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The Brooklyn Hospital Center

Keeping Brooklyn healthy.

2008 Community Service Plan
September 15, 2009

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The Brooklyn Hospital Center
Community Service Plan (CSP)

The Brooklyn Hospital Center (TBHC) presents this 2008 Community Service Plan (CSP) in accordance with New York State Public Health Law section 2803-1. The CSP reports on TBHC's accomplishments and challenges in meeting the health care needs of the community; its pledge to provide care to all who need it; and its ongoing commitment to improve access to health care for the uninsured and underserved.

I. Mission Statement

A. Mission Statement for The Brooklyn Hospital Center

Mission Statement: The Brooklyn Hospital Center is dedicated to providing outstanding health services, education, and research to keep the people of Brooklyn and greater New York healthy.

B. Changes to the Mission Statement

This mission statement was revitalized to reflect The Brooklyn Hospital Center's strategic direction for the next five years. The Mission Statement was formally adopted by The Brooklyn Hospital Center's Board of Trustees as part of the Strategic Planning process on June 18, 2009. The hospital's Vision and Values Statements also embody TBHC's commitment to providing the highest quality of care to the community, and to making the facility a premiere choice for health care in the borough and beyond.

II. Service Area

A. Hospital Service Area

The Brooklyn Hospital Center is an existing, 464-bed full service community teaching hospital located at 121 Dekalb Avenue, Brooklyn (Kings County), NY 11201. Founded in 1845, TBHC was Brooklyn's first hospital. In 1998, the Hospital entered into a sponsorship agreement with New York-Presbyterian Healthcare System, Inc. The Brooklyn Hospital Center is not only the first voluntary hospital established in the borough of Brooklyn, but one that throughout its history, has been at the forefront of medicine and the care of the sick in its neighborhood. Today, more than ever, TBHC plays a critical role in meeting the health care needs of the over one million residents who live in the communities served by the hospital.

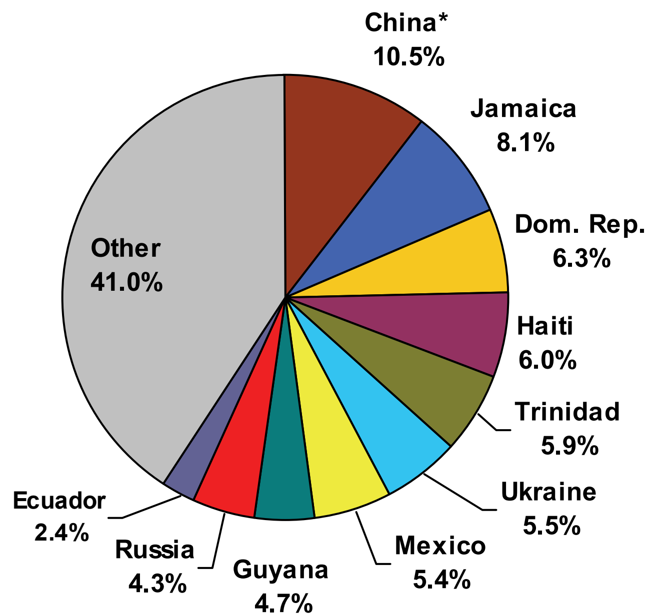
These communities are within the following zip codes: 11201, 11203, 11204, 11205, 11206, 11207, 11208, 11209, 11210, 11211, 11212, 11213, 11216, 11217, 11219, 11220, 11221, 11222, 11223, 11225, 11226, 11228, 11232, 11233, 11236, 11237, and 11238.

TBHC's primary services areas include Central and Northwest Brooklyn. These neighborhoods include: Fort Greene, Downtown Brooklyn, Bushwick, Williamsburg, Flatbush, Crown Heights, Bedford Stuyvesant, Greenpoint, East New York, Brownsville, Boro Park, Sunset Park, Fort Hamilton Parkway, and Bensonhurst. TBHC's secondary service areas cover the Borough of Brooklyn and Lower Manhattan.

As noted in the chart below, TBHC's service population is culturally and ethnically diverse. It is comprised largely of minority racial and ethnic groups. More than 80% of the residents in the community are Black or Hispanic. Within these groupings, there are large numbers of residents from Jamaica, the Dominican Republic, Haiti, Trinidad and Tobago, Mexico, and other Caribbean countries.

Top Countries of Birth for the Foreign-born

New York City and Brooklyn, 2006

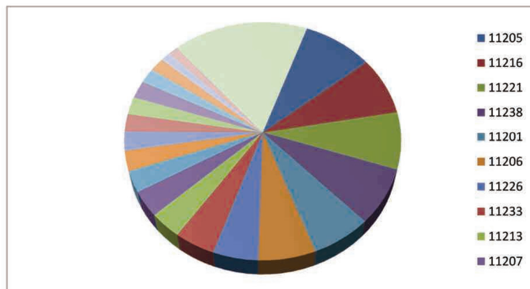


Source: NYC Dept of City Planning

B. Description of Service Area

The Brooklyn Hospital Center's service area is defined through demographic, diagnostic, and utilization data. TBHC used data from the New York City Department of Health and Mental Hygiene (NYCDOHMH), the New York City Department of City Planning, the US Census Bureau, the Centers for Medicare and Medicaid Services, and the New York State Department of Health to plan for the changing needs and demographics of its service area population, as outlined on the following chart:

The Brooklyn Hospital Center 2008 Discharges



Color Code	2008 Discharges		
	Zip Code	Total	
	11205	1790	8.79%
	11216	1596	7.84%
	11221	1584	7.78%
	11238	1552	7.62%
	11201	1341	6.59%
	11206	1285	6.31%
	11226	1009	4.96%
	11233	909	4.46%
	11213	720	3.54%
	11207	708	3.48%
	11211	587	2.88%
	11212	553	2.72%
	11225	532	2.61%
	11217	490	2.41%
	11208	487	2.39%
	11236	481	2.36%
	11220	412	2.02%
	11203	376	1.85%
	11237	257	1.26%
	11210	248	1.22%
	OTHER	3442	16.91%
		20359	

TBHC's service area residents are, in general, less healthy than New York City population as a whole, according to the NYCDOHMH. They are at much higher risk for hospitalization for heart disease, diabetes, pneumonia/influenza, stroke, cancer and mental illness than the overall New York City population. Mortality associated with heart disease, cancer, pneumonia, AIDS, lung disease and stroke is also higher among the hospital's service area residents. In addition, more of the people living in communities served by TBHC rate their own health as "Fair" or "Poor" compared to that of US or New York City residents. In some service area neighborhoods, 30% of residents give their health these low ratings.

Many of these community residents live in poverty. More than a third lives in households with incomes below the Federal Poverty Level. There are large concentrations of socio-economic deprivation within these neighborhoods, particularly in Bushwick and Bedford Stuyvesant. The average household income in the communities served by the hospital is less than the average household income of Kings County residents and New York City residents; the TBHC payor mix reflects these socio-economic characteristics. TBHC is committed to providing the residents of these neighborhoods with the best available care.

III. Public Participation

A. Participants

In keeping with its tradition of meeting the health care needs of the community, The Brooklyn Hospital Center welcomes input on its service goals and delivery. Collaborators in this process include the hospital's Board of Trustees, its Community Advisory Board (CAB), elected and appointed officials, and a range of Community-Based Organizations (CBOs):

Leadership - TBHC is governed by a Board of Trustees, which encourages communication between the hospital and the local health department, area legislators, community advisors, and community-based organizations. Trustees present oral and written reports of community activities which are relevant to the hospital's viability. As part of its corporate function, the Board oversees the development and implementation of the hospital's Strategic Plan. A general aim of the strategic plan is to develop strong policies to help the hospital continue to fulfill its mission. The current strategic plan specifically outlines the goal of continuing meaningful engagement with community stakeholders (See pages 25-30).

Community Advisory Board - TBHC's Community Advisory Board is made up of dedicated, civic-minded people from the community who help to assess and identify local health needs and offer guidance regarding the scope and quality of care that TBHC renders in the community. CAB members meet formally once a month to receive updates about the hospital and to share information about the community with TBHC leaders. Advisors are kept well informed about the hospital in between meetings,

so that they can be active representatives of the institution in the community. Additionally, the CAB helps hospital administrators with community outreach efforts, and the members monitor TBHC's patient satisfaction process to ensure that issues are addressed and resolved appropriately. Advisors reflect the needs and concerns of various ethnic, economic and cultural groups. Current members include health care professionals, TBHC consumers, civic leaders, clergy, business owners, and retirees.

Government Relations - TBHC proactively cultivates strong relationships with its Community Board and legislative officials on the federal, state, and city levels. TBHC keeps these elected and appointed representatives informed about health issues which relate to their districts and the immediate neighborhood. The hospital briefs lawmakers on the challenges and opportunities the hospital faces in meeting the health care needs of area residents, and on the impact of existing and proposed legislation on that process.

Community Based Organizations (CBOs) - TBHC's collaboration with social service agencies, health maintenance organizations (HMOs) and physician groups, educational institutions, corporate neighbors, and civic and faith-based organizations has cemented its standing as a good neighbor. While some of these alliances strengthen business, advance strategic goals, and build goodwill, TBHC's primary focus is to cultivate partnerships that enhance its health care delivery in the community.

Input from each participant category will be used to inform the process of addressing the hospital's prevention agenda priorities and assessing community health needs.

B. Outcomes

Pending the creation of a Community Service Plan Committee to further assess community health needs, The Brooklyn Hospital Center monitored its performance through patient satisfaction surveys. The hospital collected data using instruments designed externally and internally to rate patients' perception of care, treatment and services; the specific needs and expectations of patients; and how the hospital met these needs and expectations.

