BROOKDALE HOSPITAL AND MEDICAL CENTER
One Brookdale Plaza
Brooklyn, New York 11212

2013

NEW YORK STATE
COMMUNITY SERVICE PLAN
(CSP)
THREE-YEAR COMPREHENSIVE REPORT

November 14, 2013
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EXECUTIVE SUMMARY

Introduction

Brookdale Hospital and Medical Center (“Brookdale Hospital” or “Brookdale”) is a nonprofit 501(c) (3) medical services provider that is a critical part of the healthcare delivery system in the borough of Brooklyn, New York. Established in 1921 as a single facility with basic healthcare capability, Brookdale has expanded during the last 92 years to become a full-service teaching hospital campus, with multiple sites that offer healthcare services ranging from prenatal care to elder care. Located in the heart of Brownsville, one of the most economically-challenged areas in the borough, Brookdale remains dedicated to its founding mission, which is as follows:

Brookdale Hospital is committed to being the focus of a healthy community, stressing the organization’s values of caring and respect for everyone.

Today, Brookdale’s reach is extensive. Our primary service area encompasses the four contiguous, densely-populated communities of Central Brooklyn, East New York/Brownsville, Canarsie and Flatlands, and our secondary service area stretches as far out as East Flatbush, Crown Heights, Bedford Stuyvesant and Bushwick. As one of four healthcare providers in a three-mile geographic area with a population of approximately one million residents, Brookdale is a vital resource and safety net. Our patient volume is among the highest in Brooklyn – we receive approximately 100,000 emergency room visits and more than 275,000 outpatient visits annually. Many patients have a very long family healthcare history with Brookdale, and depend on us for all of their healthcare needs.

Beyond healthcare, Brookdale serves as a stabilizing force to the local economy and an important economic driver; residents from the surrounding communities account for close to 50% of the Brookdale workforce, approximately 1,800 residents. Overall, Brookdale is an essential anchor institution in the borough of Brooklyn, one of a handful that is dedicated to improving the lives of local residents, and creating significant positive social impact.

Community Service Plan (CSP) Development

The mandate to develop a Community Service Plan (CSP) presented a unique opportunity for Brookdale to work side by side with community residents, public health officials, and other key community stakeholders, to focus on one of Brookdale’s central goals: To adapt and enhance
our service delivery model to continue to meet the healthcare needs of the communities that we serve.

Our objectives for this CSP\(^1\) are to:

a. Identify the healthcare needs of the communities that we serve.

b. Identify the barriers to accessing healthcare in the communities that we serve.

c. Identify the gaps in healthcare delivery in the communities that we serve.

d. Identify the diseases and social conditions that are having the most devastating impact on residents.

e. Assess Brookdale’s capacity to work with the community, to meet the healthcare needs of residents, including addressing the priority diseases.

f. Develop a three-year plan to address two of the priority diseases identified, synergizing our efforts with the New York State “Prevention Agenda,” as well as the New York City Department of Health and Mental Hygiene “Hospital Community Health Intervention Agenda.”

g. Identify the resources and the community support systems that will help us accomplish our goals.

Brookdale, like so many New York City hospitals, is currently grappling with a fiscal crisis caused by a variety of factors. Our fiscal viability is threatened by the prolonged strain on all aspects of our operations, resulting from the high demand for high-cost medical treatments and services, by a patient population that is disproportionately affected by chronic diseases. The 2008-2009 economic downturn compounded our fiscal issues, and the transformation now underway in the healthcare marketplace is presenting a new set of challenges. We are presently working on an operational and financial restructuring plan that will strengthen our position as an important healthcare provider for the approximately one million Brooklyn residents in our primary and secondary service areas. Our senior management is confident that this restructuring process and strategic planning effort will put us in a stronger financial and operational position. Our work will allow us to invest in cutting-edge technologies, healthcare innovations, and community collaborations that will result in the delivery of superior healthcare to Brooklyn residents.

\(^1\)The three-year plan for each of the two priority diseases, developed as a result of this CSP process, can be found on pages 41-46 of this report.
Our strong network of partners and stakeholders, from both inside and outside of our service area, facilitated the development of the CSP. The qualitative and quantitative data gathered during our assessment process has enabled us to design a robust plan that will allow us to meet our restructuring objectives. Our vision is to continue to function as a leading healthcare provider in Brooklyn, one that residents from the communities that we serve will value and embrace as their preferred choice.

**Description of Community**

Brookdale serves residents primarily from the neighborhoods of Central Brooklyn, Brownsville/East New York, Canarsie and Flatlands, which are inside the geographic boundaries of Community Districts 5, 16, and 18. We made the determination that these neighborhoods comprise our primary service area based on a “hospital discharges by zip code” data analysis. In 2012, 72% of all discharges came from four zip codes in these neighborhoods (11212, 11207, 11208, and 11236). Further, we determined that another 10 zip codes, which fall within the areas of Central Brooklyn, Flatbush, Canarsie and Flatlands, Crown Heights and Bushwick (inside the geographic boundaries of Community Districts 3, 4, 8, 9 and 17), comprise our secondary service area. In 2012, 18% of all discharges came from these zip codes. Both service areas account for 90% of our discharges.

Our primary and secondary service areas have a population of approximately 400,000, and 600,000, respectively, a total of approximately one million residents. The majority of residents from both service areas are Black/African American (approximately 70%). Both service areas have a very large concentration of immigrants, which is reflected in the composition of our patient population. The 2010 U.S. Census reports that 38% of residents in both service areas are immigrants.

**Public Participation**

As we re-design our healthcare delivery model to become more efficient and responsive to the needs of the communities we serve, securing a broad range of perspectives from the public is a high priority. The CSP planning process was an opportunity to seek the involvement of a diverse group of stakeholders and obtain honest feedback with constructive recommendations. A Brookdale Hospital Working Group (the “Working Group”), comprised of a cross-section of staff from Brookdale Hospital, led the effort to:

- Identify public health officials and community stakeholders who would collaborate with us on this project;

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2 U.S. Census. 2010
3 U.S. Census. 2010
• Conduct a comprehensive survey of community residents; and

• Seek input from our healthcare professionals who are on the frontline of healthcare delivery.

Assessment and Selection of Public Health Priorities

The Working Group led the effort to secure the qualitative and quantitative data needed to develop the CSP. Beginning in February 2013, the Working Group initiated planning activities, agreed on the scope of the report and a strategy to ensure that all the reporting criteria were met. A community needs survey and an interactive survey, both designed by the Working Group, provided qualitative data. The community needs survey enabled us to capture the perspective of 563 residents from our primary service area, on various health topics. The interactive survey gave us the perspective of another 70 residents. A representative sample of the service area participated in both of the surveys i.e. male and female adults, senior citizens, immigrants, and non-immigrants.

We also reviewed the findings from three separate assessments of the Brooklyn healthcare system conducted by the Brooklyn Healthcare Improvement Project (B-HIP), Senator John Sampson’s Brooklyn Healthcare Working Group (BHWG), and the Brooklyn MRT Health Systems Redesign Work Group (the “Work Group”). Brookdale staff participated in the first two of these efforts.

The quantitative study drew on data primarily from the New York City Department of Health and Mental Hygiene (NYCDOHMH), U.S Census Data, and the U.S. Department of Health and Human Services. Data sets from our own internal database also helped inform this process.

Our assessment of the data gathered uncovered a variety of useful findings, ranging from what residents perceive to be the most important health problems in their community, to the leading causes of death. We confirmed what our clinical evidence has shown for the past two decades:

i. That the disease Obesity, and several secondary health conditions (heart disease, diabetes, hypertension, and cancer), are disproportionately prevalent; and

ii. That the disease HIV/AIDS continues to be a major health issue.

The evidence led us to conclude that Obesity and HIV/AIDS should be our two focus areas, over the course of the next three years.

Significant Qualitative Findings

Following are some of the qualitative findings that will inform our strategic approach to healthcare and our disease priorities:
• Only 14% of survey participants rated their community as healthy, while 46% rated it as “somewhat healthy,” and 27% rated it as “unhealthy.”

• When survey participants were asked to identify the most important factors that contribute to a “healthy community,” a good place to raise children and good schools ranked first (22%), safety/low crime ranked second (15%), and access to healthcare ranked third (12%). Affordable housing, and good jobs and a healthy economy each ranked fourth (10%). Participants identified several other factors as important, which together, accounted for 31% of responses.  

• Survey participants rated obesity-related diseases as the most important health problem in their community (25%), with HIV/AIDS and STDs ranking second (9%), cancer, access to healthcare, poverty and homelessness tying for third place (8%), and mental health ranking fourth (7%). Participants identified several other health problems/issues as important, which together, accounted for 35% of responses.  

• 36% of survey participants reported that they have been told by a healthcare professional that they are overweight or obese, 49% have been told that they have high-blood pressure, 42% have been told that they have high cholesterol, and 31% have been told that they have diabetes.

• When participants were asked the question “If you were given the power for one day, what changes would you make to the medical care system, to make it work better for your family and your community,” 43% said they would lower cost or provide free services, 27% said they would improve access, and 7% said faster services. Others identified educating consumers, preventive care, overhauling the system, mental health and attitudes, as priorities.

• Borough-wide surveys and analyses identified the many barriers to care that exist for Brooklyn residents, especially in the disadvantaged communities that we serve. Some of their key findings include:
  
  o The BHWG report concludes that: “Healthcare in Brooklyn is at a critical juncture. Crucial services such as primary and preventive care are lacking in communities with high healthcare needs, putting financial and systems

4 The following factors account for a total of 31% of responses: Strong family life; Healthy behaviors and lifestyles; Religious or spiritual values; Parks and recreation; Clean environment; and Arts and cultural events.

5 The following health problems/issues accounted for 35% of responses: Asthma; Aging problems; Unemployment; Firearm-related injuries; Domestic violence; Child neglect/abuse; Youth violence; Tobacco use; Teenage pregnancy; Environmental hazards; Infectious diseases; and, Rape/sexual assault.
pressures on those institutions that do exist, such as safety net hospitals and their emergency rooms.”

- The BHIP report found that: “The most problematic health utilization is concentrated in three distinct places: (a) Brownsville/East New York; (b) Crown Heights North/Bedford Stuyvesant; and, (b) Bushwick/Stuyvesant Heights.” The report goes on to state “There is a shortage of quality, accessible primary care throughout much of Northern and Central Brooklyn.”

