variety of cancer and/or treatment-related conditions and symptoms in a clinical setting.
- Emphasize lifestyle interventions specifically for prevention of type 2 diabetes in persons who are high risk.
- Gained CDC recognition which allow the program to recruit, enroll and retain Medicare and Medicaid beneficiaries from across the OBH system. This will make it easier for

people to participate in affordable, high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve overall health.

- Implement advancements and specialty programs in Rehabilitation, Emergency Medicine and the Vascular Laboratory to help ensure the most comprehensive care, treatment and detection of stroke.
- to continually improve patient care management and maintain consistent compliance with Quality Measures embedded in the Pain Management framework.
- Enhance stroke care in the community by using state-of-the-art technology, identifying patients who require urgent stroke interventions.
- Increase mammography volume by 5%. Increase CT outpatient volume by 5%.
- To create a robust schedule for education and early detection throughout the year, that increases accessibility to a variety of chronic disease prevention and education options for those who are under or uninsured.

Table 20.

NYS Prevention Agenda: 2022 – 2024: One Brooklyn Health System

Priority: Promote Well-being and Prevent Mental and Substance Use Disorders

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

BHMC has included Promote Well-being and Prevent Mental Illness and Substance Use Disorders as part of its Priority Agenda. Its primary goal is to Reduce the prevalence of major depressive disorders. This will be achieved by integrating behavioral health into the PCMH (Patient Centered Medical Home) care delivery system by implementing the IMPACT model of collaborative care. The neighborhood of Brownsville inside Brookdale's primary service area has the second highest rate of psychiatric hospitalizations in NYC. The implementation of the Collaborative Care/IMPACT, within the framework of Brookdale's PCMH, will encompass the following core activities:

1) Screening all patients 12 yrs of age and older with PHQ-2PHQ-9 for depression, AUDIT-C/AUDIT for alcohol us, and DAST-1/DAST-10 for drug use;
2) If patients screen positive, refer to the appropriate on-site behavioral health experts and document in EHR.
3) Designate individual(s) as Behavioral Health Care Manager, to provide a range of services to patients with mild to moderate depression, anxiety, or to patients who screen positive for substance abuse.
4) Hire or designate a consulting psychiatrist
5) 5)Appoint Practice Champion who will spearhead adopting IMPACT.

The program integrates depression screening and treatment with primary care, increasing the likelihood of connection to care. This is a model that is adopted system-wide at OBH and is part of the Priority Agenda at all sites.

IMC will address the Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders through three goals:

- Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
- Goal 2.2 Prevent opioid overdose deaths
- Goal 2.4 Reduce the prevalence of major depressive disorders

Under Goal 1.1, IMC will work to reduce rent burden in the area through increasing affordability and stability through approaches such as housing improvement, community land trusts and using a "whole person" approach in medical care. IMC and OBH collaborated with the state to issue Vital Brooklyn affordable housing RFPs to develop housing on hospital parcels.

The hospital and state also worked together to select the winning proposals. As a result, additional, affordable housing will be made available to at risk groups.

Goal 2.2 aims to prevent opioid deaths through increasing capacity to increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD). This will be achieved by training and licensing providers to prescribe Buprenorphine. In addition, IMC will Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine.

Finally, Goal 2.4 is aimed at reducing the prevalence of major depressive disorders. The primary vehicle to achieving reduction in the prevalence of depression is through the reduction of the stigma associated with mental health treatment by the integration of behavioral health into the primary care setting, building on the existing provider/patient relationship through the implementation of the collaborative care program (IMPACT). The intervention includes:

- Perform initial assessment using behavioral screening tools e.g., PHQ-9, GAD-7, etc.
- Administration of applicable validated rating scale(s)
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- Care planning by the primary care team jointly with the patient, with care plan revision for patients whose condition is not improving
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with a designated member of the care team

KJMC is addressing the Priority Area of Promoting Wellness and Preventing Mental Illness and Substance Use Disorders through the focus areas and objective:

2.4 Reduce the mortality gap between those living with serious mental illness and the general population

- Objective: Provide state-of-the-art, specialized care for numerous behavioral health issues. Our clinicians have a wide- range of expertise in psychiatric interventions including medication management, individual and group counseling, individually tailored treatment and discharge planning.
- Objective: Collaborate with Federally Qualified Health Centers (FQHCs) in the community in order to offer specialty care members of the community.