Patient Satisfaction Surveys - Patient Satisfaction surveys were conducted by Press Ganey and quarterly results were compiled and distributed by TBHC's Quality Management Department on January 18, 2008, April 18, 2008, July 18, 2008 and October 18, 2008. Over 20,000 inpatients, emergency treat and release patients and 5,000 ambulatory care patients were surveyed. The surveys addressed an array of questions spanning the continuum of care. For inpatients, ambulatory surgery, as well as emergency treat and release patients, surveys were mailed out a week post-discharge or post-visit. While Press Ganey administers the patient satisfaction survey, an internally developed tool is used for the Detox Unit, ambulatory care and home care patients. That survey is administered and results are totaled internally.

The survey is completed at the end of the visit or the treatment program. Survey instruments are available in English and Spanish for the inpatient and the Emergency Department. In the ambulatory care areas, in addition to English and Spanish, they are also available in Chinese, Creole and Polish to reflect the diversity of the patient population.

Hospital Consumer Assessment of Healthcare Providers and Systems - The hospital also participates in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPSP) program, a pay-for-performance patient satisfaction initiative of the Centers for Medicare and Medicaid Services. This was introduced as an initiative to improve hospital performance and for public reporting to support consumer choice. The results and improvement activities of all surveys are reported quarterly to the clinical service committees, the Quality Council and the Quality Assurance Committees and the Patient Care Committee of the Board of Trustees.

While TBHC relied on data from the NYC DOHMH and other sources to pinpoint its health priorities, the hospital intends to create a new tool to determine what its partners and members of the community perceive as the most pressing health priorities in their neighborhoods.

C. Public Notification

Online Presence - TBHC has revamped its organizational web site to make it more user-friendly and relevant to service the needs of its diverse community. In addition to visitor and contact information, which lists the telephone numbers of key departments, the site also features a menu of services. Information on patients' rights, responsibilities, and safety is also included to empower prospective patients. Additionally, the web site's health resource centers and extensive library make it a valuable depository of useful health and medical information for the community. TBHC intends to post its community assessment tool on the Internet to increase public input. Additionally, the CSP will be available on the hospital's web site as a downloadable document.

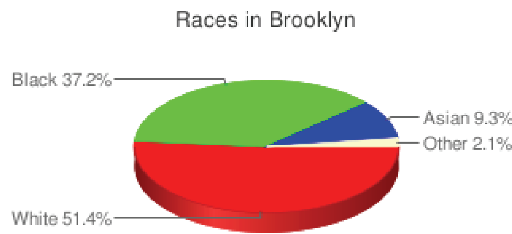
Media - The hospital's Marketing and Communications Department keeps the public informed of significant and newsworthy activities and programs through press releases, which appear in local and regional media, hospital newsletters, mass mailings, and on the hospital's web site. The department also arranges for TBHC experts to appear on local television and radio programs to provide health information and promote the hospital's programs and services. The hospital will inform the community, through the media, about its prevention agenda priorities.

IV. Assessment of Public Health Priorities

A. Criteria of Public Health Priorities

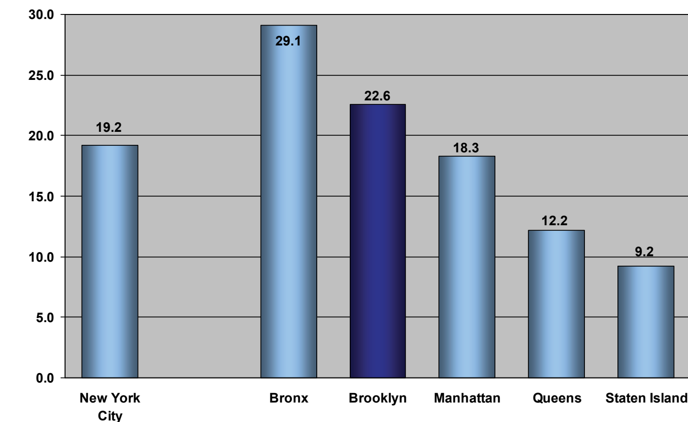
In keeping with its mission, TBHC culled information from external and internal sources to determine its public health priorities. The New York City Department of Health and Mental Hygiene reported that the link between race and poverty and health disparities in New York City results in “a disproportionate burden of illness and premature death”. As previously established, TBHC’s service area covers a population deeply affected by these disparities. Persons in this “socio-economically disadvantaged and minority populations in Brooklyn suffer with higher risks of various diseases.” The charts below identify races in Brooklyn and the borough’s ranking of persons living below the poverty level in New York City.

Chart of Brooklyn Ethnic breakdown



Data from US Census Estimate of 2008

Percent of Persons Living Below the Poverty Level
New York City and 5 Boroughs, 2006



Source: NYC Department of City Planning

Data compiled through NYC DOHMH’s ***Take Care New York*** Campaign showed that in Northwest Brooklyn, more than one in five residents or 21% of those surveyed reported not having a primary care physician. In addition, 6% of the people surveyed in Northwest Brooklyn reported that they go to the

Emergency Department when they are sick or need health advice. Internal statistics, such as its utilization rates and diagnostic data for inpatient, ambulatory care, and emergency room visits, were also used to justify the hospital's selection of its prevention agenda priorities. For example, extended wait times (two to three months) for screening and diagnostic tests, such as a mammogram, indicate a need to increase access to such services in a community faced with health disparities.

Prevention Quality Indicators (PQI) assessed by the New York State Department of Health also revealed that TBHC's service area scored worse than the statewide rate for 15 of the 16 ambulatory care sensitive conditions for both its primary and secondary service areas. This is not surprising considering the low socioeconomic status of many residents of the service area.

According to the NYSDOH PQIs, the population selected for review in TBHC's primary service area totaled 329,676 residents and consisted of 14% White, 24% Hispanic, 54% Black, 4% Asian, and 4% other. The PQI findings for this selected population are as follows:

- All Conditions: TBHC had 174% of expected admissions with an area rate adjusted for age and sex of 3,228 compared to the statewide rate of 1,854;
- All Respiratory Conditions: TBHC had 178% of expected admissions with an area rate adjusted for age and sex of 627 compared to the statewide rate of 351;
- Chronic Obstructive Pulmonary Disease: TBHC had 94% of expected admissions with an area rate adjusted for age and sex of 168 compared to the statewide rate of 178;
- Asthma: TBHC had 250% of expected admissions with an area rate adjusted for age and sex of 434 compared to the statewide rate of 174;
- All Diabetes: TBHC had 247% of expected admissions with an area rate adjusted for age and sex of 699 compared to the statewide rate of 283;
- Uncontrolled Diabetes: TBHC had 332% of expected admissions with an area rate adjusted for age and sex of 129 compared to the statewide rate of 39;
- Lower Extremity Amputation: TBHC had 225% of expected admissions with an area rate adjusted for age and sex of 84 compared to the statewide rate of 37;
- Long-Term Complication of Diabetes: TBHC had 254% of expected admissions with an area rate adjusted for age and sex of 394 compared to the statewide rate of 155;
- Short-Term Complication of Diabetes: TBHC had 184% of expected admissions with an area rate adjusted for age and sex of 95 compared to the statewide rate of 52;
- All Circulatory: TBHC had 197% of expected admissions with an area rate adjusted for age and sex of 1,090 compared to the statewide rate of 554;
- Hypertension: TBHC had 275% of expected admissions with an area rate adjusted for age and sex of 167 compared to the statewide rate of 61;
- Congestive Heart Failure: TBHC had 177% of expected admissions with an area rate adjusted for age and sex of 785 compared to the statewide rate of 443;
- Angina: TBHC had 251% of expected admissions with an area rate adjusted for age and sex of 126 compared to the statewide rate of 50;
- All Acute: TBHC had 119% of expected admissions with an area rate adjusted for age and sex of 793 compared to the statewide rate of 666;
- Urinary Tract Infections: TBHC had 123% of expected admissions with an area rate adjusted for age and sex of 208 compared to the statewide rate of 169; and
- Dehydration: TBHC had 118% of expected admissions with an area rate adjusted for age and sex of 137 compared to the statewide rate of 116; and.

- Bacterial Pneumonia: TBHC had 117% of expected admissions with an area rate adjusted for age and sex of 447 compared to the statewide rate of 381.

According to the NYSDOH data on PQIs, the population selected for review in TBHC's **secondary service area** totaled 341,066 residents and consisted of 16% White, 20% Hispanic, 58% Black, 2% Asian, and 4% other. The secondary service area PQI findings listed below are similar to TBHC's primary service area:

- All Conditions: TBHC had 174% of expected admissions with an area rate adjusted for age and sex of 3,233 compared to the statewide rate of 1,854;
- All Respiratory Conditions: TBHC had 169% of expected admissions with an area rate adjusted for age and sex of 592 compared to the statewide rate of 351;
- Chronic Obstructive Pulmonary Disease: TBHC had 89% of expected admissions with an area rate adjusted for age and sex of 158 compared to the statewide rate of 178;
- Asthma: TBHC had 236% of expected admissions with an area rate adjusted for age and sex of 410 compared to the statewide rate of 174;
- All Diabetes: TBHC had 239% of expected admissions with an area rate adjusted for age and sex of 676 compared to the statewide rate of 283;
- Uncontrolled Diabetes: TBHC had 341% of expected admissions with an area rate adjusted for age and sex of 132 compared to the statewide rate of 39;
- Lower Extremity Amputation: TBHC had 184% of expected admissions with an area rate adjusted for age and sex of 69 compared to the statewide rate of 37;
- Long-Term Complication of Diabetes: TBHC had 235% of expected admissions with an area rate adjusted for age and sex of 365 compared to the statewide rate of 155;
- Short-Term Complication of Diabetes: TBHC had 211% of expected admissions with an area rate adjusted for age and sex of 109 compared to the statewide rate of 52;
- All Circulatory: TBHC had 208% of expected admissions with an area rate adjusted for age and sex of 1,154 compared to the statewide rate of 554;
- Hypertension: TBHC had 254% of expected admissions with an area rate adjusted for age and sex of 155 compared to the statewide rate of 61;
- Congestive Heart Failure: TBHC had 198% of expected admissions with an area rate adjusted for age and sex of 880 compared to the statewide rate of 443;
- Angina: TBHC had 226% of expected admissions with an area rate adjusted for age and sex of 113 compared to the statewide rate of 50;
- All Acute: TBHC had 120% of expected admissions with an area rate adjusted for age and sex of 802 compared to the statewide rate of 666;
- Urinary Tract Infections: TBHC had 123% of expected admissions with an area rate adjusted for age and sex of 207 compared to the statewide rate of 169; and
- Dehydration: TBHC had 118% of expected admissions with an area rate adjusted for age and sex of 137 compared to the statewide rate of 116; and
- Bacterial Pneumonia: TBHC had 120% of expected admissions with an area rate adjusted for age and sex of 457 compared to the statewide rate of 381.