- The Work Group report states that: “Despite the variety of healthcare facilities and clinicians in Brooklyn, a combination of factors raises serious concerns regarding access to care, quality of care, and population health in Brooklyn. High rates of chronic disease are compounded by socioeconomic barriers to healthcare, such as lack of insurance, limited English proficiency, and poverty. Large segments of the population in several neighborhoods live in extreme poverty, have low levels of educational attainment, and are linguistically isolated.”

**Significant Quantitative Findings**

A review of quantitative data gathered from a variety of sources, gave us a better understanding of the needs in our service area. The following findings are informing the design of our healthcare strategy, and supported the selection of our priority diseases:

- In 2011, Brownsville had 177 deaths per 100,000 residents from diabetes, the highest rate of diabetes deaths city-wide. East New York followed close behind, with 135 deaths per 100,000 residents. The trend over the years indicates that this disease has a firm grip on our service area.

- Brooklyn had 445 new HIV/AIDS diagnoses during the period January-June, 2012, the most cases in New York City. The borough also had the highest number of deaths from HIV/AIDS during that period.

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9 NYC Department of Health and Mental Hygiene. “Epi Data Brief.” Jun 2013. No. 28

• The heart disease hospitalization rate in East New York and New Lots has increased by 35% in the past decade. The average annual heart hospitalization rate in 2003-2004 was 25% higher than the Brooklyn rate and 35% higher than the NYC rate.\textsuperscript{11}

• Approximately one third of adults in East New York and New Lots are obese (30%), a rate that is much higher than the Brooklyn rate (23%), and the New York City overall rate (20%).\textsuperscript{12}

• In general, the economically-challenged communities that we serve are disproportionately affected by health disparities. According to a 2010 NYC Department of Health report on health disparities,\textsuperscript{13} death rates are almost 30% higher in the low-income neighborhoods of New York City (South Bronx, East Harlem, and North and Central Brooklyn), with diseases like HIV/AIDS, diabetes, cancer, heart-related conditions, hypertension, and asthma, being the leading causes of death. The report states that in 2006, the death rate for these neighborhoods ranged from 700 to 927 deaths per 100,000, compared to wealthier neighborhoods (Upper East Side, West Side, and Lower Manhattan), where the rate ranged from 526 to 607 deaths per 100,000. A 2011 NYC Department of Health report on cancer disparities states that, “\textit{The burden of cancer incidents and deaths is unequally distributed by wealth, race and ethnicity in the city. Black New Yorkers living in the poorest neighborhoods are the most likely to die from colorectal, breast and cervical cancers, followed by Hispanics. Living in poverty makes it difficult to know about, find or access a variety of resources that promote health and prevent illness.”}\textsuperscript{14}

\textbf{Three-Year Plan}

The three-year implementation strategy is structured to prevent the spread of the two diseases that we selected as focus areas, Obesity and HIV/AIDS. We established our goals and objectives to optimize the use of successful models that we now have in place, community collaborations and other relevant resources outside of our service area.

\textbf{CSP Dissemination Plan}

The CSP will be disseminated through several distribution channels. First, the report will be placed on the Brookdale website, in an easily downloadable format, to facilitate access. We will ensure that the link to the report is readily available through major search engines. Second, the

\textsuperscript{11} NYC Department of Health and Mental Hygiene. “Community Health Profiles: Take Care East NY and New Lots.” 2006
\textsuperscript{12} Ibid.
\textsuperscript{13} NYC Department of Health and Mental Hygiene. “Health Disparities in New York City.” April 2010. No. 1
\textsuperscript{14} NYC Department of Health and Mental Hygiene. “Health Disparities in New York City.” July 2011. No. 2
report will be made available through the Office of the CEO, Office of Community Relations, and all of our medical administration offices. Third, we will distribute hard copies to our Brookdale Advisory Board, community-based organizations, faith-based organizations, Community Board Offices, elected officials, and all other stakeholders that participated in developing the CSP, who will be expected to utilize the report as an important resource, as they advocate and make policy decisions on behalf of Brooklyn communities.

**Engagement Plan after CSP Publication**

Community engagement is an important component of the multi-faceted strategy that we plan to implement, to tackle both diseases. As we progress through our three-year plan, we expect to continue to rely on our Working Group, public health officials, and other community stakeholders, to provide feedback and guidance, and to secure the buy-in of the larger community.
1. HOSPITAL MISSION STATEMENT

The Brookdale Hospital and Medical Center is committed to being the focus of a healthy community, stressing the organization’s values of caring and respect for everyone.

Vision

The Brookdale Hospital and Medical Center:

i. Provide quality, cost-effective healthcare.
ii. Assess the healthcare needs of the community.
iii. Provide an integrated healthcare system for the community.
iv. Promote and facilitate preventive care.
v. Foster education and research.
vi. Become a leader in healthcare in our area.
vii. Treat everyone with care, respect and dignity.
viii. Focus on customer satisfaction and cultural awareness.
ix. Increase pride in ourselves and what we do.
2. DESCRIPTION OF COMMUNITY

Brookdale is a non-profit teaching hospital that is located on an expansive campus at One Brookdale Plaza, Brooklyn, New York. Brookdale offers a full complement of healthcare services that include: inpatient care, ambulatory care, long-term care, senior living and emergency medicine. Brookdale is the only acute-care hospital between the neighborhoods of Brownsville and East New York and the Queens county border. Core assets that support the delivery of care to thousands of Brooklyn residents each year include:

- 530 certified acute-care beds;
- An Emergency Department, which is a New York State-designated Level-1 Trauma Center, and one of the busiest in the region;
- A 448-bed skilled-nursing facility, and an 86-unit assisted-living and independent-living facility, which both operate at a 95% or higher occupancy rate;
- Six primary care Brookdale Family Care Centers, at various locations in our service areas;
- A comprehensive Adult Day Care Center;
- A Level-3 Perinatal Center;
- A Mental and Behavioral Health Center;
- Ambulatory Surgery Center;
- A 16-chair dental suite that supports dental and oral services; and
- An HIV Center.

Demographic Composition

Brookdale serves residents primarily from the neighborhoods of Central Brooklyn, Brownsville/East New York, Canarsie and Flatlands, which are inside the geographic boundaries of Community Districts 5, 16, and 18. We made the determination that these neighborhoods comprise our primary service area based on a “hospital discharges by zip code” data analysis. In 2012, 72% of all discharges came from four zip codes in these neighborhoods (11212, 11207, 11208, and 11236). Further, we determined that another 10 zip codes, which fall within the areas of Central Brooklyn, Canarsie and Flatlands, Flatbush, Crown Heights and Bushwick (inside the geographic boundaries of Community Districts 3, 4, 8, 9 and 17), comprise our secondary service area. In 2012, 18% of all

15 These community assets are housed at either Brookdale Hospital or its affiliated entities, including: Brookdale Family Care Centers, Inc.; The Brookdale Residence Housing Development Fund Corporation (The Arlene and David Schlang Pavilion); The Schulman and Schachne Institute for Nursing and Rehabilitation, Inc.; and Urban Strategies/Brookdale Family Care Center, Inc.

16 Zip codes: 11233, 11239, 11203, 11234, 11203, 11234, 11213, 11226, 11221, 11216, 11225 and 11210.
discharges came from these zip codes. Both service areas account for 90% of our discharges.

Our primary and secondary service areas have a population of approximately 400,000, and 600,000, respectively, a total of approximately one million residents. The majority of residents from both service areas are Black/African American (approximately 70%). Both service areas have a very large concentration of immigrants, which is reflected in the composition of our patient population. The 2010 U.S. Census reports that 38% of residents in both service areas are immigrants.

The median age of residents in our primary service area is approximately 32, with approximately 31% under 19 years old. The median age in our secondary service area is slightly higher at approximately 35, with 27% under 19 years old.

Table I in the appendices section is a demographic breakdown of our patient population, based on discharges by zip code for 2012.

Socio-economic Status

Three of the four zip codes (11212, 11207 and 11208) in Brookdale’s primary service area have an average median household income of $32,000. Pockets of poverty exist in these zip codes – approximately 32% of residents live below the federal poverty level, compared to 22% for the borough of Brooklyn and 19% for New York City overall. The fourth zip code (11236) has a significantly higher median household income of approximately $62,000 and lower poverty level (approximately 12%). Our secondary service area has an average median income of $44,000. Five of 10 zip codes in the secondary service area have an average poverty rate of 28%.

The unemployment rate for the borough of Brooklyn is 9.6%, slightly higher than the rate for New York City (8.7%). Approximately 50% of residents in our service areas receive income support (Temporary Assistance for Needy Families, Supplemental Security Income, and Medicaid). In 2012, 53% of patients served paid for their healthcare with Medicaid, 29% paid with Medicare, and 14% paid with private insurance. The percentage


17 U.S. Census. 2010
18 U.S. Census. 2010
19 U.S. Census. 2010
20 U.S. Census Data. 2010
21 U.S. Census. 2010
22 U.S Bureau of Labor Statistics
of residents with no health insurance coverage ranges from 10% in Canarsie/Flatlands, to 25% in Bushwick.

Several of the service area neighborhoods are designated as “Health Professional Shortage Areas” and/or “Medically Underserved Areas” by the U.S. Department of Health and Human Services/Health Resources and Services Administration (HHS/HRSA)\textsuperscript{23}. The disease burden is high – residents suffer disproportionately from diseases like HIV/AIDS, heart disease, obesity, diabetes, cancer and sickle cell anemia. Maternal and newborn health indicators are also poor in Brookdale’s target area; several zip codes have low birth weight, premature birth, teen pregnancy, and infant mortality rates that are among the highest in Brooklyn.

Our service areas are plagued by crime, especially gun-violence. Typically, the Brookdale Emergency Room, a Level-1 Trauma Center, treats a gun-shot wound victim every 36 hours. The New York City Police Department (NYPD) recently designated our primary service area as an “Impact Zone,” due to the high number of gun murders and other crimes. This designation was based on NYPD in-depth analysis of crime stats through Compstat, and means that the area will receive intensive policing, to reduce the level of criminal activity.

In general, we can conclude that the socio-economic factors that characterize and shape the communities that we serve create many barriers to accessing the healthcare system. For example, the cultural and linguistic diversity of the large immigrant population present unique challenges. We understand that our efforts to develop a healthcare system that is responsive to the needs of\textit{all} residents in our service area must take into account the socio-economic differences.