2.4 Reduce Prevalence of major depressive disorders

- Objective: Depression screening for patients from the community to provide proper assessment and care.

2.5 Prevent suicides

- Objective: To help build a consistent effort around mental health awareness and education for the community and our medical staff. Special focus on identifying those in need of intervention and treatment.

2:2 Prevent opioid and other substance misuses/deaths

- Objective: Link with and refer to **Bridge Back to Life Center**, Inc. fully accredited and New York State OASAS- Licensed, to operate chemical dependency treatment programs.

Table 21.

NYS Prevention Agenda: 2022 – 2024: One Brooklyn Health System

Priority: Promote a Healthy and Safe Environment

Goal	Objective	Interventions	Family of Measures	Facilities
3.2: Promote healthy home and school environments	3.2.b. Increase the number of residences that are inspected for lead and other health hazards.	3.2.2 Promote the use of and increase referrals from healthcare providers, case management providers, community-based agencies and others to the Local Health Departments with Primary Prevention Programs (15 Programs cover 19 municipalities for home visits) and 19 Healthy Neighborhood Programs.	Enhance referral network to make referrals to both the childhood lead primary prevention program for home assessment and/or the healthy neighborhood program. Increase the percentage of home visits for individual's with poorly controlled asthma under the Health Neighborhoods Program. Percentage of patients all ages who report decreases in ED visits and Hospitalizations related to asthma.	IMC
3.2 Promote healthy home and school environments	1.2 Reduce violence by targeting prevention programs particularly to highest risk populations	Social Determinant & Domestic Violence Screening: HITS (Hurt, Insult, Threaten, Scream) module: Collects information re: conditions in a patient's environment that affects health and quality of life outcomes. Also screens women of childbearing age for intimate partner violence (IPV), such as domestic violence (DV), and provides or refers women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	Screenings started in July 2019, collecting 2,900 responses from patients screened for a variety of social determinants including domestic violence.	KJMC

IMC selected Promote a Healthy and Safe Environment as a Priority Area with a goal to Promote healthy home and school environments to improve the health of the community. According to the New State Department of Health, homes can be a major source of asthma triggers which can make asthma worse. In NYS there are nearly 165,000 emergency department visits, more than 38,000 hospitalizations and approximately 11 million days when people are unable to work, go to school or carry out their usual activities in NYS and asthma contributes to 255 deaths annually. The objective is to increase the number of residences that are inspected for lead and other health hazards, reducing the number of Asthma-related ED visits and Hospitalizations due to home and school environmental triggers.

This will be accomplished through Implementation of the Asthma Home Management Program and the Asthma in Day Care Program with the objectives of:

- Increasing the number of home environmental assessments performed by the Asthma Home Management Program.
- Increasing the number of Day Care Center Partners to fifty (50) day care centers providing family/staff education regarding asthma management,
- Conducting brief respiratory questionnaire (BRQ) to identify children who have or at risk for asthma and conduct environmental assessments to identify environmental triggers in the partner day care centers that may trigger an asthma episode.

KJMC plans to address promotion of a healthy and safe environment by addressing the issues of violence, especially domestic violence, to address home safety. The proposed intervention will include routine screening of primary care patients with screen-detected social determinants were more likely to have depression, diabetes and hypertension. Early identification will result in connection to services to bridge gaps in care.

Table 22				
NYS Prevention Agenda: 2022 – 2024: One Brooklyn Health System				
Priority: Promote Healthy Women, Infants, and Children				
Goal	Objective	Interventions	Family of Measures	Facilities
1.1: Increase use of primary and preventive health care services by women, with a focus on women of reproductive age	1.1.3: Increase the percentage of women ages 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy by 10% to 38.1%	1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.	Based on the Sexual and Reproductive Justice framework, will provide sexual and reproductive health care focusing on the following three measures: 1) Pregnancy Intention Screening - Percentage of women ages 13 - 45 at risk for unintended pregnancy that were screened for pregnancy intention within the last 12 months. 2) Most and Moderately Effective Methods - Percentage of women ages 13 - 45 years at risk of unintended pregnancy that are provided the most effective (i.e., female sterilization, implants, intrauterine devices or systems [IUD/IUS]) or moderately effective (i.e., injectables, oral pills, patch, ring or diaphragm) method of contraception. 3) Access to LARC: Percentage of women aged 13-45 years at risk of unintended pregnancy that are provided a long-acting reversible method of contraception (LARC), i.e., implants, intrauterine devices or systems (IUD/IUS).	BHMC IMC KJMC
1.2 Reduce Maternal Mortality and Morbidity	1.2.2: Decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate) by 34% to 3.1.	1.2.3: Increase use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.	Based on the Sexual and Reproductive Justice framework, will provide sexual and reproductive health care focusing on the same measures as goal 1.1 and intervention 1.1.2	BHMC IMC KJMC