As demonstrated by the above data, the population in TBHC's primary and secondary service area is much worse than the statewide rate for all ambulatory care sensitive conditions with the exception of chronic obstructive pulmonary disease (COPD). The table below underscores the significant

opportunities and challenges presenting TBHC, with particular emphasis on the admission rates for the African-American population, which makes up 54% of the primary service area and 58% of the secondary service area:

PQI Analysis

Ambulatory Care Sensitive Condition (ACSC)	Admissions as % Expected TBHC's PSA – Total Population	Admissions as % Expected TBHC's PSA – African-American Population	Admissions as % Expected TBHC's SSA – Total Population	Admissions as % Expected TBHC's SSA – African-American Population
All Conditions	174%	203%	174%	208%
All Respiratory	178%	194%	169%	187%
COPD	94%	105%	89%	98%
Asthma	250%	269%	236%	262%
All Diabetes	247%	304%	239%	304%
Uncontrolled Diabetes	332%	385%	341%	426%
Lower Ext. Amputation	225%	268%	184%	208%
Long-Term Comp.	254%	313%	235%	291%
Short-Term Comp.	184%	245%	211%	312%
All Circulatory	197%	243%	208%	263%
Hypertension	275%	353%	254%	315%
CHF	177%	227%	198%	257%
Angina	251%	233%	226%	251%
All Acute	119%	129%	120%	131%
UTI	123%	125%	123%	124%
Dehydration	118%	133%	118%	133%
Bacterial Pneumonia	117%	130%	120%	133%

The above PQI profile of the preventive health needs of the individuals living in TBHC's primary and secondary service area, demonstrates both a challenge and an opportunity for TBHC to expand its preventive outreach ambulatory primary care program to address the early interventional needs of its service population.

The PQI analysis underscores TBHC's status as an essential community hospital and health center for its service area.

B. Selected Prevention Agenda Priorities

While TBHC remains immersed in addressing aspects of almost all the health priorities identified by the New York State Department of Health, its major public health priorities for 2008 were: (1) Access to Quality Health Care (2) Chronic Disease, and (3) Infectious Disease. New York City Department of Health and Mental Hygiene data, specifically from NYC Community Health Profiles, provided the rationale for selecting these agenda items. Additionally, internal diagnostic and utilization statistics also supported the selection.

1) Access to Quality Health Care

Founded in 1845, TBHC has a long tradition of providing outstanding care to the residents of Brooklyn. The hospital's commitment to removing barriers to quality health care is evident by the fact that its programs are tailored to meet the specific needs of the community. TBHC sees over 20,000 inpatients each year. In 2008, the hospital registered more than 220,000 outpatient visits. Its comprehensive outpatient and ambulatory care services include outstanding medical and surgical treatments and state-of-the-art diagnostic techniques. By providing a full range of serves, TBHC addressed the following ***Take Care New York Campaign*** goals in 2008:

- **Have a Regular Doctor or Other Health Care Provider –** *In Northwest Brooklyn, more than 1 in 5 residents (21%) do not have a regular doctor, compared to the TCNY target of less than 20%. In addition, 6% of Northwest Brooklyn residents go to the ED when they are sick or need health advice.*
    - Pediatric and adult patients in TBHC's ambulatory care and family health centers are assigned a specific care provider. This process is essential for creating a 'medical home' for patients where there is planning and continuity of care.
    - Family Medicine is a vibrant example of TBHC's health care service to the community. Its Family Medicine Academy, run by the Residency Review Committee, is one effort that enables medical residents to offer community-oriented primary care. In 2008, medical residents participated in area marathons, school health fairs, community health screenings, and other activities. Additionally, Family Medicine addressed the transportation gap of seniors and other community residents who were having difficulties meeting clinic appointments by hiring a private transportation service to bring patients to and from appointments. Family Medicine also began an initiative to improve communications between referring physicians in the community and doctors who treat these patients at TBHC so that the scope and quality of care remain seamless.

  - Community Family Health Centers bring TBHC resources directly to Brooklyn's diverse neighborhoods. Each center offers primary and specialty care services, which are tailored to fit the needs of adults, seniors, and children in the area At the 8th Avenue Family Health Center, service providers accommodate the mostly Chinese-speaking members of the patient population. At La Providencia Family Medicine Center, which caters to a Hispanic population, service providers are also bi-lingual and care is provided with cultural sensitivity to that group. The Manhattan Avenue Center serves a wide Polish population. Providers and staff at the center speak the language and offer care that mirrors the community's needs. The Williamsburg Family Health Center operates under the same model of providing quality, culturally-sensitive health care to the African-American, Caribbean-American, and Jewish patient population.

  - According to NYCDOHMH, one in four residents of Northwest Brooklyn is uninsured. TBHC routinely educates patients who are uninsured or underinsured about entitlements and other programs. Outreach specialists from the New York City Health and Human Services Department show patients how to navigate Access NYC, a free online repository of benefits and programs available to New York City residents. Enrollment counselors from the Brooklyn Perinatal Network assist patients with enrolling in publicly funded health insurance programs such as Child HealthPlus, Medicaid, and Family HealthPlus. Patients are also able to use specially designated computers in the hospital's Patient Accounts Department to determine their eligibility for free or low cost insurance programs and services.

- **Be Tobacco Free -** *Less than one fifth of Northwest Brooklyn residents (17%) currently smoke, meeting the TCNY target of less than 18%. Many methods to quit smoking are available, and more than 7 in 10 smokers in Northwest Brooklyn (76%) are trying to kick the habit.*

  - TBHC's smoking cessation program*, Smoke Free Brooklyn*, is promoted in the hospital's private practices, clinics, and to employees. The program provides counseling, medications, group therapy and other support services to those who wish to stop smoking or using tobacco. In-patients who struggle with a nicotine addiction or more serious tobacco-related illnesses are counseled and appropriate therapies are administered to help them adjust to TBHC's smoke-free environment and discontinue smoking. In 2008, the Pharmacy Department distributed information on tobacco-related illnesses and conducted several smoking cessation sessions at community health fairs. One such event was held at a local college, where students were urged not to begin smoking or to quit smoking.

- **Keep Your Heart Healthy** - *The heart disease death rate in 2003-2004 (334/100,000) was similar to the rate in Brooklyn (326/100,000) but more than 10% higher than the NYC overall rate*
  - The Cardiology Department combines prevention education, exceptional patient care, and research to provide service that is geared to addressing the health care disparities related to heart disease in Brooklyn. TBHC offers a complete array of diagnostic and therapeutic services to the community. The hospital has some of the most modern equipment available to treat patients. Some of the services include screening to determine risk factors for heart disease, ambulatory cardiac monitoring, arrhythmia evaluation and treatment, diagnostic cardiac catheterization, cardiac stress testing, echocardiography, electrocardiography, pacemaker and cardiac defibrillator evaluation, pharmacologic stress testing, clinical consultations, and Tilt table testing. Cardiology services are patient-care centered and outreach focused. The department is a key contributor to TBHC's *Wellness for Life Program*, which encourages a healthy lifestyle based on nutrition and exercise.
- **Know Your HIV Status** - *The New York City Department of Health reports that as of 12/31/07, there were 25,231 people known to be living with HIV/AIDS in Brooklyn. This is approximately 26% of the 102,404 people living with HIV in New York as a whole at that time. [Source: New York City HIV/AIDS Annual Surveillance Statistics. New York City Department of Health and Mental Hygiene, 2008. Updated November 6, 2008.]*
  - TBHC's PATH (the "Program for AIDS Treatment and Health") provides the highest-quality medical and psychosocial care for adults, teens, children and families living with HIV. PATH employs a fulltime Outreach Coordinator who conducts street outreach to identify HIV-positive or at-risk individuals in parks, around housing projects, in beauty parlors and barber shops, on the street, near subway stops, and in other public places. The Outreach Coordinator encourages individuals to be tested or receive care at PATH. Known for its excellent service, PATH is a 2007 recipient of the NYSDOH 2007 Leadership in Quality Award and its medical director has been named one of the Best Doctors in New York City for the past 12 years.
- **Live Free of Dependence on Alcohol and Drugs -** *In Northwest Brooklyn, adults are more likely than those in Brooklyn and NYC overall to report engaging in at least one episode of binge drinking (defined as consuming 5 or more drinks on one occasion) in the past month.*
  - TBHC's Alcohol and Drug Detoxification Unit saw about 1,000 patients in 2008. The unit's community outreach worker interfaces with health and social service agencies in the area to admit patients who need care for substance abuse. The unit has a heavy focus on health

education, relapse prevention, harm reduction, and therapeutic outlets. Bereavement issues are also addressed by the hospital's Pastoral Care Department or visiting clergy. The aim is to have patients return to sobriety and resume their lives free of dependence on alcohol and drugs.