\textsuperscript{23} U.S. Health and Human Services/Health Resources and Services Administration. www.hpsafind.hrsa.gov
3. PUBLIC PARTICIPATION

As we re-design our healthcare delivery model to become more efficient and responsive to the needs of the communities we serve, securing a broad range of perspectives from the public is a high priority. The Community Service Plan (CSP) development process was an opportunity to seek the involvement of a diverse group of stakeholders, to obtain honest feedback and constructive recommendations. The public participation effort was led by the Brookdale Hospital Working Group (the “Working Group”), a cross-functional team from Brookdale, which included: Hospital Administrators, Nursing Leadership, Senior Leadership, Clinical Leadership, External Affairs, Finance and Operations.

Working Group Participants

Chairperson of Outpatient Services
Vice President of Outpatient Services
Vice President for External Affairs
Administrator for the Department of Medicine
Associate Administrator of Emergency Department
Director of the Treatment for Life Center
Director of Pediatric Cardiology
Director of Public Affairs
Assistant Director of Staff Development
Operations Manager
Manager of Public Affairs
Administrative Coordinator, Treatment for Life Center

Working Group Responsibilities

The Working Group was responsible for the following activities:
• Engaged stakeholders in the CSP planning process.

• Identified public health officials and community stakeholders who would support our work.

• Obtained input from our healthcare professionals who are on the frontline of healthcare delivery.

• Designed and conducted two surveys (both in English and Spanish), to obtain the perspective of community residents. The first, a multiple choice format, gauged residents’ perception of personal and community health. The second, an interactive survey, was designed to elicit residents’ vision for healthcare in the community. The surveys were distributed at various locations on the Brookdale Campus and in the larger community as follows:

  o At all six of our Brookdale Family Care Centers, located throughout the community (see map below).

  o At multiple locations throughout the hospital where patients and visitors were likely to complete the survey, including: Ambulatory Care Clinic, Pastoral Services, Laboratory Services, Emergency Room, Radiology, OB/GYN Services, Out-Patient Physical Therapy, Psychiatry, and Internal Medicine.

  o To Community Advisory Boards, including the Brookdale Hospital Community Advisory Board (members represent Community Boards 5, 14, 16, 17 and 18), and Community Boards 17’s Social Services Committee.
o A local school (JHS 275 on Rockaway and Linden Boulevard).

o At multiple local churches inside zip codes 11212, 11213, 11236, 11234, 11239, 11203, 11207 And 11208.

o At a Brookdale Community Health Fair on June 15, 2013.

o At the Barbados Day Fair on August 13, 2013.

- Coordinated and participated in numerous planning and informational meetings and events with a variety of organizations, including the Greater New York Hospital Association (GNYHA), NYC Department of Health and Mental Hygiene (NYCDOHMH), and the Brooklyn Perinatal Network. A list of meeting activities is included as an appendix.
4. ASSESSMENT AND SELECTION OF PUBLIC HEALTH PRIORITIES

The mandate to develop a CSP presented a unique opportunity for us to work side by side with community residents, public health officials, and other key community stakeholders, to focus on one of our central goals: To adapt and enhance our service delivery model, to continue to meet the healthcare needs of the communities that we serve.

Our objectives for this CSP\(^\text{24}\) are to:

a. Identify the healthcare needs of the communities that we serve.

b. Identify the barriers to accessing healthcare in the communities that we serve.

c. Identify the gaps in healthcare delivery in the communities that we serve.

d. Identify the diseases and social conditions that are having the most devastating impact on residents.

e. Assess Brookdale’s capacity to work with the community, to meet the healthcare needs of residents, including addressing the priority diseases.

f. Develop a three-year plan to address two of the priority diseases identified, synergizing our efforts with the New York State Prevention Agenda, as well as the New York City Department of Health and Mental Hygiene’s “Hospital Community Health Interventions.”

g. Identify the resources and the community support systems that will help us accomplish our goals.

\(^\text{24}\)The three-year plan for each of the two priority diseases, developed as a result of this CSP process, can be found on pages 41-46 of this report.
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<th>New York State Health Improvement Plan - Prevention Agenda Priority Areas</th>
<th>New York City Dept. of Health – Hospital Community Intervention Guide Priorities</th>
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<td>NYS Priority Area: Prevent Chronic Diseases</td>
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<td>Focus Area 1: Reduce obesity in children and adults.</td>
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<td>Priority 2: HIV/AIDS</td>
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<td>Take Care NY Priority: HIV Prevention</td>
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<td>New York State Health Priority Area: Prevent HIV, STDs, Vaccine-Preventable Diseases, and Health-Associated Infections.</td>
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<td>Focus Area 2: Human Immunodeficiency Virus (HIV)</td>
<td>Activity #8: Ensure routine HIV testing in Emergency Departments and all outpatient clinics.</td>
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<td>Intervention component: Offer all patients of unknown HIV status between the ages of 13-64 a voluntary HIV test.</td>
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<td>Activity #9: Reduce the percent of HIV positive patients with detectable viral loads.</td>
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<td>Intervention Components:</td>
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<td>• Assess viral loads of HIV positive patients and prescribe viral suppression medication as needed</td>
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<td>• Track viral loads in population of HIV patients and reduce percent with detectable viral loads as a quality improvement project.</td>
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Methodology

The Working Group led the effort to develop the CSP. Beginning in February 2013, the Working Group worked with staff across the hospital to agree on the scope of the report, and a strategy to ensure that all the reporting criteria were met. The Working Group was instrumental in creating the community momentum needed to launch a needs assessment and an interactive survey, identifying the data sets that would be relevant to the CSP development, and establishing our disease priorities. Our goal was to obtain both quantitative and qualitative data that would allow us to address the seven objectives listed in this section.

(i) Qualitative Study

A community needs survey and interactive survey, designed by our Working Group, provided qualitative data. The community needs survey enabled us to capture the perspective of 563 residents from our primary service area, on various health topics. The interactive survey gave us the perspective of another 70 residents. A representative sample of the service area participated in both of the surveys i.e. male and female adults, senior citizens, immigrants, and non-immigrants.

We also assessed findings from three separate studies of the Brooklyn healthcare system, which were conducted by the Brooklyn Healthcare Improvement Project (B-HIP), Senator John Sampson’s Brooklyn Healthcare Working Group (BHWG), and the Brooklyn MRT Health Systems Redesign Work Group (the “Work Group”).

(ii) Quantitative Study

The quantitative study drew on data primarily from the New York City Department of Health and Mental Hygiene (NYCDOHHM), U.S Census Data, and the U.S. Department of Health and Human Services Department (HHS). Data sets from our own internal database also informed this process.
• **Age** – The age distribution of our survey participant pool was representative of our service areas, and therefore, our patient population. Note that two of the age categories for the Brookdale survey (25 or less, and 26-39) vary slightly from the community categories, which come from the U.S. Census data.

• **Gender** – The overwhelming majority of survey participants were female.
• **Race** – Survey participants reflected the racial composition of our service areas, which is predominantly Black/African American.

• **Marital Status** – The majority of participants were not married/single.
• **Education** – The majority of survey participants had an education level at or above high school level.

• **Household Income** – Close to 50% of survey participants reported having household income below the federal poverty level.
• **Zip Code** – The majority of survey participants came from our primary service area.
Our review of the data gathered uncovered a variety of findings, ranging from what residents perceive to be the most important health problems in their community, to the leading causes of death. We confirmed what our clinical evidence has shown for the past two decades:

(i) That the disease **Obesity**, and several associated secondary health conditions (heart disease, diabetes, hypertension, and cancer), are disproportionately prevalent; and

(ii) That the disease **HIV/AIDS** continues to be a major health issue.

The evidence led us to conclude that Obesity and HIV/AIDS should be our two public health priorities, over the course of the next three years. In New York City, the communities of eastern and central Brooklyn have the highest number of adults and children who are obese, and individuals diagnosed and living with HIV/AIDS. These communities are in dire need of the healthcare resources and prevention programs that will help them fight both diseases. Many years ago, after recognizing the devastation that both diseases were inflicting on our patient population, our doctors developed and launched prevention and treatment models to address both (10 years for Obesity and approximately 12 years for HIV/AIDS). The three-year plan that we present in this report is intended to enhance and expand our existing models, to result in broader reach and impact.

The data presented highlight:

- The significant qualitative findings from the surveys that we conducted and other relevant studies; and,

- The significant quantitative findings that are relevant to the communities that we serve.

### Qualitative Findings

Following are some of the qualitative findings from our surveys that will inform our strategic approach to healthcare, and led to the selection of our disease priorities:

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When survey participants were asked to identify the most important factors that contribute to a “healthy community,” a good place to raise children and good schools ranked first (22%), safety/low crime ranked second (15%), and access to healthcare ranked third (12%). Affordable housing, and good jobs and a healthy economy each ranked fourth (10%). Participants identified several other factors as important, which together, accounted for 31% of responses.27

Survey participants rated obesity-related diseases as the most important health problem in their community (25%), with HIV/AIDS and STDs ranking second (9%), cancer, access to healthcare, poverty and homelessness tying for third place (8%), and mental health ranking fourth (7%). Participants identified several other diseases as important, which together, accounted for 35% of responses.28

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27 The following factors account for a total of 31% of responses: Strong family life; Healthy behaviors and lifestyles; Religious or spiritual values; Parks and recreation; Clean environment; and Arts and cultural events.

28 The following health problems/social issues accounted for 35% of responses: Asthma; Aging problems; Unemployment; Firearm-related injuries; Domestic violence; Child neglect/abuse; Youth violence; Tobacco use; Teenage pregnancy; Environmental hazards; Infectious diseases; and, Rape/sexual assault.
(iii) Survey participants ranked drug and alcohol abuse (32%) as the “most risky behaviors in our community.” Obesity-related behavior ranked second (26%), unsafe sex ranked third (12%), and 30% of participants identified several other behaviors as risky.29

![Most Risky Behaviors in our Community](image)

(iv) Only 14% of survey participants rated their community as healthy, while 46% rated it as “somewhat healthy”, and 27% rated it as “unhealthy.”

![How would you rate the overall health of our community?](image)

29 The following behaviors account for 30% of responses: Dropping out of school; Unsecured firearms; Tobacco use; Not using birth control; Not getting “shots” to prevent disease; and, Lack of maternity care.
(v) When asked about their personal health, 39% of participants believe that they are healthy.

How would you rate your own personal health?