3.2: Increase supports for children and youth with special health care needs	3.2.2: Increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year by 20% to 21.0%.	3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.	Percentage of children identified with and/or at risk for social or emotional issues. Percentage of families who establish health and meaningful psychological relationships between a child and the primary caregiver through healthy interactions over time.	BHMC IMC

BHMC has included Promote Healthy Women, Infants and Children as part of the OBH Priority Agenda. Since BHMC has the largest maternal practice in the system, this will be a significant part of the BHMC workplan. The program will include Focus Area 1: Maternal & Women's Health, with two stated goals:

1) Increase use of primary and preventive health care services by women, with a focus on women of reproductive age.

Objective:

1a) increase the number of women seeking prenatal care early in pregnancy. This early intervention will allow providers to fully assess the health of the mother and the pregnancy and intervene early to improve outcomes. This initiative is aimed at decreasing the premature delivery rate in Brownsville and East New York neighborhoods

1b) Increase patient participation in the NYC DOH Centering Pregnancy model of prenatal care and delivery. The Centering Pregnancy is a National Recognized model of providing prenatal care in a group setting of up to 10 patients with similar gestational age. The program will expand our Centering Program and also introduce the program to other prenatal care providers in the area, including area Federally Qualified Health Centers (FQHCs). Centering Pregnancy has been shown to reduce stress and prematurity in the participants.

1c) Increase participation and adherence to prenatal care. The program increases compliance of the patients in attending their prenatal and postpartum visits. Participants of the program demonstrated increase rates in exclusive breastfeeding.

2) Reduce Maternal Mortality and Morbidity

Objective:

2a) Decrease the cesarean section rate by decreasing the primary cesarean section rate and increasing vaginal births after cesarean section rate.

2b) Increase screening for abnormal placentation by increasing usage of ultrasound scans with power doppler.

2c) Annually review and update the BHMC hemorrhage protocol.

2d) Increase the frequencies of maternal hemorrhage drills to at least one every quarter. Include departments of Anesthesia, Blood Bank and Trauma services in addition to the OB/GYN to Labor and Delivery maternal hemorrhage drills.

2e). Perform Mortality and Morbidity reviews of all maternal blood loss cases requiring blood transfusion of more than 4 units of PRBC.

2f) Improve assessment of all patients prenatally, especially those at risk for hemorrhage. Alert Maternal Fetal Medicine and the Blood bank when the patient who is identified as at risk for hemorrhage is either seen in ED or admitted to the hospital for labor and delivery.

2g) Increase huddles, briefings and de-briefings for all patients at risk for hemorrhage or following a case of maternal hemorrhage.

Measures include: maternal mortality from hemorrhage related complications, caesarean section rates and VBAC rates.

IMC will address the priority focus area to Promote Healthy Women, Infants, and Children.

- Goal 1.1: Increase use of primary and preventive health care services by women, with a focus on women of reproductive age
    - Objective 1.1.3: Increase the percentage of women ages 18-44 years who report ever talking with a health care provider about ways to prepare for a healthy pregnancy.
    - Objective 1.1.2: Integrate discussion of reproductive goals, pregnancy planning, and pregnancy prevention in routine health care for all women of reproductive age.