- **Get Checked for Cancer -** *The 2003-2004 average annual cancer death rate was more than 15% higher than both the Brooklyn and NYC overall rates (188/100,000 vs. 160/100,000 in Brooklyn and 161/100,000 in NYC).*
    - TBHC participates in the Breast Health Partnership, a program that provides education and outreach to the community regarding breast and cervical cancer prevention. An outreach worker attends health fairs, church gatherings, and meetings at community organizations and schools to discuss cancer prevention and increase awareness. In addition, eligible women receive free breast and cervical cancer screenings through the program. The outreach worker is responsible for assisting women in the community to access free mammography, clinical breast exams, pelvic exams and PAP smears through the Breast Health Partnership.
- **Get the Immunizations You Need** – *The Northwest Brooklyn flu immunization rate among older adults falls short of the TCNY target by 35%.*
    - Vaccinations are essential for preventing the spread of disease among the general population. TBHC offers immunizations against childhood diseases to its pediatric population as part of their 'medical home' regimen of care. Adult and geriatric populations are also targeted in accordance with the hospital's focus on prevention and public health. Emphasis on making the influenza vaccine available to patients who need it is especially important.
- **Make Your Home Safe and Healthy** – *In 2004, 98 children in Northwest Brooklyn (12/1,000) were newly identified with lead poisoning (defined as a blood lead level greater than or equal to 10 µg/dL).*
    - New York State and New York City's lead prevention programs are directly linked to the Centers for Disease Control Initiative to eliminate childhood lead poisoning in the United States by 2010. At TBHC, children are tested at age nine months and two years for blood lead levels. If a child's blood level is elevated, he or she is treated and an environmental investigation of the home is conducted. According to TBHC's Pediatric Center, blood lead levels have fallen dramatically since 2004 and lead poisoning is no longer a major issue for

most children; however, TBHC continues to educate parents and pregnant women about the dangers of lead exposure.

- **Have a Healthy Baby** – *The average annual percent of women who received late or no prenatal care has declined by 30% in Northwest Brooklyn in the past decade. In 2003-2004, the percent (19%) was lower than in Brooklyn (27%) and NYC overall (28%).*
  - The Prenatal Care Assistance Program (PCAP) is an invaluable resource for the community that TBHC serves. Funded by New York State, PCAP enables TBHC to provide disadvantaged pregnant women in its service area with free care from the beginning of pregnancy up to two months after delivery. The babies of the mothers who are in the program receive one year of free health care. In order to fully accommodate expectant mothers, TBHC offered PCAP at its outpatient clinics and in all its family health centers. PCAP's professional staff speaks the languages of the communities they serve: Spanish, English, Arabic, Creole, Chinese, French, Yiddish, Polish and others; so interpreters are available to help these patients. In addition, TBHC provides culturally sensitive activities and snacks for patients. Transportation assistance is also available for those who need it. TBHC offers weekly tours of its labor and delivery suite, waiting room, newborn nursery and maternity unit to PCAP recipients. TBHC also partners with HealthFirst to host monthly Baby Showers where education, screenings, and care packages are offered. In 2008, community outreach efforts focused on PCAP included health and information fairs at churches, schools, community centers and other agencies.

TBHC is a teaching hospital offering fully accredited, independent residency programs in emergency medicine, family medicine, general dentistry and oral and maxillofacial surgery, general surgery, internal medicine, obstetrics and gynecology, and pediatrics through its academic and clinical affiliate of Weill Medical College of Cornell University. That affiliation also enables TBHC to provide training for urology residents and post-doctoral fellows in cardiology, gastroenterology, hematology-oncology, and pulmonology/critical care. As a teaching hospital, TBHC ensures the continuity of care in an area where health disparities abound. That care encompasses ambulatory, emergency, acute and home health services.

TBHC's Home Health Services (HHS) was founded in 1960 and is one of the oldest hospital-based certified home health agencies in New York State. In 2008 HHS established a TeleCare Management Program that builds real-time communication bridges between patients and their care teams. The overall goal of this program is to reduce hospitalization rates for tele-care patients through the following clinical objectives:

- Close clinical management, including home visits.
- Improved clinical outcomes of complex cases.
- Improved continuity of care.
- Reduced hospitalizations and ER visits.
- Improved patient and family education, behavior modification and medication/laboratory compliance.
- Enhanced remote care monitoring and web-based access to patient data.

HHS is especially tailored for patients who have chronic diseases such as cancer, diabetes and heart disease. Providing education to the patient and his or her family on self-management of the disease is also a key component of providing access to the best available care.

2) Chronic Diseases

TBHC's service area is disproportionately affected by chronic disease such as asthma, diabetes and heart disease. TBHC has made a consistent effort to use the expertise of its staff and its resources to foster prevention, provide treatment, and conduct outreach. TBHC's efforts for 2008 are summarized below:

Asthma: According to the New York City Department of Health and Mental Hygiene, asthma is one of the most prevalent diseases among children and adults in New York City. NYC DOHMH data indicates that asthma affects a disproportionate number of children and adults in Brooklyn. The Brenda Pillars Asthma Education Program, run by the Brooklyn Campus of Long Island University (LIU), notes that Community District 2, where TBHC is located, has an asthma rate of 8% compared to a 5% rate in New York City. In 2008, there were 3,693 outpatient visits for patients with asthma at TBHC. These outpatient visits included the following:

Emergency Department	2,223 visits
General Clinic	431 visits
Family Health Centers	760 visits

[La Providencia - 207, Manhattan Ave - 149, Williamsburg - 404].

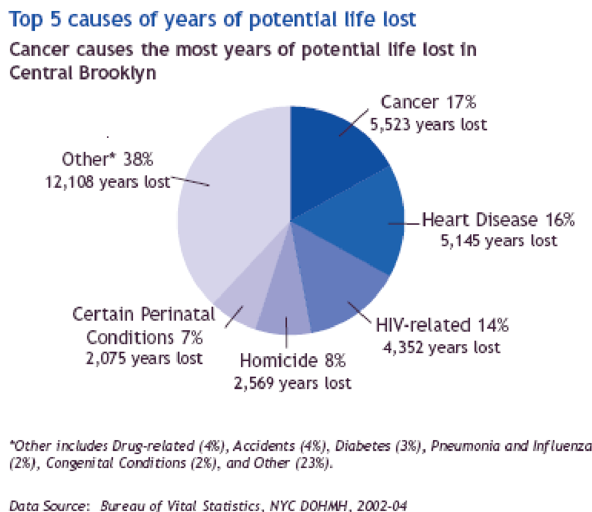
TBHC endeavors to assist children and adults to manage the disease and to offer the best available treatment protocols in order to reduce Emergency Department visits.

TBHC's asthma program is funded in part by LIU through a grant from the Centers for Disease Control. The TBHC-LIU collaboration includes a research project entitled *A Study of the Effects of Asthma Education on Hospital Resource Utilization*. The Brenda Pillars Asthma Education Program also funds

an asthma education coordinator position. The coordinator is responsible for providing asthma education, collecting data about how the disease is managed, and following up with patients after discharge. The coordinator is currently focusing on pediatric patients. The data will be submitted to NYC DOHMH for comparison with other hospitals. TBHC will analyze the data to determine strengths and weaknesses for possible improvements in asthma care.

In 2008, TBHC's Pharmacy Department, in collaboration with the Outpatient Pulmonary Clinic and the Pediatric Department, conducted weekly educational sessions to teach patients about treatment options and how to better manage the disease. During these sessions, pharmacy residents and respiratory therapists demonstrate the correct methods for using inhalers and they teach patients how to identify triggers in their environment. These health professionals also participated frequently in faith-based, school, and community health fairs. The faith-based health fairs, which focused specifically on improving the health care literacy of children and teens, were conducted in an audience response style to gauge recall of the facts. Overall, TBHC embraced the NYC DOHMH's goal of "reducing asthma morbidity and mortality." This was accomplished by improving the quality of care for children and adults with asthma, educating patients about the triggers in their environment, teaching adults and children about managing the condition, and building awareness in the community.

Cancer: The incidence of cancer and the years of life lost to cancer in the borough of Brooklyn are high according to data from the NYC DOHMH. ***Take Care New York*** reports that "the death rate due to cancer has remained fairly steady in Northwest Brooklyn during the past decade. The 2003-2004 average annual cancer death rate was more than 15% higher than both the Brooklyn and NYC overall rates (188/100,000 vs. 160/100,000 in Brooklyn and 161/100,000 in NYC)." In 2008, 169 women were diagnosed with breast cancer, 15 with cervical cancer, and 122 persons with colorectal cancer at TBHC.



TBHC has made significant improvements in its Division of Oncology and in the delivery of care to individuals diagnosed with cancer. The Division has been upgraded with new equipment and new work processes that make it much more patient-friendly and patient-centered. Delays in diagnosis and patients not following up have traditionally been problems in the community that TBHC serves. Processes have been put in place to track and follow patients once

they have been diagnosed and assist them in receiving treatment. It is hoped that these efforts will improve morbidity and mortality.

TBHC's Cancer Communication Department has been running cancer prevention and awareness programs as well as support groups for patients diagnosed with cancer for the past 15 years. These include: *I Can Cope*, an educational program designed to empower patients and individuals facing a diagnosis of cancer; the *Man-**to-Man Program***, **a monthly support group for men** diagnosed with prostate cancer; and, the *Look Good, Feel Better Program*, a free program which teaches beauty techniques to women with cancer to help them combat the appearance-related side effects of cancer treatment.