- Very Healthy: 9%
- Somewhat Healthy: 42%
- Unhealthy: 8%
- Very Unhealthy: 2%

(vi) 36% of survey participants reported that they have been told by a healthcare professional that they are overweight or obese.

Have you ever been told by health professional that you are overweight or obese?

- Yes: 36%
- No: 64%
(vii) 49% of survey participants reported that they have been told by a healthcare professional that they have high-blood pressure.

Have you ever been told by a health professional that you have high blood pressure?

No 51%
Yes 49%

(viii) 42% of survey participants reported that they have been told by a healthcare professional that they have high cholesterol.

Have you ever been told by a health professional that your cholesterol is high?

No 58%
Yes 42%
(ix) 31% of survey participants reported that they have been told by a healthcare professional that they have diabetes.

Have you ever been told by a doctor that you have diabetes?

(x) When participants were asked the question: “Are there any medical or health-related services you think your neighborhood needs more of,” 17% said more obesity-related services, 16% said more emergency room/urgent care services, and 14% said access to care.

Are there any medical or health-related services you think your neighborhood needs more of? If so, what are the services?
(xi) When participants were asked the question “If you were given the power for one day, what changes would you make to the medical care system, to make it work better for your family and your community,” 43% said they would lower cost or provide free services, 27% said they would improve access, and 7% said faster services. Others identified educating consumers, preventive care, overhauling the system, mental health and attitudes, as priorities.

If you were given the power for one day, what changes would you make in the medical care system that you feel would make it work better for you, your family, and for people in your community?

![Pie chart showing the responses]

(xii) Several assessments identified the many barriers to care that exist for Brooklyn residents, especially in the disadvantaged communities that we serve. Some of the key findings include:

(a) The BHWG study:

- Healthcare in Brooklyn is at a critical juncture. Crucial services such as primary and preventive care are lacking in communities with high healthcare needs, putting financial and systems pressures on those
institutions that do exist, such as safety net hospitals and their emergency rooms.30

- The primary care infrastructure in Brooklyn must be improved in order to reduce healthcare costs, and improve quality, and that this improved primary care capacity must be ensured before existing healthcare services are substantially re-designed or downsized.31

- There is a significant shortage of Primary Care Physicians (PCPs) to serve the health needs of the Brooklyn population.32

- The lack of access to primary care services drives patients to hospital emergency rooms for ambulatory sensitive conditions, putting strain on hospital emergency rooms and finances.33

(b) The B-HIP study:

- Patients’ perception of their own Emergency Room usage suggests that a significant number could be seen in a more appropriate venue, but that available options are inadequate to address patient need.34

- There is a shortage of quality, accessible primary care throughout much of Northern and Central Brooklyn.35

- The most problematic health utilization is concentrated in three distinct places: (a) Brownsville/East New York; (b) Crown Heights North/Bedford Stuyvesant; and, (c) Bushwick/Stuyvesant Heights.36

- Interventions to improve the healthcare system will have to include: (1) Changes to the healthcare delivery system; and, (2) Improving patient and community engagement/empowerment in their own healthcare and healthcare system.37

31 Ibid.
32 Ibid.
33 Ibid.
36 Ibid. Page 7.
37 Ibid. Page 8
(c) The Work Group study:

- “Community health needs and health care resources vary widely by neighborhood. Disparities in health status are also associated with poverty, race, and ethnicity.”  

- “Despite the variety of healthcare facilities and clinicians in Brooklyn, a combination of factors raises serious concerns regarding access to care, quality of care, and population health in Brooklyn. High rates of chronic disease are compounded by socio-economic barriers to healthcare, such as lack of insurance, limited English proficiency, and poverty. Large segments of the population in several neighborhoods live in extreme poverty, have low levels of educational attainment, and are linguistically isolated.”

- “Brooklyn faces daunting population challenges. High rates of chronic disease are exacting a human and economic toll.”

- “High rates of preventable hospitalizations and above-average lengths of stay suggest that a significant portion of inpatient care in Brooklyn hospitals would not be necessary, if primary and outpatient care were improved and inpatient care were managed more efficiently.”

> Quantitative Findings

Analysis of quantitative data gathered from a variety of sources, gave us a better understanding of the needs in our service area. The following key findings are informing the development of our overall healthcare strategy, and the selection of our disease priorities:

(i) **Obesity** - Approximately one third of adults in East New York and New Lots are obese (30%), a rate that is much higher than the Brooklyn rate (23%), and the New York City overall rate (20%). The data suggest that there is a positive correlation between poverty and obesity.

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40 Ibid. Page 5.
41 Ibid. Page 5.
42 Ibid.
Obesity - 3 in 10 adults in East New York and New Lots are obese

[Bar chart showing percent of adults who are obese in East New York & New Lots, Brooklyn, and New York City.]


Overweight and obesity among NYC public high school students, by race/ethnicity

[Bar chart showing percentage of overweight and obese high school students by race/ethnicity.]

Overweight and obesity, nutrition in NYC public high schools with low and high poverty

![Chart showing percentage of youth in overweight/obese, eating fruits and vegetables at least 2 times/day, drinking sugary drinks at least 2 times/day by poverty level.]

(ii) **Diabetes** - In 2011, Brownsville had 177 deaths per 100,000 residents from diabetes, the highest rate of diabetes deaths city-wide. East New York followed close behind with 135 deaths per 100,000 residents. The trend over the years indicates that this disease has a firm grip on our service area.\(^{43}\)

NYC community districts with highest and lowest age-adjusted related deaths, 2011

![Bar chart showing age-adjusted rate per 100,000 population for various districts of NYC.][1]

(iii) **Heart Disease** - The heart disease hospitalization rate in East New York and New Lots has increased by 35% in the past decade. The average annual heart hospitalization rate in 2003-2004 was 25% higher than the Brooklyn rate and 35% higher than the NYC rate.\(^{44}\) The age-adjusted heart disease mortality rates per 100,000 for East New York was 7% higher than the Brooklyn rate, 40% higher than the Manhattan rate, and 15% higher than the overall New York City rate.\(^{45}\)

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\(^{43}\) NYC Department of Health and Mental Hygiene. “Epi Data Brief.” Jun 2013. No. 28

\(^{44}\) NYC Department of Health and Mental Hygiene. “Community Health Profiles: Take Care East NY and New Lots.” 2006

\(^{45}\) NYC Department of Health and Mental Hygiene. Epiquery Data. 2007
(iv) **Asthma** - Residents from our primary service area are more likely to suffer from asthma than adults in NYC overall; adults in East New York have a higher rate of self-reported asthma (7%) than in NYC (5%). 46

Asthma - East New York and New Lots adults are more likely to suffer from asthma than adults in NYC overall


(v) **HIV/AIDS** - Brooklyn had 445 new HIV/AIDS diagnoses during the period January- June, 2012, the most cases in New York City. The borough also had the highest number of deaths from HIV/AIDS during that period. 47

46 Ibid.
Health Disparities - In general, the economically-challenged communities that we serve are disproportionately affected by health disparities. According to a 2010 NYC Department of Health report on health disparities, death rates are almost 30% higher in the low-income neighborhoods of New York City (South Bronx, East Harlem, and North and Central Brooklyn), with diseases like HIV/AIDS, diabetes, cancer, heart-related conditions, hypertension, and asthma, being the leading causes of death. The report states that in 2006, the death rate for these neighborhoods ranged from 700 to 927 deaths per 100,000, compared to wealthier neighborhoods (Upper East Side, West Side, and Lower Manhattan), where the rate ranged from 526 to 607 deaths per 100,000. A 2011 NYC Department of Health report on cancer disparities states that, “The burden of cancer incidents and deaths is unequally distributed by wealth, race and ethnicity in the city. Black New Yorkers living in the poorest neighborhoods are the most likely to die from colorectal, breast and cervical cancers, followed by Hispanics. Living in poverty makes it difficult to know about, find or access a variety of resources that promote health and prevent illness.”

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Death rates are higher in the poorest neighborhoods and among blacks across NYC (2004 - 2006)

NYC Dept. of Health and Mental Hygiene. Health Disparities in NYC. April 2010. No. 1
5. THREE-YEAR ACTION PLAN

Brookdale’s three-year implementation strategy is structured to prevent the spread of the two disease priorities, **Obesity** and **HIV/AIDS**. We established our goals and objectives to optimize the use of successful models that we now have in place, community collaborations and other relevant resources outside of our service area. In addition, we have elected to become a **Take Care New York Partner Hospital**, to support the larger New York City intervention efforts for Obesity and HIV/AIDS.
New York State Focus Area: Obesity (Year 1)

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<tbody>
<tr>
<td>1. Reduce the prevalence of obesity in the Brookdale Hospital and Medical Center (Brookdale) child and adult patient population, and the communities that we serve.</td>
<td>1. Develop an obesity education and training module for clinicians, to help them understand the disease obesity, identify obese patients, and provide or direct them to nutrition and fitness counseling, as appropriate.</td>
<td>The Brookdale Live Light, Live Right child obesity program expertise, leadership, and infrastructure. 2. Obesity education and training module for clinicians. 3. Clinicians who are trained in: identifying obese patients, knowing how to broach the subject, and provide or direct to appropriate counseling on nutrition and exercise. 4. EPIC (Brookdale’s electronic health records system) capacity to capture obesity assessment, counseling provided, and patient progress. 5. Nutrition guidelines (AAP Guidelines) and recommendations for patients. 6. Health and wellness workshops and newsletters for staff, patients, and community. 7. Healthy food choices for Brookdale employees and patients (cafeteria, hospital patient menus, vending machines, Green Cart). 8. HLB model to impact obesity in the community. 9. Free or low-cost exercise programs in the community. 10. Wellness Champions to support work of HLB and community roll out. 11. Community partners.</td>
<td>1. Develop and implement an obesity training and wellness module for clinicians. 2. Clinicians will identify obese patients and record and track Body Mass Index (BMI), weight and waist size for each. 3. Work with clinicians and tech staff to ensure that EPIC has capacity to capture and track obese patient data and impact of counseling. 4. Develop materials on obesity prevention, nutrition and physical activity, to share with patients at counseling, with staff, and to place at strategic locations throughout the hospital and community. 5. Coordinate workshops and information sessions on healthy living for staff, patients, and community. 6. Enroll employees in HLB physical activity/weight loss challenge. 7. Develop and maintain partnerships with local gyms and other fitness-focused entities, to offer low rates on gym memberships. 8. Identify outpatient nutrition resources in our 4 primary zip code for patient use. 9. Identify and apply for grant funding and other resources to support implementation of goals.</td>
<td>1. Obesity education and training module for clinicians developed. 2. 10% of outpatient setting clinicians received obesity education and training. 3. Mechanism in place in EPIC to capture and track obese patients. 4. 5% of clinicians are identifying patients who are obese, and providing counseling. 5. 25% of patients identified as obese receive counseling. 6. At least 5% of obese patients will show a drop in BMI, waist size, and weight. 7. At least 10% of obese patients report: reduction in intake of sugary drinks; healthy eating habits; and an increase in their level of physical activity. 8. At least 20 Wellness Champions. 9. 10% of Brookdale employees are participating in HLB. 10. Child and adult wellness education materials created to support education of patients, and staff. 11. Two community partnerships established, to support and sustain this effort in primary communities. 12. Healthier food choices available at Brookdale. 13. Linkage established to at least one local gym/other fitness-focused organization. 14. Linkages established with at least 10 CBOs/FBOs. 15. Participation in at least 12 community outreach events.</td>
<td>1. At least 10% of Brookdale clinicians are trained to identify obesity and provide counseling and treatment. 2. Brookdale’s EPIC system has the capacity to track obese patients and relevant statistics (BMI, weight, waist size). 3. At least 10% of Brookdale patients identified as obese are taking steps to healthier lives, reducing the incidence of obesity in the community. 4. Brookdale has strong relationships with external community partners, to promote physical activity and education in patient population. 5. The HLB program is having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported. 6. Brookdale has a healthy food environment, with healthier food choices, which we expect to have a positive impact on our patient population and the community.</td>
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## New York State Focus Area: Obesity (Year 2)