      The interventions include:

      • Take a thorough sexual history

      • Create sexual history template and add to EMR

      • Routinely ask all persons capable of pregnancy, about pregnancy intention

      • Provide evidence-informed contraceptive counseling that supports informed patient choice

      • Train staff and design care to provide all patients with equitable access to chosen contraceptive method

      • Stock full range of FDA approved contraceptive methods onsite including most and moderately effective methods

      • Train Staff to provide a full range of contraceptive methods including LARC methods

      • Configure clinic administrative processes to support immediate/same day access to contraceptive care

• Utilize diverse payment options, including self-pay, sliding fee and NYS Family Planning Benefit Program to increase patient access to reproductive care

• Use the confidential visit payment mechanism when indicated to ensure patient confidentiality when billing for services

- Goal 1.2: Reduce Maternal Mortality and Morbidity
    - Objective 1.2.2: Decrease the racial disparity in maternal mortality rates (ratio of black maternal mortality rate to white maternal mortality rate). The intervention calls for the increased use of effective contraceptives to prevent unintended pregnancy and support optimal birth spacing.
- Goal 3.2: Increase supports for children and youth with special health care needs.
    - Objective 3.2.2: Increase the percentage of children ages 9-35 months who received a developmental screening using a parent-completed screening tool in the past year. IMC is one of 12 practices across the nation participating in NICHQ's Pediatrics Supporting Parents (PSP) initiative. The goal of this initiative is to improve primary care to foster social and emotional development in the same way that primary care practices focus on physical health and cognitive development. The goal and vision of PSP is to help ensure that all children from birth to age 3 receive the supports they need to achieve kindergarten readiness and positive life outcomes.
    - Objective: 3.2.3: Enhance care coordination and transition support services for eligible children and youth with special health care needs.

The Interventions include:

• Family education around the social and emotional development and age-appropriate expectations during well-child visits for children ages 0-3 yrs.

• Support of child's primary caregiver's well-being and mental health

• Engagement of family with change and improvement process including primary caregivers as team members.

• Behavioral and developmental screening using validated tools (Ages and Stages Survey [ASQ]) during the well child visit.

• Assessment of interactions and relationship between primary caregiver-child during well child visit.

• Assessment of family strengths and risks.

• Assessment and support of primary caregivers' well-being and mental health.

• Referral of family to identified needed supports

KJMC will address goal 1.1: "Increase use of primary and preventive health care services by women of all ages with a focus on women of reproductive age." Priority objectives include increased access to quality GYN and prenatal care. KJMC's GYN program includes an OB/GYN from our partner institution-Brookdale Hospital Medical Center and a midwife on Kingsbrook's main campus. The midwife takes on fewer complex cases and refers the complex ones to the OB/GYN. This increases access to gyn care in a one-stop shopping model of care with all services maintained at KJMC.

Table 23				
NYS Prevention Agenda: 2022 – 2024: One Brooklyn Health System				
Priority: Prevent Communicable Diseases				
Goal	Objective	Interventions	Family of Measures	Facilities
2.2: Increase viral suppression	2.2.1 Increase the percentage of all persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load by 17% to 95%.	2.2.1 Link and retain persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission.	Percentage of patient encounters that result in linkage to care, treatment and other supportive services for people living with HIV.	BHMC IMC KJMC
3.1: Reduce the annual rate of growth for STIs	3.1.1 Reduce the annual rate of growth for early syphilis by 50% to 10% 3.1.2 Reduce the annual rate of growth for gonorrhea by 50% to 4% 3.1.3 Reduce the annual rate of growth for chlamydia by 50% to 1%	3.1.2 Increase STI testing and treatment: Ensuring that all persons at risk for STIs have access to affordable, accessible, convenient, and culturally-responsive STI testing and treatment services	Percentage of patients testing positive for STIs who receive treatment, education and prevention services	BHMC IMC KJMC
4.1: Increase the number of persons treated for Hepatitis C Virus	4.1.1 Increase the number of Medicaid enrollees treated for HCV by 10% to 8,813.	4.1.1 Conduct educational campaign promoting testing and treatment for HCV.	Percentage of patients testing positive for HCV and received testing, treatment, follow-up care and patient education	BHMC IMC KJMC
1: Vaccine Preventable Diseases	Goal 1.2: Reduce Vaccination coverage disparities	Offer vaccines in locations and hours that are convenient to the public that are accessible to people of all ages	Number of community residents fully vaccinated Number of hospital staff fully vaccinated Increased number of locations and hours for COVID-19 vaccine access	BHMC IMC KJMC