Funded by the Susan G. Komen Foundation, breast cancer awareness and screening programs offer uninsured women over 40 free mammograms and Pap smears. Other services are offered on a sliding fee scale. The program maintains high visibility in the community through health fairs in neighborhood churches, senior centers, community centers, and businesses. More than 320 women were surveyed for breast and cervical cancer in 2008, and more than 10,000 women were educated about cancer issues. Participation in local breast cancer walkathons, sponsored by local, regional or national advocacy groups, also helped to promote the visibility of TBHC's Cancer Communications program. TBHC's Cancer Communications Department maintains strong ties to the National Cancer Institute's Cancer Information Service (CIS), the American Cancer Society's Brooklyn Breast Health Partnership, and other local and regional entities.

TBHC's Cancer Resource Center helps cancer patients and others gain the information needed to manage life during and after treatment. The center is the only one of its kind in New York City. Open to the public, cancer patients, their family members, friends and caregivers can work one-on-one with a specially trained volunteer cancer survivor in a private area to learn how to navigate the plethora of information available about cancer treatments, clinical trials, early detection guidelines and much more.

Diabetes: TBHC's Diabetic Education program began based on a need within the hospital and the community. The program caters to thousands of patients through collaborative efforts with the departments of Medicine, Family Practice and Pediatrics. Monthly group sessions are held to address self-management. The program is part of the New York State Department of Health's Diabetic Registry. In May 2008, the Nurse-Family Partnership Program was added as an outreach component. The program targets low income women and children for home visits from midwives, nurses, and nurse practitioners. The program now serves more than 200 and is expected to reach its capacity of

300 by December 2009. TBHC is embarking on obtaining *Medical Home* status for its Family Medicine Ambulatory Care Center, with a focus on diabetes management.

TBHC also offers community based dialysis treatment at its Rockwell Dialysis Unit. The service provides access to this essential care for a mostly minority, low socio-economic population with end-stage renal disease due to complications of diabetes, hypertension and other chronic illnesses. Almost 100 patients access the service each day. Patient education is an important component of treatment for this population.

Heart Disease: The NYCDOHMH reports that in New York City heart disease is the number one cause of death for both men and women regardless of race or ethnicity. As a diagnostic care leader in the New York metropolitan area, TBHC offers some of the most up-to-date cardiac diagnostic technology to patients in its community. These include:

- The latest 3D video echocardiography complemented by an advanced Picture Archiving System
- Cardiac stress test
- Nuclear studies
- All-digital catheterization laboratory
- Rapid, web-based EKG interpretations
- Holter monitors and event recorders
- Pacemaker clinic
- ABI/PVR testing
- Vascular ultrasound

L-R: Councilwoman Letitia James, Congresswoman Yvette Clarke, Dr. Richard B. Becker, Samuel Lehrfeld and Earl Weiner

Recent funding for the GE LightSpeed 64 Slice VCT, the 3D video echocardiography with advanced Picture Archiving System (PACS) Computed Tomography (CT) imaging system, now allows TBHC physicians to more quickly obtain the information they need to diagnose disease and life-threatening illnesses, including cardiovascular disease, stroke and chest pain. The system has the capacity to capture images of a beating heart in five seconds, an organ in one second and perform whole body trauma scanning in ten seconds, which is more than twice as fast as conventional multi-slice CT scanners. The speed is particularly beneficial for children and for older patients who are on ventilators. The purchase of the $1.4 million scanner was made possible, in part, through a grant secured by local Congresswoman Yvette Clarke.

As standard practice, TBHC integrates results from all of technologies into a single state-of-the-art image management system, letting cardiologists make side-by-side comparisons of multiple test

results. In addition to ensuring accurate diagnoses, this cutting edge imaging technology is also used to perform interventions with a degree of precision undreamed of just a decade ago. TBHC now has a growing list of such safer, less invasive cardiology procedures that gets the patient out of the hospital much faster:

- Surgically implanted permanent pacemakers
- Pacemaker adjustment
- Automated implantable cardiac defibrillator (AICD)

Ease in accessing and being cared for are also essential. Cardiologists and other providers take the time to explain treatment procedures, to educate patients about their condition, and to answer all related questions. A single telephone number is available for appointments and talking with specialists. TBHC actively seeks to allow admitting privileges to the most qualified cardiologists in the area so that patients in the community can receive the best available care.

Wellness for Life: Now in its 14th year, *Wellness for Life* is a nutritional program designed to help fight serious diseases through diet. Founded by Karen Congro, RD, a TBHC Nutritionist, this outreach effort takes the form of a monthly seminar. Each session features lectures by TBHC specialists; educational films; and discussions on how to fight cancer, heart disease, diabetes, hypertension, and other chronic ailments through good nutrition. Information packets on health, nutrition, weight loss, exercise, and wellness are also distributed. A healthy recipe segment offers a 'how to' approach for altering diets or adjusting ingredients in cultural and ethnic foods. There are more than 300 registered members in the program and more than 70-85 attend the monthly meetings. This program is tailored for the community that TBHC serves, and is an important outreach outlet for the Oncology, Internal Medicine, Family Medicine, and Cardiology Departments.

"You Lose, You Win!" Yvonne Fergeson weighs herself for the Weight Loss Challenge. Every two months a prize is awarded to whoever sheds the most pounds.

3) Infectious Disease

TBHC concentrates on infectious disease through PATH, its Program for AIDS Treatment and Health. PATH provides medical and psychosocial care for adults, teens, children and families living with HIV. In 2007, Brooklyn ranked second in new reported HIV diagnoses in New York City, with 999. Manhattan was 1st with 1054, followed by the Bronx with 876, Queens with 549, Staten Island with 72; unknown/outside NYC accounted for 237. The total, therefore, was 3,787. There were 347 new

HIV-positive patients entering care with The Brooklyn Hospital Center in 2008. Fifty-seven were identified through the hospital's HIV testing program; the remainder entered care through referrals, the hospital's HIV service, or on the recommendation of friends or community agencies.

PATH has an active staff outreach team, which includes the executive director, the director of clinical services, the family program director, the social work manager, and a clerk, in addition to an Outreach Coordinator. The team meets approximately every three weeks to guide outreach efforts. Members of the team frequently visit community agencies to offer presentations to staff and clients, encouraging referrals for HIV testing, and care for those who are HIV positive. They facilitate entry into care for clients who are ready.

PATH also conducts special HIV awareness and prevention events throughout the year, coordinated with National HIV Testing Day, National African-American Testing Day, National Latino Testing Day, and World AIDS Day. PATH employees and volunteers staff the hospital lobby and distribute information about HIV prevention, and how to access care. In most cases, individuals who stop by can, if they wish, receive HIV testing immediately in a separate, private area.

PATH offers HIV counseling and testing at the hospital all day, five days a week, in the clinic and in the Women's Health Center. PATH assesses the effectiveness of its outreach program primarily through weekly data reports. Each week the outreach coordinator submits a written report detailing the number of individuals reached, how many new appointments were made for HIV care, and number of persons who kept appointments. The data is reported at each staff outreach team meeting, along with information about the source of referrals. The HIV counselor submits a weekly report indicating the number of individuals tested and the number of positive results. The outreach coordinator also tracks whether the newly diagnosed clients accept an appointment for care with The PATH Center (almost all do). These data are also summarized in a year-end report to PATH's major grant funder, the Federal Ryan White program.

TBHC has linkage agreements with more than 50 community-based agencies for a range of activities related to HIV education, prevention, awareness-building and treatment. These include collaborations with:

- CAMBA, Church Avenue Merchants Block Association, which provides "prevention with positives" services to help our HIV-positive patients avoid passing the virus to others, and to protect their own health.

- Diaspora (formerly Haitian Women's Program), which provides COBRA (Medicaid funded) intensive case management, including home visits and escort to appointments, for HIV-positive clients with critical issues.

- New World Creations Resource Center, a food pantry service that distributes food to the hospital's PATH Center clients. The distribution takes place in conjunction with PATH's nutritionist to ensure that foods given to the clients are appropriate for their particular nutritional needs.

- Project Street Beat, a program of Planned Parenthood, which seeks to engage HIV-positive clients who have dropped out of care, and re-engage them. Street Beat frequently brings clients to PATH to re-enter care, and appreciates that PATH is flexible and tries to accept patients whenever care is needed.

TBHC is concurrently pursuing *Medical Home* status for its PATH Centers, at the downtown campus and in the Flatbush area, which is the epicenter of HIV/AIDS pandemic in Brooklyn.

C. Status of Priorities

"Keeping Brooklyn healthy." This is the commitment that binds TBHC to the community it serves. The hospital is committed to addressing the health care needs of the 1.2 million people in its service population. With the latest in technology, and nearly 3,000 dedicated medical professionals and staff, TBHC works with its community partners to ensure that its programs -- particularly those which address disparities in care, prevalent conditions, and emerging health issues -- will continue to be offered in order to meet the needs of the community.

D. Non-Prevention Priorities Considered in Assessment Process

While TBHC will focus on the prevention agenda items outlined in this report; it will also address services and programs which meet important needs in its community. These other priorities include:

Obesity

The Brooklyn Borough President's Office has noted that obesity is at epidemic proportions in the borough. While TBHC promotes a healthy lifestyle and good nutrition, its Bariatric Surgery Weight Loss Program offers Bariatric or gastrointestinal surgery, which can be a lifesaving option for those with severe obesity (100 pounds overweight or more). TBHC surgeons recommend the operation if a patient suffers from a weight-related health problem such as type-2 diabetes, heart disease, sleep apnea or high blood pressure. The program receives internal referrals, and patients also come from community physicians and area HMOs. Bariatric patients must undergo a thorough psychological evaluation prior to the surgery.