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</tr>
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</table>
| 1. Reduce the prevalence of obesity in the Brookdale child and adult patient population, and the communities that we serve. | 1. Develop an obesity education and training module for clinicians, to help them understand the disease obesity, identify obese patients, and provide or direct them to nutrition and fitness counseling, as appropriate. | 1. The Brookdale Live Light, Live Right child obesity program expertise, leadership, and infrastructure. | 1. Implement obesity education and training for clinicians. | 1. 10% of Brookdale clinicians who provide care in the outpatient setting received obesity education and training. | 1. At least 10% of Brookdale clinicians are trained to identify obesity and provide counseling and treatment. |}
| 2. Promote physical activity in our patient population and the communities that we serve, to impact obesity and obesity-related diseases. | 2. At least 10% of obese patients utilizing EPIC data. | 2. Clinicians will track progress of obese patients utilizing EPIC data. | 2. At least 20% of clinicians are identifying patients who are obese, and providing counseling. | 2. At least 25% of Brookdale patients identified as obese are taking steps to healthier lives, reducing the incidence of obesity in the community. | 2. Brookdale’s EPIC system has the capacity to track obese patients and relevant statistics (BMI, weight, waist size). |
| 3. Promote wellness education that is focused on reducing obesity and obesity-related diseases. | 3. At least 5% of obese patients will show a drop in BMI, waist size, and weight. | 3. Distribute materials on obesity prevention, nutrition and physical activity, to share with patients at counseling, with staff, and to place at strategic locations throughout the hospital and community. | 3. At least 50% of patients/families who have been identified as obese receive counseling. | 3. At least 25% of Brookdale patients identified as obese are taking steps to healthier lives, reducing the incidence of obesity in the community. | 3. At least 25% of Brookdale patients identified as obese are taking steps to healthier lives, reducing the incidence of obesity in the community. |
| 4. Promote a healthy food environment in the communities that we serve. | 4. At least 30 Wellness Champions. | 4. Distribute materials on obesity prevention, nutrition and physical activity, to share with patients at counseling, with staff, and to place at strategic locations throughout the hospital and community. | 4. At least 5% of obese patients will show a drop in BMI, waist size, and weight. | 4. At least 10% of obese patients report: reduction in intake of sugary drinks; healthy eating habits; and an increase in their level of physical activity. | 4. Brookdale has strong relationships with external community partners, to promote physical activity and education in patient population. |
| 5. Build an extensive network of CBOs, FBOs and other community stakeholders, to support our efforts to have a positive impact on obesity and obesity-related diseases. | 5. Coordinate workshops and information sessions on healthy living for staff, patients and community; enroll employees in HLB physical activity/weight loss challenge. | 5. Coordinate workshops and information sessions on healthy living for staff, patients and community; enroll employees in HLB physical activity/weight loss challenge. | 5. Continue to develop and maintain partnerships with local gyms and other fitness-focused entities, to offer low rates on gym memberships; Identify outpatient nutrition resources in our 4 primary zip codes for patient use. | 5. At least 30 Wellness Champions. | 5. The HLB program is having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported. |
| 6. Promote wellness education and physical activity, and create a healthy food environment at Brookdale for all staff, through our newly developed “Healthy Living at Brookdale” (HLB) wellness initiative. | 6. 15% of Brookdale employees are participating in HLB. | 6. Continue to develop and maintain partnerships with local gyms and other fitness-focused entities, to offer low rates on gym memberships; Identify outpatient nutrition resources in our 4 primary zip codes for patient use. | 6. 20% of Brookdale employees are participating in HLB. | 6. 15% of Brookdale employees are participating in HLB. | 6. Brookdale has a healthy food environment, with healthier food choices, which we expect to have a positive impact on our patient population and the community. |
| 7. Identify funding opportunities and resources to support our CSP work for this priority. | 7. Healthier food choices available at gyms and other fitness-focused locations throughout the community. | 7. Healthy food choices for Brookdale employees and patients (cafeteria, hospital patient menus, vending machines, Green Cart). | 7. Healthier food choices available at gyms and other fitness-focused locations throughout the community. | 7. 15% of Brookdale employees are participating in HLB. | 7. Brookdale has a healthy food environment, with healthier food choices, which we expect to have a positive impact on our patient population and the community. |
**New York State Focus Area: Obesity (Year 3)**

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<tr>
<td>1. Reduce the prevalence of obesity in the Brookdale child and adult patient population, and the communities that we serve.</td>
<td>1. Develop an obesity education and training module for clinicians, to help them understand the disease obesity, identify obese patients, and provide or direct them to nutrition and fitness counseling, as appropriate.</td>
<td>1. The Brookdale Live Light, Live Right child obesity program expertise, leadership, and infrastructure.</td>
<td>1. Implement obesity education and training for clinicians.</td>
<td>1. 10% of Brookdale clinicians who provide care in the outpatient setting received obesity education and training.</td>
<td>1. At least 10% of Brookdale clinicians providing care in the outpatient setting are trained to identify obesity and provide counseling and treatment.</td>
</tr>
<tr>
<td>2. Promote physical activity in our patient population and the communities that we serve, to impact obesity and obesity-related diseases.</td>
<td>2. Obesity education and training module for clinicians.</td>
<td>2. Brookdale EPIC system has a database of all obese patients identified, and their relevant statistics (BMI, weight, waist size).</td>
<td>2. Clinicians will identify obese patients, and record and track Body Mass Index (BMI), weight and waist size for each.</td>
<td>2. 30% of clinicians are identifying patients who are obese, and providing counseling.</td>
<td>2. Brookdale EPIC system has a database of all obese patients identified, and their relevant statistics (BMI, weight, waist size).</td>
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<tr>
<td>3. Promote wellness education that is focused on reducing obesity and obesity-related diseases.</td>
<td>3. Clinicians who are trained in: identifying obese patients, knowing how to broach the subject, and provide or direct to appropriate counseling on nutrition and exercise.</td>
<td>3. At least 50% of Brookdale patients identified as obese are taking steps to healthier lives, reducing the incidence of obesity in the community.</td>
<td>3. Clinicians will track progress of obese patients utilizing EPIC data.</td>
<td>3. 75% of patients/families who have been identified as obese receive counseling.</td>
<td>3. At least 50% of Brookdale patients identified as obese are taking steps to healthier lives, reducing the incidence of obesity in the community.</td>
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<tr>
<td>4. Promote a healthy food environment in the communities that we serve.</td>
<td>4. EPIC (Brookdale’s electronic health records system) capacity to capture obesity assessment, counseling provided, and patient progress.</td>
<td>4. EPIC (Brookdale’s electronic health records system) capacity to capture obesity assessment, counseling provided, and patient progress.</td>
<td>4. Distribute materials on obesity prevention, nutrition and physical activity, to share with patients at counseling, with staff, and to place at strategic locations throughout the hospital and community.</td>
<td>4. At least 10% of obese patients report: reduction in intake of sugary drinks; healthy eating habits; and an increase in their level of physical activity.</td>
<td>4. At least 50% of Brookdale patients identified as obese are taking steps to healthier lives, reducing the incidence of obesity in the community.</td>
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<tr>
<td>5. Build an extensive network of CBOs, FBOs and other community stakeholders, to support our efforts to have a positive impact on obesity and obesity-related diseases.</td>
<td>5. Nutrition guidelines (AAP Guidelines) and recommendations for patients.</td>
<td>5. Improve employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
<td>5. Coordinate workshops and information sessions on healthy living for staff, patients and community.</td>
<td>5. The HLB program is integrated into Brookdale employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
<td>4. Brookdale has strong relationships with external community partners, to promote physical activity and education in patient population.</td>
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<tr>
<td>6. Promote wellness education and physical activity, and create a healthy food environment at Brookdale for all staff, through our newly developed “Healthy Living at Brookdale” (HLB) wellness initiative.</td>
<td>6. Wellness workshops and newsletters for staff, patients, and community.</td>
<td>6. The HLB module is implemented in the community.</td>
<td>6. Enroll employees in HLB, and our CSP goals.</td>
<td>6. At least 40 Wellness Champions.</td>
<td>5. The HLB program is integrated into Brookdale employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
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<tr>
<td>7. Identify funding opportunities and resources to support our CSP work for this priority.</td>
<td>7. Healthy food choices for Brookdale employees and patients (catereria, hospital patient menus, vending machines, Green Cart).</td>
<td>7. Healthy food choices for Brookdale employees and patients (catereria, hospital patient menus, vending machines, Green Cart).</td>
<td>7. Coordinate workshops and information sessions on healthy living for staff, patients and community.</td>
<td>7. 20% of Brookdale employees are participating in HLB.</td>
<td>5. The HLB program is integrated into Brookdale employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
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<tr>
<td>8. Develop a comprehensive program to support our HLB and our CSP goals.</td>
<td>8. HLB module to impact obesity in the community.</td>
<td>8. Healthy food choices for Brookdale employees and patients (catereria, hospital patient menus, vending machines, Green Cart).</td>
<td>8. Enroll employees in HLB, and our CSP goals.</td>
<td>8. Child and adult wellness education materials created to support education of patients, and staff; 2 community partnerships established, to support and sustain this effort in primary communities.</td>
<td>5. The HLB program is integrated into Brookdale employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
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<tr>
<td>9. Improve employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
<td>9. Free or low-cost exercise programs in the community.</td>
<td>9. Free or low-cost exercise programs in the community.</td>
<td>9. Identify outpatient nutrition resources in our 4 primary zip codes for patient use.</td>
<td>9. Healthier food choices available at Brookdale.</td>
<td>5. The HLB program is integrated into Brookdale employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
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<td>10. Wellness Champions to support work of HLB and community roll out.</td>
<td>10. Wellness Champions to support work of HLB and community roll out.</td>
<td>10. Wellness Champions to support work of HLB and community roll out.</td>
<td>10. Identify and apply for grant funding and other resources to implement goals.</td>
<td>10. Linkage established to at least one local gym/other fitness-focused organizations.</td>
<td>5. The HLB program is integrated into Brookdale employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
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<tr>
<td>11. Community partners.</td>
<td>11. Community partners.</td>
<td>11. Community partners.</td>
<td>11. Linkages established to at least 14 CBOs/FBOs and other community organizations.</td>
<td>11. Participation in at least 12 community outreach events.</td>
<td>5. The HLB program is integrated into Brookdale employee lifestyle and having a positive impact on the health of employees and the community, as evidenced by the number of Wellness Champions, employees and community residents enrolled, BMI, weight loss, and healthier eating reported.</td>
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New York State Focus Area: HIV/AIDS (Year 1)