IMC addresses the Priority Area of Preventing Communicable Disease through a four-pronged plan: 1. Increase viral suppression among people living with HIV; reduce sexually transmitted infections (STI); identify and connect people living with HCV to treatment; and increase vaccination rates for COVID-19. The plan is to increase the percentage of all persons living with diagnosed HIV infection (PLWDHI) who receive care with suppressed viral load. The plan hinges on linking and retaining persons diagnosed with HIV in care to maximize virus suppression so they remain healthy and prevent further transmission. This will involve partnering with the Field Service Unit, NYC DOHMH to identify previously known HIV-positive persons to return them to care with the goal to re-engage these patients in medical and notifying, testing and treating identified partners. In addition, PrEP and PEP services will be made available to people who are HIV negative and at risk for exposure.

IMC plans to increase STI testing and treatment to effectively reduce the annual rate of growth for early syphilis, gonorrhea, and chlamydia. The program will ensure all persons at risk for STIs have access to affordable, accessible, convenient, and culturally responsive STI testing and treatment services.

The Prevention Agenda includes Focus Area 4: Hepatitis C Virus (HCV), with the goal of increasing the number of persons treated for HCV. One means of achieving this aim is through the conduct of an educational campaign promoting testing and treatment for HCV.

As noted elsewhere, the COVID pandemic underscored the health inequities in our communities. NYC Health officials released data by ZIP codes that indicated disparities in the city's vaccination effort, with the share of residents who are fully vaccinated in wealthier Upper West and East Side ZIP codes, which have high proportions of white residents, were almost eight times the rate in parts of predominantly Black neighborhoods in the One Brooklyn Health service area like East New York. In order to reverse this trend, IMC will increase COVID-19

immunization rates of community residents and hospital staff through making the vaccine more available throughout the facility by implementing and promoting the use of standing orders for COVID-19 vaccine administration.

Like the goals and objectives planned at IMC for the period of 2022-2024, KJMC's role in OBH's Prevention Agenda will focus on Prevention of Communicable Diseases with a focus on addressing HIV and Hepatitis C (HCV) and increase access to vaccine. As noted elsewhere HIV poses challenges to the well-being of the community. With a goal of 2:1 Decrease HIV morbidity (new HIV cases), the program objectives were developed to align with National HIV/AIDS Strategy to End HIV/ AIDS and the Epidemic by 2020. The key is to decrease community HIV and prevent new transmission is by HIV viral load suppression. To address the effective treatment of people living with HIV, KJMC include the goal: 2:2 Increase Viral Suppression. This will be achieved by increasing linkage and retention efforts to ensure persons diagnosed with HIV are connected to health care to maximize virus suppression, so they remain healthy and prevent further transmission. In addition, goal 4:1: Increase the number of persons treated for HCV. This will be achieved through increased access to rapid HCV testing and linkage to early care. This is supported by Kingsbrook's transition to 4th generation testing (on-site testing for both HIV and Hepatitis C with results within one hour).

Finally, KJMC's Goal 1.1: Improve vaccination rates. The objective will be to increase COVID-19 immunization rates of community residents and hospital staff. The goal is to close the gap in vaccination rates that favor white residents over black and brown residents. This will be accomplished through the implementation and promotion of standing orders for COVID-19 vaccine administration.

Partner Engagement

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

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

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

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

Dissemination Plan and Community Engagement

4. The executive summary and full community service plan (CSP) will be available on OBH's website and its member hospital websites at https://onebrooklynhealth.org/, http://www.brookdalehospital.org/, http://www.interfaithmedical.com/ and https://www.kingsbrook.org/; visitors to the websites will be able to access, download, and print

a hard copy of the CSP for free. A paper copy will be available to the public without charge by contacting the Strategic Planning office at OBH/Interfaith, External Affairs at Brookdale, or Public Affairs at Kingsbrook. OBH's member hospitals will distribute the CSP to the community via their respective community representative groups including but not limited to: Brookdale's Community Advisory Board, the Coalition to Transform Interfaith and Kingsbrook's Community Leadership Council as well as the Community Action and Advocacy Workgroup convened by Community Care of Brooklyn.

In addition, the CSP will be disseminated to the relevant Community Planning Boards. To ensure that internal stakeholders are also aware of the commitments made in the CSP, OBH leadership will share the 2022-2024 priorities at senior staff and medical staff forums and Town Hall meetings.