Pediatric Safety

As part of its community education efforts, TBHC's Pediatric Center offers free courses in infant and child Resuscitation (CPR), Car Seat Safety, Choking. First Aid: Burns, Lacerations, Falls, and Poisonings. This free infant CPR training and certification, run by board certified pediatric critical care specialists and specially trained pediatric hospitalists, will cater to parents and care takers.

Stroke

TBHC treats acute and chronic vascular disorders by incorporating recent developments in emergency medicine, stroke neurology, microneurosurgery, neurointensive care, and rehabilitation neurology. Care is coordinated from the moment of first contact by a skilled team available to respond 24-hour /7 days a week. Thrombolytic therapy and state of the art neuroimaging is available for all neurovascular emergencies. Comprehensive stroke treatment includes follow-up care and rehabilitation including appropriate occupational, speech therapy and educational materials for patients and their families. Additionally, the Department of Neurology focuses on training medical students and residents to provide modern care to patients with neurological disease and translate advances in the basic and clinical sciences into meaningful therapies.

Key Statistics 2008

Service Area Population	1.2 million
Certified Beds	464
Inpatient Admissions	20,000
Outpatient Visits	220,000
Emergency Visits	65,000
Medical Staff	600
Nursing Staff	620
Average Length of Stay	5.4 Days
Dialysis Center Treatments	30,000
Employees	2,900
Annual Operating Budget	$336 million

Healthcare Services offered at The Brooklyn Hospital Center

V. Three-Year Plan of Action

Ambulatory Care	Internal Medicine	Surgery
» Outpatient Care Center - Downtown Campus » Children's Health Center » Women's Health Center » Prenatal Care Assistance Program (PCAP) » Dental Care » PATH Center » Women, Infants and Children Program (WIC) » Bariatric/Wound Care Center	» Allergy & Immunology » Cardiology » Dermatology » Dialysis Services » Endocrinology » General Medicine » Gastroenterology (GI) » Geriatrics » Hematology/Cancer Care » Infectious Diseases » Nephrology (Kidney) » Neurology » Pulmonary Medicine » Rheumatology » Urology	» General Surgery » Bariatric (weight Loss) » Cardiothoracic » Head and Neck » Neurosurgery » Ophthalmology (eye care) » Oral and Maxillofacial Surgery » Orthopedics » Otolaryngology (ENT – ear/nose/throat) » Pediatric Surgery » Plastic Surgery » Podiatry » Urology » Vascular Surgery
Radiology	**Pediatrics**	**PATH Center - Program for AIDS Treatment & Health**
» Nuclear Medicine	» Pediatric Hematology/Oncology » Pediatric Genetics	
Community Family Health Centers	**Dental Care and Oral Surgery**	**WIC Center - Women, Infants and Children Program**
Obstetrics/Gynecology	**Specialized Services**	**Support Centers**
» Gynecology Services » Gynecologic Oncology » Perinatal Diagnostic Center » Reproductive Genetics » Birthing Center/Labor and Delivery	» Support Groups » Cancer Resource Center » Home Care » Nurse-Family Partnership » Pastoral Care » Rehabilitation Services » Respiratory Therapy » Speech and Hearing	» Detox Unit » Geriatric Unit » Hospice Unit » Sleep Center » Stroke Center
Emergency Medicine	**Family Medicine**	**Pharmacy**

A. Strategies for Selected Priorities

In 2008, The Brooklyn Hospital Center initiated a strategic plan, to focus on advancing clinical care, education, and research in order to support its commitment to “Keeping Brooklyn Healthy.” TBHC applied input from a number of key stakeholders, including individuals from the community and a representative of TBHC’s Community Advisory Board (CAB), to formulate the strategic plan. The following goals were adopted for the next five years:

1. Provide superior access to patient care of outstanding quality and safety.

Strategy - The Brooklyn Hospital Center will develop standardized processes to enhance our quality and efficiency, built on a thorough grasp of the barriers impeding patient access to care. We will also update our facilities and technology to ensure our staff has the tools they need to deliver high quality, safe care, while creating a workforce committed to safety and excellence.

Measures of Success - The Brooklyn Hospital Center will gauge the success of this initiative with evidence of proven progress in attaining quality goals, including awards, growth in elective case volume, improved patient satisfaction and patient flow, a lower number of sentinel events and a decline in patient no-shows.

2. Create a patient-focused culture that values customer service.

Strategy - We will strengthen our staff development programs to promote a patient-centered customer service culture among our employees, while focusing on patient and customer service in recruiting and orienting new employees. The Brooklyn Hospital Center will also create comprehensive internal communications and recruitment orientation programs, and will develop performance management techniques to ensure the highest level of service.

Measures of Success - We will track our progress toward this goal by assessing improved patient, staff and physician satisfaction, shorter hospital stays, increased patient flow, higher patient volume, and fewer admissions through our Emergency Department.

3. Develop destination clinical programs within a modern infrastructure.

Strategy - The Brooklyn Hospital Center will target its growth and investment toward select destination clinical programs that meet specific criteria, and will position our primary care programs as a destination for patients seeking outstanding health services.

Measures of Success - The Brooklyn Hospital Center will measure the level of success of this initiative through greater volume in destination programs, increased market share, improved payer mix, higher clinical margins and expansion of our service area reach.

4. Achieve financial strength for The Brooklyn Hospital Center.

Strategy - We will implement revenue enhancement measures, significantly increase philanthropic support, and enact cost containment measures to nurture our long-term fiscal health and well-being.

Measures of Success - We will ascertain the effectiveness of our fiscal programs by attaining our financial goals and operating targets, as well as increased employee and provider satisfaction.

5. Become the employer of choice for a committed and caring staff.

Strategy - We will attain this goal by providing a supportive work environment that strengthens employee satisfaction throughout The Brooklyn Hospital Center.

Measures of Success - Improved retention rates; recruitment success; higher employee, patient and physician satisfaction; increased employee referrals and better performance reviews will all be indicators of our success in this area.

6. Build a destination medical staff.

Strategy - By fostering strong relations with and between employed and voluntary physicians on our staff as well as physicians in the community who are not on our staff, we will achieve this goal. We will also aggressively market and promote our physicians who are involved with destination programs.

Measures of success - We will monitor our progress toward this goal by measuring improved physician satisfaction, growth in elective cases, more new patient visits, external recognition of our physicians, an increase in private pay volume and higher patient referrals.

7. Strengthen The Brooklyn Hospital Center's research and educational programs.

Strategy - We will work hard to ensure that all our residency programs are consistently excellent and provide high quality training. The Brooklyn Hospital Center will also build its clinical and population-

based research programs, and will assume a leading role in providing health education to our community.

Measures of success - The Brooklyn Hospital Center will judge the effectiveness of this initiative by a higher number and dollar amount of grants and contracts, increased peer-reviewed publications, more science abstracts and presentations, and greater involvement in local and national professional societies. Other measures will include improved National Residency Match Program results, improved board passage rates and scores, and a higher number of advanced degree Registered Nurses.

8. **Position The Brooklyn Hospital Center as a leading and respected health care and educational resource to the communities of Brooklyn and greater New York.**

Strategy - Through comprehensive, fully integrated marketing and communications programs, we will build market awareness and bring The Brooklyn Hospital Center brand to life. We will supplement these programs by engaging in community outreach to serve a vast array of neighborhoods, agencies, organizations, schools and individuals. And, we will foster and implement public and media relations initiatives that deliver clear, focused messages to the community.

Measures of success - We will conduct comprehensive consumer surveys to determine greater brand recognition, and evaluate key indicators including increased website hits, improved market share, enhanced physician referral programs, and higher participation in our community outreach and education programs. A key component of achieving this goal is creating sustainable, cost-effective integrated marketing.

These goals were highlighted in a brochure with an accompanying document explaining the strategic planning process. To date, TBHC has posted its Strategic Plan to its web site at *tbh.org* and mailed the Strategic Plan package to employees, physicians and the Community Advisory Board, as well as mass mailings to legislative officials, community based organizations, and other key constituents.

The Brooklyn Hospital Center also revised its vision and values statement to reflect its strategic goals:

Our vision

We will be a destination provider of top-quality and compassionate health care to the people of Brooklyn and greater New York

Our values

Our core values CREATE our work culture.

Community Service

We are dedicated to improving the health and well-being of the people of Brooklyn and greater New York.

Respect

We honor the dignity and diversity of our patients, staff and community.

Efficiency

We judiciously manage the human and financial resources entrusted to us.

Accountability:

We are all individually responsible for the success of The Brooklyn Hospital Center.

Teamwork

As individuals and departments, we work together to help The Brooklyn Hospital Center realize its greatest potential.

Excellence

We perform work of the highest quality to deliver outstanding care.

The Brooklyn Hospital Center's Strategic Plan will inform the Three-Year Plan of Action for its Prevention Agenda Priorities.