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</thead>
<tbody>
<tr>
<td>1. To promote HIV testing, to reduce HIV/AIDS disease burden in our primary and secondary service areas.</td>
<td>1. Comply with the NYS Ch. 308 Public Health Law, by promoting awareness of HIV patient testing requirement among Brookdale staff.</td>
<td>1. NYC DOHMH and Brookdale Ch. 308 Public Health Law training.</td>
<td>1. Incorporate HIV testing requirement into orientation for new clinicians.</td>
<td>1. 50% of clinicians participate in NYCDOH or Brookdale education on Ch. 308 law and are trained to offer HIV test at all patient access points.</td>
<td>1. Brookdale is complying with NYS Ch. 308 HIV education &amp; testing law, by promoting HIV education &amp; testing requirement among clinicians.</td>
</tr>
<tr>
<td>2. To identify and coordinate a continuum of care for HIV positive patients, to maintain the number of patients with undetectable viral load, and to achieve below detection viral load in newly identified patients.</td>
<td>2. Comply with the NYS Chapter 308 Public Health Law, by increasing the number of patients who are offered an HIV test by 10%, at patient access points.</td>
<td>2. Internal processes to actively promote testing at patient access points (ER, clinics, etc.).</td>
<td>2. Mandate and facilitate DOH or Brookdale Ch. 308 Public Law training for current clinician staff.</td>
<td>2. 10% increase in the number of patients offered HIV test.</td>
<td>2. Increase in the number of patients who are offered HIV test by 10%.</td>
</tr>
<tr>
<td>3. To strengthen the Brookdale Hospital and Medical Center’s (Brookdale) community stakeholder network, to support our efforts to reduce the spread of HIV/AIDS in our primary and secondary service areas.</td>
<td>3. Increase the number of HIV tests performed by 10%.</td>
<td>3. HIV testing.</td>
<td>3. Update and renew Memoranda of Understanding (MOUs) and linkages with community groups.</td>
<td>3. 10% of patients tested at Brookdale patient access points.</td>
<td>3. Increase in the number of patients with undetectable viral load.</td>
</tr>
<tr>
<td></td>
<td>4. Increase the number of new HIV+ patients linked to a continuum of care.</td>
<td>4. Post-test counseling.</td>
<td>4. Strengthen existing relationships with CBOs, FBOs, community providers and community leaders.</td>
<td>4. Increase in the number of patients with undetectable viral load.</td>
<td>4. Cultural and linguistically appropriate brochures, flyers and other educational materials.</td>
</tr>
<tr>
<td></td>
<td>5. Conduct risk reduction among HIV positive and non-HIV positive population.</td>
<td>5. Epic (Brookdale’s electronic health records system) data capacity to capture testing and case management data.</td>
<td>5. Identify and build new community relationships.</td>
<td>5. Rigorous case management and continuum of care in place for all HIV positive patients.</td>
<td>5. 100% of the newly identified HIV positive patients are linked and retained in a continuum of care.</td>
</tr>
<tr>
<td></td>
<td>7. Conduct at least 6 community outreach and engagement events, with at least 3 in non-traditional settings (i.e. shelters, transitional housing, churches, etc.).</td>
<td>7. Outreach mechanism to access non-traditional settings, community stakeholders, Faith-Based Organizations (FBO), Community-Based Organizations (CBO).</td>
<td>7. Form and engage multi-disciplinary hospital committee, to support 3-YR CSP goals.</td>
<td>7. Culturally and linguistically appropriate brochures, flyers and other educational materials.</td>
<td>7. Active participation of community network in promotion of HIV testing and risk reduction.</td>
</tr>
</tbody>
</table>
**New York State Focus Area: HIV/AIDS (Year 2)**

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
<th>Inputs</th>
<th>Action Steps</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To promote HIV testing, to reduce HIV/AIDS disease burden in our primary and secondary service areas.</td>
<td>1. Comply with the NYS Ch. 308 Public Health Law, by promoting awareness of HIV patient testing requirement among Brookdale staff.</td>
<td>1. NYC DOHMH and Brookdale Ch. 308 Public Health Law training.</td>
<td>1. Ensure that clinicians are receiving HIV testing requirement training at orientation.</td>
<td>1. 60% of clinicians participate in NYCDOH or Brookdale education on Ch. 308 law and are trained to offer HIV test at all patient access points.</td>
<td>1. Brookdale is complying with NYS Ch. 308 HIV education &amp; testing law, by promoting HIV education &amp; testing requirement among clinician staff.</td>
</tr>
<tr>
<td>2. To identify and coordinate a continuum of care for HIV positive patients, to achieve below detection viral load in newly identified patients.</td>
<td>2. Comply with the NYS Chapter 308 Public Health Law, by increasing the number of patients who are offered an HIV test by 10%, at patient access points.</td>
<td>2. Internal processes to actively promote testing at patient access points (ER, clinics, etc.).</td>
<td>2. Mandate and facilitate DOH or Brookdale Ch. 308 Public Law training for current clinician staff.</td>
<td>2. 10% increase in the number of patients offered HIV test.</td>
<td>2. Increase in the number of patients who are offered HIV test by 10%.</td>
</tr>
<tr>
<td>3. To strengthen Brookdale’s community stakeholder network, to support our efforts to reduce the spread of HIV/AIDS in our primary and secondary service areas.</td>
<td>3. Increase the number of HIV tests performed by 10%.</td>
<td>3. HIV testing.</td>
<td>3. Post-test counseling.</td>
<td>3. 10% of patients tested at Brookdale patient access points.</td>
<td>3. Increase in the number of patients who are tested by 10%.</td>
</tr>
<tr>
<td>4. Conduct risk reduction among HIV positive and non-HIV positive population.</td>
<td>4. Increase the number of new HIV positive patients linked to a continuum of care.</td>
<td>4. Multi-disciplinary hospital committee. Outreach mechanism to access non-traditional settings, community stakeholders, FBOs, CBOs.</td>
<td>4. Strengthen existing relationships with CBOs, FBOs, community providers and community leaders.</td>
<td>4. Increase in the number of patients with undetectable viral load.</td>
<td>4. 100% of the newly identified HIV positive patients are linked and retained in a continuum of care.</td>
</tr>
<tr>
<td>5. Promote medication adherence for HIV positive patients.</td>
<td>5. Conduct at least 6 community outreach and engagement events, with at least 3 in non-traditional settings (i.e. shelters, transitional housing, churches, etc.).</td>
<td>5. Messaging around HIV/AIDS prevention, to reach residents in service area.</td>
<td>5. Identify and build new community relationships.</td>
<td>5. Rigorous case management and continuum of care in place for all HIV positive patients.</td>
<td>5. Achieve below detection viral load in newly identified HIV positive patients.</td>
</tr>
</tbody>
</table>
### New York State Focus Area: HIV/AIDS (Year 3)

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
<th>Inputs</th>
<th>Action Steps</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To promote HIV testing, to reduce HIV/AIDS disease burden in our primary and secondary service areas.</td>
<td>1. Comply with the NYS Ch. 308 Public Health Law, by promoting awareness of HIV patient testing requirement among Brookdale staff.</td>
<td>1. NYC DOHMH and Brookdale Ch. 308 Public Health Law training.</td>
<td>1. Ensure that new clinicians are receiving HIV testing requirement training at orientation.</td>
<td>1. 75% of clinicians participate in NYCDOH or Brookdale education on Ch. 308 law and are trained to offer HIV test at all patient access points.</td>
<td>1. Brookdale is complying with NYS Ch. 308 HIV education &amp; testing law, by promoting HIV education &amp; testing requirement among clinician staff.</td>
</tr>
<tr>
<td>2. To identify and coordinate a continuum of care for HIV positive patients, to achieve below detection viral load in newly identified patients.</td>
<td>2. Comply with the NYS Chapter 308 Public Health Law, by increasing the number of patients who are offered an HIV test by 10%, at patient access points.</td>
<td>2. Internal processes to actively promote testing at patient access points (ER, clinics, etc.).</td>
<td>2. Mandate and facilitate DOH or Brookdale Ch. 308 Public Law training for current clinician staff.</td>
<td>2. 10% increase in the number of patients offered HIV test.</td>
<td>2. Increase in the number of patients who are offered HIV test by 10%.</td>
</tr>
<tr>
<td>3. To strengthen Brookdale’s community stakeholder network, to support our efforts to reduce the spread of HIV/AIDS in our primary and secondary service areas.</td>
<td>3. Increase the number of HIV tests performed by 10%.</td>
<td>3. HIV testing.</td>
<td>3. Update and renew Memoranda of Understanding (MOUs) and linkages with community groups.</td>
<td>3. 10% of patients tested at Brookdale patient access points.</td>
<td>3. Increase in the number of patients with undetectable viral load.</td>
</tr>
<tr>
<td></td>
<td>4. Increase the number of new HIV+ patients linked to a continuum of care.</td>
<td>4. Post-test counseling.</td>
<td>4. Rigorous case management and continuum of care in place for all HIV positive patients.</td>
<td>4. 100% of the newly identified HIV+ patients are linked and retained in a continuum of care.</td>
<td>4. 100% of the newly identified HIV+ patients are linked and retained in a continuum of care.</td>
</tr>
<tr>
<td></td>
<td>5. Conduct risk reduction among HIV positive and the non-HIV population.</td>
<td>5. EPIC (Brookdale’s electronic health records system) data capacity to capture testing and case management data.</td>
<td>5. Strengthen existing relationships with CBOs, FBOs, community providers and community leaders.</td>
<td>5. Risk reduction process in place.</td>
<td>5. Achieve below detection viral load in newly identified HIV+ patients.</td>
</tr>
<tr>
<td></td>
<td>6. Promote medication adherence for HIV patients.</td>
<td>6. Multi-disciplinary hospital committee. Outreach mechanism to access non-traditional settings, community stakeholders, FBOs, CBOs.</td>
<td>6. Culturally and linguistically appropriate brochures, flyers and other educational materials.</td>
<td>6. Active multi-disciplinary committee in place.</td>
<td>6. Active participation of community network in promotion of HIV testing and risk reduction.</td>
</tr>
<tr>
<td></td>
<td>7. Conduct at least 6 community outreach and engagement events, with at least 3 in non-traditional settings (i.e. shelters, transitional housing, churches, etc.).</td>
<td>7. Messaging around HIV/AIDS prevention, to reach residents in service area.</td>
<td>7. Conduct patient education workshops on risk reduction and medication adherence.</td>
<td>7. 6 community outreach events conducted, 3 in non-traditional settings.</td>
<td>7. Positive impact on HIV/AIDS disease burden in service areas.</td>
</tr>
<tr>
<td></td>
<td>9. Grant funding and other resources to sustain and expand TLC work.</td>
<td></td>
<td></td>
<td>9. Established community network in place.</td>
<td></td>
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</tbody>
</table>
6. DISSEMNATION OF PLAN TO PUBLIC

The CSP will be disseminated through several distribution channels. First, the report will be placed on the Brookdale website (www.brookdalehospital.org), in an easily downloadable format, to facilitate access. We will ensure that the link to the report is readily available through major search engines. Second, the report will be made available through our Office of the CEO, Office of Community Relations, and all of our medical administration offices. Third, we will distribute hard copies to our Community Advisory Board, community-based organizations, faith-based organizations, Community Board Offices, elected officials, and all other stakeholders that participated in developing the CSP, who will be expected to utilize the report as an important resource, as they advocate and make policy decisions on behalf of Brooklyn communities.
7. DESCRIPTION OF ENGAGEMENT PLAN AFTER PUBLICATION OF CSP

Community engagement is an important component of the multi-faceted strategy that we plan to utilize to integrate our role in the community, and to tackle both diseases. As we progress through our three-year plan, we expect to continue to rely on our Community Advisory Board, our Working Group, public health officials, and other community stakeholders, to provide feedback and guidance, and to secure the buy-in of the larger community.
CONTACT INFORMATION

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   Brooklyn, New York 11212

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   Brookdale Hospital and Medical Center
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   Brooklyn, NY 11212

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   Phone: 718 – 240 – 8533
   Fax: 718 – 240 - 6492
APPENDICES

- Timeline of CSP planning meetings, and other meetings attended by staff to inform CSP development.
- Two surveys.
- Brookdale Hospital discharge data with demographic profile.
- Three-mile radius map of the area.
Preparation Activities Timeline

2/5/2013  **Brookdale Working Group (“Working Group”)** was established to begin work on the CSP and the CHNA. Worked on retrieving 2009 CSP submission prepared by Medisys, Brookdale’s former business partner.

2/12/2013  **Greater New York Hospital Association (GNYHA) team** (Lloyd Bishop and Amy Osorio) visited Brookdale to brief the Working Group about the CSP and the Community Health Needs Assessment (CHNA) requirement.

2/13/2013  Working Group met to review a draft of the Community Needs Assessment survey.

3/7/2013  Working Group met at Brookdale Hospital to approve revised survey, decide on distribution, and next steps.

3/13/2013  Working Group met to introduce the CSP development process to Brookdale Hospital staff. 1500 copies of the finalized survey (printed in English and Spanish) were distributed in bundles of 100 to the following Brookdale Department Administrators and other key staff: Ambulatory Care Clinic; Pastoral Care; Laboratory Services; Emergency services; Radiology; OB/GYN Services; Long Term Care Facility; Out-Patient Physical Therapy; Psychiatry; Internal Medicine; and, External Affairs.

3/22/2013  Working Group members attended meeting at GNYHA. Meeting agenda:

- An update and discussion on the New York State Prevention Agenda, CSP, and the IRS community health assessment expectations;
- Briefing by GNYHA finance and community health staff on the IRS proposed regulation on hospital charity care policies and expectations around community engagement;
- Discussion around regional community health planning.

3/27/2013  Working Group had a follow-up call with Lloyd Bishop and Amy Osorio from GNYHA on the CSP and CHNA.
4/1/2013  Brookdale Community Advisory Board met to discuss the CSP and CHNA with Brookdale staff, and to complete the survey.

4/1/2013  Working Group met to discuss the survey results.

4/5/2013  Survey results aggregated and sent to the Working Group for assessment.

4/12/2013  Working Group met to discuss the NYS Prevention Agenda selection.

4/16/2013  Brooklyn Perinatal Network Community Advisory Board meeting. Ngozi Moses presented the report *“The Need for Caring in North and Central Brooklyn.”*

4/18/2013  Mark Toney, CEO of Brookdale, discussed CSP and CHNA with the Brookdale Hospital Board of Directors.

4/26/2013  Working Group meeting to continue CSP discussion.

4/29/2013  Working Group attended NYC DOH “Take Care NY” (TCNY) listening session at Brooklyn Borough Hall.


5/17/2013  Working Group team met with Dr. Aletha Maybank, Assistant Commissioner at NYC Department of Health and Mental Hygiene (NYC DOHMH) at Brookdale Hospital to discuss the CSP and CHNA.

5/30/2013  Working Group team met with Ngozi Moses regarding the CSP and CHNA.

5/31/2013  CHNA presentation, Brookdale CFO’s Office.

6/5/2013  CHNA presentation, Brookdale CFO’s Office.

6/13/2013  Meeting with Judy Wessler (Community Health Policy Advocate) to discuss CSP and CHNA reports.
6/15/2013   Brookdale Health Fair – Interviewed community members for open-ended survey questions.

6/14/2013   Updated survey data distributed to the Working Group.

7/13/2013   Barbados Day Fair – Interviewed community members for open-ended survey questions.

7/19/2013   Working Group attended GNYHA meeting. CSP discussion was on the agenda.


8/1/2013    NYC DOHMH Take Care New York team (Camellia Mortezazadeh and Chelsea Doub) visited Brookdale to TCNY prevention agenda to the Working Group.

9/10/2013   Working Group participated in GNYHA call to discuss CSP progress.

9/19/2013   Working Group met to discuss and select Take Care NY intervention activities, to become a Take Care NY Partner Hospital.
Please take a minute to complete the community health survey below. The purpose of this survey is to get your opinions about community health issues in Brookdale’s primary service areas. In collaboration with our public health partners in Brooklyn, we plan to compile this information and use it as input for the development of a community health improvement plan.

This survey is anonymous. Your answers will not be connected to you in any way. Please do not write your name on this survey.

Part 1: Community Health

1. In the following list, what do you think are the three (3) most important factors for a “Healthy Community”?* (Those factors which most improve the quality of life in a community.)

Check only three (3):

- Good place to raise children
- Low crime / safe neighborhoods
- Good schools
- Access to health care (e.g., family doctor)
- Parks and recreation
- Clean environment
- Affordable housing
- Arts and cultural events

2. Using the following list, please put a check mark next to what you think are the three (3) most important “health problems” in our community. (Problems that have the greatest effect on overall community health.)

Check three (3):

- Access to health care
- Aging problems (arthritis, hearing loss, Vision loss, etc.)
- Asthma
- Cancer (What kind? _________)
- Child neglect/abuse
- Diabetes
- Domestic violence
- Environmental hazards
- West Nile Virus, rabies, Pollution, etc.
- Firearm-related injuries
- Heart disease and stroke
- High blood pressure
- HIV/AIDS
- Homelessness
- Infectious diseases (hepatitis, TB, etc.)
- Mental health (depression, Schizophrenia, etc.)
- Motor vehicle accidents
- Obesity/overweight (Child/Adult)
- Poverty
- Rape/sexual assault
- Respiratory/lung disease
- Sexually transmitted diseases (STD’s)
- Substance abuse (alcohol, drugs)
- Suicide
- Tobacco use
- Teenage pregnancy
- Unemployment
- Youth violence
- Other _____________

---

*Note: This survey is anonymous. Your answers will not be connected to you in any way. Please do not write your name on this survey.
3. In the following list, what do you think are the three (3) most important “risky behaviors” in our community? (Those behaviors which have the greatest impact on overall community health.)

Check only three (3):

- Alcohol abuse
- Being overweight
- Dropping out of school
- Drug abuse
- Lack of exercise
- Lack of maternity care
- Poor eating habits
- Not getting “shots” to prevent disease
- Tobacco use
- Not using birth control
- Unsafe sex
- Unsecured firearms
- Other

4. How would you rate the overall health of our community?

- Very Healthy
- Healthy
- Somewhat Healthy
- Unhealthy
- Very Unhealthy

Part 2: Personal Health

5. How would you rate your own personal health? Please check only one.

- Very Healthy
- Healthy
- Somewhat Healthy
- Unhealthy
- Very Unhealthy

6. During the past 12 months, was there any time that you did not have any health insurance or coverage?

- Yes
- No

7. Where do you go most often when you are sick or need advice about your health and what borough is this place located? Please check only one.