Goals	Strategies	Actions
Formalize TBHC's Community Service Plan process	Form an internal Community Service Plan Committee	Create a tool to measure community health priorities Monitor progress of prevention agenda priorities
Engage in community outreach to serve neighborhoods, agencies, organizations, academic institutions, and individuals in TBHC's service area	Use a more demographically-focused approach to community outreach by continuing and developing programs, initiatives and events to address and meet community needs	Increase participation in key community-based health fairs Host annual TBHC Health Fair in Fort Greene and at the Family Health Centers Streamline health screenings with community partners
Formalize Relationships with Community Partners in context with TBHC's *Community Service Plan*	Foster relationships with existing community partnerships Develop new community partnerships	Initiate a Clergy Forum for input from faith-based organizations Hold a legislative reception to collectively engage elected officials on TBHC-community health priorities Host a Community Partners meeting to foster dialog on prevention agenda goals

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/Community Partners
ACCESS TO HEALTH CARE				
Provide superior access to patient care of outstanding quality and safety Develop destination clinical programs within a modern infrastructure Increase community awareness of TBHC primary and specialty care services and programs Create a patient-focused culture that values quality care, customer service and patient satisfaction	Existing	Strengthen relationships between clinical leaders attending and community physicians to ensure streamlined access to TBHC services -Improve communication between primary care physicians and TBHC Emergency Department -Enhance physician referral management process to improve patient access, flow and scheduling	Increased number of outpatient visits Increased number of admissions Decrease in patients using TBHC Emergency Department for primary care	Collaborate with community partners and local health departments to address public health priorities for the community of Brooklyn and TBHC's immediate neighborhoods -Work proactively with the NYS and City DOH in order to preserve the many vital services TBHC provides to its community -Foster active participation of Community Advisory Board in educating the community about TBHC -Work with Brooklyn Community Boards within TBHC's immediate community and Family Health Center neighborhoods -Develop and strengthen relationships with city and state legislators and community-based organizations such as faith-based organization, businesses, academic institutions-health/social service agencies, etc.
	Existing	Strengthen medical and surgical specialty programs for adult and pediatric care	Increased number of inpatient visits	
		Develop performance management techniques to measure, monitor, and ensure patient satisfaction	Improved patient satisfaction scores and peer group percentile ranking	
	Existing	Create a 'Patient-Centered Medical Home' that promotes continuity of care	Increased number of outpatient visits	
	New	Strengthen staff development to promote a *Service Excellence* and create a patient-focused customer service culture	Improved patient satisfaction scores and peer group percentile ranking	
	New	Extend hours of operation for Ambulatory/Outpatient Care services -Provide transportation assistance for patients	Decreased percentage of missed appointments	
	New	Centralize ambulatory care and cashiering function	Improved access for patients to health care services; streamlined payment process; improved access to Financial Assistance Program	
	New	Update facilities to improve patient access and flow: -Emergency Room expansion -Expansion of Pediatric Intensive Care Unit (PICU) -Upgrade and maintain on- and off-site community Family Health Care Centers	Improved quality of access and service to patients and their families	
	New	Expand TBHC community health and wellness programs through expanded outreach to community-based organizations	Increased number of community events promoting TBHC clinical programs and support services	

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/Community Partners
CHRONIC DISEASE: CANCER, DIABETES AND HEART DISEASE	New	Build clinical and population-based research programs and clinical services that address Chronic Disease prevention agenda priorities and improve access to cancer care and education	*Please see details in the following sections on cancer, diabetes and heart disease*	
	Existing	Focus on preventive cancer, diabetes and heart disease conditions that affect Brooklyn and TBHC's immediate community	Increased number of screenings and follow up care	
	Existing	Partner with other institutions and community-based organizations to provide asthma, cancer, diabetes and heart disease education programs to the Brooklyn community		
	New	Offer educational programs to community physicians and general public	Increased portfolio of education events and materials available for physicians, patients and Brooklyn community	
	New	Develop educational materials to promote TBHC clinical programs		
	New	Develop Internet resources to drive patients to appropriate sources of information and clinical care	Increased web visits and length of page visits	

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/ Community Partners
CANCER	New	For TBHC community standardize education, surveillance, prevention, and treatment, addressing areas of clearly underserved and under-addressed diagnoses:		Develop and coordinate a Brooklyn-based, all-hospital and all-provider coordinating council to broadly implement evidence-based standardized processes so that patients can expect to receive appropriate information, counseling, evaluation and care throughout the borough
	New	Develop and broadly distribute effective education materials that empower patients to be their own care advocate. Support this with an information line patients can call to discuss their concerns or needs	Number of calls received and the referrals made for further care	
	New	Develop a system of screening that provides easy access for patients on their own initiative or at the direction of their personal physician	Track the number of patients who called, who were referred to a participating physician and who kept their appointment	
	New	Create a list of participating physicians who agree to see non-emergent referred patients within two (2) business days and who agree to track and share data on scheduled and kept appointments (Participating physicians will be asked to obtain and submit data on advice, follow-up, referrals, and other items needed to follow and further redesign the overall plan of care for the target patient population.)	Number of patients who do not keep scheduled referral appointments Track reason to improve the design of the effort and to improve access	
	Existing	Develop, deploy and coordinate use of evidence-based screening, referral and treatment protocols for cancers of the breast and colon-rectal cancer	Track the number of physician offices where a developed resource manual, with supporting medical literature and screening care paths, have been distributed along with a discussion of the project by a TBHC expert Track the number of physician offices receiving the manual who agree to be "participating physician" sites	

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/ Community Partners
CANCER - continued	New	Build a subspecialty evaluation and treatment referral network that agrees to provide patients with protocol driven care within clearly defined, efficient time frames	Measure time to appointment, time to results reporting, time to patient follow-up	
	Existing	Build/enhance patient navigator services	Number of patient navigator(s) hired	
	New	Create a system of follow-up to remind patients of the need for further and future care	Measure patient follow-up for procedures in the screening and future surveillance time frames	
	New	For patients with cancer, create a multidisciplinary tumor board that will review new diagnoses and create a data driven plan of care in conjunction with the patient's physician	Track all reviews and referrals in conjunction with the tumor registry Track and report diagnosis stages, morbidities and mortalities	
	New	Maximize TBHC's relationship with NewYork-Presbyterian to provide direct or referral access to clinical trials for those patients whose care needs exceed what is available in our community	Reach out, through patients with high risk indicators, to screen potentially affected family members	

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/ Community Partners
DIABETES	New	Create a systematic stepwise development of Patient Centered *Medical Home* to focus on diabetic patients that is proactive, not reactive and which can be replicated	Number of patients under the care of a personal physician or single provider Number of medical practice teams responsible for the ongoing care of patients	Develop and coordinate a Brooklyn-based, all-hospital and all-provider coordinating council to broadly implement evidence-based standardized processes so that patients can expect to receive appropriate information, counseling, evaluation and care throughout the borough Collaboration with the primary care physician through the diabetic registry and by making proactive appointments Collaborative relationships with FQHC, NYC DOH A1C Registry, National Committee for Quality Assurance (NCQA) to assist with available resources Collaboration with TBHC Family Medicine inpatient Hospitalist Services for critical care management
	New	Designate a comprehensive diabetic care clinic at TBHC Family Medicine Center that emphasizes behaviorally self-management support that gives priority to increasing patients' confidence and skills so that they can be the ultimate manager of their illness	Number of physician/team referrals to other qualified professionals to meet patients' health care needs	
	New	Develop and implement evidence-based guidelines and support those guidelines through provider education, reminders, and increased interaction between generalists and specialists	Track number of diabetic patients who are in compliance with physician care directives, i.e., medications, diet and exercise, blood pressure, cholesterol levels, etc.	
	Existing	Reorganize team function and practice systems (e.g., appointments and follow-up) to meet the needs of diabetic patients	Number of patients receiving integrated services – sub-specialties, hospital, home health service, community-based, etc.	
	New	Enhance information systems to facilitate the development of disease registries, tracking systems, and reminders and to give feedback on performance	Number of patients entered into registries Number of patients enrolled in the TeleCare Management Program Percentage of re-hospitalization reduction rates for patients in the TeleCare program	
	New	Bariatric Center of Excellence: To appropriately accommodate patients and meet the certification for this program, TBHC will create an in hospital wound care center	Number of new patients; reduction in amputations	

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/ Community Partners
HEART DISEASE	Existing	For TBHC community, standardize education, surveillance, prevention, and treatment addressing healthy lifestyle and treatments to reduce the risks or delay the development or consequences of heart disease	Percentage of patients diagnosed, number of screenings; number of educational workshops	Develop and coordinate a Brooklyn-based, all-hospital and all-provider coordinating council to broadly implement evidence-based standardized processes so that patients can expect to receive appropriate information, counseling, evaluation and care throughout the borough
	New	Develop and broadly distribute education materials that empower patients to track[1] and make knowing and smart lifestyle choices: stop smoking, diet, exercise, diabetes control and care, etc. Support this with an information line patients can call to discuss their concerns or needs	Track the number of calls received and the referrals made for further care Track the number of patients presenting for co-morbid disease prevention and control counseling (diabetes, diet, smoking cessation, etc.)	Launch a well-coordinated effort between TBHC sub-specialty providers and current and anticipated additional primary care, medical home modeled, centers
	New	Develop a system of screening that provides easy access to subspecialty care and diagnostic services for patients and their personal physicians	Track utilization, time from call to appointment, patient and referring physician satisfaction	
	New	Create a list of participating physicians who agree to see non-emergent referred patients within two (2) business days and who agree to track and share data on scheduled and kept appointments.[2]	In cooperation with patient primary care physicians, track whether actionable diagnoses are treated and whether effective treatment modalities are employed	Coordinate efforts locally with those FQHCs that exist within TBHC primary and secondary service areas.
	New	Develop, deploy and coordinate use of evidence-based screening, referral and treatment protocols for risk	Track the number of patients who called, who were referred to a participating physician and who kept	

[1] The tracking tool will make patient-provider interactions effective, data-based and directed.

[2] Participating physicians will also be asked to obtain and submit data on advice, follow-up, referrals, and other items needed to follow and further redesign the overall plan of care for the target patient population.

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/ Community Partners
HEART DISEASE - continued		factors, chest pain, exercise intolerance, and other indicia of actual or anticipated cardiac and vascular disease	their appointment Call all patients who do not keep scheduled referral appointments and track the reasons in order to test and improve the design of the effort to improve access	
	New	Build a subspecialty evaluation and treatment referral network that agrees to provide patients with protocol driven care within clearly defined, efficient time frames Build/enhance patient navigator services specific to heart disease and its main contributing risk factors	Track the number of physician offices where a developed resource manual, with supporting medical literature and screening care paths, have been distributed along with a discussion of the project by a TBHC expert Track the number of physician offices receiving the manual who agree to be "participating physician" sites	
	Existing	Create a system of follow-up and counseling to remind patients of the need for further and future care and to coach them in accepting a healthier lifestyle	Measure time to appointment and results reporting, time to patient follow-up	
	Existing	Maximize our relationship with NewYork-Presbyterian to provide direct or referral access to highly technical interventional and diagnostic modalities that exceed what is available in our community	Measure patient follow-up for procedures in the screening and future surveillance time frames Track all diagnoses and co-morbidities in a registry and create a mechanism for longitudinal review to be able to demonstrate actual population-based impact at the level of both primary or secondary heart disease and contributing co-morbid risk factors Reach out, through patients with high risk indicators, to potentially affected family members for screening	

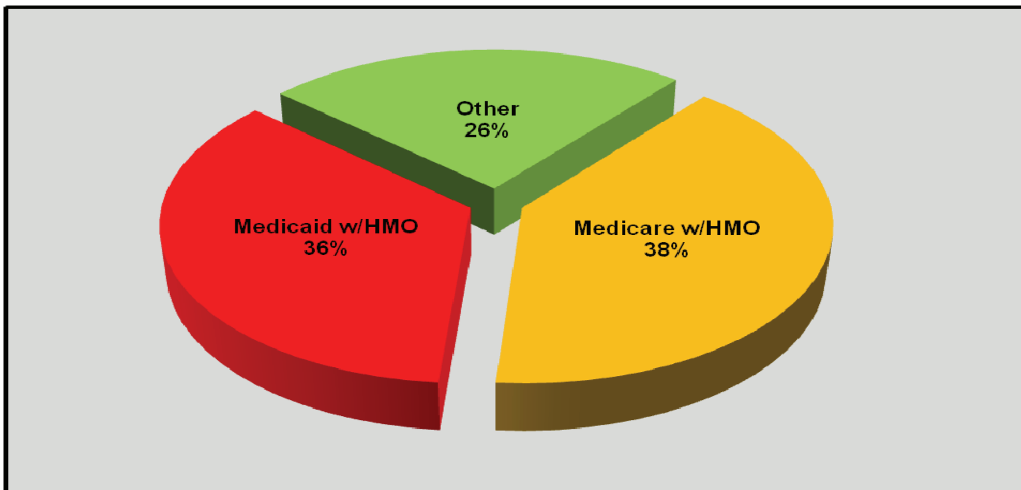
Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/ Community Partners
HEART DISEASE - continued	New	Create or participate in community, city or borough-wide initiatives/registries to study clinical processes and outcomes for cardiac patients	Number of patients enrolled in registries Number of studies approved by TBHC Institutional Review Board	Partner with area hospitals/ network and affiliate
	New	Develop an educational curriculum for patients stressing prevention, diagnosis, and treatment of heart disease	Number of patients receiving educational material Number of patients participating in workshops	Partner with TBHC Wellness for Life to reach a wider span of its members Collaborate with local faith-based and community-based organizations
	Existing	Increase collaboration with hospital and community groups to increase risk factor evaluation, and augment community screenings and workshops	Percentage of patients diagnosed Number of screenings Number of workshops	Family Health Centers Community based organizations
	New	Utilize 3D/4D software to provide cardiologists with state of the art diagnostic capability	Percentage of patients diagnosed	Work with legislators to ensure TBHC receives appropriate support

Prevention Agenda Priority	New/ Existing Priority	Priority Focus by Hospital and Community Partners	Strategies To Measure Prevention Agenda Priority	Plan to Modify Strategies for Ongoing Input and Support from TBHC/ Community Partners
INFECTIOUS DISEASE: HIV/AIDS				
Develop destination HIV/AIDS clinical programs, education and community outreach through TBHC PATH Center	Existing	Expand community HIV/AIDS awareness, health and wellness programs at the downtown campus and in the Flatbush area	Number of AIDS/HIV screenings and diagnosis Number of *new* PATH Center patients	Continue to collaborate with community partners and local health departments to address HIV/AIDS awareness in the community of Brooklyn and TBHC service area
Build a destination medical and support services staff	Existing	Create a "Patient-Centered Medical Home" that promotes continuity of care and family support services	Percentage of patients receiving *ongoing care* through the PATH Center	-Foster active participation of PATH Community Advisory Board in education of the community
	New	Achieve *Medical Home* status for its PATH Centers, at the downtown campus and in the Flatbush area	Percentage of patients who indicate family involvement Percentage of patients who note that care/outreach are culturally-centered Percentage of patients who claim PATH creates a level of partnerships between the patient and provider	-Work with Brooklyn Community Boards within TBHC's immediate community and Family Health Center neighborhoods -Develop and strengthen relationships with city and state legislators and community-based organizations -Develop and strengthen relationships with city and state legislators and community-based organizations, businesses, academic institutions, health/social service agencies, etc.
	Existing	Build clinical and population-based research programs that focus on HIV/AIDS preventive health conditions that affect Brooklyn and TBHC's service area	Number of research initiatives	
	Existing	Partner with other institutions and community-based organizations to provide HIV/AIDS education programs to the Brooklyn community	Number of new partnerships Number of new HIV/AIDS community education and outreach events	

VI. Financial Aid Program

A. Successes and Challenges

While TBHC provides financial aid to patients in accordance with Public Health Law 2807 (k) (9-a), the underlying motivation for its Financial Assistance Program (FAP) is to address the needs of the indigent, underinsured and uninsured in the community. FAP information is distributed to all patients through admissions material, a brochure, and financial counseling. The application process is simple and the program offers a fee-scale for those who qualify. FAP facilitates access to care for all who need it, despite their ability to pay. In 2008, nearly 1,000 patients benefited from FAP. In response to the economic downturn, TBHC has increased dissemination of FAP information to patients. TBHC is committed to providing these patients with the same quality care rendered to all patients.



VII. Changes Impacting Community Health/Provision of Charity Care/Access to Services

A. Potential Impacts

The Brooklyn Hospital Center remains committed to providing important community health services that include education and prevention awareness programs. Given the increasingly austere financial climate, TBHC will continuously reassess the relative value of these types of programs against its ability to deliver health care services to the community, making the appropriate adjustments as necessary.

The impact of the State's reform on TBHC will be impossible to mitigate solely with expense reductions in so short a period of time. Service contraction/reduction would be the only method to address such a

revenue shortfall. The Brooklyn community in and around TBHC has been hard hit with hospital and outpatient facility closures and the health status of its residents, along with high PQI numbers, is alarming.

With reductions in accessible care, coupled with the disproportionate number of Medicaid recipients in Brooklyn and unemployment (which translates into more residents losing health benefits and applying for government assistance), preventing many of the avoidable hospitalizations that the PQI data points out, will not occur without a transformational shift in service availability. Long term, this will likely require a comprehensive approach to healthcare in Brooklyn.

TBHC contributes to the economy of Brooklyn as an employer and purchaser of goods and services. With almost 3,000 employees, TBHC is a major employer in Downtown Brooklyn. These employees depend on TBHC for salaries that generate business sales, tax revenue, and household earnings. As a purchaser, TBHC also fuels millions of dollars in revenues to pharmacies, medical suppliers, and other vendors in the area. The hospital's most critical economic impact in the community, however, is as a supplier of health care in an urban setting where serious disparities exist. In the face of the national economic crisis, TBHC has determined, through its strategic plan, to continue measuring its economic impact in the community. The hospital is dedicated to combining sound business practices with compassionate, efficient care to ensure that it remains a viable health care entity.

VIII. Dissemination of the Report to the Public

TBHC is proud of its history of outstanding service to the community. This CSP reflects its commitment to continue that legacy of excellence. This report will be provided to the public through the following avenues:

- Preparation of a summary brochure
- The Community Advisory Board
- A mass mailing to local legislators and select members of the community
- The organization's web site and TBHC Intranet
- Presentation and handouts at Community Board meetings
- Dissemination at TBHC and its Family Health Centers

IX. Financial statement

The Brooklyn Hospital Center Financial Information

Year Ended December 31, 2008

I. Revenue	
Net patient service revenues	350,176,117
Other revenue	28,700,556
Government Grants	4,986,467
Research and Medical Education Revenue	22,190
Total revenue	383,885,330
II. Expenses	
Salaries	205,949,387
Fringe Benefits	44,225,862
Supplies and Other Expenses	96,627,279
Depreciation and Interest	17,060,221
Bad Debt Expense	15,981,226
Total expenses	379,844,015
III. Other Item	
Charity Care	31,599,444
IV. Assets	220,847,135
V. Liabilities	170,366,355
VI. Fund Balance	50,480,780

Sources

Goranson, C., Kum, S., Jasek, J., Olson, C., & Kerker, B. (2009). The New York City Community Health Survey Atlas, 2007. The New York City Department of Health and Mental Hygiene, 2009. Retrieved November 11, 2009, from http://www.nyc.gov/html/doh/downloads/pdf/epi/nyc_commhealth_atlasv2.pdf

Graham, Y. (n.d.). *Health Disparities in New York City*. Retrieved November 11, 2009, from www.wwrl1600.co/HealthDisparities.ppt

New York City HIV/AIDS Annual Surveillance Statistics, New York City Department of Health and Mental Hygiene

New York State Department of Health

Olson, E. C., Van Wye, G., Kerker, B., Thorpe, L., & Frieden, T. R. (2006). *Take Care* Greenpoint. NYC Community Health Profiles, Second Edition; 8(42):1-16.

U.S. Census. (2008). Brooklyn Population Info According to the US Government's Census Bureau estimate of 2008. Retrieved November 11, 2009, from http://www.brooklyn.com/population.html