- Primary Care Doctor's office
- Local health department
- Hospital outpatient clinic
- Hospital emergency room
- Urgent care center
- Brooklyn
- Manhattan
- Queens
- Bronx
- Staten Island
- Long Island
- Other

8. About how long has it been since you last visited a doctor for a routine checkup? Do not include times you visited the doctor because you were sick.

- Within the past year
- Within the past 2 years
- Within the past 5 years
- 5 or more years ago
- Don't know/Not sure
9. Was there a time during the past 12 months when you needed to see a doctor/dentist, but could not?

____ Yes    ____ No    if yes, check reasons:  ____ Couldn’t find a doctor/dentist
____ Couldn’t afford the cost
____ Other: ___________________

10. About how long has it been since you last visited a dental office/dentist for any reason?

____ Within the past year
____ Within the past 2 years
____ Within the past 5 years
____ 5 or more years ago
____ I have never been to a dentist

11. If a friend or family member needed counseling for a mental health, substance abuse or developmental disability problem, whom would you recommend they see?

____ Mental Health Clinic
____ Doctor
____ Minister/religious official
____ Other: ___________________
____ Private counselor or therapist
____ Don’t know

12. During the past 30 days, other than your regular job, did you participate in any physical activities (such as running, sports, weightlifting, walking, etc.) for exercise?

____ No    ____ Yes    If yes, how many times? _____

13. Considering all types of alcoholic beverages, how many times during the past 30 days did you have 2 or more drinks in a day?

____ Number of times
____ None
____ Don’t know/not sure

14. How often do you smoke cigarettes or use chewing tobacco or snuff?

____ Every Day    ____ Some Days    ____ Not at all

15. Have you ever been told by a doctor, nurse, or other health professional that you are overweight or obese?

____ Yes    ____ No

16. Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?

____ Yes    ____ No
17. Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?

_____ Yes  _____ No

18. Have you ever been told by a doctor that you have diabetes?

_____ Yes  _____ Yes, but only during pregnancy  _____ No

19. Women: Have you ever had a mammogram?  Men: Have you ever had a prostate exam?

_____ Yes  _____ No

Part 3: Demographics

20. Age: ___ 25 or less  
   ___ 26 - 39  
   ___ 40 - 54  
   ___ 55 - 64  
   ___ 65 or over

21. Sex: ___ Male  ___ Female

22. Ethnic group you most identify with:
   ___ African American / Black  
   ___ Asian / Pacific Islander  
   ___ Hispanic / Latino  
   ___ Native American  
   ___ White / Caucasian  
   ___ Other ____________________

23. Marital Status:
   ___ Married / Co-habitation  
   ___ Not married / Single

24. Education
   ___ Less than high school  
   ___ High school diploma or GED  
   ___ College degree or higher  
   ___ Other ____________________

25. Household income:
   ___ Less than $20,000
   ___ $20,000 to $39,999
   ___ $40,000 to $59,999
   ___ $60,000 to $79,999
   ___ $80,000 to $99,000
   ___ Over $100,000

26. How do you pay for your health care?
   (check all that apply)
   ___ Pay cash (no insurance)
   ___ Health insurance (e.g., private insurance, Blue Shield, HMO)
   ___ Medicaid/ Medicare
   ___ Veterans’ Administration
   ___ Other ____________________

27. Where / how you got this survey: (check one)
   ___ Church
   ___ Community Meeting
   ___ Hospital or Clinic
   ___ Other ____________________

28. In what Zip/Postal code do you live? ____

The End

Thank you very much for your time and interest in helping us to identify our most pressing problems and issues.
COMMUNITY RELATIONS SURVEY TOOL

Event: ______________________________
Date: ______________________________

1. Are there any medical or health-related services you think your neighborhood needs more of? If so, what are the services?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

2. If you were given the power for one day, what changes would you make in the medical care system that you feel would make it work better for you, your family, and for people in your community? (For example: bring services closer to your home, make services more readily available, have more of a particular kind of service, etc.)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

3. Is there anything else that you would like to tell us about you and your family’s health care, or health care services in your neighborhood? (For example: Do your children get good medical care? If not, what are the reasons?)
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
### Demographics

#### Brookdale Service Areas

<table>
<thead>
<tr>
<th>Primary Service Area</th>
<th>% of BHMC 2012 Discharges</th>
<th>Total Residents</th>
<th>Black / African American %</th>
<th>Foreign Born %</th>
<th>Not a US Citizen %</th>
<th>Median Age</th>
<th>Median Household Income</th>
<th>% of People below Poverty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>11212 Central Brooklyn</td>
<td>26%</td>
<td>84,500</td>
<td>71.964</td>
<td>85%</td>
<td>27.088</td>
<td>11.832</td>
<td>3.19</td>
<td>3.27</td>
</tr>
<tr>
<td>11207 East New York and New Lots</td>
<td>18%</td>
<td>93,386</td>
<td>62.417</td>
<td>67%</td>
<td>28.001</td>
<td>12.933</td>
<td>3.10</td>
<td>3.31</td>
</tr>
<tr>
<td>11208 East New York and New Lots</td>
<td>14%</td>
<td>94,469</td>
<td>45.147</td>
<td>48%</td>
<td>34.443</td>
<td>14.681</td>
<td>3.07</td>
<td>3.10</td>
</tr>
<tr>
<td>11236 Canarsie and Flatlands</td>
<td>13%</td>
<td>93,877</td>
<td>79.835</td>
<td>85%</td>
<td>44.670</td>
<td>15.372</td>
<td>3.64</td>
<td>3.61</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>72%</strong></td>
<td><strong>366,232</strong></td>
<td><strong>259,363</strong></td>
<td><strong>71%</strong></td>
<td><strong>134,202</strong></td>
<td><strong>54,818</strong></td>
<td><strong>32.5</strong></td>
<td><strong>39,722</strong></td>
</tr>
</tbody>
</table>

#### Weighted Average

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</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>32.5</td>
<td>Median Household Income</td>
<td>39,722</td>
<td>% of People below Poverty Level</td>
<td>27.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Secondary Service Area

<table>
<thead>
<tr>
<th>Secondary Service Area</th>
<th>% of BHMC 2012 Discharges</th>
<th>Total Residents</th>
<th>Black / African American %</th>
<th>Foreign Born %</th>
<th>Not a US Citizen %</th>
<th>Median Age</th>
<th>Median Household Income</th>
<th>% of People below Poverty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>11233 Central Brooklyn</td>
<td>5%</td>
<td>67,053</td>
<td>56.838</td>
<td>85%</td>
<td>15.102</td>
<td>7.246</td>
<td>3.21</td>
<td>3.46</td>
</tr>
<tr>
<td>11239 Canarsie and Flatlands</td>
<td>3%</td>
<td>13,393</td>
<td>7.644</td>
<td>57%</td>
<td>3.800</td>
<td>5.43</td>
<td>4.46</td>
<td>4.71</td>
</tr>
<tr>
<td>11203 Flatbush</td>
<td>2%</td>
<td>76,174</td>
<td>69.435</td>
<td>91%</td>
<td>41.079</td>
<td>14.073</td>
<td>3.90</td>
<td>4.17</td>
</tr>
<tr>
<td>11234 Canarsie and Flatlands</td>
<td>2%</td>
<td>87,757</td>
<td>37.024</td>
<td>42%</td>
<td>33.200</td>
<td>9.222</td>
<td>3.91</td>
<td>4.27</td>
</tr>
<tr>
<td>11213 Central Brooklyn</td>
<td>2%</td>
<td>63,767</td>
<td>46.454</td>
<td>73%</td>
<td>22.496</td>
<td>10.929</td>
<td>3.23</td>
<td>3.46</td>
</tr>
<tr>
<td>11226 Flatbush</td>
<td>2%</td>
<td>101,572</td>
<td>76.853</td>
<td>76%</td>
<td>51.183</td>
<td>25.738</td>
<td>3.45</td>
<td>3.81</td>
</tr>
<tr>
<td>11221 Bushwich and Williamsburg</td>
<td>1%</td>
<td>78,895</td>
<td>44.774</td>
<td>57%</td>
<td>21.304</td>
<td>12.621</td>
<td>3.19</td>
<td>3.46</td>
</tr>
<tr>
<td>11216 Central Brooklyn</td>
<td>1%</td>
<td>54,316</td>
<td>41.543</td>
<td>76%</td>
<td>14.642</td>
<td>7.111</td>
<td>3.40</td>
<td>3.74</td>
</tr>
<tr>
<td>11225 Flatbush</td>
<td>1%</td>
<td>56,829</td>
<td>42.766</td>
<td>75%</td>
<td>26.416</td>
<td>12.453</td>
<td>3.53</td>
<td>3.80</td>
</tr>
<tr>
<td>11210 Flatbush</td>
<td>1%</td>
<td>62,008</td>
<td>35.821</td>
<td>58%</td>
<td>24.881</td>
<td>9.210</td>
<td>3.41</td>
<td>3.78</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td><strong>18%</strong></td>
<td><strong>661,764</strong></td>
<td><strong>459,152</strong></td>
<td><strong>69%</strong></td>
<td><strong>254,103</strong></td>
<td><strong>109,146</strong></td>
<td><strong>35.1</strong></td>
<td><strong>44,014</strong></td>
</tr>
</tbody>
</table>

#### Weighted Average

<p>| | | | | | | | | |</p>
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Median Age</td>
<td>35.1</td>
<td>Median Household Income</td>
<td>44,014</td>
<td>% of People below Poverty Level</td>
<td>21.1%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Total

<p>| | | | | | | | | |</p>
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>% of BHMC</td>
<td>90%</td>
<td>Total</td>
<td>1,027,996</td>
<td>718,515</td>
<td>388,305</td>
<td>163,964</td>
<td>34.15</td>
<td>42,485</td>
</tr>
</tbody>
</table>

#### United States

|               |             |               |               |               |                   |           |                      |                                |
|---------------|-------------|---------------|---------------|---------------|-------------------|-----------|----------------------|                                |
| Brooklyn Total| 2,504,700   | 860,083       | 34%           | 926,511       | 37%               | 413,421   | 17%                  | 34.1                           |
| New York City Total | 8,175,133  | 2,088,510     | 26%           | 2,989,825     | 37%               | 1,447,982 | 18%                  | 35.5                           |
| United States  | 306,603,772| 38,395,857    | 13%           | 39,268,838    | 13%               | 22,118,154| 7%                   | 37.0                           |

**Source:**

US Census Data 2010 Demographic Profile  

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